SACRAMENTO COUNTY

BHSA COMMUNITY PLANNING PROCESS

Phase One: Summary

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SACRAMENTO COUNTY

Behavioral Health Services Act (BHSA)
Community Planning Process: Phase One Report

Background

Sacramento County Behavioral Health Services (BHS) provides a full continuum of care spanning **mental health** and **substance use prevention and treatment services** aimed at improving overall well-being. These include peer support, assessments, treatment planning, care coordination, therapy, counseling, crisis intervention, and medication management. Services are individualized to address a range of conditions—including anxiety, depression, addiction, psychosis, and trauma—while promoting coping skills, resilience, and long-term recovery. Care is delivered in multiple settings, from hospitals and residential programs to outpatient clinics, schools, and community-based environments.

California's **Behavioral Health Services Act (BHSA)**, passed by voters in 2024 through Proposition 1, replaces the 2004 Mental Health Services Act (MHSA). Funded by a 1% tax on personal income over $1 million, the MHSA originally transformed California's behavioral health system to serve those with or at risk of serious mental illness. The new BHSA builds upon that foundation by prioritizing individuals with significant behavioral health needs, expanding access to treatment for substance use disorders, increasing housing and supportive services, and investing in the behavioral health workforce. It also enhances oversight and accountability at both the state and local levels to promote transparency and measurable outcomes. BHSA also greatly expands the specific groups who are to be included in the Community Planning Process.

Community Planning Process

Sacramento County BHS designed the BHSA Community Planning Process (CPP) in two phases. **Phase One** spanned July through early October 2025 and Phase Two began in November 2025. In Phase One, BHS engaged hundreds of community members and partners through **in-person meetings, virtual forums, focus groups, and input sessions**. These gatherings brought together diverse perspectives—including individuals with lived experience, providers, advocates, and community organizations. BHS also developed and distributed a survey to gather additional input. To ensure inclusivity, the County also distributed surveys translated into Sacramento's seven threshold languages—Arabic, Chinese, Farsi, Hmong, Russian, Spanish, and Vietnamese—gathering additional feedback from communities historically underrepresented in planning processes.

BHS reached out to a broad array of community partner groups, which included:

Community Partner Groups			
Health & Behavioral Health Providers	**Individuals & Families with Lived Experience**	**Education, Civic, & Public Systems**	**Social & Community Services**
• Providers of mental health services and substance use disorder treatment services • Health care organizations, including hospitals • Health care service plans, including Medi-Cal Managed Care Plans (MCPs) • Disability insurers (a commercial disability insurer that covers hospital, medical or surgical benefits as defined in Insurance Code section 106, subdivision (b)) • Emergency medical services • Tribal & Indian Health Program designees established for Medi-Cal Tribal consultation purposes	• Eligible adults and older adults (individuals with lived experience) • Families of eligible children and youth, eligible adults, and eligible older adults (families with lived experience) • Youths (individuals with lived experience) or youth mental health or substance use disorder organizations	• Local education agencies • Higher education partners • Early childhood organizations • Public safety partners, including county juvenile justice agencies • The five most populous cities in counties with a population greater than 200,000 • Labor representative organizations • Veterans • Representatives from veterans' organizations • Local public health jurisdictions	• County social services and child welfare agencies • Continuums of care, including representatives from the homeless service provider community • Regional centers • Area agencies on aging • Independent living centers • Community-based organizations serving culturally and linguistically diverse constituents

Intentional efforts were made to also include diverse viewpoints from:

- Representatives from organizations specializing in working with underserved racially and ethnically diverse communities,
- Representatives from LGBTQ+ communities,
- Victims of domestic violence and sexual abuse, and
- People with lived experience of homelessness

Nearly 2,000 individuals were invited to attend multiple events in person or virtually, including agendized presentations at regularly scheduled meetings. A follow up email shared the survey version of the input session with the same partners, asking that it be also shared widely with their community contacts. The public events and survey were featured on both the Sacramento County Facebook and Instagram pages, whose followers total over 100,000. Over 500 individuals participated in events, and more than 200 responded to the surveys. The feedback from these diverse viewpoints is reflected in this report.

Sacramento County BHS launched Phase One of the BHSA Community Planning Process with a shared goal: **to strengthen behavioral health for all**. Phase One was designed to gather valuable community input on BHS, identify what is working well ("Glows"), highlight areas for improvement ("Grows"), and foster collaborations with community members and system partners. The insights gathered will guide future planning and resource allocation, ensuring that behavioral health services reflect the priorities and needs of Sacramento's diverse communities.

Phase One focused on sharing foundational information about this transition from MHSA to BHSA, introducing the key shifts that will shape the next era of behavioral health in Sacramento County. The collective insights from this phase provide a roadmap for continued collaboration, transparency, and innovation as the County works toward a more equitable and integrated behavioral health system.

As Sacramento County BHS prepares to launch **Phase Two** of the BHSA Community Planning Process, the County will share a summary of the key findings gathered during Phase One and return to the community to **validate the information**. This next phase is an opportunity to confirm that the County accurately captured community feedback and to gather any **additional insights or updates** that participants wish to share. The information collected will be used to inform the development of the first BHSA Integrated Plan across all funding sources administered as a Behavioral Health Plan.

Community Conversations: BHSA Phase One Behavioral Health Systems Findings

Key Glows	
• **Availability and Accessibility**	• **Cultural and Language Equity**
• **Reduced Stigma & Increased Community Trust**	• **Cross-Sector Coordination & Community Collaboration**
• **Commitment to Community, Engagement & Outreach**	• **Success of Current Programs and Service Expansion**
• **Workforce Development, Education, and Peer Led Services**	• **Strength Based, Trauma Informed and Innovative Approaches**

Community feedback reflected strong appreciation and recognition of BHS's progress in expanding access, promoting equity, and strengthening collaboration across systems. Respondents highlighted a wide range of "glows," demonstrating that while challenges remain, the County has made meaningful strides in creating a more responsive, coordinated, and person-centered behavioral health system.

Availability and Accessibility emerged as one of the most celebrated strengths. Participants noted that the system offers a wide range of services with increasingly low barriers to entry, including walk-in access, centralized intake for certain programs, and same-day appointments. The integration of mental health and substance use treatment services, along with the successful implementation of the 988 crisis line, has enhanced service coordination and improved response times. Many commended the expansion of CORE (*Community Outreach Recovery Empowerment*) Service Centers, the Mental Health Urgent Care Clinic, Full-Service Partnerships (FSP), and community-based outreach programs that allow people to access help where they are—whether through schools, housing programs, or community events.

Cultural and Language Equity was another major area of praise. Community members observed an increasing commitment to cultural responsiveness and language access, including bilingual and bicultural staffing, translation and interpreter services, and culturally specific programming. Respondents recognized consistent efforts to ensure that services are inclusive, reflect the diversity of Sacramento County, and are responsive to LGBTQ+, BIPOC, and immigrant communities. BHS's Cultural Competence Committee, equity-driven contracting, and community representation in leadership were seen as meaningful indicators of progress.

Efforts to **reduce stigma and build community trust** were widely acknowledged, with particular praise for campaigns such as *Stop Stigma Sacramento*, *Journey of Hope*, and the *Speakers Bureau*. These initiatives were credited with fostering understanding, reducing shame, and helping normalize conversations around mental health and

recovery. Community members expressed appreciation for outreach strategies that make behavioral health visible, relatable, and accessible to all.

Cross-sector coordination and community collaboration were repeatedly cited as defining strengths of the County's behavioral health system. Community members commended the seamless coordination among County departments, community-based organizations, and systems such as law enforcement, child welfare, and housing. Programs like the Community Wellness Response Team (CWRT), partnerships with emergency medical services, and cross-agency efforts with probation, Child Protective Services, and the Department of Human Assistance were recognized for providing holistic and compassionate care. Many respondents noted that Sacramento County's collaborative approach—holding partner meetings, blending funding streams, and prioritizing joint planning—has strengthened trust and service delivery across sectors.

The County's **commitment to community engagement and outreach** also stood out. Respondents highlighted strong partnerships with local organizations, consistent communication with community partners, and visible presence at community events. The County's willingness to listen, gather feedback, and adjust programming based on community needs was seen as both authentic and impactful. Outreach teams, school-based wellness programs, and engagement with unhoused individuals were frequently mentioned as examples of successful community-centered practice.

Several respondents praised the **success of current programs and service expansion**, noting that the system now offers a robust continuum of care—from prevention to crisis response to recovery supports. The development of new housing initiatives, wellness centers, and integrated care models was viewed as particularly transformative. Participants recognized the County's ongoing investment in CalAIM, Enhanced Care Management, and Behavioral Health Bridge Housing as evidence of forward-thinking leadership committed to meeting evolving community needs.

Workforce development, education, and peer-led services were also viewed as major glows. Respondents expressed gratitude for the many training opportunities, certifications, and ongoing professional development offered to staff and peers. The integration of peer specialists into service delivery, administrative discussions, and leadership structures was seen as a significant advancement toward a more recovery-oriented system. Peers were praised for their empathy, lived experience, and ability to bridge trust between clients and providers.

Finally, community members acknowledged the County's **strength-based, trauma-informed, and innovative approaches**. Respondents noted that programs are increasingly flexible, client-centered, and collaborative, emphasizing harm reduction, family involvement, and resilience. County and provider staff were frequently described

as caring, dedicated, and responsive qualities that have inspired renewed hope among participants.

Overall, the community celebrated Sacramento County Behavioral Health Services for its accessibility, innovation, cultural responsiveness, and strong partnerships. The County's ability to build trust, expand services, and integrate care across systems was widely recognized as a model of progress, laying a strong foundation for continued growth and equity in behavioral health care.

Key Grows	
• Housing Stability and Whole Person Support	• Access, Navigation, and System Responsiveness
• Equity Inclusion and Cultural Responsiveness	• Workforce Stability, Peer Integration, and Quality Oversight
• System Coordination, Accountability, and Transparency	• Prevention, Resilience, and Family Supports

Community and provider feedback continues to underscore the urgent need for a more accessible, coordinated, and equitable behavioral health system in Sacramento County. While progress has been made in expanding services and crisis response, many residents continue to experience barriers to timely and appropriate care. Participants described ongoing challenges with housing insecurity, complex and fragmented access pathways, workforce shortages, and inequities in service delivery. Six central themes emerged from the feedback, reflecting both longstanding needs and new opportunities for improvement.

The most important thing among these is **housing stability and whole-person support**. The community consistently identified the lack of affordable, supportive, and transitional housing as the greatest barrier to recovery. Participants called for increased housing capacity—such as shelters, safe parking, and hygiene facilities—and greater coordination between behavioral health, housing, and social services. There is also a strong emphasis on addressing social determinants of health by integrating case management, employment assistance, and transportation supports into behavioral health services.

The second major theme is **access, navigation, and system responsiveness**. Many described the behavioral health system as confusing and difficult to navigate, particularly when attempting to access crisis care. The proliferation of access points—such as 911, 988, CCIT, CWRT, and other crisis teams—has led to fragmentation and inconsistent responses. Community members strongly recommend establishing a centralized access hub with live capacity updates, multiple entry options, same-day appointments, and multilingual assistance. They also emphasized the need for broader outreach and public education to ensure people know what services are available and how to reach them.

A third key theme is **equity, inclusion, and cultural responsiveness**. Community members emphasized that language, culture, gender identity, and ethnicity often determine whether individuals feel welcomed or excluded from care. There is a call for more culturally and linguistically matched providers, including interpreters for emerging language needs such as Chinese and Farsi/Dari, as well as gender-affirming and ethnically specific programs. Community members urge Behavioral Health Services to embed equity expectations in funding and contracting, expand cultural humility training, and ensure that staff and leadership reflect the diversity of Sacramento's communities.

Workforce sustainability, peer integration, and quality oversight also emerged as a top concern. The behavioral health workforce faces burnout, high caseloads, and low pay—especially among peers and frontline staff. Participants recommended increased compensation, retention incentives, training, and safety equipment for community-based providers. They also emphasized the importance of clearly defining peer roles, supporting certification, and ensuring peers are valued as integral members of the care team.

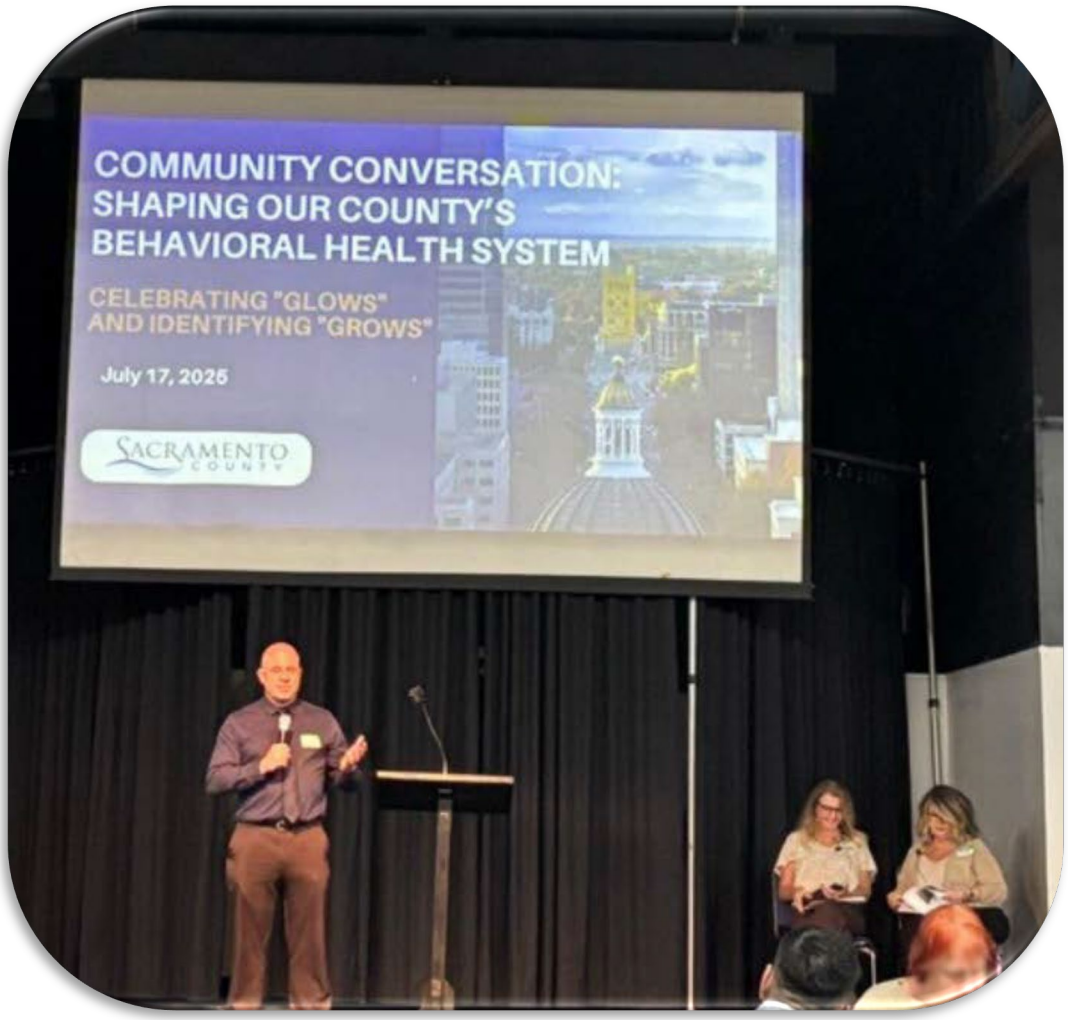
The fifth theme, **system coordination, accountability, and transparency**, reflects frustration with duplication, unclear roles, and inconsistent coordination among providers and systems. Community members noted that overlapping crisis programs and administrative processes often lead to service gaps and confusion. They highlighted the need for standardized handoffs between programs, alignment of administrative and clinical decision-making, and greater transparency in funding and outcomes. Participants recommended publicly available dashboards that track service timeliness, client satisfaction, and funding allocations to promote accountability and continuous improvement.

Finally, community members highlighted the need for **prevention, resilience, and family supports**. Participants encouraged investment in life skills, parenting, fatherhood, and family advocacy programs that promote wellness and prevent crises. There were also calls for increased supports for older adults, individuals with disabilities, and transitional youth, as well as activities that foster connection and stability before crises arise.

Overall, the feedback reflects a clear vision for a behavioral health system that is person-centered, integrated, and equitable. Sacramento County's path forward will require sustained investment in housing stability, streamlined access, culturally responsive care, workforce development, and transparent performance monitoring. Together, these efforts can ensure that community members — regardless of background or circumstance — can access the right care at the right time.

The following pages feature quotes that were thoughtfully gathered during community planning sessions, reflecting the diverse voices, experiences, and aspirations of local residents, providers, and staff. These quotes have been carefully reviewed and

categorized by common themes to highlight shared priorities, recurring concerns, and collective hopes for the future. By organizing the input in this way, BHS aims to illuminate patterns in community feedback and ensure that planning efforts remain grounded in authentic, community-driven dialogue.



***Note**: Most feedback was received in writing and was left unedited. Italicized text in parentheses was added to spell out acronyms.*

GLOWS

Availability & Accessibility – *Walk-in & After-hours Options. System Capacity & Service Variety. Locations & Mobile Services. Integration of MH and SUPT Services. Linkage & Navigation. Ease of Entry. Website & Technology. Timely Service. Other Access.*

Walk-in & After-hours Options

- Walk-in hours list increase accessibility.
- County Mental Health Adult & Child Provider Walk-in Hours List
- Walk-in/call-in availability for mental health and substance use services has increased timely access to care!
- I'm glad folks can walk in or call in and get help. They don't have to wait for a referral!
- Housing support for clients' families, allowing for walk-ins for caregivers/clients to get services quicker rather than going through Access directly
- I like that we can call, email, or walk-in to request services from Sac County contracted providers.
- Supporting early childhood mental health in walk-in clinics
- Ability for students/families to "walk-in" for mental health/counseling support at our local community partners.
- Accessing SMHS (*Specialty Mental Health Services*) has gotten better with consumers being able to call in/walk-in directly to request services
- Ability to walk into providers for an assessment.
- Creating walk-in hours for MHPs (*Mental Health Professionals*)
- Allowing walk-ins at each provider's location expedites entry into services
- Walk-in assessments improve service access
- Walk-in hours at all clinics
- Walk-in options
- It is easier to get into services, walk-ins.
- Self-referrals/walk-ins
- Walk-in CORE (*Community Outreach Recovery Empowerment*) programs
- Walk-in process
- Flexibility of supports - walk-in clinics, referral through ACCESS, etc.
- Drop-in respite programs allow youth/TAY to build relationships with service providers, which leads them to trust service providers and ask for services they need, especially for mental health.
- Increased after hour services

- The expanded hours at MHUCC (*Mental Health Urgent Care Clinic*) are wonderful
- Making urgent care clinics available 24/7.
- The open assessment hours have added more entry options
- FSPs (*Full Service Partnership*) afterhours response

System Capacity & Service Variety

- Service capacity expanding
- Capacity to serve those in need
- Capacity Building and engagement.
- Variety of MH *(Mental Health)* care in the county
- Variety of resources
- Variety of services
- Good variety of services
- Variety of services targeting demos often ignored.
- Lots of community resources available
- Wide array of services that are easy to access.
- Full continuum – good variety of services
- Built out continuum of care
- Continuum of services
- Provides an extraordinary and comprehensive range of behavioral health services
- Wide range of skills and specialties with providers
- Range of MH *(Mental Health)* services from moderate to high needs and crisis
- Range of services available for those who volunteer for treatment
- Despite not being necessarily familiar with them, the sheer amount of programs is impressive
- Comprehensive service offerings are available for people regardless of what level of care they need now or later.
- Love our consistent overview of our "system of care"
- Diverse service availability
- Diverse programming
- Services for different levels of need
- Services for multiple levels of needs
- There are a number of services available to the community
- Being a large county, we have resources that other counties do not necessarily have.
- Offer an array of services for the community
- Availability of services
- Strong/good mix of providers
- System covers everything from early intervention to more intensive services like residential
- Comprehensive Service Offerings

- Comprehensive services
- Comprehensive services-easily accessible
- Abundance of BH crisis services/programs

Locations & Mobile Services

- Number of CORE (*Community Outreach Recovery Empowerment*) locations in the county
- Geographically located CORE centers are accessible
- The new CORE service locations have made access easier
- Wide dispersal within Sacramento area
- Improving location and ease of getting to BHS
- Service providers across Sacramento County in most zip codes, which allows for easier physical access to services.
- Regional services
- Multiple locations for services
- Local service locations
- Clinicians on school sites and readily available mental health services are accessible to Sac County youth on school campuses
- Ability to provide in-office and community-based services so we can literally and figuratively meet youth and families where they're at.
- Allowing for a variety of professional services to be provided to one client/family by same agency
- Services meeting client's where they at
- Agencies encompassing many services in one stop
- Providers offering "on the streets" services
- Mobile services
- Mobile clinics
- Multiple crises access points (CCIT [*Co-response Crisis Intervention Team*], MHUCC [*Mental Health Urgent Care Clinic*], BHS-SAC [*Behavioral Health Services-Screening And Coordination*])
- Multiple entry points for services
- Lots of points of entry into BH services

Integration of Mental Health & Substance Use Prevention and Treatment Services

- Success in merging Access and SUPT (*Substance Use Prevention and Treatment*).
- I've heard great feedback about the SUD (*Substance Use Disorder*) screening process from consumers!
- SUD and Mental Health merged

- Integration of SUPT and MH across BHS
- Beginning to integrate mental health services into SUD services
- Integrating SUPT and BHS access to services.
- BHS Integration-MH and SUD Services
- Like that we combined the MH + SUPT call center numbers into one
- Integrated screening is now available
- Integrated Entry Point: BHS-SAC (*Behavioral Health Services-Screening And Coordination)*
- Integrated call center – both Mental Health and SUPT
- We are beginning to integrate more MH/SUD services into Safe Stay communities – which I think is particularly effective because people have their basic survival needs met and can focus more on MH/SUD
- Efforts are being made to offer integrated behavioral health services.
- Centralized Crisis Call Center
- Integrated mental health and substance use treatment – long overdue!
- Merging MH ACCESS and SOC SUPT access lines to a unified line
- A single number to call for both MH and SUD
- Providing streamlined access via centralized call center for those seeking MH services, providing intensive outpatient MH services that work towards stabilizing those with severe MH.
- Streamlined access to services.
- Including the AOD (*Alcohol and Other Drug*) line with the BH (*Behavioral Health*) line has improved access and client experiences
- Integrated
- Mental health and SUD integration
- Work toward integration of SUPT and BHS services
- Integrated Care Models
- Mental health and substance use merging big win
- People can get linked to MH or SUPT through one source instead of separate places
- Partnerships between mental health and substance use with reframing around “behavioral health.”

Linkage & Navigation

- Access to services, specifically when a critical need arises. Easier process for 9-8-8 access to free crisis interventions
- Linking people to housing.
- Being linked with 988 is very helpful for those in crises
- Local homeless navigator connects & supports clients getting connected to BHS
- Navigation services

- Behavioral Health Navigators to inform, connect, and assist families to apply for health insurance.
- Ability to link people to resources with easier accessibility - a simple phone call can be a game changer.
- But on the flipside, once they understand what mental health services are out there, they feel more of a sense of relief when the child returns home, knowing there is support.
- BHS including case management and connections to resources
- CORE (*Community Outreach Recovery Empowerment*) instead of RST (*Regional Support Team*) vs. TCORE (*Transitional Community Opportunities for Recovery and Engagement*) makes linkage easier with a higher level of support to clients
- Providers are also able to link to services which helps clients to be seen faster
- Linkages

Ease of Entry

- It's easy to access and there is plenty of ways to access support.
- Making services easy to access and widening the "door" to get into treatment.
- Lots of entry points.
- The access of services & the emphasis on the connection to the underserved.
- Easy to remember the number
- Assessments are straightforward with an easier process
- Multiple entry points to services
- One number to call for help
- Access to services being streamlined
- Resource repository, for those in need.
- Families can go straight to providers to access services (instead of having to go thru Access referral)
- Access - A central referral line for staff or families to refer themselves, has been a good model.
- Ease of access to mental health
- Ease of Entry
- Easier access
- Easier access to services
- Central intake for some of the services
- Implementation of “no wrong door” policy, creating ease of access to mental health
- There is no wrong way to receive support
- No wrong door
- No wrong door to access BHS
- No wrong door policies
- Improved access to services (“No wrong door”)

Website & Technology

- Progress with initiative to improve & revamp the Sac County website/webpages
- The Sacramento County website is very user-friendly and provides links to a lot of different services
- Websites that do not look like government
- Revamp website for consumers
- The BHS website has a lot of helpful information available
- Update our website on services and events that our funding has been utilized to give support to.
- The people who have the wherewithal to access services online can do a great job of that
- The web content is easily navigated and understandable
- Brilliant dashboards by data analytics
- Bringing information to all
- Well-equipped offices and functional use of technology
- Removing obstacles to care (telehealth).
- Telehealth Services
- Telehealth services
- Online forms seem more efficient for referrals
- Phone assessments are easier to complete and access
- Assessment and linkage by phone appointments

Timely Services

- Quick responsive actions
- Quick access to services
- Same-day medication provision at some sites
- Ability for clients to call SUPT (*Substance Use Prevention and Treatment)* and get a same-day assessment
- Referrals to outpatient services made same day
- Decreased time for MH Diversion Eligibility assessment
- Improved time to assessment in Diversion programs
- Response time Collab Court participation
- Reduce and placement wait times
- Clear and easy mechanisms for me differ *(to defer to*) in the field with no wait.
- Quick response to referrals for services.
- I'm glad people don't have to wait for referrals.
- Immediate resources
- Residential SUD (*Substance Use Disorder*) treatment is much quicker to get into
- The quick turnaround when assisting families
- Increased Access to Mental Health Resources – Offering more opportunities for individuals and families to receive timely behavioral health services.

Other Access

- I think you provide access to people once they are in the system
- Providing Services to clients close to the service provider
- Easier to access mental health for seniors
- I believe one of the strengths of behavioral health is its accessibility to everyone.
- Cross community access
- Access to SMH (*Specialty Mental Health*)
- Increasing access
- Increased access
- Increasing access and service levels.
- The services provided and the accessibility
- Families direct connect to services vs Access Referral
- Some strengths include lowering the barriers to treatment.
- Breaking barriers: medical necessities and access to services
- Removal of barriers in accessing services

Cultural & Language Equity *– Language Services. Diverse staff. Cultural Competence Efforts. Culturally Supportive Programs.*

Language Services

- Let all know of the services in various languages
- Language access and cultural brokerage – we are doing a great job at providing these services
- Language and cultural barriers are reduced with help of collaboration between CWRT and outreach center
- Program staffing- Being able to provide services in families' primary or preferred language rather than using an interpreter.
- Engaging diverse communities translated into programs
- Effort to promote and connect folks to services in multiple languages
- In the advertising up to this point there is no information on languages availability
- Language and Access Support
- Offers excellent multilingual services that ensure equitable access and effective communication across all language groups.
- More services offered in languages spoken by the community
- In-person interpreting and cultural brokage services
- Services offered in multiple languages
- Focus on cultural humility and ensuring our threshold languages are available not only by translation but by staff

Diverse Staff

- Diverse staff
- Diverse staff and services
- Diversity of the workplace
- Diverse workforce
- Company Diversity
- Seeing more diversity of staff
- Hiring a diverse staff to reflect the diversity of the vulnerable communities we serve.
- Having diverse/cultural staff that anyone can identify with
- Hiring diverse and inclusive staff to help support culturally competent care.
- Diversity of providers has become more reflective of communities they support
- Increase diversity of expertise in decision making processes
- Cultural competency and workforce diversity understanding of staff
- Multicultural/ethnic

Cultural Competence Efforts

- Strong collaboration within the Black community to support the mental health and social support needs of people with complex individual and family challenges
- Unwavering commitment to addressing inequities
- Behavioral Health Racial Equity Collaborative (BHREC)
- The learning collaborations like the BHREC and its focus on improving outcomes for Black people
- BHREC
- Cultural competency, committees are import
- Cultural competence committee that is thoughtful and consistent
- Cultural competence and the stretch to learn and offer culturally relevant services
- Creative and intersectional approaches to addressing historic harm caused by systemic racism in historically Black communities.
- Cultural sensitivity around taboo areas
- Collaboration in developing systems to serve diverse communities
- Collaboration with cultural communities
- Both mental health and substance use are geared at serving diverse communities
- Offering support and training related to DEI (*Diversity, Equity, and Inclusion*)
- Culturally responsive services
- Efforts in fostering cultural humility and understanding accessibility needs
- Demonstrates a strong commitment to reaching and serving every member of the community, regardless of background or circumstance.
- Addressing mental health disparities
- BHS works at being culturally responsive.
- The system has improved its cultural responsiveness.

- When inclusion is real and driven, it makes communities feel seen and heard.
- Diversity, Equity, and Inclusion
- Support for diversity, equity, and inclusion.
- Increased initiatives for culturally affirmative services for LGBTQQIA2S+ community members,
- The county has been very responsive to the unique needs of the LGBTQI population
- Increased initiatives for culturally affirmative services for people of color (POC) community members
- Nice picture, the pictures of people do not show BHS as being inclusive, colors used are to dark, brighter is more inviting
- Outreach to diverse communities
- Concerted efforts to ensure all staff are completing cultural competence trainings
- Reaches diverse clientele
- Culturally responsive care
- Culturally responsive resources.
- Culturally Responsive
- Culturally responsive services
- Unique opportunity for culturally responsive services that are often otherwise not available
- Multi-cultural
- Non-traditional
- Trying to be inclusive and innovative
- Intentional inclusivity
- Inclusivity
- Inclusiveness
- Inclusiveness
- Cultural humility
- Culturally Competent Services
- Diverse
- Diverse communities
- Diverse Stakeholders,
- Diverse work groups
- Diversity

Culturally Supportive Programs

- Delivers a diverse and culturally inclusive array of programs that reflect and honor Sacramento County's rich population.
- Bilingual/bicultural programs

- Providing respite for LGBTQ+ youth leading to improved mental health outcomes, suicide prevention, decreased isolation and increased sense of belonging. It saves LGBTQ+ lives!
- Many LGBTQ+ youth do not have affirming families. This provides affirming, inclusive care where youth are seen and celebrated for who they are.
- Many LGBT youth who seek mental health respite find themselves on the streets because their families kick them out for identifying as part of the LGBTQ+ community. We provide linkage to housing and resources.
- Having providers that are reflective of the community they are serving (culturally and linguistically reflective)
- More culturally tailored services
- Culturally responsive provider
- Focus on serving diverse clients/communities
- Our commitment to serving the needs of diverse populations.
- Our SCC (*Supporting Community Connections*) programs that serve diverse communities.
- Supporting Community Connections
- SCC funding helps with flexibility of services like prevention. Sometimes prevention is just getting folks in the door, and I love that. SCC is one of our highest in demand programs. They believe it is due to partnership with the county and willingness to look at culture as prevention. Beading lessons, open mic night and anything that is an expression of culture.
- Folks realize that they didn't know things weren't going well until they get in there. Hearing from other SCC providers in this community conversation is so great to hear how important the Sacramento county contracts are important even though nonprofits don't like contracting with the county.
- They give a break to caregivers of older adults. Culturally sensitive services helping with sharing information to prevent suicide and other resources to prevent hospitalization.
- Creating meaningful relationships with culturally aligned organizations/agencies
- We serve the native American community.
- The cultural appropriateness of services rendered to different populations and the flexibility to design relevant interventions
- Culturally focused services for folks who may not feel comfortable accessing through traditional means.
- Supporting services for a diverse community dealing with drug and/ or alcohol dependence
- Developed an array of culturally and linguistically responsive programs that provide suicide prevention and access to BH services.
- Amazing, diverse services for the diverse community we serve. For us with us!
- Culturally Responsive services
- Cultural competence and truly inclusive spaces

- Culturally Responsive Services – Providing care that respects and reflects the diverse cultural needs of the community.

Reduced Stigma & Increased Community Trust – *Praise for Stop Stigma. Other Anti-stigma efforts. Opportunities for Input. Community Trust.*

Praise for the Stop Stigma Speakers' Bureau

- Stop Stigma Speakers Bureau, Journey of Hope, speaking and tabling events. Helping fund for Augmented Board and Cares, like Psynergy.
- Speakers at the bureau
- Stop Stigma Speakers Bureau
- I have seen the positive impact from the Speakers Bureau. It helps the speaker and the public.
- Participated with Stop Stigma over the past 10 years. It is easy to overlook the number of attendees at our programs, but I have seen hundreds react to Stop Stigma from all ages.
- Staff at Stop Stigma have been top-notch and are able to accommodate vast levels of mental health sufferers to participate.
- Stop Stigma presentations are available to a wide variety of organizations and groups, including varied ages and types of groups, education levels, etc.
- Stop stigma campaign for prevention
- Speakers Bureau
- Stop Stigma Sacramento
- Use of mixed media (social media, radio, newspapers, etc.) to stop stigma in Sacramento
- Stopping stigma SMH (*Specialty Mental Health*)
- 114 events, 60 speaking events. 128 stories of lived experience, reaching 76,000 Sacramentans at events alone.
- Journey of Hope campaign. Hearing about other culturally related programs.
- Journey of Hope
- Journey of Hope
- Broad community outreach, such as Journey of Hope

Anti-Stigma Efforts

- Community Education and Awareness Campaigns – Spreading awareness about behavioral health, overdose prevention, and stigma reduction.
- Anti-Stigma billboards (multiple languages)
- Awareness campaigns to bring acceptance and empathy
- Increased awareness of community about Mental Health
- Willingness to engage in dialog spaces to talk about mental health

- Normalizing the discussion of mental health
- Community Education and Awareness Campaigns – Spreading awareness about behavioral health, overdose prevention, and stigma reduction.
- Increased numbers of Black folks seeking mental health and substance use
- services. Stigma reduction is a GLOW from MHSA.
- Clearing out the mental health stigma
- No judgement
- No longer stigmatized
- Reduction of stigma
- Community outreach reducing stigma
- More reduction of stigma of MH (*mental health*) in certain communities

Opportunities for Community Input

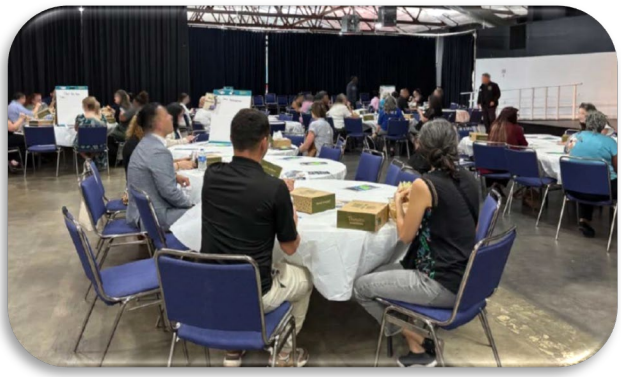
- To me the importance of having middle management staff representative accessible to listen to grassroots members is essential
- Middle management that is responsive to feedback from the community
- Sacramento County takes community/provider feedback seriously
- Willingness to hear feedback and give feedback
- Request for community feedback
- You seek feedback
- Reaching out to the community
- Open to criticism
- The intentional focus the County places on community feedback for plans like Prop 1.
- There are surveys created for individuals
- Have open meetings
- System of care being built by individuals who have prioritized the community voice in the work being done
- Community Voice is being heard
- Honoring community voices
- Having young people's voice included. And continuing to use them to get input from the youth in the community.
- Client Choice and Client Voice
- I want services with a voice and choice
- Strong community voice and input
- Youth voice and choice is a priority
- The ability to listen to the community is refreshing
- Like the events we go to or put on for the community- it really helps spread the word
- Community events
- Community conversations/inclusion

- Gathering and implementing feedback to enhance services.
- Desire to hear from the community and multiple collaborators.
- Love the community input i.e. community reps on this cabinet
- The advisory committees/ councils, youth MH (*Mental Health*) board
- Opportunity for deeper collaboration with health and housing (BHS and DHSH *[Department of Homeless Services and Housing]*)
- Representation on various boards and coalitions to under understand needs of the community
- Behavioral Health Commission
- Facilitated Groups assisted in meeting
- It is important that staff ask questions to members for clarification when they do not understand
- Acknowledging the audience's concerns when they speak at the end of meetings remind all present the BHS contact information for the different services
- The ability to attend community engagement and share about services, to collaborate with other organization(s) on events, going into schools to speak directly to clients to speak on topics.
- Community engagement
- Community engagement
- Engagement across communities
- Engagement
- Engaging the community for input
- Community input is important

Community Trust

- Commitment to the community
- Commitment to Continuous Improvement – Actively listening to community feedback to strengthen behavioral health programs and services.
- Trust building efforts
- They are focused on helping
- They say they want to improve
- Strength – The County's collaborative nature and willingness to engage partners across the County to ensure our shared communities' needs are being best met.
- This is what I can comment on thus far and as far as I am informed: Commitment to Community, Collaboration, Community Input
- It's good that the County is investing more into addressing the homelessness issue. The County seems to be really trying to make positive changes for the community and employees.
- Communicates clearly and openly about planning priorities, funding decisions, and program expenditures.
- Communicating

- Communication
- Communication
- Good communication
- Renewed hope in participants
- Renewed Hope
- Channels of communication
- Transparency in reporting.
- Transparency with the providers
- Management transparency
- Appear Transparent
- Adaptability to community needs
- Resourcefulness
- Resources
- Responsibility
- Community driven
- Community-driven



Cross-Sector Coordination – *Collaboration with Justice Services. Collaboration with Schools. Coordination Across Systems. System Partners Appreciated by the Community.*

Collaboration with Justice Services

- Partnerships with Law Enforcement
- Working with law enforcement to learn how to diffuse interactions with psychotic individuals
- Support with collaborative courts
- Collaborative courts and desire to coordinate
- Greater integration with other departments and divisions (i.e., justice-involved, public health, SUPT *[Substance Use Prevention and Treatment]*)
- Collaboration and collaborative courts
- Diversion services, collaborative courts and BHS partnerships
- Support with collaborative courts with services and treatment.
- MOUs (*Memos of Understanding*) with law enforcement and CWRT *(Community Wellness Response Team)*
- Collaboration with Justice partners
- Use of CARE Court to support families of people with SMI (*Serious Mental Illness*)
- Embedded staff in jail exit loop
- Partnerships with the county jail
- Collaboration of crisis services and law enforcement, fire, and EMS (*Emergency Medical Service*s).

- Collaboration with Justice Services
- Collaboration with Child Welfare and Probation.
- Court related and Assisted Outpatient Treatment Services
- Linking incarcerated individuals to services prior to release
- Law enforcement diversion initiatives where clinicians respond in the community to deescalate crises and link individuals to appropriate care.

Collaboration with Schools

- Partnerships with Education
- Working with schools to help them identify incipient need
- Collaborate with Sacramento State to bring services to students
- Collaboration with system partners (CPS (*Child Protective Services*), Probation, DHA [*Department of Human Assistance*], Schools, etc.)
- Schools as Centers of Wellness
- More focus on the education of substance use as well as more prevention taught practices in schools.
- Intentionality around partnership (schools/health)

Coordination Across Systems

- Collaboration with other County partners. Access to services. PSH (*Permanent Supportive Housing*) Units.
- Collaboration with SHRA (*Sacramento Housing and Redevelopment Agency*) to a very important for housing to be successful for people on fixed incomes
- Efforts to coordinate across medical, behavioral health, housing, and social services to provide holistic, person centered support.
- Having a partnership w/ Emergency medicine
- Strong collaboration and coordination efforts underway between County and MCPs (*Managed Care Plans*) to support BHSA implementation, and specifically implementation of Transitional Rent
- Appreciate the County's ongoing engagement with health plan partners. Partnerships are critical!
- Effective Collaboration with County Leadership – Working closely with county officials and advisory boards to improve behavioral health systems.
- Support specific to blending funding streams
- Holding partner meetings specific to services and supports provided to children and families receding services from CPS
- We have a good working relationship with APS (*Adult Protective Services*).
- Child and Family Team Meetings
- Child protective Services Referrals
- BHS creating and supporting a CPS (*Child Protective Services*) liaison

- Increased coordination with CPS
- Increased coordination with SUPT *(Substance Use Prevention and Treatment*)
- Coordination of care
- Coordination across systems
- Alliance with Wellspace to develop MHR (*Mental Health Resource*) center quickly
- CORE (*Community Outreach Recovery Empowerment*) programs have good collaboration with navigators and shelter staff
- Multi-disciplinary treatment teams to meet client/family goals.
- Multidisciplinary Meetings/Team Meetings
- The partnership with BHS and City of Sacramento
- How our collaboration with the City has improved and just BHS being less siloed
- Different departments talking to each other, more collaboration
- Improved communication across the system
- Inter-programmatic and departmental cooperation
- Breaking down siloes
- Less working in silos
- Adult & Children Providers work well together & support each other
- Great partnerships with sister agencies. Willingness to work in coordination to meet the needs of the children and families served
- Care coordination
- Cross coordination between agencies
- case management
- Case Management or Case Coordination
- case management/ care coordination with outside agencies
- Looking at innovative new partners and strengthening current relationships
- Thoughtful Partnership
- Collaboration with partners.
- Great partners
- Partners
- Partnership
- Partnerships
- Internal Referrals instead of External Referrals
- Warm handoff between services
- Ease of transferring providers!
- Collaboration with system partners
- Early intervention and collaboration with system partners
- The level of system partner engagement and collaboration performed by BHS.
- More collaboration and outreach with other County departments.
- Increased collaboration between county divisions has increased and is positive
- Collaboration across systems and partners
- Collaboration with other partners. Willingness to lean into new programs.

- Collaborations with system partners
- Collaboration on affordable and supportive housing opportunities
- Collaboration across systems.
- Collaboration and partnerships among agencies to create a system of support Embedded partners
- Teaming and collaboration
- Strong collaboration
- Cross department collaborations
- Collaborative approach
- Collaboration across all levels of interaction
- Collaboration across systems
- Collaborative work between all Departments
- Collaboration and communication strategies with community and system partners
- Collaboration between city, BHS and non-profits
- Collaboration through HMIS (*Homeless Management Information System*)
- Collaboration
- Collaboration
- Collaboration
- Collaboration
- Collaborative

System Partners Appreciated by the Community

- 2-1-1
- 2-1-1
- Alta California Regional Services
- BAART (*Bay Area Addiction Research and Treatment)* clinics – good rapport with clients
- Cal Voices
- CalAim
- CalVoices
- Caregiver Networks
- Department of Social Services
- Enhanced Care Management COTP (*Co-Occurring Disorders Treatment Program*)
- Hope Cooperative COTP
- Hope Cooperative COTP Program
- Hope Cooperative over all helping the people
- Mental Health Matters Day
- SacMap
- Sacramento Children's Home
- Shelters
- Shelters

- SMART
- SmartCare push
- Telecare Corporation of Sacramento!

Community Collaboration & Outreach – *Community Partnerships. Community Connections. Outreach.*

Community Partnerships

- Subcontracting with CBOs (*Community-Based Organizations*) to help do the work
- Sacramento has a strong network of community-based providers who deliver critical behavioral health services and support including early intervention, outreach and engagement, education and training, capital facilities, etc.
- Programs that support engagement with populations who may not otherwise connect to BHS (Youth Help Network, LGBT Respites, Wind Respites, CAFA)
- Funding to community organizations, youth-led education, ambassadors, interns, media, and marketing. Sac Town Youth nights through the City and County. Cultural/generational programs offered with local agencies.
- Sacramento has established a strong network of community-based providers who deliver critical housing-related services and supports (e.g. Street Medicine, CalAIM Community Supports related to housing insecurities, etc.)
- Sacramento has a strong network of community-based providers who deliver critical behavioral health services and support including early intervention, outreach and engagement, education and training, capital facilities, etc.
- Developing a network
- We feel supported in a community of providers and are able to partner with them. Language barriers are being addressed allowing Sac County residents with limited English access MH services
- Community Partnerships – Collaborating with schools, churches, nonprofits, and local agencies to expand behavioral health support and outreach.
- I appreciate Improved collaboration between resource providers in our community. When providers work together, the client receives support in all needed areas.
- Increased number of community-based organizations focused on housing issues - very hard for individuals to follow treatment or health care plans if they don't have housing.
- Community Partnerships
- Engaging with community partners
- Community-driven and co-designed programming.
- Building strong community partnerships
- Strong community partnerships
- Partnerships with other providers/organization

- Community based services
- Community-based organizations
- Community engagement and partnership building
- More embedded partners, centralized location for key stakeholders to work out of to provide support to clients
- The collaboration among the region and all jurisdictions is a positive aspect
- Working collaboratively with community partners
- Collaboration among teams and community partners
- Collaboration efforts amongst community partners
- Collaborating with community and system partners
- Collaborating with community partners and involving community members in feedback/planning processes
- Collaborations with Community Based Organizations
- More collaboration with housing partners
- Collaboration with community based partnerships
- Collaborative and communicative providers
- Collaboration with community-based organizations
- Collaboration with partners, including Sacramento County Public Health (Youth Suicide Prevention Grant, Stop Stigma Sacramento Speakers Bureau, Tobacco Education & Prevention Program) and others

Community Connections

- Engaging in the community and building stronger relationships
- Involving community in the creation of new programs/projects
- Increased visibility in the community to share about services and supports offered
- Building Stronger relationships with our community
- Support to community groups
- Trying to disseminate information with the community partners
- Trying to recruit community members
- Supportive services are available to come to the community members. For example, helpers can serve in the schools, homes, parks, and neighborhoods where families request help.
- Expanded messaging efforts and activities/opportunities (speakers bureau, 988, focus on cultural / ethnic diversity (I've seen everyone represented in different marketing/ads.
- Connected community of care – coordinating care and resources across different departments, organizations, and community partners.
- Linkage to other organizations, platforms: 2-1-1, findhelp.org, County website. Connections with nonprofits, Black Child Legacy, schools-liaison, clinics, Managed Care Plan

- Appreciation for collaboration to ensure the health and well-being of shared community members
- Commitment to providing services for the community.
- Community building
- Community Collaboration
- Community involvement
- We need to invest in culturally responsive care with both a prevention and intervention lens.
- County providers are aware of and engage with community support services that are both clinical and non-clinical
- Community engagement/partnership in program development
- Community & Collaboration
- Community based collaborative efforts
- Community connection
- Community collab
- Community driven
- Client driven programs
- Community Partnerships
- Community visits

Outreach

- Increased marketing and visibility for CWRT(*Community Wellness Response Team*)/988
- Relentless outreach for CARE Court really does a good job of engaging
- Availability of outreach and crisis services
- Your outreach program
- Strong community outreach and engagement
- Affordable housing, Community outreach.
- Intentional outreach efforts to faith-based organizations
- Honest efforts in reaching out to communities
- High efforts to outreach and engage people into treatment.
- Outreach and presence in unserved/underserved zip codes
- Resource guides are helpful to spread the word to consumers
- Support on Outreach Navigators
- Substance use navigators within hospitals to get clients connected
- Specialty behavioral health services that are provided in the community, in homes and schools, to support young people and families in learning and practicing the skills they need to succeed.
- Outreach efforts have improved in recent times and I see county and other providers making resources better known in our neighborhoods
- Community outreach

- Ability to create outreach campaigns
- Accessibility and Outreach
- Education outreach
- Outreach and Engagement to Community Sexually Exploited Youth and those at risk
- LGBTQ and BIPOC Community Outreach
- Intentional Community Outreach
- Billboard advertisements
- Outreach like billboards
- Outreach
- Outreach to underserved, unserved, inappropriately served communities
- Raising awareness through community outreach and education
- More Outreach Programs – HEART (*Homeless Engagement And Response Team)*, CST (*Community Support Team*)
- Outreach HEART team goes to clients for ease
- Outreach funds
- Outreach Teams
- Outreach events/services
- Outreach to the community to get people involved
- Outreach and education
- Outreach
- Outreach
- Outreach
- Outreach
- Outreach

Success of Current Programs & Services – *CORE & CWCs. MHUCC. HEART. CST. CWRT. FSPs. PEARLs. Crisis, Housing, Youth & Family, Justice-involved, Suicide Prevention, Ancillary, Prevention & Early Intervention, and Other Services.*

Community Outreach Recovery Empowerment (CORE) & Community Wellness Centers (CWCs)

- The Community Outreach Recovery Empowerment (CORE) Program is accessible and available in the communities.
- Access available at CORE sites around the County
- Outreach workers for CORE Clinics
- Variety of partners in CORE centers works well for those who need to transfer for some reason
- CORE Wellness Centers
- CORE case management services

- CORE Wellness Centers
- The CORE programs
- CORE model
- Providing community-based services such as CORE support.
- Its vision in implementing some of the outpatient services (FIT [*Flexible Integrated Treatment*], CORE)
- CORE support
- Inclusion of Community Wellness Centers at all CORE locations
- Wellness center
- Wellness centers
- Having wellness centers that serve folks regardless of Medi-Cal eligibility is great
- Community Wellness Centers
- Wellness centers are a great asset
- There's a lot of low level supports like CWCs (Community Wellness Centers) letting people do laundry and serving lunch.

Mental Health Urgent Care Clinic (MHUCC)

- MHUCC (*Mental Health Urgent Care Clinic*) with direct access to MHTC (*Mental Health Treatment Center*) ISU (*Intake Stabilization Unit*) if they meet criteria
- Availability of MH Urgent Care Clinics and crisis stabilization units that divert individuals from ERs (*Emergency Rooms*) and jails while connecting them to care.
- Mental Health Urgent Care Clinic
- 24-hour Mental Health Urgent Care
- Mental health urgent care services
- Mental Health Urgent Care Clinic BHS Screening and Coordination
- Mental health urgent care helps fill gaps in service access
- Urgent Care Clinic accessibility
- 24/7 Crisis Triage and Urgent Care
- 24/7 Mental Health Clinic
- Sacramento has the MHUCC
- MHUCC

Homeless Engagement And Response Team (HEART)

- Work by HEART (*Homeless Engagement and Response Team*) connecting to the resource—it's HUGE
- HEART... this team is out there in the field connecting people to behavioral health services. and following up.
- The HEART team
- I work for Hope Cooperative in the Hop Team; I have been grateful for our Heart Teams, providing MH services resulting in a Tiny Home opportunity.

- HEART program

Community Support Team (CST)

- Community Support Team
- CST responsive

Community Wellness Response (CWRT)

- 988 and CWRT (*Community Wellness Response*) teams
- 988 and CWRT programs
- Roll out of CWRT: great website, amazing widgets, strong program management
- CWRT/ Oversight commissions/ committees
- Community Wellness Response Team (aka Alternatives to 911 for Behavioral Health Crises)
- CWRT coordination with 988
- CWRT response times are faster than 911, law enforcement, fire
- CWRT program
- Multiple services for the underserved implementation of Community Wellness Response Team (CWRT), Homeless programs, and community outreach
- Community Wellness Response Team!

Full Service Partnerships (FSPs)

- Properly trained caseworkers through FSP's are effective
- Operates robust Full-Service Partnership (FSP) programs that provide holistic, wraparound support to individuals and families.
- Full service partnerships
- Full Service Partnerships to include TAY
- Fsp
- FSPs

Program to Encourage Active Rewarding Lives (PEARLS)

- PEARLS Program
- PEARLS Program

Crisis Services

- MCST program (*Mobile Crisis Support Team*)
- Success in getting mobile crisis services up and operational.
- Maintains a strong and responsive crisis continuum that ensures timely support and intervention when individuals need it most.

- Definition of crisis is subjective - no longer just if it meets 5150 (*involuntary psychiatric hold*) criteria
- Crisis triage, intervention, and stabilization for consumers of all age groups with complex, nuanced intersectional needs and presentations during NOC (*night shifts*) shifts in which community resources are limited
- Prior to 7/1, having The Source provide after-hours crisis support to all youth and families.
- Opening of the newest MHRC (*Mental Health Respite Center*), which has accepted so many MHTC (*Mental Health Treatment Center*) patients on Admin Stay, making room for other patients in the Emergency Departments who need help
- Opening up ISU (*Intake Stabilization Unit)* at MHTC (*Mental Health Treatment Center*) to law enforcement holds (not just from the Emergency Departments
- Use emergency rooms to deal with psychotic individuals
- 988 implementation
- 988 has been very helpful
- Limited exposure to 988 but hopeful that this will be effective
- Crisis support
- Strong crisis intervention support
- Crises services are easy to access
- Crisis Call Center up and running
- Crisis Intervention Resources
- Crisis intervention, and address symptoms
- Crisis

Housing Services

- Proud to be part of Behavioral Health community specially Housing Funds. Thank you
- PSH *(Permanent Supportive Housing*)
- Substance Use Programs Housing
- Housing services and support are integrated into BHS
- Housing with services
- Housing placement for the unhoused.
- Housing for the homeless
- Housing support
- Robust Housing services!
- Supporting with housing, which is a major aggravating factor to mental health
- Provision of services in the community for those who are housing insecure
- An understanding of the needs of the unhoused community
- Homeless prevention was very helpful
- The housing of the 300 people! That's awesome! Creating trauma-informed spaces.

- Temporary Housing
- Safe stay shelters
- Safe stays have replaced some homeless encampments
- Mental Health among homeless
- Lots of housing, much of it very attractive.
- Residential housing
- Direct access to housing
- Access to services and housing supports
- Concrete ways to assist with housing.
- Support for Housing
- Housing programming
- Homelessness
- Housing services
- Housing assistance
- Housing funds.
- Housing resources
- Housing supports
- Housing
- Housing
- Housing

Youth & Family Services

- CAPS (*Child and Adolescent Psychiatric Services*) Clinic provides high quality care and intervention to its consumers
- Being able to utilize a prevention approach, especially for families with young children
- Services for youth exiting hospitalizations where parents are struggling to keep the child in the home due to the high needs.
- Children's MH (*Mental Health*) services
- It's great to see youth involved in promoting BHS initiatives and taking leadership in promotional projects
- Youth residential is long overdue! Walk-in services are a definite glow
- Residential treatment for youth (females 12-17)
- Services and support for children and youth
- Child, Youth, and Family Mental Health Website
- School-based Programs
- Youth advocacy
- Youth and adult advocacy
- Transition Age Youth Programs
- Successful TAY (*Transition Age Youth*) focused programs

- Specific care is often available to meet some of my youth's crisis needs. I deeply appreciate the rehab that opened for the 18 and under in Sacramento.
- Supporting TAY and seeing them progress in our Crisis Residential Program
- TAY services
- Youth and families being able to receive life-saving mental, behavioral, psychiatric, and peer care and knowing we are making a difference
- There are resources for families and families are able to feel supported with housing if they qualify.
- Supporting early intervention and education for kids about bullying prevention and suicide prevention!! Vital work to kids safe and continue moving the needle!
- We love FIT!!! (*Flexible Integrated Treatment*)
- Family FSP (*Full Service Partnership*) support
- I currently work in the Fit /Fsp departments, and I want to point out that having different team members who focus on wellness, advocacy, therapy, and employment is definitely key to helping clients
- Family FSP-Heartland
- Family FSP addressing systemic issues
- Students graduating
- Youth and family-focused programs
- Being able to support families with youth in BH programs with rent gap services
- Services for dual diagnosis for youth and adults
- Continued honoring of youth and family voice/choice
- Family engagement
- Support and efforts to address youth substance use, Fentanyl focus overall
- Support with capacity expansion for foster care placements

Justice-Involved Services

- BHS (*Behavioral Health Services*) has been heroic in meeting the dramatic demands created by having over 1,000 individuals on felony and misdemeanor mental health diversion.
- Care Court
- Care court
- Justice-related programs
- Justice involved services
- Transitional Support Services

Suicide Prevention

- Focus on suicide prevention activities/initiatives.
- Suicide prevention project, real time data on suicide data in a dashboard.
- SCC programs that are funded for suicide prevention and work very closely with the most vulnerable communities are getting amazing results

Ancillary Services

- Transportation support
- Transportation
- Lyft rides provided to psychiatry appointments
- The incentives that are focused on improving clinical care and addressing current needs of clients (e.g., suicidality, disordered eating) has also been effective
- Therapy Transportation provided to psych appointments
- Gas cards
- Gift cards
- Healthy food
- Hygiene
- Incentives
- incentives

Prevention and Early Intervention Services

- Intervention services
- Early intervention programs are well represented
- Appreciate that the current programming allows for prevention and early intervention, as well as services for children and families
- Intervention
- Prevention and early prevention is being addressed.
- Prevention and intervention
- Prevention and early intervention activities have been very valuable.
- Prevention is less money than treatment
- Prevention services are out in the community
- Emphasis on prevention.

Other Services

- Some MHSA services are very well embedded in the community.
- 9-8-8, MH First, community health workers, home visitors, crisis response/responders, CWRT (*Community Wellness Response Team*), fentanyl and substance use awareness, in school presentations, youth serving organizations lead, unrestricted funds
- Excellent relationship with Adult Services Team
- Adult Mental Health Services
- Adult services available
- Available adult and older population mental health/medical services
- Older adult interventions
- The contracts that the County has with the state are well-funded and well-staffed – specifically with CBH (*Commission for Behavioral Health*)

- Respite programs are successful
- Respite Center
- Support for providers that have helped us navigate the new CalAIM world.
- Assistance with CalAIM services
- Being a Lead Care Manager CalAIM
- Managing your mental health condition with medicine
- Medication & psychiatry services are great
- Medicine management
- Medication Management
- PEI Grants
- PEI Grants Supported Community Connections Coproduction for marginalized communities
- Community Developed Evidence-Based Practices
- Properly run board & care homes are effective
- Access phone line
- EAP (Employee Assistance Program)
- People are getting the mental health support that they need
- Positive experience of youth/families referring their friends and extended family members for support.
- Many programs are able to demonstrate successful outcomes
- The longevity of providers (some have been around for over 40 years, which provides stability that community members can rely on)
- Some programs have had a very broad reach and impact with modest funding
- What we are doing helps impact policy
- Services meeting client's needs
- Education on regulating emotions and coping with symptoms
- Existing program infrastructure
- Gives client's coping skills to work with
- Providing therapy to low risk clients (biweekly options)
- Drug addiction programs
- Employment
- Harm reduction
- Sacramento County Mental Health Services
- Treating mental problems
- Addressing the mental health needs of adults
- Addressing the mental health needs of children
- Including children
- Counseling services
- Mental health
- Mental Health Services
- Mental Health Services

- Mental Health Treatment
- Groups
- Groups
- Therapy
- Therapeutic Services
- Substance Abuse Services and Treatment Recovery
- Addressing drug abuse
- Community Health
- Services to better the community members
- Understanding behavioral health needs in Sac
- Understanding justice involved/smi (*Serious Mental Illness)*/hou

Service Expansion & Support *– Increased/New Funding. Housing Support. Service Expansion. New Programs/New Populations, Program Support.*

Increased/New Funding

- Appreciate the breakdown of the flex, sober and safe homes/ buckets of funds. Currently, there is no max on the flex funds for utilities assistance for those that may be in arrears. This fills in gaps.
- The sheer commitment of resources is amazing! The access of Flex funding for our community outpatient clinic and our care coordination team has been so great! I just got my client into his first apt (*apartment*)
- Flexible funding to support clients
- Flex Funds to support housing. It is easier to help families maintain housing instead of after they lose it
- Addition of Outreach funds!
- Funding to support family caregivers caring for older adults
- Allocation of money towards mental and behavioral health
- Increased focus and funding
- The influx of funding and focus on this issue.
- The funding that we receive makes a difference in the lives of those who need it. Improved communication. Documentation is getting better support and resources for Peers, in my experience, has improved
- Funding for such programs as La Familia Counseling Center, El Hogar, etc.
- The amount of resource programs available to community members, especially those in need.
- Generous funding for services
- Allocation funding being broken down
- The budget that allows us to strengthen the ways that we are able to serve people.
- Valuable funding stream

- Enhanced BHS services
- More opportunities and options
- Current programming addresses most needs. Really don't want to lose anything.
- Our agency has achieved all of our outcomes for the program through this funding
- More state resources
- More clinicians, Additional resources
- Blended funding
- Suicide prevention grant
- Funding

Housing Support

- BHBH (*Behavioral Health Bridge Housing*) shelter beds with supportive services
- Behavioral Health Bridge Housing funding is a great idea to help get people into permanent housing.
- Behavioral Health Bridge Housing was able to open some facilities (yay) so less folks living in literal homelessness. Just this week our Grow Florin facility opened and our first residents moved in today!
- Behavioral Health Bridge Housing, shelter focused on specific vulnerable populations
- Behavioral Health Bridge Housing shelters, FSPs *(Full Service Partnerships*)
- Behavioral Health Bridge Housing
- Behavioral Health Bridge Housing
- Focusing on housing and PSH (*Permanent Supportive Housing*) units while recognizing the increase needs.
- Access and increase in PSH long-term for folks with long-term needs
- Standing up more permanent supported housing
- More permanent supportive housing
- Funding permanent supportive housing
- Prioritizing permanent supportive housing options for individuals experiencing homelessness with mental health needs, reducing barriers to entry.
- Tiny homes
- Seems to be more availability in tiny home space
- Outpatient providers being able to support financially with housing
- I have seen the housing support make a HUGE impact on our client's MH functioning and allowing them to participate in the MH services that they need also having Family Partners is essential
- It seems like the county is working on expanding housing options
- Work with the homeless population, including housing
- Increased residential options for youth at the highest risk
- Upholding contracted services commitment to homeless
- Expansion of housing supports

- Money for providers to do housing—NOT just for adults, but families too
- Fewer homeless encampments around town e.g. EPW (*East Parkway*), river
- We have many units that have come online serving the unhoused and it is a BEAUTIFUL sight to see!
- Adding interim beds for Behavioral Health clients.
- Love housing the homeless community some of them were living on the street for 5, 7, or 10 years. They are safely housed now with their families. Our program called Housing for Healthy California
- Additions funding allocation for BHS & housing services!
- More housing support
- Faster connection with housing services
- Additional opportunities for housing/boarding/shelter
- Doing something about housing needs
- Increased housing
- Intentional Investment in Housing Intervention
- Viewing housing as foundational for MH (Mental Health) (hierarchy of needs)
- Consideration of housing stability

Service Expansion

- Crisis continuum of services is growing
- New crisis services
- Developing an even stronger Crisis Continuum of Services.
- Expansion of services for TAY (Transition Age Youth)
- More youth led initiatives
- Addition of the family FSP (Full Service Partnership)
- Prioritizes youth-focused initiatives and targeted services
- Push for EBT's (*Evidence Based Treatments*)
- Expansion of adult system of care has been a meaningful shift for the community
- Expansion of Sacramento County Health Center to an FQHC (*Federally Qualified Health Center*)
- Increase in adult services and collaboration with homeless services
- More mobile support
- More treatment centers
- Expansion of treatment services
- Expanded Drug and Alcohol Programs
- Sac county has greatly expanded its substance use treatment facilities, which was incredibly needed. MH services have also expanded.
- Forensic FSPs (*Full Service Partnerships*)
- Increased mental health services.
- Executive leadership identifying unmet service needs
- The number of services has expanded a lot

- Expanding or creating programs to meet service needs
- There seems to be an increase in programs
- Expanding services under to ensure cooccurring treatment and recovery supports are accessible.
- Increased services to low-income communities by opening more sites

New Programs/New Populations

- Developing residential treatment for youth
- Sac County is getting a residential treatment (for boys 12-17)
- Reaching individuals that may not historically been able to receive services
- Expand the population of who can be served diagnostically
- Populations we're trying to provide services to
- Innovation projects

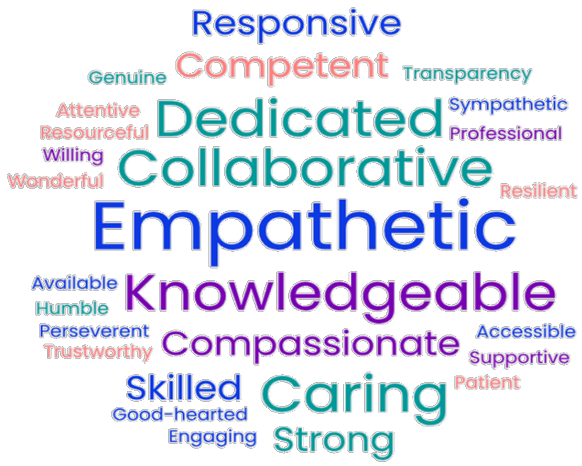
Program Support

- Expansion of IPT (*Intensive Placement Team*) staffing
- Improvements in Intensive Placement Team response time and staffing over the past two years
- Improved staffing of IPT (Intensive Placement Team)
- More people working 988
- More buy-in with the CORE collab court
- Clinical oversight is invaluable for mitigating risk.
- Streamlining ROI (Release of Information) process

Praise for Staff – Kind words for county and provider staff.

- Maintains a high level of transparency in operations, particularly since the leadership transition under Dr. Quist.
- Dr. Quist makes the effort to meet with providers every other week
- Dr. Quist is very responsive
- County leadership and contract monitoring have improved under Ryan & Sheri
- Ryan Quest is the strength for the successes of the county's behavioral health services
- BHS staff are knowledgeable, accessible, and collaborative
- The BHS staff are knowledgeable and demonstrate humility, which goes a long way with the various communities in Sacramento
- Strong County staffing
- Accessible and responsive IT (*Information Technology*) & QM (*Quality Management*)
- We have had an incredibly good experience with one of the Therapeutic Behavioral Services workers with one of our very complicated children

- Wonderful providers providing excellent services.
- Clinicians are knowledgeable
- Caring staff
- Strong advocates
- Empathy, Compassion, Willingness.
- Empathetic, resilient, dedicated.
- Dedicated service
- Not just checking a box
- They are focused on helping
- Skilled Workforce
- Good-hearted staffing
- Staff love making an impact



- We love our county funding and partners.
- Comprehensive Support, Accessibility, and Follow-Up Care
- People out there really making a difference to help those in need
- Knowledgeable, competent staff at the helm of this new directive gives me confidence that it will be reflective of what's needed most by the community
- Staff empathy and genuine care
- Avid Listener, people person
- Strong leadership
- Staff care about clients
- Dedicated caring staff
- Caring, professional staff
- Caring staff
- Employs a highly engaging, responsive, and collaborative staff team that fosters trust and strong community relationships.
- Patience, availability, perseverance, sympathy, lived experience, dedication, listening, attention, resourceful, support
- Passion in the work
- Colleagues who are here to serve community/county
- Our supportive/present supervisor
- Professionalism
- Dedicated and Compassionate Staff – Having committed professionals who care deeply about the well-being of those they serve.
- Compassion
- Compassion
- Adequate staff
- Low turnover
- Relatively stable workforce within the department
- Excellent staff and supportive culture
- Lots of bright people working hard on our BHS goals.
- High quality staff

- Well trained people providing services
- Qualified staff with innovative ideas on service delivery and areas for improvement in our system

Education, Training, & Workforce Development – *Mental Health First Aid. Peer Training. Workforce Development. Other Training.*

Mental Health First Aid

- Certifying staff and students in mental health first aid
- Access to youth mental health first aid education for all—not just staff
- BHS provides training to providers like Mental Health First (could be advertised better)

Peer Training

- Students entering peer support training
- Peer training programs
- Trainings to peers to keep us focused
- Getting a job in this field has been an amazing accomplishment of mines and receiving my CERTIFICATION FOR PEER SUPPORT with the help of Cal MHSA, I was able to learn pass my exam also continue my education
- Peer scholarships for training
- WRAP (*Wellness Response Action Plan training*)
- Our WRAP training sessions
- I've seen firsthand the impact of quality mental health services. As a Peer Support Specialist, I've had the privilege of watching families successfully complete WRAP and grow stronger together.

Workforce Development

- Providing trainings and free CEUs (*Continuing Education Credits*) for staff
- Paying for CE4Less (*Continuing Education for Mental Health Providers*)
- Paying for trainings and conferences for continued staff development
- Training for Motivational Interviewing
- Workforce development
- Grant funds to support education and workforce development at high school level
- Supported Employment & Vocational Services
- The County is making a push to invest in staff
- Implementing annual Performance Evaluations and holding supervisors accountable for completion

Other Training

- Commitment to training in the Neurosequential Model for Therapeutics to provide developmentally sensitive and trauma-informed care
- Some excellent training, including Motivational Interviewing
- Adequate training room
- Investment in training for associate level providers to improve service quality
- Thank you for the County's 14 year investment in Bullying Prevention services and 8 years investment in Suicide Prevention!!
- Training, Self-advocacy, system transformation, and education.
- Training workshops are helpful
- Certifications
- Constant trainings/education
- Glad that they provide training in BHS.
- Teaching
- Training and support
- Training certificates
- Training opportunities

Peer-Led Services *– Services from peers with lived experience.*

- I no longer believe peer support specialists plant seeds in clients' lives. I now believe, because I witness it, they yield concrete positive results right as the services are being offered. So proud!
- Access to peer support services
- The integration of Peer Support Specialists within clinical settings.
- Increase in certified peers in programs
- Outreach and peers bridging the gap
- The use of Peer Support Specialists in the County
- Use of peers in management positions within the County
- Providing empathy and support to the community, coming from a peer perspective
- Peers providing linkages to services for people who have been left out of the system
- Having peer/lived experience
- Peer-informed decisions
- Trauma-informed housing services and peer support
- A good variety of providers and services. Peer advocates who really help clients.
- Peer support staff are increasing their presence in spaces for advocacy. Strong teaming and collaboration
- Peer workforce increased
- A growing peer workforce
- Peer Support Specialists!!!

- Peer Advocates have been a huge help for engagement, skill-building & resource linkage.
- I love that peer support is getting integrated (GLOW)
- Peer advocates support families with mutuality.
- Peers provide connection and validation.
- Peer support workforce and training
- Peer workforce and training
- Access to peer support that helps individuals become open to mental health services
- Access to peers and other non-clinical support
- The areas of growth that are available for the Peer Specialists this year, including the scholarship for education.
- Medical Peer Support Specialist available
- Peers in clinical settings encourage folks to stay engaged
- Inclusive of Peers in the system of care
- Crisis Response Teams, Integrated Care, Peer Support Programs, School-Based Services, Community, Diversion Programs Collaboration
- More PWLE (*People With Lived Experience*) folks at the table with experience, designated, decision-making
- Having lived experience voices whether young or old, is beneficial for BHS
- Investment in peer support services
- The growing availability of peer support
- Increase in peer support available
- I've seen many success stories. People coming off of the streets, getting housed and getting the proper documentations they need to find employment. Lovely to watch our clients thrive (: Uplifting and empowering
- Lived experience is crucial!
- Peers connect with people because they have been there
- Peer support services
- A glow is the Medi-Cal Peer Support Specialists throughout the behavioral health system. I am in recovery, & I attribute a lot of my initial motivation to Peer Support
- The work between county and contracted peers
- Honestly, just my fellow peers
- Growing use of Peers
- Ensuring peer specialists are part of the service model.
- Ensuring the peer voice is part of SCBHS administrative meetings.
- Leadership that is more educated on peer services
- Urgent Care Center use of peers
- Active engagement in Peer Support
- Expansion of Peer Support Roles
- Hiring more peers to meet all phases of recovery and emotional needs
- Improved knowledge of what peers do

- Peer Committee can be a great space to relate to other peer support workers.
- Peer and Family Support Programs – Empowering those with lived experience to support others in recovery.
- Employees with lived experience
- Peer support from lived-experience counselors
- Peer Support Integration
- Peer and Family Support Programs – Empowering those with lived experience to support others in recovery.
- A growing peer workforce
- Services from peers with lived experience
- Lived experience is powerful!
- Peer engagement
- Peer staff employed with the county
- Peer Specialists
- Peer Support Specialists and peer support.
- Growing use of peers
- Peer led
- Peer staff
- Peer services
- Peer services – apps
- Certification of Peer Supports
- Peer Support
- Peer support services
- Peer support
- Peer support

Strategies, Approaches, & Focuses

Strategies

- Organized
- Clinical identification and treatment
- Integrating mental health support housing services addressed the individual overall well-being. I recognize that staple housing is crucial for mental health.
- Use of Evidence-Based Practices
- Emphasis on EBTs (Evidence Based Treatment); reducing documentation requirements; trying for improvements
- Evidence-Based Practice Support
- Improving EMR documentation over time
- County includes organizations that are allowed to innovate in how they reach underserved communities instead of the County providing the services

- Appreciate innovative support around travel/State guidelines
- For service providers having flexibility in contracts to be able to serve true community
- The willingness of the county to flex contract requirements for smaller organizations
- Flexibility of treatment
- Timelines for interventions
- Diversion from the justice system
- Partner with health insurance to address the needs of the non-Medi-Cal population
- Assessment at 6 months and 1 year to assess need of services
- Coordination and navigation support for those that don't qualify for Medical service
- Availability of a crisis response that does not engage law enforcement
- Classifying level of need
- Sacramento is the leader in California in my opinion.

Approaches

- Providing intensive, "whatever it takes" support that combines mental health treatment, case management, and wraparound services to keep members stable in the community.
- The County continues to do a great job at collaborating and innovating – being adaptive to best serve our community members.
- Programs and staff that are client-centered. We have served so many clients who would otherwise not been able to live successfully in the community.
- Client centered
- Person or client centric
- Personalized, client-centered care
- Individualized treatment focus
- Moving toward a more person-centered vs medical model
- Balanced appreciation for EBP (Evidence-Based Practice) and social models of treatment
- Focus on evidence-based treatment
- Evidence-based
- Holistic approach.
- Hands on approach
- Teaming Approach
- The teaming approach has allowed me to grow and have a sense of belonging.
- Innovative programs
- Innovative
- Innovative ideas that surpass other counties
- Innovation in Ideas
- Innovative

- County creativity to address challenges
- Connecting housing with SMI (I don't think some members understand Sac county is already invested in this)
- Connecting housing and basic needs to wellness
- BHS has become more trauma-informed and human centered when working with our youth
- Trauma-informed care
- Strength-based leaders increase confidence and growth.
- Strengths based approach
- Strength-based leader
- Have supervisors ensuring all providers are doing focused treatment and not just “talking” to service recipient
- Committed to improve systemic challenges and quality care
- That they are present and willing to effect change
- Continuing effort to create and improve services
- The drive to continue to push and work on providing services and improve
- Encourages family support
- Positives are that the system is ever changing. If you’re not satisfied with one service, you can request a change.
- Willing to make changes to the system to make it better.
- The strides taken to meet Clients where they are at. Tailoring ISP’s (*Interactive Screening Program*) and HSP’s to fit the mold of their desired outcome. Diversifying the types of services offered to be inclusive of our community.
- I am impressed with the County’s resiliency with managing and reallocating limited funding.
- We have moved the needle for overall mental health in this County so much!! Thank you for supporting the work! Your support of SCOE (*Sacramento County Office of Education*) + LEA’s (*Local Education Agency*) partnerships have been outstanding!
- Very collaborative county system!
- Incorporating Community Co-Production into more of the work/planning.
- Improving the quality of and accessibility to services.
- Wonderful strategic planning in allowing various feedback and collaboration across sectors.
- BHS works to adapt to the needs of the community while adhering to the requirements from the state.
- Embrace change
- Working towards county culture shifts to increase service delivery and staff satisfaction
- Having a strong QM (*Quality Management*) Department that focuses on quality assurance and quality improvement and monitoring.

- A strong DAT Dept. (*Data Analytics Team*) that clearly shows how programs meet their data points and service goals.
- Active engagement of persons suffering psychotic illness
- Moving toward facilities that provide array of services
- Increased use on multidisciplinary team meetings intervention
- Using Sacramento County employees vs. contracting out
- Employee Safety
- Safety
- Secure
- Confidential
- Positive outcomes in health and quality of life
- Treatment modality variety
- Community Provider Integration – those that can meet all needs of a client
- Improved equity in access of services
- Improved data-driven practices
- Integration of Substance Use and Mental Health Support – Addressing co-occurring conditions holistically for better outcomes.
- When system partners recognize our work.
- Somewhat support advocacy for Older Adults
- Discussion and updates provided during Plan-to-Plan meetings
- Employee benefits
- A strong union
- Workload
- Company integrity

Focuses

- Increased focus on performance based contracting and HEDIS (Healthcare Effectiveness Data and Information Set) measures
- Focus on engagement
- Focus on housing needs has escalated – very positive
- Focusing on Homeless beds
- Focus on housing
- Focus on Prevention and Early Intervention
- Focus on Prevention and Early Intervention – Promoting education and awareness to prevent crises before they occur.
- Focus on Recovery and Resilience
- Less hospitalizations
- Prioritizes youth-focused initiatives and targeted services for specific populations, addressing unique needs with care and precision.
- Family and youth focused

- Focus on services that serve the “whole” family has been incredibly helpful Strong system transparency
- Focusing on wraparound services
- Love the fact that there is more than just mental health being focused on with the switch to BHSA.
- Families (youth & caregivers)
- Community focus
- Informative
- Initiatives always centered around providing efficient services & supportive services
- Countywide focus critical
- Our program focuses on the most vulnerable.
- County is being proactive and making sure services are still provided

Other Comments

- Mental health that does not address housing, food, and safety first is a joke
- Helping those who don't want help
- Mobile crisis units are useless in my personal experience
- It exists, albeit as a shell of the service it should be.
- (*Glows*) None that I'm aware of personally
- I haven't successfully navigated the system the times I’ve needed to get services. Mental health process is a joke. Thru advocating axillary programs and using medical to get a stable provider was my path. I am going to school to learn how to serve people better. This county's tax $ went to waist on me.
- I'm sure there are other positives but I have limited experience with your current work
- I do not have enough information to be either glowing or to recommend growing in any particular area.

***Note**: Most feedback was received in writing and was left unedited. Italicized text in parentheses was added to spell out acronyms.*

Each group of participants was asked to vote on their top three (3) "Grows" on which they would like BHS to focus, and those are indicated in bold at the start of the Grow categories

GROWS

Availability & Accessibility – Transportation. Location & Centralization. Flexibility in Hours & Appointments. Website & Technology. Difficulty with Referrals. Linkage & Navigation. General Accessibility.

Top Grows:

- ✪ Providing services where people are, transportation and sweeps are major barriers
- ✪ Reduce barriers to accessing County services.
- ✪ Confusing to navigate. The increased options and innovation have enriched the offerings, but it's tricky to know where to send a client.

Transportation

- Increase accessibility (languages, locations, transportation, collaboration)
- Phone and transportation access
- Find more ways to help people access transportation to services but also continue to find ways to service people where they are.
- More options for transportation services, especially in low-income neighborhoods that lack bus stops
- Serving low-income individuals who have limited access to resources, transportation etc., and don't have a psychotic disorder
- Lack of reliable Transportation is a barrier.
- Barriers with transportation- could we offer gas cards vs Uber?
- Better access to healthcare—transportation
- Finding ways to help those needing meds without transportation
- Transportation for families so folks can be served
- Transportation funds for youth to access services.
- Transportation for youth to services
- Transportation barriers
- Transportation to referral services can be hard for those experiencing homelessness
- Medical transportation needs serious improvement
- Address Practical Barriers (Transportation and Childcare)
- Transportation and technology barriers to accessing services
- And more transportation services/bus passes are available.
- Providing transportation to needed BHS services & appts

- County services need to be available to outer locations like Galt to reduce travel
- Uber services through Medi-Cal are often unreliable for families
- Mobile crisis team only offers a ride to the hospital
- Home-based BHS that go to the client

Location & Centralization

- Change: Same services at the same places. One person preferred a location outside downtown because it was better
- Barriers are that we need more dual diagnosis facilities. Our clients do not need to attend 2 separate locations
- Too many crisis access points with no streamlined access (BHS-SAC [*Behavioral Health Services-Screening And Coordination]*, The Source, 988, CST, CCIT, CRBH)
- Treatment Needs- CSEC, eating disorders, psychosis, whole-family care under one provider
- One-stop shop for services for unhoused population
- BHS services in rural communities.
- Ease of access – provider within community neighborhoods
- Providing BHS & case management in more areas of the city
- We continue to need access for families and youth who are experiencing homelessness to mental health services, meeting them where they are at.
- Provide BHS services on wheels. Meet the community where they are at.
- Need more regional mental health clinics
- Expand Access to Services – Provide more local and easily accessible treatment options, especially in underserved communities.

Flexibility in Hours & Appointments

- Timeliness data and offering faster intake options
- Strengthen care navigation with real-time phone and online support to help people connect to the right service quickly
- Create a walk-in option for behavioral health services
- Low-barrier access: walk-ins, off-hours, and flexible providers (LEGIT NO WRONG DOOR APPROACH)
- After hours support needed
- Need for weekend or outside if typical hours for support
- Lack of 24/7 operational BHS-Sac (*Behavioral Health Services-Screening And Coordination)* with staff authorized to complete BQUIP (*Brief Questionnaire for Initial Placement*)/ASAM (*American Society of Addiction Medicine*)/MH (*Mental Health*) screenings
- Hours of operation limitations

- Limited open assessment hours and clients getting turned away.
- Providers fluctuate with being open and closed to referrals.

Website & Technology

- We would love an improved provider navigation structure with greater accessibility features on a more centralized place on your website
- Sacramento County has not been able to work out how we can use the portal for presumptive transfer: it's not BHS staff, it is your attorneys
- Improve your website so it's not so text heavy and it's easier to find things. It's impossible to find the CORE (*Community Outreach Recovery Empowerment*) clinics page if you don't know exactly how to search for it
- The website is difficult to navigate if someone was looking for support
- Too many overlapping webpages and programs with similar names, which causes confusion for the community. Consumers are unsure of which crisis program they are contacting
- Public-facing websites need to be simplified, resources and pages streamlined, and the most up-to-date content with quick access to programs and their associated brochures and forms
- Better website that is easier to navigate and share information, this includes social media presence
- Organize website to make it easier for community and partners to navigate
- Website update
- Access to technology and tech literacy are bottlenecks for service access
- Greater accessibility of information needed - updated website & streamlined for ease of retrieval
- Use of technology and telehealth
- Technology failures
- Better resource database – central need
- Universal database to prevent duplicative services

Difficulties with Referrals

- Easier referral services and access
- The inability to directly refer into programs i.e. shelter, housing etcetera is VERY frustrating…
- Just learned today that a community member who wants detox has to wait until 30 days have passed since his last assessment. That seems a bit punitive, as willingness is often fleeting.
- Streamline referral process/remove gaps.
- Improving referral tracking

Linkage & Navigation

- Programs are almost impossible to find unless you've had experience with the mental health care system
- Need for more referrals in some mental health serving programs, need for easier access to already existing support to avoid a "fail up" dynamic
- Better linkage support with crisis and county services
- Further eliminate barriers to accessibility: how people can access and be linked with services
- New onset treatment impossible to find
- Central access to services with information on capacity
- Increased navigation support, increased reporting of successes
- Streamline Navigation of Services – Make it easier for people to find, understand, and connect to the right behavioral health resources.
- Improve Health System Navigation and Linkage
- Provide a continuum document that is easy for members to navigate
- Navigating the BHS process.
- Improve system navigation for clients and family members.
- Difficulty navigating the system
- An easier way to navigate resources for clients and accessible coping skills to give to our clients.
- Need for better explanation of what is offered
- Explanation of what is offered
- Barrier with a way to find providers and help
- People not knowing where to start or go
- Availability/access to Preventive options (before it escalates), family therapy or finding alternative /holistic options.

General Accessibility

- Improvement to access support and prevention for older adult mental health services
- Improve post-residential support by ensuring every client has a follow-up appointment scheduled before leaving treatment
- Conservatorship as a barrier to services
- More services for older adults in rural areas.
- More accessible services for individuals experiencing homelessness
- Access is mythological to any lay person
- Access to resources
- Medi-Cal is very hard to reach to get clients instated - phone numbers don't work, and I witnessed clients turned away often at the supposed Medi-Cal offices
- Need to highlight accessibility at all parts of the service continuum.
- More public signs about services and behavioral health

- Please improve the signage in the parking lot for the Urgent Care Center so it is easy to read at night. The signs are too small and not always well lit.
- Difficult to access services
- Making some programs more accessible for community members.
- Sometimes person not connected due to misunderstanding,
- Easier access to resources and to housing stuff
- More accessibility to mental health services for the youth. It is always ever changing & will always be a necessity.
- Individual constraints
- Even when admitted to a locked treatment facility they are released without proper treatment
- Complex onboarding of clients
- Expanding accessible services
- Barriers to access of services

Culture, Language, & Gender Equity *– Funding Needs. Staff Diversity. Cultural Competence Focus. Culturally Competent Providers. Equitable Care. Language Equity. Immigration Stressors. Gender & LGBTQ+ Equity.*

Top Grows:

- ✪ Culture-based activities that clients would enjoy to build community and trust with potential or remaining clients
- ✪ Education, training, and technical support for communities of color with BH disorders for preparation in application processes for affordable housing opportunities, as part of treatment plans.
- ✪ Address disparities in diagnosis and treatment for Black patients
- ✪ Ensuring that the clients we serve in our BHS system are reflective of the cultural and linguistic diversity of the community. We have a long history of underserving cultural groups in our services.
- ✪ Access to more cultural competent family services/counseling
- ✪ Being open to more culturally based programming/services
- ✪ I would like to see more highlights and value given to our culturally responsive services like PEI grants, Supported Community Connections, and Behavioral Health Racial Collaborative.
- ✪ Barriers... It's important/vital to have outreach efforts by people who look like the population you're targeting!
- ✪ Provide grant-funded opportunities for local transgender-serving organizations to support gender expansive communities
- ✪ Funding for cultural competence awareness training for providers and the

Funding Needs

- I want all to receive supportive services so that the color of my skin does not indicate poor health outcomes and other disparities.
- Focus resources specifically for communities/populations most impacted with BH disparities, poverty, and housing insecurities.
- Allocate funds to support continuous inclusivity of diverse communities with a creative approach
- Minimal funding for culturally responsive interventions. I would like to see an emphasis on increasing funding to serve all of our diverse communities.
- All commissions and boards need to advocate for funding culturally responsive services. We need the voice the importance of decreasing health disparities in marginalized communities.
- Providers continue to meet clients where they're at, while at the same time, programs struggle to make ends meet now that travel time is no longer reimbursed.

Staff Diversity

- We deserve to have more diverse providers serve our diverse communities. For us, by us!
- Behavioral Health Commission needs diverse members
- Diverse workforce development and accountability
- Intentional hiring practices to ensure diverse staff
- Diversity in management

Cultural Competence Focus

- Change - would like additional meetings with BHS providers and community resources. Example - meeting focused on Black/African American community was great, but nothing has happened as a follow-up.
- We are just starting to test out culturally responsive strategies to address the complex nature of our diverse economic and social/political landscape. We need more time to build better strategies
- Deeper conversations about cultural humility like an ongoing series with more dialogue
- Intentional & focused promotion efforts to diverse communities in need of BHS Crisis Services - People can't access a service if they don't know it exists
- Advance Behavioral Health Racial Equity throughout all programs and services
- Greater cultural responsivity (beyond cultural competence) in promotion & outreach efforts of BHS crisis services
- Cultural comprehension – ask questions if you don't know
- Recognizing differences within communities – cultural competence, not grouping
- Cultural competency.

- Cultural competence
- Enhance Provider Cultural Competency Training
- More culturally inclusive and sensitive service delivery
- Culturally responsive services woven throughout, not as a standalone afterthought.
- More culturally responsive services
- More culturally responsive services for diverse communities.
- Continually updating and training staff on culturally responsive approaches
- Community Defined Practices
- The commitment to truly serving historically marginalized communities and people has to be demonstrated in supporting the local organizations that have been serving those communities for decades.
- Provide more community-based treatment options that coincide with the norms/culture of micro communities, i.e. neighborhoods
- Cultural differences
- Cultural practices and principles
- Culturally relevant practices
- Health equity for all, and people who understand this at a deep level, not only an academic or educational level, should be engrained in services
- Empowerment advocacy
- Being intentional about ensuring that everyone feels respected, supported, and a sense of belonging within the division

Culturally Competent Providers

- More ethnic-based programs
- Availability of Culturally Responsive Providers
- More resources to ethnic-based programs
- Increase the Supply of Culturally and Linguistically Matched Providers/Interpreters
- Providers from the same cultural/ethnic/spiritual backgrounds NOT rooted in westernized care
- Diverse Mental Health providers who are culturally and linguistically sensitive and who accept Medi-Cal
- All providers should focus on cultural interventions and services as they all serve diverse and marginalized populations
- More culturally responsive programs are needed for immigrant, refugee, LGBTQ+, and non-English speaking communities.
- Increase Culturally Competent Care – Ensure services reflect and respect the cultural and lived experiences of diverse populations.

Equitable Care

- Equitable access to care and services
- More resources/support for clients with physical disabilities
- Ensuring that individuals with developmental disabilities receive respectful care
- Language, cultural, and religious barriers to treatment
- Services for the disabled population
- Fatherhood support and advocacy
- Co-Ed Birth Equity Services
- Dyadic Care

Language Equity

- Language Access and Justice: Development of a comprehensive Language Access Plan to ensure non-English speakers can access services.
- Increase bilingual and culturally responsive staffing to reflect Sacramento County's diverse language and cultural needs
- Limited workforce, especially psychiatrists and bilingual clinicians, impacts timely and culturally appropriate care.
- We need more funding for LEP (Limited English Proficiency) communities to fight stigma in immigrant, refugee, and LEP populations
- Improved ASL services (interpretation)
- Punjabi is not a threshold language – however 41,000 households reportedly speak this language
- More Spanish-speaking staff
- Need multilingual MH providers who accept Medi-Cal
- More outreach to underserved communities in a variety of languages. More TV and radio announcements of services in all the threshold languages.
- Brochures for MH services are not accessible in any language (e.g., Punjabi from India written in Sanskrit, Punjabi from Pakistan written in Urdu)
- Services in different languages. Providers are culturally competent for the different communities
- Additional resources for providers to have language services
- Barrier - no County office visual information of language services at location
- Barrier - nonprofits have no office visual information of language services at location
- Addressing the difficulty in understanding and accessing services due to communities that are not well versed in community services/language barriers. Making something that is more centralized.
- Language/translation support for growing ethnic communities
- Language access
- Addressing language barriers
- Increase bilingual and culturally responsive staffing

- More outreach to the ethnic and limited English-speaking communities
- Lack of access awareness of people about mental health and language barriers
- Have more day services like the CORE (*Community Outreach Recovery Empowerment*) clinics in the rural communities and staff with diverse people with capacity to reach the language barriers

Immigration Stressors

- In light of increased statewide ICE (*Immigration and Customs Enforcement*) raids, our children are afraid and have experienced increased rates of trauma and PTSD (*Post Traumatic Stress Disorder*)
- More BHS support/services to the community, especially during challenging times. for example - ICE raids
- Trauma-informed, safe spaces for families who are impacted by ICE raids
- Youth—school age, needs for refugee youth, may become homeless due to stigma.
- Develop Systemic Capacity for Post-Migration Stressors
- Increase Dedicated Outreach to Older Adult Refugees
- Integrate Mental Health Screenings into Primary Care/Refugee Health Clinics
- Barriers- in the current political climate, youth/families are afraid of engaging in "the system" and worried about immigration
- Support immigrant children with today's trauma
- Suicide prevention and mental health access for immigrant/mixed-status/family youth
- Support indigenous/immigrant families
- We need to support our immigrant/mixed-status/family youth — fostered immigration youth

Gender & LGBTQ+ Equity

- We continue to struggle with trust and outreach to subsets of the LGBTQ community; for example, seniors, BIPOC, and families with children. They need the same type of community connection as do large groups
- Train providers to work with two spirit, transgender, non-binary, and gender expansive community members
- Transparency that Sacramento County BH has cultural comprehension and actively works with two spirit, transgender, non-binary, and gender expansive individuals
- Gender-affirming care, deliberate practice, and intentional work to honor consumers and clients' chosen names, pronouns, and gender identities
- Community (e.g., some languages lack a word for LGBT)
- Services to the older LGBTQ population

- More LGBTQ+ housing, shelter, counseling services; advertise LGBT welcome
- Gender expansive and transgender consumers and staff are still routinely misgendered, or their experiences are trivialized in treatment settings
- More gender affirming care

Intake Barriers – *Need for Autism Spectrum Disorder Screening & Services. Documentation. Cost of Services. Other Barriers.*

Top Grow:

✪ Change increase in Autism services to reduce impact on behavioral health; families need access to the support they need instead of just "waiting" for months until linkage is available

Need for Autism Spectrum Disorder Screening & Services

- Need Autism resources; Alta (*Regional*) and ABA (*Applies Behavior Analysis*) are often booked out for months at a time and families aren't able to get their needs met.
- BHS-Sac (*Behavioral Health Services-Screening And Coordination)* increasing their assessment of mental health versus developmental needs. Lots of youth with autism being referred.
- Youth with residential treatment needs are called in to CPS(*Child Protective Services*) because there is no other path to that level of treatment, even when there is no abuse in the home
- Gaps- specialties (eating disorders, Autism, psychosis that's been ongoing for more than 2 years and don't meet EDAPT [*Early Diagnosis And Preventative Treatment*] criteria)
- We definitely need more ASD (*Autism Spectrum Disorder*) supports in the community.
- Improved services for those with autism
- Autism resources
- Autism-related MH treatment
- More support for families with children who have developmental delays, especially autism

Documentation

- Changes: continue to work on decreasing required paperwork for intake assessments
- Reducing documentation requirements
- Less documentation requirements
- Decreasing documentation requirements will decrease burnout and increase retention

- The administrative burden of the paperwork to be an SCC program.
- Less paperwork (and repeated forms)
- Please make the continuum of care document easier to understand.
- Continued streamlining of documentation requirements
- Less redundancy and non-clinical paperwork for clinical staff.
- Documentation, tons of documentation which gets in the way of having more time to be with families and provide effective time and support
- Fewer documentation requirements so staff can focus on direct care.
- Decrease documentation requirements
- Lengthy referral and assessment forms with limited eligibility criteria make it harder to initiate certain services.
- Digitalize intake forms within Smart Care Enhance/improve the EHR *(Electronic Health Records*)
- Documentation takes longer than the actual service with the client.

Insurance & Financial Concerns:

- Barriers due to insurance issues or other health coverage.
- Insurance companies: crisis/liability insurance for group homes/no competition
- Complicated insurance barriers to receiving Mental Health services
- In a perfect world, mental health resources should be accessible to everyone, along with affordable prescription medications, regardless of insurance status
- Insurance/medical group confusion
- There is insufficient accessibility for those without medical insurance when more than counseling is required
- More funding to support family who don't qualify for Medi-Cal benefits (for programs that require Med-iCal as an insurance)
- Not entering treatment due to financial concerns
- Easier access to treatment options and affordable medications
- Funding for consumers if they cannot afford health care
- Limited assistance for low-income families
- Financial challenges (e.g., diversion/prevention, assistance cuts)
- Cost of services
- Cost.
- Cost

Other Barriers:

- Expand rapid-access options so community members can schedule their first behavioral health appointment the same day they reach out for help
- Quicker response to place people in rehab
- Streamlining intake processes and expanding outreach

- Streamline housing entry points
- Streamline processes
- Screening is often done by unqualified persons and the ill are not referred to proper programs
- Screener questions do not properly assess for SMI
- Screening. Brief intervention and referral treatment
- Screening is often done by unqualified persons
- There are a number of barriers and difficulty with getting people into FSP (*Full Service Partnership*) services.
- When you call Sacramento County Access, fear of involuntary hospitalization leads to dishonesty during suicide risk assessments – need clarity about how hospitalization would be voluntary
- The phone intake process involves a super-personal questionnaire administered by phone, where participants are asked to rank. Not knowing what the overall process is before engaging in the questions.
- Improve policies to encourage participation in services
- Fewer referrals
- Barriers to entry
- Intake processes not aligned with client needs or timing (e.g., calling after hours)
- Redesign "intakes".
- Identifying barriers to accessing resources
- Process for referring clients; limiting the medical necessity for access
- Still need agencies to implement a trauma symptom measure at intake assessment not all agencies do this

Stigma & Community Trust - *Stigma. Community Trust.*

Top Grow

✪ Stigma is still a barrier – better outreach for older adults, not just technology

Stigma

- Continue to focus on normalizing mental health care, knowing when to seek help, and how to access services
- Stigma is a barrier for older adults with depression and isolation.
- Stigma has to be addressed - it has to be part of early intervention if the county can no longer do "prevention".
- Clearing out the mental health stigma among different cultures.
- Expand Mental Health Literacy and Destigmatization Outreach
- Reduce Stigma – Normalize conversations about mental health and addiction to encourage more people to seek help.

- Continued need for public education and anti-stigma campaigns so community members seek help earlier and feel supported.
- Stigma is still a huge barrier
- Seeking out mental health stigma
- Stigma reduction
- Stigma, shame
- Stigma

Community Trust

- Do more positive PR and get ahead of the narrative
- Truly listening and implementing programs that the community wants & NEED
- Psychiatric medications promoted for financial incentives rather than client best interest
- Trauma from system care and therefore valid unwillingness to engage with those traumatizing services
- Consumers feel overwhelmed and intimidated by crisis services
- Alienation of MH consumers
- From disengaged entitled employees with no empathy
- Sheriff's Department policy changes have damaged trust
- Law enforcement does not or cannot act appropriately when needed
- Lack of community support

Outreach

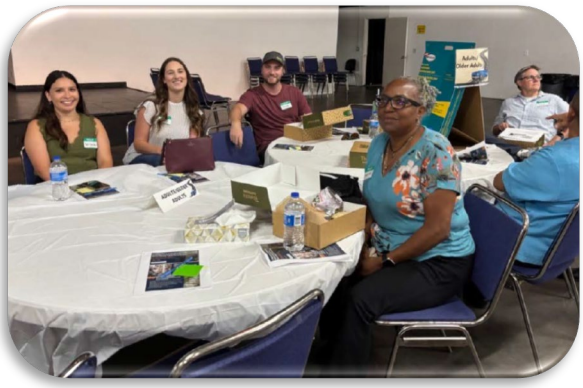
Top Grows:

✪ Do more outreach to spread information about the services we offer
✪ Expansion of outreach
✪ Better understanding of the housing programs available. Many clients are
✪ Better client engagement
✪ More outreach and education about services

- Outreach to unserved and underserved populations through investing time in activities that lead to progress on shared goals.
- Outreach for our TAY population to ensure they don’t get lost within the system
- Outreach to specific populations that are high risk especially those engaging in CSE (*Child Sexual Exploitation*)
- Follow up to outreach, not picking up the phone due to illness, worker come, site-based services
- Follow-up to outreach hindered by illness; need site-based services
- Have never seen proactive, field-based outreach from CORE (*Community Outreach Recovery Empowerment*) staff (but they will come if we call)

- CORE and FSP contracted providers need to do better about connecting with unhoused clients. They should consider coming to the shelters and providing days of services directly at the shelters.
- Improve community awareness of County programs
- Love seeing BHS/related depts in and around community. Consider tabling or presenting on school campus or local sports events
- Better engage families in Adult System of Care
- Outreach programs- HEART (*Homeless Engagement And Response Team*), CST (*Community Support Team*)
- Increase in outreach amongst the homeless population with the HEART team
- Who do you call instead of 911? People don't know about 988
- Too many people don't know about 9-8-8
- Improve outreach and education about 988 and the Community Wellness Response Team
- Unaware of what services are available and how to access them
- Lack of knowledge of how to access MH or other services
- Coordinated care plans and lack of people knowing where to go to get help.
- Ensure that info about funding opportunities and services go out in a variety of ways - not just online but street outreach (in person and paper options)
- Increase awareness of available resources and supports.
- Effectively informing the community about resources that are available to them
- People can't access programs/services they don't know exist
- Less crowded events
- General public-facing resources (e.g.: FAQs, one-pagers, etc.) that help individuals better access general and specialty behavioral health services
- Increase media campaigns.
- Increase awareness of services
- More outreach requires expansion
- More outreach to underserved community
- Need a solid outreach plan and contacts from each community group
- Knowledge, education, getting the word out
- Improve awareness of BH programs among youth
- Better exposure to services available
- Awareness of program
- More advertisement in common areas in the community
- Better outreach to specific audiences
- Build campaigns for specific target audiences
- Strategic outreach
- Better, simplified, targeted outreach
- More marketing & outreach opportunities to participate in community-based events
- Educating the community around services available and making it easier for those with MH (Mental Health) needs to navigate the system more easily.

- Engagement in communities unserved and underserved
- Increase Community Awareness – Improve education on mental health, substance misuse, and available behavioral health resources.
- Need more public knowledge/information on services
- More advertising of how to access safe stays
- More unhoused outreach
- Lack of community awareness
- Consistent provider outreach to engage clients
- Some clients don't know about you guys
- Reach more people
- Narcan needs to be available in general public, not just in areas where substance users are known to be.
- How to use Narcan needs to become common knowledge
- Outreach to underserved communities
- More outreach to diverse communities
- Outreach to rural communities
- Outreach
- Outreach
- Outreach



More Community Collaboration – *Employ More Community Organizations. Community Relationships. Community Participation in Planning. Other Collaboration.*

Top Grows:

- ✪ The county is currently working building a framework for the key policy changes taking place. I would ask we continue to remain closely connected in the implementation of BHSA and TR (*transitional rent*), specifically.
- ✪ Please continue to foster relationships with community partners and provide timely responses. Together we can impact so many lives.
- ✪ Integrate and increase funding for consumer-run organizations like peer services
- ✪ Not enough funding for community-based services
- ✪ Increase collaboration between resource providers so that community members receive a holistic and well-rounded approach to care.
- ✪ More collaborations needed with trusted CBO's (*Community Based Organizations*)
- ✪ Engaging with smaller cities

Employ More Community Organizations

- Fund smaller, culturally rooted CBOs (*Community Based Organizations*) that serve underserved populations. Best practices include: Flexible, multi-year funding. Simplified reporting. Co-designing programs with CBOs.
- Better collaboration with and presence at Community-Based Organizations
- Better collaboration with and presence at Community-Based Organizations
- Smaller providers that integrate into specific communities/neighborhoods
- Navigators who belong to the neighborhood
- Continue to strengthen community partnerships and leverage existing resources
- Partnerships with social service providers (nutrition providers, senior centers, health partners, caregivers, regional centers etc.)

Community Relationships

- Embed Equity in Funding Requirements
- Sponsor family centered community activities as a form of prevention
- Secure funding for indirect services and supports
- Streamline bureaucratic processes as much as possible to ensure programs closest to the communities in need are included in the solutions
- Roster of organizations / build connections
- Relationship building with silent partners (those that don't know your services)
- Continue to strengthen community partnerships and leverage existing resources
- Continue to foster relationships with community partners.
- Community services
- Being more involved with the centers you are funding.
- Stronger collaboration with community based orgs that are embedded in the communities
- More community engagement to better understand diverse community needs.
- More collaboration with faith based organizations.
- Barrier - not feeling welcome by staff

Community Participation in Planning

- Move opportunities to participate in County BH (*Behavioral Health*) planning
- More provider involvement
- Co-production with communities
- Need to conduct more community conversations
- More community participant sessions
- These meetings more often (In person & open conversations)
- Improving collaboration by asking for input from the community partners before making decisions

- Deeper participation in policy decisions, streamlined support systems, and prevention-focused strategies. All point toward dignity, stability, and inclusion, driving real change in behavioral health.
- Solicit input from families even when their loved one has not signed an ROI (*Release of Information*) - families want to support their loved one in any way that they can
- Hearing from those who are experiencing MH (*Mental Health*) challenges and placing them in positions to make decisions that directly affect them
- Working closely with cities on identifying pilot projects to explore new ways to address issues related to behavioral health and drug addiction.
- information to the program even if their loved one has refused to sign an ROI
- More marketing and outreach opportunities to participate in community-based events
- Getting a clear understanding of what unhoused individuals need. Bring them to the table
- Making sure vulnerable groups are at the spear of conversation
- Family members be a part in the long-term solution
- Barrier - nonprofits not demonstrating in-person feeling of welcome Community events to get feedback on continued support
- Community Conversation events
- Community events that focus on bringing people together like more free resource fairs, maybe behavioral health community lunches/hangout spots
- More community events so that people can have conversations around getting help so that they will feel comfortable in doing so
- Increase community involvement and interaction with consumers
- Increase Family Resource events, workshops, and fun activities
- Parent, caregiver, family committee meetings (hybrid)
- More programs designated for what client states needed

Other Collaboration

- Continued and enhanced support for all listed on the Glows
- More opportunities to volunteer
- Lack of consideration for family member concerns, especially when the individual is treatment resistant
- Youth engagement
- Improve stakeholder to stakeholder collaboration, recognize community resources
- More community and networking opportunities as there is only Network Cafe really
- Improve collective knowledge about available services and supports across all of BHS (both internally and with external partners).
- Motivation to support
- Other agency

- Ongoing services
- Donation

More Cross-Sector Coordination – *Communication. Justice-Involved Services. SUPT & MH. Physical Health Services. Within the County. Networking. Other Partners.*

Top Grows:

- ✪ Map out the intersections and alignment opportunities between programs/initiatives by funding buckets (FSP, CORE, FIT, etc.)
- ✪ As info gathering is underway, it will be helpful to map out the intersections and alignment operations between programs/initiatives by funding buckets (e.g. FSP, CORE, FIT, etc.)
- ✪ It would also be helpful to understand how the MCPs can best partner with the County on the implementation of BHSA and TR (transitional rent)
- ✪ Processes that can support whole-family care and support with information-sharing between agencies
- ✪ Integration needs to happen with SUPT and BHS. It is coming along but needs to happen.
- ✪ Medi-Cal transfer between counties
- ✪ Fostering physical wellness and tobacco cessation, marijuana smoke-free facilities
- ✪ Better leadership collaboration

Communication

- Communication – foster strategic partnerships
- Communication is horrible.
- Better communication!!!! Housing needs to be easier to navigate; most clients I've met trying to navigate the current system are almost always defeated / out of hope
- Transparency between departments
- Lack of transparency and communication with service providers. My experience with participants who are attempting to receive services never get a call back from the service provider
- Want- additional County-level communication around upcoming changes that impact providers or clients BEFORE they happen
- Limited communication between providers- even in larger meetings, most folks don't share openly and are often seeing each other as competition
- Communication/real time updates with the other agencies involved in supporting the youth/family
- Improved communication across BHS
- Improved clarity and communication with community to define BHP (Behavioral Health Professional) services and responsibility
- Communication with the public, as well as internally

- Improve communication and workflows
- Improve communication with all levels of staff
- Client follow-up and communication
- More communication and collaboration. More funding is still needed to address the mental health crisis youth are going through.
- Improve communication with families: let families know they can provide
- Process for collaboration/closed-loop feedback with other groups serving the client
- Coordination as individuals transition through the life span
- Improved Complex Case Management services
- STAR TAY does not appear to be as active in responding to clients in crisis as the other FSPs (*Full Service Partnership*)
- Standardize warm handoffs between crisis services, navigators, and clinics

Justice-Involved Services

- More coordination with collaborative courts and engagement of individuals with judges
- Need to collaborate with jails to look at rehabilitation services for those who are justice involved. We need meaningful rehabilitation for those eligible for re-entry
- 911 and 988 not deferring to each other
- Problems with the Sheriff's office refusing to respond to mental health calls
- Focus on continuum of care from custody to community
- More partnership with juvenile justice partners to ensure BHS is at the table and involved in treatment of this population
- Discussing with community partners, such as LE (Law Enforcement) in regard to timely responses and ensuring the County and LE are working together to better serve the community aligned.
- Recommend more collaboration with the jails, especially gearing up for CalAIM initiative. We could set a workgroup on ways to collaborate

Substance Use Prevention and Treatment (SUPT) and Mental Health (MH)

- If BHSA is about integrating SUPT (*Substance Use Prevention and Treatment*), it would be nice to see them included more in conversations and program development
- More intentional contracting and collaboration between BHS divisions (i.e. FSPs [*Full Service Partnerships*] should have SUPT programming within FSP programing)
- We need more substance use providers in these conversations
- Barrier: Access makes a decision of which treatment the client is calling for, either MH or SUPT. Both need addressing simultaneously

- More substance use treatment in shelters, youth and all ages The disbanding of the Alcohol and Drug Advisory board which may threaten that voice at the table and not have a focus of SUPT services.
- Addiction and mental health needs to be dual diagnoses
- Embed drug counselors (CADACs [*Certified Alcohol and Drug Addiction Consultant]*) into more BHS programs
- Easier/ more streamlined approaches to care coordination between mental health and substance use treatment.
- More integration

Physical Health Services

- Lack of coordination with MCP (*Managed Care Plans*) plans—clients fall through cracks after CORE (*Community Outreach Recovery Empowerment*)
- Smoother transitions and coordination with Managed Care Plans
- Developing relationships between BHS and GMCs (*Geographic Managed Care*) – easier referral process
- More collaboration with other health care systems to support with whole person care.
- Coordination – bridging the gap between physical and behavioral health
- Cross-system collaboration to ensure people stay qualified for Medi-Cal so they can remain eligible for BHS services.
- Further integrating BHS with primary care
- Integrated Care Models: Bridging physical and behavioral health.
- Not sure this is within the County's reach, but we need better behavioral health options for folks with Kaiser
- Seems like the Emergency Departments are placing many people on 5150s (*mandatory psychiatric hold*) when they may best be served on an outpatient basis

Within the County

- Increase collaboration and coordination across BHS teams to reduce silos
- Silo – more coordination and integration
- Silo'ing amongst providers
- Breaking down of silos, increasing shared awareness about available services/supports by both staff and the community, allowing more time for thoughtful planning/collaboration for new initiatives.
- Breaking down internal silos
- Breaking silos to encourage collaboration internally and externally.
- Benefits beyond/without City, County, jurisdictions/boundaries impacting access
- Continuity among counties – finances and care

- DHCS (*Departme*nt of Health Care Services) + DHA (*Department of Human Assistance*) + BHS (*Behavioral Health Services*) should collaborate more closely with community partners around Prop 47
- Cohesiveness between departments/services
- Lack on interagency cooperation
- More connections, collaboration and communication between various BHS departments.
- Internal BHS Staff event
- More encouragement cross-team collaboration for understanding broader system and consultation
- More awareness and education of other internal departments and their respective services
- There seems to be a gap of understanding between different departments

Networking

- Resources for providers (e.g., Red Cards Other partners and coordination)
- A provider email list would be lovely and help support direct contact between providers
- Resource and resource follow-up

Other Partners

- SCOE (*Sacramento County Office of Education*) and BHS serve the same population; SCOE often doesn't refer families to BHS providers due to being seen as competition
- More IHSS (*In Home Supportive Services*) workers and caregivers needed for older adults
- Collaborate (with IHSS?) for care of frail seniors in shelters
- Improved processes to streamline the coordination of care across our continuum
- Better partnership with Full Service Partnerships - oftentimes what is talked about in spaces like this is not what families and youth experience in real time
- Streamline services for families' referral process, provider-to-provider
- Sustainable Funding and Partnerships – Strengthen collaboration between nonprofits, schools, healthcare, and local agencies to sustain effective programs.
- Provides an opportunity for the County and MCPs to strengthen collaboration & coordination to improve access & better support individuals shifting between mild-to-moderate behavioral health services & specialty behavioral health
- Grow functional, intentional partnerships between affordable housing resources and behavioral health care providers.
- Would love more collaboration opportunities among providers

- Closer collaboration and alignment with system partners (CPS [*Child Protective Services*], ALTA Regional, Probation)
- Better integration/collaboration with Alta clients
- More consistent and effective collaboration between districts and outpatient providers seeking to provide school based services (at family request)
- Reduce barriers to providing support services in the schools (some sites are less able to allow external wellness providers on site without special permissions).
- Cross system collaboration e.g. school–children's providers–probation–child welfare
- Artificial barriers that prevent collaboration/support with providers from different agencies
- Emphasizing that all providers are the same or can do the same things is not yet a reality
- We should have more collaboration with veterans' service
- Increasing effective collaboration with City of Sacramento admins
- COREs (*Community Outreach Recovery Empowerment*) need to be involved
- Collaboration with Master's of Counseling or Social Work, PsyD, PhD, etc., programs to stretch the support systems given budget confines.
- It's hard to pinpoint. I work in the residential setting with foster and probation youth families. The families experience a ton of frustrations with their respective counties
- Systems need to be connected; mental health, substance use disorder, employment, and housing
- Increased coordination of care.
- Better coordination of identifying the population in need.
- Increased coordination efforts between internal and external providers
- Better transitions of care and coordination across systems
- Coordination of care
- More collaboration between resources
- Provider collaboration and continuity of care
- Strengthen relationships with our contracted providers
- Additional support from state agencies
- Encourage a more collaborative environment

Support for Existing Services – *Desire for successful programs to continue.*

Top Grow:

✪ Please continue to offer trainings to keep community partners informed

- Behavioral Health Bridge Housing
- The County is temporarily funding Community Health Workers (CHWs) in the city through American Rescue Plan Act (ARPA) funds. We would like to see future

navigation services funded through the county, as they are part of health and human services.

- Funding/contract increase for CAPS (*Child and Adolescent Psychiatric Services*) Program
- CAPS needs more in-house psychiatrists
- CORE (*Community Outreach Recovery Empowerment*)/FIT programs also adopting the "whatever it takes" model in engaging clients
- BHS-SAC (*Behavioral Health Services-Screening And Coordination)* workflow is more sustainable for employees
- I miss the virtual Sac Collab Therapy service offered during and post COVID
- Continue provision of medical services and supporting foster youth in transition.
- Support existing MH programs in awareness of service needs for older adults
- Using existing Senior support services to refer Elderly to housing/physical care and companion connections
- Keep the programs that are working, like Stop Stigma Sacramento
- Support and funding to continue SMHW (*Student Mental Health and Wellness*) Collaborative and the collective work.
- Behavioral Health Bridge Housing
- Make CCOP in-person or hybrid
- Continued support and work around bullying and suicide prevention! More capacity building at all levels of youth facing and LEA (*Local Education Agency*) supports.
- Long term, Supportive services for those who need them the most.
- Continued support
- Program is working!
- Support system for welfare check
- Improve access to services (We are already GREAT!!)
- Trauma-informed evidence-based therapy services to continue
- Family support system
- Social Service Supports/Resiliency Building
- Life Skill Building/Fostering Independence
- Integrated Care
- Preventative BHS services
- Fund Trauma-Informed, Community-Defined Services
- Reintroduce travel time reimbursement for community providers
- Consistent use of Evidence-Based Practices
- Access to non-traditional MH
- Offer programs and solutions

Service Expansion & New Ideas *– Dual treatment. Older Adults. Justice-Involved. ADHD, Lower Level. Severe Needs. Ancillary. Increase Capacity. Other Expansion.*

Top Grows:

- ✪ Early intervention
- ✪ Need for 24 hour immediate response by mental health professionals
- ✪ Provide services upon jail exit
- ✪ Residential Substance Use Disorder Treatment for Youth.
- ✪ Addressing early intervention for older adults will be key in the coming years as our aging population grows exponentially.
- ✪ Lower level outpatient needs, more therapy, it's what clients wants; needs more therapy for adults, agency isn't really on it.
- ✪ Provide more holistic services (e.g. hygiene, laundry, haircuts, and incentivize the community to help)
- ✪ Showers & laundry for families; better infrastructure (toilets, hot water)
- ✪ Allocating funds towards community prosecutor programs for cities to compel treatment for chronic mental ill and drug addicted people experiencing homelessness
- ✪ County funding of navigation services to avoid blurred lines of compassionate accountability through law enforcement and county behavioral health service provision.
- ✪ Lack of readily available housing support
- ✪ More substance related programs for youth
- ✪ Early intervention for older adults who are isolated or lack social connections.

Dual treatment

- Our county needs more dual diagnosis facilities, our consumers do not need to attend two different sites. Access shouldn't be making a decision of either MH or SUPT
- Co-occurrence expansion is needed
- Need to provide both substance use treatment and mental health treatment for those who are incarcerated
- Increase the number of providers who can meet all BH needs (SUD and MH)
- BHS Sac (both mental health and SUPT) need to be an integrated access line that is staffed 24/7 or has dedicated 24/7 staff that are able to complete screenings and authorizations at all times.

Older Adults

- Expansion of community resources for the underserved Expansion of services for our older populations
- Improve focus on older adults
- Invest in behavioral health advocates for older adults
- More programs for isolated seniors.
- Limited mental health services for older adults.
- I would like to see more in-home programs for older adults. Due to their medical conditions, attending in person visits can be a challenge.
- Home-based services for older adults
- Expand PACE (*Program for All-inclusive Care for Elderly*) reach in the community
- There are older adults who have aged out of the foster system in their 40's - 70's who have no help
- More in-home mental health services for older adults
- Services for the aging population
- Lack of services for older adults
- More low-cost care for the elderly
- Addressing the growing Older Adult homeless population
- Improvements/practice change for access to SMH (*Specialty Mental Health*) for Older Adults

Justice-Involved

- Mental Health that reduces incarceration
- More rehabilitation services to assist with thieving in the community, meet people where they are, and decrease fear of punitive services.
- More services for individuals being released from the justice system, More alignments between CBOs (*Community Based Organizations*) and FSPs (*Full Service Partnerships*). Reaching out and collaborating with the military and veteran population; to complement

Attention Deficit Hyperactivity Disorder (ADHD) services

- Services for ADHD (collaboration with Psychiatry & MIND Institute)
- ADHD services for youth and adults
- Work with MIND Institute on ADHD

Lower Level Needs

- Lower-level outpatient needs; more therapy for adults
- Work towards reducing service gaps for moderate to mild MH (*Mental Health*) needs as there appears to be more focused on severe MH for those on Medi-Cal.

- MH aftercare
- Long-term therapy
- Life skills – budgeting
- Level of intensity of services to match the level of need
- Be prepared to miss a lot of folks struggling since the focus is now on "the most complex" of situations

Severe Level Needs

- Make it easier to be offered a spot in an FSP (*Full Service Partnership*)
- Challenges with appropriate accommodations for individuals with severe needs
- Extremely limited spots for those who need it when it comes to receiving more intensive support

Ancillary Assistance

- More incentives
- Exchange system for clothing and blankets/sleeping bags
- Better functioning toilets, hot water—overall infrastructure
- Resources (utilities, temporary housing for families with children)
- Safe overnight parking for people living in their cars
- Safe place with toilet and showers for unhoused people to camp
- More showers per individual

Increase Capacity

- Need for more capacity in-patient beds
- Increase staffing & provider access, Expand bed capacity, centralize navigation tools, Improve customer service & outreach, Streamline governance
- Providers in identified zip codes with no services
- Lack of inpatient facilities
- There is a need for additional treatment centers and sober living
- Sober living environment availability is low
- More adult residential care.
- Expanding MH (*Mental Health*) clinics to also include developmental pediatricians, speech therapists, occupational therapists, physical therapists to offer comprehensive care to address all aspects of development
- More Alcohol and drug programs
- More 23-hour respites needed
- Increased residential rehab programs
- We need more therapy slots at CORE (*Community Outreach Recovery Empowerment*)
- Access to services for those with co-occurring disorders

- More community wellness centers and easy access
- More therapists for one-to-one extended therapy
- We need increased prescriber capacity
- Medi-cal needs to have more support groups
- More CRP (*Crisis Residential Program*) beds
- More residential treatment programs
- Better resources and response from providers
- Counseling services
- More people serving

Other Expansion:

- Implementing and expanding Neurosequential Model for Therapeutics training throughout the county
- We need to provide therapy for PTSD (*Post Traumatic Stress Disorder*). Not as a bonus service, but as a guaranteed part of SMHS (*Specialty Mental Health System*).
- We need to provide DBT (*Dialectical Behavior Therapy*) group therapy. We have a huge need for personality d/o (*disorder*) care.
- I'd like to see more in home support (therapy)
- Would be great if Medi-Cal covered Intensive Outpatient Programs or Partial Hospitalization
- Gaps: treatment for Problematic Sexual Behaviors; Disordered Eating
- Improve post-residential support by ensuring every client has a follow-up appointment scheduled before leaving treatment.
- Ambient listening (AI) to support documentation. Like MDs use in health care. Would assist clinicians in less time doing documentation.
- Strengthen Early intervention programming
- More prevention, less intervention
- Early Intervention for Older Adults and Disabled Individuals.
- Less restrictive timelines for care
- Need more low-barrier care programs
- CORE (*Community Outreach Recovery Empowerment*) programs don’t really facilitate SSI/SSDI applications
- More access to EBP for children's brain spotting, EMDR (*Eye Movement Desensitization and Reprocessing*), TMS (*Transcranial Magnetic Stimulation*) (not MK [*Medi-Cal?*] reimbursement)
- Need agencies to provide EBT (*Evidence Based Treatment*) for treatment of trauma
- Slow roll-out of funds for capital facilities.
- Youth engagement is great, but we must not forget about the disabled veterans and older adults who suffer out there as well

- Create podcasts
- Go Big...Drug Treatment inpatient
- Find ways to innovate and partner with agencies to provide co-occurring treatment, especially residential
- Wrap around care, including behavioral health, housing, transportation
- Initiatives to find creative ways to tackle this
- Community-based/field interventions for people with functional impairments
- Initial mental review while on street before intake
- Better parking
- Bigger parking lot
- Better beds
- Bigger TV in the A side for patients
- Succulent farm for patients
- Better food
- Healthier food options

Youth, Family, & Education Services *– Service expansion emphasis.*

Top Grows:

- ✪ More prevention & family support to allow for an integrated family-centered and patient-centered approach. Housing does not work in a vacuum without prevention services, especially with trauma
- ✪ Educate teachers, foster parents, & others how to spot signs of mental health struggles and offer support
- ✪ Concerned about loss of prevention focus in new State directive
- ✪ Focus on services that serve the “whole” family has been incredibly helpful
- ✪ Prevention can be embedded in schools
- ✪ Where do we allow parents to go? Families stuck in shelters that don’t accept kids; need more family shelters

Schools

- More school-based services
- Not sure if you connect with SCOE (*Sacramento County Office of Education*). Appreciate more counseling liaisons / clinicians on campus
- TAY (*Transition Age Youth*) and Foster Youth supports better integrated into K–12
- Education after aging out of school — NOT LOST
- Residential treatment for Boys and Girls/Youth – complexity of opening residential
- How to partner more closely with educators – recognizing their role in supporting children/youth

- Allocate funding for Prevention Programs and Parent Education classes to support early intervention
- Continued funding for bullying prevention and suicide prevention
- Substance use services in schools
- Mentorship programs embedded in schools and communities
- Mental health education in schools
- There is still much work to be done in the early intervention and prevention realm. And continued education is the key!
- More funding for job training programs for students and young adults

Youth

- Allocating more funding to support families with children ages 0-5 and the development of a therapeutic preschool
- Lack of residential options for adolescents, especially for substance abuse issues.
- More funding for AOD (*Alcohol and Other Drug*) services especially with youth
- We need inpatient Medi-Cal AOD programs for our TAY (*Transition Age Youth*) youth. Some of our youth are not living in the right environment to get sober. And only have the outpatient option can be setting the youth up to fail
- Teen sober living
- Youth substance abuse resources
- Residential Treatment programs in Sacramento for youth
- Keep ensuring youth engagement
- Increase housing supports for transition age youth who are not connected to Child Welfare/Probation
- Need substance use prevention, suicide prevention—especially for youth & families
- More higher acuity services such as crisis residential for youth, CSU for youth, eating disorder treatment, etc.
- Virtually no acute MH/psychiatric care for adolescent males
- More engagement with elementary, middle, and high school funding organizations to facilitate “edu-tainment” opportunities in the schools, as an added credit in a health science course.
- Funding for food for youth programs.
- Gap: intensive outpatient substance dependence for adolescents
- I’d like to see residential treatment options for Youth in our community.
- Intensive support for children being released from hospitalizations and parents are struggling to maintain the child in the home
- I'd like to see a team dedicated to children who are struggling to stay home or return home from a hospitalization or residential treatment center
- Lack of C-SEC (*Commercial Sexual Exploitation of Children*) programs Lack of SUD programs for youth

- We really need CSEC housing and inpatient rehabs like they have on the East Coast
- Better child services
- More young adult services
- Residential treatment for youth
- TAY (*Transition Age Youth*) youth

Families

- More services for current/former Foster Youth and parents.
- Limited safe resources for families removed from eligibility for refusing a service
- Need services to avoid CPS (*Child Protective Services*) involvement
- Evaluation of services to ensure families get what they need
- More supports for FIT (*Flexible Integrated Treatment*) programs. More hospital supports and collaboration along with resources/support groups for caregivers and families.
- Opportunity to further support Foster Youth and unhoused families. So much need for these children and families
- Finding a way to yes to meet the needs of families served. Finding the most appropriate service for the family based on their needs
- More legal strategies to get family members into care
- More support for family caregivers
- Transitional youth – assuring that the family is still involved
- Increase family resource events
- Services and engagement for families of children/youth with MH
- More/better quality support for parents/family members of adult consumers
- Expand youth and family-focused access points, including school-based and community-based services
- Family support for caretakers of MH
- Support for caregivers' mental health issues caring for children who also sufferer from mental health issues
- Childcare

Crisis Services *– Service expansion emphasis*

Top Grow:

✪ I would love to see more leveraging and use of funds to dedicate counselors or crises response in housing programs.

Involuntary Transport Gap

- Support for 5150 (*mandatory psychiatric hold*) situations now that Law enforcement is not assisting with crisis response in some areas.

- Gap: Involuntary transports are not able to be done; more issue with adult vs. youth but happens across the board
- Gap: Persons in MH crisis who also need housing shouldn't be placed in unincorporated County where sheriff no longer responds to MH calls; risk/crisis stratification needed
- Gap: BHS should develop alternative system to provide involuntary transport
- Gap: More education needed on 51/50 and 988; stronger collaboration across systems
- Inability to get an individual 5150'd – even when the mental health professional feels it is necessary
- CCIT (*Co-response Crisis Intervention Team*) was a major support in the community and it's unfortunate we don't have them as active in the community seemingly due to LE's (*Law Enforcement*) response to mental health
- Community referral sources-CWRT (*Community Wellness Response Team*) & TAD (*Triage to Alternate Destination*) -don't have the ability to initiate 5150s

More Support for Crisis Services

- Need to continue growing the crisis continuum of care - widening the entry to care as well as streamlining the journey through the lower levels of care
- Decreasing gaps in crisis continuum care - i.e., decrease wait time for follow-up appointments after the crisis situation stabilizes
- Need for more respites for those in crisis
- More crisis emergency shelter availability while on waitlists
- More urgent care centers
- Mobile Crisis Teams and urgent care services are not yet scaled to meet community wide demand 24/7.
- More BH urgent care 24 hours
- More urgent care clinics
- Expand the services for Mental Health Urgent Care
- Increase crisis services
- More mobile crisis teams and other crisis response services
- Mobile crisis units are useless
- Crisis intervention (Mobile units)
- Informing patients being admitted for 5150, and families of their rights verbally. Use a standard video message.
- How can we avoid folks incarcerated or admitted from losing their homes or possessions?
- Hospital coordination. Most hospitals are not contacting providers when a youth is on a 5150 hold.
- BHS to conduct deeper case-by-case analysis of CWRT (*Community Wellness Response Team*) calls to better define "emergency"

- Promote availability of CWRT
- Confusion due to overlapping crisis programs (MCST (*Mobile Crisis Support Team*) → CCIT (*Co-response Crisis Intervention Team*), CWRT, CST (*Community Support Team*), HEART (*Homeless Engagement And Response Team*), TAD (*Triage to Alternate Destination*))
- Immediate in-person response for families in crisis due to a mental health need
- Lack of streamlined crisis access
- Same-day access to in-patient mental health treatment
- More crisis emergency shelter availability
- Crisis response expansion
- Develop more specialized crisis intervention teams
- Intense inpatient not available with Medi-Cal unless during a crisis
- Expand and increase respite centers
- Improve post-residential support
- Lack of quickly available inpatient treatment options, possibly aside from Sierra Vista

Housing Services – *Service expansion emphasis*

Top Grow:

✪ Long term solutions to housing

- CORE (*Community Outreach Recovery Empowerment*) centers are more focused on people with severe mental health disorders than those with just substance use challenges
- CORE programs housing focus is heavy on room and boards
- CORE centers only connect people to housing if they have income to self-sustain after 3-6 months
- Ave. number of services per CORE client: Unhoused = 24.2 vs. Housed = 33.5
- Only 1% of CORE generated referrals come from shelters
- Providers only provide 0.5% of services to homeless clients at shelter. Providers don't respond to shelters or are slow to respond
- Housed clients received approximately 38% more services than the unhoused
- Homeless clients are 36% more likely to be discharged for “Disengaged From Services/Non-Compliant with Treatment”
- Homeless clients are 40% more likely to be discharged for “Never Engaged in Services”
- Only somewhat homeless (car / couch) and have no help, that’s really hard to carry knowing you have no resources to offer
- Somehow pair BHSA, CPS (*Child Protective Services*), & housing staff to help families in crisis secure stable housing while addressing mental health needs

- Create interim housing solutions that are designed to continue care from contact through placement and wrap services.
- More supportive, affordable housing for persons with bipolar disorder
- Permanent accommodation and care for unwell persons
- Long-term transitional housing with pet care and accommodation
- Shelter resources Housing services, crisis response, therapeutic services that are culturally appropriate, and additional funds to help community orgs maintain their staff
- Integrate housing navigation into behavioral health services
- Transitional housing programs with skill building
- Housing, food support, transportation, documentation, and gas reimbursement
- Lack of housing prevents some from accessing essential MH/SUD services
- Being able to help all unhoused in CA, not just a small percentage
- Limited availability of affordable housing
- Lack of housing hinders employment opportunities
- Improving clarity of services offered
- Work with county on zoning for affordable housing
- More accessible and affordable housing needed for those experiencing chronic homelessness
- More availability of homeless shelters
- Flexible housing supports need to continue to prevent homelessness
- Based on what I understand from my members, the housing that is provided is poorly managed or kept up. It's not just about housing; it's about housing with dignity.
- Easier process for linking people to housing. There is a need for additional treatment centers and sober living. And more transportation services/bus passes are available.
- Balance between housing first and people first
- Facilities on unused land for those with longer-term needs
- Shelters are not solving problems
- I'm hoping there will be substance use and mental health services offered to unhoused individuals. Also developing places where people who enjoy being outdoors can have showers and restrooms accessible
- Housing for youth with severe behavioral issues, the space for these individuals are limited
- Shelter for homeless youth parents under 18 years old with children under 12 years old
- Housing insecurity
- Access to long-term housing support
- More funding for housing
- Rental assistance subsidies
- More supportive housing options for the chronically homeless

- Helping people before they become unhoused
- FSPs slow to locate housing
- Not enough affordable housing opportunities, especially for the elderly & severely ill
- Wait time for shelters, SLEs, and low-income housing
- Triangle centers “small towns”
- Coordinated entry into housing
- Increase housing supports for transition age youth who are not connected to Child Welfare/Probation
- Streamline housing entry points
- Few providers who can support individuals unhoused and with severe MH (Mental Health) diagnoses
- People that I see often need help getting a phone and finding housing before they are ready to engage with MH (Mental Health) or SUPT (Substance Use Prevention and Treatment). Our programs tend to support after they are actively engaged with the MH (Mental Health) services.
- Build homeless facilities that can accommodate frail seniors
- Permanent supportive housing units remain insufficient compared to need
- Barriers include lack of affordable permanent housing and limited permanent housing to meet current demands.
- Insufficient bed capacity/housing resources
- Affordable, sustainable housing
- Housing options are limited.
- Access to housing options
- Unhoused population
- Housing opportunities
- Increase in long-term housing resources
- Housing
- More housing
- Long-term transitional housing with pet care
- More access to housing
- Safer transitional housing
- Supportive housing for bipolar disorder
- Lack of housing resources
- Housing the unhoused
- Shelter resources
- Not enough housing
- Not enough services that support housing
- Lack of housing
- Funding for housing
- Housing
- Housing
- Homelessness

Staffing & Wait Times - *Speed of Service. Workforce Challenges.*

Top Grow:

- ✪ Accessing services can take a long time from assessment to access.
- ✪ Reduce time to placement for all services.
- ✪ Need for timely trauma-focused MH care to avoid losing everything
- ✪ Long wait times

Speed of Service

- Wait time for shelters, SLEs (*Sober Living Environments*), and low-income housing
- Reduce wait times for substance use treatment by tracking and publicly reporting
- Shorter wait time for treatment, especially around residential AOD (*Alcohol and Other Drugs*) treatment for adults.
- Providers waiting too long to provide housing supports like requiring attending minimum amount of sessions
- When someone is ready for treatment, there should be an immediate response Substance use treatment (reduce long waitlist)
- Access is not available when needed
- Same-day access to in-patient mental health/substance use treatment
- Quicker access to higher level of care (e.g., FSPs)
- Waitlists are too long, not enough beds available
- We need increased prescriber capacity to reduce wait times for medications
- Reduce Wait Times for Specialty Mental Health Care
- Residential treatment waitlists can be long
- Less wait time—people need mental health services now
- Wait times for initial assessment and follow-up care.
- Connections sometimes lag.
- Need more immediate availability of services; system wait times are a serious challenge
- Client accessing services, most agencies have long wait lists for appointments
- When we have youth who need a higher level of care, there is a lag in services when the youth is in a moment of contemplation of being ready vs when services can be found.
- Members often face long delays for psychiatric appointments, therapy, and housing placements.
- It can take providers weeks sometimes to make engagement attempts.
- Crisis Residential can take up to 2+ weeks to accept clients-would be nice to have a couple of more CRP (*Crisis Residential Programs*)
- Decrease wait times for appointments
- Improve timeliness to services

- Referral process to be faster for services for clients
- Decrease wait times for appointments
- Improve timeliness to services
- Timely access to services
- Wait times for inpatient SUD (*Substance Use Disorder*) treatment too long
- Waitlists are too long
- Shorter waitlist
- Timeliness
- Timeliness to services
- Faster response to community needs
- Faster referrals
- Faster services
- Therapy not generally offered or long waits
- Long waitlist
- Long wait times—adult world

Workforce Challenges

- People fall in between the cracks when trying to obtain services due to getting the run-around
- Lack of follow-through, most likely due to staffing shortages, when an individual in a FSP stops accessing care
- Difficulty linking members to resources they need when programs are at capacity / so impacted the wait time takes months/years
- It can be difficult to reach the providers and staff changes over.
- Limits of having enough staffing to meet needs/demands having funding for that Employees whose performance is measured and incentivized
- Improved reimbursement rates in order to be in line with other mental health professions
- Build out infrastructure, which means more staff to support the many programs in development.
- Shortage of trained, affirming providers
- More staff to help out
- Concerted recruitment and retention efforts are warranted.
- Hire more staff to assist with large numbers of clients
- Short Staffed
- Lack of staffing
- Staff turnover
- More staffing
- More hiring
- More staff to support all the changes
- Allocating more staffing to support with the growing needs of BHS

- Improved hiring and onboarding practices
- Focus on retention strategies
- Workforce retention

Staff Support *– Overburdened Staff. Staff Support. Safety Concerns. Education and Professional Development.*

Top Grow:

- ✪ Safety risk for peers working in crisis
- ✪ Involve staff in key decisions
- ✪ Better communication at all levels (within BHS, within DHS, across departments, with providers, partners, community, etc.)
- ✪ More transparent communication from leadership
- ✪ Maintain open communication and involve relevant staff in discussions prior to decisions, ensuring inclusivity and transparency
- ✪ More transparency regarding how decisions are made. Also, more heads up regarding changes and clear instructions when implementing something new.

Overburdened Staff

- High caseloads, productivity and other expectations, and burnout with staff.
- Staff burnout
- Very high burnout and stress rate
- Too much work to get done in a 40 hour work week
- A lot of us are at risk of burnout due to the nature of crisis and would really benefit from a work from home day.
- More support for all of the work assigned.
- We also are missing out on therapists for us, when we deal with loss of life in the field. The stress of our work - we should have on-staff therapists for us, not that you can access them only twice a year
- More staff voice when it comes to making ANY decision involving MH changes, like contracts. The Board of Behavioral Health makes big changes but have no idea how things play out on the ground floor.
- For direct service staff - Not being paid enough/stress/burnout/vicarious trauma and a large caseload
- Lower caseload so that client can get support needed
- Smaller caseloads- clinicians/peers/staff in general should not be managing 90 ongoing cases
- More manageable caseload ratios for CORE staff
- Lower caseloads for CORE clinicians
- Or more case managers

- Providers have been overwhelmed and not offering adequate services
- Support the workforce so they can support clients
- Direct service staff centric
- Lower productivity expectations, or at least address staff barriers (all day trainings / client's canceling / etc.)
- Reduce staffing turnover in FSPs (*Full Service Partnerships*), especially among case managers
- We need more staff. High caseloads, unrealistic expectations

Staff Support

- More summits within the department
- Open to feedback
- More staff input
- Be truly open to feedback
- Incentives for mental health professionals
- Barriers related to no cost of living increase in years
- BH employees need better pay / better and easier access to MH services themselves. Free or reduced therapy to start
- Pay employees direct bonuses upon client satisfaction
- Increase pay and benefits to peers and other frontline staff/reduce turnover and burnout
- Increase cohesion among employees
- More support from clinicians
- Free or reduced housing for BH employees
- Complex onboarding of staff
- Investing in staff who are here to serve the community
- The above could help attract more qualified talent
- Managers who defend their employees when working with upper management
- When decisions are made to create new units, more staff need to be included.
- Address adversarial relationship with labor and unions
- Equipment
- Better chairs for staff
- Have at least one WFH (*Work From Home*) day every other month for all levels of staff.
- Increase basic acknowledgement of staff by executive leadership, saying hi, a wave. The simple things.
- Care about staff
- Or alternatively the option to work 4 days a week
- The option for dispatchers to work from home a few days a week (we are able to conduct our duties from home)

- Not enough space for staff to work in the office. The majority of staff share workstations.
- Allow supervisors to have offices
- Consider environmental health of DHS (*Department of Health Services*) buildings
- Management addressing county employees who are "just here for the pension"
- Be consistent with guidelines
- Communication within Programs. Tim is very good at communicating with us, but managers are lacking greatly
- Demeaning behavior at any level needs to be addressed, immediately
- Decision making is hoarded at the top, and staff are not included for input.
- Leadership fails to delegate, and as a result they are unreachable/unavailable to staff.

Safety Concerns

- Also, when some of our peers work in higher risk situations, there should be risk pay. Working with trafficked children, I have had guns pulled on me and pimps follow me, and I make the same as someone teaching feelings
- Not sure who to call for a mental health crisis if someone has a weapon. What does the police/sheriff/non-emergency/dispatch refer folks to? Intervention services when loved ones notice signs.
- Safety equipment for field workers

Education and Professional Development

- Professional development: more educators trained in Youth Mental Health First Aid (YMHFA)
- Enough funding for staffing and professional development of staff.
- Additional investment in staff training (professional development) beyond the required Documentation & Cultural trainings.
- Intentional staff development and retention practices
- Training for case managers new to the field; create curriculum, so they don't have to start over with new staff which impacts care and credibility.
- Behavioral providers are expected to case manage housing needs without proper training.
- Employees need to be trained to build rapport safely
- Clinical staff specifically need more training on trauma-informed and person-centered Care
- Example of escalation due to lack of empathy-trained staff
- Restructuring how agencies approach clients with MH issues
- Need career planning in college so students can go into needed fields
- Employees need to be trained to be engaged advocates

- Learn from other places—best practices, success stories (e.g. LA housing)
- Education across the continuum
- More trainings. To help us as peers know how to navigate our clients towards success. Sometimes we get caught in a rut & the clients progress is cut short.
- Also possible training that goes over coping skills that we can use with our clients
- Investing in ongoing training, supervision, and support
- Also peers not being trained in various resources that are available. Members might want me, not their case manager, to refer them somewhere because they trust me more. But I don't know where to refer, etc.
- Training and Support Groups for peer supervisor. Transportation resources Housing and utilities resources Support groups for peers Opportunities to work together with agencies
- How to invest in training while drawing down/challenge: you must deliver services to cover costs, and you have to invest in staff to provide great services
- New innovative training
- More training for BHS employees
- More training
- More training/support/resources for growth opportunities within BHS
- Expanding and providing ongoing staff training
- Scholarships/educational opportunities for leadership
- More training for leadership
- Stronger continued training and development for leadership in the areas of people management and employee cultivation
- Better support for middle managers' leadership training

Training & Provider Accountability – *Trainings for Providers and Clients. Provider Accountability.*

Top Grow:

- ✪ Operational oversight and standards of care needed for sober living programs (e.g. CADAC [*Certified Alcohol and Drug Addiction Consultant*] counselors)
- ✪ Need consistent standards of care across SLE (*Sober Living Environments*), residential, and room & board facilities
- ✪ Direct service staff don't always reflect trauma informed services. Turnover also impacts clients' willingness to engage.
- ✪ Would be very cool if school-based providers and community-based providers could participate in collaborative professional development…

Trainings for Providers & Clients:

- BH trainings/education for underserved groups/communities

- More emphasis and education surrounding the needs of reentry, specifically adults who are reintegrating back into society post-incarceration
- Short Term Residential Therapeutic Programs doing wraparound have to be WRAP (Wellness Recovery Action Plan) providers
- WRAP should be for all families!
- Address education/awareness for providers for services for the Older population
- Educate teachers, foster parents, and others how to spot signs of mental health struggles and offer support
- Basic skills training
- Advance inclusive medical training for doctors
- Repour (*rapport*) building to support client buy-in
- Enhance training for professionals, create more community Awareness programs. Strengthening social support networks.
- Compassion training
- Empathy training
- Trauma-informed care training
- ASIST training
- Clinical supervision is imperative
- Require peer certification within a time period
- More clinical trainings to support those providing direct care
- Increase training opportunities
- Train clinicians in EMDR
- Additional training for law enforcement

Provider Accountability

- Reduction in variation in quality among FSPs (*Full Service Partnerships*)
- FSPs reluctant to travel to meet clients
- Variety in quality of FSP partners - some will meet people in the field, while others require people to attend in-office appointments
- More accountability for services provided by FSPs
- More emphasis and transparency regarding provider performance
- Inspections of habitability of sober living programs, especially when vouchers are used
- Need more specific and careful monitoring of FSP contacts with providers. Too many individuals fall out of care and insufficient follow-up occurs
- Need more accountability for providers who serve those with serious mental illness in FSPs. What happens when individuals fail to engage.
- Articulating program expectations
- Consistent application and analysis of CANS (*Child and Adolescent Needs and Strengths*).

- Include increased accountability measures to help motivate participants to the successful use of behavioral health services
- Accountability for what is agreed to is essential. If we can't trust the system to hold itself accountable with integrity and transparency, then the rest of it doesn't really matter.
- Hold providers more accountable
- Uniformity of practices to eliminate duplicative services
- Use of evidence based treatments across providers
- Adequate supervision of providers

More Peer-led Services *– Increase services from Peers with Lived Experience.*

Top Grow:

✪ Use more Peers with the older adult community.

- Expand peer support services to all parts of the system
- Peers working everywhere in the system
- Create a peer hub where people could go first
- More peer support services
- More Peer Support Specialists
- More opportunities, on peer support
- Funding for therapy and peer counseling
- Residential substance treatment is a great need, but how about meeting the needs that make substance use attractive. MORE MENTORS IN THE COMMUNITY! We need sustainable practices
- Information about or Ability to bring an advocate or natural supporter with you to all kinds of meetings and to have them speak on your behalf when issues like changes in level of care arise
- Need for more funding for Peer support roles for promotional opportunities outside of direct care. Lots of opportunities for growth for peers and professional opportunities.
- Give people options to have a peer assist someone early on through the process of starting services
- When waiting for a referral to go through, have a peer guide someone in accessing basic needs, or just to be a support to talk to
- Having peer attend walk-in meetings and experience their role
- Rely more on peers, empower them and recruit them
- People with mental health challenges like autism, bipolar conditions, and multi-generational trauma are receiving conventional services that do not respond to community challenges. Need more peer navigators
- Integration of peers/cultural brokers into community service providers that promote the use of psychiatric meds.

- Have a standardized documentation process for peers providing services under county contracts
- More communication from the peer managers
- More peer programs for youth. More streamlined services.
- More people with lived experiences
- Need to train incarcerated individuals to become peers to help each other in similar situations: post-incarceration
- Increased integration of peers in CORE clinics and in FSPs
- Peer Committee could put on some events for peer support specialists in the county
- More peer support services
- Expand Peer Support Programs – Include more people with lived experience in behavioral health outreach and recovery support.

Peer Roles Misunderstood *– Peers working out of scope. Feel disrespected.*

Top Grow:

- ✪ CBOs need to be educated on the Peer role, from leadership to reception. More employers should attend training on learning the role of Peers
- ✪ Peers need to be treated as equals to their clinical counterparts. Peer support is also an evidence-based practice.

- Improve understanding of peer roles among professional staff
- CBO's (*Community Business Organizations*) leadership needs more education on the role of Peers (GROW)
- Educating clinical staff on evidence-based support such as peers and how lived experience can be used in the field - the majority currently do not know what to do with peers and treat them as their aids
- Clear definition of Peer Specialist roles
- Peer roles not clearly defined or supported
- Certification requirements needed
- Be careful not to replace clinically sound services with peer-only services
- Peer support is about community, not a job role
- Peers confused by their role due to certification training gaps
- Improve understanding of peer roles among professional staff
- Make sure that clinical team members understand the scope of a peer, and don't blur those lines when referring- it confuses clients and at times limits them.
- Sometimes the value of lived experience is not recognized in an opportunity for financial gain due to the country's regulations of different degrees that must be held.
- Peers doing clinical work for certain program is out of scope and unequal pay

- Treat peers as people with expertise!
- Team members should not be abandoning cases once a peer is on the case. A peer should not be alone on a case where a client has had a suicide attempt in the last year. That's a liability and just wrong.
- More awareness around peer support and training
- More respect to Peer Support Specialists
- Understand that lived experience is not one size fits all. Peers have areas of specialization just like their clinical counterparts
- Peers to help bridge support due to limited-service availability
- How peers fit into certain placements. There's not enough training for peers in inpatient settings to understand how their scope even applies.
- Educate clinical staff on the peer role
- Peer roles are heavily undervalued
- Better understanding of a peers' scope. We can't make people do things, that's unethical but so many other clinic members push the narrative.
- We need more exposure and education of what peer support is for not only the community, but for the organizations and partners we work with
- Peers experiencing "scope drift" into areas where we aren't experts, due to demands of organization.
- Educate staff on the peer role
- Peers need an equal seat at the table
- Lack of awareness from clinicians and others around peer support and what it means
- Require Peer Supervisor to take Peer Support certification training and exam.
- Peers do not have the answers/connections for everything. Program support and linkage is needed for it to be feasible
- Peers are frequently treated as if they are uneducated people who are just there to help keep quotas
- Require clinicians to take a peer training course
- More education for non-peers
- MDT (*Multi-Disciplinary Team*) programs need more training on the peer scope of service
- Managers that actually care about the peers that work under them
- Definitely more training on the role of a peer (especially for supervisors)!!

Wages & Opportunities for Peers – *Wage Disparities. Career Opportunities.*

Top Grow:
✪ Better pay (I should make more than a fast food worker)

Wage Disparity

- I got a 17-year-old a $30 an hour job as a cashier at Kaiser this year (a lot more than I make). It makes it hard to do the work I do. When we get paid after 5 years of experience, less than the youth we help become gainfully employed at 17 its embarrassing
- Higher wages for peers. Lived experience should be valued similarly to an education.
- Wage increases for peers
- Greater value to be invested in individuals with lived experience
- Behavioral health crisis responders are financially compensated as a first responder
- Better pay for lived experience staff
- Integration of cultural brokers into services directed toward people with more severe illness.
- Not being paid enough
- Increase pay and benefits to peers
- Higher salaries for peer advocates
- Higher pay for Behavioral Peer Specialists in emergency response
- Meaningful pay for peers to continue to inspire others to go through recovery
- Please pay us more
- Many peers receive county benefits. This means their jobs are subsidized because they are not paid fair wages.
- Show me the money
- Higher pay to reflect cost of living and even incentives like wellness or gym membership
- More pay for peers is awesome and needed. Also, more awareness/promotion for social work.
- Higher salaries for mental health clinicians and peer advocates
- Certified Peer Specialists should make more (some programs pay very little).
- Peers are badly underpaid
- Better compensation for peer staff.
- Peer Program Managers do not get paid overtime like other management classifications but are not compensated at that level.
- Other county positions that require less experience and education, such as Human Services Specialist pays more than Peer PM, and they are eligible for overtime.

Career Opportunities

- Opportunities for advancement
- Peer support and support staff are the least likely to get attention; initiatives to safeguard these folks will be important
- Low wages and lack of growth opportunities
- Better pay for peers and more opportunities for growth, especially for those who speak up about injustices and wrongdoings w/in programs. no more shutting/ pushing folks out for sharing diff views
- More growing opportunities for peers
- Support Peer Specialist Program Managers

Focus, Approaches, & Other Ideas *– Focuses. Gaps in services.*

Justice-Involved Focus

- Need to diagnose those who become justice-involved who do not already have an established diagnosis
- Need to differentiate services for those who are justice involved

Housing Focus

- Please focus on eviction defense and intersection with MH
- Sustainable housing support is a huge need. We need eviction resolutions. Our County needs to support those with evictions to work the funds off.

Severe Needs Focus

- Being able to serve more than the severely and persistently mentally ill would be a great addition to treatment options (not just prevention/early intervention).

Other Focus

- Ways to sustainability for all program initiatives
- Additional investment in EBP's
- We need a focus on the small percentage of individuals who have serious mental illness and strategies to ensure that they remain connected with services
- Need to identify those most difficult to maintain in treatment and provide extra follow-up and monitoring
- Improve ongoing engagement
- Less compliance & more quality focus.
- Problem: assuming everyone wants a house
- A major barrier I have seen is if individuals do not use the correct mental health "buzz" words, they are turned away from services

- There is too much of a focus on qualifying specialty mental health services. We should be meeting people where they are at and looking at overall recovery.
- Clients being active in their own care plans/ psycho education.
- Outcomes-based contracting and revenue
- Allocating funding where is more needed
- Less focus on checking assessment boxes and more person-centered care Family
- Helping those who don't want help
- Support
- Support relapse prevention
- Assessments
- Independence
- Supervision/Consultation
- Rehab services
- Focus on treatment

Approaches

- Creative ways to prepare for a potential increase
- Need to define what our goals are for a truly integrated behavioral health system and communicate to all so we can all work together to achieve the goals
- Improve internal collaboration across divisions and teams
- Clear definitions of roles and responsibilities internally
- Clearer directives
- Service type is limited. For example, clinical model care is not the only care that works, and cannot be the only type of care that is prioritized (again, sometimes out of county control, especially now with BHSA).
- Implementing Community Defined Evidence Practices into the BHS outpatient array of services.
- Focusing on Family Systems work to support whole families/whole person.
- People not relying on the Access Team as much
- Shift treatment approaches
- Allowing more of a genuine, supportive, and vulnerable environment when it comes to providing housing or mental health services. (those who are providing these services)
- More person-centered language
- More client-driven programs
- Learn to tell your story
- Not enough focus on recovery orientation. Still want to force people into traditional treatments.
- Reducing direct Contract Monitor interaction with youth/families. It's hard for families to open up with strangers in the room, it would be better if families could coordinate with the treatment team.

- Be unapologetic for bold choices that matter in making improvements/changes
- Recognizing and understanding that not all therapy is healing and not all healing is therapy – that the system is not the only way to heal.
- Finding a way to say yes to meet the needs of families served. Finding the most appropriate service for the family based on their needs
- Recognizing that Evidence Based Practices take more time
- Embedding trauma-informed practices across all levels
- practice trauma informed care
- Zoning for housing
- Advocacy for elderly care
- Success should be measured by outcomes of individuals
- Success should be measured by outcomes of the individuals, not how many treatment services delivered
- Consistent use of Evidence-Based Practices
- Health equity should be embedded in all services
- Creative initiatives needed to reach those not considered “most complex”
- No wrong door approach
- Find what is missing or needs to be left off practices
- Coordination as individuals transition through the life span
- Tailoring services
- Systemic barriers are acknowledged, but are not addressed
- Complexity of mental health services systems
- Inability to treat the whole person and address all problems

Other Ideas

- Services to unincorporated County at the expense of incorporated cities.
- Youth ambassador & parent leader paid interns/positions
- Classification 1-3: identify who can resolve quickly
- Ability to take therapy to the streets for those who need basic skills building
- Invest in capacity building services to include the impacted individuals, families, and communities in advisory, implementation and evaluation processes
- Pop up day service clinics in rural parts of the county
- Offer support groups to individuals in programs and in wellness centers around specific issues such as anxiety, bipolar disorder, and schizophrenia
- Not self-regulating; cut loose too soon, repeat cycle
- Comprehensive plans that address the multiple layers of the issue
- Depleting funds during times of heightened needs. Creative partnership opportunities to fill those gaps would be helpful

Data & Reporting Transparency *–Data Sharing. Data-led Decisions. Data Barriers. Community Education about BHS*

Top Grow:

✪ Shared data among the County services and users of the programs

Data Sharing

- Org chart anyone? Public facing? Kept updated?
- Would like to see the data the County is collecting to focus the spotlight on where services are needed
- Distribution of data – better reporting
- Lack of data
- More transparency and consistency are needed in reporting outcomes to show impact and guide improvements.
- We need transparency on where every dollar is being spent
- Data transparency
- Publish simple, transparent dashboards on access, timeliness, and outcomes
- More transparency with the budget
- Presentation of data for general consumption
- Include updates on numbers served, costs vs. budget in the Director's Report to the Behavioral Health Commission monthly reports.
- Ensuring that visibility is in all areas
- Make data on numbers served in programs and costs available on website
- Enhancing data collection and analysis
- Tracking Measures (CANS) are particularly ineffective
- More transparency about the reality of situations to not just "leadership," but to community and staff
- More evaluation of the program
- We need more evaluation
- While there are some good things it is not consistent
- Make data on numbers served in programs and costs available
- Data integration and data sharing to support care coordination.
- Increase data & CQI (*Continuous Quality Improvement*) feedback for County ops (*operations*)
- Data sharing

Data-Led Decisions

- Increased investment in practices & providers that demonstrate positive outcomes.
- If CBOs *(Community Based Organizations*) do not align to best practices… they should not be delivering services
- Data must drive practices including funding data

- We need to measure the efficacy of practices
- Data-driven decision making
- Consistent FSP (*Full Service Partnerships*) services and outcomes across the system
- Let the data lead the priority areas, communities, populations. Use/master communications and data to make the case for bold decisions
- Utilize the HMIS (*Homeless Management Information System*) to enhance the corresponding allocation of services and resources
- Practices where data shows no impact should be stopped
- Practices where success is clear should be replicated
- Currently it is a back the buck situation
- Not giving/ expanding contracts for providers who don't perform well in any area
- Data-driven practices
- Gather and review data on a regular basis - to make data-driven decisions.
- Data informed decision making and allocation of resources to address disparities
- Increase use of post-treatment screening for client satisfaction

Data Barriers

- Travel and Documentation burden impacts productivity and it is disincentivizing for productivity, but community-based work is so needed and necessary.
- Changes: consider getting rid of Pediatric Symptom Checklist as pre/post-measure
- Need to reduce administrative or bureaucratic tasks when able to allow programs to focus as much as possible on client services.
- Improved data collection incorporated into software, rather than relying on clinical staff to complete/track reports.
- Providers improve their data entry and documentation.

Community Education About BHS

- Collecting and reporting data that goes beyond counting services etc. and tells a story about the impact of the services to the client/community
- Lessons learned and analysis of programs /practices from MHSA that may need to evolve or be sunsetted.
- Educating the community on mental health- we are losing MHSA funds because an uneducated community thinks this will help get people off the street, when in reality there are zero $ for housing
- Honest, hard conversations about resources. Recognition that not all needs will be met all the time, rather than trying to appease everyone all the time
- Awareness to the public about BHSA
- Continue to be transparent and educate us regarding budgets and restrictions on budgets regarding the overall plan

- Data collection e.g. HMIS (*Homeless Management Information System*), SMARTCARE e.g. integration and accurate data
- Resume yearly counts of homeless to better track impacted areas that need additional or less support.

Policy & Advocacy *– Concerns about Policy Changes. Service Cuts. Funding Concerns. Other Concerns.*

Top Grows:

- ✪ 988 make sure the County address federal removing LGBTQ alternative funding or access for LGBTQ crisis response.
- ✪ When there are complex needs funding and capacity in program are limited which means complex care coordination is limited because the outcomes are siloed.
- ✪ Funding has become stagnant.
- ✪ With the change in funding, I would want the county to continue their investment in prevention/early intervention.
- ✪ Redistribute funding or resources away from the Sheriff's Dept to BHS/CWRT
- ✪ CalAIM
- ✪ SmartCare

Concerns with Policy Changes

- Health equity for all should be a policy priority
- Systemic barriers not addressed due to policy limitations
- Need to be clear about the prevention services that will be made available throughout state funding. BHSA doesn't eliminate prevention. It shifts it to the state level. What will those services be?
- I've appreciated the focus on prevention. I'm a little worried that we don't see BHSA use "prevention" in the funding categories in the same way
- Streamlining services. More advocacy support for clients in system.
- Change laws, need advocacy
- How will mental and behavioral health work as 22-member commission?
- It's not the County's fault, but the reduced priority around prevention is concerning. Schools can be such great partners in this space.
- this new model undermines the work of community based partners who currently have some services and the relationships with the community. It will take needed funding away with no replacement plan.
- Federal changes will impact access to Medi-Cal — need adaptability so families aren't left without services
- County response to protect confidentiality for LGBTQ/immigrant communities
- Do not like State handling prevention

- Do not think the State can intentionally leave out the word prevention focus
- Does BHS have the staffing and knowledge to implement the new State policy – especially around housing requirements?
- Multi-Year Contracts/ Contracts delivered prior to fiscal year launch
- Concern about focus being shifted and will take away from family caregivers
- Medi-Cal eligibility planning
- Preemptive action plan for Medi-Cal eligibility changes
- Directives/Decisions from non-clinical administration can be contrary to clinical care
- Systematic nervousness around changes
- Leveraging systems and programing in place in the development of new projects/programs
- Allocating more time for County staff to thoughtfully plan for new initiatives/project implementation
- Keep up with rapidly changing needs of the community
- Improve policies to encourage participation in services

Service Cuts

- When CSEC services were moved to mostly school-based and left only one program to meet the needs of our trafficked youth, is was a huge fail. Lived experience is lost in this and is detrimental
- Concerned with the impact of budget cuts in other areas, such as schools, combined with BHSA budget breakdown. Thinking of CSAC's Chatbot that used AI to support, how could AI help in this time safely?
- Mental health deteriorating even further begging for services
- The Source changing funding/criteria for after-hours support... loss of local support for families.
- Ability to appeal Full Service Partnership denials
- Inability to treat the whole person and address all problems
- Please improve the benefits process like Medi-Cal and SSI
- MH Urgent Care Center turning students/families away
- Unstable people need immediate care and are sent on the 211 treadmill
- 2-1-1 turning people away!
- 211 is in need of serious reform. The staff are a hit or miss on helpfulness. I had a client told he was put in the HMIS (*Homeless Management Information System*) system then when he called a month later, he actually wasn't. Setting him back
- other crisis continuum services since this department made the decision to stop responding to MH calls and redirected to CWRT (*Community Wellness Response Team*)
- Not self-regulating, cut them loose too soon and do the same thing again

- Financial challenges (cause of homelessness) – stopping assistance for refugees/ asylum seekers, diversion and prevention

Funding Concerns

- The outcomes are silo'ed to specific funding goals. People are intersectional but programs/funding are not.
- Residential treatment; outreach; funding needs
- Additional funding
- Alternative funding opportunities for prevention/early intervention services
- Funding
- Limited funding for early intervention services and support
- Proactive assessment of funding
- 15% of the overall budget is not enough to designate families overall. There should also be designated funds to ensure interested parties can obtain license to provide safe/sober home.
- Concerned over new funding limitation and impact on the great prevention work - how can we leverage and collaborate to be able to target services and funding
- No funding allocated for Prevention and Intervention programs on Mental Health will bring bigger issues over the years
- Limited funding for certain programs
- Funding across programs is a black box for those external to the County.
- More money for prevention services
- There's money to provide services
- I'm extremely concerned that there is not going to be any funding for prevention services from Sacramento County. Without some of the current services we are offering now, the problems will get worse
- Delivering the same services but not more money. But also gratitude for having the funding.
- FUNDING FUNDING FUNDING
- Limited funding
- Unpredictability of funding

Other Concerns

- There is a recurring policy gap where families dealing with high-needs children are being routed into CPS, sometimes even resulting in placement, due to a lack of behavioral health system capacity.
- Consistency is key for families. Whenever possible, it's best not to switch CPS workers, as keeping the same support person helps build trust and strengthens the family's progress.

- CalAIM reform has made this worse than ever and turns young people in the field off from doing this work (also fits here, but already placed)
- CalAIM redundant paperwork
- CalAIM takes time away from serving kids
- SmartCare can use some work