Mental Health Services Act
Community Services and Supports

SUTTER-YUBA MENTAL HEALTH SERVICES THREE-YEAR PROGRAM AND EXPENDITURE PLAN

Fiscal Years 2005-06, 2006-07, 2007-08
Approved 05/22/2006

Table of Contents

Part I: County Public Planning Process and Plan Review Process

Section I: Planning Process

1) Briefly describe how your local public planning process included meaningful involvement of consumers and families as full services partners from the inception of planning through implementation and evaluation of identified activities.

Sutter-Yuba Counties MHSA planning process included 27 individuals who formed the MHSA Leadership Committee, 106 individuals who actively participated on five workgroups, 943 individuals who attended 74 focus groups and outreach activities and the completion of 1,977 surveys by individuals throughout the community to create a Community Services and Support Plan that would best meet the needs of our community.

Bi-County Mental Health Board

In early March 2005 the Mental Health Director presented the Bi-County Mental Health Board with an overview of Proposition 63, requesting that they accept a Leadership role in the planning process and provide direction to the workgroups developed to engage the various Stakeholders throughout our communities. The Bi-County Mental Health Board, including a Board of Supervisor member from each county, unanimously voted to accept a Leadership role in the MHSA planning process.

In Sutter/Yuba Counties, 57% of the Bi-County Mental Health Board is represented by consumer and/or family members. Many of these consumer/family members also actively participated in the MHSA planning process by co-chairing workgroups and providing significant input into the local planning process. Mental Health Board members were active in the following planning activities:

- All were members of the MHSA Leadership Committee
- Co-Chairs and participants in workgroups
- Assisted in the development of MHSA program strategy plans
- Provided outreach to community and family members

National Alliance for the Mental Ill – Yuba-Sutter Chapter

Members of the National Alliance for the Mentally Ill – Yuba/Sutter (NAMI) actively participated in the local MHSA planning process. NAMI members participated in the DMH-MHSA workgroups in Sacramento and have provided significant input into the local planning process. Members have actively surveyed consumers and/or family

members about the current services and priorities for the MHSA. NAMI members participated in the following planning activities:

- Members of MHSA Consumer Workgroup
- Members of the MHSA Leadership Committee
- Facilitators for targeted focus groups
- Survey collection activities
- Outreach to consumer and/or families
- Assisted in the development of MHSA program strategy plans

The National Alliance for the Mentally Ill – Yuba/Sutter (NAMI) also included MHSA Update reports in their newsletter to help with outreach, education on recovery and resiliency and to provide updates on the progress of the MHSA planning process. To view these newsletters, please visit www.suttercounty.org.

Consumers Who Do Not Belong to Organized Advocacy Groups

Outreach to consumers and family members who do not belong to an organized advocacy group was accomplished in a number of ways, including the following:

- Consumers were contracted to participate in workgroups and attend regular meetings.
- Consumer-to-consumer outreach was done in a variety of locations including service sites, parks, hospitals, and at a consumer/family picnic.
- Community Health Fairs were used to attract participation and receive input
- Staff and workgroup members staffed a booth during the County Fair providing outreach and information about MHSA
- Staff and workgroup members provided information and gathered survey data from individuals in board and care and psychiatric treatment facilities.
- Staff and workgroup members provided outreach and information to several ethnic groups to gather data and obtain assistance in program strategy planning.

Financial Assistance to Consumers and Family Members

To ensure that barriers to participation were reduced or eliminated a portion of the MHSA planning money was utilized in the following manner:

- Food for workgroup, Town Hall and some stakeholder meetings with consumer and family members
- Transportation provided to MHSA and Town Hall meetings (door-to-door) both daytime and after hours.
- Fifteen (15) contracts with consumers (including youth) and family members to compensate for their participation on workgroups, conducting outreach activities, and assisting with the MHSA planning process, for a total of 1,002 hours.

- Travel and meal expense to consumers to attend DMH-MHSA trainings in Sacramento

- Travel and meal expense to CIMH trainings in Sacramento
- Translation services

Consumer and family members have played a crucial role in the local planning process and have provided input through focus groups, the Sutter County MHSA website, the facilitation of focus groups and by supporting other consumers to assist them in providing input.

2) In addition to consumers and family members, briefly describe how comprehensive and representative your public planning process was.

Leadership Committee

To provide leadership and direction throughout the planning process a Leadership Committee was formed. The Leadership Committee consisting of 27 people made up the following representation:

- 26% staff
- 30% consumer/family
- 26% cultural/ethnic
- 18% at-large

The 27 member Leadership Committee reviewed the progress of the Stakeholder Workgroups and provided assistance as needed to obtain the resources necessary to assist the workgroups in their phase of the planning process.

The Workgroups compiled and reviewed data regarding unmet needs collected throughout the planning process and formulated recommendations of service strategies to meet the identified highest priority needs of the community and presented them to the Leadership Committee. The Leadership Committee was charged with reviewing all the recommendations and making final decisions on what strategies to include in the Community Services and Support Plan.

Mental Health Board

All twelve members if the Mental Health Board were members of the Leadership Committee. The Mental Health Board is also responsible to assure that an interactive public hearing is conducted to consider the Community Services and Support Plan prior to it being presented to the Boards of Supervisors for both Sutter and Yuba Counties. While the Mental Health Board has representation from both Boards of Supervisors who are familiar with the public hearing process, an overview and training provided by CIMH Web cast will be viewed by members of the Mental Health Board to ensure the public hearing process is an open and interactive process.

Project Management Team

The Project Management Team was established to facilitate the planning process. They were responsible, among other things, for:

- Initial training of Stakeholder Workgroups
- Communication
- Building PowerPoint presentations, brochures, flyers, etc.
- Creating resource binders for Stakeholder Workgroups
- Webpage development and updating
- Support to Stakeholder Workgroups
- Drafting and disseminating timelines of the planning process
- Data compilation
- Ensuring Workgroups had the resources necessary to conduct targeted focus groups

The Project Management Team included:

- Program Chief
- 3 Staff Analysts
- Clerical Support

Stakeholder Workgroup Development

Stakeholder Workgroups were developed to assist with outreach activities, targeted focus groups, data collection, community needs assessment and service strategy recommendations. Workgroups were made up of an ethnically diverse group of consumers, family members, providers, other agency representatives and mental health staff. 106 people provided active participation in the five designated Stakeholder Workgroups:

- Children
- Transition Age Youth
- Adult
- Older Adult
- Cultural Competency/Cultural Outreach

Initially, Stakeholder Workgroup members received a two (2) hour interactive training: on the change process and how to conduct an interactive meeting, using the following:

- PowerPoint presentation “Leading A Successful Change Process” (See Attachment I-2a)
- PowerPoint presentation “An Invitation to Participation in Open Discussion” (See Attachment I-2b)

The presentation for the remainder of the training was conducted as a targeted focus group, using the following:

- Sutter-Yuba Mental Health Services Plan-to-Plan document

- Mental Health Services Act (MHSA) Community Training (See Attachment I-2c)
  Including:
  - Background on the Public Mental Health System
  - Description of existing local Children's Services, Adult Services and Emergency Services.
  - Overview of the Mental Health Services Act including core philosophies and intent.
  - Recovery and Resiliency
  - Cultural Competency
  - County Demographics, population and utilization data
  - Consumer self-help
  - Community collaboration
  - Planning Timelines
- Open discussion question: "What is wrong with the current mental health system?"
- Open discussion question: What strategies can be used to improve the current mental health system?"

Stakeholder Workgroups were charged with ensuring that each workgroup consisted of diverse representation from consumers and family members,, providers and agency representatives from both Yuba and Sutter Counties and Community-Based organizations. This was accomplished by Stakeholder Workgroups and staff conducting outreach and obtaining participation request forms from those individual wishing to be active members and assist with the planning process (See Attachment I-2d – "Yes! I want to participate" form).

Membership in Stakeholder Workgroups remained open, with 18 to 26 members per workgroup. Workgroup members were tasked with compiling data and information that was received through outreach, targeted focus groups and Town Hall Meetings and developing recommendations for service strategies that were then presented to the MHSA Leadership Committee.

Stakeholder Workgroups were provided with a binder containing:

- Sutter-Yuba Counties Plan-to-Plan
- DMH Letter No.: 05-01 Implementation of MHSA; Welfare and Institutions Code (WIC) Section a5847, 5858 and 5892
- Fact Sheet – Mental health Services Act
- DRAFT Program Expenditure Plan Requirements for the Mental Health Services Act
- Mental Health Services Act Community Training PowerPoint
- Final Report to the President – Achieving the Promise: Transforming Mental Health Care in America
- Descriptions of current services offered at Sutter-Yuba Mental Health Services.

Stakeholder Workgroups also viewed the video *Pathways to Wellness*.

All Stakeholder Workgroup meetings were open to attendance by any interested party and scheduled meetings were posted on the MHSA Webpage at www.suttercounty.org.

Outreach Activities that Ensured Comprehensive Community Participation

An extensive public awareness campaign was conducted to ensure inclusive and diverse input from the community. Community Health and County Fairs, informational mailings and Town Hall meetings were used to educate the community about the MHSA, concepts of resiliency and recovery and to collect data using the Sutter and Yuba Bi-County Mental Health Community Issues and Concerns Survey (See Attachment I-2e, Sutter and Yuba Bi-County Mental Health Community Issues and Concerns Survey, English, Spanish and Punjabi).

- Mental Health Services Act Webpage

  A webpage was developed to provide updated information about the Mental Health Services Act and the Sutter-Yuba Mental Health Services planning activities and to provide a link to the State MHSA webpage. The webpage can be viewed at www.suttercounty.org. The following is a listing of available documents on the webpage:

  - Mental Health Services Act overview
  - All PowerPoint Presentations
  - All Meeting Flyers
  - All Brochures
  - Description of Services
  - Agenda and Minutes of all Workgroup Meetings
  - Calendar of scheduled meetings and events
  - Issues and Concerns Surveys

- Community Health Fairs

  The following Community Health Fairs were attended by members of the Stakeholder Workgroups (staff, consumers and/or family members) where displays were set up and attendees received information about the MHSA and services available at Sutter-Yuba Mental Health Services. Attendees were offered the opportunity to complete the “Yes! I want to participate” form and were encouraged to become active in the MHSA planning process. As part of an anti-stigma effort, educational materials were provided about mental illness.

  - Harmony Health 4th Annual Spring Fling
  - Yuba Community College Spring Health Fair

- Children's Home Society Annual Children's Faire
- 4th Annual Wheatland/Beale Community Fair
- Juneteenth Celebration

- Informational Mailings

  Packets of information about the MHSA and dates of Town Hall Meetings (See Attachment I-2f, MHSA Brochure English, Spanish and Hmong) along with Issues and Concern Surveys were mailed or delivered to Community-based organizations, consumers and/or family members, other services agencies, schools and providers outside of Sutter-Yuba Mental Health Services. The surveys were distributed in English, Spanish and Punjabi. The following list includes some of the recipients of these surveys:
  - Sutter and Yuba Migrant Education
  - Sutter and Yuba School Readiness Programs
  - The Hmong American Association
  - The Sikh Temple
  - ASSA (Asian Indian Organization)
  - Bethel AME Church
  - St. Isidore's Church
  - St. Joseph's Church
  - Richland Housing
  - The Parent Assistance Network
  - California Exceptional People
  - Rideout-Fremont Home Health
  - Sutter North Home Health
  - FREED
  - Yuba and Sutter Counties' Public Guardians
  - Rideout-Fremont Hospice
  - IHSS Public Authority
  - Senior Legal Services
  - Veteran's Services
  - Live Oak District Chamber of Commerce
  - Marysville Joint Unified School District
  - Sutter and Yuba County Offices of Education

- Mental Health Services Act Consumer and Family BBQ

  Sutter-Yuba Mental Health Services hosted a Consumer/Family BBQ (See Attachment I-2g, MHSA Consumer & Family BBQ Flyer) which provided information about the MHSA and how consumers and/or family members can become involved in helping to transform the mental health system. Guest speakers included consumers in recovery.

- Town Hall Meetings

  Sutter-Yuba Mental Health Services conducted six (6) Town Hall Meetings all of which were advertised in the local newspaper (See Attachment I-2h, *Appeal Democrat* News Ad) and with posters displayed in other services agencies, community based organizations and public information boards (i.e. grocery stores, Chamber of Commerce, on city buses) (See Attachment I-2i, Town Hall Meeting Flyer English and Spanish) in an effort to educate and generate feedback from the general public.

  Attendees of the Town Hall Meetings were provided with translation services, hearing assistance devices, transportation and child care assistance. Also available were soft drinks, water, juice and a variety of fresh fruit and snack foods.

  Attendees of the Town Hall Meetings received information on current services provided by Sutter-Yuba Mental Health Services (See Attachment I-2j, Service Descriptions Youth, Adult and Emergency), a copy of the evenings' PowerPoint presentation (Mental Health Services Act Community Training) and viewed the Mental Health Services Act (MHSA) Community Training before being divided into groups which visited four age specific work stations:

    - Children
    - Transition Age Youth
    - Adult
    - Older Adult

  At these workstations participants were asked to respond to two questions:

    - What do you see as the current mental health issues/needs related to the specific age group?
    - What strategies would you like to see used to improve or remove mental health issues/needs related to the specific age group?

  All responses from the public at the Town Hall Meetings were written on easel paper and displayed throughout the meeting. The final 15 minutes of each Town Hall Meeting attendees were given a specific number of colored dots for each age category to prioritize what they felt were the highest priority issues and the best strategies to address those issues.

  Reponses from the Town Hall Meetings were compiled and provided to all workgroups for inclusion in developing recommendations.

The input received from these meetings was very valuable. In most instances there were attendees who remained after the meeting to speak one-on-one with staff and consumer/family members who facilitated the meetings.

- Cultural Outreach Community Meeting

  - Asian Indian

  The Cultural Competence/Ethnic Workgroup developed a sub-group consisting of members of the Asian Indian community. Workgroup members went into the community to meet with concerned groups through focus groups to receive feedback and to educate Asian Indians about the MHSA and distribute English/Punjabi language Issues and Concerns Surveys. Data collected was used to recommend strategies to meet the needs of this population.

  - Hmong

  The Hmong community is an under served population of Sutter and Yuba Counties. Contracted consumer/family members solicited feedback from the Hmong Community by distributing flyers, talking with members of the Hmong community at local Asian grocery stores and requesting that individuals complete the Issues and Concerns Survey. The Hmong American Association hosted a community forum, which was held with the assistance of Hmong speaking Mental Health staff. Fliers (See Attachment I-2k, Hmong Community Meeting – Hmong) were placed among the Hmong community to inform the Hmong population of the meeting

  The MHSA was explained, translating the Mental Health Services Act training into Hmong. The needs of each of the age groups were discussed and information was gathered related to the Hmong culture and how Sutter-Yuba Mental Health Services could better meet the mental health needs of the Hmong community.

  - Latino

  The Cultural Competence/Ethnic Workgroup developed a sub-group consisting of members of the Latino community. Workgroup members went to the Spanish language masses at local churches and also held a forum at a low-income housing complex frequented by farm workers. At these activities they conducted informational sessions and distributed written information about the MHSA and services currently available at Sutter-Yuba Mental Health. Hundreds of Issues and Concerns Surveys were distributed and subsequently completed. Data collected was used to recommend strategies to meet the needs of this population.

- Additional Outreach Activities

  In addition to the above mentioned outreach activities a focus group was held with Yuba-Sutter Pride regarding the specific needs of gay, lesbian, bisexual and transgender individuals,

  In addition, Stakeholder Workgroup members went out into the community to inform about the MHSA and gather Issues and Concerns Survey to ensure that the widest range of individuals possible could provide input into the planning process. The following list, which is not all inclusive, reflects the efforts of these workgroups:

  Yuba-Sutter County Fair August 4th though August 7th
  St. Isidore Catholic Church
  St. Joseph Catholic Church
  Olivehurst Community Park
  Yuba City Community Park
  Bethel African Methodist Episcopal Church
  Juneteenth Celebration
  .

Targeted focus groups

Targeted focus groups were extensively conducted by each of the workgroups as the primary focus of the initial parts of the local stakeholder process in Sutter and Yuba Counties. Use of these small, targeted focus groups as a means of disseminating and gathering information proved to be extremely successful. A total of seventy four (74) targeted focus groups were conducted at a wide variety of locations using the following criteria:

- Established gathering place for members of the focus group
- Easily accessible to the targeted group
- Existing staff meetings for agency personnel

A small sampling of the specific locations at which focus groups were conducted included:

- Yuba College – Youth Build
- Sutter County Health Department
- Yuba County Probation
- Buttes Christian Manor
- Sutter County Parent Network
- Parolee Orientation
- California Exceptional People Services

- Sutter County Sheriff
- Yuba County Sheriff
- Head Start Policy Council
- Salvation Army – Homeless Mentally Ill Program
- Yuba County Office of Education
- Sun Garden Family Care Home
- Yuba City Police Department

In order to reach significant numbers of community members and diverse types of stakeholders, targeted focus groups were conducted by large and diverse number of presenters. These presenters were members and participants of the Stakeholder Workgroups which focus on specific age groups. Presenters (staff, consumer and/or family members and representatives of Community-based organizations) were connected to the needs and interests of that specific targeted focus group.

In addition to the focus groups conducted by consumers, family members, and staff; the MHSA Project Management Team, Mental Health Director and Human Services Director conducted many informational presentations and met with key community stakeholders. The following is a representative list, not all inclusive, that reflects the efforts of the Stakeholder Workgroups' participation in the community needs assessment:

- Consumers that are not part of organized groups
- Family members that are not part of organized groups
- NAMI Yuba-Sutter
- Consumers residing in residential care facilities
- Youth receiving services in the Juvenile Hall
- Transition Age Youth
- Hospital administration and emergency department managers
- Yuba-Sutter Pride
- Racial and ethnic communities
- Community-based organizations
- Educators
- Homeless individuals
- Health care clinic staff
- SYMHS staff, clinical and administrative programs
- Probation Department staff
- Health Service Agency staff
- Superior Court Judges
- Physicians involved in providing care to low income and indigent populations
- Law enforcement
- Private Mental Health Providers, i.e. MFT, LCSW, Ph.D., M.D.
- Social Services Agency staff including Adult Protective Services, Child Protective Services and Eligibility Services
- Faith-based community representatives

- Area Agency on Aging
- Casa de Esperanza (battered women's shelter)
- Yuba County Children's Council and Sutter County Family Intervention Team
- Yuba Community College
- California Exceptional People Services
- Head Start Policy Council
- Salvation Army Homeless Mentally Ill Program
- Sutter-Yuba Gleaners
- First Steps Perinatal Treatment Program
- Early Head Start Family Education
- Parent Assistance Network
- Fremont-Rideout Consortium for Continuing Medical Education
- Butte College – ILP Youth

In summary, Sutter and Yuba Counties are confident that through the MHSA webpage, Targeted Focus Groups, community presentations and Town Hall Meetings and various other networking methods over 850 pieces of input and some 1,977 completed surveys were obtained from the multitude of community groups and individuals who participated in the Sutter-Yuba County's MHSA community outreach and information campaign; 943 people participated in 74 Focus Groups and six Town Hall meetings and 106 people were actively involved with the five MHSA workgroups.

Demographic Results of Community Outreach

Attachment I-2l shows demographic information with regards to responses and input that were received in the initial planning phase of MHSA. It should be noted that participants who completed Issues and Concerns Surveys voluntarily submitted demographic information; therefore, this data does not completely describe everyone who has responded.

Workgroup Recommendations

Stakeholder Workgroups, using the information and data collected through outreach and targeted focus groups identified the needs associated with their specific workgroup and developed recommendations for service strategies to meet those needs. These recommendations took into consideration the five essential elements: community collaboration, cultural competence, client/family driven services, and focus on wellness and integration of services.

Stakeholder Workgroups met with the Leadership Committee over a two (2) day, seven hour period and presented those recommendations. From these recommendations, the Leadership Committee provided the direction which has resulted in the Sutter-Yuba Counties Community Services and Support Plan.

3) Identify the person or persons in your county who had overall responsibility for the planning process. Please provide a brief summary of staff functions performed and the amount of time devoted to the planning process to date.

The Assistant Director of Human Services, Director of Mental Health, Joan Hoss, LCSW was tasked with the overall responsibility for the planning process associated with the MHSA. Under her guidance the Project Management Team was developed to assist with the numerous tasks associated with this undertaking.

The Project Management Team performed the following functions:

- Initial training of Stakeholder Workgroups
- Communication
- Building PowerPoint presentations, brochures, flyers, etc.
- Built resource binders for Stakeholder Workgroups
- Webpage development and updating
- Support to Stakeholder Workgroups
- Determining timelines of the planning process
- Data compilation
- Ensuring Workgroups had the resources necessary to conduct targeted focus groups

Project Management Team Members and time invested:

Name	Position	Time Invested
Lynn Tarrant	Program Chief	277 hrs
Karen Brown	Staff Analyst	277 hrs
Beverly Griffith	Staff Analyst	384 hrs
Donna Thompson	Staff Analyst	554 hrs

Stakeholder Workgroups:

Stakeholder Workgroup Leads:

Name	Position	Time Invested
Lynn Tarrant	Program Chief	262 hrs
Jackie Stanfill	Program Manager	262 hrs
Laura Ruble	Program Manager	262 hrs
Sue Shaffer	Special Projects	262 hrs
Joan Hoss	Director	105 hrs

In addition to the Stakeholder Workgroup Leads, active participants of the Stakeholder Workgroups included a combined total of 94 people, representing:

- Staff

- Consumer/family members
- Representatives of Community –based Organizations
- Other service agencies

Leadership Committee:

The 27 persons who made up the Leadership Committee committed a minimum of 5 hours monthly to review the progress of the MHSA planning and provide guidance.

General Staff:

General staff provided over 800 hours of their time to assist with outreach, presenting to targeted focus groups and providing support for Town Hall Meetings.

Consumer/Family Members:

Sutter-Yuba Mental Health Services has contracted with fifteen (15) consumer/family members to provide an accumulated 1,002 hours of service participating on workgroups, conducting outreach activities, and assisting with the MHSA planning process.

Contractual Services:

Sutter-Yuba Mental Health Services contracted with the following individuals for services:

Jan Medley –

Jan was tasked with the writing of Sutter-Yuba Counties MHSA Plan-to-Plan.

Laurie Desmond –

Laurie was tasked with providing facilitation training to Stakeholder Workgroups to ensure an open atmosphere for participation at targeted focus groups. Laurie also provided facilitation of presentations and discussions at public forums.

Duerr and Associates –

Duerr and Associated were tasked with assisting in the development of the Issues and Concerns Survey and assisting in data collection and analysis of data collected through the survey process.

4) Briefly describe the training provided to ensure full partnership of stakeholders and staff in the local planning process.

Sutter-Yuba Mental Health Services determined that in an effort to get the most valuable feedback, all participants would need the same training provided to Project Management and staff, which emphasized the five essential elements: community collaboration, cultural competence, client/family driven services, a focus on wellness and integration of services. Therefore the documents listed below were used to provide training to staff, stakeholders, targeted focus groups and Town Hall meeting attendees. In additional to this training the DMH General Stakeholder Meetings and Conference Calls were made available to those who wished to attend.

The PowerPoint presentation was provided in hard copy to all participants as were the descriptions of services.

The presentation for the remainder of the training was conducted as a targeted focus group, using the following:

- Mental Health Services Act (MHSA) Community Training (See Attachment I-2c)
  Including:
  - Background on the Public Mental Health System
  - Overview of the Mental Health Services Act including core philosophies and intent.
  - Sutter-Yuba Mental Health Services MHSA Plan-to-Plan
  - Recovery and Resiliency
  - Cultural Competency
  - Provision of integrated services
  - County Demographics, population and utilization data
  - Consumer self-help
  - Community collaboration
  - Planning Timelines
- Description of services
- Open discussion question: “What is wrong with the current mental health system?”
- Open discussion question: “What strategies can be used to improve the current mental health system?”

Part I: County Public Planning Process and Plan Review Process

Section II: Plan Review

1. **Provide a description of the process to ensure that the draft plan was circulated to representatives of stakeholder interests and any interested party who requested it.**

   September 1, 2005

   The Stakeholder Workgroup presented to the Leadership Committee their findings and recommendations developed through the MHSA planning process. The Leadership Committee reviewed and approved recommendations to be included in the CSS Plan.

   September 7, 2005

   The Stakeholder Workgroups reviewed with the Leadership Committee the budget analysis of the recommendations presented on September 1, 2005. The Leadership Committee provided direction to continue with writing the plan which will include all approved recommendations.

   October 14, 2005

   Draft CSS Plan provided to all Leadership Committee members for review and preparation of discussion at their October 20, 2005 meeting.

   October 20, 2005

   Leadership Committee provided feedback on the draft CSS Plan and finalized the Plan for release to the public for review on October 28, 2005.

   October 28, 2005

   CSS Plan published for review with Public Hearing to be held on November 28, 2005. It was posted on the website, distributed to the public libraries and publicized in the local newspaper. The draft plan or the link was sent out to all members of the Work Groups and the Leadership Committee and to other interested community members. Copies were sent as requested by the public.

   November 28, 2005.

   Sutter-Yuba Mental Health Board convened Public Hearing and received input and recommendations. The Mental Health Board then approved the draft Plan as submitted with the comments as reflected in Part 1, Section II-2 thru 4.

December , 2005

Review and approval of the CSS Plan by both Sutter and Yuba County Boards of Supervisors occurred during December, 2005. Yuba County Board of Supervisors approved the plan on December 20 and Sutter County Board of Supervisors approved the plan on December 27.

January 1, 2006

No later than 1/1/06 the CSS Plan will be submitted to the State.

2. Provide documentation of the public hearing by the Mental Health Board or commission.

The announcement of this meeting was posted in accordance with the Brown Act. See Attachment I-2m.

3. Provide the summary and analysis of any substantive recommendations for revisions.

Margery Hubbard, Chair of the Mental Health Board opened the Public Hearing at 6 pm. Twelve people attended the public hearing. Joan Hoss, Director of Mental Health Services provided an overview of the planning process and described all of the proposed program elements. Three people chose to comment.

- Claudia Hollis of FREED Center for Independent living in Marysville testified as to the need for affordable housing for people with disabilities; the need for accessible substance abuse services for people with disabilities, specifically for deaf or vision-impaired people; and the need for accessible services for people with dual mh/substance abuse disorders. She applauded the level of community involvement in the MHSA Plan.
    - The Board concurs with the need for affordable housing for people with psychiatric illnesses. Contained within the plan is a recommendation to use MHSA funds for this purpose. The Board concurs with the basic notion that all MH and Substance abuse services should be accessible to people with disabilities. The Board concurs with the need for accessible services for people with dual drug and alcohol and mental health disorders and several proposals in the MHSA focus on providing integrated dual diagnosis services
- Lonetta Riley of Yuba City inquired as to what our referral process would be to identify families and children for the 0-5 treatment program and what type of diagnoses will we accept; how will you ensure cultural competence of the staff, specifically beyond the simple question of race, and how will you train for this?

- It was explained that the CSS Plan is specifically intended to serve those individuals with serious psychiatric disorders. Children 0-5 will be referred from the integrated service teams that exist in both Sutter and Yuba Counties (FAST and YCAT). The Board concurs that providing culturally competent services is a high priority and the recruitment and training of culturally diverse staff is reflected throughout the CSS Draft Plan.

- M. Cook of Yuba City expressed concern with a lack of assistance until her issues became a crisis (she recommended more timely access to inpatient care).
    - The Board agrees that both inpatient and outpatient MH services ideally should be provided in a timely fashion and at a level that meets the needs of each consumer. The MHSA prohibits using these funds for involuntary care. Because of this prohibition and the limited funding available, the Board does not recommend that funds be committed to an expansion of inpatient services

We read into the record correspondence that we had received after our Draft Plan was posted during the public comment period.

- A letter from the California Indian Rural Health Board from Sacramento requesting that Indian Health plans be recognized as legitimate stakeholders in the MHSA planning process and that Indian Health Plans receive MHSA funding.
    - The Board is committed to providing culturally appropriate services to Native Americans. The Bicounty MH Plan has many self-identified Native American staff and the Mental Health Plan will utilize specialty outside providers as indicated on an individual case by case basis. Since there are no organized tribal entities within Sutter or Yuba Counties, Native Americans were invited to participate in the planning process through the Town Hall meetings and the 74 focus groups and outreach activities.
- A letter from Heidi Hamilton of Survivors International of San Francisco requesting that survivors of torture be recognized as legitimate stakeholders in the MHSA planning process and requesting that Survivors International receive MHSA funding to serve survivors of torture who are residents of Sutter and Yuba counties
    - The Board agrees that survivors of torture as well as other people who experienced significant trauma will often require specialty mental health services. The Board is pleased that this CSS proposal contains a commitment to obtain specialty training in trauma-based mental health treatment for the clinicians of Sutter-Yuba Mental Health. On an as-needed basis, individuals may be referred for other specialty services.
- C. Paine of Sutter-Yuba Counties recommended that mandatory classes for recipients of Mental Health services to help them understand the benefits of taking medication in order to live one's life normally

- Due to the prohibitions contained in the MHSA, the Board notes that mandatory classes cannot be funded by the MHSA. However, the Board applauds Sutter-Yuba Mental Health for its efforts to provide clients with appropriate information on diagnoses and recommended treatments.

- Daisy Shelton, Ombudsman Services of Northern California in West Sacramento recommended that counseling and/or behavioral modification classes for residents of care homes who have not been assessed with mental illness, be funded through the MHSA .
  - Contained with this CSS Plan is a recommendation to expand MHS to older adults, including those living in residential care homes. However, the Board notes that the CSS Plan of the MHSA is not intended to provide services to those who have not yet been assessed with mental illness. Future plans that focus on prevention and early intervention services may be able to address this unmet need.

4. If there are any substantive changes to the plan circulated for public review and comment, please describe those changes.

In response to the input from Claudia Hollis from FREED, we have elaborated somewhat on our proposal to expand affordable housing. Throughout the CSS planning process, the lack of available, affordable housing was identified as a community need. During the course of this three year plan, we have set aside $750,000 to be used to match to state and federal dollars to allow us to develop new affordable housing units in the Sutter-Yuba area. These units will be developed in cooperation with the Sutter and Yuba County Housing Authorities. Such housing may involve new construction or rehabilitation of existing units. The housing may involve apartment complexes, clustered duplexes, or shared congregate living houses. Our intention is for the housing to be held in ownership by the public authorities for use by eligible individuals with psychiatric disabilities. It is our intention to provide all of the necessary details in our updated 06-07 thru 08-09 plan

Part II

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

Response:

Please answer each of the following questions pertaining to how community issues resulting from a lack of community services and supports were identified in the public planning process.

1) **Please list the major community issues identified through your community planning process, by age group. Please indicate which community issues have been selected to be the focus of MHSA services over the next three years by placing an asterisk (*) next to these issues. (Please identify all issues for every age group even if some issues are common to more than one group.)**

County/Community Issues Identified in the Public Planning Process:

Children/Youth

1. Ineffective Parenting due to parental difficulties (co-occurring disorders - substance abuse and mental illness)*
2. Children in Crisis without adequate treatment*
3. SED 0-5 untreated*
4. Disruptive children in school leading to high rate of expulsions and drop outs*
5. Children using/abusing drugs and/or growing up in drug environment
6. Children placed out of home – foster/kinship/group home
7. Juvenile Justice involved children, including 601s
8. Children homeless, in poverty

Transition Age Youth

1. Lack of treatment for co-occurring disorders*
2. Inadequate temporary/emergency/transitional/permanent housing*
3. Inadequate treatment, especially insufficient range of crisis services*
4. Jobs and Workforce development*
5. Lack of relevant school/education/training*

Adults

1. Homeless adults with co-occurring disorders*
2. Incarcerated adults with a co-occurring disorder released into the community without adequate treatment.
3. Adults living in IMDs because there are no options to accommodate their level of care in a community setting.
4. Lack of help in a crisis*
5. Lack of help finding and keeping a job*

Older Adults

1. Safe Housing*
2. Help getting and keeping housing*
3. Help in a crisis*

4. Homelessness*
5. Support service to maintain independent living

2) Please describe what factors or criteria led to the selection of the issues starred above to be the focus of MHSA services over the next three years. How were issues prioritized for selection? (If one issue was selected for more than one age group, describe the factors that led to including it in each.)

Following a general training and dissemination of data, each workgroup met initially to discuss all concerns and issues brought to the table by representatives of most of the other community service providers as well as consumers, family and community members. To create the survey, these issues were captured in a couple of dozen questions for each age group on a survey which was distributed to the community. Respondents were encouraged to enter their own concerns if they were not already listed on the survey. More than 1,977 surveys were completed and returned. The top concerns identified in the survey for each age group were presented to the workgroups for their discussion along with the original concerns voiced by workgroup participants. Together, they narrowed down the concerns to the top five or less which were then presented to the Leadership Committee for consensus. Two four-hour meetings were held to present and discuss the issues of concern for each age group and the ethnic groups. The total budget was divided up equally amongst the participants. Each participant then assigned "their money" to the age and ethnic groups which they felt needed the most services. Using these allocations as a guide, program proposals and budgets were developed to address the specific issues that had been agreed upon by the Leadership Committee.

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

For **Children**, the county school drop-out rates are similar to the state's when combined, but Sutter County is significantly under the rate of the state, while Yuba County's dropout rate is almost 70% higher than the state average. Within this aggregate, Native Americans in both Yuba and Sutter Counties and Latinos and Pacific Islanders in Sutter County had higher than average rates. By contrast, Sutter County expelled 123 students – a rate (.73%) almost double that of the state average (.42%), while Yuba only expelled 13, a little more than one fifth of the state average. Latino and Asian children in Special Education for emotional disturbance are both significantly underrepresented, while Latinos are overrepresented in the Specific Learning Disability category which, while not technically a mental health issue, could certainly speak to self esteem and other mental health issues. In both counties, Asians are underrepresented in the Special Education classes, which may mean that Hmong in Yuba County and Asian Indians in Sutter County are not being adequately assessed. Children of migrant workers, who are predominantly Hispanic,

are not being seen and assessed due to many factors, including the transitory nature of their residence. From the school statistics for language breakouts for English learners we learn that both Yuba and Sutter Counties have high levels of English learners in the Hispanic communities, representing the preponderance of English learners in both counties. The secondary language in Yuba County is Hmong and in Sutter it is Punjabi. Respectively, these three languages account for more than 90% of all children learning English in school, some 17% of the total population of school children. The mental health needs of these children are unlikely to be served, especially in the very young, not only because of their inability to communicate in English, but also because their parents may be unable to find appropriate help in their language, or they have not been given information on recognizing these childhood issues as being treatable mental health problems.

For **Transitional Aged Youth**, the above inequities apply and also, there is an inequity in the arrest of Hispanic juvenile arrestees –proportionately more are arrested than are warranted by their numbers in the county. Since there are few services for Hispanics, and no Spanish-fluent mental health therapists working in the juvenile hall, this is potentially an unserved area. Several agencies are reporting that they are seeing a higher number of young transition-aged females with self-harming, high risk behaviors. In the last year, 54 such underserved young women were identified but adequate treatment is not yet available. A further 36 youth were identified as aging out of foster care and thus being unserved as there are no transitional placements for them. Between Mental Health and Probation, 65 youth transitioned to adult services, with little or no preparation. The number of Hispanic youth of this age being cited for felonies is higher than would be expected based upon their percentage of population: 31% cited vs. 27% population. Since this does not appear to be a problem in the adult population, it may be due to Hispanic gang-related activity which is becoming prevalent in both communities.

For **Adults**, the major inequities are those of language and physical distance. Persons who do not speak the language, especially females, have difficulty accessing services that they may need because there is a shortage of qualified mental health personnel who are multilingual. Where they are also isolated by distance or lack of transportation, the problem is exacerbated. Although we would like to be able to discuss these and many other disparities in detail, there were limitations to the data that we could collect. Specific data on the many homeless people who have not made use of the welfare system is difficult to find, although the Salvation Army Depot says that they have high numbers of single men and single parent families.

Older Adults have these same problems. A member of the workgroup found that older adults in IMDs were not given adequate access to services when transitioning back into the community or into another home setting.

4) If you selected any community issues that are not identified in the "Direction" section above, please describe why these issues are more

significant for your county/community and how the issues are consistent with the purpose and intent of the MHSA.
N/A

Section II: Analyzing Mental Health Needs in the Community

Direction:

1. Using the information from population data for the county and any available estimates of unserved populations, provide a narrative analysis of the unserved populations in your county by age group. Specific attention should be paid to racial ethnic disparities. Counties will have to use multiple informing factors to address this section. DMH will provide some data for counties based on the 2000 U.S. Census, updated Department of Finance population data, uninsured rates, and poverty rates by race ethnicity. Counties will also need information from other county offices, including social services, education, criminal and juvenile justice and other data sources such as recent county homeless surveys to estimate some of the populations. Ethnic-specific community-based organizations and tribal organizations often have detailed population data to contribute to this analysis.

Since we have no true full service “whatever it takes” service models in our current treatment system and no information on how many clients feel that all of their service needs are being fully met, we are potentially under serving all of our clientele. For purposes of comparison, we have determined that those receiving any services at SYMH will be used to enable some kind of statistical analysis. However, when reading the following statistics, please remember that, in essence, we may not be fully serving any of the clientele that we see. The total population of Sutter and Yuba Counties in 2000 (the date of the prevalence estimates) was 139,149. The prevalence estimates indicated that 9,232, or 6.6% of the population were in need of services from Mental Health, but only 3.5% are actually receiving them, leaving some 4,384 or 47% of the total unserved.

Youth - In our analysis by age, the primary group we are under serving is the 0-5 age group. According to the prevalence data, we are only serving 4% of the population that we should be serving, leaving some 958 children 0-5 unserved. A local survey of 22 family child care and early care and education providers identified 84 children with challenging behaviors (detached, active/hypersensitive, under reactive, difficulty regulating behavior, hurts self/adults, hurts animals/pets and abnormal non-compliance) who may be in need of mental health treatment.

Also, according to the prevalence data, more females than males are in need of treatment, so for the group as a whole, we estimate that 76% (1,578) of the females are unserved, as compared to only 48% of the males. Since our clientele are about equally male and female, it follows that we are particularly under serving females in most age categories, especially in the younger adult category (girls 6-17 are 54% unserved).

Transition Aged Youth The Transition-aged youth workgroup found a particular gap in the services for females, as some 60% of females needing services are unserved.

Adult The adult focus groups felt that although this is the age group that we are best serving, persons who are homeless with a co-occurring substance abuse disorder were most likely to be unable to obtain the range of services that they required. In this category, ethnic disparities are also prevalent as discussed below.

Older Adults The focus groups and the data concurred, based on the prevalence data we are under serving all older adults, leaving some 514 or 63% of those estimated to need mental health services unserved.

2. **Using the format provided in Chart A, indicate the estimated total number of persons needing MHSA mental health services who are already receiving services, including those currently fully served and those underserved/ inappropriately served, by age group, race ethnicity, and gender. Also provide the total county and poverty population by age group and race ethnicity. (Transition Age Youth may be shown in a separate category or as part of Children and Youth or Adults.)**

	Fully Served	Underserved/ Inappropriately Served * 03-04 data SYMH		Total Served		County Poverty Population * US Census, 1999 100% Poverty		County Population *California DOF figures 2000	
CHILDREN AND YOUTH		Male	Female	Number	**%**	Number	**%**	Number	**%**
TOTAL	0	756	449	1,205	**100%**	11,315	**100%**	41,645	**100%**
African American	0	22	15	37	**3%**	363	**3%**	991	**2%**
Asian Pacific Islander	0	21	9	30	**2%**	1,362	**12%**	5,078	**12%**
Latino	0	100	59	159	**13%**	3,904	**35%**	11,372	**27%**
Native American	0	15	11	26	**2%**	295	**3%**	724	**2%**
White	0	590	350	940	**78%**	4,459	**39%**	21,725	**52%**
Other	0	8	5	13	**1%**	932	**8%**	1,755	**4%**
TRANSITIONAL AGED YOUTH									
		Male	Female	Number	**%**	Number	**%**	Number	**%**

	Fully Served	Underserved/ Inappropriately Served * 03-04 data SYMH		Total Served		County Poverty Population * US Census, 1999 100% Poverty		County Population *California DOF figures 2000	
TOTAL	0	462	404	866	**100%**	4,348	**100%**	18,479	**100%**
African American	0	16	11	27	**3%**	101	**2%**	529	**3%**
Asian Pacific Islander	0	16	9	25	**3%**	412	**9%**	2,153	**12%**
Latino	0	80	63	143	**17%**	1,424	**33%**	5,015	**27%**
Native American	0	4	9	13	**2%**	57	**1%**	339	**2%**
White	0	339	308	647	**75%**	2,092	**48%**	9,823	**53%**
Other	0	7	4	11	**1%**	262	**6%**	620	**3%**
ADULTS									
		Male	Female	Number	**%**	Number	**%**	Number	**%**
TOTAL	0	1,496	1,948	3,444	**100%**	13,913	**100%**	76,486	**100%**
African American	0	58	55	113	**3%**	303	**2%**	1,958	**3%**
Asian Pacific Islander	0	80	162	242	**7%**	1,187	**9%**	7,624	**10%**
Latino	0	191	200	391	**11%**	4,000	**29%**	15,317	**20%**
Native American	0	26	46	72	**2%**	341	**2%**	1,404	**2%**
White	0	1,132	1,470	2,602	**76%**	7,274	**52%**	48,291	**63%**
Other	0	9	15	24	**1%**	809	**6%**	1,892	**2%**
OLDER ADULTS									
		Male	Female	Number	**%**	Number	**%**	Number	**%**
TOTAL	0	106	203	309	**100%**	2,069	**100%**	21,786	**100%**
African American	0	3	6	9	**3%**	42	**2%**	373	**2%**
Asian Pacific Islander	0	15	17	32	**10%**	221	**11%**	1,722	**8%**
Latino	0	4	19	23	**7%**	208	**10%**	1,672	**8%**

	Fully Served	Underserved/ Inappropriately Served * 03-04 data SYMH		Total Served		County Poverty Population * US Census, 1999 100% Poverty		County Population *California DOF figures 2000	
Native American	0	2	2	4	**1%**	52	**3%**	247	**1%**
White	0	80	157	237	**77%**	1,483	**72%**	17,391	**80%**
Other	0	2	2	4	**1%**	64	**3%**	381	**2%**

3. Provide a narrative discussion/analysis of the ethnic disparities in the fully served, underserved and inappropriately served populations in your county by age group as identified in Chart A. Include any available information about their age and situational characteristics as well as race ethnicity, gender, primary language, sexual orientation, and special needs.

Ethnicity

Although we are serving our African American and Native American populations at about the same rate as the white population (70-75% of the prevalence data estimate are being served), we are significantly under serving our Latino/a and Asian/Pacific Islander populations. Prevalence data indicates an unmet need of 1,464 Latino/as (72%) and 649 (67%) Asian/Pacific Islanders. Although there are variances in the rate, both groups are being consistently under served across all age categories, so the ethnic strategies that we have chosen to address these needs will be focused on the entire family. In our community, although we have no prevalence data to estimate the unmet needs within these groups, we have large Hmong and Asian Indian (mostly Sikh) populations. The characteristics of these groups are so entirely different that we must address them separately. Leaders from each of these three major local ethnic groups met separately to design potential services that would be appropriate for their own communities We had a Lesbian, Gay, Bisexual, Transgender (LGBT) focus group using members of the local Yuba Sutter Pride, but we have only anecdotal information on how well this subgroup is being served since we do not have specific data to indicate the percentage of our clients that are LGBT. There was consensus that there is a need for more services for this group because of the reported especially high national rate of suicide among LGBT teens. The Stakeholder group agreed to include specific, targeted informing materials regarding services for this group in all of their general informational handouts so that everyone will be better informed about available services and the potential for non-judgmental therapy without being specifically identified. In the current social climate, it is unlikely that we will be able to track this group sufficiently to discern other areas of disparity other than anecdotally.

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

Although Spanish is our only threshold language, Sutter-Yuba is committed to providing culturally competent services to all of our clients .Our data clearly illustrates that we consistently under serve those populations for whom English is not their primary language. We have been successful in recruiting two Hmong bicultural/bilingual Intervention Counselors and two Punjabi speaking bicultural/lingual clinical staff, a psychiatrist and a Supervising Intervention counselor. We also have three bicultural/bilingual Latina therapists and seven other Latino/a direct services staff. However, these populations remain underserved .Our primary objective related to culturally and linguistically competent services is to increase services to the three separate ethnic communities that we have identified as being significantly underserved – Latino/a, Hmong and Asian Indian. This will involve different kinds of outreach, with unique strategies for reaching each cultural group, however each outreach program includes hiring one or more staff that are both culturally and linguistically competent. Although the ethnic communities each created a service plan, they will also be implemented in conjunction with the age group plans. The Asian Indian plan's objective is to address their community's denial of mental health needs because of the stigmatization associated with seeing a mental health treatment provider within their close and tightly knit community. The Hmong community found that a history of trauma and social isolation and acculturation problems caused feelings of depression and worthlessness, leading to family problems exacerbated by unemployment and youth gang involvement. The Latino group determined that their principal need was for more information about mental health problems, available treatments, and language competent mental health treatment for all age groups provided in attractive, accessible settings to help with social isolation, depression, co-occurring substance abuse and mental health issues and family problems/domestic violence.

Other local ethnic populations are not as poorly served, but more attention needs to be focused on providing culturally appropriate services, such as utilizing faith-based services for our growing Russian populations and incorporating tribal healers for Native Americans who wish it. Although there is not a formal tribal entity in our two counties with whom we could actively plan, Sutter-Yuba Mental Health recognizes the need to link Native Americans with appropriate spiritual healing providers in concert with other treatment approaches.

Section III: Identifying Initial Populations for Full Service Partnerships

Response:

Please address each of the following questions pertaining to the identification of initial populations to be fully served during the first three years.

1) From your analysis of community issues and mental heath needs in the community, identify which initial populations will be fully served in the first three years. Please describe each population in terms of age and the situational characteristics described above (e.g., youth in the juvenile justice system, transition-age youth exiting foster care, homeless adults, older adults at risk of institutionalization, etc.). If all age groups are not included in the Full Service

Partnerships during the three-year plan period, please provide an explanation specifying why this was not feasible and describe the county's plan to address those age groups in the subsequent plans.

0-5 SED Full Service Partnership (FSP)

- Services will be developed to serve 10 children aged 0-5 per year who have severe emotional disturbances or severe mental illnesses that will result in significant social, emotional, educational and/or occupational impairments and/or who are at risk of homelessness.

TAY FSP

Services will be developed to serve 15 youth and young adults ages 16-25 per year who have severe emotional disturbance or mental illnesses that have caused significant social, emotional, educational and/or occupational impairments, and who are homeless or at risk of homelessness. Within this population priority will be given to the following:

- Young women with self-harming, high risk behavior (runaway, substance abuse, promiscuity, victimization)
- Youth aging out of foster care, and
- Youth aging out of children's mental health/probation AND aging into adult systems.

Adult/Older Adult FSP

Services will be developed to serve 30 adults and older adults who

- have mental illnesses that have caused significant impairment in social, emotional, educational and /or occupational impairments;
- and are homeless or at risk of homelessness;
- and are Adults and Older Adults with co-occurring disorders.

We will be serving Older Adults who are homeless or at risk of homelessness and have a co-occurring disorder in the above FSP. In addition we will also be developing a mobile assessment team to serve older adults who are geographically and/or physically isolated and/or unable to access clinic-based mental health services.

2) Please describe what factors were considered or criteria established that led to the selection of the initial populations for the first three years. (Distinguish between criteria used for each age group if applicable.)

Criteria used to select the Child/Youth FSP included:

- Estimates of the number of children in need, by age, gender and ethnicity
- Expertise brought to the workgroup by educators, parents, providers, clients and county staff
- Client/family/community survey and Town Hall data
- MHSA guidance to "start small and smart"
- Data on service utilization
- Are at risk of out-of-home placement, hospitalization, out-of-county placement, and/or homelessness
- Exhibit aggressive, volatile or self-injurious behaviors

Criteria used to select the TAY FSP members included:

- Estimates of the number of TAY in need, by age, gender and ethnicity
- Expertise brought to the workgroup by youth, parents, educators, law enforcement, providers, clients, and county staff
- Client/family/community survey and Town Hall data
- Data on service utilization
- MHSA guidance to "start small and smart"
- Anecdotal evidence that young women in this age group have inadequate services and supports for mental health treatment
- Anecdotal evidence that these youth are having difficulties transitioning into successful adult roles
- At risk of homelessness/hospitalization/self-destructive behaviors

Criteria used to select the Adult/Older Adult FSP included:

- Estimates of the number of adults and older adults in need, by age, gender and ethnicity, with a specific emphasis on underserved ethnic populations
- Expertise brought to the workgroups by clients, providers, county staff, law enforcement, faith community advocates for the homeless
- Client/family/community survey and Town Hall data
- Data on service utilization that shows that older adults are significantly underserved and are in need of crisis support services
- MHSA guidance to "start small and smart"
- Anecdotal evidence that services are highly inadequate to meet treatment needs and that adults/older adults often must fail before they are enrolled in services
- Prevalence data that indicates that older adults are significantly underserved
- Anecdotal evidence that many adults and older adults with SMI who have a co-occurring disorder are homeless or do not receive needed services
- Co-occurring disorders
- Homeless or at risk of homelessness

3) Please discuss how your selections of initial populations in each age group will reduce specific ethnic disparities in your county.

Racial/ethnic disparities (as demonstrated in the above table) occur most significantly among Hispanics, Hmong and Asian Indians across all age groups regardless of risk factors. We have chosen to address these ethnic inequalities by creating three separate outreach programs. These programs will actively seek out Hmong, Asian Indian and Latino clients who require the specialized services we propose to deliver through all of the CSS-funded services. These ethnic outreach programs will provide treatment services directly as well as referring

individuals as appropriate to the other proposed CSS programs as well as other Mental Health programs and services.

The initial FSP population of 0-5 SED children will include outreach, in addition to the specialized outreach programs, to Hispanic, Hmong and Asian Indian families regarding their treatment options through the strategies outlined in Section IV, thus helping to address the disparities in that age group. In addition parents of 0-5 children will be informed of and encouraged to pursue appropriate treatment options for themselves.

Our second FSP will target Transition Aged youth, aged 16 to 25, as described above, and within that set of youth, gives preference to those whose cultural identity places them in the most underserved populations within our community, notably, Hispanic, Asian Indian and Hmong.

The third FSP targets Adults and Older Adults. Adults over the age of 25 and older adults over the age of 60 will be targeted. Those with co-occurring disorders and those who are homeless or in danger of homelessness will be specifically targeted, and Latino/a, Hmong and Asian Indians will be given priority access to this FSP. In order to reduce ethnic disparities members of identified underserved ethnic groups will be identified and referred as appropriate from the Ethnic Outreach programs, from community providers and from other mental health programs to this FSP. Referrals will be made from other Sutter-Yuba Mental Health programs and will be solicited from other community providers and partner agencies.

The mobile outreach and treatment services for older adults 60 and over will specifically target those individuals who are living in geographic isolation, those who are isolated due to cultural and linguistic barriers, as well as those who cannot avail themselves of existing clinic-based services. Older adults will be screened and treated for previously untreated depression, other psychiatric disorders as well as for adjustment difficulties due to a life crisis. Those meeting the Adult/Older Adult FSP as defined above will be referred for this more comprehensive service within the capacity of this FSP.

Section IV: Identifying Program Strategies

Response

1) If your county has selected one or more strategies to implement with MHSA funds that are not listed in this section, please describe those strategies in detail in each applicable program work plan including how they are transformational and how they will promote wellness/recovery/resiliency and are consistent with the intent and purpose of the MHSA. No separate response is necessary in this section. N/A

Note: Section VI requires completion of Exhibit 4 (Program Work Plan Summary), which specifies the strategies that will be used in each program.

Section V: Assessing Capacity

Response:

1) Provide an analysis of the organization and service provider strengths and limitations in terms of capacity to meet the needs of racially and ethnically diverse populations in the county. This analysis must address the bilingual staff proficiency for threshold languages.

Spanish is our only threshold language. Aggressive recruitment of bi-lingual/bi-cultural staff has been undertaken with encouraging results. Although we have significantly increased the number of bilingual staff we have, we are still unable to have language proficient staff at all access points all of the time, especially the Psychiatric Emergency Services, Business Office and Reception. As a result these have all been trained in the use of the ATT language line. A recent study of Latino clients who did not remain in treatment indicated that this is one of our major areas for improvement. When recruiting new staff for these MHSA-funded positions hiring competent bi-cultural, bi-lingual staff will be a top priority. Creative recruitment strategies (such as using Spanish, Hmong and Punjabi language newspapers, radio and web sites will be utilized. In addition, in an effort to advance cultural competence, SYMHS has implemented cultural competency training programs to ensure familiarity with different beliefs concerning mental illness in different cultures. These trainings include an annual client culture training that focuses on the consumer and parent and/or caregiver's personal experiences. We also offer specific annual trainings regarding Hmong, Latino and Asian Indian cultures, working with the LGBT client, and this past year training on the African American community was added. Despite our success in increasing the number of bicultural/bilingual staff, it continues to be especially difficult to outreach to the Asian Indian population, even with a Punjabi speaking bicultural/bilingual psychiatrist on staff.

2) Compare and include an assessment of the percentages of culturally, ethnically and linguistically diverse direct service providers as compared to the same characteristics of the total population who may need services in the county and the total population currently served in the county.

Site	Category	Latino/ Mexican	African Am/ Black	Asian/ Pacific Islander	White	Native Am	Other
FICS	Admin/Mgmt	1	1		4		
	Support Staff				4		
	Direct Svcs	3	4		21		
MH-Main	Admin/Mgmt				12		
	Support Staff	5		2	15	3	
	Direct Svcs	9	3	6	40	5	4
CSOC	Admin/Mgmt				2		
	Support Staff	1			1		
	Direct Svcs		2		10	1	
First Steps	Admin/Mgmt				1		

Site	Category	Latino/ Mexican	African Am/ Black	Asian/ Pacific Islander	White	Native Am	Other
	Support Staff						
	Direct Svcs	1			6		
Other Community-Based	Admin/Mgmt						
	Support Staff				1		
	Direct Svcs				6		
Totals		**20**	**10**	**7**	**123**	**9**	**4**
% of Staff		11%	6%	7%	69%	5%	2%
Clients Served		12%	3%	6%	77%	2%	
Prevalence data		22%	2%	10%	63%	2%	
County population		20%	2%	10%	66%	2%	

Staff demographics are similar to client demographics. We have made great progress in recruiting both African American and Native American staff and these specific cultures are well represented, actually constituting a larger proportion than exists in the counties as a whole. However, we are under represented according to both the prevalence data and the county population statistics in serving those populations for whom English is not their primary language. We need to focus on our language proficiency to bring our proportion of bilingual staff to a level that reflects our community. We serve few people who self-identify as monolingual Spanish–speaking relative to the poverty population within the counties, and this will be addressed in our Ethnic Outreach plan. Of the 46 voluntary surveys returned by staff, 8 self-identified as having been a consumer of Mental health Services, 21 as having a family member who has been a consumer of Mental Health Services, 6 were lesbian, gay, bisexual or transgender and 1 had a physical disability.

County and Contract Mental Health Workers Language Proficiency Populations vs Clients Served and Total County Populations						
Site	Category	Hmong	Spanish	Punjabi	Other	Languages
FICS	Admin/Mgmt		1			
	Support Staff					
	Direct Svcs		5	1		
MH-Main	Admin/Mgmt		1			

	Support Staff	1	4	1	1	Tagalog
	Direct Svcs	1	11	2	9	Russian, German, Tagalog, Mandarin, French, Farsi, Hindi, Urdu, Lao, Thai
CSOC	Admin/Mgmt					
	Support Staff		1			
	Direct Svcs					
First Steps	Admin/Mgmt					
	Support Staff					
	Direct Svcs					
Other Community-Based	Admin/Mgmt					
	Support Staff		1			
	Direct Svcs					
Totals		2	24	4	9	
Staff Percentages		1%	14%	2%	5%	
Clients served		5%	3%	1%	2%	
Combined County pop		3%	16%	6%	2%	

3) Provide an analysis and include a discussion of the possible barriers your system will encounter in implementing the programs for which funding is requested in this Plan and how you will address and overcome these barriers and challenges. Challenges may include such things as difficulty in hiring staff due to human resource shortages, lack of ethnically diverse staff, lack of staff in rural areas and/or on Native American reservations and rancherias, difficulties in hiring clients and family members, need for training of staff in recovery/wellness/resiliency and cultural competence principles and approaches, need to increase collaborative efforts with other agencies and organizations, etc.

We recognize that the proliferation of MHSA funded jobs in all categories, but especially in the areas of bilingual/bicultural positions will make it even more difficult for small rural counties like ours to hire qualified bicultural/bilingual applicants. Overall staff recruitment is hampered by the remoteness of our community from “big city” cultural services and a university. We have recently increased our salaries and benefit package to enable us to recruit better applicants and a pay differential for bilingual, bicultural staff has also helped us to attract and retain bi-cultural/bi-lingual staff. We have been somewhat successful with targeted recruitment and plan to do more recruiting using media that target populations of the key ethnic groups among which we wish to recruit staff. This targeted recruitment will be crucial to filling the new positions proposed under this CSS plan, especially, but not only, for the Ethnic Outreach positions. Sutter-Yuba Mental Health has a significant historical connection with the Hmong American Association and has organized two multi-agency outreach activities to the Hmong

community through this organization. During this MHSA planning process initial contact with the Punjabi American Historical Society occurred. There is not a formal Latino cultural organization with the bi-county community but Migrant Education serves significant numbers of monolingual Latino and Asian Indian clients, Mental Health will continue to look for opportunities to build further relationships with these and other ethnic organizations within the community and to cooperatively serve our mutual clients. All current staff will be encouraged to find and assist potential applicants at all levels, and especially those who are bicultural/bilingual. Paying staff a "finder's fee" for those who are hired and complete probation is being discussed. We will encourage qualified individuals to apply for MHSA funded stipends to support advanced studies in mental health-related fields where future employment in our community seems likely. Realistically, we anticipate that with the growth in Mental Health services that will occur with the implementation of the MHSA we will be challenged to recruit the diverse staff we will be seeking. Therefore, the cultural outreach programs will each be located in different community settings where Latino, Hmong or Asian Indians already receive many services and there are support staff who are bi-lingual/bicultural readily available to assist monolingual individuals we will be serving.

.. We use our provider network to serve clients in proximity to their homes in more rural parts of the counties, however unfortunately the network has very limited cultural diversity. Every effort will be made to increase the diversity of the provider network.

We have a history of consumer employees but only limited experience with "parent partners" consumer family staff. We look forward to the opportunity to expand both consumer and family staff under this MHSA plan, and will be especially eager to increase cultural diversity among consumer and family staff. We believe we will be successful in recruiting consumer and family staff.

All of the staff will need to be given training in the recovery/wellness/ resiliency model, and MHSA dollars are being set aside to allow us to provide this important training to all staff. A combination of onsite and immersion training elsewhere will be utilized.

We already have an ongoing commitment to annual cultural competence training on Latino, Hmong, Asian Indian, LGBT and consumer cultures, and we are looking to increase our focus on specific cultural issues as they related to mental health treatment. We are also developing very specific written materials to assist staff in working with each of our major cultural groups.

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

Response:

I. Summary Information on Programs to be Developed or Expanded

1) See Exhibits 1, 2, and 3

2) See Attachment II-a

3) Please provide the estimated number of individuals expected to receive services through System Development Funds for each of the three fiscal years

and how many of those individuals are expected to have Full Service Partnerships each year.

2005-06 – 36, 2
2006-07 – 228, 7
2007-08 – 228, 7

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

2005-06 – 6, 1
2006-07 – 84, 14
2007-08 – 84, 14

5) For children, youth and families, the MHSA requires all counties to implement Wraparound services, pursuant to W&I Code Section18250, or provide substantial evidence that it is not feasible in the county in which case counties should explore collaborative projects with other counties and/or appropriate alternative strategies. Wraparound programs must be consistent with program requirements found in W&I Code Sections 18250-18252. If Wraparound services already exist in a county, it is not necessary to expand these services. If Wraparound services are under development, the county must complete the implementation within the three-year plan period.

Sutter County submitted a plan to provide wraparound services. This plan was approved by the State Department of Social Services in October, 2005. Sutter County will implement wraparound services during FY 06-07. Wraparound services are currently under development in Yuba County and the county will complete implementation within the three year plan period.

II. Programs to be Developed or Expanded

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: Sutter and Yuba	Fiscal Year: 2005-06	Program Work Plan Name: 0-5 SED Full Service Partnership
Program Work Plan #: 1		Estimated Start Date: April 2006

Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	A full-service, wraparound program for 0-5 Seriously Emotionally Disabled Youth, including parent training in an evidenced based parenting program like the Incredible Years or Triple P Parenting. The program will advance the goals of the MHSA by enabling SED children to remain in their communities, in their home, at school and out of the foster care system. Individualized service plans will address the larger needs of each family, enabling them to integrate their services through a multi-agency approach. The program will partner with each family and other important people they identify in developing service strategies and plans; that emphasize family, child/youth and community strengths rather than weaknesses; assist families in becoming the authors of their own service plans; encourage and support a shift from professionally-centered to family-centered practice; provides resources to enhance resiliency in children; and, also responds to child/youth and family needs and areas of growth. Embedded in these core values is recognition of the importance of the family's cultural values as a source of resilience, and an integral component of service delivery. This program will also allow a reduction in disparities for the identified racial and ethnic minorities who are underserved in our community; additional support for parents such as peer or mentor-led services, and a family-friendly approach to service planning and delivery; and peer/mentor-delivered services for parents. Access to assistance will be available on a 24 hr a day basis.
Priority Population: *Describe the situational characteristics of the priority population*	Services will be developed to serve youth aged 0-5 who have severe emotional disturbances or severe mental illnesses that will result in significant social, emotional, educational impairments and/or who are at risk of homelessness or going into care. As was evident by the prevalence data, this is our most underserved population, and has the most potential to need excessive resources over the longest time should they go untreated. Within this population, we will work with the Ethnic Outreach programs to find children whose cultural identity places them in underserved populations within our community (Hispanic, Asian Indian or Hmong). Up to 10 families would be identified to receive this level of care annually by the end of the third year, choosing those at the highest risk of the most disabling effects of mental illness and emotional disturbance

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
Following intensive training, consultation and the selection of screening and assessment tools for screening young children, a multi-agency assessment and treatment team will be formed within the existing System of Care enhancing it to a wraparound model capable of providing services to clients where they live, 24/7 and including consumers or family members as team members. Services will be provided to children and their parents/caregivers on a "whatever it takes" basis to enhance the functioning of the child and restore them to their	☒	☐	☐	☒	☐	☐	☐

developmental potential. This will include services to ameliorate problems for parents/caregivers when identified as a barrier to the child's functioning. Services will be delivered by professional and paraprofessional staff, including parent partners.							
Education for Primary care providers and other health care providers to increase coordination and integration of mental health and primary care and other health services.	☒	☒	☐	☒	☒	☐	☐
Family intervention services, specifically the implementation of *The Incredible Years, Triple P Parenting* or other evidence-based practices to teach parenting skills and enhance child-parent interaction.	☒	☐	☐	☒	☐	☐	☐
Cultural outreach to schools, primary care clinics and community programs in ethnic communities and through our Ethnic Outreach programs which will proactively reach children from these communities who have been unserved.	☒	☒	☒	☒	☒	☐	☐
	☐	☐	☐	☐	☐	☐	☐

Child/Youth Program 0-5 SED Full Service Partnership

1) See Exhibit 4 above

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

To fully round out the full service partnership, the strategies described above must be integrated into a supportive whole. Since the 0-5 SED group is the most underserved, they will be the focus of this Full Service Partnership. Initially training and consultation will be provided for internal and external providers (i.e. Child Protective Services, Head Start, pre-schools, pediatricians, Casa de Esperanza (domestic violence shelter) to assist in the identification of children with Serious Emotional Disturbance. We will identify and select specialized tools for Mental Health screening and assessment of young children and train providers in the use of these screening tools. The Behaviorist funded by the Children and Families Commission in Sutter County serving children 0-5 will be a key referral source.

Once the initial training has been accomplished, we will develop an integrated multi-agency team following our established CSOC model, to treat 0-5 SED children at the highest risk of the most disabling effects of mental illness and emotional disturbance. Current collaboration and involvement in the bi-county Children's System of Care through the Sutter County Family Intervention Team/CSOC and the Yuba County Children's Council will be continued and expanded to include this new program. Both of these policy groups meet regularly and have the on-going involvement of Child Welfare and Social Services, Probation, and Education as well as many other key community providers. The Wraparound model is in the process of being implemented in Sutter County. Families will identify the services they would like to receive.

All families being served by this FSP will be provided with 24/7 services by personal services coordinators (children's case managers), which will include a parent partner. The personal service coordinators will coordinate the delivery of treatment services. They will emphasize engagement of the family in treatment, will focus on wellness principles (not just illness), will communicate a message of hope and reassurance, and will promote family self-reliance, empowerment, assertiveness and perseverance. The goal is to provide immediate interventions, day or night that will reduce negative outcomes such as unnecessary hospitalizations or evictions. Caseloads will be small and the children's case managers, parent partners and other treatment team members will all be known to each family. The personal service coordinators will provide individualized, family driven planning and services.

Services will be based on a wraparound model and will include on-site (home or community based) screening and assessment, individualized treatment, parenting skills training and support. The model is based on building parental strengths, supporting and encouraging growth, intervening in negative patterns of parenting, and providing respite when needed. Services will also be provided to parents to ameliorate their own barriers to successful parenting. Such services could include mental health treatment, substance abuse treatment, assistance with employment or housing, peer support and education. Tools we will use

include two evidence based practices: Parent Child Interaction Training and a parenting skills program such as *The Incredible Years.* We anticipate that not only will the parenting skills program be used for families being served by this FSP but also for other parents of SED children.

The program will reflect the five essential elements: community collaboration, cultural competence, client/family driven services, a focus on wellness and integration of services. The program will advance the goals of the MHSA by enabling children with a SED to remain in their communities, in their home, at school and out of the foster care system. Their family generated, individualized service plans will address the larger needs of their families to enable them to integrate their services through a multi-agency program. The program will partner with families and other important people in developing service strategies and plans; to assess family, child/youth and community strengths to overcome difficulties; to assist families in becoming the authors of their own service plans; to encourage and support a shift from professionally-centered to family-centered practice and resources; and, to also assess child/youth and family needs and areas of growth. Embedded in these core values is recognition of the importance of the family's cultural values as a source of resilience, and an integral component of service delivery.

This program will also allow a reduction in disparities for the identified racial and ethnic minorities who are underserved in our community; additional support for parents such as peer or mentor-led services, and a family-friendly approach to service planning and delivery

3) Describe any housing or employment services to be provided.

Families of children in the full service partnership will have access to housing and employment supports. These issues must be resolved in order to keep the child safely at home and in school.

To the extent there is available capacity, families participating in this FSP may access the job specialist, a position shared jointly with the Adult/Older Adult and the TAY FSPs, will create connections with job coaches and with career counselors. They would provide information about what training is available to those who need more job skills, give hands-on, practical and individualized support in job search skills, and discover and assist with placement in education/training programs as appropriate. Specific flexible funding has been set aside to assist unemployed parents to obtain employment (by repairing a vehicle, buying needed tools, equipment or clothing, as examples), thereby improving the family's wellbeing and the circumstances for the identified 0-5 client.

Families will be able to access flexible funds identified for participants of this FSP to enable them to meet their housing needs. Homeless families will be given assistance in locating and accessing suitable housing. Assistance with first, last and deposit will be immediately available. The housing specialist, a position jointly shared by the Adult/Older Adult and the TAY FSPs, will be available to assist families involved in this FSP, based upon capacity. The housing specialist will be responsible for assisting the client's family in accessing temporary/

emergency/ transitional/permanent housing ; attending to issues of affordability, safety, help with paper work, or need for subsidies. The housing specialist will use vouchers for temporary/ emergency hotel stays; coordinate with existing housing programs; and develop partnerships with local landlords to ease acceptance of families with a prior history of evictions.

As new, affordable housing is developed, using the MHSA funds, all participants in each of the MHSA FSPs will be given first priority in accessing this housing. Once all of the FSP participants' needs have been met other Mental Health clients will be provided with access to this affordable housing. Of the $750,000 being committed to expand affordable housing, $150,000 has been identified for housing for families with children 0-5 in this full service partnership.

During FY 05-06 a two tiered approach to expanding affordable housing has emerged. A multi-agency committee was convened at the initiative of Mental Health. Using non-MHSA funds, Mental Health contracted with a very knowledgeable housing consultant to assist with planning for the development of a housing continuum to serve our mental health clients. In addition, a bi-county Homeless Consortium was formed; other local agencies have provided funding for this consultant to assist the Consortium in writing a Continuum of Care Housing Plan. The bi-county United Way has agreed to act as the fiduciary agent. Sutter County, Yuba County, the City of Marysville and Yuba City are all actively involved in this planning in order to expand affordable housing to the community in general. This plan specifically includes those with special needs such as those with psychiatric disabilities.

During the course of this three year plan, we have set aside $750,000 to be used to develop new, affordable housing. The initial plan is to use the identified MHSA housing funds to purchase outright an existing apartment complex that would then be rehabilitated as necessary. It is anticipated that this first property will be purchased and rehabilitated during this three year plan, As soon as this initial property is fully operational, the equity from this property will be borrowed against to allow for the purchase of additional housing. Unused funds and the accessed equity will then be used to match to state and federal dollars, such as HUD 811 funds, Supportive Housing Program funds, Shelter Plus Care Super NOFA funds, Community Development Block Grants, and/or Federal Emergency Shelter grants (as examples), to allow us to develop a significant number of new affordable housing units in the Sutter-Yuba area for those with psychiatric disabilities. These units will be developed in cooperation with the Sutter and the Yuba County Housing Authorities. Such additional housing may involve new construction or rehabilitation of existing units. The housing may involve apartment complexes, clustered duplexes, or shared congregate living houses. Our intention is for the housing to be held in ownership by the public housing authorities for use by eligible individuals with psychiatric disabilities. These units will be linked to HUD Section 8 vouchers whenever possible, Rents will be affordable, but will be set to allow for the ongoing maintenance of the facilities and to pay-off of the mortgages on the facilities over time.

The supportive services that may be needed to make retention of this housing more likely will be provided by Mental Health or contract providers, using

the personal service coordinators and other staff contained in the FSPs and other programs being funded by the MHSA as well as non-MHSA funded staff.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

FY 1 $ 22,315
FY 2 $ 19,605
FY 3 $ 20,742

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

Families in this full service program will identify the services that they need in order to function effectively. Full service program participants will be full partners in designing and implementing their service plans. The goals of recovery and resiliency will be advanced by applying an approach that, within a developmental approach, emphasizes engagement of the family in treatment, will focus on wellness principles (not just illness), will communicate a message of hope and reassurance, and will promote family self-reliance, empowerment, assertiveness and perseverance. Families will be offered parenting skills which build on resilience factors and emphasizes understanding the developmental context and focusing on strengths and wellness, not only on illness. The program will partner with families in developing service strategies and plans to encourage and support a shift from professionally-centered to family-centered practice and resources. Embedded in these core values is recognition of the importance of the family's cultural values as a source of resilience, and an integral component of service delivery.

All providers, including business and medical records staff, mental health staff, and staff from partner agencies will receive training in applying the principles of recovery and resiliency to their work.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

In our current CSOC enrollees must meet certain criteria to be involved. One of these criteria includes having many different agencies working with the family. Services provided include: family-centered planning with all agencies involved; individual, family, and/or group psychotherapy; medication monitoring; case management; rehabilitation services, mentoring, case management and coordination with all parties. The services are home and school-based, and seek to maintain resiliency for children involved. An individualized service plan is developed for each enrollee.

Currently there is no specialized treatment service for children 0-5. Also, none of the existing children's services provide the "whatever it takes" comprehensive services that will be provided through this full service partnership. This will be a specifically defined, new program element for this specific population, but it will be organizationally placed within our existing services for children.

7) Describe which services and supports clients and/or family members will provide.
Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Parent partners will be hired to provide mentoring and resiliency training. Parent partners will also be integral to the delivery of all services and will be permanent members of the treatment team. They will participate a personal service coordinators and will assist in the provision of 24/7 services. The client and their family will be instrumental in the development and implementation of the service plan. Family involvement may include members of their extended family, as they define it, as determined by the family.

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

Currently multi-agency teams meet in each county at the planning and the case management levels to review CSOC issues. Members of the policy groups include the heads of Probation, Mental Health, Health, Human Services, Sheriff, Police, Juvenile Judge, Regional Center, and Community-Based Organizations. Detailed MOUs and Releases of Information for sharing of information are in place and are HIPAA-compliant. There are no local formal tribal entities to include in this process. The policy and case management groups have some common members to promote intra-agency and inter-agency communication. There is a strong commitment to continuous improvement of services to youth and their families and improved client outcomes. These collaborative activities have proven to be very effective vehicles for facilitating this improvement, resulting in improved services for the clientele we jointly serve by reducing barriers to accessing services, fostering shared service delivery, shared inter-agency training activities to create general agreement on service styles that foster positive change in our clients and a greater understanding of the rules and limitations under which various providers operate. To further improve services and outcomes, all staff will continue to be cross-trained in relevant mental health, law enforcement, and drug and alcohol policies and procedures, as well as how to provide services that are client centered and resiliency and recovery oriented.

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

Currently children under the age of 5 are significantly under-served in our mental health programs. Children who are members of ethnic groups for whom English is not their primary language are further underserved. Mental Health treatment will be provided in the language of the client. A parenting program specifically proven to be effective for Hispanic families will be utilized. There are no evidence-based parenting programs for Asian Indian or Hmong families currently available. Efforts will be made to hire staff that is bi-cultural to help

ensure a team that is sensitive to the needs of and are representative of our diverse community. The individualized service plans will be client/family centered and will identify culturally specific resources that may include, but are not limited to: culture-specific faith healers such as curanderos or spirit healers, the client's family, other community partners, faith community, and private providers, in addition to county resources. Referrals to this FSP will be made from other Mental Health programs and community providers, in particular those providers who serve our underserved ethnic communities. Specifically, the MHSA-funded resources being developed to promote specific Ethnic Outreach will also provide referrals from the Latino, Asian Indian and Hmong communities to redress the present inequities in our system. Therapy and other services will be provided in the language of the client.

Consistent with the rest of the mental health staff, staff of the Children's 0-5 FSP and their parent partners will receive ongoing cultural competency trainings, through a number of annual specific trainings that focus on the Hmong, Asian Indian, Latino, LGBT, African American and consumer cultures.

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

All SYMH staff are trained on LGBT issues and resources. Members of the service teams from other agencies not already trained in these issues will be included in these trainings which will enhance the systems' understanding of these needs, in particular, the special needs of gay and lesbian families who are raising children. The integrated service plan will be client/family centered and staff will work to positively identify the LGBT issues which exist, as well as the resources available. These may include such local resources as Yuba-Sutter Pride and Sacramento resources through the Lamda Center in addition to those mentioned above.

Gender-specific services are recognized as necessary. Efforts are made to match genders of service providers to clients as appropriate. Groups addressing gender-specific issues will be provided as needed, such as issues of women's empowerment, and the importance of fathers in the lives of their children. Seeking Safety, a curriculum addressing trauma and substance abuse, is provided in gender-specific groups.

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

Since the majority of this project is concerned with youth residing in our counties, the emphasis will be to assist our youth to remain in their own homes. When placement is required all efforts will be made to keep the youth in this area. Foster care youth placed out of the area, or adoptees residing out-of-county will receive assistance in accessing and receiving the appropriate services in the community in which they reside through our provider network or through a purchase of service agreement between SYMHS and that county's

public mental health program. Youth placed in a group home are assigned to our interagency case management team to insure they receive the needed service and are returned to our community in a smooth and timely manner. CSOC also operates a Placement Team whose function is to help integrate youth who are placed out of county back into the community. This Placement Team will coordinate with the Children's 0-5 FSP to provide transition services.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

N/A

13) Please provide a timeline for this work plan, including all critical implementation dates.

The following timeline is tentative:
Board of Supervisor Approval – December 05
DMH approval of CSS plan – March 06
Recruit, hire and train program staff – April – June 06
Expansion of physical space of existing System of Care Program – March – April 06
Program services to begin May, 2006

14) Develop Budget Requests: Please see Exhibits 5a-c
15) A Quarterly Progress Report Please see Exhibit 6

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY		
County: Sutter and Yuba	Fiscal Year:05-06	Program Work Plan Name: Urgent Services Syst. Development
Program Work Plan #: 2		Estimated Start Date: April 2006

Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	An Urgent Services Team to address the needs of children/youth at greatest risk of harming self or others. The program will advance the goals of the MHSA by enabling children/youth with a SED to remain in their communities, in their home, at school and out of the legal system. Their Individualized service plans will address the larger needs of their families to enable them to integrate their services through a multi-agency program. The program will partner with families and other important people in developing service strategies and plans; to assess family, child/youth and community strengths rather than difficulties; to assist children/youth and families in becoming the authors of their own service plans; to encourage and support a shift from professionally-centered to client and family-centered practice and resources; and, to also assess child/youth and family needs and areas of growth. Embedded in these core values is recognition of the importance of the family's cultural values as a source of resilience, and an integral component of service delivery. The Urgent Team will be trained to provide Strategic Family therapy and Functional Family Therapy. This program will also allow a reduction in disparities for the identified racial and ethnic minorities who are underserved in our community; additional support for parents such as peer or mentor-led services, and a family-friendly approach to service planning and delivery; and peer/mentor-delivered services for youth.
Priority Population: *Describe the situational characteristics of the priority population*	Services will be developed to serve youth aged 0-18 who have acute mental health issues and are at greatest risk of harming themselves or others. We will work with the school based counselors and other school personnel to identify children at greatest risk. SYMHS Psychiatric Emergency Staff, Urgent Children's Team and School Based Counselors will be trained in evidence-based practices related to identifying and intervening in high risk behaviors. Working collaboratively with the schools will also allow us to find children whose cultural identity places them in underserved populations within our community (Hispanic, Asian Indian, Hmong).

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
Education for Primary care providers and other health care providers to increase coordination and integration of mental health and primary care and other health services.	☐	☒	☐	☒	☒	☐	☐
Development and training of an integrated Crisis/Urgent Services Team which will work with school personnel and other resources relevant to the individual and family to deliver services using the EBP Brief Therapy Model.	☒	☒	☐	☒	☒	☐	☐
Cultural outreach and services at schools, primary care clinics and community programs in ethnic communities through our Ethnic Outreach program which will proactively reach children from these communities who have been unserved.	☐	☒	☒	☒	☒	☐	☐

#2 - Child/Youth Program Urgent Services

1) See Exhibit 4 above

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

The Urgent Services Team will utilize a brief therapy model to work intensively with youth at greatest risk of harming themselves or others and their families. The Urgent Team will receive their referrals primarily from school based counselors, SYMHS Psychiatric Emergency Services and Children's Outpatient Services. Other referrals will come from the Ethnic Outreach Programs and other community providers. Efforts will be made to disseminate information about this program to providers who serve the key ethnic groups we are targeting in order to increase the proportion of ethnic clients served in this program. Parent Partners and Youth Mentors will be used to assist with engagement and support to the families and youth experiencing a high level of distress. Psychiatric assessment and medication support will be provided if needed. The Therapist will carry a small caseload of youth and will provide individual and family therapy. The Family Therapy will be an evidence based model, either Functional Family Therapy or Strategic Family Therapy depending on the age of the youth and their presenting issues. The case manager will assist the youth to increase positive social, educational and community activities, by promoting skill development and coping strategies. Development of the individualized treatment plan will be youth and family driven.

The team will integrate other supports and resources when identified as being needed, such as TBS, wraparound services, and Multidimensional Treatment Foster Care, and EBP already offered at SYMHS.

Significant training will be provided to both professionals and paraprofessionals. Training will be provided to the Urgent Services Team, Psychiatric Emergency Services staff and school based counselors as well as other key school personnel (nurses, psychologists, and administrators) to insure early identification of children at risk, utilizing practices proven to be successful interventions with high risk behaviors. This will increase the community's ability to identify and respond to children at risk. Those considered at high risk will then be referred to the Urgent Services Team for more intensive services.

The Urgent team will also be trained in parenting and family therapy models consistent with the values of building upon parental strengths, supporting and encouraging growth, intervening in negative patterns of parenting, and providing respite when needed. Tools we will use include a parenting skills program such as *The Incredible Years,* Family Therapy models of *Strategic Family Therapy* and *Functional Family Therapy.*

Services to address the significant problems that arise when children have been exposed to significant trauma will also be incorporated into this program through the use of *Building Resilience*, for children ages 5-10 and *Seeking Safety*, for adolescents. Both evidence based harm reduction curricula used to address the sequela of trauma and exposure to substance abusing parents.

Staff will utilize and promote psychosocial rehabilitation approaches, client and family directed service delivery, self-help strategies and client/family empowerment. Emphasis will be on engagement of youth, and within a developmental context, focusing on wellness, not only on illness. The Parent Partner and the rest of the staff will communicate to the youth and their family a message of hope and reassurance, by promoting self-reliance, empowerment, assertiveness and perseverance.

The program will reflect the five essential elements: community collaboration, cultural competence, client/family driven services, a focus on wellness and integration of services. The program will advance the goals of the MHSA by enabling children with psychiatric disabilities to remain in their communities, in their home, at school and out of the legal system. Their Individualized Treatment Plans will address the larger needs of their families to enable them to integrate their services through a multi-agency approach if appropriate. The program will assist children/youth and their families in becoming the authors of their own service plans; will encourage and support a shift from professionally-centered to family-centered practice and resources; and, will also assess child/youth and family needs and areas of growth. Embedded in these core values is recognition of the importance of the family's cultural values as a source of resilience, and an integral component of service delivery.

This program will also allow a reduction in disparities for the identified ethnic groups who are underserved in our community; additional support for clients through youth mentor-led services, and a family-friendly approach to service planning and delivery.

3) Describe any housing or employment services to be provided.

Youth identified by the Urgent Services Team will have access to the housing and employment supports being developed as part of the Children's 0-5, TAY and Adult/Older Adult full service partnerships, to the extent that there is capacity after the clients in the FSPs have been served, if these issues must be resolved in order to keep the child safely at home and in school. Wraparound funding and supports will also be used to assist children at risk of out of home placement to remain in their homes.

The job specialist, a position jointly shared with the Adult/Older Adult and the TAY FSPs, will create connections with job coaches and with career counselors. They will provide information about what training is available to those who need more job skills, give hands-on, practical and individualized support in job search skills, and discover and assist with placement in education/training programs as appropriate. Youth referred by the Urgent Services Team may access the services of this job specialist to the extent that there is capacity to serve additional clients beyond those involved in the FSPs.

As new, affordable housing is developed, using the MHSA funds, all participants in each of the MHSA FSPs will be given first priority in accessing this housing. Once all of the FSP participants' needs have been met other Mental Health clients will be provided with access to this affordable housing.

During the course of this three year plan, we have set aside $750,000 to be used to match to state and federal dollars, such as HUD 811 funds, Supportive Housing Program funds, Shelter Plus Care Super NOFA funds, Community Development Block Grants, and/or Federal Emergency Shelter grants (as examples), to allow us to develop a significant number of new affordable housing units in the Sutter-Yuba area for those with psychiatric disabilities. These units will be developed in cooperation with the Sutter and the Yuba County Housing Authorities. The initial plan is to use the identified MHSA housing funds to purchase outright an existing apartment complex that would then be rehabilitated as necessary. It is anticipated that this first property will be purchased and rehabilitated during this three year plan, As soon as this initial property is fully operational, the collateral from this property will be borrowed against to allow for the purchase of additional housing. Other federal funds, as referenced previously, will be actively sought to further expand the amount of new, affordable housing that can be developed.

The supportive services that may be needed in order to make retention of this housing likely will be provided by Mental Health or contract providers, using the personal service coordinators and other staff contained in the FSPs and other programs being funded by the MHSA as well as non-MHSA funded staff.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

N/A

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

Program participants will be full partners in designing and implementing their service plans. The goals of recovery and resiliency will be advanced by applying an approach that, within a developmental context, emphasizes engagement of the youth and their family in treatment, will focus on wellness principles (not just illness), will communicate a message of hope and reassurance, and will promote self-reliance, empowerment, assertiveness and perseverance. Families will be offered parenting skills which build on resilience factors and emphasize understanding the developmental stages and needs of the youth and focus on strengths and wellness. The program will encourage and support a shift from professionally-centered to client and family-centered practice and resources. The use of youth mentors who themselves have struggled with similar issues serves as a message of hope and inspiration to others. Embedded in these core values is recognition of the importance of the family's cultural values as a source of resilience, and an integral component of service delivery.

As a full systems development strategy, all providers, including business and medical records staff, mental health clinical staff, and staff from partner agencies will receive training in applying the principles of recovery and resiliency to their work.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

N/A

7) Describe which services and supports clients and/or family members will provide.

Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

The treatment team will include a Youth Mentor. The client and their family will be instrumental in the development and implementation of the service plan. Family involvement may include members of their extended family, as they define it, as determined by the family.

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

Currently multi-agency teams meet in each county at the policy and the case management levels to review children's issues of common interest and to improve collaborative service delivery. Members of the policy groups include the heads of Probation, Mental Health, Health, Human Services, Sheriff, Police, Juvenile Judge, Schools and SELPAs, the Regional Center, and community-based organizations. Detailed MOUs and Releases of Information for sharing of information are in place and are HIPAA-compliant. There are no local formal tribal entities to include in this process. The policy and case management groups have some common members to promote intra-agency and inter-agency communication. There is a strong commitment to continuous improvement of services to youth and their families and improved client outcomes. These collaborative activities have proven to be very effective vehicles for facilitating this change, resulting in improved services for the clientele we jointly serve by reducing barriers to accessing services, fostering shared service delivery, shared inter-agency training activities to create general agreement on service styles that foster positive change in our clients and a greater understanding of the rules and limitations under which various providers operate. To further improve services and outcomes, staff will continue to be cross-trained in relevant mental health, law enforcement, and drug and alcohol policies and procedures, as well as how to provide services that are client centered and resiliency and recovery oriented.

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

Members of minority groups for whom English is not their primary language (i.e. Latino, Asian Indian and Hmong) are underserved for all age groups in our existing mental health programs. Efforts will be made to disseminate information about this new service to providers who serve the ethnic groups we are specifically targeting in an effort to increase the number of ethnic youth and

families served by this program. An evidence-based parenting program specifically proven to be effective with Hispanic families will be utilized. There are no evidence-based parenting programs proven to be effective with Asian Indian or Hmong families currently available. In particular, our mental health interventions with youth who are Latino, Asian Indian and Hmong will emphasize the importance of the family and respect for family leadership. Research has shown that encouraging these youth to separate from their families and to assert their independence (as is typical among white youth) can have long-lasting negative effects on the youth and their family relationships. We will search for specific, evidence-based treatment programs for youth that have been proven to be effective with Latino, Asian Indian and/or Hmong cultures. .Efforts will be made to hire staff that is bilingual and bicultural to help ensure a team that is sensitive to the needs of our underserved populations and are representative of our diverse community. Individualized service plans will be client-centered and will identify culturally specific resources that may include, but are not limited to: culture-specific faith healers such as curanderos or spirit healers, other community partners, the faith community, and private providers, in addition to county resources. Referrals to this program may be made from other Mental Health programs and community providers; in particular those providers who serve our underserved ethnic communities. The MHSA-funded resources being developed to promote specific Ethnic Outreach will also provide referrals from the Latino, Asian Indian and Hmong communities to redress the present inequities in our system. Therapy and other services will be provided in the language of the client.

Consistent with the rest of the mental health staff, staff of the Urgent Services Team and their Youth Mentor will receive ongoing cultural competency training, through a number of annual specific trainings that focus on the Hmong, Asian Indian, Latino, LGBT, African American and consumer cultures.

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

SYMH staff are trained annually on LGBT issues and resources. Due to the much higher than average rate of suicide among gay and questioning adolescents, this is a particularly significant issue for this program. Staff who are particularly comfortable and effective dealing with LGBT issues will be provided with small rainbow flag decals that they can place in their workspace or office to signal that they are “safe to come out to.” The service plan will be client/family centered and staff will work to positively identify the LGBT issues which exist, as well as the resources available. These may include such local resources as Yuba-Sutter Pride and Sacramento resources through the Lamda Center in addition to those mentioned above.

Gender-specific services are recognized as necessary. Efforts are made to match genders of service providers to clients as appropriate. Groups addressing gender-specific issues will be provided as needed, such as issues of women’s

empowerment. Particularly among youth, gender specific groups are more productive and supportive.

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

Out-of-county clients will receive assistance in identifying appropriate services and referrals and linkages back to their home community. Mental Health operates a Placement Team whose function is to help integrate youth who are placed out of county back into their home community whenever possible. In addition, youth placed in a group home are assigned to the interagency case management team to insure they receive the needed services and are returned to our community in a smooth and timely manner.

Since this program is concerned with youth residing in our counties, the emphasis will be to assist our youth to remain in their own homes. When placement is required all efforts will be made to keep the youth in this area. Foster care youth placed out of the area, or adoptees residing out-of-county will receive assistance in accessing and receiving the appropriate services in the community in which they reside through our provider network or through purchasing services in that county's public mental health program.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

N/A

13) Please provide a timeline for this work plan, including all critical implementation dates.

The following timeline is tentative:
Board of Supervisor Approval – December 05
DMH approval of CSS plan – March 06
Recruit, hire and train program staff – April – June 06
Expansion of physical space of existing System of Care Program – March – April 06
Program services to begin May, 2006

14) Develop Budget Requests: Please see Exhibits 5a-c
15) A Quarterly Progress Report Please see Exhibit 6

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY		
County: Sutter and Yuba	Fiscal Year: 05-06	Program Work Plan Name: TAY Full Service Partnership
Program Work Plan #: 3		Estimated Start Date: April 2006

Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	A full-service, wraparound program for Transition Aged Youth The program will advance the goals of the MHSA by enabling those who participate to feel hope; obtain and maintain positive social connections; live in safety and in a setting which is of their choosing; have access to co-occurring disorders integrated mental health and drug/alcohol treatment if they choose; access assistance to engage in meaningful activity such as employment or education/ training; receive services which recognize their developmental process as "normal" and do not marginalize issues of wellness; experience respect from their providers of mental health services; feel empowered and listened to in the process of planning and obtaining their services; have continuity in their providers; and have individualized service plans. This program will also allow a reduction in disparities for the identified ethnic groups who are underserved in our community; improved integration or a single provider of drug/alcohol and mental health treatment for those with co-occurring disorders; improved integration between child and adult systems to bridge gaps in services; additional support for parents through peer or mentor-led services, and a family-friendly approach to service planning and delivery; peer-delivered services for youth; and a decrease in homelessness due to the previously unavailable housing array.
Priority Population: *Describe the situational characteristics of the priority population*	Services will be developed to serve youth aged 16-25 who have severe emotional disturbances or mental illnesses that result in significant social, emotional, educational and/or occupational impairments and who are at risk of homelessness. Specifically, the focus groups have identified particular youth and young adults who are unserved, underserved, or inappropriately served within our community: Young women with self-harming high-risk behavior (runaway, substance abuse, promiscuity, victimization); youth aging out of foster care; and youth aging out of children's mental health/probation and AGING IN to adult systems (including sex offenders and victims of sexual trauma). Further priority within these populations will be given to (1) youth with co-occurring substance abuse and mental health disorders, (2) those who are at significant risk of gang involvement, (3) the uninsured, or (4) youth whose cultural identity places them in underserved populations within our community (Latino, Asian Indian and Hmong).

	Fund Type			Age Group			
Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	FSP	Sys Dev	OE	CY	TAY	A	OA
Integrated service teams capable of providing services to clients where they live, 24/7 and including consumers or family members as team members. The primary components will be the personal service coordinator and the peer mentor for each youth. They will coordinate the mental health treatment, substance abuse treatment for dually diagnosed youth, acquisition of appropriate housing, employment or job skills, independent living skills and	☒	☐	☐	☐	☒	☐	☐

education.							
Cross-discipline training for staff in substance abuse recognition and treatment to help youth receive simultaneous, integrated substance abuse and mental health treatment with an integrated service plan.	☒	☐	☐	☐	☒	☐	☐
Development of housing options including: temporary or emergency housing/shelter/vouchers and permanent affordable housing.	☒	☒	☐	☐	☒	☒	☐
Independent Living Skills training – Classes or individual instruction from a personal services coordinator/mentor regarding what youth need to know for successful living in the community.	☒	☐	☐	☐	☒	☐	☐
Recreation and social activities	☒	☐	☐	☐	☒	☐	☐
Supportive education services	☒	☐	☐	☐	☒	☐	☐
Supportive employment including career counseling ,development of job options and job coaching for young people.	☒	☐	☐	☐	☒	☒	☐
Implementation of a values-driven evidence-based practice (yet to be determined) that is culturally and linguistically appropriate and integrated with overall service planning and supports housing, employment, and/or education goals and is consistent with the values of the youth and his/her community.	☒	☐	☐	☐	☒	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐

Transitional-Aged Youth Program

1) Please see exhibit 4 above.

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

To fully round out the full service partnership, the strategies described above must be integrated into a supportive whole. The TAY FSP will reflect the five essential elements: community collaboration, cultural competence, client/family driven services, a focus on wellness and integration of services.

Since both mental illness and substance abuse use was indicated as a major issue for this population, we will coordinate an array of appropriate treatment for youth and young adults with co-occurring disorders – from low intensity recreational and social activities, to intensive outpatient treatment services, to substance abuse residential treatment for the purposes of detoxification when this is necessary. We will obtain specific dual diagnosis training for all clinical staff so that they can address substance abuse adequately within the context of mental health services. We will promote access to existing activities and help to create additional alternative activities, especially those that focus on the expressive arts, challenging endurance or action-oriented recreation, activities involving the care of animals and youth social groups (such as Friday Night Live). The youth focus groups emphasized that drugs were sometimes turned to because other activities do not exist or are not accessible to them. This is not meant only as a prevention strategy but also directly contributes to recovery. Thus, it will be very important for staff to help youth find alternative activities. Research into other successful TAY programs indicates that harm reduction training for staff is a necessary part of these programs. Staff will be trained in the Seeking Safety program (for those who have been traumatized and are abusing substances). Seeking Safety will be offered in gender-specific treatment groups. .

We will have a housing specialist and a job/vocational specialist each of which will be jointly shared with the Adult/Older Adult FSP. The housing specialist will be responsible for assisting the client in accessing temporary/ emergency/ transitional/permanent housing; attending to issues of affordability, safety, help with paper work, or need for subsidies. The job specialist will develop employment opportunities, create connections with job coaches to help youth succeed in jobs and with career counselors to help youth discover their vocational strengths. Their duties are described in the next section.

Using a “whatever it takes” approach, program services will include integrated mental health and substance abuse treatment services, psychiatric assessment and treatment with medications if necessary, group and individual psychotherapy, assistance with housing and employment services/job training, independent living skills training, the use of personal service coordinators and youth mentors in the delivery of 24/7 services, services that are based on psychosocial rehabilitation and recovery principles.

The personal services coordinator will play a critical role in this “whatever it takes” model of service delivery. Staff will carry very small caseloads, they will be available 24/7 to insure a proactive approach and early intervention when stressful or emergent situations arise. Personal service coordinators will

individually help to coordinate the services of each participant in this FSP. All services will be provided based upon individualized service plans that are youth driven. The PSCs and Youth Mentors will assist in skill development to improve coping strategies, using an incremental, long-term approach to reduce the degree of disability a person with a serious psychiatric disability faces. Personal service coordinators will assist youth to obtain instruction in adult life issues such as banking, legal issues, budgeting, maintaining a household, formation and maintenance of healthy relationships, keeping scheduled appointments, or medication education, as examples. Youth mentors will also provide independent living skills training.

Services will emphasize the engagement of youth and young adults, utilizing a developmental context and focusing on wellness, rather than just illness. Staff will communicate messages of hope and reassurance by promoting self-reliance, empowerment, assertiveness and perseverance. Staff will provide information about services in settings to reach youth; utilizing the various culturally-related media as well as physical locations such as alternative schools. Staff will work from the concept that they are navigators who help youth through systems obstacles. The housing and job specialists will specifically provide coordination with existing housing and vocational programs, while also creating new opportunities.

This FSP will actively seek referrals from our Ethnic Outreach Programs, other Mental Health programs and other community service providers, in particular those who serve our targeted ethnic groups, in order to promote a reduction in disparities for the identified ethnic groups who are underserved in our community. Through this FSP the following improvements will occur: integration of drug/alcohol and mental health treatment for those with co-occurring disorders; improved integration between child and adult systems to bridge gaps in services; additional supports from mentor-led services and a consumer friendly approach to service planning and delivery; and a decrease in homelessness due to the previously unavailable housing array and lack of affordable housing.

3) Describe any housing or employment services to be provided.

The job specialist, a position shared with the Adult/Older Adult FSP, will help to develop employment opportunities, create connections with job coaches to help transition aged youth succeed in jobs and with career counselors to help youth discover their vocational strengths. They would provide information about what training is available to youth over 18 who need more job skills, give hands-on, practical and individualized support in job search skills, and discover and assist with placement in schools, education or training to enable youth to realize their potential. This specialist could also empower youth to create a program/council to work with schools regarding the types of programming the youth feel they need in the local schools; and will also develop a partnership with our local *Youth Build,* a program that not only builds housing but also provides instruction to youth in construction technology. The new partnership will include programming to teach independent living skills.

The housing specialist, a position jointly shared with the Adult/Older Adult FSP, will be responsible for assisting clients in accessing temporary/ emergency/ transitional/permanent housing; attending to issues of affordability, safety, help with paper work, or need for subsidies. The housing specialist will use vouchers for temporary/ emergency hotel stays; coordinate with existing housing programs; and develop partnerships with local landlords to provide support for young adults seeking local independent housing.

As new, affordable housing is developed, using the MHSA funds, all participants in each of the FSPs will be given first priority in accessing this housing. Once all of the FSP participants' needs have been met other mental health clients will be provided with access to this affordable housing. Of the $750,000 being committed to expand affordable housing, $250,000 has been identified for housing for Transition Aged Youth who are participants in this full service partnership.

During FY 05-06 a two tiered approach to expanding affordable housing emerged. A multi-agency committee was convened at the initiative of Mental Health. Using non-MHSA funds, Mental Health contracted with a very knowledgeable housing consultant to assist with planning for the development of a housing continuum to serve our mental health clients. In addition, a bi-county Homeless Consortium was formed; other local agencies have provided funding for this consultant to assist the Consortium in writing a Continuum of Care Housing Plan. The bi-county United Way has agreed to act as the fiduciary agent. Sutter County, Yuba County, the City of Marysville and Yuba City are all actively involved in this planning in order to expand affordable housing to the community in general. This plan specifically includes those with special needs such as those with psychiatric disabilities.

During the course of this three year plan, we have set aside $750,000 to be used to develop additional, affordable housing for mental health clients. The initial plan is to use the identified MHSA housing funds to purchase outright an existing apartment complex that would then be rehabilitated as necessary. It is anticipated that this first property will be purchased and rehabilitated during this three year plan, As soon as this initial property is fully operational, the equity from this property will be borrowed against to allow for the purchase of additional housing. Unused funds and the accessed equity will then be used to match to state and federal dollars, such as HUD 811 funds, Supportive Housing Program funds, Shelter Plus Care Super NOFA funds, Community Development Block Grants, and/or Federal Emergency Shelter grants (as examples), to allow us to continue to develop a significant number of new affordable housing units in the Sutter-Yuba area for those with psychiatric disabilities. These units will be developed in cooperation with the Sutter and the Yuba County Housing Authorities. Such additional housing may involve new construction or rehabilitation of existing units. The housing may involve apartment complexes, clustered duplexes, or shared congregate living houses. Our intention is for the housing to be held in ownership by the public housing authorities for use by eligible individuals with psychiatric disabilities. These units will be linked to HUD

Section 8 vouchers whenever possible, Rents will be affordable, but will be set to allow for the ongoing maintenance of the facilities and to pay-off of the mortgages on the facilities over time.

The supportive services that will be needed to make retention of this housing likely will be provided by Mental Health or contract providers, using the personal service coordinators and other staff contained in the FSPs and other programs being funded by the MHSA as well as non-MHSA funded staff.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

FY 1 $ 25,595
FY 2 $ 24,625
FY 3 $ 26,054

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

The goals of recovery and resiliency will be advanced by recognizing the FSP participants as more than the sum of their mental health diagnoses. All FSP services will be based on psychosocial rehabilitation and recovery principles. Staff will carry very small caseloads, they will be available 24/7 to insure a proactive approach and early intervention when stressful or emergent situations arise. All services will be provided based upon individualized service plans that are youth driven. The PSCs and Youth Mentors will assist in skill development to improve coping strategies, using an incremental, long-term approach to reduce the degree of disability a person with a serious psychiatric disability faces. Services will emphasize the engagement of youth and young adults, utilizing a developmental context and focusing on wellness, rather than just illness. Staff will communicate messages of hope and reassurance by promoting self-reliance, empowerment, assertiveness and perseverance. This is accomplished by applying an approach that emphasizes wellness and functionality in the community and which addresses four dimensions: Job/Career Development, Housing, Community Living, and Wellness. By focusing on these four functional areas, mental illness or emotional disturbance will become only one of the variables to be considered in improving functioning in these four areas. Continual application of a developmental perspective will keep staff and participants on track in viewing recovery and resilience as our ultimate goal. All partners, including business and medical records staff, mental health staff, youth mentors and staff from partner agencies will receive training in applying the principles of recovery and resiliency to their work.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

N/A

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Recovering young adults will be hired to provide mentoring and independent living skills training. This independent living curriculum will be developed in partnership with the young adults who are providing the training. They will also participate as part of the overall team providing the full range of services to each client, including the 24/7 support. The participating client will choose which, if any of their family will be included in developing and implementing the service plan along with their service team, and this may include members of their extended family as they define it. This allows for a developmentally appropriate inclusion of family. A Parent Partner (family member of a youth who completed this program or other mental health treatment program) will develop and operate a family support group component to provide a venue for parents and other family to gather and share experiences and learn about how to navigate the complex systems they encounter.

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

Currently multi-agency teams meet in each county at the policy and the case management levels to review children's issues of common interest and to improve collaborative service delivery. The policy and case management groups have some common members to promote intra-agency and inter-agency communication. There is a strong commitment to continuous improvement of services to youth and their families and improved client outcomes. These collaborative activities have proven to be very effective vehicles for facilitating this improvement, resulting in improved services for the clientele we jointly serve by reducing barriers to accessing services, fostering shared service delivery, shared inter-agency training activities to create general agreement on service styles that foster positive change in our clients and a greater understanding of the rules and limitations under which various providers operate. Members of the policy groups include the heads of Probation, Mental Health, Health, Human Services, Sheriff, Police, Juvenile Judge, Schools and SELPAs, the Regional Center, and Community-Based Organizations. Detailed MOUs and Releases of Information for sharing of information are in place and are HIPAA-compliant. There are no local formal tribal entities to include in this process. The case management teams include representatives from Mental Health, Social Services, Education, Yuba College, Youth Build, Employment services and various private non-profit agencies. These collaborative teams meet regularly in Sutter and Yuba Counties. These teams engage in case management staffings in order to solve problems between systems for youth who need assistance. These providers will continue to support services to youth who cross systems. In addition, individually created teams with representatives from appropriate systems work with each youth on a mutually developed plan. Through this FSP

these individual teams will be expanded to include those systems the youth will need to access, such as vocational services. There have been ongoing meetings with all vocational training and work-site providers in anticipation of the need to create collaborative systems for TAY. All staff who work with the FSP for TAY will be trained in relevant mental health, law enforcement, and drug and alcohol policies and procedures, as well as how to provide services that are client centered and resiliency/recovery oriented. These collaborative teams have proven successful in reducing the bureaucratic processes that individuals can face on their own. By developing liaisons within our various service systems, we are able to cut through to a person who is invested in our relationship and willing to assist in smoothing the access.

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

Our existing mental health programs under serve individuals for whom English is not their primary language among every age group. Therefore, efforts will be made to hire staff that is bilingual and bicultural to help ensure a team that is sensitive to the needs of our underserved populations and are representative of our diverse community. In particular, our mental health interventions with youth who are Latino, Asian Indian and Hmong will emphasize the importance of the family and respect for family leadership. Research has shown that encouraging these youth to separate from their families and to assert their independence (as is typical among white youth) can have long-lasting negative effects on the youth and their family relationships. We will search for specific, evidence-based treatment programs for transition aged youth that have been proven to be effective with Latino, Asian Indian and/or Hmong youth. Individualized service plans will be client-centered and will identify culturally specific resources that may include, but are not limited to: culture-specific faith healers such as curanderos or spirit healers, other community partners, the faith community, and private providers, in addition to county resources. Referrals to this program may be made from other Mental Health programs and community providers; in particular those providers who serve our underserved ethnic communities. The MHSA-funded resources being developed to promote specific Ethnic Outreach will also provide referrals from the Latino, Asian Indian and Hmong communities to redress the present inequities in our system. Therapy and other services will be provided in the language of the client.

Consistent with the rest of the mental health staff, staff of the TAY FSP and their Youth Mentors and Parent Partners will receive ongoing cultural competency training, through a number of annual specific trainings that focus on the Hmong, Asian Indian, Latino, LGBT, African American and consumer cultures.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of

women and men, boys and girls.

All SYMH staff are trained on LGBT issues and resources. Due to the much higher than average rate of suicide among gay and questioning adolescents and young adults, this is a particularly significant issue for this program. Staff who are particularly comfortable and effective dealing with LGBT issues will be provided with small rainbow flag decals that they can place in their workspace or office to signal that they are "safe to come out to." Members of the service teams from other agencies not already trained in these issues will be included in these trainings which will enhance the systems' understanding of these needs. The integrated service plan will be client/family centered and staff will work to positively identify the LGBT issues which exist, as well as the resources available. These may include such local resources as Yuba-Sutter Pride and Sacramento resources through the Lamda Center in addition to those mentioned above.

Gender-specific services are recognized as necessary. Efforts are made to match genders of service providers to clients as appropriate. Groups addressing gender-specific issues are provided as needed, such as issues of women's empowerment, and the importance of fathers in the lives of their children. Among adolescents gender-specific groups are particularly important and contribute to improved outcomes. Seeking Safety, a curriculum addressing trauma and substance abuse, is also being provided in gender-specific groups.

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

Out-of-county clients will receive assistance in identifying appropriate services and referrals and linkages back to their home community. Mental Health operates a Placement Team whose function is to help integrate youth who are placed out of county back into their home community whenever possible. Since this FSP is focused on youth residing in our counties, the emphasis will be to assist our youth to remain in their own homes. When placement is required all efforts will be made to keep the youth in this area. Foster care youth placed out of the area, or adoptees residing out-of-county receive assistance in accessing and receiving the appropriate services in the community in which they reside through our provider network or through purchase of service agreements between SYMHS and the public mental health program in that county . Youth placed in a group home are assigned to the interagency case management team to insure they receive the needed services and are returned to our community in a smooth and timely manner. CSOC also operates a Placement Team whose function is to help integrate youth who are placed out of county back into the community. This Placement Team will coordinate with the TAY FSP to provide transition services.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

N/A

13) Please provide a timeline for this work plan, including all critical implementation dates.

The following timeline is tentative:
Board of Supervisor Approval – December 05
DMH approval of CSS plan – March 06
Recruit, hire and train program staff – April – June 06
Expansion of physical space of existing System of Care Program – March – April 06
Program services to begin May, 2006

14) See Exhibit 5
15) See Exhibit 6

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY		
County: Sutter and Yuba Counties	Fiscal Year: 05-06	Program Work Plan Name: Adult/OlderAdult Co-occurring Disorder Homeless FSP
Program Work Plan #: 4		Estimated Start Date: April 2006
Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	Since adults and older adults with homelessness and with co-occurring disorders were identified as unserved populations, we will coordinate an array of appropriate treatment for adults and older adults with co-occurring disorders. We will obtain specific training for clinicians so that substance abuse can be addressed adequately within the context of their mental health treatment services. Referrals for intensive substance abuse treatment will occur on an as needed basis. We will have a housing specialist and a job/vocational specialist which will be shared with the TAY FSP. This FSP will advance the goals of the MHSA by offering "whatever it takes" services that focus on wellness, not only on illness, and communicate a message of hope and reassurance by promoting self-reliance, empowerment, assertiveness and perseverance, enabling those who participate to obtain and maintain positive social connections; live in safety and in a setting which is of their choosing; have access to integrated mental health and drug/alcohol treatment if they choose; receive assistance to engage in meaningful activity such as employment or education/ training; experience respect from their providers of mental health services; feel empowered and listened to in the process of planning and obtaining their services; have continuity in their providers; and have individualized service plans. This program will actively attempt to reduce disparities in services to the identified ethnic groups who are currently underserved in our community; to provide improved, integrated drug/alcohol and mental health treatment for those with co-occurring disorders; to provide assistance in obtaining housing and employment, to assure a consumer-friendly approach to service planning and delivery; to offer peer-delivered services; and as a result to decrease homelessness and substance abuse and promote recovery.	
Priority Population: *Describe the situational characteristics of the priority population*	Services will be developed to serve adults and older adults who have co-occurring mental health and substance abuse disorders and who are homeless or at risk of homelessness. Further priority will be given to those whose cultural identity places them in underserved populations within our community (Latino, Asian Indian or Hmong).	

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
Self-help and client-run programs such as a drop-in center, anti-stigma campaign, advocacy program and peer education	☒	☐	☐	☐	☐	☒	☒
Integrated substance abuse and mental health services	☒	☐	☐	☐	☐	☒	☒
Trauma-informed and trauma specific services	☐	☐	☐	☐	☐	☒	☒
Development of housing options	☒	☒	☐	☐	☒	☒	☒
Vocational Services	☒	☐	☐	☐	☒	☒	☒
Supported Education	☒	☐	☐	☐	☐	☒	☒
Classes and other instruction for clients regarding what clients need to know for successful living in the community	☒	☐	☐	☐	☐	☒	☒
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐

Adult and Older Adult Full Service Program

1) See Exhibit 4above

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

To fully round out the full service partnership, the strategies described above must be integrated into a supportive whole. Since adults and older adults who have problems associated with homelessness, or risk of homelessness, and with co-occurring disorders were identified as under served populations, we will coordinate an array of appropriate treatment services for clients with these problems. This FSP will reflect the five essential elements: community collaboration, cultural competence, client/family driven services, a focus on wellness and integration of services. We will obtain specific training for clinicians so that therapists or others can address co-occuring substance abuse adequately within the context of mental health treatment, as well as providing intensive substance abuse treatment on an as needed basis.

Using a “whatever it takes” approach, specific services will include a drop-in center that is client run and which promotes self-help, conducts an anti-stigma campaign, and provides an advocacy program as well as peer education. Mental Health treatment services will include psychiatric assessments and medication management; integrated counseling and treatment services for those with both mental illness and substance abuse; services that are trauma informed and also trauma-specific services such as Seeking Safety (a harm reduction program for those who have been traumatized and are abusing substances); specific housing and employment support services; referrals to supported education opportunities; and classes to promote successful independent living. Referrals of older adults to this FSP may come from the Older Adult outreach team, referrals of adults will likely come from existing mental health treatment services and referrals of both adults and older adults will be encouraged from the Cultural Outreach Programs proposed within this plan, as well as cultural organizations and providers who serve the targeted ethnic groups in order to increase those numbers served that this FSP.

All adults and older adults being served by this FSP will be provided with 24/7 services by personal services coordinators (case managers), which will include peer counselors. The personal service coordinators and peer counselors will assist in skill development to improve coping strategies, using an incremental, long-term approach to reduce the degree of disability a person with a serious psychiatric disability faces. The Personal Service Coordinator will individually coordinate the services of each participant in this FSP. The personal service coordinators will emphasize engagement of the individual in treatment, will focus on wellness principles (not just illness), will communicate a message of hope and reassurance, and will promote self-reliance, empowerment, assertiveness and perseverance. The goal is to provide immediate interventions, day or night that will reduce negative outcomes such as unnecessary hospitalizations or evictions. Caseloads will be small and the case managers, peer counselors and other treatment team members will all be known to each participant. . All services and supports will be directed by the individualized service plans that are client driven.

All staff will receive training regarding supported employment, housing and education; psychosocial rehabilitation approaches; client directed services and consumer empowerment; self-help strategies and crisis intervention. They will have a thorough knowledge of community resources available to support the achievement of the client's goals and to address their needs.

This program will actively attempt to reduce disparities in services to the identified ethnic groups who are currently underserved in our community; to provide improved, integrated drug/alcohol and mental health treatment for those with co-occurring disorders; to provide assistance in obtaining housing and employment, to assure a consumer-friendly approach to service planning and delivery; to offer peer-delivered services; and as a result to decrease homelessness and substance abuse and promote recovery among the participants in this FSP.

3) Describe any housing or employment services to be provided.

The job specialist, a position shared with the TAY FSP, will help to develop employment opportunities, will create connections with job coaches, with career counselors, and with local job fairs. They will provide information about what training is available to adults and older adults who need more job skills, give hands-on, practical and individualized support in job search skills, and discover and assist with placement in education or training settings to enable each client to realize their potential.

The housing specialist, a position also jointly shared with the TAY FSP, will be responsible for assisting clients in accessing temporary/ emergency/ transitional/permanent housing; attending to issues of affordability, safety, help with paper work, or need for subsidies. The housing specialist will use vouchers for temporary/ emergency hotel stays; coordinate with existing housing programs; develop partnerships with local landlords to provide enhanced access for those adults and older adults who have a history of evictions and assist clients in accessing rent subsidies.

As new, affordable housing is developed, using the MHSA funds, all participants in each of the MHSA FSPs will be given first priority in accessing this housing. Once all of the FSP participants' needs have been met other mental health clients will be provided with access to this affordable housing. Of the $750,000 being committed to expand affordable housing, $350,000 has been identified for housing for Adults and Older Adults who are participants in this full service partnership.

During FY 05-06 a two tiered approach to expanding affordable housing emerged. A multi-agency committee was convened at the initiative of Mental Health. Using non-MHSA funds, Mental Health contracted with a very knowledgeable housing consultant to assist with planning for the development of a housing continuum to serve our mental health clients. In addition, a bi-county Homeless Consortium was formed; other local agencies have provided funding for this consultant to assist the Consortium in writing a Continuum of Care Housing Plan. The bi-county United Way has agreed to act as the fiduciary agent. Sutter County, Yuba County, the City of Marysville and Yuba City are all

actively involved in this planning in order to expand affordable housing to the community in general. This plan specifically includes those with special needs such as those with psychiatric disabilities.

During the course of this three year plan, we have set aside $750,000 to be used to match to state and federal dollars, such as HUD 811 funds, Supportive Housing Program funds, Shelter Plus Care Super NOFA funds, Community Development Block Grants, and/or Federal Emergency Shelter grants (as examples), to allow us to develop a significant number of new affordable housing units in the Sutter-Yuba area for those with psychiatric disabilities. These units will be developed in cooperation with the Sutter and the Yuba County Housing Authorities.

The initial plan is to use the identified MHSA housing funds to purchase outright an existing apartment complex that would then be rehabilitated as necessary. It is anticipated that this first property will be purchased and rehabilitated during this three year plan, As soon as this initial property is fully operational, the collateral from this property will be borrowed against to allow for the purchase of additional housing. Other federal funds, as referenced previously, will be actively sought to further expand the amount of new, affordable housing that can be developed. Such additional housing may involve new construction or rehabilitation of existing units. The housing may involve apartment complexes, clustered duplexes, or shared congregate living houses. Our intention is for the housing to be held in ownership by the public housing authorities for use by eligible individuals with psychiatric disabilities. These units will be linked to HUD Section 8 vouchers whenever possible, Rents will be affordable, but will be set to allow for the ongoing maintenance of the facilities and to pay-off of the mortgages on the facilities over time.

The supportive services that may be needed to make retention of this housing likely will be provided by Mental Health or contract providers, using the personal service coordinators and other staff contained in the FSPs and other programs being funded by the MHSA as well as non-MHSA funded staff.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

Year 1 –$ 12,256
Year 2 - $ 12,440
Year 3 - $ 13,161

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

The philosophy of recovery and the principles of psychosocial rehabilitation are instrumental in advancing the goals of recovery. Staff will be trained in both the philosophy and the principles. These principles will be reflected in the manner of engagement, in the focus on wellness rather than merely illness, in

communicating messages of hope and reassurance by promoting self-reliance, empowerment, assertiveness and perseverance, and in the individualized consumer-driven treatment styles used in working with these adults and older adults with psychiatric disabilities. This is accomplished by applying an approach that emphasizes wellness and functionality in the community and which, within a developmental context, addresses four dimensions: Job/Career/Avocational Activities, Housing, Community Living, and Wellness. By focusing on these four functional areas, mental illness or emotional disturbance will become only one of the variables to be considered in improving functioning in these four areas. Peer mentors and senior peer counselors will be trained and utilized to promote self-help and recovery activities on both an individual and group basis. Ongoing staff training on the principles of psychosocial rehabilitation and recovery, that includes peer counselors and parent partners will take place regularly in order to continue to enhance staff skills and to reinforce the importance of these principles in all service delivery.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

Currently our self-help and recovery activities are very limited. Through a contract with a private non-profit we have a small drop-in program for homeless adults. The intention is to significantly expand this program to serve more adults and older adults with co-occurring disorders and with homelessness, and to insure that its services and approaches are consistent with the principles of psychosocial rehabilitation and the goals of recovery. The peer counselors will tailor their activities to support each participant's goals. More adults will be served, in a more individualized manner, for a greater length of time to insure important recovery goals with regards to housing and employment can be adequately addressed.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Recovering clients will be hired as peer counselors and senior peer counselors to provide mentoring, independent living skills training, social and recovery activities, to serve as personal service coordinators, and to provide client advocacy. Clients will be surveyed to determine what supports and activities they would like to have provided by peer counselors. Additional services will be provided, based upon the input from these surveys. Parent Partners will provide family support; serve as personal service coordinators, and client advocates. Peer counselors and Parent Partners will be employed by a contract agency. The client will choose which, if any, members of their family will be included in the development and implementation of their service plan along with their service team. This may include members of their extended family as they define it. Families will be offered ongoing educational and support groups.

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

Implementation of the FSP will result in the creation of a collaborative team comprised of Mental Health, Alcohol and Drug, Health, Probation, Welfare, Salvation Army and various private non-profit staffs. No formal tribal entities exist locally to involve in this process. These providers will provide support to this project either financially and/or in-kind. All staff will be cross-trained in relevant mental health, law enforcement, and drug and alcohol policies and procedures, as well as how to provide services that are client centered and resiliency and recovery oriented. This collaboration will contribute to future improved services for the clientele we jointly serve by reducing barriers to accessing services, fostering shared service delivery, shared inter-agency training activities to create general agreement on service styles that foster positive change in our clients and a greater understanding of the rules and limitations under which various providers operate and improved client outcomes.

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

Consistent with the rest of the mental health staff, staff of the Adult/Older Adult FSP and their peer counselors will receive ongoing cultural competency training, through a number of annual specific trainings that focus on the Hmong, Asian Indian, Latino, LGBT, African American and consumer cultures.

Currently available Mental Health services under serve within all age groups those for whom English is not their primary language. Efforts will be made to identify specific evidence-based practices that have been proven to be effective with Latino, Asian Indian and/or Hmong adults/older adults and their families. Staff will be particularly sensitive to the traditional decision-making structures in families among these cultural groups, and will focus more on family decision-making if that is the wish of the client. Efforts will be made to hire staff that is bilingual and bicultural to help ensure a team that is sensitive to the needs of our underserved populations and are representative of our diverse community. Individualized service plans will be client/family-centered and will identify culturally specific resources that may include, but are not limited to: culture-specific faith healers such as curanderos or spirit healers, other community partners, the faith community, and private providers, in addition to county resources. Referrals to this program may be made from other Mental Health programs and community providers; in particular those providers who serve our underserved ethnic communities. The MHSA-funded resources being developed to promote specific Ethnic Outreach will also provide referrals from the Latino, Asian Indian and Hmong communities to redress the present inequities in our system. Therapy and other services will be provided in the language of the client. Culturally-normed, evidence based intervention strategies will be utilized whenever possible.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of

women and men, boys and girls.

All SYMH staff are trained on LGBT issues and resources. Staff who are particularly comfortable and effective dealing with LGBT issues will be provided with small rainbow flag decals that they can place in their workspace or office to signal that they are "safe to come out to." Members of the service teams from other agencies not already trained in these issues will be included in these trainings which will enhance the systems' understanding of these needs. The integrated service plan will be client/family centered and staff will work to positively identify the LGBT issues which exist, as well as the resources available. These may include such local resources as Yuba-Sutter Pride and Sacramento resources through the Lamda Center in addition to those mentioned above.

Gender-specific services are recognized as necessary. Efforts are made to match genders of service providers to clients as appropriate. Groups addressing gender-specific issues are provided as needed, such as issues of women's empowerment, and the importance of fathers in the lives of their children. Seeking Safety, a harm reduction curriculum addressing trauma and substance abuse, is provided in gender-specific groups.

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

Sutter and Yuba residents may access emergency mental health services anywhere in the state when in psychiatric crisis to ensure the immediate safety of the individual, family, and community. Sutter-Yuba Mental Health assumes financial responsibility for MediCal eligible individuals who require inpatient care. Adults who are residing out-of-county who are not in an IMD or in a residential placement arranged by the mental health program or conservator, are no longer considered residents of Sutter or Yuba Counties. Those residing in out-of-county IMDs or residential placements will be given priority for FSP and other mental health services, as appropriate, to facilitate their return to the community.

Adults who are residing out-of-county who continue to hold a Sutter or Yuba County MediCal card will be offered assistance by our Mental Health staff to facilitate a change to the county in which they now reside. Those local residents who seek outpatient care out-of-county will be referred back to services provided by Sutter-Yuba Mental Health or they will be offered specialized services through an out-of-county network provider if appropriate.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

N/A

13) Please provide a timeline for this work plan, including all critical implementation dates.

The following timeline is tentative:
Board of Supervisor Approval – December 05

DMH approval of CSS plan – March 06
Recruit, hire and train program staff – April – June 06
Expansion of physical space of existing System of Care Program – March – April 06
Program services to begin May, 2006

14) See Exhibit 5
15) See Exhibit 6

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY		
County: Sutter and Yuba Counties	Fiscal Year: 2005-06	Program Work Plan Name: Older Adult Mobile Assistance Team
Program Work Plan #: 5		Estimated Start Date: April 2006

Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	A Mobile Assistance Program for Older Adults who are isolated physically or geographically The program will advance the goals of the MHSA by enabling those who participate to obtain and maintain positive social connections; experience respect from their providers of mental health services; feel empowered and listened to in the process of planning and obtaining their services; and have continuity in their providers. This program will also allow a reduction in disparities of services for the identified ethnic groups who are underserved in our community; a family-friendly approach to service planning and delivery; peer-delivered services; and a decrease in homelessness due to housing services and treatment leading to recovery.
Priority Population: *Describe the situational characteristics of the priority population*	Services will be developed to serve older adults aged 60 and over who are physically or geographically isolated and who have psychiatric disabilities. Further priority will be given to those whose cultural identity places them in underserved populations within our community (Latino, Asian Indian or Hmong).

	Fund Type			Age Group			
Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	FSP	Sys Dev	OE	CY	TAY	A	OA
Mobile services to reach older adults who cannot access clinics and other services due to physical disabilities, language barriers, mental disabilities or other factors	☐	☒	☒	☐	☐	☐	☒
Integrated service teams and planning with social service agencies and other community providers to meet the complex needs of older adults	☐	☒	☐	☐	☐	☐	☒
On-site or collaborative services with primary care health clinics and health care services to reduce barriers to access and increase integration of physical and mental health services	☐	☒	☐	☐	☐	☐	☒
Outreach to older adults who are homeless, or in their homes, through community service providers and through other community sites that are	☒	☐	☒	☐	☐	☐	☒

gathering places for older adults, such as Senior Centers, some service clubs and ethnic organizations							
	☒	☐	☐	☐	☒	☒	☐
	☒	☐	☐	☐	☐	☒	☐
	☒	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐

Older Adult Program

1) See Exhibit 4

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

This program will reflect the five essential elements: community collaboration, cultural competence, client/family driven services, a focus on wellness and integration of services. The program will advance the goals of the MHSA by enabling those who participate to obtain and maintain positive social connections; experience respect from their providers of mental health services; feel empowered and listened to in the process of planning and obtaining their services; and have continuity in their providers.

This program will develop and train an assessment team to collaborate with community based organizations, social services and physical health to do on site mental health screenings and assessments of older adults, while assuring confidentiality of those participating in these screenings and assessments. Assessments could take place in homes, physician's offices, senior centers, the health departments or other primary care settings, church halls and community centers. Activities such as the National Depression Screening Day will be used to create intensive local mental health screening activities provided within a context that normalizes these types of activities. A senior peer counselor will also be part of this treatment team in order to reduce the stigma associated with mental health assessments or treatment. Those in need of ongoing mental health treatment will either be served by this team or they will be transitioned to clinic-based mental health services, depending upon the needs and the desires of the individual client. Assessment and treatment services will be provided in the home for those unable or unwilling to access services in clinic or congregate settings. Assessment services will also be provided within physical health care settings to improve overall integration with healthcare providers and individual treatment outcomes for older adults.

Treatment services will include psychiatric assessments and medication management if needed; individual counseling; peer support, client advocacy, self-help and recovery activities; case management support; and referrals to other providers.

Every attempt will be made to recruit staff that is culturally diverse and multi-lingual, containing at least one Spanish-speaking team member, and possibly a Hmong or Punjabi-speaker as well. This team will also utilize the services of the Ethnic Outreach Programs to provide information to clients and to make referrals to this team. Research from focus groups indicated that older adults are more likely to trust people either closer to their own age or younger than the age of their children as there might be some mistrust of those who are their children's age due to abuses of power. Staff will be recruited with these parameters in mind.

This program will also allow a reduction in disparities for the ethnic groups who are underserved in our community; a family-friendly approach to service

planning and delivery; peer-delivered services; and a decrease in homelessness due to housing services and treatment leading to recovery.

3) Describe any housing or employment services to be provided.

Older Adults identified by this Outreach Team will have access to the housing and employment supports being developed as part of the Children's 0-5, TAY and Adult full service partnerships, to the extent that there is capacity after the clients in the FSPs have been served.

During the course of this three year plan, we have set aside $750,000 to be used to match to state and federal dollars, such as HUD 811 funds, Supportive Housing Program funds, Shelter Plus Care Super NOFA funds, Community Development Block Grants, and/or Federal Emergency Shelter grants (as examples), to allow us to develop a significant number of new affordable housing units in the Sutter-Yuba area for those with psychiatric disabilities. These units will be developed in cooperation with the Sutter and the Yuba County Housing Authorities. The initial plan is to use the identified MHSA housing funds to purchase outright an existing apartment complex that would then be rehabilitated as necessary. It is anticipated that this first property will be purchased and rehabilitated during this three year plan, As soon as this initial property is fully operational, the collateral from this property will be borrowed against to allow for the purchase of additional housing. These units will be linked to HUD Section 8 vouchers whenever possible. Rents will be affordable, but will be set to allow for the ongoing maintenance of the facilities and to pay-off of the mortgages on the facilities over time.

The supportive services that may be needed to make retention of this housing likely will be provided by Mental Health or contract providers, using the personal service coordinators and other staff contained in the FSPs and other programs being funded by the MHSA as well as non-MHSA funded staff.

Members of this outreach team will be informed about various volunteer and employment opportunities for older adults, and will assist those adults in connecting with senior referral services and employment services if they express the wish to participate in volunteer or employment opportunities.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

N/A

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

Staff will be trained in both the philosophy of recovery and the principles of psychosocial rehabilitation. These principles will be reflected in the manner of engagement, in the focus on wellness rather than merely illness, in communicating messages of hope and reassurance by promoting self-reliance,

empowerment, assertiveness and perseverance, and in the individualized consumer-driven treatment styles used in working with these older adults with psychiatric disabilities. A senior peer counselor will be trained and utilized to promote self-help and recovery activities. Ongoing staff training on the principles of psychosocial rehabilitation and recovery, that includes the senior peer counselor, will take place regularly in order to continue to enhance staff skills and to reinforce the importance of these principles in all service delivery.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

We do not currently have any specialized outreach services for older adults. We do have limited clinic-based treatment services (for example, a reminiscence group) that are specifically for older adults.

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

A senior peer counselor will provide mentoring, supportive services and client advocacy. The client will choose which, if any, members of their family will be included in the development and implementation of their service plan along with their service team. This may include members of their extended family as they define it. Families will be offered an ongoing educational and support group.

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

Collaborative teams comprised of Mental Health, Health, and Social Services exist in each county currently to staff older adults who have complex social and health issues and who are in need of multi-agency interventions. No formal tribal entities exist locally to involve in this process. These collaborative teams, as well as these individual providers, will provide support to this project and will be referral sources. These providers will be offered training in how to provide services that are client centered and resiliency and recovery-oriented. This collaboration will contribute to future improved services for the clientele we jointly serve by reducing barriers to accessing services, fostering shared service delivery, shared inter-agency training activities to create general agreement on service styles that foster positive change in our clients, and a greater understanding of the rules and limitations under which various providers operate and improved client outcomes.

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

Consistent with the rest of the mental health staff, staff of the Older Adult Outreach Team and their senior peer counselor will receive ongoing cultural competency training, through a number of annual specific trainings that focus on

the Hmong, Asian Indian, Latino, LGBT, African American and consumer cultures.

Currently available Mental Health services under-serve within all age groups those for whom English is not their primary language. In particular, older adults who are Latino, Asian Indian or Hmong are significantly under-served. Efforts will be made to identify specific evidence-based practices that have been proven to be effective with Latino, Asian Indian and/or Hmong adults older adults and their families. Staff will be particularly sensitive to the traditional decision-making structures in families among these cultural groups, and will focus more on family decision-making if that is the wish of the client. Efforts will be made to hire staff that is bilingual and bicultural to help ensure a team that is sensitive to the needs of our underserved populations and is representative of our diverse community. Individualized service plans will be client-centered and will identify culturally specific resources that may include, but are not limited to: culture-specific faith healers such as curanderos or spirit healers, other community partners, the faith community, and private providers, in addition to county resources. Referrals to this program may be made from other Mental Health programs and community providers; in particular those providers who serve our underserved ethnic communities. The MHSA-funded resources being developed to promote specific Ethnic Outreach will also provide referrals from the Latino, Asian Indian and Hmong communities to redress the present inequities in our system. Therapy and other services will be provided in the language of the client.

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

All SYMH staff are trained on LGBT issues and resources. Staff will be particularly sensitive to issues of aging among gays, and among gays and lesbians who are childless. Members of the service teams from other agencies not already trained in these issues will be included in these trainings which will enhance the systems' understanding of these needs. The integrated service plan will be client/family centered and staff will work to positively identify the LGBT issues which exist, as well as the resources available. These may include such local resources as Yuba-Sutter Pride and Sacramento resources through the Lamda Center in addition to those mentioned above.

Gender-specific services are recognized as necessary. Efforts are made to match genders of service providers to clients as appropriate. Groups addressing gender-specific issues are provided as needed, such as issues of women's empowerment, and the importance of fathers in the lives of their children. Seeking Safety, a harm reduction curriculum addressing trauma and substance abuse, is provided in gender-specific groups.

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

Sutter and Yuba residents may access emergency mental health services anywhere in the state when in psychiatric crisis to ensure the immediate safety of

the individual, family, and community. Sutter-Yuba Mental Health assumes financial responsibility for MediCal eligible individuals who require inpatient care. Adults who are residing out-of-county who are not in an IMD or in a residential placement arranged by the mental health program or conservator, are no longer considered residents of Sutter or Yuba Counties. Those residing in out-of-county IMDs or residential placements will be given priority for MHSA-funded as well as other mental health services, as appropriate, to facilitate their return to the community.

Adults who are residing out-of-county who continue to hold a Sutter or Yuba County MediCal card will be offered assistance by our Mental Health staff to facilitate a change to the county in which they now reside. Those local residents who seek outpatient care out-of-county will be referred back to services provided by Sutter-Yuba Mental Health. Occasionally they will be offered specialized services through an out-of-county network provider if appropriate.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

N/A

13) Please provide a timeline for this work plan, including all critical implementation dates.

The following timeline is tentative:
Board of Supervisor Approval – December 05
DMH approval of CSS plan – March 06
Recruit, hire and train program staff – April – June 06
Contracting for services with a community provider, or developing appropriate space for internal program - March – April 06
Program services to begin May, 2006

1**4) See Exhibit 5**
15) See Exhibit 6

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY		
County: Sutter and Yuba Counties	Fiscal Year: 2005-06	Program Work Plan Name: Ethnic Outreach Plan
Program Work Plan #: 6		Estimated Start Date: April 2006

Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	Three targeted outreaches will occur for our major underserved populations: Latino, Hmong and Punjabi/Asian Indians. The program will advance the goals of the MHSA by enabling participants to obtain and maintain positive social connections; live in safety and in a setting which is of their choosing; have access to co-occurring disorders integrated mental health and drug/alcohol treatment if they choose; obtain assistance to engage in meaningful activity such as employment or education/ training; receive services which recognize their developmental process as "normal" and do not marginalize issues of wellness; experience respect from their providers of mental health services; feel empowered and listened to in the process of planning and obtaining their services; have continuity in their providers; and have individualized service plans which recognize the uniqueness of each person within the context of their ethnic/racial/cultural identity. This program will also allow a reduction in disparities for the identified ethnic groups who are now underserved in our community; providing improved access through the provision of services in community settings actively utilized by these populations; improved integration or a single provider of drug/alcohol and mental health treatment for those with co-occurring disorders; improved integration between child and adult systems to bridge gaps in services; a culturally sensitive family-friendly approach to service planning and delivery; and peer-delivered services supporting wellness and recovery.
Priority Population: *Describe the situational characteristics of the priority population*	Each of the programs will be intergenerational, serving children, youth, transitional-aged youth, adults and older adults within that cultural group. Within these broader categories, females will be specifically targeted as they are more likely to be underserved in our entire system, and also specifically within these cultures.

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
On-site or collaborative services with primary care health clinics and health care services to reduce barriers to access and increase integration of physical health care and mental health services; linkage of these Punjabi, Latino, and	☒	☒	☒	☒	☒	☒	☒

Hmong clients to the full range of mental health services when needed							
Ethnic socialization group for children/youth and their families	☒	☒	☒	☒	☒	☒	☒
Community cultural practices	☒	☒	☒	☐	☐	☒	☐
Culturally appropriate services to reach persons of racial ethnic cultures who may be better served and/or more responsive to services in specific culture-based settings	☒	☒	☒	☐	☐	☐	☒
Ethnic-specific outreach strategies to racial ethnic populations to eliminate disparities in care. Clients and families from the targeted communities are engaged to design the strategies and messages.	☒	☒	☒	☐	☐	☒	☐
Partnerships with ethnic-specific community providers and programs	☒	☒	☒	☐	☒	☐	☐
Cultural and gender-sensitive outreach and services at schools, primary care clinics and community programs in ethnic communities which proactively reach children who may have emotional and/or behavioral disorders and which can provide easy and immediate access to mental health services when needed.	☒	☒	☐	☒	☐	☐	☐
Child care	☒	☒	☒	☒	☒	☒	☒
Transportation services	☒	☒	☒	☒	☒	☒	☒
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐

Ethnic Outreach Program

II. Programs to be Developed or Expanded

1) See Exhibit 4 above

2) Please describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

The Ethnic Outreach Program will have a three pronged approach – one for each of the significant ethnic groups we have identified as being underserved in Yuba and Sutter counties. To better serve these ethnic populations, we will buy or create public service announcements in multiple languages to better inform the general public about the services available; participate in informational television and radio shows targeted to specific ethnic viewers and purchase cultural-specific novellas for radio or television, using the local Punjabi and Spanish radio and television stations and also using the regional Hmong radio station for informational presentations. We will also develop brief written information in multiple languages about how to access Mental Health services and describing the treatment process. To assure access, assistance with childcare and transportation will also be provided when needed within each of these outreach programs. For the lesbian, gay, bisexual and transgender populations, materials will be developed identifying therapists at Bi-County Mental Health and within our provider network who identify themselves as receptive and competent in serving this population (as well as our other ethnic and special needs populations such as the deaf and those who have co-occurring developmental disabilities and psychiatric disorders). The material will also specify how services for this group may be accessed. These materials will be distributed as part of a more inclusive information packet used in all community outreach activities.

The Ethnic Outreach Program will reflect the five essential elements: community collaboration, cultural competence, client/family driven services, a focus on wellness and integration of services.

The Latino workgroup identified the need for more “professional therapists who are bi-lingual and bi-cultural” over the need for peer counselors. They stated there are significant unmet needs for mental health treatment, substance abuse treatment and treatment of domestic violence. The Latino outreach will consist of two bicultural/bilingual Mental Health Therapists who are proficient (or are willing to become proficient) in treating co-occurring disorders; one who is a child specialist and one for adults. They will also be trained in trauma based treatment programs, such a *Seeking Safety* for adults and adolescents and *Building Resilience* for children 5-10 who have been traumatized and who have been exposed to substance abusing parents. As much as possible, these therapists will be trained in the use of therapy approaches, such as *cognitive behavioral therapy*, *Brief Strategic Family Therapy* and *Familias Unidas*, all of which are evidence-based practices with at least some demonstrated effectiveness with Latino populations. They will provide screening, assessment and treatment services in community settings which already serve a predominantly Spanish-speaking clientele, such as Lindhurst Clinic, Richland

Housing Community Center, Mercy Housing and Luther, Cedar Lane and Park Avenue Schools. A high level of integration will occur between these Mental Health Therapists and the primary care physicians, educators and social services providers located in these settings. Assistance with childcare and transportation will be provided as necessary to facilitate access to treatment services.

Based on input from the Asian Indian workgroup, they emphasized that the Asian Indian community places a high value on academic achievement, success in employment and loyalty to the family. Family problems, including psychiatric disorders, substance abuse and domestic violence are kept hidden so that the family is not dishonored. The workgroup recommended against the use of peer staff. The Asian Indian/Punjabi outreach will involve a bicultural/bilingual Punjabi speaking mental health therapist who is a child specialist and who is (or can be trained to become) a dual diagnosis mental health/substance abuse specialist. Out of sensitivity to the current stigma associated with mental health treatment within the local Asian Indian community this person's working title will be Community Resource Specialist. This person will be housed at the Sutter County Health Department, as these services are routinely utilized by much of the Asian Indian community and therefore would have less stigma attached to receiving treatment in that setting. A high level of integration will occur between the primary care physicians at the Health Department and this Community Resource Specialist (aka mental health specialist). This specialist will also work closely with Migrant Education programs which serve large numbers of low-income Punjabi-speaking families. Outreach and education services will also be provided in that setting as indicated. Importance will be placed on serving emotionally disturbed children and those adults with co-occurring mental health and substance abuse disorders, with an emphasis on the substance abuse treatment. Treatment of these two specific populations will have more initial acceptance within the local Asian-Indian community. Once the Community Resource Specialist has developed more credibility within the Asian Indian Community it is anticipated that a broader range of populations and mental health treatment issues will be addressed.

Based upon the input from the Hmong Workgroup and the Hmong community forum the Hmong outreach will consist of a one stop service center at a location that is frequented by members of the Hmong Community, such as the Feather River Center in Yuba County. This one stop center will provide social supports and at the same time, it will be a place to deliver mental health, social services, probation and employment services in collaboration with Yuba County Probation and Yuba County Health and Human Services Departments. The provision of mental health services to the Hmong community is particularly challenging since there are no traditional cultural equivalents relating to psychological dynamics within the culture; instead there is widespread traditional belief in the day to day effects of spirits on individual's moods, functioning and life experiences. Most of the older Hmong in the community were significantly traumatized by their earlier life experiences in Laos and there is use of opium among this portion of the population. There are high rates of poverty and unemployment. They have been receptive to receiving psychiatric medications through SYMHS and have found

them to be useful. They have benefited from social support but not from psychotherapy, per se. Younger Hmong are more Americanized but struggle with the more typical challenge faced by recent immigrants of trying to bridge the gap between two very different cultures. There is increasing use of methamphetamine among this group. Many younger Hmong are successfully acculturating and are being trained in a variety of professions, including Social Work. Therefore, Mental Health hopes to recruit a bicultural/bilingual Mental Health Intervention Counselor and a bicultural/bilingual Hmong-speaking Therapist proficient in (or receptive to learning about) treatment of co-occurring disorders to coordinate this center and provide primarily cognitive behavioral and trauma informed therapies (such as EMDR) which the emerging literature suggests are effective with minority populations; and also psychosocial rehabilitation activities such as training in independent living skills and therapeutic recreation. Psychiatric services will be provided in this setting if it proves to be more convenient than the clinic-based services currently being provided. Over time peer/consumer staff will be identified and trained, until there is the equivalent of one FTE of paid consumer staff. This setting will also afford participants the opportunity to plan and conduct social events, fundraisers, community cultural events, trips and outings, and similar activities and also provide ESL classes. These staff will work closely with primary care providers, in particular with Peachtree Clinic, to assure better integration between primary healthcare and mental health treatment.

In these three Outreach Programs treatment will be based on the principles of psychosocial rehabilitation and the goal of recovery. Service planning will all be client/family driven, and within a developmental context, there will be an emphasis on wellness, not only on illness. Staff will communicate messages of hope and reassurance by promoting self-reliance, empowerment, assertiveness and perseverance. The program will advance the goals of the MHSA by enabling those who participate to feel hope and inclusion; obtain and maintain positive social connections; have access to integrated treatment for co-occurring mental health and drug/alcohol problems if they choose; obtain assistance in accessing meaningful activities such as employment or education/ training; receive services which recognize their developmental process as “normal” and do not marginalize issues of wellness; experience respect from their providers of mental health services; feel empowered and listened to in the process of planning and obtaining their services; have continuity in their providers; and have individualized service plans. This last is particularly important as each person has individual needs, within the context of their ethnic/racial/cultural identity.

This program will also allow a reduction in disparities for the identified ethnic groups who are underserved in our community; improved integration or a single provider of drug/alcohol and mental health treatment for those with co-occurring disorders; improved integration between child and adult systems to bridge gaps in services; a family-friendly approach to service planning and delivery; and will also allow for peer-delivered services supporting wellness and recovery.

3) Describe any housing or employment services to be provided.

Any clients from these ethnic communities who are accepted into any of the three Full Service Partnerships will receive both vocational and housing services as outlined in the FSP plans.

Staff of these Outreach Programs will be informed about various volunteer and employment opportunities for youth, adults and older adults, and will assist clients in connecting to volunteer referral services and employment services if they express the wish to participate in volunteer or employment opportunities. To the extent there is capacity, participants in these outreach programs will be given priority in accessing the Job Specialist funded by the TAY and Adult/Older Adult FSPs.

During the course of this three year plan, we have set aside $750,000 to be used to match to state and federal dollars to allow us to develop new affordable housing units in the Sutter-Yuba area. Once the needs of all of the FSP participants have been met other mental health clients will be able to access any additional affordable housing made available as a result of these efforts. The initial plan is to use the identified MHSA housing funds to purchase outright an existing apartment complex that would then be rehabilitated as necessary. It is anticipated that this first property will be purchased and rehabilitated during this three year plan, As soon as this initial property is fully operational, the equity from this property will be borrowed against to allow for the purchase of additional housing. Other federal funds will be actively sought to further expand the amount of new, affordable housing that can be developed. Such additional housing may involve new construction or rehabilitation of existing units. The housing may involve apartment complexes, clustered duplexes, or shared congregate living houses. Our intention is for the housing to be held in ownership by the public housing authorities for use by eligible individuals with psychiatric disabilities. These units will be linked to HUD Section 8 vouchers whenever possible, Rents will be affordable, but will be set to allow for the ongoing maintenance of the facilities and to pay-off of the mortgages on the facilities over time.

The supportive services that may be needed to make retention of this housing likely will be provided by Mental Health or contract providers, using the personal service coordinators and other staff contained in the FSPs and other programs being funded by the MHSA as well as non-MHSA funded staff.

4) Please provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

N/A

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

All staff will be trained in both the philosophy of recovery and the principles of psychosocial rehabilitation. Embedded in these core values is recognition of the

importance of the family's cultural values as a source of resilience/recovery, and an integral component of service delivery. These principles will be reflected in the manner of engagement, within a developmental context, that emphasizes engagement of youth, TAY, adults and/or older adults and their families in treatment with a focus on wellness rather than merely illness. Staff will communicate messages of hope and reassurance by promoting self-reliance, empowerment, assertiveness and perseverance. Program participants will be full partners in designing and implementing their service plans. The program will encourage and support a shift from professionally-centered to client and family-centered practice and resources. Families will be offered parenting skills which build on resilience factors and emphasize understanding the developmental context and needs of the youth and focus on strengths and wellness.

Within the Hmong Outreach team peer counselor(s) will be trained and utilized to promote self-help and recovery activities. Ongoing staff training on the principles of psychosocial rehabilitation and recovery, that includes the peer counselor(s), will take place regularly in order to continue to enhance staff skills and to reinforce the importance of these principles in all service delivery.

6) If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

N/A

7) Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

Recovering clients will be hired as peer counselors within the Hmong Outreach Program to provide mentoring, independent living skills training, and client advocacy. Each client involved in any of these outreach programs will choose which, if any of their family will be included in developing and implementing their service plan, along with their service team, and this may include members of their extended family as they define it.

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

These Outreach Programs will necessitate the development of several new collaborative teams comprised of representatives from Mental Health, Alcohol and Drug, Health, Probation, Welfare, and various community cultural groups from both counties. No formal tribal entities exist locally to involve in this process. These providers will provide support to these projects either financially and/or in-kind. These collaborations will contribute to future additional integrated services, improved access to a variety of services, reduced barriers to accessing services (in particular for our identified underserved ethnic populations), they will foster shared service delivery, shared inter-agency training activities to create general agreement on service styles that foster positive change in our clients and a greater understanding of the rules and limitations under which various providers operate and improved client outcomes.

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

Consistent with the rest of the mental health staff, staff of the Ethnic Outreach Programs and their peer counselors will receive ongoing cultural competency training, through a number of annual specific trainings that focus on the Hmong, Asian Indian, Latino, LGBT, African American and consumer cultures.

Currently available Mental Health under serves all age groups for whom English is not their primary language. Efforts will be made to identify specific evidence-based practices that have been proven to be effective with Latino, Asian Indian and/or Hmong children, TAY, adults or older adults and/or families. Staff will be particularly sensitive to the traditional decision-making structures in families among these cultural groups, and will focus more on family decision-making if that is the wish of the client. Staff working in these programs will be bilingual/ bicultural to ensure staff that is sensitive to the needs of our underserved populations and are representative of our diverse community. Individualized service plans will be client/family driven and will identify culturally specific resources that may include, but are not limited to: culture-specific faith healers such as curanderos or spirit healers, other community partners, the faith community, and private providers, in addition to county resources. Referrals to these programs may be made from other Mental Health programs and community providers; in particular those providers who serve our underserved ethnic communities. Therapy and other services will be provided in the language of the client.

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

SYMH staff are trained annually on LGBT issues and resources. Staff who are particularly comfortable and effective dealing with LGBT issues will be provided with small rainbow flag decals that they can place in their workspace or office to signal that they are “safe to come out to.” Among the Asian Indian culture LGBT individuals are particularly stigmatized. Asian Indian, Latino and Hmong youth are at high risk. Staff will be particularly sensitized to the cultural beliefs and values associated with a LGBT lifestyle.

Staff from other agencies not already trained in these issues will be included in these trainings which will enhance the systems’ understanding of these needs. The integrated service plan will be client/family centered and staff will work to positively identify the LGBT issues which exist, as well as the resources available. These may include such local resources as Yuba-Sutter Pride and Sacramento resources through the Lamda Center in addition to those mentioned above.

Gender-specific services are recognized as necessary. Efforts are made to match genders of service providers to clients as appropriate. Groups addressing gender-specific issues will be provided as needed, such as issues of women’s

empowerment, and the importance of fathers in the lives of their children. Adolescent groups are particularly more effective when they take place in gender-specific groups.

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

Sutter and Yuba residents may access emergency mental health services anywhere in the state when in psychiatric crisis to ensure the immediate safety of the individual, family, and community. Sutter-Yuba Mental Health assumes financial responsibility for MediCal eligible individuals who require inpatient care.

Mental Health operates a Placement Team whose function is to help integrate youth who are placed out of county back into their home community whenever possible. When placement is required all efforts will be made to keep the youth in this community. Foster care youth placed out of the area, or adoptees residing out-of-county receive assistance in accessing and receiving the appropriate services in the community in which they reside through our provider network or through purchase of service agreements between SYMHS and the public mental health program in the county in which the youth resides. Youth placed in a group home are assigned to the interagency case management team to insure they receive the needed services and are returned to our community in a smooth and timely manner.

Adults who are residing out-of-county who are not in an IMD or in a residential placement arranged by the mental health program or conservator, are no longer considered residents of Sutter or Yuba Counties. Those residing in out-of-county IMDs or residential placements will be given priority for FSP and other mental health services, as appropriate, to facilitate their return to the community. Adults who are residing out-of-county who continue to hold a Sutter or Yuba County MediCal card will be offered assistance by our Mental Health staff to facilitate a change to the county in which they now reside. Those local residents who seek outpatient care out-of-county will be referred back to services provided by Sutter-Yuba Mental Health. Occasionally they will be offered specialized services through an out-of-county network provider if appropriate.

12) If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

N/A

13) Please provide a timeline for this work plan, including all critical implementation dates.

The following timeline is tentative:
Board of Supervisor Approval – December 05
DMH approval of CSS plan – March 06
Recruit, hire and train program staff – April – June 06
Write MOUs and contract for physical space to house each outreach – March – April 06
Program services to begin May, 2006

14) See Exhibit 5
15) See Exhibit 6