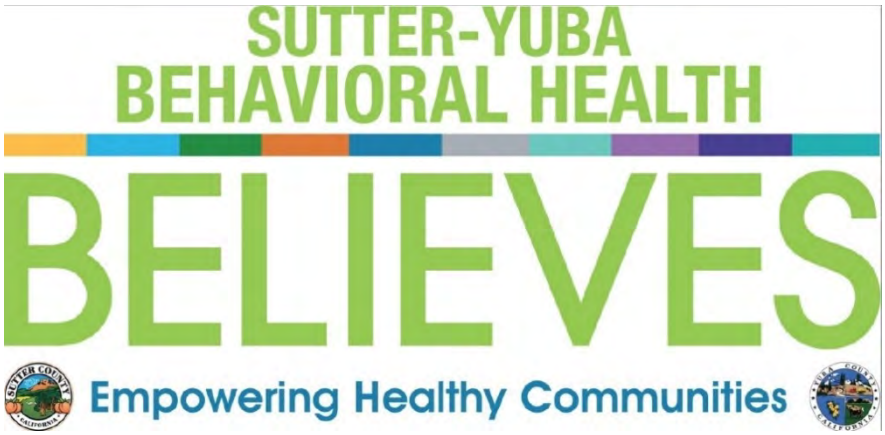


SUTTER-YUBA BEHAVIORAL HEALTH

Fiscal Years 2019-2020

Annual Update & AB 114 Reversion Spending Plan

Posted for 30-day Public Review and Comment:
February 14, 2019 - March 21, 2019

Public Hearings - March 12, 13, and 14, 2019

The intent of SYBH's Annual Update 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 Annual Update reports program activities for the Fiscal Year 2019-20 and reports on available program data from prior fiscal years.

Also included in this FY 2019-20 MHSA Annual Update is the AB114 Spending Plan for reallocated funds. Per MHSUDS Information Notice 17-059, every county must include in the Annual Update the plan for spending.

The following provides a chronological overview of the program sections included in this Annual Update:

MHSA COUNTY COMPLIANCE CERTIFICATION

County: Sutter-Yuba Behavioral Health

❑Three-Year Program and Expenditure Plan
☑Annual Update

Local Mental Health Director	Program Lead
Name: Rick Bingham, LMFT	Name: Peter Sullivan, MBA
Telephone Number: 530-822-7327	Telephone Number: 530-822-7327
E-mail: RBingham@co.sutter.ca.us	E-mail: PSullivan@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 **INSERT APPROVAL DATE- *Will be completed after Public Review Process** (tentatively - June 25, 2019)

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 Three-Year Program and Expenditure Plan are true and correct.

Mental Health Director (PRINT)	Signature	Date

MHSA 2018/19 Annual Update
FISCAL ACCOUNTABILITY CERTIFICATION[1]

County: Sutter-Yuba Behavioral Health

❑Three-Year Program and Expenditure Plan
☑Annual Update

Local Mental Health Director	County Auditor-Controller
Name:	Name: Nathan Black, CPA
Telephone Number: 530-822-7200	Telephone Number: 530-822-7127
E-mail:	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.

._____ _____

Mental Health Director (PRINT) Signature Date

I hereby certify that for the fiscal year ended June 30, 2018, 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, 2018. I further certify that for the fiscal year ended June 30, 2018, 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
30-day Public Comment period dates: February 14 – March 21, 2019
Date of Public Hearing: March 21, 2019

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) operates under the Sutter County Health and 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. The table below displays race, sex and age data for both Sutter County and Yuba County:

SUTTER COUNTY 2010 CENSUS DATA		
RACE	Number	Percent
Total population	94,737	100
One Race	89,440	94.4
White	57,749	61
Black or African American	1,919	2
American Indian and Alaska Native	1,365	1.4
Asian	13,663	14.4
Asian Indian	10,513	11.1
Chinese	326	0.3
Filipino	714	0.8
Japanese	382	0.4
Korean	156	0.2
Vietnamese	184	0.2
Other Asian	1,388	1.5
Native Hawaiian and Other Pacific Islander	281	0.3
Native Hawaiian	48	0.1
Guamanian or Chamorro	147	0.2
Samoan	15	0
Other Pacific Islander	71	0.1
Some Other Race	14,463	15.3
Two or More Races	5,297	5.6
White; American Indian and Alaska Native	1,109	1.2
White; Asian	998	1.1

Yuba County 2010 Census Data		
RACE	Number	Percent
Total population	72,155	100
One Race	67,068	92.9
White	49,332	68.4
Black or African American	2,361	3.3
American Indian and Alaska Native	1,675	2.3
Asian	4,862	6.7
Asian Indian	461	0.6
Chinese	269	0.4
Filipino	694	1
Japanese	187	0.3
Korean	108	0.1
Vietnamese	86	0.1
Other Asian	3,057	4.2
Native Hawaiian and Other Pacific Islander	293	0.4
Native Hawaiian	50	0.1
Guamanian or Chamorro	112	0.2
Samoan	53	0.1
Other Pacific Islander	78	0.1
Some Other Race	8,545	11.8
Two or More Races	5,087	7.1
White; American Indian and Alaska Native	1,664	2.3
White; Asian	698	1

White; Black or African American	466	0.5		**White; Black or African American**	599	0.8
White; Some Other Race	1,282	1.4		**White; Some Other Race**	938	1.3
Hispanic or Latino				**Hispanic or Latino**		
Total population	94,737	100		**Total population**	72,155	100
Hispanic or Latino (any race)	27,251	28.8		**Hispanic or Latino (any race)**	18,051	25
SEX				**SEX**		
Male Population	47,001	49.6		**Male Population**	36,352	50.4
Female Population	47,736	50.4		**Female Population**	35,803	49.6
AGE				**AGE**		
Under 5 years	7,153	7.6		**Under 5 years**	6,217	8.6
5 years-19 years	21,815	23		**5 years-19 years**	16,885	23.4
20 years-59 years	43,674	51.7		**20 years-59 years**	38,351	53.2
60 years +	16,683	17.6		**60 years +**	10,702	14.9

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 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 who are incarcerated at Camp Singer and Yuba-Sutter Juvenile Hall. Forensic Services also provides 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 and 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 Annual Update FY 19/20).*

The Sutter-Yuba Behavioral Health Annual Update maintains current programs at current service levels. This plan will be made available for Public Review, beginning February 14, 2019. It will remain available for 30 days at Sutter-Yuba Behavioral Health, County Libraries, and the County Administrators' Offices. In addition, this annual update will be 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 second Thursday of every month at 5:00 PM at 1965 Live Oak Blvd, Ste. A.
- Community stakeholders, clients, and family members continue to be active committee members and active stakeholders in a variety of 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.

Three Community Information Sessions are scheduled for community members and other stakeholders to attend and learn more about the MHSA Programs at Sutter-Yuba Behavioral Health. The meetings will be held at the following:

Tuesday, March 12, 2019	5:15 pm-6:15 pm	Yuba County Government Center Wheatland Room 915 Eighth Street **Marysville, CA**
Wednesday, March 13, 2019	5:15 pm-6:15 pm	Sutter-Yuba Behavioral Health Four Rivers Room 1965 Live Oak Blvd, Suite A **Yuba City, CA**

Thursday, March 14, 2019	12:15pm-1:00 pm	Sutter-Yuba Behavioral Health Four Rivers Room 1965 Live Oak Blvd, Suite A **Yuba City, CA**

The Community Planning Process was completed at the close of the Public Hearing, held during the March 21, 2019, Mental Health Advisory Board.

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	

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 MHSA 2019/20 Annual Update concluded March 21, 2019. The MHSA Annual Update Plan will be 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 will be mailed to all Behavioral Health Board members; posted at the Sutter County and Yuba County main libraries; posted in the Appeal-Democrat newspaper on February 3, and 11, 2019 and provided to anyone who requested a copy. Public comments could either be emailed to psullivan@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 was held Thursday, March 21, 2019. The public comment period is currently closed; public comments were open February 14 – March 21, 2019.

Three community information sessions were held at the afore-mentioned dates and locations, Tuesday March 12, Wednesday March 13 and Thursday March 14, 2019. There was a total of five attendees present at the three community information sessions. No substantive comments were received.

The 19/20 MHSA Annual Update & AB114 Reversion Spending Plan currently is not open for public comment. No comments were received during the Public Hearing. Following the close of the Public Hearing, the Behavioral Health Board unanimously approved the FY19/20 MHSA Plan.

Documentation of all sign-in sheets and meeting minutes will be in the Appendix of this MHSA Annual Update.

MHSA Program Component
COMMUNITY SERVICES AND SUPPORTS

Community Services & Support (CSS) is the largest component of the MHSA. The CSS component is focused on community collaboration, cultural competence, client and family driven services and systems, wellness focus, which includes concepts of recovery and resilience, integrated service experiences for clients and families, as well as serving the unserved and underserved. Housing is also a large part of the CSS component.

In the Community Services and Supports Section, you will find descriptions of the Full-Service Partnership (FSP) programs and Non-FSP programs funded by the MHSA for Sutter and Yuba counties. To better align the MHSA Plan with the Sutter County budget, the Early Childhood (0-5 FSP), Children's (6-15 FSP), and Transitional Age Youth (TAY 16-25 FSP) have been consolidated into a Children's/Youth FSP. The services offered, and the target groups remain unchanged. Reporting for the Adult/Older Adult FSP has not changed.

Community Services and Support (CSS) programs receive 45% of MHSA funding.

Children/Youth Full-Service Partnership

The Children/Youth Full Service Partnership (FSP) Program provides a wide array of services to 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. The programs assist children/youth in accessing behavioral support services such as assessment; individual, group, and family therapy; medication support services; and case management assistance (which includes, but is not limited to assistance with: transportation, obtaining housing, basic needs, concrete supports, care coordination, and linkage to community resources). Services are provided in clients' homes, schools, and other community-based locations. All FSP clients and their caregivers have access to someone known to them 24 hours a day/ seven-days a week for crisis support services. Please note, the Data Collecting Reporting System (DCR) is SYBH's external report sent to DHCS; Anasazi is used for internal tracking only.

Unique clients served by the Children/Youth FSP

FSP DCR Data:	FY 2017-2018	July 1, 2018-December 2018
0-5 FSP	54	37
6-15 FSP	152	179
TAY FSP (16-25)	60	52
TOTAL	266	268

Age 0-5 services within the Children/Youth FSP:

The 0-5 component of the 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.

In Fiscal Year 2017-2018, the 0-5 Full-Service Partnership program was contracted out to Youth for Change (YFC), a community-based organization with a long history of providing effective FSP services. Through the contracting process we were able to increase the capacity for this program to serve up to 30, 0-5 children and their families at any given time.

Program Evaluation Efforts:

In addition to data collected from the DCR outcome forms, data is also being collected using the Child and Adolescent Needs and Strengths (CANS) assessment. Both SYBH Youth and Family Services and Youth For Change are actively using this tool to capture data on client progression. The next phase of the implementation process is to make meaningful use of all the data being collected and report it using organizational dashboards.

Current challenges or barriers within the 0-5 FSP Program include:

- There has been an increase in the demand for services for the 0-5 population. In FY 2016-17, 84 unique children aged 0-5 received services[1] through SYBH; in FY 2017-18 the number of children aged 0-5 who received services increased to 106. Although, not all these children received FSP services, this data illustrates the increasing demand for local services of this age group.

- The transition of 0-5 FSP services to the contracted provider, Youth For Change, was challenging due to several factors that included Youth For Change experiencing difficulty obtaining and sustaining adequate staffing to support the program. The recent Camp Fire (in Paradise, California) significantly impacted Youth For Change's organization (as Youth For

[1] It should be noted that "received services," includes triage assessments for children who sought treatment, but may not have met medical necessity criteria to receive specialty mental health services from SYBH.

Change is based in Paradise, had multiple group homes and other organizational assets in the area, and had many staff who resided there). The YFC therapist that was assigned to the 0-5 caseload lost her home in the fire and was forced to relocate and terminate employment with YFC; they are currently recruiting for another child therapist.

- There are currently no bilingual therapists that serve children ages 0-5 in the Youth for Change FSP program. This poses a barrier to providing high quality services to our monolingual non-English speaking families. There is currently one bilingual, Spanish-speaking therapist who works for SYBH who provides services to 0-5 children, but this therapist does not provide FSP services.

- We recently made significant modifications to our existing billing/case management system (Anasazi) to better track caseloads in FSP and non-FSP units. Prior to November 2018, we were unable to track 0-5 FSP caseloads through Anasazi and have relied on the DCR for data collection.

- 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, has provided 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.

- We have previously identified a need to provide early intervention, particularly for children two and under. Some of these children may not yet meet FSP criteria due to their age, current symptoms and level of functional impairment. We continue to discuss the potential of expanding our criteria to qualify for 0-5 FSP services to meet the unique and challenging needs of infants and toddlers.

Age 6-15 services within the Children/Youth FSP:

The 6-15 component of the 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 FSP team provides these services within the resources available to help children and their families make progress on their path to recovery and wellness. The 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 the FSP program, most clients can transition to lower levels of care from high level group homes, and/or are maintained in home and community settings.

In Fiscal Year 2017-2018, the Children's Full-Service Partnership program was contracted out to Youth for Change, a community-based organization with a long history of providing effective FSP services. Through the contracting process we were able to increase the capacity for this program to serve up to 50 children/youth ages 6-15 and their families at any given time.

Program Evaluation Efforts:
In addition to data collected from the DCR outcome forms, data is also being collected using the Pediatric Symptom Checklist (PSC-35), the Child and Adolescent Level of Care Utilization System (CALOCUS), and the Child and Adolescent Needs and Strengths (CANS) assessment. Both SYBH Youth and Family Services and Youth For Change are actively using these tools to capture data on client progression. The next phase of the implementation process is to make meaningful use of all the data being collected and report it using organizational dashboards.

Current challenges or barriers within the 6-15 FSP Program include:

- There has been an ongoing demand for services for children/youth of all ages, including the population ages of 6-15. For example, in FY 2016-17, there were 474 visits (by 401 children) to the Youth Open Access Clinic,[2] which increased to 544 visits (by 450 children) in FY 2017-18. In FY 2016-17, 1,000 children aged 6-15 received services[3] through SYBH; in FY 2017-18 the number of children aged 6-15 who received services increased to

[2] It should be noted that while the Open Access Clinic is the primary point of entry for SYBH youth behavioral services, it is not the only entry point: clients enter services through the Open Access Clinic (walk-in), Urgent Services (MHSA program), Latino Outreach (MHSA program), Juvenile Hall/Camp Singer, Sutter and Yuba County child welfare agencies (imbedded therapists conduct triage assessments and facilitate access to services), and through presumptive transfer (California foster youth placed in the local area through outside county child welfare agencies). Adult Youth (ages 18-25) are sometimes referred for Youth Services via the Early Periodic Screening and Diagnostic Treatment (EPSDT) program and for the Transitional Age Youth (TAY) (MHSA program).

[3] It should be noted that "received services," includes triage assessments for children who sought treatment, but may not have met medical necessity criteria to receive specialty mental health services from SYBH.

1,036. It has been reported, anecdotally, by SYBH Open Access therapists and local community partners that the degree of acuity of children presenting for services in this age group (6-15) has increased significantly over the past few years; we are working towards developing data collection mechanism(s) to monitor this observation.

- The transition of 6-15 FSP services to the contracted provider, Youth For Change, was challenging due to several factors that included Youth For Change experiencing difficulty to obtain and sustain adequate staffing to support the program, and the recent Camp Fire (in Paradise, California) which significantly impacted Youth For Change's organization (as Youth For Change is based in Paradise, had multiple group homes and other organizational assets in the area, and had many staff who resided there).

- We continue to receive a high number of referrals to Children's FSP services from our community partners. This, combined with staff turnover and the impact of the Camp Fire, has impacted the ability of the FSP program to operate at full capacity, resulting in an inability for some youth who meet FSP criteria to access FSP services, and causing some of these youths to be underserved (for example, youth receiving outpatient services instead of FSP services). This has a direct effect on the frequency and quality of services we provide to the children/youth and their families.

- 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, has provided 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 Children's FSP children/youth and their families.

Age 16-25 (Transition Age Youth (TAY) services within the Children/Youth FSP:

The TAY services within the Children/Youth 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.

The TAY Program recently (November 2018) created "TAY Guest" services to increase access to services for youth who are currently unable to enter the program due to capacity issues (see "challenges or barriers" below). TAY Guest services allows these clients (who are being served by other youth or adult SYBH units) to participate in TAY activities and to experience the program prior to committing to the FSP. The intention is to increase access to program activities and to increase client retention for those that ultimately do enter the full TAY FSP program.

In Fiscal Year 2017/2018, 64 clients were served through TAY.
In Fiscal Year 2018 - November 30, 2018, 37 clients were served through TAY.

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 (MORS) is used to collect data on recovery progression. We are also using the Pediatric Symptom Checklist (PSC-35) and the (Child and Adolescent Needs and Strengths (CANS) assessment for youth aged 16-17. 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.

Current challenges or barriers within the TAY Program include:

- Despite the addition of a mental health therapist position in FY 2017-18 (which was helpful in allowing the program supervisor to oversee the entire TAY team and day-to-day function of the program), there continues to be more demand for services than capacity. There is a plan to expand the TAY program by utilizing an existing therapist position that is currently assigned to another Youth and Family Services unit to maintain a partial or full TAY caseload. This will allow us to move towards ensuring that caseloads are

aligned with FSP guidelines and to improve access for Transitional Age Youth.

- Aside from program expansion, it is critical that the two 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.

MHSA Youth Urgent Services:

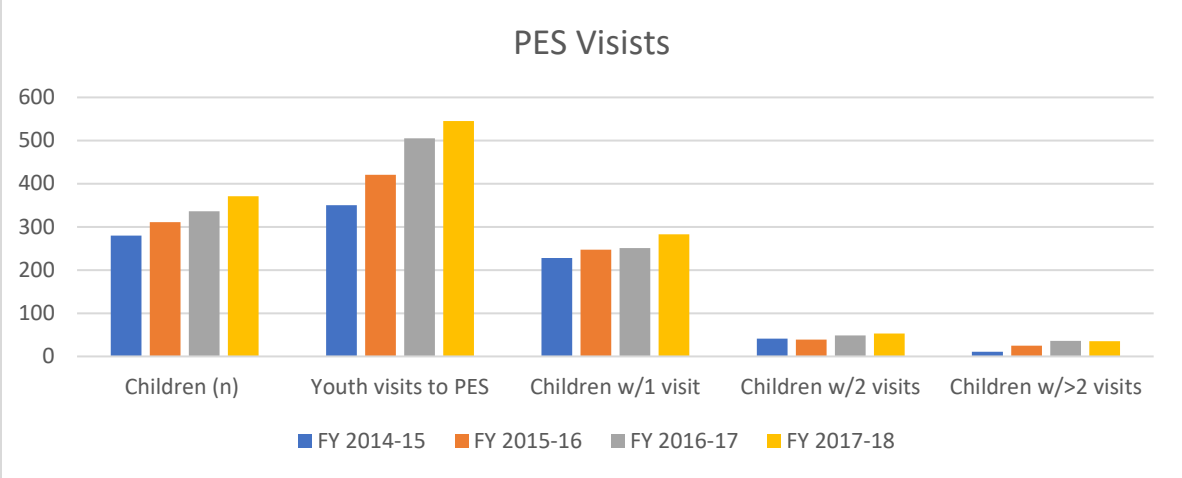
Urgent Youth Services provides expedited access to outpatient behavioral health services for youth who have been taken to Psychiatric Emergency Services (PES) experiencing suicidal ideation or homicidal ideation and are not hospitalized but are sent home with a safety plan in place. The program also 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 2017/2018: 78
- Total # Served for FY 18 - November 30, 2018: 24
- # of individuals who returned to PES within the reporting year (FY 2017-18): 24
- # of individuals served by the program who were subsequently hospitalized within the reporting year (FY 2017-18): 7

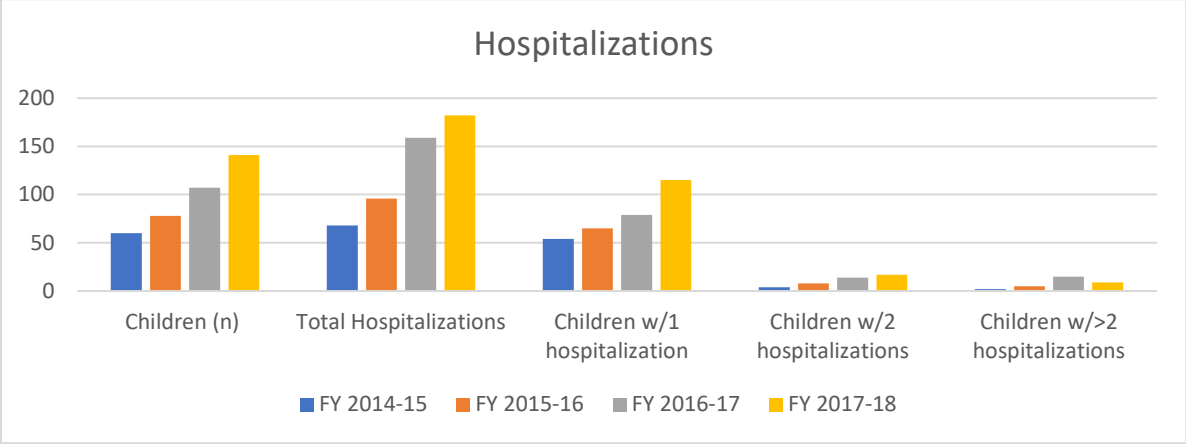
Current challenges or barriers within the Urgent Services Program include:
A significant challenge for the Urgent Youth Services program FY 17-18 was the increase in the number of children accessing services through our Psychiatric Emergency Services (PES) program and the increase in the number of children/youth who were psychiatrically hospitalized. Additionally, the retirement of our Intervention Counselor in April 2018 also added to the increase demand in addressing client needs. This person had been in this role since its inception and this position serves a unique and indispensable role on our team, collaborating with psychiatric hospitals to coordinate care and discharges for children/youth. We are transitioning an internal candidate into this role, but there will be a period of learning and adjustment associated with the complex duties of this new role.

No significant changes are requested at this time, the program is progressing as planned.

PES Visits	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Children (n)	280	311	336	371
Youth visits to PES	350	421	505	545
Children with 1 visit	228	247	251	283
Children with 2 visits	41	39	49	53
Children with > 2 visits	11	25	36	35



Hospitalizations	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Children (n)	60	78	107	141
Total Hospitalizations	68	96	159	182
Children with 1 hospitalization	54	65	79	115
Children with 2 hospitalizations	4	8	14	17
Children with >2 hospitalizations	2	5	15	9



ADULT FSP

The Adult/Older Adult FSP (also known as Healthy Options for Promoting Empowerment HOPE) 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 - Thursday 8am – 2pm at 1965 Live Oak Blvd. Yuba City CA, 95991.

In Fiscal Year 17-18, 34 clients were served through Adult/Older Adult FSP.
In Fiscal Year 2018 - November 30, 2018, 15 clients were served through Adult/Older Adult FSP.

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 provides peer staff, peer volunteers, and county providers; working 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.

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.

Current challenges and barriers within the Adult/Older Adult FSP:

- 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.

CSS- Non FSP Services (General System Development & Outreach & Engagement)

Urgent Services:

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 – Thursday 8am – 2pm. 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 2017/2018 there were a total of 1,567 sign-ins to Open Access Clinic (includes duplicates) and a total of 1,220 unduplicated clients. In Fiscal Year 18 - November 30, 2018, there were a total of 922 sign-ins to Open Access Clinic (includes duplicates) and a total of 501 unduplicated clients. A total of 699 triages were completed (includes duplicates). 353 completed intake/assessment (50% of clients seen completed intake assessments, up from the previous year's 31%). 412 individuals from Open Access Clinic were scheduled for standard psychiatric evaluations from Open Access Clinic and 96 clients were seen for urgent medication evaluations. A total of 1,276 outpatient therapy appointments were scheduled with the Urgent Services therapists.

No significant changes are requested at this time, the program is progressing as planned.

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.

The unduplicated count for those served in FY 2017/2018 was 66 individuals.
The unduplicated count for those served in FY 18 – November 30, 2018 was 50 individuals.

In FY 2017/2018, there were 4 outreach events which helped to inform and train 160 people on older adult mental health issues.

No significant changes are requested at this time, the program is progressing as planned.

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 2017/2018, there were 4 outreach events which served 193 unduplicated clients.
In FY 2018 – November 30, there was 1 outreach event which served 242 unduplicated clients.

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

Hmong Outreach Program:

The Hmong Outreach Center serves bilingual and Hmong-speaking only adults and families. 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.

In FY 2017/2018, the Hmong Program served 58 individuals and families.
In FY 2018 – November 30, 2018 the Hmong Program served 51 individuals and families.

No significant changes are requested at this time, the program is progressing as planned.

Latino Outreach Program:

The Latino Outreach Center serves bilingual and Spanish-speaking only adults, children and families. 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. There are no updates to the Latino Outreach Clinic, except for adding their Triage (Open Access Clinic) hours are Thursdays from 9am – 12pm. The address is 545 Garden Highway, Yuba City, CA. 95991. 530-674-1885.

In FY 2017/2018, the Latino Outreach Program served 222 unduplicated individuals.
In FY 2018 – November 30, 2018 the Latino Outreach Program served 190 unduplicated individuals.

Although no changes are necessary in Behavioral Health services/treatment to Latinos; we believe that there is a lot of misinformation about Mental Health in the Latinos Community and that stigma still prominent in the community. Continual dissemination of MH information through participation in community outreach events throughout the year and collaborating with other community agencies, health department, family resource centers, schools and important events for Latinos such as; Cinco de Mayo celebration, Dia de Los Muertos (Day of The Dead) celebration will be necessary.

No significant changes are requested at this time, the program is progressing as planned.

CSS Expansion Plan for FY 19/20

Existing CSS- Wellness Expansion

Peer Mentor Programs

- After putting out a Request for Bid (RFB) to two local Community Based Organizations (CBO), Youth for Change, was the only organization to submit their proposal. SYBH suggests contracting with YFC to take over the Peer Mentors Program. Currently, the Peer program is being contracted through Rush Personnel. However, Rush Personnel has not been in state compliance with running background checks. YFC will be able to handle all aspects of overseeing such a large program. We currently contract with YFC for our Youth programs through CSOC. Youth For Change will also offer our Peer Mentors an increase in salary in addition to fringe benefits in the form of medical and dental insurance, disability and retirement. This new contract with YFC is scheduled to begin at the start of the new Fiscal Year, 07/01/2019.

NEW CSS Program

Housing Program: New Haven Supportive Housing Program

SYBH will be partnering with Regional Housing Authority and Pacific West Communities during the development and construction of a 40-unit shared housing, housing-first model apartment complex.

Pacific West Communities and Regional Housing Authority will partner as codevelopers to apply for and oversee applications and finance commitment. Sutter- Yuba Behavioral Health will be the sole service provider for New Haven Court Permanent Supportive Housing Community (New Haven). Services will be accessed by Sutter and Yuba County's most vulnerable citizens – those experiencing chronic homelessness.

New Haven will provide a total of 20 NPLH units available for proactive, no-cost, on-site, case management and services as described in this plan. Similar to other housing first oriented projects, New Haven is a place where residents' lives can be enhanced and stabilized in a safe permanent supportive housing environment which allows other vital areas of their wellbeing such as health, life skills, and job training to be addressed.

Through the use of, No Place Like Home (NPLH) and MHSA Housing funds, SYBH will use its MHSA housing funds to assist in cost development. Yuba County will contribute $596,705 (total award amount) of its NPLH grant funds, Sutter County will contribute $500,000 (total award amount) of its NPLH grant funds. Additionally, SYBH will contribute $1,547,676 of its MHSA Housing funds, for a total of $2,644,381 of housing funds for the development costs at 448 Garden Highway, Yuba City. SYBH will also create 4.125 new FTE positions to provide services to the 20 NPLH units of the apartment complex which will be allocated to our target population of homeless individuals living in Sutter-Yuba County.

New positions include: Case Manager(s) 2 FTE, Therapist 1 FTE, Psychiatrist .125 FTE, SUDS Counselor .5 FTE, Medical Clerk .5 FTE.
The following Services will be provided for a minimum of 20 years by SYBH to its clients residing at New Haven Court: case management; Peer Support Activities; Mental Health Care, such as assessment, crisis counseling, individual and group therapy, and peer support groups; Substance use services, such as treatment, relapse prevention, and peer support groups; support in linking to physical health care, including access to routine and preventive health and dental care, medication management, and wellness services; benefits counseling and advocacy, including assistance in accessing SSI/SSP, enrolling in Medi-Cal; and basic housing retention skills (such as unit maintenance and upkeep, cooking, laundry, and money management) for an estimated cost of $450,000 annually to pay for these staff's salaries.

Yuba College:

SYBH plans to contact Yuba College to explore the concept of a potential partnership between Yuba College and SYBH. SYBH plans to increase its community outreach to inform the residents of Sutter and Yuba County, about Mental Health Services, while dispelling misconceptions of mental and behavioral health issues. Whether through career fairs, guest lectures, etc., SYBH plans to connect with Yuba College in order to increase our CSS component and PEI outreach.

SYBH would also like to present to Yuba College, the concept of working with them and their film department to create a Mental Health Awareness video; with the hopes it can be viewed by May 2019 Mental Health Awareness Month.

The intention for this project is to highlight cultural significances and challenges of addressing mental health issues in a rural community. Specifically, this project's aim would be on addressing mental health issues as they relate not only to the broader community but also, addressing misconceptions between cultural differences and challenges regarding addressing ones' mental and behavioral health.

MHSA Program Component
PREVENTION AND EARLY INTERVENTION (PEI)

The goal of the Prevention & Early Intervention (PEI) component of the MHSA is to help counties implement services that promote wellness, foster health, and prevent the suffering that can result from untreated mental illness. The PEI component requires collaboration with consumers and family members in the development of PEI projects and programs.

Prevention programs include outreach and education; efforts to increase access to underserved populations; improved linkage and referrals at the earliest possible onset of mental illness; and the reduction of stigma and discrimination. Early Intervention programs are intended to prevent mental illness from becoming severe and reduce the duration of untreated serious mental illness. Prevention involves increasing protective factors and diminishing an individual's risk factors for developing mental illness. By helping individuals cope with risk factors and develop stronger protective factors, mental health and wellness is improved.

Prevention and Early Intervention (PEI) programs receive 20% of MHSA funding.

Regulation Implementation Status:

Challenges: Our Prevention and Early Intervention Team has faced challenges in understanding the regulations regarding data collection and access/linkage strategies and DUMI measurements. SYBH has gone through several staff changes on our administration team, who provide support to the PEI staff. The MHSA Coordinator was on leave for 6+ months in 2017 and promoted while on leave; a new MHSA Coordinator was hired in April 2017 but did not pass probation. The current MHSA Coordinator was hired in May 2018.

The PEI demographics continued to be the most significant struggle in complying with the regulations. In the most recent webinar (March 2018), several questions were raised during the webinar regarding ethnicity, race, sex and sex identity; those questions raised more concern about the collection of demographic information, specifically in the Latino Community. We feel that more clarification on this issue needs to be provided to avoid confusion prior of collection the information.

Additionally, our prevention programs are not connected to our electronic health record. A PEI demographic database will need to be created and a process will need put in place for data input.

There is a significant training need for our PEI team. PEI staff are not clinicians and there is concern in asking individuals this potentially private information. PEI Staff will need to learn appropriate ways to asking these questions, as well as

appropriate responses to community concerns about the data that is being collected, especially on those under age 18.

As the PEI Program continues to grow, so too does the need for additional staff, to keep up with the additional work and increased outreach. The PEI Program is requesting through the use of PEI funds, to hire one peer mentor.

Future Actions for PEI Regulation Compliance:
Sutter and Yuba Counties are committed to comply with the regulations in a meaningful way to improve our PEI Services for our community. The PEI Team's next steps include:

- The PEI Team will continue to attend all PEI informative webinars and trainings;
- Collaborative meetings with our PEI Program, Administration, Psychiatric Emergency Services and Adult Services will be occurring to determine the plan for access and linkage tracking and the "DUMI" data collection.
- PEI staff will be exploring using the HIMS system for data collection, in addition to developing our own demographic database. Draft PEI Demographic forms have been created.
- The Program Manager for Community Services will be meeting with our contracted PEI contractors to begin developing plans for PEI data collection. Furthermore, the PEI contracts will be increased to account for the increased work associated with data collection and reporting.
- Current exploration of a contract or permanent position for PEI for data analytic support.

1. **Early Intervention Programs**

   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.

   1. FY 2017/2018 Provided Strengthening Families Training to 124 parents and children.

a) FY 18 – November 30, 2018 Provided Strengthening Families Training to 0 parents and children

ii. **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.

1. FY 2017/2018 Provided Aggression Replacement Training to 54 students.

a) FY 18 – November 30, 2018 Provided Aggression Replacement Training to 75 students.

2. <u>Outreach of Increasing Recognition of Early Signs of Mental Illness Program</u>

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 and Youth MHFA to our MHFA training offerings.

1. FY 2017/2018 Provided MHFA Training to 84 agency staff, community members, non-profit agencies and government agencies.

a) FY 2018 – November 30, 2018 Provided MHFA Training to 38 agency staff, community members, non-profit agencies and government agencies.

2. FY 2017/2018 Provided Spanish MHFA Training 0 community workers and Head Start workers

a) FY 2018 – November 30, 2018 Provided Spanish MHFA Training to 18 community workers and Head Start workers

3. FY 2017/2018 Provided Youth MHFA Training to 34 attendees.

a) FY 2018- November 30, 2018 Youth MHFA training was not provided.

4. FY 2017/2018 Provided Homeless Outreach Prevention to 96 community members.

a) FY 2018 – November 30, 2018 Provided Homeless Outreach Prevention to 84 community members.

5. FY 2017/2018 Provided Each Mind Matters Outreach to 964 community members.

a) FY 2018 – November 30, 2018 Provided 72 community members.

3. <u>Prevention Programs</u>

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.

1. **Community Education Trainings:**

a) **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.

i. FY 17-18 Spanish Nurtured Heart trained 345 parents/community members

i. FY 2018 - November 30, 2018 Spanish Nurtured Heart trained 147 parents/community members

ii. FY 17-18 English Nurtured Heart Training trained 300 parents/community members

i. FY 2018 – November 30, 2018 English Nurture Heart Training trained 47 parents/community member

b) FY 17-18 **The Traditional Healer Project** reached a total of 156 Hmong Community Members with outreach activities.

i. FY 2018 – November 30, 2018 **The Traditional Healer Project** reached 0 Hmong Community Members

2. **Girls' Circle** is a support and skill building group for middle and high school girls with weekly themed curriculum designed by One Circle Foundation. It is a strengths-based program recognized by the Substance Abuse and Mental Health Services Administration. It is designed to foster self-esteem, help girls maintain authentic connection with peers and adult women in their community, and allow for genuine self-expression through verbal sharing and creative activities. During the fall semester of the 2017-2018 school year, the PEI team was at five different schools providing the Girls' Circle curriculum to support the needs of the girls, counselors, and schools in our community: Live Oak High School, Live Oak Middle School, Marysville Community Day School, Marysville

High School, and Harry P. Carden School at Juvenile Hall and Camp Singer. Girls demonstrate their interest and commitment to the groups by returning each week and expressing interest in future participation, and counselors and administrations continue to request our return for this service. We plan to continue to collaborate with some of the schools we have been working with in the spring semester, as well as starting in some new schools. If you would like to learn more about Girls' Circle, please contact one of us to set-up a meeting to talk about curriculum and potential scheduling: 530-674-1885: Cynthia Martinez (ext. 111) or Kristen Batchelder (ext. 115).

a) FY 17-18 served 174 girls.

i. FY 18- November 2018 served 11 girls.

Other Prevention Programs offered throughout the year:

- **Second Step Bullying Prevention Program**: FY 17-18, 746 people engaged
  - FY 18 - November 2018, 1042 people engaged

- **Life Skills**: FY 17-18, 195 people trained.
  - FY 18 – November 2018, 141 people trained.

- **The Council for Boys and Young Men**: FY 17-18, 69 participants.
  - FY 18 – November 2018, 51 participants.

3. **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 $24,277.80 which reached approximately 88 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 17/18 Recreation Report, P.46 of the Appendix of this Three-Year Program Plan.

a) FY 17-18 88 local youth (65 Sutter County and 23 Yuba County) were served by the PEI Recreation Program.

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

a) FY 17-18 The Sutter County Mentorship has resulted in 22 matches.

b) The Camptonville Community Partnership is a mentor program through the school, 4H and other various activities and trainings. This partnership has provided outreach to 369 children and youth in the Yuba County foothills FY 17-18.

4. Suicide Prevention Program:

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 the programs are acting as access points, 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.

1. **Applied Suicide Intervention Skills Training (ASIST)** – FY 17-18 trained 82 agency staff and community members / FY 18- November 30, 2018 trained 32 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:

i. Sutter and Yuba County Probation
ii. Sutter Yuba Behavioral Health Services
iii. Sutter County Jail Staff
iv. Children Systems of Care
v. Yuba and Sutter County CPS
vi. Yuba County Health and Human Services
vii. Casa de Esperanza
viii. Rideout Hospital
ix. Beale Air Force Base
x. Pathways
xi. Yuba College
xii. Children's Hope FFA
xiii. Yuba County Jail
xiv. Casa De Esperanza
xv. Grace Source Family Resource Center
xvi. California National Guard Family Programs
xvii. Salvation Army Depot
xviii. Yuba County Office of Education
xix. Yuba City Unified School District
xx. Marysville Unified School District
xxi. Victor Community Support Services
xxii. Wheatland Elementary School District
xxiii. Live Oak Unified School District
xxiv. Nuestro Elementary School
xxv. California Tribal TANF Program

2. **Safe TALK** – FY 17-18 trained 116 partner agency and community members / FY 18 – November 30, 2018 trained 22 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:

i. Yuba Gardens Middle School
ii. Plumas Lake Elementary School District
iii. Grace Source Family Resource Center
iv. Wheatland Police Department
v. Yuba County Office of Education
vi. Bear River Family Resource Center

vii. Wheatland Union High School
viii. Beale AFB School Liaison Office

3. **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. FY 17-18 total youth trained 914 students, plus faculty and staff. FY 18- November 30, 2018 trained 1,145 students, plus faculty and staff.

4. **Signs of Suicide for Middle School Students** – 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. FY 17-18 total youth trained 1,017. FY 18- November 30, 2018 trained 524 students, plus faculty and staff.

5. **Knowing the Signs of Suicide** - Is also included in the signs of suicide for Middle School Students, FY17-18 contacted 304 students and FY 18 – Nov 30, 2018 contacted 148 students.

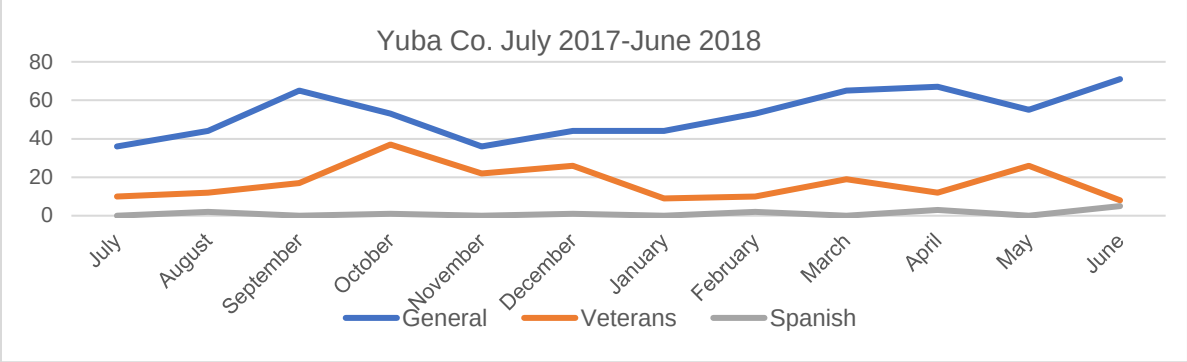
The following two table and graphs are the stats for the call data from CMAS for the knowing the Signs of Suicide website tracking for Sutter and Yuba County FY 17-18.

This spreadsheet shows call data provided by the National Suicide Prevention Lifeline (NSPL) of calls to the three NSPL numbers (General, Veterans and Spanish line) originating in Sutter-Yuba Counties, regardless of where those calls were answered. Only answered calls are included.

Please note that the Y axis (vertical line) varies from chart to chart, so use caution when comparing one year to another. Many factors can contribute to changes in call volume: increased help-seeking, changes in active promotion of the telephone numbers, greater stresses and strains in the community, high profile deaths, and other events. You are encouraged to interpret this data along with other information on suicide behavior and suicide prevention.

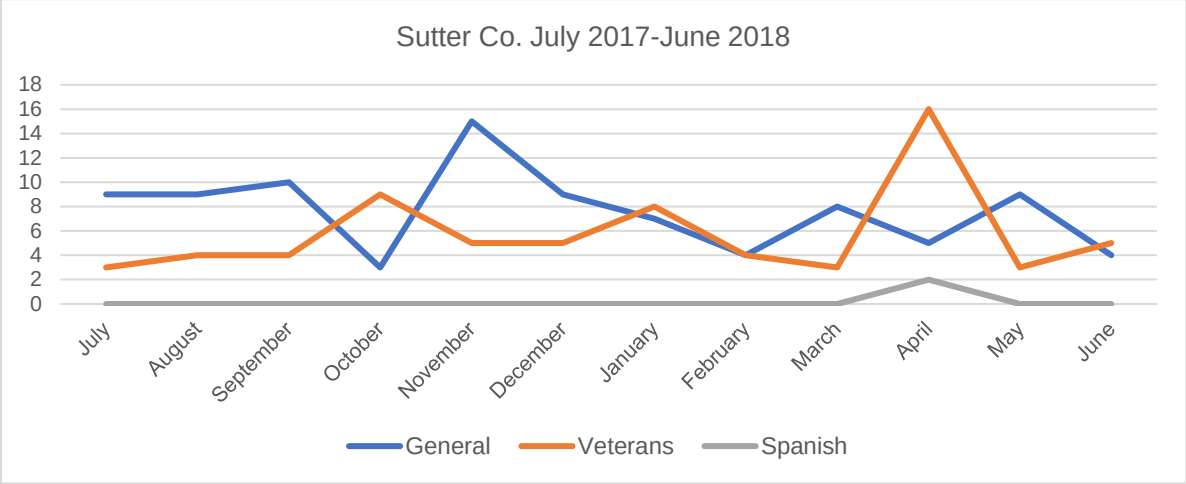
Yuba County

July 2017-June 2018	General	Veterans	Spanish	Total
July	36	10	0	46
August	44	12	2	58
September	65	17	0	82
October	53	37	1	91
November	36	22	0	58
December	44	26	1	71
January	44	9	0	53
February	53	10	2	65
March	65	19	0	84
April	67	12	3	82
May	55	26	0	81
June	71	8	5	84
	633	208	14	855



Sutter County

July 2017-June 2018	General	Veterans	Spanish	Total
July	9	3	0	12
August	9	4	0	13
September	10	4	0	14
October	3	9	0	12
November	15	5	0	20
December	9	5	0	14
January	7	8	0	15
February	4	4	0	8
March	8	3	0	11
April	5	16	2	23
May	9	3	0	12
June	4	5	0	9
	92	69	2	163



5. **Stigma Discrimination and Reduction Program**

   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 2017 - June 2018 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 222 people and provided a total of 1 referral for additional mental health services through the hotline services and 8 outreach/ support events during the past year.

   b. FY 17-18 **Promotores Project-** The Promotores Project is a new strategy recently launched by the PEI Program. The goal is to use a Promotora Peer Mentor to help improve access to services within behavioral health and other community resource for the local Latino community. Engaged a total of 52 Latino Community Members with outreach activities.

i. FY 2018 – November 30, 2018 Promotores Project – engaged 4 Latino Community Members.

6. **Access and Linkage Treatment Programs:**
   i. BEST Program Activities – Engaged 150 community members FY 17-18 and 0 community member FY 18- November 30,2018.
   ii. Ethnic Outreach Program Activities through the Hmong Center – FY 17-18 engaged 127 community members, FY 18 – November 30, 2018 engaged 78 community members.

MHSA Program Component
INNOVATION

MHSA Innovation Plan:

The MHSOAC controls funding approval for the Innovation (INN) component of MHSA. The goal of Innovation is to increase access to underserved groups, increase the quality of services, promote interagency collaboration and increase access to services. Counties select one or more goals and use those goals as the primary priority or priorities for their proposed Innovation plan.

Innovation (INN) programs receive 5% of MHSA funding.

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

A complete 48-page program evaluation and summary of Innovation Project 1 can be found in the Appendix of this MHSA Plan, p.1.

*****See AB 114 Spending Plan on Page 41 for a newly proposed Innovation Program.***

MHSA Program Component
WORKFORCE EDUCATION AND TRAINING

The goal of the Workforce Education & Training (WET) component is to develop a diverse workforce. Clients and families/caregivers are given training to help others by providing skills to promote wellness and other positive mental health outcomes, they are able to work collaboratively to deliver client-and family-driven services, provide outreach to unserved and underserved populations, as well as services that are linguistically and culturally competent and relevant, and include the viewpoints and expertise of clients and their families/caregivers.

Workforce Education and Training (WET) programs receive 10% of MHSA funding.

Sutter-Yuba Behavioral Health (SYBH) Workforce Education and Training (WET) Program provides 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. The contract with the California Institute for Behavioral Health Solutions (CIBHS) for the WET grant expired in 2018; there are currently no funds left for this program. CIBHS was previously the grant administer for these funds. CIBHS has offered to continue this service due to past relationship. However, the rate for this service comes at a cost. This cost could better be used to provide financial assistance to other employees who directly work within MHSA umbrella. SYBH is currently pursuing an option to offer in-house financial assistance to Behavioral Health employees. SYBH is pursuing an option to provide funding for other job training and educational opportunities with the use of MHSA WET Reverted funds – to be spent by June 30, 2020.

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.

<u>WET Financial Incentives: Tuition and Book Expense Reimbursement for Workforce Development</u>

Program pays 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.
The contract period for this program has ended and there are no longer funds available for this program.

Current implemented programs include:

Action Plan #1: **Public Mental Health Workforce Development- Evidence Based Practices and Skill Development**
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 addressed 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. SYBH plans to continue to expand this program. Allocating $10,000 from AB114 Reversion WET funds to the Vocational Training Program to use for staff development, to be spent by June 30, 2020.

Achievements:
FY 17/18 - Present

- CPR Training – 2 staff
- DBT Training – 3 staff
- A Strategic Approach to Tobacco Cessation for Substance Use and BH Agencies – 1 staff
- Sailing Through Change – 1 staff
- Supervisor Training Part 3, Performance Management Training – 1 staff
- WISE California 2018 Annual Conference – 4 staff
- Consumer Experience Training – 4 staff
- Sexual Harassment Training – 2 staff
- HIPPA Training – 1 staff
- Community Prevention Initiative Training (CPI) – 1 staff
- Shelter Training (American Red Cross) – 1 staff
- Nurtured Heart Approach CTI (Children's Success Foundation) – 1 staff
- Living Works Regional Summit (Living Works) – 1 staff
- Nurtured Heart Approach – 1 staff
- Mental Health First Aid (Adults) Certification – 2 staff
- Living Works Regional Trainer Summit – 1 staff
- YCOE Children's Summit: Issues & Implications – 1 staff
- Promotores Conference – 3 staff
- 2018 Bi – National Promotores Conference – 1 staff

- Latina Action Day – 2 staff
- Law and Ethic Training – 1 staff
- Mental Health & Aging Conference – 1 staff
- FNL Youth Summit – 4 staff
- Latinos Conference, CCAPP Conference – 1 staff
- Mental Health First Aid Training for Teachers – 1 staff
- Latino Conference – 1 staff
- FNL Leadership Training – 3 staff
- SUD's Conference – 1 staff
- Promotores VII Conferencia de Linderazgo para Mujeres en Sacramento – 1 staff
- FNL North State Youth Advocacy Summit in Yuba City – 1 staff
- 5th Annual Conference for Promotores in Woodland – 1 staff
- Binational Promotores Conference in Oakland – 1 staff
- Motivational Interviewing – 1 staff
- North State Youth Advocacy Summit – 1 staff
- Dialectical Behavioral Therapy Training – 1 staff
- CCAPP Multicultural Conference – 1 staff
- FNL LTI – 1 staff
- Assist Training – 1 staff
- Defensive Driving – 1 staff
- Non-Violent Crisis Intervention – 1 staff
- Transitioning to Brighter Futures: Serving transition age foster youth in the child welfare and probation systems – 5 staff

- 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. Employees and Peer Mentors are assigned at least 10 training hours annually from the Relias Training System.

MHSA Program Component
CAPITAL FACILITIES/TECHNOLOGY

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

Completion of the annual MHSA Revenue and Expenditure Report demonstrated that all MHSA funding dedicated to Capital Facilities and Technological Needs has been fully expended. Currently, there is not a plan in place for an Capital Facilities Technology programs.

Capital Facilities Technology (CFT) programs receive 10% of MHSA funding.

BUDGET

	MHSA Funding					
	CSS	**WET**	**CFTN**	**PEI**	**INN**	**Local Prudent Reserve**
A. Estimated FY 2019/20 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	$5,924,712	$268,809	$0	$4,100,630	$1,252,810	
2. Estimated New FY 2019/20 Funding	$6,015,000	$65,000		$1,520,000	$400,000	
3. Transfer in FY 2019/20						
4. Access Local Prudent Reserve in FY 2019/20						
5. Estimated Available Funding for FY 2019/20	$11,939,712	$333,809	$0	$5,620,630	$1,652,810	
B. Estimated FY 2019/20 Expenditures	$9,670,454	$329,759		$1,117,361	$0	
C. Estimated FY 2019/20 Contingency Funding	$2,269,258	$4,050	$0	$4,503,269	$1,652,810	

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, 2018	$521,836
2. Contributions to the Local Prudent Reserve in FY 2019/20	$0
3. Distributions from Local Prudent Reserve in FY 2019/20	$0
4. Estimated Local Prudent Reserve Balance on June 30, 2019	$521,836

The figures in the funding summary were released by California Department Health Care Services August 17, 2018; and represent our current MHSA Reversion Spending.

MHSA Funds Subject to Reversion by Fiscal Year by Component

Sutter-Yuba	CSS	PEI	INN	WET	CFTN	Total
FY 2005-06	$ -					$ -
FY 2006-07	$ -			$ 19,108		$ 19,108
FY 2007-08	$ -	$ -		$ 320,866	$ -	$ 320,866
FY 2008-09	$ -	$ -	$ 344,500			$ 344,500
FY 2009-10	$ -	$ 355,598	$ 344,500			$ 700,098
FY 2010-11	$ -	$ 101,047	$ 569,600			$ 670,647
FY 2011-12	$ -	$ -	$ 218,865			$ 218,865
FY 2012-13	$ -	$ 575,347	$ 98,413			$ 673,760
FY 2013-14	$ -	$ 251,172	$ -n			$ 251,172
FY 2014-15	$ -	$ 573,598	$ -			$ 573,598
Total	$ -	$ 1,856,763	$ 1,575,878	$ 339,974	$ -	$ 3,772,614

$ - No Funds Subject to
ARER expenditure data is not complete

Reversions by Year and MHSA Program

Sutter-Yuba Behavioral Health

Mental Health Services Act

Plan to Spend Reverted/Reallocated Prevention and Early Intervention, Innovation and Workforce Education Training Funds

The AB 114 Reversion Dollars were released were released August 17, 2018. The Spending Plan is based on the above budgets.

Pursuant to AB 114 (Chapter 38, Statues of 2017) and the Department of Health Care Services Information Notice 17-059, each County must prepare and publicly post a plan for MHSA funding subject to reversion from Fiscal Years 2005-06 through 2014-15.

Sutter-Yuba Counties have identified $1,856,763 of Prevention and Early Intervention (PEI) funds, $1,575,878 of Innovation (INN) funds, and $339,974 of Workforce Education Training (WET) funds that were subject to reversion as of July 1, 2017. These funds must be spent by 06/30/2020 or they will be reverted to State of California.

The following is a plan to spend these funds by June 30, 2020.

PEI:

Support Existing Approved Plans:

Expand existing PEI Contracts:

(Tri County Diversity, Camptonville, Sutter County Mentorship) to increase outreach efforts via our contracted partners and to support our contractors in their efforts to comply with the new PEI Regulations for outcome reporting. Support costs include but are not limited to technology needs, office supplies, outreach materials, training curriculum, transportation, and staff training.

Increase the amount of PEI offered Trainings and Expand Existing Programs:

<u>The Need:</u>

As the Bi-County Mental Health Plan for Sutter and Yuba Counties, SYBH is responsible for providing specialty mental health services (SMHS) to include community-based mental health and substance use disorder treatment programs for those who are underserved, unserved or inappropriately served. SYBH served 1,501 unduplicated individuals FY 17-18, through our outpatient and inpatient programs.

SYBH also receives Mental Health Service Act funding for community based mental health services. The Mental Health Services Act (MHSA) allocates a percentage of Mental Health Services Funding to counties for Prevention and Early Intervention (PEI) programs/activities that prevent mental illness from becoming severe and disabling and improve timely access for underserved populations. PEI programs also promote wellness, foster health, and prevent suffering that can result from untreated mental illness. Specifically, per California Welfare and Institutions Code (WIC) section 5840, PEI Programs are required to emphasize strategies that reduce negative outcomes that may result from untreated mental illness to include suicide, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness, and removal of children from their homes.

Over the last year, SYBH has recognized the need to develop a more robust and upstream approach to (PEI) services by increasing programs that engage, encourage, educate and facilitate learning for recognizing and responding effectively to early signs mental illness. Thus, SYBH is proposing to significantly increase community education through community training efforts utilizing universal and selective prevention activities in much greater numbers than past plans. Universal prevention activities are aimed at the general public or whole population group that have not been identified on the basis of individual risk and includes stigma reduction and suicide prevention activities. Selective prevention activities are aimed at individuals who may have an increased risk of developing behavioral health conditions. *Mrazek & Haggerty (1994) and Commonwealth of Australia (2000)*

Potential community members served through increased community education and outreach include, but are not limited to families, employers, behavioral, primary, specialty, and hospital health care providers, law enforcement, and school personnel. SYBH's increased community education efforts will include offering training activities focused on how to reach out to individuals with early signs and symptoms of a mental illness and promotion of activities that reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families.

Goal:

The primary goal for increasing community trainings is to expand the number of places in the community that easily accessible, community connected trainings are offered. Trainings offered will include, but may not be limited to the following, and focus on helping individuals and communities understand behavioral health concerns and link individuals and organizations together to best meet the needs of those with behavioral health conditions in Sutter and Yuba counties:

Mental Health First Aid© (MHFA) Mental Health First Aid© is a training course managed by the National Council for Behavioral Health. MHFA is described as an 8-hour course that teaches community members how to identify, understand, and respond to signs of mental illness and substance use disorders. The training gives participants the key skills needed to be able to reach out and provide initial help and support to someone who is developing a behavioral health problem or experiencing a behavioral health crisis. In addition to the training, it is standard practice to provide additional community resources and services information.

LEAP® ("Listen-Empathize-Agree-Partner®") shows you how to quickly gain the trust of someone you are at odds with. When you Listen – Empathize – Agree – Partner®, you stop trying to convince the other person that they're wrong, or simply misguided. Instead, you listen in a new way that conveys respect for the person's point of view and a complete lack of judgment. Sounds easy, but most people have a very hard time doing this simple thing. It is easy, once you learn LEAP®. And the result is an immediate lowering of tension, anger and defensiveness. As you convey genuine understanding, empathy and respect for his/her point of view, even when you disagree with it, you are free to find

common ground on which you can partner. And suddenly, your opinions and advice start to matter a great deal.

LEAP® focuses on transforming the relationship first. You do not win on the strength of your argument; you win on the strength of your relationship. With LEAP®, your opinions are no longer like a lot of hot air and are more like the wind in a sailboat's sails that moves the person where you want him—to safe harbors.

LEAP® is for any relationship, but it also gives you the tools you need to persuade someone in "denial" about mental illness to accept treatment and services.

The COACH Model
Engaging and empowering patients

COACH is the framework for how to build authentic healing relationships with patients that empower them to take control of their health. COACH is an acronym that describes the tools and techniques that care team members use to work with patients toward sustained behavior change and track progress in supporting patients to reach their goals.

COACH was designed for care management intervention for patients with complex health and social needs in Camden, New Jersey, but the tools and techniques it describes can be applied to behavior change interventions in a wide range of settings, in healthcare and in domains like education and social services. The COACH model was put into practice at the Camden Coalition in 2014, and was codified into a manual in 2016 with the help of the PolicyLab at the Children's Hospital of Philadelphia.

COACH stands for:

C: Connect tasks with vision and priorities
O: Observe the normal routine
A: Assume a coaching style
C: Create a backwards plan
H: Highlight progress with data

Applied Suicide Intervention Skills Training (ASIST)

Applied Suicide Intervention Skills Training (ASIST) is an evidence-based training course managed by Living Works Education. ASIST is a two-day interactive workshop in suicide first-aid. ASIST teaches diverse participants to recognize when someone may be at risk of suicide and work with them to create a plan that will support their immediate safety. ASIST can be learned and used by anyone. In the course of the two-day workshop, ASIST participants learn to: Understand the way personal and societal attitudes affect views on suicide and intervention, provide guidance and suicide first-aid to a person at risk in ways that meet their individual safety needs, identify the key elements of an effective suicide safety plan and the actions required to implement the plan, appreciate the value of improving and integrating suicide prevention resources in the community at large,

recognize other important aspects of suicide prevention including life promotion and self-care.

In addition to the above-mentioned trainings, we will also be investing PEI reversion funds in:

Increased School-based PEI projects/programs provide outreach and education to children, youth, families, and school staff to increase awareness of mental health issues and reduce stigma and discrimination, build resiliency and increase protective factors in children and youth, foster a positive school climate, prevent suicide, expand early mental health intervention services, provide professional development/training on mental health for those working with children and youth in schools, and support policies and practices that demonstrate that students' social/emotional health and competencies. Such programs are a primary part of the school's mission.

The School-Based Mental Health Prevention and Early Intervention Services Project will include a combination of prevention and intervention strategies that will work to empower families, reduce risk factors, build resiliency and strengthen culturally appropriate coping skills. Conditions associated with mental illness and poor school performance will be prevented and treated successfully through several effective research-based and school-based practices. School-based collaborative will be enhanced to provide parent education, individual and group counseling, crisis intervention, case management, community linkages, referrals, educational groups, screenings and early intervention, school-based services will also embrace youth development framework that promotes resiliency through supportive relationships and engaging and meaningful opportunities that foster a sense of physical and emotional safety. Peer-to-peer helping programs play a major role in reducing the alienation and disconnectedness many youths feel from their schools, families and society.

Positive Behavioral Interventions and Supports (PBIS) is a systems approach to increasing the success capacity of support staff, parent, and community efforts. PBIS includes practices that support students and families and uses data to guide decision making. PBIS teaches, models, reinforces, and monitors the development of pro-social behaviors for all students and their families. PBIS is a broad range of systemic and individualized strategies for achieving important social and learning outcomes while preventing mental illness, problem behavior and emotional distress. PBIS goal is to increase school's ability to educate all students, especially students with challenging social behaviors by establishing clearly defined outcomes that relate to the reduction of the incidence of mental illness, academic success and social-emotional resiliency. Preventing the development, future occurrences and worsening of emotional and behavioral problems is given top priority in all interventions. Interventions and practices will be research-based, and a full continuum of effective, efficient and relevant interventions will be utilized to support all students and their families. PBIS provides support along a continuum of need and intensity based on a three-tiered system: universal, targeted and individual.

The Need:

Violent deaths are of major public health concern in California that can both have immediate and long-term impacts on individuals, families and entire communities. Suicide and homicide are the second and third leading causes of death among adolescents and young adults ages 15-24 in California. In addition to the human tragedies associated with violent deaths, there are also tremendous economic costs. Based on only medical and work-loss costs, violent deaths result in estimated costs of $8.0 billion per year in California, with $4.9 billion of these costs due to suicides and $3.1 billion due to homicides. Effective prevention and interventions will require understanding of the full continuum of violence.

The Goal:

Provide effective School-Based Violence Prevention Education in our Sutter & Yuba County Schools to reduce school violence to help provide behavior modification & safety focused best practices.

Our Prevention & Early Intervention Program has used California Mental Health Services Act team to provide Technical assistance improving our ability to use social marketing, research and evaluation to provide a guideline to help us further our ability to use the Statewide PEI Projects in Sutter Yuba Counties. We are in our ninth year of providing Prevention and Early Intervention Services and need some additional technical support for our Each Mind Matters and Knowing the Signs of Suicide.

The Goal:

Sutter Yuba improve our capacity of use of social media educational prevention and improve our evaluation efforts of all our programs.

California MHSA serves California Counties and Cities in the dynamic delivery of mental health and supportive services. A nationally recognized leader, Cal MHSA inspires the service community through its commitment to results and values. Successful statewide and regional programs enable the voice of many to be heard.

The Statewide PEI Project is publicly known as Each Mind Matters: California's Mental Health Movement, which represents an umbrella name and vision to amplify individual efforts from the county and other organizations that are taking place across California under a united movement to reduce stigma and discrimination and prevent suicides.

Strategies of the Statewide PEI Project are guided by the approved by the Cal MHSA Board of Directors in December 2016. Current strategies include:

1. Social Marketing & Informational Resources
2. Utilize social change, social science and marketing concepts to change attitudes and behaviors regarding mental illness and accessing services

3. Disseminate an array of quality resource materials that are culturally responsive for California's diverse communities to increase awareness and knowledge of mental health, wellness and services
4. Provide outreach, engagement and technical assistance to counties, community-based organizations and other key partners to 1) access, refine, tailor and use materials, and 2) to achieve and ensure cultural relevant
5. Research, Evaluation and Surveillance
6. Carry out activities to improve understanding of suicide risk factors and population-level attitude change to verify stigma is being reduced and effective prevention and early intervention strategies across institutions and communities
7. Develop metrics for and collect data to evaluate the performance and outcomes of Statewide PEI Project activities
8. Measure results including both process and outcomes of all contracted activities.

Under these strategies, current activities and programs include:

- Maintaining and expanding public awareness and education campaigns
- Creating new outreach materials for diverse audiences
- Providing technical assistance and outreach to county agencies, schools and community-based organizations
- Providing mental health/stigma reduction trainings to diverse audiences
- Engaging youth through the Directing Change program
- Building the capacities of schools to address mental health, stigma reduction and suicide prevention

New PEI Activities:

Personnel Support:
Personnel costs for an additional contracted Peer Mentor for the PEI Program to support all of the already-approved PEI programs.
Hire two additional Intervention 1 Counselors to continue to assist with all PEI approved programs.
Exploration and possible funding of a program analyst or contract consultant for PEI data collection and analysis

New Proposed Prevention Program:

Regional Homeless Outreach Team

It also proposed that Prevention and Early Intervention (PEI) funding be used in support of efforts to create a regional outreach team that will connect homeless individuals with

needed healthcare, social services, and housing resources. While other current SYBH efforts to work with our homeless population have emphasized identifying and serving homeless individuals with already existing behavioral health problems, this project is focused on prevention.

Over the past two years there has been a significant push to more adequately address the issue of homelessness in the counties of Sutter and Yuba. With this increased focus on addressing the needs of the homeless population there has also been an increased need for the two counties to coordinate efforts to address homelessness using a regional approach to both supportive outreach and to law enforcement and code enforcement. Yuba City, the largest metro area in Sutter County, and Marysville, the largest metro area in Yuba County, are in effect one metropolitan area divided in two by a river. Because of this unique geographical layout, there are no less than four governing jurisdictions involved in providing support and enforcement in close proximity: Yuba City, Marysville, Sutter County, and Yuba County.

Officials on both sides of the river have recognized the need for a regional approach that emphasizes communication, collaboration, and unity in addressing the problems associated with homelessness. This has led to the creation of a regularly held Bi-County Homeless Services meeting which is attended by the CAOs of both counties, Supervisors from Sutter County and Yuba County, City Council members from Yuba City and Marysville, in addition to representatives from local non-profits and other agencies working to address the homeless issue. One result of this regional effort has been the creation of a committee tasked with creating a Regional Homeless Outreach and Enforcement team. A key focus of this team will be that enforcement of homeless ordinances must be preceded by providing adequate support and assistance. The team will work to identify and reach out to homeless individuals in the region and link them with a broad range of needed services ranging from healthcare to laundry to housing and beyond, prior to enforcement actions being taken.

The outreach and support provided by the Regional Outreach and Enforcement Team to homeless community members will play a role in preventing the development of behavioral health conditions, as well as identifying and providing early intervention to those susceptible to developing behavioral health and substance use disorders. The Team will consist of an outreach worker (a non-profit community partner), a behavioral health intervention counselor, a peer mentor/advocate, and a law enforcement partner. This team will use a whole-person approach to identify needs of the individuals they contact and will direct them to whatever resources are needed to improve their health, safety, and living conditions.

It is proposed that PEI funds will be used to pay for one full-time intervention counselor and one half-time peer mentor/advocate to participate on the team. The other positions (outreach worker and law enforcement partner) will be funded separately through other funding channels. The role of the intervention counselor will be to provide general support, connection to community resources, and linkage to behavioral health or social services when appropriate. The intervention counselor will also be the team leader in

the field. The peer mentor/advocate will be an individual with lived experience with homelessness who will provide peer-based support and advocacy to the individuals served. The intervention counselor and peer mentor/advocate will work in unity with the other team members to prevent development and exacerbation of behavioral health issues in the homeless population by addressing issues such as meeting basic needs, accessing health care, and finding housing

New Proposed Prevention Program:

Peer Resource Engagement Program (PREP)

The Need:

Yuba County has 41 schools, including 2 private schools.

Yuba County High Schools:

Camptonville Academy
Harry PB Carden
Lincoln - Abraham Alternative
Lindhust High School
Marysville Charter Academy for Arts
Marysville Community Day
Marysville High School
North Marysville Continuation High School
South Lindhurst Continuation High School
Thomas E. Maws Community High School
Wheatland Community Day High School
Wheatland Union High School
Yuba County Career Preparatory Charter
Yuba County Special Education

Sutter County has 43 schools, including 5 private schools.

Sutter County High Schools:

Albert Powell Continuation High School
Butte View High School
California Prep Sutter 8-12
East Nicolaus High School
Feather River Academy
Live Oak Alternative
Live Oak High School
River Valley High School
Sutter County Special Education
Sutter High School
Three Rivers High (Continuation School)
Tri-County ROP High School
Valley Oak Continuation High School
Yuba City Charter
Yuba City High School
Yuba City Independence Academy

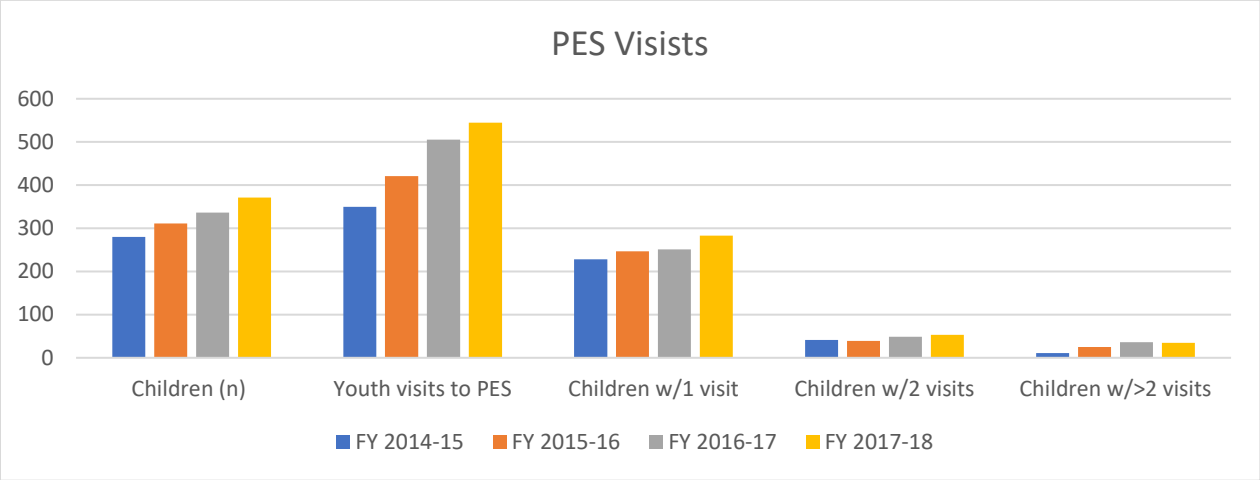
Per Kidsdata.org, there were 38,309 students in 2018 who attended public school in either Sutter or Yuba County. In 2018, Sutter County had 23,690 students enrolled in public schools, k-12. In 2018, Yuba County had 14,619 students enrolled in public schools, k-12. These numbers do not reflect school-aged youth not enrolled in school, attending private schools, or, who live in Sutter or Yuba Counties but attend school outside of the two counties.

The need to create a Peer Resource Engagement Program (PREP) came from the existing environment. Recently Sutter and Yuba Counties have seen an

increase in youth Mental Health disorders, including first episode behavioral health issues and substance use. Sutter-Yuba Behavioral Health - Urgent Youth Services currently 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.

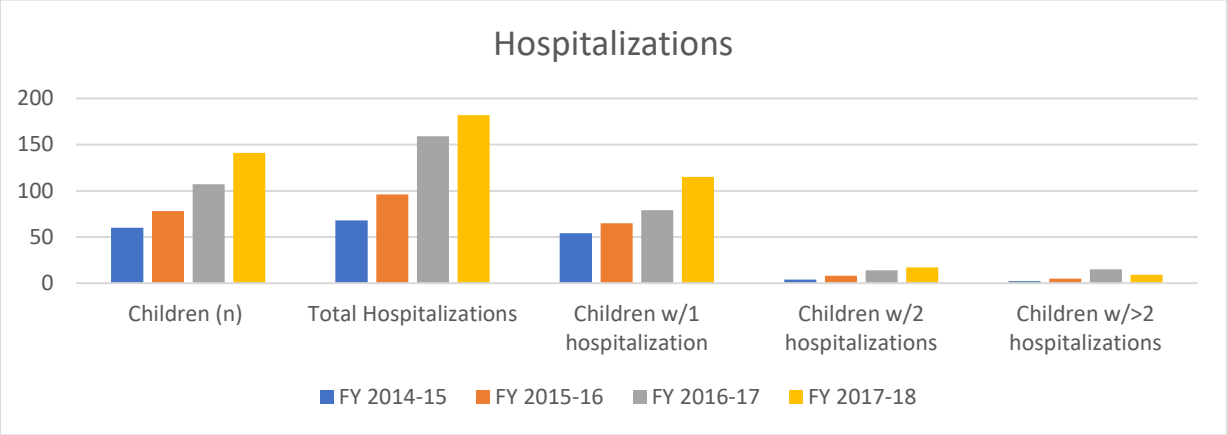
Data for Youth Psychiatric Emergency Services (PES):

PES Visits	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Children (n)	280	311	336	371
Youth visits to PES	350	421	505	545
Children with 1 visit	228	247	251	283
Children with 2 visits	41	39	49	53
Children with > 2 visits	11	25	36	35



Data for Youth Hospitalizations:

Hospitalizations	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Children (n)	60	78	107	141
Total Hospitalizations	68	96	159	182
Children with 1 hospitalization	54	65	79	115
Children with 2 hospitalizations	4	8	14	17
Children with >2 hospitalizations	2	5	15	9



The above data reflects SYBH's increase in youth accessing crisis or urgent mental health services. Additionally, the number of return visits and rehospitalizations for youth as detailed in this proposal are thought to be significantly under reported. SYBH is in the process of examining data definitions related to crisis/urgent services and will include updated information in future reports.

The proposed PEI plan will contract out a new program, the Peer Resource Engagement Program (PREP) to a local Community Based Organization (CBO), to create a peer built and run Prevention and Early Intervention team, which will be comprised of high school students. The Peer lead team will be built around the idea that High School students understand the social and emotional stressors their peers are currently challenged with and can provide a safe space to discuss, address and examine stressors and issues youth are faced with, in addition to providing engaging activities and food. Each peer who is hired to work for PREP will receive certification training in either Mental Health First Aid and, or, LEAP (Listen – Empathize – Agree – Partner). Programs will be supervised by the CBO, after a SYBH submits a Request for Bid to local community partners.

The (PREP) will create a safe environment for the 38,309 youth (23% of the Bi-County population) living in either Yuba or Sutter Counties. PREP's mission should focus on engaging youth to foster a broader sense of community, this can be witnessed through youth getting the chance to meet and connect with other youth living in the larger Bi-County region. Often youth in the Bi-Counties only interact with kids in their immediate communities, which creates feelings of isolation and separation.

Goal of PREP:

According to youth.gov, the US government website that helps create, maintain and strengthen effective youth programs, mental health promotion and prevention are at the core of a public health approach to children and youth mental health which addresses the mental health of all children, focusing on the balance of optimizing positive mental health as well as preventing and treating mental health problems.
Additionally, school-based mental health is becoming a vital part of student support systems. Schools are a natural setting for supporting mental health, and studies have shown the value of school programs that add to a student's ability to achieve academically, offer experiences that build social skills, leadership, self-awareness, and create caring connections to adults in schools and communities.

Often youth may be having a problem with: a parent, a peer, a sibling, a school administrator, stress of: work, school, home life, or, any number of other stressors which contribute to feelings of being overwhelmed, suicide, depression, anger, anxiety, or, other health concern.

Through partnership with local schools, PREP is intended to incorporate mental health promotional activities in schools and the local community that engage youth within their communities, schools, organizations, peer groups and families in a manner that recognizes, utilizes, and enhances youth strengths. The PREP program would offer opportunities for youth to foster positive relationships with peers and promote protective factors that create an openness among youth to access behavioral health services before they experience a psychiatric crisis. The cultivation of support in a safe environment for youth to meet and be with other youth will create a positive and safe space for young boys and girls to be in, free from drugs and alcohol. A pop-up style of youth lead and run events will create excitement and anticipation of building interest in participating in "exclusive" events that will be offered in different locations in the two counties bi-weekly. PREP activities and programs would be planned with, by and for students with a significant focus on student voices and opinions.

The aim of this program is to offer bi-weekly pop-up style Peer run and lead support groups which will offer food and activities youth can engage in as part of relationship building with youth within the larger Bi-County area. To have to largest impact on the community, youth should be recruited and hired as part-time employees to offer these services on a rotating location basis (pop-up), which should also be offered in our unincorporated (rural) towns. After using AB 114 dollars will be used first before using PEI program money to financially support this program.

Innovation:

New Proposed Innovation Project:

Project Name: SYBH Innovative and Consistent Application of Resources and Engagement (iCARE)
Based on the successful Innovation project in San Bernardino County, Department of Behavioral Health, Recovery Based Engagement Support Teams (RBEST), SYBH would like to implement a rural bi-county setting, a mobile engagement team focused on the

unique needs of northern counties, specifically, engagement of individuals caught in the crisis system of care cycle for which law enforcement may be called, are unengaged in non-crisis, non-emergency community based care, with co-occurring disorders. While the San Bernardino project utilizes a non-clinical engagement strategy called the Leap Model by Xavier Amador, learning from San Bernardino does not identify if this engagement approach works for individuals with co-occurring disorders. Additional research on engagement approaches will be completed and detailed in additional information submitted to the Mental Health Oversight and Accountability Commission detailing the project. The goal of the innovative project would be to allow SYBH staff to respond to individuals engaged mainly in crisis or inpatient systems of care as a majority of their care with a flexible, non-clinical, mobile, field-based approach to include responding with law enforcement, in client homes, emergency rooms or other community settings as appropriate. To be more specific, this approach would not be a case management approach, but rather an engagement approach and would include chronic 911 callers that aren't engaged with the public mental health system, but have chronic behavioral health needs.

The goal of the program would be to work with individuals prior to the need for crisis services, or upon stabilization to engage them in available outpatient care effectively. In some cases, this may mean numerous contacts with the client before they are ready to engage in treatment. As the behavioral health system is currently built to engage with individuals ready to engage in available treatment, the engagement model would focus on safely working with individuals not ready to engage with available treatment. In some cases, this will mean that the engagement team will have to bend or compel the current behavioral health system to meet the client's needs in different ways. The engagement team will be a multi-disciplinary team with strong peer leadership, alcohol and drug counselors, nursing and behavioral health clinicians with training in working with individuals with criminal justice backgrounds. The engagement team will also aim services at the clients support systems and or loved ones, seeking to increase the client's natural supports long term through therapy, education and family support for family members or care givers living with loved ones suffering from chronic, persistent and disruptive behavioral health conditions.

Learning Goals:
Will having a flexible, mobile engagement team assist clients in a non-clinical approach who largely access crisis services only, and have co-occurring conditions, to change ingrained service access patterns and engage in non-crisis, community-based outpatient systems of care? I.e., will crisis, emergency, and inpatient services go down and outpatient therapy, outpatient alcohol and drug counseling, residential treatment, collateral and or medication support services go up?

Will engagement with community support systems such as law enforcement, emergency medical response, and the local emergency room go down, and engagement in behavioral health services, to include substance use disorder treatment go up?

Will there be a reduction in the 5150's brought to the ED over a four-year period?

Will family members and care givers who ordinarily don't know much about chronic behavioral health conditions increase their knowledge of coping skills, support strategies and understanding about how to support their loved ones accessing the public mental health system, and increase their support of their love one?

Innovation: The selected category is: makes a change to an existing practice in in the field of mental health. This is a change to an existing innovative practice in applying it in a rural setting, and changing the actual concepts to fit the needs of rural counties to effectively engage individuals through a non-clinical approach for individuals with co-occurring conditions. While this project will address the major mental health diagnosis, learning will be focused on integrated care that encompasses the substance use disorders and affiliated treatment systems.

Target Population: The target population of this innovation project are individuals with co-occurring disorders that access as their main mode of treatment, services in crisis or inpatient systems of care, may have been in jail prior to AB 109 or have criminal justice backgrounds, and remain unengaged in available non-crisis, non-emergency services.

Estimated Project Length: This is proposed as a five-year project, with an estimated budget of $5,228,688 (including reverted INN funds per AB114 and 19/20 allocation).

Workforce Education and Training:

Action Plan #1: **Vocational Training Program**
Sutter-Yuba Behavioral Health plans to use WET Reversion spending to pay for our Vocational Training Program, that is currently being paid for through MHSA's CSS.

This plan will allow the current CSS money to be used to contract with Youth For Change for our Peer Mentor Program and use the WET Reversion dollars before they revert back to State of California.

To spend the Reverted WET funds - $339,974 by 6/30/2020 deadline, Sutter-Yuba will use a portion to pay for Vocational Training Program - $40,000, which may increase possibly to $65,000 if we expand this current program, that is currently being paid for from CSS, but classifies as Workforce Education Training.

Action Plan #2: **Tuition Reimbursement**
SYBH will be exploring options to create an in-house program to provide tuition re-imbursement and loan assumption to MHSA employees instead of contracting out for this. This will allow SYBH to save money when using its own MHSA funds for this program. Sutter-Yuba Behavioral Health plans to use $60,000 from AB114 Reversion WET funds to this program, to be spent by June 30, 2020.

Action Plan #3: **Vicarious Trauma and Compassion Fatigue for Behavioral Health Providers/Staff**

The SYBH psychiatric emergency services (PES) and Psychiatric Health Facility programs operate 24/7, 365 days a week, serving over 2,250 individuals annually. Compassion Fatigue training for behavioral health staff responding to psychiatric emergencies in the community is essential to ensure high-quality behavioral health services are provided to individuals served by SYBH and living with chronic behavioral health conditions. Staff training will focus on the following topics below and enhance clinical skill building that results in recovery, wellness and resilience for individuals served. This training is being assessed to be offered either bi-annually, or annually for PES/PHF emergency responders and is focused on resilience and trauma recovery, assessing and promoting resilience, trauma and vicarious trauma.

The Headington Institute, which specializes in providing training to crisis workers world-wide; would train, up to 90 staff.

Psychiatric Emergency Services (Crisis):
1 Clinical Program Manager
4 Mental Health Therapists (This includes this supervisor, we are in the process of recruiting additional therapists and may have 3 additional when the training occurs)
19 Crisis Counselors (Bachelor level with MH experience or Master's level staff)
10 Mental Health Workers (High School Diploma or equivalent and two-years-experience with MH population)

Psychiatric Health Facility:
1 Clinical Program Manager
3 Mental Health Therapists
4 Registered Nurses
12 Licensed Vocational Nurses/Licensed Psychiatric Technicians
29 Mental Health Workers

Additionally, all our Forensics Staff (except for one) provide coverage in PES or on the PHF.
1 Mental Health Therapist (Supervisor)
5 Forensic Mental Health Specialists (Master's level, licensed staff)
1 Intervention Counselor (Bachelor level)

Action Plan #4: **Training Opportunities**

SYBH Staff will be attending Leadership Institute Trainings, and other trainings for Trauma – Informed Care.

SYBH also plans to allocate the remaining $200,000 AB114 Reversion WET funds for PES staff training, to be spent by June 30, 2020.

APPENDIX:

Final Innovative Project Report

Prevention & Early Intervention Recreation Scholarship Program

Sign in Sheets March 12,13, and 14, 2019:

Public Comments Received During Public Comment Period

Sutter-Yuba Behavioral Health

Final Innovative Project Report

AB 109 - Probation Innovation Project Summary

Author: Peter Sullivan, M.B.A.
Mental Health Services Act – Coordinator

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Introduction

The Mental Health Services Act (MHSA) was a voter initiative passed in November of 2004. Under this initiative, individuals with incomes in excess of one million dollars per year are levied an additional 1% income tax to pay for expanded mental health services statewide. Sutter-Yuba Behavioral Health (SYBH) currently receives funding for MHSA Community Services and Supports, Prevention and Early Intervention, Workforce Education and Training, Capital Facilities/Information Technology, and Innovation.

The Mental Health Services Oversight and Accountability Commission approved the SYBH INN Plan on October 24, 2013. The following report provides a complete analysis and review of the approved Innovative project, including outcomes, findings, shortcomings of data gathering and suggestions moving forward.

Background

The SYBH INN Plan 001 is formally titled, “Improving Mental Health Outcome Via Interagency Collaboration and Service Delivery Learning for Supervised Offenders Who Are At-Risk of Or Have Serious Mental Illness”. It is nicknamed the “Probation INN Project” and will hereafter be referred to by its project nickname. The designed purpose of the Probation INN Project is to increase the quality of services, including improved outcomes and to promote interagency collaboration. The project satisfied the MHSA Innovation guidelines, in that it applies a new way of learning about the best way to provide a service to an underserved population.

SYBH is the only bi-county mental health agency in California, this unique structure has enabled the agency to work in a collaborative model with Sutter County Probation and Yuba County Probation to determine best local practices when trying to improve recovery and reduce recidivism in the close communities of Yuba and Sutter Counties.

Historically, in the communities, there have been poor outcomes and disconnected service delivery approaches for these underserved populations, therefore we want to measure the effectiveness of Sutter County Probation's approach to supervised offenders with the introduction of dedicated mental health clinician time and effectiveness of Yuba County Probation's approach to supervised offenders with the introduction of dedicated mental health clinician time.

The Probation Innovation Project, became operational February 1, 2015. This project's aim is to improve mental health outcomes via interagency collaboration and service delivery learning for supervised offenders who are at-risk of or have serious mental illness. The innovation project applies existing mental health approached 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). Challenges included but were not limited to staffing shortages. Identical outcome measures from each setting/county were analyzed to determine which approach SYBH should further employ to consistently offer quality services, including improved outcomes for AB109 supervised offenders and other supervised offenders.

Funding

SYBH received funding through Mental Health Services Act to establish Innovation (INN) Projects through a community planning process that is inclusive and representative of unserved, underserved, and inappropriately served individuals. INN Projects are creative, novel, and ingenious mental health practices/approaches that make changes to existing mental health practices or approaches, including, but not limited to, adaption for new settings or communities. INN projects must address one of the following as its primary purpose: (1) increase access to underserved groups (2) increase the quality of services, including measurable outcomes (3) promote interagency and community collaborations and (4) increase access to services.

Specifically, the INN Probation Plan three-year budget provides for the salary and benefit costs for two Mental Health Therapists and the project evaluation activities. The total three-year budget was $605,

SYBH INN Plan 001- Probation

The Innovation project 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 different county settings: Community-Based Setting and Institution-Based Setting. Identical outcome measures from each setting/county will be analyzed to see if there is an approach that SYBH should recommend to the Probation Departments to consistently implement.

Consistent to the innovation guidelines, this dual-county research of applying mental health approaches to a new population in new settings has never been tried.

Sutter County Probation and Yuba County Probation will each be provided mental health clinician time that is strictly dedicated to the probation population; this in itself is not a new mental health approach, but what is innovative is the evaluation. Each county will be launching a different service approach in an effort to see the effectiveness of the different strategies directed at the AB109 offenders and other supervised offenders. The mental health clinician assigned to Sutter County Probation will be embedded into an existing multi-disciplinary probation team and the clinician will be providing mental health assessments, post-release recovery plans and supports, and connections to ancillary services prior to inmate release. This setting allows services to be targeted at the supervised offenders upon release. The mental health clinician assigned to Yuba County Probation will be conducting mental health assessments, post-release recovery plans and supports, and connections to ancillary services following their release back into the community in a community-based effort.

Evaluation Design

The evaluation plan for the Probation INN Project includes both quantitative and qualitative elements. The overarching research hypothesis will test if the timing of client engagement is a predictor for improved mental health functioning and for reduced recidivism. Individual factors will be looked at as potential predictors for success, as well as system level factors.

Innovation Learning Goal/Question/Expectations

Innovation Goal 1: Increase the quality of services, including improved outcomes for the Sutter-Yuba area AB109 offenders and other supervised offenders.

Learning Question: Should Sutter-Yuba Behavioral Health use a community-based approach or an institution-based approach when providing mental health/dual diagnoses services to the AB 109 and other supervised offenders.

Expected Outcome: The mental health/dual diagnosis outcomes and recidivism outcomes from each county's service strategy will show Sutter-Yuba Behavioral Health which strategy should be recommended Innovation Goal 2: Promote interagency collaboration.

Learning Question: Does this model of collaborating with partner counties and organizations to plan, implement and evaluate different strategies to determine the most effective strategy when delivering services promote collaboration, deepen learning and create stronger working relationships?

Expected Outcome: Interagency collaboration allows for stronger relations with Sutter-Yuba Behavioral Health and their county partners, in addition to collaboration efforts improving Sutter-Yuba Behavioral Health's capacity to better serve mental health clients.

Project Outcomes

The following report section details the project measurement tools and the year outcomes.

Project Measurement Tools Overview

The primary project measurement tools include:

Milestones of Recovery Scale (MORS)

Level of Care Utilization System (LOCUS)

Level of Care Utilization System Level (LOCUS Level)

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

University of Rhode Island Change Assessment (URICA)

STRONG/Noble

Recidivism

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 SYBH, Yuba County Probation, and Sutter County Probation and the INN Team to measure our interagency collaboration; the three agencies worked together on this project. The PARTNER Tool is used to analyze 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 project partners before project implementation and will be continually administered at the start of every project year.

Probation Assessment Tool: STRONG and Noble

The Static Risk Offender Needs Guide (STRONG) is an evidence-based risk and needs assessment and supervision planning system for adult offenders. The instrument produces scores for static risk factors classifying offenders into five risk categories:

1. High Risk Violent
2. High Risk Property
3. High Risk Drug
4. Moderate Risk
5. Low Risk

Static Risk factors are not necessarily amenable to short-term intervention; but, are reported to be moderately predictive of potential for recidivism. Identification of Static Risk adds weight to appropriate allocation of services focused on the mitigation of dynamic risk factors. The Needs Assessment portion of this instrument allows for greater information gathering to be used in the identification of top criminogenic needs for case planning purposes.

In December 2015, both the Sutter and Yuba Probation Departments ended their contracts with the vendor that provided the STRONG Assessment. They both contracted with NOBLE to provide

new probation assessment tools. In May 2016, the Probation Departments finalized implementation of Noble and began obtaining baseline data for this project in May 2016.

Noble similarly provides 1) a Static Risk Assessment based on offender demographics and criminal history and 2) a Needs Assessment that allows for greater information gathering to be used in the identification of top criminogenic needs for case planning purposes.

Recidivism

The INN Team determined that the definition for recidivism for the purposes of this project is the following: Recidivism: A subsequent criminal conviction (felony/misdemeanor) while on supervision.

Admission and Discharges

To be eligible for the services with an Innovation Therapist, individuals must have been referred for a Probation Assessment based on their STRONG (Static Risk and Offender Needs Guide)/ or NOBLE Assessment. STRONG and NOBLE Assessments are county Probation Assessments which determine whether a client would be a good candidate for participating in the Probation INN Project. Mental health must have been identified as one of the top 3 needs for a project referral. Following this, the clinician will meet with the client and complete an intake assessment. If the clinician determines the individual did not meet medical necessity, contact will be made with the supervisor and probation officer to determine what community resources will be appropriate for referral.

Intake Data Analysis- MORS, URICA, LOCUS Analysis –

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.

Each county has a separate flowchart that guides the intake process and data collection schedule that becomes active after it is determined that the individual meets criteria. On the next 2 pages, you will find a Referral Flow Chart for Sutter County Probation and Yuba County Probation.

Exhibit 1 – AB109 Flowchart

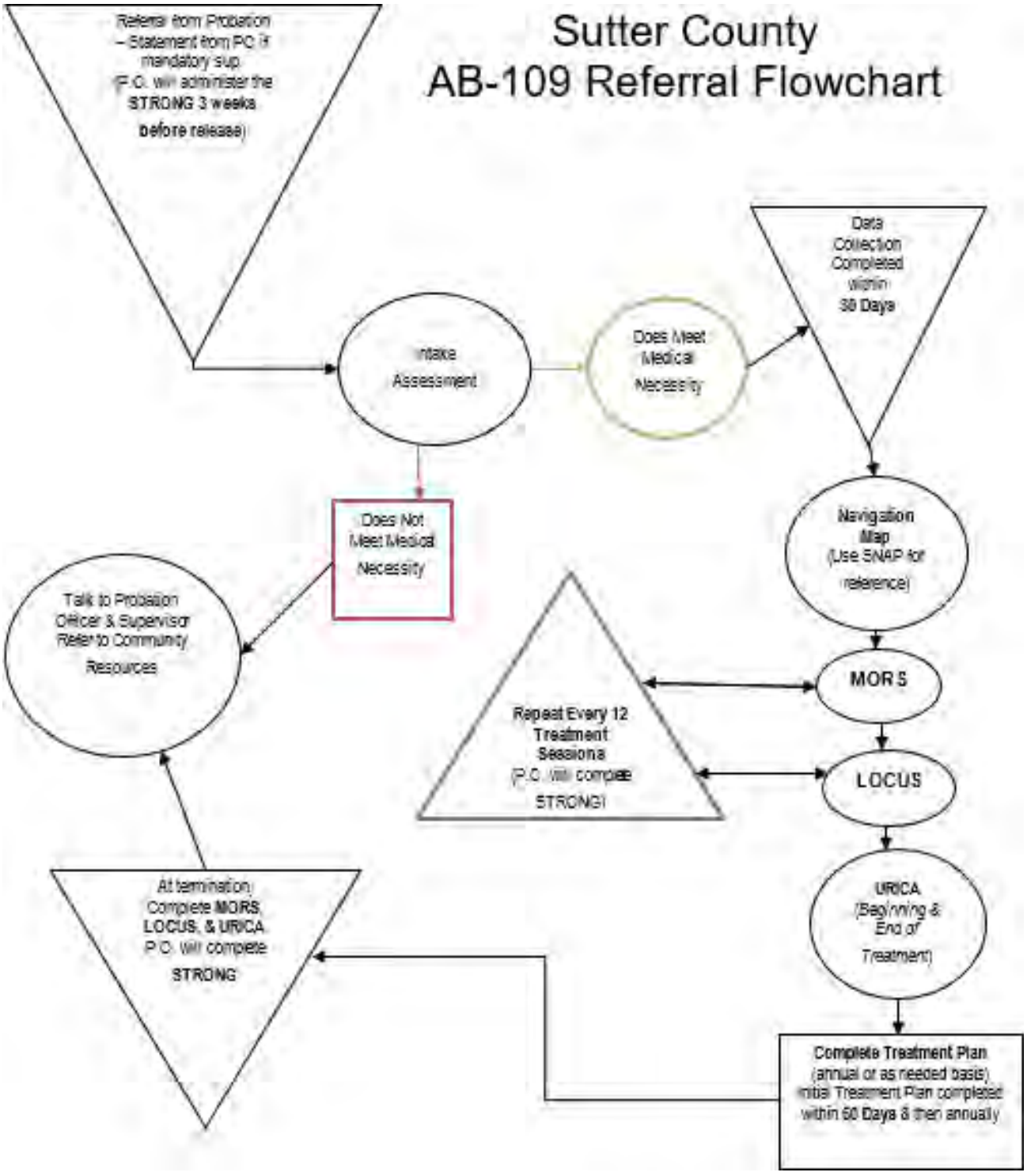
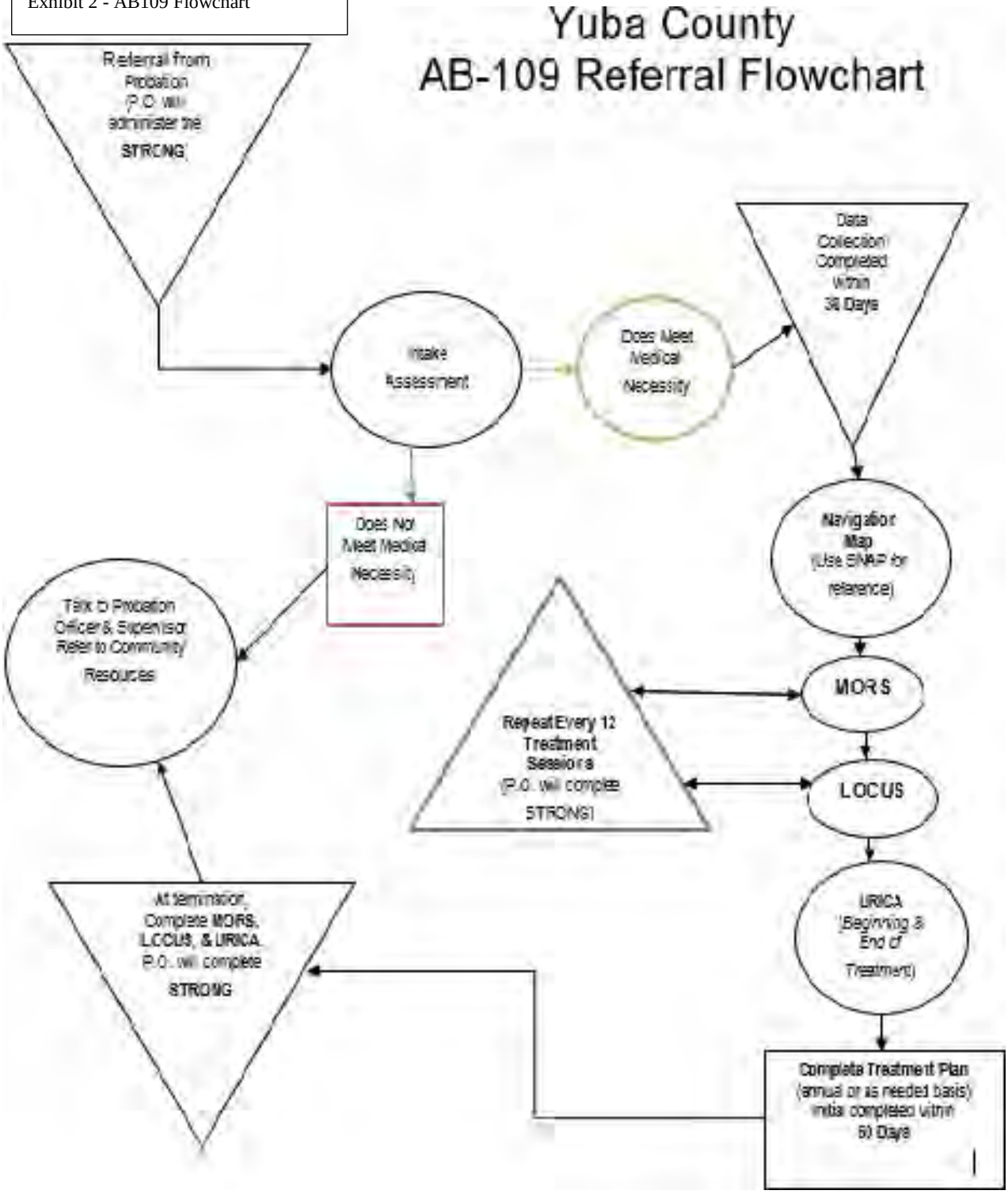


Exhibit 2 - AB109 Flowchart



As seen in the flow charts, once the client meets medical necessity, the individual is admitted to the INN Program.

Negative program discharges can be involuntary and voluntary. Involuntary discharges include non-compliance to program rules and noncompliance to probation rules, and lack of engagement. Voluntary discharges are driven by client choice, including program quits and program transfers.

Positive program discharges are characterized by the successful completion of one's probation terms during his/her time with the Innovation Project. It is the goal of the project that even after a positive program discharge that a client would transition to Adult Services and continue to work on their recovery with our mental health staff. Once an individual completes his or her probation term, they are no longer tracked for purposes of this study.

Milestones of Recovery Scale (MORS)

Once a client has been referred by the intake therapist, a baseline MORS score can be calculated. 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. MORS Score tracks three underlying dimensions of the consumer's: Level of Risk, Level of Engagement, and Level of Skills and Support. The consumer's Level of Risk is comprised of three primary factors: 1) the consumer's likelihood of causing physical harm to self or others, 2) the consumer's level of participation in risky or unsafe behaviors, and 3) the consumer's level of co-occurring disorders. The consumer's Level of Engagement is the degree of "connection" between the consumer and the mental health services system; not the amount of service. The consumer's Level of Skills and Supports should be viewed as the combination of the consumer's abilities and support network(s) and the level to which the consumer needs staff support to meet his/her needs. Level of Skills and Supports should include an assessment of their skills in independent living, cognitive impairments, whether they are engaged in meaningful roles in their life, and whether they have a support network of family and friends. This assessment should also include their ability to manage their physical and mental health, finances, and substance use, and their ability to meet their needs for intimacy and sexual expression. The ideal and perfect outcomes would show that each client would be progressing through the recovery stages as they progress through services. Each score represents the following stage in recovery:

Exhibit 3 – MORS Scale

Milestone	Risk	Engagement	Skills and Supports
1. Extreme Risk			
2. High Risk / Not Engaged			
3. High Risk / Engaged			
4, Poorly Coping / Not Engaged			
5. Poorly Coping / Engaged			
6. Coping / Rehabilitating			
7. Early Recovery			
8. Advanced Recovery			

Milestone of Recovery Scale (MORS):

1 – Extreme Risk

"These individuals are frequently and recurrently dangerous to themselves and or others for prolonged periods. They are frequently taken to hospitals and/or jails or are institutionalized in the stats hospital or an IMDB. They are unable to function well enough to meet their basic needs even with assistance. It is extremely unlikely they can be served safely in the community".

2 – High Risk/Not Engaged

"These individuals often disruptive and are often taken to hospitals and/or jails. They usually have high symptom distress. They are often homeless and may be actively abusing drugs or alcohol and experience negative consequences from it. They may have a serious co-occurring medical condition (e.g., HIV, diabetes) or other disability which they are not actively managing".

3 – High Risk/Engaged

"These individuals differ from group 2 only in that they are participating voluntarily and cooperating in ongoing mental health treatment. They are still experiencing high distress and disruption and are low functioning and not self-supportive in any way".

4 – Poorly Coping/Not Engaged

“These individuals are not disruptive. They are generally not a danger to self or others and it is unusual for them to be taken to hospitals and/or jails. They may have moderate to high symptom distress. They may use drugs or alcohol which may be causing moderate but intermittent disruption in their lives. They may not think they have a mental illness and are unlikely to be taking psychiatric medications. They are not participating voluntarily in ongoing mental health treatment and/or very uncooperative toward mental health providers”.

5 – Poorly Coping/Engaged

“These individuals differ from group 4 only in that they are voluntarily participating and cooperating in ongoing mental health treatment. They may use drugs or alcohol which may be causing moderate but intermittent disruption in their lives. They are generally not a danger to self or others and it is unusual for them to be taken to hospitals and/or jails. They may have moderate to high symptom distress. They are not functioning well and require a great deal of support”.

6 – Coping/Rehabilitating

“These individuals are abstinent or have minimal impairment from drugs or alcohol. They are rarely being taken to hospitals and almost never being taken to jail. They are managing their symptom distress usually, though not always, through medication. They are actively setting and pursuing some quality of life goals and have begun the process of establishing “non-disabled” roles. They often need substantial support and guidance, but they aren’t necessarily compliant with mental health providers. They often need substantial support and guidance but aren’t necessarily compliant with mental health providers”.

7 – Early Recovery

“These individuals are actively managing their mental health treatment to the extent that mental health staff rarely need to anticipate or respond to problems with them. Like group 6, they are rarely using hospitals and are not being taken to jails. Like group 6, they are abstinent or have minimal impairment from drugs or alcohol and they are managing their symptom distress. They

are functioning in many life areas and are very self-supporting or productive in meaningful roles. They usually have a well-defined social network including friends and/or family".

8 – Advanced Recovery

"These individuals differ from group 7 in that they are completely self-supporting. If they are receiving any public benefits, they are generally restricted to Medicaid or some other form of health benefits of health insurance because their employer does not provide health insurance. While they may still identify as having a mental health illness, they are no longer psychiatrically disabled. They are basically indistinguishable from their non-disabled neighbor".

The MORS Assessment tool has been commented on by staff as an effective and practical measurement tool. However, it is important to note the MORS Assessment is not designed to be used as a clinical assessment, rather, an administrative assessment. The assessment is quick to conduct, and it provides a clear outcome, that being the score/recovery stage. Many other programs within SYBH are incorporating a MORS assessment after seeing the ease of data collection and tracking.

A baseline MORS is completed within the first 30 days of treatment and reassessed every 12 treatment sessions.

MORS 3 Year Findings (Re-cap and Summary):

At the close of the three-year Innovation project, we determined, the lower the MORS score, the more at risk a person was not completing the program. During the 3 years, this program was in effect, Sutter Co. registered 97 clients, completing intake for 96 clients; 99% intake completion rate, and a 52% completion rate for collecting data at close, a 48% decrease from program entry. The average Sutter Co. MORS intake score was, 3.26; indicating, Sutter Co. inmates on average are, High Risk/Engaged.

During the three-years this program was in effect, Yuba Co. registered 72 clients for the MORS program, completing intake for 70 clients; 97% intake completion rate and a 68% completion rate for collecting data at close, a 30% decrease from program entry. The average Yuba Co. MORS intake score was 4.43; indicating, Yuba Co. inmates on average are, Poorly Coping/Not Engaged.

Of those who participated in the MORS program, Sutter Co. on average had lower scores than their counterparts in Yuba Co. Meaning, Suter Co. participants had a greater need of continued interventions to address low recovery rates.

The data collected for the Yuba County MORS may be skewed due to the initial MORS score (first scores) not always being collected on the day of intake and varies from client to client. Not having a unified time in the intake process can lead to skewed findings in data. When looking at engagement and recovery stages using the average intake MORS scores between Yuba and Sutter County, 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.

Exhibit 4: Average MORS Scores for Sutter and Yuba Co.

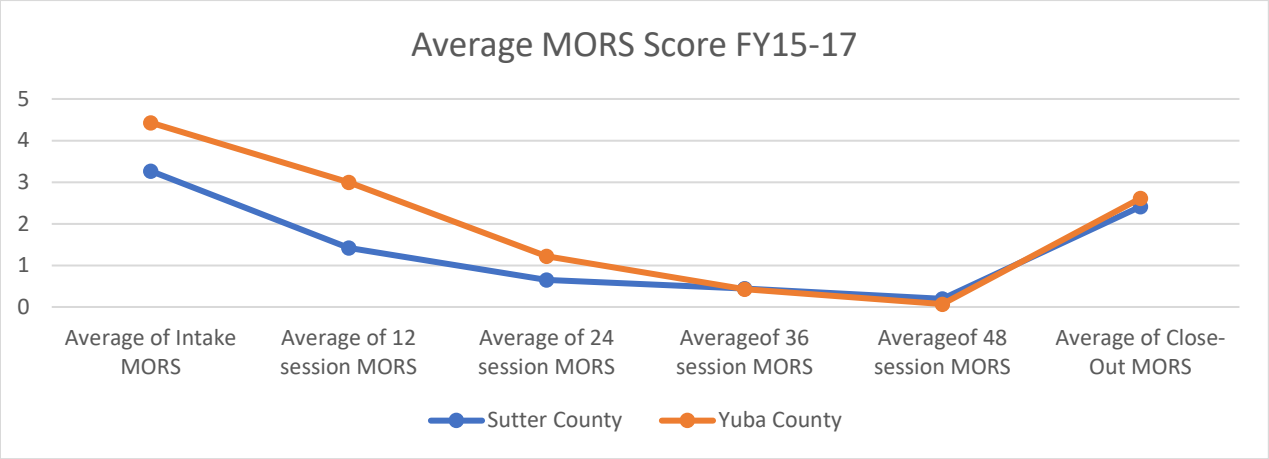


Exhibit 5: MORS Intake Scores for Sutter and Yuba Co.

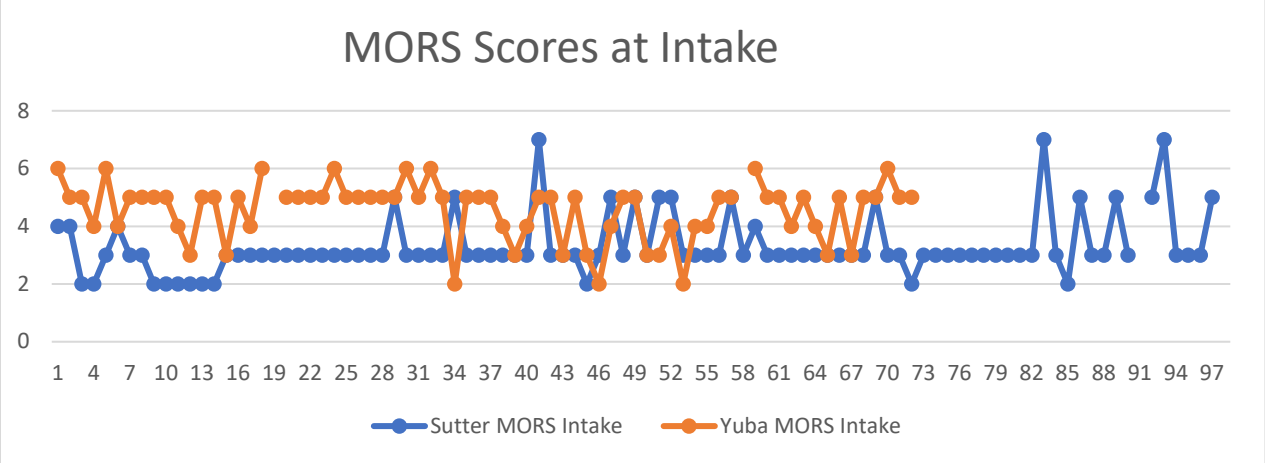


Exhibit 6: MORS Scores Interval 1 Sutter and Yuba Co.

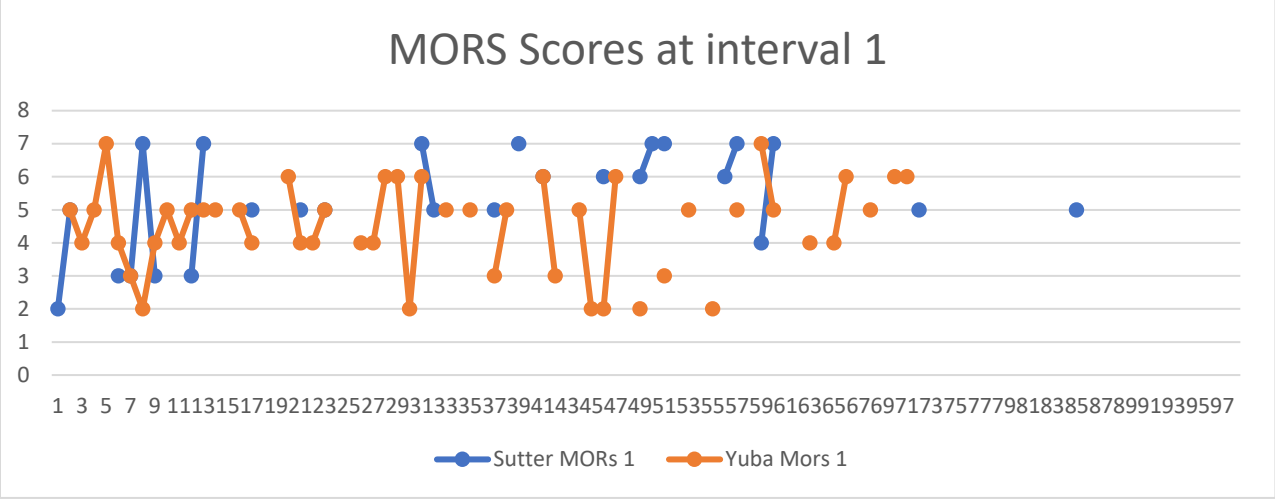


Table 7: MORS Scores Interval 2 Sutter and Yuba Co.

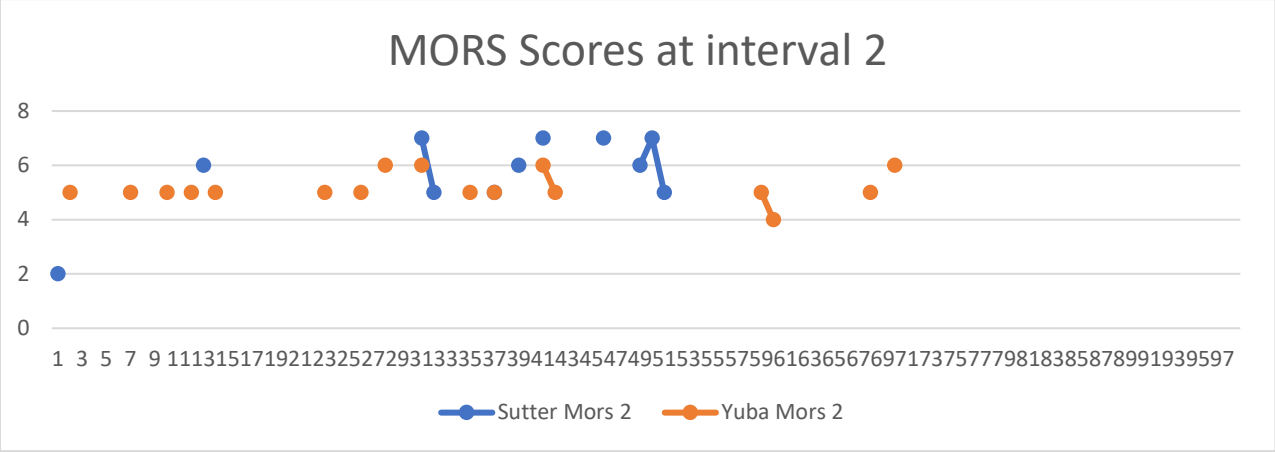


Table 8: MORS Scores Interval 3 Sutter and Yuba Co.

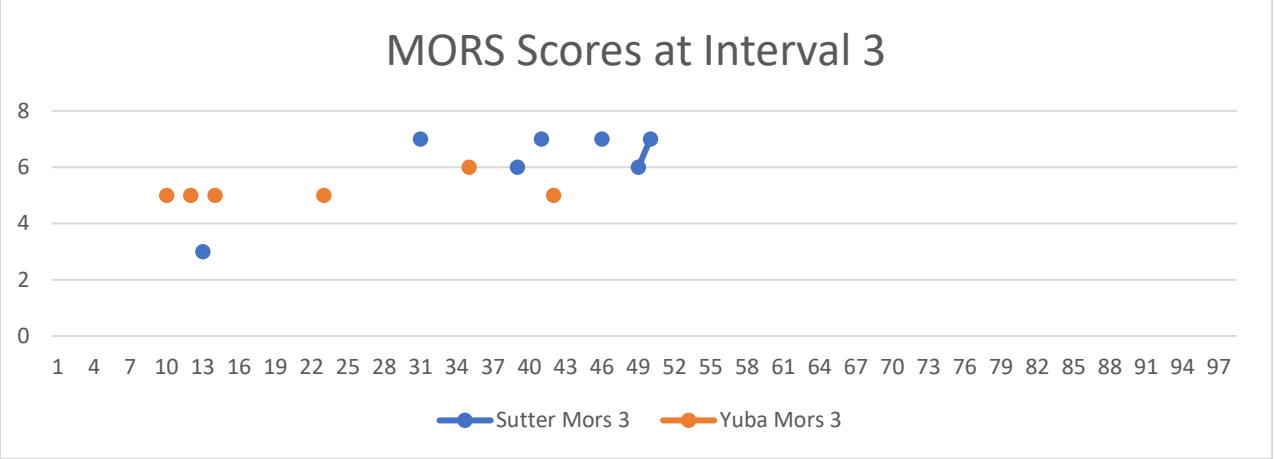
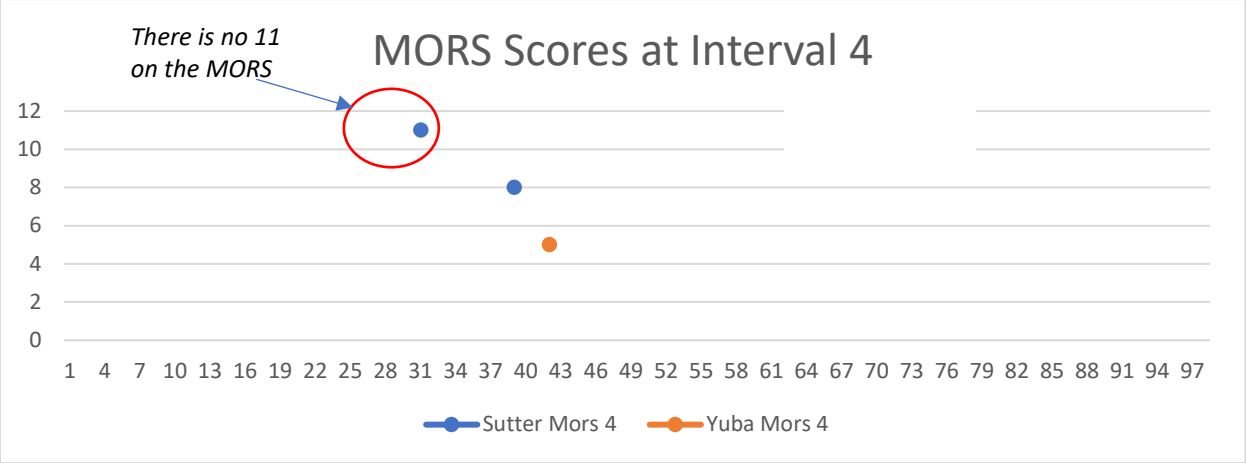


Exhibit 9: MORS Scores Interval 4 Sutter and Yuba Co.



Please note, Sutter Co. staff gave an incorrect score.

Exhibit 10: MORS Scores at Close Sutter and Yuba Co.

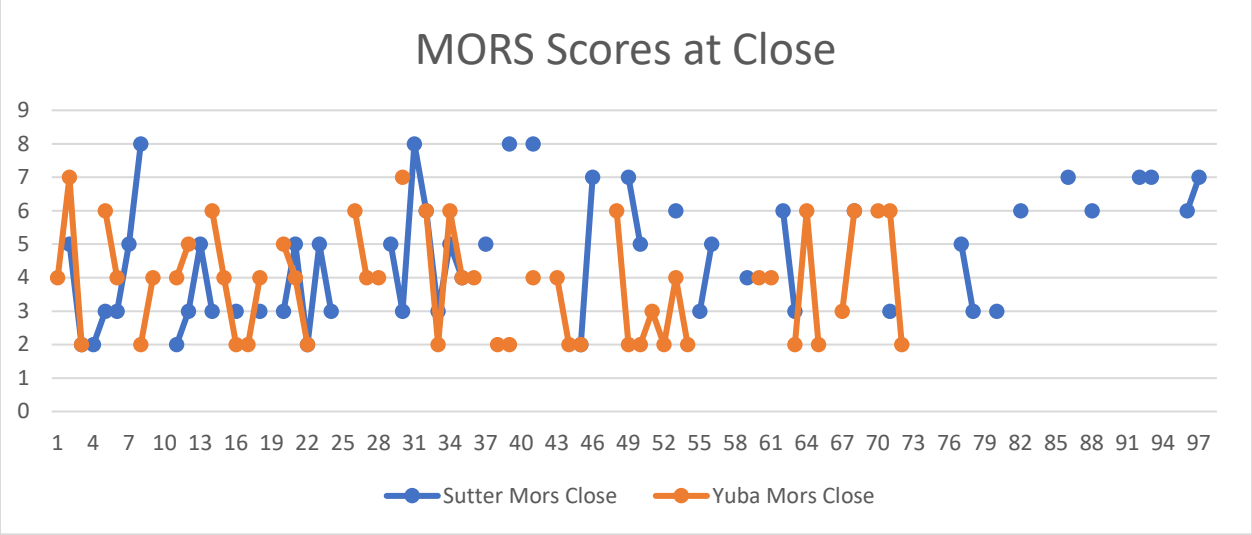
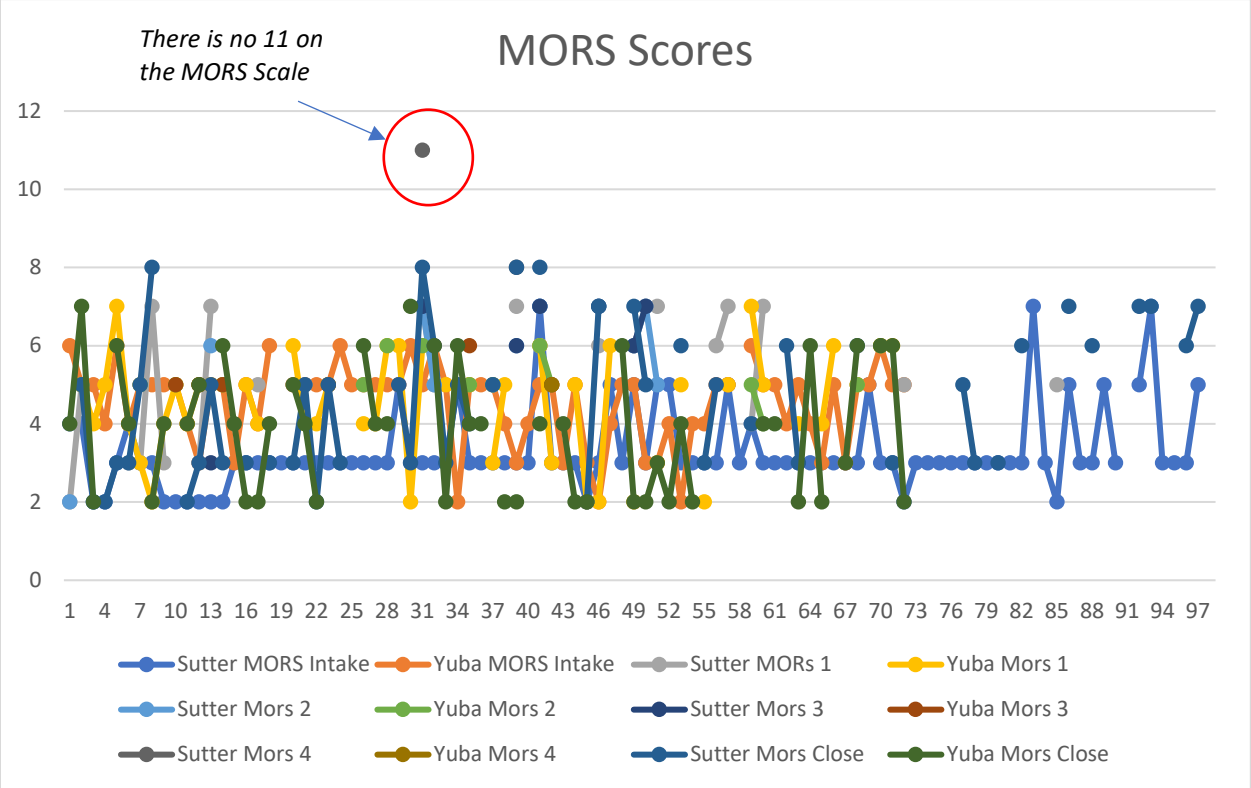


Exhibit 11: Total MORS Scores Sutter and Yuba Co.



Please note, Sutter Co. staff gave an incorrect score at Interval 4.

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.

Exhibit 12 – URICA Assessment

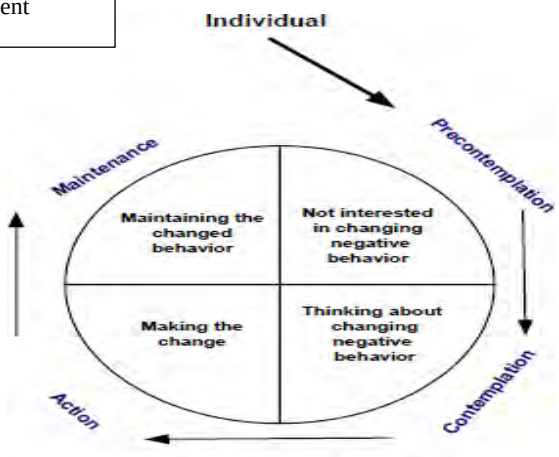


Figure 1 The Stages of Change

The stages of change are as follows:
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 as a result would rather not think or discuss their problem, much less try to change it. Readiness Score Range 8 or lower.
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. Readiness Score Range 9-11.

Action: In this phase, individuals are implementing any change plan they may have developed and begin to modify their behavior. Readiness Score Range: 12-14.
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 his or her lifestyle. Readiness Score Range: 14+.
<u>The URICA tool is administered within the first 30 days of treatment and is reassessed at the close of treatment.</u>

Year 3 Findings (Re-cap and Summary):

The URICA Scores are too inconsistent between county and the clients who are willing to participate in the assessment. The URICA Rubric is comprised of 32 questions with possible scores ranging from 1-5. Individuals should at a minimum have a score of 32, and a maximum score of 160, if they were asked all 32 questions. However, this is not reflected in the URICA reports from both Sutter and Yuba. The largest score, 16, came from a Yuba County participant at the close of this study. Meaning, based on points, this person answered half of all questions, or less, depending on how they answered. For example, an individual could have received a score of 16, by answering 3-questions “Strongly Agree” (5-points) and 1-question “Strongly Disagree” (1-point) for a total of 16-points; completing 4 out of 32 questions. Or, answered 16-questions, “Strongly Disagree” (1-point) to total 16; thus, not answering all 32 questions. This can be witnessed by all participants for both Sutter and Yuba County at beginning and close of URICA Assessment.

Due to the inconsistency of collecting data for the URICA Assessment, assessing whether an individual's readiness for treatment has improved depending on his/her setting or out of custody cannot be determined. There is also not enough data for a comparative analysis for URICA intake versus discharge. Suggestions moving forward would be consistency collecting scores at intake and discharge for both counties. Once this has been completed, an accurate analysis of a persons' willingness to change can then be assessed.

Exhibit 13: Average URICA Scores for Sutter and Yuba Co.

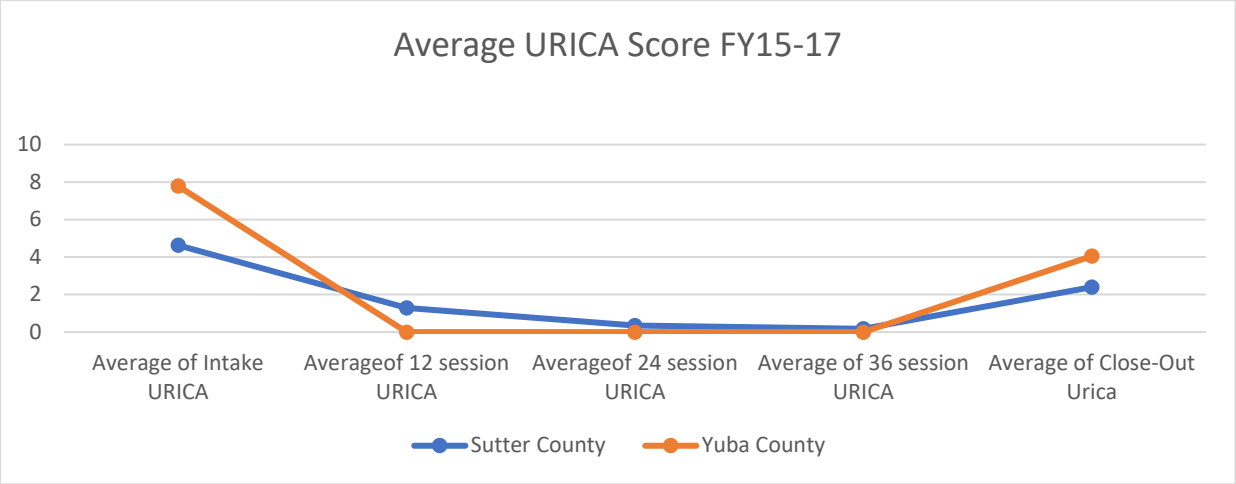


Exhibit 14: URICA Intake Scores Sutter and Yuba Co.

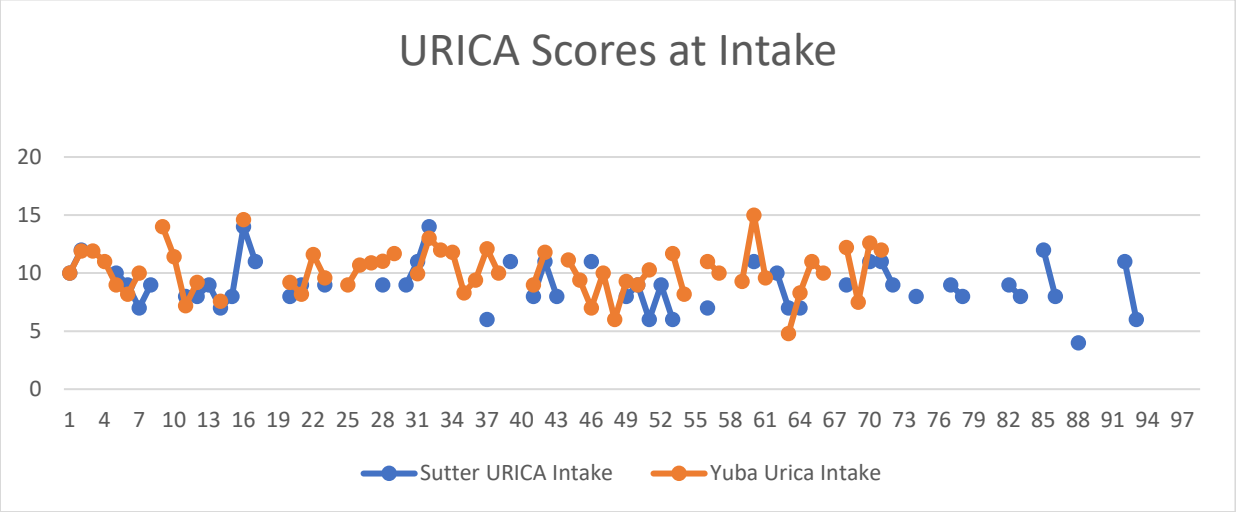
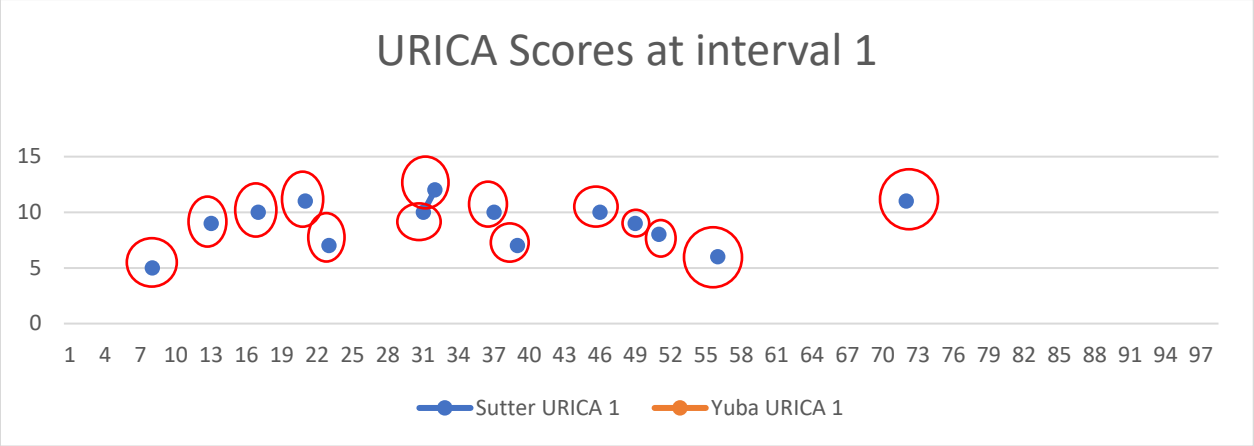


Exhibit 15: URICA Scores Interval 1 Sutter and Yuba Co.



Please note: It was reported, only four persons completed the Discharge Assessment at end of Year 1.

Exhibit 16: URICA Scores Interval 2 Sutter and Yuba Co.

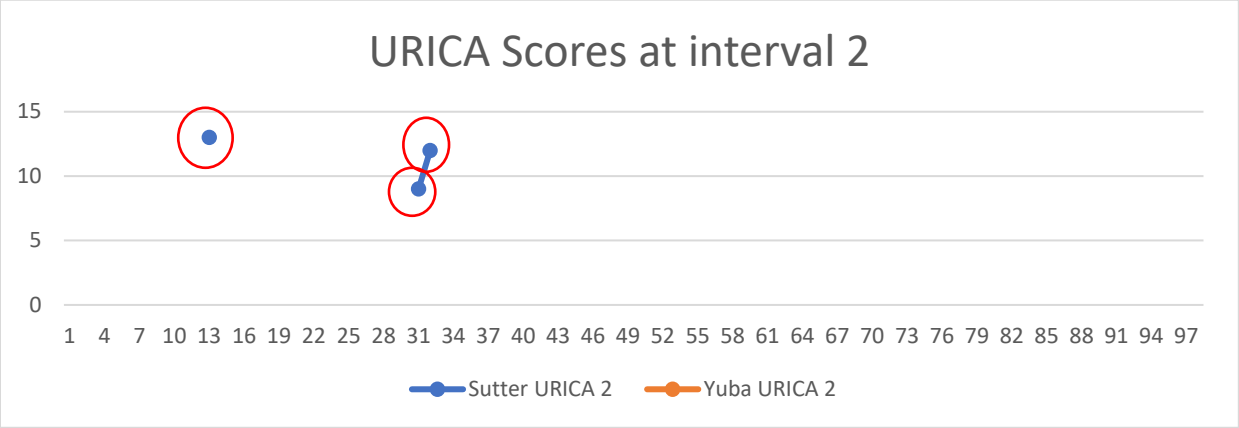


Exhibit 17: URICA Scores Interval 3 Sutter and Yuba Co.

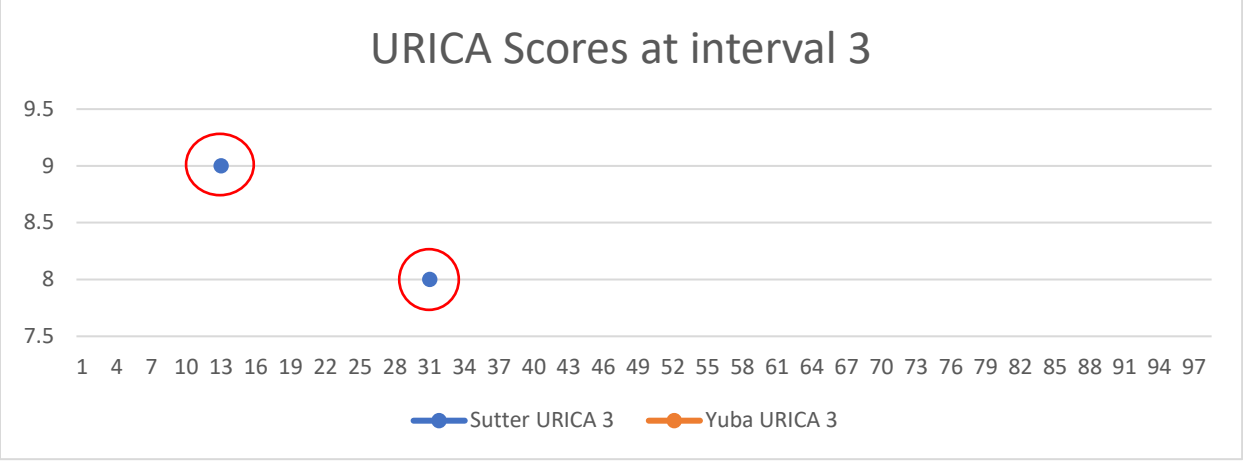


Exhibit 18: URICA Scores at Close Sutter and Yuba Co.

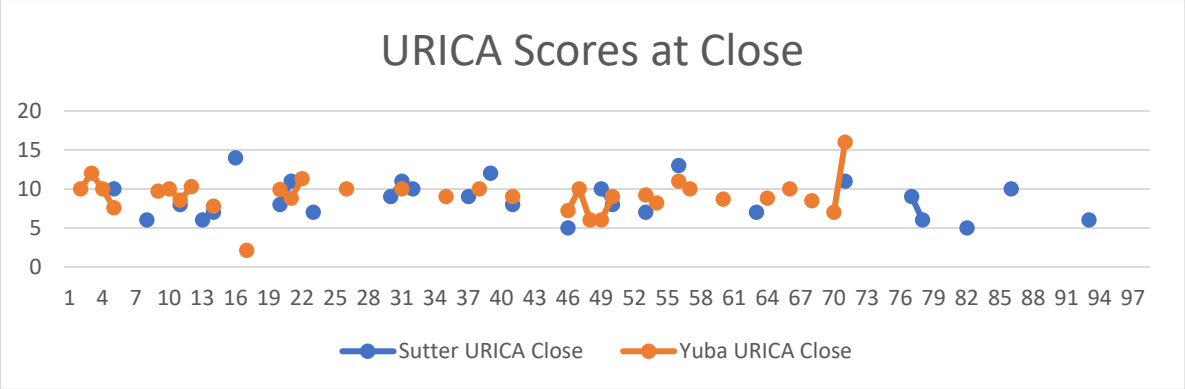
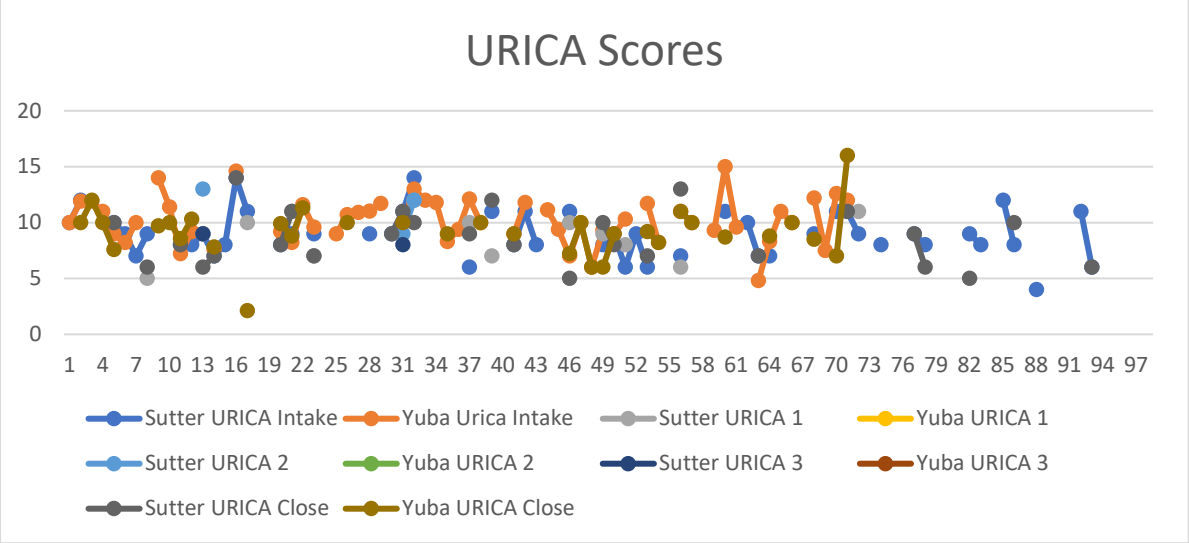


Exhibit 19: Total URICA Scores Sutter and Yuba Co.



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.

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 following are descriptions of the levels:

Basic - Describes services that should be available to all the community, including clients at levels of care (i.e. prevention services).

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 are able to 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 be independently or may be involuntarily committed to treatment.

The LOCUS Tool is administered within the first 30 days of treatment and re-administered every 12 treatment sessions.

Using a 5-point Likert Scale, LOCUS measures the following six factors to a person's overall well-being.

The six evaluation parameters are:

1. Risk of Harm

2. Functional Status

3. Medical, Addictive, and Psychiatric Co-Morbidity

4. Recovery Environment - A) Level of Stress B) Level of Support

5. Treatment and Recovery History

6. Engagement and Recovery Status

A five-point scale is constructed for each parameter.

1- Minimal Risk of Harm

No indication of suicidal or homicidal thoughts or impulses, and no history of suicidal or homicidal ideation, and no indication of significant distress.

Clear ability to care for self now and in the past.

2- Low Risk of Harm

No current suicidal or homicidal ideation, plan, intentions or severe distress, but may have had transient or passive thoughts recently or in the past.

Occasional substance use without significant episodes of potentially harmful behaviors.

Periods in the past of self-neglect without current evidence of such behavior.

3- Moderate Risk of Harm

Significant current suicidal or homicidal ideation without intent or conscious plan and without past history.

No active suicidal homicidal ideation, but extreme distress and/or a history of suicidal/homicidal behavior exists.

History of chronic impulsive suicidal/homicidal behavior or threats, but current expressions do not represent significant change from usual behavior.

Binge or excessive use of substances resulted in potentially harmful behaviors in the past, but there have been no recent episodes.

Some evidence of self-neglect and/or decrease in ability to care for oneself in current environment.

4- Serious Risk of Harm

Current suicidal or homicidal ideation with expressed intentions and/or history of carrying out such behavior but without means for carrying out the behavior, or with some expressed inability or aversion to doing so, or with ability to contract for safety.

History of chronic impulsive suicidal/homicidal behavior or threats with current expression s or behavior representing a significant elevation from usual behavior.

Recent pattern of excessive substance use resulting in loss of self-control and clearly harmful behaviors with no demonstrated ability to abstain from use.

Clear compromise of ability to care adequately for oneself or to be adequately aware of environment.

5-Extreme Risk of Harm

Current suicidal or homicidal behavior or such intentions with a plan and available means to carry out this behavior. . .

- without expressed ambivalence or significant barriers to doing so, or

- with a history of serious past attempts which are not of a chronic,

impulsive or consistent nature, or

-in presence of command hallucinations or delusions which

threaten to override usual impulse control.

Repeated episodes of violence toward self or others, or other behaviors resulting in harm while under the influence of intoxicating substances with pattern of nearly continuous and uncontrolled use.

Extreme compromise of ability to care for oneself or to adequately monitor environment with evidence of deterioration in physical condition or injury related to these deficits.

The above 5 measures are also applied to: Functional Status, Medical, Addictive and Psychiatric Co-Morbidity, Recovery environment; a) level of stress, b) level of support, Treatment and Recovery History, and, Engagement and Recovery Status. A combined score of these five measures in all six categories greater than 20 indicates a person should receive Specialty Mental Health Services. To measure ones' functional status, "The dimension of the assessment measures the degree to which a person is able to fulfill social responsibilities, to interact with others, maintain their physical functioning (such as sleep, appetite, energy, etc.), as well as a person's capacity for self-care." "The ability should be compared against an ideal level of functioning given an individual's limitations, or, may be compared to a baseline functional level as determined for an adequate time prior to onset of this episode of illness."

Year 3 Findings (Re-cap and Summary):

Using the LOCUS Rubric, we determine, individuals with a score greater than 20, should be addressed through Specialty Mental Health Services. Whereas lower scores are indicative of low stress, highly supportive environments, fully responsive to treatment and recovery management, and optimal engagement and recovery. Of the individuals who participated in the LOCUS Assessment, Sutter County on average had 32% more individuals who, per the LOCUS Rubric would classify as needing Specialty Mental Health Services (Exhibits 21, 22, 23, 24, 26 & 27). This increase can most likely be attributed to Sutter County having 26% more (97 participants), who were willing to participate in the LOCUS Assessment compared to Yuba County's 72 participants.

It is recommended the LOCUS Scale is used in subsequent studies with an increased number of participants who will be able to complete all steps to determine the effectiveness of community-based setting (post-release) vs. institution-based setting (pre-release). Due to incomplete surveys there is a lack of empirical data which would suggest whether the different strategies directed at the AB109 offenders and other supervised offenders had sufficient differences. The mental health clinician assigned to Sutter County Probation was embedded into an existing multi-disciplinary probation team and the clinician provided mental health assessments, post-release recovery plans and supports, and connections to ancillary services prior to inmate release. The mental health clinician assigned to Yuba County Probation conducted mental health assessments, post-release recovery plans and supports, and connections to ancillary services following their release back into the community in a community-based effort. The effectiveness of both service strategies cannot be determined due to inconsistent practices between both counties and client participation rates.

Table 20: Average LOCUS Scores - Sutter and Yuba Co.

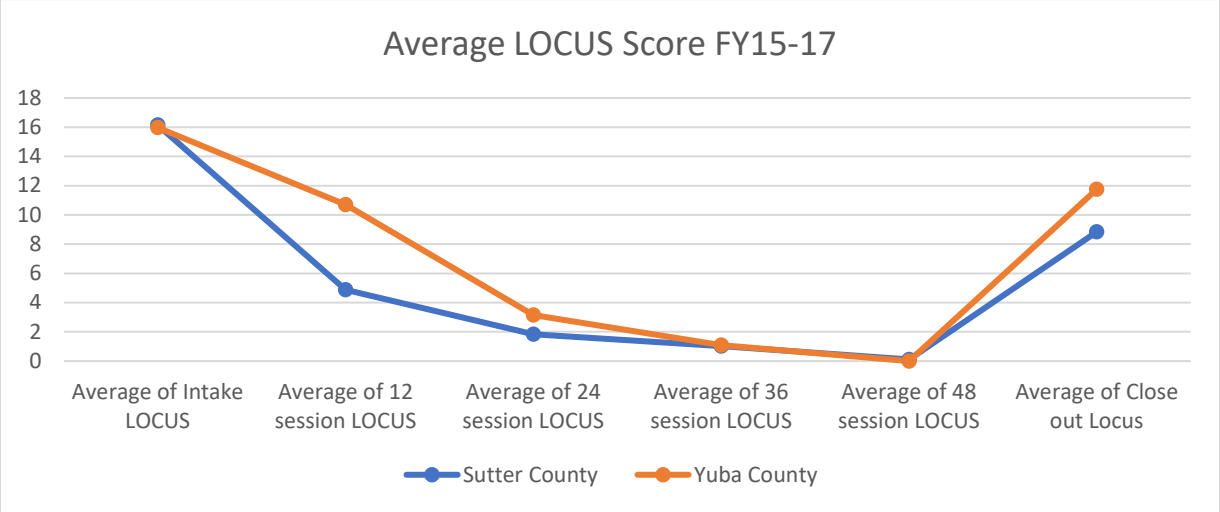


Table 21: Locus Scores at Intake - Sutter and Yuba Co.

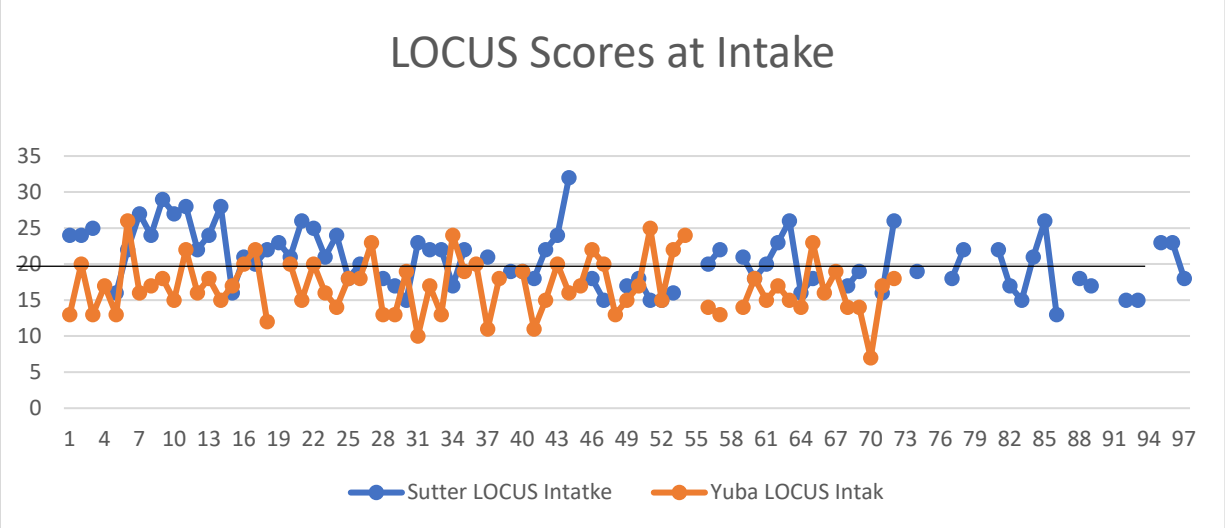


Table 22: Locus Scores at Interval 1 - Sutter and Yuba Co.

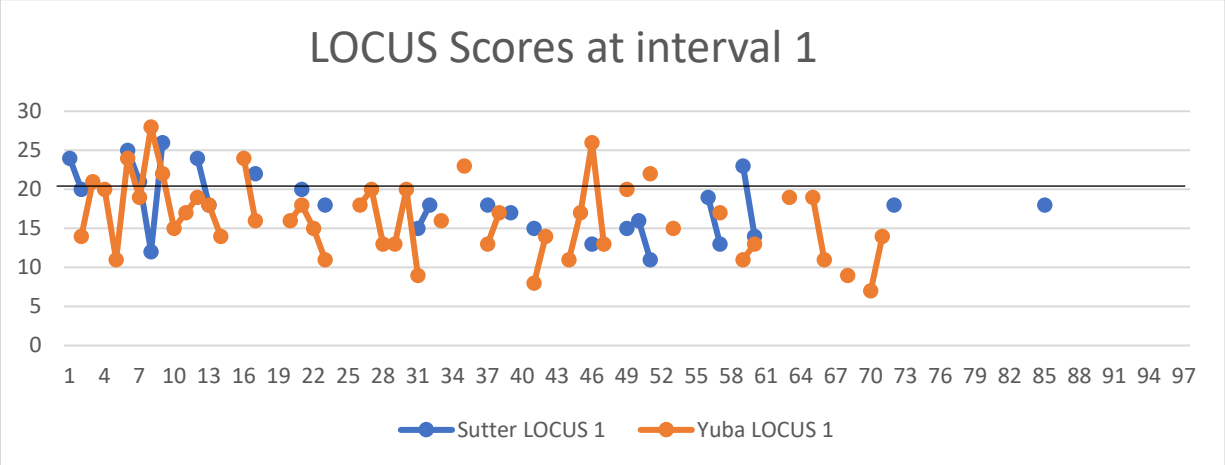


Table 23: Locus Scores at Interval 2 - Sutter and Yuba Co.

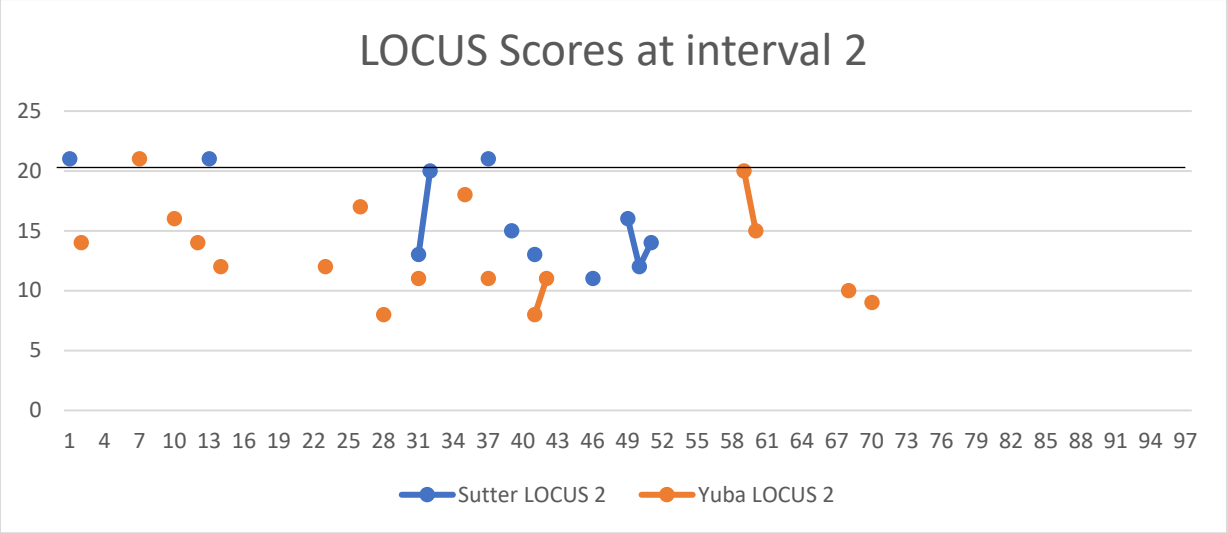


Table 24: Locus Scores at Interval 3 - Sutter and Yuba Co.

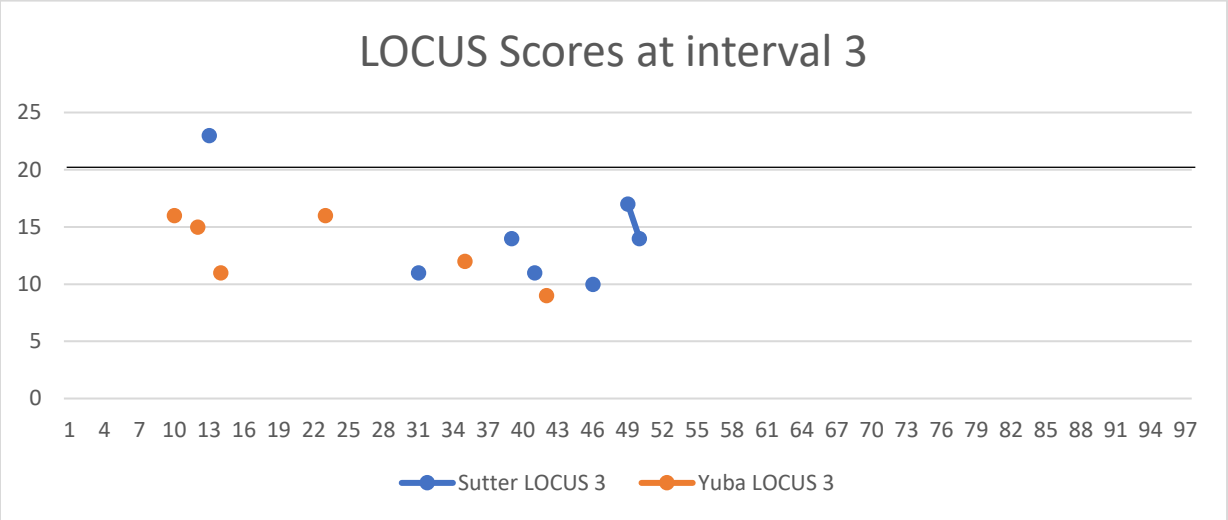


Table 25: Locus Scores at Interval 4 - Sutter and Yuba Co.

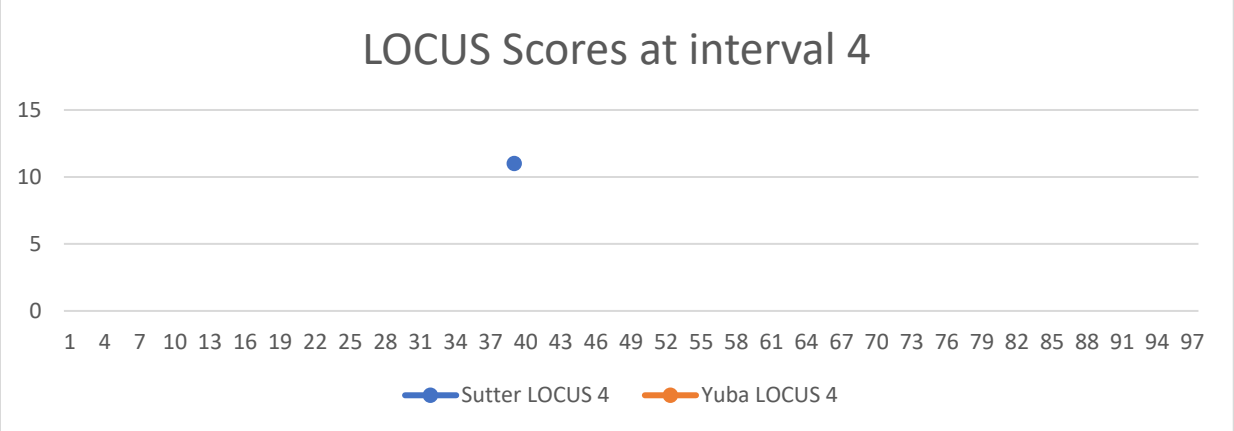


Table 26: Locus Scores at Close - Sutter and Yuba Co.

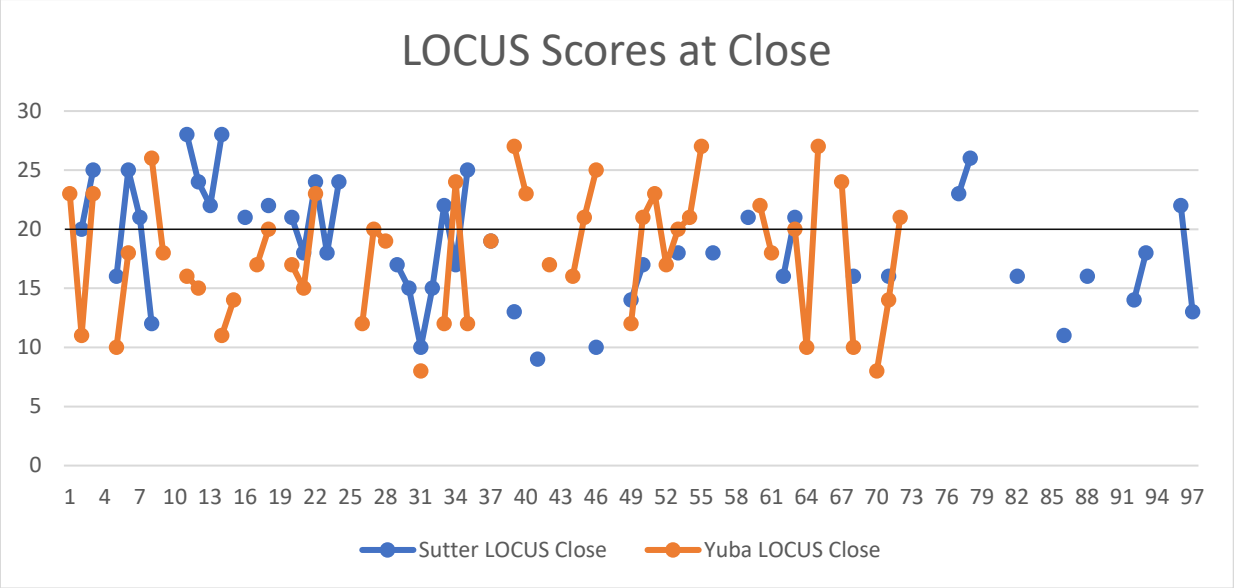
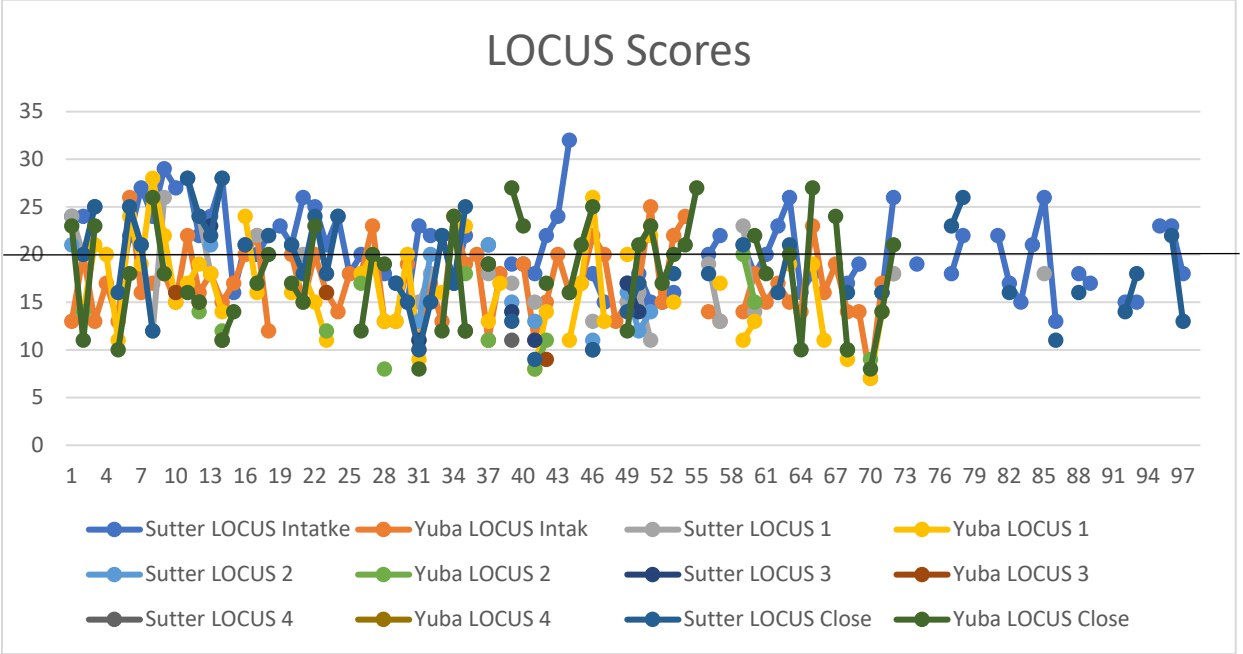


Table 27: Total LOCUS Scores Sutter and Yuba Co.



Level of Care Utilization System Level (LOCUS Level)

An individuals' LOCUS Level response is determined based on their LOCUS score. LOCUS Level scores are assigned from 0 – 6. Zero – Basic Services, Level One – Recovery Maintenance & Health Management, Level Two – Low Intensity Community-Based Services, Level Three – High Intensity Community-Based Services, Level Four – Medically Monitored Non-Residential Services, Level Five – Medically Monitored Residential Services, Level Six – Medically Managed Residential Services.

The AACP Level of Care Determination Decision Tree is used to determine the corresponding intervention to be used. If a composite score is 16 or less, and scores on Dimensions I, II, and III are all 3 or less, then Decision Tree Page 1, Entry Point A is used. If a composite score is 17 or more, and scores on Dimensions I, II or III is 4 or more, then Decision Tree Page 2, Entry Point B is used. Depending on the score a client receives will determine the appropriate response used when addressing a client's needs.

I. Level One - Recovery Maintenance and Health Management

This level of care provides treatment to clients who are living either independently or with minimal support in the community, and who have achieved significant recovery from past episodes of illness. Treatment and service needs do not require supervision or frequent contact. Recovery Maintenance programs must provide the following:

Placement Criteria:

Risk of Harm - clients with a rating of two or less may step down to this level of care.

Functional Status - clients should demonstrate ability to maintain a rating of two or less to be eligible for this level of care.

Co-morbidity - a rating of two or less is generally required for this level of care.

Recovery Environment - a combined rating of no more than four on Scale "A" and "B" should be required for treatment at this level.

Treatment and Recovery History - a rating of two or less should be required for treatment at this level.

Engagement - a rating of two or less should be obtained in this dimension for placement at this level of care.

Composite Rating - placement at this level of care implies that the client has successfully completed treatment at a more intensive level of care and primarily needs assistance in maintaining gains realized in the past. A composite rating of more than 10 but less than 14 should generally be obtained for eligibility for this service.

II. Level Two – Low Intensity Community Based Services

This level of care provides treatment to clients who need ongoing treatment, but who are living either independently or with minimal support in the community. Treatment and service needs do not require intense supervision or very frequent contact. Programs of this type have traditionally been clinic-based programs but could be provided in community locations. These programs should provide the following:

Placement Criteria:

Risk of Harm - a rating of two or less would be most appropriate for this level of care. In some cases, a rating of three could be accommodated if the composite rating falls within guidelines.

Functional Status - ratings of three or less could be managed at this level.

Co-Morbidity - a rating of two or less is required for placement at this level.

Recovery Environment - a rating of three or less on each scale and a combined score of no more than five on the “A” and “B” scales are required for treatment at this level.

Treatment and Recovery History - a rating of two or less is generally most appropriate for this level of care. In some cases, a rating of three could be attempted at this level if stepping down from a more intensive level of care and a rating of two or less is obtained on scale “B” of dimension four.

Engagement - a rating of two or less is generally most appropriate for this level of care. In some cases, a rating of three may be placed at this level if unwilling to participate in treatment at a more intensive level.

Composite Rating - placement at this level of care will generally be determined by the interaction of a variety of factors but will be excluded by a score of four or more on any dimension. A composite score of at least 14 but no more than 16 is required for treatment at this level.

III. Level Three- High Intensity Community Based Services

This level of care provides treatment to clients who need intensive support and treatment, but who are living either independently or with support in the community. Service needs do not necessarily require daily supervision, but contact is required several times per week. Programs of this type have traditionally been clinic-based programs, but they could be provided in the community as well. These programs should provide the following:

Placement Criteria:

1. Risk of Harm - a rating of three or less can be managed at this level.

2. Functional Status - a rating of three or less is required for this level of care.

3. Co-Morbidity - a rating of three or less can be managed at this level of care.

4. Recovery Environment - a rating of three or less on each scale and a combined score of no more than five on the "A" and "B" scales are required for treatment at this level.

5. Treatment and Recovery History - a rating of two is most appropriate for management at this level of care, but in many cases a rating of three can be accommodated.

6. Engagement - a rating of three or less is required for this level of care.

7. Composite Rating - placement at this level of care will generally be determined by the interaction of a variety of factors but will be excluded by a score of four or more on any dimension. A composite score of at least 17 and no more than 19 is required for treatment at this level.

IV. LEVEL FOUR - Medically Monitored Non-Residential Services

This level of care refers to services provided to clients capable of living in the community either in supportive or independent settings, but whose treatment needs require intensive management by a multi-disciplinary treatment team. Services, which would be included in this level of care,

have traditionally been described as partial hospital programs and as assertive community treatment programs.

Placement Criteria:

Risk of Harm - a rating of three or less can be managed at this level.

Functional Status - a rating of three or less is required for this level of care.

Co-Morbidity - a rating of three or less can be managed at this level of care.

Recovery Environment - a rating of three or less on each scale and a combined score of no more than five on the "A" and "B" scales are required for treatment at this level.

Treatment and Recovery History - a rating of two is most appropriate for management at this level of care, but in many cases a rating of three can be accommodated.

Engagement - a rating of three or less is required for this level of care.

Composite Rating - placement at this level of care will generally be determined by the interaction of a variety of factors but will be excluded by a score of four or more on any dimension. A composite score of at least 17 and no more than 19 is required for treatment at this level.

V. Level Five – Medically Monitored Residential Services

This level of care refers to residential treatment provided in a community setting. This level of care has traditionally been provided in non-hospital, free standing residential facilities based in the community. In some cases, longer-term care for persons with chronic, non-recoverable disability, which has traditionally been provided in nursing homes or similar facilities, may be included at this level. Level five services must provide the following:

Placement Criteria:

Risk of Harm - a rating of four requires care at this level independently of other parameters.

Functional Status - a rating of four requires care at this level independently of other dimensional ratings, with the exception of some clients who are rated at one on dimension four on both scale "A" and "B" (see level three criteria).

Co-Morbidity - a rating of four requires care at this level independently of other parameters, with the exception of some clients who are rated at one on dimension four on both scale "A" and "B" (see level three criteria).

Recovery Environment - a rating of four or higher on the "A" and "B" scale and in conjunction with a rating of at least three on one of the first three dimensions requires care at this level.

Treatment and Recovery History - a rating of three or higher in conjunction with a rating of at least three on one of the first three dimensions requires treatment at this level.

Engagement - a rating of three or higher in conjunction with a rating of at least three on one of the first three dimensions requires treatment at this level.

Composite Rating - while a client may not meet any of the above independent ratings, in some circumstances, a combination of factors may require treatment in a more structured setting. This would generally be the case for clients who have a composite rating of 24 or higher.

VI. LEVEL SIX - Medically Managed Residential Services

This is the most intense level of care in the continuum. Level six services have traditionally been provided in hospital settings, but could, in some cases, be provided in freestanding non-hospital settings. Whatever the case may be, such settings must be able to provide the following:

Placement Criteria:

Risk of Harm - a rating of five qualifies an admission independently of other parameters.

Functional Status - a rating of five qualifies placement independently of other variables.

Medical, Addictive and Psychiatric Co-Morbidity - a rating of five qualifies placement independently of other parameters.

Recovery Environment - a rating of four or more would be most appropriate for this level, but no rating in this parameter qualifies placement independently at this level, nor would it disqualify placement if otherwise warranted.

Treatment and Recovery History - a rating of four or more would be most appropriate for this level but, no rating in this dimension qualifies placement independently at this level, nor would it disqualify an otherwise warranted placement.

Engagement - a rating of four or more would be most appropriate for this level but no rating in this parameter qualifies or disqualifies placement independently at this level.

Composite Rating - in some cases, patients not meeting independent criteria in any one category, may still need treatment at this level if ratings in several categories are high, thereby increasing the risk of treatment in a less intensive setting. A composite rating of 28 (an average rating of four or more in each dimension) would indicate the need for treatment at this level.

Year 3 Findings (Re-cap and Summary):

The LOCUS Level score is used to match each participant with the corresponding intervention. However, when comparing the Average LOCUS Scores for FY15-17 with the Average LOCUS Level Score FY 15-17 we can see these two comparisons do not overlap, indicating there may be discrepancies with evaluation and numerical ratings. With the exceptions of a few outliers, most of the LOCUS Level Scores are between 1 and 5. Meaning most of the participants in the study required a level of care ranging from Low Intensity Community-Based Services to Medically Monitored Residential Services.

Table 28: LOCUS Level Scoring Rubric

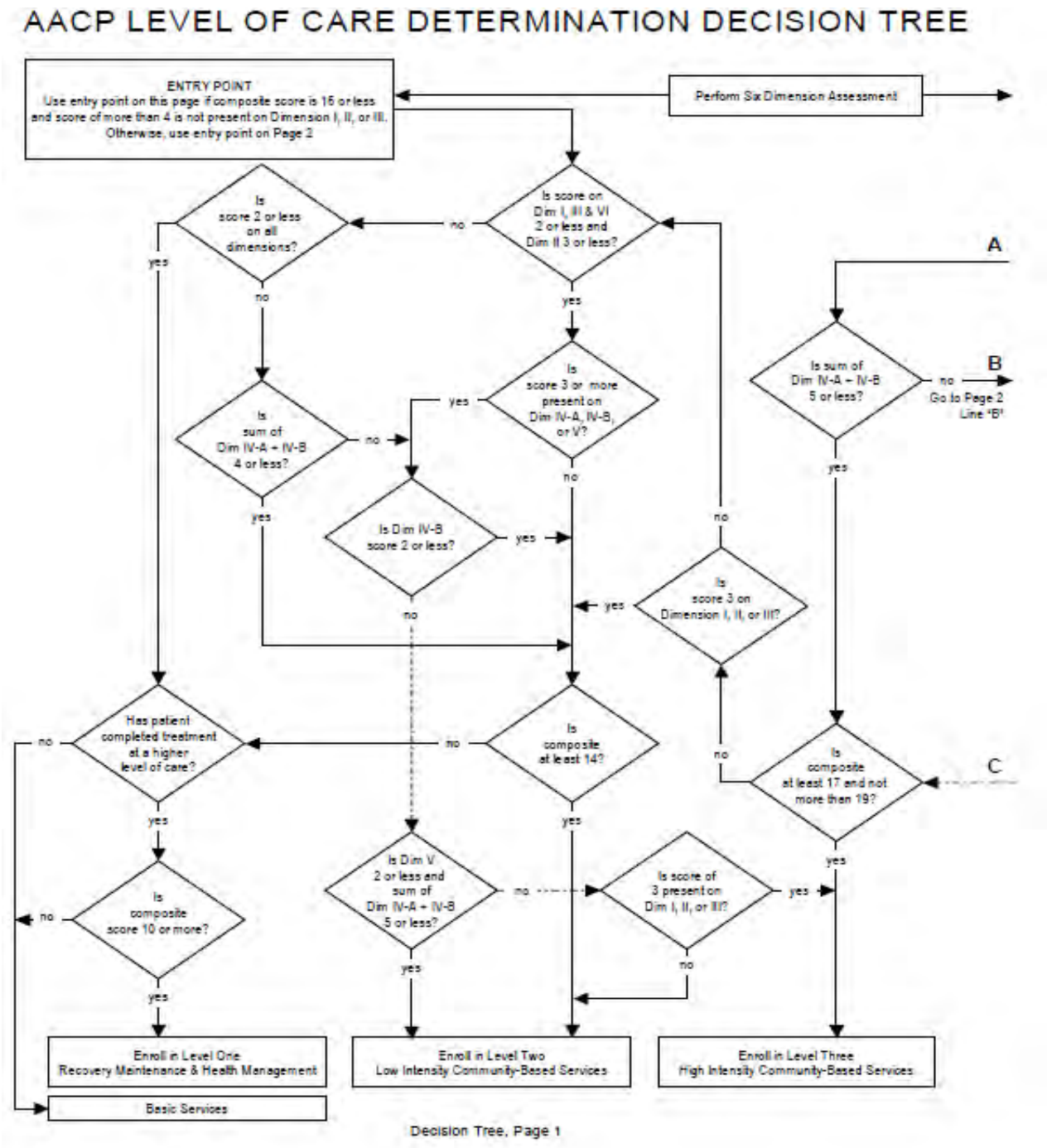
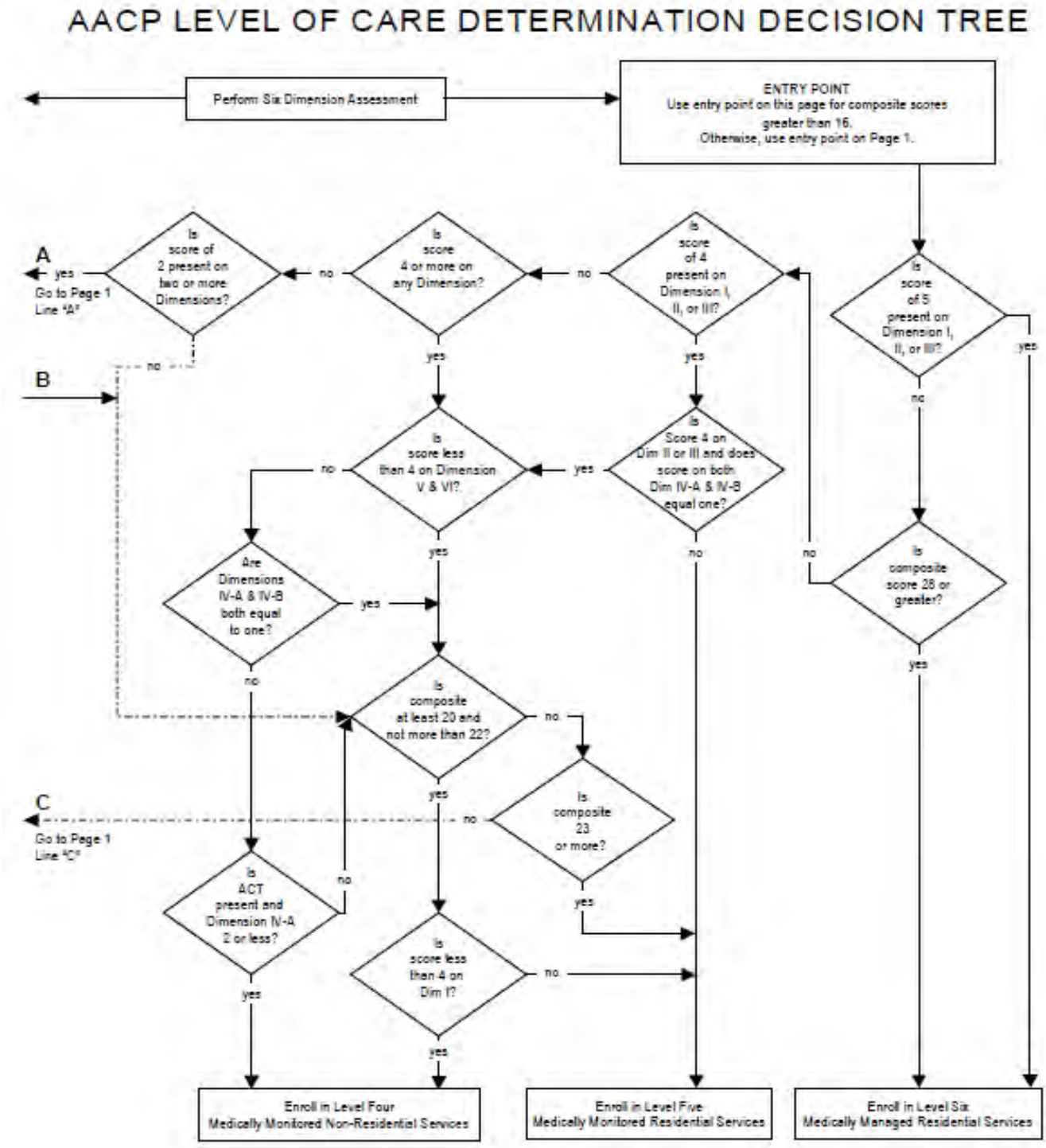


Table 29: LOCUS Level Scoring Rubric cont.



Decision Tree, Page 2

Table 30: LOCUS Level Scoring Determination Grid

LEVEL OF CARE DETERMINATION GRID

Dimensions \ Level of Care	Recovery Maintenance Health Maintenance Level 1	Low Intensity Community Based Services Level 2	High Intensity Community Based Services Level 3	Medically Monitored Non-Residential Services Level 4	Medically Monitored Residential Services Level 5	Medically Managed Residential Services Level 6
I. Risk of Harm	2 or less	2 or less	3 or less	3 or less	④ 3	⑤ 4
II. Functional Status	2 or less	2 or less	3 or less	3 or less	④* 3	⑤ 4
III. Co-Morbidity	2 or less	2 or less	3 or less	3 or less	④* 3	⑤ 4
IV A. Recovery Environment "Stress"	Sum of IV A + IV B is 4 or less	Sum of IV A + IV B is 5 or less	Sum of IV A + IV B is 5 or less	3 or 4	4 or more	4 or more
IV B. Recovery Environment "Support"				3 or less	4 or more	4 or more
V. Treatment & Recovery History	2 or less	2 or less	3 or less	3 or 4	3 or more	4 or more
VI. Engagement	2 or less	2 or less	3 or less	3 or 4	3 or more	4 or more
Composite Rating	10 to 13	14 to 16	17 to 19	20 to 22	23 to 27	28 or more

❍ indicates independent criteria - requires admission to this level regardless of composite score

* Unless sum of IV A and IV B equals 2

LOCUS 2000 Training Manual

Table 31: Average LOCUS Level Scores - Sutter and Yuba Co.

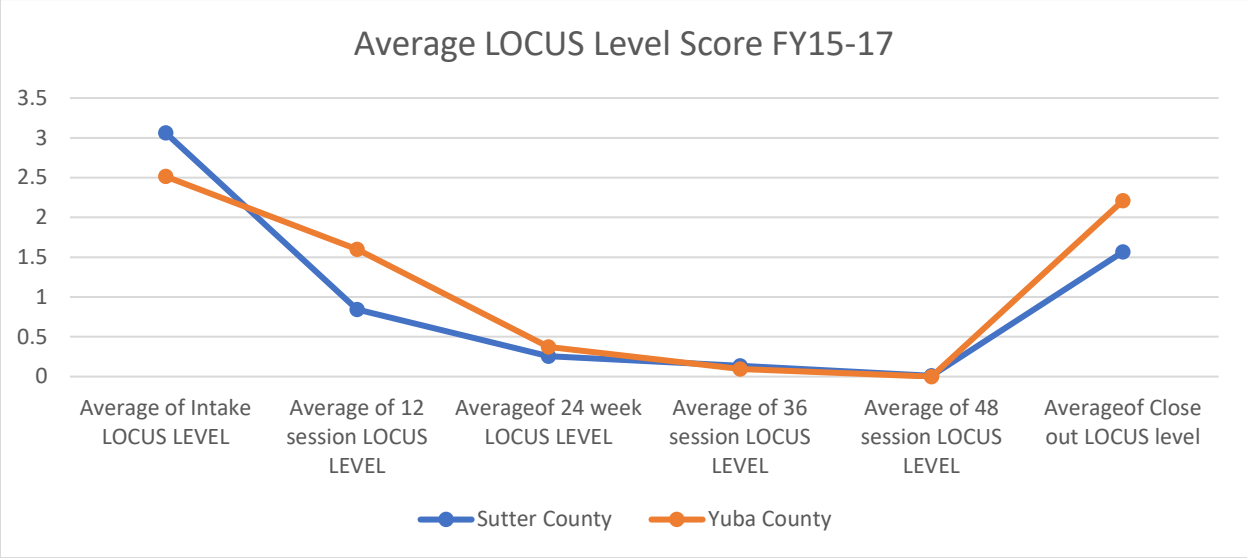


Table 32: Locus Level Scores at Intake - Sutter and Yuba Co.

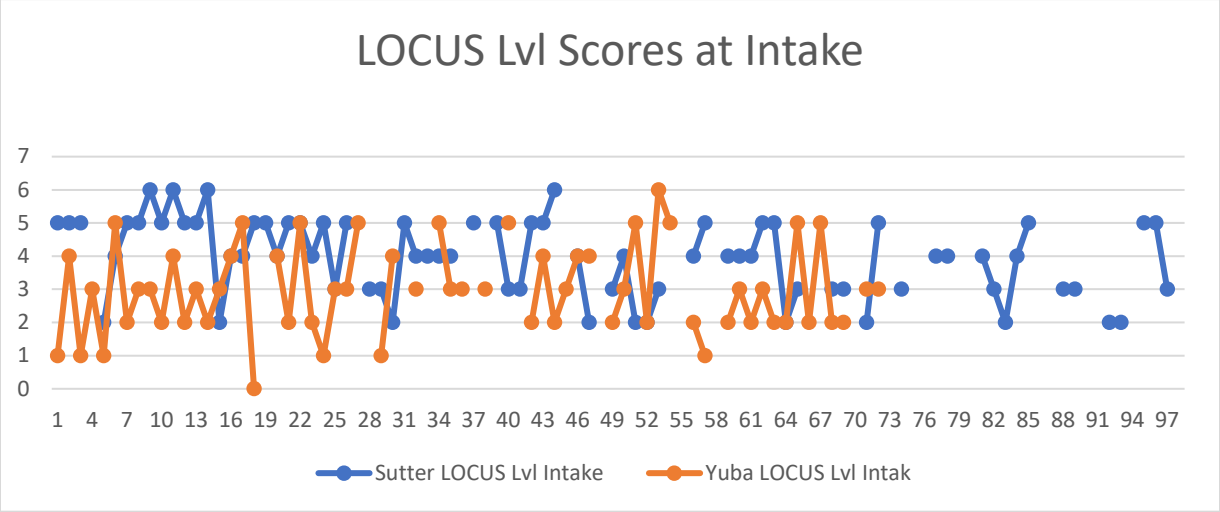


Table 33: Locus Level Scores at Interval 1 - Sutter and Yuba Co.

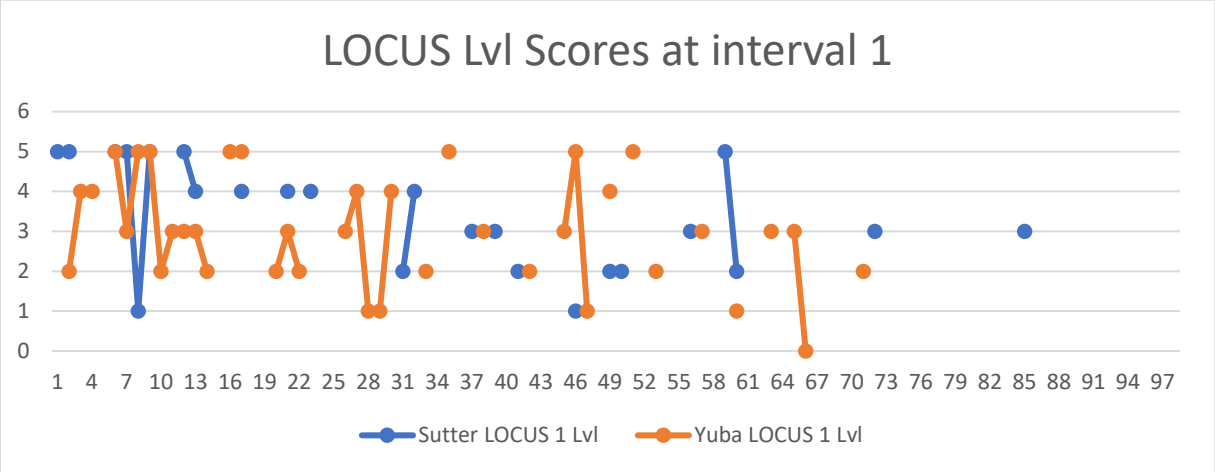


Table 34: Locus Level Scores at Interval 2 - Sutter and Yuba Co.

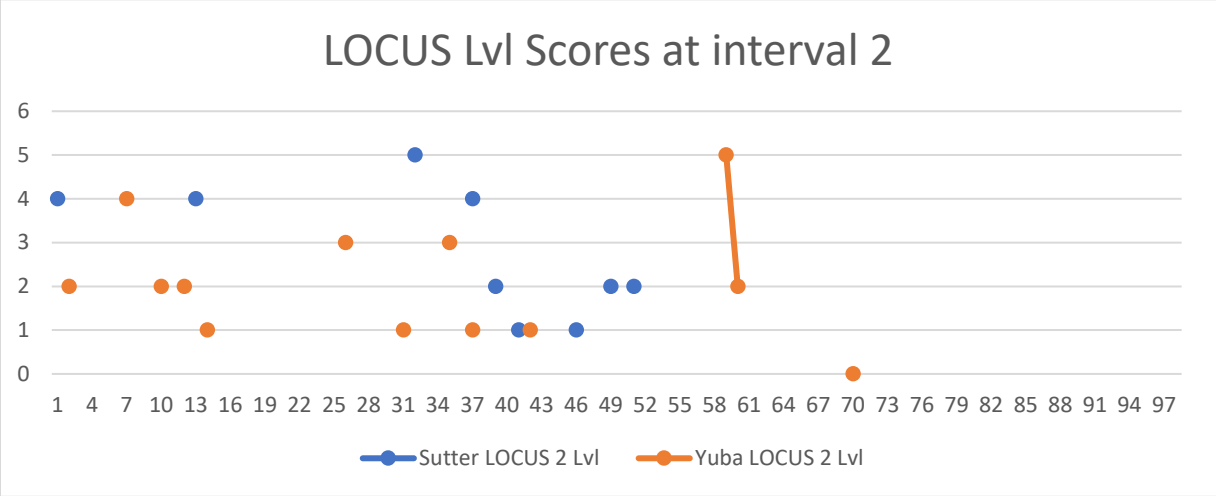


Table 35: Locus Level Scores at Interval 3 - Sutter and Yuba Co.

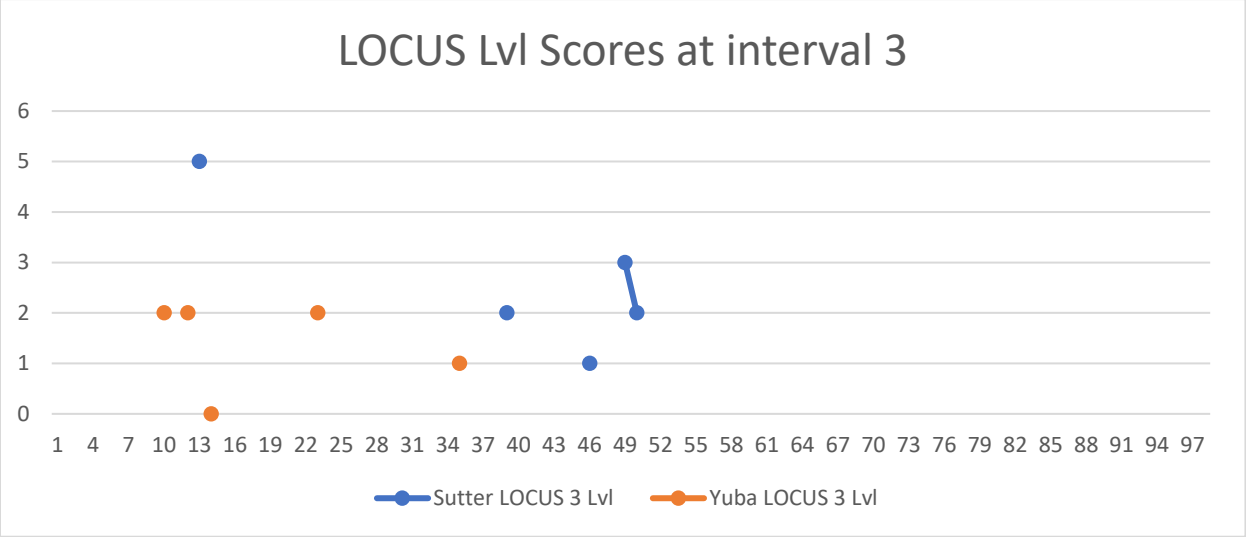


Table 36: Locus Level Scores at Interval 4 - Sutter and Yuba Co.

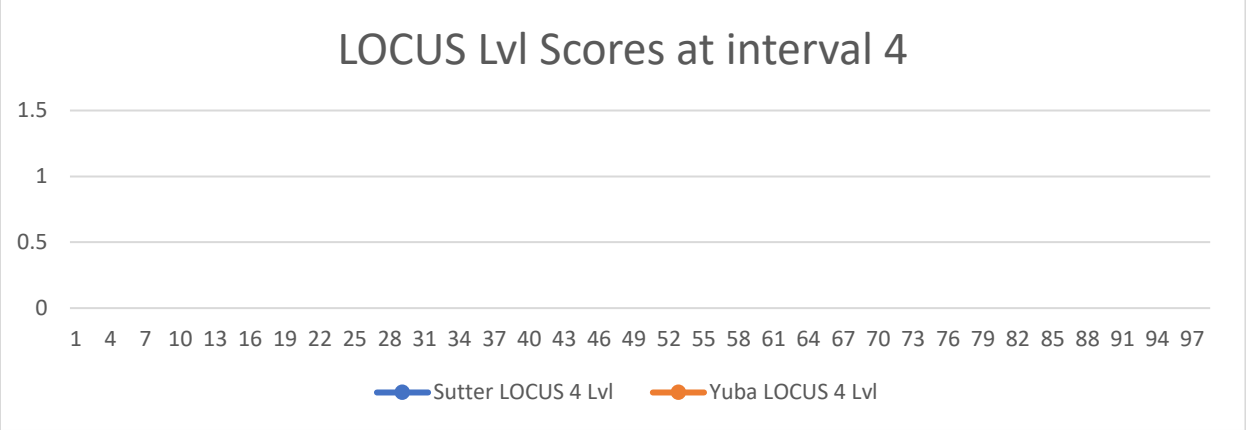
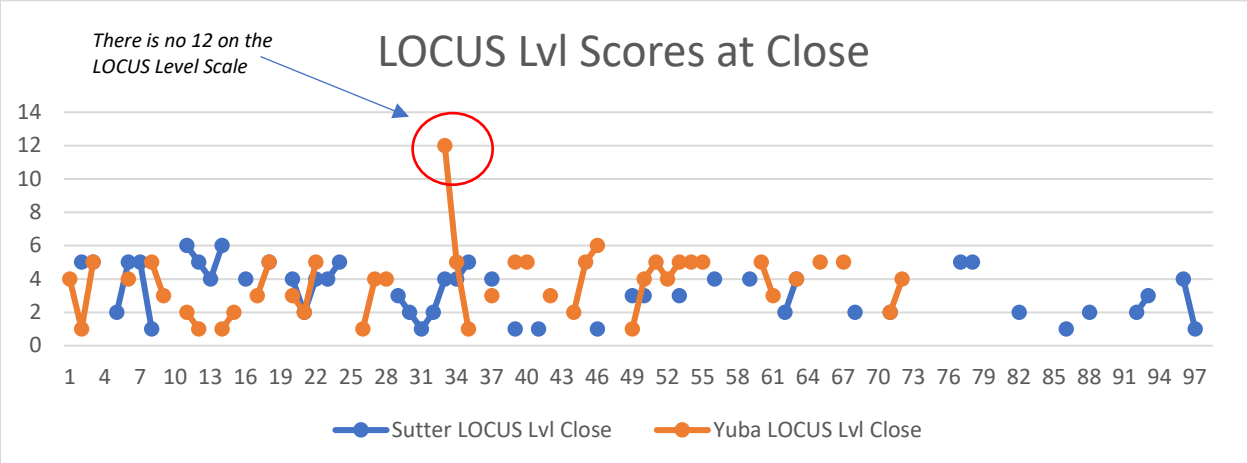
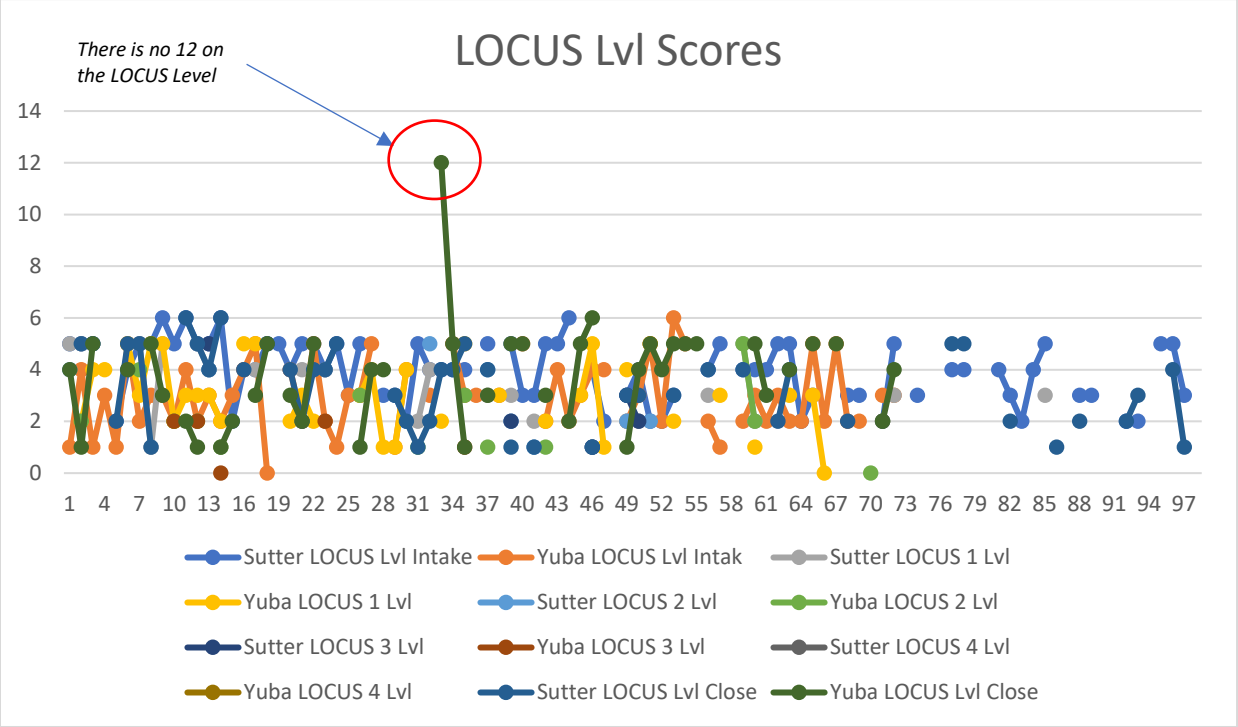


Table 37: Locus Level Scores at Close - Sutter and Yuba Co.



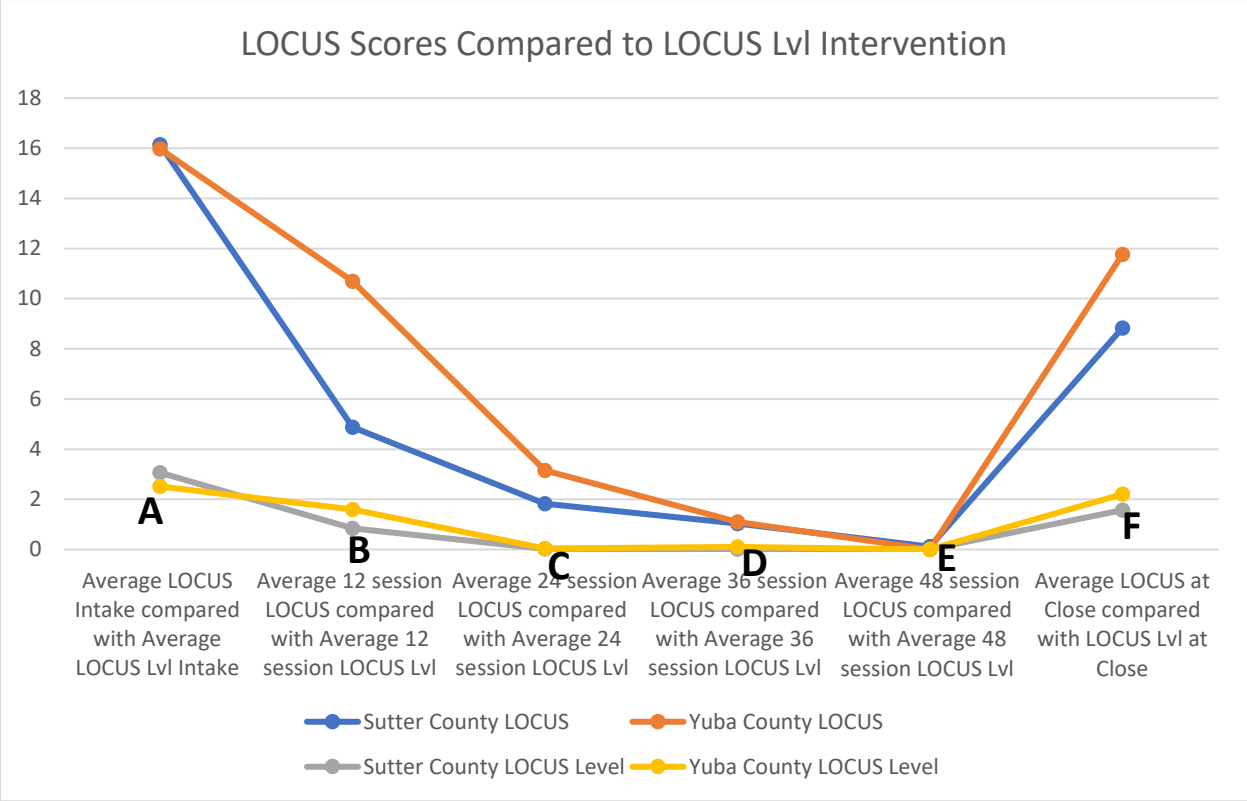
Please note, Yuba Co. staff mistakenly gave an incorrect score, skewing findings and leading to an incomplete conclusion.

Table 38: Total LOCUS Scores Sutter and Yuba Co.



Please note, Yuba Co. staff mistakenly gave an incorrect score, skewing findings and leading to an incomplete conclusion.

Table 39: Compares LOCUS Scores Sutter and Yuba Co. with LOCUS Lvl. Scores Sutter and Yuba Co.



From the above graph, we can tell, Sutter Co. staff did not accurately assign the appropriate level of care. Both Sutter and Yuba County LOCUS Level Scores should mirror their counterpart – LOCUS Scores. While they should not overlap, these lines should be an identical image, indicating an appropriate response was applied. The above graph indicates the use of incompatible interventions were applied to address participants' needs. Data limitations include the small sample sizes and the potential rater biases that may occur when assessments are being completed. When conducting a One-Tailed T-Test of the LOCUS Scores matched with LOCUS Level Scores we can examine whether the correct intervention was used at each level. While this was not done on an individual level, which would be the most accurate determination of whether the correct response was applied, the larger groups can be examined.

Table 39, Point – A (Intake), Sutter Co.'s P-Value is 2.88. Yuba Co.'s is 1.56, here we fail to reject the null hypothesis, that a relationship between the LOCUS Score and the LOCUS Level Score exists. Point – B (Interval 1), Sutter Co.'s P -Value is 4.80. Yuba Co.'s is 3.0, here we again, fail to reject the null hypothesis, that a relationship between the LOCUS Score and the LOCUS Level Score exists. Point – C (Interval 2), Sutter Co.'s P-Value is 0.002. Yuba Co.'s is 0.0001, for both Sutter and Yuba Co. we reject the null hypothesis; this is most likely due to the low number of scores reported at Interval 3. Point – D (Interval 3), Sutter Co.'s P-Value is 0.01. Yuba Co.'s is 0.01, for both Sutter and Yuba Co. we again reject the null hypothesis; this is most likely due to the low number of scores reported at Interval 4. Point – E (Interval 4), Sutter Co.'s P-Value is 0.18. Yuba Co.'s cannot be calculated due to no data being collected for this score, for both Sutter and Yuba Co. we fail to reject the null hypothesis. Point – F (Close), Sutter Co.'s P-Value is 9.10. Yuba Co.'s is 2.10, for both Sutter and Yuba Co. we fail to reject the null hypothesis.

What the above information tells us is there is a lack of empirical data to tell for certain if the correct interventions were being used for the responding LOCUS Level.

Conclusion

Analysis of Data Gathering –

There is a limited data for comparison on AB109 applied interventions between Sutter and Yuba County, however a few comparisons can be made with this data.

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 most likely have received an additional reassessment at the 90-day mark, in additional to a 12-treatment session reassessment. For this first project year, those who received a reassessment within 90 days should be analyzed separately from those who were reassessed after 12 treatment sessions.

As discussed in the intake analysis section, the data suggests that Yuba County is seeing probationers with lower level mental health needs as compared to more high risk and in need of more intensive services individuals in Sutter County. Both counties showed decreases in the intensity of services needed by their clients as they progress through the INN Program.

University Rhode Island Change Assessment (URICA)

To be included in the analysis for URICA, clients must have logged a URICA intake score and a URICA close-out score. The URICA is only reassessed if a client is being discharged.

Sutter County:

After the first project year, 11 individuals were discharged from the INN Project. Only 4 out of the 11 clients were able to complete a URICA reassessment at discharge, however 14 scores were reported from Sutter County for Interval 1. All 4 clients showed no score difference between the baseline URICA and discharge URICA. There was one client who successful completed probation and this individual was included in the group described above and again showed no improvement in URICA. UTRICA Scores should only be reported at intake, close and discharge. These scores should not be collected as regular interval reporting.

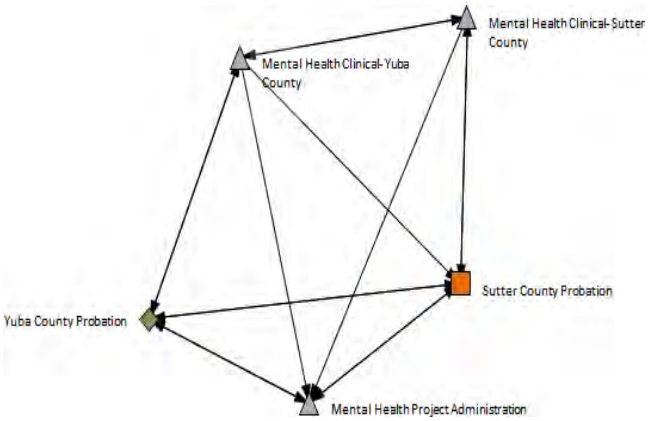
Yuba County:

After the first project year, 10 individuals were discharged from the INN Project. It was reported, only 4 out of the 10 clients were able to complete a URICA reassessment at discharge, however, these scores were not reported. It was also reported, "Three clients showed improvements following discharge". No scores were provided from Yuba County.

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

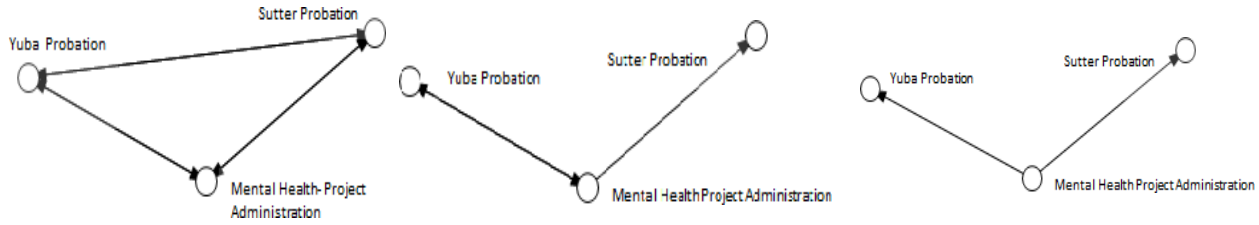
The PARTNER Survey is administered on an annual basis. The first administration of the survey occurred in March 2015. The PARTNER Survey was discontinued by the vendor in 2016.

PARTNER Survey:



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.

Level 1:	Level 2	Level 3:
Cooperative Activities:	**Coordinated Activities: Include cooperative activities in addition to intentional efforts to enhance each other's capacity for the mutual benefit of programs.**	**Integrated Activities:**
Involves exchanging information, attending meetings together, and offering resources to partners		**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 fully 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.

STRONG/Noble Data

STRONG data was collected for the first year of the project. Clients were evaluated by the STRONG every 6 months. The STRONG vendor stopped offering this evaluation partway through this study.

Noble data collection began in May 2016, after the PARTNER Survey was discontinued.

SUTTER-YUBA BEHAVIORAL HEALTH

BELIEVES

Empowering Healthy Communities

Prevention & Early Intervention Recreation Scholarship Program

Sutter-Yuba Behavioral Health

August 3, 2018

Prevention and Early Intervention (PEI) in Sutter-Yuba Behavioral Health involves reducing risk and stressors, building protective factors and skills, and increasing support. The goal of PEI is to promote positive cognitive, social, and emotional development, as well as to encourage a state of well-being that allows the individual to function well.

The **Recreational Scholarship Program** accomplishes this goal by reaching a large target population identified by the PEI

plan for Sutter and Yuba Counties—children, youth and transitional age youth (TAY) ages 16-24 who meet the following criteria:

- **Trauma exposure:** exposure to traumatic events or prolonged traumatic conditions.
- **Stressed families:** placed out of home or in families where there is substance abuse, violence, depression or other mental illness, or a lack of caregiving adults (serious health conditions or incarceration).
- *At risk of school failure*
- **At risk of, or experiencing, juvenile justice involvement**
- **Experiencing onset of serious psychiatric illness with psychosis (TAY only):** identified as presenting signs of mental illness first break.
- **Underserved populations:** ethnically/racially diverse communities, LGBTI, etc.

An application for Recreational Scholarship Funds can be completed for a youth to participate in an activity or for

equipment. This application can be completed by a professional in the community (i.e., social worker, teacher, etc.) and turned in to be reviewed by the PEI Coordinator, John Floe.

Upon approval, a 30, 60, and 90-day follow-up will be completed

by PEI staff in order to monitor and measure the effectiveness of

the scholarship for the recipient. The referring party is responsible

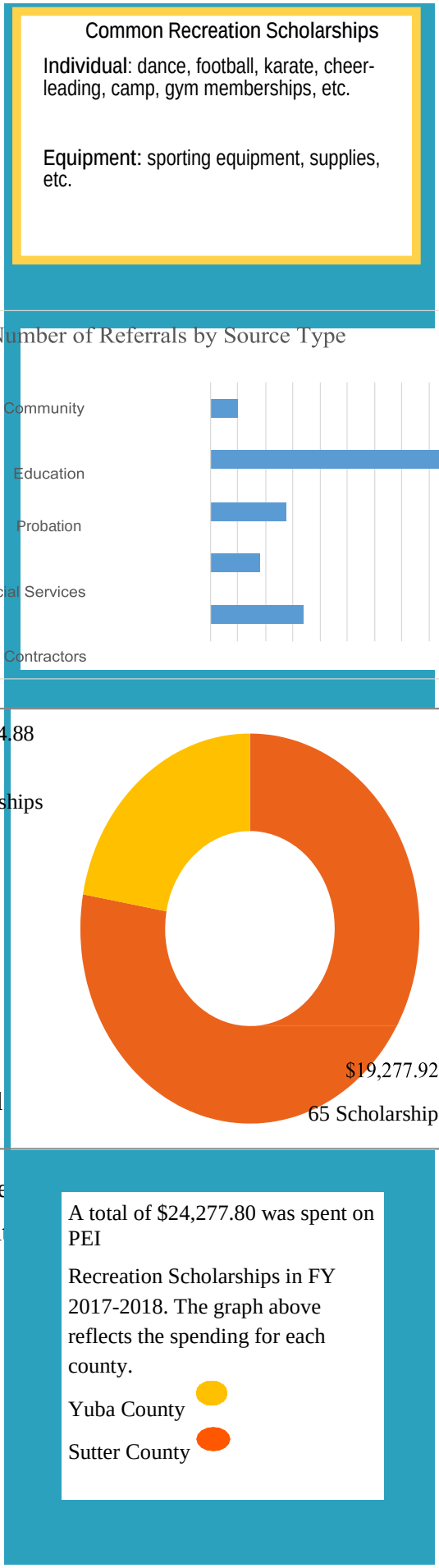
for providing information on outcomes and the recreational activi

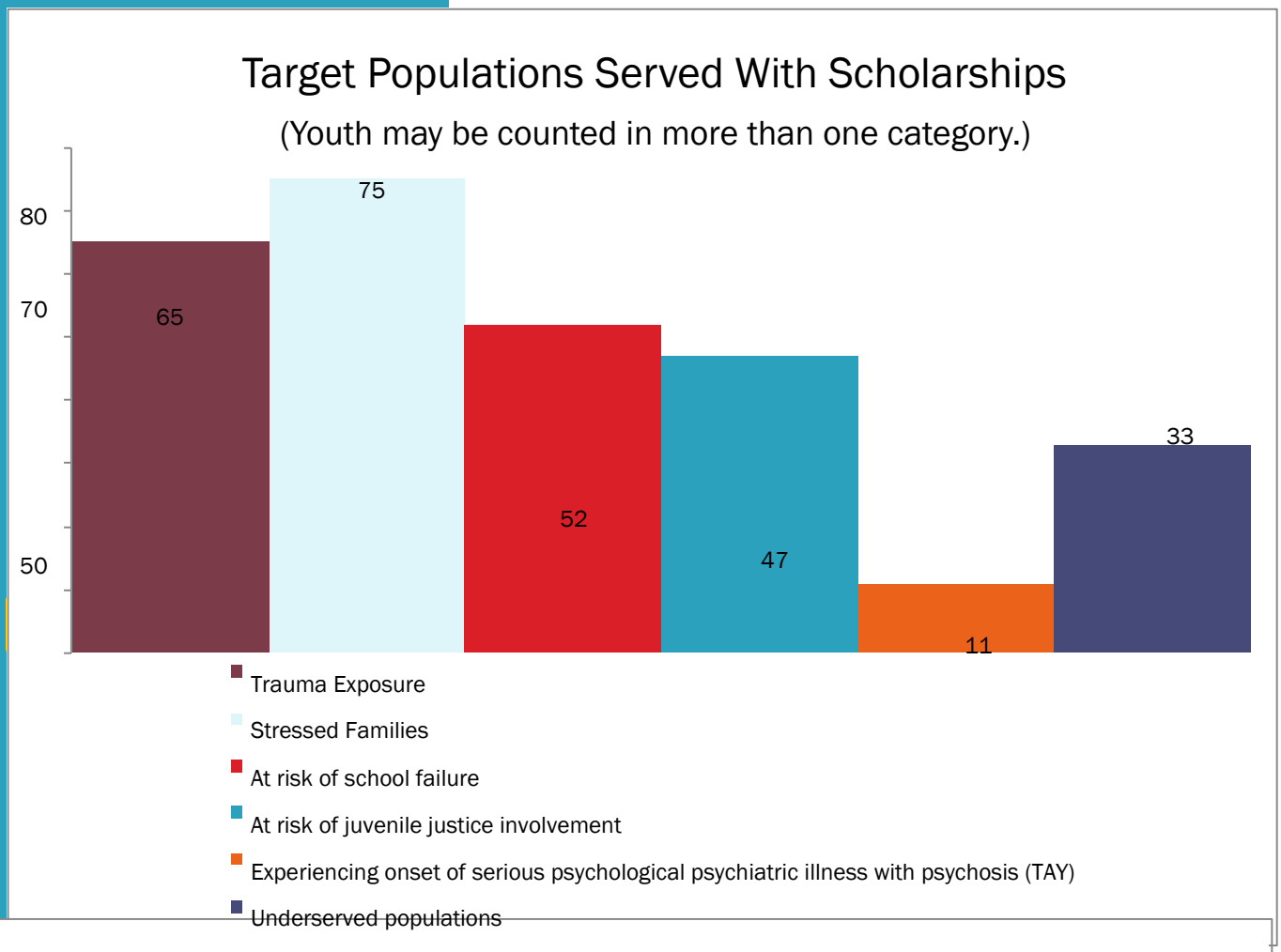
the recipient's behavior, academic progress, social skills, etc.

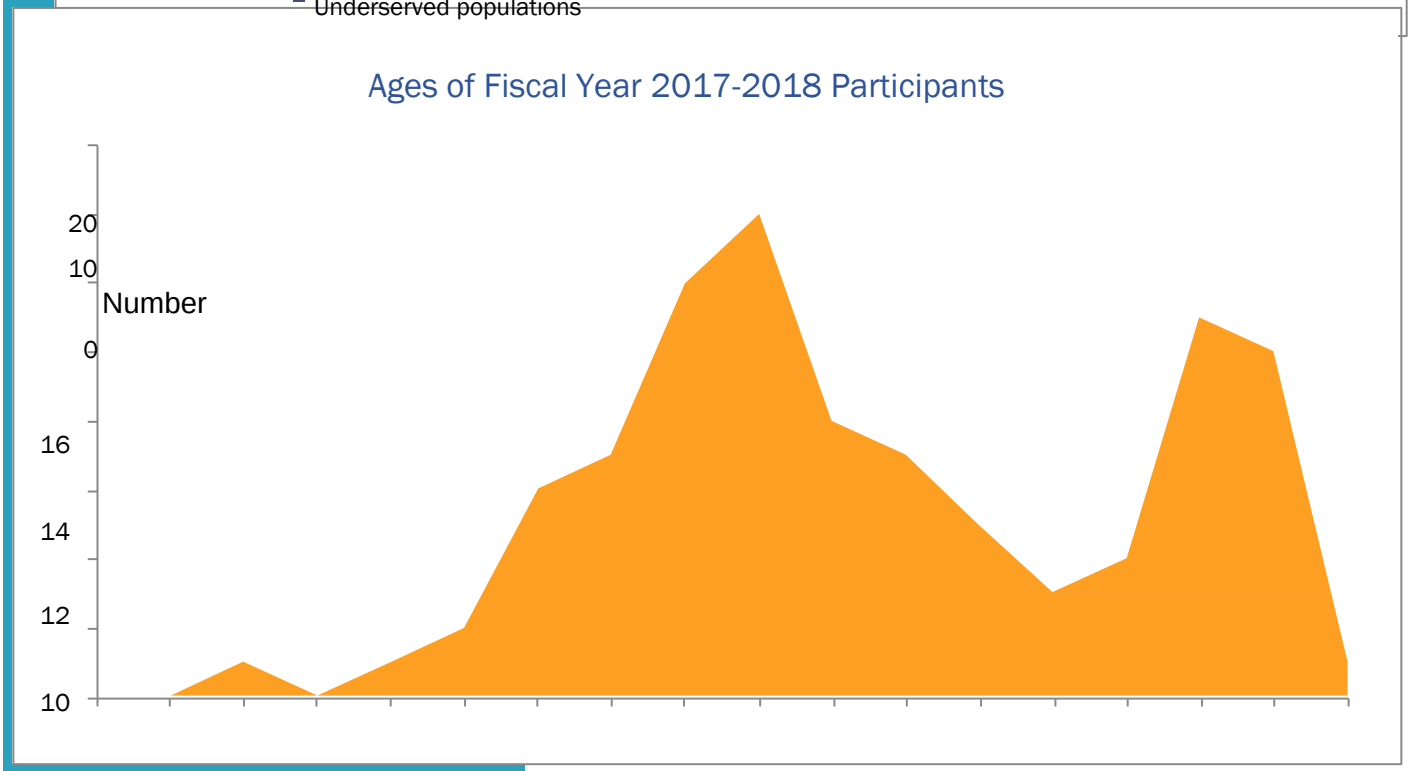
Upon completion and acceptance of the application, it is understood by the referring party that a mental health referral will be made if the referred individual shows signs of

needing a mental health evaluation.

Please see the graphs depicting approximate numbers for the Recreational Scholarship Program for fiscal year 2017-2018.




Target Populations Served With Scholarships
(Youth may be counted in more than one category.)
80
70
50
65
75
52
47
11
33
Trauma Exposure
Stressed Families
At risk of school failure
At risk of juvenile justice involvement
Experiencing onset of serious psychological psychiatric illness with psychosis (TAY)
Underserved populations


Ages of Fiscal Year 2017-2018 Participants
20
10
Number
0
16
14
12
10
84
2

Twin Cities Martial Arts Academy offers instruction in Tae Kwon Do, Hapkido Self-Defense, and Cardio Kickboxing for youth and adults. Through their programs, children learn to build self-esteem, gain better social skills, and how to control anger in a positive way. The six tenets of Tae Kwon Do are courtesy, integrity, perseverance, self-control, indomitable spirit, and victory.

Not only are these values taught in the academy during class, but staff also support families in teaching and en- forcing the values at home and at school. Each child is expected to turn in a “to do list” weekly as part of their belt requirement, showing that they have completed

the household contributions (chores), self-care, school work, and self-development. This expectation reinforces the importance of discipline, which is one of the foundations of Tae Kwon Do.

One child who received a PEI Recreation Scholarship struggled with “challenges with self-regulation and an insufficient level of focus, high impulsivity, and aggressive behavior towards peers and parents” prior to receiving a PEI Recreation Scholarship to participate in martial arts at Twin Cities Martial Arts Academy. After participating in individual instruction, the child “made excellent progress”. He enjoys the class, and it has “boosted his confidence”. He is now welcome to join

group sparring class, which “speaks to [his] increased

ability to self-regulate and socialize appropriately”.

“She [the scholarship recipient] is doing a lot better. She’s been less apt to want to physically control her peers. The activity has increased her self- esteem and helped her let go of the need for control of others.”

- Referring staff of a PEI Recreation

Scholarship Recipient

Youth who come from stressed families, including those who are placed out of the home or who are in families where there is substance abuse or violence, depression or other mental illness, or other mental illness, or a lack of caregiving adults are often at risk for school failure and/or juvenile justice involvement. Physical exercise has been shown to have many benefits beyond physical health, including improved mental health. Some other benefits include

- **Higher self-esteem.** Regular activity is an investment in your mind, body, and soul. When it be- comes habit, it can foster your sense of self-worth and make you feel strong and powerful. You'll feel better about your appearance and, by meeting even small exercise goals, you'll feel a sense of achievement.
- **Stronger resilience.** When faced with mental or emotional challenges in life, exercise can help you cope in a healthy way, instead of resorting to alcohol, drugs, or other negative behaviors that ultimately only make your symptoms worse. Regular exercise can also help boost your immune system and reduce the impact of stress.

PEI Recreation Scholarships have been funded for multiple youth facing the challenges of stressed families.

After youth have been funded for gym memberships, staff who have referred them have shared:

"Youth has more confidence and has expressed interest in joining school sports."

"Youth has improved confidence and has since graduated from high school."

"Youth appears to be more motivated to attend school and is attending summer school."

"It's helping to keep him out of trouble."

"He's coming to school more often."

Prevention & Early Intervention

Recreation Scholarship Program

Application for Funds &

Progress Report

Prevention & Early Intervention
(PEI)

Recreation Scholarship Program

Application for Funds

PEI Recreation funds provide recreational opportunities for children, youth, and transitional age youth (TAY, ages 16-24) who meet at least two of the criteria listed below:

1. **Trauma Exposure**: Exposure to traumatic events or prolonged traumatic conditions.
2. **Stressed Families**: Placed out of home, or in a family where there is substance abuse or violence, depression, or other mental illness, or a lack of caregiving adults (serious health conditions or incarceration).
3. **At risk for school failure.**
4. **At risk of, or experiencing, juvenile justice involvement**: Signs of emotional/behavioral problems and at risk of, or had contact with, juvenile justice systems.
5. **Experiencing onset of serious psychiatric illness with psychosis (TAY only):** Identified as presenting signs of mental illness first break
6. **Underserved populations**: Ethnically/racially diverse communities, LGBTI, etc.

Application must be completed by a non-family member who works with the youth/family of youth being referred. Please complete all relevant information. You may attach additional pages.

Application for:

Youth name: Age/DOB:

Target population represented (1-6):

Explain how the youth meets the definition for this target population. (Attach additional pages, if necessary):

Is the youth currently receiving mental health services?

Referral completed by: Agency:

Phone/Email:

Funds requested for:

A scholarship to participate in: (Describe activity and amount.)

Start date of activity:

Name & address of activity organization:

Purchase of sports/recreation equipment. Describe item(s) and place of purchase:

Other. Describe:

CHECK WILL BE WRITTEN TO ACTIVITY ORGANIZATION/EQUIPMENT PROVIDER. TOTAL AMOUNT REQUESTED:

Complete all items below:

Please describe how the funds will be used and/or why you believe the youth will benefit from the activity.

(Attach additional sheets, if necessary):

Please complete this brief survey:

Youth does well academically in school.

Strongly disagree Somewhat disagree Somewhat agree Strongly agree N/A

Youth does well socially in school.

Strongly disagree Somewhat disagree Somewhat agree Strongly agree N/A

Youth has a healthy sense of self confidence.

Strongly disagree Somewhat disagree Somewhat agree Strongly agree N/A

Youth has positive relationships with adults.

Strongly disagree Somewhat disagree Somewhat agree Strongly agree N/A

Youth has positive relationships with peers.

Strongly disagree Somewhat disagree Somewhat agree Strongly agree N/A

Please indicate the manner in which you would like to complete the progress reports. Please make sure you've included the appropriate contact information.

Email Phone Appointment

By signing below, you are agreeing to

Discuss/address potential transportation challenges with youth/youth's family to ensure youth's ability to regularly participate in funded activity;

2. **Use funds only for activities/equipment requested;**
3. **Use funds only for the requested youth;**
4. **Provide the PEI Recreation Scholarship check only to the activity organization or equipment provider;**
5. **Return check to PEI within 30 days if youth will not be participating in funded activity;**
6. **Provide PEI with periodic progress reports on the scholarship recipient, as requested.**

Signature Date

Please fax application to John Floe at 530.673.1810, or email to JFloe@co.sutter.ca.us.

If the individual shows signs of needing more mental health intervention, please refer to Sutter- Yuba Behavioral Health (youth) 822-7513 or (adult) 822-7200 for assessment or crisis services.

Prevention & Early Intervention

Recreation Scholarship Program

Progress Report

Youth name:

Referring person &

organization: Date the

recreational activity began:

Date of this report:

Youth does well academically in school.

☐ Strongly disagree ☐Somewhat disagree ☐Somewhat agree ☐Strongly agree ☐ N/A Youth does well socially in school.

☐ Strongly disagree ☐Somewhat disagree ☐Somewhat agree ☐Strongly agree ☐ N/A Youth has a healthy sense of self confidence.

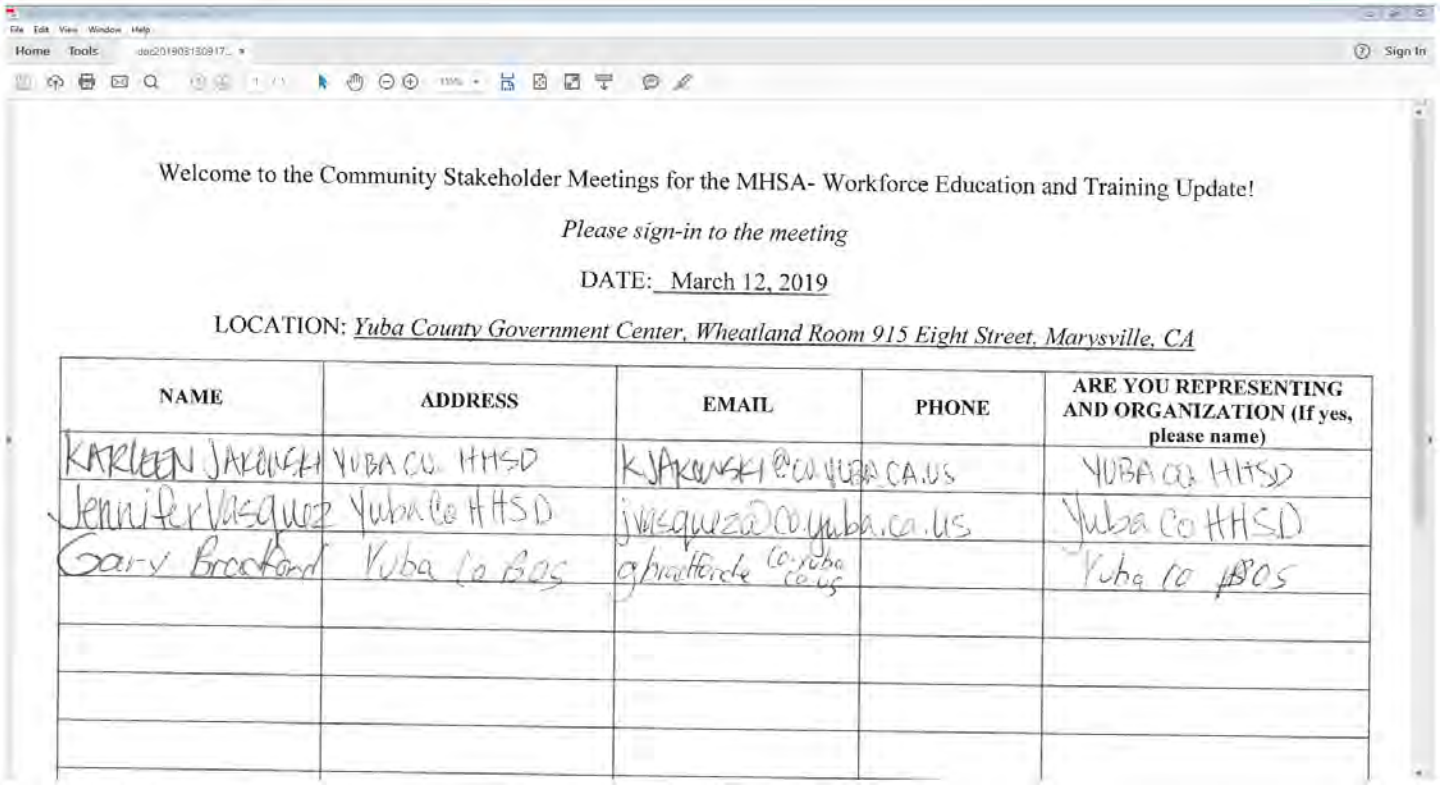
☐ Strongly disagree ☐Somewhat disagree ☐Somewhat agree ☐Strongly agree ☐ N/A Youth has positive relationships with adults.

☐ Strongly disagree ☐Somewhat disagree ☐Somewhat agree ☐Strongly agree ☐ N/A Youth has positive relationships with peers.

☐ Strongly disagree ☐Somewhat disagree ☐Somewhat agree ☐Strongly agree ☐ N/A

Additional comments/questions:

Sign-in Sheets -



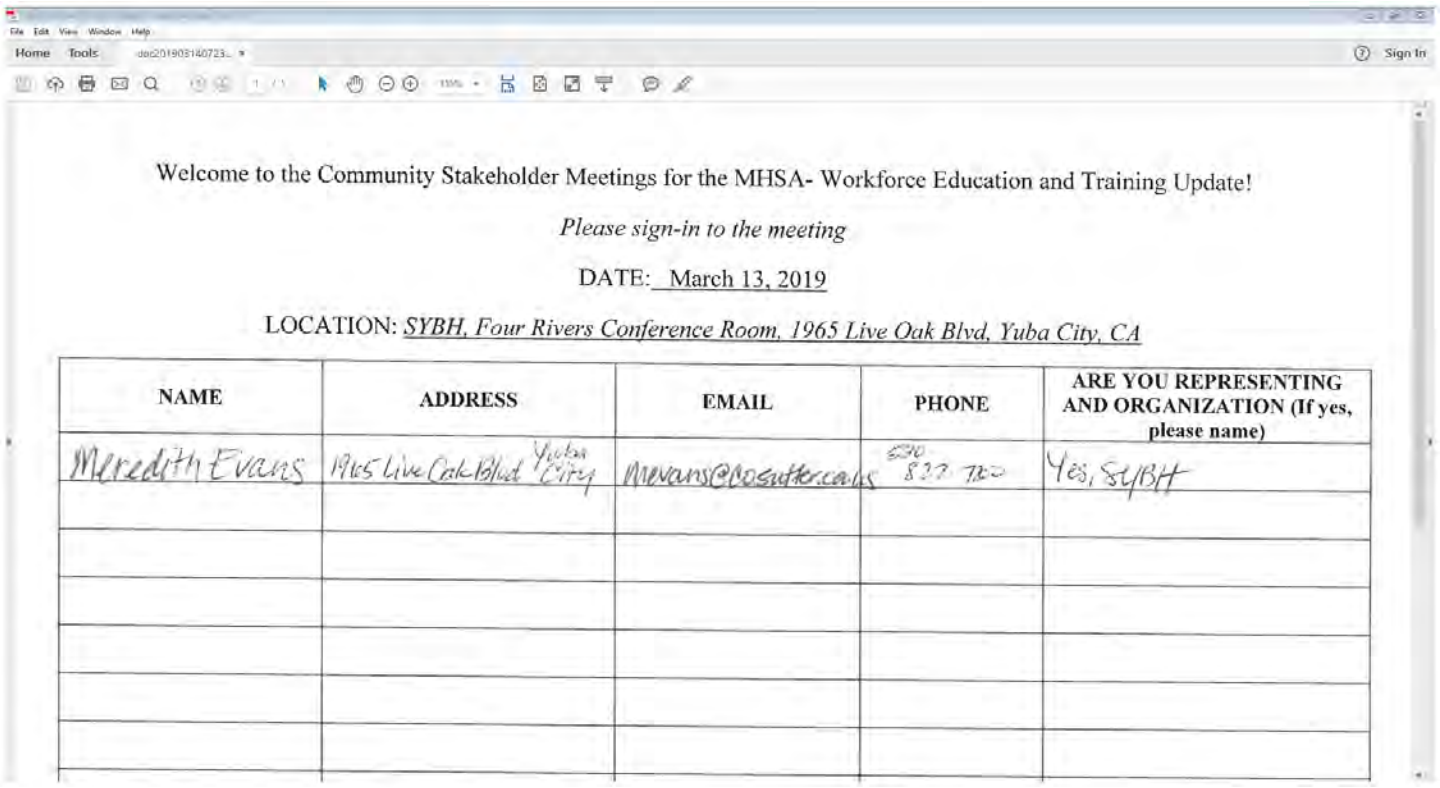
Welcome to the Community Stakeholder Meetings for the MHSA- Workforce Education and Training Update!

Please sign-in to the meeting

DATE: March 12, 2019

LOCATION: *Yuba County Government Center, Wheatland Room 915 Eight Street, Marysville, CA*

NAME	ADDRESS	EMAIL	PHONE	ARE YOU REPRESENTING AND ORGANIZATION (If yes, please name)
KATHLEEN JAKOWSKI	YUBA CO. HHSD	KJAKOWSKI@CO.YUBA.CA.US		YUBA CO. HHSD
Jennifer Vasquez	Yuba Co HHSD	jvasquez@co.yuba.ca.us		Yuba Co HHSD
Gary Bradford	Yuba Co BOS	gbradford@co.yuba.ca.us		Yuba Co BOS



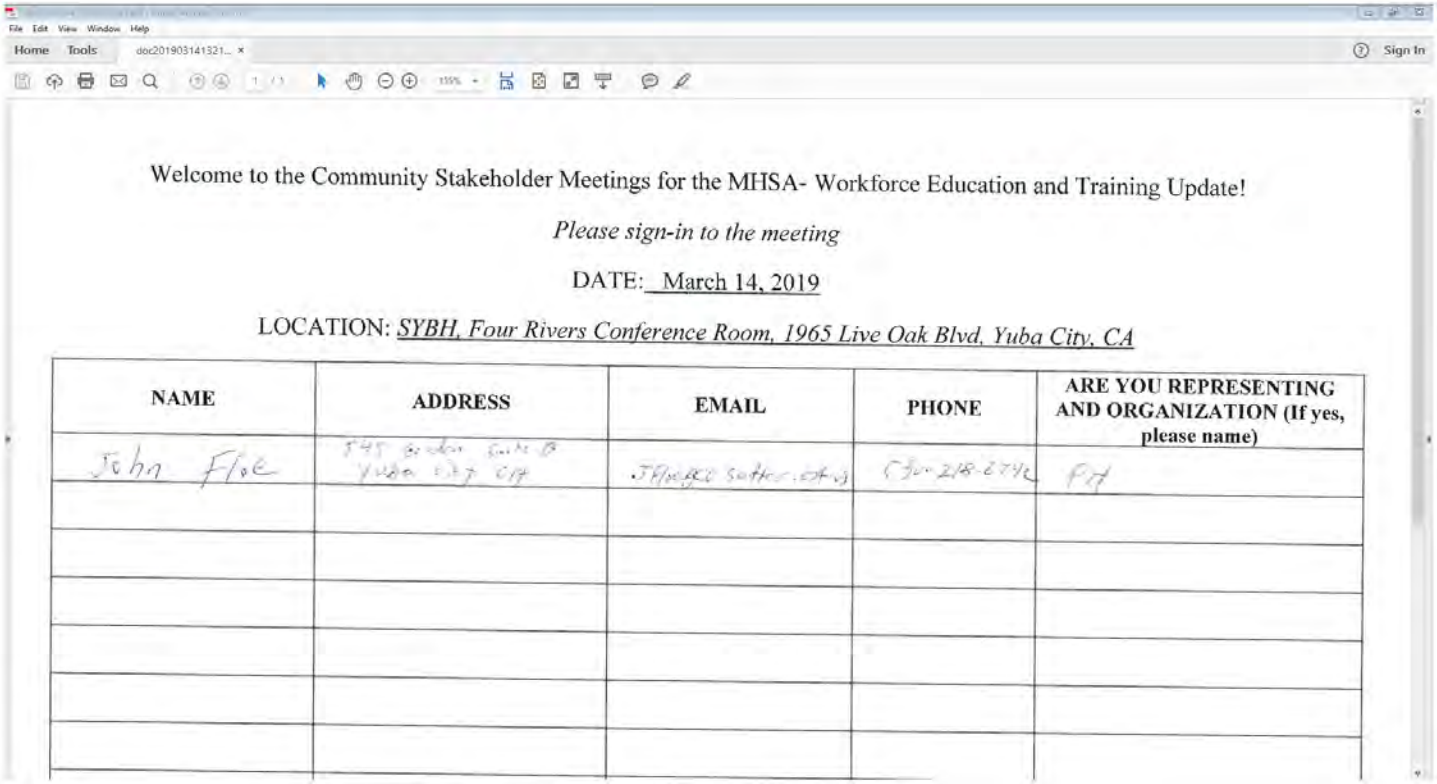
Welcome to the Community Stakeholder Meetings for the MHSA- Workforce Education and Training Update!

Please sign-in to the meeting

DATE: March 13, 2019

LOCATION: *SYBH, Four Rivers Conference Room, 1965 Live Oak Blvd, Yuba City, CA*

NAME	ADDRESS	EMAIL	PHONE	ARE YOU REPRESENTING AND ORGANIZATION (If yes, please name)
Meredith Evans	1965 Live Oak Blvd Yuba City	mevans@co.sutter.ca.us	530 822 7200	Yes, SYBH



Welcome to the Community Stakeholder Meetings for the MHSA- Workforce Education and Training Update!

Please sign-in to the meeting

DATE: March 14, 2019

LOCATION: *SYBH, Four Rivers Conference Room, 1965 Live Oak Blvd, Yuba City, CA*

NAME	ADDRESS	EMAIL	PHONE	ARE YOU REPRESENTING AND ORGANIZATION (If yes, please name)
John Floe	545 Gordon Ave B Yuba City CA	JFloe@co.sutter.ca.us	(530) 218-6742	PH