SACRAMENTO COUNTY

MENTAL HEALTH SERVICES ACT

COMMUNITY SERVICES AND SUPPORTS PLAN

IMPLEMENTATION PROGRESS REPORT
January 2007 – December 2007

JUNE 30, 2008

Introduction

In August of 2007, Sacramento County submitted an Implementation Progress Report on the Community Services and Supports (CSS) Component of the Three-year Program and Expenditure Plan for 2005 through December 2006. In accordance with the State Department of Mental Health (DMH) Information Notice Number 08-08, this Implementation Progress Report for the CSS Component will cover the timeframe of January through December 2007.

Sacramento County has three (3) Full Service Partnership (FSP) programs and two (2) General System Development (GSD) programs. No specific Outreach and Engagement (O&E) programs were developed. Instead, O&E services were built into all five program plans with the expectation that each program would conduct targeted outreach to specific communities based on community needs and preferences.

The three FSP programs are: 1) Pathways to Success after Homelessness, 2) Sierra Elder Wellness Program, and 3) Transcultural Wellness Center. Pathways to Success after Homelessness (Pathways) provides integrated services and supports for homeless individuals and families of all ages. The Sierra Elder Wellness Program (Sierra) provides intensive integrated services and supports for older adults. The Transcultural Wellness Center provides integrated services and supports designed to meet the cultural and linguistic needs of the Asian and Pacific Islander communities.

The two GSD programs are: 1) Transitional Community Opportunities for Recovery and Engagement (TCORE) and 2) Wellness and Recovery Center. The TCORE program provides intensive short-term services for individuals discharging from acute care settings until they are linked with ongoing services and supports. The Wellness and Recovery Center provides an array of services in a community-based setting to support individuals in their recovery process.

Sacramento County contracted with community-based service providers for all five (5) MHSA Programs.

A. Program/Services Implementation

1) The County is to report, by Work Plan, on how implementation of the approved program/services is proceeding including: a) whether implementation activities are proceeding as described in the County's approved Plan; b) the percent of anticipated clients enrolled; and c) the major implementation challenges that County has encountered.

Pathways to Success after Homelessness

The provider, Turning Point Community Programs (Turning Point), was one of the first MHSA programs to enroll members of all age groups. Supportive housing, mental health and support services were implemented in accordance with the County's approved CSS Plan with

DMH as well as with Turning Point's contract with Sacramento County. However, the veto of AB2034 impacted the progress being made by the Pathways program. In November of 2007, Sacramento County requested that Pathways discontinue enrolling new members in order to allow for the possible transfer of former AB2034 clients. Prior to that decision, Pathways was on target for 50% enrollment at six months and 100% enrollment at one year. Pathways enrolled the first members on June 30, 2007. As of December 31, 2007 a total of 72 members were enrolled representing 111% of the anticipated 2nd quarter target numbers (65), and 58% of the anticipated FY 07-08 annual target (125).[1]

There were several implementation challenges at both the County and Provider level. Due to a variety of County-related administrative issues, there were delays in getting the Pathways' contract executed, getting approval for additional funding from the local housing authority, and getting the CSS 07-08 Growth Funds augmentation. There was also a delay in obtaining Medi-Cal certification for the new service site. These obstacles reduced the amount of start-up time originally anticipated and affected cash flow for the Provider. There were challenges with regard to capturing the Mode 60 Housing and Flexible Supports expenditures and other MHSA allowable expenses that are prohibited under Medi-Cal. (In order to track expenditures at the client level in the County's existing service tracking and billing system, new treatment codes were developed.) The process associated with billing to these new codes has been cumbersome and time consuming at the Provider level. Finally, Pathways had to address stigma and discrimination issues toward clients at their new site. Although they worked hard with neighbors and property management on resolving these issues, the decision was made to move to the site that was being vacated by the AB2034 program. The move was time consuming and administrative issues led to a six-week gap in being able to enter billings for services rendered.

Sierra Elder Wellness Program

The Sierra Elder Wellness Program is administered by El Hogar and serves older adults with complex psychiatric medical, substance abuse and social service needs. For the most part, Sierra has implemented services and activities in accordance with the approved Plan. Due to a slow start-up and graduated enrollment, Sierra had time to adequately train staff on the documentation and reporting requirements. The County's Research, Evaluation and Performance Outcomes Unit reviewed numerous cases in December of 2007 to determine compliance with FSP reporting requirements. Overall the documentation results were very good and areas of improvement were identified and addressed.

[1] After Sacramento County submitted the CSS Plan, DMH released regulations containing the definition of "target" as it relates to Exhibit 6 reporting. Consequently, the County's definition of target differed from the definition in the released regulations. Upon consultation with DMH, the County was instructed to report Exhibit 6 numbers using the definition in the regulations, although they will not match the Exhibit 6 numbers in the approved CSS Plan. The County adjusted the target numbers as appropriate and has submitted Exhibit 6 numbers based on the new definition of "target".

Sierra provided home based services until they received Medi-Cal site certification for their new location in late November of 2007. All members were invited to a "get acquainted" lunch on November 29, 2007 and Sierra began conducting group sessions on December 3, 2007. The groups focus on recovery issues, socialization and support for depression and anxiety. Clients are also able to participate in computer lab, cooking classes and other activities suggested by Sierra's members.

There were two areas of implementation that differed from the County's approved CSS Plan. Eighty (80) of the initial referrals were originally designed to come from the County's four (4) outpatient clinics. Despite outreach by Sierra and the County, only one clinic referred the anticipated number of clients, so Sierra began looking for new referral sources. A crucial referral source was the County's Intensive Placement Team, which has referred several clients from locked facilities throughout California and the Mental Health Treatment Center. These clients have the greatest chance of success in maintaining community tenure via enrollment in a Full Service Partnership.

Another change in the approved CSS Plan was in the breakdown of age groups served. Sierra was originally designed to accept 95% of clients 60 years of age and older and 5% transitional age adults between the ages of 55 and 59. The program quickly reached the 5% capacity, but due to the high number of additional individuals in this age group needing services and meeting criteria, the Provider enrolled more than the 5% limit. Data collected by the County indicates that the highest numbers of adults over the age of 55 who utilize services at the Sacramento County Mental Health Treatment Center and in-patient hospitals are between the ages of 55 and 59. Based on these factors, Sierra now serves individuals age 55 and older.

Sierra enrolled its first members on June 30, 2007. As of December 31, 2007 a total of fifty-four (54) members were enrolled in the Sierra program, representing 117% of the anticipated 2nd quarter target numbers (46), and 60% of the anticipated FY07-08 target (90).

There were several implementation challenges for this program. Due to a variety of County-related administrative issues, there were delays in getting the contract executed which affected Sierra's ability to submit flat invoices for expenses that were supposed to occur for the first fiscal year. There were initial challenges related to the use of the new MHSA treatment codes and Mode 60 codes developed by the County to track expenses to the client level. Sierra also had difficulty billing sufficiently when the census was low, which resulted in additional fiscal challenges. Due to construction delay on Sierra's new facility, the staff had to share space with another program and was only able to provide home-based services until December of 2007. Finally, Sierra experienced administrative and management staff changes within this reporting period which affected early implementation. They worked hard to successfully fill the management level positions and have maintained a core group of dedicated staff.

Transcultural Wellness Center

The Transcultural Wellness Center (TWC) is administered by Asian Pacific Community Counseling (APCC.) APCC implemented the primary services and activities in accordance with the approved County Plan and the contract with Sacramento County. TWC provides culturally competent services for children, youth, adults, older adults and entire families, including extended relatives. They incorporate traditional healing practices into services, including shamanic healing rituals, Chinese herbal medicine, and acupuncture. They are providing services for individuals from the Asian and Pacific Islander (API) communities who, in some cases, have been misdiagnosed due to cultural misunderstandings and language barriers. An example is two Tongan clients who were referred to TWC and had been living in a locked psychiatric facility. They were assigned a Tongan staff member who understood the mental health issues in the context of language and culture. Because they are receiving integrated culturally competent services in their primary language, the clients were able to successfully move to a Board and Care home where TWC staff continues to provide culturally and linguistically appropriate services to support their recovery. TWC is also successfully addressing the isolation and decreased functioning in older adult API clients who have experienced extreme trauma. By establishing strong relationships and treating the symptoms of depression and anxiety, members have slowly been able to re-engage in the community. TWC has also provided the transportation needed to increase the connection and supports the members receive.

The only part of the approved CSS Work Plan that was not implemented during the timeframe of this report is the TWC Community Advisory Committee. Due to the many challenges regarding implementation and staffing, TWC was not able to reach out to API community leaders to begin forming this committee. TWC, however, is committed to establishing this committee in 2008.

The first members were enrolled in TWC on July 1, 2007. As of December 31, 2007 a total of 103 members were enrolled in TWC, representing 99% of the anticipated 2nd quarter target numbers (104), and 52% of the anticipated FY07-08 annual target (200).

There were a number of implementation challenges both at the County level and Provider level. Due to a variety of County-related administrative issues, there were delays in getting the contract executed which affected TWC's ability to submit flat invoices for expenses that were supposed to occur for the first fiscal year. It also resulted in a delay in hiring management staff. There were challenges in setting up and administering flexible funding and finding vendors, particularly Asian markets, who would accept third-party checks. Initially, TWC had difficulty accessing the County's billing system in part due to their IT system limitations. They were unable to enter billings and receive reimbursement for four months, seriously affecting their cash flow. TWC also faced significant staffing issues. They have done an incredible job in hiring staff who speak eight (8) of the fourteen (14) API languages, but finding bilingual/bicultural individuals who have experience in the mental health field has been problematic. Collaborations with other community-based agencies to provide services in some of the API languages were unsuccessful, which further complicated

the staffing issues. All of these workforce challenges resulted in a significant workload for the clinical supervisors and impacted the provision of services to members in the first six months of operation.

TCORE

TCORE provides intensive transitional mental health supports and services to individuals discharging from acute care settings who are not linked to on-going mental health treatment services. TCORE implemented services and activities in accordance with the County's approved CSS Plan.

TCORE enrolled its first members on July 17, 2007. As of December 31, 2007 a total of 206 members were enrolled, representing 106% of the anticipated 2nd quarter target numbers (195), and 44% of the anticipated FY07-08 annual target (475).

There have been a number of implementation challenges both at the County level and Provider level. As with the other MHSA Programs, there was a delay in contract execution which impacted the start-up progress and the program's cash flow. There were initial difficulties in adjusting to the change in the County's referral process which had been in place since 1994. In order to avoid creating a separate referral process for MHSA programs, the County established a workgroup to develop a revised system-wide referral process that was designed to reduce barriers to accessing services. Another challenge was with regard to enrollment. When the rest of Sacramento County's mental health system became fully aware of the TCORE program, utilization quickly surpassed any planned or expected number. At the provider level, the greatest challenge has been the articulation between the existing treatment system and TCORE. The program continues to face challenges in the smooth transition to long-term services. Finally, there have been significant challenges for TCORE in having to rely solely on billings for services rendered to sustain revenue, while starting up a new innovative program.

Wellness and Recovery Center

The Wellness and Recovery Center (WRC) implemented the services and activities as described in the County's approved CSS Plan. The WRC has exceeded registration goals and has moved ahead of schedule in terms of hours of operation and implementation of activities. There are a variety of activities and services provided by bilingual and bicultural staff at WRC as well as in other settings throughout the community.

The first members were enrolled at WRC on July 30, 2007. As of December 31, 2007 a total of 244 members were participating in services at WRC, representing 122% of the anticipated 2nd quarter target numbers (200). While 244 represents the number of unduplicated members receiving services in the 2nd quarter of the fiscal year, there has been a total of 313 unduplicated members that have participated in services at WRC during this reporting period. This represents 79% of the targeted annual unduplicated count of 395.

As with the other MHSA programs, the delay in contract execution posed significant challenges for WRC with regard to fiscal and siting issues. Another challenge surfaced with regarding to tracking services and outcomes. Since individuals who use WRC services are not enrolled in the same manner as others in the county system, WRC had to develop a database that tracks registrations, services utilized, demographics and outcomes. They worked very closely with the County on developing a system that was user-friendly and mutually beneficial. A key implementation challenge was recruiting and hiring a psychiatrist who not only met the requirements of providing medication support services, but who also exemplified the wellness and recovery principles that guide WRC's activities. Despite continued efforts, WRC was unable to hire a psychiatrist within the timeframe of this report. The delay in staffing this position had a considerable impact on WRC's ability to leverage Medi-Cal funds specified in the contract.

2) For each of the six general standards (MHSA Essential Elements) in the California Code of Regulations, Title 9, Section 3320, briefly describe one example of a successful activity, strategy or program implemented through CSS funding and why you think it is an example of success.

a. Community Collaboration

The Sierra Elder Wellness Program developed an important collaboration with primary health clinics and health care services to reduce the barriers to access and to promote the integration of physical and mental health services. Sierra has funding to ensure that each client has a physical exam and is linked with a primary care physician. Sierra is also working diligently on developing relationships with physicians, optometrists and dentists who are willing to work with Sierra's clients. The multidisciplinary team ensures that clients receive a comprehensive assessment and that integrated treatment includes mental health, health, case management, transportation, and in-home services. Another example of community collaboration is the relationship Sierra established with the Lyon's Club who has provided several Sierra members with free eye-glasses. While MHSA provides flexible spending, this collaboration makes those limited dollars available for other necessary items and reinforces the importance of creating community partnerships that can collectively meet the needs of individuals living with a mental illness.

b. Cultural Competence

An example of cultural competence at a program level is the Transcultural Wellness Center, which provides mental health services for members of the Asian and Pacific Islander communities. All services are provided in the client's preferred language through bilingual staff or through certified mental health interpreters. Services, including those provided by the TWC psychiatrists are often provided in the home with respect to the client's cultural needs. Comprehensive assessments utilize a cultural formulation and take into account issues related to the individual's history, acculturation, immigration and generational status. TWC has demonstrated a successful partnership of traditional and western healing practices. As mentioned previously, services include acupuncture and

shamanic healing. One member received acupuncture and medication and reported a reduction in symptoms with the combination of these treatments. The shamanic healing rituals assist clients in calling back their "soul" or utilize shamans to "talk to the souls" in the spirit world. Many clients and families have reported an improvement in symptoms after participating in the rituals. Utilizing shamanic rituals also helps keep cultural traditions alive for the clients, their families and future generations.

c. Client/Family-driven Mental Health System

TCORE actively engages families and care-givers at many levels, including decision-making regarding program and service planning, supervision and delivery of services. In 2007 TCORE employed three (3) consumers/family members in the position of consumer/family advocates, as well as fourteen (14) identified consumers/family members in a variety of other staff positions. The TCORE program engages clients in strength-based, self-directed rehabilitation plans that focus on recovery, resiliency, self sufficiency, and self-determined goals.

d. Wellness/Recovery/Resiliency Focus

The Wellness & Recovery Center provides a variety of services and supports not customarily provided by a mental health entity including, literacy groups, computer labs, alternative healing practices, self help and peer advocacy, art and creative writing groups. The services are provided in a supportive, welcoming atmosphere and are open to family members and interested members of the public. WRC seeks to integrate individuals from the community into the program as well as create opportunities for members of the program to actively engage in the community outside of mental health.

e. Integrated Services Experience for clients and families:

Pathways staff consistently provided, and continue to provide, support and encouragement to the families of children and adult members enrolled in the program. When a parent of an enrolled child needs mental health services, Pathways coordinates the services through one of Turning Point's children's programs or through another County funded program. Pathways staff recognize that the needs of the parents are frequently as great as the child's needs upon entry into the program. Additionally, it is often the parents' issues that resulted in homelessness for the family; therefore Pathways works closely with the parents to identify and address the issues that led to their homelessness. Finally, Pathways conducts multi-disciplinary meetings which include the parent and child or adult member, any identified support persons, the Clinical Director, Program Director, Program Nurse, Psychiatrist and the assigned Coordinator to address issues that may arise during treatment. This process ensures that the member and/or family are intimately involved in the decision making process when plans are developed.

A creative example of integrated and client and family-driven services, was a Baby Shower Turning point planned and threw for all of its expectant mothers and mothers

with children under two years of age. The event was a huge success and provided these new moms with various items that were beneficial to both mom and babies. The Baby Shower also offered these new mothers educational opportunities about birth control, safe sex practices, and parenting skills – all of which were provided in a fun and participatory game format.

3) For the Full Service Partnership category, provide the total amount of MHSA funding, approved as Full Service Partnership funds, used for short-term acute inpatient services.

Sacramento County did not use any Full Service Partnership funds for short-term acute inpatient services.

4) For the General System Development (GSD) category, briefly describe how the implementation of the GSD programs has strengthened or changed the County's overall public mental health system.

TCORE: The TCORE program provides intensive services for individuals discharging from acute care settings who are not linked to on-going mental health services. TCORE addresses immediate needs individuals may have upon discharge, including co-occurring substance use issues, health care, housing, benefits acquisition and medication. The program provides the necessary services and supports until the individuals are linked to appropriate care. The services are provided for an average of two to three months and the TCORE team ensures a "warm" hand-off to a service provider. The services provided by TCORE help strengthen the County's mental health system by reducing recidivism back into acute care settings. TCORE's intensive engagement practices have resulted in more individuals getting linked to longer-term appropriate services and supports. TCORE services facilitate recovery, reduce human suffering, and reduce costs to other service delivery systems.

Wellness and Recovery Center: Prior to the funding of the Wellness & Recovery Center the mental health system did not have a clearly identified exit strategy or the ability to assist people who had received treatment and were ready to pursue other endeavors. The Wellness & Recovery Center realizes that individuals may still need support and assistance with planning a future, acquiring skills that enrich lives, successfully applying for school or employment, support in maintaining employment, as well as support for general life success and failure. These needs are being recognized as essential to true recovery and to the full integration of the individual into his/her community. The Wellness and Recovery Center strengthens our system by providing these necessary services which support the MHSA goals of recovery, resiliency, and meaningful participation of individuals living with mental illness in their communities.

B. Efforts to Address Disparities

1) Briefly describe one or two successful current efforts/strategies to address disparities in access and quality of services to unserved or underserved populations targeted in the CSS component of your Plan.

In the CSS Plan, Sacramento County identified the following unserved or underserved target populations: Latino, African American, Native American, Refugee populations, Asian and Pacific Islanders (API), Homeless, Transition Age Youth (TAY) and Older Adults. There are several success strategies being used by our programs to address disparities for these populations.

In addressing the TAY, homeless, and API target populations, the Transcultural Wellness Center (TWC) has collaborated with a local homeless shelter and a domestic violence shelter for API women and their children. The TWC has engaged and enrolled several clients from both shelters and provides services in their preferred language. The culturally competent services provided by TWC incorporate traditional healing practices such as Tai Chi, shamanic healing rituals, Chinese herbal medicine and acupuncture. TWC has also been successful in outreaching to and engaging Hmong TAY (and their families) who are showing early signs of psychosis. In addition to mental health services, TWC has assisted clients with immigration issues, obtaining and maintaining permanent housing, and obtaining benefits to which they are entitled.

In addressing the homeless population, the Pathways program collaborated with a number of local agencies. They did extensive outreach to Loaves and Fishes, various shelters in the community and the newly developed Central Intake Team. Through these collaborations, Pathways enrolled forty-one (41) adults that were chronically homeless according to the Housing and Urban Development (HUD) definition; twelve (12) homeless adults; and nine-teen (19) homeless children and families. Pathways also did outreach to various senior centers and agencies that serve homeless older adults in order to ensure outreach to this population. The result of those efforts was the enrollment of two (2) homeless older adults. Finally, Pathways collaborated with the Sacramento County Mental Health Treatment Center and Turning Point's Crisis Residential program to outreach to homeless TAY. Within the first six months of operations, Pathways enrolled thirteen (13) homeless TAY.

2) Briefly describe one challenge you faced in implementing efforts/strategies to overcome disparities, including where appropriate, what you have done to overcome the challenge.

One of the goals of all the MHSA programs was to outreach to and engage clients from unserved and underserved communities. The table below illustrates the racial and ethnic breakdown of clients being served in each of the MHSA programs as compared to those we serve in the County's Mental Health Plan as a whole. Across all MHSA programs, we have been successful in enrolling higher percentages of American Indian/Alaskan Native (AIAN) and Asian Pacific

Islanders than we have in the past. Additionally, MHSA programs are serving a higher percentage of individuals that are two or more races, many of which include our underserved AIAN and API races. The following bullets summarize major successes within each program:

- Pathways and WRC have increased services to individuals of Hispanic/Latino origin.
- The Sierra Elder Wellness Program and the Wellness and Recovery Center have increased services to the AIAN populations.
- TWC has played a significant role in outreaching and providing services to the API community.
    - Out of the 78 Asian Pacific Islanders served at TWC, 80% are from Southeast Asian communities (Filipino, Hmong, Laotian, Mien, and Vietnamese), 15% are East Asian (Chinese, Japanese, and Korean) and 5% identify as Other Pacific Islander.
- TWC and Pathways are serving high percentages of multi-racial individuals, which include individuals from our underserved API and AIAN communities.
    - Of those reporting multi-racial at these two agencies, 41% report at least one race as API, and 24% report at least one race as AIAN.

Race	***Sierra***	***TWC***	***Pathways***	***TCORE***	***WRC****	***Overall***	***System 06-07***
	N=54	*N=103*	*N=72*	*N=206*	*N=196*	*N=631*	*N=32971*
African American	20.4%	0.0%	29.2%	20.9%	9.7%	14.9%	19.8%
AIAN	1.9%	1.0%	0.0%	1.0%	4.6%	2.1%	0.9%
API	0.0%	75.7%	5.6%	6.3%	2.6%	15.8%	5.5%
White	63.0%	1.0%	40.3%	47.1%	58.2%	43.6%	39.4%
Multi	7.4%	15.5%	19.4%	7.3%	9.2%	10.6%	5.3%
Other	3.7%	3.9%	4.2%	7.8%	8.2%	6.5%	10.6%
Unk/Not Reported	3.7%	2.9%	1.4%	9.7%	7.7%	6.5%	18.6%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Hispanic Origin	9.3%	7.8%	18.1%	13.6%	18.9%	14.4%	16.4%

*Note: WRC-Demographic information is only collected on those that choose to fill out a registration form so N does not equal total served as reported on Exhibit 6

The ultimate goal with respect to reducing disparities, however, is to demonstrate that we are increasing the penetration rate in unserved and underserved communities. Historically, the standard that counties have been measured against is the penetration rate of the Medi-Cal eligible population. As time has passed, however, there has been greater recognition that it is too restrictive a definition and consensus is growing that the penetration rate of the 200% of Poverty population is more applicable. Therefore, the next table illustrates both the Medi-Cal eligible and 200% of Poverty penetration rates for each population as they were prior to the implementation of the MHSA programs. This baseline data will assist us in reporting our

progress in reducing disparities in future reports. The County has also developed a technical assistance tool to work with community-based providers and county-operated programs to improve health disparities and increase penetration rates as appropriate.

Penetration					
	Population			Penetration	
	Sac Co Clients 06-07	200% Poverty Pop 2006 Estimates	Medi-Cal Eligible Jan07	200% Poverty Pop	Medi-Cal Eligible
African American	6235	50044**	52203	12.5	11.9
AIAN	206	4111	1796	5.0	11.5
API	1328	62749	34534	2.1	3.9
Hispanic	5402	87008	64839	6.2	8.3
White	11986	164097	75406	7.3	15.9
Other/Unknown	7814	20952	40869	37.3	19.1
Totals	32971	388961	269647	8.5	12.2

*Please note that Race and Ethnicity data is not collected in a standardized way by different reporting systems: (1) Sacramento County (due to State DMH requirements) collects Hispanic ethnicity separately from race. Therefore, the County Hispanic numbers in the table above reflect those clients that report they are of Hispanic origin regardless of their race. The remaining race categories report only clients that indicate they are not Hispanic; (2) Medi-Cal data regards Hispanic as one of many races only; (3) State DMH provides 200% poverty population data with Hispanic regarded as one of many races. By using Hispanic ethnicity to define Hispanic race, we discount client reported race. This method of reporting also results in an under-reporting of our Native American population, and to a lesser extent our API, African American and White populations as well.

**The poverty population would reasonably be inclusive of the Medi-Cal eligible population and would be expected to be greater than the Medi-cal eligible population, however the poverty population numbers are based on Series P5 estimates provided by State DMH and do not reflect actual counts of individuals.

3) Indicate the number of Native American organizations or tribal communities that have been funded to provide services under the MHSA and what results you are seeing.

Sacramento County has not funded any Native American organizations or tribal communities to provide services with MHSA funding.

4) List any policy or system improvements specific to reducing disparities, such as the inclusion of linguistic/cultural competence criteria to procurement documents and/or contracts.

During the timeframe of this report, Sacramento began numerous system improvement efforts with regard to reducing disparities. The County's Ethnic Services/Cultural Competence Manager began developing a tool that could be used by county and contract

providers to measure efforts toward reducing disparities in access and care. Language was inserted into all MHSA contracts requiring outreach and engagement efforts to underserved/unserved ethnic communities in Sacramento County, including but not limited to the five threshold language groups: Spanish, Russian, Hmong, Cantonese and Vietnamese. Language was also inserted into all MHSA contracts requiring bilingual/bicultural staff that reflects the diversity of the clientele being served. During the Request for Application process for the new MHSA programs, which took place prior to January of 2007, Sacramento County included individuals on the RFA evaluation panels that were knowledgeable in cultural competency issues. The MHSA Coordinator worked with the county's Ethnic Services/Cultural Competence Manager in selecting a representative for each panel. This practice has been adopted for all future RFA processes related to MHSA programs.

The MHSA contracts with providers also require that employees reflect the language and diversity in Sacramento and that specific outreach efforts be made toward Latino, Eastern European, Southeast Asian, Native American and LGBT communities. Specific dollars have been included for translation and interpretation services for those situations in which a bilingual/bicultural staff is not available.

C. Stakeholder Involvement

The Sacramento County MHSA Steering Committee, which was established for the CSS Planning Process, reconvened on January 18, 2007 to address a number of MHSA related issues. Initially, they were charged with making recommendations regarding the use of the Fiscal Year '07-08 CSS Growth Funds. They were also charged with making recommendations about the structure and stakeholder composition of a new MHSA Steering Committee. The meetings were held twice monthly and interested community members attended to provide input. The group provided feedback about their own experiences and thoughts and also discussed feedback received from the community during the CSS process. A focus group was held at one of the meetings and included participation from Steering Committee members and community stakeholders. After much discussion and a formal vote, the new composition was established. Perhaps most notable and exciting was the recommendation to add two Transition Age Youth positions. The Steering Committee also recommended adding a representative from Health, Child Protective Services and the Juvenile Court. After the recommendation on the composition of the Steering Committee had been made to the County, the County was concerned that Probation Department had not been included. Although Probation was considered by the Steering Committee as a possible stakeholder, it did not receive a sufficient number of votes and therefore, was not included in the final recommendation. After further consideration, particularly with regard to the Prevention and Early Intervention component of the MHSA, the County added a seat for a Probation representative. In maintaining the value of having 50% representation of consumers and family members on the Steering Committee, another Consumer/Family Member position was also added.

In order to ensure diversity and inclusiveness in choosing representatives for the Consumer and Family Member positions, a six-member panel was established that included a representative

from the following groups: Mental Health Association; Consumer Self-Help, Inc.; Cultural Competence; Service Providers; the Mental Health Board; and the Family Advisory Committee. An application was developed and distributed via e-mail blasts, service providers, consumer and family member groups, and it was posted on the County's MHSA website. Approximately forty-four (44) applications were received for thirteen (13) positions. Those who were not selected to be primary members were asked to serve as alternates. The final composition of Sacramento County's MHSA Steering Committee is attached. (*Attachment A*)

After the new representatives were selected or appointed, the new MHSA Steering Committee convened in October of 2007. Based on the recommendation of the prior Steering Committee, the County hired a facilitator for the meetings. The Committee met weekly through December, with the exception of the two holidays. On the evening of the first meeting, the County provided dinner and invited the Steering Committee members and the community to arrive early for an informal "meet and greet". The initial Steering Committee meetings focused on the structure of the Steering Committee, key roles and responsibilities of all entities involved in the process, and unresolved issues related to the CSS Planning process. After much discussion and looking at the County governing structure, it was clarified that the Committee was an advisory body rather than a recommending body. The Division of Mental Health and the Department of Health and Human Services were also deemed to be recommending bodies, with the final decision-making authority lying with the Board of Supervisors and/or the Department of Mental Health. Some key accomplishments of these initial meetings included:

- Selection of a Co-chair;
- Education about the MHSA;
- Adoption of a Steering Committee Charter
- Adoption of a "Comfort Agreement" to ensure a safe and inclusive process;
- Discussion of future workgroups that would focus on specific components;
- Establishment a work group to make recommendations for unapproved CSS funding and CSS One-time Funding

D. Public Review and Hearing

1. The Implementation Progress Report (IPR) was posted to Sacramento County's website for a 30-day public comment period from May 2, 2008 through June 2, 2008. The IPR was translated into Sacramento County's five (5) threshold languages (Spanish, Russian, Hmong, Vietnamese and Cantonese) and all translations were also posted to the website with links to the IPR in each respective language. Hard copies of the IPR were provided upon request. The Public Hearing was conducted by the Sacramento County Mental Health Board on June 5, 2008.

2. A Public Notice announcing the posting of the IPR was published in the Sacramento Bee on May 2, 2008. The notice indicated the report could be found on Sacramento County's website and that a hard copy would be provided upon request. Notification about the report was also sent via e-mail to approximately 1100 individuals who are on Sacramento County's

MHSA e-mail distribution list; all service providers in our Adult System of Care; and all service providers in our Children's System of Care.

3. During the 30-day posting of the IPR, a couple of comments and several requests for hard copies were received from the community. The following is a summary of the comments:
    - Acknowledgement of the nice work accomplished by the providers during the timeframe of the report.
    - Weak outreach and engagement models utilized.
    - Observation that there is no integrated system between pastoral counseling and mental health treatment and that there is a lack of formal policy establishing a linkage between faith-based organizations and the public mental health system.
    - While cultural competency is mentioned throughout the report, there is no documentation to show that the ethnic poor outside of the social milieu are being absorbed into the mainstream model of mental health service provision.

    During the public comment period at the Public Hearing on June 5, 2008, there were several comments. The following is a brief summary:

    - Acknowledgment and thanks to the county and the community for supporting the efforts of the Transcultural Wellness Center. Clients are receiving bilingual and bicultural services and supports and the program is meeting a great need in the Asian and Pacific Islander communities.
    - Acknowledgment of the challenges of implementation and the importance of working collaboratively through them; the importance of focusing on outcomes and continuously looking at ways to make services more effective and efficient.
    - A member of the Transcultural Wellness Center spoke of his family's escape to the United States and the subsequent onset of his mental illness. He experienced thoughts of suicide and had to go to crisis centers on numerous occasions. He was referred to the TWC and received a visit from the Medical Director, Dr. Hendry Ton. He expressed gratitude to Dr. Ton and the staff from TWC for all the services and supports provided to his family.
    - Another member of TWC spoke and recounted numerous stressors that led to his need for mental health services. He did not want to accept help and as the stressors increased, he wanted to commit suicide. He stated that Dr. Ton also went to his home to speak with him and his family. Since receiving services at TWC, his symptoms have improved and he feels like he has his family back. He expressed gratitude to Dr. Ton and the staff at TWC.
    - A service provider stressed the importance of moving toward full integration of MHSA into the existing system of care to avoid a bifurcated system of care in which a small portion of consumers receives enriched services while the majority receives fewer services. There must be strategic planning for integration in order to fully realize the MHSA promise of system transformation.

- A consumer spoke of the need to streamline the process of getting programs started – it took too long to get these programs operational. He echoed the need to integrate MHSA principles and funding into the existing system of care and acknowledged that this will take time – transformation is bigger than just making changes.
- A consumer and service director acknowledged the great work being accomplished at the Wellness and Recovery Center. She acknowledged how much more WRC has done from January 1, 2008 to the present. Consumers are not only learning how to manage their illness but are engaging in life-sustaining activities, integrating into their communities and transforming their lives.
- A consumer and family member acknowledged the hard work of the community and the county; she emphasized the importance of using MHSA funds for MHSA services even during this time of budget cuts and fiscal crisis. If MHSA dollars are used to fund programs being cut, we will revert back to conducting business as usual.

While the county remains committed to improving outreach and engagement, particularly to racial, cultural and ethnic communities, the comments indicate a need for improvement and a need to include faith-based organizations. We will continue in these efforts as we move forward in planning for the Prevention and Early Intervention component of the MHSA. We will also utilize community members to assist us in this important endeavor. Finally, the county is acutely aware of the need to integrate the MHSA Essential Elements, values and funding into our existing system of care, and the division will work with the MHSA Steering Committee and the community on exploring potential strategies.