GLENN COUNTY BEHAVIORAL HEALTH

Mental Health Services Act
FY 2016/2017 Annual Update

POSTED FOR PUBLIC COMMENT
June 3, 2016 through July 5, 2016

The MHSA FY 2016/2017 Annual Update is available for public review and comment from June 3, 2016 through July 5, 2016. We welcome your feedback via phone, in person, or in writing. Comments may also be made during the Public Hearing to be held on Wednesday, July 6, 2016.

Public Hearing Information:
Wednesday, July 6, 2016, 11:00 am – 12:00 pm
Community Recovery and Wellness Center (CRWC)
1187 E. South Street, Orland, CA 95963

Comments or Questions? Please contact:
Amy Lindsey, Deputy Director
Glenn County Behavioral Health
242 North Villa Street, Willows, CA 95988
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alindsey@countyofglenn.net

Thank you!

MHSA Community Program Planning and Local Review Process

County: Glenn **30-day Public Comment period dates:** June 3 – July 5, 2016

Date: 06/02/16 **Date of Public Hearing:** Wednesday, July 6, 2016

COMMUNITY PROGRAM PLANNING

1. *Briefly describe the Community Program Planning (CPP) Process for development of all components included in the FY 2016/2017 Annual Update.*

The Glenn County Behavioral Health (GCBH) Community Program Planning (CPP) process for the development of the MHSA FY 2016/2017 Annual Update builds upon the planning process that we utilized for the development of our most recent Three-Year Plan, as well as past plans and annual updates. Over the past several years, these planning processes have been comprehensive and, since 2005, have included the input of diverse stakeholders through focus groups, stakeholder meetings, and surveys. It is estimated that over 1,200 stakeholders have participated in the planning process since 2005 (an 11-year period).

For the FY 2016/2017 Annual Update planning process that occurred in Spring 2016, we conducted focus groups and stakeholder meetings at our adult wellness center (Harmony House), the Transition Age Youth (TAY) Center, and the System Improvement Committee (SIC), as well as with our Innovation School Team, the System-wide Mental Health Assessment Response Treatment (SMART) Team. The Mental Health, Alcohol and Drug Commission members also provided input throughout the planning process. On a monthly basis, MHSA activities were discussed at a number of different committee meetings, which allowed ongoing input from staff, stakeholders, and consumers. In addition, we obtained input from community stakeholders and conducted outreach to the unserved and underserved.

We reviewed the survey results obtained in 2014 as part of the Three-Year Plan program planning process, to determine if there were other opportunities for expanding services. With this compiled information, we were able to determine the unique needs of our community and maintain an MHSA program that is well designed for our county. The overall goals of the most recent MHSA Three-Year Plan and the 2015/2016 Annual Update are still valid and provide an excellent guide for continuing to deliver MHSA services in FY 2016/2017.

Our Housing funds were recently released from CalHFA and we have held stakeholder meetings to obtain input on utilizing these funds. The Housing funds are now a component of our Community Supports and Services (CSS) budget and will be utilized to support clients in finding housing, paying for first month's rent, and getting basic furnishing so the individual can successfully live in an independent living situation.

We have also analyzed data on our Full Service Partnership (FSP) clients to ensure that clients are successfully achieving positive outcomes. This outcome data includes analysis of service utilization, reduction in inpatient services, and use of crisis services. Outcome and service utilization data is analyzed and reviewed by the SIC to monitor clients' progress over time. This data has helped us to understand service utilization and evaluate client progress, and has been instrumental in our ongoing planning process to continually improve services for our clients and families.

The Prevention and Early Intervention Program (PEI) has been updated to address the new PEI regulations which have become approved in the past year. As a result, we have reviewed each of our existing PEI programs and determined how serviced can be classified to meet the new PEI regulations. We have had extensive planning periods and stakeholder input to help design our updated PEI programs.

In addition to these stakeholder groups, we routinely discuss and obtain input on the utilization of MHSA funds with our key stakeholders during our monthly SIC meetings; our MHSA Consumer Voice Meetings; Cultural and Linguistic Competence Committee (CLCC); SMART Steering Committee Meetings (our Innovation Project); Katie A meetings; AB109 service recipients; and at the Quarterly Mental Health and Alcohol and Drug Commission. There are also a number of consumers, family members, and other stakeholders who provide ongoing input into our MHSA services and activities. All stakeholder groups and boards are in full support of this MHSA Annual Update and the strategy to maintain and enhance services.

The proposed Annual Update was developed and approved by the SIC after reviewing data on our current programs (including FSP data); reviewing community needs based on stakeholder input; and determining the most effective way to further meet the needs of our unserved/ underserved populations.

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.). Include how stakeholder involvement was meaningful.*

The MHSA Annual Update community program planning process included a wide representation from the community, AB 109 service participants, social service agencies, law enforcement, probation, education, and persons with lived experience and family members. Interpreters were available to provide translation services for mono-lingual Spanish speaking clients. This process also included involvement of our TAY and peer mentors. We conducted focus groups and stakeholder meetings at both our adult wellness center (Harmony House) and the Transition Age Youth (TAY) Center. Mental Health, Alcohol and Drug Commission members also provided input throughout the planning process. Consumers comprised the majority of the focus group participants; these discussions centered on the housing fund transfer and allowable expenditures; the revised PEI regulations and planned programs, and overall satisfaction with the current MHSA services. The ideas presented by consumers will be used to enhance MHSA services in the coming year.

We continue to implement our Innovation program, SMART. The SMART meets weekly, with individuals from law enforcement, mental health, probation, schools, and child welfare in attendance. SMART has developed a collaborative process to identify high-risk children, youth, and adults and develop strategies for engaging individuals, family members, and community members in developing creative solutions to help resolve any threats or other complex situations, and implementing a cohesive plan across partner agencies. This collaboration has provided excellent opportunities to improve services in our MHSA programs.

In addition, we specifically engaged health care providers to provide input into our planning process. Our stakeholder process was comprehensive and meaningful. The combination of focus groups, personal interactions, and the surveys help to give voice to a broad range of individuals across our community. This input informed our development, plan, and implementation of our annual update.

FY 16/17 Planning Focus Groups

Group 1: **Mental Health Staff** 9 Attendees: • 2 Males • 7 Females • 1 TAY Youth age 22 • 8 Adults between age 25 to 55 • 2 Hispanic • 7 White	Group 2: **HH Consumer Group** 8 Attendees: • 2 Males • 6 Females • 1 TAY Youth age 21 • 6 Adults between age 25-55 • 1 Older Adult age 67 • 1 Hispanic • 7 White
Group 3: **TAY Consumers** 10 Attendees: • 4 Males • 6 Females • 10 TAY Youth between age 16 to 24 • 2 Hispanic • 8 White	Group 4: **SMART Partners** 10 Attendees: • 2 Males • 8 Females • 10 Adults between 25-55 • 2 Hispanic • 8 White
Group 5: **AB109 Task Force** 8 Attendees: • 4 Males • 4 Females • 7 Adults 25-55 • 1 Older Adult 66 • 1 Hispanic • 2 Native American • 5 White	

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.*

This proposed MHSA FY 2016-2017 Annual Update has been posted for a 30-day public review and comment period from June 3, 2016 through July 5, 2016. An electronic copy has also been posted on the County website with an announcement of the public review and comment period, as well as the Public Hearing information. The posting provides contact information to allow input on the plan in person, by phone, written and sent by mail, or through e-mail. A hard copy of the Annual Update has been distributed to all members of the Mental Health, Alcohol and Drug Commission; System Improvement Committee; consumer groups; and staff. Copies of the Annual Update have been placed at the clinics in Willows and Orland; at Harmony House (the Adult Wellness Center); at the TAY Center; with partner agencies; and at the local libraries. The Annual Update is also available to clients and family members at all of these sites, on the County website, and upon request.

A public hearing will be held on Wednesday, July 6, at 11:00 am – 12:00 pm at Community Recovery and Wellness Center (CRWC), 1187 E. South Street, Orland.

For comments or questions, please contact Amy Lindsey, Deputy Director at (530) 934-6582 or alindsey@countyofglenn.net.

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

Input on the MHSA FY 2015-2016 Annual Update will be reviewed and incorporated into the final document, as appropriate, prior to submission to the County Board of Supervisors for review. The final approved document will be submitted to the California Mental Health Services Oversight and Accountability Commission (MHSOAC).

MHSA Program Component
COMMUNITY SERVICES AND SUPPORTS (CSS)

1. ***Provide a program description (must include number of clients served, age, race/ethnicity). Include achievements and notable performance outcomes.***

The Glenn County MHSA activities have been very successful. We created a strong foundation of programs with our two wellness centers, Harmony House for adults and older adults, and the Transition Age Youth (TAY) center for youth. These wellness centers have created an alternative to our mental health clinics for supporting individuals in their wellness and recovery.

Our Weekend Wellness Program started as an Innovation Project, but is now fully funded with CSS and Medi-Cal dollars. This excellent program helps support individuals to successfully live in the community, following discharge from an IMD, board and care, and/or group home. This program also supports individuals to remain living in the community. This program has been extremely successful and clients feel that the program has been highly effective at providing a supportive "family" environment on the weekends, and has provided an added level of support that they do not receive during the week day programs. Fewer than 5% of all individuals participating in this program have returned to higher levels of care. All other individuals have remained living in the community and continue to thrive and work on their wellness and recovery goals. Once a month, the Weekend Wellness staff transport Glenn County clients who are residing in a Board and Care home in Red Bluff back to Orland to attend our Weekend Wellness group. This strategy helps these individuals to meet people, talk with them about how they are successful in living independently in the community, and helps the Board and Care clients to transition back into the Glenn County Community.

We offer primary care services at our Behavioral Health facility in Orland, through a contract with Ampla Health Care, our local Federally Qualified Health Center (FQHC). In recent months, Ampla has had to reduce the number of hours per month delivering primary care services at Behavioral Health. However, we are hopeful that we will be able to return to previous hours of operation in the coming months.

We continue to expand the number of different wellness and healthy living support services that we offer at Harmony House and the TAY Center. These healthy support services include nutrition and cooking classes, yoga, exercise and fitness, meditation, and wellness 101 12 week class. Our nurse also offers a one time a week nutrition class and a medication information and compliance group. The Coaches and Peer Mentors are also offering age-specific WRAP training groups with different groups focused on adults, TAY, and Children (new this year).

We have worked closely with the Primary Care Physician Assistant from Ampla Health Care to support individuals to stop smoking, manage their chronic health conditions (diabetes, high blood pressure), and reduce their dependence on pain medications. We also offer a wellness support group in Spanish to our clients who are monolingual.

To ensure a recovery focus and to support consumer voice, we utilize up to four (4) part-time Youth Peer Mentors and four (4) part-time Adult Coaches to help deliver appropriate services and navigate the mental health system. Peer Mentors and Coaches have experience with mental health services and the circumstances affecting clients at various stages of their lives. Through their personal experiences, they are knowledgeable of community resources and how to access

them to help with these transitions. Our Peer Mentors and Coaches are involved with our FSP clients, their families (when appropriate), and community support systems, ensuring that FSP clients receive "whatever it takes" to attain their goals and achieve positive outcomes. Both wellness centers also utilize volunteers to both offer additional services to individuals attending the centers and to develop core employment skills such as arriving on time, performing tasks consistently, and greeting the public in a warm and welcoming manner.

We continue to provide Outreach and Engagement activities to persons in the community who are at-risk of needing mental health services. We also offer outreach to the homeless population in the county. When needed, individuals are able to take showers when they visit Harmony House. They are encouraged to access other services, after they have developed trusting relationships with the Harmony House staff and clients.

Services are available at our two mental health clinics: the outpatient clinic located in Willows; and the Community, Recovery, and Wellness Center (CRWC) in Orland. The CRWC is the location where we offer primary care services. We developed a Transitions Learning Center (TLC) for individuals in the AB109 program and other community members to help link individuals to needed services. These individuals can receive several of their services at the TLC. These services may include primary care, mental health, psychiatry, substance use treatment, employment skills, and linkage to benefits.

We have stationed an eligibility worker and an Employment Training Worker from CalWORKS at TLC, one-half day each week. These staff help meet the needs of individuals as they transition into the community and help them to develop job-readiness skills. We also have a certified teacher visit the TLC every week to help individuals obtain their GED and/or high school diploma. Individuals are also linked to trade schools in the region, to help them develop skills for specific jobs (e.g., truck driving; auto mechanics; plumbing). Other groups that are offered include Relapse Prevention; Anger Management; Living in Balance; and Courage to Change classes. We also offer a Strengthening Families 10 week course twice a year.

As we design groups of services at the TLC, we are cognizant of individuals with different gang affiliations. We develop different groups to ensure that we are creating a safe environment for these individuals. In addition, we offer two evidence-based programs to develop skills in anger management (*Courage to Change* and *What's Good About Your Anger*, a 12-week curriculum).

We continue to improve our programs to enhance family relationships across all age groups; increase family activities to promote wellness and improved outcomes; expand our services for persons with co-occurring mental health and substance use disorders; and reduce depression and suicidal behavior.

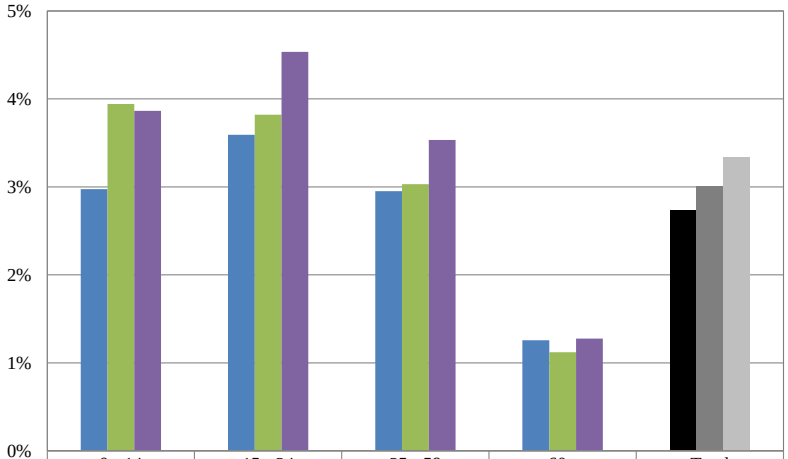
We have focused on expanding our programs and collaborating with our partner agencies, including schools, law enforcement, social services, jail, and probation. We continue to expand our services for children enrolled in the Katie A program. Mental Health and Child Welfare staff work closely to coordinate services, attend Child and Family Team meetings (CFT), and provide services to these high-risk families. In addition, we have expanded efforts to reduce bullying and improve anger management skills in school age children and youth.

We have also enhanced our services to support early recognition of depression, suicide, and help reduce the stigma of accessing mental health services. We offer training in the community to develop skills in recognizing signs and symptoms of depression and suicide, and offer skills so that community members will know how to make referrals and support the individual. This

approach includes offering Applied Suicide Intervention Skills Training (ASIST) and SAFETALK for partner agencies and other members in our community. Individuals at both TAY and Harmony House receive support for developing a Wellness and Recovery Action Plan (WRAP). We also supported a Crisis Intervention Training for local Law Enforcement and mental health staff. This 4-day training helped strengthen the relationships between law enforcement and mental health staff, and enhance skills to resolve crisis situations in the community, whenever possible.

The graphs below show the penetration rate and number of CSS clients served, by age, race/ethnicity, preferred language, and gender. The mental health penetration rate graph shows that the number of persons served has increased each year over the past three years. The penetration rate (number of persons receiving mental health services out of the total population) has increased from 2.7% in FY 2012/13 to 3.3% in FY 2014/15. The total number of persons served has increased from 769 to 938 in this three-year period.

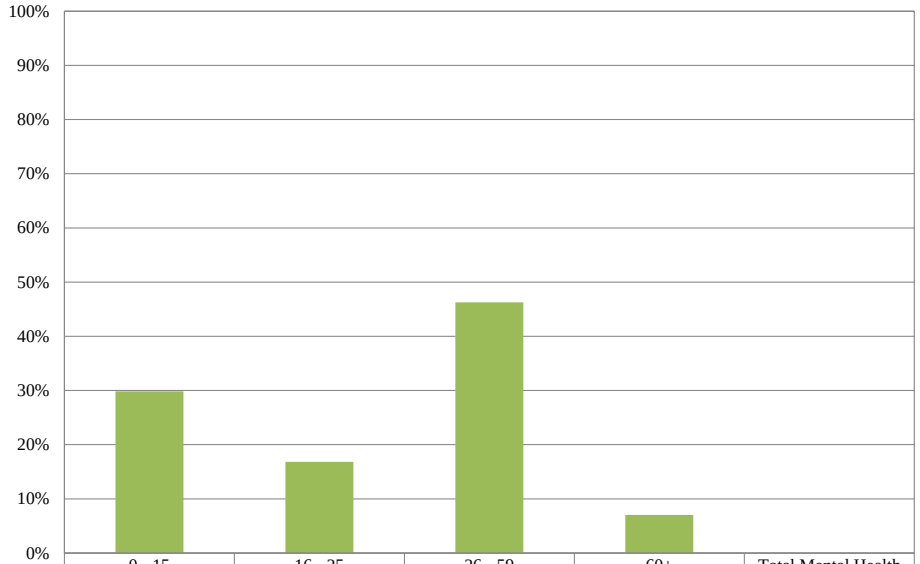
Glenn County Mental Health Services
FY 2012-13 to FY 2014-15
Mental Health <u>Penetration Rate</u>, by Age



	0 - 14	15 - 24	25 - 59	60+	Total
FY 2012-13 # Clients	194	141	369	65	769
FY 2012-13 Penetration Rate	3.0%	3.6%	3.0%	1.3%	2.7%
FY 2013-14 # Clients	257	150	379	58	844
FY 2013-14 Penetration Rate	3.9%	3.8%	3.0%	1.1%	3.0%
FY 2014-15 # Clients	252	178	442	66	938
FY 2014-15 Penetration Rate	3.9%	4.5%	3.5%	1.3%	3.3%
Glenn County Census Population	6,520	3,926	12,505	5,171	28,122

The following graph, Number and Percent of Mental Health Clients by Age, shows data for FY 2014/15. For the 938 individuals served, 29.9% were children ages 0-15; 16.8% were Transition Age Youth (TAY) ages 16-25; 46.3% were Adults ages 26-59; and 7% were Older Adults ages 60+.

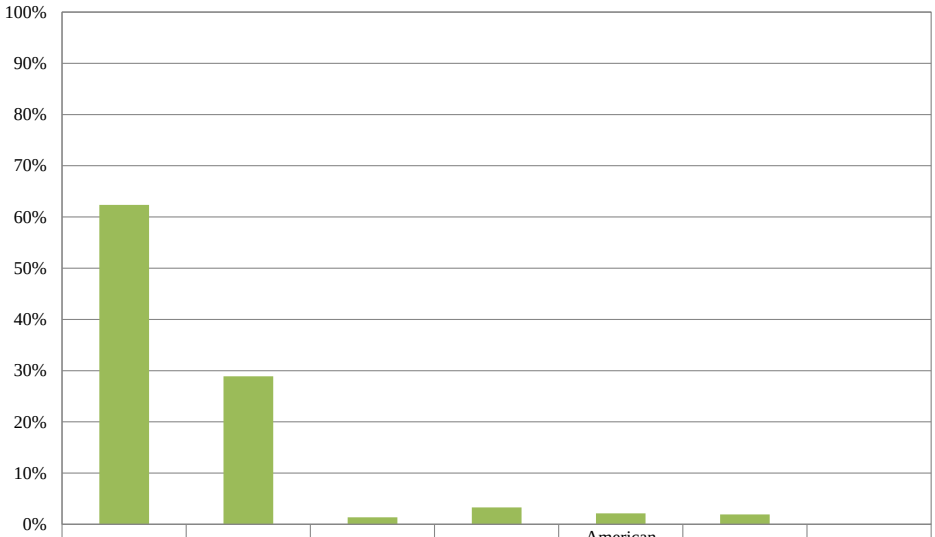
Glenn County Mental Health Services
FY 2014-15
Number and Percent of Mental Health Clients by Age



	0 - 15	16 - 25	26 - 59	60+	Total Mental Health
# of Clients	280	158	434	66	938
% of Clients	29.9%	16.8%	46.3%	7.0%	100.0%

The next graph, Number and Percent of Mental Health Clients by Race/Ethnicity, shows data for FY 2014/15. For the 938 individuals served, 62.4% were Caucasian; 28.9% were Hispanic; 1.4% Black/African American; 3.3% Asian/Pacific Islander; 2.1% American Indian; and 1.9% Other or Unknown.

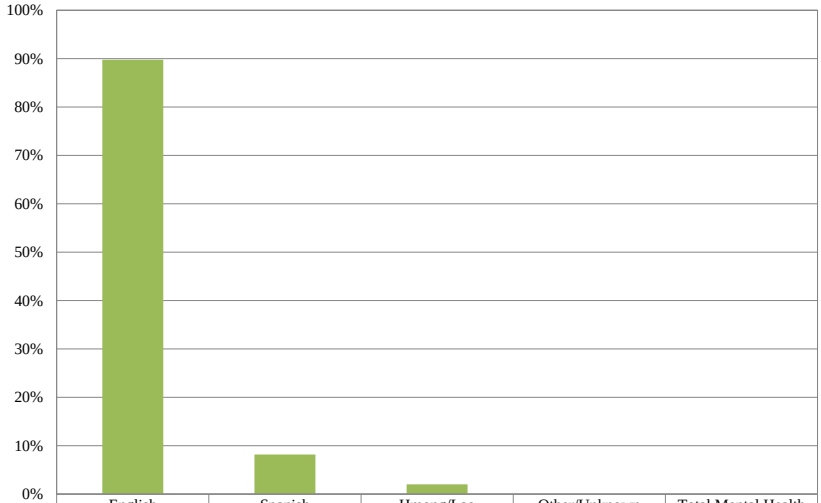
Glenn County Mental Health Services
FY 2014-15
Number and Percent of Mental Health Clients by Race/Ethnicity



	Caucasian	Hispanic	Black/African American	Asian/Pacific Islander	American Indian/Alaskan Native	Other/ Unknown	Total Mental Health
# of Clients	585	271	13	31	20	18	938
% of Clients	62.4%	28.9%	1.4%	3.3%	2.1%	1.9%	100.0%

The next graph, Number and Percent of Mental Health Clients by Preferred Language, shows data for FY 2014/15. For the 938 individuals served, 89.8% had a preferred language of English; 8.2% Spanish, and 2% Hmong/Lao.

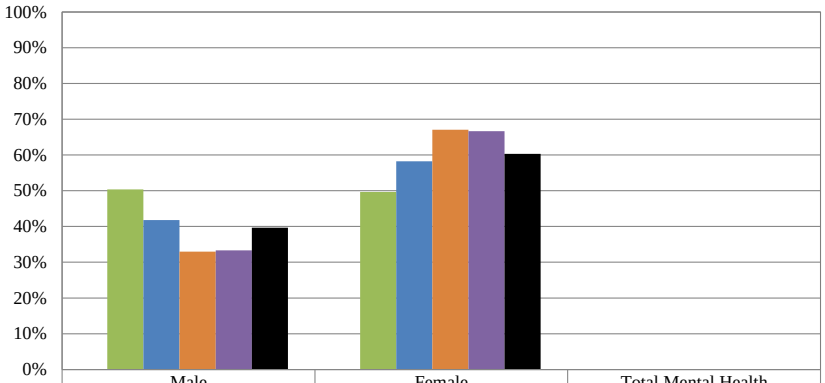
Glenn County Mental Health Services
FY 2014-15
Number and Percent of Mental Health Clients by Preferred Language



	English	Spanish	Hmong/Lao	Other/Unknown	Total Mental Health
# of Clients	842	77	19	0	938
% of Clients	89.8%	8.2%	2.0%	0.0%	100.0%

The next graph, Number and Percent of Mental Health Clients by Gender and Age, shows data for FY 2014/15. Children ages 0-15 had an equal number and percent of males and females. There were 141 males (50.4%) and 139 females (49.6%). TAY served a higher number of females. There were 92 females (58.2%) and 66 males (41.8%). Similarly, Adults also served more females. There were 291 female adults served (67.1%) and 143 males (32.9%). Older Adults also show the same trend, with 44 females (66.7%) and 22 males (33.3%). Across all ages, there were 566 females (60.3%) and 372 males served (39.7%).

Glenn County Mental Health Services
FY 2014-15
Number and Percent of Mental Health Clients by Gender and Age



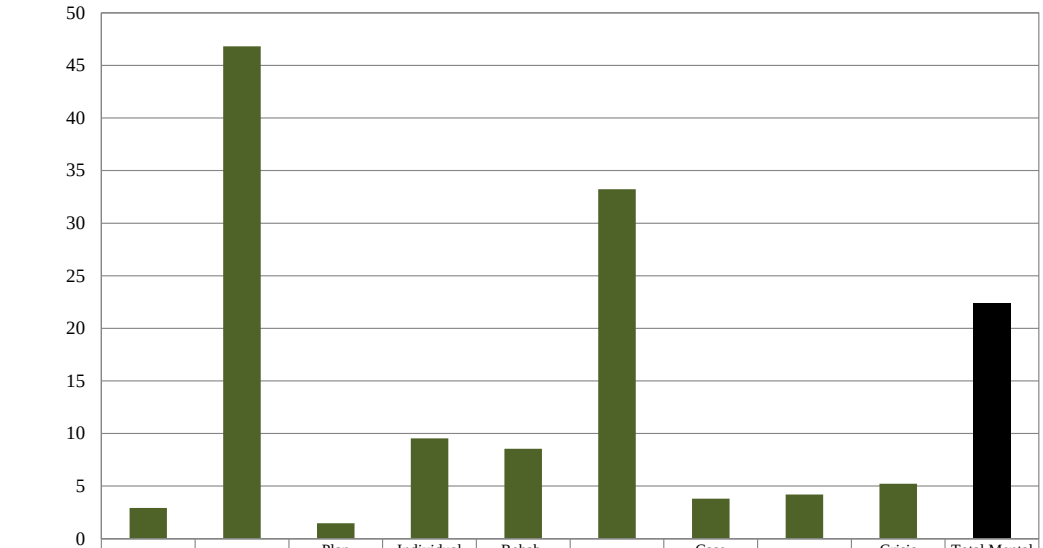
	Male	Female	Total Mental Health
# Child Clients (0 - 15)	141	139	280
% Child Clients (0 - 15)	50.4%	49.6%	100.0%
# TAY Clients (16 - 25)	66	92	158
% TAY Clients (16 - 25)	41.8%	58.2%	100.0%
# Adult Clients (26 - 59)	143	291	434
% Adult Clients (26 - 59)	32.9%	67.1%	100.0%
# Older Adult Clients (60+)	22	44	66
% Older Adult Clients (60+)	33.3%	66.7%	100.0%
# Total Clients	372	566	938
% Total Clients	39.7%	60.3%	100.0%

The final graph shows total mental health hours of service by type of service, the number of clients receiving that services, and the average hours per client by type of service. Please note that a client may receive more than one type of service in the year.

Across all services, the 938 clients served in FY 2014/15, received a total of 20,982.92 hours of service. This data averages to 22.37 hours per client. For Assessment, 617 clients received an assessment. The total number of assessment hours was 1,801.2. This data calculates into each assessment averaging 2.92 hours per client.

Katie A is an intensive service program for children who are involved in the Child Welfare system. There were only 24 children enrolled in this program. These children received 1,123.38 hours of services, for an average of 46.81 hours per child. It is important to understand the total number of clients receiving each type of service, when reviewing this graph.

Glenn County Mental Health Services
FY 2014-15
Total Mental Health Hours, Clients, and Hours per Client per Year, by Service Type
All Mental Health Clients



	Assessment	Katie A.	Plan Development	Individual Therapy	Rehab. Individual	Group	Case Management	Medication	Crisis Intervention	Total Mental Health
Total Hours	1,801.20	1,123.38	497.92	5,399.62	1,771.12	5,415.08	2,727.23	1,250.72	996.65	20,982.92
Und. Clts	617	24	338	566	207	163	717	298	191	938
Hrs/Clt	2.92	46.81	1.47	9.54	8.56	33.22	3.80	4.20	5.22	22.37

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

We are also in the process of expanding our mental health staffing to meeting the needs of our expanding Medi-Cal population and to expand services to serve persons with mental health conditions referred from our local managed care organization. We have a contract with Simpatico for delivering mental health services. We are also learning to coordinate services with the two local managed care health plans (Anthem; California Health and Wellness). We have developed contracts to provide mental health services to persons who meet medical necessity with a mild to moderate mental health disorder.

This approach has greatly expanded the number of clients who are being seen at our clinic and creates a shortage of mental health clinicians for delivering services. We continue to develop

strategies to support staff to manage higher caseloads and meet the needs of all of our clients. We are also identifying opportunities to train staff to utilize brief therapy, when appropriate.

3. List any significant changes from previous fiscal year, if applicable.

The only significant change to the CSS Program in FY 2016/2017 is the implementation of the housing funds. We are excited about the opportunity to support our clients to live independently and have the additional funds to help move into an independent living situation, and have the needed furnishings to enable each person to be successful. We will utilize a Housing First model, utilizing housing vouchers, supporting clients to move into independent living, support them to be able to perform activities of daily living (cooking, cleaning, money management), and helping clients with supportive services to ensure they are able to be successful in their independent living situation.

MHSA Program Component
PREVENTION AND EARLY INTERVENTION (PEI)

1. ***Provide a program description (must include number of clients served, age, race/ethnicity, and cost per person; try to separate data for Prevention and Early Intervention, if possible). Include achievements and notable performance outcomes.***

The new PEI regulations have outlined additional categories for delivering PEI services, including 1) Prevention; 2) Early Intervention; 3) Outreach; 4) Stigma Reduction; and 6) Suicide Prevention. Each of these PEI areas are described below, with descriptions of programs funded under each category.

1) Prevention: We have identified two programs for the Prevention component, Prevention Activities; and Access and Linkage.

a. Prevention Activities included in this component include a number of different activities offered by our TAY Peer Mentors at our schools and Adult Coaches at Harmony House. The Peer Mentors make presentations to the schools using prevention programs, such as Say It Straight and a variety of Bullying Programs. Wellness and Recovery Plans (WRAP) are taught to both TAY and Adults who attend the drop-in centers. A WRAP plan helps individuals to recognize triggers to exacerbating their mental health symptoms as well as identify support persons in their life to call, when needing additional support.

b. Access and Linkage activities includes continuing staffing our Welcoming Line to provide a "warm line" which is available to anyone in the community who has questions about mental health, needs linkage to other services, or needs a friendly voice. Currently, the line is open from 1:00 pm – 5:00 pm, Monday through Friday. The Welcoming Line is located at our MHSA Adult Wellness Center, Harmony House, and is staffed by trained individuals who are Coaches and Case Managers. It provides preventative services, responding to callers' questions about services, and quickly linking individuals to services, when needed. In addition, staff have a scheduled list of persons to call each week, to provide outreach and a connection to individuals who may feel isolated and appreciate a weekly supportive call from a peer.

The Welcoming Line project is designed to improve access to unserved and underserved populations by immediately connecting the caller to an individual who is knowledgeable about resources, and is willing to listen to the caller and determine the need for services. The Welcoming Line is utilized by many different populations, including individuals and family members experiencing stress; LGBTQ individuals; and older adults. In addition, TAY Peer Mentors also provide outreach to transition age youth and provide extra support to youth over phone. By offering immediate interactions and supportive responses to callers, we provide the support and welcoming conversation to help individuals remain stable and prevent an escalation in symptoms. We have also identified a number of people who need some extra support. We call them on a regular schedule to provide that support. In the next year, we are going to offer more training opportunities to consumer volunteers, which will allow them to participate in answering the welcome line.

Across the past twelve (12) months, there were over 244 calls to the Welcome Line. In addition, staff make over 558 calls to individuals to provide support and linkage to other services. The majority of calls are supportive calls for existing clients, providing important linkage and a warm, welcoming voice to support them when they are feeling alone and isolated.

2) **Early Intervention**: Early Intervention programs require a strong evaluation component, that includes use of an Evidence-Based Program, with pre- and post-outcomes measures to demonstrate program effectiveness. We have identified two programs for the Early Intervention component: Parent-Child Interaction Therapy (PCIT) ; and Strengthening Families.

   a. Parent-Child Interaction Therapy (PCIT) is an evidence-based practice which utilizes a specially equipped treatment room to train parents in parenting and behavioral management skills. PCIT provides families with very direct and individualized parenting skills that are developed through a process in which parents receive instruction through an earpiece that is linked to a therapist/intern. The therapist/intern, from behind a one-way mirror, observes interactions between the parent and child, coaches the development of relationship enhancement techniques, and gives behavioral interventions for how to respond to difficult parent/child situations. Each training session lasts about 1 hour; occurs for approximately 15-20 weekly visits; and shows very strong outcomes for both parents and children. Staff may provide in-home support to generalize the skills learned in the home setting, including replacement skills.

      PCIT is utilized for parents of children 0-8 years of age. PCIT combines the social-emotional development of children as related to the parent-child relationship alongside ways to help improve behaviors that have proven important for successful school performance, and to help families reduce domestic violence, child abuse and neglect.

      We utilize four (5) existing clinical staff, who have been certified as PCIT trainers, for training other staff to utilize this evidence-based practice. This strategy includes training bilingual, bicultural staff to implement PCIT for our Spanish-speaking families. This training continues to expand our capacity to offer these exemplary services to our Hispanic population. Update these numbers: There were 41 families who received PCIT this fiscal year. Seven (7) families were Spanish speaking.

   b. Strengthening Families Program is the second evidence-based program selected for the Early Intervention component of PEI. Strengthening Families is a 14-session, evidence-based parenting skills, children's social skills, and family life skills training program specifically designed for high-risk families. Parents and children participate in Strengthening Families programs both separately and together. Approximately 15 families are enrolled in the program. It is offered twice each year. Mental Health staff are funded through these PEI funds, while SUD staff are funded through the Alcohol and Drug program.

3) **Outreach:** The Outreach Program includes many of the activities of the TAY Peer Mentors and Adult Coaches. The Peer Mentors provide outreach to the community, have tabling events at the schools to inform youth of signs and symptoms of mental health, suicide, and provide linkages to services.

4) **Stigma Reduction:** We utilize PEI funds to offer stigma reduction activities. All of our PEI activities have a component that helps to reduce stigma. It is difficult to separate out Stigma Reduction from our broad range of activities for Suicide Prevention, Outreach, and other prevention activities. It is also difficult to measure a reduction in stigma separate from the outcome from other PEI programs. We will continue to develop activities to reduce stigma, and will utilize tools recommended by DHCS for measuring the reduction of stigma, as they are developed. Staff also work closely with CalMHSA on Each Mind Matters.

5) **Suicide Prevention:** The Suicide Prevention Program works to provide a number of suicide prevention activities in the county. These activities include training of staff and first responders to recognize the warning signs of suicidal behavior; developing and disseminating techniques to improve community response to situations involving suicide threat; and developing resources and linkages across agencies and within the community for individuals in crisis. Coaches/Peer Mentors, Case Managers, and clinicians are all involved in outreach and training activities.

   Staff work closely with CalMHSA to develop and expand our suicide prevention activities. We conduct outreach activities to both youth in the community and to the general adult and older adult population throughout the county. The youth outreach activities include handing out flyers and brochures; developing posters; and dispersing tangible items (such as wristbands) at the local high schools. Outreach to adults and older adults occur at community events, such as health fairs, churches, and other venues, and include educational materials and informational meetings.

   We also conduct a number of suicide prevention trainings through the year at the local high schools and with other community agencies (e.g., law enforcement, Child Welfare Services, Adult Protective Services, etc.). We utilize evidence-based practices including ASIST, SAFETALK, and Crisis Intervention Training (CIT) with law enforcement. These trainings include information on identifying risk factors for suicide; utilizing protective factors; and recognizing and responding to the warning signs of suicide. Collaboration between agencies increases support and awareness within the community.

   We participate in a Tri-County consortium with Butte and Tehama County called "Care Enough To Act." The three counties meet quarterly to discuss suicide prevention activities, and share materials and ideas for strengthening our community's skills in suicide prevention.

   The Glenn County Transition Age Youth (TAY) provides ongoing suicide prevention and bullying presentations to the local classrooms. In addition, two assemblies were held this year, one for freshmen (171 attended) and one for sophomores (184 attended). The TAY also set up a table at lunch time with information on suicide prevention, bullying, and other mental health information throughout the school year. Approximately 50 students were served during these events.

   The TAY also participated in the CHANGE (Celebrating Health and Wellness And New Growth Everywhere) Festival, in Orland, where 130 community youth and families came together to celebrate Change. The Change Festival was in honor of Children's Mental Health Day.

The TAY Center and Harmony House work in collaboration with Glenn County Cultural and Linguistic Competency Committee to organize this festival for youth and families to reduce stigma for youth and their families. Last year the festival attracted over a hundred people. The event includes resources for youth and families, as well as games and activities for children, music, face painting and a cake walk. Everyone released a balloon with hopes to end stigma. The TAY Center and Harmony House also supported the Glenn County SPEAKS (Safety Prevention Education/Environment Awareness Knowledge Stigma) event on World Suicide Prevention Day, September 11. Over 300 community members attended. This event included 15 resource tables with information and handouts, dunk tank with county administrators and law enforcement, bounce house, Speakers (family member and personal story of recovery), face painting, and a cake walk, Music DJ, Bob Pasero (retired Orland PD chief) was the Mater of Ceremony and closed the event with a candle lighting ceremony. The event challenged mental health stigma and to help educate the community regarding sign of depression and suicide.

There were two youth suicides in Glenn County last summer. The TAY Center was active in supporting the youth at the local schools and tribe. Youth and staff responded to the teaching staff and 20 youth for support and provided resources for 3 days after the youth's suicide. In addition, TAY youth and staff developed family resource packets and youth packets to local high schools and junior high schools. The packets included information regarding how to talk to youth about grief and loss, the crisis line number, and how to make a referral to mental health services, REACH OUT.com, and the TAY Center. All the teachers gave students a resource cards and was provided with a script about how to talk with the youth about suicide.

The Adult Coaches and Harmony House staff also offer courses in developing an individual's Wellness and Recovery Plans (WRAP). These WRAP trainings are available to children (new this year), TAY, and adults. There are plans to expand these trainings to individuals in the Jail or on probation at the TLC. They are also involved in the Change Festival and SPEAKS (Safety Prevention Education/ Environment Awareness Knowledge Stigma) events.

There are also a number of different events where TAY Peer Mentors and/or Coaches set up tables to hand out information on mental health, suicide, stigma, substance use treatment, and community resources.

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

The PEI programs address many of the key issues that were identified in our surveys from last year's planning process. The community is very supportive of our PEI programs, including the ongoing training in identifying depression, suicide, and bullying, and are excited about the new PEI programs being developed for FY 2016/2017.

3. ***List any significant changes from previous fiscal year, if applicable.***

Significant changes to the PEI program are described above, to address the updates in the PEI regulations.

MHSA Program Component
INNOVATION (INN)

1. ***Provide a program description (must include number of clients served, age, race/ethnicity, and cost per person). Include achievements and notable performance outcomes.***

The System-wide Mental Health Assessment Response Treatment (SMART) Team is comprised of key individuals from each of the following agencies: mental health, probation, law enforcement, child welfare, and the schools. The SMART Team meets weekly, with individuals from law enforcement, mental health, probation, schools, and child welfare in attendance. This cross-agency collaboration has created a strong and cohesive team across the sheriff's office, local police departments, mental health, social service, education, and alcohol and drug services. Children, TAY, and adults receive services from SMART.

SMART's collaborative relationship has developed a coordinated process to identify high-risk children and youth, develop strategies for engaging family members, developing creative solutions to help resolve any threats or other complex situations, and implementing a cohesive plan across partner agencies. This collaboration has helped to develop a strong, trusting relationship across agency partners, and identifies coordinated solutions to improve services across our MHSA services and accomplish positive outcomes for children, youth, and families.

The SMART Team's collaborative process responds quickly, efficiently, and consistently to crisis and critical event situations in the community, including school threats, suicidal behavior, and/or bullying. The SMART Team responds to situations across the county and conducts a comprehensive mental health and crisis evaluation. An evidence-based practice, MOSAIC, is used to determine the level of risk, for each child. This data also helps to identify the most effective strategy in each situation, and provides protocols to help respond and evaluate the situation to support a positive outcome for each situation.

In an effort to further improve outcomes for the children and youth involved in these incidents, the SMART Team also follows up with each student, classroom, teacher, and/or family member, to deliver brief therapy and assess the need for additional follow-up services. When a student needs ongoing treatment, the SMART Team links the individual to ongoing mental health, co-occurring treatment, or probation services to follow-up periodically to ensure that the incident is fully resolved.

The SMART team has served over 57 children, youth, and their families since it was implanted in 2014. In FY 2015/16, the team provided services to 39 individuals and their families. We have been successful in resolving immediate threatening situations at the schools, and work closely with high risk children and youth, and their families. SMART families are often referred to mental health services for ongoing treatment, as well as linking them to other resources in the community. The majority of children and youth are receiving ongoing mental health services and they are regularly attending school. One youth who was not attending school has been placed in a residential treatment facility to support her to develop skills in managing her behavior. Many of the children have Individual Education Plans (IEP) and these plans have been updated to address additional needs identified during the SMART assessment process. For other children, and IEP was developed, based upon the identified needs.

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

We have been very pleased with our initial implementation of this new Innovation Project. Initially, we did not obtain the parent's signed consent to coordinate service across multiple agencies. As a result, once the immediate crisis was resolved, the parents were not always as willing to sign these consent. As a result, we now obtain their consent at our first contact with the family, when the crisis is acute. At this critical time, the parents are willing to work with us to support collaboration across agencies, to help resolve the crisis. As we continue to deliver services and supports to the family, they learn the importance of everyone working together, and that everyone has the same goals for supporting healthy outcomes.

We are still working to enhance the coordination of services across all of our school districts and individual schools. We provide periodic presentation on the SMART Team, how to make a referral, and the importance of collaboration to meet the needs of the child and youth. These schools want to avoid "labeling" the child or youth, but at times may create barriers to getting the support needed to resolve a complex situation. As the SMART Team has more successes and resolves threat situations in a collaborative manner, we are able to address some of these barriers.

3. List any significant changes from previous fiscal year, if applicable.

There are no significant changes to the INN Program in FY 2016/2017.

MHSA Program Component
WORKFORCE EDUCATION AND TRAINING (WET)

1. Provide a program description. Include achievements.

Full implementation of the WET Plan was completed in FY 2009/2010. We contract with Relias Learning (formerly Essential Learning) for multi-year access to its online training curriculum. Staff utilize this program to complete various trainings, including the completion of courses for CEUs. Consumer employees also have access to this system and find it valuable for general mental health training and information.

As written in our original WET Plan, we offer both on-site and off-site training opportunities to staff and allied agency partner staff, as appropriate. This fiscal year, we anticipate sending staff and partner agency staff to regional training, including PCIT, ASIST, SAFETALK, SMART, CIT, and Mental Health First Aid training.

Staff participated in a four-day Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) training. We are also identifying additional evidence-based practices that we can use to enhance services. Specifically, we are enhancing our services to include more family support and services. Through our partnerships with other agencies, we have identified the need to train staff and partner agency staff in Evidence-Based Practices. We will utilize WET funds to support staff and partner agencies in attending these identified trainings. We will also continue to collaborate with partner agencies to provide training to staff on CHAT, the Child Welfare system, and other relevant topics.

Through the WET Program, we also offer a stipend to MSW and/or MFT interns each semester who are working at the Mental Health Clinic to help pay for mileage and other expenses. This program allows us to recruit individuals from California State University, Chico, and other institutional organizations, who might otherwise be unable to intern in our county due to commuting costs.

We have increased the number of trainings on the DSM V coding, to prepare staff for the change in the diagnostic manual and new coding structure.

Our child welfare and mental health staff have also increased the number of shared trainings. For example, mental health staff have attend a number of CWS trainings on Safety Organized Practice, which has helped develop a common language when working with our Katie A children and families, and holding Child and Family Team meetings. This has been very successful in building trust across both agencies and supporting the families to achieve their goals and reunify with their children, whenever possible. In addition, mental health and CWS staff have attended training on Trauma-Focused Cognitive Behavior Therapy, which is a very effective, evidence-based practice which is useful for working with these high-need families.

We also offered a Crisis Intervention Team (CIT) training this year to local law enforcement. This training provides an excellent model for law enforcement and mental health to work together to help resolve crises in the community. Everyone in attendance were very appreciative of the training and the opportunity to get to know each other and understand each organization's role in resolving a crisis situation.

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

We have successfully implemented the WET component and have not encountered any significant challenges or barriers. We will continue to develop opportunities to expand our training capacity for both staff and consumers. We are continually recruiting for clinicians, bilingual/bicultural clinicians, and bilingual staff to continually improve our services and ensure we are providing culturally and linguistically competent services. Currently, we have positions available for two Adult and one or more Children's Bilingual, Bicultural Clinicians.

3. ***List any significant changes from previous fiscal year, if applicable.***

There are no significant changes to the WET Program in FY 2016/2017.

MHSA Program Component
CAPITAL FACILITIES/TECHNOLOGY (CFTN)

1. ***Provide a program description (must include number of clients served, age, race/ethnicity). Include achievements.***

The Capital Facilities funds provided the opportunity to expand our existing facilities to better meet the service needs of our clients. With these funds, we purchased a modular building for service provision and office space in Orland. This Capital Facilities Project fully supports our MHSA goals and objectives to improve access for unserved and underserved clients, make services more welcoming to promote wellness and recovery, and achieve optimal outcomes. The building was fully completed and operational in September 2013.

The Technological Needs funds supported our implementation of an electronic client record through the purchase of a new server, expanded IT network, and clinical desktop software. This Technological Needs Project enhanced our MSHA activities by creating a secure network which ensures client confidentiality and creates the capacity for an electronic clinical record. This project minimizes paperwork and maximizes staff time for service delivery to our clients, promoting resiliency, wellness, and recovery so that clients achieve positive outcomes.

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

Not applicable.

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

Both projects have been successfully completed.

4. ***List any significant changes from previous fiscal year, if applicable.***

There are no significant changes to the CFTN Program in FY 2016/2017.

FY 2016/2017 Mental Health Services Act Annual Update
Funding Summary

County: **Glenn** Date: 5/20/16

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2016/2017 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	2,214,920	366,467	201,472	233,975	6,614	
2. Estimated New FY 2016/2017 Funding	2,430,145	607,536	159,878			
3. Transfer in FY 2016/2017[a/]	0					
4. Access Local Prudent Reserve in FY 2016/2017						0
5. Estimated Available Funding for FY 2016/2017	4,645,065	974,003	361,350	233,975	6,614	
B. Estimated FY 2016/2017 MHSA Expenditures	2,857,071	576,140	162,477	100,000	6,614	
G. Estimated FY 2016/2017 Unspent Fund Balance	1,787,994	397,863	198,873	133,975	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2016	88,510
2. Contributions to the Local Prudent Reserve in FY 2016/2017	0
3. Distributions from the Local Prudent Reserve in FY 2016/2017	0
4. Estimated Local Prudent Reserve Balance on June 30, 2017	88,510

a/ Pursuant to 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.

FY 2016/2017 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: Glenn Date: 5/20/16

	Fiscal Year 2016/2017					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. System Transformation (FSP)	1,455,917	719,827	514,212	73,668	111,809	36,401
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. CSS Comprehensive Service Plan	3,965,482	1,873,897	1,433,694	218,433	331,526	107,932
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	411,480	263,347	148,133			
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	5,832,879	2,857,071	2,096,039	292,101	443,335	144,333
FSP Programs as Percent of Total	51.0%					

FY 2016/2017 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: **Glenn** Date: 5/20/16

	Fiscal Year 2016/2017					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Prevention						
1. Access and Linkage	25,738	25,738				
2.	0					
3.	0					
4.	0					
5.	0					
Early Intervention						
6. Strengthening Families	34,826	34,826				
7. PCIT	133,201	100,351	16,747		16,103	
8.	0					
9.	0					
10.	0					
Outreach/Stigma Reduction/Suicide Prevention						
13. Stigma Reduction	2,669	2,669				
14. Suicide Prevention	216,077	216,077				
15. Outreach	138,865	138,865				
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	57,614	57,614				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	608,990	576,140	16,747	0	16,103	0

FY 2016/2017 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: **Glenn** Date: 5/20/16

	Fiscal Year 2016/2017					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. SMART Program (Year 3)	168,264	146,470	12,374		9,420	
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	16,007	16,007				
Total INN Program Estimated Expenditures	184,271	162,477	12,374	0	9,420	0

FY 2016/2017 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding

County: **Glenn** Date: 5/20/16

	Fiscal Year 2016/2017					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. WET Coordination	25,000	25,000				
2. Training and Technical Assistance	65,000	65,000				
3. Mental Health Consumer Pathways	2,000	2,000				
4. Internships	8,000	8,000				
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0					
Total WET Program Estimated Expenditures	100,000	100,000	0	0	0	0

FY 2016/2017 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: **Glenn** Date: 5/20/16

	Fiscal Year 2016/2017					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Orland Facility	6,614	6,614				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	6,614	6,614	0	0	0	0