MHSOAC
Mental Health Services
Oversight & Accountability Commission

INNOVATIVE PROJECT PLAN
RECOMMENDED TEMPLATE

COMPLETE APPLICATION CHECKLIST	
Innovation (INN) Project Application Packets submitted for approval by the MHSOAC should include the following prior to being scheduled before the Commission:	
☐ Final INN Project Plan with any relevant supplemental documents and examples: program flow-chart or logic model. Budget should be consistent with what has (or will be) presented to Board of Supervisors. *(Refer to CCR Title9, Sections 3910-3935 for Innovation Regulations and Requirements)*	
☐ Local Mental Health Board approval	Approval Date: ___________
☐ Completed 30 day public comment period	Comment Period: ___________
☐ BOS approval date If County has not presented before BOS, please indicate date when presentation to BOS will be scheduled: ____________________ *Note: For those Counties that require INN approval from MHSOAC prior to their county's BOS approval, the MHSOAC may issue contingency approvals for INN projects pending BOS approval on a case-by-case basis.*	Approval Date: ___________
Desired Presentation Date for Commission: ________________________ ***Note: Date requested above is not guaranteed until MHSOAC staff verifies <u>all requirements</u> have been met.***	

County Name: Butte County

Date submitted: TBD

Project Title: Center CARE Project

Total amount requested: $1,671,031

Duration of project: 3 years and 2 months

Purpose of Document: The purpose of this template is to assist County staff in preparing materials that will introduce the purpose, need, design, implementation plan, evaluation plan, and sustainability plan of an Innovation Project proposal to key stakeholders. *This document is a technical assistance tool that is recommended, not required.*

Innovation Project Defined: As stated in California Code of Regulations, Title 9, Section 3200.184, an Innovation project is defined as a project that "the County designs and implements for a defined time period and evaluates to develop new best practices in mental health services and supports". As such, an Innovation project should provide new knowledge to inform current and future mental health practices and approaches, and not merely replicate the practices/approaches of another community.

Section 1: Innovations Regulations Requirement Categories

CHOOSE A GENERAL REQUIREMENT:

An Innovative Project must be defined by one of the following general criteria. The proposed project:

- ☒ Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention
- ☒ Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- ☐ Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- ☐ Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

CHOOSE A PRIMARY PURPOSE:

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

☒ Increases access to mental health services to underserved groups
☒ Increases the quality of mental health services, including measured outcomes
☒ Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
☐ Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Section 2: Project Overview

PRIMARY PROBLEM

What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community. Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county.

Butte County lacks the resources to support the mental health of young, developing children (infant to five-years old) in multiple modalities, environmental settings, and service delivery systems.

- Early childhood mental health is unique, and while one-on-one in-room therapy may be beneficial to some young children, mental health consultation in Early Care and Education (ECE) settings is an evidence-based approach that promotes positive mental health outcomes, allows for prevention and management of early childhood trauma, and utilizes intervention strategies that are effective in supporting young children.
- Few Butte County clinicians and mental health professionals have the specialized training to provide mental health support for young children; therefore, even in clinical settings, many children are not receiving the type of treatment appropriate for their developmental needs.
- Caregivers and educators with little training in mental health or trauma recovery strategies are faced with the need to support young children as they navigate their social emotional development, alongside the intense early and multigenerational trauma that is so remarkable for Butte County. As a result, trauma manifests itself in challenging, reactive behaviors. When caregivers and educators face this without adequate training and support, it often results in professional burnout and children being expelled from Early Care and Education (ECE) environments.
- Moreover, rural communities such as ours face distinct challenges in connecting services to children and families. This is because of the distance, time, and difficult terrain between

localities; lack of an efficient, effective, or far-reaching public transit system; the choice of some families to live in geographically-isolated micro-communities; and a smaller county workforce, with a limited number of specialists available to cover the vast majority of the county territory.

Young children are facing significant trauma and disconnects in social-emotional development that are leading to challenging behaviors, interfering in their ability to learn and optimally, develop. Neurological functioning is acutely affected by childhood trauma, causing significant alterations in the child's natural brain development and cognitive functioning that may promote the development of maladaptive coping skills which impacts learning later in life (Oral et al 2016).

Butte County is intensely impacted by widespread trauma. Adverse Child Experiences (ACEs) are reliable indicators of physical health and cognitive functioning in adulthood (CWY 2014). ACEs identification can also be used as an evaluative tool to provide early intervention for youth who have experienced significant trauma in their lives. As of 2013, Butte County had the highest prevalence of residents living with one or more ACEs in California at 76.5 percent of residents, and with 30.3 percent having experienced four or more ACEs. These high rates of trauma contribute to many of the physical, mental, and family issues observed in Butte County which educational and mental health professionals struggle to address. The community needs expanded access to trauma-informed and multi-generational treatment modalities to interrupt the generational cycle of trauma, maladaptive coping strategies, and psychological distress that pervades family structures.

Butte County is considered a low-income county faced with many socio-economic burdens. Approximately 19.5 percent of persons in the County meet or fall below the federal poverty line, compared to 14.3 percent in California and 12.7 percent nationally (US Census Bureau 2017). The lower socio-economic status is often generational, and families often also struggle with higher rates of unemployment, financial instability, food insecurity, mental health issues, and substance abuse and dependence. Approximately 28 percent of residents are enrolled in Medi-Cal, compared to roughly 18 percent of Californians (DHCS 2018; US Census 2017). The foster care rates in the county are nearly twice that of the state with 338 children, infant to age 10, in placement as of January 1, 2018 (CCWIP 2018a).

In addition to these significant statistics, in early November 2018, the Butte County communities of Paradise, Magalia, Concow, and Butte Creek Canyon were decimated by the Camp Fire, the largest and most destructive wild fire in California history, displacing nearly 50,000 residents, including approximately 5,000 school-age children into surrounding towns. The fire swept through the community in a matter of a few hours. Families had to literally run for their lives from the blaze, which lead to the confirmed deaths of 86 people who were unable to escape, with three more still unaccounted for. The short-term impact is reflected by families being divided and displaced throughout the North State, living in hotels, doubled up with friends and extended family, and newly made homeless, living in shelters, trailers, and tents. It is yet known the true long-term impact of a fire with such unprecedented devastation, but research indicates that there is a predicted spike in mental health issues two to five years after a disaster. Trauma recovery for the Butte County

residents, in particular very young children who are embedding emotional resiliency in their brain development, will be exponentially challenging and immensely important in the forthcoming years (American Academy of Pediatrics, 2018).

Young children struggling with coping, trauma recovery and the development of social and emotional skills demonstrate difficult behaviors in multiple settings. The bi-product is that often adults (Families, caregivers, and preschool staff) experience secondary trauma, compassion burnout, and the development or exacerbation of other mental health conditions. There is a generational cycle of trauma, maladaptive coping strategies, and psychological distress that pervade family, educational, and social structures and dynamics (Yehuda, 2016).

There is a need for more innovative and specialized mental health and therapeutic services for young children, as well as a trauma-informed system of support for those caring for young children in Butte County. To address this, there must be an expansion of access to specialized, trauma-informed, multi-generational, and cross-sector treatment modalities offering community level education and system collaboration.

PROPOSED PROJECT

Describe the INN Project you are proposing. Include sufficient details that ensures the identified problem and potential solutions are clear. In this section, you may wish to identify how you plan to implement the project, the relevant participants/roles within the project, what participants will typically experience, and any other key activities associated with development and implementation.

A) Provide a brief narrative overview description of the proposed project.

The Center CARE (Collective Action for Resiliency and Education) Project introduces a new and innovative approach to mental health services through a comprehensive, integrated mental health system focusing on young children, infant to age five. ***The Center CARE Project builds on the research-based Infant Early Childhood Mental Health Consultation Model (IECMHC) to bring specialized mental health support to young children in community-relevant rural settings, such as natural learning and play environments, and a centrally-located multidisciplinary service, education, and research center.*** Central components will consist of a new specialized collective and collaborative service delivery model, increased professional and therapeutic capacities for therapists, and a facility offering comprehensive dynamic services centered in trauma-responsive principles and practices.

A new approach to service delivery will be the adoption of evidence-based Infant Early Childhood Mental Health Consultation (IECMHC) model, which builds the capacity of families and professionals via qualified Mental Health Consultants (MCHs) to support and sustain social and emotional development of all infants and young children across child serving systems in natural and community settings. For service delivery in Early Care and

Education (ECE) settings, the promising practices *Pyramid Model* framework will address multi-tiered systems of support within the educational context. In brief, this model uses MHCs to respond to child-centered referrals. Child observation and screening identifies focus areas and objectives. MHCs then develop a child centered plan in a multidisciplinary team, used to coach, teach, model, and support the child. Complementary focus and support are provided to the adults, caregivers, and educators surrounding the child. As the compassion and learning capacities of the adults improve, the impact shows improved child outcomes, not only of the individual referred child, but other children in the environment. (Duran, Hepburn, Kaufmann, 2010). IECHMHC research indicates that high rates of preschool expulsion decrease and overall improvement in classroom climates (Brennon, Bradley, Allen & Perry, in press). This model is being supported by three agencies within the U.S. Department of Health and Human Services: the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA) and the Administration of Children and Families (ACF).

Three-minute video about what the experts say about IECMHC:
https://www.youtube.com/watch?v=mm_SMNJN3Pk&index=1&list=PLBXgZMI_zqfSphRqkJQKvaNZmKtaBOB25

Two-minute video about the day in the life of a MHC:
https://www.youtube.com/watch?v=N8GTe0NUE-w

Of great significance and innovation is the development of a rural trauma-informed facility – "The Center" – being repurposed from the old county courthouse. The Center will be a new service, education, and research facility centrally located in Chico, California, within the densest populated city in the county. It is also the location with the highest number of people displaced from the Camp Fire; a census has yet been conducted, but it is estimated that the population of Chico has grown 10-20% with the addition of fire-displaced community members. The Center is an abandoned courthouse with unique mid-century architecture and is conveniently located near schools; California State University Chico, particularly the Child Development and Psychology departments; downtown Chico with parks, restaurants, and retail establishments; off the Esplanade, the city's trademark corridor street; and on a public transit line. The building will be repurposed as a hallmark for family support and mental health services, as well as a beacon for North State professional education and research.

The Center will be a technical assistance center and learning collaborative, occupied by a collection of professionals from multiple agencies. Services will include early learning-related mental health treatment for young children, their families, and their care providers using multiple modalities; case management including assessments and screenings; family support programs including therapeutic and community organized playgroups; peer navigators that greet families and assist them in understanding available resources; formal training of professionals and Families in state-of-the-art meeting

rooms; collaborative work spaces; research partnerships with the university located one block away… all within an inviting, park-like neighborhood setting. The Center is being developed with the innovative goals of centering all work on a trauma-informed approach with cross-sector professional partnerships. It is founded in best practices, and regularly evaluated to determine whether there is a collective impact for the community, as well as individual young children.

The innovative element of the Center CARE Project is how these approaches – currently unavailable in Butte County – are further integrated into a new rural, mental health system. (See CARE Project graphic.)

- The MHCs are the hub of service and education for children, families, service providers, and early care professionals. They are a critical part of a larger team that provides center-focused and family-focused quality enhancements in environments that have not integrated mental health practices.
- ECE locations (preschools, child care centers and homes) refer children to the CARE Project and then host MHCs at their ECE setting. The MHC will work directly with children who have been referred to the program due to behavior and/or challenging behavior. This allows mental health specialists to work with young children in remote and rural settings, wherein they are most comfortable, and which offer opportunities for interaction with peers and familiar adults.
- The MHC will train, model and support specialized professional skills for caregivers to increase capacity and sustain intervention opportunities. This integration of new mental health skills into the quality program expands the capacity of early learning specialists in improving their work in multiple learning settings for young children.
- The MHC also offers on-site trauma support for children, families and caregivers.
- The Butte County Quality Initiative, a state funded quality improvement project for early care and education programs, will intricately weave professional education and excellence standards at Early Learning and Care locations.
- Training, modeling, and coaching at the state-of-the-art Center will feature cutting-edge technology and observation training rooms.
- The Center will house new innovative multi-disciplinary teams (MDT), collectively housed in a new facility founded in trauma-informed principles and practices with innovative dynamic approaches and systems. The MDT will include mental health professionals, clinicians, early intervention special needs experts, home visitors, child development specialists, occupational therapists, nurses, university professors, students, family support specialists, and peer navigators. This intersegmental partnership will provide cross-sector training and support that is trauma-responsive and healing-centered.
- Formalized reflective supervision and support, cross-training and professional exploration, and environmental and self-healing will be part of the innovative pilot

for determining how we address secondary trauma and professional development.

- At the Center, families may participate in therapeutic services as they are offered for young children (including PCIT and other modalities), their siblings, and their Families. Families will also be supported through Family engagement groups, support family playgroups, and supervised visitation. All local threshold languages will be integrated into services.

Finally, embedded in the Center facility, the professional collective, and the service infrastructure, is the intention to address trauma at community, system, and organization levels. Integrated within the goals and objectives for children, families, and professionals, are the innovative approaches of compassionate, culturally humble, and trauma-responsive context of the work. A shared leadership model of governance will advocate for rich, diverse consumer and community input. All of these approaches, systems, and services will be part of an intensive evaluation that demonstrates a rural approach to meeting the mental health and developmental needs of young children.

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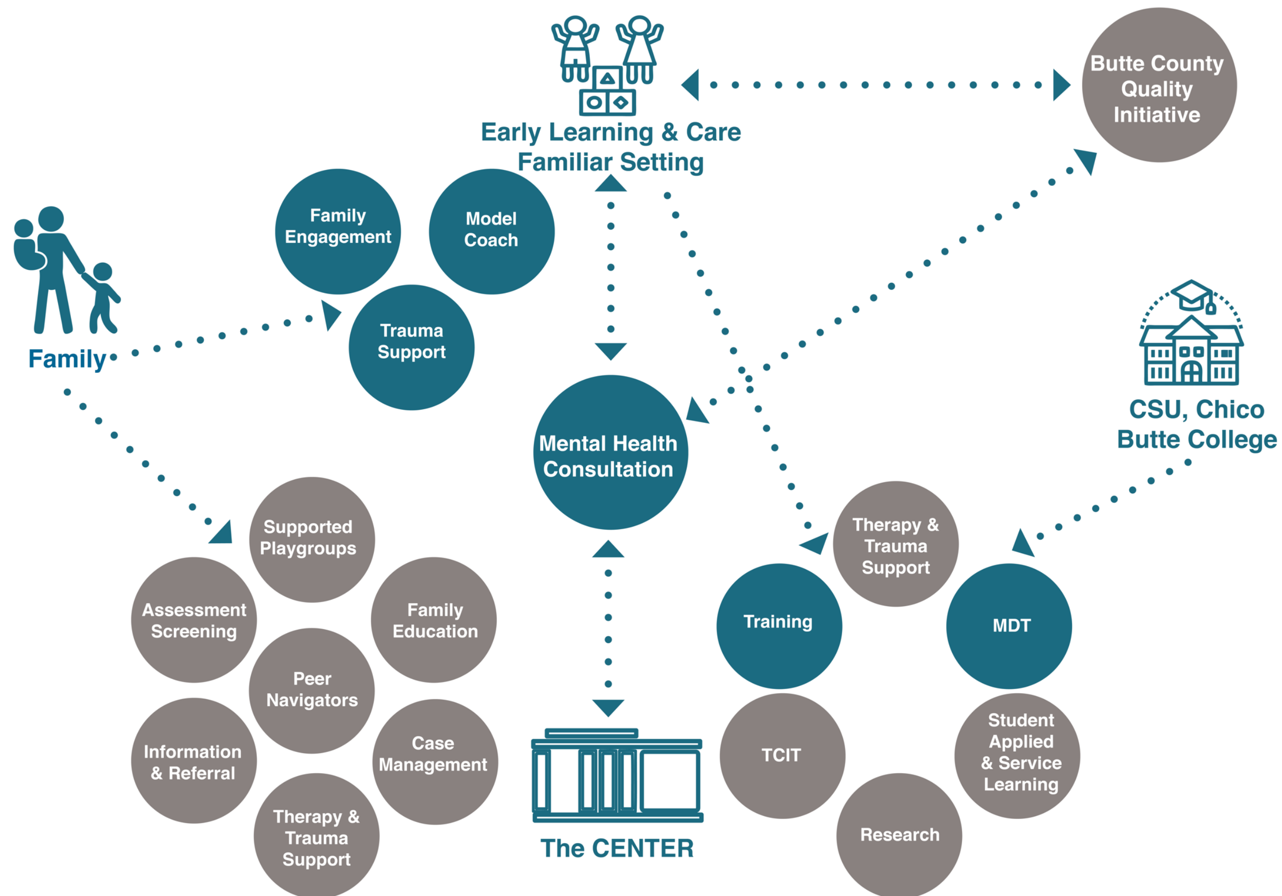
CARE Project

Collective Action for Resiliency & Education

The Center is a centrally located, multi-disciplinary service, education and research location. It encompasses an array of programs and services. The CARE Project consists of elements of the overall Center vision which integrate closely with the center-based services, as well as offers specialized mental health support for young children in familiar, and typically remote, settings. This graphic illustrates the full spectrum of the Center, highlighting CARE Project elements in aqua and partner services in gray.



B) Identify which of the three project general requirements specified above [per CCR, Title 9, Sect. 3910(a)] the project will implement.

Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention addressing the absence of critical services for 0-5 children, families and service providers.

C) Briefly explain how you have determined that your selected approach is appropriate. For example, if you intend to apply an approach from outside the mental health field, briefly describe how the practice has been historically applied.

The Center CARE Project is truly innovative, not a replication from other services or approaches. That being said, it draws from quality approaches and practices, which are then enhanced to learn how rural communities are impacted by widespread and multi-generational trauma. The Mental Health Consultation model is an approach that is an evidence-based and trauma-responsive approach that has been developed in urban settings. It is primarily researched through the Georgetown University Center for Child and Human Development. Also, Family Resource Centers and community center collaborations have been researched from a service perspective, in both urban and rural setting. Family Resource Centers have shown to improve academic achievement, Family skills, social support for families, participation in the community, and sensitivity to the needs of families by the community. While these three foundational approaches have established efficacy in their own context, the combination of them in a rural setting is uncharted.

D) Estimate the number of individuals expected to be served annually and how you arrived at this number.

- 65 young children will receive intensive mental health support in natural learning environments located in rural, remote, or frontier communities
- 230 young children will be positively impacted by being in natural learning environments when MHCs provide intensive mental health support to their peers children and training for their caregivers
- 30 young children will be referred to clinical screening and therapeutic services
- 20 Families of young children will participate in Center-based therapeutic services
- 20 mental health professionals (including at least 10 clinicians) will participate in specialized mental health training for young children to build clinical capacity in the county
- 15 early care and education providers will participate in site-based support and training

- 20 early care and education providers will participate in formal Center-based training on trauma responsive practices and social emotional development

E) Describe the population to be served, including relevant demographic information (age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate).

Children, infant to age five, of all gender identity, race, ethnicity, sexual orientation, and language used. There will not be prioritization by income or source of payment for auxiliary services.

Families – Families and siblings – of the young children referred to the program, without demographic limitation.

Professionals from the mental health, early care and education, child development, social service, special education, public health, or higher education fields, without demographic limitation.

RESEARCH ON INN COMPONENT

A) What are you proposing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

IECMHC has been implemented outside Butte County across the country and evaluated extensively by Georgetown University Center for Child and Human Development, as well as U.S. Department of Health and Human Services. What distinguishes the Center CARE Project from the traditional IECMHC model is 1) it is being implemented in a rural setting, and 2) it is integrated into a comprehensive system of a professional multi-disciplinary team within a facility grounded in a unified approach to trauma.

B) Describe the efforts made to investigate existing models or approaches close to what you're proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.

The first stage of the Planning & Development of the Center was to perform a comprehensive assessment of the county's needs and resources in order to empathize and understand what should be developed. This was coupled with an examination of the best practices in urban, rural, clinical, and community settings to ascertain what services, approaches, and systems would be the best solution to caring for the mental health needs of Butte County's young children. The following are several links that were most advantageous in ideating the Center components:

https://www.ecmhc.org/

https://www.zerotothree.org/resources/1694-early-childhood-mental-health-consultation-policies-and-practices-to-foster-the-social-emotional-development-of-young-children

https://developingchild.harvard.edu/resources/from-best-practices-to-breakthrough-impacts/
https://developingchild.harvard.edu/innovation-application/innovation-approach/

http://traumatransformed.org/

https://boston.thebasics.org/

https://vtt.ovc.ojp.gov/ojpasset/Documents/MH_Competencies_Of_Trauma_Informed_Care-508.pdf

https://store.samhsa.gov/system/files/sma14-4884.pdf

LEARNING GOALS/PROJECT AIMS

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the expansion of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the expansion of effective practices.

A) What is it that you want to learn or better understand over the course of the INN Project, and why have you prioritized these goals?

1. **If adequate, intensive mental health support can be offered for young children in natural, community-based settings, will that promote trauma recovery, healthy coping skills, emotional resilience, and positive relationships?**
   This is a priority goal because these outcomes are vital to the wellness of young children and their ability to learn. One of the primary interferents is transportation in rural communities, for multiple reasons, including lack of public transportation, chosen isolation in remote communities, time and distance to drive to a neighboring community. Yet, intensive mental health support is often considered best in a clinical setting, which necessitates that transportation. In addition, if quality support and intervention can be modeled for care providers, the secondary benefit is that those skills and interventions can be sustained by professionals in such remote settings, who regularly interact with young children.

2. **Are there clinicians within the limited rural pool who are interested in gaining capacity in meeting the mental health specialty needs of young children?**
   Through the Center Planning and Development process, a community-based assessment was conducted, and it identified no more than five clinicians in Butte County who have specialized training in meeting the mental health needs of young children. CSU Chico doesn't currently have a class or expertise in their clinical departments to prepare new therapists. Consequently, clinicians are using therapeutic modalities for young children with significant needs that are more appropriate for older children or adults.

3. **If professionals across multiple disciplines are physically located in a Center that enculturates collaboration, cross-training, and secondary trauma support, will young children and their families benefit from the comprehensive expertise?**
   Smaller counties have less funds and fewer people to meet specialized needs across geographic distances. By collaborating on case planning, assessments, training, and evaluation, it is hypothesized that each professional will increase

expertise and capacity across disciplines to better serve young children's mental health and developmental needs to increase learning potential.

4. **If caregivers receive the training and support they need to care for young children, will there be an increase in personal well-being, job satisfaction, and student sustained enrollment?**
   Caring and educating large groups of young children is challenging work. Addressing trauma, providing mental health interventions, and managing secondary trauma are not standard instruction offered to caregivers. As a result, these typically under-paid professionals often face burnout and compassion fatigue with the stress of managing children challenged with trauma. Consequently, Families have difficulty sustaining jobs, and children are further traumatized when they are separated from familiar learning and play environments.

C) How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?

Learning Goal 1 is to increase access to specialized mental health services for young children by adapting the Mental Health Consultation model designed and tested in urban communities into a rural community in which services are brought to remote natural learning sites as well as a centrally-located Center.

Learning Goal 2 is to increase the professional capacity of clinicians, who treat young children, through training, modelling, observation, and support, thereby introducing a specialized clinical system of care for young children in the county.

Learning Goal 3 is to increase interagency collaboration and expertise related to mental health services and trauma responsiveness, through training and interventions that changes existing mental health practices in the county.

Learning Goal 4 is to increase support to the caregiver workforce through professional development surrounding the emotional needs of young children, as well as on-site secondary trauma support, introducing a new approach for mental health interventions in additional sectors.

EVALUATION OR LEARNING PLAN

For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. Specifically, please identify how each goal will be measured and the proposed data you intend on using.

Hypothesis: Introducing quality, accessible mental health support service for young children, and their caregivers, will improve social-emotional skills development, providing opportunities to form healthy relationships and coping skills that promote learning.

The full scope Center will execute comprehensive evaluation and research involving a team of community experts, researchers. and an evaluation consultant. The comprehensive plan includes the following:

- Innovative new research and approaches
- Research best practices replicated in rural settings
- Collective evaluation of the collaborative Center
- Individual program evaluation
- Comprehensive monitoring system with shared client software, standardized assessment, data monitoring protocols, and consultation with college and university liaisons

The Center CARE Project will be part of that comprehensive plan, spanning across many of the research and evaluation strategies listed above. The following is the Center CARE Project compendium of evaluation and assessment tools:

- **Child Assessments** will measure and monitor social-emotional development norms and identify internalized and externalized coping strategies for the purpose of the multidisciplinary team to develop case plans and evaluation, as well as a tool to better communicate with families regarding their children's social emotional needs. Several assessments (listed below) may be utilized based on the individual needs of the child. Assessments used for all children referred to the Center CARE Project are noted in the table below, corresponding to the outcome measures.
    - **Ages and Stages Questionnaire** (ASQ) – Completed by MHCs and/or ECE providers; measures communication, gross motor, fine motor, problem solving, and personal-social skills.

  - **Ages and Stages Questionnaire: Social Emotional** (ASQ-SE) – Completed by MHCs and/or ECE providers; measures self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interaction with people.
  - **Devereaux Early Childhood Assessment: Infant/Toddler** (DECA-I/T) – Completed by MHCs and/or ECE providers and families; measures key social emotional strengths in initiative, attachment and relationships to promote children's resilience.
  - **Devereaux Early Childhood Assessment: Preschool** (DECA-P) – Completed by MHCs and/or ECE providers and families; measures attachment and relationships, initiative, and self-regulation.
  - **Devereaux Early Childhood Assessment: Clinical** (DECA-C) – Completed by MHC; measures aggression, attention problems, emotional control problems and withdrawal/depression with children who are already showing significant behavioral concerns.

- **ECE Program Assessments** for ECE sites to monitor the environments, practices and approaches associated with best practices, in order to inform site staff, MHC, and Quality Initiative Specialists on areas of accomplishment; and identify focus area for capacity building in social emotional instruction and recovery support.
  - **Infant Toddler Environment Rating Scale** and **Early Childhood Environment Rating Scale** (ITERS and ECERS) – Completed by MHCs or Butte County Quality Initiative Specialists; measures infant/toddler (ITERS) or preschool (ECERS) classrooms' interactions between staff and children, between staff and adult family members, between children themselves, and between children and their environment.
  - **Classroom Assessment Scoring System** (CLASS PreK) – Completed by MHCs or Butte County Quality Initiative Specialists; measures teacher sensitivity, emotional support, classroom, organization, and instructional support through multiple dimensions.

- **Teacher Assessments** for ECE providers to self-identify the quality of their interactions with their children and professional stress levels in order to make appropriate and meaningful modifications to approaches and support systems.
  - **Student-Teacher Relationship Scale** (STRS) – Completed by ECE provider; measure self-perception of attitudes and feelings related to the quality of the relationship between teacher and identified children with two subscales for closeness and conflict.
  - **Child Care Worker Job Stress Inventory** (CCWJSI) – Completed by ECE provider; measures perception of job demands, job control, and job resources that may help contribute to a workers' job satisfaction.

- **Clinician Assessment and Evaluation** of training to assess demonstrated and reflective understanding of specialized clinical skills for young children, and feedback on value of training series

- **Program Tracking** to monitor and report the following:
  - consumer demographics
  - types of services provided
  - referrals made as a result of the program
  - professional development and training completion
  - case management monitoring
  - collaborative interactions and capacity building

- **Center CARE Project Evaluation** to capture insight from project participants (caregivers, Families, MDT partners, community private practice and public service mental health clinicians) in order to analyze and modify strategies to improve the quality of services being offered to the community.

Goal 1: Improve child social emotional outcomes through **access to specialized mental health services** by Infant Early Childhood Mental Health Consultation at Early Learning and Care settings.

Outcome 1.1:	Decrease child problem behaviors, especially externalized behaviors for children referred to the project	• *Ages & Stages Questionnaires: Social Emotional (ASQ-SE); pre and post* • *Devereaux Early Childhood Assessment: Infant/Toddler or Preschool; pre and post*
Outcome 1.2:	Increase child emotional competence and communication skills for children referred to the project	• *Ages & Stages Questionnaires: Social Emotional (ASQ-SE); pre and post* • *Devereaux Early Childhood Assessment: Infant/Toddler or Preschool; pre and post*
Outcome 1.3:	Improve child social skills and peer relationships for children referred to the project	• *Ages & Stages Questionnaires: Social Emotional (ASQ-SE); pre and post* • *Devereaux Early Childhood Assessment: Infant/Toddler or Preschool; pre and post*
Outcome 1.4:	Increase the number of children who receive mental health consultation support	• *Referrals and case notes*

Goal 2: Increase the **capacity of Butte County clinicians** to offer specialized, therapeutic care for young children by completing a professional development series, consisting of instruction, modeling, and observation.

Outcome 2.1:	Increase the number of North State clinicians who enroll and complete the young child clinical training course	• *Registration and attendance records*
Outcome 2.2:	Increase the number of North State clinicians able to satisfy the clinical learning rubric designed to assess demonstrated learning	• *Young Child Mental Health Rubric*

Outcome 2.3:	Gain insight from clinicians on the quality, delivery, and applicability of training	• *Clinician training evaluation survey*

Goal 3: Increase **interagency collaboration and expertise** related to mental health services through multidisciplinary co-location, cross-training, collaborative screening and assessment, joint case planning, and collective evaluation.

Outcome 3.1:	Increase the number of agencies and projects that work together on a weekly basis	• *Lease agreements and meeting agendas* • *Collaborative practices assessment; pre and post*
Outcome 3.2:	Increase the number of multi-disciplinary case plans, including assessment and screening when appropriate	• *Case plans, assessments/screenings, release of information form records* • *Collaborative practices assessment; pre and post*
Outcome 3.3:	Increase the number of professionals that participate in a specialized multidisciplinary mental health training	• *Registration and attendance records*
Outcome 3.4:	Evaluate and evolve multi-disciplinary system of service delivery	• *Collaborative practices assessment; pre and post*

Goal 4: Decrease **work related stress** by increasing professional development and trauma support to ECE caregivers

Outcome 4.1:	Increase the number caregivers who have received secondary trauma training	• *Registration and attendance records*
Outcome 4.2:	Increase the number of caregivers who have received formal training on mental health support for youth children	• *Registration and attendance records*
Outcome 4.3:	Decrease job related stress for caregivers	• *Child Care Worker Job Stress Inventory (CCWJS); pre and post*
Outcome 4.4:	Improve caregiver relationship, attitudes, and interactions with children	• *Student Teacher Relationship Scale (STRS); pre and post* • *Classroom Assessment Scoring System (CLASS PreK); pre and post*
Outcome 4.5:	Increase the number of ECE sites demonstrating interactions and environments that support emotional development	• *Classroom Assessment Scoring System (CLASS PreK); pre and post* • *Infant Toddler Environment Rating Scale (ITRS) and Early Childhood Environment Rating Scale (ECERS); pre and post*

Section 3: Additional Information for Regulatory Requirements

CONTRACTING

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

The management, services delivery, and evaluation of the INN project will be contracted to Butte County Office of Education (BCOE), Child Development Programs and Services Department (CDPS). BCOE/CDPS currently provides a collection of supports to the continuum of early learning providers. Butte County Department of Behavioral Health (BCDBH) will be responsible for contract compliance and reporting to the Mental Health services Oversight & Accountability Commission. Quarterly and annual meetings will monitor compliance, discuss service delivery, iterate approaches and evaluate the project.

COMMUNITY PROGRAM PLANNING

Please describe the County's Community Program Planning process for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under-served populations, and individuals who reflect the cultural, ethnic and racial diversity of the County's community.

CDPS has facilitated an extensive planning process by developing a Center Planning and Development Committee made of 25 cross-sector county leaders, agencies and consumers. A design thinking process intrinsically set the foundation to focus on what services, programs, and systems were missing or inadequate in meeting the learning, social emotional development, mental health intervention, and trauma recovery of young children. The charge was to ignore the silos and the strategies that haven't been working in order to create something innovative.

As many great projects do, the effort began with articulating a vision: **Young children are surrounded by a community of skilled and compassionate people.** This established a solid focus on the developmental needs of young children and acknowledged the inherent needs of young children to develop in relationship to adults. Also, that adults can best support young children when they have specific skills and personal wellness.

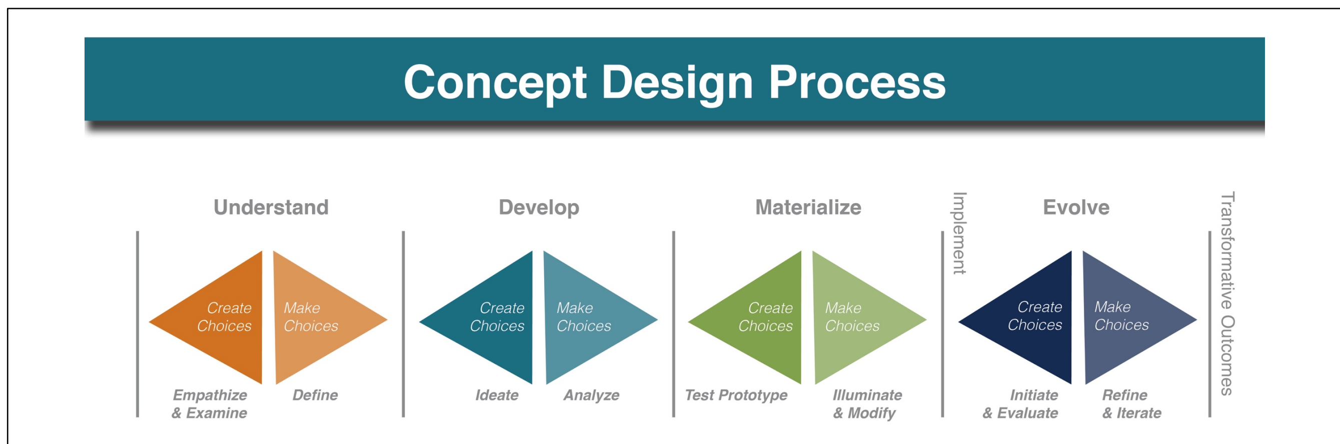
Planning & Development Committee Representation
Butte 2-1-1
Child Abuse Prevention Council Executive Staff
County ACEs Coalition
County Department of Behavioral Health
County Department of Employment & Social Services
County Department of Public Health
County First 5 Commission Executive Staff
County Office of Education, Child Development
County Office of Education, Special Education
CSU Chico, Child Development Department
CSU Chico, Education Department
CSU Chico, Social Work Department
Regional Center
Student Consumers
Head Start
North Valley Catholic Social Services (501c3)
State Preschools
Trauma Consultants
Workforce Development

The mission also focused on capacity and relationships as a means to supporting young children: **We nurture individual, relational, and community capacity so that all children have the opportunity to learn and thrive**.

From there, the Center Planning and Development Committee established guiding trauma-responsive principles that describe how services will be provided, how relationships will be formed and sustained, how decisions will be made, and what professional values are collectively ascribed to.

A Concept Design Thinking Process was developed to guide the development of the system, service, and approaches. The process was divided into four phases, each involving the collection of ideas or choices, and then analysis of those choices to gain focus toward the desired outcomes.

The first phase, the Understanding phase, accessed nationally based research and local data collection to gain understanding and define the needs and resources of the community. The committee gathered qualitative and quantitative data: to select research-based programs and approaches; to identify the unique needs and challenges of the community, as well as the specific developmental and mental health needs of young children; to recognize existing community resources that would align with quality services; and to isolate what services, systems, and approaches missing in the county that could be incorporated into the Center. Beyond the committee representatives listed above, we consulted with a variety of community members who hold insight into the needs and resources of the county (listed following).

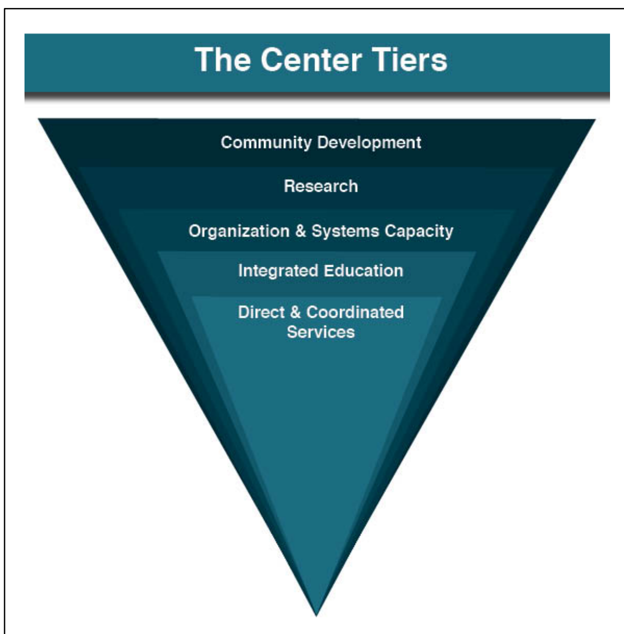


To be clear, the Center CARE Project is a core project of the Center but does not reflect the totality of the planning that has occurred in the community. The Center CARE project reflects the distinct need for more clinicians who have a specialty in therapeutic treatments for young children. It also

identified the growing number of children being expelled from child care and preschool settings because of the behavioral challenges facing early care providers and educators. Community-based sites are remote in rural Butte County, which often interferes in services being availability at the site and families' to access services. In addition, as service providers and educators began to meet, it became apparent that expertise was not actively being shared across organizations and sectors, which could otherwise support improved service delivery and professional capacity.

Consumers and service providers alike, identified that families often express and/or exhibit difficulty finding mental health services appropriate for young children. Further, families are challenged at navigating the mental health and social service systems, particularly prioritizing available resources and referrals.

Local child care providers and educators at Early Learning programs readily describe challenging child behaviors that exceed their expertise, which are leading to increasing expulsion rates.



What resulted from the Understanding phase was the development of a five-tiered model. The Center CARE Project traverses all of the five tiers. These tiers became the foundation to months of planning, crossing over the Development and Materialize phases, as previously mentioned.

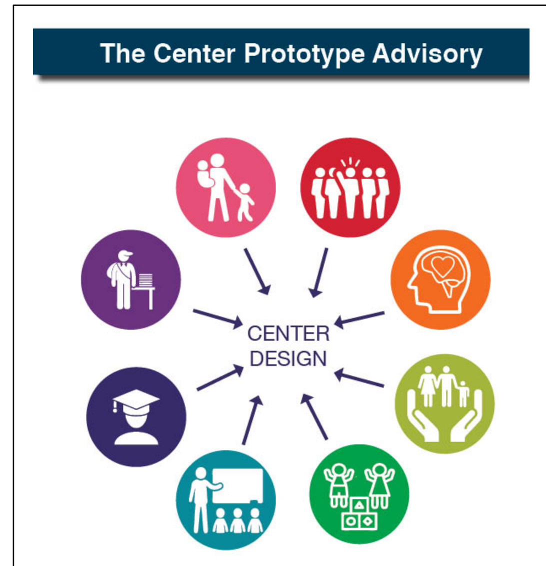
The second phase was Development and involved ideation of services, approaches and systems based on the understanding by the diverse committee. Then through a series of facilitated exercises, the theorized best ideas were selected, prioritized, and placed on a timeline for implementation over five years. The Center CARE Project was formed to include MHC at the community-based sites in partnership with improved and increased clinical services for children, and a multi-disciplinary team approach to professional services. Other services such as case management, family

Community Consultation

- African American Family Cultural Center
- Butte College, Child Development Department
- Butte College, Foster/Kinship Care Education Program
- County Board of Supervisors
- County Court
- County Local Child Care Planning Council
- County Victim/Witness Program
- CSU Chico, Art Department
- CSU Chico, Center for Economic Development
- CSU Chico, Civic Engagement
- CSU Chico, Environmental Psychology
- CSU Chico, Interior Architecture
- CSU Chico, Psychology – Graduate Therapy Program
- CSU Chico, Social Work – Graduate Therapy Program
- Hmong Cultural Center
- Inclusive Child Care Workgroup
- North Valley Community Foundation
- Family Consumers
- Private Practice Clinicians
- Remi Vista, Youth and Family Services (501c3)
- Steps to Quality Consortium
- Stonewall Alliance
- Student Consumers

playgroups, Families training, secondary trauma support, research, and community development tightly link to the Center CARE Project but are not included in the Innovations funding application.

The third step, the Materialize Phase honed the decisions into a prototype which is being tested. The purpose of the prototype test is to engage diverse stakeholders to evaluate the acceptance and value of the ideas, as well as gather insight and expertise prior to the introduction of the services, in order to iterate a more effective, meaningful design. This phase was particularly crucial because, despite significant effort, the committee was unable to sufficiently engage Families in the first two phases. The prototype test will involve eight stakeholder groups. Each stakeholder groups has an audience-specific strategy to acquire information, which might include interviews, focus groups, or surveys.



1. Professional county-wide leadership
2. Social service professionals
3. Clinicians
4. Education professionals
5. College professors
6. Field study coordinators
7. Student consumers
8. Family consumers

Family consumers efforts will involve interviews and focus groups held at preschools and child care setting, library story hours, family resource and community centers, and parks, with particular awareness to underserved populations. In Butte County, those underserved populations may be culturally, ethnically, and racially diverse, but also include families that are isolated in remote rural communities with few services or support systems. Questions will include, but not limited to:

- Hours of services
- Design and color selection of Center feature rooms
- Type of family support needed, e.g. screening and assessments, in-person case management, call-in resource and referral
- Structure of Family Education, e.g. formal classroom format for adult family members only, multi-family adult and child interactive instruction and intervention, virtual education
- Preferred counseling and mental health support options, e.g. mental health consultation at familiar learning settings, Parent Child Interactive Therapy, child therapy, family therapy
- Foreseen barriers to accessing services
- Interest in participating in governance board or advisory group

Additional consumer interviews or focus groups are taking place with the African American Family Cultural Center, the Hmong Cultural Center, Stonewall Alliance, ACCESS Consumer Advocacy (state

organization), several tribal groups to share insight on how the Center might best serve their community, so those strategies and approaches might be integrated into the implementation. For example, regular cultural competency and humility training to consider the gifts and needs of different cultural and ethnic background, and deep analysis of one's personal identity development; in-depth analysis of policies, procedures, practices, and pedagogies that enhance equity-based decision making; implement culturally conscious approaches to support all people and all families of all ages, gender identity, and sexual orientation; integrate culture-specific services such as family healing circles for indigenous community members; and create a structure of evaluation and accountability to ensure culturally humble standards are a priority.

The Center was included in the MHSA Community Input meetings throughout the county. Presentations have been made to county leaders, social service providers, educators, students, mental consumers, and the interested community, at large. In addition, an online survey (in English and Spanish) about the Center CARE Project was posted on the BCDBH website along with the MHSA survey. Although the completion rate to date has been low (14 responses), the data was largely unanimous and the written insights meaningful to the next steps of planning.

- Online survey responses regarding the worthiness of investing county funds identified that the Center CARE Project planning is on target.

Importance of Investing County Funds In the Following Approaches:	Extremely Important or Very Important
Strategies that address generational community trauma and Adverse Childhood Experiences	100.00%
Counselors and mental health professionals that are trained in specialized ways to help young children (infant to age eight) with trauma	100.00%
Child care providers and preschool teachers, who see children every day in group settings, who are trained in specialized ways to help children with trauma and social and emotional skills	100.00%
Mental health support for young children and their families who have experienced trauma due to the Camp Fire	92.85%
Education and modeling for families of young children on how to care for the emotional needs of their children	92.86%
A group of experts from different fields who work together to teach each other, do screenings, and consult on treatment for young children	85.71%
A family-friendly location for sensitive family services	85.71%
A research-driven, state of the art institute the leads the North State in trauma responsive practices	71.43%

- Feedback at Community Input presentation from family members with children who have a mental health condition has been emotional, often with feedback about how a program like this would have changed their lives.

- There were requests to begin family support earlier in the life cycle with pregnant and post-partum mothers, which is included in future planning. Detailed suggestions such as a toy lending library or art therapy will also be considered in future plans.
- Transportation concerns were expressed, as they typically are in Butte County. While there is need for transportation support within Chico, the transportation need is primarily between Chico and the remote, mountainous regions of the county. For participants who do not live in Chico, there was some disappointment that a Center would not be available in their town/city because they perceived a need for walk-in support and other associated on-site services. It was suggested by participants that mobile units be considered. It was also suggested that alternative locations be used – beyond learning settings – where additional services would be brought to remote communities at least once a month: a mobile Center, if you will.
- In regard to remote services, the online survey identified what the community believes to be the priority services to be offered:

The Value of Specific Services in Rural, Remote communities.	Very Valuable or Valuable
Specialized mental health services AT CHILD CARE SETTINGS when a child has been identified as struggling with trauma or behavior	100.00%
A mobile unit at rural school sites where families can meet with therapists	92.86%
A mobile unit at rural school sites where families can meet with specialists and have remote access to support services and information	92.85%
Virtual family education for families at home or from their phone	92.86%
Virtual training and support for child care professionals	92.86%
Virtual training and support for kindergarten through 3rd grade educators	78.57%
Series of YouTube Family education videos	78.57%
Virtual counseling for Families at their homes	78.57%

- College Students at the input sessions were extremely excited about the Center as an applied and service learning opportunity.
- Suggestions for welcoming and incorporating our diverse community, included continual (not just one-time) feedback from families from different cultural groups. In addition, there was hope of having the Center welcome homeless, impoverished, and especially, displaced fire survivors. Further, there was feedback that families that are involved in the child welfare system or families who have mental health or addiction challenges should be considered in the target consumers.
- It was also suggested that there be mandatory trauma response and secondary trauma support required for FEMA, law enforcement, fire services, nurses, doctors, teacher, or anyone whose decisions impact the lives of young children.
- There were many people who completed the online survey who expressed the need to remain positive and build on the strength of the community through the Center in the face of the fire recovery. It was suggested that the Center would allow formal and informal

gatherings that promote resilience. The Family Room could be used for spiritual healing circles, community art therapy, family strengthening potlucks, discussion of rebirth of the land and community, storytelling about strength from elders… a place for people to gather, to talk, to feel safe.

By the end of March, the research strategies will have been implemented and data collected for all eight stakeholder groups. The results will be evaluated by the research subcommittee and recommendations formed regarding additional testing. The Planning and Development Committee will modify the program design prior to the implementation process. Once implemented, a sophisticated evaluation plan will lead to an on-going analysis and evolution of the Center.

The fourth and final phase of the Concept Design Process is the Evolve phase, and it includes implementation of the approach, programs, and strategies that result from the Materialize phase. The Evolve phase will be a continual process of prioritizing quality service delivery and systems to support children, families and communities. This on-going evolution will require a robust evaluation plan, as outlined above for the Center CARE Project, and further expanded to incorporate all of the Center components.

Individuals who have participated in the Planning & Development Committee will evolve their role, and with an enhanced team of consumers and administrative leadership, will become the governance board and area specific advisory groups.

With the availability of Innovation Project funds, the CARE Project will begin ECE setting services in Summer 2019, with evaluation services. A baseline will be established. The Center design will press forward in Spring 2019 with a final opening in Winter 2019. At that time, Center-based services, MDT collaboration, and training will commence.

MHSA GENERAL STANDARDS

Using specific examples, briefly describe how your INN Project reflects, and is consistent with, all potentially applicable MHSA General Standards listed below as set forth in Title 9 California Code of Regulations, Section 3320 (Please refer to the MHSOAC Innovation Review Tool for definitions of and references for each of the General Standards.) If one or more general standards could not be applied to your INN Project, please explain why.

A) Community Collaboration

Community and Collaboration are two of the guiding principles for the Center. Both community and collaboration have been inextricably connected to the planning and will continue to be through implementation and evaluation. The following are excerpts from the Center Principles:

Community: We know that the well-being of all people – and in particular children – reflect the values of the community. Social, organizational, and political systems change, and their capacity developed, when we draw from the strengths and diversity of community

members and groups. We see the communities in the North State as having capacities unique to their size and place. We seek to respond to the challenges of service delivery in rural, small communities. We are partners in strengthening rural communities.

Collaboration: We understand without true collaboration the mission of this Center will not be successful. We believe that when people come together in relational partnerships, with a deep commitment to the common good, the resulting synergy will result in creative, results-driven outcomes that can especially benefit our rural communities. We understand that true collaboration is more than just “cooperating” with one another; it demands an intentional willingness from each individual and organization to share power and implement an accountable governance.

B) Cultural Competency

Although referred to as “Cultural Humility and Responsiveness” in the Center principles, Cultural Competency is a founding principle in the Center work. The principle reads: We are aware of our own identities and privilege. We are knowledgeable about how different social and cultural groups experience the world. We seek information so that we can be culturally responsive in our work.

Cultural responsiveness at the Center will be integrated into decision about access to, and f full utilization of, services and systems. Even in the planning phase of the Center, it was identified that the committee did not truly reflect the diversity of the community and great investment is being made to acquire input and perspective from community representatives in the prototype testing phase of the Center development.

C) Client-Driven

Again, client empowerment is a guiding principle of the Center: We believe that people overcome challenges through empowerment and resiliency, and that we can support others by honoring equity, choice, personal strengths, connection, hope, and valuing ourselves and others. Clients will be provided with the information, respect, and support to make decisions for their own future and will be encouraged to inform the Center about how services, policies, evaluation best meet their needs. Further, clients will be honored for their life experience and unique empathy that can support their peers.

D) Family-Driven

Like Client-Driven decision making, families are respected for their right to share needs, preferences, strengths, and decision making when receiving services. Although we had some clients on the Planning & Development Committee, we struggled with engaging a commitment from a Family of a young child, which is often the case with busy young families. It has become a priority now to acquire that valuable insight through interviews,

focus groups, and surveys during the prototype test phase of development to ensure the committee is on track with family-driven choices.

E) Wellness, Recovery, and Resilience-Focused

Butte County is currently faced with one of the greatest tragedies that could be faced by a deeply interconnected rural community. It is the stalwart adherence to hope, personal empowerment, respect, social connections, self-responsibility and self-determination that is guiding the way to recovery. These principles and attributes are communicated from county leaders to individual community members, in a palpable desire for recovery toward a safe and stable life.

F) Integrated Service Experience for Clients and Families

Elemental to the Center is a comprehensive, coordinated, and integrated service delivery system. Service providers and organizations work hand-in-hand at a centralized location to offer a full range of appropriate and responsive services at the Center and in remote communities.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

Explain how you plan to ensure that the Project evaluation is culturally competent and includes meaningful stakeholder participation.

Prior to Center CARE Project implementation, a prototype test with eight different stakeholder groups, across diverse communities, will be completed in order to acquire perspective and feedback for all cultural groups in the community. The development of the prototype strategies involve input from the Planning and Development Committee membership, consultation and partnership with an anti-bias education professor from Butte College, and phone consultation from ACCESS California. In addition, cultural competency training was completed by the facilitator of the prototype, through Butte County Department of Behavioral Health and ACCESS California's empowerment and leadership workshops to ensure appropriate strategies are in place. Minority and under-represented groups will receive added focus in order to begin an on-going relationship that will take into consideration their needs and hopes; these groups will include the African American Family Cultural Center, the Hmong Cultural Center, Northern Valley Indian Health, Four Winds, Promotores Program, and Stonewall Alliance, and seek specific insight from families of young children.

The prototype implementation will build on existing, trusted service providers and cultural support systems to collect information and insight. Surveys will be in multiple languages used in the county and distributed through established cultural liaisons. Likewise, presentations and focus groups will be organized and offered in partnership with cultural representatives. These efforts will serve as a means to gather information that could serve as a baseline for future relationships; for information that will inform approaches, services and priorities; and for evaluations of the Center offerings to the community.

It will be an added goal through the work of the prototype test to identify representation of different cultural groups to participate in the on-going planning, development and evaluation of the Center. A diverse and distributed governance group will be formed to evaluate the Center work and oversee the Community Development Tier, the Research Tier, and the operations of the Center. It is anticipated that stakeholder groups will be involved in evaluating programs, services, approaches, and policies throughout the project so they can be refined to meet the needs of the full community.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

Briefly describe how the County will decide whether it will continue with the INN project in its entirety, or keep particular elements of the INN project without utilizing INN Funds following project completion.

Just as decisions regarding planning and development have been made through scrutinizing research and analysis, components of the Center CARE Project will evolve or devolve as the qualitative and

quantitative data informs. Data will be collected through case management and client training, client assessments, training rubrics, administrative record keeping of meetings and registration, and stakeholder feedback acquired through surveys, interviews, and focus groups. Stakeholders may include Family consumers, county leaders, clinicians, social service professionals, educators, college and university faculty and students. Nonetheless, it is anticipated that all components will be sustained as they have been refined over the first three years of operations. One exception may be a decrease in the frequency of the specialized mental health specialty training for clinicians, as the quantity of trained clinicians is developed and stabilized.

Will individuals with serious mental illness receive services from the proposed project? If yes, describe how you plan to protect and provide continuity of care for these individuals upon project completion.

Individuals with serious mental illness might receive services through the Center CARE Project. It is anticipated that therapeutic and support services will continue after the sunset of the INN funds, to allow a continuity of care with existing clinicians and service providers. It is anticipated that many of the CARE Project components will be sustained through Early and Periodic Screening, Diagnostic and Treatment (EPSDT) match for MediCal, state preschool add on, managed care system, Help Me Grow, future blended funding between schools and BCDBH, blended funding with partner agency, as well as the often more tenuous funding source of grants and donations. Sustaining clinical services for consumers with serious mental illnesses will involve ensuring that clients are appropriately vetted and referred to specialized clinicians who match the payment source at intake (MediCal, insurance, private pay, Victim/Witness, schools' counseling programs, etc.). Additionally, donor and grant resources will be used for those without a payment source. Mental Health Consultation will be sustained by training Early Care Educators to incorporate specialized interventions at community-based sites. The quality measures will be added to the Butte County Quality Initiative, *Steps To Quality,* so that annual evaluations and support may be added to continue mental health best practices in natural settings. Likewise, clinical expertise will be sustained by offering specialized training for all interested clinicians, who can then incorporate the expertise long-term in their work.

COMMUNICATION AND DISSEMINATION PLAN

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project.

A) How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties? How will program participants or other stakeholders be involved in communication efforts?

In the past, the Center has developed periodic Center Update reports that were distributed to the county leadership and other stakeholders. In Spring 2018, a meeting was hosted in which Planning & Development Committee members presented the

progress made designing the Center. It is foreseeable that both quarterly Center Updates and an annual symposium would inform leadership stakeholders.
In addition, a Center website will be designed to feature successes, resource and referral links, and trauma responsive messages. Consumers will be asked to participate in strategizing these outreach efforts in order to ensure we are communicating to all stakeholders.

B) KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.

Mental health consultation
Service Center
Rural
Young child
Trauma

TIMELINE

A) Specify the expected start date and end date of your INN Project

The start date to the Innovations Center CARE Project will begin immediately after funds are awarded and the contract between BCDBH and BCOE is in place (approximately May 1, 2019) and conclude June 30, 2022.

B) Specify the total timeframe (duration) of the INN Project

The full duration will be three years and three months.

C) Include a project timeline that specifies key activities, milestones, and deliverables—by quarter.

FY1-Q4	Design Center facility Begin hiring process Offer secondary trauma training for mental health professionals Design evaluation plan
FY2-Q1	Hire and train Center CARE Project staff Implement CARE Project (without Center), including multidisciplinary partnerships at community learning sites Offer trauma-responsive mental health summit for child care providers Conduct CARE pretest Quarterly monitoring
FY2-Q2	Continue CARE Project (without Center) Offer multidisciplinary cross training Offer secondary trauma and cultural humility training with support group Complete construction Finalize operational planning Quarterly monitoring
FY2-Q3	Implement Center services with CARE Project Begin counseling, case management, supported playgroups at Center Offer Clinical Institute for Infant Family Early Childhood Mental Health Offer multidisciplinary cross training Quarterly monitoring
FY2-Q4	Continue Center CARE Project Offer multidisciplinary cross training Offer secondary trauma and cultural humility training with support group Conduct CARE posttest Quarterly monitoring
FY3-Q1	Analyze and hone project Conduct CARE pretest Offer trauma-responsive mental health summit for child care providers Offer multidisciplinary cross training Continue Center CARE Project Quarterly monitoring

FY3-Q2	Offer multidisciplinary cross training Offer secondary trauma and cultural humility training with support group Continue Center CARE Project Quarterly monitoring
FY3-Q3	Continue Center CARE Project Offer multidisciplinary cross training Quarterly monitoring
FY3-Q4	Continue Center CARE Project Offer multidisciplinary cross training Offer secondary trauma and cultural humility training with support group Conduct CARE posttest Quarterly monitoring
FY4-Q1	Analyze and hone project Continue Center CARE Project Offer trauma-responsive mental health summit for child care providers Offer multidisciplinary cross training Conduct CARE pretest Quarterly monitoring
FY4-Q2	Continue Center CARE Project Offer multidisciplinary cross training Offer secondary trauma and cultural humility training with support group Quarterly monitoring
FY4-Q3	Continue Center CARE Project Offer multidisciplinary cross training Quarterly monitoring
FY4-Q4	Continue Center CARE Project Offer multidisciplinary cross training Offer secondary trauma and cultural humility training with support group Conduct CARE posttest; analyze and hone project Quarterly monitoring

Section 4: INN Project Budget and Source of Expenditures

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

The next three sections identify how the MHSA funds are being utilized:

A) BUDGET NARRATIVE (Specifics about how money is being spent for the development of this project)

The Innovations budget will be spent primarily on developing a professional infrastructure to provide mental health services, including administrative expertise and oversight, direct service specialists, and program evaluation. The Mental Health Consultant (MHC) is the hub of the CARE Project, providing direct, specialized services to remote learning environments, as well as integrating social services with children, families and professionals at the Center. Two full-time MHCs are included in the budget. The introduction of the innovative Center and CARE Project requires the expertise of a Center Director, Program Manager, Clinical Supervisor, and Administrative Support. A portion of these positions are budgeted with Innovations funds and the balance will be funded by other resources.

Consultant expertise will be obtained for the purposes of training and evaluation. Local clinicians will receive training on specialized mental health approaches as a professional development institute. A consultant will also oversee the evaluation and research necessary for the Center and the Innovations project during the life of the grant.

One-time consultant funding will be used in Spring 2019 for the Architects and Designers who will develop a Center that meets the cultural and trauma sensitive needs of diverse families and professionals who have experienced trauma in the community. The Center role in the community will be multi-faceted - services, education, and research – and will place it on the map for quality, innovative work. The design of the Center is integral to meeting those goals. It is anticipated that the balance of the design, development, and building expenses will be funded through Butte County Office of Education, other grants, and community donations.

The budget is paying **salary and benefits** for FY19/20, FY20/21, and FY21/22 for the following positions:

Center Director (.5 FTE)
Clinical Director (.25 FTE)

Program Manager (.5 FTE)
Specialist "Mental Health Consultant" (2 FTE)
Administrative Support (.25 FTE)
Administrative Analyst (.25 FTE)

Consultants for FY18/19 will be a one-time expense to support the development of the Center's child and family spaces to be trauma responsive and meet identified needs, in addition to the design and evaluation plan:

Architect/Design
Landscape Architect
Consultant (Center Design and Evaluation)
Consultant (Mental Health/Secondary Trauma)

For FY19/20, FY20/21, and FY21/22, consultants will be used for evaluation and training expertise:

Evaluation Consultant
Training Consultant

Operational expenses for FY18/19 will include the purchase of assessment, curriculum, materials and office equipment.

For FY19/20, FY20/21, and FY21/22, additional expenses will be incurred in the following areas:

Screener and assessment forms
Materials and equipment
Rent and family operations
Travel for staff to remote sites
Travel for consumers to Center

Indirect cost is 7.09% in 18/19 and adjusts in 19/20 to 8.26% of expenses.

B) BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (Identification of expenses of the project by funding category and fiscal year)

See attached fiscal year category breakdown on the following page. Fiscal year estimates do not reflect potential annual variance, due to cost of living pay increases.

C) BUDGET CONTEXT (if MHSA funds are being leveraged with other funding sources)

MHSA funds are not being leveraged with other funding sources, although there is considerable investment through other funding sources for the development of the Center facility and the array of multi-disciplinary services planned.

BUDGET NARRATIVE

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project. The goal of the narrative should be to provide the interested reader with both an overview of the total project and enough detail to understand the proposed project structure. Ideally, the narrative would include an explanation of amounts budgeted to ensure/support stakeholder involvement (For example, "$5000 for annual involvement stipends for stakeholder representatives, for 3 years: Total $15,000") and identify the key personnel and contracted roles and responsibilities that will be involved in the project (For example, "Project coordinator, full-time; Statistical consultant, part-time; 2 Research assistants, part-time…"). Please include a discussion of administration expenses (direct and indirect) and evaluation expenses associated with this project. Please consider amounts associated with developing, refining, piloting and evaluating the proposed project and the dissemination of the Innovative project results.

*For a complete definition of direct and indirect costs, please use DHCS Information Notice 14-033. This notice aligns with the federal definition for direct/indirect costs.

(Budget Narrative under Section 4. Subsection A. above.)

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY					
	Year 1*	Year 2	Year 3	Year 4	Total
Personnel (Salary & Benefits)					
Center Director (.5 FTE)	-	67,898	71,292	74,857	214,047
Clinical Director (.25 FTE)	-	25,890	27,185	28,544	81,618
Program Manager (.5 FTE)	-	43,250	45,413	47,683	136,346
Specialists (2 FTE)	-	126,000	132,300	138,915	397,215
Admin Support (.25 FTE)	-	13,750	14,438	15,159	43,347
Admin Analyst/BCDBH (.25 FTE)	-	20,500	21,525	22,601	64,626
Total Personnel	**-**	**297,288**	**312,152**	**327,759**	**937,199**
Contractual					
Facility Design/Development	110,000	20,000	-	-	130,000
Contractor: Evaluation	14,000	50,000	50,000	50,000	164,000
Mental Health Training	7,000	25,000	25,000	25,000	82,000
Total Contract	**131,000**	**95,000**	**75,000**	**75,000**	**376,000**
Operational Costs					
Assessment and Curriculum	8,000	5,000	4,000	3,404	20,404
Materials and Equipment	25,000	15,000	12,500	10,000	62,500
Facility Operations	-	36,950	46,250	46,250	129,450
Travel	-	7,500	8,000	8,500	24,000
Total Operations	**33,000**	**64,450**	**70,750**	**68,154**	**236,354**
Subtotal	**164,000**	**456,738**	**457,902**	**470,913**	**1,549,553**
Indirect	**7,031**	**37,727**	**37,823**	**38,897**	**121,478**
TOTAL	**171,031**	**494,464**	**495,725**	**509,811**	**1,671,031**
*Year 1 is two months (May and June 2019)					

MHSOAC
Mental Health Services
Oversight & Accountability Commission

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)						
ADMINISTRATION:						
A.	Estimated total mentla health expenditures for ADMINISTRATION for the entire duation of this INN Project by FY and the following funding sources:	FY 18/19	FY 19/20	FY 20/21	FY 21/22	TOTAL
1	Innovative MHSA Funds	-	-	-	-	-
2	Federal Financial Participation	-	-	-	-	-
3	1991 Realignment	-	-	-	-	-
4	Behavioral Health Subaccount	-	-	-	-	-
5	Other funding	-	-	-	-	-
6	**Total Proposed Administration**	-	-	-	-	-
EVALUATION:						
B.	Estimated total mental health expenditures for EVALUATION for the entire duration of theis INN Project by FY and the following funding sources:	FY 18/19	FY 19/20	FY 20/21	FY 21/22	TOTAL
1	Innovative MHSA Funds	14,000	70,500	71,525	72,601	228,626
2	Federal Financial Participation	-	-	-	-	-
3	1991 Realignment	-	-	-	-	-
4	Behavioral Health Subaccount	-	-	-	-	-
5	Other funding	-	-	-	-	-
6	**Total Proposed Evaluation**	14,000	70,500	71,525	72,601	228,626
TOTAL:						
C.	Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY and the following funding sources:	FY 18/19	FY 19/20	FY 20/21	FY 21/22	TOTAL
1	Innovative MHSA Funds	14,000	70,500	71,525	72,601	228,626
2	Federal Financial Participation	-	-	-	-	-
3	1991 Realignment	-	-	-	-	-
4	Behavioral Health Subaccount	-	-	-	-	-
5	Other funding	-	-	-	-	-
6	**Total Proposed Expenditures**	14,000	70,500	71,525	72,601	228,626
*If "Other funding" is included, please explain.						