MENTAL HEALTH SERVICES ACT

Fiscal Year 2021-22, 2022-23, 2023-24 Three-Year Program and Expenditure Plan

August 24, 2021

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Attachments

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Sacramento

☑ Three-Year Program and Expenditure Plan
☐ Annual Update
☐ Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller / City Financial Officer
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I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/revenue and expenditure report is true and correct to the best of my knowledge.

Ryan Quist, Ph. D
Local Mental Health Director (PRINT)

Signature 8/31/21
Date

I hereby certify that for the fiscal year ended June 30, 2020, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated 11/24/20 for the fiscal year ended June 30, 2020. I further certify that for the fiscal year ended June 30, 2020, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

Maria Sandoval
County Auditor Controller / City Financial Officer (PRINT)

Signature Maria Sandoval 8/25/2021
Date

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)
Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (07/22/2013)

Executive Summary

Proposition 63 was passed by California voters in November 2004, and became known as the Mental Health Services Act (MHSA). MHSA authorized a tax increase on millionaires (1% tax on personal income in excess of $1 million) to develop and expand community-based mental health programs. The goal of MHSA is to reduce the long-term negative impact on individuals and families resulting from untreated serious mental illness.

Sacramento County is one of eighteen counties located in the Central Mental Health Region of the State of California. The State of California, Department of Finance estimates the 2019 population of Sacramento County to be approximately 1.5 million. As such, Sacramento is considered a large county, especially in comparison with the populations of surrounding counties. Sacramento is one of the most diverse communities in California with seven threshold languages (Arabic, Cantonese, Farsi, Hmong, Russian, Spanish, and Vietnamese). Historically, Sacramento County has been one of three counties with the highest number of newly arriving refugees in California. Arabic was added as a threshold language in 2017 and Farsi was added in 2020. We welcome these new residents and continue to work towards meeting the unique needs of these emerging communities.

Sacramento County Behavioral Health Services (BHS) has worked diligently on the planning and implementation of all components of MHSA. The passage of AB100 in 2011 and AB1467 in 2012 made many significant changes to MHSA, including the shift from published funding allocations to monthly distributions based on taxes collected as well as the transfer of plan/update approval authority from the State level to local Boards of Supervisors.

The plans for each component of MHSA are the result of local community planning processes. The programs contained in the plans work together with the rest of the system to create a continuum of services that address gaps in order to better meet the needs of our diverse community.

The **Community Services and Supports (CSS)** component provides funding for mental health treatment services and supports for children/youth and their families living with severe emotional disturbance and transition age youth (TAY), adults and older adults living with a serious mental illness. Housing is also a large part of the CSS component. In Sacramento County, there are ten (10) previously approved CSS Programs/Work Plans containing numerous programs. Over the years, these programs have expanded and evolved as we strive to deliver high quality and effective services to meet the needs of children/youth, TAY, adults, older adults and their families.

As addressed in the previous Three-Year Program and Expenditure Plan (Three-Year Plan), BHS facilitated a community planning process in Fiscal Year (FY) 2017-18 resulting in new and expanded mental health treatment services and housing supports for individuals living with a serious mental illness who are homeless or at-risk of homelessness. With support from the MHSA Steering Committee, BHS further expanded the CSS Component to address individuals experiencing or at-risk of homelessness. This new and expanded programming was fully implemented in FY 2020-21.

The **Prevention and Early Intervention (PEI)** component provides funding for programs and activities designed to prevent mental illness from occurring or becoming more severe and disabling. Sacramento County's PEI Plan is comprised of four (4) previously approved programs

containing programs designed to address suicide prevention and education; strengthening families; integrated health and wellness; and mental illness stigma and discrimination reduction.

The previous Three-Year Plan included a new PEI program to provide mental health services for foster youth, as recommended and supported by the MHSA Steering Committee and the Board of Supervisors. This new program was expanded to serve all youth in FY 2019-20.

In FY 2017-18, BHS facilitated a community planning process resulting in expansion of mental health services and supports for individuals living with a serious mental illness who are homeless or at-risk of homelessness in the suicide prevention programming.

The previous Annual Update included the new PEI program: Trauma Informed Wellness for the African American Community developed through a community program planning process that included the formation of an Ad Hoc Workgroup. African American Community Listening Sessions were conducted to further refine the program recommendation. In late FY 2018-19, the MHSA Steering Committee supported and recommended further expanding the PEI Component to include new time-limited community capacity building PEI programming, as well as the expansion of existing PEI programming. These expansions began mid FY 2019-20.

The **Innovation (INN)** component provides time-limited funding to test new and/or improved mental health practices or approaches with the goal of increasing access (including access for underserved groups), increasing the quality of services, or promoting interagency collaboration.

Sacramento County's first approved INN Project, known as the Respite Partnership Collaborative (RPC) spanned five years from 2011 – 2016. The mental health respite programs established through this project have transitioned to sustainable MHSA CSS/PEI funding and are described in the Three-Year Plan.

In May 2016, the Mental Health Services Oversight and Accountability Commission (MHSOAC) approved Sacramento County's second INN Project, known as the Mental Health Crisis/Urgent Care Clinic. The Clinic opened in November 2017.

The previous Three-Year Plan included the third INN Project, known as the Behavioral Health Crisis Services Collaborative (BHCSC). The project is a public/private partnership with Dignity Health and Placer County with the intent to establish integrated adult crisis stabilization services on a hospital emergency department campus in the northeastern region of Sacramento County. The MHSOAC in approved this project in May 2018. The BHCSC opened in September 2019.

The previous Annual Update included the fourth INN Project, Multi-County Full Service Partnership (FSP) INN Project. The project aims to improve how counties collect and use data to define and track outcomes that are meaningful for FSP clients and to help counties use data to inform program design and improve FSP service delivery. This project plan was approved by the MHSOAC in June 2020.

In June 2020, the MHSOAC approved Sacramento County's fifth INN Project, Forensic Behavioral Health Multi-System Teams. This project will adapt and expand a teaming approach for the adult forensic behavioral health population. Implementation progress for this Project is described in this Three-Year Plan.

The **Workforce Education and Training (WET)** component provides time-limited funding with a goal to recruit, train and retain diverse culturally and linguistically competent staff for the public mental health system and ensure they are adequately trained to provide effective services and administer programs based on wellness and recovery. Sacramento County's WET Plan is comprised of eight (8) previously approved actions. Per Welfare and Institutions Code (WIC) Section 5892(b), Counties may use a portion of the CSS funds to sustain WET activities once the time-limited WET funds are exhausted. Therefore, these activities are being sustained with CSS funding.

Through the State's WET Plan, they are awarding WET grant funding to five regional partnerships to fund activities that support the workforce needs of each of the counties within those regional partnerships. Counties are then asked to provide a match in order to access funding made available to their respective regional partnership. In April 2020, the MHSA Steering Committee supported Sacramento County's participation in the Central Regional Partnership.

The **Capital Facilities (CF)** project was completed in Fiscal Year 2015-16. The project renovated three buildings at the Stockton Boulevard complex that houses the Adult Psychiatric Support Services (APSS) clinic, Peer Partner Program and INN Project #2: Mental Health Crisis/Urgent Care Clinic. Those renovations allowed for an expansion of service capacity with space for additional consumer and family-run wellness activities and social events.

The **Technological Needs (TN)** project, contained within the Capital Facilities and Technological Needs component, funds and addresses our commitment to move to an Electronic Health Record and Personal Health Record to improve client care through a multi-phased approach. Per WIC Section 5892(b), Counties may use a portion of the CSS funds to sustain TN projects once the time-limited TN funds are exhausted. Therefore, these activities are sustained with CSS funding.

Detailed descriptions of the programs and activities for each of the above MHSA components are contained in the MHSA Fiscal Year (FY) 2021-22, 2022-23, 2023-24 Three-Year Plan.

The Draft MHSA FY 2021-22, 2022-23, 2023-24 Three-Year Plan was posted for a 30-day public comment period, from May 3 through June 2, 2021. The Mental Health Board conducted a Public Hearing, held virtually, on Wednesday, June 2, 2021, beginning at 6:00 p.m.

COVID-19 IMPACTS

When COVID-19 emerged as a global pandemic, it changed the way in which we all navigate our lives. Not only did it present a formidable public health challenge but a behavioral health challenge as well.

In response to the pandemic, Sacramento County Behavioral Health Services (BHS) focused on addressing COVID-19 and the new challenges in ensuring that clients continue to access services. BHS made adjustments in how we engaged community stakeholders in MHSA Community Program Planning (CPP) processes and MHSA funded program providers shifted from in-person services and supports to telehealth.

The following represent key strategies implemented to mitigate COVID-19 impacts to MHSA CPP and delivery of MHSA funded programming:

- MHSA Steering Committee meetings shifted from in-person to virtual meetings.
- MHSA-funded program providers shifted to providing virtual services, including video- and telephone-based care.
- Some MHSA-funded program providers continued to provide essential site based and community-based services and supports with additional safety protocols (e.g., use of personal protective equipment, staggered shifts, etc.).
- Many MHSA-funded program providers assisted clients and program participants with access to technology, including providing devices (e.g., tablets and phones) and assisting them in becoming more comfortable with technology through training and technical assistance.

Clients and program participants expressed gratitude for the provision of services through the pandemic but are eager to return to in-person services.

MHSA-funded program providers noted that more clients and program participants had unmet basic needs such as food, housing and income compounded with mental health concerns associated with social isolation, overall feelings of insecurity and instability, and increased symptoms of depression, anxiety, and stress.

Like many counties, BHS efforts to complete the MHSA FY 2020-21 Annual Update were hampered by the pandemic. Because of COVID-19 related circumstances, the California Department of Health Care Services (DHCS) implemented COVID-19 MHSA flexibilities. This included granting Counties the ability to extend the effective timeframe of the currently approved Annual Update through submission of DHCS Form 5510. BHS discussed these flexibilities with stakeholders in April and July 2020 and stakeholders were supportive. Therefore, BHS completed and submitted DHCS Form 5510 on August 28, 2020 to extend the approved FY 2019-20 Annual Update to include FY 2020-21 (*See Attachment A – DHCS Form 5510 MHSA Three-Year Plan Extension 2020-21*).

This MHSA FY 2021-22, 2022-23, 2023-24 Three-Year Program and Expenditure Plan reflects program and budgetary updates and projections.

COMMUNITY PROGRAM PLANNING

Sacramento County's MHSA Steering Committee

The MHSA Steering Committee is the core recommending body for MHSA funded programs and activities in Sacramento County and serves as the hub of the MHSA Community Program Planning Process (CPPP). Their role is to: (1) Effectively and respectfully engage clients, family members, and other community stakeholders through a broad participation process, including the creation of workgroups that include community input and recommendation development, to develop Sacramento County's MHSA plans; (2) Review and approve program proposals developed with stakeholder and community input; and, (3) Make specific program recommendations to BHS consistent with MHSA goals, guidelines, Mental Health Policy, available funding (budget), and requirements. Some members of the committee have volunteered to represent multiple stakeholder interests, including Faith-based/Spirituality.

MHSA STEERING COMMITTEE MEMBERSHIP

SLOT	STAKEHOLDER GROUP:	APPOINTED BY:	MEMBER	ALTERNATE
1	Mental Health Board*	Mental Health Board	Brad Lueth	Laura Bemis
2	Mental Health Director	Division of Behavioral Health Services Director	Ryan Quist[E]	Jane Ann Zakhary
3	Service Provider - Children	Association of Mental Health Contractors	Laurie Clothier (River Oak)	Mary Sheppard (Uplift Family Svcs)
4	Service Provider - Adults	Association of Mental Health Contractors	Erin Johansen (TLCS)	Vacant
5	Service Provider - Older Adults	Association of Mental Health Contractors	Genelle Cazares (El Hogar)	Vacant
6	Law Enforcement	Criminal Justice Cabinet	Ronald Briggs	Vacant
7	Senior and Adult Services	Department of Child and Family Services Director	Ruth MacKenzie	Heidi Richardson
8	Education	Sacramento County Office of Education	Christopher Williams	Brent Malicote
9	Department of Human Assistance	Department of Human Assistance Director	Eduardo Ameneyro	Julie Field
10	Substance Use Prevention and Treatment	Department of Health Services Director	Lori Miller	Andrew Mendonsa
11	Cultural Competence	Cultural Competence Committee	Koby Rodriguez[E]	Olivia Garcia
12	Child Welfare	Department of Child and Family Services Director	Michelle Callejas	Melissa Lloyd
13	Primary Health	Department of Health Services Director	Rosemary Younts	Vacant
14	Public Health	Department of Health Services Director	Olivia Kasirye	Staci Syas
15	Juvenile Court	Presiding Judge	Jerilyn Borack	Shelby Wineinger
16	Probation	Chief of Probation	Shaunda Cruz	Randy Marshall
17	Veterans		Rochelle Arnold	Vacant
18	Consumer - TAY	6-member panel	Arushi Mishra	Vacant
19	Consumer - TAY	6-member panel	Karly Mathews	Hafsa Hamdani
20	Consumer - Adult	6-member panel	Gretchen Bushnell	Brenna Lin
21	Consumer - Adult	6-member panel	Leslie Napper[E]	Chezia Tarleton
22	Consumer - Older Adult	6-member panel	Karen Cameron	Vacant
23	Consumer - Older Adult	6-member panel	*Vacant*	Vacant
24	Family Member/Caregiver of Child age 0-17 Yrs	6-member panel	Ebony Chambers**[E]	Vacant
25	Family Member/Caregiver of Child age 0-17 Yrs	6-member panel	Crystal Harding	Vacant
26	Family Member/Caregiver of Adult age 18-59 Yrs	6-member panel	Susan McCrea[S]	Ellen King
27	Family Member/Caregiver of Adult age 18-59 Yrs	6-member panel	Ryan McClinton[E]	Diana Burdick
28	Family Member/Caregiver of Older Adult age 60+ Yrs	6-member panel	Noel Mora	Vacant
29	Family Member/Caregiver of Older Adult age 60+ Yrs	6-member panel	Anatoliy Gridyushko	Vacant
30	Family Member/Consumer At-large	6-member panel	Daniela Guarnizo**[E]	Evin Johnson

* Note - Mental Health Board member will also be Consumer/Family Member

** Co-Chair position [E] Executive Committee member [S] Spirituality representative

NOTE - Alternates for Consumer and Family Member representatives can fill in for any absent Consumer or Family Member.

The MHSA Steering Committee elects two (2) Co-Chairs, who serve staggered two-year terms. The Co-Chairs lead the Steering Committee meetings and are seated members of the Steering Committee Executive Committee.

The Executive Committee is a six (6) member committee charged with developing the MHSA Steering Committee meeting agendas. Executive Committee members also fill-in to facilitate meetings when a co-chair is absent. The Executive Committee is comprised of the two (2) Co-Chairs, the BHS Director, and three (3) elected Steering Committee members.

MHSA Steering Committee members and BHS actively recruit consumers/peers, and family members/caregivers with lived mental health experience for committee membership. Steering Committee member application is posted on BHS' MHSA webpage. A panel of consumers and family members review completed applications for the applicants' lived experience, diversity, and advocacy experience associated with behavioral health services. Applicants are notified about their application status 30 days post review.

The monthly MHSA Steering Committee meetings occur on the fourth Thursday of each month. Steering Committee meetings are open to the public, with time allotted for Public Comment at each meeting. Meeting evalutions are provided to all Steering Committee members and members of the public. All attendees are encouraged to evaluate each meeting anonymously to inform BHS and Steering Committee members of ways to improve meeting structure, pace, and content.

MHSA Steering Committee attendance is recorded through meeting sign-in sheets. Additionally, members of the public are asked to sign-in. At Steering Committee in-person meetings, a light meal is provided to all attendees. To ensure meeting attendance from diverse community members and stakeholders, BHS offers interpreter, captioning, and ASL services to Steering Committee members and members of the public. Steering Committee members representing consumers and family member stakeholders are provided with stipends for each meeting they attend.

BHS maintains a published schedule of MHSA Steering Committee meetings on BHS' MHSA webpage. Agendas, meeting minutes, and supporting documents are also posted. BHS also emails monthly MHSA Steering Committee meeting notifications to a listserv of over 800 community members and stakeholders.

BHS Cultural Competence Committee

As has been longstanding practice, stakeholders representing unserved and underserved racial, ethnic and cultural groups who are members of the BHS Cultural Competence Committee are updated and provide feedback on MHSA activities at their monthly meetings.

Stakeholder, BHS and Provider Staff Education

To ensure meaningful partipation in all aspects of the CPPP, BHS offers MHSA education and training to MHSA Steering Committee members, BHS staff, and community members. Steering Committee members are provided a comprehensive orientation training to learn about the MHSA; MHSA Steering Committee role and member responsibilities; MHSA Steering Committee meeting structure and process; and local MHSA programs, activities, and CPPP. New BHS staff are provided with a comprehensive orientation training as well and includes extensive training on convening and facilitating CPPP. Information about the MHSA components and purpose; changes and updates to MHSA requirements regulations, and statutes; updates to Mental Health Policy; updates to local MHSA budget allocations, programs, activities, and current CPPP are provided at all Steering Committee meetings and BHS staff meetings that also include BHS peer and family member liaisons.

At Sacramento County Behavioral Health Services provider forums, provider staff, including peers and family member advocates, are informed of the MHSA components and purpose; changes and updates to MHSA requirements regulations, and statutes; updates to Mental Health Policy; updates

to local MHSA budget allocations, programs, activities, and current CPPP. Additionally, BHS Cultural Competence Committee, Sacramento County Mental Health Board and Sacramento County Board of Supervisors are informed of changes and updates to MHSA requirements regulations, and statutes; updates to local MHSA budget allocations, programs, activities, and current CPPP.

Members of the public are encouraged to email and call with questions and/or information requests relating to MHSA requirements, regulations, and statutes and local MHSA budget; Mental Health Policy; programs, activities, and CPPP. BHS responds to all requests for information relating to the MHSA and Sacramento County Behavioral Health Services.

Community Program Planning Process for the MHSA Fiscal Year (FY) 2021-22, 2022-23, 2023-24 Three-Year Program and Expenditure Plan

The Sacramento County Behavioral Health Services (BHS) Community Program Planning Process for the MHSA Fiscal Year (FY) 2021-22, 2022-23, 2023-24 Three-Year Program and Expenditure Plan (Three-Year Plan) meets the requirements contained in Section 3300 of the California Code of Regulations as described below. Sacramento County's community program planning processes for previously approved CSS, PEI, WET, INN, CF and TN Component plans and activities have been described in-depth in prior plan updates and documents submitted to the State. Those documents are available on the Reports and Workplans page on our website. All of the programs and activities contained in this Three-Year Plan have evolved from community planning processes.

The general plan for this Three-Year Plan was discussed at MHSA Steering Committee meetings throughout 2020. The Steering Committee is the highest recommending body in matters related to MHSA programs and activities. MHSA program presentations for CSS, PEI, INN and WET have been provided at MHSA Steering Committee meetings. Through these presentations, the committee has gained a deeper understanding of program services, participation of consumers and family members in the delivery of services, outcomes, and examples of how clients have benefited from the services.

The Steering Committee has also been provided with information on PEI and WET implementation as well as updates on our involvement with the California Mental Health Services Authority (CalMHSA) Joint Powers Authority and the progress CalMHSA is making with the Statewide PEI Programs. During the 30-day posting of the Draft Three-Year Plan, BHS presented to the BHS Cultural Competence Committee, MHSA Steering Committee, and the Mental Health Board to obtain additional stakeholder input.

Other Stakeholder and Community Input and Feedback

Additionally, BHS has convened many stakeholder input sessions to reach stakeholders who do not regularly participate in the MHSA Steering Committee meetings. Stakeholder input, which includes consumer and family input, is a critical component to ensuring programming is effective, respectful and responsive.

BHS is implementing a regular procurement schedule for contracted programs which is informed collectively by the stakeholder participation and input that occurs in many forms across the system.

Examples include:

- Mandatory Advisory Boards
  - Mental Health Board
  - Alcohol and Drug Advisory Board
- Recommending Bodies
  - MHSA Steering Committee
  - Cultural Competence Committee
  - Family Advisory Committee
  - Youth Advisory Committee
  - Older Adult Coalition
  - Behavioral Health Racial Equity Collaborative
  - Youth Advocacy Board (in development)
- Broader Stakeholder Sessions
  - Town Halls
  - Community Conversations
- Program/Project Specific Input
  - Anecdotal feedback from system partners, consumers/family members and providers
  - African American Ad Hoc Workgroup
  - Surveys
  - Alternatives to 911 for Mental Health Calls
  - MHSA Steering Committee Ad Hoc Workgroups
  - Key Informant Interviews
  - Focus Groups
  - Multi-County FSP Collaborative (INN Project)
  - Needs Assessments
  - Satisfaction Surveys

Examples of various outreach materials and summaries of these feedback sessions are included and inform the design and implementation of the MHSA-funded programming and activities contained in this MHSA Three-Year Plan – *See Attachment B.*

BHS published Cultural Competence & Ethnic Services Newsletters to highlight the work done in this area to showcase the diverse cultures and communities in Sacramento County. These Newsletters are included – *See Attachment C*.

On March 18 and April 15, 2021, the MHSA Steering Committee was presented with information about Assisted Outpatient Treatment (AOT) and the community input received in consideration of whether Sacramento County should implement or opt out of this programming. The MHSA Steering Committee was asked to consider whether or not to support the use of MHSA funds for AOT if implemented. After careful discussion and consideration, the Committee voted to recommend that MHSA funds not be used for this programming – *See Attachment D.*

Three Year Plan Posting and Public Hearing

BHS strives to circulate the Three-Year Plan as broadly as possible. At the beginning of the posting period, a public notice was published in The Sacramento Bee announcing the posting of the Three-Year Plan and the date and time of the public hearing. The notice includes the web link to the Three-Year Plan and also provides instructions on how to request a hard copy of the Three-Year Plan by mail. Fliers announcing the posting and public hearing were posted in public libraries throughout Sacramento. The information is also circulated through multiple email distributions, ethnic, cultural and language-specific media outlets, and hard copies are available for pick up at BHS administrative office.

The Draft MHSA Fiscal Year 2021-22, 2022-23, 2023-24 Three-Year Program and Expenditure Plan was posted for a 30-day public comment period from May 3 through June 2, 2021. The Mental Health Board conducted a Public Hearing, held virtually, on Wednesday, June 2, 2021, beginning at 6:00 p.m.

Public Comment

Several comments were received related to the Draft MHSA Fiscal Year 2021-22, 2022-23, 2023-24 Three-Year Program and Expenditure Plan (Three-Year Plan) during the 30-day public review and comment period. Below is a summary of those comments and Behavioral Health Services' response.

There were comments received in support of the content of the Three Year Plan with special recognition and appreciation for the success stories that put a face on the clients served in many of the programs included in this Three-Year Plan. There were also comments appreciating the Three-Year Plan being more accessible and less cumbersome. The MHSA Steering Committee, BHS Cultural Competence Committee and Mental Health Board were supportive of moving the Three-Year Plan forward to the Sacramento County Board of Supervisors for approval.

The Committees, Mental Health Board and community expressed ongoing support for the programs contained in the Three Year Plan, with specific attention to the array of Community Services and Supports (CSS), Prevention and Early Intervention (PEI), and Workforce Education and Training (WET) component programs and activities.

There were comments expressing appreciation for the fiscal summary and budget explanations, as well as comments expressing both support and concerns for the rapid spend down of the unspent funds balance identified in the funding summary. Comments received reflect a desire for continued clarification of the complex budgeting and expenditure projections, clarity on unspent funds (to better understand how unspent funds are calculated, reflected, and represented), reversion risk, and the plans to address these areas.

There were comments acknowledging the overall positive impact of MHSA funded programs and activities. There were comments recommending that BHS work with FSP providers to improve employment outcomes for FSP clients. There were also suggestions made to consider funding Assisted Outpatient Treatment (AOT) and homeless initiatives with MHSA funds.

Suggestions were made to consider including more MHSA PEI programming for school-based mental health services. There were comments suggesting more youth representation in all aspects of community program planning processes and program implementation, as well as expanding services for youth.

Comments also acknowledged and suggested continued support for culturally and linguistically responsive services. Comments also support increasing the cultural and linguistic diversity of our workforce and increasing collaborations with grass roots organizations with close ties to unserved and underserved diverse communities. There were also comments in support of peer certification and expanding peer employment in the system of care.

There were comments from the adult outpatient mental health service providers expressing the desire to learn more about the planned competitive bidding and future redesigned programming for adult consumers.

During the public review and comment period, the California Department of Health Care Services (DHCS) conducted the MHSA Program Review of Sacramento County's approved MHSA FY 2017-18, 2018-19, 2019-20 Three-Year Program and Expenditure Plan, MHSA FY 2019-20 Annual Update, FY 2019-20 Annual MHSA Revenue and Expenditure Report to determine compliance with regulations, statutes, and the performance contract. DHCS noted that the previously approved Three-Year Plan and Annual Update were well organized and easy to read. They also commented that they appreciated the program descriptions and success stories. Their feedback included suggested areas of improvements for future plans and updates such as describing in more detail Sacramento County's Community Program Planning Process (CPPP) steps, describing MHSA CPPP training for stakeholders and staff, and clearly characterizing some activities as an assessment of the County's capacity to deliver services.

Behavioral Health Services Response

Sacramento County Behavioral Health Services (BHS) values and appreciates the input provided by community stakeholders, including the MHSA Steering Committee, Cultural Competence Committee, and Mental Health Board. This continues to be a core value of the local community planning process.

BHS is committed to the ongoing collaboration with community stakeholders for existing program design as well as consideration of new and expanded programming. BHS remains committed to exploring new federal, state, or local grant opportunities or collaborations offering a path to leverage MHSA funds.

BHS values ongoing community and stakeholder support to use data to inform continuous improvement and evaluate the effectiveness of MHSA funded programs and activities. This includes the FSP outcomes data related to employment and will continue to work with CSS program providers to address this outcome moving forward.

BHS recognizes and supports the need for culturally specific programming in targeted communities and continues to work to develop and ensure that cultural and ethnic-specific opportunities and strategies to further reach these communities are employed in program planning

and service delivery. Strategies include translation of the MHSA Annual Update Executive Summary and announcement related to the Public Hearing in all threshold languages, as well as publishing and announcing in ethnic media outlets.

The Department of Health Services and Behavioral Health value our longstanding partnership with Education and remain committed to working together to improve services for and participation by youth across the systems (and beyond MHSA-funded programming).

BHS recognizes the volatile nature of MHSA funding as a tax-based revenue. As such, BHS continues to work closely with a fiscal consultant to develop sustainability strategies using a combination of unspent funds and new revenues to sustain current programming and to expand programming at a level that can be sustained into the future. BHS will continue to provide revenue and expenditure projections, as well as education regarding MHSA, including CSS funding demands to sustain existing CSS programs, MHSA Housing Program investments, and critical WET and CF/TN activities. BHS will also continue to provide regular program and budget updates/presentations in these key areas at MHSA Steering Committee and Mental Health Board meetings.

In response to the public comments and feedback from DHCS, several updates were made and incorporated into this MHSA Fiscal Year 2021-22, 2022-23, 2023-24 Three-Year Program and Expenditure Plan, including: expanded detail of county demographics and Community Program Planning Process activities and training for stakeholders/staff; removal of obsolete MHSA County Compliance Certification form; adding Cost per Person in PEI and INN components; and program capacity by ages served; etc.

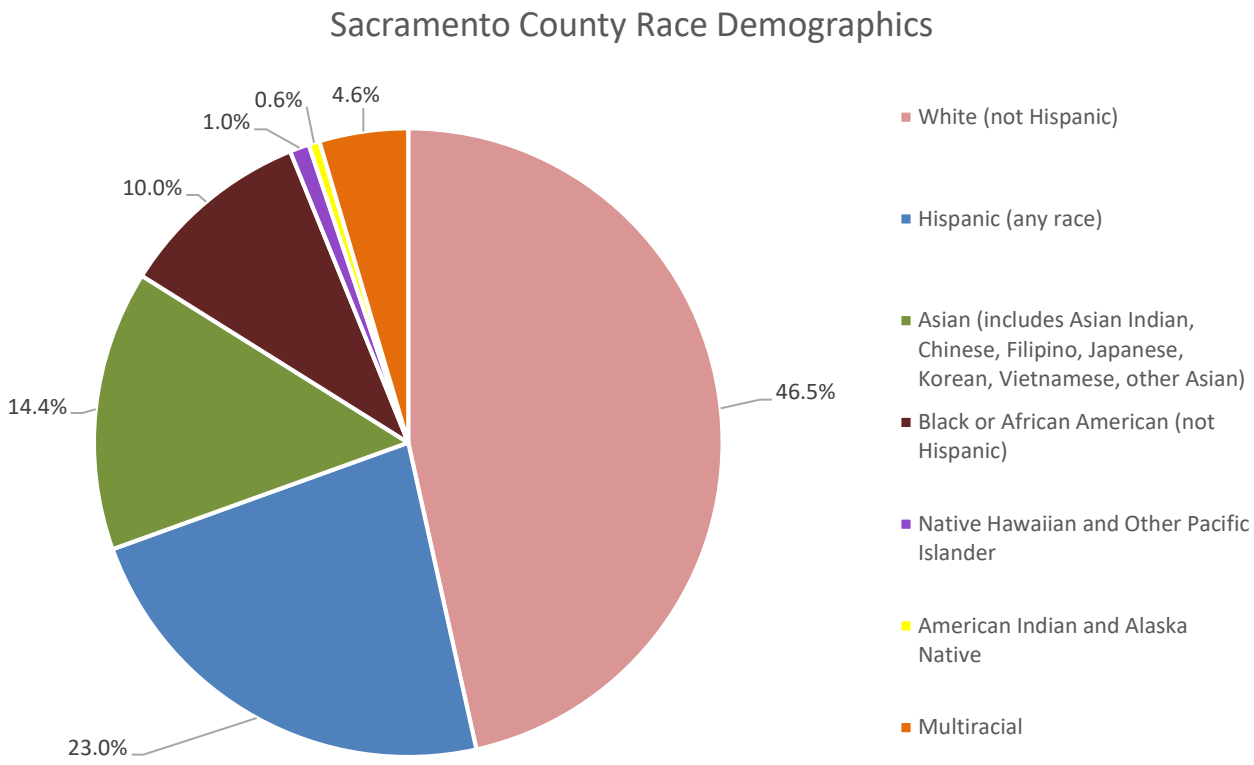
SACRAMENTO COUNTY MENTAL HEALTH PLAN SYSTEM CAPACITY

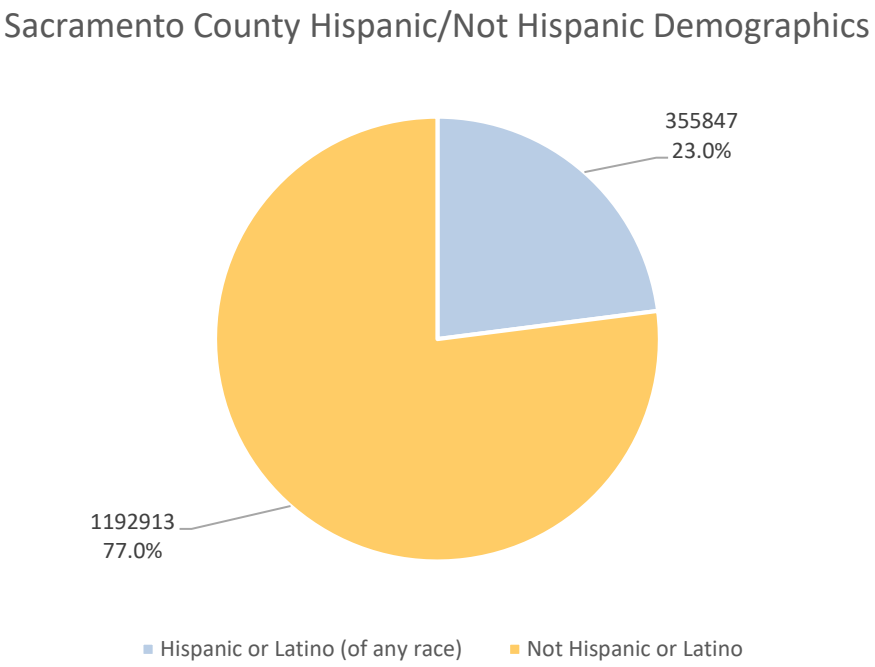
Demographic Overview

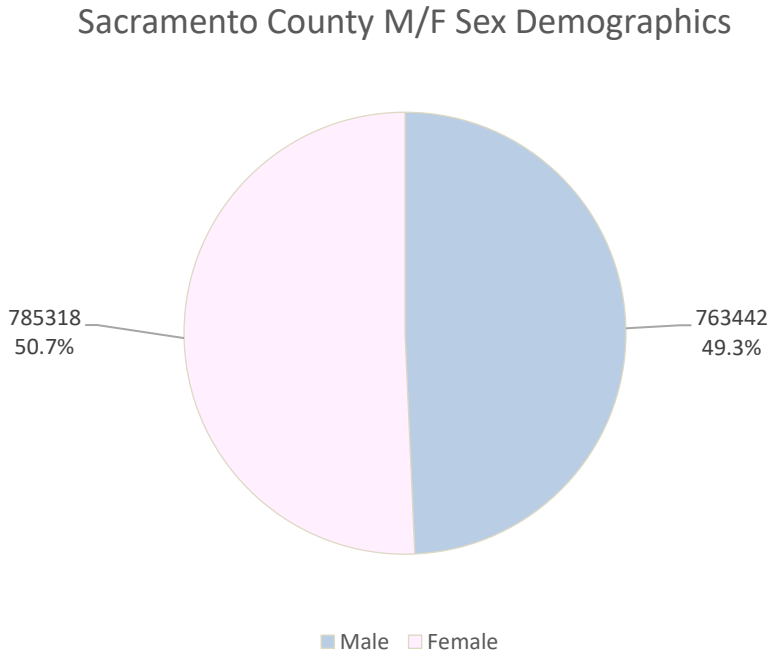
Sacramento County is one of eighteen counties located in the Central Mental Health Region of the State of California. The State of California, Department of Finance estimates the 2019 population of Sacramento County to be approximately 1.5 million. With more than a half million residents living in unincorporated Sacramento County, it makes our unincorporated county population the fifth largest in the state. As such, Sacramento is considered a large county, especially in comparison with the populations of surrounding counties.

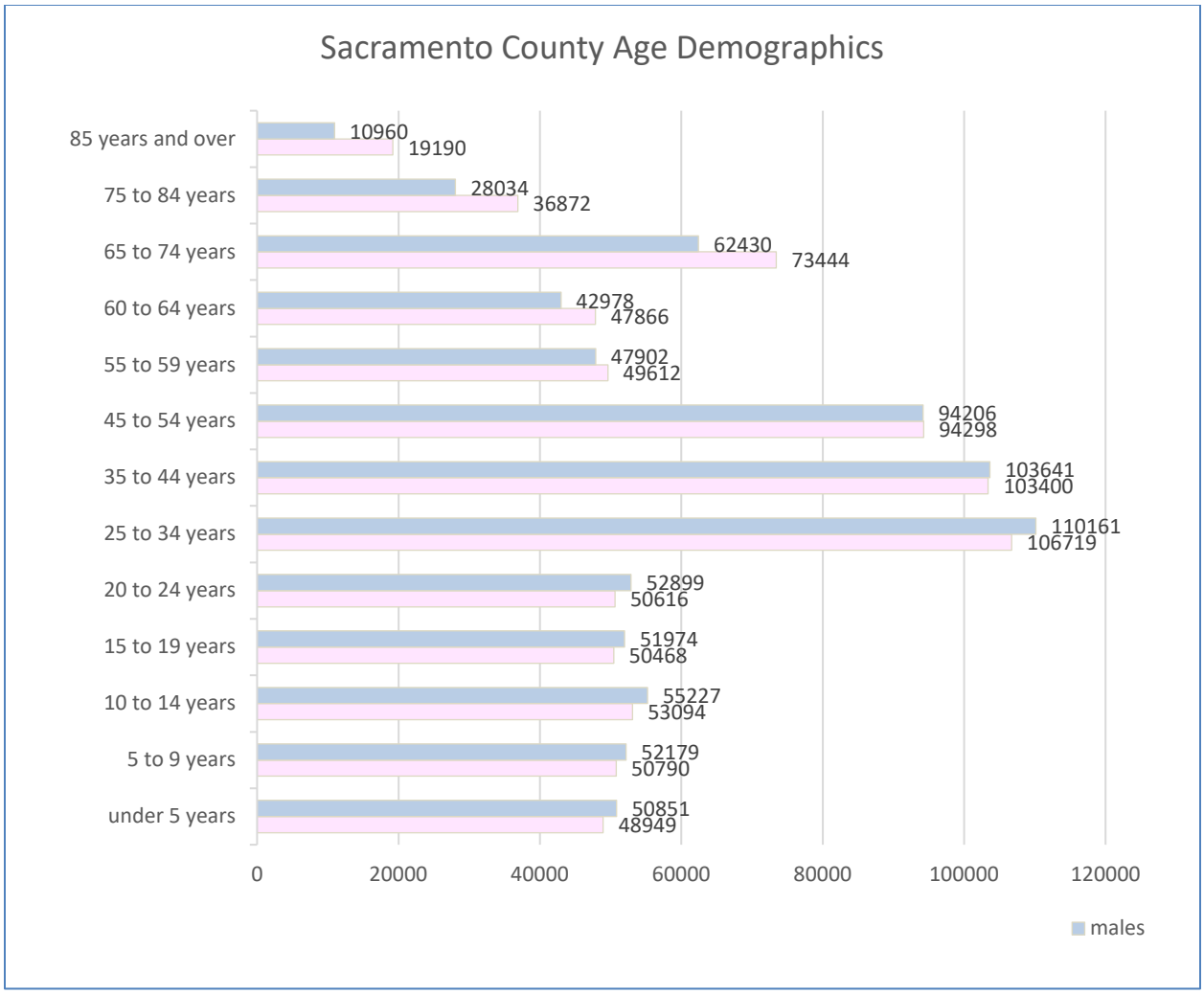
Sacramento is one of the most ethnically and racially diverse communities in California. While the Wilton Rancheria Tribe is the only Federally Recognized Tribe in Sacramento County, Native Americans from local and out of state tribes currently reside in Sacramento. Historically, Sacramento County has been one of three counties with the highest number of newly arriving refugees in California. However, in recent years, Sacramento County has resettled the most Refugees and Special Immigrant Visa holders (SIVs) as compared to any other county in California. With the addition of Arabic as a threshold language in 2017 and Farsi in 2020, Sacramento County now has a total of seven threshold languages (Arabic, Cantonese, Farsi, Hmong, Russian, Spanish, and Vietnamese).

The breakdown of Sacramento County's population by gender, age, and racial and ethnic categories is based on California Department of Finance data and reporting categories from 2019.




Sacramento County Hispanic/Not Hispanic Demographics
355847
23.0%
1192913
77.0%
Hispanic or Latino (of any race)
Not Hispanic or Latino


Sacramento County M/F Sex Demographics
785318
50.7%
763442
49.3%
Male
Female



Penetration and Retention Rates for Medi-Cal Beneficiaries

The penetration rate chart below is from Calendar Year (CY) 2019. The penetration rate is calculated as the total number of persons served divided by the number of persons eligible. When reviewing this data, it is important to consider that the penetration rate table reflects the number of Medi-Cal beneficiaries served through the specialty mental health treatment programs. It, however, does not account for any of the individuals served, irrespective of insurance status, through the Behavioral Health Services (BHS) MHSA-funded prevention and mental health respite programs. BHS funds culturally specific community based organizations to operate prevention programs that specifically serve the cultural, racial and ethnic groups listed in this table. However, due to the nature of the data collection for MHSA-funded prevention and mental health respite programs it is challenging to obtain unduplicated individual demographic data that can be merged with specialty mental health plan data. Were it possible to merge the data, we believe that the penetration rates would be more reflective of who is served by BHS through specialty mental health services, prevention and respite services.

Sacramento County is a Geographic Managed Care (GMC) county with bifurcated mental health benefits provided through plans and Sacramento County Mental Health Plan (MHP). As a result, several other organizations are providing mild to moderate mental health services to Medi-Cal

beneficiaries in Sacramento County. It is possible that penetration rates for some age, race, cultural and ethnic groups are underreported due to services being delivered in the community by community partners that are not part of the MHP, such as Federally Qualified Health Centers (FQHC) and health plans' subcontractors.

Sacramento County Mental Health Plan Penetration Rates		Calendar Year 2019				
		A		B		B/A
		Medi-Cal Eligible Beneficiaries		Medi-Cal Clients (Unduplicated)		Medi-Cal Penetration Rates
		N	%	N	%	%
Age	O to 5	65,192	12.2%	895	3.6%	1.4%
	6 to 17	129,038	24.1%	8,913	36.1%	6.9%
	18 to 59	270,743	50.5%	12,752	51.6%	4.7%
	60+	71,458	13.3%	2,147	8.7%	3.0%
	Total	**536,431**	**100.0%**	**24,707**	**100.0%**	**4.6%**
		N	%	N	%	%
Gender	Female	284,402	53.0%	13,007	52.6%	4.6%
	Male	252,029	47.0%	11,699	47.4%	4.6%
	Unknown/Not Reported	0	0.0%	1	0.0%	N/A
	Total	**536,431**	**100.0%**	**24,707**	**100.0%**	**4.6%**
		N	%	N	%	%
Race	White	123,919	23.1%	7,963	32.2%	6.4%
	African American	80,018	14.9%	5,241	21.2%	6.5%
	American Indian/Alaskan Native	3,622	0.7%	249	1.0%	6.9%
	Asian/Pacific Islander	73,606	13.7%	1,732	7.0%	2.4%
	Other	133,967	25.0%	3,870	15.7%	2.9%
	Hispanic	121,301	22.6%	5,652	22.9%	4.7%
	Total	**536,433**	**100.0%**	**24,707**	**100.0%**	**4.6%**

Review of the FY 2019-20 retention rate table below shows the number of services per individual to determine retention. Retention is defined as receiving five (5) or more specialty mental health services in a fiscal year. The table below shows, by demographic characteristic, the number of services individuals received in FY 2019-20. The majority of individuals (65.7%) received more than five (5) services during FY 2019-20 with almost 39% of individuals receiving more than 15 services in the fiscal year. Retention rates for children, aged 0 to 17 years, receiving more than 15 services, are higher than the overall system. Individuals receiving more than 15 services who speak Spanish and who speak Cantonese have higher retention rates (48.5%, 42% respectively). Males are retained at a slightly higher rate than females (39.6%, 37.9%, respectively).

Sacramento County Mental Health Plan Retention - FY 19/20														
FY 19/20		Total Served	1 Service		2 Services		3 Services		4 Services		5 to 15 Services		>15 Services	
			N	%	N	%	N	%	N	%	N	%	N	%
Race (0-17.9)	API	370	17	4.6	20	5.4	13	3.5	20	5.4	99	26.8	201	54.3
	Black	2,126	144	6.8	118	5.6	84	4.0	69	3.2	609	28.6	1,102	51.8
	Hispanic	3,256	209	6.4	158	4.9	123	3.8	94	2.9	906	27.8	1,766	54.2
	Nat-Amer	67	6	9.0	1	1.5	4	6.0	2	3.0	16	23.9	38	56.7
	White	2,101	111	5.3	112	5.3	79	3.8	68	3.2	564	26.8	1,167	55.5
	Other	761	58	7.6	36	4.7	31	4.1	18	2.4	201	26.4	417	54.8
	Unk/NR	1,010	96	9.5	72	7.1	49	4.9	35	3.5	308	30.5	450	44.6
Race (≥18)	API	1,523	111	7.3	91	6.0	85	5.6	62	4.1	691	45.4	483	31.7
	Black	3,673	427	11.6	299	8.1	215	5.9	234	6.4	1,346	36.6	1,152	31.4
	Hispanic	2,679	362	13.5	221	8.2	162	6.0	135	5.0	973	36.3	826	30.8
	Nat-Amer	182	30	16.5	11	6.0	6	3.3	6	3.3	60	33.0	69	37.9
	White	6,133	741	12.1	435	7.1	354	5.8	270	4.4	2,323	37.9	2,010	32.8
	Other	892	94	10.5	70	7.8	62	7.0	56	6.3	364	40.8	246	27.6
	Unk/NR	1,300	274	21.1	184	14.2	119	9.2	109	8.4	440	33.8	174	13.4
Age	0-17.9	9,691	641	6.6	517	5.3	383	4.0	306	3.2	2,703	27.9	5,141	53.0
	≥ 18	16,384	2,039	12.4	1,311	8.0	1,003	6.1	872	5.3	6,198	37.8	4,961	30.3
Sex	Male	12,523	1,386	11.1	876	7.0	688	5.5	554	4.4	4,055	32.4	4,964	39.6
	Female	13,552	1,293	9.5	953	7.0	697	5.1	625	4.6	4,846	35.8	5,138	37.9
	Unk/NR	14	6	42.9	2	14.3	1	7.1	0	0.0	3	21.4	2	14.3
Language	English	22901	2,388	10.4	1,631	7.1	1,216	5.3	1,035	4.5	7,610	33.2	9,021	39.4
	Spanish	1230	82	6.7	48	3.9	52	4.2	42	3.4	409	33.3	597	48.5
	Russian	246	15	6.1	6	2.4	13	5.3	6	2.4	116	47.2	90	36.6
	Hmong	247	11	4.5	4	1.6	13	5.3	9	3.6	127	51.4	83	33.6
	Vietnamese	173	12	6.9	11	6.4	7	4.0	8	4.6	88	50.9	47	27.2
	Cantonese	88	7	8.0	2	2.3	4	4.5	4	4.5	34	38.6	37	42.0
	Arabic	148	13	8.8	6	4.1	6	4.1	7	4.7	91	61.5	25	16.9
	Other	539	35	6.5	38	7.1	27	5.0	18	3.3	275	51.0	146	27.1
	Unk/NR	517	122	23.6	85	16.4	48	9.3	50	9.7	154	29.8	58	11.2
TOTAL		**26,089**	**2,685**	**10.3**	**1,831**	**7.0**	**1,386**	**5.3**	**1,179**	**4.5**	**8,904**	**34.1**	**10,104**	**38.7**

Mental Health Plan Network Adequacy

In February 2018, California Department of Health Care Services (DHCS) informed all County Mental Health Plans (MHPs) that they must meet network capacity requirements to serve the population of adults and children/youth Medi-Cal beneficiaries. Network capacity standards require that counties demonstrate timely access to care, reasonable time and distance from provider sites to beneficiary residences, and an adequate number of outpatient psychiatrist and clinical providers for Medi-Cal beneficiaries. Each MHP is required to submit at minimum, an annual Network Adequacy Certification Tool (NACT) detailing the MHPs' providers, site locations, services provided, staff composition, and language capacity. MHPs are required to submit supporting documentation such as policies and procedures relating to meeting and monitoring network capacity requirements, timeliness data, Geographic Information System (GIS) maps, and data demonstrating use of interpreters. In April 2021, DHCS provided notification that Sacramento County was in compliance with all network adequacy standards.

Human Resource Survey

The 2019 Human Resource (See Attachment G) survey includes data relating to the diversity of Sacramento County's MHP workforce. Demographic information and language capabilities of staff, volunteers and any committee members who participate in serving individuals throughout the entire County Mental Health System was collected. The purpose of the surveys is to assess demographic and linguistic information for those who provide services in our county to determine whether it is reflective of the diversity of the community as a whole.

The information collected focuses on staff ethnicity, language proficiencies, consumer/family member status, gender, sexual orientation, disability and veteran status.

Key findings:

- A total of 1,239 staff responded to at least one question on the survey.
- Of all staff surveyed, 400 (32.3%) unduplicated staff indicated speaking a language other than English. For staff who spoke one language other than English, the majority spoke Spanish (39.0%) followed by Hmong at just over 7% (7.5%). Almost nineteen percent (18.8%) indicated speaking two or more languages other than English.
- 20.5% of staff self-identify as being of Hispanic ethnicity.
- 71.5% of the staff identify as being female and 21.9% as male.
- 42.9% of staff self-identified as Caucasian, 12.8% as African American, 8.1% as Multi-ethnic, 3.3% as American/Alaska Native, 2.5% as Filipino, 2.6% as Other Asian, 3.1%as Hmong, 1.9% as Asian Indian, 1.7 % as Chinese, and 9.5% as "Other".
- 42.6% self-identify as a family member of a consumer, 24.2% of staff self-identify as a consumer of Mental Health Services, while 12.2% of staff self-reported that they live with a disability and 3.2% currently serve or have served in the US Military.
- 73.8% of the staff self-identified as being heterosexual/straight, 4.7% as bisexual, 2.7% as lesbian, 2.3% as queer, 1.9 % as gay, 1.2% pansexual, 0.6% as asexual, 0.6% as other, 0.2% as questioning and 12.0% choose not to answer the question.

- 865 direct service staff are included in the total number of staff described above.
- 20.8% of direct service staff self-identify as being of Hispanic ethnicity.
- 27.3% of direct service staff self-identify as a consumer of Mental Health Services, while 43.7% self-identify as having a family member who is a consumer of Mental Health Services.

COMMUNITY SERVICES AND SUPPORTS (CSS) COMPONENT

The **Community Services and Supports (CSS)** component provides funding for mental health treatment services and supports for children/youth and their families living with severe emotional disturbance and transition age youth (TAY), adults, and older adults living with a serious mental illness. The MHSA requires a minimum of fifty percent of CSS component funding be dedicated to Full Service Partnership (FSP) programs.

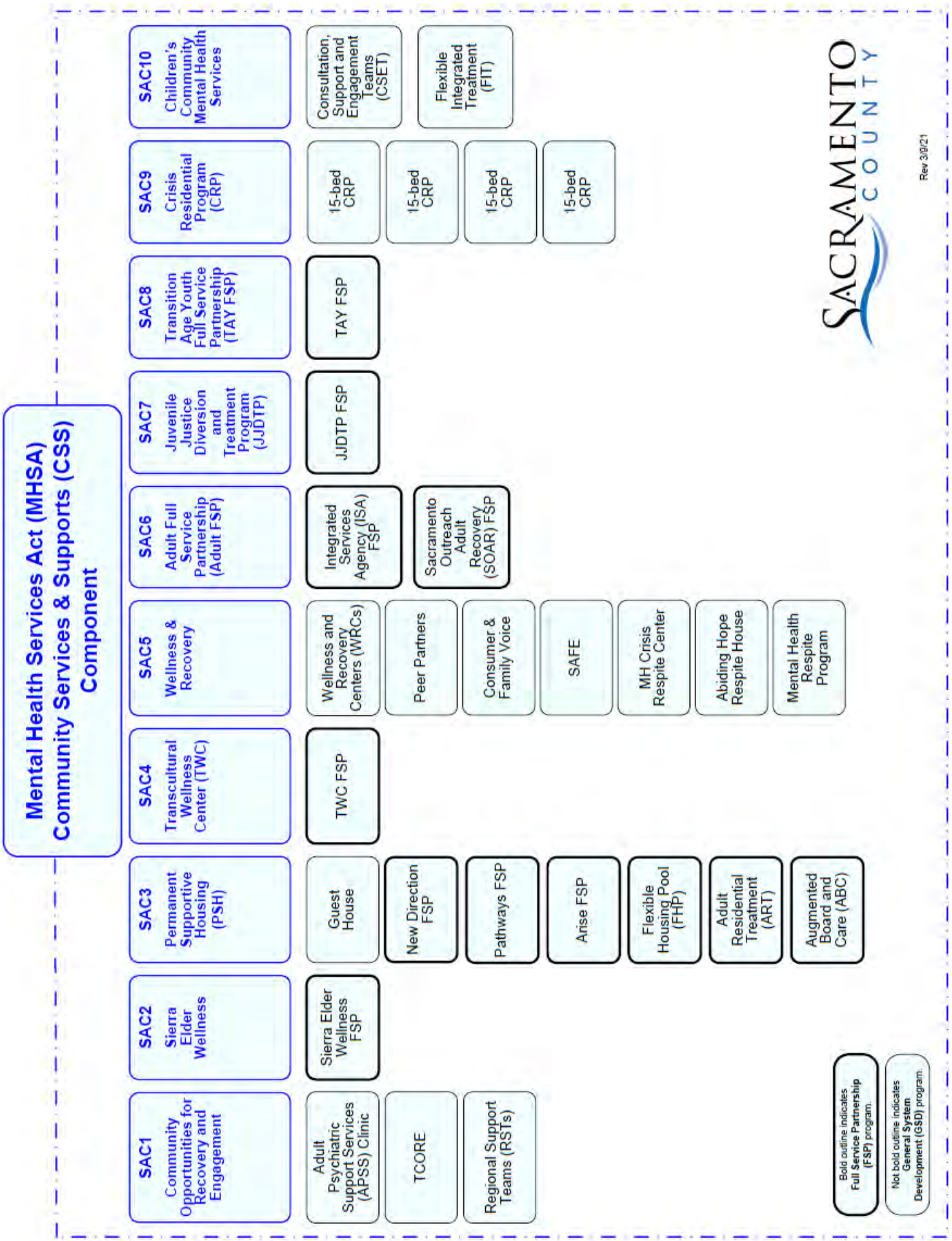
Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for Workforce Education and Training (WET), Capital Facilities and Technological Needs (CF/TN), and the Local Prudent Reserve. This means unspent CSS funding is combined with incoming revenue to sustain CSS programming/activities, as well as sustaining critical activities in the time-limited WET and CF/TN components and sustaining successful and applicable Innovation (INN) project components. CSS funding must also be used to sustain MHSA Housing Program investments (S*ee Attachment E - MHSA Funding Summary*).

There are three service categories within the CSS Component:

- Full Service Partnership (FSP) Service Category – FSPs provide the full spectrum of high intensity outpatient mental health treatment for children and youth (and their families) living with severe emotional disturbance and TAY, adults, and older adults living with serious mental illness.
- General System Development (GSD) Service Category – GSDs provide low to moderate intensity outpatient mental health services to individuals living with serious mental illness and, as appropriate, their families.
- Outreach and Engagement Service Category – Activities to reach, identify and engage unserved individuals and communities in the mental health system and reduce disparities identified by the County. In Sacramento, these activities are embedded into the design of the FSP and GSD programs.

In Fiscal Year (FY) 2019-20 the implemented FSPs served 2,596 unduplicated clients and the implemented GSDs served 14,264 unduplicated clients. Descriptions of these programs are included in this Three-Year Plan.

As presented to the MHSA Steering Committee in January and April 2021, BHS is implementing a regular procurement schedule for contracted programs, utilizing stakeholder input from various methods and groups to ensure programming is effective, respectful and responsive (*See Attachment F*). The Request for Letters of Interest for the Adult Outpatient Transformation was released on April 30, 2021, and provides an opportunity to integrate community stakeholder input to refine our outpatient system to more effectively serve our community and to enhance the overall adult outpatient mental health services delivery system.


Mental Health Services Act (MHSA)
Community Services & Supports (CSS) Component
SAC1 Community Opportunities for Recovery and Engagement
SAC2 Sierra Elder Wellness
SAC3 Permanent Supportive Housing (PSH)
SAC4 Transcultural Wellness Center (TWC)
SAC5 Wellness & Recovery
SAC6 Adult Full Service Partnership (Adult FSP)
SAC7 Juvenile Justice Diversion and Treatment Program (JJDTP)
SAC8 Transition Age Youth Full Service Partnership (TAY FSP)
SAC9 Crisis Residential Program (CRP)
SAC10 Children's Community Mental Health Services
Adult Psychiatric Support Services (APSS) Clinic
TCORE
Regional Support Teams (RSTs)
Sierra Elder Wellness FSP
Guest House
New Direction FSP
Pathways FSP
Arise FSP
Flexible Housing Pool (FHP)
Adult Residential Treatment (ART)
Augmented Board and Care (ABC)
TWC FSP
Wellness and Recovery Centers (WRCs)
Peer Partners
Consumer & Family Voice
SAFE
MH Crisis Respite Center
Abiding Hope Respite House
Mental Health Respite Program
Integrated Services Agency (ISA) FSP
Sacramento Outreach Adult Recovery (SOAR) FSP
JJDTP FSP
TAY FSP
15-bed CRP
15-bed CRP
15-bed CRP
15-bed CRP
Consultation, Support and Engagement Teams (CSET)
Flexible Integrated Treatment (FIT)
SACRAMENTO COUNTY
Rev 3/9/21
Bold outline indicates Full Service Partnership (FSP) program.
Not bold outline indicates General System Development (GSD) program.

Program: Community Opportunities for Recovery and Engagement
Work Plan #/Type: SAC1 – General System Development (GSD)
Capacity: 5,400 at any given time
Ages Served: 8% TAY, 77% Adults, 15% Older Adults

The **Community Opportunities for Recovery and Engagement** workplan, consists of the following previously approved and implemented program components: **Adult Psychiatric Support Services (APSS)** clinic, **TCORE**, and the redesigned **Regional Support Team (RST)** service delivery system. These programs offer community-based mental health services for individuals (age 18 and older) being released from acute care settings or who are at risk for entering acute care settings and are not linked to on-going mental health services.

APSS, administered by BHS, is a site-based outpatient clinic that provides behavioral health services to transition aged youth (TAY), adult, and older adult clients, ages 18 and above. Counselors with training in integrated mental health and substance abuse care are available and provide services that are closely coordinated with psychiatrists, nursing staff, peers, and other team members.

The APSS clinic includes a Peer Partner component, administered by Cal Voices, which provides culturally and linguistically relevant advocacy and support for program participants. The Peer Partner staff are members of the multidisciplinary team. The APSS service array includes: assessment, brief treatment, crisis intervention, case management, rehabilitation, medication management and support, and transition to appropriate specialty mental health services and/or community support. In January, 2020 APSS expanded services to provide centralized assessment and referrals to speciality mental health and community services for clients who are discharging from inpatient psychiatric hospitalization. In 2021, APSS will add a similar new service of providing centralized assessment and behavioral health services for clients discharging from the Sacramento County jails.

Success: APSS Clinic
A 38 year old male client came to APSS three years ago exhibiting severe symptoms of Bipolar Disorder and Post Traumatic Stress Disorder (PTSD) from childhood trauma. He had been hearing voices, struggling with anger, and had left his supervisory job. He was sleeping on the couch in his parents' home. With medication support and counseling at APSS, he became better able to manage his symptoms and started working as a volunteer with at-risk youth. The volunteer position led to a part-time job and eventually full-time employment. He is also nearing completion of a degree in psychology. He now lives in his own apartment and has a strong relationship with his son, who has just started college. When his APSS clinician spoke with the client recently in a final appointment, he expressed his happiness with his recovery and the progress he has made with the support of the APSS clinic.

Program outcomes are to promote recovery and optimize community functioning; reducing and preventing homelessness; improving overall health by increasing access to primary health care; increasing connection to community resources and benefits; supporting engagement in meaningful activities/employment; and increasing social connectedness.

TCORE, administered by TLCS, Inc. (also known as Hope Cooperative) provides flexible, recovery-oriented, strength-based, culturally competent, client-driven, and community-based specialty mental health services and supports to adult beneficiaries living with a severe mental illness. The TCORE program model includes a phased approach, initially focused on intensive engagement and assessment services for mental health consumers who are either in, or discharged from, acute care settings, or who are at demonstrated risk of requiring acute care, with the goal of assisting individuals in transitioning to a lower level of service intensity over time. TCORE also provides homeless services and supports to address the needs of individuals living with serious mental illness who are homeless or at-risk of homelessness and may also have co-occurring substance use disorders.

Success: TCORE Program
TCORE started working with a client in January 2020. By October, this client had two inpatient stays for unmanaged depression, mood changes, and substance use, all which caused major friction in the home with what family remained in her life at the time. She required a lot of motivation and time from her treatment team, during which her Personal Service Coordinator (PSC) played a significant role building a relationship with the client. That relationship was key in the client making progress in her treatment. The team increased frequency of visits with her psychiatrist (1x/month), which were face to face visits during COVID. Her PSC helped the client figure out her long-term goals for herself, the most important of which was reconnecting with her family. The team (client, PSC, doctor, housing specialist, and peer) held regular staffings to ensure that all team members were on the same page in treatment. The team made the clinical decision that substances were the major barrier to client's progress on goals. Client was challenged, encouraged, and also offered sober resources, such as clean and sober housing (where she has now been for approximately six months) and now has a community of people who are cheering her on. This client was able to visit with her grandson for the first time last month. She is currently working with her TCORE team on reconnecting with family as well.

Program outcomes are to improve access to services for individuals who are not able to utilize community services due to complex co-occurring needs; to provide flexible services/interventions necessary to reduce/prevent negative outcomes, such as avoidable emergency room utilization, psychiatric hospitalization, jail/incarceration, and eviction/homelessness; and to provide services that will increase participants' ability to function at optimal levels and as independently as possible.

The **Regional Support Team (RST)** service delivery system includes programs located in four geographic areas throughout Sacramento County. They are administered by El Hogar Community Services, Inc., TLCS, Inc. (also known as Hope Cooperative), Turning Point Community Programs, and Visions Unlimited. The RSTs provide moderate intensity mental health services and supports for TAY (age 18+), adults, and older adults who meet target population criteria for a serious mental illness. Services are flexible, culturally competent, and recovery-based, and include assessments, planning, individual and group treatment, social rehabilitation, case management, psychiatric medication services, and housing services and supports to address the needs of individuals living with serious mental illness who are homeless or at-risk of homelessness. The RSTs have Community Care Teams (CCTs) able to engage members where needed, including in the community to assist with timely engagement into services, as well as improving capacity by providing enhanced coordination of care for clients ready to step-down to lower levels of care. Staffing for each CCT includes a team lead, clinician/social worker, psychiatrist and nurse, peer/family provider, and resource specialist.

Program outcomes are to promote recovery and optimize community functioning; reducing and preventing homelessness; improving overall health by increasing access to primary health care; increasing connection to community resources and benefits; supporting engagement in meaningful activities/employment; and increasing social connectedness.

Success: El Hogar RST
An older adult client reported a great deal more depression and anxiety in the beginning months of the shelter-in-place order. Due to her age and medical history, her anxiety about the pandemic and potential exposure was to the point where she was too fearful to go to the pharmacy to pick up her meds, and she lived out of range for a pharmacy drop off. To address this, the Community Care Team (CCT) arranged times to pick up and drop off her medication while her Personal Service Coordinator (PSC) simultaneously provided coaching and skill building during phone rehabilitation sessions. Gradually, she was able to get to the point where she would call her PSC from the car on her way to the pharmacy, showing a slow taper down from the need for phone coaching altogether. This client was able to develop a skill set to help her through the pandemic and is now able to do this task independently with a self-report of well managed anxiety and stress.

Success: TLCS RST
A TLCS RST client has been with the program since 2018. In July of 2020, she achieved her goal of being off of her medication. She did this through utilizing her support system and developing learned coping skills. Client graduated from school, and is now four months employed as a CNA. Client continues to implement talk therapy for support and has mended her relationship with her daughter. She has broadened her community and sought out new interests, such as gemology - reporting that she finds relief and joy in collecting crystals and learning about them. When graduation was discussed, this client reported that she believes she is ready and excited for her future.

Success: Turning Point RST
TPCP RST staff has been working with a 62-year-old male who was homeless upon admission. Client had previously been a professor at a local university; however, his depression worsened, which led to him losing his job and housing. RST staff worked with client to secure housing that he could afford on his limited income and gave him information on helpful local resources such as food banks. RST staff is continuing to assist this client with a current legal matter related to his car that continues to impact his depression and stress levels. After providing these services along with skill building, this client is no longer living in his car and his overall well-being has improved. He has expressed how grateful he has been for the staff supporting and working with him so closely during this time.

Success: Visions RST
A Visions RST client, 61-year-old, White female stated that she appreciated receiving services and especially liked getting them by phone because her ongoing, multiple health issues as well as her age group place her in an impacted population during the pandemic. She said she enjoyed not having to worry about trying to make it to her therapy appointments in office. As a result of the changes, client was able to fully participate in her therapy services and successfully completed therapy and graduated from services as of January 2021.

The contract for the new adult outpatient program, **Haven**, was awarded to Turning Point Community Programs. Haven was scheduled to open in May 2020; however, due to the COVID-19 Pandemic, the ability to site the program became an ongoing challenge. Haven's outpatient component was intended to provide client-driven, recovery-oriented, strength-based, trauma-informed, culturally and linguistically responsive, comprehensive community-based specialty mental health services and supports to TAY (18+), adults, and older adults meeting target population. As Sacramento County considered making budget reductions due to the pandemic impact on projected revenues, programs that were not implemented, such as Haven, were reviewed and considered for elimination.

Program: Sierra Elder Wellness
Work Plan #/Type: SAC2 – Full Service Partnership (FSP)
Capacity: 140 at any given time
Ages Served: 13% Transition Age Older Adults, 87% Older Adults

The Sierra Elder Wellness Program (Sierra), administered by El Hogar Community Services, Inc., provides an array of FSP services to transition-age older adults (ages 55 to 59) and older adults (age 60+) of all genders, races, ethnicities, and cultural groups who are struggling with persistent and significant mental illness and who would otherwise utilize the most restrictive and highest level programs. Sierra provides comprehensive, integrated, culturally competent mental health services – including assessments, planning, social rehabilitation, intensive case management, co-occurring substance use services, and psychiatric medication support. Sierra also provides specialized services specific to older adults, facilitating the coordination between multidisciplinary mental health, physical health, and social service teams in order to assist community members to remain living in the community as independently as possible. FSP services also include assistance with benefit acquisition, housing subsidies and supports, employment, and transportation when needed.

Success: Sierra Elder Wellness Program
A consumer was referred to Sierra Elder Wellness Program (Sierra) from St. Helena Hospital. At the time of referral, the consumer was on temporary conservatorship through Sacramento County Public Guardian's Office. He was diagnosed with schizophrenia, paranoid type, was not taking medications as prescribed, and had a history of multiple hospitalizations. The consumer lived in a Board and Care, but was at risk of being unable to maintain this housing due to his mental health symptoms. Upon intervention by Sierra staff, the consumer was offered linkage to housing at a more appropriate Board and Care in Galt, which allowed him the space and distance from others that he wanted. He began taking his medications as prescribed and learning skills through individual therapy and social rehabilitation to better recognize and manage his paranoid thoughts. He identified his sister as a support person, and with his permission, Sierra worked to incorporate her into services. The consumer recently moved to his own apartment where he now lives independently. He will soon graduate from services due to his ability to successfully manage his mental illness symptoms, take medication as prescribed, interact with others, and articulately communicate his needs.

Sierra establishes and maintains successful collaborations with system partners and community agencies – including assisted living board and cares; law enforcement; healthcare providers; conservators; and ethnic and cultural groups to assist consumers in maintaining in the community and working toward recovery.

Program outcomes are to strengthen functioning level to support clients in maintaining the least restrictive community-based housing; reducing unnecessary emergency room/ psychiatric hospitalizations; reducing incarceration; improving health by increasing access and coordination with primary health care; reducing homelessness; and supporting engagement in meaningful employment/activities and social connectedness.

Program: Permanent Supportive Housing Program
Work Plan #/Type: SAC3 – Full Service Partnership (FSP)
Capacity: Expansion plan in progress – Currently 1,508 at any given time
Ages Served: 3% Children, 2% TAY, 44% Adults, 51% Older Adults

The **Permanent Supportive Housing Program (PSH)** is a blend of FSP and General System Development (GSD) funding and provides seamless services to meet the increasing needs of the underserved homeless population. PSH currently consists of the following previously approved and implemented components: Guest House, New Direction, Pathways, Sacramento ARISE, Flexible Housing Pool, Adult Residential Treatment, and the Augmented Board and Care Program. The PSH Program serves homeless children, TAY, adults, and older adults of all genders, races, ethnicities and cultural groups. In FY 2019-20, these programs served 896 with FSP services and 745 with GSD services.

Guest House, administered by El Hogar, is an entry point to homeless services for individuals who present with mental health conditions who are living on the street, in shelters, and in parks, etc. It provides direct access to a clinic and emergency housing for TAY (18+), adults, and older adults. Services include daily outreach, triage, case management, mental health treatment, comprehensive mental health assessments and evaluations, medication treatment, linkages to housing and other services, and application for benefits. Guest House has implemented the highly successful Sacramento Multiple Advocate Resource Team (SMART), a promising practice assisting individuals with their applications for Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI). This expedited process increases income, which improves access to housing and a wider variety of community services. Guest House also provides short term housing supports utilizing MHSA Housing Subsidies and Support Services in order to resolve and or prevent homelessness.

Guest House Connections Lounge is a drop-in center that supports guests with learning more about mental health recovery, participating in recovery and resource-focused groups, and accessing referrals and additional linkages for substance use treatment and physical health in a safe and supportive space.

Program outcomes are to reduce homelessness, engage persons experiencing homelessness in mental health treatment services, strengthen functioning level to support clients in obtaining and maintaining community tenure, reduce acute psychiatric hospitalizations, reduce incarceration, improve health by increasing access to primary health care, increase social connectedness, and support engagement in meaningful employment/activities.

Success: Guest House
In the Connections Lounge, a Guest House Service Coordinator assisted a guest who had been recently discharged from a psychiatric hospital and referred to seek mental health services. Upon discussion with the guest, it was discovered that he had come to California to live with family. However, it had not worked out and he was now homeless. He then shared that he was unable to return home to Mexico due to his mental health symptoms and he did not have anyone to turn to or any other supports. He also shared that he was unfamiliar with the area. The Service Coordinator was able to utilize the computer lab in the Connections Lounge to help locate family members on Facebook. Service Coordinator and guest met over the course of a few days in the Connections Lounge to assist him in getting reconnected with his family. Once his family was contacted and shared their desire for him to come home, Service Coordinator was able to connect with DHA and complete a Return to Residency. The guest was very grateful for the assistance.

New Direction, administered by TLCS, Inc., provides permanent supportive housing and FSP-level mental health services and supports for TAY (18+), adults, older adults, and their families. The program provides integrated, comprehensive services utilizing a "whatever it takes" approach to support consumers in meeting their desired recovery goals. Through housing supports and subsidies, New Direction addresses the housing needs of individuals living with serious mental illness who are homeless or at risk of homelessness and who may also have co-occurring substance use disorders. New Direction provides services at two permanent MHSA-financed supportive housing projects/developments, permanent supportive housing within TLCS permanent housing sites, and utilizes community-based housing vouchers and limited subsidies providing permanent housing. Additionally, New Direction Palmer Apartments provides interim housing that has been designated as a shelter to assist residents in bridging the gap from homelessness to permanent housing.

Success: New Direction
"Barry," with housing support at Grace House, has been clean from heroin for over a year. He transitioned to a MHSA unit at Hotel Berry apartments and has maintained his independence and permanent housing. He recently obtained SSI and New Direction was able to support him with transportation services that enabled him to reunify with his daughter. Barry reports he feels hopeful for the first time in a long time and is very motivated to continue his recovery and rebuild more natural supports and relationships.

Program outcomes are to reduce homelessness, strengthen functioning level to support clients in maintaining the least restrictive community-based housing, reduce acute psychiatric hospitalizations, reduce incarceration, improve health by increasing access to primary health care, increase social connectedness, and support engagement in meaningful employment/activities.

Pathways, administered by Turning Point Community Programs, provides permanent supportive housing and mental health services and supports for children/youth, TAY, adults, older adults, and families. The program provides integrated, comprehensive services utilizing a "whatever it takes" approach to support consumers and their families in meeting their desired recovery goals. Through housing supports and subsidies, Pathways addresses the housing needs of individuals living with serious mental illness who are homeless or at risk of homelessness and who may also have co-occurring substance use disorders. Pathways provides services at six MHSA-financed permanent supportive housing developments, using community-based housing vouchers and subsidies to provide permanent housing for consumers and their families.

Success: Pathways
Member was referred to Pathways by Guest House for symptoms related to depression and trauma. She was also a survivor of domestic violence and homelessness. The overwhelming stressors left her feeling unable to effectively cope. This resulted in her developing a heavy drinking habit and related risky behaviors with negative consequences, including incarceration. As a result, she temporarily lost custody of her 8 year old son. Staff were able to support her through various court dates. Pathways program linked her to substance use disorder treatment centers; she spent four months at a residential facility, maintaining sobriety throughout her stay. She graduated from the treatment facility and continues to maintain sobriety and is now employed. Pathways continued to support her by getting her placed in a sober living home, after which she was able to regain custody of her son. She continues to be committed to treatment to improve her own mental health symptoms in order to best support herself and her son.

Program outcomes are to reduce homelessness, strengthen functioning level to support clients in maintaining the least restrictive community-based housing, reduce acute psychiatric hospitalizations, reduce incarceration, improve health by increasing access to primary health care, and support engagement in meaningful employment/ activities and social connectedness.

Sacramento Adults Recovering in Strengths-based Environment (ARISE) , administered by Telecare, Inc., began providing services to clients in February 2020. Services are rooted in the evidence based practice, Strengths Model Case Management. ARISE provides an array of FSP services to TAY (18+), adults, and older adults struggling with persistent and significant mental illness who would otherwise utilize the most restrictive and highest level of care programs. ARISE provides comprehensive, flexible, client-driven, recovery-oriented, strength-based, trauma-informed, integrated, and culturally competent mental health services. This includes assessments, planning, social rehabilitation, intensive case management, co-occurring substance use services, 24/7 crisis response, and psychiatric medication support.

Success: Sacramento ARISE
When member was first connected with ARISE, they had multiple psychiatric hospitalizations, no benefits, and were on a Temporary LPS Conservatorship (T-CON). ARISE provided MHSA Flex funding to ensure they did not go homeless while they transitioned from T-CON status and started applying for benefits. When ARISE first began treatment, services were provided up to five days a week to increase the member's engagement with her treatment team. Member met regularly with their Case Manager and Peer Recovery Coach to increase socialization, build trusting relationships, and work on establishing benefits. The member and Peer worked together on identifying goals, practicing coping skills, and decreasing isolation at member's board and care. As a result, this member has increasingly become more open with their treatment team and trusting of the relationships built. They have been able to obtain social security benefits and maintain placement in the community with no major hospitalizations.

Services also include assistance with benefit acquisition, employment, education, transportation, and help with successfully completing involvement in Collaborative Courts, such as Mental Health Court. ARISE aids clients who are experiencing homelessness or are at risk of homelessness by providing services at a permanent supportive housing development, connecting to housing resources, and utilizing subsidies to provide housing supports for consumers and their families. ARISE provides services at two MHSA-financed permanent supportive housing developments. The program assists clients transitioning into the community from high-cost restrictive placements, such as the Sacramento County Mental Health Treatment Center, private psychiatric hospitals, incarcerations, and other secured settings. As an element of each client's recovery process, ARISE utilizes Peer Staff members as a part of the client's multidisciplinary team to engage and support not only the client but also family members, natural supports, and/or caregivers.

Program outcomes are strengthening clients' level of functioning, supporting clients in maintaining the least restrictive level of care in the community, reducing acute psychiatric hospitalizations, reducing incarceration, reducing homelessness, improving health by increasing access to primary health care, supporting engagement in meaningful employment/activities; and increasing social connectedness.

BHS, in partnership with Sacramento County Department of Human Assistance (DHA), implemented the **Flexibile Housing Pool (FHP)** late in FY 2019-20. The goal of the FHP is to secure quality affordable housing for clients living with a serious mental illness discharging from

jail or acute psychiatric hospitalization into homelessness and who qualify for specialty mental health services. FHP combines rent subsidies, landlord engagement, pinpointed tenant/landlord matching, and ongoing property and tenant services. Through the FHP, Property Related Tenant Services (PRTS) teams secure a broad range of housing options through the community, such as single family homes, individual apartments, blocks of units, or entire buildings with onsite support staff. In addition to housing location services, PRTS teams provide move-in assistance, rental subsidy disbursement, and assistance with landlord/neighborhood relations. In addition, BHS providers will provide ongoing mental health treatment services and intensive case management to clients to support their ongoing recovery. These services support clients in transitioning to permanent housing, promote housing stability, provide quick response when issues arise, and facilitate coordination of care.

Success: Flexible Housing Pool
In 2019, a single pregnant mother enrolled in the Flexible Housing Pool (FHP). At that time, her only income was $612 a month in cash aid from CalWORKs and she was at risk of losing her small one bedroom apartment for her family of four. The FHP program was able to provide support services to the family to assist them into moving towards a larger three (3) bedroom apartment, while case management determined the mother's barriers included not only housing but also a need for more supportive services. FHP referred the family to BHS where they were linked to providers that could address their mental health needs. Additionally, they were able to utilize MHSA flex funding for housing stability support. Since their enrollment in the FHP and mental health services, the family is now receiving a housing voucher, is stably housed, and is thriving through both programs. This member is now receiving SSI along with her cash aid and will be moving to new housing she can now afford through her voucher and program assistance.

DHA has experienced challenges in obtaining housing for clients due to a lack of appropriate housing inventory. Despite these difficulties, DHA was able to house twelve (12) individuals in FY 2019-20. DHA and BHS are actively collaborating to increase housing inventory and landlord development.

Sacramento County's **Adult Residential Treatment (ART) Program,** administered by local residential facilities, began providing services early in FY 2020-21. ART provides comprehensive, culturally competent, strength-based, recovery-oriented, outpatient specialty mental health services and 24-hour residential services to TAY (18+), adults, and older adults who live with persistent mental illness. The ART Program's outpatient services are provided in a campus model, co-located to their licensed residential facilities as part of the sub-acute continuum. ART services are provided in a less restrictive environment than a Skilled Nursing Facility (SNF), Mental Health Rehabilitation Center (MHRC), Institute of Mental Disease (IMD) facility, Psychiatric Health facility (PHF), or State Hospital. The ART's residential facilities maintain licensure from the State Community Care Licensing Division (CCLD). Residential services are provided in a structured

Success: Adult Residential Treatment
A 34-year-old male grew up one of nine siblings in a very chaotic household. His father was frequently incarcerated and his mother lived with a major mental illness. He functioned adequately through his school years and graduated high school, but began experiencing symptoms of depression and mania after graduation, which led to drinking large amounts of alcohol to be able to sleep at night. This began years of substance abuse, mostly methamphetamines and alcohol. He crashed a car into a tree when his first psychotic symptoms began. Many years of psychiatric hospitalizations followed until he was finally sent to a secured facility. He did well there, engaging in groups and attending their work program. When it came time to step down to the community a year later, he became anxious about his ability to be successful. It was decided that the ART program could provide a supportive transition where he could practice his skills and continue his sobriety. He joined the ART program in January 2021 and has been thriving since. He attends on-line substance use groups and individual therapy and has maintained his sobriety for two full months in this unlocked setting.

home environment that supports improving the recovery and independent living skills of individuals living with a psychiatric condition and co-occurring medical and/or substance use disorders for the purpose of community integration and transition to a lower level of care. Clients have the opportunity to practice new skills and coping mechanisms, set goals for the future and identify steps to reaching those goals, and to learn about medication management so they can achieve increased independence and recovery and step down to a lower level of care.

The **Augmented Board and Care (ABC)** program is a pooled contract for those meeting the minimum qualifications – the first provider started early in FY 2020-21. ABC provides 24 hour, 7 days a week board and care services to TAY (18-25), adults, and older adult residents linked to high intensity mental health services that are culturally responsive, recovery-focused, and trauma-informed. ABC services are provided to residents living with serious mental illness and co-occurring conditions who are in need of intense programming in order to maintain residency in the community. ABC provides residents with the support needed to receive treatment services at a less restrictive level of care through their outpatient provider, rather than psychiatric hospitalization or subacute services. The ABC program model provides a safe and supportive home environment for individuals to build interpersonal and independent living skills in order to support successful transition to a lower level of care. Each ABC client is supported by the Board and Care provider, the client's Full Service Partnership (FSP) and the County Intensive Placement Team (IPT). ABC clients receive care coordination, medication monitoring and treatment planning, weekly visitation from IPT and FSP treatment partners, and monthly care conferences to ensure better outcomes in the least restrictive level of care for all clients.

Success: Augmented Board and Care
ABC served a 27 year old male who had a very severe psychotic break in his late teens. He became very withdrawn, internally preoccupied and his hygiene became extremely poor. He frequently would stop his medications and leave his residence, resulting in homelessness. He stopped showering, resulting in becoming very malodorous. He rarely spoke and refused to wash or change his clothing and his hair eventually developed into a large mat on top of his head. He had multiple psychiatric hospitalizations and eventually was placed on LPS conservatorship and sent to a secured setting for two years where he worked on his recovery. He began to shower and interact more with others; however, when ready to step back down to a community setting, there were concerns about his ability to refrain from leaving his facility and ceasing his medication. It was decided that a referral to the ABC program could provide the extra support and coordination of care between the Full Service Partnership, the County ABC staff, and the board and care operator. This coordination of care has proved to be successful with this client. He has been successfully engaged in the ABC program for four months.

Program: Transcultural Wellness Center
Work Plan #/Type: SAC4 – Full Service Partnership (FSP)
Capacity: 275 at any given time
Ages Served: 15% Children, 17% TAY, 49% Adults, 19% Older Adults

The **Transcultural Wellness Center (TWC)**, administered by Asian Pacific Community Counseling, is designed to increase penetration rates and reduce mental health disparities in the Asian and Pacific Islander (API) communities in Sacramento County. The program is staffed by psychiatrists, mental health clinicians and counselors, and peer and family advocates who are reflective of the API communities. Staff assignments take into consideration the gender and specific cultural and linguistic needs of the client. Staff speak 15 API languages: Cambodian,

Cantonese, Hindi, Hmong, Japanese, Korean, Laotian, Mandarin, Mien, Punjabi, Spanish, Tagalog, Telugu, Thai, and Vietnamese.

TWC FSP services include a full range of mental health services and supports that take into consideration cultural and religious beliefs and values, traditional and natural healing practices, and associated ceremonies recognized by the API communities. TWC works to link clients, particularly adults and older adults with co-occurring medical and mental health needs, to primary care physicians for comprehensive medical assessments and ongoing medical care. Services include culturally and linguistically relevant mental health interventions and activities that reduce and prevent negative outcomes, such as avoidable emergency room utilization, psychiatric hospitalization, jail/incarceration, and eviction/homelessness. Based on client need, all services can be delivered in the home, community and school. FSP services emphasize blending cultural and traditional resources to reduce stigma.

Success: Transcultural Wellness Center

A 28 year-old Vietnamese woman came to APCC with a diagnosis of schizoaffective disorder, bipolar type, and multiple hospitalizations. In addition to psychosis, she suffered from crippling social anxiety and paranoia. Through ongoing therapy, social rehabilitation, counseling, and medication services, client was able to learn to manage her symptoms, find employment with a local retailer, and discover joy in attending church services and visiting local museums around Sacramento. The client lives with her elderly parents and needed help with activities of daily living and to learn coping skills in order to support herself and her parents. Staff supported the client in developing socialization skills such as navigating local Asian stores and restaurants and learning to shop for groceries. She is enjoying improved relationships with family members and friends. In addition, she is an avid reader and is interested in attending college soon. Client is ready for discharge and is confident that she will be able to manage her symptoms with the coping skills she has acquired.

The goals of the TWC are to improve access to services for individuals who have not typically responded to mainstream outpatient mental health/psychiatric treatment or who were unable to utilize community services due to complex co-occurring needs. Using the "whatever it takes" approach, services are provided to assist individuals in identifying goals in relation to their culture, increase individuals' ability to function at optimal levels, and to assist with their wellness, recovery, and integration into the community.

Program outcomes are to reduce psychiatric hospitalization, arrests, and incarceration and to increase linkage to employment, education, health care, and housing resources. Additionally, the program seeks to help clients develop and maintain connection to meaningful activities and improve school or job functioning.

Program: Wellness and Recovery
Work Plan #/Type: SAC5 – General System Development (GSD)
Capacity: 3,175 at any given time
Ages Served: 1% Children, 8% TAY, 75% Adults, 15% Older Adults

The **Wellness and Recovery** program consists of: the **Wellness and Recovery Centers**, the **Peer Partner Program,** the **Consumer and Family Voice Program,** and the **Sacramento Advocates for Family Empowerment (SAFE) Program**, the **Mental Health Crisis Respite Center**, **Abiding Hope Respite House**, and **Mental Health Respite Program**.

Located in the northern and southern regions of Sacramento County, the **Wellness and Recovery Centers (WRCs)**, administered by Consumer Self Help Center, are community based multi-

service centers offering an array of comprehensive services and wellness activities designed to support clients in their recovery goals. The WRCs also serve as entry points to homeless services for individuals who present with mental health conditions who are experiencing homelessness. Services are provided in a supportive environment, offering self-directed guidance for recovery and transition into community life. The WRCs serve individuals age eighteen and older of all genders, races, ethnicities and cultural groups.

WRCs offer both a treatment program and community program. The treatment program provides psychiatric and medication support services, case management, and mental health services for clients with serious mental illness. The community program provides peer and consumer driven wellness activities available to clients enrolled in the treatment program and to community residents with an interest in mental health support and wellness and recovery services. WRC activities include curriculum-driven and evidence-based skill building activities, vocational supports, family education, self-help, and peer counseling and support. Services are collaboratively designed, culturally competent, member driven, and wellness focused. Alternative services are offered in the WRCs' Community Program, including consumer facilitated art and music expression, journaling, creative writing, yoga, 12-step recovery groups, goal setting, crisis planning, natural healing practices, and other wellness services.

Key assets include a library, a resource center, and a computer lab that can be utilized by center participants and the general public interested in learning more about mental health and recovery. WRCs have scheduled programming and activities six days per week and are closed on Sundays.

Program outcomes are to increase linkage to a primary care physician and/or specialty health provider; decrease unnecessary psychiatric hospitalizations, decrease incarceration, prevent and decrease homelessness, and support engagement in meaningful employment/activities and social connectedness.

Success: Wellness and Recovery Centers
A couple signed up together for wellness services at the WRC-South Community Program in the Fall of 2017. At the time, they were homeless, sleeping in their car, and only used the Community Center for showers. As time progressed, Community Program staff were able to engage this couple in wellness activities and this couple soon became a fixture at the Community Center, eventually becoming Peer Guides (Volunteers). Like all couples, they still had their respective challenges, especially living in their car. With that said, their bond became an inspiration to the staff and other members of WRC-South Community Program.

This couple began to thrive from the resources provided by WRC-South Community Program. What started as a safe place to shower, socialize, and find stability led to a place to grow in their mental health and wellness. They participated in WRC's Homeless Orientation, which supported them in obtaining more stability through Mental Health Services, provided at the WRC's Mental Health Treatment Program.

Today, this couple is employed, own a vehicle, live in their own apartment, and most importantly, take care of their wellness and mental health needs. This couple is not only a success story, but an inspiration of hope and commitment.

The **Peer Partner Program (Peer Partners)** is administered by Cal Voices. The program provides peer support services to transition aged youth (TAY) 18+, adults, and older adults linked to the Adult Psychiatric Support Services (APSS) clinic and individuals linked to the Mental Health Treatment Center (MHTC). Peer Partner staff are consumers and family members with

lived experience. Peer Partners are integrated staff members of the APSS and MHTC multidisciplinary teams and provide peer-led recovery-oriented services for APSS and MHTC participants and their families.

The primary services provided by the Peer Partners for APSS and MHTC clients include the following: information and training about wellness and recovery; information about and referrals and connecting to mental health services and other services and resources; navigation assistance; advocacy; experiential sharing; building community; relationship building; education and support group facilitation; Wellness Recovery Action Plan (WRAP) group facilitation; skill building/mentoring/goal setting; and socialization/self-esteem building. As collaborating members of the APSS and MHTC multidisciplinary teams, Peer Partners staff role is to build awareness and provide information about the client perspective, the consumer culture, and culturally relevant engagement strategies.

Success: Consumer and Family Voice Program
An aunt contacted the Adult Family Advocate regarding an adult niece, who was having multiple issues connecting with services. Her niece had been receiving services from a mental health provider, but had not yet had any face to face interactions, aside from getting her medication. Both the aunt and her niece were dissatisfied with the services received. The family advocate worked with the aunt to contact Sacramento County Access Team to obtain another service provider for her niece. The niece also needed help with SSI recertification because she had lost her benefits so the advocate connected her to the SMART program for recertification. The advocate also provided a warm handoff to Wellness and Recovery Center South so she could go to groups and socialize. The aunt shared that the programs her niece is now engaged in are working out well.

Program outcomes include improving overall health and wellness for client, helping clients engage with their natural supports, helping clients engage in meaningful activities, and reducing psychiatric hospitalizations.

The **Consumer and Family Voice Program**, administered by Cal Voices, promotes the BHS mission to effectively provide quality mental health services to Sacramento County children, youth, TAY, adults, older adults and their families. The consumer advocate liaison, adult family advocate liaison, and family and youth advocate liaison serve as liaisons to BHS and represent, communicate, and promote the child, youth, TAY, adult consumer and family member perspective. The advocate liaisons promote and encourage children, youth, TAY, adult and older adult consumer and family involvement in the mental health system from program planning to program participation. This program provides a wide array of services and supports that assist children, youth, TAY, adult consumer and family members in their recovery process, including but not limited to advocacy, system navigation, trainings, support groups, and psycho-educational groups. Program services outcomes include increasing access to

Success: Peer Partners
Client had been struggling after a job loss and was struggling keeping her concentration at school and considering withdrawing from her classes. Client also acknowledged that her depression symptoms and her self-esteem were greatly affected by these life events. To help the client address these challenges, her Peer Partner assisted client through active listening, creating a pros/cons list to help with her decision around withdrawing from her classes, and creating a gratitude list to put some of her negative self-talk in a new perspective. Her Peer Partner also supported client in her psychiatry appointment due to extreme anxiety. The meeting was successful, the client's anxiety was decreased after a shared meeting with her peer provider and doctor and working through the pros/cons list, gratitude list activities, and having her concerns heard with active listening. The client was able to remain in her classes and expressed appreciation to her Peer Partner and APSS for giving her the tools to navigate these challenges.

services; providing knowledge and understanding of mental health, resiliency, recovery, self-determination, and empowerment; increasing knowledge of services and available community resources; and decreasing the experience of isolation and/or lack of community supports for clients.

As part of the Consumer and Family Voice Program, the advocate liaisons coordinate and facilitate an every other month meeting for clients/consumers of behavioral health services, family members, and supporters called "Expert Pool Town Hall Meetings." The purpose of these meetings is to build a peer support network, share information about local services and resources, and inform about how to become involved in shaping those services for today and the future. Consumers and family members are asked what topics or services/resources they would like to learn about. The Expert Pool Town Hall meetings include speakers with expertise in topics related to mental health and local services and resources. Advocates maintain an email database of more than 750 community members/experts, many with lived experience, in an effort to keep our community informed regarding topics pertaining to our client and family member community. Four Expert Pool Town Hall Meetings were convened in FY 2019-20, with an attendance of 25-30 individuals per meeting.

This program also coordinates and facilitates the annual client Peer Empowerment Conference that is sponsored by BHS. The last conference was held virtually on June 19, 2020 and had 262 guests participate, 57% were consumers and 32% were family members. Grub Hub orders were processed and delivered to 99 attendees to offer lunch in the virtual environment. Overall satisfaction surveys showed a 4.5 out of 5 in total satisfaction with the conference. The next conference will be on a virtual platform and will take place on June 18, 2021.

The **Sacramento Advocates for Family Empowerment (SAFE) Program**, administered by Cal Voices, promotes the BHS mission to effectively provide quality mental health services to children, youth, and families in Sacramento County. The family member/youth advocate serves as liaison to BHS and represents, communicates and promotes youth and family member perspective. The Youth and Family Advocates promote and encourage parent/caregiver and youth consumer involvement in the mental health system, from program planning to program participation. The program provides a wide array of services and supports including but not limited to direct client support services and advocacy, system navigation, trainings, support groups, and psychoeducational groups. Program outcomes include increasing access to services; providing knowledge and understanding of mental health, resiliency, recovery, self-determination, and empowerment; increasing knowledge of services and

Success: SAFE Program
A SAFE Youth Advocate is currently supporting a youth who is in the foster care system without any parental support. She was referred to the SAFE program in need of support and assistance in navigating multiple systems. The advocate supported her in obtaining documentation for herself, including her social security card, California ID, and Medi-Cal card. The advocate assisted her through the steps of contacting her insurance, changing doctors/providers, and setting up appointments. The advocate also helped her prepare, plan, and attend meetings for herself with CPS, Court, extended foster care planning, mental health provider meetings, school meetings, and showed her how to use her voice to advocate for her needs in those meetings. SAFE provided her a voucher for clothing to replace clothing she lost in the transition from her last foster home. The advocate supported her in her transition into independent living when she got her new apartment. In her own words she has expressed, "Thank you so much for helping me with anything. I felt like no one else has helped me as much as you have, I want you to come to my graduation!"

available community resources; and decreasing the experience of isolation and/or lack of community supports for clients.

As part of the program, SAFE advocates coordinate and facilitate various support groups for clients/consumers of behavioral health services and their family members, including Latino Support Groups, Teen Co-ed Support Groups, Parent/Family Support Groups, an eight-week Anger Management Group, and a 16-hour Wellness and Recovery Action Plan (WRAP) group.

Mental Health Respite Programs: The following programs originated as mental health respite programs funded through the time-limited MHSA Innovation Project 1: Respite Partnership Collaborative. With support from the MHSA Steering Committee, these programs transitioned to CSS funding during FY 2015-16.

The **Mental Health Crisis Respite Center**, administered by TLCS (also known as Hope Cooperative) provides twenty-four (24)-hour/seven (7) days a week mental health crisis respite care in a warm and supportive community-based setting to eligible TAY (18+), adults, and older adults who are experiencing overwhelming stress due to life circumstance resulting in a mental health crisis. Services include screening, resource linkage, crisis response and care management up to twenty-three (23)-hours. The program has the capacity to serve up to ten (10) individuals at any given time.

Success: Mental Health Crisis Respite Center (CRC)
Guest came to CRC reporting feeling hopeless. Guest shared he had just arrived in Sacramento looking for an opportunity to better his current situation of homelessness and substance use. Being new to the Sacramento area, guest requested linkage to supportive services to assist with managing his mental health symptoms and working toward recovery. CRC staff provided guest information for a recovery home as guest stated this was the first step he wanted to take to improve his quality of life. Just after 30 days in the recovery program, the guest lost placement in the program and returned to CRC due to his previous experience of support, crisis counseling, and linkage to supportive services from staff. These interventions assisted client in continuing down the path of "getting his life back together."

Program goals are reduced emergency department visits and acute psychiatric hospitalizations as well as increased client-reported improvement in their recovery journeys.

Abiding Hope Respite House, administered by Turning Point Community Programs, provides mental health crisis respite services in a welcoming, home-like setting, where TAY (18+), adults, and older adults, experiencing a mental health crisis can stay up to 14 days. During their stay, clients receive client-centered, recovery-oriented services that include crisis response, screening, resource linkage, peer support, and care management. There are five (5) beds in the home and all clients take part in cooking, cleaning, and groups to help them gain back a sense of purpose and dignity through

Success: Abiding Hope Respite House
"I would say, the most positive experiences were learning how to cope with life on life's terms. Asking staff for information and learning how to apply the positive tools for success. The help came in many ways. Most of the help was how to navigate the mental health system and housing resources so I can find a healthy safe place to live. I can't say enough about the support I received from staff and how much they helped me. The one thing we as humans need most in life is compassion, this was the first and foremost tool this agency and staff applied when dealing with me and others.

"I truly believe if it wasn't for Abiding Hope Respite Home and the people at this respite haven, I would not be safe, sound, and healthy."

life's routines. Program goals are reduced emergency department visits and/or acute psychiatric hospitalizations and increased client-reported improvement in their recovery journeys.

Mental Health Respite Program, administered by Saint John's Program for Real Change, provides adult women (and their children) in immediate crisis with short-term mental health and supportive services for up to seven (7) days. The program has the capacity to serve up to three (3) women (and their accompanying children) at any time. Services include assessment, treatment planning, resource linkage, crisis intervention, family intervention, and case management. Program Goals are reduced emergency department visits and acute psychiatric hospitalizations and client-reported improvement in their recovery journeys.

Success: Mental Health Respite Program
"Ann," age 34, found herself once again facing addiction and homelessness. She had just spent the prior two years getting a great job and rebuilding her life, but this progress was imperiled when she lost her living situation. Living in a car with her child, she quickly realized she could not maintain stability for the both of them under such stressful circumstances. In desperation, she reached out to Saint John's Mental Health Respite Program for safety, mental health services, and substance use disorder support (onsite meetings, referrals and linkage to treatment programs, and meeting with a counselor). This respite stay prevented a permanent disruption of the family's routine. Ann was able to maintain her job and her son's behavioral needs were met by the existing services established prior to intake into Respite. She indicated she felt reassured she could find the strength to face her challenges as she listened to the other woman share their success stories. In a short period of time, her stress and anxiety reduced and she was able to make plans for her family's future.

Program: Adult Full Service Partnership
Work Plan #/Type: SAC6 – Full Service Partnership (FSP)
Capacity: 500 at any given time
Ages Served: 1% TAY, 84% Adults, 15% Older Adults

The **Adult Full Service Partnership (FSP) Program** consists of **Integrated Services Agency (ISA)**, administered by Turning Point Community Programs, and **Sacramento Outreach Adult Recovery (SOAR)**, administered by Telecare Corporation. Both programs provide an array of high intensity FSP services to TAY (18+), adults, and older adults, struggling with persistent and significant mental illness who would otherwise utilize the most restrictive and highest level of care, such as psychiatric hospitalization and incarceration as a result of their mental illness. ISA and SOAR provide comprehensive, integrated, culturally competent, community-based mental health services, which include assessments, planning, 24/7 crisis response, individual and group treatment, social rehabilitation, case management, psychiatric medication services, and housing services and supports to address the needs of individuals living with serious mental illness who are homeless or at-risk of homelessness. Services also include assistance with benefit acquisition, employment, education, transportation, and supportive services to family members/caregivers, such as education, consultation and interventions to support members in their recovery.

ISA and SOAR have established and maintained successful collaborations with system partners, community agencies, sub-acute care providers, law enforcement, healthcare providers, conservators, and ethnic and cultural groups to assist consumers in maintaining stability and social connectedness in the community and working toward recovery.

Program outcomes are to strengthen level of functioning to support members in maintaining the least restrictive level of care in the community; reducing acute psychiatric hospitalizations; reducing incarceration; reducing homelessness; improving health by increasing access to primary health care; supporting engagement in meaningful employment/activities; and increasing social connectedness.

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Success: Integrated Services Agency
A member, age 50, was referred to ISA with Bipolar Disorder. The member was seeking help for many symptoms including manic and disorganized thinking and psychosis. The member also had an extensive history of Poly-Substance Dependence, homelessness, and criminal justice involvement. Since accepting services with ISA, the member has overcome many challenges; regaining stable housing for the past year and eventually transitioned from a board and care facility to more independent living. The member's participation in services, including individual counseling and substance use disorder support groups, has served him well in assisting him to use effective coping skills to manage his symptoms and increase his interest in employment. As a result of this member's choice to use new skills learned, adhere to his medication plan, and accept the support of his assigned service coordinator, he continues to make progress in his recovery. He has successfully achieved independent living in the past year and is actively working toward his goals of completing his college degree and rejoining the workforce.

Success: SOAR
A 39 year old, American Samoan male was referred to SOAR. At that time he had been hospitalized at a psychiatric hospital for five months and was placed on LPS conservatorship and referred to the Care+ conservatorship program. Due to high risk behaviors, including aggression and difficulty with appropriate boundaries, he lost the support of his family. His family changed the locks on the family home and did not allow him back. SOAR supported the member in locating housing placement at a board and care facility while offering mental health services. These included cognitive rehabilitation services, such as skill building to manage frustration, natural support rebuilding, and other behavioral interventions. He also met with his psychiatrist monthly to address his medication needs. After this intensive level of support, he transitioned from Care+ level of conservatorship to traditional LPS conservatorship. With further progress, he successfully contested his conservatorship and was released from it. He is now living at a board and care facility without conservatorship and, due to the work he has done at SOAR, has reunited with his family. He states his family members are his number one support again.

Program: Juvenile Justice Diversion and Treatment Program
Work Plan #/Type: SAC7 – Full Service Partnership (FSP)
Capacity: 128 at any given time
Ages Served: 22% Youth (ages 13-15) and 78% TAY (ages 16 – 25)

The **Juvenile Justice Diversion and Treatment Program (JJDTP)** is a FSP created by a partnership between BHS, Sacramento County Probation Department, and River Oak Center for Children to deliver integrated services to youth involved with juvenile justice who have multiple complex needs across several service systems. JJDTP provides screenings, assessments and intensive mental health services and FSP supports to eligible youth and their families. Youth must meet serious emotional disturbance criteria and be between the ages of 13 through 17 at enrollment. Pre-adjudicated youth are screened and given an assessment. With court approval, youth have the

opportunity to avoid incarceration and voluntarily participate in this program as long as clinically necessary through their 25th year. Adjudicated youth are referred, assessed, and have the opportunity to voluntarily receive the program's intensive, evidence-based services delivered in coordination with a specialized Probation Officer. Family and youth advocates complement clinical FSP services by providing family and peer support.

Program outcomes include youth experiencing reduced psychiatric hospitalization, increased engagement in their educational program, and reduced arrests and incarcerations. Additionally, the program seeks to link youth and families with primary care and to engage them in meaningful activities.

Success: Juvenile Justice Diversion and Treatment Program
A youth was referred to Juvenile Justice Diversion and Treatment Program (JJDTP) due to depression and substance use, which had become worse due to his family's homelessness. The youth was released from the Youth Detention Facility to his mother after the JJDTP program provided support by securing a hotel due to the family being homeless. The youth and mom connected with the JJDTP family advocate, who provided support by linking to hotel support until permanent housing could be obtained. The mom decided to leave and move in with her boyfriend. The youth and his adult sister couch surfed while the youth continued to attend school. When the JJDTP team became aware of their situation, a new housing plan was developed and hotel support was again provided. The youth obtained a job while continuing with school and his older sister worked while looking for better employment. The youth, now 18 years old, works three jobs and his sister works two jobs. The JJDTP youth advocate assisted the youth in obtaining his driver's license and purchasing a car. The JJDTP team is working with both siblings to find an apartment since they can now pay rent and bills. The youth's symptoms of depression have significantly decreased and use of substances has been eliminated. Probation recommended the youth's probation be successfully terminated.

Program: TAY Full Service Partnership
Work Plan #/Type: SAC8 – Full Service Partnership (FSP)
Capacity: 240 at any given time
Ages Served: Youth and TAY ages 16 – 25

The **Transition Age Youth (TAY) FSP Program**, administered by Capital Star Behavioral Health, provides core Full Service Partnership (FSP) services and flexible supports to TAY ages 16 through 25 who are homeless or at risk of homelessness, aging out of the child mental health system, involved in or aging out of the child welfare and/or foster care system, involved in or aging out of the juvenile/criminal justice system, at risk of involuntary psychiatric hospitalization or institutionalization, experiencing a first episode of a serious mental illness, and/or part of other at-risk populations. Services are culturally and linguistically competent with sensitivity to and affirmation of gender identity, gender expression, and sexual orientation. Services are individualized based on age, development, and culture. TAY FSP program includes outreach, engagement, retention, and transition strategies with an emphasis on independent living and life skills, mentorship, and services that are youth and family driven.

This program is designed to improve access to services for TAY who typically have not responded well to traditional outpatient mental health/ psychiatric treatment, or who are unserved, underserved, and/or inappropriately served; to ensure linkage to a Primary Care Physician (PCP) who can provide a comprehensive medical assessment and ongoing medical care, particularly for clients with co-occurring medical and mental health needs; provide various services/interventions necessary to reduce/prevent avoidable emergency room utilization, psychiatric hospitalization, jail/incarceration, and eviction/homelessness; and to provide services that will increase the participants' ability to function as independently as possible within the community.

Success: Transition Age Youth FSP Program
"Mia" was referred to TAY FSP with severe self-harm, suicidal ideations, frequent hospitalizations, homelessness, ruptured natural supports, and an inability to sustain financial independence due to depression and trauma -related symptoms. TAY FSP team consisted of Transition Care Manager, Transition Facilitator, Youth Advocate, and Housing and Resource Specialist. Throughout treatment, Mia engaged in strengths discovery, job readiness, healthy interpersonal skills, and increased her distress tolerance through group sessions with peers and one-to-one sessions with members of her team. Through the efforts of Mia and her team, she developed a passion for medical coding and billing and wants to use it to help others. She will receive a certificate soon. Mia has landed a full-time position at a healthcare company providing services to Medi-Cal recipients. Additionally, Mia recently passed her permit test and will be receiving drivers-ed training to get her license. Mia will be ready to graduate from TAY FSP soon, and plans to move into a house with her natural support/partner where she will continue working and practicing all the skills that she has learned during her time in the program.

Program: Crisis Residential Program (CRP)
Work Plan #/Type: SAC9 – General System Development (GSD)
Capacity: 60 at any given time
Ages Served: 13% TAY (ages 18-25) and 87% Adults (ages 26 – 59)

There are three 15-bed CRP sites for adults located in Rio Linda, South Sacramento, and Sacramento (all administered by Turning Point Community Programs) and another 15-bed CRP serving transition age youth (TAY) in Sacramento (administered by Capital Star Crisis Residential Program). The Sacramento Adult CRP and the TAY CRP are newly implemented and began serving clients in FY 2020-21. The fifth CRP site, a 12 bed CRP in South Sacramento, was closed by the facility owner in FY 2020-21 to address critical facility renovations.

CRPs are short-term residential treatment programs that operate in a structured home-like setting twenty-four hours a day, seven days a week. Eligible consumers may be served through the CRP for up to 30 days. These programs embrace peer facilitated activities that are culturally responsive. CRPs are designed for individuals, age 18 and up, who meet psychiatric inpatient admission criteria or are at risk of admission due to an acute psychiatric crisis, but can instead be served appropriately and voluntarily in a community setting. Beginning with an in-depth clinical assessment and development of an individual service plan, crisis residential program staff will work with consumers to identify achievable goals including a crisis plan and a Wellness Recovery Action Plan (WRAP).

Once admitted, structured day and evening services are available seven days a week that include individual and group counseling, crisis intervention, planned activities that encourage

socialization, pre-vocational and vocational counseling, consumer advocacy, medication evaluation and support, and linkages to resources that are available after leaving the program. Family members are included in counseling and plan development. Services are voluntary, community-based, and alternative to acute psychiatric care. While the services are designed to resolve the immediate crisis, they also focus on improving functioning and coping skills and encourage wellness, resiliency and recovery to enable consumers to return to the least restrictive, most independent setting in as short a time as possible. Services are designed to be culturally responsive to the needs of the diverse community members seeking treatment.

Success: Crisis Residential
A client, admitted to the newly opened Sacramento CRP, has struggled for many years with significant substance use. They were raised in an African country and were adopted by a Sacramento family as a child, but it took more than ten (10) years for the adoption to be finalized. By the time this individual was allowed travel approval they were addicted to heroin and had significant trauma from their living situation. This person was homeless since they were approximately twelve (12) years old in their country of origin. The client successfully resolved their crisis and graduated from CRP. Before leaving the program, the client wrote a poem and personal statement about their struggles and the hope they now feel after completing the program.

Part of the personal statement reads, "CRP really saved my sanity. From the first day I came here all the staff continued to care for me with respect and good humor for days and night thereafter. The facility also gave me the most precious gift I could ask for. Peace of mind."

Success: Crisis Residential
An individual came to the South Sacramento CRP extremely depressed, suicidal, and hopeless. It seemed that they had truly given up on life. During the admission, the client was pretty pessimistic and hopeless about the future. Even so, they attended the groups, participated in the program and completed chores around the house. CRP completed a needs assessment and linked the client with Telecare Arise. When they graduated from the program, CRP did a warm hand-off to Telecare, which was able to place the client in a Room & Board. The client visited CRP a week or two later to say "hello" and give staff a piece of artwork, noting that their life was truly saved by staff in the program and that they now have the motivation to live and continue to improve their life.

Success: Crisis Residential
CRP recently received a phone call from a former client, who called to update the staff that they have been using the coping skills learned at CRP as well as everything they learned from groups while in the program. This was an individual who was ready to utilize the opportunity to "work on [them] self" – had a great sense of humor and worked tirelessly to make appointments and seek employment. The power of the environment seemed to be central to the client's success as well – the right mix of clients can really help to build a motivating and supportive atmosphere. They further reported continuing to follow-up with the resources they were connected with at CRP. The client was proud to report how well they were doing, that they found a job and were back on the road as a truck driver.

Success: Crisis Residential
A client was referred to the TAY CRP in the third trimester of pregnancy (un-medicated) and on parole for assault. She was homeless at the time with minimal support from family. She had a history of blowing through housing placements due to past trauma. She had a lot of self-reported anger issues and tended to take on other's emotions, even when the situation did not have anything to do with her. At CRP she threatened to leave several times when she did not get the answer or response she was looking for. Over time at CRP, the client was able to utilize newly obtained coping skills of riding the wave, deep breathing, reading, and analyzing pros/cons of engaging in negative interactions. CRP was able to support the client in learning these skills without medication. CRP supported with transportation to OB appointments, housing interviews, and outings to enhance social skills. The client graduated the program successfully and was able to secure a two-bedroom apartment for herself and her new baby. She transitioned from presenting as the loudest resident in the program, to the quietest and became a great support for other residents who were going through their own challenges. On her last day, she became tearful and expressed her gratitude for staff. She promised to bring the baby back to CRP when it was safe to do so and stated that she was going to name her next child after a CRP Recovery Counselor."

Program goals are to provide crisis stabilization, promote recovery, and optimize community functioning through the provision of short-term, effective mental health services and supports and to decrease utilization of hospital emergency departments, the Mental Health Treatment Center (MHTC), and private psychiatric facilities, as well as decreasing incarceration

Program: Children's Community Mental Health Services
Work Plan #/Type: SAC10 – General System Development (GSD)
Capacity: 5,765 at any given time.
Ages Served: Children and Youth (up to age 21)

The Children's Community Mental Health Services workplan consists of the **Consultation, Support and Engagement Teams (CSET) Program** and **Flexible Integrated Treatment (FIT)**.

The **Consultation, Support and Engagement Teams (CSET) Program** addresses the needs of children and youth who have been commercially sexually exploited. This program has two components: 1) Outreach and engagement services for children, youth and families; contracted provider works closely with court systems to identify children and youth in need of services, and attends weekly case staffing to engage children/youth that are unlinked to supportive resources and mental health programs. This component is administered by Capital Star Community Services. 2) Regents of the University of California, Davis (UCD) conducts consultation, education and training to mental health providers and system partners that deliver treatment services to this underserved population. Annual training capacity for this component of the program is approximately 180 clinical staff and 300 support staff (unlicensed staff and advocates).

CSET for Commercially Sexually Exploited Children (CSEC) provides outreach and engagement activities to CSEC (youth who have been or are at risk of exploitation) ages twelve through twenty-one (12-21). CSET is also able to provide mental health services in interim while linking to an ongoing mental health provider. CSET receives referrals from CPS, the Juvenile Court, probation, schools, law enforcement, and other community partners. CSET attends weekly Department 90 Juvenile Court staffing for CSEC youth to facilitate referrals for CSEC youth involved in the Juvenile Justice system.

Success: Consultation, Support and Engagement Teams (CSET) Program
J is a Youth Participant who was referred to the Capital Star CSET program by UC Davis CAARE in February 2019 after an evaluation while the youth was at Youth Detention Facility. She was struggling with her religion and her sexual orientation which impacted her self-worth. She also struggles with substance use and has a history of exploitation. She engaged with multiple CSET youth advocates, and was linked to Capital Star TAY Full Service Partnership (FSP) for more intensive services. At that time, she did not engage with this program due to not being ready for change. The CSET team was able to continue to support her even though she declined TAY FSP services, and worked with her to explore her short and long term goals. The team has supported her in successfully completing an Alcohol and Drug assessment, attending recovery meetings, identifying priorities, communicating to others, building coping skills to increase her self-esteem and mood, and linking her to short term mental health services the youth felt were better for her at this time. Without this program, she would have lost mental health services, leaving her without the appropriate resources to support her continued growth and meet her where she is at in her stage of recovery.

The redesigned children's outpatient services known as **Flexible Integrated Treatment (FIT)** is administered by: Capital Star Community Services; Dignity Health Medical Foundation; La

Familia Counseling Center; River Oak Center for Children; Sacramento Children's Home; Stanford Sierra Youth & Families; HeartLand Child & Family Services; Turning Point Community Programs; The Regents of the University of California; and Uplift Family Services. FIT provides strength-based, culturally competent, flexible and integrated, child/youth-centered, family driven, developmentally appropriate, effective quality mental health services to children and youth with serious emotional disturbance under the age of 21 years. Services aim to alleviate symptoms and foster development of age appropriate cognitive, emotional, and behavioral skills necessary for maturation, and to improve mental health conditions affecting quality of life across multiple domains (e.g. home, school, community). Services include family voice and choice and are provided in collaboration with child serving systems, agencies and other individuals involved with the child/youth (such as schools, probation, child welfare, health care, etc.). Families have a high level of decision-making power and are encouraged to use their natural supports. Program outcomes are to reduce and prevent imminent homelessness; strengthen functioning level to support clients in maintaining the least restrictive community-based housing; reducing acute psychiatric hospitalizations; reduce incarceration; improve health by increasing access to primary health care; and support engagement in meaningful employment/activities and social connectedness.

Success: Flexible Integrated Treatment - Capital Star

Over the past few months, the FIT Team at Capital Stars has been able to support many families at risk of homelessness during the Covid19 pandemic. For one teenage youth, the supporting clinician became aware that her mother was struggling to pay rent after contacting Covid19 and being out of work for multiple months. In addition to this stress, the mother and youth were coping through the loss of multiple family members, exacerbating the youth's depressive symptoms. The team utilized MHSA funding to support their rent payments while the family recovered, prevented eviction, and helped them create a plan to become more financially sustainable. Over six months, the team helped the youth move into a more affordable apartment where she could have space to grieve, and supported Mom in getting back to work. With the stability around her, the youth graduated early and is looking to go to college next year.

Success: Flexible Integrated Treatment - Dignity

A 15 year old client lived in her paternal grandparents' home due to her father not having a stable job or financial means to have a place of their own. The home they lived in was a high stress environment that affected my client's pre-existing anxiety and depression. Due to the issues in the home and with the adults, the youth, her family and siblings were evicted. The back and forth of living with relatives, not having a place of their own, living with adults with mental health disorders was not suitable for her or her siblings. With the help of MHSA funding, the youth and her family were able to find affordable housing and her father was able to find a job. Since this move, the youth feels more comfortable in her own home, has family nearby that can be a support system and she is no longer fearful of what negative interactions might occur in the home on a daily basis.

Success: Flexible Integrated Treatment - HeartLand

A youth was living with his grandmother and adult brother. The grandmother became ill and passed away. The adult brother was just starting a job and suddenly became the sole caregiver and provider for his brother and himself. HeartLand used MHSA Flex Funds to pay their rent for a couple of months, connect them to resources and assisted with obtaining food. The team worked with the landlord to get the lease transferred to the brother so they did not have to move and helped to form a good relationship between the two. The young man is now able to pay the rent on his own has the lease in his name and reports being able to manage on his own.

The team was able to work with the youth and the brother to deal with the loss of the grandmother who passed from COVID, get them stabilized, form routines and connect them to natural supports. The youth and brother felt that they were stable and that they were ready to graduate from the program successfully.

Success: Flexible Integrated Treatment - La Familia
A client and their family were in need of financial assistance. The caregivers of this family are undocumented individuals who experience financial hardships associated with the pandemic. The head of the household was consistently looking for work. The other caregiver is a stay-at-home mom having to "teach" the client because of the closure of school. By providing rental assistance, the family and client remained stably housed. This stability also kept the client from experiencing symptoms from their mental health issues. The family received the help they needed to get back on their feet and become stable again.

Success: Flexible Integrated Treatment - River Oak
A female youth was quite depressed. Her mother was self-employed and the business was affected by COVID-19 and marital separation. The Family Advocate was able to help the mother brainstorm, problem solve, and combine natural supports (2 adult sons) with MHSA Funding to secure affordable housing. Mother was also helped with making decisions and actions more independently than she was used to. The youth, probably due to several factors including not worrying about her housing, is notably less depressed.

Success: Flexible Integrated Treatment – Sacramento Children's Home
SCH FIT serves a 6 y/o client who lives with his brother and mom. They were previously residing with dad as well, but needed to relocate due to DV. Due to caregiver's limited income, she was unable to afford a deposit and the first month of rent (she was the only income earner) and family thus were at risk of homelessness due to not being able to remain in their current home with dad. Mom initially paid for a hotel stay out of pocket and SCH FIT was able to use MHSA funds to pay the deposit and first month's rent to stabilize housing, totaling $2754. Use of MHSA funds helped client and caregiver escape from a DV situation and find safe and stable housing, which decreased client's symptoms of distress and allowed him to focus more on his own therapy rather than violent events in the home and housing instability.

Success: Flexible Integrated Treatment – Stanford Sierra Youth & Families
A 6 year old male was living with his grandfather and step grandmother due to being removed by CPS from his mother's care. Initial challenges included: defiance, irritability, trouble getting along with other children, bedwetting and nightmares. It was clear that the youth was struggling due to the change of being separated from his mom.

SSYF provided parenting support for grandpa, grandma, and mom, skills support for the youth, collaboration with CPS, engaging mom in services to support with reunification, and MHSA funds to help stabilize the living situation, thus stabilizing the youth's reunification with mom.

Regarding MHSA support, Housing Navigator/Family Partner supported grandpa with breaking the cycle of intergenerational substance abuse, supported grandpa and grandma in co-parenting. SSYF helped mom find an affordable place to live. She was able to move in with her mother as a roommate. Mom obtained employment. SSYF was able to support with 3 months' rent, so mom was able to pay off her traffic ticket liens and obtain her driver's license, thus securing full-time employment.

Mom's participation in Parent Child Interaction Therapy with the youth, helped to repair their relationship. The bedwetting stopped and other symptoms significantly decreased. He graduated from the FIT program in January 2021.

Success: Flexible Integrated Treatment - Turning Point
Turning Point FIT has been able to support several clients with flex funds to ensure they are able to maintain housing. One client in particular had some unique challenges to maintaining stable housing. The client's caregiver has participated in Turning Point FIT services for several years with both client and client's siblings and often struggles to accept support. Through the engagement services positive relationships were developed with client's treatment team members, so the caregiver was able to feel comfortable accepting flex funds to ensure stable housing. Several FIT team members worked together to ensure that we were able to support the family with obtaining appropriate housing and ensuring it was fit for human habitation. The client and caregiver were able to have pride in their new living situation which was supportive of client's mental health functioning.

Success: Flexible Integrated Treatment – UC Davis
During a recent collateral session with a client's caregivers, the caregivers expressed so much gratitude for everything the CAARE Center has been able to provide for them in the recent months, and specifically asked to thank the housing support team for their help with housing needs. Caregiver said they feel that the team "saved their family" because both caregivers were at such a low point after moving into a larger place only to be surrounded by a horrible pest problem. They said they have always hated asking for help but that the CAARE Center staff are the only people they have engaged with that have acknowledged their pain without making them feel ashamed of their need for support. It was so touching to know what a difference the team's hard work has made for this family. Caregiver is also still attending their own therapy, which they said they were only open to because our staff gave them hope that mental health treatment could be helpful.

Success: Flexible Integrated Treatment – Uplift Family Services
A 20 year-old mom of one was supported in obtaining housing and improving her mental wellbeing. Youth was initially referred for services a year and a half ago for depression and anxiety. In her time with Uplift, youth has been engaged in services and received weekly support from her clinician and behavioral specialist to manage her symptoms, such as panic attacks and excessive worry. Several months ago, youth found herself living in her car due to ongoing conflicts with mother. Youth's lack of stable housing and having to be separated from her child at night, had a negative impact on her mental health as she found herself having suicidal thoughts and increased panic attacks. Youth's team quickly linked youth to Uplift's housing specialist and team was able to work with natural supports to keep her housed while applying for mutual housing. Youth's team was able to get her into her own place where she lives with her daughter. Youth is actively applying for fulltime employment to sustain housing and is able to focus on her mental health treatment. Since securing housing, youth reports that she has not had any suicidal ideation and feels hopeful.

CSS Administration and Program Support

BHS provides administration and program support associated with on-going community planning, as well as implementation, training, consultation, monitoring, quality assurance and oversight of the CSS programs and activities.

The table below contains the FY2021-22 Cost per Client information for implemented programs:

FY2021-22 CSS COMPONENT BUDGET Work Plan / Program	Average Cost/Client*	Budget Amount
SAC1 - GSD: Community Opportunities for Recovery and Engagement	$ 5,736	$ 30,976,413
SAC2 - FSP: Sierra Elder Wellness	$ 16,417	$ 2,298,327
SAC3 - FSP: Permanent Supportive Housing	$ 14,947	$ 24,916,540
SAC4 - FSP: Transcultural Wellness Center	$ 9,648	$ 2,653,266
SAC5 - GSD: Wellness and Recovery	$ 2,026	$ 6,732,450
SAC6 - FSP: Adult Full Service Partnership	$ 18,856	$ 9,427,929
SAC7 - FSP: Juvenile Justice Diversion and Treatment	$ 29,452	$ 3,769,899
SAC8 - FSP: TAY Full Service Partnership	$ 17,000	$ 4,080,000
SAC9 - GSD: Crisis Residential	$ 12,036	$ 8,184,364
SAC10 - GSD: Children's Community Mental Health Services	$ 9,913	$ 57,149,965
TOTAL		**$ 150,189,153**

*Average cost per client is based on all funding sources in Work Plan divided by Work Plan capacity and only includes previously approved and implemented programs.

Full Service Partnership (FSP) Program FY 2019-20 Outcomes

During FY 2019-20, Sacramento County's implemented FSP programs served 2,596 partners (clients). FSPs showed considerable progress in reducing negative outcomes and assisting partners with mental health and/or substance use disorders to manage their conditions successfully. The following section examines outcomes over time for partners that have been receiving services in an FSP for at least one year. Of the 2,596 partners served in FY 2019-20, 1,652 (63.6%) had continuously received services in an FSP the previous year. Changes are represented in percent change from baseline (one year prior to enrollment in an FSP).

- Homeless occurrences decreased by 64.6%
- Homeless days decreased by 89.4%
- Emergency room (ER) visits for psychiatric reasons decreased by 90.8%
- Emergency room (ER) visits for medical reasons decreased by 92.9%
- Psychiatric hospitalizations decreased by 68.1%
- Psychiatric hospitalization days decreased by 91.2%
- Arrests decreased by 44.1%
- Incarcerations decreased by 54.3%
- Incarceration days decreased by 83.7%
- Employment rate - Of the total partners indicating employment as a goal (270 partners), 25.2% were working during the FY

Graph A: Partners by Program

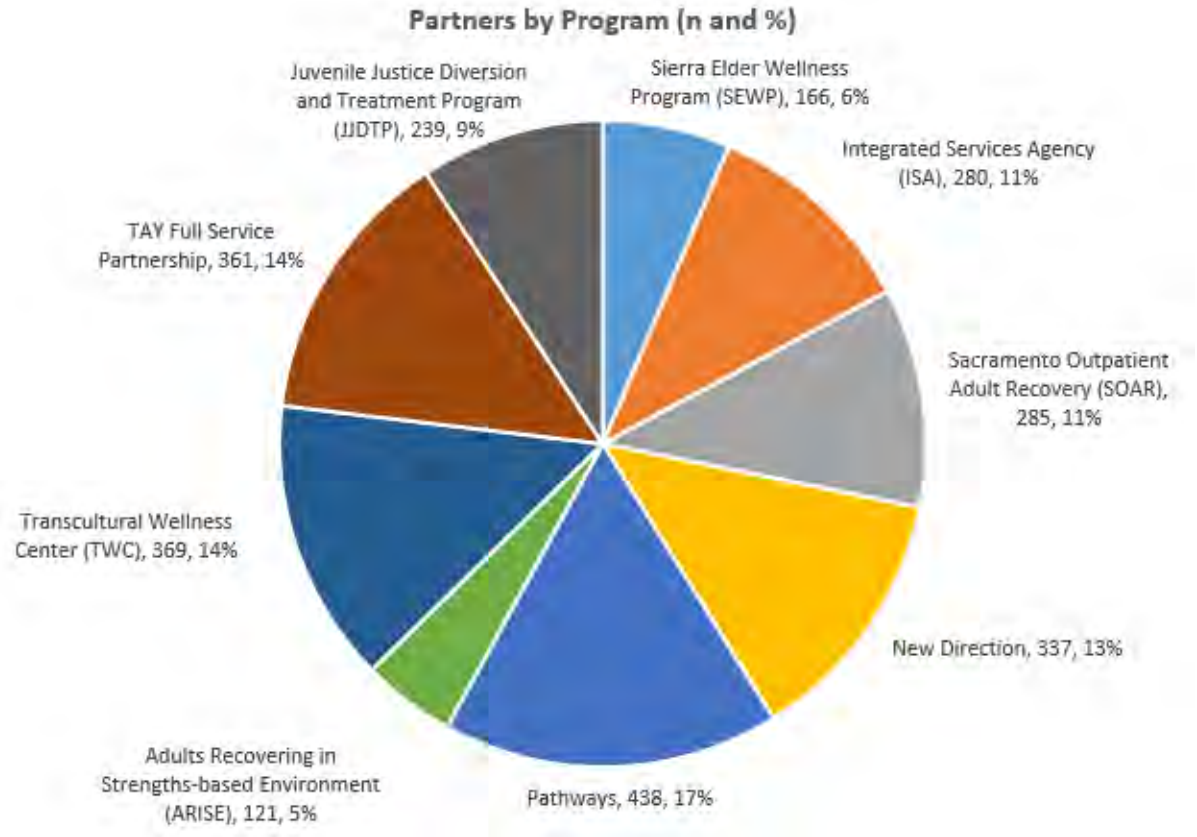


Table 1: Demographics

DEMOGRAPHICS		
Age Group	**N=2,596**	**%**
0-15 Years	157	6.0%
16-25 Years	641	24.8%
26-59 Years	1353	52.1%
60+ Years	445	17.1%
Total	2,596	100.0%
Gender	**N**	**%**
Female	1224	47.1%
Male	1371	52.8%
Unknown/Not Reported	1	0.0%
Total	2596	100.0%
Sexual Orientation	**n**	**%**
Bisexual	153	5.9%
Gay	41	1.6%
Heterosexual	1718	66.2%
Lesbian	9	0.4%
Other	16	0.6%
Queer	2	0.08%
Questioning	6	0.23%
Unknown	651	25%
Total	2,596	100.0%
Ethnicity	**n**	**%**
Hispanic/Latino	393	15.1%
Not Hispanic/Latino	1,998	77.0%
Unknown/Not Reported	205	7.9%
Total	2,596	100.0%
Race	**n**	**%**
American Indian	43	1.7%
Asian/Pacific Islander	432	16.7%
Black/African-American	759	29.2%
Multi-Ethnic	83	3.2%
Other Race	281	10.8%
Unknown/Not Reported	111	4.3%
White	887	34.2%
Total	2,596	100.0%

DEMOGRAPHICS CONT.		
Language	**n**	**%**
Arabic	3	0.1%
Cantonese	39	1.5%
English	2,269	87.4%
Hmong	63	2.4%
Other	74	2.9%
Russian	16	0.6%
Spanish	52	2.0%
Unknown / Not Reported	26	1.0%
Vietnamese	54	2.1%
Total	2,596	100.0%

Primary Diagnosis	**n**	**%**
Adjustment disorder	55	2.1%
Anxiety disorder	35	1.3%
Attention-deficit hyperactivity disorder	48	1.8%
Bipolar disorder	296	11.4%
Borderline personality disorder	24	0.9%
Conduct disorder	56	2.2%
Major depressive disorder	558	21.5%
Oppositional defiant disorder	28	1.1%
Other	132	5.1%
Post-traumatic stress disorder	252	9.7%
Schizoaffective disorder	661	25.5%
Schizophrenia	451	17.4%
Total	2,596	100.0%
Connected to Primary Care Provider	**n**	**%**
No or Unknown	487	18.8%
Yes	2,109	81.2%
Total	2,596	100.0%

The following section examines outcomes over time for partners who have received services in an FSP for at least one year. Of the 2,596 partners served in FY 2019-20, 1,652 (63.6%) had continuously received services in an FSP the previous year.

Baseline data (one year prior to enrollment) was compared to FY 2019-20 data to determine whether outcomes improved in the areas of homelessness, emergency room visits, psychiatric hospitalizations, arrests, incarcerations and employment.

The tables and graphs in the following section include the subset of partners who completed one year in an FSP to fully capture the effects of FSP participation from one year before (baseline) to one year of partnership (change is represented in percent change). Primarily, partner data was

collected using FSP outcome assessment forms as developed by the California State Department of Health Care Services. These forms include: Partnership Assessment form (PAF) that collects baseline and current data when clients first enter FSP services; Quarterly assessment form (3M) that updates the data from the PAF and is done every three months for each client as long as they are receiving FSP services; and the Key Event Tracking form (KET) that is done each time a key event (i.e. crisis visit, arrest, incarceration, hospitalization) occurs. In addition to the FSP outcomes assessment forms, the County's electronic health record (Avatar) was used to collect primary diagnosis and hospitalization data.

Homelessness/Shelter Stays

The table below illustrates the number of unduplicated partners who were homeless, the total number of homeless occurrences, and total homeless days for the year prior to enrollment compared to FY 19/20. Of the 1652 partners in the cohort, 549 (33.2%) unduplicated partners experienced homelessness prior to enrollment. Compared to baseline, the unduplicated number of partners homeless as well as total homeless occurrences and days in FY 19/20 decreased significantly overall.

All Partners who Experienced Homelessness/Shelter Stays								
1 Year Before (Baseline)			FY 19/20			Percent Change Between Baseline and After One Year of Services in FSP		
# Unduplicated Partners Homeless	Total Homeless Occurrences	# Homeless Days	# Unduplicated Partners Homeless	Total Homeless Occurrences	# Homeless Days	Percent Change Unduplicated Partners	Percent Change Total Homeless Occurrences	Percent Change Homeless Days
549	1004	68,625	117	357	7,233	-78.6	-64.4	-89.4

Emergency Room (ER) Visits for Psychiatric Reasons

The table below illustrates the number of unduplicated partners with ER visits for psychiatric reasons one year prior to enrollment compared to FY 19/20. Just over 890 (892) unduplicated partners had at least one ER visit for psychiatric reasons prior to enrollment. Compared to baseline, the unduplicated number of partners and the total ER visits for psychiatric reasons both decreased significantly.

Partners w/Mental Health Emergency Room Visits					
1 Year Before (Baseline)		FY 19/20		Percent Changes Between Baseline and After One Year of Services in FSP	
Unduplicated Partners w/MH ER Visits	Total MH ER Visits	Unduplicated Partners w/MH ER Visits	Total MH ER Visits	Percent Change Unduplicated Partners w/ MH ER Visits	Percent Change Total MH ER Visits
892	1,289	80	118	-91.0	-90.8

Emergency Room (ER) Visits for Physical Health Reasons

There were 722 partners with a total of 1,003 ER visits for physical health reasons in the year prior to admission to an FSP. That number decreased significantly to 49 unduplicated partners for a total of 71 ER visits for physical health reasons.

Partners w/Medical Emergency Room Visits					
1 Year Before (Baseline)		FY 18/19		Percent Changes Between Baseline and After One Year of Services in FSP	
Unduplicated Partners w/Medical ER Visits	Total Medical ER Visits	Unduplicated Partners w/Medical ER Visits	Total Medical ER Visits	Percent Change Unduplicated Partners w/Medical ER Visits	Percent Change Total Medical ER Visits
722	1,003	49	71	-93.2	-92.9

Psychiatric Hospitalizations

The table below illustrates the number of unduplicated partners' as well as total number of psychiatric hospitalizations one year prior to enrollment compared to FY 19/20. Nearly 540 (538) unduplicated partners had at least one hospitalization prior to enrollment. That number decreased to 208 unduplicated partners in FY 19/20.

All Partners Who Completed 1 Year w/Psychiatric Hospitalizations								
1 Year Before (Baseline)			FY 19/20			Percent Changes Between Baseline and After One Year of Services in FSP		
Unduplicated Partners Hospitalized	Total Hospitalizations	Days	Unduplicated Partners Hospitalized	Total Hospitalizations	Days	Percent Change Unduplicated Partners	Percent Change Total Hospitalizations	Percent Change Days
538	1433	120371	208	457	10479	-61.3	-68.1	-91.2

Arrests

The table below illustrates the number of unduplicated partners' as well as total number of arrests one year prior to enrollment compared to FY 19/20. Exactly 188 unduplicated partners had at least one arrest prior to enrollment. That number decreased to 117 in FY 19/20.

Arrests-All Partners Who Completed 1 Year					
1 Year Before (Baseline)		FY 19/20		Percent Change from Baseline (# of partners)	
Unduplicated Partners	Total Number of Arrests	Unduplicated Partners	Total Number of Arrests	% Change Partners	% Change Arrests
188	290	117	162	-37.7	-44.1

Incarcerations

The table below illustrates the number of unduplicated partners' as well as total number of incarcerations one year prior to enrollment compared to FY 19/20. Of the partners in the cohort, 175 unduplicated partners had at least one incarceration prior to enrollment. That number decreased to 102 in FY 19/20.

Incarcerations-All Partners Who Completed 1 Year								
1 Year Before (Baseline)			FY 19/20			Percent Change from Baseline (# of partners)		
Unduplicated Partners Incarcerated	Total Number of Incarcerations	Total Days	Unduplicated Partners Incarcerated	Total Number of Incarcerations	Total Days	% Change Partners	% Change Incarcerations	% Change Days
175	451	19,511	102	206	3,164	-41.7	-54.3	-83.7

Employment

The table below illustrates the number of partners that indicated they wanted to be employed (n=270). It compares the number of partners who had employment at the start of their partnership who had the goal of employment as part of their recovery goals. Although the number of employed individuals is relatively small, the FSPs were able to assist 7 partners to secure employment and 61 partners to maintain employment.

Unduplicated Partners w/Employment Goal		
Timeframe	**Total**	**% Employed**
At Start of Partnership (baseline)	61	22.6
FY 19/20	7	2.6
Total Partner Employed at End of FY	68	25.2

General System Development (GSD) Program FY 2019-20 Demographics

In FY 2019-20, a total of 14,264 clients were served across the implemented GSD programs. The table below displays demographic information for individuals served in each program:

Total Number Served in General System Development Programs – FY 19/20																					
Characteristic	APSS		TCORE		Regional Support Teams		Guest House		Wellness and Recovery Center		Peer Partners		Consumer and Family Voice -		Crisis Residential Program 34th St.		Crisis Residential Program M St.		Crisis Residential Program		Total	
Gender	N	%	N	%			N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Female	463	67.5%	488	46.9%	4,470	57.2%	324	43.5%	1,718	56.9%	164	52.7%	47	43.5%	80	43.0%	66	37.7%	97	54.5%	7,917	55.5%
Male	223	32.5%	553	53.1%	3,343	42.8%	421	56.5%	1,292	42.8%	147	47.3%	35	32.4%	106	57.0%	109	62.3%	81	45.5%	6,310	44.2%
Other	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Unknown/Not Reported	0	0.0%	0	0.0%	1	0.01%	0	0.0%	10	0.3%	0	0.0%	26	24.1%	0	0.0%	0	0.0%	0	0.0%	37	0.3%
Total	**686**	**100.0%**	**1,041**	**100.0%**	**7,814**	**100.0%**	**745**	**100%**	**3,020**	**100%**	**311**	**100.0%**	**108**	**100.0%**	**186**	**100.0%**	**175**	100.0%	**178**	100.0%	**14,264**	**100.0%**
Age																						
0 to 15	0	0.0%	0	0.0%	2	0.03%	0	0.0%	0	0.0%	0	0.0%	50	46.3%	0	0.0%	0	0.0%	0	0.0%	52	0.4%
16 to 25	10	1.5%	52	5.0%	727	9.3%	0	0.0%	224	7.4%	34	10.9%	24	22.2%	22	11.8%	21	12.0%	26	14.6%	1,140	8.0%
26 to 59	498	72.6%	844	81.1%	6,005	76.8%	57	7.7%	2,316	76.7%	251	80.7%	6	5.6%	154	82.8%	147	84.0%	130	73.0%	10,408	73.0%
60 and Over	178	25.9%	145	13.9%	1,080	13.8%	688	92.3%	479	15.9%	26	8.4%	2	1.9%	10	5.4%	7	4.0%	22	12.4%	2,637	18.5%
Unknown/Not Reported	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.0%	0	0.0%	26	24.1%	0	0.0%	0	0.0%	0	0.0%	27	0.2%
Total	**686**	**100.0%**	**1,041**	**100.0%**	**7,814**	**100.0%**	**745**	**100%**	**3,020**	**100%**	**311**	**100.0%**	**108**	**100.0%**	**186**	**100.0%**	**175**	100.0%	**178**	100.0%	**14,264**	**100.0%**
Ethnicity																						
Non-Hispanic	69	10.1%	169	16.2%	5,345	68.4%	584	78.4%	505	16.7%	229	73.6%	25	23.1%	31	16.7%	29	16.6%	26	14.6%	7,012	49.2%
Hispanic	521	75.9%	796	76.5%	1,229	15.7%	117	15.7%	2,002	66.3%	44	14.1%	48	44.4%	129	69.4%	125	71.4%	130	73.0%	5,141	36.0%
Unknown/Not	96	14.0%	76	7.3%	1,240	15.9%	44	5.9%	513	17.0%	38	12.2%	35	32.4%	26	14.0%	21	12.0%	22	12.4%	2,111	14.8%
Total	**686**	**100.0%**	**1,041**	**100.0%**	**7,814**	**100.0%**	**745**	**100%**	**3,020**	**100%**	**311**	**100.0%**	**108**	**100.0%**	**186**	**100.0%**	**175**	100.0%	**178**	100.0%	**14,264**	**100.0%**
Race																						
White	242	35.3%	470	45.1%	3,127	40.0%	350	47.0%	1,163	38.5%	142	45.7%	16	14.8%	85	45.7%	79	45.1%	80	44.9%	5,754	40.3%
Black	84	12.2%	251	24.1%	1,699	21.7%	268	36.0%	752	24.9%	69	22.2%	7	6.5%	48	25.8%	45	25.7%	53	29.8%	3,276	23.0%
Asian/Pacific Islander	164	23.9%	75	7.2%	630	8.1%	21	2.8%	176	5.8%	24	7.7%	2	1.9%	7	3.8%	9	5.1%	8	4.5%	1,116	7.8%
Am Indian/Alask. Nativ	11	1.6%	24	2.3%	124	1.6%	15	2.0%	94	3.1%	6	1.9%	2	1.9%	4	2.2%	7	4.0%	4	2.2%	291	2.0%
Multi-Race	6	0.9%	45	4.3%	290	3.7%	14	1.9%	124	4.1%	7	2.3%	7	6.5%	7	3.8%	9	5.1%	4	2.2%	513	3.6%
Other	91	13.3%	118	11.3%	1,032	13.2%	44	5.9%	300	9.9%	38	12.2%	35	32.4%	19	10.2%	19	10.9%	15	8.4%	1,711	12.0%
Unknown/Not	88	12.8%	58	5.6%	912	11.7%	33	4.4%	411	13.6%	25	8.0%	39	36.1%	16	8.6%	7	4.0%	14	7.9%	1,603	11.2%
Total	**686**	**100.0%**	**1,041**	**100.0%**	**7,814**	**100.0%**	**745**	**100%**	**3,020**	**100%**	**311**	**100.0%**	**108**	**100.0%**	**186**	**100.0%**	**175**	100.0%	**178**	100.0%	**14,264**	**100.0%**
Primary Language																						
English	444	64.7%	958	92.0%	6,681	85.5%	733	98.4%	2,750	91.1%	280	90.0%	50	46.3%	179	96.2%	172	98.3%	173	97.2%	12,420	87.1%
Spanish	24	3.5%	21	2.0%	154	2.0%	3	0.4%	45	1.5%	9	2.9%	0	0.0%	0	0.0%	1	0.6%	0	0.0%	257	1.8%
Other	212	30.9%	41	3.9%	556	7.1%	3	0.4%	96	3.2%	17	5.5%	26	24.1%	1	0.5%	0	0.0%	1	0.6%	953	6.7%
Unknown/Not	6	0.9%	21	2.0%	423	5.4%	6	0.8%	129	4.3%	5	1.6%	32	29.6%	6	3.2%	2	1.1%	4	2.2%	634	4.4%
Total	**686**	**100.0%**	**1,041**	**100.0%**	**7,814**	**100.0%**	**745**	**100%**	**3,020**	**100%**	**311**	**100.0%**	**108**	**100.0%**	**186**	**100.0%**	**175**	100.0%	**178**	100.0%	**14,264**	**100.0%**

Note: General System Development programs are treatment programs and enter data directly into the Electronic Health Record (EHR). Some data elements in the EHR (sexual orientation, gender identity and veteran status) are being redefined and are therefore not available at this time.

MHSA Housing Program Accomplishments

BHS places a high priority on housing for people with mental illness who are experiencing or are at-risk of homelessness. The MHSA Housing Program provides a continuum of interventions including homelessness prevention, flexible housing funds, rapid rehousing, and permanent supportive housing. Housing interventions are targeted towards consumers of Full Service Partnership (FSP) and outpatient services. In FY 2019-20, BHS deployed $4,478,874 of housing program funds and leveraged in-kind service commitments to stably house MHSA eligible consumers.

The MHSA Housing Program operates in alignment with key regional strategies to reduce homelessness among the most vulnerable members of the community. BHS works closely with the Sacramento County Director of Homeless Initiatives, Sacramento Housing and Redevelopment Agency (SHRA), Sacramento Steps Forward (lead agency working to end homelessness in the Sacramento region), consultants, and other key partners.

Permanent Supportive Housing

A primary component of the MHSA Housing Program continuum is Permanent Supportive Housing (PSH). PSH is a long-term housing intervention targeted towards individuals experiencing chronic homelessness: the program provides affordable housing rental assistance with support services. Through the MHSA Housing Program, BHS has developed a portfolio of site based PSH units reserved for individuals eligible for FSP services. Tenants of MHSA units are able to receive mental health services and intensive case management through FSPs.

Housing Successes
In FY 2019-20, the MHSA-Funded Programs:

- *Housed 563 clients/households who were literally homeless*
- *Prevented 1,431 clients/households who were at imminent risk from becoming homeless*
- *Served 161 clients/households residing in MHSA funded apartments*
- *Provided rental assistance to 4,682 clients/households*
- *Provided 7,815 services utilizing MHSA housing flex funds*

The MHSA Housing Program's PSH portfolio provides high quality housing to MHSA-eligible consumers in the Sacramento community. BHS regularly evaluates PSH investments by analyzing key performance indicators. Consistent with prior years, property partners hold true to the intent of the property and agreed-upon tenant selection processes, with outcome data showing a high rate of applicant acceptance and move-ins. In addition, housing retention 6-months after tenant move-in is 92% across the portfolio. This metric is a critical measure of the effectiveness of the PSH model and project partnerships. High rates of housing stability among MHSA-eligible households who were experiencing homelessness at intake continues to be a hallmark of BHS success.

To date, more than $20,000,000 of MHSA funding has leveraged federal, state, and local funds to finance eleven developments and create 221 units of supportive housing for MHSA eligible tenants. The built unit portfolio represents years of cultivation of effective, strategic partnerships with SHRA, non-profit housing developers, property management companies, and FSP providers. The portfolio is geographically diverse and includes new construction as well as acquisition/rehabilitation projects. Properties offer a range of unit sizes including studios and one-bedroom units to family properties offering multi-bedroom units. Most recently, in FY 2019-20,

BHS invested $4.4 million MHSA dollars in two additional projects, The Courtyards on Orange Grove (20 units) and La Mancha (40 units). The addition of the two projects also expanded service provider capacity as a new FSP provider was engaged to provide supportive services to the projects. A $2.1 million permanent supportive housing investment planned in FY 2020-21 will add an additional 15 MHSA units at the Villa Jardin development. (*Additional information on each portfolio project is included in the MHSA Housing Portfolio Catalog – See Attachment G)*

Recognizing the efficacy, value, and importance of PSH, BHS continues to look for opportunities to build or renovate housing developments with units dedicated for MHSA-eligible tenants. BHS undertook an expansion of the PSH portfolio in FY 2018-19 in partnership with SHRA by co-applying with nonprofit development partners for State No Place Like Home (NPLH) capital funds. Since then, BHS has dedicated $2,800,000 in noncompetitive NPLH funds and been awarded $24,465,091 of competitive funds in support of three housing developments: Sunrise Pointe Development in Citrus Heights (22 units), Capital Park Hotel Development in downtown Sacramento (65 units), and Mutual Housing on the Boulevard in downtown Sacramento (50 units). These pipeline developments will add 137 units of supportive housing to the BHS PSH portfolio. Most recently BHS dedicated an additional $2,287,737 of noncompetitive NPLH funds to a third-round project, On Broadway Development (37 units), also in downtown Sacramento. If the project is awarded competitive NPLH funds, it will bring the total NPLH units to 174 and the total number of built units for MHSA-eligible tenants to 395. The estimated annual in-kind value of the 20-year required service commitment for the 14 proposed and existing MHSA and NPLH projects is $3,950,000.

BHS also provides PSH in partnership with SHRA through the tenant-based Shelter Plus Care program. This legacy HUD program pairs FSP services with affordable housing rental assistance in the form of a housing voucher for consumers to use in the private rental market. BHS commits approximately $2,500,000 of in-kind mental health services to consumers through this program.

Flexible Housing Supports

In addition to supporting a portfolio of PSH projects, BHS provides flexible housing supports to assist clients in obtaining or maintaining other forms of housing. Flexible housing support funds are used to provide consumers assistance in the form of homelessness prevention and short and long-term rental subsidies.

In FY 2019-20 BHS invested MHSA funds in homelessness prevention assistance for households experiencing a housing crisis and at imminent risk of homelessness. This short-term intervention targets services and time-limited assistance to stabilize households through financial assistance, housing-focused cased management, landlord or property management mediation, connections to financial counseling or advocacy, and legal assistance as needed. Financial assistance may include payment of rental or utility arrears, rental or utility security deposits, short-term motel costs, credit repair support, or application fees. BHS consumers have also benefited from short- and long-term rental subsidies provided with MHSA flex funds. Subsidy assistance includes rental deposits, first or last month’s rent, and/or a rental subsidy. In addition, consumers receiving subsidy support receive housing focused case management, housing unit identification assistance and linkage to mainstream community resources.

To further expand capacity and access to the flexible housing dollars, BHS undertook a partnership with the Sacramento County Department of Human Assistance (DHA) to administer a flexible housing pool. DHA provides rent subsidies, landlord engagement, tenant/landlord matching, ongoing tenant services and intensive case management services to clients living with a serious mental illness who are discharging from jail or acute psychiatric hospitalization into homelessness.

PREVENTION AND EARLY INTERVENTION (PEI) COMPONENT

The **Prevention and Early Intervention (PEI)** component provides funding for programs and activities designed to prevent mental illness from occurring or becoming more severe and disabling. It is required that more than fifty percent of PEI funding be dedicated to individuals age 0-25.

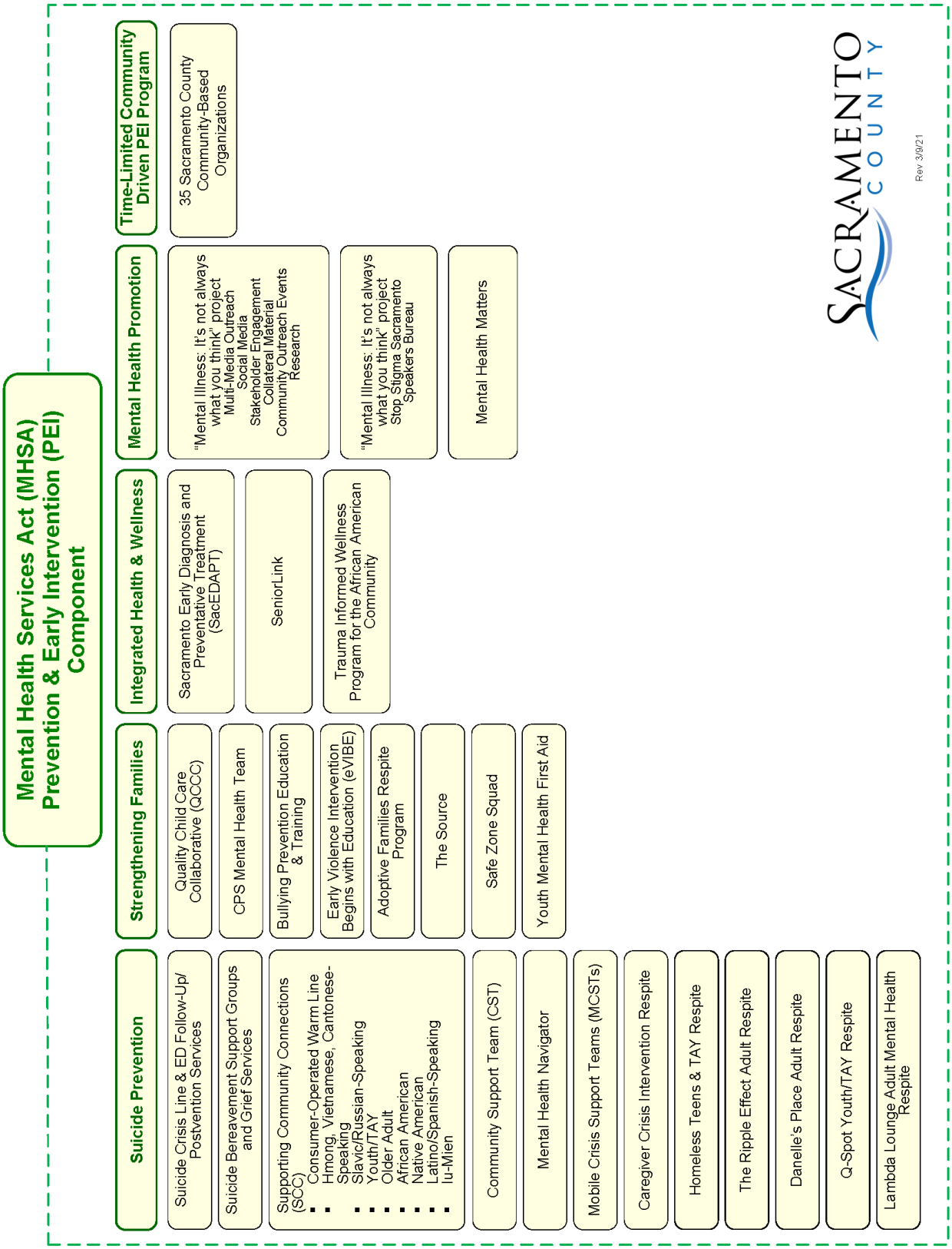
Sacramento County's PEI Plan is comprised of four (4) previously approved programs designed to address:

1) Suicide Prevention and Education;
2) Strengthening Families;
3) Integrated Health and Wellness; and
4) Mental Health Promotion (to reduce stigma and discrimination)

In FY 2019-20, BHS PEI funded programs served 51,826 individuals in selective prevention programs and 144,969 adults, children, parents/caregivers and education staff in universal prevention (Supporting Community Connections outreach and information/referral, Respite outreach, Bullying Prevention and Mental Health Promotion).

In April 2020, the MHSA Steering Committee discussed ongoing support for the California Mental Health Services Authority (CalMHSA) Joint Powers Authority and the progress CalMHSA is making with the Statewide PEI Programs. After a rich discussion, the Steering Committee recommended dedicating 3% of local PEI funding to CalMHSA to sustain the PEI Statewide Project activities.

This Three-Year Plan includes the new PEI program: Trauma Informed Wellness for the African American Community. The recommendation for this new program was developed through a community program planning process described in detail in both the FY 2018-19 and FY 2019-20 Annual Updates. It included the formation of an Ad Hoc Workgroup that developed the recommendation. African American Community Listening Sessions were conducted thereafter to further refine the program recommendation.


Mental Health Services Act (MHSA)
Prevention & Early Intervention (PEI)
Component
Suicide Prevention
Strengthening Families
Integrated Health & Wellness
Mental Health Promotion
Time-Limited Community Driven PEI Program
Suicide Crisis Line & ED Follow-Up/ Postvention Services
Suicide Bereavement Support Groups and Grief Services
Supporting Community Connections (SCC)
Consumer-Operated Warm Line
Hmong, Vietnamese, Cantonese-Speaking
Slavic/Russian-Speaking
Youth/TAY
Older Adult
African American
Native American
Latino/Spanish-Speaking
Iu-Mien
Community Support Team (CST)
Mental Health Navigator
Mobile Crisis Support Teams (MCSTs)
Caregiver Crisis Intervention Respite
Homeless Teens & TAY Respite
The Ripple Effect Adult Respite
Danelle's Place Adult Respite
Q-Spot Youth/TAY Respite
Lambda Lounge Adult Mental Health Respite
Quality Child Care Collaborative (QCCC)
CPS Mental Health Team
Bullying Prevention Education & Training
Early Violence Intervention Begins with Education (eVIBE)
Adoptive Families Respite Program
The Source
Safe Zone Squad
Youth Mental Health First Aid
Sacramento Early Diagnosis and Preventative Treatment (SacEDAPT)
SeniorLink
Trauma Informed Wellness Program for the African American Community
"Mental Illness: It's not always what you think" project
Multi-Media Outreach
Social Media
Stakeholder Engagement
Collateral Material
Community Outreach Events
Research
"Mental Illness: It's not always what you think" project
Stop Stigma Sacramento
Speakers Bureau
Mental Health Matters
35 Sacramento County Community-Based Organizations
SACRAMENTO COUNTY
Rev 3/9/21

Suicide Prevention and Education Program
Capacity: 30,000 contacts annually
Ages Served: 8% Children, 33% TAY, 47% Adults, 11% Older Adults

The Suicide Prevention and Education Program consists of several components.

Suicide Crisis Line, administered by WellSpace Health, is a *PEI Suicide Prevention program* with a 24-hour nationally accredited telephone crisis line that utilizes professional and trained volunteer staff to provide suicide prevention and crisis services to callers of all ages at risk of suicide.

In FY 2019-20, a total of 47,109 callers accessed the Crisis Line for suicide prevention support.

Success: Suicide Crisis Line
An individual called the Suicide Prevention Crisis Line, having a plan to overdose on painkillers and anxiety medications they had with them. They were at high risk of immediate suicide at the beginning of the call. They had attempted suicide previously as well. The caller was crying and feeling anxious, burdensome, confused, depressed, helpless, and hopeless. They had experienced multiple traumas, including loss of a child, a history of domestic violence, and being abused as a child by those who were supposed to protect the caller. They were able to talk with the Crisis Line Specialist, who provided empathic listening, risk assessment, and help in creating a safety plan. Formal resources and informal coping strategies were explored with the caller. The Crisis Line Specialist offered follow up calls to the caller for additional support. The caller agreed to keep safe at the end of the call, and told the Crisis Line Specialist, "You're incredible. I can't believe the amount of help I got calling this line."

In FY 2019-20, with the MHSA Steering Committee's support, the Suicide Crisis Line expanded services by adding 24/7 Suicide Crisis Line Chat and Text response.

Emergency Department Follow-up Services, administered by WellSpace Health, is a *PEI Suicide Prevention program* that provides brief individual follow-up and support services to consenting individuals seen at Sutter Medical Centers who have attempted suicide and are at high-risk for suicide. In FY 2019-20, with the MHSA Steering Committee's support, the Emergency Department Follow-Up Services expanded to include Dignity San Juan and University of California Davis Medical Center Emergency Departments (UCDMC ED).

Success: Emergency Department Follow-up Services
A young adult was referred to the Emergency Department (ED) Follow-Up Services after being seen in the ED for suicidal thoughts and then discharged. The ED Follow Up Specialists contacted this person 10 times over 30 days. They provided emotional support; ongoing evidence-based risk assessment and safety planning; debriefing; and referrals to the Mental Health Crisis Respite Center, Mental Health Urgent Care Clinic, a therapist, and 7cups.com, an online therapy site. The Specialists also discussed self-care as a means to prevention. The individual still experienced intermittent suicidal ideation, underscoring the need for this support, but was able to keep safe and improve, with no further suicide attempts or readmissions to the ED during this 30 day period. At the end of this period, the individual told the Follow Up Specialist, "I am doing really good. No more thoughts of suicide and my family is very supportive now."

In FY 2019-20, a total of 72 individuals referred by Sutter Medical Center ED and Dignity San Juan ED received 1,282 postvention follow-up and support services. Emergency Department Follow-Up Services began providing program services at UCDMC ED early in FY 2021-22.

Suicide Bereavement Support Groups and Grief Services, administered by Friends for Survival, is a program in which staff and volunteers directly impacted by suicide provide support groups and services designed to promote healing in those coping with a loss by suicide. In FY 2019-20, a total of 505 individuals participated in suicide bereavement education and support groups. Between 4,000 to 5,000 monthly *Comforting Friends* newsletters are mailed and over 55,000 are distributed locally and regionally in surrounding counties via mail or electronically each year.

Success: Friends For Survival
Comforting Friends *newsletter excerpt from a story titled* 25 Years of Healing *by a survivor of a brother's death by suicide:*

"My first Friends for Survival meeting was shocking. As each suicide survivor introduced themselves and mentioned the loved one who died by suicide, I was barely able to keep it together. But, their words gave me hope. If people could do this... speak it out loud, again and again, would it eventually hurt less? And, what a revelation it was to be able to talk openly about John and his suicide choice with people who didn't act as if they wanted to flee while I spoke. Nor did they spew those clichés about suicide. I attended faithfully that first year. I learned a lot about the grief process."

With MHSA Steering Committee support, in FY 2019-20 this program expanded by adding a part-time volunteer coordinator to expand the volunteer base, provide phone support, and coordinate community outreach events to increase postvention awareness and the number of individuals served.

Supporting Community Connections (SCC): A constellation of community based agencies working collaboratively throughout the County to provide culturally and linguistically appropriate suicide prevention support services designed to increase access to and linkage with needed services; improve self-reported life satisfaction and well-being; reduce risk factors and enhance of protective factors; divert from crisis services or decrease need for crisis services; decrease suicide risk; increase knowledge of available resources and supports; and enhance connectedness and reduce isolation. Each program is specifically tailored to meet the needs of their respective communities. The SCCs are *PEI Improving Timely Access to Services for Underserved Populations programs.*

During FY 2019-20, the SCC programs collectively outreached to 63,647 individuals and served 1,538 individuals. Supporting Community Connections consists of ten (10) programs targeting 14 specific communities/populations:

◊ **Consumer-Operated Warmline**: Administered by Cal Voices, this service is available to Sacramento County residents Monday-Friday from 9:00 AM to 5:00 PM. During FY 2019-20, the program provided 81 individual community contacts, 7,109 information and referral contacts and 219 individuals participated in groups. For each Warmline call, services include a minimum of two of the following: supported listening, coaching, mentoring, referral and

linkage, skill building and social networking. Support services include Wellness Recovery Action Plan (WRAP) workshops, community outreach and connection, support groups, one on one peer supports, community education training about mental health issues, and volunteer training, development and support.

Success: Consumer-Operated Warmline SCC
The Warmline has a regular caller by the name of "Joan," who uses the Warmline as a place to vent about her mental health struggles. Recently she was diagnosed with cancer, which negatively affected her mental health condition. When she was first diagnosed, she was very distraught about the whole situation and expressed feelings of hopelessness. One of the Warmline operators compassionately listens to her weekly and checks in on her if she doesn't happen to call. She told the Warmline operator that she appreciates the services the Warmline provides and appreciates talking with someone that can provide her with good ideas. Ever since "Joan" began talking to the Warmline operator, her overall hopelessness noticeably dissipated when it came to talking about her cancer. As a person without a lot of support, "Joan" felt alone in her current condition. However, given support from the Warmline, she now feels like she has a support system she can turn to whenever her health problems affect her.

Goals of the Consumer-Operated Warmline are to: increase access and linkage to needed services such as support services, self–help, and professional supports, etc.; improve self-reported life satisfaction and wellbeing; and reduce risk factors.

◊ **Hmong, Vietnamese, Cantonese-Speaking communities:** Administered by Asian Pacific Community Counseling (APCC), this program provides services focused on suicide prevention by addressing cultural related risk factors to Hmong, Vietnamese, and Cantonese-speaking communities across the life span. During FY 2019-20, the program provided 59 individual community contacts, 0 information and referral contacts and 1,406 individuals participated in groups.

Success: Hmong, Vietnamese, Cantonese-Speaking SCC
Written by a 77-year old Vietnamese client, wife, and mother:

"I came to the U.S. with my husband and small children and no other family to support us. We settled in the Sacramento area where my husband was able to find work with a local farming family. I dedicated all of my time to raising my children and to make sure that they had opportunities for a successful future. All three children have earned college degrees and are successful in their careers.

Although I was happy for my children, I myself became depressed and could not sleep. After searching for Vietnamese support groups, my friend came across APCC SCC webpage. My husband spoke to the counselor and took me to one of the Tai Chi classes. After a few months, we also joined the Ballroom dancing class. I realized the joy of learning something new with my husband at my side supporting and encouraging me. It has now been eight months since we first started attending the classes. I use the coping skills that I have learned in the classes to decrease my thoughts of uselessness and depression. I will continue to attend the classes and take care of myself."

The program identified risk factors in each community that increase the likelihood of suicidal thoughts, feelings or behaviors. These risk factors include isolation; feelings of geographic and social marginalization; and loss of personal worth related to being disconnected from families.

APCC provides outreach and support services to older adults in targeted communities who tend to have higher risk for suicide. The APCC-SCC program staff engages older adults in activities and social groups to increase social connectedness to decrease isolation. APCC also provides engagement and support in

community settings to adults and families with younger children to expand knowledge of and share information about mental illness and suicide. Efforts related to suicide prevention include facilitating workshops on mental health and decreasing risk factors of suicide.

With MHSA Steering Committee support, in FY 2019-20 this program expanded by offering SCC support services at a small satellite office close to where community members reside to increase program participation.

◊ **Slavic/Russian-Speaking:** Administered by Slavic Assistance Center, this program provides community workshops/forums/round tables for youth, adults and seniors to increase social connectedness, reduce isolation, and develop positive social skills. During FY 2019-20, the program provided 158 individual community contacts, 486 information and referral contacts, and 610 individuals participated in groups.

The program utilizes Russian language media, specifically newspaper, radio programming, and TV shows, to educate the Russian-speaking community about suicide prevention and emotional wellness. Program staff work closely with faith community networks and charter schools serving the Slavic community to provide SafeTalk training and other workshops about emotional wellness and suicide prevention to clergy, educators, parents, and students. Program specialists also work with young people at youth camps to educate them regarding mental health and suicide and help them overcome suicide risk factors such as addictions. The program focuses on building mutually beneficial relationships between schools, churches, faith-based organizations, community centers, and businesses serving the Russian-speaking/Slavic community.

Success: Slavic/Russian-Speaking SCC
Written by program participant: The COVID-19 pandemic negatively affected the lives of many people. Last year was especially difficult for me personally. Like many others, I lost my job at this time. From these stresses and worries, I fell into depression and began to drink heavily. I've been drinking for more than six months. Despite the requests of my wife to stop drinking, I continued drinking. I was completely unaware of the effects alcohol was having on my emotional well-being. I drank in order to suppress the negative feelings of depression. My wife was devastated. My children also suffered very much because of me. One day, she told me that unless I got help for my addiction, she was going to leave me and take the children. I didn't want to lose my family and finally decided to battle my addiction to alcohol. My wife called to the Slavic Assistance Center asking for help. The staff of the Center referred us to substance use treatment services and professional mental health specialists and has been tremendously supportive of me throughout the recovery process. Step by step, my family has begun to heal from the emotional wounds that mental illness and addiction often cause. I couldn't have accomplished any of this without the professional help I received at Slavic Assistance Center. My best advice for people suffering from addiction and depression: Seek help, there is always a way out.

◊ **Youth/Transition Age Youth (TAY):** Administered by Children's Receiving Home, this Supporting Community Connections program provides suicide prevention information and support services for youth/TAY from ages 12 years through 25 with an emphasis on the cultural and specific needs of LGBTQ, foster and homeless youth. During FY 2019-20, the program provided 477 individual community contacts and 287 individuals participated in groups. Services range from outreach and engagement activities to individual and group support

services. Program outcomes include promoting and supporting community connections, improving access to mental health services, and reducing suicide risk.

◊ **Older Adult:** Administered by Cal Voices, this program provides senior peer counseling and support including companionship, emotional support, transportation, phone support, friendship, and resource linkage for lonely, isolated, homebound older adults in Sacramento County. Other types of support provided by this program includes community connection, advocacy, community education and training about mental health issues, and volunteer development. During FY 2019-20, the program provided 17 individual community contacts, 1,101 information and referral contacts, and 131 individuals participated in groups.

> ***Success: Older Adult SCC***
> *'Josie' has lived alone for about ten years in Sacramento County. She has been struggling to afford the cost of living in Sacramento County especially with her limited income. 'Josie' was feeling very anxious, depressed and worried about how she was going to continue to live with all her income going towards rent. 'Josie' also doesn't have anyone who could support her. She then reached out to the SCC Older Adult Program and was referred to a low-income program with SMUD, PG&E, and the Salvation Army for bill payment assistance. The SCC Older Adult program also helped 'Josie' enroll in the CalFresh program for assistance in obtaining. She was also referred to Sacramento Foodbank to get groceries while waiting for her CalFresh application to be approved. 'Josie' was worried she would be homeless or go hungry but with the SCC Older Adult Program's assistance, 'Josie' is now able to save money on her utilities and live a fulfilling life. The SC Older Adult Program saw improvement in 'Josie's' mood and overall wellbeing and suppled her with much-needed resources.*

◊ **African American:** Since mid FY 2019-2020, this Supporting Community Connections (SCC) program has been administered by A Church For Us (doing business as A Church For All). This SCC program provides culturally informed outreach, engagement, and support services to African American community members across genders and all age groups. During FY 2019-20, the program provided 50 individual community contacts, 2 information and referral contacts, and 23 individuals participated in groups.

Outreach and engagement activities include attending community outreach events and conducting presentations to African American participants in faith based and community based organizations, schools, and youth after school programs. Their social media strategy provides program information and suicide prevention and resources.

Support services include individual listening sessions; ongoing support groups; Safe Black Space and Restoration Hope; and trainings such as Mental Health First Aid (MHFA) and SafeTalk. Support services are provided over the phone; in person; online via Zoom, Facebook, and Instagram; and within the community. To promote trust and ease of access, the support services are planned for co-location, two days per week, at two locations within African American neighborhoods. As needed, transportation support is provided to participants to facilitate participation in support services.

Within the first year of operation, this SCC program completed a Community Needs Assessment to engage African American Community members in identifying community-defined support service(s) related to suicide prevention. Based upon feedback from the needs assessment, this program modified their community-defined program design strategy by adding individual and group peer support, crisis intervention, and warm line services. This program also established an African American stakeholder advisory committee that has begun meeting, with the goal of providing feedback on program effectiveness.

More information about program implementation will be included in future updates.

Success: African-American SCC

While conducting outreach and recruitment for focus group participants, a 30 year African American male, (identified as AO) signed up for the African American Homeless Men focus group. He shared his story of isolation, poverty, and discrimination. He also shared moments of desperation and efforts he made to take his life. Although he had a job, he was struggling to secure housing and living out of his car. In late November, AO contacted the staff and reported that his car had been impounded. His car was his only way to get to work, contained all of his possessions, and provided him with housing. As a result, he reported a desire to end his life. SCC staff provided peer-counseling support to help AO maintain hope. They offered a referral to behavioral health services which he declined. However, he was interested in crisis respite service as well as case management support. Staff worked with a respite program to identify a resource that would donate the funds needed to release his car. SC staff also provided ongoing peer counseling to reduce AO's isolation and to help him maintain hope. SC staff were able to utilize their knowledge and community resources to aid in reducing AO's risk for

◊ **Native American:** Administered by Sacramento Native American Health Center (SNAHC), this SCC program, known as "Life is Sacred," provides Native culture-based suicide prevention training and support services to American Indian/Alaska Native (AI/AN) community members across the life span. The unique program design, which is sensitive to specific community needs, does not lend itself to individual data collection. During FY 2019-20, the program provided 17 individual community contacts, 196 information and referral contacts, and 412 individuals participated in groups.

Research clearly indicates that for AI/AN community members, culture is a determinant of health and loss of culture causes harm whereas re-connecting with culture is protective and improves health. The research also indicates that resiliency, generosity and empowerment are fundamental principles within Native cultures. High rates of mental health issues for AI/AN community members are a direct result of historical events and oppression relating to colonialism and loss of culture; therefore, improving well-being requires strategies that counter cultural loss. The incorporation of traditional Native healing practices and ceremony is an integral part of this program. The program offers an array of culturally based workshops such as Gathering of Native American Training/Workshop (GONA), Culture is Prevention (CIP) workshops, Native Family workshop, and Indian Education Self-Esteem workshops. These workshops are designed to strengthen and support community capacity, and reduce the prevalence of mental health challenges and suicide by increasing 1) Cultural Identity/Connectedness, 2) Empowerment, 3) Resilience, and 4) Generosity.

Success: Native American SCC
Submitted by a SCC Culture is Prevention group participant, highlighting the healing connection between cultural identity and connectedness:

"A new beginning to a new journey. I recently found out that I am 43% Native American. The Culture is Prevention Group was & is the perfect group for me to attend. I have learned so much, from Native Beliefs to expressing myself through art. This group is my community, a safe trusting environment to be me, and to engage with other Native Americans. The structure has made me realize how effective it is. Being here has brought comfort to me physically, mentally, emotionally and spiritually. I have been so eager to grow and to pursue happiness. Rejuvenating my inner spirit is key. This is what I have found here at the SNAHC SCC program."

The Native American Training/Workshop (GONA), a project congruent with Native culture and tradition, is a culture based intervention where community members gather to address various mental health topics, identify cultural practices and traditions, and address the effects of historical trauma to promote healing. Since it was developed in 1992, GONA has been recognized as an effective Culture Based intervention to counter culture loss and promote resiliency. The program will continue to provide a variety of suicide prevention and awareness trainings such as Mental Health First Aid, Applied Suicide Intervention Skills Training (ASIST) and SafeTalk to Native community members and providers working with Native community members. Native based suicide prevention promotional materials that were developed based on community input will continue to be used to promote the program and educate the community.

◊ **Latino/Spanish-Speaking:** Administered by La Familia Counseling Center (LFCC), this Supporting Community Connections program serves Sacramento County's Latinx communities through Latinx culturally focused suicide prevention services. During FY 2019-20, the program provided 610 individual community contacts, 486 information and referral contacts, and 610 individuals participated in groups.

LFCC staff have been trained in Applied Suicide Intervention Skills Training (ASIST) and Mental Health First Aid (MHFA) to provide information, referrals and phone support to callers in need of suicide prevention support. Through the SCC program, LFCC provides MHFA and Youth MHFA training in Spanish to the Latino/Spanish speaking communities.

LFCC SCC program provides the following support services which reduce the stigma and discrimination about mental illness and bring about awareness of suicide prevention: Grupo de Apoyo, support groups for parents and older adults; Parents of Teens, a support group using an evidence-based practice curriculum that has been adapted to improve communication between Latinx parents and teens; and, education and information sessions/groups on a regular basis at the Mexican Consulate to enhance the community's knowledge of suicide prevention. Additionally, LFCC SCC program provides outreach to their Senior Companion Partnership program through home visitation and assistance to isolated Latino seniors.

Due to the political climate and discrimination against immigrants, risk factors for Latino/Spanish speaking communities have intensified over the past several years. This has resulted in community members experiencing severe anxiety, major depression, trauma, re-traumatization, isolation, and vicarious traumatic reactions. LFCC SCC offers individual navigation to resources that will reduce the risk factors and guide the families toward wellness. Connecting individuals to mental health services remains a priority.

Success: Latino-Spanish Speaking SCC
Client endured more than 10 years of domestic violence by her husband and also suffered sexual harassment at the hands of her employer and refused to report this for fear that the employer would report her to the immigration authorities. Without knowing where to go or what to do, she entered La Familia's door and SCC program staff began assisting client by providing support and informing her about and linking her to specific resources. SCC staff linked her to medical help, the Workers' Rights Program, and other needed services. They also helped her start divorce proceedings and obtain a restraining order. They also referred her to a program that provided brief therapy so that she could overcome her struggles. Recently, the client returned to thank the SCC staff. She expressed thanks for the support and help she received from the SCC program staff.

Through the SCC program, LFCC identified unmet needs in the Latinx community. As a result, LFCC applied for and was awarded a California State Office of Health Equity grant. This program serves as a complementary partner program to the SCC program, as it provides short-term therapy and then a warm handoff to community services when needed.

In FY 2019-20, with the MHSA Steering Committee's support, this SCC program expanded by extending SCC services to the Latino/Spanish-speaking community in the north area of Sacramento.

◊ **Arabic-speaking:** Refugees Enrichment & Development Association (REDA) was awarded the contract at the beginning of FY 2020/21 to provide suicide prevention awareness and support services to the Arabic speaking community. Their Supporting Community Connections (SCC) contract was executed on November 2, 2020 and they provide culturally responsive and linguistically proficient support through the following outlets:

- Social support services through REDA's helpline which allows REDA to assess the community's needs and provide wider linkage to services providers.
- Mental health screening services to clients during both daily intake and monthly outreach events. This two-steps screening uses three professional questionnaires to assess clients' mental health needs and the need for a mental health clinician for the Arabic speaking community.
- Referring to mental health providers. Clients who display symptoms of distress, depression and PTSD are offered the option of being referred to culturally and linguistically sensitive providers. Providers can be counselors, therapists of psychiatrists.
- Outreach and community driven activities. REDA offers a monthly event where professional speakers educate community members on topics that are relevant to the Arabic speaking community. The chosen topics were identified by clients through an online survey to better engage community members in these conversations.

Success: Arabic-speaking SCC
A woman referred to REDA, whose screening indicated extreme depression, disclosed to REDA's mental health screener that she had attempted suicide in the past and lied to her family as to why she was admitted to the ER. She said she had never thought of seeking therapy or mental health services until her husband learned about the program from REDA's staff and suggested that she give it a try. The client was remarkably relieved after her session with REDA's mental health screener (a professional counselor trained to work with clients in crisis). She emotionally thanked her for listening to her story and thanked REDA for offering to connect her with a therapist.

◊ **Iu-Mien:** Administered by Iu-Mien Community Services (IMCS), this SCC program provides culturally and linguistically responsive intergenerational support groups, outreach and engagement activities, and prevention-focused culturally relevant suicide prevention services to the Iu-Mien community across the life span. The goal of this program is to decrease the likelihood of isolation and depression. The unique program design, which is sensitive to specific community needs, does not lend itself to information and referral contacts. During FY 2019-20, the program provided 106 individual community contacts, 365 information and referral contacts, and facilitated groups in which 3,217 duplicated individuals participated.

The IMCS SCC program provides peer-run adult day support services for elderly and disabled Iu-Mien community members twice per week. Support services include socialization, weekly news exchange, recreation/fieldtrips, and informational presentations regarding community concerns and services of local agencies, with the goal of decreasing the isolation, loneliness, and depression that plague many elderly and disabled Iu-Mien community members.

Additionally, the IMCS SCC program provides a weekly peer-run youth group focused on youth leadership activities, physical recreation, cultural arts, and an informational workshop regarding management of stress for improved mental or physical health.

Lastly, the IMCS SCC program provides a weekly intergenerational support group focused on communication between multi-generational family members through the promotion of oral fluency and literacy in both the Mien language and English language. The overarching goal is to provide better communication within multigenerational families that will decrease stress, support positive mental and physical health of families, increase understanding, and close the perceived generation gaps.

Success: Iu-Mien SCC
"My name is 'Jack' [name changed to protect privacy] and I'm 16 years old. I was introduced to the Peer-run Youth Group, S.A.E. Mien Youth Club Program (Seek, Act and Embrace Mien Youth Club) by my friends at West Campus High School. I have been in the club for almost two years. One activity hosted by S.A.E. Mien Youth Club was the Iu Mien New Year Celebration 2020. This really helped me and provided me with the valuable lesson of how to communicate clearly with others. Another activity is just the weekly Friday meetings, whether they may be a regular informational meeting or a fun event. These have helped me improve my social skills and taught me so much about valuable life lessons. In addition, these have become events that help me make it through each and every week, as it is one good thing I can always look forward to even in the toughest weeks at school. I look forward to meeting new people and making new friends in this program. I would strongly recommend this program to someone because it has vastly improved my mental health, taught me many social skills, and has brightened my life in general."

With MHSA Steering Committee support, in FY 2019-20 this SCC program expanded by providing transportation assistance to serve more community members, thereby decreasing barriers to community members' participation and reducing isolation.

The **Community Support Team (CST)** is a *PEI Access and Linkage to Treatment program* that provides community-based flexible services to community members experiencing mental health distress, which can include assessment, crisis intervention, safety planning, and linkage to ongoing services and supports. The CST is a collaboration between Behavioral Health Services (BHS) licensed mental health counselors and Crossroads Vocational Services peer/family specialists, creating one team with a variety of clinical and outreach skills.

The County BHS mental health counselors and the contracted peer/family specialists together engage and build bridges between family members, individuals, natural supports systems, and community resources or services. The CST serves Sacramento County children, youth, transition age youth (TAY), adults, and older adults that are experiencing mental health distress, including those at risk for suicide. The CST provides education, resources, and connections to services for individuals and their caregivers, loved-ones and other natural supports. The goal of CST is to provide services in a culturally and linguistically competent manner while promoting recovery, resiliency and well-being resulting in decreased use of crisis services and/or acute care hospitalization services; decreased risk for suicide; increased knowledge of available resources and supports; and increased personal connection and active involvement within the community.

Late FY 2019-20, CST added three of six additional BHS mental health counselors, who will partner with local law enforcement, jail, and collaborative courts partners to support individuals coming into contact with the justice system due to their mental illness. For FY 2020-21, CST plans to fill the three remaining added mental health counselor positions. A request for application was released mid FY 2020-21 for the contracted Peer component to support the CST expansion and respond to those coming into contact with the Justice System. Cal Voices was awarded the CST Peer contract and is scheduled to start early FY 2021-22.

Success: Community Support Team
The CST received a referral for an unknown age female who was being housed in an animal shed in Rio Linda by an 80 year old man who had repeatedly requested support via welfare check to gain assistance. CST Counselor went to see the individual and immediately called non-emergency number for a welfare check as client was unable to walk, was disoriented, appeared to be struggling medically and was unable to care for herself. The fire department arrived and notified the CST team that individual did not meet criteria for 5150. The individual was disoriented and did not appear aware that she was in Sacramento. The man housing her reported that she informed him she was from Tennessee and someone "dumped her" near the Rio Linda area. With consistent support and encouragement from the CST team, the individual agreed to be taken to the Mental Health Urgent Care Clinic (MHUCC) by the CST team. With CST and MHUCC support, she was assessed and MHUCC arranged transfer, by ambulance due to the complex medical presentation, to UC Davis Medical Center. CST was able to coordinate with UC Davis Medical Center, whose staff stated that getting the client to the hospital "saved her life". According to the hospital social worker, 3 weeks after admission, the client was medically stable but her name remained unknown. UC Davis Medical Center continued care and coordination to ensure both medical and mental health support was provided. They also supported linkage to ongoing care upon discharge.

Mental Health Navigator Program (MHNP): is a *PEI Access and Linkage to Treatment program* that provides brief community-based navigation services for individuals recently involved in crisis services or incarceration as a result of their mental illness. Navigators provide care coordination, advocacy, system navigation and linkage to services for individuals living with serious mental illness who are homeless, at-risk of homelessness, and/or may have a co-occurring substance use disorder. Navigators were sited at participating hospital emergency departments and law enforcement agencies as well as in the community to follow-up with individuals where needed throughout Sacramento County. The MHNP serves children, youth, TAY, adults, and older adults with the goal of reducing unnecessary hospitalizations and incarcerations, as well as mitigating unnecessary expenditures of law enforcement.

MHNP was administered by TLCS, Inc. (AKA Hope Cooperative) until April 2021. In mid FY 2020-21, the MHNP program began focusing primarily on the needs of those coming into contact with the hospital system, while also expanding hospital partners to include inpatient psychiatric hospitals and a 24 hour, 7 day a week response to referrals. A Request for Applications was released mid FY 2020-21 for this redesigned program. Bay Area Community Services (BACS) was awarded and will begin delivering services late FY 2020-21. More information about program implementation will be included in future plans and updates.

Success: Mental Health Navigator Program
A female member was referred to Mental Health Navigator Program by a Mobile Crisis Support Team clinician following an altercation involving her boyfriend attempting to harm her. The clinician was able to take her to a WEAVE Safehouse and facilitated connection to MHNP services at that safe location. The member was struggling with symptoms associated with a diagnosis of depression, methamphetamine use, and developmental disability. In the time that MHNP worked with her, MHNP supported her in signing up for SSI for income, connected her with a primary care physician (PCP) via One Community Health, and linked her with a dentist to obtain dentures. MHNP provided linkage to mental health services and transportation and support to her first appointment and ensured she had a follow-up mental health appointment scheduled. Before closing, MHNP connected her to the Flexible Housing Pool (FHP) Housing Program and assisted her in obtaining permanent housing. The MHNP was able to successfully assist her in overcoming barriers to engaging in mental health services and ensured needs were addressed to sustain stability.

Mobile Crisis Support Teams (MCST): The MCST is a *PEI Access and Linkage to Treatment program* and is a collaboration between the Behavioral Health Services (BHS) and local law enforcement agencies across Sacramento County. The MCSTs serve individuals of all ages and diversity in Sacramento County by providing timely crisis assessment and intervention to individuals who are experiencing a mental health crisis. The goals of the program are to provide safe, compassionate and effective responses to individuals with a mental illness; increase public safety; decrease unnecessary hospitalizations for community members experiencing a mental health crisis; decrease unnecessary incarceration for community members experiencing a mental health crisis; and increase consumer participation with mental health providers by problem solving barriers and increasing knowledge of local resources.

Success: Mobile Crisis Support Teams
MCST responded to a call for services for a 37 year old female whose 18 year old son contacted 911 due to mother being under the influence of alcohol and making threats to kill herself. The son reported that his mother drinks often but he was worried when she said she would be better off dead. MCST spent time with the mother and provided her with active listening, empathy, and open ended questions. She stated she did tell her son she would be better off dead and no one would notice anyway. She shared she was feeling overwhelmed with work as she is an ER nurse and taking care of her children. She continued to report that she did not believe her living or dying would make a difference in the lives of those around her. MCST validated the mother's feelings and supported her in de-escalation and identifying positive goals, including having a job and two wonderful boys who are happy and safe. A risk assessment was completed and a safety plan developed. Mother admitted, "I don't want to kill myself, sometimes I just think everyone would be better off." MCST included the son in the safety planning regarding getting rid of the alcohol in the home. The mother had an appointment with her provider on Monday regarding going into treatment. Clinician contacted her provider to verify appointment and to see if other services could be offered in the meantime. This enabled mother to get an earlier appointment for intake into an Intensive Outpatient Hospitalization Program. Subsequent to the incident, she is now linked with a local clinic and working through her challenges with mental health and substance abuse services. In addition, she has taken a leave of absence to focus on herself and her family.

Each MCST is comprised of a Police Officer/Deputy Sheriff who is trained in Crisis Intervention Training (CIT) to respond to persons experiencing mental health crisis, a BHS licensed mental health counselor, and a contracted Peer Navigator with TLCS, Inc. (AKA Hope Cooperative). The team employs a ride along, first response model where the BHS Counselor and a law enforcement Officer/Deputy respond together to emergency calls involving a mental health crises with the goal of mitigating the crisis in the community and linking individuals to resources and services. The Peer Navigator then provides follow-up engagement and services for individuals with potential mental health needs to ensure they are offered support in navigating care systems and successfully link to appropriate services.

The MCST Program currently includes seven (7) teams covering six (6) areas. These areas are inclusive of the North and South areas of unincorporated Sacramento County, as well as the cities of Citrus Heights, Elk Grove, Folsom, and Rancho Cordova. To serve these areas, BHS has partnerships with the Sacramento Sheriff Department-North Division, Sacramento Sheriff Department-Central Division, Citrus Heights Police Department, Folsom Police Department, Elk Grove Police Department, and the Rancho Cordova Police Department.

In FY 2020-21, MCST will add staff to support existing local law enforcement agency partners, including Elk Grove and Galt Police Departments, North Division Sheriff's Department, and law enforcement agencies covering the Rancho Cordova area, as well as other local first responders.

Mental Health Respite Programs: The following programs originated as mental health respite programs funded through the time-limited MHSA Innovation Project 1: Respite Partnership Collaborative. With support from the MHSA Steering Committee, these programs transitioned to PEI funding during FY 2015-16. These respite programs are *PEI Improving Timely Access to Services for Underserved Populations programs.*

Respite program goals include providing a safe environment in which participants increase their knowledge of available supports and how to access them, improve well-being, reduce stress, increase connectedness and reduce feelings of isolation, decrease risk of harm, and reduce visits to the emergency room and psychiatric hospitals.

The **Caregiver Crisis Intervention Respite Program**: administered by Del Oro Caregiver Resource Center, helps decrease hospitalizations due to mental health crises of family caregivers of people diagnosed with cognitive disorders, primarily dementia. The program provides respite care, family consultation, home visits, and an assessment with a clinician to develop a care plan focused on services, supports, and wellness. The program serves adult caregivers of all age groups with the majority of caregivers being in the 60+ age range.

With MHSA Steering Committee support, in FY 2019-20, this program expanded to increase the number of caregivers receiving respite services from 30 to 48.

Success: Caregiver Crisis Intervention Respite Program
For the past three years, a 59 year old woman has been the primary caregiver to her 87 year old mother, who is living with Alzheimer's disease. Her mother requires someone to be with her at all times and is unsteady when walking. The mother gets impatient, is argumentative, and sometimes resists her daughter's efforts to help her. As a cancer survivor with additional health issues of her own, the caregiver became depressed and overwhelmed caring for her mother. She was referred to Caregiver Crisis Intervention Respite Program by her health plan.

Caregiver Crisis Intervention Respite Program's Family Consultant provided the caregiver with counseling and respite services. Together, they developed a plan of care that included utilizing family support, stress management, and self-care. Over time the caregiver reported feeling less depressed and finding stress relief through her interest in painting and gardening.

"The Family Consultant has been so helpful to talk with. She listened and understood how stressed and overwhelmed I felt. It is a relief to have assistance with caring for my mom, all I really need is four hours of support a week."

Respite Program: (formerly named Homeless Teens and Transition Age Youth (TAY) Respite Program): administered by Wind Youth Services, provides mental health crisis respite care to youth/TAY ages 13-25 years old experiencing overwhelming stress due to life circumstance and homelessness. Services may be accessed via a drop in center or with a pre-planned visit and include screening, planning, crisis intervention, life skills workshops, health screenings, groups, crisis counseling, and case management.

Program outcomes include reducing risk factors, increasing crisis services, increasing knowledge of supports and resources, and diverting from restrictive environments.

Success: Respite Program
"J" is a 21 year old youth participant who has managed his mental health symptoms by utilizing the respite center throughout his participation in several Wind programs. Recently, he experienced a mental health crisis and the Respite Program staff helped by linking him to intensive inpatient mental health services. After the Respite Program staff successfully built rapport with this youth, he was able to identify his support needs and allowed staff to intervene. "J" was assessed and admitted into a psychiatric hospital on an involuntary hold, which was then extended. Over the course of treatment in the hospital, the Respite Program staff visited and were able to provide ongoing support throughout his stay. Respite Program staff were also able to connect with his mother and grandparents to re-build his relationship with them. Since his release, the Respite Program staff have been able to work more closely with this youth to provide support services to help him in his recovery and to connect him with appropriate resources.

The Ripple Effect Respite Program: administered by A Church For All, provides planned mental health respite care for TAY (18+), adults, and older adults, with an emphasis on people of color who may identify as LGBTQ. The program utilizes a peer-run structure to increase social connectedness and offers a daily support group. Program services are designed to prevent acute mental health crisis from occurring and to help participants overcome suicide risk factors. With MHSA Steering Committee support, in FY 2019-20 Ripple Effect Respite Program expanded to increase service capacity.

Success: Ripple Effect Respite Program
FC is a Caucasian 64 year old female who has been homeless for at least 18 months. She reports feeling depressed and mistrustful of government service providers. She has a large pit bull, which she describes as her emotional support, security, companion, and family. She has not been willing to release her dog to foster care or to the SPCA. Ripple Effect Peer Care Coordinators provide daily support through transportation, food, computer access, telephone, peer counseling support, and recently obtained a special day rate at a hotel when FC's health declined in the winter months. The Ripple Effect team secured a donated crate to house the dog while FC receives services at the center. The Ripple Effect team provides advocacy to support community services in helping FC, and support FC with being open to services. Recently, the Ripple Effect team collaborated with Sacramento County Division of Behavioral Health Services Homeless Access Clinician to enable FC to be assessed for mental health services. The relationship she developed with Ripple Effect staff supported FC in being ready for this support. She is eligible to participate in a Full Service Partnership (FSP) program that will help her address multiple needs. The Ripple Effect team will continue to offer support until she has fully transitioned to the FSP program.

Danelle's Place Respite Program: administered by Gender Health Center, provides mental health respite care via a drop in center to unserved and underserved TAY (18+), adults, and older adults who identify as lesbian, gay, bisexual, transgender, queer, questioning and/or allied. There is an emphasis on serving transgender individuals who are experiencing overwhelming stress due to life circumstances, with the goal of preventing acute mental health crisis. Services include: assessment, supportive activities, individual and group chat, narrative authoring activities, therapeutic art activities, peer counseling, other crisis prevention services, and community outreach activities. With MHSA Steering Committee support, in FY 2019-20, Danelle's Place expanded to increase service capacity.

Success: Danelle's Place Respite Program
A 22 year old trans woman is a currently unhoused community member who sought support at Danelle's Place. At first, she was struggling with trauma, hopelessness, troubles connecting socially, and vocalized self-hatred. Her car had been repossessed, resulting in the loss of important documents and her place to sleep. Through Danelle's Place, she connected to resources to replace her documentation, change her legal name, and receive hope from formerly unhoused queer folks. She originally came to Danelle's Place for respite and food; she found friends, life skills, a feeling of safety, and a burgeoning confidence in herself. Danelle's Place social nights have given her an outlet to have fun with community, allowing her to have a handful of hours each week where her focus is removed from her situation. She no longer feels alone in her experiences and believes that tomorrow can be better. Danelle's Place team collaborated with her outpatient provider mental health team to obtain permanent supportive housing through Mercy. She still struggles with personal traumas but believes she has begun to heal. She attributes her newfound self-love to the community she found through Danelle's Place.

Q Spot Youth/Transition Age Youth (TAY) Respite Program: administered by Sacramento LGBT Community Center, provides drop-in mental health respite care and supportive services to unserved and underserved youth age 13 and up/TAY who identify as LGBTQ. In addition, support groups are provided with a range of topics, including but not limited to: anti-bullying, coming out, healthy relationships, and life skills development. With MHSA Steering Committee support, in FY 2019-20 the Q Spot expanded to increase service capacity. Q-Spot program offers LGBTQ youth community with peers and staff with the same lived experience, which is critical to improving their mental health.

Success: Q Spot Youth/TAY Respite Program
Heather started coming to Q-Spot's Wednesday youth group three months ago. She struggles with large groups, loud noises, and sometimes had a hard time communicating. When Heather first started attending, she did not have any friends at group and would often sit quietly in the back. Over the three months of attending groups and Q-Spot events, Heather has grown. She has become more confident when coming to group every week, has opened up about her sexuality, and is more confident in communicating with others. Heather has made a lot of new friends and recently addressed the group by saying "coming to group every week is so important to me; you are all my family and I thank you all for being there for me."

Lambda Lounge Adult Mental Health Respite Program: administered by Sacramento LGBT Community Center, provides drop-in mental health respite care designed to prevent an acute mental health crisis from occurring, as well as suicide prevention support services to unserved and underserved adults and older adults who identify as LGBTQ. The program offers a variety of support groups focused on mitigating risk factors, building healthy relationships, health and wellness, etc. With MHSA Steering Committee support, in FY 2019-20, Lambda Lounge Adult Mental Health Respite Program expanded to increase service capacity.

Success: Lambda Lounge Adult Mental Health Respite Program
A 37 year old male started attending the Lambda Lounge Adult Mental Health Respite Program for help with an asylum letter. He's been receiving Lambda Lounge services since July 2019. He has come to the U.S. for asylum due to discrimination for his sexual orientation. He left his country of origin after telling his wife of his sexual orientation as a gay man and is currently being sponsored by a family friend whom he lives with. This individual works hard and provides financial support on a monthly basis to his family back in his home country. He came to the Lambda Lounge to feel accepted and be a part of the community. Through his time as a Lambda Lounge Adult Mental Health Respite Program participant, he became an adult respite volunteer helping community members with necessary clothing, hygiene supplies, supporting in groups, and center events. He attends many adult support groups as a member or volunteer, such as Coming Out, 20 Something, Golden Grounds, and Pansexual Pancake Breakfast to socialize with the community.

Through the collection of programming in the preceding section, Sacramento County is creating a system of suicide prevention and educating the community on suicide-risk and prevention strategies.

Strengthening Families Program
Capacity: 3,000 annually (not including the Bullying Prevention and Education Program)
Ages Served: 94% Children, 2% TAY, 4% Adults, <1% Older Adults

The Strengthening Families Program has expanded and now consists of several components.

The **Quality Child Care Collaborative (QCCC**) is a *PEI Prevention program that is a* collaboration between the Behavioral Health Services (BHS), Child Action, Sacramento County Office of Education (SCOE), and other partners. This collaborative leverages First 5 funding to provide behavioral health consultations to preschools and early childcare learning environments for children, birth through age five (5). Consultations are designed to increase teacher awareness about the meaning of behavior and to provide strategies to ensure the success of the child while in a childcare and/or preschool setting. Support and education is also available for parents. During the FY 2019-20, the program was expanded by adding a second behavioral health clinician position.

Success: Quality Child Care Collaborative (QCCC)
A four year old boy was struggling at his child care center and in jeopardy of losing his placement. He was experiencing frequent anger outbursts, hitting his peers and teachers, refusing to follow directions, and throwing objects. The provider stated she was also having difficulty communicating with his family. The mental health consultant coached the provider and child's mother on using emotional regulation strategies along with sensory activities to decrease his emotional outbursts and physical aggression. The provider and mom were encouraged to build the child's emotional vocabulary. With ongoing consultation, the child began to use his words to express himself at the center and at home, rather than physical aggression. Also, the provider was coached to give the child a "job" in order to instill a sense of control and increase his sense of belonging within the center, which in turn increased his self-esteem. The consultant encouraged the family to implement the same strategies at home as well as engaging in regular communication with the center. Upon closing the referral, the provider reported the child's concerning behaviors had decreased and his placement was no longer in jeopardy. The provider also reported the relationship with the child's family had improved.

HEARTS for Kids was a collaboration between BHS, Child Protective Services (CPS), and Public Health, leveraging First 5 funding to provide a comprehensive menu of services for children ages birth to five (5) identified by CPS. HEARTS for Kids clinicians provided culturally responsive in-home serves to foster parents, relative caretakers or biological parents.

As discussed in the Three-Year Plan and at the June 21, 2018 MHSA Steering Committee meeting, due to the loss of First 5 funding, this program was redesigned with an ongoing commitment to continued collaboration to meet the mental health needs of children of all ages within the child welfare system. BHS in partnership with Child Protective Services (CPS) has redesigned this collaborative program that is now known as the "**CPS Mental Health Team**."

The **CPS Mental Health Team** is a *PEI Improving Timely Access to Services for Underserved Populations program* that is a collaborative program with Child Protective Services (CPS) supporting the mental health needs of children within the Child Welfare system. The program serves children and youth, birth through age 20 and aligns with the implementation of Continuum of Care Reform and the requirement that a Child and Family Team (CFT) is provided to all children entering the Child Welfare system.

The program's Behavioral Health Services (BHS) clinicians complete the Child and Adolescent Needs and Strengths (CANS) tool and provide mental health consultation informing the CFT meeting process and CPS case planning. This completed CANS assessment represents a shared vision of the child and family in collaboration with the CFT.

Clinicians also participate in the CFT to identify supports, mental health referrals, and other services needed to achieve permanency, enable the child to live in the least restrictive family setting, and promote normal childhood experiences. BHS is working with CPS in FY 2021-22 to expand the team's services to include behavioral health assessments of parents/caregivers, crisis intervention, and other short term mental health services to support permanency plans.

Success: CPS Mental Health Team
A CPS-MH team Clinician was assigned four siblings ages 4, 5, 6, and 8 to complete the Child and Adolescent Needs and Strengths (CANS) assessment. The children had been removed from their mother's care due to her substance abuse that was resulting in general neglect of the children. The children were placed with their father. The Clinician collaborated with the CPS social worker and parents and completed CANS assessments by using a virtual video platform with each of the children. The Child and Family Team (CFT) Meetings convened and identified strengths that included the parents' communication, the mother's follow-up with the recommended services, and positive co-parenting with the father. All CANS assessments were finalized at the CFTM. Referrals were made for counseling for the parents, individual therapy for each child through ACCESS referrals, and Head Start services for social/emotional development and school readiness for the two youngest children. This was a successful experience given the parents' engagement, as shown by their timeliness with following through with the CPS-MH Team referral and the collaboration between the social worker and behavioral health clinician in order to share the family's story through the use of the CANS tool within the CFT Meetings.

The **Bullying Prevention Education and Training Program** is a *PEI Prevention program* administered by the Sacramento County Office of Education (SCOE) and available to all 13 Sacramento County school districts. SCOE uses a train-the-trainer model and evidence-based curricula to train school staff who then educate other school staff, students, and parents/caretakers on anti-bullying strategies. The program is implemented primarily at elementary school demonstration sites; however, it is intended to expand the program to other grades by leveraging school district resources. The long-term goal of the program is to change school climates across all 13 school districts.

In FY 2019-20, a total of 19 schools within the county's 13 districts participated in the Bullying Prevention program. There were 1,766 faculty/education staff who received bullying prevention updates/trainings; 28,862 students received bullying prevent training; 6,815 parents received bullying

Success: Bullying Prevention Education and Training Program (BPP)
The following are statements from School Staff who participated in BPP:

"A student in my class was being bullied and my principal helped right away to shut it down. We contacted parents, talked with students, and other staff members helped talk to students. We asked students to become advocates for that student, and students were very responsive."

"Ambassadors (Safe School Ambassadors are students trained to intervene/advocate) overheard a student experiencing bullying and brought it to a teacher's attention. The teacher had all students write a positive note to the bullied student to show that he was cared for and valued as a person."

"I teach the Resource Specialist Program (RSP) and there have been several times when the students have called each other names and made fun of other students for their looks, the way they talk, etc. We have always stopped the class at that exact moment and talked about bullying and how we treat people. The students are generally respectful to each other with reminders occasionally.

prevention training/resources; and over 22,168 parents, students, and educators received mental health resources, bullying prevention resources, cyberbullying prevention resources and other supports beyond academic resources. The www.sactobullyprevention.org website received 1,699 new visitors for a total of 1,865 total visitors, and the website was viewed 3,413 times.

The program goals are to reduce the number of youth at risk of violence and traumatic events and to increase school related successes. The measurable program objectives are to increase awareness of the negative effects of bullying, learn techniques to intervene early, collaboration, increase school attendance, develop best practices and policies for school staff, and to improve student perception of school safety, and reduce the incidences of bullying.

Youth Mental Health First Aid (YMHFA): Mental Health First Aid and YMHFA are supported in both the PEI and WET components. YMHFA is a *PEI Outreach for Increasing Early Signs of Mental Illness program* administered by Sacramento County Office of Education (SCOE) to increase the number of school staff and caregivers receiving YMHFA training.

Program objectives include learning about the signs of mental health challenges for youth and typical adolescent development. The program will teach a five-step action plan for how to help youth in both crisis and non-crisis situations.

Program expansion in FY 2019-20 added YMHFA training with Question, Persuade, and Respond Gatekeeper Training for Suicide Prevention (QPR). SCOE administers these trainings to school district personnel and will work directly with five (5) local school districts that already have QPR certified instructors. Trainers provide QPR activities to youth and adults at designated schools. SCOE also provides QPR trainings to community-based organization and project partners.

Success: Youth Mental Health First Aid
The following are statements from YMHFA training participants:

"I really enjoyed this training. Very useful information to take with me. "
"Instructors were engaged with the class and very informative."
"The instructors were brilliant!!"
"Well executed, informative, and paced well. Great job!!"

The following is a statement from a YMHFA Certified Instructor:

"After the conclusion of the course, participants are thankful for the information and feel armed and ready to assist in a crisis. It is a powerful day, and we see participants transform in their comfort with the topic because they are armed with information and tools."

In FY 2019-20, SCOE and its partner districts were scheduled to conduct a total of 15 YMHFA trainings, and was able to successfully conduct eight (8) YMHFA prior to the COVID-19 pandemic, in which 111 parents, educators and individuals from youth serving agencies participated, and six (6) QPR trainings in which approximately 90 individuals participated from education and youth serving agencies. The QPR trainings were conducted in-person prior to the pandemic, and resumed with one QPR training successfully conducted via Zoom in mid FY 2020-21 with approximately 15 participants.

Early Violence Intervention Begins with Education (eVIBE), administered by the Sacramento Children's Home, is a *PEI Outreach for Increasing Early Signs of Mental Illness program* that uses the evidence-based prevention approaches "Stop and Think", "Too Good For Violence", and

"Nurturing Parenting" to improve social skills, increase protective factors, prevent youth violence, and reduce or eliminate family conflict for children and youth ages six (6) to eighteen (18) and their family members/caregivers.

In FY 2019-20 the eVIBE program served 2,515 students and family members/caregivers. eVIBE facilitated the presentation of "The Stop and Think" social skills program to 1,459 students, the "Too Good For Violence Social Perspectives" (TGFV-SP) program to 894 students, and the "Nurturing Parenting Program" (NPP) to 162 family members/caregivers and children combined. These curricula were taught in 19 schools across five (5) school districts, as well as seven (7) community sites and one (1) affordable housing complex.

Success: Early Violence Intervention Begins with Education
A single mother with two sons in the eVIBE Nurturing Parenting Program shared her personal experience of the impact of the COVID-19 pandemic and how she uses self-care as a way of family bonding. She is currently unemployed and expressed the stress of being unemployed and not being eligible for unemployment. Instead of staying inside her apartment, she incorporated self-care routines such as family walks and recreation time at the park. She mentioned that her self-care routine has helped her reduce her sadness and replace it with healthy emotions by becoming stress-free and allowing her to focus more on her children and family bonding. She expressed gratitude for the program and the lesson about self-care because it came at a critical time in her life and in her family when she needed it the most.

The program goals are to reduce the risk of violence to youth and improve overall youth success in school and home-life. Measurable program objectives are to increase individual and family problem-solving behavior and reduce defiant and aggressive behavior that may lead to mental health issues.

Adoptive Families Respite Program, administered by Capital Adoptive Families Alliance, is a *PEI Prevention program* that originated as one of the mental health respite programs funded through the time-limited MHSA Innovation Project #1: Respite Partnership Collaborative. With support from the MHSA Steering Committee, this program transitioned to PEI funding during FY 2015-16.

Families take great joy in providing care for their loved ones, but the physical and emotional toll on the family caregiver can be overwhelming without outside support, such as respite. Adoptive Families Respite Program provides a break for the whole family, which research shows is beneficial for everyone involved. This respite program provides temporary relief for adoptive families caring for children with complex mental health issues. Eligible families must live in or have adopted from Sacramento County. The respite model includes planned respite during drop off events, summer camp, and recreational activities.

Success: Adoptive Families Respite Program
"I love the respite events CAFA provides; they have helped me get a much needed break. I hate to think I need to get a break from my kids, but I really do! Parenting kids with special needs has really taken a toll on me and my relationships. I am so grateful that CAFA exists!"

Program expansion in FY 2019-20 increased the number of Kid's Camps annually from one (1) to two (2), increased the number of children and families served through the Family Camp, increased quarterly drop-off events from four (4) to eight (8) per year, and added a Parent's Retreat providing respite and training for 60 parents.

The Source, administered by Sacramento Children's Home, is a PEI Improving Timely Access to Services for Underserved Populations program with a 24 hours per day, 7 days per week, 365 day per year call center providing immediate phone response, mobile in-person/face-to-face crisis intervention, triage services, mediation, follow-up support, and information and referral. The Source is available to all youth up to their 26th birthday and their caregivers, prioritizing current and former foster youth and foster parents/caregivers who are experiencing crisis or emotional or behavioral distress that, without immediate support, risks disruption to the current living situation.

In FY 2018-19, BHS was awarded a grant through the California Health Facilities Financing Authority (CHFFA) for the Investment in Mental Health Wellness Grant Program for Child and Youth. The award was leveraged to pilot expanding The Source service criteria. Up to that point, The Source served foster youths up to age 21 and their families. The expanded criteria made possible by this grant allowed The Source to serve all youths up to age 26 and their families, inclusive of current and former foster youths. This program expansion was supported by the MHSA Steering Committee and Sacramento County Board of Supervisors and implemented mid FY 2019-20. Post-grant program data revealed that the program could be sustained through the PEI allotment, without more funds needed. The CHFFA grant will end on June 30, 2021, but The Source will retain the expanded service criteria.

Success: The Source
The Source served two Spanish speaking teenagers and their caregiver. The caregiver sought help as she had been unsuccessful over the past couple of months in securing long term treatment for her children, who were experiencing depression and anxiety symptoms. Despite receiving initial services from a long term provider in their preferred language, the family was unsuccessful in fully connecting with that agency and in navigating the mental health system. During the delay in start of services, both youths increased isolation and demonstrated increasing conflict in the home causing the caregiver to reach out for further support. The Source staff were able to provide culturally responsive services to each youth and caregiver in their preferred language, establishing rapport while facilitating brokerage through the mental health system for youth. During the course of treatment, the family was successfully linked with an agency for long term services that maintained cultural responsiveness. The family noted that the youths demonstrated improvement of symptoms and reduced conflict in the home while also being able to have the support they needed to link with long term services through the system of care.

Services include peer mentoring, youth and family engagement, support and advocacy, and temporary relief for youth and/or foster parents/caregivers. To be relevant to affected youth, the program also provides outreach and information via a dedicated website, text, video conferencing, and popular social media and apps. Opportunities are provided for youth to participate in normative and developmentally appropriate activities. Additionally, the program will establish a Youth Advisory Board for the purpose of developing shared ideas, networking, sharing concerns, providing advice and recommendations, and developing solutions. The goal of this program is to maintain placement stability for foster youth; increase coping and problem solving skills; improve the quality of family relationships; refer, link and coordinate ongoing care; and increase opportunities for normative youth experiences.

Safe Zone Squad (SZS), administered by Sacramento County Office of Education (SCOE), is a *PEI Improving Timely Access to Services for Underserved Populations program* comprised of a two-person team on each campus that includes a Youth Advocate and a Safe Zone Coach (mental health counselor). SZS program provides mental health crisis and triage services to students, ages

11 to 14, at three (3) identified middle school campuses (Martin Luther King Jr. Technology Academy, Albert Einstein Middle School, and Sam Brannan Middle School). Mental health support services include, but are not limited to, crisis intervention services, listening circles, skills development, psychoeducation, stress/crisis management, parent/caregiver trainings, restorative mediation, and mental health screening to identify appropriate levels of support from the SZS and provide linkage to a mental health provider or other resources within the community. Program outcomes include enhancing school success, reducing stigma, improving relationships, and reducing hospitalizations.

SZS is funded through a Mental Health Services Oversight and Accountability Commission (MHSOAC) Senate Bill (SB) 82 Triage Personnel grant and, with MHSA Steering Committee support, PEI funding.

SZS launched mid FY 2019-20, with services provided at Albert Einstein Middle School and Sam Brannan Middle School. The services being delivered at these schools have been virtual, utilizing platforms such as Google Classroom, Google Drive, Zoom, and Social Media. Virtual services offered include: virtual support center website, Google classroom to discuss daily topics on mental health and well-being, weekly groups, outreach, triage and linkages, mentoring services, and classroom presentations on mental health topics and suicide prevention.

Mid FY 2020-21, Martin Luther King Jr. Technology Academy launched their SZS program, and is in the early stages of implementation. More information about program implementation will be included in future updates.

Success: Safe Zone Squad
A student being mentored had been going through the hardship of family stress, depression, and low self-esteem since over a year ago. The student reported this was taking a toll on them and contributing to their internal turmoil and negative outlook on life. They were aware of the Student Support Center and they knew of students who had reached out to talk with staff, but they felt fearful and could not push themself to walk into the center. The Student Support Center staff presented via Zoom in the student's classroom, which helped the student to feel more comfortable with the idea of obtaining support and reconsider contacting the center staff. The student reached out through the center online referral system and staff was able to talk to them one-on-one directly during one of their Zoom classes. They opened up to the center Advocate and decided that mentoring would be a good option for them. The student recently revealed that they no longer felt afraid and instead felt excited to be able to have a mentor they can trust. Center staff stated,

"The most rewarding moments of my time with students revolve around being able to witness the growth of our students."

Integrated Health and Wellness Program
Capacity: 420 annually
Ages Served: 14% Children, 32% TAY, 15% Adults, 38% Older Adults

The Integrated Health and Wellness Program consists of three components:

SacEDAPT (Early Diagnosis and Preventative Treatment), administered by UC Davis, Department of Psychiatry, is a PEI Early Intervention program that focuses on individuals identified as experiencing early onset of a serious mental illness or emotional disturbance with

psychotic features. SacEDAPT uses a nationally recognized treatment model utilizing an inter-disciplinary team of physicians, clinicians, support staff, consumers and family advocates to provide assessment, early identification, and treatment of the onset of psychosis. The program provides culturally and linguistically responsive psychiatric support, case management, peer support, and access to treatment, including transportation. The program also engages in outreach services throughout Sacramento County, with a particular focus on underserved populations.

Success: SacEDAPT
A 23-year-old cisgender female was referred to SacEDAPT after being hospitalized for psychotic symptoms. During her 24 months of treatment at SacEDAPT, the client has actively participated in all aspects of the program including individual therapy, medication management, group therapy, supported education and employment, and targeted case management. After participating in the full spectrum of services offered at SacEDAPT, the client experienced a full remission of psychotic symptoms within her first year of treatment and improved her overall level of functioning. During this time she began working as a primary childcare provider for a family member as a way to support herself. SacEDAPT was able to engage and work with this family member as well. The client's second year in the program has focused on achieving her occupational goals and preventing relapse. To that end, the client is currently working full-time and is planning to enroll in college classes next semester. She now has an increased sense of hopefulness for her future and is in the process of transitioning to a lower level of care.

SeniorLink, administered by El Hogar Community Services, is a *PEI Prevention program* that provides community integration support for adults aged 55 and older who are demonstrating early signs of isolation, anxiety, and/or depression. Para-professional Peer Advocates outreach to individuals in their homes or other community-based settings based on the participants' needs.

Success: SeniorLink Program
Mr. G. is a 63 year-old male referred to SeniorLink in August, 2019. Mr. G's goal upon joining SeniorLink was to socialize with others and maintain a healthy and stable lifestyle. He had experienced homelessness or been at-risk for homelessness throughout his adult life. He was housed at time of referral, but needed a more affordable apartment. With the help of SeniorLink, Mr. G. was able to secure an apartment for low-income seniors. He was also connected with primary health services and transportation resources. Mr. G participates in peer-to-peer groups, monthly socials, and scheduled outings. He recently started attending Bingo/Bunco and Arts and Crafts groups. The SeniorLink Advocate helped connect Mr. G with a local no-cost community center gym that he attends weekly. Mr. G. has expressed gratitude for the opportunities that SeniorLink has provided in connecting him to resources and services in the community. Mr. G. stated, "My Advocate has been a life saver and a blessing. I'm not sure where I would be now without all the help for housing, food, and connecting to community by SeniorLink. This is an awesome program!"

Program services include home visits, collaboration with and linkage to health care providers, socialization opportunities, transportation, service coordination, advocacy, information and referral, skill-building groups, and liaison to community services.

Trauma Informed Wellness Program for the African American Community: this new PEI Improving Timely Access to Services for Underserved Populations program will provide outreach, engagement and prevention services to African American/Black community members of all ages, and genders, with special consideration given to children, youth, and transition age youth (ages 0 to 25), who have experienced or been exposed to trauma.

This new program was developed based on feedback received from African American/Black community members who identified several strategies that would help improve their mental health and wellness. These strategies include community education around trauma, mental health conditions, Adverse Childhood Experiences; assistance with navigating complex systems of care;

and supportive services such as support groups/healing circles, cultural brokering, peer support and advocacy, life skills coaching, and age appropriate mentoring.

Culturally relevant outreach and engagement and supportive services will be provided by staff with shared cultural and lived experience who are reflective of the diverse African American/Black community. Types of services that will be provided by the program include service planning; information, referral, and linkage; resource navigation; community education; and supportive services including peer support and advocacy, coaching, skills building, mentoring, brief supportive services and intervention in crisis situations, and healing circles or support groups. Supportive services will be provided in program participants' homes and/or in community based settings.

A Request for Applications regarding this program was released in FY 2019-20. However, it was canceled due to overwhelming community input. In early FY 2020-21, BHS partnered with Sierra Health Foundation: Center for Health Program Management to administer and implement the TIWP. In mid FY 2020-21, four (4) community agencies were chosen via a competitive selection process to provide program services to the African American/Black community members in a coordinated and culturally responsive manner to reduce the impact of trauma and Adverse Childhood Experiences on African American/Black community members.

Mental Health Promotion Program
Capacity: 500,000 (estimated community members touched by program)
Ages Served: Children, TAY, Adults, Older Adults

The Mental Health Promotion Program, the "Mental Illness: It's not always what you think" project, is designed to increase community awareness about mental health issues and reduce stigma and discrimination toward individuals and families living with mental illness. The program has multiple components as described below.

The *"Mental Illness: It's not always what you think"* project:

Since June 2011, BHS has worked with Sacramento County Public Health and Edelman (a communication marketing agency), to implement its Countywide mental health promotion, and stigma and discrimination reduction program to 1) promote messages of wellness, hope and recovery; and 2) dispel the myths and stereotypes surrounding mental illness. This program aims to fundamentally alter negative attitudes and perceptions about mental illness and emotional disturbances in Sacramento County. The *"Mental Illness: It's not always what you think"* project underscores that mental illness can impact almost anyone, and also promotes community resources and support available throughout the County to foster hope and recovery.
This project doesn't provide ongoing services to the Sacramento community.

The project's year eight activities ran from July 1, 2019 – June 30, 2020. This year, the project team engaged with the community through a variety of events and activities throughout the year and coordinated stakeholder, digital activations and media outreach for *Mental Illness Awareness Week* and the *Journey of Hope Collaborative Art Exhibit*.

To measure the project's success, we assess changes in attitudes, increased awareness and impact through the number of impressions garnered on a yearly bases through various channels, such as media outreach, social media and paid advertisements. Edelman has previously completed research with the County and third-party partners, all forms of public awareness about mental illness and the project have increased (from 24 to 53 percent). The research findings, gathered through surveys, key community leader or informant interviews and focus groups, also provided valuable insight into which target audiences need more concentrated outreach, which communication methods are most effective within each community and key opportunities for improving the effectiveness of project materials.

During the 2019-2020 year, the project team conducted community testing to ascertain the effectiveness of the revised messaging and creative, targeting the local multicultural populations in Sacramento County. Testing included focus groups, discussions with leaders from community-based organizations (CBOs) and a targeted, online survey. This phase of research has helped the project to finalize messaging and creative direction for the refreshed project materials. While the project team had initially planned to launch the refreshed collateral materials, advertising creative and website in May 2020, the COVID-19 pandemic forced the team to postpone photo and video shoots, and pivot to promoting messaging and other existing mental health support during the pandemic. In the next year, the team will continue to conduct outreach efforts for the project's established programs, complete the message and creative refresh process, and look for additional ways to increase awareness of the project, and track its progress.

With support from the MHSA Steering Committee, Sacramento County has continued to fund the anti-stigma promotion program year after year, leading to the successful conclusion of eight years' work to change minds, attitudes and outcomes for those living with a mental illness.

(1) Multi-media outreach:

The project executed a heavy advertising campaign across multiple mediums to reach as many Sacramento County residents as possible. Advertising placements, including radio, online and outdoor advertising, ran from July 2019 through June 2020 and garnered 30,460,587 impressions. The below advertising categories reflect efforts to date:

Radio Ads:

Radio advertisements featuring campaign messages ran at on a diverse set of stations in July 2019 and May 2020, targeted to our key audiences throughout Sacramento County.

The project ran the existing 30-second spots in Spanish, Vietnamese, Russian, English and Hmong, which featured Sacramento Speakers Bureau everyday people sharing messages of hope, wellness and recovery, encouraging listeners to learn more by visiting the project website.

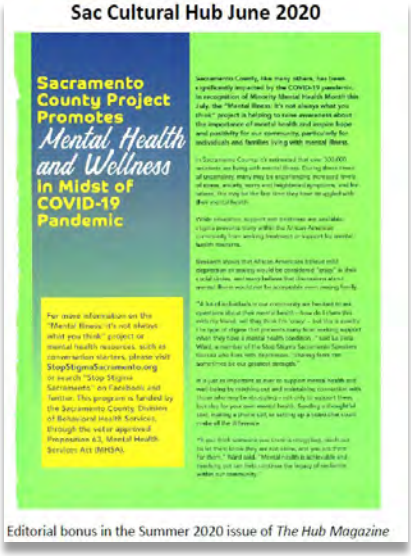
Overall, 1,524 radio advertisements ran, 496 of which were added value. These placements, which were featured on 12 music-focused, multicultural and in-language radio stations, including KRXQ (rock), KUDL (contemporary hits), KSEG (classic rock), KIFM (ESPN), KSFM (contemporary hits), KKDO (alternative), KDEE (African American), KRCX (Hispanic), KXSE (Hispanic), KFSG (Vietnamese, Russian), KEFM (Russian) and KJAY (Hmong).

Radio ads delivered over 11,582,300 impressions in this timeframe (note that the impressions for the in-language stations are not available).

Print Ads:

Print advertising ran in seven local publications, including Russian Observer, Thang Mo, Lang Magazine, Sacramento Observer, Sac Cultural Hub, Word and Deed, and d'Primeramano. Overall, 10 print ads or editorials ran in these publications, featuring real stories, often translated in-language, that share real experiences and tips from real members of the target reader community when applicable.

Additionally, Edelman worked with Media Solutions and the Sac Cultural Hub to write a bonus editorial piece focused on mental health and wellness during the COVID-19 pandemic that was published in June of 2019.

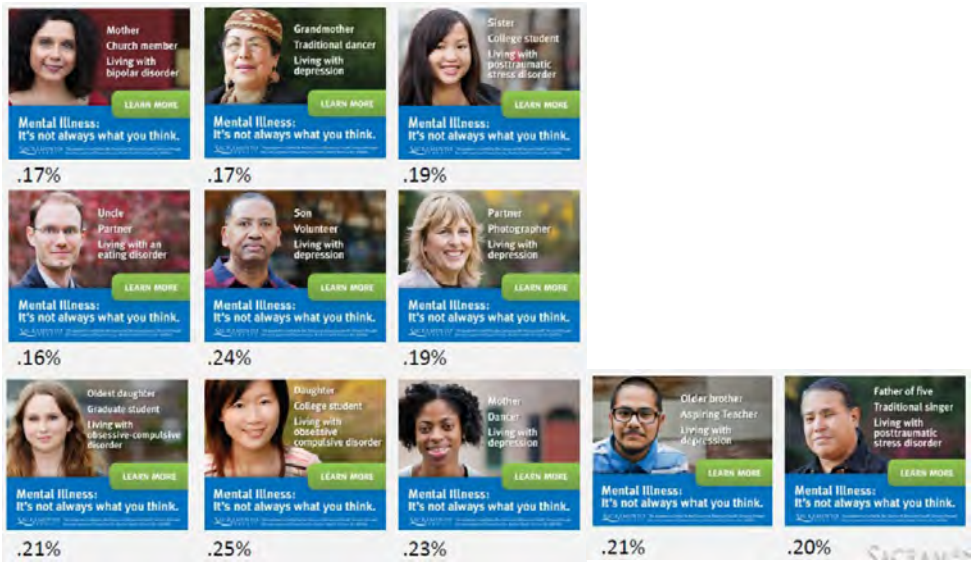


Editorial bonus in the Summer 2020 issue of *The Hub Magazine*

Online and Mobile Ads:

Digital and mobile advertisements supporting the campaign messages ran in July 2019 and from May through June 2020. Overall, online and mobile ads garnered 9,085,843 impressions (up from 6,993,946 impressions in FY19) with a cost per click of $1.97 (which is more cost effective than last year at $3.07).

The below images feature the online and mobile ads that ran during this time frame, with their accompanying click-through rate.




Older brother, aspiring teacher, living with depression.
Mental Illness: It's not always what you think.
LEARN MORE
.24%
Uncle, partner, living with an eating disorder.
Mental Illness: It's not always what you think.
LEARN MORE
.15%
Daughter, college student,
living with obsessive compulsive disorder.
Mental Illness: It's not always what you think.
LEARN MORE
.19%
Father of five, traditional singer,
living with posttraumatic stress disorder.
Mental Illness: It's not always what you think.
LEARN MORE
.24%
Sister, college student,
living with posttraumatic stress disorder.
Mental Illness: It's not always what you think.
LEARN MORE
.21%
Grandmother, traditional dancer, living with depression.
Mental Illness: It's not always what you think.
LEARN MORE
.16%
Partner, photographer, living with depression.
Mental Illness: It's not always what you think.
LEARN MORE
.17%
Mother, church member, living with bipolar disorder.
Mental Illness: It's not always what you think.
LEARN MORE
.17%
Son, volunteer, living with depression.
Mental Illness: It's not always what you think.
LEARN MORE
.25%
Mother, dancer, living with depression.
Mental Illness: It's not always what you think.
LEARN MORE
.23%
Oldest daughter, graduate student,
living with obsessive-compulsive disorder.
Mental Illness: It's not always what you think.
LEARN MORE
.17%
Father of five, traditional singer,
living with posttraumatic stress disorder.
Mental Illness: It's not always what you think.
LEARN MORE
.26%
Daughter, college student,
living with obsessive compulsive disorder.
Mental Illness: It's not always what you think.
LEARN MORE
.22%
Older brother, aspiring teacher, living with depression.
Mental Illness: It's not always what you think.
LEARN MORE
.27%
Mother, dancer, living with depression
Mental Illness: It's not always what you think.
LEARN MORE
.30%
Son, volunteer, living with depression.
Mental Illness: It's not always what you think.
LEARN MORE
.28%
Oldest daughter, graduate student,
living with obsessive-compulsive disorder.
Mental Illness: It's not always what you think.
LEARN MORE
.26%
Partner, photographer, living with depression.
Mental Illness: It's not always what you think.
LEARN MORE
.25%
Uncle, partner, living with an eating disorder.
Mental Illness: It's not always what you think.
LEARN MORE
.17%
Sister, college student,
living with posttraumatic stress disorder.
Mental Illness: It's not always what you think.
LEARN MORE
.30%
Grandmother, traditional dancer, living with depression.
Mental Illness: It's not always what you think.
LEARN MORE
.30%
Mother, church member, living with bipolar disorder.
Mental Illness: It's not always what you think.
LEARN MORE
.30%


Bệnh Tâm Thần:
Không luôn như quý vị nghĩ.
TÌM HIỂU THÊM
.19%
Madre
Feligrés
Viviendo con
Trastorno Bipolar
MÁS INFORMACIÓN
Enfermedades Mentales:
No siempre es lo que usted piensa.
.17%
KAWM NTXIV
Tus mob puas siab ntsws:
Nws tsis yog li koj ib txwm xav.
.17%
精神病:
並不總是如您所想。
.19%
Отец
Владелец малого бизнеса
Живущий с тревожным расстройством
УЗНАЙТЕ БОЛЬШЕ
Психические заболевания:
это не всегда то, что вы думаете
.15%
Hermano mayor
Quiere ser maestro
Vive con depresión
MÁS INFORMACIÓN
Enfermedades Mentales:
No siempre es lo que usted piensa.
.21%


Madre, feligrés, viviendo con Trastorno Bipolar.
Enfermedades Mentales: No siempre es lo que usted piensa.
MÁS INFORMACIÓN
.19%
KAWM NTXIV
.13%
精神病: 並不總是如您所想。
.16%
Hermano mayor, quiere ser maestro, vive con depresión.
Enfermedades Mentales: No siempre es lo que usted piensa.
MÁS INFORMACIÓN
.19%
Bệnh Tâm Thần: Không luôn như quý vị nghĩ.
TÌM HIỂU THÊM
.22%
Психические заболевания:
это не всегда то, что вы думаете
УЗНАЙТЕ БОЛЬШЕ
.16%

Earned Media:

With the help of two local multicultural outreach specialists and Edelman's media experts, the team conducted strategic outreach to Sacramento County media to promote priority project activities and milestones within the community throughout the year. The list below represents the earned (non-paid) placements and corresponding impressions secured between July 1, 2019 and June 30, 2020. The majority of media outreach took place around Journey of Hope/Mental Illness Awareness Week, with additional efforts centered around other milestones including Mental Health Month (May) and the importance of mental health during the COVID-19 pandemic. The project was included in key local news publications garnering more than 8,273,519 total impressions.

Program Media Highlights

Date	Title	Outlet	Impressions
Radio			
11/20/2019	Journey of Hope	KFBK Radio	450,900
5/11/2020	Mental Health Help During the Coronavirus Pandemic is Available	KFBK Radio	450,900
Online/Print			
9/25/2019	Arts Calendar	Elk Grove Citizen	43,283
10/1/2019	Out and About Sacramento 2019	Inside Sacramento	N/A
10/4/2019	Dismantling the Stigma	Elk Grove Citizen	43,283
12/12/2019	Story Through Art	Sacramento Magazine	23,725
12/26/2019	The Crocker starts 2020 with great exhibits, programs	Mountain Democrat	33,242
5/8/2020	Sacramento: Prioritize Your Wellbeing for Mental Health Month	Sacramento Patch	N/A
5/11/2020	Mental Health Help During the Coronavirus Pandemic is Available	KFBK Radio	23,521

Date	Title	Outlet	Impressions
5/29/20	COVID-19 and Mental Illness in Our Community	Sac Cultural Hub	1,947
TV Broadcast			
11/27/2019	Journey of Hope at the Crocker	KCRA (NBC)	63,500
12/6/2019	Journey of Hope at the Crocker	Sacramento & Company (Your California Life) at KXTV	4,235
12/12/2019	JOURNEY OF HOPE EXHIBITION ON MENTAL ILLNESS OPEN AT CROCKER ART MUSEUM	AccessLocal TV	N/A

(2) Social Media and Microsite:

To support the project's stakeholder and media outreach efforts and engage with key audiences, the team continually updated the www.StopStigmaSacramento.org microsite, as well as Facebook and Twitter pages. In total, Facebook posts generated 268.4K impressions and Twitter posts generated 252.1K impressions (up from 55.6K) during the year.

Facebook:

The team highlights project news, events and messages of hope, as well as stakeholder events on the Facebook page. Highlights to-date:

- The page currently has 9,452 likes, up from 9,139 likes from last year's EOY report.
- 81 percent of people who like the page are women, while 17 percent are men.
- 86 percent of women are regularly engaged with the page while 12 percent of men are actively engaged with the page. The project saw a 2 percent increase in male engagement since last year's report.
- The highest performing post was published on May 18 and promoted the Project's Speakers Bureau. The post generated nearly 48,493 impressions and reached 23,643 people. The post also received 1,261 post clicks, 69 link clicks, 42 reactions, 4 comments and 7 shares.

Twitter:

The team regularly highlights project news, events and messages of hope, as well as stakeholder events on the Twitter page. To date:

- The page has 944 followers, up from 736 followers noted last year.
- 50 percent of people who like the page are men, while 40 percent are women.

- The Project's audience on Twitter mostly falls within the 13+ demographic, with the 40+ age group closely following.
- During this reporting period, tweets received a .6 engagement rate, 45 retweets and 181 likes. The decrease in engagement is likely due to the pause in Twitter advertisements. We have relaunched in Twitter advertisements in FY21/20 to boost engagement on this platform.

Microsite

The project microsite, www.StopStigmaSacramento.org, is a public, online project resource which houses supportive messaging, community event details, Speakers Bureau information and the virtual Wall of Hope page, which garnered 16 positive messages of hope and recovery from visitors this year, bringing the total to 128 messages.

Engagement

To date, 457 people have submitted their email addresses through the site to receive project updates, up from 442 people in total last year.

- Unique visitors: 54,931 (up from 37,162 last year)

(3) Stakeholder Engagement:

To engage relevant community organizations and services in the project, activities included distributing collateral materials and toolkits, conducting media interviews, participating at project-sponsored or community events, sharing success stories, providing photography, promoting the project through digital and social media, and promoting the speaker's bureau. To date, we've received 129 stakeholder engagement forms and 455 email sign ups, which confirm an organization's willingness to participate in the project. To view a list of partner organizations, please visit the StopStigmaSacramento.org microsite here.

To help ensure that stakeholders have ample opportunities to engage with the project; the project team has proactively sent the following requests to the database:

- Request for art during Mental Health Month for the virtual gallery on the project's social media channels
- Request for participation in Journey of Hope and Mental Illness Awareness Week
- Requests to attend project-sponsored events

Following is a list of the most active stakeholders this year. These stakeholders partnered with the project on events and provided valuable feedback and support throughout the Creative Refresh process:

1. Each Mind Matters
2. ACC Senior Services
3. SAHA Health Center
4. NAMI Sacramento
5. Yav Pem Suab Academy
6. Sacramento Native American Health Center
7. Slavic Assistance Center
8. Hmong Organizing for Progress & Empowerment Center

9. Sacramento PFLAG Chapter
10. La Familia Counseling Center
11. Radio TNT
12. The Adult and Aging Commission

(4) Collateral Material: The team has conducted outreach to stakeholder organizations to offer free program materials, including brochures, tip cards and posters. All available collateral materials can be found on the StopStigmaSacramento.org microsite here. To date, approximately 262,189 pieces of collateral material have been distributed to stakeholder groups and at events, including approximately 6,337 project promotional materials this year alone.

(5) Community Outreach Events and Presentations:

- Journey of Hope (Oct. 5, 2019 – Jan. 5, 2020)
  - The Speakers Bureau and County planned and executed the fifth annual Journey of Hope art exhibit, which brings awareness about mental health to the community and gives others insight, inspiration, strength and understanding.
  - The collaborative art exhibit paired 54 local artists and 54 writers to share stories of hope and recovery, and for the first time, was featured at three different locations:
    - Elk Grove Fine Arts Center: October 5 – 23
    - Sacramento Poetry Center: October 29 – November 17
    - Crocker Art Museum: November 28 – January 5
  - On October 15, the project hosted a panel discussion at the Crocker Art Museum to celebrate Journey of Hope and highlight the positive contributions that art and creative collaboration have had in the Sacramento region – especially as it relates to community and mental health. The panel was attended by over 265 people.

- Virtual Art Displays (May 2020)
  - In light of the COVID-19 pandemic, Edelman converted the traditional art display event into a virtual art display which was shared via the project's Facebook page and promoted across both Twitter and Facebook. With a total of 31 submissions, these virtual art displays helped create awareness of the project and inspire hope within the community during this unusual time.

(6) Research:

This year, Edelman and the County continued to build on the multicultural research initiated by research firm, OneWorld, three years ago, and the research with Young Communications, VPE Tradigital Communications and Nakatomi & Associates from last year.

The Edelman team partnered with the multicultural firm Young Communications, VPE Tradigital Communications and Nakatomi & Associates last year to develop two new creative concepts for the project, and this year, Edelman conducted community testing with the project's target audiences. Community testing provided the project team with insights and helpful feedback to fine-tune the messaging and imagery for each audience, transcreate as needed and select one final creative concept to move forward with.

To conduct community testing, Edelman launched an online survey to test the new creative concepts and messaging with five of the project's target audiences in Sacramento County. The online survey provided an efficient, thorough platform for the project to evaluate the effectiveness of the revised materials for each community in a format that was appealing and accessible to them.

For the six communities that the project team knew, based on past research, the online survey would not effectively reach, Edelman partnered with CBOs and community leaders to lead individual, in-language focus groups with community members. Edelman worked with community leaders to develop and translate discussion guides and project materials, select a culturally appropriate and easily accessible location and many also led the focus groups.

After the focus groups and online survey had been completed, the project team evaluated the feedback and incorporated it into the creative materials – revising messaging and design to cater to each of the project's target communities.

While the project team had initially planned to launch the refreshed collateral materials, advertising creative and website in May 2020, the COVID-19 pandemic forced the team to postpone photo and video shoots, and pivot to focus on promoting mental health messages with stock imagery and footage during this unprecedented time. The refreshed collateral materials will instead be launched with custom photography in 2020-21.

The teams conducted community testing for the following cultural groups:

- General population adults with mental illness experience (ages 25-55 years)
- General population adults with no mental illness experience (ages 25-55 years)
- Older Adults/Seniors (55 years and older)
- Youth (ages 13-18 years)
- African American
- Cantonese-speaking Chinese
- Hmong
- Latino
- Native American
- Former Soviet/Russian-speaking
- Vietnamese
- Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ)
- Arabic-speaking

(7) Stop Stigma Sacramento Speakers Bureau:

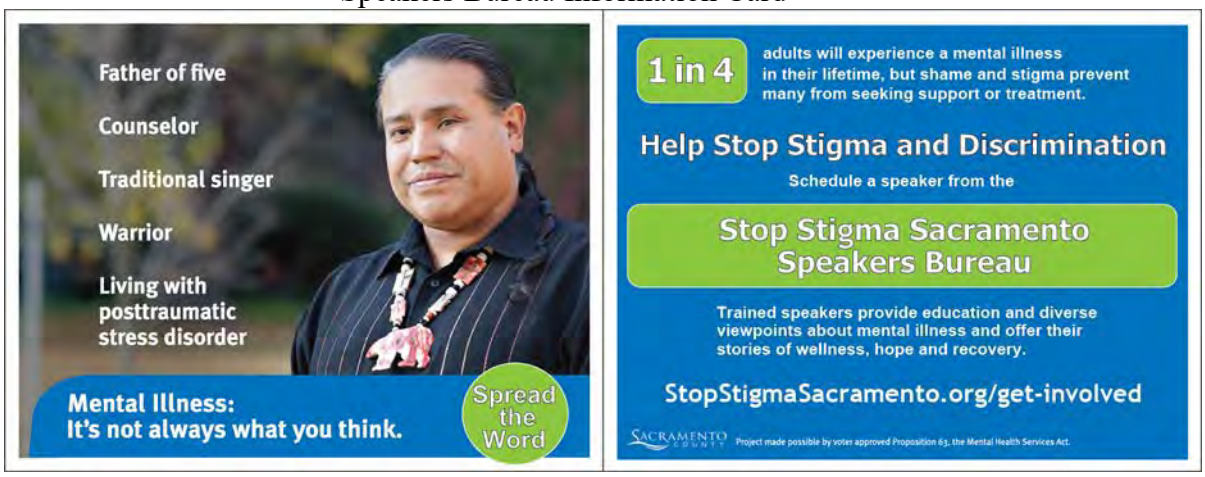
Sacramento County Public Health continued to coordinate a speakers bureau in FY 2019-20. However, because of the extreme circumstances of the SARS-CoV-2 Pandemic, all program events were cancelled, beginning the second week of March 2020 through the remainder of the fiscal year. In FY 2019-20, one Orientation and Training session was held, during which 5 community members were trained to be speakers. At the close of FY 2019-20, the Stop Stigma Sacramento Speakers Bureau had trained 202 speakers, of whom 53 were actively speaking.

In FY 2019-20, Stop Stigma Sacramento Speakers Bureau speakers shared their personal stories at 32 events with a total audience attendance of 1,823 individuals.

The following cards were available to recruit potential Speakers and to promote the Speakers Bureau:

Speaker Recruitment Card

Speakers Bureau Information Card



Practice sessions are an integral part of the Speakers Bureau. New speakers attend a minimum of two (2) practice sessions before speaking. Practice sessions allowed speakers to practice and develop their presentations, meet other speakers, and provide support and feedback to one another. Practice sessions also allowed program staff to preview and shape speaker presentation content to assure that it was consistent with the program goals and content guidelines. During this fiscal year, staff also continued to incorporate mentors in the majority of practice sessions. Mentors typically are seasoned veteran speakers who are able to provide constructive feedback, as well as share firsthand experience on how to share their stories at speaking events. The practice sessions continue to serve as a source of support and connection to the program, and have fostered supportive relationships among members.

The following table details the Speakers Bureau speaking events in FY 2019-20:

Stop Stigma Sacramento Speakers Bureau Speaking Events
July 1, 2019 – June 30, 2020

#	Date	Site/Event FY 2019-2020	# Story	# Audience
1	07.16.19	Ventanilla de Salud – Mexican Consulate	1	120
2	07.23.19	Society for the Blind	8	41
3	07.31.19	Department of Health Care Services	1	40
4	08.22.19	Ventanilla de Salud – Mexican Consulate	1	49
5	09.09.19	SCPH Leadership	1	~25
6	09.11.19	CalPERS	1	40
7	09.12.19	Pleasant Grove High School	23	296
8	09.21.19	EGUSD Saturday Staff Day	8	65
9	09.24.19	Ventanilla de Salud – Mexican Consulate	1	85
10	09.25.19	CalTrans	3	27
11	10.02.19	Edward Harris Middle School	12	260
12	10.18.19	State Controller's Office	2	15
13	10.21.19	Ventanilla de Salud – Mexican Consulate	1	50
14	10.29.19	Employment Development Department	4	35
15	10.30.19	Sac State NAMI	3	7
16	11.04.19	Ventanilla de Salud – Mexican Consulate	1	55
17	11.07.19	California Northstate University	5	~140
18	11.12.19	Valley High School	6	53
19	11.13.19	Valley High School	6	~60
20	11.19.19	NP3 High School	1	18
21	11.20.19	NP3 High School	1	18
22	11.20.19	Vista Del Lago	8	100
23	12.11.19	Edward Harris Middle School	14	400
24	01.15.20	John F. Kennedy High School	3	17
25	02.13.20	Pleasant Grove High School	19	~256
26	02.19.20	SSSSB O&T	2	5
27	02.20.20	EGUSD Middle School Leadership Conference	4	~80
28	02.25.20	NP3 High School Senior Project	1	~25
29	02.26.20	NP3 High School Senior Project	2	~25
30	03.04.20	Edward Harris Middle School	6	~300
31	03.06.20	Sac State Student Counseling Service Staff	3	27
32	03.09.20	Ventanilla de Salud – Mexican Consulate	1	~150
		FY 2019-2020 Total (32)	**153**	**1,823**

The Stop Stigma Sacramento speakers have been well received, and speaker evaluations are completed for majority of events. All audience evaluations are entered into SurveyMonkey, which allows Public Health staff to assess the potential impact of the program and individual speakers, address any training needs and share tangible findings. The emotional content of speaker subject matter means that audience members can become triggered or emotional. During the Orientation and Training, speakers are given training and resources to address this with audience members. In addition, Speakers and staff continue to provide hand outs and educational material at all speaking events. Below is an example of an internally created program resource card. The card includes phone numbers for mental health resources and crisis support services and is used to begin a conversation with audiences about resources and how to take action for a loved one, a friend, or for themselves.

Speakers Bureau Sponsored Events and Affiliated Activities

In addition to fulfilling speaking events, the Speakers Bureau creates events for Speakers Bureau speakers and sponsors events for the general public. While the specific events vary by year, the goal of promoting community and connection within the Speakers Bureau remains a fundamental goal. Also of importance in the planning of any Speakers Bureau activity is a focus on creating opportunities for personal growth, learning, and supporting the recovery of each speaker. The section below includes the FY 2019-20 events created by the Speakers Bureau by program staff and by Speakers Bureau members and program volunteers.

October 2019 – January 2020: Journey of Hope Art Event

For the fifth year, the Journey of Hope (JoH) Art Exhibit celebrated the uniqueness of pairing personal stories and corresponding original artworks. Individuals with lived mental health experience in Sacramento County were invited to submit a story or poem about their experience with mental illness. The stories and poems were given to local artists to be used as inspiration for an original art piece. The collection of art and written pieces were featured together at Elk Grove Fine Arts Center, Sacramento Fine Arts Center and Crocker Art Museum between October 5, 2019 and January 5, 2020. This was the first year that the artwork was featured at multiple galleries and was advertised as a traveling exhibit. At the community reception hosted by Elk Grove Fine Arts Center on October 5th, the gallery also set aside a window of time for participants to meet each other prior to the part of the reception open to the public. The other galleries hosted community receptions on November 9 and December 15, respectively.

Fifty-four pairs of stories and artwork were featured in the exhibit. Eight individuals participated as both writer and artist, none of whom wrote stories relating to their own contributed artwork, as described previously. This number of participants was a great increase from the previous year, with an additional dozen pairs. In total, over 1,000 individuals viewed the traveling exhibit. Table 5 outlines the attendance over the entirety of the traveling exhibit.

Table 5: Journey of Hope Attendance
October 5, 2019 – January 5, 2020

Location	Date	Reception Attendance	Remaining Attendance
Elk Grove Fine Arts Center	October 5-23, 2020	300	150
Sacramento Fine Arts Center	October 29 – November 17, 2020	150	100
Crocker Art Museum	November 28, 2019 – January 5, 2020	350	100
Total			**1,150**

Due to COVID-19, Journey of Hope events are temporarily on hold.

In FY 2019-20, active speakers in the Speakers' Bureau along with Sacramento County Public Health and Edelman staff also participated in a handful of additional community events throughout Sacramento County. The aim at participating in these events was to continue to provide information and educational materials from the "Mental Illness: It's not always what you think." project and Stop Stigma Sacramento Speakers Bureau in an effort to continue to reduce stigma and discrimination surrounding mental illness. The COVID-19 pandemic came at a time that would normally be a very busy season to engage with the community. Community events during this reporting period included:

- Sacramento Out of the Darkness Walk to Fight Suicide (September 28, 2019)
- State Controller's Office Disability & Diversity Fair (October 18, 2019)
- March for the Dream/Diversity Expo (January 20, 2020)

Mental Health Matters, administered by Cal Voices, is a monthly television talk show, produced by mental health consumers and their family members, that highlights issues relating to mental health. The show can be seen on the first Saturday of every month at 7:00 pm. Sacramento area Comcast and local television subscribers can view Mental Health Matters℠ program on channel 17; U-verse subscribers can see the show on channel 99. Mental Health Matters also provides media-based mental health promotional activities, education, outreach and videography services for consumers, family members of consumers, and community members throughout Sacramento County. Outreach activities provide consumers, family members, and the general public with the opportunity to learn and obtain training, education, and information in regard to mental health issues and concerns.

Time-Limited Community Driven PEI Program
Capacity: To be determined
Ages Served: Children, TAY, Adults and Older Adults

In May and June 2019, the MHSA Steering Committee discussed, supported and recommended expanding the PEI Component to include up to $10 million in new, time-limited, community capacity building programming. The California Mental Health Services Authority (CalMHSA), a Joint Powers of Authority, is administering these community driven time-limited programs on behalf of Sacramento County. Mid FY 2019-20, CalMHSA released a competitive selection process and included community stakeholders in the evaluation process. Thirty-four (34) community based agencies were selected to implement their proposed community building prevention programs:

- Agile Group
- Cal Voices
- California Black Women's Health Project
- Depression and Bipolar Support Alliance (DBSA) of California
- East Bay Asian Youth Center (EBAYC)
- Friends for Survival
- Health Education Council
- Her Health First
- Hmong Youth & Parents United
- Improve Your Tomorrow (IYT)
- International Rescue Committee, Inc.
- Justice Team Network
- La Familia Counseling Center, Inc.
- Lao Family Community Development (LFCD)
- Mallory Ewing & Gale Anderson – Sacramento Youth Mental Health
- Mental Health California
- Muslim American Society – Social Services Foundation (MAS-SSF)
- NAMI Sacramento
- Native Dads Network
- Neighborhood Wellness Foundation
- Nor-Cal Services for the Deaf and Hard of Hearing
- ONTRACK Program Resources
- Opening Doors, Inc.
- Public Health Advocates
- SAC Connect Therapeutic and Wellness Services
- Sacramento Covered
- Sacramento LGBT Community Center
- Safe Black Space
- Tarbiya Institute
- Teah M. Hairston
- Trans & Queer Youth Collective (TQYC
- University Enterprises, Inc. (UEI) – Sacramento State
- Vietnam Veterans of California, Inc. dba Veterans Resource Centers of America (VRC) Now- Nation's Finest
- WEAVE, Inc.

For more information on these agencies and programs, see *Attachment H – Community-Driven PEI Grants Overview*.

Early FY 2020-21, these community based agencies began implementing community building prevention programs that include culturally responsive community workshops, trainings, conference, outreach, events, individual and group support and activities, navigation support. These programs collectively address the MHSA seven (7) negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness, and removal of children from their homes.

PEI Administration and Program Support

BHS provides administration and program support associated with on-going community planning, as well as implementation, training, consultation, monitoring, quality assurance and oversight of the PEI programs and activities.

The table below contains the FY2021-22 Cost per Person information for implemented programs:

FY2021-22 PEI COMPONENT	Average Cost/Person*	Budget Amount
Suicide Prevention Program	$ 327	$ 9,813,402
Strengthening Families Program	$ 2,034.55	$ 6,103,637
Integrated Health and Wellness Program	$ 6,375.97	$ 2,677,907
Mental Health Promotion (Stigma and Discrimination Reduction)	$ 2.99	$ 1,495,750
TOTAL		**$ 20,090,696**

*Average cost per person is based on all funding sources in Program divided by program capacity and only includes previously approved and implemented programs.

PEI IMPLEMENTATION PROGRESS DATA - FISCAL YEAR 2019-20

In Fiscal Year 2019-20, a total of 51,826 individuals were served across the implemented PEI programs. In FY 2019-20, a total of 144,969 individuals were served across three PEI programs with universal components. The chart below displays demographic information for individuals served in the PEI Respite programs.

The FY 2019-20 MHSA Annual Prevention and Early Intervention Program and Evaluation Report is included as Attachment I and provides more detail. The tables on the following pages display demographic information for individuals served in each of those programs.

SUICIDE PREVENTION																
	Suicide Crisis Line		Postvention Services		Suicide Bereavement Support Groups		Supporting Community Connections		Community Support Team		Triage Navigators		Mobile Crisis Support Team		Total	
Characteristic	N=39,535	%	N=72	%	N=246	%	N=1,538	%	N=1,309	%	N=2,547	%	N=1,559	%	N=46,315	%
Age Group																
Children/Youth (0-15)	1528	3.9%	0	0.0%	0	0.0%	166	10.8%	24	1.8%	104	4.1%	111	7.1%	1933	4.2%
TAY (16-25)	5364	13.6%	0	0.0%	7	2.8%	362	23.5%	162	12.4%	440	17.3%	285	18.3%	6620	14.3%
Adults (26-59)	6723	17.0%	0	0.0%	119	48.4%	729	47.4%	882	67.4%	1162	45.6%	898	57.6%	10513	22.7%
Older Adults (60+)	1632	4.1%	0	0.0%	51	20.7%	198	12.9%	243	18.6%	336	13.2%	262	16.8%	2722	5.9%
Unknown/Not Reported	24288	61.4%	72	100.0%	69	28.0%	83	5.4%	7	0.5%	5	0.2%	3	0.2%	24527	53.0%
Ethnicity																
Hispanic or Latino	1556	3.9%	4	5.6%	13	5.3%	669	43.5%	156	11.9%	318	12.5%	172	11.0%	2888	6.2%
Non-Hispanic/Non-Latino	6049	15.3%	0	0.0%	97	39.4%	693	45.1%	648	49.5%	1417	55.6%	927	59.5%	9831	21.2%
Other	0	0.0%	0	0.0%	0	0.0%	104	6.8%	49	3.7%	0	0.0%	45	2.9%	198	0.4%
More than one ethnicity	361	0.9%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	361	0.8%
Unknown/Not Reported	31,569	79.9%	68	94.4%	136	55.3%	72	4.7%	456	34.8%	812	31.9%	415	26.6%	33528	72.4%
Race																
White	4555	11.5%	6	8.3%	124	50.4%	341	22.2%	390	29.8%	1032	40.5%	811	52.0%	7259	15.7%
Black or African American	696	1.8%	8	11.1%	2	0.8%	241	15.7%	264	20.2%	511	20.1%	251	16.1%	1973	4.3%
Asian	693	1.8%	0	0.0%	9	3.7%	178	11.6%	38	2.9%	120	4.7%	30	1.9%	1068	2.3%
American Indian or Alaska Native	39	0.1%	0	0.0%	2	0.8%	26	1.7%	23	1.8%	28	1.1%	16	1.0%	134	0.3%
Native Hawaiian or other Pacific Islander	27	0.1%	0	0.0%	8	3.3%	8	0.5%	15	1.1%	13	0.5%	63	4.0%	134	0.3%
More than one race	361	0.9%	0	0.0%	1	0.4%	51	3.3%	42	3.2%	77	3.0%	63	4.0%	595	1.3%
Other	0	0.0%	2	2.8%	3	1.2%	665	43.2%	107	8.2%	244	9.6%	150	9.6%	1171	2.5%
Unknown/Not Reported	33164	83.9%	56	77.8%	97	39.4%	28	1.8%	430	32.8%	522	20.5%	175	11.2%	34472	74.4%
Primary Language																
English	29223	73.9%	0	0.0%	160	65.0%	647	42.1%	1043	79.7%	2277	89.4%	1448	92.9%	34798	75.1%
Spanish	227	0.6%	0	0.0%	2	0.8%	570	37.1%	17	1.3%	33	1.3%	24	1.5%	873	1.9%
Vietnamese	8	0.0%	0	0.0%	0	0.0%	1	0.1%	3	0.2%	0	0.0%	5	0.3%	17	0.0%
Cantonese	3	0.0%	0	0.0%	0	0.0%	8	0.5%	4	0.3%	1	0.0%	2	0.1%	18	0.0%
Russian	3	0.0%	0	0.0%	0	0.0%	158	10.3%	4	0.3%	8	0.3%	12	0.8%	185	0.4%
Hmong	0	0.0%	0	0.0%	0	0.0%	449	29.2%	3	0.2%	1	0.0%	1	0.1%	454	1.0%
Arabic	2	0.0%	0	0.0%	0	0.0%	1	0.1%	2	0.2%	1	0.0%	1	0.1%	7	0.0%
Other	17	0.0%	0	0.0%	2	0.8%	102	6.6%	7	0.5%	26	1.0%	17	1.1%	171	0.4%
Unknown/Not Reported	10052	25.4%	72	100.0%	82	33.3%	2	0.1%	226	17.3%	200	7.9%	49	3.1%	10683	23.1%
Sexual Orientation																
Heterosexual or Straight	564	1.4%	0	0.0%	153	62.2%	1303	84.7%	131	10.0%	197	7.7%	589	37.8%	2937	6.3%
Gay or Lesbian	115	0.3%	0	0.0%	2	0.8%	40	2.6%	5	0.4%	11	0.4%	16	1.0%	189	0.4%
Bisexual	17	0.0%	0	0.0%	3	1.2%	84	5.5%	2	0.2%	17	0.7%	1	0.1%	124	0.3%
Questioning or unsure	5	0.0%	0	0.0%	0	0.0%	42	2.7%	1	0.1%	6	0.2%	7	0.4%	61	0.1%
Queer	6	0.0%	0	0.0%	4	1.6%	11	0.7%	1	0.1%	0	0.0%	0	0.0%	22	0.0%
Another sexual orientation	15	0.0%	0	0.0%	0	0.0%	25	1.6%	2	0.2%	1	0.0%	2	0.1%	45	0.1%
Unknown/Not Reported	38813	98.2%	72	100.0%	84	34.1%	33	2.1%	1167	89.2%	2315	90.9%	944	60.6%	43428	93.8%
Current Gender Identity																
Female	16008	40.5%	24	33.3%	147	59.8%	1012	65.8%	600	45.8%	439	17.2%	394	25.3%	18624	40.2%
Male	13772	34.8%	48	66.7%	45	18.3%	428	27.8%	705	53.9%	539	21.2%	419	26.9%	15956	34.5%
Transgender	165	0.4%	0	0.0%	0	0.0%	83	5.4%	0	0.0%	7	0.3%	3	0.2%	258	0.6%
Genderqueer	13	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	13	0.0%
Questioning or unsure	12	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	12	0.0%
Another gender identity	13	0.0%	0	0.0%	2	0.8%	7	0.5%	0	0.0%	2	0.1%	2	0.1%	26	0.1%
Unknown/Not Reported	9565	24.2%	0	0.0%	52	21.1%	8	0.5%	4	0.3%	1560	61.2%	741	47.5%	11930	25.8%
Veteran Status																
Yes	534	1.4%	N/R	N/R	11	4.5%	7	0.5%	N/R	N/R	N/R	N/R	N/R	N/R	18	0.0%
No	39,001	98.6%	N/R	N/R	235	95.5%	1531	99.5%	N/R	N/R	N/R	N/R	N/R	N/R	1766	3.8%
Unknown/Not Reported	0	0.0%	72	100.0%	0	0.0%	0	0.0%	1309	100.0%	2547	100.0%	1559	100.0%	5487	11.8%

	Prevention and Early Intervention (PEI) Respite Programs FY 19/20															
	Caregiver Crisis Intervention Respite		Homeless Teens and TAY Respite		Ripple Effect		Danelle's Place		Q-Spot		Lambda Lounge		Adoptive Families Respite		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Age Group																
Children/Youth (0-15)	0	0.0%	4	0.5%	0	0.0%	1	0.5%	13	6.7%	0	0.0%	74	33.9%	92	4.7%
TAY (16-25)	0	0.0%	791	97.7%	10	8.2%	45	21.3%	177	91.2%	35	9.4%	2	0.9%	1,060	53.8%
Adults (26-59)	10	23.8%	3	0.4%	93	76.2%	123	58.3%	1	0.5%	201	53.7%	64	29.4%	495	25.1%
Older Adults (60+)	32	76.2%	0	0.0%	19	15.6%	15	7.1%	0	0.0%	25	6.7%	4	1.8%	95	4.8%
Unknown/Not Reported	0	0.0%	12	1.5%	0	0.0%	27	12.8%	3	1.5%	113	30.2%	74	33.9%	229	11.6%
Total	**42**	**100.0%**	**810**	**100.0%**	**122**	**100.0%**	**211**	**100.0%**	**194**	**100.0%**	**374**	**100.0%**	**218**	**100.0%**	**1,971**	**100.0%**
Ethnicity																
Hispanic or Latino	8	19.0%	151	18.6%	12	9.8%	32	15.2%	54	27.8%	57	15.2%	21	9.6%	335	17.0%
Non-Hispanic/Non-Latino	33	78.6%	557	68.8%	65	53.3%	130	61.6%	106	54.6%	236	63.1%	134	61.5%	1,261	64.0%
Unknown/Not Reported	1	2.4%	102	12.6%	45	36.9%	49	23.2%	34	17.5%	81	21.7%	63	28.9%	375	19.0%
Total	**42**	**100.0%**	**810**	**100.0%**	**122**	**100.0%**	**211**	**100.0%**	**194**	**100.0%**	**374**	**100.0%**	**218**	**100.0%**	**1,971**	**100.0%**
Race																
American Indian or Alaska Native	3	7.1%	19	2.3%	1	0.8%	3	1.4%	10	5.2%	11	2.9%	0	0.0%	47	2.4%
Asian	2	4.8%	5	0.6%	0	0.0%	1	0.5%	0	0.0%	3	0.8%	7	3.2%	18	0.9%
Black or African American	5	11.9%	438	54.1%	14	11.5%	32	15.2%	47	24.2%	37	9.9%	58	26.6%	631	32.0%
Native Hawaiian/Pacific Islander	2	4.8%	23	2.8%	0	0.0%	11	5.2%	3	1.5%	5	1.3%	1	0.5%	45	2.3%
White	24	57.1%	188	23.2%	27	22.1%	118	55.9%	73	37.6%	172	46.0%	124	56.9%	726	36.8%
Other	5	11.9%	62	7.7%	30	24.6%	17	8.1%	18	9.3%	87	23.3%	7	3.2%	226	11.5%
More than one race	1	2.4%	45	5.6%	47	38.5%	18	8.5%	23	11.9%	20	5.3%	16	7.3%	170	8.6%
Decline to answer	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Unknown/Not Reported	0	0.0%	30	3.7%	3	2.5%	11	5.2%	20	10.3%	39	10.4%	5	2.3%	108	5.5%
Total	**42**	**100.0%**	**810**	**100.0%**	**122**	**100.0%**	**211**	**100.0%**	**194**	**100.0%**	**374**	**100.0%**	**218**	**100.0%**	**1,971**	**100.0%**
Primary Language																
English	37	88.1%	792	97.8%	120	98.4%	191	90.5%	191	98.5%	351	93.9%	188	86.2%	1,870	94.9%
Spanish	1	2.4%	0	0.0%	2	1.6%	14	6.6%	3	1.5%	11	2.9%	1	0.5%	32	1.6%
Vietnamese	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Cantonese	1	2.4%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.1%
Russian	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2	0.5%	0	0.0%	2	0.1%
Hmong	0	0.0%	0	0.0%	0	0.0%	1	0.5%	0	0.0%	1	0.3%	0	0.0%	2	0.1%
Arabic	1	2.4%	0	0.0%	0	0.0%	1	0.5%	0	0.0%	2	0.5%	0	0.0%	4	0.2%
Other	1	2.4%	12	1.5%	0	0.0%	2	1.0%	0	0.0%	1	0.3%	1	0.5%	17	0.9%
Unknown/Not Reported	1	2.4%	6	0.7%	0	0.0%	2	1.0%	0	0.0%	6	3.5%	28	12.8%	43	2.2%
Total	**42**	**100.0%**	**810**	**100.0%**	**122**	**100.0%**	**211**	**100.1%**	**194**	**100.0%**	**374**	**101.9%**	**218**	**100.0%**	**1,971**	**100.0%**

	Prevention and Early Intervention (PEI) Respite Programs FY 19/20 Cont.															
	Caregiver Crisis Intervention Respite		Homeless Teens and TAY Respite		A Church for All		Gender Health		Q-Spot		Lambda Lounge		Adoptive Families Respite		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Sexual Orientation*																
Gay or Lesbian	1	2.4%	40	4.9%	1	0.8%	0	0.0%	2	1.0%	49	13.1%	16	7.3%	109	5.5%
Heterosexual or Straight	41	97.6%	531	65.6%	29	23.8%	0	0.0%	1	0.5%	5	1.3%	146	67.0%	753	38.2%
Bisexual	0	0.0%	124	15.3%	2	1.6%	0	0.0%	2	1.0%	6	1.6%	1	0.5%	135	6.8%
Questioning or unsure	0	0.0%	6	0.7%	0	0.0%	0	0.0%	0	0.0%	4	1.1%	4	1.8%	14	0.7%
Queer	0	0.0%	6	0.7%	0	0.0%	0	0.0%	0	0.0%	7	1.9%	2	0.9%	15	0.8%
Another sexual orientation	0	0.0%	69	8.5%	0	0.0%	0	0.0%	0	0.0%	3	0.8%	7	3.2%	79	4.0%
Unknown/Not Reported	0	0.0%	34	4.2%	90	73.8%	211	100.0%	189	97.4%	300	80.2%	42	19.3%	866	43.9%
Total	**42**	**100.0%**	**810**	**100.0%**	**122**	**100.0%**	**211**	**100.0%**	**194**	**100.0%**	**374**	**100.0%**	**218**	**100.0%**	**1,971**	**100.0%**
Current Gender Identity*																
Male	10	23.8%	428	52.8%	22	18.0%	0	0.0%	2	1.0%	46	12.3%	91	41.7%	599	30.4%
Female	32	76.2%	339	41.9%	12	9.8%	0	0.0%	1	0.5%	33	8.8%	91	41.7%	508	25.8%
Transgender	0	0.0%	22	2.7%	0	0.0%	0	0.0%	2	1.0%	12	3.2%	0	0.0%	36	1.8%
Genderqueer	0	0.0%	6	0.7%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	6	0.3%
Questioning or unsure	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Another gender identity	0	0.0%	2	0.2%	0	0.0%	0	0.0%	0	0.0%	4	1.1%	2	0.9%	8	0.4%
Unknown/Not Reported	0	0.0%	13	1.6%	88	72.1%	211	100.0%	189	97.4%	279	74.6%	34	15.6%	814	41.3%
Total	**42**	**100.0%**	**810**	**100.0%**	**122**	**100.0%**	**211**	**100.0%**	**194**	**100.0%**	**374**	**100.0%**	**218**	**100.0%**	**1,971**	**100.0%**
Veteran Status																
Yes	5	11.9%	4	0.5%	11	9.0%	17	8.1%	0	0.0%	11	2.9%	0	0.0%	48	2.4%
No	37	88.1%	769	94.9%	80	65.6%	194	91.9%	172	88.7%	191	51.1%	68	31.2%	1,511	76.7%
Decline to answer	0	0.0%	37	4.6%	31	25.4%	0	0.0%	22	11.3%	172	46.0%	150	68.8%	412	20.9%
Total	**42**	**100.0%**	**810**	**100.0%**	**122**	**100.0%**	**211**	**100.0%**	**194**	**100.0%**	**374**	**100.0%**	**218**	**100.0%**	**1,971**	**100.0%**

STRENGTHENING FAMILIES										
	QCCC		CPS Mental Health Teams		eVIBE		Adoptive Families Respite		Total	
Characteristic	N=9	%	N=452	%	N=2496	%	N=218	%	N=3175	%
Age Group										
Children/Youth (0-15)	4	44.4%	420	93%	2299	92.1%	74	33.9%	2797	88.1%
TAY (16-25)	0	0.0%	30	7%	29	1.2%	2	0.9%	61	1.9%
Adults (26-59)	5	55.6%	2	0%	51	2.0%	64	29.4%	122	3.8%
Older Adults (60+)	0	0.0%	0	0%	1	0.0%	4	1.8%	5	0.2%
Unknown/Not Reported	0	0.0%	0	0%	116	4.6%	74	33.9%	190	6.0%
Ethnicity										
Hispanic or Latino	2	22.2%	53	11.7%	913	36.6%	21	9.6%	989	31.1%
Non-Hispanic/Non-Latino	4	44.4%	126	27.9%	883	35.4%	134	61.5%	1147	36.1%
Other	0	0.0%	14	3.1%	0	0.0%	0	0.0%	14	0.4%
More than one ethnicity	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Unknown/Not Reported	3	33.3%	259	57.3%	700	28.0%	63	28.9%	1025	32.3%
Race										
White	2	22.2%	120	26.5%	441	17.7%	124	56.9%	687	21.6%
Black or African American	2	22.2%	98	21.7%	241	9.7%	58	26.6%	399	12.6%
Asian	1	11.1%	17	3.8%	356	14.3%	7	3.2%	381	12.0%
American Indian or Alaska Native	0	0.0%	6	1.3%	17	0.7%	0	0.0%	23	0.7%
Native Hawaiian or other Pacific Islander	0	0.0%	9	2.0%	32	1.3%	1	0.5%	42	1.3%
More than one race	0	0.0%	27	6.0%	380	15.2%	16	7.3%	423	13.3%
Other	2	22.2%	19	4.2%	671	26.9%	7	3.2%	699	22.0%
Unknown/Not Reported	2	22.2%	156	34.5%	358	14.3%	5	2.3%	521	16.4%
Primary Language										
English	3	33.3%	326	72.1%	1831	73.4%	188	86.2%	2348	74.0%
Spanish	1	11.1%	4	0.9%	206	8.3%	1	0.5%	212	6.7%
Vietnamese	0	0.0%	0	0.0%	17	0.7%	0	0.0%	17	0.5%
Cantonese	0	0.0%	0	0.0%	23	0.9%	0	0.0%	23	0.7%
Russian	0	0.0%	0	0.0%	22	0.9%	0	0.0%	22	0.7%
Hmong	1	11.1%	4	0.9%	19	0.8%	0	0.0%	24	0.8%
Arabic	1	11.1%	0	0.0%	5	0.2%	0	0.0%	6	0.2%
Other	0	0.0%	0	0.0%	46	1.8%	1	0.5%	47	1.5%
Unknown/Not Reported	4	44.4%	118	26.1%	327	13.1%	28	12.8%	477	15.0%
Sexual Orientation										
Heterosexual or Straight	4	44.4%	19	4.2%	40	1.6%	146	67.0%	209	6.6%
Gay or Lesbian	0	0.0%	0	0.0%	1	0.0%	16	7.3%	17	0.5%
Bisexual	0	0.0%	2	0.4%	0	0.0%	1	0.5%	3	0.1%
Questioning or unsure	0	0.0%	5	1.1%	0	0.0%	4	1.8%	9	0.3%
Queer	0	0.0%	0	0.0%	0	0.0%	2	0.9%	2	0.1%
Another sexual orientation	0	0.0%	0	0.0%	0	0.0%	7	3.2%	7	0.2%
Unknown/Not Reported	5	55.6%	426	94.2%	2455	98.4%	42	19.3%	2928	92.2%
Current Gender Identity										
Female	4	44.4%	213	47.1%	1243	49.8%	91	41.7%	1551	48.9%
Male	4	44.4%	215	47.6%	1229	49.2%	91	41.7%	1539	48.5%
Transgender	0	0.0%	1	0.2%	0	0.0%	0	0.0%	1	0.0%
Genderqueer	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Questioning or unsure	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Another gender identity	0	0.0%	1	0.2%	0	0.0%	2	0.9%	3	0.1%
Unknown/Not Reported	1	11.1%	22	4.9%	24	1.0%	34	15.6%	81	2.6%
Veteran Status										
Yes	N/R	N/R	0	0	N/R	N/R	0	0.0%	0	0.0%
No	N/R	N/R	80	17.7%	N/R	N/R	68	31.2%	68	2.1%
Unknown/Not Reported	9	100.0%	372	82.3%	2496	100.0%	150	68.8%	3027	95.3%

INTEGRATED HEALTH AND WELLNESS								
	SacEDAPT		Senior Link		Senior Link Outreach		Total	
Characteristic	N=199	%	N=181	%	N=191	%	N=571	%
Age Group								
Children/Youth (0-15)	50	25.1%	0	0.0%	0	0.0%	50	8.8%
TAY (16-25)	111	55.8%	0	0.0%	0	0.0%	111	19.4%
Adults (26-59)	38	19.1%	16	8.4%	13	6.8%	67	11.7%
Older Adults (60+)	0	0.0%	134	70.2%	178	93.2%	312	54.6%
Unknown/Not Reported	0	0.0%	31	16.2%	0	0.0%	31	5.4%
Ethnicity								
Hispanic or Latino	61	30.7%	37	19.4%	47	24.6%	145	25.4%
Non-Hispanic/Non-Latino	115	57.8%	93	48.7%	118	61.8%	326	57.1%
Other	0	0.0%	0	0.0%	0	0.0%	0	0.0%
More than one ethnicity	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Unknown/Not Reported	23	11.6%	51	26.7%	26	13.6%	100	17.5%
Race								
White	56	28.1%	50	26.2%	68	35.6%	174	30.5%
Black or African American	53	26.6%	35	18.3%	36	18.8%	124	21.7%
Asian	15	7.5%	11	5.8%	6	3.1%	32	5.6%
American Indian or Alaska Native	2	1.0%	4	2.1%	6	0.5%	12	2.1%
Native Hawaiian or other Pacific Islander	1	0.5%	4	2.1%	5	3.1%	10	1.8%
More than one race	22	11.1%	0	0.0%	1	2.6%	23	4.0%
Other	42	21.1%	29	15.2%	45	23.6%	116	20.3%
Unknown/Not Reported	8	4.0%	48	25.1%	24	12.6%	80	14.0%
Primary Language								
English	184	92.4%	116	60.7%	148	77.5%	448	78.5%
Spanish	9	4.5%	19	9.9%	24	12.6%	52	9.1%
Vietnamese	1	0.5%	0	0.0%	0	0.0%	1	0.2%
Cantonese	1	0.5%	0	0.0%	2	1.0%	3	0.5%
Russian	0	0.0%	0	0.0%	2	1.0%	2	0.4%
Hmong	0	0.0%	11	5.8%	3	1.6%	14	2.5%
Arabic	0	0.0%	0	0.0%	1	0.5%	1	0.2%
Other	3	1.5%	0	0.0%	3	1.6%	6	1.1%
Unknown/Not Reported	1	0.5%	35	18.3%	8	4.2%	44	7.7%
Sexual Orientation								
Heterosexual or Straight	16	8.0%	161	84.3%	171	89.5%	348	60.9%
Gay or Lesbian	1	0.5%	1	0.5%	2	1.0%	4	0.7%
Bisexual	4	2.0%	0	0.0%	0	0.0%	4	0.7%
Questioning or unsure	2	1.0%	0	0.0%	0	0.0%	2	0.4%
Queer	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Another sexual orientation	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Unknown/Not Reported	176	88.4%	19	9.9%	18	9.4%	213	37.3%
Current Gender Identity								
Female	76	55.2%	105	55.0%	134	70.2%	315	55.2%
Male	61	44.7%	44	23.0%	55	28.8%	160	28.0%
Transgender	2	1.0%	0	0.0%	1	0.5%	3	0.5%
Genderqueer	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Questioning or unsure	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Another gender identity	4	2.0%	0	0.0%	0	0.0%	4	0.7%
Unknown/Not Reported	56	28.1%	32	16.8%	1	0.5%	89	15.6%
Veteran Status								
Yes	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R
No	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R
Unknown/Not Reported	199	100%	181	100%	191	100%	571	100.0%

WORKFORCE EDUCATION AND TRAINING (WET) COMPONENT

The WET component provides time limited funding with the goals of recruiting, hiring, training and retaining culturally diverse and linguistically proficient public mental health system staff who are reflective of the cultural, racial, ethnic, linguistic, gender and sexual diversity of the community we serve. The WET component ensures that staff receive training to provide effective services and administer programs based on the principles of wellness and recovery. Sacramento County's WET Plan is comprised of eight (8) previously approved actions.

The Sacramento County Workforce Needs Assessment, completed in 2007 as part of the Workforce Education and Training (WET) Component planning process, helped inform the development of the WET Plan. As part of the annual Cultural Competence Plan requirements, BHS conducted a Human Resource (HR) Survey and Language Proficiency Survey to provide current data on the entire mental health system. The final report of the 2019 HR Survey and Language Proficiency Survey is attached as part of this update (*see Attachment J – 2019 HR Survey*). Data from the annual HR Survey and Language Proficiency Survey suggests that BHS could provide more intentional outreach and recruitment in order to hire and retain a workforce that more closely reflects the cultural, racial, ethnic, linguistic, gender and sexual diversity of the consumers being served throughout BHS programs.

In April 2020, a presentation was made to Sacramento County's Mental Health Services Act Steering Committee to provide a summary of local WET activities as well as planned activities that could be implemented through Sacramento County's participation in the Central Regional Partnership. The State is awarding WET grant funding to five regional partnerships to fund activities that support the workforce needs of each of the counties within those regional partnerships. Counties are then asked to provide a match in order to access funding made available to their respective regional partnership. The Steering Committee supported BHS's request to contribute a match based on a statewide allocation formula in order to ensure our ability to access grants being awarded to the Central Regional Partnership during the 2020-2025 grant period.

In order to work towards recruiting and retaining a diverse workforce that will more closely reflect the cultural, racial, ethnic, linguistic, gender and sexual diversity of the clientele we serve, BHS intends to participate in the following activities that are available through the Central Regional Partnership: Undergraduate College and University Scholarships, Clinical Master and Doctoral Graduate Education Stipends, and the Loan Repayment Program

Action 1: Workforce Staffing Support

The function of the WET Coordinator is to assist in the facilitation and implementation of previously approved WET Actions. The Coordinator attends and participates in statewide WET Coordinator Meetings; the WET Central Region Partnership, the California Educational Marriage and Family Therapist (MFT) Stipend Program Selection Committee; MFT Consortium of Greater Sacramento; Health Professions Education Foundation Advisory/Selection Committee and the Valley High School-Health TECH Academy Community Advisory Board. The WET Coordinator will continue to assist in the evaluation of WET Plan implementation and effectiveness, coordinates/collaborates with other MHSA and BHS efforts, and participates in the implementation of WET Actions.

Action 2: System Training Continuum

This Action expands the training capacity for mental health staff, system partners, consumers, family members, and community members through a Training Partnership Team, Train the Trainer Models, training delivery and other community-based efforts.

As part of the System Training Continuum, both adult and youth versions of the Mental Health First Aid (MHFA) are popular trainings provided for individuals, groups, organizations, system partners and the community free of charge. MHFA is an eight-hour training that teaches participants how to help individuals developing a mental health problem or experiencing a worsening of an existing mental health problem. Both BHS staff and system partners facilitate adult and youth versions of MHFA, in both English and Spanish, targeting specific cultural populations. Since 2010, Sacramento County trained more than 1990 community members. Interest in the course and class size remains consistent.

In 2010, the MHSA Central Region Partnership Workforce, Education and Training's (CRPWET) strategic effort sponsored the initial training of local MHFA instructors. Since then, BHS leveraged CRPWET and local WET funds to train interested individuals that wished to be instructors, thereby expanding the MHFA instructor pool. Sacramento County's cadre of certified MHFA instructors have conducted several organized trainings in English and other languages in community-based sites countywide throughout the year. Specialty groups (i.e. Sacramento City College Occupational Therapy Program, Sacramento Self-Help Housing, Stars Behavioral Health Group, and Starbucks Corporation, churches and other community organizations, etc.), system partners, the community, including those with lived mental health experience have participated in MHFA trainings.

Prior to 2014, only adult MHFA training was available; however, since 2016 BHS sent additional staff to both adult and youth MHFA Trainings for Trainers to expand the pool of MHFA instructors. Currently, both adult and youth MHFA training sessions, including language/culturally specific sessions, are part of the partner training schedule and the county's Mental Health Plan (MHP). Additionally, adult and youth MHFA trainings are offered in both English and Spanish through a partnership with a community-based contract provider, La Familia Counseling Center. Other system partners, including Sacramento Native American Health Center and Muslim American Society-Social Services Foundation, also provide adult and youth MHFA trainings to community members free of charge.

MHFA and Youth MHFA (YMHFA) are supported in both the PEI and WET components. As described in the MHSA FY 2019-20 Annual Update, the Sacramento County Office of Education (SCOE) administered YMHFA moved from the WET component to PEI to align with other youth mental health and wellness efforts.

The System Training Continuum also supports the provision of Pro-ACT Training. BHS provides this training to staff at the Sacramento County Mental Health Treatment Center (MHTC) and Adult Psychiatric Support Services (APSS) clinic. These programs provide mental health treatment services in inpatient and outpatient milieus to individuals experiencing moderate to severe mental illness. Pro-ACT Training emphasizes critical thinking, continued assessment of client behaviors and needs, and employs a distinctive problem-solving approach designed to improve safety and enhance treatment outcomes.

In FY 2006-07, BHS piloted the evidence-based California Brief Multi-Cultural Competence Scale (CBMCS) and accompanying training. Since that time, BHS has successfully trained more than 1,454 individuals working in the local mental health service system. This training enhances provider staffs' knowledge in areas of identified and needed skill development and provides a means to measure providers' cultural competency. BHS requires that all providers' service delivery staff, supervisors and managers receive this training. In FY 2019-20, BHS offered five (5) CBMCS trainings and 98 participants attended. BHS plans to continue offering CBMCS trainings every year.

In FY 2019-20, BHS offered a two-day "Introduction to Interpreting in Behavioral Health Settings with 49 individuals participating and two three-day trainings, "Increasing Spanish Behavioral Health Clinical Terminology" with 24 participants in attendance. The former training meets the State requirement that all interpreters working in the public mental health system receive training specific to interpreting in a mental health/behavioral health environment. Trained interpreters are necessary to ensure accurate and complete communication to minimize risk and maximize the delivery of quality services. The training supports bilingual staff, including clinicians, case managers, administrative support staff, community members, system partners, contractors, consumers/peers, and others who are or want to become interpreters. With this training, BHS strived to achieve the standard that 98% of staff identified as interpreters complete an approved mental health/behavioral health interpreter training and receive certification. In FY 2019-20, due to staff turnover at our Assisted Access program, we were unable to meet that standard in FY 2019-20. BHS will make Behavioral Health Interpreter Training and "Training for Providers Who Use Interpreters" training sessions available in FY 2020-21 as well.

In addition to the training efforts described above, BHS sponsors the annual client culture conference. In FY 2019-20, BHS provided scholarships and support for 92 behavioral health staff, system partners, providers, stakeholders, and individuals with lived mental health experiences to attend eight (8) behavioral health related trainings and conferences.

Action 3: Office of Consumer and Family Member Employment

This Action was designed to develop entry and supportive employment opportunities for consumers, family members, and individuals from Sacramento's culturally and linguistically diverse communities to address occupational shortages identified in the Workforce Needs Assessment. Over time, many factors influenced changes to the original design of this action. For instance, the Office of Statewide Health Planning and Development (OSHPD) rolled out numerous MHSA-funded projects addressing the needs of consumer and family members interested in obtaining employment. As a result, BHS has looked for alternative opportunities to leverage these projects and further move forward the activities described in this action. In line with BHS core values and community/stakeholder input, BHS has included consumer and family member positions in all programs using creative partnerships between county and contract providers.

Action 4: High School Training

Through this Action, in FY 2013-14 a pilot behavioral health curriculum was developed in partnership with BHS' MHP providers, BHS Cultural Competence Committee, community partners and other interested stakeholders. The curriculum was designed for high school students with several goals in mind: cultivating interest in public mental/behavioral health careers;

expanding knowledge and understanding of mental/behavioral health conditions; broadening understanding of associated stigma and discrimination against individuals with mental illness; increasing awareness of community resources and available supports; increasing understanding of mental health issues from diverse ethnic and racial perspectives; and exploring mental health across age groups.

Currently two local high schools, Arthur A. Benjamin Health Professions High School (AABHPHS) and Valley High School Health TECH Academy (VHSHTA), participate in this action and offer mental/behavioral health-oriented career pathways for their student body. The pilot curriculum, built upon the principles of wellness, recovery and resiliency, has since expanded for both schools and relies on teachers and other mental health professionals to blend academic and technical curriculum in ways that connect theoretical knowledge and real-world applications.

AABHPHS and VHSHTA students are surveyed every year at the beginning and end of each term. Analysis of the previous year's data was used to modify, enhance, and improve the FY 2020/21 curriculum. Activities were expanded to include more community-based internship opportunities, participation in community outreach events, and field trips to community based organizations and higher learning institutions with mental or behavioral health programs. In addition, students heard presentations from guest speakers with lived experience on topics such as wellness and recovery, resiliency, stigma and discrimination, and barriers that discourage or hinder consumers from seeking emotional support and services.

In addition to curriculum modifications, VHSHTA students are also learning about the biology of addiction—how it affects the brain, how brain biochemistry reinforces addiction, and ways to recover from addiction. In Health Science class, 9th grade students learned that high intake of sugary foods and beverages can increase the risk of depression in many populations and weaken the body's ability to respond to stress. Students also learned overconsumption of sweeteners and highly processed foods could eventually change brain chemistry and perpetuate cravings, leading to overeating, poor nutrition, and food addiction. Through the Health Sciences curriculum, educators have helped students understand the importance of limiting sugar intake to achieve better mental health outcomes and improved brain function.

The students have increased their knowledge of mental illness through work and project-based research. Students meet with mental health professionals from community colleges, local hospitals, mental health clinics and other community-based organizations to learn about mental health disorders such as Bipolar Disorder, Post-Traumatic Stress Disorder, Obsessive Compulsive Disorder and Schizophrenia. Pairing students with local mental health professionals raises awareness about mental illness and provides authentic job preparation opportunities and skills development in the hope students will pursue future careers in the field of mental health. Internship and other work-based learning opportunities extend and deepen classroom learning and help students make progress toward learning outcomes that are difficult to achieve through classroom work alone. These ongoing opportunities help students improve their understanding of how mental illness affects an individual's daily life and provide opportunities for them to explore their own mental health and emotional coping skills.

Both AABHPHS and VHSHTA have culturally and linguistically diverse student bodies that participated in many community events in FY2019-20, including Garfield Innovation Center for Kaiser Youth Career Day on August 24, 2019, WalMart Health Fair-Delta Shores on July 20, 2019, National Night Out on August 6, 2019, and Habitat for Humanity on September 9, 2019. Other behavioral health and career related events were scheduled for later in this fiscal year, such as the Youth Leadership Summit and College Career Expo in March and April 2020, but were postponed or cancelled due to COVID-19 pandemic.

VHSHTA, in partnership with Kaiser Permanente, launched the Cultural Awareness Community Health Education (CACHE) Outreach Project. This joint collaboration gives students opportunities to learn about health disparities among racial and ethnic minority populations. The CACHE projects also help student learn and understand the importance of providing culturally competent are and communication to meet the health needs of diverse patient populations. Through the CACHE project, students learn how to engage with different cultural communities with awareness and sensitivity. As class projects, each CACHE group designs a culturally competent and linguistically appropriate health presentation for a medically underserved population in Sacramento and presents it to a diverse audience of students, teachers and community members who offer feedback and encouragement. The CACHE project not only prepares academy students to conduct health workshops, but it also allows students to learn cultural competence by connecting or reconnecting with their own culture while being exposed to medical and mental health conditions that exist in cultures other than their own.

In October 2019, VHSHTA hosted and participated in a career seminar featuring primary care and the mental/behavioral health field. Many careers and professions were represented, including mental health services coordination and geriatric social work, patient's rights advocacy, and cultural competence. The career seminar increased the students' understanding of careers in the mental/behavioral health field and provided greater understanding of the importance of providing effective and culturally responsive treatment across the culturally diverse communities in Sacramento County.

VHSHTA –Hmong Group-CACHE Presentation-2019

When COVID-19 restrictions are lifted, VHSHTA students will resume field trips to local colleges and universities, such as University of the Pacific, School of Pharmacy, University of California, Berkeley, School of Public Health, Sacramento City College, and Allied Health Programs to learn more about the social determinants of health, ever changing healthcare needs, the importance of providing patient-centered and culturally competent care, as well as advocacy, governance, and leadership skills. Additionally, VHSHTA continues to expand its Health TECH career pathway program. Students report that they continue to benefit from WET funding, which has helped create and adopt an expanded year-round curriculum for seniors: Behavioral Health Theory and Practicum for the Community Health Worker (CHW). This expansion replaced the prior single semester course, adding depth to academy students' understanding of mental and behavioral health

issues, increased instruction on careers in behavioral health, research methods in psychology, brain anatomy and function, psychological theory, abnormal psychology, and social psychology, and has been successful in engaging students in learning about career opportunities in mental/behavioral health. The current curriculum integrates a more holistic perspective in providing healthcare services and focuses on overall wellness, while exploring and understanding the more complex social determinants of health and health disparities and the long-term effects of Adverse Childhood Experiences (ACEs). Academy staff are now training the CHW students to investigate and understand how mental health and physical health affects each other. To keep students engaged and motivated, the teaching staff created realistic role-play scenarios and case studies, giving students opportunities to practice motivational interviewing skills and practice providing comfort and emotional support to others. Project based learning opportunities provided students opportunities to bridge language and cultural barriers while challenging their understanding of how environment affects both physical and mental health. Academy staff are now more deliberate in mental/behavioral health activities and promotion of mental/behavioral health awareness, informing not only VHSHTA students, but also the community of important mental/behavioral health issues and career possibilities.

During 2019, AABPHS staff took students on field trips to Sacramento Valley Psychological Association, Kaiser Permanente School of Allied Health Sciences, Richmond, CA, California State University, Chico, UC Davis, School of Medicine, Sacramento City College, and William Jessup University, School of Psychology. On October 28-29, 2019, AABHPHS's Positive Behavior Interventions and Supports (PBIS) team attended the 4th Annual PBIS Conference and presented on school curriculum, including a discussion on Mind Matters: Overcoming Adversity and Building Resilience, a curriculum that teaches young people skills and practices that cultivate healing and clears away distractions to learning and healthy relationships. Students also presented on the Faces for the Future program, a multi-year healthcare internship and leadership development program for highly resilient HPHS students. Students shared how the Faces for the Future program supports entry into healthcare professions through internships, workshops, academic support and college preparation and wellness support. In December 2019, AABHPHS also participated in community events, including Schools Challenge Day, an experiential social and emotional learning program designed to bring awareness to anti-bullying efforts, building empathy and inspiring compassion, inclusivity and a greater connectedness among students and staff. AABPHS students also participated in Blood Source blood drives and Pathways to Paychecks, a program involving Elk Grove Unified School District and other community partners and stakeholders that promotes career planning, breaking down silos between high school and colleges, and engaging industry to collaborate with schools to prepare students for jobs and careers that provide personal satisfaction and financial benefit for years to come. On April 24, 2020, AABHPHS seniors were scheduled to attend Samuel

AABHPHS – "Exploring Health Careers" 2019

Merritt University's Student Health and Counseling Center, where they would learn the importance of making healthy lifestyle choices, improving health outcomes across diverse communities and reducing disparities wherever they find them. However, due to COVID-19 precautions, all scheduled SCUSD events have been cancelled or postponed until further notice.

The partnership with both AABHPHS and VHSHTA and their feeder schools has continued to assist BHS in the goal of recruiting a diverse workforce that is reflective of the cultural and linguistic make-up of the community.

BHS continues to work with both high schools to implement stipends for students to spend time in service delivery programs and/or community agencies in order to combine knowledge they obtain in the classroom with hands-on, real world experience.

BHS serves on the Community Advisory Board that advises on student projects related to mental health and the delivery of culturally and linguistically responsive health/behavioral health services. BHS works with the selected schools with on-the-job training, mentoring, existing Regional Occupational Programs (ROP), and experiential learning opportunities for students who express interest in learning more about possible career options in mental health and public mental health.

Action 5: Psychiatric Residents and Fellowships

Action 5 was the first WET Action implemented in FY 2011-12 and continues to be administered through University of California, Davis (UCD), Department of Psychiatry. This Action includes the following components:

1. Community Education: Psychiatry Residents and Fellowship Training Program;
2. Mental Health Collaboration, Alcohol and Drug Services, and Mental Health Providers Training Program;
3. Residents and Post-Doctoral Fellows at Youth Detention Facility, serving the special needs population; and
4. Clinical Child Psychology, Pre-Doctoral Internship Training Program

Community Education: Psychiatry Residents and Fellowship Training Program

Since its implementation in academic year 2011-12, a total of 105 psychiatric residents have participated in this action and attended the required University of California Davis Psychiatric Resident Fellowship Program trainings. In FY2019-20, 13 students were enrolled in the program. Nine were dedicated to psychiatry only. Two students had combined interests in Psychiatry/Internal Medicine and two had combined interests in Psychiatry/Family Medicine.

Through this Action, psychiatrists are placed in public/community mental health settings to assist in primary care collaboration through consultation and education on mental health/primary healthcare integration. Additionally, residents, fellows, and other team members continue to receive in-service trainings on wellness and recovery principles, culture competence including consumer movement and client culture, and an integrated service delivery system. Targeted activities to understand mental health programming and promote holistic services while coordinating services with the primary care needs of consumers are a part of this integrated service delivery experience.

Mental Health Collaboration: Alcohol and Drug Services and Mental Health Providers Training

Through this Action, a team of part time dually boarded psychiatrists provide specialized training and consultation, educational seminars, and case conferences in order to improve the skillsets of behavioral health providers who offer substance use disorder services to individuals living with a serious mental illness. The enhanced skillsets will lead to an improved integrated service experience for individuals living with co-occurring disorders who are being served in both systems.

Residents and Post–Doctoral Fellows at Youth Detention Facility

Sacramento BHS has expanded the contract with UCD to include Residents and Post Doctorate Fellows providing consultation and support related to diagnostic impressions, antecedent behaviors and behavioral interventions to better serve the youth identified as having special needs residing at the Youth Detention Facility (YDF). This collaborative fosters community education opportunities for Probation staff and other stakeholders to share valuable and timely information to aid in the mental health recovery of YDF residents and optimize the care and treatment they receive. The program provides learning opportunities for Probation staff to improve communication with residents, increase development of behavioral interventions that improve outcomes such as re-offense and family relationships and increases staff's awareness and understanding of how mental illness, treated or untreated, can significantly impact a person's behavior. This program appears to have a positive impact, as Probation Officers who completed the Youth & Mental Health Education Feedback surveys overwhelmingly report that following training they feel better able to recognize early warning signs of escalating mental illness behaviors and have an increased understanding of the effects of specific mental illnesses upon behavior and how these symptoms manifest.

Clinical Child Psychology, Pre-Doctoral Internship Training Program

This program was implemented in 2018 and gives pre-doctoral interns hands-on experience at the Sacramento County Child and Adolescent Psychiatric Services (CAPS) Clinic including:

- supervised provision of psychological testing services
- psychosocial assessments
- case management services, and
- short or long-term individual, conjoint and/or group therapy services.

The objectives of the program include:

- increasing interns' skill at providing evidenced-based, developmentally appropriate, culturally sensitive, and trauma informed care;
- promoting professional development and preparing interns for independent practice as clinical child psychologists, with the hope that they become interested in working within the Sacramento County system of care; and
- providing opportunities throughout the training year for interns to coordinate and collaborate with multiple professionals involved in clients' care, especially those working in the mental health, child welfare, medical, academic, and legal domains.

Action 6: Multidisciplinary Seminar

This Action increases the number of psychiatrists and other non-licensed and licensed practitioners working in community mental health who are trained in the recovery and resiliency and integrated service models; improves retention rates; supports professional wellness by addressing work stressors and burn-out; and improves quality of care.

Implementation of this Action was delayed due to budget reductions and the focus on billable services. We recognize this is an important strategy and have sent staff to trainings that support them in the delivery of effective mental health services. Moving forward, BHS will continue to identify opportunities to establish multidisciplinary collaborations with key system partners.

Action 7: Consumer Leadership Stipends

This Action provides consumers and family members from diverse backgrounds with the opportunity to receive stipends for leadership or educational opportunities that increase knowledge, build skills, and further advocacy for consumers on mental health issues.

BHS continues to provide funding support for individuals with lived experience from diverse cultures to attend trainings/conferences offering leadership training. As previously stated, the Office of Statewide Health Planning and Development (OSHPD) has rolled out numerous MHSA WET-funded projects addressing the needs of consumer and family members interested in obtaining employment and enhancing leadership skills. BHS continues to look for opportunities to leverage these statewide efforts and to work with diverse stakeholders to determine an array of leadership and training opportunities beneficial for consumers and family members.

Action 8: Stipends for Individuals, Especially Consumers and Family Members, for Education Programs to Enter the Mental Health Field

This Action supports efforts to develop a diverse, culturally sensitive, and competent public mental health system by establishing a stipend fund to allow individuals to apply for stipends to participate in educational opportunities that will lead to employment in Sacramento County's mental health system. Through this action, BHS provides stipends that leverages local WET and other related funds as needed.

INNOVATION COMPONENT

The Innovation Component provides time-limited funding for the sole purpose of developing and trying out new practices and/or approaches in the field of mental health. An Innovation project is defined as one that contributes to learning rather than focusing on providing a service. BHS has completed one Innovation project, known as **Innovation Project 1: Respite Partnership Collaborative**. BHS is currently implementing three (3) Innovation Projects, **Innovation Project 2: Mental Health Crisis/Urgent Care Clinic** and **Innovation Project 3: Behavioral Health Crisis Services Collaborative and Innovation Project 4: Multi-County Full Service Partnership (FSP) Innovation (INN) Project**. Further, the MHSA Steering Committee supported moving forward **Innovation Project 5: Forensic Behavioral Health Multi-System Teams**, which was approved by the Mental Health Oversight and Accountability Commission (MHSOAC) in June 2020.

Innovation Project 1: Respite Partnership Collaborative (RPC)
The RPC Project spanned five-years from 2011 – 2016. The RPC was designed to be a community-driven collaborative comprised of community partners committed to developing, providing and supporting a continuum of respite services and supports designed to reduce mental health crisis in Sacramento County.

The learning opportunity for this project was using an administrative entity (Sierra Health Foundation: Center for Health Program Management) to implement the project to determine if a public/private endeavor could lead to new partnerships, increased efficiencies, and ultimately, improve services to our community members experiencing a crisis.

The RPC project was implemented in fiscal year 2012-13 and began with the formation of a Respite Partnership Collaborative comprised of twenty-two (22) stakeholders and community members. A total of five million dollars was set aside to fund grants for respite programs that could reduce the impact of crisis and create alternatives to psychiatric hospitalization. The RPC made the decision to award grants in three different funding cycles over the course of the Project.

In the role of the Administrative Entity, Sierra Health Foundation (SHF) Center for Health Program Management assisted the RPC to develop grant making procedures and practices and oversaw the distribution of grant dollars. Requests for Proposals were developed and publicized throughout the community. Organizations were invited to submit proposals for respite programs that could address mental health crisis and reduce psychiatric hospitalization. Proposals were reviewed by review teams comprised of RPC members as well as community stakeholders. All awards were determined by the RPC.

As an Innovation project, funding was time-limited for the term of the project, which meant that the mental health respite grantees had to look for sustainable funding from other sources. The Welfare and Institutions Code allows for the transition of successful innovation projects to sustainable MHSA funding, if the County so chooses. In 2015 and early 2016, the MHSA Steering Committee reviewed RPC-funded respite programs for consideration of sustainability through other MHSA components. This review was based on component funding requirements, as well as system needs. With support from the MHSA Steering Committee, all eleven mental health respite

programs transitioned to sustainable MHSA CSS and PEI funding during FY 2015-16. Descriptions of those respite programs are included in the CSS and PEI component sections of this Three-Year Plan.

Innovation Project 2: Mental Health Crisis/Urgent Care Clinic

The **Mental Health Urgent Care Clinic (MHUCC)** is a *Mental Health Services Act (MHSA) Innovation Project* that is time limited with a focus on learning and client outcomes. MHUCC provides voluntary and immediate access to short-term crisis intervention services, including integrated services for co-occurring substance abuse disorders, to individuals of all age groups (children, transitional age youth (TAY), adults, and older adults) who are experiencing a mental health crisis. Staff are reflective of the cultural, racial, ethnic, and linguistically diverse population of Sacramento County and are a collaborative team comprised of psychiatrists, nurses, clinicians, and peers. Services are designed to provide an alternative to emergency department (ED) visits for individuals with immediate mental health needs. Services include a multi-disciplinary mental health assessment with a focus on wellness and recovery, as well as linkage to ongoing community services. Interventions assist with decreasing unnecessary and lengthy involuntary inpatient treatment while increasing access to culturally competent care in a voluntary setting. The clinic is certified as a Medi-Cal outpatient clinic and has the ability to provide mental health services and supports to at least 450 clients per month (5% Children, 21% TAY, 68% Adults, and 6% Older Adults). MHUCC hours are 10:00 am - 10:00 pm weekdays and 10:00 am - 6:00 pm weekends and holidays. Based on stakeholder input, BHS is exploring expansion to 24/7 operations.

Success: Mental Health Crisis/Urgent Care Clinic

Towards the end of 2020, a male in his 30s with a diagnosis of schizophrenia came into the MHUCC for a long acting injectable (LAI) medication. The client declined all other medication, stating the LAI was the most effective medication for him. This individual showed multiple unsuccessful attempts linking with Regional Support Team (RST) services, and several recent psychiatric hospitalizations. Although he was open to receiving medication, he continued to be highly suspicious/paranoid. The clinician who initially met with the client identified that TCORE (a level three provider) would be an appropriate service to meet his needs. Due to the client's symptoms, he declined. The client reported a distrust of government services and, therefore, the clinician referred the client to follow up with his Geographic Managed Care (GMC) provider.

Because this client was receptive to LAI medication, he returned to MHUCC multiple times after his initial visit, in some cases because the MHUCC MD would have to order the medication upon the client's visit and the client would have to return several days later to receive his LAI dose when the medication was received.

When the client returned the following month, it was clear that he was having difficulty linking with his GMC provider due to his symptom distress. The MHUCC clinicians again presented TCORE as an option to the client, explaining how TCORE could best meet his needs. This time, the client was receptive to a referral to TCORE, given the way the MHUCC staff had been able to build rapport with him in this brief period of time.

The client only had to return to the clinic one more time to get his injectable medication before he was successfully connected to TCORE for ongoing services. During his last visit, MHUCC staff were able to coordinate with TCORE to ensure that there were no gaps in service.

This is an excellent example of how the MHUCC team was able to continue to engage with this individual based on his identified needs, and successfully move him to the most appropriate level of services that would avoid future decompensation and psychiatric hospitalization.

Innovation Project 3: Behavioral Health Crisis Services Collaborative

The **Behavioral Health Crisis Services Collaborative (BHCSC)** is time limited, with a focus on learning and client outcomes. BHCC serves individuals 18 years of age and older for up to 23 hours who present to an Emergency Department (ED) in Sacramento County experiencing a mental health crisis, who are medically stabilized, and who would benefit from ongoing outpatient mental health and crisis stabilization services. BHCC provides culturally competent, multi-disciplinary behavioral health services including, but not limited to, evaluation for voluntary or involuntary detention, behavioral health assessments, psychiatric assessments, medication evaluations and management, crisis stabilization, individuated recovery-oriented interventions, and safe discharging either to community or to an inpatient psychiatric facility (when necessary). Other BHCC services include integrated mental health and substance abuse screening to identify co-occurring needs, peer support, family support, care coordination with existing providers, and aftercare follow-up to ensure linkage to ongoing outpatient mental health services. Services focus on wellness and recovery, with the goal of timely and appropriate linkage to ongoing services and supports. Coordination with key resources and services includes, but is not limited to, County Mental Health Plan (MHP) services; Alcohol and Drug services; physical health services; housing services; and funding and benefit services, such as Supplemental Security Income (SSI) and Medi-Cal.

The BHCSC works in collaboration with the on-site, peer operated Resource Center (RC) to support the goals of removing client barriers to accessing mental health crisis stabilization services, reducing ED lengths of stay for individuals requiring mental health crisis stabilization, reducing unnecessary psychiatric hospitalizations, and improving the efficacy and integration of medical and mental health crisis services. RC services include, but are not limited to, on-site peer support and system navigation by peer staff, referral and linkage services to the Sacramento County MHP, Primary Care, Substance Abuse and Treatment services, and other community resources, as well as care coordination and after-care planning for Medi-Cal beneficiaries.

Success: Behavioral Health Crisis Services Collaborative

A patient was referred to the BHCSC Crisis Stabilization Unit (CSU) from the Dignity Mercy San Juan Emergency Department (ED) due to symptoms of depression and suicidal ideation. Although he was linked with an outpatient mental health provider, the patient had neither been attending his appointments nor engaging in treatment. He was also experiencing homelessness. Despite having the financial means to afford rent, he was having difficulty getting connected with the right resources and arranging housing for himself. The patient reported that his homelessness exacerbated his depression and only made it more difficult to consistently take his psychiatric medications and follow through with his health care appointments. He expressed the desire to obtain housing and to reconnect with his outpatient case manager, psychiatrist, and therapist. The BHCSC Resource Center (RC) worked closely with the patient to confirm finances through his payee and to complete an interview with a room and board manager. RC staff communicated directly with the patient's outpatient case manager to inform them of the patient's admission and involve them in the discharge planning process. It was arranged for the patient's case manager to pick him up from the CSU at discharge, take him to the pharmacy to pick up his medications, and then to transport him to his new housing placement. The RC scheduled the patient's follow-up appointments for psychiatry and therapy and provided him with mental health crisis resources.

The BHCSC began providing services in September 2019 and is open 24 hours, 7 days a week. The program will serve approximately 4,300 individuals annually (19% TAY, 72% Adults, 8% Older Adults).The program has successfully reduced ED wait times for behavioral health clients and has successfully diverted clients from inpatient hospitalization.

Innovation Project 4: Multi-County Full Service Partnership (FSP) INN Project

The Innovation Project 4: Multi-County Full Service Partnership (FSP) INN Project was supported by the MHSA Steering Committee in FY 2019-20 and was reviewed and approved by the MHSOAC on June 5, 2020. This project is a multi-county Innovation Project that provides an opportunity for counties to implement new data-informed strategies to program design and continuous improvement for FSP programs, supported by county-specific implementation and evaluation technical assistance. The overall purpose and goals of this proposed project are to: (1) improve how counties collect and use data to define and track program outcomes that are meaningful for FSP clients; (2) Develop new and/or strengthen existing processes for continuous improvement for FSP programs; (3) Develop a clear strategy for how FSP outcomes and performance measures can best be tracked and streamlined; (4) Develop a shared understanding and more consistent interpretation of the core FSP components; (5) increase the clarity and consistency of FSP enrollment criteria, referral, and graduation processes. A cohort of six diverse counties are participating and include Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura.

The cohort began efforts with a comprehensive "Landscape Assessment" phase to understand FSP programs, assets, and opportunities. Through various activities, the cohort developed a comprehensive understanding of similarities and differences across all FSP service design, populations, data collection and eligibility practices. Over the next year, the cohort plans to focus on identifying population definitions, outcomes and process metrics, state reporting recommendations. *See Attachment L – California Multi-County FSP Innovation Project Progress Report March 2021*.

Innovation Project 5: Forensic Behavioral Health Multi-System Team (MST)

The Forensic Behavioral Health Multi-System Team (MST) project was reviewed and approved by the MHSOAC in June 2020. The primary purpose of this project is to increase access to mental health services to underserved groups and to promote interagency and community collaboration related to mental health services, supports and outcomes.

This project will serve justice involved, Medi-Cal eligible individuals, 18 years and older, experiencing serious mental illness with significant functional impairment. Individuals may self-refer into the program or be referred by justice partners and Jail Psych Services.

This innovative project will adapt and expand on the Child and Family Team (CFT) model for the forensic behavioral health population. This teaming model has been successfully used in child welfare systems to address the needs of justice and/or foster system involved youth. The CFT is comprised of client, family, natural supports, system partners, and service providers involved in the individual's life. The purpose of CFT meetings is to assemble team members to create an integrated plan in order to determine how to address the client's needs and goals that promote wellness, resilience and placement stabilization. The CFT process is strength-based, client-centered, individualized, collaborative, culturally responsive, trauma-informed, and outcomes-focused.

Adapting the CFT teaming model for the forensic behavioral health population will increase collaborative efforts between system partners, immediate access to needed services, care

coordination with the goal of improving the client experience in achieving wellness and reducing recidivism back to jail. The increased collaboration among system partners and service providers will allow for immediate MJ in-reach and verification of eligible clients prior to release to ensure that they are provided with immediate support.

The Forensic Behavioral Health MST INN Project will utilize the following adapted teaming approach in engaging and collaborating with clients, developing and implementing a coordinated and integrated plan with each client that best addresses the client's needs and goals, monitoring and adapting these plans as necessary, and supporting clients in their progress toward successful community transition and wellness and recovery.

The Forensic Behavioral Health Provider will be responsible for assigning staff as MST facilitators, establishing and maintaining the MST process, and delivering the forensic behavioral health services for all eligible clients. The provider will ensure that staff are reflective of the diverse racial, ethnic, and linguistic populations.

Forensic Behavioral Health MST Composition

MST members share the responsibility to assess, plan, intervene, monitor, evaluate and refine plans, and identify needed services over time. The MST will include the MST facilitator, client, formal supports and natural supports.

The MST facilitator will be a Forensic Behavioral Health Provider staff. The facilitator's primary responsibility is to coordinate and facilitate the MST meetings. The facilitator is responsible for the following: establishing the MST composition based on clients' voice and choice, court and probation requirements, and service needs; developing agendas; scheduling and facilitating meetings; ensuring participation of all team members; holding members accountable for tasks and activities between meetings; and, communicating with members in between meetings as required.

Team members will also include formal supports and system partners, such as the Courts, District Attorney, Public Defender, JPS, Probation, Adult Protective Services, Child Welfare, Behavioral Health Services (BHS), mental health and substance use disorder treatment providers, employment and housing specialists, and Geographic Managed Care (GMCs).

The team will include natural supports identified by the client, such as family, extended family, neighbors, and faith-based representatives. Additionally, the team will include representatives from other support services, such as community mentors, peers, cultural organizations, advocates, educators, coaches, etc. These members will support client throughout the MST process.

The core member of the team is the client. Throughout the MST process, the client will be given priority voice and choice in defining their plan.

MST composition is unique to each client and will be based on their individualized coordinated and integrated plan.

Forensic Behavioral Health Multi-System Team (MST) Structure/Process:
During teaming meetings, MST members will develop an individualized, coordinated, and integrated plan that identifies the client's strengths, needs, interventions, and services that address those needs. This plan is reviewed and reassessed continuously. Team members coordinate and integrate care through consistent and ongoing communication and shared decision making.

MST meetings will result in action plans for members that support the client's goals. At any time, client or MST members may request a meeting should the need arise.

Throughout the MST process, the team will also identify and address the client's criminogenic needs. Criminogenic needs are issues, risk factors, characteristics, and/or problems that relate to the likelihood of the individual reoffending.

Forensic Behavioral Health Multi-System Team (MST) Phases:

Phase 1: Engagement: The Engagement Phase starts just before the client is released from jail or immediately thereafter. During this phase, the Forensic Behavioral Health Provider begins building rapport with clients while orienting and educating them to the MST process and initiates referrals and linkages based on immediate and basic needs identified during screening. The provider will ensure the client is linked to mentors or peers with lived experience for mentoring and peer support.

The provider will assign staff to be the MST facilitator. The facilitator and the client will then identify MST team members. Once MST members have been identified, the facilitator will schedule the initial MST meeting and develop the initial meeting agenda in coordination with other MST members.

Phase 2: Planning: Once the client has reentered the community, Phase 2 begins. In Phase 2, the Forensic Behavioral Health Provider will ensure that a comprehensive biopsychosocial assessment is conducted. This assessment identifies psychological, biological, social factors, criminogenic needs, and needed services and resources beyond what was addressed in the initial screening tool. These assessments, the client, and the MST members will inform the creation of a coordinated and integrated plan.

During this phase, the initial MST meeting is convened. At this initial meeting, the facilitator will orient the client and their support system to the teaming process and integrating planning, introduce MST members, and identify each member's role and responsibility.

At subsequent meetings, with the client taking the lead, the MST will discuss, develop, identify, and document the following in the coordinated and integrated client plan: (1) MST members, roles, and responsibilities; (2) client strengths; (3) client goals and objectives; (4) specific service and resource needs; (5) system obligations and requirements (e.g. Court and Probation requirements); (6) peer supports and other support services; (7) challenges and barriers to accessing treatment and resources; and (8) solutions for overcoming challenges and barriers will also be identified in the plan. The MST will prioritize needs and develop the actionable steps for each MST member that will be included in the client plan. Finally, the MST will agree on meeting frequency and location.

Once the coordinated and integrated client plan and MST meeting structure and schedule has been developed, the MST will move to Phase 3, Monitoring and Adapting.

Phase 3: Monitoring and Adapting: The MST will monitor progress on the integrated client plan and make individualized adaptations or revisions as needed. Additionally, the client plan will be evaluated and reassessed as needed. The MST members will review actionable items and document whether or not they have been completed. The MST will acknowledge milestones and celebrate successes, problem solve challenges, and hold client and members accountable for task completion. Once the client's primary treatment and resource needs are in place, the MST may explore and support client's additional recovery goals. The MST will continue to provide support by planning for release, problem solving what may have led to recidivism back to jail, and plan/prepare for release. Successes, new challenges and solutions, and new actionable tasks will be documented in the client plan. Updates to the client plan may also include, but are not limited to, changes to the MST membership or to the frequency or location of the MST meetings.

Phase 4: Transition: During this phase, the client takes a more active role in their coordinated and integrated plan. During MST meetings in this phase, the MST reviews the client's coordinated and integrated plan to ensure that needed services and supports are in place and that progress has been made on the goals and objectives. The MST has the opportunity to review skills learned by the client and that s/he is engaged in services and resources. Should the client need additional services and resources, the MST will identify those services and resources and define the steps that will be taken to access them. The MST and client will determine if services and resources identified in the coordinated and integrated plan are in place and if the client is able to utilize them independently. These updates will be documented in the coordinated and integrated client plan.

In Phase 4, the MST will initiate a client-driven post assessment to determine readiness for transition to the community. The ANSA will be conducted to identify client needs that have been addressed and skills that have been learned and strengthened. Ultimately, the decision to transition into the community will be client-driven and supported by the MST. As the client transitions from the project services into the community, the MST will support client in transferring to the appropriate level of care should ongoing outpatient treatment be needed. As the client prepares to graduate from the program, the client will be invited to return as an alumnus to provide peer support to other program clients. Additionally, the client will be assured by the MST that they can return any time they feel they need the support of the MST and project services.

Additional Project Services and Elements:

The project will include services and key elements that support the MST process in collaborating, coordinating and integrating the client plan, providing mental health services and supports from engagement to transition to the community. Provider staff will be reflective of the diverse racial, ethnic and linguistic populations that they are serving. Clients will have access to a drop-in center designed as a one-stop shop that will be administered by the Forensic Behavioral Health Provider. The provider will deliver mental health services at the drop-in center. System partners and other service and resource providers, such as probation officers or substance use disorder treatment staff, can co-locate and serve clients here as well. Culturally responsive peer mentoring, peer support, and peer run groups will also be offered at this drop-in center.

Clients will receive a warm hand off from jail to project services at discharge or release any time, including after hours and weekends. The provider will assist client with immediate access to housing and Property Related Tenant Services; access to other needed treatment, such as substance use disorder treatment and medication support; and support with benefits application. After initial engagement, the provider will initiate immediate comprehensive assessment to identify needs (including criminogenic needs), services, and resources to start the integrated planning process.

The provider will deliver other service elements that include 24/7 support from start to graduation from project services. Transportation is another important service element to this project. The provider will offer transportation support to clients at the time of discharge or release from jail and for ongoing needs.

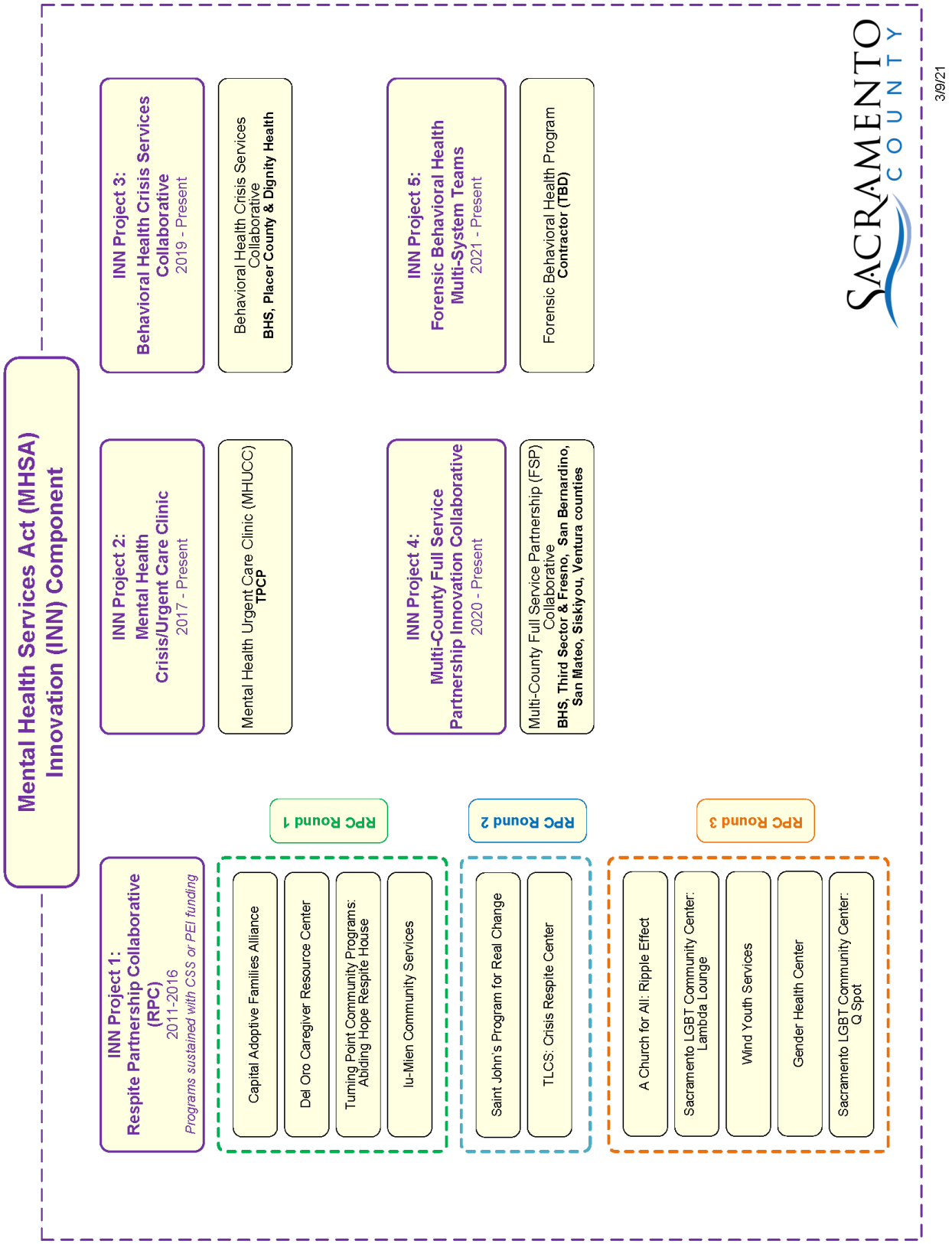
Program alumni will be encouraged to remain involved to provide peer support to other clients. Readmission to project services will be welcomed and client-driven. Finally, the provider will partner or subcontract with organizations with experience in providing culturally responsive peer mentoring and support services that are culturally responsive to this client population.

Mid FY 2020-21, BHS initiated the competitive selection process to seek out organizations interested in collaboratively operating this project. It is anticipated that project implementation will commence in FY 2021-22.

The table below contains the FY2021-22 Cost per Person information for implemented programs:

FY2021-22 INN COMPONENT	Average Cost/Person*	Budget Amount
Mental Health Urgent Care Clinic	$ 509	$ 2,750,657
Behavioral Health Crisis Services Collaborative	$ 1,009	$ 4,338,998
TOTAL		**$ 7,089,655**

*Average cost per person is based on all funding sources in Program divided by program capacity and only includes previously approved and implemented programs.


Mental Health Services Act (MHSA)
Innovation (INN) Component
INN Project 1:
Respite Partnership Collaborative (RPC)
2011-2016
Programs sustained with CSS or PEI funding
RPC Round 1
Capital Adoptive Families Alliance
Del Oro Caregiver Resource Center
Turning Point Community Programs: Abiding Hope Respite House
Iu-Mien Community Services
RPC Round 2
Saint John's Program for Real Change
TLCS: Crisis Respite Center
RPC Round 3
A Church for All: Ripple Effect
Sacramento LGBT Community Center: Lambda Lounge
Wind Youth Services
Gender Health Center
Sacramento LGBT Community Center: Q Spot
INN Project 2:
Mental Health
Crisis/Urgent Care Clinic
2017 - Present
Mental Health Urgent Care Clinic (MHUCC)
TPCP
INN Project 3:
Behavioral Health Crisis Services
Collaborative
2019 - Present
Behavioral Health Crisis Services Collaborative
BHS, Placer County & Dignity Health
INN Project 4:
Multi-County Full Service
Partnership Innovation Collaborative
2020 - Present
Multi-County Full Service Partnership (FSP) Collaborative
BHS, Third Sector & Fresno, San Bernardino, San Mateo, Siskiyou, Ventura counties
INN Project 5:
Forensic Behavioral Health
Multi-System Teams
2021 - Present
Forensic Behavioral Health Program
Contractor (TBD)
SACRAMENTO COUNTY
3/9/21

CAPITAL FACILITIES (CF) AND TECHNOLOGICAL NEEDS (TN) COMPONENT

The **Capital Facilities (CF) Project Plan** was approved in July 2012. The project involved renovations and improvements to the county-owned complexes at 2130, 2140, 2150 Stockton Boulevard. The renovations and improvements of these complexes allowed for the co-location of the MHSA-funded Adult Psychiatric Support Services (APSS), Peer Partner program, and the Mental Health Urgent Care Clinic (INN Project 2).

The Department of General Services (DGS) and the County Architects developed and implemented a Scope of Work that incorporated the community feedback and the necessary Americans with Disabilities Act (ADA) requirements. The construction was completed in late 2015 and the programs have successfully transitioned into the renovated space.

The **Technological Needs (TN) Project** consists of five phases, which began in fiscal year 2010-11, to build the infrastructure necessary to meet Sacramento's goals of the Community Services and Supports Plan by improving integrated services that are client and family driven, meet the needs of target populations and are consistent with the recovery vision in Sacramento County. This project will also further the County's efforts in achieving the federal objectives of meaningful use of electronic health records to improve client care. Per WIC Section 5892(b), Counties may use a portion of the CSS funds to sustain TN projects once the time-limited TN funds are exhausted. Therefore, these activities are being sustained with CSS funding.

There are two Roadmaps to address Sacramento County Technological needs: Sacramento's Health Information Exchange, known as SacHIE (County operated providers and those contracted providers who have chosen to use the County's electronic health record) and HIE (Contracted providers with their own electronic medical record system).

SacHIE Roadmap:

- Phase 1: Clinical Documentation, Electronic Prescribing
- Phase 2: Document Imaging, Consent Management, Billing and State Reporting Electronic Exchange
- Phase 3: Clinical Documentation Exchange
- Phase 4: Laboratory Order Entry and Lab History Exchange
- Phase 5: Health Information Exchange/Personal Health Record Implementation and Expansion

Sacramento County is currently in Phase 4 of the SacHIE project. All of our County Operated providers and those contracted outpatient providers that have chosen to use the County's electronic health record are utilizing an electronic health record (EHR) that allows for electronic requests and responses for mental health services, collection of client demographics, completion of assessments, progress notes, client plans as well as electronic prescribing of medications and claiming for services provided. Sacramento County anticipates the completion of Phase 4 of the SacHIE project by the end of fiscal year 2019-20. Next, the County will begin Phase 5 of the project, which addresses Health Information Exchange/Personal Health Record implementation and expansion.

HIE (Health Information Exchange/Providers with their own system) Roadmap:

- Phase 1: Practice Management, Electronic Prescribing
- Phase 2: Electronic Exchange of Claiming and State Reporting Information
- Phase 3: Electronic Exchange of Clinical Information
- Phase 4: Electronic Order Entry
- Phase 5: Fully Integrated Electronic Health Record and Personal Health Record

Sacramento County has completed Phase 1 of the HIE. All of the contracted providers who have chosen to use their own electronic health record will continue to utilize the County's EHR system to record electronic requests for mental health services, collection of client demographics, as well as electronic prescribing of medications and claiming for services provided until Phases 2 through 4 have been completed. Phases 2 through 5 address electronic exchange of information and are included in the scope of work in Phase 5 of the SacHIE Roadmap.

FY 2021-22 Through FY 2023-24 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary

County: Sacramento Date: 6/18/21

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2021/22 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	75,798,534	12,460,417	11,700,644	2,335,604	3,111,100	
2. Estimated New FY 2021/22 Funding	65,008,342	16,306,386	4,434,010			
3. Transfer in FY 2021/22[a/]	(5,500,000)			1,000,000	4,500,000	
4. Access Local Prudent Reserve in FY 2021/22	0	0				0
5. Estimated Available Funding for FY 2021/22	135,306,876	28,766,803	16,134,653	3,335,604	7,611,100	
B. Estimated FY 2021/22 MHSA Expenditures	68,714,263	20,042,487	6,604,731	1,361,853	4,786,440	
C. Estimated FY 2022/23 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	66,592,614	8,724,316	9,529,922	1,973,751	2,824,660	
2. Estimated New FY 2022/23 Funding	53,359,600	13,339,900	3,510,500			
3. Transfer in FY 2022/23[a/]	(5,500,000)			1,000,000	4,500,000	
4. Access Local Prudent Reserve in FY 2022/23	0	0				0
5. Estimated Available Funding for FY 2022/23	114,452,214	22,064,216	13,040,422	2,973,751	7,324,660	
D. Estimated FY 2022/23 Expenditures	73,494,365	20,175,405	3,000,000	1,378,409	4,836,747	
E. Estimated FY 2023/24 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	40,957,849	1,888,811	10,040,422	1,595,342	2,487,913	
2. Estimated New FY 2023/24 Funding	56,027,580	14,006,895	3,686,025			
3. Transfer in FY 2023/24[a/]	(5,500,000)			1,000,000	4,500,000	
4. Access Local Prudent Reserve in FY 2023/24	0					0
5. Estimated Available Funding for FY 2023/24	91,485,429	15,895,706	13,726,447	2,595,342	6,987,913	
F. Estimated FY 2023/24 Expenditures	73,884,165	20,550,037	3,000,000	1,395,461	4,888,563	
G. Estimated FY 2023/24 Unspent Fund Balance	17,601,264	(4,654,331)	10,726,447	1,199,881	2,099,350	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2021	13,196,792
2. Contributions to the Local Prudent Reserve in FY 2021/22	0
3. Distributions from the Local Prudent Reserve in FY 2021/22	0
4. Estimated Local Prudent Reserve Balance on June 30, 2022	13,196,792
5. Contributions to the Local Prudent Reserve in FY 2022/23	0
6. Distributions from the Local Prudent Reserve in FY 2022/23	0
7. Estimated Local Prudent Reserve Balance on June 30, 2023	13,196,792
8. Contributions to the Local Prudent Reserve in FY 2023/24	0
9. Distributions from the Local Prudent Reserve in FY 2023/24	0
10. Estimated Local Prudent Reserve Balance on June 30, 2024	13,196,792

a/ Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

FY 2021-22 Through FY 2023-24 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Sacramento Date: 6/18/21

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Sierra Elder Wellness	1,834,226	1,025,496	808,730			
2. Permanent Supportive Housing	16,987,118	13,284,451	3,428,967			273,700
3. Transcultural Wellness Center	2,294,988	1,183,371	1,111,617			
4. Adult Full Service Partnership	8,335,539	4,698,424	3,637,115			
5. Juvenile Justice Diversion and Treatment	2,966,530	1,792,739	1,173,791			
6. Transition Age Youth (TAY) Full Service Partr	2,823,989	1,626,241	1,197,749			
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. Transitional Community Opportunities for R	27,707,002	17,480,138	10,226,863			
2. Permanent Supportive Housing	3,409,039	2,056,327	913,938			438,774
3. Wellness and Recovery	5,684,661	3,875,625	784,862			1,024,175
4. Crisis Residential	6,393,998	3,534,721	2,859,277			
5. Children's Community Mental Health Servic	43,081,741	7,733,331	22,970,639	12,377,771		
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	10,508,741	10,423,399				85,342
CSS MHSA Housing Program Assigned Funds	0	0				
Total CSS Program Estimated Expenditures	132,027,572	68,714,263	49,113,548	12,377,771	0	1,821,991
FSP Programs as Percent of Total	60.5%					

FY 2021-22 Through FY 2023-24 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Sacramento Date: 6/18/21

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Sierra Elder Wellness	1,834,226	1,112,146	722,080			
2. Permanent Supportive Housing	16,987,117	13,651,840	3,061,577			273,700
3. Transcultural Wellness Center	2,294,988	1,302,473	992,515			
4. Adult Full Service Partnership	8,335,539	5,088,115	3,247,424			
5. Juvenile Justice Diversion and Treatment	2,823,136	1,911,821	911,314			
6. Transition Age Youth (TAY) Full Service Partr	2,823,989	1,754,571	1,069,418			
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. Transitional Community Opportunities for R	27,810,344	18,495,986	9,314,358			
2. Permanent Supportive Housing	3,426,878	2,172,088	816,016			438,774
3. Wellness and Recovery	5,684,661	3,959,717	700,770			1,024,175
4. Crisis Residential	6,217,961	3,792,774	2,425,187			
5. Children's Community Mental Health Servic	41,368,018	9,577,740	19,412,507	12,377,771		
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	10,760,436	10,675,094				85,342
CSS MHSA Housing Program Assigned Funds	0	0				
Total CSS Program Estimated Expenditures	130,367,293	73,494,365	42,673,167	12,377,771	0	1,821,991
FSP Programs as Percent of Total	55.9%					

FY 2021-22 Through FY 2023-24 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Sacramento Date: 6/18/21

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Sierra Elder Wellness	1,834,226	1,112,146	722,080			
2. Permanent Supportive Housing	16,987,117	13,651,840	3,061,577			273,700
3. Transcultural Wellness Center	2,294,988	1,302,473	992,515			
4. Adult Full Service Partnership	8,335,539	5,088,115	3,247,424			
5. Juvenile Justice Diversion and Treatment	2,828,875	1,917,560	911,314			
6. Transition Age Youth (TAY) Full Service Partr	2,823,989	1,754,571	1,069,418			
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. Transitional Community Opportunities for R	27,916,786	18,602,428	9,314,358			
2. Permanent Supportive Housing	3,445,252	2,190,462	816,016			438,774
3. Wellness and Recovery	5,684,661	3,959,717	700,770			1,024,175
4. Crisis Residential	6,217,961	3,792,774	2,425,187			
5. Children's Community Mental Health Servic	41,368,018	9,577,740	19,412,507	12,377,771		
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	11,019,681	10,934,339				85,342
CSS MHSA Housing Program Assigned Funds	0	0				
Total CSS Program Estimated Expenditures	130,757,093	73,884,165	42,673,167	12,377,771	0	1,821,991
FSP Programs as Percent of Total	55.8%					

FY 2021-22 Through FY 2023-24 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Sacramento Date: 6/18/21

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Suicide Prevention	9,813,402	9,595,296				218,105
2. Strengthening Families	6,103,637	5,746,188	58,911			298,538
3. Integrated Health and Wellness	1,826,781	1,826,781				
4. Mental Health Promotion	1,495,750	1,495,750				
5. Time-Limited Community Driven PEI Program	0	0				
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Integrated Health and Wellness - SacEDAPT	851,126	439,532	380,474			31,120
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	555,197	555,197				
PEI Assigned Funds	383,742	383,742				
Total PEI Program Estimated Expenditures	21,029,635	20,042,487	439,385	0	0	547,763

FY 2021-22 Through FY 2023-24 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Sacramento Date: 6/18/21

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Suicide Prevention	9,826,308	9,608,202				218,105
2. Strengthening Families	6,161,290	5,803,841	58,911			298,538
3. Integrated Health and Wellness	1,826,781	1,826,781				
4. Mental Health Promotion	1,501,302	1,501,302				
5. Time-Limited Community Driven PEI Program	0	0				
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Integrated Health and Wellness - SacEDAPT	851,126	480,297	339,709			31,120
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	571,240	571,240				
PEI Assigned Funds	383,742	383,742				
Total PEI Program Estimated Expenditures	21,121,789	20,175,405	398,620	0	0	547,763

FY 2021-22 Through FY 2023-24 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Sacramento Date: 6/18/21

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Suicide Prevention	10,119,315	9,901,209				218,105
2. Strengthening Families	6,220,673	5,863,224	58,911			298,538
3. Integrated Health and Wellness	1,826,781	1,826,781				
4. Mental Health Promotion	1,507,020	1,507,020				
5. Time-Limited Community Driven PEI Program	0	0				
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Integrated Health and Wellness - SacEDAPT	851,126	480,297	339,709			31,120
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	587,764	587,764				
PEI Assigned Funds	383,742	383,742				
Total PEI Program Estimated Expenditures	21,496,421	20,550,037	398,620	0	0	547,763

FY 2021-22 Through FY 2023-24 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Sacramento Date: 6/18/21

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. N/A	0					
2. Mental Health Crisis/Urgent Care Clinic	2,750,657	1,719,871	1,030,786			
3. Behavioral Health Crisis Services Collaborati	4,338,998	1,884,861	2,454,137			
4. FSP Collaborative	0	0				
5. Forensic Behavioral Health	4,150,000	3,000,000	1,150,000			
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	0	0				
Total INN Program Estimated Expenditures	11,239,655	6,604,731	4,634,923	0	0	0

FY 2021-22 Through FY 2023-24 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Sacramento Date: 6/18/21

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. N/A	0					
2. Mental Health Crisis/Urgent Care Clinic	0	0				
3. Behavioral Health Crisis Services Collaborati	0	0				
4. FSP Collaborative	0	0				
5. Forensic Behavioral Health	4,150,000	3,000,000	1,150,000			
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	0	0				
Total INN Program Estimated Expenditures	4,150,000	3,000,000	1,150,000	0	0	0

FY 2021-22 Through FY 2023-24 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Sacramento Date: 6/18/21

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. N/A	0					
2. Mental Health Crisis/Urgent Care Clinic	0	0				
3. Behavioral Health Crisis Services Collaborati	0	0				
4. FSP Collaborative	0	0				
5. Forensic Behavioral Health	4,150,000	3,000,000	1,150,000			
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	0	0				
Total INN Program Estimated Expenditures	4,150,000	3,000,000	1,150,000	0	0	0

FY 2021-22 Through FY 2023-24 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: Sacramento Date: 6/18/21

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. WET Actions	1,361,853	1,361,853				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0					
Total WET Program Estimated Expenditures	1,361,853	1,361,853	0	0	0	0

FY 2021-22 Through FY 2023-24 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: Sacramento Date: 6/18/21

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. WET Actions	1,378,409	1,378,409				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0					
Total WET Program Estimated Expenditures	1,378,409	1,378,409	0	0	0	0

FY 2021-22 Through FY 2023-24 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: Sacramento Date: 6/18/21

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. WET Actions	1,395,461	1,395,461				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0					
Total WET Program Estimated Expenditures	1,395,461	1,395,461	0	0	0	0

FY 2021-22 Through FY 2023-24 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Sacramento Date: 6/18/21

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. Upgrading System and Architecture Support	4,786,440	4,786,440				
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	4,786,440	4,786,440	0	0	0	0

FY 2021-22 Through FY 2023-24 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Sacramento Date: 6/18/21

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. Upgrading System and Architecture Support	4,836,747	4,836,747				
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	4,836,747	4,836,747	0	0	0	0

FY 2021-22 Through FY 2023-24 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Sacramento Date: 6/18/21

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. Upgrading System and Architecture Support	4,888,563	4,888,563				
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	4,888,563	4,888,563	0	0	0	0

DHCS Form 5510

MHSA Three-Year Program and Expenditure Plan or Update Extension FY 2020-21

Background and Instructions
Welfare and Institutions (W&I) Code section 5847(h), allows a county that is unable to complete and submit a Three-Year Program Expenditure Plan (Plan) or annual update (update) for fiscal year (FY) 2020-21 due to the COVID-19 Public Health Emergency to extend the effective time frame of its currently approved Plan or update to include FY 2020-21, and submit the subsequent Plan or Update on July 1, 2021. This document provides notification to DHCS that the County is extending the effective time frame of its currently approved Plan or Update to include FY 2020-21, per W&I Code section 5847(h). Please enter the requested information in the fields below and submit a completed form electronically to DHCS at MHSA@DHCS.ca.gov.
Section I: County Information
a. Type of Plan or Update: Update
b. Date current Plan/Update was approved: February 11, 2020
Section II: Stakeholder Notification
Stakeholders have been notified that the County is extending the effective time frame of its currently approved Plan or update to include FY 2020-21 as of: 4/16/20 and 7/16/20
Section III: Extension Justification
Provide a brief summary describing how the COVID-19 Public Health Emergency inhibited the County's ability to complete and submit its Three-year Plan or annual update for FY 2020-21. Sacramento County was preparing to conduct the community planning process for the 20-21, 2021-22, 2022-23 MHSA Three-Year Plan when the COVID-19 Public Health Emergency was declared. As we planned to transition to a virtual process, information about the COVID-19 impacts to the economy and subsequently, the behavioral health revenue streams (including MHSA) became apparent. Stakeholders have concerns about the sustainability of MHSA programming in these uncertain times which warrants more discussion and thoughtful planning. Therefore, Sacramento County is extending the timeframe of the current Update to allow for this process.
Section IV: Certification
The undersigned certifies that the information included in this form is complete and accurate to the best of their ability. Ryan Quist — County Behavioral Health Director Signature Ryan Quist, Ph.D. — Printed Name 8/28/2020 — Date

DHCS 5510 (06/2020)

Sacramento County
Mental Health and Quality of Life Response

Community Input on Goals and Design

Purpose

The County of Sacramento engaged community members to gather input on an emergency response for mental health and quality of life crises, including homelessness. This report describes community recommendations for a mental health and quality of life response.

Format

Behavioral Health Services provided the following two options for community input:

- Listening Sessions & Follow-up Survey. Two virtual Community Listening Sessions were held on October 29 and November 4, 2020. A total of 50 County staff from Health Services and other County departments supported the events. After the events, a survey was distributed to participants to identify their background and demographics, as well as collect feedback about their experience of the event.

  To be as inclusive as possible, interpretation was available in the following languages for both events: Arabic, Chinese, Hmong, Russian, Spanish, Vietnamese, American Sign Language (ASL) and Real Time Captioning (RTC). Upon request, interpretation was available in Tagalog for the November 4th event. Mental Health Counselors were also available for both events to provide support as needed.

- Community Input Survey. To accommodate people who were unable to attend a virtual session, an online survey was distributed with the same questions from the listening session and the background and demographic questions referenced above.

The questions asked during the Listening Sessions and on the Community Input Survey were:

A. What do you think the goals for a Mental Health and Quality of Life Response should be?
B. What types of crisis situations would you want this team to respond to?
C. How would you like to access this response?
D. What do people experiencing these types of crises need?
    a) What qualities and skills are important for the response team to have?
    b) Who should be on the response team?
E. What services should the response team be able to provide?
F. What type of follow up support would you like to receive after the crisis?

To gather more feedback about quality of life responses, a conversation with five homeless advocates was held on November 20, 2020. Additional details on the Listening Sessions can be found in Appendix A.

Participants

A total of 568 individuals participated in a Listening Session event (192 participants) or the Community Input Survey (376 participants).

568
Community members provided input about the ideal response to mental health and quality of life crises

Stakeholder Groups

Most participants (84%, 475 people) provided information about their backgrounds and demographics, including roughly half of Listening Session Participants (52%, 99 people).

As shown below, over half of participants had direct personal experience with mental health crises or experience responding to mental health crises as a friend, family member, or provider. Over one-quarter of participants had experience responding to homelessness as a friend or family member, and a few people had direct experiences of homelessness (3%) or worked with people experiencing homelessness as providers or advocates (1%). Additionally, 22% of participants identified as interested community members without any direct experience related to mental health or homelessness; 3% of participants were current or former foster youth; and 2% were veterans.

Participant Backgrounds related to Mental Health and Homelessness

- 57% Friends or family members of someone who has experienced a mental health crisis
- 28% Friends or family members of someone who has experienced homelessness
- 25% People who have experienced a mental health crisis
- 20% Behavioral health (BH) provider or staff
- 3% People who have experienced homelessness
- 2% Member of the Sacramento County Mental Health Board or Mental Health Services Act (MHSA) steering committee
- 1% Homeless service provider or advocate

In addition to the stakeholder groups listed above, participants identified as working in the following professions: Education (12%), Ethnic services provider (3%), Faith-based service provider (6%), Law enforcement (2%), Physical health provider (9%), and Social service provider (19%).

Community Member Demographics

The demographics of participants who completed the demographic survey are roughly proportional to the County population for American Indian/Alaska Native and Black/African American, and somewhat overrepresented for White/Caucasian. The racial/ethnic groups that appear to be somewhat underrepresented among participants are Asian American, Hispanic/Latino, and multiracial, despite targeted outreach to community centers representing these racial and ethnic groups. Future outreach efforts will include a focus on engaging these populations.

Race/Ethnicity	Overall Participants (n=444)	County Population[1]
American Indian/Alaska Native	3%	1%
Asian American, Native Hawaiian and Pacific Islander	9%	17%
Black/African American	10%	10%
Hispanic/Latinx (of any race)*	10%	24%
Multiracial	3%	8%
White/Caucasian	65%	53%

**Note that County Population total exceeds 100% due to the tabulation of Hispanic/Latinx of any race.*

Over three-quarters of respondents identified as female (77%); 21% identified as male; 1% identified as transgender; 1% identified as non-binary or genderqueer; 0.4% identified as intersex, and 0.2% identified as two-spirit.

The primary language of the vast majority of participants was English (97%). Other languages spoken by 1% or less of participants include Spanish, Armenian, American Sign Language, German, Hmong, Portuguese, Mandarin, and Mien.

Next Steps

Per Supervisor Kennedy's guidance to propose alternatives for a Mental Health Response, the next steps for the County are to analyze proposed models and potential pilot approaches; assess cost and determine fiscal options; and obtain Board approval for pilot program by February 2020. A plan will be developed for an advisory board with community member representation to provide input on the response and help inform its development and implementation.

Mental Health and Quality of Life Response: Summary of Community Input

The top themes that participants identified for a Mental Health and Quality of Life response are as follows:

Goals for a Mental Health and Quality of Life Response (p. 5)

1. Safely de-escalate crises.
2. Provide linkages to accessible and affordable mental health resources to decrease repeat crises and emergency department visits.
3. Offer a response team that does not include law enforcement staffing.
4. Ensure the model is community-based.
5. Decrease criminalization of mental health and homelessness.

Types of Crises (p. 8)

- Mental health/psychiatric
- Substance use
- Domestic violence and sexual assault
- People experiencing homelessness
- Other crises (e.g., welfare checks, child and vulnerable people protection, elder abuse)

Access to the Response Team (p. 9)

New 3-digit emergency phone number that is independent from 911

"No wrong door approach" to access the response team through existing service phone numbers (e.g., 211, 311, and 911)

Include language interpretation and ability to access via a website

Response Team (p. 9)

Composition

1. Mental health clinicians
2. Peers with lived experience
3. Social workers
4. Medical clinicians

Skills and Expertise

- De-escalation
- Trauma-informed
- Background in behavioral health
- Responsive to race, culture, gender & disability

Crisis Services (p. 13)

- Housing & shelter
- Mental health assessment & services
- Food, water & other survival needs
- Medical care & medication
- Crisis stabilization & respite centers

Follow Up Support (p. 14)

- Ongoing follow up & case management to connect individuals to services and social support
- Transportation & financial assistance
- Wraparound services; including family & loved ones in the follow up planning
- Needs assessments for people experiencing homelessness

Key Findings

For each question, the most commonly selected responses (up to 5 themes per question) are highlighted and described. Illustrative quotes for the main themes are also presented.

A) Goals for a Mental Health and Quality of Life Response

The top 5 overall goals that participants identified for a Mental Health and Quality of Life response are as follows:

1. Safely de-escalate crises.
   This includes ensuring physical and emotional safety by de-escalating and stabilizing the crisis with compassion and without the presence of weapons. It also includes efforts to maintain a safe environment and conduct safety planning. In addition, some participants mentioned providing resources to family members and loved ones to help address the needs of the individual in crisis.

2. Provide linkages to accessible and affordable mental health resources to decrease repeat crises and emergency department visits.
   This includes assessing individuals' needs and the circumstances that led to the crisis, then supporting them in accessing ongoing, affordable care for mental health and/or substance use. It includes providing case management services and following up as needed. Some participants also advised that this should include free, COVID-19-safe transportation to receive mental health care and wrap around services.

3. Offer a response team that does not include law enforcement staffing.
   Participants described a variety of crises, including some personal experiences, for which a law enforcement response was not warranted or well-suited. They suggested an unarmed mental health response team that is separate from law enforcement to respond to mental health and quality of life crises.

   Some people indicated that skilled mental health professionals can de-escalate aggressive individuals experiencing mental health crises, and others indicated that law enforcement presence was necessary for violent situations.

4. Ensure the model is community-based.
   This refers to staffing the response team with community-based organizations and connecting individuals to community-based services including mental health care. Participants described a need to focus on serving individuals in the community while avoiding hospitalization or incarceration.

   Some participants specifically referenced existing community-based organizations that are currently addressing these crises, particularly "Mental Health First." Some participants also recommended that a community advisory board be established to provide input on the response design and implementation.

5. Decrease criminalization of mental health and homelessness.
   This refers to diverting people experiencing mental health and quality of life crises from police contact, arrest, and incarceration.

Participant Quotes for Mental Health and Quality of Life Response Goals

Goal	Participant Quotes
1. Safely de-escalate crises	"The goals should be to primarily deescalate the situation in a non-violent way. The team responding should show compassion and not be threatening in any way. The person in crisis needs to be respected." "Maximizing care and minimizing threat - definitely no armed response in the absence of obvious peril to others." "Helping the person in crisis deescalate so they're safe in the moment, provide no-pressure options for connections to resources specifically related to their mental health and/or quality of life crisis that they can access right away or at a future time."
2. Provide linkages to accessible and affordable mental health resources to decrease repeat crises and emergency department visits	"The goal is to 1. Assure the person in crisis is in a safe environment, and 2. The person in crisis (and family or caretakers) have clear options for addressing the health crisis that are affordable and realistic." "Safety plans made in case of potential future crises and/or threat to others or one's self, clear explanations as to how to access MH care and how to navigate paying for it." "Basic needs being met first, then follow up with dignified mental health care and/or addiction treatment and personalized advice/counseling to come up with a long-term plan."
3. Offer a response team that does not include law enforcement staffing	"People respond better to peer support rather than law enforcement. A mobile integrated model with clinicians, peers, and substance use disorder specialists should be used to avoid emergency room visits or jail." "Any incident where there has not been a report of violence, for example, a domestic disturbance call from a neighbor or family member where there's only a report of raised voices but not violence, should get a community services response, not an armed response from police. Police have too much on their plates already - they're playing family counselor, mental health therapist, and nurse all at the same time. Saving armed responses for potentially violent (where credible specific and direct threats of violence have been made) or violent situations would be advisable." "As someone who works in mental healthcare, I am often confronted by aggressive, occasionally violent individuals experiencing a mental health crisis and I am trained how to respond without further escalating the situation or pulling a gun. This is what we need in the community."

Goal	Participant Quotes
4. Ensure the model is community-based	"Connect with community supports to help me navigate after the immediate crisis has passed." "Need to be from the community and familiar with the community. Continue services and invest in programs like Mental Health First, Street Team EMS doctor." "Coordinating with agencies who already have a relationship with community (i.e., La Family, Hmong) members in a joint response to resolve the crisis." "Implement a community advisory board with impacted people to inform the design and implementation of an alternative, non-law enforcement response for mental health and homeless needs."
5. Decrease criminalization of mental health and homelessness	"Eliminate situations where people with mental health crises are being put in County Jail-that is not going to help. First point of contact should be with MH professional who can help take you to the right place." "It's important to not criminalize mental health issues." "Respect and kindness from a responder with primary expertise in mental health; not a first responder with primary expertise in criminal activity." "Goal #1: Make sure we have resources through this line that have a response team that will treat anyone going through a mental health crisis with respect and care and get them the resources they need (instead of going to incarceration)."

Personal Stories

Several participants shared personal stories that illustrate the key themes, as demonstrated by the following excerpts:

"I am a Family Medicine physician living and working in Sacramento. I strongly support having an alternative response to calling 911 for people who are experiencing a mental health crisis. As a physician, I have seen countless times when calls to the police or to security escalate a tense situation rather than deescalating. Simply seeing officers in uniform trigger patients and it becomes much more difficult to provide the care that they need. Every time I am called about an agitated patient, I request the police/security to stay outside of the room and out of view so that I can talk with the patient in a calm environment without fear. I have not been afraid of harm to myself and if I or another health care provider is able to talk with the patient, we are often able to deescalate. It is much harder to deescalate when the police/security are present and creates more safety concerns for all parties involved."

Personal Stories (continued)

"…When I was going through an episode I was scared, and the cops scared me more. I was aggressive because I was scared."

"Recently, a patient of mine was concerned that their loved one has not slept in 5 days and they were saying things that didn't make sense. This person seemed to be hearing and seeing things that nobody else did. The family member had tried calling the person's primary care doctor but there were no available appointments, and they are becoming increasingly worried that their loved one would hurt themselves or get worse. So they call 911, the police show up, when the person wouldn't engage with them, the police attempt to arrest this person and when this person resists arrest, they had to restrain him which ultimately lead to him breaking his arm and being put in county jail with a broken arm.

In my opinion: what this person needed was someone to listen with undivided attention to understand where they were mentally and their families concerns. Then a plan needed to be developed as to how to get this person who was clearly in a mental health crisis into medical care. The family would have benefited from reflective listening in nonjudgmental way, take time to understand the root of the crisis and affirm the complex factors that have played into getting this person where they are.

When this person resisted arrest, as to be expected, using techniques to deescalate if someone is in crisis or making threats would have been helpful. You want someone who understands resources available and can explain how to access options as well as refer you to a higher of level care when needed."

B) Types of Crises to which the Team Should Respond

The majority of participants indicated the response team should ideally respond to mental health, psychiatric, and substance use crises. Many people also noted it would be helpful for the response team to address situations involving domestic violence and sexual assault, people experiencing homelessness, and other types of crises including welfare checks, child protection, vulnerable people protection, and elder abuse.

As one respondent described:

> *"Respond to suicidal threats, odd behaviors, delusions, hallucinations, or angry behavior that may make community members feel uncomfortable. Families calling about family members who are not eating, self-isolating, not taking care of themselves; elder abuse.*
>
> *Do not think they should respond to people with weapons or domestic violence due to safety concerns. Perhaps give people who call for domestic violence the option of law enforcement or social worker coming out to support."*

C) Access to the Response Team

Most participants expressed a need for a new 3-digit emergency phone number that is independent from 911 to dispatch the mental health and quality of life response. Some participants also noted that it would be helpful to also utilize a **"no** wrong door appr**oach,"** so people are able to access a mental health and quality of life response team through existing service phone numbers such as 211, 311, and 911.

Some participants advised that the access line should include language interpretation. Several participants noted that they would like access via a website, and that it would be helpful to publicize the new number through a communications campaign.

Quotes that illustrate these key themes include:

> *"Definitely explore alternatives to 911 that is a dedicated 3-digit number; online data entry/intake form available that may be able to be addressed the next day & needs to be a commitment to respond within 24-48 hours vs the community member needing immediate help."*
>
> *"An alternate phone number for mental health INSTEAD OF 911 is of vital importance. Law enforcement has their hands full with criminal calls with the mental health element. Lessen their burden with an alternative phone number!"*
>
> *"Those in crisis need to know that they can get better, they will get better, there are resources in the community that can help and help ASAP. An UNARMED response team available 24/7 (as opposed to the current team that is only available during business hours) that has a licensed mental health professional AND a social worker (therapist are not trained to be a community navigator)."*
>
> *"Independent dispatch systems, not connected to law enforcement, that give immediate and low barrier access to services. The #1 priority reflected in People's Budget survey data is community-based mental health support. This requires an independent emergency phone number and 24/7 dispatch system so communities can feel safe to call it during crisis, and not fear potential interaction with law enforcement."*

D) Mental Health and Quality of Life Response Team

Response Team Composition

The majority of participants recommended the following composition for a multi-disciplinary response team:

1. Mental health clinicians with psychiatric expertise to assess mental health, access mental health records, to connect individuals to providers within the system of care.
2. Peers with lived experience who can build rapport and support the individual experiencing crises.

3. Social workers who are knowledgeable about community resources and can conduct warm hand-offs, case management, and support access to benefits and housing.
4. Medical clinicians who can conduct medical assessments as well as provide emergency psychiatric medications with a doctor's order. Some participants noted a clinical health background helps address physical health issues that may accompany or underlie mental health crises.

Response Team Role	Participant Quote
1. Mental health clinicians	"Someone who is qualified to interview or have a conversation with the person to 'listen' and 'hear' them. Only a qualified therapist/ counselor/psychiatrist can really understand what a person in distress is trying to communicate or what type of mental health issue is causing adverse behavior." "…clinical skills and access to [mental health records] to be able to see if part of the system – can reach out to outpatient provider if linked and quickly connect to help avoid having to send to the emergency rooms. Able to connect to services in the community. Clinically, be able to know what we're looking at – assess what's happening (psychosis, depression, etc). Ability to demonstrate empathy and engagement." "Trained mental health professionals and social workers are able to recognize how a person is behaving and are more skilled in judging if someone is likely to hurt themselves or others, or if they just need resources, care, or advice in their time of crisis."
2. Peers	"In this team there needs to be some peer support and lived experience. Need to be trained and attuned to the system they are responding to and the dynamics of the family system and community system." "It's incredibly important that the people who show up on these calls, look like normal people and talk like normal people. Having that peer support person with lived experience is important." "Increase role of peers and community health workers specifically communities that are underrepresented, those impacted by socio-economic status, and racial and cultural stressors, and systemic oppression and interpersonal violence. Those with these experiences can take the lead as peers and community workers to deliver these services in a way that meets people where they are at."
3. Social worker	"Social workers who know the community's resources well and are not going to give them a piece of paper." "They need social workers! They need people that are able to understand their behavior and not respond with deadly force when it's unnecessary. They need people trained to LISTEN FIRST. They need people flush with knowledge of local community agencies to

Response Team Role	Participant Quote
3. Social worker (ctd.)	assist them with mental health care, housing needs, medical problems, financial resources such as assistance with SSI, etc."
4.Medical providers	"Able to have live remote access to a physician in case pharmaceutical intervention is needed." "They need trained mental health professionals; EMS personnel who can assess for and administer field care for things like substance overdose; and non-triggering supportive administrative staff (e.g., those who can get them access to needed services)."

Response Team Skills and Expertise

Participants most commonly cited the following skills and expertise as important for the response team to possess:

1. De-escalation. This refers to the ability to keep people calm and safe without the use of force.

2. Trauma-informed. Participants described this as being compassionate, listening without judgment, validating feelings, and respecting individual's choice and control. This skill helps to stabilize the crisis situation while avoiding potential triggers and minimizing additional trauma. Some people also mentioned the need to be aware of different types of trauma (e.g., complex, historical, and intergenerational traumas) and how they affect mental health crises.

3. Background in behavioral health. This refers to knowledge, experience, and training in mental health and substance use to recognize symptoms, assess their severity, and provide the appropriate response.

4. Responsive to race, culture, gender and disability. This includes multicultural and multilingual response teams that understand implicit bias and are able to respond to specific needs related to race, culture, and gender with humility. Some participants also described the importance of ensuring the response team is equipped to identify and meet the needs of specific populations, including people with disabilities (e.g., intellectual and developmental disabilities), youth, and older adults.

Skill/Expertise	Participant Quote
1. De-escalation	"The response team should be made of professionals who are trained and skilled in providing de-escalation tactics, calming the situation, and providing supportive mental assistance. This first step may be the difference between life and death, and great care, at any expense, is worthwhile to get it right the first time. After that, the appropriate post-crisis services can be provided." "They probably want to know that someone cares about them and that they aren't only perceived as a threat. They need someone who will help them feel safe and be able to get to a safe place."

Skill/Expertise	Participant Quote
1. De-escalation (ctd.)	"Someone who is calm, approachable, knowledgeable about MH crises and empathetic. I worked in one of the most intensive outpatient settings in Sac County and deescalated everything under the sun with no harm done. I am a LCSW."
2. Trauma-informed	"I really think that the most important skill is being nonjudgmental. I'm here to listen. I'm still going to treat you with some respect and dignity. Allow the person time to communicate their needs and wants during the crisis." "Training that includes being trauma-informed […] maintaining a holistic approach to offering a person culturally sensitive emotional, mental and physical safety with dignity, compassion, care and choice that reflects their path toward recovery. This can mean a faster, more complete recovery, especially with early intervention." "People in these situations are often met with judgement and treated less humanely than other members of our community. Responders should have trauma training as well to avoid re-traumatizing people while attempting to provide assistance." "Trauma informed response team, and one that understands the unique needs of the population. Efforts made to reduce law enforcement involvement to reduce fear of punishment and additional triggers that may escalate the situation."
3.Background in Behavioral Health	"They need expertise and compassion - someone level-headed and familiar with common symptoms of mental distress with knowledge of how to best respond. Likely medical professionals / mental health experts." "Need people trained in mental health, addiction, and compounded trauma response. Persons on a crisis team need to be aware of Spectrum of Intervention for Mental Health Problems to measure and assess how best to assist with dual diagnosis and co-morbidities."
4.Responsive to race, culture, gender and disability	"Having folks from diverse backgrounds are important. Race, gender, sexuality, languages." "Our county is large and has large cultural population groups – make sure we are responding to trauma and cultural and linguistic needs of different populations and subpopulations." "People responding […] who understand racial bias deeply and have done their own work, and who work to make a genuine connection with the individual."

E) Crisis Services

The most frequently described services that participants indicated the response team should be able to provide are:

1. Housing and shelter suitable to individual's needs and utilizing a housing first approach.
2. Mental health assessment/evaluation and services that individuals may be referred to after an evaluation. Some people described the importance of transportation assistance and peer accompaniment to mental health and substance use treatment services.
3. Food, water, and other survival needs. This includes providing a meal, water, and other items needed for survival to respond to an individual experiencing mental health and/or quality of life crises.
4. Medical care and medication. This includes immediate medical services for urgent needs, connection to ongoing physical health care, and assistance accessing medication.
5. Crisis stabilization and respite centers. This includes 24/7 drop-in centers where people can access mental health care and safety while intoxicated or under the influence of substances.

Service	Participant Quote
1. Housing and shelter	"Homeless: Great if there was availability to help homeless individuals resources they need to get them housed (i.e., access to shelters, temporary housing). Access to immediate resources"
	"Meet people where they're at with relevant and safe housing and services. They need to be non-punitive and without coercion to be successful."
	"We need more affordable housing, employment training programs, and robust mental health and substance abuse programs. The lack of inventory of housing and services available is what leads to the issues needing alternatives to calls to 911."
	"The obvious answer is a home. In the event of a crises they need medical attention, social work, a safe place to store belongings and shelter for pets. When people living on the streets need medical attention, they have to worry about what will happen to their belongings."
2. Mental health assessment and services	"Immediate access to counseling and wellness services."
	"Consistent availability of support services, i.e., regular counseling available weekly to address mental health factor and reduce the likelihood returning to crisis functioning (once a month does not cut it, nor does a 15-minute check in), Psychiatric assessment of mental health/meds assessment. Assessment of life issues contributing to the crisis instability (inconsistent availability of housing, food, social support system, etc.)."

Service	Participant Quote
3. Food, water, and other survival needs	"Provide food, water, on the spot health care, and an assessment of their support system, social contacts. Connect with those people and work with them for support, survival, coupons to fast food, etc." "Give people a bottle of water, a sandwich. The first moments will dictate how the situation will go." "For me, as an outreach worker, it's really important to have concrete things to offer people (car ride, etc) and to have flexibility." "Many do not believe they are mentally ill, so we need to offer other support services like shelter and food or money to bring them along to a place of trust where they will accept medication and therapy and coaching. Contact family members or friends if possible."
4. Medical care and medication	"See if they have any urgent medical issues or have alcohol or other drug issues that need attention." "I don't think every mobile team would need a health professional, but there should be one to access when needed. That way people wouldn't need to go the ED for medical clearance [before accessing the Mental Health Treatment Center]."
5. Crisis stabilization and respite centers	"A safe place to go like local 'urgent care clinics' that only specialize in behavioral health issues that are easily accessible when you have an immediate need for this type of help and where people that are trained in behavioral health can see patients to more easily follow up with after a crisis. Hopefully having better support would prevent some of the crisis situations. I have just in the last 36 hours taken my husband to a local hospital for his 2nd 5150. There are no beds available. He is now in crisis sitting in the busy emergency room where it is noisy and a lot of people coming and going. Literally the last place I want to take my already physically health compromised husband with an added mental health crisis needs during a pandemic to get treatment, i.e., drugs, to help control his mania. We sat in the ER waiting room from 10 PM to 4 AM until there was even a bed available in the ER and then other than taking his blood pressure, no one came to see him until another 6+ hours later. We can do better for all health issues, not just behavioral health issues."

F) Follow Up Support After the Crisis

The majority of participants indicated that ongoing follow up and case management is needed to ensure individuals are connected to support networks and services and to prevent mental health and quality of life crises from reoccurring. Many participants also recommended providing transportation and financial assistance to help individuals access needed services. Other specific types of follow up that participants described included support rebuilding social support systems and including family and loved ones in the follow up plan; wraparound services; needs assessments for people experiencing homelessness; and job support services.

Quotes that illustrate these key themes include:

> *"Safe, rapid response with comprehensive follow-up care and case management to prevent future crises."*
>
> *"Given the limited availability of housing/program openings, consistent case management is needed for providers to stay in touch with individuals and help them get through the process, such as applying for social security and Medi-Cal, etc."*
>
> *"Follow up should include mental health service coordinator and someone who facilitates the bridge between short term and long term care (options for housing, access to rehab, job services – whatever that definition of stability is to them). Mindfulness and coping has everything to do with long-term care."*
>
> *"Help with treatment of ongoing medical and mental health issues; help with integrating into the community, staying housed, job training, transportation, healthy food, help with obtaining documents, bank accounts, child care-rebuilding the support structure that enables one to successfully navigate life."*
>
> *"Mental health resources must remain in place indefinitely; these are often conditions that may require a lifetime of treatment and access to medication. Without ongoing support individuals will be unsuccessful in their recovery."*
>
> *"Crisis is over but the underlying reasons are still there. A follow up in person or by phone directing the individuals and family members involved to community resources that can help to alleviate the root causes of their mental health incident, such as financial assistance, healthcare access, medication management, employment aid, counseling services, childcare services, and outpatient services."*
>
> *"This is the reason for case management: someone to check back in. People easily slip back into isolation and need resources. Asking them what type of support they need or connections they want in the community."*
>
> *"Assistance getting to pharmacy to get meds, getting to appt, ability to get to Urgent care if needed. Pts need to feel they have options to get the resources they need, they often feel 'alone' to figure out the next steps of stability after short hospital intervention"*
>
> *"Feeling a sense of being connected to the process-even a card given to the person who was in crisis or an email, text message, letter in the mail. Follow up communication to let people know that they were seen and it is important that their issues are heard and hopefully solved. The person can choose the level of follow up (are you good or do you want us to continue to reach out a few days later, then a week to 14 days later, then a month later?) so they do not feel like they have been forgotten."*

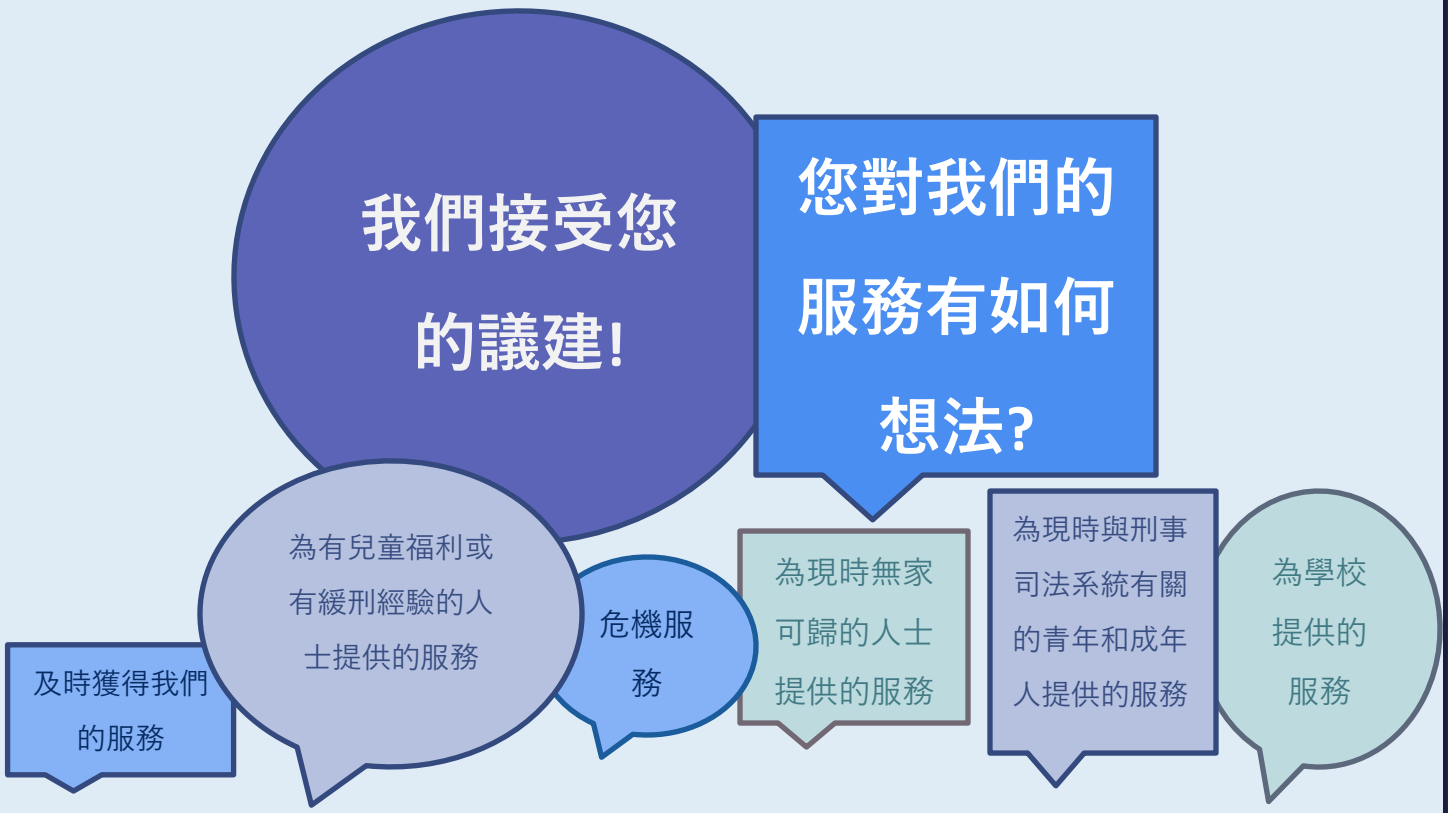
Appendix A: Community Listening Sessions and Input Survey

The Listening Sessions events consisted of a welcome and overview by Jenine Spotnitz, a Program Planner from the Department of Health Services; introductory framing by Bruce Wagstaff, the Deputy County Executive for Social Services, and Dr. Ryan Quist, the Director of Behavioral Health; followed by breakout group discussions with community members (see page 1 for the questions discussed during the breakout groups).

Process Measures	October 29, 2020 Event	November 4, 2020 Event	TOTAL
Number of participants	80	112	192
Number of staff	30	38	50
Number of breakout groups	12	22	34

The Listening Sessions and Community Input Survey were publicized via the Behavioral Health website, County's social media accounts (i.e., Facebook, Twitter, NextDoor), Public Health Twitter, Countywide Event Calendar, Behavioral Health website, Continuum of Care listserv, MHSA listserv, Cultural Competence Committee and Supporting Community Connections mailing lists.

[1] Be Healthy Sacramento. 2020 Demographics. http://www.behealthysacramento.org/index.php?module=DemographicData&controller=index&action=index



BEHAVIORAL HEALTH SERVICES

粵語社區對話

與 SACRAMENTO COUNTY
DIVISION OF BEHAVIORAL HEALTH SERVICES

Asian Pacific Community Counseling **7273 14th Ave #120b, Sacramento, CA 95820**	**December 12** **6:00 PM – 7:30 PM**	**將會有食物提供**

想了解更多信息或預訂登記, 請聯絡 Debra 潘小姐 916-388-4758

如果您想參加並需要安排其它合理要求, 請聯絡 Trang Hoang (916) 876-8804.

SACRAMENTO COUNTY

BHS Community Conversation – Cantonese speaking community
Minutes of the meeting 12/12/2019 (Feedback and Ideas)
Attendance: 13
Facilitated in Cantonese by Debra Poon (APCC)

I. Introduction regarding to the Events
3 Main Topics
1. Discussion on Mental Health Services
2. Improvement in the future
3. Questionnaires

II. Questions on improvement
1. Has the county improved on mental health services via APCC?
   a. The county has done very good to various ethnicity. We need more similar kind of agency to provide these kind of services.
   b. We have less knowledge and lack of information on mental health and resources to understand mental health
   c. We have less information regarding to specific services on mental health.
   d. We need a place where everyone can come to look for services including more advertisement and outreach.
   e. At school, it is much harder to look for Mental health information. We need a specific place to outreach to and finding services.
   f. Some non-API place has better mental health services than Asian Pacific Islanders facility.
   g. Nowadays, A lot of our children has hidden feelings, and their mental health is unstable.
   h. The parents should be aware of the children feeling to avoid gun violence's.
   i. Thank you for the services that provided to us

One participant asked

What is your agency stand for? APCC – Asian Pacific Community Counseling.

What services are servicing the community?
Answers: Mental health, prevention, computer class, and other general services through SCC.

Questions on Improvement continues….

a. There are services that we need including provide verbal translation, documents. There is only one services that I know so far. So we need more agency to provide services like APCC.
b. Our Sacramento county needs to provide more basic services to our community.
c. We need more mental health services, and most of the time we don't know where to look for.
d. Recent year of gun violent, we need more agency to inform us of mental health issues and provide us with basic information.
e. If I have a family member who has mental health, can I bring him/her to APCC?

a. We will have to refer them to Access Team.

f. We need a direct line for our community, so we don't get confuse easily.

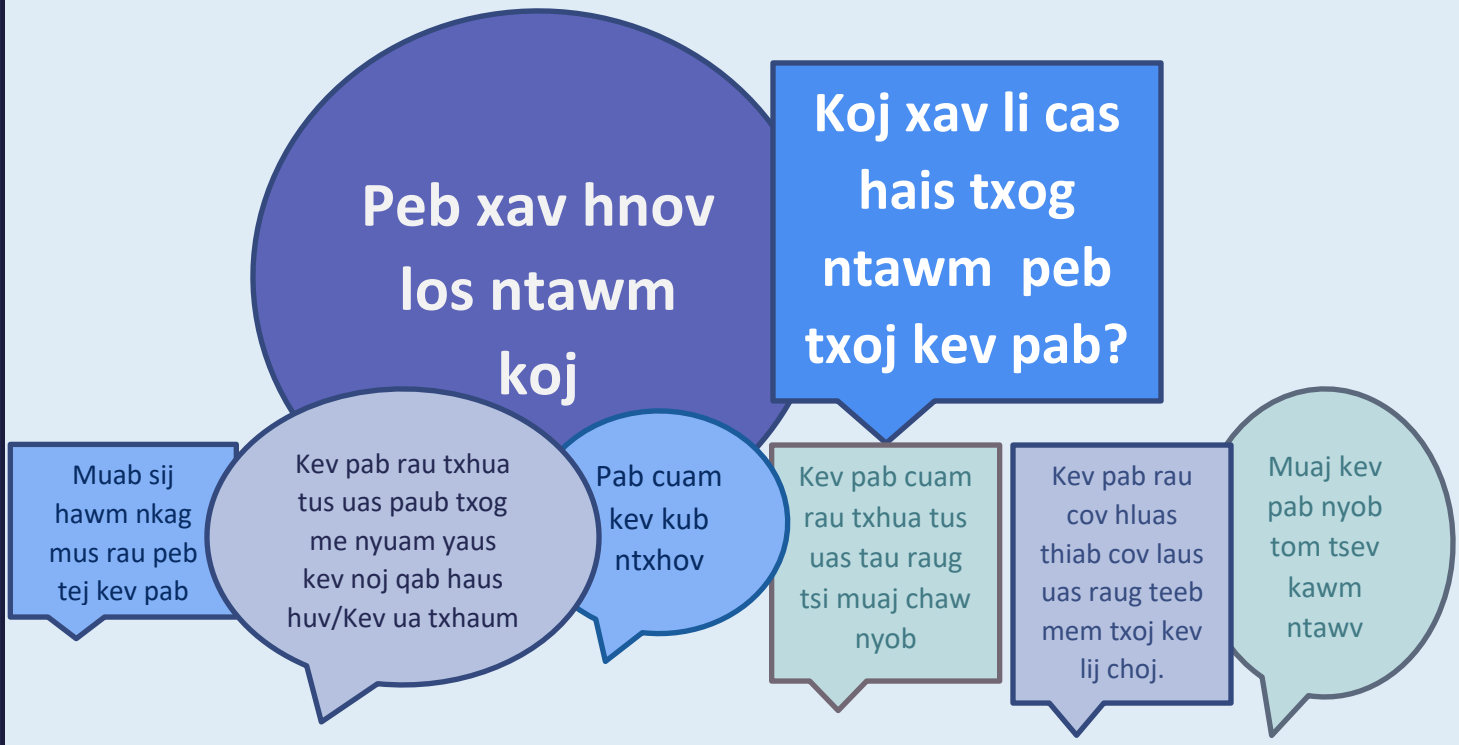
g. Sacramento county is acknowledging how important of mental health and address the issue seriously

III. There is improvement need for our community.

a. We need more people who speak different languages.
b. We need volunteers who are willing to help our community.
c. Raise awareness of services provide at agencies.
d. The downtown agency has Spanish and other language but there is limited Cantonese language to assist us.
e. Family members has to acknowledge that mental health information that available.
f. Don't take patients to hospital but it will be better for them to take to mental health agency for help.
g. Doctors have to explain to family members and suggest them to take client to see mental health.
h. I used to have mental health, I suggest family to understand and embrace us.
i. Family has to counseling their family member and understand the mental health, support, and accept them.

How and where to outreach to our community?

1. School
2. Social apps
3. Supermarket
4. Flyers
5. Booth at farmer market
6. Temple
7. Church
8. Television



BEHAVIORAL HEALTH SERVICES

COV NEEG HMOOB ROOJ SIB THAM

NROG SACRAMENTO COUNTY
DIVISION OF BEHAVIORAL HEALTH SERVICES

ADULT PSYCHIATRIC SUPPORT SERVICES (APSS) **2130 Stockton Blvd, Suite 100** **Sacramento, CA 95817**	**12 Hlis Ntuj, Nub Tim 5** **9:00 AM – 10:30 AM**	**YUAV MUAJ ZAUB MOV LOS SIS KHOOM TXOM CAUJ NOJ**

Yog xav paub ntxiv los sis koj npaj yuav tuaj koom qhov kev sib tham ntawm no, thov hu rau Norbee Xiong ntawm 916-875-0969

Yog tias koj xav mus koom lub rooj sab laj no thiab xav tau neeg txhais lus los yog kev pab, thov hu tau Trang Hoang at (916) 876-8804.

SACRAMENTO COUNTY

Hmong Community Conversation Summary

Adult Psychiatric Support Services

December 5, 2019

Number of Attendees: 14

What is working?

Having bilingual/bicultural providers, who are patient, supportive, understanding, and kind help to improve clients' mental health, and prevent clinical decompensation and further crisis.

Access to Psychiatrists who are compassionate and having psychotropic medications help clients to manage their mental health symptoms and maintain their current level of stability.

Cultural/ethnic specific support groups, provided by bilingual/bicultural providers, help to reduce isolation, increase sense of belonging, and improve overall mental health and wellness.

Behavioral health services provided in school help children/grandchildren when they are having difficulties.

What can be improved?

Education to help consumers, family members, community members and system partners to understand about available behavioral health services, patients' rights, and how to navigate the Behavioral Health Services System. Education will also include a thorough explanation of what behavioral services look like and culturally appropriate psychoeducation to help consumers and family members understand their diagnosis. Education will also need to include helping consumers and family members to know what to say when contacting law enforcement during crisis.

Education for providers to increase their awareness of cultural nuances when it comes to behavioral health services and how clients' perception about providers' expertise influences engagement and treatment. Education also needs to address how western practice of checking in with clients may create confusion for the client.

> "I get psychiatric services because I'm stress and I tell my doctor I'm stress but when I go to my appointment, the Psychiatrists still ask why am I here, so if you don't know why I'm here then why am I here?"

Include front line staff from diverse communities in the development or planning phase of events to get their buy-in and help spread the words about County sponsored events and to inform consumers and community members that bilingual/bicultural staff will be present and interpretation services are available at no cost to them.

Reduce wait time for authorization to behavioral health services

Improve law enforcement's response time in during crisis and ensure law enforcement have access to bilingual/bicultural staff or phone interpreters available to effectively communicate with non-English speaking individuals during crisis.

Allow providers to integrate culturally appropriate and community defined promising practices when providing Behavioral Health Services (i.e. conducting behavioral health support services outdoors in nature, hosting group outings out in the community, and providing participants with small stipend to make purchases during events)

Increase the number bilingual/bicultural staff to provide behavioral health support services.

Reduce system navigation barriers by allowing clients to have easy access to a Hmong phone operator instead of having to press so many different buttons to get to the right person.

BEHAVIORAL HEALTH SERVICES

Iu-Mien Community Conversation

WITH SACRAMENTO COUNTY
DIVISION OF BEHAVIORAL HEALTH SERVICES

IU-MIEN COMMUNITY SERVICES **6000 Lemon Hill** **Sacramento, CA 95824**	**DECEMBER 11th** **9:00 AM – 10:30 AM**	**FOOD WILL BE PROVIDED**

For more information or to make a reservation, please contact Kao Thun at (916) 383-3083

If you wish to attend and need to arrange for a reasonable accommodation, please contact Trang Hoang at (916) 876-8804

SACRAMENTO COUNTY

Facilitation Plan Overview
Facilitator's Version

Background: Sacramento County Division of Behavioral Health Services (BHS) conducted two Behavioral Health Town Hall meetings in July and August to gather community input. Approximately 60-80 consumers, community members and providers attended each meeting and provided their feedback. However, individuals from Sacramento County's diverse communities were not well represented. We are here today because we are interested in hearing the feedback and ideas from consumers and family members in the Iu-Mien community.

Goal: The goal of the Iu-Mien Community Conversation is to gather your feedback and ideas about the current Behavioral Health Services System.

Feedback: The feedback of the Community Conversations will influence current priorities and inform future needs for the Behavioral Health Services System.

Questions:

1) **What is working?**
    a. What are some of the things that Sacramento County is doing well when it comes to providing behavioral health services?
    b. *Optional* questions:
        i. When you've experienced a mental health crisis and had to go to the ER, Mental Health Urgent Care Clinic, or Psychiatric Hospital, what was most helpful/effective?
        ii. If you've experienced homelessness and received behavioral health services, what were some of the services you found most helpful?
        iii. When seeking behavioral health services, what was most helpful/effective for you?
        iv. If your child received behavioral health services while at school, what was most helpful/effective?
        v. If you/your child received behavioral health support services while involved with Child Welfare or Probation, what was most helpful/effective?
        vi. If you/your child received behavioral health and other support services while in Juvenile Hall, County Jail, and/or the State Prison, what was most helpful/effective?
2) **What can be improved?**
    a. What are some of the areas that Sacramento County can improve on when it comes to providing behavioral health services?
    b. What do you think are getting in the way of people accessing behavioral health services?
    c. What are some of the behavioral health services that you wished you received but were not available to you?
    d. *Optional* Questions:
        i. What can be improved when it comes to behavioral health services for individuals experiencing homelessness or crisis?
        ii. What can be improved when it comes to accessing behavioral health services?
        iii. What can be improved for youths receiving behavioral health services in schools?
        iv. What can be improved for youths/Adults receiving behavioral health services while involved with Child Welfare, Probation or the Criminal Justice System?
3) **Would you participate in a survey?**
    a. Pass out a sample survey

Iu-Mien Community Conversation – Summary

Iu-Mien Community Services

December 11, 2019

Number of Attendees: 45

What's Working:

Access to mental health services, particularly psychotropic medications, help to reduce clients' mental health symptoms and maintain current level of stability.

Utilizing the treatment team model, which includes psychiatrists, clinicians, and case managers is effective in helping clients to improve their mental wellbeing and prevent the use of crisis services.

The psychoeducation provided by treatment team are effective in helping clients to understand their diagnosis and allows them to utilize their coping skills to manage their mental health symptoms.

Access to weekly cultural/ethnic specific support services at Iu-Mien Community Services (IMCS) is effective in reducing isolation, increasing clients' sense of connection and belonging, and reducing the need for a higher level of care. The weekly support groups provide opportunities for clients to socialize with peers, and seek their advice and support with various life stressors. Additionally, attending the weekly support groups provide clients with opportunities to give back and support to others.

> "When I went through my divorce, I was very depressed and attending the weekly support group help to lessen my feelings of sadness and loneliness because I was surrounded by people like me who understand me. The group has helped with my overall depression. Also, seeing how much my peers supported one another has motivated me to help others too."

Transportation support services, provided by IMCS staff, enable clients to attend support groups when family members are unable to provide support.

The case management support services, provided by bilingual/bicultural providers at IMCS, help clients to understand different brochures and materials they have received which reduce clients' overall anxiety.

What needs to be improved:

Provide opportunities for Iu-Mien Community Services (IMCS) to expand capacity to enable the program to serve more Iu-Mien community members, increase the number of support groups offered per week, purchase culturally appropriate meals during groups, and have adequate space to host various groups and events where community members can call their home.

Create a centralized center/program, specifically for Iu-Mien people, which allows providers to integrate different cultural practices into treatment aimed at increasing clients' self-efficacy and reducing clients' mental health symptoms. An example include allowing clients to have access to a plot of land for participants to garden and farm.

Increase the number of skilled interpreters and for interpretation services to be consistent to limit the number of interpreters clients have to work with when receiving care. When utilizing interpreters,

providers should consider matching client's and interpreter' genders, especially when exploring sensitive issues to reduce client's discomfort.

Education for providers to increase their awareness of cultural nuances when it comes to behavioral health services and to ensure the questions posed in session are culturally appropriate and easy for clients to understand:

> "When I see my doctor, they ask too many questions that are difficult for me answer."

Providers should treat all clients with compassion, patience, and respect regardless of clients' ability to communicate/express their needs.

> "When I go to the clinic for services, I know how to talk so the doctors treat me better but I also see that with other clients, who don't speak the language or have a hard time with communications, the staff don't treat those clients the same."

Reduce system navigation barriers by allowing clients to have easy access to an Iu-Mien phone operator instead of having to press so many different buttons to get to the right person. This is particularly critical in crisis situations to improve response time and reduce stress for clients/family members.

Education for community members to understand all the different services provided by Sacramento County's Behavioral Health System of Care, particularly when it comes to services for the homeless population with untreated mental illness and/or substance use/abuse issues.

BEHAVIORAL HEALTH SERVICES

CUỘC HỌP CỦA CỘNG ĐỒNG NGƯỜI VIỆT

VỚI SACRAMENTO COUNTY
DIVISION OF BEHAVIORAL HEALTH SERVICES

ADULT PSYCHIATRIC SUPPORT SERVICES (APSS) **2130 Stockton Blvd, Suite 100** **Sacramento, CA 95817**	**DECEMBER 10, 2019** **9:00 AM – 10:30 AM**	**THỰC PHẨM ĐƯỢC CUNG CẤP**

Nếu quý vị muốn tham dự và cần sắp xếp thông dịch viên hoặc cần hỗ trợ đặc biệt, vui lòng liên hệ: Trang Hoang at **(916) 876-8804**

SACRAMENTO COUNTY

Vietnamese Community Conversation – Summary

Adult Psychiatric Support Services

December 10, 2019

Number of Attendees: 9

What is working?

Behavioral health providers are understanding, supportive, warm, patient and kind. Clients feel supported and understood while seeking behavioral health services, which helps to alleviate their symptoms. Clients also appreciate the emotional validation received from their treatment team members.

Behavioral health providers treat clients with respect and are attentive to clients' mental health and wellness, which help to reduce clients' fears and anxiety.

Behavioral health providers are clinically knowledgeable and effective. Providers' clinical expertise enable clients to trust the therapeutic relationship and the therapeutic process. The psychoeducation provided also help clients to understand their mental illness and how to manage their symptoms.

Psychiatrists provide good clinical care and prescribe the right psychotropic medications that are appropriate for clients. Due to good therapeutic rapport, when there are concerns about the side effects of medications, clients feel comfortable sharing their concerns and voicing their needs.

Interpreters are skilled and effective and having interpreters allow clients to communicate their needs with their providers.

What can be improved?

Allow providers to integrate culturally appropriate and community defined promising practices when providing behavioral health services (i.e. providing behavioral health support services at home or out in the community, and providing participants with small stipend to spend during outings or stipend to pay for gas, bus tickets, or transportation to participate in behavioral health events)

Increase the number of bilingual/bicultural Vietnamese providers to provide behavioral health support services since clients feel they are unable to fully express themselves through the use of interpretation services. Interpretation services, even if accurate, may not capture clients' full intent and desire. Having interpreters of a different gender can increase communication challenges when it comes to sensitive topics due to clients' embarrassment and discomfort. Clients, in general, expressed sadness due to not having Vietnamese speaking providers despite being patients in the Mental Health Plan for more than 10 years.

Need to continue to hire and retain behavioral health providers who are culturally competent, attentive, and provide good clinical care.

> A client shared that in the past, she had a psychiatrist that raised her voice at the client which caused her to feel scared and elevated her overall mental health symptoms. The client shared

about an incident where she requested to use the restroom at the start of the appointment and the psychiatrist sternly informed her that she can use the restroom after her psychiatric assessment is complete. That particular psychiatrist is no longer working at the clinic and the client reported that all the new psychiatrists have been very kind towards her.

Need for culturally appropriate support groups to allow clients to connect, socialize, and gain emotional support from peers and group leaders.

Need for bilingual/bicultural Vietnamese providers to provide case management support services to help clients understand all the different resources in the community (medical, legal, and financial) and assist clients with navigation and linkage. Two clients, in particular, focused on their need to find attorneys who are skilled and knowledgeable to assist them with their legal issues and concerns.

In addition to support groups, clients vocalized a strong need for a center, designed specifically for the Vietnamese community, where they can go to learn and receive support with medical, legal, financial, and criminal justice issues.

Stigma and discrimination is pervasive in the Vietnamese community. The prevalence of stigma and discrimination in the community is causing undue stress and pressure for many clients, causing many to withdraw socially due to fear of judgement. The stigma associated with mental illness also cause parents to be ambivalent about seeking mental health services for their child. Many would rather hide or minimize the fact that their child has mental health challenges than seek help. Many parents often wait until their child's symptoms are severe before finally seeking services, causing unnecessary pain and stress for everyone. There is a strong need for psychoeducation to help clients, caregivers, and community members to understand about mental illness. Education will help to empower clients and reduce shame. Education will also help family members and community members to have greater respect and empathy towards individuals living with mental illness.

There needs to be more interpreters since there is a shortage of available interpreters.

Community Conversation meetings like this are helpful because it allows clients to feel heard.

The meeting started at 1305.

Dr. Nassrine is introducing herself.

Mary is introducing herself.

Clients are introducing themselves. All clients are from Iraq.

Question: The county wants to improve the services, check their effectiveness, and in what ways can be improved?

Question: Who needed emergency help or faced situations where he/she had to seek psychological help?

Client #1: I visited the ER. The refugee center referred me to the Hope Center. I did not benefit from the ER.

Question: The county provides services for homeless clients who need housing?

Client #1: Housing and rentals are very expensive. I benefit from Hope. I am married. Mrs. Samira helped me through Section 8, and my name was selected.

Client #7: Mrs. Samira also helped me through section 8.

Samira is explaining what section 8 is.

Question: Do you have children?

Client #7: Three children. Schools are not good. My children have no psychological issues.

Client #6: My son suffered from bullying. They referred him to a counselor at the White House.

Question: Any problems with the police department? Courts?

Client #1: Yes, I had a problem. I got accused by somebody who ended in placing me on a restraint order. I did not go to prison. I went only to the court, and the problem was solved. Again, Samira helped me.

Question: What are the types of services provided by the center? Only psychological?

Client #8: Can you be more specific?

Dr. Nassrine: Services such as homelessness and prison. We just want to know what kind of services are you getting from the center, and how can we improve them?

Client #8: Samira helped me to apply for a job.

Question: How can we improve the services provided by the center?

Client #7: My rent is 1450. It is expensive, and I cannot afford the rental. I am applying to section 8. The rental is affecting me and impacting my psychological condition; besides that, I have many expenses. I have a low income, and the rental is getting expensive.

Client #2: Financial aid, food, water, and safety are priorities.

Client #7: Samira helped me to pay the rental; otherwise, I was about to stay in the street as the rental cannot wait.

Dr. Nassrine is explaining the role of Mary and how she can improve the services provided by the county to selective populations.

Client #8: Is the Arabic language new here? Was it recognized before?

Dr. Nassrine: The Arabic speaking population is now growing in Sacramento.

Client #8: Were you evaluating these services before? Why now?

Dr. Nassrine is explaining to Mary the financial burdens facing the refugees.

Client #8: We are not solving the fundamental problem. Section 8 is a law. It takes time to get help, and the number of refugees applying is high (millions). There should be priorities. It is not a matter of Arabic speaking.

Dr. Nassrine is explaining that Mary is here for cultural competence for the services provided by the county. Again, we just want to see how we can improve the services.

Client #2: We have no support other than the salary that we get paid, and that is what impact us psychologically.

Client #8: I tried to work for only a month. I visited the social security. If I wanted to work, can this affect my financial assistance? Yes, it will take me to the zero levels.

Samira is explaining the situation of client #8. He was applying for a part-time job, and how did she help him.

Client #8: I was disappointed with the social security. The laws, in general, are impacting us. The political and economic environment of the country plays a role. Forget about the pills and medications. It is about my strength to face these obstacles. I might crash and fall at a particular time. I am very stressed. I only go to 99 cents, and the supplies there are nasty.

Client #8 is questioning Dr. Nassrine if the research is hers?

Dr. Nassrine says: No.

Client #8: No discrimination was noticed. I am depressed. There is no safety. Money is not enough, and I cannot afford all the expenses.

Samira is explaining how the high rentals are impacting the refugees and that with the money they have, they cannot afford it.

Client #8: Psychological support is just a title, but in fact, nothing is done to help. Again, social security has no role to help with my psychological situation. All services provided by the government do not focus on this, although it states that. The advertisements regarding that are just there on media, but in reality, nothing is done.

Client #4 is explaining that refugees from Iraq and Syria have many mental health issues. She cannot study and face the community. She has migraine and back problems. The rental is high,

and her medical condition is restricting her from finding a job or working. She says the USA was my dreamland, which is not true. My mental status, besides trauma, is impacting me.

Client #8: Drugs are the biggest problem for mental health issues. For the refugees, it is different. We do not take drugs. Our mental health issues came from wars and traumas. Who takes drugs has more privileges than us. The drug abuser can overcome his problem. Refugees cannot do that because it is accumulating in the past 50 years of wars, political oppression, and violence. We are victims of politics. What are our rights as victims of these politics? He is saying that his sister helped him when he was at welfare. My food stamp is 86 dollars. Once I declared that my sister helped me financially (200 dollars), they deducted my financial support. One lady there helped me get through that and explained the situation. The county has a responsibility toward that. My example is the simplest thing.

Client #2: Our psychological conditions are destroyed.

Client #8: This is a rich country. We are here because of politics. Again, drug abusers are more spoiled than us.

Client #5: Money impacts our psychological condition. I work and earn 2800 dollars. It is not enough, and I cannot afford anything.

Dr. Nassrine is trying to explain that these are above our limits and needs laws to be changed, and it takes time.

Samira is explaining the situation of client #5. Briefly, the high costs of living, feeding their children, and employment are the challenges facing them.

Dr. Nassrine: The system is complicated.

Client #5: We are treated as other clients. We should be treated differently as victims of politics. I am innocent. The veterans are also victims, and they are adequately served. It is not just for Arabs. For 40 years and we have been tortured.

Again, Dr. Nassrine is explaining that this exceeds Mary's abilities.

Meeting still running 1405

Mary is glad to hear your stories. She can talk to her colleagues dealing with housing issues.

Client #5 again is asking for a change in laws affecting the refugees.

Dr. Nassrine is explaining that services provided for refugees now are different from those before. Politics are changing.

Question: Again, the services provided here? How can it get better? Improved? Politics are now impacting the refugees. Some things are beyond our control.

Client #8: Section 8 should take into consideration that victims of wars and traumas should be prioritized, which can solve part of the problem.

Samira and Dr. Nassrine are explaining that section 8 is a federal lottery.

Dr. Nassrine is suggesting brochures in Arabic language.

Client #8 is again questioning about section 8.

Clients #5 and #6 left the meeting @ 1415.

Client #8 is again questioning about section 8 and the lottery.

Dr. Nassrine is asking about any difficulties in this center?

All clients are happy with the services.

Client #1 is happy with the services. Samira helps me with the translation.

Client #1 is asking for Mary's role.

Dr. Nassrine is explaining the position and role of Mary and her department.

Two more clients attended the meeting at 1420.

Client #8 is asking how the county can help?

Mary is speaking, and Dr. Nassrine is translating her answer to client #8. Mary is saying we do not have control of some concerns, and we cannot advocate all.

Mary is asking about how can information be spread through the Arabic community?

Client #8 is asking what community?

Dr. Nassrine: Arabic.

Client #8 is saying that even in our countries, we do not have that.

Samira is saying that churches and mosques are helping.

Mary is saying that the county is looking for a program about emotional support for the Arabic community in order to prevent suicidal ideations.

Again client #8 is repeating the same ideas.

Clients #1 and #2 left the meeting at 1425.

Client #8 is saying that we cannot evaluate the problem.

Dr. Nassrine is asking again the new clients who attended the meeting about how we can improve the services provided by the center.

The new client is saying that his wife's doctor is very friendly and helpful. Samira is lovely, always call before appointments and remind us. He is saying that the physicians are great. His wife is doing much better.

New clients are comfortable. They have no suggestions. The language might be a problem for us, but our children speak English and are translating for us. My wife has memory problems, but Samira always helps us. The reception desk should be more welcoming because this motivates us to come to this center. We changed our clinic because we heard about Samira. In the other clinic,

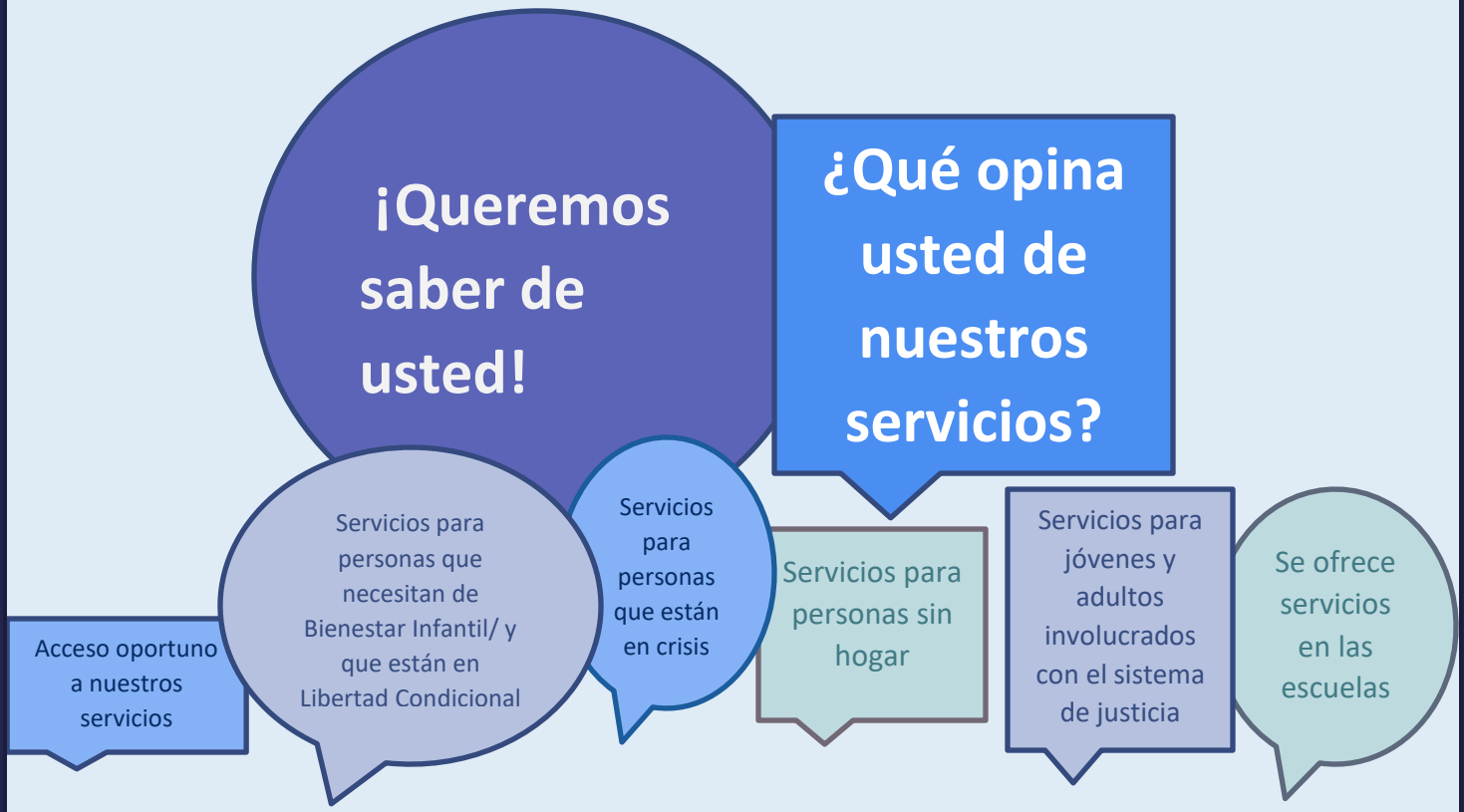
there was no interpreter. That is why they came to this clinic. People here are welcoming and impressive. The translator is always the same person and knows my situation and case; this helps in my follow-up.

Samira and Dr. Nassrine are stressing on the importance of having culturally competent and linguistic case managers.

Samira is asking Mary about the medical question regarding clients #3 and #4. She does not qualify for Medi-Cal.

Samira and Dr. Nassrine are talking with client #3 about her education. She said she would try to take the GED.

Meeting finished at 1445 PM.



BEHAVIORAL HEALTH SERVICES

Conversación con la Comunidad Latina

CON SACRAMENTO COUNTY
DIVISION OF BEHAVIORAL HEALTH SERVICES

La Familia Counseling Center – Maple Neighborhood Center **3301 37th Avenue Sacramento, 95824**	**7 de Enero del 2020** **10:00 AM – 11:30 AM**	**Se proporcionará comida**

Para mayor información o confirmar su asistencia, favor de comunicarse con Lynn Keune al 916-210-8773

Si desea asistir y necesita un intérprete o necesita ayuda especial, favor de comunicarse con Trang Hoang al (916) 876-8804.

SACRAMENTO COUNTY

Latino Community Conversation – Summary

La Familia Counseling Center

January 7, 2020

Number of Attendees: 18

What is working?

Psychotherapy and psychotropic medications, specifically tailored for the individual, are effective in helping clients to decrease their mental health symptoms and improve overall quality of life.

Mental health services provided in clients' home, with bilingual/bicultural providers, is effective in helping parents to understand how to implement various strategies and interventions at home with their children. The clients (youth) are responding positively to these behavioral interventions and parents are seeing an improvement in their children's overall behaviors. Psychoeducation is also effective in helping community members and family members to understand the underlying causes of mental illness and addiction, which help to increase compassion and decrease stigma about individuals living with mental illness and/or substance abuse.

Crisis services at the Emergency Room is effective because staff asked questions specific to clients' mental health symptoms and the subsequent treatment at the psychiatric hospital is effective in helping clients to remain stable.

Behavioral health services received while in Jail is effective in helping client to stop selling and using drugs, and help to turn client's life around after losing his home and his family due to longstanding mental illness and substance abuse.

Advertisements warning drivers about the danger of driving while under the influence is effective in helping drivers to be more conscientious about not driving under the influence.

What Can Be Improved?

There needs to be an improved cross-system collaborations between BHS and Child Welfare Services. When children are removed from their biological family, it is important for those families to receive ongoing support services to ensure that the children are not being returned to families that have not fully healed.

Behavioral health services should also focus on keeping families together to prevent onset of mental health challenges due to the trauma of being removed from their family. Behavioral health services also need to include the entire family, not just the individual client, and have options for family members to participate in support groups, focused on skills building so they have the means to provide support for the client. Behavioral health interventions also need to incorporate ongoing education and dialog with parents about substance abuse. In general, behavioral health services need to be culturally competent and for providers to treat clients and families with dignity and respect.

There is a need for mental health services to be provided in schools, particularly in the classroom, where youth may experience emotional and behavioral challenges.

There is a need for ongoing training and education in schools and in the homes, for teachers and parents, about behavioral health diagnosis, presenting symptoms, and treatment. The training will help both parents and teachers utilize positive interventions in the classroom/at home and help parents and teacher to have patience with the youth exhibiting emotional challenges. The training and education will help to reduce stigma in the community and help community members understand the concept of therapy since many community members still view therapy as an intervention used only for individuals living with severe mental illness.

There is a need for behavioral health providers to tailor services that would appeal to youths by incorporating recreational activities (sports, music, art, soccer, etc.) that youth enjoy to keep them away substance use/abuse. Since youth may not be open to seeking counseling services, support groups can serve as an introduction to talk therapy where they are encouraged to socialize with others and talk about their feelings.

There is a need for behavioral health providers to hire more bilingual/bicultural staff to conduct targeted outreach to inform community members of available services and support. Outreach strategies will need to also include advertising about services on TV, radio, and on social media to target community members across the lifespan.

There is a need to continue to hire and retain bilingual/bicultural behavioral health providers who are culturally competent to provide services for children, youth and families

Increase capacity for more agencies in the community to serve Latino community members, regardless of their annual income, and for behavioral health providers to create opportunities for community members to volunteers and serve their community.

There is a need for a 24/7 warm line, or crisis support services, that monolingual Spanish speaking community members can call to get support.

There is a need for supportive services designed to help decrease isolation for seniors by visiting them at home and to provide case management and support with other system navigation (i.e. Medi-Cal, DHA, EDD, CalWorks/CalFresh).

Increase the number of skilled interpreters to provide interpretation services for monolingual Spanish speaking clients and families

Redesign homeless shelters to look more like homes and allow individuals who are homeless a safe space to stay during day time, not just at night, to prevent those individuals from being out in the street and abusing substances to cope. The redesign should include modifying the number of rules and restrictions since rules/restrictions make it difficult for individuals to want to stay in shelters.

Welcome packets provided for clients, at one of the county contracted provider, is lengthy and need to be translated into Spanish.

There is a need to reduce barriers to services by reducing stigma associated with seeking services, increasing the number of bilingual/bicultural behavioral health providers, and providing transportation support services for clients.

BEHAVIORAL HEALTH SERVICES

African American/Black Community Conversation

WITH SACRAMENTO COUNTY
DIVISION OF BEHAVIORAL HEALTH SERVICES

SOUTHGATE COMMUNITY LIBRARY **6132 - 66th Avenue** **Sacramento, CA 95823**	**January 30th** **11:00 AM – 12:30 PM**	**FOOD WILL BE PROVIDED**

For more information or to make a reservation, please contact Debrah DeLoney-Deans at (916) 876-5128

If you wish to attend and need to arrange for a reasonable accommodation, please contact Darlene Moore at (916) 875-7227

SACRAMENTO COUNTY

BHS Community Conversation – African American/Black Community

1/30/2020

16 in attendance

Facilitated by Debrah DeLoney-Deans, BHS

Timely Access to our services

Working:
Wait was fine, there did not seem to be an excessively long wait for a referral to services
Found help through the California Black Health Network—not a county agency

Not Working:
Not publicized or well known to the community how to actually access services
There is confusion and mystery around "How do we navigate through the system?"
When clients get released from jail, they are receiving old an outdated resource packets.
The pre-release packet of resources needs to be updated
When on probation, the classes that we are required (parenting, anger management, etc.) to take interfere with employment and/or housing
Classes that are required by probation are not affordable

Services for individual with experience with Child Welfare/Probation

Not Working:
When families are connected to a FSP services, they receive a lot of support and assistance
The challenge is not all clients are eligible for FSP services; how to get access
Medi-Cal (FIT) Contracts are divided by regions, which is challenging for community agencies who are trying to provide good services
High needs service areas are disproportionately impacted with the need of more staff to provide services in those areas
Cases open with them when clients are discharged from probation or court, but when the court case is closed, the services stop, but the client still needs services and supports. There is no step down process
Having to transfer to another team after establishing relationships is traumatic having to start the process over
There is not enough help for mental illness when you are incarcerated
In the County people with mental illness are separated from the general population, which is isolating and stigmatizing
In can take weeks to see a mental health professional when you are incarcerated and often not culturally competent

Crisis Services

Not Working:
People are not being assessed properly.
There is bias in the centers where services are being provided.
It is difficult to communicate with active/untreated mental health issues
Lack of access to services can causes individuals to go to the streets for substances to help with mental illness.
Professionals need to do more follow-up.

Appropriate Medication levels are important
Over/under medicated can cause problems
Crisis is different for each individual; crisis services must be culturally competent
County definition of crisis should be expanded to include cultural considerations
Client-defined terms working in partnership with professionals.
ER doctor – no intention for long-term/ongoing care. Quick fix triage services and then back to the same old thing
Anyone who experiences any level of need should have choices other than psych services/medication/5150 holds
African Americans have a negative history with police and will not call 911
Police are not trained to respond to mental health crisis situations
Church/spiritual roots turning for help – providers need to respect
Faith is not a mental health challenge
Professionals need to learn Cultural Competence with African Americans
Historical Crisis – at the end of the rope – complex situation requires a coordinated response.

Services for individuals experiencing homelessness

Working:
More attention is being given to the homelessness crisis
More money is being directed to addressing homelessness
Homeless people with jobs get into crisis because they don't have a safe place to stay

Not Working:
Be human – don't "clear out" homeless camps. Serve people where they are.
No enough housing
Not enough shelters – not safe (bedbugs)
Not enough services
Homelessness is a mental health issue
Vouchers – not healthy without services
Rents keep rising with no cap
Racism is an issue when searching for housing options
Tents right outside County buildings and those issues are not being addressed

- **What could work**
  Paying rent
  Paying deposits
  Homeless navigator
  Assistance with qualifying for housing in light of poor credit/past evictions
  Find ways to over the challenges of keeping people housed once they get in
  When addressing homelessness, individuals stand a greater chance at being successful if housing is connected with mental health services, med management, groups, 1 on 1s, etc.
  Need support with how to maintain housing once acquired

Services for Youth and Adults involved with the criminal justice system

Not working:
Kids are receiving services, but parents are not
Provide greater education to parents
Funding favors white youth services
There are not enough programs for black youth to meet the needs
How do we help youth be successful who are considered to be "institutionalized."

There needs to be levels of transition (step down program, at least a 1 yr. long transition)
Debrief people prior to release from jail or psych hospital—set them up for success
Have a mental health officer (like probation officer)
No support services linked to probation or parole.

Services offered in schools

Not Working
Send culturally appropriate staff to the schools
(Professionals) It takes a special kind of worker to work with Black students and parents
Staff needs to look like the population they are serving
There is discrimination among the staff towards the students who have issues
Community programs are not financial compensated for their skills, which contributes to high turn over
Peer support needs to be in the classrooms
African Americans want a hand up not a hand out, but it feels like another racist system when other populations receive programs and services and African Americans are continuously ignored/disregarded

BEHAVIORAL HEALTH SERVICES

Community Conversation

WITH SACRAMENTO COUNTY
DIVISION OF BEHAVIORAL HEALTH SERVICES

Oak Park Community Center

3425 Martin Luther King Jr. Blvd. Sacramento, CA 95817

February 26, 2020
3:30 PM – 7:00 PM

Registration and refreshments at 3:30. Conversation begins at 4:00

FOOD WILL BE PROVIDED

Play care available with pre-registration

Providers are encouraged to assist community members with registration and transportation.

Link to register: https://bhs-community-conversation-tickets.eventbrite.com

For assistance with registration or questions please contact Anne-Marie Rucker at (916) 875-3861 RuckerA@SacCounty.net

SACRAMENTO COUNTY

BEHAVIORAL HEALTH SERVICES

ندوه مجتمعيه

WITH SACRAMENTO COUNTY
DIVISION OF BEHAVIORAL HEALTH SERVICES

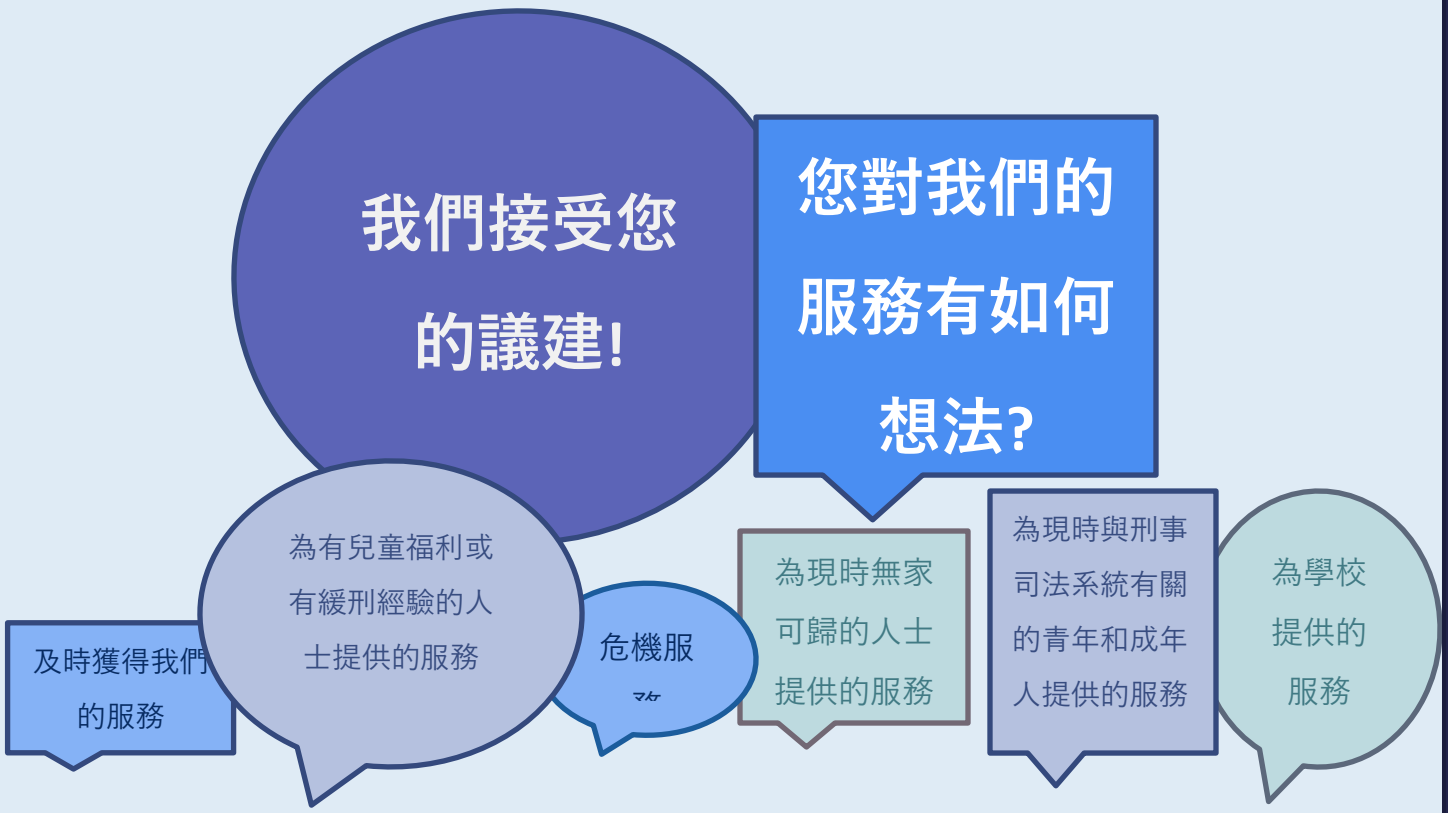
Oak Park Community Center **3425 Martin Luther King Jr. Blvd.** **Sacramento CA 95817**	**February 26, 2020** **3:30-7:00 PM** التسجيل و المقبلات في 3:30	**الطعام متوفر** **العاب و رعايه للاطفال متوفره** **(مع تسجيل الحجز المسبق)**

التسجيل من خلال الرابط : https://bhs-community-conversation-tickets.eventbrite.com

اذا كنت ترغب بحضور الاجتماع و تحتاج الى مترجم او الى مستلزمات ملائمه يرجى الاتصال

Anne-Marie Rucker at (916) 875-3861

SACRAMENTO COUNTY



BEHAVIORAL HEALTH SERVICES

社區對話

與 SACRAMENTO COUNTY
DIVISION OF BEHAVIORAL HEALTH SERVICES

Oak Park Community Center **3425 Martin Luther King Jr. Blvd. Sacramento, CA**	**February 26, 2020** **3:30-7:00 PM** **登記和小食在 3：30** **對話在 4：00 開始**	**有食物提供** **預早登記提供兒童照顧服務**

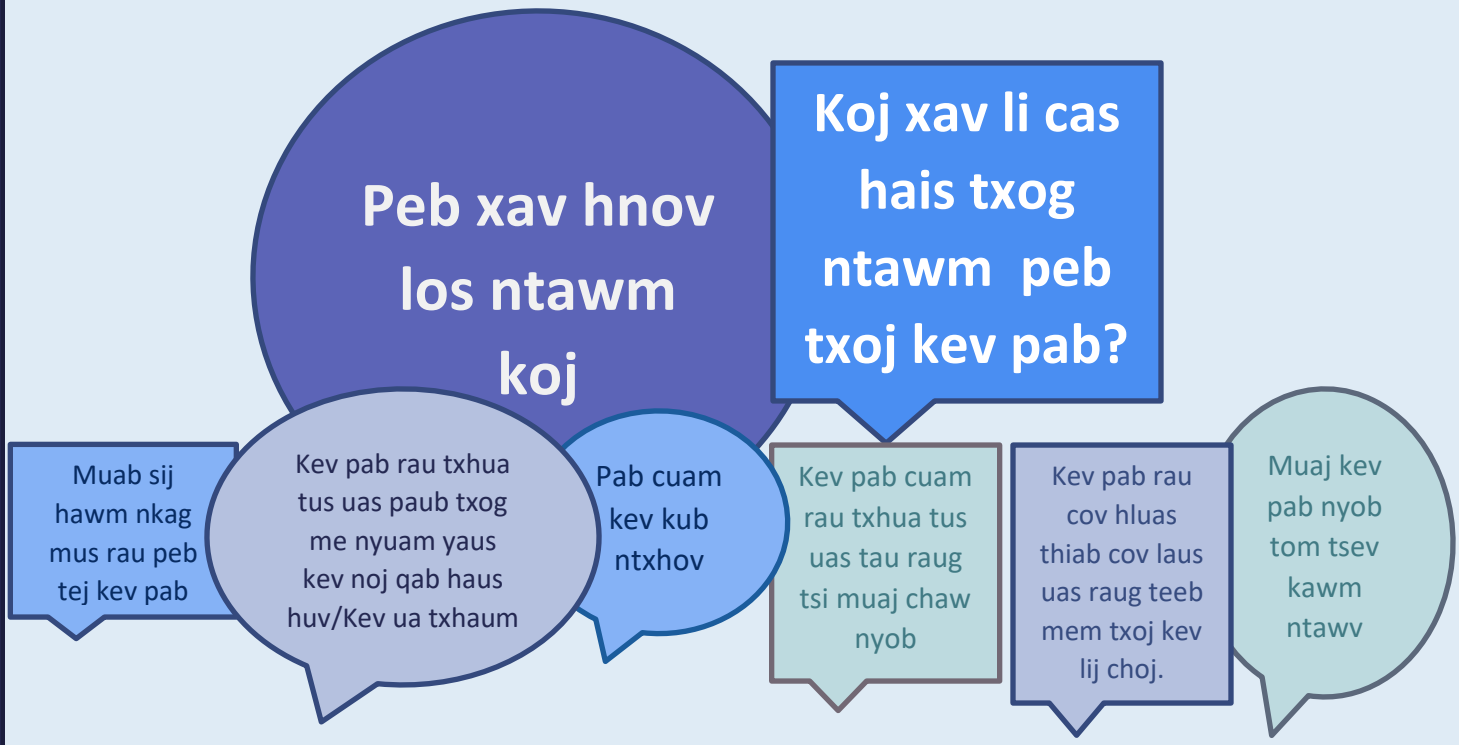
我們鼓勵提供者去協助成員登記和交通。

網站鏈接登記： https://bhs-community-conversation-tickets.eventbrite.com

如果需要協助登記或詢問，請聯絡 **Anne-Marie Rucker at (916) 875-3861**

RuckerA@SacCounty.net

SACRAMENTO COUNTY



BEHAVIORAL HEALTH SERVICES

PEJ XEEM LUB ROOJ SIB THAM

NROG SACRAMENTO COUNTY
DIVISION OF BEHAVIORAL HEALTH SERVICES

Oak Park Community Center **3425 Martin Luther King Jr. Blvd. Sacramento, CA 95817**	**2 Hlis Ntuj, Nub Tim 26, Xyoo 2020** **3:330 PM – 7:00 PM** **Kev cuv npe thiab muaj khoom txom cauj noj thaum 3:30. Kev sib tham pib thaum 4:00**	**YUAV MUAJ ZAUB MOV LOS SIS KHOOM TXOM CAUJ NOJ** Yog cuv npe ntxov ua ntej, yuav muaj kev saib xyua mes nyuam

Yeej xav kom cov koom haum pab cov neej pej xeem cuv npe thiab kom tuaj tau rau lub rooj sib tham.

Mus cuv npe: https://bhs-community-conversation-tickets.eventbrite.com

Xav tau kev pab mus cuv npe lossis yog muaj lug nug, thov hu tau Anne-Marie Rucker ntawm (916) 875-3861 RuckerA@SacCounty.net

SACRAMENTO COUNTY

BEHAVIORAL HEALTH SERVICES

Community Conversation

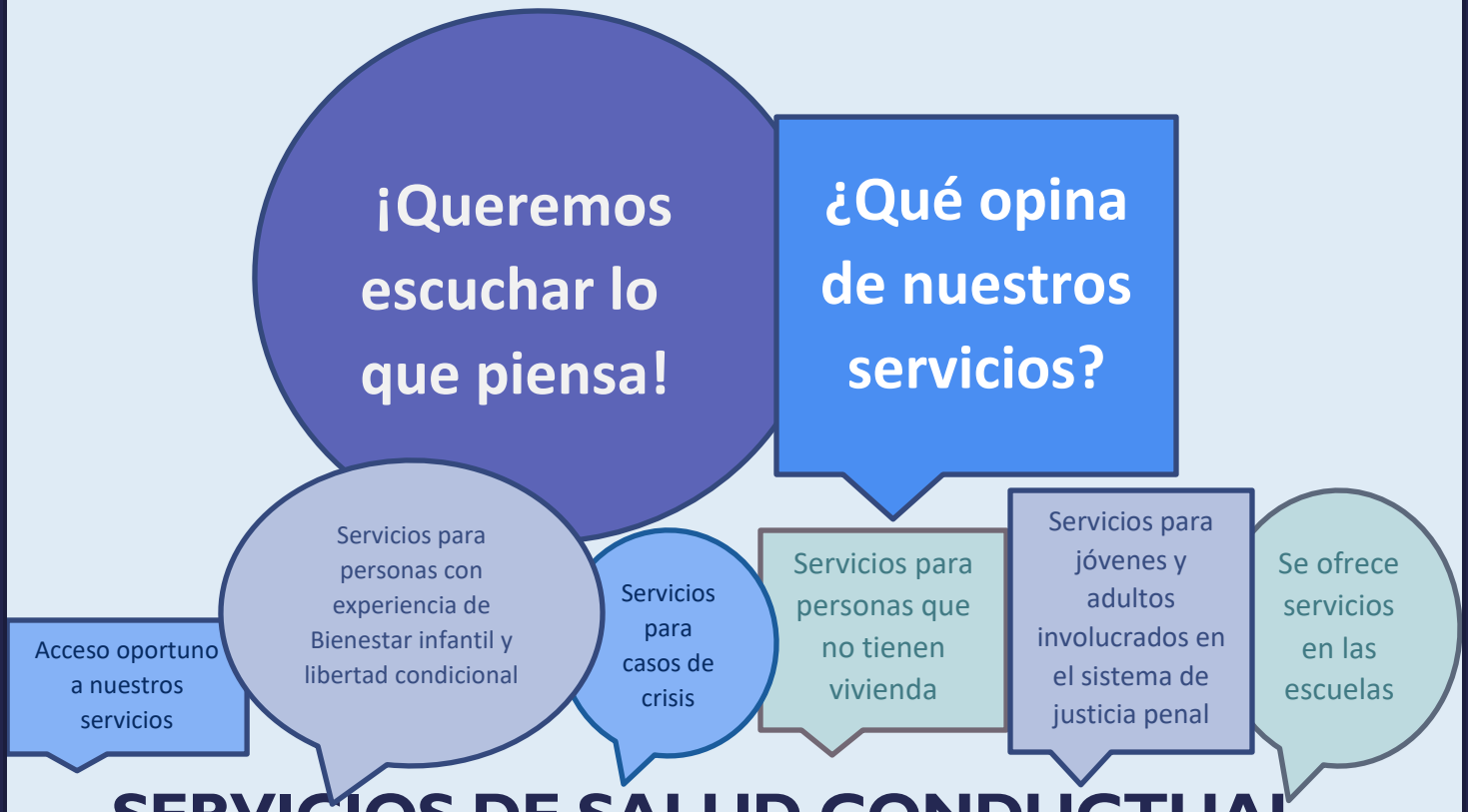
WITH SACRAMENTO COUNTY
DIVISION OF BEHAVIORAL HEALTH SERVICES

Oak Park Community Center **3425 Martin Luther King J Blvd** **Sacramento, CA 95817**	**26-е февраля 2020** **3:30 - 7:00 PM**	**ПРЕДОСТАВЛЯЕТСЯ УГОЩЕНИЕ** **Группа для детей по предворительной регистрации**

Ссылка на регистрацию: https://bhs-community-conversation-tickets.eventbrite.com

Если Вам нужен переводчик или другая помощь, пожалуйста, свяжитесь с Anne-Marie Rucker at (916) 875-3861, RuckerA@SacCounty.net.

SACRAMENTO COUNTY



SERVICIOS DE SALUD CONDUCTUAL

CONVERSACION COMUNITARIA

CON SACRAMENTO COUNTY DIVISION OF BEHAVIORAL HEALTH SERVICES

Oak Park Community Center **3425 Martin Luther King Jr. Blvd. Sacramento, CA 95817**	**26 de Febrero, 2020** **3:30-7:00 PM** **Registración y refrigerios a las 3:30. La conversación empieza a las 4:00**	**SE PROPORCIONARA COMIDA** Cuidado de niños disponible con registro previo

Se alienta a los proveedores a que ayuden a los miembros de la comunidad con el registro y transporte.

Para registrarse: https://bhs-community-conversation-tickets.eventbrite.com

Si desea acudir y necesita un intérprete o alguna adaptación razonable, contacte a Anne- Marie Rucker al (916) 875-3861 RuckerA@SacCounty.net

SACRAMENTO COUNTY

BEHAVIORAL HEALTH SERVICES

CUỘC HỌP CỦA CỘNG ĐỒNG

VỚI SACRAMENTO COUNTY
BEHAVIORAL HEALTH DIRECTOR RYAN QUIST, PH.D.

Oak Park Community Center

3425 Martin Luther King Jr. Blvd.
Sacramento, CA 95817

Ngày 26 tháng 2 năm 2020
3:30 chiều - 7:00 tối

Đăng ký và giải khát lúc 3:30 chiều.
Cuộc họp bắt đầu lúc 4:00 chiều.

THỰC PHẨM ĐƯỢC CUNG CẤP

Chăm sóc trẻ em được cung cấp nếu đăng ký trước

Vui lòng đăng ký tại đây:

https://bhs-community-conversation-tickets.eventbrite.com

Nếu quý vị muốn tham dự và cần sắp xếp thông dịch viên, vui lòng liên hệ Anne-Marie Rucker tại (916) 875-3861.

SACRAMENTO COUNTY

BEHAVIORAL HEALTH SERVICES

Native American Community Conversation

WITH SACRAMENTO COUNTY
DIVISION OF BEHAVIORAL HEALTH SERVICES

Shingle Springs Tribal TANF **2033 Howe Ave #100** **Sacramento, CA 95825**	**February 13, 2020** **5:30 PM – 7:30 PM**	**FOOD WILL BE PROVIDED**

For more information or to make a reservation, please contact Sandra Molina at (916) 341-0576 ext. 3038

If you wish to attend and need to arrange for a reasonable accommodation, please contact Sandra Molina at (916) 341-0576 ext. 3038

SACRAMENTO COUNTY

Native American Community Conversation – Raw Data

Sacramento Native American Health Center

February 13, 2020

Number of Attendees: 20

What's Working

- Mental health services provided at one of Sacramento County's contracted provider is effective

What's Not Working

- There's a need to have more agencies to provide after hours crisis services
- Improve outreach and advertisements efforts to ensure the community is aware of available services and resources
- Provide special needs to trainings for providers with front line staff
- Improve providers' assessment skills to ensure clients are accurately diagnosed and treated
- Improve law enforcements' response time during crisis and ensure law enforcement are trained to provide support for individuals living with mental illness during crisis. Law enforcement are currently not equipped to appropriately respond and provide support for individuals living with mental illness during crisis
- Improved behavioral health services for clients in custody at county jails.
- Increase capacity to provide support services for elders
- Ensure conservatorship services are in place for clients prior to clients aging out of the system.
- Ensure law enforcements are aware of the MH resources provided by the County of Sacramento
- Increase MH services for Teens/Tay in school to ensure they receive support services instead of being prescribed psychotropic medication.
- Therapy sessions are short (15 minutes long) with counselor minimize clients' symptoms.
- why Transportation support series provided by contracted providers is working. (currently available during business hrs.)
- MH services provided in school is affective
- Improved collaboration between Behavioral Health and school districts
- Improved ways to identify Native Community members to ensure Native members are receiving the needed support.
  -In order to identify as Native Community members have to request forms from the district
- When students challenged facts provided by school systems, they're being labelled as defiant.
- Ensure staff are culturally competent and provide trainings to teachers/administrators
- Prioritize more community conversations for community members to share their experiences and invite other system partners so they can hear how community members are effected by dif. systems.
- Improved training strategies and improve hiring strategies to priorities lived experience
- Quarterly community conversations and provide handouts and invite other providers/system partners
- Ensure there's diversity
- The community feel excluded

- Need to collaborate with Native organizations to provide trainings for community members that is culturally sensitive/appropriate.
  -Youth/Parents need more support
- Ensure data are disaggregated to ensure Native members are accurately captured to ensure the county is allocating funds appropriately.
- Provide more support groups for Native youth and increase capacity for providers to provide needed support services for the community.
- Increase peer/family advocates from Native Community
- Ensure providers are providing services in a way that is culturally sensitive, appropriate and respectful.
- Young children (5 y.o) with mental health symptoms are placed on IEP and are placed in hoe study.
- Native students are being bully for having long hair and teachers not aware of the culturally reasons why male youth have long hair.
  -Review existing framework to ensure Native Culture (Youth/Family) are seen/heard
- Lack of communications between systems
- Utilize social media to share info/resources
- Have booths/table with resources and talk to community members.

BEHAVIORAL HEALTH SERVICES

Russian Speaking Community Conversation

WITH SACRAMENTO COUNTY
DIVISION OF BEHAVIORAL HEALTH SERVICES

Hope Cooperative **(aka TLCS)** **3727 Marconi Ave** **Sacramento, CA 95821** **(916) 485-6500**	**7-е февраля 2020** **10:00 - 11:30**	**ПРЕДОСТАВЛЯЕТСЯ** **НЕБОЛЬШОЕ** **УГОЩЕНИЕ И ЧАЙ**

Если Вы хотите принять участие, зарегистрироваться или Вам нужна дополнительная информация, пожалуйста, обращайтесь к Елене Спекторов по телефону 916-875-2255.

Если Вам нужен переводчик или другая помощь, пожалуйста, свяжитесь с Anne-Marie Rucker at (916) 875-3861.

SACRAMENTO COUNTY

Russian Speaking Community Conversation Summary

On February 7, 2020 Anne-Marie Rucker and Elena Spektorov travelled to Hope Cooperative to participate in Russian Speaking Community Conversation. In addition to county staff, 13 consumers, 2 family members and 3 providers participated in this conversation. This diverse Russian speaking group included people from Russia, Ukraine, Kazakhstan, Moldova and Belarus.

The meeting started with participants sharing their personal experiences with this ongoing group at Hope Cooperative and then moved to describing their experience with Sacramento County Behavioral Health System of Care at large.

GROUP SPECIFIC FEEDBACK

What is working?

- Ongoing Russian speaking support group taking place every Friday for the last 13 years
- Wonderful facilitator running this group
- Relevant material and handouts during meetings
- Positive environment
- Consistency
- Making connections with other consumers
- “We are so happy this group exists!!!!!!”
- Ability to speak in the language of origin
- Cultural accommodations
  Relevant topics to address specific needs of the group
- Diversity of the group (participants of 8 countries partake in this group)

What is not working?

- Only consumers (not family members) are allowed to participate in this group
- Need for a group for family members of consumers

COUNTYWIDE FEEDBACK

1. **TIMELY ACCES TO CARE**

What is working?

- Russian speaking services coordinator, Lyubov Isayeva, assists with scheduling appointments

- Russian speaking services coordinator, Lyubov, is our go to person with any ongoing or emerging questions or needs
- During psychiatric appointments, Lyubov helps to bridge the cultural gap between psychiatrist and consumers
- Referral process was simple, no excessive paperwork, requiring only a phone call to the Access team
- Walk-in psychiatric appointments on Thursdays at Hope Cooperative

What is not working?

- Long initial appointment wait times up to 4 months
- Language barriers with front desk staff, with medication refills and when scheduling psychiatric appointments (if Lyubov is not available)
- Need for a Russian speaking psychiatrist (Hope Cooperative previously had Russian speaking psychiatrist who retired)
- Long wait times for walk-in Thursday appointments at Hope Cooperative, difficulty finding interpreter if Lyubov is not available
- Transportation is a barrier in attending services consistently. Gas money would be supportive to consistent participation.
- **Not all forms are available in Russian**

2. CRISIS SERVICES

What is working?

- Interpreters provided
- Smooth transition from ER to psychiatric hospital
- Comfortable beds and attentive staff at psychiatric hospitals
- Access to psychiatrist at Urgent Care Clinic when needed

What is not working?

- Long wait times at Urgent Care Clinic
- Long wait times at ER
- Uncomfortable rooms at ER

3. CPS/Probation

- No comments related to behavioral health services

4. SERVICES FOR INDIVIDUALS EXPERIENCING HOMELESSENESS

What is working?

- MODE 60 MHSA funds providing timely help to assist with maintaining/gaining housing

What is not working?

- Hard to access this funding source
- Challenges in meeting criteria to prove homelessness
- Excessively hard requirements to participate in the program

5. SERVICES FOR ADULTS INVOLVED WITH CRIMINAL JUSTICE SYSTEM

What is working?

- Timely access to services
- Great coordination of care efforts between Justice system staff and Hope Cooperative services coordinator, Lyubov

What is not working?

- No comments

6. SERVICES OFFERED IN SCHOOLS

What is working?

- No comments

What is not working?

- Kids need more help to decrease acting out behaviors in schools
- Kids need more services to prevent suicide
- Lack of overall resources and Russian language specific services at schools for new immigrants
- Need for anti-bulling efforts/campaigns

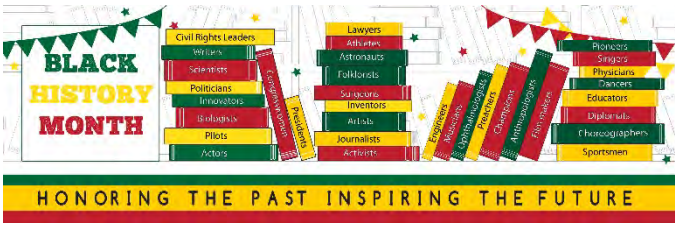
SACRAMENTO COUNTY

"I am no longer accepting the things I cannot change. I am changing the things I cannot accept."

--Angela Davis

Cultural Competence & Ethnic Services Newsletter Issue 1 | February 2021

Black History Month



February 1st marked the first day of Black History Month 2021. The month long celebration is a chance to acknowledge the historic achievements of Black Americans and to highlight their contributions and undeniable impact on American history. Prolific game changers like Malcolm X, Rosa Parks, Shirley Chisholm and Dr. Martin Luther King, Jr., are some of the names we learn more about each February. But the celebration that is now Black History Month started long before these civil rights leaders made their mark.

How It Started.

In 1915, historian Dr. Carter G. Woodson and Minister Jesse E. Moorland founded the Association for the Study of Negro Life and History, now known as the Association for the Study of African American Life and History (ASALH). This group focused on researching the advancements made by people of African descent and, in 1926, sponsored the first Negro History Week.

Why February?

The ASALH selected a week in February to coincide with Abraham Lincoln's birthday (Feb 12) and Frederick Douglass' birthday (Feb 14), as these were dates the Black community had, at the time, celebrated for decades. Though the timing was chosen based on set traditions, Woodson always had higher ideals for the celebration. "We are going back to that beautiful history and it is going to inspire us to greater achievements, he told a group of students just a few years before issuing a press release announcing Negro History Week.

Advancement

Through the 1920s, 30s and 40s, the observation of Negro History Week grew in popularity across America among budding Black History clubs. Joined with other celebrations like Negro Brotherhood Week, the period of time grew larger. Even before Woodson's death in the 1950s, cities in West Virginia and other pockets of the country were starting to elongate Negro History Week celebrations to the full month of February. Then came the civil rights movement.

In the 1960s, the focus on Black identity provided fertile ground for Negro History Week to grow into Black History Month.

In 1976, during the United States Bicentennial celebration, President Gerald Ford recognized February as Black History Month, and encouraged Americans to "seize the opportunity to honor the too often neglected accomplishments of Black Americans in every area of endeavor throughout our history."

What is the theme of Black History Month 2021?

Every year, a theme is chosen by the Association for the Study of African American Life and History, and this year the theme is*: "The Black Family: Representation, Identity and Diversity and will explore the African diaspora."* The

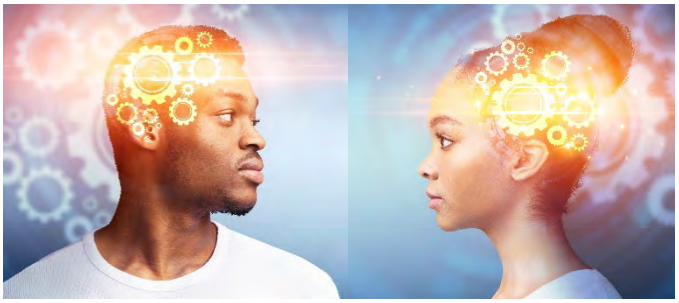
family offers a rich tapestry of images for exploring African American past and present," the ASALH writes on their website.

It is true, African Americans/Black people have made significant strides since the Civil Rights Movement towards equity, inclusion and social justice. But the current landscape of our country suggests that we still have quite a long way to go. In the famous words of Dr. Martin Luther King, Jr., "darkness cannot drive out darkness; only light can do that. Hate cannot drive out hate; only love can do that." But for now, we will continue to celebrate each day of Black History Month with pride and respect, acknowledging our struggles and our triumphs. We continue to hold our heads high as we celebrate our rich history and culture; giving wings to our dreams as we honor our robust contributions to the world. With songs of victory on our lips and genuine love in our hearts, we will face the challenges ahead with wisdom, strength and hope, acknowledging that we have come too far to turn back now!

Submitted by: Debrah DeLoney-Deans, LMFT

Celebrating African American Achievement and Invention

Black History Month honors the contributions of African Americans to U.S. history. Among prominent figures are ***Madam C.J. Walker***, who was the first U.S. woman to become a self-made millionaire; ***George Washington Carver,*** who derived nearly 300 products from the peanut; ***Rosa Parks***, who sparked the Montgomery Bus Boycott and galvanized the civil rights movement; and ***Shirley Chisholm***, who was the first African American woman elected to the U.S. House of Representatives. She was elected in 1968 and represented the State of New York.



10 extraordinary African Americans you may not know, but should:

- **Jack Johnson** became the first African American man to hold the World Heavyweight Champion boxing title in 1908. He held onto the belt until 1915.
- **John Mercer Langston** was the first Black man to become a lawyer when he passed the bar in Ohio in 1854. In 1855, he was elected to the post of Town Clerk for Brownhelm, Ohio.
- **Claudette Colvin** was 15 years old when she was arrested nine months before Rosa Parks for not giving up her bus seat to white passengers. She was the first woman to be detained for her resistance**.**
- **Hiram Rhodes Revels** was the first African American ever elected to the U.S. Senate. He represented the state of Mississippi from February 1870 to March 1871.
- **Jackie Robinson** became the first African American to play Major League Baseball when he joined the Brooklyn Dodgers on April 5, 1947. He led the league in stolen bases that season and was named Rookie of the Year.
- **Robert Johnson** became the first African American billionaire when he sold the cable station he founded, Black Entertainment Television (BET) in 2001.
- **Bessie Coleman,** the first licensed Black pilot in the world, and was not recognized as a pioneer in aviation until after her death in 1926.
- **Gwendolyn Brooks** is considered to be one of the most revered poets of the 20th century. She was the first Black author to win the Pulitzer Prize in 1950 for *Annie Allen*, and she served as poetry consultant to the Library of Congress, becoming the first Black woman to hold that position.
- **Jane Bolin,** a pioneer in law was the first Black woman to attend Yale Law School in 1931. In 1939, she became the first Black female judge in the United States, where she served for 10 years**.**
- **Dr. Rebecca Lee Crumpler** was the first Black female doctor in the United States. Dr. Crumpler graduated from the New England Female Medical College in 1860 and worked as a physician for the Freeman's Bureau for the State of Virginia.

Kamala Harris:

Vice President of the United States

Kamala Devi Harris is an American politician and attorney who is now the vice president of the United States. Harris served as a United States senator from California from 2017 to 2021, and as attorney general of California from 2011 to 2017. On Saturday, November 7, 2020, after Joe Biden had sealed enough electoral votes to become president-elect, he and running mate Kamala Harris addressed the nation from Wilmington, Delaware. Harris spoke first. Here in part, is what she said.

Congressman John Lewis, before his passing, wrote: *"Democracy is not a state. It is an act."* And what he meant was that American's democracy is not guaranteed. It is only as strong as our willingness to fight for it, to guard it and never take it for granted. And protecting our democracy takes struggle. It takes sacrifice. But there is joy in it, and there is progress. Because we the people have the power to build a better future.

And when our very democracy was on the ballot in this election, with the very soul of America at stake, and the world watching, you ushered in a new day for America. I know times have been challenging, especially the last several months—the grief, sorrow and pain, the worries and the struggles. But we have also witnessed your courage, your resilience and the generosity of your spirit.

Excerpted from the Washington Post

Meet Amanda Gorman

National youth poet laureate reads a poem during Joe Biden's inauguration ceremony on the West Front of the U.S. Capitol on Wednesday, January 20, 2021.

Poet Amanda Gorman is the youngest ever inaugural poet and the country's first ever Youth Poet Laureate. Gorman became Youth Poet Laureate of Los Angeles at age 16, and later National Youth Poet Laureate in 2017, while she was studying at Harvard University. She has written for the New York Times and has three books forthcoming with Penguin Random House.

Gorman was born and raised in Los Angeles, California and was raised by her single mother, Joan Wicks, a 6th-grade English teacher in Watts, with her two siblings. She has a twin sister, Gabrielle, who is an activist and filmmaker.

Gorman is a stunning example of persevering in the face of hardship and significant challenges. In spite of a speech impediment, she has become a phenomenal, captivating orator. After experiencing chronic ear infections as a baby, she developed an auditory processing disorder that caused a speech impediment. Gorman says "My speech impediment…was dropping several letters that I just could not say for several years, most specifically the "r" sound. I had to really work at it and practice to get where I am today."

Gorman 's inaugural poem, "The Hill We Climb" was a poignant recognition of the pain of America's past — particularly its most immediate past — and the promise of its future. Wearing a bright-yellow coat and standing in front of the Capitol her words reverberated across the

inaugural stage as she offered hope, self-criticism and self-forgiveness to a country:

“And yet the dawn is ours before we knew it.

“Somehow, we do it.

“Somehow, we’ve weathered and witnessed

“A nation that isn’t broken, but simply unfinished.”

The author of the *The Hill We Climb: An Inaugural Poem for the Country* (Viking Books for Young Readers, March 2021), the poetry collection *The Hill We Climb* (Viking, September 2021) and *The One for Whom Food Is Not Enough* (Penmanship Books, 2015). Both of Gorman’s upcoming books, which aren’t due to be released until September, are Amazon’s top selling, sitting at the site’s #1 and #2 slots.

Written in part by:

Maya King, Campaign 2020 Reporting Fellow, POLITICO
Nolan D. McCaskill, Congressional Reporter

Moderna vaccine Co-Lead

Dr. Kizzmekia S. Corbett, Ph. D

Kizzmekia "Kizzy" S. Corbett is a viral immunologist at the Vaccine Research Center at the National Institute of Allergy and Infectious Diseases, National Institutes of Health based in Bethesda, Maryland.

At the onset of the COVID-19 pandemic, Dr. Kizzmekia Corbett started working on a vaccine to protect people from coronavirus disease. Her interest in science started from an early age, but she never knew the difference she would make. "To be honest, I didn't realize the level of impact that my visibility might have… I do my work because I love my work," Corbett said.

When asked about her involvement with the development of the COVID-19 vaccine, Corbett said, “To be living in this moment where I have the opportunity to work on something that has imminent global importance… it’s just a surreal moment for me.”

In December 2020, Dr. Anthony Fauci, the Institute’s Director and nation's top infectious disease expert and a constant presence on TV during the coronavirus pandemic, was asked a blunt question during a forum hosted by the National Urban League: "Can you talk about the input of African American scientists in the vaccine process?"

Fauci didn’t hesitate when giving an answer. “Kizzy is an African American scientist who is right at the forefront of the development of the vaccine.”

"The very vaccine that's one of the two that has absolutely exquisite levels -- 94 to 95% efficacy against clinical disease and almost 100% efficacy against serious disease that are shown to be clearly safe -- that vaccine was actually developed in my institute's vaccine research center by a team of scientists led by Dr. Barney Graham and his close colleague, Dr. Kizzmekia Corbett, or Kizzy Corbett," Fauci told the forum.

Corbett is an expert on the front lines of the global race for a SARS-CoV-2 vaccine, and someone who will go down in history as one of the key players in developing the science that could end the pandemic.

Submitted by: Debrah DeLoney-Deans, LMFT
Excerpted from various media sources

SAFE BLACK SPACE:

A Healing Circle by & for People of African Ancestry

Home. Healing. Hope.

Safe Black Space
HOME. HEALING. HOPE

Safe Black Space Community Healing Circles started in April 2018 in response to increased racial tensions and trauma after the killing of Stephon Clark, an unarmed 22 year old Black man, by the Sacramento Police. Meant to provide a chance for Black people to deal with the rage, shock, fear, and sadness that so many of us were (and are) feeling.

Safe Black Space has mobilized a growing collective of local practitioners, community members and activists,

faith leaders, educators and others of African ancestry. This village has been offering Safe Black Space Community Healing Circles on a monthly basis across Sacramento, as well as advocating locally and demanding justice in instances of racism and oppression.

For more information regarding SBS:

Phone: 530-683-5101
Email: SafeBlackSpace@gmail.com
Visit on Facebook

Have you heard?

Trauma Informed Culturally Responsive Treatment (TICRT)

Sacramento County Behavioral Health Services is now offering services focused on the African American/Black community: **Trauma Informed Culturally Responsive Treatment (TICRT).**

If you are looking to work through some personal issues you are facing, please reach out directly to one of the TICRT Therapists to schedule therapeutic services impacting the Black and African American community.

Please follow the link below to choose your provider today!!
https://dhs.saccounty.net/BHS/Pages/Mental-Health-Services.aspx

If you are a licensed clinician or you know someone who is who may be interested in becoming a contracted provider to deliver services through the Sacramento County TICRT, please see the links below for more information.

Here are the TICRT Minimum Qualifications:
https://dhs.saccounty.net/Documents/Sacramento%20County%20Minimum%20Qualifications%20for%20Licensed%20Clinicians%20to%20Provide%20Trauma%20Informed%20Culturally%20Responsive%20Therapy.pdf

Here is the Credentialing Application:
https://dhs.saccounty.net/Documents/Sacramento%20County%20Credentialing%20Application%20for%20Licensed%20Clinicians%20to%20Provide%20Trauma%20Informed%20Culturally%20Responsive%20Therapy.pdf

Advancing Behavioral Health Equity

Over the past few months, the Sacramento County Board of Supervisors has declared that racism is a public health crisis and Behavioral Health Services has initiated a targeted universalism approach to advance behavioral health equity. According to SAMHSA, "Behavioral Health Equity is the right to access quality health care for all populations regardless of the individual's race, ethnicity, gender, socioeconomic status, sexual orientation, or geographical location. This includes access to prevention, treatment, and recovery services for mental and substance use disorders (https://www.samhsa.gov/behavioral-health-equity)."

Targeted Universalism involves setting a universal goal that can be achieved through targeted approaches (https://belonging.berkeley.edu/targeteduniversalism).

This year, BHS is piloting a targeted universalism approach by partnering with African American/Black/Of African Descent community members and eight BHS providers to form a Behavioral Health Racial Equity Collaborative (BHREC) in order to improve behavioral health outcomes in Sacramento County. All organizational members of the BHREC will create their own BHREC Action Plan, each using their own strategies to achieve the shared behavioral health equity goals of the BHREC. The core goals of the BHREC Action Plans will be determined during the Collaborative through various strategies, including a survey of the community, focus groups and analysis of already existing Sacramento and state level data. This Collaborative will serve as a pilot so that BHS and its providers can learn how to work effectively in and with communities to achieve equity.

To read more about the Behavioral Health Racial Equity Collaborative, please see the overview at

https://dhs.saccounty.net/BHS/Documents/BHREC/Behavioral-Health-Racial-Equity-Collaborative.pdf.

Trauma Informed Wellness Program for the African American/Black Community

Sacramento County Behavioral Health Services in partnership with The Center at Sierra Health Foundation has awarded $2.5 million to four organizations for outreach, engagement and prevention services to African American/Black Community members. Funding will focus on people of all ages and genders, with special consideration for children, youth and transition-age youth (ages 0-25) who have experienced or been exposed to trauma. Programs will incorporate an understanding of African American/Black cultural heritage, including norms and traditions, the broad multifaceted definition of family, and historical trauma.

Trauma-informed Wellness Program grants have been awarded to:

- Improve your Tomorrow, Inc.
- ONTRACK Program Resources, Inc.
- Roberts Family Development Center
- Rose Family Creative Empowerment Center

"Sacramento's Black community has long advocated for real commitment to its potential, power and wellness. We are proud to bring funding and trusted community resources together in this program for culturally relevant healing—not only during a pandemic that has disproportionately impacted Black people and families but into the future," said Chet P. Hewitt, President and CEO of Sierra Health Foundation and The Center.

"We are committed to developing and implementing new prevention programs that include activities which help to mitigate the impact of trauma experienced by African American community members who have experienced trauma or have been exposed to trauma. I am very excited about the launch of the Trauma Informed Wellness Program for the African American/Black community and look forward to the positive impact it will have in the communities we serve," said Ryan Quist, Ph.D., Sacramento County Behavioral Health Director.

If you have questions regarding the TIWP and need more information regarding the services provided, please contact Sierra Health Foundation, Monday through Friday, 8:30am to 5:00pm at: 916.922.4755 or at www.sierrahealth.org.

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Building Black Resilience in 2021…

The Living Room
African American Suicide Prevention project

At the start of 2020, we had just completed the community needs assessment survey which provided input from the community on how this project should be designed. We learned that much of the community wanted services rendered by people who looked like them and understood the needs of the Black community. We learned that although the community knew what they wanted they were unsure about how and where to get it. Much of their vision was constructed utilizing strategies delivered in traditional health care settings. The challenge with utilizing these models is that they were unsuccessful in maintaining long term relationships which the Black community. But in the absence of significant funding, resources and time, the project started with a traditional way of looking at service provision. The basic model included drop-in services at multiple sites, phone access, groups and crisis counseling. The model also made some assumptions about how Black people access services; most people in response to advertisement would drop-in or call and then, show up for an appointment.

We learned quickly that our assumptions about how people would access services was wrong. Cold call advertisement was ineffective in engaging and moving people into care. Participation was influenced by trust and trust was certified through word of mouth advertising from family and friends who had already used the service. Then COVID-19 hit!! Instantly, we had to learn how to deliver most services online through zoom. An experience that required training for both staff and participants. Everything was influenced by our ability to deliver it through an electronic resource. Without instant access to established networks, the telephones rarely rang. We learned that appointments were a waste of time and that whenever they showed up, we needed to be ready. The concept of office hours eroded into a warmline effort where calls were answered whenever the phone rang.

Groups became the staple of what we offered. But the theme of those groups needed to address hope, perseverance, courage, and faith. We found that most people were suffering from the impact of social isolation, the absence of networks like church, clubs, sports and casual dating ("booty-calls"). Every human touch had to be designed to address the immediate need and to apply a Band-Aid of resilience. We began and continue to offer Restoration Hope, an online drop in group that's open to whomever shows up. It's designed to apply first aid to individuals seeking a quick fix and a push to try again. STAND UP was designed to address the needs of people in recovery, struggling to maintain the skills they developed in the face of police killings, social injustice, fear and anxiety. New Vision New You shines a light on the foundation of who you are. Participants are encouraged to use their gifts and talents to design a new way of addressing the new challenges of the day. The Ancestral Sit Spot engaged our cultural roots in the service of faith, hope and courage to get through anticipated acts of racism and white supremacy during the inauguration. Each group was designed based upon the immediate needs of the community using a rapid response model and established networks.

We are continually learning and flexing to address the needs of the Black community. It is exciting but also challenging. We look forward to stretching more in 2021.

For More information:
Call 916-234-0178
Facebook: African American Suicide Prevention Project
Email: aaspp@achurchforall.org

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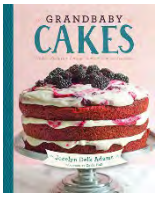
Recipe Row

Soul food, the foods and the techniques associated with the African American cuisine is a term that became popular in the 1960s during the rise of "Black pride." African Americans often find sanctuary and comfort in good food and genuine conversation.

Soul food is one of the most popular and recognizable types of cooking. For centuries, Black Americans have passed on hearty, sumptuous recipes that have marked many a special occasion. Soul food originates mostly from Georgia, Mississippi and Alabama, a collection of states commonly referred to as Deep South. There are staples at holiday dinner tables, like greens and hot water cornbread, okra, black-eyed peas, fried chicken, sweet potato pie and peace cobbler.

Jocelyn Delk Adams is the author of the award winning and best-selling cookbook Grandbaby Cakes and the founder of Grandbaby Cakes, a food blog that gives her family's, particularly her grandmother's, cherished generational recipes her modern spin while preserving the most important ingredient - tradition.



Use the link to find tasty traditional recipes for your whole family to enjoy! https://grandbaby-cakes.com/

Divas Can Cook is a food blog run by Monique Kilgore and features recipes that span from snickerdoodles to margaritas. *"I started Divas Can Cook back in 2009 when I noticed a shortage of authentic Southern recipes like the kind I grew up on. I'm talking about that deep south, Elberton, GA cooking like authentic, hamburger steak and gravy, and forgotten tea cakes. Sadly those recipes seemed to be fading away or was hard to come by. The fine folks who were actually sharing these types of recipes were much older than I and looked nothing like me. When I couldn't find my young, relatable, brown diva cooking soulful, from-scratch recipes, I decided to become her! That is when Divas Can Cook was born!"*

For Southern Recipes that anyone can cook. Find Monique and her wonderful recipes at: **https://www.Divascancook.com**

Black History Month Word Search Game
Find the words pertaining to African American history and the civil rights movement

L	O	P	P	R	E	S	S	I	O	N	Q	D	I	S	I	M
E	S	H	A	R	E	C	R	O	P	P	E	R	R	E	K	N
V	J	U	S	T	I	C	E	L	Y	Y	S	T	X	G	F	K
R	O	G	Q	B	P	R	O	T	E	S	T	T	F	R	I	N
K	C	L	P	F	M	X	N	W	T	H	Y	A	H	E	W	P
C	N	Q	Y	T	I	L	A	U	Q	E	F	T	J	G	Q	C
I	O	T	T	O	C	Y	O	B	J	R	S	W	I	A	I	O
V	I	H	O	U	Z	U	O	A	I	I	H	Y	M	T	Y	R
I	T	S	F	P	I	U	A	C	N	L	T	A	C	I	R	Y
L	A	W	U	R	V	Z	A	O	F	F	R	N	R	O	E	O
W	R	S	B	F	N	R	I	U	R	C	A	O	O	N	V	S
A	G	D	S	A	F	T	E	E	H	M	I	R	W	P	A	U
R	E	K	W	R	I	R	E	V	B	G	J	T	V	C	L	B
H	T	K	F	L	C	D	A	U	R	M	V	O	W	A	S	C
I	N	T	O	T	O	V	T	G	R	A	T	Q	W	A	W	O
I	I	B	O	M	I	W	I	M	E	E	C	M	O	N	R	X
L	A	H	H	T	R	O	N	H	T	U	O	S	H	Y	F	N

ABOLITIONIST
AFRICA
BOYCOTT
BUS
CARVER
CIVILWAR
EQUALITY
FREEDOM
INTEGRATION
JIMCROW
JUSTICE
KWANZAA
MARCH
NAACP
NORTH
OPPRESSION
PROTEST
RIGHTS
SEGREGATION
SHARECROPPER
SLAVERY
SOUTH
SUFFRAGE
TUBMAN
VOTE

Lunar New Year

The Lunar New Year (LNY), celebrated by many Asian ethnic minorities, continues to be one of most important and festive holidays of the year. Although most commonly associated with China, many Asians from Vietnam, Korea, Laos, Malaysia, Singapore, and Indonesia celebrate LNY and the tradition varies from region to region. The date of LNY changes every year based on the lunar calendar and is celebrated for a few days. Oftentimes, families spend a few days preparing for the New Year and spend the next few days celebrating Lunar New Year with relatives and friends.

In 2021, Lunar New Year falls on February 12th and represents the Year of The Ox. The Ox is believed to represent strength, reliability, fairness, and conscientiousness. Despite the lack of gatherings and public celebration during the COVID-19 pandemic, families are most likely going to celebrate by performing the honored rituals and wearing bright clothes.

According to legends, the festive celebration LNY started with the story of a mythical beast called 年兽 (nián shòu) who lived in the mountains and hunted for a living. At the end of winter when there was nothing to eat in the mountain, it would come out to the villages to hunt and devour livestock, crops, and villagers. At that time, the villagers would put food outside of their door in the hope that Nian would be satisfied from the food they put out and would not attack any villagers. Throughout the years, the villagers then found out that Nian, who had the body of a bull and the head of a lion, was afraid of three things: the color red, loud noise, and fire. The villagers then would hang red lanterns and set off firecrackers during the New Year (at the end of Winter) to frighten away the Nian.

To this day, Chinese communities all around the world continues to perform and use the lion dance on New Year's Day as a ritual to scare away bad spirits from the community.

Similar to other holidays, LNY is most commonly celebrated with families and friends at home and follow the custom of exchanging visits — with close relatives first, then with distant relatives and friends. During these New Year's visits, children and the unmarried younger generation receive red envelope (*hongbao)* from married individuals and elders. It is also common to have certain dishes on the table, such as a whole fish (*yu)* and crescent-shaped dumplings, which represents good fortune and an abundance of wealth in the upcoming year.

In the few days leading to Lunar New Year, many families follow certain rituals and avoid doing certain activities. It is common for people to do a deep cleaning of their homes to "sweep away" the evil spirits, get a haircut to cut off the bad luck from the past year, or pay off debts to prevent financial issues following them into the New Year. Even though these rituals are believed to bring good luck for the upcoming year, it is considered a *taboo* to perform any of these rituals on New Year's Day as people want to avoid accidentally throwing away good luck for the upcoming year.

In addition to the previously mentioned rituals, kitchen work and sewing are also avoided because the use of sharp objects, such as knives and needles, is strictly discouraged as they represent bad luck and severing of relationships. Another *taboo* that people continue to stay away from is receiving medicine or doctor visits on New Year's Day as this is believed to lead to bad health in the upcoming year.

Submitted by Asian Pacific Community Counseling

ASIAN PACIFIC COMMUNITY COUNSELING

http://apccounseling.org/

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Please submit your ideas for future newsletters

Sacramento County Behavioral Health Services Cultural Competence & Ethnic Services Unit will continue to produce newsletters like this one. Please help us to celebrate the rich diversity of cultures in the County of Sacramento community by sharing your original content and photos along with your contact information to:

DHS Cultural Competence Unit

DHSCCUnit@saccounty.net

Please put "**newsletter**" in the subject line. Please note that we cannot use content without citing the source and cannot use photos without permission.

SACRAMENTO COUNTY

Helpful links:

Mental Health Access Service Request Form:
https://dhs.saccounty.net/BHS/Documents/Provider-Forms/MH-Forms/Service-Request-Form.pdf

COVID-19 Resources:
Behavioral Health COVID-19 (2019 Novel Coronavirus) General Resources

Behavioral Health COVID-19 (2019 Novel Coronavirus) Provider Resources

Job Seeker Resources
https://personnel.saccounty.net/Pages/ESJobSeekerResources.aspx

SACRAMENTO COUNTY

"We realize the importance of our voice when we are silenced."

--Malala Yousafzai

Cultural Competence & Ethnic Services Newsletter Issue 2 | March 2021

Women's History Month

March 1 marked the first day of Women's History Month 2021. The month-long celebration is a chance to acknowledge the historic achievements of women.

What is the theme of Women's History Month 2021?

"Choose to Challenge" - A challenged world is an alert world. Individually, we are all responsible for our thoughts and actions - all day, every day.

We can all choose to challenge and call out gender bias and inequality. We can all choose to seek out and celebrate women's achievements. Collectively, we can all help create an inclusive world.

From challenge comes change, so let us all choose to challenge!

About Women's History Month

Women's History Month had its origins as a national celebration in 1981 when Congress passed Pub. L. 97-28, authorizing and requesting the President to proclaim the week beginning March 7, 1982 as "Women's History Week." Throughout the next five years, Congress continued to pass joint resolutions designating a week in March as "Women's History Week." In 1987, after being petitioned by the National Women's History Project, Congress passed Pub. L. 100-9, designating the month of March 1987 as "Women's History Month." Between 1988 and 1994, Congress passed additional resolutions requesting and authorizing the President to proclaim March of each year as Women's History Month. Since 1995, presidents have issued a series of annual proclamations designating the month of March as "Women's History Month." These proclamations celebrate the contributions women have made to the United States and recognize the specific achievements women such as Abigail Adams, Susan B. Anthony, Sojourner Truth, and Rosa Parks have made over the course of American history in a variety of fields.

Detective Flossie Crump

1975 Sacramento Detective Division

In honor of Women's History Month, we celebrate the accomplishment of a trailblazing Sacramento woman:

Mrs. Crump's interest in law enforcement was prompted by two major incidents in her life. When she was about 14 or 15 years old, having just recently moved from New Mexico to Madera, California, she was walking from her mother's home, to a relatives' home when she was kidnapped off the street by an older white man. ***(cont'd next page)***

(Det. Crump story from p.1)

Mrs. Crump said*, "Thank God, I was not molested or raped, but I was inappropriately touched before I managed to escape my kidnaper. Because of my upbringing, I felt so ashamed, and I even felt dirty. Having found my way home, I was comforted by my mother, who was my rock and who got me through the whole devastating ordeal. My mother was always there for me, even when I woke from my nightmares; she just seemed to be there at the right time to hold me in her arms and comfort me. At the time, I didn't understand, nor did I question, my mother's decision not to report the incident to the police. I later learned that she didn't want me to be victimized again as she explained, 'The police would not believe a little black girl who accused a white man of kidnapping her.'"*

The second reason Mrs. Crump became a detective is because of an experience working at a law office between high school and junior college. One of the cases the firm took on was a young man who beat and raped an older woman. The lawyers won the case and got their young male client off. During the debriefing, knowing that he was guilty and having gotten the young man off, the lawyers expressed concern about protecting their own families from the young man now that he was back on the street. Mrs. Crump said *"I felt that the police officer had missed something during the investigation, and I felt that I could have done a better investigation that would have prevented this miscarriage of justice. I was also reminded of the earlier incident where my mother wanting to protect me and her lack of confidence in the justice system or in law enforcement."*

A combination of the two incidents above sparked her desire to become a police detective. At the time, there was a height requirement for sworn officers in California. The height requirement was 5.6 and Mrs. Crump was 5.5 ½. Because of the height requirements, she was not tall enough to become a police officer, a sheriff deputy or California Highway Patrol officer. So, she continued to work as a District Secretary in the AT&T Engineering Division.

In 1974, when the height requirements were removed, she applied to the Sacramento Police Department, passed all the requirements, and was hired on September 30, 1974 at the Sacramento Police Department where, upon successfully completing the 13-week live-in Academy, she became one of the first two females ever on patrol in the City of Sacramento as well as in the County of Sacramento. There were no other sworn females on patrol in either the police, sheriff, or the CHP Departments. Mrs. Crump said, *"My goal was not to be the first, but to be the best officer I could be."* ***(cont'd next page)***

International Women's Day

International Women's Day is meant to celebrate all the achievements of women across the world--all the contributions they have made to social, economic, cultural, and political advancements.

It is celebrated annually on March 8 utilizing the colors purple, green and white and is also a day to focus on calls for gender equality and parity.

History

1908: 15,000 women marched through New York City demanding better pay, shorter hours and voting rights.

1909: National Women's Day was observed for the first time across the United States on February 28.

1910: A second International Conference of Working Women was held in Copenhagen first brought up the idea that every year there should be a celebration in every country of women. International Women's Day was born.

1913: It was agreed that March 8 would be International Women's Day moving forward.

1975: International Women's Day was celebrated for the first time by the United Nations.

1996: The UN announced their first annual theme.

2001: The Internationalwomensday.com platform was launched with the goal of bringing new importance to the day.

2011: The 100 year anniversary of the first International Women's Day events held in Austria, Denmark, Germany and Switzerland. President Obama also proclaimed March 2011 Women's History Month.

Slideshow Celebrating Achievement of Women

https://www.newsweek.com/2020/01/31/women-advancements-achievements-100-years-1481959.html#slideshow/1559760

(Det. Crump story from p.2)

The Police Academy consisted of recruits for the Sacramento Police Department, the County Sheriff Department and other law enforcement agencies. There were other females attending the academy; however, upon completing the academy, they were not assigned to patrol but to correction facilities such as the County Jail, Rio Correctional Center, etc., where they were assigned to searching and addressing issues associated with female inmates. These females were not assigned to patrol until after it was proven, by Flossie Crump and Felicia Murphy, that women could be successful and could contribute to law enforcement by serving on patrol. Sexism was prevalent in the academy as women were thought to be the "weaker sex."

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Vol. 234—No. 38,689 Founded 1857 SACRAMENTO, CALIFORNIA,

Bee Photos by Owen Brewer

Officers Flossie Crump, left, and Felicia Murphy attend briefing.

Women Go On Patrol

Law Has Long Arm, Soft Shoulders

By John Murphy

If you need a policeman, it will be better hereafter to call for a policeperson; otherwise you might be embarrassed.

The officer who answers your call could be Felicia Murphy, 22, or Flossie Crump, 26 if you live in the city of Sacramento, or Sandy Carlson 33, or Lena Derheim, 31 if the sheriff provides your law enforcement.

The four women currently are on patrol duty, the first women patrol in offices in Sacramento history.

All four are, or have been married and say their spouses approve of their hazardous duties.

The two policewomen started

After completing the academy, there were more firsts. Since Mrs. Crump was the first female uniformed police officer, her uniform had not been tailored to fit or accommodate the female's body as every article of the uniform was designed for the male's body. This resulted in Officer Crump having to alter extensively the same uniform. *"By the time I altered a uniform to fit, the pockets were side-by-side."* There was no equipment for females. Even the safety vests were designed for a flat chest, thus

(cont'd next page)

International Women's Day Celebrated in former Yugoslavia

March 8, the International Women's Day was a very extraordinary day in the former Yugoslavia in the 1980s, the time of my childhood. On that day, all the women in my community would receive flowers, including teachers, employees, mothers, grandmothers, sisters, spouses, and even little girls like myself. They were not expensive, elaborate bouquets, but usually just a simple carnation or two. Nonetheless, I felt so proud to be a woman on that day that celebrated all of us!

Submitted by Ajna Glisic, LMFT

(Det. Crump story from p.3)
considerably compressing the breast area. The duty belt did not fit women's hips – everything had to be altered. The Department required that even Det. Crump's hair had be cut the same length as or as short as the men even though they all had to wear a uniform hat.

There was no locker room or rest room in the locker room area for women to use. Officer Crump had to go down the stairs to use the public rest room where a couple of lockers had been placed against a wall in the rest room. The "big" change came when lockers, for women, were placed upstairs just inside the men's locker room. This consisted of tall lockers positioned to form a square, with one locker missing to form the door, in the same area with the men on the other side. As the lockers did not extend to the ceiling, sexist and racist comments and "locker room talk" could easily be heard and were meant to be heard coming from the other side of the lockers from unsupportive uniformed officers. *"Though they could not see me, because of the shift we all worked, they knew we, Felicia, and I, were there. Sometimes they would toss their dirty under shorts and other items over the top of the lockers "*accidentally.*"*

Her first assignment was in Del Paso Heights, which at the time, was considered one of the lower or lowest economic neighborhoods in Sacramento. Mrs. Crump's opinion was that Del Paso Heights was no more dangerous than any other neighborhood, but it was considered economically depressed, primarily African American, with a somewhat higher crime rate. Mrs. Crump said, *"Patrol offices at Sac PD had their own opinions about race issues and during this time, the civil rights movement was being awakened. My Call Unit was Adam 34, and this was my first time ever working swing or graveyard shift. I had my first "everything" as a rookie patrol officer as Adam 34."*

"I was fortunate to have had three awesome outstanding training officers and all of whom were white. During those days, the patrol units were "2-men" cars. My training officers were exceptional, and they took heat because they were supportive of me and of women on patrol. They were intentional, instructional, and supportive, and sometimes intimidating."

Officer Crump was on patrol for approximately a year before being reassigned to the Detective Division. Detective Crump was on vacation when she learned about her reassignment. She contacted Felicia (Murphy), the other female officer, because she was getting, obscene, racist, filthy phone calls from fellow officers. Calls like "We killed two black birds with one stone," and "N***** you don't belong there/here." Only one officer ***(cont'd next page)***

Nowruz – Afghan & Iranian New Year, March 21

Welcome Spring! Nowruz, which means New Day, is the name for the celebrations that observe the New Year for Iranian and Central Asian communities. Nowruz celebrations are strong amongst people in Afghanistan and Iran.

Submitted by: Laila Barakat, Outreach & Resource Coordinator, MAS-SSF

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(Det. Crump story from p.4)
chose to explain his anger. Despite the hurtful and angry calls, Detective Crump said, *"I didn't judge all the officers by the few"* and *"I know that not everyone held that opinion."* The reassignment started a whole new phase in her career with completely new issues and concerns.

Detective Crump

Detective Crump explained that despite the racism and sexism she endured, she chose to remain professional and to focus on her goals. *"I could not allow it to affect the things that I did, and I could not allow it to affect everyone I worked with on the force. If I ran in to any of the officers who did or said those things, you would not be able to tell."*

Further, Detective Crump shared that the difficult experiences made her a stronger and better person, saying, "*I would not have chosen to go through some of the things that I went through. But, having gone through them, I would not change a thing, because it makes me who I am today, and I really like me. In fact, I love me." "Because of the way I was taught, my faith and the things I've experienced and seen, I don't paint everyone with the same brush."*

The Detective Division is where Detective Crump always wanted to be – to protect young girls, like she had been, women and mothers, like her mother, from having to make the kind of choice her mother had to make. She said she completely understands why her mother made the decision that she did, and Detective Crump supports her mother's decision 100% even to this day.

Detective Crump's first assignment was Sex Crimes and Child Abuse. *"I was now where I had dreamed of being;"* however, the racist and sexist remarks, followed her to detective division. *"But just as I had with training officers, I had excellent supporters in the Detective division. God always had somebody there who had my back. I always had the Black police officers who protected me like their little sister."*

One of the things that happened often in Detective Division where Detective Crump was the only Black female, her lieutenant, whom she believes was sexist and racist, would refer to Black females as "N*esses" and Black males as "N****." *"He had an issue with me because I was black and female, and he was extremely critical of any work that I did and he did not think I belonged in the* ***(cont'd next page)***

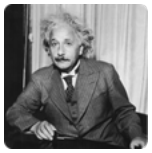
Pi Day

Celebration

Pi Day is an annual celebration of the mathematical constant π (pi). On March 12, 2009, the US House of Representatives passed a non-binding resolution recognizing March 14, 2009 as National Pi Day.

Significance of March 14

Founded in 1988 by physicist Larry Shaw, March 14 was selected as Pi Day because the numerical date (3.14) represents the first three digits of pi. It also happens to be Albert Einstein's birthday.



Idea submitted by Hafsa Hamdani, Cultural Competence Committee

Easy as Pie Apple Pie Recipe

Ingredients:

Package of 2 frozen pie crusts- (pull out to defrost a little while you make filling)
5-6 apples – peel/core/slice
½-cup honey
1-Tablespoon cinnamon
¼-teaspoon nutmeg
½ stick butter

1. Preheat oven to 375 Fahrenheit
2. Prick holes in the bottom crust
3. Toss apples and honey together with spices
4. Put everything in the pie pan
5. Cut butter into small pieces and toss on top
6. Remove 2nd pie crust from package and place on top
7. Use a fork to secure top and bottom – poke a few holes in the top with the fork
8. Bake for an hour.

(Det. Crump story from p.5)

Detective Division, especially Homicide, let alone on the Police force." She said this supervisor also required that female rape victims or female victims take a polygraph examination. This only made Detective Crump more motivated to work harder. During this time, as a race, African Americans were still considered "Negros." Contentiously and often, Police officers or supervisors would use the word "n*****" and when called on it, they would say, "You didn't hear me right," or "You misunderstood," or outright, "That is not what I said." It was not until 1982 that the Sacramento Police Department stopped using the term "Negro" and it was only after the Black Police Officers petitioned the Department to make the change.

After being recognized as a professional in areas and teaching the investigation of Sex Crimes and Child Abuse, Detective Crump became a homicide detective, being the first female and the first Black female to be assigned to that Division. She is most proud of one of her homicide cases— one of her most difficult cases— that took her to Australia where she, along with the US Marshalls apprehended, arrested, and transported the male suspect back to the United States to stand trial. The suspect was found guilty. This case required coordination with the FBI, the US Marshall Office, the Australian Consulate General, and others.

Despite all the racism and sexism, Detective Crump endured, amongst the distractors, she had some wonderful supporters, supervisors, and colleagues. One of her fondest memories of support is when she would come to her office in the mornings and there would be a voicemail or a message from fellow officers saying something like, "H*ang in there, we got your back."* Some days she would come in and there would be an orchid or flower on her desk with an encouraging note. She thinks she knows who left the orchid, but she is not positive, she is just grateful for the encouragement. Her biggest supporters were her family, her husband and her son, her mother, and her sister. *"These are the people who kept me going."*

During her successful tenure with Sacramento Police Department, Detective Crump worked in several Divisions, including Sex Crimes and Child Abuse; Homicide; and Robbery. She also trained and taught as a Corporal in the Sacramento Police Academy, the Advance Officers' training courses, POST, and C-Post. She also helped design the cases for investigation in the Robert Presley Institute, a two-week Course wherein Detectives/Investigators from all over the State attend the development and delivery of that course. Detective Crump received many ***(cont'd next page)***

Stop Asian Hate!

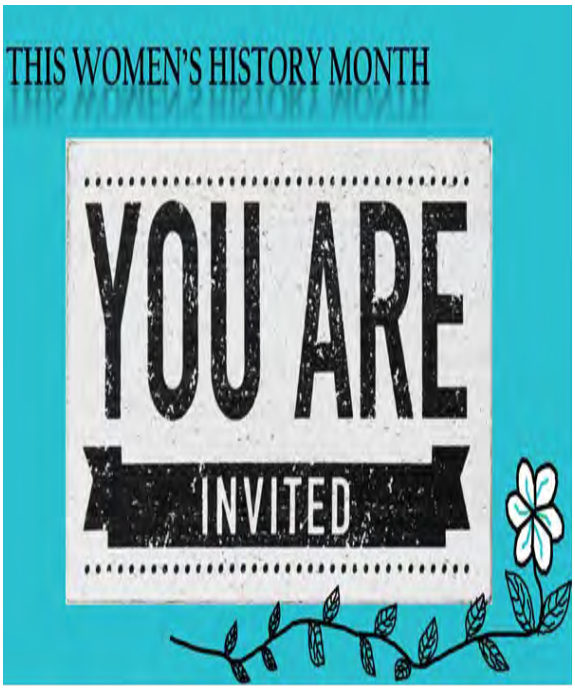
In the aftermath of the recent murder of eight people, six of them Asian-American women, people across the country are rising up in response:

"Today @POTUS and I met with Asian American leaders in Atlanta, Georgia to discuss the rise in attacks against the community. We want Asian Americans in Georgia and across our nation to know: We won't be silent. We won't standby. We will always speak out against violence."

— Vice President Kamala Harris (@VP) March 19, 2021

"Racism is a global evil.
It transcends generations and contaminates societies.
It perpetuates inequality, oppression and marginalization.
Let us work together to rid the world of racism so all may live in a world of peace, dignity and opportunity."
#FightRacism pic.twitter.com/4xarDDraq0

— António Guterres (@antonioguterres) March 20, 2021 – United Nations Secretary General



The County of Sacramento is making history this month for our women and girls by accepting applications for the new ***Sacramento County Commission on the Status of Women and Girls.***

Applications may be found at the link below:
https://sccob.saccounty.net/Pages/BoardsandCommissions.aspx

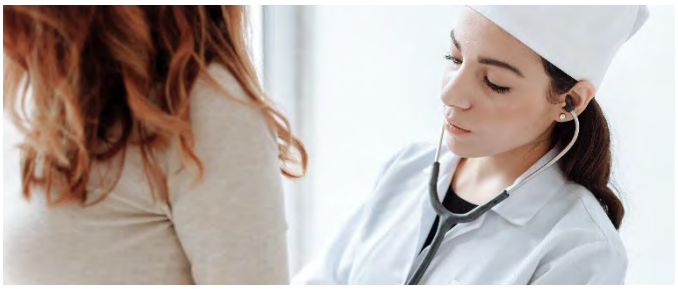
(Det. Crump story from p.6)
commendation letters and recognition from the public as well as from her supervisors throughout her career.

After retirement, the Sacramento Police Department honored Detective Crump and Officer Felicia Allen, by naming the Sacramento Safety Center (Police Department) Atrium after them. The Crump – Allen Atrium (Allen is Felicia's married name) was dedicated 3 years ago. The honor was unexpected but extremely appreciated. There is a commissioned artist painting of both Detective Crump and Officer Allen in the Atrium's Lobby.

Now retired, Mrs. Crump continues to volunteer with different organizations, including the City of Sacramento and the County of Sacramento. She is very involved with her church, the St. Paul Baptist Church in Oak Park. Mrs. Crump notes that she is very proud of her family, including her niece Amanda Gorman, the youngest Inaugural Poet who performed at the 2021 Biden-Harris Inauguration and at the Super Bowl. ☺

Submitted by Anne-Marie Rucker as told by Det. Crump

Honoring women in Healthcare



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Trans Day of Visibility (TDOV)

TDOV is a day to show your support for the Trans community. It aims to bring attention to the accomplishments of Trans people around the globe while fighting cissexism and transphobia by spreading knowledge of the trans community. Unlike Transgender Day of Remembrance, this is not a day for mourning; this is a day of empowerment and getting the recognition we deserve!

Please check out the link here transstudent.org/tdov/ and the flyer on the following page.

Trans Day of Visibility 2021

Please submit your ideas for future newsletters

Sacramento County Behavioral Health Services Cultural Competence & Ethnic Services Unit will continue to produce newsletters like this one. Please help us to celebrate the rich diversity of cultures in the County of Sacramento community by sharing your original content and photos along with your contact information:

DHS Cultural Competence Unit

DHSCCUnit@saccounty.net

Please put "**newsletter**" in the subject line. Please note that we cannot use content without citing the source and cannot use photos without permission.

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Helpful links:

Mental Health Access Service Request Form:
https://dhs.saccounty.net/BHS/Documents/Provider-Forms/MH-Forms/Service-Request-Form.pdf

COVID-19 Resources:
Behavioral Health COVID-19 (2019 Novel Coronavirus) General Resources
Behavioral Health COVID-19 (2019 Novel Coronavirus) Provider Resources

Job Seeker Resources
https://personnel.saccounty.net/Pages/ESJobSeekerResources.aspx

SACRAMENTO COUNTY

"The fight is never about grapes or lettuce. It is always about people."

■ César Chávez

Cultural Competence & Ethnic Services Newsletter Issue 3| March 2021

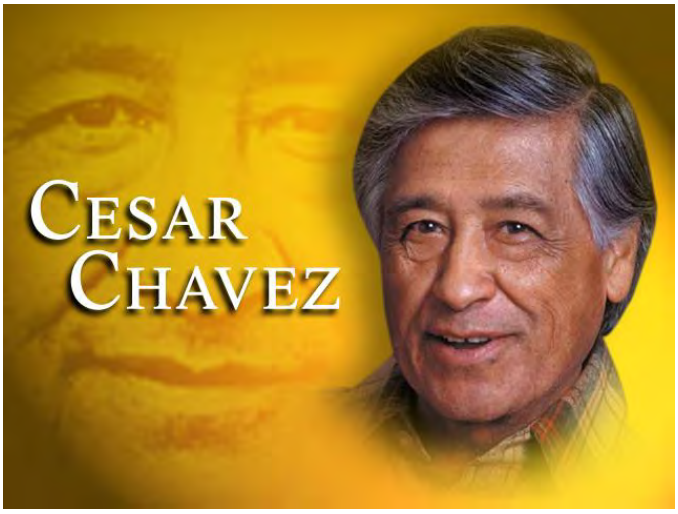
March Addendum

Special Issue:

César Chávez Day, March 31

Celebrating "La Causa"

Annual holiday on March 31 to celebrate legacy of Chávez and be a day of service



The Mexican-American labor leader and civil rights activist César Chávez dedicated his life's work to what he called "*la causa*" (the cause): the struggle of farm workers in the United States to improve their working and living conditions through organizing and negotiating contracts with their employers.

Celebrating César Chávez Day

in the County of Sacramento

The Sacramento County Board of Supervisors on June 9, 2015 approved the establishment of March 31 as an annual County Holiday and Day of Service in recognition of the late labor leader and founder of the United Farm Workers, César E. Chávez.

"Given the civil rights legacy and significance of César Chávez to this region, coupled with the fact that the State of California created the holiday in 2000, it is long overdue that Sacramento County step up and honor his contribution," said Board of Supervisors Phil Serna.

"The day will commemorate César Chávez' birth and very appropriately be used to

promote community service and civic engagement."

Presidential Proclamation

President Barack Obama dedicated a national park to Chávez and his presidential proclamation reads in part:

"César Chávez is one of the most revered civil rights leaders in the history of the United States. From humble beginnings in Yuma, Arizona, to the founding of the United Farm Workers (UFW) movement, César Chávez knew firsthand the hard work of farm workers in the fields across the United States and their contribution to feeding the Nation. He saw and experienced the difficult conditions and hardships that confronted farm worker families. And through his hard work, perseverance, and personal sacrifice, he dedicated his life to the struggle for respect and dignity for the farm workers of America."

Gravesite of César Chávez at César E. Chávez National Monument

National Park Photos

& link for more photos and information:

https://www.nps.gov/cech/index.htm

Brief biography

César Estrada Chávez was born in Yuma, Arizona on March 31, 1927. In the late 1930s, after losing their homestead to foreclosure, he and his family joined more than 300,000 people who moved to California during the Great Depression.

They became migrant farm workers.

Chávez dropped out of school after the eighth grade and began working in the fields full time. In 1946, he joined the U.S. Navy, serving for two years in a segregated unit.

After his service was over, he returned to farm work and married Helen Fabela, with whom he would eventually have eight children (and 31 grandchildren).

César Chávez photo with wife Helen and six of his children

In 1952, Chávez was working at a lumberyard in San Jose when he became a grassroots organizer for the Community Service Organization (CSO), a Latino civil rights group.

Over the next decade, he worked to register new voters and fight racial and economic discrimination, and rose to become the CSO's national director.

Chávez resigned from the CSO in 1962, after other members refused to support his efforts to form a labor union for farm workers. That same year, he used his life savings to found the National Farm Workers Association (NFWA) in Delano, California.

Chávez knew firsthand the struggles of the nation's poorest and most powerless workers, who labored to put food on the nation's tables while often going hungry themselves. Not covered by minimum wage laws, many made as little as 40 cents an hour, and did not qualify for unemployment insurance. Previous attempts to unionize farm workers had failed, as California's powerful agricultural industry fought back with all the weight of their money and political power.

Chávez died in his sleep on April 23, 1993, at the age of 66. The following year, President Bill Clinton awarded him a posthumous Presidential Medal of Freedom, the nation's highest civilian award. In a sign of the labor leader's enduring influence, Barack Obama borrowed a Chávez slogan "Si, se puede", or "Yes, we can" during his successful run to become the first Black U.S. president in 2008. Today, a bust of César Chávez is displayed prominently behind President Biden's desk in the Oval Office.

Special thanks to La Familia Counseling Center, Inc. for their contributions to this newsletter

A Personal Sacramento Connection

This writer became a photographer while serving in the U.S. Army from 1966 – 1968. It was at the time that I was going to Sacramento City College in 1968 that I was approached by members of the MAYA Club (Mexican American Youth Association). They invited me to work in the UFW (United Farm Workers). I met César Chávez and Dolores Huerta in the many protests and strikes against the grape growers and then the lettuce boycott.

In the late 1960's, my photography came in handy. I worked for the UFW for about ten years. During this period, I learned a great deal about organizing and helping the farm works get a union that would protect them.

César Chávez, CA State Capitol 1971
Photograph courtesy of the photographer Hector Gonzalez

César Chávez was also a veteran and a good photographer. Maybe that is why we were able to get along so well. We would talk photography and the movement. My involvement with the UFW was also part of my parent's story. They also came to this country from Mexico and their first job was working in the tomato fields. They encouraged me to help César and the UFW.

César Chávez, UC Davis 1971
Photograph courtesy of the photographer Hector Gonzalez

César Chávez made the citizens of the world aware of how hard and difficult conditions were in the fields. César was able to bring dignity and better working conditions to the farm workers. My friend César Chávez sacrificed his life for the form workers. He went on a 36 day fast for Life on August 21, 1968. I remembered when my friend passed away. He died in his sleep on April 23, 1993. I was teaching at C.K. McClatchy when I heard the news of his passing. Tears rolled down from my eyes. I could not believe that he was gone!

César Chávez, CSUS 1972
Photograph courtesy of the photographer Hector Gonzalez

Si Se Puede!

I will always remember the slogan that Dolores Huerta (Vice President of the UFW) coined, "Si Se Puede! Yes We Can!"

César will always be my hero. I miss him a lot. Thank you for your friendship!

Submitted by Hector Gonzalez, Sacramento

Special thanks to Hector Gonzalez for sharing his personal stories and photographs of César Chávez with me. Mr. Gonzalez taught me Spanish when I was a student at CK McClatchy High School. He inspired many young people over the years and taught us about the importance of culture as he taught us the language.

Muchas gracias, Seňor Gonzalez!

– Mary Nakamura, Behavioral Health Services Cultural Competence/Ethnic Services Manager

Please submit your ideas for future newsletters

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SACRAMENTO COUNTY

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Substance Use Prevention and Treatment Services:
https://dhs.saccounty.net/BHS/Pages/SUPT/Substance-Use-Prevention-and-Treatment.aspx

COVID-19 Resources:
Behavioral Health COVID-19 (2019 Novel Coronavirus) General Resources

Behavioral Health COVID-19 (2019 Novel Coronavirus) Provider Resources

https://www.saccounty.net/COVID-19/Pages/default.aspx

Job Seeker Resources
https://personnel.saccounty.net/Pages/ESJobSeekerResources.aspx

SACRAMENTO COUNTY

"Alone we can do so little; together we can do so much."

--Helen Keller

Cultural Competence & Ethnic Services Newsletter

Issue 4 | April 2021

April marks the month long celebration of various spiritual and cultural celebrations, festivals and observances / remembrances. In this month's edition of the Cultural Competence & Ethnic Services Newsletter, we will be taking a closer look at the intersection of behavioral health, faith and spirituality. We will also be featuring observances and holy days in April such as Easter, Lent, Passover, Yom HaShoah / Holocaust Remembrance Day, Ramadan, and cultural New Year celebrations.

Bridging the Gap

According to NAMI, one in five adults have experienced a mental illness in a given year and one in six youth between the ages of 6-17 have experienced a behavioral health disorder each year. We know that mental illness does not discriminate based on age, race, ethnicity, gender, or socioeconomic status. We also know that there is often a stigma associated with behavioral health and many do not seek help because of the associated stigma. We know that many may seek help and support from their spiritual leaders before seeking support and help through mainstream Western treatment. We also know that for many communities, faith and spirituality play an integral part in their well-being. Faith and spirituality can build protective factors and offer other benefits such as a sense of support, comfort, belonging, community, and believing in something or someone higher than one's self. We know that individuals can be supported by both their faith and spirituality and from mainstream behavioral health services.

We see a need to bridge the gap between spiritual and faith communities and mainstream behavioral health services and treatment. Bridging the gaps between the intersection of faith and spirituality and mainstream behavioral health treatment can have profound effects. Working together with faith communities can help reduce stigma and normalize issues related to behavioral health so that people can feel comfortable getting support from both their faith community and mainstream services. Each can bolster the other and be beneficial. We can work together to foster partnerships, collaborations and increase mutual understanding between faith communities and behavioral health and be the better for it.

Behavioral Health Services Cultural Competence & Ethnic Services unit staff endeavor to bridge those gaps by working with behavioral health friendly churches, mosques, synagogues, temples, and other spiritual/faith centers. We are here to support those in the faith community by offering information on behavioral health

awareness, services, and stigma reduction, and now our Cultural Competence newsletter. We provide information on how to access Sacramento County Behavioral Health Services and give out educational brochures, booklets, tip cards, and flyers from the BHS "Mental Illness: It's not always what you think" project to promote messages of hope and recovery, encourage conversation around mental illness, and underscore that mental illness can impact anyone [https://www.stopstigmasacramento.org/]. We also participate in outreach events, provide brief presentations on behavioral health awareness, staff tables/ booths at community fairs, etc., to help reach and support those in the faith and spiritual communities. We have been working with faith communities since the early 2000s. Continue reading to learn more about some of the observances and holy days in April that are important to several of our diverse communities.

Easter

The Easter celebration is a Christian observance that starts with Palm Sunday and continues until Easter Sunday (April 4, 2021). Palm Sunday is considered the first day of the Holy week and is observed on the Sunday before Easter. The observance continues on Good Friday, which is observed as the death and burial of Jesus Christ. The celebration culminates on Easter Sunday, celebrating the resurrection of Jesus Christ, which is recognized as resurrection Sunday. Many cultures celebrate by attending church, wearing their best Easter clothes, having a dinner with family and friends, kids receiving Easter baskets and having Easter egg hunts.

Lent

Lent began on Ash Wednesday, February 17 and ended on April 3, 2021. The observance of Lent marks 40 days of fasting, prayer, attending mass, and giving to others. It symbolizes Jesus' time of fasting and prayer in the wilderness. It is a season of reflection, observance and preparation before Easter and is observed by some Christian faith communities.

Passover

Passover, also called Pesach, meaning "passing over," is known as the Feast of Unleavened Bread. It is an eight-day Jewish festival celebrated during the month of Nisan in the Hebrew calendar, which began sunset on March

27, 2021 through the last night on April 4, 2021. The Passover commemorates the account in the Torah of the Israelites being freed from slavery in ancient Egypt and led out by Moses. It is celebrated with family and friends, and includes eating special Seder meals consisting of kosher foods, unleavened bread such as a flatbread called matzo/matzah, bitter herbs and having four cups of wine, lighting of candles, and refraining from food made with yeast. It is also tradition to tell the story of Passover, sing and offer prayer.

Yom HaShoah

Yom HaShoah, also known as, Holocaust and Heroism Remembrance Day, is a national memorial day in Israel and was celebrated on April 8, 2021. It commemorates the lives and heroism of the six million Jewish people who perished in the Holocaust between 1933 and 1945. It began the evening of April 7 through the evening of April 8. Yom HaShoah was first observed in Israel in 1951 and established into law in 1959. In Israel, the memorial is marked with air raid sirens sounding at 10:00 A.M., before the observation of a two-minute period of silence. Flags are flown and half-mast and many establishments are closed in observance of Yom HaShoah in Israel. Holocaust remembrance is observed in various months worldwide including in the U.S on January 27 in observance of the anniversary of Jewish liberation.

Ramadan

Ramadan is the Islamic Holy Month. In 2021, Muslims begin to observe the holy month of Ramadan, the ninth month of the Islamic lunar calendar, starting at sundown on Monday, April 12 for 30 days until sundown on Tuesday, May 11. It is a month of fasting, prayer, reflection, and generosity for Muslims worldwide. The fast lasts each day from sunrise to sunset. The fast is broken by sharing a meal with family and friends. Muslims believe that their Holy Book, The Quran, was first revealed to the Prophet Mohammed by God during the month of Ramadan. In some countries, lights or lanterns are used to decorate streets and homes in the month of Ramadan. The end of Ramadan is marked with a celebration known as Eid al-Fitr or “Festival of Breaking the Fast" where families gather and visit each other with feasts and sweet treats.

New Year Celebrations

There are several New Year celebrations held in April throughout South and Southeast Asian countries. To name a few, the New Year celebrations are called Ugadi, Gudhi Padwa, Navreh, Chitra Navaratri, Vaisakhi,

Puthandu, Vishu in different states in India. The New Year was celebrated between April 12 – 15, 2021 by cleaning the house, visiting temples, offering prayers, giving gifts, family feasts, homes being lit with oil lamps and decorated with flowers to attract blessings.

Bengali New Year or Pahela Baishakh was also celebrated on April 14, 2021. It celebrates the agricultural season and is marked by spending time with family, visiting fairs, and cleaning the house to prepare for the New Year.

Burmese New Year, also known as the Water Festival, is a Buddhist festival that was celebrated April 13-16, 2021. It is celebrated by attending a Buddhist temple, prayer, and spraying water on each other in celebration of washing away the old year and celebrating the New Year. Young people wash the hair of the elders as a sign of respect.

Laotian/Thai New Year was celebrated also on April 14-16, 2021. It celebrates the end of the dry season and celebrates rebirth and purification. People offer prayers at temples, hold ceremonies, and host parties. Flowers, perfume, traditional music and dance are all a part of the celebration. It is also celebrated with water splashing as a symbol to give a person a blessing.

Cambodian New Year was on April 14, 2021 and celebrates the end of harvest. People leave their homes and celebrate in the streets and neighborhoods.

SACRAMENTO COUNTY

County of Sacramento News April 6, 2021

Board Condemns Violence Against Asian Americans

The Board of Supervisors unanimously voted in support of a resolution that condemns and will combat racism, xenophobia, and intolerance against people in the Asian American and Pacific Islander (AAPI) community.

The resolution, brought forward by District 2 Supervisor Patrick Kennedy, confirms that Sacramento County's Board of Supervisors will work to ensure all members of AAPI communities are treated with dignity, respect and feel safe in this community.

"This resolution is, unfortunately, necessary and timely," said Supervisor Kennedy. "We condemn in the strongest terms all hate crimes and xenophobic rhetoric against AAPI individuals, communities and businesses during the pandemic. It is important for the AAPI community to know that Sacramento County stands with each and every one of you.

"We are committing ourselves today to develop real, community-led solutions that acknowledge the experiences of AAPI residents, root out systemic racism, and uplift racial unity."

Since the outbreak of the COVID-19 pandemic in California in March 2020, there has been a rise in reported hate incidents and crimes against AAPI individuals because of harmful rhetoric related to the geographic origins of the disease. Stop AAPI Hate, a national coalition aimed at addressing anti-Asian discrimination through the pandemic, received reports of more than 800 hate incidents in California against the AAPI community from March to June 2020.

The resolution also states the intent to work with AAPI community partners in support of data gathering that is culturally appropriate and to acknowledge systemic barriers to reporting hate crimes impacting people in the AAPI community.

CONTACT INFO:

KIM NAVA, SACRAMENTO COUNTY PUBLIC INFORMATION OFFICE

At The Intersection

H	M	C	I	W	E	L	L	N	E	S	S	I	H
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BHS
SYNAGOGUE
COMMUNITY
CHURCH
COLLABORTION
FAITH
WELLNESS
CULTURAL
SUPPORT
INTERSECTION
TEMPLE
MOSQUE
SPIRITUALITY
HOPE

Play this puzzle online at : https://thewordsearch.com/puzzle/2071291/

Resources and Program Highlights

In light of the rising hate crimes against Asian American and Pacific Islander (AAPI) communities, we want to provide information on support services and resources that are available to the AAPI community in Sacramento County.

Asian Pacific Community Counseling

Asian Pacific Community Counseling (APCC) is located at 7273 14th Ave, Suite 120-B Sacramento, CA 95820 - (916) 383-6783. APCC is a Supporting Community Connections (SCC) provider who provides suicide prevention education, outreach & engagement to Cantonese, Hmong, and Vietnamese speaking communities.

The Asian and Pacific Islander (API) communities in the U.S. have faced a history of xenophobia, racism, incarceration in concentration camps, anger, violence and barriers for more than hundred years. Even though they have raised their voices to be heard, they have been and continue to be silenced. The common assumption that API communities can take care of their own has led to API being left out of conversations about what it means to be a truly diverse and inclusive society where everyone's voice is heard, resources are equitably distributed and policies are fair and inclusive.

Our clients, particularly elderly clients and their families and caregivers have shared with us that, since March of 2020, there has been an increase in anti-Asian sentiment, verbal and physical assaults, hate crimes and thefts.

The following are the major steps APCC has put in place since 2020:

APCC clients

- APCC has made efforts to teach their clients, particularly elderly clients, on how to protect themselves by taking preventive measures such as avoid going out in the evenings when it is dark. Encouraged clients to go out with family members or with a friend so they are not alone and an easy target. Be aware of their surroundings.
- Encourage clients not to carry too much cash on them, as there is an increase in purse snatching and other thefts.
- Wear a whistle or personal alarm on a lanyard and blow the whistle/press the alarm if attacked or threatened.
- If attacked, shout or cry out loudly to attract the attention of a passer-by.
- Ask store security/personnel to walk them to their vehicles if they are uncomfortable going out into the parking lot by themselves.

APCC staff and resources

- APCC counselors and staff have provided training and assistance to clients and have taught them how to take precautions when they are out and about in the neighborhood
- Provided care packages to clients including necessities such as bags of rice when rice was in short supply, homemade masks, and toilet paper.

Community resources

- APCC staff have reached out to businesses where our API clients generally do their shopping to ask if they can assist by having a volunteer in the parking lot when clients are loading the shopping bags in their vehicles.
- Several not-for-profit organizations including local churches and other business have made monetary donations and given supplies to APCC to advocate for API safety.

Reporting and advocacy

- Assisted and encouraged API clients and families to report incidents on Stop AAPI Hate website to

document the number and nature of violent crimes, discrimination and hate crimes. The reporting on the website can be done in English and 11 major Asian languages.

- Some Asians are reluctant to report crimes committed against them because they do not want to draw attention, but we are encouraging clients or their family members to document the incidents to push for better protection, increased resources and policy changes.
- Working with local community organizations to advocate for API protection, safety, education and resources.

Submitted by Asian Pacific Community Counseling

Iu Mien Community Services (IMCS)

Iu Mien Community Services is located at 5657 Stockton Boulevard Sacramento, CA 95824 - (916) 383-3083. IMCS is a SCC provider who provides culturally and linguistically responsive intergenerational support groups, outreach and engagement activities, and prevention-focused culturally relevant suicide prevention services to the Iu Mien community across the life span.

In light of the recent increase in violence and hate towards the AAPI community, IMCS took steps to support the AAPI community during this time. Please see the brief highlights of how IMCS is supporting the AAPI community:

- On February 19, 2021 we gave out 95 personal device alarms for individuals during the Asian Resources Incorporated Lunar New Year drive through event.
- We have been leading all our youth events with conversation about the increased violence towards our Asian Community prior to the recent incidents.
- We have incorporated a discussion with our participants during our bi-weekly wellness check-in calls
- We are currently working on a social media message to address the recent news of the Atlanta murders
- We will have more focus and in depth conversations with our youth participants during our weekly Pop-up and youth groups, dedicating 15-30 minutes to explore feelings and share stories.
- We have plans to bring in experts like social workers and law enforcement officers to talk to our youth group.
- We are offering to be a resource and a point of contact for our community should they ever feel unsafe or need help with contacting the appropriate authorities.

Submitted by Iu Mien Community Services

Cultural Sharing Corner – How do you celebrate/ observe?

My family celebrates Easter by attending church and having a family dinner. When I was younger, we would have Easter baskets and have Easter egg hunts. As a family tradition, we would start planting a vegetable garden on Good Friday. I did not understand why we planted on Good Friday, but now I do. It represents all things Easter. Darlene Moore

Every year this time, I remember playing Holi (colored powder paint) with my siblings and family members. I remember mixing paint with water and throwing on my brothers or rubbing on their faces. This was a lot of fun for my brothers and me. Ravindra Singh

It was with great joy and anticipation that I looked forward to New Year celebrations during my childhood because we had big get-togethers with family and friends, enjoyed special dishes prepared for the festivities, wore new clothes and had a good time. Lakshmi Malroutu

I am submitting a food picture for the month of Ramadan, as well as a description of the holy month:

"Ramadan is the time of the month of when Muslims around the world fast from sunrise to sunset. It unites the Ummah (Muslim community). Muslims consist of many cultures around the globe. There are Muslims in Europe, Africa, Asia, and other parts of the world.

The holy month is the time when we focus on getting closer to God by being mindful of our thoughts and actions, as well as performing prayers and reading the Quran regularly. Not only are we restraining from food and drink, but also working on regulating our negative emotions. For some Muslims, Ramadan is a time to renew one's faith.

There are (some) Muslims who may have stopped performing the five daily prayers, or stopped going to the mosque, but they never stopped believing in God. They still consider themselves to be part of the faith even though they may struggle with practicing certain areas. No Muslim is perfect. Ramadan is a time when one can renew their faith. If the good habit is continued in the month, it is likely they will continue even outside the month."

(Photo description: Iftar, which is the meal eaten when breaking the fast, in Pakistan.) Image and cultural sharing courtesy of Hafsa Hamdani

National Child Abuse Prevention Month

National Child Abuse Prevention Month, observed in the month of April, brings awareness to the importance of families and communities working together to strengthen families and prevent child abuse and neglect. To learn more and to access the 2021/22 Prevention Resource Guide, please visit this site:

https://www.childwelfare.gov/topics/preventing/preventionmonth/

National Public Health Week

April 5 – 11, 2021

National Public Health Week is a time to recognize the contributions of public health and highlight issues that are important to improving our nation and our local community.

We went to give a shout out to our Public Health partners and all of the work they do year round to support the health and wellness of the community. To learn more about Sacramento County Public Health, please visit this site:

https://dhs.saccounty.net/PUB/Pages/PUB-Home.aspx

Black Maternal Health Week

April 11 – 17, 2021

One of our own Sac Maternal Mental Health (SacMMH) co-chairs, Jessica Walker will be involved in and advocating for multiple events throughout Black Maternal Health Week (BMHW). Please see the link for some of the BMHW events she will be involved in and share with your networks!

Learn more here: https://bit.ly/3ghPi6U

Included on behalf of Jessica Walker, Stacey Peerson, and Brenna Rizan, Sacramento Maternal Mental Health Collaborative Co-Chairs

Please submit your ideas for future newsletters

Sacramento County Behavioral Health Services Cultural Competence & Ethnic Services Unit will continue to produce newsletters like this one. Please help us to celebrate the rich diversity of cultures in the County of Sacramento community by

sharing your original content and photos along with your contact information to:

DHS Cultural Competence Unit

DHSCCUnit@saccounty.net

Please put "**newsletter**" in the subject line. Please note that we cannot use content without citing the source and cannot use photos without permission.

Please send any contributions for consideration by the 20th of the prior month. Please see the following chart for applicable submission dates:

To include in this issue:	Please submit by:
May Issue	4/20/21
June Issue	5/20/21
July Issue	6/20/21

Special thank you for contributions from Asian Pacific Community Counseling, Iu Mien Community Services, Muslim American Society - Social Services Foundation (MAS-SSF), Hafsa Hamdani, Lakshmi Malroutu, Ravindra Singh, and the Cultural Competence & Ethnic Services unit.

SACRAMENTO COUNTY

Helpful links:

Mental Health Access Service Request Form:

https://dhs.saccounty.net/BHS/Documents/Provider-Forms/MH-Forms/Service-Request-Form.pdf

Substance Use Prevention and Treatment Services:

https://dhs.saccounty.net/BHS/Pages/SUPT/Substance-Use-Prevention-and-Treatment.aspx

COVID-19 Resources:

Behavioral Health COVID-19 (2019 Novel Coronavirus) General Resources

Behavioral Health COVID-19 (2019 Novel Coronavirus) Provider Resources

https://www.saccounty.net/COVID-19/Pages/default.aspx

Job Seeker Resources

https://personnel.saccounty.net/Pages/ESJobSeekerResources.aspx

Sacramento County Behavioral Health Services is hosting a Panel on the topic Laura's Law /Assisted Outpatient Treatment (AOT)

Please register to attend the session below by clicking on the link

Registration Link Here: https://tinyurl.com/SacBHS	**Monday** **April 19, 2021** **4:00 PM – 6:00 PM**	**INTERPRETERS WILL BE PROVIDED UPON REQUEST**

Hear from a variety of perspectives about AOT, including how it is operationalized, successes, challenges, and other considerations. There will be time for attendees to ask questions. Providers are encouraged to assist community members with registration.

If you have questions or if you wish to attend and need to arrange for an interpreter or a reasonable accommodation, please contact Anne-Marie Rucker at (916) 875-3861 or ruckera@saccounty.net.

SACRAMENTO COUNTY

Assisted Outpatient Treatment
3/2/2021

Background

Assembly Bill 1421 by Assemblywoman Helen Thomson was signed into law in 2002. This law is commonly referred to as Laura's Law, named after Laura Wilcox, a mental health worker who was killed by a man who had refused psychiatric treatment. The law assigned Counties the option of implementing court-ordered Assisted Outpatient Treatment (AOT).

AB 1421 originally required a County to opt in through a resolution by the Board of Supervisors. Last legislative cycle, AB 1976 went into law changing it from an opt in program. Now, Counties are required to implement AOT or opt out by July 1, 2021.

Court Requirements

AOT is a court ordered outpatient service for adults, ages 18 years and older, who have a serious mental illness and a history of (a) psychiatric hospitalizations, (b) jailings, or (c) acts, threats or attempts of serious violent behavior towards themselves or others. Consumers must first be offered voluntary treatment within the past 10 days.

Family members, roommates, treatment providers, and law enforcement may request an investigation to determine whether the consumer meets criteria. Only the County mental health director or his or her designee may file a petition with the court. The person named in the petition has a right to a defender appointed by the court.

If a judge finds that the individual meets the criteria, the AOT order would be for a 180 day treatment period and not to exceed 180 days. After 180 days, the director of the AOT program can apply for an additional 180 days of treatment. If the consumer is not compliant with treatment, the consumer can be transported to a hospital and held up to 72 hours. After 72 hours, the same hospitalization inpatient criteria would still apply (danger to self, others, or gravely disabled).

The court cannot order involuntary administration of medications.

Program

Counties that have implemented this use the Full Service Partnership (FSP) or Assertive Community Treatment (ACT) models.

Sacramento County Behavioral Health Services

Preliminary Community Input **on Laura's Law/** Assisted Outpatient Treatment (AOT)

Purpose

The County of Sacramento engaged community members to hear input on whether to implement or opt out of Laura's Law/AOT.

Behavioral Health Services virtually hosted informational sessions on March 15 and March 16, 2021 and solicited community input via a brief survey. A third informational session is scheduled for April 19, 2021.

Survey questions included the following:

A. Do you think Sacramento County should opt in or opt out of Laura's Law/AOT?
B. Public comment

Background

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Program

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Participants

In aggregate, 245 individuals participated in the survey. Participants did not answer every question; therefore, the number of respondents varies by question.

Participant Demographics

For participants who completed the demographic portion of the survey, demographics are roughly proportional to the County population for American Indian/Alaska Native and Native Hawaiian and Pacific Islander, and overrepresented for White/Caucasian. The racial/ethnic groups that appear to be underrepresented among participants are Asian American, Black/African American, Hispanic/Latinx, and multiracial, despite targeted outreach to community centers representing these racial and ethnic groups.

Race/Ethnicity	Percent of Overall Participants (n=231)	County Population[1]
American Indian/Alaska Native	2%	1%
Asian American	8%	17%
Black/African American	7%	10%
Hispanic/Latinx (of any race)	11%	24%
Multiracial	3%	8%
Native Hawaiian and Pacific Islander	1%	1%
White/Caucasian	66%	53%

Language

The vast majority of participants spoke English as their primary language (94%, n=236), followed by Spanish (2%). Less than 1% of participants primarily spoke Farsi (0.4%), French (0.4%), Hmong (0.4%), Portuguese (0.4%), Russian (0.4%), Tagalog (0.8%), and Ukranian (0.4%).

Affiliation with Sacramento County

Most respondents were current Sacramento County residents (84%), followed by family members of residents (9%), individuals employed in Sacramento County (6%), and individuals who are neither residents or family members of residents and who are not employed in Sacramento County (2%).

Type of Affiliation	Percent (n=245)
Current resident	84%
Has a family member who is a resident, but participant does not live or work in Sacramento County	9%
Employed in Sacramento County, but not a resident	6%
Does not live, work, or have family who live in Sacramento County[1]	2%

[1] These participants were omitted from the tabulation regarding perspectives of Laura's Law/AOT.

Stakeholder Groups

Many participants identified with multiple stakeholder groups. Nearly half of participants identified as a family member of a mental health consumer (47%), one-quarter of participants were mental health consumers (25%), and 12% were interested community members. Mental health service providers comprised 16% of participants, and 7% of participants were Behavioral Health Services staff. Members of Boards/Commissions, other providers, and other professions each accounted for less than 5% of participants.

Stakeholder Type	Percent*
Community	
Family member	47%
Consumer	25%
Interested community member	12%
Boards/Commissions	
Mental Health Services Act (MHSA) Steering Committee	3%
Mental Health Board member	2%
Continuum of Care Board	0.4%
Other advisory board	1%
Providers	
Mental Health Service	16%
Social Service	6%
Advocate/Peer Provider or Mentor	3%
Homeless Service	3%
Alcohol and Other Drug Service	2%
Ethnic Services	1%
Faith Based Service	1%
Physical Health	1%
Other Professions	
Behavioral Health Services Division Staff	7%
Business	4%
Education	4%
Court	1%
Law enforcement	1%

*Categories are not mutually exclusive; participants selected all that applied.

Location

Nearly half of participants were residents of the City of Sacramento (49%), followed by unincorporated Sacramento County (26%, see table on next page for details), Elk Grove (4%), Rancho Cordova (4%), Citrus Heights (2%), Folsom (2%), and Galt (0.4%).

Location of Residence	Percent (n=245)
Antelope	2%
Arden Arcade	2%
Carmichael	7%
Citrus Heights	2%
Del Paso Heights	0.4%
Elk Grove	4%
Elverta	2%
Fair Oaks	3%
Folsom	2%
Galt	0.4%
Gold River	0.4%
Herald	0.4%
Mather	0.4%
Natomas	1%
North Natomas	0.4%
Oak Park	0.4%
Orangevale	1%
Rancho Cordova	4%
Rio Linda	3%
Rosemont	0.4%
Roseville	2%
Sacramento	49%
Unincorporated Sacramento County (not specified)	2%
Not in Sacramento County	13%

Summary

Nearly three-quarters of participants indicated that they think Sacramento County should implement Assisted Outpatient Treatment (AOT) (73%), 15% of participants indicated that they think Sacramento County should opt-out of AOT, and 13% of participants indicated that they were neutral or unsure about the decision.

Participant Perspective Regarding AOT (n=240)[2]

Public Comment

All public comments that were submitted are posted below and are organized according to each individual's survey response regarding AOT/Laura's Law: a) opt-out, b) implement, or c) neutral or unsure.

A) Opt-out

- AOT is a fail-first model that will divert funds from much-needed services at a time when realignment revenues are declining due to the COVID-19 pandemic. Moreover, MHSA funds should not be used for services that are involuntary, like AOT. Finally, unless the County can faithfully comply with each and every pre-requisite set forth in the WIC for the implementation of Laura's Law (see WIC 5348, 5348.1, 5349) - which it can't - the County should not even be considering Laura's Law as a feasible option for services.

- I am opposed to coercive treatments that are not community based, client driven and recovery focused.

- Sacramento County should expand/strengthen community based organizations to allow for individuals to receive supports and services prior to the point of crisis and definitely within their own self-determination.

- Consumer voice and choice has long been at the heart of the behavioral health delivery system in Sacramento County. Choosing to opt into this program would be a slap in the face to that core value. Instead of getting the already overburdened court system involved, the County should in all earnest spend the time and money to support innovative ways that the FSPs could reach out to and engage consumers. I am a consumer of services as well as a family member of a consumer. Coercion does not lead to recovery. Partnership in treatment between the provider and consumer is the only way to promote lasting recovery and change. It was said during the listening session that the Board of Supervisors would need to make the decision to opt in or opt out for

[2] This chart omits 5 survey respondents who did not live, work in, or have family members in Sacramento County. Of those respondents, 3 indicated support for opting in to AOT, and 2 expressed that they were neutral or unsure.

now. That decision will be largely based on the recommendation of County Behavioral Health. You have the power to choose the direction Sacramento County will take. Please do not dismiss your power so lightly. I urge you to make the responsible choice and recommend opting out currently.

- Sacramento County has several new options through MHSA that may better support my Peers that have faced barriers to treatment services. They include: 911 Alternatives (which may better support parents/caregivers of the adult-child with SMI; INN Forensics project that may better support my Peers that cycle between jails...; MHSA culturally specific services; and the work of our vendors such as Dignity Health & WellSpace, etc. Sacramento cannot afford AOT which is very expensive for a small group of privileged few. Is this a white v. Consumers of color issue? I say, YES! Sacramento County DBHS should hold accountable and invest in our existing FSP and Adult system of care to better engage & RE-ENGAGE with their clients & offer family services within for family bridge building. Also we have systems already in place such as the 5150 process & conservatorship, this is NOT an endorsement but these systems do offer the ability for medications that may also suit my Peers that are considered AOT eligible (re: stability to gain insight). Do not criminalize Mental Health any further. To compare Sac County to our surrounding sister counties that have adopted AOT is NOT a fair comparison. Sacramento County is a Hub of Mental Health Resources unparalleled to any our sister counties in Northern California. Sacramento County does NOT need to implement AOT! OPT OUT!!!

- I feel that another avenue for taking away a person rights, choices or options regarding treatment is a really bad idea. Those mechanisms are already in place. Implementing another means to impose a system or family's will to compel one into participating/complying with treatment is an unnecessary and misguided use of resources, a mirroring of service delivery in place (just calling something else), does not align with MHSA principles, and does not support the vision I have observed where county operations have worked diligently with community providers to implement recovery model oriented programs to serve our population.

- The behavioral health system already uses involuntary services to the exclusion of voluntary services in the inpatient setting and there is very little oversight of these services resulting in poor quality services, high recidivism and poor outcomes despite increased use and higher costs.

- We should have Laura's Law/Assisted Outpatient Treatment, for some mental illness who don't like to go see the doctor. Like my son, never got treatment for his PTSD since he was diagnosed for his mental illness while he was in the Iraq war, because of the law has to be volunteered. I cannot make him get treated, because he knows the law he don't have to get treatment unless he wants to.

- I urge Sacramento County to opt out of Laura's Law/AOT because there is no new funding available for it and I believe existing funds would be better used to improve gaps in the current system. I think is is imperative that this decision be made based on a careful review of the gaps in Sacramento County's unique mental health system overall and not based on comparisons to other counties, which are very different in size, demographics, and the structure of their mental health systems. There are many people and their families in Sacramento County who desire care from our public mental health system and feel they are served inadequately or inappropriately. This is particularly true of individuals utilizing inpatient care. I have spoken to countless consumers and their families who communicated that they or their family member did not have a healthy

place to stay upon release from inpatient psychiatric stays, and were released to homeless shelters or simply the street. This lack of stable, appropriate short-term housing post-inpatient, is, in my observation, a common cause of the repeat hospitalizations and other negative outcomes that AOT programs are intended to address. There are many augmentations to the current system that could address this issue without investing in a new, controversial, expensive program that will be time-consuming to develop and serve a very limited population of people. I would advocate instead for improved coordination of inpatient care for substance use disorders (as people are often hospitalized in psychiatric hospitals when what they are truly seeking and needing is substance use treatment), more crisis residential beds, use of MHSA funds for emergency housing for consumers post-inpatient even if they are not yet linked with an outpatient provider, and peer navigators assigned to all consumers leaving hospitals.

- That law vastly takes away patients' rights, is very expensive and will not solve anything except start a new type of conservatorship which is NOT needed.

- I believe protecting the civil rights of clients in the public mental health system is paramount. I believe without an accessible front door and housing available lability, AOT will change nothing in Sacramento. I do not think we should prioritize individuals who are involuntarily committed before those who are voluntarily seeking services and supports. I believe it's a fail first model and we should not use MHSA funds for any part of it.

- It is not needed! Use resources to improve current services

- I believe the threat to people's civil rights far outweighs the benefit of this program. I do not feel that services are readily available in Sacramento for those of us who actually want them - it has been hard to access any services for my loved ones and it's exhausting just trying to be honest.

- I am a family member and primary caregiver for my sister who is a client. She is an FSP participant and has no housing or supports other than me. The FSP has delivered half hearted services at best and after years in an acute setting, and now in an FSP - her symptoms have not improved and she spends most days in my home doing nothing - unless I take her to Cal Voices with me and they give her volunteer activities and other things to do. The pandemic has made this more challenging. I do not feel she has ever gotten the services she needs - even on a voluntary basis - so I see no way that AOT can improve this. FSP's can do so much more and yet they don't.

- I believe we need more access to voluntary services as they are already extremely hard to locate, access and meet the various eligibility requirements. All too often folks fall through the cracks and we see it everyday as our agency helps to link them. We see FSP clients come to our office daily because the FSP's do not provide any daily activities in which they can participate in - so I do not see how making space in an FSP for AOT clients would help them on a daily basis the way they need. Please opt out - this is not a good use of our MHSA funds.

- I believe AOT Is unconstitutional and violates the civil rights of marginalized communities such as mine. I think that services should be readily accessible and they are not in Sac County - so that needs to be fixed first.

- Mandated treatment is not client has poor outcomes. Mental health treatment has to be approached differently.

- I feel very strongly about an individual's right to choose. Forcing someone into treatment does not engender trust. I also feel Sacramento County could opt out now and see what challenges/successes other counties of similar size experience. In time, if this program is truly a good idea, then Sacramento County can always revisit the question whether to opt in. I also feel that the Department needs to have an informed estimate of how many individuals would be in the program before committing to implement. Otherwise, voluntary services will be reduced in order to meet the demand. A more informed decision is needed here.

- I strongly support an opt out option for Laura's Law.

- There are already a number of laws to allow for treating individuals who are a danger to self or others. I see no reason to expand these laws since we do not have capacity to serve those who are already voluntarily seeking services. Greater access to care is the answer and providing culturally responsive services that meet communities needs. Sac County has long had a problem with access issues and this program does nothing but divert resources away from those who desperately want services but can't seem to access them in this county.

- We need accessible, long term, effective treatment, especially for unhoused people, not more forced tx options.

- Please opt out - for communities like ours it is a very dangerous thing to allow the County to determine our needs - we should not be forced to do anything. This is why we came to America. I believe more accessible services are the answer.

- Ryan Quist said that most clients selected for this program end up volunteering for services. Then why don't you create a voluntary program targeted to high utilizers of services, effectively engage them in services, and offer them FSP level services.

- conservatorship already exist we don't need another form of it that is much more expensive and will take away peoples rights for 6 months at a time.

- Position on Assisted Outpatient Treatment
  Ann Arneill, Ph.D., Member, Sacramento County Mental Health Board

  I am opposed to Assisted Outpatient Treatment (AOT) for the following reasons:

  Recovery-Oriented Treatment System
  SAMHSA Definition of Recovery: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Self-determination and self-direction are the foundations for recovery
  https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf

  AOT is an involuntary treatment program. Despite its efforts to say that it is a client-driven, recovery-oriented program, no program that obtains a court order to mandate that a client receive treatment preserves a client's self-determination and self-direction

Agnosognosia

- E. Fuller Torrey and the Treatment Advocacy Center (TAC) argue ubiquitously that 50% of persons with schizophrenia and 40% of persons with bipolar disorder have agnosognosia and brain damage. This is one of the main reasons that the TAC advocates for the implementation of AOT
  https://www.treatmentadvocacycenter.org/aot
  - Those statistics are highly stigmatizing and insulting
  - Applied to the Sacramento County Mental Health Plan, In FY 2018-19 there would have been 2200 persons with schizophrenia and 1300 persons with bipolar disorder with agnosognosia. That is patently untrue since they are all receiving services
- Supposed "lack of insight" can also be disagreement with the treating professional
- There is no cure or ability to "magically" increase insight. Medication has not been shown to be effective in increasing awareness. (NAMI Fact Sheet)
  https://azdhs.gov/documents/az-state-hospital/the-difficulty-in-seeing-your-own-illness.pdf
- Other techniques are available to help people voluntarily accept treatment - LEAP (Listen-Empathize-Agree-Partner Method): LEAP gives family members and health providers the tools to persuade someone in **"denial"** about serious mental illness to accept treatment and services. *Amador, X. (2012) I am Not Sick I Don't Need Help. New York: Vida Press (pg. 62)*
  https://www.nami.org/getattachment/Learn-More/Mental-Health-Conditions/Related-Conditions/Anosognosia/I_am_not_sick_excerpt.pdf?lang=en-US
  - Motivational Enhancement Therapy: a science-proven method that helps people in denial accept treatment (pg.63)
    https://www.nami.org/getattachment/Learn-More/Mental-Health-Conditions/Related-Conditions/Anosognosia/I_am_not_sick_excerpt.pdf?lang=en-US
    Rusch N, Corrigan PW. Motivational interviewing to improve insight and treatment adherence in schizophrenia. Psychiatric Rehabilitation Journal. 2002; 26:23-32.
    MET uses techniques to motivate someone to either alter their self-image to accept that they have a condition or encourage them to agree treatment for their condition.
    MET often consists of helping someone look at their symptoms, behaviors, and relationships objectively. This often leads to a realization that facts point to the existence of a condition
    https://www.heathline.com/health/agnosognosia#how-to-help
  - Peer support programs that provide role models who have recovered or are successfully self-managing their illness are beneficial
    McGorry PD, McConville SB. Insight in psychosis: an elusive target. Comprehensive Psychiatry. 1999; 40:131-142.
  - Cognitive-behavioral approaches have been shown to be beneficial. A study from the United Kingdom demonstrated that a short, insight-focused cognitive-behavioral therapy intervention delivered by trained nurses in the community had lasting effects on insight and adherence
    Rathod S, Kingdon D, Smith P, Turkington D. Insight into schizophrenia: The effects of cognitive behavioural therapy on the components of insight and association with sociodemographics -- data on a previously published randomised controlled trial. Schizophrenia Research. 2005; 74:211-219.
  - Ask persons about their goals. People with schizophrenia often do not respond well to criticism. Instead of trying to convince them they're sick, ask them about their goals. Use this as a springboard to discussing the next steps. Even if the person doesn't acknowledge being ill, he'll be able to make positive progress. It

can help to clearly link the person's goal with taking their medication to prevent a relapse.
https://www.healthgrades.com/right-care/schizophrenia/how-caregivers-can-cope-with-anosognosia

- Recovery-oriented engagement
  If we want to improve the lives of people with mental illness and their families, we must shift to a culture that embraces engagement as a new standard of care. (pg. 4)
  Social inclusion is an important engagement outcome. This is especially true for individuals experiencing psychosis. An individual may refuse services and may exhibit behaviors that seem bizarre or disturbing, but communities still need to engage and support a person experiencing psychosis. These individuals are more likely to respond when treated with respect and kindness (pg.8)
  Examples of successful engagement programs (Recommendations for improving engagement in the mental health system are provided in the Appendix)
  - Housing First programs to engage unhoused persons with mental illness (pg. 22)
  - Opening Door to Recovery, Southeast Georgia
    Opening Doors includes engagement by recognizing the importance of peer support, the value of family navigators and the positive outcomes that come from giving people a meaningful day as an important motivating factor for remaining engaged in the program and working toward recovery (pg. 23)
  - MHALA Village, Los Angeles
    Effective engagement is used throughout the program in addressing the needs of individuals with serious mental health conditions. Instead of illness services, the program promotes quality of life services. Instead of coercion, the program welcomes, engages and collaborates. Clients are involved in every aspect of their treatment and recovery. (pg. 24)
  - Early Assessment Support Alliance, State of Oregon
    The program prioritizes outreach and engagement. When a person refuses to leave his or her home or refuses to participate in mental health services and supports due to symptoms, the program does not give up. Staff will repeatedly visit a person where they are at and slowly build rapport. This approach takes persistence, patience and willingness to listen and hear youth and young adults experiencing psychosis. (pg. 26)

  https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/Engagement-A-New-Standard-for-Mental-Health-Care/NAMI_Engagement_Web
- Psychiatric Advanced Directives (PADs) are legal documents, drafted when a person is well enough to consider preferences for future mental health treatment, including taking medication. PADs allow appointment of a health proxy to interpret preferences in a crisis. The PAD is used when a person becomes unable to make decisions during a mental health crisis.

Achieving Outcomes with Voluntary Services

- Services Offered in the AOT Programs
  - Community-based, mobile, multidisciplinary, highly trained mental health teams that use high staff ratios of no more that 10 clients per team members for those subject to court-ordered services pursuant to Section 5346 (WIC Section 5348(a)(1)), including a mental health personal services coordinator (WIC 5348(a)(3))
  - Full Service Partnership (FSP)-level array of services (9CCR Section 3620(a)), including mental health services, medications, supportive housing, substance use

services, vocational rehabilitation, and peer support. Services are client-directed and use psychosocial rehabilitation and recovery principles (WIC 5348(a)(2)(B)&(E)&(F))

- Positive outcomes attributed to AOT: reductions in homelessness, hospitalization, arrest, and incarceration

If a consumer that you wanted to commit to AOT was instead patiently engaged with one of the techniques described above and voluntarily offered the described Personal Services Coordinator and multidisciplinary team, and then placed in an FSP, you could achieve the same positive outcomes attributed to AOT without depriving the consumer of his/her rights and self-determination. FSPs achieve those same outcomes

Sacramento County FSPs Outcomes (FY 2016-17)

Days of Homelessness	Decreased 90.8%
Hospitalizations	Decreased 59.6%
Arrests	Decreased 60.1%
Days Incarcerated	Decreased 53%

https://dhs.saccounty.net/BHS/Documents/Advisory-Boards-Committees/Mental-Health-Board/MHB-Reports-and-Workplans/RT-MHB-Performance-Report-2019.pdf (pg. 40-41)

Prioritization of Services

With an AOT program, an AOT client goes to the head of the line in accessing services. You could have a more acute client who is bumped from voluntarily accessing services by a less acute AOT client who has just had two hospitalizations in the last 36 months (WIC Section 5348(4)(A))

Mandating Medication

- AOT legislation does not mandate routine involuntary administration of medication (WIC Section 5348(c)) Medication can only be administered involuntarily in case of emergency or with a determination of lack of capacity (WIC Sections 5332 to 5336)
- Other legal remedies are available if a consumer is really so impaired that they need to be involuntarily medicated on a routine basis. Conservatorship is available for that purpose. Public Guardians/Conservators can authorize the administration of psychotropic medications

Appendix

Recommendations to Promote a Culture of Engagement

From "Engagement: A New Standard for Mental Health Care", NAMI

Adopt 12 principles for advancing a culture of engagement:

1. Make successful engagement a priority at every level of the mental health care system. Train for it. Pay for it. Support it. Measure it.
2. Communicate hope. For those who feel hopeless, hold hope for them until they experience it themselves.
3. Share information and decision-making. Support individuals as active participants in their care.
4. Treat people with respect and dignity. Look beyond the person's condition to see the whole person.
5. Use a strengths-based approach to assessment and services. Recognize the strengths and inner resources of individuals and families.
6. Shape services and supports around life goals and interests. A person's sense of wellness and connection may be more vital than reducing symptoms.
7. Take risks and be adaptable to meet individuals where they are.

8. Provide opportunities for individuals to include family and other close supporters as essential partners in their recovery.
9. Recognize the role of community, culture, faith, sexual orientation and gender identity, age, language and economic status in recovery.
10. Provide robust, meaningful peer and family involvement in system design, clinical care and provider education and training.
11. Add peer support services for individuals and families as an essential element of mental health care.
12. Promote collaboration among a wide range of systems and providers, including primary care, emergency services, law enforcement, housing providers, and others.

Require training for mental health professionals on the lived experience of mental illness, focusing on the following areas of engagement:
1. Motivational interviewing;
2. Shared decision-making;
3. Strengths-based assessment; and
4. Including natural supports (e.g., supportive family and friends).

Training should be culturally sensitive and competent to effectively meet the needs of individuals and families in diverse communities.

Invest in research on effective engagement with a focus in the following areas:
1. Training on engagement for health care and mental health professionals.
2. The experiences of individuals and families receiving mental health services and supports.
3. Retention and dropout rates for individuals receiving mental health care, with a focus on achieving life and recovery goals.

https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/Engagement-A-New-Standard-for-Mental-Health-Care/NAMI_Engagement_Web

B) Implement

- Mental health is important and often those with it can't bring themselves for help. Their scared or can't relate to what's going on around them and often live in a none reality as they have no ability to figure out they need help.

- if we don't help our community then who will? As long as there are resources open to people and they are made aware of the options I don't see why not.

- I understand why some people may oppose the implementation of Laura's Law/AOT in Sacramento County. I truly do, and sympathize with the reasoning. The reasons against implementation are not trivial. However, as a family member, I think the reasons to move forward with it outweigh the reasons against. People's lives are in the balance, both those who will live who otherwise would not, and those whose lives will be made better who otherwise would be worse off. As individuals, we all have rights and also responsibilities to others. I believe this law helps us to better fulfill those responsibilities.

- Rich and poor of all races need to be supported around mental health issues. Mutual respect needs to be the culture behind these services. Most first world countries have a social safety net for ALL consumers. NGO peer reviews and discussion groups to support evolving social services need to be planned/funded in local adaptation of AOT.

- Some do not believe in the reality anosognosia which I experienced when I was ill. Please take time to research. Per WebMD Anosognosia is common in people with serious

mental illness. At least 40% with bipolar and 50% with schizophrenia have it. When this symptom occurs, a person cannot chose help on their own and needs ‚Äúassisted‚Äù treatment. Please help those who cannot help themselves because their brain won't let them. It is the humane thing to do. Many of my peer advocate friends promote the many excellent treatments available, but just like there are many cancer treatments available, if you don't BELIEVE you have cancer, none of them will work.

- "good idea for family and support people being able to make recommendations"
- This law is needed to help solve the problem of chronic homelessness.
- It is a good law. People don't always know when to get treatment
- We have some good FSP programs in Sacramento County, however they leave out a small percentage of the Seriously Mentally Ill (SMI). They need more help than others to get into Recovery. People are different, conditions are different and the intensity with which people experience their mental health condition is different. We need a wider variety of tools to help everyone in this county get stable and into Recovery.
- The only thing I can say to the county is to keep up with the good service.
- This sounds like a good tool for assisting severely mentally ill people who do not voluntarily access help and could be potential threats to the community.
- My father is homeless because we haven't been able to help him get help. He is skitzo-effective and has paranoia, so it's hard to get him to let us help him. I think Laura's law would be amazing, and so helpful for so many people, but it would also help us help my father get off the streets. I hate not knowing if he's warm or has food, and if we were to get any amount of help from Laura's law, we hopefully could rest a little easier knowing he has a chance to change. Thank you.
- Any and all mental health services are needed. I would rather see my community members getting the help they need rather than having to cope in unhealthy ways.
- There is such a high need for more mental health resources. It would be unethical not to give every opportunity possible if we have the means to do so.
- "As a Power of Attorney to a 63 year brother that was deemed gravely ill and who's parents went though the court in the early 70's for conservatorship, in Orange County, CA this law would be a fantastic option to get immediate treatment without all the red tape of the conservatorship process. Especially, for those families that did not have the means of hiring a lawyer. It would also lessen the load of our current jails and law enforcement that are not trained in mental illness. Passing the law would provide the opportunity for an individual to perhaps get the right combination of medication and get detoxed for further treatment. It would give the family the ""hope"" they need to continue the advocacy of their loved one. Today my brother still suffers from schizoprenhia , but he is no longer on the streets or in a mental institution. He is on a great combination of medications. He is part of the community. The team of healthcare professionals we have established in Sacramento are amazing and want to help. I no longer worry about him harming either himself or another individual. He is truly a living testimony of what can transpire."

- To fill in the gap for those who don't have medical insurance.

- Aot would help my family and help the community be more connected and stable by supporting serious mental illness

- We have mentally ill family members. Until you have dealt with the mentally ill every day for years, you really have no right to give an opinion or pass laws affecting the mentally ill and the people who care for them. Anosognosia is also common and extremely difficult to deal with. The mentally ill person has no insight into their illness. They choose to believe that they are not ill, therefore they see no need for treatment of any kind. Sometimes it takes an authority figure like a judge to order such a person with a mental illness into treatment, (CBT/DBT therapies, a bit of medication and support with an agency like Turning Point Community Programs), before that person with a mental illness gains some insight into their illness and realizes they DO need treatment, so they can re-learn to take care of themselves, accept SSDI, and become a productive member of their community -- productive not necessarily by having a job they go to, but rather their JOB is TAKING CARE OF THEMSELVES so they are not on the streets, not in jail, not in and out of hospitals / ER's, or permanently in a locked facility, (unless it is ABSOLUTLY necessary). Judges should have psychology training to recognize the disordered speech and body language of mentally ill people. Judges should want to hear from family members and friends of the mentally ill to get the full picture. Judges should show compassion and empathy when dealing with ALL people and not be afraid to order alcohol, drug, or mental health treatment. Treatment is not a bad word. Medication is not a bad word. Therapy is not a bad word. In fact, EVERYONE can benefit from therapy as part of their healthcare preventative and wellness program!

- This program is working in other counties and saving money. For to long this county has done very little to help those with SMI. Please do the right thing!

- Safety is non-negotiable.

- I think that if someone can be helped in to receive a needed treatment, not only that person is benefitted but also the family, the community and the world.

- I suffer from bipolar disorder, so I've been in the circumstances described. I think it's a fantastic idea.

- People with Serious Mental Illness cost the state and the County higher dollar amounts due to the revolving door of hospitalizations and incarceration. A program like AOT would save the county money in the long run even though it would cost more to begin services and set up the program. Clients (consumers) and family members, loved ones and caregivers would all benefit from this program. There are a lot of miss conceptions about AOT but I have seen it work in other counties and the benefits it has brought. AOT is a good program to have.

- A robust training program of referring entities should be part of the AOT program design.

- Something must be done to help these people and to keep them off the streets doing major drugs to fulfill their needs mentally .

- Hello. I am Susan McCrea, who served on the Sacramento County Mental Health Board from 2008-14 and am currently serving on the MHSA. At the time, three of us wrote a

99 page report called the Feasibility Study of Alternative for Individuals with Chronic Untreated Mental Illness in Sacramento County exploring AOT and Laura's Law for Sac County. I encourage you to make this report again available for the public and let them know about it. It was used by the County for years after the report came out. Jason Richards, the County liaison, has the link to this report as he gave it to me again. I can also send it to you. AOT could reach a very small percentage of people in the consumer spectrum (not all consumers as some erroneously fear), those who cannot be reached in any other way in most cases. The engagement of AOT would be for their good, hopefully their recovery, and the good sometimes of our community to protect us from a mentally ill individual, who could be a danger to others in our community, like in the case in Nevada County when Laura Wilcox and several other innocent people died. This tragedy inspired this law so this would not happen- never again! When a dangerous mentally ill individual acts out, this increases stigma much more that having AOT, as some people erroneously claim that AOT in our County increases stigma. I believe it is a very necessary tool to have in every county's tool box. I totally support having AOT in our county as I did in 2012. At the time, we were told that the Conservator's Office Care Plus Program would be equal to Laura's Law. That is not true as Dr. Quist pointed out in today's presentation as only people who qualify for being a conservator, a difficult process to get into, as I know with my daughter Christianne's experience, qualify for the Care Plus Program. Some are now saying the the new 911 alternative program could do the same thing as Laura's Law. Let us not make the same mistake we did in 2012 thinking some other program can substitute for AOT. AOT is unique. There is no substitute program for AOT. That is why we need this tool to help those who could not be helped with any other tool as they experience anosognosia. Let us make the compassionate and wise choice to embrace AOT/Laura's Law for our county, as so many other large counties in our state have already done. Let us OPT IN!

- This is an important piece of the solution. We need a multi-pronged approach to serving our fellow community members with mental health needs. There should be no one who cannot access services in our community despite whatever their financial or other situation.

- I have an adult son, homeless, living in a tent. He has severe paranoid schizophrenia with drug and serious alcohol addiction. He fits all of the criteria for this Assisted Outpatient Treatment program. He is so addicted and paranoid he does not seek help. His behavior has worsened and is so irratic, I do not feel safe in his presence. The police won't do a 5150. This program could help him.

- I think Sacramento County owes it to the families that are dealing with a family members mental illness to give this program a try. If the families of those mentally ill could hire someone to do this service we would. I see mental illness like a cancer of the mind; if your family member had cancer would you not try to do everything in your power to help them? I don't believe that AOT is a cure all, but it's an option; an option those of us in Sacramento County do not have.

- We need this law so we can help ours live one I live in Santa Clara county and we need it pls have compassion for us and live ones

- I am the mother of an SMI adult and was also counsel to state mental hospitals in another state for a number of years. The majority of their patients were paranoid schizophrenics (the most severe form of mental illness) and "revolving door" treatment refusers.

- It's unfortunate so much misinformation was presented on Laura's Law at last week's Sacramento Mental Health Board meeting. While voluntary treatment is always preferable, Laura's Law targets a small group of dangerous treatment-refusers. To quote Carol Stanchfield, who runs the successful Nevada County program, ""we will freeze over before these people will volunteer for services."" Too sick to know they are sick, they often have fixed delusions that medication is poison, doctors are plotting against them, etc. Such treatment-refusers cycle between repeated involuntary hospitalizations --if they are lucky-- or jail (usually for minor crimes, but sometimes for awful ones), until they die (usually by suicide or physical ailments they also don't treat, though they are the group most frequently shot by the police). Jails call it ""life on the installment plan"" because, even after being stabilized involuntarily, treatment-refusers soon throw away those ""poison"" medications and begin the cycle again. (See See ""Hard Truths about Deinstitutionalization, Then and Now"" guest commentary updated January 21, 2021 by El Dorado County District Attorney Vern Pierson at calmatters.org.) Many and perhaps most can graduate to voluntary treatment, but only after gaining the insight that only sustained treatment can provide.

- This is the group that causes the stigma for everyone, including themselves--so the best way to fight stigma is to get them into treatment. It's also the group that costs taxpayers the most, due to their history of repeated recent involuntary hospitalizations and/or repeated violence and police encounters.
- Here's how and why AOT/Laura's Law works: the Laura's Law order allows intervention before people with a pattern of past dangerousness become completely irrational and dangerous again, when they don't comply with treatment. If they again refuse voluntary options they can be given a choice: comply with the treatment order, or go to a hospital for a three day evaluation. Most don't like hospitalization, so they choose treatment, which keeps them stable and in the community. (For example, of the 70 Laura's Law patients in Nevada County, only 16 ever chose the inpatient evaluation, according to Stanchfield's recent presentation.) During the (infrequently chosen) evaluations, their concerns can be addressed by medical experts, who can initiate a 5150 and/or LPS involuntary medication procedures only if they become dangerous enough again to meet LPS standards during their stay. It's where they would have ended up anyway, if they were lucky. As with any other serious illness, getting there earlier can mean fewer hospital days.

  Studies have shown that Laura's Law/AOT recipients ACTUALLY LIKE THE PROGRAM. https://mentalillnesspolicy.org/aot/consumers-like-aot.html .

  Laura's Law and its parallel programs in other states have been shown to SAVE THE PUBLIC MONEY by keeping treatment-refusers away from police and out of hospitals and jails. See htts://mentalillnesspolicy.org/aot/overview.html ; https://mentalillnesspolicy.org/aot/aot-cuts-costs-in-half.html ; https://mentalillnesspolicy.org/kendras-law/research/kendras-law-studies.html ; https://mentalillnesspolicy.org/wp-content/uploads/Aotbygary.pdf (analysis of early Nevada County data).

- I had hoped to attach some graphs that say it all but this comment form does not allow for it. I will include them in the letter I will send to Dr. Quist and each member of the county board. The most striking graph shows the huge drop in jail days and hospital days for the same individuals, pre- and post AOT orders, in Nevada County.

- This is a very important law. As a property owner and someone born and raised in Sacramento, this law will help tremendously with the mental illness and the homeless

problems.

- We own property and have family with mental problems in the area.

- Definitely more needs to be done to help those with mental illness so they do not fall threw the cracks of they system

- This is a very beneficial law to my family members.

- "My daughter is falling through the treatment cracks in the current SCBH system. If AOT was in place today, she would meet all the criteria and treatment would happen (5 psych hospital stays of 2 weeks each in 2020, 1 DUI in Nov 2019, 1 light rail citation in 2020, continuous non-citation interactions with officers in 2020 at motels and other Sac Co public businesses, offered volunteer services many repeated times in 2019 & 2020, age 31, resident of Sac Co). Instead, she is severely mentally ill and unhoused in Sac County as I write this.

  My daughter and my family have experience in the past year and a half with the ACCESS, the CST, the Mobile Crisis Units, and the FSP services that exist already in Sac Co. Each of these services has their unique niche and have been helpful in varying degrees as long as my daughter was mentally clear/well enough to volunteer to accept these services. However, in Nov 2020 the relapse symptoms became so intense that she became unhoused and unable to take the action steps needed to accept the help offered by the FSP and by family that were connected to her requests to get back into housing.

  In Jan 2021 her FSP licensed clinician met her in an open field where she was staying overnight, and deemed a 5150 hold was needed, but Sac Co Sheriff's deputy did not uphold this assessment. The work of the FSP was undermined by the Sac Co Sheriff deputy. I realize the Sheriff Deputy's job is difficult too, but this disconnect between Sac Co agencies nullifies the potential of the FSP services to do the work of an AOT, thus leading to my main reason to support AOT.

  By March 1, 2021, she was dropped by the FSP, and she is still unhoused and unwell in Sacramento County. I respect the Recovery model the FSPs use, however, at a certain level of illness, the Medical Model is also necessary.

  This is my end user experience of all the services 'already available' in Sac Co Behavioral Health, and the experience of the infidelity of the Sac County agencies to address seriously intense levels of mental illness.

  Three more reasons I support AOT are:
  1: Accountability of stay in treatment is given to entities other than family/friends (who get really worn out over the years of being there through thick and thin 24/7 with no breaks and with our hands often tied by how the HIPPA is implemented & being told if we do not 'become the bed' our family/friend will go to a shelter or the streets--feels like emotional blackmail).
  2. Long term treatment beyond the release from psych hospitals and suicide prevention homes. Current 'help' is too short.
  3. Any Court involvement is NOT Criminal court!!!! As a family member who has been told by Sheriff's deputies to 'get a restraining order so we can take her to jail to get treatment' rather than to take the medical history and seriously consider a 5150.05 (AB 1424) in order to get treatment at a psychiatric hospital, I am tired, REALLY TIRED, of the idea that Criminalizing Mental Illness Treatment is any kind of a viable treatment

option.
That was the short version of why AOT has potential to save my daughter from continued suffering and possible death.
The following are added details.
Daughter's first diagnosis was PTSD in 2008 while at college after an assault and bullying on campus. Campus supports and therapy provided through Victim witness protection formed a 'wrap around services' effect and our daughter continued to pass classes until Sr year when stressors triggered her symptoms leading to first of may psychiatric hospital stays. Schizoaffective Disorder was added to the diagnosis, and not long after, epilepsy and non-epileptic psychogenic seizures.

Family engaged in NAMI educational and support services and learned better ways to create healing environment and daughter trusted the care system and family enough to allow us to be part of the treatment team. During the first nine years, sometimes the symptoms would flare and wellness checks would be advised by her psych care team.

When my daughter interacts with First Responders during wellness checks and calls for possible 5150, she is able to 'present well' and has the answers to the questions memorized due to multiple psychiatric hospital and suicide prevention stays in the past twelve years of her illness(s). Even when family have presented AB 1424's medical history for a possible 5150.05, first responders override this history. Officers tired of responding to our calls--we tired of having to call them but we had no other option at that time.

In year ten, daughter, age 29, was frustrated with being on SSI and 'having to live with parents' and tried to launch into living independently and create her own treatment plan. Not surprisingly this included non-prescribed substances. After several months away, she requested moving back with parents and we agreed because she agreed to seek treatment for addiction and her mental illnesses. This was rocky at best. Family learned that opening home made it even more difficult to get services during relapses because daughter could not be considered gravely disabled by first responders because she was under our roof...yet her psych care team told us to call them for help. All agencies expected family to continue to allow relapse symptoms even if these were not healthy and breaking house rules--we were told simply to 'enforce boundaries' which requires a person to understand the boundary and have enough mental capacity to know they are breaking them--not things our daughter could do in the throes of severe relapse. We needed more help yet were rendered helpless to engage that help in any way. Alas, in October 2019 we saw it was not healthy to 'be the bed' any longer. The system did not deliver enough tools for us, we were expected to just keep giving and giving and giving x infinity. AOT would add to the tool set when a person is as ill as our daughter.

Through my ten+ years of volunteering for NAMI Sacramento in the Family education and support efforts I have met many other families in similar situation to ours. This helps me know I am not alone; I am not just ONE MOTHER. Well-meaning first responders, FSP providers, Supervisor Office workers, Psych Care Pros and Sheriff's employees love to tell me ""Of course you care, you are the mom!"" but I say to you, where would you be without the hundreds of thousands of us doing this work for free? We need tools, not platitudes and thank-yous, when the person we are delivering care to is in intense relapse and is not able to volunteer yet is not blubbering enough to be conserved--AOT could be one of those tools. Thank-you, Elizabeth Kaino Hopper 916-204-3138"

- I will also add the Sacramento County sheriffs department appears to actively resist any effort to assist anyone in the homeless community. We have heard numerous times from deputies their fear of taking action to render aid or assist a providing agency because of a potential law suit. The priorities are skewed within the sheriff's department. Thank-you, Marvin W Hopper"

- My mother suffered with schizophrenia and we really wish AOT had been implemented during her lifetime! She was homeless and we could not get her help- she refused and thought we were trying to kill her. She was endangered on the street.

- This is very important for a special segment of our population who are not able to get help on their own.

- My sister & family that live in Sacramento County would benefit from Law/AOT.

- "I have a daughter with bipolar and anxiety disorders age 33 has been in and out of mental health hospitals in the last few years currently fairly stable but there was a time when she really needed more than she was getting or released too soon from the mental health hospital. We need to be able to help our loved ones and get them to help they need even if they don't want it. It's critical that this Laura laws becomes part of Sacramento county. Also I'm a retired public health nurse and have dealt with many situations of seriously impaired mental health clients that would have been more productive and successful if they had the parameters that Laura's law allows"

- It would be such a benefit for people that meet the criteria!! A great asset that Sacramento county could offer. Help fight the stigma, and each mind matters!

- AOT is a necessary part of treatment options for Sacramento County residents who suffer from severe and persistent mental illnesses. This is especially useful for those who lack insight and refuse to engage in treatment because they don't believe they are ill. There have been no options for this population in the past, short of conservatorship. For conservatorship, the person has to be gravely disabled. For AOT, the dangerousness standards are qualifiers. We could reach people before they cause great harm to themselves or to others. Participants would have ample protections of their rights and there is no option for forced medication. The idea is to keep people out of jail and hospitals and to engage them in treatment to improve their lives. It's the humane thing to do.

- We strongly support the adoption and implementation of Laura's Law and Assisted Outpatient Treatment in Sacramento County. We believe that had it been available to us as parents when our son first presented with serious mental illness that he would have been assessed and treated much sooner. His prognosis for a successful outcome would have been much more positive had he been involved in psychiatric treatment sooner. Individuals with anosognosia are not capable of perceiving the necessity of treatment, and we believe it is unconscionable to leave someone in an acute psychotic state because he or she does not perceive the need for help. We need to enact programs so that intervention takes place sooner rather than later. As it happened, he ended up harming individuals and has been incarcerated on two occasions.

- This is so important for several of my family members and friends. We've needed this kind of service for mental health for way to long, its time!

- If you "opt out" there will be a small segment of your population that are un-served because their brain is too ill and they will NEVER voluntarily ask for help. Please do not discriminate and only help those that are able and healthy enough to ask for help.

- This is long overdue for Sac. County.

- Pass Laura's law

- There need to be more options for people with mental health issues. Happy to see something is being proposed.

- This program will provide more opportunities for people with SMI who lack insight into their disease

- There are so many people that need mental health services that don't have access. They often self-medicate, become unemployed, end up homeless and/or fall outside of the law. We need to help these people. I think the long term cost would be less with early intervention.

- I can't believe Dr Quist said he didn't know how to fund AOT. What about Prop 63 the Mental Health Service Act. At least he could have mentioned it. Was it a set up question. Very upsetting.
- I think there are a lot of smart people that cannot function in society, and I appreciate that we have programs that can help them in a way that they are willing to accept, and I know firsthand that is not always easy.

- My dear sister, now 68 years old, has struggled for years with paranoid schizophrenia. I know well the signs that she is in trouble and headed into a schiziphrenic break. That is the best time to seek treatment, not afterward when she is deeply paranoid, mortally frightened, hallucinating and in flight from her demons. Please bring Laura's Law to Sacramento County! As her next of kin, her only surviving family member, I want to help and Laura's Law will be a great benefit at those tough times.

- Please adopt Laura's Law. It is one small step in truly addressing the needs of the most vulnerable mentally ill.

- I have a friend who lives in Sacramento that is severely mentally ill, but because she lives in a nice home and seems healthy yet eccentric, cannot receive sustained treatment for mental illness. She has been 5150ed and 5250ed several times, and spent months in jail out of state but manages to convince judges and others she is fine. Just as soon as she is stabilized, she begins making the case that she isn't sick. She's falling through the cracks, and increasingly paranoid and combative. I am worried she'll be unhoused if something isn't done soon.

- What does the Sacramento County's full service AOT partnership now provide for the severely mentally ill person when in crisis? Many parents do not find Sacramento County services adequate in providing long term ongoing care for their ill family members.

- For decades mental health and homelessness has been a huge issue in Sac County. Having lived in this county for nearly 50yrs, I have witnessed the disfunction as a member of the public having grave concerns about the safety of my family, the community, and the mentally ill individual, who seemingly goes untreated and are

usually also homeless. I am also a law enforcement employee, and have seen throughout my near 20yr career (nearly half of which have included working in the field), a revolving door of ill individuals who continually make poor decisions for themselves, negatively affecting the safety and well being of themselves and the public, who continually get placed in custody and released. Ignoring some of these individuals ability to make healthy choices for themselves or giving them only voluntary aide is not working. Please for the safety of these individuals and the public that must function around them I believe Laura's Law is a start in the RIGHT direction. I know much more will need to be worked out, but please get this started in Sac County.

- This will only be effective if it is properly funded to provide resources to employ clinicians who have been thoroughly trained

- If AOT had been around when my brother was refusing treatment, I believe he would not have spent 10 years of his life in locked facilities. AOT does not take away individual rights and in many cases it protects them from a worst case scenario.

- I am all for this law. As a retired firefighter for the City Of Sacramento, I have seen firsthand the tragedy of untreated mental illness in the homeless population. Too many times we firefighters respond to calls for the homeless to provide some basic first aid or to transport them to a hospital for something more major, or to put out fires when their camp fires have gotten out of control. We have also seen some of the success stories. Occasionally while in the hospital they are put back on their meds and taken home by family members. The change is tremendous. They come visit us and thank us for "saving them". Their family members are also thankful, albeit guarded. They have done this many times. They are hoping they can convince their son/daughter to stay on their meds.....knowing the day will come when he/she feels the meds are no longer needed and living on the streets is the preferred option once the meds are out of their system. Please support this law.

- If I am understanding the law correctly, it allows the courts to force mentally unstable people to get treatment. While it worries me that we would impeed on a citizens freedom by forcing them to get help, it seems necessary if their lack of help impeeds on the liberties of others.

- Sounds like a good program. I hope there are steps beyond the 180 days otherwise it maybe a cycle that helps no one.

- Embarassing to see the number of mentally ill people wandering around.

- Laura's Law provides the County with another option to get people the mental health care that they need, particularly for those who would otherwise refuse treatment. I would recommend that the County adopt Laura's Law to assist families and caregivers in providing this much needed treatment. Many times, loved ones have very few options to help their family members get treatment when it is refused. Additionally, we have a number of people languishing on our streets who would benefit from mental health care provided by programs put in place due to Laura's Law.

- "We have a daughter who works as a paramedic, and she frequently tells us how much behind Sacramento county is in it's care of the mentally ill."

- Any additional ways to help people with mental health issues is important and we need as many options as we can. Too many people are suffering and many are falling

between the cracks. They shouldn't be in a jail and shouldn't be on the streets with no treatment options.

- Patient's with serious mental health can benefit from interventions to prevent harm to them and others.

- This program is essential for those in need whom are currently falling through the cracks in the system.

- I believe mental health treatment is most successful when individuals are engaged voluntarily and that is not always possible. I think this law established clear guidelines, including well-defined circumstances under which AOT can be implemented, appropriate limitations on those who can file petitions, and a stipulation of a limited service duration.

- As a provider, we have had a small number of folks over the years for which this tool would have been very helpful in possibly saving their life.

- we sometimes need to help those who can't help themselves.

- I think there are times where this option could benefit an individual in getting the support they need.

- AOT is intended to reach a very small number of individuals that wouldn't otherwise seek MH Services. When implemented in a compassionate client centered manner, the AOT process can be done in a way that promotes self-determination and client voice and choice in treatment. As a provider of AOT in two neighboring counties, I can confidentially say that we have been able to successfully engage the majority of our AOT referrals on a voluntary basis and have rarely needed to move forward with the court ordered petition. With that said, when we have sought a court order, more often than not, individuals involved in the program choose to continue on a voluntary basis following the expiration of their order. AOT seeks to extend services and options in a non-confrontational and supportive manner, offering rehabilitative, case management, collateral, medication management, and individual and group therapy services to it's clients. It is an extremely effective program that understands the need to be patient, compassionate, and non-judgmental. The AOT team works collaboratively to support in a non-threatening, non-punitive manner that is supportive and encouraging. I believe Sacramento County would benefit tremendously if the decision was made to OPT IN.

- I work in outpatient mental health. I see first hand the impacts of mental health, substance abuse, and homelessness, and the ways in which these three areas intersect and morph into a very difficult topic to tackle. No one department or agency can handle the center of this Venn diagram of issues. Opting in to Laura's Law would be a good start. All the counties around Sacramento implement it. I cannot speak to its effectiveness, but in theory, I believe it would be a good start. I understand the hesitations inherent to this law surrounding concerns about folks civil liberties and right to choose. However, I also understand the accounts of family members concerned about loved ones who are too symptomatic to accept care, or have insight into their illness, and who disrupt, psychologically, the family unit. Untreated psychosis has extremely detrimental effects on those around it, family, neighborhood, mental health providers, law enforcement, you name it. When you couple an untreated psychotic mental illness with substance abuse (often engaged in without insight into the effects and the changes it can have on ones perception of reality) you have an individual that is no longer operating under the rules of the reality we all share. You have someone that is a danger

to themselves, and to their community. The idea that we would respect such an individuals right to choose is laughable. When one chooses outright chaos amidst a stable society, why should that be respected and honored? I see too many individuals with an extensive track record of hospitalizations due to an inability to care for themselves, or because of threats toward themselves or others, and they are out as soon as the hold is lifted, right back in the community. I see the families who are desperate to help their loved one and not turn their back, driven to the point of madness themselves because they cannot understand why "the system" doesn't have a plan in place to help someone in their loved one's situation. Respecting someone's civil liberties ceases to make sense when their subjective perception is so completely altered by mental health and/or substance abuse issues, that they are existing far beyond the realm in which those civil liberties were designed to operate. Yes to Laura's Law.

- Sacramento County needs to lead the way for the State. Please, this will set an example for the other counties to do so as well.

C) Neutral or unsure

- Is it possible to provide figures/statistics comparing the AOT costs vs # of individuals positively impacted by this program? Forcing individuals to partake in something they do not believe will benefit them could be provided existing FSP programs for those who actually want to improve their lives. The cost of this 'forced treatment' benefits few and takes funding away from existing FSP programs and enhances the stigma associated with MH treatment. Treatment in an AOT fashion is the 'stick' and offers no 'carrot'.

- I need more info of when it would be used

- I would like to learn more about the subject

- "I have 2 questions:
  1. With AOT, if medicine is not provided, how would you go about incorporating that in the plan?
  2. How would safety of the staff be implemented with AOT?"

- I am unsure how I feel about using the possibility of an AOT referral as leverage to persuade people to accept help voluntarily. I feel some who are not ready to be helped will feel forced into voluntary help. There by rendering it not really voluntary acceptance of help.

- More options would be helpful to avoid waiting until the person with mental illness is so ill that it's very hard to help them, as is sometimes the case now. With severe mental illness, early intervention is most effective before a person is lost, sometimes to the streets. That said, the rights of the person with mental illness must be respected and honored to the utmost. Early intervention for all illnesses is best and if Laura's Law helps someone get help sooner rather than later, yes. If we have Laura's Law, please fund it so the staff are not overwhelmed. Consistently overwhelmed staff = poor quality services.

- We need something more humane that what is happening now. Any type of illness, including mental illness, is more effectively treated with early intervention and evidenced based treatment. Before our very eyes we are losing wonderful human beings on the streets to mental illness by leaving them untreated and living out in the

elements, subject to abuse and addiction as they do their best to survive. It's not really that different than if they had cancer or another illness. We must do something for those who cannot protect themselves.

- How much will the program cost?

- Ongoing concern for State Legislature mandates that make implementation unfeasible for Sacramento County government agencies and local taxpayers; overlapping bureaucracies that were designed to actually help but are not able to address issues efficiently; concern for high program costs for legitimate needs with little knowledge of costs among community members who have no friends or family in the Assisted Outpatient Treatment arena - ultimately results in a rejection of the program and/or community backlash over costs and severity of behaviors that eventually reach actual communities. It would be helpful for you reveal at the outset your specific points that cause you to be undecided at this point. If you, as a subject matter expert, are undecided, how can we possibly move forward with my two cents? Give the community the good and bad up front in the clearest possible terms. (Which I, myself, did not do in the previous wordy comments *facepalm*) Thank you for your time.
- I attended the session, but they ignored my question, so I don't have/can't make an informed opinion.

- "Lilyane Glamben here. My stepmother, Linda Boyd, supervises AOT in LA County and would be willing to be available to talk about AOT implementation.

  Again, my personal position is that this decision is being made too rushed, and I do believe it meets a need...but, if it is ever to be considered here, AOT implementation needs to involve diverse communities in its planning and design."

- we have huge concerns around mental health and our unhoused. Im on bothsides of the fence on lauras law because could have catrostrophic issues if not done right where criminaization and policing are invovlved. On the same note i have families who are trying to help and are restricted by laws.

- How will the current FSP programs be impacted? Will current FSPs start receiving AOT referrals or will different programs be developed and the current FSPs remain voluntary? Will the type/severity/target pop dx of referrals to FSPs change? What does the documentation for offering voluntary services look like? How long does the voluntary OP treatment program attempt to offer voluntary services? If a consumer is referred to AOT which is provided by an FSP, what are the safety parameters to protect the FSP agency from violence/threats? What would a discharge process look like?

- "Opting in" allows for the county to utilize this provision on the, hopefully, rare occasions that it is needed.

- Outpatient Hospitalization is excellent. I don’t understand why we need AOT.

Appendix A: Supplemental Public Comment

In addition to the public comments submitted as survey responses, the report attached, "2012 Feasibility Study of Alternatives for Individuals with Chronic Untreated Mental Illness in Sacramento County" by the Mental Health Board, was submitted as a public comment.

[1] Be Healthy Sacramento. 2020 Demographics. http://www.behealthysacramento.org/index.php?module=DemographicData&controller=index&action=index

Sacramento County Mental Health Board

Ad Hoc Committee

Feasibility study of alternatives for individuals with chronic untreated mental illness in Sacramento County

July 2012
Submitted By:
Susan McCrea
Lois Cunningham
Brian Brereton

Executive Summary

The main purpose of our Sacramento County Mental Health Board (SCMHB), Ad Hoc Committee was to investigate alternative treatments for seriously mentally ill individuals, especially those with continual hospitalizations and incarcerations. Our committee formed after two presentations, pro and con, about the controversial Assisted Outpatient Treatment (AOT, AB 1421, Laura's Law) in the summer of 2011. Several SCMHB members volunteered to research issues represented in both presentations. We expanded our mission to include many issues, as well as Laura's Law. We had concern about the unreached, those who have no services, especially the mentally ill, homeless population in our county. Also recidivism of some individuals brings great cost to the struggling mental health system. We hoped to shed more light on these challenging problems.

First, using a general questionnaire, we interviewed individuals, representing both sides of the AB 1421 debate. Opponents, Meghan Stanton, Delphine Brody, and Sean Rashkis, presenters to the SCMHB, gave us many substitute programs and ideas. We also interviewed John Buck and Carol Stanchfield, providers implementing AB 1421 in Nevada County. Randall Hagar, advocate of this law and a presenter to the SCMHB, suggested more reasons for his support. He shared an outline of "The History of Mental Health Treatment." One of our members researched the details of this history and its laws, found in Appendix I. The most recent legislation is summarized on page 10 of the Introduction.

Sean suggested that Laura's Law was not necessary. The Lanterman-Petris-Short (LPS) Act already covered the concerns of this law. This comment led to in-depth research into the LPS Act. We discovered its details, some not enacted, but written into the act. We interviewed Rick Pearson at the Conservatorship Office. Paul Powell and staff at Transitional Living & Community Support, Inc. (TLCS) gave us a rich recollection of vital, twenty-year history of our county's attempts to aid some of our target population. Because of funding, many outreach programs have been discontinued. Outreach is a very important need in our county at the present time. Through Susan Gallagher and Dorian Kittrell, we learned about new outreach, the Community Support Team (CST) initiated in Sacramento about eight months ago through Mental Health Services Act (MHSA), Prevention and Early Intervention (PEI) dollars. It is the beginning of filling this important gap in our community. Uma Zykofsky and Kelli Weaver told us more about this collaborative team, utilizing both professional and peer resources, helping consumers, families, and homeless individuals access more services and support.

Through this interview process, we uncovered additional issues to be addressed and found solutions already in progress. Based upon our mission to research other alternatives, answers to some questions led us to expand our original interview base. Conversations with advocates, Michael Hansen, Michaele Beebe, and Larry Liseno, President of NAMI, added to our information. Interviews with Jane LeBlanc, MHSA, Marguerite Story-Baker, Alcohol and Drug Services (ADS), and Scott Seamons, Vice-President of the Hospital Council, rounded out our investigation. Our report contains details of all of our insightful interviews we conducted during a five-month period. We encouraged each interviewee to review our notes and make additional corrections and comments before we released them for this publication.

We found agreement among professionals and advocates alike that the forty-year old LPS Act should be modified, re-written or reactivated. One of the reasons that AB 1421 appeals to some people is that it empowers family, friends, and community members. They hope to get help, beyond current practice of LPS Law, for individuals at risk. We also looked at other means, like the CST, which has the beginnings of two missing components, more access for families and an outreach to the homeless.

The recent tragic events in Aurora, Colorado, underline the inability of our society to help some mentally ill individuals. Waiting until a crisis escalates is too often the norm. Early treatment and intervention helps both individuals and our communities, while a “crisis mentality” delays services and potential tragedies. How do we empower our community and not transgress the rights of individuals? We do not want to return to the archaic ways of the past nor shift the concept of “mental hospitals” to jails and the streets.

Recidivism of some clients drives up costs for the county through repeated hospital and/or jail visits. The Sacramento Mental Health Court (SMHC) is an attempt to stop recidivism and help mental health clients, caught up in the judicial system. We interviewed Steven Lewis, Chief Public Defender of this court. We learned how SMHC helps individuals stabilize and how the county saves money through its interventions. He said that there is room for expansion of these services.

Looking into the intricacies of the LPS Act, we explored the option of a court-ordered petition, Sections 5200-13, to help interested parties get an evaluation for an individual in need. An interpretation came from our County Counsel, Denis Zilaff, and another response from California Disabilities Rights (See pp. 61-63.). We suggest more inquiry into other possibilities within the LPS Act.

The issues discussed are complex and interdependent on many factors, available funding and present laws and their interpretation. Our ad hoc committee looked into many issues and a variety of potential programs. Our report established viable conclusions that address alternatives for individuals with chronic, untreated mental illness in Sacramento County. We hope our investigation will be only the beginning of continued awareness. One of our great American leaders stated, “The price of freedom is constant vigilance.”

Definition: “Feasibility studies aim to objectively and rationally uncover the strengths and weaknesses of a proposed venture, opportunities and threats as presented by the proposal, the resources required to carry through, and ultimately the prospects for success.”

Introduction

Mental health treatment has had a storied past. Horrible conditions, shackles, and inhumane systems were the norm for many years. With the closure of institutions in the 1960s and 1970s came a time that states and communities had to step up and create humane, respectful, and holistic approaches to the treatment of mental illness.

Currently mental health in California has a contentious issue over the existence and use of Assisted Outpatient Treatment (AOT). The California Welfare and Institutions Code (CW&IC) reflects the Lanterman-Petris-Short Act (LPS) as well as AB 1421, or Assisted Outpatient Treatment (AOT). Sacramento County is typical of most counties where the AOT controversy overshadows the subject. It has stalemated any progress to offer assistance to mental health clients with anosognosia, inability to have insight. Sadly there has developed a schism between family members and their loved ones with mental illness. The perception of consumers is fear over the idea of forced treatment based upon the past. Family members feel at a loss about how to seek services for loved ones who suffer debilitating mental illness. There are stories of individuals who are continually incarcerated and hospitalized, rather than receiving necessary treatments. How do families, friends, neighbors, and professionals seek help for an individual and yet safeguard the individual's right to make choices for themselves without coercion?

The current approach to mental health in California is described in a publication we received from the California Network of Mental Health Clients (CNMHC). The booklet is called "Building Partnerships: Key Considerations when Engaging Underserved Communities under the MHSA," written by UC Davis Center for Reducing Health Disparities. It states: "In November, 2004 California voters passed Proposition 63, which became a state law entitled the Mental Health Services Act. This Act created the expectation of a comprehensive planning process within the public mental health system that is inclusive of underserved communities over-represented among California's most vulnerable populations, such as ethnically diverse, poor, uninsured, and geographically isolated. The Act seeks to transform the mental health system to a 'help-first' approach, such that ethnic communities, clients, family members, community-based agencies, providers, public agencies, and other stakeholders in the mental health system are key partners in the decision-making process. Given the fact that California is leading the nation in diversity, partnerships with diverse communities is essential to transforming the state's mental health system."

In our introduction we have included a visual of Mental Health Services as a baseball park, a concept given us from John Buck from Turning Point. Our report chapters are divided into two major sections. The first section describes laws and the Mental Health Court. In the second section we provide information from county and community organizations, including the Hospital Council, and we discuss peer support. The appendices list other county or state solutions. We provide acronyms but complete definitions can be found in Appendix A of the Callahan Report. There are charts and information that helped us gain awareness, such as the Level of Care Utilization System (LOCUS) and Maslow's Hierarchy of Needs. One consumer leader said Maslow's theory is "the essence of a peer-run program." Statistics, and resources available, led us to some of the recommendations. Given our short time frame, this study could not be exhaustive. The proposal and mission are provided as well as the interview questions.

The text of the Ad Hoc Committee proposal, mission, and timeline, as approved by the Sacramento County Mental Health Board in November, 2011:

This proposal is submitted for the MHB members to approve an ad hoc committee that will produce a feasibility study for Sacramento County, surrounding alternative treatments for individuals with continual chronic trauma, who have the possibility for preventable physical and mental injury.

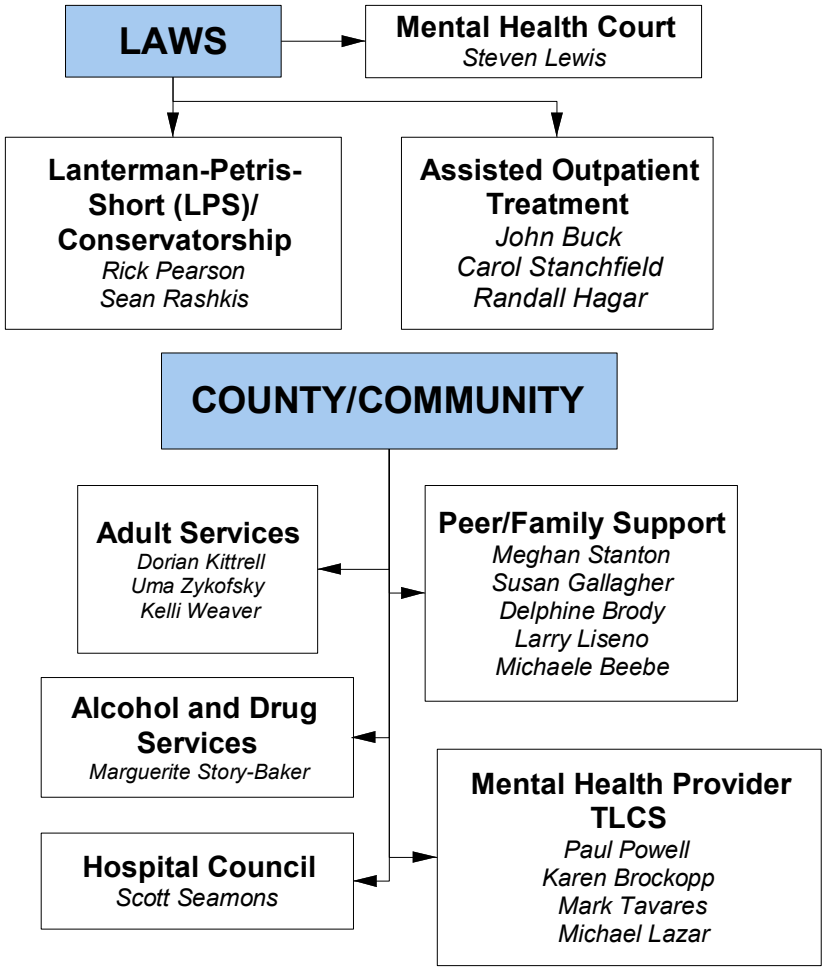
Mission: The Ad Hoc Committee will research alternative treatments for individuals with a history of continual hospitalizations and/or incarcerations that may or may not currently utilize services within the Sacramento County system of care. The goal is to identify methods to prevent further trauma. Alternatives to be considered can be new approaches within the current Sacramento County infrastructure, and possible implementation of other approaches that might require increased funding but can produce future cost savings.

Timeline: This study is to be returned back within six months to the Mental Health Board for review and possible submittal to the Sacramento County Board of Supervisors.

Final Report: The Final Report must provide recommendations to the MHB regarding the viability of any identified treatments, explaining both human and dollar costs. This report must provide verifiable facts, valid data collection, and feasibility comparisons, plus possible interviews with stakeholders. The Final Report must recommend any alternatives with implementation in Sacramento County that can be obtainable within the next three years.

Interview Questions used by the MHB Ad Hoc Committee:

- How do you feel about our mission?
- Do you think the current situation in Sacramento County covers the needs of the individuals we are targeting? If yes, how? If no, what would you suggest?
- What are your ideas for alternative treatments or solutions?
- What is your philosophy on providing services? What population do your services cover?
- How are you funded? How do you measure the success of your services? How is success quantified?
- If money was no object, what options for providing services do you think should be made available for those individuals who are at-risk and are not participating in the Sacramento County System of Care?
- If money is an issue, in your opinion, what options are possible to implement?
- Do you know the costs associated with suggested treatment services and if money can be saved in the long-term?
- Do you have any further comments that could help us in this research?
- Do you know of legislation or other documentation that would help us fulfill our mission?
- How do you feel about our mission?
- Do you think the current situation in Sacramento County covers the needs of the individuals we are targeting? If yes, then how? If no, what would you suggest?
- What are your ideas for alternative treatments or solutions?
- What is your philosophy on providing services? What population do your services cover?
- Do you know of legislation or other documentation that would help us fulfill our mission?



Steven Lewis - Chief Assistant Public Defender
Rick Pearson – Health Program Manager, LPS/Conservator Office
Sean Raskis – Attorney, Disabilities Rights California
John Buck – Turning Point, CEO
Carol Stanchfield - Turning Point, AB 1421 Program Director
Randall Hagar – Director, Government Affairs, California Psychiatric Association
Dorian Kittrell – Executive Director, Sacramento County Mental Health Treatment Center
Uma Zykofsky - Human Services Division Manager, DBHS Adult Mental Health Services
Kelli Weaver – Program Manager, DBHS Community Support Team
Marguerite Story-Baker - DBHS Health Program Manager, Alcohol and Drug Services
Meghan Stanton – Executive Director, Sacramento County Wellness and Recovery Centers
Susan Gallagher – Executive Director, Mental Health America of Northern California
Delphine Brody – MHSA and Public Policy Director, California Network of Mental Health Clients
Larry Liseno - President, Sacramento County National Alliance on Mental Illness (NAMI)
Michaele Beebe – Sacramento County Family Advocate
Paul Powell – Transitional Living and Community Support, Associate Director, Property Development & Operations
Mike Lazar - TLCS, Executive Director
Karen Brockopp - TLCS, Associate Director, Program Services
Mark Tavares - TLCS, Co-op Program Manager
Scott Seamons – Regional Vice-President, Hospital Council of Northern and Central California

LIST OF INTERVIEWS BY DATES

I. Meghan Stanton, Wellness & Recovery Center offices, February 2, 2012

II. John Buck and Carol Stanchfield, Turning Point offices, February 3, 2012

III. Paul Powell and Staff, TLCS, February 14, 2012

IV. Sean Rashkis, California Disability Rights, February 24, 2012

V. Michaele Beebe, Family Advocate, February 24, 2012

VI. Rick Pearson, DBHS Conservatorship Office, March 2, 2012

VII. Susan Gallagher, Mental Health of America¸ Friday, March 9, 2012

VIII. Dorian Kittrell, the Mental Health Treatment Center, March 14, 2012

IX. Larry Liseno, President of NAMI Sacramento, March 15, 2012

X. Delphine Brody, California Network of Mental Health Clients, March 30, 2012

XI. Randall Hagar, California Psychiatric Association, April 13, 2012

XII. Scott Seamons, Regional Vice-President, California Hospital Council, April 26, 2012

XIII. Uma Zykofsky and Kelli Weaver, DBHS Adult Mental Health Services, May 2, 2012

XIV. Jane Ann LeBlanc, DBHS Program Manager, MHSA, May 17, 2012

XV. Marguerite Story-Baker, DBHS Alcohol and Drug Services, June 8, 2012

XVI. Steven Lewis, Chief Assistant Public Defender, June 28, 2012

History of Mental Health Treatment and Legislation in America (Appendix I for more detail)

1842 Doctor Dorothea Dix discovered deplorable conditions and championed for better treatment of the mentally ill.

1880s Institutions were developed, expanded and improved in the US as well many parts of Europe.

1920-1940 Community based program movement started.

1952 Medication Era is born: Thorazine.

1963 Community Mental Health Centers Act

1963 Governor Reagan administration budget

1965 LPS concept born.

1965 Social Security Act of 1965, Medicare & Medicaid established, publicly funded healthcare.

1965 IMD Exclusion/Discrimination (21 & under and 65 & older)

1967 Lanterman-Petris-Short (LPS) Act signed into law.

1968 State deinstitutionalization starts.

1970 Transinstitutionalization begins. Prison system grows as state hospitals close.

1971-1974 Wyatt v. Stickney

1974-1976 Lessard v. Schmidt

1975 O'Connor v. Donaldson

1976 Tarasoff v. Regents of the Univ. of California

1978-1983 Rennie v. Klein

1979-1980 Guardianship of Richard Roe III

1979-1982 Rogers v. Okin

1980 Civil Rights for Institutionalized Persons (CRIPA) enacted.

1985 The Bronzan-Mojonnier Act

1988 The Wright-McCorquodale-Bronzan Mental Health Act

1989 Riese v. St. Mary's Hospital & Medical Center

1990 Americans with Disabilities Act enacted.

1990 "Decade of the Brain"/advent of widely available brain imaging

1990 Zinerman v. Burch

1992-1994 California's first realignment

1995-1999 MH Managed Care Consolidation—Counties assume risk of treatment.

1995 Coleman legislation decided.

1997 LPS Reform Taskforce

1998 Mentally Ill Offender Crime Reduction Grant Programs, (MIOCRG)

1999

Kendra's Law enacted in NY, Mental Hygiene Law; 1999 NY Statutes, effective since November 1999, established the first state law concerning involuntary outpatient commitment.

AB1800
Written by Assemblywoman Helen Thompson and modeled after Kendra's Law, it was the first viable attempt to update LPS in California. The goal was to expand the government's ability to provide involuntary treatment for the mentally ill who could not gain access.

Olmstead Case
The Supreme Court held that Title II prohibits the unjustified segregation of individuals with disabilities. Public entities are required to provide community-based services to persons with disabilities.

AB 88
The Mental Health Parity Law requires private health insurance plans to provide equal coverage for physical health and selected mental health conditions.

AB 34 (see AB 2034)
It sponsored three pilot programs, including Sacramento County.

2000

AB 2034
This legislation provided funding for all California counties, based on the success of the three pilot programs under AB 34. They were very successful in reducing the number of homeless, jail, and psychiatric hospital days experienced by enrollees.

AB 1421; AB1 424;
AB 1421, Laura's Law, was the first AOT law passed in California but only fully implemented in Nevada County;
AB 1424 requires that any person taking an individual into custody for involuntary treatment, consider available relevant information about the historical course of the person's mental disorder.

Plata vs. Schwarzenegger
The California Supreme Court found that the California Department of Corrections and Rehabilitation (CDCR) "lacks an adequate system to manage and supervise medical care." In 2004, the Health Care Services Division of the Department was ordered to implement quality management of physicians. Failing to do so, in 2005 a receivership was appointed to oversee the department.

2003

US vs. State of California (State Hospitals)
The DOJ investigation found significant and wide-ranging deficiencies in child and adolescent patient care at Metropolitan State Hospital (MSH), a state facility housing children, adolescents, and adults who suffered from mental illness.

2004

Proposition 63/ Mental Health Services Act
The passage of MHSA provided the first opportunity in many years for the California Department of Mental Health (DMH) to increase funding, personnel and other resources to support county mental health programs.

2007

Governor Schwarzenegger, with a line-item veto, cut the $55 million in funding, slated for AB 2034 programs, from the state budget.

2009

AB 2034 lawsuit fails
The lawsuit charged that Governor Schwarzenegger violated Proposition 63, now known as the Mental Health Services Act. He eliminated the program providing integrated services to homeless, mentally ill adults (the AB 2034 program). As a result, the AB 2034 programs in thirty-four of the state's counties were forced to shut down, leaving them scrambling to find alternative funding or provide services through other programs.

2011

AB 109/Prisoner Realignment
This legislation reassigns three groups of offenders, previously handled through the State Prison and Parole System to California counties.

AB 100/Update to MHSA/Prop 63
An existing law contains provisions governing the operation and financing of community mental health services in every county. This bill deleted the requirement for annual reviews, as well as the annual update requirement for the 3-year plans. The bill reduced the amount available for administrative costs to 3.5%, and requires the state, instead of the Department of Mental Health, to administer the Mental Health Services Fund.

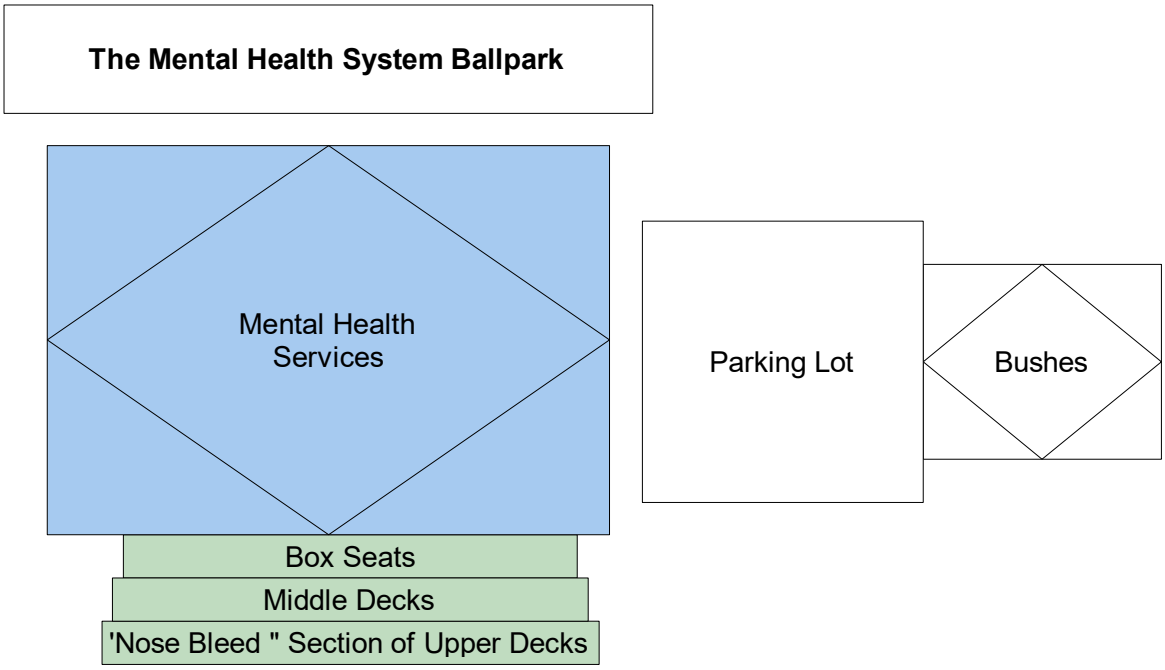
2012

AB 1693
It authorizes the State Department of Mental Health to expand a specified pilot program to establish competency restoration programs in prescribed counties. It provides treatment in county jails to individuals (found to be incompetent to stand trial) who have not been committed to a state hospital. The bill passed the Assembly in May and was recommended to pass from the Senate in July.

AB 1421, Laura's Law, (now reintroduced as AB 1539 to extend its provisions as enacted) is due to sunset January 1, 2013. It is presently going through the California Legislature. It passed the Assembly and is currently in the Senate's committees.

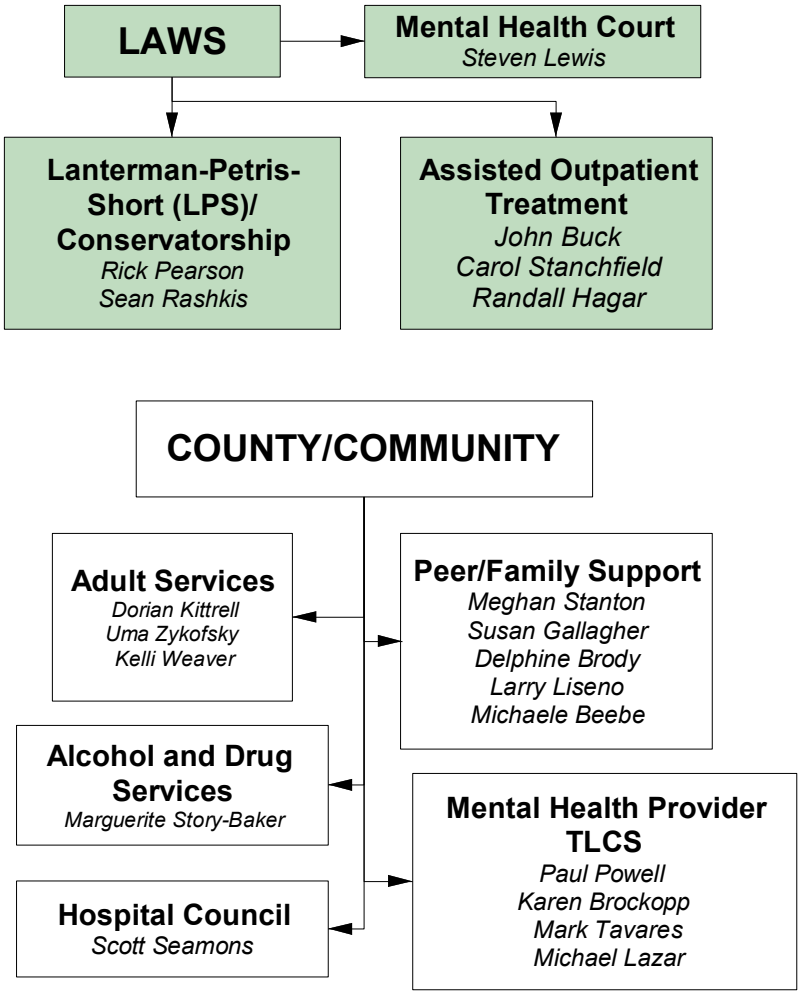
AB 2134
It expands county obligations if Laura's Law is implemented. This bill would require a county that adopts Laura's Law to provide additional services.

The outcome of these latter two bills should be watched carefully.



John Buck, Turning Point Executive Director, described a concept that views mental health concerns as a baseball park. The park represents all services that are available to an individual. The box seats, middle decks, and “nose bleed” sections represent the person’s understanding of what is accessible. “Box seats” mean the individual can see all resources and can utilize them with an understanding of the array that exists. This group may have private medical insurance. The “middle decks” represent those who have some idea of what exists, but may have limited viewpoints of the whole system. The “nose bleed sections” have only limited visibility to what may exist. Those inside the parking lot know there are supports, but do not know how to access them. Those individuals “in the bushes” represent those who do not know that there are services available to them. They may not want to participate in anything that can help with their mental health issues and improve their quality of life; they may have no insight into their illness.

The rules are different in each location. The further from the field, the enforced rules are fewer. Behavior that wouldn’t be acceptable in the box seats is likely overlooked and considered the norm. Additionally, it is what you can afford. The cost gets higher the closer you get to the diamond. Some cannot pay the high fee to enter the parking lot, let alone a box seat. Often times the people in the bushes have few finances, relationships, and supports. They often do not manage these effectively. They may choose to live by their own rules and have little interest in the noise coming from the stadium. There is a fence symbolic of access issues between the parking lot and the bushes. Some "people in the bushes" will come to the fence and ask the tailgaters for a spare hot dog, interfacing with society for brief occasions. Others, further out, are unable or unwilling to even come to the fence. They might be too fearful and may reject contact with others altogether.



Mental Health Conservatorship is outlined in the Lanterman-Petris-Short (LPS) Act of the Welfare and Institutions Code (W&IC). A mental health conservatorship makes an individual, called a conservator, responsible for a mentally ill, gravely disabled adult, called the conservatee. Conservatorship is a legal, not a clinical process. Conservatorship gives legal authority to the conservator to make certain decisions for the conservatee who is unable to take care of him or herself.

Assisted Outpatient Treatment (AOT) is usually court-supervised treatment in the community for those individuals with high-risk, who may hurt themselves or others. These individuals have failed to engage in treatment after repeated offers of the best and most intensive services. AOT ensures the support needed is provided to achieve stability and meaningful recovery.

Mental Health Court (MHC) is a specialized court addressing seriously mentally ill persons in the jails. The MHC targets those individuals who are frequently in and out of jail and have a mental illness. Once identified as a qualified candidate, Jail Psychiatric Services works to get participants stabilized, on medications, if appropriate, and refers them to MHC. A plan of action is put into place to ensure the offender succeeds through community supervision and regular monitoring.

The Lanterman-Petris-Short Act (LPS)

A law, signed originally in 1967, went into effect in California on July 1, 1972. It is officially noted in the California Welfare & Institutions Code, Division 5, Part 1, and Sections 5000-5034. This law set the precedent for modern mental health care in the United States. It cites in Section 5001, "The provisions of this part shall be construed to promote the legislative intent as follows:

- To end the inappropriate, indefinite, and involuntary commitment of mentally disordered persons, developmentally disabled, and persons impaired by chronic alcoholism, and to eliminate legal disabilities;
- To provide prompt evaluation and treatment of persons with serious mental disorders or impaired by chronic alcoholism;
- To guarantee and protect public safety;
- To safeguard individual rights through judicial review;
- To provide individualized treatment, supervision, and placement services by a conservatorship program for gravely disabled persons;
- To encourage the full use of all existing agencies, professional personnel and public funds to accomplish these objectives and to prevent duplication of services and unnecessary expenditures;
- To protect mentally disordered persons and developmentally disabled persons from criminal acts."

The Lanterman-Petris-Short Act, in effect, ended all hospital commitments by the judiciary system, except in the case for criminal sentencing and specific situations. It did not, however, impede voluntary commitments. It expanded the evaluative power of psychiatrists and created provisions and criteria for holds.

Anyone can ask a potentially mentally ill individual to get an evaluation voluntarily. If the individual refuses it, the person has two choices, asking for a court-ordered petition from the county to force the individual to get evaluated (Section 5201) or calling law enforcement to cause the individual to be taken into custody for evaluation (Section 5150). In either case, if a person requesting evaluation causes the individual to be detained, knowing that the potentially mentally ill individual is not a danger to him/herself or others, that person is guilty of a misdemeanor (Sections 5203 for the court-ordered petition; 5250.05 for law enforcement). Section 5150.05 allows the person requesting evaluation to offer historical information about the individual to law enforcement. This was added to the LPS Act in 2001 and can be an effective tool for families and concerned persons to be heard.

If an individual qualifies for a 5150, he or she has a three day, seventy-two hour hold for evaluation and treatment. During that time the psychiatrist or mental health director of the facility

can release them. After evaluation and treatment the patient gets released, referred for further care and treatment on a voluntary basis, or certified for intensive treatment, a 5250, fourteen day hold. There are opportunities many times during these holds for hearings to request early release against the hospital's wishes. Advocates of patient rights work to help individuals with these proceedings if they feel they are wrongly held against their wills.

At the end of fourteen days, a patient shall be released unless:

- He or she agrees to further treatment voluntarily.
- He or she is certified for an additional fourteen days as a suicide risk (5260).
- He or she is certified for an additional thirty days (5270).
- He or she is subject to temporary conservatorship. (5352 - 3)
- He or she is given a "dangerous person" status (5300).

After thirty days a patient is released unless he or she agrees to voluntarily continued treatment or is subject to Temporary Conservatorship (TCON) or given a "dangerous" status, where he or she is placed into long-term care. Conservatorship is derived from the Welfare & Institution codes, beginning with Section 5350. The courts cannot make a referral. Conservatorship can begin while a person is on a 5250 (fourteen day hold) or 5270 (thirty day hold). Once a referral has been made, the office, through the County Counsel, files a petition for TCON. It will generally last for about thirty days. Then there will be a hearing. A TCON cannot be continued for more than six months. A mental health client has potentially forty-seven days of evaluation and initial services, such as crisis counseling, medication adjustment, and respite care. The forty-seven days is calculated as a three-day 5150 hold; a fourteen-day 5250 hold; and a thirty-day 5270 hold. Conservatorship is a different legal hold though, than 5150, 5250 or 5270.

Permanent Conservatorships are granted up to the maximum of one-year. A conservatorship can be extended after the one-year hearing. At that time, a conservatee can request a jury, but this is not common. It is often hard on the clients to expose the details of their illness. A Riese Hearing, also known as Medication Capacity Hearing, is facility-based. It determines if a person on any of the LPS holds, other than Temporary Conservatorship or Permanent Conservatorship, has the capacity to refuse psychiatric medications. The chart on the next page explains the procedures used in Los Angeles County, which are common to most counties and illustrate the complex holds in the Act.

Lanterman-Petris-Short Act (LPS) addresses some of the issues that the Ad Hoc Committee investigated. The law is under-utilized and many professionals believe this forty year old act should be re-written.

LPS HOLDS CHART

LPS HOLDS	CRITERIA			COURT PROCEEDINGS
	GRAVELY DISABLED	DANGER TO SELF	DANGER TO OTHERS	
72-HOUR WIC 5150 EVALUATION & TREATMENT	ONE OR ALL MAY APPLY			1. No probable cause hearing 2. May request Riese hearing (Decision regarding Riese carries through 14-day hold)
14 DAY WIC 5250 3-DAY EXTENSION WHEN CONSERVATORSHIP APPLIED FOR	ONE OR ALL MAY APPLY			1. Probable cause hearing must be held during first 4 days of hold unless patient request by-pass writ of habeas corpus, 24 hr. postponement, and signs voluntary or is discharged. 2. Patient may request one writ of habeas corpus hearing at any time during 14-day hold. 3. Riese hearing maybe requested anytime during 14-day hold. Each subsequent hold requires a new Riese hearing.
ADDITIONAL 14-DAY WIC 5260		ONLY CRITERIA WHICH APPLIES		1. No probable cause or court hearing required. 2. Original additional 14 certification form and 2 affidavits must be sent to mental health court. 3. Patient may request writ of habeas corpus any time during 14-day period. 4. New Riese hearing may be requested anytime during 14-day period.
30-DAY WIC 5270	ONLY CRITERIA WHICH APPLIES			1. Probable cause hearing must be held during first 4 days of hold unless patient requests by-pass writ of habeas corpus, 24 hr. postponement, and signs voluntary or is discharged. 2. Patient may request writ of habeas corpus any time during 30-day period. 3. New Riese hearing may be requested anytime during 30-day period.
180-DAY WIC 5300 RENEWABLE			ONLY CRITERIA WHICH APPLIES	1. Requires contact with D.A. several days prior to expiration of 14-day hold. 2. Requires the District Attorney to file a petition with the court and an arraignment hearing in court. 3. New Riese hearing may be requested anytime during 180-day period.
TEMPORARY CONSERVATORSHIP 30 DAYS TO 6 MONTHS	ONLY CRITERIA WHICH APPLIES			1. Requires application by the treating physician to the Public Guardian's Office 2. Judge reviews application and determines whether to grant or deny temporary conservatorship (T-Con). 3. Patient may request writ of habeas corpus any time during T-Con period. 4. New Riese Petition may be filed with County Counsel. Hearing held in Dept. 95A.
"PERMANENT" CONSERVATORSHIP 1 YEAR RENEWABLE	ONLY CRITERIA WHICH APPLIES			1. Requires court hearing in Dept 95A. Physician may be required to testify in court. 2. Patient may request re-hearing on conservatorship, rights denied, disabilities imposed once every six months.
RE-APPOINTMENT OF "PERMANENT" CONSERVATOR	ONLY CRITERIA WHICH APPLIES			1. Requires conservator petitioning for reappointment and a court hearing.

NOTE: Each hold requires a new Riese hearing except when going from the 72 hour to the 14-day.
Superior Court of California, Los Angeles County, Office of the Counselor in Mental Health

lps holds chart doc

Assisted Outpatient Treatment (AOT)

As a possible alternative, we investigated AOT, one of the most controversial subjects encountered, in the form of AB 1421. AOT, outpatient treatment, exists in a variety of forms in forty-four states. It usually includes court-ordered treatment plans, but not always involving medication. It goes beyond the scope of current LPS Laws and can possibly give family and concerned people more of a voice than the current laws to get help for seriously, mentally ill individuals in need.

In California, 2002, Assemblywoman Helen Thomson teamed to create AB 1421 with the family of Laura Wilcox, who was killed with two others by a non-compliant, mentally ill client, Scott Thorpe. She modeled Laura's Law, as it's called, after Kendra's Law, New York, 1999. Only Nevada County fully implements this law, as part of their settlement with the Wilcox's. Surprisingly, it uses MHSA funds, as their program allows voluntary participation as well. There is also a pilot program for AB 1421 in LA County. Each county implementing this program must provide funds as there are no built-in monies for it. Every county's Board of Supervisors must approve of this law in order to have it adopted.

AB 1421, now in the form of AB 1569, is currently in the California Senate, going through a committee process, having recently passed the Assembly in an attempt to get the sunset of this bill, January 1, 2013, extended to 2019. We attended some of the committee meetings while the new bill went through Assembly sub-committees and during that time met those for and against this law.

Proponents/Opponents

Proponents claim that both hospitalization and incarceration are reduced through its use with great saving to the counties involved. Because most of these clients suffer from anosognosia, inability to discern their own mental illness, they also believe it is a humane way of getting needed early treatment for severely mentally ill individuals. Opponents site violations of civil rights from possible forced medication and other aspects of this, trauma from being in court ("Black Robe Coercion"), and potential socio-racial prejudice in the implementation of the law. There are also fears of returning to the harsh conditions existing before 1970 when consumers often had little or no rights over their court-ordered treatment. Passionate and sometimes even hostile arguments surround discussions about this law.

John Buck and Carol Stanchfield Interview

The Nevada County Laura's Law Program, which is four years old, was envisioned to help clients engage in treatments who have no insight into their illness. John Buck actually had mixed feelings about Laura's Law at the time, but in 2006 Michael Heggarty, Mental Health Director in Nevada County, asked Turning Point to provide services for Laura's Law in his county. He also knew that these services were voluntary. "Why would you want to do this?" the committee asked him. "Someone has to do this, and every person deserves the best of services. We will do the best we can."

They started in 2007 with Carol at the head. They expected to reach four to five people a year. Thirty-seven people have been referred to the program in the four years of its existence. Only nine of them have received AOT court orders, two twice and one person three times.

AACT and AOT

Carol helped us to understand the difference between AACT, Adult Assertive Community Treatment, and AOT, which are identical services, differentiated only by length, level of insight and criteria for treatment:

- AACT clients want services and have awareness of their individual need for treatment; those referred through AOT have little to no insight of their need for treatment, sometimes even afterwards.

- AACT services have no end date, versus AOT which is time limited to 180 days.

- Both AACT and AOT clients meet criteria for medical necessity (W&I Code 5600.3). Criteria for AOT are narrower, including medical necessity and requisite criteria identified in the checklist. (W&I Code 5346).

- AACT treatment includes Mental Health Court support. In the MHC process, clients may face jail through a violation of probation (VOP) if the individual fails to follow the treatment plan. AOT has no violation component and is a "no-fail" approach to treatment. This means services are not dependent on compliance with treatment expectations or timeliness of progress. Services are based on individual pace and need. Also, clients are not dis-enrolled based on expectations or their response.

One of the commonalities among clients referred is anosognosia or no awareness of their psychiatric illness, which is the primary barrier for individuals in accessing treatment.

Full Service Partnership (FSP)

Laura's Law in Nevada County is a Full Service Partnership. One key thing Carol said, "Treatment is all about relationship; building a partnering relationship is the beginning step." Cultivating the therapeutic relationship through a strength-based, client-centered approach is the basis for engagement and recovery and essential for AOT success. Laura's Law in Nevada County is a Full Service Partnership. The client's voice is respected and strongly encouraged. Choices support empowerment, independence and greater well-being. She gave an example of asking the client if he or she would see a doctor. It is a fluid process, a conversation, and a partnership. "We are all part of the team, inviting participation in the context of treatment. There is a due process in Laura's Law. You cannot jump over it or around it."

Carol gave us an example of a situation of a client threatening someone's life. As a Laura's Law client, with assessment and support, jail was averted. A 5150 would not have helped in this situation. Often clients referred for AOT present well enough at a 5150 evaluation to avoid hospitalization.

Carol gave another example of a client who for two or three years accepted engagement with no medication, but who is now actually willing to take medication. "You cannot force medication. Medication is not a cure-all." (See Riese Hearings.)

Carol discussed the importance of not waiting for treatment. "What if we wait? Avoid more damage? Delay in treatment can create more damage." She mentioned that there is documentation on the importance of not waiting for treatment. Carol also said there are "families

held hostage" by their loved ones with untreated, psychiatric disabilities. It is essential for there to a quick response to both consumers and their loved ones.

John shared his position. "I don't care what the model is. I want to keep people with psychiatric disabilities out of prison or jail. I don't care what the law is if we can have effective programs and help people without services. How can I help my brother compassionately, from a recovery standpoint? We need effective programs to keep people from getting into worse situations. Some people in our community should have a right to treatment but they don't have the capacity to make the choice." There has also been a criticism of "Black Robe Coercion," having a harsh and cold manner in court. John hasn't experienced that with Judge Tom Anderson, in Nevada County. This also does not seem to be a reality in most mental health courts.

At the conclusion of our interview, John gave us the wonderful baseball analogy that we have included previously. Carol added the issue of hope if you provide understanding. "People want respect, which is a foundation for recovery. We know that we'll never be able to engage everyone in treatment, but we can care enough to do more in preventing worsening symptoms associated with prolonged suffering. At the very least, AOT can be an investigative tool to assess the risk level of individuals referred and provide for proactive interventions and supports. AOT saves lives, improves the quality of life for those engaged in treatment and their families, saving money and increasing safety in the community. From a provider perspective, it is the right thing to do. It may provide an opportunity for a small number of people to get relief from the intense suffering that some of us can only imagine."

Nevada County won a Challenge Award in 2010 from the California Association of Counties for their implementation of Laura's Law. They also provided information about cost savings. We included this information in the statistics section of the report.

Sean Raskis Interview/the LPS Act/Conservatorship

Sean Rashkis mentioned in his presentation at the Mental Health Board and this interview the importance of using conservatorship and what already exists in the LPS Law, instead of Laura's Law. He said that AB 1421 is unnecessary as there is already provision for what it covers in the LPS Act. He confirmed that almost all of the provisions in AB 1421 are already part of the existing Act. The main problem is the enforcement, or lack of such, of the LPS Act itself. Perhaps these things are not activated and used at this time. "Laura's Law is not necessary."

Sean feels that there are various reasons for not using the LPS Act, including: a) un-informed or under-informed consumers/family and law enforcement; b) a conservator or crises system that does not work due to lack of funds, space, expertise, lack of resources or other reasons; c) nobody taking the time and/or responsibility to research the issues and hold the stakeholders accountable. Therefore, Sean concludes, "Since all of the provisions of AB1421 are almost identical to the existing law, does it make sense to promote it?" AB 1421, named Laura's Law, seemed to be a way to either innocently attempt to recharge a system that was not working or to satisfy a charged-up public, looking for solutions. It is also an admission that the current law doesn't work, for whatever reason, and nobody is willing to take the political impact of admitting the existing system doesn't work. A "not under my watch" mentality, plus finger pointing at other factors, instead of admitting a fault, seems to be the norm. As a result of these suggestions, we interviewed Rick Pearson at the Sacramento Conservatorship Office and investigated LPS Law.

He pointed out that Nevada County has a different concept of conservatorship and is "way behind." For example, they talked about how Laura's Law implementation is so much better as

contrasted with locking people up in conservatorship and having no rights. Sacramento County is much more progressive with conservatorship, using board and care and community resources more often, rather than locking people up.

Voluntary Mental Health Services

Sean believes the focus should be on increasing voluntary mental health services in the community, not involuntary services, such as Laura's Law. We talked about the importance of more voluntary services in the county, such as Crisis Residential Services. It is important to work closely with individuals who come into the county mental health system so individuals who come into the Treatment Center, don't discharge and disappear off the map of county mental health services. The Callahan Report (Appendix K) is a blueprint to improve voluntary mental health services and an individual's ability to receive timely mental health services throughout the county.

Here are some other ideas he gave us:

- Use of MHSA Prevention and Early Intervention funding can go a long way toward shoring up missing or inadequate services, such as what was available in AB 34 and subsequently AB 2034 with homeless outreach.

- Use of emergency response teams coupled with law enforcement and a mental health worker. He referred to San Diego's new crisis/outreach team. There also should be continuity of all the players and services, so that a new leader, director, or elected official in charge does not have to start over again and waste time, energy and resources.

- Conservators, either County or Private, should work closely with County Mental Health case managers, linking clients to needed services. Conservatorship is a viable option under LPS, but is severely handicapped with shortage of manpower and other resources.

- The Treatment Center should be almost exclusively used for crises services, not long-term housing for people on conservatorship. All parties need to work together with the specifics of each client in mind to place these individuals in the proper area of care. Moving persons through these various levels could also free up other areas that can be serving the clients better. Also try to develop more available sixteen bed facilities, which can increase access to Medi-Cal funds.

- Use Full Service Partnerships with intensive case management following discharge from the hospital.

Programs in Other Counties

Sean suggested other California county programs: (1) there is one program in San Diego (Appendix B), an In-Home Outreach Team, I-HOT, an alternative for AB 1421, sponsored by Telecare. It utilizes the components of three mobile outreach teams, reaching out to adults with a serious mental illness, 24/7, who are reluctant to receive mental health services. It also provides support and education to family members, an often neglected group in the process; (2) in response to an investigation of Laura's Law, Orange County has a pilot program, including teams to work with severely mentally ill individuals, removing having a judge ordering outpatient treatment. There is support to families and immediate shelter for individuals being evaluated.

We were grateful to learn of these other innovative programs, addressing important areas—the seriously mentally ill and disenfranchised families.

Meghan Stanton and Delphine Brody Interviews

The views of Meghan Stanton and Delphine Brody, who represented the opposition to AB 1421 at our MHB Meeting in August 2011, are expressed in the Peer Support section of this report. They both offered some excellent alternative ideas and constructive comments for improving our present mental health system.

Delphine told us about AB 2134, introduced by Wesley Chesbro, an assemblyman from Humboldt County, and approved by California Disability Rights and the California Psychological Association. It requires a county, which elects to implement AOT, to develop a crisis intervention team, mobile crisis teams, or psychiatric emergency response teams before implementing the law. There are other requirements attached to this law for any county, considering implementing AB 1421.

AB 2134 is a law born out of reaction to new interest in Laura's Law. If passed, it will modify AB 1569, the new number assigned to AB 1421, and make it possibly more palatable to opponents of that law. From the point of view of the proponents of AB 1569, it creates more hindrances to utilization of the law. Both AB 1569 and AB 2134 are making their way through the complex processes of committees in both the Assembly and the Senate. The outcome of both is yet to be decided as both bills are still working their way through the complex legislative process.

Rick Pearson Interview

Our conversation with Sean Rashkis led to an investigation of conservatorship. We had an opportunity to meet with Rick Pearson, Health Program Manager for the Public Guardian Conservatorship Office. Rick supervises the LPS (Lanterman-Petris-Short Act) Investigations Unit. The office has two LPS investigators and five on-going, permanent LPS conservatorship deputies.
A mental health LPS Conservatorship makes one adult, called the conservator, responsible for a mentally ill adult called the conservatee. Rick emphasized that conservatorship is a legal, not a clinical, process. LPS conservatorships are not treatments, and conservators are not making evaluations. LPS Conservatorship is only for an adult who is gravely disabled as a result of a mental illness. The conservatorship gives legal authority to the conservator to make certain decisions for conservatees who are unable to take care of themselves. The conservator can consent to mental health treatment, even if the conservatee objects to it. The conservator can agree to place the mentally ill person in a locked facility if the psychiatrist believes it is needed, and the conservator can decide where the person will live when not in a locked facility. The conservatorship starts with a referral from an inpatient director or designee from one of the six facilities within Sacramento, for example, Heritage Oaks, Sierra Vista, or the County Treatment Center.

Each county does conservatorship differently. Sacramento has three classifications: (1) Probate; (2) Public Administration Deceased; (3) LPS Conservatorship. There is differentiation in the work for each classification. For example, Probate Conservator Deputies just do probate. In Los Angeles County, the conservators have a possible caseload of about ninety individuals each. They do more than just work with individuals. They also handle estate matters, such as SSI, pension payments, and bill payments. In our county, a separate person is assigned to some of these practical functions.

Seasoned physicians and psychiatrists perform conservatorship evaluations, both initial and subsequent. The client may initially be placed in a Level IV facility or another secured facility, such as Willow Glen in Yuba County or Our House in Solano County. He or she may be able to transition to a Level III facility, such as Northgate Point or El Hogar. The consumer is assigned a Public Defender at every conservatorship hearing, and hearings are held every thirty days for a person under the conservatorship program.

There are currently about two hundred and thirty people in the LPS Conservatorship Program in Sacramento, and it receives approximately one hundred twenty referrals a year. There is some recidivism but Rick was unsure of the exact number. Of the one hundred twenty referrals last year, thirty went on Permanent Conservatorship, and thirty-seven were denied as not meeting criteria. Many may be removed from conservatorship as they either get better or are placed within the community in intensive services.

One of the issues proponents of Laura's Law contend is that conservatorships place 99% of clients in board and care facilities, while Laura's Law allows clients to live anywhere. Rick concurred that almost all of the clients go to board and care because that is the definition of conservatorship. If a person is gravely disabled, he or she cannot care for themselves or attend to basic needs, such as bathing, cooking, and dressing. There is a need for these individuals to have a place where they can get all of these living services in one location. If they are in their family home and these services are provided, there is no need for conservatorship. It is true that some board and care facilities are considered better than others, in terms of space, people and general services. It can be difficult for people to have to live with others, especially strangers. The flip side is the positive element of being around like-minded people. The county hopefully will improve advocacy and accountability covering these homes to provide greater consistency and a higher level of quality service.

Another critique of the conservatorship program is how a person presents him or herself before a judge in one of the hearings. It is sometimes easy for someone unstable earlier to quickly appear as if he or she has no problems. Rick said that he has experienced this situation before and feels it is a common attempt of persons under conservatorship. He and most other conservator offices have a good relationship with the medical professionals and trust their judgment. Conservators interface with the judge and other enforcement officials, preventing this occurrence, and get the necessary help for conservatees. When asked if conservatees have insight into their illness, Rick said that most do not (anosognosia). He emphasized that people can and do get better. He also stated that communication with psychiatrists and all involved parties is key. "More advocacy and information needs to be available to families."

We also briefly discussed "Murphy's Law" (Section 1370), where individuals "incompetent to stand trial" are conserved. These individuals are housed in Napa State Hospital for Sacramento County conservatees. They are generally given three years to be restored and Rick's office reviews those cases quarterly.

Some family members have become conservators for their loved ones in Sacramento County. They are called private conservators, different from public conservators. It is a relatively rare occurrence and has to be approved by the conservatorship office. Susan McCrea was the conservator of her daughter for a year. This was an opportunity to have more input into her daughter's treatment and care. However, at times, this put added stress on their relationship.

Randall Hagar Interview

Randall Hagar came to the MHB, July 2012, to give a presentation on AB 1421. This sparked both controversy and curiosity for some members of the Board, and created the Ad Hoc Committee. Randall defines AOT as “court-supervised treatment in the community for high-risk individuals who have failed to engage in treatment after repeated offers of the best and most intensive services available. It ensures the support needed to achieve stability and meaningful recovery.”

To meet the AOT criteria:

- The individual must be 18 years of age or older.
- The individual’s illness and stability must be deteriorating.
- The individual must be offered intensive services.
- The individual must refuse to accept the offered intensive services.
- The individual must have a mental illness and be unlikely to survive safely in the community without AOT.

An individual, who may be a relative, co-habitant, agency director, peace officer, or treatment provider, can make a referral for an individual in crisis to the county mental health director. The director investigates, and if reasonable to assume the individual meets the criteria, files a petition with the superior court for an AOT order. A hearing is held in superior court. If the judge decides the individual needs AOT, a treatment plan developed by the patient and the community service providers is presented. The judge issues a six-month treatment order that is binding for both the client and the community treatment plan.

“AOT allows for a treatment option that is less restrictive than a locked facility, involuntary inpatient care through the 5150 process. AOT does support the possibility of engaging in treatment that would not otherwise be possible for some high-risk individuals who find themselves in crisis repeatedly. Laura’s Law provides a unique community-based recovery option that not only fills a gap in a county’s treatment continuum, but can reduce mental health and criminal justice system costs.” We discussed Laura Wilcox father's comment at the Judiciary Committee, saying that his daughter’s right to live be trumped by the right to not receive treatment.

Randall prefers to use the word “leverage” instead of “coercion” when referring to AB 1421. He explained that leverage exists in all aspects of the voluntary services and is a key reason why many voluntary services are effective.

Randall mentioned the California Code of Regulations, Section 3400, explaining the allowable use of Proposition 63 funds. He said a county can use Prop 63 funds for the services provided to clients in a mental health court, or a Laura's Law ordered treatment plan, or conservatorship. He stated that this provision allowed both Nevada County and the pilot program in Los Angeles County to operate their Laura’s Law programs with funds from Proposition 63. They also used other sources of revenue.

Randall introduced us to the LPS Task Force II recommendations of which Randall was a co-author. (Appendix C) He mentioned the MIORCA Grant, 2000, which allowed coordination between jails, probation, community mental health, and hospitals to reduce recidivism in both the criminal justice and the mental health systems. Like Sean Rashkis, he suggested looking at programs in other counties. He gave us contacts that could be useful in understanding these complex problems with mental health.

Sacramento Mental Health Court

Mental health courts link offenders who would ordinarily be prison-bound to long-term community-based treatment. They rely on thorough mental health assessments, individualized treatment plans and ongoing judicial monitoring to address both the mental health needs of offenders and public safety concerns of communities.

A number of complications arise when persons with mental illness enter the criminal court system, including delays in court proceedings as a result of an incompetent-to-stand trial finding. Such delays often result in long jail stays while individuals await treatment at state hospitals. While in jail or prison the mental state of inmates often declines as the experience of being incarcerated can exacerbate psychiatric symptoms. According to the Council of State Governments, persons with mental illness spend more time in jail or prison than individuals who received similar convictions but do not have a mental illness. Without adequate community supports, this population is more likely to return to jail or prison soon after release. Recidivism rates are sometimes double that of offenders without mental illness.

Based on the success of the drug court model, a handful of jurisdictions across the country have developed specialized courts to address mental illness. Like drug courts, the central goal of mental health courts is to reduce the recidivism of defendants by providing them with court-monitored treatment. The first of these courts opened in June 1997 in Broward County, Florida. The first mental health court in California was established in San Bernardino County.

In linking defendants with mental illness to treatment alternatives, many mental health courts see themselves as practicing “therapeutic jurisprudence” - a social force producing positive life changes for defendants.

Once a defendant participates in a mental health court, one of two things happens: 1) Prosecution is frozen and, charges are dropped, after the defendant successfully completes treatment. 2) A plea is taken, which is later vacated, or charges are reduced. All of the mental health courts require a longer period of time in treatment than the defendant would have served in jail or prison if they had plead guilty to the crime charged. Most courts require participating defendants to spend a minimum of one year in treatment. The rationale behind this is two-fold: First, mandated treatment involve many fewer restrictions than being incarcerated. Many defendants are even released to their own residences. Second, mental health courts are willing to invest in treatment only if there is real promise of reducing symptom severity, thereby reducing recidivism. Experience indicates that it takes at least a year to successfully engage people with mental illness in treatment. Accordingly, many mental health courts reserve the right to extend offenders’ period of treatment in the event of non-compliance.

Sacramento County looked at mental health court in 2005, after reviewing the success in another Northern California County - Santa Clara. Judge Steven V Manley, with over thirty years of experience as a Superior Court Judge, founded Santa Clara’s Drug Court, and discovered the overwhelming need for a similar court for mentally ill offenders. In an interview with the Center for Court Innovation, Judge Manley stated “There’s a stigma with the mentally ill that they are more dangerous, which is not true. Some are; some are not. They are, however, far more difficult to work with. It makes absolutely no sense in my view to warehouse someone who is mentally ill and release them into the community with no services, when we know they will be rearrested again and go right back into jail.”

With the help of a MIOCR (Mentally Ill Offender Crime Reduction) Grant, Sacramento established a Mental Health Court in 2007.

Steven Lewis Interview

Steven Lewis, Chief Assistant Public Defender for Mental Health Court, is also a member of the AB 109 Community Corrections Partnership Committee. Mental Health Court is a collaborative court that receives no special funding. In the past there were more supporters of Mental Health Court, such as Probation and the Sheriff's Department, but with budget cuts, that support has dwindled.

Before Mental Health Court, offenders with a mental illness were often determined to be "unable to understand criminal proceedings or to assist counsel in the conduct of a defense in a rational manner (CA Penal Code Section 1368)." If they were charged with a felony, that typically meant up to three years in Napa State Hospital; if a misdemeanor, they spent six months to one year at Sacramento County Mental Health Treatment Center (SCMHTC). The sentence could include an involuntary medication order if they lacked the capacity to consent. If a mentally ill offender is restored to competence, he or she would go back to court for the resumption of criminal proceedings. For felony defendants, if they cannot be restored, they most likely would be placed in LPS or Murphy's Conservatorship.

Whether an offender is sent to the State Hospital, SCMHTC or to jail, all of these are extremely expensive. In the first year of operation (2007-08), Sacramento County Mental Health Court (SMHC) showed a savings over these other options of $6000 per year/per client.

SMHC's goal is to identify seriously mentally ill persons in jail. Once identified, try to get them stabilized, on medications if appropriate, and get them into court quickly. A plan of action would be put into place to get the offender into community supervision with regular monitoring. The SMHC and participants try to target those individuals who are frequently in and out of jail and hospitals.

The procedure actually begins with a referral from Mark Hopkins, UC Davis contractor within the Jail Psychiatric Services. No matter who identifies the individual, Mark does an assessment and refers the inmate to the program's court coordinator. If is case is appropriate for SMHC, there will a referral to Steven Lewis, as well as Rick Miller, District Attorney. The two of them must reach an agreement that the individual should go to SMHC. If so, the inmate is scheduled for the next Tuesday at SMHC and is met by one of six providers, serving Sacramento County—Turning Point ISA, Turning Point Pathways, TCORE, Telecare SOAR, TLCS New Direction, and El Hogar Sierra Elder Wellness Center.

The client has to agree to the program voluntarily. Generally, there are three criteria to be met in order for the offender to qualify for SMHC: 1) They need to have an AXIS I Disorder, such as schizophrenia or bi-polar; 2) the charges cannot involve serious sex or violence offenses, although some cases are accepted in specific situations; 3) they need to have one of the six Sacramento County Mental Health Providers working with them. The providers' Personal Service Coordinator (PSC) comes to court with the client to discuss treatment plans and subsequent progress. If the client agrees to the program, the PSC will usually pick up the client from jail the next day after the court hearing. There must be a specific plan in place for housing, treatment options and anything else the client may need to be successful.

One of the biggest keys to the program's success is its flexibility, especially with regard to sanctions for those who do not comply. The court works with the offender and the PSC to keep on the right track. Judge Manley stated, "Sanctions do not work with a mentally ill person unless they have significance. Often mentally ill clients feel that jail is a reward. They like it. Homeless people like it in the winter. What good does it do me to put people in jail for a sanction when they don't even understand what I'm talking about?"

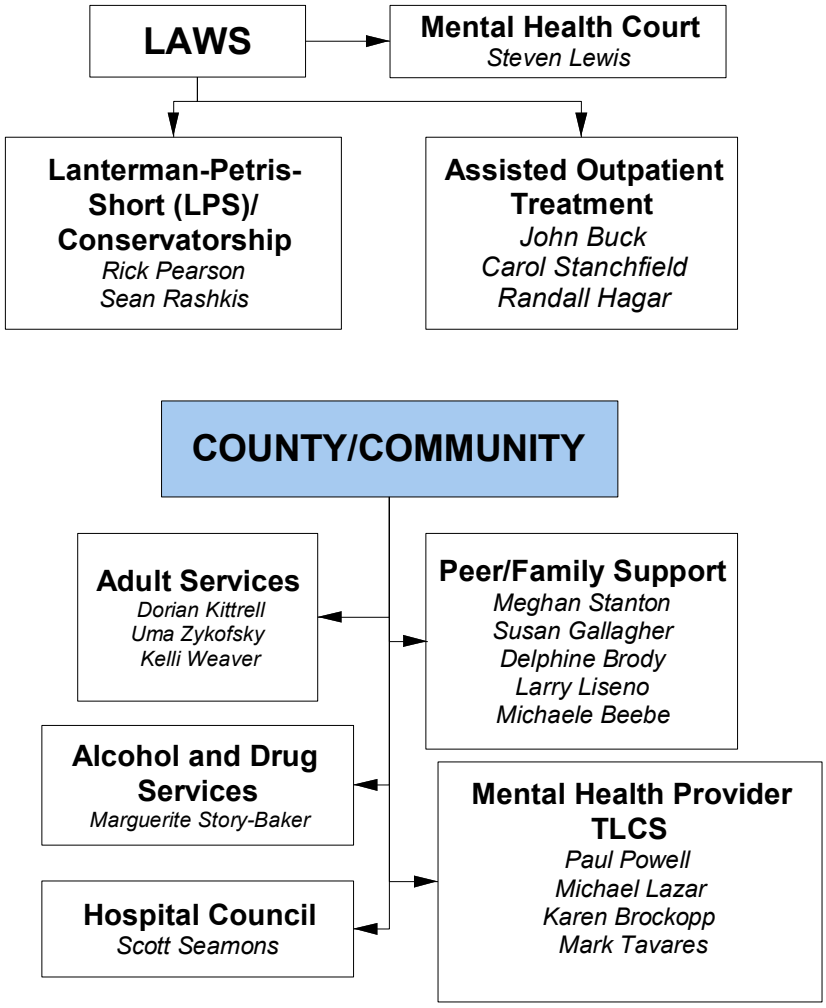
The client's incentives are fairly straightforward. In exchange for twelve to eighteen months of outpatient treatment, if successful, they will be able to withdraw their guilty plea, terminate formal probation and suspend jail time. The most imposing sanction for not complying is the reverse, with jail or inpatient status imposed as well as a criminal record. Again, any sanctions imposed are flexible. Clients start by meeting in SMHC every week to track progress. Perhaps treatments need to be adjusted. They may be ordered to attend AA/NA meetings, attend more counseling sessions, or do community service. If mistakes continue, a client may be subject to flash incarceration - an immediate trip to jail for a brief period of one or two weeks. This punishment serves hopefully as a wake-up call or time-out with the intent of getting the client back on track with his or her treatment plan. As the person's progress goes well, the court dates are gradually decreased from once a week, to every two weeks, to once a month.

In our interview, Steven Lewis said that they maintain a caseload of about thirty clients at any time, but that they have the capacity to serve closer to a hundred clients. Of course, funding is a limiting factor. Judge Jaime R. Roman, a previous SMHC judge, is returning to the team. The Public Defender and District Attorney offices are committed to the success of this program. The mental health providers in Sacramento County are supportive of an increase in potential caseloads. The only piece that is not in place at this time is the dedicated probation officers, again due to funding shortages. Unfortunately, the MIOCR Grant was only obtained in the first year of operation (2007-08). The money provided incentives for the sheriff to utilize jail staff and the county probation department could dedicate more resources to the program.

Steven hoped that either MHSA or Prisoner Realignment (Prop 109) money could be found to help SMHC. With cost savings of $6000/year per individual compared to the alternatives, of jail or hospitalization. It would seem a logical decision to support SMHC. With the scarcity of money in these difficult economic times, coupled with the realities of politics, logic does not always prevail.

California's criminal justice system is becoming increasingly responsible for large numbers of individuals with mental illness. People with mental illness are more likely to be arrested than those in the general population for similar offenses, and many enter the criminal justice system as a direct result of their unmanaged illness. Although only 5.7 percent of the general population has a serious mental illness, approximately 18.5 percent of arraigned defendants and 23 percent of California prison inmates have a serious mental illness. The criminal justice system is ill equipped to meet the needs of this population and cannot adequately provide the treatment needed by people with serious mental illness.

Asked about the SMHC capacity for accommodating AB 1421, "It seems as though everything is in place. We have a judge, a courtroom, a Public Defender, District Attorney and a collaboration of community partners all familiar with mental illness. If we had some additional funds to keep it running, I don't see why it couldn't work."



Adult Services are the Adult Mental Health Services, Sacramento County Division of Behavioral Health Services (DBHS).

Alcohol and Drug Services are the DBHS Alcohol and Drug Services for individuals suffering from substance abuse.

Mental Health Provider is a DBHS contractor (TLCS) who provides services to meet target populations in Sacramento County.

Peer and Family Supports are community support systems for individuals who suffer from mental illness and their families.

Hospital Council is the Hospital Council of Northern and Central California that convened a workgroup to study the mental health crisis, making recommendations for redesign.

Sacramento County Adult System of Care

The first few months we focused on gaining an understanding of the laws and talking with those in opposition to "Laura's Law." That was the controversy that led to the Mental Health Board creation of the Ad Hoc Committee. We interviewed consumer group leaders who spoke at the Mental Health Board meeting in opposition to AB 1421 and other community leaders. The next step was an understanding of the current county system of care.

Dorian Kittrell Interview

Based on Dorian's understanding of Assisted Outpatient Treatment (AOT), he did not feel that Laura's Law was feasible at this time in Sacramento County. It would require a significant multi-agency collaboration to be implemented and the resources for a project such as this do not exist right now. There are too many agencies and too little money to do what it is supposed to do. He didn't see a fiscal structure that would allow for it.

"LPS conservatorship is not the same as AOT." Dorian explained. "While there are some similarities in terms of oversight, conservatorship is different as it involves 100% of a person's needs, including housing and other aspects of a person's life. It is for the gravely disabled. AOT is, on the other hand, not as restrictive and provides greater choice on the part of the clients, despite the imposed consequences of that choice under the AOT."

Alternatives Dorian mentioned are mobile units with outreach and engagement. His first work in the mental health field was with the Berkeley Mobile Crisis Team, which had on-going case management. Teams of two people were available every day from 8am-11pm. The mobile team reached many people, not willing to engage in any services. A lot of them were able to avoid hospitalization. The team had law enforcement training and badge numbers. They were able to do initial assessments, go out to homes and other sites. They had the ability to write a 5150 referral, if necessary. It engendered cooperation between law enforcement and mental health, even though they were not integrated before. As a comparison, we discussed the fact that Berkeley is a different size county and not as spread out as ours. It may have had more funds accessible at that time.

Dorian discussed the need for a Crisis Stabilization Unit (CSU) as a gateway for crisis intervention. There is currently a plan in place to provide this kind of service in a different way. A new CSU would be able to stabilize a percentage of the individuals going to the emergency rooms and avoid hospitalization. Since the crisis unit closed in 2009/10, we have seen an increase in the number of inpatient hospitalizations. The Hospital Council, now called the Community Health Partnership, has recommended going forward with the Crisis Stabilization Unit

Recently Sacramento and Contra Costa were the only two counties to apply for a federal grant, creating a pilot program to receive MediCal reimbursement for inpatient services at a private hospital. The grant provides a waiver of three years to allow those with over sixteen beds to bill MediCal. Sacramento just received the grant notice award. There is a very limited amount of money for this project spread over eleven states. It is an opportunity to look at archaic MediCal regulations that prevent payment for psychiatric treatment for individuals in hospitals greater than sixteen beds. This project came from a bill sponsored by U.S. Representative Doris Matsui that became part of the health care reform law. Dorian also brought to our attention a new pilot project called Community Support Team (CST), a mobile team funded under the MHSA Suicide Prevention component.

Uma Zykofsky and Kelli Weaver Interview

Uma Zykofsky is the Human Services Division Manager of Adult Mental Health Services (See previous chart of Sacramento County System of Care). Kelli Weaver is Program Manager of the Community Support Team (CST) project. Our research led us to the fact that there was an unfulfilled need for mobile outreach in our community. This interview was conducted to understand the activities of the CST and whether it fills this identified gap.

We discussed the various steps that led up to the Community Support Team formation and questioned whether funding for this project is sustainable. We learned the project is funded through PEI and will continue. The CST is a blended team of professional and peer staff from Crossroads Diversified Inc. It will evolve with the needs of the community. The CST team provides response to care in a variety of ways: (1) it follows up on some calls received by the Access Team. (2) It responses to individuals discharged from the hospital with phone calls or field-based visits as needed. The CST makes for a “warm hand-off” between the hospital, the family and outpatient system. (3) It makes an effort to help the homeless. Once a month, the team goes out into the homeless community in conjunction with Sacramento Steps Forward. This is also in collaboration with Volunteers of America (VOA) and Department of Human Assistance (DHA) staff - a multi-system outreach to the homeless. CST has the beginnings of both of two missing components, more access for families and an outreach to the homeless. Both of these factors are some of the reasons family members and community members have shown interest in AB 1421. With AOT, a family member is sometimes empowered to get help for a loved one, resistant to any treatment. There is also through AOT the ability to work with resistant or untreated people in a community. CST aids the family and the community to get help for those getting no assistance with their mental illnesses. Expanding and adding on to this resource or creating more outreaches like this is greatly needed in Sacramento County. There also needs to be more resources and services to provide for the “people in the bushes.” Expansion of services for these individuals should also be addressed and explored. The hours of operation are Monday through Friday, 8:00 to 5:00. Hours are subject to change based on community need. The phone number is (916) 874-6015.

We briefly touched on AB109, re-entry of prisoners to the community. We also talked about hospital care and education for staff and the community. Various types of linkages for individuals in distress were discussed, including the use of faith-based and volunteer programs for formal and informal supports. Uma shared there are many factors that cause crises and stress. Frequently inpatient care and/or medication solutions are seen as the primary and only alternative. Use of medications should not be seen as the threshold for interventions. Rather we should look for blended teams where a variety of supports and staff can be involved in solution-focused treatments.

Assisted Outpatient Treatment (AOT) has specific provisions and requirements for implementation and Uma expressed the hope that our community considers those carefully so that we do not reduce outpatient resources in efforts to fund AOT. "Some of the challenges are creating programs with sustainable dollars, not relying on taking money from existing programs. People do not always take into account all the costs when programs like AOT are discussed. For example, there are expenses for courts, judges, and legal action, necessary for AOT to work. AOT depends on the same infrastructure that supports the existing systems."

"Current challenges include enormous pressure on the adult outpatient system. There is not much flexibility in the capacity of our system. Historically, the standard outpatient system has been under-funded and over-impacted by multiple referral and community needs. The RST capacity

and contracts are at a limit with no flexibility at this time. Typically, our community has seen large numbers of people needing services, and there is not enough funding to build out a large provider system. Inpatient care, high-level acute and sub-acute care needed. Expensive Realignment dollars are directed to support this level as an emergency need. Thus outpatient care is frequently at the losing end of the budget plan." Uma acknowledged that there is a great challenge in our community and “how to help the individuals not on a 5150 hold or in a hospital setting but nonetheless suffering, in distress and not hospitalized." The new Intake and Stabilization Unit (ISU) will help some of this group. They will be redirected from the emergency rooms. However, some people will get discharged from the ER to the community. There are also many people who come to the ERs with private insurance and other needs, not the county’s responsibility. However, the same ERs treat everybody in the community. We have to continue to find ways to bridge the gap between ERs, hospitals and community services. Not all the residents in the community meet the criteria for mental health services within the county system.

Uma’s staff implements the five major components of the Mental Health Services Act: Community Services and Support (CSS) Workforce Education, and Training (WET), Capital Facilities and Technology, Prevention and Early Intervention (PEI), and finally the current Innovation Plan. The essential purpose for the Innovation Plan is to promote interagency and community collaboration with general learning goals in mind. In 2011 a Sacramento Innovation Workgroup was formed with volunteers from various stakeholder groups. The Workgroup targeted “crisis respite” and created the Respite Partnership Collaborative (RPC). Sierra Health Foundation was chosen as the Administrative Entity that will coordinate the RPC with the Division of Behavioral Health Services. The Respite Partnership Collaborative must include the stakeholder representatives of Family Members, Transitional Age Youth (TAY), Adult Consumer, and Adult Consumer with Dependent Children, Family Member of Adult Consumer, Older Adult Consumer, and Family Member of Older Adult Consumer. Other stakeholder group representation can be gained by visiting the website of DBHS or Sierra Health Foundation. It offers promise to help fill more gaps in the county mental health services.

The question always comes up about outcomes and how to measure them. The challenge Uma Zykofsky brought to our attention is that it is very hard to measure recovery and resiliency. Our outcomes are important measures for optimal programming and changes in program design. Each county submits data to the state once or twice a year; then the state sends a comprehensive report with all county information back to each county. The difficulty is that each county’s resources and programming vary and it is difficult to compare data across counties. There are also flaws in the data source points and collection process, which sometimes does not tell the full story. Historically, reports back from the state have been delayed and thus the data may be outdated compared to programming on the ground. That being said, we are trying to focus on developing better measures for our programs, Uma added.

Alcohol and Drug Services

Marguerite Story-Baker Interview

Another part of the picture is an understanding of treatment for individuals with alcohol and drug problems in Sacramento County. Marguerite Story-Baker is the DBHS Health Program Manager for Alcohol and Drug Services (ADS). Marguerite has over thirty-five years experience working in the field of co-occurring disorders. She has been active in the MHSA since the beginning, working on the first CSS proposal for young adults and co-occurring awareness for juvenile justice. Regarding our mission, Marguerite agrees that the goal is to prevent further trauma, especially to those who are often at the MHTC or the jails, sometimes called "frequent flyers." It is very important to have sensitive patient care.

Marguerite believes we should consider infusing ADS staff in non-traditional avenues of treatment. Our committee feels traditional ADS treatment may also be lacking in the training and awareness of some mental health staff. According to Marguerite, there is a "No Wrong Door" policy in ADS. Child Protective Service (CPS) cases, indigent programs, court, probation, and community teams refer clients to her organization. These are also sources of client referrals to mental health.

Marguerite mentioned The Comprehensive Continuous Integrated System of Care (CCISC) by Minkoff and Cline. The general principles of CCISC are providing a welcoming, accessible, integrated, continuous, and comprehensive system of care to patients with co-occurring disorders (COD). CCISC is a model addressing co-morbidity in an organized manner within the context of existing resources. The basic premise of this model is that all programs become dual diagnosis programs meeting minimal standards of Dual Diagnosis Capability. The job of each program is based first on what it is already designed to be doing, seeing people with COD. The goal is to organize the infrastructure of the program to routinely provide matched services.

The service matching in this model is based on a set of evidence-based principles in the context of an integrated philosophic model making sense from the perspective of mental health and addiction treatment. A way of evaluating clients is using the four quadrants Minkoff proposes: high MH needs folks with low ADS needs should be MH clients first; high ADS needs folks with low MH needs should be ADS clients first; clients with high needs in both areas must be simultaneously and team treated for both issues; and low MH and low ADS issue folks can be treated on either side of DBHS.

More training for MHTC staff on issues of alcohol and drugs could be useful since a significant number of their clients have co-occurring disorders and MH staff is not routinely well trained in substance abuse issues. Most ADS county staff is trained in MH issues. Contracted providers could probably use more training for dealing with clients with co-occurring disorders. Jail staff also needs expertise in both MH and ADS. This needs to be done routinely due to staff turnover to get updated current information. Partnering helps clients be best served.

The Mental Health Treatment Center has well trained staff that helps "frequent flyers." She has concerns, however, that jail personnel do not always understand this population. Their mandate is to protect the public and administer consequences for illegal behaviors. Mental Health and Alcohol and Drug clients are not all criminal types and yet make up the majority of those incarcerated. Sometimes "frequent flyers" are arrested due to a misunderstanding. Their diagnoses or medication may make their behavior look like they are drunk or on drugs when they are neither. A statistic is 80% of adult prisoners have a substance abuse problem. In the case of

Alcohol and Drugs Services, the usage of substance is a criminal act. In reality, many mental health clients use alcohol or other drugs to ease their pain or for self-medication. Law enforcement needs to know the whole person to know what they are dealing with and what is actually happening when they are called to intervene with a “frequent flyer.” Before incarceration, screening for alcohol and drug issues should be included so that co-occurring treatment can be offered in jail. The client can be seen as someone who is in need of MH treatment. For example, methamphetamine can produce a drug-induced psychosis. Other drugs work poorly with needed MH medication. These situations produce erratic behaviors that require medical monitoring. There is a need for drug testing for persons who are mentally ill and are incarcerated.

When asked about statistics, Marguerite mentioned the DBHS Management System could add ADS data, along with mental health, if training was made available. Whenever possible, treatment should include family members and other support personnel. ADS have no peer partners like with mental health, but would love to be able to develop that sort of component. In the past there was funding for some effective youth advocates.

Alcohol and Drug Services are funded by a subsidized federal grant called SAPT Block Grant, Drug/Medi-Cal, including minor consent Drug/Medi-Cal, Cal WORKs, and some smaller grants designated for specific populations. The system to measure ADS success, an entrance and exit measure called CALOMS. Code of Federal Regulations (CFR) 42 is stricter than mental health confidentiality rules.

"If the funds existed, there should be more outreach, co-occurring disorder groups, youth programs, peer partner programs and advocate programs in ADS. There should be an ADS counselor at Jail Psychiatric Services and the MHTC, and routine information sharing. Support groups can actually be paid for with a variety of funding sources. Regardless, ADS and MH treatment costs are always less that the costs of jails and hospitals. Also the bulk of services they offer are free to the clients."

There is movement toward more
integration of ADS with mental health.
Some mental health clients seem
reluctant to receive substance abuse services, perhaps
due to the stigma associated with addictions.
A voice needs to be heard from Mental Health clients
who have struggled with ADS issues and found
treatment that involved both disorders was effective for them.

Outreach to the Homeless And Faith-based

We learned from Paul Powell and staff at Transitional Living and Community Supports (TLCS) about county history regarding outreach to the homeless. It had been estimated that at least one third of this population is suffering from mental illness. They are “the people in the bushes” of John Buck’s baseball analogy.

History

One of the most successful ideas discussed was the previous Project Outreach, impacting many people who were living on the street and in places not meant for human habitation. This program, in which TLCS partnered with law enforcement and the Volunteers of America, included outreach vans. They were dispatched in an effort to locate and establish relationships with difficult to reach homeless persons with psychiatric disabilities in our community. Project Outreach positively affected many homeless individuals, who were offered food and small personal hygiene items, and were assisted to access more mainstream services, supports, and housing.

Project Outreach impacted many people living on the street and in places not meant for human habitation. This program, in which TLCS partnered with law enforcement and the Volunteers of America, included outreach vans dispatched in an effort to locate and establish relationships with difficult to reach homeless persons with psychiatric disabilities in our community. Project Outreach positively impacted many homeless individuals, who were offered food and small personal hygiene items, and were assisted to access more mainstream services, supports, and housing. One of its keys to success was establishing relationship and trust with this population through repeated and persistent contacts.

The Volunteers of America operated a similar mobile outreach team, which assisted other homeless persons in our community. Unfortunately, both of these successful programs were closed due to budget cuts. In addition, TLCS operated a program called Redirection, which was funded under a previous Mentally Ill Offenders Crime Reduction Grant (MIOCRG). This program paired mental health and law enforcement staff by utilizing an Assertive Community Treatment (ACT) model. It proved to be very effective in reducing hospitalizations, incarcerations, and episodes of homelessness for this target population. Unfortunately, this program was also de-funded due to budget cuts.

“In 1999, El Hogar was able to significantly expand the services it provides to the homeless mentally ill in Sacramento County through the passage of Assembly Bill 34 (Steinberg), which authorized $10 million for the creation of programs to provide integrated community outreach support to individuals who were homeless, at risk of homelessness or incarceration, and had a serious mental illness. El Hogar was fortunate to be one of two providers in the Sacramento region to be selected to initiate a pilot program. In 2000, the California Legislature passed Assembly Bill 2034 (Steinberg), to appropriate approximately $55 million to expand this program to an additional 23 counties. Despite the tremendous success of this program, state funding cuts forced the closure of this program in the spring of 2008.” (from El Hogar’s website)

Project Outreach, the Mobile Outreach Team, and Project Redirection had excellent success rates in the past and should be revisited when evaluating potential ways to get the mentally ill homeless into MH services.

Present County Services to the Homeless

Presently the only access for the homeless is the Guest House, operated by El Hogar since 1987. It is an outpatient mental health clinic for homeless individuals with psychiatric disabilities. They are usually capable of servicing only two to three clients per day. It is advisable to go early to access these limited services. Its location is 1400 North A Street, Bldg. A, Sacramento, (916) 440-1500. It is open Monday through Saturday, 8:00 am to 5:00 pm.

Community and Faith-based Outreach to the Homeless

Concerned individuals in the community and faith-based organizations are aware of the tremendous problems and gaps in helping the homeless population of our county. There have been faith-based groups, ministering to the homeless for years, like Loaves and Fishes and Union Gospel Mission. Spontaneous, independent outreaches, teams going out from churches, armed with food and clothing, randomly reach out to the homeless and their immediate needs. Steps Forward, a federally operated agency in our county, is attempting to co-ordinate some of these efforts. Compassion and concern drive many to reach out to the needy in our county. Even more resources are needed to help the mentally ill, “people in the bushes,” on our county’s streets.

In addition, faith-based services should be re-evaluated with improved county support. Many potential volunteers have the right attitude, good hearts, and want to help. Unfortunately, many non-profit organizations lack the infrastructure necessary to support a volunteer program. Typically, Volunteer Coordinators are not “allowable expenses” under many restrictive grants and contracts. In addition, there are related administrative issues, including workers’ compensation insurance coverage, which need to be addressed to effectively run a volunteer program. On a related note, the county is currently offering free, two-day training sessions on “MH First Aid” and interested parties have been invited and encouraged to attend.

Level of Care Utilization System (LOCUS)

Level of Care Utilization System:

Level 1 - Federally Qualified Health Care (FQHC)

Level 2 - Wellness & Recovery Centers (WRC)
Regional Support Teams (RSTs)

Level 3 - Intensive Outpatient
Regional Support Teams (RSTs)

Level 4 - Full Service Partnership (FSP)
Integrated Service Agency (ISA)

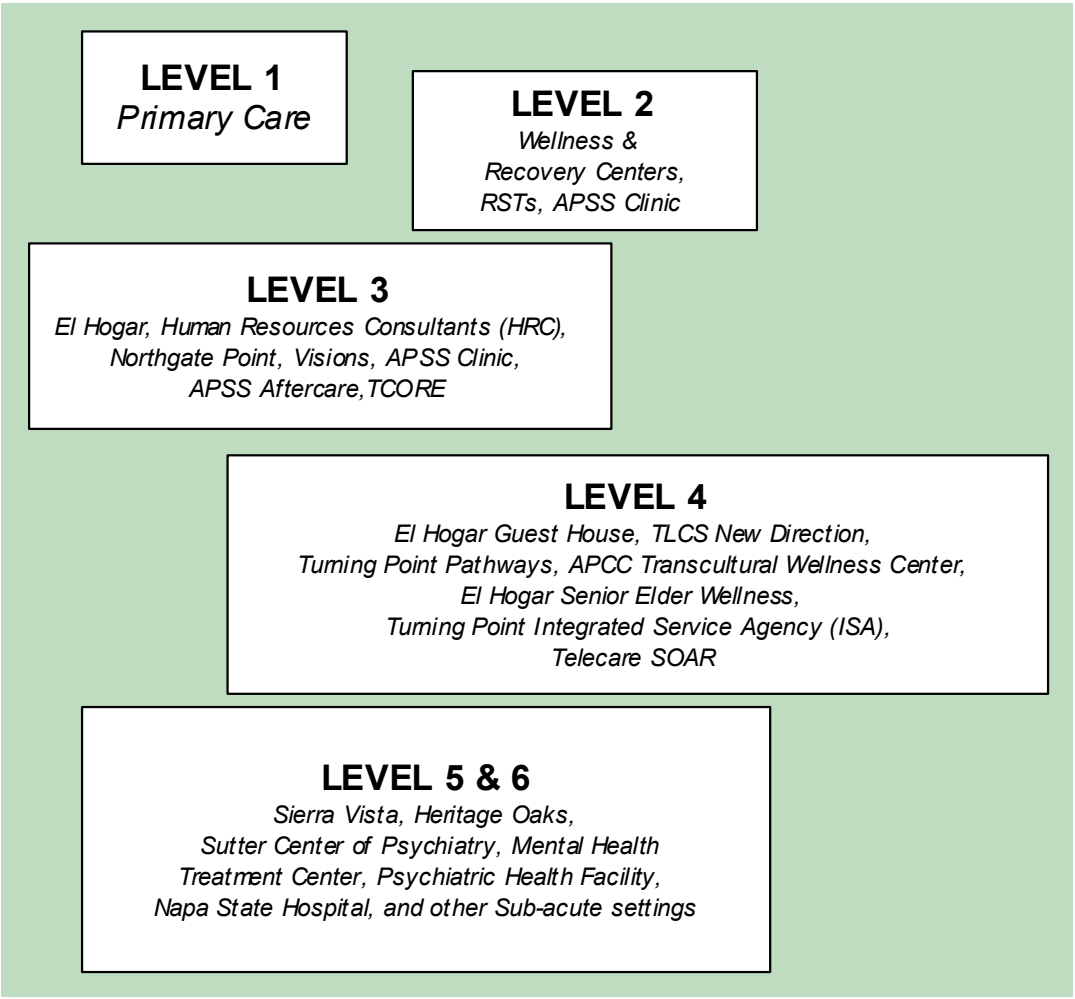
Level 5 - Institutions for Mental Disease (IMD)
Mental Health Rehabilitation Centers (MHRC)

Level 6 - Inpatient Hospitalization and Sub-acute settings

The mental health community uses the Level of Care Utilization System (LOCUS) to describe support services by a group of mental health service providers and agencies or to describe an individual's need for services. The three middle levels are considered moderate levels. The lowest two levels involve high need individuals. Level One can be psychiatric services at a primary care location. Most times, these levels are described with Roman numerals.

In the May 2011, an independent study of DBHS Adult Mental Health Services, called the Callahan Report (summary in Appendix K), the LOCUS levels of care were used as a methodology to categorize mental health providers in Sacramento County. This, however, does not represent the fact that a person is multi-faceted and that mental health community providers offer more than one level of care. We have provided the following chart as simply a visual reference to help understand the bigger picture of Sacramento County resources.

Adult Mental Health Services as portrayed in the May 2011 Callahan Report



Mental Health Provider

The Ad Hoc Committee contacted Paul Powell for some insight into past MH programs and services within Sacramento County. His organization, Transitional Living and Community Supports (TLCS), has been active in this area for over 20 years. It is a private, nonprofit, psychosocial rehabilitation agency. They "promote successful community living for individuals with psychiatric and other disabilities."

TLCS currently operates through five major tiers of services:

1. Case Management Programs for individuals experiencing homelessness and meeting the criteria for the Sacramento County Mental Health Plan: The New Direction, Full Service Partnership (FSP) program, provides intensive case management services and psychiatric/medication support services to individuals referred by the Guest House. New Direction is comprised of four teams currently including: (a) the Hope Team; (b) People Achieving Change Together (PACT); (c) the Mentally Ill Chemical Abusers Case Management Program (MICA); (d) Widening Opportunities for Rehabilitation and Knowledge (WORK). All four teams provide intensive case management, and a variety of services, including vocational services for those ready to enter the workforce.
2. Case Management Program for individuals who meet the criteria for the Sacramento County Mental Health Plan: Transitional Community Opportunities for Recovery & Engagement (TCORE) is a collaboration program between Human Resources Consultants, Inc. (HRC) and TLCS to provide intensive services to those adults living in Sacramento County who have a MH diagnosis and are currently unlinked to any outpatient services.
3. Case Management for individuals who live in the Downtown Single Room Occupancy Hotels: The SRO Collaborative Service Project serves residents in the downtown Sacramento SRO Hotels, including outreach to seniors.
4. Transitional Housing Programs for individuals who are homeless: Interim housing program for eligible homeless individuals receiving services through Guest House. Forty-eight beds are provided at the TLCS Palmer Apartments.
5. Permanent Supported Housing Programs (PSH): The TLCS Downtown Coops are comprised of the following three supportive housing communities: (1) the Ninth Street Co-op (Carol's Place), with eighteen beds; (2) the T Street Co-op, which serves nine residents with mental illness who are living with HIV/AIDS; (3) the River City Residential Club (RCRC), a fifteen bed co-op where individuals live cooperatively, share chores and activities.

TLCS also provides PSH at three apartment complexes as follows: the twenty-two bed, Bell Street Cooperative Apartments; the twenty-one units, Cardosa Village Apartments; the nineteen units, Folsom Oaks Apartments. The latter two serve families.

TLCS Interview

Paul started our discussion with an introduction to the properties described in items 4 and 5 above. In brief, TLCS houses 154 individuals in seven different residential facilities, which are funded by HUD, the Sacramento Housing and Redevelopment Agency, DBHS, and fees collected from its tenants. The TLCS Housing programs operate on budgets that average $23 per bed for its PSH slots, at a low cost for preventative care compared to the costs of crisis management services, jails or hospitals (particularly in comparison to the County Treatment Center, which can run over $1,000/ per day).

Karen Brockopp then described services provided to approximately two hundred and seventy-seven clients in the New Direction Program, which is an MHSA-funded, full service partnership (FSP) Program.

Mike Lazar noted that TLCS also operates the TCORE program (short for Transitional Community Opportunities for Recovery and Engagement) in conjunction with Human Resource Consultants, Inc. (HRC), one of the county-funded, outpatient mental health service providers. TCORE is an MHSA-funded "System Development" program.

Combined, the TLCS New Direction Program and TCORE serve approximately one thousand persons a year.

County History of RSTs

During the early-to-mid 1990's, in response to significant cuts in funding, Sacramento County reorganized its outpatient mental health services. This major reorganization followed lessons learned from some previously funded state demonstration projects. The Regional Support Teams (RSTs) were initially conceived to provide comprehensive mental health services to members in different geographic areas of the county, utilizing a one-stop model. This design could allow additional RSTs to be added to meet the needs of our citizens, as the county's population grew.

Given the available funding at the time, only three new Regional Support Teams (RST's) were established as follows: Visions, El Hogar, and Human Resources Consultants to serve the south area, the downtown area, and the eastern area of the county respectfully. Prior to establishing these three new RST's in 1993, there were seven outpatient mental health clinics. Sacramento County funded a homeless and supported housing program, operated by TLCS, and established a new Consumer Self-Help Center. Two Integrated Service Agency programs were established to serve clients who were in need of more intensive services, Turning Point and another by Sacramento County operated one model. The ISA model was later used as the basis for several major components of the current MHSA program design. Later a fourth RST was later added in the north area (Turning Point's Northgate Point RST). Initial estimates indicated that multiple RSTs with manageable caseload sizes were needed throughout the County (possibly six or more). However, as of 2012, there are still only four RSTs, with 60:1 patient to staff ratios.

Other Changes

There has been concern that too much money has been allocated to the Sacramento County Mental Health Treatment Center (SCMHTC). The inpatient unit is not eligible for Medi-Cal reimbursement, due to its large size (over sixteen beds). Over the past decade, there have been many changes in how MH services are provided with different leadership. Budget constraints had a major effect on the mental health system of care in our community. Different ideas and program designs/approaches have been examined, with various levels of successes and failures.

Paul and his staff told us about the history of outreach to the mentally ill homeless. The group also discussed some of the more recent changes to county-funded outpatient services. This included a shift to central intake through the County Access Team and the El Hogar Guest House Clinic for homeless persons. Another change is the transfer of clients from the RSTs to qualified FQHC's, including the Effort, or primary care physicians. Medi-Cal eligible clients are now no longer considered in need of more intensive "specialty mental health services."

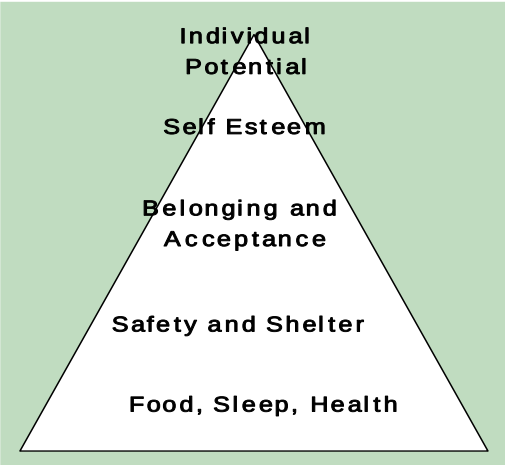
Another negative (and likely unintended or opposite) consequence of change is Medi-Cal/Medicare billing. There is increased pressure on staff to do the paperwork correctly or lose money. It has become so difficult for all parties that more Benefits Coordinators need to be hired to help both patients and providers to deal with the paperwork.

There are too many people in need of services and many programs are simply under- funded and overwhelmed. Currently many county-funded programs, the RSTs in particular, have staff that carries caseloads of almost seventy persons per caseworker, if not more, which is way too many. Ideally, this ratio should be closer to 20:1. Therefore, most efforts must currently go towards putting out the latest fire and moving on. People can fall through the cracks with this kind of pressure.

Other suggestions for improvement are increasing programs that can qualify for Medicare dollars with sixteen or less beds. Karen discussed the importance of the Crisis Residential Center of Turning Point and the role of crisis residential programs in general. A recent patient/peer supporter stated that the Turning Point Crisis Residential program, in Oak Park with twelve beds, is a great program. Unfortunately, there is pressure to get people in and out within two weeks. The county has also been sporadic in training sheriffs in MH issues, so as to better respond to community members in a crisis situation.

Perhaps Obama's healthcare model of the future, with "fully integrated health care" services will provide a good approach, but there needs to be more trained individuals to help in these new "Accountable Care Organizations." Where are the WET (Workforce Education & Training) dollars going? "Overall, we need to meet them clients where they are. We need a client-driven system with all the ups and downs that go with it. That's where to start," says Mark Tavares, echoed by Ms. Brockopp. "These people need to be treated as a partner," added Mr. Lazar.

Unfortunately, there are too many people in need of services and many programs are simply under-funded and overwhelmed.



Maslow's Hierarchy of Needs

Maslow's Hierarchy of Needs is a theory of psychology portrayed in the shape of a pyramid. The most fundamental human needs are the bottom level and the top of the pyramid is an individual's full potential. The most fundamental and basic four layers of the pyramid contain what Maslow called "deficiency needs". Maslow's theory suggests that the most basic level of needs must be met before the individual will seek higher level needs. Maslow did acknowledge that many different kinds of motivation could be going on in a human all at once. His focus in discussing the hierarchy was to identify the basic types of motivations, and the order that they generally progress as lower needs are reasonably well met. For the most part, physiological needs are the literal requirements for human survival. If these requirements are not met, the human body cannot continue to function properly. Clothing and shelter provide necessary protection from the elements. Personal security financial security, health and well-being and a safety net against accidents/illness have adverse impacts in the body. After physiological and safety needs are fulfilled, the third layer of human needs is interpersonal and involves feelings of belonging. The need is especially strong in childhood and can over-ride safety as witnessed in children who cling to abusive parents. Deficiencies with respect to this aspect of Maslow's hierarchy are due to hospitalization, neglect, shunning, ostracism – can impact individual's ability to form and maintain emotionally significant relationships. Many people become susceptible to loneliness, social anxiety, and clinical depression. This need for belonging can often overcome the physiological and security needs, depending on the strength of the peer pressure; an anorexic, for example, may ignore the need to eat and the security of health for a feeling of control and belonging. All humans have a need to be respected and to have self-esteem and self-respect. Esteem represents the normal human desire to be accepted and valued by others. People engage themselves to gain recognition and have an activity or activities that give the person a sense of contribution, to feel self-valued. Depression can also prevent one from obtaining self-esteem. "What a man can be, he must be." This concept forms the basis of the perceived need for reaching one's full potential or what Maslow called "self-actualization." This level pertains to what person's full potential is and realizing that potential. Theoretically, in order to reach this level of need, one must first not only achieve the previous ones, physiological, safety, love, and esteem, but also master these needs. The purpose of this study is to identify how individuals, who are not in the system and have "deficiency needs", can be reached for treatment, and especially those that continually cycle through hospitalizations or are involved in the judicial system. How can we break the cycle of repeated suffering and still respect the individual's rights?

Peer Support

The mental health community has endorsed the concept of providing treatment for mental illness by introducing the patient to another individual, a peer with similar symptoms who is successfully in recovery. The goal is to integrate these peer services within the traditional delivery system. Peer support provides hope because instead of emphasizing the question, what's wrong with the individual, the new focus is on what's wrong with the situation. Peer support programs change the concept of what it means to help an individual with mental illness. People who have lived experience can relate, empathize, understand, and validate. It offers practical advice and suggestions for strategies that professionals may not understand.

For peer support to work, the services must not take on the characteristics of traditional mental health. Instead there is an alternative view of services that identifies skills and a celebration of uniqueness, supporting the possibility of recovery. "Help" is redefined, not identifying a "recovered" or "better" person, but emphasizing both individuals sharing their vulnerabilities, strengths and finding value in helping each other. Even with paid peers, the relationship should be mutual and reciprocal. Basics to peer interaction are empowerment, self-direction, and help totally free from coercion. Services are consumer-run and directed.

Michael Hansen

An organization called Mental Health Consumer Concerns, located in Concord, conducted a MHSA survey of forty-eight youth and adults in acute settings (See Statistics.). All adults said, "having a case manager who cared about them" was the number one factor for their past and future success. Adolescents also felt that having a counselor to talk to was significant. Adults and children both emphasized a peer buddy or support group as very valuable. Adults also mentioned needs for transportation, medication support, job opportunities and housing options as important. The youths interviewed wanted something to occupy their time and having job opportunities. Michael Hansen, who provided this data, mentioned the importance of Wellness and Recovery Treatment Plans (WRAP) as they promote developing an individual's own strategies for self-reliance. In addition he explained that "health and safety checks" can be another tool for families.

Meghan Stanton Interview

In our interview with Meghan Stanton, Executive Director Wellness and Recovery Centers, we talked about family support. Meghan said she heard many families have problems accessing services. Families often stated that when they contacted law enforcement, they were unable to get help. Often law enforcement seemed unwilling to place a person who a family believed needed of mental health treatment with W&IC 5150. Meghan felt mental health providers, in general, should do a better job of educating people on how to get assistance for themselves and loved ones in need of mental health services. Additionally, she observed family members are often excluded from the treatment process. They are not informed or educated about what is happening with their loved ones. Often times it seems that confidentiality laws are used in a manner which excludes them when this may not even be the intention of their loved one.

Consumers are hesitant to go to the Treatment Center because they are fearful of being held against their will or institutionalized. When asked about the remodeling of the Mental Health Treatment Center, Meghan stated that unfortunately many consumers look at it as an institution, where they may have had negative experiences. The family too may have had unpleasant experiences. When their loved one receives inpatient services, families are often unaware of what is happening because of a lack of communication between the treatment team and families.

Compounding the issue is the number of people on long-term holds at the Sacramento County Mental Health Treatment—conservatorship and competency to stand trial. These situations impact the number of beds available for acute care. Meghan thinks that conservatorship should be used a little earlier and as more of a treatment intervention rather than as a last resort. Most of the interest of the conservators seems to be public safety rather than in rehabilitating or helping the clients.

Approximately 66% of clients held for additional involuntary treatment do not contest or disagree with the doctor. Treatment for individuals who agree with their diagnosis should be voluntary. Meghan felt that there could be a therapeutic component to the certification review hearings. Sometimes clients gain insight into their behavior as perceived by the hospital staff and understand how it is affecting their relationships.

Meghan realizes funding is a big issue, but if the community could look at a broader picture we could find the funds. It is a matter of priorities. The settlement agreement is a good start to looking at services along a continuum of care. There are still issues around resource allocation.

"The community would benefit from Crisis Intervention Teams (CIT) within law enforcement." Most CIT teams are provided with 40-80 hours of training specific to mental health issues. Sacramento does not currently have this program, mostly due to budget constraints. Who pays for the training? Who pays for the officers while in training? In 2005 Santa Clara County Law Enforcement involved mental health professionals on calls as backup, when needed. Eventually the mental health teams were called less and less as the officers became more proficient at dealing with the calls. They didn't need the support. In Sacramento, a psychiatric emergency response team (PERT) was proposed as a part of the Mental Health Services Act. Not open to this idea before, Meghan attended a 2005 CIT Conference in Columbus, Ohio where PERT was characterized as a precursor to CIT. The PERT proposal was unsuccessful because of funding issues of MHSA paying law enforcement salaries. Meghan liked CIT and felt that the officers were less stigmatizing towards mental health consumers than skilled mental health workers. This is another benefit of CIT is that it can change law enforcement attitudes and perceptions of the mentally ill. Meghan felt that mental health community could provide the CIT training for free by collaboration between existing agencies, including consumers' self-help. The only cost would be for the officers' salaries while in training and the cost of covering their regular shifts.

Another program that was successful at encouraging individuals resistant to accepting mental health treatment was Project Redirection, funded by a mentally ill offender grant. Meghan also explained that there are different levels of care. She believes that more individuals would be willing to accept treatment if the services we offered were of interest to the individual. Meghan also noted that often the focus of services is to manage symptoms rather than helping people realize their potential. There should be an emphasis on wellness and the whole person.

Susan Gallagher Interview

Susan was interviewed and stated that she and a number of clients and advocates helped to design the Wellness and Recovery Center programs in Sacramento County. Susan said she feels the "missing link" is crisis respite services and the key is a step-up system prior to the crisis. She feels we need a Crisis Stabilization Unit with a family and peer component. Her greatest concern is the lack of a crisis unit in Sacramento County. Susan does believe in a continuum of care that protects consumers, but peers can help with de-escalation. Susan said that there is the need for more PHFs and reimbursement to emergency rooms. She advocates for innovations in peer

partner support and warm-lines. We briefly touched on the MHSA Innovation program that plans to address the issue of crisis respite for individuals and families.

Family Support

Committee members saw the need for families to understand and learn how to cope with the issue of mental illness. Many families feel alienated, misunderstood, and alone in their daily struggles with a mental ill family member. The National Alliance on Mental Illness (NAMI) is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI has "Family-to-Family" support groups that are successful in helping families deal with the stress of loved ones who are struggling with mental illness.

Larry Liseno Interview

We interviewed Larry Liseno, President of the Sacramento County NAMI. This organization's goal is to lead the way in crafting and implementing high quality educational and support programs. He provided us with the list of the Sacramento County services offered by the local NAMI:

- Family-to-Family Training – instructs adult family members with mental illness and people who care about them with a twelve week educational curriculum.
- Family Support Groups – meet twice monthly for family support.
- Peer Support Groups – meet monthly for individuals in need of mentoring and support.
- Peer-to-Peer Training – mentors individuals with brain disorders during an eight-week training program.
- Consumer Counseling - supports consumers to share experiences and learn coping skills.
- "In Our Own Voice" newsletter–trains and manages individuals who speak about their illness for the purpose of educating the public and reducing stigma.
- Community Outreach – educate various social, professional, cultural and faith-based groups in the community about brain disorders, the services available to treat them and the need to eliminate the stigma associated with mental illness.
- Law Enforcement Training –trains new peace officers in the City and County of Sacramento about brain disorders and the symptoms of mental illness.
- Educational Materials – produce monthly newsletter, brochures, library, and website resources for individuals in need of information and support.
- Advocacy activities - participation in community forums related to mental health.

Larry mentioned some ideas for alternative treatments are 1) encourage more faith-based programs and (2) more law enforcement training of mental health issues; all with county grants or budgeting for support. He talked about CIT (Crisis Intervention Treatment), and the Expert Pool. Larry suggested mobile outreach as an option for providing services to those not currently receiving any care or services.

NAMI feels families need to be educated to understand the disorders and the challenges. Generally there should be at least one family member that can be an advocate and keep the mentally ill person continuing down the path toward treatment. Decisions should always be informed. There are several support groups for almost every discipline/illness available in Sacramento. Families and consumers alike can benefit from these groups. Currently, NAMI Sacramento does not have a firm position concerning Laura's Law.

NAMI strongly believes in the slogan "Keep Fighting Stigma!" There is no way for treatment if there is stigma and discrimination. “There are a lot of trust issues with mentally ill persons. They tend to be fearful. So many psychotic fears can get in the way of reaching them. Services need to start with outreach to gain trust then guide them to treatment. Faith-based programs can build this. Larry emphasized the importance of getting through the protective shell of psychotic fear - trust to treatment.

Michaele Beebe Interview

We interviewed Michaele Beebe who has worked for twenty years in Sacramento County as a parent and family advocate. Michaele feels we have tackled a very difficult subject and that there may be no specific answers. She believes we must emphasize the fact that the lack of appropriate and relevant treatment has a profound effect on the parents and caregivers. The issue of public safety is very important, but paramount is family safety including the seriously mentally ill individual. The direction of service comes down to two important issues: The first is trust. The mentally ill individual must have trust in the system, their therapist, the social worker, the psychiatrist, and even their peers. The second issue is the importance of continuity of treatment. Michaele’s own service delivery is, first, and foremost, to developing a relationship with the family. She has often personally driven families to a service provider. She feels the family must initially confide in her and then they will feel they have a voice. Regarding funding, Michaele believes when the county receives “public safety” funds through the current prison realignment. Opportunities for new and innovative approaches may open the door for mental health funding. The current restructuring of the Department of Mental Health may also result in new approaches to service.

Delphine Brody Interview

An individual who fully understands the issues surrounding alternatives for individuals with chronic trauma is Delphine Brody, the MHSA and Public Policy Director of the California Network of Mental Health Clients (CNMHC). CNMHC is a client-run advocacy organization that grew out of the mental health consumer/survivor movement. Delphine told us the mental health consumer/survivor movement really began at the time of de-institutionalization. Former mental patients began to meet together in groups without psychiatric professionals. These former patients shared their feelings of anger at their abusive treatment and hope for independent living. They began organizing to fight for their rights and to provide support for each other. This social change movement concentrated on direct political action and organized in autonomous, grassroots groups.

Self-help and mutual support groups exist throughout the country as do client advocacy organizations in the majority of states. There are countless county and state consumer conferences and national technical assistance centers. Research has begun about clients advocating self-help and mutual support initiatives. Also there is substantive client involvement in policy-making and program development and implementation. Clients are providers in the mental health system and at management levels. There are advances in rights protections and proliferation of lawyers and others protecting our rights. The principles of CHMHC are:

- no expansion of forced treatment or involuntary outpatient commitment
- promotion of advanced directives as a safeguard against forced treatments
- need for mental health services that do no harm
- protect and respect the rights of mental health clients

- improved regulations of and rights protections in board and care homes
- the elimination of the use of involuntary restraints and seclusion
- protection of the all rights including the right to services; the needs of people with mental disabilities who are incarcerated
- the need for social and rehabilitative community mental health services that address the real life needs of persons with psychiatric disabilities - affordable housing, income supports, jobs, friends; substance abuse issue.

Delphine said she believes the Maslow Hierarchy of Needs is the essence of peer support. She endorsed our mission and feels the goal “to prevent further trauma” is key. She also believes the mental health system ignores the plight of too many. She emphasized the need for inclusion of racial, ethnic and sexual preferences. She felt we must reduce disparities and reach marginalized individuals. Delphine believes there are different solutions for each person. Pressing issues to address in Sacramento County are incarceration, hospitalization, and the number one priority of housing. Most importantly, there must be trust “to meet them where they are". Delphine emphasized investigating current research and publications, including the Sanctuary Institute, the “Intentional Trauma Informed Peer Support and Crisis Run Alternatives, the “Bully free Workforce,” and “After the Crisis: Healing from Trauma after Disasters. The CNMHC has a publication, called “Resources for Trauma-informed Care,” which lists principles, education, training, and websites. Delphine also mentioned the Turning Point Crisis Respite Program and a European model called “democratic mental health which includes no locked facilities, and added the “open dialogue approach.”

The cornerstone of funding for peer-run programs is the Mental Health Services Act (MHSA). "Unfortunately $861M has disappeared by Gov. Brown’s covering budget shortfalls." We discussed the politics of funding. Delphine suggested letters to our congressmen is a way of showing solidarity. Various stakeholder groups are being created. Currently there is a group called “The California Stakeholder Process Coalition” that has the goal of engaging stakeholders as equal partners in the process of MHSA funding. With SB1136 taking MHSA funds she believes that should be a supplantation issue. “With the new MHSA money going directly to the counties, there are concerns about accountability. The BOS will handle the dollars, but are they educated on mental health issues and concerns? We discussed metrics for success. Delphine feels quality of service is much more important than numbers of people served. Metrics are usually third party evaluations.

Peer-Run Crisis Respite

Peer-run centers can help rebuild a sense of community for those feeling alienated. There is an emerging service philosophy of acute residential crisis services that can provide treatment for people with psychiatric disorders by offering support from others with lived experience. The goal is to encourage less dependence on the mental health system as well as assistance in avoiding the trauma of hospitalization and incarceration.

The peer-run crisis respite is usually in a safe, home-like voluntary setting. A person treated in a peer-run crisis alternative is more likely to receive assertive community treatment from aftercare and linked to the appropriate care before the next crisis. Process standards are advocacy, choice, decision-making opportunities, and a level of honesty.

Currently, the Innovation Component of the MHSA in Sacramento County is creating a crisis respite program. This Innovation Program is just getting started and has enthusiastic support from the consumer and family members as well as professional agencies.

A "peer" is the name mental health consumers give each other as a sign of respect and support. Families also need to gather support from each other and be respected. For peer support to work the services must not take on the characteristics of traditional mental health. Instead there is an alternative view of services that identifies skills and a celebration of uniqueness that supports the possibility that recovery is possible. A "peer-run respite" is a safe home-like setting where peers can learn to manage their crises and symptoms through support for each other.

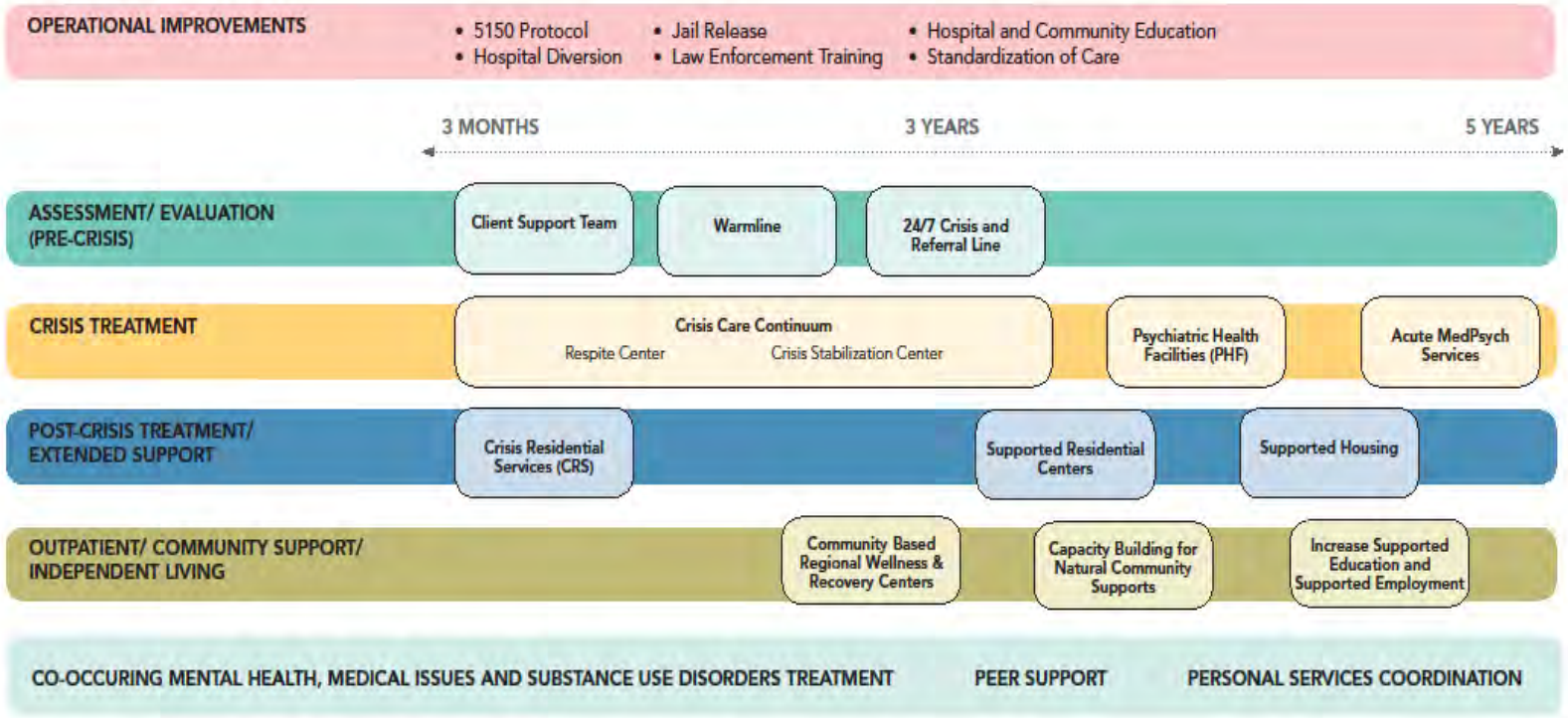
Draft Sacramento County Behavioral Heath System Redesign Recommendations

CORE VALUES

- Person/ Client centered
- Recovery Driven
- Collaborative – public/private stakeholder partnerships
- Sustainable and efficient
- Evidence based and best practices
- Cultural competance

KEY ASSUMPTIONS

- Develop an integrated system of care
- Identify best-practices appropriate for our region
- Highlight key services, not agencies that will deliver the care
- Serve uninsured and underinsured consumers
- Address immediate need to help acute care providers while developing long-term strategy to prevent hospitalizations and keep people from crisis.



Operational Improvements

Review 5150 Protocol
- Review and reconfirmation of existing 5150 designated facilities.
- Determine 5150 practices consistent with 5150 policies and procedures.
- Encourage voluntary psychiatric treatment during field assessment when possible.

Jail House
- Agreement with Sheriff not to release inmates with mental health needs until mental health assessment has been completed.
- Agreement to only release inmates with mental health needs during regular business hours.

Law Enforcement Training
- Review field protocol and practices to determine necessary adjustments to manage and place clients with acute behavioral health needs.

Standardization of Care
- Develop hospital plans of care for suicide risk, patient safety, patent's rights, safe observation, transfer to psychiatric facilities, elopements and therapeutic activities.

Hospital Diversion
- Agreement among hospitals not to divert patients from Emergency Departments for a 3-month period.

Emergency Department Data Collection
- Emergency Departments began collecting data on clients with behavioral health needs in May to identify utilization trends.

Hospital and Community Education
- Provide Prevention and Management of Aggressive Behavior (PMAB) training.
- Train ED staff, law enforcement, Emergency Medical Services (EMS) and community members.
- Utilize training videos, online education.

Crisis Treatment

Crisis Care Continuum

Respite Center
- 24-hour homelike environment with capacity to evaluate and treat psychiatric emergencies.
- Provides intensive medical oversight, nursing care, medication support, peer and family support, assessment and reassessment, Wellness Recovery Action Plan (WRAP), linkage and referral to ongoing mental health services.
- Has general mental health services and case management with the capacity to treat patients for up to 23 hours to stabilize an acute crisis.

Potential Funding
MHSA, Realignment, Medi-Cal, Medicare, FQHC and private funding.

Crisis Stabilization Center
- Provides recovery-based services as well as similar services as Respite Center.

Potential Funding
Medi-Cal, Medicare FQHC, Realignment, and private funding. MHSA only allowable for clients enrolled in MHSA Full Service Partnerships

Psychiatric Health Facilities (PHF)
- Provide inpatient service beds.
- Provide crisis stabilization, medication management, behavioral interventions, psycho-therapy, psychosocial education and a transition plan to enable a successful return to the community.
- Require regional planning.

Potential Funding
Medi-Cal (16 beds or fewer), Realignment, and private funding. MHSA only allowable for clients enrolled in MHSA Full Service Partnerships.

Acute MedPsych Services
- Create and maintain a safe, supportive, and therapeutic environment while providing intensive, individualized care to patients.
- Services are designed for adults who need to be hospitalized for a period of time for stabilization due to a psychiatric illness.
- The patient, psychiatrist and a multi-disciplinary treatment team determine the goals of hospitalization.

Potential Funding
Medi-Cal (16 beds or fewer), Realignment,Medicare, and private funding. MHSA only allowable for clients enrolled in MHSA Full Service Partnerships.

Outpatient/ Community Support/ Independent Living

Community Based Regional Wellness & Recovery Centers
- Provides extensive life skills training, peer counseling, supported education, supported employment, case management, behavior self-management, linkage to community treatment systems, WRAP, and social and recreational supports.

Potential Funding
MHSA, Realignment, Medi-Cal for specified services (e.g. "case management"), Medicare, FQHC and private funding

Capacity Building for Natural Community Supports
- Provides unique orientations designed to build and shape a community to support individuals with mental health issues through focused training and communication.
- Community organizations include faith communities, community groups, recreation centers, educational centers, school districts, employment agencies, family support centers and more.

Potential Funding
MHSA, Realignment, Medi-Cal, and private funding.

Increase Supported Education and Supported Employment
- Supported education is the continuous provision of education, training, supervision and support services designed to assist individuals to obtain employment.
- Supported employment provides integrated settings for competitive employment that provide support services to individuals to perform work.

Potential Funding
MHSA, Realignment, Medi-Cal, and private funding.

Assessment/ Evaluation (Pre-Crisis)

Client Support Team
- Interdisciplinary team of mental health professionals focused on supporting Emergency Departments specifically.
- Provides referrals to appropriate services
- Includes communication function to receive information from family members about clients.

Potential Funding[1]
Realignment, Medi-Cal, Medicare and private funding. Mental Health Services Act (MHSA-Prop 63).

Warmline
- Telephone service providing peer support, problem solving and service referral.
- Includes ability to transfer calls to emergency services when appropriate.

Potential Funding[1]
Realignment, Medi-Cal, Medicare and private funding. Mental Health Services Act (MHSA-Prop 63).

24/7 Crisis & Referral Line
- 24-hour clearinghouse of services for clients seeking acute or outpatient care.

Potential Funding[1]
Realignment, Medi-Cal, Medicare and private funding. Mental Health Services Act (MHSA-Prop 63).

Post-Crisis Treatment/ Extended Support

Crisis Residential Services (CRS)
- Expand existing programs for individuals who otherwise would require hospitalization.
- Provide a normalized living environment, integrated into residential communities.
- Follow a social rehabilitation model integrating aspects of emergency psychiatric care, psychosocial rehab, milieu therapy, case management and practical social work.

Potential Funding
MHSA, Realignment, Medi-Cal, FQHC and private funding.

Supported Housing
- Provides services and immediate access to independent, project-based or scatter-site apartments for chronically homeless individuals with serious mental illness.
- Provides support services by a team that uses a modified assertive community treatment model.

Potential Funding
MHSA, Realignment, Medi-Cal, FQHC and private funding.

Supported Residential Centers
- Focus on life skills training, linkage and community engagement.
- Serve adults in community-based residential settings.

Provide extensive life skills training, peer counseling, case management, behavioral self-management, community residential treatment systems, and WRAP.

Potential Funding
MHSA, Realignment, Medi-Cal, FQHC and private funding.

CO-OCCURING MENTAL HEALTH, MEDICAL ISSUES AND SUBSTANCE USE DISORDERS TREATMENT: All care settings should be co-occurring competent.

PEER SUPPORT: Non-clinical staff with lived experience with mental illness to provide support, encouragement, hope, mentorship and linkage to opportunities for other peer support services.

PERSONAL SERVICES COORDINATION: A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs, including determining eligibility and enrollment in appropriate public programs.

Hospitals, ERs, and Hospital Council

Scott Seamons Interview

Scott Seamons is the Regional Vice-President for the Hospital Council of Northern and Central California. The California Hospital Council has three regional associations, including all hospitals. In 2009-10 for various reasons, the Mental Health Treatment Center in Sacramento had drastic reductions—50 percent. The Crisis Stabilization Unit also closed at this time. According to Scott there was a sudden spike, 60 percent in emergency department admissions of patients with a mental or behavioral health issue. “We were scrambling to mitigate this. It was shutting us down. The hospitals were not licensed to deal with psychiatric needs, and did not have any mental health practitioners working in the ERs.”

Scott and others gathered about eighty people together – administrators, law enforcement, emergency workers and various stakeholders within the community to address this problem. The group started with the basic idea of assessing what were the community assets currently, impacting these issues. They didn’t know a lot of things, such as how to get mental health patients to the closest treatment facility, appropriate for the patient. Three work groups were formed – re-design, system and integration. They needed to define what needed to be done for immediate care, and where to send the patient. Everyone in the collaborative worked diligently to design a working continuum of care for the mental health patients. No other counties in California were addressing this problem. All eyes were on Sacramento to develop a plan. Darryl Steinberg pushed for solutions from the legislative side and appointed two individuals to the team, keeping him apprised of all progress.

Many individuals with mental illnesses are repeat users of the emergency room. In part, this is because follow-up after discharge is consistently low. Compounding this problem is insufficient community-based psychiatric and social service back-up for individuals with mental illnesses. Heavy reliance on emergency departments is not the answer. The ad hoc committee wanted to see where Sacramento County stood in relation to mental health patients and their impact on the local ERs.

In the US, emergency departments have to assess everyone who comes in the door. This is the most costly and ineffective method for treating a person not in immediate medical need. With the lack of a crises stabilization unit, all 5150 patients will go the ER first. The hospitals need to have access to psychiatric staff, whether as embedded employees or contractors. These trained professionals initiate a plan to redirect that patient to the most appropriate facility for further care. The participating hospitals supported this concept. The other participants needed to establish protocols for where patients should be referred.

There are five major hospitals systems in Sacramento:

(1) Kaiser
(2) UC Davis (Assessments team and psychiatry)
(3) Sutter (Assessment team and psychiatry)
(4) Mercy CHW (Dignity)
(5) Veterans’ Hospital

There are also Heritage Oaks and Sierra Vista, both private mental health hospitals owned by Universal Health Services. They send mobile assessment teams to Kaiser and Dignity. All indigent patients are sent from ERs to the MHTC. (See next chart of Referrals and Admits by Referral Source issued by the Community Mental Health Partnership - Hospital Council)

Statistics show that ER physicians are frequently caring for people with mental illness. Their professional education and training have not kept up with trend, leaving them ill prepared. Mental health needs at the ER are in the same category as "colds and sniffles," not crisis unless they are a danger to self or others. They can walk out of ERs on a 5150 hold because hospitals do not have locked facilities. A situation occurred when the jails when they released people to the streets at 2:00 AM. Now as a result of the workgroup, they are released after 8:00 AM.

“We need to utilize 5150’s in the right way. Use them better,” said Scott. “There are ancient laws on the books that don’t allow us to do things. Hospitals are hampered by risks they are not prepared to assume. Closure of state hospitals left many gaps. The process needs to be improved so that warm-handoffs from the hospitals to other facilities are as seamless as possible.” Counties and hospitals are now talking to each other. “We’re not 'flying blind' with both sides mistrusting each other. We are past this," said Scott. Patients presenting are getting medication and help. They are looking at the level of de-compensation and getting them to the appropriate places. Scott also mentioned crisis respite programs. Scott also suggested going out to the homeless and extending a hand and building trust. A good example of crises management is Dore Ally in San Francisco. (Appendix F)

In the US, the ERs have to see everyone who comes through the door.This is the most costly,and least effective, method of treatment for mental illness.

as of 5/29/2012

Referrals and Admits by Referral Source
Fiscal Year 2011-2012

Referrals by Referral Source

FACILITY	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Total	Average
Heritage Oaks	15	32	11	20	20	21	23	20	34	20	23		242	22
Kaiser (7/11 thru 11/11)	93	97	105	105	85	**	**	**	**	**	**	**	485	93
Kaiser Morse (12/11 thru 6/12)	**	**	**	**	**	38	47	53	36	41	42			
Kaiser South (12/11 thru 6/12)	**	**	**	**	**	53	45	35	55	66	56			
Kaiser Roseville (12/11 thru 6/12)	**	**	**	**	**	6	12	18	16	8	15			
Mercy Folsom	7	11	9	9	9	9	10	10	6	10	10		100	9
Mercy General	19	13	20	16	11	14	15	16	13	21	19		185	17
Mercy San Juan	62	68	59	65	70	74	64	65	74	72	64		738	67
Methodist	30	42	38	41	34	40	38	32	37	45	42		415	38
Other	19	16	24	19	18	13	16	20	25	13	12		201	18
Sacramento County Jail	15	8	8	8	9	10	11	8	7	9	6		84	8
Sierra Vista	45	48	51	47	42	56	52	71	54	74	49		595	54
Sutter Center for Psych	13	21	12	7	14	13	13	13	6	17	11		140	13
Sutter General	65	55	47	40	48	44	50	50	49	44	39		530	48
Sutter Memorial	11	6	3	2	3	5	4	9	6	6	6		65	6
Sutter Roseville	6	7	6	5	4	2	5	7	4	6	6		61	6
UC Davis Medical Center	77	84	83	85	79	80	76	69	69	92	86		820	84
Woodland Memorial	5	5	6	4	4	10	4	4	5	4	2		49	4
Total Referrals	**479**	**516**	**475**	**476**	**423**	**501**	**488**	**533**	**520**	**548**	**469**	**0**	**4802**	

Admits to MHTC and Crestwood PHF by Referral Source

FACILITY	Intake DCs YTD	%	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Total	Average
Heritage Oaks	1	5%	1	4	2	4	3	2	4	8	5	1	1		30	3
Kaiser	27	19%	49	34	40	58	45	**	**	**	**	**	**	**	220	44
Kaiser Morse (12/11 thru 6/12)	7		**	**	**	**	**	12	20	24	13	17	22			
Kaiser South (12/11 thru 6/12)	11		**	**	**	**	**	21	21	18	26	29	29			
Kaiser Roseville (12/11 thru 6/12)			**	**	**	**	**	1	5	2	0	0	2			
Mercy Folsom	3	6%	5	7	6	6	5	4	7	2	2	3	9		52	5
Mercy General	5	8%	10	8	10	11	7	5	9	4	6	2	5		77	7
Mercy San Juan	5	2%	28	39	28	31	43	32	37	17	28	18	29		313	28
Methodist	21	13%	10	20	19	14	19	16	12	9	7	18	19		162	15
Other	8	7%	14	10	15	14	14	15	7	12	8	10	3		122	11
Sacramento County Jail	6	8%	7	9	8	5	9	7	6	7	6	8	5		77	7
Sierra Vista	1	5%	2	1	0	2	5	1	2	2	2	3	1		21	2
Sutter Center for Psych		0%	0	2	0	0	3	0	1	0	0	0	0		6	1
Sutter General	16	7%	29	19	13	22	21	17	22	25	14	16	10		208	19
Sutter Memorial	2	8%	4	0	2	1	3	5	2	2	2	2	2		25	2
Sutter Roseville	11	23%	5	5	8	5	4	1	4	3	2	5	5		48	4
UC Davis Medical Center	15	4%	43	40	34	39	41	38	35	34	32	29	43		408	37
Woodland Memorial	2	10%	4	1	0	5	2	2	3	3	1	0	1		20	2
Total Admits	**142**		**204**	**193**	**181**	**215**	**224**	**181**	**191**	**167**	**154**	**161**	**182**		**1789**	
			MHTC=150 CW = 44	MHTC=145 CW = 48	MHTC=136 CW = 45	MHTC= 71 CW = 44	MHTC=176 CW = 48	MHTC=141 CW = 40	MHTC= 11 CW = 60	MHTC=127 CW = 40	MHTC=115 CW = 39	MHTC=114 CW = 45	MHTC=114 CW = 41			
			MHTC=76% CW = 22%	MHTC=74% CW = 25%	MHTC=75% CW = 25%	MHTC=62% CW = 38%	MHTC=79% CW = 21%	MHTC=78% CW = 22%	MHTC=74% CW = 26%	MHTC=76% CW = 24%	MHTC=75% CW = 25%	MHTC=72% CW = 28%	MHTC=72% CW = 28%			

Data source: Intake Referrals for Patient Services at MHTC

* These numbers reflect total referrals by source but do not necessarily reflect total number of 5150s seen by each source.

STATISTICS

Numerous reports exist regarding the prevalence of mental illness. We are including a few sources along with our local statistics.

National Institute of Mental Illness (NIMH) in 2010 estimated that 7.7 million Americans suffer from schizophrenia and severe bipolar disorder - approximately 3.3% of the US population when combined. Of these, approximately 40% of the individuals with schizophrenia and 51% of those with bipolar are untreated in any given year. According to the World Health Organization, mental illnesses account for more disability in developed countries than any other group of illnesses, including cancer and heart disease. The NIMH studies report that about 25% of all U.S. adults have a mental illness and that nearly 50% of U.S. adults will develop at least one mental illness during their lifetime. Rates for both intentional (e.g., homicide, suicide) and unintentional (e.g., motor vehicle) injuries are two to six times higher among people with a mental illness than in the population overall. Mental illness is associated with increased occurrence of chronic diseases such as cardiovascular disease, diabetes, obesity, asthma, epilepsy, and cancer. People with untreated psychiatric illnesses comprise one-third, or 200,000 people, of the estimated 600,000 homeless populations. The quality of life for these individuals is abysmal. Many are victimized regularly. A recent study has found that 28 percent of homeless people with previous psychiatric hospitalizations obtained some food from garbage cans and 8 percent used garbage cans as a primary food source. People with untreated serious brain disorders comprise approximately 16 percent of the total jail and prison inmate population, or nearly 300,000 individuals. These individuals are often incarcerated with misdemeanor charges but sometimes with felony charges as a result of behaviors caused by their psychotic thinking. People with untreated psychiatric illnesses spend twice as much time in jail as non-ill individuals and are more likely to commit suicide.

Bureau of Justice Statistics Special Report, "Murder in Families"

- 4.3 percent of homicides committed in 1988 were by people with a history of untreated mental illness (study based on 20,860 murders nationwide).
- Of spouses killed by spouse – 12.3 percent of defendants had a history of untreated mental illness;
- Of children killed by parent – 15.8 percent of defendants had a history of untreated mental illness;
- Of parents killed by children – 25.1 percent of defendants had a history of untreated mental illness; and
- Of siblings killed by sibling – 17.3 percent of defendants had a history of untreated mental illness.

New York's Kendra's Law

- 77 percent fewer experienced hospitalizations compared to before AOT
- 74 percent fewer experienced homelessness compared to before AOT
- 83 percent fewer experienced arrests compared to before AOT
- 88 percent fewer experienced incarceration compared to before AOT

2012 LPS Task Force II Report "Separate but Not Equal - The Case for Updating California's Mental Health Treatment Law" (Appendix C)

- Approximately 2% of the population suffers from serious mental illness with 40- 50% suffering from deficits in insight.
- Annualized cost of inpatient unit in jail is $636,500 plus court and legal costs
- Annualized cost of FSP is $24,000
- Annualized cost of Board and Care is $26,000 - $153,000
- Annualized cost of mental health treatment center is $43,000 - $78,000
- Annualized cost of Forensic skilled nursing facilities is $150,000
- Annualized cost of Napa State Hospital is $185,000
- Annualized cost of Psychiatric inpatient bed is $511,000
- Annualized cost of Jail housing is $36,000 plus treatment, court, legal costs
- Annualized cost of Prison housing is $46,000
- Annualized treatment costs are $2,000 - $185,000

Emergency rooms

Individuals with psychiatric needs are a significant proportion of those using emergency departments:

- Individuals with psychiatric illness have higher rates of ER use than the general population when compared to a national sample.
- Patients with psychiatric disorders are likely to use the ER on multiple occasions and to have multiple hospitalizations, compared to patients without psychiatric disorders.
- One in eight, or nearly 12 million ER visits in the U.S. in 2007 were due to mental health and/or substance use problems in adults. Of these, 63% were related to mental health problems, 24.4% involved substance use disorders, and 11.9% involved were co-occurring psychiatric and substance use disorders.

Mental Health Consumer Concerns

Michael Hansen, a member of the Sacramento County Mental Health Board representative for Public Interest, provided this report. Mental Health Consumer Concerns, located in Concord, conducted a MHSA survey of youth and adults in acute settings. The following 48 persons completed these surveys:

Adults:
Board and Care - 10 individuals (22%)
Hospitals – 4 individuals (8%)
MHRCs – 6 individuals (12%)
Jails – 4 individuals (8%)
Homeless – 9 individuals (19%)

Youth:
Juvenile Hall – 7 youth (15%)
Hospitals – 4 youth (8%)

Residential Programs – 4 youth (8%)

When asked what past and future supports would benefit the quality of their life:

Adults:
Better access and a “good” case manager – 16 responses (14%)
Counselor to talk to – 6 responses (5%)
Peer Buddy – 12 responses (10%)
Peer support group – 8 responses (7%)
Psychiatrist – 7 responses (6%)
Individual or group counseling – 1 response (1%)
Dual Diagnosis help – 1 response (1%)
Medication – 12 responses (10%)
Pet therapy – 5 responses (3%)
WRAP – 5 responses (4%)
Transportation – 12 responses (10%)
Something to do – 6 responses (5%)
Job opportunities – 13 responses (11%)
Place to hang out – 1 response (1%)
Housing options – 10 responses (10%)

Not on survey, but needed:
Place to get some rest
Information to get help
Incentives for participation
Call before appointments and medication reminders
Clergy counseling services

Youth responses to Mental Health Consumer Concerns survey:

Good case manager – 7 responses (16%)
Counselor to talk to – 6 responses (14%)
Peer buddy – 3 responses (7%)
Peer support group – 4 responses (9 %)
Psychiatrist – 2 responses (4.5%)
Individual or group counseling – 1 response (2%)
Pet therapy – 3 responses (7%)
WRAP – 4 responses (9%)
Transportation – 2 responses (4.5%)
Something to do – 3 responses (7%)
Job opportunities – 4 responses (9%)
School opportunities – 1 response (2%)
Place to hang out – 2 responses (4.5%)
Housing options – 2 responses (4.5%)

The adults and children all put “having a case manager who cared about them” as the number one factor to their past and future success. Adolescents felt “a counselor to talk to” was also significant. Adults and children emphasized a peer buddy or support group as valuable. Adults also wanted transportation, medication support, job opportunities, and housing options. The youth interviewed also wanted something to do and job opportunities.

Nevada County Statistics re: Assisted Outpatient Treatment

First individual entered into AOT on April 28, 2008.
Savings were based on the first 2.64 years of implementation
19 individuals enrolled during the 2.64 years, data collected on 17 individuals.

- $482,443 represents the actual amount paid by Nevada County Behavioral Health to Turning Point Providence Center for services provided to the 17 individuals who received Assertive Community Treatment.

- $1,122,264 Projected cost of hospital and jail, if not in AOT

- Total actual cost post AOT program:

  $1,122,264 Projected Cost (hospital + jail) if not in AOT
  ($136,200) Actual Post AOT Costs (hospital + jail)
  ($482,443) Treatment Cost in AOT
  $503,621 Total Cost Savings

- Every $1 invested in AOT saves $1.81

Presentation "Assisted Outpatient Treatment in California - Funding Strategies" by Michael Heggarty, MFT, Nevada County Behavioral Health February 15, 2012.

Assertive Community Treatment costs approximately $20,000 per year and must meet WI&C 5348 (a) - (d), funded by:

- Realignment
- Medi-Cal
- Mental Health Services Act (MHSA)
- Medicare
- Private insurance
- Self pay

Behavioral Health Administration
- Cost varies and minimal; possibly few new/additional costs, because these same individuals would need administrative time related to, WIC 5350 Lanterman-Petris-Short (LPS) Court, Mental Health Court, public relations, if not being dealt with in AOT Court funded by Medi-Cal, MHSA, realignment

County Counsel
- County Counsel involvement and representation related to WIC 5350 LPS Court and Dependency Court, if not being dealt with in AOT Court
- Funded by Behavioral Health Realignment, Medi-Cal, MHSA

Judge and Court Staff
- Cost varies; but, possibly few new/additional costs, because these same individuals would need representation in Criminal Court, WIC 5350 Lanterman-Petris-Short (LPS) Court,

Mental Health Court, or Adult Drug Court, if not being dealt with in AOT Court - Funded by County General Funds

Law Enforcement

- Cost varies; possibly few new/additional costs, because these same individuals would be in Criminal Court, WIC 5350 LPS Court, Mental Health Court, Dependency Court, or Adult Drug Court, if not being dealt with in AOT Court -Funded by Superior Court State funds

Psychiatric Hospitalization

- May be funded by Medi-Cal, Medicare, Private Insurance, Behavioral Health Realignment

Potential Offsets:

- Psychiatric hospitalization; $800/day, potential reduction of 47%
- County Jail; $150/day, potential reduction of 65%
- Emergency Department; $3000/visit, potential reduction of 44%

Funding LPS:

- Mostly with Realignment, for example WIC 5150, 5250, 5270, 5350, but counties also frequently use Medi-Cal and MHSA funds for mental health treatment associated with these services
- Medi-Cal is often used for WIC 5150 Assessments and 72 hour hold
- WIC 5250 14 day additional certification
- WIC 5270, 30 day additional certification
- WIC 5350, Outpatient treatment for gravely disabled individuals

MHSA used:

- WIC 5150 Assessment, Evaluation, Mobile Crisis
- WIC 5350 Individuals who are gravely disabled and needing outpatient mental health treatment
- Full Service Partnerships, such as ACT Teams, that target WIC 5350 Individuals who are gravely disabled and needing outpatient mental health treatment

How to Fund AOT?

- We tend to think of WIC 5345 as separate and distinct compared to other parts of the LPS Act, even though other parts of the Act contain much more restrictive, disruptive, and costly services.
- Consider the use of realignment, Medi-Cal, and MHSA wherever possible and allowable to pay for AOT.
- This would be consistent with how Counties fund other parts of the Act.
- AOT is a relatively low cost, front-end ‘prevention’ intervention that can greatly reduce the amount of money being directed into high cost, back end services

<u>Dorian Kittrell - Sacramento County DBHS Statistics:</u>

- MHTC Cost/Day = $1369 with cost external intake unit that provides services to Emergency Rooms and Community
- MHTC Cost/Day = $1100 MHTC county facility only 50 beds/day 18250 bed-days
- Private Hospital Cost/day = $950 paid to hospitals in Sacramento County MediCal

- Crestwood PHF Cost/day = $750 based upon negotiated value if acute MediCal eligible - $375 is paid back.
- In 2010/11:The MHTC Inpatient Unit had 1926 admissions
- Median Length of Stay: 4 days
- The average number of admissions per day: 5.3
- The average number of dischargers per day: 5.2
- Recidivism rate (meaning a patient returned to an psych. inpatient setting within 30 days of being discharged from the MHTC): 15.2%
- Percentage of patients admitted to MHTC discharged back to the community: 97.3%

Sacramento County Mental Health Court

Steven Lewis provided the Ad Hoc Committee with information regarding Sacramento County Mental Health Court. This data involves 16 clients who were enrolled in the program from February 2007 to February 2008.

The number of people arrested decreased by 80%
The total number of arrests decreased by 74.1%
The number of days incarcerated decreased by 93.6%
The number of people using the crisis unit decreased by 33.7%
The number of people admitted to inpatient psychiatric facilities decreased by 50%

Sacramento Mental Health Court (SMHC) clients cost more then $250,000 in the prior year. These same clients next year cost the system only $33,000 - a decrease of 88%. The budget for the program in 2007, “Strategies for Change,” was $824,101, including $333,981of in-kind contributions from: UC Davis, SMHC Court Coordinator, Deputy District Attorney, Superior Court Judge, Assistant Public Defender, and Court clerk, reporter, and attendant. Mr. Lewis is currently involved with 33 MHC cases, but he said, "There is the capacity for one hundred cases." The net increase would be approximately seventy more individuals participating in this type of program.

Cost Avoidance

This following chart is a cost avoidance analysis based upon the recidivism of 70 individuals and their financial impacts in Sacramento County. The costs of jails, hospitals, and the Mental Health Treatment Center are compared to the cost of an Assisted Outpatient Treatment (AOT) contract in Sacramento County similar to the Turning Point program in Nevada County. We realize there are other costs that we are ignoring. We believe this analysis shows, however, that the costs of an AOT program is offset by the trauma an individual with a hospital stay at least four days a year, a four-day stay per year at the MHTC, and a two week jail sentence. The rates of these traumas are much higher for individuals who cycle through the system on a regular basis. We recommend using this blueprint for a three-year $ 700,000 pilot program with referrals to the Mental Health Court.

Welfare and Institutions Code 5150 and 5200
Based on our understanding of existing statutes, entry into this program would utilize WIC 5150 and 5200, LPS Act provisions. The committee had taken into account the numerous suggestions that the LPS Act was under-utilized and Laura’s Law was duplicative of these provisions. WIC 5200 could provide for those persons resistant to treatment who may present well to law enforcement under a WIC 5150 visit. Therefore, they may not be held for evaluation. Since one of the key arguments against Section 5200 was the extensive agency collaboration and existing

court delays, we were pleased to find excess capacity available in Sacramento's Mental Health Court. This court works for the benefit of every mentally ill person in a very expeditious manner.

Although the committee was aware of the usage of the 5150 statute, we inquired how the 5200 provision applies in our county. We did not get a complete response with adequate time to do further interpretation, seek additional stakeholder input, and answer the questions raised in the memo. Attached is the memorandum from Sacramento's Office of the County Counsel received July 25, 2012 in response to our inquiry. It states the procedures for WIC 5200 - 5213 have not been used in Sacramento County, most likely because of time and cost constraints. On July 30th, the committee received a response to this memo from Disability Rights California

Additionally a workgroup focus should be investigating Jail Psychiatric Services. We made numerous attempts to interview them and were not successful in obtaining information in this area. We feel this is an important piece of the treatment for persons incarcerated.

Three Year Pilot Program for Sacramento County Mental Health Court

Cost Estimate based upon Nevada County data:				
	Turning Point Contract	$483,443		
	# of years	2.64		
	Total per year	$183,122		
	Individuals served	17		
	Approx. cost per individual	$10,772		
	Sac.Co. individuals	70		
	Total per year	$754,033	$.7 M	

Estimated cost avoidance for recidivism for 70 individuals:			
MHTC	$1,100.00	ave. cost per day	
	4	ave days per stay	
	70	estimate no.of individuals	
	$308,000		
Jail System	$150	ave. cost per day (Est.)	
	14	ave days per stay	
	70	estimate no.of individuals	
	$147,000		
Hospitals	$950	ave. cost per day	
	4	ave days per stay	
	70	estimate no.of individuals	
	$266,000		
Estimated cost avoidance	$721,000		$.7 M

Funding $700,000 for a Mental Health Court pilot program for 70 people

1.0 **DBHS commit $300,000/year for three years increasing each Level IV service providers' contract by $50,000 per year OR $300,000/yr. for one provider of a Nevada-like contract.**

2.0 **Sheriff and Probation Dept. commit $400,000/year for three yrs. to cover MHC costs using funds that offset services averted.**

3.0 **Referrals to Mental Health Court from the MHTC Intake Stabilization Unit. No jail time for Level IV individuals. Maybe offer voucher incentives for participating in treatment plans.**

Inter-Department Correspondence

Date: July 25, 2012

To: Mary Ann Carrasco
Deputy Director, Behavioral Health Services

From: Denis Zilaff
Supervising Deputy County Counsel

Subject: Welfare and Institutions Code §5200 et seq.; efficacy of providing a procedure for treating individuals with a suspected mental disorder

You have asked me to review Welfare and Institutions Code section 5200[1] et seq. as to its efficacy for providing medical treatment, evaluation, psychiatric medications and a treatment plan for reported mentally disordered individuals. Welf. & Inst. Code §§ 5200-5213 provide a means for a private individual to obtain a court-ordered evaluation for a subject alleged, as a result of a mental disorder, to be a danger to others, or to himself, or to be gravely disabled.

The potential benefit of this legislation is that someone otherwise unwilling to receive treatment voluntarily may agree to "receive crisis intervention services or an evaluation in his own home or in a designated facility" after an initial prepetition screening visit by a Mental Health professional (Welf. & Inst. Code § 5202).

This scenario avoids the need to call law enforcement to determine if there is probable cause to place the individual on a Welf. & Inst. Code § 5150 hold. This is the best-case scenario, and the only efficient means of utilizing this legislation. However, if after the "prepetition screening investigation," the person does not agree to receive treatment voluntarily, the steps required to properly utilize this legislation involve a cumbersome process that delays treatment and is far less efficient than calling law enforcement at the outset, because the result will be essentially the same, with the only difference being a substantial delay in treatment.

Outlined below are examples of the best and probable-case scenario of a Welf. & Inst. Code § 5200 process.

Best-Case Scenario - Steps (Under Welf. & Inst. Code § 5202)

1. A concerned citizen, family member or individual contacts the Public Guardian (designated to receive application) to apply for a petition to initiate this process.
2. The Public Guardian contacts Mental Health (designated to provide pre-petition screening).
3. Mental Health conducts a "reasonable investigation of the allegations" and makes a "reasonable effort to personally interview" the person.

As part of the investigation, Mental Health must determine if the person will agree voluntarily to receive crisis intervention services or an evaluation in his own home or designated facility. If the

[1] All references are to the Welfare and Institutions Code section unless otherwise specified.

subject agrees, this is essentially the end of the process under this statute. No petition would be filed.

The time frame for this scenario depends on the availability of the Public Guardian to receive and relay the request to Mental Health. On weekends and holidays, this process would be delayed.

RESULT - The best-case scenario would be that after one or two days, the subject is interviewed and agrees to treatment or evaluation voluntarily. If holiday or weekends are involved, this process may take a week or more.

Probable (most likely)-Case Scenario Steps (Under Welf. & Inst. Code § 5202)

1. A concerned citizen, family member, individual contacts the Public Guardian (designated to receive application) to apply for a petition to initiate this process.
2. The Public Guardian contacts Mental Health (designated to provide prepetition screening).
3. Mental Health conducts a "reasonable investigation of the allegations" and makes a "reasonable effort to personally interview" the person. As part of the investigation, Mental Health must determine if the person will agree voluntarily to receive crisis intervention services or an evaluation in his own home or designated facility. Under this scenario, the person does not agree to services, and perhaps does not agree to an interview at all.
4. Mental Health completes a confidential report containing the findings and submits the report to the Public Guardian.
5. The Public Guardian reviews the report and if satisfied there is probable cause to believe that the person is, as a result of a mental disorder, a danger to others, or to himself or herself, or gravely disabled, and that the person will not voluntarily receive evaluation or crisis intervention, submits the petition request and report to County Counsel for filing.
6. County Counsel prepares the petition and submits the petition to the court for review and determination (Welf. & Inst. Code §§ 5204-5205).
7. If the Court finds probable cause for danger to others, danger to self, or grave disability as a result of a mental disorder, and that the person has refused or failed to accept evaluation voluntarily, the judge shall issue an order notifying the person to submit to an evaluation (Welf. & Inst. Code § 5206).
    a. The court determines the time and place for the evaluation to take place.
    b. The order and petition are served "as promptly as possible" on the subject of the petition by a peace officer, mental health counselor, or court-appointed official (Welf. & Inst. Code § 5208).
    c. If the person refuses or fails to appear for evaluation after having been properly notified, the facility shall notify the person who served the order and that person will have the person to be evaluated taken into custody and placed in a facility for treatment and evaluation. (Presumably, the person will call law enforcement to have the person taken "into custody.")

As outlined above, if these steps are necessary, the process takes time and is reliant upon numerous steps occurring and multiple state and local agencies cooperating before the person would be placed on a Welf. & Inst. Code § 5150 hold, a hold that does not have involuntary medication attached to it. This process would be the most typical scenario for a person in society acting out due to a mental disorder could take months to accomplish what a Welf. & Inst. Code § 5150 hold would accomplish in a matter of hours.

Under either scenario, the person may be detained for 72 hours for evaluation and treatment if, upon evaluation, the person is found to be in need of treatment because he or she is, as a result

of mental disorder, a danger to others, or to himself or herself, or is gravely disabled. The person shall be given written and oral information on any medications provided, and this shall be indicated in the patient's chart. If the information is not, or cannot be given, the justification for not giving it must also be documented in the patient's chart (Welf. & Inst. Code § 5213). Medications cannot be given to the patient involuntarily without a Riese hearing (Welf. & Inst. Code § 5332) which will also take an additional two to five days and must be renewed for each certification.

After 72 hours, the person must either be released, referred for care and treatment on a voluntary basis, certified for intensive treatment, or recommended for conservatorship.

CONCLUSION

Section 5200 et seq. provides a procedure to have a suspected mentally disordered person evaluated for an application for a 5150 hold. This section is anachronistic, time-consuming, involves multiple local and state agencies, costly, and not a timely procedure for an act that can be accomplished by law enforcement or other mental health providers in hours instead of weeks or months. To the best of my knowledge, the Welf. & Inst. Code § 5200 procedure has never been used in Sacramento County and is not used by other counties. Furthermore, since the closing of the Treatment Center as an acute mental health treatment facility for direct drop-off by law enforcement, it appears that a Welf. & Inst. Code § 5200 process would be even more time-consuming and costly with no benefits to the mentally disordered person or the initiating party.

Below: Email Response from California Disability Rights to the above Inter-Departmental Letter from County Counsel

Sent: Monday, July 30, 2012 10:10:33 AM
Subject: Re: Response to the MHB Ad Hoc Committee

…This is from one of our attorneys in San Diego. I agree with his thoughts.

Sounds like Sacramento County doesn't think much of 5200 as an alternative to Laura's Law.

It is interesting that there is no reference to offering the full scope of services available under Laura's Law, including but not limited to highly trained teams that use high staff-to-client ratios of no more than 10 clients per team member including peer support supportive housing or other housing assistance. (Section 5348(a)(1)&(2)(B)).

Further, the Section 5200 process is designed as a 5150 diversion. The pre-petition screening process requires offering at risk individuals voluntary services at home and in the community. It also includes preliminary evaluation of whether there is probable cause for evaluation. If the 5150 criteria were met, the county could go through that process rather than a 5204 petition.

Our argument has been that there are existing procedures under the LPS Act such that Laura's Law implementation is not necessary. Sounds like Sacramento County has not fully considered how the Section 5200 process could be used as an alternative to Laura's Law implementation.

Sean Rashkis
Attorney
Disability Rights California

Ad Hoc Committee Conclusions:

- *The Lanterman-Petris-Short Act (LPS) needs to be better utilized or re-written in the form of new legislation approved by members of the mental health community. It is our understanding, if Section 5200 of the LPS Act was applied as originally intended, AB 1421 might not be necessary. As per the previous memos, conflicting interpretations preclude any definitive recommendations.*

- *Assisted Outpatient Treatment (AOT) goes beyond the scope of LPS and gives families and concerned individuals more of a voice. AOT in Nevada County is a Full Service Partnership recognized as a successful foundation for recovery. This program is partially sponsored by the Mental Health Services Act (MHSA), and does not condone forced medication. AOT is an intervention allowing for a treatment option that is a less restrictive than the 5150 process or a locked facility, including jails. If all aspects of Nevada Country's AOT program could be replicated here in Sacramento, we could be inclined to recommend AOT.*

- *The Sacramento Mental Health Court has room for expansion. We recommend the Sacramento County Board of Supervisors create a collaborative workgroup to increase the development and funding of Mental Health Court. This workgroup should include Probation and Sheriff's Departments, Hospitals, District Attorneys' and Public Defenders' offices, Department of Behavior Health Services (DBHS), Mental Health Court, the Mental Health Board, peer and family support groups, and other stakeholders.*

- *Mental Health Court could provide AOT or other treatment options for 70 more individuals with severe mental illness within its current structure. Our previous cost avoidance recommendations support this theory to reduce recidivism. We recommend implementing the Mental Health Court three-year pilot program.*

- *Mobile outreach teams are imperative, even expanding on the current Community Support Team (CST) model using a blended team of professional, peer, and family staff. We recommend establishing a Crisis Intervention Team (CIT), perhaps like the San Diego model. (Appendix B) Furthering the outreach concept, we recommend leveraging faith-based and other community organizations, such as Sacramento Steps Forward.*

- *Alcohol and Drug Services must be understood and incorporated at all levels of services and especially in the jail system. Clients with co-occurring disorders are not all criminal types, but must be identified and treated appropriately. There should be an ADS counselor at Jail Psychiatric Services and the Mental Health Treatment Center, and routine information sharing.*

- *ERs are not equipped to handle mental health treatment and we recommend sustainable funding for the new Intake and Stabilization Unit (ISU). We suggest continual representation by the MHB on the Community Health Partnership. Primary care physicians must also receive education to understand the complex issues of mental health.*

- *We recommend peer and family advocacy at all levels of care, even hospitals and the Mental Health Court. Updated service and legal information and education for all advocates is crucial. Continuity of treatment, the establishment of trust, and seamless transitions must be implemented and we support recommendations in the Callahan Report (Appendix K).*

- *Uma Zykofsky stated "Some of the challenges are creating programs with sustainable dollars, not relying on taking money from existing programs." We recommend leveraging funding with other organizations and investigating more grant opportunities.*

Throughout the course of this project, many approaches were discussed and presented to us. We have decided to include the following six examples of similar research and programs.

APPENDIX A.

State of Georgia

In Spring 2012 issue of the National Association for Mental Illness (NAMI) Advocate magazine, there was an article called “Georgia Program Aims to Break the Cycle of Recidivism”. This article explained a pilot program called Opening Doors to Recovery (ODR). The project is being led by the National Alliance on Mental Illness (NAMI) in partnership with Emory University and the Georgia Department of Behavioral Health and Developmental Disabilities (DHBDD). The following description contains excerpts from the article. Two million dollars was provided by Bristol-Myers Squibb and some of that organization's investment in mental health services are summarized on page 65.

Over the next two years, the state of Georgia is implementing an “Opening Doors to Recovery” program that will focus on people with serious and persistent mental illnesses who have an established history of recurrent homelessness, incarcerations or hospitalizations. As a pilot project, it will test a highly innovative approach to delivering tailored, recovery-oriented case management services for patients being discharged from Georgia Regional Hospital at Savannah. ODR will develop, implement and evaluate a case management service as well as a new technology system for navigating a consumer’s community-based care and for tracking utilization of non-medical supports that are critical to recovery but not typically captured in medical records. “The program is initially limited to 100 participants

“This program is a result of two previously successful collaborations in the state: the Crisis Intervention Team (CIT) program and the peer specialist initiative. A strong partnership is established among individuals, family members, local providers, hospitals, law enforcement, emergency departments, clergy, and others who touch the lives of people living with mental illness. After informed consent, the names of ODR participants may be placed in Georgia’s statewide criminal justice database to assist law enforcement in being aware of the ODR program in their lives. The ODR utilizes a team approach to helping its clients navigate the network of mental health, health, and social services. Unlike traditional mental health services, ODR has a comprehensive focus. Participants receive assistance in accessing treatment finding stable housing, developing and improving relationships and achieving meaning and success in their lives. There is also grant funding from the Georgia Transportation Department to provide access to that particularly important component to recovery, especially in rural areas.”

“The Opening Doors to Recovery project is an example of public-private partnerships used to drive much needed innovations in the nature and quality of care and support available to patients who are managing their illness in their home and community,” said Bristol-Myers Squibb Foundation Director Patricia M. Doykos. “We look forward to seeing how the project’s interventions and tools help participants avoid crisis and progress toward their recovery goals.” From the Bristol-Meyers Squibb website: “The Bristol-Myers Squibb Foundation has made a $2 million grant in support of the Opening Doors to Recovery Project (ODR) in southeast Georgia. “The mission of the Bristol-Myers Squibb Foundation is to help reduce health disparities by strengthening community-based health care worker capacity, integrating medical care and community-based supportive services, and mobilizing communities in the fight against disease. In this program area for mental health in the U.S., the Foundation aims to address the disparities that exist in the southeastern states through innovative recovery-focused and community-based interventions. Improving transitions from hospitals to community living and care is one particular area of interest.” (See following pages with list)

“The data collection and evaluation component of ODR is in the early stages… however…profiles show positive short term impacts, including adherence to treatment, maintaining sobriety, participating meaningful daytime activities, employment, reduction in crimes, incarceration and hospitalizations.” The ODR program was endorsed by Former First Lady Roselyn Carter who said, “Mental health is defined as a state of well-bring in which individuals realize their own abilities, work productively, and are able to contribute to their communities. The absence of mental health adversely affects all aspects of life.”

This article states that while the initial investment of resources in serving people with a pattern of chronic recidivism may seem high, the eventual benefits in terms of saving money and people’s lives cannot be overstated. People living with mental illness and substance abuse deserve a chance to achieve true recovery.

The following is another quote in the same periodical from Former First Lady Roselyn Carter: “Over the years, I have seen stigma against mental illness lifting some, but I know we have so much more work to do. It is my hope that one day mental illnesses will be seen as health conditions like any other and that our friends, coworkers and family members who have them are able to access the treatments and supports they deserve. The result will be more and more people in recovery included in our communities, and everyone will benefit from the expression of their fullest potential through use of their diverse skills and gifts.”

Bristol-Myers Squibb Foundation
Serious Mental Illness Initiative Current Partnerships and Grants

• NAMI Georgia/Emory University in partnership with the Georgia Department of Behavioral Health: $2,000,000 to support a demonstration project called *Opening Doors to Recovery in Southeast Georgia* that will develop, implement and evaluate a community-based case management service to reduce the recidivism among consumers being discharged from Savannah Regional Hospital. The State of Georgia is co-investing $2 million in the project as well.

• Mental Health America: $750,000 to support a program to train and mobilize peer specialists from Native American tribal communities and to educate and engage tribal leaders in de-stigmatization actions in 5 western states

• National Council for Community Behavioral Health Care: $739,170 to develop a replicable intervention model for effective services focused on illness management, recovery and supported employment for transition-aged youth (18-26 years old) living with serious mental illness.

• American Health Initiative, Ltd.: $350,000 to support the development and piloting of a Senior Health Corps to increase mental health services at primary care focused federally qualified health centers in Florida

• Boston Medical Center: $497,765 to develop, implement, and evaluate a demonstration program using peer specialist navigators to assist with the coordination of primary and mental health services of consumers

• Capital Health Foundation/Henry J Austin Community Health Center: $318,000 in grants aimed at helping expand mental health services for disadvantaged populations in Trenton, New Jersey, by co-locating a psychiatrist from a private hospital at a federally qualified health center to provide direct care and clinical mentoring and by providing didactic and Grand Rounds education to primary care providers on staff and in the Trenton area

• Dartmouth Psychiatric Research Center: $666,323 to support the adaptation of an electronic decision support system (EDSS) for smoking cessation to meet the needs of African American and Latino smokers with serious mental illness

• Family and Youth Counseling Agency in partnership with Louisiana Office of Mental Health, Office of Addictive Disorders and NAMI Southwest Louisiana: $749,744 to provide screening, assessment, treatment, supportive services and program evaluation for mothers experiencing depression and other mental illness in the Region V area of Louisiana by working with primary care, ob/gyn and mental health service providers

• NAMI Alabama in partnership with Cahaba Mental Health Center and West Alabama Mental Health Center: $97,005 to support a faith leaders' summit and other training and outreach efforts targeting African American churches to strengthen their capacity to become mental health recovery and referral resources for their congregations and communities

APPENDIX B.

San Diego County's response to AB 1421

On February 3, 2011, the County of San Diego Mental Health Board approved an action item recommending the implementation of Welfare and Institutions Code 5345 – 5349.5, also known as "Laura's Law," in this county.

In a letter addressed to San Diego County's Supervisors, dated February 22, 2011, the County's Health and Human Services Agency stated that their position on this issue was to oppose the implementation of "Laura's Law," and instead implement a more inclusive, treatment-based alternative that targets the treatment resistant population. San Diego HHSA stated, "This position is based on financial data and clinical concerns that are shared by an overwhelming majority of California counties. The cost to counties and the courts is great, and there has been no conclusive clinical evidence that this approach is beneficial."

In late 2010, San Diego HHSA proposed an alternative to the model contained in "Laura's Law." HHSA's proposal, the IN-Home Outreach Team (IHOT) program, would combine the services of a peer specialist, a family specialist, and a mental health professional to work with those with serious mental illness who are difficult to engage and resistant to treatment.

In November 2011, San Diego County contracted with Telecare to implement the IHOT program. The details of this program are described in the following, excerpted from their official pamphlet dated January 19, 2012:

Telecare In-Home Out-Reach Team (IHOT) is a centralized program offering three mobile teams to provide In-Home Out-Reach to adults with serious mental illness who are reluctant to receive mental health services. IHOT also provides support and education to family members. Three individual teams serve the Central, North Coastal, and East County regions of San Diego. Services include outreach and engagement, crisis management, transitional case management, support and educational services and assessment as needed. Eligible individuals may have a co-occurring substance abuse diagnosis in addition to a diagnosis of a serious mental illness.
Staff on the teams will include a Peer Specialist, a Family Coach, a case manager, and a Team Lead. The Peer Specialist and Family Coaches offer personal *lived-experience* to their work with participants and family members.

All services are based in a strong recovery foundation focusing on person-centered services, strengths-based interventions and non-coercive communication.
Components used to support participants and their families towards mutually agreeable plans of action are:

Out-Reach and Engagement

Team members meet with participants in homes, hospitals, jails and the community striving to develop collaborative relationships steeped in trust and rapport.

Crisis Management

The Teams will work with participants and families to identify, recognize and talk about soft-signs of symptoms before crisis occurs. Team members will model de-escalation techniques, teach how to get the right help when needed, what to expect afterwards. Staff will also be available to help respond to crises when they occur, including:

24 hours a day, 7 days a week availability (Emergency phone consultation anytime & in person on off hours as necessary)

Help in stabilizing the situation and understanding about what occurs next.

Interventions include partnering with family members and/or others involved such as law enforcement representatives.

Transitional Case Management is typically short term in nature, approximately 90 days, or more as needed. During this period, the team provides linkages to outpatient mental health services and other supports as necessary to extend community tenure and increase participant and family member satisfaction. Other linkages may include primary healthcare, faith-based institutions, ethnic organizations, peer-run programs, eligibility assistance, housing services, social/recreational activities, employment services, educational resources, advocacy, legal services, COD services, and 12-step programs as dictated by the needs and stated wishes of the participant.

Support and Education consists of information and education about mental health services and community resources. To help decrease social isolation frequently experienced by families impacted by mental illness, recovery and wellness-

based groups will provide opportunities for participants and family members to interact with one another and with IHOT staff.

Assessment: can be offered if the individual is willing to participate in a Behavioral Health Assessment, which may include of level of care needs, strengths, mental health treatment and substance abuse histories, diagnoses, etc. The ultimate goal of the program will be to reconnect participants with their hopes and dreams, to ongoing outpatient mental health services and ultimately on to their meaningful lives. The teams will serve a combined 60-75 consumers per quarter (20-25 per team), or 240-300 per year (80-100 per team)

Referrals to Telecare IHOT will derive from collaboration with numerous referral sources such as PERT, hospitals, jails, NAMI, families, RICA, etc. to target the most acute and difficult-to-engage.

All services are provided 24 hours a day, 7 days a week. After hours calls are handled with a paging system to provide prompt response.

Telecare IHOT is under contract with San Diego County Mental Health Services. These programs are partially funded by the County of San Diego, and MHSA.

APPENDIX C.

Recommendations from the 2012 California LPS Reform Task Force II Report
Entitled "Separate and Not Equal - the case for updating California's mental health treatment law"

1. Redefine the standard for “gravely disabled” to incorporate an added element that addresses the capacity of the individual to provide informed medical decisions. The standard should be amended to incorporate specific Criteria that include comprehensive details such as the probability the person would experience substantial bodily harm, serious illness, significant psychiatric deterioration or debilitation without adequate treatment.

2. Standardize the procedure for Riese Hearings. These determine a person’s capacity to give informed consent to accept or refuse psychotropic medication. There is wide variation in this procedure from county to county. Some counties hold Reise Hearings simultaneously with WIC 5250 certification hearings. Adopt concurrent legal processes to determine probable cause3 for hospitalization and capacity to refuse medication in one hearing. If the patient has previously signed an Advance Directive, medication will be administered only under the terms of the directive unless the person is imminently dangerous to self or others.

3. Length of certification has some counties using the 30-day LPS hold provision while others do not. Recommendation is after 72-hour hold, certification for treatment should be 28 day regardless, renewable for an additional 28 days.

4. LPS Conservatorship should be revised to allow efficient application from a community setting to avoid unnecessary inpatient hospitalization when the community is the least restrictive environment for the person’s needs. A judicial order appointing a conservatorship should be recognized in other California officials in other California counties and apply throughout the state, rather than only in its county of origin.

5, “Demonstrated danger” should be based on the assessment pf the present mental condition, with no time limitation regarding the consideration of past behavior. A standardized AB1424 form should be developed and approved by the appropriate mental health agency and other necessary government agencies in every county of California. This form will be accepted and used by every police force, sheriff’s department, psychiatric mobile response team, clinical and medical facilities, and superior court and hearing officer in California.

6. Historical course of an individual’s illness should be considered at each step of the evaluation process.

7. The State should develop a system of interagency collaboration among mental health departments, law enforcement, designated and non-designated hospitals and transport entities.

8. The State must develop medical necessary definitions appropriate to acute psychiatric illness episodes and ensure Medi-Cal definitions for both voluntary and involuntary hospitalization are consistently defined, monitored and applied with appeals to be conducted by a neutral third party.

9. Crisis stabilization services should be available in each county with a full array of step-down levels of care available for recovery.

10. More fully implement Laura’s Law statewide.

11. Seek expansion of mental health courts and mental health calendars in all jurisdictions and increase the capacity and utilization of current mental health courts.

12. Each county should develop a comprehensive and coordinated emergency response capacity under a legislative framework that requires emergency responder and mental health interagency collaboration and standardized training for response teams.

13. A workgroup should be established consisting of representatives for hospital, county counsel, law enforcement, and transportation entities to produce a uniform standard for custodial requirements for personnel who generate, continue, enforce or release a hold resulting from a 5150 or greater LPS Act status.

14. Ensure statewide uniform application of the Lanterman-Petris-Short Act. It is critical that the LPS Act be updated.

For more information on the LPS Reform Task Force II
Contact Carla Jacobs, 714-771-2321 or Randall Hagar, 916-442-5196

APPENDIX D.

Orange County Report from October 2011

Orange County Options Examined:

Implement AB 1421.

The Board could elect to implement AB 1421. Adoption of AB 1421 would obligate the County to provide the required services and staffing. HCA would need 6 to 12 months to complete the design and implementation of an AOT program.

Do not implement.

The high cost, lack of funding, complex requirements and limited ability to enforce a court order are seen as major disadvantages to implementing AB 1421. Also, at the time AB 1421 was enacted in 2002, County Mental Health Programs had very few intensive outpatient programs/services. With the passage of Proposition 63 in November 2004, a broad range of voluntary services has been funded and implemented in Orange County. These programs, as described in the Attachment, have demonstrated decreases in hospitalization, incarceration and homelessness as well as increases in vocational and employment activities. Many of these new treatment services are geared specifically to persons resistant to seeking help or who have historically been underserved.

Develop a pilot program with some AB 1421 features.

AB 1421 does not provide authorization for implementation of a pilot program or anything less than total implementation. However, HCA could design a voluntary pilot program that incorporates some features of AB 1421 and implement the program on a provisional or short-term basis, without the Board adopting an AB 1421 resolution. It could be a new program or modification of an existing program. Such a program would not include any court enforcement provisions or oversight; however, it would provide a dedicated resource to work with individuals to engage their loved ones in needed treatment. A period of at least 6 months would be needed to design such a program and obtain the necessary review and approval. The pilot could potentially be funded by MHSA, provide access for families and treatment providers to request an evaluation, and provide outreach and engagement services, assessment/evaluation and a comprehensive array of treatment services. Such a program would require approval of the MHSA Steering Committee, Mental Health Board and the Board of Supervisors.

A pilot program may not be considered adequate by AB 1421 proponents because they are seeking court oversight and court intervention in the care of their loved ones. However, in lieu of court oversight, the HCA Patient's Rights Program could potentially fill a mediation role, providing oversight and intervention as necessary.

Orange County Mental Health Services Similar to Those Described in AB 1421

Following is a list of current funded mental health services, totaling more than $45 million, similar those described in AB 1421, that are designed to reach and assist persons historically resistant to treatment:

Full Service Partnerships

The Mental Health Services Act (MHSA) funds several Full Service Partnerships that are intensive programs emphasizing recovery and resilience. They include individualized mental health services and offer integrated services for clients and families. These programs link to extensive services, including mental health, medical, education, employment, and housing. They have a pool of flexible funding that may be used to provide "whatever it takes" for a client to attain recovery. There are 24/7 accesses to a team member. Caseload ratio is 1:15. The target population for these programs is the chronic mentally ill who are homeless or at risk of homelessness and may also be diagnosed with substance abuse or dependence disorders. One of the newer Full Service Partnership programs serves persons admitted to the Assisted Intervention Treatment Court. This court program is for low-level offenders who are chronically mentally ill and have historically been difficult to serve. This program is similar to AB 1421, except that the client must have been involved in minor criminal offenses before a Court referral can be made. In contrast, Laura's Law is a non-criminal proceeding. The Assisted Intervention Treatment Court offers full service partnership services for up to twenty-five clients. Those services are funded by MHSA and the client voluntarily agrees to the treatment plan and court supervision. Referrals for the program generally come from the Public Defender's Office representing clients in their criminal proceedings. HCA's current budget includes approximately $31 million for Full Service Partnership programs. Program for Assertive Community Treatment Orange County has programs for Assertive Community Treatment teams for Transitional Age Youth, Adults, and Older Adults. These teams provide (1) medication services; (2) individual, group,

substance abuse, and family therapy; and (3) supportive services such as money management training, physical health care, and linkage to benefits. The target population is persons with severe and persistent mental illness that typically has high needs that include substance use, but do not meet all the criteria to enroll in a Full Service Partnership program. Clients served in the program have frequently cycled through the inpatient system and but have not been effectively linked to outpatient services. These programs provide an intensive level of services similar to Full Service Partnership programs. The main difference between the two programs is that there is not pool of flexible funding and housing resources for Program for Assertive Community Treatment programs.

HCA's current budget includes about $5 million for Program for Assertive Community Treatment Programs

Outreach and Engagement programs focus on identifying and engaging people with Severe Mental Illness who are not receiving treatment. This program employs local outreach workers trained in recovery and resiliency; they are highly visible and knowledgeable about resources. Major points of contact for the outreach staff are parks, homeless shelters, bridges, and other places where the County's homeless population may be found. In August 2011, additional Outreach and Engagement programs were added aimed at intervening with individuals and families prior to onset of serious mental illness. These programs serve people of all ages who are at risk of developing a mental illness or who are displaying early signs of emotional, behavioral or mental instability or related disorders. Services include outreach and education, screening/assessment, wellness plan development, case management including crisis management, linkage to appropriate services, short-term interventions, educational and life skills classes, support groups, and transportation support. HCA's current budget includes approximately $5 million for Outreach and Engagement services.

Orange County Center for Resiliency Education and Wellness

HCA recently implemented a new Orange County Center for Resiliency Education and Wellness. It serves persons age 14-25 experiencing the first onset of psychotic illness with duration of untreated psychosis of less than one year. Services include assessment, individual/family counseling, psychiatric services, educational family groups, health and wellness activities and educational and vocational support. Educational opportunities are also available to the greater community to learn more about psychosis, and how to improve the outcomes of young people who are affected by it. HCA's current budget includes about $3 million for the Orange County Center for Resiliency Education and Wellness.

APPENDIX E.

Santa Barbara County

Through Randal Hagar, the committee was introduced to a report from a group in Santa Barbara County that looked at the issues regarding drug and alcohol usage and mental illness among those incarcerated in their county. The following are excerpts from that report and the entire report is available on the web. (http://www.scribd.com/doc/89881761/Families-ACT-Report-In-Search-of-Solutions-to-Santa-Barbara-s-Revolving-Door-Final-Edit)

"Families ACT!" is a grassroots organization formed in 2007 by Santa Barbara families impacted by the injustice, lack of compassion and inefficient treatment of people with mental health and substance use disorders. In May of 2008, Families ACT! convened a "Santa Barbara Task Force on Co-Occurring Disorders" to address the need for alternatives to the costly "revolving door" for residents suffering with co-occurring mental health and substance use disorders. The task force published their recommendations in January 2012.

"California's recidivism rate of 67.5% is among the highest in the nation…the population cycles in and out of jail, prison, emergency rooms, shelters, sober living houses and our streets and is at great risk of dying of suicide, overdose or neglect. The goal of the Task Force was to foster much needed communication and collaboration between criminal justice and treatment providers, document the extent of the crisis and identify obstacles to and opportunities for, effective low-cost, high-impact solutions. De-institutionalization was well intentioned, but the failure to provide for the treatment needs of the patients has turned this policy into one of the greatest disasters of the twenty century."

The Santa Barbara Report identified several critical gaps in services to this subpopulation, including:

- adequate integrated mental health and substance abuse treatment
- case management and mentoring
- acute, transitional and long term residential treatment beds
- supportive housing
- meaningful volunteer or work opportunities.

Families ACT! proposed various policy reforms, including but not limited to:

- a radical reform of alcohol, drug and mental health treatment service delivery to "bring the department to the people it purports to serve",
- reallocate resources from middle management to direct services to ensure adequate mobile crisis response, acute hospitalization and street outreach to the homeless population affected by mental health disorders
- refocusing of Probation and AB-109 funds on rehabilitation programs in contrast to punitive supervision and incarceration
- redirection of funding from the District Attorney's office to holistic programs within the public defender's office

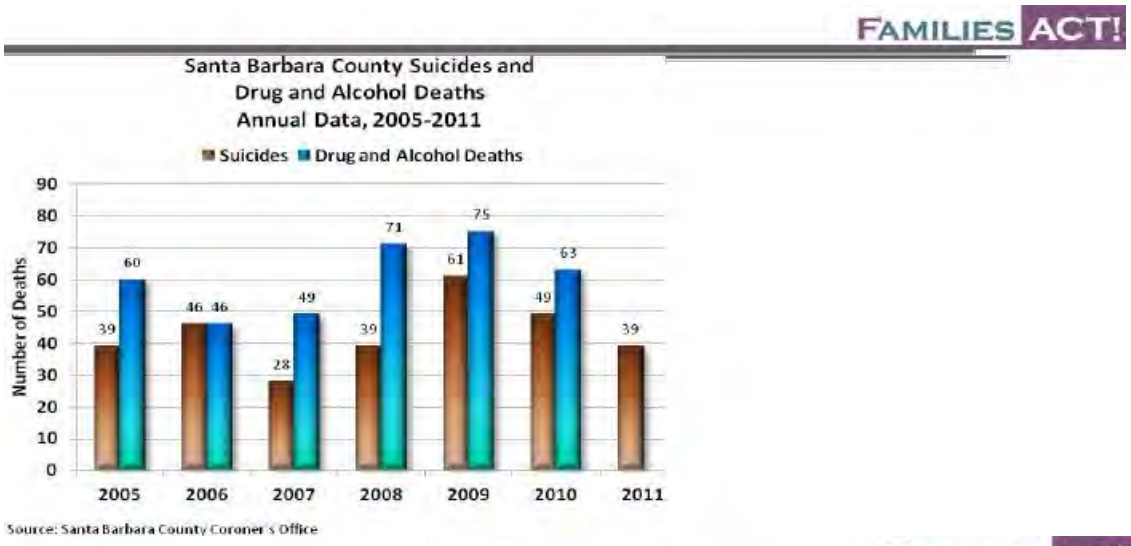
Effective solutions proposed include:

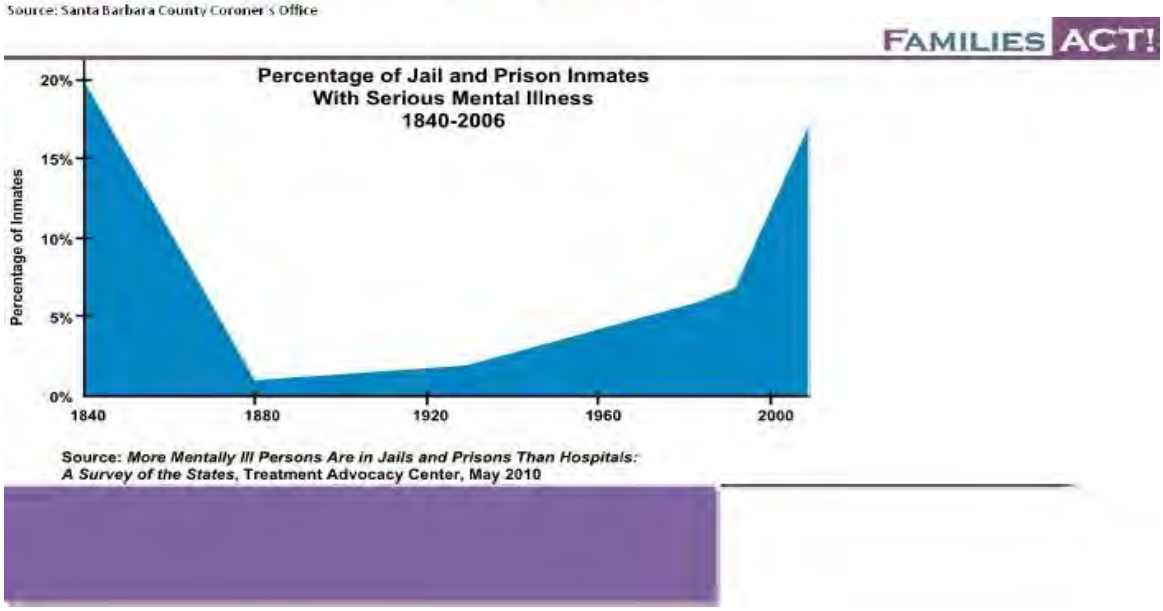
- A System-Integration/Ombudsman Office charged with streamlining a fragmented delivery system, improving intra- and inter-system communications, coordination and collaboration between service providers (including law enforcement and judicial systems)
- Expand Restorative Justice & Restorative Policing Programs
- A Cadre of Trained Volunteer Mentors, System Navigators, Paraprofessionals
- Engage the local business community

In the report these are words from the National Alliance on Mental Illness (NAMI): "Those who struggle both with serious mental illness and substance abuse face problems of enormous proportions. Mental health services tend not to be well prepared to deal with patients having both afflictions. Often only one of the two problems is identified. If both are recognized, the individual may bounce back and forth between services for mental illness and those for substance abuse, or they may be refused treatment by each of them. Fragmented and uncoordinated services create a service gap for persons with co-occurring disorders."

"The "No Wrong Door" philosophy in dual diagnosis treatment requires that each provider accept the responsibility to provide clients with, or link them to, appropriate services, regardless of where the client enters the system. It requires that relationships be built between providers and agencies to prevent clients from falling through the cracks between the jails, county mental health, detox centers, shelters, hospitals, etc. Mental Health Policy advocates warned a decade ago, that: states cannot be allowed to shirk their historic responsibilities to provide a safety net for indigent patients regardless of diagnosis. Their support is particularly needed for residential and rehabilitation services. Turning public care over to the managed care industry is not a solution; indeed, it simply exacerbates the problem."

Ideally, according to Kenneth Minkoff, "The expectation that persons with mental health disorders are struggling with drug and alcohol use must be included in every aspect of system planning, program design, clinical policy and procedure, and clinical competency, as well as incorporated in a welcoming manner in every clinical contact, to promote access to care and accurate screening and identification of individuals and families with multiple co-occurring issues." "Effective integrated treatment consists of the same health professionals, working in one setting, providing appropriate treatment for both mental health and substance abuse in a coordinated fashion. The caregivers see to it that interventions are bundled together, with no division between mental health and substance abuse assistance. The approach, philosophy and recommendations are seamless.""





APPENDIX F.

San Francisco

Over the course of fiscal year 2007-08, DPH Community Behavioral Health Services worked with Progress Foundation to establish the Dore Urgent Care Center (DUCC), which opened its doors in July 2008. The program is designed to assist SFGH Psychiatric Emergency Services (PES) and other hospital emergency services by accepting clients in psychiatric crisis who do not require hospitalization but who are overcrowding into PES for evaluation and assessment. The Dore Urgent Care Center provides a social rehabilitation model approach to crisis intervention as a helpful diversion from PES for individuals who do not require involuntary treatment, seclusion or restraint. Its goal is to improve patient care outcomes by providing services designed to meet the distinct needs of this population. The Dore Clinic is a medically staffed psychiatric crisis stabilization clinic that will be open 16 hours per day (7am – 11pm) seven days a week. DUCC also has a 14-bed short-term crisis residential treatment program capability, the Dore House, located on the same site, for clients who need continued support beyond the limited operating hours of the Dore Clinic.

After years of debate over how to deal with the city's large population of severely mentally ill people who refuse treatment, San Francisco officials have quietly implemented a version of the controversial Laura's Law.
The Department of Public Health treats 23,000 mental health patients each year. Reaching a few dozen of the worst cases could help reduce the cost for care and emergency services and improve the quality of life on the streets where residents and tourists alike often complain about mentally ill homeless people creating havoc, city leaders said.
City leaders have never adopted Laura's Law, but the Department of Public Health initiated a voluntary version of the law last year to treat a handful of people who were patients in the psychiatric ward of San Francisco General Hospital. The first set of results being evaluated now show promise, city officials said.
Laura's Law allows counties to compel outpatient treatment in extreme cases, but it does not require patients to take medication.

Under San Francisco's Community Independence Pilot Project, patients must voluntarily agree to participate once they're already hospitalized. If they do, they are assigned a public conservator who makes treatment decisions, including administering medication for the patient. Edwin Batongbacal, Director of the Health Department's Adult Behavioral Health Services Division, said San Francisco's version is cheaper and less bureaucratic, raises fewer legal questions, and could be just as successful as Laura's Law.

"It's more streamlined and friendlier to the clients," he said. "It's really about our ability to engage positively with clients rather than negatively through a court process where their rights are taken away. "Under Laura's Law, a concerned citizen like a family member or neighbor reports a mentally ill person to the county in hopes of compelling treatment. The mental health department then conducts an investigation, and patients qualify if they're severely mentally ill and have been repeatedly arrested or hospitalized because they refuse treatment.

A judge ultimately decides whether the people qualify, and the patients can argue against the decision in court. If the patients qualify, law enforcement officers have the authority to pick up the participants for hospitalization.
"There was concern that people with mental illness get help before anything bad happens, but there are a lot of complications with Laura's Law," Batongbacal said of San Francisco's decision to try an alternative approach.
So far, he said, doctors at S.F. General have referred eight patients to the program, but he had statistics only for the first six. Of those, one referral was withdrawn, one patient refused treatment, and four were admitted. Those four were found to have a serious mental disorder, multiple hospitalizations and a failure to comply with treatment. While in the program - which hooks them up with a host of social services that already exist in city government - there were no more hospitalizations. One person was incarcerated, but wants to participate when released. None is homeless; it's unclear whether they were homeless when they entered the program. No further details about the patients were provided.
Asked how severely mentally ill patients can make informed decisions about participating in the program, Batongbacal said, "We make sure they know what they're participating in. They're free to decide other things later down the road."
Laura's Law was enacted in California in 2002 and named for Laura Wilcox, a 19-year-old college student in Grass Valley who had been shot and killed by a man with untreated schizophrenia the year before. His family had known of his violent tendencies and tried to get him into treatment, but he had refused.

Under the law, each county's Board of Supervisors must pass a resolution authorizing participation. So far, only Nevada County, the site of Wilcox's killing, has fully opted in - doing so in 2008. The county has reported hospital days were reduced 61 percent among Laura's Law patients, and jail days were reduced 97 percent. The county estimates it has saved $1.81 for every $1 it has spent on the program. Whether to authorize the use of Laura's Law in San Francisco has long been a point of contention among city officials. Former Mayor Gavin Newsom supported adopting Laura's Law but wasn't able to get it by the Board of Supervisors .In 2010, then-Supervisor Michela Alioto-Pier wrote legislation to authorize Laura's Law, but didn't put it up for a vote after then-Public Health Chief Mitch Katz voiced his objections.

Chief Katz argued that the law was not very effective because it doesn't allow the county to compel medication. Proponents of the law say patients usually agree to prescribed medication once they are in the program.
San Francisco's voluntary pilot program doesn't need any particular authorization from the Board of Supervisors, and few City Hall insiders even know the program has been started. Barbara Garcia, the current public health chief, is supportive of the program. The program does have participation from several social service and criminal justice agencies within the city and is being overseen by San Francisco Superior Court Judge Mary Wiss.

Mayor Ed Lee said it's important for the city to give "sustained attention" to those individuals who are causing the most harm to themselves and others because of their mental illness. He said he wants to see the outcomes of the experiment before deciding whether to support the full-fledged adoption of Laura's Law. "It could be we don't adopt the whole thing," he said. "We just have to take a look at what's working."

APPENDIX G.

Acronyms

AACT Adult Assertive Community Treatment

AB 100 2011 Mental Health Services Act

AB 1421 WI&C Code for AOT or “Laura’s Law”

AB 1569 Extension of Laura’s Law

AB 2030 Integrated Services for Homeless Adults with a Mental Illness

ACCESS to Community Care & Effective Services and Support

ACT Assertive Community Treatment

ADA Americans with Disabilities Act

AOT Assisted Outpatient Treatment

ADS Alcohol and Drug Services

BHS Behavior Health Services

BOS Board of Supervisors

CalWORKS California Work Opportunity and Responsibilities to Kids

CALOMS California Outcomes Measurement Services

CASRA California Association of Social Rehabilitation Agencies

CDMH California Department of Mental Health

CiMH California Institute of Mental Health

CIT Crisis Intervention Team

CMHC Community Mental Health Centers

CNMHC California Network of Mental Health Clients

CPS Child Protective Services

CSS Community Services and Support MHSA Component

DHA Sacramento County Department of Human Assistance

DHHS Sacramento County Department of Health & Human Services

DBHS Sacramento County Department of Behavioral Health Services

DMH State Department of Mental Health

DSM-IV Diagnosis & Statistical Manual of Mental Disorders

EBT Evidence Based Practices

FQHC Federally Qualified Health Care

FSP Full Service Partnership

HIPAA Health Insurance Portability and Accountability Act

HRC Human Resource Consultants

HUD Housing and Redevelopment Agency

IDEA Individuals with Disabilities Education Act

IMD Institute of Mental Disease

INN Innovation Component of MHSA

ISA Integrated Service Agency

LOCUS Level of Care Utilization System

LPS Lanterman-Petris-Short Act

LRE Least Restrictive Environment

LCSW Licensed Clinical Social Worker

MDT Multi-Disciplinary Team

MERT Minor Emergency Response Team

MHANC Mental Health America of Northern California

MH Mental Health

MHB Mental Health Board

MHC Mental Health Court

MHRC Mental Health Rehabilitation Centers

MHSA Mental Health Services Act

MHTC Mental Health Treatment Center

MICA Mental Ill Chemical Abusers

MIOCR Mentally Ill Offender Crime Reduction

NAMI National Alliance on Mental Illness

NIMH National Institute of Mental Health

OAC Oversight and Accountability Commission

ODR “Opening Doors to Recover"

PACT People Achieving Change Together

PEI Prevention and Intervention component of MHSA

PHF Psychiatric Health Facility

PSH Permanent Supported Housing

RCRC River City Residential Club

RH Riese Hearings

RST Regional Support Team

SAMSHA Substance Abuse and Mental Health Services

SAPT Substance Abuse Prevention and Treatment

SMHC Sacramento Mental Health Court

SSI Social Security Income

SRO Single Room Occupancy

Technology Component of MHSA

T-Con Temporary Conservatorship

TLCS Transitional Living and Community Supports

TCORE Transitional Community Opportunities for Recovery and Engagement

VOA Volunteers of America

W & R C Wellness & Recovery Centers

WET Workforce Education & Training MHSA Component

WI&C Welfare & Institution Code

WORK Widening Opportunities for Rehabilitative and Knowledge

APPENDIX H.

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APPENDIX I.

History of Mental Health Treatment and Legislation in America

1842 Doctor Dorothea Dix discovered deplorable conditions and abuses suffered by people with mental disorders housed in Massachusetts' prisons and "apartments for idiots, and lunatic or insane persons not furiously mad." Dr. Dix spent the next forty years championing for better treatment of the mentally ill.

The Community Mental Health Centers Act

By the mid-1950s, over 500,000 Americans were housed in state run institutions. The average length of stay was measured in years. For the previous 100 years the focus was custody versus treatment. In the late 1950's President Eisenhower commissioned a study of these institutions, which found evidence of social and functional deterioration following long-term care and reinforced the notion that institutions actually caused chronic disorder.

After the "deadliest nightclub fire" in US history killed 492 people and injured many more (Coconut Grove), Dr. Erich Lindemann, a Boston Psychiatrist, studied survivors and relatives. He published "Symptomatology and Management of Acute Grief" and created the first Community Mental Health Center (CMHC) in 1948.

The first CMHCs were principally devoted to consultation and education for community agencies, but offered treatment to new groups of previously untreated, acutely ill, and emotionally troubled patients. Few persons with severe and chronic diseases were treated however.

In 1955 Congress passed the Mental Health Study Act to study the problems of mental illness.
The final report (1961 Action for Mental Health issued by the Joint Commission on Mental Health and Illness) main tenets: Immediate care be made available to mentally ill patients in community settings.
Fully staffed, full-time mental health clinics be accessible to all people living in the US.
Community based aftercare and rehabilitation services for mentally ill individuals be greatly expanded.

In 1961 John F Kennedy became president. He had personal family experience with mental illness. His sister, Rosemary had a lobotomy at age 23 and was confined to an institution until her death at age 86. President Kennedy addressed congress in 1963 outlining a bold new approach, which recommended: (1) A national mental health program to assist in the inauguration of a wholly new emphases and approach to the care of the mentally ill; (2) Focus on comprehensive community care; (3) A new type of health care facility, one which would return mental health care to the mainstream of American medicine and upgrade mental health services; (4) Authorize grants to states for the construction of comprehensive community mental health centers; (5) Authorize short term project grants for the initial staffing costs.

On October 31, 1963, The Mental Health Retardation Facilities and CMHC Construction Act was signed. This ended 109 years of federal noninvolvement in state services for the mentally ill. The CMHCs provided 5 essential services: (1) inpatient services, (2) outpatient services, (3) day treatment, (4) emergency services, and (5) consultation and education services. The premise was to ensure continuity of care between the services, be accessible to the general population and serve people regardless of their ability to pay.

Presidents Ford, Carter and Reagan Shift Responsibility for Social Services to the States

In 1975 President Gerald Ford vetoed the extension of the Community Mental Health Act. Congress overrode the veto, but passed amendments that added more requirements for the mental health centers. It did not appropriate the funds necessary to pay for the newly required services. After 1975 no new construction was attempted due to prohibitive costs, mostly because of inflation.

Most CMHCs were focused on primary and secondary prevention programs. Severely mentally ill persons, leaving state hospitals, did not receive follow-up services necessary to live in the community. Between 1955 and 1980 the population of state mental hospitals dropped from 558,000 to 140,000. Funds from the states that were supposed to follow patients from the hospital to the community did not provide sheltered housing and treatment. As a result poverty, homelessness and criminalization increased.

Community Support Systems were the NIMH's response to the unmet needs of the community mental institutions. By 1982 most states had received some sort of community support planning help for the CMHCs such as: case management, psychosocial rehabilitation, supported living, supported working and crisis care. There were also new evidence-based practices such as Assertive Community Treatment.

In 1977 a Presidential Commission, chaired by First Lady Rosalyn Carter, was created to reassess the CMHC program. The commission found persons with chronic mental illness who had been de-institutionalized, lacked the basic necessities of life, including adequate housing, clothing and food. Also half of the people released from large mental hospitals were being readmitted within a year of discharge. An effort to reinvigorate the CMHC program resulted in President Carter signing into law the National Mental Health Systems Act of 1980,one month before losing the election to Ronald Reagan.

During Reagan's "New Federalism" most of the responsibility for social programs returned to the states. The Omnibus Reconciliation Act of 1981 repealed the Mental Health Systems Act, eliminated all of the federal initiatives of the previous eighteen years, and all of the ten federal regional offices of NIMH. The Act withdrew direct federal grant support from CMHCs and replaced it with block grants from the states. It returned primary authority to states to decide how and to whom mental health services should be provided. CMHCs increased fees and reduced staffing and services. Waiting lists developed and the service quality was drastically decreased.

Medicaid and SSI

Medicaid was created in 1965 to provide health insurance for low-income parents, children, seniors, and people with disabilities. Supplemental Security Income was established in 1972 to provide welfare to those disabled due to mental illness. By the 1980s all CMHCs switched to Medicaid and away from block grant money.

In 1965 state and local psychiatric hospitals housed large numbers of persons with severe mental illness at (non-federal) public expense. The Congress made sure that the new Medicaid dollars were not supplanting this public effort with resources from state and local governments. Later, exemptions for children and the elderly were added by amendment. The exclusion for adults was upheld in a Supreme Court case. In the early 1980s, the 16-bed exemption was legislated as a response to the Court's decision. It made a moderate concession to the realities of deinstitutionalization, and restated opposition to financing warehousing in state hospitals.

Institutions for Mental Disease (IMDs) are inpatient facilities of more than 16 beds whose patient roster is more than 51% people with severe mental illness. Federal Medicaid matching payments are prohibited for IMDs with a population between the ages of 22 and 64. IMDs for persons under age 22 or over age 64 are permitted, at state option, to draw federal Medicaid matching funds.

Out of the Asylum into the Cell

CMCHs could not handle the huge number of patients who had been released after spending months or years in the large institutions. A Treatment Advocacy Briefing Paper, written in 2007, stated, "Nowhere in our society is the debacle of deinstitutionalization felt more than in our criminal justice system. America's jails and prisons are now surrogate psychiatric hospitals for thousands of individuals with the severest brain diseases. In 2008 10-16% of US inmates have serious psychiatric illnesses like schizophrenia, bipolar disorder and disabling depression."

Wyatt v. Stickney (M.D. ALA.1971; 5TH CIR. 1974)

The precipitating factor in the Wyatt case was a cut in Alabama's cigarette tax. As a result of the budget shortfall, over 100 employees at Bryce Hospital in Tuscaloosa, Alabama lost their jobs. The Department of Psychology at Bryce spearheaded the suit for reinstatement brought by those laid off. For tactical reasons it added a patient, Ricky Wyatt, the nephew of one of the laid-off employees. Adding the patient enabled the suit to allege that patients' treatment suffered as a result of the layoffs. Federal District Judge Frank M. Johnson dismissed the part of the suit brought by the professionals, holding that the Alabama Department of Mental Health had the right to lay off employees, but consented to hear the part of the suit dealing with the patients' grievances.

Judge Johnson ruled that a patient "unquestionably has a constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition", and that the programs at the hospital "failed to conform to any known minimums established for providing treatment for the mentally ill." He ruled that the due process of the Constitution was violated: "To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to deprive adequate treatment violates the very fundamentals of due process."

Wyatt was the seminal case in achieving drastic deinstitutionalization of previously committed patients. Following Judge Johnson's decision, there was similar litigation in a number of states. Rather than face costly court-imposed standards, some of them impossible to meet, states rapidly emptied their hospitals. Although in 1975, in the Donaldson Case, the Supreme Court would refuse to endorse the existence of a constitutional "right to treatment." States were not prepared to run the risk of expensive court-ordered overhauls of state mental hospitals.

Lessard v. Schmidt (E.D.WIS. 972; Vacated & Remanded 1974-421 U.S. 957, 1975; Reinstated 1976).

This legislation transformed mental health law. A federal district court in Milwaukee struck down Wisconsin's commitment law as unconstitutional. Setting aside traditional *parens-patriae* grounds for commitment, the three-judge court set a narrow dangerousness standard. Involuntary commitment was only permissible when "there is an extreme likelihood that if the person is not confined he will do immediate harm to himself or others." Moreover, the court for the first time required that commitment proceedings provide the mentally ill with all the protections accorded the criminal suspect—among them a right to counsel, a right to remain silent, exclusion of hearsay evidence and a standard of proof beyond a reasonable doubt.

In their decision, the judges acknowledge, but dismiss, the traditional argument that due process safeguards in commitment hearings can be less stringent than in criminal cases. The state is acting in a role of *parens-patriae*, with the aim of treating rather than punishing the individual. On the contrary, the judges maintain, "the interests in avoiding civil commitment are at least as high as those of persons accused of criminal offenses." They declare that the civil deprivations, faced by the mental patient, are more serious than those confronting the felon. The stigma is worse, and the mortality rates in mental hospitals are higher.

The decision was appealed, and was twice vacated and remanded by the U.S. Supreme Court. In each case the District Court substantially reinstated its earlier decision.

Lessard turned out to be the high water mark for involuntary commitment law. Most states stopped short of implementing all the restrictions demanded by the Lessard court. Few states would follow Wisconsin in according patients the "right to remain silent," or in imposing a "beyond a reasonable doubt" standard for commitment.

The psychiatric interview was regarded as too important a piece of evidence The decision veered between assuming mental illness was untreatable to arguing that commitment for treatment seriously damaged the individual, and in most cases he was better off foregoing treatment than being hospitalized for it.

O'Connor v. Donaldson, 422 U.S. 563 (1975)

This decision has been used by opponents of involuntary commitment to argue that it is unconstitutional to commit an individual involuntarily who is not imminently dangerous to himself or others.

A key paragraph in the decision reads: "A finding of mental illness alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement. In short a state cannot constitutionally confine without more a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."

The mental health bar, spearheaded by the ACLU, has interpreted this decision to mean that it is unconstitutional to commit for treatment an individual who is not imminently dangerous. It has maintained the individual must be considered "capable of surviving safely in freedom" if his life is not in immediate danger. This interpretation has been important in hampering efforts to implement changes in civil commitment law.

The Supreme Court ruled that an individual, who is "capable of surviving safely in freedom" by himself or with the help of others, could not be confined. Donaldson was fully capable of living independently, had people who were willing to support him, if necessary, and posed no danger to himself or others.

According to the Treatment Advocacy Center: "When it ruled by 'surviving safely in freedom', the Supreme Court did not have in mind rummaging in garbage cans for food or lying in the street in one's own waste. Nowhere in this decision did it say that the individual must be permitted to deteriorate to the point he is dangerous."

Tarasoff v Regents of the Univ. of California

The Supreme Court of California held that mental health professionals have a duty to protect individuals who are being threatened with bodily harm by a patient. The original 1974 decision mandated warning the threatened individual, but a 1976 rehearing of the case by the California Supreme Court called for a "duty to protect" the intended victim. The professional may discharge the duty in several ways, including notifying police, warning the intended victim, and/or taking other reasonable steps to protect the threatened individual.

Rennie v. Klein (DNJ 1978; On Remand, 720 F 2d 266-3D Cir. 1983)

This case, the first to establish an involuntary committed patient's right to refuse medication, was brought in December 1977 by 38-year-old John Rennie, a patient at Ancora State Hospital in New Jersey. His first hospitalization occurred in 1973; in the following years he became a revolving-door patient, with one of the reasons, trial judge Stanley Brotman noted, "his failure to continue taking medications after he has left the hospital's custody."

Federal District Judge Brotman dismissed the argument of Rennie's counsel that forced medication violated the first amendment by interfering with his mental process, and the Eighth Amendment constituting cruel and unusual punishment. However, he ruled that the right to refuse treatment can be based on "an emerging right of privacy" broad enough to include the "right to protect one's mental processes from government interference." Judge Brotman asserted that the uncertainty of a psychiatric diagnoses gave weight toward "leaving the final decision with the patient rather than deferring to doctors." "Whether the potential benefits are worth the risks is a uniquely personal decision which, in the absence of a strong state interest, should be free from state coercion."

Nevertheless, said Judge Brotman, the right to refuse was not absolute. Other patients in the hospital had a right to protection from harm from an assaultive patient like Rennie. The states' *parens patriae* powers also come into play, but only to the extent a fact finder determined that the patient's refusal was based on the underlying interest. The more the patient lacked insight the greater the impetus to override his right to autonomy.

In his decision, Judge Brotman stipulated that a refusing patient was entitled to a due process hearing, conducted by an independent psychiatrist. Judge Brotman also asserted the principle of the least restrictive alternative should be extended to medication; and that hearing officers should insist that the least restrictive medications should be tried prior to more intrusive medications.

Prior to be given medication, patients would have to sign consent forms that explained their side effects. Hospitals had to employ patient advocates who would act as 'informal counsel' to patients wishing to refuse treatment in hearings before independent psychiatrists. Judge Brotman established a category of "functionally incompetent" patients—patients who were not legally incompetent but could be certified by their physician as "unable to provide knowledgeable consent to treatment."

Rennie v. Klein established that an involuntarily committed, legally competent patient who refused medication had a right to professional medical review of the treating psychiatrist's decision. In contrast to the Roger's case, which provided for judicial review, Rennie left the decision-making process to medical professionals. According to the Treatment Advocacy Center, "Unfortunately, despite the Supreme Court's backing for the professional judgment standard, it is not the Rennie, but the Roger's model, which shifts psychiatric decision-making from the medical to the legal profession, that has become prevalent."

Judge Brotman's decision did establish a category of "functionally incompetent" patients. These were patients not found to be incompetent by the courts but whom the psychiatrist determined were unable to make their own treatment decisions because of lack of insight into their illness. This is precisely the situation of a great many psychiatric patients today.

Guardianship of Richard Roe III (421 N.E. Rep. 2D 40)

Massachusetts' highest court, the Supreme Judicial Court, ruled that what happens when a mentally ill individual, who is incompetent to make his own treatment decisions, refuses treatment, only a court can decide if he is to be treated. Further, it must do so on the basis of substituted judgment, i.e. what the individual would choose, given what is known of his values and preferences, if he were competent.

The Court found the evidence that Richard Roe was incompetent "more than adequate" and said Richard's judgment was so severely impaired there was a strong likelihood he would inflict serious injury on himself or others. The judges concluded he needed a guardian and his father was the appropriate choice. However his father could not make treatment decisions. The Court ruled that only a judge could conduct the "detached but passionate investigation" necessary to decide if Richard should take medication.

The Court's opinion was highly critical of anti-psychotic drugs, describing them as extraordinary medical treatment, "powerful enough to immobilize mind and body." It said "the impact of the chemicals upon the brain is sufficient to undermine the foundations of personality." The opinion also dwelt at length upon side effects: "Although the intended effects of antipsychotic drugs are extreme, their unintended effects are frequently devastating and often irreversible."

The case assumed broader significance. This was because, after the Massachusetts Supreme Judicial Court issued its opinion, the U.S. Supreme Court remanded the long running, multi-million dollar, federal Rogers case, which involved the right to refuse treatment of civilly committed hospitalized patients. What started out as a minor case – could Richard Roe's guardian decide on his treatment – became the basis for requiring that, except in emergency situations, judicial hearings must be held before a non-consenting hospitalized mental patient can be treated, with the decision to be made on the basis of "substituted judgment."

Rogers v. Okin (478 f.Supp.1342-D.Mass.1979, 634 F.2D 650-1st Cir. 1980);(Mills v. Rogers 457 U.S. 291-1982).

At the trial level Judge Touro ruled under Massachusetts law, committed mental patients were presumed to be competent to manage their own affairs. The judge stated, "Such rights pale in comparison to the intimate decision as to whether to accept or refuse psychotropic medication." He asserted that in a non-emergency "it is an unreasonable invasion of privacy, and an affront to basic concepts of human dignity to permit the forced injection of mind altering drugs…" Although the state had a duty to make treatment available to mental patients, it had no duty to impose it on "the competent involuntary patient who prefers to refuse medication, regardless of its potential benefit."

In his opinion Judge Touro took note of the defendant psychiatrist's argument. It was the state's *parens patriae* obligation to provide treatment for patients who had been committed for the purpose of treatment, even in the face of their opposition to it. He dismissed the argument on the grounds that "the State's interest in protecting the safety of the general public is the justification for commitment of mental patients." Involuntary treatment, Judge Touro ruled, "is not necessary to protect the general public, since the patient has already been quarantined by commitment." The committed mental patient, said Judge Touro, had the right to make treatment decisions until he was adjudicated incompetent by a judge. At this point, he noted, the *parens patriae* right of the state could be exercised and a guardian appointed by the court to make decisions, including treatment decisions, for the patient.

The Supreme Court granted certiorari but then remanded the case back to the court of appeals in the light of Roe. That decision required that a court, not a guardian, as in judge Touro's decision, should decide whether an incompetent patient should be treated, based on "substituted judgment. Moreover, the substituted judgment decision required a full evidentiary hearing, with counsel for both sides, independent examiners and expert witnesses, if requested.

Civil Rights of Institutionalized Persons Act (CRIPA)

CRIPA was passed in 1980 to protect the rights of people in state and locally run nursing homes, mental health facilities, institutions for people with intellectual and developmental disabilities, and correctional facilities for youth and adults.

The Special Litigation Section in the U.S. Department of Justice's Civil Rights Division is responsible for investigating and enforcing CRIPA.

In August of 1996, pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 et seq., the United States Department of Justice (DOJ) toured the Los Angeles County Jail with experts in the field of correctional mental health services. On September 5, 1997, DOJ issued a letter reporting its findings based on the tour of its experts, the County's response to the tour, and the additional information received. DOJ concluded that mental health care at the Jail violated the inmates' constitutional rights.

In its findings letter, DOJ detailed numerous alleged constitutional deficiencies with regard to mental health care, including inadequate (1) intake screening and evaluation, (2) diagnosis, (3) referral to mental health professionals, (4) treatment plans, (5) administration of medications, (6) suicide prevention, (7) tracking and medical record keeping, (8)staffing, (9) communication, and (10) quality assurance. The report also noted that the County had allegedly mistreated and abused mentally ill inmates, including using excessive force and improper restraint practices.

In 1990, Congress enacted the Americans with Disabilities Act "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." In passing this groundbreaking law, Congress recognized that "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem." For those reasons, Congress prohibited discrimination against individuals with disabilities by public entities: "No qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."

As directed by Congress, the Attorney General issued regulations implementing Title II, which are based on regulations issued under section 504 of the Rehabilitation Act. The Title II regulations require public entities to "administer services,

programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." The preamble discussion of the integration regulation explains that "the most integrated setting" is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." (See Olmstead v. LC.)

1985 The Bronzan-Mojonnier Act

This enacted significant provisions relating to: (1) identifying the shortage of services, which resulted in the criminalization of the mentally disordered, (2) community support for homeless mentally disordered persons, (3) vocational services, and (4) seriously emotionally disturbed children.

The Wright-McCorquodale-Bronzan Mental Health Act

The act funded pilot projects that combine treatment and rehabilitation and provides integrated, flexible and 24/7 services.

Riese v. St. Mary's Hospital & Medical Center (259 Cal Rptr. 669, 774 P.2D 698, 1969)

In 1987 the California State Court of Appeals overruled the traditional interpretation of California's Lanterman-Petris-Short Act of 1968. It had been assumed that the Act permitted involuntary treatment for those detained under an initial three-day hold, for evaluation and treatment, and subsequent 14-day hospitalization. The Court of Appeals found that these patients had the right to exercise informed consent to the use of antipsychotic drugs. Should they reject medication, "a judicial determination of their incapacity to make treatment decisions" was necessary before they could be involuntarily treated.

The trial court upheld the traditional interpretation of LPS and ruled that there was no right to refuse medication. But the Court of Appeals reversed its decision. It was appealed to the California Supreme Court, which refused to hear it, allowing the Court of Appeals decision to stand.

The Court of Appeals dismissed the argument of the defendant hospital – that just because LPS did not explicitly grant a right to refuse antipsychotic medication, such a right did not exist. The judges zeroed in on the issue of presumed competence of mental patients. Mental patients were presumed competent unless found incompetent by a court. In their decision they quoted a section of the LPS Act: "No person may be presumed to be incompetent because he or she has been evaluated or treated for mental disorder…regardless of whether such evaluation or treatment was voluntarily or involuntarily received." Moreover, said the court, since treatment with antipsychotic drugs "has profound effects on mind and body," the right to refuse treatment with these drugs "clearly falls within the recognized right to refuse medical treatment." That right had been established in California in 1972, four years after the passage of the LPS Act. In Cobbs v. Grant, the California Supreme Court declared the right to informed consent to medical treatment was a constitutional right, which could only be denied if the patient was incompetent. In that case the patient's "authority to consent is transferred to a guardian or the closest available relative."

In passing the then revolutionary LPS Act in 1968, the legislature had attempted to strike a balance. The commitment period would be brief, no more than seventeen days except in highly circumscribed special circumstances. Psychiatrists would be allowed to treat the patient in that time span. Indeed, LPS specified that a person detained for evaluation and treatment "shall receive whatever treatment and care as his or her condition requires for the full period that he or she is held." (See the LPS Act elsewhere in this report).

According to the Treatment Advocacy Center, "In practice, grafting the right to refuse on the LPS time limit has meant that it becomes very difficult to treat refusing patients at all. It generally takes five days to get a Riese hearing so that almost a third of the time is wasted right there. California psychiatrist Barbara Silver describes a series of results of the Riese decision similar to what has occurred in other states where there is a right to refuse treatment. There is increased use of seclusion and restraints, warehousing of patients, inappropriate release of patients to avoid the cumbersome and time-consuming hearings, injury to other patients and staff plus patient deterioration."

1995 Coleman v. Wilson

Thousands of people with mental illness are currently serving terms in California state prisons. These individuals receive inadequate medical and psychiatric care, serve longer terms than the average inmate, and are released without adequate preparation and support for their return to society. As a result, mentally ill offenders are more likely than general-population offenders to violate parole and return to prison. The poor treatment of California's mentally ill prisoners burdens the judicial system, drains the state's budget, and causes needless inmate suffering.

California treats more of the mentally ill inside prison than out. Prisons and jails treat more people with mental illness than hospitals and residential treatment centers combined. Ten-and-a-half percent of California state prisoners—

approximately 17,000—are treated with psychotropic medications, while 12.5% receive in-custody therapy from a trained professional on a regular basis. Mentally ill prisoners find themselves in a vicious circle. Mental illness leads to discipline/victimization problems, solitary confinement, and to decompensation. This worsens mental illness, resulting in further discipline/victimization and further segregation. Mentally ill prisoners get sicker, stay longer, suffer more, and wind up back in prison soon after their release.

These failures have long been apparent. In 1995, the federal district court in Coleman v. Wilson held the treatment of the mentally ill in the California corrections' system so inadequate that it violated the Eighth Amendment's prohibition on cruel and unusual punishment. The Coleman court found that the following deficiencies violated the Eighth Amendment of the U.S. Constitution: (1) the lack of any screening mechanism for mental illness; (2) inadequate mental health staffing levels; (3) the lack of quality assurance mechanisms for evaluating mental health staff; (4) delays and denials of medical attention; (5) inappropriate use of punitive measures; and (6) an "extremely deficient" records system. Judge Thelton Henderson of the Northern District of California placed the entire prison health care system into receivership in October 2005. He described the system as "broken beyond repair" and stated that the California Department of Corrections and Rehabilitation (CDCR) was "incapable of successfully implementing systemic change."

California's mental health screening process, developed in response to the Coleman lawsuit, is inadequate, notwithstanding court orders to improve it. The current screen is designed to give mentally ill prisoners a "red flag" during intake interviews; a more detailed psychiatric screening no more than seventy-two hours later; and a full psychiatric evaluation within eighteen days. In 2005, however, the Plata court found that "the reception center intake process fails to adequately identify and treat the health care problems of new prisoners." An adequate screen should take at least fifteen minutes to administer. However, prisoners' exams in CDCR reception centers typically last no more than seven minutes. Inmates are often screened in groups without regard to confidentiality so that the examinations are therefore unlikely to be accurate. Screens should also incorporate objective factors as well as self-reporting, since inmates with acute mental illness are often unable to communicate their symptoms and/or diagnoses. Screens must also account for co-occurring disorders—that is, mental illness as well as substance abuse. Co-occurring disorders present particular problems in penal mental health screening because symptoms of mental illness can be masked by or misdiagnosed as the result of drug or alcohol abuse. Screening for drug abuse alongside mental illness is crucial in the penal context; however, a state study estimated that chemical reactions in the brain cause seventy percent of California prisoners' major mental disorders, the primary cause of which is use of mind-altering drugs.

Zinermon v. Burch (494 U.S. 113 (1990)

In 1981 Darrell Burch was admitted to a Florida State Mental hospital and stayed for five months. Shortly after his release, Burch filed a complaint, stating that he had been inappropriately committed, and did not remember signing any admission or treatment forms. In February, 1985, Burch filed a Section 1983 lawsuit in federal district court arguing that his constitutional rights had been violated when he was treated as a voluntary patient. Because of evidence that his mental condition made him incapable of giving voluntary consent, he was entitled to the procedural safeguards of the involuntary placement procedure.

A divided Supreme Court (5-4) ruled that Burch was entitled to bring the suit. Writing for the majority, Judge Blackmun noted that Florida's law explicitly requires the patient to give "express and informed consent, and that the very nature of mental illness makes it foreseeable that a person needing mental health care will be unable to understand any proffered explanation and disclosure of the subject matter of the forms that person is asked to sign. He will be unable to make a knowing and willful decision whether to consent to admission." Yet, wrote Judge Blachmun, Florida statutes "do not direct any member of the facility staff to determine whether a patient is competent to give consent…"

The Court suggested that regardless of whether or not a state had a law with language similar to that in Florida, the admitting facility might need to examine the patient's competence to consent.

According to the Treatment Advocacy Center, the Court's opinion for the majority undercuts the voluntary treatment system, which has increasingly characterized care for the mentally ill. "In the early 1960s the vast majority of patients were hospitalized involuntarily. Today, as a result of what have generally been viewed as desirable reforms, 73% of the 1.6 million annual admissions are voluntary, yet little research has been done on the capacities of these patients to make their own treatment decisions. That would mean 800,000 patients who would have to go through, in the words of the Supreme Court decision, the 'established procedure for involuntary placement,' overwhelming that system. Moreover, many current voluntary patients might not be eligible for involuntary commitment, failing to meet the dangerousness standard."

Concerned about the potential impact of the decision, the American Psychiatric Association established a task force to come up with a policy for complying with the Zinermon decision, without disrupting the present largely voluntary system of care. Its conclusions were approved by the APA's Board of Trustees in 1992. The task force recommended a brief in-

hospital clinical assessment of capacity, based on easy-to-meet substantive standards. The patient need only understand that he was being admitted to a psychiatric hospital.

Again the Treatment Advocacy Center notes: “What the Zinermon decision demonstrates is the need to end the dichotomy between the standard for voluntary and involuntary treatment. Currently, in many states, voluntary patients can be treated because they need treatment, involuntary patients only because they are dangerous. The suit really points up the absurdity of the law in failing to provide a common need for treatment standard applicable to the mentally ill regardless of their mode of hospital admission.”

1991 California Realignment

In 1991, the state faced a multibillion-dollar budget problem. Initially, responding to Governor Wilson’s proposal to transfer authority over some mental health and health programs to counties, the Legislature considered a number of options to simultaneously reduce the state’s budget shortfall and improve the workings of state-county programs. Ultimately, the Legislature developed a package of realignment legislation that: (1) Transferred several programs from the state to the counties, most significantly certain health and mental health programs; (2) Changed the way state and county costs are shared for social services and health programs; (3) Increased the sales tax and vehicle license fee (VLF) and dedicated these increased revenues for the increased financial obligations of counties.

In order to fund the more than $2 billion in program transfers and shifts in cost-sharing ratios, the Legislature enacted two tax increases in 1991, with the increased revenues deposited into a state Local Revenue Fund and dedicated to funding the realigned programs. Each county created three program accounts, one each for mental health, social services, and health. Through a complicated series of accounts and subaccounts at the state level, counties receive deposits into their three accounts for spending on programs in the respective policy areas.

Before the enactment of realignment, state funding for local mental health services was subject to annual legislative appropriation, which could vary significantly from year to year depending upon the state’s financial condition. 90 percent of so-called Short-Doyle grant funding for mental health programs generally came from the state, with the remaining 10 percent funded by the counties. Local mental health services were particularly vulnerable to reductions when the state was faced with financial shortfalls. In 1990-91, for example, state expenditures for community mental health programs declined by about $54 million or 8.6 percent below the prior year’s spending level. At the time that realignment legislation was considered, mental health program experts had voiced concern that the uncertainty created by the annual state appropriations process was harmful to the development of sound community programs. The significant year-to-year swings in funding levels and uncertainty in the state budget process were also said to have discouraged county government officials from making the multiyear commitments needed to develop innovative programs. Before a pioneering new program could be staffed, made operational, and fully developed over several years, a county mental health department was at risk of having to scale back the commitment of funding and personnel for such efforts. The intent of realignment was to provide mental health programs stable and reliable funding through a dedicated revenue source in order to foster better planning and innovation.

Mentally Ill Offender Crime Reduction Grant Programs.

In 1998, the California Legislature authorized the Mentally Ill Offender Crime Reduction Grant (MIOCRG) program to fund innovative local programs targeting mentally ill offenders. MIOCRG currently provides 80 million dollars to thirty projects in twenty-six of California’s fifty-eight counties. To set the program’s priorities, county service providers and law enforcement officials were asked what their needs were in dealing with mentally ill offenders; their responses included (1) better prison discharge planning, (2) more housing options, (3) increased treatment capacity, and (4) interagency coordination. The MIOCRG programs are funded with these priorities in mind. Though the funding is disbursed at the state level, all MIOCRG programs are administered at the county level. This allows counties to tailor programs to their needs without engendering resource differentials between counties. Because mental health services are provided through counties, local administration allows community stakeholders a greater opportunity to coordinate care. Two-thirds of county programs draw on the Assertive Community Treatment model, employing a multidisciplinary group of providers that service clients as a team, with availability around the clock. A study aggregating data from the programs showed positive results. Participants scored higher on the improved Global Assessment of Functioning (GAF) and lowered rates of criminal bookings, convictions, drug and alcohol usage, and homelessness. The strategies common to the most successful programs were interagency collaboration, intensive case management, assistance in securing housing and government benefits, use of a center or clinic, assistance with transportation, and peer support for participants.

AB 1800

Written by Assemblywoman Helen Thompson & modeled after Kendra's Law, this was the first viable attempt to update LPS in California. The bill's major points were:
(1) Broadened the definition of "gravely disabled" for the purpose of involuntary detention and conservatorship to include a person who "presents, as a result of mental disorder, an acute risk of physical or psychiatric harm to the person in the absence of treatment." It also applied this expanded definition to the procedures for the involuntary administration of psychotropic medication to prisoners; (2) It placed new conditions on family members or other third parties whose assistance might prevent an individual from being determined "gravely disabled," by requiring such third parties to show they are "willing and able to assist the person in meeting his or her medical and psychiatric needs," in addition to helping provide for the person's needs for food, clothing or shelter; (3) It doubled the length of involuntary certifications (detentions), following an initial 72-hour hold, from 14 to 28 days; (4) It replaced the existing probable cause standard required for involuntary detentions, which currently requires a finding that a person is a danger to himself or herself, or to others, or is "gravely disabled," with a less restrictive "there is probable cause to believe the person certified should be involuntarily detained" standard; (5) It provided that, if a person certified for treatment refuses treatment with psychotropic medication, the certification review hearing officer shall, in addition to making the decision regarding the underlying detention, determine in the same hearing whether the person lacks the capacity to make an informed refusal of the treatment; (6) It eliminated the requirement that capacity hearings be conducted solely by a judge or court-appointed commissioners, referees, or hearing officers. Instead, the bill allowed such hearings, including the new combined detention and capacity hearings described above, to be conducted by lawyers and law students, as well as a variety of lay hearing officers, including medical doctors, licensed psychologists, registered nurses, licensed clinical social workers, and licensed marriage, family and child counselors; (7) It provided that a person subject to the expanded 28-day certification who is also determined to lack the capacity to make an informed refusal of psychotropic medication at the combined hearing may obtain a *de-novo* review of both decisions in court via a writ of habeas corpus. Current law provides for separate *de-novo* review of the detention and capacity determinations; (8) It required that a facility providing treatment to an individual subject to the expanded 28-day certification must obtain his or her medication history. Current law does not contain this requirement; (9) It doubled the length of post-certification commitments for persons who are dangerous to others from 180 days to one year; (10) It sought to assist at-risk persons by providing that individuals subject to 72-hour holds, 28-day certifications, and additional involuntary certifications, must be placed in "community assisted outpatient treatment programs" for 180 days if several conditions exist; (11) It provided that, in the event the patient does not or cannot abide by the terms of the agreed upon community treatment plan, and the person poses an acute risk of physical or psychiatric deterioration, the person may, by court order, be returned to inpatient treatment for the remaining days of the underlying involuntary treatment certification, (12) It permitted, but did not require, a county to offer a community-assisted outpatient treatment program to persons in the community who are diagnosed with a severe and persistent mental illness; (13) It required the Department of Mental Health (DMH) to provide training and technical assistance to counties and their mental health contract providers, and others involved in making involuntary commitment and treatment decisions. It also requires the department to collect certain data and report to the Legislature, on or before April 1, 2002, on the effectiveness of this legislation.

Olmstead v. L.C., 527 U.S. 581 (1999)

In the Olmstead decision the Supreme Court held that Title II prohibits the unjustified segregation of individuals with disabilities. The Supreme Court held that public entities are required to provide community-based services to persons with disabilities when (a) such services are appropriate; (b) the affected persons do not oppose community-based treatment; and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of others who are receiving disability services from the entity. The Supreme Court explained that this holding "reflects two evident judgments." First, "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." Second, "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."

To comply with the ADA's integration mandate, public entities must reasonably modify their policies, procedures or practices when necessary to avoid discrimination. The obligation to make reasonable modifications may be excused only where the public entity demonstrates that the requested modifications would "fundamentally alter" its service system.

An Olmstead Plan is a public entity's plan for implementing its obligation to provide individuals with disabilities opportunities to live, work, and be served in integrated settings. A comprehensive, effectively working plan must do more than provide vague assurances of future integrated options or describe the entity's general history of increased funding for community services and decreased institutional populations. Instead, it must reflect an analysis of the extent to which the public entity is providing services in the most integrated setting and must contain concrete and

reliable commitments to expand integrated opportunities. The plan must have specific and reasonable time frames and measurable goals for which the public entity may be held accountable, and there must be funding to support the plan, which may come from reallocating existing service dollars. The plan should include commitments for each group of persons who are unnecessarily segregated, such as individuals residing in facilities for individuals with developmental disabilities, psychiatric hospitals, nursing homes and board and care homes, or individuals spending their days in sheltered workshops or segregated day programs. To be effective, the plan must have demonstrated success in actually moving individuals to integrated settings in accordance with the plan. A public entity cannot rely on its Olmstead Plan as part of its defense unless it can prove that its plan comprehensively and effectively addresses the needless segregation of the group at issue in the case. Any plan should be evaluated in light of the length of time that has passed since the Supreme Court's decision in Olmstead, including a fact-specific inquiry into what the public entity could have accomplished in the past and what it could accomplish in the future.

Mental Health Parity Law

In 1999, California passed a mental health parity law (AB 88) requiring private health insurance plans to provide equal coverage for physical health and selected mental health conditions, including serious mental illnesses (SMI) in adults and serious emotional disturbances (SED) in children. The law requires health plans to eliminate the benefit limits and reduce the cost-sharing requirements that have traditionally made mental health benefits less comprehensive than physical health benefits.

AB 2034

In 1999 the State Legislature passed Assembly Bill, AB 34, which provided $10 million for pilot programs to provide services for homeless individuals in Stanislaus, Los Angeles, and Sacramento counties. Future funding for similar programs was dependent on the success of the three pilot programs as measured by positive client and system outcomes including cost effectiveness within that first year. The pilot programs were very successful in reducing the number of homeless days, jail days, and psychiatric hospital days experienced by enrollees. As a result of this success the legislature passed AB 2034, which expanded the pilot programs and created additional programs statewide directed at serving homeless persons, parolees, and probationers with serious mental illness. At the height of the program, AB 2034 funds were serving over 4,500 mentally ill homeless or incarcerated individuals (AB34.org) through 53 programs operating in 34 counties throughout California.

AB 2034 funds allowed localities to provide comprehensive services "to adults who have serious mental illness and who are homeless, at risk of becoming homeless, recently released from a county jail or state prison, or others who are untreated, unstable, and at significant risk of incarceration or homelessness unless treatment is provided to them." (Leg. Report 2). Due to the flexibility of funding provided under AB 2034, counties were able "to provide a comprehensive array of services including outreach, supportive housing and other housing assistance, employment, substance abuse, and mental and physical healthcare" to enrollees.

The AB 2034 programs were very effective at serving a variety of consumer needs. The success of these programs can be seen by comparing pre-enrollment information to post-enrollment information (data current as of January 31, 2003). There was marked improvement in several categories including hospitalizations, incarcerations, levels of homelessness, income, and employment. For example:

- Number of consumers hospitalized decreased 42.3%
- Number of hospital admissions decreased 28.4%
- Number of hospital days decreased 55.8%
- Number of consumers incarcerated decreased 58.3%
- Number of incarcerations decreased 45.9%
- Number of incarceration days decreased 72.1%
- The number of SSI recipients increased by 93.1%
- The number of people receiving wages from employment increased by 279.8%
- There was a 73.5% reduction in the number of consumers who were homeless
- The number of consumers who became homeless since enrollment compared to the number of consumers who were homeless prior to enrollment decreased 71.3%
- The overall number of homeless days experienced by consumers decreased by 67.3%
- There was a 19.6% increase in the number of consumers who were employed full time with a 65.4% increase in the number of days of employment
- There was a 14.4% increase in the number of consumers who were employed part-time, with a 53.1% increase in the number of days of employment
- As of January 31, 2003, 13.3% of all consumers enrolled in the program were employed

2000 Plata vs Schwarzenegger

The Court found that the California Department of Corrections and Rehabilitation (CDCR) “lacks an adequate system to manage and supervise medical care.” There is “a culture of non-accountability and non-professionalism” in the Health Care Services Division (HCSD); in September 2004, the HCSD was ordered to implement quality management of physicians but “failed to come close” to doing so. Also, corrections officers currently play too large a role in determining treatment for mentally ill prisoners, making medical decisions based primarily on security considerations. According to Dr. Michael Friedman, director of medical care at Soledad Prison, “the system, in my view, is totally corrupted” because “nonmedical staff are making medical decisions, because everything is about security, not how we look after the inmates.” Because corrections officers have daily contact with inmates, they could provide timely referrals for mental health treatment; however, COs fear that prisoners are just faking their symptoms (“malingering”) means that referrals often are not made until prisoners are grossly psychotic.

US v. State of California (State Hospitals)

On May 13, 2003, the U.S. Department of Justice’s Civil Rights Division (DOJ) sent its findings letter to California’s governor, advising him of the results of one component of the June and July 2002, DOJ investigation of conditions and practices at the Metropolitan State Hospital (MSH), a state facility housing children, adolescents, and adults who suffered from mental illness. The letter set out the DOJ’s findings concerning MSH’s child and adolescent residents. Findings regarding the adult patient component of MSH had not been completed. The investigation occurred under the authority of the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997. According to the letter, DOJ and expert consultants visited the facility, reviewed a wide array of documents there, and conducted interviews with personnel and residents. The letter commended MSH staff for providing a high level of cooperation during the investigation, as well as the dedication many showed for patient well-being. Nevertheless, the investigation found “significant and wide-ranging” deficiencies in child and adolescent patient care at MSH.

DOJ concluded that these deficiencies at MSH existed in a dozen topic areas, including (1) psychiatry; (2) nursing services; (3) psychology; (4) pharmaceutical services; (4) general medical care, including deficiencies in vision services, x-ray reviews, and incontinence and headache evaluation; (5) infection control; (6) dental care; (7) dietary services; (8) placement in the most integrated setting; (9) special education; (10) protection from harm; and (11) First Amendment and due process rights to confidentially communicate with investigators. The letter provided details of deficiencies for all twelve of these categories.

Another findings letter from the DOJ addressed deficiencies found at the Napa State Hospital (NSH), another California mental health facility. The DOJ letters eventually resulted in cooperative resolution of these hospitals’ many problems, at least on paper. California’s officials and the DOJ reached agreement that became the basis of a consent judgment filed contemporaneously with a CRIPA complaint against the state. Via DOJ Civil Rights Division lawyers, the United States, on May 2, 2006, filed in the U.S. District Court for the Central District of California a CRIPA lawsuit against California and state officials responsible for operation of MSH and NSH. The case sought declaratory and injunctive relief to end the substantial departures from generally accepted professional standards of care at each hospital in the multiple aspects mentioned in the findings letters.

Proposition 63, Mental Health Services Act (MHSA)

A 2004 new law, was written by then Assemblyman Darrell Steinberg, who later became a State Senator, and mental health lobbyist Sherman "Rusty" Selix. The new tax is to affect the wealthiest 0.1 percent of California’s taxpayers, which amounts to approximately 30,000 taxpayers. The result is approximately a 31 percent increase to the previous to Proposition 63's annual mental health budget of $2.6 billion. These funds are to be used to transform the State’s public mental health system, expand it, and revolutionize the existing system with a focus on promoting recovery-oriented programs.

The Mental Health Services Act (MHSA) was projected to generate approximately $254 million in the 2004-2005 fiscal year, $683 million in 2005-06 fiscal year, and then increasing amounts subsequently. Much of the funding provides county mental health programs funds for programs consistent with their local plans. The purpose and intent of the Proposition was to address serious mental illness among children, adults, and seniors involving prevention and early intervention services and supportive medical care; to reduce the adverse impact from untreated serious mental illness from individuals, families, and state and local budgets; to expand innovative and successful service delivery programs for children, adults, and seniors, including culturally and linguistically competent approaches for underserved populations; to provide the state and local governments with funds adequate to meet to meet the needs of all children and adults; and to ensure that all funds are spent in the most cost effective manner and services are provided following best recommended practices, with local and state oversight to ensure accountability.

The 5 Components of the MHSA are:

(1) Community Services and Supports (CSS)–provides funds for direct services to individuals with severe mental illness. (2) Capital Facilities and Technological Needs (CFTN)–provides funding for building projects and increasing technological capacity to improve mental illness service delivery. (3) Workforce, Education and Training (WET)–provides funding to improve the capacity of the mental health workforce. (4) Prevention and Early Intervention (PEI)–provides investment of 20% of the MHSA funding for outreach programs for families, providers, and others to recognize early signs of mental illness. The overall goal is to improve early access to services and programs, to reduce stigma, and discrimination experienced by individuals with mental illness. MHSA Prevention and Early Intervention Programs serve Californians of all ages. (5) Innovation (INN)–funds and evaluates new approaches increasing access to the underserved and unserved communities, promote interagency collaboration, and increase the overall quality of mental health services.

2011 AB 109 Prisoner Realignment

The AB 109 legislation reassigns three groups of offenders, previously handled through the State Prison and Parole System, to the counties. The first group includes convicted offenders receiving sentences for new non-violent, non-serious, non-sex offender (N3) crimes that will be served locally, one year or more. Offenders in this category will have no prior violent or serious convictions. The second group involves post-release offenders, up to three years, coming under Probation Department supervision for “N3” crimes released from State Prison. Offenders in this category may have had prior convictions for violent or serious crimes. The third group includes state parole violators who are revoked to custody. With the exception of offenders sentenced to life with parole, this group will be revoked to local County Jail instead of State Prison.

In the initial 2011 Public Safety Realignment Plan, developed and approved by the Sacramento County Community Corrections Partnership (CCP), limited funding was provided for mental health or alcohol / other drug service needs of this new jail inmate and offender populations. There was an analysis of the number of inmates and type of mental health services currently being provided to AB 109 custody inmates detained in the Sacramento County jail system, Main Jail and RCCC, between October 1, 2011 and March 31, 2012. It indicated that during the first six months of the Realignment implementation period, the Sheriff’s Department had processed 989 AB 109 inmates. A total of 407 (41.2%) received mental health services, crisis counseling, clinical and case management services, and medication support. Nearly 294 or 72.2% of the inmates received outpatient mental health services while 66 (16.2%) were housed in the Main Jail’s Psychiatric In-patient Unit. Another 47 inmates were assessed by psychiatric clinical staff, but refused or did not need services. Among the 407 inmates receiving jail mental health services, a total of 251 or 61.7% were prescribed psychotropic medications that are monitored and overseen by Jail Psychiatric Services clinicians.

The budget for the development and implementation of programming to address the substance abuse and mental health needs of the County Jail Prison (N3), Parole, and Flash Incarceration offenders incarcerated in the Main Jail and RCCC, for FY 2012 – 13, is $1,475,361. The cost for AOD service needs and mental health needs, including psychotropic medications for the PRCS populations, is estimated at $1,039,088. The CCP allocation request recommended by the Work Group totals $2,514,449. Unfortunately, this is approximately double what the State originally anticipated for Sacramento County’s realignment program. Hopefully the CCP will recognize the actual need and act accordingly.

AB 100 Update to MHSA/Prop 63

Existing law contains provisions governing the operation and financing of community mental health services for the mentally ill in every county through locally administered and locally controlled community mental health programs. The act funds a system of county mental health plans for the provision of mental health services, as specified. It provides that it may be amended by the Legislature by a 2/3 vote of each house as long as the amendment is consistent with and furthers the intent of the act, and that the Legislature may also clarify procedures and terms of the act by majority vote.

Existing law establishes the Mental Health Services Oversight and Accountability Commission (MHSOAC). Under existing law, the commission is required to annually review and approve county mental health programs for expenditures relating to innovative programs and prevention and early intervention programs. Existing law authorizes the State Department of Mental Health to provide technical assistance to county mental health plans, as specified. This bill would delete the requirement for these annual reviews and would authorize the commission, instead of the department, to provide technical assistance to the county mental health plans.

Existing law requires each county mental health program to prepare and submit a 3-year plan to be updated at least annually and approved by the department after review and comment by the commission. This bill would delete the

annual update requirement for the 3-year plans and the requirement that the plans be approved by the department after review and comment by the commission.

The act establishes the Mental Health Services Fund, continuously appropriated to and administered by the department, to fund specified county mental health programs. The act prohibits funds from the Mental Health Services Fund from being used to supplant existing state or county funds utilized to provide mental health services, and requires state financial support for mental health programs with not less than the same entitlements, amounts of allocations from the General Fund, and formula distributions as the 2003-04 fiscal year. Existing law also requires, subject to availability of funding, the department to distribute a single lump sum of the total amount of approved funding to each county.

This bill would require the State of California, Controller's office, instead of the department, to administer the fund. The bill would authorize continued financial support for mental health programs to come from the Local Revenue Fund 2011, in the State Treasury, and would, commencing July 1, 2012, require the Controller to distribute to the counties all unexpended and unreserved funds on deposit in the Mental Health Services Fund monthly.

Under existing law, moneys in the Mental Health Services Fund may be used only for specified purposes, including 5% for innovative programs, as specified, and 5% for administrative costs of the department, the California Mental Health Planning Council, and the commission. The bill would reduce the amount available for administrative costs to 3.5% and would make that distribution subject to appropriation each fiscal year in the annual Budget Act. The bill, for the 2011-12 fiscal year, would allocate specified funds in the Mental Health Services Fund for Medi-Cal specialty mental health services, mental health services for special education pupils, and the Early and Periodic Screening, Diagnosis, and Treatment Program. By allocating moneys in the Mental Health Services Fund for new purposes, this bill would make an appropriation.

Existing law requires the department to develop regulations, which may be enacted as emergency regulations, for the department or designated local agencies to implement the act. This bill, instead, would require the state to develop regulations for the department, the commission, or designated state and local agencies to implement the act.

AB 1693 Incompetent-to-Stand Trial

This bill authorizes the Department of Mental Health (DMH) to expand a pilot program by establishing competency restoration programs in Los Angeles County, San Diego County, Kern County, and any other county that opts to participate, jails to inmates who have been found incompetent to stand trial (IST) but not committed to a state hospital. It requires that admissions' criteria for competency restoration programs be coordinated through DMH, prioritizing ISTs most likely to be restored to competency. It specifies that competency-restoration programs shall include at least: (a) objective competency assessment upon admission; (b) individualized treatment programs; (c) multimodal, experiential competency education experiences; (d) education addressing the criminal justice system; (e) education for individuals with lacking specific knowledge; (f) periodic reassessment of competency; (g) medication treatment; and, (h) capacity and involuntary treatment assessment. It also declares that a special law is needed because of the historically long waiting lists of ISTs in the three specified counties, which expose the State to potential future court involvement from delays in the treatment of ISTs held in county jail longer than recommended by the courts.

AB 2134, proposed bill by Assemblyman Wesley Chesbro
(currently in Assembly committees, as pf July 2012)

For purposes of subdivision (e) of Section 5346, a county that elects to provide assisted outpatient treatment services pursuant to this article shall offer assisted outpatient treatment services including, but not limited to, all of the following:

(1) Community-based, mobile, multidisciplinary, highly trained mental health teams that use high staff-to-client ratios of no more than ten clients per team member for persons subject to court-ordered services pursuant to Section 5346.

(2) A service planning and delivery process that includes the following:
(A) Determination of the numbers of persons to be served and the programs and services that will be provided to meet their needs. The local director of mental health shall consult with the sheriff, the police chief, the probation officer, the mental health board, contract agencies, and family, client, ethnic, and citizen constituency groups as determined by the director; (B) Plans for services, including outreach to families whose severely mentally ill adult is living with them, design of mental health services, coordination and access to medications, psychiatric and psychological services, substance abuse services, supportive housing or other housing assistance, vocational rehabilitation, and veterans' services. Plans shall also contain evaluation strategies, which shall consider cultural, linguistic, gender, age, and special needs of minorities and those in the target populations. Provision shall be made for staff with the cultural backgrounds and linguistic skills necessary to remove barriers to mental health services as a result of having limited-English-speaking ability and cultural differences. Recipients of outreach services may include families, the public,

primary care physicians, and others who are likely to come into contact with individuals who may be suffering from an untreated severe mental illness who would be likely to become homeless if the illness continued to be untreated for a substantial period of time. Outreach to adults may include adults voluntarily or involuntarily hospitalized as a result of a severe mental illness; (C) Provision for services to meet the needs of persons who are physically disabled; (D) Provision for services to meet the special needs of older adults.(E) Provision for family support and consultation services, parenting support and consultation services, and peer support or self-help group support, where appropriate; (F) Provision for services to be client-directed and that employ psychosocial rehabilitation and recovery principles; (G) Provision for psychiatric and psychological services that are integrated with other services and for psychiatric and psychological collaboration in overall service planning; (H) Provision for services specifically directed to seriously mentally ill young adults 25 years of age or younger who are homeless or at significant risk of becoming homeless. These provisions may include continuation of services that still would be received through other funds had eligibility not been terminated as a result of age; (I) Services reflecting special needs of women from diverse cultural backgrounds, including supportive housing that accepts children, personal services coordinator therapeutic treatment, and substance treatment programs that address gender-specific trauma and abuse in the lives of persons with mental illness, and vocational rehabilitation programs that offer job training programs free of gender bias and sensitive to the needs of women; (J) Provision for housing for clients that is immediate, transitional, permanent, or all of these; (K) Provision for clients who have been suffering from an untreated severe mental illness for less than one year, and who do not require the full range of services, but are at risk of becoming homeless unless a comprehensive individual and family support services plan is implemented. These clients shall be served in a manner that is designed to meet their needs; (L) (i) Provision for services related to responding to a mental health crisis, in accordance with the best practices developed pursuant to subdivision (e). (ii) This subparagraph shall not apply to a county that, as of January 1, 2012, is providing services pursuant to this article.

(3) Each client shall have a clearly designated mental health personal services coordinator who may be part of a multidisciplinary treatment team responsible for providing or assuring needed services. Responsibilities include complete assessment of the client's needs, development of the client's personal services plan, linkage with all appropriate community services, monitoring of the quality and follow-through of services, and necessary advocacy to ensure each client receives those services that are agreed to in the personal services plan. Each client shall participate in the development of his or her personal services plan, and responsible staff shall consult with the designated conservator, if one has been appointed, and, with the consent of the client, shall consult with the family and other significant persons as appropriate.

(4) The individual personal services plan shall ensure that persons subject to assisted outpatient treatment programs receive age-appropriate, gender-appropriate, and culturally appropriate services, to the extent feasible, that are designed to enable recipients to:
(A) Live in the most independent, least restrictive housing feasible in the local community, and, for clients with children, to live in a supportive housing environment that strives for reunification with their children or assists clients in maintaining custody of their children as is appropriate; (B) Engage in the highest level of work or productive activity appropriate to their abilities and experience; (C) Create and maintain a support system consisting of friends, family, and participation in community activities; (D) Access an appropriate level of academic education or vocational training; (E) Obtain an adequate income; (F) Self-manage their illnesses and exert as much control as possible over both the day-to-day and long-term decisions that affect their lives; (G) Access necessary physical health care and maintain the best possible physical health; (H) Reduce or eliminate serious antisocial or criminal behavior, and thereby reduce or eliminate their contact with the criminal justice system.; (I) Reduce or eliminate the distress caused by the symptoms of mental illness; (J) Have freedom from dangerous addictive substances.

(5) The individual personal services plan shall describe the service array that meets the requirements of paragraph (4), and to the extent applicable to the individual, the requirements of paragraph (2): (a). A county that provides assisted outpatient treatment services pursuant to this article also shall offer the same services on a voluntary basis; (b) Involuntary medication shall not be allowed absent a separate order by the court pursuant to Sections 5332 to 5336, inclusive; (c) A county that operates an assisted outpatient treatment program pursuant to this article shall provide data to the State Department of Mental Health and, based on the data, the department shall report to the Legislature on or before May 1 of each year in which the county provides services pursuant to this article. The report shall include, at a minimum, an evaluation of the effectiveness of the strategies employed by each program operated pursuant to this article in reducing homelessness and hospitalization of persons in the program and in reducing involvement with local law enforcement by persons in the program. The evaluation and report
shall also include any other measures identified by the department regarding persons in the program and all of the following, based on information that is available:
(1) The number of persons served by the program and, of those, the number who are able to maintain housing and the number who maintain contact with the treatment system; (2) The number of persons in the program with contacts with local law enforcement, and the extent to which local and state incarceration of persons in the program has been reduced or avoided; (3) The number of persons in the program participating in employment services programs,

including competitive employment; (4) The days of hospitalization of persons in the program that have been reduced or avoided; (5) Adherence to prescribed treatment by persons in the program; (6) Other indicators of successful engagement, if any, by persons in the program; (7) Victimization of persons in the program; (8) Violent behavior of persons in the program; (9) Substance abuse by persons in the program; (10) Type, intensity, and frequency of treatment of persons in the program; (11) Extent to which enforcement mechanisms are used by the program, when applicable; (12) Social functioning of persons in the program; (13) Skills in independent living of persons in the program; (14) Satisfaction with program services both by those receiving them and by their families, when relevant.

(d) (1) A county that elects to provide assisted outpatient treatment services pursuant to this article shall develop best practices for the purposes of responding to a mental health crisis. These best practices include, but are not limited to, the utilization of crisis intervention teams, mobile crisis teams, or psychiatric emergency response teams, with an emphasis on peer support; (2) This subdivision shall not apply to a county that, as of January 1, 2012, is providing services pursuant to this article.

APPENDIX J.

Index

Interviews:

APPENDIX K.

The Callahan Report dated May 10, 2011
Summary of Transformation Recommendations for
Sacramento County Adult Mental Health Services

- Develop a Response Team to strengthen the access system.
- Providers conduct intake assessments for easy access to services.
- Redesign Crisis Response and Crisis Intervention Services at the county and provider level.
- Develop a Welcoming Line to offer consumer support 24/7.
- Redesign the regional outpatient system to offer a continuum of services at each provider.
- Improve notification of inpatient and MHTC admissions and coordinate discharge planning.
- Develop Intensive Outpatient Services (IOS) programs to help persons discharged from sub-acute residential placements successfully return to the community.
- Consolidate the two county outpatient clinics and plan how the remaining staff can best support the system transformation.
- Create wellness and recovery-focused services in a welcoming environment at each provider.
- Hire Peer Support Specialists for volunteer and paid service delivery positions.
- Provide Wellness and Recovery Training.
- Identify innovative evidence-based practices and provide training, supervision, and ongoing feedback to integrate these new skills throughout services.
- Implement a training program that facilitates communication between consumers and psychiatrists,
- Identify evidence-based practices and provide training for staff on the treatment of co-occurring disorders.
- Develop a training program to train UC Davis Residents to integrate client's voice in treatment.
- Integrate persons with lived experiences as part of the MHTC service delivery team to ensure communication.
- Develop an expedited process for helping individuals qualify for Medi-Cal benefits.
- Maximize billing for services that are eligible for Medi-Cal reimbursement.
- Expand Crisis Residential programs.
- Expand PHF Services
- Develop a Crisis Stabilization Unit
- Develop Crisis Respite Services
- Reduce the use of MHTC beds
- Reduce the use of private Psychiatric Hospitals
- Reduce the use of Mental Health Rehabilitation Centers and State Hospital.
- County leadership adopts a continuous quality improvement process to use data to inform system-level decisions.
- Develop the capacity to systematically produce accurate data reports.
- Develop an Outcomes Leadership Group composed of managers from the county and providers, as well as clients, to work together to use data to measure client and performance outcomes, identify gaps, and develop strategies to improve outcomes.

Biographies

Susan McCrea has served on the Sacramento County Mental Health Board (SCMHB) since 2007. Susan is alternate on the Sacramento County Mental Health Services Act (MHSA) Steering Committee, and the Chairperson of the Sacramento Mental Health Board Ad Hoc Committee. She is a member of the new Respite Partnership Collaborative. In November 2010, Susan and her family suffered the death of a loved one, a daughter with mental illness. Currently she is writing her memoirs and working with her husband, an assistant pastor at a local church. She has a BA in History from U.C. Berkeley, an elementary teaching credential from USF, and a license in pastoral counseling.

Lois Cunningham has been a member of the SCMHB since 2010 and is Chair of the SCMHB Budget Committee. Lois is past member of the Sacramento County Mental Health Services Act (MHSA) Steering Committee and served as a member of its Executive Committee. Lois has participated in many MHSA sub-committees, including the Innovation Workgroup and the Workforce Education and Training Workgroup. Lois' family has struggled with mental illness over the years and her frustrations with the system led her to involvement in mental health advocacy. Lois has a B.A. in Social Science from San Jose University and an MBA from the University of Santa Clara.

Brian Brereton has served on the SCMHB since June 2011. Brian has over thirty years of experience in the financial services industry and recently changed careers to work in healthcare. Brian is currently a certified EMT and Medical Assistant and has worked for the past two years in various local volunteer capacities including the Sacramento Medical Reserve Corps, and Rock Med-Haight Ashbury Clinics. Brian has a B.A. in Business Finance from Sacramento State University and an MBA from CSU, East Bay/Hayward. Brian is hoping to complete his nursing degree within the next 2 years with an emphasis on mental health.

Mental Health Services Act (MHSA) Three-Year Plan
Funding Summary

A. Community Services and Supports (CSS) Component

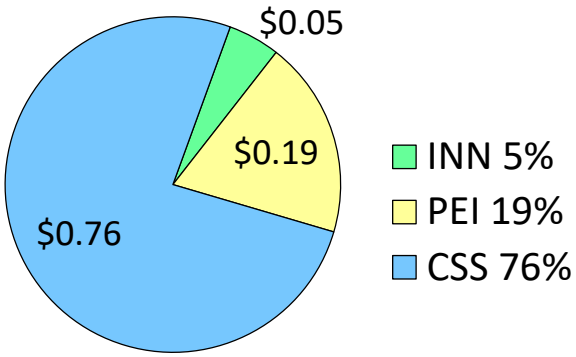
- Provides funding for mental health treatment services and supports for children/youth and their families living with severe emotional disturbance and adults living with a serious mental illness. This includes funding for the MHSA Housing Program.
- A majority of CSS funding must be directed to Full Service Partnership programs
- Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years
  - This means unspent CSS funding is combined with incoming revenue to sustain CSS programming/activities, as well as sustaining critical activities in the time-limited WET and CF/TN components, sustaining successful and applicable INN project components
  - Unspent CSS funding must also be used to sustain MHSA Housing Program investments
- 76% of each MHSA dollar is directed to the CSS Component (see funding chart below)

B. Prevention and Early Intervention (PEI) Component

- Provides funding for programs and activities designed to prevent mental illness from occurring or becoming more severe and disabling
- A majority of PEI funding must be directed to ages 0-25
- 19% of each MHSA dollar is directed to the PEI Component (see funding chart below)

C. Innovation (INN) Component

- Provides funding to test new and/or improved mental health practices or approaches with the goal of increasing access (including access for underserved groups), increasing the quality of services, or promoting interagency collaboration
- Projects can span up to 5 years – If successful, other funding must be identified to sustain
- Successful INN projects may be sustained by CSS/PEI components (as applicable), if County so chooses
- All new or changed INN projects must be approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC)
- 5% of each MHSA dollar is directed to the INN Component (see funding chart below)



D. Workforce Education and Training (WET) Component

- Provides time limited funding with a goal to recruit, train and retain diverse culturally and linguistically competent staff for the public mental health system and ensure they are adequately trained to provide effective services and administer programs based on wellness and recovery
- WET activities must be sustained by CSS funding once dedicated WET funding is exhausted

E. Capital Facilities and Technological Needs (CF/TN) Component

- Capital Facilities (CF) project – Time limited funding used to renovate the Adult Psychiatric Support Services (APSS) clinic, Peer Partner Program and INN 2 Project (Mental Health Urgent Care Clinic)
- Technological Needs project – Time limited funding to addresses our commitment to move to an Electronic Health Record and Personal Health Record to improve client care through a multi-phased approach
- CF/TN activities must be sustained by CSS funding once dedicated CF/TN funding is exhausted

F. Prudent Reserve

- Per Welfare and Institutions Code, each County must establish and maintain a prudent reserve to ensure the county program will continue to be able to serve children, adults, and seniors during years in which revenues for the Mental Health Services Fund are below recent averages

G. **Overarching Points**

- Mental Health Services Act (MHSA) funding is generated by a 1% tax on personal income in excess of $1M
  - As income tax-based revenue, MHSA funding is greatly impacted by the economy (impacts lag by approximately 2 years)
  - MHSA revenue is volatile and difficult to project
- In FY2019-20, Sacramento County allocation increased from 3.23% to 3.26% of State MHSA funding due to statewide recalculation distribution

Behavioral Health System and Stakeholder Participation

MHSA Steering Committee Presentation
January 21, 2021

Jane Ann Zakhary
Division Manager, Administration, Planning and Outcomes

Kelli Weaver, LCSW
Division Manager
Adult Mental Health

2

Background

- Behavioral Health is implementing a regular procurement schedule for contracted programs
- Stakeholder input, which includes consumer and family input, is a critical component to ensuring programming is effective, respectful and responsive
- Stakeholder participation and input occurs in many forms across the system

3

Mandated Advisory Boards

- Mental Health Board
- Alcohol and Drug Advisory Board

4

Recommending Bodies

- MHSA Steering Committee
- Cultural Competence Committee
- Family Advisory Committee
- Youth Advisory Committee
- Older Adult Coalition
- Behavioral Health Racial Equity Collaborative
- Youth Advocacy Board (in development)

5

Broader Stakeholder Sessions

- Town Halls
- Community Conversations

6

Program/Project Specific Input

- Anecdotal feedback from system partners, consumers/family members and providers
- African American Ad Hoc Workgroup
- Surveys
- Alternatives to 911 for Mental Health Calls
- MHSA SC Ad Hoc Workgroups
- Key Informant Interviews
- Focus Groups
- Multi-County FSP Collaborative (INN Project)
- Needs Assessments
- Satisfaction Surveys

7

How is Stakeholder Input Used?

- Input informs program planning, development and implementation
- Adapting programming to current/shifting community needs
- Input is balanced with Local and State oversight guidance, feedback and requirements

Report Back on Community/Stakeholder Input for the Adult Outpatient Services Transformation

Division of Behavioral Health Services

MHSA Steering Committee

April 15, 2021

Kelli Weaver, LCSW, Division Manager
Michael Ameneyro, Program Planner

SACRAMENTO COUNTY

Background

- **August 6, 2019: MHSA Update Presentation**

Provided next steps for making MHSA funds available for services in the community through strategies for planning and stakeholder input, including bringing services in line with community needs and available resources through the Adult Outpatient Services Redesign.

- **January 21, 2021: Behavioral Health System and Stakeholder Participation Presentation**

Provided an overview to the MHSA Steering Committee outlining BHS' plan to implement a regular procurement schedule for contracted programs, utilizing stakeholder input from various methods and groups to ensure programming is effective, respectful and responsive.

The *Adult Outpatient Transformation* is an opportunity to integrate community stakeholder input to refine our outpatient system to more effectively serve our community and to enhance the overall adult outpatient mental health services delivery system.

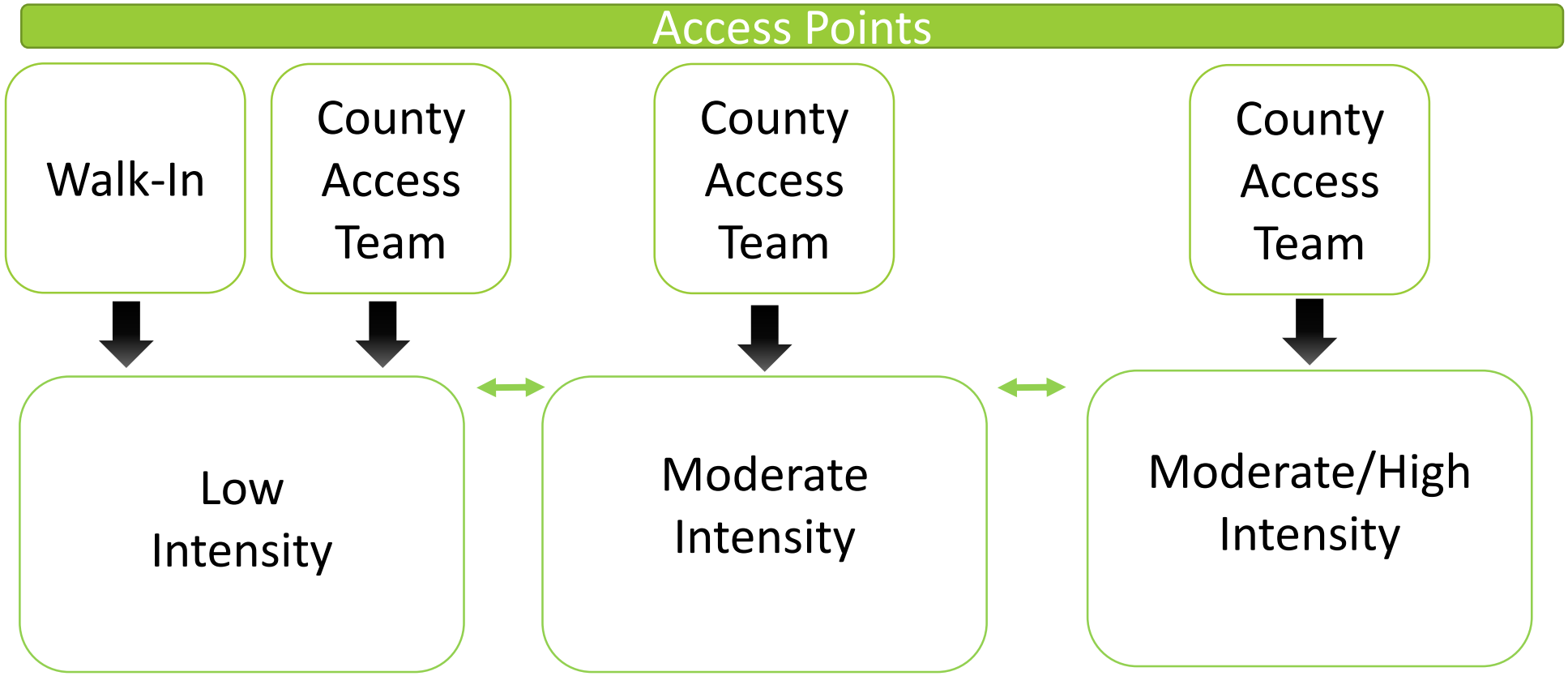
Current Outpatient Service Delivery

Current Adult Outpatient system includes:

Walk-in Centers providing site-based low to moderate level of care

Site-based clinics providing low to moderate level care

Flexible site-based & community-based services moderate to high level of care



Community Stakeholder Feedback Sessions

Community Stakeholder Feedback Sessions

Beginning in 2019, Sacramento County Behavioral Health Convened Several Stakeholder Feedback Sessions with a total of 658 participants

- **Goal:** The goal of the Stakeholder Feedback Sessions was to gather feedback and ideas about the current Behavioral Health Services System.
- **Feedback:** The feedback of the Stakeholder Feedback Sessions will influence current priorities and inform future needs for the Behavioral Health Services System.
- **Premise:** There is value in engaging those who have a high stake in the work the County is driving forward around Behavioral Health.

Community Stakeholder Feedback Sessions

Behavioral Health Community Town Halls

A total of 259 participants attended a Community Town Hall

Held On:

- 07/30/2019
- 08/01/2019
- 02/26/2020

Stakeholder Representation	Percentage
System Partners	33%
BHS Staff	23%
Community Members (including family members)	17%
Consumers	16%
Did not indicate	28%

Note: Those who indicated stakeholder category may identify in more than one category which is why the total exceeds 100%.

Community Stakeholder Feedback Sessions

Held On:

- 12/05/2019
- 12/10/2019
- 12/11/2019
- 12/12/2019
- 01/07/2020
- 01/13/2020
- 01/30/2020
- 02/07/2020
- 02/13/2020

Smaller Community Conversations

A total of 165 participants attended

Stakeholder Representation	Percentage
Iu Mien*	27%
Native American	12%
LatinX*	11%
Russian*	11%
African American/Black	10%
Hmong*	9%
Cantonese*	8%
Arabic*	7%
Vietnamese*	5%

*conducted in language

Community Stakeholder Feedback Sessions

Consumers:
- 09/01/2019
- 10/07/2019
- 10/10/2019
- 12/16/2019

Direct Services Staff:
- 10/16/2019
- 10/18/2019
- 10/21/2019

Family Members:
- 10/17/2019
- 11/01/2019

Focus Groups

Total of 59 Focus Group Participants

Stakeholder Representation	Percentage
Consumers	54%
Direct Service Staff	37%
Family Members	9%

Participants represented the following Outpatient Community-Based Organizations:

- Regional Support Teams:
  - Visions
  - Turning Point
  - TLCS/HRC
  - El Hogar
- El Hogar Guest House
- TLCS/HRC TCORE
- CSHC Wellness & Recovery Centers

Community Stakeholder Feedback Sessions

Held On:

- 01/12/2021
- 01/13/2021
- 01/14/2021
- 01/18/2021
- 01/19/2021
- 01/20/2021

Behavioral Health Racial Equity Collaborative
Focus Groups & Key Informant Interviews
Total of 31 Participants

Focus Groups with African American/Black/Of African Descent Community:

- Total of Eight Focus Groups & Two Key Informant Interviews
  - 6 focus groups with general mix of people by age, gender, and experience with County
  - 1 focus group comprised of 6th and 7th graders
  - 1 focus group comprised of formerly incarcerated men and/or individuals who worked with them
  - 2 interviews with key informants from the transgender community

Community Stakeholder Feedback Sessions

Survey open from:
03/05/21 - 03/19/21

Available in:
- English
- Spanish
- Russian
- Farsi
- Arabic
- Hmong
- Chinese
- Vietnamese

Community Survey on Outpatient Services
Total of 144 Participants

Stakeholder Representation	Percentage
Service Provider Staff	34%
Consumer	24%
Family Member	16%
Other	13%
Peer Advocate	10%
Consumer/Family Advocate	3%

Survey Distribution:
- MHSA Steering Committee Distribution List
- Mental Health Board Distribution List
- Cultural Competency Committee (CCC)
- CCC Ad Hoc Workgroup
- Supporting Community Connections

"We need to be seen, heard and genuinely supported" – participant

Community Stakeholder Feedback Sessions

Key Areas for Improvement

- Timely and Improved Access
- Culturally Responsive Services and Trauma Informed Delivery System
- Increase Peer Supports to Bridge Gaps
- Increase Family Involvement
- Data Informed Decisions
- Smaller/More Manageable Case Loads Sizes with Less Turn-Over
- No Fail Approach
- Transportation
- Telemedicine
- Walk In Capacity
- Warm Hand Off ~ Improve Care Coordination
- Diverse Workforce that Reflect and Speak the Language of the Community Served
- Improve Access through Community Hubs with Collocated Services
- Increase Opportunities for Job Training/Coaching and Integrating Employment as a Recover Goal
- Medication Support
- Inclusive Environment and Support for Consumers and Family Members

Feedback-Driven Goals for the Transformation

Goals of the Transformation

- Incorporate the four principles of **Recovery Oriented Leadership (ROL)** to increase hope, commitment, and action across the system of care.

Having a vision that is worth working towards and believing that things can improve.

Acknowledgement that people need healing, compassion and encouragement as they work towards finding wholeness and health.

People are encouraged to be a part of the community and their contributions are promoted, while they are accepted for who they are.

People with psychiatric disabilities have the power to decide their future and take meaningful action based on their beliefs and desires.

Goals for the Transformation (Con't)

- Practice values and principles that enhance culturally responsive services, recovery and resilience
- Increase treatment effectiveness through recovery framework
- Increase the use of evidenced-based practices and community-defined evidence practices
- Ensure funding is allocated to support mainstream Medi-Cal and community-defined recovery centered services, while maximizing federal funding
- Hiring and retaining staff that are able to support the unique needs of every service recipient (i.e. ethnic, racial, age, sexual orientation, gender identity and linguistic needs)
- Expand points of access points to mental health services including peer supports
- Increase supports to families, strengthen support systems and community connections

Recovery Stepping Stones

Journey To Wellness And Optimal Health

C.O.R.E

Community: Increase community engagement and connections, belonging and supportive

Outreach: Inclusive, Inviting, welcoming, educational and inspirational

Recovery: Intentional progression towards optimal health and wellbeing

Empowerment: Client and family driven goals and outcomes, independent, confident, courageous and resourceful

Next Steps

Proposed Timeline

- 2019 to 2021: Gathered Stakeholder Input
- March 5, 2021: Announcement of Upcoming Competitive Selection Opportunity on DHS Website & Media Release
- April 15, 2020: MHSA Steering Committee Presentation
- April/May 2021: Letter of Intent (LOI) Anticipated Release
- June 2021: Request For Applications (RFA) Anticipated Release*
- Fall 2021: Announcement of Awardees
- Fall/Spring 2022: Transition Period
- Summer 2022: Transformation Fully Implemented

*RFA will only be sent to organizations that respond to the LOI

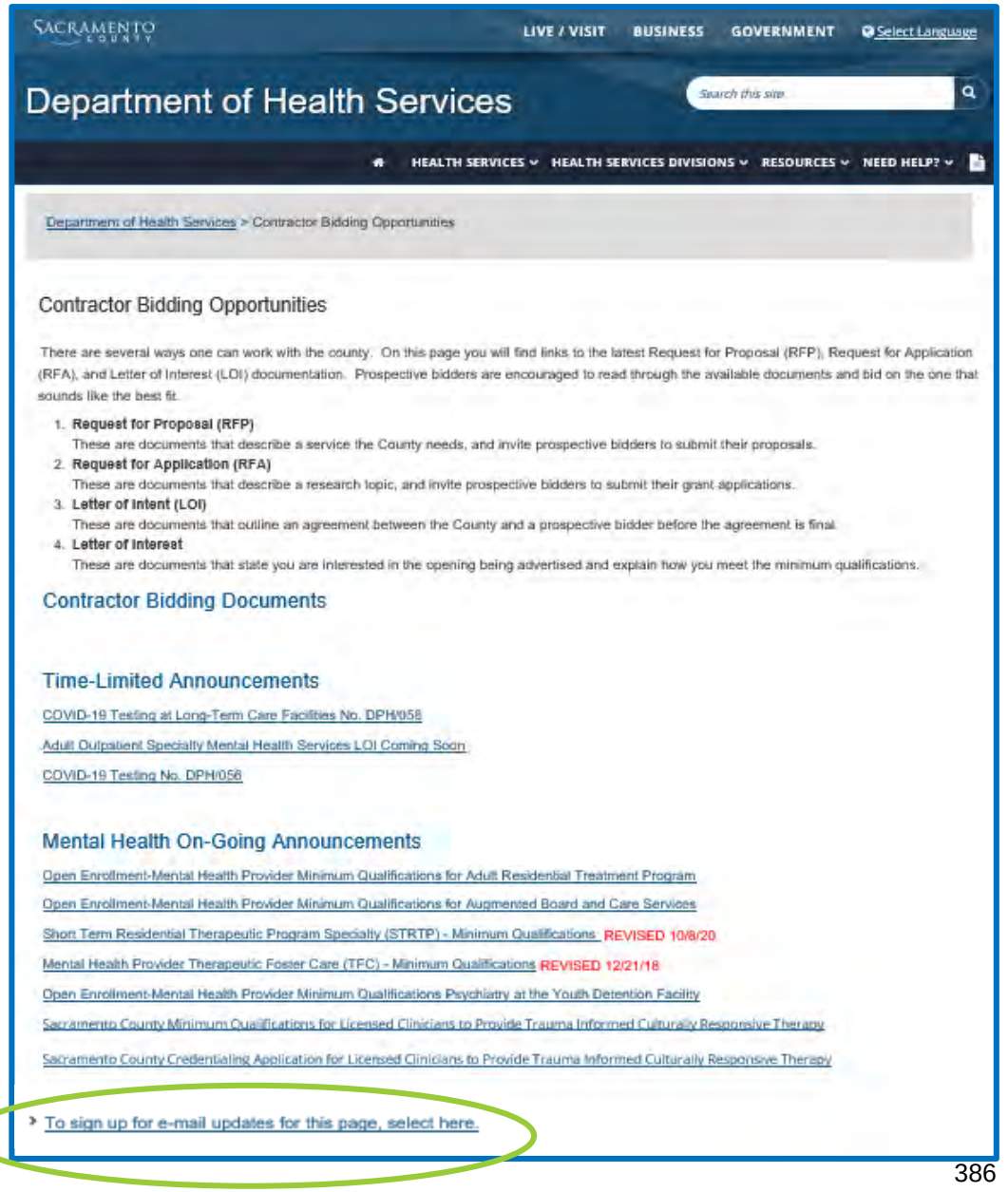
Competitive Selection Reminder

Interested organizations can subscribe to receive notifications of new opportunities at the website:

http://www.dhs.saccounty.net/Pages/Contractor-Bidding-Opportunities.aspx

and clicking:

To sign up for email updates for this page.



Questions?

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PERMANENT SUPPORTIVE HOUSING

MHSA PORTFOLIO CATALOG

SACRAMENTO COUNTY DIVISION OF BEHAVIORAL HEALTH SERVICES

7TH AND H

720 7th Street, Sacramento, 95814

PROPERTY DESCRIPTION

- ✓ Opened in 2013
- ✓ Preservation and rehabilitation of historical property / existing SRO
- ✓ Mixed use development includes ground floor health clinic and retail space
- ✓ Located in downtown Sacramento
- ✓ Largest property in portfolio with 150 affordable units; 28 MHSA units
- ✓ Studio & 1 Bedroom Units
- ✓ Well served by public transportation, walking distance to Amtrak station
- ✓ Extensive common space amenities include large community room, conference and meeting rooms, lounges, patios, and second floor rooftop deck

PARTNERS

- ✓ Mercy Housing
- ✓ Turning Point Community Programs
- ✓ WellSpace Health
- ✓ Sacramento Housing and Redevelopment Agency
- ✓ Mercy Housing California Resident Services
- ✓ Mercy Housing Management Group

ARDENAIRE

1960 Ethan Way, Sacramento, 95825

PROPERTY DESCRIPTION

- ✓ Opened in 2008
- ✓ Acquisition and rehabilitation
- ✓ First project to provide “units through development” under Ten Year Plan to End Homelessness
- ✓ 52 Affordable Housing units; 19 MHSA units; 1 unrestricted unit
- ✓ Four 2-story apartment buildings
- ✓ Property features new community room
- ✓ 1- & 2- Bedroom units

PARTNERS

- ✓ Mercy Housing
- ✓ Turning Point Community Programs
- ✓ Mercy Housing California Resident Services
- ✓ Mercy Services Corporation

BOULEVARD COURT

5321 Stockton Blvd, Sacramento, 95820

PROPERTY DESCRIPTION

- ✓ Opened in 2011
- ✓ Redevelopment of existing hotel
- ✓ Aligned with Five Year Redevelopment Implementation Plan for Stockton Boulevard Redevelopment Area
- ✓ Two story walk-up building
- ✓ Property features community space, computer room, lounge, therapy and counseling offices, basketball court / recreation area
- ✓ 74 units; 25 MHSA units
- ✓ Studio & 1 Bedroom Units

PARTNERS

- ✓ Mercy Housing
- ✓ Turning Point Community Programs
- ✓ WellSpace Health
- ✓ Sacramento Housing and Redevelopment Agency
- ✓ Mercy Housing California Resident Services
- ✓ Mercy Housing Management Group

THE COURTYARDS ON ORANGE GROVE

3425 Orange Grove Ave, North Highlands, 95660

PROPERTY DESCRIPTION

- ✓ Opened in 2020
- ✓ Adaptive reuse of existing motel
- ✓ 92 units; 20 MHSA units
- ✓ Property features counseling and therapy offices, group meeting rooms, resident lounge, commercial kitchen, computer workstations, dog run, community garden and BBQ area
- ✓ Studio & 1 Bedroom Units

PARTNERS

- ✓ Mercy Housing
- ✓ Telecare
- ✓ WellSpace Health
- ✓ Mercy Housing California Resident Services
- ✓ Mercy Housing Management Group

FOLSOM OAKS

809 Bidwell St, Folsom, 95630

PROPERTY DESCRIPTION

- ✓ Opened in 2011
- ✓ New construction
- ✓ Four residential apartment buildings
- ✓ Smallest property in portfolio at 19 units; 5 MHSA units
- ✓ Property features community room, tot lot play area
- ✓ Nearby amenities include shopping, banks, schools and parks within ½ mile of site
- ✓ Public transportation conveniently located
- ✓ 2- & 3-Bedroom Units

PARTNERS

- ✓ TLCS, Inc.
- ✓ Sacramento Housing and Redevelopment Agency

LA MANCHA

7789 La Mancha Way, Sacramento, 95823

PROPERTY DESCRIPTION

- ✓ Opened in 2020
- ✓ Acquisition and conversion of 124 room extended stay hotel
- ✓ First Homekey Program development in portfolio; funded with federal Coronavirus Relief Funds
- ✓ Located in southern Sacramento
- ✓ 100 units; 40 MHSA units
- ✓ Property will feature common spaces and outdoor amenities *(under development)*
- ✓ Conveniently located near [INSERT]
- ✓ Studio Units

PARTNERS

- ✓ Mercy Housing
- ✓ Telecare
- ✓ TLCS, Inc.
- ✓ Mercy Housing California Resident Services
- ✓ Mercy Housing Management Group

MARTIN LUTHER KING VILLAGE

3900 47th Avenue, Sacramento, 95824

PROPERTY DESCRIPTION

- ✓ Opened in 2008
- ✓ New construction
- ✓ Second project to provide “units through development” under Ten Year Plan to End Homelessness
- ✓ Single story, cottage and duplex units
- ✓ 80 units; 30 MHSA units
- ✓ Property features community room with kitchen
- ✓ 1 Bedroom Units

PARTNERS

- ✓ Mercy Housing California
- ✓ Turning Point Community Programs
- ✓ WellSpace Health
- ✓ Sacramento Housing and Redevelopment Agency
- ✓ Mercy Services Corporation

MUTUAL HOUSING AT THE HIGHLANDS

3417 Freedom Park Drive, North Highlands, 95660

PROPERTY DESCRIPTION

- ✓ Opened in 2011
- ✓ New construction
- ✓ Located in Mather/McClellan Redevelopment Area in North Highlands neighborhood
- ✓ 90 units; 33 MHSA units
- ✓ Units feature porch or patio
- ✓ Property features community room and kitchen, computer room, conference room
- ✓ Studio, 1- & 3-Bedroom Units

PARTNERS

- ✓ Sacramento Mutual Housing Association
- ✓ Turning Point Community Programs (Pathways)
- ✓ Lutheran Social Services of Northern California
- ✓ Mutual Housing Management
- ✓ Sacramento Housing and Redevelopment Agency

STUDIOS AT HOTEL BERRY

729 L. Street, Sacramento, 95814

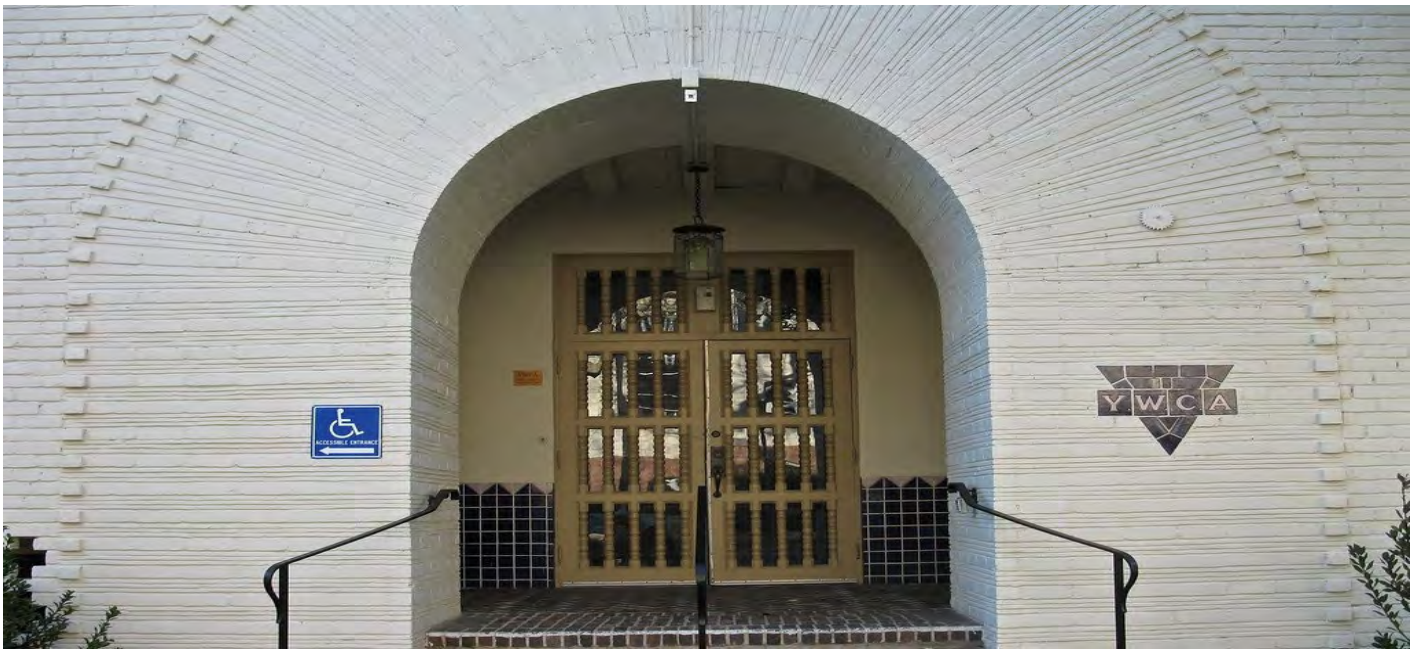
PROPERTY DESCRIPTION

- ✓ Opened in 2012
- ✓ Preservation, renovation, and modernization of Single Room Occupancy residential hotel units
- ✓ Mixed Use Development
- ✓ Conveniently located in downtown Sacramento
- ✓ 105 units; 10 MHSA units
- ✓ Property features resident lounge, community room with kitchen, computer lab, corner retail store
- ✓ Studio units

PARTNERS

- ✓ Jamboree Housing Corporation
- ✓ John Stewart Company
- ✓ TLCS, Inc.
- ✓ Sacramento Housing & Redevelopment Agency

YWCA



1122 17th Street, Sacramento, 95814

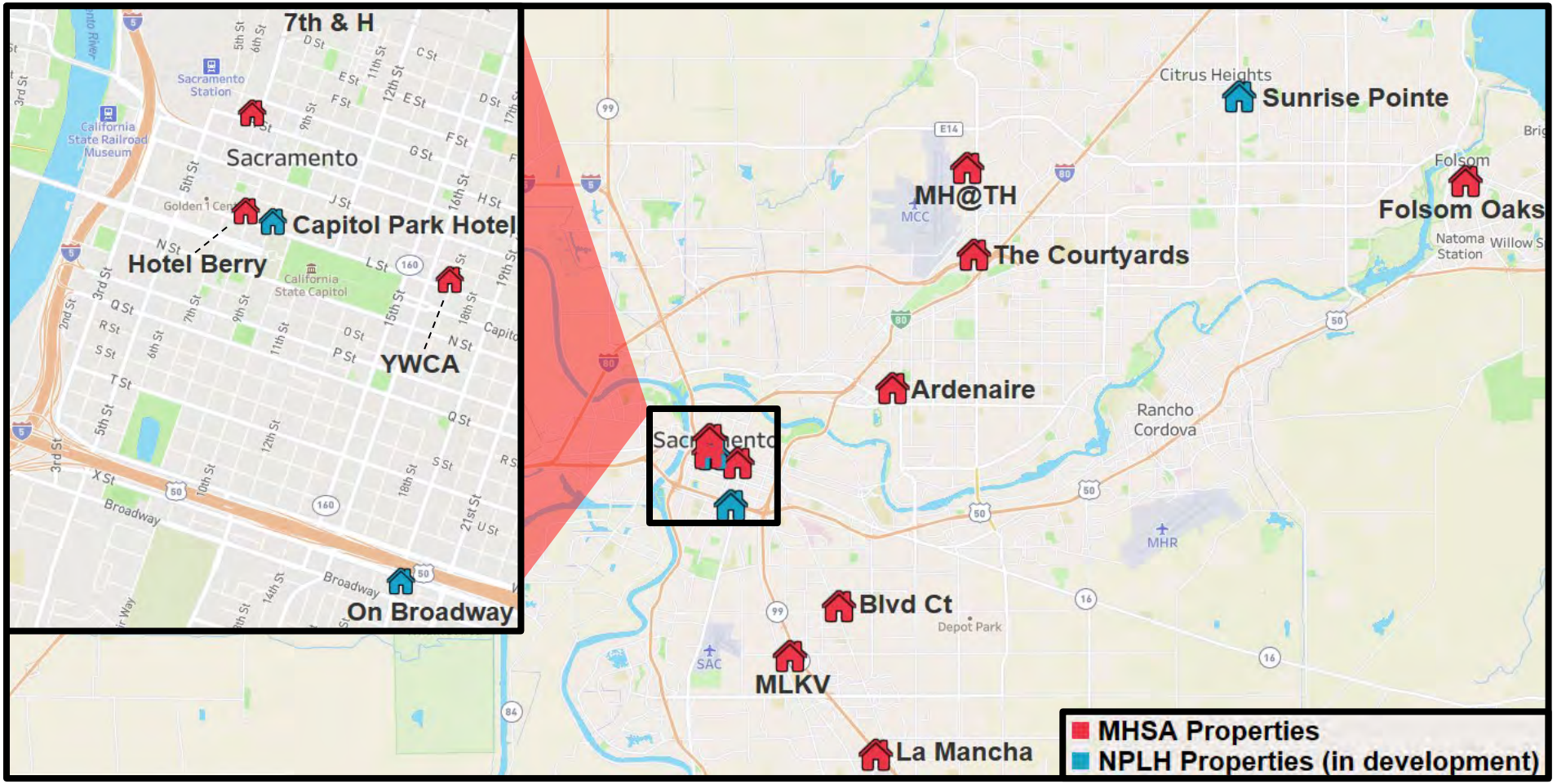
PROPERTY DESCRIPTION

- ✓ Opened in 2009
- ✓ Preservation and rehabilitation of residential hotel units
- ✓ City designated landmark building in downtown Sacramento
- ✓ Affordable housing provided at this location since 1932
- ✓ 31 units; 11 MHSA units
- ✓ Single Room Occupancy
- ✓ Fourth project to provide “units through development” under Ten Year Plan to End Homelessness
- ✓ Large main floor rooms available for community use

PARTNERS

- ✓ YWCA
- ✓ Turning Point Community Programs

MAP OF PORTFOLIO



Sacramento County Community-Driven Prevention and Early Intervention Grant Program

Organization/Individual	Contact information	Populations Served	Description of Program	Negative Outcomes Addressed
Agile Group $177,680	Michael Craft, Principal Consultant mcraft@agilegroup.us (916) 670-2932	Sacramento County Community Leaders who interact with youth, age 13 -21, specifically from low-income African American families	**Youth Mental Health First Aid Training and Wellness Support Program:** • Host a Youth Mental Wellness Day centered around normalizing mental health • Four (4) Mental Health First Aid Community Trainings • Create a Youth Mental Health Council • All activities will teach community members how to be supportive to young people experiencing mental health challenges and to empower youth to talk openly about challenges.	• Suicide • School failure/drop-out rate • Incarceration • Unemployment
Cal Voices $413,908	Stephanie Ramos, Program Manager sacmap@calvoices.org (916) 366-4600 www.calvoices.org/sacmap	Unserved, underserved and unengaged diverse communities including: • LGBTQ • TAY • Older Adults • Racial/Ethnic Groups	**SacMap** (**S**upport, **A**dvocacy, **C**are and **M**ental wellbeing for **A**ll **P**eople) SacMap is an online resource guide that provides a comprehensive list of mental health services and supports available in Sacramento County. SacMap provides workshops for community members to educate them on mental health and recovery, different types of mental health programs, and how to navigate the website and tools available. Population specific workshops are offered quarterly. Quarterly workshops for Provider/organization are available to introduce them to the SacMap resource guide and provides strategies on how provider/organization staff can assist and empower the people they serve in accessing mental health resources in Sacramento County. Learn more here: https://www.calvoices.org/sacmap.	• Prolonged Suffering • Homelessness • Suicide • School failure/drop-out rate
California Black Women's Health Project $459,210	Sonya Young Aadam, CEO sonta@cabwhp.org (310) 412-1828 www.cabwhp.org	• African American • African/Afro Latino • Afro-Caribbean Women & Girls age 14-99	**Sisters Mentally Mobilized (SMM) – Sacramento** is program that utilizes a nationally recognized, evidenced-based engagement model, Sister Circle. Sister Circle is a community outreach and community capacity building tool that uses medium such as digital communication, social media, hosted events, trainings, radio, town-halls, and community forums. SMM activities will provide Black women mental, physical and community health education, empowerment, and support resources. Activities include: • Monthly SMM-Sac Sister Circles • A time to care Affair – Mix n' Mingle (Summer 2020 & 2021) • Pre-Holiday Self-Care Sister Circle (November 2020 &2021) • Sistahs Aging with Grace & Elegance – SAGE (Fall 2020 & Spring 2021) • HAIR'apy – Stylist Circle or Hair & Care (Summer 2020 & 2021) • Leadership Circle of Resiliency (August 2020 & 2021) • Creative Soul Discovery – Art as Healing Youth Workshop (2x a year) • At the Feet of Sankofa – Emerging Leaders MH Symposium (Fall 2021) • Birth Workers Sister Circle – (Spring 2021 & 2022) • Eastern Stars – Intergenerational Soul Care (Summer 2020 & 2021)	• Unemployment • Incarceration • Prolonged suffering

Organization/Individual	Contact information	Populations Served	Description of Program	Negative Outcomes Addressed
Depression and Bipolar Support Alliance (DBSA) of California $96,000	Paul Simmons, Program Manager psimmons@dbsacalifornia.org (916) 215-4948 www.dbsalliance.org	TAY and Young Adults, age 14-18	**Selix Soft Skills Suite for Transition Age Youth and Young Adults** Is a suite of training seminars/workshops for consumers with the goal of empowering them and providing them information about peer support and MH services. Selix Soft Skills Suite was originally developed for and implemented with adults and older adult audiences. DBSA will modify and use Skills Suite for TAY and young adults.	• School failure/drop-out rate • Unemployment • Incarceration • Prolonged suffering
East Bay Asian Youth Center (EBAYC) $403,648	David Kakishiba, Executive Director junji@ebayc.org (510) 435-8582 www.ebayc.org	Sacramento County South East Asian Youth, age 14-18, including • Burmese • Cambodian • Chinese • Hmong • Laotian • Lao Lu-Mien • Vietnamese	**Groundwork II** is a community-defined evidence program that will: • Pair a youth with a youth advocate who is a life coach and mentor who provides support and assistance with developing and completing short-term goals and navigation through various systems. • Provide cultural affinity groups for both youth and advocates	• School failure/drop-out rate • Incarceration • Suicide
Friends for Survival $29,000	Marilyn Koenig, Executive Director info@friendsforsurvival.org (916) 392-0664 www.FriendsForSurvival.org	Communities/individuals who have been severely affected by suicide death and have already been in contact with Friends for Survival	**Caring Friends** is an intermediate level of support delivered by persons with similar experience targeting those who suffer from mental health issues such as anxiety, deep depression, anger, hopelessness, shame, guilt, fear, suicidal ideation Friends for Survival will establish a team of 10 trained volunteers who will provide the following support to individuals: • Regularly call and/or communicate in-person • Build rapport and offer empathy and comfort • Encouragement and support to focus on self-care and to seek out professional mental health services when needed • Information and referrals	• Suicide
Health Education Council $500,000	Amanda Bloom, MPH Director of Programs and Impact abloom@healthedcouncil.org (916) 556-3344 www.healthedcouncil.org	Spanish speaking young adults and adults, age 17-24	**Peers Helping Peers** (PHP) is a stigma reduction project designed and implemented through a collaboration between Health Education Council, Sacramento Employment and Training Agency (SETA), and citiesRISE. PHP uses a three-pronged approach by building community capacity, providing education and job experience for community residents. *SETA will participate in this program through in-kind funding. • Activity 1: Participant recruitment - PHP will recruit six (6) cohorts that include 10-15 Spanish-speaking adults and 10-15 system-involved young adults age 17-24 • Activity 2: Training Program will be offered three times a year. Training topics include Mental Health & Well-Being 101; Substance Abuse and Prevention; Conflict Mediation; Mental Health First Aid; and Work Readiness Skills • Activity 3: Peer Education on the Job Experience that includes job training and work experience	• Incarceration • School failure/drop-out rate • Prolonged suffering • Unemployment

Organization/Individual	Contact Information	Populations Served	Description of Program	Negative Outcomes Addressed
Her Health First $500,000	Shannon Shaw, Executive Director shannon@herhealthfirst.org (209) 617-0781 www.herhealthfirst.org	Low-income pregnant African-American Women	**Black Mothers United: Pregnancy & Mental Health Support Services** will utilize a five-stage approach that includes building community capacity-efforts by increasing the recognition of the early signs of postpartum depression and reducing stigma surrounding mental health within the African American community by education and trainings that include: • Black Mothers United (BMU) Program • Trauma-Informed Doula Services • Lactation Support Services • Mommy Mingles & Continuing Education • 1:1 home visitation/mentorship to improve mental health among pregnant African American women	• Suicide
Hmong Youth & Parents United $219,500	Mai Yang Thor, Executive Director Maiyang.thor@hypu.org (916) 692-4551 www.hypu.org	Hmong and other Southeast Asian community members, age 12 and up	**Mental Health & Wellbeing – Building Hmong Community Capacity** is a program designed to build community capacity regarding mental health and wellbeing through outreach activities, youth leadership activities, time-limited support groups for youth, parents, women and elderly. Program events include: • Community Engagement (October 2020 & October 2021) - Events include singing competitions, sports events, art exhibits, and paint nights, among others. • Youth Leadership Building Summit (April 2021 & April 2022) • Time-Limited Support Groups (Summer 2020 – April 2022)	• Suicide • School failure/drop-out rate • Prolonged suffering • Unemployment
Improve Your Tomorrow (IYT) $168,811	Michael Lynch, Co-Founder, CEO michael@improveyourtomorrow.org (916)-299-3432 www.improveyourtomorrow.org	Los Rios Community College District students of color, with a focus on African American Males	**Improve Your Tomorrow - Community Colleges Mental Health Initiative** is a program being developed by IYT & citiesRISE that will expand existing and implement new activities/services. Program will offer the following activities and services: • Monthly mental health workshops • Retreats • A series of barbershop sessions designed specifically for IYT-CC students • Bi-monthly sessions that offer prevention support for enrolled participants provided by a certified mental health counselor	• Incarceration • Homelessness • School failure/drop-out rate
International Rescue Committee, Inc. $368,094	Amy Watson, Sr. Program Manager – Health & Gender Amy.watson@rescue.org (916) 824-4200 www.rescue.org/sacramento	Refugee and Special Immigrant Visa holders, focusing on Dari & Arabic speaking communities	**The Community Wellness Program** will provide cultural and linguistic specific services that include: • Psychoeducation • Support groups • Youth and family cultural adjustment support • Community outreach and engagement • IRC's Community Wellness Specialist will become certified in Mental Health First Aid and will provide MHFA trainings in Dari and Arabic	• Suicide • Homelessness • Unemployment • Removal of children and/or older adults from their homes

Organization/Individual	Contact Information	Populations Served	Description of Program	Negative Outcomes Addressed
Justice Team Network $286,738	Annie Banks, Network Manager annie@justiceteams.org www.justiceteams.org	Households of color who chronically experience unemployment, homelessness, incarceration, high use of emergency medical services	**Mental Health First (MH First),** an existing program, is a mobile mental health first responder team, consisting of doctors, nurses, organizers, mental health professionals, peers and community members, who respond to mental health crises and offer domestic violence safety planning, substance use recovery support, mental health services. They will expand program services by: • Developing and facilitating eight (8) comprehensive trainings over two (2) years for community members on how to manage mental health crises without utilizing traditional methods of crisis intervention (e.g., police, EMS, and emergency rooms). • Hosting a "Together: No Stigma, No Shame" festival that will engage community members in English and Spanish and will address stigma associated with mental health issues and highlight stories about using alternative ways to maintain mental wellness.	• Homelessness • Incarceration • Unemployment
La Familia Counseling Center, Inc $250,000	Dr. Cesar A. Castaneda, EdD, LMFT – Mental Health Administrator cesarc@lafcc.org (916)- .210-8773 www.lafcc.org	South Sacramento LatinX Community focusing on: • Children • Youth • Parents • Families • Immigrant communities • Senior Citizens	**Juntos Podemos – Together We Can** is a comprehensive approach to reach marginalized communities, provide information and activities that build awareness about mental health issues, build understanding of signs of Mental Health issues within their families/communities, and provide a safe and nurturing environment. Activities will include: • Social skills building, workshops, internships that build leadership skills, promote positive behaviors, and empower youth • Parenting skills classes and workshops that provide information about parenting skills, understanding behaviors in youth, relational skills, recognizing signs of MH and dealing with past childhood trauma • Immigrant Communities trainings that provide information about understanding their rights, dealing with fear and trauma, family preparedness, public charge • MH First Aid training for community members • La Familia clinician consultation for community members about information and referrals for mental health services and other supportive services related to immigration	• School failure/drop-out rate • Prolonged suffering
Lao Family Community Development (LFCD) $500,000	Mai Quanch, Director of Programs Global Career Development Facilitator mquanch@lfcd.org (510) 533-8850 www.lfcd.org/	Sacramento County Refugee and Immigrant Community focusing on: • Afghanistan • Iraq • Southeast Asia • Middle East • US Born high barrier individuals, for example first generation born in US	**Health and Well-Being (HWB) Program** will provide the following culturally and linguistically appropriate services and activities: • Individual client centered family-focused case management • Peer support groups • Educational workshops • Weekly youth and senior events • Quarterly social events • Annual youth conference	• Suicide • Homelessness • School failure/drop-out rate • Prolonged suffering

Organization/Individual	Contact Information	Populations Served	Description of Program	Negative Outcomes Addressed
Mallory Ewing & Gale Anderson – Sacramento Youth Mental Health $148,350	Galle Anderson, Co-Founder (916) 217-8415 Mallory Ewing, Co-Founder (916) 407-8118 Sacteenmh@gmail.com www.sacymh.org	Sacramento County Teens, age 14-18, from diverse underrepresented communities	**Mindset Sacramento** will hold an annual Teen Mental Health Wellness conference in the spring 2021 & spring 2022, by youth for youth, that spreads awareness, reduces stigma associated with mental illness, and connects teens to local resources and mental health services	• Suicide • School failure/drop-out rate
Mental Health California $500,000	Kristene (K.N) Smith, CEO kn@mentalhealthca.org (916) 288-2466 www.mentalhealthca.org	Young Males of Color, age 16-26, focusing on those who identify as LGBTQIA within the following communities: • Black/African American • LatinX • Asian/Pacific Islander Native American	**Brother-Be-Well is** a virtual platform blending technology, education, awareness, and healing pathways to engage members through peer driven learnings and activities such as: • Storytelling • Creative arts • Regional workshops • Social clubs These activities will be launched at 10 schools and youth serving programs in Sacramento County	• Prolonged suffering
Muslim American Society – Social Services Foundation (MAS-SSF) $429,591	Gulshan Yusufzai, Executive Director gulshan.yusufzai@mas-ssf.org (916) 202-0707 www.mas-ssf.org/	Sacramento County South Asian and Middle Eastern immigrants and refugees	**MAS-SSF** will expand community education by offering more of the following activities: • Workshops and trainings on the following topics: Bullying prevention, raising teens in a new country, MH First Aid, Counseling 101, cultural sensitivity • Matrimonial Event • Qawwali Musical Event • Nasheed Musical Event • Mother Daughter and Father Son Events Restoring the Each Mind Matters Program training of Imams (religious leaders), Sunday school teachers, and youth to raise mental health awareness and reduce stigma	• Suicide • School failure/drop-out rate • Prolonged suffering • Unemployment • Removal of children and/or older adults from their homes

Organization/Individual	Contact Information	Populations Served	Description of Program	Negative Outcomes Addressed
NAMI Sacramento $309,000	David Bain, Executive Director david@namisacramento.org (916) 890-5467 www.namisacramento.org	Sacramento County underserved minority communities, communities of faith, schools	Through **Mental Health for All**, NAMI will expand education and support activities to reduce hospitalization, school drop-out, and unemployment due to relapse. First, NAMI will conduct community outreach to assess community need for the programs below. Following the community outreach, NAMI will tailor and provide programming based on the feedback received by the community. All programs will be data-informed, and participants will take part in surveys to improve the delivery of the project. NAMI's programs include: • Family and Connection Recovery Support Groups • "1 Degree of Separation's" mental health comedy shows • Community Advocates Reaching Everyone (CARE) classes • NAMI On Campus clubs • Ending the Silence school-age mental health awareness presentations • Our Own Voice peer presentations • Family to Family and Peer to Peer courses • WRAP	• Prolonged suffering • School failure/drop-out rate • Unemployment
Native Dads Network $9,999	Mike Duncan, CEO mikedndninc@gmail.com (916) 554-1085 www.nativedadsnetwork.org	Sacramento County Native American Communities	**Community Mental Health Capacity Building** is a one to two (1-2) day community event providing culturally driven teachings on the history of mental illness and historical trauma to a minimum of 50 unduplicated community members. The purpose of this event is to improve participants quality of life through supportive mental health activities such as: • Emotional and cognitive supportive interventions • Referrals to community service providers • Recruit and enroll participants • Educational didactics in historical trauma and its effects; effective communication; conflict resolution skills; decision making; self-care; emotional support	• Suicide • Homelessness • School failure/drop-out rate • Incarceration
Neighborhood Wellness Foundation $49,999	Gina Warren, Pharm.D., Executive Director gwarren@neighborhoodwellness.org (916) 335-8818 Marilyn Woods, CFO mwoods@neighborhoodwellness.org (916) 229-8938 www.neighborhoodwellness.org	All ethnicities with significant social emotional/economic challenges focusing on: • African American Youth, age 12-17 • African American Women, age 18-70	**Sister to Sister: Unmasking Mental Illness and Humanizing Community Awareness Program** will provide sage and trusted group sessions where participants can share individual trauma and begin to understand the neurological and resultant impact of generational adverse childhood experiences, adult trauma adversity and neighborhood toxic stress. Program activities include: • Sister weekly healing sessions for both adults and youth • 10-week empowerment program focusing on financial and digital literacy, housing stability, physical and mental women's health, parenting, socialization and workforce readiness • Humanizing Community Awareness-Host several community events as an opportunity to build community understanding and awareness of the needs of the Sister-to-Sister participants. • Sister to Sister participants will present their projects at the following events: • Assembly at Grant High School • Radio station presentation • MLK Community Wellness Expo	• Incarceration • Suicide

Organization/Individual	Contact Information	Populations Served	Description of Program	Negative Outcomes Addressed
Nor-Cal Services for the Deaf and Hard of Hearing $332,569	Christine Ellis, Peace of Mind Coordinator cellis@norcalcenter.org peaceofmind@norcalcenter.org	Sacramento County Deaf ASL Community	**Deaf Mental Health Access** will promote mental wellness in the Deaf community by providing information and services accessible in the language and culture of the Deaf community. The program will also be a resource to counseling and mental health professionals who serve Deaf individuals. Activities include: • 30 workshops for mental health providers about the language and culture of the Deaf community and how to serve Deaf and hard of hearing individuals. • Meet with 40 Deaf clients to assess need for mental health services, assist with accessing services, and advocate for their needs • Series of six (6) training sessions about suicide prevention awareness, early signs of mental illness, to a total of 25 NorCal staff and two (2) training sessions to 50 interpreters about interpreting in mental health settings • Coordinate 8 mental wellness activities in ASL with captioning to Deaf and hard of hearing community • Work with other community organizations to make their Mental Health related community events accessible to Deaf Community and promote the accessible events to Deaf Community • Contract for professional production of 5-7 ASL videos on subjects related to mental health • Facilitate peer group discussions for 50 Deaf/Hard of Hearing students at school DHH programs	• Suicide • Incarceration • Homelessness School failure/drop-out rate
ONTRACK Program Resources $462,670	Madalyn Rucker, Executive Director mcrucker@getontrack.org (916) 285-1805 www.ontrackconsulting.org	Unserved and underserved Black/African American Communities	**Soul Space African American PEI Support Services and Training** is a community based African American specific community-defined evidence-based PEI model that incorporates health education, life skills, wellness learning, social support, racially congruent support groups. Soul Space will use this model through the provision of the following activities; • Five (5) African American specific behavioral health provider trainings • Five (5) MHFA trainings to the community • 10 Soul Space community-based presentations • Support groups • Individual referral and navigation services Develop an African American Mental Health PEI toolkit for community members use	• Prolonged suffering

Organization/Individual	Contact Information	Populations Served	Description of Program	Negative Outcomes Addressed
Opening Doors, Inc. $215,000	Hibatallah Hummadi, Health Program Manager hibatallah@openingdoorsinc.org (916) 995-0379 www.openingdoorsinc.org	Afghan Women residing in the following communities: Arden-Arcade, Carmichael, Rancho Cordova and North Highlands	**Afghan Women's Wellness Program** is a non-stigmatizing women's peer support group that promotes community connectedness, coping skills, and access to mental health services with the goal of therapeutically reducing mental health stigma. Engagement with clients are trauma-informed, culturally responsive, and faith-sensitive to promote relevant and specialized services. We help empower them to become self-sufficient members of society through psychoeducation and case management. These 12-week support groups occur every quarter and are facilitated in English/Dari/Farsi.	• Suicide • Homelessness • Prolonged suffering
Public Health Advocates $250,000	DeAngelo Mack, Director of State Policy dm@phadvocates.org (916) 841-331 www.phadvocates.org	Boys and young men of color, age 13-24, residing in the following communities: Oak Park, South Sacramento, Meadowview, North Highlands and Arden Arcade	**My Brother's Keeper, Sacramento** will connect youth to supportive providers and engage youth as leaders in designing their own solutions, diminishing isolation and increasing power. My Brother's Keeper will provide the following activities: • Five (5) Trauma and Healing Learning workshops • Conduct youth led listening campaigns • Engage youth in advocating policy recommendations • Launching and promoting the Mental Health Access App to Sacramento Youth in 2021	• Suicide • School failure/drop-out rate • Incarceration
SAC Connect Therapeutic and Wellness Services $47,453	Sac Connect – Therapeutic and Wellness Services, Licensed Clinical Social Worker Thesacconnect@gmail.com (916) 400-0908 www.thesacconnect.org	Sacramento County Youth, Young Adults, and Families from low-income minority communities	**IAMHOPE (Increase Access to Mental Health Opportunities, Programs, and Education)** is a series of seminars providing opportunities for social services/mental health professionals, community organizations, or individuals with a stake in addressing disparities in mental health services, to share knowledge on available resources within different Sacramento County communities, the referral process for mental health services, effective engagement strategies for communities with the goal of reducing racial health disparities for the communities they serve. SAC Connect will host the IAMHOPE Event in the summer of 2021.	• School failure/drop-out rate • Suicide
Sacramento Covered $499,275	Jennifer Contreras, Project Manager jcontreras@sacramentocovered.org (916) 414-8333 www.sacramentocovered.org	Sacramento County Adults returning to the community following incarceration. Program will target individuals of all ethnicities who are living with a behavioral health diagnoses, particularly those who are at risk of homelessness.	**Expanding Outreach Capacity and Supportive Technology for Field-Based Behavioral Health Navigation and Cross Sector Coordination Program** will expand existing Medi-Cal coverage navigation services for individuals released from Sacramento County Jails (up to 3000). The project team will provide field- based navigation and capacity building services, including utilizing Peers and Community Health Workers. Efforts will include an enhancement and improvement of the Sacramento Covered Care Management web platform and field-based navigation/support services.	• Incarceration • Homelessness • School failure/drop-out rate • Removal of children and/or older adults from their homes • Prolonged suffering • Unemployment

Organization/Individual	Contact Information	Populations Served	Description of Program	Negative Outcomes Addressed
Sacramento LGBT Community Center $499,962	Jose Emmanuel Vega, Director of Health Services Jose.vega@saccenter.org (916) 442-0185 x122 www.saccenter.org	Sacramento County TAY & Adult LGBT Community and their families, focusing on: • Black • Indigenous • LatinX • Asian/South Asian/Pacific Islander • Homeless population • Youth at risk of incarceration • Children of parents affected by the War on Drugs	**Interrupting LGBTQ+ Mental Health Disparities** program will provide the following services: • Short-term stabilization counseling services to TAY and adults at the intersection of race and sexual identity with goal of assisting them in navigating their recovery paths • Youth outreach to inform clients about services and how to access services Triage the mental health needs of the most vulnerable clients	• Suicide • Homelessness • Incarceration • Unemployment
Safe Black Space $57,550	Dr. Kristee Haggins, Safe Black Space President safeblackspace@gmail.com (530) 683-5101 http://www.safeblackspace.org	Sacramento County youth and adults, age 14 and up, who identify as Black	**Safe Black Space** will hold monthly healing circles in a safe and supportive space for the local Black community to address racial stress and trauma by introducing participants to root causes of black racialized stress; teaching participants signs and symptoms of stress and trauma; engaging participants in culturally relevant practices for coping; and, providing participants with information on local resources.	• Prolonged suffering
Tarbiya Institute $319,000	Orooj Shahid, Nizami Director o.shahid@tarbiya.org (916) 800-4111 www.tarbiya.org	Sacramento County communities whose residents experience higher than normal emergency department visits for mental health services because of socioeconomic inequities and health disparities. Focus will be on zip codes 95841 and 95814 due to high rate of Emergency Department visits. Ability to expand to zip codes 95833, 95834 and 95835 due to easy accessibility.	**The Sakeenah Initiative** is a two-part community driven program with the goal of reducing the negative effects of untreated mental illness and ending prolonged generational suffering. **Part I:** Will consist of a series of Mental Health First Aid workshops. The workshops will be focused on the following participants: • Imams, mentors, program managers and community leaders • Parents, teachers, and various program volunteers • Youth **Part II:** A series of family friendly events that provide social-emotional support, assist in mental health stigma reduction and increase awareness of mental health services/resources. Events include: • Family sport activities • Paint nights • Hiking trips • Overnight family camping retreat • Mental health prevention screenings • Youth leadership council • Community-wide mental health resource fair • Teen-parenting communication workshop • Women's mental health workshop series	• Suicide • School failure/drop-out • Prolonged suffering
Teah M. Hairston $49,945	Teah M. Hairston Board Vice President, Sac ACT Board Vice President, SBS teahmhairston@gmail.com (916) 201-4255	Black, age 18-45, who have experienced fetal/perinatal death and are at-risk of prolonged psychological and emotional suffering	**Be Love Holistic Wellness** is a program that will offer bi-weekly trauma-informed workshops and groups over four (4) months that will address the mental, emotional, physical, and spiritual health issues related to fetal/perinatal death, and other pregnancy related problems which Black women are disproportionately affected.	• Prolonged suffering

Organization/Individual	Contact Information	Populations Served	Description of Program	Negative Outcomes Addressed
Trans & Queer Youth Collective (TQYC) $467,500	Judah Joslyn, Transgender Advocacy Director tqyouthcollective@gmail.com (916) 524-1663 www.tqyc.org	Sacramento County Transgender and Queer youth, age 10-17, of all races/ethnicities	**Trans & Queer Youth Collective (TQYC)** project will expand outreach efforts and gender affirming mental health services, LGBTQ+ education and individual and family assistance to better serve the queer and transgender teens. The Project will expand the following existing activities: • Outreach and stigma/discrimination reduction efforts using social media, resource distribution, and presentations. • Promote help-seeking and facilitate access to services/treatment by increasing partnerships • Weekly TQYC support groups from one (1) to four (4) to be held at all four locations • Two (2) to four (4) countywide convenings/events each year for TQYC youth • Assessing individual progress through self-reporting and professional tools to determine program effectiveness and quality improvement.	• Suicide • Homelessness • Incarceration • School failure/drop-out rate
University Enterprises, Inc. (UEI) – Sacramento State $98,261	Reva Wittenberg, Associate Director of Campus Wellness reva.wittenberg@csus.edu Lara Falkenstein, Health Educator Lara.falkenstein@csus.edu (916) 278-2036 www.enterprises.csus.edu	Black/African American, Latinx, Asian-American/Pacific Islander, Middle Eastern, Native American/Indigenous, and Mixed Race CSUS students who experience an equity gap in graduation rates.	**Supporting the Mental Health of Students of Color** is a two-phased program that will conduct research into mental health needs of students of color and implement culturally relevant strategies. • **Phase One:** Will consist of conducing mental health needs assessments among student groups. Through focus groups and key informant interviews, data will be collected on perceptions of mental health, risk and protective factors, and effective engagement strategies, with the intent of creating tailored, culturally responsive mental health programming and services. • **Phase Two:** UEI will implement strategies based on the findings from phase one.	• School failure/drop-out rate
Vietnam Veterans of California, Inc. dba Veterans Resource Centers of America (VRC) Now- *Nation's Finest* $325,552	Chris Cabral, CAO ccabral@nationsfinest.org (740) 501-1063 www.nationsfinest.org	Sacramento County Veterans and their family members	Through the **Veteran Mental Health Outreach, Education, and Prevention Initiative program**, VRC will host the following outreach activities that includes on-the-ground screening, information, and referral services at Mather Veterans Village. Outreach will occur through partnerships with Continuum of Care partners and at community locations (cars, parks, shelters, etc.) utilizing an organization-owned vehicle. Events include: • One (1) sporting event • Two (2) community education seminars • One (1) veteran art group • Three (3) veteran mental health resource fairs	• Suicide • Homelessness • Incarceration • Unemployment

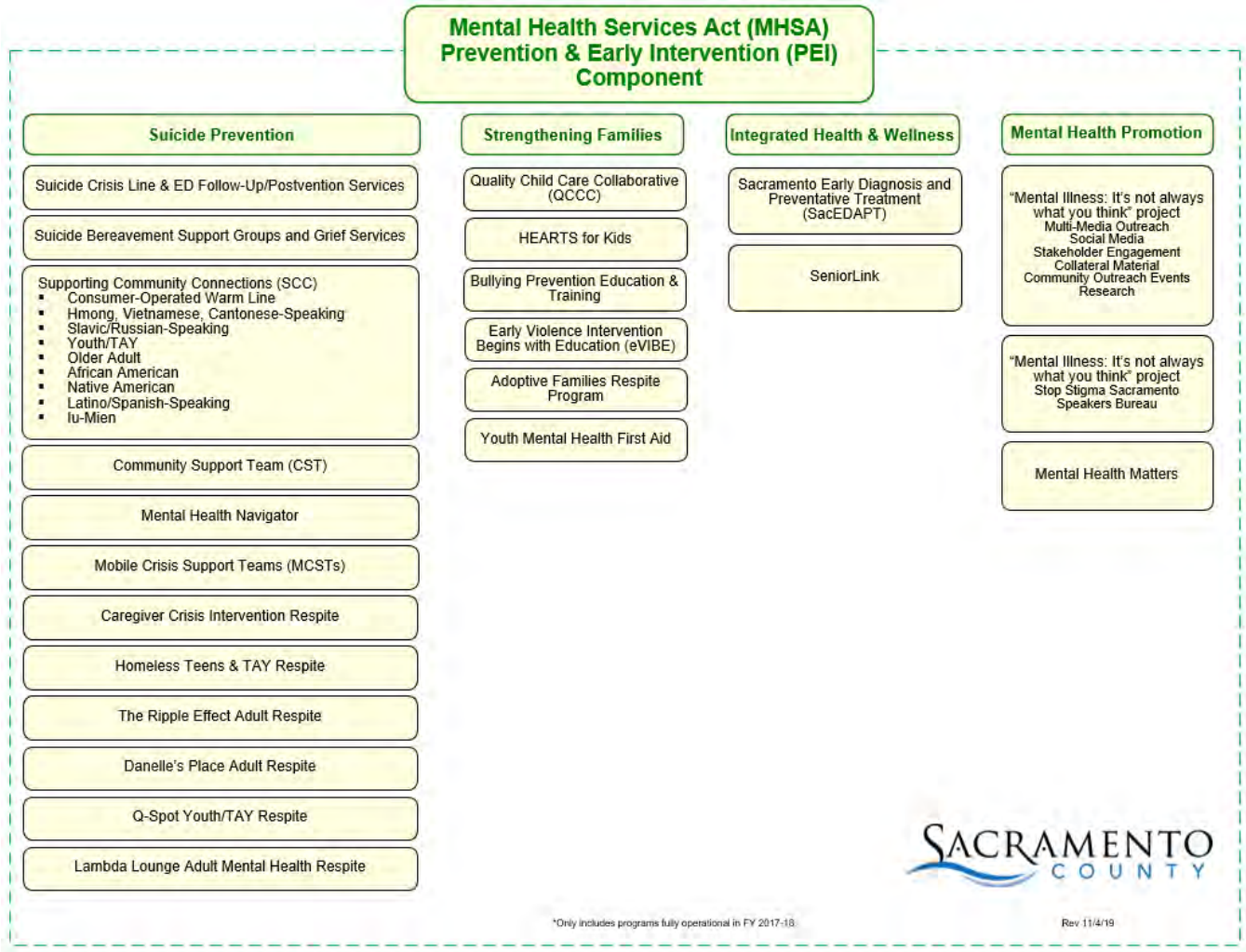
Organization/Individual	Contact Information	Populations Served	Description of Program	Negative Outcomes Addressed
WEAVE, Inc. $125,657	Gina Roberson, Chief Program Officer, Advocacy & Intervention Services groberson@weaveinc.org (916) 319-4951 www.weaveinc.org	Black/African American residents of South Sacramento's Valley Hi and Meadowview neighborhoods	**Healthy Black Families Collaborative** will train a Domestic Violence and Sexual Assault Peer Counselor Advocates, reflective of the community, who will be co- located at three (3) partner community-based organizations (CBOs) in the target neighborhoods. Advocates will be located up to 3 days/week at the partner CBO. Advocates will provide: • Emotional and mental health support • Resource and assistance navigation • Case management • Stigma reduction	• Incarceration • Removal of children and/or older adults from their homes • Prolonged suffering

Mental Health Services Act

Annual Prevention and Early Intervention Program and Evaluation Report

Fiscal Year 2019/2020

The Sacramento County Department of Health Services, Behavioral Health Services (BHS) has an array of Mental Health Services Act (MHSA) funded Prevention and Early Intervention (PEI) programs designed to serve the unserved and underserved communities in the County. The PEI programs range from outreach and engagement services to early identification and intervention for individuals experiencing early signs of psychosis. In Fiscal Year (FY) 19/20, BHS PEI funded programs served 51,826 individuals in selective prevention programs and 144,969 adults, children, parents/caregivers and education staff in universal prevention (Supporting Community Connections outreach and information/referral, Respite outreach, Bullying Prevention and Mental Health Promotion). The chart below depicts the range of programs the County offers. *Note: due to COVID-19, numbers are pending for Bullying Prevention.*



Suicide Prevention and Education Program
Ages Served: Children, TAY, Adults, Older Adults

The Suicide Prevention and Education Program consists of:

- Suicide Crisis Line
- Postvention Counseling Services
- Postvention – Suicide Bereavement Support Groups and Grief Services
- Supporting Community Connections
- Community Support Team
- Mental Health Navigator Program (Triage Navigators)
- Mobile Crisis Support Teams
- Mental Health Respite Programs

Suicide Crisis Line

Program Type: Suicide Prevention

Program Description: Administered by WellSpace Health, the 24-hour nationally accredited telephone crisis line that utilizes professional and trained volunteer staff to provide suicide prevention and crisis services to callers of all ages at risk of suicide.

Number Served: In FY 19/20, over 39,535 calls were made to the suicide hotline.

Demographics:

	N=39,535	%
Age Group		
Children/Youth (0-15)	1,915	4.8%
TAY (16-25)	6,927	17.5%
Adults (26-59)	8,376	21.2%
Older Adults (60+)	2,057	5.2%
Unknown/Not Reported	20,260	51.2%
Ethnicity		
Hispanic or Latino	1,959	5.0%
Non-Hispanic/Non-Latino	7,684	19.4%
Other	0	0.0%
More than one ethnicity	479	1.2%
Unknown/Not Reported	29,413	74.4%

Race	***N***	***%***
White	5,787	14.6%
Black or African American	901	2.3%
Asian	838	2.1%
American Indian or Alaska Native	45	0.1%
Native Hawaiian or other Pacific Islander	102	0.3%
More than one race	479	1.2%
Other	0	0.0%
Unknown/Not Reported	31,383	79.4%
Primary Language		
English	36,025	91.1%
Spanish	235	0.6%
Vietnamese	8	0.0%
Cantonese	3	0.0%
Russian	4	0.0%
Hmong	0	0.0%
Arabic	2	0.0%
Other	22	0.1%
Unknown/Not Reported	3236	8.2%
Sexual Orientation		
Heterosexual or Straight	712	1.8%
Gay or Lesbian	141	0.4%
Bisexual	24	0.1%
Questioning or unsure	11	0.0%
Queer	13	0.0%
Another sexual orientation	22	0.1%
Unknown/Not Reported	38,612	97.7%
Current Gender Identity		
Female	20,182	51.0%
Male	17,431	44.1%
Transgender	204	0.5%
Genderqueer	20	0.1%
Questioning or unsure	18	0.0%
Another gender identity	20	0.1%
Unknown/Not Reported	1,660	4.2%
Veteran Status		
Yes	706	1.8%
No	38,829	98.2%
Unknown/Not Reported	0	0.0%

Emergency Department Follow-up/Postvention Services

Program Type: Suicide Prevention

Program Description: Administered by WellSpace Health, brief individual follow-up and support services to consenting individuals seen at Sutter Medical Centers who have attempted suicide and are at high-risk for suicide.

Number Served:

In FY 19/20, 72 unduplicated individuals were served for a total of 182 contacts.

Demographics:

	N=72	%
Age Group		
Children/Youth (0-15)	0	0.0%
TAY (16-25)	0	0.0%
Adults (26-59)	0	0.0%
Older Adults (60+)	0	0.0%
Unknown/Not Reported	72	100.0%
Ethnicity		
Hispanic or Latino	4	5.6%
Non-Hispanic/Non-Latino	0	0.0%
Other	0	0.0%
More than one ethnicity	0	0.0%
Unknown/Not Reported	68	94.4%
Race		
White	6	8.3%
Black or African American	8	11.1%
Asian	0	0.0%
American Indian or Alaska Native	0	0.0%
Native Hawaiian or other Pacific Islander	0	0.0%
More than one race	0	0.0%
Other	2	2.8%
Unknown/Not Reported	56	77.8%

Primary Language		
English	0	0.0%
Spanish	0	0.0%
Vietnamese	0	0.0%
Cantonese	0	0.0%
Russian	0	0.0%
Hmong	0	0.0%
Arabic	0	0.0%
Other	0	0.0%
Unknown/Not Reported	72	100.0%
Sexual Orientation		
Heterosexual or Straight	0	0.0%
Gay or Lesbian	0	0.0%
Bisexual	0	0.0%
Questioning or unsure	0	0.0%
Queer	0	0.0%
Another sexual orientation	0	0.0%
Unknown/Not Reported	72	100.0%
Current Gender Identity		
Female	24	33.3%
Male	48	66.7%
Transgender	0	0.0%
Genderqueer	0	0.0%
Questioning or unsure	0	0.0%
Another gender identity	0	0.0%
Unknown/Not Reported	0	0.0%
Veteran Status		
Yes	N/R	N/R
No	N/R	N/R
Unknown/Not Reported	72	100.0%

Postvention – Suicide Bereavement Support Groups and Grief Services

Program Type: Suicide Prevention

Program Description: Administered by Friends for Survival, staff and volunteers directly impacted by suicide provide support groups and services designed to encourage healing for those coping with a loss by suicide.

Number Served: In FY 19/20, 246 total served. Note: this number is not unduplicated due to the anonymous nature of the program.

Demographics:

	N=246	%
Age Group		
Children/Youth (0-15)	0	0.0%
TAY (16-25)	7	2.8%
Adults (26-59)	119	48.4%
Older Adults (60+)	51	20.7%
Unknown/Not Reported	69	28.0%
Ethnicity		
Hispanic or Latino	13	5.3%
Non-Hispanic/Non-Latino	97	39.4%
Other	0	0.0%
More than one ethnicity	0	0.0%
Unknown/Not Reported	136	55.3%
Primary Language		
English	160	65.0%
Spanish	2	0.8%
Vietnamese	0	0.0%
Cantonese	0	0.0%
Russian	0	0.0%
Hmong	0	0.0%
Arabic	0	0.0%
Other	2	0.8%
Unknown/Not Reported	82	33.3%

Race		
American Indian or Alaska Native	2	0.8%
Asian	0	0.0%
Black or African American	2	0.8%
Filipino	8	3.3%
Japanese	9	3.7%
Native Hawaiian or other Pacific Islander	0	0.0%
White	124	50.4%
Other	3	1.2%
More than one race	1	0.4%
Unknown/Not Reported	97	39.4%
Sexual Orientation		
Gay or Lesbian	2	0.8%
Heterosexual or Straight	153	62.2%
Bisexual	3	1.2%
Questioning or unsure	0	0.0%
Queer	4	1.6%
Another sexual orientation	0	0.0%
Unknown/Not Reported	84	34.1%
Current Gender Identity		
Male	45	18.3%
Female	147	59.8%
Transgender	0	0.0%
Genderqueer	0	0.0%
Questioning or unsure	0	0.0%
Another gender identity	2	0.8%
Unknown/Not Reported	52	21.1%
Veteran Status		
Yes	11	4.5%
No	235	95.5%
Unknown/Not Reported	0	0.0%

Supporting Community Connections (SCC)

Program Type: Suicide Prevention

Program Description: A constellation of community based agencies working collaboratively throughout the County to provide culturally and linguistically appropriate suicide prevention support services designed to increase access to and linkage with needed services; improve self-reported life satisfaction and well-being; reduce risk factors and enhancement of protective factors; diversion from crisis services or decreased need for crisis services; decreased suicide risk; increased knowledge of available resources and supports; and enhanced connectedness and reduced isolation. Each program is specifically tailored to meet the needs of their respective communities. Eight underserved populations are served by different agencies throughout the community:

- Hmong, Vietnamese, Cantonese- speaking communities – Administered by Asian Pacific Community Counseling (APCC)
- Consumer Operated Warmline – Administered by Mental Health America of Northern California (NorCal MHA)
- Iu-Mien – Administered by Iu-Mien Community Services (IMCS)
- Native American – Administered by Sacramento Native American Health Center (SNAHC)
- Older Adult – Administered by Mental Health America of Northern California (NorCal MHA)
- Slavic/Russian Speaking Community – Administered by Slavic Assistance Center
- Latino/Spanish Speaking Community – Administered by La Family Counseling Center (LFCC)
- Youth/Transition Age Youth – Administered by the Children's Receiving Home

Number Served: In FY 19/20, SCC agencies served a total of 1,538 individuals.

Demographics:

Demographics	A Church for All (N=50)		Cantonese/ Vietnamese/Hmong (N=59)		Consumer Warmline (N=81)		Iu-Mein (N=106)		Native American (N=17)		Older Adults (N=17)		Russian Speaking/Slavic (N=158)		Spanish Speaking/Latino (N=570)		Youth/TAY (N=480)		Total (N=1538)	
			N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Age Group																				
Children/Youth (0-15)	4	8.0%	0	0.0%	0	0.0%	1	0.9%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	161	33.5%	166	10.8%
TAY (16-25)	5	10.0%	3	5.1%	6	7.4%	2	1.9%	1	5.9%	0	0.0%	6	3.8%	24	4.2%	315	65.6%	362	23.5%
Adults (26-59)	7	14.0%	22	37.3%	50	61.7%	14	13.2%	10	58.8%	10	58.8%	105	66.5%	510	89.5%	1	0.2%	729	47.4%
Older Adults (60+)	1	2.0%	23	39.0%	22	27.2%	70	66.0%	3	17.6%	6	35.3%	47	29.7%	26	4.6%	0	0.0%	198	12.9%
Unknown/Not Reported	33	66.0%	11	18.6%	3	3.7%	19	17.9%	3	17.6%	1	5.9%	0	0.0%	10	1.8%	3	0.6%	83	5.4%
Ethnicity																				
Hispanic or Latino	1	2.0%	0	0.0%	14	17.3%	1	0.9%	1	5.9%	4	23.5%	0	0.0%	568	99.6%	80	16.7%	669	43.5%
Non-Hispanic/Non-Latino	35	70.0%	58	98.3%	61	75.3%	0	0.0%	11	64.7%	11	64.7%	158	100.0%	0	0.0%	359	74.8%	693	45.1%
Other	0	0.0%	0	0.0%	0	0.0%	104	98.1%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	104	6.8%
More than one ethnicity	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Unknown/Not Reported	14	28.0%	1	1.7%	6	7.4%	1	0.9%	5	29.4%	2	11.8%	0	0.0%	2	0.4%	41	8.5%	72	4.7%
Race																				
American Indian or Alaska Native	0	0.0%	0	0.0%	0	0.0%	0	0.0%	15	88.2%	0	0.0%	0	0.0%	0	0.0%	11	2.3%	26	1.7%
Asian	0	0.0%	57	96.6%	12	14.8%	103	97.2%	1	5.9%	1	5.9%	0	0.0%	0	0.0%	4	0.8%	178	11.6%
Black or African American	48	96.0%	0	0.0%	7	8.6%	0	0.0%	0	0.0%	2	11.8%	0	0.0%	0	0.0%	184	38.3%	241	15.7%
Native Hawaiian or other Pacific Islander	0	0.0%	1	1.7%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	7	1.5%	8	0.5%
White	0	0.0%	0	0.0%	46	56.8%	1	0.9%	0	0.0%	11	64.7%	132	83.5%	0	0.0%	151	31.5%	341	22.2%
Other	0	0.0%	0	0.0%	8	9.9%	1	0.9%	0	0.0%	0	0.0%	0	0.0%	569	99.8%	87	18.1%	665	43.2%
More than one race	1	2.0%	1	1.7%	8	9.9%	1	0.9%	0	0.0%	0	0.0%	26	16.5%	0	0.0%	14	2.9%	51	3.3%
Unknown/Not Reported	1	2.0%	0	0.0%	0	0.0%	0	0.0%	1	5.9%	3	17.6%	0	0.0%	1	0.2%	22	4.6%	28	1.8%
Primary Language																				
English	50	100.0%	0	0.0%	81	100.0%	7	6.6%	17	100.0%	15	88.2%	0	0.0%	0	0.0%	477	99.4%	647	42.1%
Spanish	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	570	100.0%	0	0.0%	570	37.1%
Vietnamese	0	0.0%	1	1.7%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.1%
Cantonese	0	0.0%	8	13.6%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	8	0.5%
Russian	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	158	100.0%	0	0.0%	0	0.0%	158	10.3%
Hmong	0	0.0%	48	81.4%	0	0.0%	1	0.9%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	49	3.2%
Arabic	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	5.9%	0	0.0%	0	0.0%	0	0.0%	1	0.1%
Other	0	0.0%	2	3.4%	0	0.0%	98	92.5%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2	0.4%	102	6.6%
Unknown/Not Reported	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	5.9%	0	0.0%	0	0.0%	1	0.2%	2	0.1%
Sexual Orientation																				
Gay or Lesbian	6	12.0%	0	0.0%	4	4.9%	0	0.0%	0	0.0%	2	11.8%	0	0.0%	1	0.2%	27	5.6%	40	2.6%
Heterosexual or Straight	26	52.0%	59	100.0%	73	90.1%	100	94.3%	11	64.7%	15	88.2%	158	100.0%	567	99.5%	294	61.3%	1303	84.7%
Bisexual	3	6.0%	0	0.0%	3	3.7%	1	0.9%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	77	16.0%	84	5.5%
Questioning or unsure	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	42	8.8%	42	2.7%
Queer	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	5.9%	0	0.0%	0	0.0%	0	0.0%	10	2.1%	11	0.7%
Another sexual orientation	0	0.0%	0	0.0%	1	1.2%	0	0.0%	1	5.9%	0	0.0%	0	0.0%	1	0.2%	22	4.6%	25	1.6%
Unknown/Not Reported	15	30.0%	0	0.0%	0	0.0%	5	4.7%	4	23.5%	0	0.0%	0	0.0%	1	0.2%	8	1.7%	33	2.1%
Current Gender Identity																				
Male	18	36.0%	21	35.6%	20	24.7%	31	29.2%	1	5.9%	4	23.5%	81	51.3%	102	17.9%	150	31.3%	428	27.8%
Female	30	60.0%	38	64.4%	56	69.1%	75	70.8%	15	88.2%	13	76.5%	75	47.5%	467	81.9%	243	50.6%	1012	65.8%
Transgender	0	0.0%	0	0.0%	3	3.7%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	80	16.7%	83	5.4%
Genderqueer	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Questioning or unsure	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Another gender identity	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	7	1.5%	7	0.5%
Unknown/Not Reported	2	4.0%	0	0.0%	2	2.5%	0	0.0%	1	5.9%	0	0.0%	2	1.3%	1	0.2%	0	0.0%	8	0.5%
Veteran Status																				
Yes	1	2.0%	0	0.0%	1	1.2%	3	2.8%	0	0.0%	0	0.0%	0	0.0%	2	0.4%	0	0.0%	7	0.5%
No	49	98.0%	59	100.0%	80	98.8%	103	97.2%	17	100.0%	17	100.0%	158	100.0%	568	99.6%	480	100.0%	1531	99.5%

Supporting Community Connections (SCC) – Outreach

Program Type: Suicide Prevention – Universal Prevention

The SCC programs are required to provide outreach to the underserved communities for which they served. The agencies attend many community events throughout the year to educate their communities around suicide and mental illness.

Number Served - Outreach: In FY 19/20, the SCC programs attended 230 community events and disseminated information to 63,647 individuals.

Demographics: Due to the nature of the outreach events, demographics were not collected.

Supporting Community Connections (SCC) - Information and Referral

Program Type: Suicide Prevention – Universal Prevention

The SCC programs provide information and referrals to individuals in the community. These individuals may or may not receive ongoing services through the SCC program.

Number Served: in FY 19/20, the SCC programs disseminated information and made referrals to 9,592 individuals.

Demographics:

Demographics	A Church for All (N=2)		Children's Receiving Home (N=107)		Consumer Warmline (N=7109)		Friends for Survival (N=77)		Iu-Mein (N=365)		La Familia Counseling Center (N=486)		Norcal MHA Older Adults (N=1101)		Sacramento Native American Health Center (N=196)		Slavic Assistance Center (N=149)		Total (N=9592)	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Age Group																				
Children/Youth (0-15)	1	50.0%	0	0.0%	1	0.0%	0	0.0%	5	1.4%	0	0.0%	5	0.5%	22	11.2%	0	0.0%	34	0.4%
TAY (16-25)	0	0.0%	107	100.0%	121	1.7%	5	6.5%	36	9.9%	36	7.4%	19	1.7%	18	9.2%	6	4.0%	348	3.6%
Adults (26-59)	0	0.0%	0	0.0%	5421	76.3%	57	74.0%	86	23.6%	435	89.5%	574	52.1%	95	48.5%	96	64.4%	6764	70.5%
Older Adults (60+)	1	50.0%	0	0.0%	1542	21.7%	15	19.5%	238	65.2%	2	0.4%	455	41.3%	24	12.2%	46	30.9%	2323	24.2%
Unknown/Not Reported	0	0.0%	0	0.0%	24	0.3%	0	0.0%	0	0.0%	13	2.7%	48	4.4%	37	18.9%	1	0.7%	123	1.3%
Current Gender Identity																				
Male	0	0.0%	82	76.6%	2201	31.0%	15	19.5%	62	17.0%	76	15.6%	205	18.6%	48	24.5%	73	49.0%	2762	28.8%
Female	2	100.0%	24	22.4%	4694	66.0%	62	80.5%	303	83.0%	403	82.9%	868	78.8%	124	63.3%	73	49.0%	6553	68.3%
Transgender	0	0.0%	0	0.0%	57	0.8%	0	0.0%	0	0.0%	2	0.4%	0	0.0%	0	0.0%	0	0.0%	59	0.6%
Genderqueer	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Questioning or unsure	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Another gender identity	0	0.0%	0	0.0%	1	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.7%	2	0.0%
Unknown/Not Reported	0	0.0%	1	0.9%	156	2.2%	0	0.0%	0	0.0%	5	1.0%	28	2.5%	24	12.2%	2	1.3%	216	2.3%
Veteran Status																				
Yes	2	100.0%	1	0.9%	1	0.0%	0	0.0%	0	0.0%	0	0.0%	3	0.3%	1	0.5%	0	0.0%	8	0.1%
No	0	0.0%	106	99.1%	7108	100.0%	77	100.0%	365	100.0%	486	100.0%	1098	99.7%	195	99.5%	149	100.0%	9584	99.9%
Unknown/Not Reported	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%

Supporting Community Connections (SCC) – Satisfaction Survey Results

Survey Items	A Church for All	Asian Pacific Community Counseling (APCC)	Children's Receiving Home	Consumer Warmline	Friends For Survival	Iu-Mein	La Familia Counseling Center	Norcal MHA Older Adults	Sacramento Native American Health Center	Slavic Assistance Center
	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)
The services I received or group(s) I attended helped me in these areas										
Finding services and supports	100.0	98.9	100.0	96.9	100.0	99.6	100.0	100.0	93.7	100.0
Feeling less lonely	100.0	99.7	92.3	92.3	100.0	96.7	100.0	99.0	92.7	100.0
Manage my daily life stressors	100.0	98.7	92.0	100.0	100.0	95.5	100.0	100.0	96.1	100.0
Keeping myself safe	100.0	100.0	100.0	93.1	100.0	91.3	100.0	100.0	93.9	100.0
Managing a crisis	83.3	98.6	100.0	96.8	100.0	89.9	100.0	100.0	96.6	95.4
****I'll use these skills to help with…***										
Finding services and supports	87.5	100.0	100.0	93.7	100.0	98.4	99.8	100.0	95.8	100.0
Feeling less lonely	100.0	100.0	92.3	91.6	100.0	94.2	100.0	100.0	100.0	100.0
Manage my daily life stressors	87.5	100.0	91.7	100.0	99.3	93.6	75.0	100.0	97.3	100.0
Keeping myself safe	100.0	98.6	100.0	93.3	98.1	91.1	100.0	100.0	96.2	100.0
Managing a crisis	85.7	100.0	100.0	96.7	99.0	89.7	100.0	100.0	100.0	100.0

*The denominator varies for each question, as not all questions were applicable to every person who submitted a survey.

Satisfaction Survey Results – Cont.

Survey Items	A Church for All (N=19)	Asian Pacific Community Counseling (APCC) (N=106)	Children's Receiving Home (N=40)	Consumer Warmline (N=35)	Friends For Survival (N=277)	Iu-Mein (N=713)	La Familia Counseling Center (N=608)	Norcal MHA Older Adults (N=111)	Sacramento Native American Health Center (N=121)	Slavic Assistance Center (N=234)
	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)
I am more aware of community services and supports that can help me or others in my family as a result of the services I received or group I attended.										
Strongly Agree/Agree	84.2	99.1	75.0	97.1	74.7	95.5	100.0	100.0	92.6	89.3
Undecided	10.5	0.0	0.0	0.0	1.1	1.8	0.0	0.0	1.7	10.7
Disagree/Strongly Disagree	0.0	0.0	0.0	2.9	0.0	0.1	0.0	0.0	1.7	0.00
Not Applicable	5.3	0.0	25.0	0.0	24.2	2.5	0.0	0.0	4.1	0.00
Unknown	0.0	0.9	0.0	0.0	0.0	0.0	0.0	0.0	0	0.00
I learned skills from the services I received or groups that I attended that I use each day or share with others.										
Strongly Agree/Agree	100.0	97.2	72.5	97.1	74.7	90.3	89.3	100.0	92.6	89.3
Undecided	0.0	1.9	2.5	2.9	1.8	5.2	10.7	0.0	2.5	10.7
Disagree/Strongly Disagree	0.0	0.0	0.0	0.0	0.0	0.3	0.0	0.0	0.0	0.0
Not Applicable	0.0	0.0	25.0	0.0	23.5	4.2	0.0	0.0	5.0	0.0
Unknown/Not Reported	0.0	0.9	0.0	0.0	0.0	0	0.0	0.0	0.0	0.0
I would come back again if I needed help for myself or others in my family.										
Strongly Agree/Agree	94.7	94.3	72.5	88.6	76.5	95.1	100.0	99.1	92.6	88.9
Undecided	0.0	0.9	0.0	0.0	0.7	2.7	0.0	0.0	1.7	10.7
Disagree/Strongly Disagree	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0
Not Applicable	5.3	2.8	27.5	11.4	22.7	2.1	0.0	0.9	5.8	0.0
Unknown/Not Reported	0.0	1.9	0.0	0.0	0.0	0	0.0	0.0	0.0	0.4

Satisfaction Survey Results – Cont.

Survey Items	A Church for All (N=19)	Asian Pacific Community Counseling (APCC) (N=106)	Children's Receiving Home (N=40)	Consumer Warmline (N=35)	Friends For Survival (N=277)	Iu-Mein (N=713)	La Familia Counseling Center (N=608)	Norcal MHA Older Adults (N=111)	Sacramento Native American Health Center (N=121)	Slavic Assistance Center (N=234)
	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)
As a result of he services I received or groups I attended, I know how to get help if I knew someone who is considering suicide, harming themselves or if I felt suicidal or like harming myself.										
Strongly Agree/Agree	78.9	92.5	72.5	99.1	71.8	76.4	100.0	99.1	89.3	89.3
Undecided	21.1	3.8	0.0	0.9	1.4	9.3	0.0	0.0	2.5	10.7
Disagree/Strongly Disagree	0.0	0.0	0.0	0.0	0.7	0.6	0.0	0.0	1.7	0.0
Not Applicable	0.0	2.8	27.5	0.0	26.0	13.7	0.0	0.9	6.6	0.0
Unknown/Not Reported	0.0	0.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
I felt the services I received reflected my cultural beliefs, preferences, and values which made me feel respected.										
Strongly Agree/Agree	89.5	96.2	67.5	77.1	71.8	91.6	100.0	100.0	93.4	89.3
Undecided	0.0	0.0	2.5	0.0	2.2	4.5	0.0	0.0	2.5	10.7
Disagree/Strongly Disagree	5.3	0.0	0.0	2.9	0.4	1.1	0.0	0.0	0.0	0.0
Not Applicable	5.3	2.8	30.0	20.0	25.6	2.8	0.0	0.0	4.1	0.0
Unknown/Not Reported	0.0	0.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Community Support Team (CST)

Program Type: Suicide Prevention

Program Description: Administered jointly by BHS and Crossroads Vocational Services, the CST is a collaboration between county and community based organization staff creating one team with a variety of clinical and outreach skills. The team includes peer support specialists with lived experience, professional staff with clinical experience and family support specialists whose experience builds bridges and communication with family members, natural supports and extended family systems**.** The CST serves all age groups and the individual's family members and/or caregivers. CST provides field-based flexible services to community members experiencing a crisis. Services include assessment, support services and linkage to ongoing services and supports.

Number Served: In FY 19/20, the CST team served a total of 1250 individuals in the County Clinical program. Note: all individuals are served by County Clinical Services, but not all are served by Crossroads Peer Services. The numbers below are duplicated across components, if a client was served in both programs.

Demographics:

	Sacramento County Clinical Services (N=1250)		**Crossroads Peer Services (N=451)**	
Age Group				
Child and Youth (0-15)	22	1.8%	4	0.9%
Transition Age Youth (16-25)	113	9.0%	56	12.4%
Adult (26-59)	661	52.9%	245	54.3%
Older Adult (60+)	136	10.9%	126	27.9%
Unknown/Not Reported	318	25.4%	20	4.4%
Ethnicity				
Hispanic	149	11.9%	42	9.3%
Non-Hispanic	586	46.9%	203	45.0%
Unknown/Not Reported	515	41.2%	206	45.7%
Race				
White	356	28.5%	122	27.1%
African American	244	19.5%	81	18.0%
Asian	39	3.1%	18	4.0%
Pacific Islander	15	1.2%	6	1.3%
Native American	18	1.4%	5	1.1%
Multi-Race	36	2.9%	11	2.4%
Other	104	8.3%	33	7.3%
Unknown/Not Reported	438	35.0%	175	38.8%

	Sacramento County Clinical Services (N=1250)		Crossroads Peer Services (N=451)	
Primary Language				
English	918	73.4%	329	72.9%
Spanish	12	1.0%	6	1.3%
Vietnamese	1	0.1%	2	0.4%
Cantonese	2	0.2%	1	0.2%
Hmong	3	0.2%	1	0.2%
Russian	5	0.4%	2	0.4%
Arabic	2	0.2%	2	0.4%
Other	7	0.6%	4	0.9%
Unknown/Not Reported	300	24.0%	104	23.1%
Sexual Orientation				
Gay or Lesbian	21	1.7%	7	1.6%
Heterosexual or Straight	572	45.8%	165	36.6%
Bisexual	13	1.0%	4	0.9%
Questioning or unsure	3	0.2%	1	0.2%
Queer	1	0.1%	0	0.0%
Another sexual orientation	0	0.0%	0	0.0%
Unknown/Not Reported	640	51.2%	274	60.8%
Gender Identity				
Male	396	31.7%	87	19.3%
Female	287	23.0%	115	25.5%
Transgender	3	0.2%	1	0.2%
Genderqueer	0	0.0%	0	0.0%
Questioning or unsure	0	0.0%	0	0.0%
Another gender identity	0	0.0%	0	0.0%
Unknown/Not Reported	564	45.1%	248	55.0%
Veteran Status				
Yes	NR		NR	
No	NR		NR	
Decline to Answer	NR		NR	
Unknown/Not Reported	1,250	100.0%	451	100.0%

CST – Satisfaction Survey Results

Survey Items	N=130	%
As a result of the services I receive from the program, I am more aware of community services and supports that are available and how they can help me or others in my family.		
Strongly Agree	10	7.7%
Agree	16	12.3%
Undecided	0	0.0%
Disagree	0	0.0%
Strongly Disagree	0	0.0%
Not Applicable	104	80.0%
As a result of the services I receive from the program, I know how to access Mental Health support for myself or others in my family.		
Strongly Agree	15	11.5%
Agree	10	7.7%
Undecided	0	0.0%
Disagree	0	0.0%
Strongly Disagree	0	0.0%
Not Applicable	105	80.8%
As a result of the services I receive from the program, I know how to keep myself and/or others safe in times of crisis.		
Strongly Agree	9	6.9%
Agree	16	12.3%
Undecided	1	0.8%
Disagree	0	0.0%
Strongly Disagree	0	0.0%
Not Applicable	104	80.0%
As a result of the services I receive from the program, I feel more empowered and hopeful.		
Strongly Agree	15	11.5%
Agree	9	6.9%
Undecided	2	1.5%
Disagree	0	0.0%
Strongly Disagree	0	0.0%
Not Applicable	104	80.0%
I feel the program staff that I work with listen to me.		
Strongly Agree	17	13.1%
Agree	9	6.9%
Undecided	0	0.0%
Disagree	0	0.0%
Strongly Disagree	0	0.0%
Not Applicable	104	80.0%
I feel the services I receive from the program reflect my cultural beliefs, preferences and values.		
Strongly Agree	10	7.7%
Agree	15	11.5%
Undecided	1	0.8%
Disagree	0	0.0%
Strongly Disagree	0	0.0%
Not Applicable	104	80.0%

Mental Health Navigator Program (Triage Navigators)

Program Type: Suicide Prevention

Program Description: Administered by TLCS, Inc., provides brief site-based and community-based engagement for those recently involved in crisis services or incarceration as a result of their mental illness. Triage Navigators provide care coordination, advocacy, system navigation and linkage to services for individuals living with serious mental illness who are homeless, at-risk of homelessness, and/or may have a co-occurring substance use disorder. The navigators are sited a participating hospital emergency rooms and law enforcement agencies as well as community-based Navigators able to follow-up with individuals where needed throughout Sacramento County. The Triage Navigator program serves children, youth, Transition Age Youth (TAY), adults and older adults with the goal of reducing unnecessary hospitalizations, and incarcerations as well as mitigating unnecessary expenditures of law enforcement.

Number Served: In FY 19/20, the Triage Navigators served a total of 2,547 unduplicated individuals.

Demographics:

	N=2547	%
Age Group		
Children/Youth (0-15)	104	4.1%
TAY (16-25)	440	17.3%
Adults (26-59)	1662	65.3%
Older Adults (60+)	336	13.2%
Unknown/Not Reported	5	0.2%
Ethnicity		
Hispanic	318	12.5%
Non-Hispanic	1417	55.6%
Unknown/Not Reported	812	31.9%
Race		
American Indian or Alaska Native	28	1.1%
Asian	120	4.7%
Black or African American	511	20.1%
Native Hawaiian or other Pacific Islander	13	0.5%
White	1032	40.5%
Other	244	9.6%
More than one race	77	3.0%
Unknown/Not Reported	522	20.5%

Demos Cont.	**N**	**%**
Primary Language		
English	2277	89.4%
Spanish	33	1.3%
Vietnamese	0	0.0%
Cantonese	1	0.0%
Russian	8	0.3%
Hmong	1	0.0%
Arabic	1	0.0%
Other	26	1.0%
Unknown/Not Reported	200	7.9%
Sexual Orientation		
Gay or Lesbian	11	0.4%
Heterosexual or Straight	197	7.7%
Bisexual	17	0.7%
Questioning or unsure	6	0.2%
Queer	0	0.0%
Another sexual orientation	1	0.0%
Unknown/Not Reported	2315	90.9%
Sex at Birth		
Male	1302	51.1%
Female	1242	48.8%
Unknown/Not Reported	3	0.1%
Current Gender Identity		
Male	539	21.2%
Female	439	17.2%
Transgender	7	0.3%
Genderqueer	0	0.0%
Questioning or unsure	0	0.0%
Another gender identity	2	0.1%
Unknown/Not Reported	1560	61.3%

Mobile Crisis Support Teams (MCST)

Program Type: Suicide Prevention

Program Description: Administered in partnership with BHS, TLCS Inc., and local law enforcement. The MCSTs are dispatched through law enforcement to provide immediate engagement with individuals experiencing a mental health crisis for the purpose of providing care and maintaining community safety. At the time a mental health crisis comes to the attention of law enforcement, an officer/deputy and the Senior Mental Health Counselor are dispatched to provide timely crisis intervention and assessment. After initial contact with the individual in crisis, the Clinician works in collaboration with the TLCS Peer to provide continued support and linkage to services until stabilized and appropriate community resources and linkages are established.

Number Served: In FY 19/20, the MCST teams served a total of 1,559 unduplicated individuals in the community.

Demographics:

	N=1559	%
Age Group		
Children/Youth (0-15)	111	7.1%
TAY (16-25)	285	18.3%
Adults (26-59)	898	57.6%
Older Adults (60+)	262	16.8%
Unknown/Not Reported	3	0.2%
Ethnicity		
Hispanic or Latino	172	11.0%
Non-Hispanic/Non-Latino	927	59.5%
Other	45	2.9%
More than one Ethnicity	0	0.0%
Unknown/Not Reported	415	26.6%
Race		
White	811	52.0%
Black or African American	251	16.1%
Asian	30	1.9%
American Indian or Alaska Native	16	1.0%
Native Hawaiian or other Pacific Islander	63	4.0%
More than one race	63	4.0%
Other	150	9.6%
Unknown/Not Reported	175	11.2%
Primary Language		
English	1448	92.9%
Spanish	24	1.5%
Vietnamese	5	0.3%
Cantonese	2	0.1%
Russian	12	0.8%
Hmong	1	0.1%
Arabic	1	0.1%
Other	17	1.1%
Unknown/Not Reported	49	3.1%

Sexual Orientation		
Heterosexual or Straight	589	37.8%
Gay or Lesbian	16	1.0%
Bisexual	1	0.1%
Questioning or unsure	7	0.5%
Queer	0	0.0%
Another sexual orientation	2	0.1%
Unknown/Not Reported	944	60.6%
Current Gender Identity		
Male	419	26.9%
Female	394	25.3%
Transgender	3	0.2%
Genderqueer	0	0.0%
Questioning or unsure	0	0.0%
Another gender identity	2	0.1%
Unknown/Not Reported	741	47.5%

Mental Health Respite Programs

Program Type: Suicide Prevention

Program Description(s):

Respite program goals include providing a safe environment in which participants increase their knowledge of available supports and how to access them, improve well-being, reduce stress, increase connectedness and reduce feelings of isolation, decrease risk of harm, and reduce visits to the emergency room and psychiatric hospitals. There are currently 6 respite programs:

Caregiver Crisis Intervention Respite Program – Del Oro Caregiver Resource Center: Administered by Del Oro Caregiver Resource Center, helps decrease hospitalizations due to mental health crises of family caregivers of dementia patients. The program provides respite care, family consultation, home visits and an assessment with a Master's level clinician to develop a care plan focused on services, supports and wellness. The program serves adult caregivers of all age groups with the majority of caregivers being in the 60+ age range.

Homeless Teens and Transition Age Youth (TAY) Respite Program – Wind Youth Services: Administered by Wind Youth Services, provides mental health crisis respite care, via a drop in center or pre-planning, to transition age youth age 13-25 years old, who are experiencing overwhelming stress due to life circumstance and homelessness. Services include screening, planning, crisis intervention, enriching workshops, health screenings, groups, crisis counseling and case management.

Danelle's Place Respite Program – Gender Health Center: Administered by Gender Health Center, provides mental health respite care, via a drop in center, to unserved and underserved adults ages 18 and over, who identify as lesbian, gay, bisexual, transgender, queer, questioning and/or allied adults. There is an emphasis on serving transgender individuals who are experiencing overwhelming stress due to life circumstances, in order to prevent an acute mental health crisis. Services shall include: assessment, supportive activities, individual and group chat, narrative authoring activities, therapeutic art activities, peer counseling, other crisis prevention services, and community outreach activities.

The Ripple Effect Respite Program – A Church for All: Administered by A Church for All, provides planned mental health respite care designed to prevent acute mental health crisis from occurring for adults ages eighteen and older, with an emphasis on people of color who may identify as LGBTQ. The program utilizes a peer run structure to increase social connectedness and operates a daily support group that helps participants overcome suicide risk factors.

Lambda Lounge Adult Mental Health Respite Program - Sacramento LGBT Community Center: Administered by Sacramento LGBT Community Center, provides drop-in mental health respite care designed to prevent an acute mental health crisis from occurring, as well as suicide prevention support services to unserved and underserved adults ages twenty-four (24) and older who identify as LGBTQ. The program offers a variety of support groups focused on mitigating risk factors, building healthy relationships, health and wellness, etc.

Q Spot Youth/Transition Age Youth (TAY) Respite Program – Sacramento LGBT Community Center: Administered by Sacramento LGBT Community Center, provides drop-in mental health respite care and supportive services to unserved and underserved youth/TAY ages thirteen (13) through twenty-three (23) who

identify as LGBTQ. In FY 2016-17, several new youth groups were implemented to focus on decreasing suicide risk, promoting healthy relationships and life skill development.

Number Served: In FY 19/20, the respite programs served a total of 1,752 individuals in the community.

Demographics:

Demographics	Del Oro (N=41)		A Church for All (N=122)		Gender Health Center (N=211)		LGBT-Lambda Lounge (N=374)		LGBT-Q-Spot (N=194)		Wind Youth Services (N=810)		Total (N=1752)	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Age Group														
Children/Youth (0-15)	0	0.0%	0	0.0%	1	0.5%	0	0.0%	13	6.7%	4	0.5%	18	1.0%
TAY (16-25)	0	0.0%	10	8.2%	45	21.3%	35	9.4%	177	91.2%	791	97.7%	1058	60.4%
Adults (26-59)	10	24.4%	93	76.2%	123	58.3%	201	53.7%	1	0.5%	3	0.4%	431	24.6%
Older Adults (60+)	31	75.6%	19	15.6%	15	7.1%	25	6.7%	0	0.0%	0	0.0%	90	5.1%
Unknown/Not Reported	0	0.0%	0	0.0%	27	12.8%	113	30.2%	3	1.5%	12	1.5%	155	8.8%
Ethnicity														
Hispanic or Latino	7	17.1%	12	9.8%	32	15.2%	57	15.2%	54	27.8%	151	18.6%	313	17.9%
Non-Hispanic/Non-Latino	33	80.5%	65	53.3%	130	61.6%	236	63.1%	106	54.6%	557	68.8%	1127	64.3%
Unknown/Not Reported	1	2.4%	45	36.9%	49	23.2%	81	21.7%	34	17.5%	102	12.6%	312	17.8%
Race														
American Indian or Alaska Native	3	7.3%	1	0.8%	3	1.4%	11	2.9%	10	5.2%	19	2.3%	47	2.7%
Asian	2	4.9%	0	0.0%	1	0.5%	2	0.5%	3	1.5%	5	0.6%	13	0.7%
Black or African American	5	12.2%	14	11.5%	32	15.2%	37	9.9%	47	24.2%	438	54.1%	573	32.7%
Multi-Race	0	0.0%	47	38.5%	18	8.5%	20	5.3%	23	11.9%	45	5.6%	153	8.7%
Native Hawaiian or other Pacific Islander	2	4.9%	0	0.0%	11	5.2%	6	1.6%	3	1.5%	23	2.8%	45	2.6%
White	24	58.5%	27	22.1%	118	55.9%	172	46.0%	73	37.6%	188	23.2%	602	34.4%
Other	5	12.2%	30	24.6%	17	8.1%	87	23.3%	15	7.7%	62	7.7%	216	12.3%
Unknown/Not Reported	0	0.0%	3	2.5%	11	5.2%	39	10.4%	20	10.3%	30	3.7%	103	5.9%
Primary Language														
English	35	85.4%	120	98.4%	191	90.5%	351	93.9%	191	98.5%	792	97.8%	1680	95.9%
Non-English	5	12.2%	2	1.6%	18	8.5%	17	4.5%	3	1.5%	12	1.5%	57	3.3%
Unknown/Not Reported	1	2.4%	0	0.0%	2	0.9%	6	1.6%	0	0.0%	6	0.7%	15	0.9%

Note: numbers are unduplicated by program, but not in total. Some individuals could have been seen by multiple programs.

Demographics	Del Oro (N=41)		A Church for All (N=122)		Gender Health Center (N=211)		LGBT-Lambda Lounge (N=374)		LGBT-Q-Spot (N=194)		Wind Youth Services (N=810)		Total (N=1752)	
Gender Identity														
Agender	0	0.0%	0	0.0%	0	0.0%	0	0.0%	6	3.1%	3	0.4%	9	0.5%
Female	31	75.6%	49	104.3%	59	28.0%	86	23.0%	46	23.7%	339	41.9%	610	35.7%
Gender Fluid	0	0.0%	0	0.0%	8	3.8%	4	1.1%	6	3.1%	4	0.5%	22	1.3%
Gender Nonbinary	0	0.0%	2	4.3%	9	4.3%	6	1.6%	11	5.7%	7	0.9%	35	2.0%
Gender Queer	0	0.0%	3	6.4%	13	6.2%	7	1.9%	0	0.0%	6	0.7%	29	1.7%
Intersex	0	0.0%	0	0.0%	0	0.0%	2	0.5%	1	0.5%	1	0.1%	4	0.2%
Male	10	24.4%	77	163.8%	86	40.8%	199	53.2%	83	42.8%	428	52.8%	883	51.6%
Transgender	0	0.0%	4	8.5%	74	35.1%	22	5.9%	33	17.0%	22	2.7%	155	9.1%
Two Spirit	0	0.0%	0	0.0%	4	1.9%	1	0.3%	0	0.0%	6	0.7%	11	0.6%
Another gender identity	0	0.0%	1	2.1%	4	1.9%	1	0.3%	1	0.5%	2	0.2%	9	0.5%
Questioning	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Unknown/Not Reported	0	0.0%	0	0.0%	3	1.4%	54	14.4%	12	6.2%	14	1.7%	83	4.9%
Veteran Status														
Yes	5	12.2%	11	9.0%	17	8.1%	11	2.9%	0	0.0%	4	0.5%	48	2.8%
No	36	87.8%	80	65.6%	194	91.9%	191	51.1%	172	88.7%	769	94.9%	1442	84.3%
Unknown/Not Reported	0	0.0%	31	25.4%	0	0.0%	172	46.0%	22	11.3%	37	4.6%	262	15.3%

**Gender identity is greater than 100% as some clients' identity with more than one gender*

Satisfaction Survey Results – Respite Programs

Survey Items	Del Oro	A Church For All	Gender Health Center	Sacramento LGBT Community Center – Lambda Lounge	Sacramento LGBT Community Center – Q Spot
	(%)	(%)	(%)	(%)	(%)
The services I received or group(s) I attended helped me in these areas					
Finding services and supports	79.8	100.0	96.7	100.0	97.7
Feeling less lonely	57.4	100.0	95.9	99.8	96.9
Manage my daily life stressors	68.1	100.0	98.2	99.4	89.2
Keeping myself safe	31.9	100.0	99.4	99.3	94.6
Managing a crisis	41.5	100.0	95.4	99.2	90.7
****I'll use these skills to help with…***					
Finding services and supports	71.3	100.0	99.4	99.7	94.9
Feeling less lonely	43.6	100.0	100.0	99.8	95.3
Manage my daily life stressors	74.5	100.0	100.0	99.8	92.0
Keeping myself safe	36.2	100.0	98.7	99.5	94.7
Managing a crisis	47.9	100.0	100.0	99.6	92.7

****The denominator varies for each question, as not all questions were applicable to every person who submitted a survey.***

Satisfaction Survey Results – Cont.

Survey Items	Del Oro	A Church For All	Gender Health Center	Sacramento LGBT Community Center – Lambda Lounge	Sacramento LGBT Community Center – Q Spot
	N=94	N=163	N=184	N=1193	N=236
	(%)	(%)	(%)	(%)	(%)
I am more aware of community services and supports that can help me or others in my family as a result of the services I received or group I attended.					
Strongly Agree/Agree	82.0	93.9	87.0	95.1	81.4
Undecided	2.0	3.1	1.1	2.0	10.2
Disagree/Strongly Disagree	4.0	0.0	0.5	0.8	3.0
Not Applicable	1.0	0.0	11.4	2.1	5.5
Unknown/Not Reported	11.0	3.1	0.0	0.0	0.0
I learned skills from the services I received or groups that I attended that I use each day or share with others.					
Strongly Agree/Agree	68.0	94.5	84.2	93.0	81.4
Undecided	6.0	1.8	3.3	3.0	6.4
Disagree/Strongly Disagree	4.0	0.0	1.1	0.5	3.0
Not Applicable	6.0	0.6	11.4	3.4	8.9
Unknown/Not Reported	16.0	3.1	0.0	0.0	0.4
I would come back again if I needed help for myself or others in my family.					
Strongly Agree/Agree	82.0	96.3	96.7	96.4	90.7
Undecided	1.0	0.6	0.0	1.3	3.8
Disagree/Strongly Disagree	5.0	0.0	0.5	0.9	0.8
Not Applicable	7.0	0.0	2.7	1.4	4.7
Unknown/Not Reported	5.0	3.1	0.0	0.0	0.0
As a result of the services I received or group(s) I attended, I know how to get help if I knew someone who is suicidal or if I felt suicidal.					
Strongly Agree/Agree	66.0	87.7	76.6	88.9	72.9
Undecided	6.0	6.7	2.7	4.1	7.2
Disagree/Strongly Disagree	5.0	0.0	1.1	1.3	6.8
Not Applicable	11.0	3.1	19.6	5.7	13.1
Unknown/Not Reported	12.0	2.5	0.0	0.0	0.0
I felt the services I received reflected my cultural beliefs, preferences, and values which made me feel respected.					
Strongly Agree/Agree	73.0	96.3	89.1	94.8	76.3
Undecided	1.0	1.2	6.5	2.3	10.2
Disagree/Strongly Disagree	5.0	0.0	1.1	0.6	3.4
Not Applicable	12.0	0.0	3.3	2.3	10.2
Unknown/Not Reported	9.0	2.5	0.0	0.0	0.0
I would like this program or group to expand in order to provide more access and/or services.					
Strongly Agree/Agree	NR	96.3	92.9	96.1	81.8
Undecided	NR	0.6	3.3	2.0	7.6
Disagree/Strongly Disagree	NR	0.0	0.0	0.5	2.1
Not Applicable	NR	0.0	3.8	1.4	8.5
Unknown/Not Reported	NR	3.1	0.0	0.0	0.0

Satisfaction Survey Results - Wind Youth Services

Survey Items	N= 1196	
	N	%
I felt safer (emotionally or physically)		
Completely True	701	58.6%
Mostly True	233	19.5%
A Little True	120	10.0%
Not at All	23	1.9%
Decline to State	119	9.9%
The visit helped me make connections with others or feel less alone		
Completely True	657	54.9%
Mostly True	259	21.7%
A Little True	124	10.4%
Not at All	33	2.8%
Decline to State	123	10.3%
Staff were respectful and helped me feel accepted		
Completely True	699	58.4%
Mostly True	243	20.3%
A Little True	109	9.1%
Not at All	26	2.2%
Decline to State	119	9.9%
I learned something helpful today		
Completely True	658	55.0%
Mostly True	227	19.0%
A Little True	141	11.8%
Not at All	46	3.8%
Decline to State	124	10.4%
I know where to go if I need help		
Completely True	691	57.8%
Mostly True	244	20.4%
A Little True	113	9.4%
Not at All	30	2.5%
Decline to State	118	9.9%
This visit helped me feel less stressed		
Completely True	664	55.5%
Mostly True	242	20.2%
A Little True	127	10.6%
Not at All	33	2.8%
Decline to State	130	10.9%
If I didn't come to the center today, I probably would have gone to ...		
Emergency Room	96	8.0%
A Psychiatric Hospital	92	7.7%
Jail	107	8.9%
Other	556	46.5%
Decline to State	345	28.8%

Mental Health Respite Programs – Outreach

Program Type: Suicide Prevention – Universal Prevention

Number Served: In FY 19/20, the respite programs attended 214 community events and disseminated information to 4,553 individuals.

Demographics: Due to the nature of the outreach events, demographics were not collected.

Program	# of Events	# of Contacts
A Church For Us	38	747
Gender Health Center	1	355
Sacramento LGBT Community Center-Lambda Lounge	67	1,274
Sacramento LGBT Community Center-Q Spot	108	2,177
Wind Youth Services	0	0
Total	**214**	**4,553**

Strengthening Families Project
Ages Served: Children, TAY, Adults, Older Adults

The Strengthening Families Project consists of:

- Quality Childcare Collaborative (QCCC)
- CPS Mental Health Team
- Bullying Prevention Education and Training Program
- Early Violence Intervention Begins with Education (eVIBE)
- Adoptive Families Respite Program (CAFA)

Quality Childcare Collaborative (QCCC)

Program Type: Prevention

Program Description: QCCC is a collaboration between BHS, Child Action, Sacramento Office of Education, and the Warm Line Family Resource Center. The collaborative leverages First 5 funding to provide behavioral health consultations to preschools and early childcare learning environments for children ages birth to five. Consultations are designed to increase teacher awareness about the meaning of behavior to ensure the success of the child while in a childcare and/or preschool setting. Support and education is also available for parents/caregivers.

Number Served: In FY 19/20, 9 unduplicated caregivers and teachers utilized the QCCC service.

Demographics:

	N=9	%
Age Group		
Children/Youth (0-15)	4	44.4%
TAY (16-25)	0	0.0%
Adults (26-59)	5	55.6%
Older Adults (60+)	0	0.0%
Unknown/Not Reported	0	0.0%
Ethnicity		
Hispanic	2	22.2%
Non-Hispanic	4	44.4%
Unknown/Not Reported	3	33.3%
Race		
American Indian or Alaska Native	0	0.00%
Asian	1	11.1%
Black or African American	2	22.2%
Native Hawaiian or other Pacific Islander	0	0.0%
White	2	22.2%
Other	2	22.2%
More than one race	0	0.0%
Unknown/Not Reported	2	22.2%

Primary Language		
English	3	33.3%
Spanish	1	11.1%
Vietnamese	0	0.0%
Cantonese	0	0.0%
Russian	0	0.0%
Hmong	0	0.0%
Arabic	1	11.1%
Other	0	0.0%
Unknown/Not Reported	4	44.4%
Sexual Orientation		
Gay or Lesbian	0	0.0%
Heterosexual or Straight	4	44.4%
Bisexual	0	0.0%
Questioning or unsure	0	0.0%
Queer	0	0.0%
Another sexual orientation	0	0.0%
Unknown/Not Reported	5	55.56%
Sex at Birth		
Male	4	44.4%
Female	4	44.4%
Unknown/Not Reported	1	11.1%
Current Gender Identity		
Male	4	44.4%
Female	4	44.4%
Transgender	0	0.0%
Genderqueer	0	0.0%
Questioning or unsure	0	0.0%
Another gender identity	0	0.0%
Unknown/Not Reported	1	11.1%

Satisfaction Survey Results – Quality Childcare Collaborative

Survey Items	N=5	%
The consultant suggested and modeled appropriate strategies.		
Very Satisfied	3	60.0%
Satisfied	2	40.0%
Neutral	0	0.0%
Unsatisfied	0	0.0%
Very Unsatisfied	0	0.0%
N/A	0	0.0%
The consultant provided support and guidance to provider in implementing and maintaining strategies.		
Very Satisfied	3	60.0%
Satisfied	2	40.0%
Neutral	0	0.0%
Unsatisfied	0	0.0%
Very Unsatisfied	0	0.0%
N/A	0	0.0%
The consultant helped providers manage a crisis situation.		
Very Satisfied	4	80.0%
Satisfied	0	0.0%
Neutral	0	0.0%
Unsatisfied	0	0.0%
Very Unsatisfied	0	0.0%
N/A	1	20.0%
The consultant made recommendations for strategies to improve classroom environment.		
Very Satisfied	3	60.0%
Satisfied	1	20.0%
Neutral	0	0.0%
Unsatisfied	0	0.0%
Very Unsatisfied	0	0.0%
N/A	1	20.0%

Child-Specific Survey Items	N=5	%
The consultant consulted with teacher/director regarding observations		
Very Satisfied	4	80.0%
Satisfied	1	20.0%
Neutral	0	0.0%
Unsatisfied	0	0.0%
Very Unsatisfied	0	0.0%
N/A	0	0.0%
The consultant suggested appropriate strategies (i.e. transition times, snack time, etc.).		
Very Satisfied	3	60.0%
Satisfied	2	40.0%
Neutral	0	0.0%
Unsatisfied	0	0.0%
Very Unsatisfied	0	0.0%
N/A	0	0.0%
The consultant trained provider on strategies to use with related behavioral concern.		
Very Satisfied	3	60.0%
Satisfied	2	40.0%
Neutral	0	0.0%
Unsatisfied	0	0.0%
Very Unsatisfied	0	0.0%
N/A	0	0.0%
The consultant developed home-based strategies to help parents address child's challenging behaviors.		
Very Satisfied	3	60.0%
Satisfied	1	20.0%
Neutral	0	0.0%
Unsatisfied	0	0.0%
Very Unsatisfied	0	0.0%
N/A	1	20.0%
The consultant made recommendations for strategies to improve classroom environment.		
Very Satisfied	3	60.0%
Satisfied	1	20.0%
Neutral	0	0.0%
Unsatisfied	0	0.0%
Very Unsatisfied	0	0.0%
N/A	1	20.0%
The consultant helped providers manage a crisis situation.		
Very Satisfied	3	60.0%
Satisfied	1	20.0%
Neutral	0	0.0%
Unsatisfied	0	0.0%
Very Unsatisfied	0	0.0%
N/A	1	20.0%

Parent Survey Items	N=2	%
The consultant helped the child care center to be more responsive to the child needs.		
Strongly Agree	1	50.0%
Agree	1	50.0%
Neutral	0	0.0%
Disagree	0	0.0%
Strongly Disagree	0	0.0%
The consultant help improve the quality of the child care center.		
Strongly Agree	1	50.0%
Agree	1	50.0%
Neutral	0	0.0%
Disagree	0	0.0%
Strongly Disagree	0	0.0%
You feel you learned strategies that helped you accomplish what you wanted or needed.		
Strongly Agree	1	50.0%
Agree	1	50.0%
Neutral	0	0.0%
Disagree	0	0.0%
Strongly Disagree	0	0.0%

CPS Mental Health Team

Program Type: Access and Linkage

Program Description: The CPS Mental Health Team works in conjunction with CPS to assess youth, ages birth through 20, entering the child welfare system. The BHS clinicians complete Child and Adolescent Needs and Strengths (CANS) assessments and provide mental health consultation informing the Child and Family Team (CFT) process. The clinicians participate in the CFT to identify supports, mental health and other services need to achieve permanency, enable the child to live in the least restrictive family setting, and promote normal childhood experiences.

Number Served: In FY 18/19, 57 children, 0-20 years of age, received mental health screenings.

Demographics:

	N=57	%
Age Group		
Children/Youth (0-15)	50	87.7%
TAY (16-25)	7	12.3%
Adults (26-59)	0	0.0%
Older Adults (60+)	0	0.0%
Unknown/Not Reported	0	0.0%
Ethnicity		
Non-Hispanic	15	26.3%
Hispanic	3	5.3%
Other	1	1.8%
More than one Ethnicity	0	0.0%
Unknown/Not Reported	38	66.7%
Race		
White	11	19.3%
Black or African American	19	33.3%
Asian	0	0.0%
American Indian or Alaska Native	1	1.8%
Native Hawaiian or other Pacific Islander	0	0.0%
More than one race	3	5.3%
Other	1	1.8%
Unknown/Not Reported	22	38.6%

Demographics Cont.	N=57	%
Primary Language		
English	43	75.4%
Spanish	0	0.0%
Vietnamese	0	0.0%
Cantonese	0	0.0%
Russian	0	0.0%
Hmong	0	0.0%
Arabic	0	0.0%
Other	0	0.0%
Unknown/Not Reported	14	24.6%
Sexual Orientation		
Heterosexual or Straight	0	0.0%
Gay or Lesbian	0	0.0%
Bisexual	3	5.3%
Questioning or unsure	0	0.0%
Queer	0	0.0%
Another sexual orientation	0	0.0%
Unknown/Not Reported	57	100.0%
Current Gender Identity		
Male	31	54.4%
Female	26	45.6%
Transgender	0	0.0%
Genderqueer	0	0.0%
Questioning or unsure	0	0.0%
Another gender identity	0	0.0%
Unknown/Not Reported	0	0.0%

Note: Sexual orientation is not asked upon intake to this program

Bullying Prevention Education and Training Program

Program Description: Administered by the Sacramento County Office of Education and targets all 13 school districts in Sacramento County. A Training of Trainer (TOT) model uses evidence-based practices to train school staff, who then educates other school staff, students, and parents/caretakers on anti-bullying strategies. The project is primarily being implemented at elementary school demonstrations sites; however, it is intended to expand services to other grades by leveraging school district resources. The long-term goal of the project is to change school climates across all 13 school districts.

Program Type: Universal Prevention

Number Served: The total number of people participating in the bullying prevention program was 64,293. Of those, there were:

- Staff Trained: 1,821
- Students Served: 43,142
- Parents Served: 19,330

Demographics: Unavailable due to program design.

Early Violence Prevention Begins with Education (eVIBE)

***Program Description*:** Administered by the Sacramento Children's Home, uses universal and selective evidence-based prevention approaches to target children and youth ages six (6) to eighteen (18) and their family members/caregivers to improve social skills, increase protective factors, prevent youth violence, and reduce or eliminate family conflict.

Program Type: Prevention

Number Served: In FY 19/20, 2,496 unduplicated individuals were served.

Demographics:

	N=2496	%
Age Group		
Children/Youth (0-15)	2299	92.1
TAY (16-25)	29	1.2
Adults (26-59)	51	2.0
Older Adults (60+)	1	0.0
Unknown/Not Reported	116	4.6
Ethnicity		
Non-Hispanic	883	35.4
Hispanic	913	36.6
Other	0	0.0
More than one ethnicity	0	0.0
Unknown/Not Reported	700	28.0
Race		
White	441	17.7
Black or African American	241	9.7
Asian	356	14.3
American Indian or Alaska Native	17	0.7
Native Hawaiian or other Pacific Islander	32	1.3
More than one race	380	15.2
Other	671	26.9
Unknown/Not Reported	358	14.3

Demographics Cont.	N=2496	%
Primary Language		
English	1831	73.4
Spanish	206	8.3
Vietnamese	17	0.7
Cantonese	23	0.9
Russian	22	0.9
Hmong	19	0.8
Arabic	5	0.2
Other	46	1.8
Unknown/Not Reported	327	13.1
Sexual Orientation		
Heterosexual or Straight	40	1.6
Gay or Lesbian	1	0.0
Bisexual	0	0.0
Questioning or unsure	0	0.0
Queer	0	0.0
Another sexual orientation	0	0.0
Unknown/Not Reported	2455	98.4
Current Gender Identity		
Male	1229	49.2
Female	1243	49.8
Transgender	0	0.0
Genderqueer	0	0.0
Questioning or unsure	0	0.0
Another gender identity	0	0.0
Unknown/Not Reported	24	1.0

Adoptive Families Respite Program (CAFA)

Program Description: Administered by Capital Adoptive Families Alliance, this respite program provides temporary relief for adoptive families that are caring for children with complex mental health issues. Families must live in or have adopted from Sacramento County. The respite model includes planned respite during drop off events, summer camp and recreational activities.

Program Type: Prevention

Number Served: In FY 19/20, 49 families utilized this respite service. *Note: Demographics are not unduplicated because the same families may have utilized respite services more than once in the year.*

Demographics:

	N=194	%
Age Group		
Children/Youth (0-15)	101	52.1%
TAY (16-25)	2	1.0%
Adults (26-59)	64	33.0%
Older Adults (60+)	4	2.1%
Unknown/Not Reported	23	11.9%
Ethnicity		
Hispanic or Latino	21	10.8%
Non-Hispanic/Non-Latino	134	69.1%
Other	0	0.0%
More than one ethnicity	0	0.0%
Unknown/Not Reported	31	16.0%
Race		
White	109	56.2%
Black or African American	29	14.9%
Asian	3	1.5%
American Indian or Alaska Native	0	0.0%
Native Hawaiian or other Pacific Islander	0	0.0%
More than one race	42	21.6%
Decline to answer	0	0.0%
Other	5	2.6%
Unknown/Not Reported	6	3.1%

Demographics Cont.	**N=194**	**%**
Primary Language		
English	188	96.9%
Spanish	1	0.5%
Vietnamese	0	0.0%
Cantonese	0	0.0%
Russian	0	0.0%
Hmong	0	0.0%
Arabic	0	0.0%
Other	1	0.5%
Unknown/Not Reported	4	2.1%
Sexual Orientation		
Heterosexual or Straight	146	75.3%
Gay or Lesbian	16	8.2%
Bisexual	1	0.5%
Questioning or unsure	4	2.1%
Queer	2	1.0%
Another sexual orientation	7	3.6%
Decline to answer	0	0.0%
Unknown/Not Reported	18	9.3%
Current Gender Identity		
Female	95	49.0%
Male	97	50.0%
Transgender	0	0.0%
Genderqueer	0	0.0%
Questioning or unsure	0	0.0%
Another gender identity	2	1.0%
Unknown/Not Reported	0	0.0%
Veteran Status		
Yes	0	0.0%
No	68	35.1%
Unknown/Not Reported	126	64.9%

Satisfaction Survey Results - CAFA

Survey Items	%
As a result of the services I received or group(s) I attended, I know how to get help if I knew someone who is suicidal or if I felt suicidal.	
Strongly Agree/Agree	96%
Undecided	4%
Disagree/Strongly Disagree	0%
I felt the services I received reflected my cultural beliefs, preferences, and values which made me feel respected.	
Strongly Agree/Agree	98%
Undecided	2%
Disagree/Strongly Disagree	0%
I had a decrease in stress.	
Strongly Agree/Agree	98%
Undecided	2%
Disagree/Strongly Disagree	0%
I have an increase in well-being.	
Strongly Agree/Agree	98%
Undecided	2%
Disagree/Strongly Disagree	0%
I have an increased feeling in my ability to cope.	
Strongly Agree/Agree	98%
Undecided	2%
Disagree/Strongly Disagree	0%

Integrated Health and Wellness Project
Ages Served: Children, TAY, Adults, Older Adults

The Integrated Health and Wellness Project consists of:

- SacEDAPT (Early Diagnosis and Prevention Treatment)
- Senior Link

SacEDAPT

Program Description: Administered by UC Davis, Department of Psychiatry, SacEDAPT focuses on early onset of psychosis and has been expanded to serve those age twelve (12) to thirty (30). It is a nationally recognized treatment program utilizing an interdisciplinary team of physicians, clinicians, support staff, consumers and family advocates to provide assessment, early identification and treatment of the onset of psychosis. The program continues to engage in outreach services throughout Sacramento County with a particular focus on underserved populations. This program has informed statewide work related to assessing the impact of early psychosis programs.

Program Type: Early Intervention

Number Served: In FY 19/20, 199 unduplicated clients were served.

Demographics:

	N=199	%
Age Group		
Children/Youth (0-15)	50	25.1%
TAY (16-25)	111	55.8%
Adults (26-59)	38	19.1%
Older Adults (60+)	0	0.0%
Unknown/Not Reported	0	0.0%
Ethnicity		
Hispanic	61	30.7%
Non-Hispanic	115	57.8%
Unknown/Not Reported	23	11.6%

Demographics Cont.	**N**	**%**
Race		
American Indian or Alaska Native	2	1.0%
Asian	15	7.5%
Black or African American	53	26.6%
Native Hawaiian or other Pacific Islander	1	0.5%
White	56	28.1%
Other	42	21.1%
More than one race	22	11.1%
Unknown/Not Reported	8	4.0%
Primary Language		
English	184	92.5%
Spanish	9	4.5%
Vietnamese	1	0.5%
Cantonese	1	0.5%
Russian	0	0.0%
Hmong	0	0.0%
Arabic	0	0.0%
Other	3	1.5%
Unknown/Not Reported	1	0.5%
Sexual Orientation		
Gay or Lesbian	1	0.5%
Heterosexual or Straight	16	8.0%
Bisexual	4	2.0%
Questioning or unsure	2	1.0%
Queer	0	0.0%
Another sexual orientation	0	0.0%
Unknown/Not Reported	176	88.4%
Sex at Birth		
Male	89	44.7%
Female	110	55.3%
Unknown/Not Reported	0	0.0%

Demographics Cont.	**N**	**%**
Current Gender Identity		
Male	61	30.7%
Female	76	38.2%
Transgender	2	1.0%
Genderqueer	0	0.0%
Questioning or unsure	0	0.0%
Another gender identity	4	2.0%
Unknown/Not Reported	56	28.1%

Senior Link

Program Description: Administered by El Hogar, Senior Link provides community integration support for adults aged 55 and older who are demonstrating early signs of isolation, anxiety and/or depression. Para-professional Advocates outreach to individuals in their homes or other community-based settings based on the participant needs. Program services include home visits; collaboration with and linkage to health care providers, socialization opportunities, transportation, service coordination, advocacy, information and referral, skill-building groups and liaison to community services.

Program Type: Prevention

Number Served: In FY 19/20, 181 unduplicated older adults were served.

Demographics:

	N=181	%
Age Group		
Children/Youth (0-15)	0	0.0%
TAY (16-25)	0	0.0%
Adults (26-59)	16	8.4%
Older Adults (60+)	134	70.2%
Unknown/Not Reported	31	16.2%
Ethnicity		
Hispanic or Latino	37	19.4%
Non-Hispanic/Non-Latino	93	48.7%
Other	0	0.0%
More than one ethnicity	0	0.0%
Unknown/Not Reported	51	26.7%
Race		
White	50	26.2%
Black or African American	35	18.3%
Asian	11	5.8%
More than one race	0	0.0%
American Indian or Alaska Native	4	2.1%
Native Hawaiian or other Pacific Islander	4	2.1%
Other	29	15.2%
Unknown/Not Reported	48	25.1%

Demographics Cont.	N	%
Primary Language		
English	116	60.7%
Spanish	19	9.9%
Vietnamese	0	0.0%
Cantonese	0	0.0%
Russian	0	0.0%
Hmong	11	5.8%
Arabic	0	0.0%
Other	0	0.0%
Unknown/Not Reported	35	18.3%
Sexual Orientation		
Gay or Lesbian	1	0.5%
Heterosexual or Straight	161	84.3%
Bisexual	0	0.0%
Questioning or unsure	0	0.0%
Queer	0	0.0%
Another sexual orientation	0	0.0%
Unknown/Not Reported	19	9.9%
Current Gender Identity		
Female	105	55.0%
Male	44	23.0%
Transgender	0	0.0%
Genderqueer	0	0.0%
Questioning or unsure	0	0.0%
Another gender identity	0	0.0%
Unknown/Not Reported	32	16.8%

Senior Link – Outreach

Program Type: Prevention

Number Served: In FY 19/20, the program did outreach for 191 unduplicated older adults.

Demographics:

	N=191	%
Age Group		
Children/Youth (0-15)	0	0.0%
TAY (16-25)	0	0.0%
Adults (26-59)	13	6.8%
Older Adults (60+)	178	93.2%
Unknown/Not Reported	0	0.0%
Ethnicity		
Hispanic or Latino	47	24.6%
Non-Hispanic/Non-Latino	118	61.8%
Other	0	0.0%
More than one ethnicity	0	0.0%
Unknown/Not Reported	26	13.6%
Race		
White	68	35.6%
Black or African American	36	18.8%
Asian	6	3.1%
More than one race	1	0.5%
American Indian or Alaska Native	6	3.1%
Native Hawaiian or other Pacific Islander	5	2.6%
Other	45	23.6%
Unknown/Not Reported	24	12.6%

Demographics Cont.	N	%
Primary Language		
English	148	77.5%
Spanish	24	12.6%
Vietnamese	0	0.0%
Cantonese	2	1.0%
Russian	2	1.0%
Hmong	3	1.6%
Arabic	1	0.5%
Other	3	1.6%
Unknown/Not Reported	8	4.2%
Sexual Orientation		
Gay or Lesbian	2	1.0%
Heterosexual or Straight	171	89.5%
Bisexual	0	0.0%
Questioning or unsure	0	0.0%
Queer	0	0.0%
Another sexual orientation	0	0.0%
Unknown/Not Reported	18	9.4%
Current Gender Identity		
Female	134	70.2%
Male	55	28.8%
Transgender	1	0.5%
Genderqueer	0	0.0%
Questioning or unsure	0	0.0%
Another gender identity	0	0.0%
Unknown/Not Reported	1	0.5%

Mental Health Promotion
Ages Served: Children, TAY, Adults, Older Adults

Program Description: The Mental Health Promotion Project is designed to increase community awareness about mental health issues and reduce stigma and discrimination toward individuals and families living with mental illness.

"Mental Illness: It's not always what you think" Project: Since June of 2011, the Division of Behavioral Health Services (BHS), in partnership with Edelman, a communication marketing agency, and Division of Public Health, developed and coordinated a multi-media stigma and discrimination reduction project titled the "Mental Illness: It's not always what you think" Project. FY 2019-20 marked the ninth year of this project. The goal of the project is to reduce the stigma and discrimination associated with mental illness that keeps many from seeking support and treatment by promoting messages of wellness, hope and recovery, dispelling myths and stereotypes surrounding mental illness, and fundamentally altering negative attitudes and perceptions about mental illness and emotional disturbance. The project aims to reduce stigma and discrimination by engaging diverse communities and the general public through culturally relevant mental health information and education. The project has multiple components:

- Multi-Media Outreach
- Social Media – www.StopStigmaSacramento.org
- Stakeholder Engagement
- Collateral Material
- Community Outreach Events
- Research
- Stop Stigma Sacramento Speakers Bureau
-

Program Type: Universal Prevention

Number Served: Because this is universal outreach, the total number served is not available for many of the projects.

Stop Stigma Sacramento Speakers Bureau

The speakers bureau completed 32 events in various venues throughout Sacramento. Those events reached over 2,884 people in the community.

Limitations

The first Sacramento County BHS PEI programs were implemented in FY 09/10, with new programs being implemented as recently as 2019. At the time of program implementation reporting requirements were not established. The County established reporting requirements based on the type of program and the population served. After the updated PEI regulations were released, all PEI contracts were adjusted to attempt to meet the reporting requirements. Demographics, as well as participant satisfaction surveys were implemented in all programs. The bullets below describe some challenges the County has faced in collecting and reporting data:

- Obtaining unduplicated clients served – participants are required to complete demographic forms as well as satisfaction surveys on every visit. Participants were hesitant to give identifying information. Because of this it was very difficult to link a client to multiple visits.
- Inability to identify participants receiving services in the MHP - PEI programs were originally set up to be "Pre-Treatment", so they were not part of our Electronic Health Record (EHR). Because of that, data is collected outside of the EHR and participants are not assigned a medical record number. Participants' hesitation to provide identifying information has made it difficult to link them to the EHR to determine if they are receiving treatment services in the MHP.
- Demographic data for crisis services – obtaining demographic data on crisis services is difficult due to the nature of the program (i.e. suicide hotline). This program focuses on the crisis at hand and staff does not want to add any more stress to the situation by asking questions regarding the individuals' personal characteristics. Information is collected on these programs, but much of it is unknown due to the inability to collect data at the time of the crisis.

Future Steps

MHP is currently in the planning process for all PEI and Respite programs to be integrated into the EHR. This will give the MHP the ability to reliably report unduplicated participants served as well as demographics that are consistent across all programs. This will also give the MHP the ability to follow participants throughout the system to determine linkages to treatment services.

Sacramento County Mental Health
2019 Human Resource Survey
October 2019

Romeal Samuel
Program Planner
Research, Evaluation and Performance Outcomes
Sacramento County, Division of Behavioral Health Services

OVERVIEW

The Cultural Competence Plan Requirements (CCPR) Modification (2010), issued by the California State Department of Health Care Services in DMH Information Notice No. 10-17, states that counties are required to collect demographic information and language capabilities of staff, volunteers and any committee members who participate in serving individuals throughout the entire County Mental Health System. The purpose of the surveys is to assess demographic and linguistic information for those who provide services in our county to determine whether it is reflective of the diversity of the community as a whole.

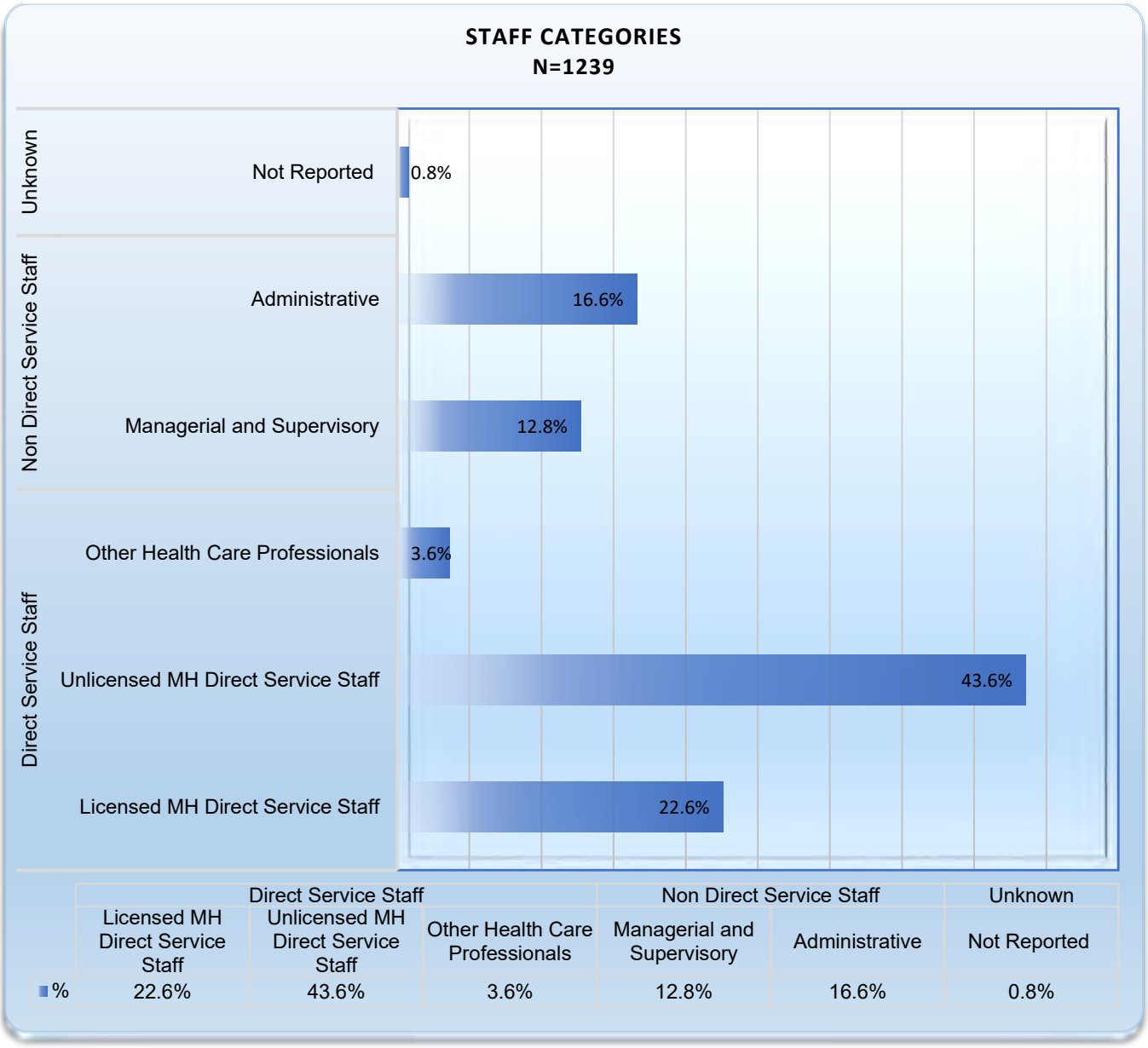
The information collected focuses on staff ethnicity, language proficiencies, consumer/family member status, gender, sexual orientation, disability and veteran status.

Key findings

- A total of 1,239 staff responded to at least one question on the survey.
- Of all staff surveyed, 400 (32.3%) unduplicated staff indicated speaking a language other than English. For staff who spoke one language other than English, the majority spoke Spanish (39.0%) followed by Hmong at just over 7% (7.5%). Almost nineteen percent (18.8%) indicated speaking two or more languages other than English.
- 20.5% of staff self-identify as being of Hispanic ethnicity.
- 71.5% of the staff identify as being female and 21.9% as male.
- 42.9% of staff self-identified as Caucasian, 12.8% as African American, 8.1% as Multi-ethnic, 3.3% as American/Alaska Native, 2.5% as Filipino, 2.6% as Other Asian, 3.1% as Hmong, 1.9 % as Asian Indian, 1.7 % as Chinese, and 9.5% as “Other”.
- 42.6% self-identify as a family member of a consumer, 24.2% of staff self-identify as a consumer of Mental Health Services, while 12.2% of staff self-reported that they live with a disability and 3.2% currently serve or have served in the US Military.
- 73.8% of the staff self-identified as being heterosexual/straight, 4.7% as bisexual, 2.7% as lesbian, 2.3% as queer, 1.9 % as gay, 1.2% pansexual, 0.6% as asexual, 0.6% as other, 0.2% as questioning and 12.0% choose not to answer the question.
- 865 direct service staff are included in the total number of staff described above.
- 20.8% of direct service staff self-identify as being of Hispanic ethnicity.
- 27.3% of direct service staff self-identify as a consumer of Mental Health Services, while 43.7% self-identify as having a family member who is a consumer of Mental Health Services.

ALL STAFF

There were a total of 1,239 active staff who responded to the survey. Direct Service Staff accounted for 820 (69.8%) of all staff surveyed, 540 (43.6%) reported being Unlicensed Direct Service Staff, 280 (22.6%) reported being Licensed Direct Service Staff and almost 45 (3.6%) reported being Other Healthcare Professionals. Administrative Staff accounted for just over 16% of all respondents and Managerial Staff accounted for 12.8%. Ten (0.8%) staff did not report.



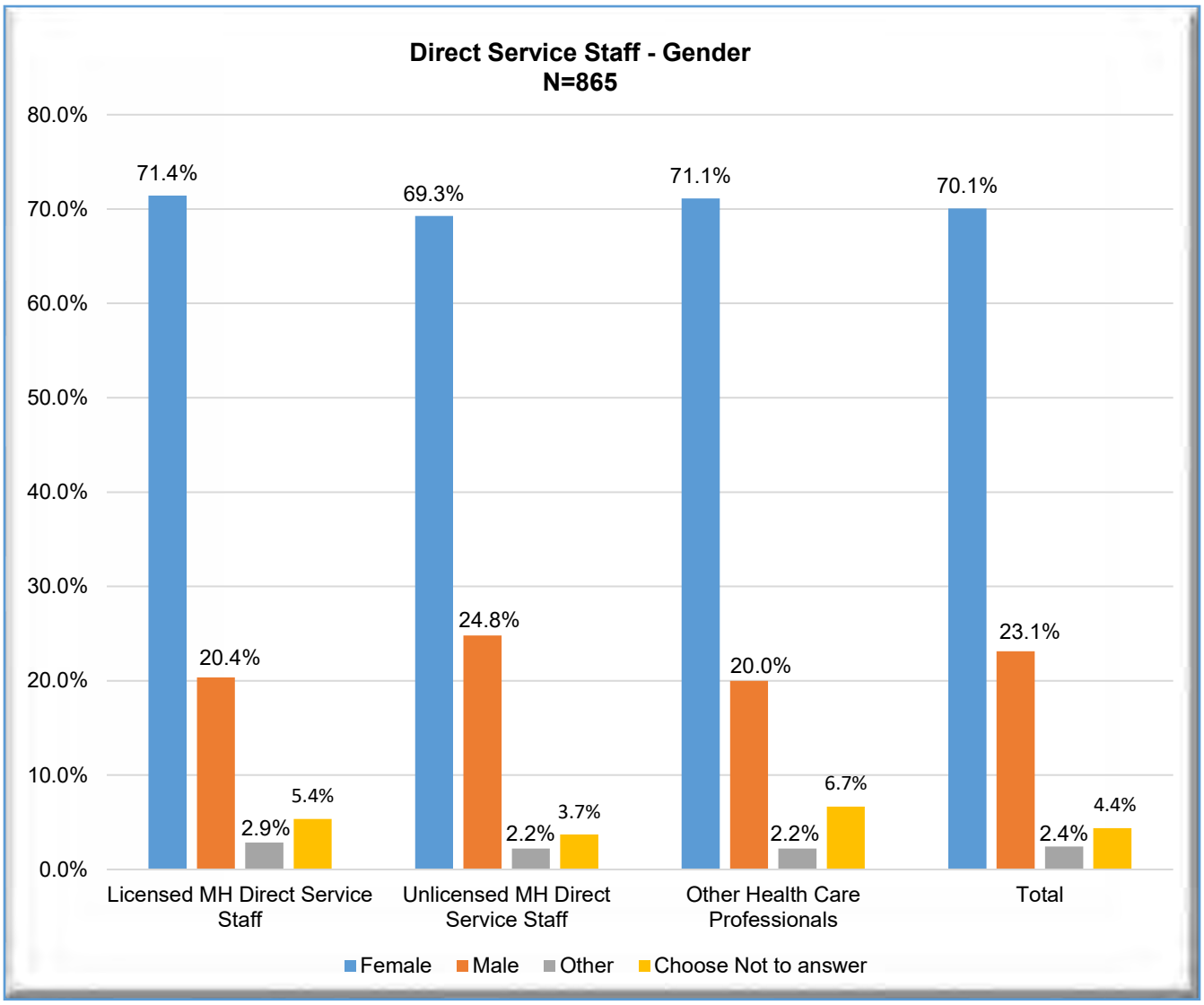
	Direct Service Staff			Non Direct Service Staff		Unknown
	Licensed MH Direct Service Staff	Unlicensed MH Direct Service Staff	Other Health Care Professionals	Managerial and Supervisory	Administrative	Not Reported
%	22.6%	43.6%	3.6%	12.8%	16.6%	0.8%

DIRECT SERVICE STAFF

There were a total of 865 survey responses from direct service staff in the system. This represents just under 70% (69.8%) of all respondents. The charts below depict the demographic characteristics for all direct service staff including Licensed MH Direct Service Staff, Unlicensed MH Direct Service Staff and Other Health Care Professionals.

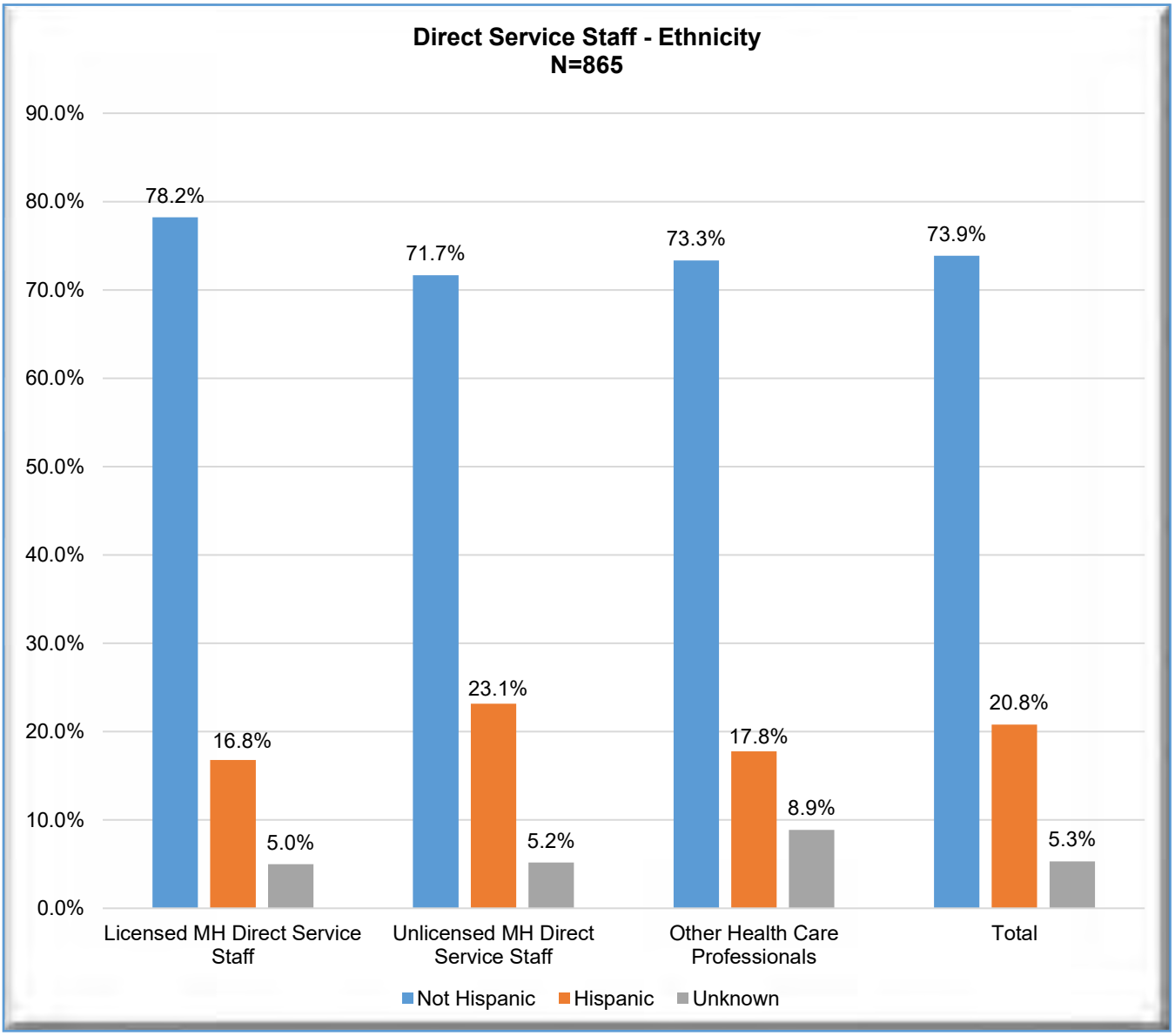
Gender

The majority of direct service staff are female, ranging from 69.3% (Unlicensed MH Direct Service Staff) to 71.4% (Licensed MH Direct Service Staff).



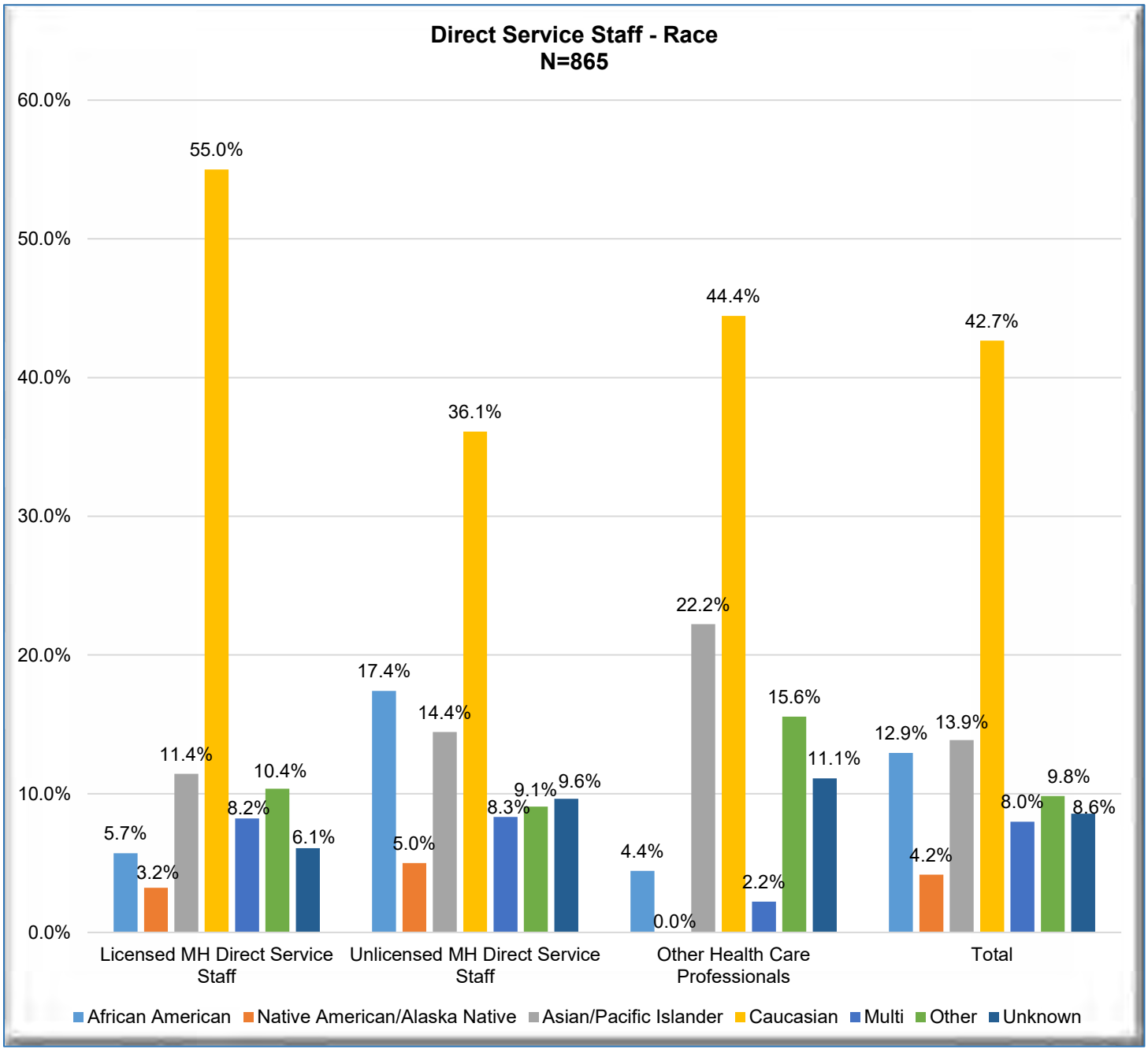
Ethnicity

There were 180 (20.8%) direct service staff who identified as Hispanic. Of all direct service staff, the Unlicensed MH Direct Service Staff had the highest percentage identifying as Hispanic at just over 23%, followed by Other Health Care Professionals at just under 18%.



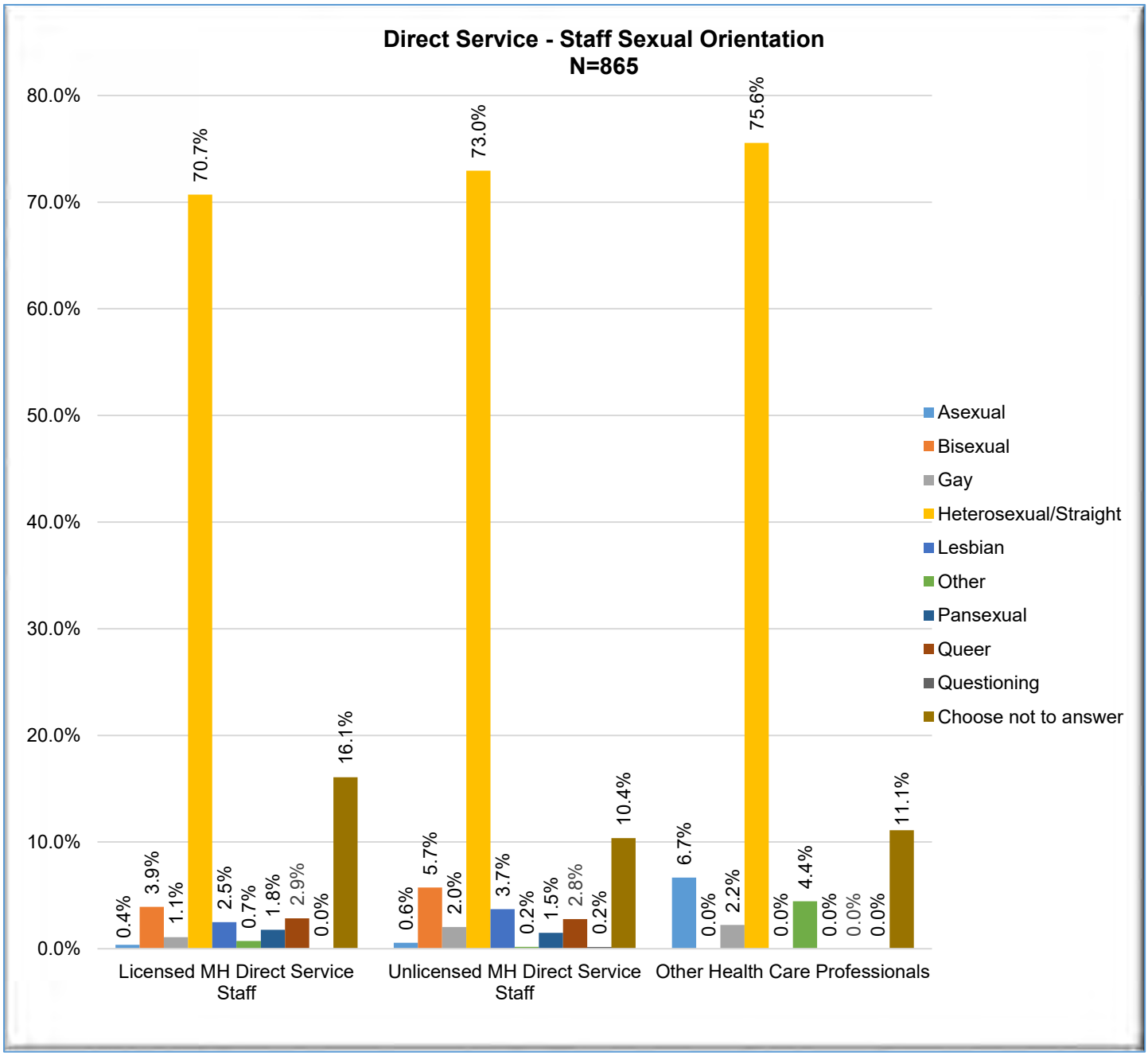
Race

There were 422 (48.8%) direct service staff who identified with a race other than Caucasian. Just over 54% (54.2%) of Unlicensed MH Direct Service Staff and 44.4% of Other Health Care Professionals identified with a race other than Caucasian, while only 38.9% of Licensed MH Direct Service Staff identified as a race other than Caucasian. *Note: Unknown is not included in the "race other than Caucasian" percentages.*



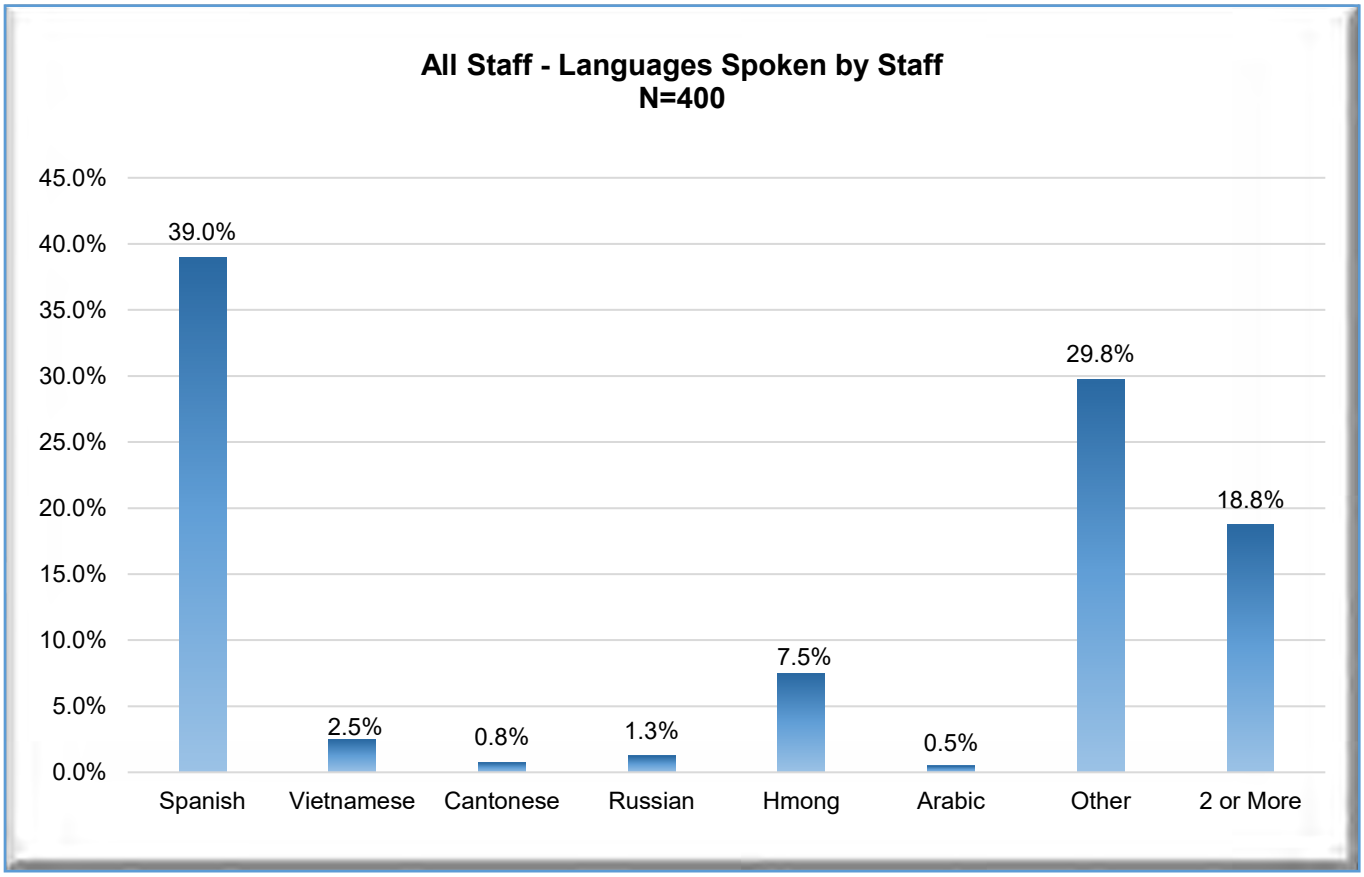
Sexual Orientation

Of the 865 staff surveyed, 626 (72.4%) identified as heterosexual/straight (198 licensed staff, 394 unlicensed staff and 34 other health care professionals). Over 106 (12.3%) staff chose not to answer.



Language

Of all staff surveyed, 400 (32.3%) unduplicated staff indicated speaking a language other than English. For staff who spoke one language other than English, the majority spoke Spanish (39.0%) followed by Hmong at just over 7% (7.5%). Almost 19% (18.8%) indicated speaking two or more languages other than English.



Consumers, Family Members, Disabled and Military

As part of the HR survey, staff were asked whether they identified as a consumer, family member, whether they have a disability, and/or have ever served or currently serving in the military.

Consumer – The graph below indicates the number of staff who identified as being a consumer of mental health services 24.2%.

Family Member – 42.6% of staff identified as having a family member who is a consumer of mental health services.

Disabled– Most of the staff reported not being disabled, while almost 10% declined to answer.

Military: The majority of staff reported not serving in the military. Of those who have served, Other Health Care Professionals represented the highest percentage at 4.4%.

	Administrative Staff/Advisory Board/Steering Committee/Other		Licensed MH Direct Staff		Managerial and Supervisory		Other Health Care Professionals		Unlicensed MH Direct Staff		Unknown		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
I am a consumer of Mental Health Services	33	16.0%	72	25.7%	29	18.4%	10	22.2%	154	28.5%	2	20.0%	300	24.2%
I have a family member who is a consumer of Mental Health Services	72	35.0%	103	36.8%	74	46.8%	13	28.9%	262	48.5%	4	40.0%	528	42.6%
I live with a disability	15	7.3%	23	8.2%	11	7.0%	5	11.1%	96	17.8%	1	10.0%	151	12.2%
I am currently or have served in the US Military	2	1.0%	12	4.3%	3	1.9%	2	4.4%	21	3.9%	0	0.0%	40	3.2%

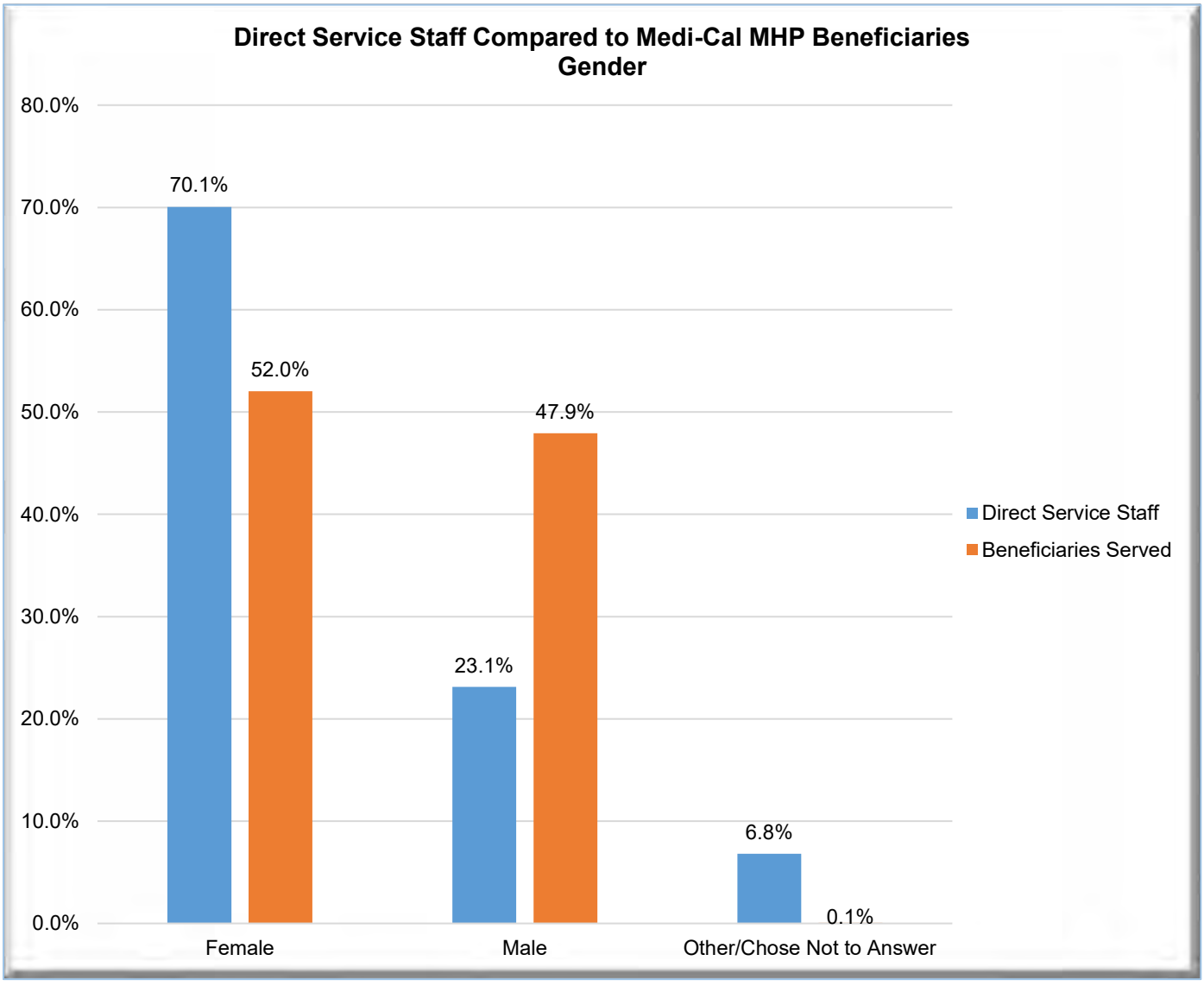
Note: The total percentage does not equal 100% as staff could identify with more than one category.

Direct Services Staff Compared to Clients served in the Mental Health Plan (MHP)

The data below compares direct service staff gender and race with the gender and race of Medi-Cal beneficiaries served in the MHP during Fiscal Year 18-19. Note: Not all demographics collected on the HR survey are comparable to the clients served, due to the way in which the data was collected.

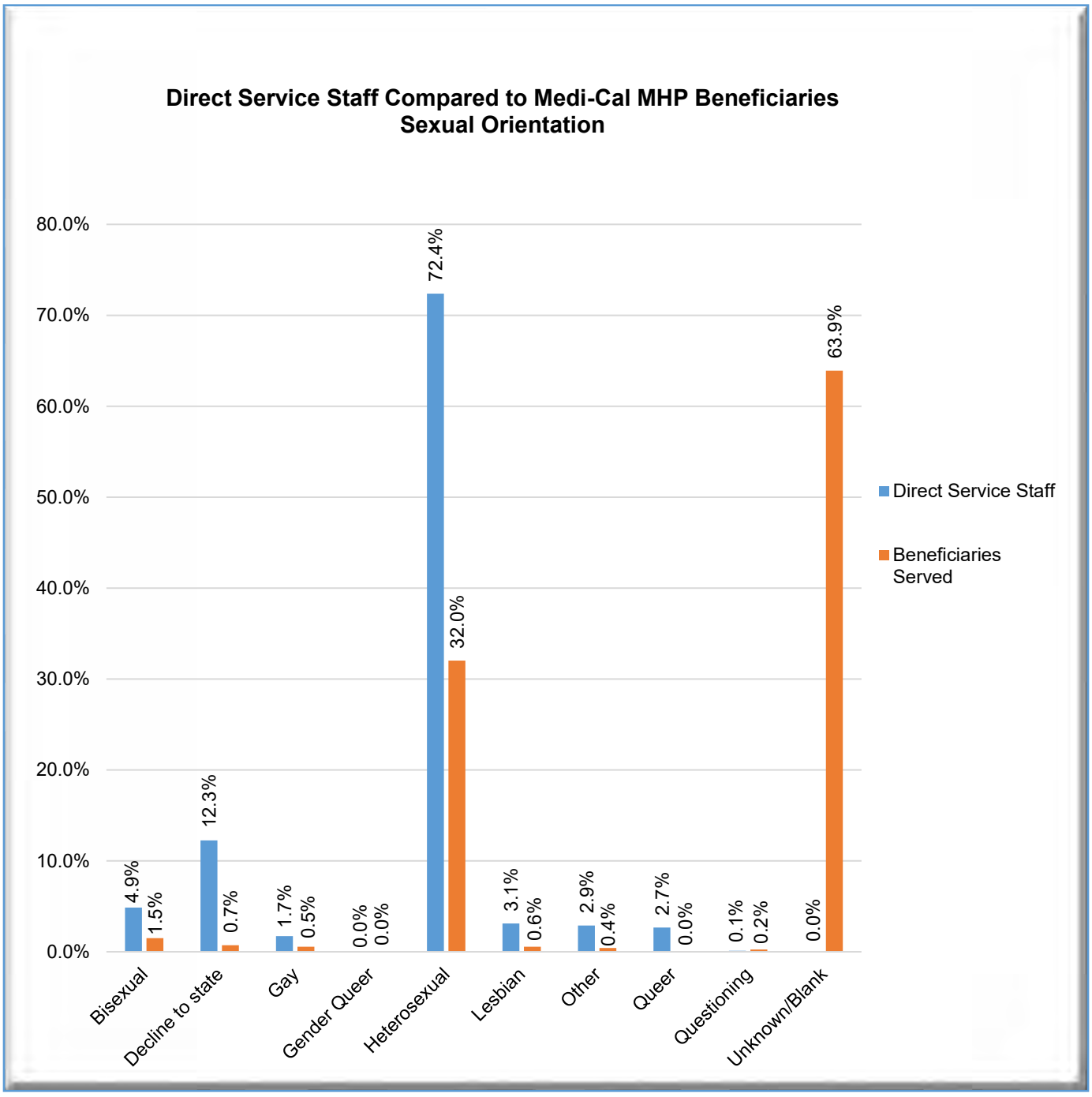
Gender

As indicated below, males are underrepresented in Direct Service Staff, compared to the number of males served in the system.



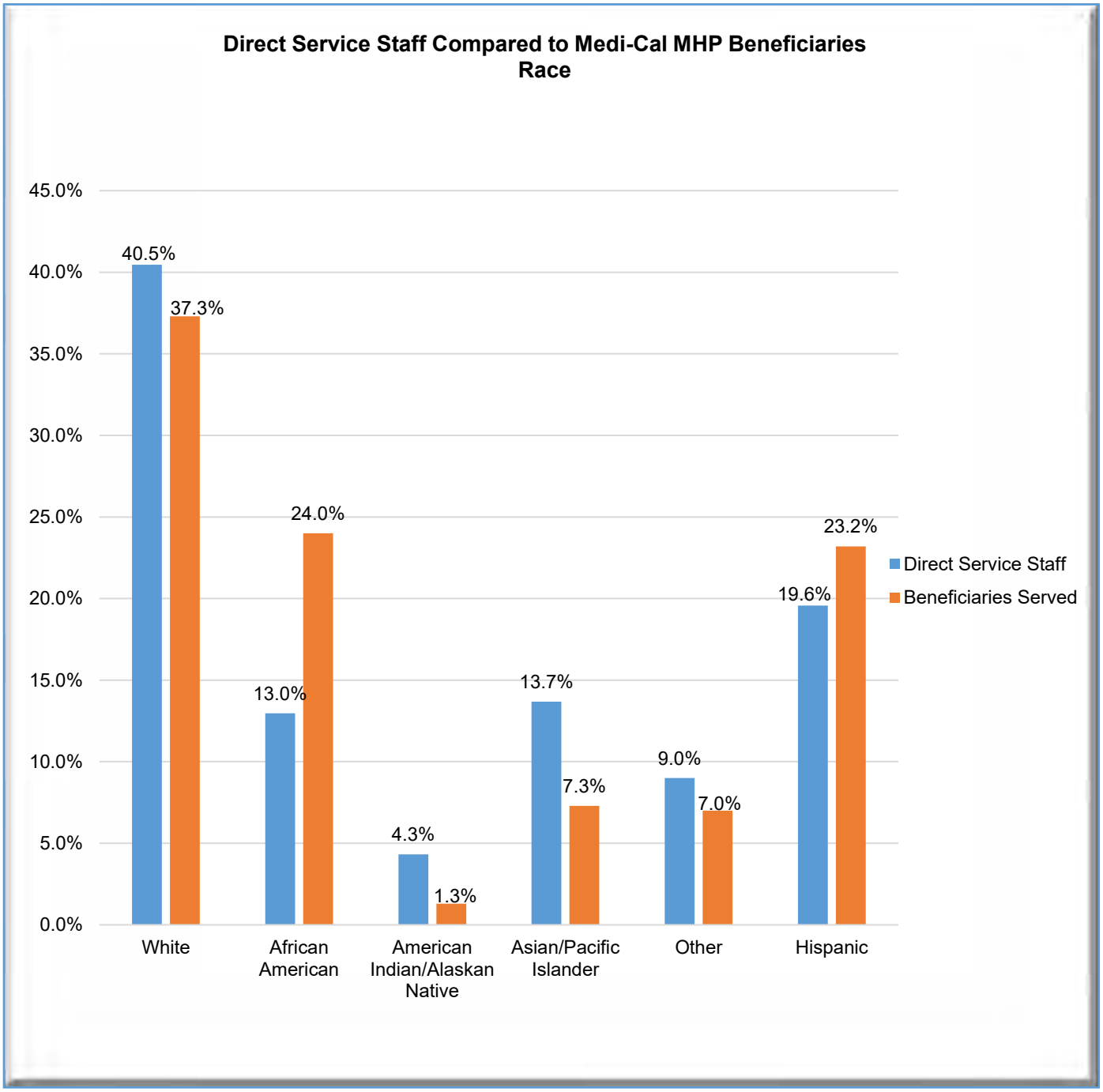
Sexual Orientation

As indicated below, more than half of the beneficiaries are unknown or not reported.



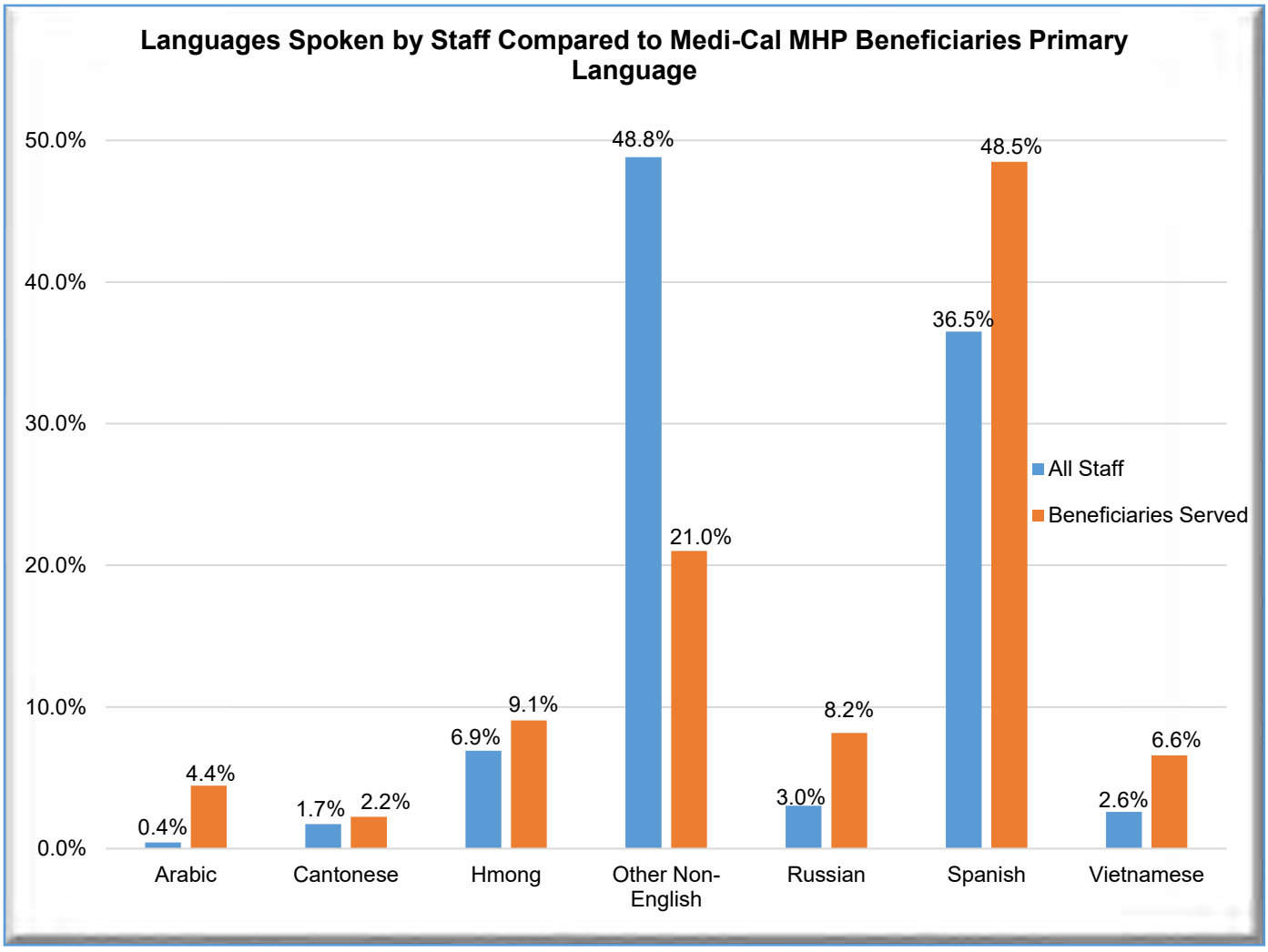
Race

In regards to race, African American and Other Direct Service Staff are underrepresented, compared to the number of African American clients served, while Caucasian and Asian/Pacific Islander Direct Service Staff are overrepresented.



Language

While the MHP has a wide variety of languages spoken by staff, the percent who speak the Sacramento County threshold languages is lower than the beneficiaries served, with the exception of “Other Non-English” languages.



Mental Health Services Act

Annual Innovation Program and Evaluation Report

Fiscal Year 2019/2020

Sacramento County Department of Health Services
Division of Behavioral Health Services
MHSA Innovation Annual Report FY 2019/2020

The Sacramento County Department of Health Services, Division of Behavioral Health Services, has prepared this Innovation Evaluation report for Fiscal Year 2019/2020.

MHSA Innovation Project #2: Mental Health Crisis/Urgent Care Clinic

Project Overview

The Mental Health Crisis/Urgent Care Clinic Innovation project was reviewed and approved by the MHSOAC in May 2016. The primary purpose of this project is to increase the quality of services, including better outcomes for individuals experiencing a mental health crisis with the secondary purpose of increasing access to services.

Over the past two decades, urgent care clinics have emerged as an alternative and effective care setting that improves access to quality healthcare, addresses intermediate physical health needs, and provides an alternative to emergency department visits. The project tests the adaptation of an urgent care clinic/medical model, which is an intermediate step between routine and emergency care, to provide crisis response/care for individuals experiencing a mental health crisis. Furthermore, this project fully incorporates wellness and recovery principles into service delivery. Specifically, the adaptations focus on: 1. Crisis Program Designation, including hours; 2. Direct Access - Provide direct linkage as an access point for both Sacramento County Mental Health Plan (MHP) and Alcohol and Drug Services (ADS); 3. Serve all ages (children, youth, adults and older adults); and 4. Pilot Medical Clearance Screening that will allow clinical staff to initially screen to identify medical issues on site as needed.

In turn, this project will test how these adaptations can improve the following client and system outcomes: 1. create an effective alternative for individuals needing crisis care; 2. improve the client experience in achieving and maintaining wellness; 3. reduce unnecessary or inappropriate psychiatric hospitalizations and incarcerations; 4. reduce emergency department visits; and 4. improve care coordination across the system of care to include linkages to other needed resources and timely access to mental health services.

Sacramento County initiated the competitive selection process in the fall of 2016 to seek out organizations interested in collaboratively operating this project and the contract was awarded to Turning Point Community Programs (TPCP).

Sacramento County, in partnership with TPCP, opened the Mental Health Crisis/Urgent Care Clinic (MHUCC) in November 2017. The MHUCC offers the following service array for individuals of any age experiencing an urgent mental health need: triage and crisis intervention services, comprehensive behavioral health assessment, medical screening, medication support, peer and family support, care coordination and linkage to other services and resources.

Data Summary

The MHUCC opened its doors to the public on November 29, 2017. This report includes data retrieved from Avatar (Sacramento County Electronic Health Record) for Fiscal Year 2019/2020 and from staff focus groups

Referrals

The majority of referrals to the MHUCC were from the individual themselves (43%) and other sources (40%)

- 8% of the referrals were from friends and family, 3% from law enforcement and 3% from primary care providers.
- When the clinic first opened, improving communication with law enforcement was one of the clinic's priorities. Over time, they have been able to develop an effective process to ensure the appropriate referrals.
- Only 2% of referrals were from local emergency departments
- Each month, between 12-20% of referrals were not admitted
- Each month, between 12-16% of admits were on a 5150
- Incomplete safety assessments by referrers is one of the challenges the clinic faces. Although those referring to the clinic screen for the risk of danger to self or others, they frequently neglect to screen for whether a client is gravely disabled.

Admissions and Discharges

- There were 3,520 unduplicated individuals admitted to the MHUCC for a total of 4,711 admissions during the fiscal year
    - 784 unduplicated individuals returned to the MHUCC during the fiscal year
- There were 4,708 discharges from the Urgent Care Clinic
- System barriers were identified that make it difficult for clients to access care. The wait times within the system contribute to clients returning.
- A large proportion of clients seen were not linked to services. Thus, much of the work of urgent care is to connect clients to services. They also teach clients how to advocate for themselves and to empower them to become active in their healthcare especially if they are dissatisfied with some aspect of their care.
- Sacramento County has a higher percentage of LEP individuals (13.6%) when compared to the U.S. percentage (8.4%). Yet, this is not reflected in the program demographics. When staff were asked about use of interpreters, they indicated they used interpreters for Spanish, Farsi, Hmong, Vietnamese, Arabic, Punjabi, Russian, American Sign Language, Armenian, Cantonese, Lao, Mandarin, Cambodian, Japanese, Korean, Mien, Thai, and Tagalog.

Sacramento County Department of Health Services
Division of Behavioral Health Services
MHSA Innovation Annual Report FY 2019/2020

Demographics

Mental Health Urgent Care Clinic FY 2019/2020 Demographics		
	Number	**Percent (N=3520)**
Race		
American Indian or Alaska Native	57	1.6%
Asian	203	5.8%
Black or African American	658	18.7%
Native Hawaiian or other Pacific Islander	24	0.7%
White	1500	42.6%
Other	362	10.3%
More than one race	234	6.6%
Unknown/Not Reported	482	13.7%
Primary Language		
English	3230	91.8%
Spanish	74	2.1%
Vietnamese	11	0.3%
Cantonese	9	0.3%
Farsi	11	0.3%
Russian	8	0.2%
Mental Health Urgent Care FY 2019/2020 Demographics Continued		
Hmong	5	0.1%
Arabic	10	0.3%
Other	36	1.0%
Unknown/Not Reported	126	3.6%
Gender		
Male	1635	46.4%
Female	1883	53.5%
Transgender	0	0.0%
Intersex	0	0.0%
Questioning	0	0.0%
Unknown/Not reported	2	0.1%
Veteran Status		
Yes	0	0.0%
No	0	0.0%
Homeless Status*	(N=4711 all admits)	
Yes	750	15.9%
No	3961	84.1%

**Number is greater than unduplicated clients as it includes all admissions*

MHUCC Client Satisfaction Questionnaire Results

Fiscal Year 2019/2020 satisfaction survey results show that overall clients are satisfied with the services received at the Mental Health Urgent Care Clinic. However, it should be noted that these results represent 30% of visits.Of those who responded, generally, clients felt respected with an average rating of 4.8.

Fiscal Year 2019/2020 Satisfaction Questionnaire Responses (N=1461)	
Survey Questions (1=Strongly Disagree, 5=Strongly Agree)	**Average Rating**
When I arrived, I felt welcomed.	**4.58**
My visit gave me hope.	**4.49**
During my visit, I was given information and guidance that was useful to me.	**4.64**
During my visit, I was told about programs and places where I could go that seemed useful to me.	**4.60**
During my visit, I was given the opportunity to make choices about my care.	**4.59**
Staff were sensitive to my cultural needs and background.	**4.59**
If I wanted them to, staff made every effort to involve the people who are important to me in planning my services.	**4.56**
Staff heard and understood what I said.	**4.69**
I was treated with respect.	**4.76**
The amount of time that I waited to be seen was acceptable to me.	**4.19**
I felt safe and supported during my visit.	**4.69**
Overall, the quality of care I received was (1=Poor, 5=Excellent).	**4.64**
Overall Rating	**4.59**

Project #3: Behavioral Health Crisis Services Collaborative

Project Overview

Behavioral Health Crisis Services Collaborative (BHCSC) project was reviewed and approved by the MHSOAC in May 2018. BHS, in partnership with Dignity Health and Placer County, implemented the BHCSC in FY 2018-19. In September 2019, the BHCSC opened for service delivery. The BHCSC establishes integrated adult crisis stabilization services on the Mercy San Juan hospital emergency department campus in the northeastern area of Sacramento County.

This innovative emergency care integration initiative advances the standard for existing crisis services in several distinctive ways:

- It is a unique public/private collaboration between Sacramento County, Placer County and Dignity Health, and engages multiple Plan and community-based partners to serve residents of both Counties.
- It represents a commitment from a large hospital system, Dignity Health, to provide quality and integrated medical and behavioral health services under the hospital's license and make a financial investment that includes:
  - Dedicated hospital campus space and construction of facilities, designed to meet crisis stabilization services specifications
  - Ongoing facility operations and maintenance
  - Client transportation
  - Funding for a hospital navigator position
- Project services:
  - Are sited in the northern region of Sacramento which lacks sufficient crisis service programs across two counties with growing populations
  - Serves TAY (18+), adults, and older adults, who:
    - Present in the emergency department (ED), are medically treated and stabilized, and would benefit from multi-disciplinary mental health evaluation and crisis stabilization services for up to 23 hours
    - Voluntarily or involuntarily elect to receive services with the expressed goal of minimizing the time being on an involuntary 5150 hold
  - Provide front door integrated medical emergency and mental health crisis stabilization services that embrace the concept of whole person care, wellness and recovery.
- It presents a new opportunity to serve both publicly and privately insured residents from both Sacramento and Placer Counties.
- It creates an opportunity to develop a model for:
  - Shared governance and regulatory responsibilities related to delivering seamless integrated medical emergency and crisis stabilization care on a hospital emergency department campus
  - Electronic medical records exchange for both clinical coordination of care and claiming processes with the goal of delivering effective and efficient seamless integrated crisis care

- A robust resource center under the same roof allows multiple community-based partners to support the project by providing care coordination, peer support and navigation, and social services support at the point of care. This ensures that consumers are directly linked to aftercare and other resources necessary for ongoing management of conditions and wellness.
- Local Health Plans operating in Sacramento and Placer Counties provide navigation and support services to their private and public enrollees that utilize project services.
- The project is a natural fit with collaborative efforts between Sacramento County and Sacramento City's Whole Person Care (WPC) initiative, and serves as a direct access point for assessing eligibility, continuity of care, and referral opportunities for homeless individuals with serious mental health conditions in the northern part of Sacramento County.

By integrating mental and physical health care and social support services in one location, the project ensures continuity of care and strengthens the region's continuum of care for an estimated 2,000 or more public and private clients annually.

The primary purpose of this emergency care integration innovation project is to demonstrate improved behavioral health outcomes through a public/private collaboration that removes existing barriers to care, increases access to, and the quality and scope of, crisis stabilization and supportive mental health services that are integrated and coordinated. Project services, sited in the northern region of Sacramento County, increase access to crisis services for underserved area residents.

The secondary purpose of this project is to improve the efficacy and integration of medical and mental health crisis stabilization services through a public/private partnership between a licensed acute care general hospital and an onsite provider of mental health rehabilitative crisis stabilization services. The project will result in the development of assessment, stabilization and treatment protocols between a hospital emergency department (ED) and an onsite mental health crisis stabilization service focused on timely intervention and restoration of civil rights, early psychosis identification and intervention, and reduced ED patient boarding. Treatment protocols will apply to two adjoining counties as well as Health Plans and include best practices to change the trajectory of care for individuals seeking crisis services.

Data Summary

The BHCSC opened its doors to the public on September 10, 2019. This report includes data retrieved from Avatar (Sacramento County Electronic Health Record) for Fiscal Year 2019/2020 as well as Dignity Health Mercy San Juan Medical Center's electronic health record system (Cerner).

Admissions and Discharges

- There were 763 unduplicated individuals admitted to the BHCSC for a total of 962 admissions during the fiscal year
    - During the fiscal year, 117 individuals returned to the BHCSC within 30 days of discharge
- There were 949 discharges from the BHCSC

Demographics

Behavioral Health Crisis Services Collaborative FY 2019/2020 Demographics		
	Number (N=763)	**Percent**
Race		
American Indian or Alaska Native	22	2.9%
Asian	12	1.6%
Asian Indian	3	0.4%
Black or African American	122	16.0%
Native Hawaiian or other Pacific Islander	23	3.0%
White	461	60.4%
Other	62	8.1%
More than one race	35	4.6%
Unknown/Not Reported	23	3.0%
Primary Language		
English	729	95.5%
Spanish	10	1.3%
Vietnamese	1	0.1%
Cantonese	1	0.1%
Russian	2	0.3%
Hmong	1	0.1%
Arabic	0	0.2%
Other	10	1.3%
Unknown/Not Reported	9	1.2%
Gender		
Male	405	53.1%
Female	358	46.9%
Transgender	0	0.0%

Intersex	0	0.0%
Behavioral Health Crisis Services Collaborative Continued	**FY 2019/2020 Demographics**	
	Number (N=763)	**Percent**
Veteran Status		
Yes	0	0.0%
No	0	0.0%
Unknown/ Not Reported	763	100.0%
Homeless Status*	(N=962 All Admits)	
Yes	222	23.1%
No	534	55.5%
Unknown/ Not Reported	206	21.4%

**Number is greater than unduplicated clients as it includes all admissions*

Timely Access

- The average ED length of stay decreased from 33 hours prior to implementation of the BHCSC to approximately 8 hours. The median length of stay by the end of the first year was 4 hours, indicating that 50 percent of individuals spend four hours or less in the ED before transfer to the BHCSC.
- The average annual length of time to medical clearance in the ED was approximately 2 hours, a decrease from more than 5 hours prior to implementation.
- The median length of stay in the BHCSC was 21 hours indicating that 50 percent of individuals spend 21 hours or less in the BHCSC prior to discharge.

Least Restrictive Intervention and Effectiveness of Services

- 70 percent of clients were admitted voluntarily to the BHCSC, while 21 percent of clients were admitted under a 72-hour involuntary hold for evaluation and treatment.
- 86 percent of clients were discharged to the community, while 14 percent were discharged to an inpatient psychiatric facility.

Utilization of Resource Center

- There were 649 unduplicated individuals admitted to the Resource Center for a total of 806 admissions during the fiscal year.
- 37 percent of clients admitted to the BHCSC were enrolled with an outpatient mental health service provider prior to admission.
- Following discharge from the BHCSC:
    - 13 percent of clients were linked to outpatient services within 30 days.

- Eight percent of clients were referred and linked to services by the County Mental Health Access Team.

Measuring Effective Collaboration and Partnership

The Measuring Effective Collaboration and Partnership (MECAP) tool was identified in the Innovation Project plan and utilized by the evaluators to measure the effectiveness of the partnership. The MECAP consists of five categories that are present in effective collaborations and partnership efforts: service access, communication, program enhancement, accountability, and outcomes. The evaluators conducted 13 interviews with more than 50 stakeholders who participated in different aspects of the project, including the planning, startup, and first year implementation phases. Interviews were grouped according to type of involvement in the project to capture views from a wide variety of participants including Dignity Health hospital leadership, Sacramento County leadership, Dignity Health operational staff in both the BHCSC and in the ED, Sacramento County operational staff, Dignity Health ED staff, and other community stakeholders and system partners such as consumers of mental health services, family members of consumers, community-based service providers, law enforcement partners, and representatives of other affiliated health providers and interested associations.

See the attached MECAP for the scoring in each category. Summarized comments from interviewees are highlighted below.

Service Access

- Strengths
  - With the BHCSC on site, the ED at Dignity Health Mercy San Juan Medical Center is now seen as a true front door to the mental health system.
  - Moving patients to the calmer environment of the BHCSC creates more alternatives for care, which benefits both patients and staff while also providing additional capacity in the ED for other medical needs.
  - The co-location of this project is seen as a critical service that the ED can quickly access and more efficiently coordinate mental health care on behalf of the patient.
  - Strong collaboration between executive teams from both the Hospital and the County as well as between the ED and BHCSC program staff on site.
- Challenges
  - Law enforcement and mobile crisis support team hand-off at the ED could be improved.
  - Stakeholders voiced a need to strengthen provider, patient, and stakeholder connection in the ED to efficiently expedite care.

- Ensure behavioral health resources including staff are available in the ED during all hours of the day to improve care coordination and the patient experience for individuals accessing outside traditional business hours.
- Providing access to the Resource Center for individuals that do not qualify for the BHCSC

Communication

- Strengths
  - Regular and frequent communication between the county and the hospital as well as between the BHCSC staff and ED staff.
  - Many steering/guiding committees were established to operationalize the implementation of the project and remained in place throughout the first year of the project.
- Challenges
  - Effective communication and outreach regarding the BHCSC to partners in the community.
  - Both the County and the hospital system had to adapt to each other's systems and procedures.

Program Enhancement

- Strengths
  - Dignity Health and Sacramento County leveraged complementary resources to implement the project. The Hospital provided dedicated space on campus for the construction of the modular facility, which was designed to meet crisis stabilization services specification and fit within the hospitalization regulatory structure. Sacramento County provided funding and federal match to operate the Innovation Project as well as the administrative and fiscal intermediary functions.
  - Dignity Health has a behavioral health nurse that helps meet the behavioral health needs of patients in the ED and serves as a liaison between the ED and BHCSC.
  - The BHCSC has a multidisciplinary team of professional staff and peer navigators (staff with lived mental health experience) that approach each client with respect.
  - Many training materials and resources were developed during the first year of the project for program staff and other staff close to the program.
- Challenges
  - Identifying an Avatar "super user" to help managing the use of the County IT system by BHCSC staff to ensure data integrity and data management functions.

- Stigma in the ED remains a challenge and interviewers recommended continued education and training in the ED that focuses on stigma reduction.

Accountability

- Strengths
  - Both partners acknowledged clarity around roles and responsibilities was critical for project success.
  - Multiple internal and external stakeholders were engaged in the decision-making process throughout many program components.
  - Open floor plan design of the BHCSC has reduced stigma and allowed for more open communication between clients and staff.
  - The mission and values of this project are grounded the public-private joint commitment to the MHSA framework.
  - Consumer input was been solicited, received, and integrated into project design and implementation.
  - Partners have regularly scheduled project meetings, communication between ED and BHCSC staff, and monitoring and oversight by clinical and administrative executive staff.
- Challenges
  - Expanding access to the Resource Center services for individuals that do not meet the requirements of the BHCSC.
  - Expanding outreach efforts as about this resource to the.
  - Challenges in placing and connecting patients to resources that are uninsured, out of county, or who have complex needs.

Outcomes

- Strengths
  - There have been many positive outcomes noted by stakeholders including: consumer satisfaction with services, reduction in length of stays, reduction in unnecessary involuntary commitments, improved community linkages and resources, and improved access to emergency medical and crisis stabilization for underserved populations.
  - Throughout workgroups during the planning stage and during implementation, the goals and objectives of the program have been clearly articulated and are aligned with the MHSA principles. Project partners have been cognizant of these goals and worked to ensure data are collected to report out on these goals and objectives.
- Challenges

- Lack of a single electronic health record for collecting information for outcome analysis as some data collected by the hospital is not captured in the County Avatar system.
- As the program continues to involve refining the staffing structure, providing additional education and training, and refining roles and responsibilities could have a positive impact on the patient experience and outcomes.

BHCSC Client Satisfaction Questionnaire Results

Satisfaction surveys show overall, clients were satisfied with the services they received at the BHCSC.

September 2019 – June 2020 Satisfaction Questionnaire Responses (N=260)	
Survey Questions (1=Strongly Disagree, 5=Strongly Agree)	**Average Rating**
When I arrived, I felt welcomed.	**4.20**
My visit gave me hope that I could overcome my struggle.	**4.13**
During my visit, I was told about programs and places where I could go that seemed useful to me.	**4.27**
During my visit, I was given the opportunity to make choices about my care.	**4.19**
Staff were sensitive to my cultural needs and background.	**4.25**
Staff heard and understood what I said.	**4.35**
I was treated with respect.	**4.44**
I felt safe and supported during my visit.	**4.42**
The amount of time that I waited to be seen was acceptable to me.	**4.31**
The psychiatrist answered my questions and addressed my concerns.	**4.30**
I understood my medication instructions upon leaving.	**4.26**
I understood the information I received about my follow-up care upon leaving.	**4.31**
Overall, the quality of care I received was (1=Poor, 5=Excellent).	**4.40**
Overall Satisfaction Rating	**4.30**

MECAP Measuring Effective Collaborations and Partnerships

COLLABORATION - "Working jointly to accomplish a shared vision and mission using joint resources"

Provide information for any section considered not applicable.

SERVICE ACCESS	1 Point	3 Points	5 Points	Comments
Point of Entry	Intake forms/procedures are separate. Referral necessary to receive services from participating agencies and are offered to consumers as need for services arise.	Intake forms/procedures are separate. Consumers offered referrals to other partners at point of entry.	Intake forms/procedures are integrated. Entry at one point ensures entry at all points of partnership.	See report narrative.
Co-Location/Coordination of Services	Partners refer consumers to other partners' offices in another location.	Partners hold regular office hours in other partners' offices.	Partners share office space or have offices at the same location.	
COMMUNICATION	**1 Point**	**3 Points**	**5 Points**	**Comments**
Key Staff	Identified management and front-line employees contact each other infrequently through e-mail or phone contact.	Identified management and front-line employees maintain an established time frame of contact through e-mail, phone contact or face to face meetings.	Identified management and front-line employees maintain weekly contact through e-mail or phone and have regularly scheduled meetings to monitor benchmarks/goals	See report narrative.
Steering/Guiding Committee	No Guiding Committee in place. Partnership communication/planning is addressed on an as needed basis.	Guiding Committee in place that consists of identified members of partner agencies and meets on a regular basis.	Guiding Committee in place that consists of identified members of partner agencies, community members, consumers.	
PROGRAM ENHANCEMENT	**1 Point**	**3 Points**	**5 Points**	**Comments**
Sharing of Resources	Partner agencies operate independently but share information re: resources and budgets for partnering activities.	Partner agencies share staff members, material resources and financial information re: partnership activities.	Partnership has a joint budget, shared staff and shared materials/space for all involved partners.	See report narrative.
Cross Training	Select staff members from each, at least two, partner organizations are cross trained at the beginning of the project.	Staff members from each participating organization are cross trained at beginning and at least one additional time during the project.	Staff members across organizational levels from all participating partners are cross trained at multiple points throughout the duration of the project.	
Information Sharing	No specific procedure in place for information sharing. Releases may be completed when sharing of confidential information is required.	Some sharing of consumer information that allows for identification of consumersnd referrals to partner agencies. Releases required for sharing other confindential information.	Intake/consent forms for one partner agency allow for sharing of consumer info among all partners, excluding therapeutic documentation.	
ACCOUNTABILITY	**1 Point**	**3 Points**	**5 Points**	**Comments**
Roles / Responsibilities	Partners discussed roles/ responsibilities of participating agencies.	Partners discussed roles/responsibilities of participating agencies and outlined roles/responsibilities in writing.	Partners signed an agreement or MOU with specifically defined roles/responsibilities of participating agencies.	See report narrative.
Decision Making	Some shared decision making between partner agencies as needed.	Decisions reached by voting process which includes all participating member agencies or Guiding Committee members.	Decisions reached by consensus of all partners, (includes members of Guiding Committee if applicable).	
Mission/Values	Partner agencies have separate mission statements which drive their decision to enter into partnership.	Leadership of partner agencies discuss their individual mission statements to ensure they are in line with the overall goals of the partnership.	All participating agencies create a joint mission statement for the project. Staff at various levels in the organization are involved in this process, or process is directed by the Guiding Committee.	
Consumer Input	Partner agencies utilize individual questionnaires for consumer feedback. Results of questionnaires are shared with partner agencies to monitor satisfaction with overall service delivery.	Partner agencies actively solicit consumer input for initial planning of partnership. A shared questionnaire for consumer feedback is utilized with results shared by all agencies for on-going project planning/monitoring.	Consumer input facilitated at all levels of project planning and implementation. Guiding Committee includes consumer representation. On-going consumer feedback utilized throughout partnership and reviewed by Guiding Committee.	
Project Planning/Coordination	Front-line staff or managers of partner agencies meet infrequently for planning and coordination.	Key figures among staff/managers of all partner agencies participate in regularly scheduled meetings for planning/coordination.	Guiding Committee in place that consists of key staff of partner agencies, community members, consumers and meets regularly for on-going planning and coordination of partnership.	
OUTCOMES	**1 Point**	**3 Points**	**5 Points**	**Comments**
Consumer Outcomes	Partner agencies have established consumer outcome goals that are individualized to their agency.	Partner agencies monitor individual consumer outcomes and share with partner agencies for on-going enhancement of services.	All partners have shared goals for consumer outcomes and utilize same tools/methods for tracking outcomes. Results are presented in Guiding Committee and drive on-going efforts to enhance services.	See report narrative.
Goals and Objectives	Partner agencies have individual goals and objectives that are actively monitored within their programs.	Partner agencies have individual goals and objectives. Strategic objectives are specifically designed to achieve the goals. Progress toward goals are regularly shared with partners.	Partner agencies create shared goals and objectives which are SMART (Specific Measurable, Acheivable, Relevant, and Timely) and are regularly monitered/ reviewed by Partners/Guiding Committee.	
Monitoring of Collaboration	Monitoring is planned. The importance of monitoring is jointly agreed upon.	Periodic meetings and reports are scheduled to review collaboration and adjust program outcomes accordingly.	Key individuals and instruments are identified for monitoring efforts. Results presented regularly to Guiding Committee. Agreed upon evaluation document utilized to track progress.	

POINT TOTALS				
Service Access =	6 /10 possible	Program Enhancement =	11 /15 possible	Outcomes = 13 /15 possible
Communication =	10 /10 possible	Accountability =	21 /25 possible	Total Points = 61 /75 possible

THIRD SECTOR

California Multi-County Full Service Partnership Innovation Project

Progress Report

MARCH 2021

Project Overview

Since the passage of the Mental Health Services Act (MHSA) in 2004, California has made significant strides in improving the lives of those living with mental illness.

In particular, Full Service Partnership (FSP) programs support people with the most severe and often co-occurring mental health needs. These MHSA-funded FSP programs are designed to apply a "whatever it takes" approach to partnering with individuals on their path to wellness and recovery. Currently, over 60,000 individuals are enrolled in an FSP program across the state.

Full Service Partnerships represent a $1 billion annual investment in public funds and have tremendous potential to reduce psychiatric hospitalizations, homelessness, incarceration, and prolonged suffering by Californians with severe mental health needs. FSP programming, however, varies greatly from county to county, with different operational definitions and lack of consistent data processes, which makes it challenging to understand and tell a statewide impact story. The Multi-County FSP Innovation Project aims to implement a more uniform data-driven approach that provides counties with an increased ability to use data to improve FSP services and outcomes. Counties will leverage the collective power and shared learnings of a cohort to collaborate on how to provide the most impactful FSP programs and ultimately drive transformational change in the delivery of mental health services.

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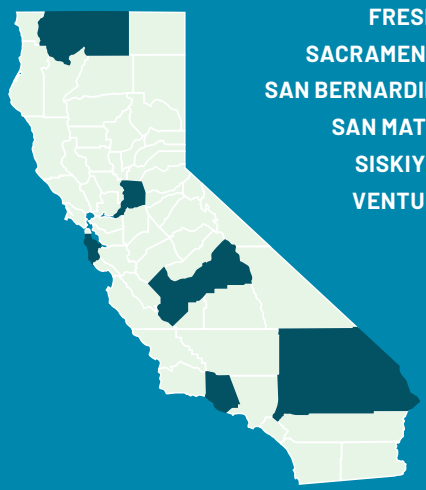

FRESNO
SACRAMENTO
SAN BERNARDINO
SAN MATEO
SISKIYOU
VENTURA

In partnership with Third Sector and the Mental Health Services Oversight and Accountability Commission (MHSOAC), a cohort of six diverse counties — Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura — are participating in a 4.5 year Multi County FSP Innovation Project that will leverage counties' collective resources and experiences to improve FSP delivery across California. Additional project partners include the California Mental Health Services Authority (CalMHSA) acting as the fiscal agent and RAND Corporation providing consultation on measurement and conducting the project's post implementation evaluation. This project furthers the efforts of LA County's Department of Mental Health FSP transformation, building on their initial groundbreaking data and outcomes efforts to new geographies and localities with a statewide perspective.

Project Purposes & Goals

The Multi-County FSP Innovation Project aims to shift the way counties design, implement, and evaluate FSPs to a more outcomes-oriented approach by:

01

Developing a shared understanding and more consistent interpretation of FSP's core components across counties, creating a common FSP framework.

02

Increasing the clarity and consistency of enrollment criteria, referral, and transition processes through developing and disseminating readily understandable tools and guidelines across stakeholders.

03

Improving how counties define, collect, and apply priority outcomes across FSP programs.

04

Developing a clear strategy for tracking outcomes and performance measures through various state-level and county-specific reporting tools.

05

Developing new and/or strengthening existing processes that leverage data to foster learning, accountability, and meaningful performance feedback in order to drive continuous improvement in program operations and outcomes.

Progress To Date

Gathering Context & Building a Vision

Counties began this effort with a comprehensive Landscape Assessment phase (January - September 2020) to understand FSP programs, assets, and opportunities. Via a combination of meetings, working group sessions, document review, and stakeholder engagement (see below), counties developed a comprehensive understanding of similarities and differences across FSP service design, populations, data collection, and eligibility/graduation practices.

Understanding that county mental and behavioral health agencies often work with limited financial and staffing resources, Third Sector and the counties leveraged the six-county "cohort" to gather and compare information in an efficient manner, sharing resources, templates, and toolkits. Regular cohort-wide meetings provided an opportunity for counties to learn from each other, sharing solutions and ideas that could be relevant for their peer counties.

These six-county cohort meetings were essential to building a collective vision and aligning on priorities for the Implementation Phase. Counties and Third Sector identified almost 30 implementation options that would respond to stakeholder feedback and identified challenges. Over the course of both county-specific and cohort-wide meetings, each county and the collective group narrowed in on a feasible set of implementation activities that would create more data-driven FSP programs and build increased consistency in the way FSPs are designed, operated, and assessed.

> "This process has revealed that every FSP program was its own island, each operating in a unique way. But the lack of an overall framework caused inconsistency. To more effectively provide these services statewide, the provider community needs to learn from each other, in collaboration with the county and state. The ideas are out there."
>
> **— Fresno County FSP Provider**

Piloting Change: The First Steps

In October 2020, counties kicked off a 12-month Implementation Phase to build and operationalize three shared "cohort-wide" FSP improvements as well as locally customized "county-specific" changes. Counties and Third Sector will continue to gather stakeholder feedback to inform these changes from FSP service providers, clients, and clients' primary caregivers throughout the process.

Cohort-wide implementation activities:

Counties are embarking on a trailblazing journey to build shared population definitions, outcomes, process measures, and statewide data recommendations. As a result, the counties will have more comparable and actionable FSP data that can be used to identify and disseminate FSP best practices. Over the course of 12 months, the six-county cohort will focus on:

- **POPULATION DEFINITIONS:** Identifying and standardizing definitions for the following priority FSP populations: homeless; at risk of homelessness; justice-involved; at-risk of justice involvement; high-utilizers of psychiatric emergency facilities; at-risk of using psychiatric emergency facilities.

- **OUTCOMES & PROCESS METRICS:** Identifying 3-5 outcomes, 3-5 process measures, and associated metrics to track what services individuals enrolled in FSP receive and how successful those services are. RAND is assessing how counties currently measure priority outcomes and examining relevant research literature in order to make recommendations for measurement that consider both county capacity and research evidence.

- **STATE REPORTING RECOMMENDATIONS:** Developing recommendations for revising the statewide Data Collection & Reporting (DCR) system. This may include suggested revisions to existing forms, metrics, and/or the format of reports that are shared with counties in order to increase the usefulness of statewide data and reduce reporting burden. This activity will begin in late Spring 2021 after the completion of the first two activities.

- **LEARNING COMMUNITIES:** Given the statewide implications of each of these cohort-wide activities, the six counties participating in the Innovation Project also plan to hold statewide "Learning Communities" in Spring/Summer 2021 to gather additional feedback from other counties across the state. Over time, counties hope to build these forums into a sustainable opportunity to share best practices and continuously improve FSP.

County-specific implementation activities:

Counties have each identified two or three priority activities for local implementation, simultaneously with the cohort activities. While multiple counties are pursuing many of the same county-specific activities, the results will vary somewhat across the state because of each county's unique population, geography, and needs. Counties can more efficiently and effectively tackle each of these improvements by sharing tools, processes, and ideas, benefitting from a cohort approach even as results show nuanced differences. These county-specific implementation activities include:

- **GRADUATION GUIDELINES (5 COUNTIES):** Standardizing graduation criteria that balance Individual Services and Supports Plans (ISSPs) and system-wide outcomes in making individual graduation decisions, including creating improved definitions of "stability" and "recovery."
- **SERVICE REQUIREMENTS (3 COUNTIES):** Developing minimum elements and service requirements of FSP to adopt as official guidance. These elements will depend on local context and priorities and could include the percentage of services that are field-based, telehealth options available, housing services offered, employment services provided, peer supports available, and so on.
- **REAUTHORIZATION PROCESS (3 COUNTIES):** Standardizing an FSP client reauthorization process and/or tools that can be used by counties to more regularly assess whether a client is ready to step down from FSP services.
- **ELIGIBILITY GUIDELINES (2 COUNTIES):** Revising county-specific FSP eligibility criteria to ensure that counties prioritize FSP services to the highest-need clients.
- **DATA COLLECTION PROCESSES (2 COUNTIES):** Streamlining existing processes and/or developing new data collection reports or methods so that counties and providers can more effectively collect, access, and utilize FSP data to inform care decisions.
- **REFERRAL PROTOCOLS (1 COUNTY):** Developing protocols for FSP referrals between county entities that ensure a warm hand-off and that clients are not being served by multiple providers.
- **REFERRAL FORMS (1 COUNTY):** Creating a standardized FSP referral form to ensure consistent data collection across a county's FSP programs.
- **YOUTH-SPECIFIC REFERRAL & ENROLLMENT PROCESS (1 COUNTY):** Developing a standardized youth FSP referral and enrollment process in which the county is involved in processing and/or approving referrals to contracted FSP providers.

Initial Collaboration Lessons

This Multi-County FSP INN project is forging a new path for statewide, cross-county collaboration, and two valuable lessons have already emerged in this first project year.

Lesson One

Multi-county collaborations must balance appropriate levels of local customization, statewide consistency, and innovation. This FSP Innovation Project has made progress on identifying the most beneficial areas for statewide collaboration, as well as some areas that may be less appropriate for future collaborative efforts. Counties and Third Sector feel that the information-gathering worksheets and templates can be used to gather standardized information to compare FSP programs across the state in the future. Additionally, the full list of implementation activities could be used by future counties seeking inspiration for potential improvements to their FSPs. While all activities could be applied to any geography, the cohort has learned that there are three categories under which these activities fall into:

- Activities around outcomes definitions, metrics, and data collection are appropriate to be worked on collectively to achieve a unified result, such as shared state data reporting requirements (e.g., for the Data Collection Reporting, or DCR, system) to support performance management forums.

- Other activities related to eligibility, graduation, and service design are more appropriate to be developed locally, while following parallel processes that can yield peer learning and resource sharing. This helps counties balance their varying geographies, populations, and histories while increasing efficiency.

- Activities related to referrals, collaboration with local institutions (e.g., jails, hospitals, etc.), and community feedback mechanisms may not be appropriate for collective projects, given the high variation in each counties' local context and existing coordination processes.

Lesson Two

The timing of statewide feedback is crucial. While counties across the state have a valuable perspective to offer on FSP best practices, it can be difficult to identify specific areas for feedback at the early stages of a collective project. It may be more appropriate to gather statewide feedback at later stages of collective projects. After an initial Learning Community session with representatives from 11 other counties in December 2019, counties learned that it was more appropriate to hold off on further involvement until this core group made additional progress and had more specifics for statewide reaction. Counties hope to re-start the Learning Communities in spring/summer 2021 after further implementation progress is made.

Stakeholder Insights

Effective stakeholder engagement leverages their knowledge and experience to provide a deeper understanding of challenges on the ground while translating stakeholder needs into tangible goals and solutions.

For the Multi-County FSP Innovation Project, these key stakeholders include FSP clients, clients' primary caregivers, and service providers. From July through September of 2020, Third Sector and participating counties engaged representatives from each of these groups to better understand FSP programs from their perspectives and used that information to prioritize which program challenges the Innovation Project will address over the next year.

Client feedback played an important role in understanding the goals and needs of those being served and will inform how counties design and execute each implementation activity in the year to come, resulting in more client-centered solutions. Recognizing some inherent selection bias within the interview process, FSP clients generally spoke highly of providers, and overall satisfaction was often based on their individual provider relationships. Individuals struggled with the implications of the COVID-19 pandemic and expressed feelings of loneliness, reduced access to services, and difficulty with telehealth. Clients also commented on staff turnover, workload, or stress level, and these observations sometimes drove feelings of confusion about who to talk to or trust in a new relationship. Despite their different geographies, individuals across the six counties hope to achieve many of the same goals in FSP, including increased independence, self-sufficiency, coping skills, housing, employment, education access, and increased social connections.

> "Recovery to me looks like happiness. I want to wake up happy and trust the world. I want small things – happiness, freedom, and to keep my life. Now I have good reasons to stay alive and active."
>
> **– Siskiyou County FSP Client**

88 **client interviews** with current or recently enrolled clients or their caregivers

80 **digital surveys** completed by Fresno and San Bernardino provider staff

17 **provider focus groups** with 108 individuals spanning all FSP programs and age groups across six participating counties, from both directly operated and in-house clinics

Provider feedback played an important role in determining the implementation activities to pursue collaboratively across six counties and which to pursue individually within each county's local context. Providers in all counties were consistent in their desire to see improved data collection alongside timely data-sharing and reports, including clearer outcomes, reduced reporting requirements, and better data quality. Other key themes included the desire to clarify eligibility and graduation requirements, to further understand the "mission and vision" of FSP, to increase coordination with other county systems, and to receive additional training to improve culturally responsive services.

> "Staff have not been trained in interpreting the data we're collecting. I understand what I'm inputting to the system, but I'm not trained in how the data should be used to influence treatment."
>
> **— Ventura County FSP Provider**

Lessons Learned & Best Practices

- **Engage stakeholders early and often** in order to maximize the amount of time spent hearing from the community and ensure their voices are included in not only the design of the solution, but also the articulation of the challenge. Through early stakeholder engagement, Siskiyou County was able to shift its perspective from addressing basic client needs to learning about aspirational client goals and is now using those goals to identify which elements of their service delivery require robust guidelines, thus shifting direction even before the design process begun. This strategic direction would not have been identified without crucial feedback from clients and providers.

- **Utilize culturally competent engagement methods** to ensure all voices are elevated, including those of people who are harder to reach and/or underrepresented. Cultural competence also supports the retention of these key stakeholders throughout the process. For the first round of stakeholder engagement, interviews were offered in both English and Spanish, but Third Sector and participating counties plan to work with providers to include interviews in more languages and culturally specific engagement methods in the coming year, leveraging language translation services and additional expert feedback on the engagement mechanisms.

- **Offer multiple forums for feedback** to expand access and encourage diverse participation. While in-person forums were limited due to COVID-19, clients were offered individual interviews by phone or video conferencing and providers were offered individual discussions, focus groups, and in some counties, digital surveys. Fresno County received over 70 provider responses to an online survey that included representation from every FSP program and age group served.

- **Compensate clients for their participation** to recognize the value of their time and contributions. All clients were given a $35 Visa gift card for providing their expertise and additional resources for compensation will be identified for any and all future engagement efforts.

A Look Ahead

Third Sector will continue to work with counties to build and implement the cohort and local activities through fall 2021. This will include facilitation of cohort and county-specific workgroups; FSP client and provider engagement by survey, focus group, and interview methods; and Learning Community events to gather feedback from other counties statewide.

By the end of November 2021, the counties and Third Sector hope to have implemented new strategies and approaches to increase the consistency of FSP services; more effectively use data to understand who is being served, what services they are receiving, and what outcomes they are achieving; advocate for changes to the statewide FSP data collection system; and have a sustainable continuous improvement process to continue peer learning. By 2024, the aim is to have a clear understanding of the impact of this collaborative process on county policy and, more importantly, the individuals served by FSP.

In addition, this project hopes to illuminate and address racial disparities in outcomes and elevate voices and communities of color especially as they provide feedback to counties on FSP programming. Overall, the Multi-County FSP Innovation Project hopes that the strategies piloted will be useful on a statewide scale, and the lessons will be shared for future statewide collaborative efforts that can benefit California's most vulnerable individuals suffering from severe mental illness.

Project Partners

COUNTY PARTNERS

Fresno County Department of Behavioral Health: Fresno County is located in the heart of California's Central Valley. Fresno County Department of Behavioral Health serves individuals across 6,000 square miles, encompassing mountain enclaves, rural communities, and urban neighborhoods of California's fifth largest city. In partnership with its diverse community, the Department is dedicated to providing quality and culturally responsive behavioral health services to promote wellness, recovery, and resiliency for individuals and families.

Sacramento County Behavioral Health Services: Sacramento County has a population of more than 1.4 million individuals and is known for its multi-cultural diversity. Situated in the middle of California's Central Valley, Sacramento County extends from the low delta lands between the Sacramento and San Joaquin rivers north to about 10 miles beyond the State Capitol and east to the foothills of the Sierra Nevada Mountains. Sacramento County Behavioral Health Services' mental health system of care includes 260 programs/agencies involving county- and contract-operated mental health services that deliver services to approximately 32,000 children and adults annually. BHS pursues intentional partnerships with the diverse communities in Sacramento County and with the goal of improving the wellness of community members.

San Bernardino County Department of Behavioral Health: San Bernardino County is the largest county in the contiguous United States with just over 20,000 square miles of land that encompasses urban, suburban, rural, and frontier terrain. According to California Department of Finance estimates for 2018, San Bernardino County had a total population of 2,174,931 with a projected growth of 28% between 2020 and 2045. San Bernardino County's Department of Behavioral Health (DBH) aims to promote wellness, recovery, and resilience that includes the values of equity, community-based collaborations, and meaningful inclusion of diverse consumers and family members. As such, San Bernardino County DBH serves more than 150,000 individuals over a broad continuum of services each year.

San Mateo County Behavioral Health and Recovery Services: Located in the Bay Area, San Mateo County is bordered by the Pacific Ocean to the west and the San Francisco Bay to the east. Within its 455 square miles, nearly three quarters of the county is open space, and agriculture remains a vital contributor to the economy and culture. Behavioral Health and Recovery Services (BHRS), a Division of San Mateo County Health, provides prevention, treatment, and recovery services to inspire hope, resiliency, and connection with others and enhance the lives of those affected by mental health, and/or substance use challenges. BHRS is dedicated to advancing inclusion, health and social equity for all people in San Mateo County and for all communities.

Siskiyou County Behavioral Health Services: Siskiyou County is a geographically large, rural county with a population of 43,724 persons located in the Shasta Cascade region of Northern California. Approximately 6,350 square miles, Siskiyou County is geographically diverse with lakes, dense forests, and high desert. Siskiyou County Behavioral Health (SCBH) is a small Behavioral Health program and is the sole provider of the Full Service Partnership Program (FSP). SCBH is committed to partnering with the participants of this Innovation Project to better define FSP criteria and improve the data collection points to assist our FSP consumers toward graduation and mental wellness. SCBH strives to deliver culturally, ethnically, and linguistically appropriate services to the community and recognizes the importance of these values in service delivery.

Ventura County Behavioral Health: Ventura County is situated along the Pacific Coast between Santa Barbara and Los Angeles counties. The county offers 42 miles of beautiful coastline along its southern border, and the Los Padres National Forest makes up its northern area. Ventura County Behavioral Health works to promote hope, resiliency, and recovery for our clients and their families by providing the highest quality prevention, intervention, treatment, and support to persons with mental health and substance abuse issues.

Project Partners

THIRD SECTOR: Based in San Francisco and Boston, Third Sector is one of the leading implementers of outcomes-oriented strategies in America. Third Sector has supported 20+ communities to redirect over $800M in public funds to data-informed, outcomes-oriented services and programs. Third Sector's experience includes working with the Los Angeles County Department of Mental Health (LACDMH) to align over $350M in annual MHSA FSP and Prevention and Early Intervention (PEI) funding and services with the achievement of meaningful life outcomes for over 25,000 Angelenos; transforming $81M in recurring mental health services in King County, WA to include new performance reporting and continuous improvement processes that enable the county and providers to better track monthly performance relative to peers and against specific, county-wide performance goals; and advising the County of Santa Clara in the development of a six-year, $32M outcomes-oriented contract intended to support individuals with serious mental illness and complex needs through the provision of community-based behavioral health services. For more information, please visit **thirdsectorcap.org/Multi-County-CA-FSP-INN/.**

CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY (CALMHSA): The California Mental Health Services Authority (CalMHSA) is a Joint Powers Authority (JPA) of the County and City public mental health departments that provides program management, administrative, and fiscal intergovernmental structure for its members. A central component of CalMHSA's vision is to continually promote systems and services arising from a commitment to community mental health. CalMHSA administers local, regional, multi-jurisdictional, and statewide projects on behalf of the County and City public mental health departments.

CALIFORNIA MENTAL HEALTH SERVICES OVERSIGHT & ACCOUNTABILITY COMMISSION (MHSOAC): In enacting Proposition 63, the Mental Health Services Act, California voters in 2004 created and charged the Mental Health Services Oversight and Accountability Commission with the responsibility of driving transformational change in public and private mental health systems to achieve the vision that everyone who needs mental health care has access to and receives effective and culturally competent care. The Commission was designed to empower stakeholders, with members representing consumers and their families, service providers, law enforcement, educators, and employers. The Commission put consumers and families at the center of decision-making. The Commission promotes community collaboration, cultural competency, and integrated service delivery. The Commission is committed to wellness and recovery, using its authorities, resources, and passion to reduce the negative outcomes of mental illness and promote the mental health and wellbeing of all Californians.

RAND: The RAND Corporation is a nonprofit, nonpartisan research organization headquartered in Santa Monica, California. RAND Health Care is a research division within RAND dedicated to promoting healthier societies by improving health care systems. We provide health care decisionmakers, practitioners, and the public with actionable, rigorous, objective evidence to support their most complex decisions. RAND has an extensive portfolio of mental health research and evaluation. Notably, we have been conducting independent, county-funded evaluations of the MHSA for almost a decade, including an evaluation of LA County DMH's FSP program and extensive work evaluating CalMHSA's statewide PEI programs. For more information, you can access over 80 reports on RAND evaluations of MHSA-funded programs at **rand.org/health-care/projects/calmhsa/publications.**