SACRAMENTO COUNTY
MENTAL HEALTH SERVICES ACT

COMMUNITY SERVICES & SUPPORTS THREE-YEAR PROGRAM AND EXPENDITURE PLAN

January 31, 2006

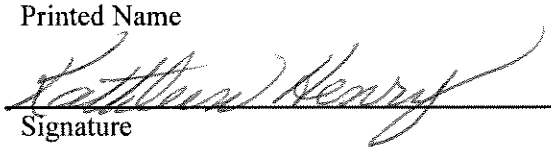
EXHIBIT 1: PROGRAM AND EXPENDITURE PLAN FACE SHEET

MENTAL HEALTH SERVICES ACT (MHSA)
THREE-YEAR PROGRAM and EXPENDITURE PLAN
COMMUNITY SERVICES AND SUPPORTS
Fiscal Years 2005-06, 2006-07, and 2007-08

County: Sacramento Date: January 31, 2006

County Mental Health Director:

Kathleen Henry
Printed Name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Revised 1/31/06

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Background

In November 2004, the voters of the State of California passed Ballot Proposition 63 as an initiative, and the Mental Health Services Act (MHSA) became state law effective January 1, 2005. The stated purpose of the MHSA is to "provide state and local funds to adequately meet the Mental Health needs of all children and adults who can be identified and enrolled in programs under this measure…and to provide services that are not already covered by federally sponsored programs or by individuals' or families' insurance programs."

The Challenges

The President's New Freedom Commission on Mental Health's *Interim Report to the President* stated, "…The [mental health delivery] system is fragmented and in disarray…lead[ing] to unnecessary and costly disability, homelessness, school failure. and incarceration."[1] The fragmented system leads to gaps in care for children and adults with serious mental illnesses. In order to provide services to this population, there must be a transformation in the delivery of mental health services in the community.

Goal of the Transformed System

The transformation of the public mental health system in California and the implementation of the MHSA is based on the goals of the President's New Freedom Commission on Mental Health, the aims of the Institute of Medicine's *Crossing the Quality Chasm*, and the California Mental Health Planning Council's *Mental Health Master Plan.*

In order to effect change in the mental health system, the State directed programs to be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers, as well as the five fundamental concepts inherent in the MHSA. These concepts are as follows:

[1] President's New Freedom Commission on Mental Health, Interim Report to the President. October 29, 2002. [Online]: http://www.mentalhealthcommission.gov/reports/Interim_Report.htm#P75_10348: October 28, 2005.

- Community collaboration;
- Cultural competence;
- Client/family driven mental health system for older adults, adults and transition age youth and a family-driven system of care for children and youth;
- Wellness focus, including the concepts of recovery and resilience; and
- Integrated service experiences for clients and their families throughout their interactions with the mental health system.

Target Populations

The target populations to be served by the MHSA funds are adults (individuals 18-59 years), and older adults (60+ years), with serious mental illness and children/youth (17 years and younger) with serious emotional disability who are not currently receiving mental health services ("unserved") or not receiving adequate mental health services to recover from the disorder or to prevent disability ("underserved"). Emphasis will be placed on providing services to members of unserved, underserved, and inadequately served communities, including but not limited to: Latinos, Native Americans, African Americans, Refugee groups, and members of the Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex (LGBTQI) and disabled communities, including Deaf and Hard of Hearing communities.

A more detailed description of the target populations may be accessed and downloaded on the Sacramento County Department of Health and Human Services, Mental Health Division's website at:
www.sacdhhs.com/CMS/download/pdfs/MQM/Determination%20for%20Medical%20Necessity%20&%20Target%20Population%2007-01-05.PDF

The Programs

Programs to be funded by the MHSA must be evidence-based or utilize promising practices that have demonstrated effectiveness in the field. All programs will be culturally, ethnically, and gender sensitive in the services provided. The programs will also include, at a minimum, training on co-occurring disorders for all staff involved in the programs. The aim will be to treat the "whole person" no matter what symptom may be primary.

There are three types of funding supporting the programs. These are:

- Full Service Partnership Funds – funds to provide "whatever it takes" for initial populations;
- General System Development Funds – funds to improve programs, services, and supports for the identified initial full service populations and for other clients; and
- Outreach and Engagement Funding – funds for outreach and engagement of those populations that are currently receiving little or no service.

The stakeholders of Sacramento County are recommending the following programs to address the mental health needs of the community with the funding available from the MHSA. Each program represents the efforts of consumers, family members, mental health providers, and members of the law enforcement, education, social services, and alcohol/drug service provider communities in developing programs based on the underserved population of mental health consumers in Sacramento County.

- Transitional Community Opportunities for Recovery and Engagement (CORE) – Workplan #SAC1

  Type of program funding: General System Development*
  Number to be served: 250 at any given time
  Age group to be served: Transition Age Youth, Adults, Transition Age Adults, and Older Adults
  Staffing: Ratio of 1:12
  Total Annual Cost: $1,635,551

  Program Description:
  CORE is an intensive community-based multi-disciplinary team approach designed to deliver comprehensive and flexible treatment. The program's targeted population is those referred for services by the acute care system (i.e., Sacramento Mental Health Treatment Center (MHTC), local acute psychiatric hospitals, Crisis Stabilization Unit, Crisis Residential Program, and Jail Psychiatric Services. The program services will be considered ongoing until the consumer has been linked and transitioned to longer-term mental health services. Services will include integrated treatment for co-occurring disorders.

  Anticipated Outcomes:
  The anticipated outcomes include: increase in the number of consumers who are able to access mental health services and supportive services following a crisis encounter or inpatient stay, reduction in the need for crisis services, hospitalization, and institutionalization, as well as increased community-based services for unlinked individuals and increased diversion from the MHTC Crisis Unit into the outpatient service system. With the program services, it is anticipated that those served will also receive housing and/or vocational supports (when the client identifies these elements as service plan goals).

- Older Adult Intensive Services Program – Workplan #SAC2
  Type of program funding: Full Service Partnership*
  Number to be served: 100 at any given time
  Staffing: Ratio of 1:15
  Age group to be served: Older Adults and Transition Age Adults
  Total Annual Cost: $1,072,415

* Although no funding was dedicated to Outreach and Engagement, it is anticipated that each program will conduct outreach and engagement activities in the normal course of business.

Program Description:
The Older Adult Intensive Services Program, modeled after the Elder Care Intensive Service Program, will provide culturally appropriate specialized geriatric psychiatric support, multidisciplinary outpatient mental health assessment, treatment, and intensive case management, as well as integrated treatment for co-occurring disorders. Both clinic and home-based services will be provided.

Anticipated Outcomes:
The goals of wellness and recovery will be achieved by older adults: gaining improved medical and functional status; increasing social supports; decreasing isolation; and reducing emergency room utilization, hospitalization, and homelessness.

- Permanent Supportive Housing Program for Homeless Individuals and Families – Workplan #SAC4
  Type of program funding: Full Service Partnership*
  Number to be served: 125 at any given time (31 seriously emotionally disturbed children and their families; 31 transitional age youth; 57 adults; and 6 older adults)
  Staffing: Ratio of 1:10
  Age groups to be served: All age groups
  Total Annual Cost: $2,178,444

  Program Description:
  The Permanent Supportive Housing Program will provide integrated, comprehensive, culturally competent, supportive housing subsidies and services to the underserved population. Initially participants will be housed in existing housing. It is anticipated that permanent housing units will be developed with leveraged housing funding through a partnership with the Sacramento Housing and Redevelopment Agency (SHRA), Sacramento County DHHS Mental Health Division, a private nonprofit housing developer, and a contracted mental health service agency. Staffing will include consumers, family/child advocates, licensed professionals, psychiatrists, nurses, bilingual/bicultural staff, housing specialists, and employment specialists. Services will include integrated treatment for co-occurring disorders.

  Anticipated Outcomes:
  In addition to permanent affordable housing, the program will provide the supports to assist the participant to succeed in his/her recovery and wellness, which will allow for re-integration into the community. There will also be a reduction in hospitalizations and jail incarcerations and an increase in employment.

* Although no funding was dedicated to Outreach and Engagement, it is anticipated that each program will conduct outreach and engagement activities in the normal course of business.

- Transcultural Wellness Center – Workplan #SAC5
  Type of program funding: Full Service Partnership*
  Number to be served: 250 at any given time
  Age groups to be served: All age groups
  Staffing: Ratio of 1:15
  Total Annual Cost: $1,336,239

  Program Description:
  The Transcultural Wellness Center will be established to specifically address the mental health needs of the Asian/Pacific Islander (API) communities in Sacramento County. The center will serve Chinese, Filipino, Japanese, Korean, Hmong, Vietnamese, Mien, Laotian, Cambodian, Tongan, Samoan, Hawaiian, and Fijian Americans, among others. The center will be the base for an efficient delivery system of culturally appropriate mental services to all age groups. The center will be developed through the use of a Steering Committee, comprised of consumers, family members, API community leaders, and elders from all API ethnicities. Consumers, family members, and community members will be recruited to fill designated program staff positions.

  Using a comprehensive and culturally competent assessment tool, a single service coordination/case management treatment plan will be developed. The plan will present culturally appropriate mental health interventions, treatment, and prevention strategies in various languages that include: cultural and religious beliefs and values; traditional practices; natural healing practices; and ceremonies recognized by the API community. Services may include: culturally appropriate wellness, resilience and recovery services; psychotherapy; counseling; psychiatric consultation; medication support; integrated treatment for co-occurring disorders; networking peer support; interpreter/translator; and psycho-educational services. The program will include a comprehensive multi-disciplinary, bicultural/bilingual staff.

  Anticipated Outcomes:
  This program will increase the number of members of the target population receiving timely and appropriate mental health services and decrease the number of individuals utilizing social services, acute care, or public safety providers as a component of untreated mental illness. It is also anticipated that with ongoing contact and communication with these systems, there will be an increased awareness of the cultural issues that need to be considered when making dispositions in individual cases.

- Wellness and Recovery Center – Workplan #SAC6
  Type of program funding: General System Development*
  Number to be served: 450 at any given time
  Staffing: Ratio of 1:47
  Age groups to be served: Transition Aged Youth, Adults, and Older Adults
  Total Annual Cost: $676,123

  Program Description:
  The Wellness and Recovery Center will be a neighborhood based multi-service center that will provide a supportive environment offering choice and self-directed guidance for recovery and transition into community life. A special effort will be made to employ consumers and family members from throughout the community to staff the center. The center will offer peer counseling, peer mentoring, interpreter/ translator, psycho-educational services, and psychiatric support, as well as natural healing practices. The program will provide linkage to treatment for co-occurring disorders. There will be opportunities to experience real life situations in a supportive and non-threatening environment. Educational partnerships will be formed with local colleges and other educational providers. A library at the center will be available to center participants as well as the general public. There will be an emphasis on mental health, recovery, and cultures in our community.

  Anticipated Outcomes:
  Through their participation at the center, consumers and family members will have the opportunity to develop wellness and recovery skills with the objectives of re-engagement in the community, relapse prevention, independence, and an improved quality of life.

- Psychiatric Emergency Response Team (PERT) – Workplan #SAC7
  Type of program funding: General System Development*
  Number to be served: 3,228 annually
  Staffing Ratio: Not applicable
  Age groups to be served: All age groups
  Total Annual Cost: $1,754,970 ($1,209,903 MHSA + $545,067 Law Enforcement)

  Program Description:
  The Psychiatric Emergency Response Team (PERT) is a collaborative community-based mental health crisis intervention program comprised of 4.5 two-member teams each consisting of one mental health clinician and one law enforcement officer with support staff (the 0.5 team consists of the PERT law enforcement supervisor and the Mental Health Program Coordinator assigned to supervise the program; half their time will be devoted to supervisory activities and the remaining half to service delivery as a two-member service team). Two consumer/family

* Although no funding was dedicated to Outreach and Engagement, it is anticipated that each program will conduct outreach and engagement activities in the normal course of business.
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advocates will provide consultation to teams and supportive services to clients. PERT will provide ethnically and culturally appropriate multidisciplinary mobile crisis assessments to: stabilize the mental health crisis; establish linkages with appropriate mental health, physical healthcare, substance abuse, other co-occurring disorders, and social services; promote wellness and recovery; increase social supports; decrease isolation; and prevent the recurrence of a crisis situation and/or hospitalization or incarceration.

Anticipated Outcomes:
It is anticipated the program will reduce unnecessary trauma to consumers and family members, avoid involuntary interventions, and reduce the utilization of higher levels of care and incarceration via diversion and alternative crisis resolution.

Plan Review and Approval

Sacramento County's MHSA Community Services and Supports Plan was available for public review and comment from October 31 through December 7, 2005. The Sacramento County Mental Health Board held a Public Hearing on Wednesday, December 7, 2005, from 6:30 pm to 10:15 pm at The Grand, 1215 J Street. Seventy-one (71) members of the public gave testimony at the Public Hearing and over 130 written comments on the Plan were received from the public during the entire review period. Those testimonies/comments were analyzed and all substantive recommendations have been incorporated into the Plan. The Sacramento County Mental Health Board reviewed the revised Draft Plan at its regularly scheduled meeting on January 4, 2006. The Mental Health Board voted to recommend implementation of the Draft Plan with one exception. The Mental Health Board recommended that the portion of PERT funding designated for the salaries and benefits of law enforcement officers assigned to PERT be paid for by the participating law enforcement agencies or be appropriated from other County monies.

The Sacramento County Board of Supervisors considered the Community Services and Supports (CSS) Draft Plan at its regular meeting on January 17, 2006. The Board voted to authorize the Mental Health Director to submit the CSS Draft Plan to the California Department of Mental Health as written.

PART I
COUNTY/COMMUNITY PUBLIC PLANNING PROCESS AND PLAN REVIEW PROCESS

Section I: Planning Process

1. Briefly describe how your local public planning process included meaningful involvement of consumers and families as full partners from the inception of planning through implementation and evaluation of identified activities.

RESPONSE:

Background:

The Division of Mental Health in Sacramento County has long recognized the importance of consumer and family involvement in all aspects of mental health programming. Through a contract with the local Mental Health Association, both an adult consumer advocate and a child and family advocate serve on the Division's Executive Management Team. Sacramento County has consumer employees, child and family advocates, and adult family advocates throughout its organizational structure. In addition, there are formal youth and family advisory subcommittees providing input through the Mental Health Board's participatory planning process. The Mental Health Board's Budget Committee, active year-round and key to the Division's planning process, has always consisted of at least 50% consumers and family members. The established involvement of consumers and family members served as a nucleus from which to build an even more inclusive system that embraces consumers and family members as full partners in the planning, implementation and evaluation of the services and supports to be provided through the MHSA. It was recognized from the outset that an even more intensive effort would be necessary to attract the participation of heretofore unserved and underserved populations, i.e., the cultural and ethnic minorities, into the MHSA local public planning process.

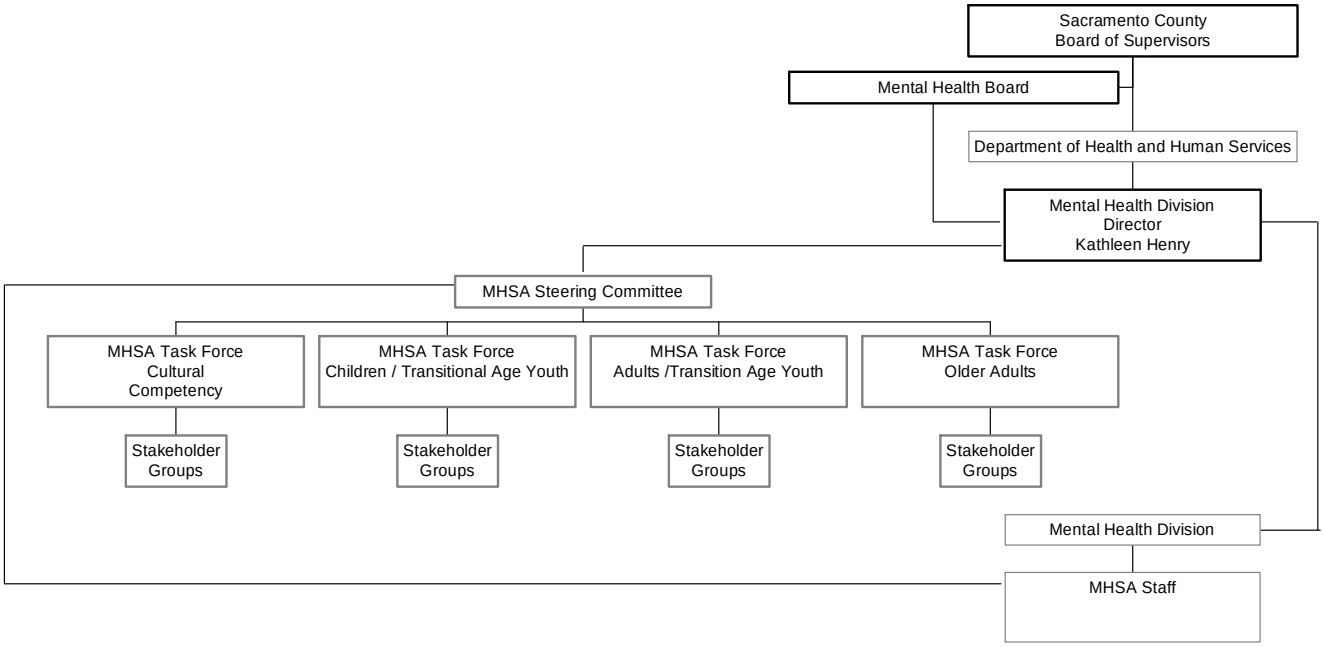
MHSA Structure and Governance

The MHSA planning process included meaningful consumer and family member involvement from the outset. The MHSA Community Services and Supports Steering Committee guided the local public planning process. This committee consisted of 22 members (50% of which are consumers and family members). The Steering Committee provided input directly to the Mental Health Director.

The structure and governance of the MHSA planning process clearly reflects Sacramento County's strong commitment to having consumers and family members as full partners in the MHSA planning process. Concerted outreach efforts were made to include cultural, ethnic, and racial minorities who have been underrepresented historically in the populations we serve.

Figure I shows in detail all aspects of the MHSA governance structure.

Figure 1. Structure and Governance of MHSA Planning Process



Following is a brief description of the elements in which consumers and family members are essential partners:

- Community Services and Supports Steering Committee

  The Steering Committee served as the umbrella over the MHSA planning, implementation and evaluation of the three-year process. The committee was made up of 22 members of whom 50% (11) were consumers and family members. The leadership of the committee included two family members as co-chairs. The Steering Committee oversaw the planning process and development of the draft Plan based on the priority recommendations received from the Task Forces described below. All meetings were open to the public for consumers, family members, and other members of the community to participate in the process.

- Community Services and Supports Task Forces

  There are four Task Forces within the MHSA structure and governance. The membership of each Task Force mirrored that of the Steering Committee, with 50% of the members being consumers and family members, for a total involvement of 44 additional consumers and family members. The Task Forces are:

  o Children and Youth/Transition Age Youth Services and Supports

- Adult/Transition Age Youth Services and Supports
- Older Adult Services and Supports
- Cultural Competence

Each of the Task Forces formed stakeholder work groups to complete assessments of the priority needs of targeted populations and to suggest programs and strategies to meet the needs. Members of the Task Forces were encouraged to participate in stakeholder groups to facilitate communication. Stakeholder groups ranked their proposals and forwarded them to the Task Forces. Following receipt of all proposals, each Task Force reviewed program components and prioritized recommendations before sending them to the Steering Committee. A detailed discussion of the stakeholder groups is provided in this section under the heading of "MHSA Stakeholder Groups."

- Timeline

  A timeline developed by the Division of Mental Health, and subsequently approved by the Steering Committee, provided a rigorous schedule for the participants. Milestones in the process included the following:

Table 1: Milestones of MHSA Timeline

Date	***Activity***
April 28, 2005	Orientation/Training for Steering Committee and Task Force Members
May 02, 2005	Orientation for all Stakeholders and formation of Stakeholder Groups
June 15, 2005	Recommendations from Stakeholders to the Task Forces
June 30, 2005	Recommendations to the Cultural Competence Review Group
July 19, 2005	Recommendations to the Steering Committee
July 30, 2005	Recommendations to the Division of Mental Health for Plan Development
Oct. 31, 2005	Draft CSS Plan posted for Public Review
Dec. 7, 2005	Mental Health Board conducts Public Hearing on CSS Draft Plan
Jan. 4, 2006	Mental Health Board recommends BOS Approval of CSS Draft Plan (with Non-MHSA Funding of PERT)
Jan. 17, 2006	Board of Supervisors approves Submittal of CSS Draft Plan to State Department of Mental Health

MHSA Kick-off

Even before the governance structure was operational, the MHSA Kick-off occurred on February 16, 2005. The purpose of the event was to engage the community and include multi-cultural, multi-ethnic, and multi-racial consumers, family members, contract providers, and local mental health partners, such as law enforcement, education and social services, in the development of the County Funding Request for the MHSA Community Program Planning. This ultimately became the County's "Plan-to-Plan."

The kick-off provided the initial step for stakeholders from diverse cultural and ethnic communities to be full partners in the planning process. The intent of the kick-off was to adhere to the spirit of the MHSA and the DMH Guiding Principles to start an inclusive process that would set the standard for all aspects of the planning, implementation and evaluation.

Highlights of the MHSA Kick-off include the following:

- Approximately 290 stakeholders attended.
- Thirty-seven percent in attendance were consumers and family members.
- Ethnic groups in attendance were: Caucasian (64%), African American (11%), Unspecified (11%), Pacific Islander (7%), Hispanic (5%), Eastern European (1%), and Other/Mixed (1%).
- Interpreters were available in Spanish, Russian, Hmong, Vietnamese, Cantonese, and American Sign Language.
- Attendees chose one of three breakout groups (children, adults, older adults) in which to put forth their views.

Funding Request for the MHSA

To continue our commitment and engagement of Sacramento County's current consumers, families, and diverse populations in the MHSA planning process, a draft of the Funding Request was placed on the Sacramento Mental Health Board's web-site. Community review was encouraged and comments were collected across a span of five days. The document was then scheduled as an agenda item at the March 2, 2005, Sacramento County Mental Health Board meeting and for open discussion. Recommendations from these sources were incorporated into the final document that was approved by the State Department of Mental Health without conditions. These activities laid the foundation for similar steps to be followed in the development of this document.

MHSA Stakeholder Orientation

Following the majority of stakeholder training, an MHSA Stakeholder Orientation was scheduled at the Sacramento County Board of Supervisors' Chambers for May 2, 2005. This was the second largest MHSA event to bring together multi-cultural, multi-ethnic, and multi-racial consumers and family members, plus agency and diverse community members to become active participants in MHSA process.

MHSA staff members utilized the information gathered at the Kick-off, and subsequently from training and outreach activities, to develop a database listing stakeholders and their contact information. This database was the primary resource that was used to notify consumers, family members, and other stakeholders of the orientation. Additional advertising of the event included: television and radio broadcasts in English, Spanish, Russian/Ukrainian, Laotian, and Hmong; newspaper publications; flyers; outreach to cultural and ethnic communities; internet; health

fairs; employers; and providers and announcements at standing meetings. The informal mental health communication network was also instrumental in getting the word out via one-on-one contact.

In preparation for the mass orientation, training for members of the Steering Committee and the four Task Forces was conducted on April 28, 2005. The purpose of the training was to test the orientation presentation and obtain suggestions on the content. Feedback resulted in revisions being made to the presentation to make it more understandable to the broad audience of stakeholders.

The MHSA Stakeholder Orientation took place on May 2, 2005, from 6:00 p.m. to 9:00 p.m. in order to accommodate maximum participation. A primary purpose of the orientation was to encourage the attendees to join a stakeholder group. A brief overview was provided of the MHSA structure and processes and preliminary data regarding identified community issues were presented. Interpreter services were again available in the threshold languages and American Sign Language. Stipends, bus passes and childcare/respite care were available for mental health consumers and family members. In addition, sandwiches, fruit, and drinks were provided, as the meeting started at a time that many participants would normally be having dinner.

Attendance at the Orientation was as follows:

- 305 attendees
- 53% of the attendees were consumers and family members,

MHSA Stakeholder Groups

The orientation was highly successful in that at the end of the evening 37 stakeholder groups were created. The process that led to the formation of the stakeholder groups consisted of the 305 attendees breaking out into one of four groups (Children and Youth, Adults, Older Adults, and Cultural Competency). The Division of Mental Health, with input from the Task Forces, tentatively suggested the creation of stakeholder groups based on shared interest in certain focal issues.. Attendees chose one of the suggested groups or added other groups generated by their concerns. The attendees then broke out into these smaller groups as they formed and set their agenda and meeting schedules for the following weeks.

Even after the initial orientation, additional stakeholder groups were created as a result of outreach and engagement strategies that focused on unserved and underserved communities and as new concerns or issues emerged that were not addressed in the originally formed stakeholder groups. There were 40 stakeholders groups that were eventually formed. The four tables below identify the stakeholder groups listed under their respective Task Force:

Table 2: Children and Youth Task Force
Stakeholder Groups

• Juvenile Justice	• Out-of-County/State Placement
• Birth to Five	• CSP-Prevention and Enhancement
• Youth Culture	• Children's Crisis/Afterhours
• Schools	• In-Home Care/Case Management
• Housing	• Music Art & Multi-Media
• Expanding Target Population	• Transitional Youth
• Services for Parents/Caregivers	• Transitional Housing for Homeless

Table 3: Adult Task Force
Stakeholder Groups

• Law Enforcement	• Employment/Vocational Services
• Assisted Outpatient Treatment	• Individuals in Secure Settings
• Adult Outpatient	• Board &Care/Board & Room
• Homeless & Housing	• Wellness Recovery Programs
• Adult Crisis/Afterhours	• Co-occurring Disorders

Table4: Older Adult Task Force
Stakeholder Groups

• Mental Health & Medical Co-occurring Disorders
• Frail, Homebound, Isolated
• Institutionalized Elderly

Table 5: Cultural Competence Task Force
Stakeholder Groups

• Latino Community	• Native American Community
• African-American Community	• Physically Disabled
• Small Refugee Populations	• Korean/Chinese/Japanese/Filipino Communities
• Southeast Asian Communities	• Tongan/Samoan/Hawaiian/Fijian Communities
• LBGTQ Community	• Russian/Ukrainian Speaking Populations
• Blind & Visually Disabled	• Deaf & Hard of Hearing
• Galt/Rural Population	

It was essential that consumers and family members from diverse cultural and ethnic populations be a part of the stakeholder groups, since they provided the reality to the issues that the groups were to examine. Several strategies were employed to maximize the participation of cultural, racial, and ethnic groups. The Cultural Competence Task Force was created to allow members of diverse groups the opportunity to focus on issues in their communities and form stakeholder groups that developed cultural/ethnic specific recommendations. Additionally, cultural competence representatives were included on each of the other three Task Forces, plus the Steering Committee.

The work of the stakeholders groups was intense in that they had six weeks in which to evaluate unserved/underserved needs of their focal populations and come to consensus with strategies for system change. The consumers, family members, diverse populations, agency representatives, County staff, and other community partners who participated in the stakeholder groups are to be commended for their diligence and dedication to the process. Their work provides a base line for future planning and system expansion within the Sacramento County Mental Health system.

Outreach and Engagement

Sacramento County developed a comprehensive approach for outreach and engagement of diverse, underserved and unserved populations. Prior to MHSA, many consumers and family members who had traditionally been underserved and unserved did not have a voice or a means to identify their service needs. However, with the MHSA, Sacramento County was able to develop an intricate work plan to facilitate outreach and engagement activities.

Sacramento County is cognizant of the great diversity within the community as reflected by the number of cultural, racial, ethnic, gender and linguistic groups that call Sacramento home. To address the disparities that are so often associated with this diversity, a position was created in 2001 for a full-time County Cultural Competence Manager. This manager is responsible for the oversight of the implementation of the Cultural Competence Plan, which was designed to eliminate health disparities, as well as overseeing the outreach activities for the MHSA.

Contracted services for outreach and engagement activities were put in place with four community-based mental health organizations: Asian Pacific Counseling Center, Consumer Self-Help, Mental Health Association, and the Southeast Asian Assistance Center. These agencies partnered with numerous community-based partner agencies that serve cultural and ethnic communities. Some of these partner agencies are Hmong Women's Heritage, Opening Doors, Inc., Migrant Worker Program, and Lambda Community Center. In total, there were 64 outreach workers from diverse cultural, racial, and ethnic groups, half of whom were consumers or family members. The outreach activities were conducted through these organizations with the intent to engage diverse communities and underserved/unserved populations in the MHSA process.

The outreach activities emphasized sensitivity to cultural considerations while creating an atmosphere that facilitates trust and meaningful communication. All of the outreach workers participated in the MHSA training that set forth the values and working principles that were to guide them in their new role. The emphasis for outreach was to meet with potential participants in their diverse communities in order to provide a friendly, culturally appropriate, and comfortable atmosphere.

A formal Outreach Work Plan was developed to guide the outreach activities. The underserved and unserved populations identified at the MHSA Kick-off in February,

2005 provided the foundation upon which to build the work plan. The target populations were identified and outreach workers were assigned to go into the community to meet with small groups or one-on-one. Listed below, in Table 6, are the target populations and locations where outreach workers made their contacts:

Table 6: Outreach Activities

Target Populations	***Outreach Locations***
Diverse Populations: African-American, Latino, Native American, Afghan, Russian, Bosnian, Eastern European Chinese, Korean, Japanese, Asian Pacific Islanders to include Hmong, Laotian, Mien, Filipino, Tongan, Samoan, Native Hawaiian, and Fijian.	Fair Oaks Park, El Hogar, Oak Park Center, Health for All, Vet's school, schools with high percentage of diverse families, home visits, KE Buena Radio Station, Asian Community Center, Asian Pacific Counseling Center, DHHS, Queen's Market, Gedatsu Church, Filipino American Christian Center, TNT Radio office, SOS office, APSS Clinic, doctors' offices, reception areas, Southeast Asian Assistance Center, Fulton Medical Center, La Bou Restaurant, Lao Radio Station, Radio Station 1430 (AM), KJAY Radio Station, Slavic Assistance Center, Lao Family Center, Ming Garden Restaurant, Sacramento County Fairgrounds, Lao churches, Hmong churches, Sacramento Area Congregations Together, Native American Health Center, Resources for Independent Living, restaurants, churches, employment services focusing on Latino migrant workers camps, physical health program focusing on low income diverse populations, and youth groups
Rural Populations, including migrant population	Consumers Self-Help Center; Galt and South Sacramento residents, and youth groups, Estrellita Ballroom (Galt), and Praise Board & Care
Lesbian, Bisexual, Gays and Transgender Populations	Consumers Self-Help Center, Mental Health Association, Lambda Center, Wind Youth Services, home visits, Uptown Studios, Sacramento Pride Alliance, Outlands Magazine, Resources for Independent Living, Gay, Lesbian, Straight Education Network, Positive Option Family Services, Sacramento Association for Family Empowerment, Area 4 Agency on Aging, and Sacramento Radical Faeries
Physically Disabled Populations	Alta California Regional Center, IHHS, Easter Seals Society, Resource for Independent Living, Eskaton Adult Day Care, and board and care homes
Older Adult Populations	IMD, Asian Pacific Community Center, Fulton Medical Center, Roberts Family Development Center, Grace Home, Eskaton Jefferson Manor, HUD Office, Asian Pacific Community Center, St.

Target Populations	*Outreach Locations*
	Mary's Board & Care, Tremblay's Board & Care, Vintage Knolls Senior Apartments, Chateau Apartments, Sierra Sunrise Retirement Center, Rancho Cordova Center, Hart Senior Center, and Sunbridge Skilled Nursing Facility
Adopted Children Populations	Sierra Adoptions, Korean adopted children, Chinese adopted children, Consumers Self-Help Center, and home visits
Children raised by Grandparent Populations	Grandparent Network and McKinley Park
Transitional Youth Populations	Wind Youth Center, SETA One Stops, Technical Schools, Conservation Corp, Job Corps, Salvation Army, Consumer Self-Help, and home visits
Substance Abuse Populations	Sacramento Mental Health Treatment Center, Mental Health Association, Consumers Self-Help Center, Department of Health and Human Services Building, picnics, and the streets of Sacramento
Homeless Populations	Loaves and Fishes, Union Gospel Mission, Cardosa Village, Salvation Army, Volunteers of America, Friendship Park, St. John's Shelter, Consumers Self-Help Center, Sequoia Hotel, Shasta Hotel, Sacramento Mental Health Treatment Center, and McKinley Park
Religious Leader Populations	Inter-Faith Council, Jewish Family Service Agency, Catholic Social Services, Muslim leaders, and churches
Survivors of Trauma Populations	Connected with veterans, refugees, sexual abuse and domestic violence victims, child abuse victims, elder abuse victims, suicide survivors and family members, and Hart Senior Center
Deaf and Hard of Hearing Populations	Sacramento County Main Administration Building, County Disability Advisory Committee, Consumers Self-Help Center, Mental Health Association, and Resources for Independent Living
Blind and Visually Disabled Populations	Society for the Blind, Consumers Self-help, Mental Health Association, and board and care homes.

Curriculum II training was the tool that the outreach workers used for their interactions (Curriculum II is described later in this Section under 4). This provided a consistent guide for the outreach workers to follow. The information was not presented in a traditional classroom manner, but rather within a conversation with open-ended questions. Outreach workers also utilized several methods of eliciting information regarding the community's concerns around unmet mental health needs (these needs assessment methods, and their results, will be described in Part 2: Section I: Identifying Community Issues).

The outreach activities were exciting and challenging and included the responsibility of documenting the activities. It was critical that a dialogue and engagement with these populations be initiated, but equally important was the necessity to record the activities. Therefore, each of the outreach workers was responsible for recording their activities by documenting the age group, specific population, and number of people with whom they interacted. By the time the outreach activities were complete, a total of 398 outreach efforts had been attempted, with an unprecedented number of 18,841 people being reached.

These outreach activities have provided meaningful involvement of consumers and family members, including those from diverse cultural and ethnic groups, in the MHSA planning. Occasionally, nominal incentives, such as picnics, snack foods/beverages, or token gift cards/certificates for groceries or to restaurants, stimulated participation in these outreach activities. Community leaders from the Tongan, Samoan, Cambodian, Lao, Hmong, Chinese, and Russian populations were also approached to assist the support of the MHSA process and resultant services. The outreach engagement activities have been a positive step in our efforts to adhere to the spirit of the MHSA. The Division of Mental Health sees the value and necessity of continuing to reach out to diverse populations to transform our mental health system into one that is inclusive of all members of our community.

Demographics of Consumer and Family Members Contributing to Needs Assessment

All stakeholders engaged through outreach and/or training had an opportunity to provide input regarding the issues they viewed as priorities to be addressed with the Community Services and Supports funding (see Part 2: Section I: Identifying Community Issues). When they provided feedback, they also responded to several demographic items including: gender, sexual orientation, ethnicity, and the group they represented such as consumer, family member, service provider, and agency representative. In order to elicit the broadest possible input, these surveys were translated into Chinese, Korean, Japanese, Tagalog, Spanish, Russian, Vietnamese, and Hmong. At the surveyed person's election, surveys were also verbally translated.

The data presented below illustrates the number and diversity of consumers and family members we were able to engage in the planning process. Data regarding other types of representation in the planning process is addressed in response Question #2.

The data reported in Table 7 clearly show that the outreach and training efforts were successful in gaining the views of a large number of consumers and family members, as well as diverse cultural and ethnic groups, the unserved and underserved. Table 7 reveals that 52% of the recipients of outreach and 40% of those trained, who contributed to the Needs Assessment, were consumers or family members. This totals 908 consumers and family members who provided input using these methods.

Table 7: Proportion of Consumers and Family Members Contributing to Needs Assessment

	Source of Information	
	Outreach	**Training**
Total Number of Responses	1163	774
Percent Consumer/Family Member	52%	40%

The data in Tables 8, 9, and 10 indicate that the consumers and family members, who were reached through outreach and training, differ from each other in certain ways and that by employing both approaches (Outreach and Training) to collect Needs Assessment Information we were able to obtain a broader representation of the community. For example, when compared to the consumers and family members who attended training, those contacted through outreach activities were:

- More likely to be male
- Less likely to report being heterosexual, and more likely to not answer the question regarding sexual orientation
- Less likely to be Caucasian, and more likely to be
    - African American
    - American Indian/Native American
    - Cambodian
    - Filipino
    - Japanese
    - Korean
    - Laotian
    - Vietnamese

Table 8: Age, Gender and Sexual Orientation of Consumers and Family Members Contributing to Needs Assessment

	Source of Information	
	Outreach	**Training**
Age Range	13-88	14-80
Average Age	45	46 years
Gender		
Male	43.7%	33.8%
Female	53.0	64.6
Transgender	0.2	0.3
No Response	3.2	1.3
Sexual Orientation		
Heterosexual	73.5%	81.5%
Gay	1.5	1.6
Lesbian	2.3	4.2
Bisexual	2.8	2.9
Questioning	2.2	1.0
No Response	17.7	8.8

Table 9: Ethnicity of Consumers and Family Members Contributing to Needs Assessment

	Source of Information	
	Outreach	**Training**
Ethnicity	%	%
African American	17.5	10.4
American Indian/Native American	3.8	1.3
Cambodian	3.5	0
Caucasian	40.7	63.0
Chinese	3.7	2.6
Filipino	2.2	0.6
Hispanic	4.8	4.5
Hmong	0.8	1.6
Japanese	1.3	0.6
Korean	1.5	0
Laotian	2.0	0
Mien	0	0.3
Pacific Islander	0.5	0.3
Russian/Former Soviet Union	0.7	0
Ukrainian	0	0
Vietnamese	3.2	0
Other	1.7	1.3
Multi-Ethnic	10.8	11.0
Not Reported	1.3	2.3

Table 10: Diverse Populations of Consumers and Family Members Contributing to Needs Assessment

	Source of Information	
	Outreach	**Training**
Diverse Populations	%	%
Adopted Children	3.5	7.0
Children Raised by Grandparents	3.7	4.7
Hearing/Visually Impaired	6.3	4.7
Homeless	13.3	11.6
Individuals with Substance Abuse Problems	13.8	16.3
LBGTQI	1.3	2.3
Physically Disabled	17.7	9.3
Older Adults in Independent Senior Housing, Board & Care/Assisted Living, Skilled Nursing	4.5	9.3
Older Adults with Co-Occurring Medical and Psychiatric Illness	3.5	9.3
Older Adults with Major Depression	4.5	14.0
Older Adults with Psychiatric Symptoms	2.0	2.3
Older Females	16.0	14.0
Older Males	13.2	18.6
Racial/Ethnic groups	12.3	23.3
Refugee	6.8	2.3
Religious Leaders	3.2	11.6
Rural Residents	9.0	14.0
Survivors of Trauma/PTSD	10.2	16.3
Transition Aged Youth	1.7	7.0
Youth in Charter/Private Schools or Special Educations	1.3	2.3
Youth in Technical Schools/CCC/Job Corp	0.3	0

Television and Radio Panels

As early as January, 2005, efforts were initiated to inform the Sacramento County communities about the MHSA. On that date, Kathleen Henry, Sacramento County Director of Mental Health, participated in a televised production at the local ACCESS Television Station, along with a transition age youth and a consumer. The emphasis of this effort was to advertise and to recruit volunteers for the MHSA process. Since that time, nine additional programs have been televised and 24 radio programs have been broadcast that highlighted the aspects of mental health and the MHSA.

Four of the nine televised productions were live call-in programs that gave the public the opportunity to interact with the panelists. Six of the radio events were in "question and answer" formats. These radio programs were specifically focused on the Latino, Hmong, Laotian, and Russian/Ukrainian populations. Consumers and/or family members were active participants in all of these programs. Having consumers and family members as panelists enhanced the depth and content of the programs, and their presence lent clarity and reality to the discussions.

Accommodations for Participation in the MHSA Planning

In an effort to encourage and facilitate the participation of consumers and family members in the MHSA planning process, the Division contracted with the Mental Health Association for a Resource Coordinator. The coordinator developed and scheduled services that would provide incentives and supports for consumer and family participation in the MHSA process. All of the notices that were circulated informing the community of the MHSA trainings, orientation, and stakeholders groups, included information of the supports and incentives available to consumers and family members.

Stipends for participation in the training accounted for the widest use of supports. Child care/respite services were also available and used to a lesser degree. Interpretive services and bus passes were provided, and refreshments were available at all of the trainings, major meetings and events. Providing these accommodations and supports were essential to ensuring that consumers and family members could play a meaningful role in the MHSA process.

Consumers and Family Members as Trainers

Details of the MHSA training are discussed later in this section. However, it is important to note that consumers and family members, from diverse communities, were active trainers, along with a Division of Mental Health staff-member, in all of the MHSA trainings.

2. In addition to consumers and family members, briefly describe how comprehensive and representative your public planning process was.

RESPONSE:

MHSA Structure and Governance

Just as consumers and family members are part of the MHSA structure and governance planning process, other community partners are also included. As indicated earlier in this section, 50% (55) of the membership on the Steering committee plus the four Task Forces were comprised of consumers and family members. Therefore, the remaining 50% (55) consisted of relevant diverse agencies and contract providers as depicted below:

- 15 Mental Health Providers
- 5 Co-chairs (Division of Mental Health)
- 5 Law Enforcement Representatives
- 5 Education Representatives
- 5 Social Services Representatives
- 5 Health Representatives
- 5 Alcohol and Other Drugs Representatives
- 5 Mental Health Division Representatives
- 5 Cultural Competency Representatives

The composition of the Steering Committee provided equal representation for consumers and family members and other relevant representatives. The Sacramento Division of Mental Health used this "balanced equation" methodology in the past with successful results.

MHSA Kick-off

The Kick-off also has been discussed earlier in this section as it relates to consumers and family members. While 37% of those in attendance at the Kick-off were consumers and family members, 63% represented other aspects of the mental health community. Specifically, they were as follows:

- 35% (102) Service Providers
- 30% (86) Social Service
- 20% (59) Education
- 10% (30) Other
- 5% (13) Law Enforcement

One of the great benefits of the Kick-off was the identification of hundreds of stakeholders that could be notified for future involvement in the MHSA process. The total list of the stakeholders was included with our Funding Request. The stakeholders were grouped under five categories as follows:

- Mental Health
- Law Enforcement
- Education
- Social Services
- Stakeholders, at Large

All of the identified stakeholders were entered into a database that was created for mass mailings for future events related to the MHSA. The database has been a critical tool that has ensured us that we have had comprehensive and representative participation in the MHSA planning process.

In addition to the database, the Sacramento Division of Mental Health developed a County website that provides up-to-date information about the happenings related to the MHSA. This also has been a useful tool for keeping the community informed and ensuring comprehensive participation in the planning process.

MHSA Stakeholder Orientation

The May 2, 2005 orientation was discussed in detail earlier in this section. Just as the sign-in sheets for the Orientation identified consumers and family members, the sign-in also identified the role of other participants. Participants were given the opportunity to identify their organization in more than one category. Therefore, there is overlap in the data. However, the data shown below illustrate a wide array of organizations that were represented at the event:

- 46 Contracted Mental Health Service Providers
- 45 Social Service Providers
- 34 Education Representatives
- 31 Interested Community Members
- 29 Mental Health Service Providers
- 28 Drug/Alcohol Service Providers
- 14 Law Enforcement Representatives
- 14 Ethnic Services Providers
- 8 Physical Health Providers

MHSA Stakeholder Groups

The stakeholder groups have also been discussed earlier in this section relative to consumers and family members. However, in addition to consumers and family members, the stakeholder groups included representatives from a wide array of disciplines within the communities. Since each of the stakeholder groups had a specific target population, the community representation was equally specialized and knowledgeable.

Outreach and Engagement

The Outreach and Engagement activities have been fully described earlier in this section. We noted that 52% of those outreached to were consumers and family members, suggesting that 48% (or 563 people) fill other roles in our community. Data regarding their demographics is presented below.

Demographics of Non-Consumer / Family Member Participants Contributing to Needs Assessment

As indicated previously, all stakeholders engaged through outreach and/or training had an opportunity to provide input regarding the issues they viewed as priorities to be addressed with the Community Services and Supports funding (see Needs Assessment in the next section). When they provided feedback, they also responded to several demographic items, including gender, sexual orientation, ethnicity, and the group they represented such as consumer, family member, service provider, and agency representative. In order to elicit the broadest possible input, these surveys were translated into Chinese, Korean, Japanese, Tagalog, Spanish, Russian, Vietnamese, and Hmong. At the surveyed person's election, surveys were also verbally translated.

The data presented below illustrates the number and diversity of community input other than the consumers and family members we were able to engage in the planning process.

The data set forth in Table 11 clearly show that the outreach and training efforts were successful in gaining the views of a large number of community members other than consumers / family members, as well as diverse cultural and ethnic groups, the unserved and underserved.

*Table 11: Participants Contributing to Needs Assessment**

	Source of Information	
	Outreach	**Training**
Total Number of Responses	1163	774
Percent Other Than Consumer/Family Member	48%	60%
Distribution of Roles for Other Than Consumer / Family Members		
Ethnic Services Provider	1.1%	7.3%
Law Enforcement	0.5	4.7
Education	5.3	14.4
Physical Health Provider	2.3	4.1
Social Service Provider	4.3	24.0
Drug/Alcohol Service Provider	2.5	7.9
Mental Health Service Provider	4.3	43.3
Management/Administrative Staff	2.8	36.1
Interested Community Member	40.0	19.3
Other	23.6	10.3

*Percentages add up to more than 100% because participants were free to indicate multiple categories of identification.

The data in Tables 12, 13, and 14 also indicate that the populations of individuals, other than consumer / family members reached through outreach and training, are

somewhat different; and that by employing both approaches to collect Needs Assessment information, we were able to ensure a wider representation of the community. For example, when compared to the community members other than consumers / family members who attended training, those contacted through outreach activities were:

- More likely to be male
- Somewhat less likely to report being heterosexual, and more likely to not answer the question regarding sexual orientation
- Less likely to be Caucasian and Hispanic, and more likely to be
    - African American
    - Chinese
    - Filipino
    - Korean
    - Pacific Islander
    - Russian/Former Soviet Union
    - Vietnamese

Table 12: Age, Gender and Sexual Orientation of Participants Contributing to Needs Assessment

	Source of Information	
	Outreach	**Training**
Age Range	9 – 94	12 – 84
Average Age	48 years	46 years
Gender		
Male	42.3%	27.9%
Female	55.6	70.4
Transgender	0	0
No Response	2.1	1.7
Sexual Orientation		
Heterosexual	70.7%	76.8%
Gay	0.2	1.3
Lesbian	1.2	4.7
Bisexual	1.8	1.1
Questioning	3.6	.6
No Response	22.6	15.5

Table 13: Ethnicity of Participants Contributing to Needs Assessment

	Source of Information	
	Outreach	**Training**
Ethnicity	%	%
African American	11.4	9.7
American Indian/Native American	1.4	1.3
Bosnian	0	0.6
Cambodian	0.4	0
Caucasian	20.6	55.6
Chinese	9.4	0
Filipino	10.8	1.1
Hispanic	4.8	7.5
Hmong	2.3	2.4
Japanese	1.8	1.7
Korean	13.1	1.3
Laotian	0.5	0.4
Mien	0	0.4
Pacific Islander	2.3	0.6
Russian/Former Soviet Union	4.3	1.5
Ukrainian	0.4	1.9
Vietnamese	3.6	1.1
Other	2.0	2.6
Multi-Ethnic	8.5	5.2
Not Reported	2.5	5.2

Table 14: Diverse Populations of Participants Contributing to Needs Assessment

	Source of Information	
	Outreach	**Training**
Diverse Populations	%	%
Adopted Children	0.5	2.3
Children Raised by Grandparents	0.5	4.7
Hearing/Visually Impaired	2.7	9.3
Homeless	8.5	7.0
Individuals with Substance Abuse Problems	3.7	7.0
LBGTQI	0.4	0
Physically Disabled	8.2	9.3
Older Adults in Independent Senior Housing, Board & Care/Assisted Living, Skilled Nursing	2.3	4.7
Older Adults with Co-Occurring Medical and Psychiatric Illness	1.8	4.7
Older Adults with Major Depression	2.3	7.0
Older Adults with Psychiatric Symptoms	1.2	4.7
Older Females	17.6	14.0
Older Males	10.8	9.3
Racial/Ethnic groups	30.9	25.6
Refugee	7.3	9.3
Religious Leaders	3.9	2.3

	Source of Information	
	Outreach	**Training**
Rural Residents	3.2	18.6
Survivors of Trauma/PTSD	2.5	7.0
Transition Aged Youth	1.2	4.7
Youth in Charter/Private Schools or Special Educations	1.8	4.7
Youth in Technical Schools/CCC/Job Corp	1.8	2.3

3. Identify the person or person in your county who had overall responsibility for the planning process. Please provide a brief summary of staff functions performed and the amount of time devoted to the planning process to date.

RESPONSE:

Kathleen Henry, County Mental Health Director, is the person with overall responsibility for the overall planning process for Sacramento's MHSA Plan. Table 15 sets forth a listing of staff functions and time devoted to MHSA Planning to date.

Table 15: Staffing for MHSA Planning

Staff	Function	% Of Time Spent
Mental Health Director	• Responsible for inter-Departmental, Inter-organizational and Statewide coordination issues • Responsible for overall planning, implementation, evaluation and oversight of MHSA planning	10%
MHSA Program Manager (Health Program Manager)	• Responsible for handling all of the organizational work of the planning process • Served as Steering Committee Coordinator	100%
Ethnic Service Manager	• Responsible for ensuring participation of stakeholders from underserved and unserved populations of consumers and families • Responsible for ensuring participation of stakeholders who are ethnically diverse • Task Force Co-Chair – Cultural Competence	50%
Research and Evaluation Manager	• Developed the questionnaires used for statistical information gathering • Supervised the research planners • Presented all data to the Steering Committee • Coordinated the distribution of data • Analyzed the underserved and unserved populations	45%
Clerical Supervisor	Supervised clerical support in the performance of their duties as it applied to MHSA program planning	100%

Clerical Support	Provided clerical support for all aspects of the MHSA program planning	100%
Secretary	• Provided secretarial support to the Plan Coordinator • Clerical support to the Steering Committee	100%
Administrative Services Officers I, II, III	• Served as Task Force Coordinators • Served as Website Developer • Responsible for budget development • Staff support to the Plan Coordinator • Training Coordinator • Responsible for contract administration	25-100% depending on involve-ment with the process
Chief, Children's System of Care	• Served as Task Force Co-Chair- Children's Task Force	25%
Chief, Adult System of Care	• Served as Task Force Co- Chair, Adult and Transition Aged Youth Task Force • Served as interim Plan Coordinator	40%
Contracted Staff	Provided outreach and engagement of ethnically diverse, underserved and unserved populations of consumers and family members to ensure participation as stakeholders	100%
Planners	• Compiled population and utilization data • Analyzed data from the surveys completed by all stakeholders • Served as a resource to task forces when additional data was requested • Responsible for the drafting of the MHSA Planning Request to DMH and the drafting of the MHSA Community Services and Supports Plan	25%
Quality Management and Training Program Manager	• Developed training curriculum for all stakeholders • Developed specific training for ethnically diverse and for the underserved or unserved	25%
MH Program Coordinators	• Served as members of the various task forces • Served as law enforcement liaison • Provided specific research in the area of law enforcement • Served as Task Force Co-Chair, Older Adult Task Force	Between 25%-50% depending on area of involve-ment
Public Information Officer	Liaison with all media outlets	5%

In addition to Mental Health Division staff, consumers, family members, the Division's Family Advocate, Children's Advocate and members of the Mental Health Board were involved in the overall planning effort.

4. Briefly describe the training provided to ensure all participation of stakeholders and staff in the local planning process.

RESPONSE:

Letter to Stakeholders

On April 5, 2005 a letter from Kathleen Henry, Director of Sacramento County's Mental Health Services, was sent to all of the stakeholders within the mass-mailing database. There were 5,226 letters sent inviting the public to participate in the MHSA planning process. The letters provided information regarding the training required before stakeholders could participate in the planning process. They were translated into five languages: Spanish, Russian, Hmong, Vietnamese, and Cantonese. This mailing was the initial step that led to the massive MHSA training effort.

Training Schedule

The first training was held on April 12, 2005. The final training, for those individuals who intended to participate in the planning process, was May 26, 2005. Trainings will continue in the future as a means to recruit community members into the on-going planning process. During the eight weeks that the initial training was offered, approximately 875 individuals were trained. To accommodate the large volume of people needing to be trained, 18 training dates were scheduled at 12 different sites throughout the county.

Location of Training

The designated sites for the trainings were mirrored after the geographic locations of Sacramento County's mental health population. In obtaining sites, particular attention was paid to cultural competency, accessibility including ADA requirements, and access to bus lines. In all, 12 sites were used for the training.

Training Curriculum

The curriculum for the training was based on DMH Letter No: 05-01, Attachment A, that set forth eight subjects that were to make up the content of the training. Two curricula were developed with respective Power Point Presentations and folders with handouts. As indicated earlier in this section, the completion of the Issues and Concerns Survey was also a part of the training activities.

Curriculum I was used for the majority of the training. It was three hours in length and provided details of the existing mental health system with comprehensive County profile data and penetration rates to highlight ethnic disparities. In addition,

the concepts of recovery, resiliency, cultural competency, and system change were addressed. This training was intended for the categories of stakeholders listed in DMH Letter NO: 05-01 that included: consumers, family members, mental health staff, mental health contractors, mental health board members, other agency personnel, MHSA Steering Committee and Task Forces.

Curriculum II was used by the Outreach Workers and was tailored for isolated communities, plus special and diverse populations, such as IMD, skilled nursing facilities, and homeless. It contained less information related to the current mental health system and emphasized ethnic disparities and the need for transforming the mental health system. The data presented was, in most situations, adapted to the specific target population to strengthen and personalize the presentation. Additional time was allocated for discussion and audience participation. The Curriculum II Power Point presentation was available to the Outreach Workers in English and Spanish. Other languages are being considered.

Trainers

Trainers included staff from the Division of Mental Health, consumers, and family members. The County staff's role was to provide information related to the current system and data. The consumer and family member addressed the transformation of the system, recovery, and resiliency. All of the trainers also participated in the development of the curricula.

Evaluation of Training

Upon completing the training, participants were given the opportunity to evaluate the content and quality of the presentation via an evaluation questionnaire. The questionnaire results revealed that the training was well-received and provided the participants with the information needed to understand the issues surrounding the MHSA.

Section II: Plan Review

1. Provide a description of the process to ensure that the draft plan was circulated to representatives of stakeholder interests and any interested party who requested it.

RESPONSE:

Sacramento County Mental Health Director, Kathleen Henry, announced on Monday, October 31, 2005 that the Division of Mental Health had posted the first draft plan for new services under the Mental Health Services Act. Simultaneous with that announcement, the draft plan, including Spanish, Russian, Hmong, Chinese, and Vietnamese translations of the Executive Summary, was posted on the Sacramento County Department of Health and Human Services website:

http://www.sacdhhs.com/print.asp?ContentID=1457

In addition, links to the plan were posted on the Sacramento County website, the Department of Health and Human Services Website, and the Mental Health Division website.

During the course of the planning process, staff accumulated and created a global electronic MHSA mail list that contained more than 1,000 names of interested parties. Individuals on the list were sent an email notifying them the plan had been posted and the link set forth above.

Paper copies of the plan were bound and distributed to county and contract provider sites utilized by stakeholders. Each public library in the county received a reference copy of the plan. By the time of the public hearing, more than 350 paper copies of the plan had been distributed.

The County Executive and each member of the Board of Supervisors received a paper copy of the draft plan. All county boards and commissions were sent either a paper copy of the plan, or an email providing the link to the plan. Copies of the draft plan were made available to the City of Sacramento and to various intergovernmental agencies dealing with issues of homelessness and housing for persons and families coping with mental illness.

Every identifiable member of the stakeholder groups, task forces, and Steering Committee was provided a link to the plan. In addition, stakeholder group facilitators and task force facilitators insured that members were made aware of the availability of the plan. Availability of the draft plan was announced at a Mental Health Division Management Team meeting and managers were asked to encourage all staff members to review it.

The Mental Health Division distributed paper copies of the plan. Members of the public were informed through public notices that they could request a paper copy of the plan by telephone or by letter and were provided a point of contact for this purpose. In addition, a supply of the paper copies of the plan was maintained at the front desk of the Department of Health and Human Services for members of the public who wished to pick up the plan personally.

2. Provide documentation of the public hearing by the mental health board or commission.

RESPONSE:

Copies of the Public Notice as published and the Public Hearing Schedule are attached. (See Attachments A and B)

3. Provide the summary and analysis of any substantive recommendations for revisions.

RESPONSE:

The Sacramento County MHSA planning process has involved a Herculean effort by both stakeholders and County staff for nearly a year. Outreach contacts were made with more than 18,000 potential stakeholders, and more than 2,000 of these completed all required training and served at some level in the needs assessment and service planning process.

By the time the draft plan was posted for public comment, stakeholders, facilitators, and others involved in the process had formed a cohesive nucleus bonded by shared experiences and shared commitment to the values of transformation, openness, shared decision making, and empowerment of stakeholders.

The MHSA draft plan for Community Services and Supports recommended six programs for funding out of the approximately 143 programs forwarded from Task Forces for Steering Committee review.

Many individuals were disappointed that the priorities for which they advocated were not recommended for funding. Due to the established decision-making process that led to the final recommendations, these individuals were able to maintain their trust in the process and resolved to continue working for system change as future components of the MHSA are rolled out over the next several years.

Much of the disappointment appeared to arise from the handling of one proposal to blend law enforcement and mental health resources to create a first-response psychiatric emergency response team (PERT). During the planning process by the Steering Committee, it was determined that law enforcement had no funds to pay for the salaries and benefits of law enforcement personnel assigned to the proposed psychiatric emergency response team and was depending on MHSA monies to do so. The Steering Committee voted not to recommend PERT for funding with MHSA dollars.

This decision served to galvanize a broader constituency of PERT supporters than had been heard from during Stakeholder Groups and Task Force Meetings. This constituency included public officials at the highest levels of County and City government, and extended to neighborhood and business associations, landlords, business owners, family members and even private citizens previously uninvolved with mental health issues.

Many of these supporters provided written comments that expressed their concerns about seeing the same people, day after day, wandering the streets, obviously homeless and appearing, at least to the layperson, to be mentally ill. Several supporters expressed their frustration over not being able to get help for the people they saw in need and others expressed the same frustration over not being able to get appropriate help for family members in mental health crisis.

Representatives from County law enforcement agencies met with California Mental Health Director, Dr. Stephen W. Mayberg, and received information from him that they believed would allow them, with only minor modifications of the PERT plan, to conform to all relevant MHSA guidelines.

In the days just prior to posting the MHSA draft plan, partnering law enforcement agencies prepared a draft PERT proposal that they believed responded to the issues that would have made the original proposal ineligible under MHSA non-supplantation guidelines.

Given the initial popularity of the PERT concept and the showing of support that emerged when the community became aware that PERT had not been recommended for funding, a decision was made to post the revised PERT proposal as an addendum to the draft MHSA plan for public comment.

During the public comment period, the First District Supervisor convened an informational meeting in his chambers to hear directly from the State Director of Mental Health the issues associated with the inclusion of PERT in the MHSA draft plan. Participants at this meeting included the California Mental Health Director, a senior member of the MHSA Oversight and Accountability Committee, the County Executive, Mayor of Sacramento, County Sheriff, Undersheriff and Chief Deputy, Agency Administrator, Chief of Police of Sacramento, DHHS Department Head, and Mental Health Director. The outcome of this meeting was a recommendation that mental health and law enforcement pursue a compromise that might allow PERT to go forward.

Representatives of these agencies met as recommended and produced a revised PERT proposal that reduced the scope of the project and made several technical changes to insure the program would be providing second-response mental health services and not law enforcement activities.

The Steering Committee created a subcommittee to review the revised PERT Proposal and then, on recommendation of the subcommittee, formally reconsidered it and recommended it for inclusion in the MHSA draft plan.

Opposition to this decision was expressed across a broad front including consumers, family members, public and private provider agencies, and advocates for specific constituencies (including PAI).

A summary of the reasons given for not wanting PERT to be funded included: (1) it supplants services already required of law enforcement; (2) it proposes to use MHSA funds to pay for prohibited purposes (law enforcement salaries and benefits); (3) Funding PERT requires elimination of vital services to older adults; and (4) Funding PERT siphons badly needed funds from the only consumer-operated program proposed for funding. For many commenters, the issue that was larger than any of the specific reasons for not funding PERT was the appearance that PERT had received special treatment.

The actual Public Hearing was orderly and productive. More than 2/3 of the comments pertained to two programs: (1) the Transcultural Wellness Center; and (2) PERT. All comments pertaining to the Transcultural Wellness Center were positive. Although comments pertaining to PERT were more than 2:1 opposed overall, strong support was offered by a number of participants.

A speaker representing the local chapter of the National Alliance for the Mentally Ill noted that arrest and incarceration should not have to be the entry point for mental health services. One speaker described the ordeal caused when out-of-control family members require outside intervention. A high level administrator in law enforcement described similar programs in other areas of the State that had successfully reduced trauma to consumers and family members.

Other comments supported particular programs or offered observations on the planning process or other matters or recommendations for revision. These recommendations included:

1. Insure that each program incorporates integrated treatments for co-occurring disorders involving mental health issues and substance abuse;
2. Increase the visibility of African American and Latino populations in plan descriptions.
3. Insure services created by the plan are able to meet the needs of hearing-impaired consumers.

Copies of substantive comments, pertaining to revision or the MHSA planning process in general, are included as Attachment C.

4. If there are any substantive changes to the plan circulated for public review and comment, please describe those changes.

RESPONSE:

The plan posted for public comment on October 31, 2005 recommended six programs for funding and addended a seventh for public comment. The posted plan included the following programs and recommended them for funding: (1) Transitional Community Opportunities for Recovery and Engagement; (2) Older Adult Intensive Services; (3) Multi-disciplinary Crisis Intervention; (4) Permanent Supportive Housing; (5) Transcultural Wellness Center; and (6) Wellness and Recovery Center. The addended plan posted for review but not recommended for funding was the Psychiatric Emergency Response Team.

The current plan, as revised following the public hearing, includes Psychiatric Emergency Response Team as a program recommended for funding and eliminates Multi-disciplinary Crisis Intervention. In addition, the Wellness and Recovery Center budget was augmented by an additional $33,750 of one-time funds and the Older Adult Intensive Services program budget was augmented by $200,000 of one-time funds.

In response to substantive recommendations for revision, each program description has been revised to:

(1) Insure attention to integrated treatment for co-occurring disorders and

(2) Insure emphasis on services to the unserved, underserved, and inadequately served groups, including, but not limited to, Latinos, Native Americans, African Americans, Refugees, and members of the Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex (LGBTQI) and disabled communities, including Deaf and Hard of Hearing.

PART II
PROGRAM AND EXPENDITURE PLAN REQUIREMENTS

Section I: Identifying Community Issues

1. Please list the major community issues identified through your community planning process, by age group. Please indicate which community issues have been selected to be the focus of MHSA services over the next three years by placing an asterisk (*) next to these issues. (Please identify all issues for every age group even if some issues are common to more than one group).

RESPONSE:

Although stakeholder groups met separately within age-domain Task Forces (Children/Youth/TAY; Adult/TAY; Older Adult; and Cultural Competency) there was consistent agreement across Task Forces on major community issues. Although stakeholder groups used different nomenclature to describe the issues there was also remarkable consistency between the issues identified through the community planning process and the issues set forth in the section providing Direction for this analysis. Table 16 below lists the major community issues identified through the community planning process using the nomenclature of the local planning process:

Table 16. Community Issues Identified Through the Public Planning Process

Children/Youth	Transition Age Youth
Affordable, safe, permanent housing*	Affordable, safe, permanent housing*
Help in a crisis*	Help in a crisis*
Underserved populations: race/ethnicity as barriers*	Underserved populations: race/ethnicity & age group as barriers*
Supportive relationships	Access to/linkage with services*
Involvement in meaningful activities	Consumer and Peer driven services*
Appropriate school placement	Alcohol/Substance Use
Physical health care	Employment
Adults	**Older Adults**
Affordable, safe, permanent housing*	Affordable, safe, permanent housing*
Help in a crisis*	Help in a crisis*
Underserved populations: race/ethnicity as barriers*	Underserved populations: race/ethnicity & age group as barriers*
Access to/linkage with services*	Access to/linkage with services*
Consumer and Peer driven services*	Consumer and Peer driven services*
Alcohol/Substance Use	Physical Health Care
Employment	Supportive Relationships

The issues are not listed in order of importance. The asterisks identify issues that will be the primary focus of programs to be developed and implemented over the next three years. However, all of the community issues listed in the table above will be addressed in the programs to be developed.

Because of their essential role in transformation, cultural competence and wellness and recovery focus will be woven through all aspects of all programs.

2. Please describe what factors or criteria led to the selection of the issues starred above to be the focus of MHSA services over the next three years. How were issues prioritized for selection? (If one issue was selected for more than one age group, describe the factors that led to including it in each.)

RESPONSE:

At least three processes with continuous feedback loops led to the final selection of community issues to be the focus for the next 3 years.

- A Community Needs Assessment was undertaken
- Population data indicating unmet need were examined
- Priorities were established using Stakeholder groups, Task Forces, and the Steering Committee. The committees were comprised of experts in each domain, with a wide representation of stakeholders, including multicultural consumers and family members.

Community Issues Identified Through the Needs Assessment Process

The Community Needs Assessment is an ongoing process that began shortly after the MHSA Kickoff in February 2005. Data for this plan were gathered through the end of June 2005. Several ways of collecting information were developed, so that data collection tools were available that were appropriate for the audience being engaged. The tools included rating scales with closed ended items, open-ended responses associated with focused questions, and open-ended items associated with very broad questions. Regardless of the format used, the goal was to elicit information about:

- issues and concerns resulting from untreated mental illness that the community thought were important enough to be focal issues in the initial three year plan
- who the focal populations should be during the first three years
- what strategies the community thought would be best suited to addressing the need

It is critical to note that the stakeholder groups utilized their expertise in combination with the data to generate proposals. System experience and knowledge was fundamental to the development of several key recommendations linked to access to services and the philosophy of service provision.

Information was gathered during each of the MHSA trainings, as well as during outreach activities. This was the start to understanding how the Sacramento County communities viewed mental health issues and what they saw as the primary issues.

Surveys were translated into Chinese, Korean, Japanese, Tagalog, Spanish, Russian, Vietnamese, and Hmong. At the surveyed person's election, surveys were also verbally translated.

Needs assessment information was gathered from 1937 people, almost 50% of whom were consumers and family members. In addition, the respondents illustrated a large degree of racial/ethnic diversity, with less than 50% being Caucasian. As described in Section I, there was representation from the following communities: African American, Native American, Cambodian, Chinese, Filipino, Hispanic, Hmong, Japanese, Korean, Laotian, Mien, Pacific Islander, Russian/Former Soviet Union, and Vietnamese. Regardless of the method used for collecting information or the group who provided input, there was an incredibly high rate of agreement about what the important community issues were. The tables below list the issues, in the order of importance as perceived by the Sacramento County community. These data were generated by community members indicating how big the issue was for the community on a 4-point scale (1= not an issue to 4= a large issue).

Table 17. Community Issues Listed in Order of Importance by Target Group

Table 17.a. Children/Youth

Issue	Rating
Help in a crisis	**3.6**
Safe housing	**3.5**
Supportive relationships	**3.5**
Involvement in meaningful activities	**3.4**
Appropriate school placement	**3.3**
Physical health care	**3.2**
Transportation	**3.2**
Juvenile justice involvement	**3.2**
Normal school environment	**3.2**
Isolation	**3.1**
Out-of-home placement	**3.1**
Psychiatric hospitalization	**3.1**
Emergency room utilization	**3.0**
Out-of-county placement	**2.8**

Table 17.b. Transition Age Youth (16-25)

Issue	Rating
Affordable housing	**3.7**
Safe housing	**3.6**
Help in a crisis	**3.6**
Alcohol/Substance Use	**3.6**
Homelessness	**3.5**
Permanent housing	**3.5**
Employment	**3.5**

Table 17.b. Transition Age Youth (16-25)

Issue	Rating
Education	**3.5**
Supportive relationships	**3.5**
Suicide	**3.4**
Involvement in meaningful activities	**3.4**
Ability to take care of self	**3.3**
Ability to live in community	**3.3**
Juvenile/criminal justice involvement	**3.3**
Physical health care	**3.2**
Transportation	**3.2**
Least restrictive level of living arrangement	**3.2**
Isolation	**3.2**
Psychiatric hospitalization	**3.1**
Out-of-home placement	**3.1**
Emergency room utilization	**3.0**
Involuntary care	**2.9**

Table 17.c. Adults

Issue	Rating
Affordable housing	**3.7**
Homelessness	**3.6**
Permanent housing	**3.5**
Safe housing	**3.5**
Alcohol/Substance Use	**3.5**
Employment	**3.5**
Help in a crisis	**3.5**
Involvement in meaningful activities	**3.3**
Supportive relationships	**3.3**
Physical health care	**3.3**
Transportation	**3.3**
Ability to live in community	**3.3**
Suicide	**3.2**
Ability to take care of self	**3.2**
Least restrictive level of living arrangement	**3.1**
Isolation	**3.1**
Education	**3.1**
Psychiatric hospitalization	**3.1**
Emergency room utilization	**3.0**
Criminal justice involvement	**3.0**
Involuntary Care	**2.9**

Table 17.d. Older Adults

Issue	Rating
Affordable housing	**3.7**
Safe housing	**3.7**
Permanent housing	**3.6**
Physical health care	**3.6**
Supportive relationships	**3.5**
Help in a crisis	**3.5**
Isolation	**3.5**
Transportation	**3.5**
Involvement in meaningful activities	**3.5**
Nursing home placement	**3.5**
Homelessness	**3.4**
Medical hospitalization	**3.4**
Ability to live in community	**3.3**
Least restrictive level of living arrangement	**3.3**
Suicide	**3.2**
Emergency room utilization	**3.2**
Alcohol/Substance Use	**3.1**
Involuntary Care	**3.0**
Psychiatric hospitalization	**3.0**
Employment	**2.8**
Education	**2.8**

Information regarding who the focal populations should be during the first three years and what strategies the community thought would be best suited to addressing the need, was gathered using open-ended responses. General themes emerged from the responses that are consistent with, and supportive of, the issues that community ranked as needing attention.

When asked about who the focal populations should be during the first three years, the following themes emerged by age group:

- Children and Youth: the uninsured, those at risk of out-of-home placement
- TAY: the homeless/those at risk of homelessness
- Adults: the homeless, those with co-occurring AOD issues
- Older Adults: the homeless/those at risk of homelessness

When asked about the strategies that would be best suited to addressing community issues, the following themes emerged by age group:

- Children and Youth: family housing, 24/7 access to services, culturally competent services, more complete assessment and diagnosis, respite

- TAY: housing (emergency and transition), 24/7 access to services, culturally competent services, bilingual/bicultural services, education/employment center, drop in centers, respite
- Adults: housing, 24/7 access to services, culturally competent services, bilingual/bicultural supportive center, self-help, peer support, mobile crisis, respite
- Older Adults: mobile services to home bound elderly, housing options, peer support, 24/7 access to services, culturally competent services, respite

Population Data Indicating Unmet Need

In Part II, Section II: Analyzing Mental Health Needs in the Community, data are presented that describe unmet need, as well as the unserved and underserved populations in Sacramento County. Although these data are described in detail later, specific highlights are listed below:

- Significant unmet need is demonstrated in all age groups, but is most apparent in the TAY and Older Adult populations.
- In youth aged 0-17, the Hispanic/Latino, Alaskan Indian/Native American, Asian, and Native Hawaiian/Pacific Islander groups have high rates of unmet need, with the most apparent need being in the Asian population.
- In adults aged 18+, the Hispanic/Latino and Asian populations have high rates of unmet need.
- For children and youth, TAY, and adults, the Latino population is underrepresented in our client population, and when they are served, they are less likely to be fully served. Older adult Latinos are also less likely to be fully served.
- For children and youth, TAY, adults, and older adults, the Asian/Pacific Islander population is underrepresented in our client population. For adults and older adults, there is a striking absence of this population in those fully served.

Stakeholder Groups, Task Forces and Steering Committee Process

As mentioned previously, data were made available in an iterative fashion during the whole process. The general themes the data spoke to did not change over time. Rather, as time passed, we grew more confident in what the community and the data were telling us. The first groups of stakeholders to integrate the data with their expertise were the Stakeholder Groups. It is critical to note that the stakeholder groups utilized their expertise in combination with the data to generate proposals. System experience and knowledge was fundamental to the development of several key recommendations linked to access to services and the philosophy of service provision. As detailed in Part I, Section I, there were 40 stakeholder groups who provided input to 4 Task Forces (Children and Youth/TAY, Adult/TAY, Older Adult, and Cultural Competence). The work of the Stakeholders groups was to evaluate the unserved/underserved needs of their focal populations and come to consensus with strategies for system change. These strategies were then forwarded to the appropriate Task Forces for further evaluation and prioritizing.

Task forces were charged with evaluating ALL strategies/program recommendations provided to them by Stakeholder groups. They evaluated them in the context of available data, as well as system knowledge. Through a ranking process, each Task Force was able to forward its strategies/program recommendation priorities to the Steering Committee. Although all strategies/program recommendations were provided to the Steering Committee, only the top 10 from each Task Force were required to have further review by the Steering Committee.

The work of the Steering Committee became very complex. It was not only required that they attend to all age groups, but they also needed to take into account whether the proposed strategy/recommendation was more likely to reflect Full Service Partnerships or System Development. Again, through an iterative process with all of the data available as well as their own system knowledge, they went through an intensive 4-day prioritization process. They began by evaluating and ranking all proposals within task force groups. Part of the evaluation of each included a discussion of whether it would best fit as a Full Service Partnership or System Development. This discussion led to groupings of proposals as either "Full Service Partnership" or "System Development" initiatives. This grouping procedure did not identify the particular task force advancing the proposal. Although each task force had weighted particular recommendations, the Steering Committee did have access to all recommendations and was authorized to re-prioritize recommendations when to do so made sense based on the overall constellation of unmet needs (across age groups and diversity populations) in the community.

Each Steering Committee member was given 2 votes per funding category to indicate the proposal(s) they viewed as most critical to implement during the initial three-year plan. The data were shared with the group, and a final session was held to review whether the top ranked proposals met the Steering Committee's mission – to make an impact on the system. Once this review was completed, the Steering Committee members were then asked to do a final vote to endorse the order of their recommendations.

3. Please describe the specific racial ethnic and gender disparities within the selected community issues for each age group, such as access disparities, disproportionate representation in the homeless population and in county juvenile or criminal justice systems, foster care disparities, access disparities on American Indian rancherias or reservations, school achievement drop-out rates, and other significant issues.

RESPONSE:

Children/Youth: The community issues selected to be a focus in the first 3-year plan for Children and Youth were: (1) affordable, safe, permanent housing; (2) providing services to underserved racial/ethnic groups of children and youth; and (3) help in a crisis.

- Housing Disparities

  Homeless children and families comprise a significant number of the homeless population. The Sacramento County Office of Education identified approximately 5,000 homeless children in the county in FY 2003-04. Currently the Sacramento Division of Mental Health has 54 children enrolled in either day shelter of transitional housing at any one time. This leaves the majority of the children unserved without housing alternatives.

  a. SED Youth. The number of these children with serious emotional disturbances is unknown since their homeless status disenfranchises them from the mainstream of mental health services. However, it is assumed there are a significant number of children with mental health issues given the instability, limited resources, and limited access to health/mental health services. This population remains profoundly underserved in that the federal homeless funding (HUD/McKinney) does not consider children/families as part of the chronically homeless.

  b. Racial / Ethnic Disparities. Data regarding racial/ethnic disparities for diversity populations are difficult to obtain. Specifically, 9 Sacramento County homeless shelters collected information over the course of a 1-year period regarding the race/ethnicity of residents. These data show that of the 385 children and youth under 18 years of age, over 50% were identified as African American, 26% as Caucasian, 6% as American Indian/Alaskan Native, and 1% as Asian. These percentages are in contrast to the County population data that shows only 14% of youth are African American, 37% are Caucasian, 2% are Native American and 14% are Asian/Pacific Islander (see Part II, Section II for County population data). Because of the way data are collected, it was difficult to ascertain the percentage of Latinos. Currently, steps are being taken to correct the data collection system to more accurately reflect data for Latinos.

  c. Disparities in Housing by Diagnosis. The Sacramento City and County Board of Homelessness Housing Committee reported in FY 2004-05 there were approximately 11,109 homeless individuals in Sacramento County, of which between 35 and 55 percent had a mental illness and/or co-occurring disorder. The homeless populations who are disabled by mental illness deserve the same guarantee of care already extended to those who face other kinds of disabilities. The disparity of services and supports for the homeless are profound and result in inadequate or lack of treatment thus decreasing the opportunities for recovery, resiliency and wellness.

- Disparities in Access to MH Services

  a. In youth aged 0-17, the Hispanic/Latino, Alaskan Indian/Native American, Asian, and Native Hawaiian/Pacific Islander groups have high rates of unmet need, with the most apparent need being in the Asian population.

b. For children and youth, the Latino population is underrepresented in our client population, and when they are being served, they are less likely to be fully served.
c. For children and youth, the Asian/Pacific Islander population is underrepresented in our client population.

Transitional Age Youth: The community issues selected to be a focus in the first 3-year plan for TAY were: (1) affordable, safe, permanent housing; (2) providing services to underserved racial/ethnic and age groups of TAY; (3) access to/linkage with services; (4) help in a crisis; and (5) providing consumer and peer driven services.

- Housing Disparities
  Transition age youth with serious emotional disturbances comprise one of the largest challenges within the homeless population. Many do not meet the traditional definition of homelessness (unsheltered, on the streets or in a homeless shelter); therefore, they are underrepresented in annual homeless counts. The survey of homeless shelters in the County included TAY information in the Children/Youth or Adult data, so the issue regarding ethnic/racial disparities for homeless TAY cannot be addressed separately.

  a. Disparities associated with Wardship or Dependency. Homelessness places TAY at great risk of unemployment, academic failure, substance abuse, victimization, juvenile/criminal justice involvement, and unplanned pregnancy. TAY with serious emotional disturbances who age out of the foster care system in Sacramento County pose the highest risk for homelessness. It is estimated that approximately 45 percent of the youth, who "age out" of the foster care system each year, will have unstable plans that leave them vulnerable to becoming homeless. This rate of homelessness is significantly higher for youth aging out of the foster care system than for youth with similar diagnoses not having been in dependency or wardship status.

  b. Sacramento County Division of Mental Health currently provides services to only 40 homeless transition youth with mental health issues. Many homeless youth have aged out of the foster care system and are not connected to mental health services. They frequently do not possess the life skills in which to manage housing, work, or health/mental health issues. The incidence of dual disorders in the population has been projected to be at the 90% level.

- Disparities of Access to MH services associated with Race/Ethnicity for TAY
  a. Significant unmet need is apparent in the TAY populations of Sacramento County.
  b. For TAY, the Latino population is underrepresented in our client population, and when they are being served, they are less likely to be fully served.
  c. For TAY, the Asian/Pacific Islander population is underrepresented in our client population.

- Access to / Linkage with Services & Providing Consumer and Peer-Driven Services
  There are no data that speak directly to the issue of disparities in access to/linkage with services or providing consumer and peer-driven services for TAY. However, based on the utilization data that exists, it appears that certain age and ethnic/racial groups have less access and/or opportunity for linkage to services and to peer-driven services than others. Presuming this assumption holds, disparities in access to/linkage with services and peer-driven services are illustrated by the same data that speak to the unserved racial/ethnic and age groups.

Adults: The community issues selected to be a focus in the first 3-year plan for Adults were: (1) affordable, safe, permanent housing; (2) providing services to underserved racial/ethnic groups of Adults; (3) access to/linkage with services; (4) help in a crisis; and (5) providing consumer and peer-driven services. Information on gender disparities is contained in the tables located at the end of section II (pp 65-68).

- Housing Disparities
  The Sacramento City and County Board of Homelessness Housing Committee reported in FY 2004-05 there were approximately 11,109 homeless individuals in Sacramento County, of which between 35 and 55 percent had a mental illness and/or co-occurring disorder. In fact, it is estimated there are between 4,000 and 6,000 homeless adults with persistent mental illness who are untreated in Sacramento County.

  a. Disparities associated with Race/Ethnicity. Some data regarding racial/ethnic disparities are available from the survey of homeless shelters in Sacramento County. These data show that of the 2161 Adults 18 years of age and older, 37% were identified as African American, 44% as Caucasian, 4% as American Indian/Alaskan Native, and 1% as Asian.
  b. The above percentages are in contrast to the County population data that shows only 10% of adults are African American, 53% are Caucasian, 2% are Native American and 14% are Asian/Pacific Islander. Because of the way data are collected, it was difficult to ascertain the percentage of Latinos.

- Disparities in MH System Involvement Associated with Race/Ethnicity for Adults
  a. In adults aged 18+, the Hispanic/Latino and Asian populations have high rates of unmet need.
  b. For adults, the Latino population is underrepresented in our client population, and when they are served, they are less likely to be fully served.
  c. For adults, the Asian/Pacific Islander population is underrepresented in our client population. There is also a striking absence of this population in those fully served.

- Access to / linkage with services & Providing consumer and peer-driven services
  Again, there are no data that speak directly to the issue of disparities in access to/linkage with services or providing consumer and peer-driven services for Adults. However, one can make assumptions based on the utilization data that exists that certain ethnic/racial groups have less access and/or opportunity for linkage to services and to peer-driven services than others. Presuming those assumptions hold, disparities in access to/linkage with services and peer-driven services are illustrated by the same data that speak to the unserved racial/ethnic groups.

Older Adults: The community issues selected to be a focus in the first 3-year plan for Older Adults were affordable, safe, permanent housing; providing services to underserved racial/ethnic and age groups of Adults; access to/linkage with services; providing consumer and peer driven services; and help in a crisis.

- Housing Disparities
  The most frequent information request received by Sacramento County's InfoLine and the Older Adult Resource Center is related to finding affordable housing and housing resources for older adults. In Sacramento County, there is a serious lack of affordable housing that can also accommodate those with accessibility requirements. The lack of affordable housing is compounded for older adults with serious mental illness, in that they frequently lack resources or support systems. Within Sacramento County's homeless population is it estimated that approximately 10% are older adults. It is assumed that the majority of these older adults have serious mental illnesses that have lead to or resulted from their homeless status. It is speculated the low number of homeless older adults may be attributable to a higher death rate among the homeless with many not reaching an older age. The survey of homeless shelters in the County included Older Adult information in the Adult data, so the issue regarding ethnic/racial disparities for homeless Older Adults cannot be addressed separately.

- Disparities of Access to MH services associated with Race/Ethnicity
  a. Significant unmet need is apparent in the Older Adult populations
  b. Older adult Latinos are also less likely to be fully served than other racial/ethnic populations.
  c. For older adults, the Asian/Pacific Islander population is underrepresented in our client population, and there is a striking absence of this population in those fully served.

- Access to / Linkage with Services, Providing Consumer and Peer-Driven Services, & Help in a Crisis
  Again, there are no data that speak directly to the issues of disparities in access to/linkage with services, providing consumer and peer-driven services, or help in a crisis for Older Adults. However, one can make assumptions based on the utilization data that exists that certain ethnic/racial groups have less access

and/or opportunity for linkage to services, to peer-driven services, and to help in a crisis than others. Presuming those assumptions hold, disparities in access to/linkage with services, peer-driven services, and help in a crisis are illustrated by the same data that speak to the unserved racial/ethnic groups.

4. If you selected any community issues that are not identified in the "Direction" section above, please describe why these issues are more significant for your county/community and how the issues are consistent with the purpose and intent of the MHSA.

RESPONSE:

Though many issues were identified by the Stakeholder Groups, those selected for MHSA services over the next three years all fall within the parameters recommended in the "Guidelines and Directions" provided by the State Department of Mental Health, Three-Year Program and Expenditure Plan Requirements, Mental Health Services Act Community Services and Supports, August 1, 2005.

Although Stakeholders did not necessarily describe local issues in the same terms referenced by the direction section provided for Section I of Part II of the Three-Year Program and Expenditure Plan Requirements. Table 17e and Table 17f (on following pages) illustrate how local issues identified through the stakeholder process are consistent with and fall within the MHSA community issues set forth in the direction.

Table 17e. Issues selected for more than one age group aligned with MHSA community issues for adults, older adults, and some transition age youth resulting from a lack of community services and supports.

MHSA-identified Community Issues	Issues/Concerns identified by community stakeholders in Sacramento County		
	for Adults	for Older Adults	for Transition-Age Youth
Homelessness	Housing/Access Linkage to Services	Housing/Access Linkage to Services	Housing/Access Linkage to Services
Frequent Hospitalization	Help in Crisis Access/Linkage to Services	Help in Crisis Access/Linkage to Services	Help in Crisis
Frequent Emergency Medical Care	Help in Crisis	Help in Crisis	Help in Crisis
Inability to Work	Access/Linkage to Services Barrier Reduction	Access/Linkage to Services	Access/Linkage to Services
Inability to Manage Independence	Housing Help in Crisis Consumer/Peer Driven Services	Housing Help in Crisis Consumer/Peer Driven Services	Housing Help in Crisis Consumer/Peer Driven Services
Isolation	Consumer/Peer Driven Services	Consumer/Peer Driven Services	Consumer/Peer Driven Services
Involuntary Care	Help in Crisis Access/Linkage to Services	Help in Crisis Access/Linkage to Services	Help in Crisis Access/Linkage to Services
Incarceration	Help in Crisis Access/Linkage to Services	Help in Crisis Access/Linkage to Services	Help in Crisis Access/Linkage to Services

Table 17f. Issues selected for more than one age group aligned with MHSA community issues for children, youth, and some transition age youth resulting from a lack of community services and supports.

MHSA-Identified Community Issues	Issues/Concerns identified by community stakeholders in Sacramento County for Children, Youth, and some Transition-Age Youth
Inability to be in Mainstream School Environment	Access/Linkage to Services Race/Ethnicity as Barriers
School Failure	Access/Linkage to Services Race/Ethnicity as Barriers
Hospitalization	Help in Crisis Access/Linkage to Services
Peer and Family Problems	Housing Access/Linkage to Services Race/Ethnicity as Barriers
Out of Home and Out of Area Placement	Housing Help in Crisis Access/Linkage to Services
Involvement in Child Welfare System	Housing Help in Crisis Access/Linkage to Services
Involvement in Juvenile Justice System	Help in Crisis Access/Linkage to Services

Section II: Analyzing Mental Health Needs in the Community

1. Using the information from population data for the county and any available estimates of unserved populations, provide a narrative analysis of the unserved populations in your county by age group. Specific attention should be paid to racial ethnic disparities.

RESPONSE:

This section summarizes information available regarding the unserved populations in Sacramento County. First, we briefly discuss the situational characteristics of some populations who are unserved in our community. Data are then presented that describe the "identifiable" unserved population in Sacramento County (i.e., those who have only utilized psychiatric services in the jail or juvenile hall, or crisis and/or inpatient services). Finally, we present population data in the context of prevalence rates that addresses unmet need by age group, and by age/ethnicity groups.

Data were obtained from a variety of sources including California Department of Mental Health, Sacramento County Information System Utilization Data, 2000 Census Information, California Department of Finance, Homeless and Outreach program data, and others agency utilization data.

Situational Characteristics of Unserved Populations

As in many other communities, Sacramento has several populations of individuals who are likely unserved or underserved by our mental health system. Examples include:

- **Older adults** with avoidable emergency room admissions – older adults with co-occurring mental health, physical health, and substance abuse problems are frequent users of crisis and first responder services, often ending up in hospital emergency rooms. They are likely to have limited family or other support, are isolated, and are at high risk for suicide. Sacramento treats less than 1% of the older adult population in the County.

- **Adults** who are homeless or at risk of homelessness – homeless outreach teams in Sacramento see almost 250 people per month. Nearly 80% have indicators suggesting mental health issues. Of those, 86% appear to also have substance abuse issues.

- **Transition Aged Youth** exiting the juvenile justice or child welfare system – these youth are at increased risk of homelessness. Agencies expert in dealing with homeless transition age youth estimate there are 800-900 homeless youth at any given point in time in Sacramento. Rates of MH service utilization after the age of 18 decrease by nearly 50 percent compared to youth still in the foster care system and under age 18.

- **Children Aged 0-17.** In youth aged 0-17, the Hispanic/Latino, Alaskan Indian/Native American, Asian, and Native Hawaiian/Pacific Islander groups have high rates of unmet need, with the most apparent need being in the Asian population. For children and youth, the Latino population is underrepresented in our client population, and when they are being served, they are less likely to be fully served. For children and youth, the Asian/Pacific Islander population is underrepresented in our client population.

- **Members of ethnic populations** – Many ethnic communities, including Latinos and Asian Pacific Islanders, demonstrate significant cultural stigma, shame, and denial regarding mental illness. This, combined with other cultural and language barriers, results in populations whose mental health utilization rates per capita are among the lowest in Sacramento County. Low utilization puts these groups at great risk for undiagnosed and untreated mental illness, greater severity of illness when treated, isolation, decompensation, and family/community disruption. If and when they are diagnosed, their communities may deny their illnesses. They may be incorrectly treated or the treatment may be incomprehensible due to language and cultural barriers.

- **Members of Native American People Groups** - "The prevalence of suicide for AI/Ans is 1.5 times the national rate. Since 1979, suicide and homicide have been leading causes of death among young AI/Ans." (Wallace et al, 1996) This quote was taken from the Native American Community Stakeholder group recommendation and highlights the need for mental health services in the Native American community. Like other ethnic communities, relatively low utilization rates puts Native Americans at greater risk for undiagnosed and untreated mental illness, greater severity of illness when treated, isolation, decompensation, and family/community disruption.

- **Members of refugee populations** – Sacramento County has the highest number of newly arriving refugees in the State. These groups present unique challenges for the mental health system. Stigma, culture and language barriers contribute to very low mental health utilization rates. Existing data collection methods, however, do not always adequately record the need of these communities. For instance, Sacramento County has very large Russian/Eastern European communities. Many data collection methods do not distinguish between these communities and the more traditional Caucasian population. The refugee community, quite rightfully, has indicated that their mental health needs are very different from traditional groups. Further, refinement of data collection methods will be required to more accurately quantify the unmet needs of some refugee groups.

Although there are likely many other unserved or underserved populations in our community, those discussed are most relevant to the focus of this three year plan.

"Identifiable" Unserved Populations by Age Groups

In defining clients "served" by Sacramento County Mental Health for this 3 year plan, we eliminated from the data all those who had ONLY utilized the crisis unit and/or were hospitalized and/or received psychiatric services in the jail or juvenile hall. In other words, clients who had only utilized these services were considered "unserved."

The data presented in the tables below describe these "unserved" clients. Again, children and youth were either seen in the crisis unit/inpatient unit or in juvenile hall, while adults were seen in the crisis unit/inpatient unit or in jail. Across all age groups, 6421 individuals fell into this category, which represents just over 20% of all clients seen in Sacramento County. It is clear that our system lacks the appropriate resources to bridge the gap between crisis stabilization points in our service continuum to the outpatient services available in our community.

Table 18. Unserved Clients by Ethnicity and Age Group

	Children & Youth (0-17)		TAY (18-24)		Adults (25-59)		Older Adults (60+)	
	N=1863	%	N=1040	%	N=3358	%	N=160	%
Gender								
Male	1275	68.4	653	62.8	2167	64.5	99	61.9
Female	586	31.5	387	37.2	1186	35.3	61	38.1
Unknown	2	0.1	---	---	5	0.1	--	--
Ethnicity								
African American	546	29.3	272	26.2	865	25.8	22	13.8
Asian/Pacific Islander	107	5.6	42	4.0	118	3.5	12	7.5
Latino	307	16.5	157	15.1	420	12.5	14	8.8
Native American	15	0.8	4	0.4	9	0.3	---	---
White	569	30.5	509	48.9	1852	55.2	108	67.5
Multi-Ethnic	104	5.6	18	1.7	22	0.7	1	0.6
Other	215	11.5	38	3.7	72	2.1	3	1.9

Taking a closer look at the data, this unserved population is more likely to consist of males than females, regardless of age group. The ethnic breakdown of this unserved population, however, is very similar to the ethnic breakdown of the population we do consider to be served (see #2 and #3 below). This suggests that disparities that exist between ethnic groups with respect to mental health services utilization also exist at the crisis stabilization points in our service continuum. Specifically, African Americans are more likely to present at these service points and Latinos and Asian/Pacific Islanders are less likely to present.

The next table presents the proportion of unserved in each age category that was encountered in the criminal justice system (i.e., juvenile hall or jail) or in the mental health system (i.e., crisis or inpatient unit).

Table 19. Proportion of Unserved Clients in Criminal Justice and Mental Health Settings

	Children & Youth (0-17)		TAY (18-24)		Adults (25-59)		Older Adults (60+)	
	% Juvenile Hall	% Crisis/ Inpatient	% Jail	% Crisis/ Inpatient	% Jail	% Crisis/ Inpatient	% Jail	% Crisis/ Inpatient
Gender								
Male	87.3	12.7	48.5	51.5	52.1	47.9	25.7	74.3
Female	63.1	36.9	29.8	70.2	35.1	64.9	1.6	98.4
Ethnicity								
African American	86.4	13.6	55.9	44.1	61.5	38.5	36.4	63.6
Asian/Pacific Islander	83.2	16.8	26.1	73.9	28.0	59.8	8.3	91.7
Latino	80.4	19.6	46.3	53.7	54.7	45.3	21.4	78.6
Native American	80.0	20.0	40.0	60.0	30.0	70.0	--	--
White	64.3	35.7	33.1	66.9	38.7	61.3	13.6	86.4
Multi-Ethnic	91.6	8.4	63.2	36.8	19.2	80.8	0.0	100.0
Other	94.0	6.0	36.8	63.2	42.9	74.6	0.0	100.0

Of the 6421 individuals, 2928 (45.6%) were seen in the mental health system. One reason for the very large proportion of clients being encountered in the criminal justice system is the propensity for young males to behave in ways that lead to public safety and law enforcement involvement.

The data show several interesting age, gender, and ethnicity patterns. In general, (1) the youngest people are seen by the criminal justice system while the oldest people are seen by the mental health system, (2) females are most likely to be seen in the mental health system, and (3) African Americans of all ages are most likely to be seen in the criminal justice system. Specific findings are detailed below.

- Children/Youth
  - Children and youth are more likely than any other age group to be identified through the criminal justice system
  - Boys are more likely than girls to be identified through the criminal justice system
  - White children and youth are less likely to be identified through the criminal justice system than any other ethnic group

- Transitional Age Youth
  - Males are just as likely to be identified through crisis/inpatient visits as through the criminal justice system
  - Females are much more likely to be identified through crisis/inpatient visits
  - The majority of African American TAY are identified through the criminal justice system, while the majority of other TAY ethnic populations are identified through crisis/inpatient visits

- Adults
  - Males are just as likely to be identified through crisis/inpatient visits as through the criminal justice system
  - Females are more likely to be identified through crisis/inpatient visits
  - The majority of African American and Latino Adults are identified through the criminal justice system, while the majority of other Adult ethnic populations are identified through crisis/inpatient visits

- Older Adults
  - Older adults are more likely than any other age group to be identified through crisis/inpatient visits, with females almost exclusively identified in that manner
  - Although identification through the criminal justice system is rare, the ethnic group most likely to be identified this way is African American

Unserved Populations by Age Group

Data presented in the tables below estimate the unmet need in different age groups assuming: (1) general population estimates, and (2) 200% of Federal Poverty Level population estimates. In either case, the columns represent the same things:

- Column 1 – the number of clients served during Calendar Year 2004. Because these estimates were used during the planning process (February through July 2005), fiscal year data were not yet available. Clients are considered "served" if they received services other than psychiatric services in the jail or juvenile hall, crisis or inpatient hospitalization. Thus, if clients ONLY utilized the crisis unit and/or were hospitalized and/or received psychiatric services in the jail or juvenile hall, they are eliminated from the data presented.

- Column 2 – the number of people who would be expected to have severe mental illness, based on prevalence rates. The prevalence rates were supplied by the State Department of Mental Health, and differed depending on whether the estimates applied to the general population or the poverty population. General population and poverty population estimates were based on the 2000 Census and were also supplied by the State Department of Mental Health. Population growth rates between 2000 and 2004 were estimated to be 9.1% for Sacramento County.

- Column 3 – the number of people who would be expected to have severe mental illness that were not served (Column 2 -- Column 1)

- Column 4 – the percentage of people within each age group who would be expected to have severe mental illness that were unserved

- Column 5 – the proportion of unserved people who fall within each age group. This column answers the question, "If there were 100 unserved people, how many would be youth, TAY, adults, and older adults?"

Table 20. Unmet Need by Population Membership and Age Group

Table 20.a. Unmet Need in General Population by Age Group

	Column 1	Column 2	Column 3	Column 4	Column 5
Age Group	MH Clients	Estimated General Pop w/ Severe MI	Unmet Need (Column 2 - Column 1)	% of Unmet Need w/in age group (Col. 3/Col 2)	% of Unmet Need (Col. 3/Tot 3)
Youth 0-17	9,906	27,487	17,581	63.96	29.16
TAY 18-24	1,963	10,809	8,846	81.84	14.67
Adults 25-64	12,470	41,361	28,891	69.85	47.92
Older Adults 65+	764	5,734	4,970	86.68	8.24
TOTALS	**25,103**	**85,391**	**60,288**		

Table 20.b. Unmet Need in Poverty Population by Age Group

	Column 1	Column 2	Column 3	Column 4	Column 5
Age Group	MH Clients	Estimated Poverty Pop w/ Severe MI	Unmet Need (Column 2 - Column 1)	% of Unmet Need w/in age group (Col. 3/Col 2)	% of Unmet Need (Col. 3/Tot 3)
Youth 0-17	9,906	14,180	4,274	30.14	32.01
TAY 18-24	1,963	6,059	4,096	67.60	30.68
Adults 25-64	12,470	15,929	3,459	21.72	25.91
Older Adults 65+	764	2,287	1,523	66.59	11.41
TOTALS	**25,103**	**38,455**	**13,352**		

The data suggest that we served approximately 25,000 clients in 2004. Regardless of whether one focuses on the general population or the poverty population, significant unmet need is demonstrated in all age groups. However, in both tables, the greatest unmet need is in the Transition Age and Older Adult populations (see grayed cells).

Table 21. Unmet Need by Ethnicity and Population Membership (General and Poverty) for Persons Age 0-17

Table 21.a. Unmet Need in General Population (0-17) by Ethnic Group

	Column 1	Column 2	Column 3	Column 4	Column 5
Ethnic Group	**MH Clients**	**Estimated General Pop w/ Severe MI**	**Unmet Need (Column 2 - Column 1)**	**% of Unmet Need w/in cultural group (Col. 3/Col 2)**	**% of Unmet Need (Col. 3/Tot 3)**
White	3,902	12,045	8,143	67.60	46.30
African American	2,634	3,429	795	***23.18***	4.52
Hispanic/Latino	1,646	6,225	4,579	73.56	26.03
AINA	61	199	138	69.35	0.78
Asian	255	3,467	3,212	92.64	18.26
NHPI	39	186	147	79.03	0.84
Other	402	100	-302	-302.00	-1.72
2 or more	967	1,844	877	47.56	4.99
Totals	**9,906**	**27,495**	**17,589**	**63.97**	

Table 21.b. Unmet Need in Poverty Population (0-17) by Ethnic Group

	Column 1	Column 2	Column 3	Column 4	Column 5
Ethnic Group	**MH Clients**	**Estimated Poverty Pop w/ Severe MI**	**Unmet Need (Column 2 - Column 1)**	**% of Unmet Need w/in cultural group (Col. 3/Col 2)**	**% of Unmet Need (Col. 3/Tot 3)**
White	3,902	4,721	819	17.35	19.16
African American	2,634	2,140	-494	***-23.08***	-11.56
Hispanic/Latino	1,646	3,680	2,034	55.27	47.59
AINA	61	124	63	50.81	1.47
Asian	255	2,426	2,171	89.49	50.80
NHPI	39	120	81	67.50	1.90
Other	402	42	-360	-857.14	-8.42
2 or more	967	927	-40	-4.31	-0.94
Totals	**9,906**	**14,180**	**4,274**	**30.14**	

Data in the preceding two tables reveals a very similar story regarding the unmet need in youth across different ethnic groups. First, African American youth have significantly less unmet need than the County average (e.g., 23.18% vs. 63.97%). Second, the Hispanic/Latino, Alaskan Indian/Native American, Asian, and Native Hawaiian/Pacific Islander groups have higher rates of unmet need than the County average, with Asian youth demonstrating the highest rate of unmet need.

Table 22. Unmet Need by Ethnicity and Population Membership (General and Poverty) for Persons Age 18 and Older

Table 22.a. Unmet Need in General Population (18+) by Ethnic Group

	Column 1	Column 2	Column 3	Column 4	Column 5
	MH Clients	Estimated General Pop w/ Severe MI	Unmet Need (Column 2 - Column 1)	% of Unmet Need w/in cultural group (Col. 3/Col 2)	% of Unmet Need (Col. 3/Tot 3)
White	7,934	35,045	27,111	77.36	63.49
African American	2,799	4,850	2,051	***42.29***	4.80
Hispanic/Latino	1,574	8,362	6,788	81.18	15.90
AINA	131	350	219	62.57	0.51
Asian	1,218	6,398	5,180	80.96	12.13
NHPI	186	381	195	51.18	0.46
Other	1,023	166	-857	-516.27	-2.01
2 or more	328	2,339	2,011	85.98	4.71
Totals	**15,193**	**57,891**	**42,698**	**73.76**	

Table 22.b. Unmet Need in Poverty Population (18+) by Ethnic Group

	Column 1	Column 2	Column 3	Column 4	Column 5
	MH Clients	Estimated Poverty Pop w/ Severe MI	Unmet Need (Column 2 - Column 1)	% of Unmet Need w/in cultural group (Col. 3/Col 2)	% of Unmet Need (Col. 3/Tot 3)
White	7,934	11,691	3,757	32.14	41.33
African American	2,799	2,666	-133	***-4.99***	-1.46
Hispanic/Latino	1,574	4,668	3,094	66.28	34.03
AINA	131	223	92	41.26	1.01
Asian	1,218	3,486	2,268	65.06	24.95
NHPI	186	255	69	27.06	0.76
Other	1,023	93	-930	-1000.0	-10.23
2 or more	328	1,202	874	72.71	9.61
Totals	**15,193**	**24,284**	**9,091**	**37.44**	

Again, data in the preceding two tables reveals that African American adults have significantly less unmet need than the County average (e.g., 42.29% vs. 73.76%). Second, the Hispanic/Latino and Asian groups have higher rates of unmet need than the County average.

Conclusions Regarding the "Unserved in Sacramento"

A large amount of data were presented that speak to a great deal of unmet need, yet it is difficult to know exactly how many people we could be serving as well as who those people are. For example, the data suggest that in terms of who we might anticipate would be considered to be severely mentally ill, we are not serving large proportions of TAY and Older Adults. If the data are correct, we can only guess at

who those people might be. We mentioned earlier that the Older Adults we might not be serving could be those who are frequent users of crisis and first responder services, and who often end up in hospital emergency rooms. They are likely to have limited family or other support, are isolated, and are at high risk for suicide.

We also mentioned that for transition aged youth who exit the child welfare system, mental health service utilization decreases by nearly 50 percent. Perhaps this is why we appear to be serving such a small proportion of TAY who might be expected to have severe mental illness.

Other data we presented shows a very high number of people who received mental health services in acute psychiatric care (crisis and inpatient) or criminal justice (juvenile hall, jail) settings. These data suggest we have a gap in services as these individuals are not successfully transitioned to outpatient services. High rates in utilization of these kinds of services are also highly correlated to homelessness and substance abuse. We mentioned earlier that homeless outreach teams in Sacramento see almost 250 people per month. Nearly 80% have indicators suggesting mental health issues, and of those, 86% appear to also have substance abuse issues. In addition, agencies expert in dealing with homeless transition age youth estimate there are 800-900 homeless youth at any given point in time in Sacramento.

With respect to racial ethnic populations, three disparities hold regardless of age group examined: there is significant unmet need in the Latino population; there is significant unmet need in the Asian population; and there appears to be much less unmet need in the African American population. In addition, the Alaskan Indian/Native American and Native Hawaiian/Pacific Islander populations in children and youth also have significant unmet need. Many of the racial ethnic communities with unmet need demonstrate significant cultural stigma, shame, and denial regarding mental illness. This, combined with other cultural and language barriers, results in populations whose mental health utilization rates per capita are extremely low. This puts them at great risk for undiagnosed and untreated mental illness, greater severity of illness when treated, isolation, decompensation, and family/community disruption. If and when they are diagnosed, they may be incorrectly treated or the treatment may be incomprehensible due to language and cultural barriers.

2. Using the format provided in Chart A, indicate the estimated total number of persons needing MHSA mental health services who are already receiving services, including those currently fully served and those underserved/inappropriately served, by age group, race ethnicity, and gender. Also provide the total county and poverty population by age group and race ethnicity. (Transition Age Youth may be shown in a separate category or as part of Children and Youth or Adults).

RESPONSE:

The charts are presented at the end of this section. Utilization data were taken from the County information system based on clients receiving services in Fiscal Year 2004/2005. Again, clients are considered "served" if they received services other than psychiatric services in the jail or juvenile hall, crisis or inpatient hospitalization. Thus, if clients ONLY utilized the crisis unit and/or were hospitalized and/or received psychiatric services in the jail or juvenile hall, they are eliminated from the data presented.

The County has 3 programs for children and youth (FOCUS, WRAP, and Building Blocks Intensive) and 3 programs for TAY, adults, and older adults (AB2034, ISA, and TISA) that it considers to provide a full range of services. Clients who received services from one of these 6 programs were categorized as "fully served." The remaining clients are considered to be "underserved" or "inappropriately served." TAY data have been shown in a separate category.

County population data for ethnicity and age were derived from the Department of Finance, while data for language were derived from the 2000 Census adjusted for 2004 population growth. Poverty population data for ethnicity and gender were derived from information supplied by the State Department of Mental Health. Poverty population data for language were not available.

3. Provide a narrative discussion/analysis of the ethnic disparities in the fully served, underserved and inappropriately served populations in your county by age group as identified in Chart A. Include any available information about their age and situational characteristics as well as race ethnicity, gender, primary language, sexual orientation, and special needs.

RESPONSE:

As before, examination of these data suggests some common themes. First, for children and youth, transition aged youth and adults, the Latino population is underrepresented in our client population, and even when they are being served, they are less likely to be fully served. Older adult Latinos are also less likely to be fully served. Second, for children and youth, transition aged youth, adults, and older adults, the Asian and Pacific Islander population is underrepresented in our client

population. Only for adults and older adults, however, is there a striking absence of this population in those fully served. In fact, for transition aged youth, the Asian Pacific Islander population is somewhat overrepresented in the fully served population.

More specific findings for each age group are presented below.

Children and Youth (Age 0-17)

Comparing the Total Served percentages with the Poverty and General Populations of the County:

- Ethnicity – based on the representation of all ethnic groups in the population at or below 200% of the poverty level, African Americans are the most likely to receive needed Mental Health services while Asian/Pacific Islander and Latino clients are underserved.
- Language – we over-serve English speaking clients and underserve Spanish, Cantonese, Hmong, Vietnamese, and Russian speaking clients
- Gender – we slightly over-serve males

Of those we DO serve, comparing the fully served population with the underserved/ inappropriately served population:

- Only 10.8% of children and youth are fully served
- Ethnicity – Latino children and youth are less likely to be fully served and White children and youth are more likely to be fully served
- Language – non-English speaking children and youth are less likely to be fully served
- Gender – Males are somewhat more likely than females to be fully served

**Latino children and youth are underrepresented in our client population, and even when they are being served, they are less likely to receive the full range of services

**Asian/Pacific Islander children and youth are underrepresented in our client population, but are proportionately represented in the full service programs

Transition Aged Youth (Age 18-24)

Comparing the Total Served percentages with the Poverty and General Populations of the County:

- Ethnicity – based on the representation of all ethnic groups in the transition aged population (18-24), African Americans are the most likely to receive needed Mental Health services, while Asian/Pacific Islander and Latino clients are underserved.
- Language – we over-serve English speaking clients and underserve Spanish speaking clients
- Gender – we slightly underserve males

Of those we DO serve, comparing the fully served population with the underserved/ inappropriately served population,

- Less than 4% of TAY are fully served
- Ethnicity – Latino TAY are less likely to be fully served and African American and Asian/Pacific Islander TAY are more likely to be fully served
- Language – non-English speaking TAY are less likely to be fully served
- Gender – Males are more likely than females to be fully served

**Latino TAY are underrepresented in our client population, and even when they are being served, they are less likely to receive the full range of services

**Asian/Pacific Islander TAY are underrepresented in our client population, and are slightly more likely to receive full service programs when they are served

**African American TAY are over-represented in our system, and are also more likely to receive full service programs when they are served

Adults (Age 25-59)

Comparing the Total Served percentages with the Poverty and General Populations of the County:

- Ethnicity – based on the representation of all ethnic groups in the population at or below 200% of poverty, African Americans are the most likely to receive needed Mental Health services, while Asian/Pacific Islander and Latino clients are underserved.
- Language – we over-serve English speaking clients and underserve Spanish speaking clients
- Gender – we underserve males

Of those we DO serve, comparing the fully served population with the underserved/ inappropriately served population

- Less than 5% of Adults are fully served
- Ethnicity – Asian/Pacific Islander and Latino Adults are less likely to be fully served and White Adults are more likely to be fully served
- Language – non-English speaking Adults are less likely to be fully served
- Gender – Males are more likely than females to be fully served

**Latino Adults are underrepresented in our client population, and even when they are being served, they are less likely to receive the full range of services

**Asian/Pacific Islander Adults are proportionately represented in our client population, but are less likely to receive full service programs when they are served

Older Adults (Age 60+)

Comparing the Total Served percentages with the Poverty and General Populations of the County:

- Ethnicity – older adults are generally served in proportion to their representation in the population

- Language – we underserve Spanish speaking clients
- Gender – we underserve males

Of those we DO serve, comparing the fully served population with the underserved/ inappropriately served population

- Just 3.2% of Older Adults are fully served
- Ethnicity – Asian/Pacific Islander and Latino Older Adults are less likely to be fully served and African American Adults are more likely to be fully served
- Language – non-English speaking Older Adults are less likely to be fully served
- Gender – Males are just as likely as females to be fully served

**Latino and Asian/Pacific Islander Older Adults are less likely to receive the full range of services

4. Identify objectives related to the need for, and provision of, culturally and linguistically competent services based on the population assessment, the county's threshold languages and the disparities or discrepancies in access and service delivery that will be addressed in this plan.

RESPONSE:

This plan addresses three primary objectives, listed below, related to the need for, and provision of culturally and linguistically competent services based on the population assessment, the county's threshold languages and the disparities or discrepancies in access and service delivery.

- **Objective 1**. To increase the total number of fully served with the Sacramento County population
- **Objective 2**. To increase the percentage of Latino, API, and Native American clients who receive services to more accurately reflect the percentage distribution of these racial and ethnic communities within the larger Sacramento County population for all age groups.
- **Objective 3.** To increase the total number of Latino, API, and Native American clients who receive service to more accurately reflect the absolute numerical distribution of these racial and ethnic communities within the larger Sacramento County population.

Our goal is to serve these clients in their primary language, which would address four out of five, of Sacramento County's threshold languages (Spanish, Russian, Vietnamese, Hmong, and Cantonese).

Table 23.a. - Table 23.d. below summarize the discrepancies in access and service delivery addressed by the plan:

Table 23. Population by Age Group, Gender, Poverty, Ethnicity, and Service Status

Table 23. a. Children and Youth (Age 0-17)

Race/Ethnicity	Fully Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population	
	N	%	N	%	N	%	N	%	N	%
African American	345	28.3	2815	28.1	3160	28.1	23386	14.7	50701	14.1
Asian/Pacific Islander	24	2.0	289	2.9	313	2.8	28209	17.8	51661	14.3
Latino	133	10.9	1662	16.6	1795	16.0	41391	26.1	95629	26.6
Native American	8	0.7	60	0.6	68	0.6	1388	0.9	6471	1.8
White	557	45.7	3925	39.1	4482	39.8	53586	33.7	134278	37.3
Multi-Ethnic	133	10.9	968	9.6	1101	9.8	10384	6.5	21292	5.9
Other	20	1.6	313	3.1	333	3.0	444	0.3		
Total	1220		10032		11252		158788		360032	

Primary Language	Fully Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population 5-17yrs	
	N	%	N	%	N	%	N	%	N	%
English	1185	97.1	9335	93.1	10520	93.5	not available		193674	73.4
Spanish	31	2.5	561	5.6	592	5.3			28412	10.8
Cantonese			8	0.1	8	0.1			4073	1.5
Mien	2	0.2	8	0.1	10	0.1				0.0
Hmong	1	0.1	28	0.3	29	0.3			8750	3.3
Vietnamese			12	0.1	12	0.1			3863	1.5
Russian			11	0.1	11	0.1			5419	2.1
Other	1	0.1	69	0.7	70	0.6			19583	7.4
Total	1220		10032		11252				263774	

Gender	Fully Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population	
	N	%	N	%	N	%	N	%	N	%
Male	734	60.2	5750	57.3	6484	57.6	79572	50.1	184332	51.2
Female	486	39.5	4282	42.7	4768	42.4	79216	49.9	175700	48.8
Total	1220		100032		11252		158788		360032	

Table 23.b. Transition Age Youth (18-24)

Race/Ethnicity	Fully Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population	
	N	%	N	%	N	%	N	%	N	%
African American	18	25.7	335	19.8	353	20.0	6497	11.8	16033	11.6
Asian/Pacific Islander	6	8.6	92	5.4	98	5.6	8379	15.2	23881	17.2
Latino	7	10.0	246	14.5	253	14.4	11144	20.2	35678	25.8
Native American	1	1.4	12	0.7	13	0.7	645	1.2	2436	1.8
White	35	50.0	831	49.1	866	49.2	26113	47.2	54897	39.6
Multi-Ethnic	1	1.4	73	4.3	74	4.2	2284	4.1	5563	4.0
Other	2	2.9	102	6.0	104	5.9	220	0.4		
Total	70		1691		1761		55282		138488	

Primary Language	Fully Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population	
	N	%	N	%	N	%	N	%	N	%
English	68	97.1	1548	91.5	1616	91.8	not available		105612	76.3
Spanish			60	3.5	60	3.4			13556	9.8
Cantonese			1	0.1	1	0.1			2849	2.1
Mien			4	0.2	4	0.2				0.0
Hmong			18	1.1	18	1.0			1292	0.9
Vietnamese	1	1.4	8	0.5	9	0.5			1784	1.3
Russian			12	0.7	12	0.7			1359	1.0
Other	1	1.4	40	2.4	41	2.3			12035	8.7
Total	70		70		1761				138488	

Gender	Fully Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population	
	N	%	N	%	N	%	N	%	N	%
Male	46	65.7	675	39.9	721	40.9	24314	44.0	70421	50.8
Female	24	34.3	1016	60.1	1040	59.1	30968	56.0	68067	49.2
Total	70		1691		1761		55282		138488	

Table 23.c. Adults (25-59)

Race/Ethnicity	Fully Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population	
	N	%	N	%	N	%	N	%	N	%
African American	125	21.7	2031	17.8	2156	18.0	18969	11.8	66796	10.0
Asian/Pacific Islander	31	5.4	1579	13.9	1610	13.5	24461	15.2	96157	14.4
Latino	44	7.6	1160	10.2	1204	10.1	32535	20.2	123756	18.6
Native American	3	0.5	98	0.9	101	0.8	1882	1.2	11132	1.7
White	348	60.3	5971	52.4	6319	52.8	76237	47.2	353402	53.0
Multi-Ethnic	13	2.3	207	1.8	220	1.8	6670	4.1	15321	2.3
Other	13	2.3	773	6.8	786	6.6	642	0.4		
Total	577		11387		11964		161396		666564	

Primary Language	Fully Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population	
	N	%	N	%	N	%	N	%	N	%
English	555	96.2	9539	83.8	10094	84.4	not available		508327	76.3
Spanish	8	1.4	396	3.5	404	3.4			65248	9.8
Cantonese			51	0.4	51	0.4			13713	2.1
Mien	1	0.2	134	1.2	135	1.1				0.0
Hmong	2	0.3	283	2.5	285	2.4			6220	0.9
Vietnamese	3	0.5	181	1.6	184	1.5			8588	1.3
Russian	1	0.2	163	1.4	164	1.4			6543	1.0
Other	7	1.2	640	5.6	647	5.4			57925	8.7
Total	577		11387		11964				666564	

Gender	Fully Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population	
	N	%	N	%	N	%	N	%	N	%
Male	317	54.9	4438	39.0	4755	39.7	70984	44.0	328218	49.2
Female	260	45.1	6947	61.0	7207	60.2	90412	56.0	338346	50.8
Unknown			2	0.0	2	0.0				
Total	577		11387		11964		161396		666564	

Table 23.d. Older Adults (60+)

Race/Ethnicity	Fully Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population	
	N	%	N	%	N	%	N	%	N	%
African American	11	27.5	119	9.9	130	10.5	5746	11.8	14310	7.2
Asian/Pacific Islander	2	5.0	144	12.0	146	11.7	7410	15.2	25784	13.0
Latino	1	2.5	100	8.3	101	8.1	9856	20.2	15445	7.8
Native American			6	0.5	6	0.5	570	1.2	2014	1.0
White	25	62.5	729	60.5	754	60.6	23094	47.2	137678	69.5
Multi-Ethnic			5	0.4	5	0.4	2020	4.1	2933	1.5
Other	1	2.5	101	8.4	102	8.2	194	0.4		
Total	40		1204		1244		48890		198164	

Primary Language	Fully Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population	
	N	%	N	%	N	%	N	%	N	%
English	38	95.0	945	78.5	983	79.0	not available		151122	76.3
Spanish	1	2.5	61	5.1	62	5.0			19398	9.8
Cantonese	1	2.5	7	0.6	8	0.6			4077	2.1
Mien			27	2.2	27	2.2				0.0
Hmong			14	1.2	14	1.1			1849	0.9
Vietnamese			30	2.5	30	2.4			2553	1.3
Russian			35	2.9	35	2.8			1945	1.0
Other			85	7.1	85	6.8			17221	8.7
Total	40		1204		1244				198165	

Gender	Fully Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population	
	N	%	N	%	N	%	N	%	N	%
Male	14	35.0	369	30.6	383	30.8	21502	44.0	84359	42.6
Female	26	65.0	834	69.3	860	69.1	27388	56.0	113805	57.4
Unknown			1	0.1	1	0.0				
Total	40		1204		1244		48890		198164	

Section III: Identifying Initial Populations for Full Service Partnerships

Sacramento County is proposing three programs that fall into the category of Full Service Partnerships:

- Older Adult Intensive Services Program
- Permanent Supportive Housing Program for Homeless Individuals and Families
- Transcultural Wellness Center

The responses to the questions asked in Section III are answered below for each of the proposed programs:

Proposed Program

OLDER ADULT INTENSIVE SERVICES PROGRAM

1. From your analysis of community issues and mental health needs in the community, identify which initial populations will be fully served in the first three years. Describe each population in terms of age and the situational characteristics.

RESPONSE:

The Older Adult Intensive Services Program will offer full service partnerships to older adults who:

- are age 60+ with serious mental illness and who meet the target population criteria of seriously mentally ill established by the Sacramento County DHHS Division of Mental Health;
- have complex, co-occurring mental health, physical health, substance abuse, and social service needs;
- require specialty multidisciplinary assessment and treatment services provided by staff with special expertise in working with older adults;
- require intensive case management to coordinate care with a range of community services and supports to promote wellness and recovery;
- are homebound and isolated, with limited family and social supports;
- are not receiving any mental health services (un-served) or are currently receiving services in the public mental health system but who are underserved;
- are at-risk for emergency room utilization, hospitalization, nursing home care, institutionalization, and eviction/homelessness, and may experience impaired personal and community functioning if they do not receive the intensive services of this full service partnership program.

The population to receive these intensive services will reflect the ethnic and cultural diversity of Sacramento County. Transition age older adults (age 55 through 59) may also be included in this full service partnership population if they have complex co-occurring mental health, medical, substance abuse, and social service needs similar to older adults that require this program's intensive services and who would be at-risk for the adverse impact of untreated mental illness without these services.

This description of the older adult and transition age adult population for full service partnership participation are consistent with the MHSA criteria and DMH priorities as described in the Community Services and Supports Three-Year Program and Expenditure Plan Requirements (p. 21-22).

2. Describe what factors were considered or criteria established that led to the selection of the initial populations for the first three years. (Distinguish between criteria used for each age group if applicable.)

RESPONSE:

The following factors contributed to the selection of older adults as a full service partnership population, and influenced the high ranking of the Older Adult Intensive Services Program by the MHSA Older Adult Task Force (ranked #1) and the MHSA Steering Committee (ranked # 2 for full service partnership funding):

- Older adults in Sacramento County with serious mental illness are un-served and underserved in the public mental health system, particularly ethnically and culturally diverse older adults. In Fiscal Year 2003-2004, 1244 older adults aged 60+ received public mental health services – about 2.5% of the poverty population in this age group, and less than 5% of the 26,221 clients served by the Mental Health System in Sacramento County. Older adults who are ethnically and culturally diverse are significantly under-represented among the limited number of older adults who are receiving mental health services (See data presented in Part II, Section II).
- The Community Needs Assessment (described in Part II, Section I) identified the following issues specific to older adults with untreated mental illness: isolation, help in a crisis, needing supportive relationships, physical health care, transportation, involvement in meaningful activities, and nursing home placement.
- Older adults benefit from specialty mental health programs. They have mental health, health, substance abuse, and social service needs distinctive from adults, which require distinctive, specialized services. Their concurrent and often complex medical needs, co-occurring with mental health needs makes assessment and treatment interventions complicated and time intensive. The complexities of geriatric assessment and treatment, including case management, require specialized staff with limited caseloads. The services provided need to

be proven effective with older adults, such as multidisciplinary assessment and treatment, case management, and mobile services.

- There are limited, specialty mental health services for older adults with serious mental illness in Sacramento County. The specialty mental health services that are available for older adults with serious mental illness include crisis intervention, limited case management, telephone reassurance, and senior peer counseling. More specialized services are needed. For example, there are no specialized outpatient intensive program services for high-risk, medically complex seniors in the Regional Support Teams that are the primary providers of outpatient mental health services in Sacramento County's mental health system. Frailty, isolation (including cultural and linguistic isolation), physical problems, and limited mobility prevent older adults from accessing existing services, particularly clinic-based services. Older adults fall through the cracks or are dropped from the outpatient RST system due to non-compliance in keeping appointments until they present in crisis, become hospitalized, or are incarcerated.

All of these factors will be positively impacted for the priority population by the full service partnership services of the Older Adult Intensive Services Program.

3. Discuss how your selections of initial populations in each age group will reduce specific ethnic disparities in your county.

RESPONSE:

Data from Sacramento's Cultural Competence Plan Update in 2003 showed the penetration rate for older adults age 65+ receiving public mental health services to be very low (1.32%) compared to the penetration rate of persons age 40-59 (11.08%). The penetration rate data by ethnicity in Sacramento County reveals that it is high for African Americans and Caucasians and relatively low for Latinos. It is particularly low for Asian and Pacific Islanders, Chinese, Laotian, and Vietnamese.

Because older adults are significantly un-served and underserved in general in Sacramento County's public mental health system, one can assume that older adults who are also ethnically and culturally diverse are also significantly under-represented. Data described in Part II, Section II supports this assumption.

The full service partnership population of older adults and transition age adults should reflect the ethnic and cultural diversity of Sacramento County's population. To reduce ethnic disparity in the utilization of mental health services, this program will focus on making its services acceptable to older adults of diverse cultures and ethnicities. This will occur by hiring staff, including family/consumer advocates and peer counselors, who are culturally diverse, culturally competent, bilingual/bicultural, and who reflect the ethnic and linguistic diversity of the population being served. Cultural competence training will be provided to all staff so that the program can

provide culturally competent services. Cultural issues such as language, race, ethnicity, customs, family structure, sexual orientation, and community dynamics will be part of the cultural competence training.

This program will identify and collaborate with service providers and organizations currently providing services to ethnically/culturally diverse older adults. Special attention will be given to identifying primary care physicians and non-traditional healthcare providers who provide medical care to ethnically diverse populations. These are important collaborative partners in order to promote the integration of mental health and medical services for ethnically/culturally diverse populations. The cultural and linguistic counselor/consultant will be utilized to enhance the ability of the program to provide culturally/linguistically competent services throughout the service planning and service delivery process.

This program will also work collaboratively with the proposed Transcultural Wellness Center to improve the utilization of mental health services by older adults in the Asian Pacific Islander (API) populations.

Proposed Program

PERMANENT SUPPORTIVE HOUSING PROGRAM FOR INDIVIDUALS AND FAMILIES

1. From your analysis of community issues and mental health needs in the community, identify which initial populations will be fully served in the first three years. Describe each population in terms of age and the situational characteristics.

RESPONSE:

During the Community Needs Assessment, the issue of the need for adequate and stable housing was identified across all age groups (see Part II, Section I). Needs assessment information was gathered from 1,937 people, almost 50% of whom were consumers and family members. Across the board, housing was near the top of the list. With the highest rank of four (4) indicating "a large issue", the Table below shows the rankings from those who provided input.

Table 24. Housing Issues and Concerns by Age Group

Issue	Children/ Youth	TAY (16-25)	Adults	Older Adults
Safe Housing	3.6	3.6	3.5	3.7
Permanent Housing	Not ranked	3.5	3.5	3.6
Affordable Housing	Not ranked	3.7	3.7	3.7

The data clearly indicates that housing is an issue that Sacramento County has identified as a priority to be addressed. Therefore, it is not surprising that a variety of proposals related to housing, for all age groups, found their way into the final prioritizing process.

Age and Situational Characteristics of Population

It is estimated there are between 4,000 and 6,000 homeless adults with persistent mental illness who are untreated in Sacramento County. Clients served by the AB 2034 programs represent only 7% of the untreated population. Other homeless mental health services in Sacramento County do not provide permanent housing, 24/7 response, or comprehensive integrated services as proposed in this program. The lack of safe, affordable and permanent housing contributes significantly to homelessness. Sacramento County has two transitional housing programs that serve 66 clients and are constantly challenged by the lack of affordable housing and the ability to transition clients to stable housing.

Children of homeless families have a greater risk of entering the foster care system and being homeless as adults. Issues of trust, developing positive relationships, mastering developmental milestones, and most important, having the opportunity to learn and achieve in school are all greatly compromised by the lack of stability due

to homelessness. The consequences of homelessness for children with serious emotional disturbances are profound in that it results in inadequate or lack of treatment thus decreasing resiliency and the opportunity for recovery and wellness.

The population of transitional age youth (TAY), ages 16-25, with serious emotional disturbance or serious mental illness poses unique challenges. Homelessness places these youth/young adults at greater risk of unemployment, academic failure, substance abuse, victimization, juvenile/criminal justice involvement, and unplanned pregnancy.

Youth/transitional age youth with serious emotional disturbances who age out of the foster care system in Sacramento County pose the highest risk for homelessness. Many of these youth have serious mental illnesses or serious emotional disturbances related to neglect and the unstable living environments they have endured throughout their lives. This lack of stability contributes to their difficulty in sustaining stable relationships and moving successfully into independence. It is estimated that approximately 45 percent of the youth, who "age out" of the foster care system each year, will have unstable plans that leave them vulnerable to becoming homeless.

Housing is also a primary concern for senior and dependent adults, according to the 2005 Strategic Plan, published by the Senior and Adult Services Division of the Sacramento County Department of Health and Human Services. Increased living costs, reduced incomes, and inadequate support systems make this population vulnerable to challenges of maintaining adequate living environments. Older adults with serious mental illness face additional challenges to maintaining safe and affordable housing. Untreated mental illness of older adults and dependent adults results in functional impairments, which can interfere with self-care abilities, and lead to untreated health conditions, victimization, hospitalization, or institutionalization.

2. Describe what factors were considered or criteria established that led to the selection of the initial populations for the first three years. (Distinguish between criteria used for each age group if applicable.)

RESPONSE:

The Sacramento County MHSA Steering Committee identified the issues of affordable, safe and permanent housing as essential to recovery, resiliency, and wellness. Therefore, they elevated housing and homelessness to their "Number 1 Priority". The priority populations this proposed program will serve are individuals and families having serious mental illness or serious emotional disturbances coupled with long-term and/or cyclical homelessness. Within this population, the initial outreach activities will be geared to transitional age youth and underserved and unserved ethnic populations.

The Sacramento City and County Board of Homelessness Housing Committee reported in FY 2004-05 there were approximately 11,109 homeless individuals in Sacramento County, of which between 35 and 55 percent had a mental illness and/or co-occurring disorder. The homeless populations who are disabled by mental illness deserve the same guarantee of care already extended to those who face other kinds of disabilities. The disparity of services and supports for the homeless are profound and result in inadequate or lack of treatment thus decreasing the opportunities for recovery, resiliency and wellness.

Homeless children and families comprise a significant number of the homeless population. The Sacramento County Office of Education identified approximately 5,000 homeless children in the county in FY 2003-04. Currently the Sacramento Division of Mental Health has 54 children enrolled in either day shelter or transitional housing at any one time. This leaves the majority of the children unserved without housing alternatives. The number of these children with serious emotional disturbances is unknown since their homeless status divorces them from the mainstream of mental health services. However, it is assumed there are a significant number of children with mental health issues given the instability, limited resources, and limited access to health/mental health services. This population remains profoundly underserved in that the federal homeless funding (HUD/McKinney) does not consider children/families as part of the chronically homeless.

Transition age youth with serious emotional disturbances comprise one of the largest challenges within the homeless population. Many do not meet the traditional definition of homelessness (unsheltered, on the streets, or in a homeless shelter); therefore, they are underrepresented in annual homeless counts. Sacramento County Division of Mental Health currently provides services to only 40 homeless transition youth with mental health issues. Many homeless youth have aged out of the foster care system and are not connected to mental health services. They frequently do not possess the life skills in which to manage housing, work, or health/mental health issues. The incidence of dual disorders in the population has been projected to be at the 90% level.

The most frequent information request received by Sacramento County's InfoLine and the Older Adult Resource Center is related to finding affordable housing and housing resources for older adults. In Sacramento County, there is a serious lack of affordable housing that can also accommodate those with accessibility requirements. The lack of affordable housing is compounded for older adults with serious mental illness, in that they frequently lack resources or support systems. Within Sacramento County's homeless population is it estimated that approximately 10% are older adults. It is assumed that the majority of these older adults have serious mental illnesses that have led to or resulted from their homeless status. It is speculated the low number of homeless older adults may be attributable to a higher death rate among the homeless with many not reaching an older age.

3. Please discuss how your selections of initial populations in each age group will reduce specific ethnic disparities in your county.

RESPONSE:

To start to understand the ethnic disparities within the homeless population, data was compiled from nine existing Sacramento County homeless shelters and reviewed from May 1, 2004, to April 30, 2005. Table 2 shows the ethnicity of the adults and children in the shelters during that time frame:

Table 25. Summary of Demographic Data from Nine Sacramento County Homeless Shelters

Ethnicity	Number of Adults	Number of Children*
African American	796	194
American Indian/Alaska Native	81	22
Asian	23	4
Caucasian	961	100
Declined to State	3	0
Hawaiian	6	0
New Category	1	0
No answer	77	12
Other	199	37
Other Polynesian	12	16
Polynesian	1	0
Samoan	1	0

* Children under 18 years of age

The Sacramento County Division of Mental Health is aware of the great diversity in the county and the data in Table 2 substantiates that diversity also exists for the homeless population. Therefore, the Division will request that any successful bidder establish a multi-cultural program with the bi-cultural, bi-lingual ability to serve populations that need supportive housing. Funding to address the pay differential for bi-cultural/bi-lingual staff is included in the cost of the program staff.

One obstacle to understanding ethnicity of this population is the methodology for gathering ethnic information. The United States Department of Housing and Urban Development (HUD) does not consider “Hispanic” to be an ethnicity; it is referred to as “race”. Consequently, Sacramento County’s Homeless Management Information System conforms to the HUD standard and when gathering demographic information asks clients to identify themselves first by race and then by ethnicity.

The ethnicity data from the nine shelters shown in Table 2 does not list any Hispanics as being shelter residents. However, in looking at the same time frame and data related to race, 240 individuals identified themselves as being members of the “Hispanic” race. Therefore, 240 Hispanic adults were in the 9 shelters but they were not counted under the ethnicity category, and in all likelihood were listed as

"Other" or "No Answer". This highlights the difficulty in understanding the ethnicity of the homeless populations and identifying the underserved and unserved.

It is known that the number of Hispanics in the county accounts for a significantly large percentage of the population. Historically, the Latino populations have been underserved or unserved due to challenges in being uninsured and undocumented, contributing to their limited access to health and mental health services. Therefore, to address housing issues among the Latino population, creative outreach methods will be used and cultural understanding will go hand in hand with the linguistic capability.

In this three-year plan, the Sacramento County Division of Mental Health is proposing a full service partnership for the Asian and Pacific Island (API) population, titled the Transcultural Wellness Center. There will be no effort to duplicate the outreach and treatment efforts of the Transcultural Wellness Center in this proposed supportive housing program. Issues of housing are treated differently in many parts of the API community, in that it is culturally acceptable for extended family to live in the same household, even when it leads to over-crowded conditions necessitated by financial constraints. Also, due to issues of stigma and shame, API families with members suffering from serious mental illness keep the family member in the home. This can lead to increased family stress and conflict. Outreach, engagement, and education accomplished by the Transcultural Wellness Center are designed to promote the use of the supportive housing program. Staff from the Transcultural Wellness Center and Permanent Supportive Housing Program for Individuals and Families will work collaboratively to ensure the supported housing needs of the API community are met in a culturally competent manner.

Because there are some communities that do not avail themselves of the existing homeless programs and are therefore not represented in the statistics, three steps will be taken to ensure this program is responsive to community, cultural, and linguistic needs:

- outreach to each cultural/ethnic community for mutual identification of goals;
- development of housing programs and supportive services that meet those mutually identified goals; and,
- the ability to adapt as needs are clarified or new needs are identified.

Proposed Program

TRANSCULTURAL WELLNESS CENTER

1. From your analysis of community issues and mental health needs in the community, identify which initial populations will be fully served in the first three years. Describe each population in terms of age and the situational characteristics.

RESPONSE:

The mental health concerns of the Asian and Pacific Island (API) communities (Cambodian, Chinese, Fijian, Filipino, Hawaiian, Hmong, Japanese, Korean, Laotian, Mien, Samoan, Tongan and Vietnamese) are largely unmet by the current mental health system in Sacramento County. According to the data in the Sacramento County Cultural Competence Plan Update (September 2003), there are no programs and services that are adequately staffed and funded to provide linguistically and culturally competent full-service mental health care for these populations. Consequently, many members of these communities, especially monolingual refugees/immigrants and their family members, suffer from undiagnosed, misdiagnosed, and untreated mental illness.

This intergenerational program intends to address a range of needs, ages, genders, and types of diagnoses prevalent in the API communities, as illustrated in the following examples:

- Monolingual refugee/immigrant adults and older adults with serious mental illness who suffer from acute levels of mental deterioration and functional impairment
- Monolingual refugee/immigrant women with serious mental illness in domestic violence situations who suffer alone and endure physical and emotional abuse
- Youth and transition-age youth (TAY) with serious emotional disturbance who are children of refugee/immigrant parents or less acculturated parents and are at high risk for suicide and delinquent behaviors

The focal population also includes APIs who do not qualify for Medi-Cal or private insurance due to immigration status or income level and are therefore uninsured or underinsured.

2. Describe what factors were considered or criteria established that led to the selection of the initial populations for the first three years. (Distinguish between criteria used for each age group if applicable.)

RESPONSE:

The API communities have been underrepresented in the Sacramento County Mental Health system. The penetration rate of API ethnicities is lower in all

categories than the Caucasian population as well as the State and County averages for all ethnicities. Table 26, below, provides data from the Sacramento County Cultural Competency Plan Update (September 2003) and compares the penetration rates of specific ethnic groups with the State average, County average, and the penetration rate for Caucasians.

Table 26. Comparative Penetration Rates for County Mental Health Clients and All Clients Identified as API

Sacramento County	
Ethnicity	Penetration Rates*
State Average	6.13
County Average	6.47
Caucasian	8.50
Pacific Islander	1.95
Cambodian	4.63
Chinese	0.67
Filipino	2.59
Hawaiian	4.46
Japanese	4.48
Korean	1.52
Laotian	0.93
Samoan	1.53
Vietnamese	0.67
Avg. All API	2.34

*Number of mental health clients divided by the number in the Medi-Cal population

Table 27, below, lists penetration rates of API clients based on their primary language. It shows that the statistics on penetration rates within Sacramento County for API for whom the primary language is other than English is even less representative for all languages except Japanese. Even with the spike in Japanese-speaking clients, the average non-English speaking API penetration rate is less than a third of English-speaking clients.

Table 27. Comparative Penetration Rates for County Mental Health Clients and API Clients with Primary Language Other than English

Sacramento County	
Language	Penetration Rate*
State Average	6.13
County Average	6.47
English	7.01
Hmong	1.05
Vietnamese	0.72
Cantonese	0.64
Mien	1.85
Lao	2.19
Japanese	9.09
Korean	0.72
Cambodian	1.47
Thai	0.00
Tagalog	0.36
Avg. All API	1.80

*Number of mental health clients divided by the number in the Medi-Cal population

The averages in the above tables are not weighted by percentage in the sub-populations, yet even as unweighted numbers they help point to the disparity in API populations singly and as a cluster. The Transitional Wellness Center is intended to treat all API populations in family-oriented treatment modalities; no age group or ethnicity within the Asian-Pacific Islander population will be singled out for emphasis or exclusion during the first or subsequent years. Programs will be developed for the special needs of different language and age groups. For example, older monolingual age groups may require more language-specific programs than the younger and bi-lingual group members.

Likewise, the representation of API ethnicities among Sacramento County's direct service staff, regardless of language skills, is lower than expected. This reality contributes to the difficulty in reaching and treating the API populations. It also reflects the unfamiliarity and discomfort these populations experience with the concepts of mental illness, mental health, and the possibilities of positive interventions and healing. To counter this trend, special efforts will be made to link with the California State University, Sacramento (CSUS), Masters of Social Work (MSW) program, focusing on the Southeast Asian immigrant and refugee experience, local community colleges, and Adult Education Programs (including English as a Second Language classes) to identify and recruit bilingual/bicultural students interested in staff positions. The program will also recruit graduate students in the MSW and Marriage and Family Therapy (MFT) programs.

3. Discuss how your selections of initial populations in each age group will reduce specific ethnic disparities in your county.

RESPONSE:

The Transcultural Wellness Center was recommended by the Cultural Competence Task Force and its Stakeholder Groups specifically to address the disparities in ethnic representation within the Mental Health system. Despite the relatively large number of API residents in Sacramento County, the API community is underrepresented in all age groups and all ethnicities within Mental Health, according to the data in the Sacramento County Cultural Competence Plan Update (September 2003). The Transcultural Wellness Center is designed to offer linguistically and culturally sensitive and appropriate outreach and engagement efforts to this unique population. Within the first three years, the annual goal is to bring services to 250 members of the API community with mental health treatment needs.

While all cultural and ethnic groups are welcome to services at the Transcultural Wellness Center, staff with bilingual/bicultural skills will specifically focus on services to individuals and families of all age groups from the API community. Age-related targets will be established for the first year, based upon relative numbers within the total populations. Underserved populations within the focal age populations will be targeted. For example, API youth with unmet mental health needs who are involved in the juvenile justice system will be targeted and engaged. Similarly, outreach will occur to API older adults who have been isolated with their psychiatric disabilities. While recognizing that outreach efforts must be especially targeted to reach some underserved age groups, it is important to remember that the API communities share a common cultural focus on the family as a structural foundation. The strength of the Transcultural Wellness Center is its recognition of this unique cultural characteristic and its focus on family groups and the delivery of family-oriented treatment modalities. Thus services will be inclusive of all family members.

This model will afford an effective delivery system for the following: culturally appropriate wellness and recovery, psychotherapy, counseling, psychiatric consultation, medication support, service coordination/case management, networking, peer support, and interpreter/translator and psycho-educational services. Services will be based on needs expressed by the community and demand-driven under the direction of a Steering Committee representing the community interests. Outreach and engagement efforts will be directed toward all API populations through the media, churches, temples, community centers, schools, and one-on-one through community leaders.

The staff will also work with other systems, such as Child Protective Services (CPS), Adult Protective Services (APS), and the criminal and juvenile justice systems, to divert individuals with serious mental illness from these systems when it is appropriate. It is anticipated that staff interactions with these systems will lead to their increased awareness of API cultural issues.

Section IV: Identifying Program Strategies

1. If your county has selected one or more strategies to implement with MHSA funds that are not listed in this section, please describe those strategies in detail in each applicable program work plan including how they are transformational and how they will promote wellness/recovery/resiliency and are consistent with the intent and purpose of the MHSA. No separate response is necessary in this section.

REPONSE:

All of the strategies that our county proposes to implement are included in the list found in Section IV of the Three-Year Program and Expenditure Plan Requirements.

Section V: Assessing Capacity

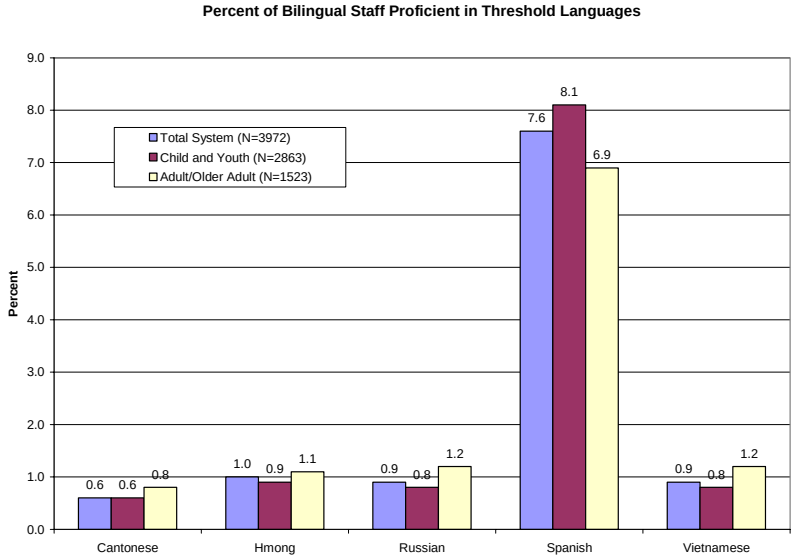
1. Provide an analysis of the organization and service provider strengths and limitations in terms of capacity to meet the needs of racially and ethnically diverse populations in the county. This analysis must address the bilingual staff proficiency for threshold languages.

RESPONSE:

Sacramento County collects information on an annual basis from all organizational providers of mental health services regarding the demographic characteristics of staff. Specific levels of staff we ask about include: Board of Directors, Administration/Management, Direct Services, Clerical Support, Interpreters/ Translators, and "Other" (which typically includes volunteers, interns, etc.). The information we collect includes: Ethnic Background (with an opportunity to indicate whether staff are consumers or family members), Language Proficiency in speaking languages other than English, Language Proficiency in reading/writing languages other than English, and the opportunity for staff to indicate their gender, their sexual orientation, and whether they self-identify as disabled (the latter three items are voluntary). The information presented here and in #2 below, is derived from the data we gathered from the 2004 Human Resources Survey. With the exception of Boards of Directors, the information presented below includes all staff.

Data are presented below that indicate the percent of staff who have the language proficiency to speak in each of Sacramento County's current threshold languages. The data are presented for the system as a whole, as well as for programs that serve TAY/adults/older adults OR children and youth/TAY. The total number of staff is less than the sum of both types of programs because some of our providers serve ALL age groups. Please note that 11% of our staff reports being proficient in at least one of our threshold languages.

Figure 1

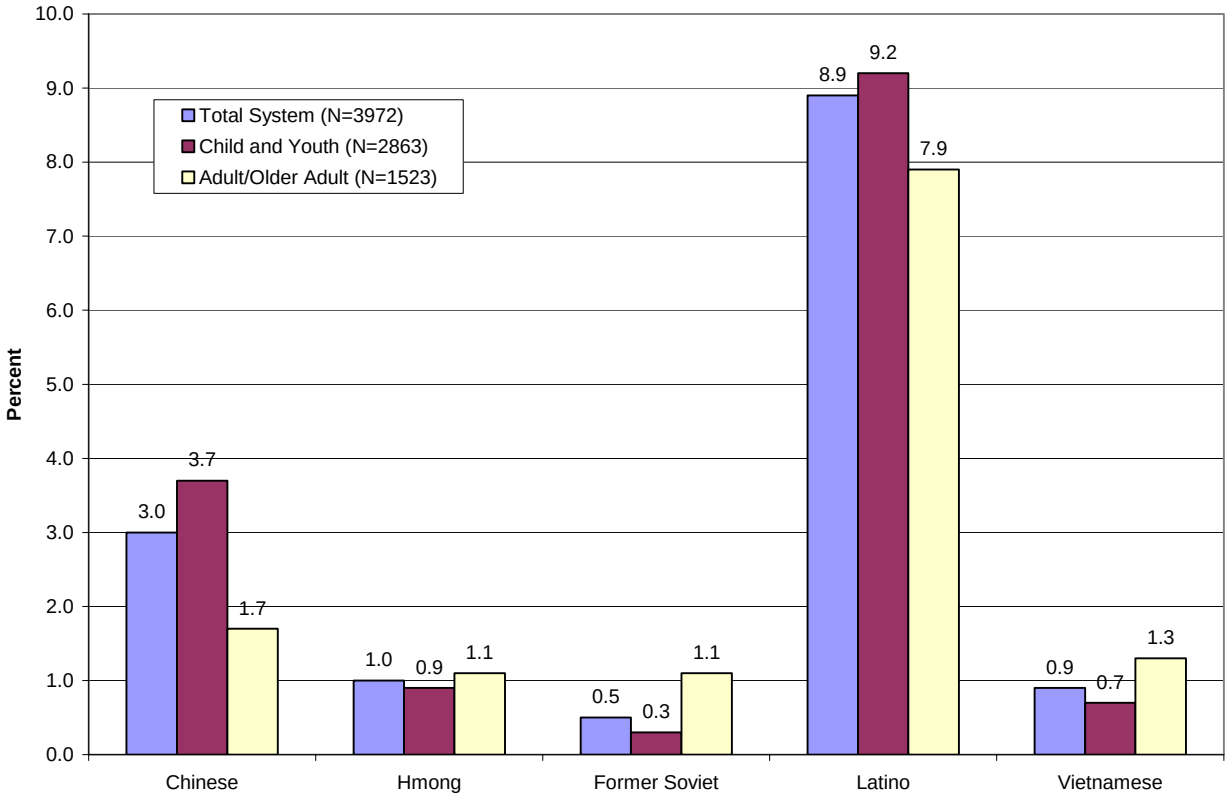


As the data indicate, we have somewhat higher percentages of staff who serve adults and older adults who are proficient in Cantonese, Hmong, Russian, and Vietnamese. This, of course, is very important given that adults and older adults are much more likely to be monolingual than children and youth. It is clear, however, that the percent of staff who are proficient in each of these four languages needs to increase. The magnitude of increase will be discussed in Question #2 below.

Next, data are presented that indicate the percent of staff who fall into the race/ethnicity categories that correspond to the threshold languages. The data paint a picture similar to that of the language data. Specifically, Sacramento needs to develop greater representation from several ethnic communities in its workforce.

Figure 2

Percent of Staff in Threshold Languages-Related Race-Ethnicity Categories



2. Compare and include an assessment of the percentages of culturally, ethnically and linguistically diverse service providers as compared to the same characteristics of the total population who may need services in the county and the total population currently served in the county.

RESPONSE:

Data are presented in a table at the end of this section. Data from the annual Human Resources Survey are presented along with the County Poverty Population and County General Population Data for both race/ethnicity and primary language. Generating the information for this table highlighted something we have previously overlooked in collecting information for the Human Resources Survey. That is, we have not asked people to specifically note whether they are multi-ethnic. Multi-ethnic has typically been coded in the "Other" category.

The data are very interesting. Regarding race/ethnicity, African American staff is somewhat over-represented when compared to the population data. On the other hand, Asian/Pacific Islander and Latino staff members are both under-represented. In fact, doubling the percentage of staff in both populations would benefit Sacramento County. The proportion of Caucasian and Native American staff is fairly representative of the population proportions.

Regarding primary language, it appears that the proportions of staff who speak Hmong, Vietnamese, and Russian are pretty much in line with what the population looks like. It is difficult to ascertain how well our staff meets the Mien need, as those county data are not available. It is clear, however, that we do not have sufficient staff who are proficient in either Spanish or Cantonese. Sacramento County will work towards increasing the percentage of Spanish speaking staff by approximately 30% and Cantonese speaking staff by 300% in order for the proportions to align with the county population.

Table 28 (next page) provides a summary of this assessment.

Table 28. Comparison of County Mental Health Staff by Program and Assignment with Ethnicity, Language, and % of County General and Poverty Populations

Race/Ethnicity	Adult/Older Adult Staff		Child/Youth Staff		All Staff		County Poverty Population		County Population	
	N	%	N	%	N	%	N	%	N	%
African American	298	19.6	402	14.0	617	15.5	18969	11.8	66796	10.0
Asian/Pacific Islander	145	9.5	268	9.4	353	8.9	24461	15.2	96157	14.4
Latino	121	7.9	262	9.2	355	8.9	32535	20.2	123756	18.6
Native American	13	0.9	36	1.3	44	1.1	1882	1.2	11132	1.7
White	780	51.2	1639	57.2	2237	56.3	76237	47.2	353402	53.0
Multi-Ethnic							6670	4.1	15321	2.3
Other	166	10.9	256	8.9	366	9.2	642	0.4		

Primary Language	Adult/Older Adult Staff		Child/Youth Staff		All Staff		County Poverty Population		County Population	
	N	%	N	%	N	%	N	%	N	%
English	1523	100.0	2863	100.0	3972	100.0	not available		508327	76.3
Spanish	105	6.9	232	8.1	302	7.6			65248	9.8
Cantonese	12	0.8	17	0.6	23	0.6			13713	2.1
Mien	6	0.4	6	0.2	10	0.3				0.0
Hmong	17	1.1	26	0.9	40	1.0			6220	0.9
Vietnamese	19	1.2	23	0.8	36	0.9			8588	1.3
Russian	19	1.2	22	0.8	35	0.9			6543	1.0
Other	124	8.1	158	5.5	206	5.2			57925	8.7

* Totals are greater than the total number of staff because staff can speak more than one language

3. Provide an analysis and include a discussion of the possible barriers your system will encounter in implementing the programs for which funding is requested in this Plan and how you will address and overcome these barriers and challenges. Challenges may include such things as difficulty in hiring staff due to human resources shortages, lack of ethnically diverse staff, lack of staff in rural areas and/or on Native American reservations and rancherias, difficulties in hiring clients and family members, need for training of staff in recovery/wellness/resiliency and cultural competence principles and approaches, need to increase collaborative efforts with other agencies and organizations.

RESPONSE:

This plan anticipates and addresses many challenges that can be expected in implementing the proposed programs.

- The challenge of recruiting and retaining culturally and linguistically competent staff requires on-going efforts. The diversity of the county contributes to the increased need for bi-lingual, bi-cultural staff. The number of threshold languages in Sacramento County has fluctuated between 5 and 7 over the last 8 years. Additionally, there are numerous relatively sizeable refugee communities that are unserved but do not meet current threshold language requirements. This Plan addresses some of those human resource issues as follows:

  - Many of the programs will be provided by contract with a community organization, providing more hiring flexibility than is available to the County.
  - Staff at all levels will be required to demonstrate bi-lingual/bi-cultural skills.
  - Linkages with the local colleges and training centers will be used to recruit staff with the necessary special skills. This includes development of a collaborative partnership with California State University, Sacramento--Division of Social Work Masters program project that focuses on Southeast Asian Immigrant and Refugee Experiences.
  - Bi-lingual differential pay for service staff has been factored into all program budgets

- Building and maintaining trusting relationships with cultural and ethnic communities is an on-going challenge. Significant outreach and engagement efforts will be directed throughout the target communities.

  - Outreach workers will make contacts through community centers, worship houses, recreation facilities and other culturally specific gathering places.
  - Outreach and engagement efforts will utilize radio, television, and print media relevant to the target communities.

- A designated Cultural Competence Program Coordinator functioning under the direction of the Ethnic Services Manager will coordinate outreach and engagement to diverse ethnic and cultural communities as well as to special populations including transitional age youth and older adults.
- Each program recommended for implementation by the Community Services and Supports Plan includes a community-based outreach and engagement component with specialized training in serving diverse ethnic and cultural communities as well as the special populations described above.

- Stigma is often an issue for these ethnic communities. The program will target the shame and stigma issues that prevent people from diverse communities from accepting mental health services.
  - A Steering Committee representing leaders from various racial and ethnic communities and age levels will advise on program directions.
  - A broad range of activities will be available to attract family members of various ages, interests, and levels of acculturation.
  - Natural healers and cultural rituals will be incorporated in treatment modalities as appropriate.
  - Treatment will focus on linguistically and culturally sensitive modalities.

- It is essential that staff members at all levels are well trained in the principles of recovery and resilience. Additionally, an understanding of the impact of culture on wellness, recovery, and resiliency is critical for the achievement of positive outcomes. One- time only money will be devoted to training in this area.

- Ensuring that all staff understand and are committed to the principles and practices of cultural competence is essential to the overall success of MHSA programs. A comprehensive training program in cultural competence has been developed and will be funded with one-time only money.

Part II, Section VI-I: Developing Workplans with Timeframes and Budgets/Staffing

I. Summary information on Programs to be Developed or Expanded

1. Please complete exhibits 1,2, and 3, providing summary information related to the detailed work plans contained in the Program and Expenditure Plan.

RESPONSE:
See Exhibits 1, 2, and 3 in this document.

2. The majority of a county's total three-year CSS funding must be for Full Service Partnerships. If individuals proposed for Full Service Partnerships also receive funds under System Development or Outreach and Engagement Funding, please estimate the portion of those funds that apply toward the requirement for the majority of funds during the three-year period.

RESPONSE:

Exhibit 2 sets forth a listing of Program Work Plans with funds requested by function and target group. The figures listed for Full Service Partnerships in the following data have been revised to include one-time CSS funding Expenditures included in the FSP budget as well as a pro rata share of General System Development funds based on estimated penetration of FSP enrollees into SD Programs

Type of Funding	FY 05/06	FY06/07	FY07/08	Total	%
Full Service Partnerships[1,2]	$5,556,649	$4,717,926	$4,608,175	$14,882,750	51.3%
General System Development	$1,117,433	$3,503,274	$3,613,025	$8,233,732	28.4%
Outreach & Engagement[3]	0	0	0	0	0%
Sub Total	$6,674,082	$8,221,200	$8,221,200	$23,116,482	79.7%
Non-Program Specific One-Time	$1,547,118	0	0	$1,547,118	5.3%

1 Includes program specific one-time CSS Funding Expenditures as reported on budget worksheet

2 Includes pro rata share of General System Development funds expected to be expended on FSP enrollees

3 **Although no funding was dedicated to Outreach and Engagement, it is anticipated that each program will conduct outreach and engagement activities in the normal course of business (see program narratives).**

3. Please provide the estimated number of individuals expected to receive services through System Development Funds for each of the three fiscal years and how many of those individuals are expected to have Full Service Partnerships each year.

RESPONSE:

Table VI.I. (3) Number of individuals expected to receive services through System Development Funds for each of the three fiscal years of the plan and expectation for enrollment in Full Service Partnerships

Year	N of Individuals	Expected to Have FSP
FY2005-06	907	33
FY2006-07	3,928	141
FY2007-08	3,928	23

4. Please provide the estimated unduplicated count of individuals expected to be reached through Outreach and Engagement strategies for each of the three fiscal years and how many of those individuals are expected to have Full Service Partnerships each year.

RESPONSE:

Year	N of Individuals	Expected to Have FSP
FY2005-06	752	113[4]
FY2006-07	3,512	351[4]
FY2007-08	3,255	96[4]

4 Estimates assume replacements enrolled to replace members lost to projected attrition from FSP over 3-year funding cycle

5. For children, youth, and families, the MHSA requires all counties to implement Wraparound services pursuant to W&I Code Section 18250 or provide substantial evidence that it is not feasible in the county in which case counties should explore collaborative projects with other counties and/or appropriate alternative strategies. Wraparound programs must be consistent with program requirements found in W&I Code sections 18250-18252. If Wraparound services already exist in a county, it is not necessary to expand these services. If Wraparound services are under development, the county must complete the implementation within the three-year plan period.

RESPONSE:

In Sacramento County, Wraparound Services have been provided for more than six years as an ongoing collaborative project involving departments of Mental Health, Probation, and Social Services. There are currently four agencies providing Wraparound Services Within the County:

- River Oak Center for Children (since 1999)
- Eastfield Ming-Quong (since 1999)
- Stanford Home for Children (since 2000)
- Sacramento Children's Home (since 2003)

Since Wraparound Services have been fully implemented in Sacramento County since 1999 they are not addressed by this submission. It goes without saying that Sacramento County has made an enduring commitment to the spirit of wraparound and that these principles have been incorporated into MHSA planning wherever possible.

Part II, Section VI – II: Programs to be Developed or Expanded

Proposed Program
TRANSITIONAL COMMUNITY OPPORTUNITIES for RECOVERY and ENGAGEMENT
Workplan #SAC1

1. Complete Exhibit 4

RESPONSE:

See Exhibit 4.

2. Describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

RESPONSE:

In developing this proposed program the MHSA goals (as set forth in Section 3 of the Act) and the MHSA Guiding Principles served as a template to create a program that will provide timely access for young adults, adults, and older adults with the most serious and intractable symptoms of mental illness with comprehensive and flexible mental health treatment, support, and services

Individuals within this serious mental illness population are un-served and underserved in Sacramento County's public mental health service system. This is substantiated by a recent sample that showed approximately 60% of the individuals hospitalized at the Sacramento County Mental Health Treatment Center (MHTC) were unlinked to outpatient services. This figure is higher than other inpatient samples that depict approximately 50% unlinked clients.

Specialty mental health services that provide multidisciplinary assessment and treatment are extremely limited in Sacramento County, and are not adequate to meet the current and projected needs of Sacramento's growing population. Due to the difficulty in accessing mental health services, many who suffer from a serious mental illness go undiagnosed and untreated. Without access to appropriate culturally competent multidisciplinary assessment, treatment, and intensive case management services, these consumers are at risk for functional deterioration, hospitalization, re-hospitalization, homelessness, and law enforcement intervention and incarceration.

There was strong support for the Transitional Community Opportunities for Recovery and Engagement (CORE) program and its service strategies throughout the MHSA planning process. The MHSA Adult Task Force ranked it #2 and the MHSA Steering

Committee ranked it within its top 3 recommendations for funding. Therefore, the CORE Program is being proposed to specifically address this un-served and underserved population of individuals who have the greatest functional impairments and complex mental health needs.

The design and components of the Core Program will be true to the purpose and intent of the MHSA in that it:

- defines serious mental illness as a condition deserving priority attention;
- reduces the long-term adverse impact from untreated serious mental illness;
- expands successful and innovative service programs, including culturally and linguistically competent approaches;
- provides state and local funds to adequately meet the needs of individuals enrolled in programs; and
- ensures funds are expended in the most effective manner and services are based on best practice.

Therefore, using the MHSA goals as its guide, the CORE Program will address the gap in available specialized mental health transitional programs for young adults, adults, and older adults in Sacramento County with serious mental illness. The program will be modeled after the Assertive Community Treatment (ACT) model of care that evolved from the work of Arnold Marx, M.D., Leonard Stein, M.D., and Mary Ann Test, Ph.D., in the late 1960s.

Adhering to the treatment principles of ACT, the program will offer intensive community-based mental health services, conducted by a multi-disciplinary team that will provide culturally appropriate, specialized mental health services with intensive case management, dual diagnosis treatment when needed, and service coordination with other service providers. The program will also provide an opportunity to promote wellness and recovery and to reduce the need for crisis services, hospitalization, and institutionalization.

The program's target population will be comprised of individuals referred from the acute care system (i.e., MHTC, local acute psychiatric hospitals, the Crisis Stabilization Unit, Jail Psychiatric inpatient unit, or the Crisis Residential Program), as well as clients who are at risk of needing acute psychiatric services. They include age 18 young adults, adults, and older adults who meet the core and expanded target population definition with a Serious Mental Illness (SMI) and/or co-occurring disorder, or are eligible by definition of medical necessity. The target population in Sacramento is defined as individuals meeting a systematized listing of diagnoses and disabling conditions established as criteria for care in the Sacramento County public mental health system. These individuals will be in transition, awaiting services from a Regional Support Team or other outpatient mental health services. They often have to wait up to three months to access services from a Regional Support Team and need continued transitional services to maintain stabilization prior to linkage to longer-term mental health services. This multi-disciplinary team approach is intended to bridge the gap of services from the Mental Health Treatment

Center and other acute settings to the outpatient services available in the community. Referrals for the CORE program will also come from the ACCESS teams, the Geriatric Network, or Jail Psychiatric Services program for those clients who may need the transitional support of the program prior to accessing linked services.

The majority of the services the CORE teams will deliver will be provided in community settings with individuals who need assistance maintaining stabilization and reaching their mutually agreed upon goals. The team may support the individual in work settings, home, or other community settings that meet the needs of the consumer. This may include, but is not limited to, working with members of the community such as landlords or employers to provide psychological education regarding mental illness, wellness, resilience, and recovery, and advocates for consumer rights. The CORE team members will be cross-trained to assist consumers in their efforts toward wellness and recovery, based on the consumers' needs rather than the team members' designated titles/positions.

Program Design Features

The following are key program design features:

- The program is designed to serve 250 clients annually at any given time. There will be a 1:12 caseload ratio.
- The program's services will be provided in community settings such as an individual's home and neighborhood, local restaurants, parks, nearby stores and other locations deemed appropriate by the consumer;
- Services will be available 24 hours a day, 7 days a week. Team members may interact with a client with acute needs multiple times a day. As the client stabilizes, the client will receive tailored services to his/her needs throughout the service period. Service type and frequency will vary depending upon an individual's needs.
- Supportive educational services will be available upon request for clients and their families that facilitate the roles of collaborative partners in the recovery process. Culturally appropriate information will be provided about mental illness and the skills needed to better manage mental illness in the context of daily life.
- Community integration is central to the CORE program to assist clients to combat social isolation and encourage participation in community activities and membership in organizations of their choice.
- Health education, access, and coordination of health care services will be essential to the program.
- The program services will be considered ongoing until the consumer has been linked and transitioned to appropriate longer-term mental health services.
- The program goals will be to: enable participants to find and live in their own residence, find and maintain work in community jobs, better manage symptoms,

achieve individual goals, maintain optimism and hope for the future, and to recover (as defined by the participant). Meeting these goals will reduce or prevent the need for crisis services, hospitalization, and institutionalization, reduce inpatient hospitalizations of unlinked individuals, increase community-based services for unlinked individuals, decrease no-show rates for new RST intake assessment appointments (i.e., service coordinator and physician), increase diversions from MHTC Crisis Unit into the outpatient service system (i.e., CORE), and to promote cultural competence, wellness, recovery, and resilience.

Program Service Components

The components that make up the Transitional Community Opportunities for Recovery and Engagement (CORE) program have incorporated the goals and guiding principles of the MHSA to build a program that looks beyond "business as usual" and moves toward transforming the Sacramento County Mental Health system. The program components are listed as follows:

Initially, a bio-psychosocial assessment that includes a cultural formulation will be conducted to determine the mental health, physical health, substance abuse, and social service needs of the client. The services will be consumer-driven, thus establishing the consumer as central to all decision-making and service selections. The program's service delivery system will be culturally and ethnically competent with collaboration with multiple disciplines, agencies, and facilities. Examples of some of the services that will be available are as follows: counseling and guidance, crisis intervention, medication management, case management, coordination of services from other agencies, vocational exploration, benefits planning and counseling, specialized employment assessments in the community; college and university education, linkage to ESL classes, vocational training, job search and placement assistance, transportation, employment support on and off the job site, tools and equipment, work clothing, assistive technology, and self-employment technical assistance.

Treatment Services: The CORE program will endorse a wellness and recovery philosophy and the treatment services will be similar to the Wellness and Recovery Action Plan. The Wellness Recovery Action Plan (WRAP) was developed by Mary Ellen Copeland, MS, MA. Copeland explains: "WRAP is a structured system for monitoring uncomfortable and distressing symptoms and, through planned responses, reducing, modifying or eliminating those symptoms." WRAP is not about clinical professionals telling clients what they need to do to get better or healthy: WRAP is a system of interventions to help figure out what the clients may need to do to help them recover.
The members of the CORE treatment team will use the basic recovery principles (hope, personal responsibility, education, self-advocacy, support, seeking good healthcare, and medication management) to deliver an integrated array of treatment interventions that will be customized with client input. This will include considerations of community and cultural norms to more adequately address the

preferences of multicultural consumers. One critical treatment intervention will be the coordination of substance abuse services. Treatment plans will be modified as needed through an ongoing assessment and goal setting process. Clients will be encouraged to invite family members or friends to participate in their treatment.

Treatment services may begin while clients are in acute settings to facilitate and ease the transition to the community. As the client stabilizes, the services will be tailored to their needs throughout the transition from the acute environment of a hospital setting to the least restrictive environment possible.

Intensive Case Management Services: The CORE team members will adopt a "whatever it takes" philosophy to provide services and supports that will promote wellness, recovery, and resilience for multicultural clients. The team members will be pro-active with clients, assisting them to participate in and continue treatment, live independently, both physically and emotionally, as culturally appropriate, and recover from disability. All team members will work collaboratively to enhance the coordination of needed services, including peer support from team members and connecting the clients/families to needed community resources.

Program services will be field-based, providing in-home assessment and treatment services when necessary. The CORE multidisciplinary team members will use their own vehicle when necessary and be reimbursed for mileage and expenses.

Transportation can be a barrier to accessing mental health services. If clients require community services and supports and are not able to access or pay for transportation, they will be provided assistance with transportation via vouchers for Paratransit, or taxi services or other alternative means of transportation as deemed culturally appropriate.

Program Service Strategies:

The service strategies that will be utilized by the Transitional Community Opportunities for Recovery and Engagement program are listed in Exhibit 4. They are consistent with those identified in Section IV of the *DMH Community Services and Supports Program and Expenditure Plan Requirements.*

Training:

This workplan for the CORE Program is one important component of transformation of mental health services in Sacramento County. It is necessary to the process of transformation but it is not sufficient in itself to produce system wide change. For this reason we are proposing to enhance the efficacy of this workplan by adding system-wide training in a variety of wellness and recovery model values and practices.

We believe that if transformation is truly to occur, all staff members must become familiar with the values, goals and practices of recovery and wellness. Unless we immerse the entire system in new ways and change our culture from "fail first" to

"whatever it takes," our workplans, no matter how well conceived, will become no more than old practices in new packages.

Equally important with training in wellness and recovery model values and practices is staff development of competence in serving persons of every culture, language group, and ethnicity. No matter how transformative the practices, if our staff is not mindful of culturally relevant practices, the transformative practices will fail and, in failing, further deny access to the very people for whom they were designed. Accordingly, we regard training in cultural competency, co-occurring disorders, and elder adult issues, across all programs and the entire Mental Health Division, to be essential to the success of our entire MHSA initiative.

Program Personnel

In accordance with the MHSA goals, all staff will be skilled in working within a multidisciplinary team framework and collaboratively with other disciplines, agencies, and facilities. To further the transformation of the mental health system, staff will be expected to have forward thinking that includes innovative and creative ideas. Team members will have experience in substance abuse treatment, wellness, recovery, resiliency treatment, cultural competence, employment and/or vocational services, peer advocacy and consumer advocacy. Staff will be culturally and linguistically diverse, highly flexible, and trained in community resources and recovery philosophy. Team members will be cross-trained to maximize the program's service capacity.

- The Program Director will be responsible for fiscal integrity of the program and will supervise all treatment team personnel and ensure legal and ethical practices are infused in the program guidelines and policies. Further, the program director will infuse cultural competence, and wellness and recovery principles and philosophy into the CORE program model.
- The Mental Health Clinical Director/Quality Assurance Coordinator will be responsible for clinical oversight of the treatment team, case staffing, review of charts for accuracy and compliance and other quality management duties. This individual will ensure the service plan is family/client focused; culturally competent; strength based and attainable in the transition time; will establish and maintain effective positive relationships with clients, as well as, all members of the multidisciplinary team.
- The Senior Mental Health Counselors will be licensed/waived mental health professionals functioning as the lead worker and will be assigned the more complex and difficult tasks and interventions. These positions will have the responsibility of providing guidance, consultation, and direction to lower level professionals and paraprofessionals as a team leader within a given shift or function, as well as in crisis situations. These positions will also coordinate with team members, probation officers, teachers, community and support services, and appropriate referrals for clients. The will work with other agencies to obtain

information, coordinate services, determine appropriate venue for services, and related matters.

- The Mental Health Counselors/Dual Diagnosis Specialists will be licensed/waived mental health professionals providing mental health treatment services including assessment, diagnosis, crisis intervention, individual and group counseling, non-medical psychotherapy, and will maintain records related to patient or client services. They will coordinate with team members, probation officers, teachers, community and support services, and appropriate referrals for clients. They will work with other agencies to obtain information, coordinate services, determine appropriate venue for service, and related matters.
- The Mental Health Rehabilitation Specialists will have the responsibility of providing an assessment for new clients and assisting with service plan development and implementation. They will work collaboratively with the team members, family, client, and friends to develop a service plan designed with goals to promote wellness, resilience, and recovery appropriate for clients from diverse cultures.
- The Psychiatric Nurse will be knowledgeable in professional nursing principles, cultural competence, procedures and techniques used in the care and treatment of psychiatric clients, medical and psychiatric terminology, and medications, including narcotics. The position will require knowledge of basic laws and regulations pertaining to psychiatric nursing and treatment of individuals with SMI, social community resources available to patients, first aid, and basic medical concepts for assessing and treating clients. This position will perform professional nursing duties while caring for SMI clients, advise and collaborate with other team staff in diagnosis and treatment planning, and assist and participate in various administrative and mental health program activities.
- The Mental Health Vocational Specialist will be a mental health professional with experience in the integration of education and vocational training and employ-ment into the recovery process.
- The Psychiatrist will manage and develop clinical practice by providing quality psychiatric care to clients and establish positive relations with facility staff to better communicate the important aspect of quality mental health services. Knowledge of acute and chronic care protocols, administrations of medications, and delivering care following the collaborative treatment plan, with emphasis on cultural competence, wellness, resiliency, and recovery, will be required.
- The Consumer/Family Advocate will be an active member of the multidisciplinary team providing emotional support, companionship, and assistance with coping skills and linkage with community resources for the consumer and family. Advocates will give and receive support through a mutual exchange of experiences, strength, and hope to assist the client in obtaining the services needed, as well as assisting the consumer in developing his/her wellness and recovery action plan, congruent with cultural norms and expectations.

- The Cultural and Linguistic Counselor will be utilized to enhance the ability of the program to provide culturally competent services and to provide interpreter and translation services as needed to ensure effective communication, understanding, and collaboration between the client and the treatment team members throughout the service planning and service delivery process.
- The Office Assistant will perform the clerical office organizational related duties including, but not limited to: customer service, document preparation, file maintenance, record keeping, office equipment maintenance, ordering office supplies, computer data input, word processing, scheduling, and telephone procedures.

Program Evidence-Based Practices

Adhering to the MHSA goals, the program will ensure that all funds are expended in the most cost-effective manner and services provided in accordance with best practices. The program will utilize evidence-based service strategies and promising practices such as WRAP, SacPort, multidisciplinary assessment and treatment, case management, mobile services/home visitation and outreach and engagement, and collaborative service planning with community providers to create a network of community services and supports to promote wellness and recovery.

3. Describe any housing or employment services to be provided.

RESPONSE:

The Transitional Community Opportunities for Recovery and Engagement program is structured to provide housing or vocational supports if the client identifies the need to locate housing or employment as a service plan goal. The program will place an emphasis on employment and meaningful activity. The team will encourage young adults and adults to participate in community employment and for older adults to participate in culturally appropriate activities that encourage socialization, volunteer activities, and other activities aimed at decreasing isolation, and depression and promoting health and wellness.

4. Provide the average cost for each Full Service Partnership Participant including all fund types and fund sources for each Full Service Partnership proposed program.

RESPONSE:

Not Applicable.

5. Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

RESPONSE:

Wellness, recovery, and resiliency are supported by access to needed mental health services. The CORE program will ensure that the needed mental health services are available to this population to facilitate recovery and resiliency. The CORE program will provide the structure for administering these services and supports.

The goals of recovery and resiliency will be promoted and reinforced by utilizing wellness tools and strategies, such as medication management, obtaining good health care, stress reduction, diet, exercise, changing negative thoughts to positive thoughts, and developing a wellness lifestyle. Using WRAP as a structured system for monitoring uncomfortable and distressing symptoms, planned responses will be developed in order to reduce, modify, or eliminate these symptoms to enable the client to make effective personal decisions and stay safe.

The CORE program will assist and encourage individuals to bounce back from adverse circumstances and to be forward thinking and positive about the future. The services that individuals require for their recovery, habituation, and resiliency are impacted by cultural norms and are unique to every client. The CORE team will work to develop collaborative partnerships with community service providers for the benefit of each client to promote their personal wellness, recovery, and resiliency.

6. If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

RESPONSE:

Not Applicable.

7. Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

RESPONSE:

The key to the successful implementation of the CORE program is the understanding of what fosters recovery and how to build environments conducive to recovery. A partnership between peer counselors, licensed mental health care providers, and the client is essential to create this environment of recovery. The role of the peer counselors, as team members and role models, is critical to illustrate hope for every consumer they serve. The role of the peer counselor is not

interchangeable with traditional staff who usually work from the perspective of their training and/or their status as licensed health care providers. The peer counselors work from the perspective of "having been there." They lend unique insight into mental illness that facilitates the hope of recovery and resiliency.

Family advocates will also serve an essential role as team members by supporting and encouraging family members. These family members are often caregivers and represent the primary support system for the client. This can be a difficult and challenging role and frequently family members experience stress and depression. The family advocates will serve a dual role by supporting families and sharing their unique insights as a means of illustrating that the quality of life can be improved for both clients and family members.

8. Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

RESPONSE:

The CORE Program will provide linkage with a continuum of mental health services providers, particularly service providers who work with ethnically diverse populations, for each client served. Cultural and ethnic specific collaborative strategies with appropriate cultural/ethnic stakeholders representing priority populations from threshold languages, Native Americans, and other unserved groups are being developed and will be implemented. This includes, but is not limited to, ethnic specific partnerships with community-based organizations, including tribal organizations, that inform and enrich outreach and engagement efforts, training, and program development. Also, the program team will strengthen existing and develop new collaborative relationships with community service providers. The program staff will maintain ongoing involvement with the clients during their stay in the program to promote recovery and wellness for the clients.

These service providers will be contacted during the formative stages of the program's development and as an ongoing program strategy. Stakeholders who participated in the MHSA planning process in the adult stakeholder groups, task force, and steering committee will also be contacted and educated about this program to promote referral linkages and collaboration.

All of these strategies are designed to facilitate services that are culturally relevant and ensure positive outcomes for multicultural consumers.

9. Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

RESPONSE:

The CORE Program is designed to bring quality, ethnically diverse, and culturally competent services to those persons in need. The practice of mobilizing team members allows for culturally sensitive skills to be brought directly to the individuals in their specific community. This will reduce ethnic disparity in utilization of mental health services. Emphasis will be placed on services to unserved, underserved, and inappropriately served groups, including but not limited to, Latinos, Native Americans, African Americans, Refugees, and members of the Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex (LGBTQI) and disabled communities, including Deaf and Hard of Hearing. To focus on making services acceptable to diverse cultures and ethnicities, the CORE program will hire staff who are culturally diverse, culturally competent, bilingual/bicultural, and who reflect the ethnic and linguistic diversity of the population being served. Cultural competence training will be provided to all staff. Special efforts will be made to identify primary care physicians and non-traditional healthcare providers who provide medical care to ethnically diverse populations. This will lead to a network for linking clients to culturally competent health care providers. The cultural and linguistic counselor/consultant will also be utilized to enhance the ability of the program to provide culturally/linguistically competent services throughout the service planning and service delivery process.

10. Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

RESPONSE:

It is essential that the CORE team's assessment process and intervention strategies be sensitive to all cultural diversity issues, including sexual orientation. The Division of Mental Health actively promotes the concept of family as one that is self-defined by the individual receiving services. Therefore, the program's assessment processes will be designed to reflect sensitivity to sexual orientation issues, particularly when assessing family structure and significant relationships. Cultural competence training will be provided for all staff and will include sexual orientation training.

11. Describe how services will be used to meet the service needs for consumers residing out-of-county.

RESPONSE:

Not Applicable.

12. If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

RESPONSE:

Not Applicable.

13. Please provide a timeline for this work plan, including all critical implementation dates.

RESPONSE:

- Execute Contract with service provider on April 1, 2006
- Facility acquisition completed within 30 days
- Recruitment, hiring, and training of staff completed within 60 days
- Begin serving clients within 45 days
- Reach full program capacity within 9-12 months

14. Develop Budget Requests: Exhibit 5

RESPONSE:

See Exhibit 5.

15. A Quarterly Progress Report: Exhibit 6

RESPONSE:

See Exhibit 6.

Proposed Program
OLDER ADULT INTENSIVE SERVICES PROGRAM
Workplan #SAC2

1. Complete Exhibit 4

RESPONSE:

See Exhibit 4.

2. Describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

RESPONSE:

In developing this proposed program, the MHSA goals (as set forth in Section 3 of the Act) as well as the MHSA Guiding Principles served as a template to create a program that will guarantee underserved and unserved older adults disabled by mental illness the treatment and services they deserve.

Older adults in Sacramento County with serious mental illness are unserved and underserved in the public mental health service system, particularly ethnically and culturally diverse older adults. In Fiscal Year 2003-2004, 1244 older adults aged 60+ received public mental health services – about 2.5% of the poverty population in this age group, and less than 5% of the 26,221 clients served by the Mental Health System in Sacramento County. Older adults who are ethnically and culturally diverse are significantly under-represented among the limited number of older adults who are receiving mental health services (See data presented in Part II, Section II). Therefore, this outpatient program will outreach to ethnically and culturally diverse older adults and engage them with culturally competent services.

There are many reasons for this underutilization of services, including the lack of available mental health services and service providers who specialize in working with older adults. Specialty outpatient mental health services for older adults that provide multidisciplinary culturally competent assessment and treatment are extremely limited in Sacramento County, and are not adequate to meet the current and projected needs of the county's growing aging population. Due to the difficulty in accessing mental health services, many who suffer from a serious mental illness go undiagnosed and untreated. *Sacramento County Older Adult Mental Health Plan, 1995; Strategic Plan 2005, Sacramento Community System of Protection for Senior and Dependent Adults, Sacramento County DHHS Senior & Adult Services Division; Older Adult System of Care Framework, California Mental Health Directors Association, 2005.*

Throughout the MHSA stakeholder process, significant support was given to the concept of a program to address the issue of the underutilization of mental health services by older adults. The MHSA Older Adult Task Force ranked this issue #1, and the MHSA Steering Committee ranked it #2 for Full Service Partnership Funding. Therefore, the Older Adult Intensive Services Program is being proposed to address this underserved and unserved population. The program has been developed to be true to the intent and purpose of the MHSA in that it:

- defines serious mental illness as a condition deserving priority attention,
- reduces the long-term adverse impact from untreated serious mental illness,
- expands successful and innovative service programs, including culturally and linguistically competent approaches,
- provides state and local funds to adequately meet the needs of individuals enrolled in programs, and
- ensures funds are expended in the most effective manner and services are based on best practices.

With these goals incorporated into its development, the Older Adult Intensive Services Program will be a full service partnership program providing specialized multidisciplinary outpatient mental health assessment including a cultural formulation, treatment, and intensive case management program for older adults age 60+ with serious mental illness who meet the target population criteria established by the Sacramento County DHHS Division of Mental Health from diverse communities. This program is modeled after the Elder Care Intensive Service Program, which was funded by a 3-year grant (2001-2003) from The California Endowment and awarded to El Hogar Mental Health and Community Service Center, Inc., one of Sacramento County's Regional Support Team (RST) Programs.

The older adults who will be offered a partnership with this intensive outpatient program will have multiple co-occurring mental health, physical health, substance abuse, and social service needs that require intensive case management services with linkage to a range of community services and supports. Transition age older adults (age 55 through 59) will be eligible for this program if they have similar, complex, co-occurring mental health, medical, substance abuse, and social service needs that would benefit from the program's service strategies. Participants in this intensive program will reflect the ethnic and cultural diversity of Sacramento County. They may also be homebound and isolated, with limited family and social supports, living in their own homes, with family/caregivers, or residing at other community locations. Or they may be homeless or at-risk for homelessness.

Program participants will include older adults/transition age adults who are not receiving mental health services (unserved) as well as those who currently receive outpatient services in the public mental health system (underserved). However, due to their complex psychiatric, medical, substance abuse, and social service needs, these underserved older adults require more intensive services than are currently

available and therefore are not achieving the wellness and recovery outcomes that are possible.

Without mental health treatment, these older adults/transition age adults are frequent users of emergency room services, are at-risk for hospitalization, institutionalization, and homelessness, and may experience impaired personal and community functioning. The staff of this program will have special expertise in working with older adults from diverse ethnic and cultural groups with serious mental illness and their family/caregivers. They will also have small caseloads necessary to provide the intensive services needed when working with older adults with complex health, mental health, substance abuse, and social service needs.

Culturally-appropriate, specialized outpatient mental health services with intensive case management and service coordination for older adults provide an opportunity to promote wellness and recovery and to reduce the long-term adverse impact of acute and institutional care. The Older Adult Intensive Services Program will address the gap in available specialized outpatient mental health programs for older adults with serious mental illness in Sacramento County, and will improve access to these services.

Program Design Features

The following are key program design features:

- The program, at capacity, is designed to serve 100 clients with a 1:15 caseload ratio. Due to client turnover/discharges, an estimated 115 unduplicated clients will receive services the first year, with a total of 145 unduplicated clients served over the three-year period;
- The program's services will be both clinic and home-based (home visits wherever the client resides), anticipating that more than 30% of the client interactions will occur in the field and will be spread among program staff;
- The minimum program operation will be Monday through Friday, 8am-5pm (or similar). On call coverage 24 hours a day, 7 days per week, will be provided (after regular program hours);
- The program goals are to promote wellness and recovery while respecting cultural norms, improve medical and functional status, increase social supports, decrease isolation, and reduce or prevent emergency room utilization, hospitalization, institutionalization, and homelessness;
- The program services are considered ongoing until the older adult's service planning goals have been achieved.

Program Service Components

The components that make up the Older Adult Intensive Service Program have incorporated the goals and guiding principles of the MHSA to build a program that

looks beyond “business as usual” and moves toward transforming the Sacramento County Mental Health system. The program components are listed as follows:

- Multidisciplinary Assessment Services: Clients will receive a comprehensive culturally competent bio-psycho-social evaluation to assess the mental health, medical, substance abuse, and social service needs of the older adult. In older adults, medical conditions and medications can cause mental health symptoms, and some medical conditions can increase the risk of having a mental illness. Determining the relationship between the medical and mental status of the older adult is an essential component of multidisciplinary assessment and treatment planning with this population. If the client does not have a primary care physician, efforts will be made to identify a primary care physician to provide a comprehensive medical assessment and ongoing medical care, particularly for older adults with co-occurring medical and mental health needs. Additional healthcare services may also be needed such as dental care, podiatry, and alternative/culturally sanctioned approaches.
- Treatment Services: A variety of treatment modalities will be provided such as individual, group, and family counseling, medical and medication services, psycho-educational services, peer counseling, and linkage with social and community supports. All services will be responsive to cultural preferences. Clients will be encouraged to invite family members to participate in their treatment.
- Intensive Case Management Services: Every client will have a Personal Service Coordinator (PSC) trained in cultural competence who will be a mental health counselor with whom they will work collaboratively to develop an individualized services and supports plan. The plan identifies treatment goals and needed community services and supports that will promote wellness and recovery. The PSC will be responsible for ensuring that the service needs and goals of the client, as identified in the individualized service plan, are met either directly by the multidisciplinary treatment team or in coordination/collaboration with community service providers. The PSC and staff providing on-call coverage will also ensure that the client receives “after hours” interventions if necessary to reduce/prevent negative outcomes such as avoidable emergency room utilization, hospitalization, and eviction/homelessness.

Program services will be both field and clinic-based, providing in-home assessment and treatment services whenever necessary. Therefore, the multidisciplinary team members would use their own vehicle when necessary and be reimbursed for mileage and expenses.

Transportation can be a barrier to accessing mental health services by older adults with mental health needs. If the older adult clients require clinic-based appointments and are not able to access or pay for transportation, they would be provided assistance with transportation via vouchers for Paratransit, taxi services or other alternative transportation methods that are culturally sanctioned.

Flexible funding is necessary for a full service partnership program to "do whatever it takes" to promote wellness and recovery for program participants. Such funding might be needed for the following services and supports: clothing, food, personal hygiene, travel/transportation, housing subsidies/vouchers, home repairs/adaptive equipment, assistive devices to improve function, and other needs yet to be determined. One-time-only funds will be utilized to expedite and support program start-up activities.

Program Service Strategies

The service strategies which will be utilized by the Older Adult Intensive Services Program are listed in Exhibit 4. They are consistent with those identified in Section IV of the DMH Community Services and Supports Program and Expenditure Plan Requirements.

Training:

This workplan for the Older Adult Intensive Services Program is one important component of transformation of mental health services in Sacramento County. It is necessary to the process of transformation but it is not sufficient in itself to produce system-wide change. For this reason, we are proposing to enhance the efficacy of this workplan by adding system-wide training in a variety of wellness and recovery model values and practices.

We believe that if transformation is truly to occur, all staff members must become familiar with the values, goals, and practices of recovery and wellness. Unless we immerse the entire system in new ways and change our culture from "fail first" to "whatever it takes," our workplans, no matter how well conceived, will become no more than old practices in new packages.

Equally important with training in wellness and recovery model values and practices is staff development of competence in serving persons of every culture, language group, and ethnicity. No matter how transformative the practices, if our staff is not mindful of culturally relevant practices, the transformative practices will fail and, in failing, further deny access to the very people for whom they were designed. Accordingly, we regard cultural competency training, across all programs and the entire Mental Health Division to be essential to the success of our entire MHSA initiative.

Program Personnel

Mental health counselors, a psychiatric nurse, psychiatrist, nurse practitioner, family/consumer advocate and senior peer counselors comprise the multidisciplinary team of this program. In accordance with the MHSA goals, all personnel will be skilled in working with older adults within a multidisciplinary team framework and in collaboration with other disciplines, agencies and facilities. All will be trained in providing culturally and linguistically competent services including working with interpreters. Hiring culturally diverse, bilingual staff that have experience working

with culturally and ethnically diverse older adults will be a priority to ensure the provision of culturally and ethnically competent services.

- The mental health counselors will have the clinical expertise and cultural competence skills to assess, diagnose, and treat older adults with mental health and co-occurring medical and substance abuse needs, who are also ethnically/culturally diverse. The mental health counselor will: 1) function as the Personal Service Coordinator (PSC), 2) have the responsibility of developing a service plan in collaboration with the client that identifies treatment goals for wellness and recovery, and 3) coordinate care with the multidisciplinary team and with community service providers. This staff person must be knowledgeable about community resources for older adults in order to link and coordinate appropriate community services and supports that will promote recovery.
- The psychiatric nurse and nurse practitioner will be knowledgeable in working with a multicultural population of frail elders who have complex medical problems and who face a variety of barriers to receiving adequate, integrated mental health and physical health care. They both will be skilled in providing medical triage and medication assessments. The psychiatric nurse will perform similar responsibilities as the mental health counselor and will function as the Personal Service Coordinator for clients who have complex, co-occurring medical and mental health needs. The nurse practitioner will be skilled in providing the following services: 1) holistic assessments and treatment planning; 2) medication evaluation; 3) home/living arrangement evaluation to determine what is needed in the living environment to promote health, safety and independence; 4) linkage and liaison with the psychiatrist and primary care physicians, home care agencies, and other community health service providers/resources to promote the integration of health and mental health services, and to improve the overall health and functional abilities of the clients.
- The psychiatrist will provide a comprehensive psychiatric evaluation, including medication and medical history review, ethnopharmacology assessment, and will provide ongoing psychiatric treatment as required to achieve wellness and recovery treatment goals. The psychiatrist will collaborate with the nurse practitioner and primary care physician regarding the integration of mental health and medical services, and will provide education for the primary care providers and other health care providers as needed to increase the coordination and integration of mental health and primary care.
- The consumer/family advocate will provide assistance to consumers and their families/caregivers to obtain the services and access the community resources needed to promote wellness and recovery, as well as providing direct support to resolve problems and concerns.
- The senior peer counselors will provide emotional support, companionship, assistance with coping skills, and the benefit of prior experience with the issues involved in living with, and recovering from, mental illness.

- A cultural/linguistic consultant will be utilized to enhance the ability of the program to provide culturally competent services, and to provide interpreter and translation services as needed to ensure effective communication, understanding, and collaboration between the client and the treatment team members throughout the service planning and service delivery process.
- The mental health program coordinator/clinical supervisor will provide administrative and clinical supervision to the multidisciplinary team members and ensure principles of wellness, recovery, and cultural competence are embedded in clinical services. The clinical supervisor will also provide training to the program staff, as well as to community service providers from whom older adult clients may receive services. The program coordinator will be responsible for developing collaborative relationships among community service providers, particularly primary care physicians, to establish a network of community services and supports for the older adult clients.
- The office assistant will work closely with the program coordinator in establishing the office infrastructure and operational activities such as client reception process, scheduling, data entry, managing client files and associated paperwork.

Evidence-Based Practices

Adhering to the MHSA goals the program will ensure that all funds are expended in the most cost effective manner and services provided in accordance with best practice. To accomplish this, promising and effective model practices will be utilized in the implementation of the program. Therefore, some of the evidenced-based service practices for older adults will be:

- multidisciplinary assessment and treatment,
- case management,
- mobile services/home visitation,
- collaborative service planning with community providers to create a network of community services and supports to promote wellness and recovery.

These practices were piloted in the Older Adult System of Care Demonstration Project and were successful in improving function and increasing satisfaction across quality of life domains—living situation, family and social relationships, financial situation, safety, emotional and physical well-being, and general quality of life (Section 3c, e) *System of Care Services for Older Adults, Analysis of the Older Adult System of Care Demonstration Project, FY 2000-2003, In Response to Welfare and Institutions Code Section 5689.8-5689.9, California Department of Mental Health, August 2004.*

3. Describe any housing or employment services to be provided.

RESPONSE:

The Older Adult Intensive Services Program is a full service partnership and therefore will do "whatever it takes" to address the mental health, medical, substance abuse and social service needs of the older adult/transitional age adult client. These needs could include housing and employment/volunteer services.

An assessment of the client's living arrangement needs will be provided as part of the multidisciplinary assessment process. This assessment, in collaboration with the client, may identify the need to improve the accessibility and safety of the current living arrangement by adapting the home to accommodate special needs/functional abilities or limitations. Or the client may identify the need to locate alternative housing as a service plan goal, requiring the PSC/mental health counselor/peer counselor to work with the client and family to achieve that goal. The living arrangement assessment is to identify whatever is needed to enhance the client's ability to live as independently/interdependently as possible, based on the client's abilities, needs, culturally appropriate preferences and cultural norms. Community resources such as home repair and adaptation services, adult day health care/adult day care, respite care services, and supportive housing/assisted living options will be explored and utilized as needed to achieve service plan goals. This program will utilize subsidies as necessary to achieve these goals and to prevent institutionalization and homelessness.

The assessment process will also help the client identify any interests in finding employment or volunteer work. The peer counselor will be helpful in working with the client to achieve those goals, which may involve learning skills and/or gaining confidence to pursue those goals.

4. Provide the average cost for each Full Service Partnership Participant including all fund types and fund sources for each Full Service Partnership proposed program.

RESPONSE:

Refer to the Budget. The estimated average annual cost for each Full Service Partnership participant is $10,724. Medi-Cal revenues were included in determining these costs.

5. Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

RESPONSE:

"The concepts of recovery and habilitation are used in mental health policy and program design and are the means for enhancing quality of life…Recovery is a personal process through which an individual can choose to change his or her goals, with the ultimate objective of living a healthy, satisfying and hopeful life despite limitations and/or continuing effects caused by his or her mental illness. Habilitation is a strength-based approach to skills development that focuses on maximizing an individual's functioning. The services that consumers require for their recovery and habilitation are unique to every older adult." *Older Adult System of Care Framework, California Mental Health Directors Association*

The ultimate goal of the Older Adult Intensive Services Program is to support the older adult in achieving wellness and recovery as defined by the client (and family/caregivers/community when relevant). A service plan will be developed that is guided by the principles of Recovery and adapted as appropriate to meet cultural norms—client directed, restores hope, emphasizes client strengths and assets, and promotes self-determination in order to achieve an improved quality of life as defined by the older adult. These are the principles that will guide the mental health counselors, psychiatric nurse, psychiatrist, nurse practitioner, family/consumer advocate, and peer counselors during the assessment, service planning/coordination, treatment, and case management process.

Recovery is supported by access to needed mental health, medical, substance abuse, and social services; safe and affordable housing; supportive relationships; meaningful activities that could include volunteer opportunities, and more. This program will work to develop collaborative partnerships with these community service providers for the benefit of the older adult clients to promote recovery.

Lastly, the following are the recovery-focused performance outcomes achieved by The Elder Care Program, which the Older Adult Intensive Services Program will work toward replicating: 1) overall improvement in the older adult client's mental health, medical, social, and functional abilities; 2) a reliable decrease in the number of psychiatric in-patient days; 3) successful linkage of clients with a primary care physician. *Elder Care Intensive Service Program Final Grant Report, El Hogar Mental Health and Community Service Center, Inc., 2003.*

6. If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

RESPONSE:

Not Applicable

7. Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

RESPONSE:

This program will utilize peer counselors as part of the multidisciplinary team. Peer counselors can provide emotional support, companionship, assistance with coping skills, and community resource linkage assistance for older adults with mental health needs. Peer counselors can also function as consumer advocates to ensure that service interventions are client-directed and focus on wellness and recovery.

Family advocates will also be utilized as part of the multidisciplinary team, to provide support to the family caregivers who are often the primary support system for the older adult. Family caregivers frequently experience stress and depression as a result of their caregiver role and responsibilities. They can benefit from assistance in navigating the community network of services to benefit the older adult client and family caregiver. Supporting the caregiver also supports the care receiver, and can prevent the need for institutionalization.

8. Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

RESPONSE:

The Older Adult Intensive Services Program will develop new and strengthen existing collaborative relationships with community service providers to promote recovery for older adult clients, particularly service providers who work with ethnically diverse populations. Special attention will be given to identifying and collaborating with health care providers to ensure that the older adult clients are receiving medical care along with mental health services. Mental health and physical health are integrally connected for the health and well being of the older adult client.

Examples of these healthcare providers include Sacramento County DHHS Primary Care Clinic, family practice/internal medicine physicians, geriatricians, dentists, podiatrists, other medical specialties, home care agencies, and traditional healing

practitioners. Other community service providers include alcohol & drug, senior centers, adult day health care/adult day care, senior nutrition programs, in-home supportive services, telephone reassurance, caregiver support services, respite care, homeless service providers, legal services, senior housing, housing repair services, faith-based, tribal organizations, and others. Organizations, which provide services to culturally/ethnically diverse older adults, include Sam Pannell Meadowview Community Center, Asian Pacific Community Center, Southeast Asian Assistance Center, Jewish Family Services, and others.

These service providers will be contacted during the formative stages of the program's development and as an ongoing program strategy to promote collaboration for referral of clients to the program as well as for providing community services and supports to promote wellness and recovery. Stakeholders who participated in the MHSA planning process in the older adult stakeholder groups, task force, and steering committee will also be contacted and educated about this program to promote referral linkages and service collaboration.

9. Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

RESPONSE:

Data from Sacramento's Cultural Competence Plan Update in 2003 showed the penetration rate for older adults age 65+ receiving public mental health services to be very low (1.32%) compared to the penetration rate of persons age 40-59 (11.08%). The penetration rate data by ethnicity in Sacramento County reveals that it is high for African Americans and Caucasians, and relatively low for Latinos. It is particularly low for API, Chinese, Laotian, and Vietnamese.

Because older adults are significantly un-served and underserved in general in Sacramento County's public mental health system, one can assume that older adults who are also ethnically and culturally diverse are also significantly under-represented. Data described in Part II, Section II supports this assumption.

To reduce ethnic disparity in utilization of mental health services, this program will focus on making its services acceptable to older adults of diverse cultures and ethnicities. Emphasis will be placed on providing services to members of unserved, underserved, and inappropriately served communities, including but not limited to, Latinos, Native Americans, African Americans, Refugee groups, and members of the Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex (LGBTQI) and disabled communities, including members of the Deaf and Hard of Hearing communities. This will occur by hiring staff, including family/consumer advocates and peer counselors, who are culturally diverse, culturally competent,

bilingual/bicultural, and who reflect the ethnic and linguistic diversity of the population being served. Cultural competence training will be provided to all staff, so that the program can provide culturally competent services. Cultural issues such as language, race, ethnicity, customs, family structure, sexual orientation, and community dynamics will be part of the cultural competence training.

As described in Response #8, this program will identify and collaborate with service providers and organizations currently providing services to ethnically/culturally diverse older adults. Special attention will be given to identifying primary care physicians and non-traditional healthcare providers who provide medical care to ethnically diverse populations. These are important collaborative partners in order to promote the integration of mental health and medical services for ethnically/culturally diverse populations. The cultural and linguistic counselor/consultant will be utilized to enhance the ability of the program to provide culturally/linguistically competent services throughout the service planning and service delivery process.

10. Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

RESPONSE:

Older adults reflect the cultural diversity of all other age groups. Thus, it is essential that the assessment process and intervention strategies with older adults consider all cultural diversity issues, including gender and sexual orientation. Assessment processes including forms will be designed to reflect sensitivity to sexual orientation issues, particularly when assessing family structure and significant relationships. Cultural competence training will be provided for all staff and will include issues of gender and sexual orientation.

11. Describe how services will be used to meet the service needs for individuals residing out-of-county.

RESPONSE:

Not Applicable

12. If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

RESPONSE:

Not Applicable.

13. Please provide a timeline for this work plan, including all critical implementation dates.

RESPONSE:

- Execute Contract with service provider on April 1, 2006
- Facility acquisition completed within 30 days
- Recruitment, hiring, and training of staff completed within 60 days
- Begin serving clients within 45 days
- Reach full program capacity within 9-12 months

14. Develop Budget Requests: Exhibit 5

RESPONSE:

See Exhibit 5.

15. A Quarterly Progress Report: Exhibit 6

RESPONSE:

See Exhibit 6.

Proposed Program
PERMANENT SUPPORTIVE HOUSING PROGRAM FOR INDIVIDUALS AND FAMILIES
Workplan #SAC4

1. Complete Exhibit 4

RESPONSE:

See Exhibit 4.

2. Describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

RESPONSE:

In developing this proposed program, the goals (as set forth in Section 3 of the Act) and the MHSA Guiding Principles served as the template to create a program that would guarantee homeless individuals disabled by mental illness the treatment and services they deserve.

Individuals who become disabled by mental illness are significantly more at risk of homelessness, loss of employment, victimization, and addiction disorders. Additionally, they have elevated use of emergency rooms, psychiatric hospitals, and jails/juvenile justice institutions. For children and families, mental illness, when coupled with homelessness, contributes to instability and out-of-home placement of children. All age groups are at higher risk for death, either through homicide, untreated health conditions, or suicide. Individuals and families who are limited English proficient (LEP) are especially vulnerable without supports and services that are culturally and linguistically relevant. Youth with serious emotional disturbances who age out of the foster care system in Sacramento County pose the highest risk for homelessness.

The Sacramento City and County Board of Homelessness Housing Committee reported in FY 2004-05 there were approximately 11,109 homeless individuals in Sacramento County, of whom between 35 and 55 percent had a mental illness and/or co-occurring disorder. The Sacramento County Office of Education identified approximately 5,000 homeless children in the county in FY 2003-04. This information contributed to the decision of the Sacramento County MHSA Steering Committee to identify the issues of affordable, safe, and permanent housing as essential to recovery, resiliency, and wellness. The information compiled during the stakeholder process related to these issues was so compelling that the Steering Committee elevated it to its "Number 1 Priority". Therefore, the Permanent Supportive Housing Program for Individuals and Families is being proposed to address these issues.

This proposed program will be true to the purpose and intent of the MHSA in that it:

- defines serious mental illness as a condition deserving priority attention;
- reduces the long-term adverse impact from untreated serious mental illness;
- expands successful and innovative service programs, including culturally and linguistically competent approaches;
- provides state and local funds to adequately meet the needs of individuals enrolled in programs;
- ensures funds are expended in the most effective manner and services are based on best practices.

The program will advance the MHSA goals in that it will be a full service partnership for all ages that will reduce the long-term adverse impact of homelessness resulting from untreated serious mental illness on individuals and families and state and local budgets. The program's priority populations will be individuals and families with long-term and/or cyclical homelessness who are disabled by serious mental illness or serious emotional disturbances. The initial outreach and engagement services will be geared to the underserved and unserved populations of transition age youth and ethnic populations. See Section III for information related to the identification of these underserved populations.

The guiding principles of this program are that individuals and families can grow, develop resiliency, and recover from mental illness/emotional disturbances when safe, affordable housing is ensured with supports and services.

Program Components

The components that make up the Permanent Supportive Housing Program for Individuals and Families have incorporated the goals and guiding principles of the MHSA to build a program that looks beyond "business as usual" and moves toward transforming the Sacramento County Mental Health System. The components of the program are discussed below.

The program will provide integrated, comprehensive, culturally competent, and supportive housing services to this underserved population. Initially, services will be provided to 125 individuals and families.

Sacramento's success with the AB 2034 program has shown that when the majority of services are self-contained in one agency, clients achieve positive outcomes while establishing community tenure. The outcomes of AB 2034 indicated a 95% success rate in keeping individuals and families housed. This proposed program will take a "no fail" approach and will employ "whatever it takes" to ensure safe, affordable housing and stability. To accomplish these outcomes, Assertive Community Treatment principles will be utilized with an emphasis on field-based services and frequent client contact.

The program is intended to be a precursor, a bridge, to the development of permanent housing units that will be developed with leveraged housing funds. The new housing units will allow the individuals and families to limit their rent expenditure to no more than 30 percent of their income. The program will begin as a supportive housing program utilizing available housing and will then transition participants to the newly constructed housing units. The new housing will be constructed through a partnership with the Sacramento Housing and Redevelopment Agency (SHRA), Sacramento County Division of Mental Health, a private non-profit housing developer, and a contract mental health service agency.

The program will adhere to the standards of supportive housing outlined by the Corporation for Supportive Housing (e.g., the housing will be permanent, affordable, and voluntary). As well, consumers of all backgrounds will be included in housing committees before and after permanent housing is developed.

To ensure that no participant in the program receives inadequate or insufficient treatment due to language or cultural barriers, the program will include a comprehensive multi-disciplinary, bicultural/bilingual staff. Caseload ratios will be 1:10 with 24/7 response capacity. Staffing will include consumers, family/child advocates, licensed professionals, psychiatrists, nurses, life-experienced staff, and staff with expertise with children and transition age youth, and will reflect the cultural diversity of the clientele, including language needs. Partnerships will be developed with schools, cultural and community groups serving ethnic populations, and businesses/employers. Using strength based and harm reduction approaches, the staff will support consumers in stabilizing their housing, strengthening their families, and reintegrating into the community, as well as fostering recovery, wellness, and resiliency.

Program Service Strategies

The service strategies that will be used by the Permanent Supportive Housing Program for Individuals and Families are listed in Exhibit 4. They are consistent with those identified in Section IV of the DMH Community Services and Supports Program and Expenditure Plan Requirements.

Training:

This workplan for the Permanent Supportive Housing Program for Individuals and Families is one important component of transformation of mental health services in Sacramento County. It is necessary to the process of transformation, but it is not sufficient in itself to produce system-wide change. For this reason, we are proposing to enhance the efficacy of this workplan by adding system-wide training in a variety of wellness and recovery, or resiliency in children, model values and practices.
We believe that if transformation is truly to occur, all staff members must become familiar with the values, goals, and practices of recovery (resiliency in children) and wellness. Unless we immerse the entire system in new ways and change our culture from “fail first” to “whatever it takes,” our workplans, no matter how well conceived, will become no more than old practices in new packages.

Equally important with training in wellness, recovery (resiliency in children), model values and practices is staff development of competence in serving persons of every culture, language group, and ethnicity. No matter how transformative the practices, if our staff is not mindful of culturally relevant practices, the transformative practices will fail, and, in failing, further deny access to the very people for whom they were designed. Accordingly, we regard cultural competency training, across all programs and the entire Mental Health Division, to be essential to the success of our entire MHSA initiative.

Program Personnel

Selection of culturally and linguistically competent staff is critical to the success of this proposed program and central to the MHSA goals. Adequate mental health care begins with proper recruitment and staffing to guide clients to wellness, recovery (resiliency in children). These will be the principles that will be used when hiring the staff for this program. Direct service staff will be proficient and/or develop expertise in treating individuals with co-occurring disorders, and accessing the entitlements and benefits for income, health care, and housing. Following are the positions that are proposed:

- The Program Director will be responsible for the overall management of the program, will oversee the development of the budget, establish a system for monitoring cash flow, aid the Clinical Director in responding to the data requirements, manage the office systems, supervise the Clinical Director, and provide administrative supervision of the Consulting Psychiatrists.
- The Licensed Clinical Director will provide clinical program direction, supervision of Team Leaders, and insure compliance with quality improvement, MHSA and other programmatic and administrative requirements.
- The Team Leaders will supervise the Personal Services Coordinators/Case Managers, review the individual service plans, and oversee day-to-day service needs of members and staff.
- The Personal Service Coordinators (PSC) will work with adults and Case Managers will work with children. Their roles will include the engagement of the consumer, the family and locating resources within the community to promote wellness, recovery (resiliency in children) and housing stability. The Personal Service Coordinators/Case Managers will assist the program participants with the coordination and implementation of the client-driven service plan. Four of these staff will have bilingual/bicultural abilities: one Vietnamese, one Native American, one Eastern European, and one Spanish. See Section III for further information regarding the need for these staff.
- The Psychiatrists (one for adults and one for children) will evaluate medication needs, prescribe medication as necessary, and work with both consumers and family members around medication issues associated with treatment and drug interactions and/or reactions.

- The Registered Nurse will work with the psychiatrists around medication issues and provide follow up with the consumers and family members. The nurse will provide health and mental health education that includes medication, diet, and exercise information. Liaison relationships will be developed with the participant's primary health care provider to ensure coordination of mental health and physical health care plans.
- The Housing Specialist Team will work in the first years of the program in finding housing alternatives for the consumers. During that time, it is expected that this team will also work in educating staff and the non-profit developer in designing housing that meets the needs of the individuals enrolled in the program. The housing specialists will also intervene with landlords, where necessary, to reach mutually acceptable expectations regarding standards of behavior that will promote stable housing.
- The Employment Specialists Team will work with the participants to help them discover work that is rewarding, meaningful, and will lead to a more independent life. They will help create supportive and competitive employment, provide job coaching, and develop partnerships with local businesses.
- The Office Assistant will work closely with the Program Director in establishing the office infrastructure and operational activities, such as the client reception process, scheduling, data entry, managing client files, and associated paperwork.

Program Evidence-based Practices

Adhering to the MHSA goals, the program will ensure that all funds are expended in the most cost-effective manner and services provided in accordance with best practices. To accomplish this, promising and effective model practices will be utilized in the implementation of the program. Many of these model practices have been successfully used in Sacramento's AB 2034 programs and assisted in achieving positive outcomes, especially in housing retention and decreases in hospitalization and incarceration. Some of the practices that are being considered for this program are: Assertive Community Treatment (ACT), Supported Employment, Integrated Dual Diagnosis Treatment, and the Social and Independent Living Skills Modules as developed by Robert Liberman, M.D., and the UCLA-Neuropsychiatric Institute. All practices will be adapted, as appropriate, for cultural and ethnic communities.

3. Describe any housing or employment services to be provided.

RESPONSE:

This proposed program will provide a housing subsidy and any services and supports that the seriously mentally ill individuals and/or seriously emotional disturbed child or youth and family needs. The program's objective is to maintain housing stability and supports to assist the participant to succeed in his/her recovery (or in the case of children, successful overcoming of adverse events).. A variety of

housing types will be available to meet the expressed wishes and needs of the consumer. Staff will be available 24/7 to respond to crises that may occur.

Employment activities will focus on creating and developing supportive and competitive employment opportunities. Employment Specialists will provide job development, job coaching, assist with employment retention, and establish partnerships/relationships with private and public businesses. Financial assistance will be provided for education and/or vocational training needed for employment, where appropriate. Persons who are not seeking employment will be encouraged to participate in meaningful volunteer activities and/or offered structured activities that are focused on recovery, or, in the case of children, resiliency.

4. Provide the average cost for each Full Service Partnership Participant including all fund types and fund sources for each Full Service Partnership proposed program.

RESPONSE:

The average annual cost for each Full Service Partnership participant will be $17,428 including Federal Financial Participation (FFP) from Medi-Cal reimbursable services. We believe this figure is appropriate, given the intense needs of a population concurrently affected by serious and persistent mental illness or severe emotional disturbance, frequent co-occurring substance abuse disorder, homelessness, unemployment, and untreated medical disorders.

In order to be successful we have designated ethnic and cultural staffing to best reach and engage individuals with linguistic, ethnic, racial and cultural needs. These are targeted individuals/families/communities currently un-served/underserved in Sacramento. Additionally, we have specified staff with expertise in serving the focal populations for children and transitional age youth.

Flexible funds will be available to pay for services that typically would not be reimbursable by Medi-Cal. Examples of use of these funds might be: rental subsidies, employment training, job coaching/mentoring, tutoring, day care services, bus passes, educational expenses (books and supplies), limited primary medical care, etc.

5. Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

RESPONSE:

The program staff will work with each of the participants to develop an individualized full service plan. Utilizing strengths-based philosophy, plans will be developed based on the participant's expressed wishes. Focus will be on consumer choice, individual strengths, empowerment, and providing hope and support in their recovery, or, in the case of children, development of resiliency. with the child/youth and parents, with the intent of maximizing resiliency. Transition-age youth will identify all individuals they want to participate in the development and implementation of their service plans.

Division of Mental Health staff will monitor client outcomes, giving close attention to employment/education, housing stability, and reduction in hospitalization and incarceration. Division staff will also monitor adherence to recovery and resiliency values by frequent site visits, attendance at staff meetings, and individual meetings with key executive and program staff.

6. If expanding an existing program or strategy, describe your existing program and how that will change under this proposal.

RESPONSE:

Not Applicable.

7. Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

RESPONSE:

Sacramento County has a long history and commitment to hiring consumers, family members, and caregivers. As in other Sacramento County mental health programs, consumers, family members, and caregivers will be considered for all positions in this proposed program. A minimum of 20 percent of the program staff, at any one time, will be from these populations, thus ensuring that consumer and/or family members are hired at all levels within the program. As members of the program staff, they will lend hope while fostering wellness, recovery (resiliency in the case of children) in participants.

Peer Counselors and family advocates from diverse cultures have been a mainstay of many of Sacramento's mental health service providers and it is assumed program

staff will work collaboratively with them to address issues and needs of the program participants. Peer support services will be an integral part of the program. For example, transition-age youth will take a leadership role in offering peer-led wellness, recovery, and resiliency self-help groups. Program staff will also work with youth, family, and consumer advocates in the community to address issues and needs of the program participants.

8. Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

RESPONSE:

The Permanent Supportive Housing Program for Individuals and Families will develop new and strengthen existing collaborative relations with community service providers to promote wellness, recovery (or in the case of children, resiliency) for its program participants. The program is based on the concept of "whatever it takes;" therefore, it will call upon many of the stakeholders associated with the AB 2034 programs and develop new collaborations as needed. Listed below are only a few of the collaborative relationships that are anticipated to be involved in this program:

- Families may be referred by Child Protective Service (CPS) and CPS may have an on-going parallel role in helping families address issues. The collaboration with CPS will strengthen and support vulnerable families and mitigate out-of-home placements and/or assist with family reunification.
- Other partnerships that will potentially refer and be members of the child/family team include: schools, probation, courts, Alta Regional, Public Health, and SETA. Partnerships with these stakeholders will provide comprehensive and cohesive implementation of service plans to mitigate fragmentation of services by key stakeholders involved with the program participants.
- Transition-age youth may be referred by the Juvenile Justice system and conditions imposed upon them may be included in the full service partnership. Thus, partnerships with the juvenile justice system will assist in identifying the behaviors that contributed to the youth's offense and lead to appropriate services that will use a "whatever it takes" approach to foster wellness, recovery, and resiliency.
- The movement of a youth from a transition age program will be negotiated with the youth and not occur until s/he feels connected with the necessary services and supports for successful community independence and/or connection with the adult mental health system, as appropriate. Therefore, stakeholders will be called upon to be involved in the transition. This strategy empowers youth in their service planning and more importantly insures that ongoing services will not be terminated as a result of "falling through the cracks".

- Adults and transition age youth will be linked with education, training, and other vocational resources. This linkage provides an identity other than mental health consumer and contributes to the participants' independence by providing the skills and tools necessary for full community integration.
- Clients will be encouraged to participate in faith-based, ethnic, cultural, or gender-related outreach, support, and/or health related programs to promote wellness and self-esteem. These programs include tribal health organizations. Assisting clients to participate in diverse support programs encourages and promotes a positive identity stemming from group and individual relationships,; promotes cultural competence for the system, and furthers community and cultural integration for the client.
- All participants may be offered services through other MHSA Community Services and Support programs (Transitional Community Opportunities for Recovery and Engagement (CORE), Transcultural Wellness Center, Older Adult Intensive, and Wellness and Recovery Center).
- Older adults will be linked appropriately to health, adult day care, senior volunteer programs, or programs such as Foster Grandparents. These linkages will enhance wellness, decrease isolation, and decrease depression and loneliness.
- Older adults will be referred to senior nutrition centers or home delivered meals when appropriate. Due to limited income and unfunded health costs, especially medications, older adults frequently must choose between medication and food. This strategy will insure that older adults receive healthy meals and nutrition, leading to a better quality of life and continued independence.
- Individuals of all ages experiencing loss will be referred to community grief counseling and self-help groups. Mental Health consumers frequently experience multiple losses, especially among the homeless. Linking program participants with peer and or professional grief counseling will assist in recovery (or resiliency in children), and focus on supporting individuals in moving forward with their lives.

9. Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II on this plan and what specific strategies will be used to meet their needs.

RESPONSE:

Active outreach and engagement efforts to the homeless unserved and underserved from ethnic and cultural populations is a core focus of this proposed program. Therefore, the program staff will be proficient in communicating and engaging with this population. The Sacramento County Division of Mental Health will request that

any successful bidder establish a program that is culturally competent and will serve diverse cultural and ethnic communities. Funding to address the pay differential for bilingual/ bicultural staff is included in the cost of the program staff.

Partnerships and collaborations will be formed that recognize the sensitivity to mental health, homelessness, and cultural/ethnic disparities. In working with these partners, strategies will be developed to identify and engage this target population.

Initially, the program will attempt to serve ethnic minority and age groups as indicated by population data and statistics generated during the planning process; see Section III for more details. Serving underserved and unserved populations has inherent problems that begin with the lack of information. Therefore, to address the lack of information this proposed program will do the following:

- develop focused outreach to each cultural/ethnic community for mutual identification of goals;
- develop housing programs and supportive services that meet the mutually identified goals of targeted cultural and ethnic groups; and
- adapt as needs are clarified or new needs are identified.

Homeless shelter data indicates the Native American population is the second largest ethnic group utilizing homeless shelters, yet they are under-represented in treatment programs. As a result, at least one full-time Native American staff has been identified to outreach and engage this underserved population. This individual will respond in a culturally appropriate manner to meet this underserved population housing and service needs.

Due to the methodology in collecting data, the Eastern European population is not identified in any homeless data. However, experience and anecdotal feedback point to this group as being underserved. For that reason a Ukraine/Russian speaking staff has been identified to reflect the cultural and linguistic need in order to better serve this population.

Already, a need has been identified for two Spanish speaking staff. While the percentage of Latinos represented in Sacramento's population would suggest that a portion of them would need homeless services, they are an under-represented population in the shelters. See Section III for data that substantiates this under-representation. Historically, it is known that the Latino populations have been underserved or unserved due to challenges of being uninsured and undocumented, thus contributing to limited access to health and mental health services. Therefore, to address housing issues among the Latino population, culturally sensitive outreach methods will go hand in hand with the linguistic capability.

The number of Native Americans in homeless shelters is documented in Section III. To adequately address the housing issues for this group, culturally appropriate

outreach and engagement strategies are critical. The program will work with local Native American providers to insure the needs of this underserved group are addressed.

The Sacramento County Division of Mental is putting forth another proposed program for a full service partnership for the Asian population, titled the "Transcultural Wellness Center". Issues of housing are treated differently in many parts of the Asian community, in that overcrowding does not automatically lead to homelessness. There will be collaboration between the two programs related to housing needs for this Asian population. While there will be no duplication of outreach or treatment efforts between the Transcultural Wellness Center and the Permanent Supportive Housing Program for Individuals and Families, both programs will work together to ensure the housing needs of the Asian Pacific Islander communities are met.

10. Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

RESPONSE:

The staff of this proposed program will engage consumers and family members in these issues at the time and place the individual is willing or comfortable in raising the issue(s). The Division of Mental Health actively promotes the concept of family as one that is self-defined by the individual receiving services. Assessment processes, including forms, will be designed to reflect sensitivity to sexual orientation issues, particularly when assessing family structure and significant relationships. Staff will be trained and experienced in cultural competence, including sexual orientation and gender sensitive issues. Staff will be encouraged to seek expertise from supervisors and/or outside resources when needed. Peer review will provide a formal opportunity to ensure the delivery of strengths-based services to individuals who are lesbian, gay, bisexual, or transgender.

11. Describe how services will be used to meet the service needs for individuals residing out-of-county.

RESPONSE:

Not Applicable.

12. If your County has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

RESPONSE:

Not Applicable.

13. Please provide a timeline for this work plan, including all critical implementation dates.

RESPONSE:

- Execute Contract with service provider on April 1, 2006
- Facility acquisition completed within 30 days
- Recruitment, hiring, and training of staff completed within 60 days
- Begin serving clients within 45 days
- Reach full program capacity within 9-12 months

14. Develop Budget Request: Exhibit 5

RESPONSE:

See Exhibit 5.

15. A Quarterly Progress Report (Exhibit 6) is required to provide estimated population to be served. A Cash Balance Quarterly Report (Exhibit 7) is required to provide information about the cash flow activity and remaining cash on hand.

RESPONSE;

See Exhibit 6.

Proposed Program
TRANSCULTURAL WELLNESS CENTER
Workplan #SAC5

1. Complete Exhibit 4

RESPONSE:

See Exhibit 4.

2. Describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

RESPONSE:

In developing this proposed program the MHSA goals (as set forth in Section 3 of the Act) and the MHSA Guiding Principles served as the template to create the program. The program name, Transcultural Wellness Center, brings together the API group's emphasis on community, culture and well-being. The inclusion of all age groups underscores the emphasis on family and allows for the flexibility required to work successfully with the community. Individual, family, and community wellness, recovery, and resilience are the hallmarks of the program.

According to the data in the Sacramento County Cultural Competence Plan Update (September 2003), the mental health concerns of the Asian and Pacific Island (API) communities (Cambodian, Chinese, Fijian, Filipino, Hawaiian, Hmong, Japanese, Korean, Laotian, Mien, Samoan, Tongan and Vietnamese) are largely unmet by the current mental health system in Sacramento County. There are no programs and services that are adequately staffed and funded to provide linguistically and culturally competent full-service mental health care for these populations. Consequently, many members of these communities, especially Limited English Proficient (LEP) refugees/immigrants and their family members, suffer from undiagnosed, misdiagnosed and, consequently, untreated mental illness.

API communities demonstrate significant cultural stigma, shame, and denial regarding mental illness, according to the data in the Sacramento County Cultural Competence Plan Update, September 2003 (See Section III for data detail). This, combined with other cultural and language barriers, results in a population whose mental health utilization rates per capita are among the lowest in Sacramento County, putting them at greater risk for undiagnosed and untreated mental illness, greater severity of illness when treated, isolation, decompensation, and family/community disruption. If and when individuals are diagnosed, their communities may deny their illnesses. They may be incorrectly treated or the treatment may be incomprehensible due to language and cultural barriers.

The creation of a center was recommended by the Cultural Competence Task Force and its Stakeholder Groups specifically to address the disparities in ethnic representation within the Sacramento County Mental Health system. The MHSA Cultural Competence Workgroup rated the API Transcultural Wellness Center as #2 and the MHSA Steering Committee ranked it as #4 on the Full Service Partnership list. A group of API stakeholders that included consumers, family members, potential consumers and family members, community leaders, and mental health providers developed comprehensive recommendations that contributed to the outline of this program.

Therefore, following the Task Force recommendations, the Transcultural Wellness Center is being proposed to specifically address this underserved and unserved API population. The Center will be true to the purpose and intent of the MHSA in that it:

- defines serious mental illness as a condition deserving priority attention;
- reduces the long-term adverse impact from untreated serious mental illness;
- expands successful and innovative service programs, including culturally and linguistically competent approaches;
- provides state and local funds to adequately meet the needs of individuals enrolled in programs;
- ensures funds are expended in the most effective manner and services are based on best practices.

Incorporating these goals into its development, the Transcultural Wellness Center will be a comprehensive full partnership for all ages disabled by serious mental illness (SMI) or serious emotional disturbances (SED). It will be an intergenerational program that will address a range of needs, ages, genders, and types of diagnoses prevalent in the API communities (See Section III for specific populations within the API community to be targeted).

The program is designed to reduce the long-term adverse impact on API individuals and families, as well as state and local budgets resulting from untreated serious mental illness. To accomplish this, the Transcultural Wellness Center will have an efficient delivery system that includes the following: culturally appropriate wellness, resilience and recovery services; psychotherapy; family counseling; psychiatric consultation; medication support; service coordination/case management; networking; peer support; interpreter/translator, and psycho-educational services.

To maintain its adherence to the MHSA goals, the program will ensure that the family/community-centered focus is compatible with API cultural norms and expectations.

To ensure that no participate in the program receives inadequate or insufficient services due to language or cultural barriers, the program will include a comprehensive multi-disciplinary, bicultural/bilingual staff. While all cultural and

ethnic groups will be welcome to services at the Transcultural Wellness Center, staff will specifically focus on providing culturally and linguistically competent services to individuals and families of all age groups from the API community

Program Components

The components that make up the Transcultural Wellness Center have incorporated the goals and guiding principles of the MHSA to build a program that looks beyond "business as usual" and moves toward transforming the Sacramento County Mental Health system. The program components are listed below:

- Establish a center specifically addressing the mental health needs of the Asian/Pacific Islander communities in Sacramento County.
- Create a program of mental health services that are youth, adult, and family driven with service coordination/case management provided in a single treatment plan for each individual/family.
- Adopt culturally appropriate mental health interventions, treatment, and prevention strategies in various languages that include: cultural and religious beliefs and values; traditional practices; natural healing practices; and ceremonies recognized by the API community.
- Utilize comprehensive and culturally competent assessment that includes the DSM IV TR Cultural Formulation, pre- and post-immigration refugee history, and a family-team approach for children and youth.
- Establish culturally appropriate individual, family, and community wellness, recovery and resilience as the hallmarks of the program.
- Develop guidance of the Center through a Steering Committee that includes all API ethnicities and age groups, to include consumers, family members, elders, and community leaders.
- Recruit clients, family and community members to fill designated program staff positions.

Program Key Features

The following are key features of the Transcultural Wellness Center:

- The program will be targeted specifically to the Asian/Pacific Island (API) community within Sacramento County. It includes Chinese, Filipino, Japanese, Korean, Hmong, Vietnamese, Mien, Laotian, Cambodian, Tongan, Samoan, Hawaiian, and Fijian Americans, among others.
- The program is designed to serve a total of 250 clients at a given time, with a 1:15 caseload ratio.
- Services will be provided at a central location convenient to and comfortable for the target population. Services will also be available in homes and at various

satellite locations frequented by the population, such as churches, temples, and community centers.

- Hours of operation will be Monday through Friday, 8 a.m. – 7 p.m., with culturally and linguistically appropriate 24/7 response capacity by program staff known to the consumer/family.
- Medical services and supports will be available as needed.
- Integrated services for individuals with mental health and alcohol and drug issues will be provided for all age groups.
- Language-specific educational materials on health/mental health issues and resources for insurance, community supports, English as a Second Language (ESL), education, legal protections, and cultural norms will be available to help facilitate acculturation.
- Outreach, engagement, and clinical services will be tailored specifically for this population (e.g., narrative therapy (storytelling) for some members of the Hmong community).
- Youth leadership activities will be provided.
- Social and recreational services will be available in multiple languages, targeting various age-groups
- A variety of workshops will be incorporated on transportation resources, employment services, and other supports that promote equal representation of this population in the workforce, establish self-worth, financial independence, family cohesion, and stability. Workshops on pre-employment requirements and strategies will also be offered.
- Linkages will be developed to existing ethnic support structures.
- Culturally competent self-directed care plans that are family-focused will be utilized.
- The program will recruit students from a variety of programs including ESL and job training programs, undergraduate programs, and masters level programs, including the California State University, Sacramento Master of Social Work Program component focusing on Southeast Asian Immigration and Refugee experiences.
- Flexible funds will be available to pay for services not typically reimbursed by Medi-Cal, i.e. non-traditional healing practices, educational services, etc.

Program Service Strategies

The service strategies, which will be utilized by the Transcultural Wellness Center, are listed in Exhibit 4. They are consistent with the strategies identified in Section IV of the DMH Community Services and Supports Program and Expenditure Plan Requirements.

Training:

The workplan for the Transcultural Wellness Center is one important component of transformation of mental health services in Sacramento County. It is necessary to the process of transformation, but it is not sufficient in itself to produce system wide change. For this reason, we are proposing to enhance the efficacy of this workplan by adding system-wide training in a variety of wellness, recovery, (resiliency in children) model values and practices.

We believe that if transformation is truly to occur, all staff members must become familiar with the values, goals, and practices of recovery (resiliency in children) and wellness. Unless we immerse the entire system in new ways and change our culture from "fail first" to "whatever it takes," our workplans, no matter how well conceived, will become no more than old practices in new packages.

Equally important with training in wellness, recovery (resiliency in children) model values and practices is staff development of competence in serving persons of every culture, language group, and ethnicity. No matter how transformative the practices, if staff is not mindful of culturally relevant practices, the transformative practices will fail and, in failing, further deny access to the very people for whom they were designed. Accordingly, cultural competency training, across all programs and the entire Mental Health Division is essential to the success of our entire MHSA initiative.

Program Personnel

Selection of culturally and linguistically competent staff is critical to the success of the Center and central to the MHSA goals. Adequate mental health care begins with proper recruitment and staffing. Among LEP clients, bilingual/bicultural staffing is a prerequisite for sound culturally competent mental health practice.

Primary sources for recruitment will be community contacts and California State University, Sacramento (CSUS) Master of Social Work Program (MSW) SEA cohort/program. Efforts will be made to recruit graduate students in MSW programs by providing internships, clinical supervision, and job conversions. Additionally, efforts will be made to attract master level therapists working toward board certification and refining their clinical skills. Community colleges and ESL providers will be contacted for potential paraprofessional staff.

- An Executive Director, will be responsible for all daily operations of the program including staffing, administration, and facilities management.
- A Clinical Director will develop and manage the clinical protocols and mental health services. This person will also provide staff training and clinical supervision to the multidisciplinary team members and community contacts that interact with the program.
- Mental Health Counselors will have the clinical experience and cultural and linguistic competence skills to assess, diagnose, and treat children, transitional

age youth, adults, and older adults with mental health and co-occurring alcohol and drug needs from the API communities. They will function as service coordinators and work with consumers to develop individualized service plans that identify treatment goals for wellness, recovery, and resiliency. They will coordinate care with health, social services, and other community agencies. Staff will be knowledgeable about appropriate community resources for the API community to link and coordinate appropriate community services and supports. One Mental Health Counselor will be designated as the Outreach Coordinator, with primary responsibility for the overall planning and implementation of outreach and engagement activities, as well as media coordination.

- The Psychiatrist will provide culturally competent psychiatric evaluation, including medication and medication history review, as well as ongoing psychiatric treatment as required to achieve wellness and recovery (resiliency in children) treatment goals.
- Mental Health Workers will provide culturally and linguistically competent rehabilitation services and service coordination for adults and older adults. They will also conduct community outreach and engagement activities, recreational and socialization programs, and provide transportation, interpretation and translation as necessary, and educational services to the API community.
- Family/Consumer Advocate/Peer Counselor will provide support, assist with coping skills, and linkage to appropriate community agencies/activities. The Family/Consumer Advocate/Peer Counselor will provide culturally and linguistically competent services.
- The Program Secretary will assist administrative and clinical staff as needed.
- The culturally and linguistically competent Office Assistant will act as a receptionist, phone back-up, and have data entry responsibility.

Program Evidence-based Practices

Adhering to the MHSA goals, the program will ensure that all funds are expended in the most cost-effective manner and services are provided in accordance with best practice. To accomplish this, promising and effective model practices will be utilized in the implementation of the program. Specifically, the program will use a modified Assertive Community Treatment evidence-based practice model for Hmong consumers from the Kajsiab House operating in Madison, WI, which is listed on the SAMHSA website.

3. Describe any housing or employment services to be provided.

RESPONSE:

Issues of housing are treated differently in many parts of the Asian community. Extended family live in the same household, even when it leads to overcrowded conditions, when required by financial constraints. Additionally, due to issues

related to stigma and shame, family members suffering from mental illness are often kept in the family home. These culturally defined conditions can lead to overcrowding, increased family distress, and conflict. To address these conditions, the Transcultural Wellness Center will work closely with the proposed Permanent Supportive Housing Program for Individuals and Families in order to insure housing is available in a manner that is acceptable to the API community.

The program will incorporate information on transportation resources, employment services, and other supports that promote equal representation of this population in the workforce, and establish self-worth, financial independence, family cohesion and stability. Workshops on pre-employment requirements and strategies will be offered.

4. Provide the average cost for each Full Service Partnership participant including all fund types and fund sources for each Full Service Partnership proposed program.

RESPONSE:

Refer to the Budget. The estimated average annual cost for each Full Service Partnership participant is $5,345. Medi-Cal revenues were included in determining these costs. We recognize this average cost is significantly lower than some other full service partnerships; however, we believe it is appropriate to meet the service needs of the population utilizing this program.

5. Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

RESPONSE:

Both recovery and resilience are impacted by culture. Recovery and resilience are personal processes that can lead to hopeful, healthy, and satisfying lives despite the limitations and/or effects of mental illness or emotional disturbance. The path that a individuals take to achieve these goals will be different based on cultural norms and expectations.

To promote recovery and resilience, program staff will work with each of the participants to develop an individualized full service plan. The service plan will be guided by the principles of recovery, and resilience, in that it will be client/family directed, restore hope, emphasize client/family and community strengths and assets, and promote self-determination in order to achieve a quality of life as defined by the participant as compatible with cultural norms.

The Center's services and activities will be based on needs expressed by the communities and demand-driven under the guidance of a Steering Committee that represents all API ethnicities and age groups.

Recovery (resiliency in children) is supported by access to needed mental health, medical care, substance abuse, and social services; safe affordable housing; supportive relationships; meaningful activities, and more. This program will provide some of these services, as well as developing collaborative community partnerships that will facilitate the participants' recovery and resilience.

6. If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

RESPONSE:

Not Applicable.

7. Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

RESPONSE:

Clients and/or family members will participate at various levels in program design, operation, and review. The program activities of the Center will be guided by a Steering Committee that is drawn from potential and active clients and community members, elders, community leaders, and youth. Clients, family, and community members will be recruited to provide services in all areas where they meet qualifications. Where they do not meet requirements for clinical positions, they will be recruited for outreach service coordination/case management and peer support positions and advocacy.

8. Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

RESPONSE:

The program staff will work collaboratively with community based organizations in Sacramento County that have been and are working with API communities, including but not limited to: Asian Resources, Asian Pacific Counseling Center, Asian Community Center, Hmong Women's Heritage, Lao Family, and Southeast Asian Assistance Center. Working with these agencies will promote outreach and engagement, assist in staff training, and facilitate community involvement. All

collaborative strategies are designed to improve services to the API community and ensure positive outcomes from clients. Additional collaborative partners include other MHSA Community Services and Support programs (Transitional Community Opportunities for Recovery and Engagement (CORE), Older Adult Intensive, Permanent Supportive Housing, and Wellness and Recovery Center), consumer and family advocates, peer mentors, Geriatric Network, Adult and Child Protective Services, Probation, alcohol and drug treatment providers, public and private health clinics, schools, outpatient mental health clinics, homeless and housing programs, food banks, culturally based organizations, and faith based organizations. Staff will also work with other systems, such as Child Protective Services (CPS), Adult Protective Services (APS) and the criminal and juvenile justice systems, as appropriate to divert individuals with serious mental illness from these systems. Further, as with other populations, undiagnosed mental illness often increases the stay in these systems. It is anticipated that the ongoing contact and communication with these systems will increase awareness of the cultural issues that need to be considered in order to determine appropriate disposition.

9. Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

RESPONSE:

Despite the relatively large number of API residents in Sacramento County, the API community is underrepresented in all age groups and all ethnicities within mental health, according to the data in the Sacramento County Cultural Competence Plan Update (September 2003). The Transcultural Wellness Center is designed to offer linguistically and culturally competent services, tailored to each of the targeted API communities. This will include outreach and engagement efforts, individual and family counseling, medication consultation and support, service coordination/case management, peer counseling, and advocacy.

While all cultural and ethnic groups are welcome to services at the Transcultural Wellness Center, staff with bilingual/bicultural skills will specifically focus on services to individuals and families of all age groups from the API community. Age-related targets will be established for the first year based upon relative numbers within the total populations.

Services will be based on needs expressed by the API community and demand-driven under the guidance of a Steering Committee representing the community interests. Outreach and engagement efforts will be directed toward all API populations through the media, churches, temples, community centers, schools, and one-on-one through community leaders.

10. Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

RESPONSE:

Staff training in the API communities' cultural norms, regarding the issues of sexual orientation and gender roles, is essential for the success of the services offered through the Transcultural Wellness Center. In order to work effectively in the API community, services will address the gap between parents and children about the beliefs and attitudes regarding sexual orientation and gender roles.

Working with Asian Americans, a Guide for Clinicians 1977, (editor Evelyn Lee), reveals several distinctions regarding the API communities and sexual orientation and gender roles. Historically, API communities have considered discussions regarding sexual orientation as taboo. There are differing views of gender roles between immigrant/refugee parents and their children, who tend to be more acculturated to American values and expectations. Parents often attribute lack of conformity in these areas to disobedience or lack of appreciation on the part of the children and youth. The community tends to stigmatize individuals with differing sexual orientation and gender roles. This, coupled with parental lack of understanding of the differing views of the children and youth, results in feelings of marginalization of individuals with questions and/or differing beliefs.

The Center will promote the discussion of sexual orientation and gender roles. Services will be carefully designed to recognize and work with the cultural norms of the community. Staff will be trained to work effectively to foster communication that promotes understanding among family members and the community. Staff will also receive training related to the different cultural views and issues of sexual orientation and gender roles. The supervisors will provide skillful supervision in this area and will assure that these issues, as well as the differing psychologies between males and females are addressed appropriately. This will be done through regular supervision, utilization review and peer review of charts.

11. Describe how services will be used to meet the service needs for individuals residing out-of-county.

RESPONSE:

Not applicable.

12. If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

RESPONSE:

Not applicable.

13. Please provide a timeline for this work plan, including all critical implementation dates.

RESPONSE:

- Execute Contract with service provider on April 1, 2006
- Facility acquisition completed within 30 days
- Recruitment, hiring, and training of staff completed within 60 days
- Begin serving clients within 45 days
- Reach full program capacity within 9-12 months

14. Develop Budget Requests: Exhibit 5

RESPONSE:

See Exhibit 5.

15. A Quarterly Progress Report (Exhibit 6) is required.

RESPONSE:

See Exhibit 6.

Proposed Program
WELLNESS AND RECOVERY CENTER
Workplan #SAC6

1. Complete Exhibit 4

RESPONSE:

See Exhibit 4.

2. Describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

RESPONSE:

In developing this proposed program, the MHSA goals (set forth in Section 3 of the Act) and the MHSA Guiding Principles served as a template to create a program that will provide wellness and recovery services to underserved and unserved transition age youth, adults, and older adults afflicted by serious and pervasive mental disorder or serious emotional disability, regardless of culture or ethnicity, funding source, or any other potential barrier to access.

The Wellness and Recovery Center (WRC) will engage 450 new participants each year in outpatient programs fostering recovery and resilience. This will significantly increase the level of participation and involvement of clients and families in the recovery process. The WRC will serve transitional age youth, adults, and older adults experiencing symptoms of serious mental illness who, historically, have been underserved by office-based medication support programs.

MHSA stakeholder groups put forth two separate recommendations (#64 and #143) for neighborhood wellness centers that have been consolidated into this proposal. The members of the Task Force concurred in this recommendation and it was ratified by the Steering Committee. The center will be true to the intent of the MHSA in that it:

- Defines serious mental illness as a condition deserving priority attention;
- Reduces the long-term adverse impact from untreated serious mental illness;
- Expands successful and innovative service programs, including culturally and linguistically competent approaches;
- Provides state and local funds to adequately meet the needs of individuals enrolled in programs; and
- Ensures funds are expended in the most effective manner and services are based on best practices.

Incorporating these goals into its development, the Wellness and Recovery Center (WRC) will be a neighborhood multi-service center that providing ethnically and culturally appropriate opportunities in a holistic, inclusive fashion and offering a spectrum of activities. Consumers and family members will direct the WRC, creating a supportive environment that offers choice and self-directed guidance for recovery and transition into community life.

Participants will be encouraged to develop a Wellness and Recovery Action Plan™ (WRAP™) that will be guided by the principles of recovery. The Center will offer a wide array of activities and supportive services that will be incorporated into the action plan. The WRC's service delivery system will include: culturally appropriate wellness and recovery principles, peer counseling, psychiatric consultation, medication education, service coordination, networking, peer mentoring, interpreter/translator and psycho-educational services, as well as alternative and natural healing practices such as nutrition, exercise, yoga, meditation, art, and music, when seen as culturally relevant and desired by participants.

The WRC will encourage participants to explore different roles and life choice opportunities to develop each person's innate gifts. A special effort will be made to employ or stipend participants and family members from the community who can personally teach and pass along their skills in language, in culture, and in recovery.

The WRC's target population will be transition age youth, adults, and older adults, disabled by serious mental illness. Since individuals experiencing serious mental illness from cultural and ethnic groups historically have been underserved and unserved, WRC outreach workers will make special efforts to invite them in for services.

The following sections will describe the WRC in detail and explain how this program advances the goals of the MHSA.

Expanding Access

Recovery is grounded on the premise that one size really doesn't fit all. No plan of recovery is likely to succeed if the person involved is unable or unwilling to commit to it. Sensitivity to issues of readiness and motivation goes a long way in facilitating engagement in recovery. Even so, barriers imposed by stigma, beliefs, attitudes, fears, and misunderstandings of mental illness may be almost insurmountable. Experience has shown that overcoming a barrier of this sort requires a relationship and that this relationship requires trust.

According to our stakeholders, existing shortages of staff and facilities simply preclude enough individual interaction and connection to create the levels of trust needed to stand in the face of stigma or any of the other barriers to access.

All too often, individuals who become disabled by serious and persistent mental disorders do not get the support they need to embrace or maintain recovery when

challenged by one or more of the barriers named above.

We believe that new participants, family members, peers, community figures, and professional mental health workers, together, can create a center that offers a culture of recovery where relationships are open, egalitarian, and collaborative and trust is nurtured. Under these conditions we expect barriers to diminish and recovery to flourish.

Program Components

The components that make up the WRC have incorporated the goals and guiding principles of the MHSA to build a center that looks beyond "business as usual" and moves toward transforming the Sacramento County Mental Health system. The WRC components are listed as follows:

- A recovery and resiliency culture will be nurtured with WRC serving as a locus for consumers and family members, mental health providers, professionals, and the community. The anticipated outcome is that the relationships that emerge within this culture will mitigate the effects of stigma associated with mental illness and will allow individuals with serious mental illness to be accepted as persons with strengths and contributions.
- The service delivery system will include peer counseling, networking, peer mentoring support, interpreter/translator and psycho-educational services; professional services (including psychiatric consultation), and alternative and natural healing practices that include but are not limited to nutrition, exercise, yoga, meditation, art, and music when seen as culturally relevant and desired by participants.
- Participants will self-identify their needs and a Wellness and Recovery Action Plan ™ (WRAP™) will be developed collaboratively with the participant that will identify wellness and recovery outcomes, utilize peer guides and family/consumer advocates as a recovery team, and provide family education and training to enhance family members' ability to support and care for participants.
- Paid and stipended Consumer Peer Guides will be available to provide outreach, guidance, and engagement in using the WRC's activities, resources, and integrating the participants into community life.
- Medication support services will be provided for eligible participants. These services will be targeted to individuals in the recovery process who do not need other outpatient services. Medi-Cal reimbursement will be sought for Medi-Cal clients.
- WRC activities will guide participants and family members to engage in such activities as a computer lab, with available one-on-one training; a kitchen area for training in nutrition and food service industry employment; a multimedia library with up-to-date information on careers, housing, self-help, medication

management; health and substance abuse education; recreation; cultural and faith based events; and other participant and family driven activities.

- Reconnecting with Community. Opportunities will be developed for participants to become engaged in the community, to experience a variety of roles, to be welcomed and valued, and to find their gifts in life with the objectives of re-engagement, relapse prevention, interdependence/interdependence, and improved quality of life as they and their communities deem appropriate.
- Education partnerships will be forged with local colleges and other educational institutions to provide instruction in computer skills, small business formation, English as a Second Language, and other relevant topics. The WRC's library will be available for students, faculty, and the general public to learn more about mental health, cultures in our community, and recovery. These resources will be continually evolving to meet the emerging needs of the participants.
- Engagement activities are paramount to the program to ensure that individuals stay connected in order to move through the recovery process and become living examples of hope. Their stories will be spread by participants, family members, staff, and community stakeholders, and will engage many other underserved and unserved persons. Welcoming and acceptance will be provided through charity, entitlements, quality of life support resources and advocacy, with “no wrong door”.

Key Features of the Wellness and Recovery Center:

The following are key features of the Wellness and Recovery Center:

- Participation at the center will be voluntary.
- The Center will have the capacity to serve 450 unduplicated participants annually.
- The Center will be open from 7a.m. to 9p.m., 7 days per week.
- Client and family members’ participation will be encouraged in all aspects of planning, service delivery, and program evaluation.
- Participants will be given the opportunity to fill multiple life roles, such as engaged participant, educator, mentor, and advocate, and within each role will have the option to provide education and training in recovery and resilience,
- The WRC culture will encourage everyone to identify and utilize linguistic and cultural opportunities that engage, inform, support, and transform.
- The WRC culture will explicitly honor collaborative relationships with agencies and service providers in order to promote linkage to community services and supports.
- WRC practices will empower recovery, resilience, and self-determination by reconnection or connection to the community through engagement with consumer-run transportation services, volunteer programs, advocacy groups,

community self-help groups, nutrition programs, faith-based providers, churches, temples, and other community resources serving transition age youth, adults, and older adults of diverse cultures and ethnicities.

- Mentors will assist participants and family members to navigate the educational system.
- The WRC will identify "recovery leaders" based on lifestyles that exemplify recovery principles and will provide them with resources, education, and training consistent with their interests and desire to serve.
- Center staff will be actively involved in forming groups on topics of interest and will nurture the creation of groups by providing meeting space and support as needed.

Program Service Strategies

The service strategies that will be utilized by the Wellness and Recovery Center are listed in Exhibit 4. They are consistent with those identified in Section IV of the DMH Community Services and Supports Program and Expenditure Plan Requirements.

Training:

The workplan for the Wellness and Recovery Center is one important component of transformation of mental health services in Sacramento County. It is necessary to the process of transformation, but it is not sufficient in itself to produce system-wide change. For this reason, we are proposing to enhance the efficacy of this workplan by adding system-wide training in a variety of wellness and recovery model values and practices.

We believe that if transformation is truly to occur, all staff members must become familiar with the values, goals and practices of recovery and wellness. Unless we immerse the entire system in new ways and change our culture from "fail first" to "whatever it takes," our workplans, no matter how well conceived, would become no more than old practices in new packages.

Equally important with training in wellness and recovery model values and practices is staff development of competence in serving persons of every culture, language group, and ethnicity. No matter how transformative the practices, if our staff is not mindful of culturally relevant practices, the transformative practices will fail and, in failing, further deny access to the very people for whom they were designed. Accordingly, we regard cultural competency training, across all programs and the entire Mental Health Division, to be essential to the success of our entire MHSA initiative.

Program Personnel

A culturally and linguistically competent staff is critical to the success of the center and central to the MHSA goals. Adequate mental health care begins with recruiting

and training staff members that will be effective in assisting clients to attain wellness and recovery.

Cultural and linguistic competence and recovery effectiveness will be the principles that will be used when hiring staff for the center. Every effort will be made to achieve maximum client and family member participation in all paid and unpaid positions, with the goal of developing the skills necessary to obtain competitive employment outside the Mental Health system.

- The Executive Director will be responsible for all daily operations of the program including staffing, administration and facilities management. The Director will have responsibility for and oversight of the development of all aspects of consumer and family member activity and recovery planning services. Duties will include the following:
  - ✓ Provide leadership and consultation to staff.
  - ✓ Provide human resource leadership for consumer staff and volunteers.
  - ✓ Ensure consumer and family participation in the development, implementation, evaluation, and monitoring of service outcome measures.
  - ✓ Develop guidelines and policies for the Center.
  - ✓ Establish consumer and family steering committee that is representative of the community served.
  - ✓ Ensure training to consumers, family members, and community stakeholders on recovery principles, self-determination planning, and cultural competence.
  - ✓ Assume liaison and leadership role with community groups, businesses, faith-based partners, boards, and relevant state and local agencies.
- The Program Coordinator will plan, organize, direct, and coordinate the activities of the Center through participant and family member involvement and supervise Center staff, including peer guides, volunteers, and support staff. Duties will include:
  - ✓ Implement the educational, self-help, vocational, and employment activities of the Center;
  - ✓ Implement, review, and evaluate the activities and experiences that occur daily at the Center;
  - ✓ Establish and maintain effective working relationships with staff, public and private agencies, and groups involved in the Centers' programs and activities;
  - ✓ Identify, measure, develop, and implement best practice models, strategies, and interventions that meet the needs and desires of members from a culturally diverse community; and
  - ✓ Utilize strength-based approaches in identifying obstacles and successes and work collaboratively with staff, consumers, family members, providers, and the community in identifying best practices and implementation strategies.
- The Senior Mental Health Counselor will be a licensed mental health professional that will provide mental health services and supervise the services provided by the mental health counselor. The Mental Health Worker is a mental health paraprofessional that will also provide mental health services. Both positions will have the responsibility of assessing new clients and assisting them to develop

and implement service plans in collaboration with the Psychiatrist. This team will work with clients to facilitate their wellness and recovery goals.

- The Office Assistant will provide clerical support for the service team and administrative support to the program.
- The Peer Guides will encourage individuals with mental illnesses to be included as collaborators, co-workers, and trainers. Peer Guide duties will include the following:
  - ✓ Actively implement recovery, resilience, and self-determination planning by providing opportunities to self-discover various life roles;
  - ✓ Engage participants in social, educational, and vocational experiences that guide participants in community integration, supportive education, advocacy, and employment;
  - ✓ Provide outreach and engagement activities that are culturally and ethnically specific that meet the identified needs of transition age youth, adults, and older adults;
  - ✓ Encourage, demonstrate, and provide opportunities for clients and family members to participate in the development, implementation, and evaluation of Center activities;
  - ✓ Educate and teach peers wellness and recovery skills. Provide opportunities for peers to teach each other methods of achieving meaningful roles in life;
  - ✓ Provide peer supportive services, including peer-counseling; and
  - ✓ Guide participants toward continued education, employment, supportive housing, community integration, substance abuse treatment, supportive education, and family strengthening.
- The Psychiatrist will provide a comprehensive psychiatric and medication consultation and support, including a medical history review, and will collaborate with the primary care physician and other healthcare professionals as required to achieve participant-identified wellness and recovery goals. The ideal candidate for this position will be a consumer.

Evidence-Based Practices

Adhering to the MHSA goals, the Center will ensure that all funds are expended in the most cost-effective manner and services provided in accordance with best practices.

The Substance Abuse and Mental Health Services Administration of the United States Department of Health and Human Services, as well as the Surgeon General of the United States, have recognized consumer-operated recovery programs as best practices and promising practices as the evidence base for efficacy continues to grow. Wellness Recovery Action Planning (WRAP ™) is considered to be a Model Program and Sacramento Psychosocial Options for Rehabilitation Training (SacPort) is a science-based program that will be utilized as appropriate.

3. Describe any housing or employment services to be provided.

RESPONSE:

The Wellness and Recovery Center will work closely with the proposed program Permanent Supportive Housing Program for Individuals and Families to assist participants to obtain safe and affordable housing that is acceptable to them.

The Center will provide linkages to transportation resources, employment services, financial services, and other supports that promote equitable and fair representation in the workforce for people from diverse cultures with disabilities arising from a mental disorder. Workshops on pre-employment requirements, benefits counseling, and strategies to achieve meaningful roles in life will be offered.

4. Provide the average cost for each Full Service Partnership Participant including all fund types and fund sources for each Full Service Partnership proposed program.

RESPONSE:

Not Applicable.

5. Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

RESPONSE:

The focus of the activities at the Center is on individuals of various ages regaining, gaining, or maintaining the ability to live, work, learn, and participate fully in the community. This represents the very definition of Recovery. Education and training focused on employment or community-living skills, peer and family support, self-help groups, and advocacy training are deeply rooted in the recovery philosophy. The program recognizes that recovery and resiliency shall be promoted and brought to life in all Center activities.

The ultimate goal of the Wellness and Recovery Center is to support the individual in achieving recovery as defined by the individual, in collaboration with community services and supports. The Wellness and Recovery Action Plan ™ will be guided by the principles of recovery and sensitive to the impact of cultural norms upon recovery. This plan will be adapted to include goals related to resiliency as deemed appropriate by the individuals receiving services.

6. If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

RESPONSE:

Not Applicable

7. Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

RESPONSE:

Participants and family members will be actively involved in all levels in program design, operation, and review. The Wellness Recovery Center will be a participant-directed and family member-directed program. The operation of the Center will be contracted, through a competitive bid process, to an organization with a proven ability to develop and employ consumer staff and work well with family members. Participants and/or family members will provide the services and supports.

8. Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

RESPONSE:

Sacramento County Department of Health and Human Services has a strong history of developing collaborative programming and maintaining strong relationships with the community toward achieving common goals. Strong partnerships currently exist with Consumer Self-Help Centers, Sacramento Chapter of the Mental Health Association, National Alliance for the Mentally Ill - Sacramento, Sac-Net, and the community mental health provider network. These partnerships will continue and be strengthened with the development of the Wellness Recovery Center.

New partnerships will be developed with faith-based communities, community colleges, ethnic and cultural specific organizations (including tribal organizations), and the community at large. These additional partnerships will improve services and outcomes by focusing on wellness and resilience and reducing stigma.

9. Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

RESPONSE:

Several stakeholder groups, including the Cultural Competence Task Force and its Stakeholder Groups recommended establishing the Wellness and Recovery Center. Stakeholders that included consumers, family members, potential consumers and family members, community leaders and mental health providers developed comprehensive recommendations that led to the outline of this program.

The Center is designed to offer linguistically and culturally competent activities for multicultural participants, including outreach and engagement efforts, medication consultation and support, service coordination/case management, peer counseling, and advocacy to this unique population.

Staffed with bi-lingual, bi-cultural staff and interpreter services as needed, the Center will be open to all cultures and ethnicities. Age-related targets will be established for the first year based upon relative numbers within the total populations. This model will afford the most efficient delivery system for the following services: peer support, natural healing practices, medication consultation and support, networking, and psychosocial and educational activities.

Establishing a recovery and resilience culture begins with proper recruitment and staffing. The Center will have an aggressive, ongoing recruitment campaign to hire consumer staff with gifts that enhance recovery and resilience. All will be trained in providing culturally and linguistically competent services. Hiring staff with bi-lingual and bi-cultural skills and experience working with ethnically diverse transition age youth, adults, and older adults with mental health needs will be a priority. In the event it is not possible to meet the linguistic needs required, interpreter and translator services will be available when necessary to ensure the provision of culturally and linguistically competent services. The hope and vision is to draw staff that is representative of the community into positions within the Center, which will improve the ability to serve the community.

Primary sources for staff recruitment will be community contacts, such as Consumer Self-Help Centers, youth self-help centers, Mental Health Associations, and ACCESS Television, along with local educational institutions, such as California State University, Sacramento (CSUS), American River College, Consumnes River College, Sacramento City College, and educational institutions that offer CASRA certification.

The contractor awarded the bid for the Center will be required to have a Cultural Competency Plan that outlines how the Center will implement requirements set forth

by the Sacramento County Division of Mental Health Services Cultural Competency Plan. The Centers' activities will be consumer and family member-focused services that meet the self-identified needs of a culturally and linguistically diverse community.

10. Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boy and girls.

RESPONSE:

Recruitment of staff that are representative of the clientele in terms of sexual orientation/gender (including transgender) is the preferred means of fostering and maintaining respectful and sensitive relationships. Although staff training in the cultural norms regarding the issues of sexual orientation and gender roles is essential for the success of the Wellness and Recovery Center and will be accomplished, diversity of staff in this area is even more important. The Division of Mental Health actively promotes the concept of family as one that is self-defined by the individual receiving services. Therefore, the Center activities and forms will be carefully designed to recognize and work with the cultural norms of the community. Staff will be encouraged to seek expertise from supervisors and/or outside experts when needed. Supervisors will also provide training and guidance related to the differing psychologies between males and females.

Program planning and activities will be based on respect for the individual's preferences, strengths and concerns. Service staff members will be fully trained in LGBTIQ (Lesbian, Gay, Bisexual, Transgender, Intersex, and Questioning) issues and family and social relationship building strategies. Education and service strategies will be employed to promote personal empowerment. Individuals will be encouraged, when appropriate, to participate in peer counseling and treatment groups that address sexual orientation and gender issues. Services to address the gap that often occurs between parents and children related to gender roles and sexual orientation issues, particularly among immigrant families, will be provided.

11. Describe how services will be used to meet the service needs for individuals residing out-of-county.

RESPONSE:

Not Applicable.

12. If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

RESPONSE:

Not Applicable.

13. Please provide a timeline for this work plan, including all critical implementation dates.

RESPONSE:

- Execute Contract with service provider on April 1, 2006
- Facility acquisition completed within 30 days
- Recruitment, hiring, and training of staff completed within 60 days
- Begin serving clients within 45 days
- Reach full program capacity within 9-12 months

14. Develop Budget Requests: Exhibit 5

RESPONSE:

See Exhibit 5.

15. A Quarterly Progress Report: (Exhibit 6) is required to provide estimated population to be served. A Cash Balance Quarterly Report (Exhibit 7) is required to provide information about the cash flow activity and remaining cash on hand.

RESPONSE:

See Exhibit 6.

Proposed Program
PSYCHIATRIC EMERGENCY RESPONSE TEAM (PERT)
Workplan #SAC7

1. Complete Exhibit 4

RESPONSE:

See Exhibit 4.

2. Describe in detail the proposed program for which you are requesting MHSA funding and how that program advances the goals of the MHSA.

RESPONSE:

In developing this proposed program, the MHSA goals (as set forth in Section 3 of the Act) and the MHSA Guiding Principles served as the foundation for creating a mental health program that will provide individuals experiencing a mental health crisis the services and supports necessary to resolve the crisis at the least restrictive level of care.

Every day, county law enforcement officers are called into situations in which they have to make decisions regarding the needs of individuals experiencing mental health crises. Although Sacramento County has a good reputation for the abilities of its officers and deputies to make difficult decisions, there is always the possibility of an adverse or ineffective outcome.

In 2000, Protection and Advocacy, Inc, a nonprofit organization providing advocacy and intervention services to a broad range of consumers with disabilities in California, as well as Patient Rights services under contract to the State of California, released an investigation into the unrelated shooting deaths of two men during the course of their attempted detentions under W&I Code Section 5150. (These incidents did not occur in Sacramento County).

Their investigation determined that these adverse outcomes were directly attributable to the lack of proper training for both mental health professionals and law enforcement officers, the absence of interagency protocols for managing high risk crisis situations, and the difficulties arising from mutual unfamiliarity of mental health professionals and law enforcement officers in working with each other collaboratively to defuse crises.

Even when no adverse outcome occurs, individuals in crisis may not become engaged with a source of help. All too often, people in crisis give up, utter a few words to reassure the officer or other first responder, and continue to suffer the effects of the disorder or situation without help. Whenever a person in crisis gives

up because no resources are available, the intervention has been ineffective, even though there may not have been an adverse outcome.

Intervention in a mental health crisis is time-consuming under the best of situations. People in crisis are often not able to listen well, process information, or follow through. Assessment and resolution of a crisis require enough time to determine what is actually fueling it. While mental illness may be a primary cause, other issues may be escalating the situation.

Although officers receive some training in identifying symptoms of mental illness, historically, this has not been their area of expertise. In addition, individuals in crisis may be under the influence of alcohol or other drugs and may or may not have a co-occurring mental illness. Making an adequate assessment is very difficult in the field, absent any treatment history or professional training.

Family members and consumers are often reluctant to involve law enforcement in an intervention in mental health crisis situations. Adverse outcomes such as those described in the PAI report cited above loom large in people's minds even though they rarely occur. There may be a great deal of fear associated with the presence of uniformed officers, particularly for some immigrants. There may be frustration when officers are called for assistance and feel unable to take an individual to psychiatric treatment because they did not directly witness signs of danger to self or others, or grave disability. Additionally, there is stigma associated with squad cars called to a private residence and mentally ill individuals being handcuffed during escort.

The mobile Psychiatric Emergency Response Team (PERT) is a strategy focusing on wellness and recovery that provides for the time and resources required for effective crisis intervention. PERT is a program co-staffed with mental health professionals, law enforcement officers, and consumers/family advocates. Integrating law enforcement assets into mobile mental health crisis response will optimize access to appropriate treatment resources as well as reduce unnecessary incarcerations. The collaboration allows for complementary utilization of the strengths of both mental health providers and law enforcement officers to provide an alternative to the criminal justice response initiated by the current 9-1-1-dispatch system.

Using the MHSA goals as its guide, the Psychiatric Emergency Response Team (PERT) will provide ethnically and culturally appropriate multidisciplinary mobile mental health crisis services to stabilize mental health crises; to establish linkages with appropriate community services, mental health services, physical healthcare, substance abuse services, and social services to promote wellness and recovery; to increase social supports; to decrease isolation; and to prevent the recurrence of crisis situations and/or hospitalization or incarceration. In addition, the PERT teams will provide ongoing brokerage and linkage services and supportive mental health services to individuals, pending their engagement with an appropriate community provider.

The mobile teams will each consist of a licensed mental health professional paired with a law enforcement officer operating from an unmarked patrol car and using a rear seat shield that drops out-of-sight when not required to insure the safety of clients or others. Further modifications of the vehicle for client comfort include removal of weapons and other law enforcement paraphernalia from the driver's compartment of the vehicle.

PERT teams will have access to mental health treatment history, including current linkages, and will be able to obtain criminal history from first responders when appropriate. The teams will respond to calls from officers in the field observing indications of an apparent mental health crisis and will provide outreach, engagement, and follow-up services to adults with serious mental illness (SMI) or children with serious emotional disturbance (SED) who have previously come into contact with the teams.

Both the mental health professionals and the PERT law enforcement officers will be carefully selected and have experience and training in working with individuals of all ages and cultures. Teams will include specialists in children's services and older adult services as well as adult services. Staff with bi-lingual and bi-cultural skills will be recruited. Interpreters will be utilized as necessary and appropriate. Consumers and family members will play a key role in training staff by sensitizing the mental health professionals, PERT liaison / coordination officers, and law enforcement officers to the needs of individuals in crisis.

The teams will be committed to recovery and resiliency models. It is anticipated the program will reduce unnecessary trauma to consumers and family, avoid involuntary interventions, and reduce the utilization of higher levels of care via diversion and alternative crisis resolution. Thus, the program will support individuals in crisis in the least restrictive manner and setting.

PERT team members and their intervention partners will follow up after their initial contact to ensure individuals have been effectively linked with appropriate treatment and services. Examples of some of the intervention partners are other MHSA Community Services and Support programs (Transitional Community Opportunities for Recovery and Engagement (CORE), Transcultural Wellness Center, Older Adult Intensive, Permanent Supportive Housing, and Wellness and Recovery Center), consumer and family advocates, peer mentors, Geriatric Network, Adult and Child Protective Services, Probation, alcohol and drug treatment providers, public and private health clinics, schools, outpatient mental health clinics, homeless and housing programs, food banks, culturally based organizations, and churches.

Program Design Features

The following are key program design features:

- Services will be mobile and provided where the individual is experiencing the mental health crisis.

- The initial operation will be limited to the days and hours of the week that existing utilization data show highest levels of involvement with individuals in mental health crisis.
- Mobile computers will provide quick access to the mental health database to determine mental health treatment status or history.
- The program will have the ability to verify benefit coverage quickly and accurately.
- The licensed mental health professional will insure the skill level necessary to conduct comprehensive field assessments independently, with the capacity to authorize services.
- The program will afford the opportunity to evaluate the entire family situation and facilitate linkage to mental health services; alcohol and drug resources, supportive services, and other needed services for the entire family.
- The crisis response and linkage services will continue until the client is stabilized and appropriate community resource linkages are established.
- Mental health professionals and PERT liaison / coordination officers will consult with law enforcement personnel to enhance officers' ability to identify and effectively interact with adults with serious mental illness (SMI) or children with serious emotional disturbance (SED).

Program Service Components

The components that make up the Psychiatric Emergency Response Team have incorporated the goals and guiding principles of the MHSA to build a program that looks beyond "business as usual" and moves toward transforming the Sacramento County Mental Health system. The components are listed below:

Assessment. When a person's personal anguish and agitation erupt into public crisis it is often the product of a lengthy process in which the person has become overwhelmed by events and demoralized and sees no hope for a favorable outcome.

Some of the complicating factors that may be involved in the acute manifestation of the crisis include medication issues, use of non-prescribed substances, untreated physical illness, and psychosocial stress arising from homelessness, poverty, family conflict, or other issues.

Only a methodical assessment of history and systems is likely to elicit the bigger picture and identify opportunities to intervene across multiple domains. Accordingly, multi-disciplinary assessment is foundational to the operations of the PERT team.

Stabilization. It has been said about crisis stabilization, "…it is not what you say to the person in crisis that is important; it is what you allow them to say to you." This illustrates the point that the investment of adequate time is crucial to stabilization.

Although in practice stabilization episodes may be extremely difficult, complex and involved, the concept is relatively simple. Either a stabilization must somehow reduce the perceived stressors or it must increase the client's resources for dealing with the stressors.

Historically, perceived stressors have been reduced either through direct intervention (speaking to significant others, landlords, neighbors, or employers on the client's behalf) or by assisting the client to change the way she or he views the stressors in order to dilute their intensity or minimize the psychological impact.

Linkage to treatment and services. Stabilization may also increase clients' capacity to deal with stressors through direct provision of resources (hospitalization, medication, shelter, food, clothing, etc.) or through linkages (appointments with providers, agencies, programs). These linkages, along with the capacity for follow-up with the individuals, are essential components of the program, with an expected outcome of reducing the re-occurrence of future crisis situations.

Referral Resources. Management of referral resource data is crucial to successful linkages in the field. Service brokers will continually update their information to ensure that contact information, addresses, and service descriptions, etc. are accurate and current. PERT team success depends on developing credibility in the community.

Consumer, Family, and Community Partnership. An Advisory Board including consumers, family members, health, mental health, and alcohol and drug treatment providers with representation of all major ethnic/cultural groups in the community will guide the development and implementation of the program.

Program Service Strategies

Service strategies that will be utilized by the Psychiatric Emergency Response Team are listed in Exhibit 4. These strategies are consistent with those identified in Section IV of the *DMH Community Services and Supports Program and Expenditure Plan Requirements.*

Program Personnel

In accordance with the MHSA goals, all staff will be skilled in working within a multidisciplinary team framework and collaboratively with other disciplines, agencies, and facilities. All staff will be trained in providing culturally and ethnically competent services, including working with interpreter and translator services as needed. Hiring staff with bicultural/bilingual skills and experience working with ethnically diverse individuals with mental health needs will be a priority.

- The **Mental Health Program Coordinator / Clinical Supervisor,** in conjunction with the PERT Law Enforcement Supervisor, will oversee all operational activities of the PERT Unit. The Program Coordinator will provide clinical supervision and continuing education and training to the team members, as well as to community

service providers and will direct service delivery. The education and training will enhance the team's ability to deliver the necessary treatment and support services that will promote wellness and recovery. The Mental Health Program Coordinator will oversee personnel matters involving PERT Team clinical members and will sit on the oversight committee as a team representative. The Program Coordinator and the PERT Liaison / Coordination Supervisor may also act as an active PERT Team as necessary. The Mental Health Program Coordinator will also be responsible for developing collaborative relationships with community providers of health, mental health, substance abuse and social services and supports, including outreach to ethnically and culturally diverse populations.

- The **PERT Law Enforcement Supervisor**, in conjunction with the Mental Health Program Coordinator, will oversee all operational activities of the PERT program. The PERT Law Enforcement Supervisor will oversee personnel matters involving PERT Team members and will sit on the oversight committee as a team representative. The Law Enforcement Supervisor and the Program Coordinator may also act as an active PERT Team as necessary. In addition to these primary duties, the Liaison / Coordination Supervisor will:

  - ✓ schedule assignments,
  - ✓ coordinate unit training,
  - ✓ ensure the completion of monthly statistics,
  - ✓ respond to complaints by the public or other government agencies,
  - ✓ investigate complaints relative to services and personnel,
  - ✓ ensure compliance with MHSA regulation,
  - ✓ evaluate work performance of assigned PERT liaison / coordination staff,
  - ✓ review and approve documentation generated by PERT teams,
  - ✓ coordinate testing and hiring procedures for Liaison / Coordination staff member candidates, and
  - ✓ perform administrative duties as required.

- The **Senior Mental Health Counselor** will be a licensed mental health professional who will provide comprehensive assessment and crisis intervention services in the field during a crisis response. The Senior Mental Health Counselor will be designated to effect involuntary detention for involuntary psychiatric evaluation under W&I Code Section 5150 and also delegated the ability to authorize mental health services. The Senior Mental Health Counselor will provide brokerage and linkage services together with the Law Enforcement Officer until the client is engaged with appropriate services. Regular follow up with clients will be provided to minimize further community crisis calls. The Senior Mental Health Counselor will consult with the assigned Liaison / Coordination officer and participate in team decision-making.

- The **Law Enforcement Officer** will provide for the safety of the consumer, the team, family members, and other members of the community involved with a crisis situation. They will complete W&I Code Section 5150 applications for 72-hour detentions and coordinate the safe transportation of the child, youth, adult, or older adult with serious emotional disturbance or serious mental illness.

Liaison with law enforcement dispatch systems will allow the teams to access information pertaining to those individuals in mental health crisis who repeatedly come into contact with law enforcement. The role of the Law Enforcement Officer is to provide referral and linkage services to individuals served by the PERT team and to provide liaison between law enforcement agencies and mental health service providers.

- The **Consumer / Family Advocate** will provide peer support to the client as well as support for family caregivers, who are often the primary support system for the individuals. Consumer/Family Advocates provide emotional support, companionship, assistance with coping skills, and community resource linkage assistance. They can also function as consumer advocates to ensure that service plans, interventions, and supports are client-directed and focused on wellness and recovery. Typical duties performed by Consumer / Family Advocates include:
  - ✓ Provide post-crisis service coordination and advocacy services for program participants
  - ✓ Serve as liaison between Consumers / Family Members and PERT team
  - ✓ Assist participants to develop service plans and monitor progress
  - ✓ Assist participants to access community-based mental health services MediCal, MEDICARE, etc
  - ✓ Serve as consultant to PERT mental health professional and liaison / coordination officer
  - ✓ Provide linkage to Assisted Access services and culturally specific services as appropriate
- The **Senior Office Assistant** will provide clerical support to PERT service providers as well as perform office management and data entry duties for the program overall.

Program Promising Practices

Adhering to the MHSA goals, the program will ensure that all funds are disbursed in the most cost-effective manner and services provided in accordance with best practices.

The PERT program draws on successful models of mental health and law enforcement partnerships across the United States.

In addition, a continuous evaluation component will be developed and monitored by the Mental Health Program Coordinator and the Division of Mental Health Research and Evaluation Unit to ensure that program practices are modified as needed to ensure best practice standards are maintained.

3. Describe any housing or employment services to be provided

RESPONSE:

Although this is not a full service partnership program, the senior mental health counselor will work collaboratively with the client/family caregiver to identify the housing needs and link the client with the appropriate, available community resources to achieve this identified service plan goal.

4. Provide the average cost for each Full Service Partnership Participant including all fund types and fund sources for each Full Service Partnership proposed program

RESPONSE:

Not Applicable.

5. Describe how the proposed program will advance the goals of recovery for adults and older adults or resiliency for children and youth. Explain how you will ensure the values of recovery and resiliency are promoted and continually reinforced.

RESPONSE:

The program will recognize that recovery model practices incorporate respect for an individual's capacity to resolve crises and return to or achieve for the first time a higher level of functioning. PERT will adhere to principles of recovery that include client directed services based on strengths and assets promoting self-determination in order to achieve the quality of life defined by the individual and a firm commitment to the idea that all individuals, but especially children and TAY, possess the innate capacity to rebound from crisis and continue to grow as empowered and effective individuals.

Recovery and resiliency are facilitated by access to needed mental health services, medical care, substance abuse services, safe affordable housing, supportive relationships, and meaningful activities. This program will provide the linkages and follow-up required to ensure that individuals receive these supports and services.

6. If expanding an existing program or strategy, please describe your existing program and how that will change under this proposal.

RESPONSE:

Not Applicable.

7. Describe which services and supports clients and/or family members will provide. Indicate whether clients and/or families will actually run the service or if they are participating as a part of a service program, team or other entity.

RESPONSE:

Clients, family members, and advocates will function as intervention partners by assisting with stabilization and support. In addition, clients, family members, and advocates will be members of the Advisory Board, which will guide program operations and training of staff. The Advisory Board, with stakeholder representation, is not only a key component of the program, but forms the basis of program development. Those clients and family members who meet the qualifications for staff positions will be encouraged to apply.

Consumer / Family Advocates will provide support to family caregivers. These family caregivers frequently experience stress and depression due to their caregiver role and responsibilities. They can benefit from assistance in navigating the community network of services.

8. Describe in detail collaboration strategies with other stakeholders that have been developed or will be implemented for this program and priority population, including those with tribal organizations. Explain how they will help improve system services and outcomes for individuals.

RESPONSE:

The Psychiatric Emergency Response Team will develop new and strengthen existing collaborative relationships with community service providers.

There currently do exist collaborative relationships among emergency service providers such as Adult Protective Services (APS), CHWMF Geriatric Network, fire departments, private ambulance companies, and the Sacramento County Mental Health Treatment Center and other psychiatric inpatient facilities, as well as medical hospital emergency departments. This program will work to strengthen communication and coordination among these service providers to coordinate effective crisis response and stabilization interventions.

PERT will develop and strengthen linkages and collaborative relationships with health, mental health, and social service providers to promote recovery beyond the crisis response and stabilization interventions. Supporting healthcare providers include Sacramento County DHHS Primary Care Clinic; family practice/internal medicine physicians; dentists; and non-traditional/alternative healthcare providers from ethnically/culturally diverse populations.

The MHSA CSS Program Transitional Community Opportunities for Recovery and Engagement (CORE) is a full partner in the success of the PERT team. Other

mental health providers include contract providers for the Sacramento County DHHS Division of Mental Health. Alcohol and drug treatment resources and a variety of social support providers, including homeless and housing programs, food banks, culturally based organizations, tribal councils, churches, and other faith-based groups will be part of the collaborative network.

The Psychiatric Emergency Response Team will also provide services to ethnically and culturally diverse individuals. Therefore, it will develop and strengthen collaborative relationships with community organizations serving diverse populations such as the Asian Pacific Community Counseling Center, Sam Pannell Meadowview Community Center, and the Southeast Asian Assistance Center, as well as faith-based organizations, tribal organizations, and others.

9. Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.

RESPONSE:

This program will recruit bilingual/bicultural staff to provide culturally competent services. This program will give priority to recruiting staff, including family/consumer advocates, who reflect the ethnic and linguistic diversity of the community and who are skilled in working with ethnically/culturally diverse populations. Cultural competence training will be provided to all staff, and will address cultural issues such as language, race, ethnicity, customs, family structure, sexual orientation, and community dynamics.

10. Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

RESPONSE:

It is essential that the assessment process and intervention strategies consider such diversity, including sexual orientation and gender differences at all ages and within the cultures represented in our community. The Division of Mental Health actively promotes the concept of family as one that is self-defined by the individual receiving services. Therefore, the program's assessment processes will be designed to reflect sensitivity to sexual orientation issues, particularly when assessing family structure and significant relationships. Cultural competence training will be provided for all staff and will include sexual orientation and gender sensitive issues.

11. Describe how services will be used to meet the service needs for individuals residing out-of-county

RESPONSE:

Not Applicable.

12. If your county has selected one or more strategies to implement with MHSA funds that are not listed in Section IV, please describe those strategies in detail including how they are transformational and how they will promote the goals of the MHSA.

RESPONSE:

Not Applicable.

13. Please provide a timeline for this work plan, including all critical implementation dates.

RESPONSE:

- Execute Memorandum of Understanding (MOU) between County of Sacramento, City of Sacramento, and Sacramento County Sheriff on April 1, 2006.
- Facility acquisition completed within 30 days
- Recruitment, hiring, and training of staff completed within 60 days
- Begin serving clients within 45 days

14. Develop Budget Requests: Exhibit 5

RESPONSE:

See Exhibit 5.

15. A Quarterly Progress Report: Exhibit 6

RESPONSE:

See Exhibit 6.

PART III – EXHIBITS
TABLE OF CONTENTS

Exhibit 2: COMMUNITY SERVICES AND SUPPORTS PROGRAM WORKPLAN LISTING

Fiscal Year : 2005/06

County: Sacramento		TOTAL FUNDS REQUESTED				FUNDS REQUESTED			
#	Program Work Plan Name	Full Service Partnerships	System Development	Outreach & Engagement *	Total Request	Children, Youth, Families	Transition Age Youth	Adult	Older Adult
SAC1	Transitional Community Opportunities for Recovery and Engagement	18,352	491,423	-	$ 509,775	n/a	$ 76,466	$ 382,331	$ 50,978
SAC2	Older Adult Intensive Services Program	531,104	-	-	$ 531,104	n/a	n/a	$ 15,933	$ 515,171
SAC4	Permanent Supportive Housing Program for Individuals and Families	4,620,583	-	-	$ 4,620,583	$ 1,192,408	$ 1,192,408	$ 2,086,716	$ 149,051
SAC5	Transcultural Wellness Center	363,232	-	-	$ 363,232	$ 145,293	$ 36,323	$ 145,293	$ 36,323
SAC6	Wellness and Recovery Center	12,489	334,423	-	$ 346,912	n/a	$ 34,691	$ 277,530	$ 34,691
SAC7	Psychiatric Emergency Response Team Program	10,889	291,587	-	$ 302,476	$ 53,841	$ 27,222	$ 191,165	$ 30,248
		$ 5,556,649	$ 1,117,433	$ -	$ 6,674,082	$ 1,391,542	$ 1,367,110	$ 3,098,968	$ 816,462

* Although no funding was dedicated to Outreach and Engagement, it is anticipated that each program will conduct outreach and engagement activities in the normal course of business (see program narratives).

Exhibit 2: COMMUNITY SERVICES AND SUPPORTS PROGRAM WORKPLAN LISTING

Fiscal Year : 2006/07

County: Sacramento		TOTAL FUNDS REQUESTED				FUNDS REQUESTED			
#	Program Work Plan Name	Full Service Partnerships	System Development	Outreach & Engagement *	Total Request	Children, Youth, Families	Transition Age Youth	Adult	Older Adult
SAC1	Transitional Community Opportunities for Recovery and Engagement	58,880	1,576,671	-	$ 1,635,551	n/a	$ 245,333	$ 1,226,663	$ 163,555
SAC2	Older Adult Intensive Services Program	1,072,415	-	-	$ 1,072,415	n/a	n/a	$ 32,172	$ 1,040,243
SAC4	Permanent Supportive Housing Program for Individuals and Families	2,178,444	-	-	$ 2,178,444	$ 540,254	$ 540,254	$ 993,370	$ 104,566
SAC5	Transcultural Wellness Center	1,336,239	-	-	$ 1,336,239	$ 545,183	$ 171,039	$ 475,702	$ 144,315
SAC6	Wellness and Recovery Center	28,391	760,257	-	$ 788,648	n/a	$ 78,865	$ 630,918	$ 78,865
SAC7	Psychiatric Emergency Response Team Program	43,557	1,166,346	-	$ 1,209,903	$ 215,363	$ 108,892	$ 764,658	$ 120,990
		$ 4,717,926	$ 3,503,274	$ -	$ 8,221,200	$ 1,300,800	$ 1,144,383	$ 4,123,483	$ 1,652,534

* Although no funding was dedicated to Outreach and Engagement, it is anticipated that each program will conduct outreach and engagement activities in the normal course of business (see program narratives).

Exhibit 2: COMMUNITY SERVICES AND SUPPORTS PROGRAM WORKPLAN LISTING

Fiscal Year : 2007/08

County: Sacramento		TOTAL FUNDS REQUESTED				FUNDS REQUESTED			
#	Program Work Plan Name	Full Service Partnerships	System Development	Outreach & Engagement *	Total Request	Children, Youth, Families	Transition Age Youth	Adult	Older Adult
SAC1	Transitional Community Opportunities for Recovery and Engagement	9,486	1,626,065	-	$ 1,635,551	n/a	$ 245,333	$ 1,226,663	$ 163,555
SAC2	Older Adult Intensive Services Program	1,072,415	-	-	$ 1,072,415	n/a	n/a	$ 32,172	$ 1,040,243
SAC4	Permanent Supportive Housing Program for Individuals and Families	2,178,444	-	-	$ 2,178,444	$ 540,254	$ 540,254	$ 993,370	$ 104,566
SAC5	Transcultural Wellness Center	1,336,239	-	-	$ 1,336,239	$ 545,183	$ 171,039	$ 475,702	$ 144,315
SAC6	Wellness and Recovery Center	4,574	784,074	-	$ 788,648	n/a	$ 78,865	$ 630,918	$ 78,865
SAC7	Psychiatric Emergency Response Team Program	7,017	1,202,886	-	$ 1,209,903	$ 215,363	$ 108,892	$ 764,658	$ 120,990
		$ 4,608,175	$ 3,613,025	$ -	$ 8,221,200	$ 1,300,800	$ 1,144,383	$ 4,123,483	$ 1,652,534

* Although no funding was dedicated to Outreach and Engagement, it is anticipated that each program will conduct outreach and engagement activities in the normal course of business (see program narratives).

EXHIBIT 3: FULL SERVICE PARTNERSHIP POPULATION – OVERVIEW

Number of individuals to be fully served:
FY 2005-06: Children and Youth: 31 Transition Age Youth: 14 Adult: 39 Older Adult: 22 TOTAL: 106
FY 2006-07: Children and Youth: 160 Transition Age Youth: 76 Adult: 179 Older Adult: 156 TOTAL: 571
FY 2007-08: Children and Youth: 160 Transition Age Youth: 76 Adult: 179 Older Adult: 156 TOTAL: 571

PERCENT OF INDIVIDUALS TO BE FULLY SERVED

	% Unserved				%Underserved				
	%Male		%Female		%Male		%Female		
Race/Ethnicity	**%Total**	**%Non-English Speaking**	**%Total**	**%Non-English Speaking**	**% Total**	**%Non-English Speaking**	**%Total**	**%Non-English Speaking**	**%TOTAL**
				2005/06					
% African American	**2.12**	0	**2.46**	0	**1.22**	0	**1.37**	0	**7.17**
% Asian Pacific Islander	**19.09**	9.55	**22.14**	11.07	**6.03**	3.02	**6.77**	3.39	**54.02**
% Latino	**5.74**	2.87	**6.66**	3.33	**1.09**	.55	**1.23**	.62	**14.72**
% Native American	**0.38**	0	**0.44**	0	**0.08**	0	**0.09**	0	**1.00**
% White	**4.69**	0	**5.44**	0	**2.17**	0	**2.43**	0	**14.73**
% Other	**2.72**	1.36	**3.15**	1.58	**1.19**	.60	**1.34**	.67	**8.39**
Total Population	**34.74**	13.78	**40.29**	15.98	**11.78**	4.17	**13.23**	4.68	**100.04**
				2006/07					
% African American	**2.12**	0	**2.46**	0	**1.22**	0	**1.37**	0	**7.17**
% Asian Pacific Islander	**19.09**	9.55	**22.14**	11.07	**6.03**	3.02	**6.77**	3.39	**54.02**
% Latino	**5.74**	2.87	**6.66**	3.33	**1.09**	.55	**1.23**	.62	**14.72**
% Native American	**0.38**	0	**0.44**	0	**0.08**	0	**0.09**	0	**1.00**
% White	**4.69**	0	**5.44**	0	**2.17**	0	**2.43**	0	**14.73**
% Other	**2.72**	1.36	**3.15**	1.58	**1.19**	.60	**1.34**	.67	**8.39**
Total Population	**34.74**	13.78	**40.29**	15.98	**11.78**	4.17	**13.23**	4.68	**100.04**
				2007/08					
% African American	**2.12**	0	**2.46**	0	**1.22**	0	**1.37**	0	**7.17**
% Asian Pacific Islander	**19.09**	9.55	**22.14**	11.07	**6.03**	3.02	**6.77**	3.39	**54.02**
% Latino	**5.74**	2.87	**6.66**	3.33	**1.09**	.55	**1.23**	.62	**14.72**
% Native American	**0.38**	0	**0.44**	0	**0.08**	0	**0.09**	0	**1.00**
% White	**4.69**	0	**5.44**	0	**2.17**	0	**2.43**	0	**14.73**
% Other	**2.72**	1.36	**3.15**	1.58	**1.19**	.60	**1.34**	.67	**8.39**
Total Population	**34.74**	13.78	**40.29**	15.98	**11.78**	4.17	**13.23**	4.68	**100.04**

Assumptions:

1. The number of clients in each age groups assumes:
   a. 10% drop out rate each year
   b. 20% client turn-over rate in years 2 and 3
2. We expect 75% of our FSP clients to come from unserved populations and 25% to come from under-served populations
3. Distributions for gender and ethnicity for unserved populations reflect the 200% poverty level County data, with the following exceptions:
   a. Clients served in the Transcultural Wellness Center will fall into the “Asian/Pacific Islander” (90%) and “Other” (10%) groups.
   b. Due to targeted outreach efforts, clients served in the Permanent Supportive Housing Program will have twice the base rate from the Latino population and three times the base rate from the Native American population.
4. Because data show that 93% of clients served in Sacramento County are under-served, distributions for gender and ethnicity for under-served populations reflect the County utilization data, with the following exceptions:
   a. Clients served in the Transcultural Wellness Center will fall into the “Asian/Pacific Islander” (90%) and “Other” (10%) groups.
   b. Due to targeted outreach efforts, clients served in the Permanent Supportive Housing Program will have twice the base rate from the Latino population and three times the base rate from the Native American population.
5. 50% of the “Asian/Pacific Islander”, “Latino” and “Other” populations will be non-English speaking.

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: Sacramento Fiscal Year: 2005/2006		Program Work Plan Name: Transitional Community Opportunities for Recovery and Engagement
Program Work Plan #SAC1		Estimated Start Date: 4/01/2006
Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	The Transitional Community Opportunities for Recovery and Engagement Program (CORE) is an intensive community-based approach to mental health service conducted by a multi-disciplinary team. The teams are tailored to the consumers who receive these services: ethnically and culturally diverse consumers from age 18 through older adulthood who meet the target population criteria established by the Sacramento County DHHS Division of Mental Health. CORE addresses a serious gap in available specialty mental health services for consumers who are un-served and under-served. CORE is appropriate for consumers who experience the most difficult to treat symptoms of severe mental illness (SMI) and/or severe emotional disturbance (SED) and the greatest level of functional impairment: persons who experience long and frequent hospitalizations, repeat use of emergency room services, homelessness, co-occurring addictive disorders, and/or involvement with the criminal justice system. The CORE team(s) will consist of staff with experience in psychiatry, licensed mental health professional, nursing, substance abuse treatment, employment services, mental health paraprofessionals, and consumer advocates. Staff will be culturally diverse, well trained in community resources, recovery philosophy, and highly flexible. This program will advance the goals of the MHSA and transform the current mental health system by: 1) providing specialized mental health services by staff with special expertise, 2) reducing ethnic and cultural barriers for ethnically diverse consumers by hiring bicultural/bilingual staff who are culturally competent in the delivery of services, and by collaborating with service providers who work with ethnically/culturally diverse populations; 3) utilizing family/consumer advocates and peer counselors as part of the treatment team, 4) utilizing wellness and recovery principles in service plan development in collaboration with the client, and 5) utilizing promising practice service strategies such as multidisciplinary assessment/treatment and mobile services/home visitation as indicated.	

Priority Population: *Describe the situational characteristics of the priority population*	This program is designed for delivery of comprehensive and flexible treatment, support, and services for consumers who have the most serious and intractable symptoms of severe mental illness, and who consequently have the greatest functional impairments and complex needs. The program's target population will be comprised of individuals who are currently receiving services in the acute care system (i.e., MHTC, local acute psychiatric hospitals, the Crisis Stabilization Unit, or the Crisis Residential Program), as well as clients who are at risk of needing acute psychiatric services. They include age 18 young adults, adults, and older adults who meet the core and expanded target population definition with a Serious Mental Illness (SMI) and/or co-occurring disorder, or are eligible by definition of medical necessity. The criteria established for the target population in Sacramento are in a systematized listing of diagnoses and disabling conditions established as criteria for care in the public mental health system. Many individuals meeting these criteria are in transition awaiting services from a Regional Support Team or other outpatient mental health services. They often have to wait up to three months to access services from a Regional Support Team, and need continued transitional services to maintain stabilization prior to linkage to longer term mental health services. CORE's multi-disciplinary team approach is intended to bridge the gap of services from the MHTC to the outpatient services available in the community. Referrals for the CORE program will also come from the ACCESS teams, Geriatric Network or Jail Psychiatric Services. The clients served will be ethnically and culturally diverse. They may have multiple co-occurring mental, physical, substance abuse, and social service needs. They may be living at home, with family/caregivers, or in other community locations. They may be homeless or at risk for homelessness. Their complex needs require multidisciplinary assessment and treatment services, as well as linkage with a range of community services and supports to promote wellness and recovery. Included in this priority population are clients who due to their complex psychiatric, medical, and social service needs may require more intensive services than can be provided by existing programs. Therefore, they are not achieving the wellness and recovery outcomes that are possible, putting them at-risk for hospitalization and institutionalization.

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
1) Integrated (multidisciplinary) assessment team that provides comprehensive mental health, physical health, social service, substance abuse, and trauma assessments (and treatment) which are strength-based and focused on engagement of clients and which can provide gender- and culture specific assessments as in the DSM-IV-TR cultural formulation.	☐	☒	☐	☐	☒	☒	☒
2) Mobile crisis and transitional stabilization services	☐	☒	☐	☐	☒	☒	☒
3) Integrated service teams and planning with social service agencies and other community providers to meet the complex needs of this population.	☐	☒	☐	☐	☒	☒	☒
4) Self-directed care plans such as Wellness Recovery Action Plans.	☐	☒	☐	☐	☒	☒	☒
5) Collaborative services with primary care health clinics and health care services to reduce barriers to access and increase integration of physical health care and mental health services; linkage of these clients to the full range of services; Education for and coordination with primary care providers to increase coordination and integration of mental health and primary care services.	☐	☒	☐	☐	☒	☒	☒
6) Peer supportive services including peer-counseling programs to provide culturally based support and to increase client/member knowledge and ability to use needed mental health services.	☐	☒	☐	☐	☒	☒	☒
7) Vocational Services: The team encourages all clients to participate in community employment and provides many vocational rehabilitation services directly.	☐	☒	☐	☐	☒	☒	☒
8) Transportation (to promote compliance with medical appointments).	☐	☒	☐	☐	☒	☒	☒
9) Family/collateral education, training, support and counseling (with consent of the client) to enhance the “therapeutic environment” of the home and/or community environment.	☐	☒	☐	☐	☒	☒	☒
10) Culturally appropriate services to reach persons of racial ethnic cultures who may be better served and/or more responsive to services in specific culture-based settings.	☐	☒	☐	☐	☒	☒	☒
11) Trauma-informed and trauma-specific services.	☐	☒	☐	☐	☒	☒	☒

12) Integrated substance abuse and mental health services where clients receive substance abuse and mental health services simultaneously, not sequentially, from one team with one service plan for one person	☐	☒	☐	☐	☒	☒

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: Sacramento Fiscal Year: 2006/2007	Program Work Plan Name: Transitional Community Opportunities for Recovery and Engagement
Program Work Plan #SAC1	Estimated Start Date: 4/01/2006
Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	The Transitional Community Opportunities for Recovery and Engagement Program (CORE) is an intensive community-based approach to mental health service conducted by a multi-disciplinary team. The teams are tailored to the consumers who receive these services: ethnically and culturally diverse consumers from age 18 through older adulthood who meet the target population criteria established by the Sacramento County DHHS Division of Mental Health. CORE addresses a serious gap in available specialty mental health services for consumers who are un-served and under-served. CORE is appropriate for consumers who experience the most difficult to treat symptoms of severe mental illness (SMI) and/or severe emotional disturbance (SED) and the greatest level of functional impairment: persons who experience long and frequent hospitalizations, repeat use of emergency room services, homelessness, co-occurring addictive disorders, and/or involvement with the criminal justice system. The CORE team(s) will consist of staff with experience in psychiatry, licensed mental health professional, nursing, substance abuse treatment, employment services, mental health paraprofessionals, and consumer advocates. Staff will be culturally diverse, well trained in community resources, recovery philosophy, and highly flexible. This program will advance the goals of the MHSA and transform the current mental health system by: 1) providing specialized mental health services by staff with special expertise, 2) reducing ethnic and cultural barriers for ethnically diverse consumers by hiring bicultural/bilingual staff who are culturally competent in the delivery of services, and by collaborating with service providers who work with ethnically/culturally diverse populations; 3) utilizing family/consumer advocates and peer counselors as part of the treatment team, 4) utilizing wellness and recovery principles in service plan development in collaboration with the client, and 5) utilizing promising practice service strategies such as multidisciplinary assessment/treatment and mobile services/home visitation as indicated.

Priority Population: *Describe the situational characteristics of the priority population*	This program is designed for delivery of comprehensive and flexible treatment, support, and services for consumers who have the most serious and intractable symptoms of severe mental illness, and who consequently have the greatest functional impairments and complex needs. The program's target population will be comprised of individuals who are currently receiving services in the acute care system (i.e., MHTC, local acute psychiatric hospitals, the Crisis Stabilization Unit, or the Crisis Residential Program), as well as clients who are at risk of needing acute psychiatric services. They include age 18 young adults, adults, and older adults who meet the core and expanded target population definition with a Serious Mental Illness (SMI) and/or co-occurring disorder, or are eligible by definition of medical necessity. The criteria established for the target population in Sacramento are in a systematized listing of diagnoses and disabling conditions established as criteria for care in the public mental health system. Many individuals meeting these criteria are in transition awaiting services from a Regional Support Team or other outpatient mental health services. They often have to wait up to three months to access services from a Regional Support Team, and need continued transitional services to maintain stabilization prior to linkage to longer term mental health services. CORE's multi-disciplinary team approach is intended to bridge the gap of services from the MHTC to the outpatient services available in the community. Referrals for the CORE program will also come from the ACCESS teams or Jail Psychiatric Services. The clients served will be ethnically and culturally diverse. They may have multiple co-occurring mental, physical, substance abuse, and social service needs. They may be living at home, with family/caregivers, or in other community locations. They may be homeless or at risk for homelessness. Their complex needs require multidisciplinary assessment and treatment services, as well as linkage with a range of community services and supports to promote wellness and recovery. Included in this priority population are clients who due to their complex psychiatric, medical, and social service needs may require more intensive services than can be provided by existing programs. Therefore, they are not achieving the wellness and recovery outcomes that are possible, putting them at-risk for hospitalization and institutionalization.

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
1) Integrated (multidisciplinary) assessment team that provides comprehensive mental health, physical health, social service, substance abuse, and trauma assessments (and treatment) which are strength-based and focused on engagement of clients and which can provide gender- and culture specific assessments as in the DSM-IV-TR cultural formulation.	☐	☒	☐	☐	☒	☒	☒
2) Mobile crisis and transitional stabilization services	☐	☒	☐	☐	☒	☒	☒
3) Integrated service teams and planning with social service agencies and other community providers to meet the complex needs of this population.	☐	☒	☐	☐	☒	☒	☒
4) Self-directed care plans such as Wellness Recovery Action Plans.	☐	☒	☐	☐	☒	☒	☒
5) Collaborative services with primary care health clinics and health care services to reduce barriers to access and increase integration of physical health care and mental health services; linkage of these clients to the full range of services; Education for and coordination with primary care providers to increase coordination and integration of mental health and primary care services.	☐	☒	☐	☐	☒	☒	☒
6) Peer supportive services including peer-counseling programs to provide culturally based support and to increase client/member knowledge and ability to use needed mental health services.	☐	☒	☐	☐	☒	☒	☒
7) Vocational Services: The team encourages all clients to participate in community employment and provides many vocational rehabilitation services directly.	☐	☒	☐	☐	☒	☒	☒
8) Transportation (to promote compliance with medical appointments).	☐	☒	☐	☐	☒	☒	☒
9) Family/collateral education, training, support and counseling (with consent of the client) to enhance the “therapeutic environment” of the home and/or community environment.	☐	☒	☐	☐	☒	☒	☒
10) Culturally appropriate services to reach persons of racial ethnic cultures who may be better served and/or more responsive to services in specific culture-based settings.	☐	☒	☐	☐	☒	☒	☒
11) Trauma-informed and trauma-specific services.	☐	☒	☐	☐	☒	☒	☒

12) Integrated substance abuse and mental health services where clients receive substance abuse and mental health services simultaneously, not sequentially, from one team with one service plan for one person	☐	☒	☐	☐	☒	☒

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: Sacramento Fiscal Year: 2007/2008	Program Work Plan Name: Transitional Community Opportunities for Recovery and Engagement
Program Work Plan #SAC1	Estimated Start Date: 4/01/2006
Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	The Transitional Community Opportunities for Recovery and Engagement Program (CORE) is an intensive community-based approach to mental health service conducted by a multi-disciplinary team. The teams are tailored to the consumers who receive these services: ethnically and culturally diverse consumers from age 18 through older adulthood who meet the target population criteria established by the Sacramento County DHHS Division of Mental Health. CORE addresses a serious gap in available specialty mental health services for consumers who are un-served and under-served. CORE is appropriate for consumers who experience the most difficult to treat symptoms of severe mental illness (SMI) and/or severe emotional disturbance (SED) and the greatest level of functional impairment: persons who experience long and frequent hospitalizations, repeat use of emergency room services, homelessness, co-occurring addictive disorders, and/or involvement with the criminal justice system. The CORE team(s) will consist of staff with experience in psychiatry, licensed mental health professional, nursing, substance abuse treatment, employment services, mental health paraprofessionals, and consumer advocates. Staff will be culturally diverse, well trained in community resources, recovery philosophy, and highly flexible. This program will advance the goals of the MHSA and transform the current mental health system by: 1) providing specialized mental health services by staff with special expertise, 2) reducing ethnic and cultural barriers for ethnically diverse consumers by hiring bicultural/bilingual staff who are culturally competent in the delivery of services, and by collaborating with service providers who work with ethnically/culturally diverse populations; 3) utilizing family/consumer advocates and peer counselors as part of the treatment team, 4) utilizing wellness and recovery principles in service plan development in collaboration with the client, and 5) utilizing promising practice service strategies such as multidisciplinary assessment/treatment and mobile services/home visitation as indicated.

Priority Population: *Describe the situational characteristics of the priority population*	This program is designed for delivery of comprehensive and flexible treatment, support, and services for consumers who have the most serious and intractable symptoms of severe mental illness, and who consequently have the greatest functional impairments and complex needs. The program's target population will be comprised of individuals who are currently receiving services in the acute care system (i.e., MHTC, local acute psychiatric hospitals, the Crisis Stabilization Unit, or the Crisis Residential Program), as well as clients who are at risk of needing acute psychiatric services. They include age 18 young adults, adults, and older adults who meet the core and expanded target population definition with a Serious Mental Illness (SMI) and/or co-occurring disorder, or are eligible by definition of medical necessity. The criteria established for the target population in Sacramento are in a systematized listing of diagnoses and disabling conditions established as criteria for care in the public mental health system. Many individuals meeting these criteria are in transition awaiting services from a Regional Support Team or other outpatient mental health services. They often have to wait up to three months to access services from a Regional Support Team, and need continued transitional services to maintain stabilization prior to linkage to longer term mental health services. CORE's multi-disciplinary team approach is intended to bridge the gap of services from the MHTC to the outpatient services available in the community. Referrals for the CORE program will also come from the ACCESS teams or Jail Psychiatric Services. The clients served will be ethnically and culturally diverse. They may have multiple co-occurring mental, physical, substance abuse, and social service needs. They may be living at home, with family/caregivers, or in other community locations. They may be homeless or at risk for homelessness. Their complex needs require multidisciplinary assessment and treatment services, as well as linkage with a range of community services and supports to promote wellness and recovery. Included in this priority population are clients who due to their complex psychiatric, medical, and social service needs may require more intensive services than can be provided by existing programs. Therefore, they are not achieving the wellness and recovery outcomes that are possible, putting them at-risk for hospitalization and institutionalization.

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
1) Integrated (multidisciplinary) assessment team that provides comprehensive mental health, physical health, social service, substance abuse, and trauma assessments (and treatment) which are strength-based and focused on engagement of clients and which can provide gender- and culture specific assessments as in the DSM-IV-TR cultural formulation.	☐	☒	☐	☐	☒	☒	☒
2) Mobile crisis and transitional stabilization services	☐	☒	☐	☐	☒	☒	☒
3) Integrated service teams and planning with social service agencies and other community providers to meet the complex needs of this population.	☐	☒	☐	☐	☒	☒	☒
4) Self-directed care plans such as Wellness Recovery Action Plans.	☐	☒	☐	☐	☒	☒	☒
5) Collaborative services with primary care health clinics and health care services to reduce barriers to access and increase integration of physical health care and mental health services; linkage of these clients to the full range of services; Education for and coordination with primary care providers to increase coordination and integration of mental health and primary care services.	☐	☒	☐	☐	☒	☒	☒
6) Peer supportive services including peer-counseling programs to provide culturally based support and to increase client/member knowledge and ability to use needed mental health services.	☐	☒	☐	☐	☒	☒	☒
7) Vocational Services: The team encourages all clients to participate in community employment and provides many vocational rehabilitation services directly.	☐	☒	☐	☐	☒	☒	☒
8) Transportation (to promote compliance with medical appointments).	☐	☒	☐	☐	☒	☒	☒
9) Family/collateral education, training, support and counseling (with consent of the client) to enhance the “therapeutic environment” of the home and/or community environment.	☐	☒	☐	☐	☒	☒	☒
10) Culturally appropriate services to reach persons of racial ethnic cultures who may be better served and/or more responsive to services in specific culture-based settings.	☐	☒	☐	☐	☒	☒	☒
11) Trauma-informed and trauma-specific services.	☐	☒	☐	☐	☒	☒	☒

12) Integrated substance abuse and mental health services where clients receive substance abuse and mental health services simultaneously, not sequentially, from one team with one service plan for one person	☐	☒	☐	☐	☒	☒

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: Sacramento	Fiscal Year: 2005/2006	Program Work Plan Name: Older Adult Intensive Services Program
Program Work Plan #SAC2		Estimated Start Date: 4/01/2006
Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	The Older Adult Intensive Services Program is a specialized, full service partnership outpatient multidisciplinary mental health assessment, treatment, and intensive case management program for older adults age 60+ with serious mental illness. It addresses a serious gap in available specialty outpatient mental health services for older adults who are un-served and under-served. Staff with specialty training in geriatric assessment and treatment will provide multidisciplinary mental health, health, substance abuse, and social service assessment and treatment services. Some treatment services may be provided in collaboration with other community service providers such as primary care/healthcare, drug & alcohol, and the aging network of services. This program will advance the goals of the MHSA (per Section 3, "Purpose and Intent") and transform the current mental health system by: 1) establishing a specialized mental health program for older adults with multiple, complex mental health, medical, substance abuse, and social service needs who are un-served and underserved, to prevent impaired personal and community functioning, emergency room utilization, hospitalization, institutionalization, and homelessness, 2) providing culturally competent services by bicultural/bilingual staff to reduce ethnic and cultural barriers for ethnically diverse older adults, and by collaborating with service providers who work with ethnically/culturally diverse populations; 3) utilizing family/consumer advocates and peer counselors as part of the treatment team to promote wellness and recovery for the client and to provide supportive services to the family/caregivers, 4) utilizing wellness and recovery principles in client-directed service plan development, 5) utilizing evidence-based practice service strategies such as multidisciplinary assessment and treatment, integrated psychiatric and medical care, case management, and mobile services for in-home visitation or wherever the client resides. This program will have the capacity to provide full service partnership	

	services to 100 clients. Due to client turnover and discharges, this program will provide services to 115 unduplicated clients during the first year of service and a total of 145 unduplicated clients by the end of three years.
Priority Population: *Describe the situational characteristics of the priority population*	This program is designed for older adults age 60+ with serious mental illness who meet the target population criteria established by the Sacramento County DHHS Division of Mental Health. The older adults who will be offered a partnership with this intensive outpatient program will have multiple co-occurring mental health, physical health, substance abuse, and social service needs that require multidisciplinary assessment and treatment services, including intensive case management to promote linkage with a range of community services and supports. Transition age older adults (age 55 through 59) will be eligible for this program if they have similar, complex co-occurring mental health, medical, substance abuse and social service needs that would benefit from the program's service strategies. Participants in this intensive program will reflect the ethnic and cultural diversity of Sacramento County. They may be homebound and isolated, with limited family and social supports, living in their own homes, with family/caregivers, or residing at other community locations. Or they may be homeless or at-risk for homelessness. Program participants will include older adults/transition age adults who are not receiving mental health services (un-served) as well as those who currently receive outpatient services in the public mental health system (underserved). However, due to their complex psychiatric, medical, substance abuse and social service needs, these underserved older adults require more intensive services than are currently available and therefore are not achieving the wellness and recovery outcomes that are possible. Older adults who will receive the services of this program experience serious mental illnesses which are debilitating and potentially life threatening. These illnesses can be chronic throughout a lifetime, or develop for the first time in later life. They can also co-occur with physical illnesses. Examples of these mental illnesses are Depressive Disorders, Bipolar Illness, and Psychotic Disorders such as Schizophrenia.

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
1) Integrated (multidisciplinary) assessment team that provides comprehensive mental health, physical health, social service, substance abuse, and trauma assessments (and treatment) which are strength-based and focused on engagement of older clients and which can provide gender- and culture specific assessments as in the DSM-IV-TR cultural formulation.	☒	☐	☐	☐	☐	☐	☒
2) Mobile services to reach older adults who cannot access clinics and other services due to physical disabilities, language barriers, mental disabilities; Home visits and outreach services to assist homebound seniors and to provide assessment of living environment.	☒	☐	☐	☐	☐	☐	☒
3) Integrated service teams and planning with social service agencies and other community providers to meet the complex needs of older adults.	☒	☐	☐	☐	☐	☐	☒
4) Self-directed care plans such as Wellness Recovery Action Plans.	☒	☐	☐	☐	☐	☐	☒
5) Collaborative services with primary care health clinics and health care services to reduce barriers to access and increase integration of physical health care and mental health services; linkage of these clients to the full range of services; education for and coordination with primary care providers to increase coordination and integration of mental health and primary care services.	☒	☐	☐	☐	☐	☐	☒
6) Peer supportive services including peer counseling programs to provide culturally-based support and to increase client/member knowledge and ability to use needed mental health services.	☒	☐	☐	☐	☐	☐	☒

7) Joint service planning with special services for seniors as needed: senior centers, senior legal aid, adult day health care/adult day care, caregiver resource centers, respite care, multi-service senior programs, senior volunteer programs, grief/loss support groups, community self-help groups, senior nutrition programs, faith-based providers, churches, temples, and any other community resource serving older adults with mental illness and their family/caregivers, organizations and settings that reach ethnically and culturally diverse older adults.	☒	☐	☐	☐	☐	☐	☒
8) Transportation (to promote compliance with medical appointments).	☒	☐	☐	☐	☐	☐	☒
9) Education for the client and family or other caregivers as appropriate regarding the nature of medications, the expected benefits and the potential side effects.	☒	☐	☐	☐	☐	☐	☒
10) Home care assistance, including training of caregivers and providers about enhancing the “therapeutic environment” of the home.	☒	☐	☐	☐	☐	☐	☒
11) Culturally appropriate services to reach persons of racial ethnic cultures who may be better served and/or more responsive to services in specific culture-based settings.	☒	☐	☐	☐	☐	☐	☒

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: Sacramento	Fiscal Year: 2006/2007	Program Work Plan Name: Older Adult Intensive Services Program
Program Work Plan #SAC2		Estimated Start Date: 4/01/2006
Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	The Older Adult Intensive Services Program is a specialized, full service partnership outpatient multidisciplinary mental health assessment, treatment, and intensive case management program for older adults age 60+ with serious mental illness. It addresses a serious gap in available specialty outpatient mental health services for older adults who are un-served and under-served. Staff with specialty training in geriatric assessment and treatment will provide multidisciplinary mental health, health, substance abuse, and social service assessment and treatment services. Some treatment services may be provided in collaboration with other community service providers such as primary care/healthcare, drug & alcohol, and the aging network of services. This program will advance the goals of the MHSA (per Section 3, "Purpose and Intent") and transform the current mental health system by: 1) establishing a specialized mental health program for older adults with multiple, complex mental health, medical, substance abuse, and social service needs who are un-served and underserved, to prevent impaired personal and community functioning, emergency room utilization, hospitalization, institutionalization, and homelessness, 2) providing culturally competent services by bicultural/bilingual staff to reduce ethnic and cultural barriers for ethnically diverse older adults, and by collaborating with service providers who work with ethnically/culturally diverse populations; 3) utilizing family/consumer advocates and peer counselors as part of the treatment team to promote wellness and recovery for the client and to provide supportive services to the family/caregivers, 4) utilizing wellness and recovery principles in client-directed service plan development, 5) utilizing evidence-based practice service strategies such as multidisciplinary assessment and treatment, integrated psychiatric and medical care, case management, and mobile services for in-home visitation or wherever the client	

	resides. This program will have the capacity to provide full service partnership services to 100 clients. Due to client turnover and discharges, this program will provide services to 115 unduplicated clients during the first year of service and a total of 145 unduplicated clients by the end of three years.
Priority Population: *Describe the situational characteristics of the priority population*	This program is designed for older adults age 60+ with serious mental illness who meet the target population criteria established by the Sacramento County DHHS Division of Mental Health. The older adults who will be offered a partnership with this intensive outpatient program will have multiple co-occurring mental health, physical health, substance abuse, and social service needs that require multidisciplinary assessment and treatment services, including intensive case management to promote linkage with a range of community services and supports. Transition age older adults (age 55 through 59) will be eligible for this program if they have similar, complex co-occurring mental health, medical, substance abuse and social service needs that would benefit from the program's service strategies. Participants in this intensive program will reflect the ethnic and cultural diversity of Sacramento County. They may be homebound and isolated, with limited family and social supports, living in their own homes, with family/caregivers, or residing at other community locations. Or they may be homeless or at-risk for homelessness. Program participants will include older adults/transition age adults who are not receiving mental health services (un-served) as well as those who currently receive outpatient services in the public mental health system (underserved). However, due to their complex psychiatric, medical, substance abuse and social service needs, these underserved older adults require more intensive services than are currently available and therefore are not achieving the wellness and recovery outcomes that are possible. Older adults who will receive the services of this program experience serious mental illnesses which are debilitating and potentially life threatening. These illnesses can be chronic throughout a lifetime, or develop for the first time in later life. They can also co-occur with physical illnesses. Examples of these mental illnesses are Depressive Disorders, Bipolar Illness, and Psychotic Disorders such as Schizophrenia.

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
1) Integrated (multidisciplinary) assessment team that provides comprehensive mental health, physical health, social service, substance abuse, and trauma assessments (and treatment) which are strength-based and focused on engagement of older clients and which can provide gender- and culture specific assessments as in the DSM-IV-TR cultural formulation.	☒	☐	☐	☐	☐	☐	☒
2) Mobile services to reach older adults who cannot access clinics and other services due to physical disabilities, language barriers, mental disabilities; Home visits and outreach services to assist homebound seniors and to provide assessment of living environment.	☒	☐	☐	☐	☐	☐	☒
3) Integrated service teams and planning with social service agencies and other community providers to meet the complex needs of older adults.	☒	☐	☐	☐	☐	☐	☒
4) Self-directed care plans such as Wellness Recovery Action Plans.	☒	☐	☐	☐	☐	☐	☒
5) Collaborative services with primary care health clinics and health care services to reduce barriers to access and increase integration of physical health care and mental health services; linkage of these clients to the full range of services; education for and coordination with primary care providers to increase coordination and integration of mental health and primary care services.	☒	☐	☐	☐	☐	☐	☒
6) Peer supportive services including peer counseling programs to provide culturally-based support and to increase client/member knowledge and ability to use needed mental health services.	☒	☐	☐	☐	☐	☐	☒

7) Joint service planning with special services for seniors as needed: senior centers, senior legal aid, adult day health care/adult day care, caregiver resource centers, respite care, multi-service senior programs, senior volunteer programs, grief/loss support groups, community self-help groups, senior nutrition programs, faith-based providers, churches, temples, and any other community resource serving older adults with mental illness and their family/caregivers, organizations and settings that reach ethnically and culturally diverse older adults.	☒	☐	☐	☐	☐	☐	☒
8) Transportation (to promote compliance with medical appointments).	☒	☐	☐	☐	☐	☐	☒
9) Education for the client and family or other caregivers as appropriate regarding the nature of medications, the expected benefits and the potential side effects.	☒	☐	☐	☐	☐	☐	☒
10) Home care assistance, including training of caregivers and providers about enhancing the “therapeutic environment” of the home.	☒	☐	☐	☐	☐	☐	☒
11) Culturally appropriate services to reach persons of racial ethnic cultures who may be better served and/or more responsive to services in specific culture-based settings.	☒	☐	☐	☐	☐	☐	☒

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: Sacramento	Fiscal Year: 2007/2008	Program Work Plan Name: Older Adult Intensive Services Program
Program Work Plan #SAC2		Estimated Start Date: 4/01/2006
Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	The Older Adult Intensive Services Program is a specialized, full service partnership outpatient multidisciplinary mental health assessment, treatment, and intensive case management program for older adults age 60+ with serious mental illness. It addresses a serious gap in available specialty outpatient mental health services for older adults who are un-served and under-served. Staff with specialty training in geriatric assessment and treatment will provide multidisciplinary mental health, health, substance abuse, and social service assessment and treatment services. Some treatment services may be provided in collaboration with other community service providers such as primary care/healthcare, drug & alcohol, and the aging network of services. This program will advance the goals of the MHSA (per Section 3, "Purpose and Intent") and transform the current mental health system by: 1) establishing a specialized mental health program for older adults with multiple, complex mental health, medical, substance abuse, and social service needs who are un-served and underserved, to prevent impaired personal and community functioning, emergency room utilization, hospitalization, institutionalization, and homelessness, 2) providing culturally competent services by bicultural/bilingual staff to reduce ethnic and cultural barriers for ethnically diverse older adults, and by collaborating with service providers who work with ethnically/culturally diverse populations; 3) utilizing family/consumer advocates and peer counselors as part of the treatment team to promote wellness and recovery for the client and to provide supportive services to the family/caregivers, 4) utilizing wellness and recovery principles in client-directed service plan development, 5) utilizing evidence-based practice service strategies such as multidisciplinary assessment and treatment, integrated psychiatric and medical care, case management, and mobile services for in-home visitation or wherever the client	

	resides. This program will have the capacity to provide full service partnership services to 100 clients. Due to client turnover and discharges, this program will provide services to 115 unduplicated clients during the first year of service and a total of 145 unduplicated clients by the end of three years.
Priority Population: *Describe the situational characteristics of the priority population*	This program is designed for older adults age 60+ with serious mental illness who meet the target population criteria established by the Sacramento County DHHS Division of Mental Health. The older adults who will be offered a partnership with this intensive outpatient program will have multiple co-occurring mental health, physical health, substance abuse, and social service needs that require multidisciplinary assessment and treatment services, including intensive case management to promote linkage with a range of community services and supports. Transition age older adults (age 55 through 59) will be eligible for this program if they have similar, complex co-occurring mental health, medical, substance abuse and social service needs that would benefit from the program's service strategies. Participants in this intensive program will reflect the ethnic and cultural diversity of Sacramento County. They may be homebound and isolated, with limited family and social supports, living in their own homes, with family/caregivers, or residing at other community locations. Or they may be homeless or at-risk for homelessness. Program participants will include older adults/transition age adults who are not receiving mental health services (un-served) as well as those who currently receive outpatient services in the public mental health system (underserved). However, due to their complex psychiatric, medical, substance abuse and social service needs, these underserved older adults require more intensive services than are currently available and therefore are not achieving the wellness and recovery outcomes that are possible. Older adults who will receive the services of this program experience serious mental illnesses which are debilitating and potentially life threatening. These illnesses can be chronic throughout a lifetime, or develop for the first time in later life. They can also co-occur with physical illnesses. Examples of these mental illnesses are Depressive Disorders, Bipolar Illness, and Psychotic Disorders such as Schizophrenia.

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
1) Integrated (multidisciplinary) assessment team that provides comprehensive mental health, physical health, social service, substance abuse, and trauma assessments (and treatment) which are strength-based and focused on engagement of older clients and which can provide gender- and culture specific assessments as in the DSM-IV-TR cultural formulation.	☒	☐	☐	☐	☐	☐	☒
2) Mobile services to reach older adults who cannot access clinics and other services due to physical disabilities, language barriers, mental disabilities; Home visits and outreach services to assist homebound seniors and to provide assessment of living environment.	☒	☐	☐	☐	☐	☐	☒
3) Integrated service teams and planning with social service agencies and other community providers to meet the complex needs of older adults.	☒	☐	☐	☐	☐	☐	☒
4) Self-directed care plans such as Wellness Recovery Action Plans.	☒	☐	☐	☐	☐	☐	☒
5) Collaborative services with primary care health clinics and health care services to reduce barriers to access and increase integration of physical health care and mental health services; linkage of these clients to the full range of services; education for and coordination with primary care providers to increase coordination and integration of mental health and primary care services.	☒	☐	☐	☐	☐	☐	☒
6) Peer supportive services including peer counseling programs to provide culturally-based support and to increase client/member knowledge and ability to use needed mental health services.	☒	☐	☐	☐	☐	☐	☒

7) Joint service planning with special services for seniors as needed: senior centers, senior legal aid, adult day health care/adult day care, caregiver resource centers, respite care, multi-service senior programs, senior volunteer programs, grief/loss support groups, community self-help groups, senior nutrition programs, faith-based providers, churches, temples, and any other community resource serving older adults with mental illness and their family/caregivers, organizations and settings that reach ethnically and culturally diverse older adults.	☒	☐	☐	☐	☐	☐	☒
8) Transportation (to promote compliance with medical appointments).	☒	☐	☐	☐	☐	☐	☒
9) Education for the client and family or other caregivers as appropriate regarding the nature of medications, the expected benefits and the potential side effects.	☒	☐	☐	☐	☐	☐	☒
10) Home care assistance, including training of caregivers and providers about enhancing the “therapeutic environment” of the home.	☒	☐	☐	☐	☐	☐	☒
11) Culturally appropriate services to reach persons of racial ethnic cultures who may be better served and/or more responsive to services in specific culture-based settings.	☒	☐	☐	☐	☐	☐	☒

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: Sacramento	Fiscal Year: 2005/2006	Program Work Plan Name: Permanent Supportive Housing Program for Individuals and Families
Program Work Plan #SAC4		Estimated Start Date: 4/01/2006
Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	The Permanent Supportive Housing Program for Individuals and Families is intended to address the negative consequences of homelessness for the seriously mentally ill and seriously emotionally disturbed. The program will provide integrated, comprehensive supportive housing services in a full service partnership. Services will be flexible, voluntary and focus on maintaining housing stability and promoting wellness. Utilizing Assertive Community Treatment (ACT) principles, the emphasis will be on field based services and frequent client contact. It will begin as an integrated service program providing supportive housing services utilizing available housing and then transition participants to new housing units. The new housing will be constructed in a partnership with the Sacramento Housing and Redevelopment Agency (SHRA), Sacramento County Division of Mental Health, a private non-profit housing developer and a contract mental health service agency The program will advance the goals of the MHSA (per Section 3 of the ACT) and transform the current mental health system by: 1) providing comprehensive services for under-served and unserved homeless population of all ages with serious mental illness and serious emotional disturbances, 2) utilizing a client, family driven approach that includes "whatever it takes" to ensure housing stability and foster recovery, wellness, and resiliency, 3) utilizing bicultural/bilingual staff who are culturally competent with a minimum of 20% being consumers, family members, and caregivers, 4) developing permanent housing units with leveraged housing funds and with one-time only funds to leverage permanent housing development, and 5) ensuring funds are expended in the most cost effective manner and services are provided utilizing evidence-based practices such as Assertive Community Treatment, Medication Management, Supported Employment and integrated Dual Diagnosis.	
Priority Population: *Describe the situational*	The program will serve all age groups who are homeless with serious mental illnesses or serious emotional disturbances. This population is significantly more at risk for	

characteristics of the priority population	victimization, addiction disorders, and recidivism to emergency rooms, psychiatric hospitalizations, and jails/juvenile justice institutions. Transition age youth are, especially, at risk to enter into the cycle of homelessness, unemployment, and substance abuse. Older adults are profoundly more at risk for victimization, abuse and untreated health conditions. All age groups are at higher risks for death either through homicide, untreated health conditions, or suicide. Individuals and families who are monolingual or limited English speakers are especially vulnerable without supports and services that are culturally and linguistically relevant. Without safe, affordable housing and the necessary supports and services to assist persons in recovery from homelessness and mental illness, individuals and families are at risk to remain in the cycle of homelessness with significant personal consequences to their recovery, wellness, and resiliency. It is also recognized that serving "underserved" and "unserved" populations is problematic due to a lack of information. Therefore, the program will develop focused outreach to these populations to determine the cultural, ethnic, gender and age-related issues associated with under-utilization.

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
1) Family Partnership Programs that include strategies to engage racially and ethnically diverse families and include services and activities such as training, information and referral, support groups and direct services self-help support and empowerment through family partnership and peer consultation	☒	☐	☐	☒	☒	☐	☐
2) Child/youth peer mentoring	☒	☐	☐	☒	☒	☐	☐
3) Youth involvement in planning and service development	☒	☐	☐	☒	☒	☐	☐
4) Cultural and gender-sensitive outreach and services	☒	☐	☐	☒	☒	☒	☒
5) Services and supports provided at school, in the community and at home	☒	☐	☐	☒	☒	☐	☐
6) Infrastructure for the Children's System of Care program as found in W&I Code Section 5856 to promote interagency collaboration, shared responsibility and accountability for effective outcomes for children/youth and their families	☒	☐	☐	☒	☒	☐	☐
7) Family preservation services, if appropriate	☒	☐	☐	☒	☐	☐	☐
8) Specialized services to address gay, lesbian, bisexual and transgender 9)	☒	☐	☐	☒	☒	☐	☐

youth diagnosed with serious emotional disorders							
9) Crisis services including a) 24-hour phone line for crisis; 2) mobile crisis services; and, 3) respite services for both children/youth and families	☒	☐	☐	☒	☒	☒	☒
10) On-site services in juvenile halls and other detention facilities, if appropriate	☒	☐	☐	☒	☒	☐	☐
11) Education for children/youth and family regarding mental health diagnosis and assessment, medications, services and supports planning, treatment modalities and other information related to children/youth's mental health services and needs	☒	☐	☐	☒	☒	☐	☐
12) Collaborative physical and mental health services	☒	☐	☐	☒	☒	☒	☒
13) Services in collaboration with faith-based communities; linkage for families to the full range of community services and supports	☒	☐	☐	☒	☒	☒	☒
14) Integrated services and supports with co-occurring mental health and substance use disorders within the context of a single services and supports plan	☒	☐	☐	☒	☒	☒	☒
15) Parental mental health education, with language access and culturally appropriate approaches	☒	☐	☐	☒	☒	☒	☐
16) Permanent supportive housing for homeless families and families re-unifying after a child or parent has been in an institution (e.g. jail, juvenile hall or hospital) or other out-of-home placement	☒	☐	☐	☒	☒	☒	☒
17) Values-driven, evidence-based and promising clinical services that are integrated with overall service planning	☒	☐	☐	☒	☒	☒	☒
18) Childcare	☒	☐	☐	☒	☒	☒	☒
19) Transportation	☒	☐	☐	☒	☒	☒	☒
20) Supportive family partnership educational opportunities	☒	☐	☐	☒	☒	☐	☐
21) Grief-loss family partnership support groups	☒	☐	☐	☒	☒	☒	☒
22) Ethnic- or tribal-specific social or community groups or other cultural-based activities	☒	☐	☐	☒	☒	☒	☒
23) Development of self-help and peer support (Includes transformative infrastructure and attitudinal change for the development of peer support and client-run services)	☒	☐	☐	☒	☒	☒	☒
24) Seamless linkages with both the children/youth mental health system and	☒	☐	☐	☐	☒	☐	☐

the adult mental health system as appropriate							
25) Cross–agency and cross-discipline training	☒	☐	☐	☒	☒	☒	☒
26) Integrate service agencies which provide and/or broker all services that a client needs	☒	☐	☐	☐	☒	☒	☒
27) Client self-directed care plans	☒	☐	☐	☐	☒	☒	☒
28) Partnerships with law enforcement, probation and courts	☒	☐	☐	☒	☒	☒	☒
29) Community and cultural practices – traditional practitioners, natural healing practices and ceremonies recognized by communities in place of or in addition to mainstream services	☒	☐	☐	☐	☒	☒	☒
30) Integrated assessment teams that provide comprehensive mental health, social, substance abuse, trauma and thorough physical health assessments which are strength-based and focused on engagement of older adults	☒	☐	☐	☒	☒	☒	☒
31) Outreach to homeless	☒	☐	☐	☒	☒	☒	☒
32) Mobile services to those who cannot access services	☒	☐	☐	☒	☒	☒	☒
33) Home care assistance, including training of caregivers and providers in enhancing the “therapeutic environment” of the home	☒	☐	☐	☐	☐	☐	☒
34) Trauma-informed and trauma-specific services	☒	☐	☐	☒	☒	☒	☒
35) Supportive and independent education opportunities	☒	☐	☐	☒	☒	☒	☒
36) Supportive employment and other productive activities and personal growth opportunities including development of job options for clients such as social enterprises, agency-supported positions and competitive employment opportunities as well as volunteerism and other creative activities	☒	☐	☐	☐	☒	☒	☒
37) Joint service planning with special services for seniors: senior center, senior legal aid, adult day health care, geriatric assessment centers, private caregiver resource centers, multi-service senior programs, senior volunteer programs, Foster Grandparents, senior nutrition centers, ethnic- and gender-specific social or community groups or other culture-based partners, grief/loss support groups, community self-help groups, etc.	☒	☐	☐	☐	☐	☐	☒

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: Sacramento	Fiscal Year: 2006/2007	Program Work Plan Name: Permanent Supportive Housing Program for Individuals and Families
Program Work Plan #SAC4		Estimated Start Date: 4/01/2006
Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	The Permanent Supportive Housing Program for Individuals and Families is intended to address the negative consequences of homelessness for the seriously mentally ill and seriously emotionally disturbed. The program will provide integrated, comprehensive supportive housing services in a full service partnership. Services will be flexible, voluntary and focus on maintaining housing stability and promoting wellness. Utilizing Assertive Community Treatment (ACT) principles, the emphasis will be on field based services and frequent client contact. It will begin as an integrated service program providing supportive housing services utilizing available housing and then transition participants to new housing units. The new housing will be constructed in a partnership with the Sacramento Housing and Redevelopment Agency (SHRA), Sacramento County Division of Mental Health, a private non-profit housing developer and a contract mental health service agency The program will advance the goals of the MHSA (per Section 3 of the ACT) and transform the current mental health system by: 1) providing comprehensive services for under-served and unserved homeless population of all ages with serious mental illness and serious emotional disturbances, 2) utilizing a client, family driven approach that includes "whatever it takes" to ensure housing stability and foster recovery, wellness, and resiliency, 3) utilizing bicultural/bilingual staff who are culturally competent with a minimum of 20% being consumers, family members, and caregivers, 4) developing permanent housing units with leveraged housing funds and with one-time only funds to leverage permanent housing development, and 5) ensuring funds are expended in the most cost effective manner and services are provided utilizing evidence-based practices such as Assertive Community Treatment, Medication Management, Supported Employment and integrated Dual Diagnosis.	
Priority Population: *Describe the situational*	The program will serve all age groups who are homeless with serious mental illnesses or serious emotional disturbances. This population is significantly more at risk for	

characteristics of the priority population	victimization, addiction disorders, and recidivism to emergency rooms, psychiatric hospitalizations, and jails/juvenile justice institutions. Transition age youth are, especially, at risk to enter into the cycle of homelessness, unemployment, and substance abuse. Older adults are profoundly more at risk for victimization, abuse and untreated health conditions. All age groups are at higher risks for death either through homicide, untreated health conditions, or suicide. Individuals and families who are monolingual or limited English speakers are especially vulnerable without supports and services that are culturally and linguistically relevant. Without safe, affordable housing and the necessary supports and services to assist persons in recovery from homelessness and mental illness, individuals and families are at risk to remain in the cycle of homelessness with significant personal consequences to their recovery, wellness, and resiliency. It is also recognized that serving "underserved" and "unserved" populations is problematic due to a lack of information. Therefore, the program will develop focused outreach to these populations to determine the cultural, ethnic, gender and age-related issues associated with under-utilization.

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
1) Family Partnership Programs that include strategies to engage racially and ethnically diverse families and include services and activities such as training, information and referral, support groups and direct services self-help support and empowerment through family partnership and peer consultation	☒	☐	☐	☒	☒	☐	☐
2) Child/youth peer mentoring	☒	☐	☐	☒	☒	☐	☐
3)Youth involvement in planning and service development	☒	☐	☐	☒	☒	☐	☐
4) Cultural and gender-sensitive outreach and services	☒	☐	☐	☒	☒	☒	☒
5) Services and supports provided at school, in the community and at home	☒	☐	☐	☒	☒	☐	☐
6) Infrastructure for the Children's System of Care program as found in W&I Code Section 5856 to promote interagency collaboration, shared responsibility and accountability for effective outcomes for children/youth and their families	☒	☐	☐	☒	☒	☐	☐
7) Family preservation services, if appropriate	☒	☐	☐	☒	☐	☐	☐
8) Specialized services to address gay, lesbian, bisexual and transgender	☒	☐	☐	☒	☒	☐	☐

youth diagnosed with serious emotional disorders							
9) Crisis services including a) 24-hour phone line for crisis; 2) mobile crisis services; and, 3) respite services for both children/youth and families	☒	☐	☐	☒	☒	☒	☒
10) On-site services in juvenile halls and other detention facilities, if appropriate	☒	☐	☐	☒	☒	☐	☐
11) Education for children/youth and family regarding mental health diagnosis and assessment, medications, services and supports planning, treatment modalities and other information related to children/youth's mental health services and needs	☒	☐	☐	☒	☒	☐	☐
12) Collaborative physical and mental health services	☒	☐	☐	☒	☒	☒	☒
13) Services in collaboration with faith-based communities; linkage for families to the full range of community services and supports	☒	☐	☐	☒	☒	☒	☒
14) Integrated services and supports with co-occurring mental health and substance use disorders within the context of a single services and supports plan	☒	☐	☐	☒	☒	☒	☒
15) Parental mental health education, with language access and culturally appropriate approaches	☒	☐	☐	☒	☒	☒	☐
16) Permanent supportive housing for homeless families and families re-unifying after a child or parent has been in an institution (e.g. jail, juvenile hall or hospital) or other out-of-home placement	☒	☐	☐	☒	☒	☒	☒
17) Values-driven, evidence-based and promising clinical services that are integrated with overall service planning	☒	☐	☐	☒	☒	☒	☒
18) Childcare	☒	☐	☐	☒	☒	☒	☒
19) Transportation	☒	☐	☐	☒	☒	☒	☒
20) Supportive family partnership educational opportunities	☒	☐	☐	☒	☒	☐	☐
21) Grief-loss family partnership support groups	☒	☐	☐	☒	☒	☒	☒
22) Ethnic- or tribal-specific social or community groups or other cultural-based activities	☒	☐	☐	☒	☒	☒	☒
23) Development of self-help and peer support (Includes transformative infrastructure and attitudinal change for the development of peer support and client-run services)	☒	☐	☐	☒	☒	☒	☒
24) Seamless linkages with both the children/youth mental health system and	☒	☐	☐	☐	☒	☐	☐

the adult mental health system as appropriate							
25) Cross–agency and cross-discipline training	☒	☐	☐	☒	☒	☒	☒
26) Integrate service agencies which provide and/or broker all services that a client needs	☒	☐	☐	☐	☒	☒	☒
27) Client self-directed care plans	☒	☐	☐	☐	☒	☒	☒
28) Partnerships with law enforcement, probation and courts	☒	☐	☐	☒	☒	☒	☒
29) Community and cultural practices – traditional practitioners, natural healing practices and ceremonies recognized by communities in place of or in addition to mainstream services	☒	☐	☐	☐	☒	☒	☒
30) Integrated assessment teams that provide comprehensive mental health, social, substance abuse, trauma and thorough physical health assessments which are strength-based and focused on engagement of older adults	☒	☐	☐	☒	☒	☒	☒
31) Outreach to homeless	☒	☐	☐	☒	☒	☒	☒
32) Mobile services to those who cannot access services	☒	☐	☐	☒	☒	☒	☒
33) Home care assistance, including training of caregivers and providers in enhancing the “therapeutic environment” of the home	☒	☐	☐	☐	☐	☐	☒
34) Trauma-informed and trauma-specific services	☒	☐	☐	☒	☒	☒	☒
35) Supportive and independent education opportunities	☒	☐	☐	☒	☒	☒	☒
36) Supportive employment and other productive activities and personal growth opportunities including development of job options for clients such as social enterprises, agency-supported positions and competitive employment opportunities as well as volunteerism and other creative activities	☒	☐	☐	☐	☒	☒	☒
37) Joint service planning with special services for seniors: senior center, senior legal aid, adult day health care, geriatric assessment centers, private caregiver resource centers, multi-service senior programs, senior volunteer programs, Foster Grandparents, senior nutrition centers, ethnic- and gender-specific social or community groups or other culture-based partners, grief/loss support groups, community self-help groups, etc.	☒	☐	☐	☐	☐	☐	☒

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: Sacramento	Fiscal Year: 2007/2008	Program Work Plan Name: Permanent Supportive Housing Program for Individuals and Families
Program Work Plan #SAC4		Estimated Start Date: 4/01/2006
Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	The Permanent Supportive Housing Program for Individuals and Families is intended to address the negative consequences of homelessness for the seriously mentally ill and seriously emotionally disturbed. The program will provide integrated, comprehensive supportive housing services in a full service partnership. Services will be flexible, voluntary and focus on maintaining housing stability and promoting wellness. Utilizing Assertive Community Treatment (ACT) principles, the emphasis will be on field based services and frequent client contact. It will begin as an integrated service program providing supportive housing services utilizing available housing and then transition participants to new housing units. The new housing will be constructed in a partnership with the Sacramento Housing and Redevelopment Agency (SHRA), Sacramento County Division of Mental Health, a private non-profit housing developer and a contract mental health service agency The program will advance the goals of the MHSA (per Section 3 of the ACT) and transform the current mental health system by: 1) providing comprehensive services for under-served and unserved homeless population of all ages with serious mental illness and serious emotional disturbances, 2) utilizing a client, family driven approach that includes "whatever it takes" to ensure housing stability and foster recovery, wellness, and resiliency, 3) utilizing bicultural/bilingual staff who are culturally competent with a minimum of 20% being consumers, family members, and caregivers, 4) developing permanent housing units with leveraged housing funds and with one-time only funds to leverage permanent housing development, and 5) ensuring funds are expended in the most cost effective manner and services are provided utilizing evidence-based practices such as Assertive Community Treatment, Medication Management, Supported Employment and integrated Dual Diagnosis.	
Priority Population: *Describe the situational*	The program will serve all age groups who are homeless with serious mental illnesses or serious emotional disturbances. This population is significantly more at risk for	

characteristics of the priority population	victimization, addiction disorders, and recidivism to emergency rooms, psychiatric hospitalizations, and jails/juvenile justice institutions. Transition age youth are, especially, at risk to enter into the cycle of homelessness, unemployment, and substance abuse. Older adults are profoundly more at risk for victimization, abuse and untreated health conditions. All age groups are at higher risks for death either through homicide, untreated health conditions, or suicide. Individuals and families who are monolingual or limited English speakers are especially vulnerable without supports and services that are culturally and linguistically relevant. Without safe, affordable housing and the necessary supports and services to assist persons in recovery from homelessness and mental illness, individuals and families are at risk to remain in the cycle of homelessness with significant personal consequences to their recovery, wellness, and resiliency. It is also recognized that serving "underserved" and "unserved" populations is problematic due to a lack of information. Therefore, the program will develop focused outreach to these populations to determine the cultural, ethnic, gender and age-related issues associated with under-utilization.

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
1) Family Partnership Programs that include strategies to engage racially and ethnically diverse families and include services and activities such as training, information and referral, support groups and direct services self-help support and empowerment through family partnership and peer consultation	☒	☐	☐	☒	☒	☐	☐
2) Child/youth peer mentoring	☒	☐	☐	☒	☒	☐	☐
3) Youth involvement in planning and service development	☒	☐	☐	☒	☒	☐	☐
4) Cultural and gender-sensitive outreach and services	☒	☐	☐	☒	☒	☒	☒
5) Services and supports provided at school, in the community and at home	☒	☐	☐	☒	☒	☐	☐
6) Infrastructure for the Children's System of Care program as found in W&I Code Section 5856 to promote interagency collaboration, shared responsibility and accountability for effective outcomes for children/youth and their families	☒	☐	☐	☒	☒	☐	☐
7) Family preservation services, if appropriate	☒	☐	☐	☒	☐	☐	☐
8) Specialized services to address gay, lesbian, bisexual and transgender	☒	☐	☐	☒	☒	☐	☐

youth diagnosed with serious emotional disorders							
9) Crisis services including a) 24-hour phone line for crisis; 2) mobile crisis services; and, 3) respite services for both children/youth and families	☒	☐	☐	☒	☒	☒	☒
10) On-site services in juvenile halls and other detention facilities, if appropriate	☒	☐	☐	☒	☒	☐	☐
11) Education for children/youth and family regarding mental health diagnosis and assessment, medications, services and supports planning, treatment modalities and other information related to children/youth's mental health services and needs	☒	☐	☐	☒	☒	☐	☐
12) Collaborative physical and mental health services	☒	☐	☐	☒	☒	☒	☒
13) Services in collaboration with faith-based communities; linkage for families to the full range of community services and supports	☒	☐	☐	☒	☒	☒	☒
14) Integrated services and supports with co-occurring mental health and substance use disorders within the context of a single services and supports plan	☒	☐	☐	☒	☒	☒	☒
15) Parental mental health education, with language access and culturally appropriate approaches	☒	☐	☐	☒	☒	☒	☐
16) Permanent supportive housing for homeless families and families re-unifying after a child or parent has been in an institution (e.g. jail, juvenile hall or hospital) or other out-of-home placement	☒	☐	☐	☒	☒	☒	☒
17) Values-driven, evidence-based and promising clinical services that are integrated with overall service planning	☒	☐	☐	☒	☒	☒	☒
18) Childcare	☒	☐	☐	☒	☒	☒	☒
19) Transportation	☒	☐	☐	☒	☒	☒	☒
20) Supportive family partnership educational opportunities	☒	☐	☐	☒	☒	☐	☐
21) Grief-loss family partnership support groups	☒	☐	☐	☒	☒	☒	☒
22) Ethnic- or tribal-specific social or community groups or other cultural-based activities	☒	☐	☐	☒	☒	☒	☒
23) Development of self-help and peer support (Includes transformative infrastructure and attitudinal change for the development of peer support and client-run services)	☒	☐	☐	☒	☒	☒	☒
24) Seamless linkages with both the children/youth mental health system and	☒	☐	☐	☐	☒	☐	☐

the adult mental health system as appropriate							
25) Cross–agency and cross-discipline training	☒	☐	☐	☒	☒	☒	☒
26) Integrate service agencies which provide and/or broker all services that a client needs	☒	☐	☐	☐	☒	☒	☒
27) Client self-directed care plans	☒	☐	☐	☐	☒	☒	☒
28) Partnerships with law enforcement, probation and courts	☒	☐	☐	☒	☒	☒	☒
29) Community and cultural practices – traditional practitioners, natural healing practices and ceremonies recognized by communities in place of or in addition to mainstream services	☒	☐	☐	☐	☒	☒	☒
30) Integrated assessment teams that provide comprehensive mental health, social, substance abuse, trauma and thorough physical health assessments which are strength-based and focused on engagement of older adults	☒	☐	☐	☒	☒	☒	☒
31) Outreach to homeless	☒	☐	☐	☒	☒	☒	☒
32) Mobile services to those who cannot access services	☒	☐	☐	☒	☒	☒	☒
33) Home care assistance, including training of caregivers and providers in enhancing the “therapeutic environment” of the home	☒	☐	☐	☐	☐	☐	☒
34) Trauma-informed and trauma-specific services	☒	☐	☐	☒	☒	☒	☒
35) Supportive and independent education opportunities	☒	☐	☐	☒	☒	☒	☒
36) Supportive employment and other productive activities and personal growth opportunities including development of job options for clients such as social enterprises, agency-supported positions and competitive employment opportunities as well as volunteerism and other creative activities	☒	☐	☐	☐	☒	☒	☒
37) Joint service planning with special services for seniors: senior center, senior legal aid, adult day health care, geriatric assessment centers, private caregiver resource centers, multi-service senior programs, senior volunteer programs, Foster Grandparents, senior nutrition centers, ethnic- and gender-specific social or community groups or other culture-based partners, grief/loss support groups, community self-help groups, etc.	☒	☐	☐	☐	☐	☐	☒

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: Sacramento	Fiscal Year: 2005/2006	Program Work Plan Name: Transcultural Wellness Center
Program Work Plan #SAC5		Estimated Start Date: 4/01/2006
Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	The Transcultural Wellness Center is a comprehensive mental health program that will provide culturally and linguistically competent services to all individuals and families from the Asian/Pacific Island (API) communities with serious mental illness (SMI) and/or serious emotional disturbance (SED). All ages will be served at the Center. The Center will include multi-disciplinary staff with caseloads of 1:15 with 24/7 response capacity. The family/community-centered focus of this program is compatible with API cultural norms and expectations. While all cultural and ethnic groups are eligible for services at the Center, staff with bilingual bicultural skills will specifically focus on services to individuals and families of all age groups from the API community. The API Transcultural Wellness Center model will afford an efficient delivery system that includes the following: culturally appropriate wellness, resilience, and recovery services, psychotherapy, counseling, psychiatric consultation, medication support, service coordination/case management, networking, peer support, interpreter/translator and psycho-educational services. The API Transcultural Wellness Center and its service will begin to advance the goals of the Mental Health Services Act (per Section 3 of the Act), and transform the Sacramento County Mental Health System as follows: 1) establish a specific program for the under-served and unserved API community of all ages with serious mental illness and serious emotional disturbance; 2) utilize culturally competent self-directed care plans that are family focused and foster recovery, resiliency, and wellness; 3.) recruit clients, family and community members for staff positions to provide support services and outreach activities; 4) hire program staff who are culturally and linguistically competent; 5) ensure funds are expended in the most cost effective manner and services are provided utilizing a modified Assertive Community Treatment, Evidence-Based Practice model specific to Kajsiab House operating in Madison, WI, which is listed on the SAMHSA website.	

Priority Population: *Describe the situational characteristics of the priority population*	The Transcultural Wellness Center will serve all ages including children, youth, transitional age youth, adults and older adults from the API communities in Sacramento County. API communities in Sacramento County include Cambodian, Chinese, Fijian, Filipino, Hawaiian, Hmong, Japanese, Korean, Laotian, Mien, Samoan, Tongan and Vietnamese among others. Individuals and families from the API community include recent immigrants/refugees or first and second-generation refugee adults with serious mental illness, qualifying older adults with serious mental illness; LEP immigrant women with serious mental illness in domestic violence situations; and children and transition-age youth with serious emotional disturbance, who are children of immigrant/refugee parents or parents who are less acculturated. Also included are those in need of related services such as outreach services, educational programs, employment programs, psychosocial programs, and support services.

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
1) Child/youth peer monitoring.	☒	☐	☐	☒	☒	☐	☐
2) Youth involvement in planning and service development, including the involvement of youth previously involved in juvenile justice settings and out-of-home placements.	☒	☐	☐	☒	☒	☐	☐
3) Cultural and gender-sensitive outreach and services at schools, primary care clinics, and community programs in ethnic communities, which proactively reach children who may have emotional and/or behavioral disorders and which can provide easy and immediate access to mental health services when needed.	☒	☐	☐	☒	☒	☐	☐
4) Services and supports provided at school, in the community and in the child/youth's home.	☒	☐	☐	☒	☒	☐	☐
5) Infrastructure for the Children's System of Care program as found in W&I Code Section 5856 to promote interagency collaboration, shared responsibility and accountability for effective outcomes for children/youth and their families.	☒	☐	☐	☒	☒	☐	☐
6) Family preservation services.	☒	☐	☐	☒	☐	☐	☐
7) Crisis services including a 24-hour phone line for crisis.	☒	☐	☐	☒	☒	☒	☒

8) Education for children/youth and family or other caregivers regarding mental health diagnosis and assessment, medications, services and supports planning, treatment modalities, and other information related to children/youth's mental health services and needs.	☒	☐	☐	☒	☒	☒	☐
9) Education for primary care providers and other health care providers to increase coordination and integration of mental health and primary care, and other health services.	☒	☐	☐	☒	☒	☒	☒
10) Services in collaboration with faith-based communities; linkage for these families to the full range of community services and supports.	☒	☐	☐	☒	☐	☐	☐
11) Services located in racial ethnic communities to reach children, youth and families who may be more responsive to services in these settings; linkage for these families to the full range of community services and supports, intergenerational strategies for children/youth and their families in which parents may have their own mental health problems. Services are delivered within the context of a single child/family services and supports plan.	☒	☐	☐	☒	☒	☐	☐
12) Integrated services and supports for children/youth, adults and older adults and their families with co-occurring mental health and substance use disorders within the context of a single child/adults/family services and supports plan.	☒	☐	☐	☒	☒	☒	☒
13) Parental mental health education, with language access and culturally appropriate approaches.	☒	☐	☐	☒	☒	☐	☐
14) Values-driven evidence-based and promising clinical services that are culturally and linguistically competent and integrated with overall service planning, supporting individuals/youth/family selected goals and consistent with community values.	☒	☐	☐	☒	☒	☒	☒
15) Transportation.	☒	☐	☐	☒	☐	☐	☐
16) Supportive family partnership educational opportunities.	☒	☐	☐	☒	☒	☐	☐
17) Grief-loss family partnership support groups.	☒	☐	☐	☒	☒	☐	☐
18) Ethnic or tribal-specific social or community groups or other culture-based activities.	☒	☐	☐	☒	☒	☒	☒

19) Development of self-help, peer support and youth/family-run programs, to add youth/families as providers in clinical settings and to develop youth training programs, including youth and family member leadership training programs.	☒	☐	☐	☐	☒	☐	☐
20) Seamless linkages with both the children/youth mental health system and the adult mental health system as appropriate. A single PSC/case manager should follow transition age youth as they move from children and youth services into adult services and/or into the community as independent adults. Transfer out of a transition age program should be negotiated with the youth and not occur until s/he feels connected with the necessary services and supports for successful community independence and/or connection with the adult mental health system as appropriate.	☒	☐	☐	☒	☒	☐	☐
21) Cross-agency and cross-discipline training. Staff working with transition age youth who are trained in the developmental and cultural needs of transition age youth, in community resources, and in operationalizing a wellness philosophy including the concepts of both recovery and resiliency. Transition age youth, themselves, should be part of the pool of hired and trained staff.	☒	☐	☐	☐	☒	☐	☐
22) Integrated substance abuse and mental health services where youth receive substance abuse and mental health services simultaneously rather than sequentially, through an integrated team with a single individualized service plan. When appropriate, specialized housing for individuals with dual disorders should be available.	☒	☐	☐	☐	☒	☐	☐
23) Integrated service teams that provide comprehensive mental health, social, cultural, physical health, substance abuse and trauma (including intergenerational trauma) assessments which are strength-based and focused on engagement of the child/youth/adults/family and which can provide gender and cultural specific assessments as in the DSM IV-R cultural formulation.	☒	☐	☐	☒	☒	☒	☒
24) Integrated county/community level service planning which identifies needs in the areas of mental health services, health services, education, job training, employment, housing, socialization, independent living skills and funding options.	☒	☐	☐	☐	☒	☐	☐

25) Youth and family-run services including peer support, self-help groups, train-the- trainer programs and culturally competent mentoring programs.	☒	☐	☐	☐	☒	☐	☐
26) Youth involvement in planning and service development, including the involvement of youth previously involved in juvenile justice settings and out-of-home placements.	☒	☐	☐	☐	☒	☐	☐
27) Classes and other instruction regarding what clients need to know for successful living in the community.	☒	☐	☐	☒	☒	☒	☒
28) Supportive employment including development of job options for young people, such as social enterprises, agency supported positions, and competitive employment options with equal pay and benefits.	☒	☐	☐	☐	☒	☐	☐
29) Supportive education services.	☒	☐	☐	☐	☒	☒	☐
30) Education for youth and family or other caregivers as appropriate regarding the nature of medications, the expected benefits and the potential side effects.	☒	☐	☐	☐	☒	☐	☐
31) Trauma-informed services and trauma-specific services (including intergenerational trauma services), particularly for young women with co-occurring disorders.	☒	☐	☐	☐	☒	☐	☐
32) Community cultural practices – traditional practitioners, natural healing practices and ceremonies recognized by communities in place of or in addition to mainstream services.	☒	☐	☐	☐	☒	☒	☒
33) Services to assist families in supporting youth during this period.	☒	☐	☐	☐	☒	☐	☐
34) Crisis services including 24-hour crisis phone line including Peer support in times of crisis.	☒	☐	☐	☐	☒	☐	☐
35) Partnership with ethnic-specific community providers and programs.	☒	☐	☐	☐	☒	☐	☐
36) Transportation (including acquisition of driver's licenses).	☒	☐	☐	☐	☒	☐	☐
37) Recreation and social activities. Transition age youth should be involved in the planning and development of activities.	☒	☐	☐	☐	☒	☐	☐
38) Integrated physical and mental health services, which includes collaboration with primary care clinics or other health care sites and providers to provide individualized, inter-disciplinary, coordinated services. Linkage must be provided for clients served in these settings to the full range of mental health services when needed. These services are	☒	☐	☐	☒	☒	☒	☒

particularly needed to serve ethnic populations and others who may be more responsive to services in health care settings and to reach individuals with co-occurring chronic or life-threatening medical conditions and youth who are frequent users of hospital emergency rooms or inpatient care.							
39) Client self-directed care plans (e.g., Wellness Recovery Action Plans or other similar models).	☒	☐	☐	☐	☐	☒	☒
40) For individuals with dual diagnosis, integrated substance abuse and mental health services where a client/member receives substance abuse and mental health services simultaneously, not sequentially, from one team with one service plan for one person; specialized housing to accompany these services as appropriate.	☒	☐	☐	☐	☐	☒	☐
41) On-site services or services in collaboration with faith-based providers, churches, temples or similar settings where clients may feel more familiar and comfortable; linkage for these clients to the full range of services.	☒	☐	☐	☐	☐	☒	☒
42) Culturally appropriate services to reach person of racial ethnic cultures who may be better served and/or more responsive to services in specific culture-based settings.	☒	☐	☐	☐	☐	☒	☒
43) Integrated services with ethnic-specific community-based organizations.	☒	☐	☐	☐	☐	☒	☐
44) Self-help and client-run programs such as drop-in centers, club houses, anti-stigma campaigns, job training classes, advocacy programs and peer education.	☒	☐	☐	☐	☐	☒	☐
45) Ethnic-specific outreach strategies to racial ethnic populations to eliminate disparities in care.	☒	☐	☐	☐	☐	☒	☐
46) Education for clients and family or other caregivers as appropriate to maximize individual choice about the nature of medications, the expected benefits and the potential side effects as well as alternatives to medications.	☒	☐	☐	☐	☐	☒	☐
47) Supportive employment and other productive activities and personal growth opportunities including development of job options for clients such as social enterprises, agency-supported positions, and competitive employment options as well as volunteerism and other creative activities.	☒	☐	☐	☐	☐	☒	☐
48) Vocational services.	☒	☐	☐	☐	☐	☒	☐

49) Family support, education, and consultation services, parenting support and consultation services, self-help groups and mentoring.	☒	☐	☐	☐	☐	☒	☐
50) Education for primary care providers and other health care providers to increase coordination and integration of mental health and primary care, and other health services.	☒	☐	☐	☐	☐	☒	☒
51) Transformative infrastructure and attitudinal change for the development of peer-support services and client-run services including peer counseling programs and programs that are inclusive of diverse ethnic providers to provide support and to increase client/member knowledge and ability to use needed mental health services and reduce disparities in care.	☒	☐	☐	☐	☐	☐	☒
52) Integrated substance abuse and mental health services where clients/members receive substance abuse and mental health services simultaneously, not sequentially, from one team with one service plan for one person; specialized housing to accompany these services.	☒	☐	☐	☐	☐	☐	☒
53) Integrated service teams and planning with social service agencies and other community providers to meet the complex needs of older adults.	☒	☐	☐	☐	☐	☐	☒
54) Collaborative services with primary care health clinics and health care services to reduce barriers to access and increase integration of physical health care and mental health services; linkage of these clients to the full range of services.	☒	☐	☐	☐	☐	☐	☒
55) Outreach to older adults who are homeless, or in their homes, through community service providers and through other community sites that are the natural gathering places for older adults.	☒	☐	☐	☐	☐	☐	☒
56) Education for clients and family or other caregivers as appropriate to maximize individual choice about the nature of medications, the expected benefits and the potential side effects.	☒	☐	☐	☐	☐	☐	☒
57) Education for and coordination or co-location with primary care providers to increase coordination and integration of mental health and primary care services.	☒	☐	☐	☐	☐	☐	☒
58) Peer-supportive services and client-run services including peer counseling programs to provide support and to increase client/member knowledge and ability to use needed mental health services.	☒	☐	☐	☐	☐	☐	☒

59) Home care assistance, including training of caregivers and providers about enhancing the 'therapeutic environment' of the home.	☒	☐	☐	☐	☐	☐	☒
60) Trauma-informed and trauma-specific services.	☒	☐	☐	☐	☐	☐	☒
61) Supportive and independent education opportunities.	☒	☐	☐	☐	☐	☐	☒
62) Joint service planning with special services for seniors: senior centers, senior legal aid, adult day health care, adult day care, geriatric assessment centers, private caregiver resource centers, multi-service senior programs, senior volunteer programs, foster grandparents, senior nutrition centers, ethnic- and gender-specific social or community groups or other culture-based partners, grief/loss support groups, community self-help groups (e.g.. COPD, Overeaters Anonymous, Hospice, cancer, asthma, pain, Parkinson's, Alzheimer's, Al-Anon, AA, NA), transportation.	☒	☐	☐	☐	☐	☐	☒

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: Sacramento	Fiscal Year: 2006/2007	Program Work Plan Name: Transcultural Wellness Center
Program Work Plan #SAC5		Estimated Start Date: 4/01/2006
Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	The Transcultural Wellness Center is a comprehensive mental health program that will provide culturally and linguistically competent services to all individuals and families from the Asian/Pacific Island (API) communities with serious mental illness (SMI) and/or serious emotional disturbance (SED). All ages will be served at the Center. The Center will include multi-disciplinary staff with caseloads of 1:15 with 24/7 response capacity. The family/community-centered focus of this program is compatible with API cultural norms and expectations. While all cultural and ethnic groups are eligible for services at the Center, staff with bilingual bicultural skills will specifically focus on services to individuals and families of all age groups from the API community. The API Transcultural Wellness Center model will afford an efficient delivery system that includes the following: culturally appropriate wellness, resilience, and recovery services, psychotherapy, counseling, psychiatric consultation, medication support, service coordination/case management, networking, peer support, interpreter/translator and psycho-educational services. The API Transcultural Wellness Center and its service will begin to advance the goals of the Mental Health Services Act (per Section 3 of the Act), and transform the Sacramento County Mental Health System as follows: 1) establish a specific program for the under-served and unserved API community of all ages with serious mental illness and serious emotional disturbance; 2) utilize culturally competent self-directed care plans that are family focused and foster recovery, resiliency, and wellness; 3.) recruit clients, family and community members for staff positions to provide support services and outreach activities; 4) hire program staff who are culturally and linguistically competent; 5) ensure funds are expended in the most cost effective manner and services are provided utilizing a modified Assertive Community Treatment, Evidence-Based Practice model specific to Kajsiab House operating in Madison, WI, which is listed on the SAMHSA website.	

Priority Population: *Describe the situational characteristics of the priority population*	The Transcultural Wellness Center will serve all ages including children, youth, transitional age youth, adults and older adults from the API communities in Sacramento County. API communities in Sacramento County include Cambodian, Chinese, Fijian, Filipino, Hawaiian, Hmong, Japanese, Korean, Laotian, Mien, Samoan, Tongan and Vietnamese among others. Individuals and families from the API community include recent immigrants/refugees or first and second-generation refugee adults with serious mental illness, qualifying older adults with serious mental illness; LEP immigrant women with serious mental illness in domestic violence situations; and children and transition-age youth with serious emotional disturbance, who are children of immigrant/refugee parents or parents who are less acculturated. Also included are those in need of related services such as outreach services, educational programs, employment programs, psychosocial programs, and support services.

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
1) Child/youth peer monitoring.	☒	☐	☐	☒	☒	☐	☐
2) Youth involvement in planning and service development, including the involvement of youth previously involved in juvenile justice settings and out-of-home placements.	☒	☐	☐	☒	☒	☐	☐
3) Cultural and gender-sensitive outreach and services at schools, primary care clinics, and community programs in ethnic communities, which proactively reach children who may have emotional and/or behavioral disorders and which can provide easy and immediate access to mental health services when needed.	☒	☐	☐	☒	☒	☐	☐
4) Services and supports provided at school, in the community and in the child/youth's home.	☒	☐	☐	☒	☒	☐	☐
5) Infrastructure for the Children's System of Care program as found in W&I Code Section 5856 to promote interagency collaboration, shared responsibility and accountability for effective outcomes for children/youth and their families.	☒	☐	☐	☒	☒	☐	☐
6) Family preservation services.	☒	☐	☐	☒	☐	☐	☐
7) Crisis services including a 24-hour phone line for crisis.	☒	☐	☐	☒	☒	☒	☒

8) Education for children/youth and family or other caregivers regarding mental health diagnosis and assessment, medications, services and supports planning, treatment modalities, and other information related to children/youth's mental health services and needs.	☒	☐	☐	☒	☒	☒	☐
9) Education for primary care providers and other health care providers to increase coordination and integration of mental health and primary care, and other health services.	☒	☐	☐	☒	☒	☒	☒
10) Services in collaboration with faith-based communities; linkage for these families to the full range of community services and supports.	☒	☐	☐	☒	☐	☐	☐
11) Services located in racial ethnic communities to reach children, youth and families who may be more responsive to services in these settings; linkage for these families to the full range of community services and supports, intergenerational strategies for children/youth and their families in which parents may have their own mental health problems. Services are delivered within the context of a single child/family services and supports plan.	☒	☐	☐	☒	☒	☐	☐
12) Integrated services and supports for children/youth, adults and older adults and their families with co-occurring mental health and substance use disorders within the context of a single child/adults/family services and supports plan.	☒	☐	☐	☒	☒	☒	☒
13) Parental mental health education, with language access and culturally appropriate approaches.	☒	☐	☐	☒	☒	☐	☐
14) Values-driven evidence-based and promising clinical services that are culturally and linguistically competent and integrated with overall service planning, supporting individuals/youth/family selected goals and consistent with community values.	☒	☐	☐	☒	☒	☒	☒
15) Transportation.	☒	☐	☐	☒	☐	☐	☐
16) Supportive family partnership educational opportunities.	☒	☐	☐	☒	☒	☐	☐
17) Grief-loss family partnership support groups.	☒	☐	☐	☒	☒	☐	☐
18) Ethnic or tribal-specific social or community groups or other culture-based activities.	☒	☐	☐	☒	☒	☒	☒

19) Development of self-help, peer support and youth/family-run programs, to add youth/families as providers in clinical settings and to develop youth training programs, including youth and family member leadership training programs.	☒	☐	☐	☐	☒	☐	☐
20) Seamless linkages with both the children/youth mental health system and the adult mental health system as appropriate. A single PSC/case manager should follow transition age youth as they move from children and youth services into adult services and/or into the community as independent adults. Transfer out of a transition age program should be negotiated with the youth and not occur until s/he feels connected with the necessary services and supports for successful community independence and/or connection with the adult mental health system as appropriate.	☒	☐	☐	☒	☒	☐	☐
21) Cross-agency and cross-discipline training. Staff working with transition age youth who are trained in the developmental and cultural needs of transition age youth, in community resources, and in operationalizing a wellness philosophy including the concepts of both recovery and resiliency. Transition age youth, themselves, should be part of the pool of hired and trained staff.	☒	☐	☐	☐	☒	☐	☐
22) Integrated substance abuse and mental health services where youth receive substance abuse and mental health services simultaneously rather than sequentially, through an integrated team with a single individualized service plan. When appropriate, specialized housing for individuals with dual disorders should be available.	☒	☐	☐	☐	☒	☐	☐
23) Integrated service teams that provide comprehensive mental health, social, cultural, physical health, substance abuse and trauma (including intergenerational trauma) assessments which are strength-based and focused on engagement of the child/youth/adults/family and which can provide gender and cultural specific assessments as in the DSM IV-R cultural formulation.	☒	☐	☐	☒	☒	☒	☒
24) Integrated county/community level service planning which identifies needs in the areas of mental health services, health services, education, job training, employment, housing, socialization, independent living skills and funding options.	☒	☐	☐	☐	☒	☐	☐

25) Youth and family-run services including peer support, self-help groups, train-the- trainer programs and culturally competent mentoring programs.	☒	☐	☐	☐	☒	☐	☐
26) Youth involvement in planning and service development, including the involvement of youth previously involved in juvenile justice settings and out-of-home placements.	☒	☐	☐	☐	☒	☐	☐
27) Classes and other instruction regarding what clients need to know for successful living in the community.	☒	☐	☐	☒	☒	☒	☒
28) Supportive employment including development of job options for young people, such as social enterprises, agency supported positions, and competitive employment options with equal pay and benefits.	☒	☐	☐	☐	☒	☐	☐
29) Supportive education services.	☒	☐	☐	☐	☒	☒	☐
30) Education for youth and family or other caregivers as appropriate regarding the nature of medications, the expected benefits and the potential side effects.	☒	☐	☐	☐	☒	☐	☐
31) Trauma-informed services and trauma-specific services (including intergenerational trauma services), particularly for young women with co-occurring disorders.	☒	☐	☐	☐	☒	☐	☐
32) Community cultural practices – traditional practitioners, natural healing practices and ceremonies recognized by communities in place of or in addition to mainstream services.	☒	☐	☐	☐	☒	☒	☒
33) Services to assist families in supporting youth during this period.	☒	☐	☐	☐	☒	☐	☐
34) Crisis services including 24-hour crisis phone line including Peer support in times of crisis.	☒	☐	☐	☐	☒	☐	☐
35) Partnership with ethnic-specific community providers and programs.	☒	☐	☐	☐	☒	☐	☐
36) Transportation (including acquisition of driver's licenses).	☒	☐	☐	☐	☒	☐	☐
37) Recreation and social activities. Transition age youth should be involved in the planning and development of activities.	☒	☐	☐	☐	☒	☐	☐
38) Integrated physical and mental health services, which includes collaboration with primary care clinics or other health care sites and providers to provide individualized, inter-disciplinary, coordinated services. Linkage must be provided for clients served in these settings to the full range of mental health services when needed. These services are	☒	☐	☐	☒	☒	☒	☒

particularly needed to serve ethnic populations and others who may be more responsive to services in health care settings and to reach individuals with co-occurring chronic or life-threatening medical conditions and youth who are frequent users of hospital emergency rooms or inpatient care.							
39) Client self-directed care plans (e.g., Wellness Recovery Action Plans or other similar models).	☒	☐	☐	☐	☐	☒	☒
40) For individuals with dual diagnosis, integrated substance abuse and mental health services where a client/member receives substance abuse and mental health services simultaneously, not sequentially, from one team with one service plan for one person; specialized housing to accompany these services as appropriate.	☒	☐	☐	☐	☐	☒	☐
41) On-site services or services in collaboration with faith-based providers, churches, temples or similar settings where clients may feel more familiar and comfortable; linkage for these clients to the full range of services.	☒	☐	☐	☐	☐	☒	☒
42) Culturally appropriate services to reach person of racial ethnic cultures who may be better served and/or more responsive to services in specific culture-based settings.	☒	☐	☐	☐	☐	☒	☒
43) Integrated services with ethnic-specific community-based organizations.	☒	☐	☐	☐	☐	☒	☐
44) Self-help and client-run programs such as drop-in centers, club houses, anti-stigma campaigns, job training classes, advocacy programs and peer education.	☒	☐	☐	☐	☐	☒	☐
45) Ethnic-specific outreach strategies to racial ethnic populations to eliminate disparities in care.	☒	☐	☐	☐	☐	☒	☐
46) Education for clients and family or other caregivers as appropriate to maximize individual choice about the nature of medications, the expected benefits and the potential side effects as well as alternatives to medications.	☒	☐	☐	☐	☐	☒	☐
47) Supportive employment and other productive activities and personal growth opportunities including development of job options for clients such as social enterprises, agency-supported positions, and competitive employment options as well as volunteerism and other creative activities.	☒	☐	☐	☐	☐	☒	☐
48) Vocational services.	☒	☐	☐	☐	☐	☒	☐

49) Family support, education, and consultation services, parenting support and consultation services, self-help groups and mentoring.	☒	☐	☐	☐	☐	☒	☐
50) Education for primary care providers and other health care providers to increase coordination and integration of mental health and primary care, and other health services.	☒	☐	☐	☐	☐	☒	☒
51) Transformative infrastructure and attitudinal change for the development of peer-support services and client-run services including peer counseling programs and programs that are inclusive of diverse ethnic providers to provide support and to increase client/member knowledge and ability to use needed mental health services and reduce disparities in care.	☒	☐	☐	☐	☐	☐	☒
52) Integrated substance abuse and mental health services where clients/members receive substance abuse and mental health services simultaneously, not sequentially, from one team with one service plan for one person; specialized housing to accompany these services.	☒	☐	☐	☐	☐	☐	☒
53) Integrated service teams and planning with social service agencies and other community providers to meet the complex needs of older adults.	☒	☐	☐	☐	☐	☐	☒
54) Collaborative services with primary care health clinics and health care services to reduce barriers to access and increase integration of physical health care and mental health services; linkage of these clients to the full range of services.	☒	☐	☐	☐	☐	☐	☒
55) Outreach to older adults who are homeless, or in their homes, through community service providers and through other community sites that are the natural gathering places for older adults.	☒	☐	☐	☐	☐	☐	☒
56) Education for clients and family or other caregivers as appropriate to maximize individual choice about the nature of medications, the expected benefits and the potential side effects.	☒	☐	☐	☐	☐	☐	☒
57) Education for and coordination or co-location with primary care providers to increase coordination and integration of mental health and primary care services.	☒	☐	☐	☐	☐	☐	☒
58) Peer-supportive services and client-run services including peer counseling programs to provide support and to increase client/member knowledge and ability to use needed mental health services.	☒	☐	☐	☐	☐	☐	☒

59) Home care assistance, including training of caregivers and providers about enhancing the 'therapeutic environment' of the home.	☒	☐	☐	☐	☐	☐	☒
60) Trauma-informed and trauma-specific services.	☒	☐	☐	☐	☐	☐	☒
61) Supportive and independent education opportunities.	☒	☐	☐	☐	☐	☐	☒
62) Joint service planning with special services for seniors: senior centers, senior legal aid, adult day health care, adult day care, geriatric assessment centers, private caregiver resource centers, multi-service senior programs, senior volunteer programs, foster grandparents, senior nutrition centers, ethnic- and gender-specific social or community groups or other culture-based partners, grief/loss support groups, community self-help groups (e.g.. COPD, Overeaters Anonymous, Hospice, cancer, asthma, pain, Parkinson's, Alzheimer's, Al-Anon, AA, NA), transportation.	☒	☐	☐	☐	☐	☐	☒

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: Sacramento	Fiscal Year: 2007/2008	Program Work Plan Name: Transcultural Wellness Center
Program Work Plan #SAC5		Estimated Start Date: 4/01/2006
Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	The Transcultural Wellness Center is a comprehensive mental health program that will provide culturally and linguistically competent services to all individuals and families from the Asian/Pacific Island (API) communities with serious mental illness (SMI) and/or serious emotional disturbance (SED). All ages will be served at the Center. The Center will include multi-disciplinary staff with caseloads of 1:15 with 24/7 response capacity. The family/community-centered focus of this program is compatible with API cultural norms and expectations. While all cultural and ethnic groups are eligible for services at the Center, staff with bilingual bicultural skills will specifically focus on services to individuals and families of all age groups from the API community. The API Transcultural Wellness Center model will afford an efficient delivery system that includes the following: culturally appropriate wellness, resilience, and recovery services, psychotherapy, counseling, psychiatric consultation, medication support, service coordination/case management, networking, peer support, interpreter/translator and psycho-educational services. The API Transcultural Wellness Center and its service will begin to advance the goals of the Mental Health Services Act (per Section 3 of the Act), and transform the Sacramento County Mental Health System as follows: 1) establish a specific program for the under-served and unserved API community of all ages with serious mental illness and serious emotional disturbance; 2) utilize culturally competent self-directed care plans that are family focused and foster recovery, resiliency, and wellness; 3.) recruit clients, family and community members for staff positions to provide support services and outreach activities; 4) hire program staff who are culturally and linguistically competent; 5) ensure funds are expended in the most cost effective manner and services are provided utilizing a modified Assertive Community Treatment, Evidence-Based Practice model specific to Kajsiab House operating in Madison, WI, which is listed on the SAMHSA website.	

Priority Population: *Describe the situational characteristics of the priority population*	The Transcultural Wellness Center will serve all ages including children, youth, transitional age youth, adults and older adults from the API communities in Sacramento County. API communities in Sacramento County include Cambodian, Chinese, Fijian, Filipino, Hawaiian, Hmong, Japanese, Korean, Laotian, Mien, Samoan, Tongan and Vietnamese among others. Individuals and families from the API community include recent immigrants/refugees or first and second-generation refugee adults with serious mental illness, qualifying older adults with serious mental illness; LEP immigrant women with serious mental illness in domestic violence situations; and children and transition-age youth with serious emotional disturbance, who are children of immigrant/refugee parents or parents who are less acculturated. Also included are those in need of related services such as outreach services, educational programs, employment programs, psychosocial programs, and support services.

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
1) Child/youth peer monitoring.	☒	☐	☐	☒	☒	☐	☐
2) Youth involvement in planning and service development, including the involvement of youth previously involved in juvenile justice settings and out-of-home placements.	☒	☐	☐	☒	☒	☐	☐
3) Cultural and gender-sensitive outreach and services at schools, primary care clinics, and community programs in ethnic communities, which proactively reach children who may have emotional and/or behavioral disorders and which can provide easy and immediate access to mental health services when needed.	☒	☐	☐	☒	☒	☐	☐
4) Services and supports provided at school, in the community and in the child/youth's home.	☒	☐	☐	☒	☒	☐	☐
5) Infrastructure for the Children's System of Care program as found in W&I Code Section 5856 to promote interagency collaboration, shared responsibility and accountability for effective outcomes for children/youth and their families.	☒	☐	☐	☒	☒	☐	☐
6) Family preservation services.	☒	☐	☐	☒	☐	☐	☐
7) Crisis services including a 24-hour phone line for crisis.	☒	☐	☐	☒	☒	☒	☒

8) Education for children/youth and family or other caregivers regarding mental health diagnosis and assessment, medications, services and supports planning, treatment modalities, and other information related to children/youth's mental health services and needs.	☒	☐	☐	☒	☒	☒	☐
9) Education for primary care providers and other health care providers to increase coordination and integration of mental health and primary care, and other health services.	☒	☐	☐	☒	☒	☒	☒
10) Services in collaboration with faith-based communities; linkage for these families to the full range of community services and supports.	☒	☐	☐	☒	☐	☐	☐
11) Services located in racial ethnic communities to reach children, youth and families who may be more responsive to services in these settings; linkage for these families to the full range of community services and supports, intergenerational strategies for children/youth and their families in which parents may have their own mental health problems. Services are delivered within the context of a single child/family services and supports plan.	☒	☐	☐	☒	☒	☐	☐
12) Integrated services and supports for children/youth, adults and older adults and their families with co-occurring mental health and substance use disorders within the context of a single child/adults/family services and supports plan.	☒	☐	☐	☒	☒	☒	☒
13) Parental mental health education, with language access and culturally appropriate approaches.	☒	☐	☐	☒	☒	☐	☐
14) Values-driven evidence-based and promising clinical services that are culturally and linguistically competent and integrated with overall service planning, supporting individuals/youth/family selected goals and consistent with community values.	☒	☐	☐	☒	☒	☒	☒
15) Transportation.	☒	☐	☐	☒	☐	☐	☐
16) Supportive family partnership educational opportunities.	☒	☐	☐	☒	☒	☐	☐
17) Grief-loss family partnership support groups.	☒	☐	☐	☒	☒	☐	☐
18) Ethnic or tribal-specific social or community groups or other culture-based activities.	☒	☐	☐	☒	☒	☒	☒

19) Development of self-help, peer support and youth/family-run programs, to add youth/families as providers in clinical settings and to develop youth training programs, including youth and family member leadership training programs.	☒	☐	☐	☐	☒	☐	☐
20) Seamless linkages with both the children/youth mental health system and the adult mental health system as appropriate. A single PSC/case manager should follow transition age youth as they move from children and youth services into adult services and/or into the community as independent adults. Transfer out of a transition age program should be negotiated with the youth and not occur until s/he feels connected with the necessary services and supports for successful community independence and/or connection with the adult mental health system as appropriate.	☒	☐	☐	☒	☒	☐	☐
21) Cross-agency and cross-discipline training. Staff working with transition age youth who are trained in the developmental and cultural needs of transition age youth, in community resources, and in operationalizing a wellness philosophy including the concepts of both recovery and resiliency. Transition age youth, themselves, should be part of the pool of hired and trained staff.	☒	☐	☐	☐	☒	☐	☐
22) Integrated substance abuse and mental health services where youth receive substance abuse and mental health services simultaneously rather than sequentially, through an integrated team with a single individualized service plan. When appropriate, specialized housing for individuals with dual disorders should be available.	☒	☐	☐	☐	☒	☐	☐
23) Integrated service teams that provide comprehensive mental health, social, cultural, physical health, substance abuse and trauma (including intergenerational trauma) assessments which are strength-based and focused on engagement of the child/youth/adults/family and which can provide gender and cultural specific assessments as in the DSM IV-R cultural formulation.	☒	☐	☐	☒	☒	☒	☒
24) Integrated county/community level service planning which identifies needs in the areas of mental health services, health services, education, job training, employment, housing, socialization, independent living skills and funding options.	☒	☐	☐	☐	☒	☐	☐

25) Youth and family-run services including peer support, self-help groups, train-the- trainer programs and culturally competent mentoring programs.	☒	☐	☐	☐	☒	☐	☐
26) Youth involvement in planning and service development, including the involvement of youth previously involved in juvenile justice settings and out-of-home placements.	☒	☐	☐	☐	☒	☐	☐
27) Classes and other instruction regarding what clients need to know for successful living in the community.	☒	☐	☐	☒	☒	☒	☒
28) Supportive employment including development of job options for young people, such as social enterprises, agency supported positions, and competitive employment options with equal pay and benefits.	☒	☐	☐	☐	☒	☐	☐
29) Supportive education services.	☒	☐	☐	☐	☒	☒	☐
30) Education for youth and family or other caregivers as appropriate regarding the nature of medications, the expected benefits and the potential side effects.	☒	☐	☐	☐	☒	☐	☐
31) Trauma-informed services and trauma-specific services (including intergenerational trauma services), particularly for young women with co-occurring disorders.	☒	☐	☐	☐	☒	☐	☐
32) Community cultural practices – traditional practitioners, natural healing practices and ceremonies recognized by communities in place of or in addition to mainstream services.	☒	☐	☐	☐	☒	☒	☒
33) Services to assist families in supporting youth during this period.	☒	☐	☐	☐	☒	☐	☐
34) Crisis services including 24-hour crisis phone line including Peer support in times of crisis.	☒	☐	☐	☐	☒	☐	☐
35) Partnership with ethnic-specific community providers and programs.	☒	☐	☐	☐	☒	☐	☐
36) Transportation (including acquisition of driver's licenses).	☒	☐	☐	☐	☒	☐	☐
37) Recreation and social activities. Transition age youth should be involved in the planning and development of activities.	☒	☐	☐	☐	☒	☐	☐
38) Integrated physical and mental health services, which includes collaboration with primary care clinics or other health care sites and providers to provide individualized, inter-disciplinary, coordinated services. Linkage must be provided for clients served in these settings to the full range of mental health services when needed. These services are	☒	☐	☐	☒	☒	☒	☒

particularly needed to serve ethnic populations and others who may be more responsive to services in health care settings and to reach individuals with co-occurring chronic or life-threatening medical conditions and youth who are frequent users of hospital emergency rooms or inpatient care.							
39) Client self-directed care plans (e.g., Wellness Recovery Action Plans or other similar models).	☒	☐	☐	☐	☐	☒	☒
40) For individuals with dual diagnosis, integrated substance abuse and mental health services where a client/member receives substance abuse and mental health services simultaneously, not sequentially, from one team with one service plan for one person; specialized housing to accompany these services as appropriate.	☒	☐	☐	☐	☐	☒	☐
41) On-site services or services in collaboration with faith-based providers, churches, temples or similar settings where clients may feel more familiar and comfortable; linkage for these clients to the full range of services.	☒	☐	☐	☐	☐	☒	☒
42) Culturally appropriate services to reach person of racial ethnic cultures who may be better served and/or more responsive to services in specific culture-based settings.	☒	☐	☐	☐	☐	☒	☒
43) Integrated services with ethnic-specific community-based organizations.	☒	☐	☐	☐	☐	☒	☐
44) Self-help and client-run programs such as drop-in centers, club houses, anti-stigma campaigns, job training classes, advocacy programs and peer education.	☒	☐	☐	☐	☐	☒	☐
45) Ethnic-specific outreach strategies to racial ethnic populations to eliminate disparities in care.	☒	☐	☐	☐	☐	☒	☐
46) Education for clients and family or other caregivers as appropriate to maximize individual choice about the nature of medications, the expected benefits and the potential side effects as well as alternatives to medications.	☒	☐	☐	☐	☐	☒	☐
47) Supportive employment and other productive activities and personal growth opportunities including development of job options for clients such as social enterprises, agency-supported positions, and competitive employment options as well as volunteerism and other creative activities.	☒	☐	☐	☐	☐	☒	☐
48) Vocational services.	☒	☐	☐	☐	☐	☒	☐

49) Family support, education, and consultation services, parenting support and consultation services, self-help groups and mentoring.	☒	☐	☐	☐	☐	☒	☐
50) Education for primary care providers and other health care providers to increase coordination and integration of mental health and primary care, and other health services.	☒	☐	☐	☐	☐	☒	☒
51) Transformative infrastructure and attitudinal change for the development of peer-support services and client-run services including peer counseling programs and programs that are inclusive of diverse ethnic providers to provide support and to increase client/member knowledge and ability to use needed mental health services and reduce disparities in care.	☒	☐	☐	☐	☐	☐	☒
52) Integrated substance abuse and mental health services where clients/members receive substance abuse and mental health services simultaneously, not sequentially, from one team with one service plan for one person; specialized housing to accompany these services.	☒	☐	☐	☐	☐	☐	☒
53) Integrated service teams and planning with social service agencies and other community providers to meet the complex needs of older adults.	☒	☐	☐	☐	☐	☐	☒
54) Collaborative services with primary care health clinics and health care services to reduce barriers to access and increase integration of physical health care and mental health services; linkage of these clients to the full range of services.	☒	☐	☐	☐	☐	☐	☒
55) Outreach to older adults who are homeless, or in their homes, through community service providers and through other community sites that are the natural gathering places for older adults.	☒	☐	☐	☐	☐	☐	☒
56) Education for clients and family or other caregivers as appropriate to maximize individual choice about the nature of medications, the expected benefits and the potential side effects.	☒	☐	☐	☐	☐	☐	☒
57) Education for and coordination or co-location with primary care providers to increase coordination and integration of mental health and primary care services.	☒	☐	☐	☐	☐	☐	☒
58) Peer-supportive services and client-run services including peer counseling programs to provide support and to increase client/member knowledge and ability to use needed mental health services.	☒	☐	☐	☐	☐	☐	☒

59) Home care assistance, including training of caregivers and providers about enhancing the 'therapeutic environment' of the home.	☒	☐	☐	☐	☐	☐	☒
60) Trauma-informed and trauma-specific services.	☒	☐	☐	☐	☐	☐	☒
61) Supportive and independent education opportunities.	☒	☐	☐	☐	☐	☐	☒
62) Joint service planning with special services for seniors: senior centers, senior legal aid, adult day health care, adult day care, geriatric assessment centers, private caregiver resource centers, multi-service senior programs, senior volunteer programs, foster grandparents, senior nutrition centers, ethnic- and gender-specific social or community groups or other culture-based partners, grief/loss support groups, community self-help groups (e.g.. COPD, Overeaters Anonymous, Hospice, cancer, asthma, pain, Parkinson's, Alzheimer's, Al-Anon, AA, NA), transportation.	☒	☐	☐	☐	☐	☐	☒

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: Sacramento Fiscal Year: 2005/2006	Program Work Plan Name: Wellness and Recovery Center
Program Work Plan #SAC6	Estimated Start Date: 4/01/2006

Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	The Wellness and Recovery multi-service center will provide multicultural, multilingual, multi-service resources in a non-clinical, non-program setting, with the specific purpose of offering participant support, choice and recovery in a neighborhood setting. Open to the community this will serve the purpose of bringing the community together by mitigating the stigma associated with mental illness and providing a community resource for information about mental health issues. The peer recovery and support model will be emphasized to enhance employment, vocational training, recovery resources, social and recreational opportunities, benefits planning, independent living skills and peer counseling. The Center will transform the current mental health system by: 1) incorporating a recovery vision with a recovery culture in local neighborhood communities, 2) reducing ethnic and cultural barriers by hiring consumers, multicultural/multilingual staff, who are culturally competent in recovery principles, 3) meeting the unmet needs of unserved transition age youth, adults and older adults of diverse cultures and ethnicities, 4) utilizing wellness and recovery principles in service development in collaboration with stakeholders, 5) Integrating values-driven evidenced based services and emerging best practices into service planning, employment, education and self-identified consumer driven recovery goals.
Priority Population: *Describe the situational characteristics of the priority population*	The Wellness and Recovery Center will serve transition age youth, adults and older adults of diverse cultures and ethnicities with serious and persistent mental illness who meet the target population criteria established by the Sacramento County Division of Mental Health.

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
1) Transform the infrastructure and attitudinal change for the development of peer-support services and participant-run activities including peer	☐	☒	☐	☐	☒	☒	☒

counseling and support; activities to increase participant knowledge and ability to use needed mental health services and reduce disparities in care							
2) Values-driven evidenced based services and emerging best practices that are integrated with overall service planning and support housing, employment and/or education goals.	☐	☒	☐	☐	☒	☒	☒
3) Peer supportive services and client and family run services	☐	☒	☐	☐	☒	☒	☒
4) Mobile services to reach participants who cannot access clinics and other services due to physical disabilities, language barriers, mental disabilities; Home visits and outreach services to provide support and offer assistance to homebound participants.	☐	☒	☐	☐	☒	☒	☒
5) Supportive employment and other productive activities; including development of job options for clients such as social enterprises, agency supported positions, and competitive employment options.	☐	☒	☐	☐	☒	☒	☒
6) Service planning with social service agencies and other community providers to provide integrated services.	☐	☒	☐	☐	☒	☒	☒
7) Integrated county/community level service planning which identifies needs in the areas of mental health services, health services, education, job training, employment, housing, socialization, independent living skills and funding options.	☐	☒	☐	☐	☒	☒	☒
8) Youth and family-run services including peer support, self-help groups, train-the-trainer programs and culturally competent mentoring programs.	☐	☒	☐	☐	☒	☒	☒
9) Wellness Recovery Action Planning-In addition to an individualized system for monitoring and responding to symptoms to achieve the highest possible levels of wellness, this strategy includes looking at each client's needs and wants for home, job, friendship, and family with the focus on life improvement.	☐	☒	☐	☐	☒	☒	☒
10) Coordination with primary care providers and other health care providers to increase coordination and integration between mental health, primary care, and other health services.	☐	☒	☐	☐	☒	☒	☒
11) Peer supportive services including peer-counseling programs to provide culturally based support and to increase client/member knowledge and ability to use needed mental health services.	☐	☒	☐	☐	☒	☒	☒

12) Recovery and self-determination planning with opportunities for volunteer programs, advocacy groups, community self-help groups, nutrition programs, faith-based providers, churches, temples, and any other community resource serving transition age youth, adults and older adults of diverse cultures and ethnicities.	☐	☒	☐	☐	☒	☒	☒
13) Consumer run transportation services to promote outreach and assistance with accessing services.	☐	☒	☐	☐	☒	☒	☒
14) Classes for successful living in the community. Opportunities for participants to teach each other how to achieve meaningful roles in life.	☐	☒	☐	☐	☒	☒	☒
15) Mentoring	☐	☒	☐	☐	☒	☒	☒
16) Partnership's with community providers, educational institutions, vocational programs, and the business community.	☐	☒	☐	☐	☒	☒	☒
17) Education for youth, family and/or other care-givers family or other caregivers as appropriate regarding the nature of medications, the expected benefits and the potential side effects	☐	☒	☐	☐	☒	☒	☒
18) Supportive educational services	☐	☒	☐	☐	☒	☒	☒
19) Vocational services	☐	☒	☐	☐	☒	☒	☒
20) Trauma informed services	☐	☒	☐	☐	☒	☒	☒
21) Crisis activities including a 24 hour warm line	☐	☒	☐	☐	☒	☒	☒
22) Family support, education and consultation services, parenting support, self-help groups and mentoring.	☐	☒	☐	☐	☒	☒	☒
23) Community specific cultural practices. Natural healing practices and ceremonies recognized by the community in place of or in addition to mainstream services such as nutrition, exercise, yoga, meditation, art and music.	☐	☒	☐	☐	☒	☒	☒
24) Ethnic specific social and/or community groups or other culture-based partners.	☐	☒	☐	☐	☒	☒	☒
25) On-site services to reach faith-based communities, ethnic cultures, and others who may be more responsive to services in this setting; linkage for these individuals to a full range of services.	☐	☒	☐	☐	☒	☒	☒

26) Outreach and linkage to connect persons of various ethnicities and cultures who may be better served and/or responsive to services in specific culture based settings.	☐	☒	☐	☐	☒	☒	☒
27) Recreational and quality of life opportunities.	☐	☒	☐	☐	☒	☒	☒
28) Services to assist families in supporting youth during this period	☐	☒	☐	☐	☒	☒	☐
29) Cross-agency and cross-discipline training. Staff working with transition age youth who are trained in the developmental and cultural needs of transition age youth, in community resources, and implementing a wellness philosophy including the concepts of both recovery and resiliency	☐	☒	☐	☐	☒	☐	☐
30) Quality of life activities that guide participants for employment, supportive housing, community integration, substance abuse treatment, supportive education, family strengthening, etc.	☐	☒	☐	☐	☒	☒	☒
31) Youth involvement in planning and activity development, including the involvement of youth previously involved in juvenile justice settings and out of home placements.	☐	☒	☐	☐	☒	☐	☐

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: Sacramento Fiscal Year: 2006/2007	Program Work Plan Name: Wellness and Recovery Center
Program Work Plan #SAC6	Estimated Start Date: 4/01/2006

Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	The Wellness and Recovery multi-service center will provide multicultural, multilingual, multi-service resources in a non-clinical, non-program setting, with the specific purpose of offering participant support, choice and recovery in a neighborhood setting. Open to the community this will serve the purpose of bringing the community together by mitigating the stigma associated with mental illness and providing a community resource for information about mental health issues. The peer recovery and support model will be emphasized to enhance employment, vocational training, recovery resources, social and recreational opportunities, benefits planning, independent living skills and peer counseling. The Center will transform the current mental health system by: 1) incorporating a recovery vision with a recovery culture in local neighborhood communities, 2) reducing ethnic and cultural barriers by hiring consumers, multicultural/multilingual staff, who are culturally competent in recovery principles, 3) meeting the unmet needs of unserved transition age youth, adults and older adults of diverse cultures and ethnicities, 4) utilizing wellness and recovery principles in service development in collaboration with stakeholders, 5) Integrating values-driven evidenced based services and emerging best practices into service planning, employment, education and self-identified consumer driven recovery goals.
Priority Population: *Describe the situational characteristics of the priority population*	The Wellness and Recovery Center will serve transition age youth, adults and older adults of diverse cultures and ethnicities with serious and persistent mental illness who meet the target population criteria established by the Sacramento County Division of Mental Health.

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
1) Transform the infrastructure and attitudinal change for the development of peer-support services and participant-run activities including peer	☐	☒	☐	☐	☒	☒	☒

counseling and support; activities to increase participant knowledge and ability to use needed mental health services and reduce disparities in care							
2) Values-driven evidenced based services and emerging best practices that are integrated with overall service planning and support housing, employment and/or education goals.	☐	☒	☐	☐	☒	☒	☒
3) Peer supportive services and client and family run services	☐	☒	☐	☐	☒	☒	☒
4) Mobile services to reach participants who cannot access clinics and other services due to physical disabilities, language barriers, mental disabilities; Home visits and outreach services to provide support and offer assistance to homebound participants.	☐	☒	☐	☐	☒	☒	☒
5) Supportive employment and other productive activities; including development of job options for clients such as social enterprises, agency supported positions, and competitive employment options.	☐	☒	☐	☐	☒	☒	☒
6) Service planning with social service agencies and other community providers to provide integrated services.	☐	☒	☐	☐	☒	☒	☒
7) Integrated county/community level service planning which identifies needs in the areas of mental health services, health services, education, job training, employment, housing, socialization, independent living skills and funding options	☐	☒	☐	☐	☒	☒	☒
8) Youth and family-run services including peer support, self-help groups, train-the-trainer programs and culturally competent mentoring programs.	☐	☒	☐	☐	☒	☒	☒
9) Wellness Recovery Action Planning-In addition to an individualized system for monitoring and responding to symptoms to achieve the highest possible levels of wellness, this strategy includes looking at each client's needs and wants for home, job, friendship, and family with the focus on life improvement.	☐	☒	☐	☐	☒	☒	☒
10) Coordination with primary care providers and other health care providers to increase coordination and integration between mental health, primary care and other health services.	☐	☒	☐	☐	☒	☒	☒
11) Peer supportive services including peer-counseling programs to provide culturally based support and to increase client/member knowledge and ability to use needed mental health services.	☐	☒	☐	☐	☒	☒	☒

12) Recovery and self-determination planning with opportunities for volunteer programs, advocacy groups, community self-help groups, nutrition programs, faith-based providers, churches, temples, and any other community resource serving transition age youth, adults and older adults of diverse cultures and ethnicities.	☐	☒	☐	☐	☒	☒	☒
13) Consumer run transportation services to promote outreach and assistance with accessing services.	☐	☒	☐	☐	☒	☒	☒
14) Classes for successful living in the community. Opportunities for participants to teach each other how to achieve meaningful roles in life.	☐	☒	☐	☐	☒	☒	☒
15) Mentoring	☐	☒	☐	☐	☒	☒	☒
16) Partnership's with community providers, educational institutions, vocational programs, and the business community.	☐	☒	☐	☐	☒	☒	☒
17) Education for youth, family and/or other care-givers family or other caregivers as appropriate regarding the nature of medications, the expected benefits and the potential side effects	☐	☒	☐	☐	☒	☒	☒
18) Supportive educational services	☐	☒	☐	☐	☒	☒	☒
19) Vocational services	☐	☒	☐	☐	☒	☒	☒
20) Trauma informed services	☐	☒	☐	☐	☒	☒	☒
21) Crisis activities including a 24 hour warm line	☐	☒	☐	☐	☒	☒	☒
22) Family support, education and consultation services, parenting support, self-help groups and mentoring.	☐	☒	☐	☐	☒	☒	☒
23) Community specific cultural practices. Natural healing practices and ceremonies recognized by the community in place of or in addition to mainstream services such as nutrition, exercise, yoga, meditation, art and music.	☐	☒	☐	☐	☒	☒	☒
24) Ethnic specific social and/or community groups or other culture-based partners.	☐	☒	☐	☐	☒	☒	☒
25) On-site services to reach faith-based communities, ethnic cultures, and others who may be more responsive to services in this setting; linkage for these individuals to a full range of services.	☐	☒	☐	☐	☒	☒	☒

26) Outreach and linkage to connect persons of various ethnicities and cultures who may be better served and/or responsive to services in specific culture based settings.	☐	☒	☐	☐	☒	☒	☒
27) Recreational and quality of life opportunities.	☐	☒	☐	☐	☒	☒	☒
28) Services to assist families in supporting youth during this period	☐	☒	☐	☐	☒	☒	☐
29) Cross-agency and cross-discipline training. Staff working with transition age youth who are trained in the developmental and cultural needs of transition age youth, in community resources, and implementing a wellness philosophy including the concepts of both recovery and resiliency	☐	☒	☐	☐	☒	☐	☐
30) Quality of life activities that guide participants for employment, supportive housing, community integration, substance abuse treatment, supportive education, family strengthening, etc.	☐	☒	☐	☐	☒	☒	☒
31) Youth involvement in planning and activity development, including the involvement of youth previously involved in juvenile justice settings and out of home placements.	☐	☒	☐	☐	☒	☐	☐

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: Sacramento Fiscal Year: 2007/2008	Program Work Plan Name: Wellness and Recovery Center
Program Work Plan #SAC6	Estimated Start Date: 4/01/2006

Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	The Wellness and Recovery multi-service center will provide multicultural, multilingual, multi-service resources in a non-clinical, non-program setting, with the specific purpose of offering participant support, choice and recovery in a neighborhood setting. Open to the community this will serve the purpose of bringing the community together by mitigating the stigma associated with mental illness and providing a community resource for information about mental health issues. The peer recovery and support model will be emphasized to enhance employment, vocational training, recovery resources, social and recreational opportunities, benefits planning, independent living skills and peer counseling. The Center will transform the current mental health system by: 1) incorporating a recovery vision with a recovery culture in local neighborhood communities, 2) reducing ethnic and cultural barriers by hiring consumers, multicultural/multilingual staff, who are culturally competent in recovery principles, 3) meeting the unmet needs of unserved transition age youth, adults and older adults of diverse cultures and ethnicities, 4) utilizing wellness and recovery principles in service development in collaboration with stakeholders, 5) Integrating values-driven evidenced based services and emerging best practices into service planning, employment, education and self-identified consumer driven recovery goals.
Priority Population: *Describe the situational characteristics of the priority population*	The Wellness and Recovery Center will serve transition age youth, adults and older adults of diverse cultures and ethnicities with serious and persistent mental illness who meet the target population criteria established by the Sacramento County Division of Mental Health.

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
1) Transform the infrastructure and attitudinal change for the development of peer-support services and participant-run activities including peer	☐	☒	☐	☐	☒	☒	☒

counseling and support; activities to increase participant knowledge and ability to use needed mental health services and reduce disparities in care							
2) Values-driven evidenced based services and emerging best practices that are integrated with overall service planning and support housing, employment and/or education goals.	☐	☒	☐	☐	☒	☒	☒
3) Peer supportive services and client and family run services	☐	☒	☐	☐	☒	☒	☒
4) Mobile services to reach participants who cannot access clinics and other services due to physical disabilities, language barriers, mental disabilities; Home visits and outreach services to provide support and offer assistance to homebound participants.	☐	☒	☐	☐	☒	☒	☒
5) Supportive employment and other productive activities; including development of job options for clients such as social enterprises, agency supported positions, and competitive employment options.	☐	☒	☐	☐	☒	☒	☒
6) Service planning with social service agencies and other community providers to provide integrated services.	☐	☒	☐	☐	☒	☒	☒
7) Integrated county/community level service planning which identifies needs in the areas of mental health services, health services, education, job training, employment, housing, socialization, independent living skills and funding options	☐	☒	☐	☐	☒	☒	☒
8) Youth and family-run services including peer support, self-help groups, train-the-trainer programs and culturally competent mentoring programs.	☐	☒	☐	☐	☒	☒	☒
9) Wellness Recovery Action Planning-In addition to an individualized system for monitoring and responding to symptoms to achieve the highest possible levels of wellness, this strategy includes looking at each client's needs and wants for home, job, friendship, and family with the focus on life improvement.	☐	☒	☐	☐	☒	☒	☒
10) Coordination with primary care providers and other health care providers to increase coordination and integration between mental health, primary care and other health services.	☐	☒	☐	☐	☒	☒	☒
11) Peer supportive services including peer-counseling programs to provide culturally based support and to increase client/member knowledge and ability to use needed mental health services.	☐	☒	☐	☐	☒	☒	☒

12) Recovery and self-determination planning with opportunities for volunteer programs, advocacy groups, community self-help groups, nutrition programs, faith-based providers, churches, temples, and any other community resource serving transition age youth, adults and older adults of diverse cultures and ethnicities.	☐	☒	☐	☐	☒	☒	☒
13) Consumer run transportation services to promote outreach and assistance with accessing services.	☐	☒	☐	☐	☒	☒	☒
14) Classes for successful living in the community. Opportunities for participants to teach each other how to achieve meaningful roles in life.	☐	☒	☐	☐	☒	☒	☒
15) Mentoring	☐	☒	☐	☐	☒	☒	☒
16) Partnership's with community providers, educational institutions, vocational programs, and the business community.	☐	☒	☐	☐	☒	☒	☒
17) Education for youth, family and/or other care-givers family or other caregivers as appropriate regarding the nature of medications, the expected benefits and the potential side effects	☐	☒	☐	☐	☒	☒	☒
18) Supportive educational services	☐	☒	☐	☐	☒	☒	☒
19) Vocational services	☐	☒	☐	☐	☒	☒	☒
20) Trauma informed services	☐	☒	☐	☐	☒	☒	☒
21) Crisis activities including a 24 hour warm line	☐	☒	☐	☐	☒	☒	☒
22) Family support, education and consultation services, parenting support, self-help groups and mentoring.	☐	☒	☐	☐	☒	☒	☒
23) Community specific cultural practices. Natural healing practices and ceremonies recognized by the community in place of or in addition to mainstream services such as nutrition, exercise, yoga, meditation, art and music.	☐	☒	☐	☐	☒	☒	☒
24) Ethnic specific social and/or community groups or other culture-based partners.	☐	☒	☐	☐	☒	☒	☒
25) On-site services to reach faith-based communities, ethnic cultures, and others who may be more responsive to services in this setting; linkage for these individuals to a full range of services.	☐	☒	☐	☐	☒	☒	☒

26) Outreach and linkage to connect persons of various ethnicities and cultures who may be better served and/or responsive to services in specific culture based settings.	☐	☒	☐	☐	☒	☒	☒
27) Recreational and quality of life opportunities.	☐	☒	☐	☐	☒	☒	☒
28) Services to assist families in supporting youth during this period	☐	☒	☐	☐	☒	☒	☐
29) Cross-agency and cross-discipline training. Staff working with transition age youth who are trained in the developmental and cultural needs of transition age youth, in community resources, and implementing a wellness philosophy including the concepts of both recovery and resiliency	☐	☒	☐	☐	☒	☐	☐
30) Quality of life activities that guide participants for employment, supportive housing, community integration, substance abuse treatment, supportive education, family strengthening, etc.	☐	☒	☐	☐	☒	☒	☒
31) Youth involvement in planning and activity development, including the involvement of youth previously involved in juvenile justice settings and out of home placements.	☐	☒	☐	☐	☒	☐	☐

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: **Sacramento**	Fiscal Year: **2005-06**	Program Work Plan Name: **Psychiatric Emergency Response Team (PERT)**
Program Work Plan #: **SAC7**		Estimated Start Date: **04/01/2006**
Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	The Psychiatric Emergency Response Team (PERT) is a collaborative community-based mental health crisis-intervention program comprised of 4.5 two-member teams, each consisting of one Senior Mental Health Counselor and one Liaison/Coordination Officer (the half team consists of the PERT Liaison/ Coordination Supervisor and the Mental Health Program Coordinator/Clinical Supervisor assigned to supervise the program; half their time will be devoted to supervisory activities and the remaining half to service delivery as a two-member service team). Using the MHSA goals as its guide, the Psychiatric Emergency Response Team (PERT) will provide ethnically and culturally appropriate multidisciplinary mobile crisis assessments to: (1) stabilize the mental health crisis; (2) establish linkages with appropriate mental health, physical healthcare, substance abuse, and social services; (3) promote wellness and recovery; (4) increase social supports; (5) decrease isolation; and (6) prevent the recurrence of a crisis situation and/or hospitalization or incarceration. Both the mental health professionals and the assigned PERT officers will be carefully selected and have experience and training in working with individuals of all ages and cultures. Teams will include specialists in children's, adults' and older adults' services. Staff with bi-lingual and bi-cultural skills will be recruited. Interpreters will be utilized as necessary and appropriate. Consumers and family members will play a key role in training staff by sensitizing the mental health professionals and law enforcement officers to the needs of individuals in crisis. PERT teams will be committed to recovery and resiliency models. It is anticipated the program will reduce unnecessary trauma to consumers and family, avoid involuntary interventions, and reduce the utilization of higher levels of care via diversion and alternative crisis resolution. Thus, the program will support individuals in achieving crisis resolution in the least restrictive manner and setting. PERT team members and their intervention partners will follow-up after their initial contact to ensure individuals have been effectively linked with appropriate treatment and services.	

	Intervention partners will include consumer and family advocates, peer mentors, Transitional Community Opportunity for Recovery and Engagement (CORE), Geriatric Network, Adult and Child Protective Services, Probation, alcohol and drug treatment providers, public and private health clinics, schools, outpatient mental health clinics, homeless and housing programs, food banks, culturally based organizations, and churches to ensure individuals have been effectively linked with appropriate treatment and services.
Priority Population: *Describe the situational characteristics of the priority population*	The PERT program has been designed to serve adults, older adults, and Transitional Age Youth (TAY) with serious and persistent mental illness and children and youth with Serious Emotional Disability (SED) who have been referred to the PERT team following crisis contact with law enforcement officers or other first responders in the community.

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
(1) Mobile crisis intervention and stabilization providing multidisciplinary assessment, direct services, and linkages in the community using mental health / law enforcement partnership model.	☐	☒	☐	☒	☒	☒	☒
(2) Culturally appropriate services to members of ethnic and linguistic communities that have historically been underserved/unserved.	☐	☒	☐	☒	☒	☒	☒
(3) Collaborative services with Mental Health treatment Center, Crisis Stabilization Program, Emergency Medical Service, Emergency Shelter, Emergency Feeding Program, Mental Health Regional Support Teams and other outpatient providers.	☐	☒	☐	☒	☒	☒	☒
(4) Peer Counselor / Advocate will provide support to the client as well as support to family members or caregivers who are often the primary support system for the individual.	☐	☒	☐	☒	☒	☒	☒
(5) Self-directed care plans such as Wellness Recovery Action Plan (WRAP) whenever appropriate.	☐	☒	☐	☒	☒	☒	☒

(6) Services and supports provided in the community and at home through ongoing follow-up by PERT team until care has been assumed by linkage resource.	☐	☒	☐	☒	☒	☒	☒
(7) Outreach to homeless adults, older adults and TAY with SMI and to children and youth with SED.	☐	☒	☐	☒	☒	☒	☒

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: **Sacramento**	Fiscal Year: **2006-07**	Program Work Plan Name: **Psychiatric Emergency Response Team (PERT)**
Program Work Plan #: **SAC7**		Estimated Start Date: **04/01/2006**
Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	The Psychiatric Emergency Response Team (PERT) is a collaborative community-based mental health crisis-intervention program comprised of 4.5 two-member teams, each consisting of one Senior Mental Health Counselor and one Liaison/Coordination Officer (the half team consists of the PERT Liaison/ Coordination Supervisor and the Mental Health Program Coordinator/Clinical Supervisor assigned to supervise the program; half their time will be devoted to supervisory activities and the remaining half to service delivery as a two-member service team). Using the MHSA goals as its guide, the Psychiatric Emergency Response Team (PERT) will provide ethnically and culturally appropriate multidisciplinary mobile crisis assessments to: (1) stabilize the mental health crisis; (2) establish linkages with appropriate mental health, physical healthcare, substance abuse, and social services; (3) promote wellness and recovery; (4) increase social supports; (5) decrease isolation; and (6) prevent the recurrence of a crisis situation and/or hospitalization or incarceration. Both the mental health professionals and the assigned PERT officers will be carefully selected and have experience and training in working with individuals of all ages and cultures. Teams will include specialists in children's, adults' and older adults' services. Staff with bi-lingual and bi-cultural skills will be recruited. Interpreters will be utilized as necessary and appropriate. Consumers and family members will play a key role in training staff by sensitizing the mental health professionals and law enforcement officers to the needs of individuals in crisis. PERT teams will be committed to recovery and resiliency models. It is anticipated the program will reduce unnecessary trauma to consumers and family, avoid involuntary interventions, and reduce the utilization of higher levels of care via diversion and alternative crisis resolution. Thus, the program will support individuals in achieving crisis resolution in the least restrictive manner and setting. PERT team members and their intervention partners will follow-up after their initial contact to ensure individuals have been effectively linked with appropriate treatment and services.	

	Intervention partners will include consumer and family advocates, peer mentors, Transitional Community Opportunity for Recovery and Engagement (CORE), Geriatric Network, Adult and Child Protective Services, Probation, alcohol and drug treatment providers, public and private health clinics, schools, outpatient mental health clinics, homeless and housing programs, food banks, culturally based organizations, and churches to ensure individuals have been effectively linked with appropriate treatment and services.
Priority Population: *Describe the situational characteristics of the priority population*	The PERT program has been designed to serve adults, older adults, and Transitional Age Youth (TAY) with serious and persistent mental illness and children and youth with Serious Emotional Disability (SED) who have been referred to the PERT team following crisis contact with law enforcement officers or other first responders in the community.

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
(1) Mobile crisis intervention and stabilization providing multidisciplinary assessment, direct services, and linkages in the community using mental health / law enforcement partnership model.	☐	☒	☐	☒	☒	☒	☒
(2) Culturally appropriate services to members of ethnic and linguistic communities that have historically been underserved/unserved.	☐	☒	☐	☒	☒	☒	☒
(3) Collaborative services with Mental Health treatment Center, Crisis Stabilization Program, Emergency Medical Service, Emergency Shelter, Emergency Feeding Program, Mental Health Regional Support Teams and other outpatient providers.	☐	☒	☐	☒	☒	☒	☒
(4) Peer Counselor / Advocate will provide support to the client as well as support to family members or caregivers who are often the primary support system for the individual.	☐	☒	☐	☒	☒	☒	☒
(5) Self-directed care plans such as Wellness Recovery Action Plan (WRAP) whenever appropriate.	☐	☒	☐	☒	☒	☒	☒

(6) Services and supports provided in the community and at home through ongoing follow-up by PERT team until care has been assumed by linkage resource.	☐	☒	☐	☒	☒	☒
(7) Outreach to homeless adults, older adults and TAY with SMI and to children and youth with SED.	☐	☒	☐	☒	☒	☒

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY

County: **Sacramento**	Fiscal Year: **2007-08**	Program Work Plan Name: **Psychiatric Emergency Response Team (PERT)**
Program Work Plan #: **SAC7**		Estimated Start Date: **04/01/2006**
Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	The Psychiatric Emergency Response Team (PERT) is a collaborative community-based mental health crisis-intervention program comprised of 4.5 two-member teams, each consisting of one Senior Mental Health Counselor and one Liaison/Coordination Officer (the half team consists of the PERT Liaison/ Coordination Supervisor and the Mental Health Program Coordinator/Clinical Supervisor assigned to supervise the program; half their time will be devoted to supervisory activities and the remaining half to service delivery as a two-member service team). Using the MHSA goals as its guide, the Psychiatric Emergency Response Team (PERT) will provide ethnically and culturally appropriate multidisciplinary mobile crisis assessments to: (1) stabilize the mental health crisis; (2) establish linkages with appropriate mental health, physical healthcare, substance abuse, and social services; (3) promote wellness and recovery; (4) increase social supports; (5) decrease isolation; and (6) prevent the recurrence of a crisis situation and/or hospitalization or incarceration. Both the mental health professionals and the assigned PERT officers will be carefully selected and have experience and training in working with individuals of all ages and cultures. Teams will include specialists in children's, adults' and older adults' services. Staff with bi-lingual and bi-cultural skills will be recruited. Interpreters will be utilized as necessary and appropriate. Consumers and family members will play a key role in training staff by sensitizing the mental health professionals and law enforcement officers to the needs of individuals in crisis. PERT teams will be committed to recovery and resiliency models. It is anticipated the program will reduce unnecessary trauma to consumers and family, avoid involuntary interventions, and reduce the utilization of higher levels of care via diversion and alternative crisis resolution. Thus, the program will support individuals in achieving crisis resolution in the least restrictive manner and setting. PERT team members and their intervention partners will follow-up after their initial contact to ensure individuals have been effectively linked with appropriate treatment and services.	

	Intervention partners will include consumer and family advocates, peer mentors, Transitional Community Opportunity for Recovery and Engagement (CORE), Geriatric Network, Adult and Child Protective Services, Probation, alcohol and drug treatment providers, public and private health clinics, schools, outpatient mental health clinics, homeless and housing programs, food banks, culturally based organizations, and churches to ensure individuals have been effectively linked with appropriate treatment and services.
Priority Population: *Describe the situational characteristics of the priority population*	The PERT program has been designed to serve adults, older adults, and Transitional Age Youth (TAY) with serious and persistent mental illness and children and youth with Serious Emotional Disability (SED) who have been referred to the PERT team following crisis contact with law enforcement officers or other first responders in the community.

Describe strategies to be used, Funding Types requested (check all that apply), Age Groups to be served (check all that apply)	Fund Type			Age Group			
	FSP	Sys Dev	OE	CY	TAY	A	OA
(1) Mobile crisis intervention and stabilization providing multidisciplinary assessment, direct services, and linkages in the community using mental health / law enforcement partnership model.	☐	☒	☐	☒	☒	☒	☒
(2) Culturally appropriate services to members of ethnic and linguistic communities that have historically been underserved/unserved.	☐	☒	☐	☒	☒	☒	☒
(3) Collaborative services with Mental Health treatment Center, Crisis Stabilization Program, Emergency Medical Service, Emergency Shelter, Emergency Feeding Program, Mental Health Regional Support Teams and other outpatient providers.	☐	☒	☐	☒	☒	☒	☒
(4) Peer Counselor / Advocate will provide support to the client as well as support to family members or caregivers who are often the primary support system for the individual.	☐	☒	☐	☒	☒	☒	☒
(5) Self-directed care plans such as Wellness Recovery Action Plan (WRAP) whenever appropriate.	☐	☒	☐	☒	☒	☒	☒

(6) Services and supports provided in the community and at home through ongoing follow-up by PERT team until care has been assumed by linkage resource.	☐	☒	☐	☒	☒	☒
(7) Outreach to homeless adults, older adults and TAY with SMI and to children and youth with SED.	☐	☒	☐	☒	☒	☒

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Sacramento | Fiscal Year: 2005-06

Program Workplan #: SAC1 | Date: 1/23/06

Program Workplan Name: Transitional Community Opportunities for Recovery and Engagement | Page ___ of ___

Type of Funding: 2. System Development | Months of Operation: 3

Proposed Total Client Capacity of Program/Service: 50 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: | Prepared by: Dave Goold

Client Capacity of Program/Service Expanded through MHSA: 50 | Telephone Number: 875-5825

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures	-			
a. Clothing, Food and Hygiene				
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0		$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)				$0
c. Employee Benefits				$0
d. Total Personnel Expenditures	$0	$0		$0
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures				$0
e. Rent, Utilities and Equipment				$0
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$0		$0
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0		$0
5. Estimated Total Expenditures when service provider is not known				$590,723
6. Total Proposed Program Budget	**$0**	**$0**	**$0**	**$590,723**
B. Revenues				
1. Existing Revenues				0
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$0	$0	$0
2. New Revenues				
a. Medi-Cal (FFP only)				$181,836
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$0
d. Other Revenue				$0
e. Total New Revenue	$0	$0	$0	$181,836
3. Total Revenues	$0	$0		$181,836
C. One-Time CSS Funding Expenditures				**$100,888**
D. Total Funding Requirements	**$0**	**$0**	**$0**	**$509,775**
E. Percent of Total Funding Requirements for Full Service Partnerships				**3.6%**

EXHIBIT 5a--Mental Health Services Act Community Services and Supports

BUDGET NARRATIVE

Transitional Community Opportunities for Recovery and Engagement - #SAC1

County: Sacramento | Fiscal Year: 2005-06

A. Expenditures

5. Estimated Total Expenditures when service provider is not known	$590,723

B. Revenues

2. New Revenues

a. Medi-Cal (FFP only)	$181,836
b. Medicare/Patient Fees/Patient Insurance	$0
c. State General Funds	$0
d. Other Revenue	$0

C. One-Time CSS Funding Expenditures **$100,888**

Computer equipment, facility improvements, and office furnishings

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Sacramento | Fiscal Year: 2005-06

Program Workplan # SAC1 | Date: 1/23/06

Program Workplan Name Transitional Community Opportunities for Recovery and Engagement | Page ___ of ___

Type of Funding 2. System Development | Months of Operation 3

Proposed Total Client Capacity of Program/Service: 50 | New Program/Service or Expansion New

Existing Client Capacity of Program/Service: 0 | Prepared by: Dave Goold

Client Capacity of Program/Service Expanded through MHSA: 50 | Telephone Number: 875-5825

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
MH Program Coordinator	*Administrative Program Director/Mgr.*		0.50		
MH Program Coordinator	*Clinical Director - Quality Assurance - Licensed*		1.00		
Sr. MH Counselors	*Licensed/Waived Professional Service Providers*		2.00		
MH Counselor - Dual Diag Spc	*Lic/Waived Dual Diagnosis Specialists*		2.00		
MH Rehabilitation Specialists	*Paraprofessional Service Providers/Case Mgrs*	7.00	14.00		
Psychiatric Nurse	*Medication Support for Psychiatrist and Clients*		1.00		
MH Vocational Specialists	*Vocational Resource*		0.50		
Consumer/Family Advocate	*Consumer and Family Education/Patients Rights*	1.00	1.00		
Psychiatrist	*Medication Services*		0.90		
Cultural/Linguistic Counselor	*Interpretation/Translation/Cultural Competence*		0.50		
Office Assistant	*Clerical Support*	2.00	2.00		
					$0
					$0
					$0
					$0
	Total New Additional Positions	10.00	25.40		
C. Total Program Positions		10.00	25.40		$0

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Sacramento | Fiscal Year: 2006-07

Program Workplan #: SAC1 | Date: 1/23/06

Program Workplan Name: Transitional Community Opportunities for Recovery and Engagement | Page ___ of ___

Type of Funding: 2. System Development | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 250 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: | Prepared by: Dave Goold

Client Capacity of Program/Service Expanded through MHSA: 250 | Telephone Number: 875-5825

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures	-			
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0		$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)				$0
c. Employee Benefits				$0
d. Total Personnel Expenditures	$0	$0		$0
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures				$0
e. Rent, Utilities and Equipment				$0
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$0		$0
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0		$0
5. Estimated Total Expenditures when service provider is not known				$2,362,892
6. Total Proposed Program Budget	**$0**	**$0**	**$0**	**$2,362,892**
B. Revenues				
1. Existing Revenues				0
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$0	$0	$0
2. New Revenues				
a. Medi-Cal (FFP only)			$727,341	$727,341
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$0
d. Other Revenue				$0
e. Total New Revenue	$0	$0	$727,341	$727,341
3. Total Revenues	$0	$0		$727,341
C. One-Time CSS Funding Expenditures				
D. Total Funding Requirements	**$0**	**$0**	**$0**	**$1,635,551**
E. Percent of Total Funding Requirements for Full Service Partnerships				**3.6%**

EXHIBIT 5a--Mental Health Services Act Community Services and Supports

BUDGET NARRATIVE

Transitional Community Opportunities for Recovery and Engagement - #SAC1

County: Sacramento | Fiscal Year: 2006-07

A. Expenditures	
5. Estimated Total Expenditures when service provider is not known	$2,362,892
B. Revenues	
2. New Revenues	
a. Medi-Cal (FFP only)	$727,341
b. Medicare/Patient Fees/Patient Insurance	$0
c. State General Funds	$0
d. Other Revenue	$0
C. One-Time CSS Funding Expenditures	**$0**

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Sacramento | Fiscal Year: 2006-07

Program Workplan # SAC1 | Date: 1/23/06

Program Workplan Name Transitional Community Opportunities for Recovery and Engagement | Page ___ of ___

Type of Funding 2. System Development | Months of Operation 12

Proposed Total Client Capacity of Program/Service: 250 | New Program/Service or Expansion New

Existing Client Capacity of Program/Service: 0 | Prepared by: Dave Goold

Client Capacity of Program/Service Expanded through MHSA: 250 | Telephone Number: 875-5825

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
MH Program Coordinator	*Administrative Program Director/Mgr.*		0.50		
MH Program Coordinator	*Clinical Director - Quality Assurance - Licensed*		1.00		
Sr. MH Counselors	*Licensed/Waived Professional Service Providers*		2.00		
MH Counselor - Dual Diag Spc	*Lic/Waived Dual Diagnosis Specialists*		2.00		
MH Rehabilitation Specialists	*Paraprofessional Service Providers/Case Mgrs*	7.00	14.00		
Psychiatric Nurse	*Medication Support for Psychiatrist and Clients*		1.00		
MH Vocational Specialists	*Vocational Resource*		0.50		
Consumer/Family Advocate	*Consumer and Family Education/Patients Rights*	1.00	1.00		
Psychiatrist	*Medication Services*		0.90		
Cultural/Linguistic Counselor	*Interpretation/Translation/Cultural Competence*		0.50		
Office Assistant	*Clerical Support*	2.00	2.00		
					$0
					$0
					$0
					$0
	Total New Additional Positions	10.00	25.40		
C. Total Program Positions		10.00	25.40		$0

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Sacramento | Fiscal Year: 2007-08

Program Workplan #: SAC1 | Date: 1/23/06

Program Workplan Name: Transitional Community Opportunities for Recovery and Engagement | Page ___ of ___

Type of Funding: 2. System Development | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 250 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: | Prepared by: Dave Goold

Client Capacity of Program/Service Expanded through MHSA: 250 | Telephone Number: 875-5825

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures	-			
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0		$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)				$0
c. Employee Benefits				$0
d. Total Personnel Expenditures	$0	$0		$0
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures				$0
e. Rent, Utilities and Equipment				$0
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$0		$0
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0		$0
5. Estimated Total Expenditures when service provider is not known				$2,362,892
6. Total Proposed Program Budget	**$0**	**$0**	**$0**	**$2,362,892**
B. Revenues				
1. Existing Revenues				0
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$0	$0	$0
2. New Revenues				
a. Medi-Cal (FFP only)				$727,341
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$0
d. Other Revenue				$0
e. Total New Revenue	$0	$0	$0	$727,341
3. Total Revenues	$0	$0		$727,341
C. One-Time CSS Funding Expenditures				
D. Total Funding Requirements	**$0**	**$0**	**$0**	**$1,635,551**
E. Percent of Total Funding Requirements for Full Service Partnerships				**0.6%**

EXHIBIT 5a--Mental Health Services Act Community Services and Supports

BUDGET NARRATIVE

Transitional Community Opportunities for Recovery and Engagement - #SAC1

County: Sacramento Fiscal Year: 2007-08

A. Expenditures	
5. Estimated Total Expenditures when service provider is not known	$2,362,892
B. Revenues	
2. New Revenues	
a. Medi-Cal (FFP only)	$727,341
b. Medicare/Patient Fees/Patient Insurance	$0
c. State General Funds	$0
d. Other Revenue	$0
C. One-Time CSS Funding Expenditures	**$0**

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Sacramento | Fiscal Year: 2007-08

Program Workplan # SAC1 | Date: 1/23/06

Program Workplan Name Transitional Community Opportunities for Recovery and Engagement | Page ___ of ___

Type of Funding 2. System Development | Months of Operation 12

Proposed Total Client Capacity of Program/Service: 250 | New Program/Service or Expansion New

Existing Client Capacity of Program/Service: 0 | Prepared by: Dave Goold

Client Capacity of Program/Service Expanded through MHSA: 250 | Telephone Number: 875-5825

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
MH Program Coordinator	*Administrative Program Director/Mgr.*		0.50		
MH Program Coordinator	*Clinical Director - Quality Assurance - Licensed*		1.00		
Sr. MH Counselors	*Licensed/Waived Professional Service Providers*		2.00		
MH Counselor - Dual Diag Spc	*Lic/Waived Dual Diagnosis Specialists*		2.00		
MH Rehabilitation Specialists	*Paraprofessional Service Providers/Case Mgrs*	7.00	14.00		
Psychiatric Nurse	*Medication Support for Psychiatrist and Clients*		1.00		
MH Vocational Specialists	*Vocational Resource*		0.50		
Consumer/Family Advocate	*Consumer and Family Education/Patients Rights*	1.00	1.00		
Psychiatrist	*Medication Services*		0.90		
Cultural/Linguistic Counselor	*Interpretation/Translation/Cultural Competence*		0.50		
Office Assistant	*Clerical Support*	2.00	2.00		
					$0
					$0
					$0
					$0
	Total New Additional Positions	10.00	25.40		
C. Total Program Positions		10.00	25.40		$0

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Sacramento | Fiscal Year: 2005-06

Program Workplan #: SAC2 | Date: 1/23/06

Program Workplan Name: Older Adult Intensive Services | Page ___ of ____

Type of Funding: 1. Full Service Partnership | Months of Operation: 3

Proposed Total Client Capacity of Program/Service: 15 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Dave Goold

Client Capacity of Program/Service Expanded through MHSA: 15 | Telephone Number: 916-875-5825

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0		$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)				$0
c. Employee Benefits				$0
d. Total Personnel Expenditures	$0	$0		$0
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures				$0
e. Rent, Utilities and Equipment				$0
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$0		$0
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0		$0
5. Estimated Total Expenditures when service provider is not known				$376,096
6. Total Proposed Program Budget	**$0**	**$0**	**$0**	**$376,096**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$0		$0
2. New Revenues				
a. Medi-Cal (FFP only)				$107,992
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$0
d. Other Revenue				$0
e. Total New Revenue	$0	$0		$107,992
3. Total Revenues	$0	$0		$107,992
C. One-Time CSS Funding Expenditures				**$263,000**
D. Total Funding Requirements	**$0**	**$0**	**$0**	**$531,104**
E. Percent of Total Funding Requirements for Full Service Partnerships				**100.0%**

EXHIBIT 5a--Mental Health Services Act Community Services and Supports

BUDGET NARRATIVE

Older Adult Intensive Services Program - #SAC2

County: Sacramento | Fiscal Year: 2005-06

A. Expenditures

5. Estimated Total Expenditures when service provider is not known $376,096

B. Revenues

2. New Revenues

a. Medi-Cal (FFP only) $107,992

b. Medicare/Patient Fees/Patient Insurance $0

c. State General Funds $0

d. Other Revenue $0

C. One-Time CSS Funding Expenditures **$263,000**

First year program operations will involve proportionately more screening of candidates than in subsequent years because it is a startup program. Comprehensive assessment of older adults requires components that may not be reimbursable from third party payors including social and community functioning assessments, substance abuse assessments, trauma history assessments, physical health assessments, strength and gifting assessments, and gender and culture specific assessments. Augmentation of this process with one-time funds is necessary to insure that all candidates for the program receive a thorough and comprehensive assessment of the whole person. $200,000

Computer equipment, facility improvements, and office furnishings $63,000

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Sacramento | Fiscal Year: 2005-06

Program Workplan #: SAC2 | Date: 1/23/06

Program Workplan Name: Older Adult Intensive Services | Page ___ of ____

Type of Funding: 1. Full Service Partnership | Months of Operation: 3

Proposed Total Client Capacity of Program/Service: 15 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Dave Goold

Client Capacity of Program/Service Expanded through MHSA: 15 | Telephone Number: 916-875-5825

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
MH Program Coord	*Clinical and Administrative Supervision*		1.00		
Mental Health Counselors	*Mental Health Services*		7.00		
Nurse Practitioner	*Physical Healthcare/Medication Management*		1.00		
Psychiatric Nurse	*Medication Mgt/Coord w/Physical Healthcare*		1.00		
Office Assistant	*Scheduling/Paperwork/Reception/Data Entry*	1.00	1.00		
Family/Consumer Advocate	*Education, Training, Patients Rights (contracted)*	0.40	0.40		
Senior Peer Counselors	*Volunteers with $85mo stipends/$40 bus passes*	4.00	4.00		
Psychiatrist	*Medication Services (contracted)*		1.00		
Cultural/Linguistic Consultant	*Cultural/Linguistic Services (contracted)*		0.20		
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	5.40	16.60		$0
C. Total Program Positions		5.40	16.60		$0

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Sacramento | Fiscal Year: 2006-07

Program Workplan #: SAC2 | Date: 1/23/06

Program Workplan Name: Older Adult Intensive Services | Page ___ of ____

Type of Funding: 1. Full Service Partnership | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 100 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: | Prepared by: Dave Goold

Client Capacity of Program/Service Expanded through MHSA: 100 | Telephone Number: 916-875-5825

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0		$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)				$0
c. Employee Benefits				$0
d. Total Personnel Expenditures	$0	$0		$0
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures				$0
e. Rent, Utilities and Equipment				$0
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$0		$0
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0		$0
5. Estimated Total Expenditures when service provider is not known				$1,504,384
6. Total Proposed Program Budget	**$0**	**$0**	**$0**	**$1,504,384**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$0		$0
2. New Revenues				
a. Medi-Cal (FFP only)				$431,969
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$0
d. Other Revenue				$0
e. Total New Revenue	$0	$0		$431,969
3. Total Revenues	$0	$0		$431,969
C. One-Time CSS Funding Expenditures				
D. Total Funding Requirements	**$0**	**$0**	**$0**	**$1,072,415**
E. Percent of Total Funding Requirements for Full Service Partnerships				**100.0%**

EXHIBIT 5a--Mental Health Services Act Community Services and Supports

BUDGET NARRATIVE

Older Adult Intensive Services Program - #SAC2

County: Sacramento | Fiscal Year: 2006-07

A. Expenditures	
5. Estimated Total Expenditures when service provider is not known	$1,504,384
B. Revenues	
2. New Revenues	
a. Medi-Cal (FFP only)	$431,969
b. Medicare/Patient Fees/Patient Insurance	$0
c. State General Funds	$0
d. Other Revenue	$0
C. One-Time CSS Funding Expenditures	**$0**

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Sacramento | Fiscal Year: 2006-07

Program Workplan #: SAC2 | Date: 1/23/06

Program Workplan Name: Older Adult Intensive Services | Page ___ of ____

Type of Funding: 1. Full Service Partnership | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 100 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Dave Goold

Client Capacity of Program/Service Expanded through MHSA: 100 | Telephone Number: 916-875-5825

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
MH Program Coord	*Clinical and Administrative Supervision*		1.00		
Mental Health Counselors	*Mental Health Services*		7.00		
Nurse Practitioner	*Physical Healthcare/Medication Management*		1.00		
Psychiatric Nurse	*Medication Mgt/Coord w/Physical Healthcare*		1.00		
Office Assistant	*Scheduling/Paperwork/Reception/Data Entry*	1.00	1.00		
Family/Consumer Advocate	*Education, Training, Patients Rights (contracted)*	0.40	0.40		
Senior Peer Counselors	*Volunteers with $85mo stipends/$40 bus passes*	4.00	4.00		
Psychiatrist	*Medication Services (contracted)*		1.00		
Cultural/Linguistic Consultant	*Cultural/Linguistic Services (contracted)*		0.20		
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	5.40	16.60		$0
C. Total Program Positions		5.40	16.60		$0

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Sacramento | Fiscal Year: 2007-08

Program Workplan #: SAC2 | Date: 1/23/06

Program Workplan Name: Older Adult Intensive Services | Page ___ of ____

Type of Funding: 1. Full Service Partnership | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 100 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: | Prepared by: Dave Goold

Client Capacity of Program/Service Expanded through MHSA: 100 | Telephone Number: 916-875-5825

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0		$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)				$0
c. Employee Benefits				$0
d. Total Personnel Expenditures	$0	$0		$0
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures				$0
e. Rent, Utilities and Equipment				$0
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$0		$0
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0		$0
5. Estimated Total Expenditures when service provider is not known				$1,504,384
6. Total Proposed Program Budget	**$0**	**$0**	**$0**	**$1,504,384**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$0		$0
2. New Revenues				
a. Medi-Cal (FFP only)				$431,969
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$0
d. Other Revenue				$0
e. Total New Revenue	$0	$0		$431,969
3. Total Revenues	$0	$0		$431,969
C. One-Time CSS Funding Expenditures				
D. Total Funding Requirements	**$0**	**$0**	**$0**	**$1,072,415**
E. Percent of Total Funding Requirements for Full Service Partnerships				**100.0%**

EXHIBIT 5a--Mental Health Services Act Community Services and Supports

BUDGET NARRATIVE

Older Adult Intensive Services Program - #SAC2

County: Sacramento | Fiscal Year: 2007-08

A. Expenditures	
5. Estimated Total Expenditures when service provider is not known	$1,504,384
B. Revenues	
2. New Revenues	
a. Medi-Cal (FFP only)	$431,969
b. Medicare/Patient Fees/Patient Insurance	$0
c. State General Funds	$0
d. Other Revenue	$0
C. One-Time CSS Funding Expenditures	**$0**

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Sacramento | Fiscal Year: 2007-08

Program Workplan #: SAC2 | Date: 1/23/06

Program Workplan Name: Older Adult Intensive Services | Page ___ of ____

Type of Funding: 1. Full Service Partnership | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 100 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Dave Goold

Client Capacity of Program/Service Expanded through MHSA: 100 | Telephone Number: 916-875-5825

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
MH Program Coord	*Clinical and Administrative Supervision*		1.00		
Mental Health Counselors	*Mental Health Services*		7.00		
Nurse Practitioner	*Physical Healthcare/Medication Management*		1.00		
Psychiatric Nurse	*Medication Mgt/Coord w/Physical Healthcare*		1.00		
Office Assistant	*Scheduling/Paperwork/Reception/Data Entry*	1.00	1.00		
Family/Consumer Advocate	*Education, Training, Patients Rights (contracted)*	0.40	0.40		
Senior Peer Counselors	*Volunteers with $85mo stipends/$40 bus passes*	4.00	4.00		
Psychiatrist	*Medication Services (contracted)*		1.00		
Cultural/Linguistic Consultant	*Cultural/Linguistic Services (contracted)*		0.20		
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	5.40	16.60		$0
C. Total Program Positions		5.40	16.60		$0

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Sacramento | Fiscal Year: 2005-06

Program Workplan #: SAC4 | Date: 1/23/06

Program Workplan Name: Permanent Supportive Housing for Individuals and Families | Page ___ of ___

Type of Funding: 1. Full Service Partnership | Months of Operation: 3

Proposed Total Client Capacity of Program/Service: 31 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Jane Ann LeBlanc

Client Capacity of Program/Service Expanded through MHSA: 31 | Telephone Number: (916) 875-0188

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0	$0	$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)				$0
c. Employee Benefits				$0
d. Total Personnel Expenditures	$0	$0	$0	$0
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures				$0
e. Rent, Utilities and Equipment				
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$0	$0	$0
4. Program Management				
a. Existing Program Management				$0
b. New Program Management			$0	$0
c. Total Program Management		$0	$0	$0
5. Estimated Total Expenditures when service provider is not known				$702,111
6. Total Proposed Program Budget	**$0**	**$0**	**$0**	**$702,111**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)				
b. Medicare/Patient Fees/Patient Insurance				
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$0	$0	$0
2. New Revenues				
a. Medi-Cal (FFP only)				$131,985
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$25,515
d. Other Revenue				$0
e. Total New Revenue	$0	$0	$0	$157,500
3. Total Revenues	$0	$0	$0	$157,500
C. One-Time CSS Funding Expenditures				**$4,075,972**
D. Total Funding Requirements	**$0**	**$0**	**$0**	**$4,620,583**
E. Percent of Total Funding Requirements for Full Service Partnerships				**100.0%**

EXHIBIT 5a--Mental Health Services Act Community Services and Supports

BUDGET NARRATIVE

Permanent Supportive Housing Program for Individuals and Families - #SAC4

County: Sacramento Fiscal Year: 2005-06

A. Expenditures

5. Estimated Total Expenditures when service provider is not known $702,111

B. Revenues

2. New Revenues

a. Medi-Cal (FFP only) $131,985

b. Medicare/Patient Fees/Patient Insurance $0

c. State General Funds $25,515

d. Other Revenue $0

C. One-Time CSS Funding Expenditures **$4,075,972**

As stated in the Executive Summary, Sacramento County Department of Health and Human Services is an active participant in local efforts to develop additional permanent supportive housing units in the County. Partners include the Sacramento Housing and Redevelopment Agency (SHRA), a private nonprofit housing developer, and a contracted mental health service agency. One-time funds will be leveraged with other funding streams, tax credits, and monies from other agencies to begin the process of creating permanent housing for our clients. $4,000,000

7-Passenger minivan purchase, computer equipment, and office furnishings $75,972

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Sacramento | Fiscal Year: 2005-06

Program Workplan # SAC4 | Date: 1/23/06

Program Workplan Name Permanent Supportive Housing for Individuals and Families | Page ___ of ___

Type of Funding 1. Full Service Partnership | Months of Operation 3

Proposed Total Client Capacity of Program/Service: 31 | New Program/Service or Expansion New

Existing Client Capacity of Program/Service: 0 | Prepared by: Jane Ann LeBlanc

Client Capacity of Program/Service Expanded through MHSA: 31 | Telephone Number: (916) 875-0188

Classification	Function	Client, FM & CG FTEs[a/1]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
MH Program Coordinator	*Program Director*	1.00	1.00		$0
MH Program Coordinator	*Licensed Clinical Director*	1.00	1.00		$0
Sr. Mental Health Counselor	*Team Leaders*	2.00	2.00		$0
Sr. Mental Health Worker	*Personal Services Coordinators/Case Mgrs*	9.00	9.00		$0
Sr. Mental Health Worker	*Personal Services Coordinators + 5% differential*	4.00	4.00		$0
Registered Nurse -- D/CF - L 2	*Registered Nurse*	1.00	1.00		$0
Psychiatrist	*Medication Services (contracted)*	0.57	0.57		$0
Housing Specialist	*Housing Specialist*	2.00	2.00		$0
Employment Specialist	*Employment Specialist*	2.00	2.00		$0
Office Assistant	*Receptionist*	2.00	2.00		$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	24.57	24.57		$0
C. Total Program Positions		24.57	24.57		$0

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

[1] A minimum of 20 percent of the program staff, at any one time, will be from these populations, thus ensuring that consumer and/or family members are hired at all levels within the program.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Sacramento | Fiscal Year: 2006-07

Program Workplan #: SAC4 | Date: 10/28/05

Program Workplan Name: Permanent Supportive Housing for Individuals and Families | Page ___ of ___

Type of Funding: 1. Full Service Partnership | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 125 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Jane Ann LeBlanc

Client Capacity of Program/Service Expanded through MHSA: 125 | Telephone Number: (916) 875-0188

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0	$0	$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)				$0
c. Employee Benefits				$0
d. Total Personnel Expenditures	$0	$0	$0	$0
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures				$0
e. Rent, Utilities and Equipment				
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$0	$0	$0
4. Program Management				
a. Existing Program Management				$0
b. New Program Management			$0	$0
c. Total Program Management		$0	$0	$0
5. Estimated Total Expenditures when service provider is not known				$2,808,444
6. Total Proposed Program Budget	**$0**	**$0**	**$0**	**$2,808,444**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)				
b. Medicare/Patient Fees/Patient Insurance				
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$0	$0	$0
2. New Revenues				
a. Medi-Cal (FFP only)				$527,940
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$102,060
d. Other Revenue				$0
e. Total New Revenue	$0	$0	$0	$630,000
3. Total Revenues	$0	$0	$0	$630,000
C. One-Time CSS Funding Expenditures				**$0**
D. Total Funding Requirements	**$0**	**$0**		**$2,178,444**
E. Percent of Total Funding Requirements for Full Service Partnerships				**100.0%**

EXHIBIT 5a--Mental Health Services Act Community Services and Supports

BUDGET NARRATIVE

Permanent Supportive Housing Program for Individuals and Families - #SAC4

County: Sacramento | Fiscal Year: 2006-07

A. Expenditures	
5. Estimated Total Expenditures when service provider is not known	$2,808,444
B. Revenues	
2. New Revenues	
a. Medi-Cal (FFP only)	$527,940
b. Medicare/Patient Fees/Patient Insurance	$0
c. State General Funds	$102,060
d. Other Revenue	$0
C. One-Time CSS Funding Expenditures	**$0**

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Sacramento | Fiscal Year: 2006-07

Program Workplan # SAC4 | Date: 1/23/06

Program Workplan Name Permanent Supportive Housing for Individuals and Families | Page ___ of ___

Type of Funding 1. Full Service Partnership | Months of Operation 12

Proposed Total Client Capacity of Program/Service: 125 | New Program/Service or Expansion New

Existing Client Capacity of Program/Service: 0 | Prepared by: Jane Ann LeBlanc

Client Capacity of Program/Service Expanded through MHSA: 125 | Telephone Number: (916) 875-0188

Classification	Function	Client, FM & CG FTEs[a/1]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
MH Program Coordinator	*Program Director*	1.00	1.00		$0
MH Program Coordinator	*Licensed Clinical Director*	1.00	1.00		$0
Sr. Mental Health Counselor	*Team Leaders*	2.00	2.00		$0
Sr. Mental Health Worker	*Personal Services Coordinators/Case Managers*	9.00	9.00		$0
Sr. Mental Health Worker	*Personal Services Coordinators + 5% differential*	4.00	4.00		$0
Registered Nurse -- D/CF - L 2	*Registered Nurse*	1.00	1.00		$0
Psychiatrist	*Medication Services (contracted)*	0.57	0.57		$0
Housing Specialist	*Housing Specialist*	2.00	2.00		$0
Employment Specialist	*Employment Specialist*	2.00	2.00		$0
Office Assistant	*Receptionist*	2.00	2.00		$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	24.57	24.57		$0
C. Total Program Positions		24.57	24.57		$0

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

[1]A minimum of 20 percent of the program staff, at any one time, will be from these populations, thus ensuring that consumer and/or family members are hired at all levels within the program.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Sacramento | Fiscal Year: 2007-08

Program Workplan #: SAC4 | Date: 10/28/05

Program Workplan Name: Permanent Supportive Housing for Individuals and Families | Page ___ of ___

Type of Funding: 1. Full Service Partnership | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 125 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Jane Ann LeBlanc

Client Capacity of Program/Service Expanded through MHSA: 125 | Telephone Number: (916) 875-0188

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0	$0	$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)				$0
c. Employee Benefits				$0
d. Total Personnel Expenditures	$0	$0	$0	$0
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures				$0
e. Rent, Utilities and Equipment				
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$0	$0	$0
4. Program Management				
a. Existing Program Management				$0
b. New Program Management			$0	$0
c. Total Program Management		$0	$0	$0
5. Estimated Total Expenditures when service provider is not known				$2,808,444
6. Total Proposed Program Budget	**$0**	**$0**	**$0**	**$2,808,444**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)				
b. Medicare/Patient Fees/Patient Insurance				
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$0	$0	$0
2. New Revenues				
a. Medi-Cal (FFP only)				$527,940
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$102,060
d. Other Revenue				$0
e. Total New Revenue	$0	$0	$0	$630,000
3. Total Revenues	$0	$0	$0	$630,000
C. One-Time CSS Funding Expenditures				**$0**
D. Total Funding Requirements	**$0**	**$0**		**$2,178,444**
E. Percent of Total Funding Requirements for Full Service Partnerships				**100.0%**

EXHIBIT 5a--Mental Health Services Act Community Services and Supports

BUDGET NARRATIVE

Permanent Supportive Housing Program for Individuals and Families - #SAC4

County: Sacramento | Fiscal Year: 2007-08

A. Expenditures	
5. Estimated Total Expenditures when service provider is not known	$2,808,444
B. Revenues	
2. New Revenues	
a. Medi-Cal (FFP only)	$527,940
b. Medicare/Patient Fees/Patient Insurance	$0
c. State General Funds	$102,060
d. Other Revenue	$0
C. One-Time CSS Funding Expenditures	**$0**

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Sacramento | Fiscal Year: 2007-08

Program Workplan #: SAC4 | Date: 1/23/06

Program Workplan Name: Permanent Supportive Housing for Individuals and Families | Page ___ of ___

Type of Funding: 1. Full Service Partnership | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 125 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Jane Ann LeBlanc

Client Capacity of Program/Service Expanded through MHSA: 125 | Telephone Number: (916) 875-0188

Classification	Function	Client, FM & CG FTEs[a/1]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
MH Program Coordinator	*Program Director*	1.00	1.00		$0
MH Program Coordinator	*Licensed Clinical Director*	1.00	1.00		$0
Sr. Mental Health Counselor	*Team Leaders*	2.00	2.00		$0
Sr. Mental Health Worker	*Personal Services Coordinators/Case Mgrs*	9.00	9.00		$0
Sr. Mental Health Worker	*Personal Services Coordinators + 5% differential*	4.00	4.00		$0
Registered Nurse -- D/CF - L 2	*Registered Nurse*	1.00	1.00		$0
Psychiatrist	*Medication Services (contracted)*	0.57	0.57		$0
Housing Specialist	*Housing Specialist*	2.00	2.00		$0
Employment Specialist	*Employment Specialist*	2.00	2.00		$0
Office Assistant	*Receptionist*	2.00	2.00		$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	24.57	24.57		$0
C. Total Program Positions		24.57	24.57		$0

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

[1] A minimum of 20 percent of the program staff, at any one time, will be from these populations, thus ensuring that consumer and/or family members are hired at all levels within the program.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Sacramento | Fiscal Year: 2005-06

Program Workplan #: SAC5 | Date: 1/23/06

Program Workplan Name: Transcultural Wellness Center | Page ____ of ____

Type of Funding: 1. Full Service Partnership | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 50 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: | Prepared by: Dave Goold

Client Capacity of Program/Service Expanded through MHSA: 50 | Telephone Number: 916-875-5825

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0		$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)				$0
c. Employee Benefits				$0
d. Total Personnel Expenditures	$0	$0		$0
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures				$0
e. Rent, Utilities and Equipment				$0
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$0		$0
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0		$0
5. Estimated Total Expenditures when service provider is not known				$506,433
6. Total Proposed Program Budget	**$0**	**$0**	**$0**	**$506,433**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$0	$0	$0
2. New Revenues				
a. Medi-Cal (FFP only)				$129,280
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$43,093
d. Other Revenue				$0
e. Total New Revenue	$0	$0	$0	$172,373
3. Total Revenues	$0	$0	$0	$172,373
C. One-Time CSS Funding Expenditures				**$29,172**
D. Total Funding Requirements	**$0**	**$0**		**$363,232**
E. Percent of Total Funding Requirements for Full Service Partnerships				**100.0%**

EXHIBIT 5a--Mental Health Services Act Community Services and Supports

BUDGET NARRATIVE

Transcultural Wellness Center - #SAC5

County: Sacramento Fiscal Year: 2005-06

A. Expenditures

5. Estimated Total Expenditures when service provider is not known $506,433

B. Revenues

2. New Revenues

a. Medi-Cal (FFP only) $129,280

b. Medicare/Patient Fees/Patient Insurance $0

c. State General Funds $43,093

d. Other Revenue $0

C. One-Time CSS Funding Expenditures **$29,172**

Computer equipment and office furnishings

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Sacramento | Fiscal Year: 2005-06

Program Workplan #: SAC5 | Date: 1/23/06

Program Workplan Name: Transcultural Wellness Center | Page ____ of ____

Type of Funding: 1. Full Service Partnership | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 50 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Dave Goold

Client Capacity of Program/Service Expanded through MHSA: 50 | Telephone Number: 916-875-5825

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
Program Coordinator	*Executive Director*		0.50		
Program Coordinator	*Clinical Director*		1.00		
Sr MH Counselor - Licensed	*Professional Mental Health Services*		3.00		
MH Counselors	*Licensed/Waived Prof MH Services/Outreach Coord*		3.00		
MH Workers	*Paraprofessional MH Services*	8.00	8.00		
Family/Consumer Counselors	*Peer Support and Resources Coordination*	2.00	2.00		
Secretary	*Administrative Support*		1.00		
Sr Office Assistant	*Clerical Support*	1.00	1.00		
Psychiatrist	*Adult Medication Services*		0.75		
Psychiatrist	*Child Medication Services*		0.25		
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	11.00	20.50		$0
C. Total Program Positions		11.00	20.50		$0

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Sacramento | Fiscal Year: 2006-07

Program Workplan #: SAC5 | Date: 1/23/06

Program Workplan Name: Transcultural Wellness Center | Page ____ of ____

Type of Funding: 1. Full Service Partnership | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 250 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: | Prepared by: Dave Goold

Client Capacity of Program/Service Expanded through MHSA: 250 | Telephone Number: 916-875-5825

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0		$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)				$0
c. Employee Benefits				$0
d. Total Personnel Expenditures	$0	$0		$0
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures				$0
e. Rent, Utilities and Equipment				$0
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$0		$0
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0		$0
5. Estimated Total Expenditures when service provider is not known				$2,025,732
6. Total Proposed Program Budget	**$0**	**$0**	**$0**	**$2,025,732**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$0	$0	$0
2. New Revenues				
a. Medi-Cal (FFP only)				$517,120
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$172,373
d. Other Revenue				$0
e. Total New Revenue	$0	$0	$0	$689,493
3. Total Revenues	$0	$0	$0	$689,493
C. One-Time CSS Funding Expenditures				**$0**
D. Total Funding Requirements	**$0**	**$0**	**$0**	**$1,336,239**
E. Percent of Total Funding Requirements for Full Service Partnerships				**100.0%**

EXHIBIT 5a--Mental Health Services Act Community Services and Supports

BUDGET NARRATIVE

Transcultural Wellness Center - #SAC5

County: Sacramento | Fiscal Year: 2006-07

A. Expenditures	
5. Estimated Total Expenditures when service provider is not known	$2,025,732
B. Revenues	
2. New Revenues	
a. Medi-Cal (FFP only)	$517,120
b. Medicare/Patient Fees/Patient Insurance	$0
c. State General Funds	$172,373
d. Other Revenue	$0
C. One-Time CSS Funding Expenditures	**$0**

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Sacramento | Fiscal Year: 2006-07

Program Workplan #: SAC5 | Date: 1/23/06

Program Workplan Name: Transcultural Wellness Center | Page ____ of ____

Type of Funding: 1. Full Service Partnership | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 250 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Dave Goold

Client Capacity of Program/Service Expanded through MHSA: 250 | Telephone Number: 916-875-5825

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
Program Coordinator	*Executive Director*		0.50		
Program Coordinator	*Clinical Director*		1.00		
Sr MH Counselor - Licensed	*Professional Mental Health Services*		3.00		
MH Counselors	*Licensed/Waived Prof MH Services/Outreach Coord*		3.00		
MH Workers	*Paraprofessional MH Services*	8.00	8.00		
Family/Consumer Counselors	*Peer Support and Resources Coordination*	2.00	2.00		
Secretary	*Administrative Support*		1.00		
Sr Office Assistant	*Clerical Support*	1.00	1.00		
Psychiatrist	*Adult Medication Services*		0.75		
Psychiatrist	*Child Medication Services*		0.25		
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	11.00	20.50		$0
C. Total Program Positions		11.00	20.50		$0

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Sacramento | Fiscal Year: 2007-08

Program Workplan #: SAC5 | Date: 1/23/06

Program Workplan Name: Transcultural Wellness Center | Page ____ of ____

Type of Funding: 1. Full Service Partnership | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 250 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: | Prepared by: Dave Goold

Client Capacity of Program/Service Expanded through MHSA: 250 | Telephone Number: 916-875-5825

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0		$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)				$0
c. Employee Benefits				$0
d. Total Personnel Expenditures	$0	$0		$0
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures				$0
e. Rent, Utilities and Equipment				$0
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$0		$0
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0		$0
5. Estimated Total Expenditures when service provider is not known				$2,025,732
6. Total Proposed Program Budget	**$0**	**$0**	**$0**	**$2,025,732**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$0	$0	$0
2. New Revenues				
a. Medi-Cal (FFP only)				$517,120
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$172,373
d. Other Revenue				$0
e. Total New Revenue	$0	$0		$689,493
3. Total Revenues	$0	$0		$689,493
C. One-Time CSS Funding Expenditures				**$0**
D. Total Funding Requirements	**$0**	**$0**	**$0**	**$1,336,239**
E. Percent of Total Funding Requirements for Full Service Partnerships				**100.0%**

EXHIBIT 5a--Mental Health Services Act Community Services and Supports

BUDGET NARRATIVE

Transcultural Wellness Center - #SAC5

County: Sacramento | Fiscal Year: 2007-08

A. Expenditures	
5. Estimated Total Expenditures when service provider is not known	$2,025,732
B. Revenues	
2. New Revenues	
a. Medi-Cal (FFP only)	$517,120
b. Medicare/Patient Fees/Patient Insurance	$0
c. State General Funds	$172,373
d. Other Revenue	$0
C. One-Time CSS Funding Expenditures	**$0**

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Sacramento | Fiscal Year: 2007-08

Program Workplan #: SAC5 | Date: 1/23/06

Program Workplan Name: Transcultural Wellness Center | Page ____ of ____

Type of Funding: 1. Full Service Partnership | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 250 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Dave Goold

Client Capacity of Program/Service Expanded through MHSA: 250 | Telephone Number: 916-875-5825

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
Program Coordinator	*Executive Director*		0.50		
Program Coordinator	*Clinical Director*		1.00		
Sr MH Counselor - Licensed	*Professional Mental Health Services*		3.00		
MH Counselors	*Licensed/Waived Prof MH Services/Outreach Coord*		3.00		
MH Workers	*Paraprofessional MH Services*	8.00	8.00		
Family/Consumer Counselors	*Peer Support and Resources Coordination*	2.00	2.00		
Secretary	*Administrative Support*		1.00		
Sr Office Assistant	*Clerical Support*	1.00	1.00		
Psychiatrist	*Adult Medication Services*		0.75		
Psychiatrist	*Child Medication Services*		0.25		
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	11.00	20.50		$0
C. Total Program Positions		11.00	20.50		$0

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Sacramento | Fiscal Year: 2005-06

Program Workplan #: SAC6 | Date: 12/15/05

Program Workplan Name: Wellness and Recovery Center | Page ____ of ____

Type of Funding: 2. System Development | Months of Operation: 3

Proposed Total Client Capacity of Program/Service: 50 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Dave Goold

Client Capacity of Program/Service Expanded through MHSA: 50 | Telephone Number: 916-875-5825

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0		$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)				$0
c. Employee Benefits				$0
d. Total Personnel Expenditures	$0	$0		$0
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures				$0
e. Rent, Utilities and Equipment				$0
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$0		$0
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0		$0
5. Estimated Total Expenditures when service provider is not known				$233,784
6. Total Proposed Program Budget	**$0**	**$0**	**$0**	**$233,784**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$0	$0	$0
2. New Revenues				
a. Medi-Cal (FFP only)				$36,622
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$0
d. Other Revenue				$0
e. Total New Revenue	$0	$0		$36,622
3. Total Revenues	$0	$0		$36,622
C. One-Time CSS Funding Expenditures				**$149,750**
D. Total Funding Requirements	**$0**	**$0**	**$0**	**$346,912**
E. Percent of Total Funding Requirements for Full Service Partnerships				**3.6%**

EXHIBIT 5a--Mental Health Services Act Community Services and Supports

BUDGET NARRATIVE

Wellness and Recovery Center - #SAC6

County: Sacramento Fiscal Year: 2005-06

A. Expenditures

5. Estimated Total Expenditures when service provider is not known $233,784

B. Revenues

2. New Revenues

a. Medi-Cal (FFP only) $36,622

b. Medicare/Patient Fees/Patient Insurance $0

c. State General Funds $0

d. Other Revenue $0

C. One-Time CSS Funding Expenditures **$149,750**

7-Passenger van purchase, computer equipment, facility improvements and office furnishings

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Sacramento | Fiscal Year: 2005-06

Program Workplan #: SAC6 | Date: 12/15/05

Program Workplan Name: Wellness and Recovery Center | Page ____ of ____

Type of Funding: 2. System Development | Months of Operation: 3

Proposed Total Client Capacity of Program/Service: 50 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Dave Goold

Client Capacity of Program/Service Expanded through MHSA: 50 | Telephone Number: 916-875-5825

Classification	Function	Client, FM & CG FTEs[a/1]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
Executive Director	*Administrative Chief*	1.00	1.00		
Program Coordinator	*Consumer Education and Employment Specialist*	1.00	1.00		
Peer Guides	*Opening, closing, user assistance, vol coordinator*	6.00	6.00		
Sr MHC - Licensed	*Professional Client Services/Clinical Oversight*	1.00	1.00		
Mental Health Worker	*Paraprofessional Client Services*	1.00	1.00		
Office Assistant	*Clerical Support*	1.00	1.00		
Psychiatrist (contracted)	*Medication Services (48 weeks/year)*	0.46	0.46		
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	11.46	11.46		$0
C. Total Program Positions		11.46	11.46		$0

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

[1] Since the psychiatrist position will be contracted, it is recognized that contractor may not be able to insure that the incumbent will be a client, family member, or caregiver. It is expected that contractor will make every reasonable effort to recruit a psychiatrist with this experience.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Sacramento | Fiscal Year: 2006-07

Program Workplan #: SAC6 | Date: 12/15/05

Program Workplan Name: Wellness and Recovery Center | Page ____ of ____

Type of Funding: 2. System Development | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 450 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Dave Goold

Client Capacity of Program/Service Expanded through MHSA: 450 | Telephone Number: 916-875-5825

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0		$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)				$0
c. Employee Benefits				$0
d. Total Personnel Expenditures	$0	$0		$0
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures				$0
e. Rent, Utilities and Equipment				$0
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$0		$0
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0		$0
5. Estimated Total Expenditures when service provider is not known				$935,137
6. Total Proposed Program Budget	**$0**	**$0**	**$0**	**$935,137**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$0	$0	$0
2. New Revenues				
a. Medi-Cal (FFP only)				$146,489
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$0
d. Other Revenue				$0
e. Total New Revenue	$0	$0		$146,489
3. Total Revenues	$0	$0		$146,489
C. One-Time CSS Funding Expenditures				
D. Total Funding Requirements	**$0**	**$0**	**$0**	**$788,648**
E. Percent of Total Funding Requirements for Full Service Partnerships				**3.6%**

EXHIBIT 5a--Mental Health Services Act Community Services and Supports

BUDGET NARRATIVE

Wellness and Recovery Center - #SAC6

County: Sacramento Fiscal Year: 2006-07

A. Expenditures

5. Estimated Total Expenditures when service provider is not known	$935,137

B. Revenues

2. New Revenues

a. Medi-Cal (FFP only)	$146,489
b. Medicare/Patient Fees/Patient Insurance	$0
c. State General Funds	$0
d. Other Revenue	$0

C. One-Time CSS Funding Expenditures **$0**

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Sacramento | Fiscal Year: 2006-07

Program Workplan #: SAC6 | Date: 12/15/05

Program Workplan Name: Wellness and Recovery Center | Page ____ of ____

Type of Funding: 2. System Development | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 450 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Dave Goold

Client Capacity of Program/Service Expanded through MHSA: 450 | Telephone Number: 916-875-5825

Classification	Function	Client, FM & CG FTEs[a/1]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
Executive Director	*Administrative Chief*	1.00	1.00		
Program Coordinator	*Consumer Education and Employment Specialist*	1.00	1.00		
Peer Guides	*Opening, closing, user assistance, vol coordinator*	6.00	6.00		
Sr MHC - Licensed	*Professional Client Services/Clinical Oversight*	1.00	1.00		
Mental Health Worker	*Paraprofessional Client Services*	1.00	1.00		
Office Assistant	*Clerical Support*	1.00	1.00		
Psychiatrist (contracted)	*Medication Services (48 weeks/year)*	0.46	0.46		
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	11.46	11.46		$0
C. Total Program Positions		11.46	11.46		$0

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

[1] Since the psychiatrist position will be contracted, it is recognized that contractor may not be able to insure that the incumbent will be a client, family member, or caregiver. It is expected that contractor will make every reasonable effort to recruit a psychiatrist with this experience.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Sacramento | Fiscal Year: 2007-08

Program Workplan #: SAC6 | Date: 12/15/05

Program Workplan Name: Wellness and Recovery Center | Page ____ of ____

Type of Funding: 2. System Development | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 450 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Dave Goold

Client Capacity of Program/Service Expanded through MHSA: 450 | Telephone Number: 916-875-5825

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures				
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0		$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)				$0
c. Employee Benefits				$0
d. Total Personnel Expenditures	$0	$0		$0
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services				$0
c. Travel and Transportation				$0
d. General Office Expenditures				$0
e. Rent, Utilities and Equipment				$0
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)				$0
h. Total Operating Expenditures	$0	$0		$0
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0		$0
5. Estimated Total Expenditures when service provider is not known				$935,137
6. Total Proposed Program Budget	**$0**	**$0**	**$0**	**$935,137**
B. Revenues				
1. Existing Revenues				
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$0	$0	$0
2. New Revenues				
a. Medi-Cal (FFP only)				$146,489
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$0
d. Other Revenue				$0
e. Total New Revenue	$0	$0		$146,489
3. Total Revenues	$0	$0		$146,489
C. One-Time CSS Funding Expenditures				
D. Total Funding Requirements	**$0**	**$0**	**$0**	**$788,648**
E. Percent of Total Funding Requirements for Full Service Partnerships				**0.6%**

EXHIBIT 5a--Mental Health Services Act Community Services and Supports

BUDGET NARRATIVE

Wellness and Recovery Center - #SAC6

County: Sacramento | Fiscal Year: 2007-08

A. Expenditures	
5. Estimated Total Expenditures when service provider is not known	$935,137
B. Revenues	
2. New Revenues	
a. Medi-Cal (FFP only)	$146,489
b. Medicare/Patient Fees/Patient Insurance	$0
c. State General Funds	$0
d. Other Revenue	$0
C. One-Time CSS Funding Expenditures	**$0**

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Sacramento | Fiscal Year: 2007-08

Program Workplan #: SAC6 | Date: 12/15/05

Program Workplan Name: Wellness and Recovery Center | Page ____ of ____

Type of Funding: 2. System Development | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 450 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Dave Goold

Client Capacity of Program/Service Expanded through MHSA: 450 | Telephone Number: 916-875-5825

Classification	Function	Client, FM & CG FTEs[a/1]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
Executive Director	*Administrative Chief*	1.00	1.00		
Program Coordinator	*Consumer Education and Employment Specialist*	1.00	1.00		
Peer Guides	*Opening, closing, user assistance, vol coordinator*	6.00	6.00		
Sr MHC - Licensed	*Professional Client Services/Clinical Oversight*	1.00	1.00		
Mental Health Worker	*Paraprofessional Client Services*	1.00	1.00		
Office Assistant	*Clerical Support*	1.00	1.00		
Psychiatrist (contracted)	*Medication Services (48 weeks/year)*	0.46	0.46		
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total New Additional Positions	11.46	11.46		$0
C. Total Program Positions		11.46	11.46		$0

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

[1] Since the psychiatrist position will be contracted, it is recognized that contractor may not be able to insure that the incumbent will be a client, family member, or caregiver. It is expected that contractor will make every reasonable effort to recruit a psychiatrist with this experience.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Sacramento | Fiscal Year: 2005-06

Program Workplan #: SAC7 | Date: 1/30/06

Program Workplan Name: Psychiatric Emergency Response Team | Page ____ of ____

Type of Funding: 2. System Development | Months of Operation: 3

Proposed Total Client Capacity of Program/Service: 807 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Dave Goold

Client Capacity of Program/Service Expanded through MHSA: 807 | Telephone Number: 875-5825

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures	-			
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0	$0	$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)	$105,269	$100,087		$205,356
c. Employee Benefits	$36,844	$53,045		$89,889
d. Total Personnel Expenditures	$142,113	$153,132	$0	$295,245
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services	$14,312			$14,312
c. Travel and Transportation				$0
d. General Office Expenditures	$21,051	$8,598		$29,649
e. Rent, Utilities and Equipment				$0
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)		$99,537		$99,537
h. Total Operating Expenditures	$35,363	$108,135	$0	$143,498
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0	$0	$0
5. Estimated Total Expenditures when service provider is not known				$0
6. Total Proposed Program Budget	**$177,476**	**$261,267**	**$0**	**$438,743**
B. Revenues				
1. Existing Revenues				0
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$0	$0	$0
2. New Revenues				
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$0
d. Other Revenue (Funding Provided by Law Enforcement)		$136,267		$136,267
e. Total New Revenue	$0	$136,267	$0	$136,267
3. Total Revenues	$0	$136,267	$0	$136,267
C. One-Time CSS Funding Expenditures	**$0**	**$0**		**$0**
D. Total Funding Requirements	**$177,476**	**$125,000**	**$0**	**$302,476**
E. Percent of Total Funding Requirements for Full Service Partnerships				**3.6%**

EXHIBIT 5a--Mental Health Services Act Community Services and Supports

BUDGET NARRATIVE

Psychiatric Emergency Response Teams - #SAC7

County: Sacramento Fiscal Year: 2005-06

A. Expenditures

1. Client, Family Member and Caregiver Support Expenditures

a. Clothing, Food and Hygiene

Not applicable.

b. Travel and Transportation

Not applicable.

c. Housing

i. Master Leases

Not applicable.

ii. Subsidies

Not applicable.

iii. Vouchers

Not applicable.

iv. Other Housing

Not applicable.

d. Employment and Education Supports

Not applicable.

e. Other Support Expenditures (provide description in budget narrative)

Not applicable.

2. Personnel Expenditures

a. Current Existing Personnel Expenditures (from Staffing Detail)

Not applicable.

b. New Additional Personnel Expenditures (from Staffing Detail)

Salaries include incentives.

c. Employee Benefits

MH position benefits calculated at 35% of MH salaries (law enforcement provided theirs due to differing pension plans). Includes Retirement, FICA, and Group Insurance.

3. Operating Expenditures

a. Professional Services

Not applicable.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports

BUDGET NARRATIVE

Psychiatric Emergency Response Teams - #SAC7

County: Sacramento Fiscal Year: 2005-06

b. Translation and Interpreter Services

On-call services for those languages not spoken by program employees. Program is emergency by nature and these services need to be available on short notice.

c. Travel and Transportation

Not applicable.

d. General Office Expenditures

General office expenditures funded by MHSA.

e. Rent, Utilities and Equipment

Not applicable.

f. Medication and Medical Supports

Not applicable.

g. Other Operating Expenses (provide description in budget narrative)

Operating expenses funded by law enforcement.

4. Program Management

a. Existing Program Management

Not applicable.

b. New Program Management

Not applicable.

5. Estimated Total Expenditures when service provider is not known

Not applicable.

B. Revenues

1. Existing Revenues

a. Medi-Cal (FFP only)

Not applicable.

b. Medicare/Patient Fees/Patient Insurance

Not applicable.

c. Realignment

Not applicable.

d. State General Funds

Not applicable.

e. County Funds

Not applicable.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports

BUDGET NARRATIVE

Psychiatric Emergency Response Teams - #SAC7

County: Sacramento Fiscal Year: 2005-06

f. Grants

Not applicable.

g. Other Revenue

Not applicable.

2. New Revenues

a. Medi-Cal (FFP only)

Not applicable.

b. Medicare/Patient Fees/Patient Insurance

Not applicable.

c. State General Funds

Not applicable.

d. Other Revenue

Funding provided by Law Enforcement.

C. One-Time CSS Funding Expenditures

Not applicable.

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Sacramento | Fiscal Year: 2005-06

Program Workplan #: SAC7 | Date: 1/30/06

Program Workplan Name: Psychiatric Emergency Response Team | Page ____ of ____

Type of Funding: 2. System Development | Months of Operation: 3

Proposed Total Client Capacity of Program/Service: 807 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Dave Goold

Client Capacity of Program/Service Expanded through MHSA: 807 | Telephone Number: 875-5825

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
MH Program Coordinator / Clinical Supervisor	*Administrative and Clinical Program Director*		1.00	$19,513	$19,513
Sr. MH Counselors - Licensed	*Licensed/Waived Professional Service Providers*		4.00	$14,658	$58,632
Sr. Office Assistant	*Clerical Support - MH*		1.00	$8,968	$8,968
Mental Health Worker	*Consumer and Family Education/Patients Rights*	2.00	2.00	$9,078	$18,156
Law Enforcement Officers (Deputy Sheriffs)	*Team Law Enforcement Staffing (Includes OT)*		2.00	$21,201	$42,402
Law Enforcement Officers (Police Officers)	*Team Law Enforcement Staffing (Includes OT)*		2.00	$16,839	$33,678
PERT Law Enforcement Supervisor (Sheriff Sergeant)	*Team Law Enforcement Supervision and Staffing*		1.00	$24,007	$24,007
					$0
					$0
					$0
					$0
	Total New Additional Positions	2.00	13.00		$205,356
C. Total Program Positions		2.00	13.00		$205,356

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Sacramento | Fiscal Year: 2006-07

Program Workplan #: SAC7 | Date: 1/30/06

Program Workplan Name: Psychiatric Emergency Response Team | Page ____ of ____

Type of Funding: 2. System Development | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 3,228 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Dave Goold

Client Capacity of Program/Service Expanded through MHSA: 3,228 | Telephone Number: 875-5825

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures	-			
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0	$0	$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)	$421,069	$400,343		$821,412
c. Employee Benefits	$147,374	$212,181		$359,555
d. Total Personnel Expenditures	$568,443	$612,524	$0	$1,180,967
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services	$57,246			$57,246
c. Travel and Transportation				$0
d. General Office Expenditures	$84,214	$34,397		$118,611
e. Rent, Utilities and Equipment				$0
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)		$398,146		$398,146
h. Total Operating Expenditures	$141,460	$432,543	$0	$574,003
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0	$0	$0
5. Estimated Total Expenditures when service provider is not known				$0
6. Total Proposed Program Budget	**$709,903**	**$1,045,067**	**$0**	**$1,754,970**
B. Revenues				
1. Existing Revenues				0
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$0	$0	$0
2. New Revenues				
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$0
d. Other Revenue (Funding Provided by Law Enforcement)		$545,067		$545,067
e. Total New Revenue	$0	$545,067	$0	$545,067
3. Total Revenues	$0	$545,067	$0	$545,067
C. One-Time CSS Funding Expenditures	**$0**	**$0**		**$0**
D. Total Funding Requirements	**$709,903**	**$500,000**	**$0**	**$1,209,903**
E. Percent of Total Funding Requirements for Full Service Partnerships				**3.6%**

EXHIBIT 5a--Mental Health Services Act Community Services and Supports

BUDGET NARRATIVE

Psychiatric Emergency Response Teams - #SAC7

County: Sacramento Fiscal Year: 2006-07

A. Expenditures

1. Client, Family Member and Caregiver Support Expenditures

a. Clothing, Food and Hygiene

Not applicable.

b. Travel and Transportation

Not applicable.

c. Housing

i. Master Leases

Not applicable.

ii. Subsidies

Not applicable.

iii. Vouchers

Not applicable.

iv. Other Housing

Not applicable.

d. Employment and Education Supports

Not applicable.

e. Other Support Expenditures (provide description in budget narrative)

Not applicable.

2. Personnel Expenditures

a. Current Existing Personnel Expenditures (from Staffing Detail)

Not applicable.

b. New Additional Personnel Expenditures (from Staffing Detail)

Salaries include incentives

c. Employee Benefits

MH position benefits calculated at 35% of MH salaries (law enforcement provided theirs due to differing pension plans). Includes Retirement, FICA, and Group Insurance.

3. Operating Expenditures

a. Professional Services

Not applicable.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports

BUDGET NARRATIVE

Psychiatric Emergency Response Teams - #SAC7

County: Sacramento Fiscal Year: 2006-07

b. Translation and Interpreter Services

On-call services for those languages not spoken by program employees. Program is emergency by nature and these services need to be available on short notice.

c. Travel and Transportation

Not applicable.

d. General Office Expenditures

General office expenditures funded by MHSA.

e. Rent, Utilities and Equipment

Not applicable.

f. Medication and Medical Supports

Not applicable.

g. Other Operating Expenses (provide description in budget narrative)

Operating expenses funded by law enforcement.

4. Program Management

a. Existing Program Management

Not applicable.

b. New Program Management

Not applicable.

5. Estimated Total Expenditures when service provider is not known

Not applicable.

B. Revenues

1. Existing Revenues

a. Medi-Cal (FFP only)

Not applicable.

b. Medicare/Patient Fees/Patient Insurance

Not applicable.

c. Realignment

Not applicable.

d. State General Funds

Not applicable.

e. County Funds

Not applicable.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports

BUDGET NARRATIVE

Psychiatric Emergency Response Teams - #SAC7

County: Sacramento Fiscal Year: 2006-07

f. Grants

Not applicable.

g. Other Revenue

Not applicable.

2. New Revenues

a. Medi-Cal (FFP only)

Not applicable.

b. Medicare/Patient Fees/Patient Insurance

Not applicable.

c. State General Funds

Not applicable.

d. Other Revenue

Funding provided by Law Enforcement.

C. One-Time CSS Funding Expenditures

Not applicable.

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Sacramento | Fiscal Year: 2006-07

Program Workplan # SAC7 | Date: 1/30/06

Program Workplan Name Psychiatric Emergency Response Team | Page ____ of ____

Type of Funding 2. System Development | Months of Operation 12

Proposed Total Client Capacity of Program/Service: 3,228 | New Program/Service or Expansion New

Existing Client Capacity of Program/Service: 0 | Prepared by: Dave Goold

Client Capacity of Program/Service Expanded through MHSA: 3,228 | Telephone Number: 875-5825

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
MH Program Coordinator / Clinical Supervisor	*Administrative and Clinical Program Director*		1.00	$78,053	$78,053
Sr. MH Counselors - Licensed	*Licensed/Waived Professional Service Providers*		4.00	$58,631	$234,524
Sr. Office Assistant	*Clerical Support - MH*		1.00	$35,872	$35,872
Mental Health Worker	*Consumer and Family Education/Patients Rights*	2.00	2.00	$36,310	$72,620
Law Enforcement Officers (Deputy Sheriffs)	*Team Law Enforcement Staffing (Includes OT)*		2.00	$84,802	$169,604
Law Enforcement Officers (Police Officers)	*Team Law Enforcement Staffing (Includes OT)*		2.00	$67,356	$134,712
PERT Law Enforcement Supervisor (Sheriff Sergeant)	*Team Law Enforcement Supervision and Staffing*		1.00	$96,027	$96,027
					$0
					$0
					$0
					$0
	Total New Additional Positions	2.00	13.00		$821,412
C. Total Program Positions		2.00	13.00		$821,412

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports Budget Worksheet

County(ies): Sacramento | Fiscal Year: 2007-08

Program Workplan #: SAC7 | Date: 1/30/06

Program Workplan Name: Psychiatric Emergency Response Team | Page ____ of ____

Type of Funding: 2. System Development | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 3,228 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Dave Goold

Client Capacity of Program/Service Expanded through MHSA: 3,228 | Telephone Number: 875-5825

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Client, Family Member and Caregiver Support Expenditures	-			
a. Clothing, Food and Hygiene				$0
b. Travel and Transportation				$0
c. Housing				
i. Master Leases				$0
ii. Subsidies				$0
iii. Vouchers				$0
iv. Other Housing				$0
d. Employment and Education Supports				$0
e. Other Support Expenditures (provide description in budget narrative)				$0
f. Total Support Expenditures	$0	$0	$0	$0
2. Personnel Expenditures				
a. Current Existing Personnel Expenditures (from Staffing Detail)				$0
b. New Additional Personnel Expenditures (from Staffing Detail)	$421,069	$400,343		$821,412
c. Employee Benefits	$147,374	$212,181		$359,555
d. Total Personnel Expenditures	$568,443	$612,524	$0	$1,180,967
3. Operating Expenditures				
a. Professional Services				$0
b. Translation and Interpreter Services	$57,246			$57,246
c. Travel and Transportation				$0
d. General Office Expenditures	$84,214	$34,397		$118,611
e. Rent, Utilities and Equipment				$0
f. Medication and Medical Supports				$0
g. Other Operating Expenses (provide description in budget narrative)		$398,146		$398,146
h. Total Operating Expenditures	$141,460	$432,543	$0	$574,003
4. Program Management				
a. Existing Program Management				$0
b. New Program Management				$0
c. Total Program Management		$0	$0	$0
5. Estimated Total Expenditures when service provider is not known				$0
6. Total Proposed Program Budget	**$709,903**	**$1,045,067**	**$0**	**$1,754,970**
B. Revenues				
1. Existing Revenues				0
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. Realignment				$0
d. State General Funds				$0
e. County Funds				$0
f. Grants				
g. Other Revenue				$0
h. Total Existing Revenues	$0	$0	$0	$0
2. New Revenues				
a. Medi-Cal (FFP only)				$0
b. Medicare/Patient Fees/Patient Insurance				$0
c. State General Funds				$0
d. Other Revenue (Funding Provided by Law Enforcement)		$545,067		$545,067
e. Total New Revenue	$0	$545,067	$0	$545,067
3. Total Revenues	$0	$545,067	$0	$545,067
C. One-Time CSS Funding Expenditures	**$0**	**$0**		**$0**
D. Total Funding Requirements	**$709,903**	**$500,000**	**$0**	**$1,209,903**
E. Percent of Total Funding Requirements for Full Service Partnerships				**0.6%**

EXHIBIT 5a--Mental Health Services Act Community Services and Supports

BUDGET NARRATIVE

Psychiatric Emergency Response Teams - #SAC7

County: Sacramento Fiscal Year: 2007-08

A. Expenditures

1. Client, Family Member and Caregiver Support Expenditures

a. Clothing, Food and Hygiene

Not applicable.

b. Travel and Transportation

Not applicable.

c. Housing

i. Master Leases

Not applicable.

ii. Subsidies

Not applicable.

iii. Vouchers

Not applicable.

iv. Other Housing

Not applicable.

d. Employment and Education Supports

Not applicable.

e. Other Support Expenditures (provide description in budget narrative)

Not applicable.

2. Personnel Expenditures

a. Current Existing Personnel Expenditures (from Staffing Detail)

Not applicable.

b. New Additional Personnel Expenditures (from Staffing Detail)

Salaries include incentives

c. Employee Benefits

MH position benefits calculated at 35% of MH salaries (law enforcement provided theirs due to differing pension plans). Includes Retirement, FICA, and Group Insurance.

3. Operating Expenditures

a. Professional Services

Not applicable.

EXHIBIT 5a--Mental Health Services Act Community Services and Supports

BUDGET NARRATIVE

Psychiatric Emergency Response Teams - #SAC7

County: Sacramento Fiscal Year: 2007-08

b. Translation and Interpreter Services

On-call services for those languages not spoken by program employees. Program is emergency by nature and these services need to be available on short notice.

c. Travel and Transportation

Not applicable.

d. General Office Expenditures

General office expenditures funded by MHSA.

e. Rent, Utilities and Equipment

Not applicable.

f. Medication and Medical Supports

Not applicable.

g. Other Operating Expenses (provide description in budget narrative)

Operating expenses funded by law enforcement.

4. Program Management

a. Existing Program Management

Not applicable.

b. New Program Management

Not applicable.

5. Estimated Total Expenditures when service provider is not known

Not applicable.

B. Revenues

1. Existing Revenues

a. Medi-Cal (FFP only)

Not applicable.

b. Medicare/Patient Fees/Patient Insurance

Not applicable.

c. Realignment

Not applicable.

d. State General Funds

Not applicable.

e. County Funds

Not applicable.

f. Grants

Not applicable.

g. Other Revenue

Not applicable.

2. New Revenues

a. Medi-Cal (FFP only)

Not applicable.

b. Medicare/Patient Fees/Patient Insurance

Not applicable.

c. State General Funds

Not applicable.

d. Other Revenue

Funding provided by Law Enforcement.

C. One-Time CSS Funding Expenditures

Not applicable.

EXHIBIT 5 b--Mental Health Services Act Community Services and Supports Staffing Detail Worksheet

County(ies): Sacramento | Fiscal Year: 2007-08

Program Workplan #: SAC7 | Date: 1/30/06

Program Workplan Name: Psychiatric Emergency Response Team | Page ____ of ____

Type of Funding: 2. System Development | Months of Operation: 12

Proposed Total Client Capacity of Program/Service: 3,228 | New Program/Service or Expansion: New

Existing Client Capacity of Program/Service: 0 | Prepared by: Dave Goold

Client Capacity of Program/Service Expanded through MHSA: 3,228 | Telephone Number: 875-5825

Classification	Function	Client, FM & CG FTEs[a/]	Total Number of FTEs	Salary, Wages and Overtime per FTE[b/]	Total Salaries. Wages and Overtime
A. Current Existing Positions					
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
					$0
	Total Current Existing Positions	0.00	0.00		$0
B. New Additional Positions					
MH Program Coordinator / Clinical Supervisor	*Administrative and Clinical Program Director*		1.00	$78,053	$78,053
Sr. MH Counselors - Licensed	*Licensed/Waived Professional Service Providers*		4.00	$58,631	$234,524
Sr. Office Assistant	*Clerical Support - MH*		1.00	$35,872	$35,872
Mental Health Worker	*Consumer and Family Education/Patients Rights*	2.00	2.00	$36,310	$72,620
Law Enforcement Officers (Deputy Sheriffs)	*Team Law Enforcement Staffing (Includes OT)*		2.00	$84,802	$169,604
Law Enforcement Officers (Police Officers)	*Team Law Enforcement Staffing (Includes OT)*		2.00	$67,356	$134,712
PERT Law Enforcement Supervisor (Sheriff Sergeant)	*Team Law Enforcement Supervision and Staffing*		1.00	$96,027	$96,027
					$0
					$0
					$0
					$0
	Total New Additional Positions	2.00	13.00		$821,412
C. Total Program Positions		2.00	13.00		$821,412

a/ Enter the number of FTE positions that will be staffed with clients, family members or caregivers.
b/ Include any bi-lingual pay supplements (if applicable). Round each amount to the nearest whole dollar.

EXHIBIT 5c--Mental Health Services Act Community Services and Supports Administration Budget Worksheet

County(ies): Sacramento Fiscal Year: 2005-06

Date: 10/28/05

	Client, Family Member and Caregiver FTEs	Total FTEs	Budgeted Expenditures
A. Expenditures			
1. Personnel Expenditures			
a. MHSA Coordinator(s)		1.00	$86,836
b. MHSA Support Staff		15.00	$769,653
c. Other Personnel (list below)			
i.			
ii.			
iii.			
iv.			
v.			
vi.			
vii.			
d. Total FTEs/Salaries	0.00	16.00	$856,489
e. Employee Benefits			$336,771
f. Total Personnel Expenditures			$1,193,260
2. Operating Expenditures			
a. Professional Services			
b. Travel and Transportation			$48,000
c. General Office Expenditures			$22,923
d. Rent, Utilities and Equipment			$58,144
e. Other Operating Expenses (provide description in budget narrative)			
f. Total Operating Expenditures			$129,067
3. County Allocated Administration			
a. Countywide Administration (A-87)			$128,473
b. Other Administration (provide description in budget narrative)			
c. Total County Allocated Administration			$128,473
4. Total Proposed County Administration Budget			**$1,450,800**
B. Revenues			
1. New Revenues			
a. Medi-Cal (FFP only)			
b. Other Revenue			
2. Total Revenues			**$0**
C. Start-up and One-Time Implementation Expenditures			
D. Total County Administration Funding Requirements			**$1,450,800**

COUNTY CERTIFICATION

I HEREBY CERTIFY under penalty of perjury that I am the official responsible for the administration of Community Mental Health Services in and for said County; that I have not violated any of the provisions of Section 5891 of the Welfare and Institution Code in that all identified funding requirements (in all related program budgets and this administration budget) represent costs related to the expansion of mental health services since passage of the MHSA and do not represent supplanting of expenditures; that fiscal year 2004-05 funds required to be incurred on mental health services will be used in providing such services; and that to the best of my knowledge and belief this administration budget and all related program budgets in all respects are true, correct, and in accordance with the law.

Date: 1-26-06 Signature Kathleen Henry

Local Mental Health Director

Executed at Sacramento, California

EXHIBIT 5c--Mental Health Services Act Community Services and Supports

ADMINISTRATION BUDGET NARRATIVE

County: Sacramento Fiscal Year: 2005-06

A. Expenditures

1. Personnel Expenditures

a. MHSA Coordinator(s)

1.0 FTE Mental Health Program Manager

b. MHSA Support Staff

5.0 FTE Program Coordinator

1.0 FTE Secretary

2.0 FTE Senior Office Assistant

1.0 FTE Sr. Mental Health Counselor

1.0 FTE Human Services Program Planner B

2.0 FTE Human Services Program Planner A

1.0 FTE Administrative Services Officer II

2.0 FTE Administrative Services Officer I

c. Other Personnel (list below)

i. n/a

d. Total FTEs/Salaries

16.0 FTE Total

e. Total Personnel Expenditures

2. Operating Expenditures

a. Professional Services

b. Travel and Transportation

Mileage calculated at 48.5 cents/mile.

c. General Office Expenditures

General office expenditures

d. Rent, Utilities and Equipment

Allocated costs per FTE

e. Other Operating Expenses (provide description in budget narrative)

f. Total Operating Expenditures

EXHIBIT 5c--Mental Health Services Act Community Services and Supports

ADMINISTRATION BUDGET NARRATIVE

County: Sacramento Fiscal Year: 2005-06

3. County Allocated Administration

a. Countywide Administration (A-87)
Calculated at 15% of salaries

b. Other Administration (provide description in budget narrative)

c. Total County Allocated Administration

4. Total Proposed County Administration Budget

B. Revenues

1. New Revenues

a. Medi-Cal (FFP only)

b. Other Revenue

2. Total Revenues

C. Start-up and One-Time Implementation Expenditures

Submitted separately

D. Total County Administration Funding Requirements

EXHIBIT 5c--Mental Health Services Act Community Services and Supports Administration Budget Worksheet

County(ies): Sacramento | Fiscal Year: 2006-07

Date: 10/28/05

	Client, Family Member and Caregiver FTEs	Total FTEs	Budgeted Expenditures
A. Expenditures			
1. Personnel Expenditures			
a. MHSA Coordinator(s)		1.00	$86,836
b. MHSA Support Staff		15.00	$769,653
c. Other Personnel (list below)			
i.			
ii.			
iii.			
iv.			
v.			
vi.			
vii.			
d. Total FTEs/Salaries	0.00	16.00	$856,489
e. Employee Benefits			$336,771
f. Total Personnel Expenditures			$1,193,260
2. Operating Expenditures			
a. Professional Services			
b. Travel and Transportation			$48,000
c. General Office Expenditures			$22,923
d. Rent, Utilities and Equipment			$58,144
e. Other Operating Expenses (provide description in budget narrative)			
f. Total Operating Expenditures			$129,067
3. County Allocated Administration			
a. Countywide Administration (A-87)			$128,473
b. Other Administration (provide description in budget narrative)			
c. Total County Allocated Administration			$128,473
4. Total Proposed County Administration Budget			**$1,450,800**
B. Revenues			
1. New Revenues			
a. Medi-Cal (FFP only)			
b. Other Revenue			
2. Total Revenues			**$0**
C. Start-up and One-Time Implementation Expenditures			
D. Total County Administration Funding Requirements			**$1,450,800**

COUNTY CERTIFICATION

I HEREBY CERTIFY under penalty of perjury that I am the official responsible for the administration of Community Mental Health Services in and for said County; that I have not violated any of the provisions of Section 5891 of the Welfare and Institution Code in that all identified funding requirements (in all related program budgets and this administration budget) represent costs related to the expansion of mental health services since passage of the MHSA and do not represent supplanting of expenditures; that fiscal year 2004-05 funds required to be incurred on mental health services will be used in providing such services; and that to the best of my knowledge and belief this administration budget and all related program budgets in all respects are true, correct, and in accordance with the law.

Date: 1-26-06 Signature: Kathleen Henry

Local Mental Health Director

Executed at Sacramento, California

EXHIBIT 5c--Mental Health Services Act Community Services and Supports

ADMINISTRATION BUDGET NARRATIVE

County: Sacramento Fiscal Year: 2006-07

A. Expenditures

1. Personnel Expenditures

a. MHSA Coordinator(s)

1.0 FTE Mental Health Program Manager

b. MHSA Support Staff

5.0 FTE Program Coordinator

1.0 FTE Secretary

2.0 FTE Senior Office Assistant

1.0 FTE Sr. Mental Health Counselor

1.0 FTE Human Services Program Planner B

2.0 FTE Human Services Program Planner A

1.0 FTE Administrative Services Officer II

2.0 FTE Administrative Services Officer I

c. Other Personnel (list below)

i. n/a

d. Total FTEs/Salaries

16.0 FTE Total

e. Total Personnel Expenditures

2. Operating Expenditures

a. Professional Services

b. Travel and Transportation

Mileage calculated at 48.5 cents/mile.

c. General Office Expenditures

General office expenditures

d. Rent, Utilities and Equipment

Allocated costs per FTE

e. Other Operating Expenses (provide description in budget narrative)

f. Total Operating Expenditures

EXHIBIT 5c--Mental Health Services Act Community Services and Supports

ADMINISTRATION BUDGET NARRATIVE

County: Sacramento Fiscal Year: 2006-07

3. County Allocated Administration

a. Countywide Administration (A-87)
Calculated at 15% of salaries

b. Other Administration (provide description in budget narrative)

c. Total County Allocated Administration

4. Total Proposed County Administration Budget

B. Revenues

1. New Revenues

a. Medi-Cal (FFP only)

b. Other Revenue

2. Total Revenues

C. Start-up and One-Time Implementation Expenditures

Submitted separately

D. Total County Administration Funding Requirements

EXHIBIT 5c--Mental Health Services Act Community Services and Supports Administration Budget Worksheet

County(ies): Sacramento Fiscal Year: 2007-08

Date: 10/28/05

	Client, Family Member and Caregiver FTEs	Total FTEs	Budgeted Expenditures
A. Expenditures			
1. Personnel Expenditures			
a. MHSA Coordinator(s)		1.00	$86,836
b. MHSA Support Staff		15.00	$769,653
c. Other Personnel (list below)			
i.			
ii.			
iii.			
iv.			
v.			
vi.			
vii.			
d. Total FTEs/Salaries	0.00	16.00	$856,489
e. Employee Benefits			$336,771
f. Total Personnel Expenditures			$1,193,260
2. Operating Expenditures			
a. Professional Services			
b. Travel and Transportation			$48,000
c. General Office Expenditures			$22,923
d. Rent, Utilities and Equipment			$58,144
e. Other Operating Expenses (provide description in budget narrative)			
f. Total Operating Expenditures			$129,067
3. County Allocated Administration			
a. Countywide Administration (A-87)			$128,473
b. Other Administration (provide description in budget narrative)			
c. Total County Allocated Administration			$128,473
4. Total Proposed County Administration Budget			**$1,450,800**
B. Revenues			
1. New Revenues			
a. Medi-Cal (FFP only)			
b. Other Revenue			
2. Total Revenues			**$0**
C. Start-up and One-Time Implementation Expenditures			
D. Total County Administration Funding Requirements			**$1,450,800**

COUNTY CERTIFICATION

I HEREBY CERTIFY under penalty of perjury that I am the official responsible for the administration of Community Mental Health Services in and for said County; that I have not violated any of the provisions of Section 5891 of the Welfare and Institution Code in that all identified funding requirements (in all related program budgets and this administration budget) represent costs related to the expansion of mental health services since passage of the MHSA and do not represent supplanting of expenditures; that fiscal year 2004-05 funds required to be incurred on mental health services will be used in providing such services; and that to the best of my knowledge and belief this administration budget and all related program budgets in all respects are true, correct, and in accordance with the law.

Date: 1-26-06 Signature Kathleen Henry

Local Mental Health Director

Executed at Sacramento, California

EXHIBIT 5c--Mental Health Services Act Community Services and Supports

ADMINISTRATION BUDGET NARRATIVE

County: Sacramento Fiscal Year: 2007-08

A. Expenditures

1. Personnel Expenditures

a. MHSA Coordinator(s)

1.0 FTE Mental Health Program Manager

b. MHSA Support Staff

5.0 FTE Program Coordinator

1.0 FTE Secretary

2.0 FTE Senior Office Assistant

1.0 FTE Sr. Mental Health Counselor

1.0 FTE Human Services Program Planner B

2.0 FTE Human Services Program Planner A

1.0 FTE Administrative Services Officer II

2.0 FTE Administrative Services Officer I

c. Other Personnel (list below)

i. n/a

d. Total FTEs/Salaries

16.0 FTE Total

e. Total Personnel Expenditures

2. Operating Expenditures

a. Professional Services

b. Travel and Transportation

Mileage calculated at 48.5 cents/mile.

c. General Office Expenditures

General office expenditures

d. Rent, Utilities and Equipment

Allocated costs per FTE

e. Other Operating Expenses (provide description in budget narrative)

f. Total Operating Expenditures

EXHIBIT 5c--Mental Health Services Act Community Services and Supports

ADMINISTRATION BUDGET NARRATIVE

County: Sacramento Fiscal Year: 2007-08

3. County Allocated Administration

a. Countywide Administration (A-87)
Calculated at 15% of salaries

b. Other Administration (provide description in budget narrative)

c. Total County Allocated Administration

4. Total Proposed County Administration Budget

B. Revenues

1. New Revenues

a. Medi-Cal (FFP only)

b. Other Revenue

2. Total Revenues

C. Start-up and One-Time Implementation Expenditures

Submitted separately

D. Total County Administration Funding Requirements

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT
Estimated/Actual Population Served

County: **Sacramento**
Program Work Plan #: **SAC1**
Program Work Plan Name: **Transitional Community Opportunities for Recovery and Engagement (CORE)**
Fiscal Year: **2005-06** *(please complete one per fiscal year)*

Full Service Partnerships		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth											
Transition Age Youth											
Adults											
Older Adults											
System Development		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
	1) Multidisciplinary teams 2) Mobile crisis and transitional stabilization services 3) Integrated service teams and planning with social service agencies and other community providers 4) Self-directed care							50		50*	

	plans 5) Collaborative services with primary care health clinics and health care services 6) Peer supportive services 7) Vocational Services 8) Transportation 9) Family/collateral education, training, support and counseling 10) Culturally appropriate services 11) Trauma-informed and trauma-specific services															
Outreach and Engagement		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**						
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**					
	1) Outreach and engagement and mobile crisis and transitional stabilization services 2) Peer supportive services 3) Family/collateral															

	education, training, support and counseling 4) Culturally appropriate services							

*It is expected that full static capacity (caseload of 250) will be reached in FY06-07. The figures presented here were not adjusted for attrition or turnover.

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT
Estimated/Actual Population Served

County: **Sacramento**
Program Work Plan #: **SAC1**
Program Work Plan Name: **Transitional Community Opportunities for Recovery and Engagement (CORE)**
Fiscal Year: **2006-07** *(please complete one per fiscal year)*

Full Service Partnerships		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth											
Transition Age Youth											
Adults											
Older Adults											
System Development		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
	1) Multidisciplinary teams 2) Mobile crisis and transitional stabilization services 3) Integrated service teams and planning with social service agencies and other community providers 4) Self-directed care	100		150		200		250		250*	

	plans 5) Collaborative services with primary care health clinics and health care services 6) Peer supportive services 7) Vocational Services 8) Transportation 9) Family/collateral education, training, support and counseling 10) Culturally appropriate services 11) Trauma-informed and trauma-specific services																			
Outreach and Engagement		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**										
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**									
	1) Outreach and engagement and mobile crisis and transitional stabilization services 2) Peer supportive services 3) Family/collateral																			

	education, training, support and counseling 4) Culturally appropriate services										

*This program has the capacity to serve 250 clients at any point in time. The figures presented here were not adjusted for attrition or turnover.

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT
Estimated/Actual Population Served

County: **Sacramento**
Program Work Plan #: **SAC1**
Program Work Plan Name: **Transitional Community Opportunities for Recovery and Engagement (CORE)**
Fiscal Year: **2007-08** *(please complete one per fiscal year)*

Full Service Partnerships		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth											
Transition Age Youth											
Adults											
Older Adults											
System Development		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
	1) Multidisciplinary teams 2) Mobile crisis and transitional stabilization services 3) Integrated service teams and planning with social service agencies and other community providers 4) Self-directed care	250		250		250		250		250*	

	plans 5) Collaborative services with primary care health clinics and health care services 6) Peer supportive services 7) Vocational Services 8) Transportation 9) Family/collateral education, training, support and counseling 10) Culturally appropriate services 11) Trauma-informed and trauma-specific services															
Outreach and Engagement		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**						
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**					
	1) Outreach and engagement and mobile crisis and transitional stabilization services 2) Peer supportive services 3) Family/collateral															

	education, training, support and counseling 4) Culturally appropriate services										

*This program has the capacity to serve 250 clients at any point in time. The figures presented here were not adjusted for attrition or turnover.

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT
Estimated/Actual Population Served

County: **Sacramento**
Program Work Plan #: **SAC2**
Program Work Plan Name: **Older Adult Intensive Services**
Fiscal Year: **2005-06** *(please complete one per fiscal year)*

Full Service Partnerships		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth	N/A										
Transition Age Youth	N/A										
Adults	Transition age older adults (age 55-59) with SMI will be eligible for this program if they have complex co-occurring mental health, medical, substance abuse and social service needs similar to those described below for older adults.							1		1*	
Older Adults	Older adults age 60+ with SMI and multiple co-occurring mental health, physical health, substance abuse, and social service needs who are at-risk for emergency room utilization, hospitalization,							14		14*	

	institutionalization, and homelessness.										
System Development		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Outreach and Engagement		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
	1) Outreach and engagement services, as well as ,collaborative services with primary care health clinics and health care services to reduce barriers to access and increase integration of physical health care and mental health services; linkage of these clients to the full range of services; Education for and coordination with primary care providers to in-crease coordination and integration of mental health and primary care services. 2) Peer supportive services including peer counseling programs to provide culturally-based support and to increase										

	client/member knowledge and ability to use needed mental health services. 3) Joint service planning with special services for seniors as needed: senior centers, senior legal aid, adult day health care/adult day care, caregiver resource centers, respite care, multi-service senior programs, senior volunteer programs, grief/loss support groups, community self-help groups, senior nutrition programs, faith-based providers, churches, temples, and any other community resource serving older adults with mental illness and their family/caregivers, organizations and settings that reach ethnically and culturally diverse older adults. 4) Education for the client and family or other caregivers as appropriate regarding the nature of medications, the

	expected benefits and the potential side effects. 5) Culturally appropriate services to reach persons of racial ethnic cultures who may be better served and/or more responsive to services in specific culture-based settings.						

*This program is expected to reach capacity in FY06/07. The figures presented here were not adjusted for attrition or turnover.

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT
Estimated/Actual Population Served

County: **Sacramento**
Program Work Plan #: **SAC2**
Program Work Plan Name: **Older Adult Intensive Services**
Fiscal Year: **2006-07** *(please complete one per fiscal year)*

Full Service Partnerships		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth	N/A										
Transition Age Youth	N/A										
Adults	Transition age older adults (age 55-59) with SMI will be eligible for this program if they have complex co-occurring mental health, medical, substance abuse and social service needs similar to those described below for older adults.	3		3		3		3		3*	
Older Adults	Older adults age 60+ with SMI and multiple co-occurring mental health, physical health, substance abuse, and social service needs who are at-risk for emergency room utilization, hospitalization,	97		97		97		97		97*	

	institutionalization, and homelessness.										
System Development		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Outreach and Engagement		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
	1) Outreach and engagement services, as well as , collaborative services with primary care health clinics and health care services to reduce barriers to access and increase integration of physical health care and mental health services; linkage of these clients to the full range of services; Education for and coordination with primary care providers to in-crease coordination and integration of mental health and primary care services. 2) Peer supportive services including peer counseling programs to provide culturally-based support and to increase										

	client/member knowledge and ability to use needed mental health services. 3) Joint service planning with special services for seniors as needed: senior centers, senior legal aid, adult day health care/adult day care, caregiver resource centers, respite care, multi-service senior programs, senior volunteer programs, grief/loss support groups, community self-help groups, senior nutrition programs, faith-based providers, churches, temples, and any other community resource serving older adults with mental illness and their family/caregivers, organizations and settings that reach ethnically and culturally diverse older adults. 4) Education for the client and family or other caregivers as appropriate regarding the nature of medications, the

	expected benefits and the potential side effects. 5) Culturally appropriate services to reach persons of racial ethnic cultures who may be better served and/or more responsive to services in specific culture-based settings.						

*This program has the capacity to serve 100 clients at any point in time. The figures presented here were not adjusted for attrition or turnover.

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT
Estimated/Actual Population Served

County: **Sacramento**
Program Work Plan #: **SAC2**
Program Work Plan Name: **Older Adult Intensive Services**
Fiscal Year: **2007-08** *(please complete one per fiscal year)*

Full Service Partnerships		Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth	N/A										
Transition Age Youth	N/A										
Adults	Transition age older adults (age 55-59) with SMI will be eligible for this program if they have complex co-occurring mental health, medical, substance abuse and social service needs similar to those described below for older adults.	3		3		3		3		3*	
Older Adults	Older adults age 60+ with SMI and multiple co-occurring mental health, physical health, substance abuse, and social service needs who are at-risk for emergency room utilization, hospitalization,	97		97		97		97		97*	

	institutionalization, and homelessness.										
System Development		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Outreach and Engagement		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
	1) Outreach and engagement services, as well as , collaborative services with primary care health clinics and health care ser-vices to reduce barriers to access and increase integration of physical health care and mental health services; linkage of these clients to the full range of services; Education for and coordination with primary care providers to in-crease coordination and integration of mental health and primary care services. 2) Peer supportive services including peer counseling programs to provide culturally-based support and to increase										

	client/member knowledge and ability to use needed mental health services. 3) Joint service planning with special services for seniors as needed: senior centers, senior legal aid, adult day health care/adult day care, caregiver resource centers, respite care, multi-service senior programs, senior volunteer programs, grief/loss support groups, community self-help groups, senior nutrition programs, faith-based providers, churches, temples, and any other community resource serving older adults with mental illness and their family/caregivers, organizations and settings that reach ethnically and culturally diverse older adults. 4) Education for the client and family or other caregivers as appropriate regarding the nature of medications, the

	expected benefits and the potential side effects. 5) Culturally appropriate services to reach persons of racial ethnic cultures who may be better served and/or more responsive to services in specific culture-based settings.										

*This program has the capacity to serve 100 clients at any point in time. The figures presented here were not adjusted for attrition or turnover.

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT
Estimated/Actual Population Served

County: **Sacramento**
Program Work Plan #: **SAC4**
Program Work Plan Name: **Permanent Supportive Housing Program for Individuals and Families**
Fiscal Year: **2005-06** *(please complete one per fiscal year)*

Full Service Partnerships		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth	Homeless in households where caregivers have SMI and homeless children w/ SED							8		8*	
Transition Age Youth	Homeless w/ SMI							8		8*	
Adults	Homeless w/ SMI							14		14*	
Older Adults	Homeless w/ SMI							1		1*	

System Development		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

Outreach and Engagement		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
	1) Family Partnership										

	Programs that include outreach and engagement strategies to engage racially and ethnically diverse families and include services and activities such as training, information and referral, support groups, and direct services 2) Child/youth peer mentoring 3) Cultural and gender-sensitive outreach and services 4) Education for children/youth and family regarding mental health diagnosis and assessment, medications, services and supports planning, treatment modalities and other information related to children/youth's mental health

	services and needs 5) Services in collaboration with faith-based communities; linkage for families to the full range of community services and supports 6) Parental mental health education, with language access and culturally appropriate approaches 7) Grief-loss family partnership support groups 8) Ethnic- or tribal-specific social or community groups or other cultural-based activities 9) Development of self-help and peer support (Includes transformative infrastructure and attitudinal change for the development of peer support and client-run services)						

	10) Seamless linkages with both the children/youth mental health system and the adult mental health system as appropriate										

*This program is expected to reach capacity in FY06/07. The figures presented here were not adjusted for attrition or turnover.

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT
Estimated/Actual Population Served

County: **Sacramento**
Program Work Plan #: **SAC4**
Program Work Plan Name: **Permanent Supportive Housing Program for Individuals and Families**
Fiscal Year: **2006-07** *(please complete one per fiscal year)*

Full Service Partnerships		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth	Homeless in households where caregivers have SMI and homeless children w/ SED	16		24		31		31		31*	
Transition Age Youth	Homeless w/ SMI	16		24		31		31		31*	
Adults	Homeless w/ SMI	28		42		57		57		57*	
Older Adults	Homeless w/ SMI	3		5		6		6		6*	

System Development		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

Outreach and Engagement		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
	1) Family Partnership										

	Programs that include outreach and engagement strategies to engage racially and ethnically diverse families and include services and activities such as training, information and referral, support groups, and direct services 2) Child/youth peer mentoring 3) Cultural and gender-sensitive outreach and services 4) Education for children/youth and family regarding mental health diagnosis and assessment, medications, services and supports planning, treatment modalities and other information related to children/youth's mental health

	services and needs 5) Services in collaboration with faith-based communities; linkage for families to the full range of community services and supports 6) Parental mental health education, with language access and culturally appropriate approaches 7) Grief-loss family partnership support groups 8) Ethnic- or tribal-specific social or community groups or other cultural-based activities 9) Development of self-help and peer support (Includes transformative infrastructure and attitudinal change for the development of peer support and client-run services)										

	10) Seamless linkages with both the children/youth mental health system and the adult mental health system as appropriate										

*This program will have the capacity to serve 125 clients at any point in time. The figures presented here were not adjusted for attrition or turnover.

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT

Estimated/Actual Population Served

County: **Sacramento**
Program Work Plan #: **SAC4**
Program Work Plan Name: **Permanent Supportive Housing Program for Individuals and Families**
Fiscal Year: **2007-08** *(please complete one per fiscal year)*

Full Service Partnerships		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth	Homeless in households where caregivers have SMI and homeless children w/ SED	31		31		31		31		31*	
Transition Age Youth	Homeless w/ SMI	31		31		31		31		31*	
Adults	Homeless w/ SMI	57		57		57		57		57*	
Older Adults	Homeless w/ SMI	6		6		6		6		6*	

System Development		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

Outreach and Engagement		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
	1) Family Partnership										

	Programs that include outreach and engagement strategies to engage racially and ethnically diverse families and include services and activities such as training, information and referral, support groups, and direct services 2) Child/youth peer mentoring 3) Cultural and gender-sensitive outreach and services 4) Education for children/youth and family regarding mental health diagnosis and assessment, medications, services and supports planning, treatment modalities and other information related to children/youth's mental health

	services and needs 5) Services in collaboration with faith-based communities; linkage for families to the full range of community services and supports 6) Parental mental health education, with language access and culturally appropriate approaches 7) Grief-loss family partnership support groups 8) Ethnic- or tribal-specific social or community groups or other cultural-based activities 9) Development of self-help and peer support (Includes transformative infrastructure and attitudinal change for the development of peer support and client-run services)						

	10) Seamless linkages with both the children/youth mental health system and the adult mental health system as appropriate										

*This program will have the capacity to serve 125 clients at any point in time. The figures presented here were not adjusted for attrition or turnover.

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT
Estimated/Actual Population Served

County: **Sacramento**
Program Work Plan #: **SAC5**
Program Work Plan Name: **Transcultural Wellness Center**
Fiscal Year: **2005-06** *(please complete one per fiscal year)*

Full Service Partnerships		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth	API w/ SED or in need of support services							20		20*	
Transition Age Youth	API with SED or SMI or in need of support services							5		5*	
Adults	API w/ SMI or in need of support services							20		20*	
Older Adults	API w/ SMI or in need of support services							5		5*	

System Development		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

Outreach and Engagement		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

	1) Child/youth peer monitoring 2) Outreach and engagement services, as well as,cultural and gender-sensitive outreach and services at schools, primary care clinics, and community programs in ethnic communities 3) Family preservation services 4) Education for children/youth and family or other caregivers regarding mental health diagnosis and assessment, medications, services and supports planning, treatment modalities, and other information related to children/youth's mental health services and needs

	5) Services in collaboration with faith-based communities; linkage for these families to the full range of community services and supports 6) Parental mental health education, with language access and culturally appropriate approaches 7) Supportive family partnership educational opportunities 8) Ethnic or tribal-specific social or community groups or other culture-based activities						

*This program is expected to reach full capacity in FY06/07. The figures presented here were not adjusted for attrition or turnover.

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT
Estimated/Actual Population Served

County: **Sacramento**
Program Work Plan #: **SAC5**
Program Work Plan Name: **Transcultural Wellness Center**
Fiscal Year: **2006-07** *(please complete one per fiscal year)*

Full Service Partnerships		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth	API w/ SED or in need of support services	62		102		102		102		102*	
Transition Age Youth	API with SED or SMI or in need of support services	18		32		32		32		32*	
Adults	API w/ SMI or in need of support services	54		89		89		89		89*	
Older Adults	API w/ SMI or in need of support services	16		27		27		27		27*	

System Development		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

Outreach and Engagement		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

	1) Child/youth peer monitoring 2) Outreach and engagement services, as well as, cultural and gender-sensitive outreach and services at schools, primary care clinics, and community programs in ethnic communities 3) Family preservation services 4) Education for children/youth and family or other caregivers regarding mental health diagnosis and assessment, medications, services and supports planning, treatment modalities, and other information related to children/youth's mental health services and needs

	5) Services in collaboration with faith-based communities; linkage for these families to the full range of community services and supports 6) Parental mental health education, with language access and culturally appropriate approaches 7) Supportive family partnership educational opportunities 8) Ethnic or tribal-specific social or community groups or other culture-based activities						

*This program will have the capacity to serve 250 clients at any point in time. The figures presented here were not adjusted for attrition or turnover.

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT
Estimated/Actual Population Served

County: **Sacramento**
Program Work Plan #: **SAC5**
Program Work Plan Name: **Transcultural Wellness Center**
Fiscal Year: **2007-08** *(please complete one per fiscal year)*

Full Service Partnerships		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth	API w/ SED or in need of support services	102		102		102		102		102*	
Transition Age Youth	API with SED or SMI or in need of support services	32		32		32		32		32*	
Adults	API w/ SMI or in need of support services	89		89		89		89		89*	
Older Adults	API w/ SMI or in need of support services	27		27		27		27		27*	

System Development		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

Outreach and Engagement		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**

	1) Child/youth peer monitoring 2) Outreach and engagement services, as well as, cultural and gender-sensitive outreach and services at schools, primary care clinics, and community programs in ethnic communities 3) Family preservation services 4) Education for children/youth and family or other caregivers regarding mental health diagnosis and assessment, medications, services and supports planning, treatment modalities, and other information related to children/youth's mental health services and needs						

	5) Services in collaboration with faith-based communities; linkage for these families to the full range of community services and supports 6) Parental mental health education, with language access and culturally appropriate approaches 7) Supportive family partnership educational opportunities 8) Ethnic or tribal-specific social or community groups or other culture-based activities						

*This program will have the capacity to serve 250 clients at any point in time. The figures presented here were not adjusted for attrition or turnover.

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT
Estimated/Actual Population Served

County: **Sacramento**
Program Work Plan #: **SAC6**
Program Work Plan Name: **Wellness and Recovery Center**
Fiscal Year: **2005-06** *(please complete one per fiscal year)*

Full Service Partnerships		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth											
Transition Age Youth											
Adults											
Older Adults											

System Development		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
	1) Transform the infrastructure and attitudinal change for the development of peer-support services and participant-run activities, including peer counseling and support; activities to increase participant							50		50*	

	knowledge and ability to use needed mental health services and reduce disparities in care 2) Values-driven evidenced based services and emerging best practices that are integrated with overall service planning and support housing, employment and/or education goals. 3) Peer supportive services and client and family run services 4) Mobile services to reach participants who cannot access clinics and other services due to physical disabilities, language barriers, mental disabilities; Home visits and outreach services to provide support and offer assistance to homebound

	participants. 5) Supportive employment and other productive activities; including development of job options for clients such as social enterprises, agency supported positions, and competitive employment options. 6) Service planning with social service agencies and other community providers to provide integrated services. 7) Integrated county/community level service planning which identifies needs in the areas of mental health services, health services, education, job training, employment, housing, socialization, independent living skills and funding

	options 8) Youth and family-run services including peer support, self-help groups, train-the-trainer programs and culturally competent mentoring programs. 9) Wellness Recovery Action Planning-In addition to an individualized system for monitoring and responding to symptoms to achieve the highest possible levels of wellness, this strategy includes looking at each client's needs and wants for home, job, friendship, and family with the focus on life improvement. 10) Coordination with primary care providers and other health care providers to

	increase coordination and integration between mental health, primary care and other health services. 11) Peer supportive services including peer-counseling programs to provide culturally based support and to increase client/member knowledge and ability to use needed mental health services. 12) Recovery and self-determination planning with opportunities for volunteer programs, advocacy groups, community self-help groups, nutrition programs, faith-based providers, churches, temples, and any other community resource serving transition

	age youth, adults and older adults of diverse cultures and ethnicities. 13) Consumer run transportation services to promote outreach and engagement with provided mental health services. 14) Classes for successful living in the community. Opportunities for participants to teach each other how to achieve meaningful roles in life. 15) Mentoring 16) Partnership's with community providers, educational institutions, vocational programs, and the business community. 17) Education for youth, family and/or other care-givers family or other						

	caregivers as appropriate regarding the nature of medications, the expected benefits and the potential side effects 18) Supportive educational services 19) Vocational services 20) Trauma informed services 21) Crisis activities including a 24 hour warm line 22) Family support, education and consultation services, parenting support, self-help groups and mentoring. 23) Community specific cultural practices. Natural healing practices and ceremonies recognized by the community in place of or in addition to mainstream services such as nutrition,

	exercise, yoga, meditation, art and music. 24) Ethnic specific social and/or community groups or other culture-based partners. 25) On-site services to reach faith-based communities, ethnic cultures, and others who may be more responsive to services in this setting; linkage for these individuals to a full range of services. 26) Outreach and linkage to connect persons of various ethnicities and cultures who may be better served and/or responsive to services in specific culture based settings. 27) Recreational and quality of life opportunities. 28) Services to

	assist families in supporting youth during this period 29) Cross-agency and cross-discipline training. Staff working with transition age youth who are trained in the developmental and cultural needs of transition age youth, in community resources, and implementing a wellness philosophy including the concepts of both recovery and resiliency 30) Quality of life activities that guide participants for employment, supportive housing, community integration, substance abuse treatment, supportive education, family strengthening, etc. 31) Youth

	involvement in planning and activity development, including the involvement of youth previously involved in juvenile justice settings and out of home placements.															
Outreach and Engagement		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**						
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**					
	1) Outreach and engagement services, peer supportive services, and client and family run services 2) Youth and family-run services including peer support, self-help groups, train-the-trainer programs and culturally competent mentoring programs. 3) Peer supportive services including peer-counseling programs to provide culturally based							150		150						

	support and to increase client/member knowledge and ability to use needed mental health services. 4) Recovery and self-determination planning with opportunities for volunteer programs, advocacy groups, community self-help groups, nutrition programs, faith-based providers, churches, temples, and any other community resource serving transition age youth, adults and older adults of diverse cultures and ethnicities. 5) Crisis activities including a 24 hour warm line 6) Family support, education and consultation services, parenting support, self-help

	groups and mentoring. Outreach and linkage to connect persons of various ethnicities and cultures who may be better served and/or responsive to services in specific culture based settings.										

*This program is expected to reach full capacity in FY06/07. The figures presented here were not adjusted for attrition or turnover.

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT
Estimated/Actual Population Served

County: **Sacramento**
Program Work Plan #: **SAC6**
Program Work Plan Name: **Wellness and Recovery Center**
Fiscal Year: **2006-07** *(please complete one per fiscal year)*

Full Service Partnerships		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth											
Transition Age Youth											
Adults											
Older Adults											

System Development		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
	1) Transform the infrastructure and attitudinal change for the development of peer-support services and participant-run activities, including peer counseling and support; activities to increase participant	100		250		325		450		450*	

	knowledge and ability to use needed mental health services and reduce disparities in care 2) Values-driven evidenced based services and emerging best practices that are integrated with overall service planning and support housing, employment and/or education goals. 3) Peer supportive services and client and family run services 4) Mobile services to reach participants who cannot access clinics and other services due to physical disabilities, language barriers, mental disabilities; Home visits and outreach services to provide support and offer assistance to homebound

	participants. 5) Supportive employment and other productive activities; including development of job options for clients such as social enterprises, agency supported positions, and competitive employment options. 6) Service planning with social service agencies and other community providers to provide integrated services. 7) Integrated county/community level service planning which identifies needs in the areas of mental health services, health services, education, job training, employment, housing, socialization, independent living skills and funding

	options 8) Youth and family-run services including peer support, self-help groups, train-the-trainer programs and culturally competent mentoring programs. 9) Wellness Recovery Action Planning-In addition to an individualized system for monitoring and responding to symptoms to achieve the highest possible levels of wellness, this strategy includes looking at each client's needs and wants for home, job, friendship, and family with the focus on life improvement. 10) Coordination with primary care providers and other health care providers to

	increase coordination and integration between mental health, primary care and other health services. 11) Peer supportive services including peer-counseling programs to provide culturally based support and to increase client/member knowledge and ability to use needed mental health services. 12) Recovery and self-determination planning with opportunities for volunteer programs, advocacy groups, community self-help groups, nutrition programs, faith-based providers, churches, temples, and any other community resource serving transition

	age youth, adults and older adults of diverse cultures and ethnicities. 13) Consumer run transportation services to promote outreach and assistance with accessing services. 14) Classes for successful living in the community. Opportunities for participants to teach each other how to achieve meaningful roles in life. 15) Mentoring 16) Partnership's with community providers, educational institutions, vocational programs, and the business community. 17) Education for youth, family and/or other care-givers family or other caregivers as

	appropriate regarding the nature of medications, the expected benefits and the potential side effects 18) Supportive educational services 19) Vocational services 20) Trauma informed services 21) Crisis activities including a 24 hour warm line 22) Family support, education and consultation services, parenting support, self-help groups and mentoring. 23) Community specific cultural practices. Natural healing practices and ceremonies recognized by the community in place of or in addition to mainstream services such as nutrition, exercise, yoga,

	meditation, art and music. 24) Ethnic specific social and/or community groups or other culture-based partners. 25) On-site services to reach faith-based communities, ethnic cultures, and others who may be more responsive to services in this setting; linkage for these individuals to a full range of services. 26) Outreach and linkage to connect persons of various ethnicities and cultures who may be better served and/or responsive to services in specific culture based settings. 27) Recreational and quality of life opportunities. 28) Services to assist families in							

	supporting youth during this period 29) Cross-agency and cross-discipline training. Staff working with transition age youth who are trained in the developmental and cultural needs of transition age youth, in community resources, and implementing a wellness philosophy including the concepts of both recovery and resiliency 30) Quality of life activities that guide participants for employment, supportive housing, community integration, substance abuse treatment, supportive education, family strengthening, etc. 31) Youth involvement in

	planning and activity development, including the involvement of youth previously involved in juvenile justice settings and out of home placements.										
Outreach and Engagement		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
	1) Outreach and engagement services, peer supportive services and client and family run services 2) Youth and family-run services including peer support, self-help groups, train-the-trainer programs and culturally competent mentoring programs. 3) Peer supportive services including peer-counseling programs to provide culturally based support and to	225		450		675		900		900	

	increase client/member knowledge and ability to use needed mental health services. 4) Recovery and self-determination planning with opportunities for volunteer programs, advocacy groups, community self-help groups, nutrition programs, faith-based providers, churches, temples, and any other community resource serving transition age youth, adults and older adults of diverse cultures and ethnicities. 5) Crisis activities including a 24 hour warm line 6) Family support, education and consultation services, parenting support, self-help groups and

	mentoring. Outreach and linkage to connect persons of various ethnicities and cultures who may be better served and/or responsive to services in specific culture based settings.										

*This program will have the capacity to serve 450 clients at any point in time. The figures presented here were not adjusted for attrition or turnover.

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT
Estimated/Actual Population Served

County: **Sacramento**
Program Work Plan #: **SAC6**
Program Work Plan Name: **Wellness and Recovery Center**
Fiscal Year: **2007-08** *(please complete one per fiscal year)*

Full Service Partnerships		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth											
Transition Age Youth											
Adults											
Older Adults											
System Development		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
	1) Transform the infrastructure and attitudinal change for the development of peer-support services and participant-run activities, including peer counseling and support; activities to increase participant	450		450		450		450		450*	

	knowledge and ability to use needed mental health services and reduce disparities in care 2) Values-driven evidenced based services and emerging best practices that are integrated with overall service planning and support housing, employment and/or education goals. 3) Peer supportive services and client and family run services 4) Mobile services to reach participants who cannot access clinics and other services due to physical disabilities, language barriers, mental disabilities; Home visits and outreach services to provide support and offer assistance to homebound

	participants. 5) Supportive employment and other productive activities; including development of job options for clients such as social enterprises, agency supported positions, and competitive employment options. 6) Service planning with social service agencies and other community providers to provide integrated services. 7) Integrated county/community level service planning which identifies needs in the areas of mental health services, health services, education, job training, employment, housing, socialization, independent living skills and funding						

	options 8) Youth and family-run services including peer support, self-help groups, train-the-trainer programs and culturally competent mentoring programs. 9) Wellness Recovery Action Planning-In addition to an individualized system for monitoring and responding to symptoms to achieve the highest possible levels of wellness, this strategy includes looking at each client's needs and wants for home, job, friendship, and family with the focus on life improvement. 10) Coordination with primary care providers and other health care providers to

	increase coordination and integration between mental health, primary care and other health services. 11) Peer supportive services including peer-counseling programs to provide culturally based support and to increase client/member knowledge and ability to use needed mental health services. 12) Recovery and self-determination planning with opportunities for volunteer programs, advocacy groups, community self-help groups, nutrition programs, faith-based providers, churches, temples, and any other community resource serving transition

	age youth, adults and older adults of diverse cultures and ethnicities. 13) Consumer run transportation services to promote outreach and assistance with accessing services. 14) Classes for successful living in the community. Opportunities for participants to teach each other how to achieve meaningful roles in life. 15) Mentoring 16) Partnership's with community providers, educational institutions, vocational programs, and the business community. 17) Education for youth, family and/or other care-givers family or other caregivers as

	appropriate regarding the nature of medications, the expected benefits and the potential side effects 18) Supportive educational services 19) Vocational services 20) Trauma informed services 21) Crisis activities including a 24 hour warm line 22) Family support, education and consultation services, parenting support, self-help groups and mentoring. 23) Community specific cultural practices. Natural healing practices and ceremonies recognized by the community in place of or in addition to mainstream services such as nutrition, exercise, yoga,

	meditation, art and music. 24) Ethnic specific social and/or community groups or other culture-based partners. 25) On-site services to reach faith-based communities, ethnic cultures, and others who may be more responsive to services in this setting; linkage for these individuals to a full range of services. 26) Outreach and linkage to connect persons of various ethnicities and cultures who may be better served and/or responsive to services in specific culture based settings. 27) Recreational and quality of life opportunities. 28) Services to assist families in							

	supporting youth during this period 29) Cross-agency and cross-discipline training. Staff working with transition age youth who are trained in the developmental and cultural needs of transition age youth, in community resources, and implementing a wellness philosophy including the concepts of both recovery and resiliency 30) Quality of life activities that guide participants for employment, supportive housing, community integration, substance abuse treatment, supportive education, family strengthening, etc. 31) Youth involvement in

	planning and activity development, including the involvement of youth previously involved in juvenile justice settings and out of home placements.															
Outreach and Engagement		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**						
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**					
	1) Outreach and engagement services, peer supportive services and client and family run services 2) Youth and family-run services including peer support, self-help groups, train-the-trainer programs and culturally competent mentoring programs. 3) Peer supportive services including peer-counseling programs to provide culturally based support and to	225		450		675		900		900						

	increase client/member knowledge and ability to use needed mental health services. 4) Recovery and self-determination planning with opportunities for volunteer programs, advocacy groups, community self-help groups, nutrition programs, faith-based providers, churches, temples, and any other community resource serving transition age youth, adults and older adults of diverse cultures and ethnicities. 5) Crisis activities including a 24 hour warm line 6) Family support, education and consultation services, parenting support, self-help groups and

	mentoring. Outreach and linkage to connect persons of various ethnicities and cultures who may be better served and/or responsive to services in specific culture based settings.							

*This program will have the capacity to serve 450 clients at any point in time. The figures presented here were not adjusted for attrition or turnover.

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT
Estimated/Actual Population Served

County: **Sacramento**
Program Work Plan #: **SAC7**
Program Work Plan Name: **Psychiatric Emergency Response Team**
Fiscal Year: **2005-06** *(please complete one per fiscal year)*

Full Service Partnerships		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth											
Transition Age Youth											
Adults											
Older Adults											

System Development		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
807	(1) Mobile crisis intervention and stabilization providing multidisciplinary assessment, direct services, and linkages in the community using mental health / law enforcement	0		0		0		807		807	

	partnership model. (2) Culturally appropriate services to members of ethnic and linguistic communities that have historically been underserved (3) Collaborative services with Mental Health treatment Center, Crisis Stabilization Program, Emergency Medical Service, Emergency Shelter, Emergency Feeding Program, Mental Health Regional Service Teams (4) Consumer / Family Advocate will provide support to the client as well as support to family members or caregivers who are often the primary support system for the individual. (5) Self-directed care plans such as

	Wellness Recovery Action Plan (WRAP) whenever appropriate. (6) Services and supports provided in the community and at home through ongoing follow-up by PERT team until care has been assumed by linkage resource. (7) Outreach to homeless adults, older adults and TAY with SMI and to children and youth with SED															
Outreach and Engagement		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**						
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**					

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT
Estimated/Actual Population Served

County: **Sacramento**
Program Work Plan #: **SAC7**
Program Work Plan Name: **Psychiatric Emergency Response Team**
Fiscal Year: **2006-07** *(please complete one per fiscal year)*

Full Service Partnerships		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth											
Transition Age Youth											
Adults											
Older Adults											

System Development		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
3228	(1) Mobile crisis intervention and stabilization providing multidisciplinary assessment, direct services, and linkages in the community using mental health / law enforcement	807		807		807		807		3228	

	partnership model. (2) Culturally appropriate services to members of ethnic and linguistic communities that have historically been underserved (3) Collaborative services with Mental Health treatment Center, Crisis Stabilization Program, Emergency Medical Service, Emergency Shelter, Emergency Feeding Program, Mental Health Regional Service Teams (4) Consumer / Family Advocate will provide support to the client as well as support to family members or caregivers who are often the primary support system for the individual. (5) Self-directed care plans such as

	Wellness Recovery Action Plan (WRAP) whenever appropriate. (6) Services and supports provided in the community and at home through ongoing follow-up by PERT team until care has been assumed by linkage resource. (7) Outreach to homeless adults, older adults and TAY with SMI and to children and youth with SED															
Outreach and Engagement		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**						
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**					

EXHIBIT 6: THREE-YEAR PLAN – QUARTERLY PROGRESS GOALS AND REPORT
Estimated/Actual Population Served

County: **Sacramento**
Program Work Plan #: **SAC7**
Program Work Plan Name: **Psychiatric Emergency Response Team**
Fiscal Year: **2007-08** *(please complete one per fiscal year)*

Full Service Partnerships		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Age Group	**Description of Initial Populations**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
Child/Youth											
Transition Age Youth											
Adults											
Older Adults											
System Development		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**	
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**
3228	(1) Mobile crisis intervention and stabilization providing multidisciplinary assessment, direct services, and linkages in the community using mental health / law enforcement	807		807		807		807		3228	

	partnership model. (2) Culturally appropriate services to members of ethnic and linguistic communities that have historically been underserved (3) Collaborative services with Mental Health treatment Center, Crisis Stabilization Program, Emergency Medical Service, Emergency Shelter, Emergency Feeding Program, Mental Health Regional Service Teams (4) Consumer / Family Advocate will provide support to the client as well as support to family members or caregivers who are often the primary support system for the individual. (5) Self-directed care plans such as						

	Wellness Recovery Action Plan (WRAP) whenever appropriate. (6) Services and supports provided in the community and at home through ongoing follow-up by PERT team until care has been assumed by linkage resource. (7) Outreach to homeless adults, older adults and TAY with SMI and to children and youth with SED															
Outreach and Engagement		**Qtr 1**		**Qtr 2**		**Qtr 3**		**Qtr 4**		**Total**						
Total Number to be served	**Services/Strategies**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**					

EXHIBIT 7--Mental Health Services Act Cash Balance Quarterly Report

County	Sacramento	Date	01/31/06
MHSA Component	Local Planning (FY 04-05 only)	Fiscal Year	2004-05
		Quarter	4th (Apr - June)

A. Cash Flow Activity	
1. Cash on hand at beginning of quarter (line 6 from prior Quarterly Report)	*
2. Quarterly advance from State DMH (insert as positive number)	
3. Total cash available (sum of lines 1 and 2)	$0
4. Actual expenditures (insert as a negative number)	
5. Adjustments of prior quarters (insert as negative or positive number, as appropriate)	
6. Cash on hand at end of quarter (report on line 1 for next Quarterly Report)	$0
B. Reserved Cash on Hand at End of Quarter (enter as negative numbers)	
1. Anticipated one-time expenditures to be incurred during quarter	
C. Cash on Hand for On-Going Operations	$0

* Information required by this quarterly report is not currently available. Updated actual Cash Balance quarterly report will be forwarded as soon as information becomes available.

COUNTY CERTIFICATION

I HEREBY CERTIFY, to the best of my knowledge and belief, under penalty of perjury, that this report is correct and complete and that all expenditures have been made in accordance with the Mental Health Services Act requirements.

Signature	
Name and Title	Richard W. Harig, MHSA Program Manager
E-Mail Address	HarigR@SacCounty.net
Telephone Number	(916) 875-6486

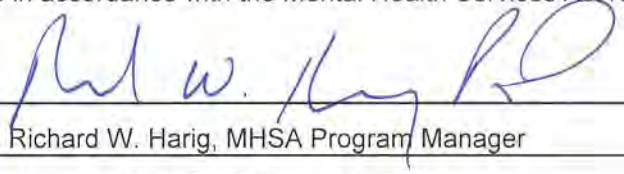
EXHIBIT 7--Mental Health Services Act Cash Balance Quarterly Report

County: Sacramento
MHSA Component: Comm. Services and Supports
Date: 01/31/06
Fiscal Year: 2005-06
Quarter: 1st (July - Sept)

A. Cash Flow Activity	
1. Cash on hand at beginning of quarter (line 6 from prior Quarterly Report)	
2. Quarterly advance from State DMH (insert as positive number)	
3. Total cash available (sum of lines 1 and 2)	$0
4. Actual expenditures (insert as a negative number)	
5. Adjustments of prior quarters (insert as negative or positive number, as appropriate)	
6. Cash on hand at end of quarter (report on line 1 for next Quarterly Report)	$0
B. Reserved Cash on Hand at End of Quarter (enter as negative numbers)	
1. Anticipated one-time expenditures to be incurred during quarter	
C. Cash on Hand for On-Going Operations	$0

COUNTY CERTIFICATION

I HEREBY CERTIFY, to the best of my knowledge and belief, under penalty of perjury, that this report is correct and complete and that all expenditures have been made in accordance with the Mental Health Services Act requirements.

Signature: 
Name and Title: Richard W. Harig, MHSA Program Manager
E-Mail Address: HarigR@SacCounty.net
Telephone Number: (916) 875-6486

The Sacramento County Mental Health Board is conducting a Public Hearing to receive public comment regarding the Draft Community Services and Supports (CSS) Plan.

To access a copy of the Plan from the Web, go to
http://www.sacdhhs.com/article.asp?ContentID=1457
If you would like to receive a paper copy of the Plan, please contact Dick Harig at (916) 875-6486.

The Public Hearing is scheduled as follows:

Wednesday, December 7, 2005
The Grand Hall Ballroom
1215 J Street
Sacramento, CA 95814
6:30 - 9:00 pm

If you need to arrange for an interpreter or a reasonable accommodation, please call Edna Utter at (916) 875-4639.

沙加缅度县精神健康委员会
公众听证会就起草社区服务
与支持规划(**CSS**) 听取意见

下列网页可找到这个规划的文本：
http://www.sacdhhs.com/article.asp?ContentID=1457
如果你需要规划的打印文本，请和**Dick Harig** 电话联系：
(916) 875-6486.

公众听证会的时间地点安排如下:
2005年12月7日，星期三
The Grand Hall Ballroom
1215 J Street
Sacramento, CA 95814
下午6:30 - 9:00

如果你需要翻译或其它方面的通融, 请和Edna Utter 电话联系:
(916) 875-4639.

Ceg Neeg Tuav Num Rau Tuam Nroog Sacramento Txog Kev Nyuaj Siab (The Sacramento County Mental Health Board) yuav tuav rooj tham txais pej xeem lus seb lawv xav li cas txog txoj kev pab thiab kev txhawb nqa rau zej zog (Draft Community Services and Supports (CSS) Plan).

Mus saib tau ntawv txog txoj kev pab no hauv internet ntawm http://www.sacdhhs.com/article.asp?ContentID=1457
Yog koj xav tau ib daig ntawv saib txog txoj kev pab no, thov hu Dick Harig ntawm (916) 875-6486.

Lub Rooj Tham no raug teem sij hawm raws li no:

Wednesday, 12 Hlis Ntuj, Tim 7, Xyoo 2005
Nyob Hauv Lub Grand Hall Ballroom
1215 J Street
Sacramento, CA 95814
6:30 - 9:00 teev tsaus ntuj

Yog koj yuav tsum tau neeg txhais lus los lwm yam uas pab tau, thov hu Edna Utter ntawm (916) 875-4639.

Комиссия по психическому здоровью округа Сакраменто проводит общественные слушания для изучения мнения общественности о проекте Плана общественных услуг и поддержки.

С планом можно ознакомиться в Интернете по адресу:
http://www.sacdhhs.com/article.asp?ContentID=1457
Если Вы хотите получить распечатанную копию плана, обращайтесь к Дику Хэригу по телефону (916) 875-6486.

Общественные слушания проводятся

в среду, 7 декабря 2005 года
по адресу

The Grand Hall Ballroom
1215 J Street
Sacramento, CA 95814
6:30 - 9:00 pm

Если вам нужен переводчик или иная помощь, пожалуйста звоните Эдне Аттер по телефону (916) 875-4639.

La Mesa Directiva de Salud Mental del Condado de Sacramento tendrá una Audiencia Pública para escuchar y recibir los comentarios de la comunidad acerca del Plan de Servicios de Apoyo Comunitario (CSS Plan)siglas en Inglés.

Para obtener una copia del Plan en el Internet vaya a la página
http://www.sacdhhs.com/article.asp?ContentID=1457
Si desea obtener una copia, favor de comunicarse con Dick Harig al número (916) 875-6486.

La Audiencia Pública se llevará a cabo el:

Miércoles, Diciembre 7, 2005
en el The Grand Hall Ballroom
1215 J Street
Sacramento, CA 95814
de 6:30 - 9:00 p.m

Si necesita la ayuda de un intérprete o requiere de ayuda adicional, favor de llamar a Edna Utter al (916) 875-4639.

Hội Đồng Y Tế Bệnh Tâm Thần Quận Hạt Sacramento sẽ điều kiển một sự Thu Thập Ý Kiến Quần Chúng để nhận ý kiến phê bình của quần chúng về Những Dự Luật Phục Vụ Cộng Đồng và Những Chương Trình Giúp Đỡ(CSS).

Để nhận được một bản sao của Chương Trình từ Mạng Lưới Điện Toán, vào http://www.sacdhhs.com/article.asp?ContentID=1457
Nếu qúy vị muốn nhận được một bản sao của Chương Trình, vui lòng liên lạc Dick Harig tại (916) 875-6486.

Sự Thu Thập Ý Kiến Quần Chúng được sắp xếp như sau đây:

Thứ Tư, Tháng Mười Hai Ngày 7, 2005
The Grand Hall Ballroom
1215 Đường J
Sacramento, CA 95814
6:30 - 9:00 tối

Nếu qúy vị cần sắp xếp để cho một người thông dịch viên hay một điều kiện hợp lý, vui lòng gọi Edna Utter tại (916) 875-4639.

NO 453 Public Notice

Correction

The Sacramento County Department of Health and Human Services (DHHS), Division of Mental Health announces the posting of the DRAFT Mental Health Services Act (MHSA Community Services and Supports (CSS) Plan on the Department Website at www.sacdhhs.com. The DRAFT Plan will be posted for 30 days to allow for public comment. Public comment may be e-mailed to MHSA@SacCounty.net or submitted in writing to the Department of Health and Human Services, Division of Mental Health, Attn: Richard Harig, 7001-A East Parkway, Suite 400, Sacramento, CA, 95823. The Sacramento County Mental Health Board will conduct a public hearing on Wednesday, December 7, 2005, at The Grand Ballroom, 1215 J Street, Sacramento, CA, 95814, from **●6:30 pm to 9:00 pm●**

CL

PUBLIC NOTICES PUBLIC NOTICES

PUBLIC NOTICE

The Sacramento County Department of Health and Human Services (DHHS), Division of Mental Health announces the posting of the DRAFT Mental Health Services Act (MHSA Community Services and Supports (CSS) Plan on the Department Website at www.sacdhhs.com. The DRAFT Plan will be posted for 30 days to allow for public comment. Public comment may be e-mailed to MHSA@SacCounty.net or submitted in writing to the Department of Health and Human Services, Division of Mental Health, Attn: Richard Harig, 7001-A East Parkway, Suite 400, Sacramento, CA 95823. The Sacramento County Mental Health Board will conduct a public hearing on Wednesday, December 7, 2005, at The Grand Ballroom, 1215 J Street, Sacramento, CA 95814, from 6:30 pm to 8:30 pm.

ANUNCIO PUBLICO

El Departamento de Salud y Servicios Humanos (DHHS) del Condado de Sacramento, División de Salud Mental anuncia la publicación del Plan Preliminar del Acta de Servicios de Salud Mental (MHSA) Plan de Servicios Comunitarios de Apoyo (CSS) en la pagina del Internet del Departamento de Salud Mental en www.sacdhhs.com

El Plan Preliminar estará publicado durante 30 días para permitir que el público haga sus recomendaciones. Las recomendaciones por parte del público pueden ser enviadas a través del email a MHSA@.SacCounty.net o las pueden enviar por escrito al Departamento de Salud y Servicios Humanos, División de Salud Mental, con atención a Richard Harig, 7001-A East Parkway, Suite 400, Sacramento, CA 95823. La Mesa Directiva de Salud Mental del Condado de Sacramento conducirá una Audiencia Pública el Miércoles, Diciembre 7, 2005, en el Grand Ballroom, ubicado en el 1215 Calle J, en Sacramento, CA 95814, de 6:30 a 8:30 de la tarde.

Mental Health Board
Public Hearing on the MHSA Plan
December 7, 2005

1. Welcome

2. Introduction of Sacramento County Mental Health Board members

3. Introductory Comments – Mental Health Director, Kathleen Henry (introduced by Jim Hunt)

4. PowerPoint Presentation on the
   a. Financial context of the MHSA
   b. Purpose of the meeting and
   c. Emphasis on civility in comment
   d. Procedures for addressing the Mental Health Board

5. Public Comment
   a. 3-minute per person limit- timer is present
   b. One turn per person until all who want to have had a chance to speak
   c. If speaking on behalf of an organization or group please state which you are representing

精神健康委员会
精神健康服务法听证会
2005年**12**月**7**日

1. 欢迎

2. 介绍沙加缅度县精神健康委员会成员

3. 引见性致词 – 精神健康服务主任, Kathleen Henry (由Jim Hunt 引见)

4. 关于下列问题的电脑图表报告
   a. 精神健康服务法的财务情况
   b. 今天会议的目的
   c. 强调文明发言
   d. 向精神健康委员会进言的程序

5. 公众发言
   a. 每人限3分钟 - 现场使用计时器
   b. 在所有的人都有机会发言之前，每人限发言一次
   c. 如果代表机构或组织发言，在发言时请说出你所代表的机构或组织

Pawg Neeg Tuav Hauj Lwm Txog Kev Nyuaj Siab Rooj Tham Rau Pej Xeem Txog Txoj Kev Pab Hu Ua MHSA Plan

Hnub tim 7, 12 Hlis Ntuj, Xyoo 2005

1. Kev zoo siab txais tos

2. Qhia txog Cov Neeg Ua Num Tuav Hauj Lwm Txog Kev Nyuaj Siab.

3. Cov lus pib – Tus Thawj Tuav Hauj Lwm Kev Nyuaj Siab, Kathleen Henry (Jim Hunt ua tus qhia txog)

4. Tso duab PowerPoint qhia txog
   a. Nyiaj txiag siv rau ntawm MHSA
   b. Hom phiaj ntawm lub rooj tham
   c. Txog kev siv lus zoo ntawm cov lus hais
   d. Cov kev hais lus rau Pawg Neeg Tuav Hauj Lwm Txog Kev Nyuaj Siab

5. Pej Xeem Cov Lus
   a. Pub 3 nas this rau ib tug neeg hais- muaj moos caws
   b. Pub ib leeg hais ib zaug xwb kom sawv daws uas xav hais hais tas tso.
   c. Yog koj sawv cev ntawm ib lub koom haum los ib pawg neeg los hais lus, thov qhia seb yog pawg dab tsi

Комиссия по психическому здоровью округа Сакраменто

общественные слушания Плана общественных услуг и поддержки

7 декабря 2005 года

1. Приветствие

2. Представление членов Комиссии по психическому здоровью округа Сакраменто

3. Вступительные комментарии – директор Отдела психического здоровья Кетлин Хенри (ее представит Джим Хант)

4. Демонстрация материалов о:
   а. Финансовом контексте Закона о психиатрическом обслуживании
   б. Целях слушаний
   в. Акценте на вежливости в выступлениях
   г. Процедурах обращения в Комиссию по психическому здоровью

5. Выступления и замечания присутствующих
   а. 3-минуты на выступление, работает таймер
   б. Одно выступление на человека, пока не выступят все желающие
   в. Если выступление от организации или группы, обязательно это указывать

Mesa Directiva de Salud Mental
Audiencia Pública del Plan de MHSA
Diciembre 7, 2005

1. Bienvenida

2. Presentación de los miembros de la Mesa Directiva de Salud Mental del Condado de Sacramento

3. Introducción – Directora de Salud Mental, Kathleen Henry (presentación por Jim Hunt)

4. Presentación con audiovisuales
   a. Estado financiero del MHSA
   b. Propósito de la junta
   c. Énfasis en los comentarios del público
   d. Procedimiento sobre como hacer preguntas a la mesa directiva

5. Comentarios del Público
   a. tiempo limitado a 3-minutos por persona
   b. Un solo turno por persona hasta que todos los que quieran hablar hayan tenido la oportunidad de haber hablado.
   c. Si habla en representación de una organización o grupo favor de identificar su organización o grupo.

Hội Đồng Sức Khỏe Bệnh Tâm Thần
Điều Trần Quần Chúng về Chương Trình MHSA
Ngày 07 Tháng 12 - 2005

1. Chào Mừng

2. Giới Thiệu của Những Người Ban Hội Đồng Sức Khỏe Bệnh Tâm Thần Quận Hạt Sacramento

3. Lời mở đầu: Giám Đốc Chương Trình Bệnh Tâm Thần, bà Kathleen Henry (giới thiệu bởi Jim Hunt)

4. Trình bày vớ sự dùng của PowerPoint về
   a. Định nghia tài chánh của MHSA
   b. Mục đích của buổi họp và
   c. Nhấn mạnh về lễ nghi trong lời phê bình
   d. Những phương cách nói chuyện với ban hội đồng sức khỏe bệnh tâm thần

5. Lời Quần Chúng
   a. Giới hạn 3 phút mỗi người - máy tính giờ là hiện diện
   b. Mỗi người một lần tới khi tất cả mọi người muốn nói đã được một lần phát biểu
   c. Nếu đại diện cho một tổ chức hay một nhóm dể nói, vui lòng chứng nhận quý vị đại diện cho ai

ATTACHMENT C

Public Comments on
Community Services and Supports Plan
for Sacramento County

Attachment C

Comments on Accessibility Issues

>>AUDIENCE MEMBER: FIRST OFF, I WANT TO THANK THE PANEL FOR ALL YOUR UNTIRING WORK ON OUR PROBLEMS AND I'LL TRY AND KEEP MY COMMENTS BRIEF FOR YOU. I'M ON THE DISABILITY ADVISORY COMMITTEE AND I'VE BEEN A DEAF ADVOCATE FOR MANY, MANY YEARS; 28 YEARS TO BE EXACT. I'M HERE TO REPRESENT THE DEAF AND THE HARD OF HEARING IN THE COMMUNITY.

WE HAVE 26,000 DEAF PEOPLE IN SACRAMENTO ALONE. THAT DOES NOT INCLUDE OTHER OUTLYING AREAS AND THESE PEOPLE DO NOT RECEIVE SERVICES, WHETHER THEY ARE IN THE AGED PROGRAMS, SENIOR CITIZENS, CHILDRENS PROGRAMS AND THESE ARE JUST SOME OF THE THINGS WE DON'T HAVE. YOU KNOW, I WROTE THINGS DOWN IN NOTES BECAUSE I CANNOT HOLD THEM AND SIGN SO I GAVE THE NOTES TO MY INTERPRETER SO SHE COULD READ THEM FOR ME PLEASE.

THERE ARE DEAF PEOPLE IN ALL OF THESE GROUPS THAT HAVE SPOKEN HERE. MENTALLY ILL, HOMELESS, AND ASIAN/PACIFIC ISLANDERS. DEAF PEOPLE NOT ONLY SUFFER FROM THE COMMON PROBLEMS SPOKEN OF, BUT ALSO FROM BIRTH ARE OFTEN CALLED THE "THROW AWAY BABIES" BECAUSE THEIR OWN FAMILIES DON'T WANT THEM. THEY GROW UP WITH THIS NEGATIVE STIGMA. THROUGHOUT HISTORY DEAF PEOPLE HAVE BEEN OPPRESSED BECAUSE THEY CANNOT "TALK ENOUGH." NO ONE PAYS ATTENTION TO THEM. I AM HERE TO SPEAK UP NOW. MAYBE THAT EXPLAINS WHY I HAVE TAUGHT SIGN LANGUAGE FOR 28 YEARS SO I COULD TALK TO PEOPLE. PLEASE JUST GIVE US ONE COUNSELOR AND LET IT HAVE A RIPPLE AFFECT SO THAT WITHIN THE NEXT 10 OR 20 YEARS, EVERY CENTER THAT HAS REQUESTED SERVICES WILL HAVE SERVICES FOR THEIR DEAF MEMBERS OF THEIR CULTURAL GROUP.

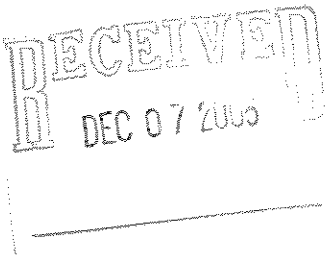
INTERPRETER: AND LOIS HAS ASKED ME AS AN INTERPRETER TO ALSO SPEAK TO THIS.

I HAVE WORKED IN THE DEAF COMMUNITY AND AS MY ROLE AS AN INTERPRETER, I TEND TO BE A CULTURAL MEDIATOR AND ALSO AN ADVOCATE.

I HAVE WITHIN THE PAST 10 YEARS, PERSONALLY MYSELF, AND THERE MUST BE ABOUT 300 TO 500 INTERPRETERS WITHIN THE SACRAMENTO AREA, I HAVE KNOWN THREE DEAF PEOPLE THAT HAVE COMMITTED SUICIDE. I'VE INTERPRETED IN SITUATIONS WHERE THEY HAVE BEEN INCARCERATED AND/OR PUT IN MENTAL INSTITUTIONS. AND THEY HAVE ALL VARIED IN THEIR ETHNIC BACKGROUND, CULTURAL BACKGROUND. I HAVE SAT IN PERSONALLY IN TWO SUICIDE WATCHES. THIS IS AN UNDERSERVED COMMUNITY; 26,000 IN SACRAMENTO ALONE. AND THEY HAVE NOT BEEN HEARD FROM PEOPLE. THEY ARE JUST DEAF. THEY ARE JUST DEAF. (APPLAUSE).

Dawson. Nedra

From: Edwards-Buckley. Ann
Sent: Tuesday, December 06, 2005 11:21 AM
To: MHSA
Subject: FW: Revised MHSA Draft CSS Plan



-----Original Message-----
From: Loisdiamond2@aol.com [mailto:Loisdiamond2@aol.com]
Sent: Monday, December 05, 2005 9:58 PM
To: Edwards-Buckley. Ann
Subject: Re: Revised MHSA Draft CSS Plan

HI:

Want to remind you that the deaf and hearing impaired people need to be included in the PERT and that they should have a qualified sign language clinical psychiatrist available to them too. We have been working with JoAnn Johnson to try and recruit one. The University of San Francisco Mental Health (USFMH) has a large psychiatric center available to the bay area deaf. The director, Nancy Mosher has offered to come out and train the Sacramento MH on how to establish a center to meet the needs of the deaf and hearing impaired of Sacramento. So far this has not been set up.

I want to make sure the deaf are not again overlooked as they have been for many years.

Thank you,
Lois Diamond

1/

There are 26,000 Deaf people in the City/County of Sacramento alone - that are not being served - If the funds diverted from the API Cultural Health & Wellbeing Center can be so diverted for PERT - why can these funds not instead be spent on some of the other proposals - child, senior + deaf services?

2/

There are deaf people in all the groups that have spoken up here. They are not getting ~~ANY~~ ~~[illegible]~~ These people often have NO communication with their families ~~[illegible]~~ no matter what language or ethnic background they are. No communication = no bonding = mental & emotional problems for LIFE!! 75% of families with deaf children cannot communicate =>

with ~~her~~ at all...

3/

[redacted] hire a counselor for DCF let it have a ripple effect. So that the next 10 or 20 yrs every center will provide this service.. to all nationalities + other underserved communities...

MHSA

Community Need

To properly determine this need, I believe that ~~the~~ ~~Reclassification~~ rate needs to be ~~re-adjusted~~ but in relationship to a groups census ~~rate~~ vs use, but based on ~~those groups~~ poverty level. It is those in or at poverty - i.e. disabled, etc that may be determining their need and not so much their ethnic group concerns. Is it

(over)

Clear for example that the asian community needs extra services (exhibited by a low penetration rate), or is it a reflection that the people in this group don't need county services (due to having private insurance coverage)?

I'm wondering if funds should be allocated by need - i.e. high penetration rate, but possibly serve needs in different ways.

Also, being legally blind, I would very much appreciate the county track the disabled using county mental health services. Thank you

Valerie Ries-Herman

Attachment C

Comments on Children and Youth

>>AUDIENCE MEMBER: I'M AN ADVOCATE WITH THE MENTAL HEALTH ASSOCIATION. I WAS A PARTICIPANT IN THE CHILDRENS TASK FORCE AND WOULD LIKE TO MAKE A COMMENT ON THAT PROCESS. OUR SYSTEM CONDUCTED BOTH NEEDS ASSESSMENT SURVEYS TO GET INFORMATION REGARDING MENTAL HEALTH GAPS IN YOUTH. WE GOT A WIDE RANGE OF INPUT FROM UNDERSERVED POPULATIONS. WE WERE SAD TO FIND OUT THAT NONE OF THE YOUTH PROPOSALS WAS FORWARDED FOR FUNDING RECOMMENDATIONS. MANY OF THE YOUTH FEEL DISCOURAGED AS A RESULT OF THIS. IT ALSO SEEMS UNFAIR SINCE LAW ENFORCEMENT IS SCHEDULED TO RECEIVE A LARGE PORTION OF MONEY THAT COULD BE ALLOCATED TO YOUTH WITH FAMILIES. I FEEL WE DID NOT HAVE PROPER REPRESENTATION AND NO FAMILY MEMBERS OF CHILDREN WHO HAVE YOUTH IN OUR MENTAL HEALTH SYSTEM WERE REPRESENTED.

I ASK THAT YOU CONSIDER FUNDING THE PERT TEAM AND ALLOCATED SERVICES TO YOUTH IN OUR COUNTY. THANK YOU. (APPLAUSE).

>>AUDIENCE MEMBER: HELLO. MY NAME IS DEBRA R. I'M A MENTAL HEALTH CONSUMER AND A VOLUNTEER FAMILY ADVOCATE FOR THE MENTAL HEALTH ASSOCIATION. I MYSELF SUFFERED FOR MANY, MANY YEARS FROM DEPRESSION THAT RENDERED ME UNABLE TO FUNCTION. I THANK GOD THAT I AM ABLE NOW TO VOLUNTEER AND TO BE OUT IN THE FIELD HELPING THE HURTING.

I'M DEEPLY CONCERNED ABOUT THE FUNDING OF PERT TEAM. CHILDREN SERVICES, THOUGH EXTREMELY CRITICAL, HAS RECEIVED NO MONEY FROM THIS PROCESS. WE ARE HANDING OVER $1 MILLION FOR THE LAW ENFORCEMENT PROGRAM. PLEASE DO NOT RECOMMEND PERT FOR FUNDING. THE STIGMA OF MENTAL ILLNESS STILL STAINS AND MENTAL HEALTH IS THE UNDERDOG. WE CANNOT AFFORD TO GIVE THIS MONEY TO POLICE OFFICERS. I MYSELF BELIEVE IN AND APPRECIATE OUR LAW ENFORCEMENT. BUT THE LAST TIME I CHECKED, HAVING A MENTAL ILLNESS WAS NOT A CRIME. (APPLAUSE).

AND IF I MIGHT JUST SAY, THE YEARS THAT I SUFFERED WITH MENTAL ILLNESS QUALIFIES ME NOW TO BE A PARENT OF A CHILD WITH MENTAL ILLNESS. AND CHILDRENS SERVICES, WE CANNOT FORGET THEM. THEY ARE OUR NEXT GENERATION. WE WILL REALLY, REALLY PAY. THANK YOU. (APPLAUSE).

Harig. Richard

From: MHSA
Sent: Tuesday, December 06, 2005 8:44 AM
To: Harig. Richard
Subject: FW: Faye's recommendations for the MHSA 2

-----Original Message-----
From: Faye Kennedy [mailto:fayek@springmail.com]
Sent: Tuesday, December 06, 2005 8:19 AM
To: MHSA
Cc: Judy Lin; Cameron Jahn; Collin. Illa; Dickinson. Roger; Bertaccini. Lisa
Subject: Faye's recommendations for the MHSA 2

December 4, 2005

Dr. Richard Harig, PhD
Program Manager
Mental Health Services Act
Sacramento County Department of Health & Human Services
7001-A East Parkway, Ste. 1000
Sacramento, CA 95823

RE: Sacramento Mental Health Services Act Draft Plan

Mr. Harig, my name is Faye Kennedy. I had the honor and pleasure of serving as the convener for the Sacramento County Mental Health Services Act's Stakeholder Group 0-5. Our shared vision and outcomes resulted in a comprehensive plan to address the *social-emotional development of children 0-5.* As the convener, I represented the Sacramento Area Black Caucus (SABC) and the Center for Collaborative Planning (CCP).

The 0-5 Stakeholder Group is diverse with a membership of over 25. Our members included: human services providers and researchers (content area specialists), parents, community members, representatives from local community based organizations, school districts, non-profits, governmental agencies, research institutions and health institutions. One outcome of this committee was the following recommendation: **"the social and emotional needs of young children birth to age five is a critical issue across all early intervention systems and needs to be addressed in a comprehensive way."**

I am writing to share my concerns and insights as an individual community member, not as a representative of the Stakeholder Group, regarding the Sacramento County's Draft Mental Health Services Act (MHSA) Three-Year Plan. Thank you for the opportunity to share my recommendations regarding the MHSA Three-Year Plan and future funding opportunities:

1. Integrity must be maintained throughout the process and by all groups. The community's input is vital to all aspects of the planning process (i.e. rating criteria, funding allocation and the overall plan). Please don't invite the community to participate in the planning process if the County is unwilling to honor the community's voice and value our time.
2. It is important in the next planning process that the funding allocation be pre-determined.
3. There needs to be a process by which funding amounts are equitably distributed among age groups.

4. The Steering Committee be should ethnically diverse and should include youth representatives, caregivers and parents of children/youth with a Serious Emotional Disturbance, and other groups.
5. Communication needs to be improved (and facilitated so that it is timely) between all groups (Stakeholder Groups, the Task Force, and the Steering Committee).
6. The proposal rating criteria must be consistent throughout the process.

Again, thank you for the opportunity to provide input on the MHSA Three-Year Plan.

Sincerely,

Faye Kennedy, Concerned Community Member
6 Rancho Torre Ct.
Sacramento, CA 95828
(916) 484-5025
fayek@springmail.com

cc: Darrell Steinberg, ESQ
Jim Hunt, Director of Department of Health & Human Services
Illa Collins, Sacramento County Board of Supervisors
Judy Lin, Sacramento Bee
Cameron Jahn, Sacramento Bee

11/16/2005

I had the honor and pleasure of serving as the convener for the Sacramento County Mental Health Services Act's Stakeholder Group 0-5. Our shared vision and outcomes were a comprehensive plan to address the *social-emotional development of children 0-5.* As the convener, I represented the Sacramento Area Black Caucus (SABC) and the Center for Collaborative Planning (CCP).

The 0-5 Stakeholder Group is diverse with a membership of over 25. Our members included:

- Parents/Consumers and Community Members
- Human Services Providers
- Researchers (content area specialists)

This diverse group also included: parents, community members, representatives from local community based organizations, school districts, non-profits, governmental agencies, research institutions and health institutions. An outcome of this committee was the following recommendation: "**the social and emotional needs of young children birth to age five is a critical issue across all early intervention systems and needs to be addressed in a comprehensive way.**"

Today, I am writing to share my concerns and insights as an individual community member and not as a representative of the 0-5 Stakeholder Group, the Center for Collaborative Planning (CCP) or the Sacramento Area Black Caucus (SABC) regarding the Sacramento County's Draft Mental Health Services Act (MHSA) Three-Year Plan.

First of all, the planning process provided the community a wonderful opportunity to develop a shared vision for mental health services and produce positive synergy. I personally witnessed first-hand everyone's creativity at work on behalf of quality mental health services for everyone.

I participated in the planning process in earnest and now I am very disappointed and sad that no children or youth proposals were recommended for final funding in the draft plan. Listed below are my concerns

1. I had the expectation that children and youth would be included. I would have understood that only adult programs would be considered if told so at the outset of the planning process.
2. The decision not to recommend funding for children and youth mental health services is unconscionable; it flies in the face of early intervention best practices.
3. I feel the integrity of the planning process and recommendations are questionable; the rating process was not consistent with the developed process or criteria.

4. The Steering Committee failed to understand the consequences of their actions (ignoring the planning process and community input). The Children's Task Force rated and ranked the 0-5 Stakeholders' proposal 10th, yet we were not recommended. The Steering Committee then chose to use new criteria entitled, "Bubble-up." Changing the rules without notifying all parties is unethical and creates distrust in government and the process as a whole.
5. The process failed our youth by ignoring their useful voices and the wonderful energy they demonstrated by developing and implementing a survey to engage local youth.

I was initially very excited about participating in the planning process, but all changed when I read the recommendations. At this time I am unwilling to continue to devote my limited time and resources to a flawed process unwilling to honor the community's voice.

Thank you for the opportunity to share my thoughts.

Faye Kennedy, Concerned Community Member

cc: Darrell Steinberg, ESQ
Jim Hunt, Director of Department of Health & Human Services
Illa Collins, Sacramento County Board of Supervisors
Judy Lin, Sacramento Bee
Cameron Jahn, Sacramento Bee

The Sacramento County Task Force for the education of Homeless Children and Youth would like to advocate once again that services be made available to children and families on or very near school campuses. This would allow for children/youth to access services with out losing excessive education hours. Currently most of the over 5000 students identified in Sacramento County

would benefit from MH services as studies have shown that individuals living in homeless situations show signs of PTSD after 3 days on the streets or in emergency shelter situations. Most of the children identified as homeless live with adults who have identified and/or not identified AOD/MH issues.

I was on both the Co-Occurring Disorder Stakeholders committee and the Children & Youth Task Force of the former committee I represented my voice for youth.

No proposals of the co-occuring disorders stakeholders went forward as "top 10" to the Steering Committee nor did any youth issues proposals.

I am very concerned about this because I do not believe that the EPSDT/Medi-

(over)

2/ Cal based youth Mental Health funding and the closely monitored small "other" funds meet youth MH needs in our County. Specifically, culturally diverse youth & dually diagnosed youth continue to be under-served, as well as non-Medi-Cal eligible youth.

From my work for many years with youth in both the MH & AOD System I believe that unserved MH youth get worse & become less approachable by the MH system as adults

3/ 2 of 2

Much good work was done by the Children & Youth Task Force and I urge the Committee not to bypass this age group with some [illegible] programs because youth are our future & they are more transformable than adults because they are still "in process."

Now, and in future phases of the MHSA Planning, give the youth voice an equal +

4/ high priority.

Co-occurring disorders are rampant in our youth population so please attend also to this as you plan, both for youth + adult programs, services + facilities!

Thank you. I have been honored to be involved and will continue to partner with MH not just because it's my job, but because I believe in the cause. Marguerite Storybaker
County AOD Youth Tx Prog Coordinator

- I'm here for Youth

- Don't think that EPSDT covers most youth MH needs – "small" part for non-Medi-Cal youth
  - cultural access need work
  - large proportion [illegible] of dually diagnosed youth MH & AOD issues
  - youth suffer stigma
- M. H youth unserved get worse & grow up to M.H. adults unserved. Let's help them early & make serving a better [illegible].

Attachment C

Comments on Co-occurring Disorders

>>AUDIENCE MEMBER: HI. GOOD EVENING. MELINDA H. AND I'M CHAIR OF THE ALCOHOL ADVISORY BOARD. I WOULD LIKE TO COMMEND THE MENTAL HEALTH BOARD AND THE DIVISION OF MENTAL HEALTH FOR THE PLANNING PROCESS OVER THE LAST SEVERAL MONTHS. SO MANY PEOPLE IN THE COMMUNITY PARTICIPATED AND THE VOICES WERE HEARD IS A REMARKABLE ACHIEVEMENT. YOUR LONG HOURS AND HARD WORK ARE EVIDENT.

WE HAVE BEEN ENGAGED IN THE PLANNING PROCESS AND COME AWAY WITH A DEEPER UNDERSTANDING OF WHAT MENTAL HEALTH CONSUMERS AND FAMILY MEMBERS FACE IN OUR COMMUNITY.

THOSE WITH (INAUDIBLE) MENTAL HEALTH AND SUBSTANCE ABUSE DISORDERS FACE EVEN MORE SERIOUS CHALLENGES. WE REGULARLY HEARD THAT THE STEERING COMMITTEE WANTED TO ENSURE THAT ALL NEW SERVICES ARE CAPABLE OF PROVIDING INTEGRATED AND EFFECTIVE SERVICES THOSE WITH DISORDERS. THE NEED IS GREAT; THE RESOURCES ARE LIMITED.

WE DO NOT CURRENTLY HAVE SUFFICIENT CAPACITY TO PROVIDE CO-CURRENT DISORDERS AND LACK OF CAPACITY LEADS TO A BARRIER OF RECOVERY TO A GREAT MANY OF CONSUMERS.

-- SUBSTANTIAL ABUSE DISORDERS RATED SECOND ONLY TO HOUSING WAS A PRIORITY TO -- THE MESSAGE WAS CLEAR. SO CLEAR IN FACT, THAT THE ISSUE OF CO-CURRENT DISORDERS WAS IDENTIFIED AS UNITED TO THE PLANS AS WELL AS THE CULTURAL COMPETENCY. WITHOUT THE CAPACITY BUILT IN TO PROVIDE MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT AND DIAGNOSE DISORDERS AND PROVIDE TREATMENT MANY CONSUMERS WOULD NEVER RECOVER NO MATTER HOW INNOVATIVE THE PROGRAM WAS.

WE URGE THE MENTAL HEALTH BOARD TO RECOMMEND THE DEPARTMENT OF MENTAL HEALTH THAT ALCOHOL AND DRUG CAPACITY BE FULLY INCORPORATED INTO THE MHSA COUNTY PLAN. AS WELL AS INTO THE COMPETITIVE BID AND SELECTION PROCESS FOR PROVIDERS. AND THE PROVIDERS AND COUNTY STAFF WHO WILL DELIVER SERVICES FUNDED BY MHSA RECEIVED O.A.D.T.I. TRAINING. THE COUNTY HAS ADOPTED A MODEL FOR THE INTEGRATION AS A CENTRAL STRATEGY AND WANT TO INCLUDE ITS INCLUSION AS WELL. ONLY WITH COMPREHENSIVE AND INTEGRATED MENTAL HEALTH SUBSTANCE ABUSE SERVICES WILL THE MANY CONSUMERS BE ABLE TO ACHIEVE THE QUALITY OF LIFE AND RECOVERY WHICH IS THE GOAL OF THE MENTAL HEALTH SERVICES ACT. THANK YOU.

Dawson. Nedra

From: Ives. Helane
Sent: Wednesday, November 30, 2005 1:09 PM
To: Harig. Richard
Subject: MSHA

My one comment, after review of the newsletter, is the absence of Alcohol and Drug issues as one of the major stumbling blocks of the Mental Health System. We have ancient relics working in a system that are so opposed to change - the staff at SCMHTC still hear alcohol or drugs and bounce people out that have truly significant mental health issues. Until we (the county) are willing to talk about the elephant in the living room, how can we affect change?. . . or yet, role model it for our surrounding community of providers or stakeholders. Alcohol & Drug services are paramount towards the future of sound mental health cares evolution in Sacramento.

Helane Ives
DHHS
Senior Mental Health Counselor
Alcohol & Drug Division

Sacramento County
Community Services and Supports
Plan

Memorandum

Comment Number: 155

SACRAMENTO COUNTY
DEPARTMENT OF

Health & Human Services

Administrative Services

Telephone: (916) 875-2002
Fax: (916) 875-1283
Mail Code: 37-1000A

December 5, 2005

TO: Richard Harig, Mental Health Services Act Program Manager

FROM: Toni Moore, Alcohol and Drug Administrator

SUBJECT: COMMENTS ON MENTAL HEALTH SERVICES ACT PLAN

I wanted to provide you with comments in writing that reflect prior communications I have had with you, Kathleen Henry and Ann Edwards Buckley and/or the MHSA Steering committee.

First, I want to commend the Mental Health Division on an exemplary public planning process. The process was well thought out, thorough, and inclusive. The initial training provided a concise overview to support the development of proposals. The number of people involved in the process was most impressive. This process serves as a good model for other DHHS planning efforts.

The configurations of the Steering Committees, Tasks Forces and Stakeholders groups were appropriate and inclusive. There was ample involvement for community participation. Working with consumers directly challenged our planning norms in a productive way.

The decision making process used by the Steering Committee worked well overall, with the exception of the handling of the PERT team proposal. I believe the group worked well together, even during times of disagreement. I was able to network with others. I particularly enjoyed the opportunity to get to know some of your Advisory Board members and consumer advocates.

The proposal to use MHSA funds to hire law enforcement officers was not supported by the Steering committee as a whole. I do support the concept of PERT teams, but do not support using MHSA funds for law enforcement positions. I believe there are other options that would be more cost effective and would lead to real capacity expansion, while achieving desired results.

I was disappointed that inaccurate information was provided to Mental Health Division staff about what service activities would be funded under the Mental Health Court proposal. Unfortunately, this information was presented to the Steering Committee and the public, resulting in the abandonment of support for this proposal. Even after I corrected the statement, there was no opportunity rectify the situation and therefore the proposal was not fairly evaluated. I continue to support the need for a Mental Health Court in the County and the use of MHSA funds for the mental health services components of the program. I hope that this will be considered when additional funding is available.

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Toni Moore
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Memorandum

Strategically, it may have been an error not to structure funding options in a manner that would ensure that at least one proposal from each Task Force was recommended for funding. It is my understanding that participants in the Children's Task Force and related Stakeholder groups were angry that no children specific proposals are being funded. It also caused some community leaders to drop out of the process and criticize the overall result. Unfortunately, this situation has created barriers with some children's advocates and community partners.

I expected to see alcohol and other drug (AOD) content in the proposals cited in the plan. When serving people with mental illness, addressing AOD issues should be a routine expectation, similar to addressing race, ethnicity and culture. The Mental Health Division and the Alcohol and Drug Services Division have already committed to building capacity to serve those with co-occurring needs, and the MHSA is an excellent opportunity to do so. AOD capacity was missing almost entirely from the plan. I am requesting that AOD content and co-occurring service capacity be (1) incorporated into the plan; (2) incorporated into the competitive bid and selection process for contract providers; and (3) that the providers and county staff hired to deliver services funded through the MHSA be mandated to participate in AODTI training and other trainings as appropriate that enhance co-occurring knowledge and skill development. I look forward to assisting with the above recommendations if needed.

With the above said, I believe the services and programs being recommended for funding are appropriate and will help address existing gaps. Dedicating the largest amount of funding to housing is important and should contribute to positive outcomes. The community assessment process clearly supports the need to enhance services for the elderly and the Asian/Pacific Islander populations. I am particularly supportive of the Wellness Center proposal. If future funding permits, expansion to other sites would be ideal.

I appreciate the opportunity to be involved in the MHSA planning process and the invitation to provide formal comment for your consideration in finalizing the County's plan.

C: Jim Hunt
Kathleen Henry
Ann Edwards-Buckley

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December 7, 2005

TO: Sacramento County Mental Health Board

FROM: Sacramento County Alcohol and Drug Advisory Board

RE: Mental Health Services Act Plan

On behalf of the Sacramento County Alcohol and Drug Advisory Board, I would like to commend the Mental Health Board and the Division of Mental Health on the MHSA planning process that has occurred over the past several months. The fact that so many people in the community participated and their voices were heard is a truly remarkable achievement. Your long hours and hard work are evident.

Our board has been actively engaged in the MHSA planning process, and we have come away with a deeper understanding of the challenges mental health consumers and their family members face in our community. Those with co-occurring mental health and substance abuse disorders face even more serious challenges. We regularly heard that the Steering Committee wanted to ensure that all new services are capable of providing integrated and effective services for those with Co-occurring Disorders.

The need is great. The resources are limited.

We do not currently have sufficient capacity to provide integrated treatment for co-occurring disorders, and this lack of capacity creates a significant barrier to recovery for a great many consumers. In the survey done at the outset of the planning process, co-occurring mental health and substance abuse disorders rated second only to housing as a priority issue in the adult and transitional age youth populations. The message was clear. So clear, in fact, that the issue of co-occurring disorders was identified as one of the Plan's umbrella issues along with cultural competency. It was recognized that without the capacity built in to provide integrated mental health and substance abuse treatment and without providers adequately trained to diagnose co-occurring disorders and provide appropriate treatment, many consumers simply would never recover, no matter how innovative the program.

We come this evening to urge the Mental Health Board to recommend to the County Department of Mental Health that alcohol and drug capacity be fully and explicitly incorporated into the MHSA County Plan, as well as into the competitive bid and selection process for providers, and that providers and county staff who will deliver services funded by MHSA receive AODTI training. We understand the County has already adopted a model for this type of integration as a central strategy and want to encourage its inclusion here as well.

Recovery is our shared vision. Only with comprehensive and integrated mental health/substance abuse services will the many consumers with co-occurring disorders be able to achieve the high quality of life in recovery that is the goal of the Mental Health Services Act.

Attachment C

Comments on Cultural Competency

Harig. Richard

From: MHSA
Sent: Monday, November 07, 2005 8:06 AM
To: Harig. Richard
Subject: FW: MHSA CSS Plan - Draft for Public Review and Comment

-----Original Message-----
From: Glenn Jorgensen [mailto:glenjrg@hotmail.com]
Sent: Friday, November 04, 2005 7:46 PM
To: MHSA
Subject: MHSA CSS Plan - Draft for Public Review and Comment

Mr. Richard Harig

I have read, with interest, this draft plan. My immediate concern is with the Transcultural Wellness Center. Considering the large Eastern European/Russian/Slavic population that our county is hosting, I do not understand how anyone can justify a wellness center that excludes this important segment of our population.

Thank you,
Glenn Jorgensen

Harig, Richard

From: MHSA
Sent: Tuesday, December 06, 2005 8:42 AM
To: Harig, Richard
Subject: FW: CSS plan comments

-----Original Message-----
From: Laura Leonelli [mailto:seacenter@sbcglobal.net]
Sent: Monday, December 05, 2005 11:56 AM
To: MHSA
Subject: CSS plan comments

Hello,
I would like to address some comments to the draft Community Services and Supports plan in advance, in case I don't get a chance to speak at the Public Hearing on Dec. 7th, or in case my comments would exceed the three-minute limit.

I am aware of the complaints that have been raised by several groups, including the Native American stakeholder group and the Romanian community represented by Dr. Marius Koga. I heard Dr. Koga's commentary on the NPR show 'Insight' (11/28/05), regarding the lack of mental health services to the large Slavic (Russian, Ukrainian, Bosnian, and Romanian) community in the greater Sacramento area. I know Dr. Koga and have respect for his concern and his unique perspective. However, I feel that these comments are being received late in the MHSA planning process.

I am the Executive Director of Southeast Asian Assistance Center, and I was the main organizer of the Russian/Slavic stakeholder group. At the time, I was also a participant in the Southeast Asian stakeholder group, as well as a member of the Cultural Competence Task force. I believed that the large Slavic community was important enough to be represented, but I did not expect to convene the group myself. As the planning process proceeded and no one else convened a Slavic stakeholder group, I decided to do it. Unfortunately, this occured only 3 weeks before the final planning deadline. However, we did convene a group representative of the Russian/Ukrainian community: the two Executive Directors of the largest social service agencies, Slavic Assistance Center and Slavic Community Center; and two Russian/Ukrainian Personal Service Coordinators at HRC. Focus groups were also conducted by a Russian PSC at Northgate Point as well as the two Russian interpreters at SAAC. We had good, substantive discussions of the mental health needs of this community, but we did not have the time to develop well-planned proposals. Also, there was some confusion about the term 'proposal' and 'recommendation' during the MHSA planning process. The Russian stakeholder group made "recommendations" for expanded, enhanced services to this ethnic community, to be delivered within the context of the existing mental health system. We did not discuss separate programs to be implemented by outside service providers, which would have required a much more detailed "proposal".

In contrast, the Asian-Pacific Islander Transcultural Wellness Proposal has been developed over several years by long-time stakeholders who have devoted much time and expertise to the planning process. This proposal reflects the community's response to a long-standing need, and the MHSA has made possible the means to finally address these unique cultural needs. I don't doubt that there are other communities with specific cultural needs that should also be addressed. However, I believe that the MHSA planning process has brought these cultural groups to the public's attention, which is a positive outcome. These ethnic communities should now lay the groundwork by convening a much larger

stakeholder network to begin their planning process for culturally-specific programs. They will have the opportunity to present their program proposals in future MHSA planning, which as I understand will be an annual process.

What I sincerely hope will NOT happen is that various ethnic/cultural communities in our wonderfully diverse area will compete against each other for scarce mental health resources. I don't believe that this will be in anyone's best interest. Thank you for your attention,

Laura Leonelli

Comment on Plan:

1) Specific AOD - integrated services (w/dually trained in one setting) needs to be robustly added to all proposals.

2) Penetration rate only does not adequately capture "underserved" While African Americans may have a "higher penetration" rate than other minority groups, they are more often homeless & receiving services in jail or juvenile hall - so something isn't "penetrating" These rates of homelessness & care in restricted settings are much higher than other ethnic groups.

3) I believe a broader definition of "culture" needs to be vibrantly & structurally represented in programs attempting to reach the underserved - While people say culture means more than culture & language - the focus in this plan is on culture & language. Please include specific language that defines culture as including all forms of diversity - diversity is the core concept here.

4) I also note that these programs (with the exception of the Transcultural Wellness Center) have no specific structures, positions or programs that specifically recognize the importance of involving significant others or providing services to them. It is a damaging stereotype to believe that only the API community needs family-based, one stop services - all groups are collectively-oriented when it comes to dealing with mental illness.

5) I also hope that there is significant attention to requiring evidence-based practices in RFP's for contracts for these programs. I am concerned that these very precious funds might be used for practices where there is no evidence for them being effective for treatment of mental health. Unfortunately some of these practices may reflect ethnic or holistic preferences - they cannot be funded simply on that basis. 6) DMH should include consumer/police sensitivity

Sacramento County
Community Services and Supports
Plan
Comment Number: 211

10/18/2005

Thank you for the information. Please be sure to include funding in the Community Services / Supports Plan for the Sacramento Native American Health Center and other Native organizations in the region that provide mental health services to Native peoples. You should already have copies of the local Native organizations' program proposals, if this is not the case let me know and I'll work to get them to you. Again, thank you for your assistance.

>>AUDIENCE MEMBER: HELLO. MY NAME IS M.K. I'M THE MEDICAL DIRECTOR OF THE ROMANIAN COMMUNITY. AND MOREOVER AS A FORMER POLITICAL REFUGEE, I RELATE AND SPEAK ON BEHALF OF THE BOSNIANS WHO SUFFER -- THE BOSNIAN PEOPLE, THE RUSSIAN PEOPLE, AND PEOPLE FROM EASTERN EUROPE. WE ARE ABOUT 20,000 STRONG IN THIS CITY. WE ARE THE LARGEST MINORITY, INVISIBLE WHITE MINORITY. PEOPLE THAT CAME FROM TRAUMA ESCAPED RELIGIOUS PERSECUTION. AND PEOPLE WHO ESCAPED THE BLOOD REVOLUTION OF ROMANIA. AND THEY HAVE BEEN NEGLECTED BY THE ACT THAT HAVE NOT BEEN CONNECTED WITH THE OUTREACH HAS COMPLETELY BYPASSED OUR COMMUNITY.

NEVERTHELESS, I DO UNDERSTAND AND APPLAUD THE WORK OF THE TASK FORCE. THE TASK THAT IS DAUNTING. WE DO NOT HAVE AN EXPERIENCE OF ADVOCACY. THEY ARE NOT AMERICANS. THEY LIVE IN A RUSSIAN SOCIETY OR ROMANIAN SOCIETY. THEY DO NOT INTERFACE. THEY EXPECT YOU TO COME TO THEM TO DO THEIR OUTREACH. WE DIDN'T HAVE ANY CHANCE TO WRITE ANY PROPOSAL. I COMMEND THE WORK OF SO MANY PEOPLE HERE SUPPORTING THEIR PLAN. WE DON'T HAVE A PLAN. WE REQUEST AN ADDITION TO YOUR DRAFT. WE REQUEST SEVEN DAYS. I CAN WRITE A PROPOSAL FOR A TASK FORCE OF THE EASTERN EUROPEAN MENTAL HEALTH TO COME TOGETHER TO DO A NEEDS ASSESSMENT AND DETERMINE WHAT IS RIGHT FOR US AND ADDRESS THE MENTAL HEALTH SERVICES IN SACRAMENTO.

I WAS TOLD THAT VERY KIND LADY WHO IS HELPING US IS DR. MAUREEN WONG IS WILLING TO TAKE THE ROMANIAN COMMUNITY UNDER HER GROUP WHICH IS THE REFUGEE POPULATION GROUP AND IT'S VERY CONSIDERATE. WE WOULD TRY TO WORK WITH HER. HOWEVER ROMANIANS DO RELATE TO RUSSIANS AND EASTERN EUROPEAN. IT IS IMPORTANT TO HAVE A TASK FORCE RATHER THAN A SMALL REFUGEE POPULATION. THANK YOU. (APPLAUSE).

>>AUDIENCE MEMBER: (SPEAKING SPANISH). I'M GOING TO BE SPEAKING IN SPANISH AND HERE IS MY INTERPRETER.

FIRST OF ALL MY NAME IS MARCIA AND I'M A MEMBER OF THE STEERING COMMITTEE AND WORKED FROM THE BEGINNING WITH THE GROUP.

FIRST OF ALL I WOULD LIKE TO GREET MY BROTHERS AND SISTERS FROM THE CHINESE AND KOREAN COMMUNITY WHO HAVE A GREAT RESPONSE TO THE ISSUE. AND AS YOU CAN SEE, THERE WAS NO RESPONSE FROM THE LATINO COMMUNITY.

THAT SHOWS YOU THAT AS A LATINO WE HAVE A STIGMA AND WE ARE TRYING TO REACH FOR MENTAL HEALTH SERVICES. WE ARE SCARED AND WE ARE NOT THERE AND MANY OTHER MINORITY GROUPS WILL NOT HAVE THAT FEAR.

I WAS CHECKING ON THE PROPOSAL THAT WAS PART OF AND IN ANY OF THE PROPOSALS, THE LATINO COMMUNITY IS MENTIONED. AS YOU MENTION THE OTHER ETHNIC GROUPS, IN NONE OF THE PROPOSALS IS THE LATINO COMMUNITY MENTIONED.

WE HAVE TO KEEP IN MIND THAT SOME OF THE CONSUMERS ARE WORKERS AND THEY DON'T HAVE THE RESOURCES TO GO AND SEARCH FOR THE HELP. AND I WOULD LIKE YOU TO TAKE THAT INTO CONSIDERATION WHEN YOU WRITE THAT PROPOSAL. GRACIAS. (APPLAUSE).

>>AUDIENCE MEMBER: GOOD EVENING. MY NAME IS A.R. I'M WITH LA FAMILIA COUNSELING CENTER. I'VE WORK WITH THE COMMUNITY FOR MANY, MANY YEARS. THE LATINO IS ONE OF THE FASTEST GROWING POPULATIONS IN OUR STATE AND SACRAMENTO COUNTY AND IT CONTINUES TO BE UNDERSERVED AND HAS BEEN UNDERSERVED FOR MANY, MANY YEARS.

I URGE THE PROGRAMS THAT ARE BEING RECOMMENDED FOR FUNDING TO REALLY MAKE A COMMITMENT AND MAKE SURE THAT THE SERVICES ARE GOING TO BE CULTURALLY AND LINGUISTICALLY APPROPRIATE TO MEET THE NEEDS OF THE MINORITY POPULATION AND THE LATINO POPULATION.

>>AUDIENCE MEMBER: I'M DR. L.A. WITH THE COMMITTEE CENTER OF SACRAMENTO. DR. KOGA HAS SPOKEN ON BEHALF OF OUR COMMUNITY OF 20,000 ROMANIANS. I AM HERE TO SUPPORT HIS REQUEST TO YOU TO ALLOW (INAUDIBLE) COMMUNITY TO SUBMIT A PROPOSAL. WE WANT TO HAVE OUR INITIATIVES WORKED BY OUTREACH AND ENCOURAGEMENT FUNDING. THANK YOU.

Question: What was the ethnic make-up of the people that determined the "cultural, ethnicity & gender, sensitive" issues to be provided? Although some ethnicities are low in percentages in some areas of state, proper representation should be provide

(1)

- Good Evening - Buenas Noches

- Maurice Camarena - Member of the Stakeholder Committee who worked since the beginning to brainstorm ideas how to serve our Latino Community.

I would like to point out that it seems that some of the issues we brainstormed were not included

② In the Executive summary

things such as:

- Mental Health Services for our Migrant Farm workers
- Reaching out to Rural Areas where these workers are.
- Having Spanish-Speaking staff

(3)

- Serving those in need even though their legal status is not up to date.

- Compliments
Permanent Supportive Housing
- Great for Foster Youth

Attachment C

Comments on
Galt Stakeholders

Dawson. Nedra

From: Sharon Gilles [sharongilles@sbcglobal.net]
Sent: Wednesday, December 07, 2005 8:21 AM
To: MHSA
Subject: Comments Regarding The Mental Health Services Plan

Please review the comments that have been gathered from Galt Stakeholders. we look forward to future dialog and opportunities for input!

To: Sacramento County Mental Health Board of Directors
From: Galt Stakeholders
Date: December 6, 2005

In reviewing the Executive Summary of the Mental Health Service Act three year program and expenditure plan and after talking to Sacramento County Mental Health Staff from the Department of Health and Human Services, it is once again evident that homelessness and the mental health and dual diagnosis needs of rural South Sacramento County residents are once again not a focus nor a priority for the Department of Health and Human Services. We do not believe that this fact is intentional, but rather based on unawareness and on the fact that because there are so many unmet needs of the urban population in Sacramento and other urbanized areas of Sacramento County that their task to change the system is so overwhelming that the larger urban population take preference over the south county rural area population.

We have Homeless!! We have many mental health issues!!! We have cultural diversity!! In fact the Hispanic population of Galt is approaching 40%. In the River Delta Area of South Sacramento County the population has reached over 50%. WE HAVE DIFFICULTY WITH ACCESSING SERVICES IN SACRAMENTO!! WE HAVE A SHORTAGE OF CULTURALLY DIVERSE MENTAL HEALTH AND DUAL DIAGNOSIS TREATMENT SERVICES!! WE HAVE A SHORTAGE OF PERMANENT SUPPORTIVE HOUSING!!!

As mentioned in the Executive Summary, the President's new Freedom Commission on Mental health's Interim Report to the President stated "... The mental health delivery system is fragmented and in disarray...leading to unnecessary and costly disability, homelessness, school failure and incarceration." The fragmented system leads to gaps in care for children and adults with serious mental illness. In order to provide services to this population, there must be a transformation in the delivery of mental health services in the community.

We wonld like to add, that in the case of Sacramento County, inclusiveness should be added to the scenario. The population in south Sacramento County is not that large, but access to services in Sacramento is very difficult when you have no car, an old car that may break down on the freeway, not much money for gasoline or you're an older adult that has no transportation. You can take the local transit system which will take a great deal of time because you stop in Elk Grove and then proceed on to 65th Street and Florin Road where you catch a connector bus. You may have to take more than one connector bus. If you have to go to Sacramento twice a week for a drug test because you are a client of the CPS system, along with having a dual diagnosis of drug addition and mental illness and you have a limited income, what are your chances of following through? What are your chances of getting the needed mental health services that you need?

If you are homeless and we have a homeless population in Galt, in fact it was reported by an outreach counselor from the local Galt Joint Union Elementary School District

that we had 39 families reported during this past school year. Those numbers do not include the homeless that are single individuals walking the streets day after day, Many of these individuals are substance abusers and have mental health issues. The number of homeless walking the streets of Galt and the River Delta Area has substantially increased over the past 2.5 years.

We are providing our input because many of us are the human service professionals that are attempting to care for and provide services to the "human beings" that live in our communities in the rural areas of South Sacramento County. We want to be recognized as being a part of Sacramento County and have focus placed on meeting our mental health needs and addressing the issues and barriers that many rural residents face.

There have been persistent difficulties in meeting the health and mental health needs of those living in rural areas. It has been recognized for some time that people living in rural America are more likely to be without a regular source of health insurance, a regular health care provider, and to be coping with higher levels of chronic and/or serious illness than people in urban areas (Norton and McMannus, 1989). Several publications including Beeson et. Al., 1998; Holzer et.a., 1998;mmLarson, et, al., 1993; Pion, et.al., 1997; Wagenfeld et. Al., 1988 and 1994, have discussed the general themes and challenges of rural mental health which include but are not limited to: mounting needs and limited resources; unique geographical and cultural challenges to service delivery; severe shortages of professional staff; inaccurate assumptions imposed by funding sources or regulators; lack of coordination among funding sources; and consistent misunderstanding of rural realties by State, County and national policy makers.

The following problems and issues were noted in the Rural Mental and Behavioral Health Policy and Action Agenda with Recommendations to the Federal Department of Health and Human Services. This list is not inclusive of all the problems and issues cited, but reflect many of the problems and issues that we face here in South Sacramento County when dealing with funding and resources to better serve individuals, children, youth, families and our older population.

PROBLEMS AND ISSUES:

* Reimbursement requirements that do not address rural realities
* Primary care providers who do not address mental health care
* Stigma as an enduring issue
* Lack of cultural competence in spite of increasing diversity in our area
* Severe shortage of specialized and basic mental health providers for the population at large
* Unaddressed behavioral health care needs of rural women
* Lack of technical expertise/capacity in many rural mental health clinics and providers
* Consumer leadership/support is more difficult to generate in rural areas
* Distance and transportation difficulties lead to problems with accessing care
* Need to establish rural mental health as a priority in public policy and funding
* Funding systems are complex and fragmented leading to increased costs for providers

* Scholarships and grants for training have been significantly reduced
* Mental health/substance abuse benefits are not generally included under many health insurance plans
* Prescription drug benefits are not generally available, especially to the self employed
* Federal, State and County governments operate under urban models and assumption
* Lack of support services (i.e. affordable housing, comprehensive rehabilitation programs)
* Lack of peer support services and consumer led groups
* Lack of support for care givers, professionals and families
  Limited capacity of rural providers to compete for funding as a part of a network due to organizational capacity/expertise and use of urban criteria for contracts.
* The cost of service delivery is often greater in rural areas due to low volume
* Shortage of specialized providers for rural children and adolescents

PROGRAMS AND ACTIVITIES THAT WORK

- Home Community Based Services Waiver (Medicaid), flexible, cost reimbursement
- Treating mental health as an economic issue
- Community based programs that involve the entire community
- Train consumers to be providers
- Advocacy training
- Cost based
- Flexibility
- Reaching out to primary care providers
- Accountability/flexibility
- Less Stigma
- More open in rural area
- Tele health programs that help accommodate accessibility
- Direct funding
- School health clinics
- Includes in-home services
- Made directly to community based organizations
- Policies strategies that allow providers to work through a variety of delivery mechanisms
- Rural specific data/research findings
- Agencies and workshops that provide financial support for rural consumers, families and clinicians to participate in various projects
- Support rural organizational development and effective operation through technical assistance and direct funding

In summary, when you allocate the funding for "Mental Health Services" under the Mental Health Services Act, remember us when it comes to providing satellite services or providing technical assistance to develop a local culturally diverse Wellness Center or local volunteer PERT team in Galt to addresses the mental health issues and needs of rural residents. Remember us when it comes to developing permanent supportive housing for individuals and families. For questions or additional information, we can be reached at (209) 481-7515 or (209) 7445420

Attachment C

Comments on In-County Services

December 4, 2005

To Whom it May Concern:

I am a stakeholder in the implementation of the Mental Health Services Act (MHSA). My sister, Mary Heinrich, is mentally ill. She had been at Crestwood Manor at 2600 Stockton Blvd., Sacramento, CA, for many years. Most of her family, including her parents, live in Sacramento. While she was at Crestwood Manor, at least once a week I, or my sister, Eileen Heinrich, visited her. We frequently took her out to parks or restaurants, so she could at least have some contact with the outside world. Her parents frequently visited her. Occasionally, her other brothers and sisters visited. She also had a friend at Turning Point, located on Stockton Blvd. close to Crestwood Manor, visit. She did not have a great life, but at least she was able to frequently visit with her friends and family and get out in the community.

Here is Mary's story since the passage of the MHSA:

1. Crestwood Manor obtained a new licensing arrangement without notifying Mary's family. This new license allowed them to cease their care of people requiring secured facilities. This resulted in Sacramento County having no place for people like Mary.
2. After the re-licensing, my sister was transferred to Crestwood in Eureka, again without prior family notification. I discovered this the day before she was transferred. I discovered this from one of the other patients at Crestwood.
3. After many frantic calls to my sister's conservator and Sacramento Mental Health, my sister was temporarily returned to Crestwood in Sacramento.
4. I was told that Crestwood in Sacramento had changed its license to provide more rehabilitation and my sister did not "fit the criteria."
5. Mary was then transferred to Crestwood in Modesto. On two occasions when I visited Mary in Modesto, she appeared old, depressed and had become very uncommunicative. This is very unlike my sister, who loves people and will talk to almost anyone.
6. My parents, who are elderly and frail, visited her once during her stay in Modesto. My father made this drive, even though he was being treated for pneumonia at the time. It turned out that he did not have pneumonia, but undiagnosed pulmonary embolism when he made this trip. Pulmonary embolism is a highly lethal condition, especially when undiagnosed.
7. I met with the supervisor of Mary's conservator, and a representative from Sacramento County Mental Health. They told me they had actually worked with Crestwood in Sacramento to change their license to preclude them from accepting people who require secure settings. **They told me there are no places in Sacramento County to place people who require secure settings**. I told them of the negative health impact this was having on Mary and the continuing hardship the long distance was putting on my family.

8. As a "make-shift" solution, Mary was transferred to Vintage Estates at 501 Jessie Ave., Sacramento. Vintage Estates is an elderly care facility focusing on people with Alzheimer's disease and dementia. There were no specific programs for Mary's illness and, although Mary knew a few of the staff there that came from Crestwood. Most of the staff were not specifically trained to handle the special needs of a patient like Mary.
9. Mary was recently "evicted" from Vintage Estates. She was transferred to the Sacramento County Mental Health Treatment Center, a "Crisis Clinic" intended for short stays for evaluation before transfer to another location. **Sacramento County currently has no place to put my sister.** The only place available for her is Crestwood in Modesto. This is the place where she became despondent. This is the place that is a hardship for my family to visit and where her friend from Turning Point cannot visit. I believe my sister will die, if she is transferred to this place indefinitely.

I would like the following questions answered:

1. With all this new money coming in to Sacramento County for the mentally ill, how does Sacramento County justify the treatment of my sister since the passage of the MHSA?

2. Who decided my sister could not be rehabilitated?

3. How does Sacramento County justify "warehousing" my sister, i.e. putting her in a place far from her family and friends with so little therapy or education that she becomes depressed?

Darrell Steinberg said he would like Sacramento County to become the model County for the MHSA. How can this happen when Sacramento County treats its mentally ill so poorly? According to the Sacramento chapter of the National Alliance for the Mentally Ill, about 107 mentally ill people from Sacramento County have been transferred out of the County. How can Sacramento County justify not dealing with this problem, when the MHSA specifically states that the money is to be used for those not currently served? The MHSA and the Sacramento County website both stress the importance of family and community in the treatment of the mentally ill. Sacramento County has ignored these things for the 107 people transferred out of the County.

My family was shut out of the MHSA planning process. On their website, Sacramento County emphasizes that they did outreach to family members and that family members provided input into the MHSA planning. My family was not aware of this planning process until my sister was transferred to Eureka. How does Sacramento County justify not notifying the family members of the mentally ill in Sacramento of this planning process?

After we became aware of the fact that Mary's transfer was because of the MHSA, my sister Eileen and I became trained to become stakeholders in the MHSA process. My sister, Laura, wrote, and I submitted, our family's proposal by the deadline of June 14, 2004. I have confirmation that this proposal was received on time. The proposal was never rated by the Adult Task Force Stakeholder Group. I went to the first meeting of this group I knew about. I discovered that a different proposal, which included a similar weaker request, had been discussed at the previous meeting and had already been rated.

I am distraught at the above outlined events. My family has been shut out of this entire process. We did not know Crestwood in Sacramento changed its license and that there were no places in Sacramento for mentally ill people who require secure settings until it was done and my sister was transferred. We did not know that the MHSA could adversely effect my sister's well being until it was too late to provide meaningful input. The input we were able to throw together at the last minute was disregarded.

This process has been heartbreaking. My sister has been treated as a "throwaway." Even though she is mentally ill, she is not stupid. Just as important, there are others like Mary, who have been "dumped" in other facilities outside of Sacramento because of lack of secured facilities.

Sacramento County's reaction to the MHSA has brought my sister and my family nothing but grief. When I voted for it, I never thought such a terrible outcome was possible. I thought that finally, my sister would get some much needed therapy. Sacramento County has been hypocritical and uncaring in its treatment of the mentally ill.

I would like my concerns, as expressed above, addressed and my questions answered. I would like to know, most of all, **what is going to happen to my sister?**

Barbara Heinrich

Barbara Heinrich
4690 58th Street
Sacramento, CA 95820

Dawson. Nedra

From: Annalisa Jones [annalisa6336@sbcglobal.net]
Sent: Thursday, November 03, 2005 3:59 PM
To: MHSA
Subject: plan for new services

Mr. Harig,

I wanted to express my complete support for the first draft plan for new services under the Mental Health Services Act. My mother, Karla Thompson, has been at Sacramento County for 10 days, and they have not been able to find adequate placement for her. She arrived at Sac. Co. after a suicide attempt, and attempted to tie a sock around her neck while at Sac. Co. My mother is Bi-Polar and this is her eleventh attempt at suicide. Without adequate treatment, it will not be her last. Yet, even though this may be the case, as of last night, her social worker was considering a half-way house or a homeless shelter. Both of which would allow my mother to walk to the local convenience store to buy supplies for her next attempt, not to mention the fact she would not be getting the psychiatric care she needs.

I will be there in December for the public hearing in order to show my support. This plan is actually my glimmer of hope that someday my mother will get the help she so desperately needs. Please e-mail or call me if I can help in any way in order to further along the process of putting this plan into action.

Annalisa Jones

916-719-5505

annalisa6336@sbcglobal.net

>>AUDIENCE MEMBER: MY NAME IS BARBARA H. I HAVE A SISTER WHO IS MENTALLY ILL. SHE'S BEEN IN THE SYSTEM FOR MANY YEARS. SHE'S BEEN IN A SECURED SETTING.

MY FIRST ENCOUNTER WITH THE MENTAL HEALTH SERVICES ACT WAS WHEN SHE WAS TRANSFERRED TO EUREKA. WE FOUND OUT THAT SACRAMENTO COUNTY AND CONSERVATOR HAD WORKED WITH CRESTWOOD TO CHANGE THEIR LICENSE. I FOUND OUT SINCE THAT THERE'S NO PLACE IN SACRAMENTO WHO BELONG IN SECURED SETTINGS.

WHEN WE COMPLAINED ABOUT HER BEING IN EUREKA, SHE WAS SENT BACK TO MODESTO. SHE DIDN'T KNOW ANYONE. SHE BECAME DEPRESSED AND UNCOMMUNICATIVE. AND THIS IS TOTALLY UNLIKE MY SISTER. SHE LIKES TO TALK TO ANYONE.

THE CONSERVATOR DID A MAKESHIFT SOLUTION AND TRANSFERRED HER TO VINTAGE ESTATES A PLACE FOR ALZHEIMER'S PATIENTS. SHE WAS EVICTED AND PUT IN THE CRISIS CLINIC. MY FAMILY AND I TRIED TO BECOME INVOLVED IN THE MENTAL HEALTH SERVICES ACT PROCESS. WE BECAME STAKEHOLDERS. WE TOOK THE TRAINING AND WE WROTE UP A PROPOSITION AND GOT IT SUBMITTED BEFORE THE DEADLINE. IT WAS NEVER HEARD. IT WAS NEVER DISCUSSED.

I JUST FOUND OUT THAT THE DAY BEFORE YESTERDAY SHE WAS TRANSFERRED BACK TO CRESTWOOD MANOR WHERE SHE WAS ORIGINALLY.

I DON'T HAVE -- TIMING IS EVERYTHING. AND THERE'S NO ASSURANCE SHE'S GOING TO STAY THERE AND AFTER ALL THIS IS DONE WE DON'T KNOW WHAT'S GOING TO HAPPEN. MENTAL HEALTH SERVICES ACT AND SACRAMENTO COUNTY WEBSITE SAYS IT'S IMPORTANT FOR THE FAMILY TO BE NEARBY AND THE COMMUNITY TO BE INVOLVED IN MENTALLY ILL PEOPLE. THIS FLIES IN THE FACE OF THAT. I'M ASKING FOR SACRAMENTO COUNTY TO PROVIDE SERVICES FOR THE MENTALLY ILL IN THEIR OWN COUNTY. (APPLAUSE).

AND I THINK IF DARRELL STEINBERG WANTS SACRAMENTO TO BE THE MODEL FOR THE MENTAL HEALTH SERVICES ACT, HE SHOULD TAKE THIS INTO ACCOUNT AND MAKE SURE IT HAPPENS. THANK YOU. (APPLAUSE).

Attachment C

Comments on Mental Health Court

Superior Court of California
County of Sacramento

TALMADGE R. JONES
Judge

December 5, 2005

Sacramento County
Community Services and Supports
Plan
Comment Number: 97

Hon. Roger Dickenson
Chairperson
Board of Supervisors
County of Sacramento
Sacramento, CA 95814

Re: **Mental Health Court**

Dear Supervisor Dickenson:

The Intermediate Punishments Committee ("Committee")[1] of the Sacramento County Criminal Justice Cabinet urges the Board to fund from the Mental Health Services Act (Proposition 63, or "Prop 63") a Mental Health Court to serve a large population of defendants with serious mental illness.

As a result of over one full year of planning, the Committee plans to implement a Mental Health Court in March 2006, but will be deficient in the funding of several important positions critical to the court's success.

Recent efforts by the Committee to fund mental health programs for the Mental Health Court under Proposition 63 ("Prop 63") were not successful because, in its Prop 63 planning documents, the committee inadvertently stated that in addition to mental health services, Prop 63 monies would be used to fund *law enforcement positions*, such as a deputy district attorney and others.

This error was of course unacceptable to the Prop 63 planning groups. Our error resulted in the Mental Health Court project, a very good idea, being relegated to Prop 63 funding in the future.

The Committee wants you to know that we will be eagerly seeking Prop 63 monies in the next round of funding from the initiative.

[1] The committee is made up of a wide collaborative of major county agencies, including the District Attorney, Public Defender, Probation, Department of Health and Human Services, Department of Mental Health, Consumer representatives, and many others.

720 Ninth Street, Department 31, Sacramento, CA 95814
(916) 874-6353 • FAX (916) 874-8229

Background

By way of background, the Sacramento County Jail houses approximately 2,400 inmates. 34% of these (or 823 defendants) receive mental health services, and 24% (or 580 defendants) receive some form of prescribed medication. The more seriously ill defendants are treated in jail as "inpatients" in a 17-bed psychiatric treatment facility operated within the jail.

Because of the involvement of UCD (a highly regarded teaching university hospital) in the provision of its mental health services, Sacramento is proud of the fact that it operates one of the most progressive, professional, and responsive mental health programs in the nation for incarcerated individuals.

Yet, like other communities, Sacramento's mentally ill defendants are often caught up in the criminal justice system because of their inability to connect with (or to remain in) community-based treatment services. Each day this court is faced with defendants:

- whose mental health problem has never been properly diagnosed, let alone treated;
- who are non-compliant and refuse to take their prescribed medications, or worse, have used street drugs in lieu of their prescription;
- whose illness is so acute that they cannot properly communicate with their legal counsel;
- who overwhelm the abilities of law enforcement to deal with them, and return to custody over and over again;
- who are chronically self-injurious with borderline personality disorders, or who are antisocial and malinger (feign) mental illness; and
- who have no trust in either the Court, counsel, or the criminal justice system.

Mentally ill offenders are frequently cyclical, caught in a revolving door of arrest – treatment – stabilization – release – absence of treatment – aberrant behavior – then rearrest. The criminal justice stakeholders (the courts, mental health professionals, prosecutors, defense bar, probation officers and others) must come to grips with this well-known web of recurring events in which the mentally ill offender is caught.

Nationally, special Mental Health Courts have been shown to reduce recidivism, reduce jail bed space, and improve the treatment of defendants with mental health issues. This has been true in Riverside, San Bernardino and Santa Clara Counties, all of which were studied by the Committee.

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Through its planning process, the Committee has established *common values* for the Mental Health Court; the *target population* of defendants to be served; and *qualifying crimes* . Presently, the Committee is establishing further *statistics and trends* about this population; *desired outcomes* of the program; the *nature and format* of mental health services to be provided; and a *Mental Health Court budget*.

Conclusion

Given the county's interagency accomplishments in the past, particularly through the collaborative efforts of the Criminal Justice Cabinet, and with the potential financial assistance provided by Prop 63, we have no doubt that a Mental Health Court could be developed that would effectively divert and/or treat criminal offenders with a mental health problem.

A well-planned, well-run Mental Health Court in Sacramento County will make the community safer, reduce incarceration, produce a better quality of life for mental health defendants, and reduce recidivism.

The attendant savings to the taxpayer in the form of incarceration and law enforcement costs would alone be well worth the effort.

But more importantly, the ability to stabilize the lives of truly ill individuals is a monumentally worthy and humane undertaking that we should do as quickly as possible.

Mentally ill persons who are incarcerated and are unable to care for themselves deserve our very best efforts. We must find treatment modalities that will shorten their stay, make them well, and return them to their families who are best able to stabilize their future endeavors.

Supervisor Dickenson, I'm sure the Board agrees that a Mental Health Court is a worthy project. In the second round of Prop 63 funding, the Committee will be urging the Board to fund, at least partially, a Mental Health Court for Sacramento County.

Very truly yours,

TALMADGE R. JONES
Judge of the Superior Court

:

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Attachment C

Comments on
Older Adults

Dawson. Nedra

From: Hester001, Robyn [Robyn.Hester001@chw.edu]
Sent: Friday, December 02, 2005 9:57 AM
To: MHSA
Subject: Executive Summary

To: Sacramento County Mental Health Board
This message is in response to the MHSA Executive Summary. As a member of the community, a stakeholder, a family member of a consumer, and a clinician serving the older adult population, I am in much support of both proposals which will serve older adults. I think this is a grossly underrepresented and underserved population, and I am extremely pleased to see that there will be more services available. I strongly encourage the funding of both the Older Adult Multidisciplinary Crisis Intervention, Stabilization, and Intensive Case Management Program, and the Older Adult Intensive Services Program. Thank you for your time and consideration.
Sincerely,
Robyn Hester-Klein, MSW

Sacramento County
Community Services and Supports Plan

Comment Number: 136

Mona Moxley

7 December 05

Mental Health Board of Sacramento County,
Mental Health Service Act Team,

It is difficult to comment on the Plan, as all the proposed programs are sorely needed, as well as the other 136 programs that were proposed.

I am extremely upset over the revision of Mental Health Service Act Community Services and Supports Plan. I have a specific concern about the loss of a program to serve Older Adults and several concerns about the process.

Failure to serve un-served population: As I understand it, the Mental Health Service Act was created to design and deliver services for the underserved and un-served individuals.
In the federal census conducted in 2000, 178,183 individuals, 60 years or older, were living in Sacramento County, and this number is increasing significantly each year. Last year, according to the Older Adult Profile, Fiscal year 04/05, published by the Division of Mental Health, regarding Research, Evaluation, and Performance Outcomes, 1323 Older Adults, 60 years of age received **any** out-patient services. [**.7%**] The Revised Plan aims to serve 200 more Older Adults, bringing the percentage to .8. In my mind, this dismal figure is the definition of an un-served population.

Institutional Ageism: Statements have been made at Steering Committee meetings that indicate that members of the community believe that services to Older Adults are simply an extension of services for Adults. For a lucky few, this is true. For a majority of Older Adults, services are significantly complicated, by medical, environmental and societal issues. This view of sameness is institutional ageism, at its baldest.

Arbitrary movement from one funding stream to another: Thirdly, when the Steering Committee voted in July on "final recommendations", various proposals were assigned to different segments of the funding stream.

In the published Plan, and the revised Plan, one of the Full Service Partnerships Proposals [T-CORE] has migrated to System Development, and now, in the revised Plan, has muscled out the third ranked System Development Proposal.
In essence, 4 of the proposals endorsed for Full Service Partnerships are being forwarded, and 2 from System Development. As I understand it, funds were to be divided 51%-49%.
How is it that the Plan can be revised at will, and at the same time, staunchly adhered to? Adherence to the recommendations of the Steering Committee was the argument used to call and second, and in fact, a third vote on the PERT proposal. This clear contradiction must be addressed. I question the migration of a plan from one funding stream to another.

Funding PERT in a vacuum: Fourthly, as I stated at the sub-committee of the Steering Committee on 30 November, I feel it is extremely dangerous to consider funding PERT "in a vacuum". If PERT is enacted, the need for follow-up referrals, stabilization and intensive case management will be enormous. In the revised Plan, the funding for T-CORE, arguably the first line referral source for PERT has been cut, by 25%. It seems to me the antithesis of transformation to fund a program that has

very limited follow-through, due to lack of appropriate funding. If MHSA does fund PERT, it is imperative to do so with adequate referral sources, i.e., significantly funded T-CORE.

Process:
Many have spoken to process issues: in Committee meetings, meetings behind closed doors, some have even gone to the media with their spin on MHSA process. Large group processes are inherently problematic, otherwise we would not need a government. We proved it in this process.

It is my hope that as a community we learn from the flaws in the process just enacted: un-clarity about authorization and roles; power struggles; political posturing; the universal pain of "assumptions"; the high cost when consensus rules are arbitrarily applied based on the requestors political power; the pain of disillusionment when ideals cannot be enacted; the joy of engagement.

If we do not learn and address the specific lessons from this engagement, we will be left, as I am, with the daily despair of serving an invisible constituency, with little political power and the clear knowledge that the invisibility remains.....as all the hope once sparked trickles away.

Respectfully submitted,

Mona Moxley

Dawson. Nedra

Caroline Prod

From: c.prod@att.net
Sent: Thursday, December 08, 2005 9:53 AM
To: MHSA
Subject: Draft CSS Plan

December 7, 2005

I actively participated in Sacramento County's efforts to implement the Mental Health Services Act. I was part of the Older Adult Co-Occurring Mental and Medical Health Needs Stakeholder Group and am a member of the Older Adult Task Force. I have enjoyed being part of the process to implement this legislation, am proud to have collaborated with so many smart, caring individuals, and will continue to lend my time and support to improving mental health services in our community.

Despite a flawed and very poorly executed process and my belief that an objective and structured process would have produced a better result, I support the plan the county has produced. I recognize the challenges faced by all involved in this process. I have been touched and reassured by their sincerity, compassion, and very strong commitment.

My comments, however, are my own and not as a representative of any group. I am a long-time resident of Sacramento and the daughter of a woman who has paranoid schizophrenia. My mother was diagnosed in 1982. In 1983, my mother lost custody of her children. In 1987, she was determined to be unfit for duty due to mental illness and she lost her job. Ironically, her employer was Sacramento County. In 1988, she became homeless. In 1992, the small amount of money that she had was frozen by the IRS because of several years of unpaid taxes. Incidentally, Sacramento County, did not consider her to be homeless until that happened. Starting in 1988, she stayed with my sister or me for brief periods, she stayed in motels, she occasionally stayed in a shelter. Starting in 1992 when her money was gone and the county considered her homeless, she stayed literally on the streets. She stayed in 24-hour restaurants and in doorways of businesses. She let me put her in a motel occasionally. Her mental and physical health deteriorated to an alarming and dangerous state. Then, in November 2004, the Sheriff responded when she fell in a parking lot. Finally, Sacramento County petitioned the court to place her on an LPS conservatorship.

My mother had lost her children, her home, her livelihood, her health, her teeth, her peace of mind, and all prospects for a full and meaningful life before the system would even acknowledge that she needed assistance. Twenty-two years. This is our system. I find it shameful.

I am extremely concerned – frightened, really – about the system that is not addressed or affected by this plan or the Mental Health Services Act. The system that will continue to exist outside of Mental Health Services Act programs. I am troubled about the two very different systems we will have in this county. One that provides very rich services to a relatively tiny number of people, and one that everyone agrees is broken. This broken system will be the only available avenue for most people needing services. At its very best, this system is fragmented, difficult to access, and inadequate. And yet, the vast majority of mentally ill individuals will be served by this system. This system that took 22 years to provide any help to my mother. Please do not neglect this system. Please.

Thank you.

Caroline Prod
9824 Pipit Way
Elk Grove, CA 95757
916/204-4512

Attachment C

Comments on PERT

DEPARTMENT OF POLICE

ALBERT NÁJERA
CHIEF OF POLICE

STEVE SEGURA
DEPUTY CHIEF OF POLICE

RICK BRAZIEL
DEPUTY CHIEF OF POLICE

CITY OF SACRAMENTO
CALIFORNIA

5770 FREEPORT BLVD., SUITE 100
SACRAMENTO, CA
95822-3516

PH 916-433-0800
FAX 916-433-0818
www.sacpd.org

November 29, 2005
REF: COP 11-26

Dear Concerned Community Member:

Across Sacramento county, law enforcement officers are called into situations where they have to make decisions regarding the needs of individuals in mental health crisis. There are few options for officers to provide mental health consumers with effective response outside of jail, emergency rooms, or the Crisis Stabilization Unit at the Mental Health Treatment Center. The current situation does not allow for providing the best emergency response to the community's mentally ill.

A strategy, called Psychiatric Emergency Response Team (PERT), has been developed for handling mental health calls in the most effective and least restrictive manner possible. PERT pairs specially trained police officers with licensed mental health clinicians who have access to mental health treatment history, links to services, and the ability to verify insurance. PERT-type programs have been highly successful in many cities by providing the best service to mental health consumers and homeless with mental illness.

Currently we have the opportunity to initiate PERT teams in the Sacramento region through funding from Proposition 63, the Mental Health Services Act (MHSA). Following the November 2004 passage of Proposition 63, Sacramento County conducted an extensive outreach effort to determine the mental health needs in our community and how the new MHSA monies should be spent. An MHSA Steering Committee reviewed over 100 mental health proposals. The PERT proposal was ranked as the number one funding priority for our community.

Although PERT received the highest ranking, the program has met stiff opposition from some members of the mental health community who do not believe that these monies should be used to fund any law enforcement component of PERT. Law enforcement leaders have met with the Director of the State Division of Mental Health, Dr. Stephen Mayberg, as well as the principal author of Proposition 63, former California Assembly Member Darrel Steinberg, who have assured us that these funds are meant to be used on programs exactly like PERT.

History has shown that to be effective, law enforcement is a necessary component for any program that hopes to meet the unmet needs of those in crisis. One can look at the downtown core area on any given day and see that there are a significant number of people who desperately need the services that only a PERT team can provide.

I need your support. The Sacramento County Mental Health Board is in the process of reviewing Sacramento's plan for these funds and are currently accepting public comment. The Sacramento County Mental Health Board will be conducting a public hearing on the draft plan following a month-long review period. The public hearing will be held at The Grand Ballroom, 1215 J Street, in Sacramento from 6:30 p.m. to 9:00 p.m. on Wednesday, December 7, 2005. Written comments may be sent directly to the Mental Health Division by e-mail to MHSA@SacCounty.net or by U. S. Mail to DHHS – MHSA, 7001-A East Parkway, Sacramento, CA 95823 attn: Richard Harig.

I am urgently requesting that you take a few moments and send an e-mail to the Mental Health Board **no later than December 6, 2005** expressing your desire that a much-needed PERT program be funded for our community. If you have any questions, please call PERT project lead, Lt. Ken Bernard at 277-6137.

Sincerely,

Albert Nájera
Chief of Police

AN:kb/mm

Harig. Richard

From: MHSA
Sent: Tuesday, December 06, 2005 4:51 PM
To: Harig. Richard
Subject: FW: Please approve PERT funding

-----Original Message-----
From: Scott Yates [mailto:SYates@inallianceinc.com]
Sent: Tuesday, December 06, 2005 4:26 PM
To: MHSA
Subject: Please approve PERT funding

Hello,

My name is Scott Yates. I am the public relations coordinator for InAlliance, a Sacramento nonprofit providing services for adults with disabilities. Our consumers receive community training, supported living and job placement services through our agency.

I would like the Sacramento City Mental Health Division to allocate funds to implement a Psychiatric Emergency Response Team (PERT) with the Sacramento Police Department. I believe a well trained, and well staffed, PERT will save the city money by reducing health care and jail administration costs.

Earlier this year, I watched police officers handcuff and take one of our consumers from our offices. The consumer was having a bad day and became frustrated. When a 50-year-old man throws a temper akin to a 5-year-old people's safety can be in jeopardy. We have strict policies in place about how to deal with a situation. We first contact our behavior specialist and she works to calm the situation. Then, when available, we contact a parent or loved one. If the consumer remains volatile and disruptive, we have no choice but to call the police. A trained officer from a Psychiatric Response Team would be able to assist in calming the situation and get the consumer to a more calming environment such as their home or the home of a loved one. There, he/she could find balance and rest without an unnecessary trip to jail where the onslaught of people and commotion are often more damaging to the situation.

I suggest a PERT officer be available 24 hours per day and response times should as quick as any other agency in the city.

Scott Yates
Public Relations Coordinator
Inalliance, Inc.
(916) 381-1300 ext. 170

Statement for the record to the Sacramento County Mental Health Board
at the MHSA Public Hearing
December 7, 2005

On behalf of the Association of Mental Health Contractors, I would like place on record our opposition to the use of Mental Health Service Act (MHSA) funds to cover the expense of law enforcement personnel and their related costs. Despite what we understand to be interpretations to the contrary, we do not believe that the employment of police officers and sheriff's deputies is consistent with the intent and spirit of the law. We remain fully supportive of efforts which involve representatives from law enforcement and the mental health community working collaboratively to address the needs of mental health consumers and their families in our County. We recognize that law enforcement must be involved as a partner in the transformation of our mental health outreach and crisis response systems.

Regarding the "PERT 2" proposal that has been incorporated into the County's proposed MHSA plan, we are very disappointed that politically influenced decisions reached at the 11th hour have compromised what had initially been a very open and transparent process. While we are not opposed to the development of PERT, we are opposed to the amount of funds proposed to be committed to this pilot, especially given about half of the proposed budget is for law enforcement positions and expenses.

Should PERT be implemented, we further recommend that an oversight and accountability commission be established by the County Mental Health Board, and that it be described and included within the submitted Sacramento County MHSA plan regarding PERT. This would nurture commitment to a shared vision, provide a constructive outlet for communication of diverse perspectives and ensure accountability to the community for a successful implementation or redirection of allocated funds.

Finally, we recommend that the decision processes guiding the use of MHSA funds be reviewed and made explicit so that active participation of all stakeholders within the community, or their identified representatives, is consistently included, politically motivated decisions are minimized, and the promise of Proposition 63 is fully realized in Sacramento County.

Thank you.

Association of Mental Health Contractors of Sacramento County

Sacramento County
Community Services and Supports
Plan
Comment Number: 96

Allowing a politicized mode to circumvent the transformative process started by MHSA is extremely disappointing. The PEER program's intention is not Recovery oriented ; walks a very thin line between what is allowable ; not allowable in MHSA.

It's extremely important for families to be able to call for help in a crisis situation w/o fear of arrest and with the comfort of knowing that services and programs will be offered and provided to all that ask for them.

RECEIVED
NC

DEC 07 2005

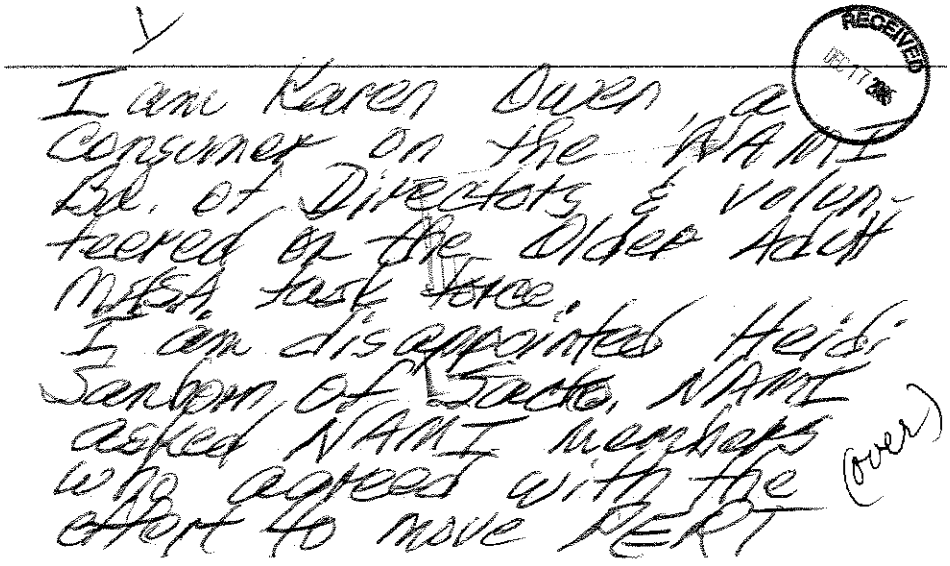
PERT does have the potential for transforming the system - it has the potential to save lives.

Please do all you can to see this valuable program begins and is funded adequately

Thankyou

-Steve

In addition to antiepileptic Program (un-necessary) trauma is the dis-continuance of 'TAZIN G' on that just 2



I am Karen Owen a consumer on the NAMI Bd. of Directors & volunteered on the Older Adult MHSA task force.
I am disappointed Heidi Seabom of Seattle, NAMI asked NAMI members who agreed with the effort to move BERT (over)

ahead. There was no request for dissenting NAHL members to be counted. I ~~[illegible]~~ advocate to the contrary. The peace officers bill is much too high - hard to law enforcement salaries

3/ #2

while only [illegible] mgn. wage earners or family members. Employment. This is not considered driven decisions were made behind closed doors for funding DEA. Since law enforcement is 2nd response - use community chaplains &

4 psych. technicians in unmarked vehicles. Bring the cost of high salaries & retirement to be more reasonable! One clinician can supervise the psych. tech's & community chaplains.

5/

A major problem is all law enforcement needs more C.I.T. - required in-depth practical hands-on mental health training so all LE re-sponders can interact appropriately with our mental illness community.

On behalf of ~~myself~~ community member & my neighbors, we fully support the PERT team & ~~its~~ funding. Not only is law enforcement the 1st responder - they are the ~~ONLY responder!~~ Who is going to assess & transport the violent & critically mentally ill? Certainly LE is the ONLY agency available to do this 24/7. The past yr LE has responded over 15 X's to a mentally ill person in our neighborhood with immediacy, compassion, & appropriateness. OVER

RECEIVED
DEC 07 2016

Huge amounts of time, money, & resources are needed to deal with the large numbers of mentally ill in Sac Co. Please, give LE the money they need to continue to respond to mental illness concerns - if not, who will do this, while, at the same time, serving the rest of our community need.

I, & my friends & neighbors request full funding for the PERT team!

Thank You,

X

Sacramento County
Community Services and Supports Plan

Dawson. Nedra Comment Number: 115

From: SACBASQUE@aol.com
Sent: Friday, December 02, 2005 8:06 AM
To: MHSA
Subject: pert team

I can't imagine within this day and age why there would be any feasible reason to have any opposition to the Sacramento Police dept being able to actually respond with a team that was trained to helping in a situation were a mentally unstable individual is involved thus risking not only the safety of the every day citizen such as myself, but also the safety of the first responders to the scene. If anything I urge you folks to help implement the actions neccessary to assist with the training & development of a program to help our officers be armed with the knowledge necessary to not have to make it a situation that would require the least amount of force necessary to gain control thus not only preventing injury to the individual requring the assistance but also our first responders also.

Thank you
Claude Arretche

Harig. Richard

From: MHSA
Sent: Tuesday, December 06, 2005 9:37 AM
To: Harig. Richard
Subject: FW: PERT support

-----Original Message-----
From: Aldo Angoletta [mailto:aangoletta@broadwaypharmacy.com]
Sent: Friday, December 02, 2005 10:53 AM
To: MHSA
Subject: PERT support

To whom it may concern,

I've been involved with the mental health community in Sacramento for the last seven years as an owner of Broadway Pharmacy. Our primary focus has been serving the mental health community by dispensing medication in our compliance packaging systems. Over the last seven years, I've had the opportunity to be a part of a number of new programs that have identified mental health patient's in a homeless and criminal settings that the primary reason the person being in the situation is due to an undiagnosed or untreated mental health condition. These programs have identified individuals, given proper psychiatric follow-up and treatment, which allowed these individuals to move to a better standard of living.

In Sacramento's evolution to address its residents with mental health conditions, a PERT team is an ideal way to have law enforcement better capable to handle residents in a mental health crisis. Often, it's our law enforcement officers that are the first people who contact individual in a mental health crisis and they should have specially trained officers, with trained support personnel, to handle the situation. Often the only alternative for these individuals is a trip to jail or the Mental Health Treatment Center.

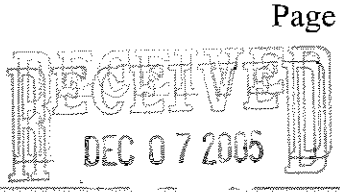
Without proper training some interactions between officers and residents in a mental health crisis have ended in violence jeopardizing the life of the officer or resident. Some of these negative interactions could be avoided with a properly trained PERT team. I give my full support to the Sacramento Police Department in implementing a Psychiatric Emergency Response Team.

Respectfully,

Aldo Angoletta, PharmD.
Broadway LTC Pharmacy
3330 Broadway
Sacramento, CA 95817
916-452-8022

Sacramento County
Community Services and Supports Plan

Comment Number: 115



Dawson. Nedra

From: Penelope Amadali [amadali@sbcglobal.net]
Sent: Tuesday, November 29, 2005 4:30 PM
To: MHSA
Subject: Sac Police Dept PERT

For several years, the number of mentally ill individuals that end up in jail has increased, an indication that the Sacramento Police Dept has had no other option but arrest when encountering the mentally ill. From the information I have read, the Psychiatric Emergency Response Team (PERT) has been developed to handle mental health calls received by Sac PD and pairs specially trained police officers with licensed mental health clinicians who have access to mental health treatment history and other essential information. PERT seems to be an obviously rational approach to these calls.

I understand that the Sacramento County Mental Health Board is in the process of reviewing Sacramento's plan for these funds and I encourage the Board to approve funding PERT.

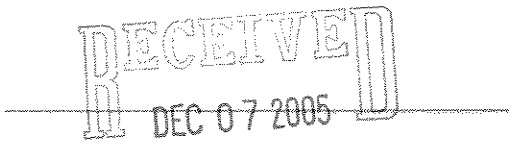
Thank you,

Penelope Amadali
3971 4th Avenue, Sacramento 95817
916-736-1578

Sacramento County
Community Services and Supports Plan

Dawson. Nedra

Comment Number: 119



From: Anita Barnes [anitab@lafcc.com]
Sent: Friday, December 02, 2005 4:46 PM
To: MHSA
Subject: Proposed Psychiatric Emergency Response Team

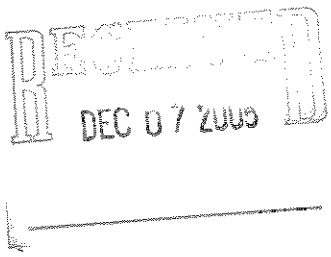
La Familia is in support of Prop. 63 funding for PERT Teams. PERT addresses a gap in our community in providing a comprehensive and timely emergency response system of care to meet the unmet needs of those in crisis. PERT is a great example of a collaborative partnership bringing together trained police officers with licensed mental health clinicians who on the spot have access to treatment history and can link to services/resources in a timely manner. When a person is in a mental health crisis this is a time when they are most at risk and in need of an immediate response that can address their crisis and bring together available resources and services in a timely manner. Time is off the essence when responding to mentally ill persons in crisis, especially the homeless with mental illness. Thank you for your consideration.

Anita Ramos Barnes
La Familia Counseling Center, Inc.

Sacramento County
Community Services and Supports Plan

Dawson. Nedra Comment Number: 126

From: Mickey Bennett [Mickey@Bennett.GG]
Sent: Tuesday, November 29, 2005 8:39 PM
To: MHSA
Cc: 'Michael Carrasco'; 'Albert Najera'
Subject: Support for Sacramento PERT Program



Dear Sacramento Mental Health Board:

As a Sacramento City and County resident, I support the establishment of a Psychiatric Emergency Response Team (PERT) under the management of the Sacramento Police Department. Police officers are the first responders to all levels of emergencies. Police supervised PERT teams have been extremely effective in other California cities and I welcome a PERT team in the Sacramento area.

Thank you,

Mickey Bennett, MS
Northern California Coordinator
Masters & Bachelors For Emergency Services Administration
Distance Learning - Professional Studies
California State University, Long Beach

(916) 838-2919
Email: Mickey@Bennett.GG
Web Site: http://www.csulb.edu/depts/ocst/distlearn.htm

Dawson. Nedra

From: Mel Billingsley [melbilljr@comcast.net]
Sent: Tuesday, November 29, 2005 3:56 PM
To: MHSA
Cc: NAG3 - Kris Wimberly
Subject: PERT program support

I would like to understand the opposition to the proposed PERT program. On the surface it certainly makes sound sense. According to a recent letter from Chief Najera, Sacramento City Police, the PERT program is designed to meet the objectives of Proposition 63, corroborated by former California Assembly Member Darrel Steinberg, its author.

Please consider this my letter of support for the PERT program, pending any evidence that might convince me otherwise.

regards,
Mel Billingsley
2805 63rd Street
Sacramento, CA 95817
916.457.6564

Sacramento County
Community Services and Supports Plan

Comment Number: 122

Dawson. Nedra

RECEIVED
DEC 07 2005

From: Franklin Burris [franklin.burris@potter-taylor.com]
Sent: Friday, December 02, 2005 11:45 AM
To: MHSA
Cc: rogerd@bos.co.sacramento.ca.us; Sandy Sheedy; Steve Cohn; Ray Tretheway
Subject: Prop 63 Funding Priority for Chamber

Hon. Members
Sacramento County Mental Health Board

On behalf of our members, their employee's and with the unanimous support of our Board of Directors, the North Sacramento Chamber of Commerce **supports** the use of Proposition 63 funds for the Psychiatric Emergency Response Team (PERT) proposal.

Representing North Sacramento, Chamber members have seen firsthand the problems of those in need of the services that could be addressed by PERT, but instead are left to fend for themselves within bureaucracy. This program should be a priority for Sacramento County, and will be a successful and compassionate intervention/referral and outreach program for the community (neighborhoods and business corridors alike).

Thank you for your dedicated service to Sacramento, and for your thoughtful consideration of funding for PERT.

Franklin Burris
President
North Sacramento Chamber of Commerce
P: | 916.923.0200
F: | 916.923.5823
W: | www.northsacramentochamber.org

Harig. Richard

From: MHSA
Sent: Wednesday, December 07, 2005 9:56 AM
To: Harig. Richard
Subject: FW: ATTN.: MR. RICHARD HARIG RE "PERTS" FUNDS

-----Original Message-----
From: BLECKLEYLAW@aol.com [mailto:BLECKLEYLAW@aol.com]
Sent: Tuesday, December 06, 2005 5:19 PM
To: MHSA
Subject: ATTN.: MR. RICHARD HARIG RE "PERTS" FUNDS

Dear Mr. Harig:
I am sending this to you to express my support that PERT funds be made available to the SACRAMENTO CITY POLICE DEPT. to support their involvement in meeting the "Mental Illness" needs in Sacramento. I am a business owner (three businesses) on Del Paso Blvd. & I am forced to deal with "mental illness" issues on a daily basis. Our only out-source is the Police Department, whose personnel, at present, are ill-equipped to deal with such.
PLEASE reconsider your position and agree to make available to the SAC PD, a portion of Prop 63 Funds for training the Officers to effectively and properly deal with the DAILY, STREET-BY-STREET "mental ill subjects". OUR ENTIRE COMMUNITY WILL BENEFIT -- WHICH SHOULD BE THE ULTIMATE TARGET FOR THESE FUNDS.

THANK YOU FOR ANY EFFORTS AND CONSIDERATIONS.

JEANETTE A. BLECKLEY, Attorney at Law
Owner: *"Going Postal 4 U"; Sunshine Carpet Cleaning*
(&, proposed: "PEPPERMINT PONZA'S DOG HOUSE".

Sacramento County
Community Services and Supports Plan

Dawson. Nedra

Comment Number: 124

From: Betty Botts [b2fred@comcast.net]
Sent: Wednesday, November 30, 2005 12:09 PM
To: MHSA
Subject: Funding community PERT program

Dear Mental Health Board,

As a Sacramento community resident, I strongly support Police Chief Najera and his efforts to stem the tide of the mental health case overload. Funding a PERT program to assist in our community's mental health crises makes good fiscal sense and supports our law enforcement officers to serve the whole community at large. When handling mental health calls in our community, local law enforcement must have support teams like PERT to effectively respond beyond ERs, jails, or overwhelmed Mental Health Treatment centers.

Please make PERT your number one funding priority for meeting these urgent community needs.

Thank you,
Betty Botts
3354 Kittiwake Drive
Sacramento, CA 95833-9790

Sacramento County
Community Services and Supports Plan

Dawson. Nedra Comment Number: 176

From: Sally Davis [sjd7@sbcglobal.net]
Sent: Friday, December 02, 2005 6:59 PM
To: MHSA
Subject: PERT

I am a mental health provider in Sacramento County who has had the experience of needing a mental health professional who could work with law enforcement to provide necessary support for an impaired person.

this PERT program appears to meet that need. I encourage support for these necessary services.

Sally Davis, LCSW

2/02/05

Dear Mr. Harig,

I am a concerned Merchant located on Del Paso Blvd, Sacramento.

Regarding the issue of the Sacramento Police Department's request for funds from Prop 63 to address the mental health issues the department encounters.

My opinion is that their request is not only reasonable but beyond logical objections. The police department is the front line of defense for the public in maintaining order and dealing with public disturbances.

Unless the County Mental Health Board is prepared to establish a hotline and rapid deployment team to respond to disturbances caused by someone mentally ill.

The police department is already set up to respond to 911 disturbance calls. It seems very reasonable to give them the tools necessary to perform mental health evaluations in the field to determine the best course of action for the treatment of the individual involved and the community at large.

Perhaps a compromise might be reached by a joint effort by the Fire Department and Police, as they work hand in hand in emergency situations already. Funding could be made available to train paramedics in the Fire Department to deal with mental illness issues as they arise.

The bottom line is to get the money where it will do the most good for the mentally ill and the community.

In my opinion, a portion of the funds should be earmarked for the agency that deals with the problem on the streets. The remainder should fund support and treatment programs.

Thank you for your efforts on our behalf.

Sincerely,

Alan F. Friedman
Advantage Promotional
1806-A Del Paso Blvd
Sacramento, CA 95815

Sacramento County
Community Services and Supports Plan

Dawson. Nedra

Comment Number: 134

From: Colleen Gordon [CKummer@csis.k12.ca.us]
Sent: Thursday, December 01, 2005 10:43 AM
To: MHSA
Subject: Re: PERT
Importance: High

Please take my recommendation that Sacramento create a PERT team in the police department to help deal with individuals in crisis. Most times, the police have to deal with these individuals and could use this help to break the cycle and help individuals get help who may not have this opportunity.

From a resident of Oak Park.

Colleen and Lloyd Gordon
2961 La Solidad Way
Sac, CA 95817

Dawson. Nedra

From: Heskin, Jessica R [heskin@skymail.csus.edu]
Sent: Wednesday, November 30, 2005 4:58 PM
To: MHSA
Subject: Support of funding for PERT, Prop 63

Dear Sacramento County Mental Health Board:

I am writing on behalf of my agency, the Sacramento State Women's Resource Center, to urge you to support the Psychiatric Emergency Response Team to be funded by Prop 63. Such teams have been successfully launched in other cities, and there is no reason this could not work in Sacramento city.

This team, which partners Sacramento City Police Dept. officers with mental health clinicians, is an innovative program designed to help our community's mentally ill population. It is imperative that we begin to deal with the mentally ill in not merely from a punitive perspective, but in a rehabilitative stance primarily. It is essential that we get these members of our community the resources they need and deserve; and what better way to do that than in conjunction with law enforcement services who are already responding to these neglected needs.

Again, I urge you to support the Psychiatric Emergency Response Team in conjunction with Sacramento county Police Department and give us the PERT team which our community so desperately needs.

Sincerely,

Jessica R. Heskin, M.A.
California State University, Sacramento
Violence and Sexual Assault Support Services
6000 J Street
Sacramento, CA 95819-6060
(916) 278-7388
fax: (916) 278-4783

Dawson. Nedra

From: Steve Huffman [steve@historicoldsacramento.com]
Sent: Friday, December 02, 2005 3:59 PM
To: MHSA
Subject: PERT Funding

Ladies and Gentlemen:

I am writing in regard to funding for PERT to help our police deal better with the mentally ill. In Old Sacramento our city's first neighborhood and our region's number one visitor attraction we see mentally ill people all too frequently. Our allies at the Downtown Sacramento Partnership help us guide them to where they can get help, but too often they are simply arrested and jailed. Our community needs to invest more in solving their problems and PERT funding would be a significant step. Thanks for listing.

Sincerely, Steve Huffman

OLD SACRAMENTO
FOUNDATION INC.

Steve Huffman, Executive Director
HISTORIC OLD SACRAMENTO FOUNDATION, INC.
OLD SACRAMENTO BUSINESS ASSOCIATION, INC.
1002 Second Street, 2nd Floor
Old Sacramento, California 95814
Office: (916)445-3054 Mobile: (916)214-4500
Fax: (916)445-3106
steve@historicoldsacramento.com

Agnes Arvai Lintz, J.D.
2220 Landon Lane
Sacramento, CA 95825
(916) 489-4623

Sacramento County Division of Mental Health
MHSA, Attn: Richard Harig
7001-A East Parkway,
Sacramento, CA 95823
mhsa@saccounty.net

December 7, 2005

RE: PUBLIC COMMENTS RE SAC CO MHSA CSS DRAFT PLAN

Dear Mr. Harig:

I am writing these comments both as a Mental Health Consumer Representative to the Sacramento County Mental Health Board (District 3) and also as co-chair of the Older Adults MHSA Task Force.

PERT

I am concerned about (1) the process that was used to include the PERT proposal in addition to (2) the fact that mental health dollars are being used to fund law enforcement activities.

The PERT Stakeholders committee was meeting prior to Sacramento County's kickoff for the MHSA Planning Process. Neither consumers nor family members were aware of this, and no family members or consumers were included in the planning. The MHSA mandates that the planning be consumer driven.

When both the Older Adult Task Force that I co-chair and the Steering Committee whose meetings I regularly attended voted on this proposal, there was an assumption by many (if not most)

members, supported by the non-supplantation provisions of the MHSA (see e.g., Welf. And Inst. Code 5813.5(b) and the DMH Frequently Asked Questions (most recently revised 11/22/05) as well as common sense, that law enforcement would pay for their own salaries.

When it was later revealed that this was not the case (that law enforcement thought the MHSA would pay for their salaries and equipment), I was present at the Steering Committee meeting that decided given law enforcement's position, the Steering Committee could no longer support funding the PERT program in this current funding cycle. In other words, that they would never have ranked it so high had they known this.

The tactics law enforcement then used to force their PERT program back into the county's plan make a mockery of the language and intent of the MHSA (see Welf. And Inst. Code 5813.5(d)) and also disrespects the weeks and months of hard work that the stakeholders put in. Despite numerous complaints that law enforcement and county officials were meeting behind closed doors to come to a compromise, no consumers were included in yet more closed door meetings to come to further compromises.

"Nothing About Us Without Us" is fundamental to both the consumer movement and the MHSA. Likewise, the MHSA was not supposed to be "business as usual" but rather a new day of recovery oriented consumer empowerment. See DMH's Vision Statement/Guiding Principles for Implementation of the MHSA (2/16/05). The importance of the integrity of the planning process is not only that the planning process is used in determining which programs get initial funding, but also that it forms the basis of future collaboration of the mental health community with the client community.

I object to the funding of the PERT program in large part due to the disrespect to the process shown by law enforcement and the resulting permanent damage to the trust and hope that the mental health consumer community placed in implementation of the MHSA.

Trust and hope, to me, are infinitely more crucial to recovery from mental illness than any medication or program. Certainly they were key to my own recovery and transition from social security to the work force.

In addition, law enforcement's argument that they are not performing law enforcement activities when they show up in uniform, carrying a gun, prepared to 5150 or arrest someone flat out violates both the plain language of the law and also common sense.

I would vastly prefer an alternative MHSA proposal that responded to the mental health calls but without the inclusion of law enforcement on the team paid for by MHSA dollars. My understanding is that there are other models where if law enforcement is called and they determine that this is a mental health situation, a MERT or CIT or some other named team of mental health workers (and hopefully including consumers) responds and is able to take over and assist the individual in de-escalating and getting the voluntary mental health services to continue on their recovery. To me, this alternative is less costly in terms of the scarce MHSA dollars our county was allocated, consistent with the intent and language of the MHSA, and would do an equally satisfactory job of addressing the concerns of both law enforcement and the community as a whole.

Almost everybody is disappointed that "their" proposal did not get funded, or did not get fleshed out the way that they had wished, or did not get funded enough. No other proposal was allowed to be "resubmitted" either due to a public relations blitz or because the proposal was re-written to try to address concerns the Steering Committee had with it.

OLDER ADULTS

I have additional concerns regarding the funding of the PERT program resulting in the elimination of the Older Adult Multidisciplinary Crisis Program.

Firstly, notifying us of this Sunday night when many of us either have to work full-time jobs starting the next morning or do not have access to e-mail hardly gives the older adult community a fair chance to comment on the de-funding of a program they all thought would be funded. I would refer the readers of this comment to the extensive public comment provided by stakeholders during both the regular Steering Committee meetings regarding the importance to the older adult community to have services separate from those provided adults, as well as the public comments at the emergency meetings of the Steering Committee opposing the folding of this proposal into the PERT proposal.

Secondly, I note that the Steering Committee ranked the TACT (now TCORE) program highly (#3) as a full service partnership. There has been no explanation given as to how the county decided (behind closed doors) to change this to a system development program and then how it decided last Sunday to de-fund the Older Adult Multidisciplinary Crisis Program (ranked #3 by the Steering Committee for system development funding).

I hope that the above comments are of assistance to you in re-writing Sacramento County's draft MHSA CSS Plan. Please feel free to contact me with further questions or requests for assistance regarding this matter.

Sincerely,

Agnes Arvai Lintz, J.D.

Dawson. Nedra

From: Lu, Selina A. [selina.lu@wamu.net]
Sent: Thursday, December 01, 2005 12:19 PM
To: MHSA
Cc: selina23@tmail.com
Subject: PERT Program

Hi I am currently a resident of the city of Sacramento, and truly believe in the PERT program. The psychiatric emergency response team is very much needed in our downtown area. There are a lot of individuals with mental disabilities downtown that are not treated properly and therefore cause problems in the city. If peace officers are specifically paired with licensed mental health clinicians who have access to mental health treatment of these individuals and links to various services that will be able to help them it will provide a much needed service for the homeless people with mental health issues. Law enforcement officers are in the downtown area patrolling everyday to keep our streets safe, the least we can do is provide them with the proper funding to help them continue this service.

Selina A Lu

WM Financial Services

Sr. Licensed Financial Rep

916-394-2570

Dawson. Nedra

From: MHSA
Sent: Friday, December 02, 2005 5:18 PM
To: Harig. Richard
Subject: FW: Support for PERT program

-----Original Message-----
From: Leo Lujan [mailto:lujanleo@earthlink.net]
Sent: Friday, December 02, 2005 2:37 PM
To: MHSA
Subject: Support for PERT program

Mr. Richard Harig,
Attached is a letter of support for funds to establish a PERT program within the City of Sacramento Police Dept..
Hard copy to follow.

Mary Ann and Leo Lujan
lujanleo@earthlink.net

Richard Harig
The Sacramento County Mental Health Board
Mental Health Division
7001-A East Parkway
Sacramento, CA 95823

Dear Mr. Harig,

We of The Robla Park Community Association would like to express our strong support for, Chief of Police Albert Najera, of the City of Sacramento to grant funds so that a Psychiatric Emergency Response Team (PERT) can be developed, in our community. This type of program has been very successful in other communities and one is much needed in ours.

Our city is projected to double in population in the next 25 years. With all of the social problems in our society to day we need a PERT program in place now.

Sincerely,

Mary Ann Lujan, President R.P.C.A.
Leo Lujan, Co-founder R.P.C.A.
(916) 925-5773

Dawson. Nedra

From: Steve Markstein [steve@marksteinbev.com]
Sent: Wednesday, November 30, 2005 12:12 PM
To: MHSA
Subject: PERT funding

Iam writing to you to make you aware of my support of funding of the PERT project. In my recent communication with Chief of Police Albert Najera he assures me that his department is well qualified and willing to take on the added responsibility to help implement this project. I have no doubt in his and the Police Departments ability and willingness to make PERT a successful project in the City.
Please do all that you can to help fund this important project.
Thankyou, Steven H. Markstein

Dawson. Nedra

From: David Middlesworth [dmiddles2@hotmail.com]
Sent: Tuesday, November 29, 2005 3:52 PM
To: MHSA
Subject: PERT

To Whom It May Concern:
I strongly urge you to vote to maintain the PERT program within the Sacramento Police Department. This program can go a long way to respond to an urgent need to deal with people suffering from a variety of mental issues.
Thank you,
David Middlesworth, PH.D
2533 9th Ave.
Sacramento, CA 95818
916-743-5407

Dawson. Nedra

From: patti "patris" [patris@lanset.com]
Sent: Tuesday, November 29, 2005 4:49 PM
To: MHSA
Subject: PERT

Hello, I am a citizen in Sacramento and I urge you to fund the PERT team with the monies from PROP 63. We need this kind of service in Sacramento and I am here to say that as a citizen I support Chief Albert Najera and his PERT team.
Sincerely submitted,
Patti Miller

Sacramento County
Community Services and Supports Plan
Comment Number: 154

Dawson. Nedra

From: AREEDX@aol.com
Sent: Tuesday, November 29, 2005 8:20 PM
To: MHSA
Subject: PERT program

I agree with Chief Najera that the PERT program could give us additional options as opposed to the standing directives of emergency rooms and jail. The current options don't seem to do anything more than provide a very expensive bed and meal to the homeless. These options also tie up officer time that could be best used protecting the general public.

While this won't solve the homeless problem, it may help with the mental illness portion of it.

Thank you,

Alice Reed
areedx@aol.com

Sacramento County
Community Services and Supports Plan

Comment Number: 152

Dawson. Nedra

From: Kathleen Regalado [kregalad@OSPR.DFG.CA.GOV]
Sent: Friday, December 02, 2005 12:57 PM
To: MHSA
Cc: dsteinberg@hansonbridgett.com
Subject: PERT Project funding

I am writing to urge the Sacramento County Mental Health Board to provide funds for the PERT project.

I know how imperative it is to help a person with a mental illness before a bad situation escalates to something worse. These people have an illness; they are not criminals. They need treatment, not jail.

The police had been called out to my sister's home several times over a two year period due to the erratic and sometimes violent behavior of my 22 year old nephew. The last time they were called to this home, almost a year ago, the policemen realized that this young man had a mental illness and was a danger to himself and needed help. Thanks to the actions of these policemen, my nephew received the psychiatric treatment he had needed for so long. Today, my nephew is receiving care and has shown so much improvement. It's like night and day. Had there been a project like PERT in place when the police had been called to my sister's house previously, I believe my nephew would have received the care he needed and would have spared my nephew, my sister and the rest of our family the grief, sadness, and fear we had lived with for too many years.

I urge you, please, please, please support this program. This program is necessary for person afflicted, the families and the community.

Kathleen Regalado

Dawson. Nedra

From: Saephanh. Frank
Sent: Friday, December 02, 2005 11:54 AM
To: MHSA
Cc: 'www.@sac-PD.org'
Subject: Psychiatric Emergency Response Team (PERT)

Dear Mental Health Services Act Division, Dr. Stephen:

As concern citizen/ Chairman of Iu Mien Community Leader, I am writing this letter in supporting Sacramento Police Department-Chief of Police- Albert Najera's proposal.

Law enforcement is a last resort when it comes to mental health crisis. It is necessary to contribute portion of the grant to the Police Department.

Sincerely yours,

Frank O. Saephanh
Chairman of Iu Mien District Leader
(916) 201-0879

Harig. Richard

From: MHSA
Sent: Tuesday, December 06, 2005 8:41 AM
To: Harig. Richard
Subject: FW: Comment on MHSA Plan

-----Original Message-----
From: Mike [mailto:mshepard@winfirst.com]
Sent: Monday, December 05, 2005 5:51 PM
To: MHSA
Cc: Susanne Gilbert; bhsan@comcast.com; Ralph Nelson; grace.mcandrews@namicalifornia.org
Subject: Comment on MHSA Plan

This is a comment on Sacramento County's Mental Health Services Act draft plan dated October 31, 2005, and the Psychiatric Emergency Response Team (PERT) Addendum.

First I would like to compliment the Department of Health and Human Services for producing a well-written, well-organized, and professional plan. I appreciate the amount of skill and work that went into making this such a polished document.

I am a member of NAMI and also an attorney (retired) who has represented many mentally ill clients, not only in their own civil legal matters, but also as their attorney in mental health commitment proceedings. My representation occured many years ago in other states, but gave me a lot of experience working with the consumer community.

I have only recently become involved again in mental health issues, too late to participate in the stakeholder input process supporting this plan. But it certainly appears that the public input process was inclusive and that the agency has indeed listened carefully to the stakeholders in drafting this plan. But those who participated in the process are better able to evaluate it.

I support the draft plan with the inclusion of the PERT program funded as proposed in the December 3, 2005, letter from Ann Edwards-Buckley. From my perspective PERT is a key element in transforming mental health services, and there is clearly strong support for it in the community. Police Chief Najera and Sacramento County Mental Health Director Kathleen Henry deserve praise for keeping this program alive after its initial rejection. Past experience has demonstrated that law enforcement officers need skilled mental health professionals to help deal with individuals experiencing mental health crises. Many integrated practice models exist and provide ample evidence that this sort of program is effective and provides tremendous long-term benefits to the community, to law enforcement, and most importantly to mentally ill individuals and their families.

Michael Shepard
1908 Richmond Street
Sacramento CA 95825

Dawson. Nedra

From: Jan Stohr [jstohr@saclibrary.org]
Sent: Friday, December 02, 2005 1:59 PM
To: MHSA
Subject: Mental Health $

As you make decisions with regard to the Prop. 63 money, I certainly hope that the police department is included for funding. If not, we would have a big gap in the appropriate delivery of services for those suffering from mental illness.

Jan Stohr
264-2786 (office #)

Harig. Richard

From: MHSA
Sent: Monday, December 05, 2005 4:15 PM
To: Harig. Richard
Subject: FW: PERT-Mr. Harig

-----Original Message-----
From: Ries, Valerie [mailto:VRies@library.ca.gov]
Sent: Monday, December 05, 2005 12:56 PM
To: MHSA
Subject: PERT-Mr. Harig

Dear Mr Harig,
Thank you for incorporating the possiblilty of PERT funding into the MHSA. I am a consumer who
is also a
member of NAMi and know from personal experience how impotant it is to have an informed
mental health intervention when police are called. Police are usually not able to adequately
deal with a mental health client appropriately. PERT funding is so very much needed so that
people who need mental health services will get the services they need instead of being needlessly
incarcerated.
Please consider that when intervention is needed a consumer may not be healthy enough to
use the Wellness program, etc. When the police are called, consumers need addequate, appropriate
care.
Thank You,
Valerie Ries-Lerman

Dawson. Nedra

From: Pamela Rogers [pamelar@stewartsac.com]
Sent: Tuesday, December 06, 2005 4:47 PM
To: MHSA
Subject: PERT

I apologize for being so brief in my comments, but I do want to make it known that I do hope funds will be applied to the PERT program that I believe will be very valuable to our community.
Thank you,

Pamela Rogers
Stewart Title of Sacramento
Escrow Officer
Title Only Desk
6700 Fair Oaks Blvd.
Carmichael, CA. 95608
Office (916) 484-6990
Fax (916) 484-7637

Harig. Richard

From: MHSA
Sent: Monday, December 05, 2005 11:13 AM
To: Harig. Richard
Subject: FW: PERT

FYI --

-----Original Message-----
From: Lalin Santini [mailto:lalin@nwsac.org]
Sent: Monday, December 05, 2005 9:39 AM
To: MHSA
Subject: PERT

To whom it may concern,
I am in support of funds for the PERT program, Psychiatric Emergency Response Team (PERT). Our officers are usually the first to meet those with Mental Health Challenges and working with a Psychiatric will provide for the best services for these people.

Lalin Santini

Please note: My email has changed to lalin@nwsac.org
Lalin Santini
Phone: 452-5356 ext 17
Fax: 431-3200
Check out our web site: www.nwsac.org

"Sacramento NHS is now doing business as ***NeighborWorks HomeOwnership Center Sacramento Region.***
Our 18 year legacy of strengthening neighborhoods and helping people obtain, maintain, and sustain homeownership continues!"

Dawson. Nedra

From: Paul Smith [p_arthur_smith@hotmail.com]
Sent: Monday, December 05, 2005 10:36 AM
To: MHSA
Cc: 'Emily Smith'
Subject: Prop 63

To Whom It May Concern: My name is Paul Smith, and I am semi-retired after serving individuals with mental and developmental disabilities for more than 40 years. My particular area of specialization concerned emergency intervention with individuals whose disabilities were sometimes manifested in assault. I am writing to support the request of the Police Chief of Sacramento, Albert Najera that there be a law enforcement component in the development of psychiatric emergency response teams in the City of Sacramento. I understand that Chief Najera is requesting prop 63 funds to include the necessary law enforcement component in such teams.

As a professional whose career in state service in included employment in both the treatment and correctional systems, and as a consultant whose practice has included providing expert testimony in cases where individuals with disabilities were killed or injured by those who were charged with supervising and protecting them, I see a close working relationship between peace officers and treatment professionals as being necessary to both custody and treatment for individuals whose disabilities bring them to the attention of law enforcement professionals.

You may contact me for further information at:

Paul A. Smith, Ph.D.
6105 Glenhurst Way
Citrus Heights, CA 95621

916-296-7171

Stanton

Dawson. Nedra

From: Barbara S [barbs992@earthlink.net]
Sent: Monday, December 05, 2005 7:53 PM
To: MHSA
Subject: Regarding Police Department PERT Teams
Importance: High

This email is in response to efforts of the police department for support of PERT Teams. PERT teams are needed for this community.

I have a family member who has a mental illness so I have prior knowledge with the police department and the way they deal and treat people with a mental illness. It is not favorable.

The police are used to dealing with criminals and with that, their minds are geared toward treating everyone as a criminal; their treatment of people with a mental illness has much to be desired. People with this illness are called 'mentals' by police members. It takes a certain person to be a mental health provider, I believe police are not those people, and unless assurances and strict adherence to those assurances were in place that these police directed PERT teams will be trained in compassion and that the mentally ill person will be treated as a sick person instead of a criminal I say no to Police Directed PERT teams.

I certainly say NO to a police 'mentally ill persons' data base.

A mentally ill person has an illness. There are times, this illness has a profound impact on the community. The person may not be diagnosed, not in compliance with medication etc. It is for these reasons that this issue should dealt with at the medical level. Not police level.

I support for the money to be directed more towards dedicated PERT teams out of Sacramento Mental Health and those places contracted out for mental health issues, such as Visions Unlimited, El Hogar, and the others. More outpatient centers such as Visions and the others. Each having two or more PERT teams available 24/7. Mental health providers to be escorted by at least one police member that has been trained exclusively in Mental Health issues. PERTs on the medical level and not police level.

Thank you for your time and attention to my remarks...

Barbara Stanton
Hagginwood Resident
barbs992@earthlink.net
(916) 927-7446

Dawson. Nedra

From: tricia [4tstinzo@comcast.net]
Sent: Tuesday, November 29, 2005 4:49 PM
To: MHSA
Subject: PERT funding

I am writing to you to express my strong desire to provide our community with the much needed Psychiatric Emergency Response Team (PERT) funding to serve the citizens of the city of Sacramento.

Thank you
Tricia Stinson
845 - 4493

Dawson. Nedra

From: Kathy Tescher [fbba@macnexus.org]
Sent: Wednesday, November 30, 2005 10:13 AM
To: MHSA
Subject: Support of PERT Teams

This email is to show our support for this program in the Sacramento area which we feel will benefit the business community on Franklin as well as others in Sacramento. Certainly, this a a step to make the police force successful when dealing with persons with mental health problems.

--
Kathy Tescher, Executive Director
Franklin Boulevard Business Association
WHERE GREAT THINGS ARE HAPPENING
Phone: 916-455-2124
Fax: 916-455-5712

Sacramento County
Community Services and Supports Plan
Comment Number: 173

Dawson. Nedra

From: Lila Watkins [LilaWat@msn.com]
Sent: Thursday, December 01, 2005 9:47 AM
To: MHSA
Subject: Psychiatric Emergency Response Team - (PERT) for SPD

I think the idea of a Psychiatric Emergency Response Team for the Sacramento Police Department is really good

I had a neighbor a few years back who was mentally disturbed. She would wander up and down our streets at all hours of the day and night babbling to herself. She'd stand in the middle of the street and challenge cars to hit her. She'd pound on the cars if they slowed down. Early one morning she ran up and down the street pounding on garage doors in the neighborhood screaming, another time she just started breaking her own and her neighbor's windows. Through the years she lived in the neighborhood she had many episodes where she engaged in other erratic behavior. Sadly, she had two small children who saw a lot of this behavior.

Officers who responded to calls about her found her a frustration to deal with. She was a nuisance, and, though at times engaging in criminal behavior, obviously not of sound mind. They would take her for psychiatric help, she would become lucid again, and be released, usually in a day or so. There seemed to be no structure in place for anyone to take proper intervention to see this lady was given appropriate mental health treatment with follow-up care. Perhaps she would not have been such a drain on the police department's time and resources if she had been properly referred for mental health treatment.

It was my understanding that she is just one of many individuals like this in Sacramento.

I think a PERT would be invaluable. Giving officers the immediate assistance of a mental health professional to deal with these individuals makes good sense.

Lila Watkins
7421 - 25th Avenue
Sacramento, California 95820

Dawson. Nedra

From: Jim Williamson [calzephyrman@yahoo.com]
Sent: Thursday, December 01, 2005 1:16 PM
To: MHSA
Subject: Support for PERT team proposal

I would like to voice my support for the concept that Chief Najera has advanced. I am a city of Sacramento resident and have seen our streets used as dumping ground for the mentally ill. Without law enforcment as a component many of these people will never get assistance and these funds will be wasted.-James Maccoun

---

Dawson. Nedra

From: Wister. Phillip
Sent: Wednesday, November 30, 2005 12:55 PM
To: MHSA
Subject: PERT

It is absolutely urgent that the County recognize and coordinate services for those peope who find themselves in Mental Health Crisis. The City and County Law Enforcement agencies lose time and money each year adding this ineffecient and foreign task to their already overburdend staff. Add this expense to the cost of an unneccesary Psychiatric Hospital stay and the cost of one incident soars to County Multi-Agancy Budget Busting proportions. We must find a solution to this hole that we have in the sevices that are provided by Sacramento County Mental Health. We must have Agencies involved in this problem work together for the financial and emotional good of our community.
Phillip Wister MFT

Sacramento County
Community Services and Supports Plan

Comment Number: 402

Department of Human Health Srvs
Mental Health Division
7001 A East Parkway
Sacramento, CA 95823

MHSA@SacCounty.net

Attn: Richard Harig

Attn: Sac. Mental Health Board Members

Mr. Harig and Board Members,

I am a citizen of Sacramento city and county who wishes **to support** the Psychiatric Emergency Response Team (PERT) development. Since Ronald Regan decreased the Mental Health Budgets in California during his governorship, the cities and counties, including this city, have an increased population of people wandering the streets with obvious mental health symptoms.

It is the police who are usually the first to see these needing people. It is the police more often than others and who can offer the first helping hand. Since PERT teams will include licensed mental health clinicians as well as specially trained police officers, this type of program can to improving the mental health of the target population; and hopefully that will be give them a chance to return to the community as both benefited and benefiting citizens.

Since the 2004 Proposition 63 provides the opportunity to implement PERT, I believe we should all support the implementation. I think the fact that former Assembly Member Darrel Steinberg, a man well versed in mental health issues authored the bill leading to the PERT concept, it a concept to take seriously. PERT can be studied as it is initiated and becomes pioneered in City and County so that we can all substantiate its benefits.

Sincerely,

Margaret Anaya Tan
mayabird02@aol.com

TALKING POINTS
Against the inclusion of PERT as designed in Sacramento's MHSA plan.

Sacramento County
Community Services and Supports Plan
Comment Number: 1605

Program Issues

The Proposed program is Not a PERT program

Goal of PERT team is as the moment of **initial contact.** It is to assist the police in relating to the person in distress in a sensitive and respectful manner at the **moment of contact**. This PERT model does not meet the PERT goal. By the time the second responders get to the scene, with the police and mental health worker, the situation has solidified in whatever direction it is going. This PERT model would not change any of the violent ends that have occurred between police and people in acute distress. A mental health worker, client and family members need to be with the first responders to actualize the goals of a PERT team. The only reason this PERT is designed with the mental health workers and police going out as second responders is to legally allow MHSA funds to pay for the police. **The money has determined the program model.**

Duplication of Efforts

It is a duplication of efforts and money to send two sets of police out to the same situation – as first and second responders. This amounts to $400,000.from MHSA funds that is supporting the second police team. (The total program itself costs $1,322,428.) These funds could and should go to community programs for people to access. In fact, the diversion of funds from needed community supports and services to support a duplication of police presence is indefensible.

Excludes Clients and Family members in a meaningful way

Clients and Family members have no real role in the program. They are not in the field, interacting with the person in distress. It is not clear what they will do. What is clear is that they were written into the plan to meet the criteria to include clients and family members.

MHSA Can Not Fund Police or non Mental Health Functions.

"California Department of Mental health (DMH)
Frequently Asked Questions
Community Services and Supports (CSS) Component
Updated November 22, 2005

1. ***Mobile Crisis Team Partnership with Law Enforcement – One of the strategies listed in the CSS Program and Expenditure Plan Requirements is a crisis intervention team partnership with law enforcement. Can you describe in more detail what this partnership is like, and since this is a collaborative effort, what costs would be fundable with MHSA funding?***

   Mobile crisis teams which pair police officers and mental health professionals are sometimes called Psychiatric Emergency Teams (PET) or Psychiatric Emergency Response Teams

(PERT). The key aspect of these teams is that they provide a co-response of both police and mental health staff in emergency situations. These teams respond on-scene to situations involving people with mental illness. Their mission is to screen and evaluate persons with mental illness who come into contact with police and to refer them to the most appropriate service available and in the least restrictive environment possible. Places where police/mental health crisis response teams have been implemented have reported increased police safety, time savings for patrol officers and savings for taxpayers.

All of the mental health costs for staffing and providing new or expanded services are allowable under the MHSA. In addition, costs for training of law enforcement personnel and for evaluation of new or expanded services are also allowable. Costs for the law enforcement officers themselves are not allowable costs and are usually paid for by the law enforcement jurisdiction, consistent with their existing responsibilities. In addition, other costs usually born by law enforcement when responding to police calls, such as police cars, radios, administrative costs, etc. cannot be funded under MHSA."

Of course, the police have avoided this funding prohibition by calling themselves second responders. This is a manipulation of words and subversion of a program model to get funds. **However, this is still a slippery slope and can influence counties across the State to use MHSA funds for non mental health personnel and operations. Or it can teach counties throughout the State how to manipulate language and masquerade as mental health functions so as to assess MHSA funds.**

Police Should NOT Perform Police Functions while Acting as Mental Health Providers

It is highly problematic to consumers for police to run warrant checks on people in crisis. This is a police function, not a mental health function. It will lead to people being sent to jail, while reducing incarceration is a goal of the MHSA.

There Should Be Evaluation Component

Especially since this PERT team is different from the design of PERT teams as first responders, it should be evaluated. One question that should be explored, given the duplication of the police presence: does this lead to more of less instances of involuntary treatment or incarceration? The reduction of involuntary treatment and incarceration is a goal of the MHSA.

Diverts Funds from Needed Programs to Support an Ineffective Program

The proposed PERT does not effect the results desired: to diffuse potentially violent incidents and provide support for people in distress by having mental health workers and peers join police at the **first contact.** Thus, the Sacramento program diverts $1,322,428. from needed community programs that would keep people out of crisis for an ineffective program. In plain language, it will decrease needed services and supports for the sake of
a money driven unworkable program.

Process Issues

The Addition of the PERT to Sacramento's MHSA Plan subverts the Stakeholder Process and defies transparency:

- PERT was initially rejected by the MHSA Steering Committee. Because of outside pressure and a series of closed meetings that produced compromises which did not reflect the express wish of consumers and others, it was deceptively brought to on the Steering Committee for new consideration and voting.
- There was a lack of clarity in the consideration of the PERT proposal as to what was being voted on and from where the funds would be taken.
- Coercive tactics were used to induce the Steering Committee to accept PERT as part of Sacramento's plan. Consumers and others were told that the Board of Supervisor would vote the whole plan down if PERT was not included.
- The agenda of the Steering Committee meeting at which it was decided to reconsider the PERT proposal was not posted in advance of the meeting. On the contrary, the meeting was advertised as a final debriefing meeting.
- After an open Steering Committee meeting at which the PERT team was turned down (again) by a tie vote, the County recounted the vote outside of public view and reversed the tally. The secrecy of this recount opens it up to suspicion.
- If the PERT is to be included in the plan (and not as an addendum), there needs to be a 30 day review period from the time it was inserted into the plan.

The process is a clear instance of an outside group using political muscle to subvert a stakeholder democratic process.

The process is a clear money grabbing instance: a group outside of mental healtb positioning itself to get MHSA funds.

Submitted By:
Sacramento Network of Mental Health Clients

December 5, 2005

Robert Luco
3930 L Street
Sacramento, CA 95816

Ann Edwards-Buckley, Chief
Adult mental Health Services
7001-A East Parkway, Suite 3000
Sacramento, California, 95823

Dear Ms. Edwards-Buckley:

I understand that the Mental Health Board will convene a public hearing related to the Mental Health Services Act (MHSA) draft PERT plan on December 7th, 2005 at 6:30pm at the Grand Ballroom located at 1215 J Street, Sacramento, CA, 95814.

Unfortunately, I am currently working on a contract in Southern California and will not be able to attend the meeting in person. This meeting and its outcome are extremely important to me and my family. As a result, I am writing to ensure that my position is on record.

I want to be on record for supporting the compromise proposal for four Psychiatric Emergency Response Teams (PERT). In addition, I am also in support of the recommendation that encourages The County of Sacramento to find new money to pay for the full PERT program of 12 teams as a way to "pay back" the mental health community for transferring $21 million dollars out of the mental health trust fund over the past 10 years.

Our family members and friends who struggle with mental illness deserve to be dealt with in a caring and compassionate manner if law enforcement interventions are required. It is too easy to brush this group aside, reduce funding or shift responsibility to some other agency. The irony is that each of us knows someone who is affected or touched by mental illness - a neighbor, a friend or a relative. Even with that, we continue to argue over funding, argue over approaches and program configurations and can not put in place the support structures needed to provide humane and caring responses during serious events. Shame on us! They deserve better.

We must not forget that our mentally ill relatives and friends are not criminals, simply ill people. They did not choose this path. Like any illness, it happened to them and they need our help. Although funding and budget limitations constrain our efforts, we need to unite and do the best we can to begin building a strong support structure that will be in their best interests. My hope is that this meeting will be the beginning of that unified, strong approach.

I look forward to a clear, unified direction from this meeting.

Yours truly,

Robert M Luco

Dawson. Nedra Dave Schroeder / unnamed

From: Dave [davedabear@juno.com]
Sent: Thursday, December 08, 2005 3:41 PM
To: MHSA
Subject: Fw: pert

Sacramento County
Community Services and Supports
Plan
Comment Number: 2 / 2

Here is one comment I received this AM

Dave

---------- Forwarded Message ----------

there was a good point brought to me buy a consumers this morning they notice on the list of things that could be cut so that pert could be funded that there where no cuts to the county moneys not even a mention that the county is getting over a million dollars for admin fees why not hire a out side community to over see the pert teem are even the mental health board. I am so sick of the powers to bee all ways dictating what is good for me, don't get me wrong I am for pert but not for taking services away from a mental health system that is all ready under funded, the price for pert is to high, the price it takes to pay one police officer I could find housing and food and treatment for 6 clients,

Sacramento County
Community Services and Supports
Plan

Comment Number: 215

Protection & Advocacy, Inc.

SACRAMENTO LEGAL OFFICE
100 Howe Avenue, Suite 235 North, Sacramento, CA 95825-8202
Telephone: (916) 488-9950 Fax: (916) 488-9960
Toll Free/TTY/TDD: (800) 776-5746
www.pai-ca.org

December 8, 2005

Richard Harig
DHHS, MHSA
7001-A East Parkway
Sacramento, CA 95833

Re: Mental Health Services Act (MHSA) and Funding for Psychiatric Emergency Response Team (PERT)

Dear Mr. Harig,

Yesterday, we submitted the enclosed comments to the county e-mail address as directed. That submission did not contain the attachments. As stated in the e-mail, I am sending to you a complete copy of our response opposing the use of MHSA monies to fund the salaries of law enforcement officers or to pay for equipment related to law enforcement duties when an officer is a member of a PERT.

This agency presented the enclosed written comments and attachments at the Sacramento Mental Health Board meeting and public hearing on the MHSA plan that took place on December 7, 2005.

Sincerely,

Suzanna Gee
Associate Managing Attorney

Enclosure: Written Comments MH Board Hearing on 12/7 on MHSA monies and PERTs

Protection & Advocacy, Inc.

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December 7, 2005

Richard Harig
DHHS, MHSA
7001-A East Parkway
Sacramento, CA 95833

Re: Comments to Public Hearing on 12/7/05 on funding of Psychiatric Emergency Response Team (PERT) with MHSA Monies

Dear Mr. Harig:

Protection and Advocacy, Inc. (PAI) submits these comments in opposition to the use of Mental Health Services Act (MHSA) monies to fund the salary of police officers and equipment for a PERT since police officer's existing duties include responding to crisis situations involving individuals with mental health issues. Funding police officers' salaries with MHSA monies will necessarily reduce or eliminate funding for proposals that are consistent with the principles and objectives of MHSA which is to expand community services and services that promote the recovery model. Funding law enforcement work with MHSA monies will result in a rejection of other projects previously proposed and supported by the mental health community such as the Older Adult Multi-disciplinary Crisis Program as born out in a recent letter by Ann Edwards-Buckley, Chief for the Division of Mental Health, County of Sacramento dated December 3, 2005. (Attachment #1)

As you may already know, PAI is the federally mandated disability rights organization. PAI operates statewide to enforce the legal rights on individuals with disabilities. Our legal advocacy staff addresses individual rights violations and systemic issues through education, training, and direct representation, investigates allegations of abuse and neglect, and advocates for the enforcement and advancement of disability rights on a local, state and federal level.

PAI does support training of police officers who respond to crisis situations involving individuals with mental health needs, as well as collaboration between mental health professionals and law enforcement when responding to a crisis situation. PAI's Investigations Unit report on the shooting death by police of two men with psychiatric disabilities[1] is in fact cited by the proponents of the PERT proposal. PAI does *not,* however, support the current proposal for the use of MHSA monies for the funding of police officer's salaries. The reason for our opposition is threefold:

Existing Law Enforcement Function

The Mental Health Services Act specifies that funds shall be utilized to expand *mental health* services. Police officers, even those responding as part of a PERT, are performing a law enforcement function and their salaries and any costs associated with this law enforcement function are not reimbursable under MHSA. The Department of Mental Health (DMH) has issued documents reflecting their position that MHSA monies cannot fund police officer salaries or equipment for a PERT:

> All of the mental health costs for staffing and providing new or expanded services are allowable under the MHSA. In addition, costs for training of law enforcement personnel and for the evaluation of new or expanded services are also allowable. Costs for the law enforcement officers themselves are not allowable cost as they are usually paid for by law enforcement jurisdiction, consistent with their existing responsibilities. In

[1] "Report of An Investigation in to the Deaths of Charles Vaughn, Sr. on May 19, 1998 and Marvin Noble on July 16, 1998" Protection and Advocacy, Inc. May 2000.

addition, other costs usually born by law enforcement when responding to police calls, such as police cars, radios, administrative costs, etc. cannot be funded under MHSA.

(Attachment #2 DMH Frequently Asked Questions for the Community Services and Supports Component (CSS), November 22, 2005.)

State DMH Director, Stephen Mayberg further stated in a September 27, 2005, letter to Sacramento Chief of Police, Albert Najera, "Law enforcement activities, even if done with individuals who have mental illness, are not considered mental health services and would not be eligible for MHSA funding." (Attachment #3)

Non-Supplantation

Even if one could make the argument that police responding to a crisis constitutes a "mental health service," MHSA funds cannot be used to cover this cost. The Mental Health Services Act specifies that funds "shall be utilized to expand mental health services. These funds shall not be used to supplant existing state or county funds utilized for mental health services. Peace officers have an existing duty to respond to crisis calls, including those related to individuals with mental health needs. These responsibilities include assessing the individual and their situation to determine the need for emergency intervention and detaining and transporting individuals who require involuntary emergency intervention. Shifting this responsibility from several officers to a few specifically designated and trained officers does not create a new service or an expansion of services. (Attachment #4 DMH Letter No.: 05-04 Mental Health Services Act- Non-Supplantation, July 18, 2005.

Intent and Spirit of MHSA

PAI is disquieted by the serious concerns that have been raised by stakeholders in the mental health community as to the manner in which the Sacramento PERT proposal has been promoted. Meaningful involvement of consumers and family members in the development of the Sacramento County plan for MHSA funding is required under the Act and what DMH has issued regarding the plan requirements. The MHSA Community Services and Supports Three-Year Program and Expenditure Plan Requirements issued August 2005 (CSS Plan) states that one of the essential elements "that must be embedded and continuously addressed throughout [this planning process for plans submitted by the county] is community

collaboration. The CSS Plan requires that counties submit detailed responses on the public planning process that is to include meaningful involvement of consumers and families as full partners.

Sincerely,

Suzanna Gee
Associate Managing Attorney

Ann Coller,
Senior Advocate

Enclosures: Attachments as listed above

cc: Sacramento County Board of Supervisors
MHSA Oversight and Accountability Commission

Countywide Services Agency

Department of
Health and Human Services

Mental Health Services
Ann Edwards-Buckley, Chief
Adult Mental Health Services

County of Sacramento

Terry Schutten, County Executive
Penelope Clarke, Agency Administrator
Jim Hunt, Department Director
Kathleen Henry, Division Director

December 3, 2005

Dear Members of the Community:

I wish to thank everyone again for your participation in the Mental Health Services Act (MHSA) planning process that began in January of this year. On October 31, 2005, the Division of Mental Health posted the draft Community Services and Supports plan for public review and comment. Since then there has been considerable support for the Psychiatric Emergency Response Team (PERT); which was included as an addendum to the plan, but not recommended for funding. As a result of public input regarding PERT, additional Steering Committee meetings were held. These meetings resulted in a compromise and a decision to recommend PERT for funding. The compromise is to fund 4.5 PERT teams versus the originally proposed 12. Additionally, both the Sheriff and the Chief of Police have agreed to contribute funding for the program.

In order to include PERT in the programs recommended for funding, other services had to be reduced. PERT is a system development funded program. Due to the State Department of Mental Health requirement that more than 50% of the funding be utilized in full service partnership programs, the reductions must come from other system development funded programs. The programs in the draft plan funded with system development funding are: the Wellness and Recovery Center, the Transitional Community Opportunities for Recovery and Engagement (CORE), and the Older Adult Multidisciplinary Crisis Intervention, Stabilization and Intensive Case Management Program.

There was no way to avoid fully cutting the Older Adult Multidisciplinary Crisis Program. Therefore, there will be designated capacity for older adults in the Transitional Community Opportunities for Recovery and Engagement (CORE) Program. Additional one-time funds will be added to the Older Adult Intensive Program, to allow for more comprehensive assessments of Older Adults as they are being assessed for membership into this full service partnership program.

Reductions were also made to the Wellness and Recovery Center and CORE. The updated budgets for these programs can be reviewed on the website at the following link: http://www.sacdhhs.com/article.asp?ContentID=1457

This was a painful process for all, as the MHSA does not provide adequate funding to meet all of the unmet needs in our community. We continue to welcome your comments on these programs recommended for funding. Comments can be provided to our MHSA e-mail address at MHSA@saccounty.net, or by sending written comments to our office at 7001 A East Parkway, Sacramento, CA 95823 attention: Richard Harig. The Mental Health Board will convene a public

hearing on the draft plan on December 7, 2005, at 6:30 pm at the Grand Ballroom located at 1215 J Street, Sacramento, CA, 95814.

Sincerely,

Ann Edwards-Buckley

Ann Edwards-Buckley
Division of Mental Health

California Department of Mental health (DMH)
FREQUENTLY ASKED QUESTIONS
Community Services and Supports (CSS) Component
Updated November 22, 2005

1. ***Mobile Crisis Team Partnership with Law Enforcement – One of the strategies listed in the CSS Program and Expenditure Plan Requirements is a crisis intervention team partnership with law enforcement. Can you describe in more detail what this partnership is like, and since this is a collaborative effort, what costs would be fundable with MHSA funding?***

   Mobile crisis teams which pair police officers and mental health professionals are sometimes called Psychiatric Emergency Teams (PET) or Psychiatric Emergency Response Teams (PERT). The key aspect of these teams is that they provide a co-response of both police and mental health staff in emergency situations. These teams respond on-scene to situations involving people with mental illness. Their mission is to screen and evaluate persons with mental illness who come into contact with police and to refer them to the most appropriate service available and in the least restrictive environment possible. Places where police/mental health crisis response teams have been implemented have reported increased police safety, time savings for patrol officers and savings for taxpayers.

   All of the mental health costs for staffing and providing new or expanded services are allowable under the MHSA. In addition, costs for training of law enforcement personnel and for evaluation of new or expanded services are also allowable. Costs for the law enforcement officers themselves are not allowable costs and are usually paid for by the law enforcement jurisdiction, consistent with their existing responsibilities. In addition, other costs usually born by law enforcement when responding to police calls, such as police cars, radios, administrative costs, etc. cannot be funded under MHSA.

2. ***Mental Health Courts – If we want to implement a mental health court in our county for persons with serious mental illness who have criminal justice charges, what costs are allowable for funding under the MHSA?***

   Mental health courts are specialized courts for defendants with mental illness. Defendants are offered the opportunity to participate in court-supervised treatment in lieu of typical criminal sanctions. Mental health courts involve customary court staff as well as additional mental health staff. The costs of customary court staff and procedures, such as the judge, the attorneys, the bailiff, etc. are not allowable MHSA costs. Mental health clinicians and case managers who provide and monitor the defendant's treatment are allowable costs for new or expanded services. Some mental health courts also employ a court coordinator or court administrator who functions as a liaison between the court and the mental health system. This position

may include both court functions, and mental health functions such as screening and/or case management. If so, the new or expanded costs attributable to the mental health functions would be an allowable MHSA cost. If there are other positions or costs with blended functions, the new or expanded costs should be allocated, with MHSA funds being used for mental health functions only.

3. ***CSS Plan Exhibits – Should counties put exhibits with each program or as appendices?***

   Exhibits 1 -3 (Face Sheet, Work Plan Listing, Full Service Partnership Population) provide an overview of the Three-Year Program and Expenditure Plan and should be near the beginning of the plan.

   Exhibits 4 and 5 (Program Work Plan Summary and Budget and Staffing Detail Worksheets) are related to each program for which funding is being requested and should be submitted with that program description.

   Exhibit 6 (Quarterly Progress Report) may be included with the overview Exhibits (1-3), or as an appendix.

   Exhibit 7 is not due until one month after the end of each quarter after the plan approval.

4. ***Are 2034 considered Full Service Partnerships?***

   Individuals being served in AB 2034 are generally considered as having Full Service Partnerships, provided that the services and supports offered to individuals in these programs meet the criteria on pages 22 and 23 of the DMH Letter 05-05, CSS Program and Expenditure Plan Requirements, dated August 1, 2005 (Requirements).

5. ***Would a three-year county plan that provided less than a majority of total funds for Full Service Partnerships be acceptable to DMH assuming that this strategy emerged from the local planning process?***

   While DMH encourages counties to use the strategies that emerge from the local planning process, these strategies must meet the requirements contained in DMH Letter 05-05, the MHSA CSS Program and Expenditure Plan Requirements released on August 1, 2005 (Requirements). Page 8 states that DMH requires counties to request a majority (more than 50%) of their total CSS funding for Full Service Partnerships for the three-year planning period. The only exception to this is for small counties, which are required to request a majority of their total CSS funding for Full Service Partnerships in Year Three (FY 2007-08). However, DMH recognizes that counties may need to establish new programs and services and conduct outreach and engagement efforts in order to begin to serve unserved populations, which are priority populations for MHSA funding. Therefore, the requirements also state that services funded from General System Development or Outreach and Engagement funds provided to individuals who have Full Service Partnerships may be counted in achieving the CSS Full Service Partnership funding requirement. This means that counties may estimate the percentage of System Development funds

and Outreach and Engagement funds that will be spent on individuals who will be receiving Full Service Partnerships within the three-year planning period and count those funds in determining the percentage of Full Service Partnership funding over the entire period. The same process is available to small counties in Year Three.

6. ***What is the difference between 'Planning Estimates' and 'Planning Funding?'***

   The MHSA (Section 5892 (c)) provides the guidance related to 'Planning Funding.' It is five percent of the total amount available for MHSA services. It is intended to support the local stakeholder and planning process. The 'Planning Estimate' is the maximum amount of MHSA funding each county can request through their CSS Program and Expenditure Plan (reference DMH Letter 05-02). It is not an allocation as traditionally used to distribute funds and therefore is not a guaranteed amount for each county. The amount the county actually receives is based on the approved plan.

7. ***Can Quality Assurance/Quality Improvement (QA/QI) activities related to MHSA be reimbursed?***

   QA and QI may be allowable under MHSA funding provided that such activities comply with the non-supplant policy outlined in DMH Letter 05-04 (services are an expansion of mental health services and were not previously provided or funded with existing state or county funds) and that the activities are intended to support the transformation agenda of the MHSA. For programs that already have QI/QA requirements, such as Medi-Cal programs, MHSA funding is available for new or expanded QA/QI activities that focus on the goals of the MHSA. These activities may be included in the MHSA Administration budget or, if the QA/QI is program-specific, may be included in the budget for the specific program.

8. ***When is it allowable to purchase IT hardware?***

   Proposed IT hardware may be included as part of the CSS budget for other one-time funding for such things as personal computers, servers and other technology equipment related to the CSS programs included in the county's CSS plan. A county may purchase the IT hardware upon approval of their CSS plan. One-time funds cannot be used to simply replace existing information technology systems, but can be used to cover incremental cost of improving the functionality of the system.

9. ***Do the proposed CSS Budgets have to be consistent with annual planning estimates?***

   DMH provided annual planning estimates to inform counties of the maximum amount of annual CSS funding available to each county for services in DMH Letter 05-02. It is possible that the sum of the CSS budgets and start-up funding proposed by the county (as described in DMH Letter 05-06) can be less than the annual planning estimates. In any event, the sum of the startup funding and the CSS budget for each year of the three-year plan cannot exceed the cumulative year-to-date planning estimates for the three-year period or the total three-year period FY 2005-06 through FY 2007-08.

10. ***What is the philosophy of DMH regarding how long an individual should be in a Full Service Partnership?***

    It is appropriate to discharge someone from an FSP when they and their personal services coordinator agree that they no longer need services from the public mental health system.

11. ***Is there a way to estimate available funding for developing each of the annual budgets for the CSS Three Year Program and Expenditure Plan?***

    DMH Letter No. 05-02, dated June 1, 2005, transmitted the Planning Estimates for each county for the first year of the CSS Three Year Program and Expenditure Plan. Click here for a chart that provides the specific Planning Estimate amounts by county for each of the three years. The increases from the initial Planning Estimates are based on the estimated increases in funding available as specified in the statute. In the event of a projected revenue shortfall, DMH will notify the counties of any change in these Planning Estimates on an annual basis.

CALIFORNIA DEPARTMENT OF
Mental Health

1600 9th Street, Sacramento, CA 95814
(916) 654-2309

September 27, 2005

Mr. Albert Nájera
Chief of Police
Sacramento Police Department
5770 Freeport Blvd., Suite 100
Sacramento, CA 95822

Captain Stephen R. Liebrock
Commander
Security Services Division
Sheriff's Department
711 G Street
Sacramento, CA 95814

Dear Chief Nájera and Captain Liebrock:

At our meeting of September 20, 2005, we discussed your proposal to provide law enforcement and mental health teams in Sacramento County with funding from the Mental Health Services Act (MHSA). It is my understanding that since our meeting, stakeholders in Sacramento County continue to refine priorities and specific strategies to be included in the county's Community Services and Supports Plan. This letter is a follow-up to our discussion to clarify requirements for these MHSA funds.

Following are some of the critical factors that will be considered in determining allowability of expenditures for joint system development programs between law enforcement and mental health

1) Does it meet the non-supplantation requirements as outlined in DMH Letter 05-04?
2) Was the proposal included in the plan that was reviewed by the public?
3) Is it consistent with the funding limitations specified in DMH letter 05-05 that requires that system development programs include only mental health services?

In the meeting, you requested clarification of the restrictions on MHSA funding of positions with blended functions. For system development programs, only the portions of time focused on providing mental health services are eligible for funding. Law enforcement activities, even if done with individuals who have mental illness, are not considered mental health services and would not be eligible for MHSA funding.

Requests for MHSA funding must be submitted by county mental health. Our performance contract will also be with the county mental health department who will be the entity that the state holds accountable for implementation of programs and achievement of positive outcomes.

If you have additional questions, we would be willing to meet with you again with representatives of Sacramento County Mental Health.

Sincerely,

STEPHEN W. MAYBERG, Ph.D.
Director

cc: Kathleen Henry, Sacramento County Mental Health
David W. Risley, Sacramento Police Department
Lieutenant Ken Bernard, Sacramento Police Department
Sergeant Matthew Reali, Sheriff's Department

CALIFORNIA DEPARTMENT OF
Mental Health

1600 9th Street, Sacramento, CA 95814
(916) 654-2309

July 18, 2005

DMH LETTER NO.: 05-04

TO: LOCAL MENTAL HEALTH DIRECTORS
LOCAL MENTAL HEALTH PROGRAM CHIEFS
LOCAL MENTAL HEALTH ADMINISTRATORS
COUNTY ADMINISTRATIVE OFFICERS
CHAIRPERSONS, LOCAL MENTAL HEALTH BOARDS

SUBJECT: MENTAL HEALTH SERVICES ACT—NON-SUPPLANTATION

REFERENCE: Implementation of MHSA, Welfare and Institutions Code (WIC) Sections 5847, 5848, 5891 and 5892

The purpose of this letter is to transmit the County Non-Supplantation policy under the Mental Health Services Act. This policy applies to all components of the Mental Health Services Act and shall be used to guide the interpretation of the Act with regard to local funding issues.

For reference, Welfare and Institutions (W&I) Code Section 5891 implemented as part of the MSHA:

> "The funding established pursuant to this act shall be utilized to expand mental health services. These funds shall not be used to supplant existing state or county funds utilized to provide mental health services. The state shall continue to provide financial support for mental health programs with not less than the same entitlements, amounts of allocations from the General Fund and formula distributions of dedicated funds as provided in the last fiscal year which ended prior to the effective date of this act. The state shall not make any change to the structure of financing mental health services, which increases a county's share of costs or financial risk for mental health services unless the state includes adequate funding to fully compensate for such increased costs or financial risk. These funds shall only be used to pay for the programs authorized in Section 5892. These funds may not be used to pay for any other program. These funds may not be loaned to the state General Fund or any other fund of the state, or a county general fund or any other county fund for any purpose other than those authorized by Section 5892."

The Department's policy related to county non-supplanting under the MHSA consists of three requirements, all of which must be met in order for an expenditure to be eligible for reimbursement under the MHSA:

1. Funds must be used for programs authorized in Section 5892 of the W&I Code
2. Funds cannot be used to replace other state or county funds required to be used to provide mental health services in fiscal year 2004-05 (the time of enactment of the MHSA)
3. Funds must be used on programs that were not in existence in the county at the time of enactment of the MHSA (new programs) or to expand the capacity of existing services that were being provided at the time of enactment of the MHSA (11/02/04).

Further detail regarding these requirements follows:

1. Programs Authorized in Section 5892 of the W&I Code

Section 5892 of the W&I Code requires that funds under the MHSA must be used for the following programs:

- Education and Training
- Capital Facilities and Technological Needs
- Prevention and Early Intervention
- Services for Children (including Transition Age Youth) and Adults and Older Adults (defined as Community Services and Supports by the Department)
- Innovative Programs
- Local Planning
- State Administration

Services that do not fall under one of the above programs and do not meet DMH MHSA requirements cannot be funded through the MHSA.

2. Replacement of Other State and/or County Funds

Counties cannot use MHSA funds to replace other state and county funds required to be used by the county mental health department to provide mental health services in fiscal year 2004-05 (the time of enactment of the MHSA). Funds required to be used by the county mental health department include all allocations either from or through the State Department of Mental Health, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) State General Fund, and realignment funds allocated for mental health services (excluding

allowable 10 percent realignment transfers). The Department will provide each county with a listing of their fiscal year 2004-05 allocations required to be used for mental health services along with an estimate of fiscal year 2004-05 EPSDT State General Fund based on settled fiscal year 2002-03 EPSDT State general funds. County expenditures will be evaluated against the fiscal year 2004-05 aggregate spending amount net of allowable realignment transfers and county overmatch, which are not required to be used on mental health services.

This does not preclude a county from ceasing to fund programs that no longer meet the needs of the county and its stakeholders as long as the aggregate state and county funds required to be used to provide mental health services are used for such purpose. This also does not preclude a county from using MHSA funds to expand the capacity of an existing program beyond the levels funded in fiscal year 2004-05.

Note that counties are still required to comply with existing statutes and regulations regarding the use of funds for mental health services. The Department does not intend to change the structure of mental health financing which would increase a county's share of cost or financial risk for mental health services. Thus, counties are required to use the following funds consistent with current statute, regulations and contracts: realignment funds allocated to the Mental Health Account (excluding the ten percent allowable transfer) for mental health services, the county maintenance of effort on realignment funds for mental health services, managed care State General Fund for mental health services, other Department of Mental Health Local Assistance State General Fund for mental health services, and any other state or county funding sources that are statutorily required to be used for mental health services. (State General Fund for EPSDT specialty mental health services are reimbursements for prior expenditures.) Counties are not required to use county realignment funds that are legally transferred to the Health or Social Services accounts in accordance with W&I Code 17600.20 for mental health services. Counties also are not required to provide county overmatch for mental health services even if this funding was previously provided by the county.

If a county transfers up to 10 percent of realignment funding out of mental health in accordance with requirements in W&I Code 17600.20, documentation of compliance with that statute must be submitted to the Department.

> "A county or city or city and county shall, at a regularly scheduled public hearing of its governing body, document that any decision to make any substantial change in its allocation of mental health, social services, or health trust fund moneys among services, facilities, programs, or providers as a result of reallocating funds pursuant to subdivision (a), (b), or (d) was based on the most cost-effective use of available resources to maximize client outcomes."

A county wishing to transfer 10 percent of realignment funding out of mental health must provide notice to the Department and the required amount will be adjusted accordingly. Annual expenditures of state and county funds must be documented as part of the cost report process to ensure compliance with this requirement.

3. Expansion of Mental Health Services

In accordance with Section 5891 of the W&I Code, MHSA funds must be used to expand mental health services beyond services that were provided or funded at the time of enactment of the MHSA, which was November 2, 2004. The Department has interpreted expansion to represent services not provided or funded in the county at the time of enactment of the MHSA (new services) or expansion of program capacity beyond what existed at the time of enactment of the MHSA (expansion of existing services). Inflationary increases in costs associated with programs in existence at the time of enactment of the MHSA are not eligible for MHSA funding because they do not represent an expansion of services through new services or increased program capacity. Increases in program costs due to expansion of existing services to a larger population are eligible for MHSA funding because they represent an expansion of services through an increase in program capacity.

Compliance

The Department will monitor county compliance with the non-supplanting requirements through the following activities:

1. The Department will provide each county with a listing of their fiscal year 2004-05 allocations required to be used for mental health services (excluding allowable 10 percent realignment transfers if the required documentation is submitted to the Department by the county).
2. The county is responsible for documenting the expenditure of these funds on mental health services through the cost report.
3. The county mental health director is responsible for certifying that the MHSA funding is to be used solely to expand services and that fiscal year 2004-05 funds required to be used for mental health services will be used in providing such services.
4. The county mental health director is responsible for certifying on the annual cost report that funding was actually used solely to expand services and that state and county funds required to be used for mental health services were used in providing such services.

If you have questions or need additional information, please contact the County Operations staff assigned to your county.

Sincerely,

Original signed by:
Robert Garcia
for

STEPHEN W. MAYBERG. Ph.D.
Director

Enclosures

cc: California Mental Health Planning Council
Chiefs, County Operations Sections

>>AUDIENCE MEMBER: HEIDI. I'M PRESIDENT OF THE NATIONAL ALLIANCE OF MENTAL ILLNESS. PLANNING PROCESS AS FAMILY MEMBERS. ONLY ORGANIZATION IN CALIFORNIA REPRESENTING A COLLABORATION BETWEEN FAMILIES AND CONSUMERS AND BOTH REPRESENTED THEM IN THIS PROCESS. WE WANTED TO REMIND THE COMMUNITY -- $21 MILLION. AFTER REVIEWING OVER 100 WORTHY PROGRAM IDEAS, WE WISH WE HAD THAT $21 MILLION; IT WOULD PAY FOR THE FULL TEAM AND THEN SOME. IT HAS FALLEN ON THE HEADS OF THE STEERING COMMITTEE.

AS YOU KNOW, THERE IS THE DIFFICULT RELATIONSHIP BETWEEN POLICE, CONSUMERS AND FAMILIES CHARACTERIZED BY FEAR AND MISTRUST. PERFORMED POLICE TRAINING FOR YEARS. WE BELIEVE THAT PERT IS OUR BEST CHANCE TO IMPROVE THE RELATIONSHIP BETWEEN LAW ENFORCEMENT AND THE FAMILIES. PERT IS THE CRITICAL FIRST POINT NECESSARY FOR SYSTEM TRANSFORMATION. ARREST AND INCARCERATION OF SICK PEOPLE -- JAILS SHOULD NOT BE THE DEFAULT SYSTEM. AND BELIEVES PERT HAS ITS PLACE ALONG OTHER IMPORTANT PROGRAMS BUT LACK SUPPORTIVE HOUSING. EFFECTIVE -- SIGNIFICANTLY IMPACT OTHER PRIORITY PROGRAMS AND FURTHER DIVIDE THE MENTAL HEALTH AND LAW ENFORCEMENT COMMUNITIES. MANY OF US ASSUMED IT WAS FOR THE FUNDING OF POLICE OFFICERS AND FUNDING SOCIAL WORKERS AND THE TRAINING, BUT WE WERE WRONG.

TO MAKE MATTERS WORTH WE HAD MISDIRECTION FROM THE STATE DEPARTMENT WITH THE MENTAL HEALTH SERVICES ACT. SO THE STEERING COMMITTEE STRUGGLED -- EVER CHANGING PROCESS. IT'S THE HOPE THAT THE FINAL OUTCOME DOES NOT CREATE DIVISION WHERE WE HAVE FOUND COMMON GROUND AND MUTUAL TRUST. SUPPORTS THE COMPROMISE OF $1.3 MILLION. HOWEVER, WE WILL CONTINUE TO ENCOURAGE THE COUNTY TO INCREASE COMMITMENT AND FIND MORE MONEY TO PAY FOR THE FULL 12 TEAM PERT PROGRAM AND THE OTHER HIGH RANKING COMMITTEES. AND RIGHTING THE WRONG OF THE MENTAL HEALTH TRUST FUNDS. THOSE WHO SUPPORT THESE COMMENTS, PLEASE STAND.

1215 I. Street
Grand Hall Ballroom

Thank you Board members:

My name is Heidi Sanborn and I am President of the National Alliance on Mental Illness - Sacramento.

- NAMI was asked to participate in the planning process as family members. However, NAMI is the only organization in California representing a collaboration between **families** and **consumers,** and both represented NAMI in this process.
- We also want to remind the community that NAMI has opposed for the last ten years the County's repeated transfers from the mental health trust fund which now total $21 million. After reviewing over 100 worthy program ideas, we wish we had that $21 million dollars now as it would pay for the full **12-team PERT program** and then some....
- Since that is not the case, it has fallen on the shoulders of the steering committee to make very tough decisions. How can $9 million per year "transform" such a broken system?

- As you know, there is a difficult relationship between the police, consumers, and families characterized by fear and mistrust. To address this, NAMI has been performing police trainings for years but it's not enough - We believe that **PERT is our best chance to improve the relationship** between law enforcement and the consumers and families.
- NAMI believes PERT is a critical first point of contact program that is **necessary for system transformation.** To prevent the inappropriate arrest and incarceration of sick people is the most humane thing we can do - **jails should not be the "default" system of care in Sacramento County.**
- NAMI wants what is best for the entire community and believes PERT has its place alongside the other important programs like supportive housing and wellness centers. However, we are concerned that the cost for an effective PERT program could significantly impact our ability to fund other priority programs and to further divide the mental health and law enforcement communities.

- When NAMI originally voted for PERT, many of us assumed it was with the police funding police officers and MHSA funding the Social Workers and the training. We were wrong.
- To make matters worse, we received inconsistent direction from the State Department of Mental Health as to what is and is not allowed with MHSA money, so the Steering Committee struggled to find a clear path of consensus through an ever-changing process. It is NAMI's hope that the final outcome of this effort **does NOT create division** where we have been able to find common ground and mutual trust.
- To conclude, due to lack of a better funding option, **NAMI supports the compromise of 1.3 million dollars of MHSA money to fund the PERT program.** However, we will **continue to encourage the county to increase its commitment** and find more money to help pay for the full 12-team PERT program, mental health court, and other high ranking programs. That would go a long way to partially righting the wrong of the previous mental health trust fund transfers.

- **Turn to the audience:** Will NAMI members who support these comments please stand?

Sacramento County
Community Services and Supports Plan
Comment Number: ATTACHMENT C
10 147

>>AUDIENCE MEMBER: I'M DR. RONALD P. I WAS A PART OF PLANNING COMMITTEE AND OLDER ADULTS. I WANT TO SPEAK TO REJECTION OF THE REVISION. IT IS INAPPROPRIATE TO MIX PSYCHOLOGISTS AND MENTAL HEALTH WORKERS WITH POLICE FORCES. THE TWO POSITIONS AND RESPONSIBILITIES ARE ENTIRELY DIFFERENT AND PUTTING A PERSON OF SOCIAL SERVICE CAPABILITIES ON A POLICE DETAIL WHICH IS MOST TRAINED TO SUPPRESS AND REDUCE CONFLICT IS ASKING FOR DANGER TO ALL PARTIES INVOLVED.

THE POLICE OFFICERS HAVE TO BE CONCERNED ABOUT ANOTHER PERSON BEING A PART OF THE TEAM THAT DOES NOT HAVE THE TRAINING THAT THEY DO IN SUPPRESSION. AND AS WELL AS THE POLICE OR THE SOCIAL WORKER THEMSELVES OR MENTAL HEALTH WORKERS THEMSELVES BEING IN DANGER.

I THINK THAT WHAT HAPPENED AT MIAMI TODAY IS A GOOD EXAMPLE OF WHAT CAN TAKE PLACE.

THE SECOND POINT IS IT'S A WASTE OF MONEY. THESE PEOPLE ARE AVAILABLE TO BE SEEN WHEN A POLICE OFFICER IS ABLE TO IDENTIFY A PERSON AS BEING POSSIBLY SUFFERING FROM SOME SORT OF MENTAL ILLNESS, AND THEY CAN BE SOUGHT AND SECURE THEIR INFORMATION AND EXPERTISE. BUT TO RIDE AROUND IN A CAR ALL EVENING AND AVOID THE TIME THAT WOULD BE NECESSARY TO SEE A REGULAR CASELOAD WOULD BE UNFORTUNATE.

THE MONEY IS LIMITED. AND TO PUT IT INVOLVED IN A -- FOLLOW A POLICE PATROL UNIT ON THE STREET WOULD NOT BE THE MOST EFFORT TO USE THE MONEY. THAN TO ALLOW THE POLICE DEPARTMENT TO ABSORB SOME SORT OF MENTAL HEALTH RESPONSIBILITIES. I THINK THE MENTAL HEALTH SHOULD STAY THE MENTAL HEALTH AND NOT GO WITH THE POLICE FORCE. (APPLAUSE).

>>AUDIENCE MEMBER: HELLO. SUSAN GALLAGHER. I'M THE EXECUTIVE DIRECTOR OF THE MENTAL HEALTH ASSOCIATION IN SACRAMENTO. I WOULD LIKE TO SAY THIS IS NOT A FASHION STATEMENT, ALTHOUGH IT LOOKS PRETTY GOOD, I THINK. IT REPRESENTS WHAT TRANSFORMATION NEEDS TO BE ABOUT FOR THE MENTAL HEALTH SERVICES ACT. NOTHING ABOUT US WITHOUT US AND TOTAL INVOLVEMENT AT EVERY STAGE.

I WOULD LIKE TO BEGIN BY TELLING YOU AS THE DIRECTOR OF MENTAL HEALTH ASSOCIATION I'VE HAD THE HONOR TO SUPPORT A WIDE ARRAY OF ACTIVITIES ASSOCIATED WITH THE MENTAL HEALTH SERVICES ACT HERE IN SACRAMENTO COUNTY.

IT HAS BEEN A VERY ARDUOUS TASK. WE'VE HAD LITERALLY HUNDREDS OF MENTAL HEALTH CLIENTS FAMILIES, UNDERSERVED COMMUNITIES REPRESENTED IN THIS PROCESS. IT'S BEEN ONE OF THE MOST EXCITING OPPORTUNITIES THAT I'VE EXPERIENCED IN MY WORK IN MENTAL HEALTH. I HAVE BEEN PLEASED WITH THE PROCESS. I HAVEN'T ALWAYS AGREED WITH THE RECOMMENDATIONS BUT THE PROCESS HAS BEEN TRANSPARENT AND THAT IT HAS BEEN FAIR.

I DO NOT SUPPORT THE PERT PROGRAM. I THINK THAT LAW ENFORCEMENT HAS TAKEN AN END RUN WITH THE PERT IN THE CONCLUSION OF THE PROCESS. THIS IS UNFORTUNATE BECAUSE MUCH NEEDED RESOURCES ARE BEING SHIFTED AWAY FROM COMMUNITY SERVICES AND SUPPORTS THAT HAD BEEN IDENTIFIED FOR FUNDING AND NOW BEING USED FOR LAW ENFORCEMENT PERSONNEL COSTS. THESE ARE ALLOWABLE UNDER THE MENTAL HEALTH SERVICES ACT.

THE OLDER ADULT MULTIDISCIPLINARY TEAM. AS MOST OF THE CHILDRENS PROGRAMS WERE NOT FUNDED. WE HAVE A SIGNIFICANT CUT TO THE WELLNESS AND RECOVERY CENTER AND THIS IS THE ONLY PROGRAM IN THE TABLE THAT IS A CONSUMER RUN AND OPERATED PROGRAM.

I FEEL STRONGLY THAT LAW ENFORCEMENT TRIED TO MANEUVER THIS -- SINCE THAT IS REALLY THE CRISIS INTERVENTION THAT IS NEEDED. AND FOR TRANSFORMATION TO REALLY TAKE PLACE, CONSUMER MEMBERS, MENTAL HEALTH PERSONNEL NEED TO BE PART OF THE INITIAL CONTACT. WE SHOULD NOT BE DUPLICATING EFFORTS.

IT HAS IMPLICATIONS FOR INVOLUNTARY COMMITMENT. 5150 SHOULD NOT BE ALLOWED TO SUPPORT. AND IT WAS ORIGINALLY VOTED DOWN AT THE STEERING COMMITTEE TO BE RESURRECTED OUTSIDE OF THE PUBLIC PROCESS. I STRONGLY DO NOT SUPPORT THE PERT. IT SHOULD BE AN ADDENDUM AND NOW HAVE 30 DAYS TO REVIEW BY THE PUBLIC. THANK YOU FOR LISTENING. (APPLAUSE).

Susan Gallagher
Mental Health Association

No County

Public Comment

As the Director of the Mental Health Association, I have had the honor and privilege of supporting a wide array of outreach and engagement activities associated with MHSA here in our county. It has been an arduous task. We've had literally hundreds of mental health clients, family members and underserved communities represented in this process. It has been one of the most exciting opportunities I have experienced in my work with the mental health community. For the most part, I have been pleased with the process. While I haven't always agreed with all the recommendations I have felt that the process was fair and transparent. As usual, though I have some concerns

However, I am not able to express those hopeful sentiments in terms of the PERT program. I think Law Enforcement took an "end run" with the PERT at the conclusion of the process. This is really unfortunate as much needed resources are now being shifted away from community services and supports that had been identified for funding to be used for Law Enforcement personnel costs. These costs remain un-allowable under the MHSA. The older adult multidisciplinary team suffers as do programs that could help children and families in our community. The Wellness & Recovery Center has also been significantly reduced in order to suit $$ to Law Enforcement

Law Enforcement continued to maneuver their vision of this program in order to fit funding criteria. It is no longer considered a "first response" which concerns many of us in the mh community as that is the "crisis intervention" that is needed. It may also have implications for involuntary commitment (5150 holds) that MHSA funds should not support. Additionally, it was originally voted down at the Steering Committee level only to be resurrected due to a "closed door compromises" which were made outside of the public process.

Urge You not to: ~~recommend~~ recommend the PERT

I strongly ~~recommend that this program~~ not be recommended to the State Dept of MH for funding under the MHSA.

PERT should have been included as an addendum since it was not available for review for 30 days— at least not in its current form.

Sacramento County
Community Services and Supports Plan
Comment Number: 169

RECEIVED
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>>AUDIENCE MEMBER: MY NAME IS KATHRYN T. I WAS THE CONSUMER REPRESENTATIVE ON THE STEERING COMMITTEE AND I'M HERE TO REPRESENT THE CLIENTS VOICE. ALL OF THE STEERING COMMITTEE MEMBERS VOTED NO ON THE PERT PLAN AS WRITTEN. THE RESOUNDING VOICE THAT I HEAR IS NOT IN MY NAME. I BELIEVE THE PERT PLAN USES MENTAL HEALTH SERVICES TO PAY FOR A BACK UP POLICE OFFICER RESPONDING TO THE POLICE OFFICER ON THE SCENE AND A DUPLICATION OF SERVICE. IT'S A LAW ENFORCEMENT SERVICE AND NOT A MENTAL HEALTH SERVICE. A WARRANT AND CRIMINAL CHECK IS NOT A MENTAL HEALTH SERVICE. THE TRANSPORTATION OF CLIENTS TO JAIL MAY INCREASE INCARCERATION. THE GOAL OF THE MENTAL HEALTH IS TO DECREASE INCARCERATION. THE MARGINALIZATION OF CLIENTS AS WRITTEN DOES NOT HAVE MENTAL HEALTH CLIENTS PROVIDING MENTAL HEALTH SERVICES.

I BELIEVE THE RECOVERING MENTAL HEALTH TEAM AND THE MENTAL HEALTH PROFESSIONAL RESPONDING TO THE FIRST OFFICER IS PROVIDING THE MENTAL HEALTH SERVICES THAT ARE PROVEN TO BE EFFECTIVE AND TRANSFORMATIVE AS A WELLNESS RECOVERY TEAM.

THE PERT PLAN TAKES MONEY FROM PLANS TO BE EFFECTIVE TO SUPPLEMENT A LAW ENFORCEMENT PROGRAM THAT IS THEN UNPROVABLE AND INEFFECTIVE. PERT WAS FIRST REJECTED BY THE STEERING COMMITTEE. AND A MESSAGE TO A SPECIAL MEETING TO LAW ENFORCEMENT TO PUSH THE PERT PLAN. AGAIN THE PLAN WAS REJECTED.

THE STEERING COMMITTEE WAS CALLED TOGETHER WITH THE PRETENSE OF DEBRIEFING AND LAW ENFORCEMENT TO FORCE THEIR PERT PLAN. THE STEERING COMMITTEE SENT THE PLAN TO A SUBCOMMITTEE. CONSUMER ADVOCATES FELT PRESSED TO VOTE FOR THE PLAN AND THERE A TIE VOTE WAS RECORDED.

THE FOLLOWING DAY THE DIVISION OF MENTAL HEALTH MET IN SECRET. THE COUNTY DECIDED MY REQUEST FOR A REVOTE. AND THEY VOTED THE MENTAL HEALTH SERVICES ACT AND THREATENED BEHAVIORS AND SECRET COUNTING OF VOTES. (APPLAUSE).

THEREFORE, THE PERT PROPOSAL AS WRITTEN MUST BE OMITTED BECAUSE IT DOES NOT REPRESENT THE WISHES OF STAKEHOLDERS AND DID AN END RUN AROUND THE STAKEHOLDER PROCESS. (APPLAUSE).

Sacramento County
Community Services and Supports Plan

Comment Number: 156

NOT IN MY NAME
I am here to represent the client's voice. All of the Steering Committee members representing the client's voice voted no on the PERT plan as written. The resounding voice that I hear is "Not In My Name".

BACKUP POLICE
I believe that the PERT plan uses Mental Health Services Act money to pay for a backup police officer responding to the first officer on the scene is a duplication of service that is a law enforcement service and not a mental health service.

WARRANT CHECKS
I believe a warrant and criminal check is not a mental health service.

TRANSPORTING CLIENTS
The transportation of clients to jail or the Treatment Center may increase incarceration and involuntary treatment. Whereas, the goal of the Mental Health Services Act is to decrease incarceration and involuntary services.

MARGINALIZATION OF CLIENT AND FAMILY MEMBERS
I believe that the PERT plan as written does not have mental health clients or family members in a substantial role providing mental health services.

I believe a recovered/recovering mental health client teamed with a family member and mental health professional responding to the first officer is providing mental health services that are proven to be effective and transformative as a wellness recovery team.

SACRAFICING THE MHSA FOR LAW ENFORCEMENT
The PERT plan as written takes money from programs that have proven to be effective to supplement a law enforcement program that is unworkable and ineffective.

THE PROCESS
Pert was first rejected by the Steering Committee. The Steering Committee then received a message to a "Special meeting" for law enforcement to push their PERT plan. Again the plan was rejected.

The Steering Committee was called together again with the pretense of a debriefing, but was in fact another tactic of law enforcement to force their PERT plan.

The Steering Committee sent the plan to a sub committee.

Consumer advocates ~~were~~ felt threatened and coerced to vote yes on the plan and the Sub Committee voted to send it back to the Steering Committee where there a tie vote was recorded.

The following day the Division of Mental Health met in secret meeting for a re-count. The County denied my request for a public re-vote.

Consequently, the County and law enforcement destroyed the spirit of the Mental Health Services Act process with their secret meetings, their threatening behavior, and secret counting of the votes.

Therefore, the PERT proposal as written must be omitted because it does not represent the wishes of the stakeholders and did an end run around the stakeholder process.

I request that this document be included with the required submission of public comments.

Kathryn Travis

>>AUDIENCE MEMBER: GOOD EVENING. MY NAME IS BARBARA S. AND I'M HERE BECAUSE I HAVE A FAMILY MEMBER THAT HAS A MENTAL HEALTH. BECAUSE THEY HAVE HAD EXTENSIVE EXPERIENCE WITH POLICE DEPARTMENT MEMBERS BUT I WILL SPEAK REGARDING THE PERT.

I HAVE A COUPLE COMMENTS AND QUESTIONS THAT I DID NOT SEE ASKED OR ANSWERED IN THE ANSWER PORTION OF THE PERT ADDENDUM.

POLICE OFFICERS ARE OF A CERTAIN MINDSET. THEY MAY HAVE MILITARY BACKGROUND AND DO NOT HAVE A TOUCHY-FEELY BACKGROUND AND RIGHTLY SO BECAUSE THEY NEED TO DEAL WITH CRIMINALS. HOWEVER DEALING WITH PEOPLE WITH A MENTAL ILLNESS IS AS DIFFERENT AS APPLES AND ORANGES. WHO WILL BE ASSIGNED TO CONDUCT THE TRAINING OF OFFICERS ASSIGNED TO THE PERT? WILL THEY BE EXPERIENCED HEALTHCARE PROVIDERS? HOW WILL OFFICERS BE ASSIGNED? VOLUNTEER OR RANDOM. IF RANDOM IT WILL BE SET UP FOR FAILURE FROM THE BEGINNING BECAUSE NOT ALL OFFICERS WILL WANT THIS TYPE OF DUTY AND WILL NOT BUY INTO THE CONCEPT. IF VOLUNTEER, WILL THE OFFICER HAVE A HUMAN SERVICES BACKGROUND AND WILL THEY BE SCREENED FOR SUITABILITY FOR THE PERT? WHO WILL EVALUATE THE OFFICERS ONCE THEY ARE IN THE FIELD? I BELIEVE AND STRONGLY SUGGEST THAT THESE QUESTIONS REGARDING LAW ENFORCEMENT NEED TO BE REVIEWED AT LENGTH IF PERTS ARE TO BE PLACED IN SERVICE. (APPLAUSE).

>>AUDIENCE MEMBER: GOOD EVENING. THANK YOU FOR ALL THE HARD WORK YOU GUYS HAVE DONE ON THIS. I DO HAVE SOME QUESTIONS. MY NAME IS RANDY HICKS. I'M WITH THE CALIFORNIA DISABILITIES RIGHT. I WORK FOR THE CALIFORNIA NETWORK OF MENTAL HEALTH CLIENTS. AS I SAW THE NEED FOR THESE CLIENTS THEY NEED RESOURCES TO REACH OUT TO AREAS WHERE THEY ARE UNDERSERVED.

I HAD MY OWN RUN-IN WITH THE POLICE SIX YEARS AGO. I WENT DOWN THE WRONG WAY ONE-WAY STREET. THEY THOUGHT I WAS ON A NARCOTIC. I HAVE A DIFFICULT DISEASE TO DEAL WITH.

POLICE SHOULD NOT PERFORM POLICE FUNCTIONS WHEN THEY ARE -- RUN WARRANT CHECKS ON PEOPLE IN CRISIS. THIS IS A POLICE FUNCTION NOT A MENTAL HEALTH FUNCTION. IT WILL LEAD TO PEOPLE BEING SENT TO JAIL WHILE REDUCING INCARCERATION IS THE CALL OF THE MENTAL HEALTH SERVICES ACT.

THERE IS NOT AN EVALUATION PROGRAM. PERT TEAM IS DIFFERENT; IT SHOULD BE EVALUATED. ONE QUESTION THAT SHOULD BE EXPLORED GIVEN THE DUPLICATION OF POLICE PRESENCE. DOES THIS LEAD TO INVOLUNTARY TREATMENT OR INCARCERATION? THE REDUCTION OF INVOLUNTARY TREATMENT AND INCARCERATION. WE ARE WEARING THESE T-SHIRTS FROM THE CALIFORNIA NETWORK AND MENTAL HEALTH CLIENTS. YOU CANNOT DO ANYTHING WITH US OR WITHOUT US. THANK YOU. (APPLAUSE).

>>AUDIENCE MEMBER: AND I STAND BEFORE YOU TODAY AS A SERVICE PROVIDER, CONSUMER, FAMILY MEMBER, AND FRIEND. I URGE YOU TO TAKE THE MESSAGE BACK TO THE POWERS THAT BE TO FUND ALL POSSIBLE RECOMMENDATIONS THAT HAVE BEEN -- HAVE WENT FORWARD.

AND ALSO I WANTED TO SHARE WITH YOU THAT I HAVE BEEN VERY LUCKY TO BE PART OF THIS PROCESS AND TO BE STANDING BEFORE YOU AND TO SPEAK TO YOU ABOUT HOW MY CONCERN IS FOR THE POLICE DEPARTMENT.

I HAVE BEEN VERY LUCKY TO HAVE COMMUNITY WHERE I LIVE TO REALLY LOOK AT ME WHEN I AM NOT DOING WELL. LAST TIME TWO YEARS AGO I LOST MY MOTHER -- ACTUALLY THREE YEARS AGO, I LOST MY MOTHER, AND I WAS DEPRESSED, PSYCHOTIC, AT THE SAME TIME SUICIDAL. I WENT TO MY NEIGHBOR AND MY NEIGHBOR TOOK ME TO THE HOSPITAL. ALL THOUGH IT WAS NOT A POLICE DEPARTMENT THAT I HAD AN ENCOUNTER, BUT IN THE HOSPITAL THERE WERE SECURITY GUARDS WITH GUNS IN THEIR BELT.

I REACHED FOR THE GUN. AND I WAS HANDCUFFED AND ON THE GURNEY FOR SEVERAL HOURS. I DON'T REMEMBER HOW LONG. THAT IS MY CONCERN.

AND THERE'S NO -- DISRESPECT WHO PEOPLE WHO ARE DEALING WITH SUBSTANCE ABUSE OR HAVE BEEN IN JAIL MANY TIMES FROM CLIENTS THAT I SERVE, I HAVE HEARD THAT THEY HAVE BEEN MISTAKEN FOR DRUG-USE PERSON. BECAUSE THEY WERE, AGAIN, DEPRESSED, PSYCHOTIC AND SUICIDAL.

AND WHEN WE ARE FEELING SUICIDAL, IT DOESN'T MATTER. WE TAKE ANY SITUATION AND OPPORTUNITY TO END THE SUFFERING. THANK YOU VERY MUCH. (APPLAUSE).

>>AUDIENCE MEMBER: HI. MY NAME IS M. AND I GUESS I JUST REPRESENT MYSELF. I'M A MENTAL HEALTH THERAPIST AND I WORK WITH MATH. AND I'VE BEEN IN THE FIELD FOR ABOUT SIX YEARS.

I HAVE ONLY BEEN LISTENING TONIGHT MAYBE WITH MY THERAPIST EARS AND I JUST HAVE THREE COMMENTS.

ONE OF THEM IS THE CONCEPT OF A WELLNESS CENTER AND/OR WHAT WE WOULD CALL A FAMILY RESOURCE CENTER. THEY WORK. THEY WORK. THEY ARE EASY TO FUND. AND THEY WORK NOT ONLY ON THE TREATMENT LEVEL, BUT THEY WORK ON THE COMMUNITY DEVELOPMENT LEVEL.

THEY WORK TO CREATE COHESIVENESS IN A COMMUNITY THAT IS TYPICALLY ISOLATED FROM THE REST. SO I COULD NOT BE MORE IN SUPPORT OF THAT.

NUMBER TWO IS ON THIS PERT THING. WE TALK A LOT ABOUT THE TRANSFORMATIVE PROCESS THAT ALL OF THE STAKEHOLDERS HERE ARE GOING THROUGH. AND HOW WE AS A BODY ARE BEING TRANSFORMED BY THE PROCESS THAT WE ARE ENGAGED IN.

THIS IS SO EXTREMELY VALUABLE. WHAT THAT MEANS IS IF ALL OF US ARE GOING TO BE COMMITTED TO THE GROWTH THAT WE'VE EXPERIENCED, THEN WE HAVE TO BE COMMITTED TO THE IDEA THAT IT'S NOT OVER YET. AND NO ONE SAYS THAT WE CANNOT REJECT THE END RUN THAT HAS BEEN FACILITATED BY OLD STYLE POLITICS. WHO SAYS WE HAVE TO ACCEPT THAT?

(APPLAUSE). RIGHT HERE ALL OF US CAN DECIDE, YOU KNOW WHAT, WE WERE DOING PRETTY GOOD. AND YOU KNOW, WE SLIPPED, RELAPSED. WE HAD A MOMENT OF STUPIDITY. YOU KNOW, HELL, I'M STUPID EVERY DAY. AND MY CLIENTS ARE PRETTY GLAD THAT I ADMIT IT, TOO.

YOU KNOW, LET'S DON'T CLOSE THE MIND JUST BECAUSE THAT'S WHAT WE ARE USED TO. YOU KNOW, WE CAN SAY, YOU KNOW WHAT, ACCEPTING THE PERT THING, I THINK IT WAS A MISTAKE AND JUST GO FORWARD.

AND THE LAST ONE IS... I THINK MAYBE SOMETHING AROUND PERT MIGHT BE USEFUL AT SOME TIME. BUT WE ARE TOO YOUNG IN THE TRANSFORMATIVE PROCESS OF THE MENTAL HEALTH SYSTEM. AND I WOULD LIKE TO SEE THIS CONSIDERED AGAIN IN ANOTHER PHASE OF TRANSFORMATION. THANK YOU. (APPLAUSE).

>>AUDIENCE MEMBER: HELLO. MY NAME IS RHONDA IRWIN. AND I'M HERE -- BEFORE I TELL YOU MY STORY, WHAT I WOULD LIKE TO SAY IS IT IS IMPORTANT THAT FUNDING FOR THE MENTALLY ILL IS GIVEN TO THE MENTALLY ILL. (APPLAUSE).

IT IS EQUALLY IMPORTANT THAT WE UNDERSTAND THAT FAR TOO OFTEN IN SACRAMENTO FUNDING THAT IS DESIGNED FOR A PROGRAM IS TAKEN AWAY FROM THAT PROGRAM. $31 MILLION WENT TO ENHANCE THE JUVENILE FACILITY WHEN WE HAVE YOUTH WITHIN THAT FACILITY WHO NEEDED TO BE MENTALLY TREATED. $6.8 MILLION WENT TO THE SACRAMENTO POLICE DEPARTMENT FOR OFFICERS IN SCHOOLS, WHEN WE HAVE STUDENTS IN SCHOOLS WHO ARE MENTALLY ILL. $1.2 MILLION RECENTLY WENT TO THE SHERIFF'S DEPARTMENT FOR 10 MOTORCYCLE COPS DEPUTIES IN GANG AREAS. I LIVE IN A GANG AREA. I SEEN THEM ONE TIME. I SAW THEM YESTERDAY FOR TWO HOURS ON -- NOT IN THE CENTRAL DIVISION, BUT FURTHER UP NEAR FOLSOM GIVING OUT CITATIONS TO SPEEDERS.

WHERE I LIVE, PEOPLE ARE DYING. FOR 20 YEARS IN THE CITY OF SACRAMENTO, BLACK PEOPLE ARE DYING. WE ARE NOT IGNORANT TO PREVENTION. WE ARE IGNORED. OUR CRIES HAVE ECHOED FROM ONE NEIGHBORHOOD TO ANOTHER.

NOW I DO NOT MAKE LIGHT OF THE FACT THAT PEOPLE WHO ARE DYING HAVE SCHIZOPHRENIA DESERVE THE MONEY. WE NEED TO REACH OUT TO PEOPLE WHO HAVE BEEN MOURNING, SUFFERING, DYING AND CRYING IN THIS CITY FOR 20 YEARS.

IT IS IMPORTANT THAT WE UNDERSTAND THAT THE COMMUNITY IS NOT IGNORANT. AND WE REALIZE THAT TO ENHANCE DEPARTMENTS IS NOT WHAT PROPOSITION 63 WAS DESIGNED FOR. THANK YOU. (APPLAUSE).

>>AUDIENCE MEMBER: GOOD EVENING. MY NAME IS J. YVONNE A. I'M HERE ON BEHALF OF TWO GROUPS. MOMS. THAT GROUP IS MOMS OF METHODS OF SYSTEM. AND EXECUTIVE BOARD MEMBER OF THE NAACP. I'M NOT ONLY HERE ON BEHALF OF CIVIL RIGHTS OF MENTAL HEALTH, BUT MOST IMPORTANTLY, I'M THE MOTHER OF A 27 YEAR OLD DIAGNOSED SCHIZOPHRENIC. NO ONE REALLY KNOWS. BIPOLAR. MY SON WAS ONE OF THE PEOPLE -- I READ THE NEWSPAPER, RAVED IN THE STREET. MY SON DID ALL THIS. HE WAS ALSO A SELF-MEDICATED PERSON WHO TOOK DRUGS AND TOOK ALCOHOL TO STOP THE VOICES IN HIS HEAD. I SEE HIM GO IN THE BATHROOM, SHAVE HIS HEAD, AND SHAVE HIS EYEBROWS, AND TALK TO HIMSELF. HE IS ONE OF THE 28,000-PLUS INMATES IN THE CALIFORNIA PRISON SYSTEM TODAY.

YOU SEE HE WAS GIVEN A SENTENCE OF 104 YEARS FOR AN ACCUSED CRIME. IF AN EFFECTIVE MENTAL HEALTH PROGRAM HAD BEEN PUT IN PLACE AT THAT TIME MAYBE HE WOULD NOT HAVE BEEN SENTENCED TO A LIFE SENTENCE.

HE WAS A PERSON NOW THAT THE AUTHORITIES ARE CONTINUING TO OVERLOOK. MENTAL HEALTH IS A PROBLEM IN CALIFORNIA AS WELL AS IN THE UNITED STATES. SOMETHING MUST BE DONE. I'M APPALLED THAT THE MONEY FOR PROPOSITION 63 FOR MENTAL HEALTH WILL NOT BE ALLOCATED PROPERLY.

RESPONSE PROGRAMS SHOULD NOT BE SCALED DOWN. MORE OFFICERS SHOULD BE TRAINED TO DEAL WITH MENTAL HEALTH PROBLEMS.

WE NEED MORE HOUSING. MOST OF YOUR HOMELESS PEOPLE OUT THERE, THEY HAVE MENTAL HEALTH PROBLEMS. HOW CAN WE WALK AROUND AND OVERLOOK THIS. EVERYDAY DOWNTOWN YOU SEE A LOT OF MENTAL HEALTH PEOPLE NOWHERE TO LIVE OR GO. WE WALK AROUND WITH OUR JOBS LIKE EVERYTHING IS OKAY AND THEY HAVE NOWHERE TO GO.

WE NEED REHABILITATION FOR MENTAL HEALTH. TOO LONG THE MENTALLY ILL HAS BEEN IGNORED. IT'S TIME TO MAKE A CHANGE TO HELP THE ONES IN NEED.

TO HELP THE ONES IN NEED WITH THE HELP. YOU KNOW YOU NEED TO THINK ABOUT IT BECAUSE IT COULD BE OUR MOMS, OUR DADS, OUR SISTERS, OUR BROTHERS, EVEN OUR CHILDREN. MAYBE WE COULD EVEN HAVE MENTAL HEALTH PROBLEMS.

BECAUSE BEFORE IT IS ALL SAID AND DONE, BECAUSE I DON'T SLEEP AT NIGHT, BECAUSE I'M DEPRESSED CONSTANTLY, BECAUSE OF WHAT I'M GOING THROUGH WITH MY SON, I MAY NEED MENTAL HEALTH CARE. SO THINK ABOUT IT. (APPLAUSE).

>>AUDIENCE MEMBER: HELLO. MY NAME (INAUDIBLE). I WORK FOR PROTECTION AND ADVOCACY. IT IS THE FEDERALLY MANDATED DISABILITY RIGHTS ORGANIZATION. WE PROVIDE LEGAL REPRESENTATION. WE'VE PROVIDED WRITTEN COMMENTS. I'LL KEEP THIS BRIEF.

I'M NOT HERE TO ADDRESS THE PROCESS BY WHICH THE PERT PROPOSAL GOT ON THE COUNTY'S PLAN OR ON THE PROPOSED PLAN. BUT I WILL SAY THAT WE ARE CONCERNED ABOUT WHAT WE ARE HEARING AND READING ABOUT HOW THAT HAPPENED.

PUTTING THAT ASIDE, I WANT TO MAKE ONE POINT AND THAT IS THAT THE PROPOSAL AS IT'S CURRENTLY WRITTEN, WE DO NOT BELIEVE MEETS THE REQUIREMENTS OF THE MENTAL HEALTH SERVICES ACT. THE MENTAL HEALTH SERVICES ACT SPECIFIES IT BE UTILIZED TO EXPAND MENTAL HEALTH SERVICES. IT'S OUR POSITION THAT POLICE OFFICERS, EVEN THOSE RESPONDING AS PART OF THE PERT, ARE PERFORMING A LAW ENFORCEMENT FUNCTION AND THEIR SALARIES AND COSTS ASSOCIATED WITH LAW ENFORCEMENT IS NOT REIMBURSABLE UNDER THE MENTAL HEALTH SERVICES ACT.

IT'S NOT APPROPRIATE USE OF FUNDS BECAUSE IT CANNOT SUPPLANT STATE OR COUNTY FUNDS. POLICE OFFICERS HAVE EXISTING DUTY TO CALL FOR CRISIS CALLS EVEN WHEN THE CRISIS CALLS INVOLVE MENTAL HEALTH NEEDS.

THE LAW ENFORCEMENT IS ALREADY FUNDING THOSE SERVICES. AND SHIFTING THIS RESPONSIBILITY FROM SEVERAL OFFICERS TO A FEW SPECIFICALLY DESIGNATED AND TRAINED OFFICERS DOES NOT DESIGNATE A NEW SERVICE; IT IS JUST MOVING THE RESPONSIBILITY.

AND FINALLY, I GUESS THE ONE THING I'D LIKE TO SAY, I THINK EVERYBODY IN THIS ROOM SAY THAT POLICE OFFICERS NEED MORE TRAINING IN DEALING WITH PEOPLE WITH DISABILITIES. BUT THAT SHOULD BE A BASE LEVEL. PEOPLE SHOULD NOT BE GRADUATING FROM THE POLICE ACADEMY WITHOUT TRAINING AND BASIC KNOWLEDGE AND UNDERSTANDING OF HOW TO DEAL WITH PEOPLE IN ALL SITUATIONS; MOSTLY DISABILITY COMPETENCE AND CULTURAL COMPETENCE. THANK YOU VERY MUCH. (APPLAUSE).

>>AUDIENCE MEMBER: HELLO. SALLY ZINMAN. AND I THOUGHT ABOUT WHETHER IT WAS APPROPRIATE FOR ME TO BE SPEAKING, ALTHOUGH I WORK IN SACRAMENTO, I DON'T LIVE IN SACRAMENTO. AND DECIDED IT WAS BECAUSE THE DIFFERENT PERSPECTIVE I HAVE IS FROM THE STATE ORGANIZATION, THE CALIFORNIA MENTAL NETWORK OF MENTAL HEALTH CLIENTS. WE ARE ACROSS THE STATE. WE ARE VERY CONCERNED THAT YOUR FUNDING OF PERT, YOUR FUNDING OF POLICE MASQUERADING. SACRAMENTO IS A MODEL COUNTY. IT'S WHERE STEINBERG LIVES. PEOPLE WILL LOOK TO SACRAMENTO WHAT HAPPENS.

THE MENTAL HEALTH SERVICES ACT, IT DEFIES THE SPIRIT AND INTENT OF THE MENTAL HEALTH SERVICES ACT TO FUND NON-MENTAL HEALTH FUNCTIONS WITH THOSE MONIES.

I LOOKED AT THE PERT, WELL, I THOUGHT, LET'S LOOK AT THE PROGRAM. THE FACT IS THE PROGRAM PRESENTED TO YOU IS SO CHANGED THAT IT'S NO LONGER A PROGRAM. IT'S NOT A FIRST RESPONDER PROGRAM. WHEN POLICE WALK INTO THE HOUSE AND SOMEONE IS IN CRISIS, THAT'S WHEN THINGS START HAPPENING. BY THE TIME YOU CALL THE SECOND CAR, SOMETHING BAD HAS HAPPENED OR NOT HAPPENED. THE PERT TEAMS ARE FIRST RESPONDERS.

AND THEN I WONDERED, WHY DID THEY MAKE IT SECOND RESPONDERS. IT'S CLEAR; THE POLICE COULD NOT GET THE MONEY AS FIRST RESPONDERS. THE DEPARTMENT OF MENTAL HEALTH SAYS THAT MENTAL HEALTH SERVICES ACT COULD NOT BE USED FOR POLICE FUNCTIONS SO THEY ARE MASQUERADING AS A FUNCTION OF THE POLICE AND MENTAL HEALTH WORKERS TO GET MENTAL HEALTH SERVICES ACT FUNDS. AND THIS WILL SET A PRECEDENT THROUGHOUT THE WHOLE STATE.

FOR A PROGRAM THAT IS NOT WORKABLE; WILL NOT BE EFFECTIVE. BECAUSE IF THEY ARE NOT THE FIRST TIME RESPONDERS, THEY ARE NOT THE FIRST PEOPLE ON SCENE OF THE PERSON WHO IS IN CRISIS. YOU ARE TAKING $1.3 MILLION THAT WILL SERVE PEOPLE AND KEEP THEM OUT OF THE CRISIS FOR WHICH POLICE ARE CALLED. (APPLAUSE).

>>AUDIENCE MEMBER: MY NAME IS CARLTON. I'M A CONSUMER. I'M ALSO A PROVIDER. I'M HERE TO TALK ABOUT TRANSFORMATION. AND I'M ALSO HERE TO TALK ABOUT MY SUPPORT FOR THE TRANSCULTURAL WELLNESS CENTER.

I'M ALSO HERE TO SAY THAT I DO AGREE WITH THE PERSONS WHO ARE AGAINST THE PERT TEAM. THE PERT TEAM HAS ROBBED FUNDS FROM THE ELDER COMMUNITY AND HAS TAKEN $400,000 FROM THE WELLNESS RECOVERY PROGRAM WHICH IS WHAT IS DESCRIBING IS THE TRANSFORMATION PROCESS THAT WE ARE LOOKING AT.

THIS IS THE ONE PROGRAM THAT IS CONSUMER RUN AND FOR CONSUMERS AND RUN BY CONSUMERS.

I AM CONCERNED AND I AM HOPEFUL. I AM HOPEFUL THAT SOMETHING WILL BE DONE IN THE PROCESS THAT IS TO COME THAT WILL RENEW THE HOPE THAT THIS PROCESS BEGAN WITH BACK A YEAR AGO.

WHAT IS TRANSFORMATION? THE SPEAKER TWO SPEAKERS AGO TALKED ABOUT HOPE. HOPE IS EMPOWERMENT. EMPOWERMENT IS THE CONSUMER MOVEMENT. PLEASE RETURN THE FUNDS TO THE CONSUMERS. THANK YOU. (APPLAUSE).

>>AUDIENCE MEMBER: HI. MY NAME IS PATTY GAINER. I'M A RESIDENT OF SACRAMENTO. AND I'VE BEEN VERY INVOLVED WITH CONSUMER ADVOCACY AND ESPECIALLY IN PLANNING THE MENTAL HEALTH SERVICES ACT FUNDS BOTH AT THE STAKEHOLDER PROCESS AND LOCAL PROCESS.

WHAT IS BEING CALLED NOW AS THE PERT PROPOSAL IS NEITHER AUTHENTIC PERT OR AN HONEST PROPOSAL.

THE WHOLE THING, YOU KNOW, ABOUT THIS MISREPRESENTATION THAT IT IS A PERT AND THAT IT'S A PROPOSAL MAKES ME VERY ANGRY.

LAW ENFORCEMENT DID NOT FOLLOW REQUIREMENTS SET BY THE DEPARTMENT OF MENTAL HEALTH AND THE STATE OF CALIFORNIA AND THE STAKEHOLDER PROCESS.

NOR FOLLOW THE INCLUSIVE DEMOCRATIC PROCESS ESTABLISHED BY THE COUNTY AND MHSA STEERING COMMITTEE. THE WORDS AND ACTIONS OF LAW ENFORCEMENT REVEALED THEY FELT ENTITLED TO A LONG CHUNK OF MONEY SO THEY RESORTED TO DIRTY POLITICS AND HARD NOSED -- TO FORCE US AND OUR COMMUNITY TO FUND WHAT I AM CALLING A PSEUDO PERT. A TRUE PERT IS A COLLABORATIVE TEAM OF CONSUMERS. CONSUMERS LOVED ONES, MENTAL HEALTH PROVIDERS AS WELL AS LAW ENFORCEMENT WHO ARE THE FIRST RESPONDERS TO REDUCE TRAUMA.

LAW ENFORCEMENT IS MISLEADING THE PUBLIC IN THE SURVEYS SAYING THAT THEIR PROPOSAL IS THE OVERWHELMING NUMBER ONE PRIORITY FOR PROP 63 FUNDS.

I'D LIKE TO REFER PEOPLE TO THE PLAN, PAGES 3-5, PART 2, SECTION 1. I'M VERY CONCERNED THAT THE BROWN ACT AND THE INTENT OF OUR LOCAL AND STATE STAKEHOLDER PROCESSES WERE NOT FOLLOWED. I'M NOT A LAWYER SO I DO NOT KNOW SPECIFICALLY ABOUT THE BROWN ACT. I DO KNOW -- I DON'T THINK -- I THINK WE MADE THREE ERRORS AND I WON'T GO INTO THAT.

BUT I MADE A LIST OF THE FUNDING PROBLEMS THAT HAVE OCCURRED WITH THE CHANGES AND THE PROPOSALS AFTER PERT WAS ADDED IN. I'M RUNNING LOW ON TIME.

I THINK IT'S A TRAVESTY, THE DIFFERENCE THAT IS COME OUT AFTER, YOU KNOW, AFTER YOU SUBTRACT FROM THE LAW ENFORCEMENT ADDITION. IS THAT IT? THANK YOU. (APPLAUSE).

>>AUDIENCE MEMBER: HI. MY NAME IS MICHAEL LEVY, CHAIRMAN OF THE FAMILY ADVOCATE COMMITTEE HERE IN SACRAMENTO COUNTY. THERE'S 35 OF US ON THAT COMMITTEE. WE WORK IN CHILDRENS MENTAL HEALTH AND THE VARIOUS PROVIDERS THROUGHOUT THE COUNTY. WE ARE COUNTY MANDATED TO BE THERE.

WE ARE PARENTS AND CAREGIVERS IN THE CHILDRENS MENTAL HEALTH SYSTEM AND LIKE MYSELF AND HAVE A DAUGHTER ALSO IN THE ADULT CONSUMER MENTAL HEALTH.

WE KNOW FIRSTHAND WHAT IT'S LIKE TO HAVE A CHILD UNABLE TO STAY IN SCHOOL, OFTEN MUST BE PLACED OUT OF HOME, AND SOME OF US HAVE HAD TO GIVE UP CUSTODY TO GET TREATMENT FOR OUR CHILDREN.

MANY OF US SERVE ON THE TASK FORCE AND IN THE STAKEHOLDER PROCESS. AND I'M HERE TO TELL YOU THAT WE ARE VERY DISAPPOINTED IN THE OUTCOMES OF OUR PROPOSALS THAT DIDN'T GET FUNDED OR EVEN LOOKED AT.

THOUGH WE RECOGNIZE THE BENEFITS OF THE PERT TEAM AND WE DO SUPPORT THAT KIND OF PROGRAM. WE ARE NOT IN AGREEMENT OF THE CURRENT PROPOSAL.

WE DO NOT FEEL THAT IT REPRESENTS THE TRANSFORMATION AND THE SPIRIT OF THE MENTAL HEALTH SERVICES ACT. WE ALSO WANT TO SAY THAT KIDS IN JUVENILE HALL ARE NOT MENTIONED IN ANY OF THE PROPOSALS EVEN THOUGH THEY ARE UNDERSERVED. THEY DO NOT RECEIVE APPROPRIATE SERVICES IN JUVENILE HALL AND END UP STAYING IN LONGER PERIODS DUE TO UNAVAILABILITY OF APPROPRIATE PLACEMENTS. WE FEEL THOSE OF US IN CHILDRENS MENTAL HEALTH REALLY FEEL LIKE WE'VE BEEN IGNORED AND NOT LISTENED TO AND THERE'S A MISNOMER IN THE COMMUNITY THAT CHILDREN HAVE ALL THIS MONEY. AND THE FACT IS WE DO HAVE A LARGE PORTION OF MONEY. AND WE DO NEED TO LEARN HOW TO SPEND IT, MAYBE, BETTER, BUT WE NEED THE SERVICES TOO. THANK YOU. (APPLAUSE).

>>AUDIENCE MEMBER: MY NAME IS SCOTT HOWARD AND I WORK FOR SENIOR AND ADULT SERVICES. I WANT TO MAKE BRIEF COMMENTS. ACCORDING TO THE CENTER FOR MENTAL HEALTH SERVICES THE PROJECTED UNDERMET SERVICE GAP FOR SACRAMENTO SENIORS IS OVER 9,500 INDIVIDUALS WHO ARE UNABLE TO ACCESS SERVICES.

THE NATIONAL INSTITUTE FOR MENTAL HEALTH BETWEEN 15 AND 25% OF INDIVIDUALS OVER THE AGE OF 60 WILL REQUIRE SOME FORM OF MENTAL HEALTH SERVICES WITH INCIDENCE OF PSYCHOSIS 60-PLUS AGE GROUP MORE THAN DOUBLE THE RATE OF 20 TO 30 YEAR OLDS. INCREASED RISK FOR MENTAL HEALTH PROBLEMS AS THEY LOSE KEY FAMILY AND SOCIAL SUPPORTS. LEADING TO DEPRESSION AND SELF-MEDICATION AND CLINICALLY DEVASTATING PROBLEMS AND REDUCE THE LIKELIHOOD THAT THEY CAN BE IDENTIFIED AS NEEDING INTERVENTIONS OR ACCESS OVERWHELMED SERVICES.

THE SENIOR MULTIDISCIPLINARY AND NOT WAIT FOR SENIORS TO SEEK THEM OUT. THE PSYCHIATRIC EMERGENCY RESPONSE TEAM ARE GOOD IDEAS AND -- HOWEVER THE LAUNCH PERT OF THE --

(READING DOCUMENT) -- THE MENTAL HEALTH SERVICES ACT COULD LAUNCH TWO PERT TEAMS INSTEAD OF FOUR. NOT JUST PRESUPPOSE ITS VALUE BASED ON THE EXPERIENCE OF OTHER MODELS IN DIFFERENT COMMUNITIES FOR A SMALLER COST AND STILL KEEP THE CRISIS RESPONSE EFFORTS FOR SENIORS ALIVE.

YES, IT WILL IMPACT PERT. IT WILL SLOW SOME EXPANSION UNTIL MORE FUNDS BECOME AVAILABLE IN ONE OR TWO YEARS. IT COULD PROVE IT'S WORTH THAT THE LAW ENFORCEMENT WOULD BE WILLING TO PAY FOR THEIR OWN OFFICERS INSTEAD OF USING MENTAL HEALTH SERVICES ACT FUNDS TO PAY FOR THEM. AND NOT IGNORE THE VISION THAT WAS BUILT THROUGH THE COMPREHENSIVE AND COLLABORATIVE COMMUNITY PROCESS. (APPLAUSE).

>>AUDIENCE MEMBER: HELLO. MY NAME IS ANDREA HILLERMAN. AND I'M THE LIAISON FOR SACRAMENTO COUNTY AND I WAS ALSO A CONSUMER MEMBER ON THE STEERING COMMITTEE. I'M GOING TO ECHO THE PREVIOUS SENTIMENT.

I'M SO PROUD TO REPRESENT A GROUP OF INDIVIDUALS THAT HAVE SO MUCH INTEGRITY. THIS HAS BEEN AN INCREDIBLE JOURNEY. WE CAN NEVER ASSUME THERE'S A REASON WHY PERT RATED SO HIGH AT THE TASK FORCE AND STEERING COMMITTEE LEVELS. CONSUMERS WANT TO HAVE A GOOD AND HEALTHY RELATIONSHIP WITH LAW ENFORCEMENT. CAN WE REALLY DO -- AND WE APPRECIATE YOU STICKING IN THERE BECAUSE YOU'VE TAKEN A BEATING. (APPLAUSE).

PEOPLE WHO KNOW ME WELL KNOW THAT I'M ABOUT THE BOTTOM LINE. AND THE BOTTOM LINE IS WE DON'T WANT TO PAY FOR LAW ENFORCEMENT SALARIES. I THINK IT'S TIME THAT WE LISTENED TO THOSE WHO ARE GOING TO BE SERVED AND I THINK THAT'S THE TRUE SPIRIT OF TRANSFORMATION. THANK YOU. (APPLAUSE).

>>AUDIENCE MEMBER: GOOD EVENING. GEORGE ANDERSON. CHIEF DEPUTY WITH THE SACRAMENTO SHERIFF'S DEPARTMENT. I URGE YOU TO SUPPORT PERT. PERT IS A MENTAL HEALTH PROGRAM. IT IS NOT A LAW ENFORCEMENT PROGRAM. IT'S A REGIONAL PROGRAM PROVEN ITSELF IN SAN DIEGO AND LONG BEACH AND A PROGRAM THAT I THINK WAS POINTED OUT IN THE PROPOSITION 63 AS FIRST BEING DISCUSSED BY THE AUTHORS. IT WAS A TYPE OF PROGRAM BROUGHT UP AS A CRISIS INTERVENTION PROGRAM THAT NEEDS EXPANSION IN THE STATE OF CALIFORNIA. WE SEE IT EACH AND EVERY DAY. IT WILL BE A REGIONAL PROGRAM BRINGING TOGETHER PARTNERSHIP WITH MENTAL HEALTH AND LAW ENFORCEMENT.

ONE OF THE BENEFITS OF PERT WILL BRING. PROVIDING THE TIME (READING DOCUMENT.) PROVIDES FOR COMPLIMENTARY UTILIZATION OF MENTAL HEALTH AND LAW ENFORCEMENT PROFESSIONALS. TEAMS WILL PROVIDE ASSISTANCE TO OFFICERS IN THE FAMILY NEEDING CONSULTATION FOR MENTAL HEALTH CRISIS AND OUTREACH AND FOLLOW-UP SERVICES.

PROVIDE BETTER ALTERNATIVES FOR CONSUMERS RATHER THAN JAIL AND MENTAL HEALTH TREATMENT CENTER. AND ENSURE THAT CONSUMERS ARE TAKING MEDICATION. REDUCE REPEATED CALLS FOR SERVICE AND MOST OF ALL UNNECESSARY INCARCERATION. AND IT WILL REDUCE TRAUMA TO CONSUMERS AND THEIR FAMILIES.

WE BELIEVE WE'VE WORKED COLLABORATIVELY WITH THE STEERING COMMITTEE AND REACHED A COMPROMISE PROPOSAL THAT WE THINK IS BEST FOR THE SACRAMENTO COMMUNITY AND THE MENTAL HEALTH NEEDS OF THE COMMUNITY.

WE ALSO IN THE LAW ENFORCEMENT COMMUNITY WANT TO SEE A REDUCTION IN INCARCERATION AND NUMBER OF CALLS THAT WE NEED TO RESPOND TO IN CRISIS SITUATIONS. IT'S A STRONG PROGRAM AND GOOD PROGRAM AND LIKE TO SEE IT RECOMMENDED TO THE BOARD OF SUPERVISORS. THANK YOU. (APPLAUSE).

>>AUDIENCE MEMBER: DEPUTY CHIEF OF POLICE FOR THE SACRAMENTO POLICE DEPARTMENT. I'M HERE TO SUPPORT PERT AS WELL. I'M NOT GOING TO REITERATE WHAT CHIEF ANDERSON EXPLAINED TO YOU, BUT TO GIVE YOU BACKGROUND AND OUR PARTNERSHIP AND OUR COMMITMENT TO THE MENTAL HEALTH COMMUNITY.

I'VE BEEN WITH THE DEPARTMENT 28 YEARS AND I THINK IT WAS QUITE TELLING WHEN MR. HUNT OPENED THE MEETING TALKING ABOUT THE INDIVIDUAL WHO WAS LOOKING IN THE GARBAGE CONTAINER. HE ASKED THE QUESTION: "WHAT DO YOU DO WITH THAT PERSON?" I'VE ASKED THAT QUESTION FOR 28 YEARS. IF IT'S NOT A CRIME -- IT'S NOT A CRIME TO BE MENTALLY ILL -- WHAT DO WE DO? THERE ARE NOT ENOUGH RESOURCES TO PROVIDE FOR THE NUMBER OF CONSUMERS IN THIS COMMUNITY. BUT IN PARTNERSHIP WITH MENTAL HEALTH, WE ARE COMMITTED AND WE ARE CONVINCED THAT WE CAN DO SOMETHING DIFFERENT.

AND THAT TYPE OF INCIDENT THAT YOU SEE TODAY LATER WITH THE PROGRAM, YOU MIGHT SEE A DIFFERENT RESPONSE. BECAUSE WITH THE EXPERT, WITH THE OFFICER IN THE CAR, WE WILL HAVE THE ABILITY TO DO SOMETHING THAT CAN'T BE DONE RIGHT NOW. WE CANNOT DO WHAT WE WOULD LIKE TO DO FOR THE CONSUMER COMMUNITY TODAY. IT CAN'T HAPPEN. WITH THE PROGRAM, IT CAN. IT HAS BEEN DEMONSTRATED. SACRAMENTO WILL BE AS SUCCESSFUL. WE ARE COMMITTED TO THAT. WE ARE LOOKING FOR A GREAT PARTNERSHIP WITH THE COMMUNITY. WE ARE LOOKING FOR A GREAT PARTNERSHIP WITH THE MENTAL HEALTH COMMUNITY AND ALL OF THE WORK THAT WE KNOW THAT WE CAN MAKE THIS WORK. SO WE APPRECIATE YOUR CONCERN. (APPLAUSE).

>>AUDIENCE MEMBER: HELLO. JUNE SUGAR. AND I'M HERE BECAUSE I'M A GERONTOLOGY STUDENT AT SACRAMENTO STATE. POLICE OFFICERS HAVE BECOME MENTAL HEALTH -- I CAME HERE TO COLLECT INFORMATION. I'M SAD TO SAY THAT IT SEEMS LIKE THE SAME KIND OF TAKING ADVANTAGE TO RUSH PERT THROUGH IS WHAT WE SAW IN THE PATRIOT ACT AFTER 9/11. AS A NURSE, I'M AN ADVOCATE. WE PAY FOR HEALTHCARE TO TREAT ILLNESSES THAT ARE ALREADY THERE AND 5% ON PREVENTION. WE NEED TO TURN IT AROUND AND USE PREVENTION AND USE THE MONEY WHERE PROGRAMS ARE NEEDED MORE. AND I ASK YOU TO BE AN ADVOCATE TOO AND DON'T BE INTIMIDATED AND RUSHED INTO FORCING THIS THROUGH BECAUSE IT'S UP TO YOU WHERE THIS MONEY GOES. THANK YOU. (APPLAUSE).

>>AUDIENCE MEMBER: HI. MY NAME IS KIM. AND I'M GOING TO BE BRIEF SINCE IT'S SO DARN COLD IN HERE. ON BEHALF OF MYSELF AS A COMMUNITY MEMBER AND ONE OF MY NEIGHBORS ONE THAT HAS CALLED LAW ENFORCEMENT TO CONTROL AND STABILIZE AND TRANSPORT A MENTALLY ILL FAMILY MEMBER AND -- WE SUPPORT THE PERT TEAM PROPOSAL. WHO ELSE DOES THE LEGAL AND MANPOWER RESOURCES TO PROVIDE THIS SERVICE WITHOUT DIRECT COST TO THAT FAMILY AND WHO WILL RESPOND 24/7? AT TIMES IT HAS BEEN 2:00-3:00 O'CLOCK IN THE MORNING THAT THEY HAVE BEEN CALLED AND SAVING POSSIBLE LIVES WITHIN THE COMMUNITY AND IN OUR NEIGHBORHOOD.

IT'S NECESSARY TO HAVE A FIRST TEAM RESPOND AND STABILIZE AND THE TEAM TO ASSIST IN APPROPRIATE DECISIONS REGARDING THE FAMILY AND THEIR NEIGHBORS AND THE MENTALLY ILL INDIVIDUAL. IT WILL FREE UP THE FIRST RESPONDER TEAM TO MOVE ON TO THE COMMUNITY NEEDS. WE INDICATE OUR SUPPORT OF FULL PERT FUNDING. THANK YOU. (APPLAUSE).

>>AUDIENCE MEMBER: HELLO. MY NAME IS K. TUCKER. I'M A CONSUMER, MENTAL HEALTH CONSUMER. I'M A CONSUMER ADVOCATE AND ALSO A SERVICE PROVIDER HERE IN SACRAMENTO.

I CONCUR WITH NOT SUPPORTING THE PERT PROGRAM. AND, WELL, I JUST HAVE SOMETHING BRIEF TO SAY. I PROMISE YOU I'LL BE VERY BRIEF.

I AM A MEMBER OF THE STEERING COMMITTEE AND I FEEL VERY STRONG THAT THIS PROCESS TO IMPLEMENT PERT HAS BEEN VIOLATED BY ALLOWING CONSUMERS TO BE EXCLUDED FROM PRIVATE MEETINGS WHERE COMPROMISES WERE MADE WITHOUT CONSUMER INPUT.

THE STATE DEPARTMENT OF MENTAL HEALTH SET FORTH A MANDATE THAT CONSUMERS AND FAMILY MEMBERS WERE TO BE INCLUDED IN ALL LEVELS OF THAT PLAN. THIS INCLUDES CLOSED DOOR MEETINGS THAT SHOULD HAVE NEVER TAKEN PLACE. IT HAS BEEN SAID THAT EYES ARE WATCHING CALIFORNIA TO SEE HOW WE HANDLE THE MENTAL HEALTH SERVICES ACT. I'M SORRY TO SAY, I WONDER WHAT THEY ARE GOING TO SEE HERE?

I FEEL THAT PERT MUST BE A FIRST RESPONDER TO BE AN EFFECTIVE PROGRAM AND THAT THE MENTAL HEALTH SERVICES ACT SHOULD NOT BE USED TO FUND LAW ENFORCEMENT.

FROM WHAT WE'VE HEARD TONIGHT THE TRANSCULTURAL WELLNESS CENTER DESPERATELY NEEDS TO COME TO FRUITION TO BEGIN THE HEALING PROCESS FOR SO MANY WHO HAVE SUFFERED FOR SO LONG. I URGE YOU TO CONSIDER FUNDING THE TRANSCULTURAL WELLNESS CENTER. THANK YOU. (APPLAUSE).

>>AUDIENCE MEMBER: HELLO. MY NAME IS JOEL. I'M A CONSUMER. I'M OPPOSED TO USING MHSA FUNDING FOR LAW ENFORCEMENT. PLEASE OPPOSE THE PERT PROGRAM.

WE NEED THE FUNDING FOR CURRENT SERVICES. WE DON'T HAVE ENOUGH,. THANK YOU. (APPLAUSE).

Attachment C

Comments on Process

TO: Members, Mental Health Board

FROM: Lynn Manchester, co-chair
Lisa Bertaccini, co-chair
Members
MHSA Task Force on Children and Transitional-Age Youth

SUBJECT: RESPONSE TO THE DRAFT MENTAL HEALTH SERVICES ACT (MHSA) THREE-YEAR PLAN

Members of the Mental Health Services Act (MHSA) Task Force on Children and Transitional-Age Youth met on November 1, 2005, for the purpose of developing comments on the draft of the MHSA draft plan. The Task Force began by reviewing the priority list of programs created by the Steering Committee and compared those with the ones developed by the Task Force.

That review generated two observations: 1) no children's proposals were ranked high by the Steering Committee and 2) some proposals ranked lower by the Task Force were elevated above some of the 10 highest proposals prioritized by the Task Force. Based on those observations, the Task Force focused its efforts in commenting on the process as adopted by the Steering Committee and the resulting outcome.

That outcome, generating the programs included in the draft plan, was perceived by the attendees as violating their expectations of the integrity of the process between the Task Force and the Steering Committee since the ranked priority order of the Children's Taskforce was disregarded. There was general agreement that the collaborative process that existed between the Task Force and its stakeholder groups was missing in the relationship between the Task Force and the Steering Committee. Specifically, the Children's Taskforce spent a great deal of time understanding the intent and thinking of the stakeholders' recommendations. It is not clear that this occurred by the Steering Committee.

There was also a general concern regarding the limited youth, youth family/caretakers and youth service agency representation on the Steering Committee. One of the strengths noted in the transmittal from the Task Force to the Steering Committee recommending the top 10 programs was the value of the exchange among stakeholders and Task Force members and its transformative value. Without that dialogue to reflect the complexity of children's issues, the Steering Committee appeared to have limited ability to truly evaluate either the issue for families and youth **or** the careful developmental ordering of the priorities presented.

Attending were also stakeholders whose comments are included in the following list. The notation following the item ("TF" for Task Force or "S" for stakeholder) differentiates comments between task force and stakeholders. A "Y" following the "TF" designation indicates the comment from Task Force youth representatives. That special designation was generated by the belief that in light of the expectations created when

youth were included in the process, their comments on that process deserved highlighting.

While this report reflects the combined comments at the November 1, 2005, meeting, all persons who were participants in the children's Task Force and/or stakeholder groups were encouraged to respond as they considered appropriate to the MHSA draft plan. Every effort was made to reflect the exact statement made by task force members and stakeholders; they have been organized into categories.

What worked

- Incredible energy
- Creativity
- Work to build on

Equity among target populations

- It is important in the next [planning] process that the funding allocation be pre-determined (TF)
- There needs to be a process by which funding amounts are equitably distributed among age groups (S)
- I was initially excited about the process set up to let voices be heard, but if populations were going to be excluded, then the effort need not be expended. What happened needs to be explained at the hearing. (S)
- There was a breakdown in terms of the expectation that certain groups would be excluded
- People had expectations that children would be included and would have understood if only adult programs would be considered [if told at the outset] (S)

Steering Committee membership

- The composition of the Steering Committee did not have enough child/youth representation. Nor was there any representation of parents or caregivers of youth with a Serious Emotional Disturbance. (TF)
- [It was] a little irritating to think there were cliques [on the Steering Committee]; you need diverse representation to reflect diverse needs. (TF-Y)

- It was good that youth were represented at the stakeholder and task force levels and in order to have them continue in the process, they need to know that they were heard. There need to be youth represented on the Steering Committee (TF)

Communication

- Rating the proposals there was no consistent process or criteria. (TF)
- I didn't hear what was going on with proposals – Steering Committee didn't respond (TF)
- Accountability should be operationalized – Steering Committee to Task Force communication with integrity (TF)
- The Steering Committee did not answer questions from the Task Forces or stakeholders in a timely fashion. Redesign Steering Committee with task forces (TF)
- What kind of direction did the Steering Committee get from the county? What process was in place? (S)
- Where is the point person for the Steering Committee to be liaison? (TF)
- All these new groups have to learn a new language to participate and get discouraged (TF-Y)
- This is a product of the state [DMH] not rolling it out in a timely manner. They were disorganized. [It was also] flawed by Daryl Steinberg coming out advocating the housing proposal and unduly influencing the process (TF)

Integrity of the process

- There is a perception that there was a set agenda initially and when the plan came out it validated that perception (S)
- It was demoralizing that the rules changed while the process was going on (TF)
- The process is flawed when we came to the table in earnest and identified the top programs to be funded and our recommendations were ignored. It is insulting and I am unwilling to come back to the table (S)
- This is why community members distrust government (S)
- Being at the table was not a guarantee that your voice would be heard (TF)

- There is the perception that the department was in charge [of the process] (S)
- The Steering Committee must understand the consequences of ignoring community input (S)
- We've lost participants who felt ignored by the decision (TF)
- Bubble up – how does a proposal "bubble up"? One Steering Committee members can decide? Not a good process – [do we need] new rules? (TF)
- The bubble-up process did not honor the priority order of the Task Force representation (TF)
- What purpose do we serve by continuing to meet? Folks thought there would be an annual review and now we hear three years (TF)
- Why would the Children's Task Force continue when they are not being heard? (TF)
- We all got punk'd in this process (S)
- Youth get discouraged when we're told you're our future and then you ignore us (TF)
- Integrity was maintained between the stakeholder groups and the Task Force but not with the Steering Committee and the Task Force. Integrity must be maintained (TF)
- The process went well in getting the community youth involved [by the youth culture committee in surveys] and who then had expectations, but they will be disappointed [when their recommendations are not reflected] (TF-Y)

Harig. Richard

From: MHSA
Sent: Tuesday, December 06, 2005 11:43 AM
To: Harig. Richard
Subject: FW: MHSA COMMENTS

Here's another that I thought you should be made aware of.

~ Nedra
-----Original Message-----
From: cscsw [mailto:cscsw@pacbell.net]
Sent: Tuesday, December 06, 2005 10:28 AM
To: MHSA
Subject: MHSA COMMENTS

In all my years as a professional and as a community mental health advocate, I must admit to having never seen a process so worthy become so flawed so quickly, as what we have just witnessed in the Sacramento County MHSA Community Service and Support Plan.

Those of us who are advocates are used to speaking to powerful legislators and officials, and we understand that you make your best case and then you win some and you lose some. We truly thought that this MHSA process would be a different concept. To hold out the promise, especially to consumers, that the dream of a new mental health system could begin to take shape through an inclusive, community-wide planning process, allowed even the most jaded of us the possibility of hope.

These past two months we have watched all of the work and the spirit of empowerment be tossed aside, subverted through a series of top-down, closed-door negotiations more reminiscent of the legislature than any community process.

In the final analysis what has been lost, besides a fine older adult proposal, is the long term trust and enthusiasm of those of us who actually believed we could make a difference this time.

As I mentioned above, some of us are used to the ups and downs of hard core politics, but I do not think the consumers I have met throughout this process were expecting it to end this way. I fear the long term results of this breach of trust will be reflected down the road when the community is again called upon to assist in implementing CSS and in planning future programs.

Geri Esposito
Chair, Older Adults Committee
Mental Health Board

Dawson. Nedra

From: Freitas. Frances
Sent: Wednesday, December 07, 2005 9:34 AM
To: MHSA
Subject: Response to the revised MHSA PLAN

Re: response to Sacramento County's MHSA revised Plan proposal.

I would like to document my opposition to the revised MHSA Plan proposal that was posted December 4, 2005. My opposition to this revision is based on the circumvention to the planning process agreed to by the Sacramento County's stakeholders and defined by the State Department of Mental Health. This decision was made after the conclusion to the previously adopted Plan and one and one-half weeks prior to the public hearing. Further, and equally important, this decision resulted in the elimination of one program and deep cuts to at least one other proposal. The overarching issue, however, is the abandonment and circumvention to the planning process.

Frances Freitas

Memorandum

SACRAMENTO COUNTY
DEPARTMENT OF

Health & Human Services

Jim Hunt
Director

Lynn Frank
Administrative Services

Telephone: (916) 875-2002
Fax: (916) 875-1283
Mail Code: 37-1000A

December 5, 2005

TO: Richard Harig, Mental Health Services Act Program Manager

FROM: Toni Moore, Alcohol and Drug Administrator

SUBJECT: COMMENTS ON MENTAL HEALTH SERVICES ACT PLAN

I wanted to provide you with comments in writing that reflect prior communications I have had with you, Kathleen Henry and Ann Edwards Buckley and/or the MHSA Steering committee.

First, I want to commend the Mental Health Division on an exemplary public planning process. The process was well thought out, thorough, and inclusive. The initial training provided a concise overview to support the development of proposals. The number of people involved in the process was most impressive. This process serves as a good model for other DHHS planning efforts.

The configurations of the Steering Committees, Tasks Forces and Stakeholders groups were appropriate and inclusive. There was ample involvement for community participation. Working with consumers directly challenged our planning norms in a productive way.

The decision making process used by the Steering Committee worked well overall, with the exception of the handling of the PERT team proposal. I believe the group worked well together, even during times of disagreement. I was able to network with others. I particularly enjoyed the opportunity to get to know some of your Advisory Board members and consumer advocates.

The proposal to use MHSA funds to hire law enforcement officers was not supported by the Steering committee as a whole. I do support the concept of PERT teams, but do not support using MHSA funds for law enforcement positions. I believe there are other options that would be more cost effective and would lead to real capacity expansion, while achieving desired results.

I was disappointed that inaccurate information was provided to Mental Health Division staff about what service activities would be funded under the Mental Health Court proposal. Unfortunately, this information was presented to the Steering Committee and the public, resulting in the abandonment of support for this proposal. Even after I corrected the statement, there was no opportunity rectify the situation and therefore the proposal was not fairly evaluated. I continue to support the need for a Mental Health Court in the County and the use of MHSA funds for the mental health services components of the program. I hope that this will be considered when additional funding is available.

Bert Bettis
Senior & Adult Services
Phone: 874-9598
Fax: 874-9682
Mail Code: 13-149A

Toni Moore
Alcohol & Drug Services
Phone: 875-2050
Fax: 875-2035
Mail Code: 37-500A

Kathleen Henry
Mental Health Services
Phone: 875-5521
Fax: 875-6970
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Leland Tom
Child Protective Services
Phone: 875-0123
Fax: 875-0191
Mail Code: 37-700C

Glennah Trochet, M.D.
County Health Officer
Phone: 875-5881
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Mail Code: 37-600A

Keith Andrews, M.D.
Primary Health Services
Phone: 875-5701
Fax: 875-6366
Mail Code: 37-500P

Strategically, it may have been an error not to structure funding options in a manner that would ensure that at least one proposal from each Task Force was recommended for funding. It is my understanding that participants in the Children's Task Force and related Stakeholder groups were angry that no children specific proposals are being funded. It also caused some community leaders to drop out of the process and criticize the overall result. Unfortunately, this situation has created barriers with some children's advocates and community partners.

I expected to see alcohol and other drug (AOD) content in the proposals cited in the plan. When serving people with mental illness, addressing AOD issues should be a routine expectation, similar to addressing race, ethnicity and culture. The Mental Health Division and the Alcohol and Drug Services Division have already committed to building capacity to serve those with co-occurring needs, and the MHSA is an excellent opportunity to do so. AOD capacity was missing almost entirely from the plan. I am requesting that AOD content and co-occurring service capacity be (1) incorporated into the plan; (2) incorporated into the competitive bid and selection process for contract providers; and (3) that the providers and county staff hired to deliver services funded through the MHSA be mandated to participate in AODTI training and other trainings as appropriate that enhance co-occurring knowledge and skill development. I look forward to assisting with the above recommendations if needed.

With the above said, I believe the services and programs being recommended for funding are appropriate and will help address existing gaps. Dedicating the largest amount of funding to housing is important and should contribute to positive outcomes. The community assessment process clearly supports the need to enhance services for the elderly and the Asian/Pacific Islander populations. I am particularly supportive of the Wellness Center proposal. If future funding permits, expansion to other sites would be ideal.

I appreciate the opportunity to be involved in the MHSA planning process and the invitation to provide formal comment for your consideration in finalizing the County's plan.

C: Jim Hunt
Kathleen Henry
Ann Edwards-Buckley

Bert Bettis
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Phone: 874-9598
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Sacramento County
Division of Mental Health
Mental Health Services Act Public Comment
7001-A East Parkway, Suite 400
Sacramento, CA 95823

To whom it may concern,

Following are my public comments regarding the Mental Health Services Act Community Services and Supports planning process and the revised plan.

Process Comments:

I am disheartened by the politicizing of what began as an open and transparent community process and the way in which the PERT program was incorporated into the core MHSA CSS Plan. I feel strongly that Law Enforcement has a responsibility to meet the needs of all people in the community and that they should not place that burden solely on Mental Health. If officers were adequately trained and if meeting the needs of the Mental Health community were priorities, they would develop strategies within their own departments to address the issues and concerns that PERT appears to address. Other Law Enforcement agencies in the State and throughout the Nation are recognizing the Mental Health needs in their communities and responding without funding from Mental Health.

There were additional process issues that I would also like to address so that future planning processes can be improved. The trainings that were conducted focused solely on the current system and the glaring inadequacies of the system to meet the needs of the Mental Health population. Most of this information was developed by the Division of Mental Health. Contract Provider, Consumers and Families were not collaborators in developing the training materials. The "train the trainer" information was predominantly a reiteration of the initial training with the addition of a survey which was again developed by the Division of Mental Health and many of the trainers felt that the questions on the surveys were leading and/or difficult to understand. Additionally, the information that was obtainable was gleaned concurrently with the meetings of stakeholder groups, task force meetings and steering committee meetings, which meant that the data from the surveys was not really incorporated in any meaningful way into the planning process. I believe the urgency to develop the plan resulted in a loss of meaningful input from Consumers and possibly other groups in the community. There was a great deal of data collected during the process; however data that I had requested on the numbers of Consumers and family members participating in the stakeholder groups was never provided. I still have concerns that proposals which have been incorporated into the plan represented very little input from Consumers at the Stakeholder level. Most of the Consumer representatives which sat on the Task Force and Steering

Committee levels were employed consumer providers because of the sophisticated nature of the process. In the future I hope that we might transform our processes to include participants who have not been willing to participate simply because the process is to difficult for them to understand but who still have meaningful things to say.

Plan Comments:

The T-Core proposal looks very similar to the Transitional ISA which was developed to assist in the reduction of the census of the Sacramento County Mental Health Treatment Center. The T-Core program should be accessible from the Community Mental Health Programs and not through the sub-acute or acute care system. I will reiterate that using the Treatment Center as the gatekeeper for community programs compounds the problems of the treatment center; it does not improve them. Community agencies must be able to divert people from the Treatment Center by having access to other community resources.

The Wellness and Recovery program states that it will be Consumer operated; however it does not explicitly state that it will be operated by a Consumer owned and operated agency. I would like to see language that explicitly states that the Wellness and Recovery Center will be run by a Consumer owned and operated agency.
Additionally, during the stakeholder process Consumers developing the proposal for the Wellness and Recovery Center did not agree that there should be Clinicians and Psychiatrists on staff. Since there was no consensus on the issue it was deliberately left out of the proposal. The Division of Mental Health Staff wants the Wellness and Recovery Center to have Clinical and Psychiatric services. The stakeholders do not.

Due to the controversy of the PERT program and the many consumers and family members who have related negative experiences with law enforcement, I believe that the PERT program should have an oversight and accountability commission appointed by the Mental Health Board. The commission would report to the Board of Supervisors to ensure that the program is responsive to the needs of families and consumers as it promises to be. It is imperative that consumers and families share decision making authority equally with Mental Health and Law Enforcement if this program is to be transformative and trusting relationships built. Additionally, it is essential that consumers and family members are incorporated into the PERT team in a substantive manner. In the proposal there are several titles used for the consumers/family members who are to be a part of the PERT team. This is confusing. In Exhibit 5a the positions are referred to as Consumer/Family Advocate positions. In other parts of the proposal they are referred to as Peer Counselors. I believe that it is important to have Advocates as integral members of the PERT team both to assist the PERT team in accessing community resources and to educate the Officers and Clinicians in the program. I believe that if implemented correctly this program has tremendous potential to impact the perceptions of law enforcement, Mental Health providers, consumers and families in a fundamental way.

In closing I would like to thank all who have participated in this process which in itself has been a transformative experience in my own life. The effort, willingness, passion and struggle I have encountered both in myself and in other participants have impacted me profoundly both personally and professionally. I have learned a great deal and hopefully will continue to learn more.

Sincerely,

Meghan Stanton

Cc. Sacramento County Mental Health Board
Cc. Larry Boone, Sacramento Division of Mental Health

Public Comment for MHSA CSS Public Hearing
December 7, 2005

While I am disheartened by the political processes which have overshadowed what began as an open and transparent community process I remain hopeful that the community will continue the work that has begun with this plan and strive to realize the full potential of the Mental Health Services Act.

Consumers Self Help began a very informal questionnaire to begin a dialogue with some of the Consumers in Sacramento.

So far we have interviewed approximately 55 consumers from the self help centers, board and care and Sutter Center for Psychiatry.

The individuals interviewed were given a brief description of each program from the executive summary portion of the proposal in the CSS plan and asked if they believed they personally would likely use the program and if they believed the program was valuable to the community.

The overall results tallied as follows. Additional comments were written in by some of the respondents.

Age groups:

20-30yrs old:	**5 respondents**
31-40yrs old:	**11 respondents**
41-54yrs old:	**27 respondents**
55 and above:	**9 respondents**
Did not answer:	**3 respondents**

Ethnic groups identified by respondents:

African American	**14 respondents**
Asian	**4 respondents**
Hispanic	**4 respondents**
Caucasian	**30 respondents**

Housing Status:

12 respondents stated they were homeless
35 respondents stated they had housing of some kind.

When asked if respondents were likely to use the following programs:

Transitional Community Opportunity for Recovery Program:

Yes: 35 respondents **No: 15 respondents**

On a scale from 1-5 thought the program was valuable to the community:

Ranked 1= 4 Ranked 2 = 3 Ranked 3 = 3 Ranked 4 = 6 Ranked 5 = 38

Older Adult Intensive Services Program:

Yes: 32 respondents **No: 20 respondents**

On a scale from 1-5 thought the program was valuable to the community:

Ranked 1 = 5 Ranked 2 = 4 Ranked 3 = 4 Ranked 4 = 8 Ranked 5 = 36

Older Adult Crisis Intervention and Intensive Case Management:

Yes: 28 **No: 23**

On a scale from 1-5 thought the program was valuable to the community:

Ranked 1 = 0 Ranked 2 = 4 Ranked 3 = 6 Ranked 4 = 9 Ranked 5 = 33

Permanent Supportive Housing Program for Singles and Families

Yes: 46 **No: 5**

On a scale from 1-5 thought the program was valuable to the community:

Ranked 1 = 0 Ranked 2 = 3 Ranked 3 = 4 Ranked 4 = 3 Ranked 5 = 47

Transcultural Wellness Center:

Yes: 31 **No: 19**

On a scale from 1-5 thought the program was valuable to the community:

Ranked 1 = 5 Ranked 2 = 7 Ranked 3 = 6 Ranked 4 = 5 Ranked 5 = 30

Wellness and Recovery Center:

Yes: 45 **No: 5**

On a scale from 1-5 thought the program was valuable to the community:

Ranked 1 = 1 Ranked 2 = 4 Ranked 3 = 2 Ranked 4 = 5 Ranked 5 = 39

PERT (Psychiatric Emergency Response Team)

Yes: 33 **No: 17**

On a scale from 1-5 thought the program was valuable to the community:

Ranked 1 = 3 Ranked 2 = 2 Ranked 3 = 3 Ranked 4 = 8 Ranked 5 = 34

Dawson. Nedra

From: Edwards-Buckley. Ann
Sent: Monday, December 05, 2005 1:33 PM
To: MHSA
Subject: FW: MHSA PERT Steering Committee Vote

Please include this in the public comments
-----Original Message-----
From: Main Staff [mailto:main@californiaclients.org]
Sent: Saturday, December 03, 2005 2:44 PM
To: Edwards-Buckley. Ann
Cc: Carole Ford; Agnes Lintz; Anita Shumaker; Ben Jones; David Schroeder; Frank Smith; Kay Tucker; Meghan Stanton; Dr. Theresa Roberts; Rusty Selix; Susan Gallager
Subject: RE: MHSA PERT Steering Committee Vote

This another request for another meeting and vote with the counting done in full view of the public.

When we left the Steering Committee meeting December 1, 2005 the vote was tied. Steering Committee member Lyn Farr said that she wanted to change her vote to a no vote; she was told that it did not matter because the vote was tied and the addendum would not go forth.

On Friday December 2, 2005 I received a call that the Division of Mental Health was holding a private meeting to go over the votes. When I arrived at the Division the meeting was over.

Later I receive an e mail that the vote was miscounted and the decision was now to accept the addendum.

This count is highly suspicious because it was done in private. I want this post as part of the public record because of the lack of transparency of the counting of the vote.

This e mail represents my view as a local advocate and member of the Sacramento Mental Health Services Act Steering Committee and not those of the California Network of Mental Health Clients, its Board of Directors, Staff, or membership. I am using the CNMHC computer because I do not have one.

Sacramento County
Community Services and Supports Plan
Comment Number: 124

--- "Edwards-Buckley. Ann" <Edwards-BuckleyA@SacCounty.net> wrote:

From: "Edwards-Buckley. Ann" <Edwards-BuckleyA@SacCounty.net>
Date: Fri, 2 Dec 2005 18:35:42 -0800
To: <main@californiaclients.org>, "Najera. Albert (DA External)" <anajera@pd.cityofsacramento.org>, "Al Rowlett (E-mail)" <alrowlett@tpcp.org>, "Albert Lipson (E-mail)" <alipsons@starstream.net>, "Hillerman. Andrea" <hillermana@SacCounty.net>, "Anita Shumaker (E-mail)" <anitashumaker@aol.com>, "Bettis. Bert" <BettisB@SacCounty.net>, "Brian Bratcher (E-mail)" <bbratcher@elhogarinc.org>, "Danny Marquez (E-mail)" <dmkickball@osbtown.com>, "Dave Schroeder (E-mail)" <davedabear@juno.com>, "David Risley (E-mail)" <drisley@pd.cityofsacramento.org>, "Klopp. Guy Howard" <KloppG@SacCounty.net>, "Hank Lee (E-mail)" <hankleeLTC@yahoo.com>, "Heidi Sanborn (E-mail)" <bhsan@comcast.net>, "Hendry Ton (E-mail)" <hton@ucdavis.edu>, "John Buck (E-mail)" <johnbuck@tpcp.org>, "John Haddock (E-mail)" <johado9@aol.com>, "Henry. Kathleen" <HenryK@SacCounty.net>, "Kay Tucker (E-mail)" <hopeequalslife@yahoo.com>, "Andrews. Keith" <AndrewsK@SacCounty.net>, "Bernard. Ken (DA External)" <kbernard@pd.cityofsacramento.org>, "Saunders. Lee" <saunderslee@saccounty.net>, "Lyn Farr (E-mail)" <lfarr@emq.org>, "Lynn Efken (E-mail)" <lefken@scoe.net>, "McGinnis. Marilyn" <mcginnism@SacCounty.net>, "Mary McFadden (E-mail)" <mmcfadden@pd.cityofsacramento.org>, "Meghan Stanton (E-mail)" <mstantl@aol.com>, "Melinda Avey (E-mail)" <mavey50@comcast.net>, "Mona Moxley (E-mail)" <mona.moxley@chw.edu>, "Patricia Pavone (E-mail)" <pavone@surewest.net>, "Damiano. Sandy" <DamianoSa@SacCounty.net>, "Sayuri Sion (E-mail)" <lplace@hrcsac.org>, "Swapna Jain (E-mail)" <swapna@globalband.net>, "Theresa Roberts (E-mail)" <tarobert@pacbell.net>, "Moore. Toni" <MooreT@SacCounty.net>, "Williams Romero (E-mail)" <bdonovan@cbhi.net>
Cc: "Harig. Richard" <HarigR@SacCounty.net>, "Hunt. Jim" <JimHunt@saccounty.net>
Subject: RE: MHSA PERT Steering Committee Vote

I just want to clarify there is no second vote. The purpose of this email and the phone calls being made is to confirm votes made last night. I again thank you for your patience.
Ann
-----Original Message-----
From: Main Staff [mailto:main@californiaclients.org]
Sent: Friday, December 02, 2005 6:31 PM
To: Edwards-Buckley. Ann; Najera. Albert (DA External); Al Rowlett (E-mail); Albert Lipson (E-mail); Hillerman. Andrea; Anita Shumaker (E-mail); Bettis. Bert; Brian Bratcher (E-mail); Danny Marquez (E-mail); Dave Schroeder (E-mail); David Risley (E-mail); Klopp. Guy Howard; Hank Lee (E-mail); Heidi Sanborn (E-mail); Hendry Ton (E-mail); John Buck (E-mail); John Haddock (E-mail); Henry. Kathleen; Kathy Trevino (E-mail); Kay Tucker (E-mail); Andrews. Keith; Bernard. Ken (DA External); Saunders. Lee; Lyn Farr (E-mail); Lynn Efken (E-mail); McGinnis. Marilyn; Mary McFadden (E-mail); Meghan Stanton (E-mail); Melinda Avey (E-mail); Mona Moxley (E-mail); Patricia Pavone (E-mail); Damiano. Sandy; Sayuri Sion (E-mail); Swapna Jain (E-mail); Theresa Roberts (E-mail); Moore. Toni; Williams Romero (E-mail)
Cc: Harig. Richard; Hunt. Jim
Subject: Re: MHSA PERT Steering Committee Vote

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and vote with the counting done in full view of the public. Kathryn Trevino

--- "Edwards-Buckley. Ann" <Edwards-BuckleyA@SacCounty.net> wrote:

From: "Edwards-Buckley. Ann" <Edwards-BuckleyA@SacCounty.net>
Date: Fri, 2 Dec 2005 17:07:58 -0800
To: "Al Najera (E-mail)" <anajera@pd.cityofsacramento.org>,
"Al Rowlett (E-mail)" <alrowlett@tpcp.org>,
"Albert Lipson (E-mail)" <alipsons@starstream.net>,
"Andrea Hillerman (E-mail)" <hillermana@SacCounty.net>,
"Anita Shumaker (E-mail)" <anitashumaker@aol.com>,
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"Brian Bratcher (E-mail)" <bbratcher@elhogarinc.org>,
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"Hendry Ton (E-mail)" <hton@ucdavis.edu>,
"John Buck (E-mail)" <johnbuck@tpcp.org>,
"John Haddock (E-mail)" <johado9@aol.com>,
"Kathleen Henry (E-mail)" <HenryK@SacCounty.net>,
"Kathy Trevino (E-mail)" <Main@californiaclients.org>,
"Kay Tucker (E-mail)" <hopeequalslife@yahoo.com>,
"Keith Andrews (E-mail)" <AndrewsK@SacCounty.net>,
"Ken Bernard (E-mail)" <kbernard@pd.cityofsacramento.org>,
"Lee Saunders (E-mail)" <saunderslee@saccounty.net>,
"Lyn Farr (E-mail)" <lfarr@emq.org>,
"Lynn Efken (E-mail)" <lefken@scoe.net>,
"Marilyn McGinnis (E-mail)" <mcginnism@SacCounty.net>,
"Mary McFadden (E-mail)" <mmcfadden@pd.cityofsacramento.org>,
"Meghan Stanton (E-mail)" <mstantl@aol.com>,
"Melinda Avey (E-mail)" <mavey50@comcast.net>,
"Mona Moxley (E-mail)" <mona.moxley@chw.edu>,
"Patricia Pavone (E-mail)" <pavone@surewest.net>,
"Sandy Damiano (E-mail)" <DamianoSa@SacCounty.net>,
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"Toni Moore (E-mail)" <MooreT@SacCounty.net>,
"Williams Romero (E-mail)" <bdonovan@cbhi.net>
Cc: "Harig. Richard" <HarigR@SacCounty.net>,
"Hunt. Jim" <JimHunt@saccounty.net>
Subject: MHSA PERT Steering Committee Vote

Dear Steering Committee Members,

Thank you for your participation in the meeting last night to discuss PERT. In preparing the minutes it came to our attention there may have been an error in the counting of the votes. To insure the votes of all voting members and voting alternates are accurately accounted for, I am asking members to please confirm your vote from last night. I will list the name of each voting member or alternate below, and the vote we have recorded for that member. Please reply and confirm we documented your vote accurately. You may also receive a phone call as it is urgent we clarify before the end of the weekend in order to be prepared for the public hearing scheduled for Wednesday, December 7. Thank you for your patience and dedication.

John Buck Yes
Bimla Jain Yes

Pakash Jain Yes
Ken Bernard Yes
Heidi Sanborn Yes
Patricia Pavone Yes
Kathleen Henry Yes
Lyn Farr Yes
Hank Lee Yes
Toni Moore No
Guy Klopp No
Dave Schroeder No
Kathy Trevino No
Andrea Hillerman No
Meghan Stanton No
Sayuri Sion No
Brian Bratcher No
Melissa Drake Abstain

Ann Edwards-Buckley, MFT
Chief, Sacramento County Adult Mental Health Services
7001 A East Parkway, Suite 300
Sacramento, CA 95826
(916) 875-9904
(916) 875-6705 fax
edwardsbuckleya@saccounty.net

CONFIDENTIAL PATIENT INFORMATION
SEE W&I CODE 5328

Harig. Richard

From: MHSA
Sent: Tuesday, December 06, 2005 9:31 AM
To: Harig. Richard
Subject: FW: MHSA PERT Steering Committee Vote

-----Original Message-----
From: Edwards-Buckley. Ann
Sent: Monday, December 05, 2005 1:33 PM
To: MHSA
Subject: FW: MHSA PERT Steering Committee Vote

Please include this as public comment.

-----Original Message-----
From: Main Staff [mailto:main@californiaclients.org]
Sent: Monday, December 05, 2005 12:30 PM
To: main@californiaclients.org; Edwards-Buckley. Ann
Cc: Carole Ford; Agnes Lintz; Anita Shumaker; Ben Jones; David Schroeder; Frank Smith; Kay Tucker; Meghan Stanton; Dr. Theresa Roberts; Rusty Selix; Susan Gallager
Subject: RE: MHSA PERT Steering Committee Vote

This is the third request for another Steering Committee meeting and vote with the counting done in full view of the public. In addition, I want to hear the recorded minutes of the last steering committee meeting.

When we left the Steering Committee meeting December 1, 2005 the vote was tied. Steering Committee member Lyn Farr said that she wanted to change her vote to a no vote; she was told that it did not matter because the vote was tied and the addendum would not go forth.

On Friday December 2, 2005 I received a call that the Division of Mental Health was holding a private meeting to go over the votes. When I arrived at the Division the meeting was over.
Later I receive an e mail that the vote was miscounted and the decision was now to accept the addendum.

This count is highly suspicious because it was done in private. I want this post as part of the public record because of the lack of transparency of the counting of the vote.

This e mail represents my view as a local advocate and member of the Sacramento Mental Health Services Act Steering Committee and not those of the California Network of Mental Health Clients, its Board of Directors, Staff, or membership. I am using the CNMHC computer because I do not have one. Kathryn Trevino

--- "Edwards-Buckley. Ann" <Edwards-BuckleyA@SacCounty.net> wrote:

From: "Edwards-Buckley. Ann" <Edwards-BuckleyA@SacCounty.net>
Date: Fri, 2 Dec 2005 18:35:42 -0800
To: <main@californiaclients.org>, "Najera. Albert (DA External)" <anajera@pd.cityofsacramento.org>, "Al Rowlett (E-mail)" <alrowlett@tpcp.org>, "Albert Lipson (E-mail)" <alipsons@starstream.net>, "Hillerman. Andrea" <hillermana@SacCounty.net>, "Anita Shumaker (E-mail)" <anitashumaker@aol.com>, "Bettis. Bert" <BettisB@SacCounty.net>, "Brian Bratcher (E-mail)" <bbratcher@elhogarinc.org>, "Danny Marquez (E-mail)" <dmkickball@osbtown.com>, "Dave Schroeder (E-mail)" <davedabear@juno.com>, "David Risley (E-mail)" <drisley@pd.cityofsacramento.org>, "Klopp. Guy Howard" <KloppG@SacCounty.net>, "Hank Lee (E-mail)" <hankleeLTC@yahoo.com>, "Heidi Sanborn (E-mail)" <bhsan@comcast.net>, "Hendry Ton (E-mail)" <hton@ucdavis.edu>, "John Buck (E-mail)" <johnbuck@tpcp.org>, "John Haddock (E-mail)" <johado9@aol.com>, "Henry. Kathleen" <HenryK@SacCounty.net>, "Kay Tucker (E-mail)" <hopeequalslife@yahoo.com>, "Andrews. Keith" <AndrewsK@SacCounty.net>, "Bernard. Ken (DA External)" <kbernard@pd.cityofsacramento.org>, "Saunders. Lee" <saunderslee@saccounty.net>, "Lyn Farr (E-mail)" <lfarr@emq.org>, "Lynn Efken (E-mail)" <lefken@scoe.net>, "McGinnis. Marilyn" <mcginnism@SacCounty.net>, "Mary McFadden (E-mail)" <mmcfadden@pd.cityofsacramento.org>, "Meghan Stanton (E-mail)" <mstantl@aol.com>, "Melinda Avey (E-mail)" <mavey50@comcast.net>, "Mona Moxley (E-mail)" <mona.moxley@chw.edu>, "Patricia Pavone (E-mail)" <pavone@surewest.net>, "Damiano. Sandy" <DamianoSa@SacCounty.net>, "Sayuri Sion (E-mail)" <lplace@hrcsac.org>, "Swapna Jain (E-mail)" <swapna@globalband.net>, "Theresa Roberts (E-mail)" <tarobert@pacbell.net>, "Moore. Toni" <MooreT@SacCounty.net>, "Williams Romero (E-mail)" <bdonovan@cbhi.net>
Cc: "Harig. Richard" <HarigR@SacCounty.net>, "Hunt. Jim" <JimHunt@saccounty.net>
Subject: RE: MHSA PERT Steering Committee Vote

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-----Original Message-----

From: Main Staff [mailto:main@californiaclients.org]
Sent: Friday, December 02, 2005 6:31 PM
To: Edwards-Buckley. Ann; Najera. Albert (DA External); Al Rowlett (E-mail); Albert Lipson (E-mail); Hillerman. Andrea; Anita Shumaker (E-mail); Bettis. Bert; Brian Bratcher (E-mail); Danny Marquez (E-mail); Dave Schroeder (E-mail); David Risley (E-mail); Klopp. Guy Howard; Hank Lee (E-mail); Heidi Sanborn (E-mail); Hendry Ton (E-mail); John Buck (E-mail); John Haddock (E-mail); Henry. Kathleen; Kathy Trevino (E-mail); Kay Tucker (E-mail); Andrews. Keith; Bernard. Ken (DA External); Saunders. Lee; Lyn Farr (E-mail); Lynn Efken (E-mail); McGinnis. Marilyn; Mary McFadden (E-mail); Meghan Stanton (E-mail); Melinda Avey (E-mail); Mona Moxley (E-mail); Patricia Pavone (E-mail); Damiano. Sandy; Sayuri Sion (E-mail); Swapna Jain (E-mail); Theresa Roberts (E-mail); Moore. Toni; Williams Romero (E-mail)
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wrote:

From: "Edwards-Buckley. Ann" <Edwards-BuckleyA@SacCounty.net>
Date: Fri, 2 Dec 2005 17:07:58 -0800
To: "Al Najera (E-mail)" <anajera@pd.cityofsacramento.org>,
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"Toni Moore (E-mail)" <MooreT@SacCounty.net>,
"Williams Romero (E-mail)" <bdonovan@cbhi.net>

Cc: "Harig. Richard" <HarigR@SacCounty.net>,
"Hunt. Jim" <JimHunt@saccounty.net>
Subject: MHSA PERT Steering Committee Vote

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John Buck Yes
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Heidi Sanborn Yes
Patricia Pavone Yes
Kathleen Henry Yes
Lyn Farr Yes
Hank Lee Yes
Toni Moore No
Guy Klopp No
Dave Schroeder No
Kathy Trevino No
Andrea Hillerman No
Meghan Stanton No
Sayuri Sion No
Brian Bratcher No
Melissa Drake Abstain

Ann Edwards-Buckley, MFT
Chief, Sacramento County Adult Mental Health Services
7001 A East Parkway, Suite 300
Sacramento, CA 95826
(916) 875-9904
(916) 875-6705 fax
edwardsbuckleya@saccounty.net

CONFIDENTIAL PATIENT INFORMATION
SEE W&I CODE 5328

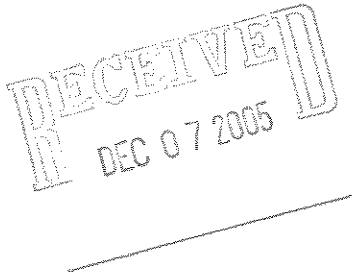
Dawson. Nedra

From: MHSA
Sent: Monday, November 28, 2005 3:18 PM
To: Harig. Richard
Subject: FW: draft proposal

Diana White

Per Jane Ann's request --

~ Nedra



-----Original Message-----
From: LeBlanc. Jane Ann
Sent: Monday, November 28, 2005 3:16 PM
To: MHSA
Subject: RE: draft proposal

Please forward to Dick for reply.

Thanks,
Jane Ann

Sacramento County
Community Services and Supports Plan
Comment Number: 172

-----Original Message-----
From: MHSA
Sent: Monday, November 28, 2005 3:14 PM
To: LeBlanc. Jane Ann
Subject: FW: draft proposal

Jane Ann --

Please copy me in your reply. I'm not sure how to respond to this.

Thanks --

~ Nedra

-----Original Message-----
From: Diana White [mailto:DianaWhite@tpcp.org]
Sent: Wednesday, November 23, 2005 5:02 PM
To: MHSA
Subject: draft proposal

I very much appreciated the hard work of the family and community members who gave of their time to draft and review proposals. Their perspective in identifying needs and potential solutions is incredibly important. I am concerned with putting a process in place "bubble up", that seems to negate that good work. I would not want to see family and community members disengage from this planning, thinking they would ultimately not be heard. I hope that future decisions can be made that will enhance not comprimise trust in this process.

Diana White LMFT

Sacramento County
Community Services and Supports
Plan

Comment Number: 1467

DEC 0 7 2005

RECEIVED

12/7/05

The decision to allow law enforcement to submit a revised proposal ~~is~~ is illegal. You can call it a revision of the original proposal. But it is a second separate proposal after knowing what was wrong with the original proposal.

The rule for the proposal process does not allow for a second chance proposal or a revision of your original proposal.

The committee by allowing law enforcement to do this does a disservice to the rule of law and our democratic process.

If the committee allow law enforcement to revised their proposal, why did they not allow other agencies to revised their proposal?

Second, the count of the voting. It appears that the vote count was reported incorrectly (8-8-1) ~~It~~ It was actually 9-8-1 (I'm told). The committee followed the Brown Act in it's proceedings although I'm told that they did not have to. But the committee did until they discovered the voting error. In such a close vote, all necessary precaution should have been taken. I would like to suggest that the Brown Act should have been followed. That is a new agenda formation posted announcing the recount due to error. For the committee to do it outside of public view has created an ~~impression~~ appearance of corrupting the democratic process.

One of the speakers asked what is transformation? If the committee approved the PERT proposal, they will be allowing the transformation of the democratic process where the rich and powerful do not have to follow the rule of law. ~~The~~ The civic lesson learned is that if you have power you can do what you want.

Harig. Richard

From: MHSA
Sent: Tuesday, December 06, 2005 4:45 PM
To: Edwards-Buckley. Ann; Harig. Richard
Subject: FW: MHSA Comments

One more for you to look at -- I've added it to the others.

~ Nedra

-----Original Message-----
From: Joan B Lee [mailto:joanblee78@lanset.com]
Sent: Tuesday, December 06, 2005 12:26 PM
To: MHSA; Esposito Geri
Subject: MHSA Comments

MHSA Public Comment - 12-14-05

Gray Panthers of Sacramento have participated in Prop 63 planning since the beginning of Sacramento's efforts. We have had representatives on several older adult stakeholders groups and on the Older Adult Task Force. We supported the inclusiveness and the creativity of the process. We understood that there would necessarily be a "whittling down" process among the many proposals submitted by stakeholders.

We supported Sacramento's efforts right up to the time when the entire process was turned on its head as police and sheriff's leadership decided to play political hardball to get Prop 63 money to pay for _all_ aspects of a PERT team proposal.

We have watched this debacle with extreme disappointment and outrage: police come up at the last minute with money to help fund a modified PERT proposal, after the rest of the plan is prepared and on the web for public discussion; then a hurried "modified" plan is placed before the people two days before a public hearing. The Police Chief is sending out pleas for community support at the hearing, neglecting to mention how this late entry came to be.

This is a travesty on the consumers, professionals and community at large, who worked so hard for the integrity of the plan. No one has ever questioned the validity of PERT teams nor the need for them, but someone needs to send a message to law enforcement as well as county leadership that this was not a union negotiation - this was the heart and soul of a community-wide process they destroyed.

Joan Lee
Gray Panthers of Sacramento

cc:Geri Esposito, Gray Panthers Steering Committee

Joan B. Lee
Legislative Liaison
Gray Panthers California
916-332-5980
FAX 916-332-5980
5313 Fernwood Way
Sacramento, CA 95841

>>AUDIENCE MEMBER: I'M JAMES BENNETT. AND I WROTE A PROPOSAL FOR SIX CRISIS RESIDENTIALS AND IT RANKED NUMBER FIVE IN THE ADULT TASK FORCE AND IT DID PRETTY WELL WITH THE STEERING COMMITTEE. UNFORTUNATELY, I DIDN'T HAVE THE OPTION OF TALKING TO OTHER PEOPLE WHEN IT WAS REJECTED TO GET IT PUT ON A CALENDAR AND MOVED UP.

I'M KIND OF DISAPPOINTED THAT I DON'T HAVE THE SAME AVENUES FOR EXPRESSION OF MY IDEAS AS SOME OTHERS DO. I FIND THAT DISAPPOINTING AND UNFORTUNATELY BECAUSE I THINK MY IDEAS ARE JUST AS GOOD.

(APPLAUSE).

THE TRANSFORMED SYSTEM SHOULD BE A COLLABORATIVE EFFORT FOR BEST RESULTS. CONSUMERS MUST BE THE PRIMARY DETERMINERS OF THEIR OWN DESTINIES. AND THE WELLNESS THERAPIES SHOULD BE TRULY THERAPEUTIC. CONSUMERS MUST BE THE PRIMARY DETERMINERS OF THEIR OWN THERAPEUTIC COMMUNITIES. THANK YOU VERY MUCH. (APPLAUSE).

>>AUDIENCE MEMBER: LYNN FARR. ON BEHALF OF THE ASSOCIATION OF MENTAL HEALTH CONTRACTS, I WANT TO PLACE ON RECORD OUR OPPOSITION TO THE USE OF MENTAL HEALTH SERVICES ACT FUNDS TO COVER THE FUNDS OF LAW ENFORCEMENT PERSONNEL AND THE RELATED COSTS. DESPITE WHAT WE BELIEVE TO BE INTERPRETATION TO THE CONTRARY WE DO NOT BELIEVE THAT SHERIFF DEPUTIES IS CONSISTENT WITH THE INTENT OF THE LAW. REPRESENTATIVES FROM LAW ENFORCEMENT AND MENTAL HEALTH COMMUNITY WORKING COLLABORATIVELY TO ADDRESS THE NEEDS OF PEOPLE AND FAMILIES OF THIS COUNTY.

TRANSFORMATION OF OUR MENTAL HEALTH OUTREACH AND CRISIS RESPONSE SYSTEM.

REGARDING THE REVISED PROPOSAL INCORPORATED INTO THE COUNTY'S MENTAL HEALTH SERVICES ACT PLAN WE ARE VERY DISAPPOINTED THAT POLITICAL DECISIONS REACHED IN THE ELEVENTH HOUR WAS NOT A TRANSPARENT PROCESS. WE ARE NOT OPPOSED TO THE PERT; WE ARE OPPOSED TO FUNDS COMMITTED TO THIS PILOT GIVEN THAT HALF OF IT IS FOR LAW ENFORCEMENT POSITIONS AND EXPENSES.

WE FURTHER RECOMMEND THAT OVERSIGHT AND ACCOUNTABILITY COMMISSION BE ESTABLISHED BY THE COUNTY MENTAL HEALTH BOARD AND DESCRIBED AND INCLUDED WITHIN THE SUBMITTED MHSA SITE PLAN. AND PROVIDE CONSTRUCTIVE OUTLET FOR COMMUNICATION OF DIVERSE PERSPECTIVES AND ENSURE ACCOUNTABILITY TO THE COMMUNITY FOR SUCCESSFUL IMPLEMENTATION OR REDIRECTED FUNDS.

WE RECOMMEND THE DECISION PROCESS OF MHSA FUNDS BE REVIEWED AND MADE EXPLICIT SO ALL STAKEHOLDERS WITHIN THE COMMUNITY OR IDENTIFIED REPRESENTATIVES IS -- AND THE PROMISE OF PROPOSITION 63 IS FULLY REALIZED IN SACRAMENTO COUNTY. WE APPRECIATE THE FACT YOU ARE GOING TO SUPPORT THE REVIEW OF THE PROCESS AND WE THINK THAT WILL GO A LONG WAY TO HELP REBUILDING TRUST. THANK YOU. (APPLAUSE).

>>AUDIENCE MEMBER: GOOD EVENING. I'M A CONSUMER ADVOCATE AND FAMILY MEMBER. KATHRYN POWERS WHO IS THE DIRECT OF HEALTH AND HUMAN SERVICES AT THE FEDERAL LEVEL GAVE A SPEECH BASED ON THE PRESIDENT'S NEW FREEDOM ACT. AND THAT SPEECH SHE SPOKE VERY ELOQUENTLY ON SELF TRANSFORMATION AND WHAT IT ENTAILED.

WHAT SHE HIGHLIGHTED OUT OF EVERYTHING WAS THE IMPORTANCE OF THE CONSUMER VOICE BEING PARAMOUNT IN ANY DEVELOPMENT OF SERVICES.

THE MENTAL HEALTH SERVICES ACT HERE IN SACRAMENTO WAS INTENDED TO DO THE SAME THING. TO CREATE -- TO TRANSFORM OUR SYSTEM IN A WAY THAT WAS INCLUSIVE OF ALL PEOPLE BUT MORE IMPORTANTLY, IT PUT THE VOICE OF COMMUNITY AND CONSUMERS FIRST.

IT WAS MEANT TO CREATE A NEW AND DIFFERENT WAY OF HOW WE DID BUSINESS. AND HOW WE WORK WITH ONE ANOTHER. WHAT IT MEANT WAS THAT POLITICS TOOK THE BACK SEAT TO NEEDS.

ALTHOUGH THE PROCESSES HAVE BEEN GREAT FOR THE MOST PART, SOME PARTS OF IT HAS BEEN VERY TAINTED BY POLITICS.

AT THIS TIME I FEEL THAT PERHAPS MAYBE DECISIONS HAVE ALREADY BEEN MADE. AND WITH THAT IN MIND, I FEEL IT NECESSARY TO TALK ABOUT WHAT WE CAN DO TO AMEND SO THAT THE BEST CHANCES THAT CONSUMERS AND FAMILY MEMBERS WILL BE SERVED WILL BE PUT FIRST.

THE PERT TEAM, SPECIFICALLY, IF IT IS TO TAKE PLACE, IT SHOULD BE AMENDED TO INCLUDE FAMILY MEMBERS ACTUALLY CONSUMERS. MY FEELING IS THAT THEY WILL BE OVER POWERED.

THE MENTAL HEALTH TREATMENT CENTER IS ALREADY AT FULL CAPACITY. I HAVEN'T SEEN IN THE PERT PROPOSAL WHERE THERE'S A PLAN TO LINK CONSUMERS TO OTHER SERVICES. I WOULD LIKE TO SEE THAT. LINK -- TO --

WE SET EVERYBODY UP FOR FAILURE. WE NEED A PERT TEAM, BUT WE NEED TO THINK IT THROUGH. WE NEED OTHER THINGS TO BE IN PLACE FIRST. WE NEED -- CONSUMERS ONCE THEY IDENTIFY THEM AND BEGIN TO WORK WITH THEM. WE DON'T HAVE ENOUGH OF THEM.

WE NEED MULTICULTURAL RESOURCE WELLNESS CENTERS THAT WILL ACCOMMODATE ALL OF SACRAMENTO'S COMMUNITY.

I WOULD BE REMISS IF I DID NOT SPEAK ABOUT AFRICA AMERICANS. ALTHOUGH THE COUNTY ITSELF STATS SHOW THAT AFRICA AMERICANS HAVE HIGH PENETRATION. THE REALITY IS THERE'S HIGH PENETRATION, BUT THEY GET NO CARE. THEY ARE NOT ABLE TO MOVE FORWARD, SO WE NEED TO DO BETTER. THERE'S A LOT OF SUFFERING. AND BEFORE WE START PUTTING MONEY OR BEING PRESSURED TO PUT MONEY THAT'S NOT GOING TO BENEFIT ALL PEOPLE. WE NEED TO STEP BACK AND THINK ABOUT IT. (APPLAUSE). THANK YOU.

>>AUDIENCE MEMBER: I'M CURRENTLY THE EXECUTIVE DIRECTOR OF CONSUMER SELF-HELP CENTERS AND I ALSO HAVE A CREDIT FOR PATIENT RIGHTS AND WAS A STEERING COMMITTEE MEMBER, CONSUMER REPRESENTATIVE.

I'M HERE ACTUALLY TONIGHT TO REPRESENT SOME OTHER CONSUMERS IN ADDITION TO MYSELF, BECAUSE I TALK ALL THE TIME.

WHILE I AM DISHEARTENED BY THE POLITICAL PROCESS WHAT BEGAN AS AN OPEN AND TRANSPARENT PROCESS, I REMAIN HOPEFUL THAT THE COMMUNITY WILL CONTINUE WITH THE WORK THAT BEGAN WITH THIS PLAN. CONSUMER SELF-HELP BEGAN IN AN INFORMAL QUESTIONNAIRE.

WE HAVE INTERVIEWED APPROXIMATELY 55 CONSUMERS FROM THE SELF-HELP SYSTEM BOARD AND CARE AND PSYCHIATRY. THE INDIVIDUALS WERE GIVEN A BRIEF DESCRIPTION OF EACH PROGRAM FROM THE EXECUTIVE SUMMARY PORTION OF THE PROPOSALS IN THE CCS PROGRAM. AND THEY BELIEVE THE PROGRAM WAS VALUABLE TO THE COMMUNITY.

THE OVERALL RESULTS WERE AS FOLLOWS. THIS IS THE ORIGINAL PLAN NOT THE REVISED PLAN BECAUSE WE DIDN'T HAVE TIME TO DO THE REVISED PLAN. WE WILL WORK HARDER.

THERE ARE SOME ADDITIONAL COMMENTS THAT WERE HANDWRITTEN AND I DIDN'T WANT TO PARAPHRASE THEM BUT I HAVE COPIES OF ALL OF THE SURVEYS AND QUESTIONNAIRES.

THE AGE GROUPS WERE 20 TO 30 YEAR OLDS; FIVE. 31-40; THREE DIDN'T REVEAL THEIR AGE.

ETHNIC GROUPS. THEY WROTE IN WHAT THEY WANTED. AFRICA AMERICAN 14, ASIAN 4, HISPANIC 4, CAUCASIAN 30.

HOUSING STATUS; WE ASKED THAT BECAUSE WE THOUGHT THAT WAS A CRITICAL PIECE OF INFORMATION. TWELVE RESPONDENTS SAID THEY WERE HOMELESS. THIRTY-FIVE HAD HOUSING OF SOME KIND. ONE TO SEVEN, TRANSITIONAL COMMUNITY, OPPORTUNITY FOR RECOVERY PROGRAM. THIRTY-FIVE RESPONDENTS SAID THEY WOULD LIKELY USE THE PROGRAM. FIFTEEN SAID NO. I'M NOT GOING TO BE ABLE TO FINISH IN 30 SECONDS, SO I WILL JUST LEAVE THIS FOR YOU TO REVIEW. SHOULD I GIVE IT TO DICK?

>>AUDIENCE MEMBER: I'M THE PROGRAM MANAGER OF GERIATRIC -- I'M UPSET ABOUT THE REVISION OF THE MENTAL HEALTH SERVICE ACT PLAN.

I'M SPECIFICALLY CONCERNED ABOUT THE LOSS OF THE OLDER ADULT PROGRAM.

THE FEDERAL CENSUS OF 2000, 178,000 INDIVIDUALS LIVE IN THE COUNTY. THE OLDER ADULT POPULATION IS THE FASTEST GROWING SEGMENT OF THE WORLD, ALL OVER THE WORLD. LAST YEAR ACCORDING TO FIGURES FROM THE COUNTY, 1,323 OLDER ADULTS RECEIVED ANY KIND OF OUTPATIENT SERVICES.

THAT IS POINT SEVEN PERCENT OF THE POPULATION RECEIVED SERVICES.

THE REVISED PLAN STATES THAT 200 MORE OLDER ADULTS WILL RECEIVE SERVICES. THAT WILL BRING THE PERCENTAGE TO POINT EIGHT PERCENT. THIS FIGURE IS THE DEFINITION OF AN UNSERVED POPULATION.

STATEMENTS HAVE BEEN MADE AT THE STEERING COMMITTEE, AND I THINK IT'S EMBEDDED IN THE PLAN, THAT MEMBERS OF THE OLDER ADULT POPULATION ARE SIMPLY AN EXTENSION OF SERVICES TO ADULTS. FOR ONLY A LUCKY FEW IS THIS TRUE.

FOR A MAJORITY OF OLDER ADULTS SERVICES ARE SIGNIFICANTLY COMPLICATED BY MEDICAL, ENVIRONMENTAL, AND SOCIETAL ISSUES. THIS VIEW OF SANENESS IS INSTITUTIONALIZED -- I HAVE A COMMENT TO MAKE -- IN THE VOTING ON THE STEERING COMMITTEE IN JULY, PROPOSALS WERE CONSIDERED FROM TWO BUCKETS OF MONEY. FULL SERVICE AND SYSTEM DEVELOPMENT. IN THE DEVELOPMENT OF THE PLAN, ONE OF THE -- SORRY. LOST MY PLACE -- ONE OF THE PLANS MIGRATED. RIGHT NOW ON THE PLAN THERE ARE FOUR PROPOSALS FROM THE ORIGINAL -- FROM FULL SERVICE PARTNERSHIPS AND ONLY TWO FROM SYSTEM DEVELOPMENT. I QUESTION THE MIGRATION OF THE PLAN FROM ONE FUNDING STREAM TO ANOTHER.

WE HAVE BEEN ASKED NOT TO SPEAK ABOUT THE PROCESS. I FEEL THAT IF WE DON'T LEARN THE LESSONS FROM THIS ENGAGEMENT, WE WILL BE LEFT WITH DESPAIR OF SERVING AN INVISIBLE CONSTITUENCY AND LOOKS LIKE THEY ARE GOING TO REMAIN INVISIBLE AT POINT EIGHT PERCENT. THANK YOU. (APPLAUSE).

>>AUDIENCE MEMBER: HI. MY NAME IS HENRY KAHN. I'M A COMMUNITY PSYCHIATRIST AND I WAS ON THE STEERING COMMITTEE.

JUST A COUPLE OF THOUGHTS THAT I HAD ABOUT THIS. FIRST OF ALL, I THINK IT WAS A VERY HARD PROCESS BEING ON THE STEERING COMMITTEE. IT WAS A VERY HUMBLING EXPERIENCE FOR ME TO TRY TO THINK ABOUT COMING INTO THE PROCESS THINKING THAT I COULD CHANGE THE COUNTY. AND THEN COMING OUT OF THE PROCESS REALIZING THAT, YOU KNOW, WHAT HAVE I CHANGED? WHAT HAVE WE CHANGED?

$8 MILLION IS LESS THAN 10% OF THE ENTIRE COUNTY BUDGET. IT'S NOT ENOUGH. WHERE IS THE TRANSFORMATION? I'VE BEEN THINKING A LOT ABOUT WHAT TRANSFORMATION MEANS. AND TRANSFORMATION DOESN'T MEAN DIVIDING UP THE SMALL POT. IT MEANS SOMETHING ELSE. AND I'VE BEEN TRYING TO FIGURE OUT WHAT THAT MEANS. I'M BEEN HUMBLED BY THE PROCESS AND THE EXPERIENCE. THE STRENGTH OF COMMUNITIES SUCH AS THE CONSUMER COMMUNITY WHO HAVE BEEN VERY, VERY OUTSPOKEN AND THE API COMMUNITY WHO HAVE BEEN ORGANIZED BY THIS AND HUMBLED BY THAT.

WHAT IS TRANSFORMATION? IT IS HOPE. WE SAW 168 HOPEFUL CONCEPTS HERE. AND I HOPE THAT WE RESPECT THAT AND SOMEHOW ALONG THE WAY INCORPORATE THAT.

I HAVE BEEN TROUBLED AS WELL. I'VE BEEN TROUBLED AND I'VE HAD SOME DESPAIR AROUND THIS. I'VE BEEN TROUBLED THAT MANY OF OUR COMMUNITIES HAVE REMAINED INVISIBLE IN THIS PUBLIC FORUM; THE LATINO COMMUNITY, AFRICA AMERICAN COMMUNITY, THE PHYSICALLY IMPAIRED COMMUNITY. THERE ARE MANY COMMUNITIES OUT THERE THAT ARE INVISIBLE TO ME AS WELL. I HOPE AS WE CONTINUE THIS PROCESS, WE FIND A NEW PROCESS TO INCORPORATE PEOPLE TO OUTREACH TO THOSE COMMUNITIES THAT HAVE REMAINED INVISIBLE.

WHAT IS TRANSFORMATION? TRANSFORMATION IS WHAT'S AROUND US RIGHT NOW. IT'S THE RELATIONSHIP THAT WE ARE BUILDING. THAT'S WHAT I FOUND.

AFTER THE STEERING COMMITTEE MEETINGS I MET WITH MEG STANTON WHO IS FROM THE CONSUMER SELF-HELP AND SHE TAUGHT ME A LOT. I BROUGHT MY MEDICAL STUDENTS TO HER ORGANIZATION AND I THINK THAT THERE WAS A LITTLE BIT OF TRANSFORMATION THERE.

WE ARE ALL PUBLIC. AND I THINK THAT THIS IS JUST ONE PART OF THE PROCESS. WE NEED TO THINK ABOUT THIS LONGITUDINALLY. WE NEED TO THINK ABOUT THIS ONGOING BASIS. TRANSFORMATION DOESN'T HAPPEN IN ONE PHASE. IT'S A LIFELONG ENDEAVOR. (APPLAUSE).

Attachment C

Comments on Refugee-Survivor Issues

>>AUDIENCE MEMBER: MY NAME IS MARIE WAN. I'M WITH AN AGENCY CALLED OPENING DOORS. WE ARE RESPONSIBLE FOR THE 200 REFUGEES THAT COME INTO THE COUNTY EACH YEAR. YOU ARE FACING A DAUNTING TASK AND I REALLY APPRECIATE WHAT YOU ARE DOING.

I DO WANT TO SPEAK ON BEHALF OF THE REFUGEES WHO ARE NOT API. WE HAVE PEOPLE FROM EASTERN EUROPE. WE HAVE MANY PEOPLE. THE LARGEST REFUGEE COUNTY IS FROM THE FORMER SOVIET UNION. WE HAVE AFGHAN REFUGEES. LIBERIAN REFUGEES. EAST AFRICAN REFUGEES. THESE ALL FACE THE SAME PROBLEM ACCESSING MENTAL HEALTH SERVICES. THEY ARE SUFFERING FROM POST DRAMATIC STRESS DISORDER. THE FAMILY BREAKDOWN AND EVERYTHING THAT GOES WITH. THIS IS COMPLICATED BECAUSE THEY ARE TRYING TO ADJUST TO A NEW AND VERY STRANGE CULTURE WHICH IS VERY UNLIKE WHAT THEIR HOME CULTURES ARE LIKE. AND TRYING TO SEPARATE WHAT IS A CULTURE OR A REFUGEE EXPERIENCE SOMETIMES GETS TO BE A PROBLEMATIC ISSUE.

WE FEEL THAT LAW ENFORCEMENT HAS MANY SOURCES OF INCOME BESIDES THE PROP 63 MONEY. THERE ARE SO MANY OTHER PEOPLE WHO BADLY NEED THE HELP.

TO SUMMARIZE, I THINK YOU NEED TO CONSIDER THE NEEDS OF THESE POPULATIONS. THANK YOU VERY MUCH. (APPLAUSE).

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Survivors International's Position Paper on
Survivors of Torture in Northern California and the Mental Health Services Act

October 27, 2005

Dear Sir/Madam:

Survivors of torture, legal residents of Northern California, are currently unrepresented, severely marginalized and in desperate need of your help. On behalf of survivors of politically motivated torture in your county, I am asking you to specifically recognize survivors of torture as stakeholders[1] in your county's Mental Health Services Act (MHSA) planning process in which Proposition 63 funds are distributed to marginalized and underrepresented people suffering from mental illness. Without your help, survivors of torture will continue to be excluded from the MHSA process.

The MHSA process has failed our clients because of unique challenges with which Survivors International (SI) is faced. We serve clients from over 16 different counties. As a result, and as a consequence of SI's extremely limited resources, we were able to concentrate on only one of these 16 counties. Each county has numerous meetings to attend (large group meetings, small group meetings, task force meetings, etc); attending them all is a full time job and takes necessary time away from providing essential, direct services to our clients. Secondly, even with the attendance at these meetings, it was difficult to be recognized and heard by the MHSA officials. For example, even when a Survivors International representative attended a meeting, oftentimes she was refused the opportunity to speak.

This position paper was created to convince those in charge of each county's MHSA implementation why survivors of torture deserve to be recognized as legitimate stakeholders in the MHSA process. This paper is comprised of five sections:

We welcome the opportunity to talk with you further about this and to answer any questions you may have. Thank you in advance for your time and consideration.

Sincerely,

Uwe Jacobs, Ph.D.
Executive Director, SI

[1] In Santa Clara and San Diego counties Survivors of Torture have been recognized specifically as stakeholders in the MHSA process under the sub-section of "underserved ethnic populations."

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A. Survivors of Torture: An Overview of the Community

Survivors of torture (Survivors) are comprised of legal immigrants, refugees, and political asylum seekers usually suffering from Posttraumatic Stress Disorder (PTSD) and Major Depressive Disorder who rarely – if ever – receive the mental health treatment they need. Congress estimates there are 400,000 torture survivors in the United States alone (Federal Register, 2004). California itself is estimated to have 80,000 Survivors – of which 20,000 (approximately) live in the Bay Area. However, the vast majority of Survivors accounted for in these figures found our services without any targeted outreach programs; therefore, these numbers only scratch the surface of those living in the shadow of torture.

The most powerful way to demonstrate the need to provide torture survivors with mental health services and MHSA Funding – and specifically why Survivors deserve to be recognized as legitimate stakeholders in the MHSA process – is illustrated through the case of RN, one of our clients.

> RN is a 24-year old man from a central African country[2]. Mr. N's father worked within a previous government of the Republic, which was overthrown by a coup in 2003. Following the coup, Mr. N's father disappeared, and Mr. N was imprisoned by supporters of the new regime. Mr. N was kept naked and alone in a dark cell for two weeks, then transferred to a larger cell, where he was forced to drink the guards' urine and clean their feces with his hands. Mr. N was only taken from his cell to be forced to watch executions and torture of others, including beheadings with knives. In certain cases, Mr. N was made to wrap the bodies of the dead and throw them into the nearby river. After two and a half months, Mr. N escaped, naked and alone, thanks to the aid of a guard; eventually, he fled to the United States, leaving behind his mother and sister. Mr. N suffers severe Posttraumatic Stress Disorder and Major Depressive Disorder, with such symptoms as insomnia, avoidance of stimuli, hyperarousal, and dissociative flashbacks.
>
> Mr. N was referred to SI through the Lawyers Committee for Civil Rights. He received a medical and psychological evaluation by SI clinicians to support his asylum claim. Mr. N's experiences left him so severely traumatized that he collapsed while discussing them at SI and became immobile and mute during sessions. He has been seeing a French-speaking psychotherapist on a regular basis at the SI office. The SI Case Manager linked Mr. N to food services, as well as extensive English tutoring, to help him cope with his situation of poverty. The psychotherapist and the SI-trained medical doctor are in regular consultation about Mr. N's care. He improved considerably, began to attend city college and will be going to a university next year. Mr. N was recently granted asylum and also, through SI's connections to the Red Cross, found his mother and sister. After about one year of treatment, Mr. N's therapist could no longer see him for reasons unrelated to his case but he felt well enough to cope on his own.
>
> Over the entire course of Mr. N's treatment the county mental health system never became involved.

As a result of the legal limbo in which non-citizens such as Mr. N find themselves (ie they are legal asylum applicants, green card holders, etc and are waiting to obtain their full citizenship status) many Survivors are ineligible for most government funded health care programs and public benefits. Survivors are usually without the resources to obtain the necessary psychological help for themselves that would allow them to become successful and productive members of society.

Over the past fifteen years, SI has treated 1800 torture survivors from over 93 countries from around the world. The majority of Survivors live in San Francisco and Alameda County; however, a significant number come from 14 other counties including Contra Costa County, San Mateo County, Sonoma County and Sacramento County. The county refugee coordinators for San Francisco County and Alameda County estimate that there are roughly 15,000 refugees in San Francisco, and 50,000 refugees in Alameda. This figure does not account for asylum seekers. According to the U.S. Citizenship and Immigration Services, in 2003 *alone*, 5,343 applications for political asylum were filed with the San Francisco Asylum Office.[3] Asylum seekers are very often survivors of torture and/or have experienced gender-based persecution but the number of torture claims has not been disclosed. Survivors International has asked for more precise information about the type of claims filed through a Freedom of Information Act request, so that the percentage of torture claims in asylum petitions may be determined.

[2] Identifying information has been changed on all cases.

[3] Dept. of Homeland Security, "Fiscal Year 2003 Yearbook of Immigration Statistics." Table 19, "Asylum cases filed with USCIS Asylum officers by asylum off and state of residence".

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The majority of torture survivors suffer from significant psychological consequences that require treatment, with Posttraumatic Stress Disorder being the most common problem[4]. At present capacity, SI cannot accommodate all requests for assistance. Moreover, innovative mental health interventions that aspire to be cross-culturally sensitive and effective require significant funding. SI has been able to pioneer such approaches to the degree that specially designated funding was available. There is a significant gap in services for torture survivors not only in terms of general access to mental health services but specifically access to the most appropriate culturally sensitive intervention.

The currently existing gap in services, once it is recognized at the state and county level, also presents an opportunity to shape new and effective programs and provide more support to more torture survivors through the Mental Health Services Act planning process. SI staff is hoping to provide their knowledge and experience and join forces with counties in Northern California to close this gap, so that torture survivors may no longer be an underserved population.

[4] Paker et al. (1992) found in a large study of prisoners that 39% of those who had been tortured suffered from PTSD, whereas none of those prisoners did who had not suffered torture. In addition, most torture survivors seen at SI suffer from significant mood disorders and/or other disorders.

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B. Survivors International: Mission, History, Approach

Mission Statement - Survivors International is a 501(c)3 organization based in San Francisco that provides mental health services, medical treatment and other social services to survivors of torture living in the Bay Area and other parts of Northern California. We are a multiple disciplinary network of professionals and volunteers from the fields of psychology, medicine, law, public health and human rights dedicated to helping those who have been affected by torture. The goal of SI is to help Survivors to build healthy and productive lives after suffering the trauma of torture. (For additional information please refer to our website: www.survivorsintl.org.)

History – SI is one of the oldest and most experienced torture rehabilitation programs in the United States. Its staff and board members have contributed to setting the standards for providing treatment and evaluation services for over 15 years, both nationally and internationally. However, we have currently received massive funding cuts from the Bush administration and now receive no federal funding. This is why the MHSA is essential to the well being of our clients; without its support, we will not be able to provide mental health services at minimal cost or for free.

Over the past 15 years, SI has provided essential psychological services over 1800 survivors of torture from 93 countries at minimal or no cost. The vast majority of our clients are asylees, asylum applicants, green card holders, and those who obtained legal refugee status before arriving in the US. They are sizable, limited and clearly enumerated population who the MHSA was designed to benefit. Beginning in 2004, we are also serving international survivors of gender-based persecution, including severe domestic violence, female genital cutting, and persecution on account of gender and sexual orientation. In providing services to Survivors, SI relies heavily on a network of dedicated professionals who provide their services for significantly reduced fees or pro bono. SI staff and board members have developed internationally recognized expertise in the field of torture rehabilitation and have contributed to the development of professional standards of care, the academic literature and the training of health professionals.

General Approach – At all levels, including Board, staff and provider network, SI follows a multidisciplinary approach to torture rehabilitation. SI believes that all torture survivors should have proper access to medical, psychological, case management and community-based intervention. Every Survivor is seen by an experienced team that includes a physician, a psychologist and a case manager. This professional team performs an individualized needs assessment and coordinates and follows care through consultation and liaison with affiliated care providers. Support groups and alternative healing methods, such as movement and relaxation-oriented groups, acupuncture and bodywork, are also made available to clients.

Community Projects - Apart from individualized and professional care, SI has been engaged in a number of projects working with region-specific groups of torture survivors living in the Bay Area. For example, working with Iraqi refugees, SI originally developed and housed the Iraqi Community Association, which is now a fully independent community organization. SI also organized many community events in partnership with Bosnian refugees and served dozens of Bosnian Survivors in groups and on an individual basis. Two groups of Cambodian female torture survivors have been held regularly over several years. SI is currently involved in developing a similar initiative with recently resettled torture survivors from West Africa, using close ties with African community leaders, partnership with Refugee Transitions and the expertise of two psychologists who have extensive experience of working with torture survivors in West Africa.

Cultural Competence - Many SI staff and clinicians have relevant cultural and linguistic expertise, including fluency in Spanish, French, and Arabic as well as having worked with torture survivors overseas. More often than not, clients can be matched with clinicians who are fluent in their primary language. In cases where this is not possible, SI relies on trained interpreters and bicultural community health workers.

Collaboration and Referral – To increase its effectiveness and impact, SI works closely with other groups and organizations that serve torture survivors. For the many SI clients with immigration concerns, SI utilizes a network of partner agencies and lawyers with whom we have long-standing ties. We also refer our clients for primary medical care

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to specially trained physicians working in the community. One such doctor has personally cared for more than one hundred of our clients and stays in constant contact with the SI Medical Director. Our community partner agencies include the East Bay Sanctuary Covenant, Refugee Transitions, the Lawyers Committee for Civil Rights, the International Rescue Committee, the Liberian Community Foundation, Upwardly Global, the Newcomers Program, and others.

Program Evaluation and Accountability – SI has implemented outcome, satisfaction and quality assurance measures to ensure that all clients receive necessary services. SI includes clients in the design and delivery of care and continually redesigns our programs based on feedback we regularly seek out from those we serve.

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C. The Importance of Receiving MHSA Funding

The Mental Health Services Act provides an invaluable opportunity to overcome barriers preventing the delivery of critical mental health services to a large and poorly served community in profound need: survivors of torture. Survivors of torture face unique and serious mental health problems and consequently require specialized, culturally competent treatment programs. Shame, fear and alienation make most survivors of torture shy away from seeking help. Lacking access to the mental health services they desperately need, survivors of torture suffer in silence, less capable of fully integrating into the larger community and building fully productive lives here in the U.S.

When Survivors International (SI) was founded in 1986, the organization represented a rare and innovative resource for survivors of torture living in the Northern California. In the entire United States, only Minnesota and Los Angeles had centers dedicated to serving the mental health needs of survivors of torture. These services have largely been provided through dedicated volunteer clinicians, with funding from international and foundation sources. Last year, all of our federal funding was eliminated. To date, we have received only indirect and minimal support from city and county mental health agencies within the communities in which we work.

Among the refugee and the mental health communities, SI has earned a reputation of being a specialist in the treatment of survivors of torture. As such, we serve not only as a resource for our clients, but for other agencies and hospitals, which often refer to us those whom they are finding too difficult to treat. Treating survivors poses an array of special challenges – clinical, cultural and linguistic. Survivors come from all over the world and speak many different languages. Their customs and religious beliefs vary widely. To be effective, SI must recruit and train culturally competent clinicians expert in treating this particularly severe form of trauma. We also must work comfortably with interpreters who also function as cultural informant. Further, to effectively treat survivors of torture, clinicians must understand the political context of the survivor's life as well as be able to interface with the distinct religious, cultural and social support opportunities within a specific community.

Cases to illustrate the problem

Case 1

For ten years, Ali was tortured by Saddam Hussein's regime, shackled to a wall in a dark, windowless dungeon. In addition to his own extreme suffering, he was forced to watch as other men were tortured and killed beside him. While Ali managed to survive, he suffered from extensive brain damage caused by the torture and was never the same again. Ali sought refuge in San Francisco. Here he lived in constant fear, wandering the streets and relying on the charity of Middle Eastern store owners for food. He had no home and slept in the cramped closet of a friend's apartment. He was brought to SI by a community elder who had been exposed to SI through SI's work to develop the Iraqi Community Association. An average SI client receives one or two hours of care a week. Ali was so damaged, however, that an SI social work intern spent 10-12 hours a week exclusively working on his case. In addition, SI provided Ali with psychological and psychiatric treatment on a weekly basis. SI's care of Ali went well beyond psychotherapy. Unemployed, homeless, and unable to care for himself in the most basic of ways, Ali had nevertheless twice been rejected for Social Security Insurance. Stunned, SI's director advocated directly in seeking SSI benefits for Ali and managed, after several months, to get Ali benefits. During the two years that he was cared for by SI staff and volunteers, the county mental health system never became involved.

Case 2

FA is a 64-year-old Sudanese woman, whose father is of the Dar Fur ethnic group and mother of the Nuba Mountain ethnic group, and has one daughter. Working in the medical field in Sudan, Ms. A participated in campaigns against female genital cutting and for better medical care, and later in campaigns against government massacres in the Nuba Mountain and Dar Fur. Within this context, Ms. A was imprisoned in over eleven instances, where she was subjected to whipping, sleep deprivation, solitary confinement, minimal food, and degradation. These left scars along her back and leg, and have resulted in headaches, palpitations, increased arousal, re-experiencing, avoidance, and numerous other symptoms indicative of PTSD.

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Ms. A came to SI through East Bay Sanctuary Covenant, who has been representing the client in her asylum claim. SI provided a medical evaluation which detailed both the medical and psychological sequelae of her torture. Ms. A was soon after granted "Recommended Approval" by the Bureau of Citizenship and Immigration Services (BCIS) and is only pending the processing of her standard background clearance to receive asylum. In the meantime, the SI Case Manager has advocated on behalf of Ms. A with the Oakland Public Housing Authority to help the client obtain shelter and has also connected Ms. A to long-term medical care at Highland Hospital Human Rights Clinic and to emergency food services. Ms. A's daughter has expressed repeated gratitude on behalf of her mother and has even offered her services as a volunteer Arabic interpreter for SI.

Case 3

CM is a 25 year-old lesbian from Romania. She had kept her sexual orientation a secret from her family and friends and did not engage in romantic relationships until she confided in a co-worker, who then told her boyfriend, a member of the local police. This policeman tried to coerce Ms. M into having sex with him through threats, but she refused. In retaliation, he and his police friends arrested her from her parental home and told the parents she was a lesbian and that they were taking her for questioning. The police detained her for a day and night and took turns raping her and beating her severely. Ms. M was released after her father paid them a bribe. However, the persecution did not stop, and eventually her father arranged for her escape and she came to the US.

Ms. M was initially denied political asylum by an asylum officer and referred to immigration court. Her attorney referred her to SI because she was despondent and depressed and required treatment as well as supportive documentation. Upon intake, she presented as severely traumatized. However, she made a strong connection with the SI Director, who met with her weekly for psychotherapy sessions and provided a report for the immigration judge. She was then granted asylum. Throughout therapy sessions, Ms. M wept frequently and discussed not only the impact of the rape and beatings but also of the shock of having been disowned by her parents because of her sexual orientation. While her father was at least willing to keep quiet and plan and finance her escape to the US, her mother continues to refuse to speak to her and hangs up on her when she phones home. However, Ms. M was able to make excellent use of therapy and improved very steadily in her symptoms, even prior to getting political asylum. She also worked closely with the case manager. She involved herself in new friendships and a romantic relationship and quickly found employment after she got her work permit. She was no longer able to come to sessions after she found a job but stayed in touch, reporting that she was doing much better and feeling much happier.

Case 4

Ms. S is a 44 year-old woman from the Philippines who was referred to SI by an attorney who was assisting in her application for political asylum. As a teenager, in the Philippines, she was forcefully abducted from the safety of her family home by members of the armed wing of a political party. She was taken to an unknown destination in the woods. Here, she was extensively physically tortured and repeatedly raped by multiple members of this organization. She was detained and tortured over a period of weeks but her detention was preceded and followed by persistent threats to her and her family. Although it has been years since this event, Ms. S continues to experience considerable psychological symptoms. Her tremendous feelings of shame, anxiety, and depression required a careful assessment which was conducted over several sessions. A report was then provided to her referring attorney. She continues to meet regularly for therapy with the same clinician where she has examined issues of diminished trust and interpersonal isolation. Ms. S. now states that she was "like a stone" for many years, preferring the perception of safety related to not allowing herself to become close with anyone, but feeling more and more lonely and estranged all the time. When Ms. S first arrived at SI, she preferred to sit near the door and on the edge of the couch, guarded, anxious and prepared to leave at a moment's notice. She now allows herself to sit back a little further and even allows a smile to escape from time to time.

Case 5

CF is a 27-year old man from El Salvador. When Mr. F was seven, war broke out and his village was attacked by soldiers. After watching villagers murdered in front of his eyes, he was rounded up and detained in a cell with others and moved from one army garrison/detention center to another over the next three years. He was constantly raped and physically abused by the soldiers. Finally, an evangelical pastor arranged for Mr. F's release into his care, where the situation remained dire. Mr. F was beaten on a daily basis by the pastor and his wife, placed in dark isolation for periods of up to two weeks, and sexually abused by the pastor's son. After three years, Mr. F managed to escape and lived on the

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streets until he was fifteen, when he went in search of his family. At 17, he was finally reunited with his family but was unable to stay with them due to his sexual orientation and condition. Shortly thereafter, he was forcibly recruited by the guerillas, with whom he served for several years. After the war ended, Mr. F was denied any war benefits by the new government – land, compensation, etc – on the basis of his homosexuality. His life had deteriorated to the point where he worked the streets a as a prostitute, where he was subjected to constant extortion and beating by cops. He moved through Guatemala, and Mexico to the United States, where he now lives with his sister.

Shortly before coming to SI, Mr. F discovered he was HIV + and turned for legal help to Lawyer's Committee for Civil Rights, who referred the client to our services. Psychological evaluation by SI's clinician revealed severe PTSD and depression, and a history of several suicide attempts and drug and alcohol abuse. Following the evaluation and medical examination, Mr. F was granted asylum. SI linked him to one-on-one English tutoring through Refugee Transitions, low-cost dental care, as well as a San Francisco-based project serving people from Latin America living with HIV/AIDS, that provides him a network of community support and access to consistent medical care.

Case 6

RQ is a 40 year old Guatemalan woman who escaped to the United States after suffering and witnessing torture perpetrated by soldiers of the Guatemalan army. Her husband was shot in the head and killed. Ms. Q states that her world ended that day. Since her teenage years, Ms. Q witnessed killings and often came across corpses left hanging by the roadside or floating down rivers. Her best friend was shot by the army and died, bleeding, in her arms. When Ms. Q came to SI at the referral of her lawyer, she related years of somatic and psychological symptoms that she did not relate to her torture experiences. She had frequent nightmares that disrupted her sleep, as well as headache, chest pain, and palpitations.

With Ms. Q's permission, the SI Medical Director communicated Ms. Q's torture history to Ms. Q's primary care physician, as Ms. Q felt uncomfortable and embarrassed to reveal this herself. She educated Ms. Q's physician about the physical and psychological consequences of torture and communicated medication recommendations. A SI Staff Psychologist conducted a forensic psychological evaluation that will be used by Ms. Q's attorney to help her gain asylum in the United States. Since coming to SI, Ms. Q reports a marked improvement in her physical and psychological symptoms. She attributes this improvement to the opportunity she has been given to safely reveal and provide a language for the painful events of her past.

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D. Application of MHSA Reserve Funds to Create Regional Torture Treatment Centers

SI produces successful outcomes because our staff possesses the knowledge, skill and unique program model to effectively treat the severe consequences of torture. As mentioned on page four, SI is one of the oldest and most experienced torture rehabilitation programs in the United States and has set the standards for providing treatment and evaluation services for over 15 years, both nationally and internationally. SI follows a multidisciplinary approach to torture rehabilitation and has developed a unique treatment model that incorporates medical, psychological, case management and community-based intervention services. Along these lines, many SI staff and clinicians have relevant cultural and linguistic expertise. SI has implemented outcome, satisfaction and quality assurance measures to ensure that all clients receive necessary services. SI includes clients in the design and delivery of care and continually redesigns our programs based on feedback we regularly seek out from those we serve. (Please see page four for additional information.)

SI is in an excellent position to become one of the regional torture treatment centers that provides services to torture survivors residing in the Northern California region. Alameda, San Francisco and other Northern California counties could set aside funding to serve Survivors residing in these various counties. Services will also be offered to survivors of torture who come from other counties on a fee-for-service basis by the regional centers.

The goals of the regional torture treatment centers are the same as those espoused by the MHSA. Once established, the regional centers would lead to educational, employment and community activities, as well as promoting the supportive relationships between providers and the communities they serve. In addition, the creation of regional centers would lead to the reduction in homelessness and would provide access to emergency crisis services.

E. Request for Mental Health Services and MHSA Funding for Survivors of Torture
On behalf of torture survivors living in your county and in Northern California, we ask you to:

(1) identify survivors of torture as legitimate stakeholders in the MHSA process who have unique mental health needs that need to be addressed by specialized torture treatment centers;

(2) recognize that programs designed to treat survivors of torture share the same goals as the MHSA;

(3) support MHSA proposals from torture treatment centers such as Survivors International;

(4) establish Survivors International as one of the regional torture treatment centers in Northern California.

While untreated, survivors of torture struggle with the debilitating mental and emotional consequences of experiencing extreme trauma; however, with appropriate mental health services, they become some of the most industrious and inspirational members of society. Most Survivors are the leaders of the countries in which they were tortured and were targeted primarily because of their exceptional abilities. They have diverse backgrounds and professions: many are engineers, doctors, lawyers and human rights advocates. With the appropriate mental health services, Survivors are able to reclaim their former selves and become extremely productive members of society.

Please recognize survivors of torture as legitimate stakeholders in your county's Mental Health Services Act planning process. Thank you again for your time and consideration.

Attachment C

Comments on Training

>>AUDIENCE MEMBER: MY NAME IS BOBBY, AND I WASN'T EXPECTING TO SPEAK TONIGHT AND I'M NOT GOOD AT IT. I'M THE PERSON THAT'S IN THE BACK OF THE COP CAR ALL THE TIME.

I WAS -- I HAVE BEEN THERE AT LEAST THREE TIMES OVER THE PAST MONTH. I HAD A REAL BAD MONTH.

AND I'VE ALSO -- I'M FROM SANTA CLARA COUNTY WHERE THE POLICE OFFICERS ARE JUST -- THEY ARE VERY GOOD. THEY ARE VERY RESPECTFUL. THEY TREAT EVERYBODY WITH RESPECT. AND THEY DEFUSE SITUATIONS. AND I WOULD LOVE TO SEE THE SAME THING HAPPENING THERE. THE FACT THAT THEY ARE ADMITTING THERE IS A PROBLEM IS IMPRESSIVE TO ME. I KNOW THE DIFFERENCE BETWEEN BEING PICKED UP BY AN OFFICER WHO IS GOING TO MAKE FUN OF ME. TREAT ME LIKE -- JUST BECAUSE I DON'T HAVE A BRAIN AT THE MOMENT, DOESN'T MEAN I'M NOT GOING TO GET IT BACK AND REMEMBER.

THEY DON'T REALIZE THAT THEY ARE SCHOOLYARD BULLIES. AND THERE ARE THE FEW THAT ARE OUT THERE THAT ARE HELPFUL, LET THEM GET EXTRA TRAINING. I APPLAUD THEM FOR HAVING THE INTEREST IN US, IN HELPING US, YOU KNOW, AT THE BEGINNING. BECAUSE I FEEL IT'S NEEDED BECAUSE I'M ALWAYS IN THE BACK OF THE COP CAR. THAT'S ALL.

>>AUDIENCE MEMBER: MY NAME IS JOYCE. I'M A MOTHER OF THREE MENTALLY ILL SONS. THE FIRST WAS DIAGNOSED 17 YEARS AGO IN THE MILITARY WITH SCHIZOPHRENIA BIPOLAR AND INSULIN DEPENDENT AND BRINGS ON DIABETES. HIS BROTHER HAS SCHIZOPHRENIA AND THE YOUNGEST SON IS PROBABLY BORDERLINE; I CANNOT EVEN GET HIM DIAGNOSED.

THEY HAVE ALL BEEN IN BOARD AND CARE. THE TWO THAT HAVE DEFINITELY BEEN DIAGNOSED. ONE BY THE VETERAN'S ADMINISTRATION AND THE SACRAMENTO COUNTY MAIN JAIL 15 YEARS AGO. THEY HAVE BEEN TAKEN TO MEDICAL DOCTORS BEFORE THAT DIAGNOSIS. THE MEDICAL DOCTORS TOLD ME THAT THEY WERE ON DRUGS. AND I WAS -- IT WAS HOPELESS FOR ME. IT WAS A HORRIBLE THING UNTIL THEY WERE FINALLY DIAGNOSED.

THEY HAVE BEEN IN BOARD AND CARE AND HAVE LEFT BOARD AND CARES. THEY HAVE HAD ROOMMATES AND IT HASN'T WORKED OUT. THEY ARE HOME NOW. AND THEY HAVE BEEN FOR SEVEN OR EIGHT YEARS OFF AND ON. AND I HAVE HAD THE POLICE AT MY HOUSE OFTEN, VERY OFTEN.

THEY WERE CALLED IN THE BEGINNING SO OFTEN THAT I RECEIVED A LETTER SAYING THAT I WAS GOING TO BE BILLED FOR THEIR SERVICES IF THE PROBLEM DIDN'T STOP.

THEN THERE WAS A TASK FORCE SENT TO MY HOUSE SAYING -- THE TASK FORCE WAS TO STOP THE CALLS TO THE POLICE DEPARTMENT FROM MY HOUSE.

THAT DIDN'T WORK.

THEN I NOTICED THAT DURING SOME OF THESE CALLS THAT MORE AND MORE OFFICERS WERE COMING TO MY HOUSE, MORE THAN NECESSARY. AND I THOUGHT THIS WAS A CURIOSITY. AND THEN I FOUND OUT THEY WERE LISTENING AND LEARNING. AND WHEN THERE WAS A CALL AND THIS SON HAS BEEN DIAGNOSED FOR 17 YEARS WITH SCHIZOPHRENIA BIPOLAR AND HE'S AN INSULIN DEPENDENT DIABETIC. IT COMPLICATES THE WHOLE SITUATION. THEN I WOULD STAND BACK AND I WAS QUIET AND MY SON WOULD TAKE OVER AND DIFFERENT OFFICERS WOULD GIVE INPUT. AN OFFICER MAY STEP UP AND SAY, THIS IS ONE WAY YOU CAN HANDLE IT AND THIS IS ANOTHER WAY. THIS WENT ON FOR MANY MONTHS. AND I WAS SO EMBARRASSED TO SEE MY NEIGHBORS SEE THE COP CARS DOWN THE STREET AND THEY WERE AT MY HOUSE.

AFTER A PERIOD OF TIME, YOU FINALLY GET DESENSITIZED TO THAT AND GET INTO WHAT'S NECESSARY. THEY WERE LEARNING ABOUT MENTALLY ILL PEOPLE. AND I DON'T KNOW WHO -- WHOSE IDEA IT WAS FINALLY TO DECIDE, BUT I SURE APPRECIATE THE ROCKYHAM POLICE FORCE.

ONE MORE THING I NEED TO SAY, WHEN POLICE OFFICERS WERE SENT TO MY OFFICE, THEY HAD NOT HAD EXPERIENCE THERE AND WE HAD PROBLEMS. I LOST MY JOB.

>>AUDIENCE MEMBER: I'D LIKE TO SAY SOMETHING. YES. I WAS IN THE MILITARY FOR TWO YEARS AND I GRADUATED SECOND HIGHEST IN MY CLASS. I GOT AN HONORABLE DISCHARGE. THAT'S MY MOM THAT JUST SPOKE.

POLICE OFFICERS WOULD COME TO MY HOUSE. THEY WOULD NOT TALK ABOUT THE ISSUE. THEY WOULD PUT ME IN HANDCUFFS. THROW ME TO THE GROUND. BUT THEY DIDN'T WANT TO BE PATIENT WITH ME. GOD IS ALL ABOUT PATIENCE. YOU DON'T HAVE TO JUST GRAB SOMEBODY, THROW THEM IN THE BACK OF THE CAR, AND THEN JUST TAKE THEM TO JAIL OR TAKE THEM TO A MENTAL HEALTH CLINIC. ALL THEY HAVE TO DO IS TALK TO ME. THEY SEEMED LIKE THEY WANT TO, YOU KNOW.

WOMEN, THEY WILL LISTEN TO FIRST. I'M NOT AGAINST WOMEN, BUT IF A WOMAN IS UNDER 18, GUESS WHAT, AND SHE HAS SEX WITH A MAN UNDER 18, THEY ARE BOTH RESPONSIBLE FOR STATUTORY RAPE NOT JUST THE MAN. WOMEN DO THINGS IN THEIR HEADS ALSO TO TRY AND SCREW A MAN OVER.

BUT THERE ARE POLICE OFFICERS THAT DON'T TALK TO YOU, WILL BELIEVE ONE STORY OVER ANOTHER, AND THEY WILL LIE ABOUT IT. THAT'S ALL I GOT TO SAY. THEY THINK THEY ARE IN CHARGE OF EVERYTHING. WE HAVE THE SAME RIGHTS AS THE POLICE OFFICERS DO.

Attachment C

Comments on
Transcultural Wellness Center

"I am here to speak in support of the Transcultural Wellness Center. My name is Naomi Fualau, and I am a member of the Indigenous Pacific Islander Council, an organization of Polynesian community members networking together to address the needs and concerns of our Polynesian community.

The development of a Transcultural Wellness Center will provide much needed culturally sensitive care for the Asian and Pacific Islander communities. Our cultures are such that domestic violence, and abusive treatments of some types are accepted as the norm. What is also the norm is you are expected to suffer from this abuse quietly and honorably and in isolation because to talk about it will bring shame and dishonor to the family. Family value and honor come before all else, and silence is the golden rule. Beyond the silence is the language barrier - knowing just enough of the language to get by, yet unable to understand and express clearly just what needs to be said and understood. To continue to ignore the need of a culturally sensitive wellness center is to continue providing services of a one-size fits all type that is currently in place.

The vision of the Transcultural Wellness Center is to provide care and healing that is culturally appropriate and accepted to the Asian and Pacific Islander community. This is done with the development of a Transcultural Wellness Center, staffing the center with culturally trained or Asian and Pacific Islander professionals, and providing educational opportunities and incentive programs to promote career professionals in the Asian and Pacific Islander communities. Please support the Transcultural Wellness Center.

Thank you.

STATEMENT IN SUPPORT OF TRANSCULTURAL WELLNESS CENTER

I speak here today as a prosecutor, having prosecuted domestic violence and homicide cases; former Board President of My Sister's House (the first domestic violence shelter here in the Sacramento region which provides culturally competent services to API women and children), and current Board President of CAPITAL Foundation, a non-profit organization with an aim to educate and collaborate to serve and advance the needs of our API community.

In these capacities, I have seen many silent victims – those who can not and do not speak for themselves because of physical and emotional abuse, language barriers, cultural barriers, socioeconomic barriers, and a system that is unprepared and unknowing on how to provide the services to meet the needs of these victims. I speak to you tonight on the unmet needs of not only domestic violence victims, but other crime victims and perpetrators in our API community.

There is a privilege of living a safe life that women and children in homes of domestic violence and those who suffer mental illness simply do not know. When there is the added barriers of language and cultural stigma and pressure, these women suffer alone and endure physical and emotional and psychological abuse because they are afraid; they have nowhere to go; and they do not have access to culturally and linguistically competent domestic violence services.

That is why an organization like My Sister's House is vital to serve the needs of monolingual immigrant women.

That is why the Transcultural Wellness Center is so critical to meet the mental health needs of the API community – a need that has been ignored, swept under the cover, silent, festering, and if continue to be unmet, will have broad sweeping impact in our community. We have only to pick up a newspaper or turn on the news to some of those issues surfacing.

As we all well know in working with social services ~ even if you have the funding, you may not be able to meet the goals of what you are trying to achieve because you do not have access to the community, you do not have the outreach, and you do not have the people to make it happen.

Let me tell you that after I have heard about and met with and learned about the vision of the Transcultural Wellness Center,

There is no doubt that there is a need, a tremendous need.

There is no doubt that TWC's vision is supported by an entire API community with organizations such as CAPITAL that covers the breadth of the API community here.

There is no doubt that we have the expertise to provide the culturally and linguistically competent mental health services to meet the needs of the broad API community.

And finally, there can be no doubt that you have a commitment ~ so clearly evident from the people here tonight – ranging from consumers, professionals, community leaders to make the TWC a success ~ a model in this country.

Thank you,

Alice Wong
Deputy District Attorney
Board President of CAPITAL Foundation
Past Board President of My Sister's House

TRANSCULTURAL WELLNESS CENTER

I am here to speak in support of the Transcultural Wellness Center. My name is Karen Kurasaki, and I am an officer of the executive committee of C.A.P.I.T.A.L. (Council of Asian Pacific Islanders Together for Advocacy and Leadership) – an umbrella organization of about 100 Asian Pacific Islander (API) grassroots community groups – and a board of director of the Florin J.A.C.L. (Japanese American Citizens League) – a grassroots community organization with a membership of more than 300 Japanese Americans in Sacramento County.

Many Sacramento Asian Pacific Islander older adults are not getting the mental health care they need due to an absence of culturally and linguistically appropriate, skilled mental health care, and due to a lack of outreach and education efforts to help them become aware that what they are experiencing is treatable mental health symptoms.

This is particularly true for Korean Americans. In a recent community survey conducted among 221 Korean American older adults in Sacramento over the age of 59, 91% were relatively recent immigrants. Only 5% indicated that they had "fair" English language proficiency, whereas 95% had only "some", "poor" or "no" English language proficiency. 98% received SSI and did not have any other income resources. 42% reported symptoms of depression and/or psychosomatic complaints. The barriers to mental health care among monolingual, non-English-speaking, Korean American older adults are numerous. Monolingual, non-English-speaking, Korean American older adults do not have access to information in their language about depressive symptoms, or about medications or other treatments that are available for persons experiencing depression. They are not familiar with health care systems in this county and so do not know how to navigate our complex system to access the care that they need. Being dependent on others for transportation, they choose to suffer quietly rather than be a burden on their adult children and grandchildren. Furthermore, current county programs are not adequately staffed with bilingual and bicultural, skilled mental health providers to provide equitable and quality care to monolingual, non-English-speaking, Korean American older adults.

The Transcultural Wellness Center would fill a serious gap in services in this county for Korean American and other Asian Pacific Islander older adults who are monolingual, non-English-speaking and whose mental health needs are similarly neglected by the current provider system. It would be a very important step toward correcting the inequities in mental health care for Asian Pacific Islanders in this county. For this reason, the Transcultural Wellness Center should be Sacramento County's top priority for the use of its Mental Health Services Act allocation.

Thank you,
Karen Kurasaki, Ph.D.
Secretary, Council of Asian Pacific Islanders Together for Advocacy and Leadership
3rd Vice President, Japanese American Citizens League, Florin Chapter
Telephone: 916/320-7417
Email: kurasaki@comcast.net

Statement for MHSA Public Hearing, Sacramento County
By Judy Fong Heary
December 7, 2005

Thank you for the opportunity to offer my comments. I am here to speak in support of the Transcultural Wellness Center. My name is Judy Fong Heary and I am the Executive Director of Asian Pacific Community Counseling. Our agency's mission is to promote mental health in Asian Pacific Islander communities through culturally and linguistically relevant outreach, prevention, education, counseling and recovery support services. As an agency with a county contract for Assisted Access services, we have provided interpretation and translation services for over 25 years. We assist the monolingual Cantonese, Japanese, Korean, Tagalog, Tongan, Hmong and Vietnamese-speakers in accessing mainstream mental health services in Sacramento County.

As an active participant of the Chinese, Japanese, Korean and Filipino stakeholder group, convener of the Pacific Islander stakeholder group and the Cultural Competence Task Force, I have witnessed an all out effort on the county's behalf to include all members of our diverse population. It was hard work to make this a truly public engagement process. Some glitches of communication and misunderstanding also occurred. However, the County is to be commended for the vision to include the Transcultural Wellness Center as part of the proposed County plan. The API population is growing larger, not smaller, the demand for services will increase before they decrease, and the problems will grow before they shrink. This proposal is a meaningful attempt to address these alarming trends.

The Division of Mental Health data shows that the API community has among the lowest utilization rates across all categories for the County of Sacramento. We expect that the utilization rate will increase through partnering with other API service agencies and making linguistically and culturally appropriate care accessible. Culturally relevant supports and services that are available to our community in non-traditional and traditional sites are more likely to encourage use of public mental health services. The API community looks forward to working with the County to transform the current service delivery system by adding culture and client-friendly services that are meaningful to API consumers and their family members.

Judy Fong Heary
Executive Director
Asian Pacific Community Counseling
5330 Power Inn Road, Suite A
Sacramento, CA 95820

December 7, 2005

MHSA and personal Statement for Public hearing

My name is Viva Vang. I am here to speak in support for the proposal for the Transcultural Wellness Center. I am pleased the proposal was drafted as I believe this is a monumental step towards meeting the needs of the Asian Pacific Islander (API) Community. It also leads to an opportunity to focus on the Mental Health needs of the Hmong community. I have been providing services to the Hmong community for the past 7-8 years in Sacramento County.

As a professional and concerned community member, I have seen that there is a high Mental Health need in the Hmong community. Many Hmong individuals go untreated due to lack of access, lack of services, lack of bilingual/bicultural staffs, stigma and shame that an individual may bring to his or her family if associated with current existing mental health services. As a result, Hmong individuals who need mental health services go undiagnosed and untreated for years. When Hmong individuals eventually seek services, they are reportedly more severe. Their disabling mental illness could have been prevented and treated if they were linguistically and culturally adequate services in place.

For instance, a client I had seen suffered from many auditory and visual hallucinations in which she saw shadows of an animal gliding across her bedroom walls and disappearing into the air vents. Then she would hear heavy breathing through the vents which would scare this woman every night to where she would stay up all night and

sleep during the day when she was safe around her children and husband. When she saw a Shaman he states that her soul was wondering away from her body. In order for her to be well, her family needs to sacrifice a pig to lure her soul back. After a few years, the shadows reappear. After seeing me and receiving education about psychotherapy she agreed to see the psychiatrist while working in collaboration with traditional healing. The psychiatrist prescribed her an anti-psychotic and sleep medication which helped her sleep and the shadows went away.

Another major barrier to mental health care that is repeatedly reported in the API community is language. For the Hmong people, this is one of the greatest obstacle with multiple layers. Recent and former Hmong refugees whom have been living in the US for the past 30 years still rely on oral communication. Translated materials currently used in the mainstream mental health services do little justice since many Hmong individuals do not even read or write in Hmong. Furthermore, many concepts applied to the mainstream society are not culturally appropriate to the Hmong community. For instance, when the discussions of self-care comes up in counseling. None of the examples I suggested or brought into session based on my western trained education such as taking a bath, going for a walk, writing in a journal, coloring with your children or hugging a teddy bear are helpful to a group of mid-age Hmong women. However, when I brought in freshly picked corn with the husk and hair still in tact, my women's group smiled and started talking about the happy days when they were preteen and sitting at the farm. The Hmong woman would dress them up like they did in the old days and none of the worries about finances, disobedient children, cheating husband or somatic complaints came into mind but just they focus of relieving happy moments.

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In summary, I fully support the proposal for the Transcultural Wellness Center. It is not just a proposal but a promise to the API community for those who came into this field knowing that we need to strive for cultural competence. The Transcultural Wellness Center will give this opportunity to reduce many obstacles currently existing in the Hmong community. Importantly, it will be a chance to administer full service mental health services to the Hmong community through cultural appropriate interventions and services.

I'm Raymond Lee, one of the organizers of the Asian Pacific Islander Stakeholder's Coalition.

On behalf of the coalition which is made up of

TheTongan/Samoan/Hawaiian/Fijian Communities Stakeholder Group, chaired by Judy Heary;

The Southeast Asian Communities Stakeholder Group ~~and~~ chaired by Viva Vang;

The Korean, Chinese, Japanese, Filipino Stakeholder's Group chaired by Karen Kurasaki;

We want to thank the County Mental Health staff and

The MHSA Steering Committee, for recommending the Transcultural Wellness Center;

~~The Mental health board~~

We also want to thank

~~And most especially~~ all the community representatives and members

who took the time to be here tonight.

We want to finally thank Dr. Luke Kim for his support, his professional guidance and his spiritual leadership. ~~He kept us honest~~.

I'm Harold Fong, Trustee on the Sacramento County Board of Education. I'm here speaking as an interested community person. Some 30 years ago, as a community activist, I helped get the first Asian American counselor hired at Sacramento City College. Her name was Marian Chin Ono. In her twenty plus years there, she counseled thousands of students. She was bilingual and bicultural.

During that time, I advocated for bilingual social services workers and mental health counselors. They were many Asian Pacific Islander American who came to this county and experience mental health needs but were not able to receive care.

First generation Americans who have limited English proficiency have very little access to information in their own language about what mental health and mental illness is, what services are available to them, and how to access these services, and the care they receive is often compromised by having to go through a translator.

Funding from the county to community agencies that serve monolingual Americans have historically been limited to translation services or what is known as "access services."

The Transcultural Wellness Center would provide full services mental health care to monolingual Americans, including psychotherapy and medication support, and would greatly enhance the quality of mental health services to monolingual Asian Pacific Islander Americans.

I'm here to support the funding of the Transcultural Wellness Center. It will be a great addition to services needed in the community to assist and help new Americans who have mental health needs.

Testimony to the Sacramento County Mental Health Board
Wednesday, December 07, 2005, 7 pm
By
Harriet A. Taniguchi, Ed.D.
Emeritus Administrator and Faculty, California State University, Sacramento
Stakeholder
Board Member, Asian Pacific Community Counseling, Inc.

Good evening. I would like to thank the Mental Health Board for this opportunity to present public testimony in support of the Transcultural Wellness Center as proposed in the Draft Community Services and Supports Three-Year Program and Expenditure Plan.

This has been an incredible journey for Sacramento County's Asian and Pacific Islander communities. We have been advocating for a culturally and linguistically appropriate comprehensive mental health Center since 1977 – almost 27 years ago! At this point I would like to state for the record that Dr. Luke Kim who 27 years ago was one of the original individuals with myself to begin this advocacy effort. After a community meeting on Monday, he became ill yesterday; thus, is not able to testify tonight. He has been our "guiding light and force" to ensure that culturally and linguistically based mental health services are provided to the API communities. I know that Dr. Luke and his wife Grace are with us in "spirit" here tonight. We all know that Sacramento has been identified as the most multicultural city in the nation; thus, the Transcultural Wellness Center will make a tremendous impact and serve as a model for provision of services for other communities as well.

In 1977, when a coalition of the ethnic communities brought to the County's attention the lack of appropriate mental health services; the County responded by funding several programs. As a result La Familia, Terkensha, Visions and Turning Point were funded to provide clinical services for the African American and Latino communities. We encourage the County to continue funding the ethnically based programs and, if appropriate, increase their funding to meet the unmet needs of their communities. At that time Asian Pacific Community Counseling was funded to provide peer counseling and supportive services and referring the API clients to the existing County clinical services.

It was also, our hope that the existing County clinical services would be able to provide bilingual and bicultural services. This did not transpire. We then became part of an effort with Turning Point to provide clinical services in the late 1990s; however, this was not effective.

Presently, the limited services particularly for monolingual API individuals which are available to the API community is a patchwork of providers not speaking the appropriate language, using different approaches, who do not have the skills to ensure that culturally relevant services are provided and trying their best not to confuse clients. This is particularly germane to the refugee populations.

We had over twenty five individuals actively participate in the stakeholders meetings, expressed the needs in the API communities and as a result the Steering Committee recognized the tremendous unmet needs; thus, the inclusion of the Transcultural Wellness Center as one of the Programs to be funded as a Full Service Partnership and Outreach and Engagement Program.

In an April, 2005 study entitled "Overcoming Language Barriers to Public Mental Health Services in California" commissioned by the California Department of Mental Health and conducted by the California Policy Research Center, University of California, that with the passage of Proposition 63, that bilingual providers should be a high priority to improve access for citizens with limited English proficiency.

It is time for Sacramento County to boldly address the tremendous unmet mental health needs of the API communities and support the Transcultural Wellness Center. As you can see we have the broad support of Sacramento's Asian Pacific Islander communities. We ask for your support and endorsement. To conclude; it is time that the Center is funded because I don't to be here in 2032 which is 27 years from now to provide testimony again. Instead we can have an exemplary model program that can be replicated here and throughout the nation.

TRANSCULTURAL WELLNESS CENTER

I am here to speak in strong support of the Transcultural Wellness Center (TWC). I believe the development of a culturally competent service should be of the highest priority in providing mental health care for Sacramento County. My name is Mike Lee, Associate Vice President and Dean for Academic Programs at California State University, Sacramento. I also serve on the Board of Asian Pacific Community Counseling (APCC).

California State University, Sacramento, or Sacramento State, has been playing a vital role in developing a strong work force for this region. Reflecting the diverse population of Sacramento County, the student population of Sacramento State is diverse as well. This student diversity has enabled us to prepare graduates to work effectively in the diverse population of the state and the region. A large percentage of our students are first generation college students who are bilingual and help bridge between the ethnic communities and the mental service providers.

There are three academic programs offered at Sacramento State that have been developing a strong work force for mental health related services in Sacramento County. These programs are Counselor Education, Social Work, and Psychology and have a total enrollment of 2,320 students. All three programs have diverse student population and represent multiple Asian linguistic groups in Sacramento County. Internship and supervised clinical practice are integral components of our program requirement to meet state regulations and national accreditation standards. Asian Pacific Community Counseling (APCC) has been providing some opportunities but the number has been small. The Transcultural Wellness Center (TWC) proposal will provide a significant number of opportunities to our students to complete their training. The practical training provided by the proposal would not only develop the students' skills in working with the Asian community, but also help bring about greater diversity in the future leadership of mental health profession.

I have reviewed all the proposals, and I believe Transcultural Wellness Center (TWC) will generate the most impact with the least amount of fund. I urge your full support of the proposal as written, especially for the Transcultural Wellness Center (TWC).

Thank you,

Mike Lee, Ph.D.
Associate Vice President
and Dean for Academic Programs
California State University, Sacramento
(916) 278-5186
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TRANSCULTURAL WELLNESS CENTER

I am here to speak in support of the Transcultural Wellness Center. I believe the development of a culturally competent service should be of the highest priority in providing mental health care for Asian Americans. As a Physician specializing in Internal Medicine, I wish to share with you a Report on Mental Health from the 16th Surgeon General of the United States, stating that Asians face the greatest challenges, because so many within our communities have gone without treatment or have been given substandard care in the field of mental health.

This report is the product of collaboration between two federal agencies (the Substance Abuse and Mental Health Services Administration and National Institutes of Health). Study after study, the report shows that Asian and Pacific Islanders (APIs) underutilize mental health services much more than other populations. APIs of our communities have the lowest rates of utilization of mental health services among ethnic populations, and yet Asians are not mentally healthier. Asian Americans are 50% less likely than whites to mention their mental health problems to a friend or relative, and 85% less likely to mention mental health problems to a psychiatrist or mental health specialist and 75% less likely to tell a physician. This is because of social stigma and shame over using such services and a problem with cultural inappropriateness of services.

Asian and Pacific Islanders in the United States have great linguistic diversity, speaking over 100 languages and dialects. A 2001 report from the President's Advisory Commission on Asian Americans and Pacific Islanders states that a large percentage of Asians are living in linguistically isolated households, where no one age 14 or older speaks English "well". That includes 61% Hmong Americans, 56% Cambodian Americans, 52% Laotian Americans, 44% Vietnamese Americans, 41% Korean Americans, and 40% Chinese Americans. This results in limitations of nearly half of the Asian American population's ability to use the mental health care system, due to the lack of English proficiency, not to mention the shortage of providers who possess appropriate language skills in an organized unit to reach out to the community effectively. The Transcultural Wellness Center will provide this unit.

Ethnic matching of therapists with clients and the services of ethnic-specific programs have been found to be associated with increased use of services and favorable treatment outcomes. The development of culturally and linguistically competent services should be of the highest priority in providing mental health care for Asian Americans.

Thank you,

Jennifer Choy, D.O.
Diplomate, American Board of Internal Medicine

The Permanente Medical Group, Inc
10725 International Drive
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916.213.7301

TRANSCULTURAL WELLNESS CENTER
December 7, 2005

I am here to speak in support of the Transcultural Wellness Center. My name is Timothy Fong, and I am the director of the Asian American Studies Program at California State University, Sacramento. I am also author of the book, *The Contemporary Asian American Experience: Beyond the Model Minority*, which will soon be published in its third edition. The book examines the contemporary history, culture, and social relationships that form the fundamental issues confronted by Asian Pacific Islander Americans (APIs) today. Many of the issues covered in the book focus on family, ethnic identity, and mental health.

The general perception of APIs is of a homogenous group relatively free of adjustment and mental health problems. But there are "stressors" created by dramatically changing roles within API families, as well as societal challenges to individual and ethnic identity, that can lead to serious mental health concerns. A number of studies have found the combination of minority status, racism, cultural conflicts, immigrant status, refugee experiences, and linguistic isolation, are all sources of stress for many API communities.

Within this, culturally appropriate mental health services and culturally sensitive mental health professionals are greatly needed. The most dramatic example of this can be seen immediately after the 1989 schoolyard shooting in Stockton. The incident left 5 children dead and 30 wounded, mostly Southeast Asian refugees. In response to the shootings, over 120 mental health clinicians came to Stockton to help grieving families and distraught residents. But the situation called for a great deal of sensitivity to the refugee's historical and cultural experiences that goes well beyond traditional individual or group therapy practices.

Then and as now, bilingual and bicultural API staff members are severely underrepresented in the workforce within the Department of Mental Health and its subcontractors. Adequate mental health care begins with proper recruitment of trained service providers. The Transcultural Wellness Center would first and foremost provide much needed services to the API community. The Transcultural Wellness Center would also provide opportunities for social work, counselor education, and educational psychology students from Sacramento State and other colleges and universities to have a place to receive their practice hours under professional supervision. In the long run, this would serve to increase Sacramento County's capacity to provide even more important services to the API communities in the future.

Thank you.

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December 7, 2005

To the Mental Health Board of Sacramento County:

I am here to speak in support of the Transcultural Wellness Center. My name is Russell Lim, Associate Clinical Professor at UC Davis Department of Psychiatry, and I was the former Medical Director of Northgate Point RST. My area of interest is Cultural Competence, and I train the Psychiatric Residents at the Medical Center, as well as the medical students in culturally competent mental health care. In Sacramento County, we have the most diverse patient population in the country, and we need to provide appropriate services for this population.

The Transcultural Wellness Center will meet an unmet need in the county for Asian Pacific Islander population. We have four RST's, and Adult Psychiatric Support Services Clinic, where I currently work, but we have no Ethnic Specific Services for the API patients. While it is true that the State of California has a Cultural Competence plan, and Sacramento County has created their own plan that requires culturally competent services in seven threshold languages, there are still many API patients still in need of mental heath services.

Why are these patients not in treatment? Stigma is a large reason. Many potential API patients do not want to be known as a "mental patient," and go to see a mental health professional as a last resort. When they do go, they may be fortunate enough to get a bilingual and bicultural case manager, as provided at Visions, or Northgate Point RST, but often times, they do not, and they are lucky enough to get a trained, professional interpreter.

The Transcultural Wellness Clinic has many innovative aspects. All staff will be trained in Cultural Competence Principles, including the DSM-IV-TR (Diagnostic and Statistical Manual, Fourth Edition, Text Revision) Outline for Cultural Formulation, something I have used for the last ten years in training mental health professionals across the country. It will serve all age groups, and provide child services, critical for API clients, who culturally are group oriented, as opposed to individual oriented like westerners. Families would be able to go the same agency, instead of being split up among two different agencies. The services will be tailored to the client, instead of the other way around, which is how it is done now.

In conclusion, The Transcultural Wellness Clinic will be a welcome addition to the County Mental Health System, and would be attractive to the API population due to its cultural emphasis and community outreach.

I thank you for your attention.

Russell Lim, MD

Good evening. My name is Jerry Chong and I am the Chief Legal Counsel for CAPITAL, the acronym for Council of Asian Pacific Islanders Together for Advocacy and Leadership. CAPITAL is a council composed of over 90 Asian Pacific Islander organizations in the greater Sacramento Valley region. CAPITAL includes organizations from the Chinese, Taiwanese, Japanese, Korean, Vietnamese, Hmong, Filipino, Tongan, Hawaiian, Samoan and Fijian communities. CAPITAL speaks as one voice on behalf of the Sacramento API community. Many of the API speakers tonight are highly respected and influential leaders in their community and CAPITAL.

I speak on behalf of the 90 plus API organizations in CAPITAL when I say we support the Transcultural Wellness Center. The API community has historically been ignored or disregarded in regards to its need on mental health issues. Some of this may be due to our reluctance or refusal to accept the existence of mental health in our families or communities. It is culturally taboo for API families to have mental illness. For whatever cultural reasons, it is believed to be a stain on the families and evidence of "bad blood" or defective genes in the family. The API community, especially the Southeast Asians, are in desperate need of mental health education, help and treatment. Many of the Southeast Asians are here today because of the Vietnam War. Many of the men who fought in the war or

the people who escaped from Vietnam, Laos and Cambodia witnessed and experienced horrendous atrocities, brutality, torture and deaths and were traumatized by their experiences. However, they say nothing about it. They keep it to themselves and suffer silently and stoically. They do not know why they are depressed, unhappy, angry, have nightmares and are unable to sleep at night. They do not know about post traumatic stress disorder because no one has ever told them about it or explained to them what and why they are experiencing these symptoms. They do not know they are suffering an emotional disorder as a result of their traumatic experiences.

Unfortunately, these untreated symptoms have led to tragedies and violent behavior which have brought these unfortunate people before the criminal justice system. Many of the Southeast Asian refugees cannot speak English and are reluctant or unwilling to discuss their personal feelings or traumatic experiences. A mental health center that is culturally sensitive, familiar with the history and experiences of the refugees and can speak their language will be of tremendous benefit to the API community and the community at large. It will address a need in the API community that has been lacking, disregarded and ignored for too long in this community.

Thank you.

A safe haven for battered Asian & Pacific Islander women and children

My Sister's House

3053 Freeport Blvd., No. 120, Sacramento, CA 95818 • PHONE: 916.396.4992 • FAX: 916.324.6230 • www.my-sisters-house.org

December 7, 2005

To: Sacramento County Mental Health

From: Nilda Valmores
Executive Director
My Sister's House

My name is Nilda Valmores and I am the Executive Director for My Sister's House, a non-profit organization whose mission is to provide shelter and services for Asian/Pacific Islander women and children fleeing domestic violence.

My Sister's House was formed about 5 years ago because of a belief that many monolingual immigrant women, and those whose families have resided in the states for several generations, stay in domestic violence situations because of a lack of culturally and linguistically competent services.

I have been in this position for little more than a year. I can tell you of many clients who were afraid to get help because they didn't believe that anyone would understand their backgrounds.

I can tell you of the many clients who wanted to stay in bed all day, couldn't eat, complaining headaches, and stress, and other ailments that would take forever to go away. I can speak of the too many to count requests for counseling services for someone who can speak their language and understand their culture and their values.

It is a desire and a vision of our organization to have ethnic specific and ethnic sensitive mental health services. With that assistance, rebuilding their lives will be quicker and easier.

Although our board of directors is predominantly Asian/Pacific Islander, our board representation is ethnically diverse. My Sister's House board of directors and its staff stand together in its desire to access appropriate and effective services for battered Asian/Pacific Islander women and children. We appreciate your support in removing this fundamental barrier to care and your role in helping end unnecessary toleration of physical, emotional, legal, financial, spiritual, and mental abuse.

On behalf of our silent clients, we thank you for your support of a Transcultural Wellness Center.

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I am here to speak in support of the Transcultural Wellness Center. My name is Ia Moua and I have provided interpretation, translation and health navigation support services for 5 years to assist monolingual Hmong speaking adults and youth in accessing mainstream mental health services in Sacramento County.

One of the foremost barriers to mental health care for Hmong is language. First generation Hmong immigrants or refugees who are monolingual or have limited English proficiency have very little access to information in their own language about what mental health and mental illness is, what services are available to them, and how to access these services. The care they receive is often compromised by having to go through a translator. In a recent community mental health awareness workshop that my staff and I facilitated for monolingual Hmong speaking refugees, 53 out of the 55 participants indicated that they frequently experience symptoms related to anxiety, depression, and somatic disorders. Many of the participants openly cried for help and expressed that death was the only way to end their physical and mental health sufferings. This simple workshop demonstrated the dire need of our community for real mental health care.

Funding from the county to community agencies that serve monolingual Hmongs has historically been limited to translation services or what is known as "access services."

The Transcultural Wellness Center would provide full service mental health care to monolingual Hmongs, including psychotherapy and medication support, and would greatly enhance the quality of mental health services to monolingual Hmongs in this county.

Michael Carag
API Stakeholders Group
MHSA Consumer
TRANS CULTURAL WELLNESS CNTR.

As a Filipino growing up as an immigrant in America, it was strange. When I came to America at the age of sixteen, I was bi-polar, but that was not what my family called it – I was called "maculit" or high strung.

My mother, who I found out later, suffered from major depression, never asked for help; and when I did my first term at juvenile hall for possession of illegal substance, the counselors diagnosed my as manic depressive. My mother translated it crazy. I remember the doctor telling her that I was manic depressive and her reply was, "yes, I know he's crazy, that's why he's here."

I've had a history of drug use; with heroin and speed, marijuana, ecstasy, and anything I could get my hands on. I have a history of committing crimes while I was manic, and when depression would kick in I would be so confused and suicidal, wondering why I stole this stuff. I have been incarcerated numerous times, as well as fifty-two / fifty'd.

I grew up thinking that I was crazy, and that I would die this way. It wasn't until I came to the **Filipino American Christian Fellowship** that someone from my own community was able to communicate to me the need for me to take, and stay on my medications. **FACF** was there to guide me through the paper work necessary for me to apply for CMISP at the Sacramento County Health Department, Primary Care Center on Broadway. **FACF** was there to take me to appointments at the Primary Care Center, and they still take me to El Hogar for my counseling appointments when I need it. **FACF** has been doing this on a consistent basis for the last six to seven years with others from the Filipino community who were in need.

In the two years since I began taking medications, and staying on it, I have been able to stay clean. Through my church, I have learned to form healthy relationships. I have not committed a crime nor have I injured anyone since I've began treatment. I am now attending Bible College, and serve in my church in a consistent basis. I tell this story not to brag on **FACF**, but to help show the need in the Filipino community, and the Asian Pacific Islander group as a whole. It is important for the Mental Health Services, that they employ facilities that are relevant to the community that it is targeting to serve. It is important that Mental Health be pertinent to the community it is trying to reach. Mental health needs to be addressed in a culturally relevant language to the people it is trying to serve.

I believe that the plan proposed by the API Stakeholders be given serious consideration by the board as well as others who work in Mental Health Services.

Thank you.

I am here to speak in support of the Transcultural Wellness Center. My name is Shinder Gill-Saeltzer and I am a second generation Sikh(Asian-Indian). I have been a past consumer of mental health services and a current mental health resource specialist (MHRS). I am here today to provide you a small glimpse into what struggles immigrant children such as myself have and continue to encounter.

In the year 2003, I made the decision to marry a non-Sikh. My decision was received with grave disappointment and resulted in being disowned by my family. Sikh families practice arranged marriages between Sikhs only. Sikh cultural values emphasis goodness in the existence of a collective consciousness or "familial self". Since I chose to act on an independent level over cultural loyalty, I experienced extreme sadness and guilt about being erased from my family.

The loss of my family slowly resulted in severe depression. I was hesitant to seek outside resources, afraid that health care providers would not understand my dilemma. Unfortunately, when I did, I found treatment to be culturally inappropriate and was bounced around from one provider to the next. The final straw was when one provider told me, "You need to get over losing your family!" When I asked, "How does someone in my predicament do this?" I was told, "I don't know." After this, I realized that there was no one that could understand the significance of my struggle and was forced to do it on my own.

Since that time, I have worked hard to recover from depression. With the support of the API community, I have made it a mission to work towards finding a solution for Sikhs and other Asian Indians to have culturally appropriate services available. I know of countless other Asian Indians who suffer in silence based on the lack of culturally appropriate services. This is why I am here today to support a positive future for the API community in building a Transcultural Wellness Center and to end the suffering.

API STAKE HOLDERS GROUP

Issue No. 6 / 11. Cultural values, religious or spiritual beliefs. Rev. Criste Silverio

Sometime ago working as an intern-volunteer with Asian Pacific Community Counseling, I had the opportunity to study different kinds of approaches that emphasized the importance of cultural relevance in the treatment of mental health issues. Culture means language, customs, tradition, beliefs either religious and or spiritual.

One major reason that Filipinos make up the lowest percentage of mental health services is the cultural perception that asking for help is a sign of weakness – and such weakness brings "loss of face" that extends to the entire family, not just the individual seeking help. Even for those who do manage to overcome the fear being branded as "loko," or crazy, the services that are provided may directly conflict with their cultural beliefs. For example, while mainstream American culture enables many to comfortably discuss their issues in a group setting, that type of open disclosure to strangers is almost impossible to consider for many Filipinos. Admissions of problems, conflict and other issues are viewed as merely "airing one's dirty laundry" – again, a shameful prospect. Instead of discussion, Filipinos will more often remain silent or minimize their situations. For those Filipinos involved in non culturally sensitive services, the potential for successful treatment is almost an impossibility. Anyone who forgets language looses ones culture and thus assimilated by the dominant society. I have learned that religious denominations that send their missionaries overseas are required to teach the cultural values, customs, traditions, main dialect and or language of that particular county.

The economic standard brought upon the Philippine government itself to its own people became a wall that needed to be overcome. No wonder the Filipinos are in 82 different countries of the world due to economy.

Since my arrival here in the US, the overwhelming feeling has not left me even after forty-five years due to different experiences in dealing with particular issues. The indifferences of cultural values amongst my countrymen, even their outlook, meaning of life (some provinces have two to three different dialects).

Anyone who avail the use of mental health is branded to be crazy (loko) and are not only avoided but shunned. The whole family is stereo-typed that they are not to be trusted. The whole clan becomes the scourged socially.

Trying to getting into the system that is full of questionnaires that is "Latin" an old Roman dead language, to them. Examples are forms that have areas of selections about heritage of different countries and do not specify the particular race such as "Malay" or "Filipino".

No wonder the Filipinos have the lowest percentage of usage in our mental health program. The values we have carried from not just our past but also from how generations were brought up.

Traditionally, we carry these issues until one learns through experience coupled with educational awareness from outside the family circle.

These are just the most obvious manifestations I saw. How about others who have to let loose their own moral values just to stay here in the US because they are without proper immigration papers?

A Transcultural Wellness Center is definitely extremely needed. The FACF in collaboration with APCC has been trying for the past five years in penetrating the community and are having success slowly. We are currently using the facilities of FACF and APCC in reaching out to the API community.

>>AUDIENCE MEMBER: RUSSELL. HELLO. I'M A PSYCHIATRIST AND PROFESSOR AT U.C. DAVIS AND NORTHGATE R.S.T. I'M HERE TO SPEAK IN FAVOR. I TRAIN THE RESIDENTS AT THE MEDICAL CENTER AND CULTURAL COMPETENCE HEALTHCARE. WE HAVE THE MOST DIVERSE POPULATION IN THE COUNTRY. THE TRANSCULTURAL WELLNESS CENTER WILL MEET UNMET NEED. WE HAVE ADULT PSYCHIATRIC ADULTS SERVICES WHERE WE HAVE NO ETHIC-SPECIFIC SERVICES. IT'S A CULTURAL COMPETENCE PLAN AND SACRAMENTO COUNTY HAS ITS OWN PLAN. THERE ARE STILL A NEED OF MENTAL HEALTH SERVICES. WHY ARE THESE PATIENTS NOT IN TREATMENT? THEY DO NOT WANT TO BE KNOWN AS A MENTAL HEALTH PATIENT AND GO TO SEE A MENTAL HEALTH DOCTOR. OR THEY MAY NOT GET -- AND LUCKY ENOUGH TO GET AN INTERPRETER.

ALSO STAFF WILL BE TRAINED CULTURAL COMPETENCE PRINCIPLES -- T.R. OUTLINED FOR CULTURAL -- FOR THE LAST 10 YEARS OF TRAINING (READING DOCUMENT). ALL AGE GROUPS CRITICAL FOR H.I. CLIENTS WHO ARE GROUP ORIENTED WHO ARE INDIVIDUALLY ORIENTED. THEREFORE FAMILIES WOULD NOT HAVE TO BE SPLIT UP. THE GUYS SHOULD GO TO THE SAME AGENCY. TAILORED TO THE CLIENT INSTEAD OF THE OTHER WAY AROUND WHICH IS THE WAY IT'S DONE NOW. THE TRANSCULTURAL WELLNESS CLINIC WOULD BE ATTRACTIVE TO THE COMMUNITY AND COMMUNITY OUTREACH. I THANK YOU FOR YOUR ATTENTION.

>>AUDIENCE MEMBER: MY NAME IS MICHAEL. I'M WITH THE FILIPINO KOREAN, JAPANESE STAKEHOLDERS. AS AN IMMIGRANT IN AMERICA, IT WAS STRANGE. I WAS BIPOLAR, BUT THAT WAS NOT WHAT MY FAMILY CALLED IT. MY MOTHER, WHO I FOUND TO HAVE SUFFERED FROM DEPRESSION, NEVER ASKED FOR HELP. THE COUNSELORS DIAGNOSED ME AS MANIC-DEPRESSION. I REMEMBER THE DOCTOR TELLING HER THAT I WAS MANIC-DEPRESSION. I KNOW HE'S CRAZY, THAT'S WHY HE'S HERE. I'VE HAD A HISTORY OF DRUG USE. ANYTHING THAT I CAN GET MY HANDS ON. I HAVE A HISTORY OF COMMITTING CRIMES.

I'VE BEEN IN INCARCERATED NUMEROUS TIMES AS WELL AS 5250. IT WASN'T UNTIL I CAME TO THE FILIPINO TRANSITIONAL FELLOWSHIP THAT SOMEBODY WAS ABLE TO COMMUNICATE TO ME TO TAKE AND STAY ON MY MEDICATIONS. THEY WERE THERE TO GUIDE ME THROUGH THE PAPERWORK AND PRIMARY CARRY CENTER AT BROADWAY. THEY WERE THERE TO MAKE APPOINTMENTS FOR ME. AND THEY TAKE ME TO MY COUNSELING APPOINTMENTS WHEN I NEED IT. THEY HAVE BEEN DOING THIS ON A CONSISTENT BASIS WITH OTHERS FROM THE FILIPINO COMMUNITY WHO ARE IN NEED.

IN THE TWO YEARS THAT I BEGAN TAKING MEDICATION I HAVE BEEN ABLE TO STAY CLEAN AND FORM HEALTHY RELATIONSHIPS. I HAVE NOT COMMITTED A CRIME SINCE I BEGAN TREATMENT. I'M NOW ATTENDING BIBLE COLLEGE AND SERVE MY CHURCH. I TELL THIS STORY TO HELP SHOW THE NEED IN THE FILIPINO COMMUNITY AND THE ASIAN/PACIFIC ISLANDER GROUP. AND RELEVANT TO THE COMMUNITY THAT THEY ARE TARGETING TO SERVE. IT IS IMPORTANT THAT MENTAL HEALTH BE PERTINENT TO THE COMMUNITY THAT IT IS TRYING TO REACH. MENTAL HEALTH NEEDS TO -- THE PLAN BY API STAKEHOLDERS BE GIVEN SERIOUS CONSIDERATION BY THE BOARD AS WELL AS OTHERS WHO WORK IN THE MENTAL HEALTH SERVICES. THANK YOU. (APPLAUSE).

>>AUDIENCE MEMBER: ALOHA. I'M JAN A. AND I REPRESENT THE PACIFIC ISLANDER COMMUNITY. I TRAVELED 267 MILES BECAUSE I THOUGHT THAT THIS HEARING WAS VERY CRITICAL TO ME AND MY FAMILY.

MY GRANDSON WHO TRANSITIONED FROM YOUTH TO ADULT MENTAL HEALTH PROBLEMS WAS JUST RECENTLY DIAGNOSED WITH A BIPOLAR DISORDER. IT WAS EMOTIONAL FOR ME. HIS FATHER HAS BEEN IN AND OUT OF THE STATE PRISON SYSTEM SINCE HE WAS AN INFANT. IT WAS EMOTIONAL FOR ME TO SEE MY GRANDSON COME OUT FROM THE INSTITUTION IN A CATASTROPHIC STAGE.

I COME FROM BAKERSFIELD AREA AND I'M GOING TO BE HERE IN THIS COMMUNITY REMINDING THIS COUNTY OF WHERE I'VE LIVED FOR THE PAST NINE YEARS UP UNTIL 1993, THAT THE ASIAN/PACIFIC ISLANDER HAVE LONG BEEN IGNORED FOR SESSION SERVICES. BECAUSE OF MY FAMILY INVOLVEMENT BECAUSE OF THE FACT THAT MY GRANDSON IS A VICTIM THAT MONEY SHOULD BE SPENT AND EXTENDED TO RECOGNIZE THE SERVICES THAT ARE NEEDED FOR OUR ASIAN/PACIFIC ISLANDER COMMUNITIES.

WOMEN OF ASIAN/PACIFIC ANCESTRY OF 65 AND UP HAVE THE HIGHEST SUICIDE RATES. NATIVE HAWAIIANS HAVE THE HIGHEST RATE OF PSYCHOTIC YOUNG YOUTH. MORE AND MORE OF THESE PEOPLE ARE ADDING ON TO OUR POPULATION HERE IN SACRAMENTO. AND I'M VERY PROUD TONIGHT TO SEE THAT I HAVE A GOOD REPRESENTATION OF THE PACIFIC ISLANDER COMMUNITY ON THIS SIDE OF THE ROOM AND THEY HAVE SHOWN UP TONIGHT SIMPLY BECAUSE THEY KNOW THEY HAVE THESE PROBLEMS IN THEIR COMMUNITY. THEY ARE SHROUDED BY FEAR AND IGNORANCE AND UNAWARENESS OF PROGRAMS THAT HAVE NOT BEEN EXTENDED TO THESE COMMUNITIES. I'M EXTENDING MY PLEA TO YOU THAT MONEY SHOULD BE EXTENDED FOR THESE PROGRAMS.

I DO ALSO WANT TO SHARE ANOTHER EXPERIENCE THAT PERT I THINK WOULD HAVE AN IMPORTANT ROLE IN THE COMMUNITY. MY GRANDSON WHO TERRORIZED HIS FAMILY WHEN HE RETURNED HOME FROM HIS FIRST EXPERIENCE IN A MENTAL HOSPITAL. TERRORIZED HIS FAMILY. HAD IT NOT BEEN FOR THE POLICE FORCE AND WE ARE LUCKY THAT THESE TWO POLICE OFFICERS KNOW WHAT TO DO WITH HIM AND THEY WERE KIND AND GENEROUS AND THEY KNEW EXACTLY WHERE TO COMMIT HIM AND I'M THANKFUL FOR THAT. THERE'S AN ASIAN/PACIFIC COMMUNITY HERE THAT REALLY NEEDS THE SERVICES. THANK YOU. (APPLAUSE).

>>AUDIENCE MEMBER: I AM HERE TO SUPPORT THE TRANSCULTURAL CENTER. I'M SECOND GENERATION SIKH. A SIKH IS AN ASIAN INDIAN.

I AM HERE TODAY TO PROVIDE YOU A SMALL GLIMPSE WHAT IMMIGRANT CHILDREN SUCH AS MYSELF HAS ENCOUNTERED AND CONTINUE TO ENCOUNTER.

IN THE YEAR 2003, I MARRIED A NON-SIKH. MY DECISION WAS THAT I WAS DISOWNED BY MY FAMILY. THE FAMILY PRACTICE OF ARRANGED MARRIAGES. SINCE I CHOSE TO ACT ON A PERSONAL LEVEL, I HAVE SADNESS AND QUILT OF BEING RAISED BY MY FAMILY AND RESULTED IN SEVERE DEPRESSION. I WAS HESITANT TO SPEAK OUT. AFRAID THAT HEALTHCARE PROVIDERS WOULD NOT UNDERSTAND MY DILEMMA. I DID FIND TREATMENT; IT WAS CULTURALLY INAPPROPRIATE. THE FINAL STRAW WAS WHEN ONE PROVIDER TOLD ME YOU NEED TO GET OVER LOSING YOUR FAMILY. HOW DOES SOMEONE IN MY PREDICAMENT DO THIS; I WAS TOLD, I DON'T KNOW. THEY WOULD NOT UNDERSTAND THE SIGNIFICANCE OF MY STRUGGLE. I HAVE WORKED HARD TO RECOVER FROM DEPRESSION. WITH THE COMMUNITY I HAVE MADE A MISSION TO FIND A SOLUTION FOR SIKHS AND OTHER ASIAN INDIANS TO HAVE CULTURALLY APPROPRIATE SERVICES AVAILABLE. I KNOW OF COUNTLESS ASIAN INDIANS WHO SUFFER IN SILENCE BECAUSE OF LACK OF SERVICES.

I'M HERE TO SUPPORT A POSITIVE FUTURE FOR THE API COMMUNITY IN BUILDING A TRANSCULTURAL CENTER AND END THE SUFFERING. THANK YOU. (APPLAUSE).

>>AUDIENCE MEMBER: HI. I'M HERE TO SPEAK IN SUPPORT OF TRANSCULTURAL WELLNESS CENTER. I'M THE EXECUTIVE DIRECTOR OF WOMEN'S HERITAGE ASSOCIATION A COMMUNITY BASED ORGANIZATION IN SACRAMENTO SERVING FAMILIES. WE PROVIDE SERVICES TO OVER 200 CLIENTS PER MONTH. WE ACTUALLY STARTED OUT AS A SMALL SUPPORT GROUP.

AND WHAT WE HAVE EXPERIENCED IS THAT WHEN PEOPLE COME THROUGH OUR DOORS AND WE REFER THEM OUT TO OTHER PEOPLE WHO HAVE THE EXPERTISE AND THE EXPERIENCES, THESE CLIENTS COME BACK THROUGH OUR DOOR BECAUSE THEY CANNOT ACCESS THE SERVICES DUE TO THE LANGUAGE AND CULTURAL BARRIERS. I WANT TO URGE FOR YOUR SUPPORT OF THE TRANSCULTURAL WELLNESS CENTER. AND I BROUGHT TWO OF OUR CLIENTS WHO WILL SHARE THEIR EXPERIENCE WITH YOU.

>>AUDIENCE MEMBER: I'M A HOMEMAKER. I'VE HAD SOME HARDSHIPS. I DON'T HAVE A HUSBAND. MY HUSBAND WAS A SOLDIER AND HE PASSED AWAY IN THE OLD COUNTRY.

IN THIS COUNTRY I DON'T KNOW THE LANGUAGE. I CAN'T MAKE A LIVING. I'M VERY SAD. I CAN'T GO LEARN THE LANGUAGE OR GET AN EDUCATION BECAUSE I DON'T KNOW HOW.

I'M VERY DEPRESSED. I DON'T WANT TO BE LIVING AND I WISH THERE WAS A WAY TO HELP MYSELF AND MY FAMILY.

IN THIS COUNTRY, I DON'T HAVE A HUSBAND, I DON'T HAVE ANY RELATIVES. I DON'T HAVE ANY WAY OF MAKING A LIVING. SINCE WE HAVE THE HMONG WOMEN'S ORGANIZATION TO HELP OUT, THAT'S THE ONLY TIME I'VE RECEIVED SOME HELP.

CHILDREN, I'VE LOST A FEW OF THEM. I'M VERY DEPRESSED. I WISH THAT YOU WOULD HAVE SOME SYMPATHY FOR THOSE OF US WHO NEED HELP.

ANITA SHOEMAKER: THANK YOU. (APPLAUSE).

>>AUDIENCE MEMBER: I AM ALSO A HOMEMAKER AND MY HUSBAND WAS ALSO A SOLDIER FOR A LONG TIME IN LAOS.

WHEN WE GOT TO THIS COUNTRY, MY HUSBAND BECAME SICK AND HE PASSED AWAY AND HE LEFT MYSELF AND MY 12 CHILDREN ALONE.

I DON'T KNOW ANY ENGLISH AND I HAVEN'T HAD A CHANCE TO GO GET AN EDUCATION.

I'M VERY DEPRESSED. MY HUSBAND HAS BEEN DECEASED FOR SIX YEARS.

AFTER THAT MY DAUGHTER AND HER HUSBAND KILLED EACH OTHER. THEY LEFT ME A SMALL CHILD THAT WAS TWO YEARS OLD. I DON'T KNOW HOW TO BE A HUMAN BEING ANYMORE EVEN THOUGH I'M HERE TODAY. I DON'T KNOW WHY I'M HERE.

I LOVE MY CHILDREN. AND THAT'S THE ONLY REASON WHY I'M STILL ALIVE. I WOULD LIKE SOME HELP FROM PEOPLE WHO CAN UNDERSTAND ME AND UNDERSTAND MY LANGUAGE.

AND UNDERSTAND ME SO THAT THEY CAN HELP ME WITH THE THINGS THAT I NEED HELP WITH. I BELIEVE THAT IT'S VERY GOOD THAT I'M LIVING IN THIS COUNTRY. BUT I FEEL LIKE I'VE ALREADY PASSED AWAY AND I'M STILL ALIVE BUT I'VE ALREADY PASSED AWAY.

THIS IS BECAUSE I DON'T KNOW HOW TO SPEAK ENGLISH AND I DON'T HAVE AN EDUCATION AND I CANNOT HELP MYSELF.

I BELIEVE THAT IT'S BETTER FOR ME TO DIE, BUT I STILL LOVE MY CHILDREN THAT'S WHY I'M STILL ALIVE. I WOULD LIKE HELP FROM THOSE WHO ARE IN CONTROL.

>>AUDIENCE MEMBER: I'M HARRIET. AND I REPRESENT STAKEHOLDERS GROUP AS WELL AS A BOARD MEMBER OF ASIAN/PACIFIC COMMUNITY COUNSELING. THE PREVIOUS TESTIMONY JUST REALLY SPEAKS VOLUMES TO THE TOTAL NEGLECT OF THE MENTAL HEALTH NEEDS OF THE API COMMUNITY. THIS HAS BEEN A TREMENDOUS JOURNEY.

-- MENTAL HEALTH CENTER SINCE 1977. ALMOST 28 YEARS AGO. AT THIS POINT I WOULD LIKE TO ACKNOWLEDGE THE -- AND STATE FOR THE RECORD THAT DR. KIM WAS THE ORIGINAL PEOPLE TO DEVELOP THIS EFFORT. HE BECAME ILL YESTERDAY AND UNABLE TO TESTIFY TONIGHT. HE'S BEEN THE GUIDING LIGHT TO ENSURE THAT THE SERVICES ARE PROVIDED TO THE API COMMUNITIES. I KNOW THEY ARE WITH US IN SPIRIT HERE TONIGHT. WE KNOW THAT SACRAMENTO HAS BEEN IDENTIFIED AS THE MOST MULTICULTURAL CITY IN THE NATION AND A TRANSCULTURAL WELLNESS CENTER WILL MAKE AN IMPACT FOR A PROVISION OF SERVICES FOR OTHER COMMUNITIES AS WELL.

FOR THE RECORD IN 1977, I CAN'T BELIEVE THAT I HAD, AT THAT TIME, ALSO TESTIFIED TO THE MENTAL HEALTH AT THAT POINT ADVISORY BOARD, WITH THE COALITION OF ETHIC COMMUNITIES TO BRING TO THE COUNTY'S ATTENTION LACK OF ATTENTION AND API NATIVE AMERICAN API COMMUNITIES. THE COUNTY WILL LISTEN TO A CERTAIN EXTENT AND AS A RESULT THERE WAS PROGRAMS ESTABLISHED AND TURNING POINT WERE FUNDED AND WERE PROVIDED.

WE CERTAINLY ENCOURAGE THE COUNTY TO CONTINUE TO PROVIDE THESE SERVICES FOR THOSE RESPECTIVE COMMUNITIES.

AT THAT TIME ASIAN/PACIFIC COMMUNITY COUNSELING WAS FUNDED TO PROVIDE OUTREACH AND SUPPORTIVE SERVICES AND REFERRING API CLIENTS TO EXISTING COUNTY CLINICAL SERVICES.

WE THEN BECAME PART OF AN EFFORT WITH TURNING POINT TO PROVIDE CLINICAL SERVICES FOR THE LATE 1970'S. HOWEVER IT WAS NOT EFFECTIVE. WE ARE REALLY IN NEED OF FULL FUNDING FOR THE TRANSITIONAL -- I'M SORRY, FOR THIS PARTICULAR TRANSCULTURAL WELLNESS CENTER. I DON'T WANT TO BE BACK HERE IN 2035 TO BE TESTIFYING AGAIN -- BACK HERE -- THE TIME IS NOW THAT WE REALLY NEED TO FUND THIS PARTICULAR PROJECT. AND WE CAN REALLY BECOME AN EXEMPLARY PROGRAM FOR THE COUNTY AND THE NATION.

>>AUDIENCE MEMBER: GOOD EVENING. THANK YOU FOR YOUR TIME. MY NAME IS JENNIFER. I'M A PHYSICIAN AND I SPECIALIST IN INTERNAL MEDICINE. I'M HERE TODAY TO SPEAK IN SUPPORT OF TRANSCULTURAL WELLNESS CENTER. BECAUSE WE ARE SPEAKING ABOUT MENTAL HEALTH, I WANT TO SHARE WITH YOU A REPORT, MENTAL HEALTH REPORT FROM THE SURGEON GENERAL. ASIAN AND PACIFIC ISLANDERS HAVE THE LOWEST RATE OF MENTAL HEALTH SERVICES BUT THEY ARE NOT MENTALLY HEALTHIER. INSTEAD ASIAN AMERICANS COMPARED TO CAUCASIAN ARE LESS LIKELY TO MENTION MENTAL HEALTH PROBLEMS TO A FRIEND OR RELATIVE AND 80% LESS LIKELY TO TALK TO A PSYCHOLOGIST OR TALK TO A PHYSICIAN; A PRIMARY PHYSICIAN, A FAMILY PHYSICIAN. THIS IS BECAUSE OF SOCIAL STIGMA. OUR COMMUNITY IS NOT RECEIVING TREATMENT. AND WHEN WE DO RECEIVE TREATMENT, IT IS SUBSTANDARD CARE.

THE TRANSCULTURAL WELLNESS CENTER WILL SERVE AS A COMMUNITY PROJECT TO COMBAT THE FEAR AND THE STIGMA. THEY SPEAK OVER 100 DIFFERENT LANGUAGES AND DIALECTS. ACCORDING TO THE SURGEON GENERAL, UP TO 40 TO 50% OF ASIAN AND PACIFIC ISLANDERS LIVE IN LINGUISTICALLY ISOLATED FAMILIES. AND THEY DO NOT RECEIVE HEALTHCARE SIMPLY BECAUSE THEY DO NOT SPEAK THE LANGUAGE. AND THE TRANSCULTURAL WELLNESS CENTER WILL PROVIDE HEALTHCARE TO THE LINGUISTICALLY -- AND LACK OF CULTURE APPROPRIATE SERVICES IS IN THE AREA OF DOMESTIC VIOLENCE AND IMPACT.

I'M -- I SERVE ON THE BOARD OF THE DOMESTIC VIOLENCE CENTER. AND "MY SISTERS HOUSE" SERVES THE ASIAN COMMUNITY. EVERY YEAR WITHOUT A DOUBT THE NUMBER OF VICTIMS ARE -- HAS ALWAYS BEEN IN THE MILLIONS. THEY EFFECT THE ASIAN COMMUNITY JUST AS IN EVERY OTHER COMMUNITY. HOWEVER, BUT FOR ASIANS, IT IS MUCH WORSE FOR US. IT IS MUCH WORSE BECAUSE OF LANGUAGE BARRIERS AND BECAUSE OF CULTURE. ASIAN WOMEN FIND THEM IN SHELTERS AND THEY ARE UNABLE TO PARTICIPATE IN COUNSELING SESSIONS OR SUPPORT GROUPS. THEY END UP SUFFERING ALONE AND IN SILENCE. SO I WANT TO SUPPORT THE TRANSCULTURAL WELLNESS CENTER, AND I THANK YOU FOR YOUR ATTENTION. (APPLAUSE).

>>AUDIENCE MEMBER: I'M HERE IN SUPPORT OF TRANSCULTURAL WELLNESS CENTER. I'M THE EXECUTIVE DIRECTOR OF "MY SISTERS HOUSE." WE PROVIDE SHELTER AND SERVICES FOR ASIAN/PACIFIC ISLANDERS FLEEING DOMESTIC VIOLENCE. MANY MONOLINGUAL WOMEN STAY IN DOMESTIC VIOLENCE SITUATIONS BECAUSE OF CULTURAL COMPETENT SERVICES. I'VE BEEN IN THIS POSITION A LITTLE MORE THAN A YEAR. MANY OF THE CLIENTS WHO ARE AFRAID TO GET HELP BECAUSE THEY DIDN'T BELIEVE THAT ANYONE WOULD UNDERSTAND THEIR BACKGROUNDS. THE CLIENTS THAT WANTED TO STAY IN BED ALL DAY, COMPLAINING OF HEADACHES AND STRESSING UNDER ELEMENTS THAT SEEMED TO TAKE FOREVER TO GO AWAY. AND SOMEONE WHO CAN SPEAK THEIR LANGUAGE AND UNDERSTAND THEIR CULTURE AND THEIR VALUES.

IT IS A DESIRE TO HAVE ETHNIC SPECIFIC MENTAL HEALTH SERVICES. WITH THAT ASSISTANCE REBUILDING THEIR LIVES WILL BE QUICKER AND EASIER. ALTHOUGH OUR BOARD OF DIRECTORS IS BASICALLY ASIAN/PACIFIC ISLANDERS. THE BOARD OF DIRECTORS AND STAFF STAND TOGETHER IN DESIRE TO ACCESS APPROPRIATE AND EFFECTIVE SERVICES FOR BATTERED ASIAN/PACIFIC ISLANDER WOMEN AND CHILDREN. WE APPRECIATE YOUR SUPPORT IN REMOVING THE FUNDAMENTAL BARRIER TO CARE AND UNNECESSARY TOLERATION OF EMOTIONAL, LEGAL AND FINANCIAL AND MENTAL ABUSE. AND ON BEHALF OF OUR SILENT CLIENTS WE THANK YOU FOR YOUR SUPPORT OF A TRANSCULTURAL WELLNESS CENTER.

>>AUDIENCE MEMBER: GOOD EVENING. MY NAME IS JERRY JONG AND I'M THE CHIEF LEGAL COUNSEL FOR CAPITAL. CAPITAL IS A COUNCIL COMPOSED OF 90 ASIAN/PACIFIC ISLANDER ORGANIZATIONS IN THE GREATER SACRAMENTO VALLEY REGION. IT INCLUDES ORGANIZATION FROM THE CHINESE, TAIWANESE. KOREAN, HMONG, ET CETERA. CAPITAL SPEAKS AS ONE VOICE ON THE BEHALF OF API COMMUNITY. THEY ARE HIGHLY RESPECTED AND INFLUENTIAL LEADERS IN THEIR COMMUNITY.

I SPEAK ON BEHALF OF THE ORGANIZATION WHEN I SAY WE SUPPORT THE TRANSCULTURAL WELLNESS CENTER. API HAS BEEN IGNORED IN NEED FOR MENTAL HEALTH ISSUES; THE SOUTHEAST ASIANS ARE IN DESPERATE NEED OF TREATMENT. THEY ARE HERE TODAY BECAUSE OF THE VIETNAM WAR. MANY OF THE PEOPLE WHO FOUGHT IN THE WAR AND ESCAPED WITNESSED AND EXPERIENCED TORTURE AND DEATH AND TRAUMATIZED BY THEIR EXPERIENCE. THEY DO NOT KNOW WHY THEY ARE DEPRESSED, UNHAPPY, ANGRY, HAVE NIGHTMARES AND UNABLE TO SLEEP AT NIGHT. THEY DO NOT KNOW ABOUT POST DRAMATIC DISORDER. THEY DO NOT KNOW THEY ARE SUFFERING AN EMOTIONAL DISORDER.

THESE UNTREATED SYMPTOMS HAVE LEAD TO CRIMINAL BEHAVIORS AND BROUGHT THEM BEFORE THE CRIMINAL JUSTICE SYSTEM. MANY OF THE REFUGEES CANNOT SPEAK ENGLISH AND UNWILLING TO DISCUSS THEIR PERSONAL FEELINGS. A CULTURAL CENTER THAT IS FAMILIAR WITH THE THEM AND SPEAK THEIR LANGUAGE WILL BE A BENEFIT TO THE API COMMUNITY AND THE COMMUNITY AT LARGE. IT WILL ADDRESS THE NEED IN THE ASIAN/PACIFIC ISLANDER COMMUNITY THAT HAS BEEN LACKING AND DISREGARDED AND IGNORED TOO LONG IN THIS COMMUNITY. THANK YOU. (APPLAUSE).

>>AUDIENCE MEMBER: HI. I'M HERE TO SPEAK IN SUPPORT OF THE TRANSCULTURAL WELLNESS CENTER. A NONPROFIT COMMUNITY ORGANIZATION (READING DOCUMENT.) WE ARE PART OF NATIONAL ORGANIZATIONS ALL OVER THE COUNTRY. IT IS IMPORTANT AS YOU CAN TELL BY THE SPEAKERS TONIGHT. I URGE YOU TO VOTE FOR THE TRANSCULTURAL WELLNESS CENTER. THANK YOU. (APPLAUSE).

>>AUDIENCE MEMBER: GOOD EVENING. I'M HERE TO SPEAK IN SUPPORT OF THE TRANSCULTURAL WELLNESS CENTER AND SUPPORT THE JUVENILE SUPPORT SERVICES THAT WOULD LEAD TO CRIMINAL AND GANG ACTIVITY.

I GREW UP IN SAN FRANCISCO AND DESPITE, I DON'T KNOW IF YOU HAVE THESE STEREOTYPES, ASIAN/PACIFIC ISLANDERS ARE NOT ALL COLLEGE EXCELLORS.

MANY OF MY FRIENDS AND CLASSMATES WERE PARTICIPATING IN INTERVENTION CRIMINAL GANG COUNSELING PROGRAMS THAT WERE WITHIN THE COMMUNITY IN SAN FRANCISCO. THESE COUNSELING CENTERS WERE CULTURALLY COMPETENT. AND I CAN SPEAK ON BEHALF OF MY FRIENDS, PEERS AND CLASSMATES, THESE COUNSELING SERVICES ARE EFFECTIVE. PROOF OF THAT IS THEY LACK CRIMINAL ACTIVITIES AND THEY HAVE GONE TO COLLEGE. THAT'S IT; THANK YOU FOR YOUR CONSIDERATION. (APPLAUSE).

>>AUDIENCE MEMBER: GOOD EVENING. MY NAME IS TOMMY CHONG. THE TWO LADIES -- THE TWO HMONG LADIES GAVE EMOTIONAL TESTIMONY HERE EARLIER. AND I'M HERE TO REPRESENT WHERE THE HMONG COME FROM. THEY HAVE ETHIC PEOPLE FROM THAILAND AND LAOS. BEFORE 1960 THE HMONG LIVED IN LAOS. A HMONG -- EVERY CULTURAL SOCIETY. AND THEY LIVE IN THE MOUNTAIN PEOPLE. IN 1960 THE AMERICAN GOVERNMENT CAME TO LAOS AND RECRUITED HMONG TO HELP THEM FIGHT AGAINST THE VIET CONG IN 1960. THE HMONG HELPED AMERICA FIGHT; 1960 TO 1965. THE AMERICANS LOST THE WAR TO THE VIET CONG.

IN 15 YEARS MANY HMONG PEOPLE LOST THEIR LIVES. LOST THEIR BROTHER, SISTER, FRIENDS, THOUSANDS OF THEM.

1975, THE HMONG HAD NO WAY TO SERVICE, SO THE HMONG HAD TO ESCAPE FROM LAOS AT THE TIME AND CAME TO AMERICA. THE HMONG ALREADY HAVE SO MANY DIFFICULTIES. SOME STRESS, TRAUMA, AND WHATEVER HAPPENED IN LAOS.

THE HMONG ARRIVED TO THE U.S. ABOUT 25 TO 35,000 PEOPLE LIVED NEAR SACRAMENTO. THEY FACED 4,000-PLUS HMONG PEOPLE WHO JUST RECENTLY CAME FROM THAILAND TO SACRAMENTO. RECENTLY. SO THE HMONG FACE A LOT OF DIFFICULTIES. THEY DON'T HAVE THE LANGUAGE, THE CULTURE, AND THEY ALSO DON'T HAVE THE WORK EXPERIENCE HERE IN THIS COUNTRY.

SO THE HMONG -- THEY ALSO HAVE DIFFICULTIES RAISING CHILDREN IN AMERICA BECAUSE -- SO THE HMONG HAVE MANY PROBLEMS AND MENTAL ILLNESS AND COMMIT SUICIDE BECAUSE OF THOSE ISSUES. WE HMONG PEOPLE ASK API COMMITTEE AND HELP THE HMONG PEOPLE AND API PEOPLE SO WE CAN REDUCE THE CRIME OF PEOPLE WHO WANT TO STAY PEACEFULLY AND QUIETLY. THANK YOU VERY MUCH. (APPLAUSE).

>>AUDIENCE MEMBER: GOOD EVENING. I'M HERE TO SPEAK IN SUPPORT OF TRANSCULTURAL WELLNESS CENTER. I'M THE DIRECTOR OF THE STUDIES PROGRAM AT STATE UNIVERSITY SACRAMENTO. I'M THE AUTHOR OF THE BOOK "THE CONTEMPORARY ASIAN EXPERIENCE" WHICH WILL BE PUBLISHED IN THE THIRD EDITION. THE CULTURE AND SOCIAL RELATIONSHIPS THAT FORM THE FUNDAMENTAL ISSUES OF ASIAN ISLANDERS TODAY.

FOCUS ON ETHNIC IDENTITY AND MENTAL HEALTH. THE ASIAN/PACIFIC ISLANDERS IS A HOMOGENEOUS GROUP RELATIVELY FREE OF ADJUSTMENT AND MENTAL HEALTH PROBLEMS.

AND DRAMATIC ROLES IN FAMILIES AS WELL AS SOCIETAL CHALLENGES TO INDIVIDUAL AND ETHNIC IDENTITY THAT CAN LEAD TO SERIOUS MENTAL HEALTH CONCERNS.

A NUMBER OF STUDIES HAVE FOUND A COMBINATION OF MINORITY STATUS; RACISM, CULTURAL CONFLICTS, REFUGEE EXPERIENCES, AND LINGUISTIC ISOLATION ARE ALL SOURCES OF STRESS FOR MANY IN THE API COMMUNITY.

WITHIN THIS CULTURALLY APPROPRIATE MENTAL HEALTH SERVICES AND CULTURAL SERVICES, MENTAL HEALTH SERVICES ARE GREATLY NEEDED. THE MOST DRAMATIC EXAMPLE IS IMMEDIATELY AFTER THE 1989 SCHOOLYARD SHOOTING IN STOCKTON. LEFT FIVE CHILDREN DEAD AND 40 WOUNDED. IN RESPONSE TO THE SHOOTINGS OVER 120 MENTAL HEALTH CLINICIANS CAME TO STOCKTON TO HELP THE GRIEVING FAMILIES.

IT CALLED FOR A GREAT DEAL OF -- WELCOMING THE TRADITIONAL GROUP AND GROUP THERAPY PRACTICES. BILINGUAL AND BICULTURAL API STAFF MEMBERS HAVE UNDER PREPARED IN THE WORK FORCE AND SUBCONTRACTORS.

ADEQUATE MENTAL HEALTH WITH PROPER RECRUITMENT OF TRAINED SERVICE PROVIDERS. THE TRANSCULTURAL WELLNESS CENTER WILL PROVIDE MUCH NEEDED SERVICES TO THE ASIAN/PACIFIC ISLANDER COMMUNITY. THE TRANSCULTURAL WELLNESS CENTER WILL PROVIDE OPPORTUNITIES FOR SOCIAL WORK, COUNSELING EDUCATION AND EDUCATIONAL PSYCHOLOGY IN STATE UNIVERSITIES AND OTHER UNIVERSITIES AND COLLEGES TO HAVE A PLACE TO RECEIVE PRACTICE HOURS AND PROFESSIONAL SUPERVISION. THIS WILL SERVE TO INCREASE SACRAMENTO'S COUNTY CAPACITY TO PROVIDE MORE IMPORTANT MENTAL HEALTH SERVICES FOR THE ASIAN/PACIFIC ISLANDER COMMUNITIES IN THE FUTURE. THANK YOU VERY MUCH. (APPLAUSE).

>>AUDIENCE MEMBER: THANK YOU. MY NAME IS MARGIE K. AND I'M THE PRESIDENT OF ACT, WHICH IS THE AMBASSADORS PROJECT FOR THE GAY AND LESBIAN COMPANY. I'M HERE TO SPEAK ON BEHALF OF THE TRANSCULTURAL WELLNESS CENTER. BESIDES THE GENDER AND ETHNICITY AND SOCIETY AND G.L.B.T. MEMBERS AND FAMILIES ARE TREATED FOR THE ISOLATION AND SILENCE THAT DR. JENNIFER CHOY SPOKE ABOUT, BECAUSE THEY HAVE VIOLENCE AGAINST THE ASIAN POPULATION IN GENERAL AND THE ASIAN G.L.B.T. COMMUNITY IN PARTICULAR.

STUDIES DONE BY DR. GREGORY HARRIET AT U.C. DAVIS FOUND THAT GAY AND LESBIAN VICTIMS OF VIOLENCE EXPERIENCE THIS FIVE YEARS AFTER THE ATTACK.

TRANSCULTURAL WELLNESS CENTER WILL INCLUDE SEXUAL ORIENTATION IN TREATMENT MODALITY. (INAUDIBLE) HELLO.

>>AUDIENCE MEMBER: I'M HERE TO SPEAK IN SUPPORT OF THE TRANSCULTURAL WELLNESS CENTER. MY NAME IS O.N. PRESIDENT OF THE SACRAMENTO INCORPORATE. EXECUTIVE BOARD MEMBER FOR PACIFIC ISLANDS CORPORATION. EXECUTIVE COMMITTEE MEMBER FOR REPRESENTING THE PACIFIC ISLANDERS FOR THE CAPITOL AND A TEAM LEADER FOR THE REGIONAL SUPPORT TEAM. I HAVE PROVIDED INTERPRETATION AND TRANSLATION SERVICES FOR 10 YEARS TO ASSIST MONOLINGUAL MAINSTREAM MENTAL HEALTH SERVICES IN SACRAMENTO COUNTY.

ONE OF THE FOREMOST BARRIERS TO MENTAL HEALTHCARE FOR ASIAN/PACIFIC ISLANDERS IS LANGUAGE. LADIES AND GENTLEMEN, WITH ME TONIGHT IS L.D. A FIRST GENERATION TONGAN IMMIGRANT WITH LIMITED ENGLISH PROFICIENCY. SHE HAD NO ACCESS TO INFORMATION IN HER OWN LANGUAGE ABOUT WHAT MENTAL HEALTH AND MENTAL HEALTH ILLNESS IS. WHAT SERVICES WERE AVAILABLE TO HER AND HOW TO ACCESS THESE SERVICES.

BECAUSE OF THIS LANGUAGE BARRIER AND UNTREATED MENTAL HEALTH ILLNESS SHE SUFFERED MANY YEARS. INCLUDING INCREASED MARITAL PROBLEMS. LOSING HER CHILDREN. INCARCERATED AND MISDIAGNOSED WHILE IN -- WHILE WITH MENTAL HEALTH ILLNESS. UPON DISCHARGE THERE WAS NO INFORMATION TO SERVICES. BECAME HOMELESS AGAIN AND WHILE BEGGING ON THE STREET ONE EVENING HER COMMUNITY LEADER, ONE OF HER COMMUNITY LEADERS, LUCY RECOGNIZED HER VOICE. AND IT TOOK HER AWHILE TO PERSUADE RENEE THAT HER COMMUNITY CARED FOR HER. LUCY TOOK HER TO HER HOME AND CALLED ME. SINCE THAT EVENING, RENEE -- HER OFFICER WAS CONTACTED. SHE WAS CONNECTED WITH ASIAN/PACIFIC COMMUNITY CENTER AND MENTAL HEALTH TREATMENT AND OTHER SERVICES INCLUDING GOING BACK TO SCHOOL. LUCY IS THE VICE PRESIDENT OF THE SACRAMENTO (INAUDIBLE) THAT OPERATE WITH VOLUNTEERS.

RENEE IS AN ASIAN/PACIFIC ISLANDER CITIZEN WHO WILL BENEFIT FROM THE TRANSCULTURAL WELLNESS CENTER. A ONE STOP CENTER THAT WILL PROVIDE MENTAL HEALTH CARE INCLUDING PSYCHOTHERAPY AND MEDICATION SUPPORT AND WOULD GREATLY ENHANCE THE QUALITY OF MENTAL HEALTH SERVICES TO MONOLINGUAL API. THANK YOU. RENEE.

>>AUDIENCE MEMBER: API WELLNESS CENTER. I NEED HELP AND KNOW THIS PROGRAM WILL HELP FRIENDS LIKE ME. THANK YOU VERY MUCH. (APPLAUSE).

>>AUDIENCE MEMBER: I'M HERE TO SPEAK IN SUPPORT OF THE TRANSCULTURAL WELLNESS CENTER. TOGETHER FOR ADVOCACY AND LEADERSHIP. UMBRELLA ORGANIZATION OF 100 PACIFIC ISLANDER GRASS ROOTS. AND A GRASS ROOTS COMMUNITY GROUP.

MANY SACRAMENTO ASIAN/PACIFIC ISLANDER OLDER ADULTS ARE NOT GETTING WHAT THEY NEED (READING DOCUMENT.) AND DUE TO LACK OF OUTREACH TO HELP THEM BECOME AWARE WHAT THEY ARE EXPERIENCING IS TREATABLE MENTAL HEALTH SYSTEMS.

THIS IS PARTICULARLY TRUE FOR KOREAN AMERICANS. AMONG KOREAN OLDER ADULTS IN SACRAMENTO OVER THE AGE OF 59, 91% WERE RELATIVELY RECENT IMMIGRANTS. ONLY 5% A FAIR ENGLISH LANGUAGE PROFICIENCY. NINETY-FIVE PERCENT HAD SOME POOR OR NO LANGUAGE PROFICIENCY. FORTY-TWO PERCENT REPORTED SYMPTOMS OF DEPRESSION AND/OR PSYCHOSOMATIC SYMPTOMS.

-- (READING DOCUMENT) -- DO NOT HAVE ACCESS TO INFORMATION IN THEIR OWN LANGUAGE ABOUT MEDICATIONS THAT ARE AVAILABLE -- THEY ARE NOT FAMILIAR WITH OUR HEALTHCARE SYSTEM IN THIS COUNTRY. BEING DEPENDENT ON OTHERS FOR TRANSPORTATION. THEY RATHER SIT QUIETLY RATHER THAN BE A BURDEN.

TO PROVIDE EQUITABLE AND QUALITY CARE TO THIS POPULATION THE TRANSCULTURAL WELLNESS CENTER WOULD FILL A GAP FOR THOSE WHO ARE MONOLINGUAL AND MENTAL HEALTH NEEDS ARE IGNORED BY THE CURRENT SYSTEM. IT WOULD BE A STEP TO CORRECT THE INEQUITIES FOR API'S IN THIS COUNTY AND FOR THIS REASON THIS CULTURAL CENTER SHOULD BE THE SACRAMENTO COUNTY'S TOP PRIORITY. THANK YOU VERY MUCH. (APPLAUSE).

>>AUDIENCE MEMBER: MY NAME IS G. FROM THE FILIPINO CHRISTIAN FELLOWSHIP. I'M HERE TO SUPPORT THE TRANSCULTURAL CENTER. YOU HEARD A MESSAGE FROM MICHAEL. WITH COLLABORATION WITH THE ASIAN/PACIFIC COUNSELING. HAS BEEN TRYING FOR THE PAST FIVE YEARS AND HAD SUCCESS SLOWLY, BUT WE ARE DOING IT ON OUR OWN. NO FUNDING FROM THE GOVERNMENT. WE ARE USING THE FACILITIES AT OUR OWN CHURCH.

SOMETIME AGO WORKING AS AN INTERN VOLUNTEER WITH THE ASIAN/PACIFIC COUNSELING, I HAD THE OPPORTUNITY TO STUDY DIFFERENT KINDS OF APPROACHES AND EMPHASIZE THE IMPORTANCE OF CULTURAL (INAUDIBLE) AND THE TREATMENT OF MENTAL HEALTH ISSUES. CULTURE MEANS, LANGUAGE, BELIEFS, RELIGIOUS OR SPIRITUAL. MOST PERCENTAGE OF MENTAL HEALTH ISSUES IS THAT CULTURE DECISION IS ASKING FOR HELP IS A SIGN OF WEAKNESS AND THAT EXTENDS TO THE ENTIRE FAMILY. NOT JUST THE INDIVIDUAL SEEKING HELP.

EVEN FOR THOSE WHO DO NOT OVERCOME THE FEAR OF BEING BRANDED AS LOCAL OR CRAZY, THE SERVICES BY THE DIRECT CONFLICT WITH CULTURAL BELIEFS. MAINSTREAM CULTURE COMPETENTLY DISCUSS, THAT TYPE OF DISCUSSION IS IMPOSSIBLE TO CONSIDER FOR FILIPINOS.

ADMISSION OF PROBLEMS. CONFLICTS ARE VIEWED AS AIRING OUT ONE'S DIRTY LAUNDRY. INSTEAD OF DISCUSSION, FILIPINOS WILL REMAIN SILENT OR MINIMIZE THE SITUATION. FILIPINOS IN NONCULTURAL SERVICES, SUCCESSFUL TREATMENT IS ALMOST AN IMPOSSIBILITY. EVERYBODY LOSES LANGUAGE AND CULTURE AND ASSIMILATED BY DOMINANT SOCIETY.

I HAVE LEARNED THAT RELIGIOUS NOMINATIONS THAT SEND MISSIONARIES OVERSEAS TEACH THE CULTURAL VALUES, CUSTOMS IN ALL LANGUAGES OF THAT PARTICULAR COUNTRY. SINCE MY ARRIVAL IN THE UNITED STATES THE OVERWHELMING FEELING HAS NOT LEFT ME OVER 45 YEARS DUE TO DIFFERENT EXPERIENCES IN DEALING WITH PARTICULAR ISSUES. THE INDIFFERENCE OF CULTURE OF VALUES EVEN MY OWN COUNTRYMAN AND OUTLOOK MEANING OF LIFE, PROVINCES TWO OR THREE DIALECTS BECOMES THE ISSUE. TRY TO GET INTO THE SYSTEM THAT IS FULL OF QUESTIONS. PEOPLE CALL IT GREEK. TO THEM THEY CANNOT UNDERSTAND THIS.

>>AUDIENCE MEMBER: HELLO. MY NAME IS N.B. I'M A SOCIAL WORKER FOR SACRAMENTO COUNTY PROTECTIVE SERVICES. I'M ALSO ACTIVE IN THE FILIPINO COMMUNITY IN SACRAMENTO AND BELONG TO SEVERAL FILIPINO ORGANIZATIONS AND ASIAN GROUPS. I'VE BEEN WORKING AS A SOCIAL WORKER FOR 27 YEARS. MY FIRST JOB WAS A FILIPINO WORKER FOR ASIAN/PACIFIC COUNSELING. I'M SUPPORTING YOUR PLAN RECOMMENDATION FOR THE TRANSCULTURAL WELLNESS CENTER.

I BELIEVE THAT IT IS IMPORTANT THAT THIS CENTER BE REALIZED BECAUSE FOR MY PAST EXPERIENCES IN MY PROFESSION, THE BILINGUAL BICULTURAL STAFF IS MUCH NEEDED IN OUR COMMUNITY. I HAVE WORKED WITH PEOPLE FROM ALL WALKS OF LIFE AND ETHIC BACKGROUND. I WORK WITH FAMILIES, WITH SENIOR CITIZENS, WITH YOUNG CHILDREN, WITH YOUTH.

I KNOW WHAT IT IS LIKE TO WORK WITH SOMEONE WHO DOESN'T SPEAK ENGLISH; MUCH LESS UNDERSTAND THE AMERICAN WAY OF LIFE.

IMAGINE WHAT IT WOULD BE LIKE TO THE CLIENT/PATIENT. I'M A FAMILY OF SUCH A CLIENT WHO DOES NOT SPEAK ENGLISH OR UNDERSTAND THE WORKINGS OF OUR MENTAL HEALTH SYSTEM WHEN THERE'S A CRISIS SITUATION. IMAGINE FEELING LOST, FRUSTRATED, NOT KNOWING WHAT TO DO OR HOW TO HANDLE THE SITUATION. I DON'T THINK I NEED TO SAY MORE ABOUT THAT.

IN MY PAST EXPERIENCES AS AN ASIAN/PACIFIC CLIENTELE HAVE TO DO WITH WHAT LITTLE THEY HAVE AND KNOW OF OR SUFFER QUIETLY. A FEW BILINGUAL PROFESSIONALS HAVE TRIED TO ASSIST AS BEST THEY CAN.

IN MY CURRENT WORK, I HAVE BEEN ASKED TO ASSIST IN THE BICULTURAL EXPERIENCE WHEN THE OTHER CO-WORKER IS WORKING WITH A FAMILY. I'M NOT A CERTIFIED FILIPINO BICULTURAL WORKER. BECAUSE MY COLLEAGUES KNEW THE QUALITY OF MY WORK AND BACKGROUND, I'VE BEEN ASKED REPEATEDLY TO DO THIS SERVICE.

THIS HAPPENS TO OTHER PROFESSIONALS WHO HAVE THE KNOWLEDGE OF YOUR CULTURE AND WILL STEP IN TO HELP. I KNOW OF FILIPINO CLERKS ASKED TO INTERPRET EVEN THOUGH IT'S NOT PART OF THEIR JOB DESCRIPTION OR PROFESSIONAL TRAINING.

CAN YOU SEE THE DETRIMENT TO THE CLIENT IN SUCH A SCENARIO? I KNOW YOU KNOW HOW IMPORTANT IT IS TO HAVE A CORRECT DIAGNOSIS. HOPEFULLY THIS BOARD WILL PREVENT ANY INAPPROPRIATE MENTAL HEALTH TREATMENT BY HAVING A REAL MULTI STAFF, MULTICULTURAL FOR DIFFERENT NEEDS FOR MENTAL HEALTH SERVICES.

I COMMEND YOU THUS FAR. THANK YOU.

ANITA SHOEMAKER: TIME.

>>AUDIENCE MEMBER: GOOD EVENING. I'M HERE TO SPEAK AS A PART OF THE TRANSCULTURAL WELLNESS CENTER. MY NAME IS NAOMI AND I'M A MEMBER OF THE INDIGENOUS ISLANDER CENTER. AND WORK TOGETHER TO ADDRESS THE NEEDS OF POLYNESIAN COMMUNITY. AND I'M WITH THE SAMOAN COMMUNITY. AND IN TURN EVEN A SMALLER COMMUNITY IN THE API COMMUNITY AND EVEN SMALLER IN SACRAMENTO. BUT WE DO HAVE A COMMUNITY OF PEOPLE THAT DUE TO THE CULTURE, IT'S THE NORM TO SUFFER SILENTLY.

AND IT IS THE NORM TO ACCEPT DOMESTIC VIOLENCE AND TO SEEK OUT SERVICES OR NOT EVEN KNOW THAT THOSE IN THEMSELVES ARE ILLNESSES THAT CAN BE KILLED AND HELPED IS NOT DONE BECAUSE IT WILL BRING SHAME TO THE FAMILY.

AFTER SAYING THAT, I WANT LET YOU KNOW THAT I DID LOOK AT THE PROPOSAL. AND WHAT I ASK YOU TONIGHT IS THAT NOT ONLY DO YOU SUPPORT THIS PROPOSAL BUT PLEASE PROVIDE ENOUGH FUNDING FOR THIS PROPOSAL SO THAT IT WILL HAVE ENOUGH OF THE EXPERTISE AND PROFESSIONALS TO PEOPLE INVOLVED IN THE API COMMUNITY. I GOT INVOLVED BECAUSE SOMEONE IN MY COMMUNITY NEEDED HELP AND WHEN I LOOKED AROUND THERE WAS NO GROUP TO GO TO. I APPROACHED ONE OF THE API COMMUNITY, APPC AND FROM THEN ON JUDY HAS HELPED US TRY TO CREATE SOMETHING LIKE THIS.

I WAS VERY EXCITED WHEN SHE CALLED US TO SUPPORT THIS AND WORK ON THIS PROPOSAL. I URGE YOU PLEASE, EVEN THOUGH WE ARE A SMALL MINORITY IN THIS COMMUNITY, WE SUFFER JUST THE SAME.

>>AUDIENCE MEMBER: I'M HERE TO SPEAK IN SUPPORT -- THANK YOU. I AM HERE TO SPEAK IN SUPPORT OF THE TRANSCULTURAL WELLNESS CENTER. MY NAME IS A. MULA. LOAN TASK FORCE. AND WITHOUT WOMEN'S ASSOCIATION, I HAVE PROVIDED INTERPRETATION AND TRANSLATION AND HELP SUPPORT SERVICES FOR FIVE USERS TO ASSIST MONOLINGUAL MEN AND ACCESS MAINSTREAM -- THE PRIMARY BARRIERS TO MENTAL HEALTH IS LANGUAGE.

(READING DOCUMENT) -- LIMITED ENGLISH HAVE VERY LITTLE ACCESS TO INFORMATION IN THEIR OWN LANGUAGE ABOUT WHAT MENTAL HEALTH AND MENTAL HEALTH ILLNESS IS, WHAT SERVICES ARE AVAILABLE TO THEM, AND HOW TO ACCESS THESE SERVICES. THE CARE THEY RECEIVE IS COMPROMISED BY HAVING TO GO THROUGH AN INTERPRETER. IN A RECENT COMMUNITY MENTAL HEALTH AWARENESS WORKSHOP THAT WE FACILITATED FOR HMONG SPEAKING REFUGEES. FIFTY-THREE OF THE 55 PARTICIPANTS INDICATED THAT THEY FREQUENTLY EXPERIENCED ANXIETY, DEPRESSION AND DISORDERS.

ALL OF THE PARTICIPATORS LACK OF AWARENESS OF MENTAL HEALTH SERVICES AND INABILITY TO ACCESS SERVICES DUE TO LANGUAGE AND CULTURAL AND SYSTEMIC DIFFERENCES.

THIS IS JUST ONE EXAMPLE OF MANY EXAMPLES OF THE DIRE NEED OF OUR COMMUNITY FOR COMPREHENSIVE AND CULTURE RESPONSIVE MENTAL HEALTH CARE. THE TRANSCULTURAL WELLNESS CENTER WILL PROVIDE FULL SERVICE TO MONOLINGUAL ASIAN/PACIFIC ISLANDER COMMUNITIES. I ASK YOU TO SUPPORT THIS.

>>AUDIENCE MEMBER: HELLO. MY NAME IS VIVA VANG. I AM IN FAVOR OF THE TRANSCULTURAL WELLNESS CENTER. THIS IS A STEP TOWARD MEETING THE NEEDS OF THE API COMMUNITY. IT ALSO LEADS TO AN OPPORTUNITY TO FOCUS ON THE MENTAL HEALTH NEEDS OF THE HMONG COMMUNITY. AS A PROFESSIONAL I HAVE SEEN THAT THERE IS A HIGH NEED IN THE HMONG COMMUNITY. MANY HMONG INDIVIDUALS GO UNTREATED DUE TO LACK OF ACCESS, LACK OF SERVICES, AND LACK OF BILINGUAL, BICULTURAL STAFF. ASHAMED THAT THEY MAY EMBARRASS THEIR FAMILY -- MENTAL HEALTH SERVICES. AS A RESULT HMONG INDIVIDUALS WHO NEED MENTAL HEALTH SERVICES GO UNDIAGNOSED AND UNTREATED FOR YEARS.

WHEN HMONG INDIVIDUALS SEEK SERVICES, THEY ARE MORE SEVERE. IT COULD HAVE BEEN PREVENTED AND TREATED IF THEY ARE LINGUISTICALLY IN PLACE.

ANOTHER BARRIER TO MENTAL HEALTHCARE THAT IS REPEATEDLY REPORTED IN THE API COMMUNITY IS LANGUAGE. FOR THE HMONG COMMUNITY THIS IS ONE OF THE GREATEST OBSTACLES. RECENT AND FORMER REFUGEES WHO HAVE BEEN LIVING IN THE U.S. FOR THE PAST 30 YEARS STILL RELY ON ORAL COMMUNICATION. USED IN THE MAINSTREAM MENTAL HEALTH SERVICES TODAY BECAUSE THEY CANNOT READ OR WRITE IN HMONG. MANY CONCEPTS APPLY TO THE MAINSTREAM SOCIETY ARE NOT CULTURALLY APPROPRIATE TO THE HMONG COMMUNITY.

FOR INSTANCE, AS A GROUP COUNSELOR WHEN THE DISCUSSION OF SELF-CARE COMES UP IN COUNSELING, NONE OF THE EXAMPLES THAT I USE OR BROUGHT UP IN SESSION BASED IN MY WESTERN TRAINED EDUCATION SUCH AS TAKING A BATH, GOING FOR A WALK, WRITING IN YOUR JOURNAL, COLORING WITH YOUR CHILDREN ARE NOT HELPFUL TO MID-AGED HMONG WOMEN. WHEN I BROUGHT IN FRESHLY PICKED CORN, THE WOMEN'S GROUP SMILED AND STARTED TALKING ABOUT THE HAPPY DAYS WHEN THEY WERE PRE-TEEN AND SITTING AROUND AT THE FARM.

THE HMONG WOMEN DRESSED THEM UP LIKE THEY DID IN THE OLD DAYS AND NOT WORRIED ABOUT FINANCING OR DISOBEDIENT CHILDREN, BUT THE FOCUS OF RELIVING THOSE HAPPY MOMENTS. I SUPPORT THE PROPOSAL FOR THE TRANSCULTURAL WELLNESS CENTER AS THIS WILL GIVE OPPORTUNITY TO REMOVE OBSTACLES FROM THE HMONG COMMUNITY AND ADMINISTER FULLY SERVICED AND HEALTH SERVICES TO THE HMONG COMMUNITY FOR PREVENTION AND SERVICES. THANK YOU. (APPLAUSE).

>>AUDIENCE MEMBER: I'M HERE TO SPEAK IN SUPPORT OF THE TRANSCULTURAL WELLNESS CENTER. MY NAME IS P.K. BANKS. I HAVE WORKED DIRECTLY IN THE HMONG COMMUNITY FOR SEVERAL YEARS AND TODAY I REPRESENT THE SACRAMENTO TASK FORCE. OUR GROUP IS COMPOSED OF COMMUNITY MEMBERS, LOCAL LEADERS COMMITTED TO EFFECTING POSITIVE CHANGES IN BUILDING A NETWORK OF COORDINATED SUPPORT FOR THE HMONG COMMUNITY.

SACRAMENTO IS HOME TO HUNDREDS OF HMONG FAMILIES MAKING IT ONE OF THE LARGEST INHABITED COUNTIES IN THE UNITED STATES. IT IS THE FIRST GENUINELY EFFORT TO -- ASSOCIATED WITH MENTAL HEALTH ILLNESS AND THE LACK OF CULTURALLY SENSITIVE AND RESPONSIVE MENTAL HEALTH SERVICES TO OUR COMMUNITY.

MANY HMONG CHILDREN OF REFUGEE PARENTS HAVE SHARED WITH ME AND TALK ABOUT BEING CAUGHT BETWEEN TWO WORLDS AND FITTING INTO NEITHER. THEY FEEL ALIENATED FROM BOTH CULTURES AS THEY ATTEMPT TO BALANCE THE DIFFERENCE AND SOMETIMES OPPOSING CULTURAL PRACTICES, VALUES AND EXPECTATIONS WITH LITTLE SUPPORT OR ASSISTANCE.

IN THEIR LONGING TO FEEL ACCEPTABLE AND TO BELONG THEY MAY TURN TO THE WRONG CROWD, JOIN GANGS, PARTICIPATE IN CRIMINAL ACTIVITIES, DROP OUT OF THE SCHOOL, AND GET MARRIED YOUNG, AND BECOME TEEN PARENTS, AND ABUSE ALCOHOL.

ACCORDING TO THE RESULTS OF A REALITY SURVEY ADMINISTERED IN 2004-2005 IN THE HMONG CIRCLE PROGRAM, 53 PARTICIPANTS STATED THAT THEY HAVE USED DRUGS OR ALCOHOL. EIGHT PERCENT REPORTED THAT THEY DO USE DRUGS OR ALCOHOL ON A REGULAR BASIS. ANOTHER 58 PARTICIPANTS STATED THAT THEY WERE EITHER HIT OR BEATEN BY SOMEONE. FIFTY-EIGHT PERCENT ALSO STATED THAT THEY HAVE BEEN INVOLVED IN A VIOLENT ACT OF HITTING SOMEONE ELSE. SIXTY-NINE PERCENT SAID THAT THEY WERE OFTEN -- FEEL THAT THEY ARE DEPRESSED. THIRTY-THREE PERCENT ATTEMPTED SUICIDE. AND FOURTEEN PERCENT SAYS THAT THEY HAVE CONTEMPLATED SUICIDE.

LITTLE OR NO SUPPORT FOR RESOURCES AND DEPRESSED AND DROPPING OUT OF SCHOOL AND BECOMING INVOLVED IN GANG ACTIVITIES.

EARLY PREVENTION WILL REALLY HELP OUR COMMUNITY. (APPLAUSE).

>>AUDIENCE MEMBER: GOOD EVENING. MY NAME IS TONIO. I'M THE PRESIDENT OF THE ORGANIZATION UNDER THE PACIFIC ISLANDERS. WE ARE IN CHARGE OF THE PACIFIC ISLANDERS WHO KNOW AND UNDERSTAND URGENCY TREATING PACIFIC ISLANDERS.

I WOULD LIKE TO FOCUS IN ON MENTAL HEALTH IN PACIFIC ISLANDS. I CONCUR WITH EVERYTHING THAT HAS BEEN SAID, BUT I WOULD LIKE TO GO A LITTLE BIT FURTHER AND SAY A LITTLE BIT MORE FROM MY EXPERIENCE.

WHILE IN THE ISLANDS, I HAVE EXPERIENCED A LOT AND I'VE ALSO WORKED WITH PEOPLE WITH MENTAL HEALTH IN THIS. IN THE PACIFIC ISLANDS, WE DON'T HAVE A NAME FOR MENTAL ILLNESS. THEY DON'T KNOW HOW TO IDENTIFY WHAT IS MENTAL ILLNESS. WHEN I STARTED TO WORK HERE IN THE UNITED STATES, I FOUND THAT THE SYMPTOMS THAT I HAD EXPERIENCED WERE EVERYTHING HAVING TO DO WITH MENTAL ILLNESS. THEY SUFFER FROM BIPOLAR AND SCHIZOPHRENIA AND A LOT OF DEPRESSION.

AND I'M THINKING WHILE I WAS HERE -- I WAS THINKING, WELL, I HAD NO IDEA HOW RAMPANT MENTAL HEALTH IS IN THE PACIFIC ISLANDERS. THE WOMEN ARE UNDER SUCH STRESS AND DEMANDS, BECAUSE ITS CULTURE IS RUN BY MEN. I HOPE AND I PRAY THAT YOU WILL TAKE INTO CONSIDERATION THE MONEY THAT GOES INTO THE MENTAL HEALTH FOR THE PACIFIC ISLANDERS. ASIAN/PACIFIC ISLANDERS, I SHOULD SAY. AND I THINK MIGHT BE ABLE TO TEACH MENTAL ILLNESS AMONG THOSE WHO COME IN AND SEEK FOR HELP.

SOME OF THE THINGS THAT I'VE ALSO NOTICED IS THERE'S INEFFECTIVE TRAINING IN THE OUTREACH METHOD THAT I SEE TODAY. IGNORANCE OF CULTURAL VALUES AND SPIRITUAL VALUES ARE MINUS. BREAKING THE STIGMA AMONG MENTAL ILLNESS IS IMPOSSIBLE. BUT WITH FUNDING A HELP WE COULD GET REALITY. WE HAVE PACIFIC ISLANDERS IN TRAINING AND GETTING EXPERIENCE, BUT WE WOULD LIKE TO SEE MORE.

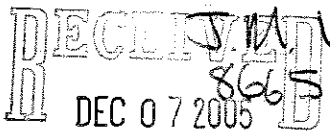
ASIAN/PACIFIC ISLANDERS ARE PROUD PEOPLE AND NOT SEEK HELP EASILY. PLEASE, I CALL OUT FOR HELP ON BEHALF OF MY PEOPLE AND THOSE THAT ARE HERE TODAY AND THANK YOU VERY MUCH.

Attachment C

Comments on
Wellness and Recovery Center

Dec. 7, 2005

I support the
Wellness and Recovery Center.



Sincerely, Willis
8665 Florin Rd #17
Sacramento, CA
95828

Attachment C

Comments on Other

>>AUDIENCE MEMBER: MY NAME IS JOHNNY W. AND I'M FROM THE NATIONAL LIFE, THE MENTALLY ILL. IS THERE ANYONE HERE WHO IS A SCHIZOPHRENIC WHO HAS NEVER BEEN RAPED OR HAS A LOVED ONE THAT HAS BEEN RAPED? THAT INCLUDES ME. SOME TOO MANY PEOPLE. I'M REPRESENTING THOSE SCHIZOPHRENICS WHO ARE OUT ON THE STREETS. THERE'S NO WAITING LIST FOR SECTION 8. WE DON'T KNOW HOW BIG THE PROBLEM IS FOR HOUSING.

THERE'S NO REASONABLE ESTIMATE HOW MANY PEOPLE ARE IN NEED. THE CITY HAS FLOODED DOWNTOWN WITH LOFTS. VINTAGE LOOKING CONDOMINIUMS AND -- WE DO NOT GET FOOD STAMPS. THAT'S ILLEGAL. IF YOU HAVE TWO EVICTIONS OR TWO EVICTIONS OR BAD CREDIT, YOU CAN BE PREVENTED FROM GETTING ANY HOUSING AT ALL. JUST LIKE SENIOR LIVING, WE NEED DISABLED LIVING ESPECIALLY FOR MENTALLY ILL PEOPLE WHO BECOME THE PERFECT VICTIM OUT ON THE STREET. WHEN SOMEBODY GOES BACK TO PRISON FOR RAPE THEY PICK ON PROSTITUTES AND MENTALLY ILL WOMEN. MY COUSINS HAVE BEEN RAPED AND MURDERED. ANOTHER ONE WAS RAPED AND MY OTHER COUSIN JUST COMMITTED SUICIDE ON NOVEMBER 16TH BECAUSE HE DIDN'T HAVE HOUSING AND HE WAS HOMELESS. THEY DON'T WANT TO GO BACK TO PRISON AND THAT'S WHY THEY RAPE PROSTITUTES. AND THEY TAKE OUT VIOLENCE ON THE PROSTITUTES.

IT HAPPENS THAT MANY SCHIZOPHRENIC MEN ARE -- I'M NOT COMFORTABLE UP HERE TELLING A GROUP OF STRANGERS THAT I'VE BEEN SEXUALLY ASSAULTED. AFTER EIGHT YEARS, I COULD NOT SPEAK OR UNDERSTAND THINGS SUCH AS "DO YOU WANT COFFEE." SINCE THEN I'VE TRIED TO COMMIT SUICIDE 14 TIMES. RONALD REAGAN LET THE MENTALLY DISABLED OUT AND UNDERSTANDING THAT THE COUNTY WOULD PROVIDE HOUSING. IF HE DIDN'T HAVE A LOVING FAMILY HE WOULD BE OUT ON THE STREET BEGGING FOR MONEY.

I USED TO BE A MENTAL HEALTH WORKER AND THAT HELPED ME DEAL WITH THE SEXUAL ASSAULT THAT I WENT THROUGH. IT CAN HAPPEN TO ANYONE EVEN THOSE IN THE MENTAL HEALTH PROFESSION.

ONE PERCENT -- THE WORLD HEALTH ORGANIZATION SAYS ONE PERCENT OF THE POPULATION HAS SEVERE MENTAL ILLNESS. WE ARE EXPECTED TO GROW 20 MILLION PEOPLE IN THE NEXT 20 YEARS THAT'S 20,000 SEVERELY DISTURBED PEOPLE WHO DO NOT HAVE HOUSING AND ARE OUT ON THE STREETS WHO WILL BE THE VICTIMS.

THERESA ROBERTS: I'M SORRY; YOU WILL HAVE TO ALLOW SOMEONE ELSE TO SPEAK NOW.

>>AUDIENCE MEMBER: I WANT TO CLOSE THAT THE POLICE HAVE -- NOT TOO MANY HOMELESS PEOPLE WHO HAVE BEEN RAPED ARE SCHIZOPHRENIC, SO LET'S KEEP THAT ON THE RECORD. (APPLAUSE).

>>AUDIENCE MEMBER: I DO HAVE A PREPARED STATEMENT BUT I'M NOT GOING TO READ FROM THAT. MIKE LEE. ASSOCIATE VICE PRESIDENT CALIFORNIA STATE UNIVERSITY SACRAMENTO AND SERVE ON THE BOARD OF ATTC. I WANT TO SAY SOMETHING ABOUT THE STAFF THAT HAS BEEN WORKING IN THE MENTAL HEALTH AREA. THIS IS A PROFESSION UNFORTUNATELY HAS NOT BEEN PROPERLY REWARDED MONETARILY. IT TAKES A LONG TIME TO PREPARE A GOOD MENTAL HEALTH WORKER AND I WANT TO APPRECIATE THOSE PEOPLE AND MANY OF THE PROGRAMS PROPOSED HERE TODAY WILL PROVIDE OPPORTUNITY FOR THEM. AND I THANK YOU FOR THAT. (APPLAUSE).

>>AUDIENCE MEMBER: TWO THINGS THAT HAVE BEEN TOUCHED ON. ONE IS WEAVE. A SELF-HELP ORGANIZATION FOR WOMEN WHO HAVE BEEN RAPED AND MEN WHO HAVE BEEN RAPED. WEAVE REALLY MAKES A DIFFERENCE AND THEY ALSO HAVE THRIFT STORES THAT YOU CAN DONATE TO. A LOT OF PEOPLE ARE NOT COMFORTABLE TALKING TO AN OFFICER. WEAVE CAN TRANSLATE THE INFORMATION TO THE POLICE WITHOUT HAVING THEM TO DO THAT.

THE OTHER FANTASTIC ORGANIZATION THAT TONY TOOK 16 YEARS TO HELP BUILD IS RIVER OAK CENTER FOR CHILDREN WHICH TREATS CHILDREN THAT ARE PRIMARILY THE VICTIMS OF INCEST AND SEXUAL RAPE. IT'S SO FANTASTIC BASED ON POSITIVE REINFORCEMENT. WHEN I WAS THERE BEFORE I BECAME MENTALLY ILL IN 1990, WE SAW 43 CHILDREN COULD NOT GO INTO FOSTER CARE BECAUSE THEY WOULD MOLEST THEIR SIBLINGS. IT'S ALL BASED ON POSITIVE REINFORCEMENT AND THIS MAN IS A GREAT HERO SO I JUST WANTED TO BRING THAT UP THAT WE NEED TO KEEP IN MIND THAT WE DO HAVE MENTALLY ILL CHILDREN. AND WHEN THEY TURN 18, WHAT HAPPENS TO THEM? (APPLAUSE).