

CALIFORNIA
DEPARTMENT OF
MENTAL HEALTH
CULTURAL
COMPETENCE PLAN

BUTTE COUNTY, CALIFORNIA

DECEMBER, 2017

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Criterion 1: Commitment to Cultural Competence

I. County Mental Health System commitment to cultural competence

Butte County Department of Behavioral Health's (BCDBH) procedures and practices reflect the Department's commitment to recognize and value racial, ethnic, and cultural diversity within the county mental health system. The Department has a solid foundation of honoring diversity in program design and implementation.

BCDBH recognizes that cultures within race/ethnicity and culture within community can be diverse and fluid. A person's beliefs, norms, values and language affect how they perceive and experience the world. There is considerable diversity within and across races, ethnicities, and culture heritages. Other cultures and subcultures often exist within larger cultures. As such, BCDBH strives to address the behavioral health needs of prominent cultural groups that encircle race/ethnicity in our community through culturally competence practices.

Developing cultural competence is an ongoing process that begins with cultural awareness and a commitment to understanding the role that culture plays in behavioral health services. This includes establishing and understanding our own organizational identity in order to develop and implement goals to strengthen access to quality service delivery.

BCDBH highlights our strong partnerships with community based organizations and the use of Community Defined Practices in disparate communities to reduce stigma, leading to increased access to mental health services and treatment throughout the county. Internally, BCDBH adapts service delivery based on understanding of cultural diversity through required and voluntary trainings. Programs and services are delivered in a way that reflects the culture and traditions of the people served.

Butte County Department of Behavioral Health values the rich diversity our organization and aspires always to demonstrate respect for the uniqueness of each individual's beliefs, values, traditions, and behaviors.

We encourage each contribution to the establishment of an open, inclusive environment that supports and empowers our employees.

Our commitment to diversity includes both the development of a diverse workforce and the delivery of culturally competent care to our clients.

The first step to providing culturally competent care is to embrace our own diversity – to celebrate, enhance, and learn from it. Our diversity is also our strength.

BUTTE COUNTY BEHAVIORAL HEALTH
CULTURAL COMPETENCE WEBSITE

A. The county shall have the following available on site during the compliance review

Documents	Completed
1. Mission Statement	<input checked="" type="checkbox"/>
2. Statements of Philosophy	<input checked="" type="checkbox"/>
3. Strategic Plans	<input checked="" type="checkbox"/>
4. Policy and Procedure Manuals	<input checked="" type="checkbox"/>
5. Human Resource Training and Recruitment Policies	<input checked="" type="checkbox"/>
6. Contract Requirements	<input checked="" type="checkbox"/>
7. Other Key Documents	<input checked="" type="checkbox"/>

These documents are available upon request.

II. County recognition, value, and inclusion of racial, ethnic, cultural, and linguistic diversity within the system.

- A. A description of practices and activities that demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, and linguistic communities with mental health disparities; include, recognition and value of racial, ethnic, cultural, and linguistic diversity within the system. That may include the solicitation of diverse input to local mental health planning processes and services development.

Mental Health Services Act

The Mental Health Services Act (MHSA) community input processes have regularly provided the opportunity for the Department to engage with unserved and underserved populations and/or their care providers in Butte County. Community meetings are held across the County at locations where translators are available upon request to ensure that monolingual individuals can participate. In addition, focus groups are conducted to obtain input from our unserved and underserved populations. African American, LGBTQI+ (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and other Gender/Sexual minorities), Latino, Hmong, older adults, and consumers from various programs participated. The Cultural Competence Manager and other leadership staff are in attendance during these focus groups. Through this process, MHSA has been instrumental in providing resources for honoring diversity in program design and implementation. MHSA specifically funds several programs that were specially designed for diverse populations, and/or were implemented in communities and at sites where diverse populations may access services.

The Sixth Street Center: provides services to homeless youth between the ages of 14-24 in Chico. A large percentage of those youth 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. 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. 6th 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. 6th Street staff and BCDBH work closely to coordinate care and assist the youth towards wellness and recovery.

African American Family and Cultural Center: integrates African American culture into services that focus on early detection, prevention, and awareness of mental health issues. These services include: outreach to families, increase access and linkage to medical care, reducing stigma associated with mental illness and reducing discrimination against people living with mental illness.

Live Spot programs in Oroville and Gridley: provides prevention services to students from high schools with ethnic populations. 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. The Live Spot offers youth led, youth developed programming, workshops, vocational/job opportunities, mentoring, supportive services and events. The Live Spot employs young people to develop, implement and evaluate Live Spot services. Young people are the primary partners at The Live Spot and are recruited to plan and implement all facets of youth activity at the center, from co-facilitating solution focused group meetings to being trained as youth evaluators.

National Alliance for Mental Illness (NAMI): NAMI Butte County implements mental health awareness, education, support and advocacy programs to support the culture surrounding consumers of mental health services. 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 as family-to-family supports.

Passages: The Older Adult Suicide Prevention and Education Program seeks 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.

Promotores: provides services to the Latino population in the Gridley community and to Latinos and Hmong populations at two specific apartment complexes in Chico. 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.

Stonewall Alliance: The LGBTQI+ Suicide Prevention and Education Program provides suicide prevention, education, and outreach services throughout Butte County to gay, lesbian, bisexual, transgender, queer and intersex (LGBTQI+) youth and young adults, as well as their families, friends, allies and institutions, organizations, service providers and educational facilities.

Wellness and Recovery Centers: There are three Wellness and Recovery Centers located throughout Butte County. These centers are consumer driven and emphasize recovery oriented activities including peer support, socialization opportunities, life skill groups, reintegration into the community, employment services, and medication support. There is an on-site clinician to help consumers run their own groups and provide limited mental health support. At one location there is a warm line, staffed by trained consumers to provide non-crisis assistance to consumers needing support after hours.

Zoosiab: Originally an Innovation program (approved June 2010), designed specifically for the Hmong population. 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.

Workforce and Translation Services

BCDBH is committed to developing a culturally and linguistically competent behavioral health workforce throughout our system of care. The department strives to employ a workforce that reflects the cultural identities of our consumers to ensure effective service delivery.

BCDBH actively recruits for Spanish and Hmong language clinicians, counselors, and interns. Additionally, BCDBH offers a bilingual pay differential pending verification of the employee's language or communication skill ability. Key BCDBH staff in Gridley are bilingual and bicultural employees who are embedded in the community and actively involved in such community activities as soccer, church, cultural events, etc. The Promotores program in Gridley and Chico provides outreach to the Latino and Hmong communities with staff from those communities who are bilingual and bicultural.

Translation services, written and oral, are available through a number of contracted translation service providers if there are no BCDBH bilingual staff available. Staff may also connect individuals to the AT&T Language Line (1-800-974-9246) if there is a language barrier and bilingual staff are not available, as dictated in Policy and Procedure BCDBH – 089. Standardized procedures are used for contacting AT&T Language Line Services for interpretation when required for non-English speaking clients who are on the telephone or in the office.

Cultural Competency Assessment

Working with the Cultural Competency Committee (CCC), BCDBH implemented a cultural competency assessment of the Butte County Behavioral Health Workforce in 2015. The analysis of this assessment guides the development of future trainings and recruitment practices for BCDBH. Implementation of an organizational cultural competency assessment strengthens our commitment to sustaining a culturally competent system. Cultural competence requires agency leaders to make an ongoing commitment to fact finding in order to determine whether individuals of diverse backgrounds are served fairly and capably by their agencies. Analysis of this assessment is found in Appendix A.

B. A narrative discussing how the county is working on skills development and strengthening of community organizations involved in providing essential services.

BCDBH endeavors to create and enhance a culturally diverse, client and family driven, mental health workforce capable of meeting the needs of our diverse communities. This is accomplished through a commitment to training mental health staff and community partners in evidence-based, promising, emerging and community-defined mental health practices. BCDBH offers free cultural competency trainings via the eLearning platform, Relias. In the past, BCDBH has offered monthly Grand Rounds trainings which include presentations from various cultural perspectives. Examples of Grand Rounds trainings have included, *Drum Connections: Using Rhythm & Percussion in Therapy* provided by * and *In Our Own Voice: Unmasking Mental Illness* provided by NAMI. BCDBH is currently coordinating a relaunch of Grand Rounds trainings via the department's Cultural Competency Committee in 2018.

Additionally, BCDBH has successfully used MHSa Prevention and Early Intervention (PEI) funds to provide skill development and strengthen community organizations in order to increase the ability to effectively serve our diverse communities. The community organizations that are funded by PEI directly

impact and address disparity in mental health access and outcomes. These programs are included in the list above, beginning on page 2.

Supporting and maintaining the Cultural Competency Committee (CCC) has been beneficial in preserving relationships with community organizations. These strong relationships allow for effective networking and promotion of cultural events between agencies. BCDBH welcomes diverse perspectives and representatives to the Committee and provides staff support for the group.

In working with contracted community based organizations BCDBH is committed to ensuring that culturally competent practices are followed. Efforts to accomplish this goal include:

- All contracts include a separate cultural competence statement and the inclusion of all five fundamental concepts of MHSA, which specifically sites cultural competence.
- Contract providers are required to be members of the Cultural Competency Committee (CCC) and the Quality Improvement Committee (QIC).
- Contract providers participate in the process of developing the plan and implementation of the Butte County Behavioral Health Workforce Cultural Competence Assessment.
- Our MHSA PEI programs are specifically designed to meet the needs of our culturally diverse populations. Our PEI contracts mandate the hiring of local and culturally competent staff (e.g., African American Family & Culture Center, Zoosiab, Promotores)
- Assisting our contracted agencies to leverage funding for program expansion.
 - In 2016, Zoosiab was awarded a grant from the California Reducing Disparities Project (CRDP). The CRDP focuses on achieving mental health equity for 5 population groups recognized as being most adversely affected by disparities: African American, Asian and Pacific Islander, Latino, LGBTQI+ and Native American. The award of this five year grant will allow for Zoosiab demonstrate the effectiveness of their program model at a statewide level.

C. Share lessons learned on efforts made on the items above.

- It is crucial to have ongoing relationships within the community, and to have ongoing system review, with our partner agencies to monitor what is working and what is not.
- When gathering input it is important to complete the communication loop and get back to the community with an explanation of how the input was used, and what, if any, actions were taken.
- Providing food and translators is vital when hosting meetings to gather community input. It is equally important to set the tone as warm, friendly, and to understand how past and/or current actions by the Department or other government agencies can influence the comfort level of participants and their likelihood to speak freely.
- Engagement, recruitment, and buy-in are essential in the success of long processes.
- Sometimes someone from the outside needs to lead and facilitate the meeting. A government agency is not always perceived as neutral – especially in the eyes of some community members. No matter how open the agency is to change and no matter how skillful staff members are at facilitation, they may not always be the best vehicle for soliciting community input and feedback.
- Patience and the willingness to let the process unfold, even when it doesn't adhere to tasks and timelines, is essential. Be flexible.
- Ensuring an effective community process takes time: you must prepare the ground fully if you want meaningful feedback that can translate into successful community programs.

- It is important to continually communicate with stakeholders, ask how the process is going, and what could improve the process.
- Never assume that a stakeholder does not want to participate if they decline an initial invitation, or do not show up at a meeting; it is important to reach out often to encourage engagement with the process.

III. Each county has a designated Cultural Competence/Ethnic Services Manager (CC/ESM) responsible for cultural competence.

The County has an identified Cultural Competence Manager (CCM) whose role also aligns as the MHSA Coordinator. Cultural competency is one of the five fundamental guiding principles in the MHSA and the transformation and strengthening of cultural competency practices is embedded within each of those roles.

The responsibilities, roles, and duties of the CCM are as follows:

- A member of the BCDBH Leadership Team who reports directly to the Director of Behavioral Health.
- Regularly participates in California Behavioral Health Directors Association (CBHDA) ESM conference calls and meetings.
- Chairs the Superior Region ESM committee.
- Is a member of the BCDBH Quality Improvement Committee (QIC).
- Regularly advocates for services that meet the needs of the diverse and unserved/underserved populations as evidenced in the approved MHSA plans.
- Coordinates the BCDBH Cultural Competency Advisory Team.
- Consistently takes steps to strengthen relationships between BCDBH and the diverse unserved and underserved populations in Butte County.
- Serves as a liaison with the Butte County Behavioral Health Board and provides monthly reports at board meetings issues related to MHSA and Cultural Competency.

In addition, the CCM attends workshops and conferences sponsored by state entities, such as California Behavioral Health Directors Association (CBHDA) and California Institute for Behavioral Health Solutions (CIBHS). CCM participates in the Cultural Competency, Equity and Social Justice Committee, a subcommittee of CBHDA, quarterly meetings and conference calls. The CCM is actively pursuing the integration of the *Framework for Eliminating Cultural, Linguistic, Racial and Ethnic Behavioral Health Disparities*, a guideline developed by CBHDA on how to integrate national Culturally and Linguistically Appropriate Service (CLAS) standards. CLAS standards are intended to advance healthy equity, improve quality, and help eliminate health care disparities.

IV. Identify budget resources targeted for culturally competent activities

The following **programs** are specifically funded services to culturally diverse groups:

- African American Family and Cultural Center
- Promotores
- Stonewall Alliance- LGBTQI+ Suicide Prevention and Education Program
- Zoosiab- Historical Trauma & Hmong Elders
- Interpreter/Translation Services

The following **services** are provided in a culturally competent manner and have percentages of participants who are members of Butte County's diverse populations:

- Live Spot Gridley
- Live Spot Oroville
- Stepping Stones- Perinatal program
- Youth Intensive Programs

Department-wide cultural and linguistic services include:

- Interpreters/Translators
- 24 hour interpreter line
- Culturally appropriate mental health services
- Compensation for culturally and linguistically competent providers and non-traditional providers/healers

Financial incentives for culturally and linguistically competent providers, non-traditional providers, and/or natural healers include the County’s bilingual staff pay differential. BCDBH encourages contract providers to provide financial incentives for their bilingual staff members.

The below figure depicts programs that serve with culturally diverse populations and their allocated funding streams.

Figure 1.1

Funding	MHSA Component	Program
MHSA /Medi-Cal/ Realignment	Community Services and Support	Youth Intensive Program
Medi-Cal/Realignment	N/A	Translators
SAPT- Perinatal/Realignment	N/A	Stepping Stones
MHSA	Prevention Early Intervention	African American Family & Cultural Center
MHSA	Prevention Early Intervention	Promotores
MHSA	Prevention Early Intervention	Stonewall: LGBTQI+
MHSA /Medi-Cal	Prevention Early Intervention	Hmong Elder Program
MHSA /SAMHSA MHBG/STOP	Prevention Early Intervention	Live Spots - Gridley & Oroville
MHSA	Prevention Early Intervention	National Alliance for Mental Illness
MHSA	Workforce Education and Training	Cultural Competency Training

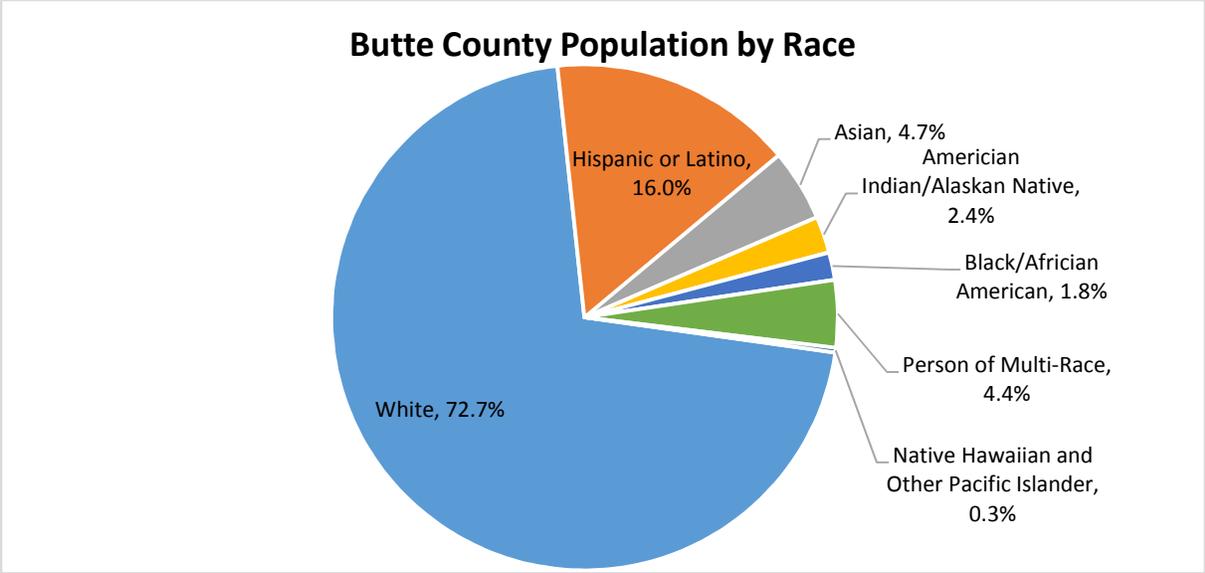
Criterion 2: Updated Assessment of Service Needs

I. General Population

Summarize the county’s general population by race, ethnicity, age, and gender. The summary may be a narrative or as a display of data (other social/cultural groups may be addressed as data is available and collected locally).

The population estimate for Butte County in 2016 was roughly 227,000 according to the United States Census Bureau. Individuals who self-identify as White (not Hispanic or Latino) comprise 8% of the County’s population followed by Hispanic or Latino at 15.4%, Asian at 4.7%, American Indian/Alaska Native at 2.4%, and African American/Black at 1.8%; persons of multi-races included 4.4% of the population.¹

Figure 2.1: Butte County Population Data by Race, 2016



The age and sex distribution in Butte County was available in 2016 through the United States Census Bureau *American Community Survey*², which releases new datasets annually. The data is presented in Tables 1 and 2:

Table 2.1: Butte County Population Data, 2016

Sex	Estimate	Percent
Male	110,926	49.5%
Female	112,951	50.5%
Total Population	223,877	100%

¹ <http://www.census.gov/quickfacts/table/RHI105210/06007>
² <https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF>

Table 2.2: Butte County Population Data, 2016

Age	Estimate	Percent
Under 15 years	37,564	16.78%
15 to 24 years	41,918	18.72%
25 to 59 years	91,820	41.01%
60 years and over	52,575	23.48%
Total Population	223,877	100%

Narrative of Context

Race/Ethnic groups

American Indian/Alaskan Native

The 2016 United States Census Bureau *American Community Survey* reports that 2.4% of individuals in Butte County self-reported their race to be American Indian/Alaskan Native. For the Fiscal Year of 2013-14 BCDBH served 264 individuals who self-reported as American Indian, which comprised of 3.4% of the entire population served.

Native Americans indigenous to the area are primarily Maidu, with sizable numbers of Wintu, Pomo, and Miwok. Many are unaffiliated with a Rancheria (a problem in California caused by federal tribal termination policies), and hold no voting power on the Rancherias. There are approximately 8,000 Native Americans living in the area. Of those about half are from local tribes. According to the 2016 U.S. Census, 1.1% of the population of Butte County is Native American, located mostly in the Oroville area. This census estimate is thought to be a low statistic for many reasons including that many Native Americans are being reported as Hispanic due to surnames. Among the four Rancherias in the area, the population distribution is as follows: Berry Creek Rancheria: 304; Mooretown Rancheria: 1,170; Enterprise Rancheria: 395; and, Chico Rancheria: 321 (Individual Rancheria data, 2003).

Hmong American

Hmong is the third largest minority group in Laos who came to the United State as refugees in the mid 1970's after fifteen years of service side by side with the United States Central Intelligence Agency (CIA) in Laos. This war is known as the "Secret War" in Laos. Hmong refugees came to the United State of America after the fall of Saigon, from the middle of 1975's to early 1980's as the first wave, and late 90's and 2005 as the last waves of Hmong Refugees from the refugee camps in Thailand. Hmong believes in animism, which is the belief that human beings and everything have souls and spirits. Hmong believed that when a Hmong person is sick, his or her souls and spirits are no longer with the body. The shaman is the first contact person and his job is to bring harmony to the individual, their family, and their community by performing various rituals in communication with the souls or spirits and bring them back to the body.

In the early 1980's Hmong moved to Butte County with a few Hmong in Chico and Oroville. In the late 90's to now, many Hmong families are moving to Butte County. Butte County is home for more than nine thousand Hmong because of the natural beauty and farming similarities to where they came from the mountains of Laos. Hmong still practice their cultural traditions and belief at home. For example, if member of the family is sick, herbal medication is the first form of treatment, and if that does not help,

a shaman will be called to do a ritual. If the ritual does not treat the sick family member, then the last resort is taking the sick person to see a doctor or seek Western treatment.

Latino American

Latino Americans comprise about 16% of the Butte County population. While the vast majority of residents are originally from Mexico, there are Latino Americans in Butte County that are also from many countries in Central and South America. Latino Americans live throughout Butte County, though the majority of people live in Gridley. Gridley is the fourth smallest of Butte County cities with its primary economy based on the local agricultural business. “La familia” and “la comunidad” (family and community) are central for the Latino culture’s wellness, which includes its language (Spanish or Indian dialect), traditions, folklores/mythology, music, food, and religious or spiritual affiliation: all are fundamental for family norms to be transmitted from one generation to the next. Latino families needing services, however, are predominately from family systems that are culturally broken, have ceased to bond or prosper due to assimilation/acclulturation, experience severe trauma via violence in the home, have strict male patriarchy via *machismo*, ongoing immigration legal issues, and traumatic deportation histories. Although migration experiences to the U.S. may be similar, each family has its own story that often reflects an ongoing generational trauma and can be an extremely painful experience. Situations leading to U.S. immigration include poverty, political persecution, drug cartel wars, hope of a better future for their children, and limited job opportunities within countries of origin. When Latino families experience mental health, drug and substance abuse issues, and/or the presence of gang influences/violence within the home, it often creates ongoing shame and embarrassment for individuals, ostracism from their religious community, and the fracturing of the family system.

African American

African Americans are about two percent of the population in Butte County and are primarily living in the cities of Oroville and Chico, with the greater concentration occurring in Oroville. Most African Americans in Butte County live in poverty and have insufficient healthcare. Infant mortality among African Americans in the County is more than twice that of other ethnic groups (8.8 per 1000 births) and about one in 20 of their children are living in out-of-home placements. Most African American community members in Butte County are descendants of Africans who were forcibly removed from their homeland and enslaved in America. Sadly, the forced separation of family members in slavery continued in a new form under Jim Crow laws and Black Codes. In Butte County, many African American families came due to assurances of good jobs associated with building the Oroville Dam, with the state promising that much of the economic boom of this project would be directed to Butte County. Unfortunately, this economic boom did not materialize, and the African American families that moved to this county for employment and benefits of the project were left without local jobs. Many leaders and gifted members of the community have moved for higher paying jobs in other areas resulting in disconnecting families and/or poverty. Many local African American families have for generations been subject to trauma, had disrupted family life, and struggled with poverty. The experience of perceived racial discrimination leads to lower levels of mastery, and higher levels of psychological distress. Many males respond to trauma and other stressors through aggressive and angry behavior towards self and others and/or using drugs. With the immense difficulties of coping and racial profiling, many of these males in the community were criminalized.

Cultural Groups

In addition to the four distinct racial/ethnic groups in Butte County, the agency also recognizes that there are many cultural groups that are in Butte County. Through work meeting with the BCDBH Cultural Competence Committee, there are 6 cultural groups that will be included in the context of this report.

Lesbian, Gay, Bisexual, Transgender, Queer, Intersexual and Other Sexuality, Gender or Sex Identities (LGBTQI+)

Over the past 15 years, research has suggested that adolescence can continue into the third decade of life. As those of us who work with adolescents and their families can attest, getting there is half the battle. And while adolescence is a period of increased stress and excitement for a majority of youth, some definitely have more of a struggle on their hands than others. Numerous studies report on the high percentage of LGBTQI+ youth that feel isolated from peers and additional feelings of isolation, and difficulties caused by their parents' rejection due to their sexual orientation. As a result of their families' rejection, as many as 26% of LGBTQI+ youth feel forced to leave home.

Schools often unwittingly or by complicity reinforce that it is not healthy or safe to be gay, lesbian, or bisexual. A study at Lincoln-Sudbury Regional High School in Boston revealed that 97% of the student body reported hearing anti-gay comments on campus. Such disparaging and often prejudicial remarks are often ignored or, even worse, tacitly encouraged by faculty and administration. Over the last two decades, research findings have pointed to disproportionately high rates of suicidal behavior among LGBTQI+ adolescents and young adults. Suicide attempts in this population have been linked to a variety of factors including lack of support, family problems, violence/ victimization, and mental health problems, notably depression and substance abuse or dependency. One study found that when compared to their heterosexual peers, LGBTQI+ youth are:

- Over five times more likely to have attempted suicide in the past year.
- Over three times more likely to miss school in the past month because of feeling unsafe.
- Over three times more likely to have been injured or threatened with a weapon at school.

Parents' attitudes and behaviors toward their gay, lesbian, and bisexual offspring are key determinants of their children's risks of suicide, substance abuse, and depression, according to a new study (December 2009) published in the journal *Pediatrics*. The study in *Pediatrics* found that rejection by one or both parents and/or efforts to change sexual orientation were significantly associated with higher risks of suicide and poorer health outcomes among this population.

Lesbian, gay, and bisexual young adults who reported higher levels of family rejection during adolescence were 8.4 times more likely to report having attempted suicide, 5.9 times more likely to report high levels of depression, 3.4 times more likely to use illegal drugs, and 3.4 times more likely to report having engaged in unprotected sexual intercourse compared with peers from families that reported no or low levels of family rejection. It is important to note that stigma associated with homosexuality and gender identity causes many affected individuals to be wary of "governmental" service providers, and of receiving services at typical governmental offices. The mental health field especially has a long history of institutionalize homophobia which is in of itself a barrier to treatment for LGBTQI+ + community.

Trust is a most significant factor for the LGBTQI+ + populations and the effort to reach out with trusted community liaisons will lead to improved prevention efforts and lessen the risk of suicide, depression, and other risky behaviors.

Older Adult

In Butte County, approximately 22% of the population is over the age of 59, compared to the statewide proportion of 18%.

Older adults are at considerably higher risk for mental illness, particularly depression. According to national statistics, they are the most likely individuals to successfully complete suicide. A key finding of Enloe Medical Center, the primary hospital in Butte County, found that 29% of adults in this area had depression lasting two years or more, particularly, people aged 65 and older (2007 Community Health Survey, Enloe Medical Center). Many older adults have chronic health conditions that contribute to signs and symptoms of mental illness, e.g. diabetes and stroke are very closely correlated to depression in older adults. In fact, the 2007 Community Health Survey shows that in Butte County 3.2% of adults suffer from or have been diagnosed with cerebrovascular disease (stroke), a rate higher than the statewide figure of 2.4%. More than 18% of adults older than age 65 have diabetes (Centers for Disease Control and Prevention). Butte County has a higher rate of this disease in adults (10.5%) than the state proportion of 7.1%.

It is acknowledged that in Butte County, the incidence of mental illness and severe emotional distress among older clients is high; older adult have presented with symptoms/diagnoses of depression, bipolar disorder, complicated grief/loss, anxiety, PTSD (post-traumatic stress disorder), panic disorders, psychotic disorders, medication misuse, overuse and mismanagement; and obsessive-compulsive disorder. Furthermore, older adults who are experiencing initial symptoms of substantial emotional distress are not accessing mental health services in proportion to their numbers. These older adults are facing profound and unremitting sadness, grief/loss, social isolation, fear, and physical symptoms. They frequently do not know the cause of these symptoms, or that the proper early intervention treatment of older adults is generally successful. They may believe and accept that the nature of being old is to be sad: that depression is a “normal” part of aging. They often express the sentiment that these feelings are “their fault” and that they need to “pick themselves up by the bootstraps” if they want to feel better. If they have had treatment that did not include thorough education, support, and follow-up, then they may believe that treatment, in general, doesn’t work. Consequently, they may not seek help or disclose symptoms after that failed intervention.

The result of the lack of early identification and appropriate in-home intervention and services are substantial and include escalation of symptoms, institutional placement, self-harm, and suicide.

Veterans

The total number of Veterans documented in Butte County for 2010-2014 was 17,116.³ The total number of individuals that self-identified as Veteran served by BCDBH for the Fiscal Year of 2013-14 BCDBH was 240. According to the RAND Center for Military Health Policy Research, 20% of the vets who served in either Iraq or Afghanistan suffer from either major depression or post-traumatic stress disorder and only about ½ of veterans who need mental health services will receive them. Veteran

³ <https://www.census.gov/quickfacts/table/PST045214/06007>

mental health services are critical to recovery, however, veterans face barriers to treatment which includes the following⁴:

- Personal embarrassment about service related mental disabilities
- Long wait times to receive mental health treatment
- Shame over needing to seek mental health treatment
- Fear of being seen as weak
- Stigma associated with mental health issues
- A lack of understanding or lack of awareness about mental health problems and treatment options
- Logistical problems, such as long travel distances in order to receive this type of care
- Concerns over the veteran mental health treatment offered by the VA
- Demographic barriers and false perceptions based on these demographics such as age or gender

Foster Care

For the Fiscal Year of 2013-14 BCDBH served 270 youth that self-identified as in Foster Care. Up to 80 percent of children in foster care have significant mental health issues, compared to approximately 18-22 percent of the general population. Factors contributing to the mental and behavioral health of children and youth in foster care includes the history of complex trauma, frequently changing situations and transitions, broken family relationships, inconsistent and inadequate access to mental health services and the over-prescription of psychotropic medications.⁵

Homeless

For the Fiscal Year of 2013-14 BCDBH served 587 individuals that self-identified as Homeless. An estimated 26% of homeless adults staying in shelters live with serious mental illness and an estimated 46% live with severe mental illness and/or substance use disorders. Additionally, California has the highest number of homeless than any other state.⁶ The homeless population have barriers to mental health treatment which includes, but is not limited to, transportation, lack of resources, stigma, family support, ability to access insurance, and negotiating systems.

Consistently since 2008, the adult homeless population in Butte County has reported that the number one cause of their homeless status is job loss/lack of employment and/or other financial reasons. Family problems and eviction are also cited as primary reasons. For both unaccompanied and transition-aged youth, being kicked out of the family home, running away, or family violence are the primary reasons for homelessness.

Being homeless is a very traumatic experience. On a physical level, those experiencing homelessness are at elevated risk for communicable disease, chronic illness, and being victims of violence. Psychologically, they are more likely to experience poor mental health and to develop substance-related and addictive disorders due to their attempt to survive in high stress, unhealthy and dangerous environments. The dynamic is even worse for those persons who already had a behavioral health condition when they became homeless. In addition, those who are homeless are often marginalized, isolated and discriminated against by society, compounding their trauma. It is estimated that the mortality rate for homeless persons may be up to 9 times greater than for the general population.

⁴ <https://nvf.org/veteran-mental-health-facts-statistics/>

⁵ <http://www.ncsl.org/research/human-services/mental-health-and-foster-care.aspx>

⁶ <https://www.hudexchange.info/resources/documents/2010HomelessAssessmentReport.pdf>

Consumer

For the Fiscal Year of 2013-14, BCDBH served a total of 7,747 individuals from their mental health service programs. A mental illness is a condition that affects a person's thinking, feeling or mood. Such conditions may affect someone's ability to relate to others and function each day. Each person will have different experiences, even people with the same diagnosis.

Cultures within mental health communities can be defined around diagnosis, symptoms, and treatment. For example, Bipolar Support Communities or Asperger's Support Communities can arise based on diagnosis and explicit symptoms. On the other hand, communities can develop based on treatment communities, i.e. support programs offered by BCDBH or other community mental health programs may promote identification and interactions between members of this community.

Because mental illness is present in all ethnicities and social groups, it is important to identify and address the intersection of mental illness and other social groups:

- Race/Ethnicity
- Language
- LGBTQI+
- Veterans
- Children in and emerging from foster care
- Culture of Poverty

Consumer Employment

Butte County has been a leader in consumer/peer employment since 2006. Subcontractor NVCSS (Northern Valley Talk Line/Iversen Center) employs 25 peer staff from part to full time, in every job classification. BCDBH employs peer staff for several departments (Computer Labs, Crisis, the HUB). Peer staff have been able to access better job opportunities, i.e. case manager, medical records tech, and supervisor after their entry into peer based services. Peer staff have also left employment to pursue education at the BA and MSW levels.

II. MEDI-CAL population service needs (Use Current EQRO data if available.)

Summarize Medi-Cal population and client utilization data by race, ethnicity, language, age, and gender (other social/cultural groups may be addressed as data is available and collected locally).

Medi-Cal Population Summary

As reported by the California External Quality Review Organization (CalEQRO), the average number of Medi-Cal enrollees per month in 2014 for Butte County was 60,273. Of that population, there were 5,515 beneficiaries served annually by BCDBH. Tables 2-5 show the demographic break down of the Medi-Cal population by race/ethnicity, age group, gender, and eligibility category. CalEQRO data represents clients receiving mental health services and does not include clients receiving substance abuse disorder services.

Table 2.3: Butte County Medi-Cal Population for Calendar Year 2014

Butte County Medi-Cal Enrollees and Beneficiaries Served in CY14 by Race/Ethnicity		
Race/Ethnicity	Average Monthly Medi-Cal Enrollees	Annual Count of Beneficiaries Served
White	36,422	3,801
Hispanic	11,086	582
African-American	1,591	196
Asian/Pacific Islander	4,348	241
Native American	1,216	104
Other	5,613	591

Table 2.4: Butte County Medi-Cal Population for Calendar Year 2014

Butte County Medi-Cal Enrollees and Beneficiaries Served in CY14 by Age		
Age	Average Monthly Medi-Cal Enrollees	Annual Count of Beneficiaries Served
0-5	9,058	286
6-17	16,575	2,030
18-59	26,375	2,780
60 +	8,266	419

Table 2.5: Butte County Medi-Cal Population for Calendar Year 2014

Butte County Medi-Cal Enrollees and Beneficiaries Served in CY14 by Sex		
Sex	Average Monthly Medi-Cal Enrollees	Annual Count of Beneficiaries Served
Female	32,759	2,809
Male	27,515	2,582

Table 2.6: Butte County Medi-Cal Population for Calendar Year 2014

Butte County Medi-Cal Enrollees and Beneficiaries Served in CY14 by Eligibility Categories		
Categories	Average Monthly Medi-Cal Enrollees	Annual Count of Beneficiaries Served
Disabled	14,250	2,441
Foster Care	652	308
Other Child	24,019	1,875
Family Adult	14,685	815
Other Adult	5,706	128

The following figures show BCDBH penetration rates by demographics compared to statewide penetration rates as reported by CalEQRO. The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average enrollee count.

Figure 2.2

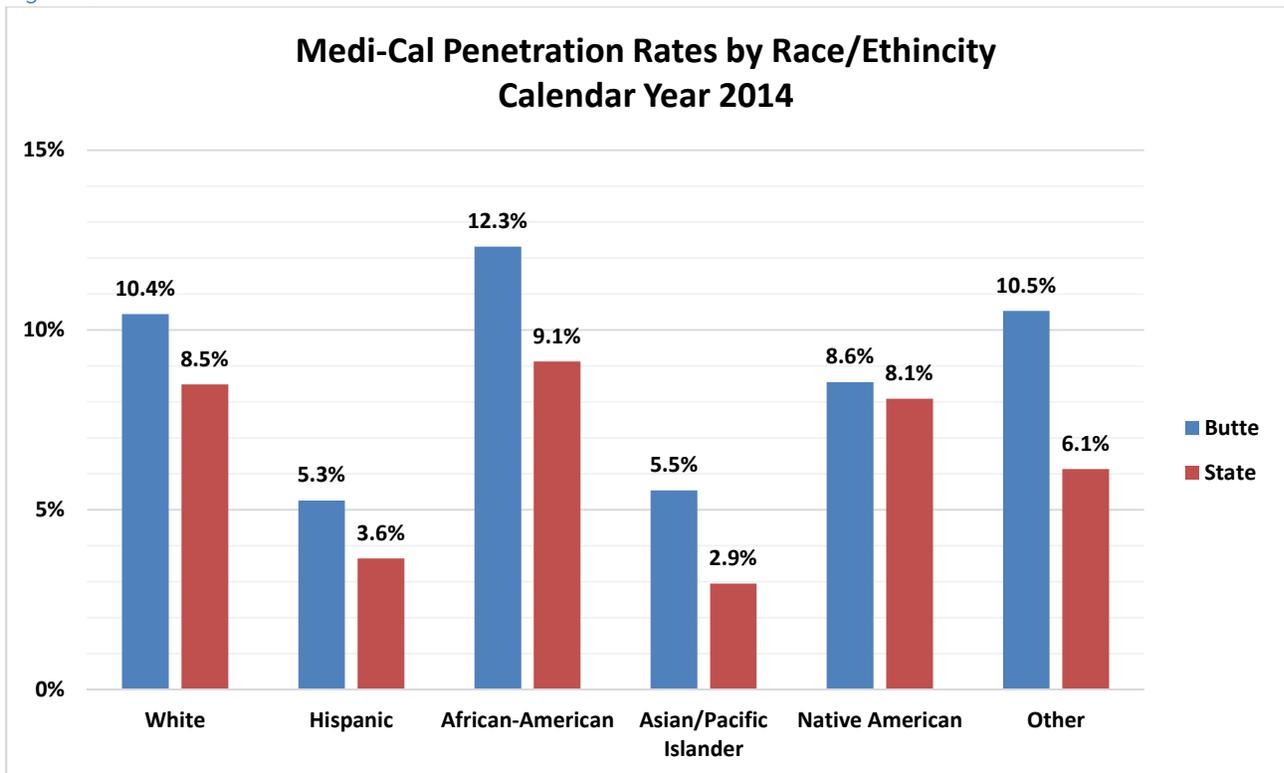


Figure 2.2 shows the utilization rate by Butte County residents who have Medi-Cal. One can see that approximately 12.3% of African Americans with Medi-Cal accessed services at BCDBH. This was the highest cultural group. Most racial/ethnic groups were accessing at similar rates, except the Hispanic/Latino and Asian/Pacific Islander cultural groups, which were 5.3% and 5.5% respectively.

Figure 2.3

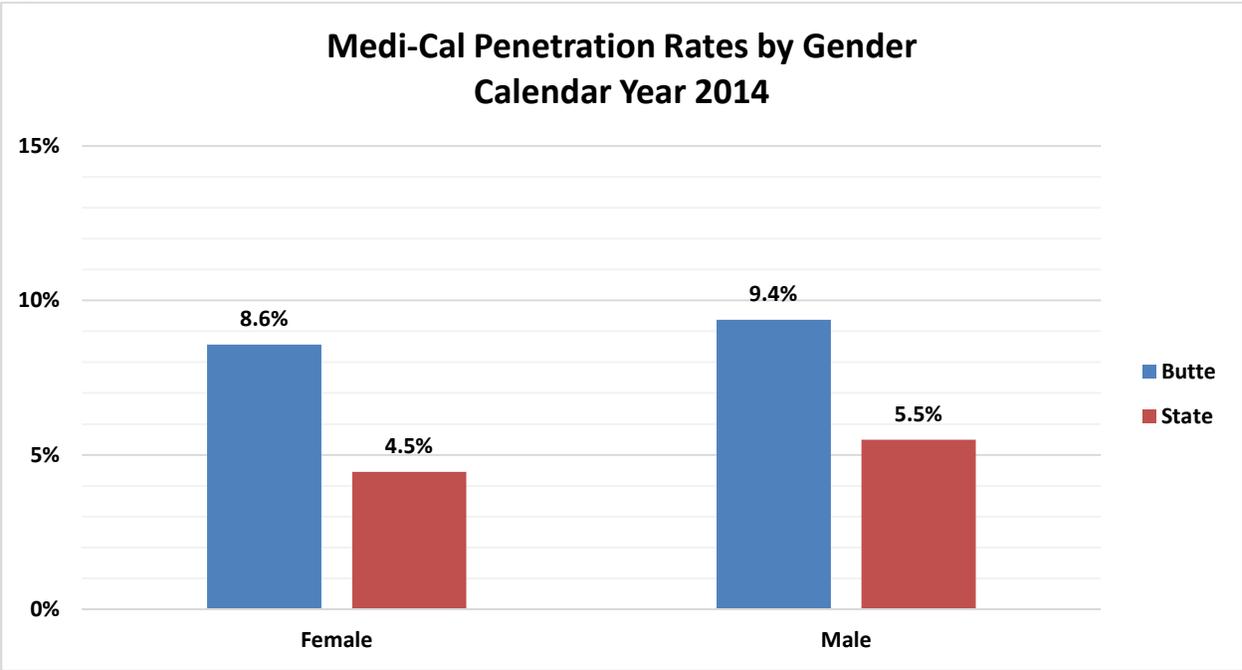
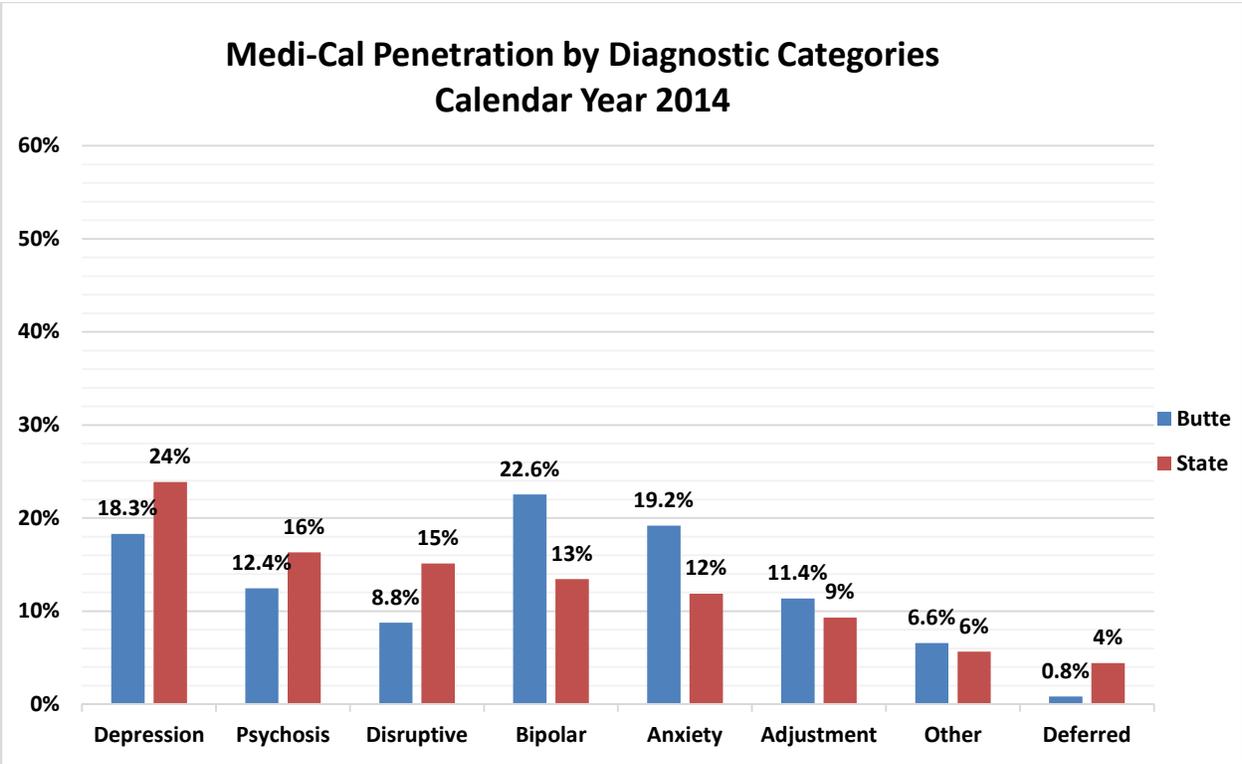


Figure 2.3 shows penetration rates by gender in Butte County compared to the statewide average.

Figure 2.4



Client utilization rate for Butte County Medi-Cal is significantly higher than the statewide averages for its comparable populations. Regardless of having this excellent penetration and service rate, BCDBH continues to actively pursue a variety of programs that work to increase services and access to this

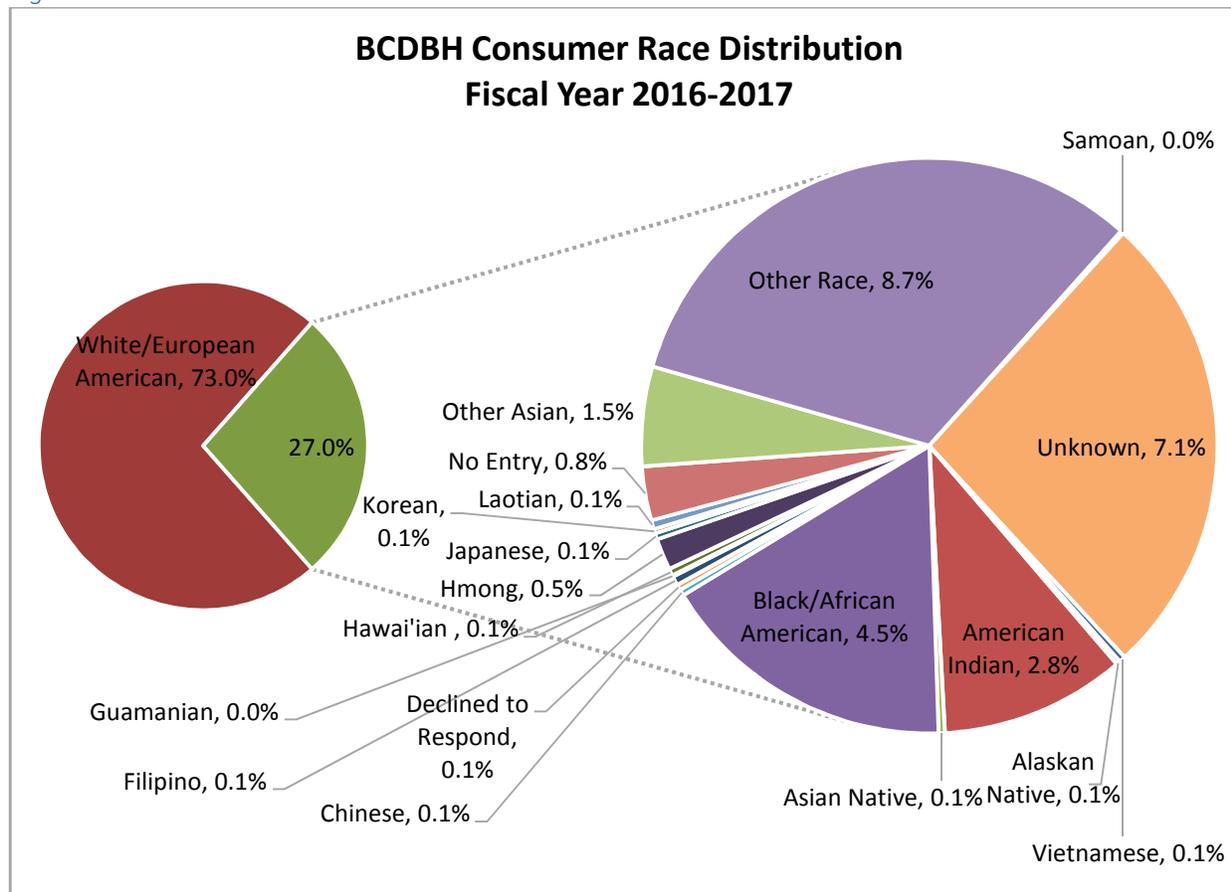
group. In addition, the Department makes continued efforts to increase its bilingual and bicultural support in clinical and supervisorial staff.

Client Utilization Summary

This data is collected through Avatar, the Electronic Health Record that is used exclusively by BCDBH staff. The client demographic data is collected at admission. The number of distinct clients that obtained mental health and substance use disorder services during the fiscal year (July 1st-June 30th) 2016-2017 is 9,409.

The following figures show the demographic break down of BCDBH consumers by race/ethnicity in Fiscal year 2016-2017. This data represents all clients receiving mental health services and receiving substance abuse disorder services.

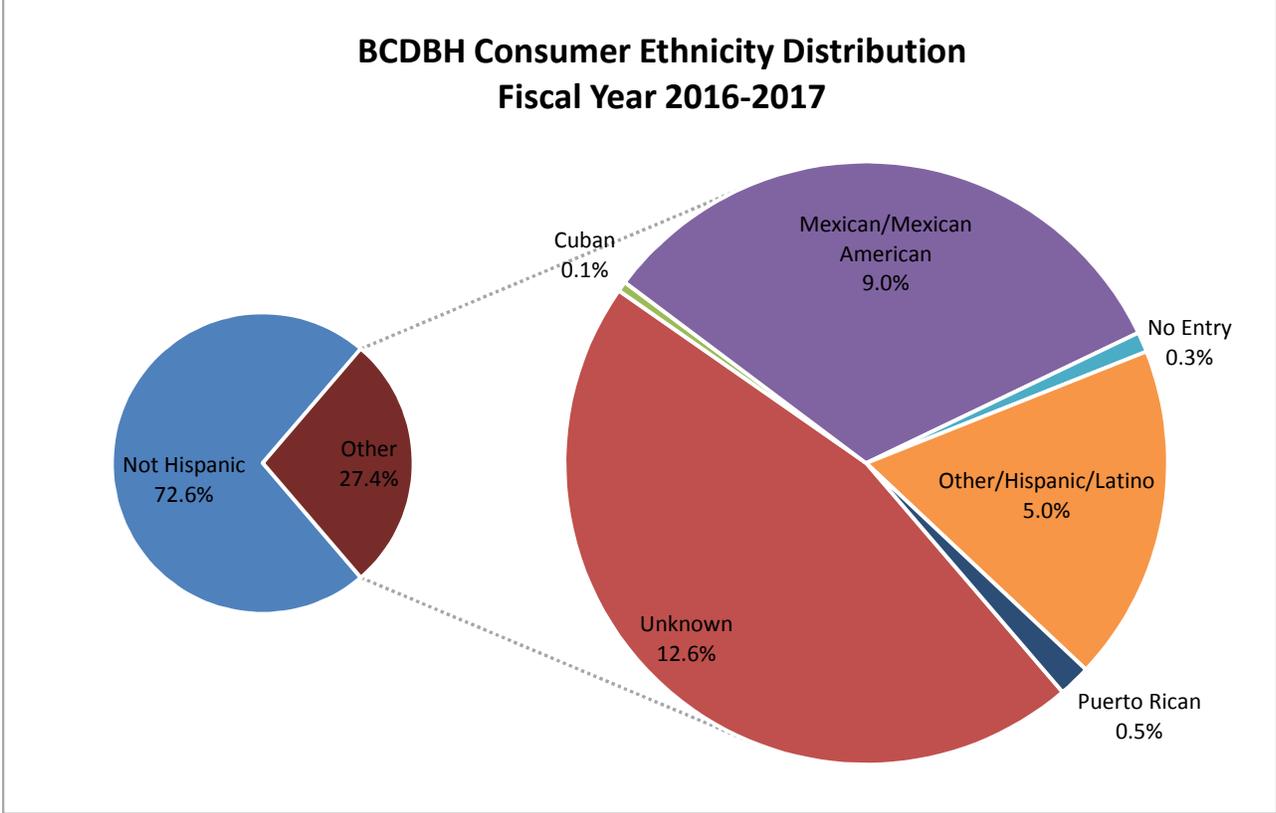
Figure 2.5



Race			
White/European American	6869	Hmong	45
Alaskan Native	6	Japanese	9
American Indian	264	Korean	6
Asian Native	9	Laotian	13
Black/African American	427	No Entry	77
Chinese	9	Other Asian	142
Declined to Respond	8	Other Race	817
Filipino	13	Samoan	4

Guamanian	2	Unknown	670
Hawai'ian	10	Vietnamese	9
		Total	9409

Figure 2.6



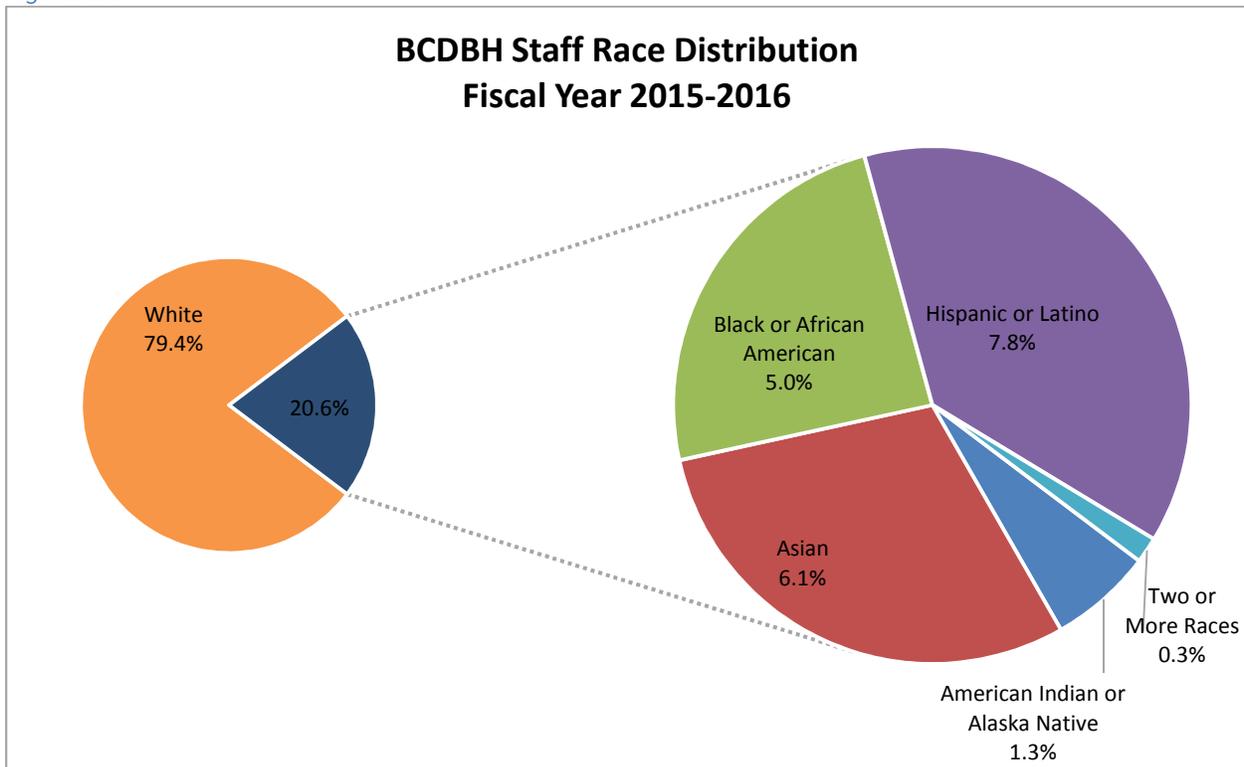
Ethnicity

Not Hispanic	6827	No Entry	28
Unknown	1187	Other/Hispanic/Latino	466
Cuban	14	Puerto Rican	44
Mexican/Mexican American	843	Total	9409

BCDBH Staff Summary

This data is collected through PeopleTrack by the BCDBH Human Resource Department.

Figure 2.8



Race			
American Indian or Alaska Native	8	Hispanic or Latino	47
Asian	37	Two or More Races	2
Black or African American	30	White	479
		Total	603

Provide an analysis of disparities as identified in the above summary.

Note: Objectives and strategies for these defined disparities will be identified in Criterion 3.

The charts below, portray utilization patterns by race and ethnicity of client (red bar), and compares the race and ethnicity of staff (blue bar) relative to the entire Butte County population. The graph provides information in two areas:

- 1) Proportionality for the number of African American, Asian, and BCDBH staff members by cultures across BCDBH programs. There is a need for more Native American staff and Latino Staff.
- 2) Female staff (71.7%) far exceed the proportion for female consumers (51.7%).
- 3)

The graphs assumes that all groups will have the same need for services as other groups, and particularly the white group. However, the numbers in the graph do not reflect that some cultural groups have experienced historical trauma (e.g., Hmong war and refugee camps; Native American Forced Boarding schools, etc.) and therefore have a higher need for services. Stakeholders from culturally diverse groups substantiate that there are many unmet service needs in their communities, in particular, culture-based services that are congruent with cultural traditions.

Figure 2.9

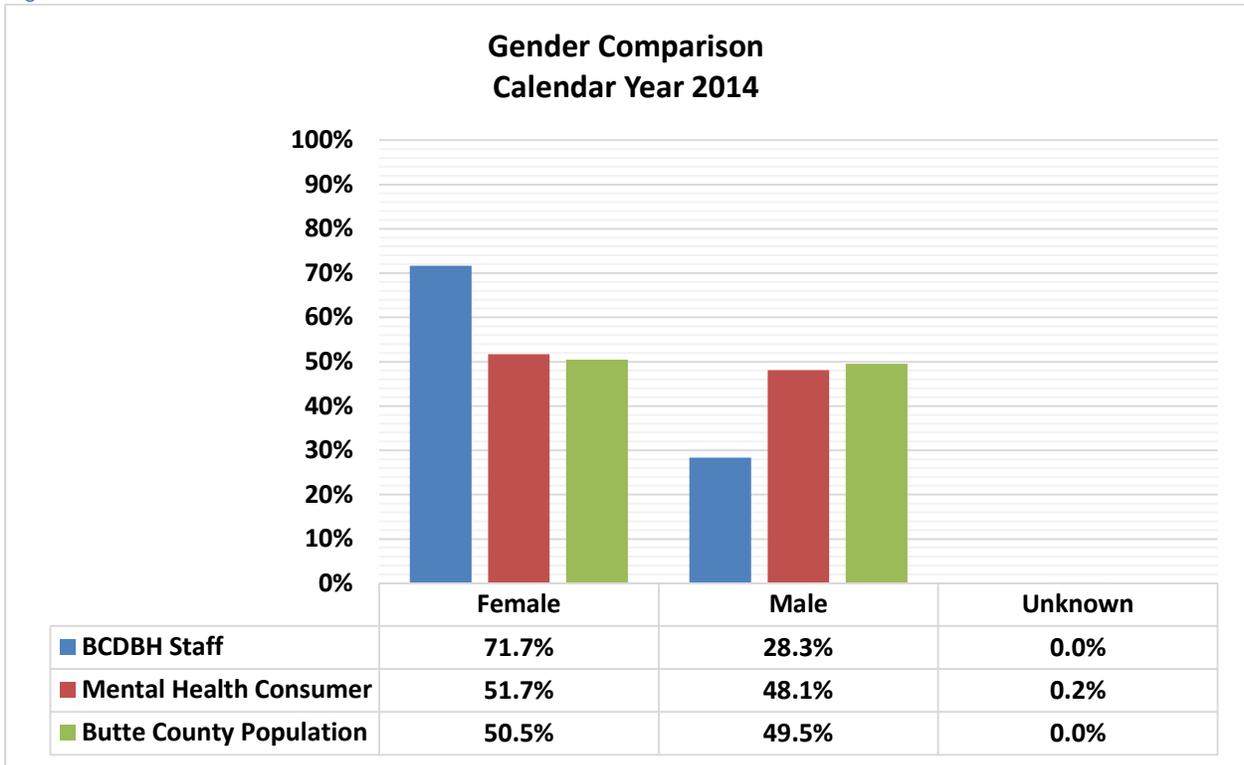


Figure 2.10

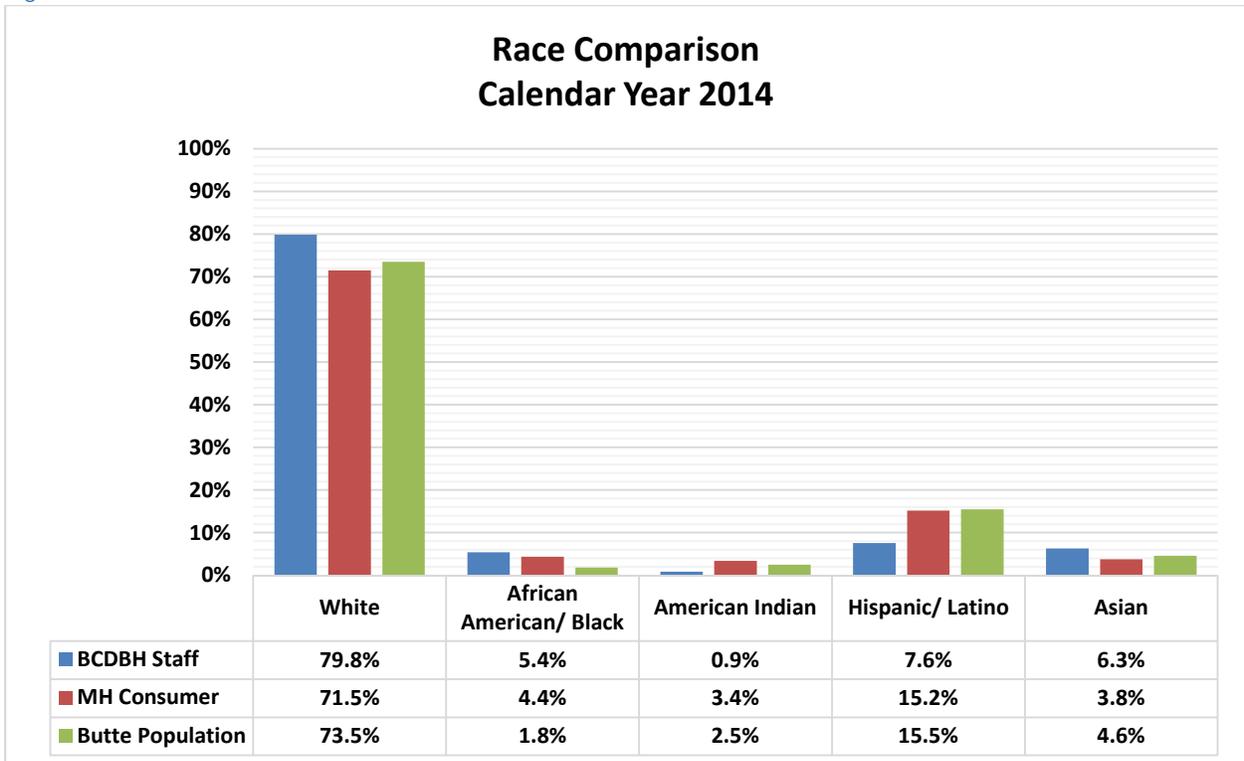
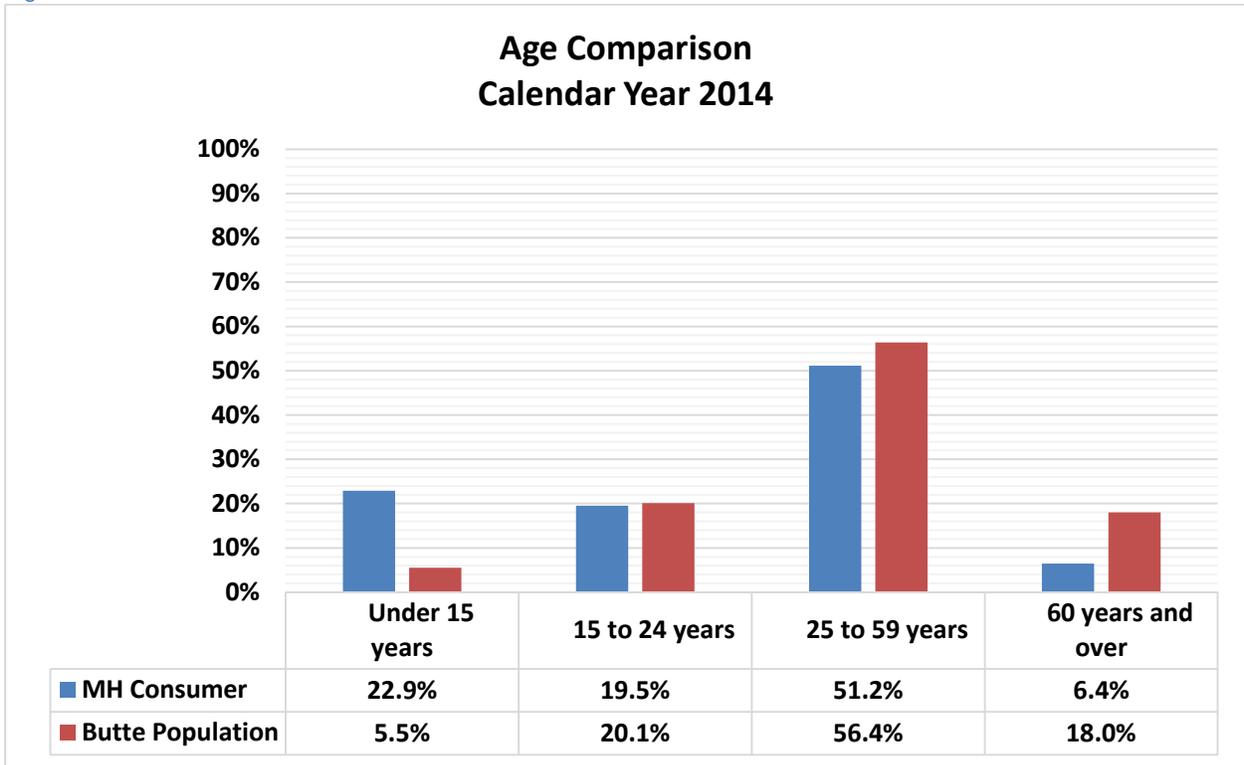


Figure 2.11



III. 200% of Poverty (minus Medi-Cal) population and service needs

Summarize the 200% of poverty (minus Medi-Cal population) and client utilization data by race, ethnicity, language, age, and gender (other social/cultural groups may be addressed as data is available and collected locally).

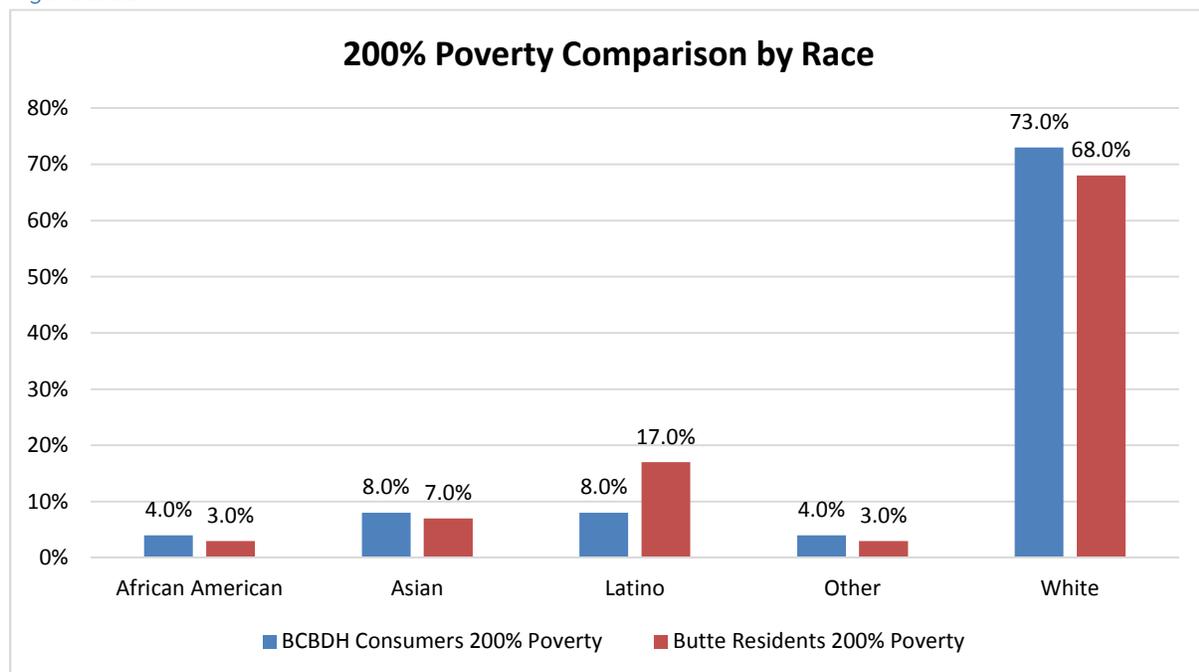
According to the American Community Survey’s 2006-2008 three-year estimates⁷, 89,726 persons in Butte County have incomes below 200% of the Federal Poverty Level. Based on 48,780 Medi-Cal recipients in the County, the difference in persons at 200% of poverty that do not receive Medi-Cal is 40,946 (89,726 – 48,780). Based on the limitations of available data, BCDBH estimates 3.7% penetration rate for this population and a proportional distribution of race and ethnicity that is analogous to Medi-Cal consumers. In 2010-2014, 22 percent of people were in poverty. An estimated 24 percent of related children under 18 were below the poverty level, compared with 8 percent of people 65 years old and over. An estimated 13 percent of all families and 32 percent of families with a female householder and no husband present had incomes below the poverty level.⁸

Provide an analysis of disparities as identified in the above summary.

Note: Objectives for these defined disparities will be identified in Criterion 3.

Individuals at or below 200% of poverty without Medi-Cal are much less likely to receive services at BCDBH than their Medi-Cal counterparts (3.7% vs. 9.14%). This difference pertains to the core target population of BCDBH: 1) BCDBH is the provider for people with Medi-Cal, and 2) Butte County focuses on the severely impaired who are more likely to be on long-term disability and have Medi-Cal. Latinos underutilize mental health services compared to other groups, which is typical at Butte County Behavioral Health, and in the United States in general.

Figure 2.12



⁷ American Community Survey, 2006-2008 3-year estimate

⁸ Population and Housing Narrative Profile 2010-2014 American Community Survey 5-Year Estimates

http://thedataweb.rm.census.gov/TheDataWeb_HotReport2/profile/2014/5yr/np01.html?SUMLEV=50&county=007&state=06

IV. MHSA Community Services and Supports (CS&S) population assessment and service needs.

From the county's approved CS&S plan, extract a copy of the population assessment. If updates have been made to this assessment, please include the updates. Summarize population and client utilization data by race, ethnicity, language, age, and gender (other social/cultural groups may be addressed as data is available and collected locally). The full population and utilization assessment from the originally approved MHSA plan.

In summary, the goal of the initial CS&S Plan was to provide system development in the form of a Crisis Stabilization Unit (CSU), the development of wellness centers, and increased services to homeless and at risk of homeless youth and adults. Subsequent increases in the budget saw the inclusion of services for older adults, a hospital alternative program for youth, and a consumer run warm-line.

The overall CS&S cultural competence strategy was to integrate cultural competency within the new MHSA programs through staff training. Specific strategies included:

- Specific training for Crisis Stabilization Unit staff on LGBTQI+ issues.
- Targeted outreach to the homeless.
- Target outreach to the homeless Latino population.
- Development of an Older Adult Program.
- Targeted outreach to the Hmong Elders in conjunction with an older adult program.

Provide an analysis of disparities as identified in the above summary.

Note: Objectives will be identified in Criterion 3, Section III.

The data suggests that in 2005, when the CSS plan was developed, all age groups and ethnicity were being underserved. It is particularly noteworthy that at that time only 9 youth from African American, Asian, Latino and Native America communities were receiving all services needed through a recovery plan. Today, with the help of MHSA funding and the CCOC grant program, the number is almost 150. To date, only 27 adults and elders from these ethnic groups are receiving these services. Two MHSA programs that are being used to address this need include Hmong Culture Based Treatments for Trauma in Elders and the African American Family and Cultural Center. For all types of services Latinos are under accessing any type of service. A new MHSA program Los Promotores is being used to address this difficulty.

V. Prevention and Early Intervention (PEI) Plan: The process used to identify the PEI priority populations

- A. The county shall include the following the Cultural Competence Plan (CCP):
- B. Underserved cultural populations
- C. Individuals experiencing onset of serious psychiatric illness
- D. Children/youth in stressed families
- E. Trauma-exposed
- F. Children/youth at risk of school failure
- G. Children/youth at risk or experiencing juvenile justice involvement

Table 2.7: PEI Projects

Butte County Department of Behavioral Health PEI Projects and Budgets By Community Mental Health Need, Age Groups, and PEI Priority Populations											
PEI Projects	Age Groups				PEI Priority Populations						
Many of these projects address multiple Community Mental Health Needs and multiple PEI Priority Populations. This chart shows each program by the Need and Priority Population that are its greatest focus.	Children and Youth (C/Y)	Transition Age Youth (TAY)	Adults	Older Adults	1. Trauma Exposed Individuals	2. Onset of Serious Psychiatric Illness	3. C/Y in Stressed Families	4. C/Y at Risk for School Failure	5. C/Y at Risk/Experiencing Juvenile Justice Involvement	6. Underserved Cultural Populations	
	Disparities in Mental Health Services Access										
	Promotores	X		X		X		X			X
	African American Family and Community Center	X	X	X	X	X		X			X
	Integrated Primary Care and Mental Health	X	X	X	X	X		X			X
	At-Risk Children/Youth, Young Adult Population										
	Mobile Transition Age Youth (TAY) Project		X				X	X			X
	Gridley Live Spot	X							X	X	X
	Therapeutic Childcare	X				X		X	X		
	Stigma and Discrimination										
Mental Health Awareness*	X	X	X	X							

Suicide Risk										
LGBTQI+ Suicide Prevention and Education		X			X					X
Older Adult Suicide Prevention and Education				X	X					
* This prevention program will be available for all populations, including the general population.										

Current PEI Strategies/projects to address:

- Underserved Populations
 - African American Family and Cultural Center
 - Promotores
 - LGBTQI+ Suicide Prevention and Education
 - Older Adult Suicide Prevention and Education
- Individuals experiencing onset of serious psychiatric illness
 - Transition Age Youth (TAY) Mobile Program
- Trauma Exposed
 - Therapeutic Childcare
- Children/Youth at risk of school failure and at risk or experiencing juvenile justice involvement
 - Live Spot Gridley
- All PEI Priority Populations
 - Mental Health Awareness

Describe the process and rationale used by the county in selecting their PEI priority population(s) (e.g., assessment tools or method utilized).

BCDBH designed a process for collecting and analyzing data for the PEI Community Workgroup to study and determine priority populations and service needs. The workgroup reviewed six sources of community input, and data were gathered between September 2007 and March 2008 included: survey, community meetings, targeted focus groups, additional written input from staff and the community, census data, and Butte County Behavioral Health service data. The 32 member community workgroup identified seven local needs for PEI services, matched them with the PEI State priority populations. The group subsequently recommended the development of specific services and programs, and this ultimately became the approved MHSA plan.

The overall strategy to ensure that PEI priority populations were addressed in the plan included expanded outreach, community involvement, and input access points to diverse demographical populations. BCDBH made extensive efforts to include previously identified unserved/underserved populations. This process included:

- Community Input Meetings held in Chico, Oroville, Paradise, and Gridley that focused on the five PEI Community Needs: disparities in access to mental health services, psycho-social impact of trauma, at-risk children/youth/youth adults, stigma and discrimination, and suicide risk. Participants were asked to identify what condition the community was in, and possible solutions.

- Targeted focus groups were conducted for traditionally unserved/underserved populations: Latinos, Hmong, Native Americans, African Americans, consumers with serious mental illness (SMI), older adults, and LGBTQI+ members. These meetings were tailored to be sensitive and relevant to each diverse group. Questions include the five PEI Community Needs, personal experiences with BCDBH, and services they would like to see. Meetings included flyers in threshold languages and translators.
- Survey of Behavioral Health staff, partner organization staff, consumers and family members, community members, and Behavioral Health Board members. Surveys were distributed at staff meetings, drop-in center consumer meetings, and community meetings. The surveys requested demographical information and input on the PEI Community Needs.
- Community members, families, consumers, and service providers were offered opportunities to contact the BCDBH with additional input.
- Census data focused on comparing age, location, race/ethnic, poverty, and threshold languages spoken at home.
- Butte County Department of Behavioral Health service data.

This was a facilitated process designed to identify key community mental health needs and priority populations. After the information was compiled, it was presented to the PEI Community Workgroup. The Workgroup represented Butte County's diverse ethnic, cultural, and racial populations. The Workgroup utilized the above information when developing the PEI Plan, which designed nine programs that assist all of the priority populations.

The diversity of the PEI Community Workgroup is evidence of the inclusive manner in which the community was invited to participate in the planning process. The community meetings, targeted focus groups, and written input also speak to the effectiveness of the community planning process, which ensures that mental health needs concerning all priority populations were considered.

Criterion 3: Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities

I. Identified unserved/underserved target populations (with disparities):

Target populations specific to Butte County identified by their correlating MHSA component:

CS&S FSP Populations

- Homeless and risk of homelessness adults
- Homeless, at-risk of homelessness TAY
- Foster children
- Older adults

WET - Targets for Workforce Growth

Findings from the BCDBH MHSA WET Workforce Needs Assessment include a shortage of bilingual/bicultural staff in the local public mental health workforce. Specifically, Latino/Spanish speaking and Hmong/Hmong speaking staff remain hard to recruit/retain. BCDBH is committed to expanding the diversity of its workforce to include a higher percentage of staff members from all unserved and underserved groups.

Prevention Early Intervention

- Unserved & Underserved Populations
- Stressed Families and Children, including new moms
- TAY
- African American
- Hmong
- Latino
- LGBTQ+
- Older Adults

Target populations specific to Butte County Medi-Cal include:

- Underserved cultural populations
 - Latino
 - Hmong
 - African American
 - Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQI+)
- Individuals experiencing onset of serious psychiatric illness
- Children/youth in stressed families
 - Latino
 - Hmong
 - African American

- Trauma-exposed
 - Latino
 - Hmong
 - African American
 - LGBTQ+
- Children/youth at risk of school failure
 - Latino
- Children/youth at risk or experiencing juvenile justice involvement
 - Latino

II. Identified disparities (within the target populations)

CS&S FSP Populations

Homeless and Risk of Homelessness Adults:

The Homeless Continuum of Care, which BCDBH partnered with, conducted a Point in Time Homeless Census and Survey. This survey identified 1,983 individuals in 1,583 Butte County households, living without safe, adequate housing. The survey contained demographic information that assisted BCDBH in identifying homeless disparities. The information below are direct excerpts from the 2017 Point in Time (PIT) Homeless Census and Survey that highlight homeless households and breakdown homelessness by age, gender, sexual orientation, race and ethnicity. The following data observations are excerpts from the 2017 PIT (see Appendix B for entire survey)

Household Make-Up

“Household make up consists of three types: households with only adults (single or multiple adults with no children present), households with adults and children, and households with only children (minor-age unaccompanied youth). Households without children account for 86% of the households. Families with children account for 8% and Unaccompanied Youth account for 6% of the total households.”⁹

Table 3.0

HOUSEHOLDS	Chico	Gridley	Oroville	Paradise	Other	Total	%
Single Adults	748	25	508	57	13	1351	85.3%
Adults with Children	87	1	26	16	2	132	8.3%
Children without Adults	14	0	77	6	3	100	6.3%
Total	849	26	611	79	18	1583	100%

The household make-up was similar across the communities of Chico, Gridley, Oroville, Paradise, and Other, consistently showing that the majority of homeless individuals counted were single adults. The number of children reported is likely low, considering that the Butte County Office of Education has collected data from 2005-2008 which reflect between 400-600 school aged children experiencing homelessness in Butte throughout one academic year. One reason for this discrepancy could be the difference in methodology (i.e. point-in-time versus yearlong data collection). Additional reasons could be the difference between the HUD and Department of Education definitions of homelessness and/or the unwillingness of survey respondents to share information about their children.

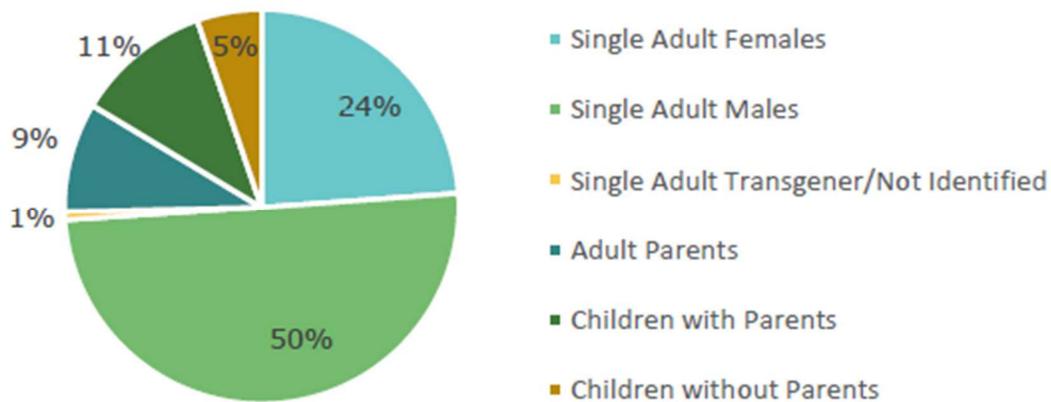
⁹ <http://www.buttehomelesscoc.com/reports/pit/index.php>

Table 3.1

INDIVIDUALS	Chico	Gridley	Oroville	Paradise	Other	Total
Adults Only	815	26	551	72	16	1480
Females	253	11	173	29	7	473
Males	553	15	375	41	9	993
Transgender	4	0	3	0	0	7
Not Identify	5	0	0	2	0	7
Adult/Children	267	2	85	37	7	398
Adults (all genders)	122	1	32	19	4	178
Children	145	1	53	18	3	220
Children without Adults	14	0	77	11	3	105
Female	8	0	47	2	1	58
Male	6	0	30	9	2	47
Total	1096	28	713	120	26	1983

Table 3.1 (above) “shows that single males are the most common individual type within the Adults Only household type, at over half of the surveys completed within Chico, Gridley and Oroville. Paradise and the Other communities are proportionally slightly higher with family households. The majority of households with unaccompanied youth are in Oroville, 60% of which are made up of females.” Figure 3.2 (below) depicts the distribution of individuals by their category for the entirety of survey respondents.

Figure 3.0



Age

“Of those surveyed, adults are more frequently homeless than youth or children, with the highest percent (29%) between 36 and 50 years old. The total number of adults is 1,658. There are 69 young children – infants, toddlers, and preschoolers – who must be cared for by parents, or in child care, during the day. Another 121 children are elementary and middle school aged. About the same percent of children are teens. The number of children – infant to age 18 have increased by 172 since the 2015, which is a 119% increase. The number of transition age youth (18-24 year olds) remain consistent with the 2015 PIT

findings, while their percentage of the population has decreased 46% due to the overall higher count. For the older residents, there are 53 elderly people (as old as 82 years old) without stable housing who completed a survey.”

Table 3.3

AGE RANGES	Chico	Gridley	Oroville	Paradise	Other	Total	%
5 years old or younger	48	0	20	1	0	69	3%
6-14 year olds	74	1	35	11	0	121	6%
15-17 year olds	37	0	75	17	6	135	7%
18-24 year olds	95	0	37	7	4	143	7%
25-35 year olds	267	7	141	18	6	439	22%
36-50 year olds	322	9	203	37	3	574	29%
51-65 year olds	217	11	187	27	7	449	23%
66 years old or older	36	0	15	2	0	53	3%
Total	1096	28	713	120	26	1983	100%

Gender Identity

“Male residents continue to be the majority of the homeless population, at 62%, although there was a slight decrease in percentage since the 2015 PIT. Females comprise 37% of those surveyed, transgender residents and those who do not identify as female, male or transgender are each less than 1% of the population.”

Table 3.4

GENDER	Chico	Gridley	Oroville	Paradise	Other	Total	%
Female	401	11	259	47	11	729	37%
Male	685	17	452	70	14	1238	62%
Transgender	4	0	2	0	1	7	0.5%
Doesn't identify as female, male or transgender	5	0	0	3	0	8	0.5%
Total	1095	28	713	120	26	1982	100.0%

Sexual Orientation

“The sexual orientation of the adults who completed surveys was primarily straight (88%). Another 34 adults (2%) were lesbian or gay. Four individuals identified themselves as bi-sexual and another four as questioning. An additional 13 people identified as a sexual orientation not from the list, such as human or queer. (The sexual orientation question was unanswered on 8% of the surveys).”

Race/Ethnicity

“Butte County is racially homogeneous. The homeless population closely reflects the county at large, with one exception. The percent of those with Asian heritage are 9% of the county population, while only 1%

of the homeless population. The ethnicity was 14% Hispanic or Latino; while it is 16% of the full Butte County population.”

Table 3.5

RACE	Chico	Gridley	Oroville	Paradise	Other	Total	%
American Indian/ Native Alaskan	67	1	56	1	1	126	6%
Asian	4	0	13	0	2	19	1%
Black/African American	33	0	37	0	1	71	4%
Native Hawaiian/ Other Pacific Islander	14	2	10	1	1	28	1%
Multiple Races	193	4	81	13	7	298	15%
White	785	21	516	105	14	1441	73%
Total	1096	28	713	120	26	1983	100%

“When asked about race, 73% of Butte survey respondents answered White, 4% answered Black/African American, 1% answered Asian, 1% answered Native Hawaiian/Other Pacific Islander, 6% answered American Indian/Native Alaskan, and 15% answered Multiple Races. When asked about ethnicity, 14% of Butte survey respondents answered Hispanic. These results are somewhat surprising when compared to the Butte County general population, at 16%.”

Older Adults

Some of the biggest barriers to accessing treatment for older adults is isolation, lack of mobility/transportation, and stigma surrounding mental health treatment. In the ethnically diverse populations elders are a key part of the family system and the community. The Hmong community has gone through a revolutionary change of geography and culture in the last 40 years. Many of the Hmong elders are suffering from severe trauma and loss. The Native American and African American elders suffer from untreated generational trauma, have low levels of trust for the government and government services, and generally have a significant level of stigma associated with accessing mental health services.

PEI Priority Populations

- The Hmong and Latino populations face many of the same barriers in accessing mental health services. These barriers include: (1) language barriers for community members with limited English proficiency; (2) lack of information and education about emotional wellness, mental health issues, and behavioral health services; (3) currently funded programs that do not provide the prevention/early intervention services most desired by these cultural populations; (4) linguistic specialty programs that are not adequately resourced to meet the needs of the populations; (5) stigma, shame, and discrimination associated with recognizing symptoms and seeking treatment; and (6) fear of the consequences of seeking help from the public mental health system.
- The Latino population has expressed their unique trauma in Gridley associated with (1) gang violence and (2) drug trafficking.

Criterion 3

- The African American population spoke to their cultural disparities: (1) young adults who don't know how to help their parents with mental illness; (2) being unable to access county mental health services because people were not "sick enough" (did not meet "medical necessity"); (3) young men who return from prison to no jobs, discrimination, and who decline into depression, lowering self-esteem, and giving up; (4) "healthy" African Americans don't stay in the community to mentor youth; (5) a feeling of stress with no one to talk to who has been through the same thing as an African American; (6) feeling invisible in a world dominated by white people; (7) cultural trauma; and (8) African American youth with a very high rate of incarceration and involvement in violence.
- The LGBTQ+ cultural population attributes their disparities to (1) a lack of support from families or services, (2) violence or victimization, (3) depression, (4) substance abuse or dependency, (5) family rejection due to sexual orientation, (6) feel forced to leave home, (7) feeling of severe isolation, and (8) institutional (school system) reinforcement of LGBTQ+ lifestyle being unhealthy.

III. Identified strategies

Butte County has implemented projects that reach a wide array of geographical, age, and cultural populations within our county. Projects include prevention and early intervention for youth, transitional aged youth, adults, and older adults. The African American, Latino, Hmong, and LGBTQI+ communities receive specialized PEI services. All programs include elements to address suicide prevention and the reduction of stigma and discrimination. Most of the programs address multiple identified needs and priority populations.

Table 3.6

Strategy/Project	Populations	Description	Actions
<i>To empower and embrace African American Families and community by reclaiming, restoring, and revitalizing our cultural heritage, values and identity.</i>	MHSA PEI priority	The African American Family Cultural Center (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.	This program is providing services. Continue to evaluate outcomes and provide support to AFFCC.
<i>Reduce disparities and increase access to mental health services to our Latino and Hmong communities.</i>	MHSA PEI priority	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— <i>promotores</i> —who are local residents trained as community health promoters and community liaisons. Latino and Hmong communities find reassurance by speaking with locally trained residents that share their culture and language.	This program is providing services. Continue to evaluate outcomes and provide support to Promotores.
<i>Support, Employment, Assistance, Recovery, Consumer Housing (SEARCH) Project</i>	MHSA/CS&S Population	This program provides Full Service Partnership services to individuals who are homeless or at-risk of homelessness, who suffer from severe mental illness.	This program is providing services. Continue to evaluate outcomes and provide support to SEARCH.

Strategy/Project	Populations	Description	Actions
<i>Prevent suicide, decrease stigma of mental illness, increase access to mental health services within the LGBTQI+ community</i>	MHSA PEI priority	Stonewall Alliance Center of Chico provides suicide prevention, education, and outreach services throughout Butte County to gay, lesbian, bisexual, transgender, queer and intersex (LGBTQI+) youth and young adults, as well as their families, friends, allies and institutions, organizations, service providers and educational facilities.	This program is providing services. Continue to evaluate outcomes and provide support to Stonewall.
<i>Older Adult Suicide Prevention and Education Program</i>	MHSA PEI priority	Services provided by Passages 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.	This program is providing services. Continue to evaluate outcomes and provide support to Passages.
<i>Serve Hmong elders who have experienced historical trauma often associated with the Vietnam War</i>	MHSA PEI Priority	Zoosiab staff perform outreach activities to assist Hmong 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.	This program is providing services. Continue to evaluate outcomes and provide support to Zoosiab.
<i>Engage the youth in culturally diverse communities (Gridley and Oroville) to participate in prevention and early intervention services</i>	MHSA PEI Priority Youth and Transitional Aged Youth	The Live Spot offers daily activities, workshops, school success services, special events and employment opportunities for youth. This program blends youth development principles with youth-led environmental prevention strategies and school climate initiatives. The project 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.	This program is providing services. Continue to evaluate outcomes and provide support to the Live Spot.

Strategy/Project	Populations	Description	Actions
<i>Increase number of bilingual, bicultural staff</i>	MHSA/CS&S/PEI population	Recruit for Hmong and Spanish Speaking Staff. Continue to increase the number of African American, Native American, Latino, Hmong, LGBTQI+, staff members.	Recruit for Hmong and Spanish speaking staff. When possible, hire local staff from the community that is being served.
	Medi-Cal population MHSA/CS&S/PEI population	Increase trust and enhance positive working relationships with the African American, Hmong, Latino, LGBTQI+, Native American, and older adult communities.	Continue to provide liaisons to communities. Continue to collaborate with community members. Be intentional and specific about collecting input from communities.
<i>Develop environments at BCDBH and contract providers that allow LGBTQI+ staff to feel safe in coming out at work.</i>	BCDBH and contract provider staff		Increase numbers of LGBTQI+ staff that are 'out' at work and can therefore provide expertise regarding the LGBTQI+ community to both staff and consumers.
	Medi-Cal population		
	MHSA/CS&S/PEI population		
<i>Identify ways in which BCDBH department leadership follows up on identified strategies to promote and assist with successful implementation of strategies.</i>	Medi-Cal population	To have BCDBH department leadership actively engaged in monitoring of implementation of cultural competency strategies.	Have BCDBH cultural competency manager review cultural competency strategies with BCDBH Director on a quarterly basis. Have BCDBH Cultural Competency Committee review on a quarterly basis.
	MHSA/CS&S/PEI population		

Strategy/Project	Populations	Description	Actions
<i>Provide training in unique issues related to psychiatric crisis and in the African American Native American LGBTQ+, Hmong, Latino and older adult communities.</i>	BCDBH and contract provider staff Medi-Cal population MHSA/CS&S/PEI population	Provide access to Cultural Competency Trainings to staff and providers	Grand Rounds trainings are relaunching in 2018 through coordination from the Cultural Competency Committee. Develop workgroup to design and implement cultural competency academy.
<i>Provide training and education to department staff about Native American, African American, Hmong, Latino, LGBTQ+ communities.</i>	BCDBH and contract provider staff Medi-Cal population MHSA/CS&S/PEI population	Provide access to Cultural Competency Trainings to staff and providers	Grand Rounds trainings are relaunching in 2018 through coordination from the Cultural Competency Committee. Develop workgroup to design and implement cultural competency academy.
<i>Offer training and education to tribal communities about MH, substance abuse, and co-occurring disorders, including outreach.</i>	BCDBH and contract provider staff Medi-Cal population MHSA/CS&S/PEI population	Offer partnership and training to local tribal communities.	Develop partnership to identify methods of training and outreach regarding co-occurring disorders in the Native American Population. Identify action steps to take regarding training and outreach.
<i>Increase the competency of the procedure used to capture race and ethnicity for BCDBH staff</i>	BCDBH staff	The choices available for race/ethnicity selection for our staff members are very small, especially when comparing with the options available in Avatar for our consumers.	BCDBH Human Resources department has agreed to implement changes that would allow for a larger dictionary of race and ethnicity for staff to choose from.

Strategy/Project	Populations	Description	Actions
<p><i>Integration of the Framework for Eliminating Cultural, Linguistic, Racial and Ethnic Behavioral Health Disparities</i></p>	<p>BCDBH and contract provider staff</p>	<p>This Framework is a guideline developed by California Behavioral Health Directors Association on how to integrate national Culturally and Linguistically Appropriate Service (CLAS) standards. CLAS standards are intended to advance healthy equity, improve quality, and help eliminate health care disparities.</p>	<p>The Cultural Competency Manager will complete the Framework Checklist to provide an accurate reflection of the Cultural Competency of the agency.</p>
	<p>Medi-Cal population</p>		
	<p>MHSA/CS&S/PEI population</p>		
<p><i>Have a process in place to ensure that interpreters are trained and monitored for language competence</i></p>	<p>BCDBH staff BCDBH and contract provider staff</p>	<p>Ensure that staff who are receiving bilingual pay and/or contracted for translated services have been trained in or have experience in the mental health field.</p>	<p>The Cultural Competency Manager will initiate an evaluation of how to implement this process.</p>
	<p>Medi-Cal population</p>	<p>Translator/Interpreter Service Evaluation is used to monitor individuals on their skills and ability to cooperate with staff and consumers.</p>	
	<p>MHSA/CS&S/PEI population</p>		

IV. Planning and monitoring of identified strategies/objectives/actions/timelines to reduce mental health disparities

Method for monitoring CCP strategies

The annual Cultural Competence Plan will be reviewed by the Cultural Competency Advisory Team, the Leadership Team, and the Behavioral Health Board on a regular basis. The following table illustrates the plan for monitoring implementation:

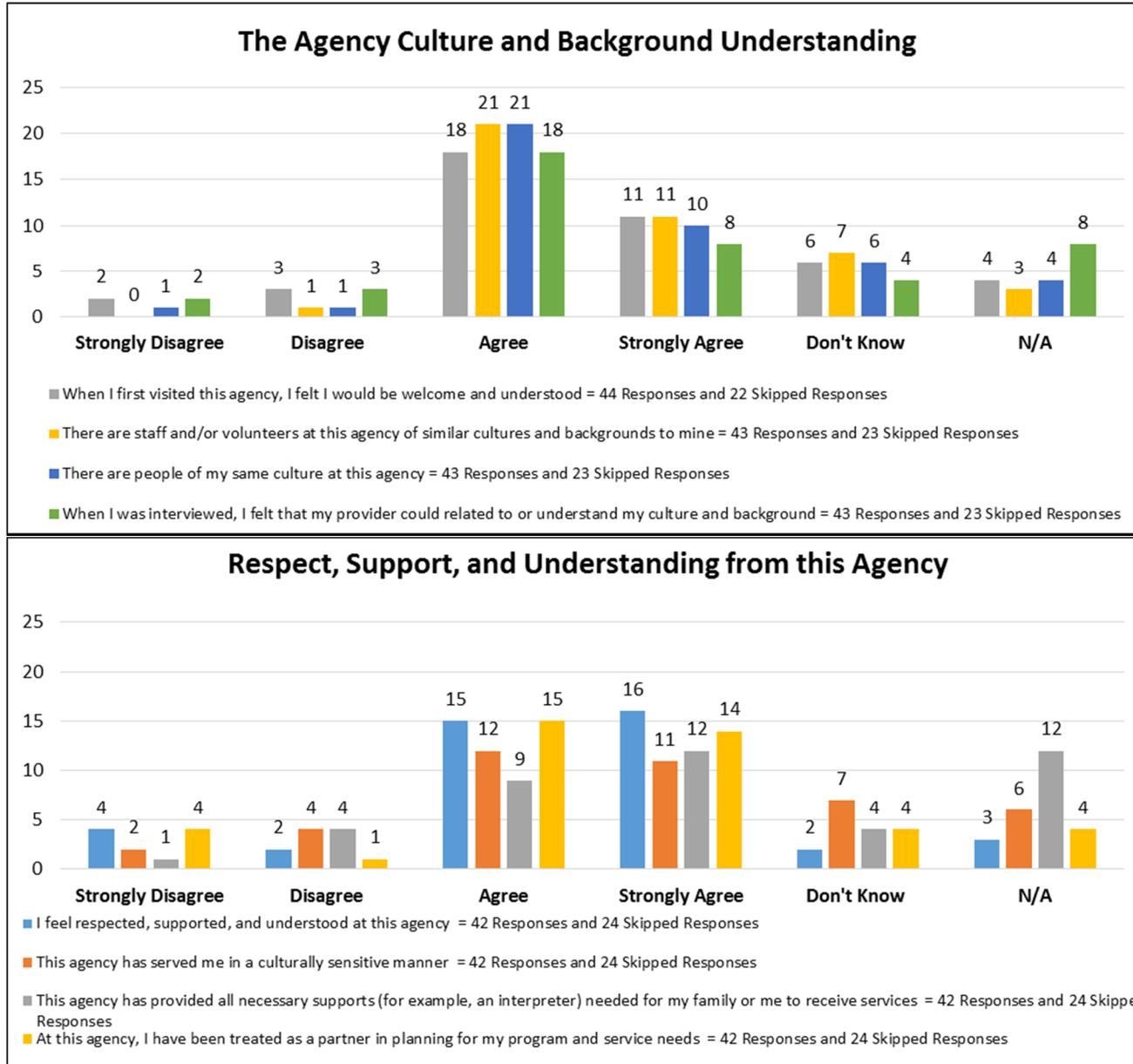
Table 3.7

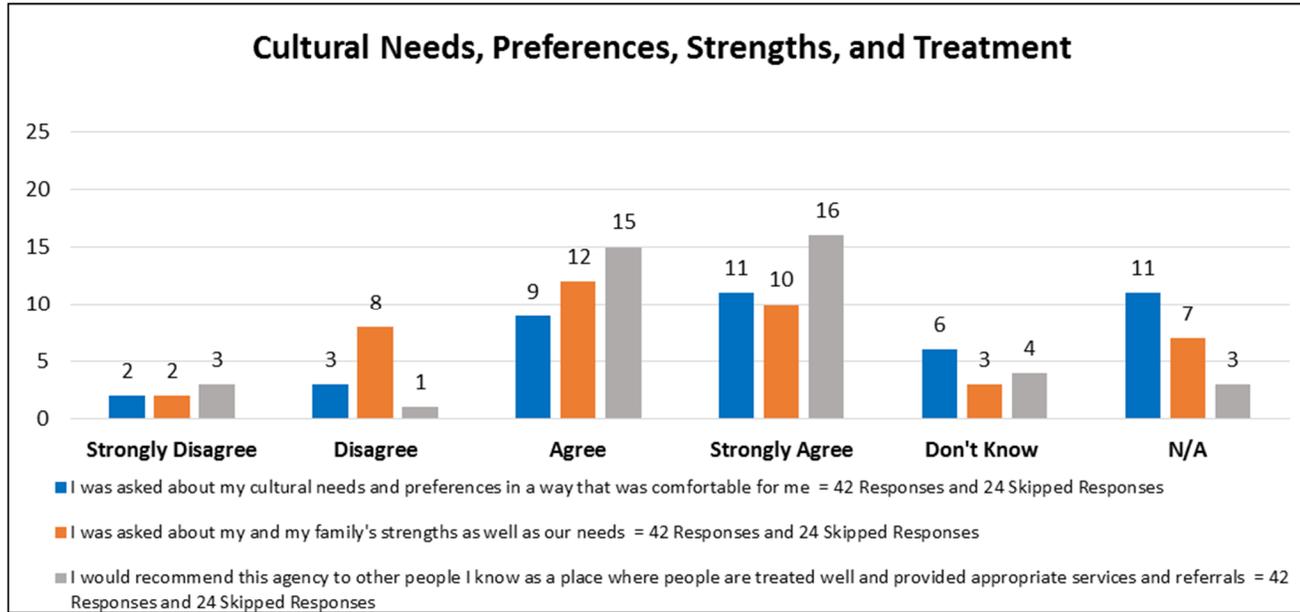
Who Will Review and Comment	Frequency	Method
<i>Cultural Competency Manager</i>	On-going	
<i>BCDBH Director</i>	Quarterly	Cultural Competence Manger will meet with BCDBH Director and review plan
<i>Cultural Competency Advisory Committee</i>	Quarterly	Will review plan during meeting and make comments/recommendations regarding progress
<i>BCDBH Leadership Team</i>	Quarterly	Member of the Cultural Competency Committee will report results of their review with comments and recommendations to the BCDBH Leadership Team
<i>BCDBH Behavioral Health Advisory Board</i>	Quarterly	The BCDBH Behavioral Health Advisory Board will receive a quarterly update regarding the progress of the CCP.

Organizational Cultural Assessment

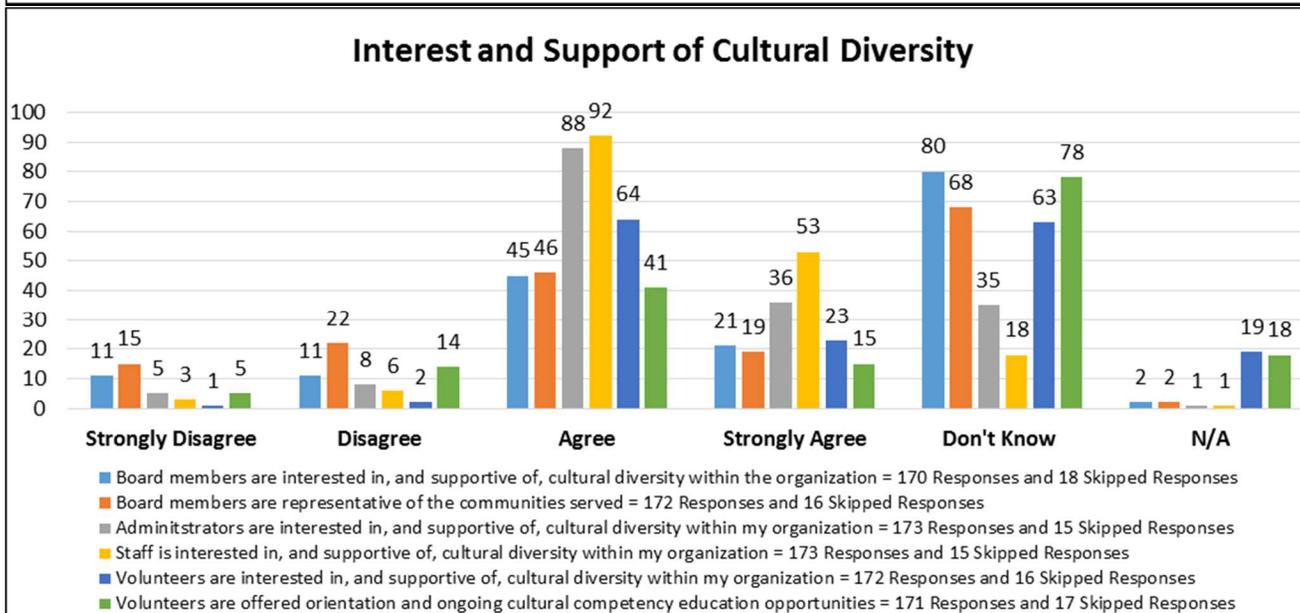
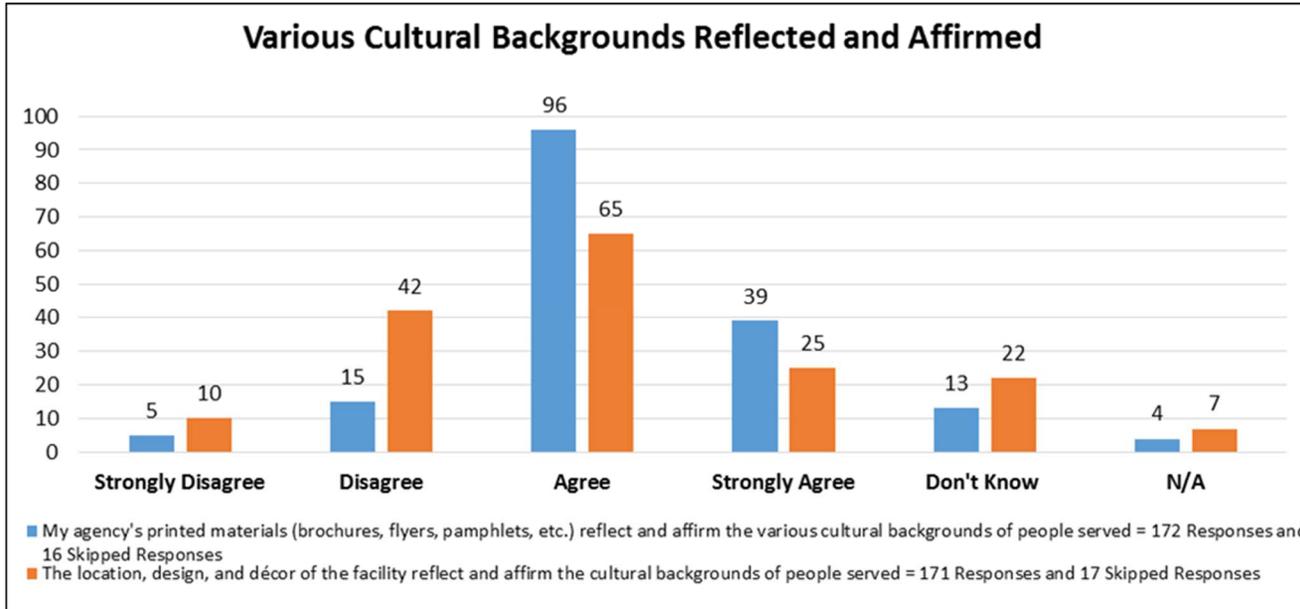
In 2014, the BCDBH identified a need for an Organization Cultural Assessment. The CCC reviewed questions and methods and provided input and feedback on the assessment. There were two versions of the assessment developed using the structure of the 2010 Assessment. BCDBH tried to model the previous assessment as much as possible to allow for patterns or changes in responses to be determined. There was a staff assessment and a consumer assessment. They were distributed via email and paper copy to all internal and contracted staff and paper copies were provided to clients. There were 188 responses from staff and 66 consumers surveys returned. The entirety of this analysis of this assessment can be found in Appendix A.

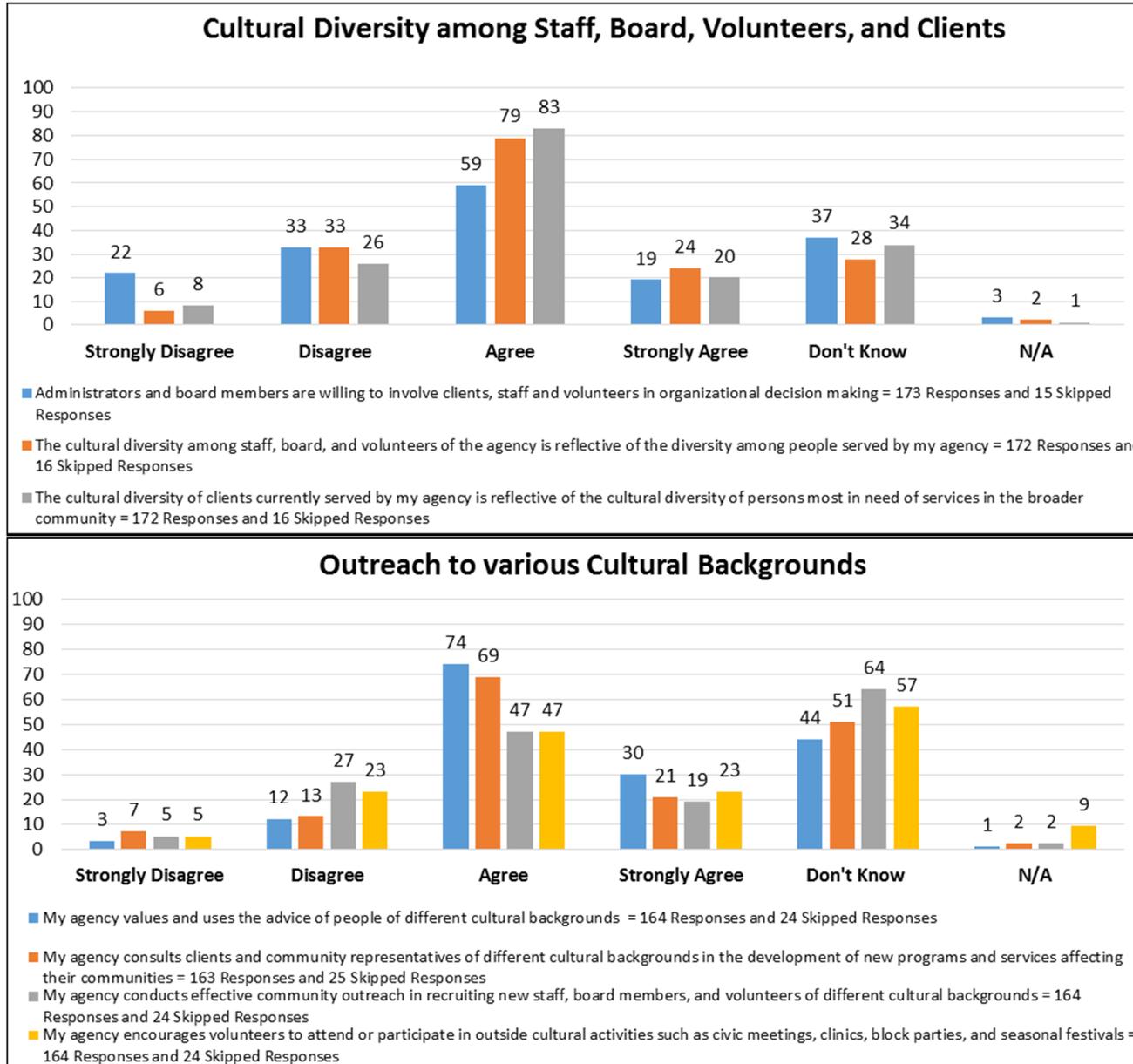
Consumer Outcomes

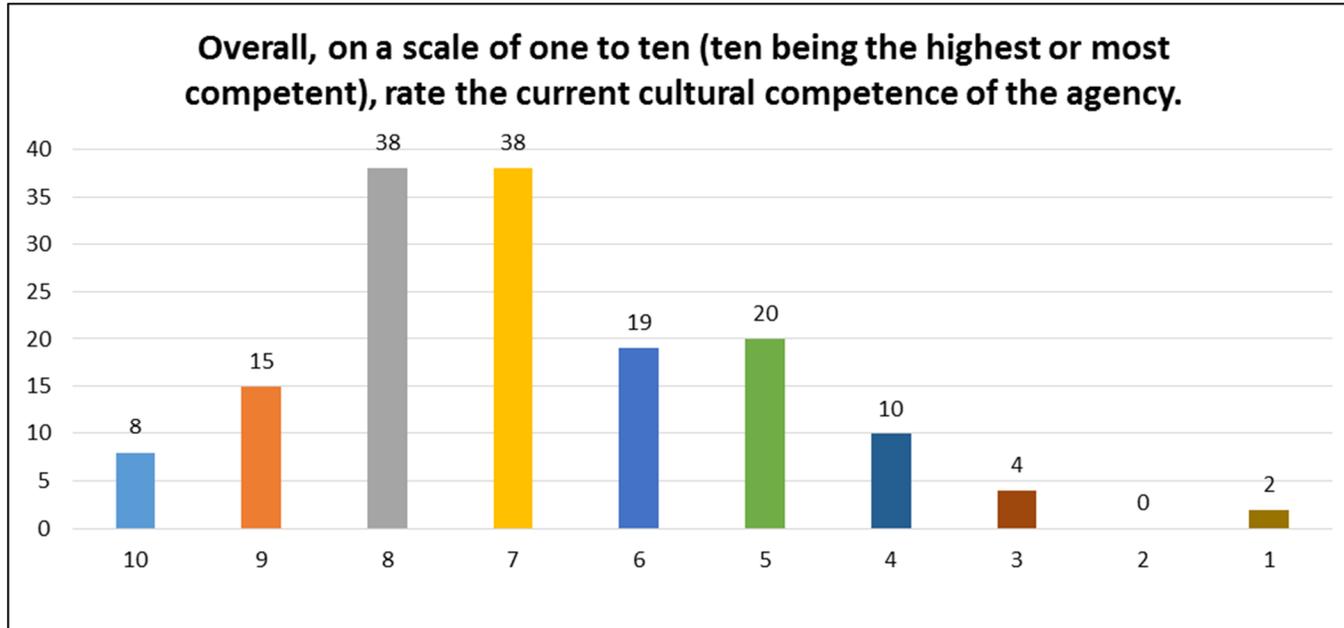




Staff Outcomes







Criterion 4: Client/Family Member/Community Committee: Integration of the Committee within the County Mental Health System

I. The county has a Cultural Competence Committee, or other group that addresses cultural issues and has participation from cultural groups, that is reflective of the community.

A. Brief description of the Cultural Competence Committee or other similar group (organizational structure, frequency of meetings, functions, and role).

The Cultural Competency Committee (CCC) includes various community members, cultural organizations, and BCDBH staff. The CCC is designed to include representatives from local racial, ethnic, and cultural groups to ensure an accurate representation of the diversity in Butte County and the client's the MHP serves. The CCC reviews the representative positions on annual basis to ensure that the CCC is an accurate and robust depiction of the local population. Recruitment for representatives is on-going, and positions are filled as they are vacated.

Current Representatives	
African American	Homeless Shelter
BCDBH Cultural Competency Coordinator	Latino/a--Spanish Speaker
BCDBH Systems Performance Unit Analyst	LGBTQ+
BCDBH Training Coordinator	Native American
Consumer Patient's Rights Advocate	Older Adult
Consumer/Wellness Center	Public Health Department
Family Member	Substance Use Disorder
Foster Care Advocate	Veterans Services Officer
Hmong	Youth, Homeless

Frequency of Meetings

At a minimum, meetings take place quarterly. However, when working on large projects the committee has, and will, meet monthly. At this time the committee has agreed to meet monthly for six months and then reevaluate whether to continue the monthly meeting schedule or move back to the quarterly meeting schedule.

Functions and Roles

In 2017, the Committee was able to define a mission statement:

“The Cultural Competence Committee works to enhance the behavioral health system of care by reducing behavioral healthcare disparities through collaborating with diverse populations and sharing diverse perspectives. This committee takes ownership of promoting cultural understanding and appreciation through education, advisement, and recommendations of culturally sensitive policies and practices to our community. This committee strives to recognize personal and social biases and to consciously build respectful interactions.”

The committee’s current long term goals are to assist in updating the Cultural Competence Plan based on the new state guidelines, guide the department as an updated mental health workforce Cultural Competence Assessment is completed, and actively participate in policy and grant review to confirm culturally appropriate considerations. Short term goals include supporting and coordinating the relaunch of Grand Rounds trainings in 2018. The Committee has offered to provide free cultural trainings on a quarterly basis to internal and contracted staff.

General practice for retaining culturally/linguistically members in the Cultural Competency Committee is to maintain a membership that includes various cultural/linguistic backgrounds that reflect the makeup of the County, which includes a mix of community members, contract providers, and BCDBH staff members. The balance of the Cultural Competency Committee is assessed on an ongoing basis and when needed new members are identified to fill gaps.

Cultural Competency representation is included in contract language for contracted providers to ensure that the community partners who are culturally and linguistically diverse are included on the CCC. Meeting minutes from a recent CCC meeting can be found in Appendix C.

B. The Cultural Competence Committee, or other group with responsibility for cultural competence, is integrated within the County Mental Health System.

The BCDBH Cultural Competency Committee reviewed its history and contribution to the Department; a workforce cultural competency assessment and participation in the input and review of the Cultural Competency Plan (CCP).

Organization Assessment

History

The CCC identified and contributed to a cultural competency assessment of the Butte County behavioral health workforce in 2009. The CCC was clear that participation from BCDBH and BCDBH contract providers was essential. Another key desire was to have input from all levels, consumers, volunteers, line staff, supervisor/manager, and administration. Additionally, a review of organizational cultural competency was desired. To the CCC this meant a review of policies, procedures, forms and other documents, and evaluation of the organization structure.

In 2009, the CCC reviewed several different cultural competency assessment tools. The sub-committee engaged Robert Martinez to review the Greenbook Assessment. Robert Martinez identified the Greenbook as a tool that would meet the needs of BCDBH. The CCC recommended that BCDBH use the Greenbook Assessment. The CCC further recommended that the questions be expanded to include questions about specific unserved/underserved groups. The goal of these additional questions is to be able to identify specific areas in which the workforce is doing well and areas that would benefit from training and education.

The Greenbook Project Cultural Competency Organizational Self-Assessment Toolkit was adopted as the BCDBH cultural competency assessment tool in 2010. Gary Bess Associates and BCDBH Systems Performance, Research and Evaluation (SPRE) Unit developed and field tested the additional questions. In July 2010 the cultural competence assessment took place. The assessment was available in English, Spanish, and Hmong.

Current

In 2014, the BCDBH identified a need for an updated Organization Assessment. The CCC reviewed questions and methods and provided input and feedback on the assessment. There were two versions of the assessment developed using the structure of the 2010 Assessment. BCDBH tried to model the previous assessment as much as possible to allow for patterns or changes in responses to be determined. There was a staff assessment and a consumer assessment. They were distributed via email and paper copy to all internal and contracted staff and paper copies were provided to clients. There were 188 responses from staff and 66 consumers surveys returned. The implementation of this data collection cycle was facilitated by the department's SPRE Unit. The analysis of this assessment can be found in Appendix A.

CCC Input and Review of the Cultural Competency Plan (CCP)

The CCC has provided active input into the CCP by identify and evaluating current and existing strategies and recommending new strategies. CCP made recommendations for new strategies to address issues of disparity and cultural competence. Additionally, all members of the CCC had the opportunity to review the draft Cultural Competence Plan and make recommendations before it was submitted.

Other Contributions

In early 2017, the CCC reviewed the MHSA Three Year Program and Expenditure Plan 2017/2018, and recommended that the plan move forward to the Behavioral Health Board and Board of Supervisors for approval.

The CCC contributed insightful feedback on the New Employee Orientation. This enhanced initiative will train all new employees on Cultural Competency; state and federal requirements, the population we serve, and the agency's commitment to building culturally competency through knowledge, awareness, and sensitivity. This presentation can be found in Appendix D.

Criterion 5:

Culturally Competent Training Activities

I. The county system shall require all staff and stakeholders to receive annual cultural competence training.

The Department's Cultural Competency Manager, Cultural Competency Committee, and Training Coordinator collaborate in the development and application of culturally competent trainings to ensure that all staff have receive at least one annual culturally competent training (BCDBH Policy 68, Appendix E).

The Committee has developed a plan for implementing a quarterly "Grand Rounds Cultural Training" to all Behavioral Health staff and contracted staff in 2018. In addition to these trainings, our electronic learning system, "Relias", has several cultural training offerings that are available to all staff at all times. These selections include the following:

- A Culture-Centered Approach to Recovery
- Cultural Diversity
- Cultural Issues in Treatment for Paraprofessionals
- Infusion of Culturally Responsive Practices
- Relapse Prevention: Cultural Issues
- Advocacy and Multicultural Care
- Groundwork for Multicultural Care

As appropriate, the MHSA fundamental concepts are embedded into all trainings. During the planning process, the trainer reviewed the MHSA fundamental concepts, and incorporated relevant elements into the curriculum. Please see Appendix F for the reported list of annual trainings for staff.

The Cultural Competency Committee is dedicated to organizing and providing comprehensive trainings representing the diverse racial and ethnic populations in Butte County including Latino, Hmong, Native American, and African American families; as well as socially and culturally diverse groups such as LGBTQI+, older adult, transitional aged youth, the homeless population, veterans and foster care youth. These trainings are open to the entire Butte County workforce, including contracted staff. The trainings have been well attended and include the following topics:

- Best Practices in Serving LGBTQI+ Individuals and Families
- Intimate Partner Violence: Considerations for LGBTQI+ and Youth Victims and Survivors
- Transgender* Clients: Language, Sensitivity, Identities and Emotional Transition
- Historic Trauma and Family Dynamics
- Cultural Proficiency Training: Weaving Cultural Proficiency into Effective Behavioral Health Practice
- Hmong Cultural Center – More specifics on the training for Grand Rounds is needed
- African American Family Cultural Center– More specifics on the training for Grand Rounds is needed
- NAMI– More specifics on the training for Grand Rounds is needed
- In Our Own Voice: Unmasking Mental Illness presentations by consumers
- Culturally Based Wraparound: Listening to Culturally Diverse Families

II. Counties must have a process for the incorporation of Client Culture Training throughout the mental health system.

BCDBH has demonstrated a strong support of the client culture through a variety of trainings. In 2014 and 2015 these have included the following:

- BCDBH worked with several of our former clients that are now part of the workforce to present their own stories, experiences, as well as providing a question and answer session. These trainings help staff to better understand preconceived notions, stereotypes, and examine attitudes regarding mental illness. Attendees gained a more accurate view of a stigmatized and misunderstood experience, and had a more humanized perception of people living with mental illness.
- BCDBH currently has an initiative to become a Trauma-Informed organization and there have been trainings provided for an introduction to Trauma-Informed Systems trainings to provide the base knowledge and shared language around the subject of Trauma. These trainings have been the foundational trainings and there will be more trainings that will develop upon this foundational training over the remainder of the 1718 fiscal year, continuing on through the next fiscal year and annually to keep our staff “Trauma-Informed”. This training helps our workforce become more culturally sensitive to our peers, as well as the clients we serve by providing a better foundational understanding of their backgrounds and how an individual’s actions can affect another person’s reaction.
- BCDBH is working with community members on the Cultural Competency Committee to provide quarterly culturally and socially competent trainings to our staff. This will be developing into more trainings throughout the year as training opportunities are needed to ensure staff are receiving adequate exposure trainings that represent our demographic population that we serve.
- BCDBH collaborated with BJ North and our own staff members, including lead WRAP Facilitator Tony Stefanetti, in providing a five day Copeland’s Certified Wellness Recovery Action Plan (WRAP) facilitator training to Butte County staff, which included many of our Peer Advocate staff, and community partners this August. The goal of providing this training was to develop a cadre of consumers who are able to lead WRAP groups and help consumers complete WRAP plans. This collaborative has broadened WRAP resources in the region by offering at least one annual train the trainer workshop and at least one 3 days WRAP Seminar I course for our staff and community partners. Placing emphasis on WRAP plans has highlighted their effectiveness and increased their use and success throughout BCDBH.

Criterion 6: County's Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff

I. Recruitment, hiring, and retention of a multicultural workforce from, or experienced with, the identified unserved and underserved populations

Butte County Department of Behavioral Health (BCDBH) is committed to developing a culturally and linguistically competent behavioral health workforce throughout our system of care. The department strives to employ a workforce that reflects the cultural identities of our consumers to ensure effective service delivery. BCDBH actively recruits for Spanish and Hmong language clinicians, counselors, and interns. BCDBH offers a bilingual pay differential pending verification of the employee's language or communication skill ability. Key BCDBH staff in Gridley are bilingual and bicultural employees who are embedded in the community and actively involved in such community activities as soccer, church, cultural events, etc. The Promotores program in Gridley and Chico provides outreach to the Latino and Hmong communities with staff from those communities who are bilingual and bicultural.

Our MHSAs funded community based contractors have focused on underserved communities and has improved both the workforce race/ethnicity comparability and the penetration rates in serving these communities. Hmong and Spanish speaking staff are available in Chico, Oroville, and through Crisis Services. A major obstacle has been recruiting and retaining psychiatrists, family nurse practitioners, and nurses, as well as licensed Hmong, African American, Native American, and Latino staff. It is worth noting that as of December 2016, California ranks number one¹⁰ in the country for Mental Health Care Health Professional Shortages Area (HPSA). "The primary factor used to determine a HPSA designation is the number of health professionals relative to the population with consideration of high need. Federal regulations stipulate that, in order to be considered as having a shortage of providers, an area must have a population-to-provider ratio of a certain threshold. For mental health, the population to provider ratio must be at least 30,000 to 1 (20,000 to 1 if there are unusually high needs in the community)." When considering the implications of this data point, in addition to the need for a diverse population of mental health care providers one can determine the high challenge for meeting the need for hiring and retaining culturally and linguistically competent staff.

¹⁰<http://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Total%20Mental%20Health%20Care%20HPSA%20Designations%22,%22sort%22:%22desc%22%7D>

Data

The charts and tables below depict the distribution of race and ethnicity for BCDBH consumers and race for BCDBH staff.

Table 6.0

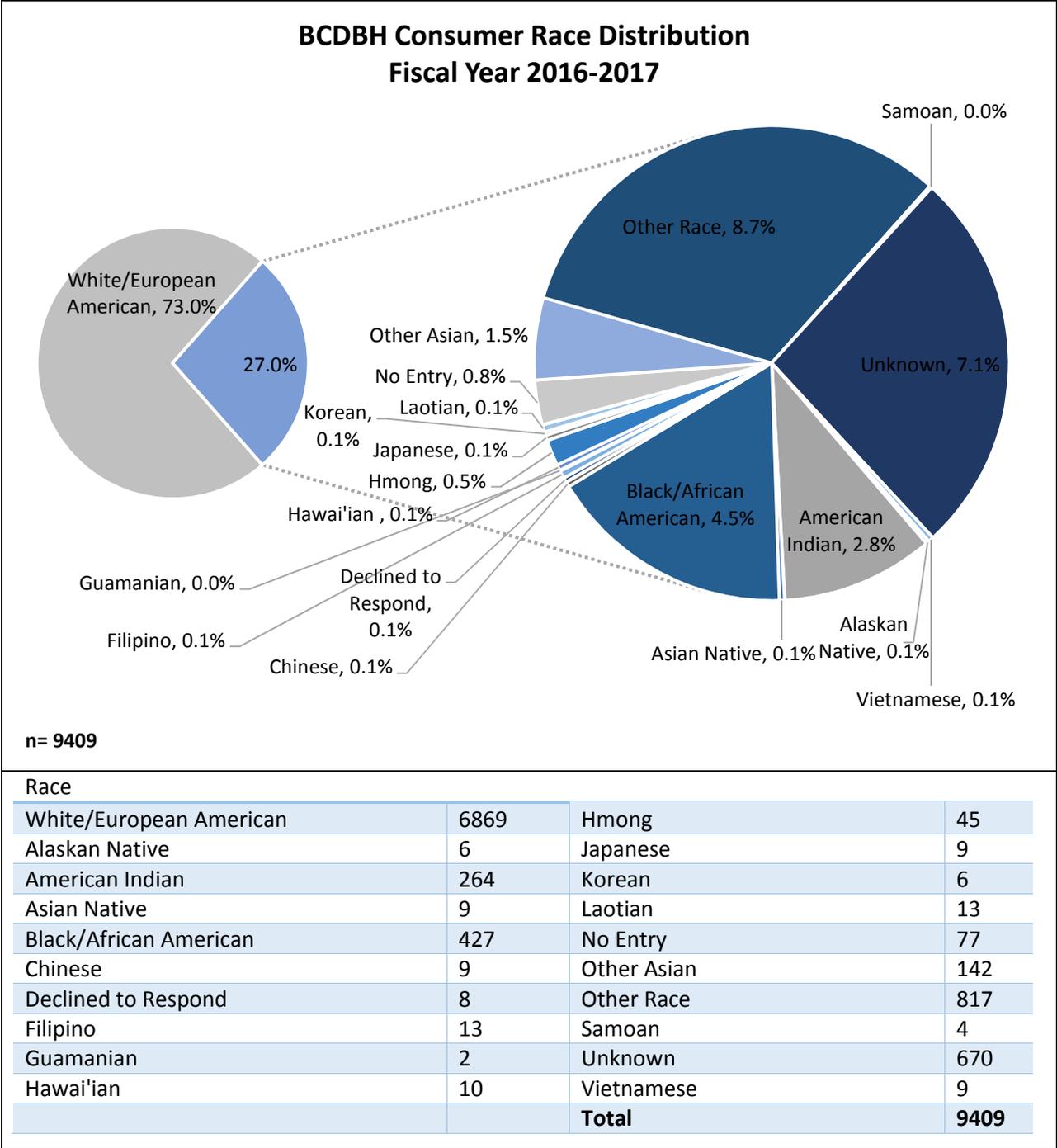
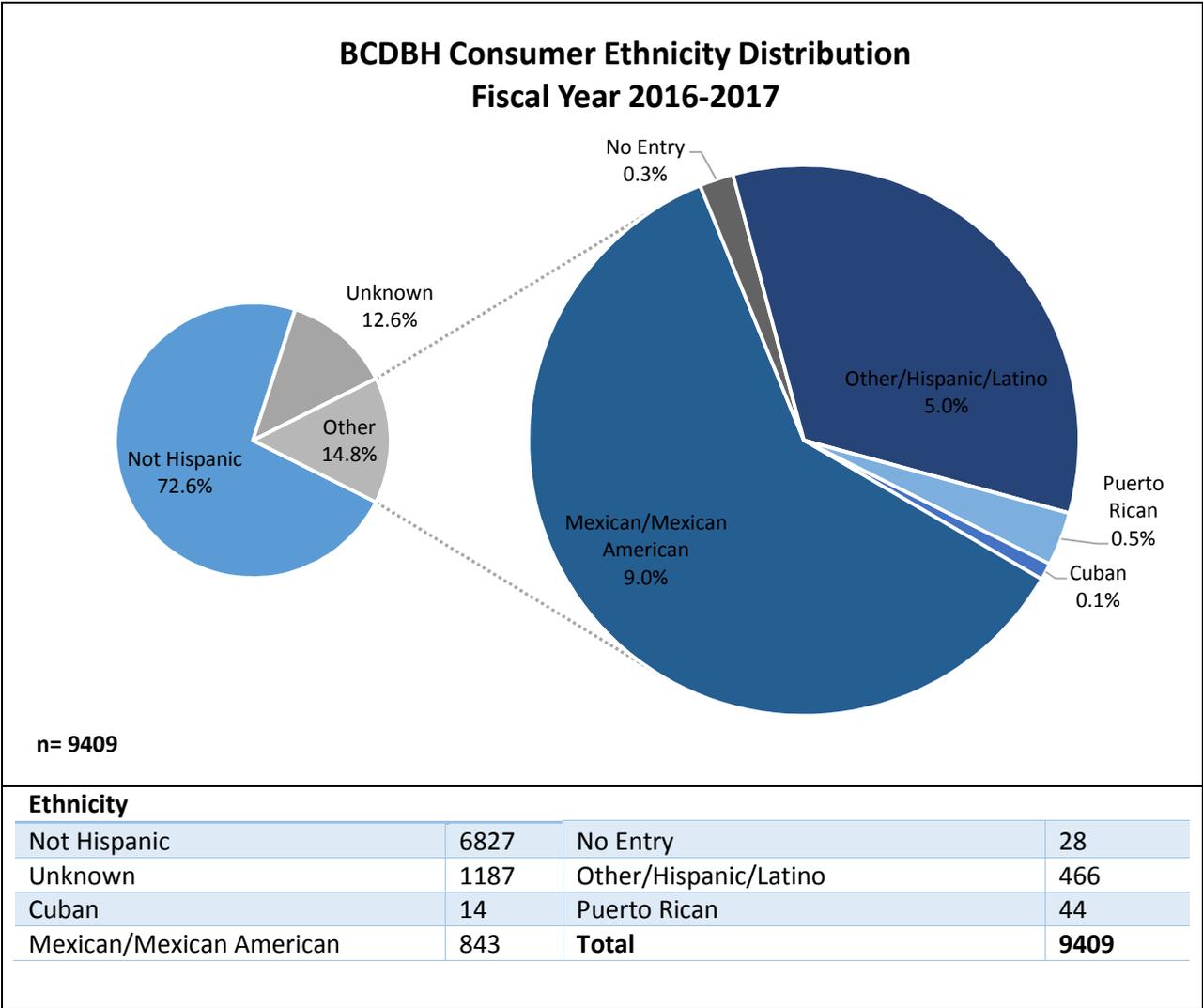
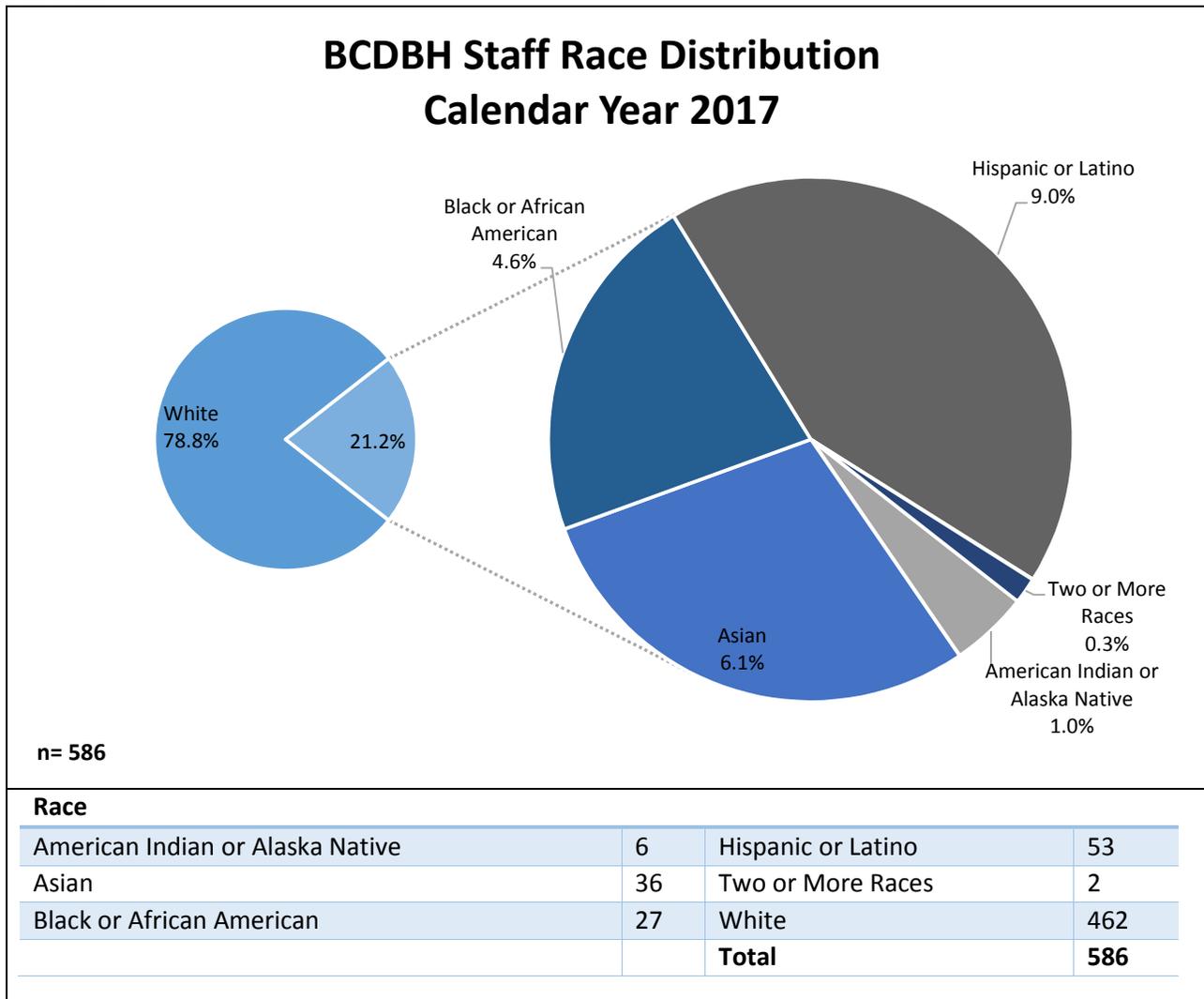


Table 6.1



All consumer data is extracted from our Electron Health Record, Avatar.

Table 6.2



The staff data is collected through PeopleTrack by the BCDBH Human Resource Department.

Analysis

Unfortunately, our existing staff does not represent our service population, with Caucasian (White) staff at 78.8% compared to our consumer population percentage of 73.0%. The ethnic community that is least represented is the Hispanic/Latino population where our Latino staff are only 9.0% yet Latino ethnicity is 14.6% of our service population. The staff to consumer ratio for Black/African American is equivalent. It seems that our staff to consumer ratio for the Asian population exceeds the need, but there are questions about how the staff data is being captured.

After closer inspection of the processes that go into identifying staff’s race, it was determined that there is an opportunity to change our process to portray a better reflection of staff demographics. For example, the choices available for race/ethnicity selection are very small, especially when comparing with the options available to our consumers. Behavioral Health’s Human Resources department has agreed to implement changes that would allow for a larger dictionary of race and ethnicity for staff to choose from. This project has been added to our Identified Strategies in Criterion Three.

MHSA: Workforce, Education, and Training

Peer Employment

One strategy that has increased the multicultural nature of the workforce is designating positions that require consumer/family member experience. A variety of BCDBH and contract provider programs have employed this method including: Wellness Centers, SEARCH, LGBTQI+ Suicide Prevention and Education Program (Stonewall), Promotores, African American Family and Cultural Center, Zoosiab: A Community Based Treatment for Historical Trauma to Help Hmong Elders, The Warm Line, and Passages Older Adult programs.

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 behavioral health 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, BCDBH 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 successes and challenges and provides a forum for problem-solving, goal setting, and addressing other employment issues as needed. This ongoing group will continue to evolve as more consumer and family members join the workforce.

Regional Partnership: Distributed Learning

The state administered Superior Regional WET Partnership supports the planning, development, and implementation of a distance learning system. This program encourages the strengthening of curricula in Superior California to support wellness and recovery principles, and assure that mental health departments support and encourage career paths throughout the higher education system. This partnership has identified on-line training resources and county needs for those resources. The MHSA Coordinator participates in the development and work of the proposed Superior Regional WET Partnership. There is no cost for this initiative besides staffing time. Objectives include:

1. Increase the availability of information on regional education and employment activities
2. Increase the coordination of education programs available for regional students to pursue mental health employment
3. Provide a forum for the exchange of strategies and best practices for training, encouragement of mental health career paths

Please see Appendix G for the *Regional Partnership Summary Report of Accomplishments and Lessons Learned*.

Criterion 7: Language Capacity

I. Increase bilingual workforce capacity

Evidence of dedicated resources and strategies counties are undertaking to grow bilingual staff capacity.

Butte County recognizes the Department's need for "bilingual language skills or specialized communication skills" to improve customer experience and reduce cultural/linguistic disparities, therefore, implemented Personnel Rule 11.15 Bilingual Pay Differential. Bilingual pay differential is an incentive for bilingual staff to utilize their skills and for departments to discover untapped resources. This rule does require verification of language and communication skills as defined and administered by the Butte County Human Resources Department.

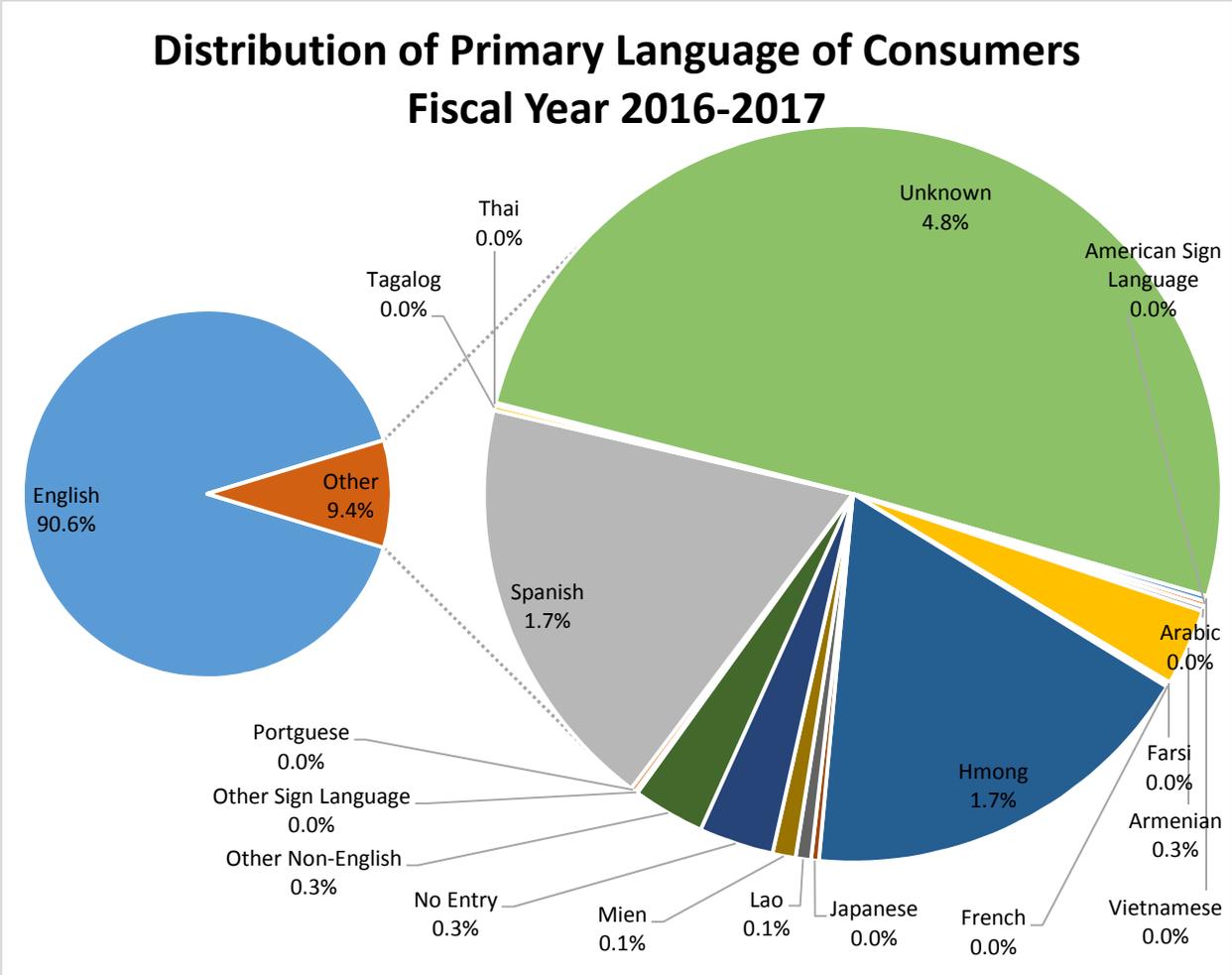
The implementation of the MHSAs has given counties the opportunity and encouragement to increase linguistic capacity. Since implementation, a couple of strategies have been created to combat language barriers between staff and consumers, with the goal of building bilingual capacity. While dedicating bilingual positions is not new, MHSAs embeds this idea into cultural competent programs. For example, the Promotores program dedicates a full time Behavioral Health Counselor "to provide culturally and linguistically appropriate services including screening, assessment, and case management services".

The mission of BCDBH is "to promote culturally and linguistically competent, recovery-oriented service delivery, the Department of Behavioral Health is committed to organizational assessment, provision of education and training, recruitment and retention of bilingual/bicultural direct service employees". The intention is to increase our bilingual staff capacity, thereby, decreasing linguistic barriers. There is a marked improvement in staff cultural and linguistic competency in the following areas:

- Culturally appropriate policies and procedures.
- Front line culturally competent staff.
- Staff communication skills with other races, ethnicities, or cultures.
- Staff assessment of their ability to work with interpreters.
- Staff's ability to elicit assessment history from diverse populations.
- Staff's ability to collaborate with community other than their own.
- Ability to recognize and define their own biases and stereotyping.
- Ability to recognize occasional discomfort with other races and cultures, and not let it interfere with client interactions.
- Ability to negotiate and problem-solve with consumers of another race, etc.

BCDBH also uses contractor translators/interpreters for non-bilingual staff to utilize. The goal of this strategy is to increase the availability of translators/interpreters to staff and decrease language barriers for consumers, thereby, increasing our bilingual capacity.

Table 7.0



Primary Language			
English	8522	No Entry	29
American Sign Language	2	Other Non-English	28
Arabic	2	Other Sign Language	1
Armenian	30	Portguese	2
Farsi	1	Spanish	163
French	1	Tagalog	2
Hmong	157	Thai	1
Japanese	3	Unknown	448
Lao	6	Vietnamese	2
Mien	9	Total	9409

II. Provide services to persons who have Limited English Proficiency (LEP) by using interpreter services

Evidence of policies, procedures, and practices in place for meeting clients' language needs.

Clients can call our toll-free, 24-hour Crisis Line at 1-800-334-6622 to contact our Crisis Services or Access department. Crisis phone operators will connect individuals to the AT&T Language Line (1-800-974-9246) if there is a language barrier and bilingual staff are not available, as dictated in Policy and Procedure BCDBH – 089 (Appendix H). Policy and Procedure – 92 (Appendix I) provides instruction to assist hearing-impaired individuals. Citing to use the California Relay Service (1-800-735-2929) for TDD to Voice and/or (1-800-735-2922) for Voice to TDD.

Standardized procedures are used for contacting AT&T Language Line Services for interpretation when required for non-English speaking clients who are on the telephone or in the office. The AT&T language Line service is a quick, easy way to help Butte County Department of Behavioral Health provide quality service to our clients who speak limited or no English. The list in the evidence book explains the procedures to follow when the AT&T Language Line Service is needed.

New staff orientation includes review of all policies and procedures, which incorporate instructions on accessing the 24-hour Language Line or California Relay Service systems. Staff regularly using the 24-hour phone line are trained onsite by their supervisors.

Evidence that clients are informed in writing in their primary language, of their rights to language assistance services. Including posting of this right.

BCDBH sites are provided a list of material in threshold languages to make available in their lobbies. The Mental Health Patients' Rights poster specifically state "You have the right: To services and information in a language you can understand and that is sensitive to cultural diversity and special needs". The Member Information brochure is another source of information stating under Member Rights "Receive services that are culturally competent and sensitive to language and cultural differences. Interpreter services are provided at no charge. A list of interpreters can be obtained at the reception desk." The client will most likely make first contact with the front desk. If there is a language barrier issue, front desk staff are provided a Determining Language Preference list (Appendix J) that they may hand to the individual who can then indicate what language they need assistance in. The literature required in lobbies are provided by the Cultural Competency Manager and must be available in English, Spanish, and Hmong. Provided in Guide to Medi-Cal Mental Health Services.

Evidence that the county/agency providing accommodation to persons who have LEP and have needed interpreter services or who use bilingual staff.

BCDBH strives to accommodate individuals that may struggle with linguistic barriers through use of bilingual staff and/or interpreter services. When an individual first enters the system and their language has been identified, staff will schedule those individuals with bilingual staff for future meetings. Bilingual staff are self-identified or part of the bilingual pay differential program. If bilingual staff are unavailable, staff are trained to utilize the Translator List provided by the Contracts Unit.

III. Provide bilingual staff and/or interpreters for the threshold languages at all points of contact

Evidence of availability of interpreter (e.g. posters/bulletins) and/or bilingual staff for the languages spoken by community.

BCDBH sites are provided a list of material in threshold languages to make available in their lobbies. The Mental Health Patients' Rights poster specifically state "You have the right: To services and information in a language you can understand and that is sensitive to cultural diversity and special needs". The Member Information brochure is another source of information stating under Member Rights "Receive services that are culturally competent and sensitive to language and cultural differences. Interpreter services are provided at no charge. A list of interpreters can be obtained at the reception desk." The client will most likely make first contact with the front desk. If there is a language barrier issue, front desk staff are provided a Determining Language Preference list that they may hand to the individual who can then indicate what language they need assistance in. The literature required in lobbies are provided by the Cultural Competence Manager and must be available in English, Spanish, and Hmong.

Interpreter services are available for non-English speaking clients, including clinicians and counselors fluent in Spanish, interpreters in non-threshold languages, AT&T Language Line Services and TDD Services for the hearing impaired. The Translator List available through BCDBH intranet website.

Documented evidence that interpreter services are offered and provided and the response to the offer is recorded.

Once an individual becomes a client, the offer and acceptance of interpreter services is documented in their Progress Notes.

Evidence of providing contract or agency staff that are linguistically proficient in threshold languages during regular day operating hours.

The current list of bilingual staff is in Appendix K and Translator List can be found in Appendix L.

Evidence that counties have a process in place to ensure that interpreters are trained and monitored for language competence (e.g., formal testing).

This was determined to be an opportunity for our agency. This has been added to Criterion 3 for Identified Strategies and Projects.

IV. Provide services to all LEP clients not meeting the threshold language criteria who encounter the mental health system at all points of contact.

Policies, procedures, and practices are county uses that include the capability to refer, and otherwise link, clients who do not meet the threshold language criteria (e.g., LEP clients) who encounter the mental health system at all key points of contact, to culturally and linguistically appropriate services.

The department extends its invitation for translators/interpreters to all bilingual individuals in the community. If needed, a separate recruitment is sent out to maintain demand for threshold languages. This practice permitted BCDBH to pool a variety of linguists. During the past fiscal year the Translator/Interpreter List listed nine languages.

A provider list with available non-English languages spoken gives staff the ability to refer clients to services that would match their cultural and linguistic needs.

Provide a written plan for how clients who do not meet the threshold language criteria, are assisted to secure, or linked to culturally and linguistically appropriate services.

Behavioral Health uses various methods to secure or to link clients to culturally and linguistically appropriate services. At the base, recruitment for contract translators/interpreters is open to all languages. Currently, BCDBH offers six additional languages (Hmong, Laotian, Mien, Punjabi, Hindi, and Urdu) aside from threshold or disability requirements. This list is available to all staff each fiscal year and is resent when updates occur. Staff follow the contracted translator/interpreter procedures to acquire these services.

We have staff who speak non-threshold languages fluently. Each site is aware of these individuals and utilizes them when necessary.

Initial phone contact with non-threshold language clients will prompt staff to utilize the AT&T Language Line Services policy and procedure, if there are no equally linguistic staff available to the client. Each site has a Determining Language Preference sheet that clients may use to mark which language they speak. It lists Chinese, English, Hmong, Japanese, Korean, Laotian, Spanish, Thai, and Mien for choices. If the client chooses a choice and it's not an available language, the staff will follow AT&T Language Line procedures.

Many Medi-Cal providers we contract with provide services in multiple languages. Listed languages are Polish, Spanish, Tagalog, Russian, Hmong, ASL, Laotian, Thai, Mien, Italian, German, Japanese, and Vietnamese. A few providers have the available to receive services in any language if necessary. All of this information has been compiled into a list provided to staff for referrals and provided in the Guide to Medi-Cal Mental Health Services given to clients.

Policies, procedures, and practices that comply with the following Title VI of the Civil Rights Act of 1964 requirements.

Title VI of the Civil Rights Act of 1964 is incorporated in BCDBH Policy and Procedure 207: Protection of Beneficiary Rights and the Guide to Medi-Cal Mental Health Services (Appendix M). Both policies and procedures acknowledge compliance to Federal and State laws, specifically referencing Title VI of the Civil Rights Act of 1964. The guide notifies clients of their right to receive language services, availability of interpreter/translators, and that the service is free. General practice from staff deter client from utilizing minor children as interpreters, but that clients retain the right to use an interpreter of their choice.

V. Required translated documents, forms, signage, and client informing materials.

Culturally and linguistically appropriate written information for threshold language, including the following, at minimum.

Documents	Completed
1. Member service handbook or brochure	<input checked="" type="checkbox"/>
2. General correspondence	<input checked="" type="checkbox"/>

3. Beneficiary problem, resolution, grievance, and fair hearing materials	<input checked="" type="checkbox"/>
4. Beneficiary satisfaction surveys	<input checked="" type="checkbox"/>
5. Informed Consent for Medication form	<input checked="" type="checkbox"/>
6. Confidentiality and Release of Information form	<input checked="" type="checkbox"/>
7. Service orientation for clients	<input checked="" type="checkbox"/>
8. Mental health education materials	<input checked="" type="checkbox"/>
9. Evidence of appropriately distributed and utilized translated materials	<input checked="" type="checkbox"/>

These materials are available upon request.

Documented evidence in the clinical chart, that clinical findings/reports are communicational in the clients' preferred language.

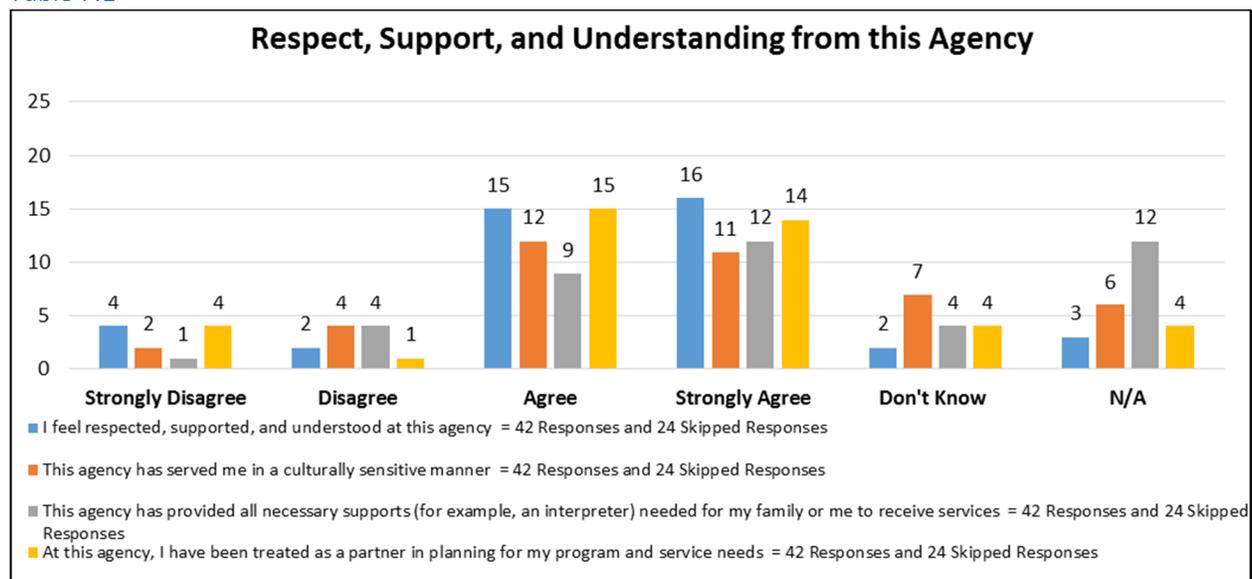
The Department of Behavioral Health strives to provide linguistically comprehensive services. Clinical services utilize bilingual staff or receive translator/interpreter assistance to ensure clients are communicated clinical findings/reports in their preferred language. This communication is documented in the client chart. The Client Plans and Annual Medication Treatment Plans, in English and Spanish, are completed with the client.

Consumer satisfaction survey translated in threshold languages, including a summary report of the results (e.g., back translation and culturally appropriate field testing).

Currently, a Client Satisfaction Survey is available in all of our service site lobbies. The survey is available in English, Spanish, and Hmong throughout the year. This survey is also available on our Behavioral Health website. The outcomes for Fiscal Year 2016-2017 can be found in Appendix N.

The 2015 Organizational Cultural Assessment survey was translated into Spanish and Hmong.

Table 7.1



The question, "This agency has provide all necessary supports (for example, an interpreter) needed for my family or me to receive services" showed high satisfaction or indicated that translator services were

not applicable. The full analysis of Butte County Behavioral Health Cultural Competency Survey Report can be viewed in Appendix A.

Mechanism for ensuring accuracy of translated materials in terms of both language and cultural (e.g., back translation and culturally appropriate field testing).

When there is a request to translate a document we use a contracted translator. The document is sent to the translator and once translation is completed, it is returned to the requestor. The requestor forwards the translated document to a bilingual staff member for review. Feedback and corrections are deliberated and necessary changes made.

Mechanism for ensuring translated materials is at an appropriate reading level (6th grade).

All forms are field tested for clarity and readability. This method measures the general public literacy level. Staff continually ensure public understanding through retesting and adapting per input.

Criterion 8:

Adaptation of Services

I. Client driven/operated recovery and wellness programs

BCDBH has many programs which are client and family driven/operated. These include many of the programs referred to in previous sections of this document. Client and family driven/operated programs include:

Wellness Centers

BCDBH has three Wellness Centers within the County. The *Iversen Center* in Chico, *The Hub* in Paradise, and the *Oroville Wellness and Recovery Center* in Oroville. These centers are consumer driven and emphasize recovery oriented activities including peer support, socialization opportunities, life skill groups, reintegration into the community, employment services, and medication support. There is an on-site clinician to help consumers run their own groups and provide limited mental health support.

The North Valley Talk Line

The North Valley Talk Line is a warm line which is funded by BCDBH and operated by North Valley Catholic Social Services. This is a consumer run and operated warm line. The Talk Line provides sub-crisis support to a variety of community members. The phone operators attend extensive training and report a high level of satisfaction with their jobs. The Talk Line began accepting calls in August 2010.

The African American Family and Cultural Center

The African American Family & Cultural Center (AAFCC) serves as a place where the community can gather to express itself through cultural events. Simultaneously, the center is a place where people are able to learn about and connect with services and agencies such as Behavioral Health. Behavioral Health staff are located in the Center to provide on-site services at times convenient to community members and to be a liaison between the AAFCC and County. The AAFCC integrates African American history and culture into everything that is provided there. With the integration of African American cultural, the center will focus on the prevention of mental illness, providing early interventions to prevent the need for a higher level of care, decrease mental illness stigma and discrimination and increase the community awareness and acceptance of mental health services.

Stonewall

Stonewall Alliance Center of Chico provides education, outreach, and training to lesbian, gay, bi-sexual, transgender, and queer/questioning (LGBTQ) individuals, caregivers/parents, community individuals, agency staff and volunteers, and community groups for the purpose of preventing suicide and reducing mental health challenges in the LGBTQ population. By doing so will decrease social stigma associated with mental illness, accessing mental health services and the LGBTQ community.

Live Spot

The Live Spot program provides hope, reassurance, and 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.

National Alliance on Mental Illness (NAMI)

The Chico branch of National Alliance on Mental Illness supports the NAMI mission - improving the lives of individuals and families affected by mental illness. NAMI provides a variety of support, education, and training throughout Butte County for individuals with mental illness, their families, providers, and community members. NAMI leads the nation through public awareness events and activities, including Mental Illness Awareness Week (MIAW) and other efforts, to successfully combat stigma and encourage understanding.

Passages

The Passages Older Adult Prevention and Early Intervention (OAPEI) Program 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. OAPEI 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.

Promotores

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. Fundamental components of their work are the interactive presentations and outreach activities that reduce cultural and linguistic barriers to services and knowledge.

Zoosiab

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.

II. Responsiveness of mental health services

Documented evidence that the county/contractor has available, as appropriate, alternatives and options that accommodate individual preference, or cultural and linguistic preferences, demonstrated by the provision of culture-specific programs, provided by the county/contractor and/or referral to community-based, culturally-appropriate, non-traditional mental health provider.

The Butte County Department of Behavioral Health Provider list (Appendix P) provides a list of Medi-Cal providers contracted with BCDBH and what cultural/linguistic services they offer. The Member Information and Services Directory brochures notify clients of cultural and linguistic services that are available upon request. Additionally the county posts a notification in each of the clinics that translation services are available free of charge.

Evidence that the county informs clients of the availability of the above listing in their member services brochure. If it is not already in the member services brochure, the county will include it in their next printing or within one year of the submission of their CCP.

The Butte County Department of Behavioral Health Provider list (Appendix O) provides a list of Medi-Cal providers contracted with BCDBH and what cultural/linguistic services they offer. The Member Information and Services Directory brochures notify clients of cultural and linguistic services that are available upon request.

Counties have policies, procedures, and practices to inform all Medi-Cal beneficiaries of available services under consolidation of specialty mental health services.

Policy and Procedure BCDBH 207 mandates BCDBH provide and inform Medi-Cal beneficiaries of available services, which includes the Provider list and Guide to Medi-Cal Mental Health Services booklet. The booklet provides written information about available specialty mental health services.

Evidence that the county has assessed factors and developed plans to facilitate the ease with which culturally and linguistically diverse populations can obtain services.

Assessment of disparity in accessing behavioral health services have been explored in the all of the MHA planning processes. As noted in other parts of this report BCDBH has made a concerted effort to provide community based services specifically designed for unserved and underserved populations. These programs are embedded in locations comfortable to diverse cultural populations. Great efforts have been made to design offices that are welcoming to the cultural groups served. Efforts continue to increase the level of multicultural staff members.

Furthermore, BCDBH has implemented a project to create welcoming and inviting environments for persons of diverse cultural backgrounds. Two art projects have been implemented with the purpose integrating cultural art in offices, specifically lobbies. The Recovery Model Pilot Teams were utilized to develop creative and unique ways to make each of their offices welcoming for consumers and staff. The goal of these projects was to integrate and reflect consumer's cultures within the Department.

III. Quality of Care: Contract Providers

BCDBH contracts with Contract Providers (primarily Organizational Providers) include stipulations of mandatory cultural competency requirements including primary language needs, written materials, documentation, and outreach efforts. Monitoring for quality of services, including specific issues of Cultural Competency, occurs primarily - though not exclusively - within the activity of clinical record Utilization Review (UR) referred to at BCDBH as Quality Management. As defined in the Departments Annual Quality Improvement Plan, a group of licensed Clinical Supervisors reviews a random selection of client charts once a month, including records from contract providers. Included in utilization review the team monitors and measures compliance and efforts to reach cultural competency including notations of primary language, use of interpreters, etc. In addition, routine QI activities includes the analysis of language and ethnic make-up of contract provider caseloads in order to evaluate community needs to meet identified Departmental goals.

IV. Quality Assurance

BCDBH has a variety of mechanisms in place to implement and evaluate Cultural Competencies issues within the areas of Quality Assurance/Improvement (QI/QA). Primary to meeting this need is inclusion of the Chair of the Cultural Competency Committee as a standing member of the Quality Improvement Committee. The QIC meets monthly with a standing agenda that addresses issues of Quality Service including access, patient's rights, etc. This forum allows for issues of cultural competency to be fully identified, addressed, and/or corrected - whether related to specific identified improvement activities, or identified problem areas brought to light by the Cultural Competency Committee or the office of Patient's Rights through complaints/grievances. As noted previously, the QIC also analyzes issue of cultural competency needs through data analysis of client caseloads with regard to geographic location of language needs, outreach efforts, etc.

Quality Improvement Committee

The Quality Improvement Committee (QIC) is responsible for monitoring, assessing, and improving client care and service in the Butte County Specialty Mental Health Plan. The QIC recommends policy changes, reviews and evaluates the results of Quality Improvement (QI) activities, institutes needed QI actions, and ensures follow-up of QI processes. The licensed QI Coordinator is responsible for the clinical oversight of the QI process. The QIC meets monthly to monitor State Fair Hearings, Notice of Action (NOAs), Performance Improvement Projects, Beneficiary Grievances and Appeals, Cultural Competence Issues, Provider Information and Provider Grievances, Change of Provider Requests, Training, Timeliness of Consumer Access to services, and Crisis Line response.

QIC meeting minutes are kept in the QI folder on the DBH intranet and may be accessed electronically by all QI Committee members. Consumer confidentiality is protected at all times in the QIC minutes. The minutes reflect all QI deliberations, decisions, recommendations, and actions to insure that ongoing efforts are made to improve the quality of service provided by the department the QI Committee will establish yearly goals. The goals are selected by the QI Committee and may be directed toward improvement in any area of operation of the department.

The following Department of Behavioral Health Committees and sub-groups report at the Quality Improvement Committee:

- Cultural Competence
- Quality Management Chart Review Committee
- Compliance Committee
- Authorization/Access
- Systems Performance, Research and Evaluation
- Organizational Providers
- Patient's Rights Advocacy
- Training Coordinator

Appendix

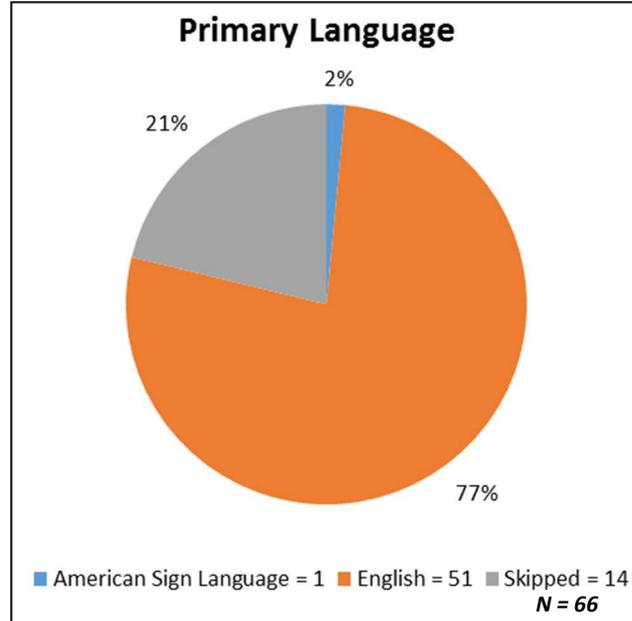
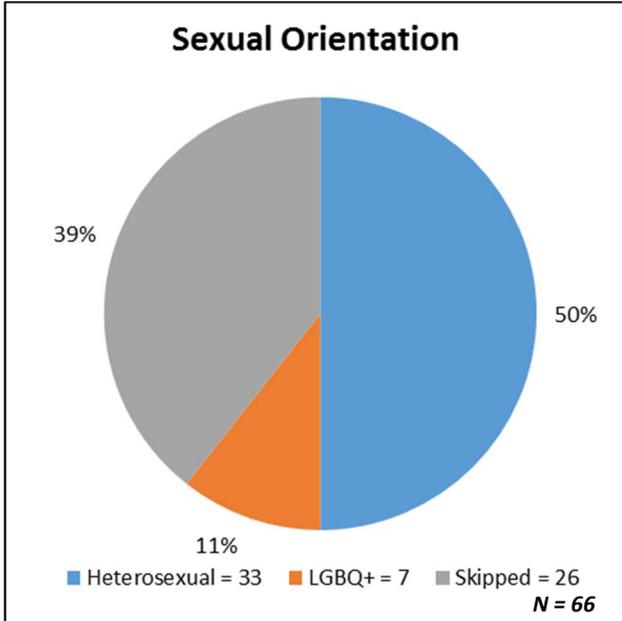
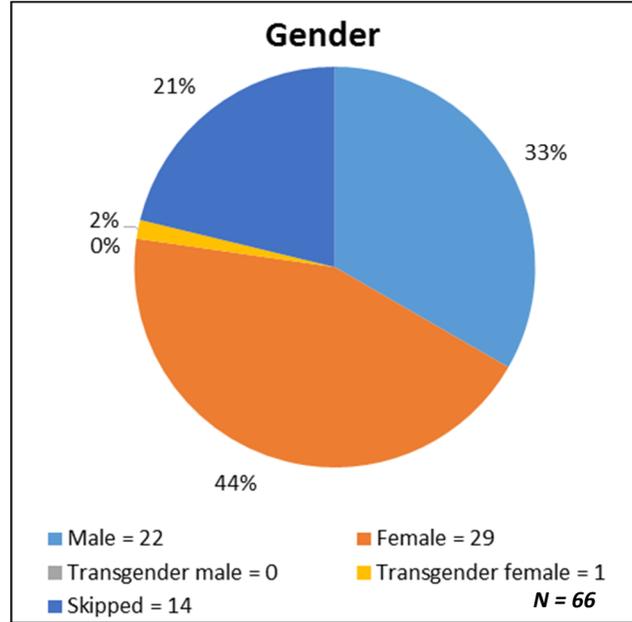
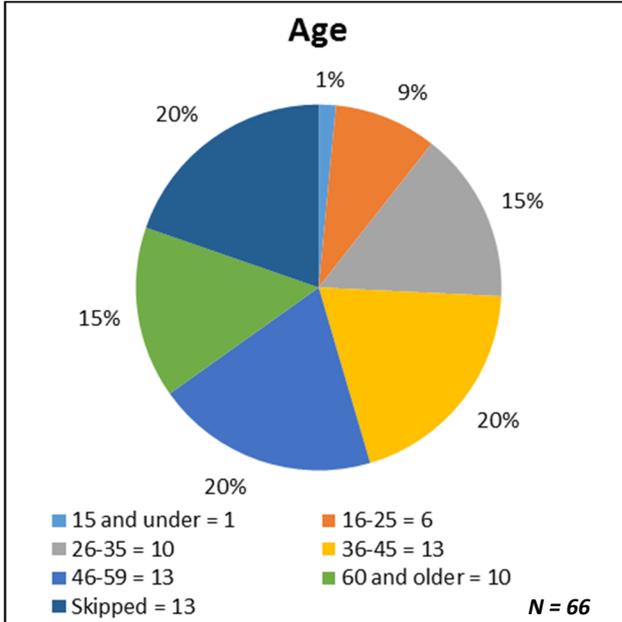
- A. 2015 Organizational Cultural Competency Assessment
- B. Point In Time Census and Survey 2017
- C. Meeting Minutes from Cultural Competence Committee
- D. New Employee Orientation
- E. Policy 68
- F. Cultural Competency Training Tracker
- G. Regional Partnership Summary Report of Accomplishments and Lessons Learned
- H. Language and Translation Policy
- I. Americans with Disabilities Policy
- J. Determining Language Preference List
- K. Staff Receiving Bi-Lingual Pay Differential
- L. Translator List
- M. Guide to Medi-Cal Mental Health Services
- N. Consumer Satisfaction Outcomes for 2016-2017
- O. Butte County Department of Behavioral Health Provider List

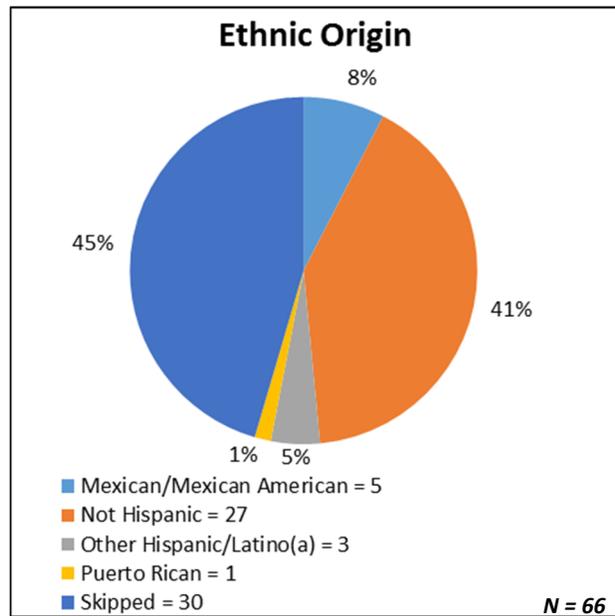
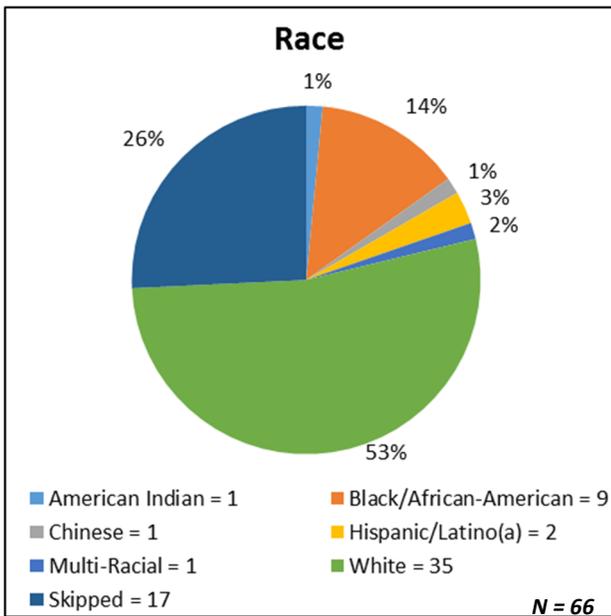
Organizational Cultural Competency

Assessment for Consumers

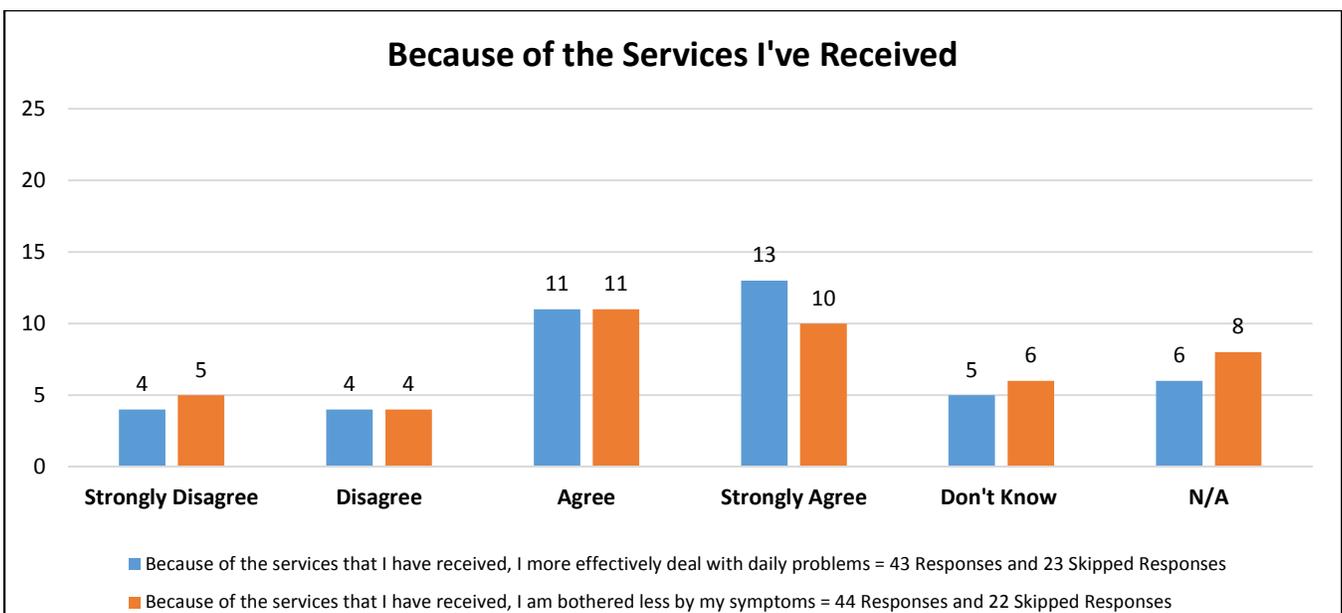
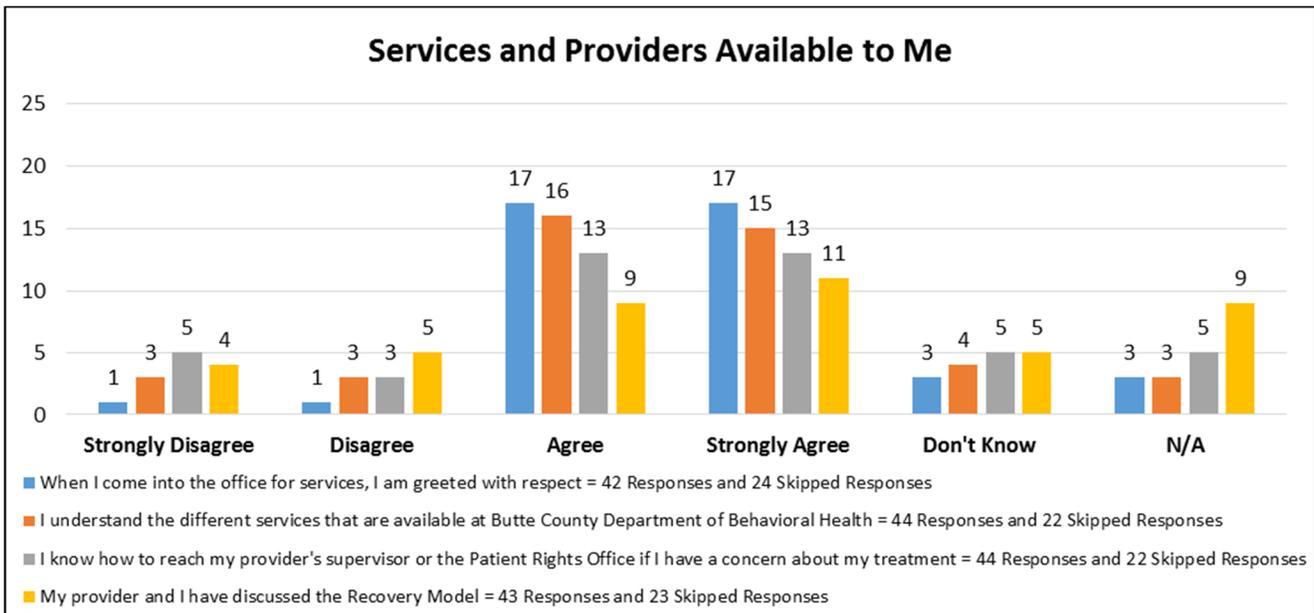
This survey was offered to consumers of services at Butte County Behavioral Health and its contracted providers in the Fall of 2015. There were **66 surveys** taken.

Demographics

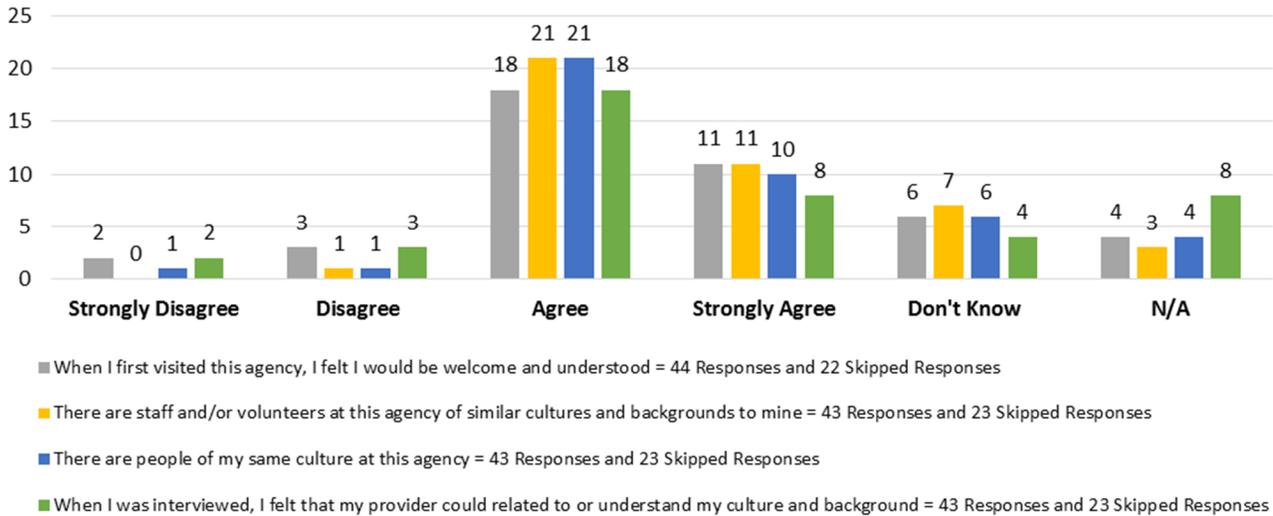




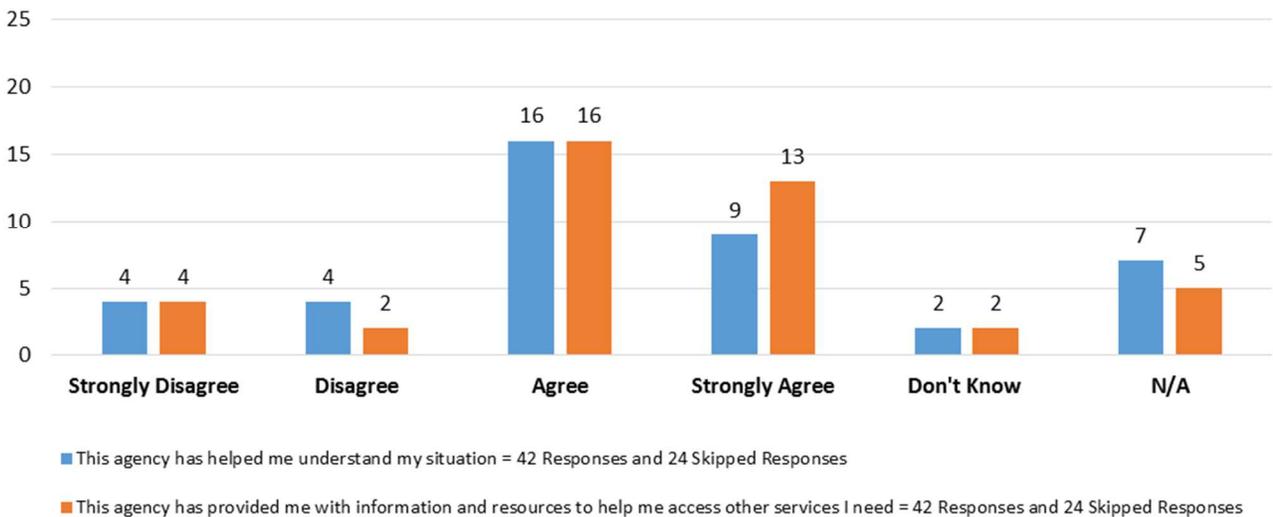
Outcomes



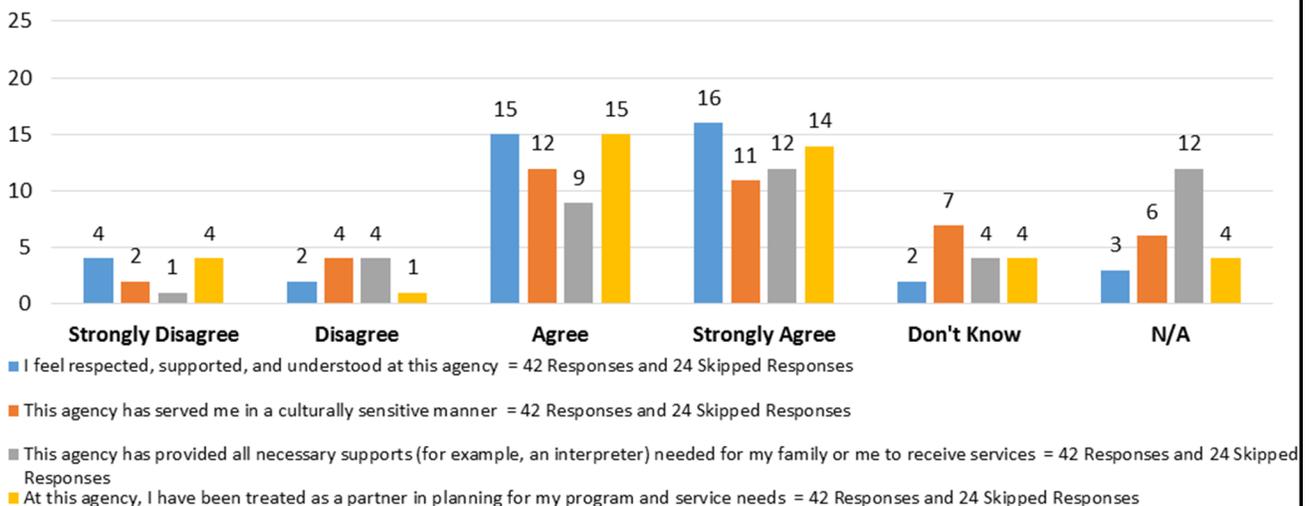
The Agency Culture and Background Understanding



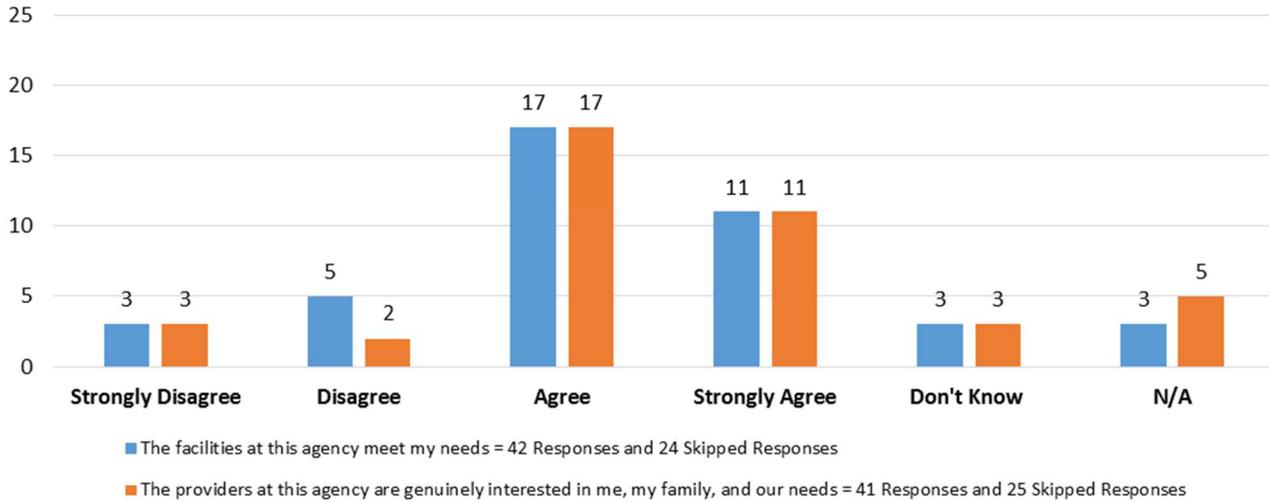
Information and Resources Provided by this Agency



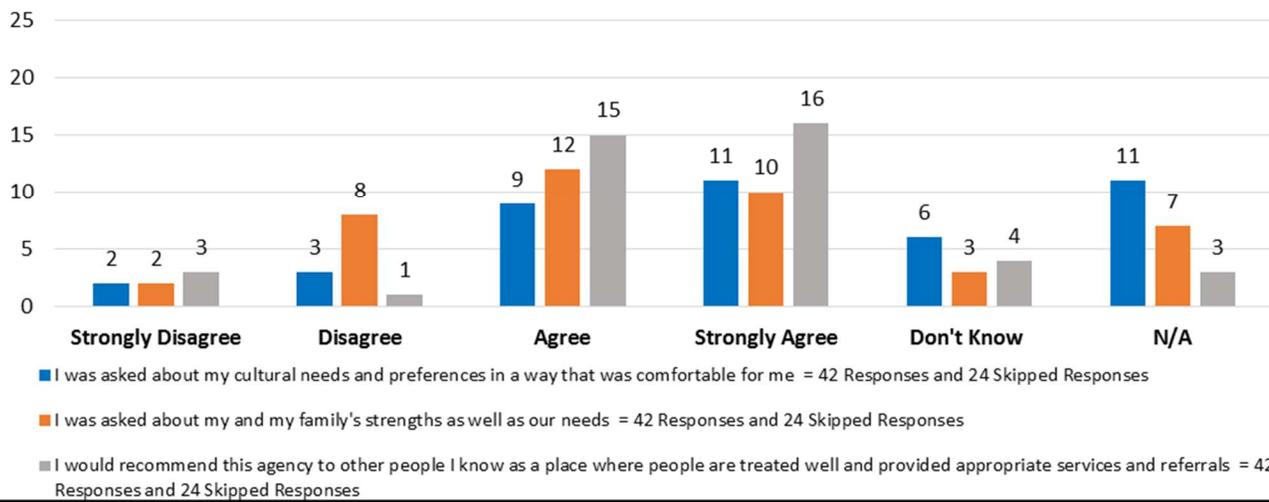
Respect, Support, and Understanding from this Agency



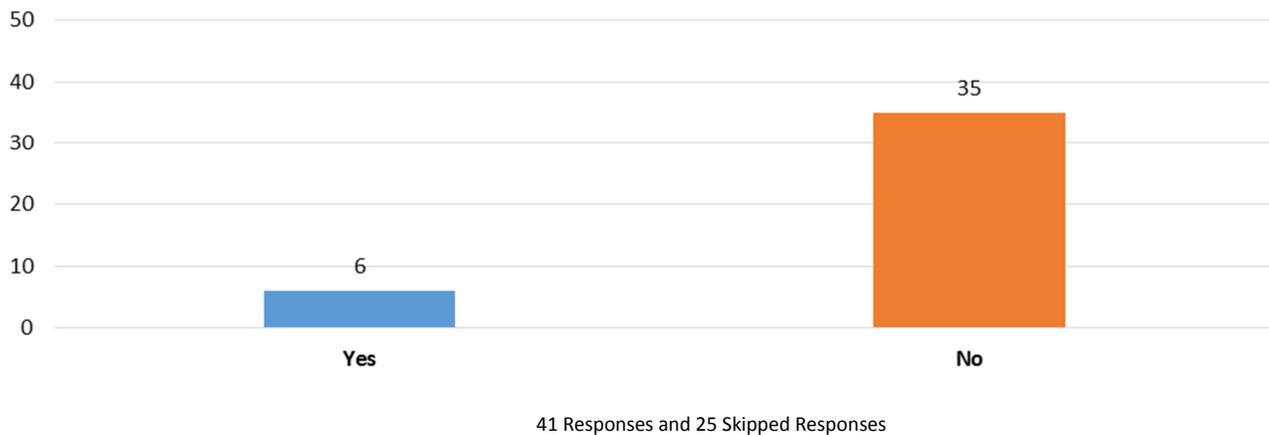
Agency Meeting my Family's and My Needs



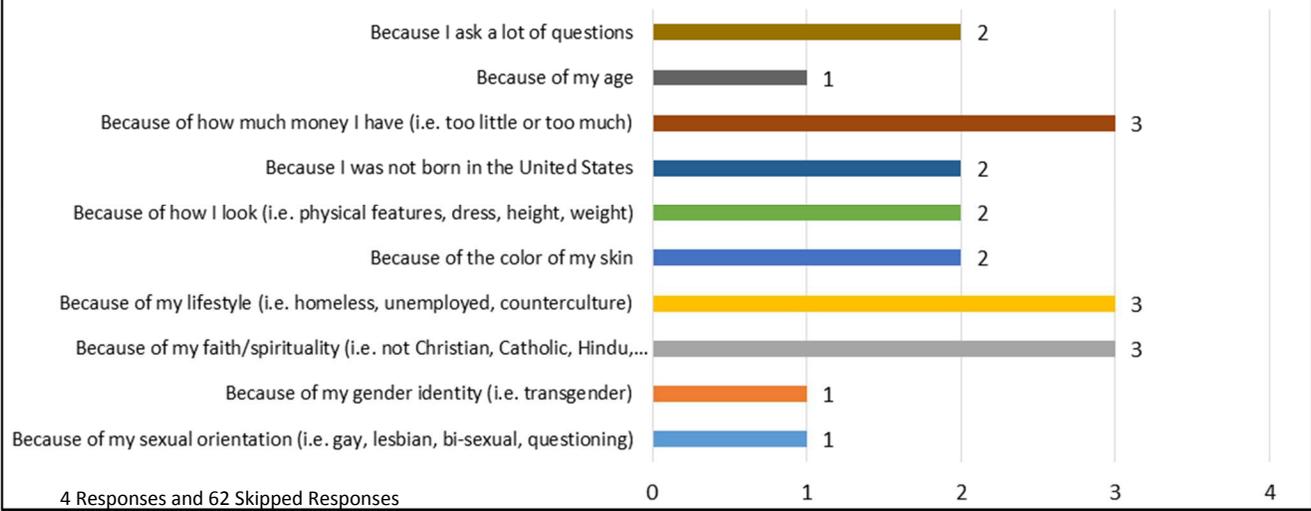
Cultural Needs, Preferences, Strengths, and Treatment



Have you experienced any unfair or biased treatment because of personal characteristics (race, age, gender identity, sexual orientation, religion, financial status)?



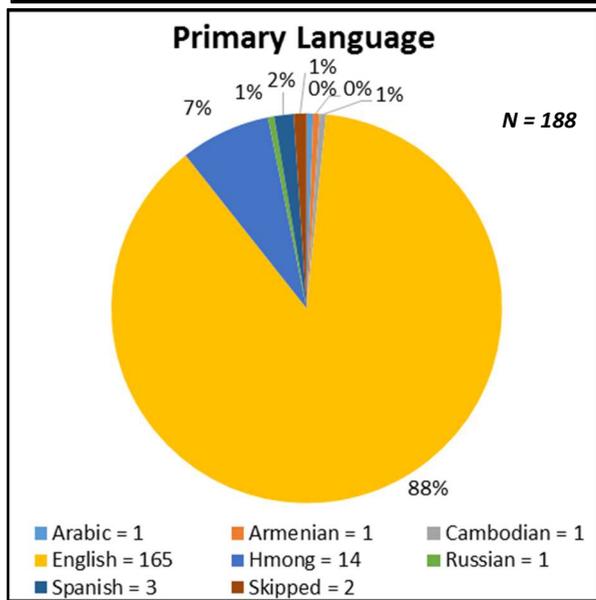
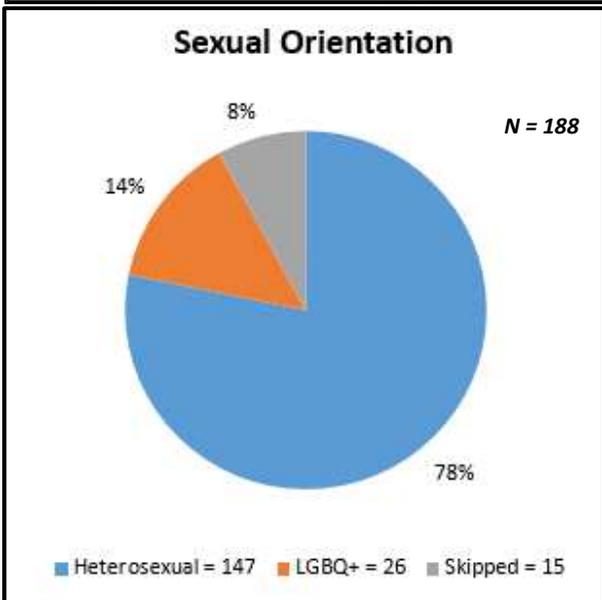
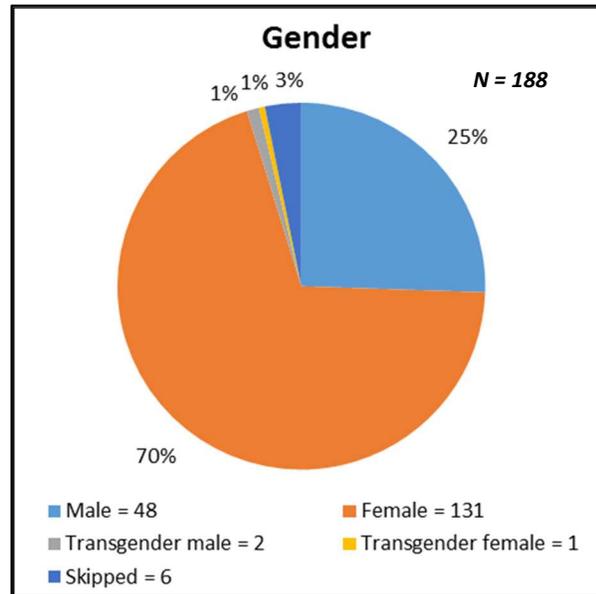
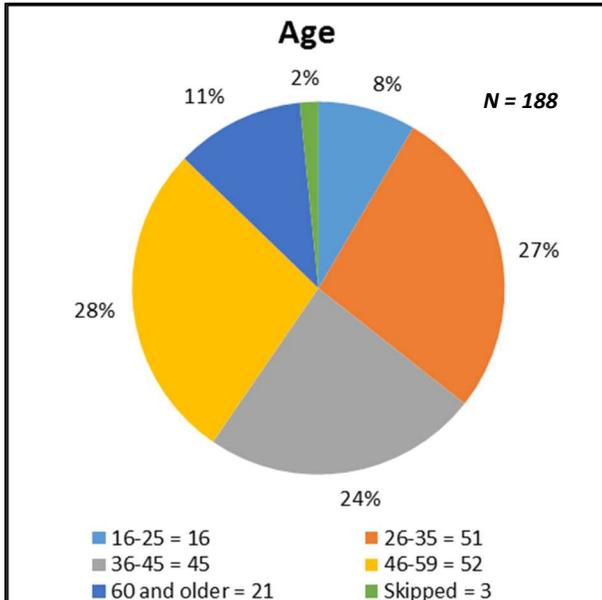
Please check one or more boxes that describes the kind of prejudice or bias that you have experienced.

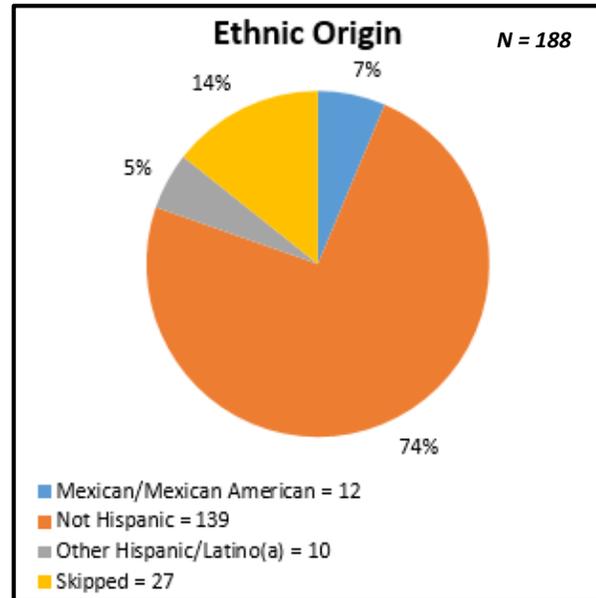
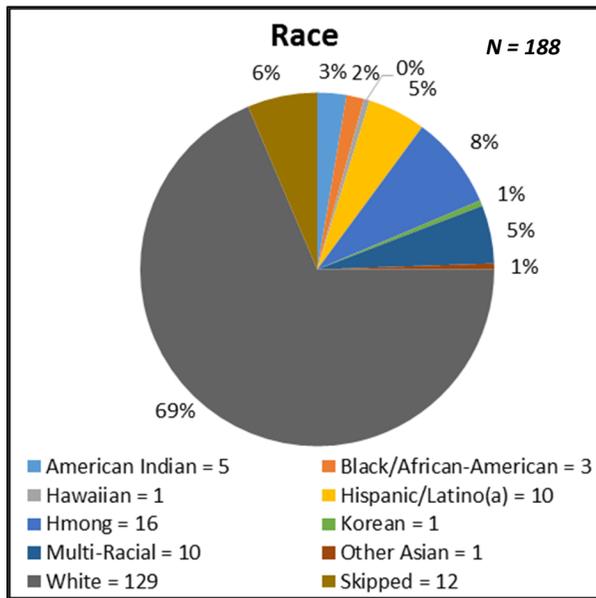


Organizational Cultural Competency Assessment for Staff

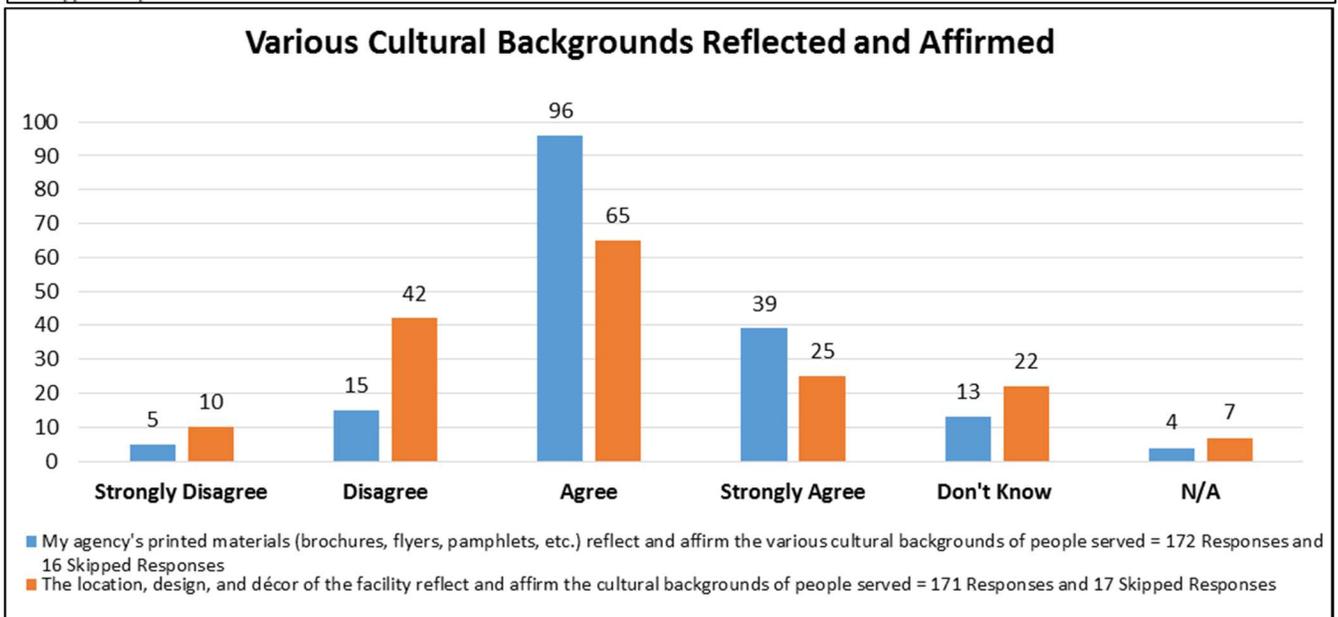
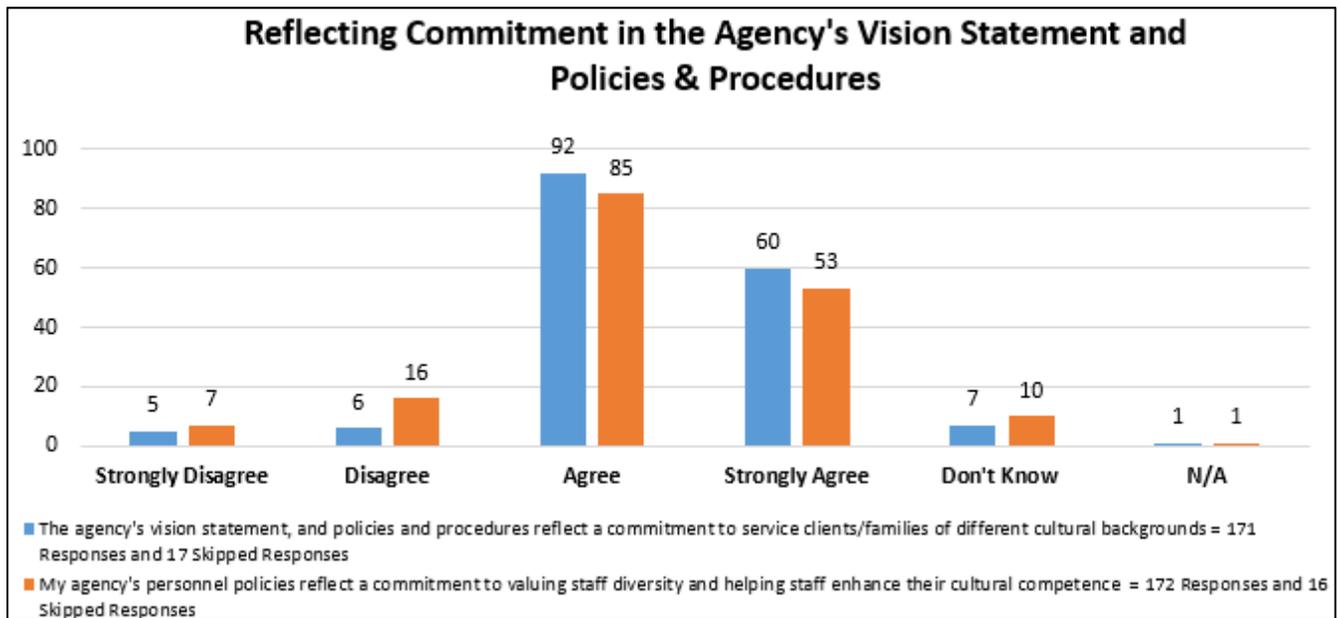
This survey was offered to staff of Butte County Behavioral Health and contracted providers in the Fall of 2015. There were **188 surveys** taken.

Demographics

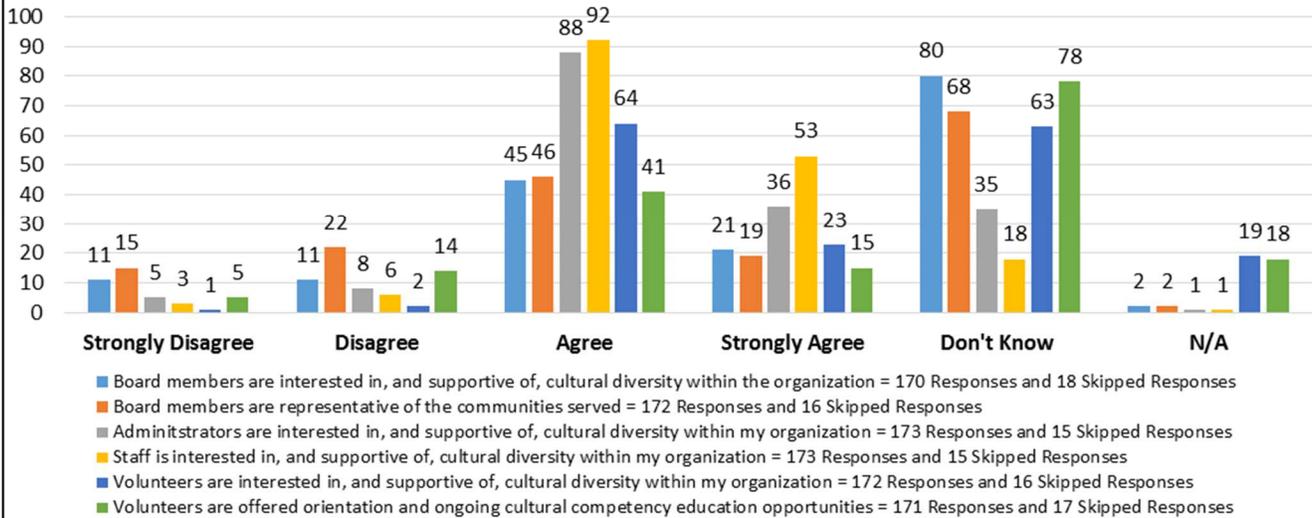




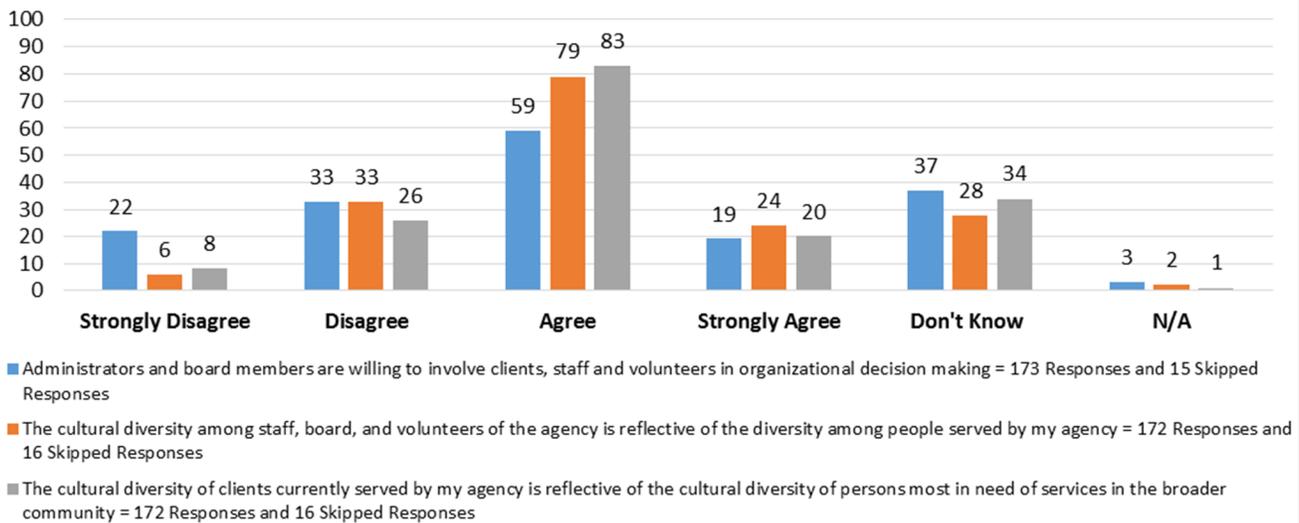
Outcomes



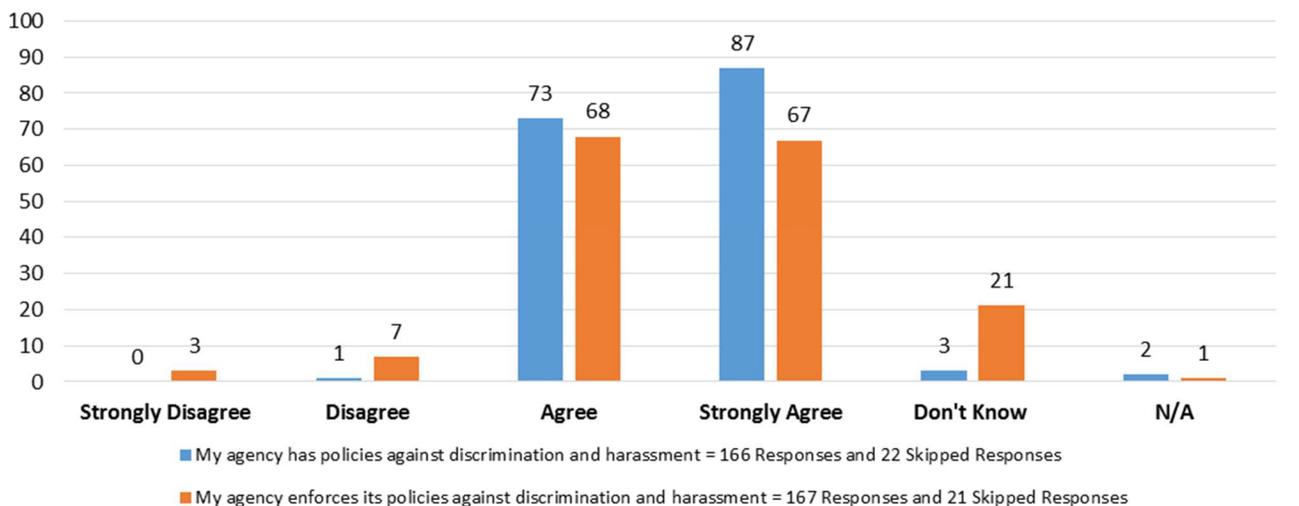
Interest and Support of Cultural Diversity



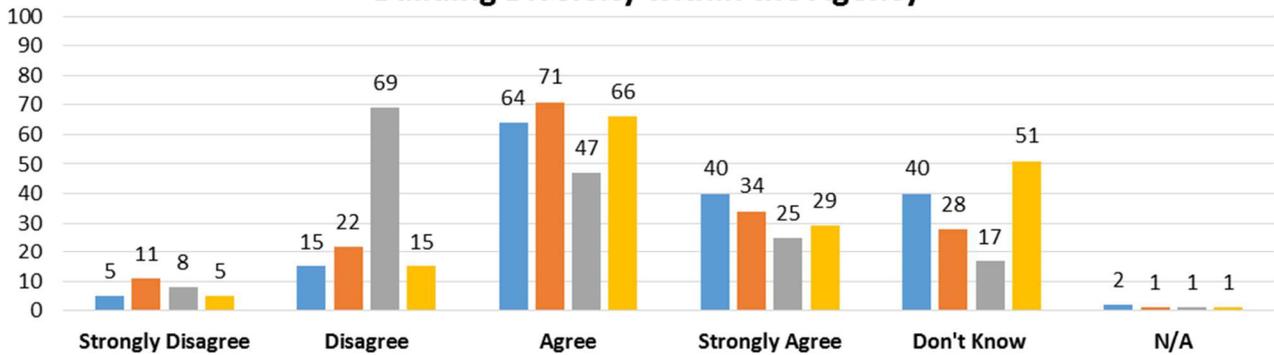
Cultural Diversity among Staff, Board, Volunteers, and Clients



Agency Policies on Discrimination and Harassment

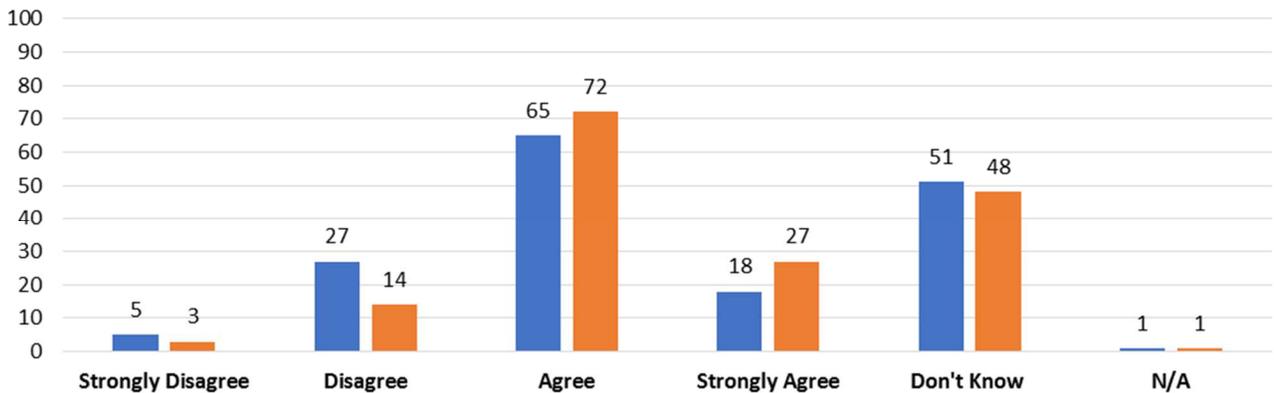


Building Diversity within the Agency



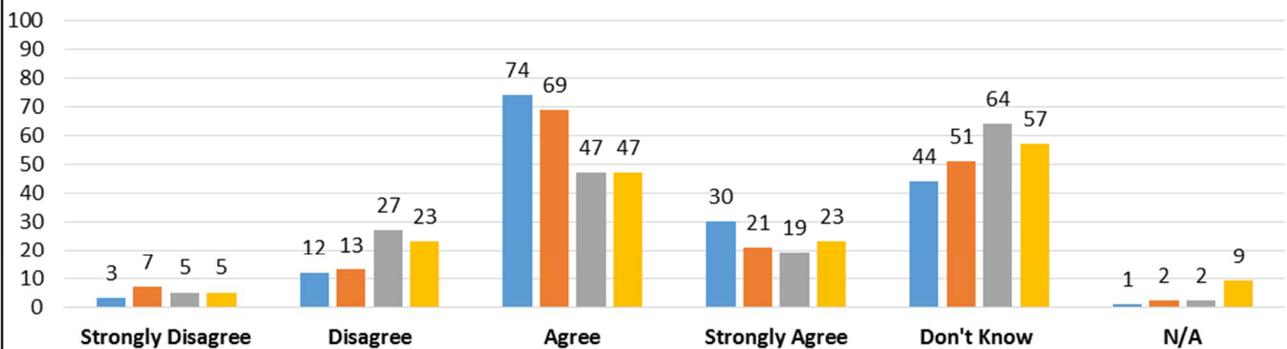
- My agency's recruitment, interviewing, and hiring processes are supportive of building a diverse staff = 166 Responses and 22 Skipped Responses
- My agency provides opportunities for leadership development and advancement for all staff, including staff of diverse cultural backgrounds = 167 Responses and 21 Skipped Responses
- My agency provides adequate training regarding the cultures of the clients served, staff, community, and the interaction among them = 167 Responses and 21 Skipped Responses
- My agency values and recognizes staff that suggests new culturally relevant projects or programs = 167 Responses and 21 Skipped Responses

Addressing and Supporting Cultural Differences



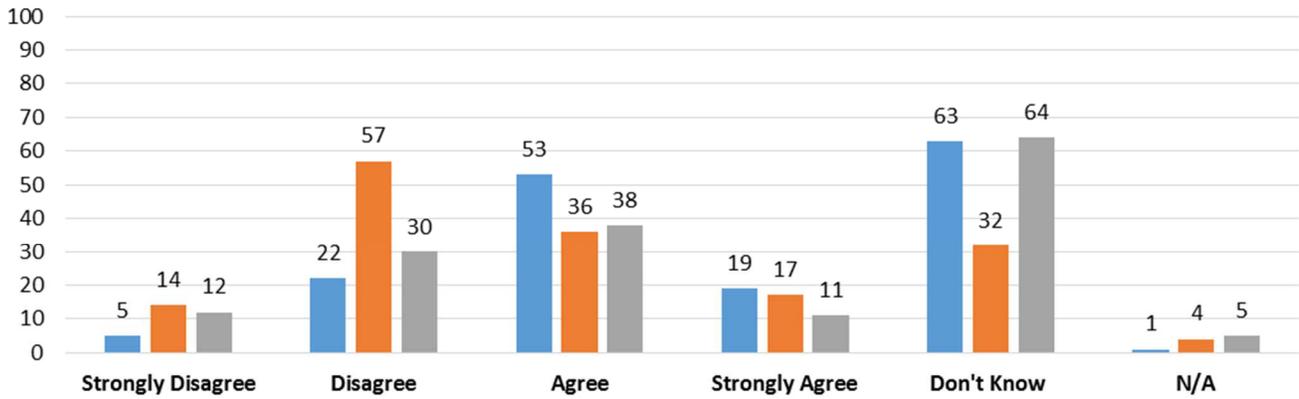
- My agency addresses cultural tensions that arise, both within the organization and within the broader community = 167 Responses and 21 Skipped Responses
- My agency supports the ability of staff to raise issues arising from cultural differences = 165 Responses and 23 Skipped Responses

Outreach to various Cultural Backgrounds



- My agency values and uses the advice of people of different cultural backgrounds = 164 Responses and 24 Skipped Responses
- My agency consults clients and community representatives of different cultural backgrounds in the development of new programs and services affecting their communities = 163 Responses and 25 Skipped Responses
- My agency conducts effective community outreach in recruiting new staff, board members, and volunteers of different cultural backgrounds = 164 Responses and 24 Skipped Responses
- My agency encourages volunteers to attend or participate in outside cultural activities such as civic meetings, clinics, block parties, and seasonal festivals = 164 Responses and 24 Skipped Responses

Conducting, Providing, and Welcoming various Cultural Backgrounds

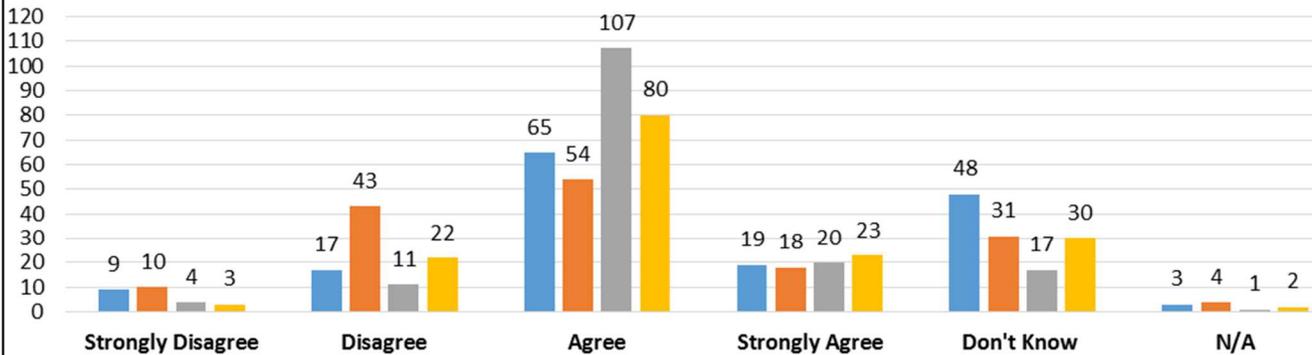


■ My agency conducts effective outreach to clients of different cultural backgrounds = 163 Responses and 25 Skipped Responses

■ My agency provides multi-cultural programming to complement a wide variety of cultural events (e.g. Black History Month, Jewish High Holidays, Asian New Year's Celebrations, Gay Pride Festivals) = 160 Responses and 28 Skipped Responses

■ My agency welcomes community healers to provide additional support to people served = 160 Responses and 28 Skipped Responses

Agency's Efforts in Encouraging Staff



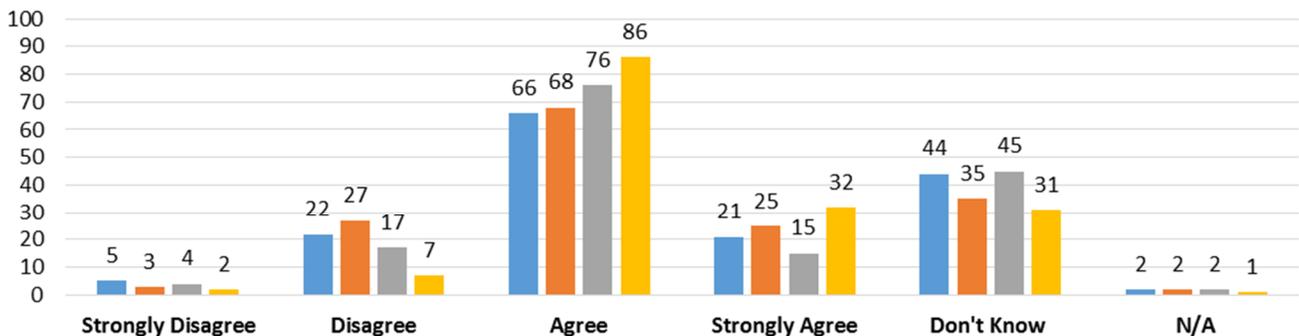
■ My agency encourages staff to draw on the expertise of people of different cultural backgrounds in providing services to clients of those backgrounds, and provides a mechanism for maintaining communication = 161 Responses and 27 Skipped Responses

■ My agency encourages staff to become aware of their own culture and facilitates the educational process = 160 Responses and 28 Skipped Responses

■ Staff understand and respect the communication and other behavioral implications of different client cultures = 160 Responses and 28 Skipped Responses

■ Staff is encouraged to openly discuss cultural differences and influences with clients = 160 Responses and 28 Skipped Responses

Agency's Efforts in Encouragement and Leadership among Clients, Staff and Volunteers



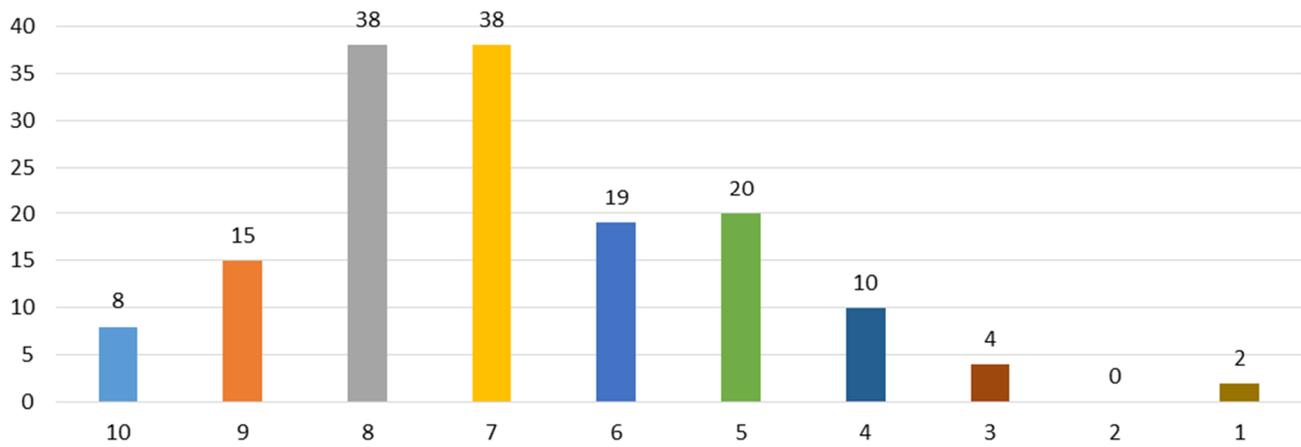
■ My agency encourages clients to examine their own cultures and the cultures of their peers, and to develop their own appreciation of diversity = 160 Responses and 28 Skipped Responses

■ My agency recognizes leadership among clients, staff, and volunteers of different cultural backgrounds = 160 Responses and 28 Skipped Responses

■ My agency considers the cultural implications of various options in making decisions about programs and services offered to clients = 159 Responses and 29 Skipped Responses

■ My agency values client feedback on its services and its cultural competence = 159 Responses and 29 Skipped Responses

Overall, on a scale of one to ten (ten being the highest or most competent), rate the current cultural competence of the agency.



159 Responses and 29 Skipped Responses

2017 HOMELESS POINT IN TIME CENSUS & SURVEY REPORT

BUTTE COUNTYWIDE HOMELESS CONTINUUM OF CARE



Prepared by Housing Tools

BUTTE COUNTYWIDE HOMELESS CONTINUUM OF CARE

Council Members

Steve Baxter

Consumer Representative

Benson

Chico Locality Representative

Marie Demers

Local Government Representative

Ed Mayer

Butte Countywide Homeless Continuum of Care, Vice Chair I
Public Housing Agency Representative

Nancy Jorth

Runaway and Unaccompanied Youth Representative

Brad Montgomery

Homeless Assistance Provider

Anastacia L. Snyder

Victim Services Provider Representative

Donnell Taylor

Butte Countywide Homeless Continuum of Care, Vice Chair II
Mental Health Agency and Drug and Alcohol Treatment Representative

Thomas Tenario

Butte Countywide Homeless Continuum of Care, Chair
Affordable Housing Developer Representative

Anny Terry

Faith-based Organization Representative

Bobby Walden

Veteran Service Provider Representative

Carol Zannon

Oroville Locality Representative

Vacant

Paradise Locality Representative
Specialty Representative
Specialty Representative

2017 HOMELESS POINT IN TIME CENSUS & SURVEY REPORT

Butte Countywide Homeless Continuum of Care

We cannot solve our problems with the same thinking
we used when we created them.

Albert Einstein

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Executive Summary

The Butte County Homeless Point In Time (PIT) collected informational surveys from 1,983 individuals experiencing homeless on January 25, 2017. This marks an 76% increase from the 2015 PIT, and reflects the largest count captured in the county to date. Despite the significant increase, it does not suggest a complete count of those experiencing homelessness in the county, but a base number of people located during a 24-hour period, and represents only one measure of the human and housing crisis facing the county.

The Butte Countywide Homeless Continuum of Care (CoC) uses PIT data to generate two reports – the HUD Report and the Census and Survey Report. The HUD Report is required by the US Department of Housing and Urban Development (HUD) every other year, and includes a portion of the overall data captured for the Census and Survey Report. The HUD Report monitors progress toward ending homelessness, and determines eligibility and funding levels for certain state and federal grants. A more comprehensive picture of the data captured during the PIT is provided in the Census and Survey Report. The Census and Survey Report’s overarching goal is to help the community to better understand homelessness in their area. It is used by public officials and housing departments to meet reporting requirements and to better understand the priorities for limited public funds. Service providers use the Census and Survey Report to inform their practices, as well as to assist them in developing timely and effective housing and services. Communities access the findings to better understand local homelessness and to in develop common knowledge with their community leaders.

The community PIT offers these highlighted findings:

HOUSEHOLDS: The 1,983 individuals experiencing homelessness were part of 1,583 households, 85% of which were made up of adults only, another 8% were family households, and 6% were households of minor unaccompanied youth.

COUNT BY COMMUNITY: Chico had the highest count at 1,096 individuals, a 92% increase since 2015. Oroville had the second highest count with 713 people, a 83% increase. Paradise’s count increased to 120 people, a 145% increase, and almost evenly split between Paradise and Magalia. Gridley saw a decrease of 8 people to 26, or 22% decrease.

RESIDENCY: The survey data shows that more than three-fourths of the adults and unaccompanied youth had lived in Butte County for more than three years, and more than half of those surveyed had lived in the county for over 10 years. Almost 80% were living in Butte County when they became homeless and nearly 90% confirmed that Butte County is their home. Those not originally from Butte County, moved to the county for reasons analogous to those **not** in a homeless situation, such as family, college, quality of life, job opportunities, etc.

CHRONIC HOMELESSNESS: Nearly half (47%) of the individuals (929) met the definition of chronically homeless (which is a combination of time spent homeless and the existence of a disabling condition) implying that individuals and families are remaining homeless for long periods of time, and doing so while trying to manage persistent physical, mental, and/or developmental conditions.

HOMELESSNESS PREVENTION: The capacity of local prevention and diversion services were insufficient to prevent 555 people who completed the survey from becoming homeless for the first time.

NIGHTTIME HABITATION: Of those surveyed, the largest number of respondents (747 people) reported spending the night of the PIT in a place not meant for human habitation, a 164% increase from 2015. Another 729 respondents stayed in programs specifically designed to house those who are homeless: 351 stayed in emergency shelters, 341 in transitional housing projects, and 37 in hotels with a subsidized voucher. There were 438 individuals doubled up with friends and family, without onsite support services and relying on community member resources for shelter. Finally, 69 people were in facilities (treatment centers, hospitals or jail) for the night, but were homeless prior to admission and with no home available to them when released.

CAUSES: The top two causes for homelessness in the county, according to the survey respondents, were family crisis and employment/financial problems.

BARRIERS: The number one barrier to permanently ending homelessness was the absence of affordable housing. The county's extremely low (1-2%) housing vacancy rate fuels the demand for housing as well as higher rents. The second highest reported barrier was lack of money to pay rent and/or a deposit.

PUBLIC SAFETY: According to the survey data, ordinances about sitting, lying and storing property in public places have led 181 people who completed the survey reportedly being ticketed, 80 arrested, and nearly 50 incarcerated in the past year. The county jail had 147 homeless inmates (25% of the jail occupancy) on the night of the PIT but who would otherwise be homeless. The survey data confirmed that most unhoused people have little or no encounters with law enforcement, while about 90 people had over 20 contacts.

HEALTHCARE: There is a growing body of evidence that housing is a healthcare need. While about 40% of residents experiencing homelessness accessed clinics and health centers, about 34% accessed hospitals that offer medical care often without payment. This financial burden to hospitals was not distributed across the homeless population but concentrated on a limited number of high frequency users; 36 people who completed the surveys reported using the hospital 12 or more times a year, and 90 people reported staying 12 or more days.

EDUCATION: There is a critical need for housing and food support for the growing number of homeless college students, particularly because education is often correlated with future financial stability and self-sufficiency, and may be seen as homelessness prevention. In general, unhoused residents have less education than those who are housed. Local studies by Butte College and Chico State support the local need to bolster educational housing and food support for low income students.

INCOME & HOUSING: For 90% of those surveyed, their income would not cover the (county median) rent, let alone typical household and family expenses.

VETERANS: There were 137 veterans who completed the survey, a significant increase from the 2015 count. More than half of the veterans were unsheltered and a third have a physical disability and/or Post Traumatic Stress Disorder.

DOMESTIC VIOLENCE: Three hundred people surveyed reported being a victim of domestic violence, with one third revealing they were homeless for the first time. The data showed that 40% of those identifying as a victim of domestic violence were men. Nearly half reported having Post Traumatic Stress Disorder and/or a mental health condition.

YOUTH: Surveys were collected from 105 minor, unaccompanied youth (UY) and from 145 Transitional Age Youth (TAY), who were 18 to 24 years old. Most of the UY (73%) were interviewed in Oroville and most of the TAY (66%) were interviewed in Chico. Twenty-five of the TAY were parents. Youth were long-term county residents, with 56% living in the county over ten years. Despite their age, 23% of the youth (10% of UY and 32% of TAY) already met the definition of chronically homeless.

2017 HOMELESS POINT IN TIME CENSUS & SURVEY REPORT

Overview and Methodology

The Butte Countywide Homeless Continuum of Care (CoC) biennially leads a homeless Point In Time (PIT) to collect information over a 24-hour period of time about those experiencing homelessness. The data collected through the PIT is used to generate two reports – the HUD Report and the Census and Survey Report. These two reports differ by their definition of homeless, the type of information that is gathered and reported, and how the findings are used. This document represents the Census and Survey Report.

The HUD Report must meet HUD standards for a PIT, including an adaptation of their definition of “homeless” which includes only those that are unsheltered, in emergency shelters, or in transitional housing projects. On the other hand, the Census and Survey Report uses a broader definition of homelessness in collecting and reporting PIT data, more closely matching the full HUD Interim Rule definition, includes those who are temporarily staying with friends or family, who would otherwise be homeless. While *the PIT cannot account for every individual experiencing homelessness*, using the broader definition allows for a more accurate count for the community. (See the Appendix for the HUD Interim Rule definition of homeless.)

The HUD Report involves entering data collected from the PIT into a federal database that is used to monitor the county’s progress in ending homelessness. It also establishes a comparative benchmark with other CoCs that is used by the federal and state government in determining eligibility and funding levels. The HUD-required data includes a count and demographic makeup of individuals and households (households without children, households with children, and households with only children), and for veteran and youth subpopulations. In addition, the number of chronically homeless individuals and households are reported. The final requirements include a count of the number of people without homes who are victims of domestic violence, those who are HIV positive or have AIDS, those who have a serious mental illness, and those with substance use disorders. (See Appendix for the HUD Report.)

The Census and Survey Report offers a more comprehensive insight into the local homeless crisis by using a more inclusive definition of “homeless” and by adding over 20 additional questions the community believes is important to address local assumptions, policies, needs, and concerns. The data is used to track trends, successes, and barriers. This information guides decisions by service providers regarding the type of housing and services that are needed, and may be used to prioritize limited funding opportunities. The information is also used as a platform for shared knowledge across the community, so that decisions and efforts in addressing homelessness can be founded in timely, relevant data.

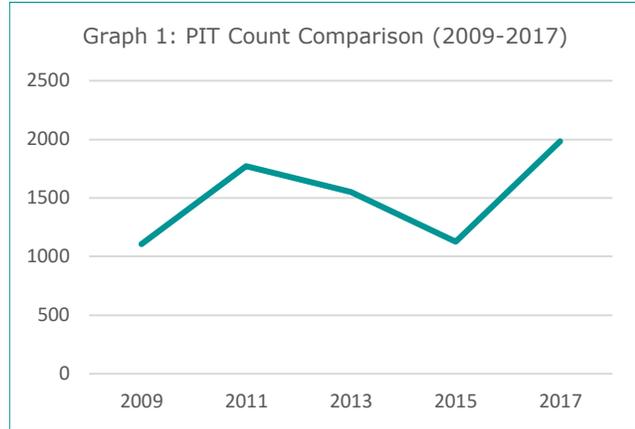
The PIT is community driven, led by a Steering Committee, and facilitated by service professionals and community members. A survey is developed to gather HUD-required, as well as community-prioritized, data.

Those surveys are administered by the community to residents without homes who are sleeping in places not meant for human habitation (parks, creek beds, etc.); emergency shelters; transitional housing projects; temporarily doubled up with friends or family; and in treatment facilities, hospitals, and jails, but would otherwise be without shelter. Funding for the project was provided by Butte County Department of Behavioral Health and the City of Chico (See the Appendix for the 2017 PIT methodology report and survey.)

Homeless Count

The 2017 Point In Time identified 1,983 individuals in 1,583 Butte County households, living without safe, adequate housing. This is the highest PIT count from all previous biennial studies. The individual person count increased by 856 people (an 76% increase), from the 2015 PIT.

For the purposes of this report, individuals were grouped by community, based on the location in which they slept on the night of the PIT. This allows municipalities to understand and plan for their community, as well as the county at large. As shown in Table 1, the Gridley/Biggs area gathered surveys from 28 people, most of which were from Gridley. Chico gathered the highest number of surveys at 1,096. Oroville –



COMMUNITIES	Households	People
Gridley/Biggs Area	26	28
Biggs	2	2
Gridley	24	26
Chico Area	849	1096
Oroville Area	611	713
Oroville	607	706
Palermo	3	6
Thermalito	1	1
Paradise/Ridge Area	79	120
Magalia	40	59
Paradise	39	61
Other Areas	18	26
Bangor, Butte County	3	5
Berry Creek, Butte County	1	1
Concow, Butte County	1	1
Corning, Tehama County	1	3
Durham, Butte County	3	3
Feather River, Butte County	1	1
Greenville, Plumas County	1	1
Red Bluff, Tehama County	1	2
Willows, Glenn County	2	2
Yankee Hill, Butte County	1	1
Yuba City, Sutter County	1	4
Unanswered	2	2
TOTAL	1583	1983

comprised of Oroville proper, Palermo, and Thermalito – completed 713 surveys. The Paradise/Ridge area collected 120 surveys, almost evenly divided between Paradise and Magalia. An additional 26 surveys were gathered from individuals who had stayed in smaller Butte County townships, (such as Bangor and Yankee Hill), or neighboring counties, the night of the PIT but were able to relocate into one of the four larger Butte County communities to complete a survey. The overall percent of residents without homes is 0.88% of the Butte County population. ¹

The change across biennial PIT studies by community is illustrated in Graph 2 and numerically detailed by year in Table 2. The findings indicate that when comparing communities from 2015 to 2017, there was a 145% increase in the Paradise/Ridge area, a 92% increase in Chico, and an 83% increase in Oroville. There was a decrease of eight people (22%) in Gridley. The “other” category showed a 68% decrease between 2015 and 2017, which may reflect an improvement in methodology between the two years as the 2015 PIT had many surveys

¹ 4/1/16 United States Census used for population.

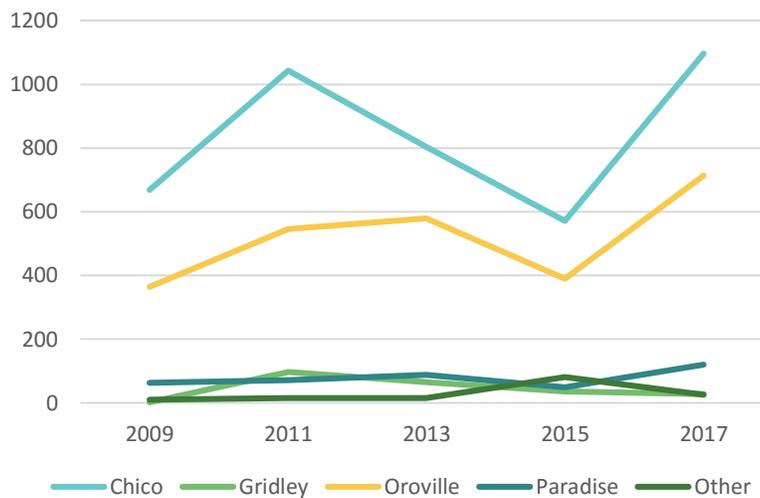
without a specified location. In 2017, more surveys identified a specific community as a place of habitation to more accurately reflect where individuals were residing countywide.

Table 2: PIT Count by Community (2009 to 2017)

COMMUNITIES	2009	2011	2013	2015	2017	# Difference 2015 to 2017	% Difference 2015 to 2017
Chico	668	1043	804	571	1096	525	92%
Gridley	2	97	65	36	28	-8	-22%
Oroville	364	545	579	390	713	323	83%
Paradise	62	71	89	49	120	71	145%
Other	10	16	16	81	26	-55	-68%
Total	1106	1772	1553	1127	1983	856	76%

The PIT methodology is complex, with myriad of strategies and factors that can significantly impact the number of surveys gathered. The count variance across years may be the result of improved methodology as well as an increase in the homeless population. Graph 2 shows a population spike in 2011; anecdotally, the inclusion of sober living environments in transitional housing projects in the 2011 PIT, which were not included in the other studies at the same level, may have impacted the increased count. Likewise, the significant decrease in 2015 may have been influenced by the lack of a PIT coordinator to facilitate the planning and execution of the PIT methodology.

Graph 2: Count by Community (2009-2017)



Household Make Up

Household make up consists of three types: households with only adults (single or multiple adults with no children present), households with adults and children, and households with only children (minor-age unaccompanied youth). Households without children account for 86% of the households. Families with children account for 8% and Unaccompanied Youth account for 6% of the total households.

Table 3: Number of Households by Household Type and Community

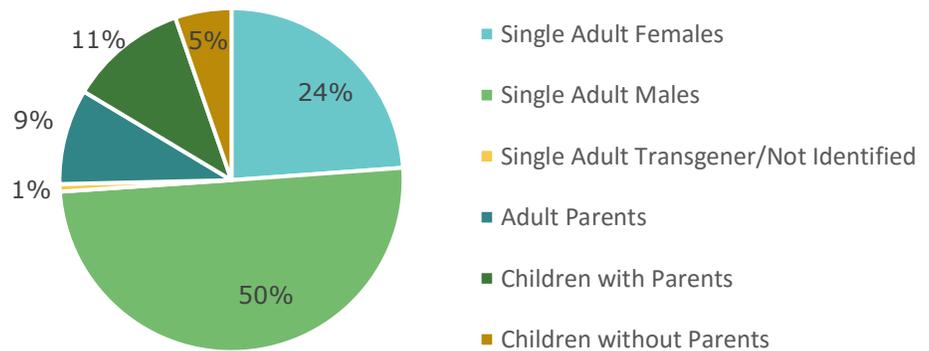
HOUSEHOLDS	Chico	Gridley	Oroville	Paradise	Other	Total	%
Single Adults	748	25	508	57	13	1351	85.3%
Adults with Children	87	1	26	16	2	132	8.3%
Children without Adults	14	0	77	6	3	100	6.3%
Total	849	26	611	79	18	1583	100%

Household make up data provides information about what type of housing might adequately meet the needs of the local homeless residents. Table 4 shows that single males are the most common individual type within the Adults Only household type, at over half of the surveys completed within Chico, Gridley and Oroville. Paradise and the Other communities are proportionally slightly higher with family households. The majority of households with unaccompanied youth are in Oroville, 60% of which are made up of females.

Table 4: Number of Individuals by Household Type and Community

INDIVIDUALS	Chico	Gridley	Oroville	Paradise	Other	Total
Adults Only	815	26	551	72	16	1480
Females	253	11	173	29	7	473
Males	553	15	375	41	9	993
Transgender	4	0	3	0	0	7
Not Identify	5	0	0	2	0	7
Adult/Children	267	2	85	37	7	398
Adults (all genders)	122	1	32	19	4	178
Children	145	1	53	18	3	220
Children without Adults	14	0	77	11	3	105
Female	8	0	47	2	1	58
Male	6	0	30	9	2	47
Total	1096	28	713	120	26	1983

Graph 3: Household Make Up



Demographics

Demographics offers a snapshot description of who is living in our communities: age, gender identification, sexual orientation, race, and ethnicity.

AGE: Of those surveyed, adults are more frequently homeless than youth or children, with the highest percent (29%) between 36 and 50 years old. The total number of adults is 1,658. There are 69 young children – infants, toddlers, and preschoolers – who must be cared for by parents, or in child care, during the day. Another 121 children are elementary and middle school aged. About the same percent of children are teens. The number of children – infant to age 18 have increased by 172 since the 2015, which is a 119% increase. The number of transition age youth (18-24 year olds) remain consistent with the 2015 PIT findings, while their percentage of the population has decreased 46% due to the overall higher count. (See the Youth section of this report.) For the older residents, there are 53 elderly people (as old as 82 years old) without stable housing who completed a survey.

TABLE 5: Number of Individuals by Age Ranges

AGE RANGES	Chico	Gridley	Oroville	Paradise	Other	Total	%
5 years old or younger	48	0	20	1	0	69	3%
6-14 year olds	74	1	35	11	0	121	6%
15-17 year olds	37	0	75	17	6	135	7%
18-24 year olds	95	0	37	7	4	143	7%
25-35 year olds	267	7	141	18	6	439	22%
36-50 year olds	322	9	203	37	3	574	29%
51-65 year olds	217	11	187	27	7	449	23%
66 years old or older	36	0	15	2	0	53	3%
Total	1096	28	713	120	26	1983	100%

GENDER IDENTITY: Male residents continue to be the majority of the homeless population, at 62%, although there was a slight decrease in percentage since the 2015 PIT. Females comprise 37% of those surveyed, transgender residents and those who do not identify as female, male or transgender are each less than 1% of the population.

Table 6: Number of people by Gender Identification

GENDER	Chico	Gridley	Oroville	Paradise	Other	Total	%
Female	401	11	259	47	11	729	37%
Male	685	17	452	70	14	1238	62%
Transgender	4	0	2	0	1	7	0.5%
Doesn't identify as female, male or transgender	5	0	0	3	0	8	0.5%
Total	1095	28	713	120	26	1982	100.0%

SEXUAL ORIENTATION: The sexual orientation of the adults who completed surveys was primarily straight (88%). Another 34 adults (2%) were lesbian or gay. Four individuals identified themselves as bi-sexual and another four as questioning. An additional 13 people identified as a sexual orientation not from the list, such as human or queer. (The sexual orientation question was unanswered on 8% of the surveys).

RACE and ETHNICITY: Butte County is racially homogeneous. The homeless population closely reflects the county at large, with one exception. The percent of those with Asian heritage are 9% of the county population, while only 1% of the homeless population. The ethnicity was 14% Hispanic or Latino; while it is 16% of the full Butte County population.

Table 7: Number of people by Race

RACE	Chico	Gridley	Oroville	Paradise	Other	Total	%
American Indian/ Native Alaskan	67	1	56	1	1	126	6%
Asian	4	0	13	0	2	19	1%
Black/African American	33	0	37	0	1	71	4%
Native Hawaiian/ Other Pacific Islander	14	2	10	1	1	28	1%
Multiple Races	193	4	81	13	7	298	15%
White	785	21	516	105	14	1441	73%
Total	1096	28	713	120	26	1983	100%

Nighttime Habitation

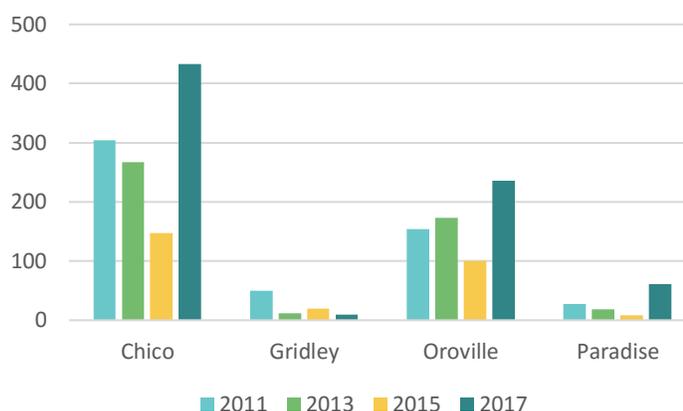
There are limited nighttime options to adequately shelter the 1,983 people without permanent, stable homes.² Table 8 lists the number and percent of people accessing each of the options.

TABLE 8: NIGHTTIME HABITATION

HABITATION	Chico		Gridley		Oroville		Paradise		Other		Total	
Unsheltered	433	40%	10	36%	236	33%	61	51%	5	19%	747	38%
Emergency Shelter	280	26%	0	0%	65	9%	1	1%	5	19%	351	18%
Hotel Voucher	14	1%	0	0%	23	3%	0	0%	0	0%	37	2%
Transitional Housing	162	15%	0	0%	177	25%	0	0%	2	8%	341	17%
Friends and Family	160	15%	17	61%	194	27%	57	48%	10	38%	438	22%
Treatment Facility	20	2%	0	0%	1	0%	0	0%	1	4%	22	1%
Hospital	21	2%	0	0%	3	0%	0	0%	2	8%	26	1%
Jail	4	0%	1	3%	14	2%	1	1%	1	4%	21	1%
Total	1096	100%	28	4%	713	100%	120	100%	26	100%	1983	100%

UNSHeltered: There were 747 people (or 38%) who completed a survey who were sleeping in a place not meant for human habitation the night of the PIT, such as parks, creeks beds, and bus stations. There was a 164% increase from the 2015 PIT. More than half of the Paradise homeless community, 36% of the Gridley, and 33% of Oroville were unsheltered. Despite the cold winds of the night, 40% of the Chico homeless population were unsheltered, many reported huddling six to seven to a car when the outside elements became too harsh to endure. Graph 4 illustrates that the number of unsheltered people in Chico, Oroville, and Paradise has not been higher than in the 2017 PIT.

Graph 4: Sleeping In Place Not Meant for Human Habitation



EMERGENCY SHELTERS: Butte County has five emergency shelter options: Catalyst's Haven for victims of domestic violence; the Torres Shelter for men, women and families in Chico; the Oroville Rescue Mission in Oroville; the Jesus Center's Sabbath house for women and children in Chico; and Safe Space, a nomad wet shelter in Chico. All shelter options are in Chico and Oroville. Only the Domestic Violence shelter permits their guests to stay at the shelter during the day, and the county does not have a day program. Consequently, on the day of the PIT, 337 people had no place to go but in public places. Chico saw an increase of 84 individuals in their shelters from 2015, an increase of 43%. On occasion, vouchers for hotels

² HUD requires CoCs to report the supply of beds and units available in emergency shelters and transitional housing projects, along with the number of people who occupied those beds on the night of the PIT in the Housing Inventory Count Report (Appendix).

are provided by charitable organizations as a means of emergency sheltering, as seen in Chico and Oroville on the night of the PIT.

TRANSITIONAL HOUSING: Transitional Housing allows occupants to sign a housing agreement from one to 24 months to stabilize their housing and prepare for permanent housing. In 2017, new partners who offer a sober living environment were added to the count, increasing the number of reported people from 80 to 340, increasing the reported capacity by 326%. (Accounting for this increase, the full count still increased by approximately 600 people.)

FAMILY AND FRIENDS: Of those surveyed, 22% were staying with friends and family the night of the PIT. The number of people in this homeless more than circumstance doubled from 2015 to 2017, for a total increase of 233 individuals. This was the primary living situation for 88% of unaccompanied (minor) youth. Just less than 30% of families, 20% of single women and 15% of single men were able to stay with friends or family the night of the PIT. These are often the unseen people experiencing homeless, because they may not access services or occupy public places during the day, but they struggle with housing and life instability nonetheless. This scenario draws from other community members' resources to shelter those who might otherwise be sleeping on the street, and often places considerable demands on citizens to meet their guests' intensive level of personal and housing needs.

TREATMENT FACILITIES: Individuals who are receiving overnight treatment in a facility (such as inpatient psychiatric or drug and alcohol treatment), but would otherwise be without a home are included in the local Census and Survey Report. There were 22 people who completed a survey that were homeless prior to admission and would not have a place to live when released.

HOSPITALS: Twenty-six people reported staying in the hospital the night of the PIT, whether admitted overnight or seeking emergency room care throughout the night. Cold winter months often draw people experiencing homelessness to the hospital for warmth and medical care for conditions that have become unmanageable on the street. (See Healthcare section for information about hospital visits.)

JAIL: There were 21 individuals who spent the night of the PIT in jail who completed a survey; only these people have been included in the data findings of this report. The Butte County Sheriff's department reported that, in fact, 147 homeless people were in their jail the night of the PIT but were unable to be interviewed. The 147 homeless inmates represent 26% of the jail occupancy that night. Eighty-four (84%) of the charges were for felonies and 23% for misdemeanors.³ The arrests were made in these communities:

- 53% Oroville
- 33% Chico
- 7% Paradise/Magalia
- 3% Other Butte County areas
- 4% Outside Butte County

Incarceration is listed as the cause of homelessness for 206 of the adults who completed the PIT survey. Similarly, criminal history was listed by 265 adults as a primary barrier to ending their homelessness and finding permanent housing (see Causes and Barriers sections).

³ In the case of inmates with a felony charge or conviction, the number of days spent in jail may exceed the 90-day stipulation in the HUD definition of homeless, yet all 147 inmates met the requirement of being homeless prior to, and potentially following, incarceration.

Chronic Homelessness

HUD requires CoCs to monitor the number of people who are chronically homeless, based on duration, frequency, and recidivism of homelessness, coupled with the existence of a disabling condition (see definition for chronically homeless in the side bar). HUD expects those who are chronically homeless to be prioritized for placement in permanent supported housing units when housing becomes available. According to the narrow definition of homelessness reported to HUD (see Overview section and Appendix), there are 464 households and 531 individuals that are chronically homeless. This will be the count that the CoC will reference when annually reporting on the county's progress to end chronic homelessness.

When using the more inclusive definition of homelessness used in this report and then applying the criteria for chronically homeless, there are *780 households and 929 individuals who are chronically homeless*. Nearly half (49%) of homeless households and nearly half of homeless individuals (47%) are chronically homeless. This suggests that people are staying homeless for long periods of time and/or having repeat episodes in Butte County. And, they are doing so with conditions that are difficult to manage, particularly without stable housing, basic amenities, and support.

The surveys showed that 555 individuals were homeless for the first time this year, indicating a lack of affordable housing and diversion services that might prevent homelessness for individuals and families.

Adults who completed the PIT survey were asked questions about the frequency, duration, and recidivism of their homelessness. Of respondents who answered these questions:

- 39% were homeless for the first time this year
- 65% had been homeless four or more times in the past three years
- 55% had been homeless longer than one year
- 17% had been homeless five or more years

Chronically Homeless

- A.** Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
- B.** Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last three years where the combined length of time homeless in those occasions is at least twelve months; and
- C.** Has a disability.

NOTE: When a household with one or more members includes an adult or minor head of household who qualifies as chronically homeless, then all members of that household are counted as a chronically homeless person in the applicable household type.

Disabling Conditions

Adults identified the existence of disabling conditions from a list of eight broad categories. Table 9 lists the number of people who reported the presence of one or more conditions.⁴ The top disabling condition (which is traditionally under-reported) was the existence of a mental health condition. Next, was the presence of a disabling physical condition (such as diabetes, cancer, heart disease, blindness, seizures, and limited mobility). Both Post Traumatic Stress Disorder and Drug Use Conditions were reported on a quarter of the surveys. Alcohol abuse was also a condition for 17% of the people. Just less than 10% of the people had a developmental disability of some kind, and/or a Traumatic Brain Injury. Thirteen people without stable housing and other primary needs being met are HIV positive or have AIDS.

Table 9: People with Disabling Conditions

CONDITIONS	#	%
Mental Health Condition	461	30%
Physical Condition	446	29%
Post Traumatic Stress Disorder	377	24%
Drug Use	366	24%
Alcohol Abuse	265	17%
Developmental Disability	134	9%
Traumatic Brain Injury	112	7%
HIV+/AIDS	13	1%

⁴ Those surveyed selected as many disabling conditions as applicable, without ranking them. The percent was determined by the number of adults and unaccompanied youth that completed a survey through this question; in other words, those surveys with only demographic information were not used to determine the percent of people with that disability.

Causes of Homelessness

Homelessness can be prevented when people and families are offered the support that they need during a housing, personal or financial crisis. Prevention and diversion service can be improved by a better understanding among specialized and mainstream service providers of the causes of homelessness in the community. In addition, public and private entities with financial resources can invest wisely when they understand the tipping points that lead to homelessness.

Fundamental to preventing homelessness is an affordable housing inventory. Table 10 reports the causes that those completing the survey felt led to their homelessness. Interestingly, consistent with the reasons that people came to Butte County (see Residency section), family is the number one contributing cause of homelessness, as well as the number one reason people report moving to Chico. High on the list, are employment, financial reasons, and mental illness.

Table 10: What Led To Homelessness

CAUSES	#
Family crisis	515
Employment/financial reasons	447
Mental illness	254
Eviction	219
Incarceration	206
Medical/disability problems	179
Other	175
Domestic violence/partner abuse	146
Substandard housing	68
Personal choice to be homeless	60
Alcohol/substance abuse	45
Parent/foster parent abuse	46
Natural or other disasters	46
Age out of foster/group home	37
Post release controlled supervision	27
Intolerance of sexual orientation or gender identity	16
Recent immigration	4

Barriers to Permanent Housing

Simultaneous to preventing homelessness, the community must understand and prioritize removing the barriers that interfere with securing **permanent** housing to end homelessness. Adults completing the PIT survey offered insight in what they believe to be their greatest barriers. These answers are provided in Table 11.

The primary reason, by more than 100 responses, was finding affordable housing. The second top reason was lack of money for rent or deposit, closely related to the first barrier of finding affordable housing. The next two reasons – finding a job and poor credit – are also finance related barriers.

Table 11: Challenges to End Homelessness

CHALLENGE	#
Finding affordable housing	822
No money for rent or deposit	711
Finding a job	587
Poor/no credit	536
Managing my mental health	295
Finding services to help me	291
Transportation to services	277
Criminal history	265
Substance use	252
Rental history	229
Lack of an ID card	197
Other	157
Pets	108
Nothing, I prefer to be homeless	28

Residency

Residency can be a concept that facilitates or deters solutions to homelessness. Does it matter if someone is a resident of a county to help them end their homelessness? How does one define residency? While the data does not answer those philosophical questions, it does provide important insight into who is homeless in our community, and where they consider home.

- 78% of adults and unaccompanied youth were living in Butte County when they became homeless
- 88% of adults and unaccompanied youth consider themselves a Butte County resident

Table 12 specifies the number and percent of adults who have lived in Butte County for specific time ranges. It shows that 87% of the adults have lived in Butte County for one or more years, 65% have lived here over five years, 56% ten or more years, and 36% over an adult life time.

Table 12: Length of Butte County Residency

LENGTH OF RESIDENCY	#	%	Cumulative
Less than 1 month	41	3%	100%
More than a month but less than 1 year	140	10%	97%
1-2 years	122	9%	87%
3-5 years	165	12%	77%
6-9 years	127	9%	65%
10-19 years	268	20%	56%
20+ years	480	36%	36%
Total	1,343	100%	
<i>Didn't Answer</i>	626		

Many people who completed a survey were originally from Butte County. For those who were not Butte County

natives and residing in Butte County in a homeless situation, the survey data suggests that they came to the county for reasons analogous to those who are **not** in a homeless situation: family, college, quality of life, job opportunities, etc. The top reason was family; specific scenarios included being the child of parent who moved to the county, a parent whose children or grandchildren lived in the county, marriage and partnership

Table 13: Reasons People Move to Butte County

REASONS	#	%	REASONS	#	%
Family	74	24.0%	Services	10	3.2%
Sober Living	24	7.8%	Quality of Life	10	3.2%
Friends	23	7.5%	Death in the Family	7	2.3%
Job Opportunity	20	6.5%	College	6	1.9%
Jail/Parole/Release Program	20	6.5%	Medical Care for Themselves/Family	5	1.6%
Travel Thru and Decided To Stay	20	6.5%	Victim of Crime	5	1.6%
Marriage/Partner Relationship	19	6.2%	Climate	4	1.3%
Better Life/Fresh Start	19	6.2%	Foster/Adoption	3	1.0%
Children or Grandchildren	13	4.2%	Drugs	3	1.0%
Housing Opportunity	12	3.9%	Make It on the Street	1	0.3%
Shelter	10	3.2%			

commitments, caring for a sick family member, or the death of a family member. The full list of reasons, and the number and percent of those who selected them, are found in Table 13.

Ordinances

Some local municipalities have established ordinances designed to mitigate the effects of a growing homeless population. These ordinances focus on life-sustaining actions (sitting, lying down) of residents without homes, and often initiate a cycle of frequent encounters with law enforcement and use of local public resources. Those completing the PIT survey reported their level of involvement in the criminal justice system and legal outcomes of encounters with law enforcement due to local ordinances.

- Law enforcement offered warnings in the past year to 478 survey respondents. Warnings were offered to these individuals on average of two and a half times for every ticket that was written.
- 181 individuals who completed the surveys had been ticketed.
- 80 individuals were reportedly arrested due to violating an ordinance.
- Over 60% of those arrested were also incarcerated.
- Over a quarter of the individuals ticketed were also incarcerated, in some part related to the ordinances (such as an outstanding bench warrant or failure to appear in court).

About half of the people who answered PIT questions about the ordinances indicated they had been approached by law enforcement about an ordinance. The outcome of those encounters is shown in Table 14. There is a 70% difference between the number of people residing in Chico on the night of the PIT who reported being warned, compared to all other communities combined. Likewise, there was a 114% difference in ticketing, 70% in arrests, and 94% in incarceration, compared to the other communities.

Table 14: Result of Ordinance Related Interaction with Law Enforcement by Community

RESULT	Chico	Gridley	Oroville	Paradise	Other	Total
Warned	323	12	116	22	5	478
Ticketed	142	1	32	5	1	181
Arrested	54	0	23	2	1	80
Incarcerated	36	0	11	1	1	49

Indeed, a 2017 Chico State study determined there was a statistically significant increase in the arrests of those who are homeless since the introduction of the Chico ordinances. The study also showed that as ordinances designated specific locations, in the center of Chico, in which homeless residents could not publicly reside, the mean geographic location for arrests had moved North over time, presumably following the migration of those who need an alternative location to dwell.⁵

Those who completed a survey estimated the number of total contacts they have had with law enforcement in the past year, for whatever reason: violation of an ordinance, arrest for a law against a person, seeking safety, reporting a crime, etc. The average number of contacts was just less than 11 times per person.

The findings show although the average number of encounters with law enforcement was 11, most people have a low number of encounters with law enforcement each year. The mode was zero, meaning that the most frequently reported number of contacts was zero. In fact, 363 people (30%) said they had no contact at

⁵ Impacts of Chico's Public Safety Approach to Homelessness: Initial Analysis, 2017

all. Another 539 people (44%) had between one and five contacts, so nearly three quarters of the people had five or less encounters with law enforcement. For people with a higher number of contacts, the surveys showed 89 people (14%) had over 20 contacts; 43 people (4%) had over 50 contacts; and 21 people (2%) had over 100 contacts.

The PIT survey findings offer insight as to whether the local ordinances are meeting local public safety and prosperity goals. In other words, “How are the ordinances influencing the choices that homeless individuals make?” Countywide, less than half (46%) of the people who answered the question, reported that they no longer sit, lie down, sleep or keep property in certain places because of these laws. This percent ranged from 42% in Oroville to 56% in Gridley. Eighty-three percent (83%) reported that the ordinances did not lead them to leave a community.

Nationwide, homeless people are ticketed, arrested, and jailed under laws that treat life-sustaining practices such as sleeping or sitting as a criminal offense. These city ordinances are based on the theory that they are necessary to protect the public interest, and to improve the economic health of the city. Butte County cities/towns are not alone – although still the minority - in having these ordinances. Of different concern to this theory is research showing that these laws violate civil rights, are ineffective, and are expensive.



Lack of affordable housing is the leading cause of homelessness. Ordinances do not address this, or any other, underlying cause of homeless, and ultimately worsen the problem. Those who have been arrested return to their communities, still with nowhere to live and now laden with financial obligations and legal burdens. Any efforts these residents were making toward stabilization, such as employment, medical and mental health care, accessing public benefits to pay for housing, and participating in supportive relationships have been disrupted and taxed. Further, the ordinances contribute to a cycle of homelessness (illustrated in the diagram to the right provided by the National Law Center on Homelessness and Poverty).^{6 7 8}

Laws that penalize people for unavoidable human actions such as sitting or sleeping, are among the most expensive ways of addressing homelessness. Law enforcement, and associated city/town funds, are burdened with sustaining the cycle, and with little positive outcome. Furthermore, only housing removes people from the street to stabilize their lives so that they can begin contributing positively to the community.

⁶ Housing Not Handcuffs: Ending the Criminalization of Homelessness in U.S. Cities, National Law Center on Homelessness & Poverty

⁷ No Safe Place: The Criminalization of Homelessness in U.S. Cities, National Law Center on Homelessness & Poverty

⁸ Searching Out Solutions: Constructive Alternatives to the Criminalization of Homelessness, U.S. Interagency Council on Homelessness, 2012

Redirecting funds into affordable housing saves the community money. In fact, HUD states that it costs the community approximately \$40,000 per person who is homeless each year, between emergency sheltering, medical care, and jail time. A recent study conducted by Chico State, in cooperation with the Chico Police Department, found that there has been an average annual increased cost of \$138,744 for law enforcement to implement the local ordinances.⁹

The United States Housing and Urban Development (HUD) states that “criminalization policies further marginalize men and women who are experiencing homelessness, fuel inflammatory attitudes, and may even unduly restrict constitutionally protected liberties...” and that these approaches only “temporarily reduce the visibility of homelessness in the communities.”¹⁰ As a federal governing entity, HUD has incentivized communities taking action, by established that CoCs that prevent criminalization in their community are awarded points in their annual funding application. In 2016, the Butte County CoC applied for \$545,894, for funds primarily used to house chronically homeless individuals, transition age youth, and victims of domestic violence. Loss of these funds would result in loss of housing for these individuals and families.

⁹ Impacts of Chico’s Public Safety Approach to Homelessness: Initial Analysis, 2017

¹⁰ Decriminalizing Homelessness, hudexchange, 2016

Health Care

Countywide, over 8% of people under the age 65 do not have health insurance.¹¹ Of the 1,315 who answered the questions about health care coverage, 1,073 (82%) reported having health insurance, 210 (16%) did not have health insurance, and 33 (3%) weren't sure. Of the 210 who did not have insurance, 84 believed that they had applied for it.

In Butte County, 708 adults, or more than half of the adults experiencing homelessness have seen a doctor in the last year. By comparison, 298 adults (23%) have seen a dentist in that time. For children, 126 have seen a doctor and 91 have seen a dentist.

Most people struggling with homelessness do not have a primary physician for personalized, long-term treatment. The majority of people completing the survey use clinics and health centers for their health care. Table 16 lists the types of health care providers and the number of people who frequent them.

Since hospital emergency departments are a community resource that serves everybody regardless of the ability to pay, they are also often used for immediate and on-going medical needs. The cost of care often falls to hospitals, at an average of \$3,700 a visit.¹²

The survey results offer better understanding of the frequent use of hospitals. The results indicate that 519 people (39%) reported not using the hospital at all. Another 36% only had one or two visits. Yet, 36 individuals were high frequency patients, visiting the Emergency Room over 12 times in a year. Likewise, the number of days in the hospital were low for most people, but particularly high for 90 people (7%), who stayed more than 12 days. Tables 17 and 18 on the following pages shows the frequency of emergency room use by community.

Table 15: The Last Time Adults Saw A Doctor and Dentist

VISITS	Doctor		Dentist	
	#	%	#	%
Less than a year ago	708	56%	298	23%
1+ years	162	13%	187	15%
2+ years	98	8%	179	14%
3+ years	288	23%	624	48%
TOTAL	1256		1288	

Table 16: Frequented Health Care Providers

Health Care Providers	#
Clinic/Health Centers (e.g. Ampla, Tribal Health)	644
Hospital	545
Doctors Office	195
Alcohol/Drug Dependency Programs	33
Veterans Affairs	31
County Offices (e.g. Behavioral Health)	10
Mobile Medical/Dental Vans	8
Schools/University Health Center	6
Self	5
Health Fair	2
Computer	2
Jesus Center	1
WalMart	1

¹¹ U.S. Census, 2016

¹² The Connection Between Housing and Healthcare Needs: Growing Evidence Base for Housing as a Social Determinant of Health, U.S. Department of Housing and Urban Development.

There is a growing body of evidence that shows housing and health are inextricably linked together. The sick and vulnerable are more likely to become homeless, and the homeless are more likely to become sicker and more vulnerable. Sickness and injury often lead to homelessness because it makes it difficult to hold a job. The combination of unemployment and poor health can lead to financial ruin. In fact, 57% of bankruptcies are due to medical bills.¹³

Table 17: Number of Times the Emergency Room Was Used in One Year

# Times	Chico	Gridley	Oroville	Paradise	Other	Total	%
0	306	11	177	23	2	519	39%
1-2	272	9	158	24	6	469	36%
3-6	145	2	78	18	3	246	19%
7-12	26	2	17	2	0	47	4%
12+	15	0	16	4	1	36	3%
TOTAL	764	24	446	71	12	1317	100%

Table 18: Number of Days in the Hospital in One Year

# Days	Chico	Gridley	Oroville	Paradise	Other	Total	%
0	488	14	266	46	6	820	63%
1-2	100	5	59	5	1	170	13%
3-6	75	3	54	9	0	141	11%
7-12	37	2	29	0	3	71	5%
12+	53	0	28	7	2	90	7%
TOTAL	753	24	436	67	12	1292	100%

Treatment regimens for chronic illnesses are nearly impossible to manage without regular mealtimes, access to medication, and on-going management. What’s more, most adults experiencing homelessness experience more than one health-related issue (see Disabling Conditions section). Mental illness and substance use disorders make focus, rational judgments, and planning difficult to care for oneself or secure housing. Those without homes are also faced with vulnerability of exposure that can lead to violence against them, leading to injury. Homeless individuals use emergency rooms up to four times more often than other low-income residents. Ultimately, those without homes die decades younger than those with homes.¹⁴

Access to health care for those without stable shelter is vital to survival. This involves health insurance, a personal physician, dentists, and other specialists, and emergency care. These health needs are the same for every human, but more frequent for those without homes because of the lack of safety, resources, transportation, and stabilization of their living circumstances.

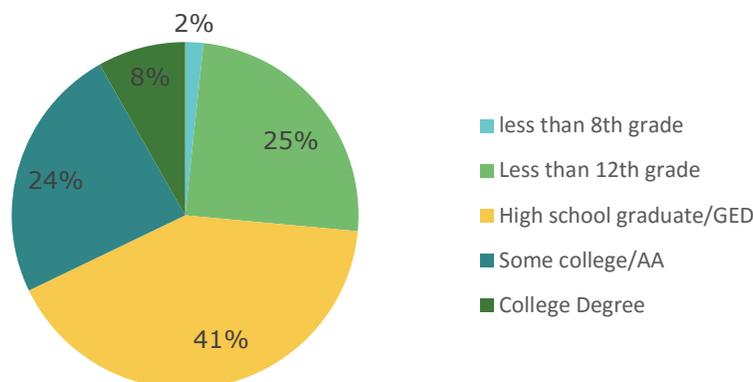
¹³ How Health and Homelessness are Connected- Medically, The Atlantic, 2016

¹⁴ How Health and Homelessness are Connected- Medically, The Atlantic, 2016

Education

Academic achievement is correlated with employment, self-sufficiency and financial stability. In Butte County, 88% of the residents have at least a high school education, this is 15% higher than the homeless residents who completed the survey. Further, 26% of the county residents have a Bachelor's degree, which is 17% higher than the unhoused population.¹⁵

Graphic 5: Adult Educational Success Levels



The number of college students experiencing homelessness is on the rise. A recent study of 70 community colleges across 24 states found that two-thirds of the students are food insecure, around half are housing insecure, and about 14% are homeless. These students are more likely to have jobs that do not earn a living wage.¹⁶ In fact, nationally, about 56,000 students self-reported as homeless on the annual student aid form.¹⁷

While a college education can be a dividing factor in future financial stability between lower and middle income households, the challenges associated with obtaining that degree have become nearly prohibitive for the lower income student. The Butte College Chancellor's office initiated a student survey in September 2016 and found local students are in jeopardy of not having their basic needs met. The results showed that 90% of the responding students were experiencing some level of food insecurity and 93% some level of housing displacement.¹⁸ A CalFresh study at California State University, Chico (CSUC) reported 46% their 707 survey respondents suffered from low to very low food insecurity.¹⁹ A 2016 Status University study revealed that 8% to 12% of Chico State students are in unstable housing situations.²⁰ Chico State's President released a statement in May 2017 reporting that nearly half the students are struggling to afford food and one in 12 are unstably housed. Fortunately, for Chico State students, the Chico Care Endowment has been established to create perpetual and immediate support for students' unmet basic needs.

¹⁵ U.S. Census, 2016

¹⁶ Hungry and Homeless in College: Results From a National Study of Basic Needs Insecurity in Higher Education, Wisconsin HOPE Lab, 2017

¹⁷ National Association for the Education of Homeless Children and Youth

¹⁸ California Community Colleges presentation

¹⁹ Identifying Food Insecure Students and Constraints for SNAP/CalFresh Participation at California State University, Chico, 2016

²⁰ Serving Displaced and Food Insecure Students in the CSU, California State University, Long Beach, 2016

Income and Housing

Homelessness is a housing crisis. In the most simple terms, ending homelessness for most people requires financial resources and available affordable housing. In Butte County, both of these are scarcities for some residents.

The median annual household income in Butte County is \$43,444 (ranging from \$35,455 to \$49,861 depending on the community) and the median gross rent is \$905. But over 20% of the population who live in poverty cannot come close to affording median gross rent.²¹ According to the PIT surveys, 45% of the people living without a home have no income whatsoever, and another 19%, have less than \$500 a month to cover all living expenses. Just less than 28% (340 people) have income between \$500-\$1000, consistent with a SSI payment, which was the type of income most often reported by those completing the survey (see Tables 19 and 20). HUD designates that families who pay more than 30% of their income for housing are considered cost burdened and may have difficulty affording necessities such as food, clothing, transportation and medical care. Yet, the income of approximately 90% of the residents who completed the survey is less than the county's median rent alone.

Butte County has an extremely low housing inventory, with vacancy rates ranging from 1.5% to 2.5% throughout 2016.²² The impact of this is that landlords may increase rental rates to adjust to the supply and demand in the area, pricing out very low income tenants. This can contribute to low-income tenants losing their housing with even a slight change in expenses, such as lost work due to illness. It can also prevent those who are trying to end their homelessness from securing housing that is priced outside of their income, particularly if a security deposit, first and last months' rent must be paid at one time.

Table 19: Income Levels of Butte County Homeless

INCOME LEVEL	#	%
No Income	548	45%
\$1-\$250	150	12%
\$251-\$500	87	7%
\$501-\$1000	340	28%
\$1001-\$1500	74	6%
\$1501-\$2000	23	2%
More than \$2000	9	1%

Table 20: Sources of Income

Income Source	#	Income Source	#
SSI	275	Unemployment	15
Recycling	251	Student Aid/Grants	15
General Assistance	139	Illegal: selling drugs, shoplifting, hustling	9
Job/Paid Internship	137	Sell property	8
Pan Handling	125	Barter	7
Friends or Family	124	Charity/Community/God	7
Other	102	AB109/ACS	3
Social Security	102	Child Support	3
Temporary Employment, Odd Jobs	91	Find Money	3
SSDI	89	Foster/Adoption Services	2
TANF	73	Family	2
Cal Fresh/Food Stamps	44	Survivor Benefits	2
Veteran's Benefits	20	Workers comp	2
Retirement/Pension	16	Tribal	1

²¹ U.S. Census, 2016

²² North Valley Property Owners Association

Another impact of a low housing inventory is that even when financial support can be offered, through a Section 8 voucher or rapid rehousing projects, there are still few housing options available for which to use these supports. In too many cases, this has resulted in continued homeless and loss of program support because adequate housing cannot be acquired in time to access the housing support.

Veterans

Remarkable progress was made nationally and locally to reach HUD’s goal of ending veteran homeless by 2015.²³ But much is yet to be accomplished to stabilize the lives of returning heroes, who may have unique post-service challenges. Although there was a decrease in the number of unhoused veterans between 2013 (150 veterans) and 2015 (73 veterans), the number has increased again in 2017, to 144 veterans. This increase may be due to the ’s change in methodology of the count, as well as a possible increase in number of homeless veterans. Regardless, there continues to be a countywide need to house veterans without homes, and rapidly rehouse those who are imminently homeless.

There are 137 homeless veteran households in Butte County, consisting of 138 single adults, 19 parents, and nine children (adult count in households includes non-veteran spouses). The majority of both types of households are residing in Chico.

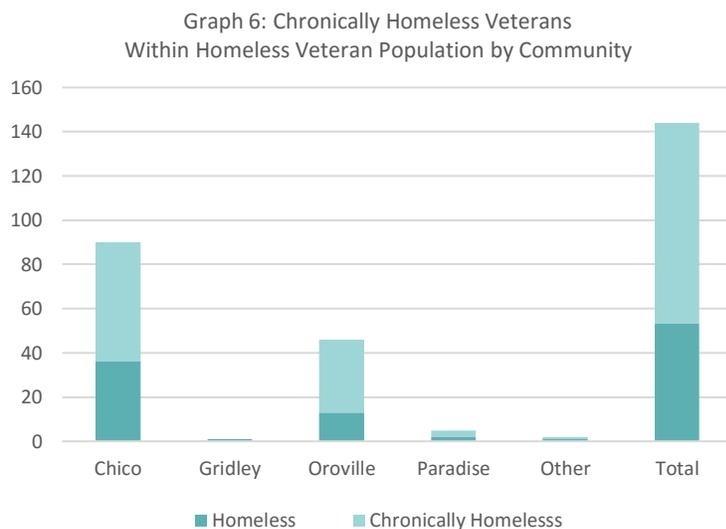
Table 21: Household Type by Community

HOUSEHOLDS	Chico	Gridley	Oroville	Paradise	Other	Total
Single Adults	81	1	44	5	0	131
Adults with Children	3	0	1	0	2	6
Total	84	1	45	5	2	137

The total number of veteran individuals without a home is 144. As shown in Table 22, most veterans live in Chico (90) and in Oroville (46). There are 17 (12%) female, 125 (87%) male, and 2 veterans who do not identify as male, female or transgender.

Table 22: Number of people by Gender Identification

GENDER	Chico	Gridley	Oroville	Paradise	Other	Total	%
Female	12	0	3	1	1	17	12%
Male	77	1	43	3	1	125	87%
Transgender	0	0	0	0	0	0	0%
Doesn't identify as female, male or transgender	1	0	0	1	0	2	1%
Total	90	1	46	5	2	144	100%



Chronically homeless veterans make up 63% of the veteran homeless population. Oroville’s chronically homeless veteran population is 72% of the full veteran population, and it is 60% for both Chico and Paradise.

²³ Opening Doors Across America: A USICH Call to Action, US. Interagency Council on Homelessness

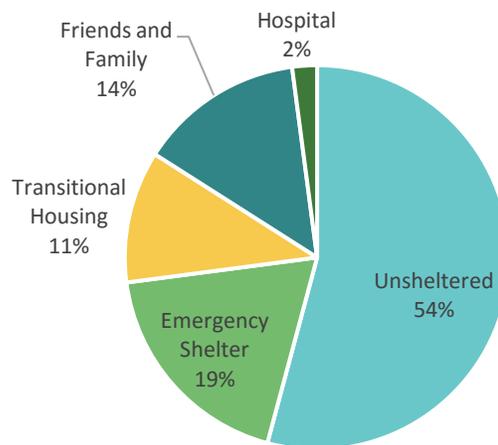
To meet the definition of chronically homeless, the individual must have at least one disabling condition. In the case of veterans, 38% of them reported on their survey to have a physical condition, 33% Post Traumatic Stress Disorder, and 26% a mental health condition, all of which may have been caused or influenced by their time in service.

Table 23: Disabling Conditions

DISABLING CONDITION	#	%
Physical Condition	54	38%
Post Traumatic Stress Disorder	47	33%
Mental Health Condition	37	26%
Drug Use	26	18%
Alcohol Abuse	24	17%
Traumatic Brain Injury	11	8%
Developmental Disability	10	7%
HIV/AIDS	2	1%

More than half of veterans experiencing homelessness are unsheltered. As shown Graph 7, 19% are staying in an emergency shelter, 14% are temporarily staying with friends or family, 11% are in transitional housing, and 2% were in the hospital the night of the PIT count.

Graph 7: Nighttime Habitation



The number one challenge in ending homelessness, for veterans who completed the survey, is finding affordable housing. The other top reasons include money for rent or a deposit, finding a job, or managing their poor credit. The veterans identified several barriers that could be supported with the array of veteran service provided in Butte County. Only five veterans reported that they prefer to be homeless.

Table 24: Challenges to Ending Homelessness

CHALLENGE	#	%
Finding affordable housing	81	56%
No money for rent or deposit	61	42%
Finding a job	60	42%
Poor/no credit	38	26%
Managing my mental health	28	19%
Finding services to help me	38	26%
Transportation to services	32	22%
Criminal history	27	19%
Substance use	19	13%
Rental history	18	13%
Lack of an ID card	18	12%
Pets	14	10%
Nothing, I prefer to be homeless	5	3%

Domestic Violence

There is a distinct connection between domestic violence and homelessness. The United States Department of Justice reports that one in four homeless women is homeless because of violence committed against her. Victims of domestic violence with limited economic resources are particularly vulnerable to homelessness. The victim may need to leave an unsafe environment without the ability to secure a new safe place to live. If housing is dependent on finding affordable housing or having enough money for rent and a deposit, the only option for those fleeing abuse may be to become homeless.²⁴

There were 300 people who identified as being a victim of domestic violence on the PIT survey, which is almost 20% of the all adults completing the survey. Table 25 shows the number of victims of domestic violence reported by each community.

Table 25: Number of Victims of Domestic Violence by Community

INDIVIDUALS	Chico	Gridley	Oroville	Paradise	Other	Total
# VICTIMS	185	5	89	16	5	300

There were 297 households associated with the 300 victims: 253 households were occupied by only adults, 56 households with adults and children, and five households with unaccompanied youth. There were 77 children living with their parents and 5 households with only minor youth.

Table 26: Households by Type and by Community

HOUSEHOLDS	Chico	Gridley	Oroville	Paradise	Other	Total
Single Adults	153	5	75	13	3	249
Adults with Children	29	0	11	2	1	43
Children without Adults	2	0	1	1	1	5
Total	184	5	87	16	5	297

The individuals with the 297 households total 391 people: 253 single adults, 56 parents, 77 children with a parent, and 5 unaccompanied youth with a parent.

Table 27: Adults and Children by Household Type and by Community

INDIVIDUALS	Chico	Gridley	Oroville	Paradise	Other	Total
Single Adults	155	5	77	13	3	253
Adult/Children	86	0	39	5	3	133
Adults	37	0	15	3	1	56
Children	49	0	24	2	2	77
Children without Adults	2	0	1	1	1	5
Total	243	5	117	19	7	391

²⁴ Domestic Violence and Homelessness, National Coalition for the Homeless

Although, domestic violence is often considered a crime against women, a growing number of men disclose partner abuse. In the case of Butte County surveys, 58% of the victims were female, 40% were male, 1% was transgender and 1% didn't identify as female, male, or transgender.

Table 28: Gender Identify of Victims

GENDER	#	%
Female	174	58%
Male	121	40%
Transgender	3	1%
Doesn't identify as female, male or transgender	2	1%
Total	300	100%

The residents who identified themselves as a victim of domestic violence, reported that for almost two-thirds of them, this was not the first time they were experiencing homelessness.

The primary causes of homelessness reported on the surveys, included family crisis (47%), domestic violence/partner abuse (31%), and employment and financial reasons (28%). The survey did not distinguish whether the person was currently fleeing domestic violence or had previously been in an abusive

Table 29: Causes of Homelessness

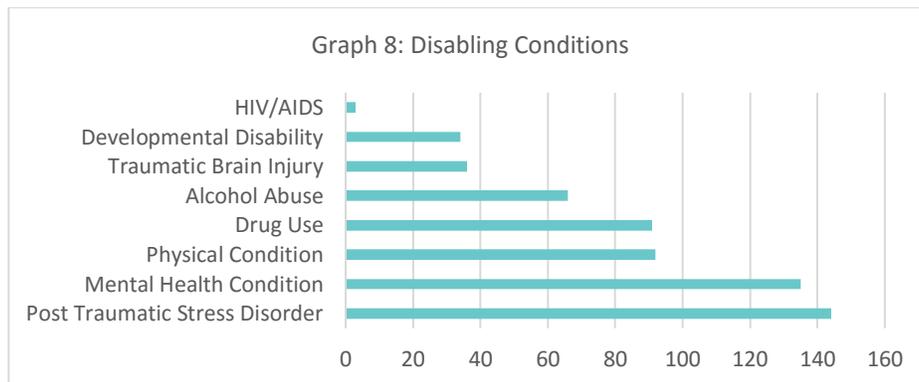
CAUSES	#	%
Family Crisis	142	47%
Domestic violence/partner abuse	94	31%
Employment/financial reasons	84	28%
Mental illness	74	25%
Evicted	39	13%
Medical/disability problems	36	12%
Incarceration	35	12%
Personal choice to be homeless	20	7%
Substandard housing	17	6%
Alcohol/substance abuse	17	6%
Parent/foster parent abuse	17	6%
Age out of foster/group home	13	4%
Natural or other disasters	7	2%
Post release controlled supervision	4	1%
Intolerance of sexual orientation or gender identity	2	1%
Recent immigration	1	0%

relationship. Nevertheless, a family crisis and lack of financial resources are consistent with homeless causation for victims of domestic violence.

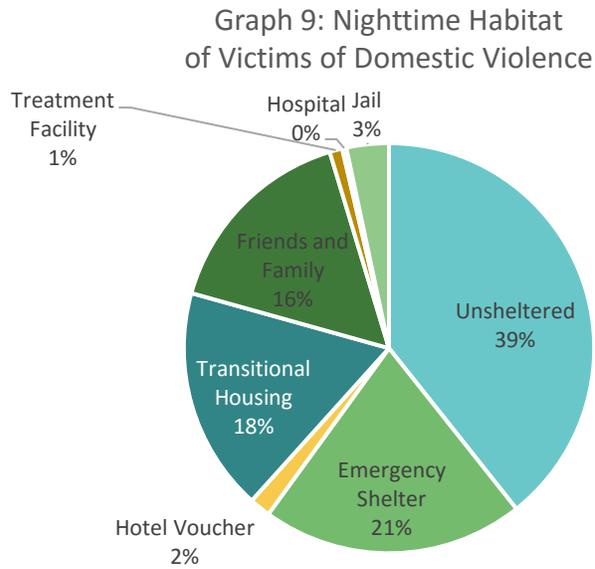
Likewise, the survey results specified disabling conditions that might be associated with victims of domestic violence, including a high occurrence of Post Traumatic Stress Disorder (48%) and mental health issues (45%).

Table 30: Disabling Conditions

DISABLING CONDITION	#	%
Post Traumatic Stress Disorder	144	48%
Mental Health Condition	135	45%
Physical Condition	92	31%
Drug Use	91	30%
Alcohol Abuse	66	22%
Traumatic Brain Injury	36	12%
Developmental Disability	34	11%
HIV/AIDS	3	1%



Butte County has a sheltering and support service agency for victims of domestic violence and their children. Nonetheless, not everyone opts to stay in that shelter, and not everyone who identified themselves as victims of domestic violence are currently fleeing abusive relationships. Graph 9 illustrates the various locations for nighttime habitation on the night of the PIT. This illustrates the need for all shelter and service providers to have a knowledge of best practices associated with serving victims of domestic violence, as well as strong partnerships with the local specialized service provider.



Youth

Youth are not simply young adults; they have unique developmental needs, vulnerabilities, and strengths. This is also the case for youth without homes. Each year, thousands of minor youth across the nation run away from home or are asked to leave their homes, and become homeless. Once homeless, survival often results in harmful situations at a higher rate than adults, such as survival sex, human trafficking, violence, and substance abuse. Studies show that causes of homelessness, like family problems, economic circumstances, racial disparities, mental health and substance use disorders, history in foster care system, and sexual orientation must be considered when finding solutions to homelessness. Other studies reveal the following findings nationwide:

- More than 90,000 unaccompanied youth identified themselves as homeless when they enrolled in public school in 2013-2014.
- 19% of youth who were in foster care at 17 years old reported two years later that they had been homeless at some point during those two years.
- 20%-40% of youth experiencing homelessness identify as LGBTQ.
- 25% of youth served through Family and Youth Services Bureau-funded programs were pregnant or parenting in 2014.²⁵

Butte County sees many of these same trends with their youth residents. For the purposes of this report, many of the findings are provided in two age categories:

<18 = Unaccompanied Youth (UY)

Youth younger than 18 years old and living without their parents

18-24 = Transition Age Youth (TAY)

Youth 18 to 24 years old, not living with their parents, and who may or may not have their own children

The PIT survey was completed by 105 UY and 144 TAY. Table 31 details the number of youth by age group.

- Three-quarters of the 105 UY surveys were in Oroville.
- Two thirds of the TAY surveys were completed in Chico.
- There were 120 TAY without children and 25 in a household with children.
- There were 32 children of TAY.
- No UY with children complete a survey.

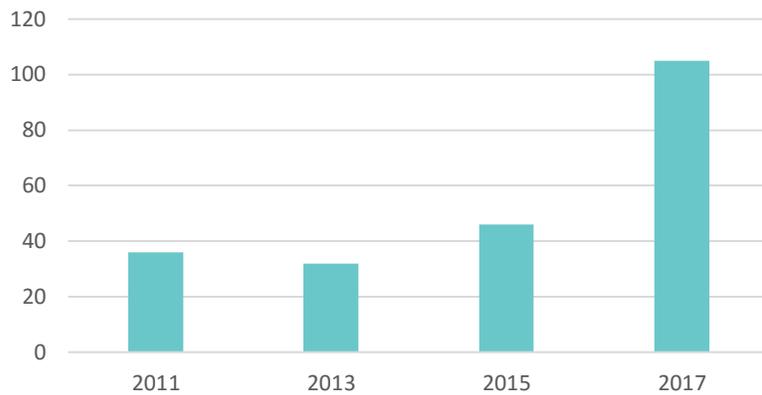
Table 31: Homeless Youth by Group and Community

YOUTH GROUPS	Chico	Gridley	Oroville	Paradise	Other	Total
Unaccompanied Youth (Younger than 18)	14	0	77	11	3	105
Transitional Age Youth (18-24)	73	0	37	7	3	120
Parenting Transitional Age Youth (18-24)	22	0	0	0	3	24
Children of Parenting Youth	31	0	0	0	1	32
TOTAL YOUTH	140	0	114	18	10	282

²⁵ Preventing and Ending Youth Homelessness: A Coordinated Community Response, US Interagency Council on Homelessness

The number of Unaccompanied Youth who completed PIT surveys has risen dramatically since 2011. Graph 10 shows the change from 36 youth in 2011 to 105 in 2017. That is a 128% increase since 2015, a 228% increase since 2013 and a 192% increase since 2011. (Historically, the number of TAY were not separated from other adults in PIT reports in order to monitor change in that age group across years.)

Graph 10: Unaccompanied Youth (<18)



The image of homelessness is often young people, temporarily moving through the Butte County communities. A series of survey questions about residency paint a different picture of our youth. As illustrated in Graph 11 and Table 32, only 18% of the youth have been in Butte County less than a year and

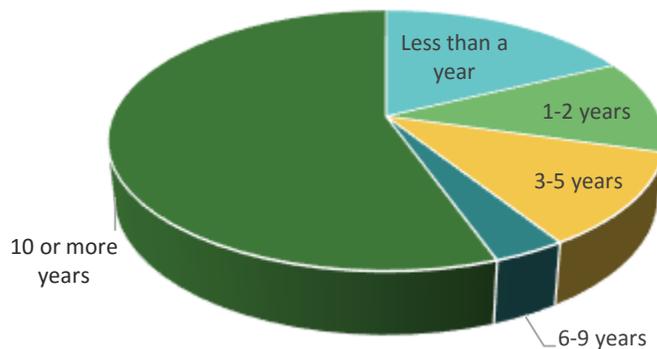
Table 32: Length of Residency in Butte County

LENGTH OF RESIDENCY	%	Cumulative %
Less than 1 month	5%	100%
More than a month but less than 1 year	13%	95%
1-2 years	12%	83%
3-5 years	12%	71%
6-9 years	4%	59%
10-19 years	24%	56%
20+ years	32%	32%

another 12% here one to two years. Further, 16% have lived in the county between three and nine years, and while not likely born in the county, have arguably decided to become residents. *More than half, 56% of youth, have been in the county for 10 or more years (32% for over 20 years).*

This is substantiated by 80% of the youth reporting that they were living in Butte County when they became homeless. And finally, 86% of the youth reported they consider Butte County their home.

Graph 11: Length of Time Youth Have Lived In Butte County



There are about 57 females in both age groups, with 10 fewer males in the UY group and 25 more males in the older TAY group. From another perspective, there are 35 fewer males in the younger group than the older group. It is undetermined whether this is actually a trend or based on the difficulty in locating youth this age. The sexual orientation reported in 2017 continues to be primarily straight across age groups.

Table 33: Gender Identity by Youth Age Group

AGE GROUPS	<18		18-24		<25	
	#	%	#	%	#	%
Female	58	55%	57	40%	115	46%
Male	47	45%	82	57%	129	52%
Transgender	0	0%	3	2%	3	1%
Not Female, Male, or Transgender	0	0%	1	1%	1	0%
TOTAL	105	100%	143	100%	248	100%

Table 34: Sexual Orientation by Youth Age Group

AGE GROUPS	<18		18-24		<25	
	#	%	#	%	#	%
Orientation	#	%	#	%	#	%
Straight	19	76%	87	89%	106	86%
Lesbian	1	4%	2	2%	3	2%
Bisexual	4	16%	6	6%	10	8%
Questioning	0	0%	0	0%	0	0%
Identifies as something not on the list	1	4%	3	3%	4	3%
TOTAL	25	100%	98	100%	123	100%

Analyzing chronic homelessness is not typical for youth. It might not be expected that their young age would lend itself to an extended time without a home or many of the disabling conditions that are not as prevalent in youth. Unfortunately, 10% of the UY – younger than 18 years old – already meet the qualifications for the definition of chronic homelessness. Another 46 TAY, or 32%, are also chronically homeless.

Table 35: Chronically Homeless Youth

CHRONIC HOMELESSNESS	<18	18-24	Total
# Chronically Homeless	11	46	57
Percent Chronically Homeless	10%	32%	23%

These and other homeless youth may also have challenges associated with a disabling condition or conditions. For those that do, 43 youth disclosed a mental health condition, and another 30 have Post Traumatic Stress Disorder. It is undetermined whether these conditions were present prior to their homelessness or developed as a result of their homelessness. Another 28 youth have a physical condition and 10 have a Traumatic Brain Injury. There were 31 youth with a drug use and 18 with alcohol use condition. There are six youth with a developmental disability that they may receive special education services for in school. One individual is HIV+ or has AIDS.

Further, five UT and 18 TAY reported already being a victim of domestic violence.

Table 37: Causes of Homelessness

CAUSES	#
Employment/financial reasons	38
Family Crisis	37
Mental illness	24
Evicted	19
Incarceration	13
Age out of foster/group home	10
Personal choice to be homeless	8
Parent/foster parent abuse	8
Medical/disability problems	8
Domestic violence/partner abuse	8
Alcohol/substance abuse	8
Substandard housing	6
Natural or other disasters	3

Table 38: Biggest Challenges Facing Youth In Ending Homelessness

BIGGEST CHALLENGE	#	%
Finding affordable housing	69	28%
No money for rent or deposit	57	23%
Finding a job	47	19%
Poor/no credit	52	21%
Managing my mental health	19	8%
Finding services to help me	21	8%
Transportation to services	17	7%
Criminal history	17	7%
Substance use	16	6%
Rental history	18	7%
Lack of an ID card	17	7%
Other	14	6%
Pets	10	4%
Nothing, I prefer to be homeless	1	0%

The top reasons Butte County youth identify as causes for their homeless is employment/financial reasons and family crisis, similar to the older population. Mental illness and eviction were also reported as major causes. Other causes of homelessness stated by one or two youth, and not listed on Table 37 included involvement with the legal system such as juvenile hall, post release controlled supervision or having children detained by Children’s Services; being a victim of crime or having a family member who was a victim of domestic violence; financial and housing problems such a foreclosure, being evicted, losing Section 8 vouchers, or being kicked out of their house by their parents.

Similar to the older homeless population, the primary barriers to ending homelessness is finding affordable housing, having enough money for rent or a deposit, finding a job, or managing their poor credit. Other issues such as needing an ID card or a place that accepts pets continues to be a burden. Again, a preference for homeless is the least selected option.

It is notable when youth, not under the supervision of parents, opt to attend school and prioritize their education, particularly when managing the complications of surviving without adequate housing and finances. Three youth had less than an 8th grade education and 28 less than a 12th grade education. Forty-four youth had graduated High School or earned their GED. Despite the obstacles that youth must encounter in a homeless situation, a quarter of the TAY youth had completed some college, and an additional 6% already have a college degree. (See Education Section for more information about homeless college students.)

Table 39: Educational Level of TAY

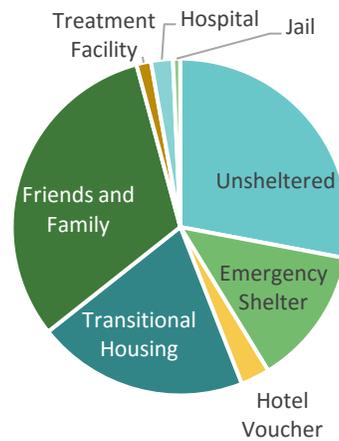
EDUCATION	#	%
less than 8th grade	3	3%
Less than 12th grade	28	26%
High school graduate/GED	44	41%
Some college/AA	27	25%
College Degree	6	6%

Where youth stay differs by the age group. The younger Unaccompanied Youth have less sheltering options due to their age. Consequently, 88% were temporarily staying with friends or family, 8% were unsheltered, and 5% were in juvenile hall. For the older TAY there are more options. The most frequently reported nighttime habitation was, again, staying with friends or family, but with only 31% using this option, almost as often as being unsheltered (28%). Another 36% had sought housing support by living in a transitional housing project (20%), staying at an emergency shelter (13%), or accessing a short-term hotel vouchers (3%).

Graph 12: Nighttime Habitation for Unaccompanied Youth



Graph 13: Nighttime Habitation for Transition Age Youth



Moving Forward As A Community

Thanks to the commitment and generosity of the Butte County community – both unhoused and housed – in contributing to the PIT, we have a rich opportunity to learn how to move forward within a complex crisis. The number of people experiencing homelessness has increased, both those who have been homeless long-term (considered chronically homelessness) and those who are homeless for the first time. Further, we see this trend for all subpopulations: veterans, college students, youth, victims of domestic violence, single adults, and families. We also see a considerable increase in three of the four communities: Chico, Oroville, and Paradise. There has been a sizable increase in those who are unsheltered, in emergency shelters, and doubled up with friends and family. And while there are valiant stories of individuals ending their homelessness in our community, we are neither ending nor preventing homelessness at a pace that is changing the face of who we see suffering in the streets.

The local findings are consistent with national research, that fundamental to ending homelessness is increasing the housing stock and offering individualized support in areas of key need. Health problems and other disabling conditions are pervasive in the county's homeless populations, and without at least a minimal level of housing stability and safety, it is likely that these conditions will worsen. Considerable private and public funds are being spent locally, which do not address the fundamental causes of homelessness. As seen nationally, the homeless crisis will continue to exhaust local funds and overtax current care systems. In short, the problem is not going away with the existing solutions in place.

The primary solution, as identified in national studies and repeatedly throughout the analysis of the local PIT data, is an increase in affordable housing inventory. People are losing their housing and are unable to secure housing because there simply is not enough available housing, particularly for people with low income.

The PIT shows again that the vast majority of those who are without homes in Butte County, lost their homes while living here. In fact, they are most often originally from the county. And while there are some individuals that are temporarily in the county, it should not distract from ensuring that the community has the safety and support necessary to end homelessness for their residents.

The PIT findings also show evidence that while the majority of those experiencing homelessness are single adults, the larger family system is a primary contributing influencer of homelessness. There is a need for multiple, specialized, immediate, long-term services - health, mental health, employment, tenant legal support, sheltering, public safety, and crisis support, in conjunction with housing - to be offered *as a system* across all households in the community. As funding sources seek to prioritize their investments and service providers hone their practices and partnerships based on the new PIT findings, we must move forward in a system of care and on a foundation of housing to ensure individuals, youth, and families receive the support they need to become healthy and self-sufficient.

Appendix

HUD Interim Rule Homeless Definition

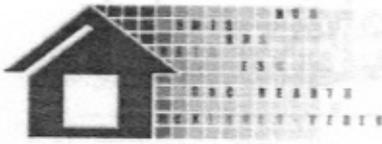
2017 HUD Housing Inventory Count

2017 HUD Point In Time Count

2017 HIC and PIT Methodology Report and PIT Survey

2017 PIT Debrief Report

Butte Countywide Homeless Continuum of Care Membership Roster



Homeless Definition

CRITERIA FOR DEFINING HOMELESS	Category 1	Literally Homeless	<p>(1) Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:</p> <ul style="list-style-type: none"> (i) Has a primary nighttime residence that is a public or private place not meant for human habitation; (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); <u>or</u> (iii) Is exiting an institution where (s)he has resided for 90 days or less <u>and</u> who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution
	Category 2	Imminent Risk of Homelessness	<p>(2) Individual or family who will imminently lose their primary nighttime residence, provided that:</p> <ul style="list-style-type: none"> (i) Residence will be lost within 14 days of the date of application for homeless assistance; (ii) No subsequent residence has been identified; <u>and</u> (iii) The individual or family lacks the resources or support networks needed to obtain other permanent housing
	Category 3	Homeless under other Federal statutes	<p>(3) Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:</p> <ul style="list-style-type: none"> (i) Are defined as homeless under the other listed federal statutes; (ii) Have not had a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to the homeless assistance application; (iii) Have experienced persistent instability as measured by two moves or more during in the preceding 60 days; <u>and</u> (iv) Can be expected to continue in such status for an extended period of time due to special needs or barriers
	Category 4	Fleeing/ Attempting to Flee DV	<p>(4) Any individual or family who:</p> <ul style="list-style-type: none"> (i) Is fleeing, or is attempting to flee, domestic violence; (ii) Has no other residence; <u>and</u> (iii) Lacks the resources or support networks to obtain other permanent housing



At Risk of Homelessness

CRITERIA FOR DEFINING AT RISK OF HOMELESSNESS	Category 1	Individuals and Families	<p>An individual or family who:</p> <ul style="list-style-type: none"> (i) Has an annual income below <u>30%</u> of median family income for the area; <u>AND</u> (ii) Does not have sufficient resources or support networks immediately available to prevent them from moving to an emergency shelter or another place defined in Category 1 of the "homeless" definition; <u>AND</u> (iii) Meets one of the following conditions: <ul style="list-style-type: none"> (A) Has moved because of economic reasons 2 or more times during the 60 days immediately preceding the application for assistance; <u>OR</u> (B) Is living in the home of another because of economic hardship; <u>OR</u> (C) Has been notified that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance; <u>OR</u> (D) Lives in a hotel or motel and the cost is not paid for by charitable organizations or by Federal, State, or local government programs for low-income individuals; <u>OR</u> (E) Lives in an SRO or efficiency apartment unit in which there reside more than 2 persons or lives in a larger housing unit in which there reside more than one and a half persons per room; <u>OR</u> (F) Is exiting a publicly funded institution or system of care; <u>OR</u> (G) Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved Con Plan
	Category 2	Unaccompanied Children and Youth	A child or youth who does not qualify as homeless under the homeless definition, but qualifies as homeless under another Federal statute
	Category 3	Families with Children and Youth	An unaccompanied youth who does not qualify as homeless under the homeless definition, but qualifies as homeless under section 725(2) of the McKinney-Vento Homeless Assistance Act, and the parent(s) or guardian(s) or that child or youth if living with him or her.

Butte County HUD PIT Report*

Chart 1: Homeless Households & Demographics by Housing Type

Households & Individuals	Emergency Shelter	Transitional Housing	Unsheltered	Total
Total number of households	241	111	624	976
Total number of persons	285	165	745	1195
Number of children (under age 18)	31	48	39	118
Number of young adults (age 18 to 24)	15	20	40	75
Number of adults (over age 24)	239	97	666	1002
Gender				
Female	105	80	212	397
Male	178	82	530	790
Transgender	1	3	1	5
Don't identify as male, female, or transgender	1	0	2	3
Ethnicity				
Non-Hispanic/Non-Latino	244	132	685	1061
Hispanic/Latino	41	33	60	134
Race				
White	217	104	565	886
Black or African-American	15	4	14	33
Asian	2	1	6	9
American Indian or Alaska Native	16	11	48	75
Native Hawaiian or Other Pacific Islander	2	0	15	17
Multiple Races	33	45	97	175
Chronically Homeless				
Total number of households	93		371	464
Total number of persons	111		420	531

*Data meets HUD's more narrow definition for homelessness used for the PIT count.

Butte County HUD PIT Report*

Chart 2: Households with at Least One Adult and One Child

Households & Individuals	Emergency Shelter	Transitional Housing	Unsheltered	Total
Total number of households	22	26	18	66
Total number of persons	61	80	57	198
Number of children (under age 18)	31	48	31	110
Number of young adults (age 18 to 24)	3	6	1	10
Number of adults (over age 24)	27	26	25	78
Gender				
Female	26	49	20	95
Male	35	31	37	103
Transgender	0	0	0	0
Don't identify as male, female, or transgender	0	0	0	0
Ethnicity				
Non-Hispanic/Non-Latino	48	62	46	156
Hispanic/Latino	13	18	11	42
Race				
White	37	54	31	122
Black or African-American	5	1	0	6
Asian	1	0	4	5
American Indian or Alaska Native	6	2	4	12
Native Hawaiian or Other Pacific Islander	0	0	8	8
Multiple Races	12	23	10	45
Chronically Homeless				
Total number of households	7		5	12
Total number of persons	19		17	36

**Data meets HUD's more narrow definition for homelessness used for the PIT count.*

Butte County HUD PIT Report*

Chart 3: Households without Children

Households & Individuals	Emergency Shelter	Transitional Housing	Unsheltered	Total
Total number of households	219	85	601	905
Total number of persons	224	85	680	989
Number of young adults (age 18 to 24)	12	14	39	65
Number of adults (over age 24)	212	71	641	924
Gender				
Female	79	31	189	299
Male	143	51	488	682
Transgender	1	3	1	5
Don't identify as male, female, or transgender	1	0	2	3
Ethnicity				
Non-Hispanic/Non-Latino	196	70	632	898
Hispanic/Latino	28	15	48	91
Race				
White	180	50	527	757
Black or African-American	10	3	14	27
Asian	1	1	2	4
American Indian or Alaska Native	10	9	44	63
Native Hawaiian or Other Pacific Islander	2	0	7	9
Multiple Races	21	22	86	129
Chronically Homeless				
Total number of households	86		365	451
Total number of persons	92		402	494

**Data meets HUD's more narrow definition for homelessness used for the PIT count.*

Butte County HUD PIT Report*

Chart 4: Households with Only Children (under age 18)

Households & Individuals	Emergency Shelter	Transitional Housing	Unsheltered	Total
Total number of households	0	0	5	5
Total number of persons	0	0	8	8
Number of children (under age 18)	0	0	8	8
Gender				
Female	0	0	3	3
Male	0	0	5	5
Transgender	0	0	0	0
Don't identify as male, female, or transgender	0	0	0	0
Ethnicity				
Non-Hispanic/Non-Latino	0	0	7	7
Hispanic/Latino	0	0	1	1
Race				
White	0	0	7	7
Black or African-American	0	0	0	0
Asian	0	0	0	0
American Indian or Alaska Native	0	0	0	0
Native Hawaiian or Other Pacific Islander	0	0	0	0
Multiple Races	0	0	1	1
Chronically Homeless				
Total number of households	0		1	1
Total number of persons	0		1	1

**Data meets HUD's more narrow definition for homelessness used for the PIT count.*

Butte County HUD PIT Report*

Chart 5: Veteran Households with at Least One Adult and One Child

Households & Individuals	Emergency Shelter	Transitional Housing	Unsheltered	Total
Total number of households	2	0	1	3
Total number of persons	5	0	3	8
Total number of veterans	2	0	1	3
Gender				
Female	1	0	0	1
Male	1	0	1	2
Transgender	0	0	0	0
Don't identify as male, female, or transgender	0	0	0	0
Ethnicity				
Non-Hispanic/Non-Latino	2	0	1	3
Hispanic/Latino	0	0	0	0
Race				
White	2	0	1	3
Black or African-American	0	0	0	0
Asian	0	0	0	0
American Indian or Alaska Native	0	0	0	0
Native Hawaiian or Other Pacific Islander	0	0	0	0
Multiple Races	0	0	0	0
Chronically Homeless				
Total number of households	1		0	1
Total number of persons	3		0	3

**Data meets HUD's more narrow definition for homelessness used for the PIT count.*

Butte County HUD PIT Report*

Chart 6: Veteran Households without Children

Households & Individuals	Emergency Shelter	Transitional Housing	Unsheltered	Total
Total number of households	20	8	79	107
Total number of persons	21	8	80	109
Total number of veterans	20	8	79	107
Gender				
Female	0	0	12	12
Male	19	8	67	94
Transgender	0	0	0	0
Don't identify as male, female, or transgender	1	0	0	1
Ethnicity				
Non-Hispanic/Non-Latino	17	8	69	94
Hispanic/Latino	3	0	10	13
Race				
White	18	4	56	78
Black or African-American	0	0	2	2
Asian	0	0	0	0
American Indian or Alaska Native	1	2	6	9
Native Hawaiian or Other Pacific Islander	0	0	0	0
Multiple Races	1	2	15	18
Chronically Homeless				
Total number of households	11		57	68
Total number of persons	13		61	74

**Data meets HUD's more narrow definition for homelessness used for the PIT count.*

Butte County HUD PIT Report*

Chart 7: Unaccompanied Youth Households

Households & Individuals	Emergency Shelter	Transitional Housing	Unsheltered	Total
Total number of unaccompanied households	12	14	39	65
Total number of unaccompanied persons	12	14	42	68
Number of children (under age 18)	0	0	9	9
Number of young adults (age 18 to 24)	12	14	34	60
Gender				
Female	5	3	14	22
Male	6	9	28	43
Transgender	0	2	0	2
Don't identify as male, female, or transgender	1	0	0	1
Ethnicity				
Non-Hispanic/Non-Latino	9	9	37	55
Hispanic/Latino	3	5	5	13
Race				
White	4	9	34	47
Black or African-American	1	1	0	2
Asian	0	0	0	0
American Indian or Alaska Native	0	0	1	1
Native Hawaiian or Other Pacific Islander	0	0	0	0
Multiple Races	7	4	7	18
Chronically Homeless				
Total number of households	5		11	16
Total number of persons	6		11	17

**Data meets HUD's more narrow definition for homelessness used for the PIT count.*

Butte County HUD PIT Report*

Chart 8: Parenting Youth Households

Households & Individuals	Emergency Shelter	Transitional Housing	Unsheltered	Total
Total number of households	1	5	1	7
Total number of persons in households	3	15	2	20
Number of parenting youth	2	5	1	8
Number of parenting youth (under age 18)	0	0	0	0
Number of parenting youth (age 18 to 24)	2	5	1	8
Number of children with parenting youth	1	10	1	12
Gender				
Female	1	5	1	7
Male	1	0	0	1
Transgender	0	0	0	0
Don't identify as male, female, or transgender	0	0	0	0
Ethnicity				
Non-Hispanic/Non-Latino	2	4	1	7
Hispanic/Latino	0	1	0	1
Race				
White	2	4	1	7
Black or African-American	0	0	0	0
Asian	0	0	0	0
American Indian or Alaska Native	0	0	0	0
Native Hawaiian or Other Pacific Islander	0	0	0	0
Multiple Races	0	1	0	1
Chronically Homeless				
Total number of households	0		0	0
Total number of persons	0		0	0

*Data meets HUD's more narrow definition for homelessness used for the PIT count.

Butte County HUD PIT Report*

Chart 9: Butte County Homeless Subpopulations (HUD PIT Count*)

Households & Individuals	Emergency Shelter	Transitional Housing	Unsheltered	Total
Adults with serious mental illness	106	66	268	440
Adults with substance abuse disorder	74	60	165	299
Adults with HIV/AIDS	4	3	4	11
Victims of Domestic Violence	47	30	117	194

**Data meets HUD's more narrow definition for homelessness used for the PIT count.*

Year	Proj. Type	Organization Name	Project Name	Geo Code	Inventory Type	Bed Type	Target Pop. A	Target Pop. B	McKinney-Vento
2017	ES	Catalyst Domestic Violence Services	Women's DV Shelter	60684	C	Facility-based beds	SMF+HC	DV	No
2017	ES	Chico Community Shelter Partnership	Torres Shelter	60684	C	Facility-based beds	SMF+HC	NA	Yes
2017	ES	Chico Housing Action Team	Safe Space	60684	C	Other beds	SMF	NA	No
2017	ES	Jesus Center	Sabbath House	60684	C	Facility-based beds	SFHC	NA	No
2017	ES	Oroville Rescue Mission	Men's Emergency Shelter	69007	N	Facility-based beds	SMI		No
2017	ES	Oroville Rescue Mission	Women and Children's Shelter	69007	C	Facility-based beds	SFHC	NA	No
2017	ES	Youth For Change	RHY Housing	60684	C	Other beds	YMF	NA	No
2017	TH	Catalyst Domestic Violence Services	Catalyst Transitional Housing Cottage Program	60684	C		SMF+HC	DV	No
2017	TH	Chico Community Shelter Partnership	Friends House	60684	C		SMHC	NA	No
2017	TH	Community Action Agency of Butte County Inc.	Esplanade House TH	60684	C		HC	NA	No
2017	TH	Jesus Center	Birch House	60684	N		SMHC		No
2017	TH	Jesus Center	House of Hope	60684	C		SFHC	NA	No
2017	TH	Jesus Center	Myrtle House	60684	N		SFHC	NA	No
2017	TH	Jesus Center	Sage House	60684	N		SF	NA	No
2017	TH	Jordan Crossing Church	Jordan Crossing for Men	69007	C		SMI	NA	No
2017	TH	Jordan Crossing Church	Second Step Cabins	69007	N		SMHC	NA	No
2017	TH	Jordan Crossing Church	Second Step Houses	69007	N		SMF+HC	NA	No
2017	TH	Northern California Treatment	Transitional Housing	69007	N		SMF	NA	No
2017	TH	Oroville Rescue Mission	Jonah House	69007	N		SMI	NA	No
2017	TH	Oroville Rescue Mission	Women's Transitional Program	69007	C		SFHC	NA	No
2017	TH	Oroville Rescue Mission	Wonder House	69007	N		SFHC	NA	No
2017	TH	Stairways Programming	Stairways Transitional Housing	60684	C		SMF	NA	No
2017	TH	TriCounties Treatment	TriCounties Treatment Residential	69007	C		SMI	NA	No
2017	TH	TriCounties Treatment	TriCounties Treatment Transitional SLE Housing	69007	N		SMI		No

Year	Proj. Type	Organization Name	Project Name	Geo Code	Inventory Type	Bed Type	Target Pop. A	Target Pop. B	McKinney-Vento
2017	TH	Veterans Executive Corporation to Organize Rehabilitative Services (VECTORS)	Jerry L Knight Residential	60684	C		SMI	NA	No
2017	TH	Youth For Change	Colleen's House - TAY Transitional Housing	60684	C		SMF+HC	NA	No
2017	TH	Youth For Change	MHSA Master Lease	60684	C		SMF+HC	NA	No
2017	TH	Youth For Change	Olive House - TAY Transitional Housing	60684	C		SMF	NA	No
2017	RRH	Catalyst Domestic Violence Services	Rapid Rehousing Program	69007	N		SMF+HC	DV	Yes
2017	RRH	Veterans Resource Centers of America	Supportive Services Veterans Families	69007	C		SMF+HC	NA	No
2017	PSH	Butte County Department of Behavioral Health	LINK Permanent Housing Bonus	69007	C		SMF	NA	Yes
2017	PSH	Butte County Department of Behavioral Health	SEARCH II - SHP	69007	C		SMF	NA	Yes
2017	PSH	Butte County Department of Behavioral Health	SEARCH II Permanent Housing Bonus	69007	C		SMF	NA	Yes
2017	PSH	Butte County Department of Behavioral Health	SEARCH III	69007	C		SMF	NA	Yes
2017	PSH	Butte County Department of Behavioral Health	SEARCH Samaritan Bonus	69007	C		SMF	NA	Yes
2017	PSH	Camihar	Avenida House	60684	C		SMF	NA	Yes
2017	PSH	Community Action Agency of Butte County Inc.	Esplanade House PH - Phase 2	60684	C		HC	NA	No
2017	PSH	Housing Authority of Butte County	HUD-VASH	69007	C		SMF+HC	NA	No
2017	PSH	Housing Authority of Butte County	Search South - SPC	69007	C		SMF	NA	Yes
2017	OPH	Chico Housing Action Team	Our Place	60684	C		SMF	NA	No

Project Name	Veteran Beds HH w/ Children	Youth Beds HH w/ Children	CH Beds HH w/ Children	Veteran Beds HH w/o Children	Youth Beds HH w/o Children	CH Beds HH w/o Children	CH Beds HH w/ only Children
Women's DV Shelter	0	0		0	0		
Torres Shelter	0	0		0	0		
Safe Space							
Sabbath House	0	0		0	0		
Men's Emergency Shelter	0	0		0	0		
Women and Children's Shelter	0	0		0	0		
RHY Housing	0	4		0	0		
Catalyst Transitional Housing							
Cottage Program	0	0		0	0		
Friends House	0	0					
Esplanade House TH	0	0		0	0		
Birch House	0	0					
House of Hope	0	0		0	0		
Myrtle House	0	0					
Sage House				0	0		
Jordan Crossing for Men				0	0		
Second Step Cabins	0	0					
Second Step Houses	0	0					
Transitional Housing				0	0		
Jonah House				0	0		
Women's Transitional Program	0	0					
Wonder House	0	0					
Stairways Transitional Housing				0	0		
TriCounties Treatment Residential				0	0		
TriCounties Treatment Transitional							
SLE Housing				0	0		

Project Name	Veteran Beds HH w/ Children	Youth Beds HH w/ Children	CH Beds HH w/ Children	Veteran Beds HH w/o Children	Youth Beds HH w/o Children	CH Beds HH w/o Children	CH Beds HH w/ only Children
Jerry L Knight Residential	0	0		15	0		
Colleen's House - TAY Transitional Housing	0	3					
MHSA Master Lease	0	7					
Olive House - TAY Transitional Housing				0	2		
Rapid Rehousing Program	0	0					
Supportive Services Veterans Families	0	0		5	0		
LINK Permanent Housing Bonus	0	0		0	0	3	0
SEARCH II - SHP	0	0		0	0	0	
SEARCH III Permanent Housing Bonus	0	0		0	0	3	0
SEARCH III	0	0		0	0	0	
SEARCH Samaritan Bonus	0	0		0	0	4	
Avenida House	0	0		0	0	14	
Esplanade House PH - Phase 2	0	0	0				
HUD-VASH	48	0	0	83	0	0	0
Search South - SPC	0	0		0	0	5	
Our Place				0	0		
	Sum : 48	Sum : 14	Sum : 0	Sum : 103	Sum : 2	Sum : 29	Sum : 0

Project Name	Year-Round Beds	Total Seasonal Beds	Overflow Beds	HMIS Overflow Beds	PI Count	Total Beds	Utilization Rate
Women's DV Shelter	26	0	0	0	13	26	50%
Torres Shelter	132	0	23	23	155	155	100%
Safe Space		39			39	39	100%
Sabbath House	23	0		0	20	23	87%
Men's Emergency Shelter	32	0	15	15	46	47	98%
Women and Children's Shelter	14	0	3	3	12	17	71%
RHY Housing	4	0	0	0	0	4	0%
Catalyst Transitional Housing							
Cottage Program	9				9	9	100%
Friends House	8				3	8	38%
Esplanade House TH	96				56	96	58%
Birch House	10				10	10	100%
House of Hope	8				8	8	100%
Myrtle House	12				7	12	58%
Sage House	3				3	3	100%
Jordan Crossing for Men	35				18	35	51%
Second Step Cabins	13				6	13	46%
Second Step Houses	41				39	41	95%
Transitional Housing	60				46	60	77%
Jonah House	6				6	6	100%
Women's Transitional Program	6				6	6	100%
Wonder House	5				5	5	100%
Stairways Transitional Housing	42				35	42	83%
TriCounties Treatment Residential	39				30	39	77%
TriCounties Treatment Transitional							
SLE Housing	19				16	19	84%

Project Name	Year-Round Beds	Total Seasonal Beds	Overflow Beds	HMIS Overflow Beds	PIT Count	Total Beds	Utilization Rate
Jerry L Knight Residential	15				7	15	47%
Colleen's House - TAY Transitional Housing	3				3	3	100%
MHSA Master Lease	7				6	7	86%
Olive House - TAY Transitional Housing	2				1	2	50%
Rapid Rehousing Program	12				12	12	100%
Supportive Services Veterans Families	5				5	5	100%
LINK Permanent Housing Bonus	3				1	3	33%
SEARCH II - SHP	5				5	5	100%
SEARCH III Permanent Housing Bonus	3				3	3	100%
SEARCH III	3				3	3	100%
SEARCH Samaritan Bonus	4				3	4	75%
Avenida House	14				14	14	100%
Esplanade House PH - Phase 2	120				89	120	74%
HUD-VASH	171				117	171	68%
Search South - SPC	5				5	5	100%
Our Place	18				18	18	100%
Sum :	1033	Sum : 39	Sum : 41	Sum : 41	Sum : 880		

**BUTTE COUNTY HOMELESS CONTINUUM OF CARE
STAFF REPORT**

Date: December 19, 2016
To: Butte Countywide Homeless Continuum of Care Council
From: Sherisse Allen, Housing Tools
Re: 2017 HIC and PIT Methodology

Background

HUD requires that all Continua of Care (CoC) conduct an annual Housing Inventory Count (HIC) and sheltered Point In Time (PIT) study, and report those findings into a national database. Every two years, CoCs are required to expand the PIT to also include those who are living unsheltered. There are myriad of purposes for the HIC and PIT, and consequently great value placed on the study. A quality methodology and survey are key to ensuring credibility and accuracy.

- The purpose of the HIC is to track the supply and demand of beds available in the county for Emergency Shelters, Transitional Housing, and Permanent Housing (including Permanent Supportive Housing and Rapid Rehousing Programs).
- HUD's purpose of the PIT is to count the number of people who are experiencing homelessness in order to inform national priorities and funding decisions. It also influences the CoC Program funding awards.
- Locally, the PIT is an important source for local program and system planning: to be responsive and adjust services according to human need; to prioritize funding to efficiently use limited resources; to justify program design and funding applications for projects throughout the county; and to raise public awareness and garner support through the findings.
- Additionally, the CoC provides PIT data to Consolidated Plan jurisdictions that receive Emergency Solutions Grants, Community Development Block Grants, HOME Investment Partnership and/or Housing Opportunities for Persons with AIDS. The data is used to inform the strategic planning of these jurisdictions to meet their reporting obligations.

While the HIC and PIT data findings are considered valuable for many reasons, HUD recognizes the complexity and impossibility of an accurate PIT count. The study nets a count that is a minimum number of people in the county in a homeless situation. To ensure that CoCs avail themselves of all opportunities of an accurate count, HUD has designed 14 PIT count standards to guide methodology choices. In addition, HUD requires that specific data is captured, while allowing CoCs to determine what additional data might be collected based on the priorities of the county.

HUD's annual Consolidated Application recommends that CoCs state in their Governance Charter that the HIC and PIT methodology will be presented to and approved by the CoC prior to its execution. Additional points are awarded if that Charter requirement is met. The inclusion of Council action in the minutes will meet the requirement for approval of the methodology prior to execution. The inclusion of a statement in the Charter will be a separate but related action of the Council that is also included as part of this proposal. There is significant detail included in the description of the methodology proposed to be used to conduct the PIT count. However this detail is intended to be illustrative of a process that can be used. The detail contained in this methodology is not intended to restrict the Council in the future from considering other activities to accomplish its responsibilities to conduct PIT and HIC counts.

2017 HIC & PIT STUDY METHODOLOGY

January 25, 2017 marks the day in which the Butte Countywide Homeless Continuum of Care (CoC) will conduct their HIC, as well as the sheltered and unsheltered PIT count.

The Methodology described herein is in compliance with HUD's 14 Standards in the *2014 Point-in-Time Count Methodology Guide* and notice CPD-16-060, *Notice for Housing Inventory Count (HIC) and Point-In-Time (PIT) Data Collection for Continuum of Care (CoC) Program and the Emergency Solutions Grant (ESG) Program*, and 24 CFR 578.3 *Interim Rule*, HUD Exchange HIC and PIT resource pages, and HUD webinars. If anything in this description and methodology is inconsistent with HUD standards and requirements currently or in successive issuances then those standards and requirements will take precedence. The CoC Council reserves the right to modify its methodology when it is determined appropriate to do so.

HIC Methodology

The Housing Inventory Count (HIC) reports project information for all Emergency Shelters, Transitional Housing Projects and Permanent Housing Projects (including Permanent Supportive Housing and Rapid Rehousing). A list of all such projects will be assembled by the CoC Designee and a form corresponding with project type will be completed by the sheltering project. The CoC Designee will offer administrative support to complete the form along with the instructions embedded in the form itself. This information will be entered into the HUD database by the CoC Designee. A spreadsheet report that is generated by project type from that database which will be provided to the CoC Homeless Management Information System (HMIS) staff to cross reference with local HMIS data.

Key to the accurate completion of the HIC is that the reported number of people who stayed at the project on the night of the PIT corresponds with the number of surveys completed by the guests. Discrepancies will be resolved with each sheltering project. If a PIT survey was not completed for each guest the night of the PIT, the number of occupied beds will be decreased in the HIC report to match the number of PIT surveys.

There are a few changes in the HIC requirements from previous years. Most notably, beds dedicated for youth, and specifically youth head of household (or parenting youth) will be reported separately. This is consistent with PIT reporting of this subpopulation. A locally-orchestrated 2017 enhancement for Sober Living Environments that qualify as Transitional Housing Projects will be included.

PIT Methodology

The Point in Time (PIT) survey involves an annual sheltered and biennial unsheltered count. The specific methodology strategies described below have been selected based on HUD requirements, input from the Butte County PIT Committee, Butte County resources and limitations, and lessons learned from the county's previous PIT studies.

The **shelter count** methodology will be to conduct a complete coverage of shelters the night of January 24th to achieve the highest level of accuracy. Shelter staff in all projects will complete the surveys with their guests. New sheltering projects, in particular Sober Living Environments, will be added to the sheltered count. Community volunteers will support the administration of surveys for sheltering projects that are unwilling or unable to invest staff time to attend a training and administer the survey. A shortened shelter-only training on administering the survey is scheduled to honor the limited time shelter staff have, particularly during the winter months. The CoC Designee will directly oversee the sheltered count.

The **unsheltered count** methodology will be coordinated through a PIT Committee. The methodology was selected based on the HUD requirements, what has been previously successful, and areas identified in the 2015 PIT Debrief meeting as needing improvement. A census count approach will also be selected for the unsheltered count. Although it is ambitious to attempt to account for and report on all unsheltered homeless people residing in the county, it allows for more accuracy than sampling and extrapolation, particularly when identifying subpopulation trends.

Representatives from the four main localities oversee the count in the communities: Chico, Oroville, Paradise/Magalia, and Gridley/Biggs. Each locality representative designs the unsheltered methodology for their community, which also adheres to the broad strategies agreed upon by the PIT Committee. Local strategy implementation includes: the selection of **Hub** locations and incentives at those locations; selection and coordination of service-based sites; coordination of street sites; volunteer training, screening and assignments; and local outreach. At least one Hub in each locality will serve as the command center for volunteers to check in and out, pick up materials, and receive information and support. Volunteers will also be present at the Hub to assist with survey completion, and service of warm food. An additional six or more Hubs will be in place this year to better cover the county and accommodate individuals living further from the city/town centers. Key to the success of the Hubs is the ability for the outreach marketing plan to bring people to the locations.

In addition to Hubs, the **service-based count** approach will be used at non-sheltered locations. Many of these locations will be at service organizations designed specifically for people experiencing homelessness (e.g. Iverson Center, Hope Center, Jesus Center). There are also numerous other locations frequented by homeless individuals during the day for warmth and shelter that were not originally designed to serve those in need (e.g. library, recycling centers, hospital, jails) that will also be attended to by volunteers. The HUD-defined homeless count will be submitted into the HDX system. Additional counts not meeting the HUD-definition will be restricted from the HDX report and included only in a community report. (See *Homeless and Housing Assistance Definitions & Qualification for PIT* attached.)

Hub leaders will develop a list of service centers to be included in the count with the CoC Designee and together arrange for their participation. Either the service organization assigns their own staff to attend the training and assist with the surveys, or volunteers are assigned to the location.

The **street count** approach involves counting people who are staying in public or private places not designated for, or ordinarily used as, a regular sleeping accommodation for human beings (cars, parks, abandoned buildings, bus stations, camp grounds, etc.). It is conducted the night before, and early morning of, the count. The method avails itself to highly trained professionals in the county (such as Butte County Department of Behavioral Health, Stairways Programming, and Torres Shelter staff) to lead small teams into more isolated areas in the community. Each team has a leader who guides the positive approach and safety of the interaction. Teams are assembled based on expertise, volatility of the location, and geographic spans. All professional volunteers check in and out at the locality Hub.

The goal will be comprehensive coverage to obtain the most complete and accurate count, starting with known locations. A list is developed based on informed and reasonable reconnaissance with community partners, and will be updated a few days prior to the PIT. Law enforcement will be involved on the day of the PIT as appropriate. Locations will be eliminated if volunteer safety may be compromised or the terrain would suggest that there would be no human occupation. An alternative Observation Form will be completed in these situations when possible (see attached).

Butte 2-1-1 will be used to conduct over the **phone surveys**. This strategy may be appealing for individuals who do not have transportation to a Hub, do not want to go to the Hub, or are hesitant to complete the survey in a public setting. Individuals that complete a survey can still receive a food card if they leave their first name with the 2-1-1 case manager. The names will be emailed to walk-in centers in three localities where food cards can be picked up before the end of the week.

The PIT Committee also consists of individuals overseeing **subpopulations** (youth, schools, veterans), service areas (street outreach, sober living environments, health, behavioral health), Hub locations, and data/research partners (HMIS team, CSUC). These individuals lend expertise in specific areas and assist in streamlining countywide elements such as outreach, recruitment, county department partnerships, data collection, survey design, call in survey

completion, etc. Whenever possible a representative from the PIT Committee coordinates a subpopulation component in coordination with the CoC Designee. This reserves fiscal resources, while encouraging new relationships to be built between service providers or strengthens existing relationships.

At the time of this report, the **youth** strategies continue to be developed. Confirmed strategies in Chico include special outreach for youth, a taco truck for a magnet event, and youth participation in planning; all associated with 6th Street Drop In Center. The PIT Committee is continuing to target strategies to reach youth throughout the county based on learning from the 2015 Youth *You Count* grant. There will be special consideration to locate Butte College and Chico State students who are without stable housing.

Adult and youth consultants called “**Navigators**” will receive a stipend for offering their expertise in the planning and implementation of the study. The stipend will be based on participation in planning meetings, identifying encampments and other unsheltered locations, distribution of outreach material, piloting the survey, and assisting in the completion of the surveys on the day of the PIT.

Marketing plans have been developed and will be executed for volunteer recruitment and participant outreach. The volunteer recruitment plan involves large and small flyers which have been designed and distributed throughout the county through the CoC membership and service providers’ listservs. Social media has been used on CoC and Project Homeless Connect Facebook pages. A press release was sent to the local media.

The participant outreach plan is targeted to individuals who are unstably housed. Flyers with all county Hub locations, as well as a flyer for each locality, have been designed. A business-size card with the Hub locations has also been designed for ease of participants to keep the information in their belongings. A separate, more youth-appealing flyer and card has been designed to reach youth. The outreach will be distributed through listservs and community meetings. The Hub leaders will also assemble teams to distribute the materials at non-service sites throughout the county.

Volunteers who have been recruited through the marketing plan will commit to two hours of training and at least one two-hours shift. Volunteers may be local professionals with experience working with those who are homeless, as well as lay community volunteers. The training agenda will include survey logistic, how to complete the survey, safety, and shift assignments. All volunteers will be trained to complete the survey by the CoC designee to bring consistency of administration across the study. Shift sign-ups will designate the level of expertise for each assignment.

Incentives are a crucial part of the unsheltered PIT because they motivate individuals to participate and thank them for volunteering their time and offering their personal information. Every Hub will offer food. In addition a \$5 food card will be given out for every completed survey. Packaged food will be offered at most sites. Hub sites may also organize distribution of other essential items such as socks.

Seven unique improvements to the HIC and PIT methodology this year include the following:

1. *Stronger support and representation of Behavior Health Specialists and Outreach Workers*

Butte County Department of Behavioral Health has dedicated staff time in each locality at significant numbers; Stairways Programming and other outreach workers are also participating.

2. *Consistent Administration of the Survey*

Instructions for how to administer the survey will be put in writing; training will be offered the week prior to the PIT to help volunteers remember how to administer it; one individual will provide the survey instruction at all trainings throughout the county; shorter trainings will be provided on-site for professionals when appropriate.

3. Develop strong partnerships with health and medical community

Representatives from all local hospitals have been working with the CoC designee to understand the value of the PIT in understanding the impact of homelessness in their hospital or health center; Public Health staff has been established as the liaison with hospitals in setting up health protocols and administering surveys.

4. Reach individuals who do not reside in public places

As in previous year, expert-led teams will search for individuals and families in encampments and other in-field locations. The number of Hubs and service-based locations to cover the spans of localities and county have increased. This year, a full 50 locations in Chico alone have been identified. The police departments have been asked to refrain from encampment sweeps the week prior to the PIT in order for people to settle in and be observed at encampment locations.

5. Increased access to the survey for participants

Butte 2-1-1 has extended participation from referral to direct service and full outreach. 2-1-1 will conduct interviews over the phone to complete the surveys. At the 2016 Project Homeless Connect, participants were assisted in acquiring identification cards that allowed them to have a free cell phone. They immediately registered their cell phone with Butte 2-1-1 to receive announcements pertinent to their needs. (This also built familiarity with the 2-1-1 services.) Those who are registered will receive notification of the PIT locations. Also over the next month, the CoC Designee will work with service providers to register more participants.

6. Intending reach with technology and volunteer base

Social Media has been used to connect to the community invested in finding support and solutions for homelessness, in order to recruit volunteers and receive resources.

7. Respecting and utilizing community resources

Countywide Navigators who have experienced homelessness will be hired to participate in the planning, outreach, survey development, and survey administration.

The PIT Survey

HUD data requirements expect a relatively sophisticated survey to capture the information that will allow an accurate analysis. Page one of the survey completes the HUD requirements. Page two are questions proposed by the PIT Committee. The CoC Designee worked directly with specialists in the community to hone the type and phrasing of questions. (Attached for approval.)

HUD's required survey changes include gender identify fields, reporting chronic homelessness by household type, and considering all individuals in a household which meet the definition of chronically homeless if one individual meets the definition. These changes are accommodated through the survey fields, data analysis, and reporting.

An **Observation Form** was developed to be used only when the person or household is unwilling or unable to complete a survey, or if it is unsafe to approach an individual or group. Unlike previously used observation or tally forms, this particular tool specifies the demographic information required by HUD, allowing the individual to be counted in the study. The only fields missing are those associated with chronic homelessness, so the individual will default to not chronically homeless. (Attached for approval.)

Data Analysis and Reporting

The HIC forms will be entered into the HUD database by the CoC Designee, and a copy of the output spreadsheet provided to the HMIS team. The spreadsheets will also be included in the appendix of a final PIT report. The vast majority of shelters store quality data in the CoC's HMIS system, and the HMIS team will run data quality checks during the week of the PIT. Data that corresponds with HUD's required fields for the PIT will be exported into an Excel spreadsheet.

Survey **data entry** will be completed by Housing Authority of the County of Butte (HACB) staff and the CoC Designee. The CoC Designee will then migrate guests' records for the household and demographic fields into a spreadsheet, including the guests' initials and birthdate. The CoC Designee will use these fields to identify the individual within the PIT survey so that the rest of the data can be added to the spreadsheet for analysis. Once the survey is approved by the CoC Council, the HMIS team and the CoC Designee will review the current plan to determine if exporting the HMIS data will offer any efficiencies or accuracy over data entry of all fields.

Data analysis and reporting will be performed by the CoC Designee. The data will be de-duplicated using initials, birthdate, and household make up – and name when available. It will be enumerated and analyzed to complete the HUD required fields and reporting elements. The data will then be entered into the HUD database, and analyzed for production of a survey report that will be made available to the general public.

Analysis of the community oriented survey questions will be discussed with the PIT Committee to ensure the community reporting and planning needs are met. The data findings will be documented into a community-based report. The report will be released to the CoC, the county and locality public administration, elected officials, and the Consolidated Plan Jurisdictions in May 2017.

Governance Charter Amendment

The Governance Charter of the CoC Council must be amended to include the statement that its role is to review and approve the methodology of the Point-In-Time and Housing Inventory Count efforts prior to their execution. This will require planning to develop and introduce the material for adequate Council review and action. It is proposed that Section II, subsection 6 of the Governance Charter, entitled "Responsibilities" be amended to add one line and read as follows:

"Additional responsibilities set forth by the Continuum of Care include:

- Receive community and public policy updates relevant to homelessness issues.
- Receive updates on the 10-Year Strategy to End Homelessness
- Review and approve the methodology to conduct the Point in Time and Housing Inventory Count prior to execution."

Future Consideration

- Take advantage of the biennial unsheltered count to update the Coordinated Entry database.
- Assemble an on-call multi-discipline team in each locality for the day of the PIT to respond to immediate needs.
- Set up a DMV/Birth Certificate booth at the Hubs.
- Design a simple survey in 2019 as a trial in completing it in the field electronically. This will decrease the resources used for printing surveys and entering data.

Recommendations

1. Approve the 2017 PIT Survey Form and Observational Form as presented.
2. Approve the 2017 methodology as presented.
3. Approve the Governance Charter amendment as described above.

2017 HOMELESS BARRIERS & SOLUTIONS SURVEY

Have you already completed a survey today? Yes No (If yes, do not complete another survey)

Interviewer _____ Name _____ Location _____

All information is confidential

The information you share helps us better understand the circumstances of your homelessness, so that housing and services can be offered that best meet your needs. All answers are received without judgment and are kept confidential.

1. What best describes you in your current household situation? (choose one)

- I'm an adult (18 or over) without children
- I'm an adult (18 or over) with at least one child
- I'm a young person (younger than 18) without a parent
- I'm a young person (younger than 18) with a child

1.a. How many adults and children are in your household? Adults _____ Children _____

List all members (adults and children) of your household in the boxes below. If there are more than four people in your household, add another sheet and attach them together. Adults that are not "self" should complete their own survey too.

Person 1	Person 2	Person 3	Person 4
Relation: <u>self</u> Initials: _____ 2. Age: _____ Date of Birth: ____/____/____ 3. Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multiple Race 3a. Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino 4. Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Don't identify as male, female or transgender	Relation: _____ Initials: _____ 2. Age: _____ Date of Birth: ____/____/____ 3. Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multiple Race 3a. Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino 4. Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Don't identify as male, female or transgender	Relation: _____ Initials: _____ 2. Age: _____ Date of Birth: ____/____/____ 3. Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multiple Race 3a. Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino 4. Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Don't identify as male, female or transgender	Relation: _____ Initials: _____ 2. Age: _____ Date of Birth: ____/____/____ 3. Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multiple Race 3a. Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino 4. Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Don't identify as male, female or transgender

5. What area did you stay in last night?

- Chico Oroville Paradise Magalia Gridley Biggs Other location in Butte County _____
- Outside Butte County _____ DNA

6. Where did you stay last night?

- Unsheltered (camp, car, abandoned building, etc.) Emergency Shelter Hotel w/voucher Transitional Housing
- Temporarily with friends or family Hospital Treatment Facility Jail Other _____

6.a. If in a hospital, treatment facility or jail... please answer the following questions:

- 1) Have you been there less than 90 days? Yes No DNA
- 2) Were you homeless when you entered? Yes No DNA
- 3) Will you have stable, permanent housing to go to when you leave? Yes No DNA

The rest of the questions should be answered only for the person filling out the survey (not any other members in the household)

7. Have you served in the United States military, or have you been in active duty for the National Guard or as a Reservist? Yes No

8. Which best represents how you think of yourself? (Check all that you identify as)

- Straight Lesbian or Gay Bisexual Questioning I identify as: _____ DNA

9. Is this the first time you've been homeless? Yes No (If yes, skip question 11)

10. How long have you been homeless this time? less than 1 year 1-2 years 3-4 years 5+ years

11. Have you been homeless more than four times in the past three years? Yes No

11.a. If yes, what is the combined total time you have been homeless? less than 1 year 1-2 years 3-4 years 5+ years

12. Do you have any of the following conditions or challenging circumstances which might prevent you from maintaining housing, relationships or employment? (reference card)

- Physical Condition Traumatic Brain Injury HIV/AIDS Alcohol Abuse
- Developmental Disability PTSD Mental Health Condition Drug Use

13. Are you a victim of domestic violence? Yes No

14. How long have you lived in Butte County? (check one) DNA
 less than 1 month more than a month but less than 1 year 1-2 years 3-5 years 6-9 years 10-19 years 20+ years
15. Were you living in Butte County when you became homeless? Yes No DNA
16. If you came to Butte County after becoming homeless, what brought you here? _____ DNA
17. Do you consider Butte County your home? Yes No DNA
18. What is your biggest challenge in ending your homeless situation and finding **permanent** housing? (check all that are true)
 Finding affordable housing Finding a job No money for rent or deposit Rental history
 Poor/no credit Lack of an ID card Criminal history Substance Use
 Managing my mental health Finding services to help me Transportation to services Pets
 Nothing, I prefer to be homeless Other: _____ DNA
19. What do you think led to your homelessness? (check all that are true)
 Family crisis such as a death or serious illness in the family, divorce, family conflict, or another family problem
 Leaving your house due to intolerance of your sexual orientation or gender identity
 Natural/other disasters Parent/foster parent abuse Domestic violence/partner abuse
 Employment/Financial Reasons Evicted Recent immigration
 Alcohol or substance use/abuse Mental illness Medical/disability problems
 Incarceration Substandard Housing PRCS (Post Release Controlled Supervision)
 Personal choice to be homeless Age out of foster/group home Other _____ DNA
20. Have you been approached by law enforcement because of laws about sitting, lying, camping, storing property, and other public actions which impact people who are homeless? Yes No DNA
a. If yes, what was the result of that interaction? (check all that apply) Warned Ticketed Arrested Incarcerated DNA
21. Do you currently **not** sit, lie down, sleep, or keep property in certain places because of these laws? Yes No DNA
22. Have you left a community, or plan to leave, because these laws make living there too difficult? Yes No DNA
a. If yes, which community or communities? (check all that apply) Chico Oroville Paradise/Magalia Gridley/Biggs
 Other location in Butte County _____ Outside Butte County _____ DNA
23. Approximately how many times have you been in contact with law enforcement this past year? _____ DNA
24. Do you have health insurance? Yes No Not sure DNA 24a. If no, have you tried to apply? Yes No DNA
25. Where do you go most often to access health care services for yourself and your family?
 Hospital Clinic/Health Centers Doctors Office Veterans Affairs Schools/University Health Center Health Fair
 Mobile Medical/Dental Vans Alcohol/Drug Dependency Programs Other: _____ DNA
26. In the last year, how many times have you gone to the Emergency Room? 0 1-2 3-6 7-12 12+ _____ DNA
27. In the last year, how many total days have you spent in the hospital? 0 1-2 3-6 7-11 12+ _____ DNA
28. When did you last see a doctor other than in the hospital? Less than a year ago 1+ year 2+ years 3+ years DNA
29. When did you last see a dentist? Less than a year ago 1+ year 2+ years 3+ years DNA
30. If you have minor children, please mark all that apply: Medical visit within last year Dental visit within last year DNA
31. What was the last grade level you completed in school? (check one)
 Less than 8th grade Less than 12th grade High school grad/GED Some college/AA College Degree DNA
32. What is your approximate monthly income? (check one)
 No income \$1-\$250 \$251-500 \$501-\$1000 \$1001-1500 \$1501-2000 Over \$2000 DNA
33. How do you get money? (check all that are true)
 Job/paid internship Temporary Employment Unemployment SSI SSDI
 General Assistance TANF Retirement/Pension Social Security Friends or family
 Student Aid/Grants Veteran's Benefits Pan Handling Recycling Other _____ DNA

Food Card # _____

2017 HOMELESS BARRIERS & SOLUTIONS OBSERVATIONS

When To Use: This observation form is used only when the person or household is unwilling or unable to complete a survey, or if it is unsafe to approach an individual or group.

The Form: A new tally form is started for each new location. The Interviewer completes the top section with his/her name, and writes the name of the specific location, for example: Depot Park.

Q1. Location Type: Check the box which describes the location type, or describe the location in "other."

Q2. City/Town: Check the box for the city or town or indicate another Butte County location.

Q3. Household: Every person belongs to a household. Indicate the household type you think best matches what you observe. *A household might consist of one person, or many people. The household's composition will vary between adults only, children only, and adults with children. Start a new Question 3 for each household.*

Q4. #People: Indicate the number of people in the household. *There may be multiple people and households at one location. Do not count the same person more than once.*

Individual Data: Complete a demographic box for each person counted in Question 4 (including children). *There are eight boxes available per household on the observation form. Leave the boxes blank if the number of boxes exceeds the number of people in the household. If the household exceeds eight members, continue completing boxes on the back of the form WITHOUT answering Questions 3 and 4 again on the back.*

Demographics: Indicate the approximate age, and your best guess of the gender, race, and ethnicity for each person.

Interviewer _____ Location _____

1. Hospital Hotel/Motel Jail Treatment Facility Unsheltered Other _____
 2. Chico Oroville Paradise Magalia Biggs Gridley Other town in Butte County _____

3. What best describes the household? (choose one) 4. Number of people: _____
 Adult/s (over 18) without children Adult/s (over 18) with at least one child
 Young person/s (younger than 18) without a parent Young person/s (younger than 18) with a child

Head of Household Age: _____ Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multiple Race Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino	Person 2 Age: _____ Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multiple Race Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino	Person 3 Age: _____ Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multiple Race Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino	Person 4 Age: _____ Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multiple Race Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino
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Person 5 Age: _____ Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multiple Race Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino	Person 6 Age: _____ Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multiple Race Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino	Person 7 Age: _____ Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multiple Race Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino	Person 8 Age: _____ Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multiple Race Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino
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Homeless and Housing Assistance Definitions & Qualifications for the PIT

*The following are definitions and qualifications set by HUD. * When applicable, local, reasonable modifications have been made to accommodate housing needs for those experiencing homelessness in rural Butte County.*

Homeless

HUD: An individual who lacks a fixed, regular, and adequate nighttime residence; as well as an individual who has a primary nighttime residence that is a supervised publicly or privately operated shelter designed to provide temporary living accommodations; an institution that provides a temporary residence for individuals intended to be institutionalized; or a public or private place not designated for, or ordinarily used as, a regular sleeping accommodation for human beings.

Household

HUD: All people who occupy a housing unit. The household includes the related family members and all the unrelated people, if any, such as lodgers, foster children, wards, employees who share the housing unit. A person living alone in a housing unit, or a group of unrelated people sharing a housing unit such as partners or roomers, is also counted as a household.

LOCAL: For the purpose of the PIT, the definition will be expanded to all family members and unrelated people who would be sharing a housing unit if they had one.

HIC Qualified Housing Projects

HUD: Beds and units in the HIC must be dedicated to serving homeless persons, or for permanent housing projects, dedicated for persons who were homeless at entry.

1. The primary intent of the project is to serve homeless persons
2. The project verifies homeless status as part of its eligibility determination
3. The actual project clients are predominantly homeless or were at entry

Beds in institutional settings not specifically dedicated for persons who are homeless such as detox facilities, emergency rooms, jails, and acute crisis or treatment centers should not be included in the HIC. HUD considers extreme weather shelters as dedicated homeless inventory and should be included in the HIC.

LOCAL: *Sober Living Environments (SLEs)* that meet the definition of Transitional Housing (TH) will be included in the HIC as a TH unit (see definition of TH within this document). A limited number of SLEs that qualify as Transitional Housing and that primarily, but not exclusively, serve those who are homeless at project entry, will be included in the HIC; only those beds occupied by those who were previously homeless will be counted.** Treatment Centers (TC) will be analyzed on a case-by-case basis prior to the PIT to determine if they qualify as an SLE/TH project or qualify as a TC. Jails, hospitals and treatment centers will not be included on the HIC but may be included on the PIT community report.

Unsheltered

HUD: Individuals and families with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport or camping ground.

Emergency Shelter

HUD: Any facility whose primary purpose is to provide temporary or transitional shelter for the homeless in general or for specific populations of the homeless.

Haven (Catalyst Domestic Violence Services)

Men's Emergency Shelter and Women and Children's Shelter (Oroville Rescue Mission)

Runaway and Homeless Youth Project (Youth For Change)

Sabbath House (Jesus Center)

Safe Space (CHAT)

Torres Shelter (Chico Shelter Partnership)

Hotels paid for by a social service agency and/or faith-based organization

Transitional Housing

HUD: Housing in which all program participants have participant rights in housing, and a signed lease or occupancy agreement for the purpose of which is to facilitate the movement of homeless individuals and families into permanent housing within 24 months or such longer period as HUD determines necessary. The program participant must have a lease or occupancy agreement for a term of at least one month that ends in 24 months and cannot be extended. Transitional housing includes housing primarily designed to serve deinstitutionalize homeless individuals and other homeless individuals with mental or physical disabilities and homeless families with children.

6th Street Transitional Housing (Youth For Change)

Cottages (Catalyst Domestic Violence Services)

Esplanade House Transitional Housing (Community Action Agency of Butte County)

Friends House (Chico Community Shelter Partnership)

House of Hope, Myrtle House, Birch House, Sage House (Jesus Center)

Jerry L Knight Residence (VECTORS)

TAY Transitional Housing (BCDBH)

Stairways Programming – 30

Sober Living Environments

HUD: Must meet the definition of Transitional Housing AND the qualifications of being used in the HIC.

1. The primary intent of the project is to serve homeless persons
2. The project verifies homeless status as part of its eligibility determination
3. The actual project clients are predominantly homeless or were at entry

LOCAL: SLEs that meet the HUD qualifications above will be included in the HIC/PIT database as sheltered in TH. A limited number of SLEs that qualify as Transitional Housing and that primarily, but not exclusively, serve those who are homeless at project entry, will be included in the HIC; only those beds occupied by those who were previously homeless will be counted. Those not qualifying as a TH/SLE will be categorized as a Treatment Centers (TC) and included only in the community report.**

Permanent Housing

HUD: Community-based housing without a designated length of stay, and includes permanent supportive housing and rapid rehousing. Tenant must be on a lease for a term of at least one year, which is renewable for terms for a minimum of one month long, and is terminable only for cause. This definition includes Permanent Supportive Housing, Other Permanent Housing, or Rapid Rehousing.

Permanent Supportive Housing

HUD: Housing in which supportive services are provided to assist homeless persons with a disability to live independently, admitted to the project from homelessness.

Avenidas Apartments (Caminar)

Esplanade House (Community Action Agency of Butte County)

HUD-VASH (HACB)

LINK Permanent Housing Bonus (BCDBH)

MHSA Master Lease Program (YFC)

CHAT House 1, 2, and 3

SEARCH Samaritan Bonus (BCDBH)

SEARCH II – PHB (BCDBH)

SEARCH II – SHP (BCDBH)

SEARCH III-SHP (BCDBH)

SEARCH South Shelter Plus Care (HACB)

(Stairways Programming) - 8

Other Permanent Housing

HUD: Long-term housing and support services for individuals or families without a disability OR long-term housing only for individuals admitted to the project from homelessness.

Rapid Rehousing

HUD: Rapid Rehousing projects are considered permanent housing and are included in the HIC. Although, if an individual is enrolled in a RRH project but currently is not living in permanent housing (for example, she is still living in a shelter or on the street awaiting a permanent house) that person should complete a PIT survey and counted in the housing type she currently resides.

Rapid Rehousing Program (Catalyst Domestic Violence Services)

Rapid Rehousing Program (Chico Community Shelter Partnership)

Rapid Rehousing Program (Community Action Agency of Butte County)

Supportive Services Veterans Families (Veterans Resource Center)

Rental Assistance

HUD: Provision of rental assistance to provide *transitional* or *permanent* housing to eligible persons. It can be used for PSH, RRH, or Homelessness Prevention. Rental assistance can be tenant-based, sponsor-based, or project based. Project participants execute a lease directly with the landowner. The length of assistance may be short term (up to 3 months), medium term (3 to 24 months) or long term (longer than 24 months). Rent is awarded at Fair Market Rent but capped at Rent Reasonableness. May pay rent for a maximum of 30 days from the end of the month in which the unit was vacated.

BCDBH CoC-funded projects

Leasing

HUD: Leasing of property, or portions of property, not owned by the recipient or project sponsor involved, for use in providing *transitional* or *permanent* housing, or providing supportive services. The funding recipient contracts for the space from a landowner, and is responsible for the housing space, if it's being contracted to provide supportive services. The lease may cover structure, portions of a building, or individual units. Funds may not exceed Rent Reasonableness amount of Fair Market Rent, whichever is lower.

CHAT houses

Stairways Programming

Master Lease*

A master lease involves an agency leasing scattered, individual units or a house from property owner(s) to sublease to eligible program participants. The agency meets the owner's qualifications for the units, and in turn lowers housing barriers to program participants.

CHAT houses

Stairways Programming

Shared Housing*

A housing unit that is occupied by people who are unrelated and would not otherwise be sharing a house. Each occupant holds a rental agreement with a landlord, and has their own bedroom with a lock on the door. Shared housing can be Transitional Housing, Permanent Housing or Permanent Supportive Housing.

CHAT houses

Stairways Programming

Hotels/Motels

HUD: Hotel/Motel stays that are paid for by a stipend or other financial assistance is considered Emergency Sheltering. Hotels/Motels paid for by the client are not. Occupants may be considered imminently homeless, but are not included in the PIT.

Treatment Centers

HUD: Not be counted in the HIC unless the beds are specifically dedicated for persons who are homeless.

LOCAL: Individuals who were homeless at admission to the program and do not know their housing situation at discharge, or will be homeless at discharge will be counted as unsheltered for the community report only.

Hospitals

HUD: Individuals receiving care at a hospital without residing in the institution are considered homeless if they meet the definition of homeless. For the purpose of the PIT, individuals residing in the hospital are not homeless.

LOCAL: Individuals seeking care in the emergency room on the night of the PIT and would otherwise be unsheltered, will be counted as unsheltered in the PIT. Individuals admitted to the hospital who were homeless on admission and/or will be homeless at discharge will be counted as homeless community report.

Jails

HUD: Not be counted unless the beds are specifically dedicated for persons who are homeless.

Local: Individuals who were homeless prior to admission and will be homeless at discharge will be counted as unsheltered in the PIT community report.

Not To Include in the HUD/HDX PIT Report

HUD:

- Persons in Permanent Supportive Housing (including VASH) and Other Permanent Housing (including TIP)
- Any sheltering project not included in the HIC
- Doubled Up/Couch surfers
- Housing the person rents or owns, including RRH projects
- Persons residing in institutions (jails, juvenile correction facilities, foster care, hospital beds, detox centers)

LOCAL: For the purpose of the local report, those who are doubled up, and those who are residing in institutions (if they were homeless upon admission to the institution and/or will discharge to homelessness) will be included in the community report.

**Master Lease and Shared Housing not HUD Components*

****HUD qualification:** For non-HUD funded homeless programs, the CoC is ultimately responsible for assigning the project type.

**BUTTE COUNTY HOMELESS CONTINUUM OF CARE
STAFF REPORT**

Date: February 14, 2016
To: Butte Countywide Homeless Continuum of Care Council
From: Sherisse Allen, Housing Tools
Re: 2017 Homeless Point In Time Debrief

Background

In accordance with HUD requirements, Butte Countywide Homeless Continuum of Care members, and the community at large, implemented the 2017 Housing Inventory Count (HIC) and Point In Time (PIT) data collection methodology on January 25, 2017. This effort including gathering PIT survey data from all located individuals and families experiencing homelessness – whether sheltered or unsheltered – within a 24-hour period. In addition, local housing agencies provided corresponding program information for the HIC report. Following its execution, the PIT Steering Committee met to outline the successes and failures of the study in anticipation of the 2019 study.

Greatest Successes and Improvements Made

- Community volunteers and service providers collected approximately **1800 PIT surveys**.
- **Members of the community** - whether they were completing the survey or were assisting in the completion of the survey – commented again and again how the experience taught them something about each other and that everyone felt accepted and respected.
- A **PIT Coordinator** was hired to oversee the planning process and coordinate across all communities and homeless subpopulations.
- The **PIT Steering Committee** was comprised of individuals from multiple organizations throughout the county, who oversaw specific aspects of the project (such as locality hub leaders or sub-population coordinator), rather than a “come all” planning format.
- The **survey** was dramatically improved, removing errors and bringing clarity. The survey was built first on HUD requirements, then on longitudinal data and lessons learned, and finally on new community priorities. Vital questions were moved to the top of the survey to improve the odds of being completed. Consultation with local experts helped design the questions.
- There was an increase in the **number of locations** in which surveys were completed: Hubs, Static Sites, In-Field Locations, and Butte 2-1-1, to improve the census coverage of the county.
- There was a dramatic increase in the number of community **volunteers**. In fact, the Chico leaders were surprised to see 85 people lined up down the street in the rain for volunteer training. This might reflect the growing concern and commitment of the community in ending homelessness. It might also be a result of media coverage and quality outreach materials.
- There was a cadre of **professional volunteers**, in particular Butte County Department of Behavioral Health (BCDBH), entered more tenuous encampment areas. These professionals, and shelter staff, were offered a half-hour training rather than a two-hour community training, honoring their expertise and valuing their time to prioritize services during the winter.
- The **healthcare industry** collaborated across hospitals, clinics, and Butte County Public Health to gathering surveys from those seeking medical care. The collaborative developed health related questions for the survey. Three out of four hospitals and Ampla Health invested staff time in training and survey collection at hospitals and clinics throughout the county. Public Health staff were assigned to a variety of professional environments to coordinate and collect surveys.

- There was coordination and cooperation with **law enforcement** throughout the county. The survey was brought into the jail to extrapolate data. Juvenile hall was also included.
- The **youth count** reflected the We Count methodology (except a separate survey was not added in 2017) by accessing local resources.
- **Sober Living Environments** in Transitional Housing settings were researched for eligibility and interest. Several participated this year, adding their beds and participants to the HIC and PIT counts, and starting a dialogue about a communitywide approach to ending homelessness.
- **Navigators** (consultants who have been homeless) were funded by BCDBH in two communities, in addition to Caminar's youth staff for the youth project.
- **Outreach** and **Incentives** attracted people to the Hubs. The outreach included small cards that could be easily distributed to and stored by those who might attend. Flyers were mailed throughout the county. In addition, there was significant media coverage (Facebook pages/posts, emails, three newspaper articles, one radio interview, and one TV interview). The food cards continue to persuade people to commit to completing the full survey. All Hubs offered warm meals, many offered food to take, dog food, socks, or other giveaways.
- Remarkable **uniform administration** of the survey and clean data collection was achieved by using the same trainer for all volunteer trainings and investing a significant amount of the training time to accurate completion. It's expected that **quality data entry** will be maintained by enlisting Housing Authority of the County of Butte clerical professionals (data entry in progress at the time of this report).
- Tally forms were redesigned as an **Observational Tool** to allow HUD required data to be collected and reported without a complete survey, improving the HDX count. The tools was sparingly used in field to not impact duplication.
- **Consolidated Application**, Section 4 will be complete at the conclusion of the project, and progress in Section 1 has been made.

Suggested Improvements for 2019

- **Set the PIT date for January 30, 2019** to include college students in the study.
- **Simplify the survey and further master the data collection.** Build on what we know works; consider whether the longitudinal questions we ask are being used for this purpose; only ask questions we don't know the answers to; acquire data that will end homelessness; do not ask intrusive or potentially traumatizing questions; only ask the number of questions we need to.
- Capturing full survey data for all adults and unaccompanied youth in a household was improved by reformatting the survey, conducting thorough volunteer training, and providing written instructions. As a safeguard, the HUD-required questions were moved to the top of the survey, with fields for multiple family members; this successfully secured vital information for HUD. The following are strategies to remedy the challenge of capturing full survey data for each person:
 - Continue to **place HUD-required questions at the beginning of the survey** to ensure the data necessary for HUD's PIT report is captured.
 - Continue to **collect unique data** (initials and birthdate) for all family members on each survey to both de-duplicate surveys and to keep household data together.
 - **Run two columns of the questions on each survey** to capture the full data for at least two adults in the household, as shown in the attached sample. (Children will complete a portion of the survey and attach it to their parents' survey.)
 - **Pilot the survey** more extensively. Have several *volunteers* administer the survey to unhoused individuals to master collecting household-oriented information.

- **Collect surveys for an entire week** with Transitional Housing projects and jails (and other residences where people do not frequently leave) so that large programs have more time to complete them and volunteers can support survey collection for more than a 24-hour period. Also, deliver food cards to these more stably housed individuals and to the schools after the PIT to deplete the card overage.
- **Version the survey** for specific audiences – jails and youth – by deleting only, so that the information is clear and relevant to their unique situation.
- **Improve HUB coordination** to adapt to the increased number of surveys, volunteers, hubs, etc. Utilize technological tools in coordinating volunteers. Streamline the sign in/out process to reduce waiting, and better coordinate food cards.
- **Purchase more cards to cover multiple sites.** To adequately cover volunteers dispatched throughout the county, purchase approximately 500 extra cards than the anticipated number of completed surveys. In other words, if in 2019, it's estimated that 2000 surveys will be completed, there should be an inventory of least 2500 cards (this is based on not adding children to the card distribution). The remaining supply from 2017 is 278 cards. In 2019, purchase 2,222 cards at a cost of \$11,110.
- **Share the financial burden of the study** with service providers and cities/towns who use the PIT data, particularly those who are required to do so by a grant or jurisdictional entitlement for CDBG and HOME funds. The following is an enhanced budget for 2019 based on PIT Steering Committee input:

\$11,110	Food Cards (2,222) for adults and unaccompanied youth
\$1,500	Food Cards (300) for children with parents
\$1,200	Navigators (especially for smaller towns)
\$400	Youth Food Truck
\$400	Print Costs (surveys, training packets, forms, etc.)
\$450	Outreach Printing (flyers and cards)
\$500	Contingency (incentives for inmates, magnet events, etc.)
<u>\$1,700</u>	Indirect (approximate amount)
\$17,260	TOTAL without PIT Coordinator Contract/Salary

Recommendations

It is recommended that planning for the 2019 PIT study begin in August 2018, and that the methodology outlined in the 2017 HIC and PIT Methodology and the 2017 Homeless Point In Time Debrief reports serve as the framework for 2019 HIC/PIT planning.

All information is confidential

The information you share helps us better understand the circumstances of your homelessness, so that housing and services can be offered that best meet your needs. All answers are received without judgment and are kept confidential.

- What town did you stay in last night?
 Chico Oroville Paradise Magalia Gridley Biggs Other location in Butte County _____
 Outside Butte County _____
- Where did you stay last night?
 Unsheltered (camp, car, abandoned building, etc.) Emergency Shelter Hotel w/voucher Transitional Housing
 Temporarily with friends or family Hospital Treatment Facility Jail Other _____

We need to keep the surveys together for all your family members **who were staying with you last night**. These questions (in the shaded area) help us do that but will not be in the report. Complete information for **each person** and attach surveys together.

How many adults and children are in your household?		# Adults _____	# Children _____	# Surveys _____	
<u>You</u>	<u>Person 2</u>	<u>Person 3</u>	<u>Person 4</u>	<u>Person 5</u>	<u>Person 6</u>
Initials _____	Initials _____	Initials _____	Initials _____	Initials _____	Initials _____
Birthdate ___/___/___	Birthdate ___/___/___	Birthdate ___/___/___	Birthdate ___/___/___	Birthdate ___/___/___	Birthdate ___/___/___

<ol style="list-style-type: none"> What best describes you in your current household situation? (choose one) <input type="checkbox"/> I'm an adult (18 or over) without children <input type="checkbox"/> I'm an adult (18 or over) with at least one child <input type="checkbox"/> I'm a young person (younger than 18) without a parent <input type="checkbox"/> I'm a young person (younger than 18) with a child <input type="checkbox"/> I'm a young person (younger than 18) with a parent Age: _____ 3. Date of Birth: ___/___/___ Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multiple Race Ethnicity:<input type="checkbox"/> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Don't identify as male, female or transgender <p>Children do not answer the following questions:</p> <ol style="list-style-type: none"> Have you served in the US military, or have you been in active duty for the National Guard or as a Reservist? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you a victim of domestic violence?<input type="checkbox"/> <input type="checkbox"/> Yes <input type="checkbox"/> No Is this the first time you've been homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No How long have you been homeless this time? <input type="checkbox"/> less than 1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> 3-4 years <input type="checkbox"/> 5+ years Have you been homeless more than four times in the past three years? <input type="checkbox"/> Yes <input type="checkbox"/> No 11.a. If yes, what is the combined total time you have been homeless? <input type="checkbox"/> less than 1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> 3-4 years <input type="checkbox"/> 5+ years 	<ol style="list-style-type: none"> What best describes you in your current household situation? (choose one) <input type="checkbox"/> I'm an adult (18 or over) without children <input type="checkbox"/> I'm an adult (18 or over) with at least one child <input type="checkbox"/> I'm a young person (younger than 18) without a parent <input type="checkbox"/> I'm a young person (younger than 18) with a child <input type="checkbox"/> I'm a young person (younger than 18) with a parent Age: _____ 3. Date of Birth: ___/___/___ Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multiple Race Ethnicity:<input type="checkbox"/> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Don't identify as male, female or transgender <p>Children do not answer the following questions:</p> <ol style="list-style-type: none"> Have you served in the US military, or have you been in active duty for the National Guard or as a Reservist? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you a victim of domestic violence?<input type="checkbox"/> <input type="checkbox"/> Yes <input type="checkbox"/> No Is this the first time you've been homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No How long have you been homeless this time? <input type="checkbox"/> less than 1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> 3-4 years <input type="checkbox"/> 5+ years Have you been homeless more than four times in the past three years? <input type="checkbox"/> Yes <input type="checkbox"/> No 11.a. If yes, what is the combined total time you have been homeless? <input type="checkbox"/> less than 1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> 3-4 years <input type="checkbox"/> 5+ years
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Butte Countywide Homeless Continuum of Care

Membership Roster

Butte County Department of Behavioral Health
Butte County Department of Employment and Social Services
Butte County Housing Authority
Butte County Office of Education
Butte County Sheriff's Department
Butte Environmental Council
Caminar
Caring Choices
Catalyst Domestic Violence Services
CHAT
City of Chico
City of Oroville
Community Action Agency of Butte County, Inc.
Department of Veteran Affairs
Enloe
Greater Chico Homeless Task Force
Help Central Inc./Butte 211
Hope Center
Housing Tools
Jesus Center
Oroville Rescue Mission
SHOR
Stairways Programming
Symmetric Solutions
Torres Shelter
Veterans Resource Center
Youth For Change



Cultural Competency

Holli Drobny, Community Services Program Manager
Mental Health Services Act
Cultural Competency

Ice Breaker

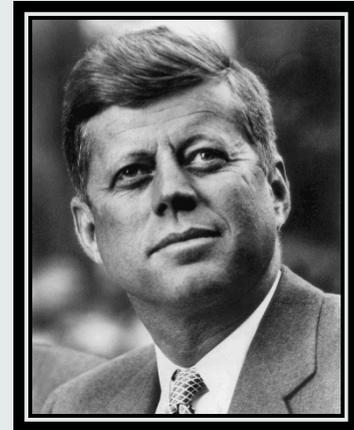
What culture(s) do you identify with?

- Religion
- Race
- Socio-economic status
- Age
- Sexual Orientation
- Ethnicity
- Education
- Family History
- Disability
- Gender
- Nationality
- Generation

Introduction to Federal and State Guidelines Regarding Cultural Competency

Federal Authority

- Title VI of the Civil Rights Act of 1964
 - It prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance.
 - “Simple justice requires that public funds, to which all taxpayers of all races [colors, and national origins] contribute, not be spent in any fashion which encourages, entrenches, subsidizes or results in racial [color or national origin] discrimination”
- Executive Order 13166, August 2000
 - “Improving Access to Services for Persons with Limited English Proficiency.”
 - The Executive Order requires Federal agencies to examine the services they provide, identify any need for services to those with limited English proficiency (LEP), and develop and implement a system to provide those services so LEP persons can have meaningful access to them.



State Authority

- California Code of Regulations, Title 9, Rehabilitative and Developmental Services
 - Section 1810.410, Cultural and Linguistic Requirements
 - Each Mental Health Plan (MHP) shall comply with the cultural competence and linguistic requirements included in this Section, the terms of the contract between the MHP and the Department, and the MHP's **Cultural Competence Plan**.



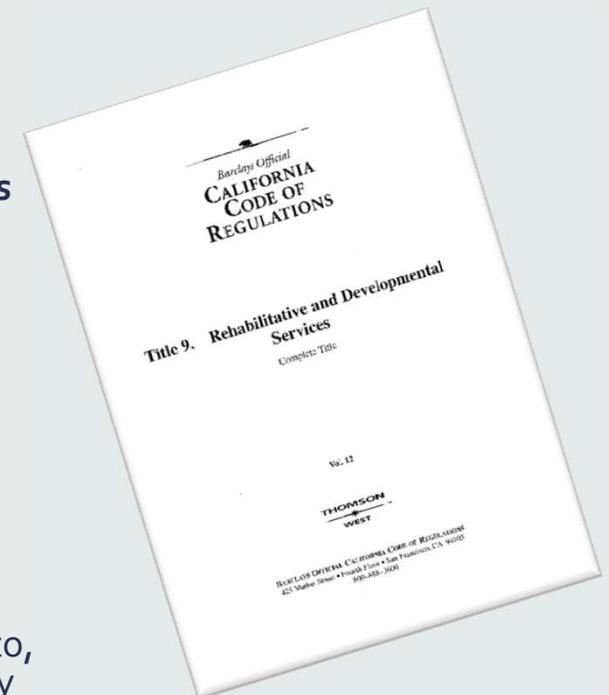
Definitions

- **“Primary language”** means that language, including sign language, which must be used by the beneficiary to communicate effectively and which is so identified by the beneficiary.
- **“Threshold Language”** means a language that has been identified as the primary language, of 3,000 beneficiaries *or* five percent of the beneficiary population, whichever is lower, in an identified geographic area.
 - Butte County threshold languages:
 - English
 - Spanish
 - Hmong (unofficially)
- **“Key points of contact”** means common points of access to specialty mental health services from the MHP, including but not limited to the MHP's beneficiary problem resolution process, county owned or operated or contract hospitals, and any other central access locations established by the MHP.

Title IX Requirements

Each MHP shall have:

1. A statewide, toll-free telephone number.
2. Oral interpreter services in threshold languages at **key points of contact** available to assist beneficiaries whose **primary language** is a **threshold language** to access the specialty mental health services or related services available through that **key point of contact**.
3. Policies and procedures to assist beneficiaries who need oral interpreter services in languages other than **threshold languages** to access the specialty mental health services or related services available through that **key point of contact**.
4. General program literature used by the MHP to assist beneficiaries in accessing services including, but not limited to, the beneficiary brochure, materials explaining the beneficiary problem resolution and fair hearing processes, and mental health education materials used by the MHP, in threshold languages, based on the threshold languages in the county as a whole.



Cultural Competence Plan

Each MHP shall develop and implement a Cultural Competence Plan that includes the following components:

1. Objectives and strategies for improving the MHP's cultural competence based on the assessments required and the MHP's performance on the established standards.
2. A population assessment and an organizational and service provider assessment focusing on issues of cultural competence and linguistic capability.
3. A listing of specialty mental health services and other MHP services available for beneficiaries in their primary language by location of the services.
4. A plan for cultural competency training for the administrative and management staff of the MHP, the persons providing specialty mental health services employed by or contracting with the MHP or with contractors of the MHP, and the persons employed by or contracting with the MHP or with contractors of the MHP to provide interpreter or other support services to beneficiaries.

Cultural Competence Plan Requirements

Department of Health Care Services

Context

- Since 1997, three evolutions of the plan have been developed and implemented culminating in the most recent version, the Cultural Competence Plan Requirements (CCPR).
- The CCPR works toward the development of the most culturally and linguistically competent programs and services to meet the needs of California's diverse racial, ethnic, cultural, and linguistic communities in the mental health system of care.
- Updated CCPR is in development from DHCS and will be integrated in 2018.



Criterion

- Department of Health Care Services established eight Cultural Competence Plan Criterion based on (2001) National Standards For Culturally and Linguistically Appropriate Services in Health Care (CLAS).
- The **National CLAS Standards** are a set of 15 action steps intended to *advance health equity, improve quality, and help eliminate health care disparities* by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services.



CCPR Criterion

These eight Criterion are a mechanism to examine where counties lie on the scale of cultural competence.

Having used the criteria to form a logic model (plan), the development and inclusion of the eight criteria allow counties to implement cultural and linguistic competence in a variety of settings and move toward operationalizing the concept of cultural competence.

An assessment portion of the Cultural Competence Plan will identify areas the county may need resources, supports, and leverage to support its efforts in operationalizing cultural competence.

- CRITERION 1: Commitment to Cultural Competence
- CRITERION 2: Updated Assessment of Service Needs
- CRITERION 3: Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities
- CRITERION 4: Client/Family Member/Community Committee: Integration of the Committee within the County Mental Health System
- CRITERION 5: Culturally Competent Training Activities
- CRITERION 6: County's Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff
- CRITERION 7: Language Capacity
- CRITERION 8: Adaptation of Services

Timeline

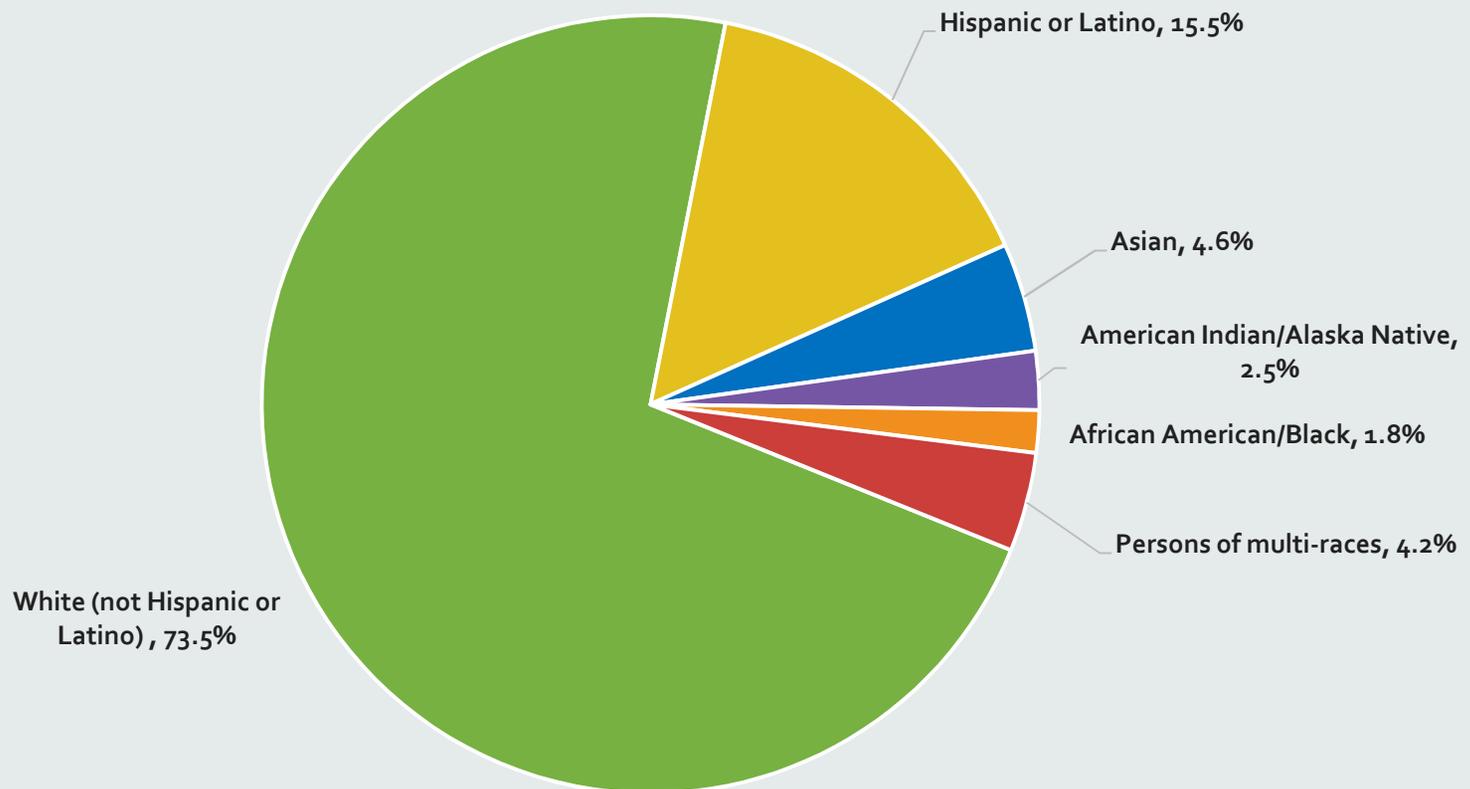
A comprehensive Cultural Competency Plan modification is submitted every three years and an Annual Update is submitted in the interim years.

Comprehensive Modifications	2017	2020
Annual Updates	2018	2019

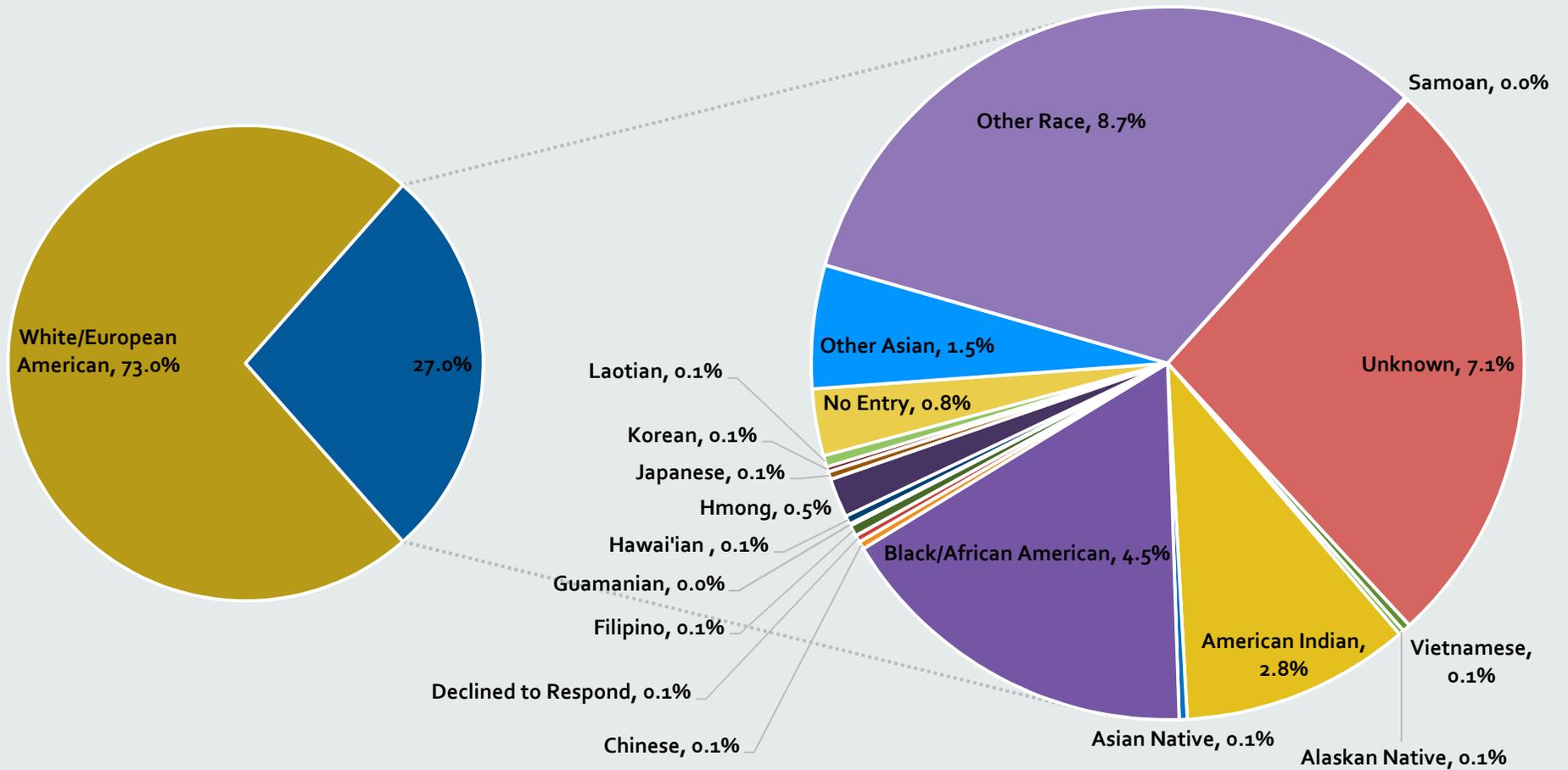
Butte County Behavioral Health

Commitment to Cultural Diversity

Butte County Population by Race/Ethnicity, United States Census Bureau, 2014



Butte County Behavioral Health Consumer Race Distribution for Fiscal Year 2015-2016



Why is Cultural Competency Important?

Health disparity is defined as “a particular type of **health difference** that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect **groups of people who have systematically experienced greater obstacles to health** based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other **characteristics historically linked to discrimination or exclusion.**”

Why is Cultural Competency Important?

Influences on overall health include the **availability of and access to:**

- High-quality education
- Nutritious food
- Decent and safe housing
- Affordable, reliable public transportation
- **Culturally sensitive health care providers**
- Health insurance
- Clean water and non-polluted air

Known Mental Health Disparities

- **Veterans** exhibit significantly higher suicide risk compared with the US general population
- **Non-Spanish speaking Latino immigrants**, who are eligible for county mental health services, are struggling to access care because few providers speak their indigenous languages
- **California's lesbian, gay, bisexual, transgender, queer, and/or questioning communities (LGBTQ)** have disproportionately higher rates of poverty, suicide, homelessness, isolation, substance abuse, and trauma associated with violence
- Certain groups, such as **transgender people of color** and **LGBTQ youth**, experience cultural stigma and high rates of suicide

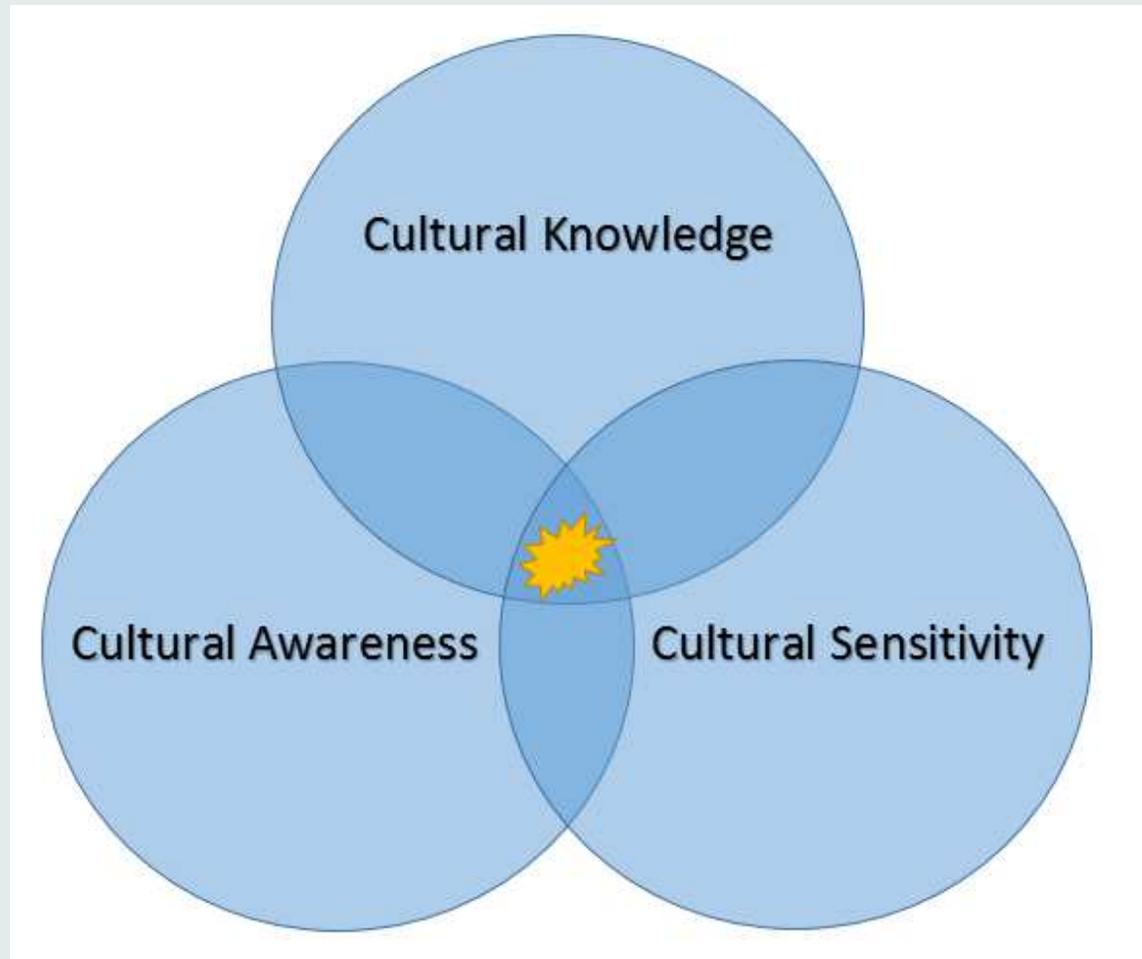
Our Commitment to Cultural Competence

"Developing cultural competence is an ongoing process that begins with cultural awareness and a commitment to understanding the role that culture plays in behavioral health services."

*Substance Abuse and Mental Health Services Administration:
Improving Cultural Competence*

- **Value Diversity:** in order to establish the policies and procedures needed to become culturally competent
- **Have the Capacity for Cultural Self-Assessment:** establish and understand organizational identity in order to develop and implement goals
- **Be Conscious of the Dynamics Inherent When Cultures Interact:** how and where services are provided are critical to service delivery
- **Institutionalize Cultural Knowledge:** all levels of the organization must be culturally aware
- **Adapt Service Delivery Based on Understanding of Cultural Diversity:** programs and services are delivered in a way that reflects the culture and traditions of the people served

Framework for Building Cultural Competence



Our Commitment to Cultural Competence

Butte County Department of Behavioral Health values the rich diversity our organization and aspires always to demonstrate respect for the uniqueness of each individual's beliefs, values, traditions, and behaviors.

We encourage each contribution to the establishment of an open, inclusive environment that supports and empowers our employees.

Our commitment to diversity includes both the development of a diverse workforce and the delivery of culturally competent care to our clients.

The first step to providing culturally competent care is to embrace our own diversity – to celebrate, enhance, and learn from it. Our diversity is also our strength.

Butte County Behavioral Health Cultural Competence Website

Community Based Cultural Programs

- Promotores
- Zoosiab- Hmong Cultural Center
- African American Family & Cultural Center
- National Alliance Mental Illness
- Stonewall Alliance
- Passages- Older Adult Outreach
- 6th St Drop-in Center for Homeless Youth
- Wellness Centers:
 - Iversen- Chico
 - The HUB- Paradise
 - Oroville Wellness & Recovery

Oroville & Gridley Livespot

*These programs are supported through Butte County funding from the Mental Health Services Act

Cultural Competence Committee

- The Cultural Competency Committee (CCC) includes various community members, cultural organizations, and BCDBH staff. The CCC is designed to include representatives from local racial, ethnic, and cultural groups to ensure an accurate representation of the diversity in Butte County and the client's the MHP serves.

Current Representatives	
African American	Homeless Shelter
BCDBH Cultural Competency Coordinator	Latino/a--Spanish Speaker
BCDBH Systems Performance Unit Analyst	LGBTQ+
BCDBH Training Coordinator	Native American
BCDBH Quality Management	Older Adult
Consumer/Wellness Center	Public Health Department
Family Member	Substance Use Disorder
Foster Care Advocate	Veterans Services Officer
Hmong	Youth, Homeless

Translation Services

- Bilingual Staff
- Contracted translators
 - Translator List on the intranet
- AT&T Language Line (1-800-974-9246)
- Materials provided in Spanish and Hmong



Thank you



Cultural Competence Committee Meeting Notes— 9/21/2017

Mission Statement:

"The Cultural Competence Committee works to enhance the behavioral health system of care by reducing behavioral healthcare disparities through collaborating with diverse populations and sharing diverse perspectives. This committee takes ownership of promoting cultural understanding and appreciation through education, advisement, and recommendations of culturally sensitive policies and practices to our community. This committee strives to recognize personal and social biases and to consciously build respectful interactions."

Core Values:

Respect	Celebration
Honor	Collaboration
Dignity	Humility
Wellness	

- 1) **Criterion One of Cultural Competency Plan:** committee reviewed and provided feedback
- 2) **Cultural Innovation Idea:** discussion of the project continued. It was agreed that a subcommittee may be formed to continue development of the idea.
- 3) **Grand Round Trainings:** It was agreed to provide quarterly cultural trainings. Dates were chosen and 3 of 4 spots were claimed for 2018

Overall Goals/Objectives of Committee

- Educate Community
- Link Organizations together and create better connections with each other (Put a link to other organizations on each other's websites)
- Review and provide feedback on grant applications and policies.
- Create a letter of support that can be attached to grant applications that we feel promote access to underserved populations and are culturally sensitive.
- System for information to flow within committee and community
 - a. Newsletter? Facebook? Email Chain?
- Develop Culturally relevant trainings that are specific to Butte County
- Share success stories at committee meetings
- Update Cultural Competence Committee Plan 2018

Actions

- Start sign-up sheet for organizations to present on their program and/or invite committee to tour facility.
- Continue recruiting for open positions
 - American Indian representative
 - SUD representative

BCDBH-068

**BUTTE COUNTY DEPARTMENT OF BEHAVIORAL HEALTH
POLICY/PROCEDURE**

Subject: Cultural Competence

Section: Education and Training
Sub-Section:

Effective Date: 12/03/2015
Review Date: 12/14/2018

POLICY: It is the policy of Butte County Department of Behavioral Health to comply with California Code of Regulations (CCR) Title 9 § 3200, 100, cultural competence by incorporating and working to achieve the items listed below, into all aspects of policy-making, program design, administration and service delivery.

The following are the goals for cultural competence:

1. Equal access to services;
2. Treatment interventions and outreach;
3. Reduction of disparities in services;
4. Understanding of the diverse belief system concerning behavioral health and illness;
5. Understanding the impact of historical bias, racism and other discriminations have on behavioral health;
6. Improvement of services and supports unique to individuals' racial/ethnic, cultural and linguistic populations
7. Development and implementation of strategies to promote equal opportunities for administrators, service providers and others involved in service delivery who share the diverse racial/ethnic and linguistic characteristics of individuals being served.

Procedure:

- I. It is required that all employees attend one cultural competency training per fiscal year.
 - a. The Department will offer multiple trainings through electronic learning management system, Relias, in person training, webinars, Grand Rounds and other modalities to accommodate staff needs and work schedules.
 - b. Attendance of the trainings will be tracked and monitored in Relias to ensure meeting requirements.

BCDBH-068

Effective Date: 12/03/2015

Review Date: 12/14/2018

- II. To monitor this requirement, The Executive Committee, Managers, and Supervisors will be provided with a report quarterly showing which staff have attended and completed a cultural competency training.
 - a. Managers and Supervisors will work with staff that have not attended a training in that past quarter to identify an upcoming training to attend.
 - b. Any staff that does not meet the requirement within the fiscal year will be followed up with appropriate personnel action that may result in disciplinary action.

- III. BCDBH Contract Providers will be required to demonstrate that all of their staff have attend an annual cultural competency training within the fiscal year July 1st and June 30th.
 - a. The Contract Providers will submit documentation to BCDBH attesting that all staff have attended an annual cultural competency training prior to the end of the contract date (June 30th, annually).
 - b. The documentation will include: full roster of staff, classification, cultural competency training attended (topic), date attended, and a justification with corrective action if staff were not able to attend within the fiscal year.

- IV. Translators and interpreters that contract with BCDBH will also be required to attend an annual cultural competency training within the fiscal year.
 - a. Translators and interpreters will provide a copy of a training certificate and/or verification of the training attended/completed.

Authority: California Code of Regulations (CCR) Title 9 § 3200, 100

<u>Jeremy Wilson, MPPA</u>	<u>10/13/2015</u>	<u>Compliance Committee</u>	<u>12/22/2016</u>
Author	Date	Compliance/Leadership	Date
<u>Mary Jauregui</u>	<u>12/14/2016</u>	<u>Dorian Kittrell</u>	<u>12/22/2016</u>
Reviewed for Content/ Form	Date	BCDBH Director	Date

APPENDIX F: CULTURAL COMPETENCY TRAINING TRACKER

Training Event	Description of Training	How Long and How Often	Attendance by Function	# of Attendees and Total	Date of Training	Name of Presenter(s)
Cultural Proficiency Training: Weaving Cultural Proficiency into Effective Behavioral Health Practice	Become Familiar with the Cultural Proficiency Approach & Four Tools; Learn to Use the Tools for Personal & Organizational Change; Recognize Healthy & Non-Productive Practices & Policies.	Six hours, annually	*Direct Services - County *Direct Services - Contractors *Administration Total Attendees	18 3 2 23	9/18/2012	Phyllis Avilla & Yvonne Nenadal, MPA
Cultural Proficiency Training: Weaving Cultural Proficiency into Effective Behavioral Health Practice	Become Familiar with the Cultural Proficiency Approach & Four Tools; Learn to Use the Tools for Personal & Organizational Change; Recognize Healthy & Non-Productive Practices & Policies.	Six hours, annually	*Direct Services - County *Direct Services - Contractors *Administration Total Attendees	15 10 0 25	4/16/2013	Phyllis Avilla & Yvonne Nenadal, MPA
Cultural Proficiency Training: Weaving Cultural Proficiency into Effective Behavioral Health Practice	Become Familiar with the Cultural Proficiency Approach & Four Tools; Learn to Use the Tools for Personal & Organizational Change; Recognize Healthy & Non-Productive Practices & Policies.	Six hours, annually	*Direct Services - County *Direct Services - Contractors *Administration Total Attendees	2 10 3 15	5/23/2013	Phyllis Avilla & Yvonne Nenadal, MPA
Cultural Proficiency Training: Weaving Cultural Proficiency into Effective Behavioral Health Practice	Become Familiar with the Cultural Proficiency Approach & Four Tools; Learn to Use the Tools for Personal & Organizational Change; Recognize Healthy & Non-Productive Practices & Policies.	Six hours, annually	*Direct Services - County *Direct Services - Contractors *Administration Total Attendees	18 5 4 27	3/11/2014	Phyllis Avilla & Yvonne Nenadal, MPA
Trans* Clients - Prescribing Hormones and Medical Decisions	Social, emotional, and medical needs of transgender youth; Use of puberty blockers and hormone therapy for gender-nonconforming children and transgender adolescents	Two hours, annually	*Direct Services - County *Direct Services - Contractors *Administration Total Attendees	20 5 1 26	4/3/2014	Johanna Olson, MD & Aydin Kennedy, MSW, ACSW
Working With Trans* People: Legal, Medical, Social, & Clinical Considerations	Privilege, heteronormativity, and heterosexism, and their subsequent impact on gender and sexual minority people; Use of puberty blockers and hormone therapy for gender-nonconforming children and transgender adolescents; Legal and education-related matters; Special education, discrimination, constitutional rights, and discipline; Transgender mental health care	Five and a half hours, annually	*Direct Services - County *Direct Services - Contractors *Administration Total Attendees	52 6 1 59	4/4/2014	Johanna Olson, MD & Aydin Kennedy, MSW, ACSW, Asaf Orr, Esq., & David Nylund, PhD, LCSW

Training Event	Description of Training	How Long and How Often	Attendance by Function	# of Attendees and Total	Date of Training	Name of Presenter(s)
Cultural Proficiency Training: Weaving Cultural Proficiency into Effective Behavioral Health Practice	Become Familiar with the Cultural Proficiency Approach & Four Tools; Learn to Use the Tools for Personal & Organizational Change; Recognize Healthy & Non-Productive Practices & Policies.	Six hours, annually	*Direct Services - County *Direct Services - Contractors *Administration Total Attendees	3 2 3 8	5/13/2014	Phyllis Avilla & Yvonne Nenadal, MPA
In Our Own Voice: Unmasking Mental Illness	Presentations from people living with mental illness. Through the telling of their own stories, videos, and questions and answers, you will: Be able to examine attitudes, preconceived notions, and stereotypes regarding mental illness; Gain a more accurate view of a stigmatized and misunderstood experience; Gain a humanized perception of what people living with mental illness are actually like.	One and a half hours, monthly	*Direct Services - County *Direct Services - Contractors *Administration Total Attendees	7 0 3 10	6/4/2014	Various Clients and Community Members
In Our Own Voice: Unmasking Mental Illness	Presentations from people living with mental illness. Through the telling of their own stories, videos, and questions and answers, you will: Be able to examine attitudes, preconceived notions, and stereotypes regarding mental illness; Gain a more accurate view of a stigmatized and misunderstood experience; Gain a humanized perception of what people living with mental illness are actually like.	One and a half hours, monthly	*Direct Services - County *Direct Services - Contractors *Administration Total Attendees	1 0 0 1	6/11/2014	Various Clients and Community Members
In Our Own Voice: Unmasking Mental Illness	Presentations from people living with mental illness. Through the telling of their own stories, videos, and questions and answers, you will: Be able to examine attitudes, preconceived notions, and stereotypes regarding mental illness; Gain a more accurate view of a stigmatized and misunderstood experience; Gain a humanized perception of what people living with mental illness are actually like.	One and a half hours, monthly	*Direct Services - County *Direct Services - Contractors *Administration Total Attendees	3 0 0 3	11/12/2014	Various Clients and Community Members
In Our Own Voice: Unmasking Mental Illness	Presentations from people living with mental illness. Through the telling of their own stories, videos, and questions and answers, you will: Be able to examine attitudes, preconceived notions, and stereotypes regarding mental illness; Gain a more accurate view of a stigmatized and misunderstood experience; Gain a humanized perception of what people living with mental illness are actually like.	One and a half hours, monthly	*Direct Services - County *Direct Services - Contractors *Administration Total Attendees	3 2 1 6	12/10/2014	Various Clients and Community Members
In Our Own Voice: Unmasking Mental Illness	Presentations from people living with mental illness. Through the telling of their own stories, videos, and questions and answers, you will: Be able to examine attitudes, preconceived notions, and stereotypes regarding mental illness; Gain a more accurate view of a stigmatized and misunderstood experience; Gain a humanized perception of what people living with mental illness are actually like.	One and a half hours, monthly	*Direct Services - County *Direct Services - Contractors *Administration Total Attendees	0 2 0 2	4/22/2015	Various Clients and Community Members

Training Event	Description of Training	How Long and How Often	Attendance by Function	# of Attendees and Total	Date of Training	Name of Presenter(s)
In Our Own Voice: Unmasking Mental Illness	Presentations from people living with mental illness. Through the telling of their own stories, videos, and questions and answers, you will: Be able to examine attitudes, preconceived notions, and stereotypes regarding mental illness; Gain a more accurate view of a stigmatized and misunderstood experience; Gain a humanized perception of what people living with mental illness are actually like.	One and a half hours, monthly	*Direct Services - County *Direct Services - Contractors *Administration Total Attendees	0 2 0 2	5/27/2015	Various Clients and Community Members
In Our Own Voice: Unmasking Mental Illness	Presentations from people living with mental illness. Through the telling of their own stories, videos, and questions and answers, you will: Be able to examine attitudes, preconceived notions, and stereotypes regarding mental illness; Gain a more accurate view of a stigmatized and misunderstood experience; Gain a humanized perception of what people living with mental illness are actually like.	One and a half hours, monthly	*Direct Services - County *Direct Services - Contractors *Administration Total Attendees	0 27 0 27	6/24/2015	Various Clients and Community Members
Transgender* Clients: Language, Sensitivity, Identities and Emotional Transition	Definitions; Language; Some Issues & Concerns to the LGBT*Q+ Community; Activity/Discussion; Being an ally	Two hours, annually	*Direct Services - County *Direct Services - Contractors *Administration Total Attendees	10 9 1 20	11/18/2014	Thomas Kelem, LMFT & Ian Ruddell
Culturally Sensitive Intake, Assessment & Treatment	Culturally and linguistically appropriate blueprints for intake and assessment; The importance and use of ethno-cultural competence from a clinical perspective; Hands-on exercises demonstrating clinical approaches to maximize clients' motivation and retention in treatment	Three hours, One Time	*Direct Services - County *Direct Services - Contractors *Administration Total Attendees	10 5 0 15	12/10/2014	Ebony Williams, PsyD
Best Practices in Serving LGBTQ Individuals and Families		Three hours, One Time	*Direct Services - County *Direct Services - Contractors *Administration Total Attendees	12 22 0 34	12/10/2014	
Grand Round- Intimate Partner Violence: Considerations for LGBTQ + and Youth Victims and Survivors	Develop an understanding of the dynamics of abuse in relationships; Explore considerations for youth victims and survivors of intimate partner violence; Explore considerations for LGBTQ+ victims and survivors of intimate partner violence	Two hours, annually	*Direct Services - County *Direct Services - Contractors *Administration Total Attendees	3 10 3 16	2/24/2015	Alexandria Brown

Training Event	Description of Training	How Long and How Often	Attendance by Function	# of Attendees and Total	Date of Training	Name of Presenter(s)
Working With Trans* People: Legal, Medical, Social, & Clinical Considerations	Privilege, heteronormativity, and heterosexism, and their subsequent impact on gender and sexual minority people; Use of puberty blockers and hormone therapy for gender-nonconforming children and transgender adolescents; Legal and education-related matters; Special education, discrimination, constitutional rights, and discipline; Transgender mental health care	Two and a half hours, annually	*Direct Services - County *Direct Services - Contractors *Administration Total Attendees	0 20 0 20	3/27/2015	Johanna Olson, MD & Aydin Kennedy, MSW, ACSW, Liza Thantranon, JD, Max Antor MST LMFT
Grand Round-Promotores & Latino Community	Latino Community cultural values, strengths and weaknesses; Bring awareness in relation to barriers related to accessing services; Practice concerns; The inclusion on Cultural Celebrations as Community Define Practices with healing purposes	Two hours, annually	*Direct Services - County *Direct Services - Contractors *Administration Total Attendees	6 9 0 15	2/18/2016	Martha Martinez & Eneida Sweringen
The LGBT*Q+ Community	The difference between sexuality and gender identity; What makes us feel safe; key language and concepts of being an ally; Legal updates; What being healthy looks like; Who gets services from Stonewall and how we help.	Two hours, annually	*Direct Services - County *Direct Services - Contractors *Administration Total Attendees	5 5 0 10	4/21/2016	Thomas Kelem, LMFT
LGBTQ+ Stonewall Alliance Cultural Sensitivity Training	LGBT*Q Terms and Definitions; Suicide Prevention & Support; Being and Ally and a Resource to Trans* People.	Two hours, annually	*Direct Services - County *Direct Services - Contractors *Administration Total Attendees	11 0 0 11	11/30/2017	Maya Rand

Superior Region Partnership Summary Report of Top Three Accomplishments and Lessons Learned for Fiscal Year 2014-15 through Fiscal Year 2016-17 Contract #14-5014

Top Accomplishments

	Program, Project or Activity Description	Number Served	Who Was Served
1.	Social Work Distributed Learning Programs at California State University, Chico and Humboldt State University	<p>HSU DL Graduates as of May 2017: BSW 91 MSW 67</p> <p>HSU Current Enrollments / pending graduation 2018-19 BSW 39 MSW 74</p> <p>CSU Chico (BSW) 26 DL graduates 2014 -17 39 currently enrolled pending graduation 2018-20</p> <p>CSU Chico (MSW)* 76 DL graduates 2012-17 45 currently enrolled pending graduation 2018</p> <p>* CSU, Chico utilizes a three year cohort model for admissions into the MSW DL program</p>	Superior Region residents historically precluded from access to social work higher education due to location, family and employment obligations. Persons with lived experience seeking higher education.
2.	<p>Consumer Training Programs</p> <ul style="list-style-type: none"> • Basic WRAP Training (Mary Ellen Copeland) • WRAP Facilitator Training • Peer Provider Core Competency Training Program (via CASRA) • Peer Provider Train the Trainer Program 	<ul style="list-style-type: none"> • 30 Individuals from the Superior Region participated in the basic WRAP Training Program • 18 individuals from the Superior Region participated in the WRAP Facilitator Training • 27 individuals from the Superior Region participated in the Peer Provider Core Competency Training Program 	Superior Region consumers, peer providers, and county peer provider staff

		<ul style="list-style-type: none"> 22 individuals from the Superior Region participated in the Peer Provider Training for Trainer program 	
3.	Supervision Support Programs	Supervision of MSW Distributed Learning students enrolled in field internship placements in which qualified program staff (individuals with an MSW degree) are not available for educational supervision support	Nine MSW Distributed Learning Students in rural county field placements

Lessons Learned

1.	<p>Distributed Learning Programs</p> <ul style="list-style-type: none"> Distributed Learning Programs at CSU, Chico and HSU have proven to be a successful means to “grow” and retain qualified staff for superior Region Counties Distributed Learning Programs are in demand as enrollment numbers in graduate DL programs have exceeded enrollments in traditional campus based programs A regional approach to WET needs serves to facilitate a dialogue/collaboration between counties, educators and consumers. This on-going collaboration has served to inform and educate partners regarding WET training needs and opportunities. <p>Examples:</p> <p>Collaboration between consumers, counties and education resulted in the creation of Mental Health Recovery classes at CSU Chico and HSU. The recovery classes at CSU Chico are provided to both Social Work and MFT Program students.</p> <p>Collaboration between consumers, counties and educators serves to keep all participants informed about training and education needs, recent program challenges and developments, as well as state and local policy implications.</p> <p>Collaboration between consumers, counties and educators has resulted in coordinated outreach for distributed learning and other training opportunities.</p> <ul style="list-style-type: none"> Distributed Education is well supported by the Title 4E stipend program, the Mental Health Loan repayment program and individual counties student support programs utilizing local WET funds. Counties providing financial support to local students have higher distributed learning enrollment rates as well as higher MSW employment retention rates.
2.	<p>Consumer Training Programs</p> <ul style="list-style-type: none"> Regional consumer training programs provide opportunities for participants to develop relationships with other peer provider organizations and other individuals with lived experience. Special accommodations for consumers should be considered when planning remote training events. Some individuals reported stress related to travel, meeting times and training duration. Special accommodations for consideration include; group travel arrangements, limiting distance to training, reducing duration of training, adjusting start and finish times,

	<p>recognizing that training subjective matter might induce stress reactions related to past trauma.</p> <ul style="list-style-type: none"> • It is important to assure that trainees are afforded opportunities to put training into practice as soon as possible following completed training. • It is beneficial to have trainers of trainers receive the same basic core competency training as the group receiving basic peer provider competency training
3.	<p>Supervision Support Programs</p> <p>Many students enrolled in rural distributed learning programs participate in employment based field internships. Some small field placement agencies lack qualified staff (holders of an MSW degree) necessary for field supervision. The Superior Region has provided contracted supervision support for students placed in these agencies.</p> <ul style="list-style-type: none"> • When considering implementation of distributed learning programs it is critical to recognize that agencies in small rural counties may lack resources to provide supervision for student interns. • Workload requirement for students in employment-based placements may interfere with time available for student intern learning experiences. • On some occasions student interns may hold the highest level of educational attainment thereby making supervision challenging.

This report is complete and true to the best of my knowledge.

Ken Crandall

Superior Region Coordinator

October 2, 2017

Date

**BUTTE COUNTY DEPARTMENT OF BEHAVIORAL HEALTH
POLICY/PROCEDURE**

Subject: A T & T Language Line Services and Translation Policy

Section: Specialty Mental Health and SUD

Effective Date: 04/23/2014

Sub-Section: BCDBH All

Review Date: 04/23/2018

POLICY: Butte County Department of Behavioral health (BCDBH) provides free access to translation services as required in State Regulations: 42 CFR 438.10 (c 4-5) (d 1-2), CCR Title 9 Ch. 11 Sec. 1810.405 (C-D) 1810.410 (c, 3) (E 1-2), Ca. W&I Div. 4 Part 1 Chap. 3 Sec. 4080 e (1) (T).

RATIONALE: To provide free alternative service accessibility for limited or non-English speaking consumers, and for hearing and/or speech impaired consumers.

PROCEDURE:

I. In Person

- A. BCDBH employs bilingual staff that can provide direct services in our area threshold language of Spanish. Staff may also be available to provide translation, or some service in additional languages, depending on staff availability.
- B. When a non-English speaking consumer can be served by our BCDBH bilingual speaking staff, this will be the first option utilized. Each site will have a list posted of language capabilities of staff members and the schedule of availability of services offered in each language provided by bilingual staff.
- C. For hearing or speech impaired consumers, the American Sign Language, or the Nor Cal Services for the Deaf and Hard of Hearing will be contacted 24-7 to assist in sign translation (See Attachment A).
- D. In addition BCDBH has a list of contract interpreters who may be utilized to provide services in the consumer's language (See Attachment A).
- E. If BCDBH staff or a contracted interpreter is not available, to provide interpreting, the AT&T Language Line services is a free alternative service.

This service is provided by phone and may be utilized to interpret during appointments. (See Attachment B)

II. Over the Phone Telephone Communication

- A. If an individual calls a BCDBH clinic and an interpreter is required during that call, BCDBH will first try to identify the language being spoken, and then locate BCDBH staff on site that may be available to provide language services over the phone. If staff is not available then call the free AT&T Language Line for alternative translation assistance into services (See Attachment B).
- B. American Telephone and Telegraph (AT&T) Language Line Services provides the consumer free over-the-phone interpretation.
 - 1. As an alternative to the AT&T line, BCDBH can also use Language Line Solutions, another free to consumer alternative language translation services with phone and internet translation capabilities.
 - 2. For hearing and speech impaired consumers, BCDBH has access to the statewide TDD/TYY Telephone Service, and to NorCal Services for the Deaf & Hard of Hearing, which is also free to the consumer. Please see attachment A for current available translating services.
- C. If staff is not available then call the free AT&T Language Line for alternative translation assistance into services (See Attachment B). For Sign Language and TDD/TTY Consumers see Attachment A for free phone or on-line interpreter service contact information.

Authority: 42 CFR 438.10 (C 4-5) (D 1-2), CCR Title 9 Ch. 11, Sec. 1810.405 (C-D), and 1810.410 (C, 3) (E, 1-2), W & I Division 4, Part 1, Chapter 3, Section 4080 e (1) (T).

<u>P Bjerke, LMFT</u>	<u>04/23/2014</u>	<u>Compliance</u>	<u>12/14/2015</u>
Author	Date	Compliance/Leadership	Date

<u>B McGuire, MPA</u>	<u>12/10/2015</u>	<u>Dorian Kittrell</u>	<u>12/14/2015</u>
Reviewed for Content/Form	Date	BCDBH Director	Date

ATTACHMENT A

Butte County Department of Behavioral Health FY 2015-2016 Translator/Interpreter List

*TDD/TTY: Assistance for Hearing Impaired Individuals via Telephone Send questions or comments to lgoodliffe@buttecounty.net (530)879-3827 Updated 7/2/15

Please try to use the **BOLDED and underlined** translators primarily as they are under contract
TRANSLATOR
INTERPRETER

	PHONE/EMAIL	AVAILABILITY	NOTES
American Sign Language (ASL)			
NorCal Service for Deaf & Hard of Hearing	(916) 349-7525 ssnapp@norcalcenter.org	24/7	Use request form; Spoken English to ASL, vice versa
Alternative Language			
Language Line	(800)752-6096	24/7	Phone translation services Multiple languages Statewide access
TDD/TTY Telephone Service*	(800) 735-2929 (800) 735-2922 (voice call)	24/7	
Hmong			
Hmong Cultural Center Seng Yang	(530) 534-7474 info@hmongculturalcenter.com	24/7	Translate documents/Hmong to English/English to Hmong
Laotian			
Seng Gaine Saecha	(530) 990-2186 (530) 534-0229	Tue-Fri 8 am -12 pm	
Khae Shelly Tern			
Ye Xiong	(530) 282-3515 (530) 532-5890 (530) 282-3006 Yexiong1435@yahoo.com	Mon-Fri 3 pm – 5 pm By Appointment	Oroville preferred; Can do evenings Chico, Gridley, Oroville preferred
Mien			
Seng Gaine Saechao	(530) 990-2186 (530) 534-0229	Tue-Fri 8 am -12 pm	
Khae Shelly Tern			
	(530) 282-3515 (530) 532-5890	Mon-Fri 3 pm – 5 pm	Oroville preferred; Can do evenings
Punjabi, Hindi, Urdu			
Kirpal Singh Arman	(530) 742-4220 kirpalsarman@gmail.com	By Appointment	

Spanish

Alicia Cuevas	(530) 534-0514 (530) 370-3369 5acuevas@att.net	Mon.-Sun Oroville, Chico, Paradise, Gridley	Written, Verbal and Reading translation
Joe Avila	(530) 566-7183 530joe@gmail.com	24/7	Translates English to Spanish
Martha Martinez	(530) 228-9762 marthaedithmtz@hotmail. com	By Appointment	Translates English to Spanish
Washington Quezada	(530) 624-3496 (cell) (530) 343-6640 wquezada@chiphousing. org	24/7	Chico preferred; Translation

ATTACHMENT B**DIRECTIONS FOR ACCESSING THE AT&T LANGUAGE LINE**

When receiving a call from a client who speaks a language in which you are not fluent:

- First, **identify the language being spoken**. If you are unsure, ask the client to identify his/her language. If the client is unable to understand this request, make an educated guess based on your perceptions.
- Next, quickly **check if there are any staff on site who speak the identified language of the client calling** (each site should have an exclusive list posted of each staff person and their ethnic, cultural, and linguistic attributes as well as their regularly scheduled days and hours). In the circumstance that no staff is available who speak the given language, proceed to the next step below.

To connect to the AT&T language line, **press the flash button*** to place the non-English speaker on hold:

- **Dial Routine: 1-800-874-9426 / Emergency: 1-800-523-1786**
- **Give Information:**
 - Language needed (as determined)
 - Client I. D. Number 201723
 - Organization name Butte County Department of Behavioral Health
 - Personal Code Your employee ID #
- **Add** non-English speaker to the line by depressing the flash button*
- **Wait** for the AT&T Language Line operator to add the Interpreter onto the line. (Sometimes the AT&T Language Line operator may be able to help to further assist you with language identification if necessary).
- **Brief** the interpreter. Quickly summarize what you wish to accomplish and give any special instructions.
- **Say “end of call”** to the interpreter when the call is completed.

***Not all phones are the same!** Please be familiar with how to transfer calls and connect three-way callers on the phone you are using.

HELPFUL HINTS:

- Be familiar with this process, staff linguistic capabilities, phone mechanisms, etc., to ensure that the caller receives services in his/her language as quickly and smoothly as possible.
- To facilitate interpretation, avoid using slang, jargon, acronyms, or technical terms that may not interpret well into another language.
- You can also use Language Line services to place outgoing calls to non-English speaking clients, to set up appointments, convey important treatment information, etc. Please note to primarily use bilingual staff or interpreters in non-emergency situations in order to increase cost efficiency.
- If you would like to listen to a demonstration on how the system works, please call 1-800-821-0301 or visit their web site at: <http://www.att.com/languageLine>

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**BUTTE COUNTY DEPARTMENT OF BEHAVIORAL HEALTH
POLICY/PROCEDURE**

Subject: Americans with Disabilities Act Compliance

**Section: Administration
Sub-Section: DBH All**

**Effective Date: 04/29/2014
Review Date: 04/29/2016**

POLICY:

Butte County Department of Behavioral Health (BCDBH) will comply with the Americans with Disabilities Act (ADA) as passed by Congress on July 26, 1990.

RATIONALE:

Through compliance with the ADA of 1990, BCDBH will meet the needs of individuals with disabilities in the areas of employment, public accommodations, local government services and telecommunications.

PROCEDURE:

I. Physical Barriers

A. Buildings and/or office space owned/leased for conducting County business shall meet the provisions of Title II of the Americans with Disabilities Act. All barriers will be abated that deny the benefits of services, programs, and/or activities of the County of Butte to individuals with those disabilities as defined within the ADA. Abatement efforts shall conform to the minimum requirements of the accessibility guidelines outlined in the "Federal Register" Part 3, 28 CFR Part 36.

II. Language Barriers

A. Language interpretation for non-English speaking members of the public will be provided in one of two ways: (please see policy 089A AT&T Language Line Services and Translation Policy)

1. Contract with AT&T Language Line Services for over the phone interpretation services.
2. Contract with individuals for, on-site, face-to-face language interpretation in Spanish, Hmong, Mien, Laotian and Thai, etc.

B. Language interpretation for hearing-impaired members of the public will be provided in one of two ways:

1. Use the California Relay Service by dialing 800 735-2929 for TDD to Voice and/or 800 735-2922 for Voice to TDD.
2. Contract with individuals for face-to-face sign interpretation.

III. Work barriers

A. All work area and telecommunication barriers will be abated that preclude any individual with those disabilities as defined within the ADA from being employed by the BCDBH.

Authority: BCDBH Director; Title II ADA, 28 CFR Part 36 and Federal Register Part 3

<u>M. Sivesind</u>	<u>08/12/1998</u>	<u>Compliance/Leadership</u>	<u>06/02/2014</u>
Author	Date	Compliance/Leadership	Date
<u>Pam Bjerke, LMFT</u>	<u>04/29/2014</u>	<u>Dorian Kittrell, LMFT</u>	<u>06/12/2014</u>
Reviewed for Content/Form	Date	Dorian Kittrell, LMFT, Director	Date

Determining Language Preference



This is a tool to use in determining language being spoken and/or read. To use, simply hand this sheet to the individual and note the language they indicate.

馬克這一個盒子如果你讀或者說華語。 Chinese

Mark this box if you read or speak English. English

Kos lub voj no yog koj paub twm thiab hais lus Hmoob. Hmong

もしあなたが日本語を読むか、あるいは話すなら、この箱を特徴づけなさい。 Japanese

만일 당신이 한국어를 읽거나, 말하면 이 박스를 채점해라. Korean

ການເຮັດເຄື່ອງຫມາຍ ໃສ່ລຸ່ງນີ້ ຖ້າຫາກວ່າທ່ານ
ອ່ານຫລື ເວົ້າ ລາວ Laotian

Marque esta caja si usted lee o habla español. Spanish

ทำเครื่องหมาย ช่องนี้ หากคุณ อ่านหรือ พูด
ภาษาไทย Thai

Dimv naaiv box gorngv hnangr mein doqc mien, aengx gorngv mien waac. Mien

APPENDIX K: STAFF RECEIVING BI-LINGUAL PAY DIFFERENTIAL

BI-LINGUAL EMPLOYEES

DATE	PROGRAM	CLASSIFICATION	EMPLOYEE NAME	LANGUAGE
11/9/17	Youth GRIDLEY	BH COUNSELOR II	AMAYA SOTERO	Spanish
11/9/17	Adult PHF	BH WORKER	ANAYA NORMA	Spanish
11/9/17	Youth PARADISE	MEDICAL RECORDS TECH., SR.	BONNER GRACIELA	Spanish
11/9/17	Adult GRIDLEY	BH COUNSELOR II	CALDERON DIAZ J	Spanish
11/9/17	Department CRISIS	BH COUNSELOR II	CERVANTES AURORA	Spanish
11/9/17	Administration ADMINISTRATION	ACCOUNTANT	CORONEL GRISELDA	Spanish
11/9/17	Youth CHICO	BH CLINICIAN I	FLORES NICOLAS	Spanish
11/9/17	Youth CHICO	BH CLINICIAN I	HERNANDEZ CRISTINA	Spanish
11/9/17	Youth PARADISE	BH COUNSELOR I	HINOJOSA IVETTE	Spanish
11/9/17	Adult CHICO	BH COUNSELOR II	LOPEZ VICTOR	Spanish
11/9/17	Adult CHICO	MEDICAL RECORDS TECH.	MARTINEZ JENNIFER	Spanish
11/9/17	Youth CHICO	BH COUNSELOR II	MARTINEZ PABLO	Spanish
11/9/17	Youth CHICO	BH COUNSELOR II	MEDINA JESUS	Spanish
11/9/17	Adult CHICO	BH COUNSELOR II	MUNIZ EMILIO	Spanish
11/9/17	Department CRISIS	BH COUNSELOR I	PRICE STEPHANIE	Spanish
11/9/17	Youth GRIDLEY	BH CLINICIAN I	RAMIREZ JESUS	Spanish
11/9/17	Youth OROVILLE	BH COUNSELOR I	SAECHAO KAE	Hmong
11/9/17	Youth CHICO	BH CLINICIAN I	THAO ALENA	Hmong
11/9/17	Youth OROVILLE	SUPERVISOR, BH CLINICIAN	THAO-LEE CHIA	Hmong
11/9/17	Adult CHICO	SUPERVISOR, BH CLINICIAN	TOWNER CARO KARIN	Hmong
11/9/17	Adult OROVILLE	BH COUNSELOR II	VANG CHAO	Hmong
11/9/17	Youth OROVILLE	BH CLINICIAN II	VANG KIA	Hmong
11/9/17	Adult OROVILLE	BH CLINICIAN I	VANG PAI	Hmong
11/9/17	Youth OROVILLE	BH COUNSELOR II	VANG TENG	Hmong
11/9/17	Adult OROVILLE	BH CLINICIAN I	VANG THAO VALERIE	Hmong
11/9/17	Adult CHICO	BH CLINICIAN II	WEINRICH DEBRA	Spanish
11/9/17	Adult CHICO	BH CLINICIAN I	XIONG CHOU	Hmong
11/9/17	Adult OROVILLE	BH CLINICIAN I	YANG DALE	Hmong
11/9/17	Adult CHICO	BH CLINICIAN I	YANG DIA	Hmong

Hmong	12
Spanish	17

**Butte County Department of Behavioral Health
FY 2017-2018 Translator/Interpreter List**

Please try to use the **BOLDED and underlined** translators primarily as they are under contract

TRANSLATOR INTERPRETER	PHONE/EMAIL	AVAILABILITY	NOTES
American Sign Language (ASL)			
<u>NorCal Service for Deaf & Hard of Hearing</u>	(916) 349-7525 ssnapp@norcalcenter.org	24/7	Use request form; Spoken English to ASL, vice versa
Alternative Language			
Language Line	(800)752-6096	24/7	Phone translation services Multiple languages
TDD/TTY Telephone Service*	(800) 735-2929 (800) 735-2922 (voice call)	24/7	Statewide access
Hmong			
Hmong Cultural Center Seng Yang	(530) 534-7474 info@hmongculturalcenter.com	24/7	Translate documents/Hmong to English/English to Hmong
Laotian			
Seng Gaine Saechao	(530) 990-2186 (530) 534-0229	Weekends only	
Ye Xiong	(530) 282-3006 Yexiong1435@yahoo.com	By Appointment	Chico, Gridley, Oroville preferred
Mien			
Seng Gaine Saechao	(530) 990-2186 (530) 534-0229	Weekends only	
<u>Khae Shelly Tern</u>	(530) 282-3515 (530) 532-5890	Mon-Fri 3 pm – 5 pm	Oroville preferred; Can do evenings
Punjabi, Hindi, Urdu			
Kirpal Singh Arman	(530) 742-4220 kirpalsarman@gmail.com	By Appointment	
Spanish			
<u>Alicia Cuevas</u>	(530) 534-0514 (530) 370-3369 5acuevas@att.net	Mon.-Sun Oroville, Chico, Paradise, Gridley	Written, Verbal and Reading translation
<u>Martha Martinez</u>	(530) 228-9762 marthaedithmtz@hotmail.com	By Appointment (Evenings/Weekends)	Translates English to Spanish
<u>Washington Quezada</u>	(530) 624-3496 (cell) (530) 343-6640 wquezada@chiphousing.org	24/7	Chico preferred; Document Translation

*TDD/TTY: Assistance for Hearing Impaired Individuals via Telephone
Send questions or comments to DBH-ASDContracts@buttecounty.net (530)891-2851 Updated 6/29/17



GUIDE TO

Medi-Cal Mental Health Services





If you are having an emergency, please call 9-1-1 or visit the nearest hospital emergency room.

If you would like additional information to help you decide if this is an emergency, please see the information on State of California page 6 in this booklet.



Important Telephone Numbers

Emergency 911

Butte County Behavioral Health

Adult: (530) 891-2810
(800) 334-6622 **24-hours**

Youth: (530) 891-2794
(800) 371-4373 **24-hours**

To request services during (800) 334-6622
business hours (530) 891-2810

Patient's Rights Advocate (530) 343-1731
(800) 497-1445

Enloe Hospital (Chico) (530) 332-7300

Oroville Hospital (Oroville) (530) 533-8500



How To Get A Provider List:

You may ask for, and your Mental Health Plan (MHP) should give to you, a directory of people, clinics and hospitals where you can get mental health services in your area. This is called a 'provider list' and contains names, phone numbers and addresses of doctors, therapists, hospitals and other places where you may be able to get help. You may need to contact your MHP first, before you go to seek help. Call your MHP's 24-hour, toll-free number above to request a provider list and to ask if you need to contact the MHP before going to a service provider's office, clinic or hospital for help.



In What Other Languages And Formats Are These Materials Available?

Este folleto (o información) esta disponible en Español. Usted puede solicitarlo llamando al número de teléfono gratuito mencionado anteriormente.

Welcome to Medi-Cal Mental Health Services

Why Did I Get This Booklet And Why Is It Important?

You are getting this booklet because you are eligible for Medi-Cal and need to know about the mental health services that Butte County offers and how to get these services if you need them.

If you are now getting services from Butte County, this booklet just tells you more about how things work. This booklet tells you about mental health services, but does not change the services you are getting. You may want to keep this booklet so you can read it again.

If you are not getting services right now, you may want to keep this booklet in case you, or someone you know, need to know about mental health services in the future.



If you have trouble with this booklet, please call the MHP at (800) 334-6622 or (530) 891-2810 to ask for help or to find out about other ways you can get this important information.



What Is A Mental Health Emergency?

An emergency is a serious mental or emotional problem, such as:

When a person is a danger to himself, herself, or others because of what seems like a mental illness, or

When a person cannot get or use the food, shelter, or clothing they need because of what seems like a mental illness.

In an emergency, please call 9-1-1 or take the person to a hospital emergency room.

How Do I Use This Booklet?

This booklet will help you know what specialty mental health services are, if you may get them, and how you can get help from the Butte County MHP.

This booklet has two sections. The first section tells you how to get help from the Butte County MHP and how it works.

The second section is from the State of California and gives you more general information about specialty mental health services. It tells you how to get other services, how to resolve problems, and what your rights are under the program.

This booklet also tells you how to get information about the doctors, clinics and hospitals the Butte County MHP uses to provide services and where they are located.

What Is My County's Mental Health Plan (MHP)?

Mental health services are available to people on Medi-Cal, including children, young people, adults and older adults in Butte County.

Sometimes these services are available through your regular doctor. Sometimes they are provided by a specialist, and called 'specialty' mental health services. These specialty services are provided through the Butte County "Mental Health Plan" or MHP, which is separate from your regular doctor. The Butte County MHP operates under rules set by the State of California and the federal government. Each county in California has its own MHP.



If you feel you have a mental health problem, you may contact the Butte County MHP directly at **(800) 334-6622**. This is a toll-free telephone number that is available 24-hours a day, seven days a week. Written and verbal interpretation of your rights, benefits and treatments is available in your preferred language. You do not need to see your regular doctor first or get permission or a referral before you call.



You may also request a State Fair Hearing. Please see page 26 in the State of California section of this booklet for more information.

If you believe you would benefit from specialty mental health services and are eligible for Medi-Cal, the Butte County MHP will help you find out if you may get mental health treatments and services. If you would like more information about specific services, please see the sections on 'Services' on the State of California page 9 in this booklet.

What If I Have A Problem Getting Help?

If you have a problem getting help, please call the Butte County MHP's 24-hour, toll-free phone number at **(800) 334-6622**. You may also call your county's Patient's Right Advocate at **(530) 343-1731**.

If that does not solve your problem, you may call the State of California's Ombudsman for help:

(800) 896-4042 - CA Only

(916) 654-3890

(800) 896-2512 TTY

FAX: **(916) 653-9194**

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Welcome to the Butte County Mental Health Plan



We welcome you to Butte County Mental Health Services, and to the Medi-Cal Mental Health Plan.

We provide specialty mental health services for people who live in Butte County and are eligible for Medi-Cal. Please read this booklet carefully. It contains important information you need to know.

As Your Mental Health Services Plan We Will:

- Get answers to your questions about mental health treatment
- Tell you what mental health services are covered by Medi-Cal
- Determine what types of mental health services you need and help you get them
- Treat you with respect
- Ensure you receive services in a safe environment
- Help you get culturally competent care

As A Participant, You Also Have Specific Responsibilities:

- Give honest and complete information about your mental health needs
- Take an active part in your mental health treatment
- Keep your appointments as scheduled
- Call if you cannot keep your appointment
- Work on treatment goals with your provider



Important Telephone Numbers

Emergency	911
Butte County Behavioral Health, Adult:	(530) 891-2810 (800) 334-6622 24-hours
Butte County Behavioral Health, Youth:	(530) 891-2794 (800) 371-4373 24-hours
To request services during business hours:	(800) 334-6622 (530) 891-2810
For informing materials:	(530) 891-2810 (800) 334-6622
Patient's Rights Advocate:	(530) 343-1731 (800) 497-1445
Enloe Hospital (Chico):	(530) 332-7300
Oroville Hospital (Oroville):	(530) 533-8500

How Do I Know If Someone Needs Help Right Away?

Even if there is no emergency, a person with mental health problems needs help right away if one or more of these things is true:

- Hearing or seeing things others believe are not there
- Extreme and frequent thoughts of, or talking about, death
- Giving away their things
- Threatening to kill themselves (suicide)
- Wanting to hurt themselves or others

If one or more of these things is true, call 911 or the Butte County MHP at **(800) 334-6622** (24-hours toll free). Mental Health workers are on-call 24-hours a day.

What Specialty Mental Health Services Does Butte County Provide?

The Adult Services Division provides a broad range of services to people with mental illness in Butte County. These services are for Medi-Cal recipients, and they include:

- 24-hour crisis intervention and assessment
- Outpatient mental health assessment and treatment
- Dual diagnosis (substance abuse and mental disorders) treatment
- Residential services
- Day treatment services
- Case management
- Inpatient psychiatric health facility (PHF)
- Outreach community services



Other services may be available. See page 9 in the State of California (middle) section on 'Services' for a list of available services.

- Housing services
- Outreach to ethnically diverse groups
- Young adult transition program
- Patient advocacy
- Older adult services

The Youth Services Division provides a broad range of services to people with Medi-Cal, including:

- Psychiatric evaluations
- Mental health assessments
- Psychological testing
- Substance abuse education and treatment
- Individual, family, and group therapy

The services listed above are the services that the Butte County MHP thinks are most likely to help people who need services from us. Sometimes other services may be needed. The other services that are sometimes needed are included in the list on pages 9 (adults) and 12 (children) in the State of California section of this booklet.

How Do I Get These Services?

You may receive a phone screening for services. Individuals who meet medical necessity criteria will receive a referral for assessment for Behavioral Health services. The timeline to next appointment, frequency of appointments, and duration of appointments is determined by your clinical needs.

To request services, Behavioral Health has a toll free number **(800) 334-6622** and local number **(530) 891-2810** for requesting services from 8:00 a.m. to 5:00 p.m. The ACCESS department provides phone screening and scheduling of appointments for services, once your presenting problems have been evaluated as meeting medical necessity.

In What Other Languages And Formats Are These Materials Available?

In Butte County, Spanish is the only threshold language by state standards. However, many of the forms and brochures have been translated into Hmong, as well. Materials are also available in large print and audio formats.

Behavioral Health has a contract with the AT&T language line that provides phone translation in 140 languages. In addition, contracted interpreters to provide on-site translation in 6 languages (Spanish, Hmong, Lao, Thai, Mien, American Sign Language) are available for staff to utilize in sessions.

What Does It Mean To Be “Authorized” To Receive Mental Health Services And How Do I Become “Authorized” In Butte County?

You, your provider and the Butte County MHP are all involved in deciding what services you need to receive through the MHP, including how often you will need services and for how long.

The Butte County MHP may require your provider to ask the MHP to review the reasons the provider thinks you need a service before the service is provided. The Butte County MHP uses a qualified mental health professional to do the review. This review process is called an MHP payment authorization process.

The State requires the Butte County MHP to have an authorization process for day treatment intensive, day rehabilitation, and therapeutic behavioral services (TBS); however, urgent or emergency conditions do not require prior authorization. The Butte County MHP follows state rules for our MHP payment authorization process, which are described on page 3 in the State Of California section of this booklet. If you would like more information on how the Butte County MHP does MHP payment authorizations, or on when we require your provider to request an MHP payment authorization for services, please contact the Butte County MHP at **(530) 891-2810**.

How Do I Get More Information About Butte County’s Mental Health Services Including Doctors, Therapists, Clinics And Hospitals?

Services are provided in Paradise, Oroville, Chico, and Gridley. There are a number of different programs and locations in each of these cities. If you would like additional information on the structure and operation of the Butte County MHP, please contact the Butte County MHP at **(530) 891-2810**, 592 Rio Lindo Ave., Chico, CA 95926. For the location nearest you, call **(800) 334-6622**, or you can check our Web site (www.butte-dbh.org).

How Do I Get A Provider List?

You will be given a provider list at your assessment appointment and upon request at our ACCESS unit. For an assessment, please call **(800) 334-6622** or the local number **(530) 891-2810** for requesting services from 8:00 a.m. to 5:00 p.m.

Can I See Any Doctor, Therapist, Clinic Or Hospital On Butte County’s “Provider List”?

We require that you contact us first because we want to make sure that:

- 1) Your services are authorized and
- 2) The provider you choose is accepting new Medi-Cal beneficiaries.

What If I Want To Change Doctors, Therapists Or Clinics?

Call the Butte County MHP at **(800) 334-6622**.

Can I Use The “Provider List” To Find Someone To Help Me?

To see a doctor, clinic or hospital, you first need to contact the Butte County MHP at **(800) 334-6622** or **(530) 891-2810**.

What If I Want To See A Doctor, Clinic Or Hospital That Is Not Listed On Butte County’s “Provider List”?

Butte County has Emergency Room contracts with both hospitals (Enloe Hospital in Chico and Oroville Hospital in Oroville), for those clients needing to access hospital care for their non-mental health needs.

We also maintain a county-run Psychiatric Health Facility (PHF), which utilizes Enloe Prompt Care to provide health assessments onsite as needed.

What If I Need Urgent-Care Mental Health Services On A Weekend Or At Night?

You can call the Behavioral Health 24-Hour crisis line:

Adult: **(530) 891-2810** or **(800) 334-6622**

Youth: **(530) 891-2794** or **(800) 371-4373**

How Do I Get Mental Health Services That My Mental Health Provider Does Not Offer?

Though Butte County does not have a Managed Care Plan for physical health care, a Federally Qualified Health Center (FQHC) has been established in each of our main communities. Behavioral Health has established relationships with the FQHCs and meets with them as needed. Our providers/practitioners are able to connect you with this resource. Please call the Butte County MHP at **(800) 334-6622** to ask for more information or help getting the services you need.

What If I Need To See A Doctor For Something Other Than Mental Health Treatment? How Are People Referred To Medi-Cal Services Other Than Mental Health Care In Butte County?

Butte County has Emergency Room contracts with both hospitals (Enloe in Chico and Oroville Hospital in Oroville), for those clients needing to access hospital care for their non-mental health needs.

We also maintain a county-run Psychiatric Health Facility (PHF), which utilizes a local urgent care facility to provide health assessments onsite as needed.

If you need Medi-Cal services, apart from your mental health needs, your case manager will help you access community services.



For more information on Grievances, Appeals and State Fair Hearings, please turn to the section about 'Problem Resolution Processes' in the State of California section on page 22 in this booklet.

What Can I Do If I Have A Problem Or I Am Not Satisfied With My Mental Health Treatment?

If you have a concern or problem or are not satisfied with your mental health services, the MHP wants to be sure your concerns are resolved simply and quickly. Please contact the MHP at **(800) 334-6622** to find out how to resolve your concerns.

There are three ways you can work with the MHP to resolve concerns about services or other problems. You can file a Grievance verbally or in writing with the MHP about any MHP-related issue. You can file an Appeal verbally (and follow up in writing) or in writing with the MHP. You can also file for a State Fair Hearing with the Department of Social Services.

For more information about how the MHP Grievance and Appeal processes and the State Fair Hearing process work, please turn to the section about Grievances, Appeals and State Fair Hearings on page 22 of the State of California section of this booklet.

Your problem will be handled as quickly and simply as possible. It will be kept confidential. You will not be subject to discrimination or any other penalty for filing a Grievance, Appeal, or State Fair Hearing. You may authorize another person to act on your behalf in the Grievance, Appeal, or State Fair Hearing Process.

Beneficiary Protections tracks and responds to all client Grievances and Appeals. They ensure clients receive oral or written resolution. They ensure Grievance and benefits information is available at each program site. They can be contacted at **(530) 879-2456** or 1196 E. Lassen, Suite 130, Chico, CA 95973

Who Is Butte County's Patient's Right Advocate, What Do They Do And How Do I Contact Them?

Patient's Rights Advocate
1196 E. Lassen, Suite 130
Chico, CA 95973
(530) 343-1731 or **(800) 497-1445**

The Patient's Rights Advocate attends LPS-contested hearings, State Fair Hearings and 14-day involuntary placements. They also offer assistance with problems occurring with landlords, SSI, Medi-Cal benefits, and Board & Care. They are located in the Behavioral Health Drop-In Center.

Does Butte County Keep My Mental Health Records Private?

By law, your mental health services and records are handled with confidentiality. Your provider cannot tell anyone outside of the provider network any clinical information you give Butte County, unless you supply written permission or a court deems it acceptable.

General Statewide Information



Why Is It Important To Read This Booklet?

The first section of this booklet tells you how to get Medi-Cal mental health services through your county's Mental Health Plan.

This second section of the booklet tells you more about how the Medi-Cal program works, and about how Medi-Cal specialty health services work in all counties of the state.

If you don't read this section now, you may want to keep this booklet so you can read it later.

County Mental Health Plans

If you think you qualify for Medi-Cal and you think you need mental health services, call the Mental Health Plan in your county and say, "I want to find out about mental health services."

What Are Specialty Mental Health Services?

Specialty Mental health services are special health care services for people who have a mental illness or emotional problems that a regular doctor cannot treat.

Some specialty mental health services include:

- Crisis counseling to help people who are having a serious emotional crisis
- Individual, group, or family therapy
- Rehabilitation or recovery services that help a person with mental illness to develop coping skills for daily living
- Special day programs for people with mental illnesses
- Prescriptions for medicines that help treat mental illness
- Help managing medicines that help treat mental illness
- Help to find the mental health services you need

Where Can I Get Mental Health Services?

You can get mental health services in the county where you live. Each county has a Mental Health Plan for children, teens, adults and older adults. Your county Mental Health Plan has mental health providers (doctors who are psychiatrists or psychologists, and others).

How Do I Get Services At My County Mental Health Plan?

Call your county Mental Health Plan and ask for services. You do not need to ask your regular doctor for permission or get a referral. Just call the number for your county in the front of this booklet. The call is free.

You can also go to a federally qualified health center, a rural health center or an Indian health clinic in your area for Medi-Cal mental health services. (These are official names for different kinds of clinics in your area. If you are not sure about a clinic in your area, ask the clinic workers. These kinds of clinics generally serve people who do not have insurance.)

As part of providing mental health services for you, your county Mental Health Plan is responsible for:

- Figuring out if someone is eligible for specialty mental health services from the MHP.
- Providing a toll-free phone number that is answered 24-hours a day and 7 days a week that can tell you about how to get services from the MHP.
- Having enough providers to make sure that you can get the specialty mental health services covered by the MHP if you need them.
- Informing and educating you about services available from your county's MHP
- Providing you services in the language of your choice or by an interpreter (if necessary) free of charge and letting you know that these interpreter services are available.
- Providing you with written information about what is available to you in other languages or forms, depending upon the needs in your county.

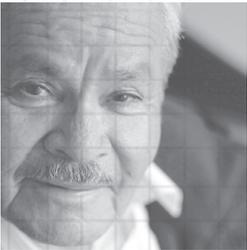
■ Important Information About Medi-Cal



Who Can Get Medi-Cal?

You may qualify for Medi-Cal if you are in one of these groups:

- 65 years old, or older
- Under 21 years of age
- An adult, between 21 and 65 with a minor child living with you (a child who is not married and who is under the age of 21)
- Blind or disabled
- Pregnant
- Certain refugees, or Cuban/Haitian immigrants
- Receiving care in a nursing home



If you are not in one of these groups, call your county social service agency to see if you qualify for a county-operated medical assistance program.

You must be living in California to qualify for Medi-Cal. Call or visit your local county social services office to ask for a Medi-Cal application, or get one on the Internet at www.dhs.ca.gov/mcs/medi-calhome/MC210.htm



Do I Have To Pay For Medi-Cal?

You may have to pay for Medi-Cal depending on the amount of money you get or earn each month.

- If your income is less than Medi-Cal limits for your family size, you will not have to pay for Medi-Cal services.
- If your income is more than Medi-Cal limits for your family size, you will have to pay some money for your medical or mental health services. The amount that you pay is called your '**share of cost.**' Once you have paid your 'share of cost,' Medi-Cal will pay the rest of your covered medical bills for that month. In the months that you don't have medical expenses, you don't have to pay anything.
- You may have to pay a 'co-payment' for any treatment under Medi-Cal. You may have to pay \$1.00 each time you get a medical or mental health services or a prescribed drug (medicine) and \$5.00 if you go to a hospital emergency room for your regular services.

Your provider will tell you if you need to make a co-payment.

Always take your Beneficiary Identification Card and health plan card, if you have one, when you go to the doctor, clinic, or hospital.

How Do I Get Medi-Cal Services That Are Not Covered By The Mental Health Plan?

There are two ways to get Medi-Cal services:

1. By joining a Medi-Cal managed care health plan.

If you are a member of a Medi-Cal managed care health plan:

- Your health plan needs to find a provider for you if you need health care.
- You get your health care through a health plan, an HMO (health maintenance organization) or a primary care case manager.
- You must use the providers and clinics in the health plan, unless you need emergency care.
- You may use a provider outside your health plan for family planning services.
- You can only join a health plan if you do not pay a share of cost.

2. From individual health care providers or clinics that take Medi-Cal.

- You get health care from individual providers or clinics that take Medi-Cal
- You must tell your provider that you have Medi-Cal before you first get services. Otherwise, you may be billed for those services.
- Individual health care providers and clinics do not have to see Medi-Cal patients, or may only see a few Medi-Cal patients.
- Everyone who has a share of cost (see page 3, State of California) will get health care this way.

If you need mental health services that are not covered by the Mental Health Plan:

- And you are in a health plan, you may be able to get services from your health plan. If you need mental health services the health plan doesn't cover, your primary care provider at the health plan may be able to help you find a provider or clinic that can help you.
- Except in San Mateo County, your health plan's pharmacies will fill prescriptions to treat your mental illness, even if the prescriptions were written by the mental health plan's psychiatrist, or will tell you how to get your prescription filled from a regular Medi-Cal pharmacy. (In San Mateo County, the mental health plan will fill your prescriptions.)
- And you are not in a health plan, you may be able to get services from individual providers and clinics that take Medi-Cal. Except in San Mateo County, any pharmacy that accepts Medi-Cal can fill prescriptions to treat your mental illness, even if the prescriptions were written by the MHP's psychiatrist. (In San Mateo County, the mental health plan will fill your prescriptions.)
- The Mental Health Plan may be able to help you find a provider or clinic that can help you or give you some ideas on how to find a provider or clinic.



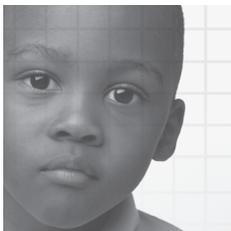
If you have trouble getting to your medical or mental health appointments, the Medi-Cal program can help you find transportation.

If you have trouble getting to your medical appointments or mental health appointments, the Medi-Cal program can help you find transportation.

- For children, the county Child Health and Disability Prevention (CHDP) program can help. Or, you may wish to contact your county’s social services office. These phone numbers can be found in your local telephone book in the ‘County Government’ pages. You can also get information online by visiting **www.dhs.ca.gov**, then clicking on ‘Services’ and then on ‘Medi-Cal Information.’
- For adults, your county social services office can help. You can get information about your county’s social services office by checking your local telephone book. Or you can get information online by visiting **www.dhs.ca.gov**, then clicking on ‘Services’ and then on ‘Medi-Cal Information.’

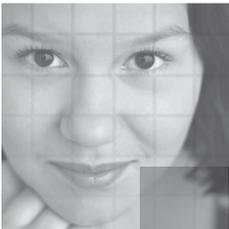
What Is The Child Health And Disability Prevention (CHDP) Program?

The CHDP program is a preventive health program serving California’s children and youth from birth to age 21. CHDP makes early health care available to children and youth with health problems, as well as to those who seem well. Children and youth can receive regular preventive health assessments. Children and youth with suspected problems are then referred for diagnosis and treatment. Many health problems can be prevented or corrected, or the severity reduced, by early detection and prompt diagnosis and treatment.



CHDP works with a wide range of health care providers and organizations to ensure that eligible children and youth receive appropriate services. These may include private physicians, local health departments, schools, nurse practitioners, dentists, health educators, nutritionists, laboratories, community clinics, nonprofit health agencies, and social and community service agencies. CHDP can also assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services.

You can find out more about CHDP by contacting your local county health department or visiting **www.dhs.ca.gov/pcfh/cms/chdp/directory.htm**.



Where Can I Get More Information?

You can get more information about mental health services by visiting the California Department of Mental Health’s website at **www.dmh.ca.gov**. You can get more information about Medi-Cal by asking your county eligibility worker or by visiting **www.dhs.ca.gov/mcs/medi-calhome**.

Basic Emergency Information



In case of an emergency medical or psychiatric condition, call 9-1-1 or go to any emergency room for help.

Are You Having An Emergency?

An emergency medical condition has symptoms so severe (possibly including severe pain) that an average person could expect the following might happen at any moment:

- The health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) could be in serious trouble,
- Serious problems with bodily functions,
- Serious problems with any bodily organ or part.

An emergency psychiatric condition occurs when an average person thinks that someone:

- Is a current danger to himself or herself or another person because of what seems like a mental illness.
- Is immediately unable to provide or eat food, or use clothing or shelter because of what seems like a mental illness.

In case of an emergency medical or psychiatric condition, call 9-1-1 or go to any emergency room for help.

The Medi-Cal program will cover emergency conditions, whether the condition is medical or psychiatric (emotional or mental). If you are on Medi-Cal, you will not receive a bill to pay for going to the emergency room, even if it turns out to not be an emergency.

If you aren't sure if the condition is truly an emergency, or if you're not sure whether the condition is medical or psychiatric, you may still go to the emergency room and let qualified medical professionals make the decision about what is needed. If the emergency room professionals decide there is a psychiatric emergency, you will be admitted to the hospital to receive immediate help from a mental health professional. If the hospital doesn't have the kind of services necessary, the hospital will find a hospital that does have the services.

A person may be helped through a mental health crisis by services from your county's Mental Health Plan (MHP) in ways other than going into the hospital. If you think you need help but don't think you need to go into the hospital, you can call your county MHP's toll-free phone number and ask for help.



What Kind Of Emergency-Related Services Are Provided?

Emergency services are paid for by Medi-Cal when you go to a hospital or use outpatient services (with no overnight stay involved) furnished in a hospital emergency room by a qualified provider (doctor, psychiatrist, psychologist or other mental health provider). They are needed to evaluate or stabilize someone in an emergency.

Your county's Mental Health Plan (MHP) should provide specific information about how emergency services are administered in your County. The following state and federal rules apply to emergency services covered by the MHP:

- The hospital does not need to get advance approval from the MHP (sometimes called “prior authorization”) or have a contract with your MHP to get paid for the emergency services the hospital provides to you.
- The MHP needs to tell you how to get emergency services, including the use of 9-1-1.
- The MHP needs to tell you the location of any places where providers and hospitals furnish emergency services and post-stabilization services.
- You can go to a hospital for emergency care if you believe there is a psychiatric emergency.
- Specialty mental health services to treat your urgent condition are available 24-hours a day, seven days per week. (An urgent condition means a mental health crisis that would turn into an emergency if you do not get help very quickly.)
- You can receive these inpatient hospital services from the MHP on a voluntary basis, if you can be properly served without being involuntarily held. The state laws that cover voluntary and involuntary admissions to the hospital for mental illness are not part of state or federal Medi-Cal rules, but it may be important for you to know a little bit about them:
 - 1. Voluntary admission:** This means you give your OK to go into and stay in the hospital.
 - 2. Involuntary admission:** This means the hospital keeps you in the hospital for up to 72 hours without your OK. The hospital can do this when the hospital thinks that you are likely to harm yourself or someone else or that you are unable to take care of your own food, clothing and housing needs. The hospital will tell you in writing what the hospital is doing for you and what your rights are. If the doctors treating you think you need to stay longer than 72 hours, you have a right to a lawyer and a hearing before a judge and the hospital will tell you how to ask for this.

Your county's Mental Health Plan (MHP) should pay for post-stabilization care services obtained within the MHP's provider list or coverage area. Your MHP will pay for such services if they are pre-approved by an MHP provider or other MHP representative.

Post-stabilization care services are covered services that are needed after an emergency. These services are provided after the emergency is over to continue to improve or resolve the condition.

Your MHP is financially responsible for (will pay for) post-stabilization care services to maintain, improve, or resolve the stabilized condition if:

- The MHP does not respond to a request from the provider for pre-approval within 1 hour
- The MHP cannot be contacted by the provider
- The MHP representative and the treating physician cannot reach an agreement concerning your care and an MHP physician is not available for consultation. In this situation, the MHP must give the treating physician the opportunity to consult with an MHP physician. The treating physician may continue with care of the patient until one of the conditions for ending post-stabilization care is met. The MHP must make sure you don't pay anything extra for post-stabilization care.

When Does My County MHP's Responsibility For Covering Post-Stabilization Care End?

Your county's MHP is NOT required to pay for post-stabilization care services that are not pre-approved when:

- An MHP physician with privileges at the treating hospital assumes responsibility for your care.
- An MHP physician assumes responsibility for your care through transfer.
- An MHP representative and the treating physician reach an agreement concerning your care (the MHP and the physician will follow their agreement about the care you need).
- You are discharged (sent home from the facility by a doctor or other professional).

ADULTS AND OLDER ADULTS



How Do I Know When I Need Help?

Many people have difficult times in life and may experience mental health problems. While many think major mental and emotional disorders are rare, the truth is one in five individuals will have a mental (psychiatric) disorder at some point in their life. Like many other illnesses, mental illness can be caused by many things.

The most important thing to remember when asking yourself if you need professional help is to trust your feelings. If you are eligible for Medi-Cal and you feel you may need professional help, you should request an assessment from your county’s MHP to find out for sure.

What Are Signs I May Need Help?

If you can answer ‘yes’ to one or more of the following AND these symptoms persist for several weeks AND they significantly interfere with your ability to function daily, AND the symptoms are not related to the abuse of alcohol or drugs. If this is the case, you should consider contacting your county’s Mental Health Plan (MHP).

A professional from the MHP will determine if you need specialty mental health services from the MHP. If a professional decides you are not in need of specialty mental health services, you may still be treated by your regular medical doctor or primary care provider, or you may Appeal that decision (see page 23).

You may need help if you have SEVERAL of the following feelings:

- Depressed (or feeling hopeless or helpless or worthless or very down) most of the day, nearly every day
- Loss of interest in pleasurable activities
- Weight loss or gain of more than 5% in one month
- Excessive sleep or lack of sleep
- Slowed or excessive physical movements
- Fatigue nearly every day
- Feelings of worthlessness or excessive guilt
- Difficulty thinking or concentrating or making a decision
- Decreased need for sleep – feeling ‘rested’ after only a few hours of sleep
- ‘Racing’ thoughts too fast for you to keep up with
- Talking very fast and can’t stop talking
- Feel that people are ‘out to get you’
- Hear voices and sounds others do not hear
- See things others do not see
- Unable to go to work or school



If you feel you have several of the signs listed, and feel this way for several weeks, you may want to be assessed by a professional. If you are not sure, you should ask your family doctor or other health care professional for their opinion.

- Do not care about personal hygiene (being clean)
- Have serious relationship problems
- Isolate or withdraw from other people
- Cry frequently and for ‘no reason’
- Are often angry and ‘blow up’ for ‘no reason’
- Have severe mood swings
- Feel anxious or worried most of the time
- Have what others call strange or bizarre behaviors

What Services Are Available?

As an adult on Medi-Cal, you may be eligible to receive specialty mental health services from the MHP. Your MHP is required to help you determine if you need these services. Some of the services your county’s MHP is required to make available, if you need them, include:

Mental Health Services – These services include mental health treatment services, such as counseling and psychotherapy, provided by psychiatrists, psychologists, licensed clinical social workers, marriage and family therapists and psychiatric nurses. Mental health services may also be called rehabilitation or recovery services, and they help a person with mental illness to develop coping skills for daily living. Mental health services can be provided in a clinic or provider office, over the phone, or in the home or other community setting.

- These services may sometimes be provided to one person at a time (individual therapy or rehabilitation), two or more people at the same time (group therapy or group rehabilitation services), and to families (family therapy).

Medication Support Services – These services include the prescribing, administering, dispensing and monitoring of psychiatric medicines; medication management by psychiatrists; and education and monitoring related to psychiatric medicines. Medication support services can be provided in a clinic or provider office, over the phone, or in the home or other community setting.

Targeted Case Management – This service helps with getting medical, educational, social, prevocational, vocational, rehabilitative, or other community services when these services may be hard for people with mental illness to do on their own. Targeted case management includes plan development; communication, coordination, and referral; monitoring service delivery to ensure the person’s access to service and the service delivery system; and monitoring of the person’s progress.

Crisis Intervention and Crisis Stabilization – These services provide mental health treatment for people with a mental health problem that can’t wait for a regular, scheduled appointment. Crisis intervention can last up to eight hours and can be provided in a clinic or provider office, over the phone, or in the home or other community setting. Crisis stabilization can last up to 20 hours and is provided in a clinic or other facility site.

Adult Residential Treatment Services – These services provide mental health treatment for people who are living in licensed facilities that provide residential services for people with mental illness. These services are available 24-hours a day, seven days a week. Medi-Cal doesn't cover the room and board cost to be in the facility that offers adult residential treatment services.

Crisis Residential Treatment Services – These services provide mental health treatment for people having a serious psychiatric episode or crisis, but who do not present medical complications requiring nursing care. Services are available 24-hours a day, seven days a week in licensed facilities that provide residential crisis services to people with mental illness. Medi-Cal doesn't cover the room and board cost to be in the facility that offers adult residential treatment services.

Day Treatment Intensive - This is a structured program of mental health treatment provided to a group of people who might otherwise need to be in the hospital or another 24-hour care facility. The program lasts at least three hours a day. People can go to their own homes at night. The program includes skill-building activities (life skills, socialization with other people, etc.) and therapies (art, recreation, music, dance, etc.), as well as psychotherapy.

Day Rehabilitation – This is a structured program of mental health treatment to improve, maintain or restore independence and functioning. The program is designed to help people with mental illness learn and develop skills. The program lasts at least three hours per day. People go to their own homes at night. The program includes skill-building activities (life skills, socialization with other people, etc.) and therapies (art, recreation, music, dance, etc.).

Psychiatric Inpatient Hospital Services – These are services provided in a hospital where the person stays overnight either because there is a psychiatric emergency or because the person needs mental health treatment that can only be done in the hospital.

Psychiatric Health Facility Services – These services are provided in a hospital-like setting where the person stays overnight either because there is a psychiatric emergency or because the person needs mental health treatment that can only be done in a hospital-like setting. Psychiatric health facilities must have an arrangement with a nearby hospital or clinic to meet the physical health care needs of the people in the facility.

These services also include work that the provider does to help make the services work better for the person receiving the services. These kinds of things include assessments to see if you need the service and if the service is working; plan development to decide the goals of the person's mental health treatment and the specific services that will be provided; and "collateral", which means working with family members and important people in the person's life (if the person gives permission), if it will help the person improve or maintain his or her mental health status.

Each county's MHP may have slightly different ways of making these services available, so please consult the front section of this booklet for more information, or contact your MHP's toll-free phone number to ask for additional information.

How Do I Know When A Child Needs Help?

For children from birth to age 5, there are signs that may show a need for specialty mental health services. These include:

- Parents who feel overwhelmed by being a parent or who have mental health problems
- A major source of stress in the family, such as divorce or death of a family member
- Abuse of alcohol or other drugs by someone in the house
- Unusual or difficult behavior by the child
- Violence or disruption in the house

If one of the above conditions is present in a house where a child up to age 5 is living, specialty mental health services may be needed. You should contact your county's MHP to request additional information and an assessment for services to see if the MHP can help you.

For school-age children, the following checklist includes some signs that should help you decide if your child would benefit from mental health services. Your child:

- Displays unusual changes in emotions or behavior
- Has no friends or has difficulty getting along with other children
- Is doing poorly in school, misses school frequently or does not want to attend school
- Has many minor illnesses or accidents
- Is very fearful
- Is very aggressive
- Does not want to be away from you
- Has many disturbing dreams
- Has difficulty falling asleep, wakes up during the night, or insists on sleeping with you
- Suddenly refuses to be alone with a certain family member or friend or acts very disturbed when the family member or friend is present
- Displays affection inappropriately or makes abnormal sexual gestures or remarks
- Becomes suddenly withdrawn or angry
- Refuses to eat
- Is frequently tearful

You may contact your county's MHP for an assessment for your child if you feel he or she is showing any of the signs above. If your child qualifies for Medi-Cal and the MHP's assessment indicates that specialty mental health services covered by the MHP are needed, the MHP will arrange for the child to receive the services.

How Do I Know When An Adolescent Or Young Person Needs Help?

Adolescents (12-18 years of age) are under many pressures facing teens. Young people aged 18 to 21 are in a transitional age with their own unique pressures and, since they are legally adults, are able to seek services as adults.

Some unusual behavior by an adolescent or young person may be related to the physical and psychological changes taking place as they become an adult. Young adults are establishing a sense of self-identity and shifting from relying on parents to independence. A parent or concerned friend, or the young person may have difficulty deciding between what 'normal behavior' is and what may be signs of emotional or mental problems that require professional help.

Some mental illnesses can begin in the years between 12 and 21. The checklist below should help you decide if an adolescent requires help. If more than one sign is present or persists over a long period of time, it may indicate a more serious problem requiring professional help. If an adolescent:

- Pulls back from usual family, friend and/or normal activities
- Experiences an unexplained decline in school work
- Neglects their appearance
- Shows a marked change in weight
- Runs away from home
- Has violent or very rebellious behavior
- Has physical symptoms with no apparent illness
- Abuses drugs or alcohol

Parents or caregivers of adolescents, or the adolescent may contact the county's MHP for an assessment to see if mental health services are needed. As an adult; a young person (age 18 to 20) may ask the MHP for an assessment. If the adolescent or young person qualifies for Medi-Cal and the MHP's assessment indicates that specialty mental health services covered by the MHP are needed, the MHP will arrange for the adolescent or young person to receive the services.

What Services Are Available?

The same services that are available for adults are also available for children, adolescents and young people. The services that are available are mental health services, medication support services, targeted case management, crisis intervention, crisis stabilization, day treatment intensive, day rehabilitation, adult residential treatment services, crisis residential treatment services, psychiatric inpatient hospital services, and psychiatric health facility services. MHPs also cover additional special services that are only available to children, adolescents and young people under age 21 and eligible for full-scope Medi-Cal (full-scope Medi-Cal means that Medi-Cal coverage isn't limited to a specific type of services, for example, emergency services only).

Each county's MHP may have slightly different ways of making these services available, so please consult the front section of this booklet for more information, or contact your MHP's toll-free phone number to ask for additional information.



A young person aged 18 to 21 should look at the list to the right and at the list of issues for adults on pages 9 and 10 to help decide if mental health services may be needed.

Are There Special Services Available For Children, Adolescents And Young Adults?

There are special services available from the MHP for children, adolescents and young people called Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) supplemental specialty mental health services. These EPSDT services include a service called Therapeutic Behavioral Services or TBS, which is described in the next section, and also include new services as they are identified by experts in mental health treatment as services that really work. These services are available from the MHP if they are needed to correct or ameliorate (improve) the mental health for a person under the age of 21 who is eligible for full-scope Medi-Cal and has a mental illness covered by the MHP (see page 10 for information on the mental illnesses covered by the MHP).

The MHP is not required to provide these special services if the MHP decides that one of the regular services covered by the MHP is available and would meet the child, adolescent, or young person's needs. The MHP is also not required to provide these special services in home and community settings if the MHP determines the total cost of providing the special services at home or in the community is greater than the total cost of providing similar services in an otherwise appropriate institutional level of care.

What Are Therapeutic Behavioral Services (TBS)?

TBS are a type of specialty mental health service available through each county's MHP if you have serious emotional problems. You must be under 21 and have full-scope Medi-Cal to get TBS.

- If you are living at home, the TBS staff person can work one-to-one with you to reduce severe behavior problems to try to keep you from needing to go to a higher level of care, such as a group home for children, adolescents and young people with very serious emotional problems.
- If you are living in a group home for children, adolescents and young people with very serious emotional problems, a TBS staff person can work with you so you may be able to move to a lower level of care, such as a foster home or back home. TBS will help you and your family, caregiver or guardian learn new ways of controlling problem behavior and ways of increasing the kinds of behavior that will allow you to be successful. You, the TBS staff person, and your family, caregiver or guardian will work together very intensively for a short period of time, until you no longer need TBS. You will have a TBS plan that will say what you, your family, caregiver or guardian, and the TBS staff person will do during TBS, and when and where TBS will occur. The TBS staff person can work with you in most places where you are likely to need help with your problem behavior. This includes your home, foster home, group home, school, day treatment program and other areas in the community.

Who Can Get TBS?

You may be able to get TBS if you have full-scope Medi-Cal, are under 21 years old, have serious emotional problems AND:

- Live in a group home for children, adolescents and young people with very serious emotional problems. (These group homes are sometimes called Rate Classification Level [RCL] 12, 13 or 14 group homes); OR
- Live in a state mental health hospital, a nursing facility that specializes in mental health treatment or a Mental Health Rehabilitation Center (these places are also called institutions for mental diseases or IMDs); OR
- Are at risk of having to live in a group home (RCL 12, 13 or 14), a mental health hospital or IMD; OR
- Have been hospitalized, within the last 2 years, for emergency mental health problems.

Are There Other Things That Must Happen For Me To Get TBS?

Yes. You must be getting other specialty mental health services. TBS adds to other specialty mental health services. It doesn't take the place of them. Since TBS is short-term, other specialty mental health services may be needed to keep problems from coming back or getting worse after TBS has ended.

TBS is NOT provided if the reason it is needed is:

- Only to help you follow a court order about probation
- Only to protect your physical safety or the safety of other people
- Only to make things easier for your family, caregiver, guardian or teachers
- Only to help with behaviors that are not part of your mental health problems

You cannot get TBS while you are in a mental health hospital, an IMD, or locked juvenile justice setting, such as a juvenile hall. If you are in a mental health hospital or an IMD, though, you may be able to leave the mental hospital or IMD sooner, because TBS can be added to other specialty mental health services to help you stay in a lower level of care (home, a foster home or a group home).

How Do I Get TBS?

If you think you may need TBS, ask your psychiatrist, therapist or case manager, if you already have one, or contact the MHP and request services. A family member, caregiver, guardian, doctor, psychologist, counselor or social worker may call and ask for information about TBS or other specialty mental health services for you. You may also call the MHP and ask about TBS.

Who Decides If I Need TBS And Where Can I Get Them?

The MHP decides if you need specialty mental health services, including TBS. Usually an MHP staff person will talk with you, your family, caregiver or guardian, and others who are important in your life and will make a plan for all the mental health services you need, including a TBS plan if TBS is needed. This may take one or two meetings face-to-face, sometimes more. If you need TBS, someone will be assigned as your TBS staff person.

What Should Be In My TBS Plan?

Your TBS plan will spell out the problem behaviors that need to change and what the TBS staff person, you and sometimes your family, caregiver or guardian will do when TBS happens. The TBS plan will say how many hours a day and the number of days a week the TBS staff person will work with you and your family, caregiver or guardian. The hours in the TBS Plan may be during the day, early morning, evening or night. The days in the TBS Plan may be on weekends as well as weekdays. The TBS plan will say how long you will receive TBS. The TBS Plan will be reviewed regularly. TBS may go on for a longer period of time, if the review shows you are making progress but need more time.

■ 'Medical Necessity' Criteria

What Is 'Medical Necessity' And Why Is It So Important?

One of the conditions necessary for receiving specialty mental health services through your county's MHP is something called 'medical necessity.' This means a doctor or other mental health professional will talk with you to decide if there is a medical need for services, and if you can be helped by services if you receive them.

The term 'medical necessity' is important because it will help decide what kind of services you may get and how you may get them. Deciding 'medical necessity' is a very important part of the process of getting specialty mental health services.



What Are The 'Medical Necessity' Criteria For Coverage Of Specialty Mental Health Services Except For Hospital Services?

As part of deciding if you need specialty mental health services, your county's MHP will work with you and your provider to decide if the services are a 'medical necessity,' as explained above. This section explains how your MHP will make that decision.

You don't need to know if you have a diagnosis, or a specific mental illness, to ask for help. Your county MHP will help you get this information with an 'assessment.'

There are four conditions your MHP will look for to decide if your services are a 'medical necessity' and qualify for coverage by the MHP:

(1) You must be diagnosed by the MHP with one of the following mental illnesses as described in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association:

- Pervasive Developmental Disorders, except Autistic Disorders
- Disruptive Behavior and Attention Deficit Disorders
- Feeding and Eating Disorders of Infancy and Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood, or Adolescence
- Schizophrenia and other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilias
- Gender Identity Disorder
- Eating Disorders
- Impulse Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders, excluding Antisocial Personality Disorder
- Medication-Induced Movement Disorders related to other included diagnoses

You don't need to know what kind of mental illness you have to ask the MHP for an assessment to see if you need specialty mental health services from the MHP.

AND

(2) You must have at least one of the following problems as a result of the diagnosis:

- A significant difficulty in an important area of life-functioning
- A probability of significant deterioration in an important area of life functioning
- Except as provided in the section for people under 21 years of age, a probability that a child will not progress developmentally as individually appropriate

AND

(3) The expectation is that the proposed treatment will:

- Significantly reduce the problem
- Prevent significant deterioration in an important area of life-functioning
- Allow a child to progress developmentally as individually appropriate

AND

(4) The condition would not be responsive to physical health care based treatment.

When the requirements of this 'medical necessity' section are met, you are eligible to receive specialty mental health services from the MHP.

If you do NOT meet these criteria, it does not mean that you cannot receive help. Help may be available from your regular Medi-Cal doctor, or through the standard Medi-Cal program.

What Are The 'Medical Necessity' Criteria for Specialty Mental Health Services For People Under 21 Years of Age?

If you are under the age of 21, have full-scope Medi-Cal and have one of the diagnosis listed in (1) above, but don't meet the criteria in (2) and (3) above, the MHP would need to work with you and your provider to decide if mental health treatment would correct or ameliorate (improve) your mental health. If services covered by the MHP would correct or improve your mental health, the MHP will provide the services.

What Are The 'Medical Necessity' Criteria For Reimbursement Of Psychiatric Inpatient Hospital Services?

One way that your MHP decides if you need to stay overnight in the hospital for mental health treatment is how 'medically necessary' it is for your treatment. If it is medically necessary, as explained above, then your MHP will pay for your stay in the hospital. An assessment will be made to help make this determination.

When you and the MHP or your MHP provider plan for your admission to the hospital, the MHP will decide about medical necessity before you go to the hospital. More often, people go to the hospital in an emergency and the MHP and the hospital work together to decide about medical necessity. You don't need to worry about whether or not the services are medically necessary if you go to the hospital in an emergency (see State of California page 6 for more information about how emergencies are covered).

If you need these hospital services, your MHP pays for an admission to the hospital, if you meet the conditions to the right, called medical necessity criteria.

You have a mental illness or symptoms of mental illness and you cannot be safely treated at a lower level of care, and, because of the mental illness or symptoms of mental illness, you:

- Represent a current danger to yourself or others, or significant property destruction
- Are prevented from providing for or using food, clothing or shelter
- Present a severe risk to your physical health
- Have a recent, significant deterioration in ability to function, and
- Need psychiatric evaluation, medication treatment, or other treatment that can only be provided in the hospital.

Your county's MHP will pay for a longer stay in a psychiatric inpatient hospital if you have one of the following:

- The continued presence of the 'medical necessity' criteria described above
- A serious and negative reaction to medications, procedures or therapies requiring continued hospitalization
- The presence of new problems which meet medical necessity criteria
- The need for continued medical evaluation or treatment that can only be provided in a psychiatric inpatient hospital

Your county's MHP can have you released from a psychiatric inpatient (overnight stay) hospital when your doctor says you are stable. This means when the doctor expects you would not get worse if you were transferred out of the hospital.

What Is A Notice of Action?

A Notice of Action sometimes called an NOA, is a form that your county's Mental Health Plan (MHP) uses to tell you when the MHP makes a decision about whether or not you will get Medi-Cal specialty mental health services. A Notice of Action is also used to tell you if your Grievance, Appeal, or expedited Appeal was not resolved in time, or if you didn't get services within the MHP's timeline standards for providing services.



When Will I Get A Notice of Action?

You will get a Notice of Action:

- If your MHP or one of the MHP's providers decides that you do not qualify to receive any Medi-Cal specialty mental health services because you do not meet the medical necessity criteria. See page 17 for information about medical necessity.
- If your provider thinks you need a specialty mental health service and asks the MHP for approval, but the MHP does not agree and says "no" to your provider's request, or changes the type or frequency of service. Most of the time you will receive a Notice of Action before you receive the service, but sometimes the Notice of Action will come after you already received the service, or while you are receiving the service. If you get a Notice of Action after you have already received the service, you do not have to pay for the service.
- If your provider has asked the MHP for approval, but the MHP needs more information to make a decision and doesn't complete the approval process on time.
- If your MHP does not provide services to you based on the timelines the MHP has set up. Call your county's MHP to find out if the MHP has set up timeline standards.
- If you file a Grievance with the MHP and the MHP does not get back to you with a written decision on your Grievance within 60 days. See page 28 for more information on Grievances.
- If you file an Appeal with the MHP and the MHP does not get back to you with a written decision on your Appeal within 45 days, or if you filed an expedited Appeal within three working days. See page 23 for more information on Appeals.

Please see the next section in this booklet on the Problem Resolution Processes for more information on Grievances, Appeals and State Fair Hearings.

Will I Always Get A Notice of Action When I Don't Get The Services I Want?

There are some cases where you may not receive a Notice of Action. If you and your provider do not agree on the services you need, you will not get a Notice of Action from the MHP. If you think the MHP is not providing services to you quickly enough, but the MHP hasn't set a timeline, you won't receive a Notice of Action.

You may still file an Appeal with the MHP or request a State Fair Hearing when these things happen. Information on how to file an Appeal or request a State Fair Hearing is included in this booklet starting on page 22. Information should also be available in your provider's office.

What Will The Notice of Action Tell Me?

The Notice of Action will tell you:

- What your county's MHP did that affects you and your ability to get services.
- The effective date of the decision and the reason the MHP made its decision.
- The state or federal rules the MHP was following when it made the decision.
- What your rights are if you do not agree with what the MHP did.
- How to file an Appeal with the MHP.
- How to request a State Fair Hearing.
- How to request an expedited Appeal or an expedited State Fair Hearing.
- How to get help filing an Appeal or requesting a State Fair Hearing.
- How long you have to file an Appeal or request a State Fair Hearing.
- If you are eligible to continue to receive services while you wait for a State Fair Hearing decision.
- When you have to file your State Fair Hearing request if you want the services to continue.

You should decide if you agree with what the MHP says on the form. If you decide that you don't agree, you can file an Appeal with your MHP or request a State Fair Hearing, being careful to file on time. Most of the time, you will have 90 days to request a State Fair Hearing or file an Appeal.

What Should I Do When I Get A Notice of Action?

When you get a Notice of Action you should read all the information on the form carefully. If you don't understand the form, your MHP can help you. You may also ask another person to help you.

If the Notice of Action form tells you that you can continue services while you are waiting for a State Fair Hearing decision, you must request the State Fair Hearing within 10 days from the date the Notice of Action was mailed or personally given to you or, if the Notice of Action is sent more than 10 days before the effective date for the change in services, before the effective date of the change.

■ Problem Resolution Processes

What If I Don't Get the Services I Want From My County MHP?

Your county's MHP has a way for you to work out a problem about any issue related to the specialty mental health services you are receiving. This is called the problem resolution process and it could involve:

- 1. The Appeal Process** - review of a decision (denial or changes to services) that was made about your specialty mental health services by the MHP or your provider.
- 2. The State Fair Hearing Process** - review to make sure you receive the mental health services which you are entitled to under the Medi-Cal program.
- 3. The Grievance Process** - an expression of unhappiness about anything regarding your specialty mental health services that is not one of the problems covered by the Appeal and State Fair Hearing processes.

Your MHP will provide Grievance and Appeal forms and self-addressed envelopes for you at all provider sites, and you should not have to ask anyone to get one. Your county's MHP must post notices explaining the Grievance and Appeal process procedures in locations at all provider sites, and make language interpreting services available at no charge, along with toll-free numbers to help you during normal business hours.

You will not be punished for filing a Grievance, Appeal or State Fair Hearing. When your Grievance or Appeal is complete, your county's MHP will notify you and others involved of the final outcome. When your State Fair Hearing is complete, the State Hearing Office will notify you and others involved of the final outcome.

The State's Mental Health Ombudsman Services can be reached at (800) 896-4042 (interpreter services are available) or TTY (800) 896-2512, by sending a fax to (916) 653-9194, or by e-mailing to ombudsmn@dmhhq.state.ca.us.

Can I Get Help To File An Appeal, Grievance Or State Fair Hearing?

Your county's MHP will have people available to explain these processes to you and to help you report a problem either as an Appeal, a Grievance, or as a request for State Fair Hearing. They may also help you know if you qualify for what's called an 'expedited' process, which means it will be reviewed more quickly because your health or stability is at risk. You may also authorize another person to act on your behalf, including your mental health care provider.

What If I Need Help To Solve A Problem With My MHP But Don't Want To File A Grievance Or Appeal?

You can get help from the State if you are having trouble finding the right people at the MHP to help you find your way through the MHP system. The State has a Mental Health Ombudsman Services program that can provide you with information on how the MHP system works, explain your rights and choices, help you solve problems with getting the services you need, and refer you to others at the MHP or in your community who may be of help.

■ ■ ■ ■ THE Appeals PROCESSES (Standard and Expedited)

Your MHP is responsible for allowing you to request a review of a decision that was made about your specialty mental health services by the MHP or your providers. There are two ways you can request a review. One way is using the standard Appeals process. The second way is by using the expedited Appeals process. These two forms of Appeals are similar; however, there are specific requirements to qualify for an expedited Appeal. The specific requirements are explained below.

What Is A Standard Appeal?

A Standard Appeal is a request for review of a problem you have with the MHP or your provider that involves denial or changes to services you think you need. If you request a standard Appeal, the MHP may take up to 45 days to review it. If you think waiting 45 days will put your health at risk, you should ask for an ‘expedited Appeal.’

The standard Appeals process will:

- Allow you to file an Appeal in person, on the phone, or in writing. If you submit your Appeal in person or on the phone, you must follow it up with a signed, written Appeal. If you do not follow-up with a signed written Appeal, your Appeal will not be resolved. However, the date that you submitted the oral Appeal is the filing date.
- Ensure filing an Appeal will not count against you or your provider in any way.
- Allow you to authorize another person to act on your behalf, including a provider. If you authorize another person to act on your behalf, the MHP might ask you to sign a form authorizing the MHP to release information to that person.
- Ensure that the individuals making the decisions are qualified to do so and not involved in any previous level of review or decision-making.
- Allow you or your representative to examine your case file, including your medical record, and any other documents or records considered during the Appeal process, before and during the Appeal process.
- Allow you to have a reasonable opportunity to present evidence and allegations of fact or law, in person or in writing.
- Allow you, your representative, or the legal representative of a deceased beneficiary’s estate to be included as parties to the Appeal.
- Let you know your Appeal is being reviewed by sending you written confirmation.
- Inform you of your right to request a State Fair Hearing at any time during the Appeal process.

When Can I File An Appeal?

You can file an Appeal with your county's MHP:

- If your MHP or one of the MHP's providers decides that you do not qualify to receive any Medi-Cal specialty mental health services because you do not meet the medical necessity criteria. (See page 17 for information about medical necessity.)
- If your provider thinks you need a specialty mental health service and asks the MHP for approval, but the MHP does not agree and says "no" to your provider's request, or changes the type or frequency of service.
- If your provider has asked the MHP for approval, but the MHP needs more information to make a decision and doesn't complete the approval process on time.
- If your MHP doesn't provide services to you based on the timelines the MHP has set up.
- If you don't think the MHP is providing services soon enough to meet your needs.
- If your Grievance, Appeal or expedited Appeal wasn't resolved in time.
- If you and your provider do not agree on the services you need.

How Can I File An Appeal?

See the front part of this booklet for information on how to file an Appeal with your MHP. You may call your county MHP's toll-free telephone number (also included in the front part of this booklet) to get help with filing an Appeal. The MHP will provide self-addressed envelopes at all provider sites for you to mail in your Appeal.

How Do I Know If My Appeal Has Been Decided?

Your MHP will notify you or your representative in writing about their decision for your Appeal. The notification will have the following information:

- The results of the Appeal resolution process
- The date the Appeal decision was made
- If the Appeal is not resolved wholly in your favor, the notice will also contain information regarding your right to a State Fair Hearing and the procedure for filing a State Fair Hearing.

Is There A Deadline To File An Appeal?

You must file an Appeal within 90 days of the date of the action you're Appealing when you get a Notice of Action (see page 20). Keep in mind that you will not always get a Notice of Action. There are no deadlines for filing an Appeal when you do not get a Notice of Action, so you may file at any time.

When Will A Decision Be Made About My Appeal?

The MHP must decide on your Appeal within 45 calendar days from when the MHP receives your request for the Appeal. Timeframes may be extended by up to 14 calendar days if you request an extension, or if the MHP feels that there is a need for additional information and that the delay is for your benefit. An example of when a delay might be for your benefit is when the MHP thinks it might be able to approve your Appeal if the MHP had a little more time to get information from you or your provider.

What If I Can't Wait 45 Days For My Appeal Decision?

The Appeal process may be faster if it qualifies for the expedited Appeals process. (Please see the section on Expedited Appeals below.) You have the right to request a State Fair Hearing at any time during the Appeals process.

What Is An Expedited Appeal?

An expedited Appeal is a faster way to decide an Appeal. The expedited Appeals process follows a process similar to the standard Appeals process. However,

- Your Appeal has to meet certain requirements (see below).
- The expedited Appeals process also follows different deadlines than the standard Appeals process.
- You can make a verbal request for an expedited Appeal. You do not have to put your expedited Appeal request in writing.

When Can I File an Expedited Appeal?

If you think that waiting up to 45 days for a standard Appeal decision will jeopardize your life, health or ability to attain, maintain or regain maximum function, you may request an expedited Appeal. If the MHP agrees that your Appeal meets the requirements for an expedited Appeal, your MHP will resolve your expedited Appeal within 3 working days after the MHP receives the expedited Appeal. Timeframes may be extended by up to 14 calendar days if you request an extension, or if the MHP feels that there is a need for additional information and that the delay is in your interest. If your MHP extends the timeframes, the MHP will give you a written explanation as to why the timeframes were extended.

If the MHP decides that your Appeal does not qualify for an expedited Appeal, your MHP will notify you right away orally and will notify you in writing within 2 calendar days. Your Appeal will then follow the standard Appeal timeframes outlined earlier in this section. If you disagree with the MHP's decision that your Appeal doesn't meet the expedited Appeal criteria, you may file a Grievance (see the description of the Grievance process below).

Once your MHP resolves your expedited Appeal, the MHP will notify you and all affected parties orally and in writing.

THE State Fair Hearing PROCESSES (Standard and Expedited)

What Is A State Fair Hearing?

A State Fair Hearing is an independent review conducted by the California Department of Social Services to ensure you receive the specialty mental health services to which you are entitled under the Medi-Cal program.

What Are My State Fair Hearing Rights?

You have the right to:

- Have a hearing before the California Department of Social Services (also called a State Fair Hearing).
- Be told about how to ask for a State Fair Hearing.
- Be told about the rules that govern representation at the State Fair Hearing.
- Have your benefits continued upon your request during the State Fair Hearing process if you ask for a State Fair Hearing within the required timeframes.
- Ask for a State Fair Hearing whether or not you use the MHP's Appeal process and whether or not you have received a Notice of Action as described earlier in this booklet.



When Can I File For A State Fair Hearing?

You can file for a State Fair Hearing:

- If your MHP or one of the MHP's providers decides that you do not qualify to receive any Medi-Cal specialty mental health services because you do not meet the medical necessity criteria. (See page 17 for information about medical necessity.)
- If your provider thinks you need a specialty mental health service and asks the MHP for approval, but the MHP does not agree and says "no" to your provider's request, or changes the type or frequency of service.
- If your provider has asked the MHP for approval, but the MHP needs more information to make a decision and doesn't complete the approval process on time.
- If your MHP doesn't provide services to you based on the timelines the MHP has set up.
- If you don't think the MHP is providing services soon enough to meet your needs.
- If your Grievance, Appeal or expedited Appeal wasn't resolved in time.
- If you and your provider do not agree on the services you need.

How Do I Request a State Fair Hearing?

You can request a State Fair Hearing directly from the California Department of Social Services. You can ask for a State Fair Hearing by writing to:

State Hearing Division
California Department of Social Services
P.O. Box 9424443, Mail Station 19-37
Sacramento, CA 94244-2430

To request a State Fair Hearing, you may also call **(800) 952-5253**, send a fax to **(916) 229-4110**, or write to the Department of Social Services/State Hearings Division, P.O. Box 944243, Mail Station 19-37, Sacramento, CA 94244-2430.

Is There A Deadline For Filing For A State Fair Hearing?

If you didn't receive a Notice of Action or file an Appeal with the MHP, you may file for a State Fair Hearing at any time.

If you get a Notice of Action and decide to file for a State Fair Hearing instead of, or in addition to, filing an Appeal with the MHP, you must file for the State Fair Hearing within 90 days of the date your Notice of Action was mailed or personally given to you.

If you file an Appeal with the MHP and want to file for a State Fair Hearing after you get the MHP's decision on your Appeal, you must file for the State Fair Hearing within 90 days of the postmark date of the MHP's Appeal decision.

If you get a Notice of Action and decide to file for a State Fair Hearing instead of, or in addition to, filing an Appeal with the MHP, you must file for the State Fair Hearing within 90 days of the date your Notice of Action was mailed or personally given to you.

Can I Continue Services While I'm Waiting For A State Fair Hearing Decision?

You can continue services while you're waiting for a State Fair Hearing decision if your provider thinks the specialty mental health service you are already receiving need to continue and asks the MHP for approval to continue, but the MHP does not agree and says "no" to your provider's request, or changes the type or frequency of service the provider requested. You will always receive a Notice of Action from the MHP when this happens. Additionally, you will not have to pay for services given while the State Fair Hearing is pending.

What Do I Need To Do If I Want To Continue Services While I'm Waiting For A State Fair Hearing Decision?

If you want services to continue during the State Fair Hearing process, you must request a State Fair Hearing within 10 days from the date your Notice of Action was mailed or personally given to you.

What If I Can't Wait 90 Days For My State Fair Hearing Decision?

You may ask for an expedited (quicker) State Fair Hearing if you think the normal 90-day timeframe will cause serious problems with your mental health, including problems with your ability to gain, maintain, or regain important life functions. The Department of Social Services, State Hearings Division, will review your request for an expedited State Fair Hearing and decide if it qualifies. If your expedited hearing request is approved, a hearing will be held and a hearing decision will be issued within 3 working days of the date your request is received by the State Hearings Division.

THE Grievance PROCESS

In 2003, some of the words used to describe the MHP processes to help you solve problems with the MHP have changed. Please note that State Fair Hearings cannot help you with the problems for which you can file a Grievance. You may no longer request a State Fair Hearing at any time during the Grievance process; however, you may request a State Fair Hearing during the Appeal process.

What Is A Grievance?

A Grievance is an expression of unhappiness about anything regarding your specialty mental health services that are not one of the problems covered by the Appeal and State Fair Hearing processes (see pages 23 and 26 for information on the Appeal and State Fair Hearing processes).

The Grievance process will:

- Involve simple, and easily understood procedures that allow you to present your Grievance orally or in writing.
- Not count against you or your provider in any way.
- Allow you to authorize another person to act on your behalf, including a provider. If you authorize another person to act on your behalf, the MHP might ask you to sign a form authorizing the MHP to release information to that person.
- Ensure that the individuals making the decisions are qualified to do so and not involved in any previous levels of review or decision-making.
- Identify the roles and responsibilities of you, your MHP and your provider.
- Provide resolution for the Grievance in the required timeframes.

When Can I File A Grievance?

You can file a Grievance with the MHP if you are unhappy with the specialty mental health services you are receiving from the MHP or have another concern regarding the MHP.

How Can I File A Grievance?

You may call your county MHP's toll-free telephone number to get help with a Grievance. The MHP will provide self-addressed envelopes at all the providers' sites for you to mail in your Grievance. Grievances can be filed orally or in writing. Oral Grievances do not have to be followed up in writing.

How Do I Know If The MHP Received My Grievance?

Your MHP will let you know that it received your Grievance by sending you a written confirmation.

When Will My Grievance Be Decided?

The MHP must make a decision about your Grievance within 60 calendar days from the date you filed your Grievance. Timeframes may be extended by up to 14 calendar days if you request more time, or if the MHP feels there is a need for additional information and that the delay was for your benefit. An example of when a delay might be for your benefit is when the MHP thinks it might be able to approve your Grievance if the MHP had a little more time to get information from you or other people involved.

How Do I Know If The MHP Has Made A Decision About My Grievance?

When a decision has been made regarding your Grievance, the MHP will notify you or your representative in writing of the decision. If your MHP fails to notify you or any affected parties of the Grievance decision on time, the MHP will provide you with a Notice of Action advising you of your right to request a State Fair Hearing. Your MHP will provide you with a Notice of Action on the date the timeframe expires.

Is There A Deadline To File To Grievance?

You may file a Grievance at any time.

What Are My Rights?

As a person eligible for Medi-Cal, you have a right to receive medically necessary specialty mental health services from the MHP. When accessing these services, you have the right to:



- Be treated with personal respect and respect for your dignity and privacy.
- Receive information on available treatment options and alternatives; and have them presented in a manner you can understand.
- Participate in decisions regarding your mental health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, punishment or retaliation as specified in federal rules about the use of restraints and seclusion in facilities such as hospitals, nursing facilities and psychiatric residential treatment facilities where you stay overnight for treatment.
- Request and receive a copy of your medical records, and request that they be amended or corrected.
- Receive the information in this booklet about the services covered by the MHP, other obligations of the MHP and your rights as described here. You also have the right to receive this information and other information provided to you by the MHP in a form that is easy to understand. This means, for example, that the MHP must make its written information available in the languages that are used by at least 5 percent or 3,000, whichever is less, of Medi-Cal eligible people in the MHP's county and make oral interpreter services available free of charge for people who speak other languages. This also means that the MHP must provide different materials for people with special needs, such as people who are blind or have limited vision or people who have trouble reading.
- Receive specialty mental health services from a MHP that follows the requirements of its contract with the State in the areas of availability of services, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services. The MHP is required to:
 - Employ or have written contracts with enough providers to make sure that all Medi-Cal eligible individuals who qualify for specialty mental health services can receive them in a timely manner.
 - Cover medically necessary services out-of-network for you in a timely manner, if the MHP doesn't have an employee or contract provider who can deliver the services. "Out-of-network provider" means a provider who is not on the MHP's list of providers. The MHP must make sure you don't pay anything extra for seeing an out-of-network provider.
 - Make sure providers are qualified to deliver the specialty mental health services that the providers agreed to cover.

- Make sure that the specialty mental health services the MHP covers are adequate in amount, duration and scope to meet the needs of the Medi-Cal eligible individuals it serves. This includes making sure the MHP's system for authorizing payment for services is based on medical necessity and uses processes that ensure fair application of the medical necessity criteria.
- Ensure that its providers perform adequate assessments of individuals who may receive services and work with the individuals who will receive services to develop a treatment plan that includes the goals of treatment and the services that will be delivered.
- Provide for a second opinion from a qualified health care professional within the MHP's network, or one outside the network, at no additional cost to you.
- Coordinate the services it provides with services being provided to an individual through a Medi-Cal managed care health plan or with your primary care provider, if necessary, and in the coordination process, to make sure the privacy of each individual receiving services is protected as specified in federal rules on the privacy of health information.
- Provide timely access to care, including making services available 24-hours a day, 7 days a week, when medically necessary to treat an emergency psychiatric condition or an urgent or crisis condition.
- Participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

Your MHP must ensure your treatment is not adversely affected as a result of you using your rights. Your Mental Health Plan is required to follow other applicable Federal and State laws (such as: title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; and titles II and III of the Americans with Disabilities Act) as well as the rights described here. You may have additional rights under state laws about mental health treatment and may wish to contact your county's Patients' Rights Advocate (call your county mental health department listed in the local phone book and ask for the Patients' Rights Advocate) with specific questions.

■■■■ ADVANCE DIRECTIVES

What Is An Advance Directive?

You have the right to have an advance directive. An advance directive is a written instruction about your health care that is recognized under California law. It usually states how you would like health care provided, or says what decisions you would like to be made, if or when you are unable to speak for yourself. You may sometimes hear an advance directive described as a living will or durable power of attorney.



California law defines an advance directive as either an oral or written individual health care instruction or a power of attorney (a written document giving someone permission to make decisions for you). All MHPs are required to have advance directive policies in place. Your MHP is required to provide any adult who is Medi-Cal eligible with written information on the MHP's advance directive policies and a description of applicable state law, if the adult asks for the information. If you would like to request the information, you should call your MHP's toll-free phone number listed in the front part of this booklet for more information.

An advance directive is designed to allow people to have control over their own treatment, especially when they are unable to provide instructions about their own care. It is a legal document that allows people to say, in advance, what their wishes would be, if they become unable to make health care decisions. This may include such things as the right to accept or refuse medical treatment, surgery, or to make other health care choices. In California, an advance directive consists of two parts:

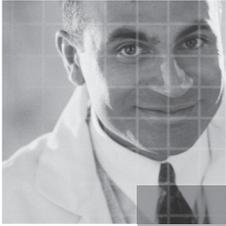
1. Your appointment of an agent (a person) making decisions about your health care, and
2. Your individual health care instructions.

If you have a complaint about advance directive requirements, you may contact the California Department of Health Services, Licensing and Certification Division, by calling **(800) 236-9747**, or by mail at P.O. Box 997413, Sacramento, California 95899-1413.

■■■■ CULTURAL COMPETENCY

Why Are Cultural Considerations And Language Access Important?

A culturally competent mental health system includes skills, attitudes and policies that make sure the needs of everyone are addressed in a society of diverse values, beliefs and orientations, and different races, religions and languages. It is a system that improves the quality of care for all of California's many different peoples and provides them with understanding and respect for those differences.



Your county's MHP is responsible for providing the people it serves with culturally and linguistically competent specialty mental health services. For example; non-English or limited English speaking persons have the right to receive services in their preferred language and the right to request an interpreter. If an interpreter is requested, one must be provided at no cost. People seeking services do not have to bring their own interpreters. Verbal and oral interpretation of your rights, benefits and treatments is available in your preferred language. Information is also available in alternative formats if someone cannot read or has visual challenges. The front part of this booklet tells you how to obtain this information. Your county's MHP is required to:

- Provide specialty mental health services in your preferred language.
- Provide culturally appropriate assessments and treatments.
- Provide a combination of culturally specific approaches to address various cultural needs that exist in the MHP's county to create a safe and culturally responsive system.
- Make efforts to reduce language barriers.
- Make efforts to address the culturally specific needs of individuals receiving services.
- Provide services with sensitivity to culturally specific views of illness and wellness.
- Consider your world view in providing you specialty mental health services.
- Have a process for teaching MHP employees and contractors about what it means to live with mental illness from the point of view of people who are mentally ill.
- Provide a listing of cultural/linguistic services available through your MHP.
- Provide a listing of specialty mental health services and other MHP services available in your primary language (sorted by location and services provided).
- Provide oral interpretation services available free of charge. This applies to all non-English languages.
- Provide written information in threshold languages and alternative formats, in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.

Non-English or limited English speaking persons have the right to receive services in their preferred language and the right to request an interpreter.

- Provide a statewide, toll-free telephone number available 24-hours a day, 7 days a week, with language capability in your language to provide information to you about how to access specialty mental health services. This includes services needed to treat your urgent condition, and how to use the MHP problem resolution and State Fair Hearing processes.
- Find out at least once a year if people from culturally, ethnically and linguistically diverse communities see themselves as getting the same benefit from services as people in general.

■ How Services May be Provided to You

How Do I Get Specialty Mental Health Services?

If you think you need specialty mental health services, you can get services by asking the MHP for them yourself. You can call your MHP's toll-free phone number listed in the front section of this booklet. The front part of this booklet and the section called "Services" on page 9 of the booklet give you information about services and how to get them from the MHP.

You may also be referred to your MHP for specialty mental health services in other ways. Your MHP is required to accept referrals for specialty mental health services from doctors and other primary care providers who think you may need these services and from your Medi-Cal managed care health plan, if you are a member. Usually the provider or the Medi-Cal managed care health plan will need your permission or the permission of the parent or caregiver of a child to make the referral, unless there's an emergency. Other people and organizations may also make referrals to the MHP, including schools; county welfare or social services departments; conservators, guardians or family members; and law enforcement agencies.



Please see the provider directory following this section for more information about this topic, or the front section of this booklet with information about your MHP's specific approval or referral information.

How Do I Find A Provider For The Specialty Mental Health Services I Need?

Some MHPs require you to receive approval from your county's MHP before you contact a service provider. Some MHPs will refer you to a provider who is ready to see you. Other MHPs allow you to contact a provider directly.

The MHP may put some limits on your choice of providers. Your county's MHP must give you a chance to choose between at least two providers when you first start services, unless the MHP has a good reason why it can't provide a choice (for example, there is only one provider who can deliver the service you need). Your MHP must also allow you to change providers. When you ask to change providers, the MHP must allow you to choose between at least two providers, unless there is a good reason not to do so.

Sometimes MHP contract providers leave the MHP on their own or at the request of the MHP. When this happens, the MHP must make a good faith effort to give written notice of termination of a MHP-contracted provider within 15 days after receipt or issuance of the termination notice to each person who was receiving specialty mental health services from the provider.

Once I Find A Provider, Can The MHP Tell The Provider What Services I Get?

You, your provider and the MHP are all involved in deciding what services you need to receive through the MHP by following the medical necessity criteria and the list of covered services (see pages 17 and 10). Sometimes the MHP will leave the decision to you and the provider. Other times, the MHP may require your provider to ask the MHP to review the reasons the provider thinks you need a service before the service is provided. The MHP must use a qualified mental health professional to do the review. This review process is called an MHP payment authorization process. The State requires the MHP to have an authorization process for day treatment intensive, day rehabilitation, and therapeutic behavioral services (TBS).

The MHP's authorization process must follow specific timelines. For a standard authorization, the MHP must make a decision on your provider's request within 14 calendar days. If you or your provider request information or if the MHP thinks it is in your interest to get more information from your provider, the timeline can be extended for up to another 14 calendar days. An example of when an extension might be in your interest is when the MHP thinks it might be able to approve your provider's request for authorization if the MHP had additional information from your provider and would have to deny the request without the information. If the MHP extends the timeline, the MHP will send you a written notice about the extension.



If you didn't get a list of providers with this booklet, you may ask the MHP to send you a list by calling the MHP's toll-free telephone number located in the front section of this booklet.

If your provider or the MHP thinks your life, health or ability to attain, maintain or regain maximum function will be jeopardized by the 14-day timeframe, the MHP must make a decision within 3 working days. If you or your provider request information or if the MHP thinks it is in your interest to get more information from your provider, the timeline can be extended up to an additional 14 calendar days.

If the MHP doesn't make a decision within the timeline required for a standard or expedited authorization request, the MHP must send you a Notice of Action telling you that the services are denied and that you may file an Appeal or ask for a State Fair Hearing (see page 26).

You may ask the MHP for more information about its authorization process. Check the front section of this booklet to see how to request the information. If you don't agree with the MHP's decision on an authorization process, you may file an Appeal with the MHP or ask for a State Fair Hearing (see page 26).

Which Providers Does My MHP Use?

Most MHPs use four different types of providers to provide specialty mental health services. These include:

Individual Providers: Mental health professionals, such as doctors, who have contracts with your county's MHP to provide specialty mental health services in an office and/or community setting.

Group Providers: These are groups of mental health professionals who, as a group of professionals, have contracts with your county's MHP to offer specialty mental health services in an office and/or community setting.

Organizational Providers: These are mental health clinics, agencies or facilities that are owned or run by the MHP, or that have contracts with your county's MHP to provide services in a clinic and/or community setting.

Hospital Providers: You may receive care or services in a hospital. This may be as a part of emergency treatment, or because your MHP provides the services you need in this type of setting.

If you are new to the MHP, a complete list of providers in your county's MHP follows this section of the booklet and contains information about where providers are located, the specialty mental health services they provide, and other information to help you access care, including information about the cultural and language services that are available from the providers. If you have questions about providers, call your MHP's toll-free telephone number located in the front section of this booklet.



Web Links

State of California's Medi-Cal program:
<http://www.dhs.ca.gov/mcs/medi-calhome>

State of California Department of Mental Health:
<http://www.dmh.ca.gov>

State of California Department of Health Services:
<http://www.dhs.ca.gov>

Online Health Resources:
<http://www.dhs.ca.gov/home/hsites/>

U.S. Department of Health and Human Services:
<http://www.os.dhhs.gov>

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration:
<http://www.samhsa.gov>





Butte County Behavioral Health
Systems Performance, Research & Evaluations
Consumer Satisfaction Survey Report
for FY 16-17

Séscha Zinn, Psy.D.

Systems Performance, Research & Evaluations Manager

Butte County Behavioral Health

(530) 891-3280

szinn@buttecounty.net

BCDBH Data Display Board

Dear Community Members,

We would like to present to you data collected during Fiscal Year 2016-2017. On this board you will find Consumer Satisfaction Survey data collected from all the programs who submitted surveys throughout the fiscal year.

We thank you for your feedback! We also encourage everyone to complete one of the surveys in the waiting area to help us continually improve the services provided by this agency.

Sincerely,

Butte County Department of Behavioral Health



Comments:

"I am grateful for this chance & help I've been given. Thank you all."

"The staff are great, compassionate, and professional. Thanks."

"Better communication with meds getting refills or meds period. Thanks."

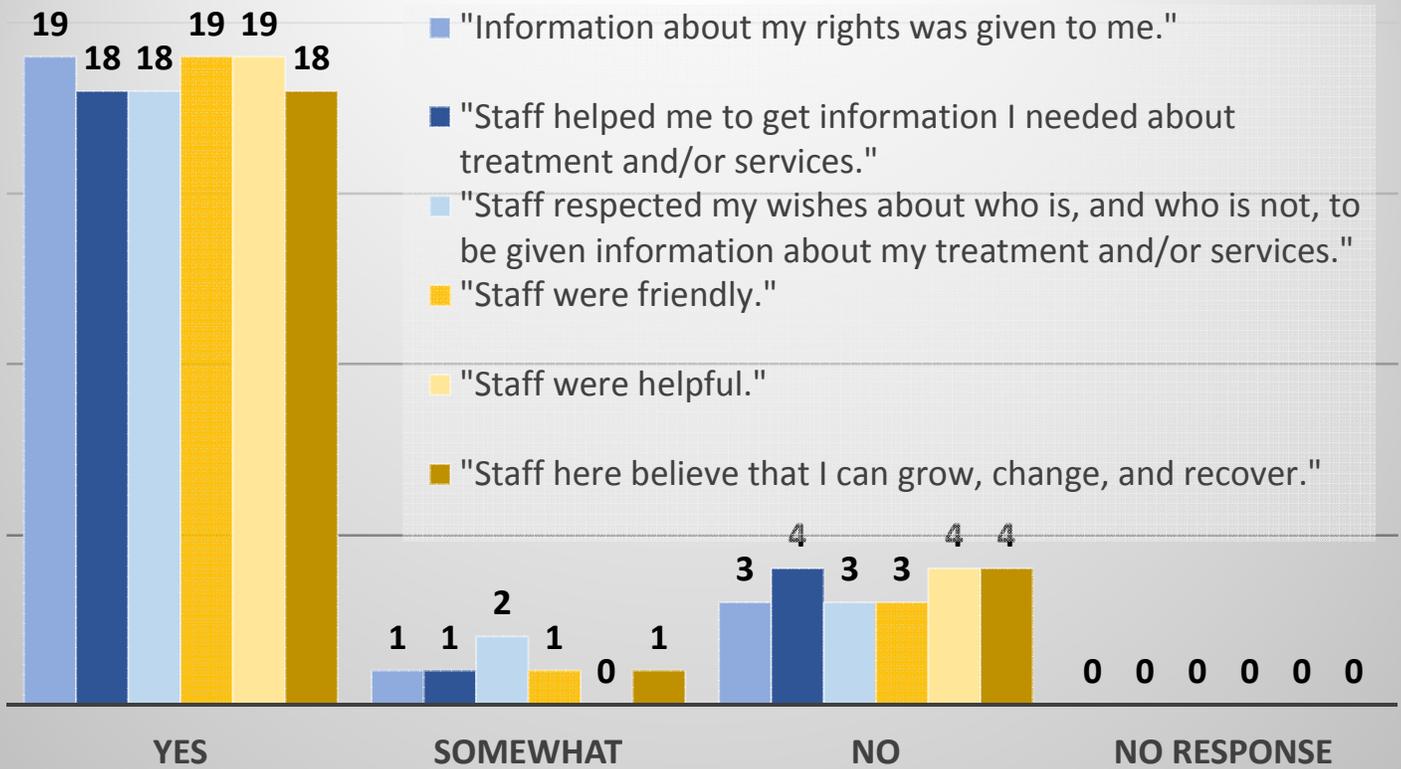
"The cooperation of the staff working together is GREAT! Great! The staff starting to help each person with respect + value."

"You guys and gals were very helpful, thank you."

"This was a big help for I was able to sleep. I had not slept in two days. Thank you."

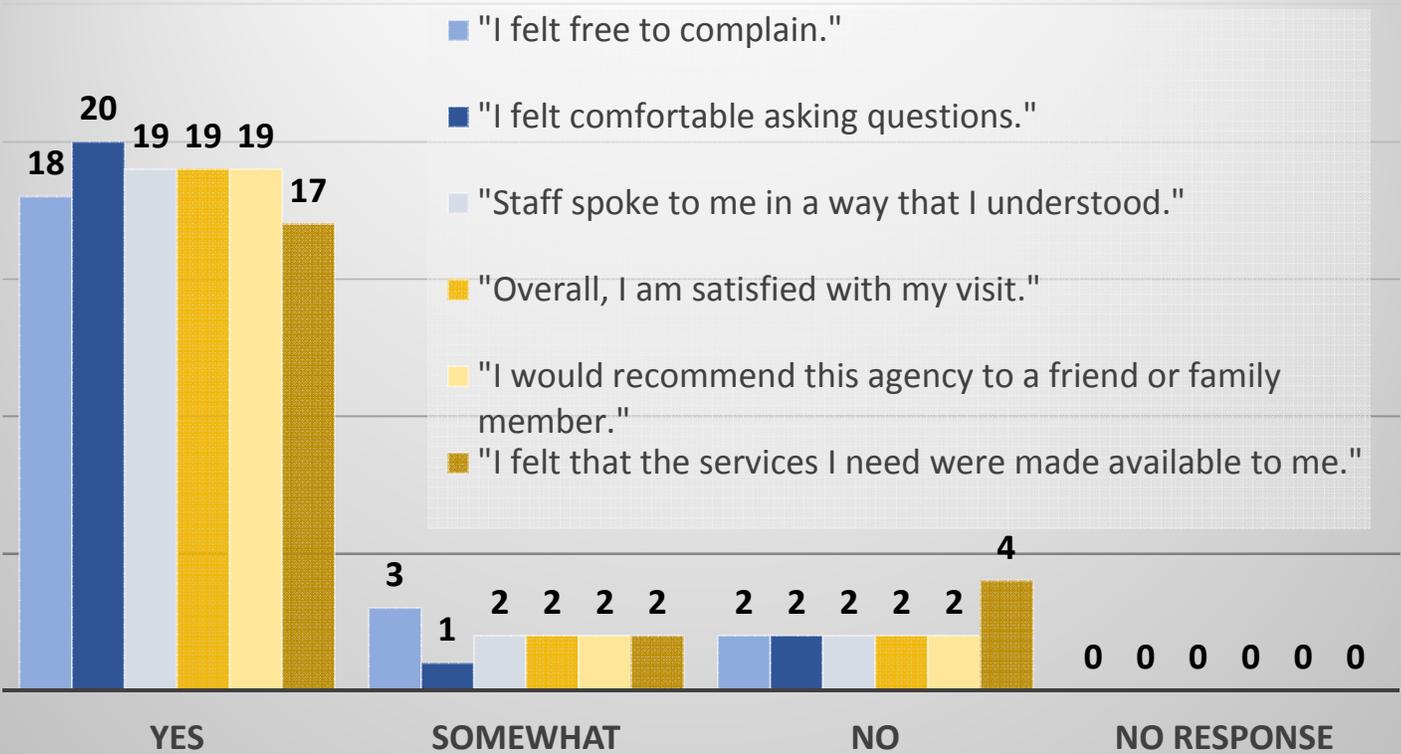
Outpatient Lobby Surveys

7/1/2016 - 6/30/2017



Outpatient Lobby Surveys

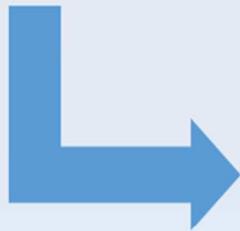
7/1/2016 - 6/30/2017



On the Consumer Satisfaction Surveys last fiscal year, you said...

I would like more information about:

Finding a Job



Butte County Department of Employment and Social Services

Chico

Butte Community Employment
Center - Chico

[2445 Carmichael Drive](#)
[Chico, CA 95928](#)

Oroville

Butte Community Employment
Center - Oroville

[78 Table Mountain Blvd.](#)
[Oroville, CA 95965](#)

Adult Services – Butte County
800.664.9774

Customer Service Center
877.410.8803

Butte 211

Dial 211

Or visit

Butte211.org

Recovery Topics or Issues You Wanted to Learn More About :

“I want to learn more about co-dependency.”

“Drug addiction and spousal recovery.”

“New therapy/new drugs/new studies/new info.”

“More about the curriculum of how to become a drug and alcohol counselor.”

“Maintenance of recovery – staying clean after a longer period of sobriety.”

“Overcoming barriers/hurdles anxiety in recovery.”

Barriers You Face in Your Recovery:

"Isolation."

"Old friends/Old haunts/Old habits!!!"

"Anxiety"

"Transportation and Childcare"

"Maintenance: I had 20 months of sobriety. I always have issues with residential treatment."

"Same people and same triggers."

"Rental History."

"Homeless and unemployed I need help with these issues and a computer with internet access to be able to study and find resources."

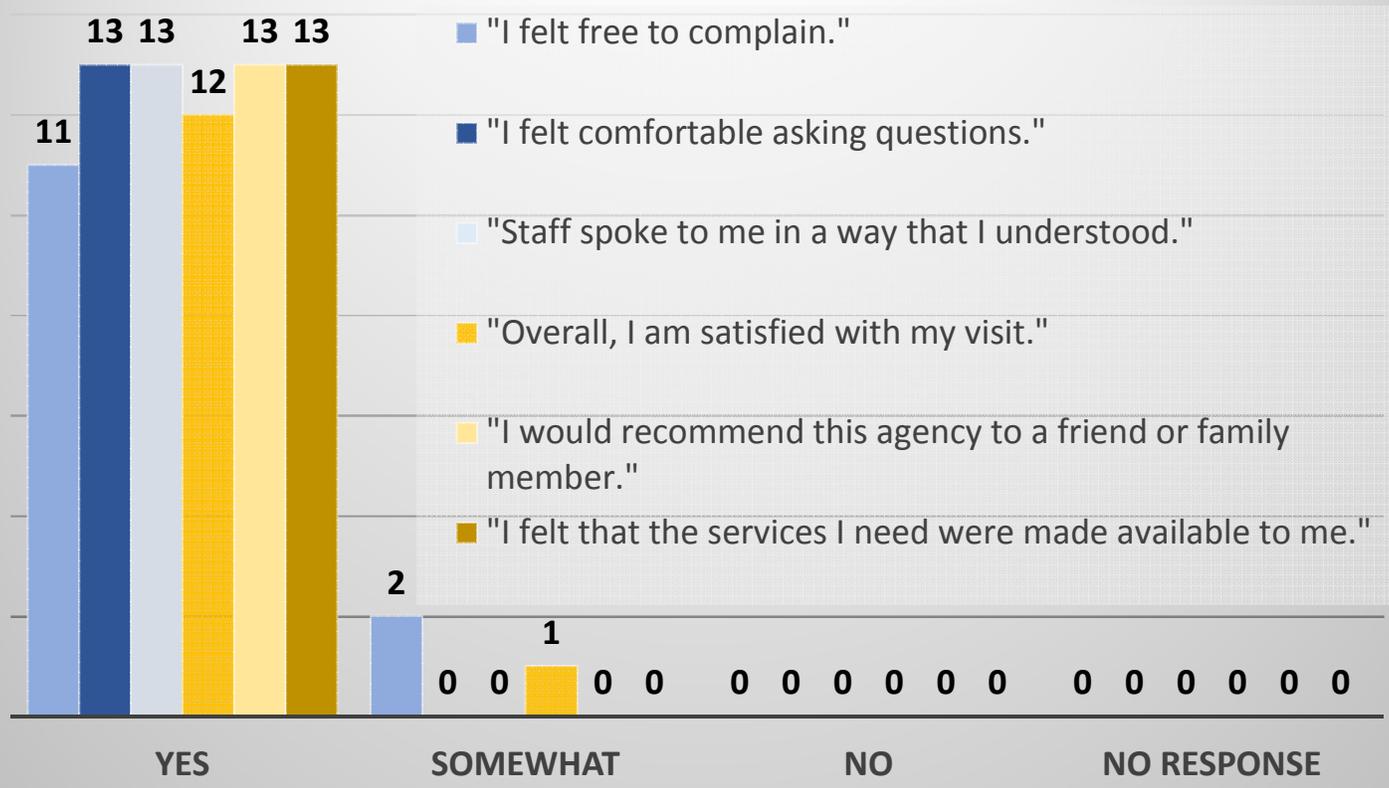
"Myself Mostly."

Treatment/Recovery Center Lobby Surveys

7/1/2016 - 6/30/2017

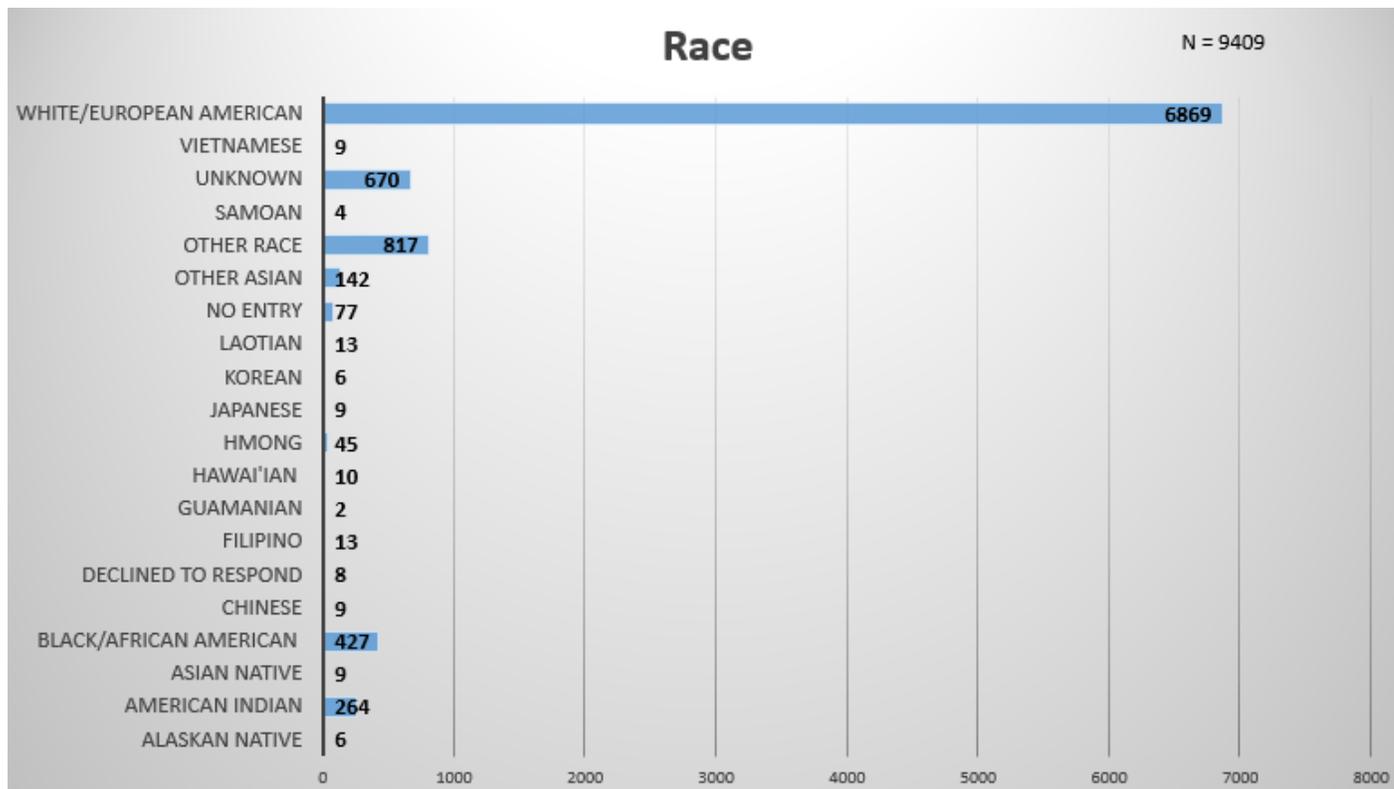
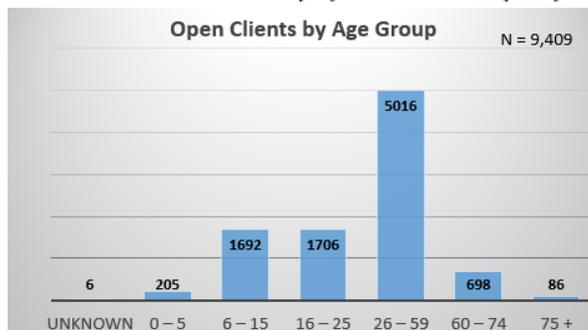
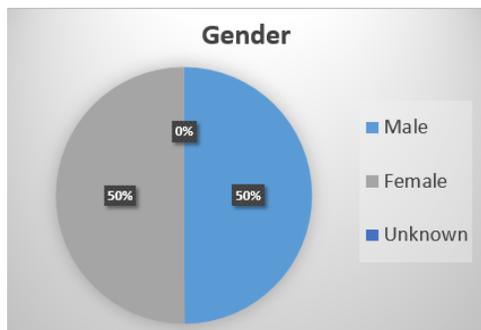


Treatment/Recovery Center Lobby Surveys 7/1/2016 - 6/30/2017

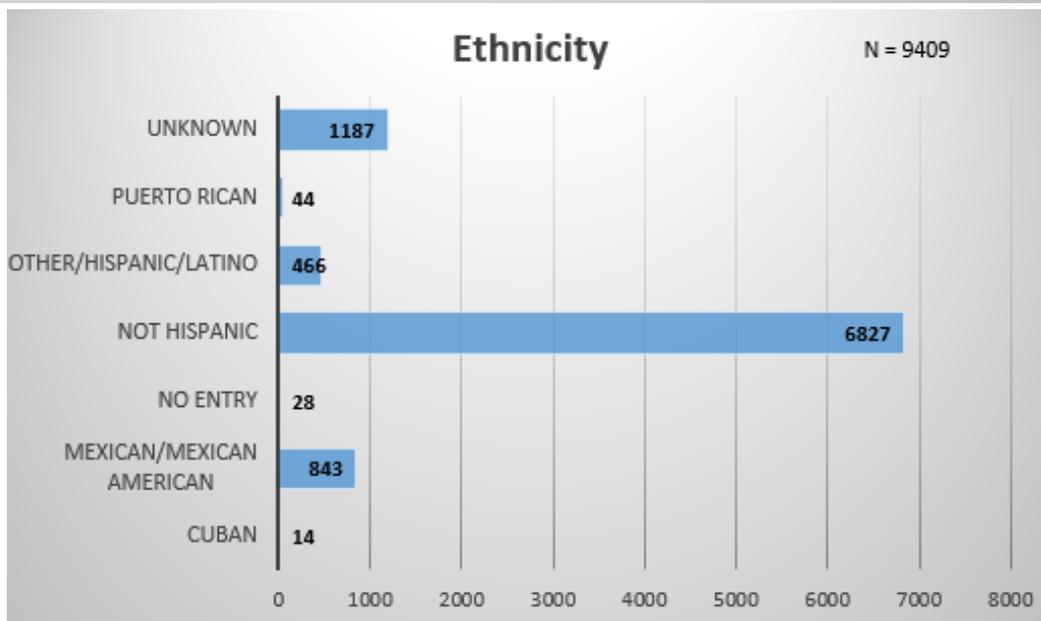


BCDBH Consumer Demographic Dashboard

This dashboard report shows percentage and numerical distributions for ethnicity, age, race, gender and primary language for all BCDBH consumers who received services between 7/1/2016 and 6/30/2017.



Primary Language	Count
American Sign Language	2
Arabic	2
Armenian	30
English	8522
Farsi	1
French	1
Hmong	157
Japanese	3
Lao	6
Mien	9
No Entry	29
Other Non-English	8
Other Sign Language	1
Portuguese	2
Spanish	163
Tagalog	2
Thai	1
Unknown	448
Vietnamese	2





Butte County Department of Behavioral Health Provider List

Provider Name	Address	Phone	Type of Services Provided	Specialty/Cultural Services	Age Groups Served	Accepting New Referrals	Language Alt. & Services
Board and Care Homes							
Casa Serenity	100 Orchard Way Red Bluff, CA 96080	(530) 529-5114	Board & Care		Youth 18-21 Adults 21-59	Yes	Spanish
Casey Manor	100 Casey Ct Oroville, CA 95965	(530) 534-5422	Board & Care		Youth 18-21 Adults 21-59	Yes	Spanish
Modesto Residential Living Center	1932 Evergreen Ave Modesto, CA 95350	(209) 530-9300	Board & Care		Youth 18-21 Adults 21-59	Yes	Spanish, ASL
TLC Living	15 Vermillion Cir Chico, CA 95973	(530) 519-0261	Board & Care		Youth 18-21 Adults 21-59	Yes	Spanish
Willow Glen Care Center	1547 Plumas Ct Yuba City, CA 95991	(530) 755-0992	Board & Care		Youth 18-21 Adults 21-59	Yes	Spanish
Hospitals							
Oroville Hospital	2767 Olive Hwy Oroville, CA 95966	(530) 532-8509	Emergency Medical Services		All ages	Yes	Spanish, Hmong
Feather River Hospital	5974 Pentz Rd Paradise, CA 95969	(530) 877-9361	Emergency Medical Services		All ages	Yes	Language Access Network
Orchard Hospital	240 Spruce St Gridley, CA 95948	(420) 846-9000	Emergency Medical Services		All ages	Yes	Language Access Network



Butte County Department of Behavioral Health Provider List

Provider Name	Address	Phone	Type of Services Provided	Specialty/Cultural Services	Age Groups Served	Accepting New Referrals	Language Alt. & Services
Enloe Medical Hospital	1531 Esplanade Chico, CA 95926	(530) 332-7300	Emergency Medical Services		All ages	Yes	Spanish, Hmong, French, Portuguese
Individual Providers							
Adeyemo, Adegoke M.D.	560 Cohasset Rd, Ste 175 Chico, CA 95926	(530) 891-2784	Psychiatrist (Telemed)		Youth 18-21 Adults 21-59 Adults 60 +	*	#
Alb, Larry M.D.	18 County Center Dr Oroville, CA 95965	(530) 538-7705	Locum Psychiatrist (Telemed)		Youth 18-21 Adults 21-59 Adults 60 +	*	#
Gray, Jeffery M.D.	560 Cohasset Rd, Ste 175 Chico, CA 95926	(530) 891-2784	Psychiatrist		Youth 18-21 Adults 21-59 Adults 60 +	*	#
Heitzman, George M.D.	18 County Center Dr Oroville, CA 95965	(530) 538-7705	Psychiatrist		Youth 18-21 Adults 21-59 Adults 60 +	*	#
Kimura, Carolyn M.D	592 Rio Lindo Ave Chico, CA 95926	(530) 891-2810	Psychiatrist		All ages	*	#
LaRiviere, Lori M.D.	592 Rio Lindo Ave Chico, CA 95926	(530) 891-2810	Locum Psychiatrist		Youth 18-21 Adults 21-59 Adults 60 +	*	#
Lema, Margarita M.D	109 Parmac Rd, Ste 1 Chico, CA 95926	(530) 891-2945	Psychiatrist		Children 0-13 Teens 14-17 Youth 18-20	*	#



Butte County Department of Behavioral Health Provider List

Provider Name	Address	Phone	Type of Services Provided	Specialty/Cultural Services	Age Groups Served	Accepting New Referrals	Language Alt. & Services
Long, J. Gregory D.O.	995 Spruce St Gridley, CA 95948	(530) 846-7305	Psychiatrist		All ages	*	#
Lofy, Mohammed M.D.	560 Cohasset Rd, Ste 175 Chico, CA 95926	(530) 891-2784	Psychiatrist		Youth 18-21 Adults 21-59 Adults 60 +	*	#
Maguire, Gerald M.D.	805 Cedar St Paradise, CA 95969	(530) 872-6347	Psychiatrist		Youth 18-21 Adults 21-59 Adults 60 +	*	#
Mian, Abid R. M.D.	560 Cohasset Rd Chico, CA 95926	(530) 891-2784	Locum Psychiatrist (Telemed)		Youth 18-21 Adults 21-59 Adults 60 +	*	#
Tomar, Diane M.D.	5910 Clark Rd, Ste W Paradise, CA 95969	(530) 872-6328	Locum Psychiatrist		Children 0-13 Teens 14-17 Youth 18-20	*	#
Wang, Dora M.D.	805 Cedar St Paradise, CA 95969	(530) 872-6347	Psychiatrist (Telemed)		Youth 18-21 Adults 21-59 Adults 60 +	*	#
Medical Staff Providers							
All's Well Healthcare Services	327 W Broadway Glendale, CA 91204	(562) 706-4694	Locum Nurses			*	#
Avid HealthCare Services	8880 Cal Center Dr Ste 400 Sacramento, CA 95826	(916) 903-4423	Locum Nurses			*	#



Butte County Department of Behavioral Health Provider List

Provider Name	Address	Phone	Type of Services Provided	Specialty/Cultural Services	Age Groups Served	Accepting New Referrals	Language Alt. & Services
California Locums, P.C.	2655 Northwinds Parkway Alpharetta, GA 30009	(770) 643-5744	Psychiatrist-Group			*	#
Cell Staff, LLC	1715 N Westshore Blvd, Ste 410 Tampa, FL 33607	(855) 561-1715	Locum Nurses			*	#
DRWanted.com, LLC	4170 Ashford Dunwoody Rd NE, Ste 485 Brookhaven, GA 30319	(404) 996-6587	Locum Nurses			*	#
Golden State Physicians	2655 Northwinds Parkway, Ste 300 Alpharetta, GA 30009	(866) 999-8396	Locum Nurses			*	#
Maxim Healthcare	7227 Lee Deforest Dr Columbia, MD 21046	(916) 614-9539	Locum Nurses			*	#
On Site Medical Registry	23840 Pigtail Ln Orland, CA 95963	(530) 591-9787	Medical Screening			*	#
Spectrum Accountable Care Company	930 S 3rd St, Ste 200 Las Vegas, NV 89101	(702) 728-3550 x301	Locum Nurses			*	#
Staff Today, Inc. (STI)	212 E Rowland St #313 Covina, CA 91723	(800) 928-5561	Locum Nurses			*	#



Butte County Department of Behavioral Health Provider List

Provider Name	Address	Phone	Type of Services Provided	Specialty/Cultural Services	Age Groups Served	Accepting New Referrals	Language Alt. & Services
Inpatient Facilities							
Alta Bates Summit Medical Center	2001 Dwight Way Berkeley, CA 94705	(510) 204-4444	Inpatient Hospitalization		Children 12-13 Teens 14-17	+	CyraCom International
Aurora Behavioral Healthcare-Santa Rosa	1287 Fulton Rd Santa Rosa, CA 95401	(707) 800-7700	Inpatient Hospitalization		Teens 13-17 Youth 18-20 Adults 21-59 Adults 60 +	+	#
BHC Heritage Oaks Hospital	4250 Auburn Boulevard Sacramento, CA 95841	(916) 489-3336	Inpatient Hospitalization		Teens 13-17 Youth 18-20 Adults 21-59 Adults 60 +	+	#
BHC Sierra Vista Hospital	8001 Bruceville Rd Sacramento, CA 95823	(916) 288-0300	Inpatient Hospitalization		Teens 13-17 Youth 18-20 Adults 21-59 Adults 60 +	+	#
Woodland Memorial Hospital	1325 Cottonwood St Woodland, CA 95695	(530) 662-3961	Inpatient Hospitalization		Youth 18-21 Adults 21-59 Adults 60 +	+	Spanish #
Enloe Behavioral Health	1531 Esplanade Chico, CA 95926	(530) 332-5250	Inpatient Hospitalization		Youth 18-21 Adults 21-59 Adults 60 +	+	CyraCom International



Butte County Department of Behavioral Health Provider List

Provider Name	Address	Phone	Type of Services Provided	Specialty/Cultural Services	Age Groups Served	Accepting New Referrals	Language Alt. & Services
Fremont Hospital	39001 Sundale Dr Fremont, CA 94538	(510) 769-1100	Inpatient Hospitalization		Children 12-13 Teens 14-17 Youth 18-21 Adults 21-59 Adults 60 +	+	
John Muir Hospital	2740 Grant St Concord, CA 94520	(925) 674-4100	Inpatient Hospitalization		Children 4-12	+	Health Care Interpreter Network
North Valley Behavioral Health	1535 Plumas Ct, Ste A Yuba City, CA 95991	(530) 790-2520	Inpatient Hospitalization		Youth 18-21 Adults 21-59 Adults 60 +	+	Spanish, Hindi, Punjabi
St. Helena Hospital-Vallejo	525 Oregon St Vallejo, CA 94590	(707) 649-4976	Inpatient Hospitalization		Youth 18-21 Adults 21-59 Adults 60 +	+	Spanish, Filipino #
St. Helena Hospital-St. Helena	10 Woodland St St. Helena, CA 94574	(707) 963-3611	Inpatient Hospitalization		Children 4-13 Teens 14-17 Youth 18-20 Adults 21-59 Adults 60 +	+	Spanish, Filipino #
St. Mary's	2200 Hayes San Francisco, CA 94117	(415) 750-5649	Inpatient Hospitalization		Children 11-13 Teens 14-17	+	CyraCom International
Sutter Center for Psychiatry	7700 Folsom Boulevard Sacramento, CA 95826	(916) 386-3020	Inpatient Hospitalization		Children 5-13 Youth 18-21 Adults 21-59 Adults 60 +	+	Spanish



Butte County Department of Behavioral Health Provider List

Provider Name	Address	Phone	Type of Services Provided	Specialty/Cultural Services	Age Groups Served	Accepting New Referrals	Language Alt. & Services
Residential Provider							
Crestwood Behavioral Health	520 Capital Mall, Ste 800 Sacramento, CA 95814	(916) 471-2244	Long term Residential Facility		Youth 18-21 Adults 21-59 Adults 60 +	+	Spanish, Vietnamese, #
Kindred Healthcare-Medical Hill	475 29th St Oakland, CA 95609	(510) 832-3222	Long term Residential Facility		Youth 18-21 Adults 21-59 Adults 60 +	+	Spanish, Chinese, Filipino
Iris House	556 Cohasset Rd Chico, CA 95926	(530) 592-3498 (530) 755-0992 (530) 809-0798	Short Term Crisis Residential	Hospitalization Alternative / Dual Diagnosis	Youth 18-20 Adults 21-59 Adults 60 +	Yes	Spanish, Hmong
Trinity Pines	2753 White Ave Chico, CA 95973	(530) 413-9041	Social Rehabilitation Facility		Youth 18-20 Adults 21-59	Yes	Spanish, Hmong
Victor Treatment Centers, Inc.	1360 Lassen Ave Chico, CA 95973	(530) 893-0758	Mental Health Residential Services		Children 8-13 Teens 14-17 Youth 18	Yes	Spanish
Community Provider							
African American Family Cultural Center	3300 Spencer Ave Oroville, CA 95966	(530) 532-1205	Outreach Services		All ages		None



Butte County Department of Behavioral Health Provider List

Provider Name	Address	Phone	Type of Services Provided	Specialty/ Cultural Services	Age Groups Served	Accepting New Referrals	Language Alt. & Services
Casa Pacifica	1722 S Lewis Rd Camarillo, CA 93012	(805) 366-4040	Mental Health Services / Medication Support / Case Management	Transitional Age Youth Services	Children 0-13 Teens 14-17 Youth 18-21		Varies by program
CSUC Passages	25 Main St Chico, CA 95929	(800) 822-0109	Outreach and Education, Intervention Services		Adults 60 +		Spanish
Catalyst	PO Box 4184 Chico, CA 95927	(530) 343-7711	Domestic Violence Assistance Program	Domestic Abuse	All ages		Spanish and TTY
Caminar, Inc.	376 Rio Lindo Ave Chico, CA 95926	(530) 343-4472	Vocational Services		Youth 18-21 Adults 21-59 Adults 60 +	Yes	Spanish
Charis Youth Center	714 Main St Grass Valley, CA 65945	(530) 477-9800	Residential treatment / Therapeutic Behavioral Services / Rehabilitation		Children 0-13 Teens 14-17 Youth 18-21	Yes	Spanish
Counseling Solutions	130 Yellowstone Dr, Ste 110 Chico, CA 95973	(530) 879-5991	Mental Health Services / Crisis Services	ADHD / Addiction / Adoption / Domestic Abuse / Eating Disorders /	Children 0-13 Teens 14-17 Youth 18	Yes	Spanish
	1847 Robinson St Oroville, CA 95965	(530) 879-5991	Mental Health Services				



Butte County Department of Behavioral Health Provider List

Provider Name	Address	Phone	Type of Services Provided	Specialty/ Cultural Services	Age Groups Served	Accepting New Referrals	Language Alt. & Services
				Grief / Sexual Abuse / Trauma and PTSD / Youth			
Dreamcatchers	1125 Missouri St, Ste 109 Fairfield, CA 94533	(707) 558-1775	Day Services- Vocational		Youth 18-21 Adults 21-59 Adults 60 +	Yes	Spanish
Jesus Center	1297 Park Ave Chico, CA 95928	(530) 345-2640	Resource Center / Vocational Training	Homeless	Youth 18-20 Adults 21-59 Adults 60 +	Yes	Spanish
Mountain Valley Child and Family Services (formerly Milhous)	24077 State Hwy 49 Nevada City, CA 95959	(530) 265-9057	Mental Health Services/ Day Services- Vocational		Children 0-13 Teens 14-17 Youth 18	Yes	None
Northern Valley Catholic Social Services	10 Independence Circle Chico, CA 95973	(530) 345-1600	Mental Health Services / School Based Counseling / Rural Mountain Team (Wraparound) / Mother's Well (Perinatal) / Promotores (Latino) / Zoosiab (Hmong) /	Domestic Abuse / Domestic Violence / Homeless / Native Americans / Perinatal Mothers	Children 6-13 Teens 14-17 Youth 18-20 Adults 21-59 Adults 60 +	Yes	Spanish, Hmong, Vietnamese
	2185 Baldwin Ave, Oroville, CA 95966	(530) 538-8221					
	996 A Spruce St, Gridley, CA 95948	(530) 846-6175					
Northern Valley Talk Line		(855) 582-5554	Non-Crisis peer to peer telephone service		All ages		



Butte County Department of Behavioral Health Provider List

Provider Name	Address	Phone	Type of Services Provided	Specialty/ Cultural Services	Age Groups Served	Accepting New Referrals	Language Alt. & Services
Iverson Center	492 Rio Lindo Chico, CA 95973	(530) 879-3311	Recovery Center / Peer Led groups		Youth 18-20 Adults 21-59 Adults 60 +	Yes	Spanish
Summitview Child Treatment Center	768 Pleasant Valley Rd #304 Diamond Springs, CA 95619	(530) 621-9800	Outpatient Mental Health / Wraparound / Residential treatment / Therapeutic Behavioral Services / Day Rehabilitation	Sexual Abuse / Substance Abuse	Children 0-13 Teens 14-17 Youth 18-21	Yes	Spanish
Stonewall Alliance	358 East 6th St Chico, CA 95928	(530) 893-3336	LGBTQ Mental Health Outreach	LGBTQ	All ages	Yes	Spanish
Torres Shelter	101 Silver Dollar Way Chico, CA 95928	(530) 891-9048	Community Shelter	Homeless	All ages	Yes	Spanish
Valley Oaks Children's Services	3210 Cohasset Rd #6 Chico, CA 95973	(530) 895-3572	Mental Health Services	ADHD / Domestic Violence / Homeless / Trauma and PTSD / Youth	Children 0-5	Yes	Spanish, Hmong
Victor Comm. Support Services, Inc.	1360 Lassen Ave Chico, CA 95973	(530) 267-1700	School Based Counseling / Therapeutic Behavioral Services / In-Home Based Services /	ADHD / Addiction / African Americans / Eating Disorders / Grief / Homeless /	Children 0-13 Teens 14-17 Youth 18-21	Yes	Spanish, Hmong



Butte County Department of Behavioral Health Provider List

Provider Name	Address	Phone	Type of Services Provided	Specialty/Cultural Services	Age Groups Served	Accepting New Referrals	Language Alt. & Services
			Medication Management	Intellectual Disability / Latino / LGBTQ / Sexual Abuse / Trauma and PTSD / Men / Women / Youth			
Youth for Change	5538 Skyway Paradise, CA 95967	(530) 877-8187	School Based Counseling / Therapeutic Behavioral Services / Parent-Child Interaction Therapy / Medication Management	ADHD / Addiction / Adoption / Asian / Domestic Abuse / Dual Diagnosis / Homeless / Latino / LGBTQ / Pacific Islanders / Sexual Abuse / Substance Abuse / Trauma and PTSD	Children 0-13 Teens 14-17 Youth 18-21	Yes	Spanish, Hmong
<i>Specialty Services</i>	7200 Skyway Paradise, CA 95969	(530) 877-1965	Medication Management / Residential Treatment	Homeless / Latino / LGBTQ / Pacific Islanders / Sexual Abuse / Substance Abuse / Trauma and PTSD	Children 0-13 Teens 14-17 Youth 18-21	Yes	Spanish, Hmong
<i>Community Services</i>	7204 Skyway Paradise, CA 95969	(530) 872-2103	Therapeutic Behavioral Services / Wraparound		Children 0-13 Teens 14-17 Youth 18-21	Yes	Spanish, Hmong
<i>Rio Lindo Counseling Center</i>	578 Rio Lindo Ave, Ste 3 Chico, CA 95926	(530) 894-5933	In-home Parenting / Hospital Alternatives Program / Parent-Child		Children 0-13 Teens 14-17 Youth 18-21	Yes	Spanish, Hmong



Butte County Department of Behavioral Health Provider List

Provider Name	Address	Phone	Type of Services Provided	Specialty/Cultural Services	Age Groups Served	Accepting New Referrals	Language Alt. & Services
			Interaction Therapy				
<i>Maxwell Services Center</i>	6083 Maxwell Dr Paradise, CA 95969		Parent-Child Interaction Therapy / School Based Counseling		Children 0-13 Teens 14-17 Youth 18-21	Yes	Spanish, Hmong
<i>Oroville Highway Counseling Center</i>	2856 Olive Hwy, Ste A Oroville, CA 95966	(530) 533-1576	Parent-Child Interaction Therapy		Children 0-13 Teens 14-17 Youth 18-21	Yes	Spanish, Hmong
<i>6th Street</i>	130 W 6th St Chico, CA 95926	(530) 894-8008	Transitional Age Youth Services		Children 0-13 Teens 14-17 Youth 18-21	Yes	Spanish, Hmong
Organizational Provider-Substance Use Disorder Treatment (SUD)							
Aegis Medical Systems, Inc.	590 Rio Lindo Ave Chico, CA 95926	(530) 345-3491	SUD Narcotic Treatment Services		Youth 18-21 Adults 21-59 Adults 60 +	Yes	Spanish, ASL
Elijah House	PO Box 2456 Oroville, CA 95965	(530) 679-0709	SUD Residential Treatment		Youth 18-21 Adults 21-59 Adults 60 +	Yes	
Empire Recovery	1237 California St Redding, CA 96001	(530) 243-7470	SUD Residential Treatment		Youth 18-21 Adults 21-59 Adults 60 +	Yes	Spanish
Skyway House	40 Landing Cir, STE 1 Chico, CA 95973	(530) 898-8326	SUD Residential Treatment		Youth 18-21 Adults 21-59 Adults 60 +	Yes	



Butte County Department of Behavioral Health Provider List

Provider Name	Address	Phone	Type of Services Provided	Specialty/Cultural Services	Age Groups Served	Accepting New Referrals	Language Alt. & Services
Pathways	430 Teegarden Ave Yuba City, CA 95991	(530) 674-4530	SUD Residential Treatment		Youth 18-21 Adults 21-59 Adults 60 +	Yes	
Progress House	PO Box 1666 Placerville, CA 95667	(530) 626-9240	SUD Residential Treatment		Youth 18-21 Adults 21-59 Adults 60 +	Yes	
Camino	5494 Pony Express Trail Camino, CA 95709	(530) 644-3758	Perinatal SUD Residential Treatment	Women	Youth 18-21 Adults 21-59 Adults 60 +	Yes	
Coloma	838 Beach Ct Lotus, CA 95651	(530) 626-7252	SUD Residential Treatment	Men	Youth 18-21 Adults 21-59 Adults 60 +	Yes	
Garden Valley	5607 Mount Murphy Rd Garden Valley, CA 95633	(530) 333-9460	SUD Residential Treatment	Women	Youth 18-21 Adults 21-59 Adults 60 +	Yes	
Yolo	15450 County Rd 99 Woodland, CA 95695	(530) 668-9627	SUD Residential Treatment	Women	Youth 18-21 Adults 21-59 Adults 60 +	Yes	
Solutions for Positive Choices	645 Normal Ave Chico, CA 95928	(530) 898-8333	DUI Education		Youth 18-21 Adults 21-59 Adults 60 +	Yes	
	1855 Myers St Oroville, CA 95966	(530) 532-6969					
	5923 Clark Rd Ste G & F Paradise, CA 95969	(530) 877-5336					



Butte County Department of Behavioral Health Provider List

Provider Name	Address	Phone	Type of Services Provided	Specialty/ Cultural Services	Age Groups Served	Accepting New Referrals	Language Alt. & Services
Visions of the Cross	3648 El Portal Dr Redding, CA 96002	(530) 722-1114	SUD Residential Treatment	Women	Youth 18-21 Adults 21-59 Adults 60 +	Yes	
Individual Providers							
Lundberg, Mark M.D.	560 Cohasset Rd Ste 165 Chico, CA 95926	(530) 879-3950	Addiction Specialist		Youth 18-21 Adults 21-59 Adults 60 +	*	#

Contracted interpreters for ASL, Punjabi, Hindi, Urdu, Hmong, Laotian, Thai, Mien, Spanish, TTY/TTD, and ATT Language line are available at these locations

* Medical Staff provide services through BCDBH Services, do not contact provider directly for services

+ Placement in hospital determined by ACCESS/Crisis Team