MENTAL HEALTH SERVICES ACT

Draft
Fiscal Year 2015-16
Annual Update to the Three-Year Program and Expenditure Plan

Posted for 30-day Public Review and Comment
January 4, 2016 through February 3, 2016

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 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 2012 United States Census Bureau estimates the population of Sacramento County to be approximately 1.45 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 five threshold languages (Spanish, Russian, Vietnamese, Hmong, and Cantonese). Historically, Sacramento County has been one of three counties with the highest number of newly arriving refugees in California. We welcome these new residents and continue to work towards meeting the unique needs of these communities.

Sacramento County 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. These changes also provide counties with the opportunity to present MHSA annual updates in a way that is more meaningful to local stakeholders.

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 adults living with a serious mental illness. In Sacramento County, there are seven (7) previously approved CSS Work Plans containing fourteen (14) operational 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, adults, older adults and their families.

As addressed in the Three-Year Plan, the Division of Behavioral Health Services facilitated a three-phased community planning process to expand CSS programming beginning in 2014. This new and expanded programming is in varying stages of implementation as described in this Annual Update.

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 projects containing twenty-two (22) programs designed to address suicide prevention and education;

strengthening families; integrated health and wellness; and mental illness stigma and discrimination reduction. This component includes the new mental health respite and Mobile Crisis Support Teams programming identified in the 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 that are implemented or in advanced stages of planning.

The **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. Sacramento County currently has one previously approved INN Project, known as INN Project 1: Respite Partnership Collaborative (RPC). The RPC INN Project term spans five years from 2011 – 2016.

The RPC is a 22-member community driven collaborative that promotes interagency collaboration in funding mental health respite services through a public-private partnership between the Division of Behavioral Health Services, the Sierra Health Foundation: Center for Health Program Management as the Administrative Entity and the Collaborative. The RPC awarded six (6) mental health respite services grants in funding Rounds 1 and 2. Round 3 awarded five additional respite grants which will be implemented in early 2015.

In Fiscal Year 2015-16, the Division held a community planning process to develop a second INN Project, known as INN Project 2: Mental Health Crisis/Urgent Care Clinic. This project is described in detail as an attachment to this Annual Update.

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.

The **Capital Facilities (CF)** project focuses on the renovation of three buildings at the Stockton Boulevard complex in order to consolidate the Adult Psychiatric Support Services (APSS) clinics. These renovations allow for an expansion of service capacity with space for additional consumer and family-run wellness activities and social events. The renovations and consolidation will be completed during Fiscal Year 2015-16.

Detailed descriptions of the programs and activities for each of the above MHSA components are contained in the MHSA Fiscal Year 2015-16 Annual Update.

The Draft MHSA FY2015-16 Annual Update is being posted for a 30-day public comment period from January 4, 2016 through February 3, 2016. The Mental Health Board will conduct a Public Hearing on Wednesday, February 3, 2016 beginning at 6:00 p.m. at the Grantland L.

Johnson Center for Health and Human Services, located at 7001-A East Parkway, Sacramento, CA 95823.

If a community member would like to attend the Public Hearing and needs to arrange for an interpreter or a reasonable accommodation, please contact Jay Ma as soon as possible but no later than Wednesday, January 27, 2016, at (916) 875-4639 or MaJay@saccounty.net.

COMMUNITY PROGRAM PLANNING

The Sacramento County Division of Behavioral Health Services Community Program Planning Process for the Draft MHSA Fiscal Year (FY) 2015-16 Annual Update to the Three-Year Program and Expenditure Plan meets the requirements described in Section 3300 of the California Code of Regulations. Sacramento County's community 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 Annual Update have evolved from community planning processes. As previously reported in the MHSA Fiscal Year 2014-15, 2015-16, 2016-17 Three-Year Plan, in 2014 the Division of Behavioral Health Services facilitated a three-phased community planning process to expand CSS programming. This process, as well as the new and expanded programming resulting from Phases A and B are described in detail in the CSS Component section of the Three-Year Plan. The Phase C expansion planning process and resulting new and expanded programming are described in this Draft Fiscal Year 2015-16 Annual Update.

The general plan for this Draft Annual Update was discussed at MHSA Steering Committee meetings on April 16, 2015, July 16, 2015, November 19, 2015 and December 17, 2015. The Steering Committee is the highest recommending body in matters related to MHSA programs and activities. MHSA program presentations for CSS, PEI, 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 Annual Update, DBHS will present to the Mental Health Board, the MHSA Steering Committee, and the Cultural Competence Committee in order to obtain additional stakeholder input.

The MHSA Steering Committee is comprised of one primary member and one alternate from the following groups: Sacramento County Mental Health Board; Sacramento County's Division of Behavioral Health Services (DBHS) Mental Health Director; 3 Service Providers (Child, Adult, and Older Adult); Law Enforcement; Adult Protective Services/Senior and Adult Services; Education; Department of Human Assistance; Alcohol and Drug Services; Cultural Competence; Child Protective Services; Primary Health; Juvenile Court; Probation; Veterans; 2 Transition Age Youth Consumers; 2 Adult Consumers; 2 Older Adult Consumers; 2 Family Members/Caregivers of Children 0 – 17; 2 Family Members/Caregivers of Adults 18 – 59; 2 Family Members/Caregivers of Older Adults 60 +; and 1 Consumer At-large. Some members of the committee have volunteered to represent other stakeholder interests including Veterans and Faith-based.

MHSA Steering Committee meetings are open to the public with time allotted for Public Comment at each meeting. Agendas, meeting minutes and supporting documents are posted to the Division's MHSA webpage.

Additionally, stakeholders representing unserved and underserved racial, ethnic and cultural groups who are members of the DBHS Cultural Competence Committee were updated and provided feedback on MHSA activities at their monthly meetings.

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COMMUNITY SERVICES AND SUPPORTS (CSS) COMPONENT

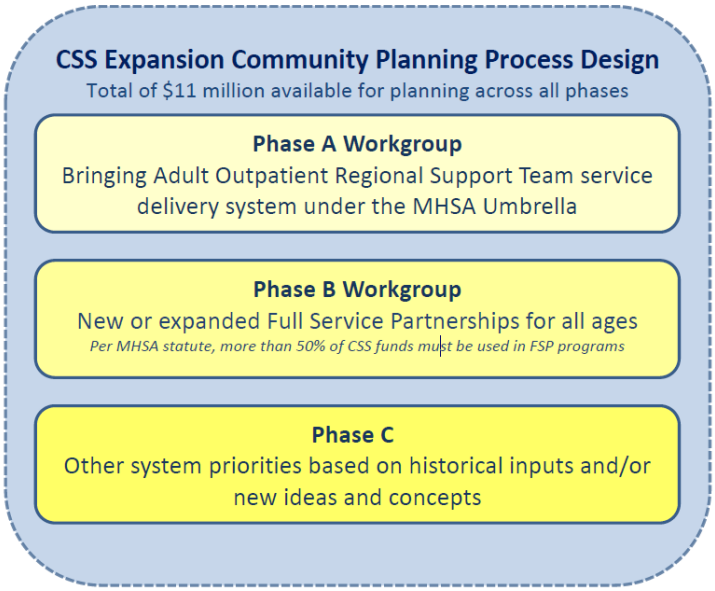
The **Community Services and Supports (CSS)** component provides funding for mental health treatment services and supports for children/youth and their families living with severe emotional disturbance and adults living with a serious mental illness. The MHSA requires that a minimum of fifty percent 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 (see Attachment A - MHSA Funding Summary Presentation).

As previously reported, in 2013 the Division of Behavioral Health Services (DBHS), with fiscal consultation, identified up to $16 million in CSS sustainable growth funding. This sustainable growth funding figure was determined by combining increased future revenue projections with unexpended funds from prior years.

As required by statute, an inclusive community planning process for new and enhanced services was introduced to the MHSA Steering Committee for discussion and input in January 2014. Based on compelling data, previous community stakeholder input and other source documents from the previous five years, the overarching focus of the CSS Expansion is increased timeliness to services and expanded system capacity.

The MHSA Steering Committee approved the $11 million three-phased community planning process outlined below at their February 2014 meeting.



The Phase A and Phase B community planning processes and resulting new and expanded programming were described in detail in the MHSA Fiscal Year 2014-15, 2015-16 and 2016-17 Three-Year Plan.

Phase C of the community planning process was approached in stages and focused on other system priorities based on historical inputs and/or new ideas and concepts, as well as evolving new initiatives benefitting mental health clients. As previously reported, in January 2014 the Division submitted a grant proposal to the California Health Facilities Financing Authority (CHFFA) in response to SB82, "Investment in Mental Health Wellness Act of 2013." The proposal included both a request for capital funding for the existing 12-bed crisis residential program, as well as capital and personnel funding for the implementation of two Mobile Crisis Support Teams (MCSTs). The Division received a grant award in April 2014 for the implementation of the MCSTs. Unfortunately, the crisis residential portion of the first round CHFFA proposal was not awarded because the request focused on the facility of the existing 12-bed program.

CHFFA announced a second round of grant funding in July 2014. On July 17, 2014 a presentation was made outlining crisis residential services in Sacramento County and the data supporting the need for expansion. The Steering Committee was reminded that Sacramento currently has only 12 crisis residential beds in the community, compared to approximately 300 inpatient psychiatric beds, and crisis residential has been identified as a gap in our system of care. In repeated planning workgroups since 2007, crisis residential programming has been a recognized gap in the local mental health services continuum.

The MHSA Steering Committee, after a rich discussion with passionate consumer testimony, urged the Division to pursue a new 15-bed Crisis Residential Capital Funding grant and allocated up to $1.5 million in CSS Expansion dollars from Phase C to fund the related services (Medi-Cal will be leveraged). The Division submitted a new proposal and was awarded funding in December 2014. The new 15-bed Crisis Residential Program was included in the Three-Year Plan as SAC10 Crisis Residential Program.

Phase C expansion planning continued at the MHSA Steering Committee in May 2015, with a focus on new and/or expanded programming to meet the coordinated mental health service needs of children in foster care (also referred to as the Katie A. population), as well as expansion of existing programming not addressed in Phases A or B. In June 2015, the MHSA Steering Committee recommended that responsibility for creating proposals for serving the Katie A. population be delegated to the existing Katie A. Steering Committee (with additional stakeholder representation). At the same meeting, the MHSA Steering Committee recommended that to DBHS work with TCORE and the Wellness and Recovery Centers to negotiate expansion to address timeliness and capacity issues.

In October 2015, the Phase C Katie A. Workgroup recommendation was approved by the MHSA Steering Committee (see Attachment B). Programming resulting from implementation of this recommendation will be described in the Fiscal Year 2016-17 Annual Update.

Program: Transitional Community Opportunities for Recovery and Engagement
Work Plan #/Type: SAC1 – General System Development (GSD)
Capacity: 8,000 annually
Ages Served: TAY, Adults, Older Adults

The **Transitional Community Opportunities for Recovery and Engagement (TCORE)** workplan was expanded in the Three-Year plan and now consists of three previously approved and implemented program components: **Adult Psychiatric Support Services (APSS)** clinic, administered by DBHS, **TCORE**, administered by Human Resources Consultants (HRC) and TLCS, Inc. and the redesigned Regional Support Team (RST) service delivery system. These programs offer low to moderate intensity community-based 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 is a site-based outpatient clinic that provides mental health and rehabilitation services. Counselors with training in integrated mental health and substance abuse care are available and specialize in treatment for co-occurring disorders. In Fiscal Year 2015-16, the two APSS clinics were co-located to the newly renovated Stockton Boulevard complex as a result of the MHSA Capital Facilities project described later in this Annual Update.

Success: Recovery and Support
A 29 year-old male had been experiencing severe symptoms related to schizophrenia for many years resulting in arrests and multiple hospitalizations. An APSS counselor and psychiatrist were assigned following a 12-day hospitalization. The client now states that "after years of suffering" and "hearing too many voices", he "got the right treatment" and his life has changed. A Peer Partner was also assigned to provide support and assist with the client's employment and resource needs. The Peer helped the client prepare for job interviews and referred him to Crossroads for employment training. He now works nearly full time and is happily married. He also reports no longer hearing voices that had been part of his symptoms.

The APSS clinic includes a Peer Partner component, administered by Mental Health America of Northern California, 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. Additional program goals include wellness planning, family support, and discharge planning, when appropriate, to community services.

TCORE is a countywide collaborative effort between Human Resources Consultants (HRC) and TLCS, Inc. TCORE has the flexibility to provide a range of moderate to high intensity services – primarily community-based mental health and rehabilitation services to adult community members who are experiencing frequent acute mental health episodes or who are at risk of losing their ability to live and function in the community. Individuals are assigned to a service team familiar with each client's needs. Team staff include a Team Leader, four (4) Personal Service Coordinators (PSCs) and a Consumer/Family Advocate. There is also a Benefits Acquisition Specialist and an Employment Specialist available to all participants. There is also a co-located health clinic available for clients.

Program outcomes are to improve access to services through community-based targeted engagement and assessment services; strengthen functioning level to support clients in the least restrictive, least costly community-based housing; and reduce unnecessary use of emergency rooms, hospitals, and jails. The strategies of integrated assessment, mobile crisis intervention, self-directed care, peer supports, vocational services, integrated mental health, and co-occurring substance use services are further supported by available medication supports and services, provided by Physicians, Physician's Assistants, and nursing staff. To support participation, transportation is available for all clinic-based activities and necessary field or community services. Services are delivered wherever necessary to meet clients needs – in-home, clinic, community, etc.

Success: Transition
A 22 year old HRC TCORE consumer was referred due to his mental health challenges impacting his ability to maintain housing, employment, and important relationships. In working with his Personal Service Coordinator he was linked to a Psychiatrist and other needed resources, such as the Department of Rehabilitation and housing. The consumer has learned skills to assist him in attaining and maintaining his recovery – including managing his finances in order to live independently, working a full-time job with benefits, and receiving additional support from his family. Due to his length of stability and success, the consumer is requesting his medication support be transferred to his Primary Care Physician in preparation for stepping-down from TCORE services.

Regional Support Teams (RSTs): Phase A of the CSS Expansion Planning Process resulted in the expansion of the MHSA CSS Component to include the **Regional Support Team (RST)** service delivery system. The RSTs provide mental health services and supports for TAY (age 18+), adults, and older adults residing in Sacramento County. Individuals must meet target population criteria for a serious mental illness (with an included diagnosis) and significant impairments in important areas of functioning. Currently, there are four RST programs operated by: 1) El Hogar Community Services, Inc., 2) Human Resources Consultants (HRC), 3) Turning Point Community Programs, and 4) Visions, Inc., through contracts with DBHS. Each RST provides individual and group treatment, rehabilitation services, medication evaluations and monitoring, and case management. RST programs are located in four geographic areas (regions) throughout Sacramento County and serve individuals with low to moderate intensity service needs.

Resulting from the previously described CSS Expansion Phase A community planning process, in redesigning the RST service delivery system, each RST implemented a **Community Care Team** with the purpose of enhancing engagement and timely access to services at the RSTs using culturally and linguistically competent services. These teams operationalized in July 2015 and deliver flexible, recovery-based individualized services, allowing for seamless transitions throughout the continuum of outpatient services and supports available in Sacramento County. Staffing for each team includes a team lead, clinician/social worker, psychiatrist and nurse, peer/family provider, resource specialist.

Program: Sierra Elder Wellness
Work Plan #/Type: SAC2 – Full Service Partnership (FSP)
Capacity: Expansion in process. Currently 150 at any given time
Ages Served: Transition Age Older Adults, 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 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 geriatric services, facilitating the coordination between multidisciplinary mental health, physical health, and social service teams. FSP services also include assistance with benefit acquisition, housing, employment, and transportation. Intended program outcomes are to reduce/prevent unnecessary emergency room, psychiatric hospital, and jail utilization in order to assist community members to remain living in the community at the least restrictive level of care – as independently as possible.

Success: Recovery
Upon entry to Sierra Elder Wellness program, an older adult male consumer was experiencing significant mental health challenges resulting in dozens of emergency room visits and three psychiatric hospitalizations within a three month period. His unmanaged symptoms also impacted his ability to live independently and manage his finances and/or medications. Through the FSP services provided by Sierra Elder Wellness, the consumer has moved into independent living; driving his own vehicle; managing his medications and finances; and managing his mental health symptoms using a variety of coping skills. Currently, the consumer has started classes at American River College after connection with a school guidance counselor and receiving a scholarship.

Sierra establishes and maintains successful collaborations with system partners and community agencies – including sub-acute settings; 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 psychiatric hospitalizations; reduce incarceration; improve health by increasing access to primary health care; reduce homelessness; and support engagement in meaningful employment/activities and social connectedness.

Program: Permanent Supportive Housing Program
Work Plan #/Type: SAC4 – Full Service Partnership (FSP)
Capacity: Expansion plan in progress – Currently 1,200 at any given time
Ages Served: Children, TAY, Adults, 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. It consists of three components: PSH-Guest House, administered by El Hogar, PSH-New Direction, administered by TLCS, Inc., and PSH-Pathways,

administered by Turning Point Community Programs. The PSH Program serves homeless children, transition-aged youth, adults, and older adults of all genders, races, ethnicities and cultural groups. The programs serve 600-700 with FSP services and 500 with GSD services.

Guest House is the front door for homeless mental health services with a clinic open for direct access by homeless individuals and temporary housing for adults age 18 and older. Services include daily triage, comprehensive mental health assessments and evaluations, assessments of service needs, medication treatment, linkages to housing, and application for benefits. PSH-Guest House has implemented the highly successful Sacramento Multiple Advocate Resource Team (SMART), a promising practice targeting homeless individuals with their applications for SSI/SSDI and by default, Medi-Cal. This expedited process improves access to resources and provides opportunities for participants to benefit from a wider variety of community services.

New Direction provides permanent supportive housing and an FSP level of mental health services and supports for adults, including 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. New Direction provides services at two permanent supportive MHSA-financed housing 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 Brief Interim Housing provides services and supports in short-term housing, focuses on rapid access to permanent housing within 30 days once income is secured. Longer term temporary housing is available for individuals awaiting openings in MHSA-financed housing developments.

Success: Responsive Services
Client first came to New Direction via the Guest House clinic. He was referred to Carol's Place (a 30 day shelter for the homeless adults with mental illness). He was immediately connected with Shelter Plus Care housing subsidy and moved into his first subsidized apartment within two months. Staff worked closely with him providing regular home visits, connecting him to community services, and supporting him as he improved his daily living activities. He has attended his psychiatric appointments and therapy sessions at New Direction with some hesitation and variability, due to anxiety symptoms. New Direction has worked closely with him, supporting and encouraging him and never giving up hope that recovery is possible. In the past 19 months, following a particularly difficult substance relapse, he has been clean and sober, attends therapy regularly, is meeting with his psychiatrist as scheduled, has a healthy and supportive relationship with his family, support from his church, and most recently he began part-time employment. He continues to experience ongoing mental health symptoms, but with the support of New Direction he is learning to manage those symptoms, reach out for support when he needs it, and learn how to effectively attend to his daily living activities.

Pathways program provides permanent supportive housing and an FSP level of mental health services and supports for children, youth, 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. Pathways provides services at six permanent supportive MHSA-financed housing developments, community-based housing vouchers and utilizes subsidies to provide permanent housing for consumers and their families.

Program outcomes are to reduce 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.

Program: Transcultural Wellness Center
Work Plan #/Type: SAC5 – Full Service Partnership (FSP)
Capacity: Expanded to 300 at any given time
Ages Served: Children, TAY, Adults, 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/Pacific Islander (API) communities in Sacramento County. The program is staffed by clinicians, peers, family members, and community members and provides a full range of services with interventions and treatment that take into account the cultural and religious beliefs and values, traditional and natural healing practices, and associated ceremonies recognized by the API communities.

Services, including psychiatric services, are provided in the home, local community and school with an emphasis on blending with the existing cultural and traditional resources so as to reduce stigma. Staff assignments are made taking into consideration the gender and specific cultural and linguistic needs of the client. Language specific services are available in Vietnamese, Hmong, Ilocano, Punjabi, Hindi, Laotian, Cantonese, Mandarin, Tongan, Mien and Korean.

The goals of the TWC are to increase timely and appropriate mental health services to API populations and to decrease the number of individuals utilizing social services, acute care, or public safety providers as a component of untreated mental illness.

Program outcomes are to reduce psychiatric hospitalization, arrests and incarceration and increase linkage to employment and/or education and primary health care providers. Additionally, the program seeks to help clients develop and maintain connection to meaningful activities such as cultural groups, creative groups, volunteer and activist positions. Service goals include wellness and recovery as defined by the program members in relation to their cultural identity.

Program: Wellness and Recovery Center
Work Plan #/Type: SAC6 – General System Development (GSD)
Capacity: 3,000 annually
Ages Served: Children, TAY, Adults, Older Adults

The **Wellness and Recovery Center** program consists of three components: the **Wellness and Recovery Centers (WRCs)**, the **Peer Partner Program** and the **Consumer and Family Voice Program**. In Fiscal Year 2015-16, this work plan was expanded to include the **Mental Health Crisis Respite Center**, **Abiding Hope Respite House**, and **Wellness and Recovery Respite Program**.

The **WRCs**, administered by Consumer Self Help Center, are located in Eastern and Southern Sacramento County and offer a consumer driven recovery environment. WRCs offer an array of comprehensive services and wellness activities designed to support clients in their recovery goals. WRCs provide psychiatric and medication support services and wellness activities, and are open to enrolled clients and community residents with an interest in mental health support, wellness and recovery services. The WRCs serve individuals age eighteen (18) and older of all genders, races, ethnicities and cultural groups. The WRCs are community based multi-service centers that provide a supportive environment offering choice and self-directed guidance for recovery and transition into community life. They employ consumers and train individuals for peer counseling, peer mentoring, advocacy, and leadership opportunities throughout Sacramento County. WRCs provide curriculum driven and evidence-based skill building activities, vocational supports, family education, self-help, peer counseling and support. Services are collaboratively designed, culturally competent, member driven and wellness focused; per the MHSA Essential Elements. Alternative therapies include 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 6 days per week and are closed on Sunday. All wellness activities at WRCs are free and open to the public.

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

The **Peer Partner Program (Peer Partners)**, was previously administered by two providers. One provider chose to step away from the program; therefore the program is currently administered solely by Mental Health America of Northern California (Norcal MHA). The program provides peer support services to adults and older adults, from diverse backgrounds, linked to the APSS clinic. Peer Partners (consumers and family members) are integrated staff members of the APSS multidisciplinary team. Peer Partners provide peer-led services that support APSS participants and their family in their recovery process. Individual support, peer-led support groups, mentoring, and benefits acquisition are key strategies contributing to successful outcomes.

The **Consumer and Family Voice Program**, administered by Mental Health America of Northern California, promotes the DBHS mission to effectively provide quality mental health services to children, youth, adults, older adults and families in Sacramento County. The consumer and family member advocates promote and encourage parent/caregiver, youth, adult, and older adult consumer involvement in the mental health system from program planning to program participation. This program provides a wide array of services and supports to all age groups including, but not limited to, advocacy, system navigation, trainings, support groups, and psycho-educational groups. This program also coordinates and facilitates the annual Consumer Speaks Conference.

As part of the Consumer and Family Voice Program, an every other month meeting for clients/consumers of behavioral health services, family members and supporters called "Expert Pool Town Hall Meetings" are facilitated by Norcal MHA. The purpose of these meetings is to build a peer support network, share information about local services and resources, and to inform about how to become involved to shape services for today and the future. Consumers and family members are asked what topics or services/resources they would like to learn about. The program organizes meetings to include speakers that have expertise in various topics related to mental health, local services and resources. In FY 2013-14, six (6) Expert Pool Town Hall Meetings were convened with an average attendance of 36 individuals per meeting.

Success: Consumer Speaks Conference
The 2015 annual client culture Consumer Speaks Conference was highly successful with a record-breaking attendance of over 250 community members (clients, family members, providers and county behavioral health team members). The morning session included a presentation on the LGBTQ Statewide Reducing Disparities Project and the keynote address was given by Cheryl S. Sharp, MSW, ALWF, CPSST with the National Council for Community Behavioral Healthcare. The focus was on educating our community around Trauma-Informed services of care. Feedback by attendees was very positive.

In Fiscal Year 2015-16, the **Sacramento Advocacy for Family Empowerment Program (SAFE) Program**, also administered by Mental Health America of Northern California, was split off from the Consumer and Family Voice Program to facilitate better coordination with the children's system of care. The SAFE Program promotes the DBHS mission to effectively provide quality mental health services to children, youth, transition age youth and families in Sacramento County. SAFE advocates promote family member as well as youth consumer involvement and partnership in the mental health system. This is accomplished through system advocacy, direct client support services and advocacy, as well as training services to children, youth, transition age youth and their families.

Success: Advocacy and Support
Child Protective Services referred a mother and her 16 yr. old daughter to the SAFE Program for support, navigation and linkage. CPS did not want to open a case due to the daughter's significant mental health issues. While the daughter was being treated at an inpatient facility outside of Sacramento, her first hospitalization, the SAFE Family Advocate supported the mother to effectively advocate for her daughter and connected her to a local service provider. The Youth Advocate supported the daughter during her hospitalization and upon her return home. The Family Advocate and Youth Advocate were essential in supporting the family make a successful discharge and transition home.

Mental Health Respite Programs: The following three programs were added to the Wellness and Recovery Center Work Plan in Fiscal Year 2015-16. They 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 sustainable CSS funding during FY 2015-16.

Success: Crisis Respite
A female guest stayed overnight at the Mental Health Crisis Respite Center after being released from a local inpatient psychiatric hospital without a working plan. The guest shared, "The (Crisis Respite Center) program and the staff were all placed at that specific place and time in my life for good reason. Thank you for caring about my safety and the wellbeing of my unborn baby… I am safe and cared for and about now. Thank you for your care and support during the worst time of my life. Please make sure (staff) know I am ok and staying with my family."

The **Mental Health Crisis Respite Center**, administered by TLCS, Inc., promotes stabilization for adults experiencing a mental health crisis by providing voluntary 24-hour/7 day-a-week mental health crisis respite services that can be accessed on a drop-in basis in a warm and supportive community-based setting. Primary program goal is provide a stable and supportive environment so the "guest" is better positioned to explore their crisis with a solution oriented mindset. Every guest leaves with an individualized resource plan.

Abiding Hope Respite House, administered by Turning Point Community Programs in partnership with Welcome Home Housing and NAMI Sacramento, provides a welcoming home-like environment for peer-directed recovery services for adults with psychiatric disabilities who need relief from the stresses of life. Five beds with a communal kitchen and living area are located in a neighborhood with nearby access to a psychiatric tech/registered nurse, therapist, and psychiatrist to attend to client needs. Individuals and their caregivers will develop new skills to help cope with future mental health challenges and avoid relapse. NAMI Sacramento provides support to family and community members.

In Fiscal Year 2013-14, Abiding Hope served eighty-five (85) individuals and reported: homeless days were reduced by 72.2%; psychiatric hospital days were reduces by 77.8%; and jail days dropped by 64%.

Wellness and Recovery Respite, 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. Services include comprehensive evaluation, support services and referrals to stabilize the current crisis and promote recovery.

Program: Adult Full Service Partnership
Work Plan #/Type: SAC7 – Full Service Partnership (FSP)
Capacity: Expanded to 450 at any given time
Ages Served: TAY, Adults, Older Adults

The **Adult Full Service Partnership Program** consists of two components: **Turning Point's Integrated Services Agency (ISA)** and **Telecare's Sacramento Outreach Adult Recovery (SOAR)**. Both programs provide an array of FSP services to adults, age 18 and older, struggling with persistent and significant mental illness who would otherwise utilize the most restrictive and highest level programs. Turning Point ISA and Telecare SOAR provide comprehensive, integrated, culturally competent mental health services – including assessments, planning, social rehabilitation, intensive case management, co-occurring substance use services, 24/7 crisis response, and psychiatric medication support.

Services also include assistance with benefit acquisition, housing, employment, education, and transportation. The programs assist consumers 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. In addition, family members and/or caregivers are engaged as much as possible at the initiation of services and offered support services, such as education, consultation and intervention, as a crucial element of the consumer's recovery process.

As part of the Phase B FSP expansion to increase capacity and improve timeliness to services for community members, Telecare SOAR and Turning Point ISA are working on identifying and implementing Evidence-Based Practice models to assist consumers to more effectively fulfill their goals for recovery – including co-occurring substance use issues and successful completion of Mental Health Court and Co-Occurring Mental Health Court. Program

Success: Recovery
When initially referred to Telecare SOAR, a female Transitional Age Youth was suffering from severe mental health symptoms, resulting in extreme isolation, estrangement from family, frequent psychiatric hospitalizations, frequent contact with law enforcement, and having to drop out of college. Telecare SOAR provided support by meeting with the member and her family at their home and supported her recovery by helping her identify her values, her view of herself, her hopes and dreams, and setting goals that mattered in her life. Linkage to necessary benefits and assisted living housing was provided. Through her services with Telecare SOAR, she learned life skills such as living and contributing in her community; taking actions to help her feel more in control over her life; spending her time meaningfully; making meaningful connections; and staying well physically, mentally, and spiritually. The member developed a recovery plan that worked for her and set a goal to become a Certified Medical Assistant. Examples of individualized support from Telecare SOAR to help her work toward her goals consisted of: Linkage to career counseling classes at the University; lessons on drafting a resume and completion of job applications; support with selecting an interview wardrobe; practicing mock interviews; assertive coordination and advocacy for a much needed surgery to address an untreated injury; psychoeducation about her illness to help with decreasing stigma within her relationships and self-identity; and therapeutic interventions (DBT) and skill building to manage her symptoms.

Currently, she has been free from hospitalizations for two years, and demonstrates confidence in advocating for herself. She is living in her own apartment and has developed a strong natural support system – including reunification with her family. Shortly, she will earn her Medical Assisting Certificate/AA degree and has already been selected to intern at a local clinic. As she prepares to successfully transition out of services with Telecare SOAR, she has communicated that her next goal is to attain a driver's license and car.

outcomes are to reduce/prevent unnecessary emergency room, hospital, and jail utilization in order to assist community members to remain living the community at the least restrictive level of care – as independently as possible.

Turning Point ISA and Telecare SOAR establish and maintain successful collaborations with system partners and community agencies, including sub-acute settings; 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 acute psychiatric hospitalizations; reduce incarceration; reduce homelessness; improve health by increasing access to primary health care; and support engagement in meaningful employment/activities and social connectedness.

Program: Juvenile Justice Diversion and Treatment Program
Work Plan #/Type: SAC8 – Full Service Partnership (FSP)
Capacity: Expansion plan in progress – Currently 92 at any given time
Ages Served: Youth and TAY ages 13 – 25

The **Juvenile Justice Diversion and Treatment Program (JJDTP)** is a contracted FSP that brings together a partnership between DBHS, Sacramento County Probation Department, and River Oak Center for Children to deliver integrated services to a population of youth involved with juvenile justice with multiple complex needs cutting across service areas . JJDTP provides screenings, assessments and intensive mental health services and FSP supports to eligible youth (and their families) involved in the Juvenile Justice System. 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, these youth will have the opportunity to avoid incarceration and voluntarily participate in this program as long as clinically necessary up to their 26th birthday. Adjudicated youth are referred, assessed, and have the opportunity to voluntarily receive intensive, evidence-based services that are delivered in coordination with a specialized Probation Officer. Family and youth advocates complement clinical services.

Success: Support Through Collaboration
A transition age youth was arrested for stealing a car and stealing items from a home with a couple of other youth. She lived with an aunt who took her in at 7 years old. The youth started to struggle when her grandmother died a couple of years ago and had become depressed and suicidal. After intake into JJDTP, the youth tried to overdose on medication. The team provided youth advocacy support, individual therapy and intensive case management. Within 3 months, the youth was off probation, had improved attendance and participation at school and had decreased suicidal and depressive symptomology.

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

Program: TAY Full Service Partnership
Work Plan #/Type: SAC9 – Full Service Partnership (FSP)
Capacity: 200 at any given time
Ages Served: Youth and TAY ages 16 – 25

The new **Transition Age Youth (TAY) FSP** Program will be implemented in FY 2016-17. As previously reported, in Phase B of CSS Expansion planning, the MHSA Steering Committee approved the recommendation for the development of a new TAY FSP program that will serve youth between the ages of 16-25 who are unserved, underserved and/or inappropriately served. Services will be culturally and linguistically competent with sensitivity to and affirmation of gender identity, gender expression and sexual orientation. Services will be individualized based on age, development and culture. The program will provide core FSP services and flexible supports to TAY that 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 other at-risk population. The new TAY FSP program will include outreach, engagement, retention and transition strategies with an emphasis in independent living and life skills, mentorship and services that are youth and family driven.

Program: Crisis Residential Program
Work Plan #/Type: SAC10 – General System Development (GSD)
Capacity: 15 at any given time
Ages Served: Adults ages 18 - 59

In FY 2015-16, a new **15-bed Crisis Residential Program** will be operated by Turning Point Community Programs (TPCP). As previously reported, this program was approved by the MHSA Steering Committee using CSS Expansion funds from Phase C. This program will be modeled after the existing successful 12-bed crisis residential program also operated by TPCP. The addition of this new 15-bed program will significantly increase community-based crisis residential service capacity in Sacramento from 12 to 27 beds for individuals served by the County, which represents a 125% increase.

The 15-bed Crisis Residential Program will build on the successful existing practice in place for notifying community partners and other referral sources when openings occur. With the addition of this second program and additional staffing, crisis residential staff will be better able to reach out to local hospitals, community partners, and law enforcement.

Crisis Residential Program services are designed for persons who meet psychiatric inpatient admission criteria or are at risk of admission due to an acute psychiatric crisis, but can appropriately be served 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). The goal is to receive the referral,

interview the consumer, and admit the individual to the crisis residential program within the same day.

Once admitted, structured day and evening services will be 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, linkages to resources that are available after leaving the program. Family members will be 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 will also focus on improving the functioning and coping skills, and encourage wellness, resiliency and recovery so that consumers can return to the least restrictive, most independent setting in as short of time as possible. Services will also be designed to be culturally responsive to the needs of the diverse community members seeking treatment.

CSS Administration and Program Support

DBHS 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 FY2015-16 Cost per Client information for implemented programs:

FY2015-16 CSS COMPONENT BUDGET Work Plan / Program	Average Cost/Client*	Budget Amount
SAC1 - GSD: TCORE	$ 1,408.73	$ 11,269,878
SAC2 - FSP: Sierra Elder Wellness	$ 13,387.76	$ 2,008,164
SAC4 - FSP: Permanent Supportive Housing	$ 8,149.31	$ 9,779,170
SAC5 - FSP: Transcultural Wellness Center	$ 8,454.85	$ 2,536,456
SAC6 - GSD: Wellness and Recovery Center	$ 1,679.29	$ 5,037,871
SAC7 - FSP: Adult Full Service Partnership	$ 15,920.33	$ 7,164,147
SAC8 - FSP: Juvenile Justice Diversion and Treatment	$ 31,058.02	$ 2,857,338
TOTAL		**$ 40,653,024**

*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

PENETRATION RATES* IN SACRAMENTO COUNTY

Penetration Rates – Calendar Years 2013 and 2014

Medi-Cal eligible beneficiary numbers are based on claims data received from the External Quality Review Organization (EQRO)

Penetration CY 2013 and 2014		Calendar Year 2013					Calendar Year 2014					
		A		B		B/A	A		B		B/A	
		Medi-Cal Eligible Beneficiaries		Medi-Cal Clients (Undup)		Medi-Cal Penetration Rates	Medi-Cal Eligible Beneficiaries		Medi-Cal Clients (Undup)		Medi-Cal Penetration Rates	Percent Change From CY13 to CY14
		N	%	N	%	%	N	%	N	%	%	%
Age Group	0 to 5	63,883	17.7%	907	4.5%	1.4%	68,908	17.1%	1,011	4.9%	1.5%	7.1%
	6 to 17	109,448	30.3%	7,711	38.7%	7.0%	123,220	30.5%	7,855	37.9%	6.4%	-9.8%
	18 to 59	143,854	39.8%	9,900	49.6%	6.9%	162,903	40.4%	10,362	49.9%	6.4%	-7.2%
	60+	44,462	12.3%	1,426	7.2%	3.2%	48,316	12.0%	1,524	7.3%	3.2%	0.0%
	Total	361,647	100.0%	19,944	100.0%	5.5%	403,347	100.0%	20,752	100.0%	5.1%	-7.3%
		N	%	N	%	%	N	%	N	%	%	%
Gender	Female	200,121	55.3%	10,267	51.5%	5.1%	222,117	55.1%	10,749	51.8%	4.8%	-5.9%
	Male	161,525	44.7%	9,633	48.3%	6.0%	181,229	44.9%	9,991	48.1%	5.5%	-8.3%
	Unknown	1	-	44	0.2%	-	1	0.0%	12	0.1%	-	-
	Total	361,647	100.0%	19,944	100.0%	5.5%	403,347	100.0%	20,752	100.0%	5.1%	-7.3%
		N	%	N	%	%	N	%	N	%	%	%
Race	White	94,656	26.2%	7,069	35.4%	7.5%	104,315	25.9%	7,229	34.8%	6.9%	-8.0%
	African American	65,361	18.1%	4,847	24.3%	7.4%	68,367	16.9%	4,980	24.0%	7.3%	-1.4%
	American Indian/Alaskan Native	3,060	0.8%	170	0.9%	5.6%	3,123	0.8%	190	0.9%	6.1%	8.9%
	Asian/Pacific Islander	55,771	15.4%	1,525	7.6%	2.7%	67,493	16.7%	1,490	7.2%	2.2%	-18.5%
	Other	54,691	15.1%	2,512	12.6%	4.6%	65,396	16.2%	2,776	13.4%	4.2%	-8.7%
	Hispanic	88,108	24.4%	3,821	19.2%	4.3%	94,653	23.5%	4,087	19.7%	4.3%	0.0%
	Total	361,647	100.0%	19,944	100.0%	5.5%	403,347	100.0%	20,752	100.0%	5.1%	-7.3%

*Penetration Rates are defined as the total number of persons served divided by the number of persons eligible.

Medi-Cal eligible beneficiary data for language not available CY2012 (Numbers are based on data received from Department of Human Assistance)

		Calendar Year 2012					Calendar Year 2013					
		A		B		B/A	A		B		B/A	
		Medi-Cal Eligible Beneficiaries		Medi-Cal Clients (undup)		Medi-cal Penetration Rates	Medi-Cal Eligible Beneficiaries		Medi-Cal Clients (undup)		Medi-cal Penetration Rates	Percent Change From CY12 to CY13
		N	%	N	%		N	%	N	%		
Language	English	NA		NA		NA	268,968	73.5	17,252	86.5	6.4	NA
	Spanish						51,037	13.9	1,127	5.7	2.2	
	Russian						14,593	4.0	212	1.1	1.5	
	Hmong						7,096	1.9	388	1.9	5.5	
	Vietnamese						6,402	1.7	220	1.1	3.4	
	Cantonese						4,231	1.2	64	0.3	1.5	
	Other/Unk*						13,602	3.7	681	3.4	5.0	
	Total						365,929	100.0	19,944	100.0	5.5	

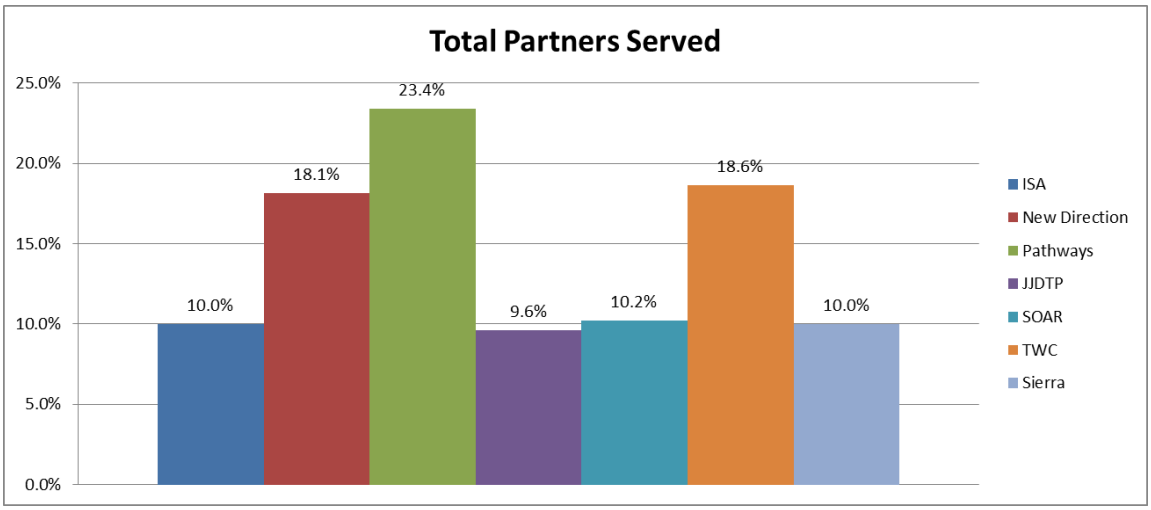
Review of the penetration rate chart shows a negative trend from Calendar Year (CY) 2013 to CY 2014. There are two factors that may be contributing to this trend. First, the penetration table reflects the number of Medi-Cal beneficiaries served, irrespective of insurance status, through the specialty mental health treatment programs; however, it does not account for any of the individuals served through the DBHS prevention and mental health respite programs. DBHS 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 PEI programs it is challenging to obtain PEI 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 being served by DBHS through specialty mental health services and prevention services. And secondly, efforts related to health care reform that were underway in 2013 may also account for

some of the changes experienced in the penetration rates. Changes in the health care landscape, including the Low Income Health Plan (LIHP) program have more and more individuals seeking mental health services from their primary care provider. With future changes in health care anticipated by the implementation of the Affordable Care Act (ACA) in January 2014, the impact to the penetration rates and recipients of public mental health services is not fully understood. Methods used to determine penetration will need to be examined and we will need to work with our healthcare partners to understand the impacts of the ACA on our diverse community.

Full Service Partnership (FSP) Program Fiscal Year 2013-14 Outcomes

During FY 2013-14 all FSP programs showed significant improvement and great individual success in decreasing all negative outcomes. Partners are staying out of psychiatric facilities, jail, streets and emergency rooms. The percentages below represent the percent of change overall across all programs:

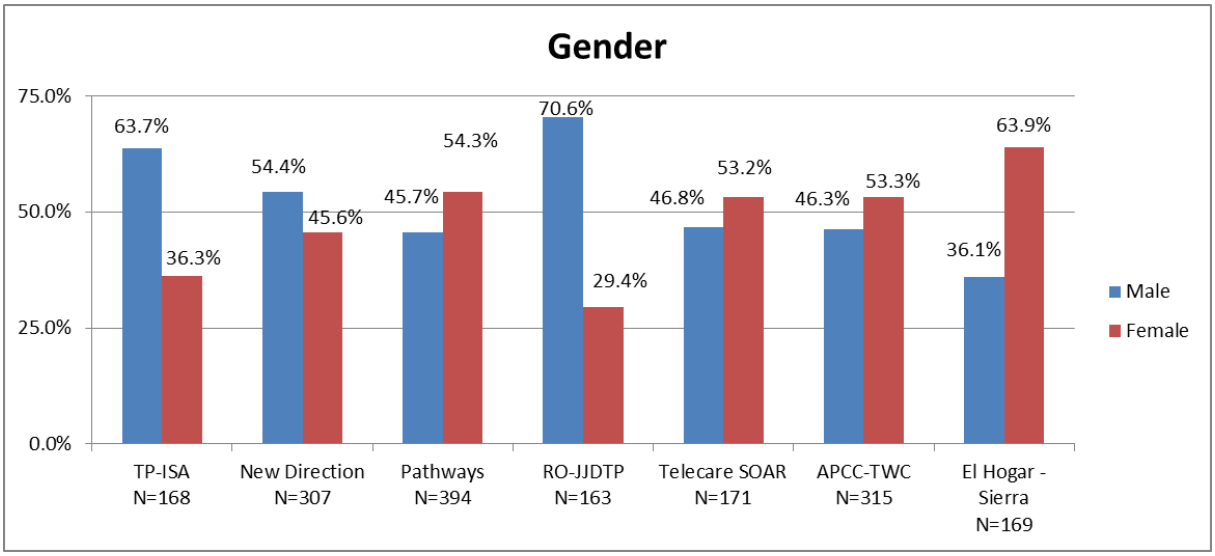
- Hospitalizations decreased by 68%
- Hospital days decreased by 78%
- Arrests decreased by 63%
- Incarcerations decreased by 36%
- Incarceration days decreased by 30%
- Homeless occurrences decreased by 75%
- Homeless days decreased by 86%
- Employment rate decreased by 59%
- Partners with Primary Care Physicians increased by 23%



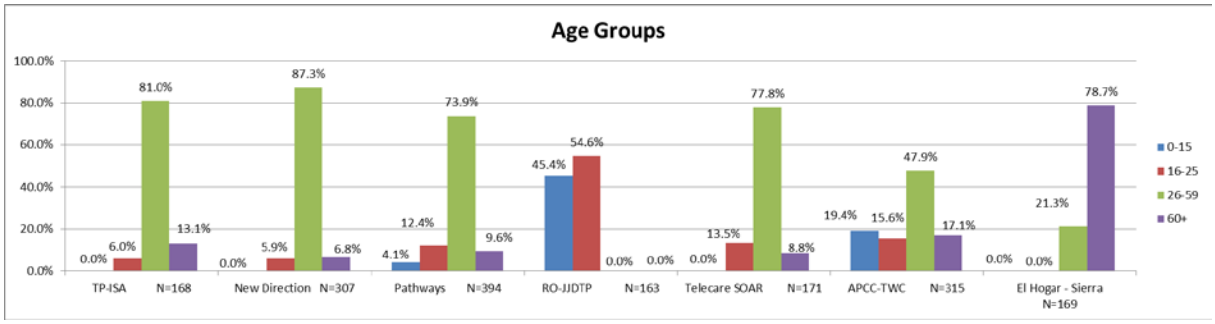
Unduplicated FSP Clients Served by Episode	Undup # Served (N)	Percent	Undup # of Ptnrs Admitted in Year	Undup # of Ptnrs Discharged in Year	Avg LOS	Attrition Rate
TP-ISA	169	10.0%	25	23	2.8 Years	15.6%
TLCS New Direction	307	18.1%	62	46	2.5 years	17.8%
TP-Pathways	396	23.4%	42	41	3.1 Years	11.5%
RO-JJDTP	163	9.6%	80	83	11.8 Months	98.8%
Telecare SOAR	173	10.2%	26	21	2.8 Years	14.0%
APCC-TWC	315	18.6%	86	71	2.1 Years	29.6%
El Hogar - Sierra	169	10.0%	48	39	2.9 Years	30.5%
Total	1692	100.0%	369	324	2.2 Years	23.8%

Full Service Partnership (FSP) Program Fiscal Year 2013-14 Outcomes (continued)

In Fiscal Year 2013-14, a total of 1,692 unduplicated clients were served across the seven implemented FSPs. The charts and tables on the following pages show demographic information and outcomes in each of the FSPs:

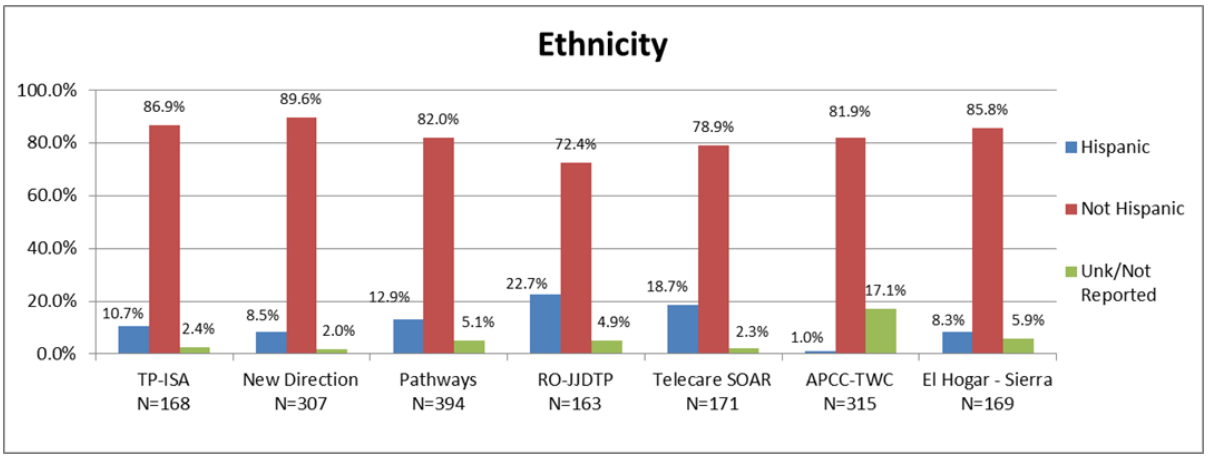


Gender	TP-ISA N=168		New Direction N=307		Pathways N=394		RO-JJDTP N=163		Telecare SOAR N=171		APCC-TWC N=315		El Hogar - Sierra N=169	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Male	107	63.7%	167	54.4%	180	45.7%	115	70.6%	80	46.8%	146	46.3%	61	36.1%
Female	61	36.3%	140	45.6%	214	54.3%	48	29.4%	91	53.2%	168	53.3%	108	63.9%



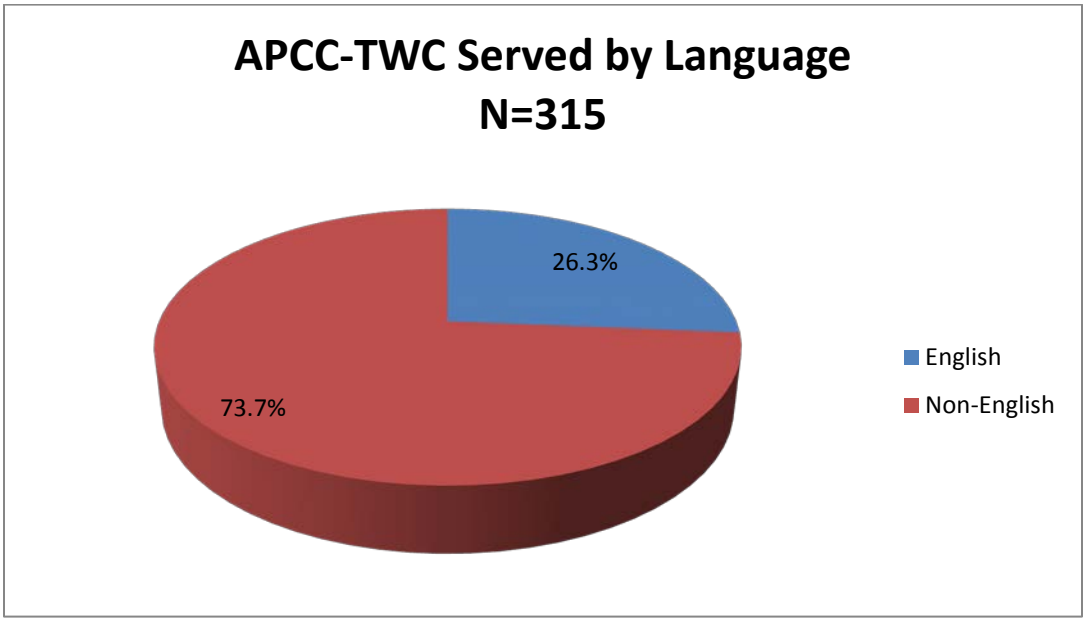
Age Group	TP-ISA N=168		New Direction N=307		Pathways N=394		RO-JJDTP N=163		Telecare SOAR N=171		APCC-TWC N=315		El Hogar - Sierra N=169	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
0-15	0	0.0%	0	0.0%	16	4.1%	74	45.4%	0	0.0%	61	19.4%	0	0.0%
16-25	10	6.0%	18	5.9%	49	12.4%	89	54.6%	23	13.5%	49	15.6%	0	0.0%
26-59	136	81.0%	268	87.3%	291	73.9%	0	0.0%	133	77.8%	151	47.9%	36	21.3%
60+	22	13.1%	21	6.8%	38	9.6%	0	0.0%	15	8.8%	54	17.1%	133	78.7%

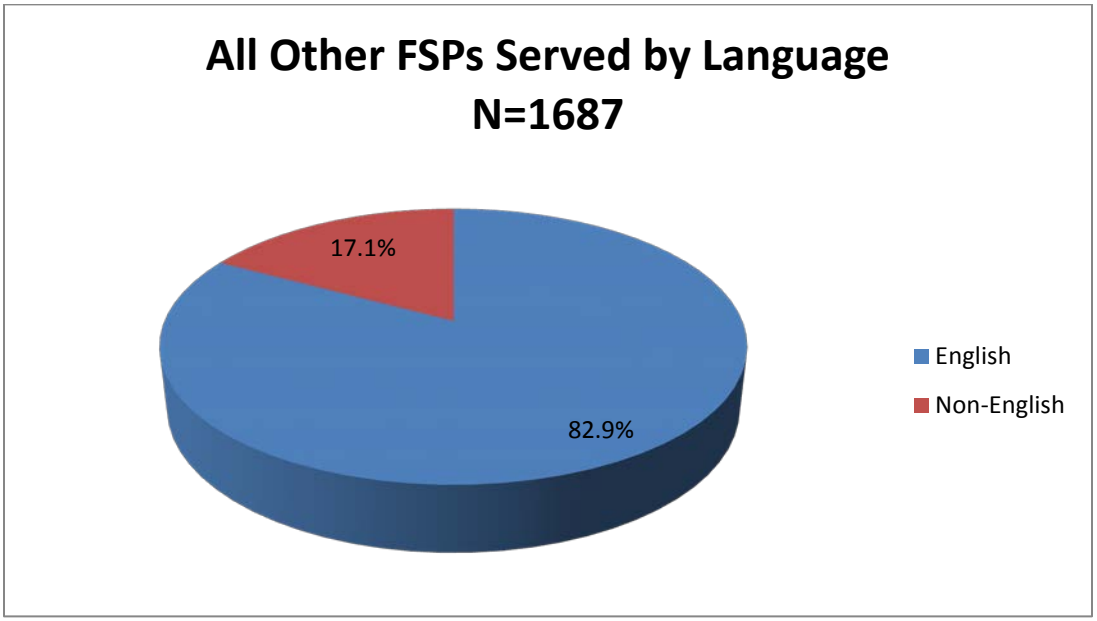
Full Service Partnership (FSP) Program Fiscal Year 2013-14 Outcomes (continued)



Ethnicity	TP-ISA N=168		New Direction N=307		Pathways N=394		RO-JJDTP N=163		Telecare SOAR N=171		APCC-TWC N=315		El Hogar - Sierra N=169	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Hispanic	18	10.7%	26	8.5%	51	12.9%	37	22.7%	32	18.7%	3	1.0%	14	8.3%
Not Hispanic	146	86.9%	275	89.6%	323	82.0%	118	72.4%	135	78.9%	258	81.9%	145	85.8%
Unk/Not Reported	4	2.4%	6	2.0%	20	5.1%	8	4.9%	4	2.3%	54	17.1%	10	5.9%

Full Service Partnership (FSP) Program Fiscal Year 2013-14 Outcomes (continued)





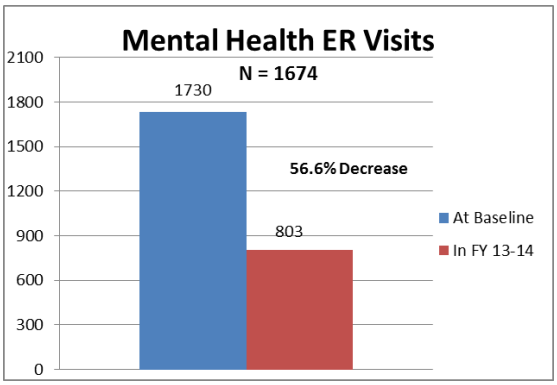
Full Service Partnership (FSP) Program Fiscal Year 2013-14 Outcomes (continued)

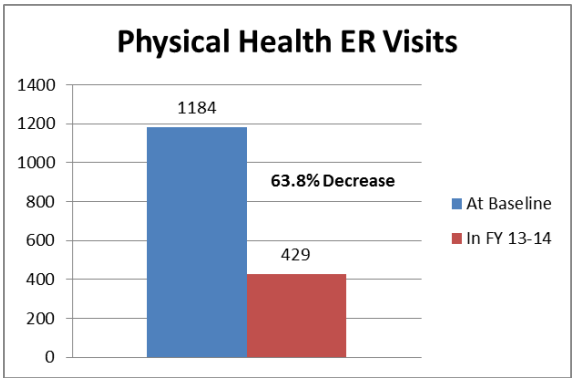
Primary Language	TP-ISA N=169	New Direction N=307	Pathways N=396	RO-JJDTP N=163	Telecare SOAR N=173	APCC-TWC N=315	El Hogar - Sierra N=169
English	90.5%	98.4%	97.0%	96.9%	95.9%	26.3%	93.5%
Spanish	2.4%	1.0%	1.8%	2.5%	0.6%	1.3%	4.1%
Russian	1.8%	0.3%	0.3%	0.0%	1.2%	0.0%	0.6%
Cantonese	0.6%	0.0%	0.0%	0.0%	0.0%	11.1%	0.0%
Vietnamese	0.6%	0.0%	0.0%	0.0%	0.0%	19.7%	0.0%
Hmong	0.0%	0.0%	0.0%	0.0%	1.2%	23.2%	0.0%
Other	3.6%	0.3%	1.0%	0.6%	1.2%	15.6%	0.6%
Unknown/Not Reported	0.6%	0.0%	0.0%	0.0%	0.0%	2.9%	1.2%

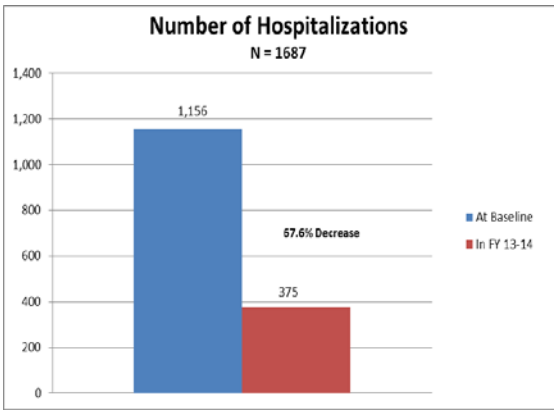
	TP-ISA N=168		New Direction N=307		Pathways N=394		RO-JJDTP N=163		Telecare SOAR N=171		APCC-TWC N=315		El Hogar - Sierra N=169	
Race	#	%	#	%	#	%	#	%	#	%	#	%	#	%
White	89	53.0%	169	55.0%	176	44.7%	47	28.8%	85	49.7%	5	1.6%	104	61.5%
Black/Af. Am.	31	18.5%	98	31.9%	139	35.3%	69	42.3%	43	25.1%	1	0.3%	31	18.3%
American Indian	0	0.0%	5	1.6%	7	1.8%	3	1.8%	1	0.6%	0	0.0%	1	0.6%
Asian/Pacific Islander	22	13.1%	7	2.3%	15	3.8%	9	5.5%	13	7.6%	278	88.3%	7	4.1%
Multi Race	1	0.6%	7	2.3%	4	1.0%	3	1.8%	0	0.0%	3	1.0%	2	1.2%
Other Race	20	11.9%	18	5.9%	37	9.4%	30	18.4%	25	14.6%	5	1.6%	15	8.9%
Unknown/Not Reported	5	3.0%	3	1.0%	16	4.1%	2	1.2%	4	2.3%	23	7.3%	9	5.3%

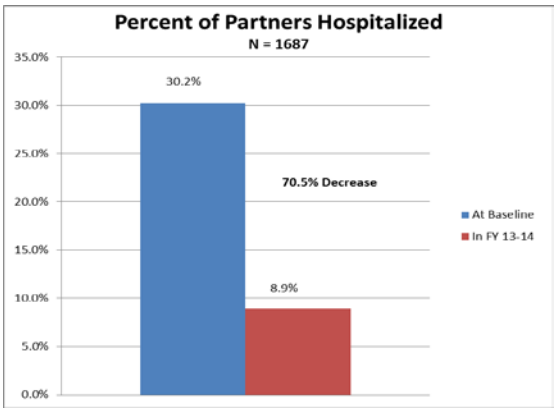
	TP-ISA N=168		New Direction N=307		Pathways N=394		RO-JJDTP N=163		Telecare SOAR N=171		APCC-TWC N=315		El Hogar - Sierra N=169	
Primary Diagnosis	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Depressive	2	1.2%	76	24.8%	93	23.6%	37	22.7%	6	3.5%	134	42.5%	29	17.2%
Bipolar	7	4.2%	85	27.7%	85	21.6%	1	0.6%	17	9.9%	16	5.1%	32	18.9%
Psychotic	157	93.5%	95	30.9%	97	24.6%	7	4.3%	145	84.8%	76	24.1%	102	60.4%
Anxiety/PTSD	2	1.2%	35	11.4%	73	18.5%	10	6.1%	1	0.6%	26	8.3%	1	0.6%
Disruptive Disorders	0	0.0%	0	0.0%	13	3.3%	100	61.3%	0	0.0%	25	7.9%	0	0.0%
Adjustment	0	0.0%	0	0.0%	14	3.6%	4	2.5%	0	0.0%	25	7.9%	0	0.0%
Substance Related	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Personality Disorder	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Other*	0	0.0%	16	5.2%	19	4.8%	3	1.8%	1	0.6%	7	2.2%	4	2.4%
Unknown/Not Reported	0	0.0%	0	0.0%	0	0.0%	1	0.6%	1	0.6%	6	1.9%	1	0.6%

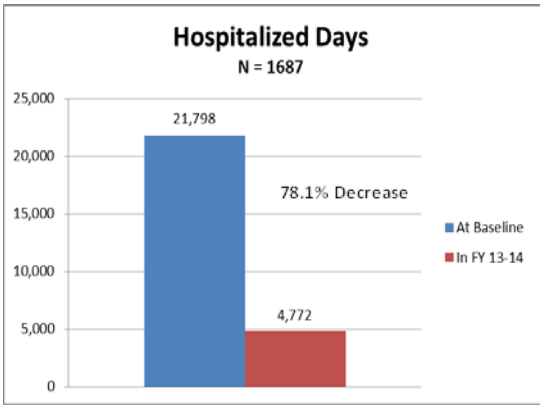
Full Service Partnership (FSP) Program Fiscal Year 2013-14 Outcomes (continued)

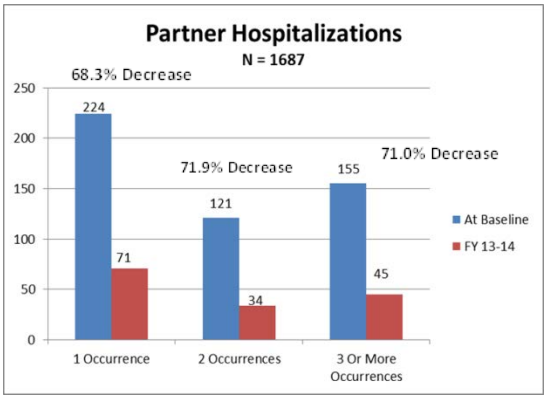




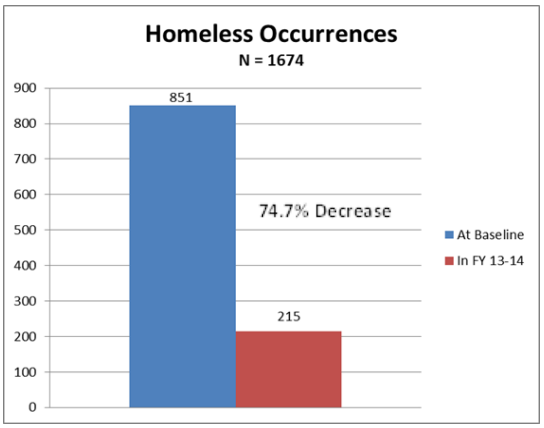


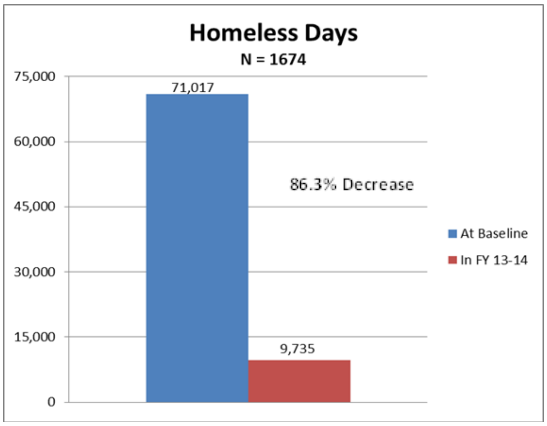


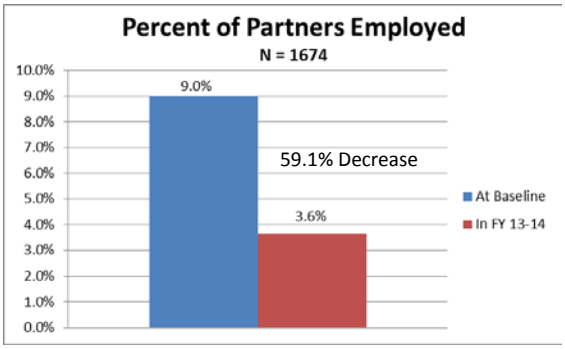


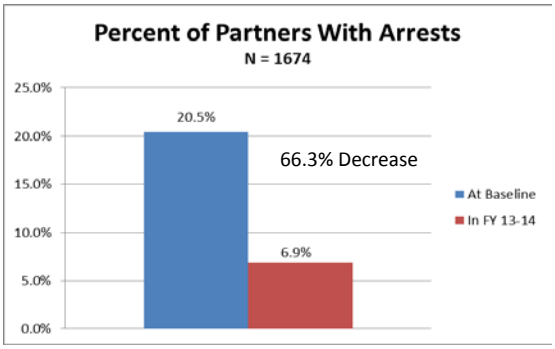


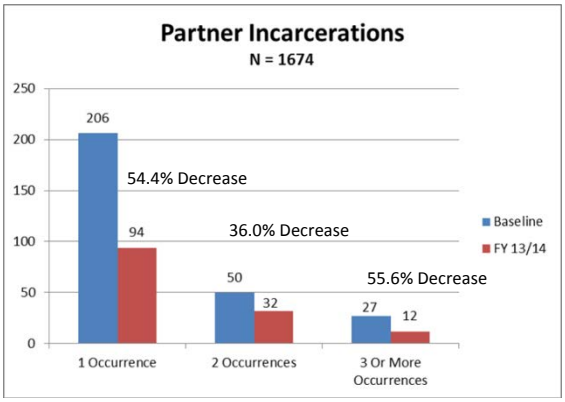
Full Service Partnership (FSP) Program Fiscal Year 2013-14 Outcomes (continued)

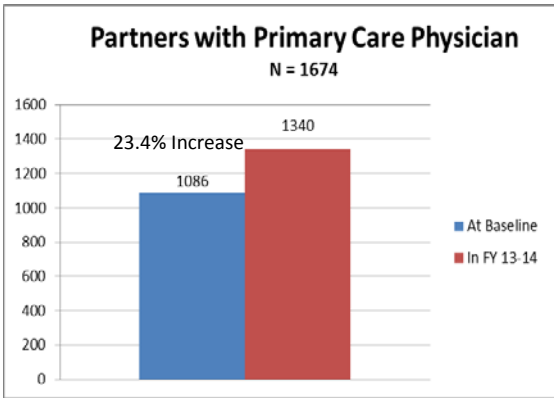




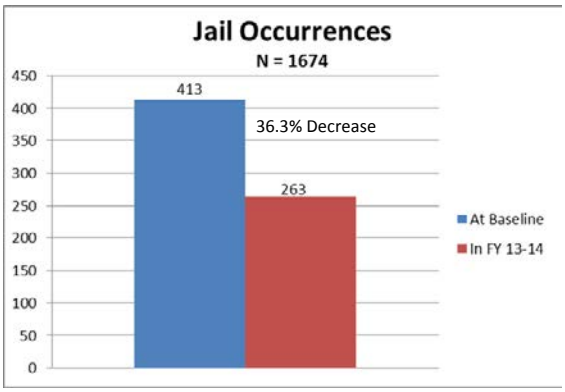


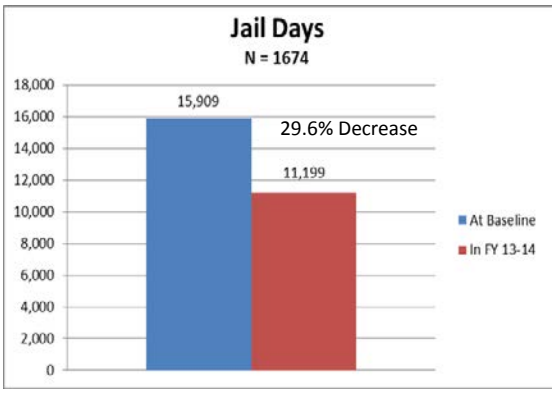


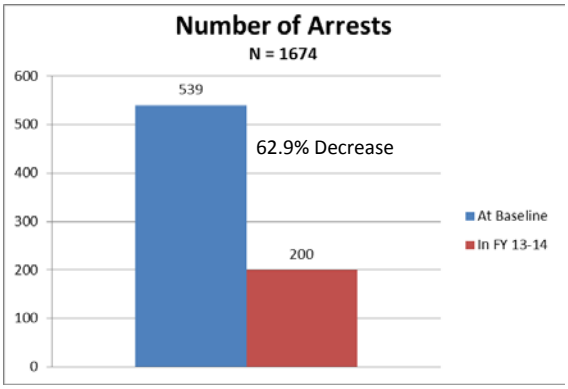


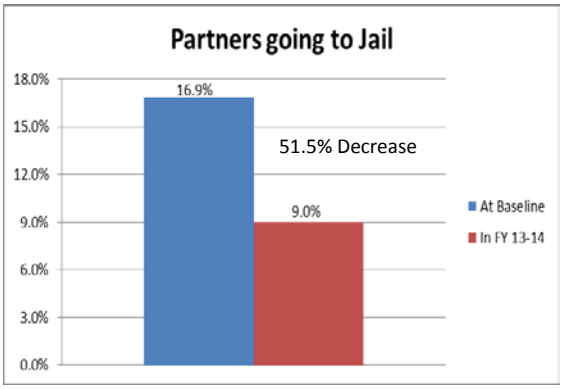


Full Service Partnership (FSP) Program Fiscal Year 2013-14 Outcomes (continued)









General System Development (GSD) Program Fiscal Year 2013-14 Demographics

In Fiscal Year 2013-14, a total of 7,666 unduplicated clients were served across the seven GSD programs. This number is up slightly from the 7,047 unduplicated clients served in Fiscal Year 2012-13. The chart below displays demographic information for individuals served in each of the programs:

ALL SERVED BY PROGRAM – FISCAL YEAR 2013-14																
Characteristic	TCORE - APSS N=3,337		TCORE HRC N=971		Guest House N=782		Peer Partners HWHA N=460		Peer Partners MHANCA N=469		WRC * N=1473		Consumer and Family Voice N=174		Total N=7,666	
Gender	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Female	1968	59.0%	460	47.4%	492	62.9%	274	59.6%	289	61.6%	1013	68.8%	42	24.1%	4,538	59.2%
Male	1358	40.7%	510	52.5%	288	36.8%	186	40.4%	178	38.0%	458	31.1%	64	36.8%	3,042	39.7%
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%
Unknown	11	0.3%	1	0.1%	2	0.3%	0	0.0%	2	0.4%	2	0.1%	68	39.1%	86	1.1%
Age																
0 to 15	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	86	49.4%	86	1.1%
16 to 25	339	10.2%	130	13.4%	57	7.3%	54	11.7%	55	11.7%	109	7.4%	38	21.8%	782	10.2%
26 to 59	2,745	82.3%	746	76.8%	689	88.1%	378	82.2%	386	82.3%	1232	83.6%	12	6.9%	6188	80.7%
60 and Over	226	6.8%	85	8.8%	36	4.6%	28	6.1%	28	6.0%	132	9.0%	1	0.6%	536	7.0%
Unknown	27	0.8%	10	1.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	37	21.3%	74	1.0%
Hispanic/Latino Origin																
No	2,174	65.1%	840	86.5%	646	82.6%	276	60.0%	269	57.4%	1099	74.6%	58	33.3%	5,362	69.9%
Yes	350	10.5%	109	11.2%	101	12.9%	38	8.3%	45	9.6%	196	13.3%	30	17.2%	869	11.3%
Unknown/Not Reported	813	24.4%	22	2.3%	35	4.5%	146	31.7%	155	33.0%	178	12.1%	86	49.4%	1,435	18.7%
Race																
White	1230	36.9%	526	54.2%	358	45.8%	122	26.5%	169	36.0%	693	47.0%	44	25.3%	3,142	41.0%
Black	507	15.2%	211	21.7%	262	33.5%	49	10.7%	74	15.8%	376	25.5%	18	10.3%	1,497	19.5%
Asian/PI	376	11.3%	74	7.6%	24	3.1%	79	17.2%	17	3.6%	90	6.1%	4	2.3%	664	8.7%
Am Indian/Alask. Nat.	32	1.0%	13	1.3%	19	2.4%	5	1.1%	6	1.3%	42	2.9%	1	0.6%	118	1.5%
Multi-Race	61	1.8%	12	1.2%	14	1.8%	14	3.0%	7	1.5%	13	0.9%	11	6.3%	132	1.7%
Other Race	313	9.4%	115	11.8%	87	11.1%	35	7.6%	28	6.0%	170	11.5%	9	5.2%	757	9.9%
Unknown/Not Reported	818	24.5%	20	2.1%	18	2.3%	156	33.9%	168	35.8%	89	6.0%	87	50.0%	1,356	17.7%
Primary Language																
English	2,770	83.0%	902	92.9%	772	98.7%	331	72.0%	410	87.4%	1,345	91.3%	92	52.9%	6,622	86.4%
Other	240	7.2%	27	2.8%	4	0.5%	88	19.1%	10	2.1%	78	5.3%	1	0.6%	448	5.8%
Spanish	76	2.3%	15	1.5%	2	0.3%	4	0.9%	13	2.8%	16	1.1%	13	7.5%	139	1.8%
Unknown/Not Reported	251	7.5%	27	2.8%	4	0.5%	37	8.0%	36	7.7%	34	2.3%	68	39.1%	457	6.0%

*Only inclusive of clients receiving medication supports at the Wellness and Recovery Centers

NOTE: There were 7,492 unduplicated clients served across all programs. The sum of clients served in programs is greater than the number of unduplicated clients as some clients were served in more than one program.

MHSA Housing Program Accomplishments

Since the inception of MHSA planning, housing for homeless people with mental illness has been a high priority. Using the local one-time set-aside of MHSA funding and/or county MHSA dollars administered by the California Housing Finance Agency (CalHFA), in total, more than $16 million of MHSA funds along with over $130 million of federal, state, and local leveraged funds financed hundreds of units, of which 161 are dedicated to MHSA tenants. These apartments are financed for 16-20 years, so that low-income tenants will pay 30% of their income for rent for the financial life of the projects.

MHSA funds supported the development of eight supportive housing projects throughout Sacramento County. Now in operation for more than five years, these properties are operating well and provide high quality housing to the most vulnerable members of the Sacramento community. One metric of success is an extremely low vacancy rate of 4.4% in 2014, well below the standard for special needs housing which is a 10% vacancy rate. Keeping these units filled with eligible MHSA homeless individuals has been a program priority. Another measure of success is 82% of all MHSA tenants were able to maintain their housing for more than six months in 2014. Permanent Support Housing services for clients residing in these units are provided by Pathways and New Direction Full Service Partnership Programs. Housing stability and the ability to successfully live independently are important client outcomes and the achievement surpasses the federal Department of Housing and Urban Development's (HUD) established performance standard for permanent supportive housing.

In addition to the newly built and remodeled units, the MHSA housing program also uses rental subsidies and community partnerships to provide an additional 425 housing units throughout the community. Finally, a carefully designed system for assessing and housing homeless with mental illness includes interim housing and unsubsidized units in the community.

Success: Housing
As a result of efforts to date, approximately 660 households, with a total of about 760 homeless persons with mental illness, are housed thanks to MHSA funding in Sacramento. Efforts to create more housing opportunities are underway.

During this phase in the life of the projects, the goal is to support the ongoing needs of the current units and to ensure their effective use as part of the overall community strategy to end homelessness for people with serious mental illness. Paying close attention to prioritizing these units to the highest need MHSA clients with the most significant barriers to housing is a critical element of Sacramento County's efforts to end homelessness. The Division works closely with Sacramento Steps Forward, the lead agency working to end homelessness in the Sacramento region, to ensure that our efforts in the MHSA housing program not only meet the needs of our FSP clients, but also fit into key regional strategies to reduce homelessness among the most vulnerable members of the community.

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 projects containing 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 Fiscal Year 2013-14, more than 19,000 individuals were served and more than 17,000 individuals received universal screenings across the PEI programs described below.

In October 2015, revised PEI Regulations were adopted statewide. Sacramento County is participating with other counties in statewide discussions related to the implementation AND impact of the new regulations. DBHS will continue to update the MHSA Steering Committee on the implementation progress as information becomes available. The new regulations will be presented at the MHSA Steering Committee meetings and highlighted in the subsequent MHSA Plan/Annual Update.

Suicide Prevention and Education Program
Capacity: 42,000 annually
Ages Served: Children, TAY, Adults, Older Adults

The Suicide Prevention and Education Project consists of seven (7) components:

Crisis Line, administered by WellSpace Health: 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. The Crisis Line also participates with the California Mental Health Services Authority (CalMHSA) Statewide PEI Projects network of crisis lines.

In Fiscal Year 2013-14, a total of 33,637 callers accessed the Crisis Line for suicide prevention support.

Postvention Counseling Services, administered by Wellspace Health: Brief individual and group counseling services available to individuals and/or families who have attempted suicide, are at high-risk for suicide or are dealing with recent bereavement due to loss by suicide.

In Fiscal Year 2013-14, a total of 200 individuals received 598 postvention counseling sessions.

Postvention - Suicide Bereavement Support Groups and Grief Services, 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.

Supporting Community Connections (SCC): A constellation of community based agencies working collaboratively throughout the County to provide culturally and linguistically appropriate support services designed 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.

Supporting Community Connections consists of nine (9) programs targeting twelve (12) specific communities/ populations:

◊ **Consumer-Operated Warm Line:** Administered by Mental Health America of Northern California (Norcal MHA), this service is open to all (age 18+) including consumers, family members and friends. During Fiscal Year 2013-14, the program provided 48 individual community contacts, 1,521 information and referral contacts and 190 individuals participated in groups.

Services include phone support (coaching, supportive listening, mentoring, skill building, social networking, and information and resource referral), Wellness Action Recovery Plan (WRAP) workshops, community outreach, intensive services and other supportive services, community connection, prevention & early intervention, community education training about mental health issues and volunteer development.

Success:
The SCC Consumer Operated Warm Line received a call from a woman saying stating that she was contemplating suicide. Warm Line Staff provided support and compassion to the woman telling her she had value on this earth and that people appreciated her. The caller said that no one has ever told her that and it really touched her. At the end of the call, the caller said that she was very happy that she got to talk to Warm Line staff and that she wasn't thinking about suicide anymore.

◊ **Hmong, Vietnamese, Cantonese-Speaking communities:** Administered by Asian Pacific Community Counseling (APCC), this program continues to provide services focused on suicide prevention by addressing cultural related risk factors to Hmong, Vietnamese, and Cantonese-speaking communities across the life span. During Fiscal Year 2013-14, the program provided 293 individual community contacts, 237 information and referral contacts and 3,644 individuals participated in groups.

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. The widening generation gap that is influenced by acculturation rates and other factors can further impact these feelings and experiences. Recognizing that older adults in targeted communities have higher risk for suicide, the APCC SCC program staff continues to engage older adults in activities and social groups to

increase social connectedness to decrease isolation. Engagement with younger adults and families with younger children have been an effective means for SCC program staff to expand knowledge of and share information about mental illness and suicide with adults, school-age students and transitional age youth in academic and non-academic settings. Efforts related to suicide prevention include facilitating workshops on mental health and decreasing risk factors of suicide.

◊ 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 Fiscal Year 2013-14, the program provided 246 individual community contacts, 228 information and referral contacts and 264 individuals participated in groups.

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

Success: Meaningful Involvement
I (55 year old male) came to Sacramento from Ukraine with my wife and child. Over the years we have enjoyed a wonderful relationship in many respects. But unfortunately my mother suddenly died in Ukraine. I felt very guilty of the fact that I wasn't there to help her and I got depressed. So, maybe that was the reason we started to experience some difficulties in our marriage. Struggling to survive, trying to adjust to a new country and culture, with limited English and finances – we consistently had difficulty managing conflict in a healthy way. So, the time came when we hit the bottom and were unsure if we could continue…I've heard about Mental Health workshops listening to the radio program "Mental Health. It's very popular among the Slavic community weekly radio show hosted by Roman Romaso and Ivan Leshchuk. At that time they were talking about refugee marriage issues and depression and invited those refugees who were in crisis to attend special workshops at the Slavic Assistance Center. At that time my family I were depressed and I was really unaware of the specific problems we were facing as a family, but we decided to attend the workshops anyways… As a result, my wife and I were both deeply touched by the program. We learned so much and have begun to implement the communication techniques we have learned. Currently we are achieving much success and are forevermore

◊ Youth/Transition Age Youth: Administered by Children's Receiving Home, services are targeted towards individuals from ages 12 years through 25 with an emphasis on the cultural and specific needs of LGBTQ, foster and homeless youth. During Fiscal Year 2013-14, the program provided 555 individual community contacts, 145 information and referral contacts and 987 individuals participated in groups.

Services range from outreach and engagement activities to promote and support community connections and improve access to mental health through support services that will address suicide prevention. These services may include individual and group support services.

◊ Older Adult: Administered by MHANCA, 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 include community connection, advocacy, community education and training about mental health issues and volunteer development.

During Fiscal Year 2013-14, the program provided 260 individual community contacts, 1,787 information and referral contacts and 245 individuals participated in groups.

◊ African American: Administered by G.O.A.L.S. for Women, this program provides culturally informed support services across the life span known as Kitchen Table Talk (KTT) small groups; Just Like Sunday Dinners (JLSD), mid-size intergenerational/family-like groups; and Faith Community Roundtables (FCRT) with members of churches and congregations within the African American community.

Success: Resiliency
The program received a very inspiring activity report from one community member (a male truck driver trainee) who desired to become a KTT facilitator and hold groups for Black men. Part of the facilitator task is to complete a two page activity report summarizing themes the group identified as important as well as successes and challenges. The facilitator reported that he initially felt uncertain he could complete the reports appropriately and handle his facilitator role effectively through the series of four groups. In his final report, he stated, "We learned that if we stick together and encourage each other, we can get through the hard times. And, I learned that I could do this and I'm proud of myself for sticking with it all." We see the impact from our work on a community, family and individual level and are excited to see community members embracing and shaping the KTT Peer groups. However, overall, tapping into the resilience and hope of community members and seeing them maximize it and choose life is one of the most rewarding program successes thus far.

During Fiscal Year 2013-14, the program provided 13 individual community contacts, 108 information and referral contacts and 132 individuals participated in groups.

In addition to working with faith community members in FCRTs, staff also provides church leaders with culturally sensitive African American suicide prevention resources to disseminate in their churches/communities. Resources are available in both print and electronic download PDF formats. In order to enhance the program and build community capacity, a KTT Peer Facilitator training was developed in FY 14/15. Through the online learning management system, community members who wish to become KTT facilitators will be able to access training materials and engage with a training cohort while they build their peer group facilitation skills and bring KTTs to the community.

◊ Native American: Administered by California Rural Indian Health Board (CRIHB), this program provides Native culture-based training to Native American community members across the life span about suicide prevention. During Fiscal Year 2013-14, the program provided 2 individual community contacts, 19 information and referral contacts and 256 individuals participated in groups.

The program also provides ASIST and SafeTalk training to Native community members. Native based suicide prevention promotional materials were developed based on community input and are being used to promote the program and educate the community. The incorporation of traditional Native healing practices and ceremony is an integral part of this program. One of the risk factors experienced by Native youth is bullying. The program provided an avenue by which a bullying prevention video was created by Native youth to bring positive messaging. The youth formed a committee to provide guidance on addressing mental health, suicide and related issues affecting American Indian/Alaska Native youth. The program also provided support to the Native American Two Spirit Society (LGBTQ group) for their Spoken Word events to bring voice to the challenges they face and provide culturally based workshops and ceremony to strengthen the community and reduce stigma. All of these efforts include sharing of mental health suicide prevention resources.

Success: Responsive Services
The Life is Sacred SCC Program continues to make a positive impact on American Indian/Alaska Native (AIAN) community members in Sacramento County. An AIAN elder who identifies as two spirit (LBGT) moved to Sacramento in 2013 and was experiencing multiple health issues. She was having thoughts of suicide and received an intervention from a Life is Sacred staff member who referred her to the Sacramento Native American Health Center for mental health and primary care services. Later, she reported feeling better but somewhat isolated due to issues with transportation. She attended the Sacramento Valley Two Spirit Society's Spoken Word event in November 2014 and shared her story through a poetry reading. She connected with other AIAN two spirit community members and made lasting friendships with two new friends who experience similar health challenges. They have become a support network for each other to enhance the mental health services they currently receive. This program funding has made it possible to convene culturally specific workshops, training, and events so that our community members can reduce barriers of being connected to mental health services so they can move forward on their journey of wellness.

◊ Latino/Spanish-Speaking: Administered by La Familia Counseling Center (LFCC), this program conducts outreach and provides support services across the life span throughout Sacramento County, including Latino communities in remote rural regions that are typically underserved. During Fiscal Year 2013-14, the program provided 614 individual community contacts, 449 information and referral contacts and 1,108 individuals participated in groups.

Agency staff has been trained in ASIST and Mental Health First Aid (MHFA) in order to provide information, referrals and phone support to callers in need of suicide prevention support. LFCC provides MHFA and Youth MHFA training in Spanish to the Latino/Spanish speaking community. Additionally, LFCC provides the following support services: Grupo de Apoyo, support groups for parents and older adults; Parents of Teens, a support group using a curriculum that is an evidence-based practice and has been adapted to improve communication between Latino 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.

◊ Campus Connections: Administered by CSU Sacramento, is a Suicide Awareness and Prevention program for faculty and students on campus. This program established the infrastructure for CSU Sacramento faculty to provide valuable suicide awareness and prevention information through ASIST trainings, classroom presentations and other campus outreach activities. This program ended in Fiscal Year 2014-15.

◊ Iu-Mien: Administered by Iu-Mien Community Services, 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 sustainable PEI funding during FY 2015-16. The design of the respite program closely aligned with the design of the Supporting Community Connections programming. As an SCC program, this 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.

These community based agencies together form the Supporting Community Connections Collaborative which allows for referral exchanges and cross training.

Community Support Team (CST) is administered jointly by DBHS and Crossroads Vocational Services: The Community Support Team 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.

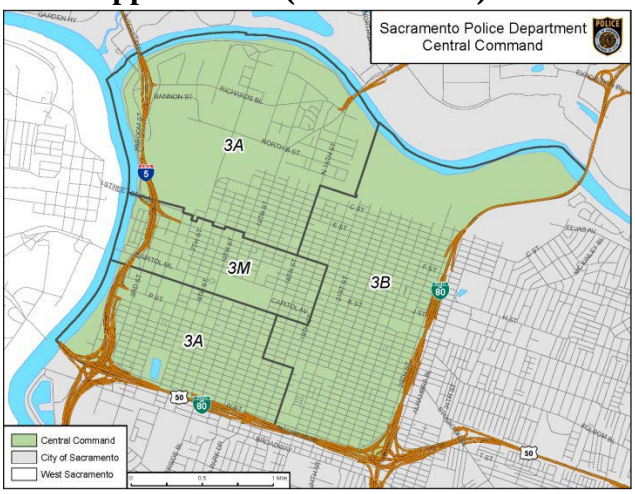
Success: Employment
A young man came to CST after he was expelled from vocational school and was not working. The school counselor supported him in reaching out to CST. The young man seemed lost and did not have any idea what to do. He presented with anger issues and no history of mental health services. Staff coached him regarding relational skills. The team gave him referrals and information for employment assistance and a referral to free counseling which he took advantage of. He was able to get linked to counseling and attended regularly. He received needed supports and has started a new job.

Mobile Crisis Support Teams (MCSTs): Resulting from a partial funding award from the California Health Facilities Financing Authority (CHFFA), two **Mobile Crisis Support Teams (MCSTs)** were implemented in partnership with the Sacramento Police Department (SPD) and Sacramento County Sheriff's Department (SSD) in April 2015.

The MCSTs provide timely crisis intervention and assessment when an individual experiencing a mental health crisis comes to the attention of law enforcement. The crisis response, support, and linkage to services continue until the client is stabilized and appropriate community resources and linkages are established. Teams collaborate with the CST, newly established Triage/Peer Navigator Team (implemented in August 2015), Downtown Sacramento Partnership (DSP), SPD's Homeless Detail, local hospital emergency departments (EDs) to coordinate services,

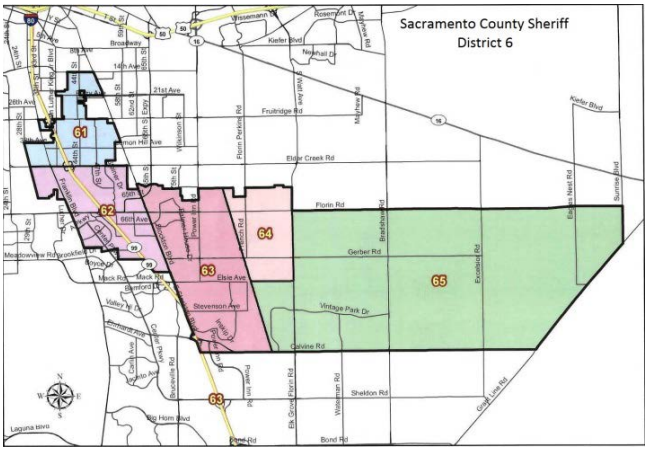
share information and resources. The Teams are included in SPD and SSD's "roll call" where law enforcement officers meet for daily briefings and announcements.

The **Sacramento Police Department Mobile Crisis Support Team (SPD - MCST)** consists of a licensed mental health professional paired with a law enforcement officer. Together they respond to calls from the "Central Command" area of Sacramento which includes the downtown corridor. The Central Command is a densely populated area noted for a high degree of police calls in response to "5150" or other mental health related issues.



The SPD - MCST consists of one SPD officer and one mental health clinician who work together and operate from an unmarked SPD vehicle. This specialized team responds to calls that come into dispatch from the Central Command area and are related to a mental health situation. The unmarked car is customized to allow for "courtesy transports" for individuals that may need or request to be transported to a service, home, hospital, or other location. SPD - MCST also coordinates with the Triage/Peer Navigator Program staff, especially those sited at the homeless services campus located within the Central Command to provide added levels of support and services.

The **Sacramento County Sheriff's Department Mobile Crisis Support Team (SSD - MCST),** responsible for law enforcement response within unincorporated areas of the county, provides coverage to District 6 located in south Sacramento. In 2012, District 6 Sheriff responded to 533 "5150" calls and 1,988 welfare checks. Approximately one third of the welfare checks were mental health related. Because SSD responds to a larger geographic area in a mostly suburban environment, the team consists of a licensed mental health clinician and peer with lived experience who meet law enforcement officers in the field, as well as respond with officers once the scene has been cleared.



In a separate vehicle, the SSD–MCST clinician/peer responds to calls from dispatch or calls at the request of an officer already at the scene. After arriving, when law enforcement determines the scene is safe, the clinician and peer provide crisis intervention services. The officer stays onsite until s/he is no longer needed. Officers are then free to handle other calls. The law enforcement officer may not always be the same for each call. The MCST Clinician is also available for "ride-a-longs" with officers to support immediate response after scenes have been cleared allowing the MCST peer to provide follow up to other individuals who

have stabilized after an initial contact and require additional support with linkage to services and resources.

Success: Suicide Prevention
The Mobile Crisis Support Team responded to a possible mental health crisis call from dispatch. The individual's adult sister called 911 reporting that her brother had a gun and threatened suicide. She also stated that a possible fight with Deputies might ensue upon dispatch due to his history and perception of interactions with law enforcement.

The MCST Clinician met deputies at a nearby school and developed plan for the Clinician to contact the individual via phone to negotiate support to the individual and family (wife and daughter). The Clinician was able to connect with the individual by phone and assessed for suicide ideation and thoughts of harm to others including if the individual had a plan or means for harm. The Clinician was able to obtain agreement from the individual to allow deputies and the Clinician to safely respond to the home for further support. The Clinician supported the individual in making a stabilization plan including releasing weapons to deputies and contacting his psychiatrist for a visit to discuss medications and mental health needs. The Clinician also provided support to family members on the scene to develop safety plans including an alternative place to stay for the evening and resource options for ongoing mental health support for the daughter. The situation was resolved without any use of force.

Follow up support was provided to the individual to ensure connection to his psychiatrist and other mental health supports were in place to continue ongoing care.

The **Caregiver Crisis Intervention Respite Program**, administered by Del Oro Caregiver Resource Center, is another 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 sustainable PEI funding during FY 2015-16. This program helps decrease hospitalizations due to mental health crisis of family caregivers of dementia and Alzheimer's patients by providing respite are and counseling, and helping caregivers develop skills and care plan to help stabilize their situation.

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

Strengthening Families Project
Capacity: 3,800 annually (not including the Bullying Prevention and Education Program)
Ages Served: Children, TAY, Adults, Older Adults

The Strengthening Families Program consists of six components:

The **Quality Child Care Collaborative (QCCC**) is a collaboration between DBHS, 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.

HEARTS for Kids is a collaboration between DBHS, Child Protective Services, and Public Health. This collaborative leverages First 5 funding to provide a comprehensive menu of services (health exams, assessments, referrals and treatment services) for children ages birth to five that come to the attention of CPS or are placed into protective custody.

The **Bullying Prevention Education and Training Program** is 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.

In Fiscal Year 2013-14, nineteen (19) schools participated in the Bullying Prevention Program with over 1,200 school personnel trained and 24,400 students educated about bullying awareness, education and prevention.

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

Bullying Prevention Education and Training Program Highlights and Successes:

- *Since Fiscal Year 2011-12, the Bullying Prevention Education and Training Program has educated 138,537 students in bullying awareness, education and prevention across all thirteen (13) school districts in Sacramento County.*
- *Spring 2015 BPP Demonstration Site School Staff Survey showed statistically significant increases/ improvements in student initiated prevention activities, reduction of bullying incidents, school climate and school commitment to the program for the 2014-15 school year (comparison to baseline data collected in fall 2011 for the beliefs about the 2010-11 year).*
- *Demonstration Site school staff surveyed in spring 2015 reported an increase in the area of student prevented fighting and a strong increase in the area of student prevented shoving.*
- *Bullying Prevention Project program expansion was successful in 2014 -15 at which time the program had expanded to 350 collective grade levels at schools across the 13 districts.*

Elk Grove Unified School District (EGUSD)

A Touch of Understanding (ATOU) disability awareness training provides education to students to understand challenges associated with disabilities and to respect all individuals. ATOU enhances the Bullying Prevention Program curriculum and brings positive attitudes within school aged children. ATOU training was conducted with 5th grade students at Ehrhardt elementary school in May. Three elementary schools (Feikert, Ehrhardt and Butler) had ATOU present with over 300 students receiving training. Additionally, A Touch of Understanding disability awareness training was hosted for EGUSD employees in April. Twenty-four staff attended the training and had outstanding reviews.

Folsom Cordova Unified School District (FCUSD)

A districtwide Bullying Prevention Task Force comprised of district employees at all levels, parents, and community partners was formed during the 2014-15 school year. This Task Force is working hard to address bullying prevention and character education in our schools. Some of the things that have been implemented at the end of the 2014-15 year include launching the FCUSD Character Development and Bully Prevention website designed to assist students, parents and staff and development of a uniform online bully reporting form for all school sites to use.

San Juan Unified School District (SJUSD)

In 2014-15, three assemblies were held for 4th-6th grade students titled Words That Hurt. Assemblies used video vignettes to prompt small group and large group discussion and problem-solving focused on how words impact others in negative, positive, and long-lasting ways. Assemblies were held at Mariposa Elementary, Cottage Elementary, and Dewey Fundamental Elementary with a total of 463 4th-6th grade students participating. Teachers were provided with related follow-up activities and resources to use with their classes. A total of 18 school staff, primarily classroom teachers, participated as small group facilitators.

Early Violence Intervention Begins with Education (eVIBE) is 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.

In Fiscal Year 2013-14 the eVIBE program Stop and Think model served 1,200 students, the Too Good For Violence model served 500 students. These curricula were taught in thirteen (13) schools across four school district, as well as two community sites and two affordable housing complexes.

Success: Parenting Support
A parent who attended the Nurturing Parenting program in-home session wrote the following letter to the Family Support Trainer. "When I started the Nurturing Parenting Program I had a hard time communicating with my family. We would argue and fight about them doing their chores or just how they talked to me and me to them. After a short time into this program, my family and I could communicate nicely. I placed our new House Rules that we all agreed on, up in multiple places to be seen by everyone. Our communication skills towards each other started improving and have changed dramatically. The girls do their chores when they are supposed to be done. The fighting and arguing does not exist anymore. Thank you for all your support and education you have provided."

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

Independent Living Program (ILP) 2.0 is a collaboration with Child Protective Services to expand the Independent Living Program to non-foster, homeless, and LGBTQ youth ages sixteen (16) to twenty-five (25) to gain positive, proactive, successful life skills either through a classroom setting or through individual life skills counseling. Services are administered by Twin Rivers Unified School District, Sacramento City Unified School District, Elk Grove Unified School District, and San Juan Unified School District on school campuses and in the community.

With the passage of AB12, foster youth can choose to participate in Child Protective Services Independent Living Program until their 21st birthday. This has impacted the original design of this program and may necessitate changes to this program in Fiscal Year 2016-17.

Adoptive Families Respite Program, administered by Capital Adoptive Families Alliance, is another 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 sustainable PEI funding during FY 2015-16. While families take great joy in providing care for their loved ones, the physical and emotional consequences for the family caregiver can be overwhelming without some support, such as respite. Respite provides a break for the whole family, which research shows, is beneficial for everyone involved. 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.

Integrated Health and Wellness Project
Capacity: 13,900 annually
Ages Served: Children, TAY, Adults, 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, 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.

Success: Early Intervention
After receiving SacEDAPT early intervention services, an adult female client realized she had met all of the goals she identified in her medication service plan. Prior to her involvement in our program she was struggling to accept her diagnosis and trying to understand it. With medication her mood has stabilized and she has been able to participate in therapy with a focus on working through her fears of becoming ill again. She went from living at home, never socializing and being unemployed to now having a full time job she enjoys, living with a boyfriend and regularly socializing. She is really proud of her accomplishments and is now thinking about going to law school.

SeniorLink, administered by El Hogar, 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.

Success: Supportive Services
A 60 year old self-referred participant to SeniorLink provided the following statement after six months in the program: "Last year was probably the worst year of my life. I had lost my house, my job, my wife, and my eyesight all at the same time. Through a lot of patience, understanding, and help I have managed to find a new life that I enjoy and look forward to. The resources that SeniorLink provided enabled me to reach out to others and the community in a way I did not know was possible. My advocate kept me on track with my life goals and showed me true understanding for my condition. As a result, I am doing well, and thriving with the new and even better life I have now. Nothing is impossible or too hopeless with real and concerned help."

Screening, Assessment and Brief Treatment: This program, fully implemented in fiscal year 2013-14, is administered by four Federally Qualified Health Centers. The purpose of this program is to integrate medical and behavioral health services in a community health care setting.

Each of the clinics use the Patient Health Questionnaire to screen clients for depression. If the screen indicates a mental health need, the individual is assessed for further treatment. Services

can include: (1) screening and assessment in a primary care clinic setting designed to increase early detection and treatment of depression, anxiety, substance use/abuse and symptoms related to trauma; (2) brief treatment when clinically indicated; (3) case management and follow-up care; and (4) linkages to individual counseling, support groups and other kinds of supports.

Due to the implementation of the Affordable Health Care Act and changes in Medi-Cal, this program may evolve over time, however initially it has allowed these four FQHC's to begin to change the culture of their clinics and address the much needed mental health aspects of service.

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

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. The project has multiple components as described below.

"Mental Illness: It's not always what you think" Project:
Since June of 2011, the Division of Behavioral Health Services (DHHS/DBHS), in partnership with Daniel J. Edelman Company 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 2013-14 marked the third 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.

(1) **Multi-media outreach**: The project included a heavy advertising component across multiple mediums in an effort to reach as many Sacramento County residents as possible. Advertising placements, including TV, radio, online and outdoor advertising, scheduled December 2013 through May 2014 garnered 127,247,892 impressions. The below advertising categories reflect efforts to date. In Fiscal Year 2013-14, twenty-four (24) billboards with individuals representing the diversity of community within Sacramento were displayed across the County. Some examples of materials include:

(2) **Social media**: a microsite (www.StopStigmaSacramento.org), Facebook and Twitter pages were updated regularly. In year three:

- The Facebook page received 3,827 likes, up from 1,900 likes from year two
- The Project published approximately 500 Facebook posts
- The Twitter account had 130 followers, up from 77 followers the previous year
- The Twitter page followed 157 other pages and posted 511 tweets
- 268 people submitted their email address through the site to receive project updates, up from 151 people in the previous year
- The Project microsite had a total of 11,131 website visits and 9,114 unique visitors in year three

(3) **Stakeholder Engagement**: One hundred and seven organizations confirmed their willingness to participate and be official partners for the project. To help ensure that stakeholders had a chance to participate and provide as much feedback as possible; the project team has sent out the following requests for input:

- Request for personal stories
- Request for Stop Stigma Sacramento Speaker's Bureau participants
- Requests for artwork and help in promoting the May activities
- Requests to attend Project-sponsored events

(4) **Collateral Material**: In this third year, many of the in-language project collateral materials were updated with new text, based on stakeholder feedback regarding the language used. Text updates were made to Russian, Vietnamese, Hmong and Cantonese brochures, tip cards and posters. Program materials, including brochure, tip cards and posters, were offered to stakeholders and other interested community members to distribute at provider sites and community events. To date, approximately 150,000 pieces of collateral material have been distributed to stakeholder groups and at events.

(5) Community Outreach Events:

Mental Illness Awareness Week Community Event (Oct. 10, 2013) - An event celebrating Mental Illness Awareness Week, the project coordinated a community event at the Elk Grove City Hall Chambers. The event featured speakers from the Stop Stigma Sacramento Speakers Bureau and several informational booths. Elk Grove City Mayor Gary Davis shared brief remarks.

A Panel Discussion of Community Perspectives (Jan. 24, 2014) - A panel discussion, moderated by Jennifer Whitney, took place in January. The event featured a light breakfast reception, personal stories from Stop Stigma Sacramento Speakers Bureau participants and a panel on reducing stigma and discrimination. Senate President pro Tem Darrell Steinberg and Supervisor Don Nottoli shared brief remarks.

Art Displays (May 2014) - Two art displays, a rotating display in the lobby of the Sierra Health Foundation promoted the campaign from May through August and a week-long display outside the Governor's Office at the Capitol, created awareness of the project.

Breakfast Reception and Visual Display at State Capitol (May 8, 2014) - In honor of May is Mental Health Month, project partners were invited to attend a breakfast reception in the Governor's Office Council Room. Senate President pro Tem Darrell Steinberg, Supervisor Don Nottoli and Dr. Sherri Heller shared brief remarks. A visual display on the North Steps of the State Capitol Building featured a Wall of Hope, where attendees wrote and displayed messages of hope and recovery.

(6) Research

A Wave 3 research survey was conducted in the fall of 2013. In order to gain more insight from the project's target audiences, research outreach was expanded in Wave 3. The enhanced survey outreach gathered enough responses from each community to allow the team to have a valid sample of specific multicultural groups; however, it is important to note that the response was limited to those who had access to the internet and that it's possible their responses may not be representative of their entire community. Key research findings included:

- Over the past three years, more people are continuing to see the project materials and advertisements, and are more familiar with the campaign.
- People increasingly say that they would engage in positive behaviors, such as talking more openly about mental illness or suggesting a friend or family member seek help.
- Comfort discussing specific mental illnesses with a health professional and interacting with people living with mental illness continues to increase.

(7) **Stop Stigma Sacramento Speakers Bureau:** Sacramento County's Division of Public Health continued to coordinate a speakers bureau in year three of this project. During year three, four (4) Orientation and Training sessions were held, during which 20 community members were trained to be speakers. At the close of year three, the Stop Stigma Sacramento Speakers Bureau had a membership of of 66 speakers, of which 37 were actively speaking or preparing to speak.

In year three of the project, Stop Stigma Sacramento Speakers Bureau speakers shared their personal stories at 32 events with a total audience attendance of 800 individuals. In school settings, school counseling staff are also invited to attend the scheduled presentations.

This card is distributed to recruit potential Speakers:

Practice sessions are an integral part of the Speakers Bureau. New speakers attend a minimum of two 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 project staff to preview and shape speaker presentation content to assure that it was consistent with the project goals and content guidelines. Increasingly, the practice sessions began to serve as a source of support and connection to the project, and have fostered supportive relationships among members.

The following table details the Speakers Bureau speaking events for year three:

Stop Stigma Sacramento Speakers Bureau Speaking Events: Year 3

July 1, 2013 – June 30, 2014

	Date	Site/Event	# Speakers	# in Audience
1	08.16.13	Stop Stigma Sacramento: Orientation	1	6
2	08.22.13	DHS US Citizenship and Immigration	3	21
3	10.10.13	Elk Grove City Hall	3	11
4	10.15.13	Inderkum High School	7	93
5	11.20.13	CA Secretary of State	1	12
6	12.13.13	Stop Stigma Sacramento: Orientation	1	4

	Date	Site/Event	# Speakers	# in Audience
7	01.31.14	Inderkum High School	6	124
8	02.04.14	Sheriff's Advanced Officer Training (AOT)	1	15
9	02.04.14	DBHS Training	2	35
10	02.11.14	Sheriff's Advanced Officer Training (AOT)	1	15
11	02.08.14	Sheriff's Advanced Officer Training (AOT)	1	15
12	02.21.14	Stop Stigma Sacramento: Orientation	1	6
13	03.04.14	Sheriff's Advanced Officer Training (AOT)	1	15
14	03.11.14	Sheriff's Advanced Officer Training (AOT)	1	15
15	03.18.14	Sheriff's Advanced Officer Training (AOT)	1	15
16	03.25.14	Sheriff's Advanced Officer Training (AOT)	1	15
17	04.01.14	Natomas High School	5	78
18	04.04.14	Hiram Johnson High School (parent group)	3	16
19	04.08.14	Sacramento State: School of Social Work	4	34
20	04.08.14	Sheriff's Advanced Officer Training (AOT)	1	15
21	04.15.14	Sheriff's Advanced Officer Training (AOT)	1	15
22	05.02.14	Stop Stigma Sacramento: Orientation	1	4
23	05.06.14	DBHS Competency Training	2	35
24	05.13.14	Sheriff's Advanced Officer Training (AOT)	1	15
25	05.20.14	Sheriff's Advanced Officer Training (AOT)	1	15
26	05.30.14	Wellness and Recovery Center (support group)	2	21
27	06.03.14	Sheriff's Advanced Officer Training (AOT)	1	15
28	06.10.14	Sheriff's Advanced Officer Training (AOT)	1	15
29	06.11.14	Bipolar/Depression Support Group: Sutter	2	32
30	06.17.14	Sheriff's Advanced Officer Training (AOT)	1	15
31	06.19.14	Sacramento Food Bank: Network Cafe	1	43
32	06.24.14	Sheriff's Advanced Officer Training (AOT)	1	15
	Total		**60**	**800**

The Stop Stigma Sacramento speakers have been well received, and speaker evaluations are completed for each event. All audience evaluations are entered into a database, which allows Public Health staff to assess the potential impact of the project 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. As well, a project resource card was developed for the speakers to hand out, which offers phone numbers for mental health resources and crisis support services.

Speakers Bureau audiences receive this resource card:

Speakers Bureau Open House

An open house was held May 31, 2014 for all Speakers Bureau speakers and affiliated staff. A total of 21 people (staff and speakers) attended. A PowerPoint presentation was given and summarized the results of 474 presentation evaluations returned for speaking events April 2013-May 2014. The event offered speakers and staff an opportunity to collaboratively view the potential impact of the Speakers Bureau presentations via the presentation evaluation results, offer feedback, and discuss next steps in the coming year.

Speakers Bureau Planned Expansion

In addition to continued management of the Speakers Bureau, an additional objective for year 3 was to develop a plan for increasing membership and collaboration to allow the Speakers Bureau to:

- Accommodate an increased number of speaking requests,
- Offer presentations in languages other than English,
- Increase outreach to racial, ethnic, cultural groups to assess future involvement in a culturally appropriate manner,
- Enlist minor youth as speakers, and
- Engage specific workforce sectors (e.g. health care, media, higher education, etc.) for stigma reduction efforts and educational presentations.

With a core group of 37 speakers, the Speakers Bureau is able to manage a range of speaking requests above the current number of requests. To pursue expansion, Public Health staff consulted with Edelman and DBHS to develop outreach strategies and identify key networks for engaging with different communities.

Increased email outreach was carried out via DBHS's distribution lists, including Project stakeholders, PH staff increased contact with school districts and institutions of higher learning, and additional promotion was carried out via the Project's social media outlets.

The increased outreach resulted in securing 3 speakers who are bilingual in Spanish, an invitation to speak at Sheriff's Advanced Officer Training (15 class sessions), and an invitation to speak to Sacramento State School of Social Work students.

Increasing cultural, racial and ethnic diversity

An important conversation that emerged during discussions of engaging different community groups around the issue of mental illness and stigma reduction, is the need to move beyond the approach of simply training and enlisting in-language speakers to join the Speakers Bureau and offer presentations "in language." For example, in approaching the issue of mental illness and mental wellness, speaking to a large audience may not fit all cultural groups and instead community leaders might choose to lead small discussions. As well, other communities may decide to address the issue of stigma in more creative ways such as through performance or community gatherings.

To initiate a dialogue and discuss expanding our approach to include different forms of communication and cultural traditions, a multicultural planning session was held in March 2014 in collaboration with Edelman and DBHS. The purpose of the planning session was to:

- To learn more about what hinders communication and conversations about mental illness in various cultural and ethnics communities,
- To garner opinions regarding culturally effective communication methods/activities that people living with mental illness could draw on as vehicles to *"tell their stories"* (ex. music, poetry, storytelling, etc.) and increase community engagement, and
- To gather input as to how the Stop Stigma Sacramento Speakers Bureau can invite and facilitate the participation of individuals representing the various cultural and ethnic communities in Sacramento County.

A total of 23 individuals representing various ethnic, racial and cultural groups attended the planning session, which utilized small focus groups to gather information. After the planning session, participants expressed a desire to continue meeting and collaborate further to learn from one another and join around similarities. This initial meeting became the first of subsequent meetings that continued into year 4.

Next Steps In Year 4

In managing the Speakers Bureau in the next project year, Public Health staff will continue to utilize existing networks and consult with Edelman and DBHS staff so that the Speakers Bureau can:

1. Complete an increased number of speaking events,
2. Engage with ethnically and racially diverse communities in culturally relevant and meaningful ways (as defined by the communities),
3. Enlist minor youth as speakers, and
4. Target specific workforce sectors (e.g. health care, media, higher education, law enforcement, etc.) for stigma reduction efforts and presentations.

PEI Administration and Program Support

DBHS 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.

PEI IMPLEMENTATION PROGRESS DATA - FISCAL YEAR 2013-14

In Fiscal Year 2013-14, a total of 19,167 individuals were served across eight* of the PEI programs. The chart below displays demographic information for individuals served in each of those programs:

Total Number of Individuals Served in PEI Programs									
	Senior Link	eVIBE	ILP 2.0	Quality Childcare Collaborative	Supporting Community Connections	HEARTS for Kids	Sac EDAPT	SABT	Total
	# of served individuals only								
Age Group									
Child and Youth	0	2054	33	56	242	595	41	NR	3,021
Transition Age Youth	0	53	467	0	465	0	64	NR	1,049
Adult	43	210	0	0	932	0	2	NR	1,187
Older Adult	189	9	0	0	359	0	0	NR	557
Not Reported	0	59	139	0	33	0	0	13,122	13,353
Total	**232**	**2385**	**639**	**56**	**2031**	**595**	**107**	**13,122**	**19,167**
Race/Ethnicity									
White	103	353	124	NR	521	164	32	NR	1,297
African American	47	262	173	NR	261	146	27	NR	916
Asian	10	125	26	NR	324	39	8	NR	532
Pacific Islander	1	16	4	NR	0	0	3	NR	24
Native	3	15	5	NR	4	4	1	NR	32
Hispanic	31	729	111	NR	561	127	26	NR	1,585
Multi	0	401	55	NR	291	24	4	NR	775
Other	12	49	1	NR	13	30	2	NR	107
Not Reported	25	435	140	56	56	61	4	13122	13,899
Total	**232**	**2385**	**639**	**56**	**2031**	**595**	**107**	**13122**	**19,167**
Primary Language									
Spanish	16	376	11	NR	553	NR	8	NR	964
Vietnamese	0	3	0	NR	97	NR	0	NR	100
Cantonese	0	0	0	NR	94	NR	0	NR	94
Mandarin	1	1	0	NR	3	NR	0	NR	5
Tagalog	0	0	0	NR	0	NR	0	NR	0
Cambodian	0	1	0	NR	0	NR	0	NR	1
Hmong	9	25	1	NR	78	NR	0	NR	113
Russian	6	5	0	NR	243	NR	0	NR	254
Farsi	1	2	0	NR	0	NR	0	NR	3
Arabic	0	10	0	NR	0	NR	0	NR	10
Other	186	1846	473	NR	5	NR	99	NR	2609
Not Reported	13	116	154	56	958	595	0	13122	15014
Total	**232**	**2385**	**639**	**56**	**2031**	**595**	**107**	**13122**	**19167**

*Note – The chart above displays number of served individuals only. It does not contain data for individuals served and reached by the following PEI Programs: Suicide Crisis Line; Postvention Services; Mobile Crisis Support Teams; and Mental Health Promotion project.

PEI IMPLEMENTATION PROGRESS DATA - FISCAL YEAR 2013-14 (cont'd)

In Fiscal Year 2013-14, a total of 17,607 individuals were served across the four PEI programs with universal components. The chart below displays demographic information for individuals served in each of those programs:

Total Number Served in Universal Prevention					
	Senior Link	**Quality Childcare Collaborative**	**Supporting Community Connections**	**SABT**	**Total**
	Universal prevention estimates and # of served individuals				
Age Group					
Child and Youth	0	1,110	2,657	NR	3,767
Transition Age Youth	0	0	2,028	NR	2,028
Adult	54	0	6,217	NR	6,271
Older Adult	248	0	2,718	NR	2,966
Not Reported	0	0	323	2,252	2,575
Total	**302**	**1110**	**13,943**	**2,252**	**17,607**
Race/Ethnicity					
White	136	NR	740	529	1,405
African American	60	NR	613	285	958
Asian	18	NR	3,758	130	3,906
Pacific Islander	1	NR		22	23
Native	3	NR	150	25	178
Hispanic	41	NR	1,090	202	1,333
Multi	0	NR	526	55	581
Other	16	NR	55	25	96
Not Reported	27	1110	7,011	979	9,127
Total	**302**	**1110**	**13,943**	**2252**	**17,607**
Primary Language					
Spanish	19	NR	NR	NR	19
Vietnamese	0	NR	NR	NR	0
Cantonese	1	NR	NR	NR	1
Mandarin	1	NR	NR	NR	1
Tagalog	0	NR	NR	NR	0
Cambodian	0	NR	NR	NR	0
Hmong	14	NR	NR	NR	14
Russian	6	NR	NR	NR	6
Farsi	1	NR	NR	NR	1
Arabic	0	NR	NR	NR	0
Other	246	NR	NR	NR	246
Not Reported	14	1110	13943	2252	17319
Total	**302**	**1110**	**13943**	**2252**	**17607**

Note: Only four of Sacramento County's PEI programs utilize universal screenings

WORKFORCE EDUCATION AND TRAINING (WET) COMPONENT

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 that are implemented or in advanced stages of planning.

The Sacramento County Workforce Needs Assessment, which was used to help inform the development of the WET Plan, was completed in 2007 as part of the Workforce Education and Training (WET) Component planning process. In 2010, as part of the annual Cultural Competence Plan (CCP), a human resources survey and report was completed that provided an overview of human resources system-wide. Subsequently, DBHS was advised by the state Department of Health Care Services (DHCS) that they would be releasing updated CCP requirements that would impact the annual Sacramento County Human Resources Survey/MHSA Workforce Assessment. We are still anticipating the release of these updated requirements. When the new requirements are released, DBHS will tailor a new human resources survey document to provide data on the entire mental health system, including an updated assessment of resources and needs based on the current job market indicators.
The WET Component consists of eight (8) previously approved Actions:

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; twice monthly WET Coordinator Conference Calls; and the WET Central Region Partnership, including the Transitional Age Youth (TAY) Workgroup, Training Sub-Committee, and the Community College Workgroup. The WET Coordinator will continue to assist in the evaluation of WET plan implementation and effectiveness; coordinate efforts with other MHSA and Division/Department efforts; and participate in the implementation of WET Actions.

Action 2: System Training Continuum

This Action expands the training capacity of 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 training efforts.

September 2015 Latino Behavioral Health Community Training Event

In 2010, a Crisis Responder Training Workgroup was established as the first Training Partnership Team and resulted in the development of a two (2) hour mental health training education program that trained Sacramento City Police Department (SPD) and Citrus Heights Police officers and supervisors. In 2012, the training program was updated and now meets Police Officer Standards and Training (POST) certification requirements. The two-hour mental health education module is designed to provide information and resources as well as

increase the safety of patrol officers, consumers, family members and other citizens in the community by providing a basic overview of mental illness symptomology and strategies for communicating with individuals who suffer from mental illness, thereby reducing the potential for use of deadly force tactics when LE encounter individuals who suffer from mental illness in the field.
The Sacramento County Sheriff's Department requested that the training be part of their 2012-13 and 2013-14 Advanced Officer Training (AOT) schedule. During that time 92 training sessions were provided to all deputies and Sheriff Office staff who were required to attend AOT. On January 1, 2015, the two-hour mental health education training was discontinued, as Sacramento County Sheriff's Department began providing Crisis Intervention Training (CIT) to its deputies and later in the year began partnering deputies in the field with behavioral health specialists to assist with calls involving individuals who are mentally ill. DBHS participates in CIT training, by providing local resource information to support the education component of the training curriculum.

DBHS was recently contacted by the California Highway Patrol (CHP) with requests to provide mental health education training to their field officers and dispatch staff. Plans for further communication with CHP are underway. Additionally, in an effort to assist first responders with identifying and assisting individuals with mental illness, DBHS plans to formally extend the training to other local law enforcement agencies that have expressed interest. As we move forward, DBHS will continue to look for opportunities to partner with local law enforcement on educational/training activities.

Mental Health First Aid (MHFA) is another training that is provided to our community and system partners as part of the System Training Continuum at no cost to them. Since beginning to offer MHFA, Sacramento County has found that class size remains fairly consistent, but slightly increases during certain times of year, depending on other activities occurring in the community. The following table provides information regarding average class size and number of participants.

Fiscal Year	**Average Class Size**	**Number of Participants**
2011-12	17	175
2012-13	17	256
2013-14	20	362
2014-15	19	270
TOTAL		**1028**
2015-16 (projected numbers)	23	266

The initial training of local instructors was sponsored by the MHSA Central Region Partnership Workforce, Education, and Training's (CRPWET) strategic effort in 2010. Since then, Sacramento County DBHS has continued to leverage CRPWET funds to expand the trainer pool and uses local WET funds to provide training opportunities to participants at no charge. Sacramento County began offering MHFA to system partners and the community at large in 2011/12. The community continues to express significant interest in this training and several classes have been offered each fiscal year since the beginning. In addition to the DBHS

organized trainings, community partners have held additional MHFA trainings in languages other than English in community based sites throughout the county.

In August 2015, Sacramento DBHS had two additional staff successfully complete the five-day Adult MHFA Training 4 Trainers (T4T) training and are now a part of the existing pool of trainers who provide MHFA training to the diverse communities in Sacramento County. Additionally, in December 2015, three additional staff were certified as Youth MHFA trainers and are now a part of the existing pool of certified trainers. Since the initial roll out, some of the sessions have been provided to specialty groups (i.e., Sacramento Employment and Training Agency (SETA), Head Start, church and community organizations, etc.) but the majority of them were open to system partners and the general public, including those with lived experience. Participants in the general public courses included but were not limited to: Mental Health Board members, educators (both elementary and higher education), clergy, students in behavioral health programs, staff from supported housing providers, staff from supported employment sites, staff from local regional transit, probation officers, staff from both state and local government agencies that work with individuals who have mental health conditions, peer organizations, family members and others with lived experience. In 2014 we added Youth Mental Health First Aid instructors and included general public sessions as well as language/cultural specific sessions as part of the MHP and partner training schedule. The Adult MHFA and Youth MHFA have been provided in both English and Spanish through a partnership with a community-based contract provider, La Familia Counseling Center. Additional sessions are scheduled through the end of 2015.

To expand the number of individuals receiving the YMHFA training, in 2014, Sacramento County DBHS initiated a project that is funded through Action 2 and administered by the Sacramento County Office of Education, designed to educate teachers, school staff, and caregivers on how to help adolescents ages 12-18 who may be experiencing mental health or addiction challenges or other emotional crisis situations. “The course introduces common mental health challenges for youth, reviews typical adolescent development, and teaches a 5-step action plan for how to help young people in both crisis and non-crisis situations. Topics covered include anxiety, depression, substance use, disorders in which psychosis may occur, disruptive behavior disorders (including Attention Deficit Hyperactivity Disorder), and eating disorders.” In FY 2014-15, twenty-four (24) school district staff were trained. Future trainings for master trainers will train up to 30 additional school district staff that will then provide ongoing certified training to other teachers, school staff, and caregivers.

In addition to the training efforts described above, DBHS provided scholarships and/or support for more than 260 behavioral health staff, system partners, providers and persons with lived mental health experiences and other mental health stakeholders to attend 36 behavioral health related trainings and conferences in Fiscal Year (FY) 2013-14.

Sacramento County, DBHS has continued to expand Action 2 by offering Wellness Recovery Action Plan (WRAP) Facilitators Training to system partners and community based organizations (CBO) at no cost to them. In November 2015, nineteen (19) individuals participated in and successfully completed a 5-day intensive WRAP Facilitator’s training. Those 19 individuals are now certified WRAP Facilitators, providing WRAP groups to consumers, their

family members and others throughout Sacramento County and surrounding areas. Built upon earlier efforts, and in partnership with Mental Health America of Northern California (Norcal MHA), in September 2015 DBHS held a two-day WRAP refresher course for identified individuals that attended prior year WRAP conferences. The two-day refresher was designed to prepare participants for the intensive five-day WRAP facilitator's training that took place in November 2015. This most recent cohort of recovery educators are now certified to facilitate WRAP groups within their respective communities, throughout Sacramento County, training others to use the concepts of prevention and wellness to get well, stay well and fulfill their life dreams and goals. Having attended the intensive five-day training, the new WRAP facilitators gained a much deeper understanding of the mental health recovery process and learned how to work more effectively with people who have mental health challenges. They learned how to modeling resilience and how to empower others towards the discovery of personal strengths that can be used to enhance their mental health recovery. Sacramento County staff, together with NorCal MHA, worked very diligently to develop an application and selection process for the five-day training, which resulted in 19 system partners and employees of local community based agencies being certified as WRAP Facilitators. Moving forward, the cohort will have ongoing support from Advanced level WRAP facilitators and a quarterly support group/conference call where facilitators can come together for providing and evaluating relevant information, sharing personal experiences and coping strategies, and providing sympathetic understanding.

November 2015 WRAP Facilitator Training

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.

Due to budget reductions and lack of employment opportunities from 2008-2013, implementation of this Action was delayed. While employment was challenging across the state during this period, Sacramento County ranked second for the highest unemployment in the state. Efforts to train existing Consumers, Family Members, and Caregivers to ensure successful service delivery and employment have taken place through other initiatives and partnerships including leveraging funding from the Central Region Partnership and state agencies to provide training opportunities for persons with lived experience from diverse communities. Additionally the landscape has changed over the last years—both on the county and contract provider/community based organization side where program planning and design have included peers, consumer staff and family advocacy within the milieu. As we move forward on full implementation of this Action, we will consider these changes as well as data from a planned

updated human resource and workforce needs assessment to ensure that our efforts are aligned with this new landscape.

Action 4: High School Training

Through this Action, a pilot behavioral health curriculum was developed in fiscal year 2013-14. Currently two high schools are involved in this action and offer health-oriented career pathways for their student body. The participating high schools are Arthur A. Benjamin Health Professions High School and Valley High School-Health Tech Academy. The pilot curriculum for both schools was built upon a foundation developed through partnerships between Mental Health Plan providers and the Cultural Competence Committee, including community partners and other interested stakeholders. The curriculum focuses on introducing behavioral health to high school youth (9th through 12th grade) during the time they are typically considering career opportunities. Additional areas of focus include, but are not be limited to, addressing issues of stigma and discrimination toward individuals and family members living with mental illness; increasing understanding of mental health issues from diverse racial and ethnic perspectives; exploring mental health issues across age groups; exploring the various career opportunities in public mental health; and other areas. Students from Arthur A. Benjamin Health Professions High School were surveyed and analysis of data from this effort resulted in modification to the 2014/15 curriculum. The area of related activities was expanded to include more guest speakers with lived experience to present to students on topics such as stigma, discrimination and barriers that hinder consumers from seeking emotional support and services. In addition to curriculum modifications, the students were able to increase their knowledge of mental illness through work based learning experiences wherein they met with mental health professionals from local hospitals and mental health clinics to do project research on specific disorders such as Bipolar and Obsessive Compulsive Disorder. These learning opportunities helped students better understand how mental illness can interfere with a person's daily life and provided opportunities for them to explore their own mental health and emotional coping skills. By pairing students with local mental health professionals, the students were given greater exposure to a wide array of mental health careers in hopes they will pursue future careers in the field of mental health.

Students from Arthur A. Benjamin Health Professions High School participate in mental health event at the Capitol

Sacramento County continues to serve on the Community Advisory Committee and advises on student projects related to mental health and cultural competence delivery in healthcare services. Sacramento County works with the selected schools with on-the-job training, mentoring, existing Regional Opportunity Programs (ROP), and experiential learning opportunities for public high school youth who express interest in learning more about mental health and public mental health as a possible career option.

Valley High School-Health Tech Academy and Arthur A. Benjamin Health Professions High School, have culturally and linguistically diverse student bodies and have participated in many community events throughout the year, including Stigma Free 2015 and the Health and Fitness Expo.

Valley High Health Tech Academy (VHHTA) participated in a career seminar featuring primary care and mental/behavioral health professions. There was a significant variety of careers and professions represented, including geriatric social work, mental health services coordination, patients' rights and cultural competence. The career seminar increased the students' understanding of careers in mental/behavioral health field and provided a greater understanding of the importance of providing effective and sensitive treatment across the various cultures in our community. Additionally, VHHTA informed us that through the WET grant they were able to create and adopt a new year-round curriculum for seniors, Behavioral Health Theory and Practicum for the Community Health Worker (CHW), to replace the prior single semester course. "The expansion added tremendous depth to academy students' understanding of mental and behavioral health issues and was successful in engaging students in learning about mental/behavioral health as possible careers. Additionally, it increased instruction on careers in behavioral health, research methods in psychology and enhanced their existing units in brain anatomy and function, psychological theory, abnormal psychology and social psychology." Through our partnership, VHHTA was able to add additional coursework and units for courses, including mental health attitudes, issues and subgroups, cultural competence in behavioral health, mental health case management and the role of the CHW. Through our efforts and works with VHHTA, they were able to expand opportunities toward educating students in the field of mental/behavioral health and increase student knowledge about mental health conditions and related careers. Academy staff can now be more deliberate in its mental/behavioral health activities and promotion of mental/behavioral health awareness, informing not on VHHTA students, but also the general public of important mental health issues and career possibilities.
Partnering with both Arthur A. Benjamin Health Professions High School and Valley High Health Tech Academy and their feeder schools has continued to assist DBHS in our goal to recruit diverse staffs that are reflective of the cultural and linguistic make-up of the community.

Action 5: Psychiatric Residents and Fellowships

This Action was implemented in fiscal year 2011/12 and continues to be administered through a partnership with UC Davis, Department of Psychiatry. Through this action the following two components have been implemented: Community Education Training for Residents and Fellows and Primary Care Collaborative. A third component, Residents and Post-Doctoral Fellows at Youth Detention Facility (YDF)--Special Needs Unit will be implemented in early 2016.

Community Education Training for Resident and Fellows: Residents, fellows, and other team members receive on- going 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. Since its implementation in academic year 2011/2012, a total of 53 psychiatric residents have participated in this action and attended the required Psychiatric Resident Fellowship Program (PRFP) trainings. Some of the participating psychiatric residents have dual interest in psychiatry and other areas such as primary care/family medicine or internal medicine. Below is a chart indicating the number of residents enrolled in the program

since FY 2011-12. The chart also indicates the total number of residents that have psychiatry as their sole interest as well as those with dual interest in other related medical specialties.

Academic Year	Number of Residents Enrolled	Number of Residents with Dual Interest
2011/12	12	2
2012/13	9	4
2013/14	12	4
2014/15	11	3
2015/16	9	2
Total	**53**	

Primary Care Collaborative: Through this action, no less than two psychiatrists are placed in public/community mental health settings to assist in primary care collaboration with physicians through consultation and education on mental health/primary healthcare integration with staff and consumers. DBHS will continue to refine this component based on system needs.

Residents and Post-Doctoral Fellows at YDF --Special Needs Unit: DBHS is in the process of expanding 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 residing at the Youth Detention Facility, Special Needs Unit. DBHS is continuing to explore current needs and additional functions that can be employed to advance this Action.

Action 6: Multidisciplinary Seminar

This Action increases the number of psychiatrists and other non-licensed and licensed practitioners working in community mental health that 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 training that supports them in the delivery of effective mental health services. Given clear indicators that the economy is stabilizing, DBHS is assessing the design of the program in light of current market trends and available resources and is moving towards formal implementation of this Action.

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. Educational opportunities include, but are not limited to: the California Association of Social Rehabilitation Association (CASRA) social rehabilitation certificate and certification in group facilitation. During FY 2014/15, Sacramento County leveraged Central Region Partnership funds to pay for on-line Human Services courses using CASRA curriculum at Modesto Junior College (MJC) for individuals with lived experience. For the 2015 academic school year, Sacramento County has four (4) students enrolled in on-line classes through MJC. At the completion of their

coursework, the students will be able to advance to the next level, eventually leading to a Certified Psychiatric Rehabilitation Practitioner (CPRP) credential. The CPRP credential is a test-based certification curriculum that fosters the growth of a qualified, ethical and culturally diverse workforce and is designed to provide wellness and recovery oriented services for individuals who are coping with mental health issues. During the 2015 academic year, Sacramento County had students who completed the required on-line coursework. DBHS continues to offer emotional support and financial assistance to those students who are pursuing the CPRP certification. The CPRP curriculum is specifically designed to meet the goal of developing a multicultural, diverse, and recovery-oriented mental health workforce. The courses provide core training in the values and principles of psychosocial rehabilitation and the skills necessary to provide hope-filled, values-driven services to consumers.

Additionally Sacramento County continues to provide funding support for individuals with lived experience from diverse cultures to attend trainings/conferences that offer leadership training. Sacramento County is also exploring other strategies to further implement this Action to address logistics that are challenging for the county to manage. The county will continue to work with diverse stakeholders to determine an array of leadership and training opportunities that would be beneficial for consumers and also establish fair and equitable selection criteria for the awarding of Stipends.

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. Sacramento County has a mechanism to provide stipends that leverages County 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. DBHS has one implemented Innovation project, known as **Innovation Project 1: Respite Partnership Collaborative** and a new proposed project, known as **Innovation Project 2: Mental Health Crisis/Urgent Care Clinic.** The proposed plan for the Mental Health Crisis/Urgent Care Clinic is attached to this Annual Update (see Attachment C - Innovation Project 2 Plan).

DBHS Innovation Project 1: Respite Partnership Collaborative (RPC)
The RPC Project spans 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 is using an administrative entity (Sierra Health Foundation: Center for Health Program Management) to implement the project to determine if a public/private endeavor will 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) 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. The first round of funding in November 2012 awarded four respite programs a total of $394,137. Each of the programs was funded for a two year period. In September 2013, the second round of funding awarded $1.55 million dollars to three agencies for a two year period and in January 2015 the third and final Round of funding for $575,000 was awarded to four agencies for a 13 month period. An overview of all of the respite programs is provided in the grid below.

In FY 2015-16, all of the grant awards will have been distributed. The RPC will focus on the final phase and wind-down of the Respite Partnership Collaborative Project which includes evaluating the impact of the learning goals. In the early part of this project, an external evaluation was commissioned by the RPC. American Institutes for Research (AIR) was selected to be the Evaluator. AIR has been gathering data, conducting interviews and analyzing the collective parts of the project. The evaluation will be a major focus of the last year of the RPC Project. The Division looks forward to sharing evaluation findings as they become available.

As an Innovation project, funding is time-limited for the term of the project, which means that the mental health respite grantees must 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. At their meetings in February, March and April 2015, the MHSA Steering Committee review the Round 1 and Round 2 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. In April 2015, the MHSA Steering Committee recommended that DBHS work with each of the Round 1 and Round 2 grantees to determine whether or not their services were viable to fit within the MHSA model. As a result, all six (6) of the Round 1 and Round 2 respite programs were transitioned to sustainable MHSA Community Services and Supports (CSS) or Prevention and Early Intervention (PEI) funding in October 2015.

In December 2015, the MHSA Steering Committee considered and recommended sustainable MHSA PEI funding for three of the Round 3 respite programs. DBHS will provide additional updates regarding this Innovation Project in the MHSA Fiscal Year 2016-17 Annual Update.

Respite Partnership Collaborative Fact Sheet

Center for Health Program Management
Sierra Health Foundation

Respite Partnership Collaborative

Sacramento County

Respite Partnership Collaborative

The Respite Partnership Collaborative is a community-driven body of dedicated individuals working together on a Mental Health Services Act Innovation Project that supports respite programs as a way to respond to mental health crisis in the Sacramento Region.

The Respite Partnership Collaborative (RPC), formed in May 2012 to support the development and provision of respite services in Sacramento County, is a public-private partnership comprised of the County of Sacramento Division of Behavioral Health Services (DBHS), Sierra Health Foundation: Center for Health Program Management and community members who serve as members on the RPC. RPC members are volunteers who are committed to the mission of the project and represent a diverse cross-section of interests related to respite care in Sacramento County.

The RPC is comprised of up to 25 diverse stakeholders representing mental health consumers and family members, traditional and non-traditional service providers, cultural leaders, faith-based providers, and other subject matter experts. Members are selected through a competitive application process.

The essential purpose of this five-year project is to test whether a community-driven process, which includes decision-making and program design, will promote stronger interagency and community collaboration.

Sacramento County has a pressing need for a respite care facility to alleviate the overflow of adults with psychiatric issues at local emergency rooms.

John Buck, CEO
Turning Point Community Programs

Mission

The Respite Partnership Collaborative supports respite options to help reduce the need for psychiatric hospitalizations that could occur as a result of mental health crisis. The RPC awards funds for mental health respite services that meet certain criteria. To date, six programs have been funded to create a continuum of mental health respite services. In addition to the funding role, the RPC works to:

- Establish partnership and networking opportunities with other community resources and Mental Health Services Act (MHSA) programs
- Explore options for leveraging and sustainability of crisis respite
- Participate in RPC project evaluation

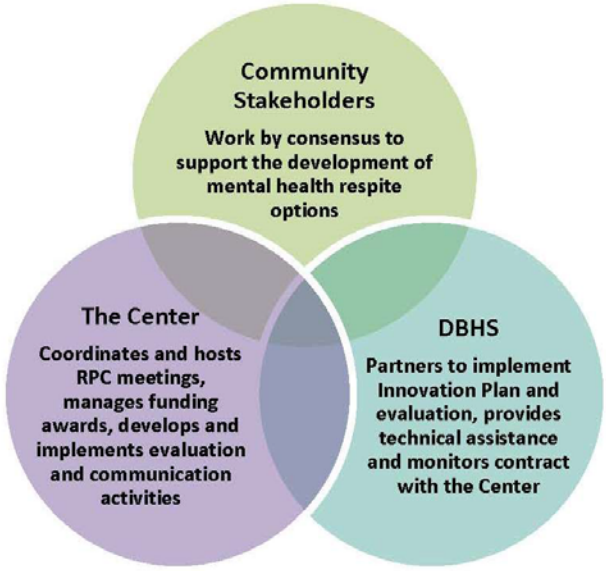
Respite Partnership Collaborative Fact Sheet (continued)

Funding

Financing for the RPC comes from Sacramento County's Mental Health Services Act (MHSA) Innovation component. MHSA, a state initiative passed by voters in 2004, provides funding to help counties transform mental health services across all age groups and addresses a broad continuum of prevention, early intervention, treatment and recovery needs. Innovation projects offer an opportunity to develop and test new mental health approaches and, therefore, primarily focus on learning rather than providing a service.

Innovation projects and funding are time-limited, and funds cannot be used to sustain the activities. Sustainability of respite programs demonstrating success will depend on the identification of future public/private funding opportunities. A comprehensive evaluation of the learning objective and the respite services is included in the project.

Innovation Project Partners



RPC Meetings

The RPC meets regularly at Sierra Health Foundation. The meetings are open to the public; however, a limited number of seats are available and must be reserved at least one week in advance. A meeting schedule, meeting documents, a public registration form and other materials are posted on the RPC web page at www.shfcenter.org/rpc.

Learn More

For more information about the Respite Partnership Collaborative, contact Program Officer Myel Jenkins at mjenkins@sierrahealth.org or (916) 922-4755 x3315.

Round 1 Respite Grant Awards		
Provider/Program	**FY2014-15 Grant Award**	**Respite Model**
Capital Adoptive Families Alliance (CAFA)	$30,090	Works to improve family stability by providing family respite camp for adoptive parents and their emotionally disturbed children, expanding peer support and developing children's social skills.
Del Oro Caregiver Resource Center	$80,895	Helps decrease hospitalizations due to mental health crisis of family caregivers of dementia patients by providing respite care and respite counseling, and helping caregivers develop skills and developing a care plan to help stabilize their situation.
Turning Point Community Programs Abiding Hope Respite House	$545,576	Helps decrease hospitalizations due to mental health crisis by providing residential and peer-directed respite services at *Abiding Hope Respite House*, a home-like environment for adults age 18 and older.
Iu-Mien Community Services	$70,705	Works to reduce mental health crisis in the Iu-Mien community by raising awareness of mental health issues through intergenerational respite support that is culturally and linguistically appropriate. Respite services support youth through older adults, with a crisis hotline as part of the services.

Round 2 Respite Grant Awards		
Provider/Program	**FY2014-15 Grant Award**	**Respite Model**
Saint John's Program for Real Change	$300,000	Works to de-escalate a mental health crisis for adult women by providing short-term respite and on-site support services and linkages to community services on site at the shelter.
TLCS, Inc. Crisis Respite Center	$1,000,000	Promotes stabilization for adults experiencing a mental health crisis by providing 24-hour/7 day-a-week mental health crisis respite services that can be accessed on a drop-in basis in a warm and supportive community-based setting.

Round 3 Respite Grant Awards – To be implemented in early 2015		
Provider/Program	**FY2014-15 Grant Award**	**Respite Model**
Youth/Transition Age Youth (TAY) Respite Awards		
Sacramento LGBT Community Center	$100,988* *corrected	Will work to de-escalate mental health crisis for lesbian, gay, bisexual, transgender, queer, questioning and allied youth by providing short-term respite and drop-in support groups in a safe place.
Wind Youth Services	$249,015* *corrected	Will work to reduce mental health crisis for youth between the ages of 13 to 25 who are homeless or at risk of being homeless by providing linkages to community services and peer-directed respite.
Unserved and Underserved Populations Respite Awards – Designed to meet the needs of adults (and the people who support them) who self-identify as lesbian, gay, bisexual, transgender, queer and questioning		
A Church For All	$75,000	Will work to de-escalate mental health crisis for adults by offering short-term peer-run drop in respite services in a safe space.
Gender Health Center	$75,000	Will work to promote stabilization for adults in crisis through neighborhood based drop-in respite services and supportive activities.
Sacramento LGBT Community Center	$75,000	Will work to promote stabilization for adults age 25 and older in crisis with drop in and planned respite in a supportive setting.

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) and Peer Partner programs and consolidating its current two APSS programs into one location.

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 APSS and Peer Partners programs have successfully transitioned into the renovated space.

The **Technological Needs (TN)** Project consists of five phases over a five-year period 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.

There two Roadmaps to address Sacramento County Technological needs; Sacramento's Health Information Exchange, known as SacHIE (County operated providers and those contracted providers that 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 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 in the last quarter of fiscal year 15-16. The County will then move into 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 is currently in Phase 2 of the HIE project. All of contracted providers that have chosen to use their own electronic health record 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. Sacramento County anticipates completion of Phase 2 of the HIE project (electronic exchange of claiming and state reporting information) in the last quarter of FY 2015-16.

FY 2015/16 Mental Health Services Act Annual Update
Funding Summary

County: Sacramento Date: 1/4/16

	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 2015/16 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	68,914,911	15,996,162	8,591,737	3,040,313	7,281,873	
2. Estimated New FY 2015/16 Funding	33,390,235	8,347,558	2,196,726			
3. Transfer in FY 2015/16[a/]	0			0	0	
4. Access Local Prudent Reserve in FY 2015/16	0	0				0
5. Estimated Available Funding for FY 2015/16	102,305,146	24,343,720	10,788,463	3,040,313	7,281,873	
B. Estimated FY 2015/16 MHSA Expenditures	42,357,656	12,447,866	3,729,514	2,327,109	3,013,136	
G. Estimated FY 2015/16 Unspent Fund Balance	59,947,490	11,895,854	7,058,949	713,204	4,268,737	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2015	19,391,847
2. Contributions to the Local Prudent Reserve in FY 2015/16	0
3. Distributions from the Local Prudent Reserve in FY 2015/16	0
4. Estimated Local Prudent Reserve Balance on June 30, 2016	19,391,847

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 2015/16 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: Sacramento Date: 1/4/16

	Fiscal Year 2015/16					
	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	2,008,164	1,190,304	817,860			
2. Permanent Supportive Housing	9,779,170	6,466,021	2,456,230		163,901	693,018
3. Transcultural Wellness Center	2,536,456	1,846,963	689,493			
4. Adult Full Service Partnership	7,164,147	4,210,863	2,953,284			
5. Juvenile Justice Diversion and Treatment	2,857,338	1,825,098	516,120		516,120	
6. CSS Phase B - TAY Full Service Partnership	2,500,000	2,500,000				
7. CSS Phase B - Existing FSP Expansion	3,000,000	3,000,000				
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	11,269,878	7,102,574	2,235,359		354,619	1,577,326
2. Wellness and Recovery Center	5,037,871	4,432,592	605,279			
3. Crisis Residential Program	1,500,000	1,500,000				
4. CSS Expansion - Phase C Implementation	1,600,000	1,600,000				
5. CSS Expansion - Unforeseen Need	2,323,909	2,323,909				
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	4,359,332	4,359,332				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	55,936,265	42,357,656	10,273,625	0	1,034,640	2,270,344
FSP Programs as Percent of Total	70.5%					

FY 2015/16 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: Sacramento Date: 1/4/16

	Fiscal Year 2015/16					
	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	3,679,093	3,679,093				
2. Strengthening Families	2,452,264	2,452,264				
3. Integrated Health and Wellness	1,885,000	1,885,000				
4. Mental Health Promotion	961,502	961,502				
5. Placeholder for PEI Expansion	1,423,499	1,423,499				
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Integrated Health and Wellness - SacEDAPT	735,756	485,000	75,676		54,455	120,625
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	1,219,022	1,219,022				
PEI Assigned Funds	342,486	342,486				
Total PEI Program Estimated Expenditures	12,698,622	12,447,866	75,676	0	54,455	120,625

FY 2015/16 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: Sacramento Date: 1/4/16

	Fiscal Year 2015/16					
	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. INN Project 2: MH Crisis/Urgent Care Clinic	3,500,000	3,500,000				
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					
INN Administration	229,514	229,514				
Total INN Program Estimated Expenditures	3,729,514	3,729,514	0	0	0	0

FY 2015/16 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding

County: Sacramento Date: 1/4/16

	Fiscal Year 2015/16					
	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	2,327,109	2,327,109				
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	2,327,109	2,327,109	0	0	0	0

FY 2015/16 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: Sacramento Date: 1/4/16

	Fiscal Year 2015/16					
	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	3,013,136	3,013,136				
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	3,013,136	3,013,136	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary Presentation to Mental Health Board (9/02/15)
Modified and Provided to MHSA Steering Committee December 17, 2015

A. Community Services and Supports (CSS) Component

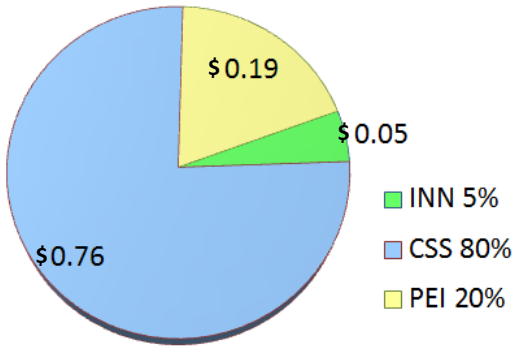
- Provides funding for mental health treatment services and supports for children/youth and their families living with severe emotional disturbance and adults living with a serious mental illness. This includes funding for the MHSA Housing Program.
- A majority of CSS funding must be directed to Full 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
    - MHSA funds have resulted in 161 built units across 8 developments since 2008
    - MHSA investment of $15m must be replenished as projects mature
- 80% 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
- 20% 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 must be sustained by CSS/PEI components (as applicable), if County so chooses
- 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 to renovate three buildings at the Stockton Boulevard complex in order to consolidate the Adult Psychiatric Support Services (APSS) clinics
- 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)
  - State revenue projections may be overestimated by $150-200M annually
- Sacramento County allocation has been reduced from 3.21% to 3.16% of State MHSA funding due to statewide recalculation of distribution methodology

CSS Expansion Phase C: Katie A. Workgroup Recommendation Approved by MHSA Steering Committee (10/15/15)

The Katie A. Workgroup recommends to the MHSA Steering Committee allocating up to $800,000 in CSS Expansion Phase C funds to increase the capacity to serve Commercially and Sexually Exploited Children (CSEC) children and youth that meet Katie A subclass criteria, as follows:

> Augmenting current Flexibly Integrated Treatment (FIT) providers AND augmenting selected outpatient providers to become FIT providers.

Competitive selection process should require:

- FIT programs be geographically located throughout Sacramento County.
- FIT programs have the capacity to meet the needs of the Commercially and Sexually Exploited Children (CSEC) subclass population.
- Clients have access to peer and family support at all stages of intake and service delivery.
- Services must be trauma-informed and responsive to the needs of the Katie A. subclass population, to include substance use disorders.
- Services should meet the needs of the diversity of the community, including but not limited to cultural competency, and include evidence-based and community-defined/promising practices that alleviate the symptoms of trauma.

Existing FIT providers would need to agree to meet the above criteria in order to receive augmentation.

MENTAL HEALTH SERVICES ACT

Draft
Innovation Project 2 Plan:
Mental Health Crisis/
Urgent Care Clinic

Posted for 30-day Public Review and Comment
January 4, 2016 through February 3, 2016

EXHIBIT B

INNOVATION WORK PLAN
Description of Community Program Planning and Local Review Processes

County Name: Sacramento
Work Plan Name: Mental Health Crisis/Urgent Care Clinic

Instructions: Utilizing the following format please provide a brief description of the Community Program Planning and Local Review Processes that were conducted as part of this Annual Update.

1. **Briefly describe the Community Program Planning Process for development of the Innovation Work Plan. It shall include the methods for obtaining stakeholder input. (suggested length – one-half page)**

The Sacramento County Division of Behavioral Health Services (DBHS) Community Planning Process for the second Innovation Project began at the February 26, 2015 Mental Health Services Act (MHSA) Steering Committee meeting. At this meeting, gaps and needs for crisis services were reviewed and the Innovation component was explained. The concept of an Innovation Project focused on adapting an urgent care/medical clinic model for individuals experiencing a mental health crisis was introduced to the MHSA Steering Committee. The Steering Committee wanted to thoughtfully consider this innovation concept and therefore continued discussion and decision to their March 2015 meeting. On March 19, 2015 the MHSA Steering Committee voted in full support of DBHS moving this proposed second Innovation Project forward.

Consistent with DBHS practice, the Division designed and conducted a community planning process to inform the development this proposed Innovation Project #2. This process included community input sessions and the formation of an Innovation Project #2 Workgroup.

In total, DBHS facilitated four (4) community input sessions with 125 participants in August 2015 to provide focused input into the design of the project and inform the Workgroup in carrying out their charge (see Attachment D):

1. August 10, 2015: Consumer and Family Member Input Session (44 participants)
2. August 11, 2015: DBHS Pharmacy and Therapeutics Committee (33 participants)
3. August 27, 2015: DBHS Cultural Competency Committee (17 participants)
4. August 31, 2015: Provider Input Session (31 participants)

The Innovation Project #2 Workgroup was comprised of fourteen members representing diverse stakeholder perspectives. The first Workgroup meeting was held on September 10, 2015. At this meeting, Workgroup members reviewed the Innovation component guidelines, current array of crisis services in the system of care, data supporting more crisis service alternatives, other urgent care clinic models, feedback from the

participants of the input sessions. The Workgroup members then began discussing the important service elements of the proposed clinic. The Workgroup met on September 16, 2015 for their second meeting. Following a robust discussion about triage services, peer support, accessing pharmacy and medical support, hours of operation, and the importance of building partnerships and collaborating with system partners, the Workgroup developed a recommendation to present to the MHA Steering Committee.

On October 15, 2015, the MHSA Steering Committee reviewed and discussed the Draft Innovation Project #2 recommendation and provided input to further shape the recommendation (see Attachment E). The Steering Committee unanimously supported moving forward with finalizing the Plan for submission to the Sacramento County Board of Supervisors and the Mental Health Services Oversight and Accountability Commission.

2. Identify the stakeholder entities involved in the Community Program Planning Process.

A fourteen member Innovation Project #2 Workgroup representing a wide array of stakeholders was established to develop a recommendation that adapts an urgent care clinic model for individuals experiencing a mental health crisis. Two members were consumer advocates, two members were family advocates (representing adults and children), four members were DBHS representatives, two members represented cultural competence/ethnic services, two member represented psychiatric services, one member represented law enforcement and one member represented the Mental Health Board (see Attachment F).

As mentioned above, four community input sessions convened to solicit input on the development of a mental health crisis/urgent care clinic. Stakeholders representing the The following participated in these input sessions: Consumers, family members; Cultural Competency Committee that included representation from the Latino, Hmong, Vietnamese, Chinese, Mien, LGBTQ, Native American, African American communities; medical and mental health service providers; system partners.

3. List the dates of the 30-day stakeholder review and public hearing. Attach substantive comments received during the stakeholder review and public hearing and responses to those comments. Indicate if none received.

The Draft Innovation Project #2 Plan will be posted as an attachment to the MHSA Fiscal Year 2015-16 Annual Update from January 4 through February 3, 2016. The Public Hearing will be conducted by the Mental Health Board on February 3, 2016 beginning at 6:00 p.m. The Public Hearing will be held at the Grantland L Johnson Center for Health and Human Services located at 7001-A East Parkway, Sacramento, California 95823 in Conference Room 1.

Innovation Work Plan Narrative

Date: January 4, 2016

County: Sacramento

Work Plan #: 2

Work Plan Name: Mental Health Crisis/Urgent Care Clinic

Purpose of Proposed Innovation Project (check all that apply)

☐ INCREASE ACCESS TO UNDERSERVED GROUPS
☒ INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
☐ PROMOTE INTERAGENCY COLLABORATION
☒ INCREASE ACCESS TO SERVICES

Briefly explain the reason for selecting the above purpose(s).

The primary purpose of this project is to increase the quality of services, including better outcomes for individuals experiencing a mental health crisis and the secondary purpose is to increase access to services. Throughout the MHSA Community Planning Processes to date, crisis services and help in a crisis has been a recurring community concern. During the economic downturn and recession, Sacramento County experienced an erosion of available community-based mental health services at all levels, including reductions to crisis response service capacity. Due to these significant budget cuts in 2009, Sacramento County's crisis response service capacity was reduced. The Crisis Stabilization Unit (CSU) closed for direct community admissions and the Mental Health Treatment Center capacity was reduced from 100 to 50 psychiatric health facility beds. Individuals in crisis and in need of mental health treatment began seeking initial crisis assistance at local emergency departments. Emergency Departments (ED) report being unable to manage the influx of individuals with a variety of mental health needs. Additionally, law enforcement officers spend large amounts of time waiting in emergency departments with individuals who present as a danger to self or others, taking officers away from other vital community responsibilities. Many community members are unable to access crisis services or immediate assistance and are inappropriately and unnecessarily hospitalized or incarcerated, utilizing more expensive hospital-based care or criminal justice system resources. This proposed program will triage and assess mental health need and level of service need for individuals experiencing a mental health crisis. By providing this service: (1) the inclusion of this program in the system of care service array will increase quality of services and result in better outcomes for individuals; (2) individuals experiencing a mental health crisis will access crisis services and linkages to mental health services, thereby increasing access to services.

Over the past two decades, urgent care clinics have emerged as an alternative care setting that improves access to quality healthcare and addresses intermediate physical health needs. Urgent care clinics also provide an alternative to emergency department

visits. There is a gap within Sacramento County's current mental health system of care for services that provide intermediate care for individuals experiencing a mental health crisis. Through the community planning process, Sacramento County's consumers, family members, community stakeholders and system partners recommend adapting an urgent care clinic/medical model as an intermediate step between routine outpatient mental health care and mental health crisis interventions.

This proposed Innovation Project will test the adaptation of an effective 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. In addition, this project will integrate wellness and recovery principles into service delivery. Sacramento County, Division of Behavioral Health Services (DBHS) seeks to learn whether this adaptation will result in improving quality of service as well as increased access to services. In turn, this adaptation will achieve better client outcomes including the following: creating an effective alternative for individuals needing crisis care, improving the client experience in achieving and maintaining wellness, reducing unnecessary or inappropriate psychiatric hospitalizations and incarcerations, reducing emergency department visits, improving care coordination across the system of care to include linkages to other needed resources and timely access to mental health services.

Innovation Work Plan Narrative

Project Description

Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (Suggested length - one page)

The learning component of this project will test adapting an urgent care clinic/medical model, which is an intermediate step between routine and emergency care, to provide mental health services for individuals of any age experiencing an urgent mental health need.

Project outcomes include:
- creating alternatives for individuals needing urgent mental health care
- improving the client experience in achieving and maintaining wellness
- reducing unnecessary or inappropriate psychiatric hospitalizations and incarcerations
- reducing emergency department visits for urgent mental health needs
- improving care coordination across the system of care

Clinic will be warm and inviting, with an open un-locked environment. Clinic should be sited with access to public transportation and pharmacy, as well as easy access to medical care. Clinic will provide services in a timely manner. Services will be culturally and linguistically competent, with sensitivity to diverse cultures. Services will be individualized based on culture, age, and development.

Clinic will focus on targeting an urgent mental health need rather than providing ongoing services, and will complement rather than augment services of existing mental health outpatient providers. As a mental health urgent care clinic, services are distinctly different from respite or crisis residential services. Clinic will provide alcohol and drug screening but will not provide detox.

Service array will include:
- Triage (to include Peer and Family support)
- Phone triage available
- Comprehensive Behavioral Health Assessment (to include bio/psycho/social and tailored to be appropriate for this clinic model)
- Medical Screening
- Crisis Intervention
- Medication Support
- Peer and Family Support
- Care Coordination/Linkage to Services
- Transportation Assistance

The Clinic will be staffed/supported by:

- Peers and Family Members
- Registered Nurse, Licensed Vocational Nurse, or Nurse Practitioner (ideal)
- Psychiatrist
- Licensed Clinicians (MFT, LCSW, LPCC)
- Alcohol and other Drug Specialist
- Support/Administrative staff (reception, billing, etc.)
- Care Coordination/Case Manager (to include discharge planning function)
- Psychiatric Residents
- Volunteers/Trainees
- Capacity to provide playcare
- Interpreter/Cultural Broker
- Staff will be cross-trained in resource referral and linkage

The clinic hours would ideally be 24/7 operations; however, at minimum, clinic will be open after-hours, weekends and holidays, seven (7) days per week.

Innovation Work Plan Narrative

Contribution to Learning

Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (Suggested length - one page)

Urgent care clinics have been recognized as a successful intermediate step between routine and emergency care in the physical health realm. This proposed Innovation Project will adapt the effective urgent care clinic/medical model to provide crisis response/care for individuals experiencing a mental health crisis. In addition, this project will integrate wellness and recovery principles into delivery of services. Sacramento County, Division of Behavioral Health Services (DBHS) seeks to learn *whether* this adaptation will result in improving quality of service as well as increased access to services. In turn, this project will test *how* the adaption can improve the following client and system outcomes: creating an effective alternative for individuals needing crisis care, improving the client experience in achieving and maintaining wellness, reducing unnecessary or inappropriate psychiatric hospitalizations and incarcerations, reducing emergency department visits, improving care coordination across the system of care to include linkages to other needed resources and timely access to mental health services.

Innovation Work Plan Narrative

Timeline

Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (Suggested length - one page)

Implementation/Completion Dates: 05/16 – 5/21
MM/YY – MM/YY

This Innovation Project will span five years and will be implemented in phases.

Phase One: May 2016 – April 2017 activities

1. The Division of Behavioral Health Services (DBHS) will develop and facilitate a competitive selection process to award a contract to an organization to implement Project/program services.
2. DBHS will negotiate and enter into a contract/agreement with selected organization (contractor) to implement Project/program services.
3. DBHS, in collaboration with University of California (UC) Davis Department of Psychiatry, and contractor, will develop an evaluation core and framework.
4. Contractor will propose clinic site, develop procedures and hire and train clinic staff.
5. DBHS will provide technical support and direction during program start-up/initial implementation to contractor related to program start-up tasks, data collection and evaluation framework.

Phase Two: May 2017 – April 2018 activities

1. Contractor will begin service delivery.
2. DBHS and contractor will outreach to the community, system partners, mental health service providers, local emergency departments, law enforcement, to provide information about Project/program and program access.
3. DBHS will provide ongoing technical support and direction during to contractor related to program service delivery, data collection and evaluation activities.

Phase Three: May 2018 – November 2020

1. Project/program services will be fully implemented, including implementation of evaluation framework.
2. Routine meetings will be convened to report out on the evaluation framework and process.

3. Sustainability options will be explored and discussed. Throughout Project implementation, significant efforts will be directed toward sustainability options should the project be successful.

Phase Four: December 2020 – May 2021

1. Evaluation framework and process will be in its final stages and a final report will be developed.
2. Feasibility of replication will be determined.

Innovation Work Plan Narrative

Project Measurement

Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.

DBHS in collaboration with the University of California (UC) Davis Department of Psychiatry will evaluate the effectiveness of adapting an urgent care clinic/medical model in a mental health setting, focusing on wellness and recovery. The following client and system outcomes will be assessed and evaluated: improving the client experience in achieving and maintaining wellness, reducing unnecessary or inappropriate psychiatric hospitalizations and incarcerations, reducing emergency department visits, improving care coordination across the system of care to include linkages to other needed resources and timely access to mental health services.

Leveraging UC Davis Department of Psychiatry expertise, in collaboration with DBHS Research, Evaluation, and Performance Outcomes (REPO) Unit, the evaluation team will develop an evaluation framework to include client satisfaction surveys and pre and post client data. Pre and post data may include hospitalizations, emergency department (ED) utilization, incarceration, time spent by law enforcement, etc. There will be many levels to this Project and the stakeholders will have input along the way.

Project progress and outcomes will be communicated to the community through MHSA email blasts and presentations and updates provided at MHSA Steering Committee and Mental Health Board meetings.

Innovation Work Plan Narrative

Leveraging Resources (if applicable)

Provide a list of resources expected to be leveraged, if applicable.

The Division of Behavioral Health Services (DBHS) will collaborate with University of California (UC) Davis Department of Psychiatry on the evaluation for this Innovation project. This is a natural partnership as we jointly strive to provide high quality services that promote holistic recovery, optimum health and resiliency.

The UC Davis Department of Psychiatry will provide in kind faculty research and necessary research support staff, to include statistical assistance, as part of the evaluation core at no cost to the Project. As indicated, the evaluation of the Project will include two distinct evaluation components: evaluation of the urgent care model adaption and assessment of client and system outcomes. These in kind services will include working with DBHS in identifying the variables which will be measured in order to determine the overall success or failure of the Project and including measuring relative client and system outcomes.

The evaluation framework will include statistical support, program design, and general consultation services. The evaluation team will obtain approval from the County of Sacramento Research Review Committee (RRC) and the UC Davis Institutional Review Board (IRB).

Innovation Project #2: Mental Health Urgent/Crisis Care Clinic
Community Planning Process Summary

February 19 & March 19, 2015	Introduced to MHSA Steering Committee: Innovative Project #2: Mental Health Urgent/Crisis Care Clinic Learning: Adapting Urgent Care Clinic model for individuals experiencing a mental health crisis effective strategy for reducing unnecessary ED visits, unnecessary hospitalizations, improve the client experience, in our community Action: MHSA Steering Committee tasked Workgroup with developing a recommendation
Aug. 10, 2015	Consumer/Family Member Focus Group – 44 participants Takeaways: 24/7, medication support, crisis intervention, information and referral and system navigation, coordination of care, short wait time, transportation, good alternative to hospitalization
Aug. 11, 2015	Pharmacy and Therapeutics Committee Focus Group – 33 participants Takeaways: Medication support, triage services, medical clearance, coordination of care, point of entry to MH services, transportation
Aug. 27, 2015	Cultural Competence Committee Focus Group – 17 participants Takeaways: Triage services, coordination of care, information and referral and system navigation, support and education to family members, point of entry to MH services, transportation, outreach and education to ethnic communities and CBOs
Aug. 31, 2015	Provider Focus Group – 31 participants Takeaways: Medication support, peer support, triage services, crisis intervention, medical clearance, coordination of care, point of entry to MH services, bridging support from time client has been referred for outpatient services to medication appointment, transportation
Sept. 10, 2015 Sept. 16, 2015	Workgroup Workgroup Composition: Consumers, Family Members, MHSA Steering Committee Members, MHB Member, Cultural Competency Representatives, Law Enforcement, Adult and Child Psychiatrists, DBHS Staff Meeting Discussion included: • Innovation Component Guidelines • Current array of crisis services in system of care • Data presentation related to service gaps and needs • Other Crisis Walk-in Clinics – other models and operations • Focus Groups input presented to inform discussion
Oct 15, 2015	Recommendation was presented to the Steering Committee. Steering Committee refined the recommendation and supported moving it forward to include in the Annual Update.

INN Project #2: Mental Health Urgent Care Clinic Workgroup Recommendation as Approved by the MHSA Steering Committee (10/15/15)

The Innovation Project #2 Workgroup recommends to the MHSA Steering Committee allocating up to $2.5m in INN Component funds per year for five years for the development of one new Mental Health Urgent Care Clinic for individuals experiencing an urgent mental health need.

The learning component of this project will test adapting an urgent care clinic model, which is an intermediate step between routine and emergency care, to provide mental health services for individuals of any age experiencing an urgent mental health need.

Project outcomes include:

- creating alternatives for individuals needing urgent mental health care
- improving the client experience in achieving and maintaining wellness
- reducing unnecessary or inappropriate psychiatric hospitalizations and incarcerations
- reducing emergency department visits for urgent mental health needs
- improving care coordination across the system of care

Clinic will be warm and inviting, with an open un-locked environment. Clinic should be sited with access to public transportation and pharmacy, as well as easy access to medical care. Clinic will provide services in a timely manner. Services will be culturally and linguistically competent, with sensitivity to diverse cultures. Services will be individualized based on culture, age, and development.

Clinic will focus on targeting an urgent mental health need rather than providing ongoing services, and will complement rather than augment services of existing mental health outpatient providers. As a mental health urgent care clinic, services are distinctly different from respite or crisis residential services. Clinic will provide alcohol and drug screening but will not provide detox.

Service array will include:

- Triage (to include Peer and Family support)
  - Phone triage available
- Comprehensive Behavioral Health Assessment (to include bio/psycho/social and tailored to be appropriate for this clinic model)
- Medical Screening
- Crisis Intervention
- Medication Support
- Peer and Family Support
- Care Coordination/Linkage to Services
- Transportation Assistance

The Clinic will be staffed by:

- Peers and Family Members
- RN, LVN, or NP (ideal)
- Psychiatrist
- Licensed Clinicians (MFT, LCSW,LPCC)
- AOD Specialist
- Support/Admin staff (reception, billing, etc)
- Care Coordination/Case Manager (to include discharge planning function)
- Psychiatric Residents
- Volunteers/Trainees
- Capacity to provide playcare
- Interpreter/Cultural Broker

Overarching values:

- Bilingual/bicultural staff
- Staff cross-trained in resource referral and linkage

Clinic hours: Ideally 24/7 operations, if funding permits. If 24/7 is not possible, at minimum after-hours, weekends and holidays (7 days per week).

Sacramento County MHSA
Innovation Project #2
Mental Health Crisis Care Clinic

Innovation Project #2 Workgroup Composition & Membership	
Stakeholder Group	**Member**
UC Davis Department of Psychiatry and Behavioral Sciences	Robert Hales, M.D.
UC Davis Department of Psychiatry and Behavioral Sciences	Robert Horst, M.D.
Division of Behavioral Health Services	Melissa Jacobs
Division of Behavioral Health Services	Steve Davidson
Division of Behavioral Health Services	Kelli Weaver
Division of Behavioral Health Services Research, Evaluations and Performance Outcomes	Dawn Williams
Ethnic Services/Cultural Competency	Mary Nakamura
Consumer Advocate	Andrea Crook
Family Advocate	Sandena Bader
Adult Family Advocate	Blia Cha
Crossroads Diversified	Iris Rivera
Law Enforcement	Kim Mojica
MHSA SC: Consumer, Older Adult	Frank Topping
Mental Health Board	Leonard Marowitz

MHSA COUNTY COMPLIANCE CERTIFICATION

County/City: Sacramento

☐ Three-Year Program and Expenditure Plan
☒ Annual Update

Local Mental Health Director		Program Lead	
Name:	Uma K. Zykofsky	Name:	Jane Ann LeBlanc
Telephone Number:	(916) 875-9904	Telephone Number:	(916) 875-0188
E-mail:	zykofskyu@saccounty.net	E-mail:	leblancj@saccounty.net
Local Mental Health Mailing Address:			
7001-A East Parkway, Suite 400 Sacramento, CA 95823			

I hereby certify that I am the official responsible for the administration of county/city mental health services in and for said county/city and that the County/City has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this Three-Year Program and Expenditure Plan or Annual Update, including stakeholder participation and nonsupplantation requirements.

This Three-Year Program and Expenditure Plan or Annual Update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft Three-Year Program and Expenditure Plan or Annual Update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on _____.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

All documents in the attached annual update are true and correct.

Uma K. Zykofsky _____
Local Mental Health Director (PRINT)

_____
Signature Date

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	
Name:	Uma K. Zykofsky	Name:	
Telephone Number:	(916) 875-9904	Telephone Number:	
E-mail:	zykofskyu@saccounty.net	E-mail:	
Local Mental Health Mailing Address: 7001-A East Parkway, Suite 400 Sacramento, CA 95823			

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.

Uma K. Zykofsky _____
Local Mental Health Director (PRINT) Signature Date

I hereby certify that for the fiscal year ended June 30, _____, 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 _____ for the fiscal year ended June 30,_____. I further certify that for the fiscal year ended June 30,_____, 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.

_____ _____
County Auditor Controller / City Financial Officer (PRINT) Signature Date

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)