MENTAL HEALTH SERVICES ACT

Innovation Component of the Three-Year Program and Expenditure Plan

June 21, 2011

EXHIBIT A

INNOVATION WORK PLAN
COUNTY CERTIFICATION

County Name: SACRAMENTO

County Mental Health Director	Project Lead
Name: Mary Ann Bennett Telephone Number: 916-875-9904 E-mail: Bennettma@saccounty.net	Name: Michelle Callejas, MFT Telephone Number: 916-875-6486 E-mail: Callejasm@saccounty.net
Mailing Address: Sacramento County Division of Behavioral Health Services 7001-A East Parkway, Suite 400 Sacramento, CA 95823	Mailing Address: Sacramento County Division of Behavioral Health Services 7001-A East Parkway, Suite 300 Sacramento, CA 95823

I hereby certify that I am the official responsible for the administration of public community mental health services in and for said County and that the County has complied with all pertinent regulations, laws and statutes for this Innovation Work Plan. Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code Section 5891 and Title 9, California Code of Regulations (CCR), Section 3410, Non-Supplant.

This Work Plan has been developed with the participation of stakeholders, in accordance with Title 9, CCR Sections 3300, 3310(d) and 3315(a). The draft Work Plan was circulated for 30 days to stakeholders for review and comment and a public hearing was held by the local mental health board or commission. All input has been considered with adjustments made, as appropriate. Any Work Plan requiring participation from individuals has been designed for voluntary participation therefore all participation by individuals in the proposed Work Plan is voluntary, pursuant to Title 9, CCR, Section 3400 (b)(2).

All documents in the attached Work Plan are true and correct.

Mary Ann Bennett	6-21-11	Deputy Director, DBHS
Signature (Local Mental Health Director/Designee)	Date	Title

Executive Summary

Introduction

Since the passage of Proposition 63 in November of 2004, Sacramento County has worked diligently on the planning and implementation of the Mental Health Services Act (MHSA). To date, we have planned and implemented the following components: Community Services and Supports (CSS), Workforce Education and Training (WET), Prevention and Early Intervention (PEI) and Technological Needs. Many programs across all components are fully implemented and yielding positive outcomes, while others are in various stages of implementation.

Sacramento County started the Community Planning Process (CPP) for Innovation in September of 2010, with an official community Kick-Off Meeting in November of 2010. An Innovation Workgroup, comprised of community members representing various stakeholders, was established to develop a draft plan for Sacramento County's Innovation Plan. In developing the plan strategies and soliciting community input, the Division of Behavioral Health Services (DBHS) coordinated a total of three (3) full-day Workgroup meetings, one (1) half-day Workgroup meeting, two (2) large Community Meetings, and ten (10) small Community Meetings with unserved and underserved racial, cultural and ethnic communities. DBHS is extremely grateful for all the work completed by the Workgroup Members and the community. In total, over 1400 volunteer hours were put in to developing Sacramento's Innovation Plan.

The proposed Innovation Plan is referred to as the **Respite Partnership Collaborative**. Sacramento County will contract and partner with a community-based organization which will serve as the Administrative Entity for this project. Sacramento seeks to learn whether this partnership can expedite the release of program funding into the community, lead to the leveraging of new and existing resources, and lead to new partnerships that can help address crisis and other mental health issues in our community. Additionally, the County wants to learn whether the formation of a Respite Partnership Collaborative that is community-driven, rather than county-driven, can lead to effective crisis respite programs that serve all age groups in various locations within our community.

Innovation Funding Request and Time Line

Sacramento County is requesting $8,810,600 in Innovation funding to implement this project. The project has four (4) phases and will begin in July of 2011 and end in June of 2016.

EXHIBIT B

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

County Name: Sacramento
Work Plan Name: Respite Partnership Collaborative

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

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

The Sacramento County Community Planning Process for Innovation officially began in September of 2010 with MHSA Steering Committee support. On November 30, 2010, a community Kick-Off meeting was held and 75 community members attended. At this meeting, prior MHSA planning processes were reviewed and the Innovation component was explained to the community. A schedule for future planning meetings was presented and an invitation to stay involved was extended to those in attendance.

Following the Innovation Kick-Off, an Orientation meeting was held January 12, 2011, for the Innovation Workgroup, a committee of twenty individuals representing diverse stakeholders that agreed to work on the Innovation Plan. A major focus of this meeting was how the group would use Levels of Agreement to achieve consensus for decision-making throughout the planning process. (See Attachment D)

In total, three (3) full-day and one (1) half-day Innovation Workgroup meetings were held from January through April. Each meeting was publicized by the MHSA internet distribution list that goes to approximately 1700 recipients, as well as at various Division and community meetings, and the public was invited and encouraged to attend. In addition, time for public comment was built into each Innovation Workgroup meeting agenda.

At the first full-day Innovation Workgroup meeting, members reviewed data from prior MHSA planning processes, crisis statistics, system partner data related to crisis, results from the Innovation Survey, and data from the local Hospital Council meetings. One of the Workgroup members provided information on various peer-run services models and the DBHS Deputy Director presented the DBHS vision for crisis services. (See Attachment E)

At the second Workgroup meeting, members developed a definition of crisis and developed five (5) preliminary strategies to be presented to the community for feedback. (See Attachments F and G) The strategies were presented at two (2) large community

and ten (10) smaller meetings with unserved and underserved racial, cultural and ethnic communities. At each of the community meetings, participants were asked what could strengthen or improve each strategy. In addition to providing input into specific strategies, overall input was solicited, especially from the smaller culturally specific meetings. In an attempt to reach more community members, the larger meetings were held on a Saturday morning and a Tuesday evening at two different locations. (See Attachment H)

The final two Workgroup meetings focused on refining the strategies based on community feedback, identifying priorities, and preparing final recommendations to move forward to the MHSA Steering Committee. (See Attachments I and J)

On May 5, 2011, the MHSA Steering Committee reviewed and discussed the Draft Innovation Plan and unanimously supported moving forward with finalizing the Plan for submission to the Department of Mental Health and the Mental Health Services Oversight and Accountability Commission.

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

A twenty member Innovation Workgroup representing a wide array of stakeholders was established to explore innovative approaches to address the issue of crisis in Sacramento County. Six members were consumer advocates, five members were family advocates (representing adults and children), two members were DBHS representatives, two members were mental health providers and one member each represented the Mental Health Board, law enforcement, Disability Rights of California, Cultural Competence and physical health. (See Attachment B)

As mentioned above, nine small groups were convened by community members with assistance from DBHS staff to solicit input on the strategies developed by the Innovation Workgroup. The following communities participated in the small meetings: Latino, Hmong, Vietnamese, Chinese (Cantonese speaking), Mien, LGBTQ, Muslim, Native American, African American and Transition Age Youth.

Overall, the estimated number of volunteer hours put in by community members was 1,443. (See Attachment C for more detail)

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

The Draft Innovation Plan was posted from May 17, 2011, through June 16, 2011. A Public Hearing was conducted by the Mental Health Board on Thursday, June 16, 2011, beginning at 6:00 p.m., and was held at the Department of Health and Human Services Administrative Building at 7001-A East Parkway, Conference Room 1, Sacramento, California 95823.

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There were several comments received during the 30-day public review and comment period. Below is a summary of the comments and the Division of Behavioral Health Services' response.

Comments

- The Division should require or strongly suggest to the administrative entity that the MHSA Steering Committee be consulted in the selection of the evaluator.
- Evaluation is important and we should emphasize learning in real time rather than waiting for evaluation feedback. If we develop learning collaboratives, we can test processes out through the PDSA (Plan, Do, Study, Act) model and make real-time changes. We have very little time and should not waste any of it waiting for an evaluation.
- There appears to be no definition of respite care in the document.
- Concerns about the legality of the Division contracting with an administrative entity.

Members of the DBHS Cultural Competence Committee organized and facilitated various focus groups within their respective communities during the Innovation Community Planning Process. In a written statement, members of the committee expressed appreciation for the manner in which comments from the community focus groups were incorporated into the Innovation Workgroup's draft plan. Additionally, the Cultural Competence Committee reviewed the Innovation draft plan and documented what they liked about the plan:

- Important to have respite available
- Adults in crisis with dependent children – this group of people often falls between the crack so it is good that they are included as one of the populations to be served
- Importance of designing respite option that is culturally responsive (population #2 in Attachment A)
  - Addresses program design that is culturally appropriate and incorporates staff that is culturally and linguistically competent.
  - Involves working with traditional community leadership to design the program

- Meaningful involvement of community leaders/cultural brokers/representatives in the Respite Partnership Collaborative
- Culturally responsive traditional healing practices
- Community based programs providing services based on community practices.

DBHS Response

This Division will work with the Administrative Entity and advocate that one or more members of the Steering Committee be included in the competitive bid process used to select the evaluator.

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The Division is aware that there is no formal definition included in the Innovation Plan for “Crisis Respite.” This issue arose during the Innovation Workgroup meetings and there were many rich discussions about the topic. What came to light was that “respite” has many meanings to different individuals and groups in our community. In order to ensure flexibility in program design and allow for innovative approaches, the Workgroup elected not to include a formal definition.

With regard to concerns about contracting with an Administrative Entity, DBHS will work with County Counsel on any legal matters pertaining to this project.

The Division extends its appreciation to the Cultural Competence Committee for playing such a vital role in arranging for the small community meetings focused on specific cultural and ethnic groups. The participating agencies mobilized in a very short timeframe, conducted the meetings, and provided written responses to the Division. The feedback was very helpful in finalizing the Plan. The Division also appreciates the comments that were submitted in support of the Innovation Plan and will consider all feedback as we move forward with implementation.

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Innovation Work Plan Narrative

Date: June 21, 2011

County: Sacramento

Work Plan #: 1

Work Plan Name: Respite Partnership Collaborative

Purpose of Proposed Innovation Project (check all that apply)

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

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

Promote interagency collaboration: There were a couple of reasons for selecting the promotion of interagency and community collaboration regarding the issue of crisis. Throughout all of the MHSA Community planning processes, crisis services and help in a crisis across all age groups has been a recurring community concern. Over the past several years, Sacramento County, like many other counties across the state, has faced reductions in funding for mental health services. One of the consequences of reduced funding was the closure of the Sacramento County Crisis Stabilization Unit which subsequently resulted in an increase in local emergency room visits and hospitalizations. This situation led Sacramento County's MHSA Steering Committee to support an Innovation Project focused on crisis and alternatives to hospitalization.

During the numerous community planning processes, community members and providers have given positive feedback about how extensive and inclusive the planning has been. However, they have asked for greater input into the design and implementation of the mental health services created from the planning processes. This Innovation project provides opportunities for community partners to come together to design and implement a range of respite services that can respond to crisis situations across all age groups.

The essential purpose of the Sacramento County Innovation Project is to test whether a community-driven process, that includes decision-making and program design, will promote stronger interagency and community collaboration. Additionally, the County seeks to learn whether this community-driven collaborative approach can lead to new partnerships that can maximize existing resources to establish a continuum of respite services that will reduce mental health crisis.

Increase the quality of services, including better outcomes: The secondary purpose of this Innovation Project is to determine whether this community-driven collaborative leads to an increase in the quality of services being delivered, including achieving better outcomes. Given that there is a dearth of respite options in the county, it is expected

that building a continuum of services to meet different crisis needs will improve the quality of services for those experiencing a crisis and ultimately improve their outcomes.

In implementing a range of respite options designed by community partners, DBHS will test whether a process unlike the traditional government process now in place will facilitate a different outcome, be more expedient, improve relationships in the community, and create greater trust between the community and the County. It will also test whether adopting a model that gives community members program choice will improve the quality of services and produce better outcomes.

Innovation Work Plan Narrative

Project Description

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

After an extensive review and discussion of crisis data and statistics in Sacramento County, the Innovation Workgroup grappled with what makes the issue of crisis so difficult to solve and how can it be approached in an innovative way. Through a series of Innovation Workgroup meetings and twelve (12) small and large community meetings, an Innovation Project was developed that proposes to establish a Respite Partnership Collaborative (RPC). The RPC will come together to forge new partnerships and establish a continuum of crisis respite services.

What makes this Project innovative and what will create the learning opportunities is in how the project will be developed and administered. In the past, DBHS has heard from mental health providers that although we may have done a good job in planning, we have sometimes not integrated community feedback as well into implementation. Both the community and providers have expressed a desire to have more of a voice in program development and implementation. Additionally, there has been frustration with the amount of time it takes to get funding out into the community. The rules and restrictions inherent in government bureaucracy create barriers, delays and limit creative opportunities.

In responding to this feedback, the County will select an Administrative Entity to receive and administer the funding for this project. The chosen Administrative Entity will be experienced in working with collaborative efforts and serve to bring community members and system partners together to work in a transparent and inclusive way. The Administrative Entity will not be a provider of services, but they will serve as a member of the RPC. They will facilitate the formation of the Respite Partnership Collaborative, administer an award selection process, oversee the distribution of funds and manage contracts or awards. They will host and facilitate meetings and develop and implement a communication plan and an evaluation framework.

This Innovation Project proposes to allow the community, through the formation of a self-governing collaborative, to address program implementation in a new and innovative way. Membership in the RPC will be comprised of community members that have a commitment to the mission of the project, including but not limited to consumers, family members of consumers, representatives of the five populations to be served, mental health agencies, non-traditional mental health providers, homeless programs, faith-based providers, system partners, cultural brokers/representatives, advocates and other subject matter experts. MHSA principles and general standards identified in the MHSA CCR, Title 9 Section 3320 will be adhered to and will guide the development of a

governance structure and decision-making process that will be supported by both the County and the Administrative Entity.

A process will be developed asking the community to propose program models that can provide respite options for up to five different target populations. The five populations are: Parents with Seriously Emotionally Disturbed children that need a break; Teens and TAY in crisis; adults, including older adults in crisis; adults in crisis with dependant children; and respite options to address specialized cultural or ethnic population(s).

The RPC will work with the Administrative Entity on establishing a selection process. Once awards are made, the administrative organization will develop contracts and distribute funds. The RPC will assist in overall coordination and implementation of respite programs including, but not limited to: leveraging new and existing community resources; tracking and coordinating respite options; providing linkage with other MHSA programs including WET to deliver Trauma Informed Care training; host regular stakeholder meetings to keep the community updated on progress; and participate in a Project evaluation. (See Attachment A)

Innovation Work Plan Narrative

Contribution to Learning

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

This Innovation Project is expected to contribute to learning in several ways. At a macro level, it is anticipated that both the County and the community will learn whether a community-driven collaborative planning approach can lead to new partnerships, maximize existing resources, and result in a better coordination of care. The County hopes to learn whether turning over decision-making authority and program development to the community will promote and enhance successful interagency and community collaboration. The outcomes of this learning will potentially inform future decision-making and program development in the area of mental health. Additionally, other government agencies faced with similar bureaucratic barriers may be able to consider a similar type of approach.

On a micro level, based on community response, DBHS will learn what kind of respite services the community values. The hypothesis is that a community-driven collaborative approach will lead to new partnerships that can establish innovative mental health practices tailored to meet the unique needs of specific cultural populations and communities.

Once implemented it will become clear whether or not a continuum of respite services that use a range of practices will, in fact, improve the delivery of mental health services and whether or not this kind of approach can lead to better and more effective practices. In implementing a continuum of respite options designed by community partners, the County hopes to learn whether interagency and community collaboration can lead to new mental health practices that produce better outcomes, including reduced hospitalization. Community providers have asked for greater input into the design of mental health services; this project provides that opportunity.

Innovation Work Plan Narrative

Timeline

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

Implementation/Completion Dates: 07/11 – 06/16
MM/YY – MM/YY

This Innovation Project will be for four years and the plan is to implement in phases. However, should opportunities and resources arise that support implementing activities in a later phase sooner, the RPC may consider doing so.

The first phase will be dedicated to Program Implementation and design. It is anticipated that upon approval of the Innovation Plan, the County will enter into a contract with an Administrative Entity to implement the necessary infrastructure to: 1) form the Respite Partnership Collaborative; and 2) establish an administrative process. In addition, an evaluator will be selected in the first phase to ensure a strong evaluation of the project.

In Phase II, the RPC will be fully implemented and have a process in place for selecting respite programs. The evaluation will be developed and regular stakeholder meetings will be convened to report on progress of the Project.

In Phase III, depending on resources and based on what has been learned, there will be a second round of awards made.

In Phase IV, the Evaluation will be in its final stages and the feasibility of replication will be determined. Throughout the project, significant efforts will be directed toward sustainability options should the project be successful.

Phase I: July 2011 – April 2012 Activities:

1. Establish contract with Administrative Entity
2. Administrative Entity establishes Respite Partnership Collaborative; RPC establishes governance and decision-making processes
3. Administrative Entity puts in place contracting and communication processes
4. Administrative Entity hires project evaluator

Phase II: May 2012 – June 2012 Activities

1. Respite Partnership Collaborative selects first round of programs
2. Administrative Entity develops contracts/awards and distributes dollars
3. RPC assists in implementation on new program
4. Respite tracking system in place

Phase III: July 2012 – June 2013

1. Based on outcome and resources/ second round of grants
2. Evaluation of RPC process, community engagement and relationship with Administrative Entity
3. Regular Stakeholder meetings

Phase IV: June 2013 – June 2016

1. Evaluation continues
2. Respite Collaborative Partnership meets on a regular basis
3. Quarterly Stakeholder community meetings occur
4. Final Evaluation Report

Innovation Work Plan Narrative

Project Measurement

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

As part of this Innovation Plan, an Evaluator will be hired by the Administrative Entity to evaluate all aspects of the project. The Evaluator will work with the RPC to create a logic model to determine how to measure short and long term goals. The Respite Partnership Collaborative will be involved in providing input into the evaluation design and assisting in defining the activities and processes that will measure and evaluate how the RPC will get to their stated goals. There will be many levels to this Project and the Respite Partnership Collaborative will have input all along the way.

Prior to beginning Innovation Planning, a community survey was conducted. One of the questions was: “We want to keep you informed about what we are learning with our Innovation projects. Which THREE way do you think would be most effective?”

The survey listed nine items to rank. Two hundred and eighty seven (287) people responded. The top three responses were: 1) via MHSA emails; 2) via the MHSA website; and 3) via newspaper articles.

All three of these approaches will be utilized in communicating progress and outcomes to the community. Additionally, the Administrative Entity, in collaboration with the RPC, will host regular informational meetings for the community to share progress and to hear input. A communication structure will be formed by the RPC to gather input from the community.

Innovation Work Plan Narrative

Leveraging Resources (if applicable)

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

It is unknown at this time what organization will be selected as the Administrative Entity. Therefore, it is not possible to identify specific leveraging resources; however, it will be an expectation that the entity selected to administer this program will have an infrastructure in place that can be leveraged to facilitate a selection process, award funding and manage contracts. Although efforts will be directed toward sustainability and leveraging, one of the objectives of this Innovation Project is to learn whether a community-driven collaborative approach can lead to the leveraging of new and existing resources to address crisis and support this project in our community.

EXHIBIT D

Innovation Work Plan Description
(For Posting on DMH Website)

County Name

Sacramento

Work Plan Name

Respite Partnership Collaborative

Annual Number of Clients to Be Served (If Applicable)
TBD Total

Population to Be Served (if applicable):

This project seeks to learn how a collaborative partnership between a county and a non-governmental entity can lead to new partnerships that will leverage new and existing resources and ultimately inform program development, delivery of services and mental health practices in Sacramento County. The second phase seeks to utilize the partnership and community-driven collaborative process to establish crisis respite programs that target all age groups.

Project Description (suggested length - one-half page): Provide a concise overall description of the proposed Innovation.

Sacramento County will contract and partner with a community-based organization which will serve as the Administrative Entity for this project. Sacramento seeks to learn whether this partnership can expedite the release of program funding into the community, lead to the leveraging of new and existing resources, and lead to new partnerships that can help address crisis and other mental health issues in our community. Additionally, the County wants to learn whether the formation of a Respite Partnership Collaborative that is community-driven, rather than county-driven, can lead to effective crisis respite programs that serve all age groups in various locations within our community.

EXHIBIT E

Mental Health Services Act
Innovation Funding Request

County: Sacramento Date: 6/21/2011

	Innovation Work Plans		07/11-06/16 Required MHSA Funding	Estimated Funds by Age Group (if applicable)			
	No.	Name		Children, Youth,	Transition Age Youth	Adult	Older Adult
1	1	Respite Partnership Collaborative	$8,810,600				
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26	Subtotal: Work Plans		$8,810,600	$0	$0	$0	$0
27	Plus County Administration		$0				
28	Plus Optional 10% Operating Reserve		$0				
29	Total MHSA Funds Required for Innovation		$8,810,600				

EXHIBIT F

Innovation Projected Revenues and Expenditures

County: Sacramento

Fiscal Year: 09-10, 10-11, 11-12

Work Plan #: 1

Work Plan Name: Respite Partnersh

New Work Plan ☑

Expansion ☐

Months of Operation: 07/11 - 06/16
MM/YY - MM/YY

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures*			8,810,600	$8,810,600
2. Operating Expenditures				$0
3. Non-recurring expenditures				$0
4. Training Consultant Contracts				$0
5. Work Plan Management				$0
Expenditures	**$0**	**$0**	**$8,810,600**	**$8,810,600**
B. Revenues				
1. Existing Revenues				$0
2. Additional Revenues				
a. (insert source of revenue)				$0
b. (insert source of revenue)				$0
c. (insert source of revenue)				$0
3. Total New Revenue	**$0**	**$0**	**$0**	**$0**
4. Total Revenues	**$0**	**$0**	**$0**	**$0**
C. Total Funding Requirements	**$0**	**$0**	**$8,810,600**	**$8,810,600**

*Contract has not yet been awarded; therefore line item expenditures have not been determined

Prepared by: Jane Ann LeBlanc

Date: 6/21/2011

Telephone Number: (916) 875-0188

Draft Innovation Plan

ATTACHMENT A
Rev 5/13/11

Essential Purpose for Innovation: *To promote interagency and community collaboration*

Learning Goal(s): *Can a community-driven collaborative approach lead to new partnerships that can maximize existing resources and establish a continuum of respite services that will reduce mental health crisis? Does this type of collaboration lead to better planning? Will the Respite Partnership Collaborative lead to better coordination of care and new practices that improve the delivery of mental health services?*

Administrative Entity to serve as Administrative and Fiscal Agent

↓

Respite Partnership Collaborative

A collaborative comprised of community partners to develop, provide or support respite options in Sacramento County

Make recommendations about RPC membership and governance structure
Participate in regular RPC meetings and community stakeholder meetings
Establish partnership and networking opportunities with other community resources and MHSA programs
Explore options for leveraging and sustainability for crisis respite and other innovative options
Participate in respite program selection process
Participate in project evaluation
Develop technology to identify and track respite options in Sacramento County

Each proposed respite program will address the following criteria:

❖ Maximize inclusion of Youth/Peer/Family/Caregivers in employment, volunteer, and leadership opportunities ❖ Peer/Youth/Family/Caregiver Support Services
❖ Culturally responsive traditional healing practices and alternative approaches ❖ Transportation ❖ Located in neighborhood or home-like setting
❖ Voluntary ❖ Trauma Informed Care ❖ Wellness and Recovery Principles ❖ Assessment/linkage/triage

UP TO FIVE POPULATIONS TO BE SERVED

1.	2.	3.	4.	5.
Seriously Emotionally Disturbed Children in crisis Parents need a break	Respite option for a specialized, or cultural or ethnic population	Teens/ TAY in crisis	Adults/Older Adults in Crisis	Adults in Crisis who have dependent children

RESPITE PARTNERSHIP COLLABORATIVE (RPC)

Background: An Innovation Workgroup comprised of diverse stakeholders was established to strategize innovative ideas that can respond to mental health crisis in Sacramento County. Two of five strategies proposed by the Workgroup included some form of respite. All five strategies developed by the Workgroup were presented to the community at large as well as to nine small community groups to elicit feedback and recommendations on ways to enhance the strategies. Input and feedback from the community and the Innovation workgroup was synthesized and is represented in this proposal.

Essential Purpose for Innovation/Learning Goals: The Innovation project that Sacramento County proposes to the Mental Health Services Oversight and Accountability Commission must identify the essential purpose that will address learning and change. In implementing a continuum of respite options designed by community partners, the essential purpose would be to improve interagency and community collaboration. Over the past year, community providers have asked for greater input into the design of mental health services. This proposal provides opportunities for community partners to come together to propose and implement services that could provide a continuum of respite options. DBHS hopes to learn *whether or not a community-driven collaborative approach will lead to new partnerships that can maximize existing resources to establish a continuum of respite services that will reduce mental health crisis.*

Administrative Entity: The model being proposed calls for using a competitive process to select one organization that will serve as the administrative entity for the Innovation project. The complete scope of this administrative organization is still being defined, however, duties may include but not be limited to the following: establish the Respite Partnership Collaborative (RPC); facilitate award selection processes , oversee the distribution of funds and manage contracts; serve as a member of the RPC but not provide respite services; coordinate and work with DBHS to implement the Innovation Project; provide technical assistance to the RPC; host and facilitate meetings; and develop and implement a communication plan and evaluation framework.

Funding: DBHS will request dollars from the Mental Health Services Act (MHSA) Innovation component to fund this RPC Innovation Project. Upon approval and allocation of funding, DBHS will contract with an Administrative entity to implement the project. (Insert approximate funding amount)

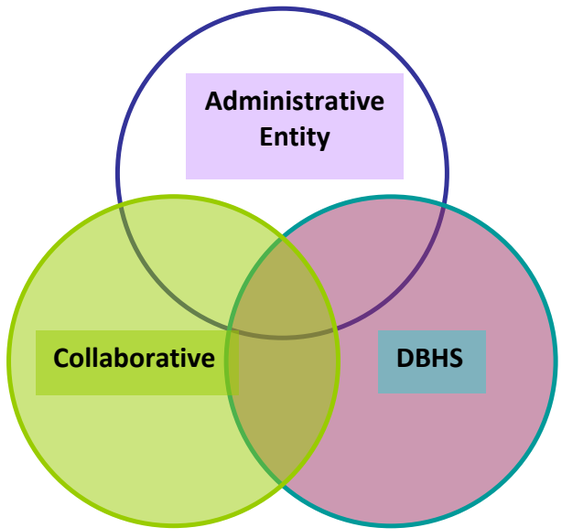
Respite Partnership Collaborative: A Respite Partnership Collaborative will be developed to support respite options throughout Sacramento County. The Innovation Workgroup may continue functioning as the interim Collaborative while the RPC is being established**.** The RPC will develop a governance structure and decision making process that is transparent, inclusive and utilizes the overarching principles established by the Innovation Workgroup. DBHS will provide support to build infrastructure for this collaborative. Membership will be comprised of community groups that have a commitment to the mission of this project, including but not limited to consumers, family members of consumers, representatives of the five populations to be served, mental health agencies, non traditional mental health providers, homeless programs, faith based providers, system partners, cultural brokers/representatives, advocates and other subject matter experts. The RPC will assist in overall coordination, implementation and leveraging of new and existing community resources. Other functions of the RPC will include the following: 1) participate in regular RPC and community stakeholder meetings; 2) establish partnership and networking opportunities with other community resources and MHSA programs, including WET to deliver Trauma Informed Care training; 3) participate in respite program selection process; 4) participate in a RPC Project evaluation; 5) develop technology to identify and track respite options in Sacramento County; and 6) others to be determined.

Choosing Community Respite Options A process will be developed to ask the community to propose program models that can provide respite options for up to five different target populations. Each respite option must include criteria set forth by the Innovation Plan and address the five areas below. The RPC will establish a selection process, form a selection committee and develop selection criteria. Once awards are made, the administrative organization will develop contracts and distribute funds.

Potential Items to be addressed in applications for a respite program:

1. **TYPE of respite being proposed and why – To include: what staffing will be needed, how will peer and family support be utilized; use of alternative and/or complementary healing approaches; assessment, triage and linkage; transportation options** (Examples, not an exhaustive list)
    - Designated allocation – Example: 40 hours of respite per month for a family with a child having a mental health diagnosis
    - Brief Time Out respite
    - Volunteer respite co-op where families provide respite to one another
    - Peer-Operated Crisis Respite Program – unlocked, voluntary mental health consumer managed crisis residential program
    - Recreational respite – hours of planned recreational respite
    - Hub Model – a designated group receives respite from one Hub family that can provide day, overnight, planned and/or crisis respite
    - Coordinated community-based respite for family caregivers caring for individuals with special needs of all ages; relies on partnerships to build and ensure respite capacity
    - Faith in Action – multi-faith volunteers working to provide in-home care for neighbors with long-term health needs
    - Support Team Network – groups of volunteer organized to pool talents, creativity, time, and leadership to offer more than one volunteer can provide alone
    - Medical Respite – respite care focused on individuals with medical issues
    - Group respite – social adult day care model, 4 hours a week, staffed by paid professional
    - Inter-generational respite using trained college students to provide companionship and services to the frail elderly
    - Respite Center/neighborhood based/culturally specific center
2. **DURATION – amount of time being proposed and why**
3. **METHOD for administering respite – what methods are being proposed and why** (Examples, not an exhaustive list)
    - Respite voucher program – gives individuals/families ability to choose respite provider, become the employer by hiring the respite worker, negotiates the rate of pay and manages and provides some of the training
    - Respite care agency – recruits, trains and recommends licensing of respite care providers
    - Use of motel rooms with monitoring
    - Free standing respite facility
    - Neighborhood home
    - Contracted services to a Board and Care
    - Respite brokerage service for paid and volunteer services
    - Respite consultants – provide short-term respite while working with family to identify and train long-range respite resources
4. **LEVERAGING – What will be leveraged by applicant agency? How will the respite link to existing community resources, including other MHSA programs?**
5. **BUDGET**

Mental Health Services Act
Draft Respite Partnership Collaborative
Roles and Responsibilities



Administrative Entity	Respite Partnership Collaborative (RPC)	Division of Behavioral Health Services (DBHS)
1. Coordinate and partner with DBHS to implement Innovation Plan 2. Establish RPC 3. Host/coordinate and participate in RPC and community meetings 4. Facilitate Respite Program selection process 5. Oversee and manage funding awards 6. Develop and implement evaluation activities to assess progress on learning goals, provide data to RPC, DBHS, and community 7. Develop and implement communication plan (to engage community, share learning)	1. Make recommendations about RPC membership and governance structure 2. Participate in regular RPC meetings and community stakeholder meetings 3. Establish partnership and networking opportunities with other community resources and MHSA programs 4. Explore options for leveraging and sustainability 5. Participate in respite program selection process 6. Participate in project evaluation 7. Develop technology to identify and track respite options in Sacramento County	1. Coordinate/partner with Administrative Entity to implement Innovation Plan 2. Develop criteria for RPC based on Innovation Plan 3. Provide liaison and Technical Assistance to Administrative Entity and RPC and facilitate connections to other Mental Health Services Act programs 4. Participate in RPC 5. Partner with Administrative Entity to develop evaluation framework 6. Monitor contract with Administrative Entity 7. Report results to Department of Mental Health and Oversight and Accountability Commission

Sacramento County Innovation Workgroup Roster

#	Name	Alternate	Stakeholder Group
1	Mary Ann Bennett	Lisa Bertaccini	DBHS/MHSA Steering Committee
2	Delphine Brody		Consumer Advocate
3	Caroline Caton		Family Advocate/MHSA Steering Committee
4	Ebony Chambers	Ken Borton	Family Advocate
5	Lois Cunningham	Michaele Beebe	Family Advocate/MHSA Steering Committee
6	Clara Evans	Rosemary Younts	Physical Health Provider
7	Patty Gainer	Randy Hicks	Consumer Advocate
8	Michael Hansen	Kathleen Derby	Mental Health Board
9	Marilyn Hillerman	Sherlie Magers	Family Advocate/MHSA Steering Committee
10	Ben Jones		Consumer Advocate/MHSA Steering Committee
11	Dorian Kittrel	Bonnie Cooper-Elsberry	DBHS/MHSA Steering Committee
12	Sandra Marley		Consumer Advocate
13	Jonathan Porteus	Liseanne Wick	Mental Health Provider
14	Stephanie Ramos		Family Advocate/MHSA Steering Committee
15	Marbella Sala		Ethnic Services/MHSA Steering Committee
16	Dave Schroeder		Consumer Advocate/MHSA Steering Committee
17	Stuart Seaborn	Suzanna Gee	Disability Rights CA
18	Frank Topping	E.J. Hullana	Consumer Advocate/MHSA Steering Committee
19	Glen Xiong	Richard Cross	Mental Health Provider
20	Jon Zwolinski		Law Enforcement

Deb Marois Facilitator
Carol Wright Facilitator

Mental Health Services Act **Innovation Planning Community Participation Overview**	
Community Volunteer Hours – 1,443.50	
Self-Identified Ethnicities	
African American (Black)	Japanese
Apache	Laotian
Arab	Latino/a (Hispanic)
Asian	Mien
Bi-Racial	Multi-Racial
Cambodian	Native American
Chinese	Paiute
Filipino	Puerto Rican
Hmong	Slavic
Hungarian	Scottish
Iranian	Vietnamese
Italian	White
Identified Stakeholder Groups (not inclusive)	
Advocates	Hospital Council
Asian Pacific Counseling Center	Hospitals (Heritage Oaks, UCD)
Consumers	Inter-tribal Council of CA, Inc
Crisis Residential	Lao Family Community Development
Department of Human Assistance	Law Enforcement
Department of Health and Human Services	LGBTQ
Disability Rights CA	Mental Health America of Northern CA
Division of Behavioral Health Services	Mental Health Providers (multiple)
Education	MHSA Steering Committee
Faith-based (multiple)	Transition-Age Youth
Family Members	The Gardens
Gender Health Center	

Sacramento County MHSA Innovation Workgroup Orientation Meeting Summary

January 12, 2011, 3:00 – 6:00 pm

7001-A East Parkway, Sacramento, CA 95823 Conference Room 1

Goals for Meeting

- Understand MHSA and Innovation from State perspective
- Become familiar with the Innovation collaborative planning process, goals and timeline
- Understand roles and responsibilities of workgroup, DBHS staff and facilitation team
- Begin to build relationships among workgroup members
- Review outcomes of Innovation Kickoff
- Introduce sources of existing data and identify additional data needs

I. Welcome & Introductions

Michelle Callejas, MHSA Program Manager, Division of Behavioral Health Services welcomed the Innovation Workgroup members and members of the public. Deb Marois, Innovation Planning Project Consultant from Marois Consulting & Research, and her co-facilitator, Carol Wright, reviewed the ground rules introduced and accepted at the Kickoff. They noted that these would be used at future Innovation meetings.

The facilitation team also reviewed the parameters for public comment and informed Workgroup members and the public that there would be opportunities for public participation throughout the meeting and time for public comment at the end.

Innovation Workgroup members were asked to complete the "Who's in the Room?" form to identify members' affiliations and interests. Information from these forms will be compiled and presented at the January 21 meeting.

Innovation Workgroup members and the public were then paired up to introduce each other, their affiliation, and the gift that they bring to the Innovation Planning Process. Gifts that Innovation Workgroup members bring include attentiveness, lived experience, passion, knowledge, grounded, empathy, attention to detail, communication, inclusiveness, openness and patience. Reviewing the ground rules and acknowledging the gifts that members bring to this collaboration built a strong foundation for this planning process.

II. Mental Health Innovation in California

Wanda Kato and Vivian Lee, members of the MHSA Oversight and Accountability Commission (OAC) provided an overview of the OAC's role in the Innovation component and reviewed the "Innovation Work Plan Success Top Ten List," included in Workgroup binder materials. Additionally, Ms. Kato distributed a compilation of other counties approved Innovation Projects.

Key points included:

- OAC has approval authority for all Innovation Work Plans
- Top ten tips for developing a successful Innovation Work Plan
- Definition of Reversion
- Importance of developing a "specific learning goal" verses focusing on service provision
- Avoiding duplication of any Innovation project that other California counties are currently implementing

III. Overview of Collaborative Planning Process and Workgroup Orientation

Before launching in the overview of the Workgroup charge, the facilitation team first asked Innovation Workgroup members to reflect upon a time that they were part of a group or team that worked well together. The elements that make for a successful collaboration from Workgroup members past experience include: having a shared vision; working hard to listen; communication and trust; sticking to timelines; allowing each member to maximize skills; appreciated differences and diversity; building on cultural differences and gifts; having mutual respect for voices; being patient.

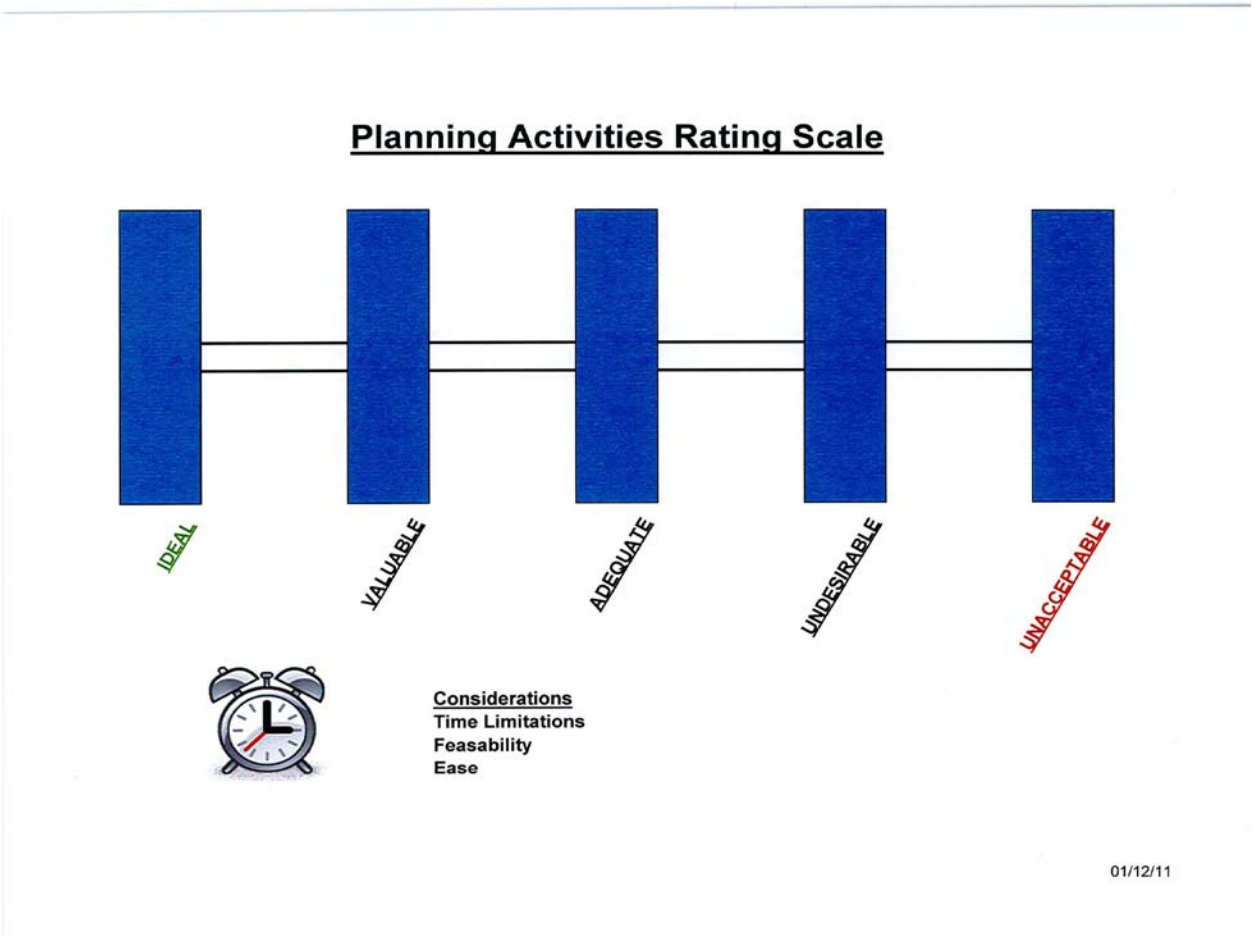
The facilitation team reviewed other elements of a collaborative planning process and provided an orientation to the planning process. Presentation highlights included: frequent sources of conflict in collaborative planning, conflict management, Sacramento County MHSA Innovation Workgroup Charge, Workgroup and Community Meeting schedule.

Work Toward Consensus

The facilitation team introduced the concept of consensus as a fundamental principle in the decision making process. Some Workgroup members asked questions about voting and the structure of the Workgroup. A few members expressed the desire for Workgroup co-chairs and adoption of Robert's Rules in order to make motions. Concerns were expressed regarding the need for transparency and to ensure all information is provided. Examples of past issues were voiced, especially the System Integration Workgroup. Facilitators used this example to

demonstrate the principle of focusing on issues rather than positions. A position is "We want co-chairs." An underlying concern that can be met multiple ways is, "We want a fair, inclusive and transparent process." Facilitators also explained that voting can result in a 51% majority "winning" and a 49% minority "losing." In complex issues that require collaboration of multiple stakeholders in an advisory capacity, recommendations that have the most consensus carry more weight. For issues where the group can not reach consensus, the Division requests multiple options be included for the consideration of the full MHSA Steering Committee. The facilitation team further explained that the group will only meet four times to develop its recommendations and facilitators will serve as a communication channel for issues members want to raise for the whole group, a role typically fulfilled by co-chairs. Facilitators requested follow up discussions with members who continue to have concerns about the need for co-chairs.

The "Planning Activities Rating Scale" was introduced to assist in evaluating suggestions made for the Innovation planning process. When suggestions are generated, members are asked to consider where it falls on the scale and to consider factors such as time, feasibility, and available resources. Some suggestions, while ideal, will not be able to be implemented given time and resources available. Members agreed that any suggestion that is rated as ideal, valuable or adequate would be considered.



The definition of consensus: Consensus means that all group members agree that they can live with a decision.

"Levels of Agreement" is a tool that will assist with consensus building among members of a collaborative. Members may hold different levels of agreement along a six-point continuum that range from strong agreement to strong disagreement. In between are levels whereby members may express disagreement without stopping progress in allowing a recommendation to move forward. Unlike Roberts Rules, collaborative members avoid the sense of winning and loosing and can work towards solutions that result in greater consensus. The facilitators guided Innovation Workgroup members and members of the public through a "Level of Agreement" exercise so that they could experience consensus building.

As a practice question, the group responded to the question: **Do you agree to recommend to DBHS to allow Innovation Funds to revert to the State?** At the conclusion of the exercise, all participants reached consensus to move forward with the Innovation planning process.

1	2	3	4	5	6
Strong Agreement	**Agreement with Minor Concern**	**Agreement with Reservations**	**Stand Aside**	**Disagreement with Major Concern**	**Strong Disagreement**
I support the proposal	*Basically, I support the proposal.*	*I can live with it*	*I don't like this, but I don't want to hold up the group*	*I don't want to stop the proposal, but I have serious concerns.*	*I do not support this proposal*

1-5 means that the member supports the proposal and constitutes consensus.
Only"6" represents a divergent opinion.

IV. Introduction to Existing Data

Lisa Sabillo, Research Evaluation Performance Outcomes (REPO) Planner, introduced the data sources that will be presented at the next Innovation Workgroup meeting. Existing Data from previous MHSA Community Planning Processes, Innovation Survey and other relevant community data related to crisis will be reviewed.

Innovation Workgroup members were asked for suggestions of other data that is important and necessary for this planning process. The following is a list of additional data sources that member suggested: Sacramento County suicide rates, Suicide Prevention Crisis Line, Crisis Residential Programs, effectiveness of Turning Point Crisis Residential Program, Mental Health Planning Council, AB2034, System Integration Workgroup recommendations, Loaves and Fishes data related to deaths and suicide, Sacramento Steps Forward, unemployment, homelessness, domestic violence, police and sheriff's data, Mental Health Treatment Center Crisis Residential data, private psychiatric hospital data, demographics on various cultures, who gets served in a crisis, homelessness due to mental illness, Sacramento County Access Team data, school and other community agencies data related to crisis, California Department of Public Health data on

suicide prevention, incarceration due to untreated mental illness, grief support groups, rape crisis line data, hospital ER visits, Office of Rehabilitation, Community Colleges Office of Disability.

V. Public Comment

A member of the public encouraged the Workgroup to consider how to leverage funds to increase employment for mental health consumers and their families by exploring greater collaboration with Community Colleges and the Department of Rehabilitation.

VI. Next Steps and Meeting Evaluation

Innovation Workgroup members and members of the public were invited to submit written comments to evaluate the meeting. Innovation workgroup members also provided verbal feedback about the meeting. What the Workgroup members regarded as positive included: the introduction exercise, timelines and dates, reiterating and reviewing ground rules, good organization, inclusiveness, positive energy. Changes or improvements for the meeting that the Workgroup members suggested included: develop electronic collaboration process; concerns were not addressed or not adequately addressed; focus on the past and not adhering to the ground rule of being future focused; smaller tables are preferred; lack of participatory exercises; tension needs to be channeled in a positive way.

Innovation Workgroup members were given homework assignments in preparation for the next meeting:

- Review contents of their Innovation Workgroup binders
- Reminder to bring the binder to each meeting
- Provide needed data to DBHS staff by Tuesday, January 18
- Think about how you will communicate with your constituencies about the Innovation Planning Process
- If desired, appoint an alternate and provide contact information to DBHS.

The next Innovation Workgroup meeting is on Friday, January 21, 9am – 5pm.

Sacramento County MHSA Innovation Workgroup Meeting #1
Meeting Summary
January 21, 2011, 9:00 am – 5:00 pm

7001-A East Parkway, Sacramento, CA 95823 Conference Room 1

Goals

- Identify innovative ideas for community engagement in Innovation planning.
- Review and discuss data, existing plans and ideas to better understand mental health crisis and response.
- Identify barriers to resolving issues of response to crisis and alternatives to hospitalization.
- Identify assets and potential opportunities to address crisis response and alternatives to hospitalization.
- Begin to define crisis for the purposes of Innovation Planning.
- Prioritize draft learning goals for the Innovation plan recommendations.
- Strengthen the foundation of trust among Innovation Workgroup team members.

I. WELCOME & INTRODUCTIONS

Welcome and Introductory remarks were made by Michelle Callejas, MHSA Program Manager. Deb Marois, Innovation Planning facilitator, introduced Carol Wright, co-facilitator, and Greg Gollaher, Graphic Illustrator. A PowerPoint presentation (see PowerPoint handout) highlighted the meeting summary purpose, review of the planning process and ground rules. The concepts of a straw poll and "dotocracy" were introduced as ways to test ideas. Going around the room, workgroup members introduced themselves, their affiliation and were asked to name ***one thing that helps build trust or one reason to have group ground rules***. The Workgroup members came up with the following: honesty, common interest/goals, staying positive, assume that everyone has good intent, being on the same page/expectations, open and honest communication, integrity, working together towards one goal, input, transparency, and acknowledgement that we all have value.

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II. Engaging Community Members in Innovation Planning

From the January 12, 2011 Innovation Orientation Meeting "Who's in the Room" exercise, Workgroup members identified their employer or volunteer affiliations and the constituency groups they represent. That information was presented as a graph to inform the Workgroup about what voices are and are not represented in the room (see "Who's in the Room" handouts).

The facilitators led the Workgroup members in a discussion regarding how to ensure that missing voices are included in planning and ways to increase community engagement.

In small groups, Workgroup members were asked to brainstorm how to fulfill the responsibility of representing others in the Innovation Planning process. Each small group reported back to the large group an innovative idea, who will do it, the resources needed, and next steps.

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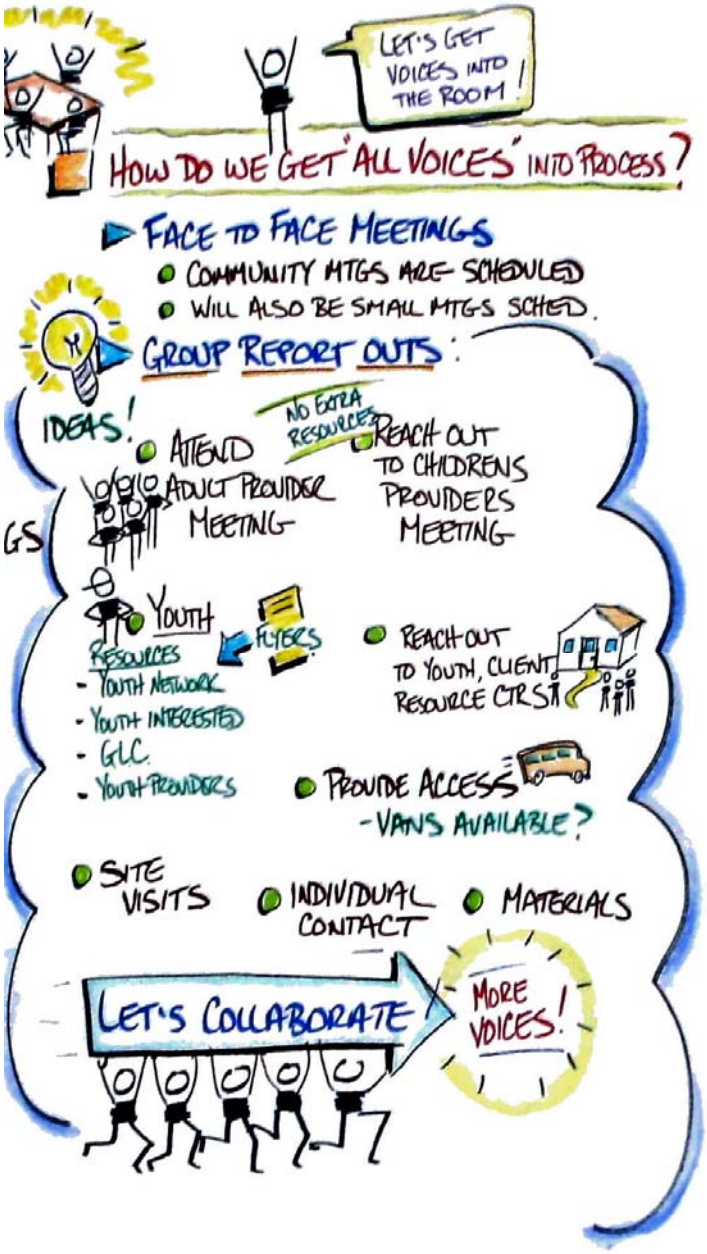

Other ideas that were generated included: developing fliers, providing transportation to meetings, other locations for additional Community Input meetings, getting clients in acute or residential settings to meetings, utilizing websites and Facebook, email distributions, site visits to service agencies, youth advisory groups, youth advocates recruiting other youth, community and cultural resource centers. The members of the public offered the following ideas: Public PSAs; television; ads in newspapers; advertise in grocery stores, laundromats, and welfare and county offices; identify specific goals and questions prior to doing outreach; ensure inclusion of working-class families who do not have Medi-Cal coverage.

Carol Wright reminded everyone that the Community Input meetings are scheduled for March 5 and March 8. She asked members to think of ways to get their constituents to these meetings. Additionally, several Workgroup members volunteered to collaborate with the DBHS Cultural Competence Committee on reaching out and engaging unserved and underserved communities to participate.

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III. Overview of MHSA Planning Data

Deb Marois shared insights from Stakeholder Interviews conducted by the facilitators prior to Workgroup meetings (see Stakeholder Interviews handout). The interviews were conducted to gain background and learn about any underlying issues that might influence the Innovation planning process. Deb reviewed a summary of strengths, challenges, and advice from the stakeholders. The design for the Innovation planning process is, in part, based on feedback from the interviews, with an emphasis on ensuring transparency and comprehensiveness. It was acknowledged that previous community engagement processes have been perceived as challenged; however, it was also acknowledged that relationships are improving.

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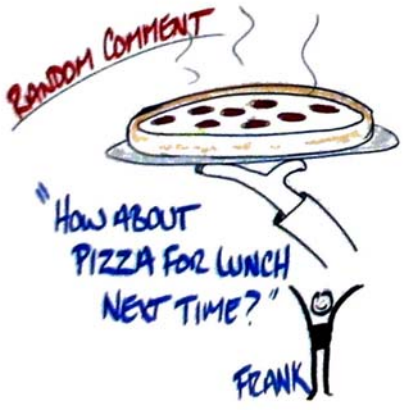
Crisis and Innovation In Sacramento County: What Does The Data Say?

MHSA Planning Processes: Michelle Callejas provided an overview of the previous community planning processes that were part of the three MHSA components: Community Services and Supports (CSS), Workforce Education and Training (WET), and Prevention and Early Intervention (PEI) (see MHSA Community Planning Process handouts). She explained that each planning process identified themes, ideas and issues, many of which had a relationship to crisis, either before a crisis occurs, the actual crisis or after a crisis has happened. Some of the themes ideas or issues identified in the planning process resulted in funded community programs. Those that were not funded were provided to the workgroup as ideas to think about as we move forward.

Workgroup members were asked to think about what information impacted them the most. They listed the following: need for "Clearinghouses" that are linked to each other, Summer Camp, disappointment that MHSA Components were not connected to each other, lack of connections with dually diagnosed, many of the post-crisis ideas could be moved to pre-crisis ideas, many ideas can fit in multiple boxes.



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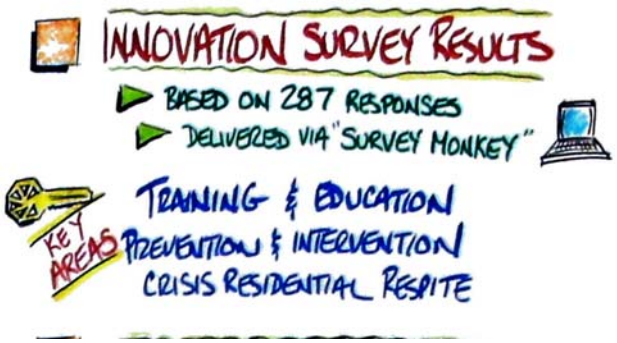

Crisis Statistics: Lisa Sabillo, Program Planner with DBHS Research, Evaluation, Performance Outcomes Unit (REPO), provided an overview of data used by DBHS in trying to understand the current state of crisis in Sacramento County. The data included most of the sources requested by the Workgroup during the Orientation meeting (see Crisis in Sacramento County and Crisis in the Community handouts).

Innovation Survey: Lisa then summarized Innovation Survey results. Over 280 people responded to the survey (see MHSA Innovation Survey handout). The survey revealed three primary areas that were important to respondents, in addition to crisis: Training and Education, Prevention and Intervention Services, and Crisis Respite and Crisis Residential Services.

Throughout the survey, the following themes were frequently mentioned: 24/7 services, accessible services, collaboration with partners (peers, law enforcement, education, CPS, other system partners), culturally specific services, peer run services, services along the crisis continuum. Survey participants wanted to learn effective strategies for preventing crisis, types of supports needed to prevent crisis, how training and education can support the community in providing prevention and crisis services, how to collaborate with others to provide culturally relevant services, how to provide accessible treatment, how to provide cost effective and peer run services.

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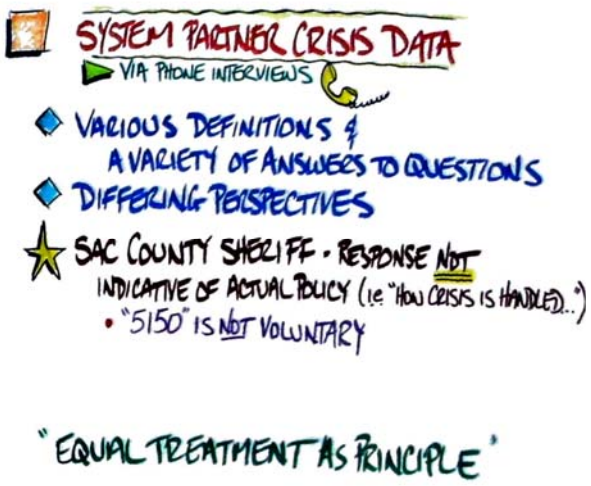
<u>System Partners Perspective</u>: In an attempt to learn how crisis is defined in other systems, DBHS interviewed system partners asking for their perspective on crisis. Input was shared with the Workgroup members (see System Partners handout).



Deb reminded Workgroup members not to jump to conclusions about the data but to carefully consider the information presented. She encouraged members to listen for and focus on what they were interested in learning.

In small groups, Workgroup members were asked to reflect on the data and to think about the following:

What picture does the data paint of crisis in Sacramento County? What stands out? What insights or connections occurred to you? What questions does it raise? Workgroup members reported the following: (See illustration to the right).

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The Workgroup members identified words that jumped out or missing words that define crisis. (See illustration to left).

A number of Workgroup members volunteered to form a subcommittee to draft a definition of crisis. They will bring the draft definition back to Workgroup Meeting #2.

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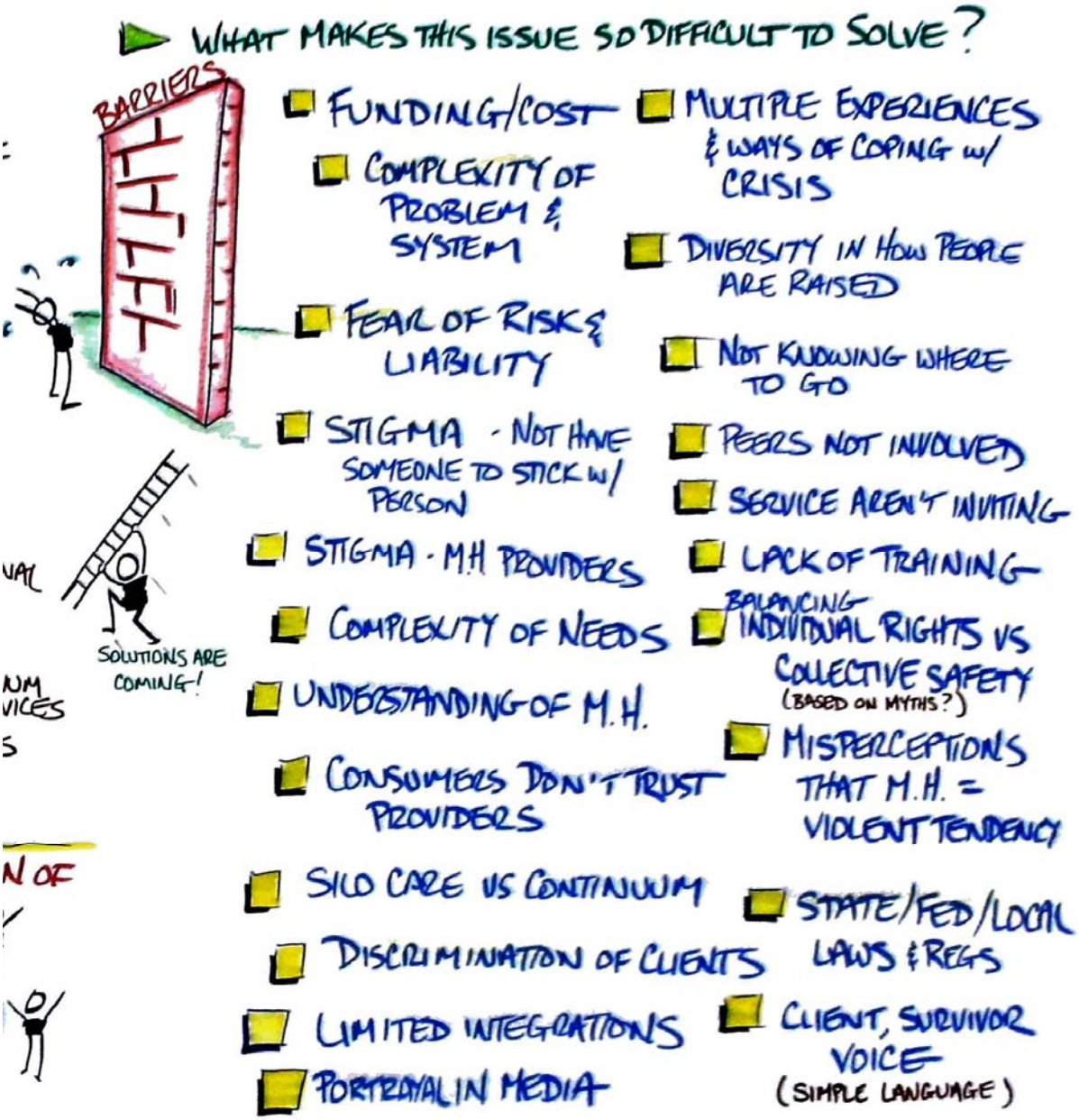
In small groups, Workgroup members identified why the issue of crisis is so difficult to solve. Before reporting their results, Deb cautioned the Workgroup that focusing on barriers can make the challenges seem overwhelming and that it can be more effective to build on assets. Workgroup members identified the following barriers:



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PANEL: CONTEXT FOR INNOVATIVE PLANNING

Presenters were asked to provide a brief overview of concepts and ideas raised by the stakeholder interviews. This information is intended to provide background and context to Workgroup members as they develop their recommendations.

Clara Evans, Catholic Health Care West Policy Director, presented on the Hospital Council Plan: The Hospital Council was established in response to the influx of mental health consumers in local hospital emergency departments. The Hospital Council membership is comprised of community providers, partners, consumers and family members whose goal is to address how we can all work together to ameliorate crises and to collaboratively take care of people in crisis. Their work started in March 2010 and recommendations were developed by July 2010. Clara reviewed the "Sacramento County Behavioral Health System Redesign Recommendations" and charge of each workgroup (see Draft Sacramento County Behavioral Health System Redesign Recommendations handout).

Delphine Brody, California Network of Mental Health Clients MHSA Public Policy Director, presented on Peer Run Services: Delphine Brody briefly described the handouts about peer-run services included in Workgroup members meeting packet. She provided an overview of peer-run services and discussed how involuntary holds in a locked facility can cause more harm than good, the positive outcomes of peer-run crisis respite services, and model programs. California Network of Mental Health Clients would like to see more peer-run MHSA funded programs (see Peer-Run Crisis Alternatives PowerPoint and peer-run model articles).

Mary Ann Bennett, DBHS Deputy Director, presented on Sacramento County's Vision for Crisis Services: In establishing a framework for a vision for the community, Mary Ann emphasized that government, including DBHS, is part of the community and that we all need to work together on solutions. The vision is inclusive of peers/consumers, family members and culturally competent providers and incorporates a safe and trusting environment for everyone. The vision is a continuum of services available for people at all phases of their recovery. There are three levels of services on the continuum: pre-crisis/prevention; crisis; and post-crisis. Peer support is envisioned throughout all levels to help consumers navigate the system. She also discussed the hopes of changing the culture and environment of the Sacramento County Mental Health Treatment Center campus and discussed the opportunity to leverage existing space that is paid for by DBHS but is not being utilized.

Michelle Callejas, MHSA Program Manager, presented on the Innovation Budget data: Michelle Callejas reviewed the Innovation Component Budget and explained reversion issues in FY 2011/2012 and the projected drop in funding in FY 12/13 (see Innovation Funding handout). It

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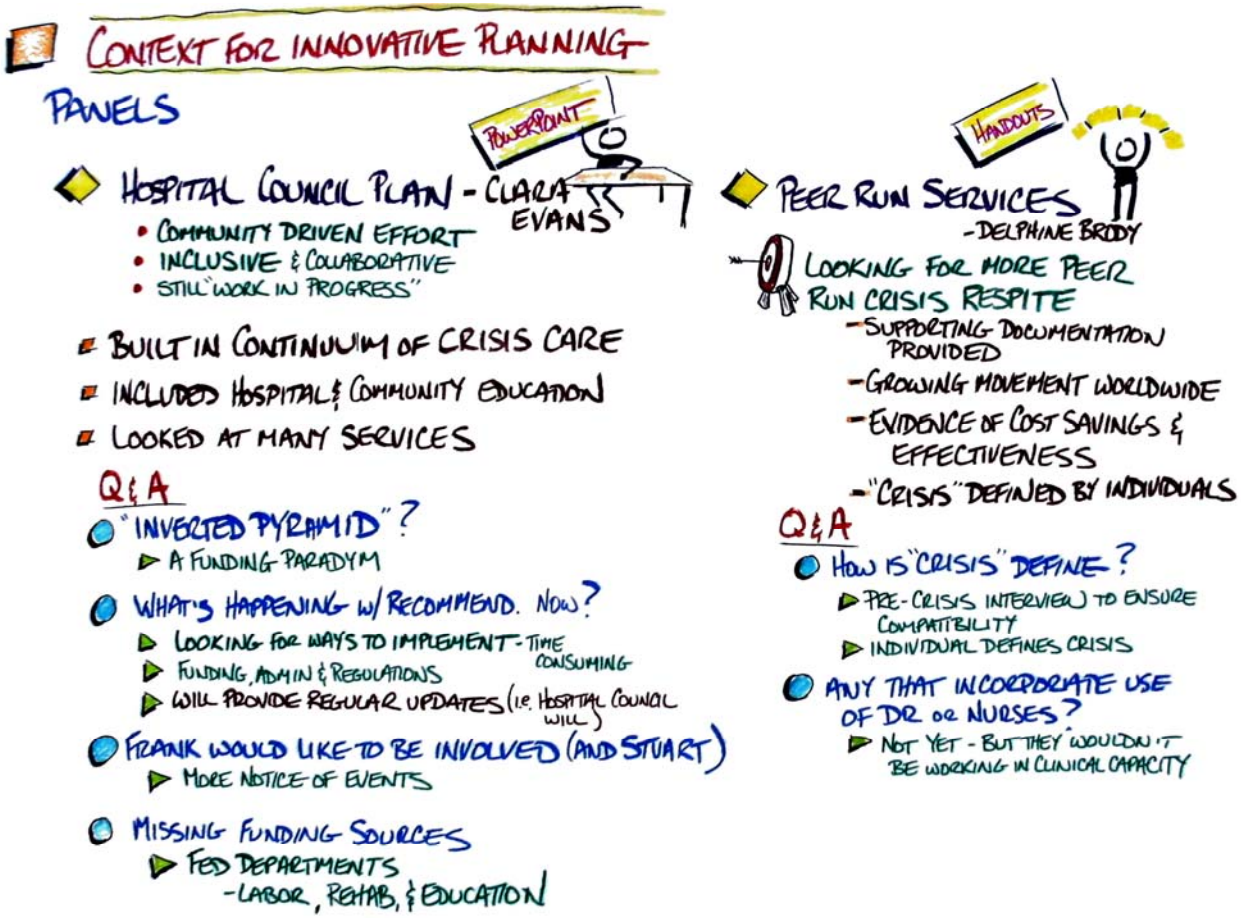
will be important for Workgroup members to consider what we want to learn in the next three years, costs involved in implementation, and sustainability.

The following graphics reflect the presentations by Clara Evans and Delphine Brody.



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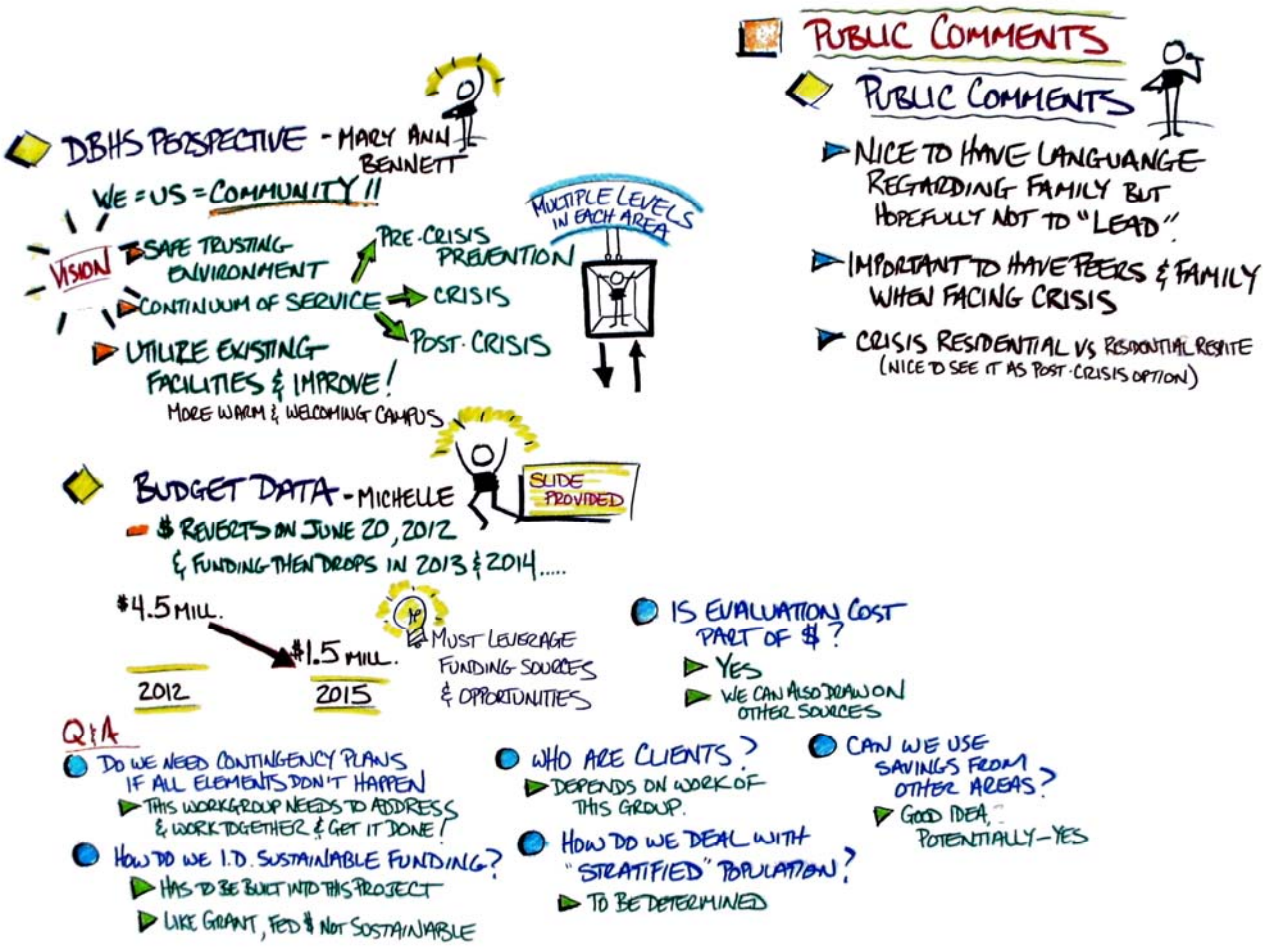
The following graphics reflect the presentations by Mary Ann Bennett and Michelle Callejas.



IV: Learning: The Heart of Innovation

Workgroup members worked in small groups to review the list of Innovation learning goals identified at the Kickoff and Orientation. Members were asked to consider if any learning goals needed to be added and then come to consensus in the small group to prioritize them. Members of the public also formed a small group and participated in the exercise. No new goals were added, though Workgroup members suggested rewording some. The results in order of support are as follows:

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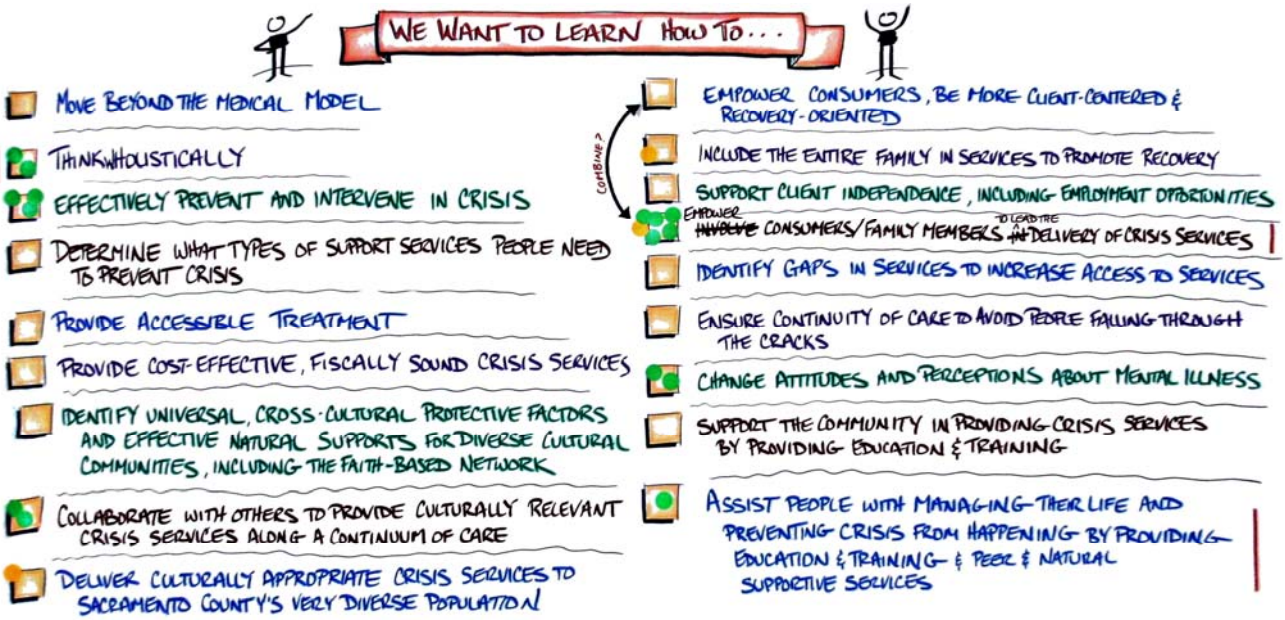
- ☐ Empower consumers/family members to lead the deliver of crisis services that are more client-centered and recovery-oriented
- ☐ Effectively prevent and intervene in crisis
- ☐ Collaborate with others to provide culturally relevant crisis services along a continuum of care
- ☐ Think "wholistically"
- ☐ Change attitudes and perceptions about mental illness
- ☐ Assist people with managing their life and preventing crisis from happening by providing education and training



V. Public Comment

Members of the public offered the following:

- Are there any existing services for any population group that are less effective than existing models of services for that group? If so, can those existing services be replaced/transformed?
- Need training and awareness of the consumer experience and how that translates to more effective services

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- Challenge of balancing individual rights/right to self-determination verses collective rights of safety
- Data might suggest learning goals of which crisis services are effective verses non-effective
- Stigma that peer involvement is not to be trusted, therefore, not seeing the obvious solutions that peers need to be involved at every level to increase empathy, effectiveness of services. Services that would be inviting, that would be freely chosen by individuals prior to crisis and also chosen by individuals in crisis. Needs to be training within the system toward understanding of this type of expertise and how it translates to more effective services.
- Crisis: Equalization and participation on getting better

VI. Next Steps

- Innovation Workgroup Meeting #2: February 10, 2010, 9am – 5pm. Review data and arrive prepared to develop draft strategies to achieve learning goals.
- Crisis Definition Subcommittee will bring a definition back to Workgroup Meeting #2.
- Workgroup members who are interested in working on community outreach and engagement will contact Carol Wright or Julie Leung.
- In response to discussion following the panel presentations, a schedule to tour the Sacramento County Mental Health Treatment Center will be emailed to Workgroup members.
- Catch-up Alternate members before Workgroup Meeting #2.
- Keep constituencies informed of Workgroup progress and send "save the date" notices for community meetings in March.
- Send any correspondence to InnovationWorkgroup@SacCounty.net

Sacramento County MHSA Innovation Workgroup Meeting #2
Meeting Summary
February 10, 2011, 9:00 am – 5:00 pm

7001-A East Parkway, Sacramento, CA 95823 Conference Room 1

Goals

- Create draft strategies to achieve learning goals.
- Adopt a draft definition of crisis.
- Review strategies for community engagement.
- Strengthen the foundation of trust among Innovation Workgroup team members.

I. WELCOME & INTRODUCTIONS

Welcome and opening remarks were made by Michelle Callejas, MHSA Program Manager. Deb Marois, Innovation Planning facilitator, re-introduced Carol Wright, co-facilitator, and Greg Gollaher, Graphic Illustrator. Deb reviewed the agenda and group rules. Going around the room, workgroup members introduced themselves and were asked to share one word to describe how they feel about the progress of the Innovation planning process and the focus on crisis at this time.

Deb reviewed highlights from the January 21, 2011 meeting which included

- A review of the previous Sacramento County MHSA Community Planning Processes
- An overview of the current state of crisis in Sacramento County through data
- Innovation Survey results
- System Partners Perspective on Crisis
- Panel of presenters:

Sacramento County MHSA Innovation Workgroup Meeting #2
Meeting Summary
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7001-A East Parkway, Sacramento, CA 95823 Conference Room 1

- Clara Evans who presented the Community Mental Health Partnership Plan
- Delphine Brody who presented on Peer-Run Services
- Mary Ann Bennett who presented Sacramento County's Vision for Crisis Services
- Michelle Callejas who presented Sacramento County's MHSA Innovation Budget

Deb acknowledged Susanna Gee for sending workgroup members the Innovation plans of Los Angeles and Trinity County. Those plans included a peer run model of crisis services. In response to the data and panel presentations, Workgroup members were invited to tour the Sacramento County Mental Health Treatment Center. Workgroup member Delphine Brody subsequently coordinated a Turning Point Crisis Residential Program Tour for Workgroup members. Both Deb and Carol reminded the Workgroup members that the coordination of data and panel presentations and facility tours were in response to Workgroup member questions and requests with the purpose of informing the decision-making process.

The Workgroup members provided the following feedback related to both the Turning Point Crisis Residential Program and the Sacramento County Mental Health Treatment Center Tours:

II. DEFINING CRISIS

A number of Workgroup members formed a subcommittee to draft a definition of crisis. The definition was reviewed along with an overview of their process in developing the draft definition. The Workgroup members were asked to review the proposed definition and propose new language as needed.

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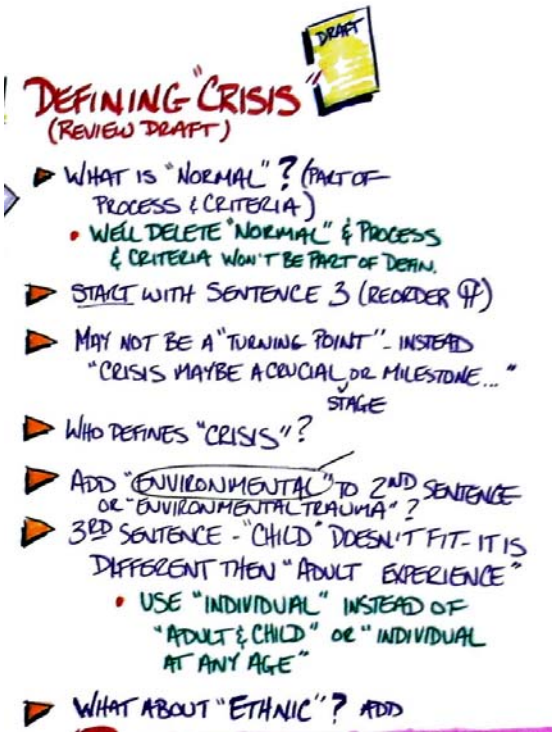

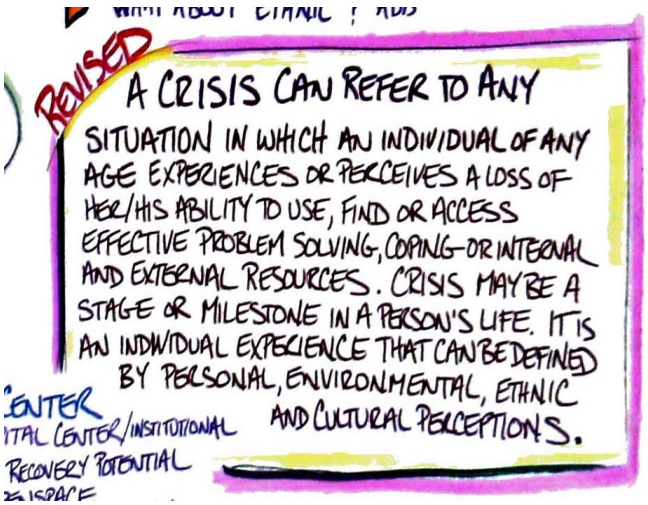

III. A Framework for Innovation

To help Workgroup members build a framework for the Innovation plan, Deb introduced considerations for strategy development and the concept of avoiding either/or thinking but rather to focus on the possibility of integrating ideas. She also reviewed both the Spectrum of Prevention and Strategy Circle concepts which promote the idea of developing multiple strategies at multiple levels and that overlap. (See Considerations for Strategy Development, Spectrum of Prevention, and Strategy Circle handouts). Deb then facilitated a visioning exercise that asked Workgroup members to imagine themselves five years from now where everything that the Workgroup wanted to learn in 2011 had been accomplished. How is life better for consumers, children and families who experience a mental health crisis?

Strategy Development: Workgroup members, individually and then in small groups, began brainstorming Innovative ideas to bring to the larger group that answered the key question: How can we learn more about how to address crisis and alternative to hospitalization in Sacramento County? Susanna Gee, Innovation Workgroup member presented language from Title 9 of the California Code of Regulations, Section 1810.208 that defines "under Medi-Cal

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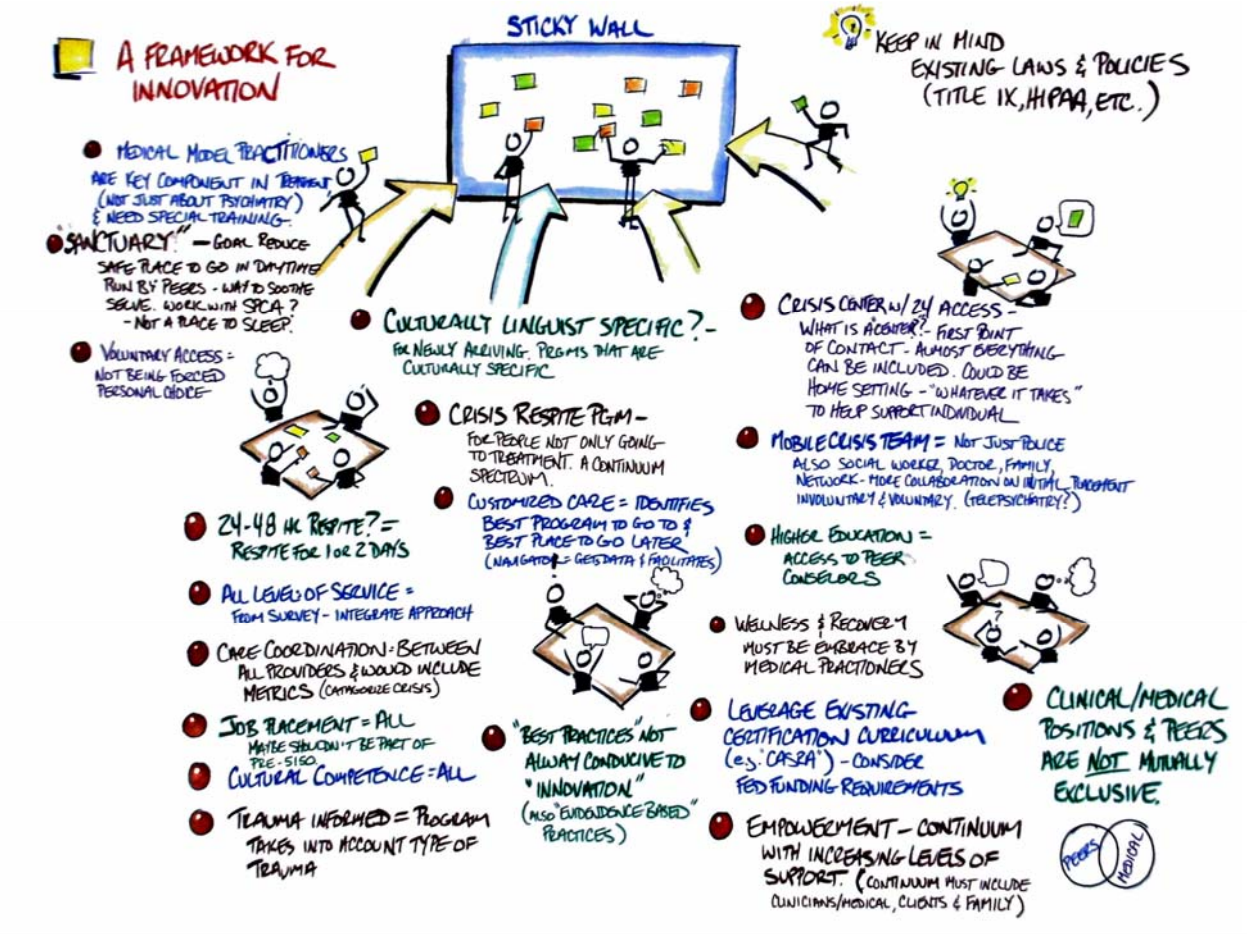
that crisis residential services means therapeutic or rehabilitative services provided in a non-institutional residential setting. Each small group first identified their most critical idea. Second, each group shared their most innovative idea. Groups then contributed an additional idea followed by an emerging idea. All ideas were clustered. Small groups then created names that represented a strategy describing all ideas within each cluster.



To shape and form each strategy, Workgroup members were assigned to a strategy to answer the following questions:

- What will be different as a result of implementing this strategy?
- What existing assets or opportunities can be tapped or combined to leverage resources for this strategy?
- What partners could help carry out this strategy?

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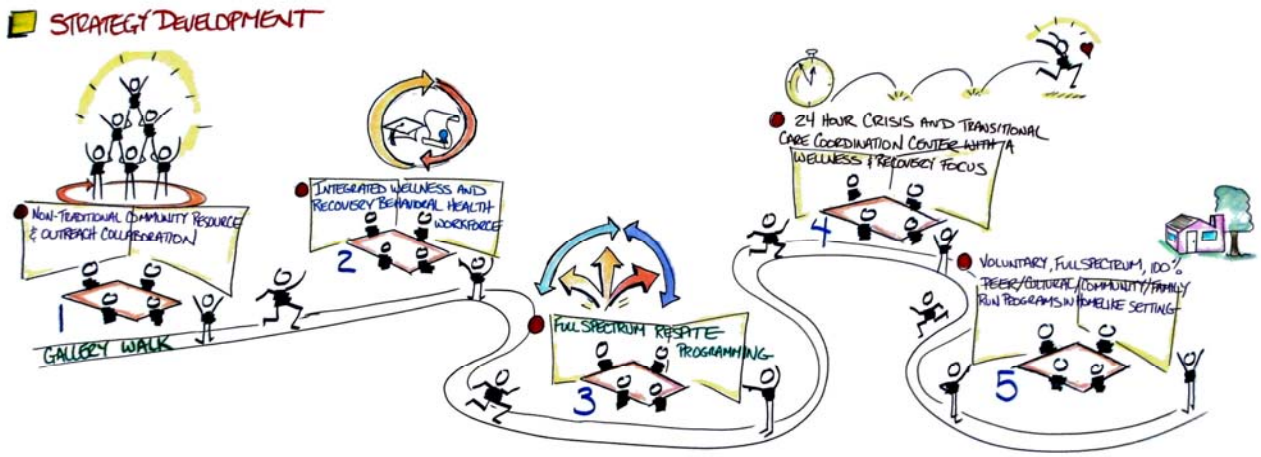
- What primary barriers will need to be overcome to implement this strategy? (See draft Innovation Workgroup Strategies handouts)

Gallery Walk: Workgroup members and the public visited all strategy areas to view the work completed and add additional comments. Using post-it notes, participants answered the following questions:

- What are the strengths of the strategy?
- What questions or concerns do you have?
- What ideas would strengthen the strategy?



IV. Community Meetings

The Workgroup members were reminded of their role of being ambassadors to their constituents and to take steps to encourage their constituents to attend and participate at the Community Input Meetings.

Julie Leung, MHSA Program Coordinator, and Stephanie Ramos, Innovation Workgroup Member, updated Workgroup members about the results of the Innovation Community Engagement Meeting on February 1. Several members of both the Innovation Workgroup and Sacramento County Cultural Competence participated and generated concrete ideas related to encouraging their respective community members to attend and participate in the larger Community Input Meetings. Also, several participants representing local community based organizations agreed to host and facilitate smaller Community Input Meetings for members of

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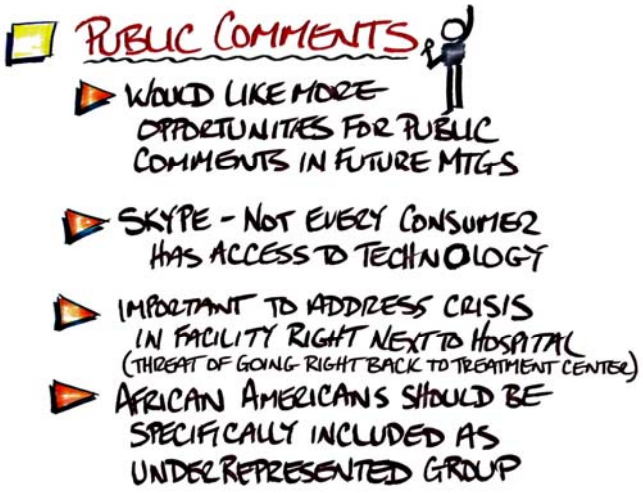
diverse communities who experience language barriers and are more comfortable in a smaller group setting.

V. Public Comment

Members of the public offered the following:



VI. Next Steps

Workgroup members were reminded of the following:

- Consider attending at least one upcoming Community Input Meeting:
  - Saturday, March 5, 2011, 10am – 2pm, Department of Human Assistance, 2700 Fulton Avenue, Sacramento **OR**
  - Tuesday, March 8, 2011, 5:30 – 9:00pm, Samuel Pannell Community Center, 2450 Meadowview Road, Sacramento
- Keep constituencies informed of Workgroup progress and send "Save the Date" notices for community meetings on March 5 and March 8. Encourage your constituencies to participate!
- Innovation Workgroup Meeting #3: March 30, 2011, 9am – 5pm, Voter Registration, 7000 65th Street, Sacramento. Review draft strategies/recommendations.
- Provide updates to Alternate members before Workgroup Meeting #3.
- Send any correspondence to InnovationWorkgroup@SacCounty.net

Mental Health Services Act – Innovation Workgroup: Draft Strategy Recommendations

ATTACHMENT G

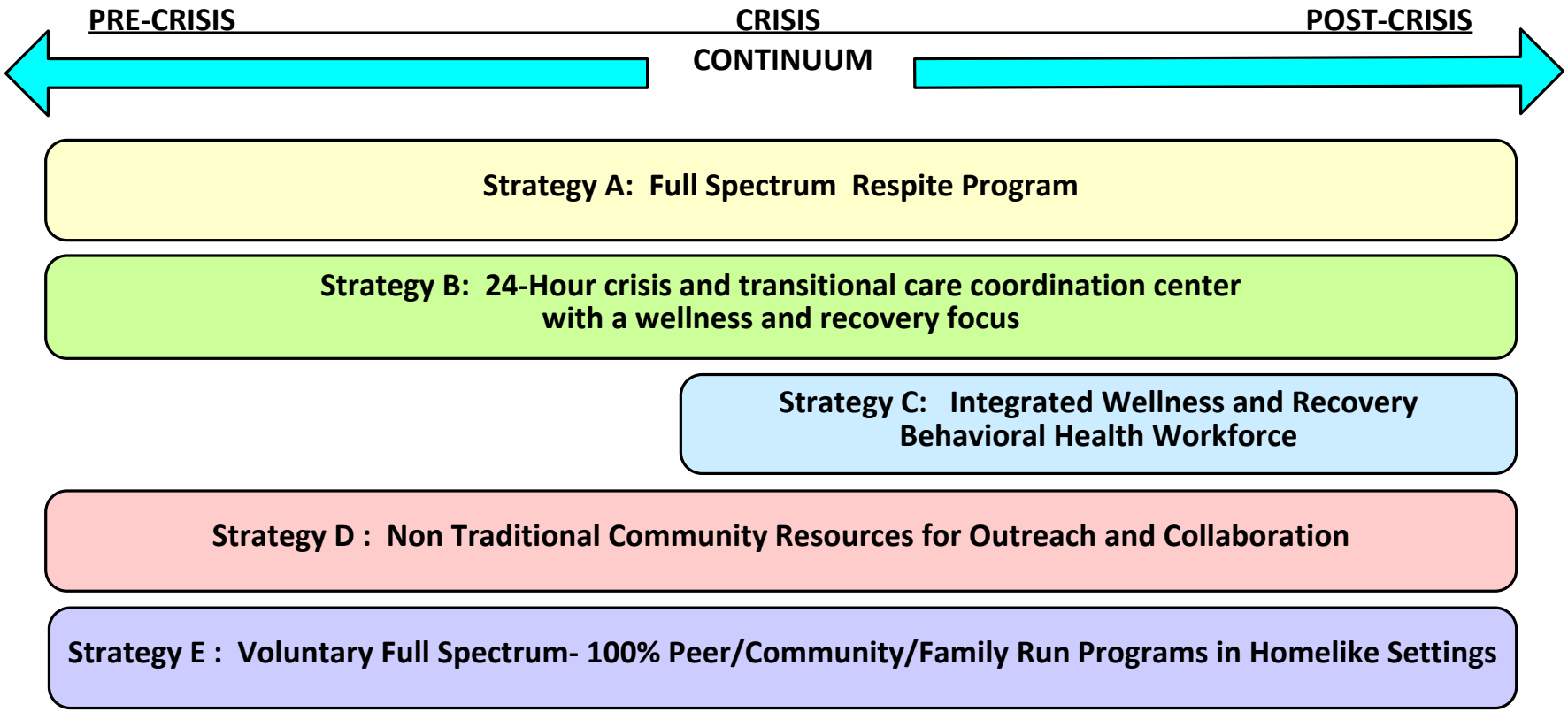
Mental Health CRISIS: can refer to any situation in which an individual of any age experiences or perceives a loss of her/his ability to use, find or access effective problem solving, coping, or internal and external resources. CRISIS may be a stage or milestone in a person's life. It is an individual experience that can be defined by personal, environmental, ethnic and cultural perceptions.
(Adopted by Innovation Workgroup on 02/10/11)

Over-arching Principles Related to Strategies

a) Voluntary access
b) Questioning "best practice"
c) Enhance dignity through alternative to acute care
d) Foster resilience, resourcefulness, personal and social responsibility
e) Integrated approach to care at all levels of service
f) Clinical and peer staff are not mutually exclusive
g) Data collection at intake to find cause of crisis
h) Data collection post-crisis (what worked, what didn't)

Learning Goals

a) Empower consumers/family members to lead the delivery of crisis services that are more client-centered and recovery-oriented
b) Effectively prevent and intervene in crisis
c) Collaborate with others to provide culturally relevant crisis services along a continuum of care
d) Think "Wholistically"
e) Change attitudes and perceptions about mental illness
f) Assist people with managing their life and preventing crisis from happening by providing education and training



Sacramento County Mental Health Services Act

Innovation Community Input Meetings Summary & Data

Mental Health Services Act
Innovation Community Input Meetings Summary

Background:

At the February 10, 2011, Innovation Workgroup meeting, five strategies were developed to address crisis in Sacramento County. The five strategies developed by the Innovation Workgroup were presented to the community for input during the first two weeks of Match, 2011. To solicit diverse viewpoints, Innovation Workgroup members partnered with the DBHS Cultural Competence Committee to identify organizations interested in hosting small group meetings. The following table is an overview of two large Community meetings facilitated by County and nine smaller community meetings facilitated by host agencies through Sacramento.

Focus	Host Agency	Date	Number of Participants (including facilitators)
Community at large	Division of Behavioral Health Services	3/5/2011	26
Latino	La Familia	3/7/2011	48
Mien	Lao Family Community Development	3/7/2011	13
Native American	Sacramento Native American Health Center	3/7/2011	18
Youth / Transition Age Youth	Stanford Home	3/7/2011	11
Community at large	Division of Behavioral Health Services	3/8/2011	34
African American	The Gardens	3/9/2011	7

Focus	Host Agency	Date	Number of Participants (including facilitators)
LGBTQ	Mental Health America of Northern California	3/9/2011	9
Cantonese, Hmong, Vietnamese	Asian Pacific Community Counseling	3/10/2011	8
Hmong	Asian Pacific Community Counseling	3/10/2011	9
Cantonese	Asian Pacific Community Counseling	3/9/2011	6
Muslim	Muslim American Society of the Sacramento Region	3/12/2011	6
		TOTAL	**169**

Summary of what the community said about crisis:

The following summary is intended to capture the main themes and ideas of three questions asked in the two (2) Innovation Large Community Groups and nine (9) Innovation Small Group meetings held in March 2011: What or who helped the most? What might have helped to prevent a crisis? What would have helped after the crisis?

What or who helped the most?

Being able to turn to family and friends and having a support system in place including neighbors and community was a dominant theme throughout all of the community meetings.

Cultivating self help skills and the ability to use them when feeling stressed was another theme. Learning to understand individual feelings and knowing when to ask for help if things become too challenging, being able to use coping strategies like listening to music, watching funny movies, gardening or playing with pets were mentioned

Connecting with mental health and other health professionals including primary care doctors, emergency room nurses, personal service coordinators, psychiatrists, and therapists was mentioned many times. Working with family and peers advocates as well as

being able to advocate for yourself was also helpful. Accessing community services like Turning Point's Crisis Residential Program or Loaves & Fishes, Crestwood, day program, adhering to a 12-step program and taking medications.

Turning to one's own personal faith or religion was cited as being helpful as well as going to a mosque, church or synagogue. Law enforcement was also helpful for some, especially when in situation where someone may be considered dangerous to self or others.

Some small groups focused more on what did not help including: having non-English speaking therapists or police that responding to a crisis call but not taking the person in crisis in for help, leaving the family terrorized.

What might have helped to prevent a crisis?

Many of the things that participants identified in the section above were also things that might have helped prevent a crisis. Things that were not listed include: transportation, access to community centers or other safe places to go to with 24/7 options, the ability to get immediate response for a mental health condition that is leading to a crisis, language specific 24/7 hotlines, daily rituals to maintain wellness, employee assistance programs (EAP) at work, having a Wellness and Recovery, Relapse prevention training, detoxification programs, linkages to services, integration of physical and mental health and housing supports

A theme of safety came up with idea of self defense courses and tools for protection such as pepper spray. Opportunities to release frustration included punching bags in different locations in the community

Smaller groups emphasized the need to have increased language capacity where services are provided including hospitals and mental health agencies. Services need be affordable. In addition to increased language capacity, there was also interest in a public education campaign to promote better understanding of how and where to get help and what are mental health services and how to identify triggers. Providing education on western medicine practices and eastern medicine practices would be helpful.

What could have helped after the crisis?

Aftercare and transitional services was a dominant theme in this segment. Having a support person to stay with the consumer throughout services, family and peer advocates all working together, follow-up therapy, phone calls, visits, assessments and linkages to resources were identified.

A second focus was increasing supports within the community, utilizing natural helpers like clergy, peer respite, peer drop-in and counseling services, community settings open to socialization opportunities and wellness activities could have helped.

Strategy A : Full Spectrum Respite Program

Description:

- Full spectrum respite services that are easy to access and are in various locations in the community
- Respite would be a first point of contact and would be brief/time-limited, up to 24-48 hours
- Services would include treatment practices that can reduce the stress and pressures that come from a crisis experience
- Respite services empower individuals to feel supported and able to maintain without needing hospitalization
- Services would build on the existing network of mental health services, expanding a service continuum and enhancing options for consumers and family members.
- There is the potential to leverage existing facilities to implement this strategy.

Community Input: What suggestions or ideas do you have to improve and strengthen this Strategy?

- **Children/Youth:** There is a need to provide options for adults experiencing a crisis and who have dependent children in the home. There is a need to have separate services for youth/TAY that include separate living arrangements, provide education on different issues, hire staff that understand youth issues.
- **Structure:** Some participants favor a drop in over a residential program and favor flexibility in the kinds of services available. They see it open 24 hours but not for overnight stays.
- **Services:** Recommendations to have ways to deal with stress release such as having punching bags available, dance class or music. Have a specific focus on individuals going off of substances. Teach mindfulness, coping skills. Residents should be able to come and go as they want. The program should be longer than 48 hours. An aftercare service should be included. There should be opportunities to go outside.
- **Outreach:** Promote services in ways that can be heard and understood by different cultural communities. The way services are presented need to appeal to and make sense to different cultural groups. The idea of linkages continues to be supported

Strategy B: 24-Hour Crisis and Transitional Care Coordination Center with a Wellness and Recovery focus

Description:

- Coordination of care that is centralized
- Services include
  - crisis and triage services
  - immediate access to support
  - trained peer "navigators" to help navigate the system and link to other needed services
  - transportation
  - aftercare or transitional care to assist with continued progress
- Wellness and Recovery and Medical models are combined and practiced
- Psychiatrists and physicians will be trained in Wellness and Recovery concepts
- Service providers would also link to each other or develop a network, therefore creating a system consumers could easily navigate
- The following data/information will be collected: consumer information at intake and discharge, cause of crisis, and service satisfaction

Community Input: What suggestions or ideas do you have to improve and strengthen this Strategy?

- **Volunteer Capacity:** Use consumer and community members as volunteers to leverage for sustainability and provide aftercare, one on one support or support groups. Use trainees and interns and volunteers to provide alternative services
- **Outreach:** Offer a 24/7 warm line for counseling or referrals to other services. Create an interactive website that maps and links services. Have computers on site for networking. Recruit local businesses for sponsorship of alternative services
- **Services**: Have bi-lingual staff available on site. Consider using Peer Sponsors, similar to the AA model. Offer alternative services such as meditation, workout room, yoga acupuncture, healing, music, and massage.

Questions to consider: Will there be bi-lingual staff available 24/7? Transportation needs to be clearly defined (e.g. taxi services, door-to-door transportation, vans, mileage reimbursement). Specific services need to be defined. Will mobile services be offered? What is the eligibility criteria? Does this model include residential? The scope of this strategy seem very broad and ambitious and the workgroup might consider limiting the scope.

Strategy C: Integrated Wellness and Recovery Behavioral Health Workforce

Description:

- Peers, family members, interns, and licensed staff without lived experience mutually learn, and share experiences and resources related to wellness and recovery and clinical practice with each other
- Leverage and collaborate with existing partners such as the Department of Rehabilitation, Department of Labor, UC Davis, CSUS, community colleges and consumer advocates and networks

Community Input: What suggestions or ideas do you have to improve and strengthen this Strategy?

- Develop a peer certificate program where the purpose is consumer empowerment (rather than building a workforce) or
- Develop a "Peer Academy" where peers and professionals learn about the recovery process as equals
- **Principles**: Include education classes for families. Define a skill set that is tiered to a set of competencies. Have clear expectations.
- **Specifics**: Teach relationship skills, Emotional Freedom Techniques, self care, exercise, nutrition, yoga, meditation, dragon breathing, and wellness. Celebrate milestones with wellness activities at things like graduation, weddings deaths, etc.
- **Sustainability:** Use volunteers, leverage existing resources

Strategy D : Non Traditional Community Resources for Outreach and Collaboration

Description:

- Develop a project that can address crisis in culturally and linguistically specific ways because:
  - Some languages or cultures have unique beliefs and understanding about mental health
  - In some cultures there is no specific word to use to translate the concept of mental health
  - Without a culturally specific crisis model, there is a tendency to use a "one-size fits all" approach
  - Not everyone understands what 911 means or what to expect when 911 is called for an emergency or crisis
- Examples
  - Develop a crisis response tailored to assist African Americans
  - Develop a Peer Run program serving a specific cultural community
- To meet the needs of cultural and linguistic communities, utilize non traditional services such as
  - Faith-based community
  - Colleges and universities where student peer support services could be provided

Intended Outcomes:

- A more diverse and culturally competent provider network that can provide increased access to underserved
- Culturally tailored services such as housing, respite care, community support groups that can reduce isolation
- A more supportive community able to value differences and able to respond appropriately to crisis

Community Input: What suggestions or ideas do you have to improve and strengthen this Strategy?

- **Program Location:** Cultural and ethnic community members recommended that they would feel more comfortable receiving services at Community Centers. Because of transportation issues, program services should also be provided at multiple sites.
- **Program Services:** Incorporate nature, animal therapy, prevention, and early intervention into services. Parent education and support services are available for parents. Services are provided at the community members homes. Program provides language support for 911 dispatchers and law enforcement. Crisis and Warm Line services are available for specific cultural and ethnic communities. One-Stop services, social activities, after hour services and information line with language support are available for our cultural and ethnic communities.
- **Education:** Education about mental health, mental wellness, services and resources is provided to families. Youth will train youth on mental wellness and cultural awareness in schools.
- **Program Staff:** Staff and community providers will be trained on how to use interpreters.

- **Training for Other Providers/Partners and Community Leaders:** Training about mental health, services and resources, cultural sensitivity, use of interpreters is available to other providers, partners, community leaders.
- **Outreach and Promotion:** Outreach activities are provided at community members homes. Employ different types of media to outreach, educate, and promote services (e.g., Ted.com, YouTube, Twitter, Facebook, Tumblr, Downelink, and other social media/networking). Promote services through local churches and ethnic community radio, papers, TV stations. Target outreach to people that lack transportation.

Questions to consider: Will this program include residential treatment? If so, long or short term? Would there be repercussions with CPS? What about services for undocumented individuals? Strategy D concepts should be incorporated into other strategies.

Strategy E : Voluntary Full Spectrum- 100% Peer/Community/Family Run Programs in Homelike Settings

Description:

- A program that can address crisis primarily in a neighborhood homelike setting
- Array of crisis services would be voluntary, peer run and designed to meet a variety of needs
- Access to services would be 24/7 and available through phone consultation, walk-in or some kind of mobile service
- Creating a feeling of safety and sanctuary would be a guiding principle
- Child and family support and transportation to and from this program would be provided
- Services would not be restricted by age; rather they would include the whole family

Goal:

- More people will seek services prior to a crisis escalating and requiring hospitalization. The ability to work through a crisis in an environment where there is a support system in place and the opportunity to stabilize in the least restrictive setting could allow an individual to progress at their own pace. Overcoming a crisis can sometimes be a growth opportunity and contribute to an increased sense of empowerment and self esteem.

Intended Outcomes:

- Increased awareness of peer support as a modality for care.
- Decrease in expensive hospitalization
- Enhance the existing continuum of services

Community Input: What suggestions or ideas do you have to improve and strengthen this Strategy?

- **Program Location**: Multiple locations with home-like settings, sited in neighborhoods, sited where community members live.
- **Program Structure and Services**: Program is culturally specific (to include the provision of traditional healing practices), language specific, age specific, gender specific. Program incorporates faith-based community in the provision of services. Program services are offered to veterans and those with other disabilities. Prevention services, linkage to other resources and services are included. Information line with language support is another service of this program. Education about mental health, resources and services and Western approaches to mental health treatment. Bi-lingual staff or interpreters are available to assist with navigating the system.
- **Program Staff and Staff Training**: Staffing is integrated and represents those with lived experience, have other types of lived experience (e.g., homelessness), reflect different age ranges, the cultural diversity of the county, are identified as

LGBTQQIA, bi-lingual, professional. Train staff on "Shame Resilience Theory" (Brené Brown), cultural sensitivity, and traditional healing practices.

- **Outreach and Promotion**: Implement outreach activities to promote services to unserved and underserved communities.

Sacramento County MHSA Innovation Workgroup Meeting #3
Meeting Summary
March 30, 2011, 9:00 am – 5:00 pm

Voter Registration Office, 7000 65th Street, Sacramento, CA 95823

Goals

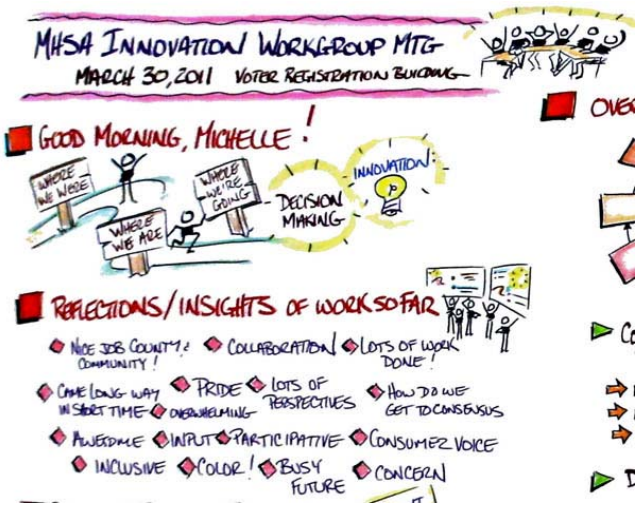
- Review the Innovation planning process, including roles, responsibilities and next steps.
- Introduce the draft Innovation Recommendation, which incorporates the draft strategies and community input.
- Identify priorities, clarify terms and discuss pro/cons of options in order to refine the draft Innovation Recommendation.
- Strengthen the foundation of trust among Innovation Workgroup team members.

I. WELCOME & INTRODUCTIONS

Welcome and opening remarks were made by Michelle Callejas, MHSA Program Manager. Michelle thanked Innovation Workgroup members for their hard work up to this point in time and asked them to have open minds and hearts as they develop a plan that best serves our community.

Deb Marois, Innovation Planning facilitator, re-introduced Greg Gollaher, Graphic Illustrator, and announced that Carol Wright, Innovation Planning co-facilitator was not able to attend this meeting. Deb reviewed the agenda, goals for the meetings, ground rules. The meeting materials were also reviewed including the February 10, 2011 Meeting Summary that brought in Susanna Gee's suggested additions: that she asked Workgroup members to consider Los Angeles and Trinity Counties Innovation Plans and the Title 9 definition of crisis residential treatment services.

Workgroup members re-introduced themselves and were invited to peruse walls of the room covered with Innovation Workgroup Planning meeting graphic recordings to date. Workgroup members were asked to reflect on their work and to share one thing that stood out for them in the process thus far.



Sacramento County MHSA Innovation Workgroup Meeting #3
Meeting Summary
March 30, 2011, 9:00 am – 5:00 pm
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II. PLANNING PROCESS REFRESHER

Deb revisited the Innovation Planning process. The Planning process is now just over mid-way. At the last meeting, the Workgroup members developed draft strategies that were not fully "cooked" to allow for community input. Since then, the Community's input has been integrated into the draft recommendation. Deb reminded the Workgroup to focus on interests rather than positions. Multiple stakeholder groups have and will contribute input in the Innovation Plan; therefore, the greater level of consensus equals greater level of potential for implementation. (Refer to "Contributors to the Plan" and "Refresher Power Point" Handouts)

III. OVERVIEW OF DRAFT INNOVATION RECOMMENDATION

MHSA Team presented an overview of steps that were taken to build the draft Innovation recommendation:

Michelle Callejas, MHSA Program Manager, acknowledged the hard work of the Workgroup members and that their thinking and work was the primary basis for the draft recommendation. The Workgroup started with the Kick-off and Orientation meetings which consisted of learning about the principles of the Innovation Component, presentation of past planning processes and data related to crisis in Sacramento County, tours, development of crisis definition, discussing learning goals. The Workgroup took into consideration all of the information presented and their generated ideas and concepts and developed many strategies. The MHSA Team captured, organized and synthesized the Workgroups ideas and sent five (5) strategies back to the Workgroup members for review and feedback. The Team incorporated Workgroup members' feedback, made adjustments, and prepared the draft strategies for community input.

Sacramento County MHSA Innovation Workgroup Meeting #3
Meeting Summary
March 30, 2011, 9:00 am – 5:00 pm
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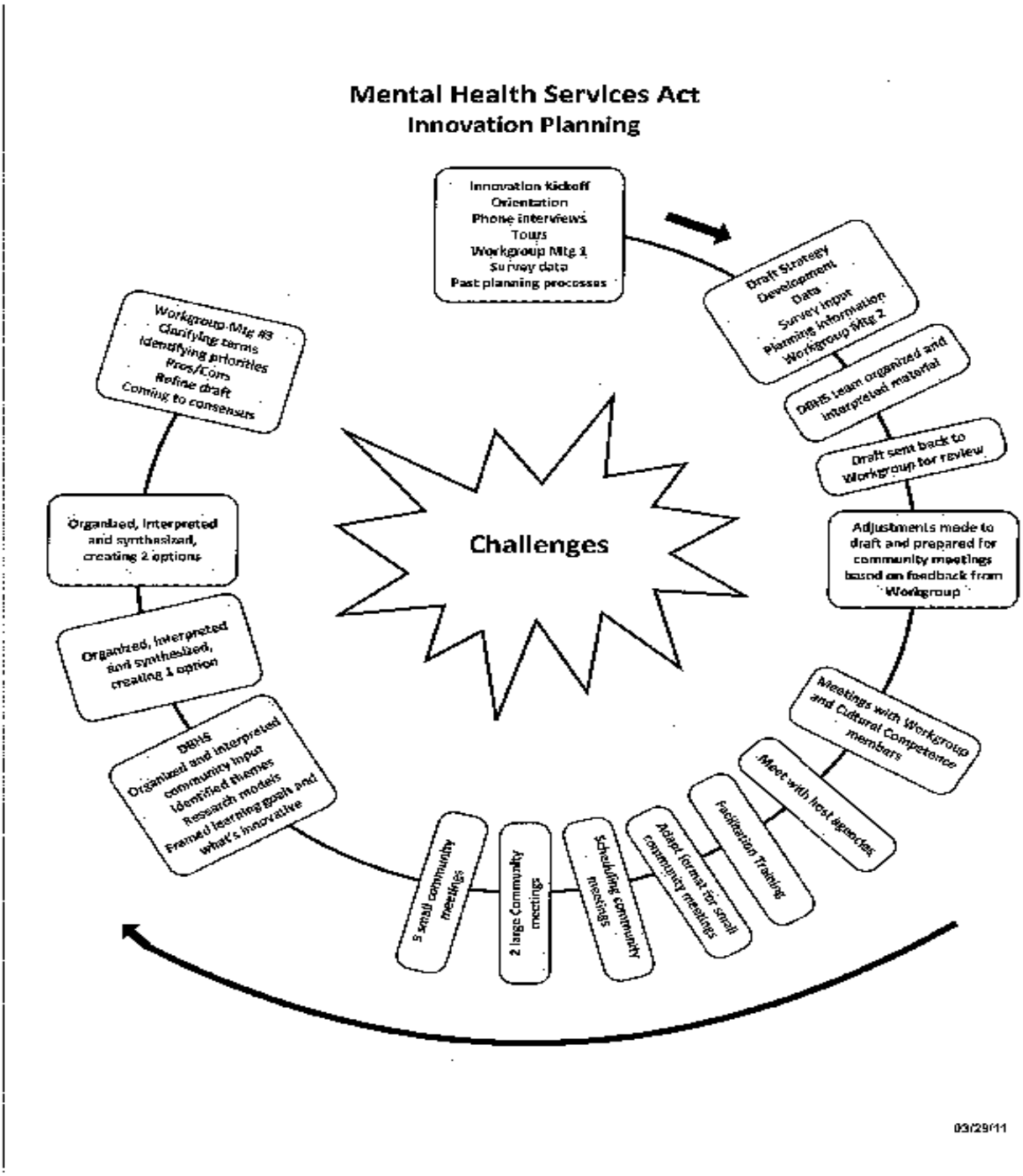


Sacramento County MHSA Innovation Workgroup Meeting #3 Meeting Summary

March 30, 2011, 9:00 am – 5:00 pm

Voter Registration Office, 7000 65th Street, Sacramento, CA 95823

Julie Leung, MHSA Program Coordinator, reviewed the Community Input process. Two (2) Community Input meetings were already scheduled for the community at large. However, Workgroup members together with DBHS Cultural Competency Committee members were committed to reaching out to our cultural and ethnic communities for their input. Members of both groups met to develop a plan for outreach which resulted in brainstorming recruitment strategies and identifying host agencies for small group community input.

Those host agencies met to further develop small group input meetings targeting cultural and ethnic communities. These agencies hosted (9) small group community input meetings. Both large and small group community meetings resulted in a total of 169 people in attendance and providing input into the Workgroup's draft strategies.

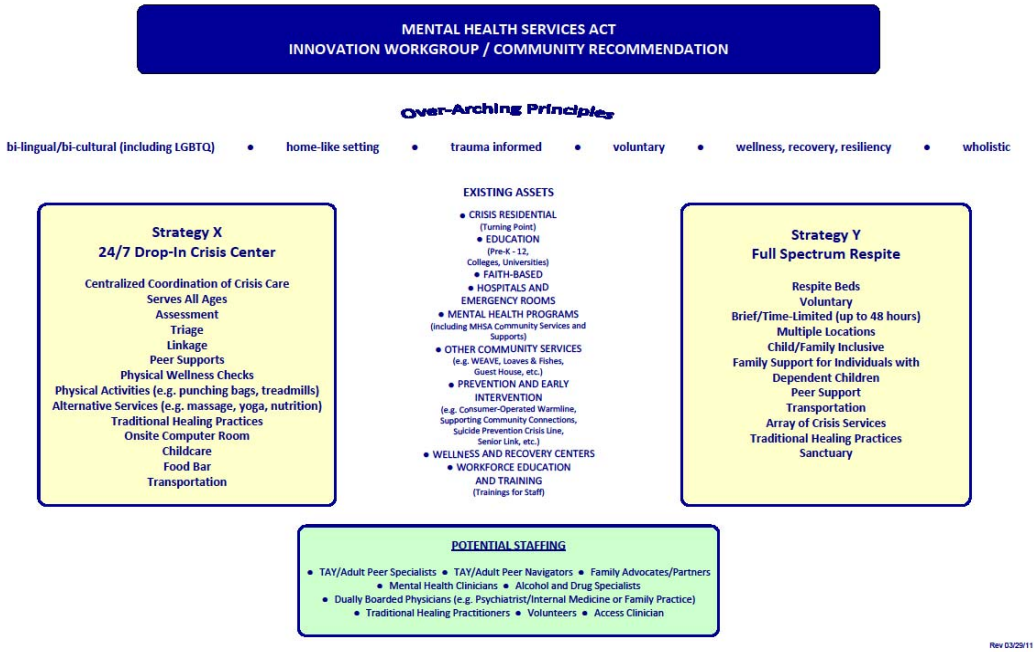
There were common and divergent themes that emerged from both the large and small community input meetings:

Kathryn Skrabo, MHSA Program Planner, discussed the challenges of organizing, integrating, and synthesizing all information, ideas, and input from the Innovation Planning process to date. There were challenges in determining the learning goal and what was innovative. Kathryn walked the Workgroup through the different iterations of the draft strategies, the elements of the five (5) draft strategies that were included or excluded, decision points, resource limitations and leveraging opportunities with existing assets. She also reviewed existing MHSA funded programs to illustrate that some of the Workgroups' ideas were already in place or ready to be implemented. Additionally these existing MHSA funded programs present opportunities for linkage and leveraging.

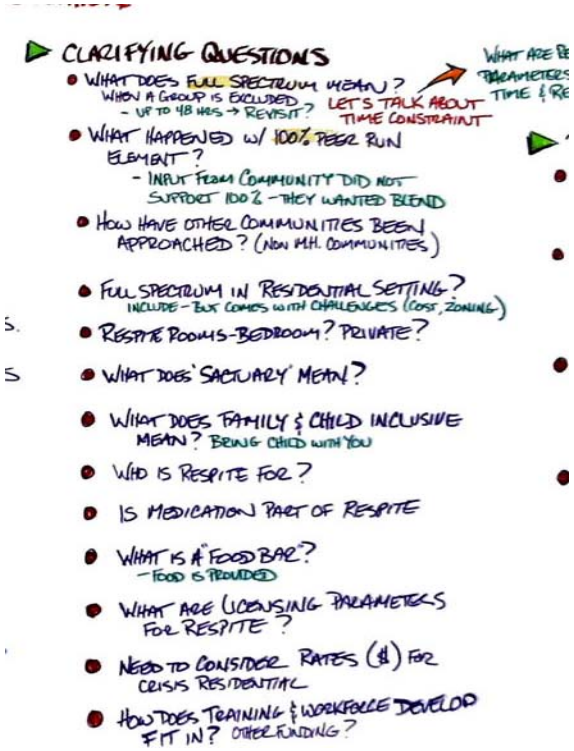
Sacramento County MHSA Innovation Workgroup Meeting #3 Meeting Summary

March 30, 2011, 9:00 am – 5:00 pm

Voter Registration Office, 7000 65th Street, Sacramento, CA 95823



Michelle Callejas concluded the review by describing the strengths and questions/concerns about the current draft recommendation. Strengths of this recommendation include: 1) reflects community input; 2) included alternatives not seen before in Sacramento e.g. yoga blending of peer and medical models; 3) potential for specific elements to be innovative. Remaining questions and concerns include: 1) what is the learning goal; 2) what is innovative; 3) multiple locations; 4) siting and zoning concerns.



The Workgroup members and members of the public also contributed clarifying questions:

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Rules and Regulations related to crisis residential siting:

John Buck, Turning Point Community Programs, Mike Lazar, Transitional Living Community Services, and Lynn Place, Human Resources Consultant, informed Workgroup members about rules and regulations related to crisis residential siting:

IV. RECOMMENDATION REVIEW AND REFINEMENT

Deb Marois directed Workgroup members to work in trios to discuss and answer the following questions: What concepts/elements are most important to include in the final Innovation recommendation? Could any of the elements be combined to create a more Innovative recommendation? If so, how?

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Workgroup members selected the following concepts as important to include in the final recommendation:

Important Concepts	Workgroup Dots	Public Dots
Peer Support o On-going training o Navigating the system o Individuals with lived experience o Youth, parents/caregivers	15	6
Family support o For both parents and child o Broad family support/helping the whole family unit o Can include members of family/loved ones o Training o Navigating o Not mandatory	14	4
Complementary and alternative methods o culturally, traditional healing practices o culturally specific	12	5
Centralized coordinated care o place where people know they can call o serves as a starting place	12	1
Transportation	10	6
Multiple locations	10	2
Assessment, triage and linkages o Benefits coordination	9	3
In neighborhoods	8	5
Staff with lived experience	6	2
Respite space	5	2
In-Home respite o families can live there	4	1
Close connection with all existing services o Care coordination if requested o Active communication with other service providers	1	7
Respite that is not structured unless requested o Structure is available but not required	0	2
Serves all ages	0	1
Self-referral/self-directed ○Self-determination, autonomy	0	1

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Deb then had Workgroup members and members of the audience dot-vote for three of their most important concepts/elements (see table above). After everyone dot-voted, the following concepts/elements "made the cut":

The Workgroup members were asked again to work in trios to discuss how these prioritized elements could be implemented in an Innovative way. Deb reminded the Workgroup of the following approaches:

- New, adapt, or adopt models or practices from other fields
- Unique collaborations: funding mechanisms, specific populations
- Combining elements in new ways or at new locations
- Shared learning opportunities
- Address multiple issues

The Workgroup members and members of the public reported out with the following Innovative ideas:

- Roving Supervision
- Psychiatric interns and Peers trained together
- Use of technology: access to computers to reduce isolation, improve access, connections, and provide tele-support
- Coordination to improve access to alternative/complementary services
- Ways to build capacity for competitive bidding for community based organizations (e.g. scholarship fund, grant writers)
- Wholistic Center that addresses multiple issues
- Address transport issues to prevent relapse because they can't get to appointments; a "Ride for Help"; find ways to get people where they need to go
- Using culturally trained drivers to provide transportation
- How can volunteers be used innovatively; volunteers can provide transportation
- Native American Health Center model – smaller and in African American community

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- Getting services to person as quickly as possible, more authority at first contact
- Engage culturally specific groups in small learning circles, innovations in prevention
- Be a model for Peers getting reimbursement from Medi-Cal; Peer services are Medi-Cal eligible; create more opportunities for Peer reimbursements; different states have different Medi-Cal rules
- Sustained funding from emergency rooms to help fund (incentive for hospital) – Outcome: reduce over crowding (national problem)
- Measure results and show improvements
- Employ those with "lived experience"; peer staff at all levels; reimburse Peer services; use people with "lived experience" and training, etc (include language training)
- End "hand offs", maintain community and consistency throughout continuum; peer and cultural support
- Language training for competency

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VI. NEXT STEPS

Workgroup members were reminded of the following:

- Innovation Workgroup Meeting #4: April 19, 2011, 12pm – 5pm, 7001A East Parkway, Conference Room 1, Sacramento.
- Provide updates to Alternate members before Workgroup Meeting #4.
- Homework: Think about models, methods and/or practices that can be used to implement the concepts/elements you dot-voted on in an Innovative way. Is there a model, method or practice that is new or that can be adopted or adopted that incorporates these ideas/elements? Share your ideas and concepts by sending them to InnovationWorkgroup@SacCounty.net by noon, April 6, 2011.
- Send any correspondence to InnovationWorkgroup@SacCounty.net

Sacramento County MHSA Innovation Workgroup Meeting #4
Meeting Summary
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Goals

- Review the draft Innovation recommendation and provide final comments before it is brought to the MHSA Steering Committee for review.
- Reflect on lessons learned and provide feedback on the Innovation planning process.
- Discuss next steps in finalizing the Innovation plan and the role of Workgroup members as community ambassadors.
- Strengthen the foundation of trust among Innovation Workgroup team members.
- Celebrate the conclusion of the Innovation planning process and acknowledge contributions of team members.

I. WELCOME & INTRODUCTIONS

Welcome and opening remarks were made by Michelle Callejas, MHSA Program Manager. Michelle reminded the Workgroup members that this is our last meeting and thanked members and alternates for their contribution to this process. Today's the focus will be to refine the Innovation recommendation, take it forward to the MHSA Steering Committee, and celebrate.

Deb Marois, Innovation Planning Facilitator, reviewed the agenda, goals for the meeting, ground rules, and meeting materials. Deb facilitated a warm-up reflection exercise. She asked Workgroups members to think about that they've as a result of participating in the Innovation planning process. Workgroup members were asked to write down their responses and to also share one thought from their reflection:

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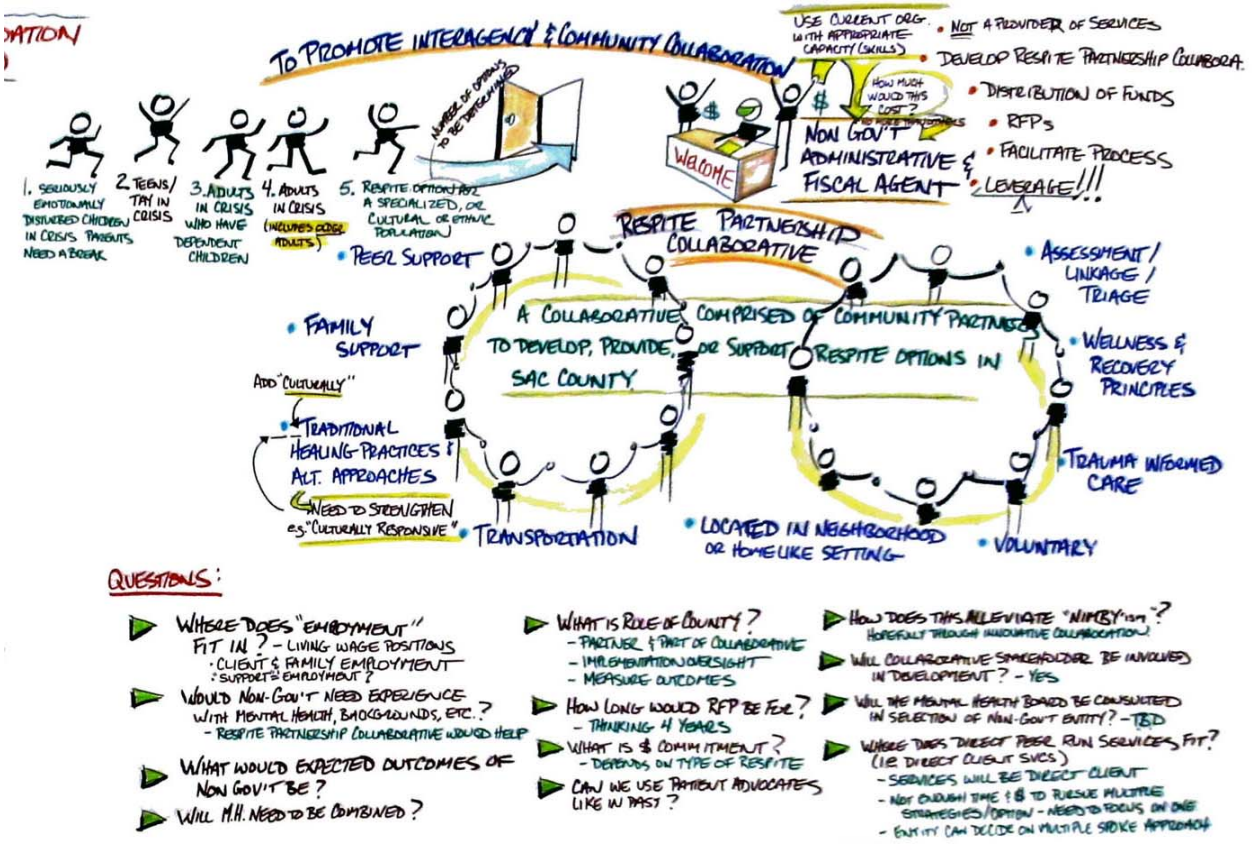
II. OVERVIEW OF RECOMMENDATION

Michelle Callejas reviewed the draft recommendation with the WG members. Based on the ideas that came out of this planning process and prior planning processes and feedback from the community related to the County's limitations in the implementation processes, the MHSA Team developed the Respite Partnership Collaborative. This Respite Partnership Collaborative's composition would be community partners that would develop, provide or support respite options in Sacramento County. They would be responsible for tracking and coordinating respite options, building linkages to other community resources and MHSA programs, host community stakeholder meetings, evaluate respite programs, ensuring that all programs incorporate guiding principles, maintain networking technology. The Respite Partnership Collaborative could be established, organized and facilitated by a non-county administrative which would provide administrative and fiscal support for respite projects developed by the Collaborative. Goal is to build new partnerships that can lead to better coordination of care and new practices, maximize existing resources, establish a continuum of respite services that will reduce mental health crisis. (Refer to Draft Innovation Plan)



Using the levels of agreement, Deb Marois asked the Workgroup members how much did each member agreed to the following question: Should the draft Innovation plan move forward to the MHSA Steering Committee? Those that were in "strong support" expressed the following:

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1) the draft plan is a new and innovative way about providing respite services; 2) they were excited about putting respite in the project; 3) acknowledged that the plan is inclusive of parents. Members who were "supportive with minor concerns" wanted concepts to be further clarified: 1) needs more strength based language related to peer and family member support/employment; 2) concerned about selecting the administrative entity; 3) unclear about the administrative entity; 4) administrative entity's role needs to be true to the intent of the draft recommendation; 5) relationship between the Respite Partnership Collaborative and administrative entity needs to be more clear; 6) the Collaborative's process for selecting services needs to clarified. Those that had "strong concerns" noted that they did not have enough information to support the draft recommendation. Members that "could not support" the recommendation were concerned that employment of consumers and family members was excluded from the recommendation.

Following the straw pole exercise, Workgroup members were directed to work in trios to discuss and answer the following questions: What values or principles are important to consider in forming this collaborative? What do we need to consider as we move forward? Workgroup members reported out the following:

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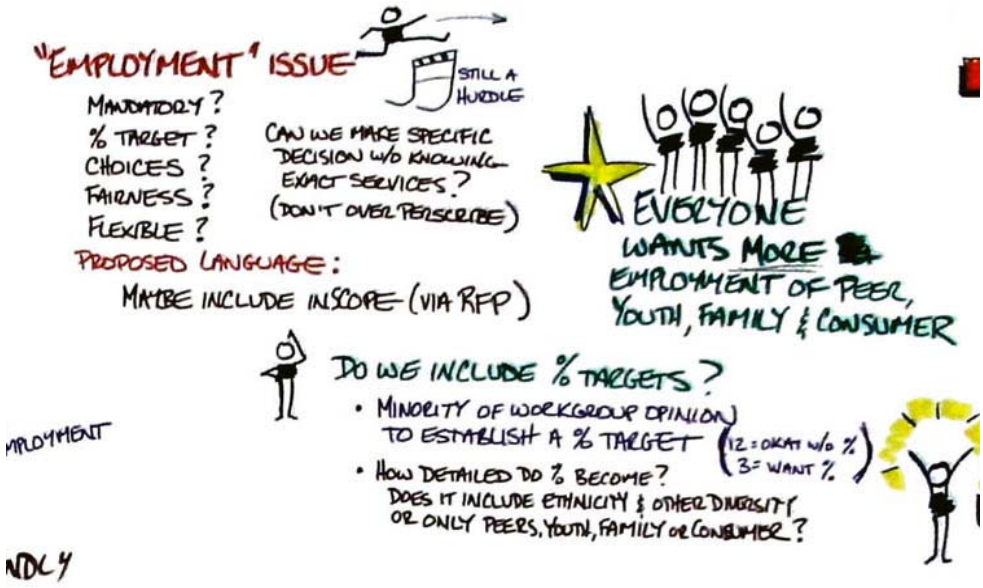
Some Workgroup members voiced their concerns consumer and family member representation on the Respite Partnership Collaborative and suggested that the draft recommendation identify a specific percentage of consumer and family member Collaborative representation. A majority of the Workgroup members voted for flexibility within the draft recommendation rather than being tied to specific percentages and details.



Deb Marois called for a final vote, using levels of agreement. A very small number of Workgroup members had major concerns with the draft recommendation but were okay about sending the document forward.

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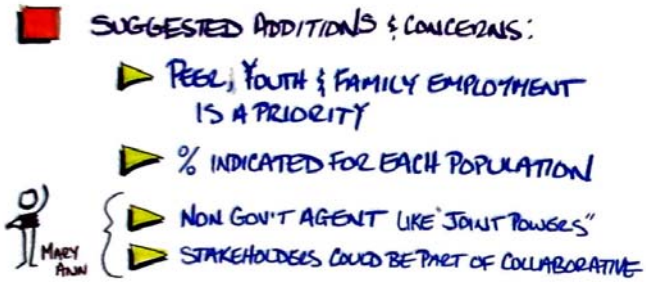
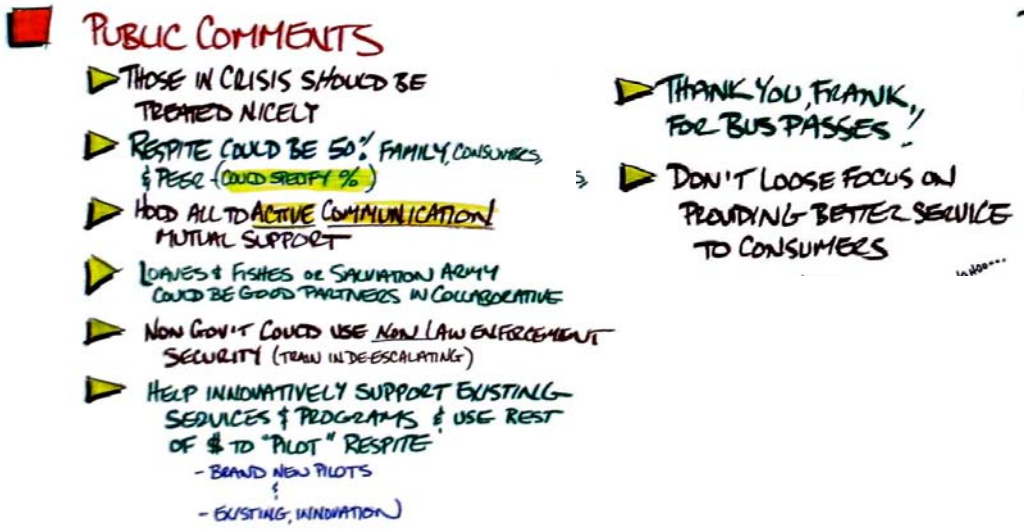
A majority of all Workgroup members were in strong support of the draft recommendation and expressed their excitement about the plan.

The Workgroup members made some suggestions for additions:



III. PUBLIC COMMENT



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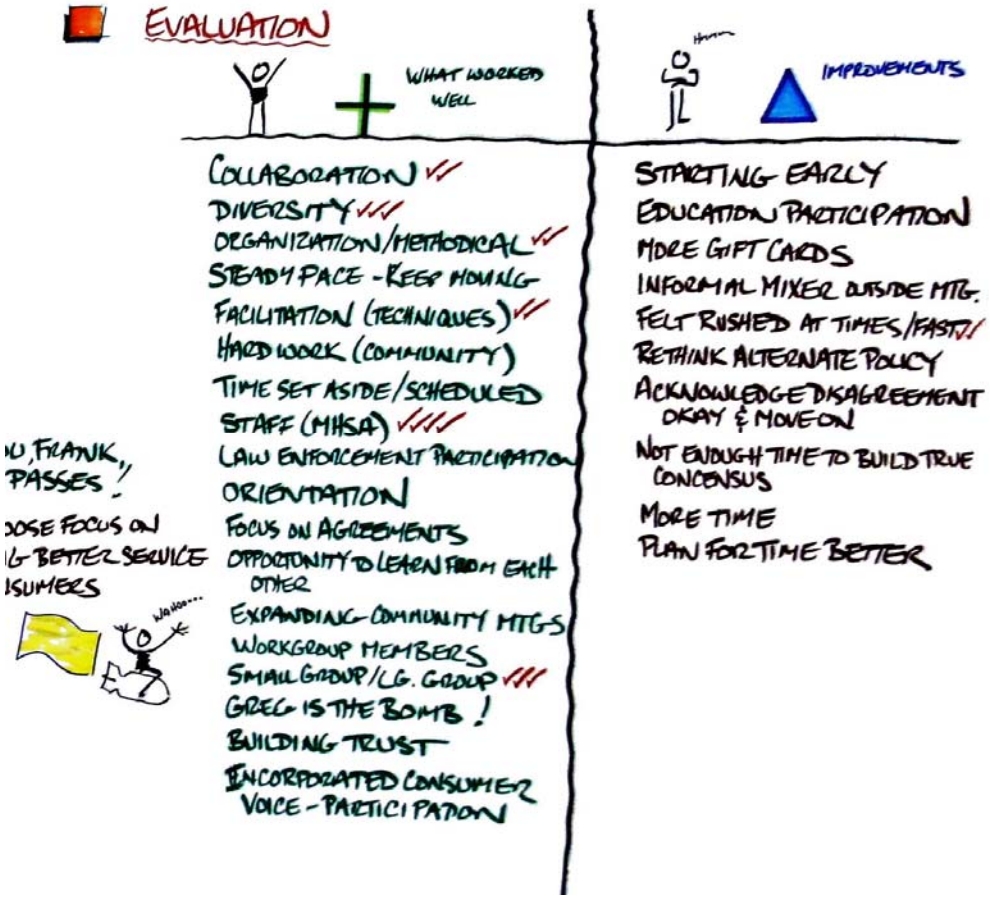
IV. INNOVATION PLANNING PROCESS EVALUATION

Deb Marois asked all Workgroup participants and the public to complete the Innovation Planning Process Evaluation. In a large group discussion, she asked all participants: What worked well with this planning process? What suggestions do you have to improve future planning processes?



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VI. CELEBRATION AND CLOSING

MHSA Team acknowledged the contribution of the Workgroup and presented each Workgroup member with a certification of appreciation and an Innovation "light bulb". The team also acknowledged the public for their contributions.

VII. NEXT STEPS

- MHSA Team will refine the Draft Recommendation to include important concepts generated by the Workgroup members from Meeting #4
- Draft Recommendation will be presented to the MHSA Steering Committee on May 5, 2011, 6:30 – 8:30pm, 7001A East Parkway, Conference Room 1, Sacramento. All Workgroup members and alternates are encouraged to come to this meeting.
- Send any correspondence to InnovationWorkgroup@SacCounty.net