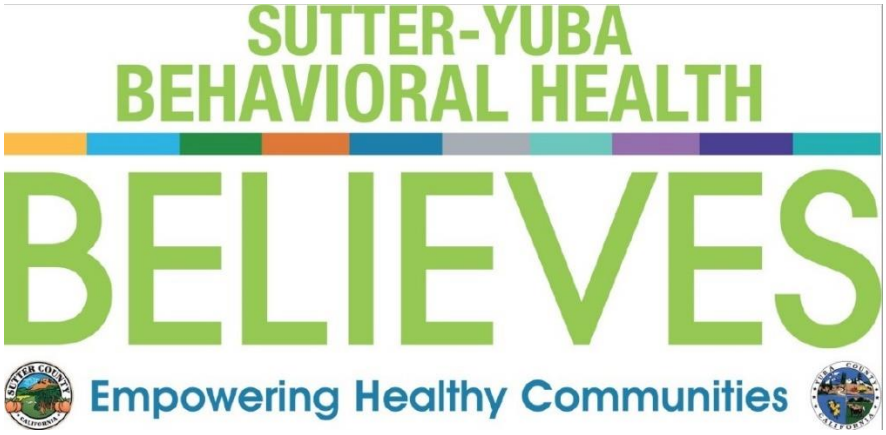


SUTTER-YUBA BEHAVIORAL HEALTH

Fiscal Years 2017-2020

Three-Year Program and Expenditure Plan

Posted for 30-day Public Review and Comment:

January 9, 2017 to February 9, 2017

The intent of SYBH's Three-Year Plan is to provide the Sutter/Yuba communities with a progress report of each of the components within MHSA: 1- Community Services and Supports; 2-Prevention and Early Intervention; 3-Workforce, Education and Training; 4-Innovation; and 5-Capital Facilities/Technological Needs and provide the community with information related to significant changes to the previous year's programming or new funding.

Per MHSA regulations, County Mental Health Departments are required to submit a Three-Year Program and Expenditure plan and update it on an annual basis, based on the estimates provided by the State and in accordance with established stakeholder engagement and planning requirements. This Three-Year Plan reports program activities for the Fiscal Years 2017/2018 through 2019/2020. A projected Three-Year MHSA Budget Summary can be found of page 71.

The following provides a chronological overview of the program sections included in this Three-Year Plan:

MHSA COUNTY COMPLIANCE CERTIFICATION

County: Sutter-Yuba Behavioral Health

→ Three-Year Program and Expenditure Plan
❑Annual Update

Local Mental Health Director	Program Lead
Name: Tony Hobson, Ph.D.	Name: Megan Ginilo, MPA
Telephone Number: 530-822-7200	Telephone Number: 530-822-7200
E-mail: THobson@co.sutter.ca.us	E-mail: MGinilo@co.sutter.ca.us
Local Mental Health Mailing Address 1965 Live Oak Blvd., Suite A P.O. Box 1520 Yuba City, CA 95992-1520	

I hereby certify that I am the official responsible for the administration of county/city mental health services in and for said county/city and that the County/City has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this Three-Year Program and Expenditure Plan or Annual Update, including stakeholder participation and nonsupplantation requirements.

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

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

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

Tony Hobson, Ph.D.

Mental Health Director (PRINT)	Signature	Date

MHSA FY 2015/2016 Annual Update
FISCAL ACCOUNTABILITY CERTIFICATION[1]

County: Sutter-Yuba Behavioral Health

✓ Three-Year Program and Expenditure Plan
☐ Annual Update
❑ Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller
Name: Tony Hobson, Ph.D. Telephone Number: 530-822-7200 E-mail: THobson@co.sutter.ca.us	Name: Nate Black, CPA Telephone Number: 530-822-7127 E-mail: NBlack@co.sutter.ca.us
Local Mental Health Department Mailing Address: 1965 Live Oak Blvd., Suite A P.O. Box 150 Yuba City, CA 95992-1520	

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

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

Tony Hobson, Ph.D._____ _____

Mental Health Director (PRINT) Signature Date

I hereby certify that for the fiscal year ended June 30, , the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated for the fiscal year ended June 30, 2015 . I further certify that for the fiscal year ended June 30, 2015, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

Nathan Black, CPA_____ _____

County Auditor-Controller (PRINT) Signature Date

MHSA Community Program Planning and Local Review Process

County: Sutter-Yuba Behavioral Health
30-day Public Comment period dates: January 9, 2017 to February 9, 2017
Date of Public Hearing: February 9, 2017

COUNTY DEMOGRAPHICS AND DESCRIPTION

The Sutter and Yuba Bi-County Behavioral Services organization serves the communities of both Sutter and Yuba Counties, including Marysville and Yuba City. Sutter and Yuba Counties are unique in their geographic and demographic characteristics. The counties include more than 1200 square miles of rural, agricultural land, about forty miles north of Sacramento's metropolitan area. Most of the population is at the center of the bi-county area, where the two largest cities, Marysville and Yuba City, face each other on the opposite banks of the Feather River. The community is culturally diverse, and includes people of several different backgrounds that reside in the area including Chinese, African-American, Latino, Laotian (Hmong), and Asian Indian. Yuba County is also the location of Beale Air Force Base, which is a large employer in the area.

Sutter- Yuba Behavioral Health (SYBH) is a division of the Sutter County Human Services Department. SYBH has a bi-county structure through a Joint Powers Agreement that provides mental health services and substance use disorder services to residents of both Sutter County and Yuba County. SYBH oversees the full range of clinical operations for specialty mental health and crisis services. SYBH serves on average over 5,000 unique mental health clients each year. Spanish is our only threshold language.

The following counties demographics are from the most current and available 2010 U.S. Census data.

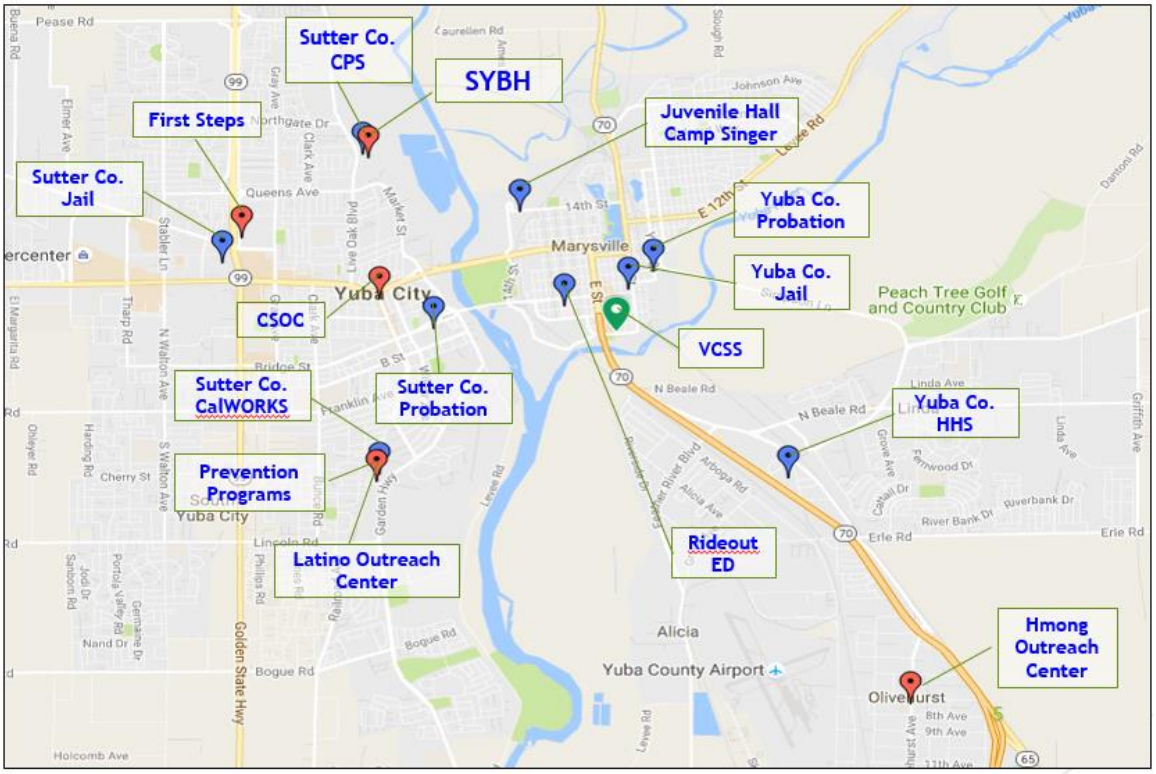
Sutter County is in Northern California with 609 square miles and is home to approximately 94,737 people. 61% of Sutter County residents identify as White, followed by 28.8% identifying as Hispanic or Latino, 16.5% identifying as Asian alone, 5.6% identifying as two or more races, 2% identifying as Black or African American, 1.4% identifying as American Indian or Alaska Native and 0.3% identifying as Native Hawaiian or Pacific Islander. The number of people aged under 5 is 7.6%, aged under 18 is 27.6%, and aged over 65 is 12.7%. Women comprise just over 50% of the population.

Yuba County is located in Northern California with 644 square miles and is home to approximately 72,155 people. 68.4% of Yuba County residents identify as White, followed by 25% identifying as Hispanic or Latino, 6.7% identify as Asian alone, 7.1% identifying as two or more races, 3.3% identifying as Black or African

American, 2.3% identifying as American Indian or Alaskan Native, and 0.4% identifying as Native Hawaiian or Pacific Islander. The number of people aged under 5 is 8.6%, aged under 18 is 29.1%, and aged over 65 is 10.1%. Women comprise just fewer than 50% of the population.

The County seat in Yuba County is Marysville and the County seat in Sutter County is Yuba City. As seen in the map below, the county seats are separated by the Feather River and they are less than 2 miles apart.

SYBH provides services at many sites throughout the Yuba and Sutter communities. The map below shows all the services areas.



In addition to all of areas shows on the map, SYBH also funds services in numerous schools and other organizations.

SYBH offers a broad range of services. Below you will find descriptions of each of the major service areas.

- Emergency Mental Health Services are provided through our inpatient psychiatric health facility and our psychiatric emergency services unit. Services include inpatient treatment of acute psychiatric conditions, crisis counseling, emergency assessment, crisis line intervention, safety planning and resource education.

- Adult Services provides outpatient assessment, diagnosis and treatment of serious mental health conditions and co-occurring mental health and substance use disorders. The treatment team consists of therapists, psychiatrists, nursing staff, counselors, peer mentors, case managers and support staff. We strive to provide a broad range of culturally sensitive, consumer-driven supports and services.

- Youth and Family Services provides outpatient behavioral health services designed to meet the social-emotional and behavioral needs of children, youth and families. Services offered include assessment, individual, group and family therapy, medication support services and case management. Youth and Family Services utilizes a continuum of care to help keep children, youth and their families healthy, safe, and successful in school and in their transition into adulthood, while living in a home and community that supports recovery and wellness.

- Forensic Services provides psychiatric care, crisis intervention and therapeutic services to youth and adults who are incarcerated at Camp Singer, Yuba-Sutter Juvenile Hall, Sutter County Jail, Yuba County Jail. Forensic Services also provide services to clients who receive services at both Yuba and Sutter County Probation Departments.

- The Substance Use Disorders (SUDS) Program provides outpatient, intensive outpatient, residential placements and referrals for adults, and adolescent counseling.

- The Prevention & Early Intervention (PEI) Program at Sutter-Yuba Behavioral Health provides a multitude of free services and trainings for community members, school staff, and law enforcement personnel. Prevention & Early Intervention activities are designed to increase awareness of risk factors and early warning signs of mental health disorders

and decrease stigma, as well as to create awareness of, and alternatives to substance use among youth.

COMMUNITY PROGRAM PLANNING

Provide a brief description of the Community Program Planning and Local Review Processes that were conducted as part of this annual update per Title 9 of the California Code of Regulations, Sections 3300 and 3315.

1. *Briefly describe the Community Program Planning (CPP) Process for development of all components included in the Three-Year Plan (FY 17/18- FY 19/20).*

Sutter-Yuba Behavioral Health Three-Year Plan maintains current programs at current service levels. This plan was made available for Public Review, beginning January 9, 2017. It will remain available for 30 days at Sutter-Yuba Behavioral Health, County Libraries, and the County Administrators' Offices. In addition, this annual update was posted on our County website along with the original plan and the augmentation to the plan. Clients, family members, and stakeholders continue to be involved in the ongoing planning and implementation of the Plan. Participation occurs throughout the organization. A brief description of some of the ways in which participation occurs is below:

- The Behavioral Health Advisory Board membership is composed of consumers, family members and community stakeholders and meets the first Thursday of every month.
- Community stakeholders, clients, and family members continue to be active committee members and active stakeholders in a variety ways, which include, but are not limited to: Monthly Cultural Competence Committee Meetings, Innovation Program- Annual Learning Meeting Sessions, MHSA Annual Update Community Information Sessions, Latino Outreach Center Meetings, Workforce Education and Training Activity Meetings, and SYBH Training Attendees. These opportunities enable the community, clients, and family members to give input on system design issues and make recommendations for improvement.

Currently, 3 Community Information Sessions are planned for community members and other stakeholders to attend and learn more about the MHSA Programs at Sutter-Yuba Behavioral Health. We will welcome public review and comment on the Annual Update. The meeting information is as follows:

Date	Time	Place
Tuesday, January 10, 2017	5:30 pm-6:15 pm	Yuba County Government Center Wheatland Room 915 Eighth Street **Marysville, CA**
Wednesday, January 11, 2017	5:30 pm-6:15 pm	Sutter-Yuba Behavioral Health Four Rivers Room 1965 Live Oak Blvd, Suite A **Yuba City, CA**
Friday, January 13, 2017	12:15 pm-1:00 pm	Sutter-Yuba Behavioral Health Four Rivers Room 1965 Live Oak Blvd, Suite A **Yuba City, CA**

As these meetings occur, this section will be updated with an overview of the meeting and any substantive feedback that is received.

2. *Identify the stakeholders involved in the Community Program Planning (CPP) Process (e.g., agency affiliation, populations represented, ages, race/ethnicity, client/family member affiliation, primary languages spoken, etc.).*

Area 4 Agency on Aging	Sutter County Office of Education
Behavioral Health Advisory Board	Sutter County Probation
Bridges to Housing	Sutter County Sheriff
Casa De Esperanza	Sutter County Welfare
Catholic Ladies Relief Society	Sutter-Yuba Friday Night Live
Consumers/Family Members	SYBH Adult Services
Contracted Peer Staff	SYBH Children's Services
Domestic Violence Services provider	SYBH CSOC
Family SOUP	SYBH Ethnic Services
FREED	SYBH PES
Foster Parents Association	SYBH Resource Services
Grace Source	SYBH Substance Use Disorders
Hands of Hope	Victor Treatment Services
Harmony Health Clinic	Western Farm Workers Association
Hmong American Association	Yuba City Police Department
Homeless Consortium	Yuba City Unified School District
Local LGBTQ Representatives	Yuba County APS
Marysville Joint Unified School District	Yuba County BOS
Marysville Police	Yuba County CalWorks

NorCal Services for the Deaf and Hearing	Yuba County CPS
Options for Change First Steps	Yuba County Department of Social
REST	Yuba County Health and Human Services
Rideout Hospital	Yuba County HHSD
Salvation Army and the Depot	Yuba County Probation
Services	Yuba County Sheriff
St. Andrew's Church	Yuba County Welfare
St. John's Church	
Sutter County BOS	
Sutter County CPS	
Sutter County Employment Services	
Sutter County Jail	

In addition to mass email distribution of the plan and the different community information meetings, SYBH also conducted an:" Issues and Concerns" Community Survey that was used at two significant community outreaches. The goal of this survey was to have stakeholders identify their major issues and concerns in relation to issues for children, transition-age youth (TAY), adults and older adults. The survey was available in English, Spanish and Hmong.

The survey was distributed at the Annual Recovery and Wellness Rally and at the Annual Veteran Stand Down. While we were hoping for a larger turnout on the survey, we still received 25 surveys from stakeholders. The Adult survey was completed 14 times, the TAY survey was completed 4 times, the Child survey was completed 1 time and the Older Adults survey was completed 2 times. There were 4 surveys that showed that had demographic data, but the individuals chose not to identify any issues.

Survey Respondents Demographics:

Age Range	
0-15	0 (0%)
16-17	0 (0%)
18-24	4 (16%)
25-59	21 (84%)
Gender	
Male	13 (52%)
Female	12 (48%)
Race	
Caucasian	13 (52%)
African American	1 (4%)
Asian Indian	2 (8%)
American Indian	2 (8%)
Latino, Hispanic, Mexican	0 (0%)

Other Asian or Pacific Islander	3 (12%)
Other	4 (16%) (write in answers include- Hmong and Cherokee)
Decline to answer	0 (0%)
Representation (please note there were many representation options; respondents could select more than one. The categories listed below is not the exhaustive list, rather it is only the ones that were selected).	
Client/Consumer	14 (46%)
Family Member	2 (7%)
Education or Teacher	1 (3%)
SYBH Staff	7 (23%)
Law Enforcement	1 (3%)
Other County/State	2 (7%)
Social Services	1 (3%)
Community-Based Provider	1 (3%)
Business/Community Member	1 (3%)

Top issues identified by age group:

- Child
  - Bullying
  - Safe housing
  - Help in Crisis
  - Children exposed to drugs in home
- TAY
  - Help finding and keeping a job
  - Alcohol and substance use
  - Peer support services
  - Education
- Adult
  - Homelessness
  - Supportive relationships
  - Peer support services
  - Assistance obtaining needed benefits
  - Help finding and keeping a job

The survey results were shared at the community information sessions and at various administrative settings. The proposed MHSA plan addresses all the issues identified in the community survey.

LOCAL REVIEW PROCESS

1. *Describe methods used to circulate, for the purpose of public comment, the annual update. Provide information on the public hearing held by the local mental health board after the close of the 30-day review.*

The minimum 30-day public comment process for review of the Three-Year Plan (FY 17/18- FY 19/20*)* will end on January 9, 2017. The MHSA Three-Year and Expenditure Plan was distributed to all Sutter-Yuba Behavioral Health provider sites, and made available at the Sutter County and the Yuba County main libraries. The notification of public hearing and the update were available for public review at the Sutter-Yuba Behavioral Health website, Network of Care website for Sutter County, Network of Care website for Yuba County, Facebook, and LinkedIn. The internet addresses are listed below:

http://www.suttercounty.org/SYBH
http://www.Sutter.networkofcare.org
http://www.Yuba.networkofcare.org
http://www.sutter.networkofcare.org/veterans
http: www.yuba.networkofcare.org/veterans

The Notice of Public Hearing was mailed to all Behavioral Health Board members; was posted at the Sutter County and Yuba County main libraries; was posted in the Appeal-Democrat newspaper; and was provided to anyone who requested a copy. Public comments could either be emailed to mginilo@co.sutter.ca.us or mailed to MHSA Coordinator, Sutter-Yuba Behavioral Health, at 1965 Live Oak Blvd., Suite A, and P.O. Box 1520, Yuba City, CA 95992-1520 or presented in person. The public hearing before the local Behavioral Health Board will be held on February 9, 2017. The public comment period will be ended after that meeting.

As the community planning process progresses, all updates will be provided in this section.

2. *Include summary of substantive recommendations received during the stakeholder review and public hearing, and responses to those comments. Include a description of any substantive changes made to the annual update that was circulated. Indicate if no substantive comments were received.*

This section will be updated following the February 9, 2017 Public Hearing.

MHSA Program Component
COMMUNITY SERVICES AND SUPPORTS

In the Community Services and Supports Section, you will find individual program descriptions, available program-specific data, and any challenges and significant updates. Below is a general overview of the SYBH Integrated Full Service Partnership (FSP):

FSP Age Group	***Total Clients Served***
Child	67 (44.7%)
TAY	65 (43.3%)
Adult	16 (10.7%)
Older Adult	2 (1.3%)
TOTAL SERVED	**150**
Gender	
Male	59 (39.3%)
Female	91 (60.7%)
Race	
American Native or Alaskan Native	4 (2.7%)
Asian Indian	1 (0.7%)
Black or African American	6 (4.0%)
Cambodian	1 (0.7%)
Hmong	3 (2.0%)
Laotian	1 (0.7%)
Multiple	5 (3.3%)
Other	16 (10.7%)
Other Asian	1 (0.6%)
Unknown/Not Reported	2 (1.3%)
Vietnamese	1 (0.7%)
White	1 (0.6%)
White or Caucasian	108 (72.0%)

Full Service Partnership Outcome Data

The following tables represent SYBH FSP Data for Children, TAY, Adults and Older Adults who have been served by the various services within the Integrated FSP. Outcome reports were generated from the Data Collection Reporting (DRC) System.

CHILDREN (Partners Who Completed at Least 1 Year of Partnership)

HOMELESSNESS	
1 year prior to partnership, # of days homeless	**71**
Year 1 during partnership, # of days homeless	**0**
1 year prior, # of partners homeless	**1**
Year 1 during partnership, # of partners homeless	**0**
PSYCHIATRIC HOSPITAL USE	
1 year prior to partnership, # of days in nursing psychiatric or psychiatric hospital	**83**
Year 1 during partnership, # of days in nursing psychiatric or psychiatric hospital	**81**
1 year prior, # of partners in nursing psychiatric or psychiatric hospital	**6**
Year 1 during partnership, # of partners in nursing psychiatric or psychiatric hospital	**4**
MENTAL HEALTH EMERGENCY EVENTS	
1 year prior to partnership, # of mental health emergency events	**25**
Year 1 during, # of mental health emergency events	**2**
INCARCERATIONS	
1 year prior to partnership, # of partners with incarceration days	**9**
Year 1 during partnership, # of partners with incarceration days	**7**
ARRESTS	
1 year prior to partnership, # of partners with arrests	**12**
Year 1 during partnership, # of partners with arrests	**2**

TAY (Partners Who Completed at Least 1 Year of Partnership)

HOMELESSNESS	
1 year prior to partnership, # of days homeless	**434**
Year 1 during partnership, # of days homeless	**0**
Year 1 during partnership, # of partners homeless	**5**
Year 2 during partnership, # of partners homeless	**0**
PSYCHIATRIC HOSPITAL USE	
1 year prior to partnership, # of days in nursing psychiatric or psychiatric hospital	**455**
Year 1 during partnership, # of days in nursing psychiatric or psychiatric hospital	**86**
1 year prior, # of partners in nursing psychiatric or psychiatric hospital	**14**
Year 1 during partnership, # of partners in nursing psychiatric or psychiatric hospital	**5**
MENTAL HEALTH EMERGENCY EVENTS	
1 year prior to partnership, # of mental health emergency events	**41**
Year 1 during, # of mental health emergency events	**7**
INCARCERATIONS	
1 year prior to partnership, # of partners with incarceration days	**2**
Year 1 during partnership, # of partners with incarceration days	**1**
ARRESTS	
1 year prior to partnership, # of partners with arrests	**8**
Year 1 during partnership, # of partners with arrests	**3**

ADULTS (Partners Who Completed at Least 2 Years of Partnership)

HOMELESSNESS	
1 year prior to partnership, # of days homeless	**31**
Year 1 during partnership, # of days homeless	**0**
Year 2 during partnership, # of days homeless	**0**
1 year prior to partnership, # of partners homeless	**2**
Year 1 during partnership, # of partners homeless	**0**
Year 2 during partnership, # of partners homeless	**0**
PSYCHIATRIC HOSPITAL USE	
1 year prior to partnership, # of days in nursing psychiatric or psychiatric hospital	**197**
Year 1 during partnership, # of days in nursing psychiatric or psychiatric hospital	**67**
Year 2 during partnership, # of days in nursing psychiatric or psychiatric hospital	**4**
1 year prior, # of partners in nursing psychiatric or psychiatric hospital	**5**
Year 1 during partnership, # of partners in nursing psychiatric or psychiatric hospital	**3**
Year 2 during partnership, # of partners in nursing psychiatric or psychiatric hospital	**1**
MENTAL HEALTH EMERGENCY EVENTS	
1 year prior to partnership, # of mental health emergency events	**18**
Year 1 during, # of mental health emergency events	**18**
Year 2 during, # of mental health emergency events	**0**
INCARCERATIONS	
1 year prior to partnership, # of partners with incarceration days	**1**
Year 1 during partnership, # of partners with incarceration days	**0**
Year 2 during partnership, # of partners with incarceration days	**0**
ARRESTS	
1 year prior to partnership, # of partners with arrests	**3**
Year 1 during partnership, # of partners with arrests	**0**
Year 2 during partnership, # of partners with arrests	**0**

OLDER ADULTS (Partners Who Completed at Least 2 Years of Partnership)

HOMELESSNESS	
1 year prior to partnership, # of days homeless	**0**
Year 1 during partnership, # of days homeless	**0**
Year 2 during partnership, # of days homeless	**0**
1 year prior to partnership, # of partners homeless	**0**
Year 1 during partnership, # of partners homeless	**0**
Year 2 during partnership, # of partners homeless	**0**
PSYCHIATRIC HOSPITAL USE	
1 year prior to partnership, # of days in nursing psychiatric or psychiatric hospital	**65**
Year 1 during partnership, # of days in nursing psychiatric or psychiatric hospital	**0**
Year 2 during partnership, # of days in nursing psychiatric or psychiatric hospital	**0**
1 year prior, # of partners in nursing psychiatric or psychiatric hospital	**1**
Year 1 during partnership, # of partners in nursing psychiatric or psychiatric hospital	**0**
Year 2 during partnership, # of partners in nursing psychiatric or psychiatric hospital	**0**
MENTAL HEALTH EMERGENCY EVENTS	
1 year prior to partnership, # of mental health emergency events	**5**
Year 1 during partnership, # of mental health emergency events	**0**

Year 2 during partnership, # of mental health emergency events	**0**
INCARCERATIONS	
1 year prior to partnership, # of partners with incarceration days	**0**
Year 1 during partnership, # of partners with incarceration days	**0**
Year 2 during partnership, # of partners with incarceration days	**0**
ARRESTS	
1 year prior to partnership, # of partners with arrests	**1**
Year 1 during partnership, # of partners with arrests	**0**
Year 2 during partnership, # of partners with arrests	**0**

MHSA Program Component
COMMUNITY SERVICES AND SUPPORTS

1. ***Provide a program description.*** ***Include achievements and notable performance outcomes.***

Age 0-5 Program within the Integrated Full-Service Partnership

The 0-5 FSP program offers specialized intervention services to meet the unique needs of infants, toddlers, preschoolers and their parents/caregivers. The children served have behavioral struggles that significantly impact their social, emotional and educational experiences. Families may present with one or more of the following risk factors: children are at risk of out of home care; children have been exposed to violence in the home and/or community; the parent(s)/caregiver(s) may have a history of or current mental health and/or substance use issues; the family is at risk of homelessness; and/or the family belongs to a racial/ethnic minority or disadvantaged group.These services help build positive relationships between young children and their caregivers, and create a foundation for healthy social and emotional development. The 0-5 FSP program offers a variety of clinic, community and home-based interventions tailored to each child's unique family, culture, strengths, and needs.

Approximately 23 unduplicated clients were served in the 0-5 Program for FY 2015/2016.

Program Evaluation Efforts:

In addition to data collected from the DCR outcome forms, data is also being collected using the Child Behavior Checklist (CBCL) for Ages 1.5-5. Youth and Family Services Staff are actively using both tools to capture data on client progression. The next phase of the outcome implementation process is to make meaningful use of all the data being collected and report it using organization dashboards.

2. ***Describe any challenges or barriers, and strategies to mitigate.***
   - An ongoing challenge is the lack of dedicated therapy space and adequate therapy supplies/toys that are age appropriate for the 0-5 population. Strategies to mitigate this challenge include working with agency administration to purchase additional supplies and toys to create a high-quality play therapy space and as a result, improve the quality of services we are able to provide to the 0-5 population.
   - The limited availability of local, regional and online trainings to keep therapists and intervention counselors up to date on current research and effective interventions for the 0-5 population continues to pose a challenge for our program. The implementation of our online training

program, Relias, in 2017 will provide increased access to training material for our team. Additional strategies to mitigate this challenge include investing in local, regional or statewide training opportunities for our therapists and case managers to continue to support their professional development in serving this unique and important population.

- Having a single therapist, who is also a supervisor, and intervention counselor for the 0-5 program has made it difficult to match a therapist and intervention counselor team to each family in order to meet their unique needs, including cultural and linguistic needs. Additionally, the supervisor has been unable to devote adequate time to supervising staff and engaging in program development projects due to being the sole therapist for the 0-5 program and carrying a high caseload. A strategy to mitigate this barrier is to increase the flexibility of assigning teams to 0-5 families. This can be accomplished by providing 0-5 specific training to additional therapists and intervention counselors in our CSOC FSP program to increase their clinical skills and expertise to be able to effectively serve these families. This will result in a more flexible approach to serving children and families, matching teams to families based and providing more individualized services. Additionally, this will decrease the current supervisor and 0-5 therapist's caseload so that she is able to effectively supervise staff and devote more time to program oversight and program development projects.
- We do not currently have an intervention counselor in our 0-5 or Children's FSP program that is bilingual in Spanish. This poses a barrier to providing high quality services to our monolingual Spanish speaking families. A potential solution to mitigate this challenge is to hire a bilingual Spanish speaking intervention counselor.
- Transportation is a significant barrier for our families in the 0-5 FSP program. We regularly need to provide them with transportation to/from appointments. This makes it difficult to allow for enough time to provide services in addition to the time it takes to transport the family to/from appointments. The addition of another parent partner to assist in providing transportation for our families would greatly improve the overall service delivery to these families.
- Over the last year, we have identified a need to provide early intervention, particularly for children 2 and under. Some of these children may not yet meet FSP criteria due to their age, current symptoms and level of functional impairment. Over the next year, we plan to discuss the potential of expanding our criteria to qualify for 0-5 FSP services in order to meet the unique and challenging needs of infants and toddlers.

3. List any significant changes, if applicable.

SYBH Administration is looking at co-locating what was previously known as Children's System of Care and Youth Services in one location, where both

programs will identify as Youth and Family Services. It is felt that this change is necessary because it will allow for a more efficient and effective continuum of care for our youth clients and their families. This significant change was also noted in the previous 2016/2017 Annual Update.

MHSA Program Component
COMMUNITY SERVICES AND SUPPORTS

1. ***Provide a program description.*** ***Include achievements and notable performance outcomes.***

Age 6-15/ Children's System of Care (CSOC) within the Integrated Full-Service Partnership

The Children's System of Care (CSOC) FSP program provides a wide array of community and home-based services and supports to children ages 6-15 and their families. FSP services are available to youth who are experiencing significant emotional, psychological or behavioral struggles that are interfering with their well-being, and their families, utilizing a "whatever it takes", multi-agency team approach. The CSOC FSP team provides these services within the resources available to help children and their families make progress on their particular path to recovery and wellness. The CSOC team coordinates the efforts of several county agencies, including Probation, Child Welfare Services, the schools and Behavioral Health to provide a single plan for intensive services that are necessary to keep children in the most natural and least restrictive setting as possible.

Each family participates in the process of planning and assessing the services and interventions they receive to help child/youth function more effectively in school, at home and in the community. Services include case management, therapy, substance abuse counseling (when appropriate), psychiatric services, crisis services, and housing support services. Because of the services provided through CSOC, most clients can transition to lower levels of care from high level group homes or are maintained home and community settings.

During FY 2015/2016, there were approximately 53 clients served through CSOC.

Program Evaluation Efforts:

Please see the FSP Outcomes page and review the "Child 0-15" Outcomes.

In addition to data collected from the DCR outcome forms, data is also being collected using the Child and Adolescent Level of Care Utilization System (CALOCUS) and the Child Behavior Checklist (CBCL) for Ages 6-18. Youth and Family Services Staff are actively using both tools to capture data on client progression. The next phase of the outcome implementation process is to make meaningful use of all the data being collected and report it using organization dashboards.

2. ***Describe any challenges or barriers, and strategies to mitigate.***

- The limited availability of local, regional and online trainings to keep therapists and intervention counselors up to date on current research and effective interventions for children/youth ages 6-15 with moderate to severe mental health challenges and poses a challenge for our program. The implementation of our online training program, Relias, in 2017 will provide increased access to training material for our team. Additional strategies to mitigate this challenge include investing in local, regional or statewide training opportunities for our therapists and case managers to continue to support their professional development in serving CSOC children/youth and their families.

- Additionally, the supervisors in our CSOC program have identified that there is an overall lack of training regarding FSPs including their history, purpose and how should be implemented into our client's lives. A potential strategy is to create a formalized training process regarding Full Service Partnerships and their history to be provided to each new staff member during the onboarding process.

- A similar lack of training existed regarding Child and Family Team (CFT) meetings. CFTs are an integral component to the work we do in CSOC and we have not had a formalized training process in place for training new staff as they join the CSOC team. We recently sent 2 staff to a "Train the Trainer" for CFT facilitation and participation. We are in the process of implementing a strategy to mitigate this challenge by developing a formalized training for CFTs. Our hope is to have this become a part of the onboarding process for anyone who joins our FSP teams (0-5, CSOC and TAY).

- Over the last year, we continued to receive a high number of referrals to CSOC from our community partners. With staff turnover and the length of time it takes to replace and train new staff, it has resulted in high caseloads for the therapists and intervention counselor. This can directly impact the frequency and quality of services we provide to the children/youth and families in the CSOC program. Potential strategies to mitigate these challenges include: hiring additional staff to reduce caseloads to those typical of FSP staff and reducing the time it takes to recruit, hire and onboard new staff through more effective hiring practices and the implementation of formalized training programs for new staff.

- An ongoing challenge is the lack of dedicated therapy and meeting space and adequate therapy supplies/toys that are age appropriate for the 6-15-year-old population. Strategies to mitigate this challenge include working with agency administration to purchase additional supplies and toys to create a high-quality play and talk therapy spaces and as a result, improve the quality of services we are able to provide to the children/youth and families we serve in our CSOC program.

- Over the last year, we have observed an ongoing decline in the attendance of and engagement in our weekly FSP meetings by our agency partners. A potential strategy to mitigate this challenge is to initiate manager/director level conversation with our community partners to explore barriers to their full engagement in this important component of our FSP programs. Additionally, providing orientation to our community partners about the history of FSPs, their purpose and how they should be implemented, may help to provide our partners with the context for these meetings.

3. List any significant changes in Annual Update, if applicable.

SYBH Administration is looking at co-locating what was previously known as Children's System of Care and Youth Services in one location, where both programs will identify as Youth and Family Services. It is felt that this change is necessary because it will allow for a more efficient and effective continuum of care for our youth clients and their families. This significant change was also noted in the previous 2016/2017 Annual Update.

MHSA Program Component
COMMUNITY SERVICES AND SUPPORTS

1. ***Provide a program description.*** ***Include achievements and notable performance outcomes.***

Transition-age Youth (TAY), Ages 16-25 within the Integrated Full-Service Partnership

The TAY FSP program provides a wide array of office, community and home-based services and supports to youth ages 16-25 and their families. These services are available to youth and young adults who are experiencing significant emotional, psychological or behavioral problems that are interfering with their wellbeing and their families, utilizing a "whatever it takes" and team approach. The TAY FSP program emphasizes outreach and engagement of Transition-Age Youth who are currently unserved or under-served, including those who are homeless, gang-involved, aging out of the foster care, probation and/or children's mental health system, those with co-occurring mental health and substance abuse disorders and those whose cultural identity places them in underserved populations within our community. Youth enrolled in TAY FSP will receive behavioral health services that are individually tailored and consistent with each youth's individual needs and goals.

TAY "students" are served by a multi-disciplinary treatment team of mental health professionals including a Therapist, Intervention Counselor Substance Abuse Counselor, Peer Mentors, Housing Resource Specialist, Vocational Resource Specialist, Nurse and a Psychiatrist. TAY students choose from a menu of services offered by these professionals. The treatment is individualized to best meet the recovery needs and current developmental stage of each TAY student. Many of the services are provided where it is most convenient for the student-home, community or the TAY office.

In Fiscal Year 2015/2016, 65 clients were served through TAY.

Program Evaluation Efforts:

Please see the FSP Outcomes page and review the "Transition Age Youth" Outcomes.

In addition to utilizing data from the DCR, the Levels of Care Utilization Scale (LOCUS) is used to determine the level of service intervention a client needs and the Milestones of Recovery Scale used to collect data on recover progression. The next phase of the outcome implementation process is to make meaningful use of all the data being collected and report it using organization dashboards.

2. ***Describe any challenges or barriers, and strategies to mitigate.***

The TAY program has consistently had a wait list over the last year. Additionally, the sole therapist for the program is also the program supervisor, overseeing the entire TAY team and day-to-day function of the program. Since there is consistently more demand for services than capacity, it would be helpful to expand the TAY program to improve access for Transitional Age Youth. To accomplish this, additional staff and office space would be a necessity. The TAY program would benefit from the addition of a therapist and case manager to actualize expansion and meet the complex needs of the TAY clients.

Aside from program expansion, it is critical that the 2 vacant peer mentor positions in TAY are filled. Peer mentors are an essential component for a Full Service Partnership and TAY has been without any peer mentors for more than one year.

3. ***List any significant changes in Annual Update, if applicable.***

SYBH Administration is looking at co-locating what was previously known as Children's System of Care and Youth Services in one location, where both programs will identify as Youth and Family Services. It is felt that this change is necessary because it will allow for a more efficient and effective continuum of care for our youth clients and their families. This significant change was also noted in the previous 2016/2017 Annual Update.

MHSA Program Component
COMMUNITY SERVICES AND SUPPORTS

1. ***Provide a program description.*** ***Include achievements and notable performance outcomes.***

Healthy Options Promoting Empowerment (HOPE)-Adult/ Older Adult Program *within the Integrated Full-Service Partnership*

The HOPE team provides intensive case management and rehabilitation services to adults with serious mental health conditions or co-occurring mental health and substance use disorders. Participants in the HOPE program receive intensive support from intervention counselors who work with them individually toward recovery goals. An important part of this program is helping participants to meet basic needs, participate fully in community life and increase independence. Services are accessed by clinician referral after attending the Adult Services Open Access Clinic held Monday-Friday 8 am–2 pm at 1965 Live Oak Blvd. Yuba City CA, 95991.

18 individuals were served by the Adult/Older Adult FSP during the 15/16 Fiscal Year. Of this 18, 16 were adults and 2 were older adults.

FSP SUPPORT:

- Housing Resource Specialist: Coordinates with existing housing programs; develops partnerships with local landlords; assists clients in locating affordable temporary/ emergency/ transitional/ permanent housing. The Housing Resource Specialist assists clients with paper work and navigating systems to avoid homelessness.
- Employment Resource Specialist: Assesses and provides a wide variety of employment and pre-employment resources for clients who have expressed interest in community employment. The Employment Resource Specialist coordinates a Vocational Training Program that provides time-limited paid work skills training through supported employment at a variety of local businesses.
- Wellness & Recovery Center: Peer Staff, Peer Volunteers, and County providers work as an integrated team to provide a wide range of wellness and recovery-oriented activities and services such as Culinary Academy, Home Economics, Double Trouble, Pathways to Recovery, Town Hall, Art and Music Groups, Peer Counseling, building social support, community reintegration, and employment training opportunities.

Program Evaluation Efforts:

Please see the FSP Outcomes page and review the “Adults” and “Older Adults” Outcomes.

In addition to utilizing data from the DCR, the Levels of Care Utilization Scale (LOCUS) is used to determine the level of service intervention a client needs and the Milestones of Recovery Scale used to collect data on recover progression. The next phase of the outcome implementation process is to make meaningful use of all the data being collected and report it using organization dashboards.

1. Describe any challenges or barriers, and strengths to mitigate.

Historically, there have been challenges with the Adult and Older Adult FSP Partnership being identified as a program. Staff and clients will typically identify with our FSP supports, such as Wellness and Recovery or Housing. The Adult Service Program Manager and the CSS Supervisor will be working to develop a program identity and market it to staff and clients. Additionally, the Adult and Older Adult FSP has historically utilized the Salvation Army contract to request FSP monies. The Salvation Army contract is no longer active and the FSP needs to determine a procedure and plan for spending FSP monies outside of personnel costs.

2. List any significant changes in Annual Update, if applicable.

None at this time, the program is progressing as planned.

MHSA Program Component
COMMUNITY SERVICES AND SUPPORTS

1. ***Provide a program description.*** ***Include achievements and notable performance outcomes.***

MHSA Adult Urgent Services

The Urgent Services team provides timely access to all adult mental health and substance use disorder services on a walk-in basis through our Open Access Clinic, Monday-Friday 8 am–2 pm. This team consists of therapists, substance abuse counselors and nursing staff who provide urgent assessment, diagnosis and brief treatment of mental health and substance use conditions. The Urgent Services team provides referrals to all other longer-term adult services within the agency and provides referrals to community resources and supports.

In FY 2015/2016 there were a total of 1,375 sign-ins to Open Access Clinic (includes duplicates) and a total of 1,102 unduplicated clients. A total of 1,031 triages were completed (includes duplicates). 340 clients (30.8% of all clients seen) completed intake/assessment. 210 individuals from Open Access Clinic were scheduled for standard psychiatric evaluations from Open Access Clinic and 90 were seen for urgent medication evaluations. A total of 3,101 outpatient therapy appointments were scheduled with the Urgent Services therapists. The considerable increase in number of therapy appointments offered over last year is due to adding two new therapist staff members to the team.

Program Evaluation Efforts:
In addition to utilizing data from the DCR, the Levels of Care Utilization Scale (LOCUS) is used to determine the level of service intervention a client needs and the Milestones of Recovery Scale used to collect data on recover progression. The next phase of the outcome implementation process is to make meaningful use of all the data being collected and report it using organization dashboards.

The program will also continue to measure wait-time outcomes for all offered services, to continually provide quick access to services

1. ***Describe any challenges or barriers, and strategies to mitigate.***

A barrier we experience is that we are currently have longer wait times for standard medication evaluations than we would like. We are exploring options for adopting a walk-in model for intake assessment similar to the walk-in triage and intake model we currently follow. Although the details of a model for walk-in psychiatric services have not been clarified, we are in the early exploration phase.

2. List any significant changes in Annual Update, if applicable.

None at this time, the program is progressing as planned.

MHSA Program Component
COMMUNITY SERVICES AND SUPPORTS

1. ***Provide a program description.*** ***Include achievements and notable performance outcomes.***

MHSA Youth Urgent Services

Urgent Youth Services provides expedited access to outpatient behavioral health services for youth who have been taken to Psychiatric Emergency Services (PES) experiencing suicidal ideation or homicidal ideation and are not hospitalized but are sent home with a safety plan in place. The program also provides expedited mental health assessments for youth who have been hospitalized as a danger to self, danger to others or as gravely disabled. The Urgent Youth Services team is comprised of a licensed therapist and a case manager. A youth is assessed (generally within 3 days of their PES visit) and the team works to address current crisis and risk needs to stabilize the youth and family and refer to ongoing behavioral health services or to stabilize the youth and family to discharge. The team conducts weekly reviews with a multidisciplinary team to ensure every child who visits Psychiatric Emergency Services or is hospitalized has been offered expedited and adequate care.

- Total # Served for Fiscal Year 2015/2016: 63
- # of individuals who returned to PES within the reporting 2015/2016 year: 5
- # of individuals served by the program who were hospitalized within the reporting 2015/2016 year: 6

2. ***Describe any challenges or barriers, and strategies to mitigate.***

A significant challenge for the Urgent Youth Services program this year was going without our Intervention Counselor who was on leave from February-November. This position serves a unique and indispensable role on our team, collaborating with psychiatric hospitals to coordinate care and discharges for children/youth.

3. ***List any significant changes in Annual Update, if applicable.***

SYBH Administration is looking at co-locating what was previously known as Children's System of Care and Youth Services in one location, where both programs will identify as Youth and Family Services. It is felt that this change is necessary because it will allow for a more efficient and effective continuum of care for our youth clients and their families. This significant change was also noted in the previous 2016/2017 Annual Update.

MHSA Program Component
COMMUNITY SERVICES AND SUPPORTS

1. ***Provide a program description.*** ***Include achievements and notable performance outcomes.***

Bi-County Elder Services Team (BEST)

The BEST program serves older adults (age 60+) in both Sutter and Yuba Counties with serious mental health conditions or co-occurring mental health and substance use conditions. The BEST therapist provides outreach, assessment, individual therapy, case management, linkage to other adult services such as medication support or substance use disorder treatment and linkage to community resources and supports. Collaboration with individuals, families, social service agencies, public health and other community agencies is central to the BEST approach. The BEST therapist is available to provide community presentations on older adult mental health issues and how to get help. Services are accessed by attending the Adult Services Open Access Clinic held Monday-Friday 8 am–2 pm at 1965 Live Oak Blvd. Yuba City CA, 95991.

Since program inception, the BEST program continues to maintain relationships with community entities that serve older adults, such as Sutter/Yuba counties' Adult Protective Services, senior housing entities, senior legal services, private caregiver companies, etc. BEST has continued to be in high demand for outreaches, as there are many requests for community outreaches, even after having educated over a 1000 people in Sutter/Yuba communities about older adult mental health issues over the past decade.

The unduplicated count for those served in FY 2015/2016 was 63 individuals.
In FY 2015/2016, there have been 12 outreach events and 112 individuals trained in older adult mental health issues.

Program Evaluation Efforts:
The Adult Services Program which provides oversight to this program, enforces the use of the Level of Care Utilization System (LOCUS) tool for evidence-based treatment planning and the Milestone of Recovery Scale (MORS). Reassessments for each tool are completed every 6 months.

1. ***Describe any challenges or barriers, and strategies to mitigate.***

In previous MHSA Annual Updates, it was reported that the FTE assigned to the program was only at .55 FTE and this resulted in program challenges. This has since been resolved by the individual assigned to this program has been restored to 90% BEST and 10% PEI. There are no challenges to report at this time.

2. ***List any significant changes in Annual Update, if applicable.***

There are none at this time; the program is progressing as planned.

MHSA Program Component
COMMUNITY SERVICES AND SUPPORTS

SYBH Ethnic Outreach Program

The MHSA Ethnic Outreach Team consists of Latino and Hmong providers who have sensitivity to and understanding of the mental health and other special needs of the persons they serve. Bilingual outreach, referral, linkage, counseling, and other services are provided in a variety of settings, such as schools, homes, local primary care clinics, community agencies, SYBH Clinic, and the Hmong Outreach Center.

In FY 2015/2016, the Ethnic Services Program served 295 unduplicated clients.

Please read below for more specific Ethnic Outreach program descriptions, program challenges, and significant changes.

Hmong Outreach Program:

1. ***Provide a program description. Include achievements and notable performance outcomes.***

The Hmong Outreach Center serves bilingual and Hmong-speaking only adults and families. The Center provides outpatient assessment, diagnosis and treatment of mental health conditions and co-occurring mental health and substance use disorders. The Hmong Outreach Center team consists of one therapist, two intervention counselors and a peer specialist. Services offered include individual therapy, group and individual rehabilitation services, case management, linkage to other adult services such as medication support or substance use disorder treatment and linkage to community resources and supports. Services are accessed by calling the Hmong Outreach Center directly to request services, or by attending the Adult Services Open Access Clinic held Monday-Friday 8 am–2 pm at 1965 Live Oak Blvd. Yuba City CA, 95991. Services in Hmong or interpreting services are available during Open Access Clinic.

The most notable program achievement for FY 15/16 includes:

- Developing culturally responsive rehab group services that runs 5 days/week and being able to engage/retain 49 individuals in this service.
- Completed a logo content to engage the Hmong Community.
- Staff made efforts to engage Hmong Youth in a DirectingChange.org film contest. The film focuses on culture and suicide prevention.

In FY 2015/2016, the Hmong Program has served 70 individuals and families.

Program Evaluation Efforts:
The Adult Services Program which provides oversight to this program, enforces the use of the Level of Care Utilization System (LOCUS) tool for evidence-based treatment planning and the Milestone of Recovery Scale (MORS). Reassessments for each tool are completed every 6 months. The next phase of the outcome implementation process is to make meaningful use of all the data being collected and report it using organization dashboards.

1. ***Describe any challenges or barriers, and strategies to mitigate.***

The different perceptions of health/wellness and difficulty in understanding the concepts of mental health counseling (because the concepts don't exist in the Hmong culture) continue to create challenges with engagement/retention and consumer recovery. For example, while consumers report noticing that there is an overall benefit if they make efforts to come in regularly for services, some report difficulties with regular engagement due to experiencing cognitive dissonance and/or to lack of support from family members because of the emphasis on family before the self in the culture and lack understanding about mental health services and concepts. Another example is that some patients attribute some of their mental health symptoms to spiritual causes and thus are not as compliant with recommended treatment because they may feel they are irrelevant. Also, due to historical trauma, oppression, and perhaps other cultural factors, older Hmong adults tend to have a more external locus of control affecting their perception, motivation, and understanding of recovery.

Providing transportation to/from group has proven successful in increasing engagement and reducing access barriers, but has taken a toll on staff time due to the amount of time spent transporting 48 clients to weekly groups that run Monday-Friday. The HOC has made efforts to train clients to use public transportation but was met with much opposition, fear, and anxiety.

A few months ago, the HOC began collaborating with the Hmong Cultural Center of Butte Co (HCC) in efforts to overcome cultural challenges and better serve the Hmong community. The HCC also reports experiencing the same challenges as the HOC in proving mental health services to the Hmong population. The HOC will continue to collaborate with the HCC to brainstorm and work on overcoming challenges in providing services to this population.

Other challenges that the HOC has been met with is engagement of Hmong youths in mental health services. There continues to be very few Hmong youths who utilizes mental health services and this could be due to several reasons, including stigma, lack of parents' understanding of services, and insurance coverage. The HOC hosted a logo contest for the Center and attempted to engage Hmong Youths by sponsoring them in participating in a suicide prevention video contest through Directing Change but was not very successful. There were only a few submissions for the logo contest and only 2 students expressed interest in the video contest but

the deadline was too close. The HOC is currently conducting a Hmong Youth Needs Assessment to look at local Hmong youths and to try to find out how best to serve Hmong youth mental health needs

2. ***List any significant changes in Annual Update, if applicable.***

There are none at this time; the program is progressing as planned.

Latino Outreach Program:

1. ***Provide a program description. Include achievements and notable performance outcomes.***

The Latino Outreach Center serves bilingual and Spanish-speaking only adults, children and families. The Center provides outpatient assessment, diagnosis and treatment of mental health conditions and co-occurring mental health and substance use disorders. The Latino Outreach Center team consists of three therapists and a peer specialist. Services offered include individual and group therapy, case management, linkage to other adult services such as medication support or substance use disorder treatment and linkage to community resources and supports. Services are accessed by attending the walk-in Latino Open Access Clinic held Thursdays 9 am – 12 pm or by appointment as needed. Transportation is also available as needed.

In FY 2015/2016, the Latino Outreach Program served 225 unduplicated individuals.

The Latino Outreach Center hosted an Open House event for the community and had 71 individuals, representative of the community, consumers, family members and SYBH, there to tour the Latino Outreach Center.

Program Evaluation Efforts:
The Adult Services Program which provides oversight to this program, enforces the use of the Level of Care Utilization System (LOCUS) tool for evidence-based treatment planning and the Milestone of Recovery Scale (MORS). Reassessments for each tool are completed every 6 months. The next phase of the outcome implementation process is to make meaningful use of all the data being collected and report it using organization dashboards.

1. ***Describe any challenges or barriers, and strategies to mitigate.***

Many Latinos still are not aware that the Latino Outreach Center re-located to Holly Oak, so this has been a barrier. We have learned about this during some of the outreaches that we have done thus far. Moreover, not being fully staffed has also provided difficulties in providing services. Not having a case manager on site has also created some difficulties for staff in providing other much needed services for

the population. While being at Holly Oak has been a good move, the fact that there is limited parking can be a challenge.

2. List any significant changes in Annual Update, if applicable.

There are none at this time; the program is progressing as planned

MHSA Program Component
PREVENTION AND EARLY INTERVENTION (PEI)

1. ***Provide a program description.*** ***Include achievements and notable performance outcomes.***

Prevention and Early Intervention Services (PEI) provides for a multitude of free services and trainings for community members, staff of schools and law enforcement personnel. Activities are designed to increase awareness of risk factors and early warning signs of mental health disorders and to decrease stigma.

The MHSA Coordinator, the Director of Mental Health, the Substance Use Disorders Service Program Manager and the PEI Prevention Coordinator have been active in the PEI Regulations Public Comment period and Mental Health Services Oversight and Accountability Commission (MHSOAC) Implementation Workshops.

Regulation Implementation Status: The PEI Team has been debriefed on the requirements on the newly implemented regulations. A PEI demographic database has been created to collect data. The forms are currently being finalized. Demographic collection is expected to begin in early 2017; however, there is a significant staff training need. Please review the PEI challenges section for more detail. Collaborative meetings with our PEI department, Administration, Psychiatric Emergency Services and Adult Services will be occurring needed to plan the access and linkage tracking and the "DUMI" data collection. These meetings are expected to begin in January 2017.

The SYBH Prevention Team has recently categorized all our PEI programs to fit the new reporting criteria set by the MHSOAC.

1. **Early Intervention Programs**
    a. **Strengthening Families** is a nationally and internationally recognized parenting and family strengthening program for high-risk and general population families. SFP is an evidence-based family skills training program found to significantly improve parenting skills and family relationships, reduce problem behaviors, delinquency and alcohol and drug abuse in children, and to improve social competencies and school performance. The Strengthening Families Program is offered locally as a seven-week program for families with children 10-14 years old. Families are provided with dinner, then parents and youth go into separate classes for age-appropriate skill building, activities, and discussion. Families reunite to work together

in a family class. Childcare is provided for younger children. Each session is two and a half hours long, including a family dinner.

i. Provided Strengthening Families Training to 269 parents and children.

b. **Aggression Replacement Training (ART)** is a ten-week course offered for adolescents on a high school campus. It is a cognitive behavioral intervention that trains participants to cope with their aggressive and/or violent behaviors. It is taught in three one-hour classes per week, focusing on Social Skills, Anger Control Training, and Moral Reasoning. Participants are selected by school administration, not to exceed 15 participants per course. PEI provides trained instructors and all materials to a limited number of high schools. We trained at Marysville Community Day School and Feather River Academy.

i. Provided Aggression Replacement Training to 46 students.

2. **Outreach of Increasing Recognition of Early Signs of Mental Illness Program**

a. **Mental Health First Aid –** is a national program to teach the skills to respond to the sign of mental illness and substance use. It also provides information to help reduce stigma and discrimination. Some of the partner agencies who have received this training include: California Highway Patrol, Yuba County Jail Staff and Sutter and Yuba County Probation. More recently, we have added a Spanish MHFA to our MHFA training offerings.

i. Provided MHFA Training to 161 agency staff, community members, non-profit agencies and government agencies.

ii. Provided Spanish MHFA Training to 18 community workers and Head Start workers

3. **Prevention Programs**

a. Community Prevention Team- The Community Prevention team provides the bulk of the PEI Trainings. Theses prevention trainings focus on a variety of stigma reduction, early signs of mental illness, and ethnic outreach topics.

i. **Community Education Trainings:**

1. **Nurtured Heart Approach** is relationship-focused methodology focused on helping children (and adults) build their Inner Wealth and use their intensity in successful ways. Originally developed for working with the most difficult children, including children diagnosed with ADHD, Oppositional Defiant Disorder, Reactive Attachment Disorder and other behavioral, emotional

and anxiety related symptoms, it has been used effectively to help all kinds of families and children to better communicate and interact. Offered in multiple locations in Yuba and Sutter counties in English and in Spanish, Nurtured Heart classes run for an hour and a half a week for five weeks. Classes are intended for adult participants.

a. Spanish Nurtured Heart has trained 417 parents/community members

b. English Nurtured Heart Training has trained 397 parents/community members

2. **The Traditional Healer Program** reached a total of 175 Hmong Community Members with outreach activities.
3. **Older Adult Mental Health Awareness -** Training for In Home Supportive Services providers about what to look for in older adults that will indicate a need for help and how to access the help. **186 people trained**.

ii. **Recreational Opportunities** is a program that increased recreational opportunities to identified at risk populations throughout the bi-county area. To date have approved projects totaling $14,192.88 which will reach approximately 96 youth. Projects range from individuals taking dance, basketball, archery, gymnastics, etc. classes to provision of equipment that will be used by large numbers of youth in the target population. The provision of funds is accompanied by information for recipient agencies about the purpose of the funds to reduce need for mental health services, but also to identify the need for mental health care sooner to improve outcomes of treatment. Funds contingent upon agreement to make referrals to mental health as the need is seen. For more information, please see the FY 15/16 Recreation Report in the Appendix of this Three-Year Program Plan.

1. 96 local youth (60 Sutter County and 36 Yuba County) were served by the PEI Recreation Program.

iii. **The PEI Mentorship Program** includes two mentorship opportunities for local youth: Suter County Superintendent of Schools Mentorship Program and the Camptonville Community Partnership.

1. The Sutter County Mentorship has resulted in 21 matches.
2. The Camptonville Community Partnership is a mentor program through the school, 4H and other various activities and trainings. This partnership has provided outreach to 203 children and youth in the Yuba County foothills.

4. <u>Access and Linkage Treatment Programs:</u>

a. **Community Action Team- Suicide Prevention** is a series of suicide prevention trainings that focus on training community members, students, educators, law enforcement, etc. to recognize the signs of mental illness and respond. It is here that our PEI Team reinforces the resources we have readily available within the community. To track how they programs are acting as access point, cards are being created that will be passed out at these training- which outside of self-reporting will signal to our SYBH staff that this person was linked to services by a PEI Program.

i. **Applied Suicide Intervention Skills Training (ASIST)** – trained 89 agency staff and community members to be able to effectively intervene and obtain help for individuals who are suicidal. Some of the community partner agencies who have received this training include:

a. Sutter and Yuba County Probation
b. Sutter Yuba Behavioral Health Services
c. Sutter County Jail Staff
d. Children Systems of Care
e. Yuba and Sutter County CPS
f. Yuba County Health and Human Services
g. Casa de Esperanza
h. Rideout Hospital
i. Beale Air Force Base
j. Pathways
k. Yuba College
l. Children's Hope FFA
m. Yuba County Jail
n. Casa De Esperanza
o. Grace Source Family Resource Center
p. California National Guard Family Programs
q. Salvation Army Depot
r. Yuba County Office of Education

s. Yuba City Unified School District
t. Marysville Unified School District
u. Victor Community Support Services
v. Wheatland Elementary School District
w. Live Oak Unified School District
x. Nuestro Elementary School
y. California Tribal TANF Program

ii. **Safe TALK** – trained 21 partner agency and community members in a model of talking with someone who is suicidal and connecting them with professionals for more thorough assistance. Some of the partner agencies who have received this training include:
    a. Yuba Gardens Middle School
    b. Plumas Lake Elementary School District
    c. Grace Source Family Resource Center
    d. Wheatland Police Department
    e. Yuba County Office of Education
    f. Bear River Family Resource Center
    g. Wheatland Union High School
    h. Beale AFB School Liaison Office

iii. **Yellow Ribbon Suicide Prevention Program** – trained Yuba City High School, Marysville High School, Albert Powell High School, Live Oak Alternative School, South Lindhurst High School, and Marysville Community Day School, in a model that teaches "it's always ok to ask for help". Teaches students to be gatekeepers for their peers and teaches staff how to connect kids to more help. Total youth trained will exceed 4,377 students, plus faculty and staff.

iv. **Signs of Suicide Prevention Program** –trained Riverside Meadows Intermediate School, Bear River Middle School, Live Oak Middle School, Robbins-Winship School District, Grace Christian Academy, Faith Christian Jr. & Sr. High School, YES Charter Academy, Nuestro Elementary School, and April Lane Elementary School, in a model that teaches "it's always ok to ask for help". Teaches students to be gatekeepers for their peers and teaches staff how to connect kids to more help. Total youth trained will exceed 1,518 students, plus faculty and staff.

5. <u>Stigma Discrimination and Reduction Program</u>

a. The Tri County Diversity Contract provides many opportunities for

social interaction to encourage support, education, and community involvement in a safe and supportive environment for LGBTQIA individuals in our community with outreach and support events. Throughout the July 2015 - June 2016 contract year, Tri-County Diversity has provided a Sunday Brunch and a Boy's Night Out event monthly. During that period, we also held our annual Weekend Campout as well as the annual Halloween Ball. We organized activities throughout the year for member participation, utilizing local venues. Our organization also created opportunities for members to attend local community events held during the year as a group. Tri-County Diversity Board Members provided an educational program to the foster program for foster children and their foster parents. Our hotline services were open through the year to provide program and referral service information and support.

i. Tri-County Diversity has served a total of 342 people and provided a total of 17 referrals for additional mental health services through the hotline services and 42 outreach/ support events during the past year.

2. Describe any challenges or barriers, and strategies to mitigate.

As vocalized during the many opportunities for public comment, there are some complications with implementing the PEI Regulations. There is much logistics planning that is still needed to implement the regulations.

Specifically, PEI staff need trained on the appropriate ways to collect the demographic information, especially from children and youth. We are hopeful that the MHSOAC will sponsor trainings to help mitigate this challenge.

3. List any significant changes in Annual Update, if applicable.

There are none at this time; the program is progressing as planned.

MHSA Program Component
INNOVATION

Sutter-Yuba Behavioral Health (SYBH) has an approved MHSA Innovation Plan with three innovation projects in various stages of implementation. The projects were designed with a thorough community planning process. The projects were approved for funding by the Mental Health Services Oversight & Accountability Commission (MHSOAC) on October 24, 2013.

Detailed below are each SYBH Innovation Program Annual Reports and the accompanying program description, implementation status, barriers/challenges, and any significant changes anticipated in the next 3 years.

Please note that SYBH is proposing to discontinue Innovation Project: #2 A culturally competent collaboration to address serious mental illness in the Traditional Hmong population.

Innovation Annual Reports

Title: Innovation Project #1- Improving mental health outcomes via interagency collaboration and service delivery learning for supervised offenders who are at-risk of or have serious mental illness (Innovation Project 1).

Purpose:

- Increase the quality of services, including improved outcomes
- Promote interagency collaboration

Description:

Innovation Project 1 utilizes, to its advantage, the bi-county structure and new pioneering relationships with county probation departments and applies existing mental health approaches to the AB109 offenders and other supervised offenders in two new and different county settings: community- based setting (post-release) and institution- based setting (pre-release). Identical outcome measures from each setting/county will be analyzed to see which approach SYBH should be further considered to consistently offer quality services, including improved outcomes for AB109 supervised offenders and other supervised offenders. Fellow counties in California usually must pick an approach and blindly employ it for duration of time before they can determine if it is the best for their population. It is our hope that if our innovation is successful, other counties can learn to partner with other like-counties with like- populations and together launch two different strategies and evaluate in a parallel analysis each county's outcomes to determine the best approach. This removes the need for an individual county to try relentlessly to find the best approaches. It enables counties to innovatively evaluate service approaches. Counties so often work in isolated silos and we want to promote

collaboration between counties and the sharing of information, failures, successes, and resources.

Project Status:

The project became operational on February 1, 2015. The following information represents the first year of data collected on the project.

Outcome Tool Descriptions:

Milestones of Recovery Scale (MORS):

The Milestones of Recovery Scale (MORS) is one of the project measurement tools for the Probation Project. The MORS is a recovery-based outcome tool that provides data from reoccurring and consistent assessments that help to track the individual process of recovery for each project client. The ideal and perfect outcomes would show that each client would be progressing through the recovery stages as they progress through services. The plan was to initially conduct the MORS every 90 days, however as the project became operational, it was determined that clinical data would be collected every 12 treatment sessions. See the challenges section for a more thorough explanation.

University Rhode Island Change Assessment (URICA):

The URICA is a 32-item self-report measure that includes 4 subscales measuring the stages of change: Precontemplation, Contemplation, Action, and Maintenance. Responses are given on a 5-point Likert scale ranging from 1 (strong disagreement) to 5 (strong agreement). The subscales can be combined arithmetically (C + A + M – PC) to yield a second-order continuous Readiness to Change score that can be used to assess readiness to change at entrance to treatment. For this study, a URICA score is conducted at the beginning of treatment and at the close of treatment.

The stages of change are as follows:

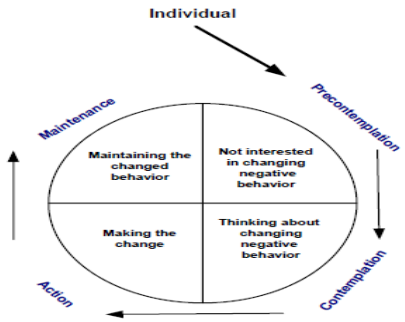


Figure 1 The Stages of Change

Precontemplation: Precontemplators are individuals who are either not thinking about changing their behavior or do not want to change their behavior. These individuals often feel discouraged about their situation and thus would rather not think or discuss their problem, much less try to change it.

Contemplation: During this stage, individuals recognize that they have a problem. They weigh the pros and cons of the problem behavior versus improving it and begin to think about changing their behavior.

Action: In this phase, individuals are implementing any change plan they may have developed and begin to modify their behavior.

Maintenance: If the individual is successful in sustaining the problem behavior for three to six months, then the individual moves to the maintenance stage. It is during this stage that the individual focuses on incorporating the new improved behavior into this or her lifestyle.

Level of Care Utilization System (LOCUS):

The LOCUS is a short assessment of a client's current level of care needs completed by clinicians. LOCUS has three main objectives: (1) to provide a system for assessment of service needs for adults with mental illness based on 6 evaluation parameters; (2) to describe a continuum of service arrays which vary according to the amount and scope of resources available at each "level" of care in each of four service categories; and (3) to create a methodology for quantifying the assessment of service needs to permit reliable determinations for placement in the service continuum. This tool has evolved since it was first introduced in the year 2000, and now includes content related to recovery status. (LOCUS Adult Version 2010.)

The six evaluation parameters include: (1) risk of harm; (2) functional status; (3) medical, addictive and psychiatric co-morbidity; (4) recovery environment; (5) treatment and recovery history; and (6) engagement and recovery status. A five-point scale is constructed for each parameter.

The LOCUS defines six "levels of care" in the service continuum in terms of four variables: care environment, clinical services, support services and crisis resolution and prevention services. The six "levels of care" include: (1) recovery maintenance and health management; (2) low intensity community based services; (3) high intensity community based services; (4) medically monitored non-residential services; (5) medically monitored residential services; and (6) medically managed residential services.

The four service categories are as follows:
Level 1 – describes community services for consumers who have achieved a level of independence from the county mental health system

Level 2 – describes the beginning of more independence from the mental health system, persons have an established wellness plan, and can manage their illness including emergencies

Level 3 – describes an intensive level of services that may be brief or need to be sustained for several years. Consumers who need Level 3 services may be in pre-contemplation or contemplation stages, and have started to engage in their treatment.

Level 4 – describes services that may be known as “assertive community treatment” and is best for consumers at imminent risk of involuntary treatment, or persons who would not be discharged without the availability of intensive community support.

Level 5 – identifies individuals who require residential treatment provided in a community setting, non-hospital free standing residential facilities.

Level 6 – identifies individuals who need the most intensive level on the continuum of care available and individuals may me independently or may be involuntarily committed to treatment

Program to Analyze, Record, and Track Networks to Enhance Relationships (PARTNER:

PARTNER is a social network analysis tool. This is a joint innovation project between Sutter-Yuba Behavioral Health, Yuba County Probation, and Sutter County Probation and the team thought it would be valuable to measure our interagency collaboration as all the 3 agencies work together on this project. The PARTNER Tool is able to identify gaps, strengths, and areas of improvement, identifies key players, measures trust and value, and captures perceptions of project outcomes. A baseline survey was sent to all of the project partners on March 10, 2015. The plan is to conduct an identical survey every year to measure progress.

Demographics:

Table #1 outlines the primary demographics of the total population (both Sutter and Yuba) served by the Probation INN Program during the first project year.

Overall, male clients represent 64% of the program, while female clients represent 36%. Approximately 25% of the clients are from underserved ethnic and cultural communities, including American Indian/Alaskan Native (3%), Asian (2%), Black/African American (7%), other (11%) and Clients identified as Bi/Multi- Racial/Ethnic (2%). There were 0 individuals aged 0-15 served by the INN Program as their needs are better served by our juvenile programs. 4 (4%) of the clients are age 16-25, but the program primarily serves those aged 26-59, which accounts for 89% of total program roster. Only 7% of the program is 59+.

Demographic	Number & Percentage
Gender	
Male	58 (64%)
Female	32(36%)
Race	
American Indian/Alaskan Native	3 (3%)
Asian	2 (2%)
Black/African American	6 (7%)
Native Hawaiian/Pacific Islander	0 (0%)
White	67 (74%)
Other	10 (11%)
More than one race	2 (2%)
Ethnicity	
Hispanic	12 (13%)
Non-Hispanic	78(87%)
Age	
16-25	4 (4%)
26-59	80 (89%)
59+	6 (7%)

A total of 90 individuals have initiated services with the Innovation Treatment Team.

On the following page, you will find disaggregated tables for the caseloads for Sutter County and Yuba County.

Table 2 and Table 3: Disaggregated Data

SUTTER COUNTY	
Demographic	**Number & Percentage**
Gender	
Male	29 (63%)
Female	17 (37%)
Race	
American Indian/Alaskan Native	3 (7%)
Asian	2 (4%)
Black/African American	2 (4%)
Native Hawaiian or Other Pacific Islander	0 (0%)
White	34 (74%)
Other	4 (9%)
More than one race	1 (2%)
Ethnicity	
Hispanic	4 (9%)
Non-Hispanic	42 (91%)
Age	
16-25	0 (0%)
26-59	42 (91%)
59+	4 (9%)

YUBA COUNTY	
Demographic	**Number & Percentage**
Gender	
Male	29 (66%)
Female	15 (34%)
Race	
American Indian/Alaskan Native	0 (0%)
Asian	0 (0%)
Black/African American	4 (9%)
Native Hawaiian or Other Pacific Islander	0 (0%)
White	33 (75%)
Other	6 (14%)
More than one race	1 (2%)
Ethnicity	
Hispanic	8 (18%)
Non-Hispanic	36 (82%)
Age	
16-25	4 (9%)
26-59	38 (86%)
59+	2 (5%)

Intake Data Analysis- MORS, URICA, LOCUS Analysis – Year 1:
To be included in the intake data analysis for this section, clients must have logged baseline scores in LOCUS, MORS, and URICA within 30 days of treatment. All clients who completed an intake were included. This helps the INN Project Team to understand what the clinical status of the INN participants is prior to beginning treatment. The baseline data will also be crucial for determining client progression.

Sutter County:
While in-custody, Sutter County clients were assigned a level of care placement based on their LOCUS assessment. For project year 1, LOCUS levels ranged from

level 2 to level 6. The average LOCUS intake level was 4.73 (n=42). A level 4 placement describes services that may be known as “assertive community treatment” and is best for consumers at imminent risk of involuntary treatment, or persons who would not be discharged without the availability of intensive community support. Sutter County INN team initiated services with 34 individuals in need of very intensive services (Levels 4,5 and 6), which accounts for 81% of the therapist’s caseload.

A MORS intake was also completed. MORS baseline scores ranged from scores of 2 to 5. The average intake MORS Score was 3.04 (n=46) (Experiencing high risk/engaged with mental health provider(s)).

Lastly, a URICA score was also assigned to INN clients to determine what their readiness to change level was prior to treatment. In Sutter County, readiness scores ranged from 8 to 14. The average readiness score was 9.44 (n=26), which is the Contemplators Stage. At this stage, individuals recognize that they have a problem. They weigh the pros and cons of the problem behavior versus improving it and begin to think about changing their behavior. Of this total number of individuals evaluated using the URICA, 8 (31%) were identified as Precontemplators, which is described as individuals who are either are not thinking about changing their behavior or do not want to change their behavior, despite mental health being identified as one of their top 3 needs.

Yuba County:
When released from custody, Yuba County clients were assigned a level of care placement based on their LOCUS assessment. For project year 1, LOCUS levels ranged from Basic to level 5. To calculate the average LOCUS intake score, the basic level score was quantified to 0 because the lowest level score is 1 and basic services falls below that level. The average LOCUS intake level was 2.83 (n=44). A level 2 placement describes the beginning of more independence from the mental health system, clients have an established wellness plan, and are able to manage their illness, including emergencies. Yuba County INN initiated services with 14 individuals in need of very intensive services (Levels 4,5 and 6), which accounts for 32% of the therapist’s caseload.

A MORS intake was also completed. MORS baseline scores ranged from scores of 2 to 6. The average intake MORS Score was 4.43 (n=45) Not coping successfully/not engaged with mental health provider(s).

Lastly, a URICA score was also assigned to INN clients to determine what their readiness to change level was prior to treatment. In Sutter County, readiness scores ranged from 7.2 to 15. The average readiness score was 10.3 (n=33), which is the Contemplation Stage. At this stage, individuals recognize that they have a problem. They weigh the pros and cons of the problem behavior versus improving it and begin to think about changing their behavior. Of this total number of individuals evaluated using the URICA, 8 (24%) were identified as

Precontemplators, which is described as individuals who are either are not thinking about changing their behavior or do not want to change their behavior, despite mental health being identified as one of their top 3 needs.

Comparing Intake for Both Counties:
There is a limited sample of data for comparison after 1 year of data collection on the project clients, however a few comparisons can be made with this data.

When learning about the intensity of services required from the clients within the two different settings, the aggregated intake data from both counties for the LOCUS suggests that at the point of engagement in Sutter County, clients are in need for a much higher level of care (level 4) in comparison to the lower level of care (level 2) needed by clients in Yuba County.

When looking at engagement and recovery stages using the average intake MORS scores between Yuba and Sutter, the data suggests that the client engagement level is higher at the onset of services in Sutter County, but that they are considered more high risk when the therapist engages with them while in custody. In Yuba County, the therapist engages after the individual's release from custody and the data suggests that at this point the individual is not as high risk, but they are having difficulty with engagement.

Both counties similarly show that predominantly when clients begin the intake process with the INN program, that they are in a contemplative mindset and are open to treatment. However, it should be noted that each therapist has encountered individuals within their caseload that are displaying defiant attitudes towards the treatment process at the onset.

Data Analysis- MORS, LOCUS and URICA Analysis – Year 1:

To be included for analysis for this section of the report, individuals must have logged a baseline score and a reassessment score for MORS and LOCUS. The initial reassessment for the outcome tools was planned to occur every 90-days; however, shortly after implementation, it was realized that determining re-administration frequency based on time did not seem suitable for this project. For example, one client may have attended 2 treatment sessions within the reassessment timeframe, while others may have attended 9 treatment sessions within the time frame. To quantify recovery growth and improve comparative analysis, the INN Project Team decided to use a prescribed number of treatment sessions as the determinant for a tool reassessment rather than a time frequency. Following INN Team discussion, it was determined that every 12 treatment sessions a reassessment would be completed.

The INN project officially began in February 2015, and the decision to change the reassessment frequency occurred in October 2015. Many of the early intake clients for the project will have received an additional reassessment at the 90-day mark,

in addition to a 12-treatment session reassessment. For this first project year, those who received a reassessment within 90 days will be analyzed separately from those who were reassessed after 12 treatment sessions.

The URICA was analyzed separately from the LOCUS and MORS as it is only re-administered at the beginning of treatment and at the close of treatment.

MORS Sutter County:

Within the first 90 days of the program, the average MORS score growth for Sutter County was 0.5. After completing 12 treatment sessions, the average MORS score growth was 2.4. All clients who completed 12 treatment sessions showed recovery gains.

For those clients who were discharged from the program and had logged a baseline MORS score and MORS reassessment, the data shows that these individuals showed a 0.63 score increase at the time of discharge. In this analysis group, 63% were discharged due to engagement issues and of these discharged individuals, 60% increased their recovery by 1 milestone, but still left the program. The highest milestone achieved by those who left the program was milestone 5. The remaining discharged individuals left the program at milestone 2 and 3, which characterizes them as high risk individuals.

The following is a MORS Contingency Matrix for Sutter County. This shows the difference in score assignment following their intake assessment for the MORS. This matrix shows all the individuals who logged a baseline score and reassessment score.

FOLLOW-UP

INTAKE		1	2	3	4	5	6	7	8	N at Intake	% at Intake
		Extreme Risk	High Risk, Unengaged	High Risk, Engaged	Poorly Coping, Unengaged	Poorly Coping, Engaged	Coping, Rehabilitating	Early Recovery	Advanced Recovery		
1	Extreme Risk									0	0%
2	High Risk, Unengaged		2	3						5	31%
3	High Risk, Engaged			2		5		2		9	56%
4	Poorly Coping, Unengaged		1			1				2	13%
5	Poorly Coping, Engaged									0	0%
6	Coping, Rehabilitating									0	0%
7	Early Recovery									0	0%
8	Advanced Recovery									0	0%
N at Follow-up		0	3	5	0	6	0	2	0	16	100%
% at Follow-up		0%	19%	31%	0%	38%	0%	13%	0%	101%	
% Change from Intake			-40%	-44.4%	-100%	n/a +6		n/a +2			

****Note: Percentage growth from values of 0 is not within the concept of percentage change.**

The Sutter County MORS Contingency Matrix shows that there have been positive percentage declines in milestones 2-4 and increases in milestones 5 and 7 at reassessment. It is ideal to see declines in the lower level milestones and increases in milestones at higher levels at follow-up.

Yuba County:

Within the first 90 days of the program, the average MORS score growth for Yuba County was 0 milestones. After completing 12 treatment sessions, the average MORS score progression was -1 milestone.

For those clients who were discharged from the program and had logged a baseline MORS score and MORS reassessment at the close of services, the data shows that these individuals showed on average a -1-score reduction at the close of services.

The following is a MORS Contingency Matrix for Yuba County. This shows the difference in score assignment following their intake assessment for the MORS. This matrix shows all the individuals who logged a baseline score and reassessment score.

FOLLOW-UP

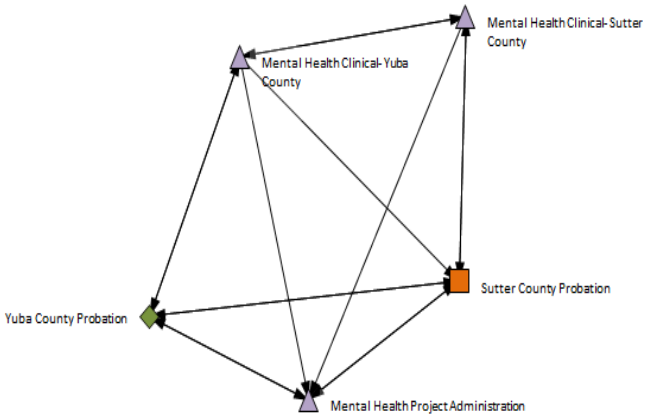
INTAKE		1	2	3	4	5	6	7	8	N at Intake	% at Intake
		Extreme Risk	High Risk, Unengaged	High Risk, Engaged	Poorly Coping, Unengaged	Poorly Coping, Engaged	Coping, Rehabilitating	Early Recovery	Advanced Recovery		
1	Extreme Risk									0	
2	High Risk, Unengaged		1			1				2	7%
3	High Risk, Engaged		1	1	1	1				4	14%
4	Poorly Coping, Unengaged		1		3		1			5	18%
5	Poorly Coping, Engaged		1	1	5	6	2			15	54%
6	Coping, Rehabilitating							2		2	7%
7	Early Recovery										
8	Advanced Recovery										
N at Follow-up			4	2	9	8	3	2	0		
% at Follow-up			7%	14%	32%	29%	11%	7%			100%
% Change from Intake			100%	0% No change	125%	-6.6%	50%	0% No change			

The matrix above shows that there have been percentage increases in milestones 2-4 at the reassessment stage and little percentage growth in milestones 5 and 7. It is ideal to see declines in the lower level milestones and increases in milestones at higher levels at follow-up. The data here suggests that client's engagement level in Yuba County decreased as they participated in the program.

Collaboration Outcomes:

March 10, 2015 PARTNER Survey Administration:

Overall Network Activity on a Monthly Basis:

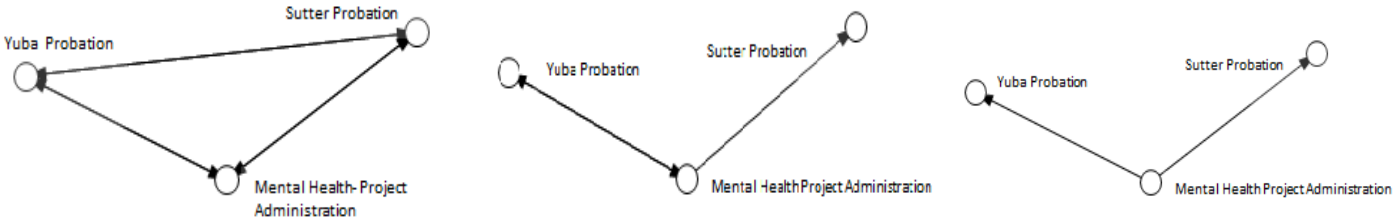


Each triangle represents a respective agency. Mental Health is divided into 3 areas because mental health is providing the clinical aspects to the program, as well as the lead administrative role. The graphic to the left shows an appropriate level of communication between each project partner. Mental health project administration is having bidirectional communication with each partner. Bidirectional communication is also occurring between the respective probation departments and between the respective clinicians. This represents that during the implementation stage that communication between all partners was reported as present.

When project partners were asked to evaluate the success of the collaborative in reaching their goals, individuals rated the project at varying success levels, ranging from somewhat successful to very successful. Project administration is hopeful that by the end of the 3-year term, all project partners will rate the collaborative as being completely successful and very successful. When analyzing trust within the collaborative, partners' responses resulted in a 94.6% trust score, which is very high. Project administration hopes +to sustain and even increase this trust score among the collaborative as the project progresses.

Lastly, when visualizing collaboration, it is ideal to see that all project partners visualize the same level of collaboration. Below is a description of each collaboration level.

Level 1:	Level 2	Level 3:
<u>Cooperative Activities:</u> Involves exchanging information, attending meetings together, and offering resources to partners	**<u>Coordinated Activities:</u> Include cooperative activities in addition to intentional efforts to enhance each other's capacity for the mutual benefit of programs.**	**<u>Integrated Activities:</u> In addition to cooperative and coordinated activities, this is the act of using commonalities to create a unified center of knowledge and programming that supports work in related content areas.**

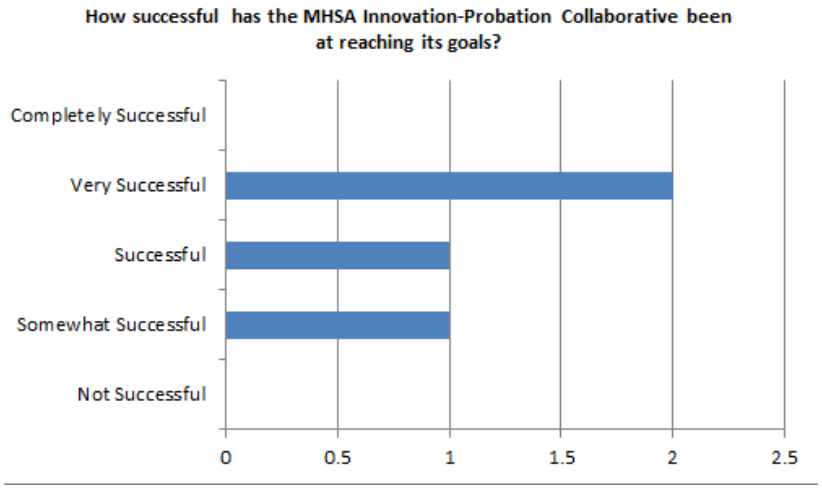


When looking at Level 1, the graphic shows an enclosed triangle with bidirectional arrows from each point, this illustrates that Level 1 collaboration is full perceived by all 3 major project partners. Level 2 and Level 3 are less interconnected and relay the need for further partner discussion on how to enhance cooperative activities.

June 2016- 2nd Survey Administration:

The monthly network activity map was not able to be created during the second survey administration due to incomplete data. It is believed that the survey respondents were unable to identify each other because the Partner Tool decoded the names to unrecognizable terms. Further work will be done with Partner to resolve this issue by the third and last survey administration.

During the second administration, project partners were asked to reevaluate the success of the collaborative at reaching its goals. As the bar chart on the following page illustrates, there has been an increase in the perception that the collaborative has been "very successful". While we saw an increase in very successful perception, we also saw a decrease in the "somewhat successful" perception. These results have shown the need for a discussion about goals and success within the collaborative. We are proud to see that there has been no growth in the "not successful" perception category.



After the second administration, our collective perception of trust remains in the 94th percentile. The trust score percentage this time was 94.4% and previously it was 94.6%. This is still a very impressive trust percentage and we are hopeful that this remains constant after the third survey analysis.

Unfortunately, because of the same issues associated with the monthly network activity map, collaboration triangle

Challenges:

2015/2016 Challenges:

Initially, the Innovation treatment team envisioned that the assessment, post recovery plan, and connections to ancillary services would be completed in the first 30 days of client contact while he/she is still in-custody at jail. However, after implementation, it was identified by Sutter County clinical staff that this is very difficult and impossible at times to conduct the post recovery plan immediately with the client and that it rushes the entire process. In moving forward, the initial assessment will be conducted by Sutter-County within the jail, but the post recovery plan may be conducted while the client is in probation. Project staff will still attempt to do as much as time permits within the in-custody setting, but will not do so in a manner that can affect the quality of services for the innovation client.

2016/2017 Challenges:

- Initially, both probation departments would be utilizing the STRONG (Static Risk and Offender Needs Guide) assessment tool. This was done from February 2015 through December 2015. Both the Sutter and Yuba Probation Departments ended their contracts with the vendor that provides the STRONG. They both contracted with NOBLE to provide new probation assessment tools. All project partners are working to identify a new probation to be used for project year 2. The new tool is expected to be operational by May 2016.

- Initially, all data was expected to be collected every 90 days. However, after implementation, it was discovered that the population we were collecting data on tends to be sporadic at attending treatment and the team felt that we were not getting accurate data at the 3-month interval because there could potentially only be 1-2 treatment sessions at that point, which would not provide information on if the treatments were working. Also, it made it very difficult to compare clients' outcomes because if one had 15 treatment sessions within the 90 days, while another only had 5 treatment sessions. Rather it was agreed upon by all project partners that data would be collected every 12 treatment sessions. This made it to where we were evaluating each client the same.

Significant Changes:

See above for the challenges and the mitigation strategies for changes to the plan.

Innovation Project #2- A culturally competent collaboration to address serious mental illness in the Traditional Hmong population (Innovation Project 2)

Purpose:

- Increase the quality of services, including improved outcomes

Description:

The Hmong community in the Sutter and Yuba counties is an underserved population that has a unique understanding of what they believe about mental health. The concepts of mental health do not exist in the traditional Hmong culture. To traditional Hmong clients', mental health ailments, such as low energy, sadness, auditory and visual hallucinations, nightmares, poor appetites, racing thoughts, etc. are considered to stem from spiritual causes. SYBH has historically been successful in proactively addressing the cultural needs of the mentally ill Hmong population. SYBH provides a Hmong Outreach Center, which is a place where the Hmong population can socialize and receive culturally appropriate services. Additionally, SYBH created the Traditional Healers Project, which provided a unique way for us to bridge a gap between the mental health clinical staff and community Traditional Healers for sharing information, and training each other on western mental health and general health practices/beliefs and traditional Hmong practices/beliefs.

Innovation Project 2 is a cultural collaboration that is the next step in this continuum of learning. The innovation project seeks to learn if traditional Hmong alternative treatment methods are integrated into western modalities and if spirituality is addressed, will this result in an increase in the quality of services and improved mental health outcomes for Hmong clients with serious mental illness? This dual use of westernized mental health treatment and traditional practices for the treatment of Hmong clients' mental health symptoms is considered innovative because this is a new concept to mental health. The project introduces a new mental health approach and practice for the Hmong mental health clients, with the goal that other communities could learn from the outcomes of the innovation and replicate it to improve the mental health outcomes for their respective Hmong clients.

The project will assist Hmong clients by providing them access to traditional Hmong healing through provided coordination services and funds that will aid in covering some of the costs of the ceremonies, rituals, and offerings. The funding of this project supports a project staff member whose role is to assist the client in accessing an appropriate traditional healer that specializes in treating the identified symptoms. Additionally, this staff person coordinates the client's traditional healing services with his/her current mental health services.

Project Status:

SYBH has experienced many challenges with Innovation Project 2, specifically with the obtainment of the cultural materials needed for the traditional ceremonies and staffing challenges. After much analysis and looking at other county's processes, it was decided that a cultural broker within the Yuba-Sutter communities is needed to help us achieve the project goals. SYBH Administration has worked the last two fiscal years to find an appropriate agency to contract with for this project, but has not been able to secure a contract. Additionally, a key staff member that would have been providing the interpreting and documentation for this project will be leaving her position with SYBH. The position will not be re-filled and other Hmong Outreach Center Staff do not possess the skills needed for the bilingual translations required for the project evaluation.

The inability to contract a local cultural broker and the lack of staff expertise to complete the project evaluation has resulted in a proposal to discontinue this MHSA Innovation Project in the FY 17/20 MHSA 3-year Plan.

No clients were served by this program; thus, no transition plans are necessary. However, there is still much support for integrating Hmong Traditional Healing Practices into the mental health treatment plan. It was decided that if there is a client request for this type of service, that SYBH would explore the feasibility of the request on an ad hoc basis.

Challenges*:*
See above- Project status

Significant Changes:
Proposal to discontinue/early termination of: Innovation Project #2: A culturally competent collaboration to address serious mental illness in the Traditional Hmong population. See above Project Status section for more details.

Innovation Project #3- Continued mental health and wellness support for the new Post-TAY clients who are in recovery from a serious mental illness (Innovation Project 3)

Purpose:

- Increase the quality of services, including improved outcomes

Description:

The purpose of continuing mental health and wellness support to the Post-TAY (Transition Age Youth) population that is recovering from serious mental illness is to increase the quality of services, including improved outcomes for the Post-TAY with the introduction of specialized mental health and wellness support services that address the unique needs of this population. The Post-TAY population consists of those youths who are ending TAY Services, but whose needs would not be well served in the HOPE Full Service Partnership (FSP) or Adult Outpatient Programs. Following the conclusion of the TAY services, many of the now Post-TAY have experienced poorer mental health outcomes because they are further transitioning and coping with life stresses from the increased independence and responsibilities of adulthood, while also simultaneously trying to maintain their mental health and recovery without the in-place supports they experienced in the TAY Program.

The innovation project seeks to learn if a continuum of mental health support and wellness support is provided and targeted to Post-TAY clients who are in recovery from a serious mental illness; will there be an increase in the quality of services, including improved mental health outcomes? Providing mental health, wellness services, and community resources is not a new mental health practice, but what is innovative is that we are adapting those services to a new population to learn if this more intensive wellness approach provides for improved outcomes and thus reduces the need for former TAY clients to utilize crisis services in the adult system.

The project utilizes an Intervention Counselor to provide services and provide connections to community resources for housing stability, continuing education, and vocational support tailored to help guide the Post-TAY clients in this transition to adulthood. Rather than a bridge to adult services, the concept is to launch these young adults successfully into the community and support them in this often-difficult transition to adulthood. This service is under the management of the CSOC/TAY Program Manager and is directly supervised by the TAY supervisor.

Project Status:

Following MHSOAC funding approval, we immediately began designing the program and we hired an Intervention Counselor, to serve as the Post-TAY Program Counselor in February 2014. Following the hiring of the project staff, all the Post-TAY staff was trained to conduct and collect data via the Milestones of

Recovery Scale (MORS), which is a recovery-based outcome tool that tracks the process of recovery for individuals with mental illness and helps us to better understand if the Post-TAY services we are offering is helping individuals to achieve more meaningful lives. The project was considered fully implemented in March 2014, and we have begun to collect data for each of the clients.

The project will be considered completed in March 2017. SYBH Administration, Youth and Family Services management, and TAY management will be setting up a series of meetings to begin the final data review. This data review will help us to determine if the project should be continually funded with CSS services dollars, if the project should be discontinued in its entirely, or if the project should be continued with modifications. The decision-making process will begin in December. Client transition plans will be created during these meetings.

General Program Data:

As of March 2016, we have served 14 unduplicated Post-TAY Students. Program clients represent a diverse client population. Male clients represent 64% of the client population, while female clients represent 36% of total program admissions. Half of the first-year Post-TAY clients are from underserved ethnic and cultural communities, including Black/African American (14%), Hispanic/Latino (14%), and clients identified as Bi/Multi- Racial/Ethnic (21%).

Third year data is not due until February 2017.

Per the newly-approved Innovation regulations, expanded demographics collection is now mandated. The Post-TAY project began the expanded demographic collection in August 2016. All active treatment and new clients are asked to fill out the new demographic form. To date, there have been under 10 individuals who have filled out the form for the Post-TAY Program. The data is shown below. Because of the small number of respondents, only the percentage per response will be displayed. Once we have learned how to report small numbers for small counties, with respect to privacy, then we will post the actual numbers.

Client declines to answer all demographic questions	0%
Age	
0-15	0%
16-25	100%
26-59	0%
60+	0%
Decline to answer	0%
Race	
American Indian or Alaska Native	0%
Asian	0%
Black or African American	0%

Native Hawaiian or Pacific Islander	0%
White	50%
Other	13%
More than one race	38%
Decline to answer	0%
Language	
English	100%
Spanish	0%
Decline to answer	0%
Veteran Status	
Yes	0%
No	100%
Decline to answer	0%
Disabilities	

Yes
• Communication Disability:
  ○ Difficulty Seeing- 7%
  ○ Difficult Hearing/Speech-21%
• Mental Disability- 50%
• Physical Disability-7%
• Chronic Disability-7%
• Other- 7%
	100%

No	0%
Decline to answer	0%
Ethnicities	
Hispanic/Latino: Caribbean	0%
Hispanic/Latino: Central American	0%
Hispanic/Latino: Mexican-American/Chicano	13%
Hispanic/Latino: Puerto Rican	0%
Hispanic/Latino: South American	0%
Hispanic/Latino: Other	0%
Non-Hispanic/Non-Latino: African	0%
Non-Hispanic/Non-Latino: Asian Indian/South Asian	0%
Non-Hispanic/Non-Latino: Cambodian	0%
Non-Hispanic/Non-Latino: Chinese	0%
Non-Hispanic/Non-Latino: Eastern European	0%
Non-Hispanic/Non-Latino: European	0%
Non-Hispanic/Non-Latino: Filipino	13%
Non-Hispanic/Non-Latino: Japanese	0%
Non-Hispanic/Non-Latino: Korean	0%
Non-Hispanic/Non-Latino: Middle Eastern	0%
Non-Hispanic/Non-Latino: Vietnamese	0%
Non-Hispanic/Non-Latino: Other	50%
I identify with more than one ethnicity	13%
Decline to answer	13%

Sexual Orientation	
Gay or Lesbian	0%
Heterosexual or Straight	63%
Bisexual	13%
Questioning or Unsure	0%
Queer	0%
Another sexual orientation	0%
Decline to answer	25%
Gender Assigned at Birth	
Male	63%
Female	34%
Decline to answer	0%
Current Gender Identity	
Male	63%
Female	37%
Transgender	0%
Genderqueer	0%
Questioning or Unsure	0%
Another Gender Identity	0%
Decline to answer	0%

Milestones of Recovery Scale (MORS):

The Milestones of Recovery Scale (MORS) is the primary project measurement tools for the Probation Project. The MORS is a recovery-based outcome tool that provides data from reoccurring and consistent assessments that help to track the individual process of recovery for each project client. The ideal and perfect outcomes would show that each client would be progressing through the recovery stages as they progress through services. The MORS is conducted monthly for this project.

When looking at pre-scores for all the clients served for year 1 and year 2, the clients' baseline/ or if n/a first recorded MORS scores, ranged from 2 to 7, with the average score admittance being 5.5/ MORS status "not coping successfully/engaged with mental health provider(s"). There was a .03 increase in the average pre-services MOR score from the first project year. The highest recovery stage received by an individual client in the program has remained at the score of 7, which is described as the stage of early recovery. 3 clients have successfully graduated from the Post-TAY Program, which means that they have successfully mastered living independently, as well as demonstrated consistent, productive involvement in school, work, or volunteering activities. Program graduates have an average length of stay of 12.3 months. However, the number of graduates is very small and this has not been demonstrated as a consistent trend yet.

For the purposes of analyzing recovery growth, client progression is only analyzed if the client has been in the Post-TAY program for at least 6-months. 11 out of the 14 total served clients met this criterion (79%) met this criterion. Only 2 out of the 4 unduplicated clients for year two could meet this criterion.

When looking at the MORS scores for the unduplicated clients for year 2, 14% of the unduplicated clients experienced slight regressions when comparing their current (January 2016) MORS score with their baseline regression. The regressions are attributed to program disengagement and psychiatric emergencies. However, in both cases, clients have re-engaged with the Post-TAY counselor and MORS scores have been gradually increasing.

When looking at the baseline score compared to the current (January 2016) MORS score, 6 out of the 14 clients demonstrated (43%) an increase in their recovery prior to the program. Score increases were attributed to program re-engagement (if disengagement had occurred), educational gains, employment gains, and consistent program contact. 2 (14%) of the total served clients have maintained an identical pre-and current MORS score and 21% clients have regressed when compared to their pre-services MORS score. In each case, regression was attributed to loss of housing, employment, and program disengagement.
Program clients are surveyed every 6 months and asked to rate their satisfaction on varying program aspects.

When looking at overall satisfaction with the support received from the program, 11 total survey responses were received within the 1 year survey period and 64% of the clients responded that they strongly agree that they are satisfied with the program, while another 18% agreed. 0% of clients disagreed/strongly disagreed with this statement.

Challenges:

- We initially experienced hiring challenges, but we have overcome this challenge.
- Client recruitment to the Post-TAY project has been less than expected. Additionally, the average caseload after two years of services is 7 individuals, which is lower than the average intervention counselor caseload in the Integrated Full Service Partnership.

Significant Changes:

The Post-TAY Innovation Program will conclude in March 2017. The MHSA Coordinator hosted a Year 2 Learning session and met with client stakeholders to discuss their experiences in the program and their thoughts on the future of the program. There was preference by the stakeholder to keep the program, as he/she enjoyed having the step-down from TAY. Additionally, 2 rounds of satisfaction surveys were conducted. Both rounds showed high client satisfaction with the Post Tay Services. In addition to reviewing the program annually with client stakeholders, the MHSA Coordinator assembled a SYBH Administrative Review

Team, which consisted of the MHSA Coordinator, Deputy Director for Clinical Services, Youth and Family Services Program Manager and the TAY Program Supervisor. While the program yields, high client satisfaction it has not been an actively used program. To date, the program has served a total of 19 clients.

The Administrative Review Team analyzed the recovery data, client satisfaction data, clients served data, and treatment team feedback. The Team has proposed continually funding the Intervention Counselor with CSS funding and re-designing the Phase III portion of TAY to mirror Post-TAY, while also creating a more coordinated transition to the Adult Full Service Partnership (FSP) Program. The Intervention Counselor would also be a liaison to the Adult FSP. Absorbing the Intervention Counselor position into TAY would help with the waiting list for TAY. The Administrative Review Team proposed the plan to the Behavioral Director and received approval to include this as a significant change in the Three-Year Plan for public review and comment.

*** Please Note- SYBH will not be requesting review/approval for any new Innovation Programs. We currently want to focus our efforts on our already approved programs.**

MHSA Program Component
WORKFORCE EDUCATION AND TRAINING

1. ***Provide a program description. Include achievements.***

Sutter-Yuba Behavioral Health (SYBH) Workforce Education and Training (WET) Program provides for training, education and skill development for all the MHSA programs. Via its WET Program, SYBH has maintained an active partnership with the Central Region Partnership, the Health Professions Educational Foundation, and the California Institute for Behavioral Health Solutions (CIBHS). These partnerships have provided SYBH with many training opportunities, technical assistance on workforce programs and training, and staff opportunities for the state-level Mental Health Loan Assumption Program. The WET Plan's action strategies focus on workforce development, cultural competence, youth awareness of mental health careers, internships, and a local financial incentive program for the SYBH workforce.

Current implemented programs include:

<u>Action Plan 2: Public Mental Health Workforce Development- Evidence Based Practices and Skill Development</u>

Program provides funds for continuing education training, core competency trainings, and evidence-based practices for SYBH staff, contract providers, contracted peer staff, community stakeholders, consumers, and family members. Trainings address a variety of content areas, including but not limited to wellness, recovery, resiliency, stigma and discrimination reduction, suicide prevention, early identification and intervention for trauma and serious psychiatric illness, integrated service experience, cultural competence, treatment of co-occurring disorders, and mental health integration in schools, primary health care, and community services. An emphasis will be put on prioritizing and investing in evidence-based practice trainings.

Achievements:

FY 14/15

- Funded EBP Training, Aggressive Replacement Therapy (ART). Trained an 8-person ART Trained Development Team.
- Supplemental Funding for EBP Seeking Safety Training sponsored by the Central Region Partnership. Trained 12 SYBH staff clinicians and 1 Yuba County Sheriff Department Representative.
- Supplemental Funding for UACF Educate, Equip, and Support (EES) Train-the Trainer Training. We now have 3 Train-the Trainers- 1 SYBH Staff and two Parent Partners.
- Funded Working Well Together- Building a Wellness Workplace: WRAP for work and Peer Support. Trained: 1 SYBH Staff and 2 Peer Mentors.

- Supplemental Funding for UC Davis Extension- CiMH Leadership in Mental Health Services Training Series. Trained 5 staff members.
- Supplemental Funding for Mental Health First Aid (MHFA) Instructor Certification for Youth Curriculum. Trained 1 SYBH staff and 1 Education Partner.
- Supplemental Funding for Trauma- Informed CBT. Trained 3 staff members.
- Supplemental Funding for the CIBHS Leadership Institute.
- Funded 50% of the costs for the MHALA MORS Trainer Certification for 2 staff members who are now certified trainers. Two on-site Introductory MORS trainings have occurred. 12 SYBH staff have been trained in the MORS.
- Funded CIT Training for 14 PES staff members.
- Funded a Nurtured Heart Trainer Certification for one staff member. Subsequent on-site trainings will be occurring for other SYBH staff members now that we have a trainer.
- Funded MHALA Villages 3-day Immersion Training for 20 SYBH staff members.

FY 15/16

- Funded Gang Awareness Training for 4 SYBH staff members who are helping to develop a Forensics Program for SYBH.
- Funded Crisis Intervention Training (CIT) Train-the Trainer Series for 2 SYBH staff members.
- Funded Critical Incident Stress Management (CISM) for 2 SYBH staff members
- Funded Seeking Safety Training on-site for 45 staff members.
- Funded Pain Management and Mindfulness Training for 2 SYBH staff members. The staff members are now in the process of creating a support group based on the skills learned from the training.
- Funded Moral Reconation Therapy (MRT) for 8 staff members.
- Supplemental Funding for CIBHS Co-Occurring Training for 5 staff members
- Supplemental Funding for CIBHS UC Davis Leadership Institute for 3 staff members.
- Funded Non-Crisis Intervention Trainer Certification for one staff from our Psychiatric Health Facility.
- Funded Law and Ethics Training for all County Behavioral Health Staff. Trained 48 staff members.

FY 16/17

- Funded Level of Care Utilization System (LOCUS) and Child and Adolescent Level of Care Utilization System (CALOCUS). Trained 59 staff members.
- In October 2016, SYBH entered into a multi-year contract with Relias Learning. The Relias Training System provides for specialized behavioral health courses, allows for the uploading of an unlimited

quantity of materials, such as all the behavioral health policies and in-service training PowerPoint presentations, and enables centralized tracking and reporting of employee training for improved compliance with regulatory and licensing training requirements. The contract with Relias will expend the remaining WET Funds in this Action Plan.

Action Plan 3: Integrating Cultural Competence in the Public Mental Health System

Program provides funds for developing and furthering an understanding of multicultural knowledge, cultural barriers, cultural sensitivity, cultural responsiveness, socio-cultural diversity, and the diverse needs of our underserved populations, which include Latino, Hmong, Asian Indian, LGBT, and other ethnic and diverse communities.

Achievements:

- Hosted Culturally and Linguistically Appropriate Services (CLAS) Standards Overview Training. Trained Administrative staff, Cultural Competence Committee, and the Latino Performance and Improvement Project Committee 15 representatives.
- Supplemental Funding for the Cultural Competence and Mental Health Northern Region Summit XI- Cultural Competence and Workforce Development Conference. Trained 7 SYBH Staff and 3 Consumers/Family Member representatives.
- Hosted Culturally Responsive Services for Latinos Training. Trained 35 SYBH staff members and 1consumer/family member representative.
- Sponsored an organization-wide survey for collecting staff perspective on improving the services for our Latino population.
- Funded 2 staff members to attend the “Each Mind Matters- “The Spirituality Factor: Weaving Spirituality and Behavioral Health Using Evidence and Practice”: California Mental Health and Spirituality Initiative Northern Region Conference”.
- Funded cultural formation focused training, titled “Cultural Complexities in Assessment, Diagnosis, and Engagement” for SYBH staff, clients, family members, and network providers. 63 staff members were trained.

FY 15/16

- Funded Spirituality Training for 47 staff members.
- Funded Disability Cultural Competence Training 49 staff members.
- Funded 8 stipends to consumers who presented at the Annual Consumer Client Culture Training.

FY 16/17

- Funded 6 stipends to consumer who presented at the Annual Consumer Client Training.
- Funded a contract with Visio y Comprimiso to provide promotora training for 40 community members.

- A portion of funding from this action plan will be dedicated to funding the Relias Contract, as many of the courses focus on cultural competence.

Action Plan #4: Youth Workforce and Career Program

Program promotes post-secondary education and careers in public mental health, targeted to high school and community college youth.

Achievements:

FY 14/15

- Development of Speakers Bureau of mental health professionals that work in a variety of entry-level to advanced-level careers.
- Speaking engagements held at local high schools and AVID clubs.
- Staffed 3 high school career booths to pass out mental health career profiles and promote post-secondary education and training in mental health and substance abuse.
- Developed a Public Mental Health Careers binder that was distributed to all high school and community college counselors in the area (32 binders distributed).

FY 15/16

- The Mental Health Director and the MHSA Coordinator attended and presented at the Live Oak High School Career Fair. Entry-level to advanced-lever mental health careers were discussed and the binders were presented.
- Current efforts are being made with the PEI Team to use funds to tap into their PLUS leadership groups to create mental health career presentations.

FY 16/17

- There are ongoing meetings with the PEI Team to determine how to use the remaining Youth Workforce and Career Program funds.

Action Plan #5: Employment/Education Support: Consumer and Family Leadership Opportunities and Mental Health Educational/Training Opportunities

Program expands consumer and family member awareness of leadership opportunities in the mental health field and provides incentives for individuals to further their recovery and obtain needed education and training for employment in the public mental health workforce force.

Achievements:

- The program is newly implemented as of January 2015. Marketing efforts are being conducted by the overseeing committee to provide awareness about the financial incentives to active treatment clients and family members.
- Due to the lack of applications, a new marketing strategy to the community colleges will be being implemented to increase program awareness.

FY 15/16

- 1 Parent Partner was funded to attend a Wellness Recovery Action Plan Conference.

FY 16/17

- The program will be continually marketed to increase awareness about the availability of funds.

Action Plan #6: Intern Supervision Program

Program provides for clinical supervision and internship placements to interns who would help to address hard-to-fill positions and address cultural and linguistic workforce needs.

Achievements:

FY 14/15

- 67.15 clinical supervision hours have been provided to staff working in new and expanded capacities in Youth Outpatient Services. $2704 has been expended on this project in the 14/15 Fiscal Year.

FY 15/16

- 116.55 clinical supervision hours have been provided to staff working in new and expanded capacities in the Youth and Family Services Program and the Forensics Program. $4,792.68 has been expended on this project in the 15/16 Fiscal Year.

FY 16/17

- As of November 7, 2016, 79.5 clinical supervision hours have been provided to staff working in new and expanded capacities in Youth and Family Services and the Forensics Program.

Action Plan #7: WET Financial Incentives: Tuition and Book Expense Reimbursement for Workforce Development

Program will pay towards costs related to: tuition, registration fees, and books. All reimbursements will be associated with SYBH employees and contracted peer staff participating in educational activities that possess a direct link to addressing occupational shortages related to clinical/administrative skills needed in: licenses, language proficiency and positions requiring advanced degrees and the under representation of racial/ethnic, cultural and linguistic groups in the SYBH workforce. Participants receiving reimbursements would agree to remain employed at SYBH or the SYBH Employer Record for Contracted Peer Staff for a period up to two years' dependent upon total reimbursement amount.

Achievements:

- Successfully partnered with the California Institute for Behavioral Health Solutions (CIBHS) and completed the 2013/2014 WET Scholarship Program Cycle. WET Funding provided 7 scholarships for educational program tuition and educational expenses, totaling $30,577 for Post-Graduate, Bachelor, and Associates programs addressing hard-to-fill positions. Fields of study include Marriage and Family Therapy, Substance Abuse and Alcohol, Public Administration, Psychiatric Nursing, Social Work, and Psychology. 5 SYBH staff members were awarded and 2 Contracted Peer Staff were awarded.

FY 14-15

- The 2014/2015 Program Cycle was opened on March 2, 2015. Applications to the program were mailed to CIBHS and are being reviewed by an independent CIBHS application committee.
- 4 SYBH staff were recommended to be awarded this cycle. All recommended awardees are focusing on graduate-level studies, specifically Marriage and Family Therapy. $16,500 was expended this cycle.

FY 15-16

- The 2015/2016 Program Cycle was opened on March 14, 2016. SYBH again partnered with CIBHS to administer the WET Competitive Scholarship/Tuition Reimbursement Program.
- 5 SYBH Staff were recommended to be awarded for this cycle. 4 of the recommended awardees are focusing on studies in Psychology and Marriage and Family Therapy and one awardee is focusing on graduate-level nursing education. $42,500 is expected to be expended this cycle.

FY 16/17

- The 2016/2017 Program Cycle is expected to open in March of 2017.

2. ***Describe any challenges or barriers, and strategies to mitigate. Identify shortages in personnel, if any.***

The updated WET Plan is progressing as planned. We are challenged by our re-occurring workforce shortages in MFTs, MSWS, and Psychiatry.

3. ***List any significant changes in Three-Year Plan, if applicable.***

There are none at this time; the program is progressing as planned.

MHSA Program Component
CAPITAL FACILITIES/TECHNOLOGY

Capital Facilities Plan:

1. ***Provide a program description***

SYBH intends to use the Capital Facilities funds to improve the County's property and Adult Education Work Activity Center's department's ability to provide vocational and pre-employment skills to individuals with mental illness who are wanting to enter the workforce. Learning environments will include an on-site culinary teaching kitchen and an onsite computer classroom.

The renovated space will create an industrial teaching kitchen that will service as the work experience classroom for SYBH clients. With the expanded space, the WAC plans to expand the curriculum to include training topics that consumers requested, such as computer training, budgeting, vocational activities, such as sewing, and competitive employment skills.

The WAC Expansion Project is consistent with the goals of SYBH CSS Three-Year Plan and is consistent with the Capital Facilities and Technological Needs Component. The program is an available resource for the SYBH Integrated Full Service Partnership and the Wellness and Recovery Program. The Program is client-driven and wellness focused. Every activity and training offered by the WAC embodies the MHSA spirit of helping people recover by providing them a safe space to explore what their interests are while also teaching them valuable work skills that can be used on a resume.

2. ***Describe any challenges or barriers, and strategies to mitigate.***

Renovation has yet to begin, as the site to be renovated is still occupied by other programs that are waiting to be moved. Planning for the space is still ongoing, but construction will be on hold until the space become unoccupied.

3. ***List any significant changes, if applicable.***

No significant changes are anticipated.

IT Facility Plan:

1. ***Provide a program description***

The technology portion of the SYBH Cap/IT Plan was to institute an Electronic Health Record (EHR) and associated support structures to meet state and federal mandates to provide Health Information Exchange (HIE). This included the purchase of an EHR, the future purchase of network and workstation hardware to enable use of the EHR and a consumer program to begin training consumers and stakeholders to be able to use the information provided by an EHR. The goal of the EHR, at this stage of the plan, is to set the stage for the SYBH to move to a full implementation as defined by the State for the exchange of health information. The plan scope and the timeframe of this plan do not allow for

the complete implementation of a full EHR but are a major step in this direction. Our EHR went live on April 1, 2012.

2. ***Describe any challenges or barriers, and strategies to mitigate.***

None now.

3. ***Describe if the county is meeting/met benchmarks and goals, or provide the reasons for delays to implementation.***

The EHR Project went live on April 1, 2012 and is progressing as planned. The next project goal is to implement a client portal.

4. ***List any significant changes, if applicable.***

No significant changes are anticipated.

MHSA Housing Update for Stakeholders:

In addition to the two housing properties included in the current MHSA Supportive Housing Program, SYBH is working with a variety of stakeholders to explore the expansion of this program. While the project is in the exploration phase, we wanted the intent to explore this to be included in the MHSA Three-Year Program Plan.

If you are interested in participating in future stakeholder meetings, please provide your contact information to the MHSA Coordinator, Megan Ginilo.

BUDGET

Please see the funding summary of FY 2017/18 Fiscal Year below. The figures in the funding summary constitute our best estimation of funding and costs at the time of the Three-Year Plan submission.

County: Sutter-Yuba Behavioral Health **Date:** 1/6/2017

	MHSA Funding					
	CSS	WET	CFTN	PEI	INN	Local Prudent Reserve
A. Estimated FY 2017/18 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	$3,354,242	$473,533	$39,500	$1,903,133	$1,676,572	
2. Estimated New FY 2017/18 Funding	$5,810,247			$1,187,500	$312,500	
3. Transfer in FY 2017/18[a/]						
4. Access Local Prudent Reserve in FY 2017/18						
5. Estimated Available Funding for FY 2017/18	$9,164,489	$473,533	$39,500	$3,090,633	$1,989,072	
B. Estimated FY 2017/18 Expenditures	$8,336,048	$180,000	$0	$1,347,931	$485,751	
C. Estimated FY 2017/18 Contingency Funding	$828,441	$293,533	$39,500	$1,742,702	$1,503,320	

[a/]Per Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

D. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2017	$873,950
2. Contributions to the Local Prudent Reserve in FY 2017/18	$0
3. Distributions from Local Prudent Reserve in FY 2017/18	$0
4. Estimated Local Prudent Reserve Balance on June 30, 2018	$873,950

Appendix