On behalf of Cal Voices, we would like to provide comment regarding Sacramento's Behavioral Health system of care as well as Sacramento County, Division of Behavioral Health's recent presentation to the MH Advisory Board.

EQRO Report

Does the Division share the EQRO report with the MH Advisory Board and/or the MHSA Steering Committee? It seems reasonable that any public planning efforts should include access to care data. The recent EQRO revealed several serious gaps in service delivery and other delinquencies and access to service issues. Of particular concern is the waiting time to connect to services (47 days), as well as the recidivism at the MHTC within 30 days (18% of clients returning), and the lack of a front door crisis continuum (still having to go through law enforcement to access crisis), and finally the fact that 30% of individuals seen inpatient **never** receive any services.

We would hope innovation funds would address some of these needs, rather than fund a criminal justice project that did not undergo a robust community planning process.

Budget –

The Section in the report to the MH Board entitled Outpatient Program Funding identifies 1991 Realignment as funding stream, but makes no mention of the 2011 Public Safety Realignment that supports MH. Where is that funding indicated in the budget materials?

MHTC – 37m. – From what we can recall the budget for MHTC was approximately 28m. in fiscal year2009-10 when the County decided to close down 50 of the 100 beds available, reducing the capacity by 50% to save County costs. Yet 10 years later the MHTC budget has increased to 37m., and has not expanded and no one can enter it from the front door.

Furthermore, Sac County would be better served by developing smaller, more home like units, 16 slots and under in order to bill MediCal - something advocates have been supporting for many years.

Crisis Continuum

According to the budget figures shared on Page 4 of the report shared at the MH Board meeting, Sac County is spending $97 million on inpatient/crisis continuum Services with no indication of positive outcomes. This is nearly 25% or ¼th of the overall MH Budget, and yet individuals and families still cannot enter crisis services through a front door. They cannot go directly to any psychiatric hospital without first going to an Emergency Department, calling 911 and being escorted by Law

Enforcement, to the Crisis Stabilization Unit or the SCMHTC. The Division has repeatedly cited the need for people needing to be screened first in the emergency department prior to entering a psychiatric facility, but that is simply not the case for anyone with private insurance. Therefore, we ask the County to reconsider this disparate policy.

Given the enormous amount of funding for institutional care, we feel the Division should be making these services far more accessible to the mental health community and the general public at large. There is simply no clear rationale indicating any of these services are client or family focused, because clients and families have been clamoring about this system barrier for a decade now.

Clients can access Crisis Respite Services directly but are not offered any psychiatric care at these programs, nor is there any evidenced based peer run crisis centers in Sacramento.

Urgent Care is a great program, but is not open 24 hours a day, and is not necessarily the appropriate program for someone experiencing a psychiatric crisis.

Alcohol and Drug Services

It is unclear as to where someone can receive evidenced based peer support services or supports for their AOD challenges as there is nothing listed, yet we know there is strong data pointing to the need for these services in AOD programs. Residential Treatment is also listed as a service funded by MediCal but again, from what we can see on the ground, there are really no available slots in the MediCal funded Residential Treatment programs, and the waiting lists are very long.

MHSA: The Big Picture

Housing Supports – Sac County invested approximately 100m. in the whole person care project (in 2018) to increase housing supports, yet homelessness continues to rise. From what we can garner on the ground, none of these funds have actually been used for housing units. If we do not build and create housing, the structural problem will never go away and we continue to throw money at supports and services that are incapable of "creating" housing units. Can we view some data on the efficacy of these programs?

Expanded collaboration with Child Welfare – how is MHSA funding being used to expand Child Welfare services? Has the MHSA Steering Committee and MH Board approved these expenditures? Since Child Welfare does not have the level of client/family involvement, (no child/family advocates working on MDT teams, etc.) how/why are we using our MHSA funds for these services? It is our belief (supported by SAMHSA) that we need youth and family advocates imbedded in the CW system, to ensure the youth and family voice is elevated in policy and program development, to provide evidenced based peer support for the youth and families,

and to ensure a recovery oriented system is in practice. Our agency provides these services in Placer County's system of care, and could certainly expand our SAFE program to do such in Sac County – which would be an excellent and transformative way to use MHSA funds.

Homelessness Behavioral Health Services – where are these and what distinguishes these services from other BH services? What are the outcomes for these programs?

A careful review of the RFP indicates the County is putting out to bid all of the various Anti-Stigma campaigns they have been conducting throughout the years – such as Speakers' Bureau, Journey of Hope, Mental Illness is not what you think, etc. These are all nice things, but we do not necessarily feel that any of them have moved the needle or improved access to care in Sacramento County. If you have data that contradicts this, we would be very interested in seeing it. It appears that the outcomes for these services are about how many PSA's or impressions were provided, not about increasing access to care. Even the billboards that the County funded listed 211 on them, rather than the County's Access Team number, so anyone who was actually suffering with a mental health condition would not end up at the right door. We believe prevention should include outreach, engagement, and linkage, not just a broad based media campaign.

Link to 2018-2019 MHSA Annual Update - see p 69

MHSA Fiscal Year 2019-20

Important to note that the $113m in unspent funds is in addition to the 33% that is part of the prudent reserve. Governor Newsom has already declared (Sac Bee, Jan, 2020), that he is going to fully implement reversion this June to any counties who are not spending down their full MHSA allocation (aside from their prudent reserves). Regardless of the Governor's intended actions, Sac County has a legal mandate to spend down their full allocation of MHSA (aside from prudent reserve) **each and every year** and has never done so. Given the critical unmet needs and problems with timely access to services, Sac County should be focusing all of their efforts and their funding to fix these problems in order to ensure citizens of Sacramento County are adequately served by our PMHS.

MHSA Fiscal Year 2021-22

According to these budget figures, there continues to be 42m. unspent funds even at the end of the 2022 fiscal year, in addition to the prudent reserve account. Prudent reserves are for sustainability and rainy days, not the existing allocations. We find it inhumane for Sac County to know these unmet needs related to lack of timeliness of services, ineffective and inappropriate gateways to services, and high numbers of homelessness while they continue to have more than enough funding to address these needs and simply won't.

Crisis Continuum: The Big Picture

Psychiatric Hospitals and MHTC

For decades now, we have had a number of freestanding psychiatric hospitals and very few psychiatric health facilities (PHF) that can bill MediCal. We are curious to the reason why Sacramento County continues to lose money in this fashion and if there are any **MHSA** funds being used for these services? Given the limited amount of realignment funds, and the need to ensure we receive the Federal Financial Participation match on those funds, why would we continue to spend hundreds of millions of dollars on these services?

Psychiatric Hospital Front Door:

Urgent Care and Crisis Stabilization Unit – Urgent Care is a front door, but from what we can gather the CSU is still only open for Law Enforcement, yet is listed on this report as a front door. No one can go directly to the CSU – there is no front door access for the community. If there is a front door for the CSU, why aren't we fully educating the public about this resource?

The Mercy Crisis Stabilization Unit, which was funded with MHSA funds, is currently listed as a locked, inpatient facility, which is not supposed to be funded with MHSA funds. On the ground, we hear that it is being used as backfill to the Emergency Department and not a front door.

3 Crisis Residential Teams – again from my understanding none of these services can be accessed via the front door. Clients must go through the ACCESS gatekeeping service, and not directly into any of these programs. There is a huge demand for these services to be utilized as a step-down service when people are being discharged from the hospital. They are not being used to decrease hospitalization or to avoid hospitalization, as is a best practice for crisis residential, which would reduce hospitalization costs in the long haul. Additionally, crisis residential programs have very little clinical or psychiatric support and are largely run by case managers, not even peers.

6 Mobile Crisis Support Teams – where are these located? Is the only way to access these services by calling 911? We need Mobile Crisis Support teams that are not only accessed through law enforcement.

2.5m in Adult Residential Treatment on the way – what does this look like? Is this for substance use? Is it being paid for with MHSA funds? Was it borne out of a CPP?

2.5m. in Augmented Board and Care on the way – I think this is a good program and can be helpful, but it does not appear that there was a robust CPP involved in the planning.

Challenges

Again, there is no mention of the 2011 Public Safety Realignment - also a funding stream.

If 1991 realignment only covers roughly 46m of inpatient services, what funds the rest? Is MHSA funding being utilized to backfill realignment for inpatient services?

So, what does a recovery oriented, client driven system of care look like:

- Less funding for acute, inpatient, locked hospital settings and more for community based mental health services and prevention
- Recovery is the goal, and all services reflect the core principles of recovery
- Services would be easily accessible from the front door – no Emergency Departments, no 911 and law enforcement
- Robust evidenced based peer support services would be integrated through every program and service
- Clients and family members from all communities in Sacramento County would be part of all planning and program development efforts, including the budget and allocation of funding in a far more transparent manner.
- Shared decision making models

Outcomes associated with a recovery-oriented system:

- Client driven services that track recovery oriented outcomes
- Easily accessible front door crisis services available every single day – reducing the need for inpatient hospitalization
- No need to go to an emergency department or call law enforcement when you are in a crisis - improving access to care
- Evidenced based peer support services integrated into all behavioral health service settings would reduce hospitalizations, incarceration and increase self determination, and improve recovery outcomes
- Extensive engagement of all underserved clients in order to hear those voices in meaningful ways to transform service delivery

In short, we ask that Sac County use its MHSA funds to create recovery outcomes, and implement robust evidence based peer support services, while improving access to crisis and other mental health services. We firmly believe the results will improve outcomes for the thousands of individuals being served in our system of care, as well as those in need of services and support living in our community.