MENTAL HEALTH SERVICES ACT
Fiscal Year 2025-26
Annual Update to the Two-Year Program and Expenditure Plan

6/10/2025

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TABLE OF CONTENTS

Table of Contents 3
MHSA County Fiscal Accountability Certification 4
Letter from the Director 5
Executive Summary 7
Sacramento County Mental Health Plan System Capacity 11
Community Program Planning 16
Community Services and Supports (CSS) Component 29
Prevention and Early Intervention (PEI) Component 77
Workplace Education and Training (WET) Component 139
Innovation (INN) Component 153
Capital Facilities (CF) and Technological Needs (TN) Component 173
Budget Pages 175

Attachments

Attachment A: Human Resources Survey Report 2024 181
Attachment B: MHSA Annual Update Funding Summary 207
Attachment C: Peer Toolkit for Workplace Success 209
Attachment D: Peer Employer Toolkit 285
Attachment E: BHS MHSA Housing Portfolio Catalog 365
Attachment F: Community Driven PEI Grant – CalMHSA Program Report FY 2023-24 391
Attachment G: FY 2023-24 MHSA Annual Prevention and Early Intervention Program and Evaluation Report 419
Attachment H: Multi-County FSP - CalMHSA Final Evaluation Report 507
Attachment I: Acronym List 531

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Sacramento

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

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Ryan Quist, Ph. D	Name: Maria Sandoval
Telephone Number: (916) 875-9904	Telephone Number: (916) 875-1248
E-mail: QuistR@SacCounty.net	E-mail: SandovalM@SacCounty.net
Local Mental Health Mailing Address: 7001A East Parkway, Suite 100 Sacramento, CA 95823	

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

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

Ryan Quist, Ph. D — Local Mental Health Director (PRINT)
Signature — Date: 6/12/2025

I hereby certify that for the fiscal year ended June 30, 2024, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated 12/03/2024 for the fiscal year ended June 30, 2024. I further certify that for the fiscal year ended June 30, 2024, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

Maria Sandoval — County Auditor Controller / City Financial Officer (PRINT)
Signature — Date: 6/11/2025

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

County Executive
David Villanueva

Deputy County Executive
Chevon Kothari
Social Services

County of Sacramento

Department of Health Services
Timothy W. Lutz, Director

Divisions
Administration
Behavioral Health
Primary Health
Public Health

Dear Sacramento County Community Partner,

California voters passed Proposition 1 in March 2024, replacing the Mental Health Services Act (MHSA) of 2004 with the Behavioral Health Services Act (BHSA). The BHSA expands access to mental health and substance misuse services and represents a comprehensive effort to address the intertwined issues of mental health, substance use disorders, and homelessness. The BHSA will be implemented beginning July 1, 2026, making this the last MHSA Annual Update.

The Fiscal Year 2025-26 Annual Update was developed with local community partners including adults and seniors with severe mental illness, families of children, adults and seniors living with severe mental illness, providers of services, law enforcement agencies, educators, social service agencies, veterans, providers of substance misuse and prevention services, health care organizations, and other important interests.

Behavioral Health Services remains committed to partnering with constituents and stakeholders throughout the process which includes meaningful community partner involvement on behavioral health policy, program planning and implementation, monitoring, quality improvement, evaluation and budget allocation.

The MHSA has provided Sacramento County Behavioral Health Services and the diverse communities we serve an unprecedented opportunity to engage and partner in developing and promoting a shared plan to serve our clients across their lifespan. Building on the successes we have achieved over the years and embracing the opportunities for growth, we are steadfast in our commitment to uphold the **MHSA General Standards** which are the bedrock of the MHSA and Sacramento County's Behavioral Health Services values.

In solidarity with the community,

Ryan Quist, Ph.D.
Director, Behavioral Health Services

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EXECUTIVE SUMMARY

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

California voters passed Proposition 1 in March 2024, replacing the Mental Health Services Act (MHSA) of 2004 with the Behavioral Health Services Act (BHSA). The BHSA expands access to mental health and substance misuse services and represents a comprehensive effort to address the intertwined issues of mental health, substance use disorders, and homelessness. The BHSA will be implemented beginning July 1, 2026, making this the last MHSA Annual Update.

Sacramento County is one of twenty counties located in the Central Mental Health Region of the State of California. The State of California, Department of Finance estimates the 2024 population of Sacramento County to be approximately 1.6 million. As such, Sacramento is considered a large county, especially in comparison with the populations of surrounding counties. Sacramento County contains one of the most ethnically and racially diverse communities in California. The Sacramento American Indian/Alaska Native community includes tribal people from many different States and regions with unique cultures and histories, including the first indigenous communities of Sacramento; the Nisenan people, the Southern Maidu, Valley and Plains Miwok, Patwin Wintun peoples, and Wilton Rancheria, Sacramento's only federally recognized Tribe. For some years, Sacramento County has been one of three counties with the highest number of newly arriving refugees in California. In recent years, Sacramento County has resettled more Refugees and Special Immigrant Visa holders than any other county in California. Global events transpiring over the past years have resulted in an increase in the number of refugees arriving from Afghanistan and Ukraine, thereby enriching the diversity of our community. With the addition of Arabic as a threshold language in 2017 and Farsi in 2020, Sacramento County now has a total of seven threshold languages (Arabic, Cantonese, Farsi, Hmong, Russian, Spanish, and Vietnamese). We welcome these new residents and continue to work towards meeting the unique needs of these emerging communities.

Sacramento County has worked diligently on the planning and implementation of every MHSA component. The plans for each component of MHSA are the result of local community planning processes. The programs contained in the plans work together with the rest of the system to create a continuum of services that address gaps to better meet the needs of our diverse community.

The **Community Services and Supports (CSS)** component provides funding for mental health treatment services and supports for children/youth and their families living with severe emotional disturbance and Transition Age Youth (TAY), adults and older adults living with a serious mental illness. Housing is also a large part of the CSS component. In Sacramento County, there are 12 approved CSS Work Plans, together containing numerous programs. Over the years, these programs have expanded and evolved as we strive to deliver high quality and effective services to meet the needs of children/youth, transition age youth (TAY), adults, older adults and their families.

The **Prevention and Early Intervention (PEI)** component provides funding for programs and activities designed to prevent mental illness from occurring or becoming more severe and

disabling. Sacramento County's PEI Plan is comprised of four (4) previously approved programs containing programs designed to address suicide prevention and education; strengthening families; integrated health and wellness; and mental illness stigma and discrimination reduction.

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

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

In May 2016, the Mental Health Services Oversight and Accountability Commission (MHSOAC) approved Sacramento County's second INN Project, known as the Mental Health Crisis/Urgent Care Clinic. The Clinic began providing services in November 2017. With support from the MHSA Steering Committee, the services in this INN Project transitioned to MHSA CSS funding in July 2022.

In May 2018, the MHSOAC approved Sacramento County's third INN Project, known as the Behavioral Health Crisis Services Collaborative (BHCSC). The project was a public/private partnership with Dignity Health and Placer County with the intent to establish integrated adult crisis stabilization services on a hospital emergency department campus in the northeastern region of Sacramento County. The BHCSC began providing services in September 2019. The project term ended in February 2023.

In June 2020, the MHSOAC approved Sacramento County's fourth INN Project, Multi-County Full Service Partnership (FSP) INN Project. The project aimed to improve how counties collect and use data to define and track outcomes that are meaningful for FSP clients and to help counties use data to inform program design and improve FSP service delivery. The project term ended in December 2024.

In June 2020, the MHSOAC also approved Sacramento County's fifth INN Project, Forensic Behavioral Health Multi-System Teams, now known as Community Justice Support Program. This project adapts and expands a teaming approach for the adult forensic behavioral health population. Project services and multi-system teams began delivering services in FY 2021-22.

In November 2023, the MHSOAC approved Sacramento County's sixth INN project, allcove® Sacramento, awarded to the Greater Sacramento Urban League. This project is a youth drop-in center that aims to increase accessibility to affordable mental health and wellness services for youth between the ages of 12-25 and their families, including behavioral health, physical health, housing, education, employment support, and linkage to other services.

In January 2024, the MHSOAC approved Sacramento County's seventh INN project, Community-Defined Mental Wellness Practices for the African American/Black/African Descent Unhoused community members. This community-defined approach will be operationalized by trusted community sites located in neighborhoods accessible to the focus population, co-locating clinicians and peer specialists, who are community members with lived experience, using

community defined strategies, methods and practices to deliver mental health, peer support and navigation services to the focus population.

The **Workforce Education and Training** (WET) component provides time-limited funding with a goal to recruit, train and retain diverse culturally and linguistically competent staff for the public mental health system and ensure they are adequately trained to provide effective services and administer programs based on wellness and recovery. Sacramento County's WET Plan is comprised of seven (7) approved actions. Per Welfare and Institutions Code (WIC) Section 5892(b), counties may use a portion of the CSS funds to sustain WET activities once the time-limited WET funds are exhausted. Today, these activities are being sustained with CSS funding.

Through California's Office of Statewide Health Planning and Development WET Plan, WET grant funding was awarded to five (5) regional partnerships to fund activities that support the workforce needs of each of the counties within those regional partnerships. Participating counties are required to provide a match to access funding made available to their respective regional partnership. With MHSA Steering Committee support, Sacramento County is participating in the Central Regional Partnership.

On September 25, 2020, California Governor Gavin Newsom signed Senate Bill (SB) 803, which directed the State of California Department of Health Care Services (DHCS) to establish Peer certification requirements by July 1, 2022, validating the importance of peer support services in mental health treatment by recognizing peers as Medi-Cal providers. In alignment with SB 803, DHCS established statewide requirements for the development of Medi-Cal certification programs for Peer Support Specialists. The California Mental Health Services Authority (CalMHSA), on behalf of California counties, will implement and administer all components of the Peer Support Specialist Certification program, including required data collection and submission to DHCS, certification of Peers, exam administration, investigations, approvals, auditing, and monitoring of training vendors.

During FY 2020-21, the County established within the County employment system a Behavioral Health Peer Specialist series that includes the creation of Behavioral Health Peer Specialist, Senior Behavioral Health Peer Specialist, and Behavioral Health Peer Specialist Program Manager classifications. With MHSA Steering Committee support, Sacramento County's Behavioral Health Peer Specialist Program Managers will oversee the implementation of the Peer Support Specialist Certification program in Sacramento County in close collaboration with CalMHSA. As of January 2025, Sacramento County has over 290 Medi-Cal Certified Peer Support Specialists, and this number continues to grow.

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

The **Technological Needs (TN)** project, contained within the Capital Facilities and Technological Needs component, funds and addresses our commitment to move to an Electronic Health Record and Personal Health Record to improve client care. Per WIC Section 5892(b), Counties may use a

portion of the CSS funds to sustain TN projects once the time-limited TN funds are exhausted. Today, these activities are being sustained with CSS funding.

Detailed descriptions of the programs and activities for each of the above MHSA components are contained in the MHSA Fiscal Year (FY) 2025-26 Annual Update.

The Draft MHSA FY 2025-26 Annual Update was posted for a 30-day public comment period, from March 3 through April 2, 2025. The Mental Health Board conducted a hybrid Public Hearing, held in person and virtually, on Wednesday, April 2, 2025, beginning at 6:00 p.m.

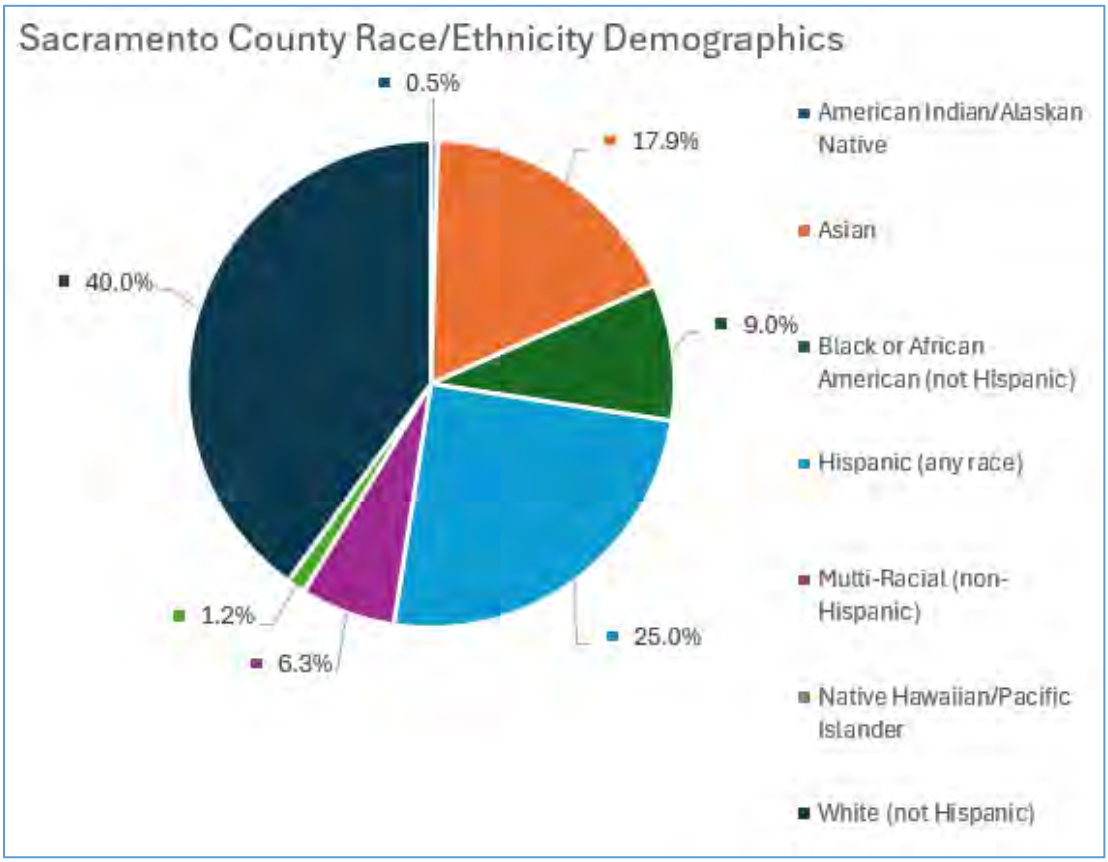
This Public Hearing was a hybrid meeting held at 7001-A East Parkway, Sacramento, CA 95823, in Conference Room 1. Community members attended in person and virtually. Dinner was provided for those who attended in person. Teleconference access information was posted on the MHSA webpage, https://dhs.saccounty.gov/BHS/Pages/MHSA/Mental-Health-Services-Act-(MHSA)-Homepage.aspx, and on the Mental Health Board website, https://dhs.saccounty.gov/BHS/Pages/Advisory-Boards-Committees/Mental-Health-Board/BC-Mental-Health-Board-Meetings-2025.aspx, one (1) week prior to the Public Hearing and arrangements for an interpreter and/or reasonable accommodation were offered.

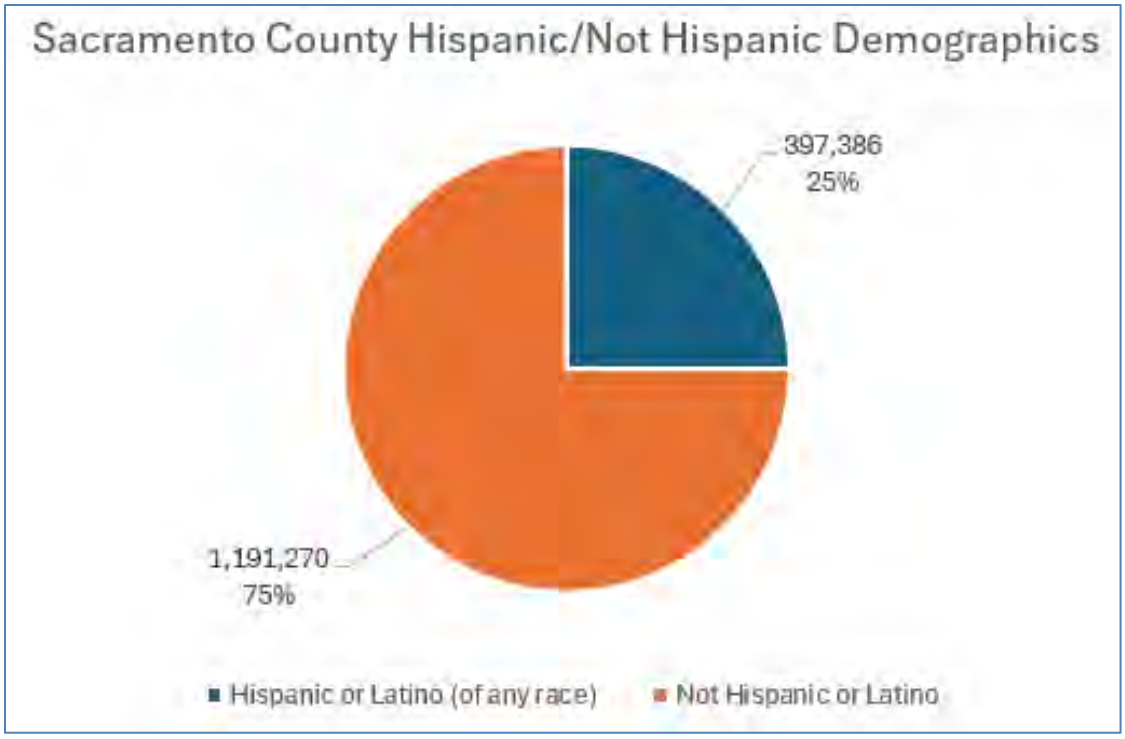
Sacramento County Mental Health Plan System Capacity

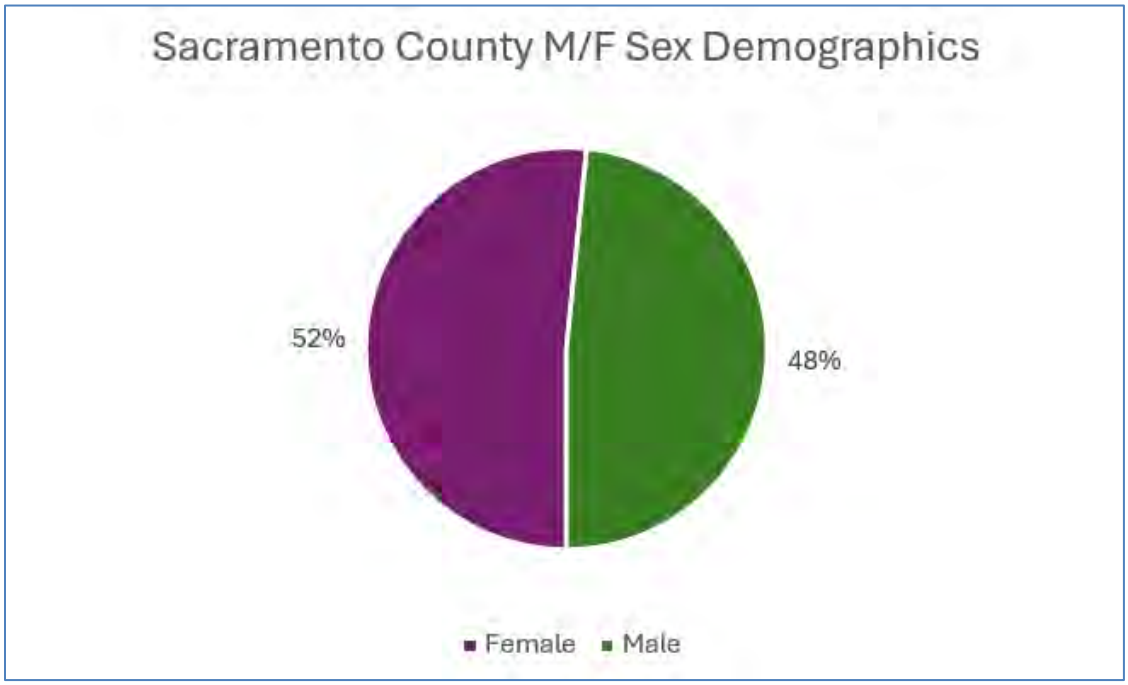
Demographic Overview

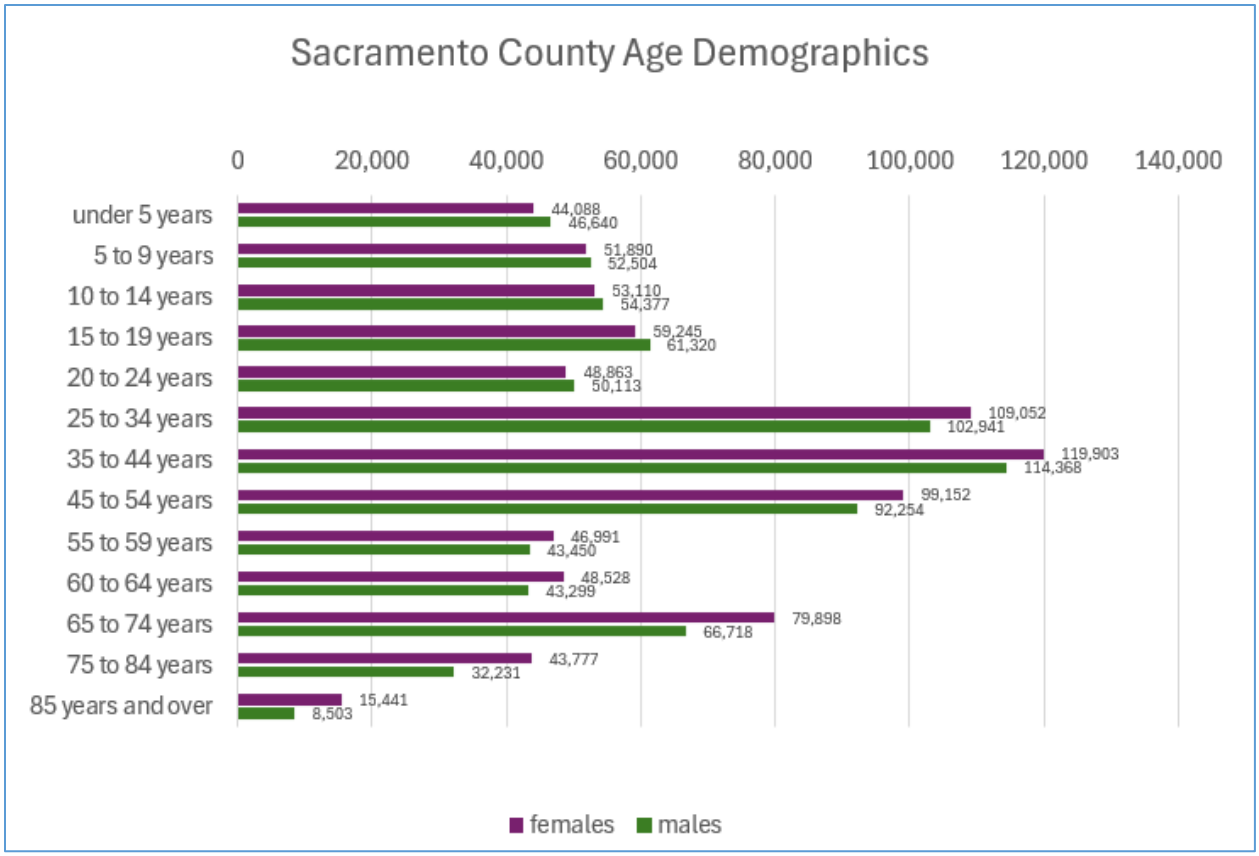
Sacramento County is one of twenty (20) counties located in the Central Mental Health Region of the State of California. The State of California, Department of Finance, estimates the 2024 population of Sacramento County to be approximately 1.6 million. With more than a half million residents living in unincorporated Sacramento County, it makes our unincorporated county population the fifth largest in the state. As such, Sacramento is considered a large county, especially when compared with the populations of surrounding counties.

Sacramento is one of the most ethnically and racially diverse communities in California. While the Wilton Rancheria Tribe is the only federally recognized tribe in Sacramento County, Native Americans from multiple nearby, local, and out-of-state tribes currently reside in Sacramento. Moreover, historically, Sacramento County has been one of three counties with the highest number of newly arriving refugees in California. In recent years, Sacramento County has resettled the most Refugees and Special Immigrant Visa holders (SIVs) as compared to any other county in California. With the addition of Arabic as a threshold language in 2017 and Farsi in 2020, Sacramento County now has a total of seven (7) threshold languages (Arabic, Cantonese, Farsi, Hmong, Russian, Spanish, and Vietnamese). The following graphics break down Sacramento County's population by gender, age, and racial and ethnic categories, and are based on California Department of Finance data from 2024.




Sacramento County Hispanic/Not Hispanic Demographics
397,386
25%
1,191,270
75%
Hispanic or Latino (of any race)
Not Hispanic or Latino


Sacramento County M/F Sex Demographics
52%
48%
Female
Male



Penetration and Retention Rates for Medi-Cal Beneficiaries

The penetration rate chart below is from Calendar Year (CY) 2023. The penetration rate is calculated as the total number of people served divided by the number of persons eligible. When reviewing this data, it is important to consider that the penetration rate table reflects the number of Medi-Cal beneficiaries served through the specialty mental health treatment programs. It, however, does not account for any of the individuals served, irrespective of insurance status, through the Behavioral Health Services (BHS) MHSA-funded prevention and mental health respite programs. BHS funds culturally specific community-based organizations to operate prevention programs that specifically serve the cultural, racial and ethnic groups listed in this table. However, due to the nature of the data collection for MHSA-funded prevention and mental health respite programs, it is challenging to obtain unduplicated individual demographic data that can be merged with specialty mental health plan data. Were it possible to merge the data, we believe that the penetration rates would be more reflective of who is served by BHS through specialty mental health services, prevention and respite services.

Sacramento County is a Geographic Managed Care (GMC) county with bifurcated mental health benefits provided through plans and Sacramento County Mental Health Plan (MHP). As a result, several other organizations are providing mild to moderate mental health services to Medi-Cal beneficiaries in Sacramento County. It is possible that penetration rates for some age, race, cultural and ethnic groups are underreported due to services being delivered in the community-by-community partners that are not part of the MHP, such as Federally Qualified Health Centers (FQHC) and health plans' subcontractors.

Penetration Rates		2023				
		A		B		B/A
		Medi-Cal Eligible Beneficiaries		MHP Medi-Cal Beneficiaries		
		N	%	N	%	%
Age Group	0-18	227,668	35.1%	8,877	34.8%	3.9%
	19-44	245,344	37.8%	10,139	39.8%	4.1%
	45-64	119,989	18.5%	5,521	21.7%	4.6%
	65+	56,300	8.7%	964	3.8%	1.7%
	Total	649,301	100.0%	25,501	100.0%	3.9%
		N	%	N	%	%
Gender	Female	339,834	52.3%	12,810	50.2%	3.8%
	Male	309,467	47.7%	12,543	49.2%	4.1%
	Unknown	0	0.0%	148	0.6%	N/A
	Total	649,301	100.0%	25,501	100.0%	3.9%
		N	%	N	%	%
	Hispanic	156,747	24.1%	3,158	12.4%	2.0%
	White	122,585	18.9%	7,742	30.4%	6.3%
	Asian/Pacific Islander	80,162	12.3%	1,428	5.6%	1.8%
	African American	78,264	12.1%	6,096	23.9%	7.8%
	American Indian/Alaskan Native	3,092	0.5%	378	1.5%	12.2%
	Other	0	0.0%	3,357	13.2%	N/A
	Unknown/Not Reported	208,451	32.1%	3,342	13.1%	1.6%
	Total	649,301	100.0%	25,501	100.0%	3.9%
		N	%	N	%	%
Primary Language	English	478,170	73.6%	22,348	87.6%	4.7%
	Spanish	69,405	10.7%	1,108	4.3%	1.6%
	Russian	28,616	4.4%	179	0.7%	0.6%
	Vietnamese	11,187	1.7%	85	0.3%	0.8%
	Cantonese	8,569	1.3%	51	0.2%	0.6%
	Farsi	6,634	1.0%	59	0.2%	0.9%
	Hmong	5,468	0.8%	107	0.4%	2.0%
	Arabic	3,507	0.5%	50	0.2%	1.4%
	Other	31,534	4.9%	269	1.1%	0.9%
	Unknown/Not Reported	6,211	1.0%	1,245	4.9%	20.0%
	Total	649,301	100.0%	25,501	100.0%	3.9%

Review of the FY 2023-24 retention rate table on the next page shows the number of services per individual to determine retention. Retention is defined as receiving five (5) or more specialty mental health services in a fiscal year. The table below shows, by demographic characteristic, the number of services individuals received in FY 2023-24. The majority of individuals (64.0%) received five (5) or more services during FY 2023-24 with 41.0% of individuals receiving more than 15 services in the fiscal year. Retention rates for children aged 0 to 17 years, receiving more than 15 services are higher than the overall system. Individuals receiving more than 15 services who speak Hmong also have a high retention rate (54.4%).

Sacramento County Mental Health Plan Retention - FY 2023/2024														
Characteristics		Total Served	1 Service		2 Services		3 Services		4 Services		5 to 15 Services		>15 Services	
		N	N	%	N	%	N	%	N	%	N	%	N	%
Race/Ethnicity (0-17)	American Indian/Alaskan Native	79	9	11.4%	6	7.6%	2	2.5%	2	2.5%	17	21.5%	43	54.4%
	Asian/Pacific Islander	312	31	9.9%	17	5.4%	13	4.2%	10	3.2%	77	24.7%	164	52.6%
	Black/African American	1,773	126	7.1%	87	4.9%	79	4.5%	47	2.7%	416	23.5%	1,018	57.4%
	Hispanic/Latinx	1,465	94	6.4%	64	4.4%	72	4.9%	53	3.6%	337	23.0%	845	57.7%
	Multi-Racial	1,282	66	5.1%	65	5.1%	41	3.2%	38	3.0%	305	23.8%	767	59.8%
	White/Caucasian	1,977	141	7.1%	76	3.8%	65	3.3%	61	3.1%	413	20.9%	1,221	61.8%
	Other	282	29	10.3%	12	4.3%	10	3.5%	9	3.2%	78	27.7%	144	51.1%
	Unknown/Not Reported	1,289	258	20.0%	197	15.3%	131	10.2%	75	5.8%	270	20.9%	358	27.8%
Race/Ethnicity (18+)	American Indian/Alaskan Native	262	51	19.5%	22	8.4%	9	3.4%	10	3.8%	62	23.7%	108	41.2%
	Asian/Pacific Islander	1,085	172	15.9%	83	7.6%	50	4.6%	29	2.7%	312	28.8%	439	40.5%
	Black/African American	3,911	706	18.1%	308	7.9%	217	5.5%	167	4.3%	984	25.2%	1,529	39.1%
	Hispanic/Latinx	1,555	312	20.1%	127	8.2%	89	5.7%	73	4.7%	354	22.8%	600	38.6%
	Multi-Racial	1,334	260	19.5%	124	9.3%	56	4.2%	61	4.6%	327	24.5%	506	37.9%
	White/Caucasian	5,697	1,290	22.6%	463	8.1%	293	5.1%	211	3.7%	1,274	22.4%	2,166	38.0%
	Other	448	111	24.8%	50	11.2%	20	4.5%	14	3.1%	108	24.1%	145	32.4%
	Unknown/Not Reported	2,483	995	40.1%	359	14.5%	228	9.2%	140	5.6%	479	19.3%	282	11.4%
Age	0-17	8,459	754	8.9%	524	6.2%	413	4.9%	295	3.5%	1,913	22.6%	4,560	53.9%
	18+	16,775	3,897	23.2%	1,536	9.2%	962	5.7%	705	4.2%	3,900	23.2%	5,775	34.4%
Sex	Male	12,812	2,275	17.8%	1,016	7.9%	676	5.3%	497	3.9%	2,935	22.9%	5,413	42.2%
	Female	11,928	2,174	18.2%	917	7.7%	609	5.1%	465	3.9%	2,847	23.9%	4,916	41.2%
	Unknown	494	202	40.9%	127	25.7%	90	18.2%	38	7.7%	31	6.3%	6	1.2%
Primary Language	English	21,514	3,700	17.2%	1,586	7.4%	1,071	5.0%	808	3.8%	5,005	23.3%	9,344	43.4%
	Spanish	1,139	154	13.5%	82	7.2%	52	4.6%	40	3.5%	267	23.4%	544	47.8%
	Russian	177	24	13.6%	7	4.0%	7	4.0%	7	4.0%	44	24.9%	88	49.7%
	Hmong	103	7	6.8%	4	3.9%	7	6.8%	1	1.0%	28	27.2%	56	54.4%
	Vietnamese	83	8	9.6%	8	9.6%	2	2.4%	0	0.0%	31	37.3%	34	41.0%
	Cantonese	48	3	6.3%	3	6.3%	1	2.1%	0	0.0%	18	37.5%	23	47.9%
	Arabic	48	3	6.3%	3	6.3%	3	6.3%	2	4.2%	17	35.4%	20	41.7%
	Farsi	60	13	21.7%	5	8.3%	4	6.7%	1	1.7%	27	45.0%	10	16.7%
	Other Non-English	272	34	12.5%	17	6.3%	13	4.8%	20	7.4%	89	32.7%	99	36.4%
	Unknown / Not Reported	1,790	705	39.4%	345	19.3%	215	12.0%	121	6.8%	287	16.0%	117	6.5%

COMMUNITY PROGRAM PLANNING

Sacramento County's MHSA Steering Committee

The MHSA Steering Committee (SC) is the core recommending body for MHSA funded programs and activities in Sacramento County and serves as the hub of the MHSA Community Program Planning Process (CPPP). The MHSA Steering Committee (SC) is the core recommending body for MHSA funded programs and activities in Sacramento County and serves as the hub of the CPPP. The Committee is a thirty (30) member body comprised of one primary member seat and one alternate from the following groups: Sacramento County Mental Health Board; Sacramento County Behavioral Health Services (BHS) Director; three (3) Service Providers (Children, Adults, and Older Adults); Law Enforcement; Senior and Adult Services; Education; Department of Human Assistance; Substance Use Prevention and Treatment; Cultural Competence; Child Welfare; Primary Health; Public Health, Juvenile Court; Probation; Veterans; two (2) Consumer - Transition Age Youth (TAY); two (2) Consumer - Adult; two (2) Consumer - Older Adult; two (2) Family Member/Caregiver of Child age 0-17; two (2) Family Member/Caregiver of Adult age 18-59; two (2) Family Member/Caregiver of Older Adults age 60+; and one (1) Consumer/Family Member At-Large. Some members of the committee have volunteered to represent multiple partner interests, including Faith-based/Spirituality.

The MHSA SC role is to: (1) Effectively and respectfully engage clients, family members, and other community partners through a broad participation process, including the creation of workgroups that include community input and recommendation development, to develop Sacramento County's MHSA Plans and Annual Updates; (2) Review and approve program proposals developed with partner and community input; and (3) Make specific program recommendations to BHS consistent with MHSA goals, guidelines, and requirements.

The MHSA Steering Committee elects two (2) Co-Chairs, who serve staggered two-year terms. The Co-Chairs lead the Steering Committee meetings and are seated members of the Steering Committee Executive Committee. At least one of the co-chairs must be a client/family member.

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

MHSA Steering Committee members and BHS actively recruit consumers/peers, and family members/caregivers with lived mental health experience for committee membership. The member application is posted on the BHS MHSA Steering Committee webpage. Both the MHSA Steering Committee and Executive Committee are responsible for recruiting consumer and family members to serve as Steering Committee primary and alternate members.

MHSA Steering Committee meetings are held virtually the third Thursday of each month (with breaks in July and December) and are open to the public, with time allotted for Public Comment at every meeting. Meeting evaluations are provided to all Steering Committee members and members of the public. All attendees are encouraged to evaluate each meeting and provide topic ideas for future meetings. This information informs BHS and MHSA Steering Committee Executive Committee members of ways to improve meeting structure, pace, and content.

MHSA Steering Committee meeting attendance is recorded through Zoom virtual meeting reports. These participation attendance lists include both Steering Committee members and attendees from the public. To encourage meeting attendance from diverse community members and partners, BHS offers interpreter, captioning, and American Sign Language services to Steering Committee members and members of the public. Steering Committee members representing consumers and family member partners are provided with stipends for each meeting they attend. In February 2025, BHS successfully hosted its first hybrid meeting, offering an in-person option for the first time since the COVID-19 pandemic. Dinner was provided.

BHS maintains a published schedule of MHSA Steering Committee meetings on the BHS MHSA Steering Committee webpage. Agendas, meeting minutes, and supporting documents are also posted. BHS also emails monthly MHSA Steering Committee meeting notifications to a listserv of over 860 community members and partners.

BHS Cultural Competence Committee

The BHS Cultural Competence Committee is a subcommittee of the BHS Quality Improvement Committee. Following longstanding practice, partners representing unserved and underserved racial, ethnic, and cultural groups who are members of the BHS Cultural Competence Committee are updated and provide feedback on MHSA activities at their monthly meetings. The Committee also reviews and provides collective comment on MHSA Plans and Annual Updates during the 30-day posting period.

Partner, BHS, and Provider Staff Education

To ensure meaningful participation in all aspects of the Community Program Planning Process (CPPP), BHS offers MHSA education and training to MHSA Steering Committee members, BHS staff, and community members. Steering Committee members are provided with comprehensive orientation training to learn about the MHSA; MHSA Steering Committee role and member responsibilities; MHSA Steering Committee meeting structure and process; and local MHSA programs, activities, and CPPP. New BHS staff are provided with comprehensive orientation training as well, which includes extensive training on convening and facilitating CPPP. Information about the MHSA components and purpose; changes and updates to MHSA requirements, regulations, and statutes; and updates to local MHSA budget allocations, programs, activities, and current CPPP are provided at the Steering Committee meetings and BHS staff meetings. Client and Family member representation is a core value and is present in both external and internal planning teams.

At Sacramento County Behavioral Health Services provider forums, providers, including peers, are informed of the MHSA components and purpose; changes and updates to MHSA requirements, regulations, and statutes; and updates to local MHSA budget allocations, programs, activities, and current CPPP. Additionally, BHS Cultural Competence Committee, Sacramento County Mental Health Board, and Sacramento County Board of Supervisors are informed of changes and updates to MHSA requirements, regulations, and statutes, as well as updates to local MHSA budget allocations, programs, activities, and current CPPP.

Members of the public are encouraged to email and/or call with questions and/or information requests relating to MHSA requirements, regulations, and statutes and local MHSA budget,

programs, activities, and CPPP. BHS responds to all requests for information relating to the MHSA and Sacramento County Behavioral Health Services.

Other Partner and Community Input and Feedback

BHS has convened many partner input sessions to reach individuals who do not regularly participate in the MHSA Steering Committee meetings. Partner input, which includes client and family input, is a critical component to ensure programming is effective, respectful, and responsive. BHS has implemented a regular procurement schedule for contracted programs which is informed collectively by the partner participation and input that occurs in many forms across the system. Examples include:

- **Mandatory Advisory Boards**
  - Mental Health Board
  - Alcohol and Drug Advisory Board
- **Recommending Bodies**
  - MHSA Steering Committee
  - BHS Cultural Competence Committee
  - Family, Parent, and Caregiver Peer Support Committee
  - Youth Peer Support Committee
  - Adult Peer Support Committee
  - Behavioral Health Racial Equity Collaborative (BHREC)
  - Behavioral Health Youth Advisory Board (YAB)
- **Broader Partner Sessions**
  - Town Halls
  - Community Conversations
  - Listening Sessions
- **Program/Project Specific Input**
  - Anecdotal feedback from system partners, clients/family members, community partners, and providers
  - Surveys
  - MHSA Steering Committee Ad Hoc Workgroups
  - Key Informant Interviews
  - Focus Groups
  - Needs Assessments
  - Satisfaction Surveys

Community Program Planning Processes (CPPP) for the MHSA FY 2025-26 Annual Update to the Two-Year Program and Expenditure Plan

The Sacramento County Behavioral Health Services (BHS) Community Program Planning Process (CPPP) for the MHSA Fiscal Years (FY) 2025-26 Annual Update to the Two-Year Plan meets the requirements contained in Section 3300 of the California Code of Regulations as described below. Sacramento County's community program planning processes for previously approved CSS, PEI, WET, INN, CF and TN Component plans and activities have been described in-depth in prior plan updates and documents submitted to the State. Those documents are available on the Reports and Workplans page on our website. All programs and activities contained in this Annual Update have evolved from a CPPP.

The general outline for this Annual Update was discussed at MHSA Steering Committee (SC) meetings throughout FY 2024-25. The Steering Committee is the highest recommending body in matters related to MHSA programs and activities. MHSA SC meetings are open to the public, and the meeting minutes are posted publicly after each meeting. MHSA program presentations for CSS, PEI, INN and WET are provided at MHSA SC meetings. Through these presentations, the committee has gained a deeper understanding of program services, participation of peers in the delivery of services, program outcomes, and examples of how clients have benefited from these services. During the 30-day posting of the Draft Annual Update, BHS presented to the MHSA SC, BHS Cultural Competence Committee, and the Mental Health Board to obtain additional input.

FY 2024-25, BHS implemented its seventh Innovation project (INN7): Community-Defined Mental Wellness Practices for African American/Black/African Descent (AA/B/AD) Unhoused. The approved INN7 project involves a phased approach.

Phase 1: Engaging the focus population in community planning and decision-making regarding the development of services.

Phase 2: Standard procurement process, followed by hiring and training of staff.

Phase 3: Implementation and evaluation.

Preliminary focus groups with the AA/B/AD community were conducted in July 2023 to inform the plan's development. Feedback from these sessions guided Phase 1 research and outreach. The community emphasized the importance of engaging AA/B/AD individuals who are currently experiencing or at risk of homelessness and consulting various age groups, individuals with disabilities, and members of the LGBTQ+ community. They also identified trusted organizations BHS could engage in Phase 1 community planning.

Phase 1 began in June 2024, with BHS engaging the AA/B/AD community to define mental health and wellness; identify strategies, methods, and practices that promote mental wellness; understand the role of peer specialists; and identify trusted organizations. BHS adopted two approaches to engage this focus population:

1. **Engagement Through Trusted Community Sites**

   BHS asked trusted community sites (identified by the community in 2023) to recruit, facilitate, and host Focus Groups/Community Listening sessions with the AA/B/AD focus population. A sponsorship of $2,500 was offered to each participating site, including an amount set aside for financial compensation for participants.

One of the most frequently mentioned organizations in the 2023 Focus Groups as a trusted community site was WEAVE, Inc. BHS contacted their Director of Inclusion, Diversity, Equity, and Access (IDEA) and they hosted four (4) listening sessions for this project.

WEAVE Inc. invited BHS to attend the bi-monthly South Sacramento Health Black Families Collaborative to advertise the sponsorship opportunity. From this contact, support was garnered from the **Greater Sacramento Urban League** and **A Church for All**, each hosting one (1) Focus Group.

As the research progressed, it became clear that a special effort was needed to reach Transition Age Youth (TAY), as the community had emphasized that this viewpoint would be essential to the project. While BHS was conducting sidewalk outreach in the North C Street area, **First Step Communities** supported the INN7 outreach by allowing a table to be set up in front of their building. They also have a TAY shelter. Due to their enthusiastic support of these efforts, and their ability to reach the focus population, BHS offered this agency the opportunity to have the County sponsor Focus Groups. They quickly organized six (6) Focus Groups at their downtown shelter, Roseville Road shelter, and their TAY shelter in Del Paso Heights.

BHS reached out to the African American/Black/of African Descent ad hoc Committee, which branched off of and was created by the Behavioral Health Racial Equity Committee. **California Institute for Behavioral Health Solutions (CIBHS)** agreed to host a focus group on their behalf, involving many community partners with an interest in this topic.

BHS sponsored a total of 13 Focus Groups with the focus population, led by community partners.

2. **Direct Outreach**

A team of BHS employees, including the Behavioral Health Peer Specialist Program Managers, conducted visits to encampments, shelters, and sidewalk outreach to directly engage with unhoused individuals. The team partnered with Sacramento County BHS's Homeless Engagement and Response Team (HEART), who identified incentive items needed by the unhoused community members. These items included: monthly Regional Transit (RT) passes, collapsible all-terrain carts, solar-powered chargers, hygiene kits and wet wipes, dog food and bowls, and dog harnesses and leashes.

HEART introduced the team to large encampment locations with individuals with whom they were familiar and who have been generally receptive to outsiders offering services. HEART also facilitated collaboration with One Community Health, which invited BHS to a library where HEART had scheduled appointments with unhoused individuals.

Demographic sheets were kept with the notes from each individual, to enable focus on feedback from those who identified as AA/B/AD.

A total of 154 demographic surveys and feedback notes from this focus population were collected. Their feedback was compiled, categorized, and analyzed and will inform the standard procurement process. The report on this feedback was summarized in a presentation to the MHSA Steering Committee on January 16, 2025, and was well received.

INN7 Phase 2 began in January 2025, following the standard procurement process to find a provider to implement services to this focus population.

Annual Update Posting and Public Hearing

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

The Draft MHSA FY 2025-26 Annual Update was posted for a 30-day public comment period, from March 3 through April 2, 2025. The Mental Health Board conducted a hybrid Public Hearing, held in person and virtually, on Wednesday, April 2, 2025, beginning at 6:00 p.m.

This Public Hearing was a hybrid meeting held at 7001-A East Parkway, Sacramento, CA 95823, in Conference Room 1. Community members attended in person and virtually. Dinner was provided for those who attended in person. Teleconference access information was posted on the MHSA webpage, https://dhs.saccounty.gov/BHS/Pages/MHSA/Mental-Health-Services-Act-(MHSA)-Homepage.aspx, and on the Mental Health Board website, https://dhs.saccounty.gov/BHS/Pages/Advisory-Boards-Committees/Mental-Health-Board/BC-Mental-Health-Board-Meetings-2025.aspx, one (1) week prior to the Public Hearing and arrangements for an interpreter and/or reasonable accommodation were offered.

Public Comment

During the 30-day public review period, Sacramento County Behavioral Health Services (BHS) presented a summary of its MHSA Annual Update to the MHSA Steering Committee and the Sacramento County Cultural Competence Committee, as well as the Mental Health Board, which conducted a public hearing on this Annual Update. Our partners and community members shared their questions, comments, and feedback. Below is a summary of that input.

The Committees, Mental Health Board, and community expressed ongoing appreciation for the programs contained in the Annual Update. Some Board members expressed looking forward to fully supporting the Annual Update once the final document incorporates public comments and BHS response. Many expressed appreciation for the array of programs available for consumers and family members, especially for vulnerable populations such as the LGBTQ+ community. Others enjoyed the success stories and the data that was shared – particularly when including comparison to the previous reporting year. Some expressed an appreciation for the radio advertisements, stating that they are helpful in outreaching to rural areas. Another expressed appreciation for the staff to beneficiary ratio.

Many comments expressed appreciation for the valuable support provided by the Supporting Community Connections (SCC) program, with many older adults sharing personal stories of improved mental and physical well-being due to the program's language-accessible support, social activities, exercise, and computer classes. Appreciation was expressed for providers who are mindful of religious practices.

Several questions and requests for further explanation also emerged**.** Inquiries were made about how the 30-day review period was advertised and the reason for the feedback submission deadline.

A question was asked about the expected opening date of the allcove Sacramento Innovation Project. A request was made to name the four (4) community partner providers/subcontractors for the Community Responsive Wellness Program for Black Communities Program (CRWP).

A question was asked about how data is collected to assess the effectiveness and reach of the PEI Mental Health Promotion program. More detailed demographic data was requested, particularly regarding LGBTQ+ identities. A question was asked about how age ranges are identified, including Transition Age Youth, under MHSA.

The need for more services for older adults was expressed. A suggestion was made to consider including bullying prevention efforts in workplaces, in addition to schools. A recommendation was made to allow the Mental Health Urgent Care Clinic to prescribe new medications, not just refills.

Behavioral Health Services Response

Sacramento County Behavioral Health Services (BHS) greatly values the input and feedback provided by the public and community partners, including the MHSA Steering Committee, Cultural Competence Committee, and Mental Health Board. Gathering and incorporating this input continues to be a core value of the local community planning process. The Community Program Planning Process (CPPP) section of this Annual Update details the various communication methods to advertise the 30-day review period. BHS welcomes suggestions to garner increased community planning engagement and input.

As indicated in the allcove Sacramento INN Project section, BHS anticipates the opening of allcove Sacramento in summer 2025.

The program description for the Community Responsive Wellness Program for Black Communities (CRWP) has been updated to identify four community partner subcontractors: Improve Your Tomorrow, ONTRACK Program Resources, Roberts Family Development Center, and Rose Family Creative Empowerment Center.

The Mental Health Promotion Program section includes data on the "Mental Illness: It's not always what you think" Project as well as the variety of data collection methods, tools, impact and reach.

Data collection and reporting requirements for each MHSA funding category are established in regulations and code. BHS works continuously to improve data collection methods and reporting to ensure compliance. Based on the public comments, the data tables have been updated, narrative explanations have been expanded, and language has been clarified. The MHSA age range definitions were added to the introductions of each section.

BHS appreciates recommendations and suggestions for expanded and/or enhanced programming and will consider these suggestions as part of the continuous quality improvement process for our behavioral health system of care.

The MHSA Steering Committee, BHS Cultural Competence Committee, and Mental Health Board have expressed their support for moving the revised Annual Update forward for approval by the Sacramento County Board of Supervisors.

Challenges and Barriers to Program Implementation

For Sacramento County's MHSA funded programs, service providers identified three key challenges emerging as the most significant:

1. Staffing Recruitment and Retention

2. Lack of Housing Resources, and

3. Collaboration with System Partners.

Each of these barriers is described below, along with strategies employed by service providers to mitigate them.

Staffing Recruitment and Retention. BHS and contract providers continue to grapple with understaffing, a longstanding and ongoing challenge in the behavioral health sector. Constant short-staffing leads to increased burnout among staff.

The most difficult positions to fill and retain are those within locations offering high-intensity mental health services. Providers report that not only is it difficult to get qualified applicants for these positions, but also that many new hires have minimal experience and are overwhelmed with the demanding workload. Additionally, candidates often find more financial compensation in positions offering lower intensity services.

To address this problem, many providers regularly review their salary and compensation packages, hoping to make them competitive with those in other fields. Many provider agencies have their Human Resources departments focusing on identifying opportunities to provide hiring bonuses and stipends for the positions most challenging to fill. Some agencies offer salary differentials and/or performance-based bonuses and incentives. Program service providers have also been seeking to clarify career pathways for new hires. For example, one organization focused on hiring individuals who are working towards earning their license and establishing an agreed upon timetable for moving them into licensed positions.

Special attention has been applied to recruitment efforts. Providers commonly attend job fairs and utilize job hiring websites such as Indeed. Some organizations have directed their Human Resources to re-write job descriptions so that expectations for candidates are clear. One provider began including a site tour in their interviews so that candidates better understand what their daily duties may look like. Some have established Talent Acquisition teams that help recruit and screen highly qualified interviewees.

Providers have made improvements to their training models, making trainers and management support more readily available on an ongoing basis to empower their teams in effectively managing and supporting the diverse needs of their clients. Efforts to support staff wellbeing have included introducing Wellness Committees, mindfulness workshops, and fun activities outside of the office.

Lack of Housing Resources. The lack of affordable housing continues to be one of the most common challenges for clients and service providers. Housing is a social determinant of health. A safe house away from potential hazards can promote recovery from a behavioral health condition, while living in unsafe or unsuitable housing conditions contributes to instances of mental health crisis. Unhoused individuals face long waitlists for shelters and are frequently displaced from encampments by law enforcement, which can lead to discouragement and loss of contact for treatment and supportive services. Unhoused individuals do not always have access to temporary

housing during nights and weekends and this is when many psychiatric emergencies occur. This leads to clinically inappropriate Emergency Department visits. Many available housing options are not able to accommodate special needs, such as for patients leaving the hospital who still need acute care, detox services, or housing that is suitable for older adults and adults with mobility issues. Patients with medical needs are unable to access all the services they need if they lack a home address. For example, an In-Home Supportive Services worker cannot be assigned while a client is living outside.

Clients are deeply troubled by the overwhelming scarcity of housing options and opportunities available to them. Recognizing the systemwide shortage of housing resources within Sacramento County, providers actively work to collaborate with outpatient programs and community resources and to negotiate more affordable housing rates for clients.

Providers are disheartened as they turn away vulnerable clients because they are at capacity. When they are able, they provide financial/rental assistance, linkage to affordable housing programs, access to crisis intervention, and counseling to help sustain long term housing. Providers know the importance of exploring cost saving measures with clients to help them make informed decisions on their finances. When long term housing is not available, providers assist clients in navigating alternatives such as room and board options, pathway to shelter referrals, and other respite centers and resources. Across the continuum of care, providers continue to do their best to ensure they are appropriately matching resources to individual needs.

Our providers work to mitigate the lack of affordable housing by building and maintaining strong partnerships with system partners, housing providers, and landlords. By networking this way, providers can connect clients to other treatment programs that may have housing resources available. At times, extensions to treatment can be offered so that clients can remain eligible while on housing waiting lists. Some attend multidisciplinary teams with the hospitals to assist with recommendations. One provider established an Intensive Placement Team to decide on placements in the Augmented Board and Care facilities. They also offer landlord incentives to house individuals with serious mental illness.

Providers often offer extensions for services to support clients who are navigating these housing challenges. Knowing that housing is such a widespread problem, providers have amplified their efforts in preventing homelessness, identifying opportunities for early intervention to maintain housing. When possible, providers use MHSA flex funds and contract savings for housing.

Collaboration with System Partners. BHS providers collaborate with a range of system partners, such as hospitals, schools, Community Based Organizations, non-profit organizations, law enforcement agencies, etc. Communication is essential in establishing functioning relationships that generate the best outcomes for clients. It can be frustrating when these channels are not well-defined or if an organization is not responsive.

Some providers reported frequent confusion when communicating with Primary Care Physicians. For example, they may not believe they are responsible for issuing psychotropic medications. The responsibility sometimes falls back on the provider even though the client has transitioned to a managed care plan.

Contract monitors with BHS assist with communication, for example by establishing updated contact information for each hospital and ensuring they inform the appropriate provider when a

client is discharged. Providers have also been reaching out to organizations to coordinate participation in the Child and Family Team meetings when a youth is in transition. Providers reach out to system partners frequently and prefer to establish a point person to ensure a warm handoff when services change.

Providers advocate when they see a gap in services. For example, when a provider found it difficult to find respite services that serve adults on probation, they developed their collaboration with organizations who have historically been open to accepting these clients.

CalAIM: California Advancing and Innovating Medi-Cal

CalAIM is a multi-year initiative by the California Department of Health Care Services (DHCS) to enhance the quality of life and health outcomes for Medi-Cal beneficiaries. It aims to reform the delivery system, programs, and payments across Medi-Cal services. The behavioral health aspects of CalAIM simplify and standardize access to mental health and substance use disorder (SUD) treatment for Medi-Cal members in all 58 counties, improving quality outcomes and reducing health disparities.

Previously implemented behavioral health initiatives under CalAIM include:

- No Wrong Door - allows providers to obtain federal reimbursements to support beneficiaries in navigating to the correct service provider and to provide a warm handoff to prevent beneficiaries from falling out of care.
- Documentation and Payment Reform - streamlines paperwork requirements and the federal reimbursement process.
- Enhanced Care Management (ECM) - a statewide benefit and opportunity to obtain federal reimbursement for coordinated and comprehensive care management services that federal funds traditionally have not been able to reimburse. ECM is embedded with many MHSA Community Services and Supports (CSS)-funded treatment programs. In FY 2023-24, there were 1,231 unduplicated clients served in ECM.
- Community Support (CS) - a statewide benefit and opportunity to obtain federal reimbursements for supportive services relating to housing/homelessness and other services intended to support individuals in lieu of utilizing inpatient facility services. BHS does not directly provide CS and provides eligible beneficiaries to CS providers.

Starting January 1, 2025, BHS implemented CalAIM Behavioral Health Administrative Integration. Counties historically administered two separate Medi-Cal programs: one for mental health services and another for SUD treatment services, each with distinct state agreements and funding. Individuals with serious mental health needs receive care through the County's Mental Health Plan (MHP), while SUD treatment is provided via the Drug Medi-Cal Organized Delivery System (DMC-ODS). Both programs share similar contract requirements alongside specific mandates for documentation, compliance reviews, billing, licensing, and certification. This administrative complexity has created barriers for clients seeking care for co-occurring mental health and substance use conditions. As such, BHS launched the new Behavioral Health Services-Screening and Coordination (BHS-SAC) call center, which combined the Mental Health Access Team with the Substance Use Prevention and Treatment System of Care call centers. Through the new integrated call center, individuals only need to call one number for both mental health and SUD

treatment services. BHS-SAC can be reached at 916-875-1055, CA Relay 711, or toll free at 888-881-4881.

Behavioral Health Plans Network Adequacy

Per the Centers for Medicare and Medicaid Services (CMS) Final Rule, states are required to establish network adequacy standards to improve access to services for members. The California Department of Health Care Services (DHCS) has set standards for counties' Behavioral Health Plans (BHP) that include MHP and DMC-ODS. To validate these standards counties are required to submit evidence verifying compliance with the required Provider-to-Member ratios, mandatory provider types, and time or distance standards. Once submitted DHCS will review and provide results of the validation process. If counties are in compliance, they will receive a report confirming the passing result. If there are areas that are found to be deficient or receive a conditional pass, counties are required to develop a corrective action plan (CAP) to address the deficiencies and submit to DHCS for approval. For FY23/24 the MHP and DMC-ODS have received the findings and certification from DHCS.

Human Resource Survey

Sacramento County MHP administered the Human Resource (HR) Survey in FY 2023-24. The survey included data relating to the diversity of Sacramento County's MHP workforce. Demographic information and language capabilities of staff, volunteers, and any committee members who participated in serving individuals throughout the entire County Mental Health System was collected. The purpose of the survey was to assess demographic and linguistic information for those who provide services in our county to determine whether it is reflective of the diversity of the community. The 2024 HR Survey and analysis of the findings are included in this Annual Update. See *Attachment A: Human Resources Survey Report 2024.*

Behavioral Health Services Recruitment Efforts

Building on the success of the two-day in-person hiring and career fair that BHS held with Sacramento County Department of Personnel Services (DPS) in September of 2022, BHS conducted a BHS Hiring Fair on June 28, 2024. The focus of the Hiring Fair was to recruit candidates in BHS's top 4 vacancies, including Senior Mental Health Counselor, Mental Health Counselor, Mental Health Worker-Licensed, and Mental Health Worker. BHS worked collaboratively with DPS and the Public Information Officer to develop a targeted advertising campaign to reach diverse candidates for the classifications with the most vacancies. The advertising and social media campaign generated interest in the event and increased the number of applicants.

In preparation for the event, there were five (5) Meet & Greet sessions conducted over Zoom that were open to the public and did not require registration. Participants had the opportunity to learn about open positions and the programs they serve as well as to talk with hiring managers about completing applications and preparing for interviews. American Sign Language was available for all sessions. BHS interviewed 28 Mental Health Counselors, 8 Senior Mental Health Counselors, 13 Mental Health Workers, and 28 Mental Health Worker-Licensed, totaling 77 interviewees at the event. A total of 201 attendees attended the Hiring Fair and 63 volunteers participated in planning and/or assisted with the event. This resulted in the numbers of candidates for all four eligible lists increasing significantly and a diverse range of candidates. In the month following the hiring event, 24 candidates accepted offers of employment.

Additionally, the WET Planner worked with local universities to host webinars regarding the County's application process to students attending: 1) California State University, Sacramento Social Work Program (bachelor's and master's level) 2) California State University, Sacramento MS in Counseling Program and 3) University of Pacific Social Work Program (MSW). These webinars were shared with BHS staff and contracted providers seeking to advance careers in public behavioral health. The WET Planner developed a new robust BHS employment webpage on the BHS website. The website includes an updated list of vacant positions, application resources, list of benefits, overall application steps, and recordings of various helpful webinars, including webinars on careers in behavioral health and the University webinars mentioned above.

In FY 2022-23, Sacramento County WET Mental Health Loan Repayment Program (LRP) Round 1, awarded 125 individuals who work in either a Sacramento County Behavioral Health County-operated mental health setting or in a contracted, community-based mental health agency. Individual awards ranged from $25,000, $12,500, and $10,000 to approved applicants, totaling $1,485,000 in funds. Awardees were notified by California Mental Health Services Authority (CalMHSA) of the amount and terms. Awardees receive 100% of the award amount at the beginning of the contract and, in return, LRP awardees are required to work 24 months (two-years) in a hard-to-fill or hard-to-retain position in Sacramento County's Public Mental Health System. In FY 2023-24, BHS WET provided an equity award to Round 1 awardees, increasing award amounts by an additional $10,000 or $12,500, with no additional service commitment. In 2024, BHS opened another round of WET LRP and received over 200 applicants. BHS is in the final stages of awarding awards for this round, projecting an additional 40-45 individuals will be selected.

Behavioral Health Racial Equity Collaborative

BHS, in partnership with the California Institute for Behavioral Health Solutions (CIBHS), implemented a Behavioral Health Racial Equity Collaborative (BHREC) pilot at the start of FY 2020-21 to address behavioral health inequities and build a higher level of trust with the African American/Black Community. BHREC developed and adopted the following vision statement:

> *BHS envisions a community where all Sacramento County residents thrive and have equitable access to optimal behavioral and emotional wellness. By racial equity we mean closing the gaps so that race does not predict one's success, while also improving outcomes for all.*

The AA/B/AD BHREC pilot concluded in December 2022. However, BHS is committed to continuing the intentional work with the AA/B/AD community and continued the activities that nurture the transformational relationships developed between community members and BHS leadership. In FY 2023-24, the AA/B/AD BHREC Steering Committee became a monthly Ad Hoc Committee of the BHS Cultural Competence Committee, focusing on the needs of AA/B/AD community members. Additionally, BHS will continue to work on the Racial Equity Action Plans that BHS developed during the BHREC pilot.

BHREC's initial focus on the AA/B/AD was based on the long-standing behavioral health inequities among this community, addressing and rectifying the existing lack of trust necessary for authentic relationships that support the implementation of behavioral health equity, and the growing awareness of the unique experiences of racism experienced by this community. In FY 2023-24, BHS announced the focus on the Latino/Latinx/Latine/Hispanic (L/LX/LE/H) community. This is based on the low utilization of specialty mental health or substance use prevention and treatment services despite the high percentage (24%, US Census. 2021: ACS 5-

Year Estimates Data) of Hispanic or Latinos residing in Sacramento County, the need for bilingual BHS providers and staff to serve this community, as well as the need to tailor engagement strategies and services to a community that is ethnically and demographically diverse.

Latino/Latinx/Latine/Hispanic (L/LX/LE/H) BHREC initiatives started in July 2023 and will extend to June 2025. Activities completed thus far include:

- BHS hosted two (2) Virtual Community Forums (July 2023)
- BHS hosted two (2) In-Person Community Forums called Tarde Social
- BHS distributed a Latino Community Readiness Model Survey. There was a total of 69 respondents (39 in English and 30 in Spanish). A report outlining the findings has been approved by the BHREC Steering Committee.
- BHS conducted 10 Focus Groups, and a summary report has been shared with the BHREC Steering Committee.
- BHS conducted 11 Key Informant Interviews with Community Members representing different behavioral health systems of care (i.e. Primary Care, Schools, Faith-Based, Consumer Advocates, Leaders, and Elected Officials).

Currently, L/LX/LE/H BHREC has been conducting monthly steering committee meetings that include BHS leadership and L/LX/LE/H community leaders representing many sectors and community organizations. The Learning Collaborative will begin in early 2025, involving BHS mental health and substance use disorder provider organizations and community members. The emphasis on this BHREC Learning Collaborative is to co-produce programs with community and BHS leadership, ensuring services are relevant and meaningful to the L/LX/LE/H communities.

COMMUNITY SERVICES AND SUPPORTS (CSS) COMPONENT

The **Community Services and Supports (CSS)** component is the largest of the MHSA. CSS provides direct services to individuals living with a mental health condition using a client-centered, wellness, and recovery-focused approach, including housing. The CSS component provides funding for mental health treatment services and supports for children/youth and their families living with severe emotional disturbance and transition age youth (TAY), adults, and older adults living with a serious mental illness. The MHSA requires a minimum of fifty percent of CSS component funding be dedicated to Full Service Partnership (FSP) programs and Sacramento County is in compliance with this requirement.

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

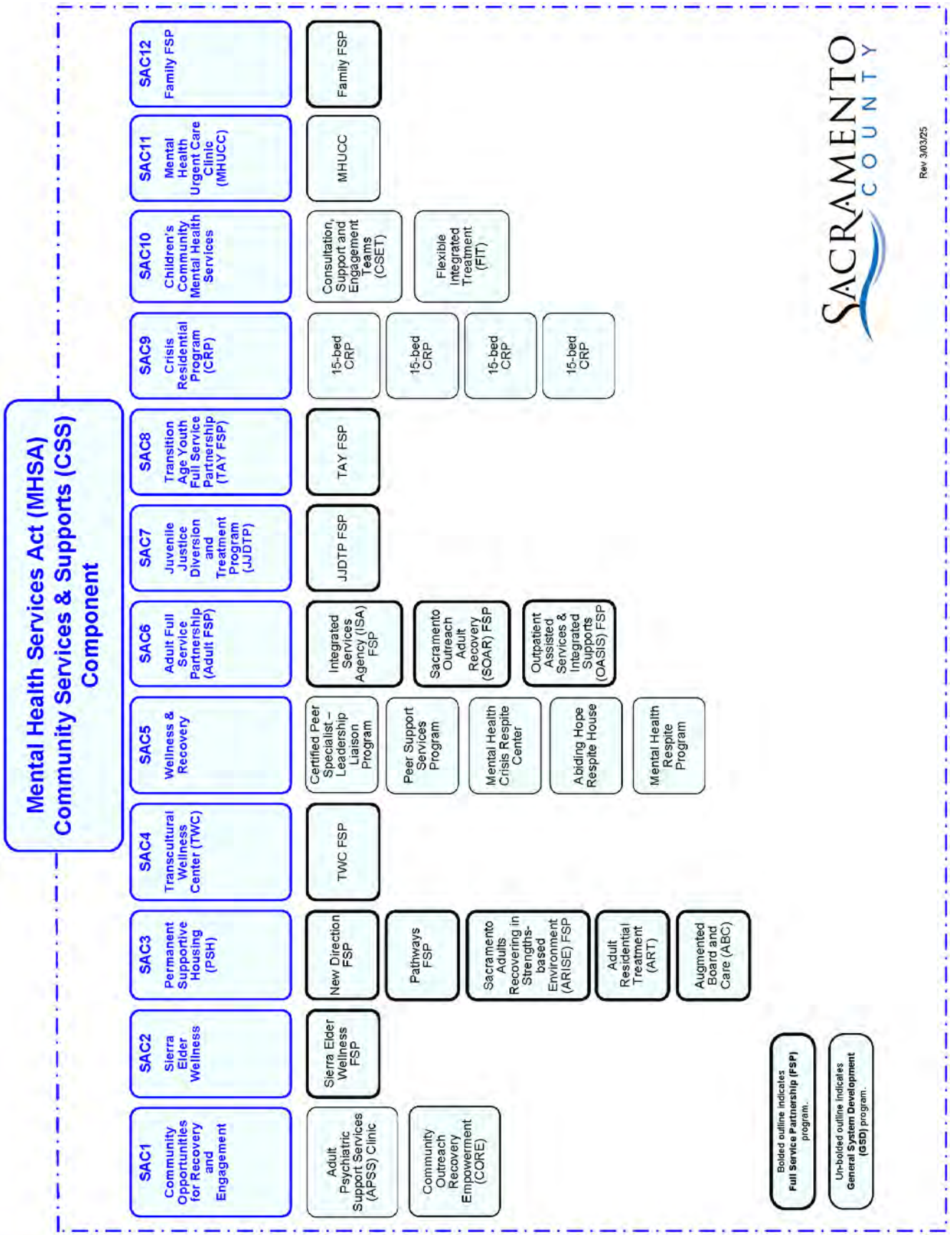
There are three service categories within the CSS Component:

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

In Fiscal Year (FY) 2023-24, the implemented FSPs served 3,147 unduplicated partners (clients) and the implemented GSDs served 27,361 unduplicated clients. Descriptions of these programs are included in this Annual Update.

MHSA defined age categories are as follows:

- Children and youth = birth – 17-years-old
- Transition Age Youth (TAY) = 16-years-old – 25-years-old
- Adult = 18-years-old – 59-years-old
- Older Adult = 60-years-old+


Mental Health Services Act (MHSA)
Community Services & Supports (CSS)
Component
SAC1 Community Opportunities for Recovery and Engagement
SAC2 Sierra Elder Wellness
SAC3 Permanent Supportive Housing (PSH)
SAC4 Transcultural Wellness Center (TWC)
SAC5 Wellness & Recovery
SAC6 Adult Full Service Partnership (Adult FSP)
SAC7 Juvenile Justice Diversion and Treatment Program (JJDTP)
SAC8 Transition Age Youth Full Service Partnership (TAY FSP)
SAC9 Crisis Residential Program (CRP)
SAC10 Children's Community Mental Health Services
SAC11 Mental Health Urgent Care Clinic (MHUCC)
SAC12 Family FSP
Adult Psychiatric Support Services (APSS) Clinic
Community Outreach Recovery Empowerment (CORE)
Sierra Elder Wellness FSP
New Direction FSP
Pathways FSP
Sacramento Adults Recovering in Strengths-based Environment (ARISE) FSP
Adult Residential Treatment (ART)
Augmented Board and Care (ABC)
TWC FSP
Certified Peer Specialist – Leadership Liaison Program
Peer Support Services Program
Mental Health Crisis Respite Center
Abiding Hope Respite House
Mental Health Respite Program
Integrated Services Agency (ISA) FSP
Sacramento Outreach Adult Recovery (SOAR) FSP
Outpatient Assisted Services & Integrated Supports (OASIS) FSP
JJDTP FSP
TAY FSP
15-bed CRP
15-bed CRP
15-bed CRP
15-bed CRP
Consultation, Support and Engagement Teams (CSET)
Flexible Integrated Treatment (FIT)
MHUCC
Family FSP
Bolded outline indicates Full Service Partnership (FSP) program.
Un-bolded outline indicates General System Development (GSD) program.
SACRAMENTO COUNTY
Rev 3/03/25

Program: Community Opportunities for Recovery and Engagement
Work Plan #/Type: SAC1 – General System Development (GSD)
FY 2025-26 Capacity: 8,125 at any given time, plus 6,600 at any given time at Community Wellness Centers
Ages Served: 6% TAY, 74% Adults, 20% Older Adults

The **Community Opportunities for Recovery and Engagement** program consists of the following previously approved and implemented components: **Adult Psychiatric Support Services (APSS)** clinic and the Adult Outpatient Transformation: **Community Outreach Recovery Empowerment (CORE)** program. These programs offer community-based behavioral health services for individuals (age 18 and older) being released from acute care settings or who are at risk for entering acute care settings and are not linked to on-going mental health services.

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

The APSS clinic includes a Peer Support Services component, which provides culturally and linguistically relevant services and supports for program participants. The peer staff are members of the multidisciplinary team and are embedded onsite at the APSS clinic. For FY 2023-24, Capital Stars began providing these peer services.

The APSS service array includes assessment, brief treatment, crisis intervention, case management, rehabilitation, medication management and support, and transition to appropriate specialty mental health services and/or community support. Since 2020, APSS also provides centralized assessment and referrals to specialty mental health providers for clients who are discharging from inpatient psychiatric hospitalization. In 2021, APSS added a similar centralized assessment service for clients discharging from the Sacramento County jails.

Success: APSS Clinic
APSS was referred a 54-year-old female. After working with the APSS clinician for approximately 6 months, the client disclosed that her home was unsatisfactory due to client hoarding furniture for many years. Client's home needed to be replumbed, but client was fearful of letting anyone in her home due to anxiety and shame. The client was presented with an opportunity to apply for a grant through SHRA for plumbing repairs which meant that client would need to allow a plumber into her home. Client applied and was approved for the SHRA grant. For the next month the client worked with her clinician at APSS to learn how to cope with anxiety through mindfulness and distress tolerance. The client was able to develop a structured plan to breakdown decluttering her home into manageable steps allowing her to begin to remove furniture from her home. Over the next several weeks the clinician utilized in vivo therapy with her client. Ultimately, her client was able to tackle her anxiety, successfully declutter her home, and allow a plumber to enter her home to assess for repairs. This client exhibited a sense of pride in her accomplishment that she went out and bought a houseplant; something that she has not done in years.

For the medication management portion of services, APSS partners with UC Davis. At present there is a team of three attending psychiatrists on staff, in addition to two residents and two medical students who rotate through the clinic.

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

The adult outpatient services model, **Community Outreach Recovery Empowerment (CORE)**, has eleven (11) sites administered by Bay Area Community Services (BACS), El Hogar Community Services, TLCS, Inc. (doing business as Hope Cooperative), and Turning Point Community Programs. CORE offers flexibility in its service delivery, increases access to services, and emphasizes a client-centered, recovery-focused, and outcome-driven system of care. This flexibility allows clients to maintain the levels of needed supportive services without having to transfer to a different provider, preserving client-provider relationships as their needs fluctuate or change. CORE programs also have a 24/7 response to crisis, as well as a community based approach for all services. Each CORE program site also has a peer-led, co-located Community Wellness Center (CWC) that offers walk-in access to mental health services and supports, groups, recreational activities, and resources for all Sacramento residents age 18 and older.

In 2023, the CWCs expanded services to include Community Outreach Workers to assist unhoused community members with accessing Medi-Cal benefits and on-going behavioral health services.

Success: CORE – BACS

An individual began attending CORE Community Wellness Center this past summer. She presented as disorganized, could not hold a conversation, and was apparently experiencing psychosis. She was also experiencing homelessness, and shared that she was self-medicating with methamphetamine and other drugs. After two months of attending the CORE Wellness Center, she agreed to engage in CORE mental health services. Initially, she saw a CORE prescriber but struggled to engage and no-showed to a follow up for a medication injection. With the support of her CORE clinician, care coordinator, and wellness center peer staff, the client successfully re-engaged in services and was able to receive her first injection. Since then, there has been a dramatic difference in client's behavior and presentation. She is focused, clear, and goal oriented. She has begun attending and participating in wellness center groups regularly and works closely with her clinical team to continue meeting her goals of employment and getting permanently housed. She recently has made steps toward her desired goal of employment and had an interview with a local wellness provider and is awaiting a response to start a job training.

Success: CORE – El Hogar

A couple came into CORE Community Wellness Center seeking services. They were experiencing homelessness, living in their car with their cat, and the female individual was pregnant. Through the walk-in process, the female client expressed desire to get connected for more mental health support to support symptoms of depression. She was assessed and linked to CORE Mariposa Clinical Program. She was working with her clinician, service coordinator, and housing specialist to find stable housing before the baby came. After a change of medical conditions complicated by a car accident, CORE used flex funds to secure an apartment and assist the client with moving expenses to have the newborn in a safe environment. The client remains engaged, participating in case management and counseling, has stable housing, and is committed to her recovery.

Success: CORE – Turning Point

A 58-year-old female presenting with symptoms congruent with a primary diagnosis of Post-Traumatic Stress Disorder (PTSD), reported symptoms including being easily startled, blocked memory, persistent low mood and fatigue, poor sleep, nightmares, intrusive thoughts, and suicidal ideation. The client has a secondary diagnosis of substance use disorder involving methamphetamine and is in early remission. This client also had housing instability. CORE developed a plan with the client to support her housing needs via MHSA housing subsidies. While they supported the client with recovery, CORE also provided linkage to the Department of Rehabilitation (DOR) and identified training programs and employment opportunities. The client worked with a recovery specialist, attends recovery groups and Alcoholics Anonymous/Narcotics Anonymous meetings, and has now been in recovery for 6 months. The stable housing has supported the client in alleviating her symptoms of PTSD, which has allowed her to look for work opportunities. She has identified trucking school as a goal. CORE continues to provide housing support while the client pursues job opportunities. This client has recently learned that the Department of Rehabilitation will aid her with tuition for trucking school, which is another step toward her sustainability plan for stable housing. This housing and employment support is integral in ensuring she focus on her sobriety while learning and practicing new coping skills with her treatment team, and working toward economic stability.

Success: CORE – Hope Cooperative

A woman (44 years old) came to the CORE Community Wellness Center (CWC) with her spouse requesting help for her violent impulses and the "voices that tell her to harm people." They were also seeking support with finding stable housing and getting linked with a Primary Care Physician. Both expressed that they were experiencing challenges, struggling to feel safe on the streets, and were being victimized due to their physical disabilities and gender identities. These members have openly discussed with staff that they struggle to trust others and do not feel safe when separated from one another. They are working with a shared Personal Service Coordinator, at their request, who worked with them to identify needs regarding housing and what type of environment they would feel most safe in. This couple was referred to a housing specialist, who worked with the couple to find a room and board with a private room and bathroom in which these members could live together with their support animal. MHSA flex funds were utilized to pay for this room and board, while these members looked for a more long-term solution. These members were able to work with the treatment team at the Community Wellness Center to focus on their treatment goals and after two months were selected for a housing voucher. CORE was able to provide the first month's rent and deposit with MHSA funds and now these members are maintaining their own stable housing. They now live as a family unit with their support animal and visit the CWC eager to show off all the decorating and work they have done to turn their apartment into a home and are now able to focus on improving their overall wellbeing and recovery.

Program: Sierra Elder Wellness
Work Plan #/Type: SAC2 – Full Service Partnership (FSP)
FY 2025-26 Capacity: 150 at any given time
Ages Served: 8% Transition Age Older Adults, 92% Older Adults

Success: Sierra Elder Wellness Program

A Client who was enrolled in Sierra in March 2024 came into the program with a long history of repeated incarceration over a period of more than 20 years. Client reported having struggles with accessing safe housing, and feelings of depression and isolation. The client faced additional challenges with parole violations related to homelessness and difficulties in charging their ankle monitor. Since joining the Sierra and partnering with the treatment team to receive intensive case management and support, the client has successfully achieved safe and stable housing, attended a Primary Care Provider appointment for the first time in over 15 years, and obtained a California ID, while following their parole requirements. The client's housing stability is largely due to Sierra's effective use of MHSA flex funds to subsidize rent. The client expressed to Sierra staff that these provisions made a significant impact, stating that they helped him feel recognized as an individual rather than just a number, as the way he felt during his time in incarceration. The support provided by Sierra, aided by MHSA flex funds, has empowered the client to break the cycle of repeated incarceration and fostered renewed hope in his mental health recovery journey.

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

Sierra establishes and maintains successful collaborations with system partners and community agencies – including assisted living board and cares; law enforcement; healthcare providers;

conservators; and ethnic and cultural groups to assist consumers in maintaining in the community and working toward recovery.

Program outcomes are to strengthen functioning level to support clients in maintaining the least restrictive community-based housing; reducing unnecessary emergency room/psychiatric hospitalizations; reducing incarceration; improving health by increasing access and coordination with primary health care; reducing homelessness; and supporting engagement in meaningful employment/ activities and social connectedness. In 2024, Sierra expanded their interventions to include Individual Placement and Support (IPS), a supported employment evidence-based practice, that emphasizes clients' strengths, promotes wellness and recovery, and focuses on building skills to obtain and maintain employment for individuals experiencing serious mental illness.

In 2025 Sierra will begin supporting clients residing at one of the MHSA-financed supportive housing projects/developments.

Program: Permanent Supportive Housing Program
Work Plan #/Type: SAC3 – Full Service Partnership (FSP)
FY 2025-26 Capacity: 1,077 at any given time
Ages Served: 2% Children, 5% TAY, 76% Adults, 17% Older Adults

The **Permanent Supportive Housing Program (PSH)** consists of the following previously approved and implemented components: **New Direction, Pathways, Sacramento ARISE, Adult Residential Treatment,** and the **Augmented Board and Care Program.** The PSH Program serves homeless children, transition age youth (TAY), adults, and older adults of all genders, races, ethnicities and cultural groups.

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

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

In 2024, the program expanded their interventions to include Individual Placement and Support (IPS), a supported employment evidence-based practice, that emphasizes clients' strengths, promotes wellness and recovery, and focuses on building skills to obtain and maintain employment

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

Success: New Direction
Before joining New Direction in 2024, Mr. G had been homeless for the past ten years. He was connected to services after experiencing symptoms of schizophrenia, including auditory and visual hallucinations and paranoia, which additionally impacted his ability to remain in safe housing and follow through on daily activities. New Direction supported Mr. G with mental health services to address new ways of managing symptoms and by providing temporary housing using MHSA flex funds. Through intensive coordination with other agencies, New Direction was able to qualify the client as 'chronically homeless' to meet special requirements for certain housing. Mr. G qualified for a housing voucher and he was accepted into one of these properties in Folsom. New Direction supported Mr. G with food, clothing, hygiene supplies, and pet supplies for his two emotional support dogs whom he considers family. These supports were offered to provide quality of life support and other community resources were explored. Currently with New Direction's support, Mr. G is tackling his next goal of applying for Supplemental Security Income (SSI) and CalFresh benefits so he may continue to increase his independence and provide for his emotional support dogs. Mr. G is an example of the success New Direction demonstrates when partnering with clients to support their mental health, housing, and general well-being.

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

Success: Pathways
A 43-year-old client entered Pathways program in April 2024. He presented with a history of suicidal ideation, multiple hospitalizations, homelessness, incarceration due to a felony charge of arson, and methamphetamine use. Client was enrolled in the Mental Health Treatment Court (MHTC) to resolve the felony conviction for fire setting. Early on, Client had difficulty connecting and missed appointments with the treatment team. The Pathways Treatment Team, including case managers, clinicians and peers, reengaged client and collaboratively helped him see the importance of setting and attending all scheduled appointments including his court appearances, and following the treatment plan toward his future goals. As part of their intensive case management support, Pathways supported the client with applications to get in a MHSA funded Permanent Supportive Housing (PSH) unit. Since the client's connection to Pathways, he has not been readmitted for psychiatric hospitalization and has been maintaining his housing. The court has consistently commended the member for his adherence to probation, progress in treatment, and for maintaining sobriety. This encourages the client to maintain his current trajectory in recovery. With the support of Pathways, Client has built confidence within himself and his abilities and is slated for graduation from MHTC in December 2024.

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

In 2024, the program expanded their interventions to include Individual Placement and Support (IPS), a supported employment evidence-based practice, that emphasizes clients' strengths, promotes wellness and recovery, and focuses on building skills to obtain and maintain employment for individuals experiencing serious mental illness.

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

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

Success: Sacramento ARISE
A man was referred to ARISE from Heritage Oaks Hospital, where he had received inpatient services due to suicidal ideations. He reported challenges with depression, psychosis, suicidal ideation/attempts, history of substance abuse, mood dysregulation and severe interpersonal conflicts with his roommates and others in his life. He said his goals were "finding a place with my own room, getting in touch with my kids and going to truck driving school". Housing team, Case Managers, Psychiatrist, and Benefits Specialist met with member regularly to support his goals and to identify barriers. Member was provided transportation to the Social Security Office and DMV to aid him in getting documents he needed to work towards his goals. The ARISE team provided support to member in developing emotional regulation skills to reduce thoughts of harming others and provided crisis intervention as needed. Member needed housing and, due to his financial constraints, ARISE provided MHSA flex funds in the interval before he began receiving his social security payments to support with housing, bus passes, and additional resources. Member was able to reunite with his adult daughter and is currently at peace with their relationship. Member now receives his social security payments and is able to pay for his own rent and food and has also enrolled himself in truck driving classes at the community college.

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

In 2024, the program expanded their interventions to include Individual Placement and Support (IPS), a supported employment evidence-based practice, that emphasizes clients' strengths,

promotes wellness and recovery, and focuses on building skills to obtain and maintain employment for individuals experiencing serious mental illness.

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

Success: Adult Residential Treatment (ART)
A 24 year old male with a mental health diagnosis of schizoaffective disorder was referred to the County's BHS Intensive Placement Team (IPT) from the jail where client was being held. In addition to assaultive behavior, this client had previously made several extremely lethal suicide attempts by overdose, as well as an incident in which he intentionally gave himself third degree burns. His family was naturally incredibly concerned for his safety. Due to their excellent support and advocacy, he was placed on conservatorship. He was approved for placement at Crestwood Sacramento Mental Health Rehabilitation Center and had again become very assaultive there. After a period of stabilization, he was referred to ART.

At this program, a specialized treatment plan was developed that included his family's participation. He attended an internal day program five days per week to promote his recovery. He received psychoeducation about his diagnosis and illness, as well as about his medications and the science behind why they helped to reduce his symptoms. He learned coping skills to help him deal with the extreme auditory command hallucinations he was having. He learned about the reparative qualities of not isolating himself and reaching out to others for support. He received individual and group therapy with his family and was able to practice better communication skills with his family. His family also benefited from the psychoeducation regarding his diagnosis.

After an 18 month stay, this client was able to begin graduating from the program. His conservatorship moved from the Public Guardians office to his father. The client was able to graduate from the ART program to the community. He has not had any psychiatric hospitalizations, law enforcement contacts, self-harm, nor assaultive behaviors in 18 months.

The ART's residential facilities maintain licensure from the State Community Care Licensing Division (CCLD). Residential services are provided in a structured home environment that supports improving the recovery and independent living skills of individuals living with a psychiatric condition and co-occurring medical and/or substance use disorders for the purpose of community integration and transition to a lower level of care. Clients have the opportunity to practice new skills and coping mechanisms, set goals for the future, identify steps to reach those goals, and to learn about medication management so they can achieve increased independence and recovery, as well as stepping down to a lower level of care.

The **Augmented Board and Care (ABC)** program provides 24 hour, 7 days a week board and care services to TAY (18-25), adults, and older adult residents linked to high intensity mental health services that are culturally responsive, recovery-focused, and trauma-informed. ABC services are provided to residents living with serious mental illness and co-occurring conditions who are in need of intense programming (e.g. Full Service Partnership (FSP) services) in order to maintain residency in the community. ABC provides the support needed to receive treatment services at a less restrictive level of care through their outpatient provider, rather than psychiatric hospitalization or subacute services. The ABC program provides a safe and supportive home

environment for individuals to build interpersonal and independent living skills in order to support successful transition to a lower level of care. Each ABC client is supported by the Board and Care provider, the client's FSP, and the County Intensive Placement Team. ABC clients receive care coordination, medication monitoring and treatment planning, weekly visitation from the Intensive Placement Team and FSP treatment partners, and monthly care conferences to ensure better outcomes in the least restrictive level of care for all clients.

Program: Transcultural Wellness Center
Work Plan #/Type: SAC4 – Full Service Partnership (FSP)

Success: Augmented Board and Care (ABC)
The Augmented Board and Care (ABC) program served a 53-year-old African American female who was diagnosed with schizophrenia. Prior to coming to the ABC program, she had been struggling in the community to stay out of the hospital and take her medications as prescribed. Obstacles this client faced due to her condition included delusions about medical conditions, responding to internal stimuli, and extremely poor hygiene and grooming.

During a four-year period, she had nine admissions to Sierra Vista Hospital. She had received high intensity supports in the community and still struggled to stay stable. Eventually, she was placed on conservatorship and approved for sub-acute treatment. She did well in this highly structured environment but was anxious regarding her return to the community and felt extreme concern about performing well without as much structure and support.

The option to step down to the recovery-oriented ABC program was presented to the client and her conservator, and both agreed this would be a supportive option as she transitioned back to the community. She was placed in a 6-bed ABC home with the support of high intensity outpatient services. The conservator, the ABC home staff, the ABC program staff, and the outpatient provider all coordinated carefully to ensure this client's recovery plan was tailored to her needs. As part of this plan, she began to practice independent living skills, including cooking, using the bus, and doing chores around the home. A big part of her culture is attending church weekly. All parties coordinated so she could attend consistently and reconnect with her community there. She reported early on that she was considered the matriarch of her family. For this reason, graduating from the ABC program was very important to her so she could have a private place to host her family gatherings. At the ABC home her recovery really accelerated and, after a one-year stay, she was able to come off conservatorship and graduate to living independently. She now takes her medications on her own, makes all her own care decisions, and to date has not required any further hospitalizations.

FY 2025-26 Capacity: 200 at any given time
Ages Served: 7% Children, 14% TAY, 65% Adults, 14% Older Adults

The **Transcultural Wellness Center (TWC)**, administered by Asian Pacific Community Counseling, is designed to increase penetration rates and reduce mental health disparities in the Asian and Pacific Islander (API) communities in Sacramento County. The program is staffed by psychiatrists, mental health clinicians, counselors, and peer support specialists who are reflective of the API communities. Staff assignments take into consideration the gender and specific cultural and linguistic needs of the client. Staff speak 15 API languages: Cambodian, Cantonese, Hindi, Hmong, Japanese, Korean, Laotian, Mandarin, Mien, Punjabi, Spanish, Tagalog, Telugu, Thai, and Vietnamese.

TWC FSP services include a full range of mental health services and support that take into consideration cultural and religious beliefs and values, traditional and natural healing practices, and associated ceremonies recognized by the API communities. TWC works to link clients, particularly adults and older adults with co-occurring medical and mental health needs, to primary care physicians for comprehensive medical assessments and ongoing medical care. Services

include culturally and linguistically relevant mental health interventions and activities that reduce and prevent negative outcomes, such as avoidable emergency room utilization, psychiatric hospitalization, jail/incarceration, and eviction/homelessness. Based on client needs, all services may be delivered in the home, community, and/or school. FSP services emphasize blending cultural and traditional resources to reduce stigma and support client needs.

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

Success: Transcultural Wellness Center

A 31-year-old transgender female was referred to TWC in 2022. She had a history of frequent hospitalizations and self-harming behavior. Client engaged in excessive alcohol consumption and had reported challenges coping with symptoms of depression and suicidal ideation.

After receiving ongoing mental health and intensive case management services from Asian Pacific Community Counseling staff, she has shown significant improvement in the last year, reporting new feelings of hope. TWC supported the client with finding an apartment and paying a portion of her rent using MHSA flex funds. Client has been able to remain in the same housing for an extended period; has been able to manage feelings of suicidal ideation through use of positive coping skills, like playing the guitar; and has not required psychiatric hospitalization in over 12 months. She has made a commitment to quit drinking alcohol and is able to make a nominal living by playing her guitar on live streaming platforms.

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

In 2024, the program expanded their interventions to include Individual Placement and Support (IPS), a supported employment evidence-based practice, that emphasizes clients' strengths, promotes wellness and recovery, and focuses on building skills to obtain and maintain employment for individuals experiencing serious mental illness.

Program: Wellness and Recovery
Work Plan #/Type: SAC5 – General System Development (GSD)
FY 2025-26 Capacity: 2,375 annually
Ages Served: 11% Children, 16% TAY, 65% Adults, 8% Older Adults

The **Wellness and Recovery** program consists of the following previously approved and implemented components: **Peer Support Services Program,** redesigned **Certified Peer Support - Leadership Liaison Program**, **Mental Health Crisis Respite Center**, **Abiding Hope Respite House**, and the **Mental Health Respite Program**.

The **Peer Support Services (PSS) Program** is a collaborative and integrated program within the following County Operated Programs: Adult Psychiatric Support Services (APSS), Child and Adolescent Psychiatric Services (CAPS), Youth Detention Facility (YDF), Intensive Placement Committee (IPC), and the Mental Health Treatment Center (MHTC). PSS Program staff come with their unique behavioral health lived experience. The program provides peer services to

children, TAY, adults, older adults, and family members and/or natural support(s) who are receiving services through the County Operated Programs listed above.

The peer services include outreach and engagement activities, direct client support services and advocacy, system navigation, safety-planning, benefits acquisition, linkage to community supports and services, employment training, educational resources, self-help, and support groups. Clients are supported in decision-making and encouraged to use their natural support(s).

Additional services include peer support services for up to 30 days for individuals who have discharged from the MHTC or released from YDF for the purpose of ensuring ongoing support from discharge/release to linkage with an on-going service provider.

All peer services are intended to be client-driven, wellness and recovery-oriented, strength-based, trauma-informed, culturally, and linguistically responsive, community-based, caregiver/child/youth-centered, and family and needs driven. Program outcomes include successful linkage to needed supports and/or community resources, developing and achieving client-driven goals, and reducing psychiatric hospitalizations. Peers within the Peer Support Services Program are Certified Peers or in the process of Certification.

Success: Peer Support Services (PSS) Program
A young single mother client at APSS was referred to the PSS program, as she was experiencing challenges with income, unemployment, and navigating motherhood. The assigned Peer was able to help her apply and get approved for Women, Infants, and Children (WIC), CalWORKs, CalFresh, and unemployment benefits. The Peer also introduced her to the Seeking Safety curriculum to assist her in working on new interventions to manage her stress. The PSS program was also able to help match her with a community program that supported her with a free booster seat. With new income and support with stress management and parenting techniques, she was able to return to school full time at Sacramento City College.

The **Certified Peer Support - Leadership Liaison Program (CPS-LLP)** is administered by Cal Voices in partnership with Sacramento County's Behavioral Health Peer Support Specialist Program Managers. The CPS-LLP provides training about the evidence-based practice of Peer Support services and supports, including a Medi-Cal Peer Support Specialist (PSS) Best Practices Toolkits for Peer Specialists working in the BHS system of care and their employers (system providers). *See Attachment C: Peer Toolkit for Workplace Success)* The BHS system providers Employer Best Practices Toolkit aims to facilitate efforts to grow the peer workforce; support peers in the workplace; develop peer equity and leadership; and collect and utilize client, family member, and other stakeholder input into all aspects of program development and service delivery. *(See Attachment D: Peer Employer Toolkit)*. The CPS-LLP will consistently seek input from peers, peer specialists, providers, and peer employers to inform, update, and improve the training curriculum and toolkits content.

CPS-LLP goals include:

(1) Build capacity and expertise of the local Peer workforce and providers that employ Peers;
(2) Increase the number of Certified Medi-Cal Peer Support Specialists in the BHS system of care;
(3) Increase the number of peer specialists representing un- and under-served communities;
(4) Provide additional tools and resources to Medi-Cal Certified Peer Support Specialists; and,
(5) Increase BHS system providers' knowledge and resources relating to developing, expanding, and retaining a peer workforce.

Success: Certified Peer Support - Leadership Liaison Program (CPS-LLP)
The Certified Peer Specialist Leadership Liaison Program has spearheaded a series of innovative initiatives aimed at significantly enhancing the growth of Sacramento County's Certified Medi-Cal Peer Support Specialist Workforce. Through this initiative, the program has successfully delivered continuing education and specialized employer and provider training, benefiting 158 unduplicated participants.

By offering open office hours, the CPS-LLP has facilitated collaborative and transparent conversations between Peers and their employers, fostering mutual recognition of the value and benefits of Peer support practices in client services. Focus groups and listening sessions have yielded invaluable insights into client perspectives on Peer Support Services, enabling the program to identify effective strategies and potential needs. This comprehensive approach explores Peer integration within behavioral health programs, identifies growth opportunities for both Peers and employers, and outlines the support required to enhance diversity, capacity, and expertise within the Medi-Cal Certified Peer Support Specialist workforce and the organizations that employ them. The program has engaged in focused and intentional outreach to cultural community-based organizations (CBOs) previously unconnected with Behavioral Health Services (BHS), creating new opportunities to build trusting relationships with over 1,300 unique individuals.

At the 2024 Annual Peer Empowerment Conference, the focus shifted to Peer employment, attracting 154 attendees who expressed their gratitude for such a large and impactful event.

The creative, dedicated, and skilled efforts of the Certified Peer Specialist Leadership Liaison Program are instrumental in advancing valuable peer-to-peer services, continually reducing stigma and promoting lasting wellness and recovery.

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

◊ The **Mental Health Crisis Respite Center (CRC)**, administered by Hope Cooperative, CRC provides 24 hours/7 days a week mental health crisis respite care in a warm and supportive community-based setting to eligible TAY (18+), adults, and older adults who are experiencing overwhelming stress due to life circumstance resulting in a mental health crisis. CRC provides a range of services, including screening, resource linkage, crisis response and care management for up to 23 hours.

Success: Mental Health Crisis Respite Center (CRC)
A guest had been accessing Crisis Respite Center (CRC) services on a regular basis due to struggles managing his mental health symptoms. This guest had previously called multiple times a day struggling to maintain placement in room and boards and had struggled in the shelters due to his unstable mental health symptoms and ongoing delusions. CRC staff not only completed a referral to the BHS Services-Screening and Coordination (BHS SAC) team, resulting in the guest getting connected to CORE Marconi, where he collaborated with CORE Marconi staff to develop a mental health plan and establish boundaries to support him in his recovery. In mid-July, the guest contacted the center, and he shared that since CRC connected him to services through CORE Marconi he has been able to improve his mental health, obtain employment, and is close to getting his own apartment.

Program goals are to reduce emergency department visits and acute psychiatric hospitalizations, connect or establish new access to mental health services, and increase client-reported improvement in their recovery journeys. Specifically, clients who leave the CRC who have specific mental health service needs had an identified mental health follow- up contact, including but not limited to linkage to mental health services through their managed care provider; a referral through the Behavioral Health Services-Screening and Coordination (BHS

SAC) for specialty mental health services; follow up with the BHS Community Support Team (CST); and/or planned contact with natural supports or services in place prior to the crisis.

◊ **Abiding Hope Respite House**, administered by Turning Point Community Programs, provides mental health crisis respite services in a welcoming, home-like setting, where TAY (18+), adults, and older adults, experiencing a mental health crisis can stay up to 14 days. During their stay, clients receive client-centered, recovery-oriented services that include crisis response, screening, resource linkage, peer support, and care management. There are five (5) beds in the home and all clients take part in cooking, cleaning, and groups to help them gain back a sense of purpose and dignity through life's routines. Program goals include: reduced emergency department visits and/or acute psychiatric hospitalizations, and increased client-reported improvement in their recovery journey.

Success: Abiding Hope Respite House
An individual was referred to Abiding Hope Respite House from a Crisis Residential Program. The client had recently been connected with an outpatient mental health provider but would have been unhoused in the interim before those mental health services began. While at Abiding Hope, the client participated in daily activities, building a sense of accomplishment. In addition to providing them with a safe space to work on housing with their case manager, Abiding Hope provided screening, resource linkage, peer support, and case management services, including providing them with transportation to and from necessary appointments.

From the participant: "Abiding Hope provided a safe and stable temporary housing when I would have otherwise been living on the street, which would have worsened my mental health. This program granted me the physical and mental emotional safety to focus on finding housing."

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

Success: St. John's
Participant, a 38-year-old white woman, called the Respite Line in search of support, as she was extremely overwhelmed and struggling with her first episode of homelessness for a week after she fled domestic violence in another county. She was admitted to the Respite Program. Due to the injuries she sustained from the domestic violence, she frequently called out from work in the hopes of concealing her home life, and this led to her losing her job as a restaurant server. Participant, new to the Sacramento area, was in survival mode. She presented as extremely depressed and anxious, unsure of how to create a path to move forward. She called the Mental Health Respite program at Saint John's Program for Real Change in the hopes that she could receive mental health support, as well as information about resources to help her get back on her feet. Participant was able to discuss her trauma in a safe environment, allowing her to feel comfortable with continuing mental health services her stay. In addition, the communal environment of the program allowed her to decrease her feelings of isolation. While in respite, Participant received guidance and began the process of transferring her health insurance from her home county to Sacramento County. After her respite stay ended, Participant entered the vocational training program at Saint John's Program for Real Change, optimistic about the resources that would continue being at her disposal and hopeful that she now had a path forward towards long-term well-being and stability.

Program: Adult Full Service Partnerships (FSP)
Work Plan #/Type: SAC6 – Full Service Partnership (FSP)
FY 2025-26 Capacity: 729 at any given time
Ages Served: 2% TAY, 82% Adults, 16% Older Adults

The Adult Full Service Partnership (FSP) Program consists of the following previously approved and implemented components**: Integrated Services Agency (ISA), Sacramento Outreach Adult Recovery (SOAR)** and **Outpatient Assisted Services & Integrated Supports** (**OASIS)**

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

ISA and SOAR have established and maintained successful collaborations with system partners, community agencies, sub-acute care providers, law enforcement, healthcare providers, conservators, and ethnic and cultural groups to assist consumers in maintaining stability and social connectedness in the community and working toward recovery. In 2024, the program expanded their interventions to include Individual Placement and Support (IPS), a supported employment evidence-based practice, that emphasizes clients' strengths, promotes wellness and recovery, and focuses on building skills to obtain and maintain employment for individuals experiencing serious mental illness.

Success: Integrated Services Agency (ISA)
When ISA member was referred, he presented with various challenges that included substance use, criminal history, familial issues, and extreme anxiety. Member had been denied Social Security due to his substance use and related challenges, despite the assistance of the ISA team and several attempts to appeal his denials. Member was encouraged to identify goals and stated, "I want to learn how to deal with my anger, nightmares, and voices so I can get another job and eventually get an apartment." Member engaged with the assigned ISA worker and was open to feedback that supported his intended goals. This aided him in developing positive ways to cope and manage his symptoms of psychosis and substance use challenges. With the continued support of the ISA team, he has been able to identify triggers and work with the ISA team on how to manage the substance use urges. The ISA team provided support by enrolling him in community classes in preparation for his goal of obtaining gainful employment and, after he found employment, member asked and ISA was able to help him acquire a work uniform and weekly bus passes with MHSA flex funds, as his current employment compensation was not sufficient to cover his basic living needs. Currently, the member receives monthly assistance from ISA to cover his rent that otherwise would not be sustainable without the use of MHSA flex funds. Although member continues to struggle with anger, he has reported improvement. He is still engaging with his assigned case worker, is encouraged to attend groups, and is utilizing ISA resources/services to maintain and continue to improve his level of independence in the community.

Success: Sacramento Outreach Adult Recovery (SOAR)
Member has been with SOAR for a little over five years and has made great strides forward in her recovery. Her goals were to address her substance use problems, to continue her education in art, and to remain in the community so she can grow more independent. When she came to SOAR, she had challenges with substance use, anxiety, depression, and symptoms resulting from trauma. SOAR has partnered with this member to provide a variety of services, including medication support, case management, skill building, housing supports, therapy, and group. SOAR also linked her to Enhanced Case Management (ECM) to support member with additional coordination around her medical needs and Substance Use Prevention and Treatment (SUPT) services. Through Narcotics Anonymous, she found a natural support system and has been sober for over two years now. To continue to support her symptoms with anxiety, depression, and trauma, she continues to be consistent in attending her appointments with SOAR and SOAR is providing regular community visits to support her. Attending appointments and continuous visits with the SOAR team has allowed her to improve in symptom management. She has recently moved into an apartment of her own and is grateful for the support SOAR has provided her. She continues to receive support from SOAR and to focus on her own growth and independence.

Outpatient Assisted Services and Integration Support (OASIS), administered by Telecare, is an adult Full Service Partnership (FSP) program that provides mental health services and permanent supportive housing supports for TAY (age 18 and up), adults, and older adults. The program provides integrated and comprehensive services utilizing a "whatever it takes" approach to support consumers and their families in meeting their desired recovery goals. Through housing supports and subsidies, OASIS addresses the housing needs of individuals living with serious mental illness who are homeless or at risk of homelessness and who may also have co-occurring substance use disorders. OASIS provides services at two (2) MHSA-financed permanent supportive housing developments, using community-based housing vouchers and subsidies to provide permanent housing for consumers and their families. Additionally, this program provides engagement and FSP services for up to 45 adults who meet eligibility for Assisted Outpatient Treatment (AOT) and referred by the Sacramento County AOT Engagement Team. FSP services provided to Assisted Outpatient Treatment eligible clients are funded through Medi-Cal and Realignment.

Program goals for all clients are to reduce homelessness, strengthen functioning level to support clients in maintaining the least restrictive community-based housing, reduce acute psychiatric hospitalizations, reduce incarceration, improve health by increasing access to primary health care, and support engagement in meaningful employment/activities and social connectedness. In 2024, OASIS expanded their interventions to include Individual Placement and Support (IPS), a supported employment evidence-based practice, that emphasizes clients' strengths, promotes wellness and recovery, and focuses on building skills to obtain and maintain employment for individuals experiencing serious mental illness.

Success: Outpatient Assisted Services and Integration Support (OASIS)
OASIS member was featured in the Sacramento Bee to shine a light on their journey of resilience and the dedicated efforts of the OASIS team. After member lost their godmother, whom they had been caring for, they were faced with losing their housing and living in their car, while the grief only compounded their mental health symptoms of depression. With the aid of OASIS, Member sought out resources, with a top priority of being housed. OASIS collaborated with County resources to assist member in getting project-based vouchers that allowed for a smooth transition into a shelter and then into Permanent Supportive Housing (PSH) at Capitol Park. OASIS supported member through regular case management, rehabilitation and coping skills and coordination with PSH staff and member had a successful move in. As member settled into their new home, OASIS was actively involved in providing frequent therapeutic support that allowed member to make significant strides in their healing process. In addition to therapy, OASIS has been supporting member explore employment opportunities and supporting member's goals to more independence.

Program: Juvenile Justice Diversion and Treatment Program
Work Plan #/Type: SAC7 – Full Service Partnership (FSP)
FY 2025-26 Capacity: 131 at any given time
Ages Served: 16% Youth (ages 13-15) and 84% TAY (ages 16 – 25)

The **Juvenile Justice Diversion and Treatment Program (JJDTP)** is a Full Service Partnership (FSP) administered by a partnership between BHS, Sacramento County Probation Department, and River Oak Center for Children that delivers integrated services to youth involved with juvenile justice who have multiple and complex needs across several service systems. JJDTP provides screenings, assessments, and intensive mental health services and FSP supports to eligible youth and their families. Youth must meet serious emotional disturbance criteria and be between the ages of 13 through 17 at enrollment. Pre-adjudicated youth are screened and given an assessment. With court approval, youth are offered an alternative to incarceration by voluntarily participating in this program as long as clinically necessary through their 25th year. Adjudicated youth are referred, assessed, and have the opportunity to voluntarily receive the program's intensive, evidence-based services delivered in coordination with a specialized Probation Officer. Family and youth advocates complement clinical FSP services by providing peer support.

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

Success: Juvenile Justice Diversion and Treatment Program (JJDTP)
Youth was referred to the JJDTP Program from the Department of Juvenile Justice (DJJ) in August 2022. Initial referral listed the youth's diagnosis of schizophreniform disorder. The Department of Juvenile Justice transitioned youth to Youth Detention Facility (YDF), with a plan for youth to return home with JJDTP support in place. Staff met with the youth while in YDF to build rapport and engagement and, post assessments, the team determined he had suffered significant trauma. During the two years youth participated in JJDTP, he successfully discharged from probation, remained substance free, graduated high school, became an active member in his local church, obtained employment in a school district, and obtained housing with his girlfriend and baby. The youth was fully engaged in all services for the entirety of the two years. The program provided support to assist youth with his security deposit, rent, cleaning items for his new apartment, baby items, and grocery supports.

Program: Transition Age Youth Full Service Partnership (TAY FSP)
Work Plan #/Type: SAC8 – Full Service Partnership (FSP)
FY 2025-26 Capacity: 257 at any given time
Ages Served: 100% Youth and TAY ages 16 – 25

The **Transition Age Youth (TAY) FSP Program**, administered by Capital Star Community Services, provides FSP services and flexible supports to TAY ages 16 through 25 who are homeless or at risk of homelessness, aging out of the child mental health system, involved in or aging out of the child welfare and/or foster care system, involved in or aging out of the juvenile/criminal justice system, at risk of involuntary psychiatric hospitalization or institutionalization, experiencing a first episode of a serious mental illness, and/or part of other at-risk populations. Services are culturally and linguistically competent with sensitivity to and affirmation of gender identity, gender expression, and sexual orientation. Services are individualized based on age, development, and culture. TAY FSP program includes outreach,

engagement, retention, and transition strategies with an emphasis on independent living and life skills, mentorship, and services that are youth and family driven.

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

Success: Transition Age Youth FSP Program
Youth joined the program in June 2022 and was at risk of homelessness, experiencing depressed mood and negative thoughts daily, suicidal ideations weekly, and struggled with engaging in healthy relationships. With the support of her TAY FSP team, youth was able to obtain safe and independent housing, return to college, and obtain a career position with the State of California. Youth developed skills to maintain healthy boundaries worked through childhood trauma in order to repair relationships, while successfully engaging in psychiatry services, where she reported noticeable changes in her mood and ability to function daily without suicidal ideations, including improvement in sleep. Youth also utilized the Enhanced Care Management Program (ECM) to link to a primary care provider, dentist, and a medical specialist. Due to reaching treatment goals, youth is in the process of transitioning out of services.

TAY FSP provides services to clients residing at one permanent MHSA-financed supportive housing project. Once clients are housed, the TAY FSP supports them in maintaining stable housing.

Program: Crisis Residential Program (CRP)
Work Plan #/Type: SAC9 – General System Development (GSD)
FY 2025-26 Capacity: 623 served annually
Ages Served: 27% TAY (ages 18-25) and 74% Adults (ages 26 – 59)

There are three (3) 15-bed **Crisis Residential Program (CRP)** sites for adults administered by Turning Point Community Programs located in Rio Linda, Sacramento, and South Sacramento, and another 15-bed CRP serving TAY administered by Capital Star Crisis Residential Program located in Sacramento.

CRPs are short-term residential treatment programs that operate in a structured home-like setting 24 hours a day, 7 days a week. Eligible clients may be served through the CRP for up to 30 days. These programs embrace peer facilitated activities that are culturally responsive. CRPs are designed for individuals aged 18-59 who meet psychiatric inpatient admission criteria, or who are at risk of admission due to an acute psychiatric crisis and can instead be served appropriately and voluntarily in a community setting. Beginning with an in-depth clinical assessment and development of an individual service plan, crisis residential program staff work with clients to identify achievable goals, including a Wellness Recovery Action Plan (WRAP).

Once admitted, structured day and evening services are available seven days a week that include individual and group counseling, crisis intervention, planned activities that encourage socialization, pre-vocational and vocational counseling, consumer advocacy, medication evaluation and support, and linkages to resources that are available after leaving the program.

Family members are included in counseling and plan development. Services are voluntary, community-based, and alternative to acute psychiatric care. While the services are designed to resolve the immediate crisis, they also focus on improving functioning and coping skills and encouraging wellness, resiliency, and recovery to enable clients to return to the least restrictive, most independent setting possible in as short a time as possible. Services are designed to be culturally responsive to the needs of the diverse community members seeking treatment.

Success: Crisis Residential Program (CRP), Rio Linda

This individual began services with CRP after discharging from a locked psychiatric hospital. The client was struggling with depressed mood, paranoia, delusions, sleep disturbance, weight loss, inappropriate guilt, tangential thoughts, and flight of ideas. The client appeared to experience significant obstacles to daily living related to both trauma and paranoia. They were well-known to CRP from previous admissions that had been marked by limited engagement, discharges against clinical advice, and subsequent relapses. During this admission, the client not only appeared more motivated, but engaged in treatment and was able to make significant progress toward improving their mental health. The client was able to build more insight and lean into their coping skills (writing, poetry, singing, faith) to ground and support them during intense symptom experiences. The program's resource team assisted the client with developing a viable discharge plan and establishing a placement and mental health services within Alameda County per the client's desire to live near their children again. This individual made immense progress at stabilizing and preparing to return to the community and was able to successfully reunite with their kids after not being in their lives for an extended period. This story serves as a great example of the resilience of the individuals we serve, along with the importance of having services available at all stages of the recovery journey.

Success: Crisis Residential Program (CRP), Sacramento TAY

A youth was referred to CRP by Sutter Center for Psychiatry. Throughout his stay, the youth consistently met with the treatment team, engaged with program activities, and completed his assigned chores in a timely manner, which increased his independent daily living skills. The youth remained medication compliant, was able to enhance his personal hygiene and grooming, and was able to utilize his coping skills during times he felt anxious and triggered by a stimulus. During his stay, the youth got linked to a new outpatient provider for mental health services, was supported with getting a replacement ID, benefits acquisition, applied to SSI, and scheduled an appointment with primary care provider. Before discharge, he was also supported in utilizing a pharmacy that can provide medication in bubble packs to support him in maintaining his wellness and progress. The youth completed his stay and was successfully discharged to his outpatient provider. The youth reported that he was very grateful for receiving the support and skills he gained here during his stay and was feeling confident about his discharge.

Success: Crisis Residential Program, South Sacramento

Member was referred to CRP by Sierra Vista Hospital. This individual had been hospitalized frequently over the last year and there were some concerns about the admission to CRP due to limitations in functioning and communication. While at CRP, the member was able to work with the psychiatrist to identify medications to help decrease his symptoms. He engaged in therapeutic groups and received a cell phone. He participated in weekly outings and completed his daily house chores. He was also able to reestablish communication with his outpatient provider, Turning Point Pathways. Pathways was able to assist the client with finding a Board and Care versus the client going to a Room and Board or shelter. The client struggles with medication management as well as attending to his activities of daily living. Board and Care facilities are licensed and able to provide member's medication to him as prescribed. Staff will also be able to coach member on attending to his activities of daily living. Based on the client's history, had he gone to a Room and Board or shelter, he would likely have been re-hospitalized, experienced an increase in his mental health symptoms, and stopped communicating with his outpatient provider.

Success: Crisis Residential Program (CRP), Sacramento
Member presented to CRP with depressed mood and affect, anxiety, hopelessness, helplessness and poor insight. Staff built rapport with member and offered validation of his feelings while supporting him in his desire to obtain housing and a job. The member struggled with their negative thinking and feelings of shame and guilt. Staff utilized motivational interviewing, and the member was receptive to the support from staff reminding him to reframe his thinking and practice gratitude. Member was able to decrease his feelings of depression and hopelessness and stayed committed to his goals. In spite of multiple setbacks in his attempts to secure housing, member remained positive. He also offered motivation and encouragement to other members at CRP and formed strong relationships with them. With the support of staff, member achieved his goal and was accepted into a luxury residential recovery home where he will live rent free for the next year. He is committed to maintaining his sobriety and obtaining employment to support his unborn child who is due in August. The short term crisis services provided by the CRP has helped shape a new path to recovery.

Program: Children's Community Mental Health Services
Work Plan #/Type: SAC10 – General System Development (GSD)
FY 2025-26 Capacity: 8,009 served annually
Ages Served: 50% Children (0-15) and 50% Youth (16-21)

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

The **Consultation, Support and Engagement Teams (CSET) Program** addresses the needs of children and TAY who have been commercially sexually exploited or at risk of sexual exploitation. This program has two components:

- Outreach and engagement services for children, TAY, and families; contracted provider works closely with court systems to identify children and youth in need of services and attends weekly case staffing to engage children/youth who are unlinked to supportive resources and mental health programs. This component is administered by Capital Star Community Services.
- Training for the entire mental health plan. This component is currently in the process of being reevaluated to meet the needs of the county mental health plan providers and those they serve. A new training plan and activities will go live in late Spring 2025.

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

Success: Consultation, Support and Engagement Teams (CSET) Program
A 10-year-old, multiracial, female young person was referred to CSET by Step Up Housing Program after they recognized high risk factors for this young person after a presentation from the CSET program. The Youth was being recruited into exploitative activities by older sisters. Youth and her mother have been chronically homeless, and the youth has struggled with school attendance due to a history of bullying at school. The team was able to support mom with working with the school to explore how to support with school attendance. The team worked with the youth to build her confidence and sense of self. At first, she was very shy and needed the youth advocate to go with her to any activity. Today she is able to engages in activities on her own as her confidence has grown. CSET worked with her mom to enroll the youth and caregiver in Family FSP services for housing support and long-term mental health services for the entire family.

In 2022, BHS was awarded a time limited Office for Victims of Crime (OVC) grant (FY 2022 Field- Generated Strategies to Address the Criminalization of Minor Victims of Sex Trafficking) to expand CSET services. This expansion has increased the staffing, enabling the program to serve more youth, co-located at the Welcome Homes, and implement the Lighthouse (respite services) for youth. The County is working with the Office for Victims of Crime to explore sustainability funding for this expansion to continue after the grant discontinues.

Flexible Integrated Treatment (FIT), providing children's outpatient services, has 16 sites across the region and is administered by ten (10) providers: Capital Star Community Services; Dignity Health Medical Foundation; La Familia Counseling Center; River Oak Center for Children; Sacramento Children's Home; Stanford Sierra Youth & Families; HeartLand Child & Family Services; Turning Point Community Programs; The Regents of the University of California; and Pacific Clinics (formerly known as Uplift Family Services).

FIT provides strength-based, culturally competent, flexible, integrated, child/youth-centered, family driven, developmentally appropriate, effective quality mental health services to children and TAY with serious emotional disturbance under the age of 21 years. Services aim to alleviate symptoms and foster development of age-appropriate cognitive, emotional, and behavioral skills necessary for maturation, and to improve mental health conditions affecting quality of life across multiple domains (e.g. home, school, community). Services incorporate client and family voice and choice, and are provided in collaboration with child serving systems, agencies and other individuals involved with the child/youth (such as schools, probation, child welfare, health care, etc.). Families maintain a high level of decision-making power and are encouraged to use their natural supports.

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

In FY 2023-24 the 16th FIT was added. This site, administered by Heartland Child and Family Services, was designed to partner with Community Based Organizations in underserved zip codes. HeartLand Child and Family Services set up their central location and established partnerships in traditionally underserved zip codes serving families early 2024.

Success: Flexible Integrated Treatment – UC Davis CAARE Center
The Child and Adolescent Abuse Resource and Evaluation (CAARE) Center successfully transitioned to adult mental health system provider a young adult who had started services as a young teen in children's services. This process can be quite scary for a young person who has built a strong relationship with their provider. The Client expressed her appreciation for the team's support. Client received supportive services in advance with housing, education, and budgeting, including navigating her return to college. We supported her with obtaining housing with flex funds, supported her through the apartment inspections, and provided psychoeducation on the importance of maintaining good relationships with landlord and having a good rental history. The CAARE team collaborated to ensure the client's transition was a warm handoff and the client received resources to meet her immediate needs. With this support, the client experienced true partnership and further developed her autonomy.

Success: Flexible Integrated Treatment - Capital Star Community Services

Capital Star FIT, A Clinician, a Family Specialist and a Resource Specialist worked with a 6-year-old female who was struggling several days per week for nearly a year with emotional regulation and experiencing anger outbursts, yelling, hitting, kicking and biting. In addition, she was having relationship challenges with her brother and struggling with following adult directives. Caregiver implemented strategies to decrease the client's emotional outbursts taught during in-home rehabilitation sessions. In addition, the caregiver created a custom chore chart and reward system to help client increase motivation and sleep in her own bed. The client engaged in therapy and learned to express her emotions, identify triggers, and utilize her coping skills. Further, the family developed a housing plan, and the caregiver learned to use the budgeting skills taught by the Resource Specialist to ensure housing stability. At the end of the services, the client showed increased functioning in her home and emotional environments. The client graduated from services with Capital Star FIT in August 2024 after successfully reaching her treatment goals.

Success: Flexible Integrated Treatment - Dignity

Our clinicians and case managers provided services for an 8 year old male youth experiencing significant symptoms of anxiety, which worsened after his caregiver lost employment and was at risk of losing housing due to lack of income. Our team was able to support the family with MHSA flex funding to cover the gap in rent while we also supported the caregiver in vocational development and searching for employment. With the support of flex funding, the family's housing was stabilized while we assisted the caregiver in finding full time work. The caregiver successfully found employment and was able to cover the cost of her rent, no longer needing support with housing. As a result of the family's stabilized housing situation, the client's anxiety symptoms significantly reduced, and he was able to graduate from our services and we ensured they knew how to access services again in the future if they are in need.

Success: Flexible Integrated Treatment - HeartLand

A 7-year-old client and her mother were referred a year ago. Youth was struggling with anxiety, impulse control issues, family functioning issues, and poor social skills at school. The clinician put together a supportive team for the family including a behavioral specialist, family advocate, and the housing staff. The behavioral specialist was able to aid the youth in finding fun in being at school. With the reduction of the anxiety, the youth was able to see peers as not scary and to be avoided but fun and to be joined in with. The youth now has a small group of friends she plays with on the playground and is enjoying school. The family advocate with lived experience was added to aid the caregiver in supporting the youth in making friends and supporting her in finding school to be enjoyable. Some of this happened by helping the mother to decrease her own anxiety. The housing team assisted by connecting the caregiver to community supports to address past trauma and shared information with mom about a group to aid with financial education. The housing team was able to work with the caregiver to access the Department of Human Assistance program to get the family payment for a hotel for 14 days, as the mother and youth were now homeless after leaving the previous environment. The housing team also supported mother in getting a job that increased her income, enabling her to get an apartment. The team was ready to support the caregiver with additional hotel payments, but mother was able to afford to pay for it herself due to the very short time it took and her new job. The family was able to get into a new apartment in less than a month and is now stably housed, in an apartment of their own.

Success: Flexible Integrated Treatment - La Familia

A 14-year-old Mexican American female youth was referred to mental health services after being hospitalized. The client was experiencing various depressive symptoms that had been impacting her wellbeing, family functioning, and school functioning. The client had stopped attending school for several months prior to the referral and the caregiver was unsure how to support the client. Throughout their time in services, the caregiver was connected to Family Advocate services to support the strengthening of positive parenting tools and to empower the caregiver's role in supporting the client. The client received weekly therapy services to support the decrease of symptoms as well as psychiatric services to support client's mood and sleep. Client has returned to school full-time and has reported having decreased symptoms. The client no longer engages in behaviors that led to hospitalization and now has various hobbies she engages in and reports she enjoys being back at school and seeing her friends. The client reports an overall sense of serenity and is beginning to feel confident in public spaces and engaging with others. Although our work is not done, the client's wellbeing has greatly increased and allows her and her family the space to enjoy the daily joys of life and adolescence.

Success: Flexible Integrated Treatment – Pacific Clinics

A 4-year-old African American male and his caregiver came to the clinic as a walk-in for symptoms related to trauma. The treatment team included a Clinician, Behavior Specialist, and Peer Advocate to support the youth and his caregiver in reducing the impact of the client's symptoms. The caregiver shared that the client had lost school placement at five preschools due to his symptoms and the caregiver soon lost her job due to missing work because of the frequent calls to collect her son from preschool. FIT's Peer Advocate worked closely with the caregiver to link her to mental health services for depression and to develop a housing plan to support with past due rent. Unfortunately, despite the best efforts of the caregiver and the team, the lending office initiated the eviction process, and the client and caregiver faced imminent homelessness. The Peer Advocate linked the caregiver with a pro-bono lawyer and with the support and collaboration of our clinical care team, Sacramento County Behavioral Health, and MHSA flex funds. The team was successful in paying all the back-owed rent and all the court fees so that the caregiver would not have an eviction on her rental record, which would have made obtaining new housing very difficult. The caregiver and client are now in temporary housing while our Peer Advocate works with community programs to help the family obtain affordable housing. The caregiver is now employed full-time and has shared that the client's symptoms have improved significantly both at home and at school.

Success: Flexible Integrated Treatment - River Oak

A 15-year-old was referred due to concerns about depression and suicidal ideation. The family had lost their housing to financial instability caused by loss of income. Because they had extremely limited resources, they were not able to afford storage to keep their furniture or many of their personal possessions. With support of the Housing and Benefits Coordinator (HBC), Mom was connected to multiple community and housing resources, including Birth and Beyond Family Resource Center (FRC) to assist with the family's financial, housing and food insecurities. With HBC support, Mom secured affordable housing through SHRA. MHSA funds were utilized to support with rent and utilities to stabilize the family's housing while the HBC supported Mom with exploring employment opportunities and budgeting to build a sustainability plan. HBC coordinated with FRC Intervention Specialist to successfully connect Mom with furniture resources. The family was able to get basic furniture and new beds for each of the children in the home. Mom gained employment and MHSA flex funding continued to support with rent and utilities so Mom could build-up funds to stabilize her family and maintain housing. The youth's most recent assessment indicates a reduction in depression, anxiety, and suicidal ideation. Youth now has a sense of stability which allows them to focus on school.

Success: Flexible Integrated Treatment – Sacramento Children's Home

A 13-year-old Latina American was referred to Sacramento Children's Home (SCH) FIT by caregiver in 2023 to address concerns related to post-traumatic stress disorder (PTSD). Client presented with irritability, low concentration, low interest in activities, avoidance, sleep disruption, and negative thinking. Client and her family were temporarily staying with extended family but became unhoused after family conflict. To avoid exacerbating the client's symptoms of PTSD, SCH FIT utilized MHSA flex funds to pay for a temporary stay at a hotel. Caregiver then used all her employment income for a security deposit at a new residence so was unable to also pay all of their first two months of rent. SCH provided MHSA flex funds to pay a portion of their first two months of rent to avoid becoming unhoused again. Housing stability provided client and family with the opportunity to focus fully on participating in individual therapy for client to target symptoms of PTSD and skill building with a Youth Peer Mentor who taught healthy coping skills and helped her destigmatize mental health while reinforcing hope for the future. Caregiver also received parenting support (i.e. psychoeducation regarding client's needs and helpful ways to respond), advocacy support in securing and maintaining safe and stable housing, and assistance linking to various resources in the community. Client made significant progress in reducing symptoms of PTSD and successfully discharged from the program in 2024.

Success: Flexible Integrated Treatment – Stanford Sierra Youth & Families
An 8 year old male was referred for services due to physical and verbal aggression, negative behaviors, and making negative self-statements. Client's mental health was severely impacted by inability to live with his primary caregiver. The program provided psychiatry and medication support, housing support, case coordination, skill building, and family partner support.

A referral was made for a Housing Navigator after the caregiver lost stable employment and received an eviction notice due to non-payment of rent. The Housing Navigator enrolled the family in the Homeless Management Information System (HMIS) and immediately began seeking resources. A plan was developed in a Child and Family Team (CFT) Meeting to immediately stabilize housing and decrease risk of imminent homelessness by using MHSA flex funds to pay past due rent and legal fees associated with the eviction. The Housing Navigator also worked closely with the caregiver and landlord to create an agreement that stopped the eviction process.

The housing stability achieved by using MHSA flex funds allowed caregiver to focus on employment and the FIT team connected caregiver to multiple job opportunities. Caregiver now maintains a stable budget, can save money, and is maintaining secure housing. Client is now living with caregiver full time and no longer moves between multiple family members which has significantly reduced symptoms. Client is utilizing learned skills at home and school and is actively working towards graduation from the program.

Success: Flexible Integrated Treatment - Turning Point
The Turning Point FIT (Flexible Integrated Treatment) program has provided direct support through MHSA Flex Funds to address an urgent housing need, which had put a 13-year-old African American client and his caregiver at risk of eviction. This situation had the potential to hinder the client's progress in treatment, so the caregiver's request for support was promptly addressed. MHSA flex funds were accessed to bring the family up to date on their rent, effectively stabilizing their housing situation and ensuring continuity of care. The client actively participated in rehabilitation and medication management services to address his behavioral health challenges, while caregiver received collateral support to assist in maintaining the client's mental wellbeing. The stabilization of housing has been instrumental in preventing any disruptions in the client's care. Despite the initial challenges, the client has made remarkable progress, successfully transitioning to high school and recently expressed a positive outlook by requesting a cessation of services.

Program: Mental Health Urgent Care Clinic
Work Plan #/Type: SAC11 – General System Development (GSD)
FY 2025-26 Capacity: 7,800 served annually
Ages Served: 15% Children, 19% TAY, 60% Adults, 6% Older Adults

The **Mental Health Urgent Care Clinic (MHUCC)** originated from the time-limited MHSA Innovation (INN) Project 2. With support from the MHSA Steering Committee, the services in this project transitioned to Community Support Services (CSS) funding in FY 2022-23. MHUCC, administered by Turning Point Community Programs, provides 24/7 voluntary and immediate access to short-term crisis intervention services, including integrated services for co-occurring substance use disorders, to individuals of all age groups (children, TAY, adults, and older adults) who are experiencing a mental health crisis. Staff are reflective of the cultural, racial, ethnic, and linguistically diverse population of Sacramento County and are a collaborative team comprised of psychiatrists, nurses, clinicians, and

Success: Mental Health Crisis/Urgent Care Clinic
A 58 yrs old Asian Indian female client was brought in by son for a potential medication consult. The client was engaged by a clinician who speaks Hindi. The client had previously received psychiatric treatment for a few years in India after the death of her husband. During the assessment, it was found that the client had recently joined her only son in California and is having adjustment issues due to her missing social support system. The clinician met with both Mom and Son, allowing client to process her emotions in her native language, and client got consultation from the doctor onsite. As she completed the services, the client shared with the clinician that she felt relieved after talking to someone in her own language. She stated that she was so scared when she came to MHUCC, but her anxiety went away as her cultural and linguistic needs were accommodated.

peers. Services are designed to provide an alternative to emergency department (ED) visits for individuals with immediate mental health needs. Services include a multi-disciplinary mental health assessment with a focus on wellness and recovery, and linkage to ongoing community services. Interventions assist with decreasing unnecessary and lengthy involuntary inpatient treatment while increasing access to culturally competent care in a voluntary setting. The clinic is certified as a Medi-Cal outpatient clinic and has the ability to provide mental health services and supports to at least 650 clients per month.

Program: Family Full Service Partnership
Work Plan #/Type: SAC12 – Full Service Partnership (FSP)
FY 2025-26 Capacity: 120 at any given time
Ages Served: Children (age 0-21), Adult Parents/Caregivers of Children (age 0-21) and their families

The **Family Full Service Partnership (FSP)** is administered by HeartLand Child & Family Services. The Family Full Service Partnership serves children and TAY, and their immediate family, as well as adults with at least one child under age 21 who either lives in the home or will be imminently living in the home. At least one person in the family must consent to receive FSP services and meet the target population and medical necessity criteria as defined by BHS. The Family Full Service Partnership targets complex family dynamics, including but not limited to: homelessness; involvement with the criminal justice system; co-occurring substance use disorder; co-occurring eating disorder or disordered eating symptoms in youth; frequent psychiatric hospitalizations; frequent incarcerations; vulnerabilities and risks associated with poverty; intergenerational trauma that includes high Adverse Childhood Experiences (ACEs) screening scores; factors found in the school to prison pipeline; domestic violence; and court-ordered mental health treatment. Services are comprehensive and are provided in the home, community, school, or office depending on client need. Using a harm reduction “whatever it takes” approach, the Family Full Service Partnership assists families in maintaining stability in the community. Families with children are offered culturally diverse and linguistically appropriate supportive services so they can stay together and be part of the community.

In fiscal year 2023-2024, The Family Full Service Partnership exceeded contract requirements in the number of individuals served, and the County realized the need to support more individuals. In fiscal year 2024-2025, the increase in numbers of individuals served from 120 to 170 was approved in order to serve more individuals and family systems.

Success: Family FSP
A family was referred to Family FSP due to being unhoused and having significant parent-child conflict. The caregiver was struggling with a history of substance use, housing instability, and limited access to employment resources. The client (child) was struggling at school behaviorally and academically, unable to emotionally regulate, was impulsive, and had trouble communicating her feelings. The treatment team supported mom to empower her to find her confidence in parenting skills and set clear expectations for the client, which helped client feel safe and secure. The FSP team worked with the client to build communication skills at home and school, while working with Mom to self-regulate and support the client in self-regulating as well. The client's behaviors at home and at school have improved significantly. As stated, when this family came to Heartland, they were unhoused, but they have been housed since November 2023. Mom was able to access a job at a college, and the housing team is currently working with mom to help her get into a low-income apartment to provide long term stability. Client and Mom's relationship has improved, and they are doing activities with one another such as art and spending time with each other. The client is less impulsive and is problem-solving before acting out. With the support of Family FSP, family members were able to increase their autonomy, build their confidence in one another and individually, and are now working towards stability and graduation from services.

CSS Administration and Program Support

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

The table below contains the FY 2025-26 Cost per Client information for implemented programs:

FY2025-26 CSS COMPONENT Work Plan / Program	Average Cost/Client*	Budget Amount
SAC1 - GSD: Community Opportunities for Recovery and Engagement	$ 5,546	$ 63,572,999
SAC2 - FSP: Sierra Elder Wellness	$ 23,943	$ 3,591,512
SAC3 - FSP: Permanent Supportive Housing	$ 25,897	$ 27,890,765
SAC4 - FSP: Transcultural Wellness Center	$ 13,755	$ 3,521,337
SAC5 - GSD: Wellness and Recovery	$ 1,272	$ 3,021,007
SAC6 - FSP: Adult Full Service Partnership	$ 26,398	$ 19,244,414
SAC7 - FSP: Juvenile Justice Diversion and Treatment	$ 36,423	$ 4,771,451
SAC8 - FSP: TAY Full Service Partnership	$ 15,406	$ 5,099,242
SAC9 - GSD: Crisis Residential	$ 4,849	$ 10,419,576
SAC10 - GSD: Children's Community Mental Health Services	$ 1,301	$ 79,340,990
SAC11 - GSD: Mental Health Urgent Care Clinic	$ 10,172	$ 6,093,847
SAC12 - FSP: Family FSP	$ 54,446	$ 6,533,514
TOTAL		**$ 233,100,653**

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

Full-Service Partnership (FSP) Program Outcomes FY 2023-24

In FY 2023-24, the county's Full-Service Partnership (FSPs) programs served 3,147 partners, 463 more than the previous fiscal year.[1] FSPs showed considerable progress in assisting partners with mental health and/or substance use disorders to navigate their conditions effectively and reducing negative outcomes accordingly. The section below on *Demographics* examines current outcomes utilizing the County's electronic health record (SmartCare) for all partners served at any given time in FY 2023-24. The section following *Demographics* is called *Outcomes Over Time* and examines partners who have been receiving services in an FSP for an entire year, and up to two years for some outcomes, using the year prior to FSP participation as the comparison period (baseline). The *Outcomes Over Time* data was collected utilizing the California State Behavioral Health Information System's (BHIS) Data Collection and Reporting (DCR) application. Progress for these partners is summarized in *percent change* from baseline (one year prior to enrollment to an FSP).

FSPs aid people with mental health and/or substance use disorders manage their conditions successfully. Sacramento County provides recovery-oriented treatment services including screening, assessment, clinical case management, individual/group therapy, and medication management.

Demographics Main Points

- **Age:** More than half of partners served were adults in the 26-59 years age category (57.2%). The TAY age group (16-25 years) made up 17.9% and older adults (60 or more years) represented 18.5%. Children (ages 15 years or less) made up the remainder of those served (6.5%).
- **Gender/Sexual Orientation:** Overall, more men were served (54.9%) than women (45.1%). Most partners identified as "Heterosexual/Straight" (58.8%), followed by "Unknown/Not Reported" (34.3%).
- **Race:** Sacramento County's FSPs served partners from various racial backgrounds and just under one-third (33%) of partners reported their race as White/Caucasian, followed by 32% who reported being Black/African American.
- **Primary Language:** The primary language utilized by partners is English at just over 90% (93.5%).
- **Primary Diagnosis:** Nearly 30% (28.4%) of partners had a primary diagnosis of Schizoaffective Disorder, followed by Schizophrenia (19.8%) and Major Depressive Disorder (15.4%).
- **Discharges:** Just over 22% (22.4%) of discharged partners were discharged as "Disengaged from services/Non-compliant with treatment", followed by "Successful completion" (11.5%) and closely thereafter by "Never engaged in services" (11.4%).
- **Employment:** Nearly 40% (39.7%) of partners are "Disabled not in workforce", followed by "Unknown/Not Reported at 16.2, then "Other not in labor force" (15.9%). Students made up the next largest designation at just over 15% (15.1%).

[1] Data extracted from Sacramento County's Electronic Health Record SmartCare 08.16.2024, and from the California State Behavioral Health Information System's (BHIS) Data Collection and Reporting application for *Outcomes Over Time* 08.23.2024. This data excludes Community Justice Support Program (CJSP) FSP partners (n=310) that are reported separately.

Outcomes Over Time

Outcomes over time were examined for partners who had been in an FSP for at least two years. The baseline data (one year prior to enrollment) was compared to the partners first year in the program and the partners second year.

- The number of partners who reported being homeless at baseline decreased by nearly 65% in the first year of enrollment, and nearly 80% in the second year.
- The number of partners who reported mental health emergency room visits and/or mental health with substance abuse at baseline decreased by 60% in the first year of enrollment, and then to just over 68% in the second year.
- Psychiatric/psychiatric hospitalizations decreased by over 21% in the first year of enrollment and by 50% in the second year.
- The number of partners who self-reported being arrested at baseline decreased by nearly 65% in the first year of enrollment and subsequently decreased by nearly 81% in the second year.
- The number of partners incarcerated at baseline decreased by almost 31% in the first year of enrollment and by nearly 78% in the second year.
- Just over 23% of those who declared they wanted to be employed as part of their recovery goal.

Demographics

Graph: Total Served by Program (n and %)

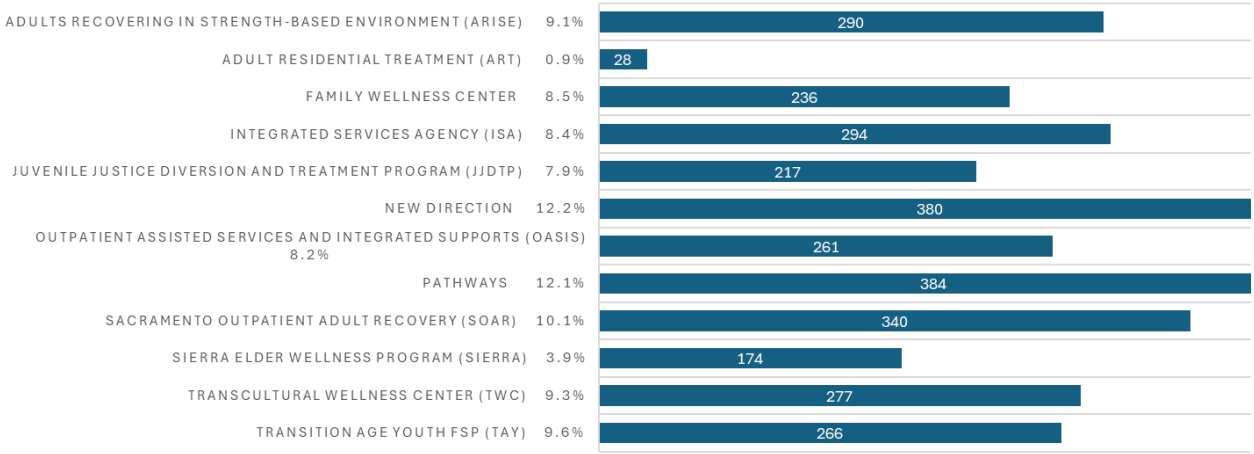


Table: Age Group

Program Name	Age 0-15		Age 16-25		Age 26-59		Age 60+		Total	
	n	%	n	%	n	%	n	%	n	%
Adult Residential Treatment (ART)	0	0.0%	2	0.1%	23	0.7%	3	0.1%	28	0.9%
Adults Recovering in Strength-based Environment (ARISE)	0	0.0%	9	0.3%	246	7.8%	35	1.1%	290	9.2%
Family Wellness Center (FWC)	103	3.3%	57	1.8%	72	2.3%	4	0.1%	236	7.5%
Integrated Services Agency (ISA)	0	0.0%	2	0.1%	229	7.3%	63	2.0%	294	9.3%
Juvenile Justice Diversion and Treatment Program (JJDTP)	60	1.9%	157	5.0%	0	0.0%	0	0.0%	217	6.9%
New Direction	0	0.0%	6	0.2%	273	8.7%	101	3.2%	380	12.1%
Outpatient Assisted Services and Integrated Support (OASIS)	0	0.0%	20	0.6%	212	6.7%	29	0.9%	261	8.3%
Pathways	23	0.7%	17	0.5%	275	8.7%	69	2.2%	384	12.2%
Sacramento Outpatient Adult Recovery (SOAR)	0	0.0%	1	0.0%	279	8.9%	60	1.9%	340	10.8%
Sierra Elder Wellness Program (Sierra)	0	0.0%	0	0.0%	10	0.3%	164	5.2%	174	5.5%
Transcultural Wellness Center (TWC)	17	0.5%	32	1.0%	176	5.6%	52	1.7%	277	8.8%
Transitional Age Youth FSP (TAY)	0	0.0%	260	8.3%	5	0.2%	1	0.0%	266	8.5%
Grand Total	**203**	**6.5%**	**563**	**17.9%**	**1800**	**57.2%**	**581**	**18.5%**	**3147**	**100%**

Table: Sex

Program Name	Female		Male		Total	
	n	%	n	%	n	%
Adult Residential Treatment (ART)	15	0.5%	13	0.4%	28	0.9%
Adults Recovering in Strength-based Environment (ARISE)	113	3.6%	177	5.6%	290	9.2%
Family Wellness Center (FWC)	146	4.6%	90	2.9%	236	7.5%
Integrated Services Agency (ISA)	116	3.7%	178	5.7%	294	9.3%
Juvenile Justice Diversion and Treatment Program (JJDTP)	50	1.6%	167	5.3%	217	6.9%
New Direction	161	5.1%	219	7.0%	380	12.1%
Outpatient Assisted Services and Integrated Support (OASIS)	100	3.2%	161	5.1%	261	8.3%
Pathways	198	6.3%	186	5.9%	384	12.2%
Sacramento Outpatient Adult Recovery (SOAR)	155	4.9%	185	5.9%	340	10.8%
Sierra Elder Wellness Program (Sierra)	94	3.0%	80	2.5%	174	5.5%
Transcultural Wellness Center (TWC)	123	3.9%	154	4.9%	277	8.8%
Transitional Age Youth FSP (TAY)	148	4.7%	118	3.7%	266	8.5%
Grand Total	**1419**	**45.1%**	**1728**	**54.9%**	**3147**	**100%**

Table: Sexual Orientation

Program Name	Bisexual		Gay (Male)		Heterosexual /Straight		Lesbian (Female)		Transgender		Unknown/Not Reported		Unsure/ Questioning		Total	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Adult Residential Treatment (ART)	1	0.0%	0	0.0%	15	0.5%	1	0.0%	2	0.1%	9	0.3%	0	0.0%	28	0.9%
Adults Recovering in Strength-based Environment (ARISE)	10	0.3%	4	0.1%	156	5.0%	2	0.1%	1	0.0%	117	3.7%	0	0.0%	290	9.2%
Family Wellness Center (FWC)	12	0.4%	2	0.1%	158	5.0%	6	0.2%	0	0.0%	46	1.5%	12	0.4%	236	7.5%
Integrated Services Agency (ISA)	4	0.1%	0	0.0%	176	5.6%	1	0.0%	1	0.0%	110	3.5%	2	0.1%	294	9.3%
Juvenile Justice Diversion and Treatment Program (JJDTP)	2	0.1%	0	0.0%	67	2.1%	2	0.1%	0	0.0%	145	4.6%	1	0.0%	217	6.9%
New Direction	5	0.2%	1	0.0%	154	4.9%	2	0.1%	0	0.0%	217	6.9%	1	0.0%	380	12.1%
Outpatient Assisted Services and Integrated Support (OASIS)	11	0.3%	2	0.1%	179	5.7%	3	0.1%	0	0.0%	66	2.1%	0	0.0%	261	8.3%
Pathways	20	0.6%	7	0.2%	295	9.4%	6	0.2%	0	0.0%	54	1.7%	2	0.1%	384	12.2%
Sacramento Outpatient Adult Recovery (SOAR)	3	0.1%	1	0.0%	116	3.7%	0	0.0%	1	0.0%	216	6.9%	3	0.1%	340	10.8%
Sierra Elder Wellness Program (Sierra)	0	0.0%	2	0.1%	153	4.9%	0	0.0%	1	0.0%	18	0.6%	0	0.0%	174	5.5%
Transcultural Wellness Center (TWC)	7	0.2%	1	0.0%	243	7.7%	8	0.3%	2	0.1%	13	0.4%	3	0.1%	277	8.8%
Transitional Age Youth FSP (TAY)	33	1.0%	7	0.2%	139	4.4%	4	0.1%	3	0.1%	67	2.1%	13	0.4%	266	8.5%
Grand Total	**108**	**3.4%**	**27**	**0.9%**	**1851**	**58.8%**	**35**	**1.1%**	**11**	**0.3%**	**1078**	**34.3%**	**37**	**1.2%**	**3147**	**100%**

Table: Race

Program	Alaskan Native		American Indian		Black/ African American		Multiracial		Other		Unknown/ Not Reported		White/ Caucasian		Hispanic/ Latinx		Asian/PI		Total	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Adult Residential Treatment (ART)	0	0.00%	1	0.04%	8	0.23%	3	0.11%	1	0.04%	1	0.04%	12	0.39%	2	0.04%	0	0.00%	28	0.87%
Adults Recovering in Strength-based Environment (ARISE)	1	0.04%	10	0.28%	87	2.71%	17	0.49%	10	0.34%	12	0.36%	111	3.45%	31	0.99%	11	0.40%	290	9.05%
Family Wellness Center (FWC)	2	0.07%	9	0.33%	82	2.92%	17	0.62%	13	0.47%	24	0.85%	51	1.81%	31	1.12%	7	0.26%	236	8.46%
Integrated Services Agency (ISA)	2	0.04%	7	0.24%	80	2.30%	13	0.38%	8	0.28%	6	0.16%	122	3.45%	34	0.87%	22	0.64%	294	8.35%
Juvenile Justice Diversion and Treatment Program (JJDTP)	1	0.04%	6	0.22%	116	4.22%	20	0.73%	4	0.15%	13	0.48%	33	1.20%	19	0.69%	5	0.18%	217	7.90%
New Direction	2	0.04%	11	0.28%	136	4.43%	11	0.36%	5	0.17%	13	0.43%	163	5.30%	27	0.83%	12	0.39%	380	12.23%
Outpatient Assisted Services and Integrated Support (OASIS)	2	0.07%	22	0.69%	94	2.92%	13	0.41%	2	0.07%	7	0.25%	83	2.59%	21	0.66%	17	0.56%	261	8.22%
Pathways	0	0.00%	16	0.52%	151	4.62%	14	0.42%	8	0.25%	6	0.22%	149	4.86%	26	0.81%	14	0.41%	384	12.10%
Sacramento Outpatient Adult Recovery (SOAR)	0	0.00%	12	0.41%	102	3.06%	13	0.45%	9	0.27%	11	0.39%	141	4.05%	33	0.91%	19	0.51%	340	10.06%
Sierra Elder Wellness Program (Sierra)	0	0.00%	4	0.07%	45	1.03%	2	0.06%	5	0.06%	9	0.28%	96	2.07%	9	0.28%	4	0.07%	174	3.92%
Transcultural Wellness Center (TWC)	2	0.07%	3	0.09%	30	0.94%	10	0.31%	9	0.29%	5	0.17%	18	0.54%	12	0.42%	188	6.42%	277	9.26%
Transitional Age Youth FSP (TAY)	10	0.36%	12	0.43%	99	3.55%	17	0.61%	12	0.44%	13	0.47%	64	2.32%	32	1.15%	7	0.25%	266	9.58%
Grand Total	**22**	**0.72%**	**113**	**3.59%**	**1030**	**32.92%**	**150**	**4.94%**	**86**	**2.82%**	**120**	**4.09%**	**1043**	**32.04%**	**277**	**8.78%**	**306**	**10.09%**	**3147**	**100%**

Sacramento County MHSA Fiscal Year 2025-26 Annual Update

Table: Primary Language

Program Name	Arabic		English		Russian		Spanish		Unknown/Not Reported		Asian Languages		Other		Total	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Adults Recovering in Strength-based Environment (ARISE)	0	0.0%	28	0.9%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	28	0.9%
Adult Residential Treatment (ART)	0	0.0%	284	9.0%	0	0.0%	3	0.1%	1	0.0%	2	0.1%	0	0.0%	290	9.2%
Family Wellness Center	0	0.0%	221	7.0%	0	0.0%	7	0.2%	7	0.2%	1	0.0%	0	0.0%	236	7.5%
Integrated Services Agency (ISA)	0	0.0%	283	9.0%	4	0.1%	3	0.1%	0	0.0%	4	0.1%	0	0.0%	294	9.3%
Juvenile Justice Diversion and Treatment Program (JJDTP)	0	0.0%	206	6.5%	0	0.0%	4	0.1%	7	0.2%	0	0.0%	0	0.0%	217	6.9%
New Direction	0	0.0%	372	11.8%	0	0.0%	3	0.1%	3	0.1%	1	0.0%	1	0.0%	380	12.1%
Outpatient Assisted Services and Integrated Supports (OASIS)	0	0.0%	260	8.3%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.0%	261	8.3%
Pathways	0	0.0%	380	12.1%	0	0.0%	1	0.0%	3	0.1%	0	0.0%	0	0.0%	384	12.2%
Sacramento Outpatient Adult Recovery (SOAR)	0	0.0%	329	10.5%	3	0.1%	4	0.1%	0	0.0%	3	0.1%	1	0.0%	340	10.8%
Sierra Elder Wellness Program (Sierra)	0	0.0%	167	5.3%	1	0.0%	2	0.1%	3	0.1%	0	0.0%	1	0.0%	174	5.5%
Transcultural Wellness Center (TWC)	4	0.1%	163	5.2%	2	0.1%	6	0.2%	0	0.0%	95	3.0%	7	0.2%	277	8.8%
Transition Age Youth FSP (TAY)	0	0.0%	251	8.0%	0	0.0%	2	0.1%	11	0.3%	1	0.0%	1	0.0%	266	8.5%
Grand Total	**4**	**0.1%**	**2944**	**93.5%**	**10**	**0.3%**	**35**	**1.1%**	**35**	**1.1%**	**107**	**3.4%**	**12**	**0.4%**	**3147**	**100%**

Asian languages include: Cambodian, Cantonese, Hmong, Japanese, Korean, Lao, Vietnamese, Mandarin, Mien, Other Chinese, Tagalog, and Thai.

Sacramento County MHSA Fiscal Year 2025-26 Annual Update

Table: Current Housing Status

Program Name	Homeless-Bridge/ Interim		Homeless-Sheltered		Housed/No Imminent Risk of Homelessness		Imminent Risk for Homelessness		Literally Homeless-Chronic Homelessness		Literally Homeless-Not Chronic Homeless		Not Reported		Transitional Temporary Housing		Total	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Adults Recovering in Strength-based Environment (ARISE)	0	0.0%	0	0.0%	12	0%	1	0.0%	0	0.0%	0	0.0%	15	0.5%	0	0.0%	28	0.9%
Adult Residential Treatment (ART)	0	0.0%	3	0.1%	184	6%	10	0.3%	11	0.3%	7	0.2%	75	2.4%	0	0.0%	290	9.2%
Family Wellness Center	0	0.0%	16	0.5%	107	3%	7	0.2%	0	0.0%	1	0.0%	105	3.3%	0	0.0%	236	7.5%
Integrated Services Agency (ISA)	0	0.0%	1	0.0%	208	7%	6	0.2%	11	0.3%	4	0.1%	64	2.0%	0	0.0%	294	9.3%
Juvenile Justice Diversion and Treatment Program (JJDTP)	0	0.0%	0	0.0%	90	3%	5	0.2%	3	0.1%	0	0.0%	119	3.8%	0	0.0%	217	6.9%
New Direction	2	0.1%	21	0.7%	270	9%	15	0.5%	22	0.7%	10	0.3%	40	1.3%	0	0.0%	380	12.1%
Outpatient Assisted Services and Integrated Supports (OASIS)	0	0.0%	4	0.1%	109	3%	19	0.6%	18	0.6%	22	0.7%	89	2.8%	0	0.0%	261	8.3%
Pathways	0	0.0%	40	1.3%	243	8%	3	0.1%	13	0.4%	23	0.7%	62	2.0%	0	0.0%	384	12.2%
Sacramento Outpatient Adult Recovery (SOAR)	1	0.0%	2	0.1%	232	7%	5	0.2%	9	0.3%	12	0.4%	78	2.5%	1	0.0%	340	10.8%
Sierra Elder Wellness Program (Sierra)	0	0.0%	0	0.0%	103	3%	32	1.0%	9	0.3%	1	0.0%	29	0.9%	0	0.0%	174	5.5%
Transcultural Wellness Center (TWC)	0	0.0%	25	0.8%	164	5%	2	0.1%	3	0.1%	2	0.1%	81	2.6%	0	0.0%	277	8.8%
Transition Age Youth FSP (TAY)	0	0.0%	3	0.1%	89	3%	21	0.7%	24	0.8%	28	0.9%	101	3.2%	0	0.0%	266	8.5%
Grand Total	**3**	**0.1%**	**115**	**3.7%**	**1811**	**57.5%**	**126**	**4.0%**	**123**	**3.9%**	**110**	**3.5%**	**858**	**27.3%**	**1**	**0.0%**	**3147**	**100%**

Note: Data is extracted from the special population section in SmartCare

Sacramento County MHSA Fiscal Year 2025-26 Annual Update

Table: Military Status

Program Name	No		Yes		Unknown/ Not Reported		Total	
	n	%	n	%	n	%	n	%
Adult Residential Treatment (ART)	1	0.0%	0	0.0%	27	0.9%	28	0.9%
Adults Recovering in Strength-based Environment (ARISE)	52	1.7%	0	0.0%	238	7.6%	290	9.2%
Family Wellness Center	158	5.0%	0	0.0%	78	2.5%	236	7.5%
Integrated Services Agency (ISA)	35	1.1%	1	0.0%	258	8.2%	294	9.3%
Juvenile Justice Diversion and Treatment Program (JJDTP)	26	0.8%	0	0.0%	191	6.1%	217	6.9%
New Direction	33	1.0%	0	0.0%	347	11.0%	380	12.1%
Pathways	44	1.4%	1	0.0%	339	10.8%	384	12.2%
Sacramento Outpatient Adult Recovery (SOAR)	52	1.7%	0	0.0%	288	9.2%	340	10.8%
Sierra Elder Wellness Program (Sierra)	11	0.3%	0	0.0%	163	5.2%	174	5.5%
Outpatient Assisted Services and Integrated Supports (OASIS)	59	1.9%	1	0.0%	201	6.4%	261	8.3%
Transcultural Wellness Center (TWC)	133	4.2%	2	0.1%	142	4.5%	277	8.8%
Transitional Age Youth FSP (TAY)	69	2.2%	0	0.0%	197	6.3%	266	8.5%
Grand Total	**673**	**21.4%**	**5**	**0.2%**	**2469**	**78.5%**	**3147**	**100%**

Sacramento County MHSA Fiscal Year 2025-26 Annual Update

Table: Primary Diagnosis Across All Programs

Diagnosis	n	%
ADHD	56	1.8%
Adjustment disorder	42	1.3%
Bipolar	349	11.1%
Borderline personality disorder	23	0.7%
Conduct disorder	8	0.3%
Depressive disorder	47	1.5%
Disruptive mood disorder	26	0.8%
Encounter for observation for other suspected diseases and conditions ruled ou	20	0.6%
Generalized anxiety disorder	41	1.3%
Major depressive disorder	485	15.4%
Other	65	2.1%
Paranoid schizophrenia	32	1.0%
Problems related to other legal circumstances	13	0.4%
PTSD	393	12.5%
Schizoaffective disorder	894	28.4%
Schizophrenia	624	19.8%
Unknown/Not Reported	4	0.1%
Unspecified psychosis not due to a substance or known physiological condition	25	0.8%
Grand Total	**3147**	**100%**

FSPs are intended to use a "whatever it takes" approach to services, offering a broad range of services from the traditional medication management and crisis services, to more non-traditional services, such as housing and alternative healing practices.

Table: Employment

Program Name	Disabled Not in Workforce		Employed Full Time		Employed Part-Time		Other-Not in Workforce		Student		Unemployed-Not Seeking Work		Unemployed-Seeking Work		Unknown/ Not Reported		Total	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Adult Residential Treatment (ART)	25	0.8%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.0%	2	0.1%	28	0.9%
Adults Recovering in Strength-based Environment (ARISE)	204	6.5%	2	0.1%	3	0.1%	39	1.2%	1	0.0%	4	0.1%	15	0.5%	22	0.7%	290	9.2%
Family Wellness Center (FWC)	10	0.3%	10	0.3%	9	0.3%	10	0.3%	129	4.1%	13	0.4%	22	0.7%	33	1.0%	236	7.5%
Integrated Services Agency (ISA)	127	4.0%	1	0.0%	3	0.1%	68	2.2%	5	0.2%	3	0.1%	22	0.7%	65	2.1%	294	9.3%
Juvenile Justice Diversion and Treatment Program (JJDTP)	1	0.0%	0	0.0%	1	0.0%	1	0.0%	185	5.9%	0	0.0%	4	0.1%	25	0.8%	217	6.9%
New Direction	155	4.9%	1	0.0%	6	0.2%	67	2.1%	4	0.1%	3	0.1%	46	1.5%	98	3.1%	380	12.1%
Outpatient Assisted Services and Integrated Support (OASIS)	229	7.3%	1	0.0%	2	0.1%	9	0.3%	1	0.0%	1	0.0%	8	0.3%	10	0.3%	261	8.3%
Pathways	108	3.4%	4	0.1%	12	0.4%	124	3.9%	28	0.9%	8	0.3%	42	1.3%	58	1.8%	384	12.2%
Sacramento Outpatient Adult Recovery (SOAR)	195	6.2%	3	0.1%	4	0.1%	72	2.3%	0	0.0%	2	0.1%	19	0.6%	45	1.4%	340	10.8%
Sierra Elder Wellness Program (Sierra)	81	2.6%	0	0.0%	1	0.0%	50	1.6%	0	0.0%	2	0.1%	5	0.2%	35	1.1%	174	5.5%
Transcultural Wellness Center (TWC)	98	3.1%	4	0.1%	8	0.3%	52	1.7%	38	1.2%	16	0.5%	30	1.0%	31	1.0%	277	8.8%
Transitional Age Youth FSP (TAY)	17	0.5%	11	0.3%	8	0.3%	9	0.3%	85	2.7%	9	0.3%	42	1.3%	85	2.7%	266	8.5%
Grand Total	**1250**	**39.7%**	**37**	**1.2%**	**57**	**1.8%**	**501**	**15.9%**	**476**	**15.1%**	**61**	**1.9%**	**256**	**8.1%**	**509**	**16.2%**	**3147**	**100%**

Table: Discharges

Program Name	Admin Discharge		Deceased		Disengaged/ Non-compliant w/treatment		Incarcerated		Moved out of area		Never Engaged		Other		Services no longer needed		Successful completion		Transfer Higher Level		Transfer Lower Level		Transferred to Diff Program		Total	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Adult Residential Treatment (ART)	1	0.1%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2	0.3%	0	0.0%	0	0.0%	3	0.4%
Adults Recovering in Strength-based Environment (ARISE)	1	0.1%	5	0.7%	22	3.0%	14	1.9%	4	0.5%	4	0.5%	0	0.0%	0	0.0%	7	1.0%	7	1.0%	1	0.1%	3	0.4%	68	9.2%
Family Wellness Center (FWC)	5	0.7%	0	0.0%	29	3.9%	2	0.3%	5	0.7%	22	3.0%	0	0.0%	12	1.6%	17	2.3%	0	0.0%	3	0.4%	4	0.5%	99	13.5%
Integrated Services Agency (ISA)	2	0.3%	6	0.8%	7	1.0%	7	1.0%	3	0.4%	1	0.1%	0	0.0%	1	0.1%	3	0.4%	2	0.3%	1	0.1%	0	0.0%	33	4.5%
Juvenile Justice Diversion and Treatment Program (JJDTP)	28	3.8%	0	0.0%	4	0.5%	10	1.4%	6	0.8%	12	1.6%	0	0.0%	11	1.5%	18	2.4%	4	0.5%	0	0.0%	4	0.5%	97	13.2%
New Direction	1	0.1%	15	2.0%	14	1.9%	3	0.4%	5	0.7%	3	0.4%	0	0.0%	2	0.3%	0	0.0%	2	0.3%	0	0.0%	4	0.5%	49	6.7%
Outpatient Assisted Services and Integrated Support (OASIS)	7	1.0%	4	0.5%	11	1.5%	15	2.0%	1	0.1%	17	2.3%	0	0.0%	1	0.1%	0	0.0%	6	0.8%	0	0.0%	2	0.3%	64	8.7%
Pathways	8	1.1%	14	1.9%	13	1.8%	7	1.0%	9	1.2%	0	0.0%	2	0.3%	0	0.0%	1	0.1%	4	0.5%	2	0.3%	3	0.4%	63	8.6%
Sacramento Outpatient Adult Recovery (SOAR)	1	0.1%	7	1.0%	10	1.4%	1	0.1%	3	0.4%	5	0.7%	1	0.1%	0	0.0%	1	0.1%	11	1.5%	4	0.5%	1	0.1%	45	6.1%
Sierra Elder Wellness Program (Sierra)	1	0.1%	4	0.5%	0	0.0%	0	0.0%	1	0.1%	3	0.4%	1	0.1%	1	0.1%	2	0.3%	1	0.1%	0	0.0%	2	0.3%	16	2.2%
Transcultural Wellness Center (TWC)	2	0.3%	4	0.5%	17	2.3%	5	0.7%	4	0.5%	15	2.0%	1	0.1%	7	1.0%	26	3.5%	2	0.3%	12	1.6%	2	0.3%	97	13.2%
Transitional Age Youth FSP (TAY)	4	0.5%	2	0.3%	38	5.2%	3	0.4%	6	0.8%	2	0.3%	6	0.8%	5	0.7%	10	1.4%	3	0.4%	16	2.2%	7	1.0%	102	13.9%
Grand Total	**61**	**8.3%**	**61**	**8.3%**	**165**	**22.4%**	**67**	**9.1%**	**47**	**6.4%**	**84**	**11.4%**	**11**	**1.5%**	**40**	**5.4%**	**85**	**11.5%**	**44**	**6.0%**	**39**	**5.3%**	**32**	**4.3%**	**736**	**100%**

Sacramento County MHSA Fiscal Year 2025-26 Annual Update

Outcomes Over Time

The following section examines outcomes over time for partners who received services and completed an entire year and up to two years for some outcomes. Comparing a baseline to performance is important because it provides a reference point to measure progress and understand the impact of interventions and changes made, for FSPs, the focus is on housing stability, emergency events, psychiatric hospitalizations, arrests, incarcerations and employment.

For this segment, data primarily was self-reported by partners and documented using FSP outcome assessment forms developed by the California State Department of Health Care Services. These forms include: Partnership Assessment Form (PAF) which collects baseline and current data when clients first enter FSP services; Quarterly Assessment Form (3M) which updates the data from the PAF and is done every three months for each client as long as they are receiving FSP services; and the Key Event Tracking form (KET) which is completed each time a key event (i.e. crisis visit, arrest, incarceration, hospitalization) occurs. The graphic below highlights partner trajectory through the FSP program.

The table below illustrates the number of unduplicated partners who were in an unstable housing status (unsheltered) and total homeless days for the year prior to enrollment compared to one full year of partnership and two full years of partnership. Of the 1,516 partners in the cohort, 621 unduplicated partners experienced unstable housing prior to enrollment. Compared to baseline, the unduplicated number of partners as well as total days decreased significantly over the two-year period.

Table: Housing Stability (Homeless)

Partners who Completed Two Years (n=1,516)	One Year Before Partnership (Baseline)		Year One During Partnership		Percent Change from Baseline		Year Two During Partnership		Percent Change from Baseline	
	# Unduplicated Partners Homeless	# Homeless Days	# Unduplicated Partners Homeless	# Homeless Days	Percent Change Unduplicated Partners Homeless	Percent Change Homeless Days	# Unduplicated Partners Homeless	# Homeless Days	Percent Change Unduplicated Partners Homeless	Percent Change Homeless Days
	621	128,581	218	23,535	-64.9	-81.7	136	15,954	-79.0	-87.6

Graph: Housing Stability-Homeless

Sacramento County MHSA Fiscal Year 2025-26 Annual Update

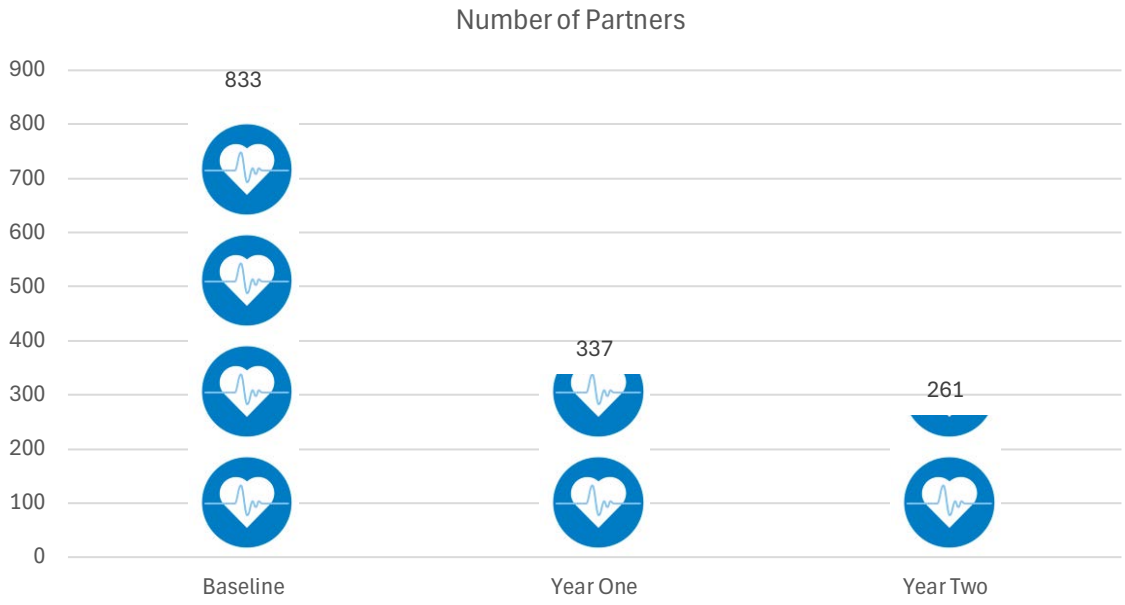
The table below illustrates the number of unduplicated partners with emergency events for mental health and mental health with substance abuse reasons one year prior to enrollment (baseline) compared to one full year of partnership and two full years of partnership. Just over 800 (n=833) unduplicated partners had at least one emergency room visit prior to enrollment. Compared to baseline, the unduplicated number of partners and the total emergency visits for both decreased significantly for partners through year two of participation.

Table: Partners w/Emergency Room Visits for Mental Health and Mental Health/Substance Abuse Reasons

Partners who Completed Two Years (n=1,516)	One Year Before Partnership (Baseline)		Year One of Partnership		Percent Change from Baseline		Year Two of Partnership		Percent Change from Baseline	
	Unduplicated Partners w/ER Visits	Total ER Visits	Unduplicated Partners w/ER Visits	Total ER Visits	Percent Change Unduplicated Partners	Percent Change Events	Unduplicated Partners w/ER Visits	Total ER Visits	Percent Change Unduplicated Partners	Percent Change Events
	833	2,501	337	770	-60.0	-69.0	261	554	-68.6	-77.8

Sacramento County MHSA Fiscal Year 2025-26 Annual Update

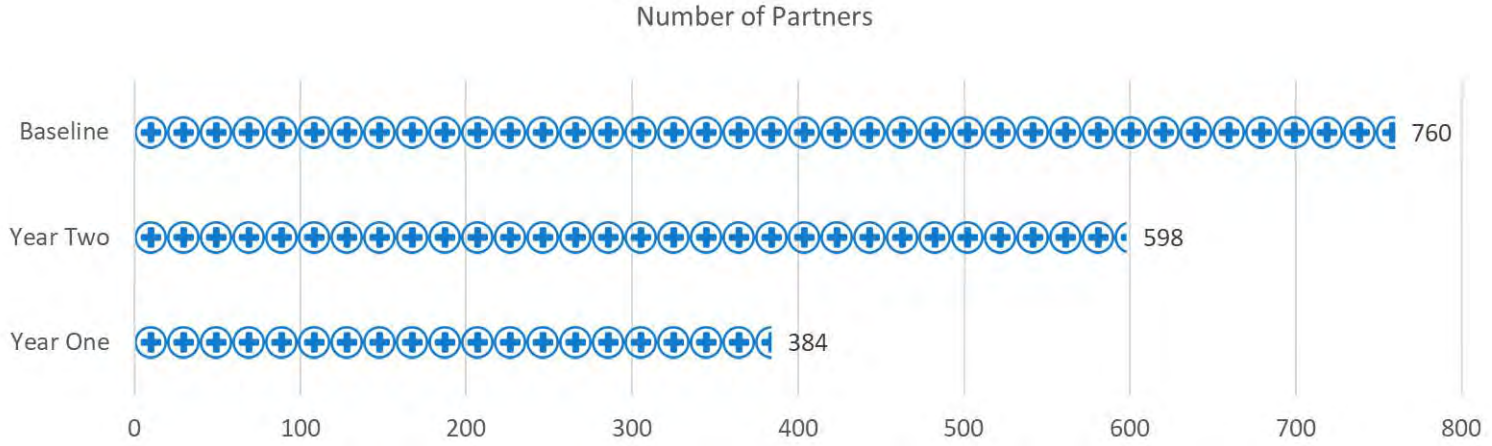
Graph: Partners w/Emergency Room Visits for Mental Health and Mental Health/Substance Abuse Reasons



The table below illustrates the number of unduplicated partners' as well as total number of psychiatric hospitalizations one year prior to enrollment compared to one full year of partnership and two full years of partnership. Nearly 800 (n=760) unduplicated partners had at least one hospitalization prior to enrollment. That number decreased to 598 in year one and continued a downward trajectory to 384 in year two. Of note, although partner numbers decreased every year, partner days increased in the first year and decreased in the second year of participation. There are some possible reasons for the increase in days reported in psychiatric hospitalizations in year one. One possibility is that when partners start receiving care in an FSP, they have access to an array of services they didn't have prior to participation. Partners may also develop and establish a relationship with a Personal Care Physician (PCP), leading to stability and health history building with providers and an increase in length of stays as they receive needed care.

Table: Psychiatric Hospitalizations

Partners who Completed Two Years (n=1,516)	One Year Before Partnership (Baseline)		Year One of Partnership		Percent Change from Baseline		Year Two of Partnership		Percent Change from Baseline	
	Unduplicated Partners w/Psych Visits	Total Psych Days	Unduplicated Partners w/Psych Visits	Total Psych Days	Percent Change Unduplicated Partners	Percent Change Psych Days	Unduplicated Partners w/Psych Visits	Total Psych Days	Percent Change Unduplicated Partners	Percent Change Psych Days
	760	48,355	598	63,168	-21.3	30.6	384	57,157	-49.5	18.2



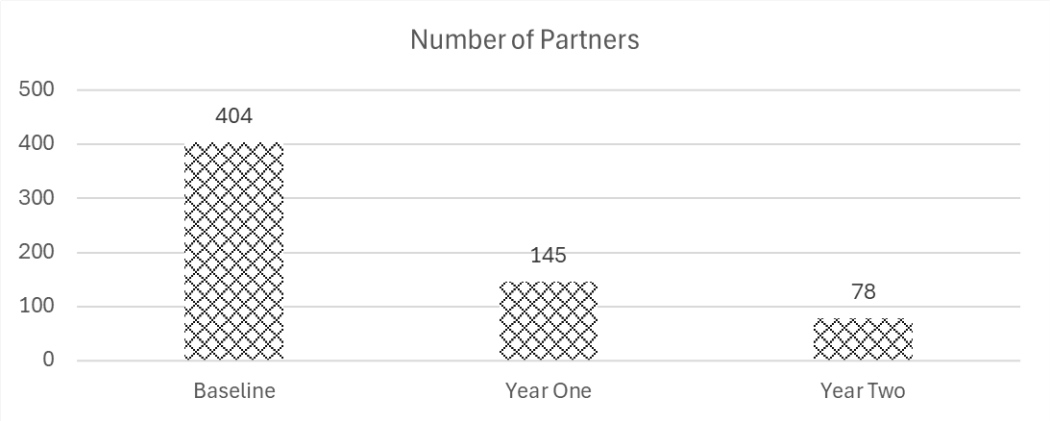
Sacramento County MHSA Fiscal Year 2025-26 Annual Update

The table below illustrates the number of unduplicated partners as well as total number of arrests one year prior to enrollment compared to year one of partnership. Just over 400 (404) unduplicated partners had at least one arrest prior to enrollment. That number decreased to 145 in year one of participation and continued to decrease in year two to 78.

Table: Arrests

Partners who Completed Two Years (n=1,516)	One Year Before Partnership (Baseline)		Year One of Partnership		Percent Change from Baseline		Year Two of Partnership		Percent Change from Baseline	
	Unduplicated Partners w/Arrests	Total Arrests	Unduplicated Partners w/Arrests	Total Arrests	Percent Change Unduplicated Partners	Percent Change Arrests	Unduplicated Partners w/Arrests	Total Arrests	Percent Change Unduplicated Partners	Percent Change Arrests
	404	656	145	208	-64.1	-68.3	78	91	-80.6	-86.1

Graph: Arrests

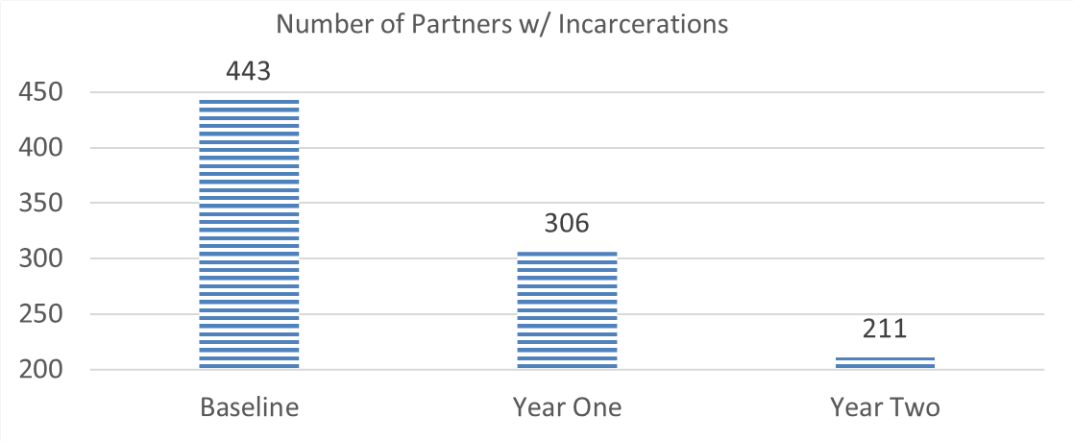


The table below illustrates the number of unduplicated partners' as well as total number of incarcerations days one year prior to enrollment compared to year one of participation. Of the partners in the cohort, 443 unduplicated partners had at least one incarceration prior to enrollment. That number decreased to 306 in year one of participation. Of note, although partners incarcerated are higher than arrests, both arrests and incarcerations are self-reported by the partner and not always disclosed and/or captured on the KETs for reporting purposes (incarcerations are reported as a residential change).

Table: Incarcerations

Partners who Completed Two Years (n=1,516)	One Year Before Partnership (Baseline)		Year One of Partnership		Percent Change from Baseline		Year Two of Partnership		Percent Change from Baseline	
	Unduplicated Partners w/ Incarcerations	Total Incarcerations	Unduplicated Partners w/ Incarcerations	Total Incarcerations	Percent Change Unduplicated Partners	Percent Change Incarcerations	Unduplicated Partners w/ Incarcerations	Total Incarcerations	Percent Change Unduplicated Partners	Percent Change Incarcerations
	443	56,531	306	22,030	-30.9	-61.0	211	12,540	-52.3	-77.8

Graph: Incarcerations



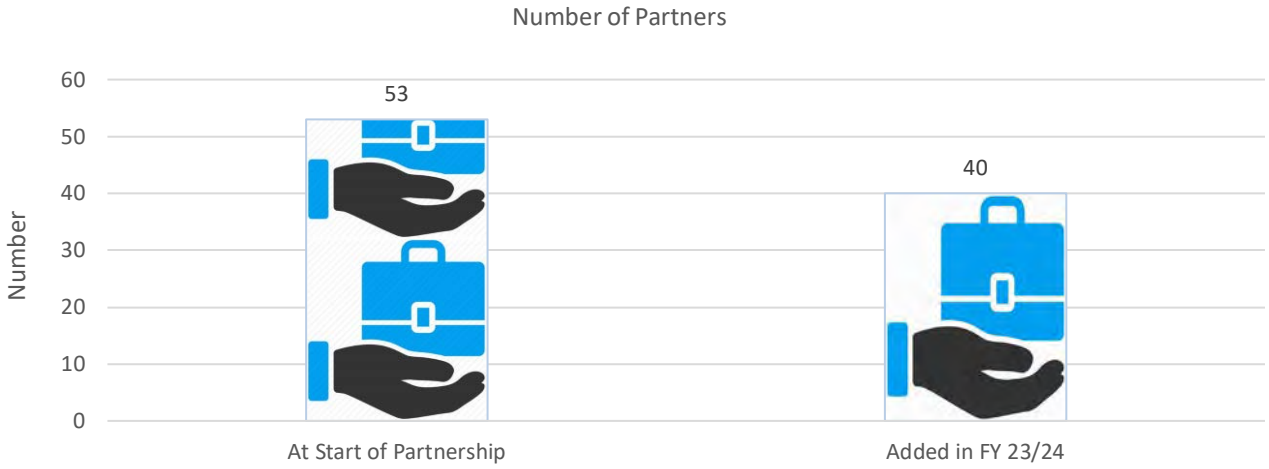
Sacramento County MHSA Fiscal Year 2025-26 Annual Update

The table below illustrates the number of partners who indicated they wanted to be employed (n=419) as part of their recovery goal. Of those, FSPs assisted 40 partners to secure employment. Although the number of newly employed is relatively small, the FSPs were also able to assist 53 partners to maintain employment, totaling 93 partners employed at the end of the FY.

Table: Employment

Partners w/Employment Recovery Goal N=419		
Timeframe	Total	%
Employed at Start of Partnership	53	12.6
Added in FY 2023-24	40	9.6
Total Partners Employed at End of FY	93	22.2%

Graph: Employment



General System Development (GSD) Program FY 2023-24 Demographics

In FY 2023-24, a total of 27,361 clients were served across the implemented GSD and GSD Respite programs. The two tables on this page and the next display demographic information for individuals served in each program:

GENERAL SYSTEM DEVELOPMENT - FY 23/24																								
Characteristic	APSS (N=329)		CORE (N=7,434)		CORE CWC (N=4,318)		Peer Support Program at APSS CAPS etc. (N=80)		Crisis Residential Program-Adults (M St.) (N=150)		Crisis Residential Program-Adults (Henrietta Dr.) (N=156)		Crisis Residential Program-Adults (Viking Dr.) (N=168)		Crisis Residential Program-TAY (CRP 4) (N=149)		Flexible Integrated Treatment (FIT) (N=7,922)		Consultation, Support and Engagement Teams (CSET) (N=87)		Mental Health Urgent Care Clinic (MHUCC) (N=4,428)		Total (N=25,221)	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Age																								
0 to 15	0	0.0%	0	0.0%	0	0.0%	26	32.5%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	5,895	74.4%	38	43.7%	485	11.0%	6,444	25.6%
16 to 25	28	8.5%	706	9.5%	310	7.2%	8	10.0%	1	0.7%	4	2.6%	10	6.0%	99	66.4%	2,027	25.6%	49	56.3%	1,226	27.7%	4,468	17.7%
26 to 59	214	65.0%	5,687	76.5%	3382	78.3%	36	45.0%	140	93.3%	141	90.4%	145	86.3%	50	33.6%	0	0.0%	0	0.0%	2,415	54.5%	12,210	48.4%
60 and Over	87	26.4%	1,041	14.0%	625	14.5%	10	12.5%	9	6.0%	11	7.1%	13	7.7%	0	0.0%	0	0.0%	0	0.0%	302	6.8%	2,098	8.3%
Unknown/Not Reported	0	0.0%	0	0.0%	1	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.0%
Gender																								
Female	207	62.9%	3,759	50.6%	1,711	39.6%	42	52.5%	53	35.3%	52	33.3%	86	51.2%	81	54.4%	2,747	34.7%	44	50.6%	2,162	48.8%	10,944	43.4%
Male	122	37.1%	3,652	49.1%	2307	53.4%	11	13.8%	97	64.7%	104	66.7%	81	48.2%	68	45.6%	2,466	31.1%	2	2.3%	2,253	50.9%	11,163	44.3%
Other	0	0.0%	0	0.0%	0	0.0%	1	1.3%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	266	3.4%	3	3.4%	0	0.0%	270	1.1%
Unknown/Not Reported	0	0.0%	23	0.3%	300	6.9%	26	32.5%	0	0.0%	0	0.0%	1	0.6%	0	0.0%	2,443	30.8%	38	43.7%	13	0.3%	2,844	11.3%
Ethnicity																								
Non-Hispanic	205	62.3%	4,350	58.5%	2,124	49.2%	47	58.8%	94	62.7%	99	63.5%	107	63.7%	94	63.1%	3,252	41.1%	46	52.9%	3,075	69.4%	13,493	53.5%
Hispanic	72	21.9%	1,517	20.4%	736	17.0%	24	30.0%	35	23.3%	28	17.9%	32	19.0%	28	18.8%	2,819	35.6%	20	23.0%	917	20.7%	6,228	24.7%
Unknown/Not Reported	52	15.8%	1,567	21.1%	1,458	33.8%	9	11.3%	21	14.0%	29	18.6%	29	17.3%	27	18.1%	1,851	23.4%	21	24.1%	436	9.8%	5,500	21.8%
Race*																								
Am Indian/Alask. Native	3	0.9%	124	1.7%	73	1.7%	1	1.3%	1	0.7%	1	0.6%	4	2.4%	2	1.3%	63	0.8%	3	3.4%	397	9.0%	672	2.7%
Asian/Pacific Islander	50	15.2%	540	7.3%	176	4.1%	5	6.3%	2	1.3%	8	5.1%	9	5.4%	5	3.4%	312	3.9%	2	2.3%	787	17.8%	1,896	7.5%
Black	50	15.2%	1,882	25.3%	947	21.9%	16	20.0%	35	23.3%	35	22.4%	47	28.0%	55	36.9%	1,645	20.8%	27	31.0%	982	22.2%	5,721	22.7%
Multi-Race	15	4.6%	585	7.9%	248	5.7%	8	10.0%	16	10.7%	30	19.2%	19	11.3%	26	17.4%	1,276	16.1%	20	23.0%	219	4.9%	2,462	9.8%
Other	59	17.9%	805	10.8%	324	7.5%	14	17.5%	18	12.0%	12	7.7%	12	7.1%	8	5.4%	1,633	20.6%	1	1.1%	244	5.5%	3,130	12.4%
White	120	36.5%	2,560	34.4%	1,286	29.8%	32	40.0%	66	44.0%	50	32.1%	68	40.5%	46	30.9%	1,938	24.5%	23	26.4%	1,751	39.5%	7,940	31.5%
Unknown/Not Reported	32	9.7%	938	12.6%	1,264	29.3%	4	5.0%	12	8.0%	20	12.8%	9	5.4%	7	4.7%	1,055	13.3%	11	12.6%	771	17.4%	4,123	16.3%
Primary Language																								
English	245	74.5%	6,615	89.0%	3,379	78.3%	72	90.0%	145	96.7%	144	92.3%	160	95.2%	143	96.0%	6,795	85.8%	79	90.8%	3,991	90.1%	21,768	86.3%
Spanish	10	3.0%	144	1.9%	32	0.7%	3	3.8%	0	0.0%	0	0.0%	2	1.2%	0	0.0%	803	10.1%	0	0.0%	130	2.9%	1,124	4.5%
Other	65	19.8%	347	4.7%	43	1.0%	4	5.0%	4	2.7%	1	0.6%	2	1.2%	2	1.3%	120	1.5%	0	0.0%	193	4.4%	781	3.1%
Unknown/Not Reported	9	2.7%	328	4.4%	864	20.0%	1	1.3%	1	0.7%	11	7.1%	4	2.4%	4	2.7%	204	2.6%	8	9.2%	114	2.6%	1,548	6.1%

*Totals are higher than other categories as clients select multiple categories

Sacramento County MHSA Fiscal Year 2025-26 Annual Update

GENERAL SYSTEM DEVELOPMENT - RESPITE PROGRAMS - FY 23/24								
Characteristic	Mental Health Respite Program for Women & Children (N=52)		Mental Health Crisis Respite Center (N=1,976)		Abiding Hope Respite House (N=112)		Total (N=2,140)	
	N	%	N	%	N	%	N	%
Age Group								
Children/Youth (0-15)	0	0.0%	7	0.4%	0	0.0%	7	0.3%
TAY (16-25)	5	9.6%	155	7.8%	3	2.7%	163	7.6%
Adults (26-59)	39	75.0%	1620	82.0%	102	91.1%	1,761	82.3%
Older Adults (60+)	1	1.9%	179	9.1%	7	6.3%	187	8.7%
Unknown/Not Reported	7	13.5%	15	0.8%	0	0.0%	22	1.0%
Ethnicity								
Hispanic or Latino	8	15.4%	255	12.9%	17	15.2%	280	13.1%
Non-Hispanic/Non-Latino	35	67.3%	881	44.6%	80	71.4%	996	46.5%
Unknown/Not Reported	9	17.3%	840	42.5%	15	13.4%	864	40.4%
Race								
American Indian or Alaska Native	1	1.9%	41	2.1%	0	0.0%	42	2.0%
Asian	1	1.9%	45	2.3%	1	0.9%	47	2.2%
Black or African American	26	50.0%	555	28.1%	35	31.3%	616	28.8%
Multi-Racial	4	7.7%	275	13.9%	4	3.6%	283	13.2%
Native Hawaiian/Pacific Islander	1	1.9%	6	0.3%	0	0.0%	7	0.3%
Other	5	9.6%	133	6.7%	15	13.4%	153	7.1%
White	9	17.3%	656	33.2%	54	48.2%	719	33.6%
Unknown/Not Reported	5	9.6%	265	13.4%	3	2.7%	273	12.8%
Primary Language								
Arabic	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Cantonese	0	0.0%	2	0.1%	0	0.0%	2	0.1%
English	51	98.1%	1751	88.6%	104	92.9%	1,906	89.1%
Farsi	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Hmong	0	0.0%	1	0.1%	0	0.0%	1	0.0%
Other	0	0.0%	21	1.1%	1	0.9%	22	1.0%
Russian	0	0.0%	2	0.1%	0	0.0%	2	0.1%
Spanish	1	1.9%	22	1.1%	0	0.0%	23	1.1%
Vietnamese	0	0.0%	1	0.1%	0	0.0%	1	0.0%
Unknown/Not Reported	0	0.0%	176	8.9%	7	6.3%	183	8.6%
Sexual Orientation*								
Gay or Lesbian	0	0.0%	110	5.6%	5	4.5%	115	5.4%
Heterosexual or Straight	41	78.8%	1182	59.8%	91	81.3%	1,314	61.4%
Bisexual	0	0.0%	154	7.8%	4	3.6%	158	7.4%
Questioning or unsure	0	0.0%	12	0.6%	0	0.0%	12	0.6%
Queer	0	0.0%	15	0.8%	0	0.0%	15	0.7%
Another sexual orientation	5	9.6%	167	8.5%	0	0.0%	172	8.0%
Unknown/Not Reported	6	11.5%	391	19.8%	12	10.7%	409	19.1%
Current Gender Identity*								
Male	0	0.0%	1007	51.0%	56	50.0%	1,063	49.7%
Female	49	94.2%	706	35.7%	59	52.7%	814	38.0%
Transgender	0	0.0%	31	1.6%	11	9.8%	42	2.0%
Genderqueer	0	0.0%	10	0.5%	6	5.4%	16	0.7%
Questioning or unsure	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Another gender identity	0	0.0%	25	1.3%	0	0.0%	25	1.2%
Unknown/Not Reported	3	5.8%	211	10.7%	2	1.8%	216	10.1%
Veteran Status								
Yes	0	0.0%	74	3.7%	0	0.0%	74	3.5%
No	52	100.0%	1902	96.3%	112	100.0%	2,066	96.5%
Decline to answer	0	0.0%	0	0.0%	0	0.0%	0	0.0%

*Totals are higher than other categories as clients select multiple categories

MHSA Housing Program Accomplishments

BHS places a high priority on housing for people living with mental illness who are experiencing or are at-risk of homelessness. The MHSA Housing Program provides a continuum of interventions including homelessness prevention, flexible housing funds, rapid rehousing, and permanent supportive housing. Housing interventions are targeted towards consumers of Full Service Partnership (FSP) and outpatient services.

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

Permanent Supportive Housing

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

Housing Successes

- *$75 million invested since 2007*
- *159 apartments online between 2008-2012*
- *302 apartments online since 2020*
- *18 active developments*
- *115 units across five pipeline properties projected to be in service 2025 – 2027*

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

Recognizing the efficacy, value, and importance of PSH, BHS continues to look for opportunities to build or renovate housing developments with units dedicated for MHSA-eligible tenants. BHS undertook an expansion of the PSH portfolio in FY 2018-19 in partnership with SHRA by co-applying with nonprofit housing development partners for State No Place Like Home (NPLH) capital funds. Since then, BHS has dedicated $5,087,737 in noncompetitive NPLH funds and been awarded $31,457,671 of competitive funds in support of four housing developments: Sunrise Pointe Development in Citrus Heights (22 units), Capitol Park Hotel Development in downtown Sacramento (65 units), Mutual Housing on the Boulevard in Sacramento (50 units), and the On Broadway Development in downtown Sacramento (37 units). These NPLH developments add 174 units of supportive housing to the BHS PSH portfolio.

In FY 2020-21 and FY 2021-22, BHS committed $8.9 million in MHSA Housing Program funding for 62 new dedicated permanent supportive housing units at four developments: Central Sac

Studios (15 units); Villa Jardin/Coral Gables (15 units); Vista Nueva Apartments (15 units); and Donner Senior Apartments (17 units). In FY 2022-23, BHS committed an additional $6.4 million in MHSA Housing Program funding for 75 additional new dedicated permanent supportive housing units at three developments in the pipeline: Madison Square Studios (Super 8) (15 units); Hope Landing (Arden Star) (30 units); and Powell's Landing (Rodeway Inn) (30 units). In FY 2023-24, BHS committed $2.1 million in MHSA Housing Program funding for The Sequoia (16 units).

To date, Sacramento County's MHSA Housing Program portfolio has 461 built units at 18 developments, which will grow to 546 as future vacancies become MHSA units. An additional 115 units are in the pipeline at five developments. The estimated annual in-kind value of the 20-year required behavioral health service commitment for the 661 built units at the 23 active and pipeline MHSA and NPLH projects is $6.6 million.

MHSA funding has leveraged federal, state, and local funds to finance these dedicated units of supportive housing for MHSA eligible tenants. The built unit portfolio represents years of cultivation of effective, strategic partnerships with SHRA, non-profit housing developers, property management companies, and FSP providers. The portfolio is geographically diverse and includes new construction as well as acquisition/rehabilitation projects. Properties offer a range of unit sizes including studios and one-bedroom units to family properties offering multi-bedroom units. Additional information on each portfolio project is included in the MHSA Housing Portfolio Catalog *(*See *Attachment E: BHS MHSA Housing Portfolio Catalog).* Efforts to expand the MHSA Housing Portfolio are ongoing and remain a priority.

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

Flexible Housing Supports

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

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

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PREVENTION AND EARLY INTERVENTION (PEI) COMPONENT

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

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

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

PEI Component regulations (9 California Code of Regulations § 3705, 3715, 3720, 3725, 3726, 3730, 3750) were revised in 2018 and redefined required and optional PEI program types to include in counties Three Year Program and Expenditure Plans and Annual Updates:

1) **Prevention**
2) **Early Intervention**
3) **Outreach for Increasing Recognition of Early Signs of Mental Illness**
4) **Access and Linkage to Treatment**
5) **Stigma and Discrimination Reduction**
6) **Improve Timely Access for Services for Underserved Populations**
7) **Suicide Prevention**

Additionally, the following six PEI priorities were established in 2020 (WIC § 5840.7):

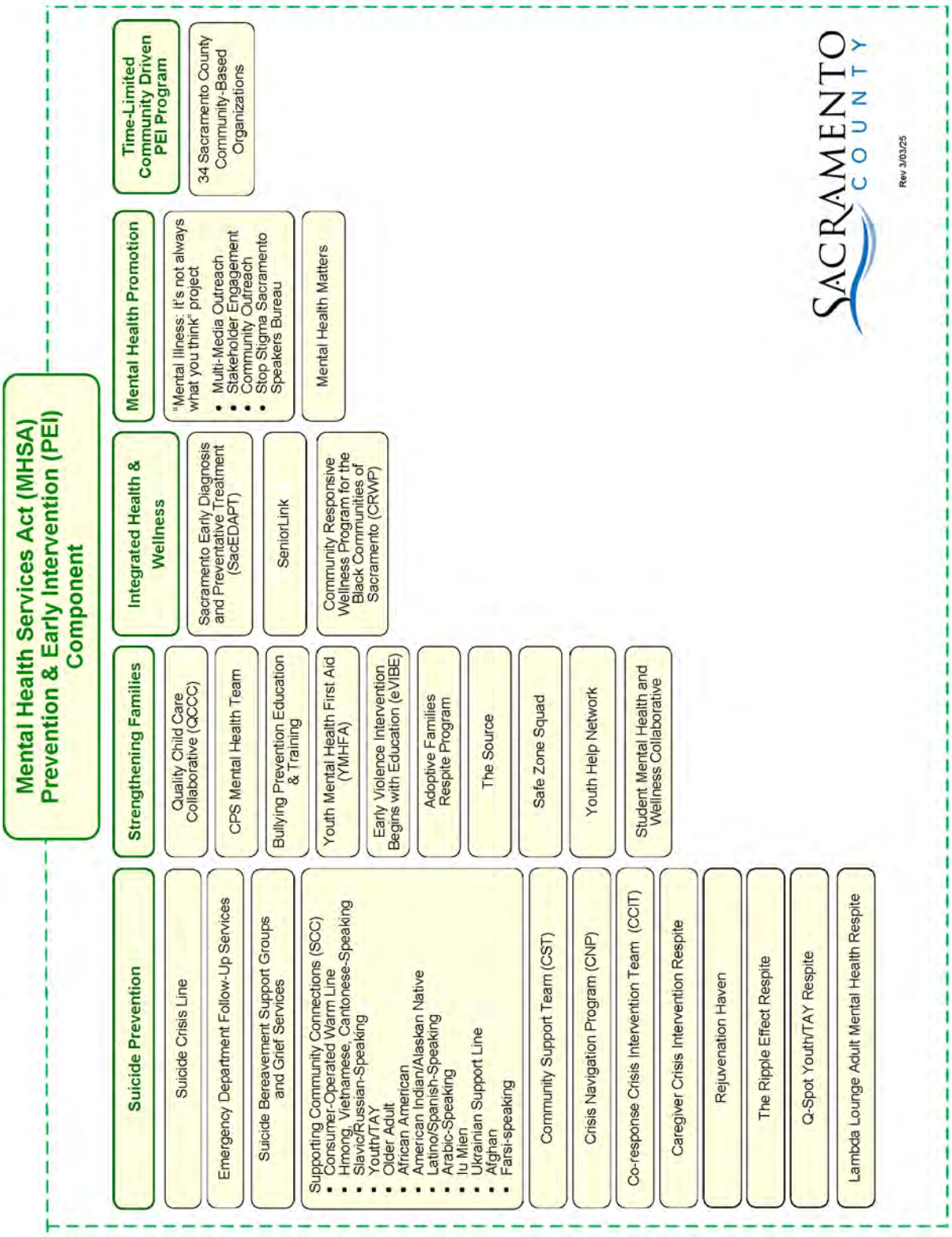
1) **Childhood trauma prevention and early intervention to deal with early origins of mental health needs.**
2) **Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan.**
3) **Youth outreach and engagement strategies that target secondary school and transition age youth, with priority on partnership with college mental health programs.**
4) **Culturally competent and linguistically appropriate prevention and intervention.**
5) **Strategies targeting the mental health needs of older adults.**
6) **Other programs the commission (Mental Health Services Oversight and Accountability Commission) identifies, with stakeholder participation, that are proven effective in achieving and are reflective of the goals stated in Section 5840.**

In FY 2023-24, PEI Suicide Prevention and Education program served 79,713 and outreached to over 47,000 individuals by providing individual outreach and participating in 677 community events. The Strengthening Families program served 3,874 individuals and offered prevention trainings and information to over 13,000 students, parents/caregivers, education staff, and other partners. The Integrated Health and Wellness program served 2,054 and outreached and distributed

information to 1,901 individuals. The Mental Health Promotion program "Mental Illness: It's not always what you think" project utilizes television, radio, social media and print material to advertise across the Sacramento area. In FY 2023-24, there were 6,163,960 impressions from the radio, 649 TV ads, 17 print ads, 34,291,209 impressions from outdoor ads and 21,863,540 impressions from online and mobile ads. The Project's Stop Stigma Sacramento Speakers Bureau speakers shared their personal stories 138 times, at 64 events, with a total audience attendance of 2,913 individuals. Descriptions of these programs are included in this Annual Update.

MHSA defined age categories are as follows:

- Children and youth = birth – 17-years-old
- Transition Age Youth (TAY) = 16-years-old – 25-years-old
- Adult = 18-years-old – 59-years-old
- Older Adult = 60-years-old+


Mental Health Services Act (MHSA)
Prevention & Early Intervention (PEI)
Component
Suicide Prevention
Suicide Crisis Line
Emergency Department Follow-Up Services
Suicide Bereavement Support Groups and Grief Services
Supporting Community Connections (SCC)
Consumer-Operated Warm Line
Hmong, Vietnamese, Cantonese-Speaking
Slavic/Russian-Speaking
Youth/TAY
Older Adult
African American
American Indian/Alaskan Native
Latino/Spanish-Speaking
Arabic-Speaking
Iu Mien
Ukrainian Support Line
Afghan
Farsi-speaking
Community Support Team (CST)
Crisis Navigation Program (CNP)
Co-response Crisis Intervention Team (CCIT)
Caregiver Crisis Intervention Respite
Rejuvenation Haven
The Ripple Effect Respite
Q-Spot Youth/TAY Respite
Lambda Lounge Adult Mental Health Respite
Strengthening Families
Quality Child Care Collaborative (QCCC)
CPS Mental Health Team
Bullying Prevention Education & Training
Youth Mental Health First Aid (YMHFA)
Early Violence Intervention Begins with Education (eVIBE)
Adoptive Families Respite Program
The Source
Safe Zone Squad
Youth Help Network
Student Mental Health and Wellness Collaborative
Integrated Health & Wellness
Sacramento Early Diagnosis and Preventative Treatment (SacEDAPT)
SeniorLink
Community Responsive Wellness Program for the Black Communities of Sacramento (CRWP)
Mental Health Promotion
"Mental Illness: it's not always what you think" project
Multi-Media Outreach
Stakeholder Engagement
Community Outreach
Stop Stigma Sacramento Speakers Bureau
Mental Health Matters
Time-Limited Community Driven PEI Program
34 Sacramento County Community-Based Organizations
SACRAMENTO COUNTY
Rev 3/03/25

Suicide Prevention and Education Program
FY 2025-26 Capacity: 65,000 contacts annually
Ages Served: 10% Children, 18% TAY, 55% Adults, 17% Older Adults

The Suicide Prevention and Education Program consists of several components collectively aimed at recognizing and reducing suicide risk, improving timely access to services for underserved populations, and assisting individuals in accessing and linking to treatment programs.

Suicide Crisis Line, administered by WellSpace Health, is a *PEI Suicide Prevention program* in alignment with the following PEI priority: *Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan (WIC § 5840.7).*

This program operates around the clock as part of the nationally accredited 988 Suicide & Crisis Lifeline (formerly known as the National Suicide Prevention Lifeline). It leverages both professional staff and trained volunteers to provide immediate and effective suicide prevention and crisis support to individuals of all ages at risk of suicide. The services offered include in-person phone responses, a 24/7 chat and text support feature, and connections to community resources for additional help. Additionally, the program coordinates with mobile response teams and law enforcement to manage in-person crises, ensure safety, and address the immediate needs of callers.

Success: Suicide Crisis Line
A 49-year old male called into 988 while having suicidal ideation. The caller reported he was standing in front of a large body of water contemplating his plan to end his life. The caller reported his partner was ending their long-term relationship and that his partner was his primary support and his world. The counselor initiated means restriction and asked the caller to move away from the large body of water in an effort to disable the plan to end his life. The caller agreed to step away from the water while engaged in the call. The counselor supported the caller with validation, empathy, and active listening and used their training to deescalate the caller. After building rapport with the caller, the counselor extended continuity of care by recommending the Community Wellness Response Team. The caller agreed and accepted CWRT's services. The counselor successfully completed a warm transfer to the dispatcher.

The next day, a clinical counselor conducted a follow up call to reassess for risk and suicidal ideation. The caller reported he was grateful for the counselor's compassion, patience, and care. The caller stated he was not feeling suicidal at the time of this follow-up because of all the support he had received and the beneficial resources he had been linked to from 988 and CWRT. The caller shared that he felt heard, seen, and validated and said thank you.

Emergency Department Follow-up Services (EDFU), administered by WellSpace Health, is a *PEI Suicide Prevention program* in alignment with the following PEI priority: *Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan (WIC § 5840.7).*

The program provides brief individual follow-up and support services to consenting individuals seen at Sutter Medical Center, Dignity Health, and University of California Davis Medical Center (UCDMC) Emergency Departments (ED), who have attempted suicide or are in suicidal crisis and are at high-risk for suicide post discharge.

In FY 2023-24, a total of 87 individuals referred by Sutter Medical Center ED, Dignity Health's Methodist Hospital of Sacramento ED, and UCDMC ED, received postvention follow up and

support services.

Success: Emergency Department Follow-Up (EDFU) Services
A 9-year-old participant was referred to WellSpace Health's Emergency Department Follow Up (EDFU) program due to suicidal ideation and a history of such thoughts. The EDFU Program Coordinator engaged with the participant and their parents over a four-week period, maintaining weekly contact with the participant.

During this time, the EDFU Program Coordinator assisted with referrals to a therapist and provided support in developing coping tools. The participant reported during weekly follow-up calls that they had connected with the therapist and were attending weekly therapy sessions. They found the therapist to be helpful and enjoyed their visits.

By the fourth week, the participant reported that they no longer experienced suicidal ideation, attributing this improvement to the support received. They also demonstrated an understanding of how to use their coping tools and the therapist's guidance upon recognizing warning signs.

The participant's mother expressed deep appreciation for the EDFU Program Coordinator, noting how meaningful it was for her as a mother to have regular check-ins for her child.

Suicide Bereavement Support Groups and Grief Services is a *PEI Suicide Prevention program* in alignment with the following PEI priority: *Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan (WIC § 5840.7).*

Administered by Friends for Survival, this is a program in which staff and volunteers directly impacted by suicide provide support groups and services designed to promote healing in those coping with a loss by suicide. Services offered include a variety of supports that comfort those in grief, encourage healing and growth, and foster the development of skills to cope with loss by suicide.

Success: Suicide Bereavement Support Group - Friends For Survival
Two survivors (mom and grandfather) who tragically lost their loved one to suicide have shown remarkable resilience and dedication to supporting others. After attending both in-person and virtual meetings with Friends for Survival for the past two years, they organized a 5K walk in her honor during the summer of 2024. The donations from this event were generously presented to Friends for Survival.

In a heartfelt letter of gratitude, the survivors expressed their deep appreciation for the overwhelming support they received from Friends for Survival and the community. They emphasized the importance of honoring their daughter's memory and raising awareness about suicide. They also acknowledged the invaluable support provided by Friends for Survival throughout their grieving process.

Excerpt from the letter:

"THANK YOU!!! We did it all with your support! 110 walkers strong!

On Saturday, July 20, 2024, I was humbled and extremely grateful by the amount of support, love, compassion and enthusiasm shown and felt from each one of you, as we walked the trail and completed our first 5K walk.

***$2700** in total donations received by many of you in support of the "Friends for Survival" national support group, which helps many survivors (friends/family) by providing in-person monthly support group meetings, library resources, tools/materials and a safe space for those in need of a compassionate heart and ears as they share their stories and receive comfort from a community of others experiencing the same. The endless peer support is never a charge for the individual.*

*This event is evidence and a reminder of what **we** can do as a community and for the love of others.*

So, thank you all for answering your call, you have helped touch the lives of many."

In FY 2023-24, 2,633 individuals participated in suicide bereavement education and support groups. Staff emailed a total of 20,925 monthly *Comforting Friends* eNewsletters (average of 1,744 per month) and mailed a total of 14,270 monthly *Comforting Friends* newsletters (average of 1,189per month). Newsletters and eNewsletters were distributed regionally and to surrounding counties.

Supporting Community Connections (SCC): A constellation of community based agencies working collaboratively throughout the County to provide culturally and linguistically appropriate suicide prevention support services designed to increase access to and linkage with needed services; improve self-reported life satisfaction and well-being; reduce risk factors and enhance of protective factors; divert from crisis services or decrease need for crisis services; decrease suicide risk; increase knowledge of available resources and supports; and enhance connectedness and reduce isolation. Each program is specifically tailored to meet the needs of their respective communities. The SCCs are *PEI Improving Timely Access to Services for Underserved Populations* programs and address all six (6) *PEI priorities.*

During FY 2023-24, the SCC programs attended 598 community events and had direct contact with 32,281 individuals and served 7,593 individuals (duplicated count). Supporting Community Connections consists of thirteen (13) programs targeting specific communities/populations:

◊ **Consumer-Operated Warmline SCC** is administered by Cal Voices. The peer-run program provides non-crisis culturally appropriate supportive services to Sacramento County adult residents, with the goals of increasing access and linkage to needed services (e.g., support services, resources, and professional supports); improving self- reported life satisfaction and well-being; and reducing suicide risk factors by building protective factors and skills to increase the individual's support network.

The program collaborates with community partners to provide outreach and education to mental health consumers and/or their family members to decrease suicide risks. The program offers telephone support during peak weekday hours. Callers are provided with information, resources, and referrals to address their expressed needs, either immediately or via return/follow up call. Program staff and volunteers receive one-on-one peer support and training to provide a variety of supports to Warmline callers. Referrals include community supports and assistance to apply for and access Medi-Cal, as well as referrals to other County BHS programs. Like all SCC Programs, this program provides several types of individual support, including linkage and referrals to specialty mental health and/or substance use prevention and treatment services as issues are identified with callers.

Success: Consumer-Operated Warmline SCC
The SCC Consumer Operated Warmline received a call from a 22-year-old African American man who was referred to the Warmline by medical staff. He reported experiencing recent physical health challenges including mobility issues. He is afraid this may be a permanent condition and is still awaiting a diagnosis. He reported feeling very anxious and is extremely worried about the unknown. He does not feel supported by his family and says they don't understand him. He has a therapist and a physical therapist but finds the Warmline to be extremely helpful with managing his anxiety. He has been calling the Warmline almost daily (sometimes multiple times a day) for emotional support in order to stay positive. He feels better after speaking with staff but mentioned that weekends are hard as Warmline is not open. Warmline staff provided him with referrals to additional warmlines to help support him on the weekends.

The program also provides a variety of individual support, including supportive listening, coaching, mentoring, linkage and referral to community resources, skill building, and social networking. They also assist with linking callers to needed community resources including medical/behavioral health services, housing support, and financial assistance.

Additionally, the SCC program offers quarterly Wellness Recovery Action Plan (WRAP) groups. Each group is held over six (6) weeks and assists individuals in learning how to identify warning signs that may lead to difficulties within their lives, developing healthy coping skills to help overcome life challenges, and increasing overall wellness.

A Community Needs Assessment was completed in FY 2023-24 to assess for suicide prevention services and strategies that best meet the current needs of Sacramento County adult residents across cultural/ethnic specific groups, the LGBTQ+ community, and other unserved and underserved communities. Based upon the feedback received, the program determined that their current services are addressing the needs of adult community members.

◊ **Hmong, Vietnamese, Cantonese-Speaking communities SCC**, administered by Asian Pacific Community Counseling (APCC), provides services to promote community connectedness, improve access to mental health and other needed services (such as support services, crisis services, benefits acquisition), and address suicide prevention for Hmong, Vietnamese, and Cantonese-speaking community members across the lifespan in Sacramento County. The program addresses identified suicide risk factors in each community, which include feelings of isolation or geographic/social marginalization, and loss of personal worth related to feeling disconnected from family.

This program provides culturally responsive support that aligns with beliefs, traditions, and practices held by community members and was developed with community support and input. The program offers multiple groups that incorporate activities commonly found and enjoyed by Hmong, Vietnamese, or Cantonese-speaking community members. These include a Vietnamese Elderly Support Group (building wellness and connectedness through ballroom dancing and other physical activities), a Tai Chi and Meditation group for Cantonese speaking elderly, and a Hmong Youth and Young Adults group focused on life skills and navigating family dynamics. These groups help participants connect to their culture and find positive ways to increase social connection and create an environment of caring and inclusion, thereby reducing risk factors such as isolation, depression, and suicidal ideation.

Success: Hmong, Vietnamese, Cantonese-Speaking SCC

An SCC participant experienced a tremendous loss when her husband suddenly passed away. She reported feeling very alone as well as being overwhelmed with sadness, hopelessness, and despair. Initially, the participant was hesitant to join the Tai Chi group, but the SCC counselor provided encouragement while sharing that the group will be helpful both physically and emotionally. Since joining the group, participant's outlook has improved, and she has found strength in the supportive environment around her. Each day, she makes progress toward healing and acceptance. Additionally, she is gradually opening up to talk about her grief and loss. It is remarkable to see how the power of connectivity and positivity is making such an impact in the participant's life.

Another SCC participant, an elderly Hmong gentleman who became depressed and isolated during the pandemic, was encouraged to join the Hmong Older Adults Socialization Group activities. He was initially reluctant but eventually participated in several of the outdoor group activities, including walking and fishing. Due to participating in these groups, he reports having more energy, is no longer depressed, and has become eager to engage with other group members.

The program facilitates workshops and presentations at community events and local community colleges to provide education about mental health and wellness. The program also facilitates informal opportunities for youth and elderly community members to interact and share experiences about their home country or immigrating to the United States. These opportunities help foster greater connection and allow individuals from different generations to learn from each other, such as ways to overcome adversity and to better foster stronger inter-generational relationships.

Additionally, this program provides several types of individual support including linkage and referrals to specialty mental health services and/or substance use prevention and treatment services if a participant requires more treatment support that what is currently provided by the program. Other linkages include helping participants explore potential employment opportunities, complete applications for various assistance programs, and assistance with linkage to needed resources (e.g., public benefits such as Medi-Cal, English as a second language (ESL) courses, vocational training, employment resources and referrals, and assistance for immigration needs).

◊ **Slavic/Russian-Speaking SCC**, administered by Slavic Assistance Center, provides community workshops/forums/round tables for youth, adults, and seniors to increase social connectedness, reduce isolation, and develop positive social skills.

The program's full array of services is designed for the Slavic community in terms of culture and language and is a trusted local source for information and an effective vehicle for addressing stigma. Staff who can communicate regarding the value of mental health services are effective because they understand cultural considerations as well as language. The most effective strategies to address stigma have been: Russian language media, faith community outreach, and school outreach. The program utilizes Russian language media, specifically newspaper, radio programming, and TV shows, to educate the Russian-speaking community about suicide prevention and emotional wellness. This reduction in stigma facilitates referrals to the Medi-Cal program as well as to other County BHS programs.

Success: Slavic/Russian-Speaking SCC
Translated from Ukrainian to English

I came to the USA 2 years ago, from Ukraine, with my wife and three children. Many years, I was suffering from anxiety and mood disorders. Looking back, I realize I never really had a chance to recover from my psychological mood disorder because I was suffering from another illness – alcoholism. After arriving in America, I continued drinking, completely unaware of the effects alcohol was having on my emotional well-being. I drank to suppress the negative emotional feelings. The more I drank the sicker I became, yet I would not address my alcohol problem because alcohol had become my "best friend." My wife was devastated. She told me that unless I got help for my addiction, she was going to leave me and take the children. I did not want to lose my family and decided to battle my mood disorder and my alcoholism. Looking for help, I contacted the Slavic Assistance Center. A representative of the center listened to me very carefully and immediately referred me to a bilingual mental health specialist who has extensive experience working with people with addiction. Step by step, I started to stop drinking and recover from my mood disorders. Working with a professional counselor who understood my mood disorders as well as my addiction disorder has been key to my recovery. My family has begun to heal from the emotional wounds that mental illness and addiction often cause. My wife was also very supportive of me throughout the recovery process. Now I understand how my addiction was hurting her and our children, and I never want that to happen again. I do recommend that people suffering from mental illness seek help. Abstinence from alcohol and understanding of my illness has greatly improved my mood swings and ability to lead a normal life. I couldn't have accomplished any of this without the professional help I received at Slavic Assistance Center.

Like all SCC programs, this program provides several types of individual support, including linkage and referrals to specialty mental health and/or substance use prevention and treatment services as issues are identified through participant services. In addition, program staff work closely with faith community networks and charter schools serving the Slavic community to provide safeTALK training and other workshops about emotional wellness and suicide prevention to clergy, educators, parents, and students. Program specialists also work with young people at youth camps to educate them regarding mental health and suicide and help them overcome suicide risk factors such as addiction. The program focuses on building mutually beneficial relationships between schools, churches, faith-based organizations, community centers, and businesses serving the Russian- speaking/Slavic community.

◊ **Youth/Transition Age Youth (TAY) SCC** is administered by Children's Receiving Home of Sacramento, provides suicide prevention and supportive services for youth and TAY aged 12 through 25, with an emphasis on the cultural and specific needs of LGBTQ+ youth, current and former foster youth, and unhoused youth. The purpose of this program is to promote community connectedness, improve access to mental health and other needed services (such as support services, crisis services, and benefits acquisition), and employ appropriate and effective suicide prevention strategies for youth in Sacramento County.

This program provides individual supportive services, including independent living skills training (such as employment readiness training) as well as social and recreational activities (to promote socialization, reduce isolation/risk factors, and build natural supports). Many contacts with youth are made through street outreach or at local youth shelters. The program also utilizes engagement strategies commonly used by youth such social media, phone contact, and by partnering with local organizations frequented by youth.

Success: Youth/Transition Age Youth (TAY):
An 18-year-old unhoused transgender female was experiencing severe anxiety and depression as a result of struggling to find gender-affirming resources and support. She reported feeling disconnected and overwhelmed by the lack of acceptance and understanding in her current environment. SCC staff connected the participant with a comprehensive array of services, including individual therapy, support groups for LGBTQIA+ TAY, workshops on gender identity/affirmation, gender-affirming healthcare providers, and legal resources. SCC staff helped the participant to feel seen, heard, and valued and ensured that her unique needs and goals were prioritized. Through these services in the safe space provided by the SCC program and staff, the participant gained a sense of empowerment, self-efficacy, and felt more in control of her life and her gender affirmation journey.

The program also supports youth with linkage to needed resources including behavioral health services, shelter placement/housing supports, educational services, and vocational training. Particularly while engaging in street outreach, the program utilizes creative strategies such as providing Sunshine Boxes (care packages) to youth that include needed supplies (such as water, snacks, and hygiene products) and uses these opportunities to provide education about local resources and offer linkage support as needed.

Youth/TAY SCC program offers several groups focusing on various youth- specific topics, such as life skills, LGBTQ+ support, and former foster youth support. Groups are hosted in various settings to meet youth where they are at, including youth shelters, in the community, and the Children's Receiving Home campus. The program also provides Sexual Orientation and Gender Identity/Expression (SOGIE) training on campus and to other organizations on a requested basis.

Additionally, Youth/TAY SCC program provides several types of individual support, including linkage and referrals to specialty mental health and/or substance use prevention and treatment services if a participant requires more treatment support than what is currently provided by the program.

◊ **Older Adult SCC** is administered by La Familia Counseling Center (LFCC). This program provides cultural and age-appropriate services to older adults (ages 55 and older) to promote community connectedness, improve access to mental health and other needed services (such as support services, crisis services, and benefits acquisition, including Medi-Cal benefits), and address suicide through appropriate and effective prevention strategies for older adults in Sacramento County.

The Older Adult SCC provides advocacy support to participants including linkage and referral to needed resources such as housing, medical, and transportation. Referrals to BHS programs to address mental health and substance use treatment needs are prioritized. Like all SCC programs, this program provides several types of individual support, including linkage and referrals to specialty mental health and/or substance use prevention and treatment services as issues are identified in engaging with participants. The program currently offers two groups - Senior Activity Group, which provides seniors with socialization opportunities to reduce isolation/increase overall wellbeing, and Techno Sabios (Tech Savvy) Senior Group, which helps seniors build technological skills so they may communicate with loved ones. The program is also developing partnerships with other local organizations serving older adults to share relevant resources and create opportunities for older adult participants to learn about and discuss issues that are relevant to their unique needs.

The Older Adult SCC is creating intentional partnerships with organizations/locations frequented by older adults such as health clinics/pharmacies/fairs, social or cultural events, and religious sites/places of worship to provide information about their program's services and available resources. The program also utilizes a variety of culturally responsive approaches to decrease stigma around talking about mental health or suicide. Additionally, the program is identifying and addressing potential barriers impacting older adults from being able to access services such as transportation (particularly for individuals who reside in remote/rural areas).

Success: Older Adult SCC
A 70-year-old Filipino woman came to LFCC Maple Neighborhood Center seeking engagement opportunities. She reported experiencing isolation for the past two years after she was no longer able to volunteer at the local food bank where she had volunteered for many years. SCC staff invited the individual to participate in the Senior Activity Group. Due to the support received and her participation in the group, she reported having a more positive outlook on life and a desire to improve her physical/mental health. She shared that she was able to enjoy interacting with others, engaging in meaningful activities, and vocalizing her needs. By assisting the participant, the SCC program was able to reduce her risk factors of isolation and a sense of disconnectedness, both of which are often associated with the prevalence of suicide rate.

A Community Needs Assessment was completed in FY 2023-24 to obtain input regarding strategies and services that prevent suicide and depression amongst older adults. Feedback was collected from older adults across cultural/ethnic specific groups, the LGBTQ+ community, and other unserved and underserved communities. Based upon the feedback, the program will continue to find ways to address potential transportation barriers to support older adult community members with accessing needed services. Additionally, the program will facilitate

open and safe spaces for older adults to have culturally responsive conversations ("platicas") among peers about diverse themes.

◊ **The Living Room SCC**, administered by A Church For Us (doing business as A Church For All), provides cultural and ethnic-specific outreach, engagement, and supportive services to African American community members across all genders and age groups who reside in Sacramento County. The program's purpose is to increase community connectedness, improve access to mental health and other needed services (e.g., support services, crisis services, benefits acquisition), and address suicide prevention by promoting hope and protective factors to reduce the impact of chronic stress and improve resilience for individuals.

The SCC program offers a variety of suicide prevention supportive services, including peer-facilitated individual listening sessions, crisis intervention, case management, coaching, and mentoring to individuals who are at-risk of suicide or are experiencing an emotional crisis. The program also assists with screenings and linkages to needed resources such as behavioral health services (specialty mental health and/or substance use prevention and treatment services) and housing supports. The program engages in outreach activities via social media as well as through partnerships with faith and community-based organizations to share program information and suicide prevention resources with community members.

Additionally, the program offers several drop-in support groups and topic-oriented psychoeducational experiences to address issues such as managing stress or emotional challenges, reducing social isolation, and promoting ongoing health and wellbeing. Group topics include stress reduction, physical health, self-care, parent/caregiver support, crisis management, suicide prevention, and reducing mental health stigma. Both Mental Health First Aid (MHFA) training and safeTALK training are offered to key stakeholder groups. Additionally, the program provides crisis intervention services that may include emotional support, listening sessions, psychoeducation, and advocacy through community partnerships with other youth-serving organizations.

Success: The Living Room SCC
The Living Room supported a 10 year old African American male who presented with verbal aggression, destructive behaviors in the home, and who expressed a desire to "give up and die." The youth had been previously diagnosed with Attention-Deficit/Hyperactivity Disorder, and SCC staff supported the mother with reconnecting with the youth's medical provider for further follow up. During services, it became evident that the youth longed for a connection with his estranged father. SCC staff provided a safe space for the youth to express his desires and feelings about his mother's efforts to protect him from disappointment triggered by his relationship with his father. SCC staff also learned about the mother's challenges and helped her to manage her past traumas while also boosting her self-esteem and confidence. Through the support provided by the SCC program, both the youth and his mother actively engaged with their new support systems and expressed hope. They also reported a decrease in feelings of anxiety and conflict in their own relationship.

The SCC program's African American Stakeholder Advisory Committee continues to review and provide feedback to update the program's initial community needs assessment. This feedback will be used to influence culturally relevant interventions and strategies for program refinement to continue to reduce suicide risks within the African American community.

◊ **American Indian/Alaskan Native/Indigenous (AI/AN/I) SCC** is administered by Sacramento Native American Health Center (SNAHC). This SCC program, known as "Life is Sacred," provides Native culture-based suicide prevention training and support services to AI/AN/I community members across the life span. Although the Life is Sacred program provides an array of services, the unique program design has demonstrated that groups which focus on bringing community together, including Gathering of Native Americans (GONA) Training/Workshop, Culture is Prevention (CIP) workshops, and suicide prevention trainings, have been more effective for the AI/AN/I community members.

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

Success: American Indian/Alaskan Native SCC
Excerpt from a letter written and by a tribal Elder from Wilton Rancheria, dated January 29, 2024:

"I have had multiple people pass in my life since 2014, all of whom were a big part of my life. I have taken time off work due to my blood pressure & health due to learning about my son's neuroendocrine lung cancer. My journey has been filled with ups & downs, with stress, depression, and many emotions within me. I am a person who keeps things within myself, and I know that's not good as well as healthy. I feel attending the (Cultures is Prevention) classes at SNAHC has given has helped me realize some of my emotions, it's therapy for one's heart and soul.

I know that I still have a journey to get through this all. I know that these workshops have helped me to relax more and interact with others. The positive blessings in the music, drums, prayers, and workshops are food for the soul and heart and I truly appreciate you for all you have done, and you always take the time to go around and speak to everyone. Your heart is in your work, and I truly thank you."

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

Additionally, this program provides several types of individual support including linkage and referrals to specialty mental health and/or substance use prevention and treatment services if a

participant requires more treatment support than what is currently provided by the program.

◊ **Latino/Spanish-Speaking SCC**, administered by La Familia Counseling Center (LFCC), provides suicide prevention and supportive services to Sacramento County's Latino/a/x communities. The program's purpose is to promote community connectedness, improve access to mental health and other needed services (e.g. support services, crisis services, benefits acquisition, etc.), and address suicide prevention through appropriate and effective strategies for Latino community members in Sacramento County.

This SCC program utilizes culturally relevant service strategies to address suicide risk factors, including isolation, poor nutrition, and lack of connectedness to mainstream communities, and provides individual supportive services to reduce the stigma and discrimination about mental illness and bring about awareness of suicide prevention.

Due to the political climate and discrimination against immigrants, risk factors for Latino/Spanish-speaking communities have intensified over the past several years. This has resulted in community members experiencing severe anxiety, major depression, trauma, re-traumatization, isolation, and vicarious traumatic reactions. The program offers individual navigation to resources that will reduce risk factors and guide community members toward wellness. A high priority continues to be supporting individuals by assisting with connection to needed mental health services through on-site BHS-contracted therapists and other BHS services. Like all SCC programs, this program provides several types of individual support, including linkage and referrals to specialty mental health and/or substance use prevention and treatment services when these needs are identified while working with individuals.

Success: Latino-Spanish Speaking SCC
A 49 year old Spanish-speaking female came to LFCC very stressed, scared, and asking for help. The individual reported experiencing domestic violence and wanting to leave her husband. SCC staff provided extensive support, including connecting her to resources to help her obtain a restraining order and an attorney, receive therapy with a LFCC counselor, and be linked to services at a domestic violence shelter, My Sister's House. The individual reported feeling less stressed and more empowered by the support she received from SCC staff. The individual later returned to LFCC to share her progress. She reported that she now has custody of her children and will be receiving assets from the divorce. She shared that she could not have done all of this without LFCC's assistance and felt very thankful to staff for their support.

In addition, the program offers several groups including support groups for seniors, individuals experiencing grief and bereavement, as well as survivors of domestic violence.

The agency also provides a variety of training opportunities to community members including Applied Suicide Intervention Skills Training and Mental Health First Aid (MHFA). Through their SCC program, MHFA and Youth MHFA trainings are provided in Spanish to Latino/Spanish-speaking community members.

In 2016, LFCC was awarded a California State Office of Health Equity grant to identify and address unmet needs in the Latinx community through their SCC program. Their grant-funded program, known as Centro de Apoyo Latino (CAL), provides short-term therapy and, when needed, a warm handoff to community services and serves as a complementary partner program to the SCC program.

◊ **Arabic-speaking SCC,** administered by Refugee Enrichment & Development Association (REDA), provides suicide prevention awareness and support services to the Arabic speaking community. Their Supporting Community Connections (SCC) program provides culturally responsive and linguistically proficient support through the following outlets: 1) Social support services offered through REDA's helpline which allows REDA to assess the community's needs and provide wider linkage to service providers; 2) Mental health screening services provided to clients during both daily intake and monthly outreach events. This screening uses a questionnaire to assess clients' mental health needs and the need for a mental health clinician for the Arabic speaking community; 3) Referrals to mental health providers and for clients who display symptoms of distress, depression, and PTSD, they are offered the option of being referred to culturally and linguistically sensitive providers (counselors, therapists, or psychiatrists); 4) Outreach and Mental Health Education. REDA created a series of videos in Arabic featuring stories of mental health survivors to break the stigma existing around mental health issues. In addition to this video series, called "Stories of Hope", REDA created an online blog of mental health resources in Arabic; and 5) Community engagement activities. REDA offers monthly events to Arabic speaking families and youth, including educational workshops and outdoor trips. REDA also offers at least five (5) educational workshops annually to the Arabic-speaking community, with topics on personal care and well-being. Culturally sensitive speakers offer presentations addressing the worldview of the diverse community groups inclusive of all ages and use strategies known to culturally engage the community.

Success: Arabic-speaking SCC

REDA volunteers met A.S who reported that she had lost over 17 family members in the recent attack on Gaza. In addition to grieving their loss and to her attempts to process frustration and anger, she struggled with guilt as a taxpayer funding genocide. In a work environment where life was expected to go on as usual, and with co-workers or friends who seemed disconnected or indifferent to her family's fate, A.S. felt alienated. Despite being from a mixed heritage family (half Latino – half Arab) in which mental health is "not something that we talk about because we always have to be strong" she needed to feel heard and connected.

A.S. was invited by REDA to share her story in a 10-min video that received very wide support and solidarity. This video is one among several videos posted as part of the "Gaza Children Are Not Numbers" Campaign; a campaign launched by REDA for community members to share stories of loved ones they lost in Gaza. A.S also started attending the campaign's monthly healing circles. The opportunity to tell and share her story and the healing circles provided A.S. with the emotional support she needed at this time. One of the things she mentioned was: "I broke up with my best friend when I sent her a message telling her I lost 5 family members in Gaza, and she only replied a few days later with a completely unrelated topic. I felt alone, betrayed and I felt a need to build a new community that I can feel connected to. It's here, with other comrades who do not stay silent when action is needed that I feel heard and connected."

◊ **Iu Mien SCC** is administered by Iu Mien Community Services (IMCS). This SCC program provides culturally and linguistically responsive intergenerational support groups, outreach and engagement activities, and prevention-focused culturally relevant suicide prevention services to the Iu Mien community across the life span. Although the program provides an array of services, the culturally specific activities as defined by the community are paramount. The goal of this program is to facilitate referrals to behavioral health services for clients who display symptoms of distress, depression, substance misuse, and/or symptoms related to Post Traumatic Stress Disorder (PTSD). The referrals include linkages to specialty mental health and/or substance use prevention and treatment services if a participant requires more treatment support than what is currently provided by the program.

Success: Iu Mien SCC
Participant attends our weekly senior programs and visits us during office drop in hours for additional services. IMCS has helped him with site translation of letters received and has called his doctors to make medical appointments or clarify instructions. The senior group and our agency's services have provided him with support he needed to prevent feelings of isolation. Participant states that his children are busy working and do not have time to help him. He recently underwent a cataracts surgery that IMCS helped him schedule and now can see clearly again. This has given him the opportunity to continue his independence and provided mobility that he would have otherwise lost.

The Iu Mien SCC program provides weekly peer-run adult day support services for elderly and disabled Iu Mien community members. Support services include socialization, weekly news exchange, recreation/field trips, and presentations regarding community concerns and services of local agencies, with the goal of decreasing the isolation, loneliness, and depression plaguing many elderly and disabled Iu Mien community members.

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

◊ **Ukrainian Support Line** is administered by the Slavic Assistance Center. In response to the war in Ukraine, BHS worked with the Slavic Assistance Center, a SCC provider serving the Russian-speaking community, to implement a phone support line to be answered in Ukrainian or Russian to listen to the needs of local community members who have family or friends back in Ukraine and provide appropriate emotional support and referral information during this challenging time.

Success: Ukrainian Support Line SCC
[Name withheld]: I am the pastor of the Bethany Slavic Missionary Church, and my ministry is to help refugees. The flow of refugees began to decrease in 2021, and we thought of closing this ministry in 2022. Then we observed the suspicious actions of the Russian army on the border with Ukraine and we were preparing for a lot of work with refugees. On February 24, 2022, our forecasts were confirmed, Putin launched aggression against Ukraine. Millions of Ukrainian refugees fled to European borders, and a lot of refugees began to cross the Mexican American border, saving their lives from the aggressor. Our church volunteers organized transportation to transport refugees to Sacramento. We have set up temporary shelters for women with children and elderly refugees. Our team worked at the border 24/7 every day from the end of February to the end of April 2022. We tried to help in any way we could, but sometimes we failed in the direction of centralized informatics and relief councils to attract government programs for refugees. Then, at our current working meeting, staff from the Slavic Assistance Center, came and informed us that the Ukrainian Support Line (916-925-1010) was open, which can inform refugees and give advice on settling in a new country. This telephone line operates five days a day from 8 am to 7 pm and on Saturdays from 8 am to 12 pm. It was a pleasant surprise for us. This telephone line is a very important tool for refugees to receive information and provide help in their native language. I thank God that someone came up with this service that helps Ukrainian refugees solve many issues in adapting to a new life in the United States. May God bless you for your work for the benefit of people in need.

--Translated from Ukrainian into English

In addition to serving local residents, new Ukrainian Refugees are calling the support line to obtain information about applying for permanent residence and a path to citizenship. Many new Ukrainian Refugees are in urgent need of housing. Currently, there are local Ukrainian homeowners willing to share housing with two or even three families which gives new arrivals time to find work and save up for rent. Callers are connected with resources to access the

Medi-Cal program and referrals are made to County BHS programs as needed. Like all SCC programs, this program provides several types of individual support, including linkage and referrals to specialty mental health and/or substance use prevention and treatment services as issues are identified.

The Ukrainian Support Line is promoted through Slavic Language radio and television programming as well as through flyers distributed in the Slavic community including schools, churches, and local refugee organizations.

◊ **Afghan SCC**: This program was awarded to Refugees Enrichment and Development Association through a competitive selection process. The contract was executed in February of 2024. Their Supporting Community Connections (SCC) program provides culturally responsive and linguistically proficient support through the following three outlets: 1) Social support services offered through REDA's helpline, allowing REDA to assess the community's needs and provide wider linkage to service providers; 2) Mental health screening services provided to clients during both daily intake and monthly outreach events. This screening uses a questionnaire to assess clients' mental health needs and the need for a mental health clinician for the Afghan community; and 3) Referrals to mental health providers; clients who display symptoms of distress, depression, and PTSD are offered the option of being referred to culturally and linguistically sensitive providers (counselors, therapists, or psychiatrists).

Success: Afghan SCC
An Afghan family was referred to us from San Juan Unified School District. The girl, age 7, was refusing to go to school. She was always alone, did not communicate with anyone, and was afraid to be in class. REDA's case manager contacted the parent, who stated that his two older sons were also experiencing anxiety, fear, and nightmares. The family asked for referral to a professional mental health provider. All three children received therapy. They have recently stopped their therapy sessions. The father stated his children have recovered from the fears they were experiencing. His elder son has registered for REDA's Summer Youth Mentoring Program, and his girl is adjusting well at home and in school.

REDA also offers at least five (5) educational workshops annually to the Afghan community on personal care and emotional well-being. Culturally sensitive speakers offer presentations addressing the needs of the diverse community groups (men, women, teens, seniors and children) and in-person interpretation is available when needed.

◊ **Farsi-speaking SCC**: The program was awarded to the Refugee Enrichment and Development Association (REDA) through a competitive selection process. The contract was executed in February 2024. Their Supporting Community Connections (SCC) program provides culturally responsive and linguistically proficient support through the following three outlets: 1) Social support services offered through REDA's helpline, allowing REDA to assess the community's needs and provide wider linkage to service providers; 2) Mental health screening services provided to clients during both daily intake and monthly outreach events. This screening uses a questionnaire to assess Farsi-speaking clients' mental health needs and the need for a mental health clinician for the Farsi-speaking community; and 3) Referrals to mental health providers; clients who display symptoms of distress, depression, and PTSD are offered the option of being referred to culturally and linguistically sensitive providers (counselors, therapists, or psychiatrists).

Success: Farsi Speaking SCC
A newly relocated family was having difficulty navigating the social services and education systems, causing a great deal of emotional and psychological strain in the family. The wife contacted REDA through the Helpline and asked for assistance. REDA's case manager helped the family complete online applications for Food Stamps, Cash Aid, and Medi-Cal, as well as assisting in enrolling the two children in a nearby school. Both parents screened positive for mental health needs, due to the high level of stress, anxiety, and adjustment challenges. The case manager invited both parents to attend REDA's Wellness workshop on May 24, 2024, where they got the chance to meet the therapist who presented the workshop in Farsi. A few days later, the wife called and shared how this workshop helped change the behavior of her husband at home. She requested to be referred for family therapy. The wife was appreciative of the therapy sessions they received. Furthermore, both parents are now enrolled in ESL classes and REDA is assisting the husband with his resume and job search. He will also be receiving his driver's license in two weeks.

REDA also offers at least five (5) educational workshops annually to the Farsi-speaking community on personal care and emotional well-being. Culturally sensitive speakers offer presentations addressing the needs of the diverse community groups (men, women, teens, seniors and children) and in-person interpretation is available when needed.

The **Community Support Team (CST)** is a *PEI Access and Linkage to Treatment program* that is in alignment with the following PEI categories: *Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan;* and *Culturally competent and linguistically appropriate prevention and intervention (WIC § 5840.7).*

The Community Support Team (CST) program serves Sacramento County children, youth, Transition Age Youth (TAY), adults, and older adults who are experiencing mental health distress, including those at risk for suicide. The CST program consists of Sacramento County-employed Mental Health Counselors (MHCs), Senior Mental Health Counselors (SMHCs) and contracted Peer Specialists, who respond to referrals directly from the community to provide community-based mental health assessments, interventions, system navigation, and linkage to services for individuals and families. The CST partners with programs and community partners, including the Co-response Crisis Intervention Team (CCIT), the County Jail, Community Wellness and Response Team (CWRT), and law enforcement agencies throughout Sacramento County to provide CST services to individuals coming into contact with the justice system. The CST collaborates with programs and community partners in order to provide quality interventions and linkages to ongoing needed services for up to 60 calendar days, in order to promote recovery and prevent relapse into crisis, including the justice system.

Success: Community Support Team (CST)
CST Peer Specialist and CST Senior Mental Health Counselor (SMHC) conducted a home visit with a client who did not have an active cell phone. The client also supported his disabled wife. He reported that he had connected with the appropriate support in other domains but needed help with mental health services and housing/rent support. During this engagement, the client expressed his hopelessness with his situation and job loss. The client also expressed that he was feeling caregiver burn-out due to being the primary source of income for the household and primary support for his disabled wife. The client shared that he had no family members that could help with his situation. During this dialog, CST Peer Specialist and SMHC offered supportive listening and motivational interviewing. The client shared that his number one concern was that he was unhoused and that he had difficulty talking on the phone. Before the next visit, the Peer Specialist created a list of resources for him based on the information from the referral. During the home visit, the client also showed the Peer Specialist and SMHC that he had no food in the house and did not have transportation. The Peer Specialist and SMHC made calls to a veteran's services resource and sent in a referral for rent help. Because several local food bank and outlets were closed given the time of day, CST accessed the program's client support funds for food from the grocery store to last until the following week. Peer Specialist and SMHC also discussed ways to obtain food boxes with client. The client shared that he was connected to the Veteran Affairs and had scheduled an appointment. The client was also aware of the Mental Health Urgent Care Clinic in case of a mental health emergency. The Peer Specialist reviewed with client the resources for basic needs, benefits for which he could apply, information and crisis lines. The client was very appreciative during the visit. The visit went longer than anticipated; however, by working together as a team, all of the client's needs were met during this one home visit. The CST were able to problem solve with the client to connect him to early intervention resources.

Crisis Navigation Program (CNP) is a *PEI Access and Linkage to Treatment program* that is in alignment with the following PEI priorities: *Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan;* and *Culturally competent and linguistically appropriate prevention and intervention (WIC § 5840.7).*

Administered by Bay Area Community Services (BACS), this program provides 24 hours, 7 days a week on-call support to clients in crisis and response to referrals. This program serves children, youth, TAY, adults, and older adults with the goal of reducing a relapse into crisis, unnecessary hospitalizations, and incarcerations. The CNP team provides brief community-based navigation services for individuals recently involved in crisis services as a result of their mental illness. Navigators are Peer Specialists who have mental health lived experience. Navigators provide triage, recovery-focused crisis intervention, peer support, care coordination, advocacy, system navigation and linkage to services for individuals living with serious mental illness. Navigators are field-based and dispatched out to respond to new referrals from Sacramento County emergency rooms and psychiatric hospitals, providing the majority of services in the community.

The CNP team continues to build and expand partnerships with hospitals. The team has also focused on strengthening and building relationships with the Emergency Departments, inpatient psychiatric hospitals, and community-based agencies and organizations and engaging in community outreach events to inform stakeholders and community members about CNP services.

Navigators have remained field-based, being dispatched out to new referrals and to community locations to locate community members who have been referred to services.

The CNP team continues to build and expand partnerships with hospitals. Navigators have remained field based, being dispatched out to new referrals and to community locations to locate community members who have been referred to services.

Success: Crisis Navigation Program (CNP)
Client, a 26-year-old female, was referred to CNP from a local psychiatric hospital following an involuntary hold due to grave disability. At the hospital, she was disorganized, disoriented, and experiencing delusions. The Care Coordinator met with the client and her family, who were concerned but felt overwhelmed by her severe mental health needs.

The Care Coordinator continued to engage with the client to assess her needs and goals and determine the best approach for linking her to outpatient mental health services (CORE Adult Mental Health Services). Although client was initially reserved, she expressed interest in receiving services. Following her discharge from the hospital, the Care Coordinator assessed her situation and suggested using walk-in assessment hours at the nearest CORE program to ensure quick access to services, as her responses might not qualify her for a referral to BHS Screening and Coordination (BHS SAC) team services.

Despite her initial mistrust, client felt comfortable with the Care Coordinator's support. The Care Coordinator facilitated transportation to the walk-in assessment and provided additional information during the assessment with client's consent.

The client has been successfully linked to the local CORE program and has started taking medication with positive results. She is now pursuing further education by enrolling in a local community college to work towards her associate's degree.

In FY 2023-24, CNP received 2197 referrals reaching its highest capacity and individuals served since opening and an increase of 482 referrals from the previous year.

Co-response Crisis Intervention Team (CCIT), formerly known as the Mobile Crisis Support Teams (MCST), is a *PEI Access and Linkage to Treatment program* that is in alignment with the following PEI priorities*: Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan;* and *Culturally competent and linguistically appropriate prevention and intervention (WIC § 5840.7).*

The program is a collaboration between BHS and local law enforcement agencies across Sacramento County. The program transitioned to a new name, CCIT, in early 2025 to better reflect their unique role and services. CCIT serves individuals of all ages and diversity in Sacramento County by providing timely crisis assessment and intervention to individuals who are experiencing a mental health crisis. The goals of the program are to provide safe, compassionate, and effective responses to individuals with a mental illness; increase public safety; decrease unnecessary hospitalizations for community members experiencing a mental health crisis; decrease unnecessary incarceration for community members experiencing a mental health crisis; and increase consumer participation with mental health providers by problem solving barriers and increasing knowledge of local resources.

Each CCIT is comprised of a Police Officer/Deputy Sheriff who is trained in Crisis Intervention (CIT) to respond to persons experiencing mental health crisis, a BHS licensed mental health counselor, and advocates through a contracted provider: Cal Voices – Community Support Team. The team employs a ride along, first response model where the BHS Counselor and a law enforcement Officer/Deputy respond together to emergency calls involving a mental health crisis with the goal of mitigating the crisis in the community and linking individuals to resources and services. The Advocate then provides follow-up engagement and services for individuals with potential mental health needs to ensure they are offered support in navigating care systems and successfully linked to appropriate services.

The CCIT Program currently includes seven (7) teams covering seven (7) areas. These areas are inclusive of the North and South areas of unincorporated Sacramento County, the cities of Citrus Heights, Folsom, Galt, Rancho Cordova, as well as Sacramento County located campuses in the Los Rios Community College District. To serve these areas, BHS has partnerships with the Sacramento Sheriff Department-North Division, Sacramento Sheriff Department-Central Division, Citrus Heights Police Department, Folsom Police Department, Rancho Cordova Police Department, Galt Police Department, and Los Rios Police Department.

Success: Co-response Crisis Intervention Team (CCIT)
CCIT responded to a local hospital after a client reported a sexual assault and expressed a desire to file a police report. The CCIT clinician played a crucial role in ensuring the client received the necessary emotional support, safety planning, and linkages to trauma and mental health services during this vulnerable time. Upon arrival, the clinician, familiar with the client from previous interactions, immediately established rapport, creating a sense of trust. While the officer conducted the police interview, the clinician provided emotional support, using grounding techniques to help the client manage distress. Recognizing the client's heightened vulnerability, the clinician began initial safety planning, ensuring the client felt secure and supported throughout the interaction. Understanding the importance of addressing both immediate and long-term needs, the clinician recommended a visit to a specialized trauma clinic for a comprehensive exam. The clinician facilitated transportation and coordinated with the clinic to ensure a seamless transition for the client. Additionally, the clinician contacted a local advocacy group to provide trauma-informed support at the clinic, ensuring the client had an advocate present during the exam. To further assist with recovery, the clinician worked on linking the client to mental health services. After discussing available resources, the clinician facilitated a referral to a culturally appropriate mental health provider. The clinician discreetly contacted the provider, sharing relevant information and ensuring they would follow up with the client.

When the clinician followed up, the client reported being engaged with mental health services and grateful for the comprehensive support. This case demonstrates the clinician's vital role in safety planning, trauma support, and ensuring strong linkages to mental health services, which were essential in helping the client navigate this difficult experience and move toward recovery.

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

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

◊ **The Caregiver Crisis Intervention Respite Program**, administered by Del Oro Caregiver Resource Center, is in alignment with the following PEI priorities*: Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan;* and *Culturally competent and linguistically appropriate prevention and intervention; and strategies targeting the mental health needs of older adults (WIC § 5840.7).*

This program helps decrease hospitalizations due to mental health crises of family caregivers of people diagnosed with cognitive disorders, primarily dementia. The program provides

respite care, family consultation, home visits, and an assessment with a clinician to develop a care plan focused on services, supports, and wellness. The program serves adult caregivers of all age groups with the majority of caregivers being in the 60+ age range.

Success: Caregiver Crisis Intervention Respite Program
Caregiver is a 76-year-old Latino man, referred by a family friend, caring for his 75-year-old wife with frontotemporal dementia. Caregiver indicates the care receiver needs "full" assistance with all Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). The caregiver has been caring for his wife since 2021. He was enrolled in a Sacramento County program for respite and increased supportive services from his Family Consultant. Additional funding was also leveraged to provide counseling services for the client, who verbalized signs and symptoms of depression and scores on Zarit Burden Interview (a caregiver self-report measure) were also indicators. Caregiver wrote to his Family Consultant after receiving respite funding and shared, "I am passionate about my faith, and I try to hope where there is despair. I give thanks to my children and people like you and those who care for [name of his wife] at Day Care. Thank you for continuing to be a bright light."

◊ **Rejuvenation Haven** (formerly named Respite Program), administered by Wind Youth Services, is in alignment with the following PEI priorities*: Childhood trauma prevention and early intervention to deal with the early origins of mental health needs; Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan;* and *Culturally competent and linguistically appropriate prevention and intervention (WIC § 5840.7).*

This program provides mental health drop-in respite services to youth and TAY ages 13-25 years old experiencing overwhelming stress due to life circumstance and homelessness. Services may be accessed via a drop in center or with a pre-planned visit and include screening, planning, crisis intervention, life skills workshops, health screenings, groups, crisis counseling, and case management.

Success: Rejuvenation Haven
The drop-in center case manager assisted a young individual from another state who had lost all their identification documents. Using grant funds, the case manager ordered out-of-state documents through a vital records partner and had them mailed to our drop-in center. This support allowed the individual to secure identification, obtain a space in a local shelter, and start a part-time job at a restaurant. The individual, now proud of their accomplishments, continues to work and has applied for the Transitional Housing Program.

Program outcomes include reducing risk factors, increasing access to mental health crisis support services, increasing knowledge of available supports and resources, and diversion from restrictive environments.

◊ **The Ripple Effect Respite Program**, administered by A Church For All, is in alignment with the following PEI priorities: *Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan;* and *Culturally competent and linguistically appropriate prevention and intervention (WIC § 5840.7).*

The program, a mental health drop-in respite service, provides respite services to unserved and underserved TAY (18+), adults, and older adults, with an emphasis on people of color who may identify as LGBTQ+ at risk of or experiencing a mental health crisis. Services include screening, supportive services, individual and group support, linkage to other services, peer

supports, other crisis response services, and community outreach activities. The Ripple Effect promotes community connection and other supportive resources, so participants leave feeling less stressed than when they arrived. Participants may return to utilize respite services as needed.

Success: Ripple Effect Respite Program
The Ripple Effect re-established relationships with the local probation office, resulting in an increased number of participants under their supervision. The program is now mentoring these individuals to become peer care coordinators. Notably, one participant completed mental health training through A Church For Us and the County and now is actively volunteering to support his peers and Ripple Effect staff.

◊ **Q-Spot Youth/Transition Age Youth (TAY) Respite Program**, administered by Sacramento LGBT Community Center, is in alignment with the following PEI priorities: *Childhood trauma prevention and early intervention to deal with the early origins of mental health needs; Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan;* and *Culturally competent and linguistically appropriate prevention and intervention (WIC § 5840.7).*

The program provides drop-in mental health respite care and supportive services to unserved and underserved youth and TAY, age 13 to 25 who identify as LGBTQ+. In addition, support groups are provided with a range of topics, including but not limited to: anti-bullying, coming out, healthy relationships, and life skills development. Q-Spot program offers the LGBTQ+ youth community respite services provided by peers and staff with the same lived experience, which is critical to improving their mental health.

Success: Q-Spot Youth/TAY Respite Program
"Kay" is a 19-year-old client who came to Q-Spot in September of 2024. While living in a park in South Sacramento, she was found by other clients from our youth respite center. These clients approached her and learned she was alone, had nothing with her, and no one to help her. They brought her to Q-Spot, where she was met with kind and compassionate staff and a safe and inclusive environment.

Kay was connected to a youth advocate in Q-Spot who assessed Kay's needs and learned more about her current situation and challenges. She was staying at the park because she had run away from her mother's house where she had experienced severe abuse. She shared she is on the autism spectrum, struggles with communication, had no personal documents, money, job, friends, or supportive family, and experiences severe anxiety and depression. Kay's mental health was declining, and she disclosed having suicidal ideation. Q-Spot staff immediately connected her with our in-house mental health clinician to assess risk, provide safety planning, and address the effects of the abuse and other urgent mental health needs. The youth advocate helped Kay access emergency housing services through 2-1-1. Kay was immediately housed at the Short-Term Transitional Emergency Placement (STEP), the Center's emergency housing shelter for unhoused TAY. Kay continued to seek support and access services at Q-Spot, which assisted her in ordering personal documents. Since she came to Q-Spot, Kay has accomplished numerous tasks and overcome many challenges. She has obtained her birth certificate and state ID, made friends with other youth, accessed career development programming to become financially stable, attended harm reduction workshops, joined in youth activities, and has identified future safe and stable housing beyond emergency shelter. Within hours of Kay being brought to Q-Spot by other clients, she was supported with mental health crisis intervention and counseling which then led to de-escalation, clothing, food, a shower, and ongoing support and resources. This support helped to stabilize her mental health crisis, decrease suicidality, and provide linkage to critical resources, connection with other youth, a significant decrease in isolation, and housed in a safe environment where she can continue to heal from trauma and move toward her goal of independent living.

◊ **Lambda Lounge Adult Mental Health Respite Program**, administered by Sacramento LGBT Community Center is in alignment with the following PEI priorities*: Early psychosis*

and mood disorder detection and intervention; mood disorder and suicide prevention programming that occurs across the lifespan; and *Culturally competent and linguistically appropriate prevention and intervention (WIC § 5840.7).*

The program provides mental health respite care, via a drop-in center and supportive services, to unserved and underserved adults and older adults who identify as lesbian, gay, bisexual, transgender, and/or questioning (LGBTQ+). Respite services are short-term time-limited breaks in a safe environment for individuals who are at risk of or experiencing a mental health crisis. Respite services are designed to prevent an acute mental health crisis from occurring and may provide an alternative to emergency department visits or psychiatric hospitalizations. Services include screening, individual and group support, linkage to other services, peer supports, crisis response services, and community outreach activities.

Success: Lambda Lounge Adult Mental Health Respite Program
The Bilingual Community Resources and Outreach Coordinator at the Lambda Lounge (the Center) ensures that the Center's services are accessible to Spanish-speaking clients. Recently, a transgender, Spanish-speaking community member sought support at the Center's adult respite program. The Coordinator connected with them, addressing their needs for guidance, resources, and emotional support in their primary language.

Additionally, the Coordinator referred the client to career counseling and provided information about the Center's job fair. With assistance in resume building and interview skills, the client secured a position at a local medical clinic. The Center celebrated the client's new job, and the client expressed gratitude for the Adult Respite program, the Bilingual Coordinator, and the Economic Justice Coordinator.

Strengthening Families Program
FY 2025-26 Capacity: 20,503 annually (including the Bullying Prevention and Education Program)
Ages Served: 73% Children, 10% TAY, 15% Adults, 2% Older Adults

The Strengthening Families Program consists of several components collectively aimed at reducing risk factors for developing a potentially serious mental illness and to build protective factors, outreaching to increase recognition of early signs of mental illness, and improving timely access to services for underserved populations.

Quality Child Care Collaborative (QCCC) is a *PEI Prevention program* which is in alignment with the following PEI priorities*: Childhood trauma prevention and early intervention to deal with the early origins of mental health needs,* and *Culturally competent and linguistically appropriate prevention and intervention (WIC § 5840.7).*

The QCCC is a collaboration between Behavioral Health Services (BHS), Child Action, Sacramento County Office of Education (SCOE), and other partners. This collaborative leverages First 5 funding to provide behavioral health consultations to preschools and early childcare learning environments for children, birth through age five (5). Consultations are designed to increase teacher awareness about the meaning of behavior and to provide strategies to ensure the success of the child while in a childcare and/or preschool setting, resulting in high quality childcare for children and families. Support and education are also available for parents. During FY 2021-22, the program was expanded by adding a second behavioral health clinician position. Services were provided predominantly in-person. In addition, a new monthly training series began, offered

to providers, families, and community members around topics specific to serving the 0-5 population.

Success: Quality Child Care Collaborative (QCCC)
QCCC received a referral from a childcare center seeking support regarding a four-year-old child who was struggling with managing her emotions and getting along with peers. The QCCC Consultant provided coaching to the teacher on how to use children's literature to build the child's emotional vocabulary, along with helping her to label her emotions throughout the day using a feeling words chart. Emotional regulation strategies were modeled including deep breathing activities. Once the child started displaying more regulated behaviors consultation began to focus on strengthening the child's interactions with her peers. Consultant coached the provider on teaching friendship skills using social stories, puppets, and having children role play positive interactions with the teacher's support. Upon completion of consultation services, the teacher reported a decrease in the child's emotional outbursts, as well as an increase in using her words to express herself. These behavior changes improved the child's relationships with her peer group. Providing the teacher with consultation and interventions made for a more successful childcare experience for all involved. Consultation affected change and positively impacted this child's school trajectory. Consultation also taught the teacher skills she can continue to use with other children that come into her care making for more quality childcare.

The **CPS Mental Health Team** is a *PEI Improving Timely Access to Services for Underserved Populations program* that is in alignment with the following PEI priorities: *Childhood trauma prevention and early intervention to deal with the early origins of mental health needs,* and *Culturally competent and linguistically appropriate prevention and intervention (WIC § 5840.7).*

This is a collaborative program between BHS and Child Protective Services (CPS) that supports the mental health needs of children within the Child Welfare system. The program serves children and youth, birth through age 20 and aligns with the implementation of Continuum of Care Reform and the requirement that a Child and Family Team (CFT) is provided to all children entering the Child Welfare system.

The program's BHS clinicians complete the Child and Adolescent Needs and Strengths (CANS) tool and provide mental health consultations that inform the CFT meeting process and CPS case planning. This completed CANS assessment represents a shared vision of the child, family, and the CFT.

BHS clinicians also participate in the CFT to identify supports, mental health referrals, and other services needed to achieve permanency; enable the child to live in the least restrictive family setting; and promote normal childhood experiences.

Success: CPS Mental Health Team
CPS MH team Clinician met with the father of a five-month-old baby to conduct the Child, Adolescent Needs and Strengths (CANS) tool to determine needs and strengths of the family in order to present at the Child and Family Team (CFT) Meeting. Child Protective Services had engaged with the family due to general neglect. The clinician met with the father and explained part of the purpose of this assessment is to gather and report the strengths of the family. The father shared he had not felt heard from previous professionals and was happy to be asked what was going well with his family. Initially, he had some fears that the CANS interview would "count against him". The clinician worked to assure the father the tool was used as a communication tool to share amongst his team of support. This clinician encouraged Dad to share during the CFT. The father shared how positive his interactions were with the Clinician and how the CANS tool provided an opportunity to focus on some positive aspects of himself and his family while experiencing this very stressful event. CPS-MH Team program works to deter or decrease entry into the child welfare system and to provide opportunities for the family to share their story. This father was able to feel heard, which created a safe space within his CFT meeting to not only focus on his case plan but to also note what was positive about his family.

The team's services also include behavioral health assessments of parents/caregivers, crisis intervention, and other short term mental health services to support permanency plans. The team has also been deployed to assist CPS with crisis intervention and referral/linkage services at its emergency short term placement facility.

The **Bullying Prevention Education and Training Program** is a *PEI Prevention program* and is in alignment with the following PEI priorities: *Childhood trauma prevention and early intervention to deal with the early origins of mental health needs,* and *Culturally competent and linguistically appropriate prevention and intervention (WIC § 5840.7).*

Administered by the Sacramento County Office of Education (SCOE), this training program is available to all 13 Sacramento County school districts.

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

The program goals are to (1) Reduce risk factors related to bullying by developing proactive strategies (2) Reduce prolonged suffering of youth at risk of bullying; (3) Increase students' emotional wellbeing; (4) Reduce violence risk in schools; (5) Increase coping skills and resilience that improve behavioral functioning; (6) Build empathy and understanding; and (7) Increase pro-social skills to reduce isolation and anxiety.

Success: Bullying Prevention Education and Training Program (BPP)
The older students have taken on a pivotal role in fostering empathy and understanding among their peers by sharing their personal experiences with bullying. They actively engage in open discussions, helping their classmates grasp the profound emotional toll that bullying takes on individuals. Through these conversations, they explain the range of feelings—such as isolation, fear, and sadness—that victims of bullying often experience, as well as the lasting consequences it can have on their mental and emotional well-being. The Bullying Prevention Programming (BPP) not only allows students to reflect on their past actions but also promotes a culture of kindness and mutual respect.

A particularly inspiring aspect of BPP is witnessing the transformation of former bullies into advocates for positive change. Students who were once involved in bullying each other are now forging genuine friendships and offering support to those they once hurt. This shift in relationships is a testament to the power of education, empathy-building, and the collective effort to create a more inclusive and understanding school environment. The success of this program is evident when we see students who have experienced both the harm and healing of bullying, now standing together as allies, showing that growth and change are possible.

Youth Mental Health First Aid (YMHFA): The program is supported in both the PEI and WET components. YMHFA is a *PEI Outreach for Increasing Early Signs of Mental Illness Program* and supports the following PEI priorities: *Childhood trauma prevention and early intervention to deal with the early origins of mental health needs; Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan;* and *Culturally competent and linguistically appropriate prevention and intervention (WIC § 5840.7).*

Administered by Sacramento County Office of Education (SCOE), the program's activities include trainings, professional development, consultation, and evaluation activities necessary for effective

and sustainable training implementation and maintenance within the County. Trainings provided will educate teachers, school staff, caregivers, and others, and will include strategies to assist a youth who is experiencing mental health or in crisis. Trainings utilized are YMHFA and Question, Persuade, and Refer (QPR) Suicide Prevention Trainings. In FY 2023-24, 17 training courses were held with a total of 341 participants. For YMHFA and 28 trainings courses were held with a total of 678 participants for QPR training.

Success: Youth Mental Health First Aid
"The informative Youth Mental Health First Aid training prepared me to assist a colleague just a few months after I was trained. My colleague confided in me that their high school-aged daughter was having suicidal ideation and practicing self-harm. I was able to provide immediate support to my colleague to identify next steps and available resources. And because I had practiced at the training, I was able to ask questions without judgement and without leading. I also shared some of the ideas and resource materials I was given at the training so they could have successful discussions with their daughter at home. As a result of our quick response, and the training I had, my colleague's daughter received counseling and supports that enabled her to stop self-harming, rejoin her peers at her school (she had been temporarily removed from the school for her personal safety), and establish better communication with her parents. This young lady is now excelling in school, has built better friendships focused on positivity (instead of the bullying she previously endured), and is back to playing on her school's rugby team. This experience proved to me that when adults are equipped with the resources and the knowledge to intervene in a crisis and listen in the right way, we can make a huge difference in the life of the youth we interact with, and care about."

Program goals: (1) Increase the number of diverse, qualified individuals who have skills and knowledge to recognize youth mental health or addiction challenges or crisis; (2) Reduce stigma and discrimination associated with mental illness or addiction; (3) Improve attitudes and social norms that can lead to social distancing from individuals with mental health challenges; (4) Increase access to mental health care in the community; and (5) Increase pro-social skills to reduce isolation and anxiety.

Early Violence Intervention Begins with Education (eVIBE) is a *PEI Outreach for Increasing Early Signs of Mental Illness program* and is in alignment with the following PEI priorities: *Childhood trauma prevention and early intervention to deal with the early origins of mental health needs; Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs;* and *Culturally competent and linguistically appropriate prevention and intervention (WIC § 5840.7).*

Early Violence Intervention Begins with Education (eVIBE), administered by Sacramento Children's Home, implements Too Good for Violence - Social Perspectives (TGFV-SP) and Nurturing Parent Program (NPP) trainings. TGFV-SP is an educational program designed for youth from grades three through 12, focused on building positive peer relationships while teaching youth to recognize specific developmental and environmental risks and with an emphasis on preventing youth violence. NPP is an educational program designed for families with children from birth to age 18 years and can be offered in an in-home setting and group settings at local schools or community sites. The focus of NPP is to build nurturing familial relationships and utilize positive problem solving skills to reduce conflict effectively within the family.

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

Success: Early Violence Intervention Begins with Education (eVIBE)
At Sutterville Elementary, the 3rd-grade students enjoyed Lesson 3 from the Too Good for Violence curriculum, which focuses on identifying and managing their emotions. One of the impactful strategies students learned in this lesson is how to express their emotions using an "I-message," allowing them to communicate their feelings and needs effectively. In Lesson 4, students further developed these skills by learning about Effective Communication. For example, a student shared how he communicated effectively with his dad by calmly expressing his emotions through an "I-message," resulting in a positive outcome. His father apologized to him immediately and hugged him. The student was excited to share the outcome of this episode and said that using "I-message" really works.

Adoptive Families Respite Program, administered by Capital Adoptive Families Alliance, is a *PEI Prevention program* that is in alignment with the following PEI priorities: *Childhood trauma prevention and early intervention to deal with the early origins of mental health needs;* and *Culturally competent and linguistically appropriate prevention and intervention (WIC § 5840.7).*

The program originated as one of the mental health respite programs funded through the time-limited MHSA Innovation Project #1: Respite Partnership Collaborative. With support from the MHSA Steering Committee, this program transitioned to PEI funding during FY 2015-16.

Success: Adoptive Families Respite Program
"My husband and I have three children who were adopted from foster care. The two youngest are biological siblings. They also have three biological brothers who were adopted by another couple. While we live in separate households and more than an hour apart, we all see each other as one big family of 10. We have visits together at least once a month, but it is rare that we have uninterrupted quality time for more than a few hours. Camp CAFA allows our big family the much-needed opportunity to keep our family ties strong. It allows all six siblings vital time to be all together again and allows us four parents the chance to strengthen our bonds and support one another in this parenting journey. We share one big cabin with the kids on one side and the parents on the other. We relish the time together doing everyday things -- eating meals together, brushing teeth together, tucking the kids in to bed and sharing stories when darkness falls. Without CAFA's annual camp, this time together would not be possible."

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

The Source, administered by Sacramento Children's Home, is *a PEI Improving Timely Access to Services for Underserved Populations program* in alignment with the following PEI priorities: *Childhood trauma prevention and early intervention to deal with the early origins of mental health needs,* and *Culturally competent and linguistically appropriate prevention and intervention (WIC § 5840.7).*

The program is a 24 hours per day, 7 days per week, 365 day per year call center providing immediate phone response, mobile in-person/face-to-face crisis intervention, triage services, mediation, follow-up support, and information and referral. The Source is available to all youth up to their 26th birthday and their caregivers, prioritizing current and former foster youth and foster

parents/caregivers who are experiencing crisis or emotional or behavioral distress that, without immediate support, risks disruption to the current living situation.

The program also includes peer mentoring, family engagement, support and advocacy, temporary relief for youth and caregivers, and developmentally appropriate activities for foster and former foster youth. Outreach and education are provided through social media platforms, ensuring Health Insurance Portability and Accountability Act (HIPAA) compliance. The program supports youth and families in crisis by offering de-escalation and short-term relief, and it conducts quarterly crisis intervention training for community professionals. Additionally, it hosts monthly activities for foster and former foster youth, informs the community about accessing Medi-Cal services, and assists individuals, including those reluctant to seek help, in understanding and obtaining Medi-Cal-covered mental health services.

The goals of this program are to maintain placement stability for foster youth; increase coping and problem-solving skills; improve the quality of family relationships; refer, link, and coordinate ongoing care; and increase opportunities for normative youth experiences.

Success: The Source

The Source Mobile Response Team (SMRT) responded to a call from a caregiver who reported a physical altercation between herself and her 14-year-old daughter. The conflict arose after the daughter argued with her mother and her mother's boyfriend the night before, resulting in the mother confiscating the daughter's phone. The youth's reaction included physical aggression towards her mother and refusal to take her medications.

Upon arrival, SMRT members spoke separately with each individual to de-escalate the situation. The youth peer mentor worked with the daughter to emphasize that physical aggression is unacceptable and stressed the importance of adhering to prescribed medications. SMRT staff provided psychoeducation on effective communication, conflict resolution, and parenting strategies to help the mother manage her daughter's behavior more effectively in the future. A safety plan was also discussed with both parties.

The daughter agreed to a follow-up call from a youth advocate the next day, and the mother consented to a follow-up call from a family partner. The caregiver expressed gratitude for the support provided by the SMRT.

The daughter was receptive to our youth peer mentors support and feedback acknowledging her part that escalated the situation while venting her fears/hurts in a safe nonjudgemental space.

The caregiver was again grateful for the support and was encouraged to share her experiences navigating the challenges parenting a teen. She was invited to our caregiver support group and encouraged to keep up with appointments for her daughter. We reiterated to both the caregiver and daughter we can be reached anytime they want to talk or more focused case management/connection to resources.

Safe Zone Squad (SZS), administered by Sacramento County Office of Education (SCOE), is a *PEI Improving Timely Access to Services for Underserved Populations*, and is in alignment with the following PEI priorities: *Childhood trauma prevention and early intervention to deal with the early origins of mental health needs; Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs;* and *Culturally competent and linguistically appropriate prevention and intervention (WIC § 5840.7)*

The SZS program is comprised of a three-person team on each campus that includes two Youth Advocates and a Safe Zone Coach (mental health counselor). SZS program provides mental health crisis and triage services to students, ages 11 to 14, at two (2) identified middle school campuses (Albert Einstein Middle School and Rosa Parks K-8 School).

Success: Safe Zone Squad
A student was referred to Safe Zone Squad due to concerning behaviors, including excessive outbursts, poor attendance, and negative interactions. The student had a history of trauma and a negative perception of mental health services. The student often missed appointments or appeared disengaged during sessions. As sessions continued, the coordinator worked on simply building rapport with the student and learned that the student enjoyed reading and writing. Through the Support Center's tailored interventions, including music therapy and journaling, the student was able to process trauma and emotions. Additionally, the SZS offered support to the student's mother, connecting her with a community-based agency for family home-based services. As a result, the student's attendance improved, behavior issues decreased, and they became more engaged in school activities. The student's teachers and administration reported positive interactions and improved relationships, demonstrating the effectiveness of the Support Center's interventions in helping the student overcome challenges and achieve positive outcomes.

Mental health support services include, but are not limited to; crisis intervention services, listening circles, skills development, psychoeducation, stress/crisis management, parent/caregiver trainings, restorative mediation, mental health screening to identify appropriate levels of support from the SZS, and linkage to a mental health provider or other resources within the community. Program outcomes include enhancing school success, reducing stigma, improving relationships, and reducing hospitalizations.

Student Mental Health and Wellness Collaborative *is a PEI Outreach for Increasing Recognition of Early Signs of Mental Illness activity* and is in alignment with the following PEI priorities: *Childhood trauma prevention and early intervention to deal with the early origins of mental health needs; Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs;* and *Culturally competent and linguistically appropriate prevention and intervention (WIC § 5840.7)*

The SMHW Collaborative was established in June 2009 and charged with developing a plan for a comprehensive approach to coordinating mental health services in educational settings. The SMHW Collaborative is facilitated and led by Sacramento County Office of Education (SCOE), in partnership with BHS, and consists of a broad range of stakeholder groups in Sacramento County that include representatives from SCOE, BHS, local school districts, the California Department of Education, Family and Youth Advocates, private education providers, mental health and social service providers, community-based agencies, and the general community. This year, Ray Green, Program Officer of My Brother’s Keeper Sacramento Collaborative, has agreed to co-facilitate the meetings, further solidifying our partnership with community organizations.

Nearly a decade after the initial plan was developed, the COVID-19 pandemic magnified the negative societal factors that impact student mental health including stigma, racial discrimination, and inequity. In FY 2021-22, SCOE and BHS convened a participatory process to develop a new plan for student mental health and wellness in Sacramento County.

The plan was developed in three key phases: 1) a discovery phase focused on understanding the strengths, challenges, and opportunities related to student mental health and wellness in Sacramento County; 2) a design phase to identify a collective vision and plan for student mental health and wellness in Sacramento County; and 3) a delivery phase to finalize the plan.

During the 2023-24 fiscal year, the Collaborative met quarterly and consists of over 473 members with an average of 40-50 participants per meeting. The collaborative members are members of the community representing countywide systems as well as community-based organizations and

community members. The participants narrowed the previous five strategies of interest into three workgroups: Elevating Youth Voice, Workforce Development, and Increasing Awareness and Reducing Stigma. The participants worked through their Strategic, Measurable, Ambitious, Realistic, and Time-bound (SMART) goals and reported out to attendees on action steps taken to move towards those goals.

Success: Student Mental Health and Wellness Collaborative
As part of the work of the Collaborative, a social media campaign has been developed in partnership with Behavioral Health Services and the Sacramento County Mental Health Board. This initiative has been funded through Senate Bill 75, passed in 2019, which included the Mental Health Services Act (MHSA) grant, and we have contracted with an organization, NTI Upstream. This project will build upon the work of Safer Sacramento and will lean heavily on the Elevating Youth Voice to engage young people, develop topics, and curate content for the campaign. Currently, members of the Elevating Youth Voice workgroup are coordinating focus groups and interviews through community partners and schools.

Working together to operationalize the Student Mental Health and Wellness Plan, the consolidated subgroups continued their work in alignment with the SMHW Plan priorities and their SMART goals. Progress was made across all workgroups, and all are excited to continue the work in 2024-2025.

Youth Help Network (YHN), administered by Capital Star Community Services, *is a PEI Improving Timely Access to Services for Underserved Populations program* and is in alignment with the following PEI priorities: *Childhood trauma prevention and early intervention to deal with the early origins of mental health needs,* and *Culturally competent and linguistically appropriate prevention and intervention (WIC § 5840.7).*

YHN provides short term triage and navigation services that are community centered and culturally and generationally attuned, flexible, and evidence-informed and effective outreach, engagement and crisis support up to 90 days for TAY ages 16 through 25 years old. Outreach, engagement, and crisis support services are provided to TAY in areas they are known to congregate YHN staff co-locate at local agency sites that serve TAY including drop-in centers and TAY shelters, schools, and community locations. YHN co-located staff and YHN street teams provide on demand crisis support, demystify, and destigmatize behavioral health services, and educate TAY on managing behavioral health crises. This level of support aims to reduce geographic barriers and improve timeliness to services by basing the linkage approach on urgency and assessment. The program also provides outreach and information via a dedicated, secured website and targeted social media known to be popular and relevant to TAY.

Success: Youth Help Network
Youth is a 24-year-old young person who identifies as Caucasian and female and presented with symptoms of schizoaffective disorder and chronic homelessness. After Youth was observed exhibiting odd behaviors at the Creation District during an art activity, YHN staff were able to engage with her and support with self-enrollment in the program. The peer support specialists collaborated with the YHN's clinician to provide Youth with a mental health assessment. The team then successfully linked Youth to housing at the Short-Term Transitional Emergency Placement (STEP) shelter, crisis stabilization at The Stay CRP, and mental health services with the TAY FSP program. During this process YHN utilized collaborative partnerships to confirm the presence of natural supports in the local area for Youth. Since referral, Youth has remained stable in TAY FSP and is receiving the medication management and therapy that are integral to her wellness and recovery.

Integrated Health and Wellness Program
FY 2025-26 Capacity: 800 annually
Ages Served: 18% Children, 38% TAY, 14% Adults, 30% Older Adults

The Integrated Health and Wellness Program consists of three components collectively aimed at addressing and promoting recovering and positive outcomes for a mental illness early in its emergence, reducing risk factors for developing a potentially serious mental illness and to build protective factors, outreaching to increase recognition of early signs of mental illness, and improving timely access to services for underserved populations.

SacEDAPT (Early Diagnosis and Preventative Treatment), administered by UC Davis, Department of Psychiatry, is a *PEI Early Intervention* program, and is in alignment with the following PEI priorities: *Childhood trauma prevention and early intervention to deal with the early origins of mental health needs; Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan;* and *Culturally competent and linguistically appropriate prevention and intervention (WIC § 5840.7).*

The program serves individuals, age 12 to 30, identified as experiencing early onset of a serious mental illness or emotional disturbance with psychotic features. SacEDAPT uses a nationally recognized treatment model utilizing an inter-disciplinary team of physicians; clinicians; support staff; and consumer and family advocates to provide assessment, early identification, and treatment of the early onset of psychosis. The program provides culturally and linguistically responsive psychiatric support, case management, peer support, and access to treatment, including transportation. The program also engages in outreach services throughout Sacramento County, with a particular focus on underserved populations.

Success: SacEDAPT (Early Diagnosis and Preventative Treatment)
An African American male born in Uganda had an intake assessment in January at which he reported experiencing racial trauma from previous hospitalizations and mental health programs. Client and family described several examples of past providers not listening to the family, over-pathologizing, and seeing the client as threatening when that was not the case. It was the family and client's strong impression that client's cultural traditions and dress were disrespected and labeled "bizarre" by these past programs. The assessing clinician was able to respectfully gather information, allow the family and client to express what was important to them, and provide a more positive and culturally sensitive experience with mental health providers. Through team discussion regarding this client, it brought increased awareness to the clinic regarding bias in documentation and the extreme harm it could do to an individual. It was also clear that the client's harmful prior experiences with health care contributed to an increased duration of untreated symptoms. The program and treatment team have continued providing treatment and support for client and family over the past few months.

SeniorLink, administered by El Hogar Community Services, is a *PEI Prevention program,* and is in alignment with the following PEI priorities: *Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan; Culturally competent and linguistically appropriate prevention and intervention;* and *Strategies targeting the mental health needs of older adults (WIC § 5840.7).*

The program provides community integration support for adults aged 55 and older demonstrating early signs of isolation, anxiety, and/or depression. Para-professional Peer Advocates provide outreach to individuals in their homes or other community-based settings that are centered on the participants' needs.

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

Success: SeniorLink Program
A 74-year-old man was referred to SeniorLink by Adult Protective Services in December 2023. For the past two years, he had been living in multiple room and board houses at different locations throughout Sacramento County. Prior to moving into a room and board, Participant was renting a home but was evicted while he was in the hospital. Participant lost all his belongings, family and friends' contact information, and connections to his family. Upon enrollment with SeniorLink, Advocate helped with getting Participant connected to a Primary Care Physician to evaluate his health and wellbeing; worked with him on getting a Senior Identification Card and Medicare Card and helped him obtain a cell phone. To help Participant regain his independence, Advocate was encouraging and showed him how to increase socialization opportunities. Participant had one goal listed, to find his family. Participant, with the help of Advocate, was able to locate a sister in a nearby city. He sent a letter and is currently awaiting a response. Participant expressed to Advocate that he was feeling a bit more hopeful since joining SeniorLink. He said he will attempt to attend one of the program's socials to increase his socialization and build new relationships while waiting to connect with his family.

Community Responsive Wellness Program for Black Communities of Sacramento (CRWP) (formerly known as Trauma Informed Wellness Program for the African American Community) is a *PEI Improving Timely Access to Services for Underserved Populations program,* and is in alignment with the following PEI priorities: *Childhood trauma prevention and early intervention to deal with the early origins of mental health needs;* and *Culturally competent and linguistically appropriate prevention and intervention (WIC § 5840.7).*

The CRWP administered by Sierra Health Foundation: Center for Health Program Management (The Center), provides culturally relevant outreach, engagement, and prevention services to Sacramento County's African American/Black/African Descent Community (AA/B/AD) residents of all ages and genders who have experienced or have been exposed to trauma with special consideration given to children, youth, and transition age youth.

CRWP goals include: (1) Educating the public on common mental health needs and wellness practices; (2) Supporting access to culturally responsive mental health services; (3) Building the capacity of mental health service providers to identify and be responsive to common mental health needs; (4) Ensuring that service providers maintain an accurate account of the context of mental health needs; and (5) Reducing violence through the promotion of mental health and wellness.

Success: Community Responsive Wellness Program
One participant experienced a profound transformation while engaging in Our Soul Sistah's Healing Circle. She had been carrying the weight of past trauma and struggled with self-esteem issues. The participant found a safe space to heal and grow while engaging in CRWP programming such as ancestral libations, mindfulness activities, wellness movements, and emotional releasing techniques. She was able to deeply connect with her ancestral heritage, find strength in honoring her roots, as well as navigate challenging emotions with clarity and grace through mindfulness practices. The participant's physical health and confidence increased while engaging in wellness movements. Most importantly, she learned to release the emotional burdens she had been carrying which allowed her to embrace life with newfound resilience and joy. The participant shared, "This program has help me become a better mother with my daughter and a more confident woman. Thank you all so much!" Her journey exemplifies the effectiveness of CRWP services to empower Black women to heal, thrive, and build supportive communities.

Through CRWP, four (4) community partner programs provide culturally responsive trauma-informed services to AA/B/AD members. In addition to the administrative support provided by

The Center, these partner programs employ staff members with shared cultural background and lived experience to provide culturally relevant outreach, engagement, and supportive services to AA/B/AD members. The four community partner subcontractors are Improve Your Tomorrow, ONTRACK Program Resources, Roberts Family Development Center, and Rose Family Creative Empowerment Center.

The program provides outreach and engagement activities, including sharing program information, education about the Medi-Cal healthcare system, and linkage assistance to Medi-Cal resources for eligible individuals. The program also offers a variety of services to AA/B/AD members, including resource navigation, linkage and referral to needed services and supportive services (e.g., supportive counseling; coaching/skills building training; healing circles; support groups; crisis intervention), and community education about mental health, substance use issues, impacts of trauma, and adverse childhood experiences (ACEs) on community members).

In FY 2023-24, CRWP design expanded to include a Trauma Informed Culturally Responsive Treatment (TICRT) component that incorporates licensed mental health therapists into the array of services offered. The Center subcontracts with A Different Path to provide culturally responsive Quality Improvement and clinical oversight for the TICRT component. The TICRT therapists provide short-term/brief, strength-based, culturally informed, and responsive therapeutic services to individuals of minority communities who are impacted by serious mental illness and trauma, with a special focus on AA/B/AD community members. The TICRT therapists work in collaboration with the community partner programs to reinforce CRWP's goal of supporting access to culturally responsive mental health services and thereby create avenues for a continuum of care. In FY 2024-2025, The Center completed a Request for Qualifications process and is subcontracting with Holding Spaces to provide the therapy sessions.

Mental Health Promotion Program
FY 2025-26 Capacity: 500,000 (estimated community members reached by program)
Ages Served: Children, Transition Age Youth (TAY), Adults, Older Adults

The Mental Health Promotion Program is *a PEI Stigma and Discrimination Reduction program* and is in alignment with the following PEI priorities: *Culturally competent and linguistically appropriate prevention and intervention; Stigma reduction, as well as other programs the commission identified, with partner participation, that are proven effective in achieving, and are reflective of, the goals stated in section 5840 (WIC § 5840.7).* It consists of several components collectively aimed at reducing stigma and discrimination associated with mental illness.

"Mental Illness: It's not always what you think" Project:

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

Since June 2011, Division of Behavioral Health Services (BHS) has worked with the Division of Public Health and Edelman (a communication marketing agency), to implement its Countywide mental health promotion, and stigma and discrimination reduction program to 1) promote messages of wellness, hope and recovery; and 2) dispel the myths and stereotypes surrounding mental illness. This program aims to fundamentally alter negative attitudes and perceptions about

mental illness and emotional disturbances. The "Mental Illness: It's not always what you think" project underscores that mental illness can impact almost anyone and also promotes community resources and support available throughout the County to foster hope and recovery.

This year, the team continued its ongoing efforts to raise awareness about the project and reduce mental health stigma in Sacramento County. Key highlights included multiple media features, paid advertising campaigns targeting multicultural audiences, and social media and blog content that focused on mental health observances and key topics. Additionally, the team expanded its outreach by incorporating Farsi as a new language, ensuring greater access to mental health education in underserved communities.

The project also conducted a photoshoot featuring Sacramento County's diverse residents to refresh campaign materials. Leveraging key moments like Mental Health Awareness Month (May) and Mental Illness Awareness Week (October), the team strengthened relationships with community-based organizations (CBOs), the Cultural Competence Committee, and the Stop Stigma Sacramento Speakers Bureau. These partnerships were instrumental in reaching new community members, shifting attitudes about mental illness, and ensuring the project's messages and materials resonated with all target audiences in Sacramento County.

These accomplishments reflect our commitment to making a meaningful impact on the mental health landscape and provide a strong foundation for future progress in reducing mental health stigma.

(1) Multi-media outreach:

The project executed large advertising campaigns across multiple mediums to reach as many Sacramento County residents as possible. Advertising placements, including radio, television, online and outdoor advertising, ran from July 2023 through June 2024 and garnered 69,030,815 impressions. An impression is when a user sees or hears an advertisement.

The advertising categories below reflect efforts to date:

Radio Ads:

Radio advertisements featuring campaign messages ran at various times on numerous stations from July 2023 – June 2024 Overall, radio ads delivered more than 6,163,960 impressions (of note: in-language radio placements were made, but impressions are not available for those placements).

The project ran the 30-second spots in Spanish, Vietnamese, Russian, English, Iranian and Hmong, sharing messages of hope, wellness and recovery and encouraging listeners to learn more by visiting the project's website.

Overall, 4,308 radio advertisements ran. These placements were featured on 16 music-focused, multicultural and in-language radio stations, including, KHYL (Rhythmic AC), KSEG (classic rock), KSFM (contemporary hits), KKDO (alternative), KDEE (Audience: African American), KRCX (Audience: Hispanic), KXSE (Audience: Hispanic), KFSG (Audience: Vietnamese, Russian), KEFM (Audience: Russian) and KJAY (Audience: Hmong), KYMX (Adult contemporary), KNCI (country), KVMX (Audience: Spanish), KUDL (Adult contemporary).

Television Ads:
Television advertisements supporting the campaign messages and branding ran at various times on numerous stations from July 2023 – June 2024. Overall, 649 TV spots ran, and there was a total of 6,712,106 impressions delivered from the television ads.

Print Ads:
Print advertising ran in eight local publications, including: Thang Mo (Audience: Vietnamese-speaking), Sac Cultural Hub (Audience: Black and African American), Sacramento Observer (Audience: Black and African American), Diaspora (Audience: Russian-speaking), Word and Deed (Audience: Russian-speaking), Outword Magazine (Audience: LGBTQ+), the Crescent (Audience: Arabic) and d'Primeramano (Audience: Spanish-speaking). Overall, 17 print ads or editorials ran in these publications, featuring real stories, often translated in language, that shared real experiences and tips.

Outdoor Ads:
Outdoor advertising ran from July 2023 – June 2024. Advertising included bus tails, digital billboards, airport boards and premiere panels. In total, these paid placements garnered an estimated 34,291,209 impressions.

Online and Mobile Ads:
Digital and mobile advertisements supporting the campaign ran from July 2023 – June 2024. Overall, online and mobile ads garnered 21,863,540 impressions (slightly up from 16,250,236 impressions in the previous fiscal year) with a cost per click of $1.87.

Impressions by Age Demographic:
18-25: 28% of total impressions; 5,400,231 (up 4% from last year)
26-59: 50% of total impressions; 9,696,430 (up 4% from last year)
60+: 22% of total impressions; 4,231,805 (down 8% from last year)

Clicks by Age Demographic:
18-25: 26% of total impressions; 13,483
26-59: 47% of total impressions; 24,592
60+: 27% of total impressions; 13,816

Digital Advertising: Click-Through Rates By Advertisement:
The following images include screenshots of each digital advertisement and the click through rate. A click is when a user engages in an advertisement and follows the link. The click through rate is found by calculating clicks divided by impressions.

General Audience

.19%

.28%

.23%

.18%

Older Adult

.50%

.92%

1.38%

1.18%

LGBTQ

.25%

.49%

.63%

.26%

Transgender

.40%

1.14%

1.05%

African American

.23%

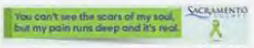
.19%

.24%

.26%

.24%

.39%



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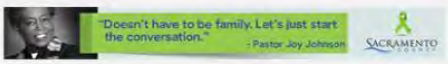

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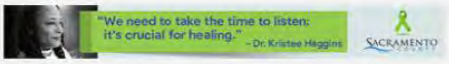

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Native American

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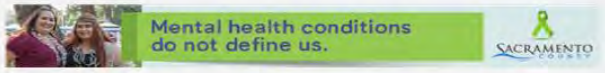

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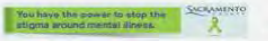

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In-Language Audience

Spanish

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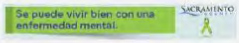

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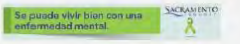

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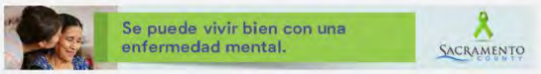

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Vietnamese

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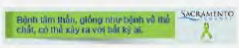

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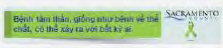

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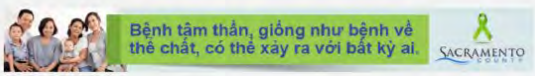

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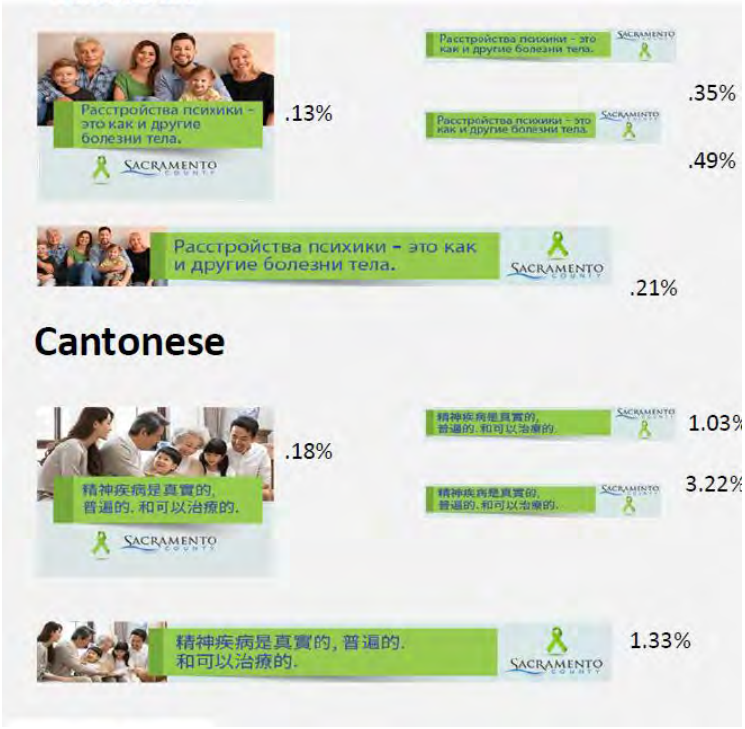
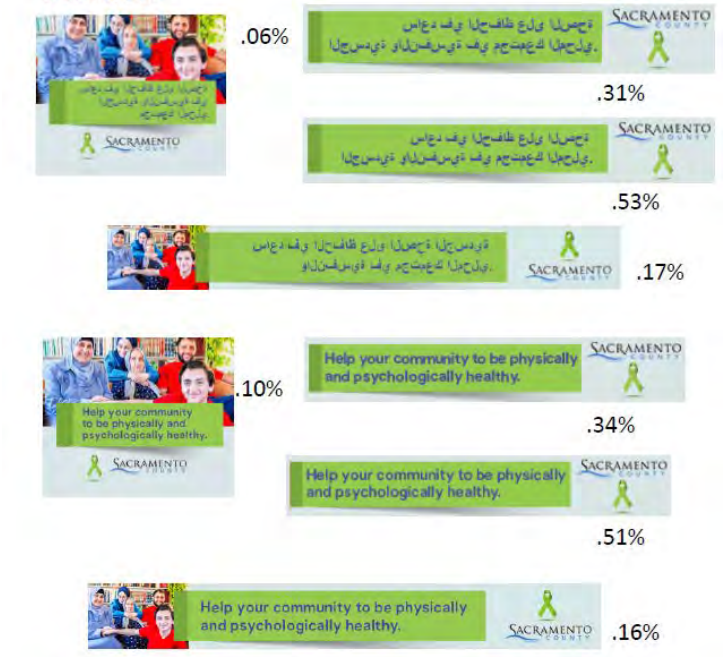
Russian



Cantonese

Arabic



Added Value Items:

- Crossings TV: Hmong interview aired in Sacramento on May 26th, May 27th, & May 28th
- CBS: Health Watch Sponsorship
- Fox: Studio 40Live interview aired on 5/29 x30 spots on Antenna Station NTXL
- Clear Channel: Airport Baggage Claim added value spots 1,277; Digital Bulletins 1 Bonus Board; 12 paid Premiere Pannels ran 14 plus ran for an additional week
- Lamar: 11 Bus Tail Posted for 35 additional days & x54 Bus interior cards posted for an additional 25 days
- Sacramento Cultural Hub: Bonus editorial piece
- Outword Magazine: Bonus editorial piece
- Sac Observer: Bonus editorial piece
- KVMX: 30-minute Spanish interview aired on July 30th
- Audacy: Mental health PSA interview aired on May 19th on KSEG, KUDL, KKDO, KIFM, KRXQ and KSFM

(2) Earned Media:

Edelman's media experts conducted strategic outreach to local and regional media to promote various project activities, Speakers Bureau stories and milestones within the community throughout the year.

The list below represents the 11 earned (non-paid) placements and corresponding impressions secured between July 1, 2023, and June 30, 2024. The majority of media outreach took place around timely observances and key milestones, such as Mental Illness Awareness Week, Black History Month, and the holidays. The project was included in key local news publications garnering more than 5,409,955 total impressions. Impressions are defined as any interaction with a piece of content.

Date	Title	Outlet	Impressions/ Audience
Radio			
12/19/2023	Holiday Blues	KTSE/KFBK	144,940
Online/Print			
8/24/2023	Prepare Students for a Mentally Strong School Year	Carmichael Times	7,000
2/13/2024	Ajna Glisic Of Sacramento County Department of Behavioral Health: Five Things I Wish Someone Told Me When I Was First Diagnosed With Mental Illness	Authority Magazine	500,000
3/18/2024	Wounded Healer	Sacramento Observer	50,000
5/21/2024	How arts in the Sacramento region can improve our health	Sacramento News & Review	13,184
5/23/2024	'We can get through it together': Sacramento art exhibit puts spotlight on mental health	KCRA Online	1,892,840
TV Broadcast			
7/20/2023	Minority Mental Health Month	Univision	10,000
8/20/2023	Back to school and mental health: Tips for parents, students	ABC 10	879,151
9/25/2023	Suicide Awareness Month	Univision	10,000
10/17/2023	Mental Illness Awareness Week	Univision	10,000
5/23/2024	Mental Health Awareness Month Art Exhibit	KCRA	1,892,840

(3) Social Media and Microsite:

To support the project's stakeholder and media outreach efforts and engage with key audiences, the team continually updated the www.StopStigmaSacramento.org microsite, as well as Instagram, Facebook and X (previously Twitter) pages.

Instagram posts generated a total of 61.7K impressions*, down from 183.9K, while Facebook posts saw an increase, reaching 787K impressions, up from 214.8K. The drop in Instagram impressions from previous years is likely due to ongoing algorithm changes and the oversaturation of Reels on the platform. Audience insights on X are no longer available, and other analytics features are evolving under Elon Musk's leadership as CEO.

**Impressions are the number of times the project's content is displayed.*

Facebook:

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

- The page currently has 9,531 likes, slightly up from 9,478 likes from last year's EOY report and reached 787,030 people last year.
  - 82.4% of people who like the page are women, while 17.6% are men. (Of note, these metrics are binary, and we acknowledge that not all of our followers will identify with either of these genders. These metrics are supplied to us by Facebook.)
  - The highest demographic of women Facebook followers were aged 65+, representing 22.8% of female followers. The same is true for men, with 4.7% of male followers being age 65+.
  - The highest performing post was published on May 4, 2024.and promoting the project's art displays for Mental Health Awareness Month. The post reached 3,996 people. The post also received 265 post clicks and engagements.

X:

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

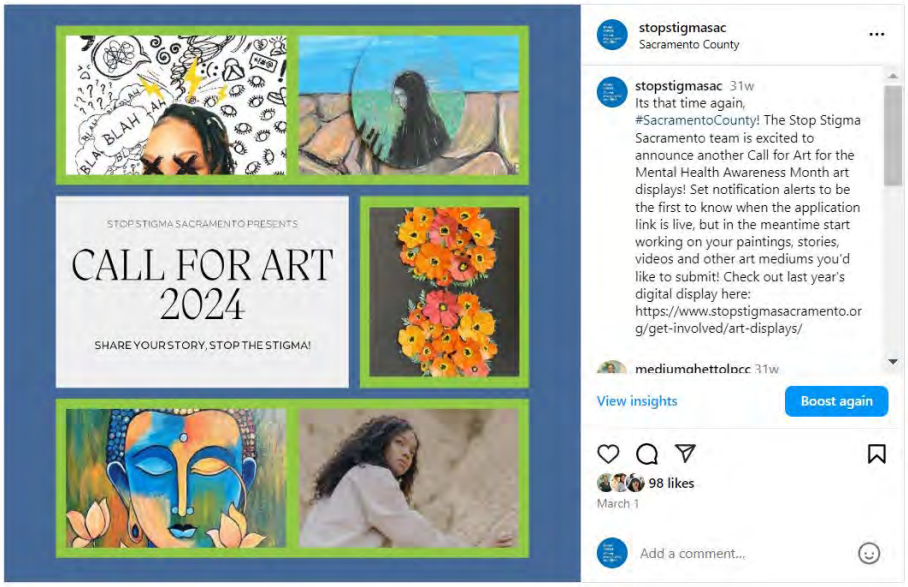
- The page has 1,056 followers, down from 1,086 followers noted last year.
- The top performing tweet was published on May 10, 2024, and promoted Stop Stigma Sacramento art displays at the Sacraments

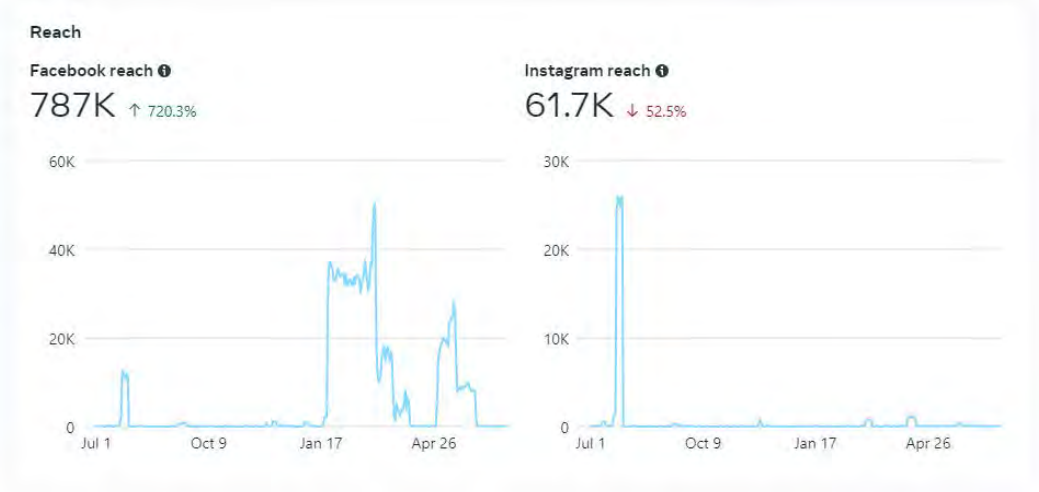
LGBTQ Center for Menal health Awareness month. It generated 425 impressions.

- **Note: Audience insights are no longer available on Twitter, and other analytics features are changing since Elon Musk has become CEO of Twitter/X.*

Instagram:
The team launched the project's Instagram account in October 2020, and since then, it has grown exponentially. To date:

- The page currently has 1.1K followers, up from 993, and reached 61.7K people in the last fiscal year.
- 82% of people who follow the page are women, while 18% are men.
- A majority of our audiences live in Sacramento, Carmichael, and Citrus Heights.
- The highest-performing post was a call for art published during Mental Health Awareness Month. The post reached 2,639 people. The post also received 98 likes, 43 saves and 29 shares.





Microsite:

The project microsite, www.StopStigmaSacramento.org, serves as a public, online resource that provides supportive messaging, community event details, Speakers Bureau information, and more.

In September 2020, the team launched a refreshed version of the site, which has been continuously updated since then. Key features include community-specific webpages with tailored, in-language messaging for 13 target audiences. These audiences include residents who primarily speak Arabic, Cantonese, Hmong, Russian, Spanish, Vietnamese, and now Farsi, as well as those who speak English and identify as Black/African American, Latino, American Indian/Alaska Native, older adults, young adults, or members of the LGBTQ+ community. The microsite also hosts a library of mental health stories from Speakers Bureau members, conversation tips to help people reach out to someone struggling with mental health (available in each target language), a blog with posts from community leaders and Speakers Bureau members, and a list of vetted community resources and partners for support.

Engagement

To date, 518 people have submitted their email addresses through the site to receive project updates, up from 493 people in total last year.

Analytics (July 1, 2023 – June 30, 2024)

Note: *Google Analytics required a transition to a new measurement platform. Therefore, the below metrics reflect website traffic and insights from April 1, 2023).*

- Total website visits: 49K (up from 43K in the previous year).
- Unique page views: 110K
- The most popular page was the General Community page, with 7K page views.
    - Blog Landing Page 6K
    - LGBTQ Community Page 5K
    - Cantonese Speaking Community Page 4K
    - Spanish Speaking Community Page 3.5K
    - Vietnamese Speaking Community Page 3K
- Paid search generated the most page views, while direct, organic search and social media trailed behind.

Plot rows | Search... | Rows per page: 10 | Go to: 1 | 1-10 of 137

	Page path and screen class	Views	Active users	Views per active user	Average engagement time per active user	Event count All events	Key events All events	Total revenue
	Total	70,552 100% of total	49,137 100% of total	1.44 Avg 0%	15s Avg 0%	198,587 100% of total	0.00	$0.00
1	/	10,675	7,837	1.36	17s	32,938	0.00	$0.00
2	/communities/general-community/	6,696	5,870	1.14	7s	19,454	0.00	$0.00
3	/about/blog/	6,664	5,132	1.30	2s	18,179	0.00	$0.00
4	/communities/lgbtq/	4,593	3,393	1.35	4s	12,541	0.00	$0.00
5	/communities/英語/	4,450	4,294	1.04	0s	13,153	0.00	$0.00
6	/communities/espanol/	3,529	3,241	1.09	3s	10,636	0.00	$0.00
7	/communities/tieng-viet/	3,082	2,516	1.22	2s	8,641	0.00	$0.00
8	/communities/african-american-black-community/	3,054	2,926	1.04	1s	8,943	0.00	$0.00
9	/services/	2,376	1,665	1.43	42s	5,430	0.00	$0.00
10	/communities/русский/	2,331	2,194	1.06	1s	6,828	0.00	$0.00

(4) Stakeholder Engagement:

The team focused on enhancing community engagement through partnerships with Community-Based Organizations (CBOs) this fiscal year. Following the listening sessions conducted with school, faith, and business communities in 2023, we gained deeper insights into mental health perceptions within these groups. These learnings were integrated into our communication strategies throughout the fiscal year to bolster relationships with CBO partners, who remain instrumental in driving project credibility and effectively reaching diverse audiences.

Farsi-Speaking Community: One key achievement was the integration of the Farsi-speaking community, which became a primary focus in the beginning of 2024. We incorporated this community into all project materials and outreach efforts, finalizing culturally relevant stock imagery with the guidance of Farsi-speaking CBO leaders and county officials. Additionally, we conducted research and key informant interviews to better understand perceptions of mental health within this community, identifying barriers to seeking help and ensuring cultural and linguistic accuracy in all collateral materials.

Cultural Competence Committee: Throughout the year, we continued to engage with the County's Cultural Competence Committee, providing project updates and seeking feedback. At the February 2024 meeting, we shared plans for Mental Health Awareness Month (MHAM) and explored collaboration opportunities. We also extended invitations to community leaders for their involvement and referrals for the spring photoshoot, aimed at capturing authentic images of Sacramento residents. Photos from this photoshoot were used to replace stock imagery in project materials, ensuring visual and cultural relevance to our target audiences.

***Mental Health Awareness Month (MHAM)*:** MHAM in May 2024 served as a significant activation point, with a variety of initiatives planned to promote awareness and engagement. The team organized multiple MHAM art displays throughout Sacramento County, highlighting works that celebrate the community's diversity. An online gallery was created to showcase these artworks virtually, in addition to promoting them on the project's social media channels. The team also took part in Mental Health Matters Day at the State Capitol, where two Speakers Bureau members, Lavontae Hill and Claudia Niedzielski, shared their personal experiences living with mental health conditions, further fostering community dialogue around this important issue.

Content distribution: To engage relevant community organizations and services in the project, activities included distributing collateral materials and toolkits, conducting media interviews, sharing success stories, providing photography, promoting the project through digital and social media and promoting the speaker's bureau. To date, we have received 711 email sign-ups, which confirm an individual's or organization's willingness to participate in the project. To view a list of partner organizations, please visit the StopStigmaSacramento.org microsite here.

The following is a list of the most active stakeholders this year. These stakeholders partnered with the project on events and provided valuable feedback and support for media interviews, blogs and social media activations:

1. Iranian American Cultural and Educational Center/Radio Bamdad
2. Sacramento LGBT Center
3. Gender Health Center
4. SCOE

5. CalTrans
6. NAMI Sacramento
7. Russian Information & Support Services
8. Refugee Enrichment & Development Association (REDA)
9. International Rescue Committee (IRC)
10. American Foundation for Suicide Prevention (AFSP)
11. Health Education Council

(5) Collateral Material:

The team has conducted outreach to stakeholder organizations to offer free program materials, informational booklets, tip cards and project-branded promotional items. All available tip card collateral materials can be found on the StopStigmaSacramento.org microsite here. From April to June 2024, approximately 16,849 pieces of collateral and promotional materials have been distributed to stakeholder groups and at events.

(6) Research:

To assess changes in residents' attitudes and perceptions toward mental health, the team conducted a comprehensive survey of individuals who have lived in the county for five or more years. This survey aimed to measure shifts in perceptions over the past five years and evaluate the effectiveness of mental health awareness initiatives among those familiar with the project.

Key measures included baseline insights for Farsi speakers, changes in comfort levels discussing mental illness, the impact of current events on residents' mental health, and feedback on mental health awareness efforts in Sacramento County. Additionally, we analyzed demographic differences across various groups, including older adults, transition-age youth, LGBTQ+ individuals, and diverse ethnic communities. The research findings will be integrated into project outreach tactics, messaging, and materials, providing a solid foundation for future communication initiatives.

(7) Stop Stigma Sacramento Speakers Bureau:

Sacramento County Public Health continued to coordinate the Stop Stigma Sacramento Speakers Bureau in FY 2023-2024. The Stop Stigma Sacramento Speakers Bureau is funded by the Sacramento County Division of Behavioral Health Services through the voter approved Proposition 63, Mental Health Services Act (MHSA).

The "Mental Illness: It's not always what you think" project was initiated by Sacramento County Department of Health Services/ Division of Behavioral Health Services (DHS/BHS) to:

- Reduce stigma and discrimination
- Promote mental health and wellness
- Inspire hope for people and families living with mental illness

The Stop Stigma Sacramento Speakers Bureau is operated by the Health Education Unit of Sacramento County Public Health.

At the close of FY 2023-2024, the Stop Stigma Sacramento Speakers Bureau had trained 224 speakers since the inception of the project, of whom 37 were actively speaking (participated in at

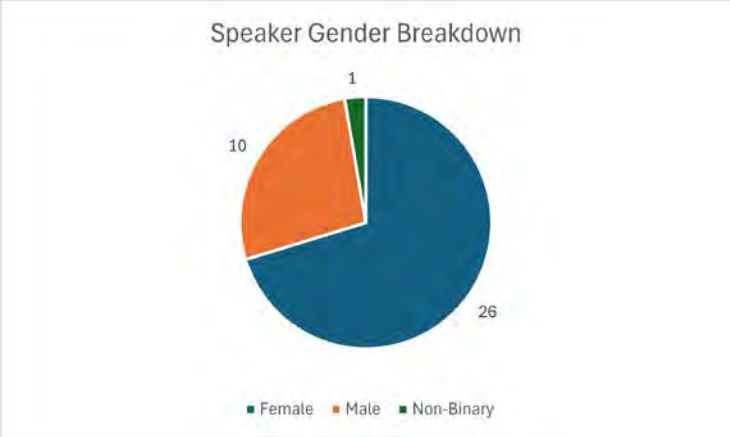
least one tabling or speaking event) during the most recent fiscal year. We continued to recruit potential speakers via the StopStigmaSacramento.org webpage as well as at speaking and tabling events. This year extra effort was made to recruit speakers from project target demographics, including the Ukrainian- and Farsi-speaking communities. We received 12 potential speaker applications during FY 2023-2024, resulting in 6 active speakers.

The Speakers Bureau participated in 64 speaking events. Of these events 24 were virtual (37.5%) and 40 were in person (62.5%).

The Speakers Bureau participated in 36 in-person tabling events. Tabling events continue to be an excellent avenue for both speaking event and speaker recruitment.

*For a full list of speaking events please see the table at the end of the report. *

In FY 2023-24, Stop Stigma Sacramento Speakers Bureau speakers shared their personal stories 138 times at 64 events with a total audience attendance of over 2,913 individuals. 36 Tabling Events exposed to the project to over 15,300 attendees.



The Speakers Bureau maintained 37 active speakers during FY 2023-2024. Speakers were considered active if they participated in at least one speaking or tabling event during the FY. The Speakers Bureau brought on 6 new active speakers during the 2023-2024 FY. Our active speaker gender makeup consists of 26 females, 10 males, and 1 non-binary speaker. The Speakers Bureau continues to understand the need for more male and gender non-conforming speakers and will make this a top priority in FY 2024-2025.

Practice Sessions

Practice sessions continued to be an integral part of the Speakers Bureau during FY 2023-2024. Practice sessions were offered at least weekly and allowed both new and experienced speakers to practice and develop their presentations, meet and maintain contact with other speakers, and provide support and feedback to one another. During FY 2023-2024, 20 hours of practice sessions were performed. Practice sessions allowed program staff to preview and shape speaker presentation content to assure that it was consistent with the program goals and content guidelines.

Figure 1: New speaker LaVontae speaks at the TEDxFolsom event in April 2024. Practice sessions allowed LaVontae to refine his story and led to his selection to speak at this prestigious event.

Speakers Bureau Sponsored Events and Affiliated Activities

Community Events

In FY 2023-2024, the Speakers Bureau attended 36 tabling events and exposed to the project to over 15,300 attendees. The Bureau continued to attend general population community events but also prioritized on participating in community events that focused on project target populations. Examples include the Exceptional Woman of Color Gala (African American/Black), Coming Out Day (LGBTQ & Transgender & Gender Non-Conforming) and Hmong University Student Association Culture Show (Hmong) to name a few. Tabling in these communities allowed the Speakers Bureau to share the message of mental wellness and build trust with community members. At these tabling events the Speakers Bureau shared mental health resources, passed out applications to join the Bureau, and networked for potential speaking events.

Figure 1: Community events also allow the project to recruit new speakers! While tabling at this event in South Sacramento, Health Educator Amelia successfully recruited new speaker Paula to join the Speakers Bureau.

Figure 1: Speakers Claudia & Desiree table at the Exceptional Women of Color Gala in September 2023. This year the project prioritized events serving marginalized demographics, such as the African American/Black community.

Speakers Bureau Coffee Chats

During FY 2023-2024 Coffee Chats were implemented to boost speaker engagement and allow project staff to conduct informal satisfaction check-ins.

Coffee Chats were hosted at the Starbucks on N Street in Midtown Sacramento. The site was chosen due to its central location and proximity to public transportation.

The Speakers Bureau hosted 6 Coffee Chats from December 2023-June 2024 (December (x2), February, March, April, June), which were attended by 10 unique speakers. The chats were held at various times to encourage participation, including before and after normal working hours.

The coffee chats were well received and have become a cherished monthly tradition. The chats also allow for newer speakers to network with experienced speakers, obtain advice on their stories, and hear about other stigma-reduction opportunities.

The Speakers Bureau plans to continue hosting Coffee Chats monthly or bi-monthly as budget allows.

Figure 4: Beginning in December 2023, monthly Coffee Chats were offered to active speakers to come enjoy a coffee or sweet treat and network with project staff and other speakers.

Figure 5: Project staff enjoy a mid-morning coffee with 4 members of the Speakers Bureau.

Speaker Newsletter

A quarterly Speaker Newsletter was developed during the 2023-2024 FY in order to keep speakers up to date with Speakers Bureau related information. The speaker newsletter was sent to the 37 active speakers, as well as project staff. The newsletter was met with a positive response from speakers.

Two quarterly newsletters were published during FY 2023-2024. One in April 2024, and another in July 2024. Newsletter content included:

- Upcoming Events (Coffee Chats, Trainings)
- Gift Card Increases
- Speaker Spotlights
- Speaker Media Involvement
- Upcoming O&T and Practice Sessions

As well as project contact information and speaker and event requests.

Figure 6: Two quarterly newsletters were published this FY. The newsletter covers all things related to the Speakers Bureau and aims to inform speakers of opportunities, boost engagement, and recruit potential speakers.

According to Mailchimp, the April newsletter had a 70.5% open rate with an 11.4% click rate, and the July newsletter had a 75% open rate with a 6.7% click rate. Content the speakers clicked on included the practice session schedule, new speaker application, the Stop Stigma Sacramento blog posts, and speaker media highlights.

Journey of Hope Art Event

The Journey of Hope art event was revitalized in FY 2023-2024. The reception was held on October 5, 2024, and the exhibit was held on Wednesday-Sunday, October 2nd-31st, 2024.

Journey of Hope is a collaborative art event that pairs stories and poems of mental health with local artists who use the story as inspiration for an original art piece which are displayed throughout the month of October. Journey of Hope consists of 65 participants and features 33 unique art

pieces. All 33 writers who participated in Journey of Hope 2024 have lived experience with mental illness.

In FY 2023-2024, special attention was paid to making the event more diverse and inclusive. The reception and exhibit were held at The Gallery by We Are Sacramento which is an independent Art Gallery located in the lively Uptown District of Old North Sacramento. The Gallery is owned and operated by a coalition of BIPOC artists and business owners who share a deep love for Sacramento's art community. In an effort to improve recruitment for future shows, demographics of participants were collected for the first time in FY 2023-2024. Finally, headshots and bios were requested from participants in order to showcase the diversity of artists and writers.

The project leadership will work with the Journey of Hope committee and Edelman Public Relations to recruit and represent a diverse community for a Journey of Hope that will be relatable to a larger percentage of the community.

Testimonials

Testimonials collected during FY 2023-2024. Speaker names have been removed for privacy.

"Thank you to all the presenters who shared their stories. You are brave and champion advocates for mental health awareness and help."

"Thank you! We need more of this for not only us but for the younger generations."

"Very well done. Difficult to get engagement in a large work setting, but it was well done."

"Personalization of mental health challenges is key for a larger understanding. I was surprised at how fast the hour went by and I found myself wanting to hear more. Fantastic job to Amelia, SPEAKER, SPEAKER, and SPEAKER! Thank you for the time and the bravery! I would love to see this presentation again."

"As a Black woman I appreciated her candor about our home environments and the traumas (known and unknown) that have an effect on us. I'm grateful she normalized for any other Black person to seek out help. Thank you for your story."

"She explained her struggle with anxiety and depression which I also have, and it made me feel less alone."

"She was very honest and humble in sharing and gave her childhood perspective as well as adult perspective which really captured the humanity of mental health struggles."

"SPEAKER's presentation was exceptionally poignant and relatable. His calm delivery and demeanor gracefully set the stage for the event."

"He was so brave and honest; my heart is with him, and I am so grateful that he has the strength to share what he endured as a child to help bring awareness to the painfulness of abuse. I will never forget his story or his bravery in sharing. Thank you."

"SPEAKER's explanation of her journey with mental health was great. Her matter-of-fact delivery touched with her warmth was impactful."

Stop Stigma Sacramento Speakers Bureau Speaking Events

July 1, 2023 – June 30, 2024

#	Date	Site/Event FY 2023-2024	Speakers	Audience
1	07.18.2023	International Rescue Committee	2	15
2	08.08.2023	San Juan Unified School District Teachers	4	20
3	09.09.2023	Out of the Darkness	1	500
4	09.18.2023	Pleasant Grove High School (PGHS)-Period 1, Class A	2	30
5	09.18.2023	PGHS-Period 1, Class B	2	30
6	09.18.2023	PGHS-Period 2, Class A	2	30
7	09.18.2023	PGHS-Period 2, Class B	2	30
8	09.18.2023	PGHS-Period 3, Class A	1	30
9	09.18.2023	PGHS-Period 3, Class B	1	30
10	09.18.2023	PGHS-Period 4, Class A	2	30
11	09.18.2023	PGHS-Period 4, Class B	2	30
12	09.18.2023	PGHS-Period 6, Class A	2	30
13	09.18.2023	PGHS-Period 7, Class A	2	30
14	09.18.2023	PGHS-Period 7, Class B	2	30
15	09.18.2023	Elk Grove Sr. Men's Group	4	30
16	09.28.2023	Schools Coordinator Meeting	2	15
17	10.03.2023	California Department of Tax and Fee Administration's Disability Advisory Committee	1	100
18	10.05.2023	Financial Information System for California (Fi$Cal)	2	60
19	10.09.2023	Board of Equalization's Disability Advisory Comm.	1	20
20	10.10.2023	Orientation & Training (O&T)	3	6

#	Date	Site/Event FY 2023-2024	Speakers	Audience
21	10.24.2023	Vision Service Plan	2	50
22	10.23.2023	Meals on Wheels	3	50
23	10.26.2023	California Department of Real Estate	3	20
24	11.01.2023	ACC Senior Services	3	30
25	12.11.2023	O&T	2	3
26	12.19.2023	O&T	2	5
27	01.30.2024	NP3 High School	2	15
28	02.05.2024	Cal Northstate University	2	5
29	02.16.2024	Cal Northstate University	3	5
30	02.20.2024	NP3 High School	2	15
31	02.21.2024	Cal Northstate University	1	5
32	02.26.2024	Cal Northstate University	1	5
33	02.29.2024	O&T	2	6
34	03.05.2024	NP3 High School	2	15
35	03.06.2024	Supporting Community Connections	3	5
36	03.06.2024	Cal Northstate University	3	5
37	03.11.2024	Meals on Wheels	3	10
38	03.18.2024	Cal Northstate University	1	5
39	03.25.2024	Cal Northstate University	1	5
40	03.26.2024	Cal Northstate University	2	5
41	04.03.2024	Elizabeth Pinkerton Middle School	2	100
42	04.03.2024	Iranian American Cultural & Educational Center	1	20
43	04.05.2024	Sacramento County National Public Health Week	1	30
44	04.08.2024	Cal Northstate University	1	5
45	04.09.2024	NP3 High School	1	15
46	04.15.2024	Cal Northstate University	2	5
47	04.19.2024	Leroy Greene Academy-Per. 1	1	10
48	04.19.2024	Leroy Greene Academy-Per. 2	1	10
49	04.19.2024	Leroy Greene Academy-Per. 3	2	10
50	04.19.2024	Leroy Greene Academy-Per. 4	2	10
51	04.22.2024	Grandparents Meeting	2	40
52	04.23.2024	California Department of Transportation (Caltrans)	3	500
53	05.07.2024	Sacramento County Board of Supervisors	1	60
54	05.09.2024	Psynergy	4	55

#	Date	Site/Event FY 2023-2024	Speakers	Audience
55	05.13.2024	Carrie's Touch	1	100
56	05.14.2024	NP3 High School	1	18
57	05.21.2024	California Department of Human Resources (CalHR)	3	75
58	05.23.2024	Caltrans	4	300
59	05.29.2024	California Department of Food and Agriculture	3	40
60	05.30.2024	John F. Kennedy High School (JFK) Per. 1	3	30
61	05.30.2024	JFK Per. 2	4	30
62	05.30.2024	JFK Per. 3	3	30
63	05.30.2024	JFK Per. 4	4	30
64	05.30.2024	JFK Per. 5	4	30
		FY 2023-2024 Total Events (64)	138	2338

Speakers and staff continue to provide resources and educational material at all speaking events. The resources include phone numbers for mental health services, crisis support services, and the link to our StopStigmaSacramento.org website.

Mental Health Matters, administered by Cal Voices, is a monthly television talk show, produced by mental health consumers and their family members, that highlights issues relating to mental health. The show also promotes and informs the community about available local resources, community events, and activities relating to mental health and wellness. The show can be seen on the first Saturday of every month at 7:00 pm. Sacramento area Comcast and local television subscribers can view Mental Health Matters℠ program on channel 17; U-verse subscribers can see the show on channel 14. In FY 2022-23, viewership was approximately 25,000. Mental Health Matters shows are also accessible anytime on the Mental Health Matters' YouTube channel, www.youtube.com/@CalVoicesMHM. In FY 2023-24, YouTube viewership was approximately 855 views.

Time-Limited Community Driven PEI Grant Program
FY 2025-26 Capacity: 6835 across all programs
Ages Served: Children, TAY, Adults and Older Adults

Every Time-Limited Community Driven PEI Grant program and activity is in alignment with the following PEI priorities: childhood trauma prevention and early intervention to deal with the early origins of mental health needs; youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs; culturally competent and linguistically appropriate prevention and intervention; and strategies targeting the mental health needs of older adults (WIC § 5840.7).

The Time Limited Community Driven PEI Grant program is administered by California Mental Health Services Authority (CalMHSA), a Joint Powers of Authority, on behalf of Sacramento County. Mid FY 2022-23, CalMHSA released a second round PEI Grant program application

process. Local community members participated in the evaluation of grant applications. Twenty-seven (27) community-based agencies' applications were awarded grant funds to implement their proposed community capacity building prevention programs and activities that will serve youth, adults, older adults, members of local refugee communities and members of ethnically and culturally diverse communities.

These community building services and activities include culturally responsive community workshops, trainings, conference, outreach, events, individual and group support and activities, navigation support. The services and activities collectively address the MHSA seven (7) negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness, and removal of children from their homes. For more information on these agencies and programs, see *Attachment F: Community-Driven Prevention and Early Intervention Grants - CalMHSA Program Report FY 2023-24*.

With MHSA Steering Committee support, a second round of grant awards were granted at the end of FY 2022-23.

PEI Administration and Program Support

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

The table below contains the FY 2025-26 Cost per Person information for implemented programs:

FY2025-26 PEI COMPONENT	Average Cost/Person*	Budget Amount
Suicide Prevention Program	$ 151	$ 12,012,304
Strengthening Families Program	$ 378	$ 7,748,988
Integrated Health and Wellness Program	$ 2,679	$ 5,503,345
Mental Health Promotion (Stigma and Discrimination Reduction)	$ 1	$ 694,239
TOTAL		**$ 25,958,875**

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

PEI IMPLEMENTATION PROGRESS DATA - FISCAL YEAR 2023-24

In FY 2023-24, PEI Suicide Prevention and Education program served 79,713 (duplicated count; this total includes PEI Suicide Prevention, PEI Respite, and PEI SCC tables shown on following pages) and outreached to over 47,000 individuals by providing individual outreach and participating in 677 community events. The Strengthening Families program served 7,373 individuals and offered prevention trainings and information to over 13,000 students, parents/caregivers, education staff, and other partners. The Integrated Health and Wellness program served 2,054 and outreached to 1,901 individuals. The Mental Health Promotion program "Mental Illness: It's not always what you think" project utilizes television, radio, social media and print material to advertise across the Sacramento area. In FY 2023-24, there were 6,163,960 impressions from the radio, 649 TV ads for a total of 6,712,106 impressions, 17 print ads, 34,291,209 impressions from outdoor ads and 21,863,540 impressions from online and mobile ads. The Project's Stop Stigma Sacramento Speakers Bureau speakers shared their personal stories 138 times, at 64 events, with a total audience attendance of 2,913 individuals. The time limited PEI programs engaged 6,835 individuals.

The tables below and on the following pages display demographic information for individuals served in each of the PEI programs. See *Attachment G: FY 2023-24 MHSA Annual Prevention and Early Intervention Program and Evaluation Report* for additional detail.

PREVENTION AND EARLY INTERVENTION - SUICIDE PREVENTION - FY 23/24														
Characteristic	Suicide Crisis Line (N=67,339)		Emergency Department Follow-Up Services (N=120)		Suicide Bereavement Support Groups & Grief Services (N=39)		Community Support Team (N=922)		Crisis Navigation Program (N=870)		Mobile Crisis Support Team (N=859)		Total (N=70,149)	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Age Group														
Children/Youth (0-15)	1,420	2.11%	6	5.0%	0	0.0%	66	7.2%	15	1.7%	70	8.1%	1,577	2.2%
TAY (16-25)	7,573	11.25%	16	13.3%	0	0.0%	164	17.8%	115	13.2%	141	16.4%	8,009	11.4%
Adults (26-59)	13,441	19.96%	53	44.2%	32	82.1%	423	45.9%	624	71.7%	418	48.7%	14,991	21.4%
Older Adults (60+)	5,093	7.56%	31	25.8%	7	17.9%	269	29.2%	115	13.2%	160	18.6%	5,675	8.1%
Unknown/Not Reported	39,812	59.12%	14	11.7%	0	0.0%	0	0.0%	1	0.1%	70	8.1%	39,897	56.9%
Ethnicity														
Hispanic/Latino	2,045	3.0%	10	8.3%	0	0.0%	92	10.0%	136	15.6%	113	13.2%	2,396	3.4%
Non-Hispanic/Non-Latino	8,819	13.1%	25	20.8%	39	100.0%	311	33.7%	454	52.2%	353	41.1%	10,001	14.3%
More than one ethnicity	647	1.0%	5	4.2%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	652	0.9%
Unknown/Not Reported	55,828	82.9%	80	66.7%	0	0.0%	519	56.3%	280	32.2%	393	45.8%	57,100	81.4%
Race														
American Indian/Alaska Native	91	0.1%	0	0.0%	0	0.0%	4	0.4%	18	2.1%	8	0.9%	121	0.2%
Asian	2,030	3.0%	2	1.7%	2	5.1%	43	4.7%	34	3.9%	14	1.6%	2,125	3.0%
Black/African American	1,596	2.4%	11	9.2%	1	2.6%	100	10.8%	164	18.9%	124	14.4%	1,996	2.8%
More than one race	647	1.0%	5	4.2%	3	7.7%	87	9.4%	62	7.1%	23	2.7%	827	1.2%
Native Hawaiian/Other Pacific Islander	55	0.1%	0	0.0%	0	0.0%	8	0.9%	8	0.9%	17	2.0%	88	0.1%
Other	2,435	3.6%	10	8.3%	4	10.3%	40	4.3%	78	9.0%	70	8.1%	2,637	3.8%
White/Caucasian	4,657	6.9%	12	10.0%	20	51.3%	208	22.6%	274	31.5%	347	40.4%	5,518	7.9%
Unknown/Not Reported	55,828	82.9%	80	66.7%	9	23.1%	432	46.85%	232	26.7%	256	29.8%	56,837	81.0%
Primary Language														
English	58,099	86.3%	12	10.0%	37	94.9%	571	61.9%	715	82.2%	618	71.9%	60,052	85.6%
Spanish	69	0.1%	0	0.0%	0	0.0%	14	1.5%	25	2.9%	9	1.0%	117	0.2%
Vietnamese	5	0.0%	0	0.0%	0	0.0%	4	0.4%	0	0.0%	0	0.0%	9	0.0%
Cantonese	17	0.0%	1	0.8%	0	0.0%	0	0.0%	1	0.1%	0	0.0%	19	0.0%
Russian	18	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.1%	4	0.5%	23	0.0%
Hmong	9	0.0%	0	0.0%	0	0.0%	2	0.2%	0	0.0%	0	0.0%	11	0.0%
Arabic	5	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	5	0.0%
Farsi	0	0.0%	0	0.0%	0	0.0%	1	0.1%	2	0.2%	1	0.1%	4	0.0%
Other	93	0.1%	0	0.0%	0	0.0%	16	1.7%	8	0.9%	5	0.6%	122	0.2%
Unknown/Not Reported	9,024	13.4%	107	89.2%	2	5.1%	314	34.1%	118	13.6%	222	25.8%	9,787	14.0%
Sexual Orientation*														
Heterosexual/Straight	1,672	2.5%	0	0.0%	26	66.7%	201	21.8%	396	45.5%	286	33.3%	2,581	3.7%
Gay/Lesbian	143	0.2%	0	0.0%	0	0.0%	8	0.9%	18	2.1%	10	1.2%	179	0.3%
Bisexual	86	0.1%	0	0.0%	0	0.0%	10	1.1%	26	3.0%	13	1.5%	135	0.2%
Questioning/Unsure	24	0.0%	0	0.0%	0	0.0%	7	0.8%	2	0.2%	6	0.7%	39	0.1%
Queer	46	0.1%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	46	0.1%
Another sexual orientation	51	0.1%	1	0.8%	1	2.6%	0	0.0%	3	0.3%	0	0.0%	56	0.1%
Unknown/Not Reported	65,317	97.0%	119	99.2%	12	30.8%	696	75.5%	425	48.9%	544	63.3%	67,113	95.7%
Current Gender Identity*														
Female	31,482	46.8%	12	10.0%	27	69.2%	216	23.4%	300	34.5%	219	25.5%	32,256	46.0%
Male	28,526	42.4%	12	10.0%	5	12.8%	175	19.0%	307	35.3%	223	26.0%	29,248	41.7%
Transgender	258	0.4%	3	2.5%	0	0.0%	1	0.1%	9	1.0%	8	0.9%	279	0.4%
Genderqueer	49	0.1%	0	0.0%	0	0.0%	1	0.1%	1	0.1%	1	0.1%	52	0.1%
Questioning/Unsure	29	0.0%	0	0.0%	0	0.0%	1	0.1%	0	0.0%	2	0.2%	32	0.0%
Another gender identity	64	0.1%	0	0.0%	0	0.0%	4	0.4%	7	0.8%	3	0.3%	78	0.1%
Unknown/Not Reported	6,931	10.3%	93	77.5%	7	17.9%	524	56.8%	246	28.3%	403	46.9%	8,204	11.7%
Veteran Status														
Yes	207	0.3%	1	0.8%	0	0.0%	0	0.0%	0	0.0%	18	2.1%	226	0.3%
No	67,132	99.7%	119	99.2%	39	100.0%	128	13.9%	0	0.0%	350	40.7%	67,768	96.6%
Unknown/Not Reported	0	0.0%	0	0.0%	0	0.0%	794	86.1%	870	100.0%	491	57.2%	2,155	3.1%

*Some totals are higher than other categories as clients select multiple categories

PREVENTION AND EARLY INTERVENTION - RESPITE PROGRAMS - FY23/24												
Characteristic	Caregiver Crisis Intervention Respite (N=83)		Rejuvenation Haven (N=846)		The Ripple Effect (N=246)		Lambda Lounge (N=245)		Q-Spot (N=551)		Total (N=1,971)	
	N	%	N	%	N	%	N	%	N	%	N	%
Age Group												
Children/Youth (0-15)	0	0.0%	6	0.7%	10	4.1%	9	3.7%	54	9.8%	79	4.0%
TAY (16-25)	1	1.2%	125	14.8%	16	6.5%	8	3.3%	333	60.4%	483	24.5%
Adults (26-59)	22	26.5%	0	0.0%	149	60.6%	110	44.9%	4	0.7%	285	14.5%
Older Adults (60+)	60	72.3%	0	0.0%	32	13.0%	18	7.3%	1	0.2%	111	5.6%
Unknown/Not Reported	0	0.0%	715	84.5%	39	15.9%	100	40.8%	159	28.9%	1,013	51.4%
Ethnicity												
Hispanic or Latino	15	18.1%	21	2.5%	19	7.7%	26	10.6%	48	8.7%	129	6.5%
Non-Hispanic/Non-Latino	68	81.9%	105	12.4%	187	76.0%	119	48.6%	344	62.4%	823	41.8%
More than one ethnicity	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Unknown/Not Reported	0	0.0%	720	85.1%	40	16.3%	100	40.8%	159	28.9%	1,019	51.7%
Race*												
American Indian or Alaska Native	2	2.4%	2	0.2%	11	4.5%	4	1.6%	8	1.5%	27	1.4%
Asian	10	12.0%	1	0.1%	3	1.2%	5	2.0%	8	1.5%	27	1.4%
Black or African American	8	9.6%	37	4.4%	57	23.2%	21	8.6%	39	7.1%	162	8.2%
Native Hawaiian/Pacific Islander	0	0.0%	0	0.0%	6	2.4%	4	1.6%	8	1.5%	18	0.9%
White	50	60.2%	28	3.3%	107	43.5%	22	9.0%	89	16.2%	296	15.0%
Other	13	15.7%	44	5.2%	48	19.5%	43	17.6%	68	12.3%	216	11.0%
Unknown/Not Reported	0	0.0%	745	88.1%	40	16.3%	146	59.6%	331	60.1%	1,262	64.0%
Primary Language												
English	83	100.0%	82	9.7%	121	49.2%	75	30.6%	107	19.4%	468	23.7%
Non-English	0	0.0%	0	0.0%	5	2.0%	2	0.8%	3	0.5%	10	0.5%
Unknown/Not Reported	0	0.0%	764	90.3%	120	48.8%	168	68.6%	441	80.0%	1,493	75.7%
Sexual Orientation												
Gay or Lesbian	2	2.4%	7	0.8%	4	1.6%	18	7.3%	41	7.4%	72	3.7%
Heterosexual or Straight	80	96.4%	42	5.0%	190	77.2%	22	9.0%	22	4.0%	356	18.1%
Bisexual	1	1.2%	20	2.4%	4	1.6%	12	4.9%	48	8.7%	85	4.3%
Questioning or unsure	0	0.0%	1	0.1%	0	0.0%	5	2.0%	6	1.1%	12	0.6%
Queer	0	0.0%	0	0.0%	0	0.0%	1	0.4%	7	1.3%	8	0.4%
Another sexual orientation	0	0.0%	18	2.1%	0	0.0%	9	3.7%	46	8.3%	73	3.7%
Unknown/Not Reported	0	0.0%	758	89.6%	48	19.5%	178	72.7%	381	69.1%	1,365	69.3%
Current Gender Identity												
Male	17	20.5%	28	3.3%	104	42.3%	32	13.1%	33	6.0%	214	10.9%
Female	66	79.5%	30	3.5%	100	40.7%	9	3.7%	18	3.3%	223	11.3%
Transgender	0	0.0%	3	0.4%	0	0.0%	8	3.3%	33	6.0%	44	2.2%
Genderqueer	0	0.0%	1	0.1%	0	0.0%	1	0.4%	7	1.3%	9	0.5%
Questioning or unsure	0	0.0%	0	0.0%	0	0.0%	3	1.2%	2	0.4%	5	0.3%
Another gender identity	0	0.0%	24	2.8%	0	0.0%	14	5.7%	78	14.2%	116	5.9%
Unknown/Not Reported	0	0.0%	760	89.8%	42	17.1%	178	72.7%	380	69.0%	1,360	69.0%
Veteran Status												
Yes	6	7.2%	0	0.0%	4	1.6%	3	1.2%	1	0.2%	14	0.7%
No	77	92.8%	131	15.5%	203	82.5%	142	58.0%	391	71.0%	944	47.9%
Decline to answer	0	0.0%	715	84.5%	39	15.9%	100	40.8%	159	28.9%	1,013	51.4%

*Some totals are higher than other categories as clients select multiple categories

PREVENTION AND EARLY INTERVENTION - SUPPORTING COMMUNITY CONNECTIONS (SCC) - FY 23/24																												
Characteristic	Afghan (N=207)		African American (N=246)		Arabic-Speaking (N=173)		Cantonese, Vietnamese, & Hmong-Speaking (N=350)		Consumer Operated Warmline (N=277)		Farsi-Speaking (N=74)		Iu-Mien (N=355)		Native American (N=271)		Older Adults (N=155)		Russian-Speaking/Slavic (N=286)		Spanish-Speaking/Latino (N=648)		Ukrainian Support Line (N=4275)		Youth/TAY (N=276)		Total (N=7593)	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Age Group																												
Children/Youth (0-15)	12	5.8%	27	11.0%	5	2.9%	0	0.0%	0	0.0%	4	5.4%	79	22.3%	44	16.2%	0	0.0%	0	0.0%	0	0.0%	5	0.1%	23	8.3%	198	2.6%
TAY (16-25)	38	18.4%	46	18.7%	23	13.3%	8	2.3%	16	5.8%	15	20.3%	14	3.9%	47	17.3%	0	0.0%	29	10.1%	27	4.2%	1071	25.1%	252	91.3%	1,586	20.9%
Adults (26-59)	153	73.9%	117	47.6%	123	71.1%	183	52.3%	237	85.6%	52	70.3%	65	18.3%	135	49.8%	50	32.3%	166	58.0%	463	71.5%	2794	65.4%	1	0.4%	4,539	59.8%
Older Adults (60+)	4	1.9%	56	22.8%	21	12.1%	159	45.4%	24	8.7%	3	4.1%	197	55.5%	42	15.5%	103	66.5%	91	31.8%	155	23.9%	405	9.5%	0	0.0%	1,260	16.6%
Unknown/Not Reported	0	0.0%	0	0.0%	1	0.6%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	3	1.1%	2	1.3%	0	0.0%	3	0.5%	0	0.0%	0	0.0%	9	0.1%
Ethnicity																												
Hispanic/Latino	1	0.5%	9	3.7%	0	0.0%	1	0.3%	40	14.4%	0	0.0%	11	3.1%	88	32.5%	145	93.5%	1	0.3%	635	98.0%	0	0.0%	102	37.0%	1,033	13.6%
Non-Hispanic/Non-Latino	206	99.5%	237	96.3%	173	100.0%	348	99.4%	237	85.6%	74	100.0%	343	96.6%	182	67.2%	9	5.8%	285	99.7%	12	1.9%	4275	100.0%	174	63.0%	6,555	86.3%
More than one ethnicity	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Unknown/Not Reported	0	0.0%	0	0.0%	0	0.0%	1	0.3%	0	0.0%	0	0.0%	1	0.3%	1	0.4%	1	0.6%	0	0.0%	1	0.2%	0	0.0%	0	0.0%	5	0.1%
Race																												
American Indian/Alaska Native	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.4%	0	0.0%	0	0.0%	130	48.0%	2	1.3%	0	0.0%	2	0.3%	0	0.0%	2	0.7%	137	1.1%
Asian	0	0.0%	3	1.2%	1	0.6%	337	96.3%	11	4.0%	0	0.0%	307	86.5%	13	4.8%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	9	3.3%	681	20.5%
Black/African American	0	0.0%	222	90.2%	0	0.0%	0	0.0%	18	6.5%	0	0.0%	6	1.7%	12	4.4%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	98	35.5%	356	10.7%
More than one race	3	1.4%	4	1.6%	8	4.6%	9	2.6%	7	2.5%	9	12.2%	31	8.7%	74	27.3%	0	0.0%	117	40.9%	0	0.0%	0	0.0%	50	18.1%	312	9.4%
Native Hawaiian/Other Pacific Islander	0	0.0%	1	0.4%	0	0.0%	0	0.0%	1	0.4%	0	0.0%	2	0.6%	1	0.4%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2	0.7%	7	0.2%
Other	204	98.6%	5	2.0%	119	68.8%	0	0.0%	28	10.1%	65	87.8%	8	2.3%	23	8.5%	142	91.6%	166	58.0%	637	98.3%	0	0.0%	51	18.5%	1,448	43.6%
Unknown/Not Reported	0	0.0%	8	3.3%	44	25.4%	2	0.6%	152	54.9%	0	0.0%	1	0.3%	5	1.8%	5	3.2%	0	0.0%	4	0.6%	0	0.0%	2	0.7%	223	6.7%
White/Caucasian	0	0.0%	3	1.2%	1	0.6%	2	0.6%	59	21.3%	0	0.0%	0	0.0%	13	4.8%	6	3.9%	3	1.0%	5	0.8%	4275	100.0%	62	22.5%	4,429	4.6%
Primary Language																												
English	0	0.0%	244	99.2%	0	0.0%	2	0.6%	271	97.8%	0	0.0%	124	34.9%	256	94.5%	10	6.5%	0	0.0%	14	2.2%	0	0.0%	276	100.0%	1,197	15.8%
Spanish	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2	0.7%	0	0.0%	0	0.0%	3	1.1%	143	92.3%	0	0.0%	631	97.4%	0	0.0%	0	0.0%	779	10.3%
Vietnamese	0	0.0%	1	0.4%	1	0.6%	168	48.0%	0	0.0%	0	0.0%	3	0.8%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	173	2.3%
Cantonese	0	0.0%	0	0.0%	0	0.0%	25	7.1%	0	0.0%	0	0.0%	0	0.0%	1	0.4%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	26	0.3%
Russian	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	286	100.0%	0	0.0%	0	0.0%	0	0.0%	286	3.8%
Hmong	0	0.0%	0	0.0%	0	0.0%	154	44.0%	0	0.0%	0	0.0%	3	0.8%	1	0.4%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	158	2.1%
Arabic	1	0.5%	0	0.0%	165	95.4%	0	0.0%	1	0.4%	0	0.0%	0	0.0%	2	0.7%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	168	2.2%
Other	206	99.5%	1	0.4%	5	2.9%	1	0.3%	0	0.0%	74	100.0%	223	62.8%	1	0.4%	0	0.0%	0	0.0%	1	0.2%	0	0.0%	0	0.0%	512	6.7%
Unknown/Not Reported	0	0.0%	0	0.0%	2	1.2%	0	0.0%	3	1.1%	0	0.0%	2	0.6%	7	2.6%	2	1.3%	0	0.0%	2	0.3%	4275	100.0%	0	0.0%	4,293	56.5%
Sexual Orientation																												
Heterosexual/Straight	207	100.0%	127	51.6%	134	77.5%	347	99.1%	85	30.7%	74	100.0%	303	85.4%	178	65.7%	146	94.2%	286	100.0%	539	98.6%	0	0.0%	87	31.5%	2,613	34.4%
Gay/Lesbian	0	0.0%	15	6.1%	0	0.0%	0	0.0%	4	1.4%	0	0.0%	0	0.0%	5	1.8%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	12	4.3%	36	0.5%
Bisexual	0	0.0%	3	1.2%	0	0.0%	0	0.0%	3	1.1%	0	0.0%	3	0.8%	6	2.2%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	24	8.7%	39	0.5%
Questioning/Unsure	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.4%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	17	6.2%	18	0.2%
Queer	0	0.0%	2	0.8%	0	0.0%	0	0.0%	1	0.4%	0	0.0%	0	0.0%	4	1.5%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	120	43.5%	127	1.7%
Another sexual orientation	0	0.0%	0	0.0%	9	5.2%	3	0.9%	5	1.8%	0	0.0%	4	1.1%	21	7.7%	0	0.0%	0	0.0%	2	0.3%	0	0.0%	8	2.9%	52	0.7%
Unknown/Not Reported	0	0.0%	99	40.2%	30	17.3%	0	0.0%	179	64.6%	0	0.0%	45	12.7%	56	20.7%	9	5.8%	0	0.0%	7	1.1%	4275	100.0%	8	2.9%	4,708	62.0%
Gender Identity																												
Female	65	31.4%	150	61.0%	85	49.1%	178	50.9%	127	45.8%	34	45.9%	239	67.3%	180	66.4%	117	75.5%	147	51.4%	498	76.9%	2412	56.4%	99	35.9%	4,329	57.0%
Male	142	68.6%	64	26.0%	88	50.9%	172	49.1%	52	18.8%	40	54.1%	111	31.3%	67	24.7%	36	23.2%	139	48.6%	149	23.0%	1861	43.5%	119	43.1%	3,040	40.0%
Transgender	0	0.0%	2	0.8%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	4	1.5%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	25	9.1%	31	0.4%
Genderqueer	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2	0.7%	2	0.0%
Questioning/Unsure	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2	0.7%	2	0.0%
Another gender identity	0	0.0%	2	0.8%	0	0.0%	0	0.0%	2	0.7%	0	0.0%	0	0.0%	7	2.6%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	27	9.8%	38	0.5%
Unknown/Not Reported	0	0.0%	28	11.4%	0	0.0%	0	0.0%	96	34.7%	0	0.0%	5	1.4%	13	4.8%	2	1.3%	0	0.0%	3	0.5%	2	0.0%	2	0.7%	151	2.0%
Veteran Status																												
Yes	0	0.0%	2	0.8%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	6	2.2%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	8	0.1%
No	207	100.0%	244	99.2%	173	100.0%	350	100.0%	277	100.0%	74	100.0%	355	100.0%	265	97.8%	155	100.0%	286	100.0%	648	100.0%	0	0.0%	276	100.0%	3,310	43.6%
Unknown/Not Reported	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	4275	100.0%	0	0.0%	4,275	56.3%

PREVENTION AND EARLY INTERVENTION - STRENGTHENING FAMILIES - FY 23/24																
Characteristic	QCCC (N=577)		CPS Mental Health Teams (N=574)		eVIBE (N=1,962)		Adoptive Families Respite (N=423)		The Source (N=2247)		Safe Zone Squad (N=1332)		Youth Help Network (N=258)		Total (N=7,373)	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Age Group																
Children/Youth (0-15)	28	4.9%	479	83.4%	1,847	94.1%	187	44.2%	63	2.8%	0	0.0%	1	0.4%	2,605	35.3%
TAY (16-25)	3	0.5%	47	8.2%	40	2.0%	45	10.6%	17	0.8%	0	0.0%	257	99.6%	409	5.5%
Adults (26-59)	18	3.1%	47	8.2%	48	2.4%	178	42.1%	0	0.0%	0	0.0%	0	0.0%	291	3.9%
Older Adults (60+)	0	0.0%	1	0.2%	1	0.1%	11	2.6%	0	0.0%	0	0.0%	0	0.0%	13	0.2%
Unknown/Not Reported	528	91.5%	0	0.0%	26	1.3%	2	0.5%	2167	96.4%	1332	100.0%	0	0.0%	4,055	55.0%
Ethnicity																
Hispanic or Latino	4	0.7%	54	9.4%	820	41.8%	90	21.3%	18	0.8%	0	0.0%	47	18.2%	1,033	14.0%
Non-Hispanic/Non-Latino	18	3.1%	124	21.6%	735	37.5%	333	78.7%	51	2.3%	0	0.0%	108	41.9%	1,369	18.6%
More than one ethnicity	13	2.3%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	13	0.2%
Unknown/Not Reported	542	93.9%	396	69.0%	407	20.7%	0	0.0%	2178	96.9%	1332	100.0%	103	39.9%	4,958	67.2%
Race																
American Indian or Alaska Native	0	0.0%	0	0.0%	13	0.7%	12	2.8%	0	0.0%	0	0.0%	3	1.2%	28	0.7%
Asian	0	0.0%	3	0.5%	272	13.9%	5	1.2%	0	0.0%	0	0.0%	6	2.3%	286	7.4%
Black or African American	10	1.7%	81	14.1%	207	10.6%	77	18.2%	25	1.1%	0	0.0%	119	46.1%	519	13.4%
More than one race	5	0.9%	46	8.0%	374	19.1%	57	13.5%	19	0.8%	0	0.0%	24	9.3%	525	13.6%
Native Hawaiian or other Pacific Islander	0	0.0%	3	0.5%	41	2.1%	0	0.0%	1	0.0%	0	0.0%	2	0.8%	47	1.2%
Other	7	1.2%	25	4.4%	578	29.5%	41	9.7%	3	0.1%	0	0.0%	20	7.8%	674	17.4%
White	19	3.3%	72	12.5%	281	14.3%	221	52.2%	24	1.1%	0	0.0%	52	20.2%	669	17.3%
Unknown/Not Reported	536	92.9%	344	59.9%	196	10.0%	10	2.4%	2175	96.8%	1332	100.0%	32	12.4%	1,126	29.1%
Primary Language																
English	40	6.9%	243	42.3%	1456	74.2%	423	100.0%	78	3.5%	0	0.0%	197	76.4%	2,437	33.1%
Spanish	5	0.9%	8	1.4%	155	7.9%	0	0.0%	2	0.1%	0	0.0%	3	1.2%	173	2.3%
Vietnamese	0	0.0%	0	0.0%	12	0.6%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	12	0.2%
Cantonese	0	0.0%	0	0.0%	21	1.1%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	21	0.3%
Russian	0	0.0%	2	0.3%	12	0.6%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	14	0.2%
Hmong	0	0.0%	0	0.0%	3	0.2%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	3	0.0%
Arabic	2	0.3%	0	0.0%	3	0.2%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	5	0.1%
Farsi	0	0.0%	1	0.2%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.0%
Other	3	0.5%	5	0.9%	63	3.2%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	71	1.0%
Unknown/Not Reported	527	91.3%	315	54.9%	237	12.1%	0	0.0%	2167	96.4%	1332	100.0%	58	22.5%	4,636	62.9%
Sexual Orientation																
Heterosexual or Straight	15	2.6%	121	21.1%	33	1.7%	291	68.8%	33	1.5%	0	0.0%	127	49.2%	620	8.4%
Gay or Lesbian	1	0.2%	1	0.2%	0	0.0%	34	8.0%	3	0.1%	0	0.0%	12	4.7%	51	0.7%
Bisexual	0	0.0%	7	1.2%	5	0.3%	17	4.0%	3	0.1%	0	0.0%	24	9.3%	56	0.8%
Questioning or unsure	0	0.0%	9	1.6%	0	0.0%	38	9.0%	7	0.3%	0	0.0%	2	0.8%	56	0.8%
Queer	0	0.0%	0	0.0%	0	0.0%	1	0.2%	0	0.0%	0	0.0%	0	0.0%	1	0.0%
Another sexual orientation	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.4%	1	0.0%
Unknown/Not Reported	561	97.2%	436	76.0%	1924	98.1%	42	9.9%	2201	98.0%	1332	100.0%	92	35.7%	6,588	89.4%
Current Gender Identity																
Female	30	5.2%	133	23.2%	981	50.0%	238	56.3%	35	1.6%	0	0.0%	65	25.2%	1,482	20.1%
Male	20	3.5%	81	14.1%	955	48.7%	142	33.6%	25	1.1%	0	0.0%	47	18.2%	1,270	17.2%
Transgender	0	0.0%	0	0.0%	1	0.1%	9	2.1%	2	0.1%	0	0.0%	13	5.0%	25	0.3%
Genderqueer	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2	0.1%	0	0.0%	0	0.0%	2	0.0%
Questioning or unsure	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.0%	0	0.0%	0	0.0%	1	0.0%
Another gender identity	0	0.0%	1	0.2%	0	0.0%	8	1.9%	2	0.1%	0	0.0%	14	5.4%	25	0.3%
Unknown/Not Reported	527	91.3%	359	62.5%	25	1.3%	26	6.1%	2180	97.0%	1332	100.0%	119	46.1%	4,568	62.0%
Veteran Status																
Yes	0	0.0%	0	0.0%	0	0.0%	6	1.4%	0	0.0%	0	0.0%	0	0.0%	6	0.1%
No	50	8.7%	120	20.9%	0	0.0%	415	98.1%	56	2.5%	0	0.0%	41	15.9%	682	9.2%
Unknown/Not Reported	527	91.3%	454	79.1%	1962	100.0%	2	0.5%	2191	97.5%	1332	100.0%	217	84.1%	6,685	90.7%

PREVENTION AND EARLY INTERVENTION - INTEGRATED HEALTH AND WELLNESS - FY 23/24														
Characteristic	SacEDAPT (N=137)		Senior Link (N=253)		Community Responsive Wellness Program (CRWP)								Total (N=2054)	
					Improve Your Tomorrow (N=51)		ONTRACK Program Resources, Inc. (N=26)		Roberts Family Development Center (N=654)		Rose Family Creative Empowerment Center (N=933)			
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Age Group														
Children/Youth (0-15)	43	31.4%	0	0.0%	29	56.9%	0	0.0%	128	19.6%	204	21.9%	404	19.7%
TAY (16-25)	85	62.0%	0	0.0%	22	43.1%	5	19.2%	95	14.5%	134	14.4%	341	16.6%
Adults (26-59)	9	6.6%	7	2.8%	0	0.0%	17	65.4%	362	55.4%	498	53.4%	893	43.5%
Older Adults (60+)	0	0.0%	186	73.5%	0	0.0%	4	15.4%	66	10.1%	97	10.4%	353	17.2%
Unknown/Not Reported	0	0.0%	60	23.7%	0	0.0%	0	0.0%	3	0.5%	0	0.0%	63	3.1%
Ethnicity														
Hispanic/Latino	49	35.8%	18	7.1%	4	7.8%	2	7.7%	82	12.5%	150	16.1%	305	14.8%
Non-Hispanic/Non-Latino	66	48.2%	160	63.2%	42	82.4%	24	92.3%	562	85.9%	774	83.0%	1628	79.3%
More than one ethnicity	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Unknown/Not Reported	22	16.1%	75	29.6%	5	9.8%	0	0.0%	10	1.5%	9	1.0%	121	5.9%
Race														
American Indian/Alaska Native	1	0.7%	3	1.2%	0	0.0%	0	0.0%	8	1.2%	12	1.3%	24	1.2%
Asian	10	7.3%	7	2.8%	0	0.0%	0	0.0%	1	0.2%	38	4.1%	56	2.7%
Black/African American	35	25.5%	65	25.7%	42	82.4%	22	84.6%	455	69.6%	576	61.7%	1195	58.2%
More than one race	28	20.4%	2	0.8%	9	17.6%	3	11.5%	19	2.9%	12	1.3%	73	3.6%
Native Hawaiian/Other Pacific Islander	0	0.0%	3	1.2%	0	0.0%	0	0.0%	2	0.3%	4	0.4%	9	0.4%
Other	23	16.8%	14	5.5%	0	0.0%	1	3.8%	37	5.7%	100	10.7%	175	8.5%
White/Caucasian	38	27.7%	88	34.8%	0	0.0%	0	0.0%	51	7.8%	83	8.9%	260	12.7%
Unknown/Not Reported	2	1.5%	71	28.1%	0	0.0%	0	0.0%	81	12.4%	108	11.6%	262	12.8%
Primary Language														
English	123	89.8%	185	73.1%	51	100.0%	26	100.0%	576	88.1%	928	99.5%	1889	92.0%
Spanish	9	6.6%	1	0.4%	0	0.0%	0	0.0%	0	0.0%	1	0.1%	11	0.5%
Vietnamese	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Cantonese	0	0.0%	3	1.2%	0	0.0%	0	0.0%	0	0.0%	1	0.1%	4	0.2%
Russian	2	1.5%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2	0.1%
Hmong	1	0.7%	1	0.4%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2	0.1%
Arabic	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Farsi	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Other	2	1.5%	1	0.4%	0	0.0%	0	0.0%	1	0.2%	0	0.0%	4	0.2%
Unknown/Not Reported	0	0.0%	62	24.5%	0	0.0%	0	0.0%	77	11.8%	3	0.3%	142	6.9%
Sexual Orientation														
Heterosexual/ Straight	102	74.5%	165	65.2%	47	92.2%	26	100.0%	372	56.9%	925	99.1%	1637	79.7%
Gay/Lesbian	6	4.4%	7	2.8%	1	2.0%	0	0.0%	6	0.9%	2	0.2%	22	1.1%
Bisexual	13	9.5%	1	0.4%	0	0.0%	0	0.0%	25	3.8%	1	0.1%	40	1.9%
Questioning/Unsure	4	2.9%	0	0.0%	0	0.0%	0	0.0%	5	0.8%	0	0.0%	9	0.4%
Queer	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2	0.3%	1	0.1%	3	0.1%
Another sexual orientation	0	0.0%	4	1.6%	1	2.0%	0	0.0%	37	5.7%	1	0.1%	43	2.1%
Unknown/Not Reported	12	8.8%	76	30.0%	2	3.9%	0	0.0%	207	31.7%	3	0.3%	300	14.6%
Gender Identity														
Female	56	40.9%	155	61.3%	0	0.0%	20	76.9%	441	67.4%	614	65.8%	1286	62.6%
Male	69	50.4%	35	13.8%	48	94.1%	6	23.1%	194	29.7%	316	33.9%	668	32.5%
Transgender	5	3.6%	2	0.8%	0	0.0%	0	0.0%	1	0.2%	0	0.0%	8	0.4%
Genderqueer	1	0.7%	0	0.0%	1	2.0%	0	0.0%	1	0.2%	0	0.0%	3	0.1%
Questioning/Unsure	1	0.7%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.0%
Another gender identity	3	2.2%	0	0.0%	0	0.0%	0	0.0%	4	0.6%	1	0.1%	8	0.4%
Unknown/Not Reported	1	1.5%	61	24.1%	2	3.9%	0	0.0%	13	2.0%	2	0.2%	80	3.9%
Veteran Status														
Yes	0	0.0%	10	4.0%	1	2.0%	2	7.7%	0	0.0%	0	0.0%	13	0.6%
No	0	0.0%	0	0.0%	50	98.0%	24	92.3%	654	100.0%	933	100.0%	1661	80.9%
Unknown/Not Reported	137	100.0%	243	96.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	380	18.5%

*Some totals are higher than other categories as clients select multiple categories

PREVENTION AND EARLY INTERVENTION - TIME LIMITED GRANTS - FY 23/24		
Characteristic	PEI Grant Total (all programs)	
	N=6,835	%
Age Group		
Children/Youth (0-15)	881	12.9%
TAY (16-25)	566	8.3%
Adults (26-59)	2,438	35.7%
Older Adults (60+)	1,454	21.3%
Unknown/Not Reported	1,496	21.9%
Ethnicity		
Hispanic or Latino	2,333	34.1%
Non-Hispanic/Non-Latino	2,801	41.0%
More than one ethnicity	0	0.0%
Unknown/Not Reported	1,701	24.9%
Race		
American Indian or Alaska Native	107	0.1%
Asian	225	0.0%
Black or African American	1,297	4.6%
More than one race	42	0.1%
Native Hawaiian or other Pacific Islander	15	0.0%
Other	2,555	2.7%
White	812	9.4%
Unknown/Not Reported	1,782	83.1%
Primary Language		
English	2,561	37.5%
Spanish	1,953	28.6%
Vietnamese	4	0.1%
Cantonese	9	0.1%
Russian	0	0.0%
Hmong	12	0.2%
Arabic	0	0.0%
Other	786	11.5%
Unknown/Not Reported	1,510	22.1%
Sexual Orientation		
Heterosexual or Straight	3,441	50.3%
Gay or Lesbian	91	1.3%
Bisexual	117	1.7%
Questioning or unsure	37	0.5%
Queer	41	0.6%
Another sexual orientation	599	8.8%
Unknown/Not Reported	2,509	36.7%
Current Gender Identity		
Female	3,134	45.9%
Male	1,916	28.0%
Transgender	45	0.7%
Genderqueer	9	0.1%
Questioning or unsure	11	0.2%
Another gender identity	99	1.4%
Unknown/Not Reported	1,621	23.7%
Veteran Status		
Yes	50	0.7%
No	5,290	77.4%
Unknown/Not Reported	1,495	21.9%

WORKFORCE EDUCATION AND TRAINING (WET) COMPONENT

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

The Sacramento County initial Workforce Needs Assessment, completed as part of the Workforce Education and Training (WET) Component planning process, helped inform the development of the WET Plan. As part of the annual Cultural Competence Plan requirements, BHS conducts a Human Resource (HR) Survey and Language Proficiency Survey to provide current data on the entire mental health system.

In February of 2023, BHS disseminated the Human Resource (HR) and Language Proficiency surveys to all staff who work for a BHS county operated or BHS funded contract provider. The Human Resource (HR) Survey is intended to comply with the National Culturally and Linguistically Appropriate Services (CLAS) Standard 3: Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

The HR Survey collects information regarding individuals who work and/or provide support (directly or indirectly) to Medi-Cal beneficiaries in the Sacramento County Behavioral Health System. The data is then utilized to compare the workforce to the population served.

In addition to the HR Survey, the Language Proficiency Survey collects information regarding the linguistic proficiency of individuals involved in the provision of behavioral health services. The information collected from both surveys focuses on staff ethnicity, language proficiencies, gender, sexual orientation, consumer/family member status, disability, and veteran status. The Sacramento County BHS 2023 Human Resource Survey findings are summarized in a report found in *Attachment A: Human Resources Report 2024.*

MHSA defined age categories are as follows:

- Children and youth = birth – 17-years-old
- Transition Age Youth (TAY) = 16-years-old – 25-years-old
- Adult = 18-years-old – 59-years-old
- Older Adult = 60-years-old+

Mental Health Services Act (MHSA)
Workforce Education and Training (WET) Component

Action 1: Workplace Staffing Support

BHS WET Coordinator

Action 2: System Training Continuum

BHS, SCOE, Contracted Providers, System Partners

Action 3: Consumer and Family Member Employment and Stipends for Individuals, Especially Consumers and Family Members, for Education Programs to Enter the Mental Health Field

BHS, System Partners, Consumers, Family Members, Individuals from Culturally and Linguistic Diverse Communities

Action 4: High School Training

Arthur A. Benjamin Health Professions High School (AABHPHS)
Valley High School Health TECH Academy (Tech)

Action 5: Psychiatric Residents and Fellowships

UCD Psychiatric Residents and Fellowship Training, Cal-AIM Provider Training, UCD Residents and Post–Doctoral Fellows at Youth Detention Facility, BHS Clinical Child Psychology, Pre-Doctoral Internship Training Program

Action 6: Multidiscipline Workforce Recruitment and Retention

BHS Loan Repayment Program

Action 7: Consumer Leadership Stipends

Consumers, Family Members, Individuals with Lived Experience from Culturally and Linguistic Diverse Communities

SACRAMENTO COUNTY

Rev 3/04/2024

Action 1: Workforce Staffing Support

The function of the WET Coordinator is to assist in the facilitation and implementation of previously approved WET Actions. The Coordinator attends and participates in statewide WET Coordinator Meetings; the WET Central Region Partnership; the Grow Your Own Mental/Behavioral Health (MBH) Advisory Group; the Student Mental Health and Wellness Collaborative; Health Professions Education Foundation Advisory/Selection Committee; and the Valley High School-Health TECH Academy Community Advisory Board. The WET Coordinator continues to assist in the evaluation of WET Plan implementation and effectiveness, coordinates/collaborates with other MHSA and BHS efforts, and participates in the implementation of WET Actions.

The WET Coordinator is in frequent communication with non-profits, universities, and colleges regarding workforce pipeline development, which resulted in three (3) five-year Memorandums of Understanding for FY 2023-2028 for clinical student placements for social work, counseling, nursing, allied health, and physician assistant students. The WET Planner in FY 2023-24 supported efforts for job seekers and interns seeking careers in public behavioral health. The WET Coordinator provided over a dozen one-on-one consultations for job seekers or students seeking internships in public behavioral health. This included directing job seekers to the newly developed BHS Employment webpage; sharing resources, vacant positions, and application steps; and referring students to contracted providers who have clinical internship programs. Additionally, the WET Coordinator supported numerous community job fairs or presented at targeted recruitments events, including colleges and universities.

The WET Coordinator will continue to work collaboratively with the Department of Personnel Services, professional societies, and non-profits to support the recruitment efforts outlined in detail under Action 6.

Action 2: System Training Continuum

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

BHS Quality Management

Since 2010, Sacramento County BHS, Quality Management team has offered both Mental Health First Aid (MHFA) and Youth Mental Health First Aid (YMHFA) trainings at no cost to community members. Due to trainer limitations, Sacramento County is only able to offer MHFA training. For FY 2023-24, twelve (12), once a month, MHFA trainings were completed. A total of 78 participants were training in FY 2023-24. There are plans in motion to train more Behavioral Health services staff in YMHFA and MHFA, including, offering MHFA training in Spanish, which will increase training frequency. Training is currently offered monthly and advertised on the BHS website. Currently, MHFA training is offered monthly with hopes of expansion to YMHA and offering Spanish MHFA once staff are trained and receive their certification.

Sacramento County Office of Education (SCOE)

In FY 2023-24, Sacramento County Office of Education (SCOE) supported YMHFA and Question Persuade Refer (QPR) trainings at four (4) school districts, including Twin Rivers Unified School District, Elk Grove Unified School District, SCOE, and Sacramento City Unified School Districts.

A total of 55 adult participants were trained in YMFA and 95 adults in QPR, totaling 150. SCOE anticipates conducting YMHFA and QPR trainings per year for the next three (3) years, reaching 450 participants.

Supporting Community Connections (SCC) Providers

Currently, both adult and youth MHFA training sessions, including language/culturally specific sessions, are part of the partner training schedule and the county's Mental Health Plan (MHP) and are offered in both English and Spanish through a partnership with a community-based contract provider. The following providers implemented community trainings in FY 2023-24

- The Children's Receiving Home conducted one (1) Applied Suicide Intervention Skills Training (ASIST) to 10 community members. The Children's Receiving Home plans to offer another ASIST training in FY 2024-2025
- La Familia Counseling Center conducted five Spanish language MHFA training, with a total of 78 participants. La Familia plans to continue to conduct trainings in FY 2024-25, with a goal of four (4) per year.
- Sacramento Native American Health Center (SNAHC) offered five (5) Question Persuade and Response (QPR) trainings to community members free of charge, with a total of 101 participants. SNAHC has plans to offer YMHFA, MHFA, and QPR training in FY 2024-25.

In FY 2023-24, a total of 189 individuals were trained by community-based contract providers. All providers listed above and A Church For All have declared their intention to continue offering free of charge training to community members in future years.

Mental Health Treatment Center (MHTC)

The System Training Continuum also supports the provision of Pro-ACT (Professional Assault Crisis Training). BHS provides this training to staff at the Sacramento County Mental Health Treatment Center (MHTC). Pro-ACT Training emphasizes critical thinking, continued assessment of client behaviors and needs, and employs a distinctive problem-solving approach designed to improve safety and enhance treatment outcomes. MHTC conducted 41 Pro-ACT trainings during FY 2023-24. This included a combination of Pro-ACT Initial, Pro-ACT Refresher, Pro-ACT Support, and Intro to Pro-ACT for Med Students. All of the trainings are conducted onsite. A total of 221 participants were trained, all of whom were MHTC staff, UC Davis Physicians, or UC Davis medical students (who rotate providing services throughout the year). It is projected the training numbers will be the same throughout the three funding years.

Annual BHS Cultural Competence Training

BHS requires all persons who are providing specialty mental health services or providing interpreter or other support services to beneficiaries and who are employed by or contracting with the Mental Health Plan (MHP) or with contractors of the MHP to receive annual cultural competence training (California Code of Regulations Title 9, Division 1, Chapter 11, Subchapter 1, Article 4, § 1810.410, (c)(4)).

To align with state requirements and our commitment to developing and providing culturally responsive services, BHS offered a new training series in FY 2023-24 and FY 2024-25 focusing on cultural humility. Over the next two years, BHS will partner with the California Institute for

Behavioral Health Solutions (CIBHS) to provide five live (virtual) trainings, each two hours in length.

The dates of the trainings listed below were live sessions and participants received a certificate of participation. The trainings offer CEs to eligible professionals who attend a live training. For those who were unable to attend the live training dates, trainings are recorded and available on-demand in the new learning management system. If staff do not attend a live training, then they will be required to watch the recorded training(s) by June 30, 2025. The next MHSA annual update will include the number of participants and completion percentages.

FY 2023-24 and FY 2024-25 Training Series

1. Training 1: Cultural Humility as a Framework in Advancing Justice, Equity, Diversity, and Inclusion - April 11, 2024
2. Training 2: Equity and Inclusion for People with Disabilities in Behavioral Health Services: Part 1 – Applying the Americans with Disabilities Act (ADA) - May 9, 2024
3. Training 3: Practicing Cultural Formulation - May 23, 2024 (Required only for clinical teams)
4. Training 4: Cultural Humility: Communities identifying as Transgender and Gender Diverse - June 13, 2024
5. Training 5: Equity and Inclusion for People with Disabilities in Behavioral Health Services: Part 2 - Cultural and Systemic Barriers and the Lived Experience - September 26, 2024

Annual Interpreter Training

In FY 2023-24, BHS virtually offered *Behavioral Health Interpreter Training: Introduction to Interpreting in Behavioral Health*, an intensive two-day training for 7 hours each day intended for bilingual staff fluent in English and at least one other language who use their linguistic skills to provide interpreting services. Twenty-one (21) participants completed the training. This training is required for direct service staff, clinicians, administrative support staff, bilingual community members, contractors, consumers, case management staff, and others currently serving as language interpreters in mental health and/or substance use disorders programs, as well as those who want to become interpreters.

“Therapeutic Cross-Cultural Communication,” is a training provided for monolingual English speaking clinicians working with language interpreters’ services. Twenty-two (22) participants completed this two-day virtual training (3.5 hours each day) during FY 2023-24.

This is a decrease in participants from the previous year of twenty-eight participants attending Introduction to Interpreting Behavioral Health Settings and thirty-five participants for Therapeutic Cross-Cultural Communication. These two (2) trainings meet State requirements and support bilingual staff, including clinicians, case managers, administrative support staff, community members, system partners, contractors, consumers/peers, and others who are or want to become interpreters. Through them, BHS strove to achieve the BHS-identified standard that 98% of staff identified as interpreters complete an approved mental health/behavioral health interpreter training and receive certification. In FY 2023-24, all (100%) staff identified as interpreters in the Assisted Access program completed the training.

Training Scholarships

In FY 2022-23, BHS provided scholarships and support for 176 behavioral health staff, system partners, providers, partners, and individuals with lived mental health experiences to attend ten (10) behavioral health related trainings and conferences. This included conferences or trainings by Sacramento Valley Psychology Association Conference, National Council for Mental Wellbeing, Mental Health First Aid Training, Human Trafficking Conference, and Wellness Recovery Action Plan Training.

Action 3: Consumer and Family Member Employment and Stipends for Individuals, Especially Consumers and Family Members, for Education Programs to Enter the Mental Health Field

This Action combines **Action 3: Consumer and Family Member Employment** and **Action 8: Stipends for Individuals, Especially Consumers and Family Members, for Education Programs to Enter the Mental Health Field**, as described in the previous Three-Year Plan. This Action is designed to develop entry and supportive employment opportunities for consumers, family members, and individuals from Sacramento County's culturally and linguistically diverse communities to address occupational shortages identified in the Human Resource and Language Proficiency Surveys or additional workforce needs assessment data. Additionally, this action supports efforts to develop a diverse, culturally responsive, and linguistically proficient public mental health system by establishing a stipend fund to allow individuals to apply for stipends to participate in educational opportunities that will lead to employment in Sacramento County's mental health system. BHS will encourage individuals, particularly consumers and family members with lived experience, who are reflective of the diversity of the county to apply for educational stipends as they become available through the WET Central Regional Partnership as described in Action 6.

In line with BHS core values and community/partner input, BHS created a career path and a career ladder for Behavioral Health Peer Specialists. Currently, Behavioral Health Peer Specialists are employed throughout our Behavioral Health programs. The role of Behavioral Health Peer Support Specialists has been defined as "offering and receiving help, based on shared understanding, respect and mutual empowerment between people in similar situations." Peer support has been described as "a system of giving and receiving help: based on key principles that include "shared responsibility, and mutual agreement of what is helpful." Behavioral Health Peer Support Specialists engage in a wide range of activities, including advocacy, linkage to resource sharing of experience, community and relationship building, group facilitation, skill building, mentoring, goal setting, and more. In FY 2021-22, the County hired a Health Program Manager with lived behavioral health experience. In FY 2022-23, the County hired a Behavioral Health Peer Specialist Program Manager and hired two additional Behavioral Health Peer Specialist Program Managers in FY 2023-24. Additionally, the County has hired numerous Behavioral Health Peer Specialists and Senior Behavioral Health Peer Specialists and continues to recruit for new Behavioral Health Peer Specialist positions. These positions provide peer services and supports with expertise based on lived experiences to consumers of behavioral health services and their families/caregivers. Through this Action, the Behavioral Health Peer Specialist Program Managers oversee the implementation of the Medi-Cal Peer Support Specialist Certification program in Sacramento County in close collaboration with CalMHSA. In FY 2022-23 BHS dedicated $50,000 to support twenty-three (23) Peers seeking Medi-Cal Peer Support Specialist Certification. This includes

covering the costs of the application, core competency training, and one-time exam. BHS is exploring purchasing additional bundles as described above for the growing Behavioral Health Peer Specialist workforce.[2] In FY 2023-24 BHS dedicated at additional $200,000 towards the Medical Peer Support Specialist Certification to support the growing Peer Specialist workforce. These additional funds supported the costs associated with 91 application fees, 96 core competency trainings, 93 certification exams and three (3) biennial certification renewals.

CalMHSA, on behalf of California counties, implements and administers all components of the Peer Support Specialist Certification program, including required data collection and submission to DHCS, certification of Peers, exam administration, investigations, and approval, auditing, and monitoring of training vendors. Although the Medi-Cal Peer Support Specialist Certification program is an optional benefit to counties, the Peer Support Specialist Certification program is available to any individual seeking to be recognized as a Certified Peer Support Specialist. BHS has been promoting the program and encouraging individuals with experience providing peer support to apply for a scholarship for the Peer Certification Training so they can receive the respective certification.

Action 4: High School Training

This Action was designed to create behavioral health career pathways for High School students, with the goal of cultivating interest in public mental/behavioral health career pathways, expanding knowledge and understanding of mental/behavioral health conditions from diverse ethnic and racial perspectives, and increasing awareness of community resources and available supports. Each school year, Valley High School Health TECH Academy (Health TECH) and Arthur A. Benjamin Health Professions High School (AABPHS) build upon existing curriculum items for their student bodies that promote the principles of wellness, recovery and resiliency and rely on teachers and other mental health professionals to blend academic and technical knowledge in ways that connect theory and real-world application. WET funds have supported stipend placement of these students at various internship positions.

Valley High School Health TECH Academy (Health TECH)

Health TECH incorporates mental health throughout the curriculum, which trains students to view and treat patients holistically (physical, psychological/emotional, and social well-being. Students learn through case studies, which are designed to train students to identify patients experiencing mental health issues such as depression, anxiety, bipolar disorder, biology of addiction, and schizophrenia.

In the 2023-24 school year, Health TECH accomplished the following activities:

- Health TECH participated in twenty-three (23) community events (health fairs, festivals, etc.) between July 1, 2023, and June 30, 2024. Health TECH students performed 674 blood pressure screenings, 400 BMI tests, educated 1,382 people in nutrition, and provided mental health and wellness resources.
- Health TECH opened a school site health clinic with Sowing Seeds Health to provide reimbursable Community Health Worker (CHW) services to Medi-Cal patients. WET

[2] Substance Abuse and Mental Health Services Administration (SAMHSA - Core Competencies for Peer Workers in Behavioral Health Services

funds were used to hire high school interns who provide screenings, health education, one-on-one counseling, and service coordination to Anthem and community members, addressing social determinants of health. Health TECH interns provide mental health screenings including depression, anxiety, and adverse childhood experiences (ACEs). Health TECH 12th graders are ACEs-Aware trained and certified.

- Health TECH hosted its annual health and fitness expo on April 12, 2024. Health TECH students from all classes participated in the expo, designing pamphlets, comic strip boards, and games/activities for their booths. This included providing education depression, anxiety, eating disorders, and substance use.

Arthur A. Benjamin Health Professions High School (AABPHS)

AABHPHS implemented a schoolwide curriculum across multiple content areas and classes designed to increase student knowledge of behavioral health, careers, and reduce mental health stigma. This included, a 10th grade work-based learning project asking students "How can we improve mental health, inclusion, and engagement by students, families, and community members on our campus?" Students met with the district leaders to develop their proposals and presented them during an Open House in May. Project proposals included holding a Mental Health Fair, creating more spaces on campus to display student art, and repairing and renovating the bathrooms to provide more privacy and inclusivity.

In the 2023-24 school year, AABPHS accomplished the following activities:

- AABPHS trained school staff in YMFA and has plans to expand training to 25% of students and 80% of the staff in the FY 2024-25. Certification in YMHFA will feed into the County's Behavioral Health needs for Peer Specialists.

- AABPHS 9th grade students conducted empathy interviews and developed personal plans for success that included how they would support their own mental wellness and be attuned to the wellbeing of their peers.

- AABPHS 12th grade students completed a short-documentary film project as their capstone project. Their task was to examine a specific mental health issue, provide background and context, and interview professionals and other stakeholders in an effort to educate the public and, if possible, suggest solutions or action plans to address the issues presented. Some of the topics students chose to explore were generational trauma in refugee and immigrant communities, homelessness, food insecurity, postpartum depression, weight-bias in medical care, and the effects of domestic violence on children in the home. In the reflection papers, students reported that they appreciated the challenges they'd faced and felt that they had gained transferable skills, confidence in their own abilities, and a sense of accomplishment in bringing awareness to mental health issues that mattered to them specifically.

- AABPHS implemented Pre and Post Behavioral Health Career Project Survey designed to track changes in their understanding, knowledge, and attitudes about Mental and Behavioral Health (MBH) and MBH careers. Students reported that they felt less need in the second semester and observed fewer instances of distress in their peers. Additionally, it was pointed out that because student wellbeing was so frequently and explicitly addressed school-wide, students didn't feel the need to reach out individually to peers who

were already being supported. Over 75% of the students stated they knew "A Lot" about careers/jobs in behavioral Health.

Action 5: Psychiatric Residents and Fellowships

Community Education: Psychiatry Residents and Fellowship Training Program

Psychiatrists are placed in public/community mental health settings to assist in primary care collaboration through consultation and education on mental health/primary healthcare integration. Additionally, residents, fellows, and other team members continue to receive in-service trainings on wellness and recovery principles, cultural competence including consumer movement and client culture, and an integrated service delivery system. This Action continues to be administered through University of California, Davis (UCD), Department of Psychiatry and includes the following components:

- Explain the components of the recovery model of care (patient care, professionalism, interpersonal and communication skills)
- Discuss the benefits of consumer advocacy and how psychiatrists can partner with individuals with lived experience to deliver care to their patients (patient care, professionalism, systems-based practice)
- Discuss the Sacramento County behavioral health system and how to appropriately refer patients to community resources (patient care, systems-based practice)
- Identify community resources that may be appropriate for patient populations with unique needs (patient care, systems-based practice)
- Discuss the interface between the mental health system of care and the legal system (systems-based practice)
- Develop an appreciation of the need for self-care and discuss strategies for self-care (professionalism, practice-based learning, and improvement)
- Discuss four potential advantages of working in community-based settings and consider if working in a community-based setting is a good fit for one's career (practice-based learning and improvement, professionalism)

In FY 2023-24, nine (9) residents were enrolled in this program and all received specialized community mental health supervision from the Psychiatry Faculty at UC Davis. The course sessions covered recovery-oriented care, patience-centered care, peer delivered services and integrated a co-instructor with lived experience providing a diverse range of perspectives. Seven (7) of the nine (9) residents indicated they had plans to continue working in community mental health.

Mental Health Collaboration: Mental Health and Substance Use Prevention and Treatment Services Providers Training

The implementation of CalAIM and Enhanced Care Management (ECM) in FY 2022-23 has resulted in an increased need for BHS providers to offer culturally responsive services that include interventions which integrate physical health and behavioral health. Starting in FY 2023-24 BHS provided training and consultation, educational seminars, in-service trainings, and case conferences, in order to: 1) increase provider's knowledge and understanding of co-occurring disorders and medical co-morbidities; 2) improve treatment outcomes for individuals living with co-occurring

disorders and medical co-morbidities, and 3) enhance the skills of treating physicians, clinicians and other members of treatment teams at BHS Substance Use Prevention Treatment (SUPT) and Mental Health (MH) provider agencies.

In collaboration with UC Davis, Substance Use Prevention Treatment (SUPT), Mental Health (MH), and CalAIM, the following trainings were offered in FY 2023-24. Continuing Education Units (CEUs) were offered to participants, reaching a total of 242 participants.

- 1/24/24: Cal AIM 101(45 participants)
- 2/28/24: BEST PRACTICES FOR OPIOID USE DISORDER (43 participants)
- 3/27/24: BEST PRACTICES FOR ALCOHOL USE DISORDER (43 participants)
- 4/24/24: RESOURCES FOR OPIOID AND ALCOHOL USE DISORDERS (43 participants)
- 5/22/24: OBESITY WITH CLIENTS WITH SEVERE MENTAL ILLNES (43 participants)
- 6/26/24: REDUCING STIGMA (25 participants)

Residents and Post–Doctoral Fellows at Youth Detention Facility

Through this activity, UCD Residents and Post Doctorate Fellows provide learning opportunities for Probation staff to: (1) recognize signs and symptoms of mental illness, (2) identify early warning signs of worsening mental illness, and (3) increase understanding of the effects of specific mental illnesses upon behavior and how these symptoms manifest.

In FY 2023-24, UCD Residents and Post Doctorate Fellows provided 27 informal training sessions for probation staff. Probation Officers who completed the Youth & Mental Health Education Feedback surveys overwhelmingly report that following training they felt better equipped to recognize early warning signs of mental illness or escalating behaviors, increased their understanding of childhood trauma and intellectual disabilities, increased their ability to use evidenced based strategies and interventions to manage or deescalate negative behaviors, and possessed more confidence in their ability to positively engage and support incarcerated youth who are living with mental illness or intellectual/learning disabilities.

Clinical Child Psychology, Pre-Doctoral Internship Training Program

The UC Davis Clinical Child and Adolescent Psychology (CCAP) Doctoral Internship Program was implemented in 2018 and gives doctoral interns psychological experience at the Sacramento County Child and Adolescent Psychiatric Services (CAPS) Clinic. In FY 2023-24, two (2) full-time doctoral interns graduated from the program, each having completed a total of 2,000 supervised hours. The 2023-24 interns completed 24 hours/week (0.6 FTE) of their internship at the CAPS Clinic. In FY 2023-24, CAPS recruited one (1), full-time doctoral interns who are staffed at the CAPS Clinic for 24 hours/week (0.6FTE).

The Clinical Child and Adolescent Psychology Doctoral Internship Training Program has developed a positive reputation. Applications from potential intern applicants who are interested in working with underserved and diverse communities are being continually received. Although CAPS did not retain the FY 2023-24 interns, they both highly recommend the program.

Collectively, in FY 2023-24 pre-doctoral interns held nine (9) clients on their therapy caseloads, in addition to completing eight (8) psychological testing cases. Current interns have the capacity to treat five (5) to six (6) therapy clients and complete three (3) to four (4) psychological testing for clients throughout the training year. The interns employ a client-centered, collaborative/therapeutic approach for their testing with clients. Interns receive training from the MIND Institute that allows them to utilize specialized therapeutic interventions for some of their therapy clients with Autism Spectrum Disorder (ASD). In addition, interns receive training in the ADOS-2 (Autism Diagnostic Observation Schedule, Second Edition) to provide differential diagnosis for testing clients presenting with symptoms of Autism Spectrum Disorder. The interns employed evidence-based practices with their therapy clients, including Cognitive Behavioral Therapy (CBT) and Trauma Focused (TF-CBT). Interns were responsive to emergent and urgent clinical issues, including mandated reporting, crisis intervention, and risk management.

In evaluating the program, interns consistently provide very positive feedback about their psychological testing/assessment experience at the CAPS Clinic. Interns indicated that the approach to testing and complex referral questions has prepared them well for entry-level practice as a health service psychologist.

CAPS strives to work with county partners to continue offering evidence-based, trauma-informed, and culturally responsive psychological services to CAPS Clinic children and families.

Action 6: Multidiscipline Workforce Recruitment and Retention

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

BHS recognizes the importance of this strategy and has continued to identify opportunities to establish multidisciplinary collaborations with key system partners. In April 2020, the Mental Health Services Act Steering Committee provided their support to BHS dedicating local MHSA WET dollars as match funds to participate in the WET Central Regional Partnership. California Department of Health Care Access and Information (HCAI) outlined in their 2020-25 WET Five-Year Plan a local match to five regional partnerships to fund specific types of activities that support the workforce needs of individuals within those regional partnerships. In collaboration with other counties in the Central Region, Sacramento County partnered with the CalMHSA to make funding available to the county Public Mental Health System (PMHS) workforce. BHS has made loan repayment a priority to help with recruitment and retention and introduced a Central Region application period for the Loan Repayment Program (LRP).

In FY 2022-23, BHS approved FY 2021/2022 Sacramento County WET Mental Health Loan Repayment Program (LRP), Round 1, awarded 125 individuals who work in either a Sacramento County Behavioral Health County-operated mental health setting or in a contracted, community-based mental health agency. Individual awards ranged from $25,000, $12,500, and $10,000 to approved applicants, totaling $1,485,000 in funds. Awardees were notified by California Mental Health Services Authority (CalMHSA) of the amount and terms. Awardees received 100% of the award amount at the beginning of the contract and in return, LRP awardees are required to work 24 months (two-years) in a hard-to-fill or hard-to-retain position in Sacramento County's Public Mental Health System to be eligible for program participation. In FY 2023-24, BHS WET

provided an equity award to Round 1 awardees, increasing award amounts by an additional $10,000 or $12,500, with no additional service commitment. In 2024, BHS opened another round of WET LRP and received over 200 applicants. BHS is in the final stages of awarding awards, projecting to award around another 40-45 more individuals. Additionally, BHS has shared numerous HCAI loan repayment, recruitment, and retention funding opportunities to behavioral health contracted providers. Building on the success of the two-day in-person hiring and career fair that BHS held with Sacramento County Department of Personnel Services (DPS) in September of 2022, BHS conducted a BHS Hiring Fair on June 28, 2024. The focus of the Hiring Fair was to recruit candidates in BHS top 4 vacancies: Senior Mental Health Counselor, Mental Health Counselor, Mental Health Worker-Licensed and Mental Health Worker. BHS worked collaboratively with DPS and the Public Information Officer to develop a targeted advertising campaign to reach diverse candidates for the classifications with the most vacancies. The advertising and social media campaign generated interest in the event and increased the number of applicants.

In preparation for the event, there were 5 Meet & Greet sessions conducted over Zoom that were open to the public and did not require registration. Participants had the opportunity to learn about open positions and the programs they serve as well as to talk with hiring managers about completing applications and preparing for interviews. American Sign Language was available for all sessions. BHS interviewed 28 Mental Health Counselors, 8 Senior Mental Health Counselors, 13 Mental Health Workers, and 28 Mental Health Worker- Licensed, totaling 77 interviewees at the event. A total of 201 attendees attended the Hiring Fair and 63 volunteers participated in planning and/or assisted with the event. This resulted in the numbers of candidates for all four eligible lists increasing significantly and a diverse range of candidates. In the month following the hiring event 24 candidates accepted offers of employment.

The WET Coordinator continues to work with local universities to host webinars regarding applying to 1) California State University, Sacramento Social Work Program (bachelor's and master's level); 2) California State University, Sacramento Master's in Counseling Program; and 3) University of Pacific Social Work Program (MSW). These webinars were shared with BHS staff and contracted providers seeking to advance careers in public behavioral health. The WET Coordinator developed a new robust BHS employment webpage on the BHS website. The website includes an updated list of vacant positions, application resources, list of benefits, overall application steps, and recordings of various helpful webinars, including careers in behavioral health and the university webinars mentioned above. The link to the webpage can be found here: https://dhs.saccounty.gov/BHS/Pages/Employment/Jobs-in-Behavioral-Health.aspx

BHS and DPS worked collaboratively to develop two recruitment brochures for clinician positions. These brochures are extensive and include a list of the County operated programs who hire the classification. The links to the current brochures are referenced below.

- Senior Mental Health Counselor: https://personnel.saccounty.net/Documents/SeniorMentalHealthCounselorBrochure.pdf
- Mental Health Counselor: https://personnel.saccounty.net/Documents/MentalHealthCounselorBrochure.pdf

With the assistance of the Public Information Officer (PIO), two recruitment videos were developed to recruit nursing and behavioral health professions. Both videos emphasized career

paths and work-life balance and featured perspectives from cultural and linguistically diverse staff. In FY 2023-24, the WET Coordinator worked with DPS to develop additional videos, specifically for the Behavioral Health Peer Classifications. The video links to the completed videos are below.

- Nursing Team: https://www.youtube.com/watch?v=rExG1BsBLCQ
- Behavioral Health Career Ladders: https://www.youtube.com/watch?v=GFHD0Wn8AK8

Lastly, the WET Coordinator will continue to work in partnership with community members and organizations to develop and streamline workforce development opportunities. The WET coordinator has supported four community events, sharing job opportunities with diverse job seekers in FY 2024-25 and will continue to share job opportunities with job seekers moving forward.

Action 7: Consumer Leadership Stipends

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

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

During FY 2023-24, BHS provided consumer and family member leadership stipends to eligible community members that served on the Latino/Latinx/Latine/Hispanic Behavioral Health Racial Equity Collaborative (BHREC) Steering Committee and African American/Black/African Descent Ad-Hoc Committee. Stipends will continue to be offered in future years.

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INNOVATION COMPONENT

The **Innovation (INN)** component provides funding for ***time-limited projects*** for the purpose of developing and trying out new or adapted practices and/or approaches in the field of mental health. An INN Project must do one of the following:

- Introduce a mental health practice or approach that is new to the overall mental health system, including, but not limited to, prevention and early intervention.
- Make a change to an existing practice in the field of mental health, including but not limited to, application to a different population.
- Apply to the mental health system a promising community-driven practice or approach that has been successful in non-mental health contexts or settings.

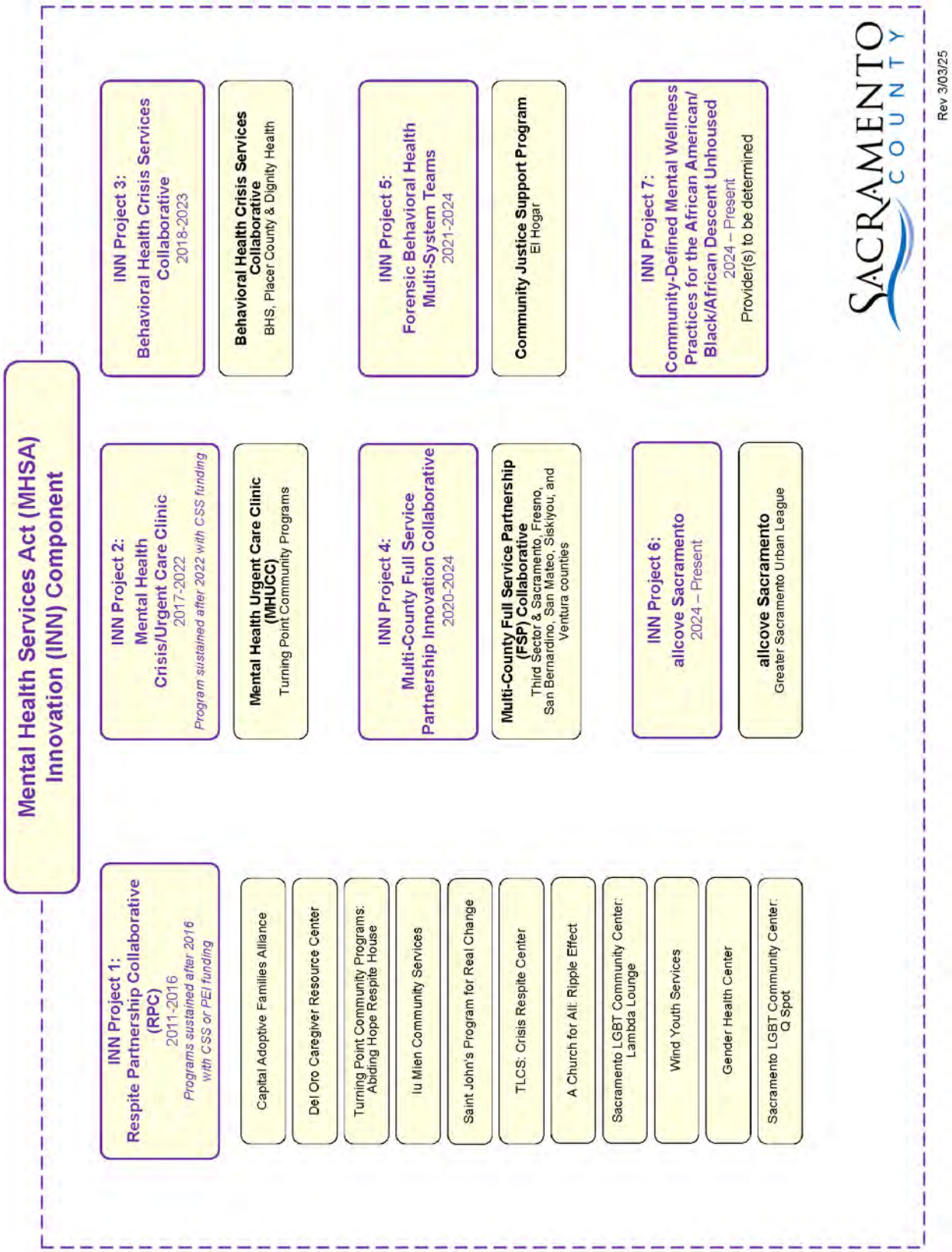
An Innovation project is defined as one that ***contributes to learning*** rather than focusing on providing a service.

Sacramento County INN Projects to date:

1) **Respite Partnership Collaborative (*completed*);**
2) **Mental Health Crisis/Urgent Care Clinic *(completed)*;**
3) **Behavioral Health Crisis Services Collaborative *(completed)*;**
4) **Multi-County Full Service Partnership (FSP) Innovation (INN) Project *(completed)*;**
5) **Forensic Behavioral Health Multi-System Teams (now known as Community Justice Support Program (CJSP)) *(in progress)*;**
6) **allcove® Sacramento *(in progress);* and**
7) **Community-Defined Mental Wellness Practices for African American/Black/African Descent Unhoused *(in progress)***

MHSA defined age categories are as follows:

- Children and youth = birth – 17-years-old
- Transition Age Youth (TAY) = 16-years-old – 25-years-old
- Adult = 18-years-old – 59-years-old
- Older Adult = 60-years-old+


Mental Health Services Act (MHSA)
Innovation (INN) Component
INN Project 1:
Respite Partnership Collaborative (RPC)
2011-2016
Programs sustained after 2016 with CSS or PEI funding
Capital Adoptive Families Alliance
Del Oro Caregiver Resource Center
Turning Point Community Programs: Abiding Hope Respite House
Iu Mien Community Services
Saint John's Program for Real Change
TLCS: Crisis Respite Center
A Church for All: Ripple Effect
Sacramento LGBT Community Center: Lambda Lounge
Wind Youth Services
Gender Health Center
Sacramento LGBT Community Center: Q Spot
INN Project 2:
Mental Health Crisis/Urgent Care Clinic
2017-2022
Program sustained after 2022 with CSS funding
Mental Health Urgent Care Clinic (MHUCC)
Turning Point Community Programs
INN Project 3:
Behavioral Health Crisis Services Collaborative
2018-2023
Behavioral Health Crisis Services Collaborative
BHS, Placer County & Dignity Health
INN Project 4:
Multi-County Full Service Partnership Innovation Collaborative
2020-2024
Multi-County Full Service Partnership (FSP) Collaborative
Third Sector & Sacramento, Fresno, San Bernardino, San Mateo, Siskiyou, and Ventura counties
INN Project 5:
Forensic Behavioral Health Multi-System Teams
2021-2024
Community Justice Support Program
El Hogar
INN Project 6:
allcove Sacramento
2024 – Present
allcove Sacramento
Greater Sacramento Urban League
INN Project 7:
Community-Defined Mental Wellness Practices for the African American/ Black/African Descent Unhoused
2024 – Present
Provider(s) to be determined
SACRAMENTO COUNTY
Rev 3/03/25

Innovation Project 1: Respite Partnership Collaborative (RPC)

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

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

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

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

As an Innovation project, funding was time-limited for the term of the project, which meant that the mental health respite grantees had to look for sustainable funding from other sources. The Welfare and Institutions Code allows for the transition of successful innovation projects to sustainable MHSA funding, if the County chooses. In 2015 and early 2016, the MHSA Steering Committee reviewed RPC-funded respite programs for consideration of sustainability through other MHSA components. This review was based on component funding requirements, as well as system needs. With support from the MHSA Steering Committee, all eleven mental health respite programs transitioned to sustainable MHSA CSS and PEI funding during FY 2015-16. Descriptions of those respite programs are included in the CSS and PEI component sections of this Three-Year Plan.

Innovation Project 2: Mental Health Crisis/Urgent Care Clinic

The Mental Health Crisis/Urgent Care Clinic (MHUCC) project was reviewed and approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC) in May 2016. The primary purpose of this project is to increase the quality of services, including better outcomes for individuals experiencing a mental health crisis with the secondary purpose of increasing access to services.

This project tested the adaptation of an urgent care clinic/medical model, which is an intermediate step between routine and emergency care, to provide crisis response/care for individuals experiencing a mental health crisis. Furthermore, this project incorporated wellness and recovery principles into service delivery. Specifically, the adaptations focused on operating an extended hours outpatient treatment program versus a Crisis Stabilization Unit allowing for a more flexible staffing pattern to tailor services that better met community needs; provided direct linkage as an

access point for the Sacramento County Mental Health Plan (MHP) and Substance Use Prevention and Treatment Services (SUPT); and served all ages (children/youth, TAY, adults, and older adults).

MHUCC provided voluntary and immediate access to short-term crisis intervention services, including integrated services for co-occurring substance abuse disorders, to individuals of all age groups (children, transitional age youth (TAY), adults, and older adults) who are experiencing a mental health crisis. Staff were reflective of the cultural, racial, ethnic, and linguistically diverse population of Sacramento County and were a collaborative team comprised of psychiatrists, nurses, clinicians, and peers. Services were designed to provide an alternative to emergency department (ED) visits for individuals with immediate mental health needs. Services included a multi-disciplinary mental health assessment with a focus on wellness and recovery, as well as linkage to ongoing community services. Interventions assisted with decreasing unnecessary and lengthy involuntary inpatient treatment while increasing access to culturally competent care in a voluntary setting. The clinic was certified as a Medi-Cal outpatient clinic and had the ability to provide mental health services and supports to at least 450 clients per month. The project term ended June 30, 2022. With support from the MHSA Steering Committee, the services in this INN Project transitioned to sustainable MHSA CSS funding FY 2022-23.

Innovation Project 3: Behavioral Health Crisis Services Collaborative

The Behavioral Health Crisis Services Collaborative (BHCSC) project was reviewed and approved by the MHSOAC in May 2018. The BHCSC established integrated adult crisis stabilization services on the Mercy San Juan hospital emergency department campus in the northeastern area of Sacramento County.

The primary purpose of this emergency care integration innovation project was to demonstrate improved behavioral health outcomes through a public/private collaboration that removed existing barriers to care, increased access to, and the quality and scope of, crisis stabilization and supportive mental health services that are integrated and coordinated. Project services, sited in the northern region of Sacramento County, increased access to crisis services for underserved area residents.

The secondary purpose of this project was to improve the efficacy and integration of medical and mental health crisis stabilization services through a public/private partnership between a licensed acute care general hospital and an onsite provider of mental health rehabilitative crisis stabilization services.

BHCSC served individuals 18 years of age and older for up to 23 hours who presented to an Emergency Department (ED) in Sacramento County experiencing a mental health crisis, medically stabilized, and would benefit from ongoing outpatient mental health and crisis stabilization services. BHCSC provided culturally competent, multi-disciplinary behavioral health services including, but not limited to, evaluation for voluntary or involuntary detention, behavioral health assessments, psychiatric assessments, medication evaluations and management, crisis stabilization, individuated recovery-oriented interventions, and safe discharging either to community or to an inpatient psychiatric facility (when necessary). Other BHCSC services included integrated mental health and substance abuse screening to identify co-occurring needs, peer support, family support, care coordination with existing providers, and aftercare follow-up to ensure linkage to ongoing outpatient mental health services. Services focused on wellness and recovery, with the goal of timely and appropriate linkage to ongoing services and supports.

Coordination with key resources and services included but not limited to, County Mental Health Plan services; Substance Use Prevention and Treatment (SUPT) services; physical health services; housing services; and funding and benefit services, such as Supplemental Security Income (SSI) and Medi-Cal.

The BHCSC collaborated with the on-site, peer operated Resource Center to support the goals of removing client barriers to accessing mental health crisis stabilization services, reducing ED lengths of stay for individuals requiring mental health crisis stabilization, reducing unnecessary psychiatric hospitalizations, and improving the efficacy and integration of medical and mental health crisis services. Resource Center services included, but not limited to, on-site peer support and system navigation by peer staff, referral and linkage services to the Sacramento County Mental Health Plan, SUPT services, Primary Care, and other community resources, as well as care coordination and after-care planning for Medi-Cal beneficiaries.

The BHCSC began providing services in September 2019. The program has successfully reduced emergency department wait times for behavioral health clients and has successfully diverted clients from inpatient hospitalization.

In FY 2021-22, the MHSA Steering Committee considered extending the term of this project for a fifth year. After thoughtful discussion, the Committee recommended against the extension; therefore, this INN project term ended mid FY 2022-23.

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

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

The multi-county cohort began efforts with a comprehensive “Landscape Assessment” phase to understand FSP programs, assets, and opportunities. Through various activities, the cohort developed a comprehensive understanding of similarities and differences across all FSP service designs, populations, data collection and eligibility practices. Currently, the multi-county cohort activities have focused on cross-county data to identify population definitions, outcomes and process metrics, as well as state reporting recommendations.

An evaluation report was published in April 2024 which shared the following key findings:

- The initial cohort of six counties participating in the California Multi-County Full Service Partnership (FSP) Innovation Project successfully developed standardized definitions for key populations served, as well as common process and outcome metrics. A subset of the

counties succeeded in developing program stepdown and graduation guidelines, improved data collection processes, and referral guidelines or processes. After the initial development of planned changes to the FSP programs the extent of on-the-ground implementation and sustainment varied by county and by innovation area. Outcomes for FSP participants improved during the first 12 months of involvement. Participants experienced reduced psychiatric inpatient admissions, increased stable housing, and decreased judicial system involvement. Improvement in individuals' outcomes increased after participation in the FSP Innovation Project, suggesting that the project facilitated improved quality of care.

CalMHSA concluded this project in December 2024. The final report is *Attachment H: Multi-County FSP – CalMHSA Final Evaluation Report.*

Innovation Project 5: Community Justice Support Program (CJSP)

Proposition 63 was enacted into law in January 2005 and became known as the Mental Health Services Act (MHSA). The passage of the MHSA enabled California to make significant progress in improving the lives of those living with mental illness. MHSA Full Service Partnership (FSP) programs support people with the most severe mental health and/substance abuse conditions. At the core of FSP programs is to apply a "*whatever it takes, 24/7"* approach to partnering with individuals on their course to well-being and healing. FSP programs provide individuals experiencing mental health illness with intensive and comprehensive case management, treatment, and supportive services. FSPs endeavor to move partners (clients) toward achieving greater independence, living meaningful and productive lives, all while utilizing a client and family centered approach. Currently, more than 3,000 (n=3,147) individuals are enrolled across Sacramento county's thirteen (13) FSPs. The Community Justice Support Program (CJSP) is just one of the county's FSP programs and it has been designated as an innovation project. It was approved by Sacramento County Board of Supervisors August 2020 and subsequently implemented in late FY 21/22. CJSP has tremendous potential to decrease psychiatric hospitalizations, homelessness, and continued suffering for mentally ill justice involved residents. The foundation of CJSPs innovative approach is to maximize FSP resources and in due course drive transformational change in the provision of mental health services through its implementation of forensic behavioral health Multi-System Teams (MST) for the justice involved population of Sacramento County.

Goal

CJSPs goal is to increase the quality of services, including better outcomes for individuals experiencing mental health crisis, while simultaneously increasing access to services for justice involved persons. CJSP is invested in reducing jail recidivism for the forensic behavioral health population. The challenges involved in meeting multiple system requirements and overcoming barriers to access needed and complex services and resources increase the likelihood of these

individuals returning to incarceration. CJSP utilizes a teaming approach to address this population's complex needs and multi-system involvement. This innovation project is testing whether the adaptation of an existing teaming model, Child Welfare's Child Family Team (CFT), for the adult forensic behavioral health population will lead to the following outcomes: reduce jail recidivism, improve client experience in achieving and maintaining wellness; improve care coordination across multiple system; and improve access to needed services.

Population Served

Population engaged with CJSP must be justice involved, Medi-Cal eligible, and experiencing serious mental illness with significant functional impairment. Individuals may self-refer to the program or be referred by justice partners or jail psychiatric services.

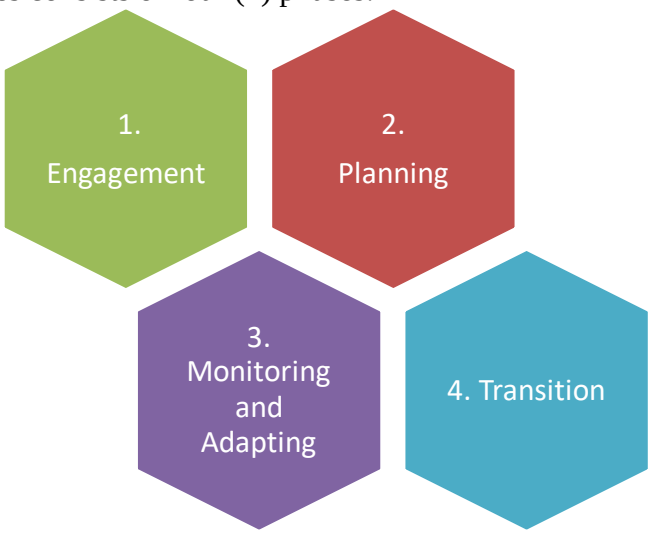
Forensic Behavioral Health Multi-System Teams (MSTs)

The MST is comprised of the client, family, natural supports, system partners, and service providers involved in the individual's treatment and recovery. System involved parties may include the Courts, District Attorney (DA), Public Defender (PD), Jail Psychiatric Services (JPS), Probation, Adult Protective Services (APS), Child Welfare (CPS), Behavioral Health Services (BHS), mental health and substance use disorder treatment providers, employment and housing specialists, and Geographic Managed Care (GMCs). The MST process is strength-based, client-centered, individualized, collaborative, culturally responsive, trauma-informed, and outcomes-focused.

The CJSP is expected to increase access to services for the adult forensic behavioral health population and promote collaboration amongst system partners, providers, natural supports, community mentors/peers, and the client, through a formalized teaming approach.

MST Phases

The MST process consists of four (4) phases:



Phase 1 Engagement:

- Engagement starts early while client is in custody or immediately after release

- Implementation of brief and broad screening tool to determine client readiness and to identify needs
- MST team facilitator and members will be identified; MST member roles and responsibilities will be defined
- Peer mentors begin providing ongoing mentoring and peer support
- MST immediately initiates integrated client assessment and plan

Phase 2 Planning:

- MST assists client in accessing resources for immediate needs
- MST reviews the integrated client plan or completes developing the plan

Phase 3 Monitoring and Adapting:

- Team members re-clarifying role and responsibilities and meeting frequency
- MST revisits and updates client goals, milestones, crisis plan
- MST celebrates successes

Phase 4 Transition:

- Client takes a more active role in plan and services
- MST initiates client-driven post-assessment to determine readiness for transition to the community
- MST reviews progress
- MST ensures that needed services and supports are in place
- MST identify services and supports not in place and develop plan to access them Forensic Behavioral Health Program. The Forensic Behavioral Health Program provider will be responsible for taking lead on facilitating the MST – including assigning staff as MST facilitators, collaborating with justice partners involved with the client to establish and maintain the MST process, and deliver the forensic behavioral health services for all eligible clients.

CJSP will incorporate trauma-informed care and identify and address the client's criminogenic needs in all aspects of service delivery. Criminogenic needs are issues, risk factors, characteristics, and/or problems that relate to the likelihood of the individual reoffending. There are three (3) primary learning objectives for this innovative project:

1. Will adapting the CFT model for the forensic behavioral health population increase collaboration among system partners, service providers, peers, clients and family members?
2. Will implementation of the teaming model increase immediate access to needed services and resources for the forensic behavioral health population?
3. Will the development and implementation of coordinated and integrated client plans through the MST process reduce jail recidivism, reduce time in custody, jail exposure, and overall justice involvement?

The project will test whether or not adapting a teaming model as well as developing and implementing a coordinated and integrated client plan for the forensic behavioral health population will lead to the following outcomes:

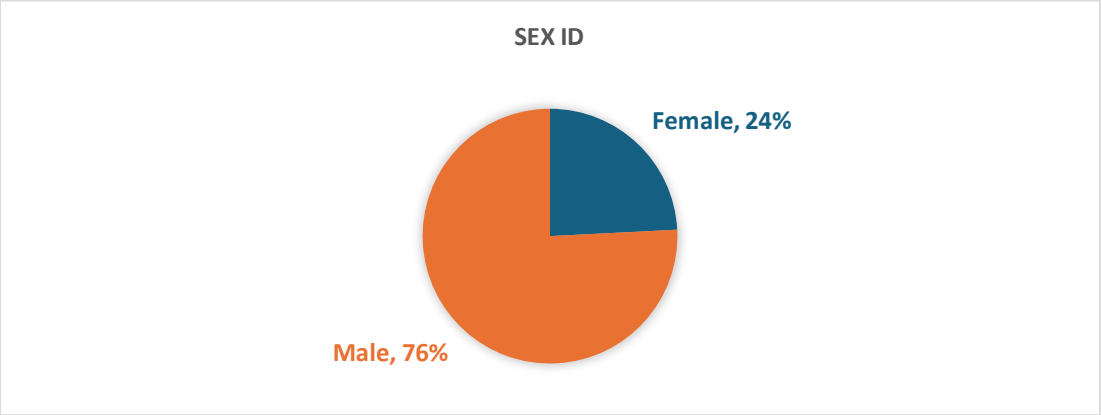
1. Improve care coordination and integration across multiple systems (i.e., Jail Psychiatric Services, BHS, Probation, Courts, Geographic Managed Care, Adult/Child Protective Services, etc.)
2. Reduce jail recidivism, reduce time in custody, and reduce overall justice involvement
3. Improve the client experience in achieving and maintaining wellness
4. Improve access to services such as but not limited to housing support, medication support services, mental health and substance use disorder treatment services.

CJSP implements a more uniform, data-driven approach, enhancing the county's ability to use data to improve FSP services and outcomes. This innovative project spans five (5) years, which allows sufficient time for learning to occur and to demonstrate project feasibility. During the project's term, changes and modifications are expected and may be key contributions to learning.

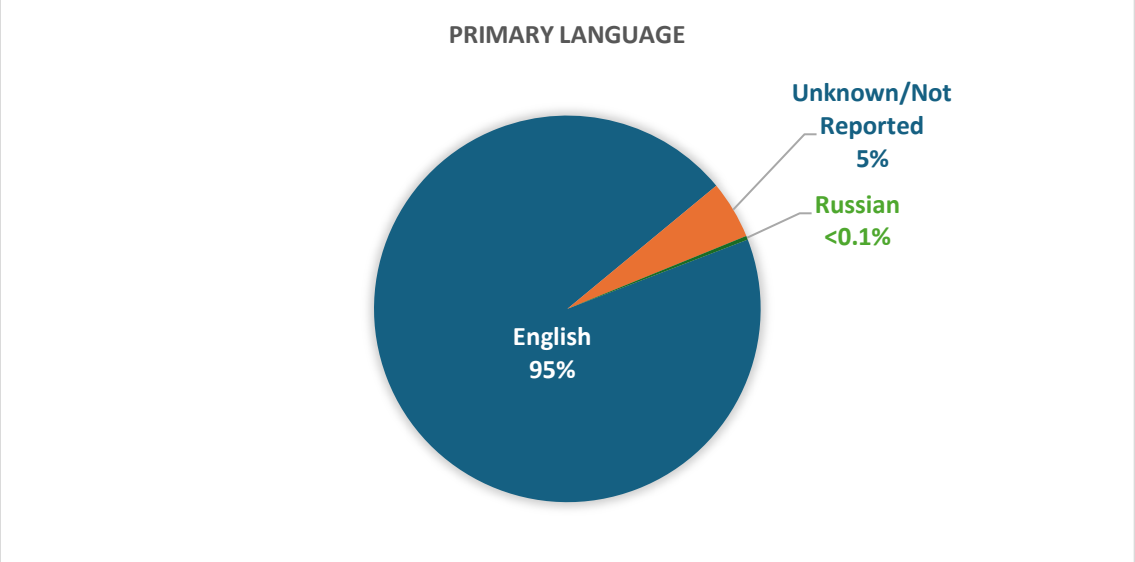
Data Summary

In Fiscal Year 2023/2024, CJSP served 310 justice involved partners based on the county's electronic health record (SmartCare).

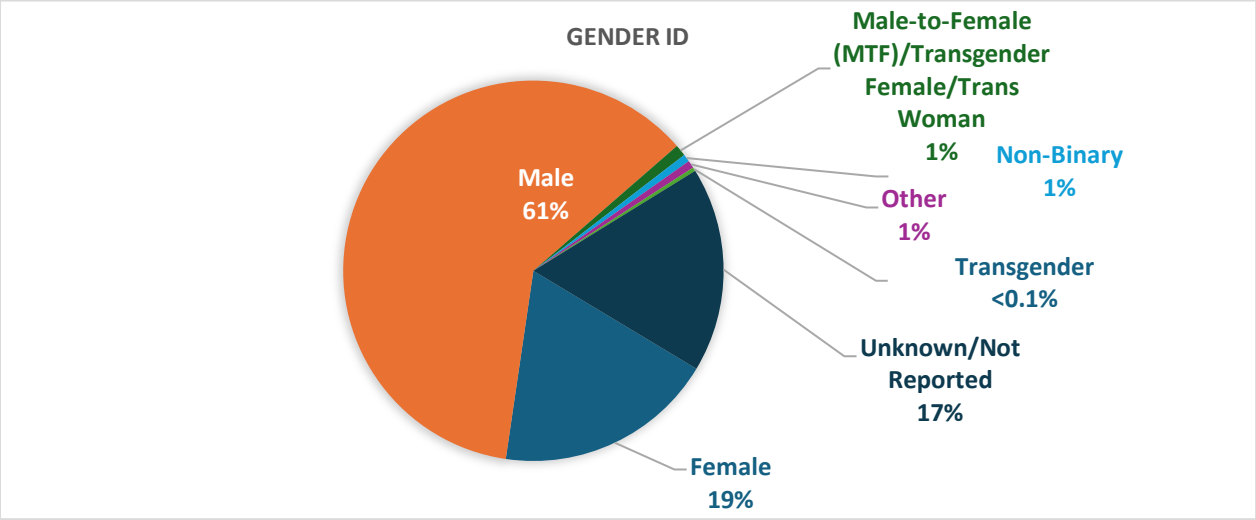
The sexual identity of the majority of partners was Male, at 76%, followed by Female, at 24%. Males are highly overrepresented in CJSP compared to the overall mental health system, in which they make up just under 50% of those served.



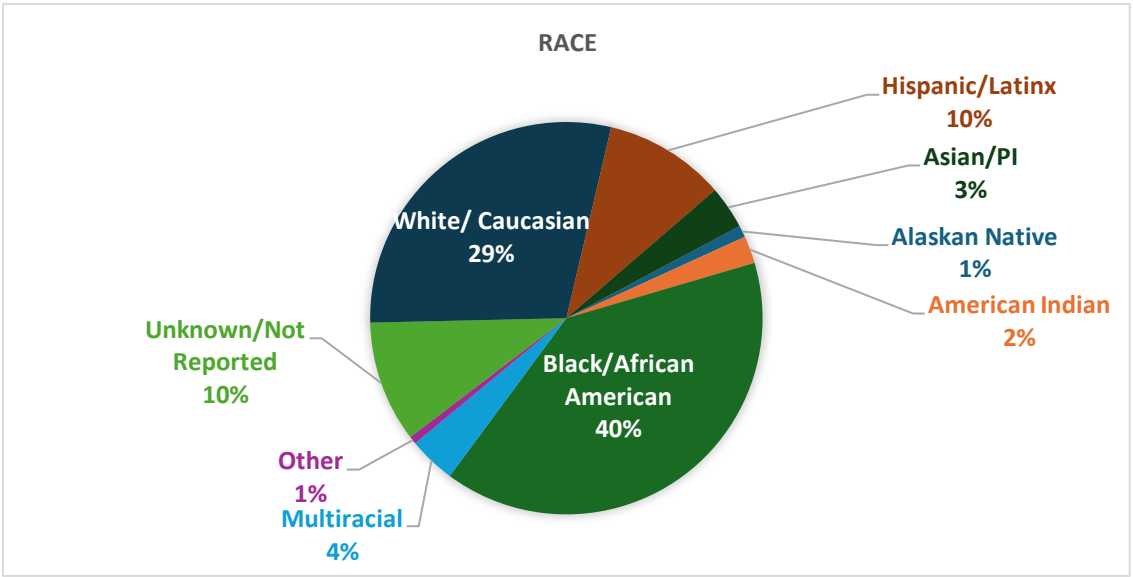
Most partners identified their primary language as English, at 95%.



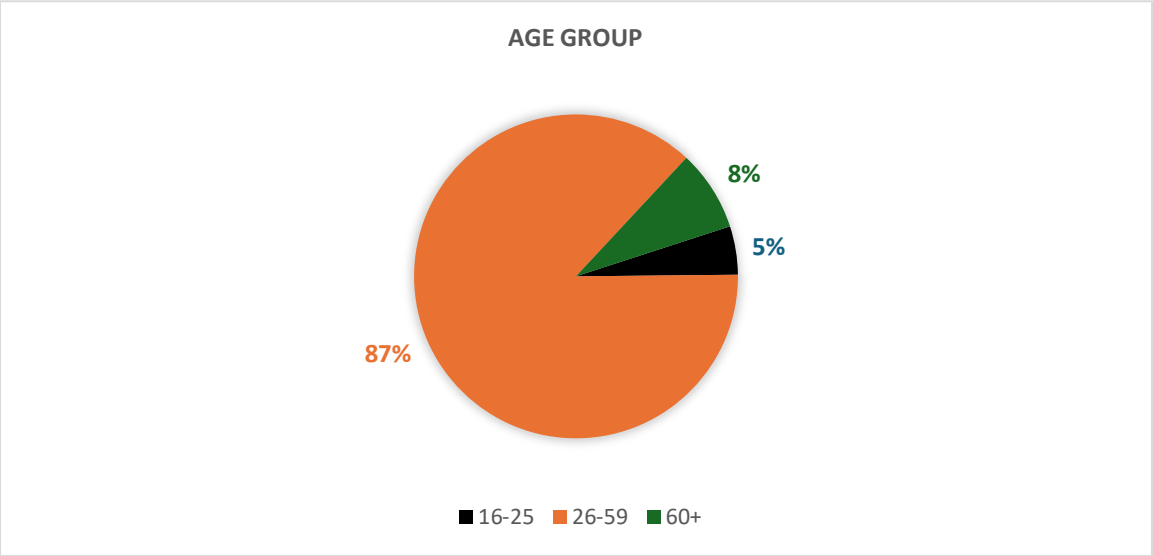
Most partners identified themselves as Male at 61%, followed by Female at 19%. Partners identifying themselves as male are overrepresented in CJSP compared to the overall mental health system at just under 33%.



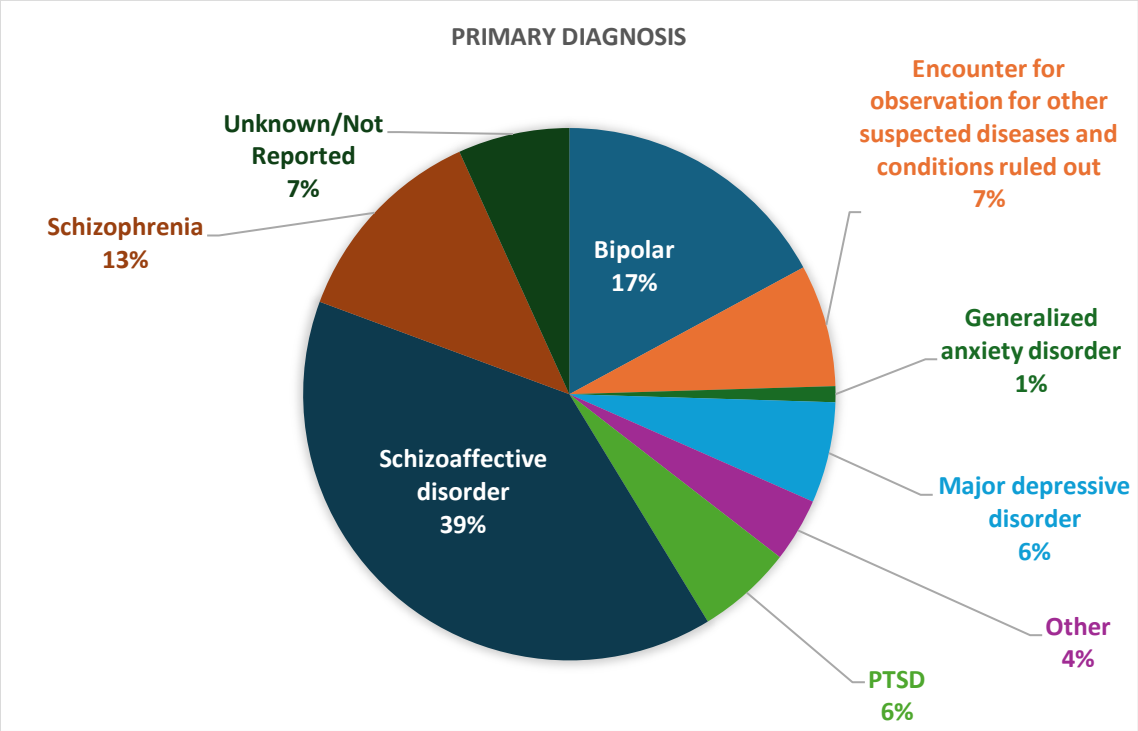
The largest group of partners indicated their race as Black/African American, at 40%, followed by White/Caucasian at 29%. African Americans are significantly overrepresented in CJSP compared to the overall mental health system at just under 19%.



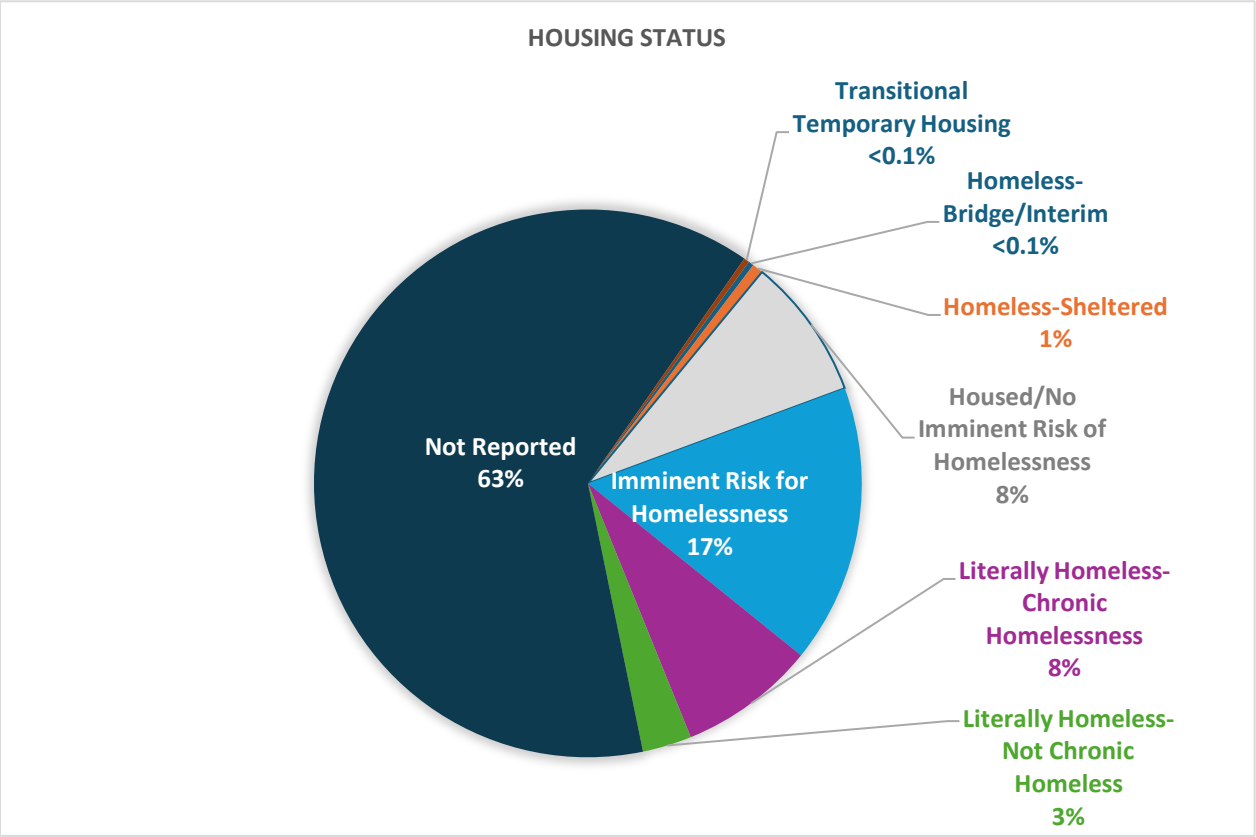
Most partners were between the ages of 26 and 59 (87%), followed by the 60+ year age group at 8%.



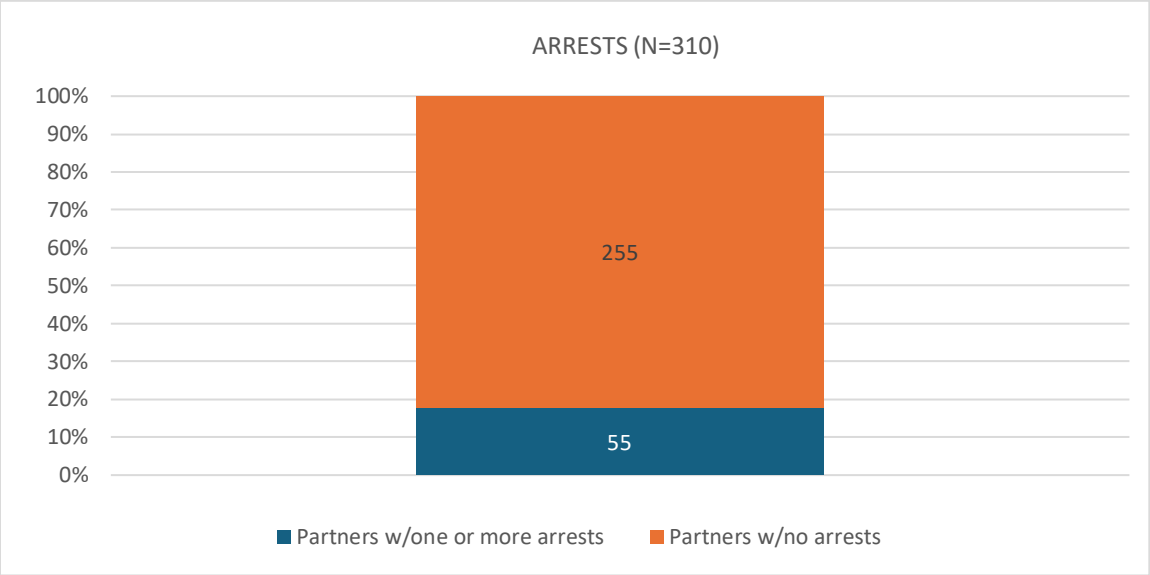
The most common primary diagnosis of partners was schizoaffective disorder (39%), followed by Bipolar at 17%.



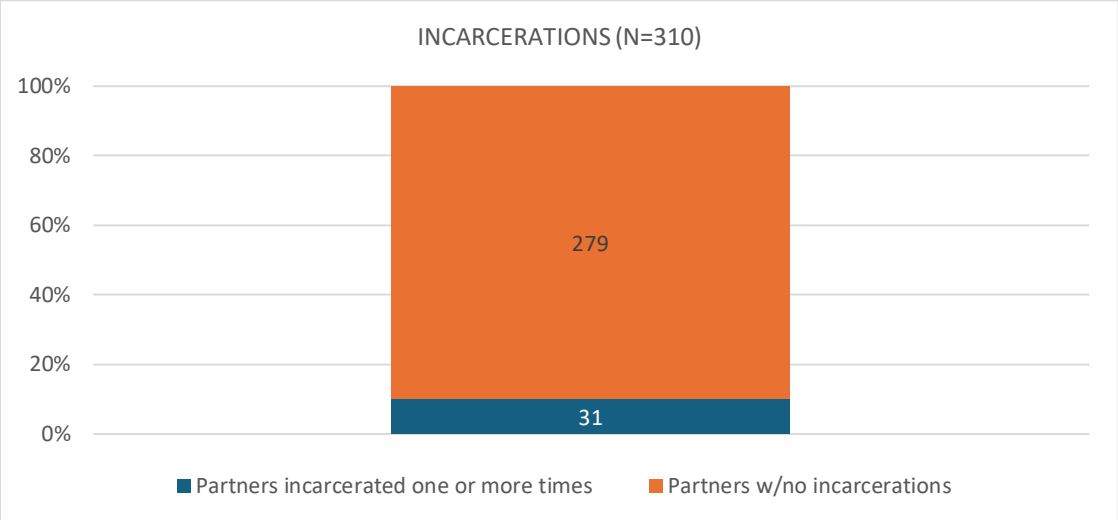
Most partners did not have a housing status reported in the system, 63%. Of those that were reported, 17% reported Imminent Risk for Homelessness.



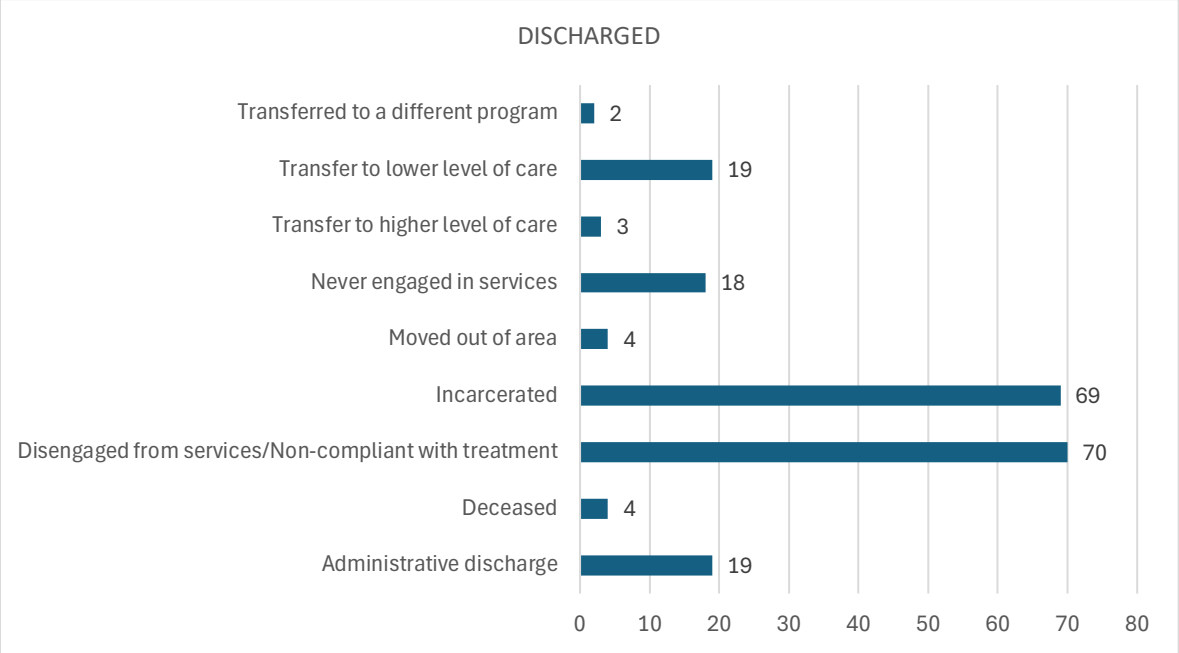
Of the 310 partners served, 17.7% of partners had one or more arrests. Arrest data comes from the Key Event Tracking (KET) Form and is self-reported to the program by the partners.



Of the 310 partners served, 10% of partners had one or more incarcerations. Incarcerations data comes from the Key Event Tracking (KET) Form and is self-reported to the program by the partners.



A total of 208 clients were discharged during the FY. Just over one-third of partners were discharged to Disengaged from services/Non-compliant (33.6%), followed by Incarcerated at 33.1%.



MST Data

The Community Justice Support Program utilizes a Multi System Team (MST) model to promote interagency and community collaboration to mental health services to justice involved individuals who are experiencing serious mental illness. However, MSTs were completed and documented only for the period of 4/1/24 to 6/30/24. In that period, the number of documented MSTs equaled thirty-five (n=35).

The primary reason for the lack of MST data for the period of 7/1/23 to 3/31/24 was that Current Procedural Terminology (CPT) codes did not accurately track MSTs held during that time. Further, only specific staff could utilize the team case conferencing function, which impacted tracking within the system. The transition of leadership following the departure of the previous Program Director added to these challenges. Since that time, staff have been tracking the data on an internal tracker to ensure that MST sessions are conducted and tracked accurately, regardless of the limitations posed by the CPT codes in SmartCare.

Innovation Project 6: allcove® Sacramento

allcove® is a multi-county initiative led by the MHSOAC which began in 2020. Grant funds were allocated to serve as seed funding to counties interested in establishing an allcove Youth Drop-in Center in their communities, and Sacramento BHS was awarded. On August 23, 2022, the Board of Supervisors authorized BHS to execute a multiyear expenditure contract with the Greater Sacramento Urban League (GSUL) to start up the allcove Sacramento Youth Drop-in Center.

allcove Sacramento was then proposed as an Innovation Project. The project meets the General Requirement that introduces a new practice or approach to the overall mental health system. The Primary Purpose is to increase access to mental health services to underserved groups. After gaining support from the MHSA Steering Committee, the project plan for allcove Sacramento was reviewed and approved first by the MHSOAC on November 16, 2023, and then by the Board of Supervisors December 5, 2023.

The focus of the allcove Sacramento INN Project is on youth 12 to 25 years of age and vulnerable youth populations such as those who identify as historically marginalized, unserved/underserved, and socioeconomically disadvantaged, including but not limited to youth who identify as LGBTQ+, homeless/experiencing housing instability, of racial minority - particularly AA/B/AD, served by Child Welfare/Probation, at risk of or experiencing exploitation, refugees, immigrants, and indigenous youth.

Each allcove center is made up of a coalition of service providers and community-based agencies joining together under one unified allcove brand identity in an integrated approach to serve young people. As an integrated service, the allcove model addresses the overlapping needs of young people, whether through providing educational and vocational support, reducing mental health distress, or starting conversations with a peer support specialist that may lead to an appointment with a substance use specialist or primary care staff. allcove's model will engage young people and their families and enable them to access a variety of services and levels of care at one site rather than the youth and families having to go to multiple places for multiple services. Same space services will include locally tailored, culturally responsive prevention and early intervention-focused, community-based, whole person care.

allcove Sacramento will have its own Youth Advisory Group (YAG) composed of young people from the local community who represent diversity in race, ethnicity, gender identity and expression, sexual orientation, lived experience, ability, and socio-economic status. The YAG's goal is to ensure that youth voice and experience are included in that center's development and services. YAG members also serve as community ambassadors for the program, conducting outreach and education through schools, community events, conferences, and social media within their own peer groups. Participation in the allcove YAG also presents opportunities for youth skill and leadership development through individual and group advocacy, outreach projects, and training across a range of relevant topics such as youth mental health first aid, developing healthy relationships, and public speaking.

The allcove Sacramento INN Project will span up to five years with a total budget of $10,000,000 in MHSA INN funding. This project will test whether adapting the allcove model for the Sacramento youth population will lead to the following outcomes: increased access to the priority youth groups, youth reach their health and wellbeing goals, services are effective for youth and

their families, and youth engage early and/or access services they otherwise may not have accessed.

As part of the MHSOAC's multi-county initiative, allcove centers have common learning goals:

1. To learn about the efficacy of the allcove integrated youth mental health model in a local context, by evaluating how allcove:
   a. Engages with young people and supports them in connecting to services when they want them and before a crisis, leading to better outcomes for youth and cost savings for communities;
   b. Destigmatizes mental health and normalizes wellness and prevention and early intervention as important to everyone; and
   c. Reimagines mental health and wellbeing for young people.
2. To learn the benefits for youth and their families in accessing services from a network of centers that work collaboratively to adapt and test a new model within a multi-county initiative.

Since receiving the INN Project 6 funding for Sacramento County BHS, the contractor, GSUL, has begun implementing the project and opening the site to align with the model's requirements. This process is being carried out in collaboration with the Central allcove Team (CaT), which is operated by Stanford University. The goal is to ensure the site meets model integrity while addressing the needs of Sacramento youth.

The Youth Advisory Group (YAG) and Community Consortium have been fully established and are actively working on the model integrity documents. Key achievements so far:

- Hired essential leadership staff, including a Center Manager, Clinical Director, and Youth Outreach Specialist.
- Launched the first cohort of the YAG and are setting up the second cohort. allcove Sacramento is one of the few YAG's where members are paid and treated as both employees and advisors.
- Completed the construction of the physical space, incorporating YAG input into the environmental design.
- Hosted multiple outreach events and participated in various partnership meetings to build referral networks and collaborations.
- allcove Sacramento will offer 6 types of services: mental health, physical health, substance use prevention and early intervention, peer support, family support, and employment/education support. GSUL has identified the services they will provide (mental health, employment/education support, peer support, and family support) and is working on agreements for substance use and physical health services with A Choice Another Chance and Peach Tree, respectively. allcove Sacramento plans to start offering services to young people by summer 2025.

Innovation Project 7: Community Defined Mental Wellness Practices for African American/Black/African Descent (AA/B/AD) Unhoused

The primary purpose of this project is to increase access to mental health services for an underserved population. The general requirement will be to introduce a new application of a

successful non-mental health promising community-driven practice/approach to the mental health system. The success others have had with peer workforce driven initiatives in Sacramento County will be used to model the INN Project and be applied to mental health services.

Through this project, BHS will partner with trusted community organizations that have not historically provided mental health services to learn together from the AA/B/AD community the strategies, methods, and practices that will help expand access to and engagement/retention in mental health services for community members who are unhoused or at risk of becoming unhoused.

BHS will build community capacity by first engaging the AA/B/AD community to define mental health and wellness; the strategies, methods, and practices that bring about mental wellness; the role of peer specialists; and organizations they trust. Community capacity building will utilize and expand upon the knowledge, skill, and resources of the AA/B/AD community to develop and implement their own concepts and solutions in addressing how mental health services are delivered. This community-defined approach will be operationalized by trusted community organizations that are sited in neighborhoods accessible to the focus population. They will co-locate clinicians and staff who will use community defined strategies, methods, and practices to deliver mental health services to the focus population. Additionally, these trusted community organizations will build a peer workforce by co-locating peer specialists, who are community members of the focus population with lived experience. These peer specialists will use community defined strategies, methods, and practices to deliver peer support and navigation services to the focus population.

The Community-Defined Mental Wellness Practices for the AA/B/AD Unhoused INN Project will span up to five years. with a total budget of $15,000,000 in MHSA INN funding. This project will test whether delivering community- defined mental wellness practices through trusted community organizations that have not historically provided mental health services, and co-locating clinicians and peer specialists to use community defined strategies to deliver mental health, peer support, and navigation services to the focus population, will lead to the following outcomes: improved access to and engagement in mental health services from the target population, and the reduction of racial disparity in the homeless data.

With support from the Focus Group and the MHSA Steering Committee, the plan entitled **INN7: Community-Defined Mental Wellness Practices for the African American/Black/of African Descent (AA/B/AD) Unhoused** was approved by the Sacramento County Board of Supervisors, and the Mental Health Services Oversight and Accountability Commission in January 2024. The project will be implemented in three phases:

- **Phase 1:** Collaborate with community organizations to engage directly with AA/B/AD community members, including individuals experiencing homelessness, to learn exactly what mental wellness means to them, identify effective strategies and practices, and to determine which organizations they trust.
- **Phase 2:** Partner with those trusted organizations to build an AA/B/AD workforce that implements the strategies and practices identified in phase 1.
- **Phase 3**: Trusted organizations and their AA/B/AD workforce will deliver the defined strategies and practices to promote mental wellness.

There are four primary learning objectives for this project:

1. Will the community defined strategies, methods, and practices bring about mental wellness for the focus population?
2. If trusted community-based organizations provide mental health services, peer support, and navigation services as defined by the focus population, will this lead to better access to and engagement in mental health services?
3. Will peer support and navigation services delivered by peer specialists, as defined by the focus population, decrease the number of days individuals are homeless?
4. Will maintaining a positive partnership with trusted community-based organizations create learning opportunities and improve trust, knowledge of, and access to mental health services for the focus population?

Phase 1 began in June 2024. BHS set out to engage the AA/B/AD community to define mental health and wellness; the strategies, methods, and practices that bring about mental wellness; the role of peer specialists; and organizations they trust. BHS took two approaches to engage this focus population:

3. **Engagement Through Trusted Community Sites:** BHS asked trusted community sites (identified by the community in 2023) to recruit, facilitate, and host Focus Groups/Community Listening sessions with this focus population. A sponsorship of $2,500 was offered, including an amount set aside for financial compensation for participants. BHS sponsored a total of 13 Focus Groups.

   One of the most frequently mentioned organizations identified in the 2023 Focus Groups as a trusted community site was **WEAVE**, Inc. BHS contacted their Director of Inclusion, Diversity, Equity, and Access (IDEA). They hosted four (4) listening sessions for this project.

   WEAVE, Inc. invited BHS to attend the bi-monthly South Sacramento Health Black Families Collaborative to advertise the sponsorship opportunity. From this contact, support was garnered from the **Greater Sacramento Urban League** and **A Church for All** to each host one (1) Focus Group.

   As the research progressed, it became clear that a special effort was needed to reach Transition Age Youth (TAY), as the community had expressed that this viewpoint would be essential to the project. While BHS was conducting sidewalk outreach in the North C Street area, **First Step Communities** supported the INN7 outreach by allowing a table to be set up in front of their building. They also have a TAY shelter. Due to their enthusiastic support of these efforts, and their ability to reach the focus population, BHS offered this agency the opportunity to have the County sponsor Focus Groups. They quickly organized six (6) Focus Groups at their downtown shelter, Roseville Road shelter, and their TAY shelter in Del Paso Heights.

   BHS reached out to the African American/Black/of African Descent ad hoc Committee, which branched off of the Behavioral Health Racial Equity Committee. **The California Institute for Behavioral Health Solutions (CIBHS)** agreed to host a focus group on their behalf, involving many community partners with an interest in this topic.

4. **Direct Outreach** A team of BHS employees, including the Behavioral Health Peer Specialist Program Managers, conducted visits to encampments, shelters, and sidewalk outreach to directly engage with unhoused individuals. The team partnered with Sacramento County BHS's Homeless Engagement And Response Team (HEART), who identified incentive items needed by the unhoused community members. These purchased items included:

    - Monthly Regional Transit (RT) passes
    - Collapsible, all-terrain carts
    - Solar-powered chargers
    - Hygiene kits and wet wipes
    - Dog food and bowls
    - Dog harnesses and leashes

    HEART introduced the team to large encampment locations with individuals with whom they were familiar and who have been generally receptive to outsiders offering services. HEART also facilitated collaboration with One Community Health, which invited BHS to the library where they had scheduled appointments with unhoused individuals.

Demographic sheets were kept with the notes from each individual, so the feedback from those who identified as AA/B/AD could be focused on. A total of 154 demographic surveys and feedback notes from this focus population were collected.

The standard Sacramento County Procurement Process is Phase 2 and began in January 2024.

The table below contains the FY 2025-26 Cost per Person information for implemented programs:

FY2025-26 INN COMPONENT	Average Cost/Person*	Budget Amount
Community Justice Support Program	$ 17,761	$ 3,108,218
TOTAL		**$ 3,108,218**

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

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

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

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

The **Technological Needs (TN) Project** began in Fiscal Year 2010-11 with a phased approach to build the infrastructure necessary to support Sacramento County's Behavioral Health Services (BHS) system with the goal of improving integrated services that are client and family driven, meet the needs of target populations, and are consistent with the recovery vision in Sacramento County. This project also advances the County's efforts to achieve the federal objective of the meaningful use of electronic health records to improve client care. Per WIC Section 5892(b), Counties may use a portion of the CSS funds to sustain TN projects once the time-limited TN funds are exhausted. Therefore, these activities are being sustained with CSS funding.

BHS has been successful with the implementation of clinical documentation, electronic prescribing, document imaging, billing, State Reporting and clinical documentation exchange through the use of the current electronic health record (EHR) used by County-operated providers, contracted providers, including contracted providers with their own EHR. BHS continues to work to implement lab order entry and lab history exchange.

Moving forward, BHS is focused on continuing to implement California Advancing and Innovating Medi-Cal (CalAIM) initiatives, which is California's commitment to transform and strengthen the Medicaid program in California (Medi-Cal). For the first time in many years, a significant behavioral health focus is being incorporated into the CalAIM initiatives. This includes two of the most important behavioral health initiatives: (1) documentation redesign, and (2) payment reform In order to meet the requirements of CalAIM, BHS has transitioned from Sacramento's Health Information Exchange (SacHIE) technology project to the new California-centric Enterprise Health Record, a new semi-statewide EHR project. We continue to make improvements to streamline processes in the new EHR. BHS is also focused on California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration, which is California's initiative to enhance community-based behavioral health care services to support individuals facing significant behavioral health challenges across the full continuum of care. BH-CONNECT aims to reduce reliance on facility-based care while strengthening community support to improve access and outcomes with individuals with significant behavioral health needs.

BHS is partnering with California Mental Health Services Authority (CalMHSA) to work to achieve the County's goals. CalMHSA, in collaboration with and on behalf of behavioral health and counties from across the state, continues to work on a semi-statewide EHR to help implement all of the CalAIM initiatives. In FY 2021-22, BHS participated in the competitive process led by

CalMHSA to select a vendor and EHR system. On May 19, 2022, the MHSA Steering Committee expressed support for BHS joining in the implementation of this new semi-statewide EHR as a Technology Needs project.

In FY 2022-23, BHS worked in collaboration with participating counties to co-create the requirements for the new semi-statewide EHR. The semi-statewide EHR was designed to support counties' core business requirements and address all regulatory requirements specific to the State of California.

In FY 2023-24, BHS transitioned Sacramento County operated providers, contracted providers who use the County's EHR, and contracted providers with their own EHR to the new semi-statewide EHR, SmartCare.

In FY 2024-25, BHS transitioned our County Crisis and Inpatient facility to SmartCare for documentation. The County Crisis and Inpatient facility continues to use our previous SacHIE technology and will transition to SmartCare for electronic medication administration and doctor's orders in the summer of 2025. BHS is continuing the partnership with CalMHSA to provide a managed Interoperability Software as a Service (SaaS) solution to assist Sacramento County in meeting state and federal interoperability requirements. The solution will facilitate the exchange of protected health information (PHI), personally identifiable information (PII) and other information between organizations and will assist in connecting to larger national exchange networks. Additionally, CalMHSA will be providing BHS with a Microsoft Cloud database solution and professional implementation and support services to assist with archiving legacy application Electronic Medical Record (EMR) databases to a secure Cloud environment. Through this program, CalMHSA will work with BHS to retain copies of and access to legacy EMR data, while also assisting in taking steps toward meeting future interoperability requirements.

FY 2025-26 Mental Health Services Act Expenditure Plan
Funding Summary

County: Sacramento

Date: 3/3/25

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2025/26 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	4,141,629	5,911,842	24,161,761	1,566,911	3,492,021	
2. Estimated New FY 2025/26 Funding	71,366,640	17,841,660	4,695,170			
3. Transfer in FY 2025/26a/	0			0	0	
4. Access Local Prudent Reserve in FY 2025/26	0	0				0
5. Estimated Available Funding for FY 2025/26	75,508,269	23,753,502	28,856,931	1,566,911	3,492,021	
B. Estimated FY 2025/26 MHSA Expenditures	75,508,269	19,945,034	7,465,007	1,566,911	3,492,021	
C. Estimated FY 2025/26 Unspent Fund Balance	0	3,808,468	21,391,924	0	0	

F. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2025	13,196,792
2. Contributions to the Local Prudent Reserve in FY 2025/26	0
3. Distributions from the Local Prudent Reserve in FY 2025/26	0
4. Estimated Local Prudent Reserve Balance on June 30, 2026	13,196,792

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

FY 2025-26 Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Sacramento Date: 3/3/25

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Sierra Elder Wellness	3,591,512	1,582,483	1,666,384			342,644
2. Permanent Supportive Housing	27,890,765	15,439,325	10,775,883			1,675,557
3. Transcultural Wellness Center	3,521,337	1,620,911	1,600,427			300,000
4. Adult Full Service Partnership	19,244,414	8,244,739	8,339,575	1,760,100		900,000
5. Juvenile Justice Diversion and Treatment	4,771,451	2,507,292	1,623,148	641,011		
6. Transition Age Youth (TAY) Full Service Part	5,099,242	2,364,323	2,434,919			300,000
7. Family FSP	6,533,514	2,424,883	3,958,631			150,000
8.	0					
9. Other Funding*	0	-14,174,679				14,174,679
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. Transitional Community Opportunities for	63,572,999	29,635,684	30,802,316			3,135,000
2. Wellness and Recovery	3,021,007	2,449,637	285,685			285,685
3. Crisis Residential	10,419,576	6,002,582	4,416,994			
4. Children's Community Mental Health Servi	79,340,990	16,833,426	46,437,207	15,709,025		361,333
5. MH Crisis/Urgent Care Clinic	6,093,847	4,100,513	1,993,334			
6.						
7. Other Funding*	0	-14,174,679				14,174,679
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
CSS Administration	13,103,013	10,651,831		2,451,182		
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	246,203,666	75,508,269	114,334,501	20,561,318		35,799,578
FSP Programs as Percent of Total	93.6%					

FY 2025-26 Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Sacramento Date: 3/3/25

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Suicide Prevention	12,012,304	9,566,816	2,445,488			
2. Strengthening Families	7,748,988	5,446,870	1,388,234			913,884
3. Integrated Health and Wellness	2,927,630	2,450,800	272,830			204,000
4. Mental Health Promotion	694,239	694,239				
5. Time-Limited Community Driven PEI Program	0	0				
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Integrated Health and Wellness - SacEDAPT	2,575,715	120,280	1,595,698			859,737
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	1,366,030	1,366,030				
PEI Assigned Funds	300,000	300,000				
Total PEI Program Estimated Expenditures	27,624,905	19,945,034	5,702,250	0	0	1,977,621

FY 2025-26 Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Sacramento Date: 3/3/25

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. *Completed - Respite Partnership Collaborat*	0	0				
2. *Completed - Mental Health Crisis/Urgent C*	0	0				
3. *Completed - Behavioral Health Crisis Servic*	0	0				
4. *Completed - FSP Collaborative*	0	0				
5. Community Justice Support Program	3,108,218	1,666,724	1,236,251			205,243
6. allcove	2,623,296	1,600,000				1,023,296
7. Community-Defined Mental Wellness Prac	4,198,283	4,198,283				
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	0	0				
Total INN Program Estimated Expenditures	9,929,797	7,465,007	1,236,251	0	0	1,228,539

FY 2025-26 Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: Sacramento Date: 3/3/25

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. WET Actions	2,327,834	2,327,834				
2.	0					
3. Other Funding*	0	-760,923				760,923
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0					
Total WET Program Estimated Expenditures	2,327,834	1,566,911	0	0	0	760,923

FY 2025-26 Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Sacramento Date: 3/3/25

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. Upgrading System and Architecture Suppo	6,550,677	6,550,677				
12.	0					
13. Other Funding*	0	-3,058,656				3,058,656
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	6,550,677	3,492,021	0	0	0	3,058,656

Behavioral Health Services
2024 Human Resources Survey

Lien Lam
Program Planner
Data Analytics Team
Division of Behavioral Health Services

OVERVIEW

Title 9, California Code of Regulations, Chapter 11, Medi-Cal Specialty MHS, Article 4, Section 1810.410 (c)-(d) states each Behavioral Health Plan (BHP) shall submit an annual Cultural Competence Plan Report (CCPR) consistent with the plan reporting requirements, including the population assessment and organizational and service provider assessments. In 2022, the CCPR requirements included strategies to address Culturally and Linguistically Appropriate Services (CLAS) standards.

The Human Resources (HR) Survey is intended to comply with the CLAS standard 3: *Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.*

The HR Survey collects information regarding individuals who work and/or provide support (directly or indirectly) to Medi-Cal beneficiaries in the Sacramento County Behavioral Health System. The data is then utilized to compare the workforce to the population served.

In addition to the HR Survey, the Language Proficiency Survey collects information regarding the linguistic proficiency of individuals involved in the provision of behavioral health services. The information collected from both surveys focuses on staff ethnicity, language proficiencies, gender, sexual orientation, consumer/family member status, disability, and veteran status.

KEY FINDINGS

- 1,227 staff members responded to at least one question on the HR Survey. This is not an unduplicated count as the HR Survey was anonymous.

- Of the 1,227 survey respondents, 70.3% provided direct services while 25.8% provided indirect services.

- Mental Health (MH) Services staff comprised 77.2% of survey respondents, and 19.0% of surveys were Substance Use Prevention & Treatment (SUPT) Services staff.

- 68.6% of staff members self-identified as Female, 17.6% as Male, 11.0% declined to state their gender, and 2.9% self-identified as a gender that fell into the "Other" category (Agender, Gender Fluid, Genderqueer, Intersex, Non-Binary, Other, Questioning/Unsure, Transgender, and Two Spirit.)

- While White/Caucasian represented 35.0% of respondents, the majority (57.0%) of staff identify with a race other than Caucasian (0.7% American Indian, 11.9% Asian/Pacific Islander, 11.9% Black/African American, 2.0% Other, 16.0% Hispanic/Latino, and 14.5% Multi-Ethnic). The remaining 7.9% of respondents declined to state their race.

- Out of all respondents, 66.6% self-identified as Heterosexual/Straight, 17.3% declined to answer, and 16.1% self-identified as part of the LGBTQIA+ community (2.0% Asexual, 5.1% Bisexual, 1.7% Gay, 2.1% Lesbian, 1.9% Queer, and 3.3% Other).

- 29.0% of staff members reported being a current/former recipient of Mental Health or Substance Use Treatment Services, and 10.5% as the parent/caregiver of a youth, who is a current/former recipient of Mental Health or Substance Use Treatment Services. 12.3% of staff members reported living with a disability, and 3.2% are current/former members of the US Military Service.

- 1,062 unduplicated staff members responded to at least one question on the Language Proficiency Survey. 37.8% of staff members reported being proficient in another language other than English. In total, 37 different languages were represented among staff. Spanish was the most frequently reported non-English language (19.8%).

ALL STAFF

Staff Categories

Of the 1,227 staff members who reported their staff category, the majority (70.3%) were direct service providers (Behavioral Health Peer Provider, Licensed Direct Service Staff, Other Health Care Professionals, Unlicensed Direct Service Staff, or Registered/Certified Direct Service Staff). The remaining 25.8% of respondents fulfill indirect service provision roles (Administrative or Managerial & Supervisory).

The survey respondents were 77.2% Mental Health (MH) Services staff while 19.0% were Substance Use Prevention and Treatment (SUPT) Services staff, and 3.8% declined to state their staff category.

Figure 1 provides a visual depiction of the staff categories, and Table 1 offers a detailed breakdown of staff categories. In addition, detailed descriptions of each category may be found in Appendix A.

Figure 1. Staff Categories (N=1227)

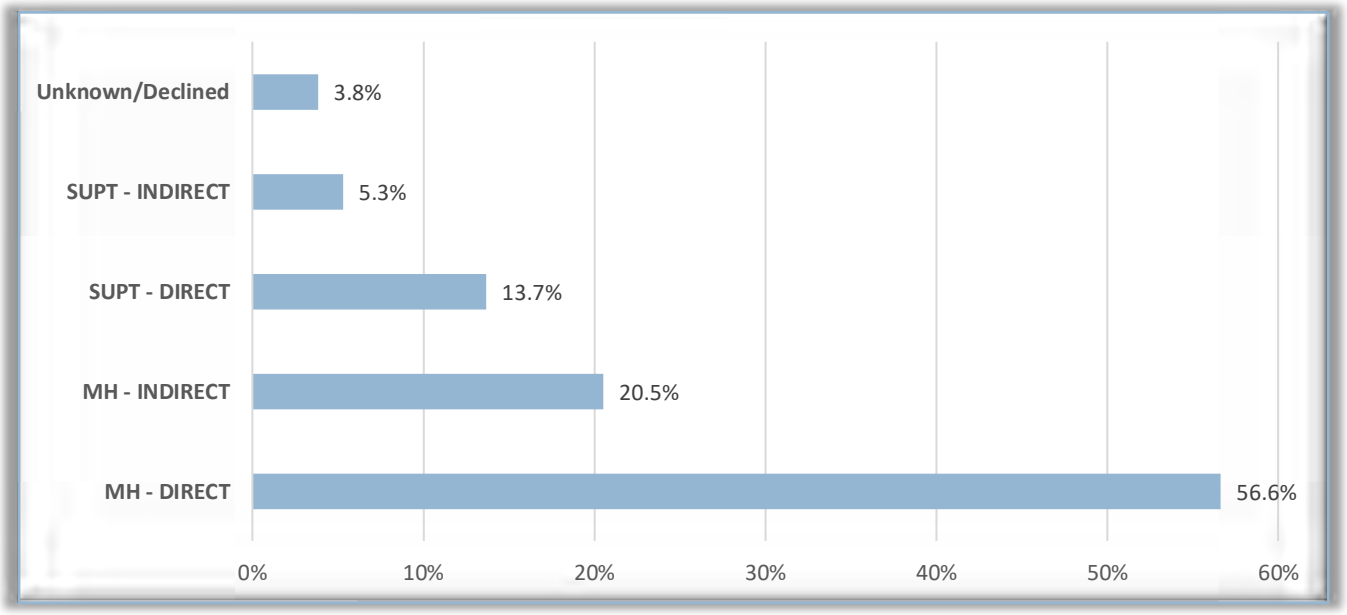


Table 1. Staff Categories (N=1227)

SERVICES	DIRECT		INDIRECT		DECLINED		TOTAL	
Mental Health	695	56.6%	252	20.5%	0	0.0%	947	77.2%
Substance Use Prevention & Treatment	168	13.7%	65	5.3%	0	0.0%	233	19.0%
Unknown/Declined	0	0.0%	0	0.0%	47	3.8%	47	3.8%
TOTAL	**863**	**70.3%**	**317**	**25.8%**	**47**	**3.8%**	**1227**	**100.0%**

STAFF DEMOGRAPHICS

Gender Identity

Most staff members self-identified as Female (68.6%). About 17.6% identified as Male and 11.0% declined to state their gender. The remaining 2.9% of staff members reported nine different gender identities that fall into the "Other" category, which includes Agender (0.2%), Gender Fluid (0.2%), Genderqueer (0.1%), Intersex (0.1%), Non-Binary (1.5%), Other (0.4%), Questioning/Unsure (0.2%), Transgender (0.1%), and Two Spirit (0.1%).

Figure 2 shows the staff members' gender identities in the context of staff categories, and Table 2 offers a detailed breakdown of each gender identity.

Figure 2. Gender Identity by Staff Category (N=1227)

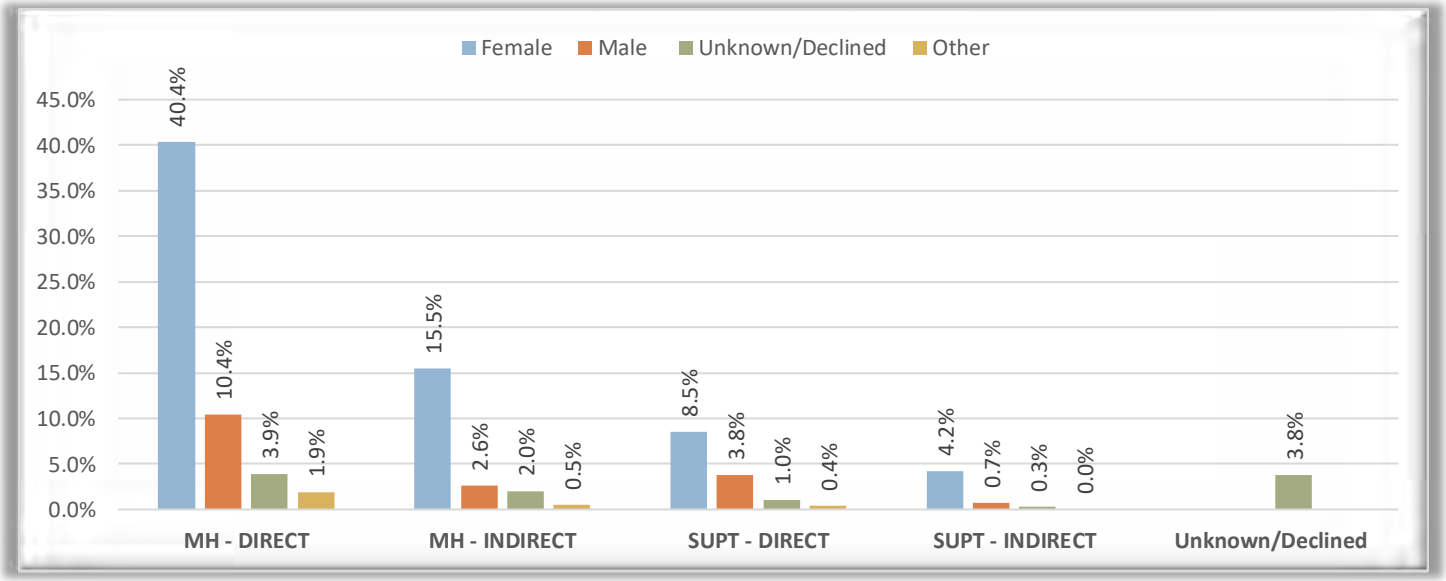


Table 2. Gender Identity (N=1227)

GENDER IDENTITY	MH DIRECT		MH INDIRECT		SUPT DIRECT		SUPT INDIRECT		DECLINED		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%
Female	496	40.4%	190	15.5%	104	8.5%	52	4.2%	0	0.0%	842	68.6%
Male	128	10.4%	32	2.6%	47	3.8%	9	0.7%	0	0.0%	216	17.6%
Unknown/Declined	48	3.9%	24	2.0%	12	1.0%	4	0.3%	47	3.8%	135	11.0%
Other												
Agender	1	0.1%	0	0.0%	1	0.1%	0	0.0%	0	0.0%	2	0.2%
Gender Fluid	1	0.1%	1	0.1%	1	0.1%	0	0.0%	0	0.0%	3	0.2%
Genderqueer	0	0.0%	1	0.1%	0	0.0%	0	0.0%	0	0.0%	1	0.1%
Intersex	1	0.1%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.1%
Non-Binary	14	1.1%	3	0.2%	1	0.1%	0	0.0%	0	0.0%	18	1.5%
Other	4	0.3%	0	0.0%	1	0.1%	0	0.0%	0	0.0%	5	0.4%
Questioning/Unsure	1	0.1%	0	0.0%	1	0.1%	0	0.0%	0	0.0%	2	0.2%
Transgender	1	0.1%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.1%
Two Spirit	0	0.0%	1	0.1%	0	0.0%	0	0.0%	0	0.0%	1	0.1%
TOTAL	**695**	**56.6%**	**252**	**20.5%**	**168**	**13.7%**	**65**	**5.3%**	**47**	**3.8%**	**1227**	**100.0%**

Race

While White/Caucasian represented 35.0% of respondents, the majority (57.0%) of staff identify with a race other than Caucasian (0.7% American Indian, 11.9% Asian/Pacific Islander, 11.9% Black/African American, 2.0% Other, 16.0% Hispanic/Latino, and 14.5% Multi-Ethnic). The remaining 7.9% of respondents declined to state their race. Direct mental health service providers were significantly more likely to self-identify with a race other than White/Caucasian when compared to the other three staff categories. These differences are visualized in Figure 3. In addition, Figure 4 and Table 3 offer detailed information regarding the racial makeup of staff categories by noting specific races reported by staff members.

Figure 3. Racial Makeup of Staff Categories (N=1227)

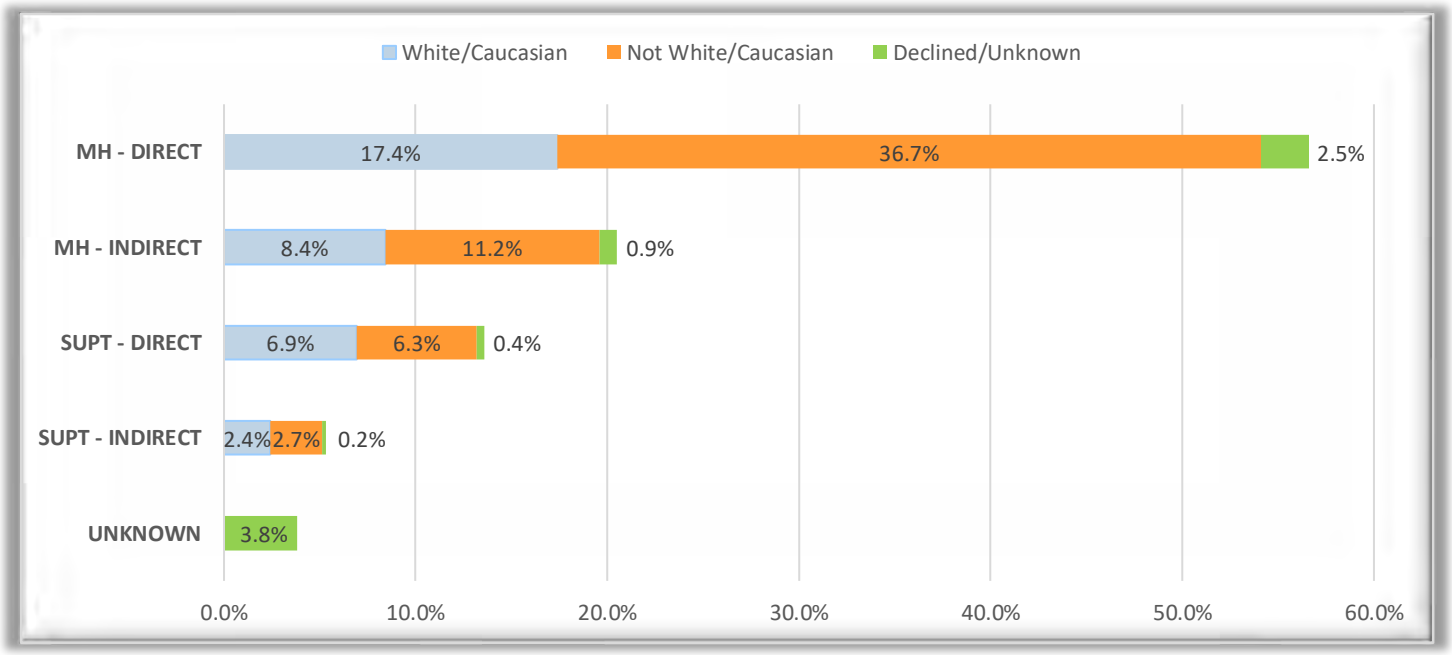


Figure 4. Race by Staff Category (N=1227)

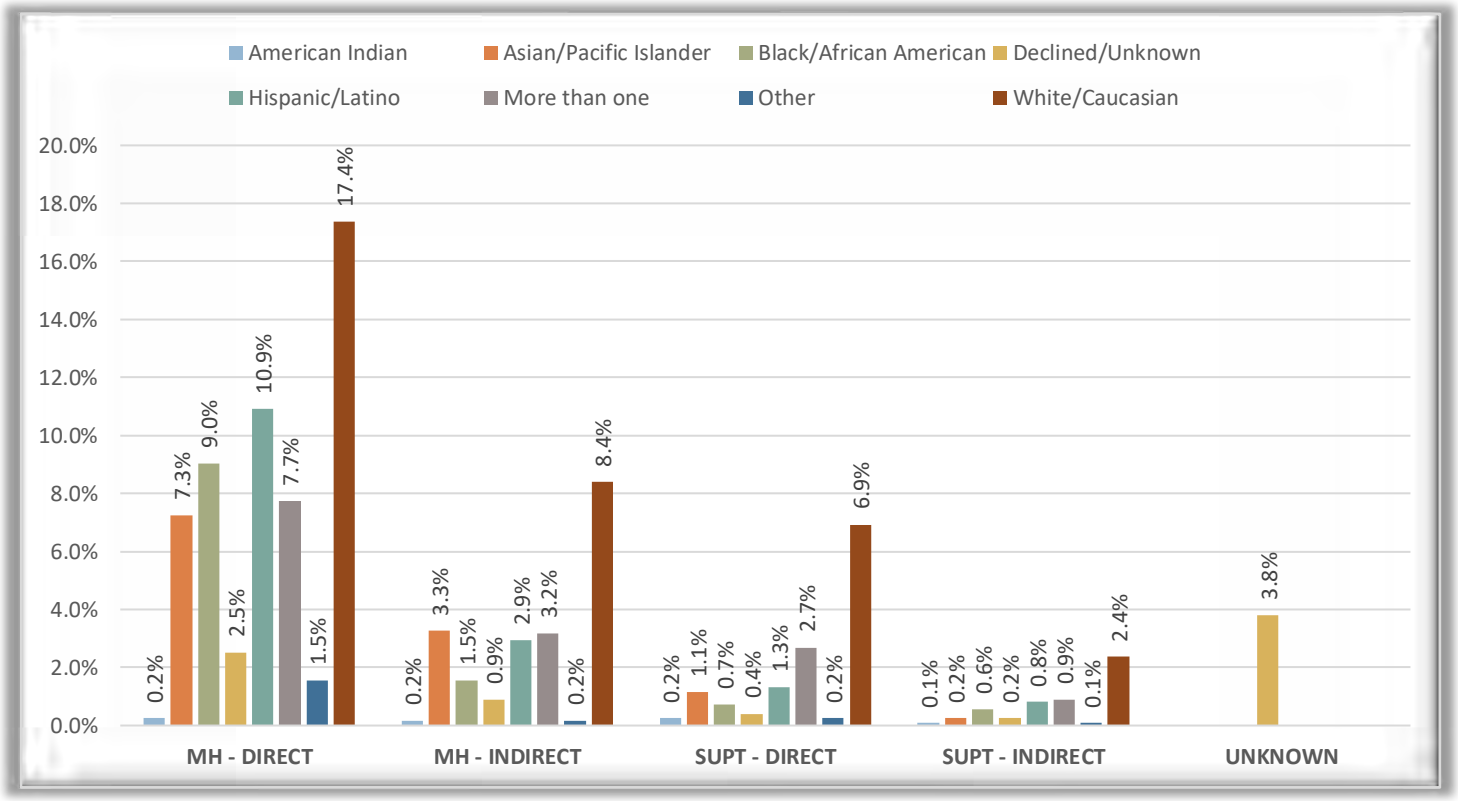


Table 3. Race (N=1227)

RACE	MH DIRECT		MH INDIRECT		SUPT DIRECT		SUPT INDIRECT		UNKNOWN		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%
American Indian	3	0.2%	2	0.2%	3	0.2%	1	0.1%	0	0.0%	9	0.7%
Asian/Pacific Islander	89	7.3%	40	3.3%	14	1.1%	3	0.2%	0	0.0%	146	11.9%
Black/African American	111	9.0%	19	1.5%	9	0.7%	7	0.6%	0	0.0%	146	11.9%
Declined/Unknown	31	2.5%	11	0.9%	5	0.4%	3	0.2%	47	3.8%	97	7.9%
Hispanic/Latino	134	10.9%	36	2.9%	16	1.3%	10	0.8%	0	0.0%	196	16.0%
More than one	95	7.7%	39	3.2%	33	2.7%	11	0.9%	0	0.0%	178	14.5%
Other	19	1.5%	2	0.2%	3	0.2%	1	0.1%	0	0.0%	25	2.0%
White/Caucasian	213	17.4%	103	8.4%	85	6.9%	29	2.4%	0	0.0%	430	35.0%
TOTAL	**695**	**56.6%**	**252**	**20.5%**	**168**	**13.7%**	**65**	**5.3%**	**47**	**3.8%**	**1227**	**100.0%**

Sexual Orientation

Out of all respondents, 66.6% self-identified as Heterosexual/Straight, 17.3% declined to answer, and 16.1% self-identified as part of the LGBTQIA+ community (2.0% Asexual, 5.1% Bisexual, 1.7% Gay, 2.1% Lesbian, 1.9% Queer, and 3.3% Other). The "Other" category included 0.1% Demisexual, 0.7% Fluid, 0.1% Graysexual, 0.4% Other, 1.7% Pansexual, 0.3% Questioning, and 0.1% Unsure. Direct mental health service providers were most likely to self-identify as part of the LGBTQIA+ community when compared to the other three staff categories.

Figure 5 shows the LGBTQIA+ representation. Figure 6 and Table 4 offer detailed information regarding the sexual orientations of staff categories.

Figure 5. LGBTQIA+ Representation (N=1227)

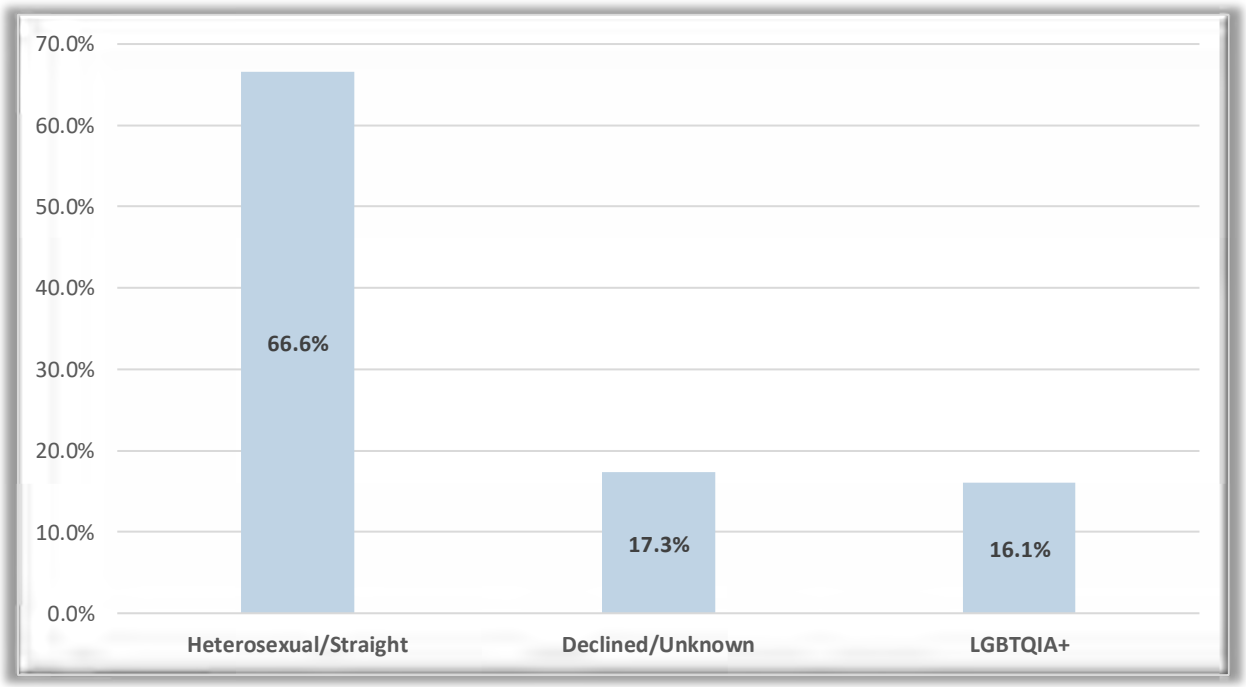


Figure 6. Sexual Orientation by Staff Category (N=1227)

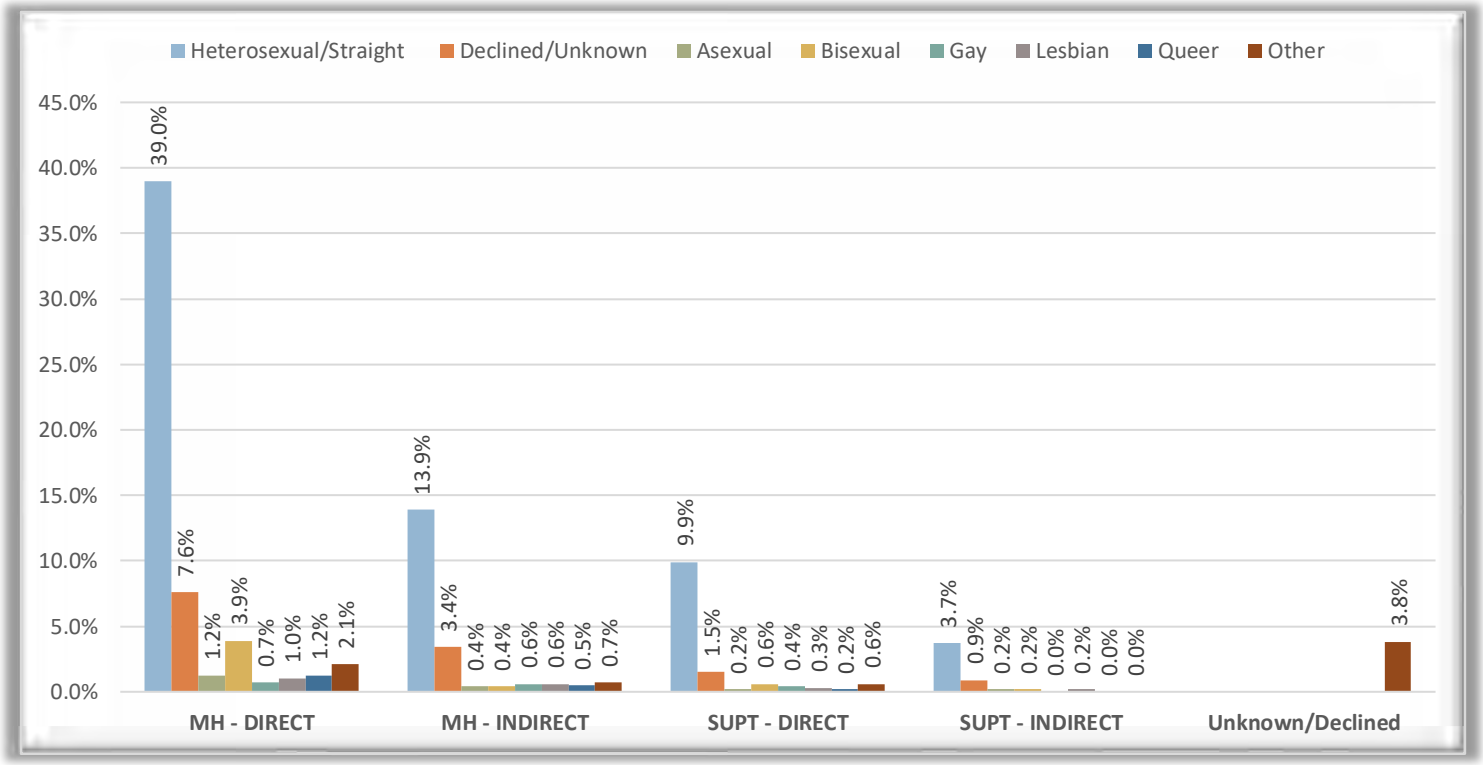


Table 4. Sexual Orientation (N=1227)

SEXUAL ORIENTATION	MH DIRECT		MH INDIRECT		SUPT DIRECT		SUPT INDIRECT		DECLINED		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%
Heterosexual/Straight	478	39.0%	171	13.9%	122	9.9%	46	3.7%	0	0.0%	817	66.6%
Declined/Unknown	93	7.6%	42	3.4%	19	1.5%	11	0.9%	47	3.8%	212	17.3%
Asexual	15	1.2%	5	0.4%	2	0.2%	3	0.2%	0	0.0%	25	2.0%
Bisexual	48	3.9%	5	0.4%	7	0.6%	2	0.2%	0	0.0%	62	5.1%
Gay	9	0.7%	7	0.6%	5	0.4%	0	0.0%	0	0.0%	21	1.7%
Lesbian	12	1.0%	7	0.6%	4	0.3%	3	0.2%	0	0.0%	26	2.1%
Queer	15	1.2%	6	0.5%	2	0.2%	0	0.0%	0	0.0%	23	1.9%
Other												
Demisexual	1	0.1%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.1%
Fluid	7	0.6%	1	0.1%	0	0.0%	0	0.0%	0	0.0%	8	0.7%
Graysexual	1	0.1%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.1%
Other	3	0.2%	0	0.0%	2	0.2%	0	0.0%	0	0.0%	5	0.4%
Pansexual	10	0.8%	7	0.6%	4	0.3%	0	0.0%	0	0.0%	21	1.7%
Questioning	2	0.2%	1	0.1%	1	0.1%	0	0.0%	0	0.0%	4	0.3%
Unsure	1	0.1%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.1%
TOTAL	**695**	**56.6%**	**252**	**20.5%**	**168**	**13.7%**	**65**	**5.3%**	**47**	**3.8%**	**1227**	**100.0%**

Recipients, Family Members, Disabled and Military

As part of the HR survey, staff were asked whether they identified as a recipient, family member, having a disability, and/or US military service history. In response, 29.0% reported being a current/former recipient of Mental Health or Substance Use Treatment Services, and 10.5% as the parent/caregiver of a youth, who is a current/former recipient of Mental Health or Substance Use Treatment Services. A reported 12.3% of staff members live with a disability, and 3.2% are current/former members of the US Military Service. Staff responses are broken down by staff category in Table 5.

Table 5. Recipient Status, Disabilities, & Military Service by Staff Category (N=1227)

CONSUMER STATUS, DISABILITIES, & MILITARY SERVICE	MH - DIRECT		MH - INDIRECT		SUPT - DIRECT		SUPT - INDIRECT		UNKNOWN		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%
I am a current/former recipient of Mental Health or Substance Use Treatment Services.	199	16.2%	50	4.1%	94	7.7%	13	1.1%	0	0.0%	356	29.0%
I am the parent/caregiver of a youth, who is/was a recipient of Mental Health or Substance Use Treatment Services.	73	5.9%	28	2.3%	23	1.9%	5	0.4%	0	0.0%	129	10.5%
I live with a disability.	99	8.1%	24	2.0%	24	2.0%	4	0.3%	0	0.0%	151	12.3%
I am currently or have served in the US Military.	29	2.4%	3	0.2%	7	0.6%	0	0.0%	0	0.0%	39	3.2%
Not Applicable/Declined	295	24.0%	147	12.0%	20	1.6%	43	3.5%	47	3.8%	552	45.0%
TOTAL	**695**	**56.6%**	**252**	**20.5%**	**168**	**13.7%**	**65**	**5.3%**	**47**	**3.8%**	**1227**	**100.0%**

Language

When asked whether they were able to speak a language other than English, 37.8% of staff members responded "yes." Overall, survey responses highlighted varying levels of language proficiency among staff categories, with direct mental health service providers standing out for notable linguistic diversity. Staff members who provide direct mental health services to consumers makeup 67.8% of staff members who can speak a language other than English. Differences in non-English language proficiency between staff categories are outlined in Figure 7 and Table 6 below.

Figure 7. Non-English Language Proficiency by Staff Category (N=1062)*

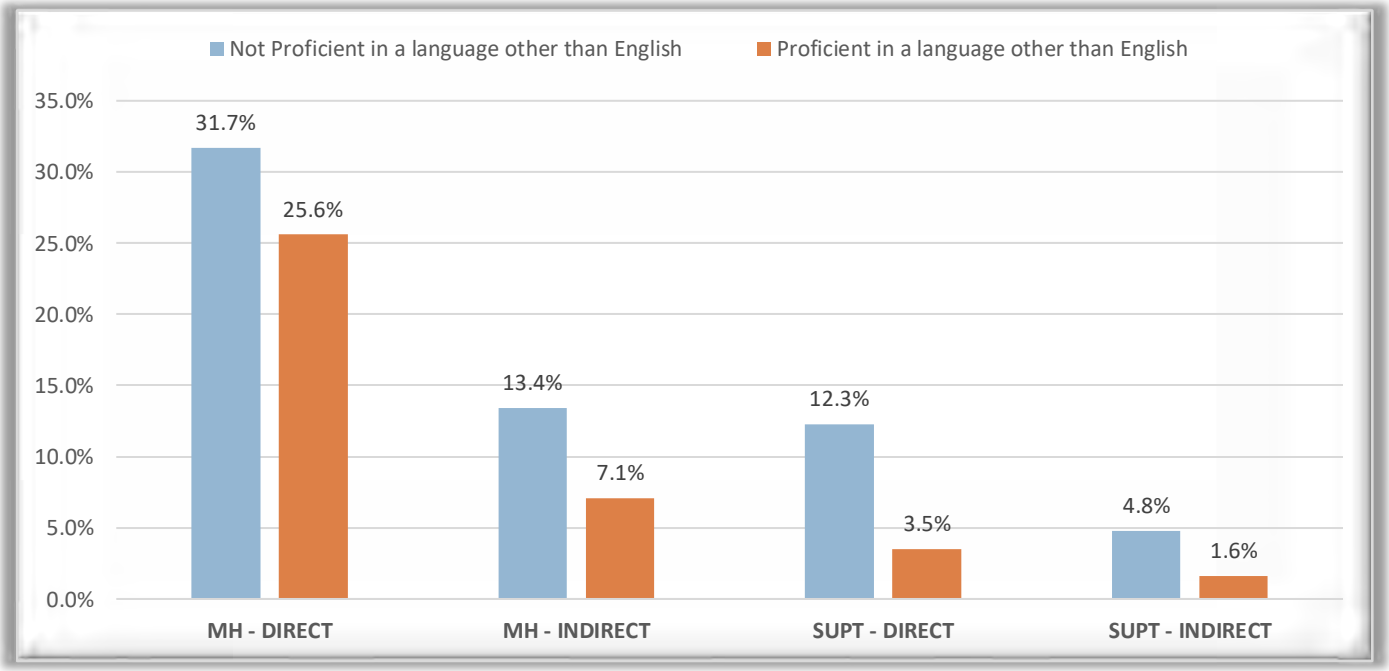


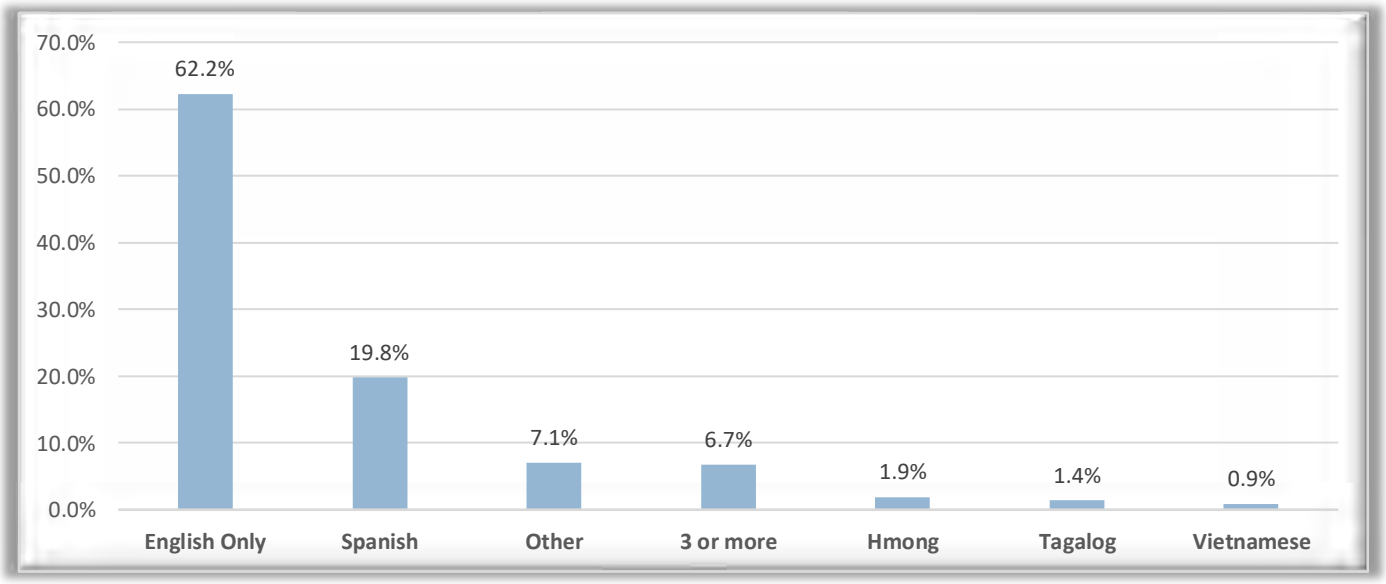
Table 6. Non-English Language Proficiency by Staff Category (N=1062)*

LANGUAGE PROFICIENCY	MH DIRECT		MH INDIRECT		SUPT DIRECT		SUPT INDIRECT		TOTAL*	
	N	%	N	%	N	%	N	%	N	%
Not proficient in a language other than English	337	31.7%	142	13.4%	131	12.3%	51	4.8%	661	62.2%
Proficient in a language other than English	272	25.6%	75	7.1%	37	3.5%	17	1.6%	401	37.8%
TOTAL	**609**	**57.3%**	**217**	**20.4%**	**168**	**15.8%**	**68**	**6.4%**	**1062**	**100.0%**

*N is lower than other demographics included in this Report and represents an unduplicated count. The Language Proficiency Survey used to collect language data was completed by fewer staff members (N=1062) than the HR Survey used to collect other demographic data (N=1227).

While 62.2% of all staff members reported only being able to speak English, 37.8% reported having "good" to "fluent" proficiency in other languages. In total, 37 different languages are represented among staff. Spanish was the most frequently reported non-English language (19.8%). Additionally, 6.7% of staff members are proficient in three or more languages, reflecting their multilingual abilities. A variety of other languages are also spoken by staff. Notably, 1.9% of staff members speak Hmong, 1.4% speak Tagalog, and 0.9% speak Vietnamese. Further contributing to this linguistic diversity, a group categorized as "Other" languages constitutes 7.1% of all staff and is comprised of 33 different languages. Out of the direct mental health service providers, 44.7% reported possessing the ability to speak a language other than English, with Spanish being the most common language reported (14.2%) amongst that group. Figure 8 and Table 7 showcase the diverse array of non-English languages spoken by staff members.

Figure 8. Languages Spoken by Staff (N=1062)*



*N is lower than other demographics included in this Report and represents an unduplicated count. The Language Proficiency Survey used to collect language data was completed by fewer staff members (N=1062) than the HR Survey used to collect other demographic data (N=1227).

Table 7. Non-English Languages Spoken by Staff (N=1062)*

LANGUAGES	MH DIRECT		MH INDIRECT		SUPT DIRECT		SUPT INDIRECT		TOTAL*	
	N	%	N	%	N	%	N	%	N	%
English Only	337	31.7%	142	13.4%	131	12.3%	51	4.8%	661	62.2%
Hmong	12	1.1%	6	0.6%	0	0.0%	2	0.2%	20	1.9%
3 or more	47	4.4%	14	1.3%	10	0.9%	0	0.0%	71	6.7%
Spanish	151	14.2%	32	3.0%	16	1.5%	11	1.0%	210	19.8%
Tagalog	10	0.9%	2	0.2%	3	0.3%	0	0.0%	15	1.4%
Vietnamese	8	0.8%	1	0.1%	0	0.0%	1	0.1%	10	0.9%
Other										
American Sign Language	2	0.2%	1	0.1%	0	0.0%	1	0.1%	4	0.4%
Arabic	2	0.2%	1	0.1%	0	0.0%	0	0.0%	3	0.3%
Armenian	1	0.1%	0	0.0%	0	0.0%	0	0.0%	1	0.1%
Bisaya	1	0.1%	0	0.0%	0	0.0%	0	0.0%	1	0.1%
Bulgarian	1	0.1%	0	0.0%	0	0.0%	0	0.0%	1	0.1%
Cambodian/Khmer	3	0.3%	0	0.0%	1	0.1%	0	0.0%	4	0.4%
Cantonese	4	0.4%	0	0.0%	0	0.0%	1	0.1%	5	0.5%
Chinese	0	0.0%	2	0.2%	0	0.0%	0	0.0%	2	0.2%
Farsi	2	0.2%	0	0.0%	0	0.0%	0	0.0%	2	0.2%
Filipino	1	0.1%	0	0.0%	0	0.0%	0	0.0%	1	0.1%
French	6	0.6%	1	0.1%	0	0.0%	0	0.0%	7	0.7%
German	2	0.2%	1	0.1%	0	0.0%	0	0.0%	3	0.3%
Gujarati	0	0.0%	0	0.0%	1	0.1%	0	0.0%	1	0.1%
Hebrew	1	0.1%	0	0.0%	0	0.0%	0	0.0%	1	0.1%
Hindi	0	0.0%	1	0.1%	2	0.2%	0	0.0%	3	0.3%
Igbo	1	0.1%	0	0.0%	0	0.0%	0	0.0%	1	0.1%
Italian	1	0.1%	0	0.0%	0	0.0%	0	0.0%	1	0.1%
Japanese	1	0.1%	3	0.3%	0	0.0%	0	0.0%	4	0.4%
Korean	2	0.2%	2	0.2%	0	0.0%	0	0.0%	4	0.4%
Mandarin	0	0.0%	1	0.1%	0	0.0%	0	0.0%	1	0.1%
Mien	2	0.2%	1	0.1%	0	0.0%	0	0.0%	3	0.3%
Other	0	0.0%	1	0.1%	0	0.0%	1	0.1%	2	0.2%
Pangasinan	1	0.1%	0	0.0%	0	0.0%	0	0.0%	1	0.1%
Polish	0	0.0%	1	0.1%	0	0.0%	0	0.0%	1	0.1%
Portuguese	0	0.0%	1	0.1%	0	0.0%	0	0.0%	1	0.1%
Punjabi	2	0.2%	0	0.0%	2	0.2%	0	0.0%	4	0.4%
Russian	3	0.3%	1	0.1%	0	0.0%	0	0.0%	4	0.4%
Swahili	1	0.1%	0	0.0%	0	0.0%	0	0.0%	1	0.1%
Thai	1	0.1%	0	0.0%	0	0.0%	0	0.0%	1	0.1%
Tongan	0	0.0%	1	0.1%	1	0.1%	0	0.0%	2	0.2%
Turkish	1	0.1%	0	0.0%	0	0.0%	0	0.0%	1	0.1%
Urdu	1	0.1%	1	0.1%	0	0.0%	0	0.0%	2	0.2%
Yoruba	1	0.1%	0	0.0%	1	0.1%	0	0.0%	2	0.2%
TOTAL	**609**	**57.3%**	**217**	**20.4%**	**168**	**15.8%**	**68**	**6.4%**	**1062**	**100.0%**

*N is lower than other demographics included in this Report and represents an unduplicated count. The Language Proficiency Survey used to collect language data was completed by fewer staff members (N=1062) than the HR Survey used to collect other demographic data (N=1227).

DIRECT SERVICE STAFF COMPARED TO MEDI-CAL BENEFICIARIES SERVED IN THE MENTAL HEALTH PLAN (MHP)

The data below compares the demographics of direct mental health services staff to the demographics of Medi-Cal beneficiaries served in the MHP during Fiscal Year 23-24. Please note that not all demographics collected on the HR survey are comparable to the clients served, due to differences in collection methods. Therefore, some categories and labels were combined and/or renamed to support continuity. Aggregated MHP beneficiary demographics data can be found in Appendix B.

Gender

A comparison of direct mental health services staff and MHP beneficiaries' genders found that Females are overrepresented among staff (71.4%) when compared to that of beneficiaries (34.9%). In contrast, Males are underrepresented in the direct staff category based on 18.4% of staff identified as male compared to 34.7% of MHP beneficiaries. The individuals who declined to specify their gender identity are significantly higher among MHP beneficiaries, 28.0% versus 6.9% of direct staff. The proportions of transgender and "Other" categories are minimal, indicating a consistent trend of smaller representation. These findings are visualized in Figure 9 and Table 8.

Figure 9. Gender – MH Direct Service Staff Compared to MHP Beneficiaries

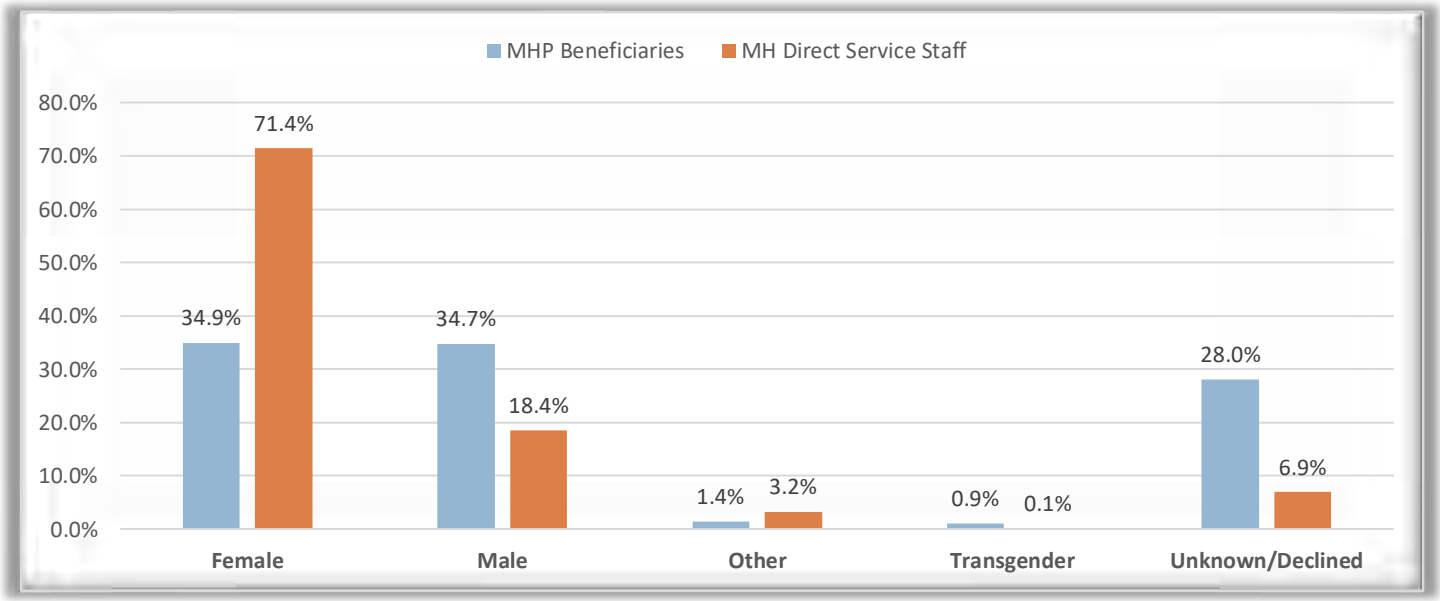


Table 8. Gender - Direct Service Staff Compared to MHP Beneficiaries

GENDER IDENTITY	MHP BENEFICIARIES		MH DIRECT SERVICE STAFF	
	N	%	N	%
Female	8,903	34.9%	496	71.4%
Male	8,853	34.7%	128	18.4%
Other	356	1.4%	22	3.2%
Transgender	238	0.9%	1	0.1%
Unknown/Declined	7151	28.0%	48	6.9%
TOTAL	**25,501**	**100.0%**	**695**	**100.0%**

Race

White/Caucasian individuals are the most prevalent racial group among both direct mental health services staff (30.6%) and MHP beneficiaries (30.4%). Black/African American individuals are underrepresented amongst staff (16.0%) when compared to MHP beneficiaries (23.9%). In contrast, Asian/Pacific Islander individuals are overrepresented amongst staff (12.8%) when compared to 5.6% of beneficiaries. The Hispanic/Latino (19.3% staff, 12.4% beneficiaries) and Multi-Racial individuals (13.7% staff, 10.4% beneficiaries) are also overrepresented. The American Indian/Alaskan Native individuals are similarly represented (0.4% staff, 1.5% beneficiaries), as are individuals represented by "Other" race (2.7% staff, 2.8% beneficiaries). Lastly, a noteworthy portion of MHP beneficiaries (13.1%) preferred to not disclose their race, compared to only 4.5% of direct service staff. Figure 10 and Table 9 showcase similarities and differences between staff and MHP beneficiary race distribution.

Figure 10. Race - Direct Service Staff Compared to MHP Beneficiaries

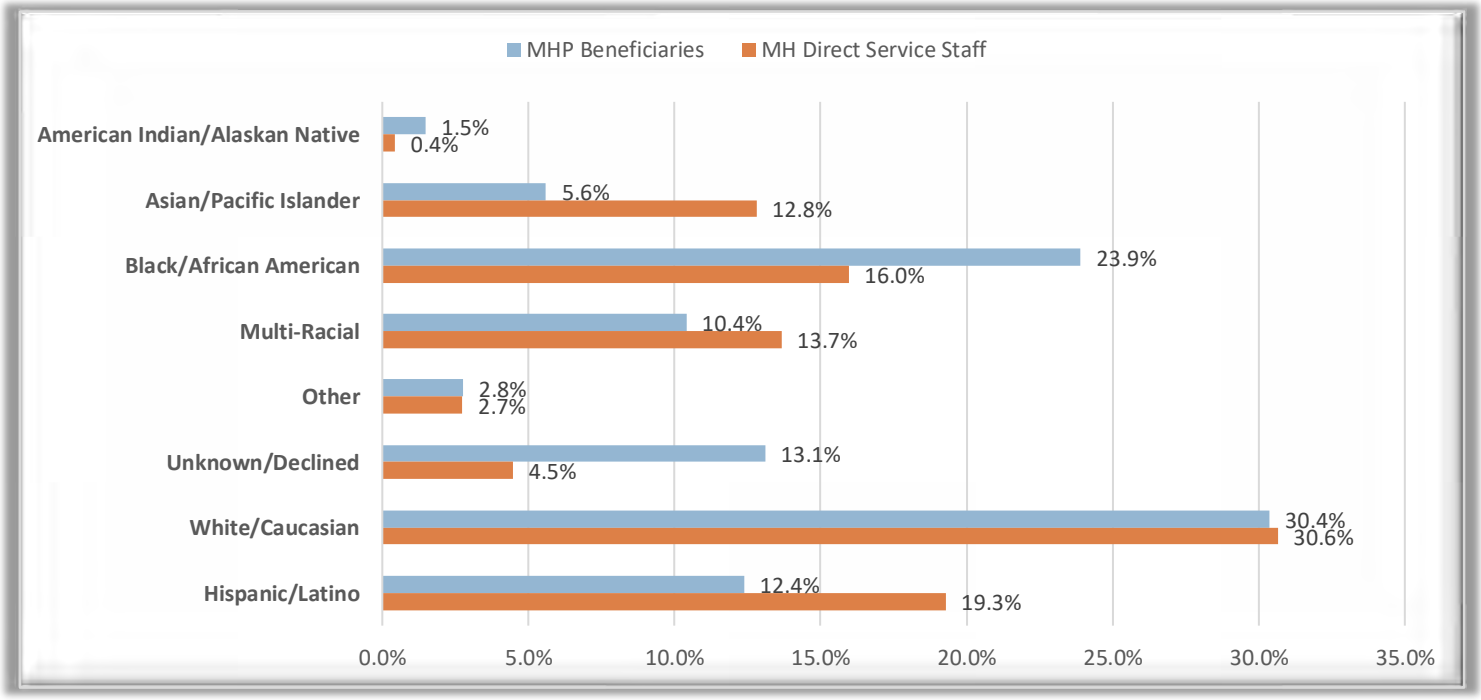


Table 9. Race - Direct Service Staff Compared to MHP Beneficiaries

RACE	MHP BENEFICIARIES		MH DIRECT SERVICE STAFF	
	N	%	N	%
American Indian/Alaskan Native	378	1.5%	3	0.4%
Asian/Pacific Islander	1,428	5.6%	89	12.8%
Black/African American	6,096	23.9%	111	16.0%
Multi-Racial	2,654	10.4%	95	13.7%
Other	703	2.8%	19	2.7%
Unknown/Declined	3,342	13.1%	31	4.5%
White/Caucasian	7,742	30.4%	213	30.6%
Hispanic/Latino	3,158	12.4%	134	19.3%
TOTAL	**25,501**	**100.0%**	**695**	**100.0%**

Sexual Orientation

The most notable difference when comparing direct mental health services staff and MHP beneficiaries' sexual orientation is that many MHP beneficiaries (46.4%) chose to not report their sexual orientation at all, compared to only 13.4% of direct staff. Straight/Heterosexual individuals are the predominant sexual orientation reported by both staff (68.8%) and MHP beneficiaries (46.0%). Staff were overrepresented in the remaining sexual orientation categories, which include Bisexual (6.9% staff, 3.6% beneficiaries), Lesbian/Gay (3.0% staff, 1.6% beneficiaries), and "Other" (7.9% staff, 2.3% beneficiaries). These findings are visualized in Figure 11 and Table 10 below.

Figure 11. Sexual Orientation - Direct Service Staff Compared to MHP Beneficiaries

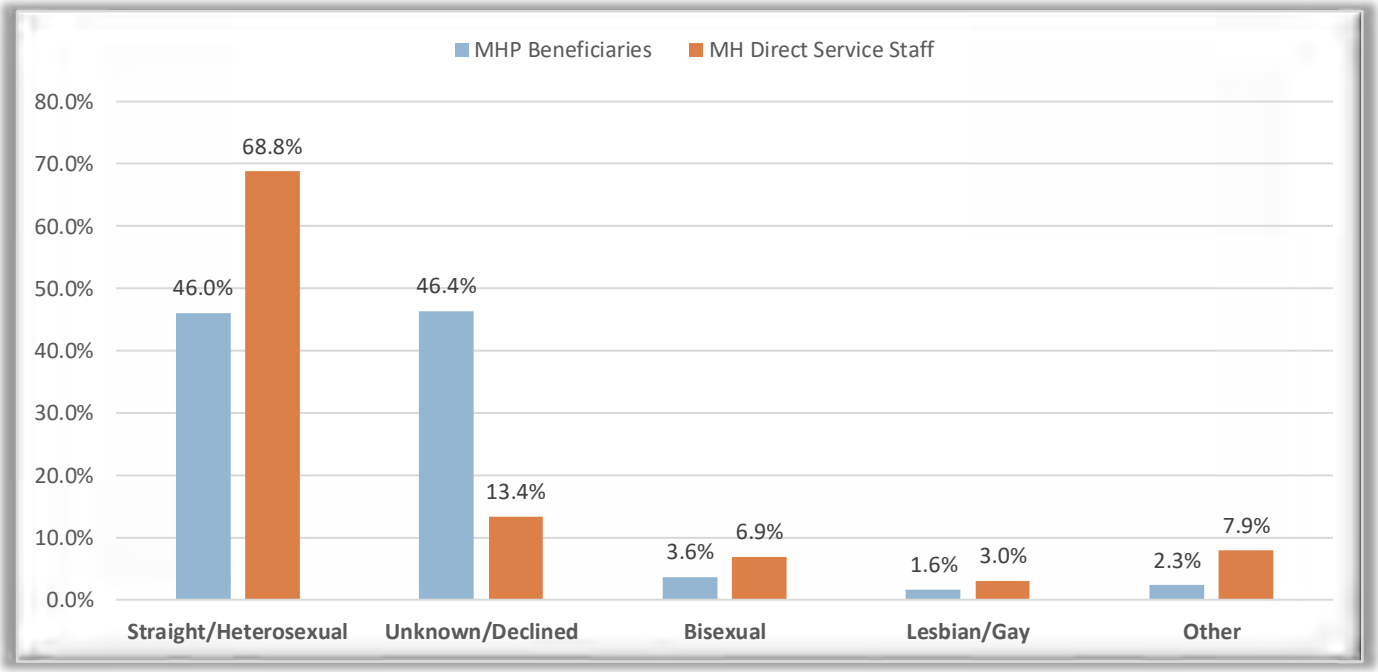


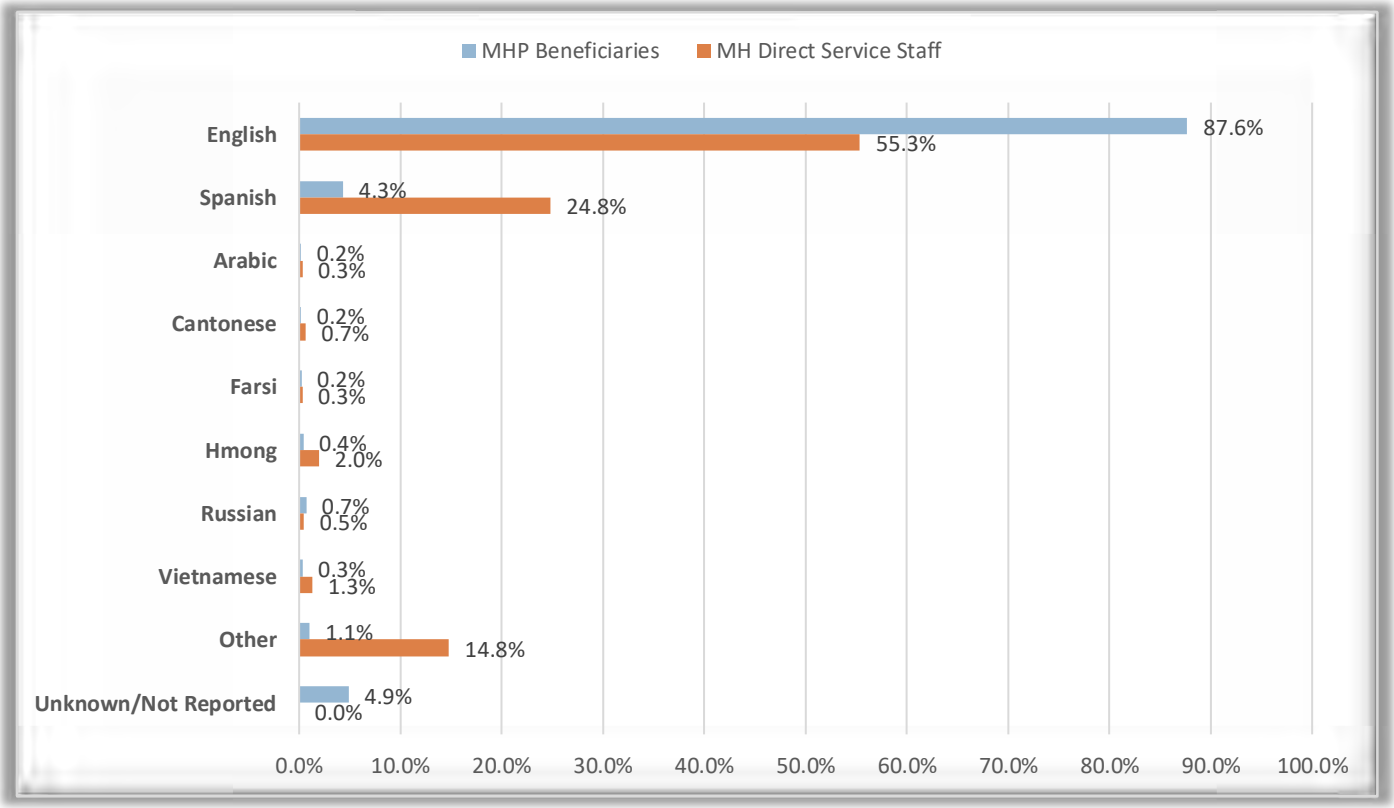
Table 10. Sexual Orientation – Direct Service Staff Compared to MHP Beneficiaries

SEXUAL ORIENTATION	MHP BENEFICIARIES		MH DIRECT SERVICE STAFF	
	N	%	N	%
Straight/Heterosexual	11,740	46.0%	478	68.8%
Unknown/Declined	11,830	46.4%	93	13.4%
Bisexual	923	3.6%	48	6.9%
Lesbian/Gay	416	1.6%	21	3.0%
Other	592	2.3%	55	7.9%
TOTAL	**25,501**	**100.0%**	**695**	**100.0%**

Language

A comparison of languages spoken by direct mental health services staff and MHP beneficiaries highlights the significant presence of Spanish among staff, the varying representation of different languages, and the importance of linguistic diversity. Overall, English was the most common language both among staff (55.3%) and MHP beneficiaries (87.6%). In total, staff members were significantly more likely to possess the ability to speak a non-English language (44.7%) than beneficiaries (7.4%). Staff were more likely to be proficient in Arabic, Cantonese, Farsi, Hmong, Spanish and Vietnamese when compared to MHP beneficiaries. "Other" languages also have a notable presence among staff (14.8%) than beneficiaries (1.1%). Russian is the only non-English language slightly underrepresented among staff (0.5% staff versus 0.7% beneficiaries). Figure 12 and Table 11 showcase similarities and differences between non-English languages spoken by direct mental health service staff and MHP beneficiaries.

Figure 12. Language - Direct Service Staff Compared to MHP Beneficiaries*



*N is lower than other demographics included in this report. The survey used to collect language data was completed by fewer direct mental health service providers (N=609) than the survey used to collect other demographic data (N=695).

Table 11. Language - Direct Service Staff Compared to MHP Beneficiary

LANGUAGES	MHP BENEFICIARIES		MH DIRECT SERVICE STAFF*	
	N	%	N	%
English	22,348	87.6%	337	55.3%
Spanish	1,108	4.3%	151	24.8%
Arabic	50	0.2%	2	0.3%
Cantonese	51	0.2%	4	0.7%
Farsi	59	0.2%	2	0.3%
Hmong	107	0.4%	12	2.0%
Russian	179	0.7%	3	0.5%
Vietnamese	85	0.3%	8	1.3%
Other	269	1.1%	90	14.8%
Unknown/Not Reported	1,245	4.9%	N/A	0.0%
TOTAL	**25,501**	**100.0%**	**609**	**100.0%**

DIRECT SERVICE STAFF COMPARED TO MEDI-CAL BENEFICIARIES SERVED IN SUBSTANCE USE PREVENTION AND TREATMENT SERVICES (SUPT)

Data below compares the demographics of direct SUPT service providers to the demographics of Medi-Cal beneficiaries served in SUPT during Fiscal Year 23-24. Please note that not all demographics collected on the HR survey are comparable to the clients served, due to differences in collection methods. Therefore, some categories and labels were combined and/or renamed to support continuity. Aggregated SUPT beneficiary demographics data can be found in Appendix C.

Gender

A comparison of SUPT direct staff and SUPT beneficiaries' gender found that Females are overrepresented among staff (61.9%) when compared to Female beneficiaries (30.8%). In contrast, Males are underrepresented among staff (28.0% staff, 35.9% SUPT beneficiaries). The individuals who declined to specify their gender identity are significantly higher among SUPT beneficiaries, 32.7% versus 7.1% of direct staff. The Transgender and "Other" categories are notably smaller among both staff and SUPT beneficiaries. Figure 13 and Table 12 reflect these findings.

Figure 13. Gender - Direct Service Staff Compared to SUPT Beneficiaries

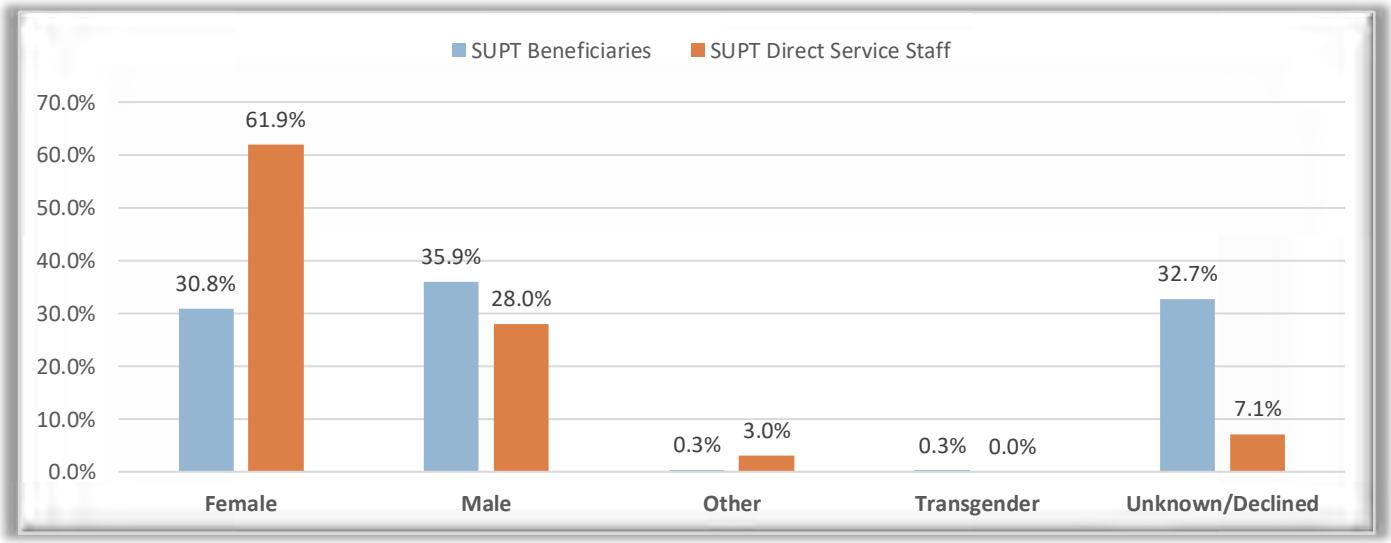


Table 12. Gender - Direct Service Staff Compared to SUPT Beneficiaries

GENDER IDENTITY	SUPT BENEFICIARIES		SUPT DIRECT SERVICE STAFF	
	N	%	N	%
Female	1,829	30.8%	104	61.9%
Male	2,131	35.9%	47	28.0%
Other	19	0.3%	5	3.0%
Transgender	15	0.3%	0	0.0%
Unknown/Declined	1942	32.7%	12	7.1%
TOTAL	**5,936**	**100.0%**	**168**	**100.0%**

Race

White/Caucasian individuals are the most prevalent demographic group among both direct SUPT services staff (50.6%) and SUPT beneficiaries (44.7%). Black/African American individuals are underrepresented amongst staff (5.4%) when compared to SUPT beneficiaries (16.3%). In contrast, Asian/Pacific Islander individuals are overrepresented amongst staff (8.3%) when compared to 3.3% of beneficiaries. The Multi-Racial individuals are also overrepresented (19.6% staff , 6.2% beneficiaries). The American Indian/Alaskan Native individuals are similarly represented (1.8% staff, 1.7% beneficiaries), as are individuals represented by "Other" race (1.8% staff, 2.4% beneficiaries). The Hispanic/Latino are slightly underrepresented amongst staff (9.5%) compared to 11.1% of beneficiaries. SUPT beneficiaries were more likely to decline to provide their race (14.3% beneficiaries, 3.0% staff). These findings are outlined in Figure 14 and Table 13 below.

Figure 14. Race - Direct Service Staff Compared to SUPT Beneficiaries*

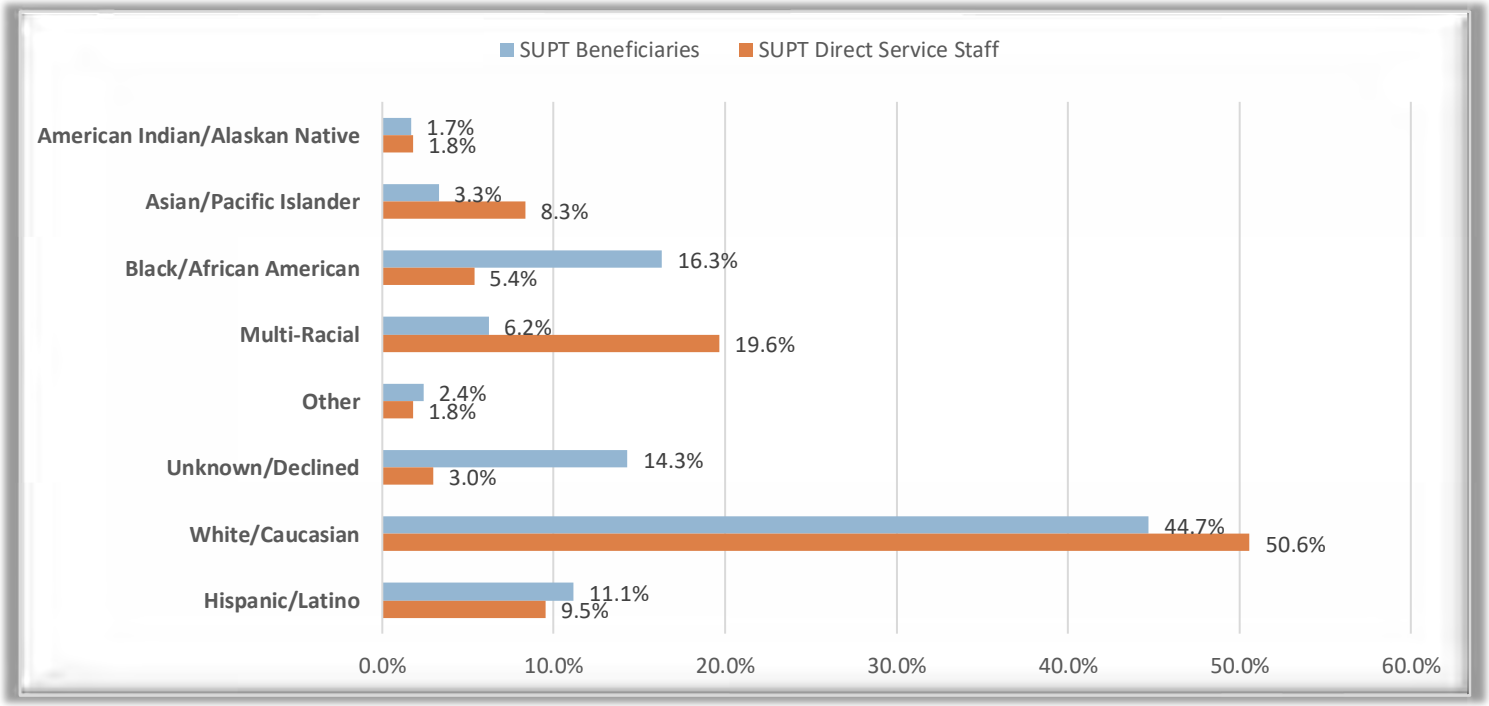


Table 13. Race - Direct Service Staff Compared to SUPT Beneficiaries

RACE	SUPT BENEFICIARIES		SUPT DIRECT SERVICE STAFF	
	N	%	N	%
American Indian/Alaskan Native	100	1.7%	3	1.8%
Asian/Pacific Islander	195	3.3%	14	8.3%
Black/African American	968	16.3%	9	5.4%
Multi-Racial	368	6.2%	33	19.6%
Other	142	2.4%	3	1.8%
Unknown/Declined	849	14.3%	5	3.0%
White/Caucasian	2,653	44.7%	85	50.6%
Hispanic/Latino	661	11.1%	16	9.5%
TOTAL	**5,936**	**100.0%**	**168**	**100.0%**

Sexual Orientation

The most notable difference when comparing direct SUPT services staff and SUPT beneficiaries' sexual orientation is that many beneficiaries (43.3%) chose to not report their sexual orientation at all, compared to only 11.3% of direct staff. Straight/Heterosexual individuals are the predominant sexual orientation reported by both staff (72.6%) and SUPT beneficiaries (52.8%). Staff were overrepresented in the remaining sexual orientation categories, which include Bisexual (4.2% staff, 2.1% beneficiaries), Lesbian/Gay (5.4% staff, 1.3% beneficiaries), and "Other" (6.5 % staff, 0.4% beneficiaries). Figure 15 and Table 14 showcase these similarities and differences.

Figure 15. Sexual Orientation - Direct Service Staff Compared to SUPT Beneficiaries

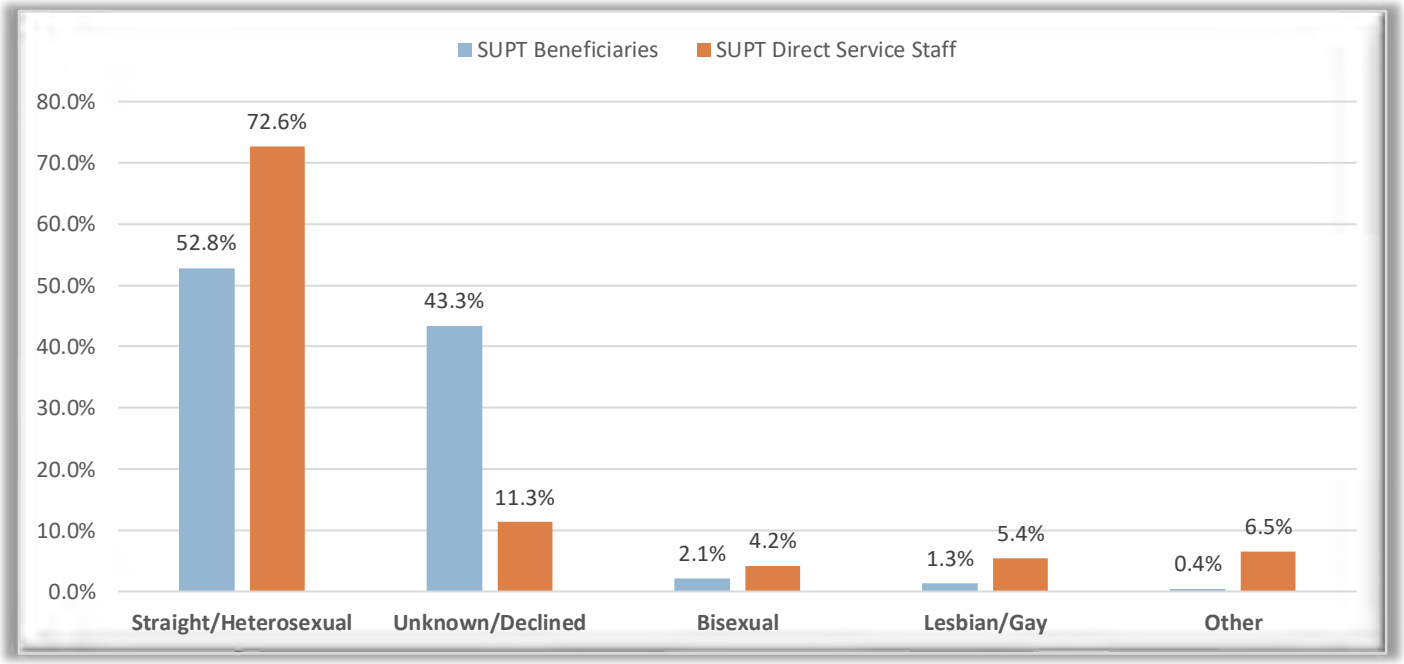


Table 14. Sexual Orientation - Direct Service Staff Compared to SUPT Beneficiaries

SEXUAL ORIENTATION	SUPT BENEFICIARIES		SUPT DIRECT SERVICE STAFF	
	N	%	N	%
Straight/Heterosexual	3,133	52.8%	122	72.6%
Unknown/Declined	2,573	43.3%	19	11.3%
Bisexual	127	2.1%	7	4.2%
Lesbian/Gay	77	1.3%	9	5.4%
Other	26	0.4%	11	6.5%
TOTAL	**5,936**	**100.0%**	**168**	**100.0%**

Language

Overall, English was the most common language reported among both direct SUPT services staff (78.0%) and SUPT beneficiaries (88.5%). In total, staff members were significantly more likely to possess the ability to speak a Non-English language (22.0%) than beneficiaries (2.2%). Similarly, staff were more likely to report having the ability to speak Spanish (9.5% staff, 1.2% beneficiaries) and "Other" languages (12.5% staff, 0.2% beneficiaries). Arabic, Cantonese, Farsi, Hmong, Russian, and Vietnamese have similar representations with very minor variations. Figure 16 and Table 15 showcase similarities and differences between languages spoken by staff and SUPT beneficiaries.

Figure 16. Languages - Direct Service Staff Compared to SUPT Beneficiaries

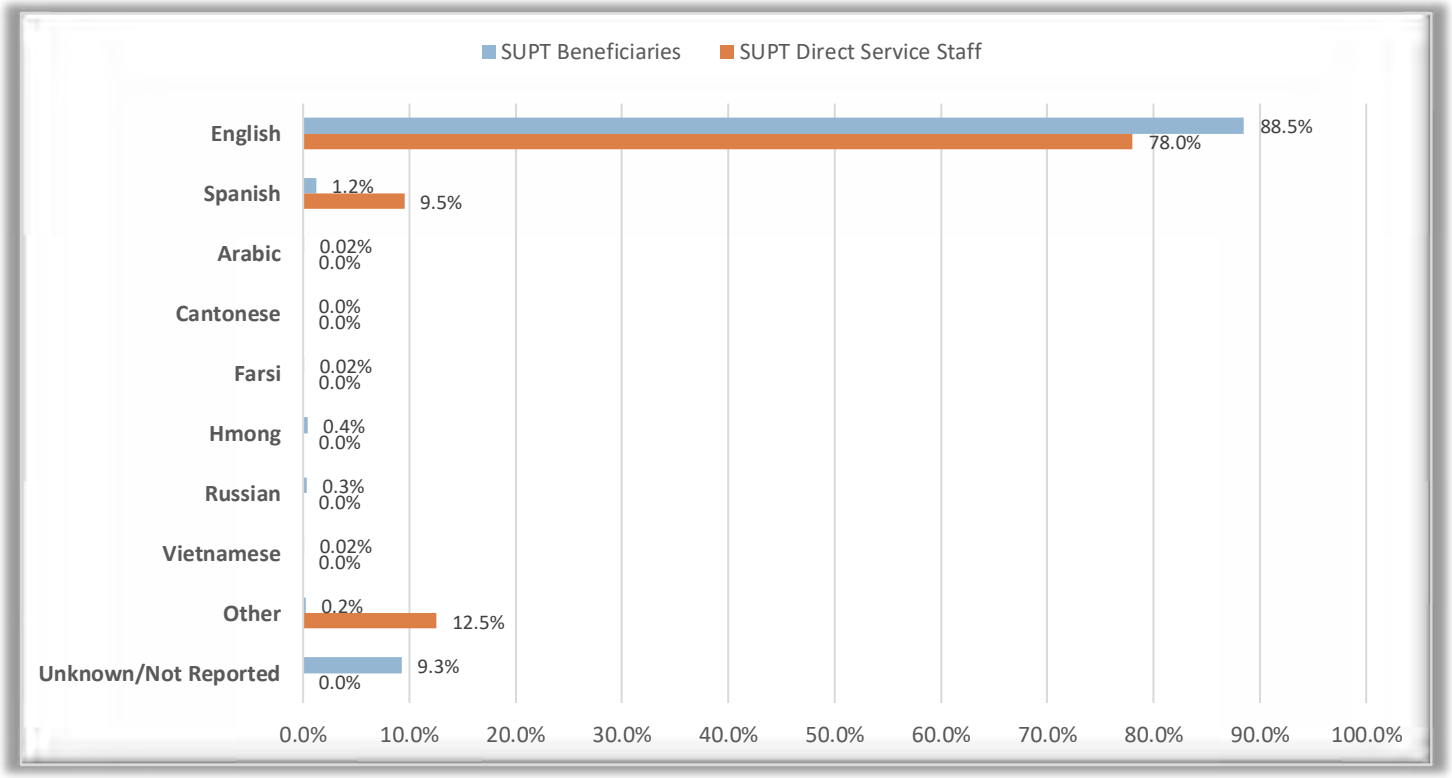


Table 15. Languages - Direct Service Staff Compared to SUPT Beneficiaries

LANGUAGES	SUPT BENEFICIARIES		SUPT DIRECT SERVICE STAFF	
	N	%	N	%
English	5,251	88.5%	131	78.0%
Spanish	73	1.2%	16	9.5%
Arabic	1	0.02%	0	0.0%
Cantonese	0	0.0%	0	0.0%
Farsi	1	0.02%	0	0.0%
Hmong	24	0.4%	0	0.0%
Russian	20	0.3%	0	0.0%
Vietnamese	1	0.02%	0	0.0%
Other	14	0.2%	21	12.5%
Unknown/Not Reported	551	9.3%	N/A	0.0%
TOTAL	**5,936**	**100.0%**	**168**	**100.0%**

APPENDIX A - Position Descriptions by Staff Category

Category	Position Descriptions
MH - DIRECT	**Behavioral Health Peer Provider:** This category includes Medi-Cal certified peer provider. Titles may include Peer Specialist, Consumer Advocate, Peer Mentor, Peer Advocate, Peer Support Aide, Family Advocate, and Family Partner.
	Licensed Mental Health Direct Service Staff: This category includes Psychiatrist, Psychiatric/Family Nurse Practitioner, Clinical Nurse Specialist, Licensed Psychiatric Technician, Licensed Clinical Psychologist, Psychologist registered intern (or waivered), LCSW, MSW registered intern (or waivered), MFT, MFT registered intern (or waivered), and other licensed direct service mental health staff.
	Other Mental Health Care Professionals: This category includes Physician, Registered Nurse, Licensed Vocational Nurse, Physician Assistant, Occupational Therapist, other therapist (physical, recreation, art, dance), or other direct service health care staff. This category can include such titles as traditional cultural healers.
	Unlicensed Mental Health Direct Service Staff: This category includes Mental Health Rehabilitation Specialist (MHRS), Case Manager/Service Coordinator, Employment Services Staff, Housing Services Staff, Consumer Support Staff, Family Member Support Staff, Benefits/Eligibility Specialist, and other unlicensed mental health direct service staff. This category is for all staff classified by the MHP as MHRS, even if the staff duties fall in another category. Service Coordinators, Personal Service Coordinators, and Case Managers belong in this category. Titles may include Job Developer, Employment Consultant, Employment Specialist, Vocational Assistant, Employment Coordinator, Vocational Activities Coordinator, Educational Support Specialist, Employment Aide and Job Coach, Peer Specialist, Consumer Advocate, Peer Mentor, Peer Advocate, Peer Counselor, Parent Partner, Family Member Provider, Family Advocate, Family Partner, Family Member Manager, Family Services Worker, and Family Liaison, Mental Health Treatment Center (MHTC) Workers, and Therapeutic Behavioral Services (TBS) Workers, among others.
MH - INDIRECT	**Mental Health Administrative Staff/Advisory Board/Steering Committee/Other Advisory Groups:** This category includes Analysts, Tech Support, Quality Assurance, Education, Training, Clerical, Secretary, Administrative Assistants, and other administrative staff. This category includes Information Technology support, with titles such as Information Systems/Performance Measurement Staff. Quality assurance includes quality improvement, compliance, and related job titles where the individual's primary duties are in quality assurance. Other job titles may include Staff Development Officer, Training Coordinator, Training Officer, Secretaries, Clerks, Administrative or Office Assistants, Billing Clerk, Medical Records Specialist, Grant Writer, Public Information Officer, Planners and Contract Monitors, Board Members among others.
	Mental Health Managerial and Supervisory Staff: This category includes CEO or manager above direct supervisor, Supervising Psychiatrist (or other physician), Licensed Supervising Clinician and other managers and supervisors. Count positions for licensed and non-licensed managerial and supervisory personnel if 50% of more of the person's time is managerial/supervisory. Job titles may include Program Manager, Service Chief, Health Care Program Manager, Program Director, Assistant Program Director, Nursing Supervisor, Supervising Psychiatric Social Worker, Team Leader, Unit Supervisor, Supervising Case Manager, Supervisor of Clerical Staff, among others.
SUPT - DIRECT	**SUPT Licensed Direct Service Staff:** This category includes Licensed Practitioners of the Healing Arts who provide direct substance use prevention and treatment services: Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologists, Licensed Clinical Social Workers, Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, and licensed eligible practitioners working under the supervision of a licensed clinician.
	SUPT Other Health Care Professionals: This category includes other direct service health care staff such as Occupational Therapists, other therapists (physical, recreation, art, dance), or traditional cultural healers.
	SUPT Registered & Certified Direct Service Staff: This category includes registered and certified staff who provide direct substance use prevention and treatment services: Certified Alcohol Drug Counselor (CADCI, CADCII, CADCIII), Registered Alcohol Drug Technician (RADT, RADTI, RADTII), etc. Job titles may include Case Manager, Service Coordinator, Personal Service Coordinators, Job Developer, Employment Consultant, Employment Specialist, Vocational Assistant, Employment Coordinator, Vocational Activities Coordinator, Educational Support Specialist, Employment Aide and Job Coach, Peer Specialist, Consumer Advocate, Peer Mentor, Peer Advocate, Peer Support Aide, Peer Guide, Peer Coach, and Peer Counselor, Parent Partner, Family Member Provider, Family Advocate, Family Partner, Family Member Manager, Family Services Worker, and Family Liaison, Alumni Liaison or staff.
SUPT - INDIRECT	**SUPT Administrative Services/Advisory Boards/Advisory Board Committees/Other Advisory Groups:** This category includes staff that perform duties that support the provision of substance use prevention and treatment services, but do not provide direct services. Such as program planning, monitoring, evaluation; quality assurance/improvement; information technology/Avatar; fiscal services, training/education; administrative tasks; members of provider agency Boards, the Sacramento County Alcohol and Drug Advisory Board (SCADAB), SCADAB committee members (Prevention and Education Committee, Treatment Committee, Budget and Evaluation Committee, Criminal Justice Committee), Program Coordinator/Contract Monitor, and Administrative Services.
	SUPT Managerial and Supervisory Staff: This category includes positions for licensed, unlicensed, registered, or certified managers and supervisors in which 50% or more of their time is focused on managerial/supervisory duties. Job titles may include Chief Executive Officer (CEO), Executive Director (ED), Clinical Director, Program Director, Division Manager, Program Manager, Team Leader, Unit Supervisor, Supervisor of Clerical Staff, etc.

APPENDIX B – MEDI-CAL MHP BENEFICIARY DEMOGRAPHICS

DEMOGRAPHICS	AGES										TOTAL	
	0-17		18-25		26-59		60+		UNKNOWN			
GENDER IDENTITY	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Female	2,698	10.6%	1,050	4.1%	4,306	16.9%	849	3.3%	0	0.0%	8,903	34.9%
Male	2,631	10.3%	872	3.4%	4,632	18.2%	718	2.8%	0	0.0%	8,853	34.7%
Other	152	0.6%	105	0.4%	91	0.4%	8	0.0%	0	0.0%	356	1.4%
Transgender	76	0.3%	79	0.3%	80	0.3%	3	0.0%	0	0.0%	238	0.9%
Unknown/Declined	2,666	10.5%	853	3.3%	3,071	12.0%	560	2.2%	1	0.0%	7,151	28.0%
SEXUAL ORIENTATION	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Straight/Heterosexual	3,041	11.9%	1,245	4.9%	6,315	24.8%	1,139	4.5%	0	0.0%	11,740	46.0%
Lesbian/Gay	98	0.4%	77	0.3%	226	0.9%	15	0.1%	0	0.0%	416	1.6%
Bisexual	260	1.0%	256	1.0%	397	1.6%	10	0.0%	0	0.0%	923	3.6%
Other	449	1.8%	79	0.3%	62	0.2%	2	0.0%	0	0.0%	592	2.3%
Unknown/Declined	4,375	17.2%	1,302	5.1%	5,180	20.3%	972	3.8%	1	0.0%	11,830	46.4%
RACE	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
American Indian/Alaskan Native	80	0.3%	37	0.1%	228	0.9%	33	0.1%	0	0.0%	378	1.5%
Asian/Pacific Islander	309	1.2%	177	0.7%	793	3.1%	149	0.6%	0	0.0%	1,428	5.6%
Black/African American	1,850	7.3%	797	3.1%	2,947	11.6%	502	2.0%	0	0.0%	6,096	23.9%
Hispanic/Latino	1,490	5.8%	420	1.6%	1,101	4.3%	147	0.6%	0	0.0%	3,158	12.4%
Multi-Racial	1,278	5.0%	376	1.5%	914	3.6%	86	0.3%	0	0.0%	2,654	10.4%
Other	274	1.1%	73	0.3%	292	1.1%	64	0.3%	0	0.0%	703	2.8%
Unknown/Declined	986	3.9%	334	1.3%	1,750	6.9%	271	1.1%	1	0.0%	3,342	13.1%
White/Caucasian	1,956	7.7%	745	2.9%	4,155	16.3%	886	3.5%	0	0.0%	7,742	30.4%
PRIMARY LANGUAGE	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Arabic	8	0.0%	3	0.0%	31	0.1%	8	0.0%	0	0.0%	50	0.2%
Cantonese	14	0.1%	2	0.0%	24	0.1%	11	0.0%	0	0.0%	51	0.2%
English	7063	27.7%	2,675	10.5%	10,785	42.3%	1824	7.2%	1	0.0%	22,348	87.6%
Farsi	14	0.1%	5	0.0%	35	0.1%	5	0.0%	0	0.0%	59	0.2%
Hmong	6	0.0%	2	0.0%	81	0.3%	18	0.1%	0	0.0%	107	0.4%
Other	34	0.1%	18	0.1%	154	0.6%	63	0.2%	0	0.0%	269	1.1%
Russian	37	0.1%	7	0.0%	96	0.4%	39	0.2%	0	0.0%	179	0.7%
Spanish	765	3.0%	104	0.4%	201	0.8%	38	0.1%	0	0.0%	1,108	4.3%
Unknown/Declined	274	1.1%	138	0.5%	721	2.8%	112	0.4%	0	0.0%	1,245	4.9%
Vietnamese	8	0.0%	5	0.0%	52	0.2%	20	0.1%	0	0.0%	85	0.3%
TOTAL	**8,223**	**32.2%**	**2,959**	**11.6%**	**12,180**	**47.8%**	**2,138**	**8.4%**	**1**	**0.0%**	**25,501**	**100.0%**

APPENDIX C - MEDI-CAL SUPT BENEFICIARY DEMOGRAPHIC

DEMOGRAPHICS	AGES								TOTAL	
	0-17		18-25		26-59		60+			
GENDER IDENTITY	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Female	48	0.8%	142	2.4%	1,476	24.9%	163	2.7%	1,829	30.8%
Male	94	1.6%	184	3.1%	1,715	28.9%	138	2.3%	2,131	35.9%
Other	1	0.0%	2	0.0%	14	0.2%	2	0.0%	19	0.3%
Transgender	0	0.0%	4	0.1%	11	0.2%	0	0.0%	15	0.3%
Unknown/Declined	96	1.6%	119	2.0%	1,507	25.4%	220	3.7%	1,942	32.7%
SEXUAL ORIENTATION	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Straight/Heterosexual	112	1.9%	261	4.4%	2,561	43.1%	199	3.4%	3,133	52.8%
Lesbian/Gay	3	0.1%	8	0.1%	62	1.0%	4	0.1%	77	1.3%
Bisexual	10	0.2%	22	0.4%	94	1.6%	1	0.0%	127	2.1%
Other	3	0.1%	4	0.1%	19	0.3%	0	0.0%	26	0.4%
Unknown/Declined	111	1.9%	156	2.6%	1,987	33.5%	319	5.4%	2,573	43.3%
RACE	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
American Indian/Alaskan Native	4	0.1%	5	0.1%	80	1.3%	11	0.2%	100	1.7%
Asian/Pacific Islander	8	0.1%	18	0.3%	154	2.6%	15	0.3%	195	3.3%
Black/African American	71	1.2%	86	1.4%	707	11.9%	104	1.8%	968	16.3%
Hispanic/Latino	36	0.6%	70	1.2%	510	8.6%	45	0.8%	661	11.1%
Multi-Racial	33	0.6%	61	1.0%	266	4.5%	8	0.1%	368	6.2%
Other	6	0.1%	16	0.3%	110	1.9%	10	0.2%	142	2.4%
Unknown/Declined	33	0.6%	48	0.8%	665	11.2%	103	1.7%	849	14.3%
White/Caucasian	48	0.8%	147	2.5%	2,231	37.6%	227	3.8%	2,653	44.7%
PRIMARY LANGUAGE	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Arabic	0	0.0%	0	0.0%	1	0.0%	0	0.0%	1	0.0%
Cantonese	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
English	208	3.5%	413	7.0%	4,191	70.6%	439	7.4%	5,251	88.5%
Farsi	0	0.0%	0	0.0%	1	0.0%	0	0.0%	1	0.0%
Hmong	0	0.0%	0	0.0%	13	0.2%	11	0.2%	24	0.4%
Other	0	0.0%	0	0.0%	11	0.2%	3	0.1%	14	0.2%
Russian	1	0.0%	0	0.0%	18	0.3%	1	0.0%	20	0.3%
Spanish	6	0.1%	8	0.1%	53	0.9%	6	0.1%	73	1.2%
Unknown/Declined	24	0.4%	30	0.5%	435	7.3%	62	1.0%	551	9.3%
Vietnamese	0	0.0%	0	0.0%	0	0.0%	1	0.0%	1	0.0%
TOTAL	**239**	**4.0%**	**451**	**7.6%**	**4,723**	**79.6%**	**523**	**8.8%**	**5,936**	**100.0%**

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Mental Health Services Act (MHSA) Annual Update
Funding Summary

A. Community Services and Supports (CSS) Component

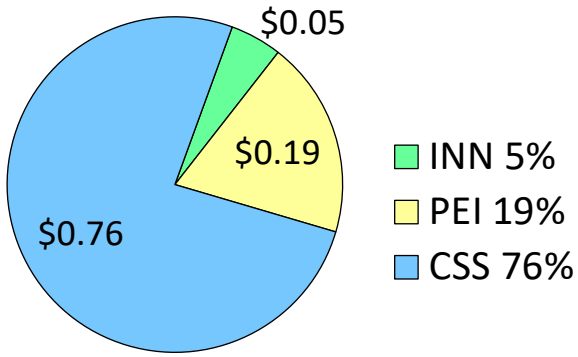
- Provides funding for mental health treatment services and supports for children/youth and their families living with severe emotional disturbance and adults living with a serious mental illness. This includes funding for the MHSA Housing Program.
- A majority of CSS funding must be directed to Full Service Partnership programs
- Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years
  - This means unspent CSS funding is combined with incoming revenue to sustain CSS programming/activities, as well as sustaining critical activities in the time-limited WET and CF/TN components, sustaining successful and applicable INN project components
  - Unspent CSS funding must also be used to sustain MHSA Housing Program investments
- 76% of each MHSA dollar is directed to the CSS Component (see funding chart below)

B. Prevention and Early Intervention (PEI) Component

- Provides funding for programs and activities designed to prevent mental illness from occurring or becoming more severe and disabling
- A majority of PEI funding must be directed to ages 0-25
- 19% of each MHSA dollar is directed to the PEI Component (see funding chart below)

C. Innovation (INN) Component

- Provides funding to test new and/or improved mental health practices or approaches with the goal of increasing access (including access for underserved groups), increasing the quality of services, or promoting interagency collaboration
- Projects can span up to 5 years – If successful, other funding must be identified to sustain
- Successful INN projects may be sustained by CSS/PEI components (as applicable), if County so chooses
- All new or changed INN projects must be approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC)
- 5% of each MHSA dollar is directed to the INN Component (see funding chart below)



D. Workforce Education and Training (WET) Component

- Provides time limited funding with a goal to recruit, train and retain diverse culturally and linguistically competent staff for the public mental health system and ensure they are adequately trained to provide effective services and administer programs based on wellness and recovery
- WET activities must be sustained by CSS funding once dedicated WET funding is exhausted

E. Capital Facilities and Technological Needs (CF/TN) Component

- Capital Facilities (CF) project – Time limited funding used to renovate the Adult Psychiatric Support Services (APSS) clinic, Peer Partner Program and INN 2 Project (Mental Health Urgent Care Clinic)
- Technological Needs project – Time limited funding to address our commitment to move to an Electronic Health Record and Personal Health Record to improve client care through a multi-phased approach
- CF/TN activities must be sustained by CSS funding once dedicated CF/TN funding is exhausted

F. Prudent Reserve

- Per Welfare and Institutions Code, each County must establish and maintain a prudent reserve to ensure the county program will continue to be able to serve children, adults, and seniors during years in which revenues for the Mental Health Services Fund are below recent averages

G. Overarching Points

- Mental Health Services Act (MHSA) funding is generated by a 1% tax on personal income in excess of $1M
  - As income tax-based revenue, MHSA funding is greatly impacted by the economy (impacts lag by approximately 2 years)
  - MHSA revenue is volatile and difficult to project
- In FY 2024-25, Sacramento County allocation decreased from 3.54% to 3.44% of State MHSA funding due to statewide recalculation distribution

CAL VOICES

ADVOCACY • RECOVERY • PEER SUPPORT

2024 PEER TOOLKIT FOR WORKPLACE SUCCESS

SACRAMENTO COUNTY

The Certified Peer Support Specialist Leadership Liaison Program is a collaborative program of Cal Voices and Sacramento County Department of Health Services, Division of Behavioral Health Services, funded through the voter-approved Proposition 63, the Mental Health Services Act.

2024 PEER TOOLKIT FOR WORKPLACE SUCCESS

Welcome

Welcome to the 2024 Cal Voices Peer Toolkit for Workplace Success (Toolkit). This Toolkit provides a handy reference guide for Peers to help them achieve workplace success in the Public Behavioral Health System (PBHS). The Toolkit provides tools, resources, best practices, and workplace supports related to maintaining peer employment in the PBHS. Both certified and non-certified peers will be able to use these vital resources to succeed in their current positions.

In this toolkit, you will find information on the following topics:

- California's Medi-Cal Peer Support Specialist Certification Background
- Peer Support and Recovery-Oriented Care
- Core Competencies for Certified Medi-Cal Peer Support Specialists (CMPSS)
- Ethics, Boundaries, and Confidentiality
- Tools and Tips for Maintaining Employment
- Self-Care for Certified Medi-Cal Peer Support Specialists (CMPSS)

This toolkit will be revised on an annual basis through 2026 based on feedback and reflections received and observed by Peer Support Specialists and Peer Employers. To provide feedback or to share training and informational needs, please email us at peerleadership@calvoices.org.

Overview

The Mental Health Services Act (MHSA) requires Counties to utilize funding to establish peer support and family education support services or expand these services to meet the needs and preferences of clients and/or family members (9 CCR § 3610(d)). Despite the MHSA's mandate to employ peers throughout the PBHS, consumers and family members are starkly underrepresented amongst the staff of county behavioral health departments and their contracted Community Based Organizations. Peers who are fortunate enough to gain employment in the PMHS are often marginally employed, relegated to stagnant entry-level positions, and struggling to make a living wage. Current training approaches have focused primarily on the peer role and the values/goals of the consumer movement, which do little to provide peers with practical skills and hands-on training experiences. Nor do these courses address systemic barriers to peer job placement and career advancement. Peers are often left to chart their own courses in low paying positions with little or no professional development, which is essential to peers' lasting professional success.

To elevate the peer role throughout the PBHS and help peers accomplish long-term career objectives, peers require comprehensive training and support to build and reinforce the core competencies, work-related skills, and foundational knowledge necessary to the effective practice of peer support. While peer support is a recognized evidence-based practice, it only works when done correctly. Peers need access to quality educational resources to ensure they are well prepared to perform the duties of their

positions, while PMHS organizations and their supervisory staff require ongoing evaluation, guidance, strategies, tools, and support to achieve a truly integrated workforce that welcomes and values peers' unique contributions.

About Cal Voices

Founded in 1946, Cal Voices is California's oldest Peer-run mental health advocacy agency. Cal Voices has worked in County Behavioral Health Systems for over four decades, employing peers in a variety of programs including wellness centers, warmlines, county operated clinics, and advocacy and training programs.

Cal Voices is a proud recipient of the Platinum Mental Health America's Bell Seal for Workplace Mental Health. The Bell Seal for Workplace Mental Health is a distinction awarded by Mental Health America (MHA) to companies that meet mentally healthy workplace standards. Cal Voices' status as a Platinum Bell Seal-certified organization demonstrates Cal Voices' outstanding commitment to employee mental health and well-being. To learn more, visit: mhanational.org/bestemployers.

Over 95% of our staff identify as consumers, family members, and/or parents/caregivers including our entire Executive Leadership team and all of our program managers. Since 2015, Cal Voices has trained, coached, and mentored thousands of Peers in California to build their knowledge and expertise. We have conducted key informant interviews, organizational assessments, training, and technical assistance for hundreds of counties and Peer providers in California's Public Behavioral Health System (PBHS).

Certified Peer Support Specialists Leadership Liaison Program

The Certified Peer Support Specialist Leadership Liaison Program is for Sacramento County BHS service providers. The Program works to:

- Expand the number of diverse Certified Medi-Cal Peer Support Specialists (CMPSS)
- Increase the tools and resources available to support Medi-Cal Peer Support Services in Sacramento County
- Increase the knowledge of CMPSS staff relating to the evidence-based practice of peer support
- Increase BHS providers' knowledge about developing, expanding, and retaining a diverse peer workforce.

Glossary of Terms

Client

A general term for consumer or family member/caregiver who receives peer support services.

Consumer

An adult living with a behavior health challenge.

California Department of Health Care Services (DHCS)

Finances and administers a number of individual health care service delivery programs, including Medi-Cal, which provides health care services to low-income people.

California Mental Health Service Authority (CalMHSA)

CalMHSA is a Joint Powers of Authority (JPA) formed in 2009 by counties throughout the state to work on collaborative, multi-county projects that improve behavioral health care for all Californians. By pooling resources, forging partnerships, and leveraging technical expertise on behalf of counties, CalMHSA develops strategies and programs with an eye toward transforming community mental health; creates cross-county innovations; and is dedicated to addressing equity to better meet the needs of our most vulnerable populations. CalMHSA is also the certifying entity for Medi-Cal Peer Support Specialist Certification.

Family Member/Caregiver

A family member or caregiver of someone who has a behavioral health challenge. The family member or caregiver may provide/receives support from other family members or caregivers.

Lived Experience

Refers to an individual's first-hand experience with a mental health and/or substance use challenge.

Certified Medi-Cal Peer Support Specialist (CMPSS)

A peer certified by the State of California who provides reimbursable peer support services.

Mental Health Service Act (MHSA)

The MHSA was passed by California voters in 2004 and is funded by a one percent income tax on personal income in excess of $1 million per year. It is designed to expand and transform California's behavioral health system to better serve individuals with, and at risk of, serious mental health challenges, and their families. MHSA addresses a broad continuum of prevention, early intervention, and service needs and the necessary infrastructure, technology, and training elements that effectively support the public behavioral health system.

Peer

For this Toolkit, a peer refers to someone who has experienced the healing process of recovery from psychiatric, traumatic and/or substance use challenges and, as a result, can offer assistance and support to promote another peer's own personal recovery journey. The peer support volunteers to share portions of his or her recovery experience in an appropriate and effective manner.

Peer Support

Peer support is the process of giving and receiving non-clinical assistance to achieve long-term recovery from severe psychiatric, traumatic or addiction challenges. This support is provided by peer supporters - people who have "lived experience" and have been trained to assist others in initiating and maintaining long-term recovery and enhancing the quality of life for individuals and their families. Peer support services are inherently designed, developed, delivered, evaluated and supervised by peers in long-term recovery.

Peer Support Relationship

The qualities that make an effective peer supporter are best defined by the individual receiving support, rather than by an organization or provider of care. Matching peer supporters with peers often encompasses shared cultural characteristics, such as age, gender, ethnicity, language, sexual orientation, co-occurring challenges, and experience in the military or with the criminal justice system or any other

identity-shaping life experience that increases common language, mutual understanding, trust, confidence and safety.

Peer Support Services

Peer Support Services are provided by Peer Support Specialists. A Peer Support Specialist is an individual with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification and who meets all other applicable California state requirements, including ongoing education requirements.

Public Behavioral Health System (PBHS)

Publicly-funded behavioral health programs/services and entities that are administered, in whole or in part, by the County. It does not include programs and/or services administered, in whole or in part, by federal, state, county or private correctional entities or programs and/or services provided in correctional facilities. The facility must be contracted or sub-contracted with the County.

Substance Abuse and Mental Health Administration (SAMHSA)

SAMHSA is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation and to improve the lives of individuals living with mental and substance use challenges, and their families.

MEDI-CAL PEER SUPPORT SPECIALIST CERTIFICATION

Background

Peers became eligible for certification in California with the with the passage of SB 803 in 2020. SB 803 recognized Certified Medi-Cal Peer Support Specialists as a distinct Medi-Cal provider type. It also established that Peer Support Specialist Services delivered by CMPSS workers to Medi-Cal clients were eligible for federal reimbursement.

The California legislature had specific goals in mind when introducing SB 803. Through this legislation, they intend to achieve all of the following[1]:

(a) Support the ongoing provision of services for individuals experiencing mental health care needs, substance use disorder needs, or both, by certified peer support specialists.

(b) Support coaching, linkage, and skill building of individuals with mental health needs, substance use disorder needs, or both, and to families or significant support persons.

(c) Increase family support by building on the strengths of families and helping them achieve a better understanding of mental illness in order to help individuals achieve desired outcomes.

(d) Support collaboration with others providing care or support to the individual or family.

(e) Assist parents, families, and individuals in developing coping mechanisms and problem-solving skills in order to help individuals achieve desired outcomes.

(f) Promote skill building for individuals in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

(g) Encourage employment under the peer support specialist certification to reflect the culture, ethnicity, sexual orientation, gender identity, mental health service experiences, and substance use disorder experiences of the individuals the peer support specialists serve.

Additionally, establishing the CMPSS certification in California has potential to improve the experience of those working in CMPSS roles:

- Legitimizes Peer Support Services
- Elevates the role of Peer Support workers
- Creates a distinct category of paraprofessionals that can collectively advocate for better pay, benefits, and working conditions for all Peers
- Improves effectiveness of services and supports:
    - Diversifies behavioral health workforce

[1] *California Legislative Information. Senate Bill SB-803 Mental Health Services: Peer Support Specialist Certification, 2020.*

  - Expands availability of Peer services (and job opportunities for consumers)
  - Provides consistent core competencies, education standards, code of ethics, and scope of practice/services for Peer professionals
- Generates greater revenue for services that already exist
- On the other hand, certification may mean higher wages and greater opportunities for advancement. Consider the trade-offs and your long-term career goals when considering certification.

The State defines Peer Support Services provided by CMPSS workers as culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower beneficiaries through strength-based coaching, support linkages to community resources, and to educate beneficiaries and their families about their conditions and the process of recovery.

Specifically, CMPSS Peer Support Services include the following service components[2]:

- Educational Skill Building Groups: Providing a supportive environment in which beneficiaries and their families learn coping mechanisms and problem- solving skills in order to help the beneficiaries achieve desired outcomes. These groups promote skill building for the beneficiaries in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.
- Engagement: Peer Support Specialist led activities and coaching to encourage and support beneficiaries to participate in behavioral health treatment. Engagement may include supporting beneficiaries in their transitions between levels of care and supporting beneficiaries in developing their own recovery goals and processes.
- Therapeutic Activity: A structured non-clinical activity provided by a Peer Support Specialist to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the beneficiary's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the beneficiary; promotion of self-advocacy; resource navigation; and collaboration with the beneficiaries and others providing care or support to the beneficiary, family members, or significant support persons. Non-certified are funded to provide these services by other means, such as grants or MHSA funding.

Certified Medi-Cal Peer Support Specialists are able to bill for Peer Services using two Procedure Codes:

- Behavioral Health Prevention Education Services (Educational Skill Building Groups – see description above)
- Self-Help/Peer Services (Engagement and Therapeutic Activities – see description above)

[2] *Department of Health Care Services. Behavioral Health Information Notice No. 22-026: Drug Medi-Cal(DMC), Drug Medi-Cal Organized Delivery System (DMC-ODS) and Specialty Mental Health Services (SMHS) Peer Support Services, 2022.*

Becoming a Certified Medi-Cal Peer Support Specialist

The California Mental Health Services Authority (CalMHSA) is the certifying body in California for the CMPSS Certification. Although each County may develop their own peer support specialist certification program, the California Behavioral Health Directors Association voted to appoint CalMHSA as the administrator of the Certification program for counties to ensure consistency statewide.

Peers interested in certification must complete the Initial Certification process. Certification is administered by CalMHSA through established policies, procedures, and documents specific to the certification program. Peer Support Specialists certified through the certification program administered by CalMHSA will be recognized as Medi-Cal Peer Support Specialists by all counties who elect to participate in the Medi-Cal Peer Benefit under agreement with the Department of Health Care Services.

Eligibility Requirements

1. Be at least 18 years of age.
2. Possess a high school diploma or equivalent degree.
3. Be self-identified as having experience with the process of recovery from a mental health or substance use challenge, either as a consumer of these services or as the parent, caregiver or family member of a consumer.
4. Be willing to share their experience.
5. Have a strong dedication to recovery.
6. Agree, in writing, to adhere to the Code of Ethics.
7. Successfully complete the 80-hour training requirements for a peer support specialist (must be from an approved training vendor)
8. Pass the certification examination.

Peers should apply for certification once they meet all of the above eligibility requirements and have documentation proving they meet all eligibility requirements (e.g., certificate proving you have successfully passed the 80-hour training requirement). If CalMHSA approves an application they let candidates know they are eligible to take the Certification Exam. Once a Peer passes the Certification Exam, CalMHSA will issue a Medi-Cal Peer Support Specialist Certification to them.

Fees

There are a number of fees related to the CMPSS Certification:

- Certification Application: $100.00
- Certification Exam: $150.00
- Certification Exam retake: $150.00
- Certification Renewal Application Fee (every two years): $80.00

Certification Renewal

Certification must be renewed every two years. CalMHSA will send a notification of renewal via email to eligible individuals 90 days prior to date of expiration. CalMHSA will use the email address on file. Expired, suspended, and revoked certifications are not considered in good standing and therefore not eligible for renewal.

To be eligible for renewal, peers must complete 20 hours of Continuing Education every two years from the date of the initial certification and thereafter for biennial renewal. Courses may be taken in various ways, including asynchronous, in-person, and online and through a variety of trainers.

- Six hours of law and ethics training are required during each two-year cycle.
- Applicants are responsible for taking CE courses within their scope of practice.
- Training courses must be non-repetitive (e.g., the same CE course cannot be claimed more than one time during each certification period, even if the course was taken annually).

Training Topics within the CMPSS Scope of Practice

- Courses fundamental to the understanding or practice of peer support;
- Courses of the discipline of peer support in which significant recent developments have occurred;
- Courses of other disciplines that enhance the understanding of the practice of peer support specialists; and
- Courses related to the treatment of the client population being served (e.g., theoretical frameworks of recovery and wellness; intervention techniques with individuals, families, and systems of care).
- Medi-Cal Peer Support Specialist certification training and training in areas of specialization (CalMHSA-approved training providers).
- Courses that cover pragmatic aspects of clinical practice (e.g., legal or ethical issues, consultation, recordkeeping, supervision training).

Law and Ethics

CalMHSA identifies the following topic areas related to Law and Ethics:

- Law and ethics relevant to California
- Treatment of minors
- State and federal confidentiality laws
- Record keeping
- Crisis support
- Client access to records
- Dual relationships
- Child abuse
- Elder and dependent adult abuse
- Telehealth services
- Insurance reimbursement
- Civil liability
- Disciplinary actions and unprofessional conduct
- Ethics complaints and ethical standards
- Standards of care
- Relevant family law
- Disclosures to clients
- The application of legal and ethical standards in different types of work settings, etc.

Continuing Education Providers

For continuing education (CE) hours towards renewal of certification, CalMHSA will accept CE hours for the following:

- CalMHSA CE approved training providers
- The following pre-approved courses taught by CalMHSA-approved training providers
  - Medi-Cal Peer Support Specialist Core Competency Training
  - Peer Services Specialized Training
- Training that is offered by the County Behavioral Health Departments, and its contracted network providers.
- Training courses completed through accredited schools, including vocational education.
- Training courses by professional certification and licensing boards (i.e., CAADE, CADTP, CAMFT, BBS, APA).

Specialization

Certified Peers may choose to also obtain an area of specialization. The CalMHSA Guidelines, Standards and Procedure Manual states that these areas of specialization "will build on the knowledge, skills, and abilities of Medi-Cal Peer Support Specialists" (p. 16)[3].

Currently, there are only 4 areas of specialization:

- Parent, Caregiver, and Family Member Peers
- Crisis Services
- Forensic (Justice Involved)
- Homelessness

Specialization trainings take 40 hours to complete. When choosing whether to obtain an area of specialization, consider whether your employer requires you to be trained in an area of specialization and if they will provide you with the time and financial support to complete a specialization training.

Peers apply for specialization through CalMHSA and must have a current Medi-Cal Peer Support Specialist Certification in good standing. Peers must complete a specialization registration form and specialization training. Specialization training must be taught by a CalMHSA approved training vendor. There is no specialization exam and peers do not have to complete biennial Specialization CE hours.

Specialization areas were determined by the Department of Health Care Services (DHCS).[4]

Any supplemental areas of specialization must be approved by DHCS. A Medi-Cal Peer Support Specialist Certification Program (CalMHSA) may add supplemental areas of specialization at their own discretion; however, they must first submit the curriculum and core competencies for the area of specialization to DHCS by May 1 prior to the start of the State Fiscal Year (SFY) (July 1 – June 30) in which the area of specialization will start. Medi-Cal Peer Support Specialist Certification Programs are the only entities that can submit curriculum and core competencies for a supplemental area of specialization. This process will occur every SFY for any new areas of specialization.

[3] *https://www.capeercertification.org/guideline-standards-procedure-standards/*

[4] *Department of Health Care Services, Behavioral Health Information Notice 22-061, 2022*

Stay Informed

Stay up-to-date on California's Medi-Cal Peer Support Specialist Certification Program:

- California Mental Health Services Authority (CalMHSA)
  County behavioral health plans selected CalMHSA to implement a single, standardized Medi-Cal Peer Support Specialist certification program, including: creating and implementing the certification program; approving training entities; certifying individuals; conducting investigations and collecting data; administering and disbursing scholarships; monitoring program activities, evaluation and quality assurance; and processing complaints and appeals.
  Email: PeerCertification@calmhsa.org | Phone: (279) 234-0699 | Web: www.californiapeers.org

- CalMHSA Medi-Cal Peer Certification Stakeholder Advisory Council
  The Advisory Council serves as an avenue for ongoing stakeholder feedback related to the Medi-Cal Peer Support Specialist Certification Program. Email: PeerCertification@calmhsa.org
  Phone: (279) 234-0699 | Web: https://www.calmhsa.org/peer-certification/

- Department of Health Care Services (DHCS)
  DHCS has statutory authority to establish Medi-Cal statewide certification program standards. DHCS ensures adherence to all federal and state requirements.
  Email: Peers@dhcs.ca.gov | Phone: (916) 440-7800
  Web: https://www.dhcs.ca.gov/services/Pages/Peer-Support-Services.aspx

- California Association of Peer Professionals
  The California Association of Peer Professionals (CAPP) is a program of Cal Voices. The membership-based program provides services and benefits to both certified and non-certified behavioral health peer professionals in California, with an emphasis on education, practice guidelines, professional standards, working conditions, career development, and competent supervision.
  Email: capp@calvoices.org | Web: www.californiapeers.org

PEER SUPPORT AND RECOVERY-ORIENTED CARE

Overview of Peer Support

To understand peer support it is helpful to understand what is meant by common terms.

Peer

In this toolkit a peer refers to someone who has experienced the healing process of recovery from psychiatric, traumatic and/or substance use challenges and, as a result, can offer assistance and support to promote another peer's own personal recovery journey. The peer support volunteers to share portions of his or her recovery experience in an appropriate and effective manner.

Others also refer to peers as someone living with a psychiatric, traumatic and/or substance use challenge.

Peer Support

Peer support is a system of giving and receiving non-clinical assistance to achieve long-term recovery from severe psychiatric, traumatic or addiction challenges.

Lived Experience

Peers are two people who have similar life experiences or come from similar backgrounds; they have Common Lived Experience. Lived Experience is the circumstances, situations, and events someone has directly (not vicariously) gone through that carry a particular meaning or significance for them. Peer Support is a system of giving and receiving help based on key principles that include shared responsibility, and mutual agreement of what is helpful. It's not uncommon for people with similar Lived Experiences to offer each other practical advice and suggestions for strategies that other professionals may not offer or even know about.

How is Peer Support Different?

The primary distinction between Peer Support services and other behavioral health services is that Peers draw upon their personal Lived Experience and experiential knowledge in their approach to helping others. It is a relationship of equals. Peers support is grounded in the fact that there are many pathways to recovery and that progress is determined based on client achievement of self-defined goals.

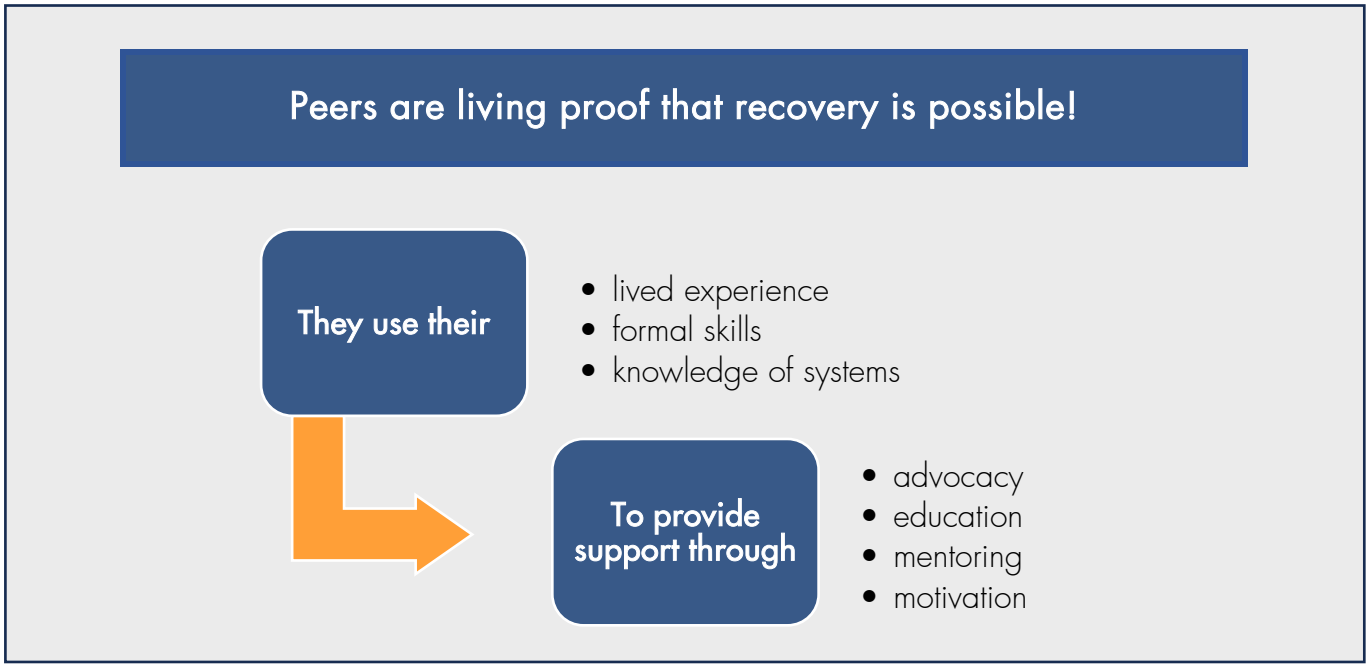
Peers can play many roles in supporting people living with mental health and/or substance use challenges:

- Support groups
- Peer counseling
- Advocacy
- Personal plan creation
- Wellness Recovery Action Plan Facilitator
- Engagement
- Socialization
- Cultural brokerage
- Service referrals
- Health education/ navigation
- Systems navigation
- Benefits acquisition
- Crisis intervention
- Natural support development

The Peer Formula

Peers share their Lived Experience with others experiencing a similar life challenge. They **use** their Lived Experience to create an authentic connection and **model** how they overcame their challenge(s) to **inspire** and **motivate** others who are now going through it. Peers must have the same Lived Experience as the clients they are serving.

1. Lived Experience of a specific life challenge
    a. Consumers: Having a behavioral health condition
    b. Family Members: Caring for someone with a behavioral health condition
2. Lived Experience of overcoming this life challenge
    a. Consumers: Recovering from a behavioral health condition
    b. Family Members: Achieving resiliency and self-care



Evidence shows Peer Support reduces:

- Number of admissions and days spent in hospitals
- Use of acute services (e.g., ERs/detox centers)
- Substance use
- Depression and demoralization
- Average service costs per person

Evidence shows Peer Support increases:

- Time in the community
- Engagement in outpatient treatment
- Active involvement in care planning and self-care
- Hope, quality of life, and satisfaction with life
- Rates of family reunification
- Social functioning
- Chances for long-term recovery

What is Recovery?

In the general sense, recovery refers to the regaining of something that was lost or taken away. There are a number of other generic definitions of recovery that apply in many contexts, but each definition implies the loss of something that is later restored or regained. In the behavioral health context, we talk about recovery as alleviation of the ongoing mental or emotional distress, or the undesired symptoms and impacts of a behavioral health challenge. What recovery from a behavioral health challenge looks like is different for different people. It is a process and an outcome.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance use and mental health challenges on America's communities. Congress established the SAMHSA in 1992 to make substance use and health information, services, and research more accessible. It is SAMHSA's mission to reduce the impact of substance use and mental health challenges on America's communities.

SAMHSA developed the following working definition of recovery by engaging key stakeholders in the mental health consumer and substance use recovery communities:

Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.[5]

Throughout this Toolkit, the term "recovery" refers to this definition. This definition does not describe recovery as an end state, but rather as a process. Complete symptom remission is neither a prerequisite of recovery nor a necessary outcome of the process. According the SAMHSA Working Definition of Recovery, recovery can have many pathways that may include "professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches."[6]

The goal of the Recovery Model is to improve lives. Fundamentally, recovery is subjective. A person's recovery is driven by their personal lived experience of mental health and/or substance use challenges and wellness. It is a journey. Recovery outcomes include empowerment, hope, self-advocacy, choice, self-identified goals, healing, well-being, and control of symptoms. Care is person-focused and one's diagnosis is not permanent. It can be cured.

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5 Substance Abuse and Mental Health Services Administration. SAMHSA's Working Definition of Recovery. PEP12-RECDEF, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2012.

6 Substance Abuse and Mental Health Services Administration. SAMHSA's Working Definition of Recovery. PEP12-RECDEF, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2012.

4 Major Definitions of Recovery

SAMHSA also identified 4 major dimensions that contribute and support a life in recovery. These are Health, Home, Purpose and Community.

Health

Overcoming or managing one's disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and for everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing.

Home

A stable and safe space to live

Purpose

Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society

Community

Relationships and social networks that provide support, friendship, love, and hope

Recovery in Mental Health and Substance Use

Mental health and substance use prevention and treatment services are becoming more integrated under the single category of "behavioral health". These services have historically had different definitions of recovery that predate this merger. Each arose from shared understandings of the nature of illness reinforced over time within their respective fields, and the systems, institutions, paradigms, and consumer cultures that grew up around these fields

The culture is different!

Mental Health Culture	Substance Use Culture
Psychosocial factors, social determinants, trauma	Individual behaviors, personal decisions
Mental illness is something that happens to you	Substance misuse is something you cause to happen
"You are product of your environment"	"You are a product of your choices and actions"
"Client/Consumer"	"Addict/User"

The traditional approach to substance misuse treatment and recovery falls somewhere between the Medical Model and Recovery Model. SAMHSA's Working Definition of Recovery applies equally to mental health and substance misuse challenges. These recovery principles, concepts, and definitions are universal in that recovery-oriented services focus on clients' individual goals, strengths, challenges, and barriers, not their diagnosis.

SAMHSA's 10 Guiding Principles of Recovery[7]

SAMHSA developed 10 Guiding Principles of Recovery essential to recovery from a behavioral health issue. These principles promote healing and positivity during one's recovery journey.

Hope

Hope is the catalyst of the recovery process. People can and do overcome internal and external challenges, barriers, and obstacles. Hope is fostered by peers, family members, providers and allies.

Person-Driven

Recovery is based on self-determination and self-direction. Clients define their own life goals and unique paths towards these goals. They exercise choice over services and treatments.

Many Pathways

Recovery occurs via many pathways. It is highly personalized and may include different treatments, services, and supports. The recovery process is not linear and may involve setbacks.

Holistic

Recovery encompasses whole life, including mind, body spirit and community

Peer Support

Recovery is supported by peers and allies. Peers encourage one another and provide a vital sense of belonging, supportive relationships, valued roles and community.

Relational

Recovery is supported through relationships and social networks. Positive relationships help clients engage in new roles, achieve a greater sense of belonging, and find new strategies for change.

Culture

Recovery is culturally based and influenced. Culture or background keys in determining a person's unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet each individual's unique needs

Addresses Trauma

Recovery is supported by addressing trauma. Trauma is often a precursor to or associated with mental health challenges and related issues/ Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.

Strengths/Responsibility

Recovery involves individual, family, and community strengths and responsibility. Individuals, families, and communities have strengths and resources that serve as a foundation for recovery.

Respect

Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use challenges—including protecting their rights and eliminating discrimination—are crucial. Taking steps towards recovery often requires great courage

[7] *Substance Abuse and Mental Health Services Administration. SAMHSA's Working Definition of Recovery. PEP12-RECDEF, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2012.*

Recovery Resources

The Pillars of Recovery

Self-Determination

SAMHSA's Working Definition of Recovery Principles

What is a Recovery Oriented Approach

What does the recovery model look like today? (video)

National Recovery Month

Recovery and Mental Illness Fact Sheet

Stages of Change

Motivational Interviewing, A Theory for Change (client centered)

PEOPLE RECOVERING FROM MENTAL ILLNESSES SAY IT FEELS LIKE:

Image Credit: Mental Health America National

CORE COMPETENCIES FOR PEER SUPPORT SPECIALISTS

What are Core Competencies

Core competencies are often described as clusters of the knowledge, skills, and attitudes a person needs to have in order to successfully perform a role or job or as the ability to integrate the necessary knowledge, skills, and attitudes. Training, mentoring, and supervision can help people develop the competencies needed to perform a role or job.[8][9]

Why do We Need Core Competencies for Peer Workers?

Peers have become increasingly central to people's efforts to live with or recover from mental health and substance use challenges. Community-based organizations led by people who have lived experience of mental health conditions and/or who are in recovery from substance use challenges are playing a growing role in helping people find recovery in the community. Both the mental health consumer and the substance use recovery communities have recognized the need for Core Competencies and both communities actively participated in the development of these Peer Support Specialist competencies.

Potential Uses of Core Competencies

Core Competencies have the potential to guide delivery and promote best practices in peer support. They can be used to inform peer training programs, assist in developing standards for certification, and inform job descriptions. Supervisors will be able to use competencies to appraise peer workers' job performance, and peers will be able to assess their own work performance and set goals for continued development of these competencies. Core Competencies are not intended to create a barrier for people wishing to enter the peer workforce. Rather, they are intended to provide guidance for the development of initial and on-going training designed to support peer workers' entry into this important work and continued skill development.

California's Core Competencies for Peer Support Specialists

1. The concepts of hope, recovery, and wellness.
2. The role of advocacy.
3. The role of consumers and family members.
4. Psychiatric rehabilitation skills and service delivery, and addiction recovery principles, including defined practices.
5. Cultural and structural competence trainings.
6. Trauma-informed care.
7. Group facilitation skills.
8. Self-awareness and self-care.
9. Co-occurring disorders of mental health and substance use.
10. Conflict resolution.
11. Professional boundaries and ethics.
12. Preparation for employment opportunities, including study and test-taking skills, application and résumé preparation, interviewing, and other potential requirements for employment.
13. Safety and crisis planning.
14. Navigation of, and referral to, other services.
15. Documentation skills and standards.
16. Confidentiality.
17. Digital literacy.

[8] Hernandez, R.S., O'Connor, S.J. (2010). Strategic Human Resources Management in Health Services Organizations. Third Edition. Delmar Cengage Learning. P. 83.
[9] Sperry, L. (2010). Core Competencies in Counseling and Psychotherapy: Becoming a Highly Competent and Effective Therapist. Routledge. P. 5.

Each core competency is reviewed over the next several pages.

- Learn about each core competency
- Understand skills needed for each competency
- Learn about resources to help expand skills in each core competency

Principles and Values

Core Competencies for peer workers reflect certain foundational principles identified by members of mental health and substance use recovery communities. These are:

- Recovery-Oriented: Peer workers hold out hope to those they serve, partnering with them to envision and achieve a meaningful and purposeful life. Peer workers help those they serve identify and build on strengths and empower them to choose for themselves, recognizing that there are multiple pathways to recovery.
- Person-Centered: Peer recovery support services are always directed by the person participating in services. Peer recovery support is personalized to align with the specific hopes, goals, and preferences of the individual served and to respond to specific needs the individuals has identified to the peer worker.
- Voluntary: Peer workers are partners or consultants to those they serve. They do not dictate the types of services provided or the elements of recovery plans that will guide their work with peers. Participation in peer recovery support services is always contingent on peer choice.
- Relationship Focused: The relationship between the peer worker and the peer is the foundation on which peer recovery support services and support are provided. The relationship between the peer worker and peer is respectful, trusting, empathetic, collaborative, and mutual.
- Trauma Informed: Peer recovery support utilizes a strengths-based framework that emphasizes physical, psychological, and emotional safety and creates opportunities for survivors to rebuild a sense of control and empowerment.

Core Competency 1: The concepts of hope, recovery, and wellness

Peers support services are founded on hope, recovery and wellness. They are person-focused, self-determined and voluntary.

Skills that can be assigned to this core competency include:

- The ability to promote hope, the potential for change, and personal empowerment.
- The ability to create healing relationships based on respect, compassion, open and honest communication, active listening, and cultural humility.
- How to foster individual choice and self-determination.
- How to establish and maintain relationships based on mutuality, respect, acceptance, and compassion.
- Understand the peer experience.
- Demonstrate consistent support to individuals during times of wellness as well as during challenging times.
- Demonstrate non-judgmental behavior.
- Apply principles of empowerment.
- Define the concept of a wellness-focused approach to recovery.
- Address internal and external stigma.
- Know the basic five stages in the recovery process and what is helpful and not helpful at each stage.
- Know the role of peer support services at each stage of the recovery process.
- Know the basic definition and dynamics of recovery.
- Identify beliefs and values individuals hold that work against recovery.
- Be Strengths-Based.
- Know the difference between treatment goals and recovery goals.
- Know the difference between focusing on the symptoms of mental health and substance use challenges and focusing on their impact on individuals and families.
- Understand the role of culture in recovery.
- Be trauma informed.
- Promote a wellness-focused approach to recovery.
- Be able to identify the beliefs and values an individual holds that support and enrich their recovery.
- Be able to identify the beliefs and values an individual holds that works against their recovery.
- Know the five stages in the recovery process, what is helpful and not helpful at each stage and the role of peer support services at each stage of the recovery process.
- Know the ten guiding principles of recovery as defined by the federal Substance Abuse and Mental Health Services Administration (SAMHSA).

Resources:

The 4 Pillars of Recovery

Self-Determination

The Role of Peer Workers (SAMHSA)

Recovery and Recovery Support (SAMHSA)

Assessment of Practitioner's Values, Beliefs, and Biases

SAMHSA's Working Definition of Recovery Brochure

Core Competency 2: The role of advocacy

Peers encourage individuals to make their own choices (self-advocacy) and help clients develop communication and decision-making skills. Peers also advocate for the needs and desires of individuals in treatment team meetings, community services, living situations, and with family. In addition, participate in efforts to eliminate prejudice and discrimination towards people who have behavioral health conditions and their families.

Skills that can be assigned to this core competency includes:

- Develop a working knowledge of the terms "peer support", "peer", and "recovery" as established by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the International Association of Peer Supporters (NAPS).
- Develop a working knowledge of the SAMHSA and NAPS guiding principles, practice guidelines, and core values of peer support.
- Understand the basic structure of the state Mental Health System (MHS) and how it works.
- Know the civil and human rights foundations from which the peer support movement arose, including issues related to prejudice, discrimination, and stigma associated with behavioral health.
- Know strategies to address internal and external stigma.
- Understand how peer support is shifting care from an illness model to a recovery model.
- Use knowledge of legal resources and advocacy organizations to help an individual build an advocacy plan.
- Help Peers develop self-advocacy skills.
- Advocate for multiple pathways to recovery/wellness.
- Know how to teach advocacy strategies that promote self-determination.
- Model how to self-advocate.
- Have a basic knowledge of empowerment and the goals and objectives of the consumer movement.
- Understand relevant rights and laws (ADA, HIPAA, Olmstead, etc.) to ensure that peers' rights are respected.

Resources:

SAMHSA Core Competencies for Peer Workers

NAPS National Practice Guidelines for Peer Supporters

Personal Bill of Rights

Advocacy Toolkit

10 Reasons Why Advocacy is Important

Disability Rights California: Mental Health

Your Employment Rights as an Individual with a Disability

Health Information Privacy (HIPPA)

Olmstead v. L.C.

Sacramento County Patients' Rights & Privacy Rights

Patients' "Rights for Individuals in Mental Health Facilities" Handbook

Core Competency 3: The role of consumers and family members

The role of consumer peer support specialists is to support other consumers through shared lived experience. Family peer support specialists support other family members through shared lived experience. Both use their experience to role model resiliency and recovery to their peers.

Skills that can be assigned to this core competency include:

- The role of consumers or family members is to give permission to recognize when self-care is needed and to practice it.
- Use personal stories of lived experience to support and empower the person receiving services.
- To build community and a sense of meaning and fulfillment.
- Advocates for the needs and desires of individuals in treatment team meetings, community services, living situations, and with family.
- Connect people to independent social support networks particularly self-help support groups.
- Recovery involves individual, family, and community strengths and responsibility.
- Individuals, families, and communities have strengths and resources that serve as a foundation for recovery. In addition, individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals should be supported in speaking for themselves.
- Relate to the individual as an advocate
- Advocate within systems to promote person-centered recovery/wellness support services.
- Describe the individual's rights and responsibilities.
- Explain importance of self-advocacy as a component of recovery/wellness.
- Differentiate between the levels of advocacy.
- Demonstrate a working knowledge of relevant rights and laws to ensure that the individual's rights are maintained.
- Use knowledge of relevant rights and laws (ADA, HIPAA, Olmstead, etc.) to ensure that individuals' rights are respected.
- Use knowledge of legal resources and advocacy organization to build an advocacy plan.
- Describe the civil and human rights foundations from which the peer support movement arose, including issues related to prejudice, discrimination, and stigma associated with behavioral health.

Resources

Mental Health Peer Support Workforce Designline

Person and Family-Centered Care and Peer Support

The Power of Sharing Lived Experience

Sharing Your Story

Making Effective Use of Your Recovery Story in Peer Support Relationships

Share Your Story: A How-to Guide for Digital Storytelling

Why Consumers and Advocates Must Work Together

Core Competency 4: Psychiatric rehabilitation skills and service delivery, and addiction recovery principles, including defined practices

Peer recovery support services are always directed by the person participating in services. The primary responsibility of Certified Peer Specialists is to help individuals achieve their own needs, wants, and goals. Certified Peer Specialists will be guided by the principle of self-determination for all. Participation in peer recovery support services is always contingent on peer choice. Psychiatric Rehabilitation Skills and Service Delivery utilizes a strengths-based approach.

Skills that can be assigned to this core competency include:

- Recognize the stages of change, recovery, and wellness.
- Recognize signs of distress.
- Understand the basic philosophy and principles of psychosocial rehabilitation and substance use recovery strategies.
- Be able to use dissatisfaction as an Avenue for Change.
- Be able to help a Peer articulate, set and accomplish his/her goals, including whole health and wellness goals.
- Understand the role of healthcare professionals that may be members of an individual's care team, including psychiatrists, psychologists, therapists, primary-care doctors/nurses, specialty-care doctors/nurses, community health workers, case managers, and other professionals.
- Support individuals in defining spirituality on their own terms.
- Certified Peers Specialists will keep current with emerging knowledge relevant to recovery, and openly share this knowledge with their colleagues.
- Know how to assist other healthcare team members to learn about the process of recovery, the concept of resiliency, and the relationship between person-centered, self-directed care and achievement of whole health goals.
- Social Development
- Recovery Management skills.
- Knowledge of Addiction and the Stages of Recovery.
- Knowledge of Addiction and Brain Chemistry / Pharmacology.
- Recovery Management skills.
- Understanding of Co-occurring Disorders.
- Understand the Harm Reduction model.
- Lapse/Relapse Prevention tools.
- Motivational Enhancement tools.
- Identifying one's own strengths and help individuals identify theirs.
- Distinguishing between sympathy and empathy.
- Understand learned helplessness; what it is, how it is taught and how to assist others in overcoming its effects
- Understand the benefits of addressing mental health symptoms and substance use challenges at the same time.
- Know how to facilitate groups.
- Recognize that there are multiple pathways to recovery/wellness.
- Be able to help individuals combat negative self-talk, overcome fears, and solve problems.
- Be able to help individuals create a Person-Centered Plan.

Resources

SAMHSA's Working Definition of Recovery Principles

What is a Recovery Oriented Approach

What is Psychosocial Rehabilitation?

Motivational Interviewing, A Theory for Change (client centered)

Wellness Recovery Action Plan

Action Planning for Prevention and Recovery

Whole Health Action Management: Training Participant Guide

Understanding Treatment of Substance Use Disorder (CDC)

The Science of Addiction (National Institute of Drug Abuse)

About Harm Reduction for Substance Use Disorder (SAMHSA)

Stages of Change

Addictionary: Destigmatizing Language

The Importance of Patient Preferences in Treatment Decisions

Core Competency 5: Cultural and structural competence trainings

Learn how to be responsive to the unique cultural identities of others. Being responsive to others requires an understanding of your own cultural identities. Apply multicultural interaction skills to all your interpersonal interactions. These skills include being able to help people express and utilize positive aspects of their cultural identity to promote recovery.

Skills that can be assigned to this core competency include:

- Cultural humility.
- Recognize and understand your own personal values, culture, and spiritual beliefs; how they may contribute to your own judgments, biases, and beliefs about others; and how to respond if they inhibit your ability to effectively serve another individual.
- Knowledge of cultural sensitivity and practice.
- Define culture, elements of culture, and its impact.
- Ability to communicate utilizing person first and person-centered language.
- Recognize different types of cultures.
- Explain key recovery language and culture concepts.
- Knowledge of the influence of cultural heritage on individuals and groups.
- Knowledge of and sensitivity to how cultural identity can influence the dynamics in communication.
- Knowledge of and sensitivity to how cultural identity shapes the helping process.
- Appreciate, recognize, and respect the personal values, cultural, spiritual beliefs, and practices of peers and their families and how these play a role in achieving their whole health goals.
- Recognize the importance of a holistic (e.g., mind, body, spirit, environment) approach to recovery/wellness.
- Be able to describe successful multicultural interactions and explain why the topic is important to peer services.
- Understand the concept of 'seeking out common ground'.
- An understanding of structural racism and how it creates disparities in Wealth, Employment, Education, Housing Discrimination, Government Surveillance, Incarceration, Drug Arrests, Immigration Arrests, and Infant Mortality.
- An understanding of how structural racism impacts health and recovery outcomes for people of color.
- Recognize the Connections between Behavioral Health Conditions and Trauma, Health Disparities, and Social Inequity

Resources

Behavioral Health Equity (SAMHSA)

How Does Implicit Bias Influence Behavior?

Structural Racism and Health Inequities

Structural and Cultural Competency

Building Bridges: Cultural Humility Toolkit

Understanding Transference and Countertransference

Core Competency 6: Trauma-informed care

Trauma-informed peer support can counter the impact of trauma on people in recovery by reducing the effects of unresolved and secondary trauma and supporting healing.

Skills that can be assigned to this core competency include:

- Understand the core principles of trauma-informed care.
- Understand the prevalence of trauma and its impact on physical, behavioral, and emotional wellness.
- Be familiar with the ACE (Adverse Childhood Events) model.
- Understand cultural considerations and the effect of trauma on how we view our cultural experiences and the lens in which we view the world.
- Recognize signs of distress.
- Assist the individual in identifying basic needs.
- Recognize risk indicators that may affect the individual's welfare and safety. Respond to personal risk indicators to assure welfare and safety.
- Identify examples of traumatic events and individual responses.

Resources

What are ACES?

How Childhood Trauma Affects Health Across a Lifetime (Video)

Maslow's Hierarchy of Needs Explained

Signs and Symptoms of Distress

Trauma Informed Peer Support

Trauma Informed Peer Support: Center for Excellence in Peer Support

Fundamentals of Trauma Informed Care

Trauma-Informed Care Champions: From Treaters to Healers

Engaging Women in Trauma-Informed Peer Support: A Guidebook

Trauma-Informed Care Model for Immigrant Hispanic and Latino Clients

Core Competency 7: Group facilitation skills

Understand how to facilitate peer support/self-help groups.

Skills that can be assigned to this core competency include:

- Understand the difference between treatment goals and recovery goals and be able to create and facilitate a variety of group activities that support and strengthen recovery.
- Describe, select, and appropriately use strategies from accepted and culturally appropriate models for group counseling.

Resources

Facilitation Skills: Definitions and Examples

Tools for Support Group Facilitators

Support Group Facilitation Guide (2016)

The Ultimate Guide To Facilitating A Peer Support Group

Using Group Agreements in Engaging Events

Difference Between Therapy Groups and Support Groups

Keep It Up, You're Doing Great!

Recovery Goals

Recovery Oriented Language Guide

Active Listening – 7 Techniques

Core Competency 8: Self-awareness and self-care

Develop self-care skills and coping practices for helping professionals. Know resources to promote personal resilience; and, understanding burnout and using self-awareness to prevent compassion fatigue, vicarious trauma and secondary traumatic stress.

Skills that can be assigned to this core competency include:

- Recognize the importance of self-care.
- Develop self-care skills and coping practices for helping professionals.
- Know the importance of ongoing supports for overcoming stress in the workplace.
- Know resources to promote personal resilience.
- Understand burnout and using self-awareness to prevent compassion fatigue, vicarious trauma and secondary traumatic stress.
- Strengthen social skills and healthy social networks including peer and natural support systems.
- Be able to discuss their own tools for taking care of themselves.
- Learn to respond appropriately to personal stressors, triggers and indicators.
- Understand the concept of dual/complex relationships.
- Understand the dynamics of power, conflict and integrity in the workplace.
- Anticipate and avert or safely manage any re-experience of symptoms of their own challenge(s) to ensure continued wellness.
- Develop a working knowledge of the concepts of "activation" and "self-management" of whole health goals.

Resources

Compassion Fatigue and Self-care for Crisis Counselors

How and Why to Practice Self-Care

The Importance of Wellness in Peer Support

Burnout Prevention and Treatment

Self-Care During Compassion Fatigue

Family Peer Support: Self-Care

RecoveryU: Self-Care and Recovery

Wellness Recovery Action Plan

Action Planning for Prevention and Recovery

Whole Health Action Management: Training Participant Guide

Creating a Healthier Life: A Step-By-Step Guide to Wellness

"In dealing with those who are undergoing great suffering, if you feel 'burnout' setting in, if you feel demoralized and exhausted, it is best, for the sake of everyone, to withdraw and restore yourself. The point is to have a long-term perspective."

– Dalai Lama

Core Competency 9: Co-occurring disorders of mental health and substance use

Understand co-occurring disorders of mental health and substance use and the methods used to treat both conditions.

Skills that can be assigned to this core competency include:

- The ability to promote hope, the potential for change, and personal empowerment.
- The ability to create healing relationships based on respect, compassion, open and honest communication, active listening, and cultural humility.
- How to foster individual choice and self-determination.
- Use active listening skills.
- Use empathic listening skills.
- Communicate genuine emotion.
- Recognize and use person-centered language.
- Define the concept of a wellness-focused approach to recovery.
- Have a basic knowledge of treatment approaches such as Medication Assisted Treatment (MAT) and Medication Assisted Recovery (MAR).
- Understand the prevalence of trauma in the lived experience of people with co-occurring disorders.
- Meet people where they are.
- Understand Harm Reduction.
- Be able to communicate their lived experience in a way that is supportive.
- Peers support Peers in whatever their goal is.
- Understand the Stages of Change.
- Understand Recovery Capital
- Understand Recovery Action Planning.
- Have a basic understanding of the Disease Model of Addiction and the difference between prevention, treatment, and recovery.
- Understand Recovery Management Planning to support individuals with life domains.
- Know the science of addiction and the history of addiction.
- Embrace all pathways to recovery.
- Be active in your own recovery.
- Identify your own triggers and actively manage your recovery.
- Develop and maintain your own support system.
- Conduct yourself in a manner that fosters your own recovery.

Resources

Overcoming the Stigma of Dual Diagnosis

Positive Self-Talk

Understanding Recovery Capital

Stages of Change

The Science of Addiction (National Institute of Drug Abuse)

Substance Use and Co-Occurring Mental Disorder (NIMH)

Understanding Treatment of Substance Use Disorder (CDC)

About Harm Reduction for Substance Use Disorder (SAMHSA)

Core Competency 10 Conflict resolution

Be able to personally deal with conflict and difficult interpersonal relations in the Workplace. Also be able to resolve conflicts in relationships with peers and others in their support network.

Skills that can be assigned to this core competency include:

- Develop effective communication skills.
- Develop conflict resolution skills.
- Develop problem-solving skills.
- Be able to use de-escalation techniques
- Understand the dynamics of power, conflict, and integrity in the workplace,
- Understand the concept of seeking out common ground.

Resources

De-Escalation Techniques

Conflict Resolution Skills

Emotional Intelligence

The Center for Nonviolent Communication

Effective Communication

How to Navigate Conflict with Coworkers

Building Bridges: A Guide To Conflict Resolution in Peer Support

Core Competency 11: Professional boundaries and ethics

Perform all job duties in accordance with federal and state rules and regulations and published code of ethics and professional conduct for certified peer support specialists.

Skills that can be assigned to this core competency include:

- The role of consumer peer support specialists is to support other consumers through shared lived experience.
- The role of family peer support specialists is to support other family members through shared lived experience.
- The role of peers or family members is to use their experience to role model resiliency and recovery to their peers.
- Recognize situations outside the competencies of a Peer Support Specialist.
- Understand how to establish, negotiate, and maintain appropriate interpersonal limits and boundaries that are necessary to promote effective peer support services.
- Understand the Peer Support Specialists' scope of service (i.e., know what you can and cannot do as a credentialed Peer Support Specialist).
- Conduct self-evaluations of professional performance applying ethical, legal, and professional standards to enhance self-awareness and performance.

Resources

A Recovery-Oriented Approach to Professional Boundaries (YouTube Video)

Boundary Issues in Peer Support

California Code of Ethics for Peer Support Specialists and Ethics Violation Guidelines

NAPS National Practice Guidelines for Peer Supporters

Peer Support: A Theoretical Perspective

A Framework for Ethical Decision Making

The Essential Role of Informed Consent in Peer Support

Core Competency 12: Preparation for employment opportunities, including study and test-taking skills, application and résumé preparation, interviewing, and other potential requirements for employment

Learn employment skills such as study and test-taking skills, application and résumé preparation, interviewing, and other potential requirements for employment. Utilize employment development resources such as job centers, community colleges, and others. Teach, coach, and model the skills and attributes needed to attain and maintain long-term, stable employment and housing.

Skills that can be assigned to this core competency include:

- Know community resources for employment skills development.
- Be familiar with how to transition from Social Security and other disability benefits.
- Peers assist, guide, and support in developing education and employment skills as a Peer.
- How to use shared experience to leverage social capital and networking.
- Preparation for employment opportunities, including study and test-taking skills, application and résumé preparation, interviewing, and other potential requirements for employment.

Resources

Interview Skills

Resume Builder

Sacramento Works

Department of Rehabilitation

Qualities of a Good Employee

Test Taking Strategies

Study Less Study Smart

How to Learn Faster with the Feynman Technique

CalMHSA Medi-Cal Peer Support Specialist Certification Preparation Guide

How to Beat Test Anxiety and Take on Exams Without Stress

Your Employment Rights as an Individual with a Disability

Clearing a Criminal Record - Expungement

Core Competency 13: Safety and crisis planning

Recognize various crisis and emergency situations and signs of distress and threats to safety among peers and in their environments. Recognize risk indicators that may affect the individual's welfare and safety. Respond to personal risk indicators to assure welfare and safety.

Skills that can be assigned to this core competency include:

- Understand basic de-escalation techniques.
- Recognize various crisis and emergency situations.
- Recognize and respond to risk indicators to assure welfare and safety.
- Recognize signs of distress and threats to safety among peers and in their environments.
- Understand basic suicide prevention concepts and techniques

Resources

Peer Support Services in Crisis Care

Emotional CPR

Mental Health First Aid

Navigating a Mental Health Crisis: A NAMI Resource Guide

Practice Guidelines: Core Elements in Responding to Mental Health Crises (SAMHSA)

Suicide Prevention Interventions and Treatments

Safety Plan Template

How to Create a Relapse Prevention Plan

Wellness Recovery Action Plan

Action Planning for Prevention and Recovery

Psychiatric Advance Directive

California's Mandated Reporter Law

Risk and Protective Factors for Suicide

A Comprehensive Approach to Siocide Prevention

988 Suicide and Crisis Lifeline

Core Competency 14: Navigation of, and referral to, other services

Develop a working knowledge of available community resources, services and healthcare benefits for individuals living with debilitating behavioral health conditions in order to help the individual navigate and choose between options.

Skills that can be assigned to this core competency include:

- Develop and maintain up-to-date information about community resources and services.
- Have a basic understanding of mental health and substance use challenges and the behavioral health system.
- Develop tools for effective outreach and continued support.
- Have the ability to assist in establishing support systems and interfacing with agencies, organizations, and groups.
- Collaborate with individual to identify, link, and coordinate choices with resources.

Resources

SacMap

Sacramento County Resource List: Substance Use Prevention and Treatment Services

Sacramento County Resource Lists: Mental Health Providers

211 Sacramento

Greater Sacramento Resource Guide

Findhelp.org

California Network of Care

Findtreatment.gov

Supporting Patients' Decision-Making Abilities and Preferences

Core Competency 15: Documentation skills and standards

Demonstrate a basic knowledge of medical language and chart/record documentation standards to communicate effectively with members of the care team and help the individual understand clinical situations and/or terminology

Skills that can be assigned to this core competency include:

- Understand current documentation requirements for submitting bills to Medi-Cal.
- Understand the concept of accountability.
- Understand and follow Mandatory Reporting requirements.

Resources:

Strengthening Peer Support Documentation Practices

Using Strength-Based Language

What is Strength-Based Documentation?

Guide to Equity Terminology: Promoting Behavioral Health Equity through the Words We Use

How to Write Progress Notes

Clinical Documentation Guide for Certified Peer Support Specialists

Sacramento County Documentation Training (Video Series)

Sacramento County Progress Note Policy

Mandated Child Abuse Reporter Training

Elder and Dependent Mandated Reporter Training

Core Competency 16: Confidentiality

Understand basic federal, state, employer regulations regarding confidentiality.

Skills that can be assigned to this core competency include:

- Understand the Health Insurance Portability and Accountability Act (HIPAA)
- Understand Substance Abuse Confidentiality rules (42 CFR Part 2).
- Understand basic federal, state, employer regulations regarding confidentiality.

Resources

Health Information Privacy (HIPPA)

HIPPA for Professionals

Patient's Rights and Privacy Rights: Sacramento County

Sacramento County Privacy Practices

Substance Use Confidentiality Regulations (42 CFR Part 2)

Understanding Confidentiality and Minor Consent in California

California Minor Consent and Confidentiality Laws

Core Competency 17: Digital literacy

Be able to apply appropriate technologies to deliver peer support services education, training, technical assistance and other information.

Skills that can be assigned to this core competency include:

- Understand digital platforms that can be used for service delivery, benefits acquisition, and resource connections.
- Understand digital privacy protections.

Resources

What is Digital Literacy

Assessment: Basic Computer Skills (38 questions)

Assessment Internet Basics (34 questions)

Assessment: Information Literacy (32 questions)

More free online digital literacy assessments

Northstar Digital Literacy

GCF Global E-Learning

Health Policy and Privacy Challenges Associated With Digital Technology

Why Health Privacy Online is a Myth

My Social Security Online Account

Apply for Medi-Cal Coverage

ETHICS AND BOUNDARIES

What are ethics?

Ethics are moral principles that govern personal behavior. Ethical and legal issues arise in the performance of Peer Support Specialist services just like in any other behavioral health profession.

Why do Peer Support Specialists need a code of ethics?

We are all vulnerable to errors in judgment, particularly when we find ourselves in situations we have not faced before. Ethics are moral principles that govern personal behavior. They are also ethical and legal issues that arise in the performance of Peer Support Specialist services.

Peers need a Code of Ethics in order to:

- Set professional standards and expectations
- Increase confidence in and legitimizes Peer profession
- Define acceptable behaviors
- Identify core values of Peer Support
- Create accountability through self-reflection and self-evaluation
- Establish and reinforce Peers' occupational identity

When peers adhere to strong ethical standards, they:

- Prevent negative impacts to clients, providers, the system, Peers, and the Peer Profession;
- Support the competent delivery of Peer services; and
- Improve clients' wellness, recovery, and resilience outcomes

Medi-Cal Code of Ethics for Peer Support Specialists in California[10]

The California Department of Health Care Services (DHCS) has developed principles in the Code of Ethics for Medi-Cal Peer Support Specialists. All Medi-Cal Peer Support Specialist agree not to violate, or assist in or abet the violation of, or conspire to violate, any provision or term of this Code of Ethics. Certified peers who are found in violation of this Code of Ethics are subject to sanctions. All peers, regardless of certification, should follow these principles when they are providing peer support services.

1. Values Hope
2. Person-Driven
3. Family Driven and Child-Centered
4. Holistic Wellness
5. Authenticity
6. Cultural Responsiveness and Humility
7. Respect
8. Integrity
9. Advocacy
10. Confidentiality
11. Safety and Protection
12. Education
13. Mutuality
14. Reciprocity
15. Strengths-Based
16. Wellness, Recovery, and Resiliency

[10] *Code of Ethics and Violation Guidelines, https://www.capeercertification.org/code-of-ethics/, CalMHSA, 2023,*

Ethical Standard	Description
1. Values Hope	1. Inspire hope in those engaging in services by living a life of Recovery and/or Resiliency.
2. Person Driven	1. Support individuals receiving services and their support network within the context of the individual's worldview, to achieve their goals based upon their needs and wants. 2. Focus on self-determination, as defined by the person engaging in services, and support the person's participation in their own recovery. 3. Inform others about options, provide information about choices, and then respect peers' decisions. 4. Encourage people to look at the options, take risks, learn from mistakes, and grow toward healthy interdependence with others. 5. Uphold the principle of non-coercion as essential to recovery and encourage those engaging in services to make their own decisions, even when the person engaging in services is under mandated treatment. 6. Assist those they support to access additional resources. 7. Disclose lived experiences of recovery in a way that maintains the focus on and is beneficial to the person engaging in services. 8. Support the recovery process for the peer, allowing the person to direct their own process 9. Shall not force any values or beliefs onto the person engaging in services. 10. Recognize there are many pathways to recovery that can be very different than their own journey.
3. Family Driven and Child-Centered	1. Promote the family member's ethical decision-making and personal responsibility consistent with that family member's culture, values, and beliefs 2. Respect and value the beliefs, opinions, and preferences of children, youth, family members, parents, and caregivers in service planning. 3. Promote the family members' voices and the articulation of their values in planning and evaluating behavioral health related challenges or concerns. 4. Support other family members as peers with a common background and history. 5. Disclose personal lived experiences of building resiliency in a way that focuses on and is beneficial to the child, youth, family member, parent, or caregiver engaging in services. 6. Build supports on the strengths of the child, youth, family, or caregiver. 7. Build partnerships with others who are involved in the care of our children, youth, or adult family members.

Ethical Standard	Description
	8. Communicate clearly and honestly with children, youth, family members, and caregivers
4. Holistic Wellness	1. Promote the family member's ethical decision-making and personal responsibility consistent with that family member's culture, values, and beliefs. 2. Practice in a holistic manner that considers and addresses the whole health of those engaging in services. 3. Recognize the impact of co-occurring challenges (substance use, developmental and physical challenges) in the recovery resiliency journey and provide supports sensitive to those needs. 4. Recognize the impact of trauma on the recovery/resiliency journey and provide the support specific to those challenges. 5. Honor the right of persons engaging in services to choose alternative treatments and practices, including culturally specific traditional methods, healing arts, including acupuncture and meditation, spiritual practices or secular beliefs, and harm reduction practices.
5. Authenticity	1. Practice honest and direct communication in a culturally relevant manner, saying what is on their mind in a respectful way. Difficult circumstances are addressed with those who are directly involved. Direct communication moves beyond the fear of conflict or hurting other people to the ability to work together to resolve challenges with caring and compassion. 2. Share own lived experience to provide hope and inspiration for recovery. 3. Practice healthy disclosure about their own experience focused on providing hope and direction toward recovery and/or resiliency. 4. Work within their scope of practice as defined by this Code of Ethics and their employing agency. 5. Remain aware of their skills and limitations, and do not provide services or represent themselves as an expert in areas for which they do not have sufficient knowledge or expertise. 6. Know that maintaining the authenticity and integrity of their role is critical to the effectiveness of peer support services. 7. Seek supervision, peer support services, and/or other contact with peer colleagues or other supports to stay within their scope of practice.

Ethical Standard	Description
6. Cultural Responsiveness	1. Acknowledge the importance of language and culture, intersecting identities, knowledge, and acceptance of dynamics of cultural differences, expansion of cultural knowledge, curiosity, and adaptation of services to meet culturally unique needs. 2. Strive to provide culturally responsive and relevant services to those they support. 3. Respect cultural identities and preferences of those engaging in services and their families and respect the right of others to hold opinions, beliefs, and values different from their own. 4. Shall not discriminate against others on the basis of gender, race, ethnicity, sexual orientation or gender identity, age, religion, national origin, marital status, political belief, or mental or physical differences. 5. Shall not discriminate against others on the basis of any other preference, personal characteristic, condition, state, or cultural factor protected under Federal, State or local law. 6. Seek further information, education, and training in cultural competence as necessary to assist those they support.
7. Respect	1. Provide a welcoming environment for persons engaging in services. 2. Approach each person, youth, parent or family member with openness, genuine interest, and appreciation. 3. Accept each person/family and situation as unique. 4. Provide empathy and be able to "put oneself in the other person's shoes." 5. Will make an honest effort to empathize with the emotional connection and cultural context that the persons engaging in services bring to the recovery /resiliency relationship. 6. View everyone as having something important and unique to contribute. 7. Value and treat others with kindness, warmth, dignity, and without judgment. 8. Accept each other and are open to sharing with people from many diverse backgrounds including ethnicity, educational levels, socio-economic background, sexual preference, and religion/spirituality. 9. Honor and make room for everyone's opinions and see each other as equally capable of contributing. 10. Demonstrate respect toward those supported, colleagues and the community. 11. Use language that is respectful, "person-first," and culturally mindful to, and with, those supported, colleagues and the community. 12. Never use language that could be construed as, or is, derogatory, insulting, or demeaning in written, electronic, or verbal communications.

Ethical Standard	Description
	13. Communicate with co-workers and colleagues in ways that promote hope, compassion, and solution-focused interactions.
8. Integrity	1. Act in accordance with the highest standards of professional integrity. 2. Avoid relationships or commitments that conflict with the interests of persons engaging in services, impair professional judgment, imply a conflict of interest, or create risk of harm to those supported. 3. Conduct themselves in a way that does not jeopardize the integrity of the peer relationship. 4. Seek supervision to handle any real or potential conflicts when and if a dual relationship is unavoidable. 5. Follow organizational policies and guidelines regarding giving and receiving gifts. 6. Consider the cultural context and other potential considerations related to gifts. 7. Do not lend, give, or receive money or payment for any services to, or from, persons they support. 8. Demonstrate accountability in fulfilling commitments. 9. Resist influences that interfere with professional performance. 10. Shall not commit fraud, waste or abuse in the delivery of Medi-Cal services. 11. Cooperate with complaint investigations and supply information requested during complaint investigations unless such disclosure of information would violate the confidentiality requirements of Subpart 2, Title 42, Code of Federal Regulations. 12. Shall not provide services under the influence of any amount of alcohol, marijuana, or illicit drugs. "Illicit drugs" means any substance defied as a drug in Section 11014, Chapter 1, Division 10, Health and Safety Code, except: • Drugs or medications prescribed by a physician or other person authorized to prescribe drugs, in accordance with Section 4036, Chapter 9, Division 2, Business and Professions Code, and used in the dosage and frequency prescribed; or • Over-the-counter drugs or medications used in the dosage and frequency described on the box, bottle, or package insert. 13. Shall not secure a certification by fraud, deceit, or misrepresentation. This includes, but is not limited to: • Making a false statement on any application for certification. • Withholding material information on any application for certification.

Ethical Standard	Description
	• Impersonating another Medi-Cal Peer Support Specialist or permitting or allowing another person to use their certification for the purpose of providing peer support services. 14. Shall not engage in gross negligence or incompetence in the performance of peer support services. This includes: • Failing to maintain records consistent with sound judgement, the standards of the profession, and the nature of the services being rendered.
9. Advocacy	1. Support the formulation, development, enactment, and implementation of public policies of concern to the profession. 2. Demonstrate and promote activities that respect diversity. 3. Support and defend human rights and freedoms regardless of nationality, national origin, gender identity, ethnicity, religion or spiritual persuasion, language, disability, sexual identity, or socio-economic status. Human rights include civil and political rights, such as the right to life, liberty, and freedom of expression; social, cultural, and economic rights including the right to cultural expression, the right to have basic needs met, and the right to work and receive an education. 4. Advocate for inclusion of those supported in all aspects of services. 5. Advocate for the full involvement of those supported in the communities of their choice and will promote their value to those communities. 6. Understand, encourage, and empower self-advocacy. 7. Recognize that all individuals/families have the right to live in the safest and least restrictive, culturally congruent environment. 8. Strive to eliminate stigma and discrimination.
10. Confidentiality	1. Respect the rights, dignity, privacy, and confidentiality of persons engaging in services at all times. 2. Respect the right to privacy of those supported and shall not solicit private information from those supported unless it is essential. Once private information is shared, standards of confidentiality apply. 3. Respect confidential information shared by colleagues in the course of their professional relationships and interactions unless such information relates to an unethical or illegal activity. However, confidentiality should be honored when Peers are supporting clients with a substance use disorder where the illegal activity is limited to personal use of substances.

Ethical Standard	Description
	4. Comply with all applicable federal and state confidentiality laws and guidelines. (In accordance with Part 2, Title 42, Code of Federal Regulations and HIPAA requirements). 5. Discuss with persons engaging in services, and other interested parties, the nature of confidentiality and limitations of the right to confidentiality.
11. Safety and Protection	1. Never engage in romantic or sexual/intimate activities with the persons engaging in services. 2. Shall not provide services to individuals with whom they have had a prior romantic or sexual relationship. 3. Shall not engage in exploitive relationships with coworkers or those they support to further their personal, religious, political, or business interests. 4. Follow applicable federal, state and local laws in the prevention of harm. 5. Inform appropriate persons when disclosure is necessary to prevent serious, foreseeable, and imminent harm to persons served or other identifiable persons. In all instances, Peer Support Specialists should disclose the least amount of confidential information necessary to achieve the desired purpose. 6. Never intimidate, threaten, harass, use undue influence, physical force, or verbal abuse, or make unwarranted promises of benefits to persons engaging in services. 7. Recognize the unique nature of the peer relationship and seek supervision and/or peer support services, as necessary, to maintain appropriate boundaries with persons engaging in services. 8. Treat colleagues with respect, courtesy, fairness, and good faith, and uphold the Code of Ethics. Strive to provide a safe environment that is respectful of the impact of trauma on persons engaging in services.
12. Education	1. Remain current regarding new developments in recovery, resiliency and wellness theories, methods, and approaches of related disciplines/systems with whom those who are engaging in services interface. 2. Accept responsibility for continuing education and professional development as part of their commitment to provide quality services. 3. Become familiar with local resources for self-sufficiency, including benefits and employment opportunities and supportive resources for families, parents, and caregivers
13. Mutuality	1. Engage in a relationship of mutual responsibility where power is shared and the Peer Support Specialist and the persons engaging in services are equally responsible for maintaining a peer relationship that is mutually beneficial. 2. Take responsibility for voicing their own needs and feelings.

Ethical Standard	Description
	3. Make decisions in collaboration with persons served and do not make decisions for persons engaging in services. 4. Ensure that people give and take the lead in discussions, everyone is offered a chance to speak, and decisions are made in collaboration with one another.
14. Reciprocity	1. Ensure that the relationship is reciprocal. Every participant in the peer relationship both gives and receives in a fluid, constantly changing dynamic. 2. Belief that peer relationships are not hierarchical; no one is more qualified, advanced, or better than another. 3. Learn from each other. 4. View asking for help as reaching across (not up nor down).
15. Strengths-Based	1. Provide strength-based services acknowledging that every person has skills, gifts, and talents they can use to better their lives. 2. Focus on what is strong, not what is wrong. 3. Assist others to identify these strengths and explore how those identified strengths can be used for their benefit.
16. Wellness Recovery, and Resiliency	1. Engage in and model regular self-care activities. 2. Communicate and behave in ways that promote wellness, recovery, and resiliency. 3. Use language that reflects wellness, recovery, and resiliency principles. 4. Shall not impose limitations on the possibility for wellness, recovery, and resiliency of those engaging in services. 5. Recognize the importance of supportive relationships and community in wellness, recovery and resiliency and encourage persons to identify and develop natural supports. 6. Promote self-sufficiency in the wellness, recovery, and resiliency journey.

A Peer Support Specialist MAY NOT:

1. Practice outside of their scope of competence
2. Engage in any services requiring a license
3. Falsify any documentation related to application, training, testing, certification, or services provided.
4. Retaliate against any person who, in good faith, makes a complaint against the peer support specialist regarding services provided.

5. Engage in conduct that is prohibited by state, federal, or local law, including laws prohibiting the use, possession, or distribution of drugs and alcohol.
6. Participate in, condone, or promote discrimination on the basis of race, creed, color, national origin, gender identity, sexual orientation, religion, age, physical disability, or economic status in the performance of responsibilities as a peer support specialist.
7. Violate law, rule, or policy related to a recipient's privacy and confidentiality.
8. Have a dual relationship with a recipient of services.

Violation Guidelines

The Code of Ethic Violation Guidelines are used to address violations of the Medi-Cal Code Ethics for Certified Peer Support Specialists in California by the California Mental Health Services Authority. The guidelines will be used by the certifying entity for the determination of sanctions. The guidelines are not considered all-inclusive as there may be violations not addressed or sanctions that have not yet been described for a specific violation. The certifying entity reserves the right to make modifications under circumstances in the absence of sanctions.

Ethical Decision Making

When sorting through the complexity of a situation and determining the best course of action that one could take in that situation, ask four questions:

1. Who has the potential of being harmed in this situation, what is the possible harm, how great is the risk for harm?
2. What is the goal with the client? What is your role in helping to reach that goal?
3. Are there any core recovery values that apply, and what course of action would these values suggest be taken?
4. What laws, organizational policies, or ethical standards apply and what actions would they suggest or dictate?

Clients, community members, relevant communities and you, yourself can be harmed by what you do or fail to do. It is important to identify who may be harmed by the choices you make. When you have identified those who will be harmed think about the worst-case scenario and how likely or unlikely it is to happen. If you can foresee a negative consequence, look for ways to avoid or mitigate it.

If a Peer is supporting the client's wellness/recovery/resiliency their actions and behaviors must align with these goals. The actions of a peer must also reflect core recovery values and principles, as well as federal, state and local laws, standards and ethics for peer support workers, and any organizational policies and procedures.

Remember that ethical standards apply outside the peer relationship. Peer should conduct themselves as ethical employees, coworkers, citizens, and human beings. This includes off-duty and non-scope activities that may harm the reputation of the worker, their employer, or the profession.

Consider whether you can justify your actions:

- Would you behave this way in front of your parent, supervisor, religious leader, a judge, or someone else you hold in high regard?
- Could you easily explain your behavior if required to?
- Would you tell your child, younger sibling, or someone who looks up to you that it's ok to behave this way?
- If the answer to any of these is "no," don't do it!

Use the Ethical Decision-Making worksheet on the next page to guide your decisions.

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Certified Peer Support Specialist Leadership Liaison Program (CPS-LLP)
Ethical Decision-Making Worksheet

A model of ethical decision-making is simply a guide to sorting through the complexity of a situation and an aid in determining the best course of action that one could take in that situation. Those providing recovery support services ask five questions to guide their decision-making.

Question 1: Who is vulnerable to harm in this situation and what is the degree of such harm?

Use this matrix to identify who is vulnerable to harm, what might be the harm, and the degree of such harm possible.

Vulnerable Party	Significant Risk of Harm (√)	Moderate Risk of Harm (√)	Minimal Risk of Harm (√)
Client			
Client's Family/Friends/Loved Ones			
Peer Support Specialist (You)			
Peer Support Specialist's Employer			
Peer Support Profession			
Recovery Community			
Community at Large			

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Question 2: What core recovery values and principles apply to this situation and what action would they suggest be taken? (Note: Refer to SAMHSA's Working Definition of Recovery.)

- ☐ Health (making informed, healthy choices that support physical and emotional well-being).
- ☐ Home (A stable and safe place to live).
- ☐ Purpose (Meaningful daily activities; income and resources to participate in society).
- ☐ Community (Relationships/social networks that provide support, friendship, love, and hope).
- ☐ Hope (Recovery is real; message of a better future).
- ☐ Person-Driven (Self-determination and self-direction, autonomy, independence).
- ☐ Many Pathways (Distinct needs, strengths, preferences, goals, culture, background).
- ☐ Holistic (Whole life, mind, body, spirit, and community).
- ☐ Peer Support (Sharing of experiential knowledge & skills; sense of belonging; linkage).
- ☐ Relational (Involvement of people who believe in the person's ability to recover).
- ☐ Culture (values, traditions, and beliefs).
- ☐ Addresses Trauma (foster safety and trust; promote choice, empowerment, and collaboration).
- ☐ Strengths/Responsibility (Individuals, families, and communities; foster inclusion).
- ☐ Respect (Acceptance and appreciation; protecting rights, eliminating discrimination)

Question 3: What Medi-Cal Peer Support Specialist core competencies apply to this situation and what action would they suggest be taken?

(Note: Refer to the Landscape Analysis for Peer Certification Training Curriculum Core Competencies.)

- ☐ The concepts of hope, recovery, and wellness.
- ☐ The role of advocacy.
- ☐ The role of consumers and family members.
- ☐ Psychiatric rehabilitation skills and service delivery, and addiction recovery principles, including defined practices.
- ☐ Cultural and structural competence trainings.
- ☐ Trauma-informed care.
- ☐ Group facilitation skills.
- ☐ Self-awareness and self-care.
- ☐ Co-occurring disorders of mental health and substance use.
- ☐ Conflict resolution.
- ☐ Professional boundaries and ethics.
- ☐ Safety and crisis planning.
- ☐ Navigation of, and referral to, other services.
- ☐ Documentation skills and standards.
- ☐ Confidentiality.
- ☐ Digital literacy.

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Question 4: What Medi-Cal Peer Support Specialists ethical guidelines apply to this situation and what action would they suggest be taken? (Note: Refer to the Code of Ethics and Violation Guidelines.)

- ☐ Hope.
- ☐ Person Driven.
- ☐ Family Driven and Child-Centered.
- ☐ Holistic Wellness.
- ☐ Authenticity.
- ☐ Cultural Responsiveness.
- ☐ Respect.
- ☐ Integrity.
- ☐ Advocacy.
- ☐ Confidentiality.
- ☐ Safety and Protection.
- ☐ Education.
- ☐ Mutuality.
- ☐ Reciprocity.
- ☐ Strengths-Based.
- ☐ Wellness, Recovery, Resiliency.
- ☐ A Peer Support Specialist May Not:

1. Practice outside of their scope of competence
2. Engage in any services requiring a license
3. Falsify documentation related to application, training, testing, certification, or services […].
4. Retaliate against any person who, in good faith, makes a complaint […].
5. Engage in conduct that is prohibited by state, federal, or local law, including laws prohibiting the use, possession, or distribution of drugs and alcohol.
6. Participate in, condone, or promote discrimination […] as a peer support specialist.
7. Violate law, rule, or policy related to a recipient's privacy and confidentiality.
8. Have a dual relationship with a recipient of services.

Question 5 What laws, standards, or historical practices could guide our conduct in this situation?

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Follow up: Where the risk of injury is great to multiple parties, document:

What I considered:

_____

_____

_____

_____

_____

_____

Who I consulted:

_____

_____

_____

_____

_____

_____

What I decided and did:

_____

_____

_____

_____

_____

_____

The outcome of the decisions I made and actions I took:

_____

_____

_____

_____

_____

(adapted from Cal Voices' WISE U Medi-Cal Peer Support Specialist Program)

Recognizing and Respecting Boundaries

Boundaries what is or is not okay in a given situation. These are the limits Peers set for themselves within the peer support relationship. Healthy boundaries allow Peers to say "no" to others when appropriate, and allow others "in" when appropriate. Appropriateness depends on the type of relationship, setting, context, and cultural norms/expectations. Having good boundaries with clients helps you protect yourself and your clients, set clear roles and rules in the peer support relationship and create a safe and respectful environment.

Boundaries are governed by:

- Federal, state, and local laws
- Professional codes of ethics
- Organizational rules of conduct, policies, and procedures

Boundaries are also informed by your own personal values, beliefs, comfort, context, norms, and lived experience.

Peers must recognize that it is their responsibility for managing and modeling healthy boundaries. Healthy boundaries are where most professional interactions should occur. A person with healthy boundaries

- Values their own opinions
- Doesn't compromise values for others
- Share personal information in an appropriate way (does not over or under share
- Knows their personal wants and needs, and can communicate them
- Accepts when others say "no" to them (UC BERKELEY/THERAPIST AID, LLC, 2016)

While client relationships with traditional service providers are more hierarchical and detached, peer support relationships rely on reciprocity and minimizing social distance. [11] In peer support relationships boundaries of inappropriateness may differ considerably. The relationship between a Peer and their clients exists on an intimacy continuum, with three zones of safety. The three zones of safety are:

- A zone of safety in which actions are always okay
- A zone of vulnerability in which actions are sometimes okay and sometimes not okay
- A zone of abuse in which actions are never okay

Peers and their clients must have open and honest conversations about boundaries, and what is okay and not okay. Peers are responsible for managing boundaries.

[11] *https://dbhids.org/wp-content/uploads/2015/07/Philadelphia-Papers-Ethical-Guidelines-for-the-Delivery-of-Peer-Based-Recovery-Support-Services.pdf*

Strengths-Based Language

The Old Worldview Hides in Our Language

Because the illness worldview still predominates, we need to be very intentional with our language: It is how we best express our new worldview. Now is a good time to start rethinking how you refer to yourself and others. Although we will not prescribe terms or language that we all must use, we will challenge each other to consider language that strengthens our wellness worldview and avoid language that may undermine it. Old habits die hard and so do old worldviews, so let's challenge each other respectfully, but challenge each other nonetheless.

The Power of Worldview: The power of how we see things is sadly revealed in the way people interpret a person's behavior simply on the basis of their perception of that person as normal or diagnosed:

You as "Normal"	Me as "Diagnosed"
If you are overly excited, you're happy.	If I'm overly excited, I'm manic.
If you imagine the phone ringing all day, you're just stressed out.	If I imagine the phone ringing, I'm psychotic.
If you're crying and sleeping all day, you're sad and need some time off.	If I'm crying and sleeping all day, I'm depressed and need to get up.
If you're afraid to leave the house at night you're cautious.	If I'm afraid to leave the house at night, I'm paranoid.
If you speak your mind and express your opinions, you're assertive.	If I speak my mind and express my opinions, I'm aggressive.
If you don't like something and mention it, you're being honest.	If I don't like something and mention it, I'm being difficult.
If you get angry, you're upset.	If I get angry, I'm dangerous and need to get medicated or restrained.
If you overreact to something, you're sensitive.	If I overreact to something, I'm out of control.
If you don't want to be around other people, you're taking care of yourself and relaxing.	If I don't want to be around other people, I'm isolating and avoiding.
If you talk to strangers, you're being friendly.	If I talk to strangers, I'm being inappropriate.
If you speak bluntly to others, you're being rude.	If I speak bluntly to others, I have a behavior problem.
If you don't follow orders, you don't like being told what to do.	If I don't follow orders, I'm being noncompliant.
If your house is messy, you probably don't like housework.	If my house is messy, I need to learn some ADLs (Activities of Daily Living).
If you ask someone out, it's a date.	When I ask someone out, it's an outing to learn social skills.
For all these behaviors you are considered to be a human being having a normal emotional response.	**For many of these behaviors, I'm told to take a pill, or hospitalized.**

The difference between **You** and **Me** is our labels.

The Power of Language: Language has the power to stigmatize and demean, or respect and uplift. Some people who receive mental health or substances use services use the term "consumer" to refer to themselves and others, while others prefer to be called "survivors." Some people now prefer the term "peer" while others simply prefer to be referred to as a "person" or a "person who receives services" or "individual living with a mental health condition."

However, as people who are truly seeking wellness, let's consider the power that language has before we make our personal choices. Let's look at words that can hurt or help people.

Words that stigmatize, demean and pathologize and invite discrimination:	Words that uplift us. Words that recognize and respect our shared humanity and strength:
Manipulation	Survival mode; overwhelmed and trying to get needs met
Low functioning, under developed	Coping, fighter flight
Case, Patient, client consumer	Person receiving services, person, individual living with a mental health condition
Decompensating	Becoming ill, things are breaking down; things aren't working
Non-compliant (or compliant)	Independent, autonomous, taking personal responsibility, freely exercising rights
Frequent flyer	Trying to get it right. Giving lots of opportunities to help
Unmotivated	Not ready, not helpful
"A _____." (fill in the blank with any diagnosis)	"A person who has been given the diagnosis of _____."
Depressed	Sad, down in the dumps, worn out, need time to get well, anger/ fear
Symptomatic	Experiencing big feelings, intense feelings
Cutter	Experiencing pain through self-harm
Grandiose	Thinking big, expressing hopes and dreams, ambitious

(Thanks to Elaine Popovic and Debbie Sesula)

MAINTAINING EMPLOYMENT

Why do we work?

Working provides protective factors, and supports recovery and the maintenance of personal wellness. By getting a job and staying employed, you are contributing to your own recovery. Working provides the following benefits:

- Routine: It provides us with a reason to get up in the morning. Now sometimes we may not wish we didn't have to work, but actually, this routine keeps us healthy.
- Activity: Work gives us something to do each day. The very act of saying to one's self: "I have something to do today" protects our mental health.
- Purpose, Contribution: Our work may also be something that meets our needs for purpose and contribution. These are protective factors for mental health.
- Connection and Social Support: We spend more daylight hours with the people we work with than those we live with. We are social animals who connect to each other and when we are away from work, we miss the social interaction. When people are away from work, they are socially isolated. Isolation is both a predictor and risk factor for mental challenges.
- Identity: I could ask each one of you what you do and you would answer without thinking, either your title or what you do. If you are off work, say for a year or more, and someone asks you, "So what do you do?" you find it difficult to answer, difficult to define yourself to the other person in terms that are true… by society's values and standards, you are a nothing because you are not "doing" something.
- Resources, Independence: Maintaining gainful employment allows people to get off disability and provide for themselves financially, allowing them to become independent and fully participate in society. In addition to financial resources, it provides individuals with important skills and access to information, both of which can be used to improve their own lives. In building healthy relationships, working allows people to build social capital as well, giving them access to opportunities they may not have had before.

Key reminders

- You were hired to do a job
- Your employer expects you to do this job consistently and to the best of your ability
- If you don't do your job (or don't meet the required standards and expectations), your job is at risk
- Your job security is directly tied to the value of your contributions and ability to prevent/avoid problems
- You're there to make your boss's job easier, not harder
- Know how to do your job well
- Do your job to the best of your ability, every day, without reminders, threats, or cajoling
- Consistently show up and step up when needed
- Don't create more problems or unnecessary work for your boss or anyone else

Common Workplace Challenges for Peer Support Specialists

Peers experience barriers to workplace success. Specifically, they experience role confusion, stigma, isolation, co-optation, and challenging work conditions. In this section, we cover each barrier and provide strategies to overcome these barriers.

Working Conditions

When Peer leadership roles are lacking and Peers are relegated to the confines of their assigned programs without representation in management or a voice at the table when important matters are decided, their workplace needs go unaddressed. Many peers experience low pay, non-existent or unaffordable benefits, job stagnation – lack of career growth, and job insecurity. Additional structural barriers include human resource departments that have rigid hiring practices for Peer positions, and institutionalized stigma that results in different treatment and practices applicable only to Peer staff (prohibiting Peer access to client data; walling off Peers from important activities and information because Peers are more "risky;" facing unsaid discrimination when applying for other non-Peer positions, etc.).

To address the working conditions for peers, it is important that peers receive training, skill building and professional development opportunities, and are able to network and explore different careers. Moreover, peers can advocate on their behalf for improved conditions.

Role Confusion

Peers may experience role confusion if there is uncertainty about the peer role in general. Either the peer is uncertain about what they should be doing or the supervisor is unsure. Peers also experience a desire to fit in like anyone else and they may be viewed as different, in part, because they may be transitioning roles. For example, they may be moving from recipient to provider, from client to coworker, or acquaintance to mentor.

To overcome role confusions, Peers should:

- Model recovery at all times
- Educate others about your role
- Review your job description
- Review the Medi-Cal Code of Ethics
- Maintain appropriate interpersonal boundaries
- Understand the principles of peer support and key recovery concepts

Stigma

Peers may experience stigma in the workplace due to mentalism, macro/micro-aggressions, low expectations, marginalization, and tokenism. To overcome these challenges, Peers can:

- Model recovery and strength-based language at all times
- Raise consciousness
  - Name mentalism and microaggressions when they happen
  - Strategically respond to stigma, whether or not intentional
  - Inform and educate others about the Peer role
- Support and validate one another

Isolation

Our sense of belonging on a team has a direct impact on our commitment to task, sense of role clarity, and collaborative effectiveness. One implication of feeling lonely at work is that we may intentionally conceal parts of our authentic identity and start to pretend to be someone else. And when we pretend to be someone other than who we are, we emotionally withdraw. Isolation can occur when a peer is the only peer on a team, not asked to share opinions and not encouraged to participate. Isolation can occur also when there is a lack of support for the peer role and there are no mentoring or networking opportunities. To overcome isolation peer workers should:

- Get out of your own head
- Engage in self-empathy and self-care
- Initiate interaction; make small gestures
- Speak up in group settings
- Seek out supportive coworkers
- Participate in group activities and community events
- Find support from Peers in other programs and agencies
- Participate in County Peer Committees

Co-optation

Co-optation refers to the "Professionalization" of the peer role. As peers become acculturated into the treatment environment, they can drift towards more traditional (medical model) practices. They may adopt the values, attributes, and style of personal interactions associated with clinical providers.

Examples of co-optation may include:

- Not telling your story
- Going with the flow; not "rocking the boat"
- Using clinical language
- Not advocating for client/family member interests
- Misusing your position with clients/family members to push clinical agenda

Peers can overcome cooptation by creating a strong peer identity. Create a bubble that insulates you from clinical orientation. Organizations can limit cooptation by:

- Having more than one peer in the organization,
- Supervision of peers by peers,
- Educating clinical and treatment staff about the peer role
- Using recovery-based language
- Creating career ladders for peers

How to be a Great Employee

There are many sources for information on how to be a great employee. There are also a number of sources of traits of good/great employees. In this section, we share our favorite traits that we have found for individuals to be successful peer workers.

Four Traits of Great Employees

Our favorite traits of great employees are Smart, Reliable, Work Hard, and Plays Well with Others. In this section we will provide tips on how to achieve each of these traits in your current position.

How to be Smart

Be Smart Tip #1: Get to Know Your Agency

- Mission, vision, values
- Programs, services, activities
- Key people and partnerships
- Organizational structure
- Organizational culture

Be Smart Tip #2: Figure Out Your Role in the Bigger Picture

- What your program does
- What your position does
- What is your role in the program
- Why it matters to the agency
- Why it matters to you
- Your unique contributions
- Understand the Behavioral Health Ecosystem

Be Smart Tip #3: Always Meet or Exceed Expectations*

- Performance
- Attitude
- Behavior

*Expectations can be found in your job description, performance evaluations, employee handbook, the Core Competencies and Code of Ethics for Medi-Cal Peer Support Specialists. Expectations also come from your boss, coworkers, and organizational culture. It is important to understand each expectation and meet or exceed those expectations.

Be Smart Tip #4: Demonstrate Enthusiasm and Take Initiative

- Show interest in your agency and what it does
- Understand the issues that impact your organization
- Stay informed about developments in mental health and peer support
- Don't grumble!

Be Smart Tip #5: Develop digital literacy

- Know computer basics
- Be proficient with email, word processing, printing
- Practice proper email etiquette
- Know how to maintain client confidentiality
- Understand digital platforms that can be used for service delivery, benefits acquisition, and resource connections.
- Understand digital privacy protections.
- Be able to find, evaluate, and communicate information using typing or digital media platforms

Be Smart Tip #6: Use Technology Appropriately

- Nothing on work equipment is private
- Maintain client confidentiality

How to be Reliable

Be Reliable Tip #1: Maintain regular attendance and punctuality

- Minimize unplanned absences
- Show up on time, ready, willing, and able to work
- Request time off or schedule changes as far in advance as possible
- Keep a minimum balance of leave/PTO

Be Reliable #2: Create Trust

- Keep your word
- Under-promise and over-deliver
- If you said you'd do it, do it
- Be honest with yourself and others
- Don't hide your mistakes
- Take personal responsibility
- Ask for help if you need it

Be Reliable Tip #3: Remain Consistent

- Commit to quality work
- People will learn what to expect from you – leave them with a good impression
- Meet your deadlines
- Step up when you are needed
- Accept new tasks and responsibilities
- Do the little things, every day, that add up in the long run
- Pace yourself and try not to burn yourself out

How to be a Hard Worker

Work Hard Tip #1: Stay Motivated

- Eat the frog first (least favorite activities)
- If you can't avoid it, learn to love it
- Spend your effort where it counts
- Focus on the outcome
- Find an external motivator
- Avoid distractions/time-wasting activities
- Break up big projects into smaller tasks
- Just start!

How to Play Well with Others

Play Well Tip #1: Maintain Basic Etiquette

- Stay positive
- Assume good intent
- Ask questions
- Be nice
- Avoid gossip
- Enforce healthy boundaries
- Offer compassion, empathy, and support
- Use your personal wellness plan!

The Bare Minimum

Remember that you were hired to do a job. Your employer expects you to do this job consistently and to the best of your ability.

- Know how to do your job well
- Do your job to the best of your ability, every day, without reminders, threats, or cajoling
- Consistently show up and step up when needed
- Don't create more problems or unnecessary work for your boss or anyone else
- Reduce unproductive friction

Digital Literacy

With the increasing use of electronic health records, telehealth, and digital communication, the ability to use computers and other electronic devices has become an essential skill necessary for all professions in the behavioral health field. Digital literacy is a Core Competency for Certified Medi-Cal Peer Support Specialists. All Peers – regardless of position type or certification status – need basic digital literacy skills and familiarity with common workplace technology. Digital literacy is "the ability to find, evaluate, utilize and create information using digital technology," and involves:

- Using multiple forms of technology (computer, cell phone, printer, etc.)
- Finding, using, and critically evaluating online information
- Curating data and media sources
- Communicating, collaborating, and participating in online environments
- Managing data security and privacy
- Creating online content (not just consuming it)

Ask yourself the following questions about your own digital skills.

- Do you know how to use a computer?
- Can you use a tablet and a smartphone?
- Do you know basic computer functions, such as emailing and word processing?
- Do you know how to write professional emails and digital communications?
- How well can you use Microsoft Office programs (Word, Excel, PowerPoint), web-based apps, and virtual meeting platforms (like Zoom, Teams, etc.)?
- Do you know how to save digital files, retrieve them, navigate files on a server, convert file types, attach documents to emails, and share files with others?
- Can you perform basic online research?
- Can you use social media (responsibly)?
- Do you understand digital data security?
- Can you use a printer, copier, fax?

Digital Skills Assessment

Take this brief assessment to determine where you think your skills are now. Consider what you need for your current employment. If you are needing additional training to accomplish your work tasks, ask your employer if they can pay for and/or provide time during your working hours to obtain training.

Skills	Advanced	Intermediate	Beginner	None
Basic computer operations (using a desktop/laptop computer, accessing programs, saving and retrieving files, etc.)				
Internet searches and website navigation				
Digital record-keeping and documentation				
Electronic Health Record (EHR) systems				
Emailing/digital communications				
Typing/word processing				
MS Office (Word, PowerPoint, Excel)				
Copying, scanning, printing, faxing				
HIPAA/digital privacy and security practices				
Learning new devices/programs/apps				

Resources

NorthStar Digital Literacy Assessments

Microsoft's Digital Literacy Courses

Adobe Training and Tutorials

GCF Free Microsoft Office Learning

Coursera: Web based training site

Google Calendar (YouTube)

Google Drive (YouTube)

How to open multiple tabs in Google. (YouTube)

SELF-CARE FOR PEER SUPPORT WORKERS

Why Do Peers Need Self-Care

Self-care is incredibly important for individuals who care for others and who may overlook themselves in the process. Peers may experience compassion fatigue as the result of a progressive and cumulative stress that is caused by prolonged, continuous, and intensive contact with clients. This can lead to burnout and secondary traumatic stress. In addition, peer staff are more likely to be affected by an unhealthy work environment.

Peer Support Specialists may be overexposed to risks such as:

- Stigma and discrimination
- Limited career prospects
- Low pay and poor benefits
- Demand-control imbalance
- Role confusion and conflict

Dimensions of Self-Care

Self-care is about actively looking after your own mental health and wellbeing so that you can more effectively support the people you work with. It involves engaging in activities and practices that give you energy, lower your stress and contribute to your wellbeing. It is important to do these activities regularly before a crisis or stress at work. Make a commitment to your health and well-being so that you can properly support others.

- Emotional: Allow yourself to safely experience your full range of emotions
  - Examples: Journal, use affirmations, meditate, talk with friends or family, practice gratitude
- Physical: Activities to help you to stay fit, healthy, and energized to get through work and personal commitments
  - Examples: Regular sleep routine, exercise, eat healthy foods, drink lots of water, health check ups
- Intellectual: Activities that help stimulate your brain
  - Examples: Listen to a podcast, read a book, take a class, start a new hobby
- Social: Maintaining healthy, supportive relationships, and ensuring you have diversity in your relationships so that you are not only connected to work people
  - Examples: Prioritize close relationships in your life, attend special events for friends and family, snuggle your pet, call someone you care about
- Spiritual: Having a sense of perspective beyond the day-to-day of life.
  - Examples: Spend time in nature, pray or attend religious service, meditate, do yoga, listen to inspiring music
- Practical: Ensuring day to day activities are accomplished
  - Examples: Catch up on housework, get groceries, pay bills, meal prep
- Occupational: Activities and actions that support feeling balanced and fulfilled in your career.
  - Examples: Set manageable goals, engage in career planning, say no and unplug after hours, connect with coworkers

Self-Care at Work

It is important to take a little time throughout your workday to prioritize yourself. The following are self-care examples you can engage in at work:

- Practice deep breathing for at least 5 minutes each day
- Organize your workspace
- Complete a task you have been putting off
- Take an activity break every hour
- Attend workplace social events
- Build pauses into your work schedule
- Regular supervision with a supervisor
- Consultation with more experienced colleagues
- Attend or set up a support group with other peer workers
- Maintain boundaries with clients
- Read journals and articles about Peer Support work
- Engage in professional development opportunities

Creating a Self-Care Plan

Most people find it difficult to incorporate self-care into their lives. Barriers to self-care include

1. Lack of energy
2. Too many responsibilities
3. Fear of vulnerability
4. Not prioritizing self
5. Unrealistic expectations of self
6. Under-earning

Creating a self-care plan can help you what you need and value as part of your day-to-day life. There is no one size fits all self-care plan, but generally it is a commitment to attend to all the domains of your life. Self-care plans help you enhance your health and well-being, manage stress and maintain professionalism in the workplace.

At the start of creating your Self-Care plan you will:

- Take inventory
- Identify sources of stress
- Identify sources of positive energy
- Identify signs of when you may need help
- Identify personal resources and supports
- Take your time in developing your plan

After you complete your assessment, reflect on the following questions:

1. What areas do you want to work on?
2. What is the best possible outcome?
3. What is important about this to you?
4. What qualities do you need to bring out of yourself in order to accomplish this? What is the first step?

You will find a self-care assessment and a template to help you create a self-care plan on the next couple of pages.

Self-Care Assessment[1]

As a professional, you need to practice self-care in all aspects of your life so you can perform at your best when working with people. A good place to start is with assessing where you're at and then making a plan to improve your self-care. Complete the self-care assessment to find out how you're managing your self-care at the moment.

Physical Self-Care

Involves activities that help you to stay fit and healthy, and with enough energy to get through your work and personal commitments. Physical self-care includes getting adequate sleep, healthy and regular eating, and regular exercise. It also includes rest and nurturing yourself if you do get sick.

To what extent do you do these activities? Select "Never" if you have never thought about it or do not know what it is.

	Never	Rarely	Sometimes	Often	Always
Eat regularly (e.g., breakfast, lunch and dinner)					
Eat healthily					
Exercise regularly					
Access medical care when needed (both preventative and acute)					
Take time off when sick					
Regular physical activity that I enjoy					
Get enough sleep					

[1] Self-Care Assessment | © ReachOut.com | Cal Voices' WISE U Surviving and Thriving Training (2022)

Emotional Self-Care

Involves activities that allow you to safely experience your full range of emotions. This means having work and non-work friends, doing enjoyable activities, debriefing at the end of challenging days, and prioritizing supportive relationships.

To what extent do you do these activities? Select "Never" if you have never thought about it or do not know what it is.

	Never	Rarely	Sometimes	Often	Always
Spend time with non-work friends, family and acquaintances					
Stay in contact with important people in your life					
Acknowledge when you have done well					
Value yourself					
Identify energizing/positive activities people and places, and actively seek them out					
Allow yourself to cry or be upset					
Find things that make you laugh					
Express your opinion on social issues outside of work					

Intellectual Self-Care

Involves activities that help you to feel clear-headed and able to intellectually engage with the professional challenges that are found in your work. It may also include strategies for your own personal life, outside work, but that remain relevant for your working career (e.g., if a partner, or your child, becomes ill).

To what extent do you do these activities? Select "Never" if you have never thought about it or do not know what it is.

	Never	Rarely	Sometimes	Often	Always
Take time out (trips out of town, to the beach or a weekend away)					
Take time away from telephones, email, social media and the internet					
Make time for self-reflection					
Notice your inner dialogue (listen to your thoughts and feelings)					
Have your own personal development and/or external supervision					
Write in a journal/diary					
Read, watch or engage with interests unrelated to work					
Do something at which you are not an expert or in charge (different to your work role)					
Actively minimize stress in your life					
Engage in new ways of thinking (e.g., attend a sports event, theatre, gallery, library, public talks)					
Be curious about life					
Say no occasionally					

Social Self-Care

Closely related to emotional self-care. It is about maintaining healthy, supportive relationships, and ensuring you have diversity in your relationships so that you are not only connected to work people.

To what extent do you do these activities? Select "Never" if you have never thought about it or do not know what it is.

	Never	Rarely	Sometimes	Often	Always
Schedule regular time with significant others (e.g., partner, kids, friends, family)					
Stay in contact with mates, acquaintances and networks					
Make time to reply to personal correspondence					
Allow others to do things for you					
Meet new people					
Ask for help when you need it					
Share your feelings: good, bad or other with someone you trust					
Maintain a healthy physical space or home					

Spiritual Self-Care

Involves having a sense of perspective beyond the day-to-day of life. For some people this means engaging with organized religion, for others it is more about ensuring a sense of possibility and optimism.

To what extent do you do these activities? Select "Never" if you have never thought about it or do not know what it is.

	Never	Rarely	Sometimes	Often	Always
Do some form of reflective practice (meditate, pray or reflect)					
Spend time in natural environments					
Connect to a community or network with shared values					
Be open to feeling inspiration, awe and other positive emotions					
Nurture your optimism and hope					
Be open to not knowing					
Identify what is meaningful to you and notice it's place in your life					
Contribute to causes in which you believe in outside of work					

Practical Self-Care

Involves activities that fulfill core aspects of your life in order to prevent future stressful situations. Practical self-care includes catching up on chores, buying groceries, and paying bills.

To what extent do you do these activities? Select "Never" if you have never thought about it or do not know what it is.

	Never	Rarely	Sometimes	Often	Always
Catch up on chores					
Get groceries					
Fix things around the house					
Meal Prep					
Do laundry					
Pay bills					
Prepare for holidays or family events					
Get your vehicle serviced (if applicable)					

Occupational Self-Care

Involves activities that help you to stay focused, organized, and have enough energy to get through your work day. Occupational self-care includes taking your breaks, connecting with coworkers, and setting boundaries.

To what extent do you do these activities? Select "Never" if you have never thought about it or do not know what it is.

	Never	Rarely	Sometimes	Often	Always
Take your breaks					
Organize/declutter your workspace					
Set manageable goals					
Say "no" and unplug after hours					
Connect with your coworkers					
Ask for help when you need it					
Schedule personal time off					
Do career planning					

Overall Balance

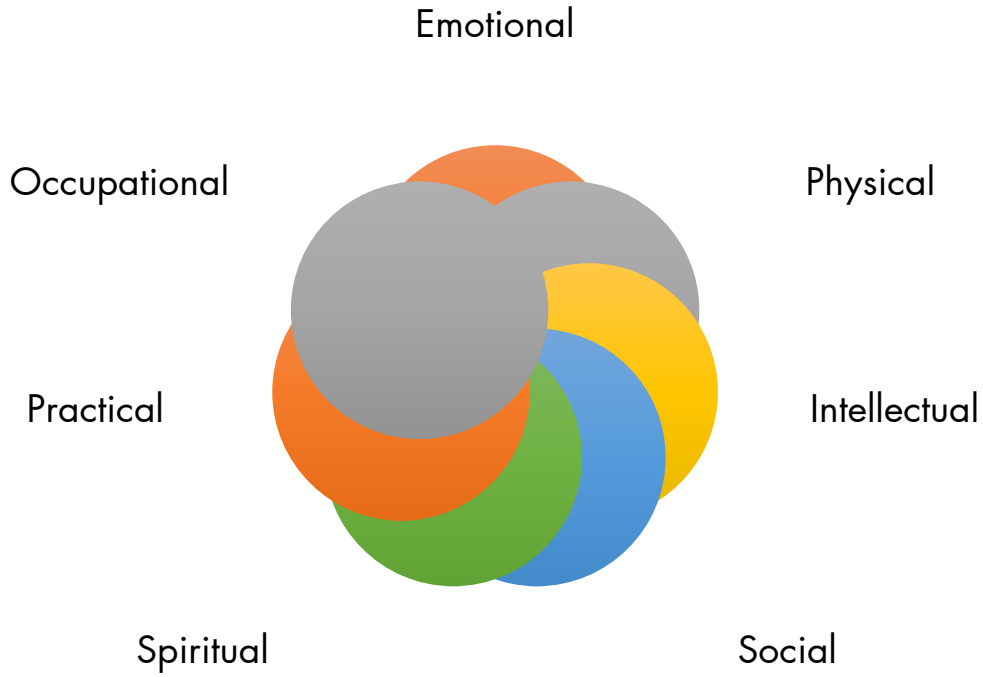
How well do you balance the demands of work life and your personal life?

To what extent do you do these activities? Select "Never" if you have never thought about it or do not know what it is.

	Never	Rarely	Sometimes	Often	Always
Strive for balance within your work-life and work-day					
Strive for balance among work, family, relationships, play and rest					

Now that you have completed your survey, identify areas where you would like to make a change.

DIMENSIONS OF SELF CARE



Self-Care Plan[12]

There is no one size fits all when it comes to self-care plans. Each one of us has different needs and strengths. Establishing a self-care plan may help you prevent burnout, build self-esteem, reduce anxiety and stress, and increase your productivity. Self-care may also help you prevent future diseases.

To complete your Self-Care plan, first complete the Self-Care Assessment. The Self-Care Assessment lets you know how you are currently managing your self-care at the moment. Then use what you learn from the assessment to help you complete your Self-Care plan.

Your Self-Care plan will focus on seven dimensions of self-care

1. Emotional: The actions we take to connect with our emotions and process them in a healthy way.
2. Physical: Any activities used to enhance your physical well-being.
3. Intellectual: Activities that help you understand and develop a loving relationship with your mind.
4. Social: Activities that nurture relationships with others.
5. Spiritual: Any activities that help you connect with and nurture your soul.
6. Practical: Any actions taken to fulfill your core needs and reduce stress.
7. Occupational: Activities and actions that support feeling balanced and fulfilled in your career.

[12] Self-Care Plan | Adapted by Shirley Reiser, LCSW and Lisa D. Butler, PhD from materials provided by Sandra A. Lopez, LCSW, ACSW, University of Houston, Graduate School of Social Work. | Cal Voices WISE U Surviving and Thriving Training (2022)

My Self Care Plan

Area of Self-Care	Current Practices	Practices to Try	How Will Implementing These Practices Make You Feel?
Physical (e.g., eat regular and healthy meals, good sleep habits, regular exercise, medical check-ups, etc.)			
Emotional (e.g., engage in positive activities, acknowledge my own accomplishments, express emotions in a healthy way, etc.)			
Intellectual (e.g., listen to a podcast, watch educational videos, practice a new hobby, read a book, take a class, etc.)			
Social (e.g., healthy relationships, make time for family/friends, schedule dates with partner/spouse, ask for support from family and friends, etc.)			

Area of Self-Care	Current Practices	Practices to Try	How Will Implementing These Practices Make You Feel?
Spiritual (e.g., read inspirational literature, self-reflection, spend time in nature, meditate, explore spiritual connections, etc.)			
Practical (e.g., Do homework, catch up on chores, do some financial planning, get groceries, meal prep, etc.)			
Occupational (e.g., Take your breaks, set manageable goals, say no, unplug after hours, get support etc.)			

Identify barriers to maintaining your Self Care strategies.

How will you overcome these barriers?

Identify negative coping strategies you would like to target for change and how you will change them.

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The Certified Peer Support Specialist Leadership Liaison Program is a collaborative program of Cal Voices and Sacramento County Department of Health Services, Division of Behavioral Health Services, funded through the voter-approved Proposition 63, the Mental Health Services Act.

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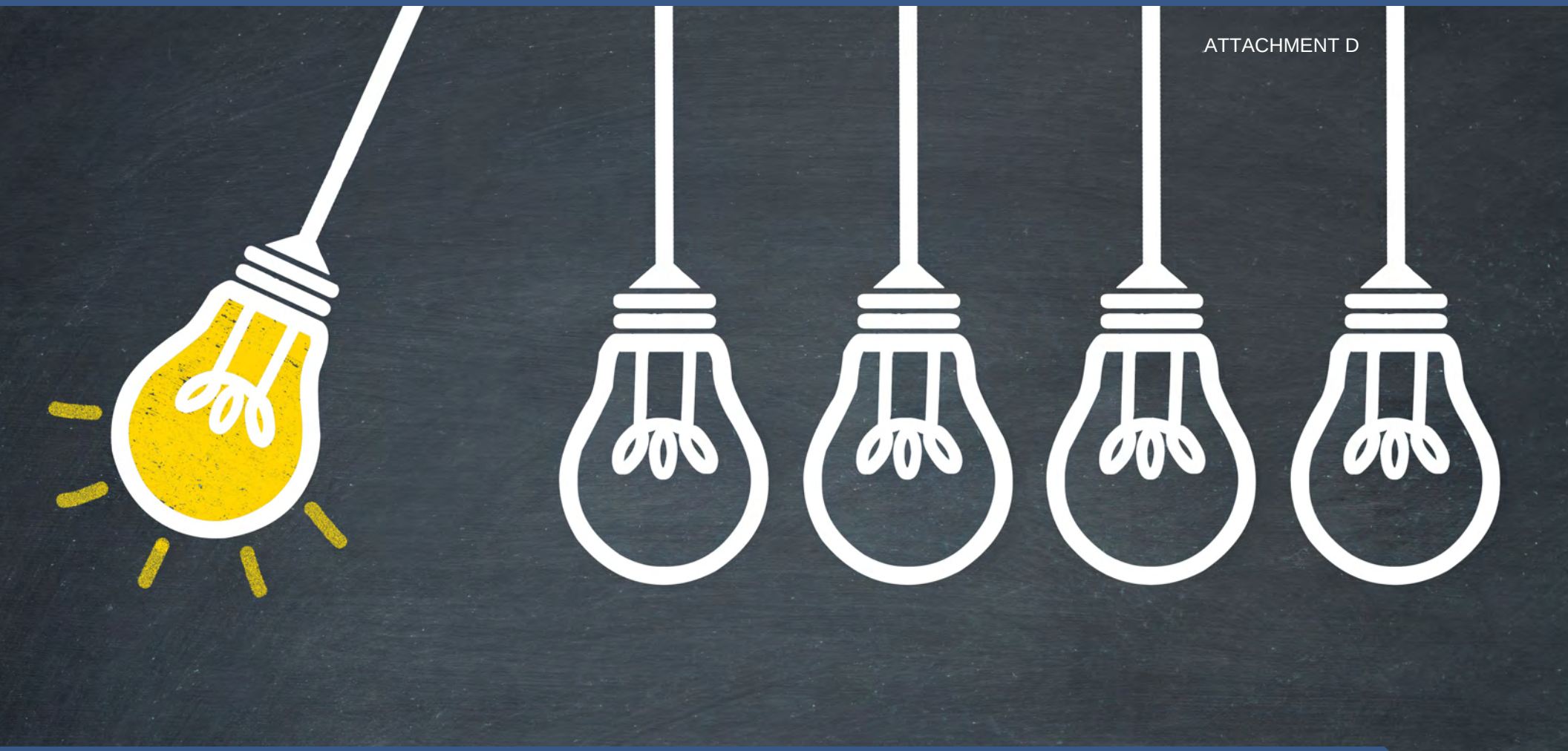

Peer Employer Toolkit

Walking the Talk: Understanding the Peer Support Specialist Role in the Age of Certification

CAL VOICES
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SACRAMENTO COUNTY

The Certified Peer Support Specialist Leadership Liaison Program is a collaborative program of Cal Voices and Sacramento County Department of Health Services, Division of Behavioral Health Services, funded through the voter-approved Proposition 63, the Mental Health Services Act.

Introduction

Peer support services are becoming more popular as evidence-based treatments for individuals who are dealing with behavioral health conditions. However, many behavioral health organizations are not equipped to handle this shift. This Employer Toolkit has been designed to effectively help organizations incorporate peer support workers into their traditional behavioral health settings.

What's included in this Toolkit

- Information and resources about the peer role and the recovery model
- Challenges organizations experience when integrating peer support workers
- Recommendations and strategies for integrating peer support workers into traditional behavioral health settings
- Agency Policies and Practices that Address the 13 Psychosocial Risk Factors at Work
- Tools and templates for employing peer workers

This toolkit will be revised on an annual basis through 2026 based on feedback and reflections received and observed by Peer Support Specialists and Peer Employers. To provide feedback or to share training and informational needs, please email us at peerleadership@calvoices.org.

About Cal Voices

Founded in 1946, Cal Voices is California's oldest Peer-run mental health advocacy agency. Cal Voices has worked in County Behavioral Health Systems for over four decades, employing peers in various programs including wellness centers, warmlines, county-operated clinics, and advocacy and training programs.

Cal Voices is a proud recipient of the Platinum Mental Health America's Bell Seal for Workplace Mental Health. The Bell Seal for Workplace Mental Health is a distinction awarded by Mental Health America (MHA) to companies that meet mentally healthy workplace standards. Cal Voices' status as a Platinum Bell Seal-certified organization demonstrates Cal Voices' outstanding commitment to employee mental health and well-being. To learn more, visit: mhanational.org/bestemployers.

Over 95% of our staff identify as consumers, family members, and/or parents/caregivers including our entire Executive Leadership team and our program managers. Since 2015, Cal Voices has trained, coached, and mentored thousands of Peers in California to build their knowledge and expertise. We have conducted key informant interviews, organizational assessments, training, and technical assistance for hundreds of counties and Peer providers in California's Public Behavioral Health System (PBHS).

Glossary of Terms

Client

A general term for a consumer or family member/caregiver who receives peer support services.

Consumer

An adult living with a behavior health challenge who receives peer support services.

California Department of Health Care Services (DHCS)

Finances and administers many individual healthcare service delivery programs, including Medi-Cal, which provides healthcare services to low-income people.

California Mental Health Service Authority (CalMHSA)

CalMHSA is a Joint Powers of Authority (JPA) formed in 2009 by counties throughout the state to improve behavioral health care for all Californians. By pooling resources, forging partnerships, and leveraging technical expertise, CalMHSA develops strategies and programs to transform community mental health; creates cross-county innovations; and is dedicated to addressing equity to better meet the needs of our most vulnerable populations. CalMHSA is also the certifying entity for Medi-Cal Peer Support Specialist Certification.

Family Member/Caregiver

A family member or caregiver of someone who has a behavioral health issue. The family member or caregiver receives support from other family members or caregivers.

Lived Experience

Refers to an individual's first-hand experience with a mental health and/or substance use challenge.

Medi-Cal Peer Support Specialist (MPSS)

A peer certified by the State of California who provides reimbursable peer support services.

Mental Health Service Act (MHSA)

The MHSA was passed by California voters in 2004 and is funded by a one percent income tax on personal income over $1 million per year. It is designed to expand and transform California's behavioral health system to better serve individuals with, and at risk of, serious mental health issues, and their families. MHSA addresses a broad continuum of prevention, early intervention, and service needs and the necessary infrastructure, technology, and training elements that effectively support the public behavioral health system.

Glossary of Terms

Peer

For this Toolkit, a peer refers to someone who has experienced the healing process of recovery from psychiatric, traumatic, and/or substance use challenges and, as a result, can offer assistance and support to promote another peer's recovery journey. The peer support volunteers to share portions of his or her recovery experience appropriately and effectively.

Peer Support

Peer support is the process of giving and receiving non-clinical assistance to achieve long-term recovery from severe psychiatric, traumatic, or substance use challenges. This support is provided by peer supporters - people who have "lived experience" and have been trained to assist others in initiating and maintaining long-term recovery and enhancing the quality of life for individuals and their families. Peer support services are inherently designed, developed, delivered, evaluated, and supervised by peers in long-term recovery.

Peer Support Relationship

The qualities that make an effective peer supporter are best defined by the individual receiving support, rather than by an organization or provider of care. Matching peer supporters with peers often encompasses shared cultural characteristics, such as age, gender, ethnicity, language, sexual orientation, co-occurring challenges, and experience in the military or with the criminal justice system or any other identity-shaping life experience that increases common language, mutual understanding, trust, confidence, and safety.

Public Behavioral Health System (PBHS)

Publicly funded mental health programs/services and entities that are administered, in whole or in part, by the County. It does not include programs and/or services administered, in whole or in part, by federal, state, county, or private correctional entities or programs and/or services provided in correctional facilities. The facility must be contracted or subcontracted with the County.

Substance Abuse and Mental Health Administration (SAMHSA)

SAMHSA is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation and to improve the lives of individuals living with mental and substance use challenges, and their families.

What is Recovery?

In a general sense, recovery refers to the regaining of something that was lost or taken away. Several other generic definitions of recovery apply in many contexts, but each definition implies the loss of something that is later **restored or regained**. In the behavioral health context, we talk about recovery as the alleviation of ongoing mental or emotional distress or the undesired symptoms and impacts of a behavioral health condition. What recovery from a behavioral health condition looks like is different for different people. It is a process and an outcome.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. Congress established the SAMHSA in 1992 to make substance use and mental health information, services, and research more accessible.

SAMHSA developed the following working definition of recovery by engaging key stakeholders in mental health and substance use recovery communities:

Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.[1]

Throughout this Toolkit, the term "recovery" refers to this definition. This definition does not describe recovery as an end state, but rather as a process. Complete symptom remission is neither a prerequisite of recovery nor a necessary outcome of the process. According to the SAMHSA Working Definition of Recovery, recovery can have many pathways that may include "professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches."[2]

The goal of the Recovery Model is to improve lives. Fundamentally, recovery is subjective. A person's recovery is driven by their personal lived experience of mental health challenges and wellness. It is a journey. Recovery outcomes include empowerment, hope, self-advocacy, choice, self-identified goals, healing, well-being, and control of symptoms. Care is person-focused and one's diagnosis is not permanent. It can be cured.

[1] *Substance Abuse and Mental Health Services Administration. SAMHSA's Working Definition of Recovery. PEP12-RECDEF, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2012.*

[2] *Substance Abuse and Mental Health Services Administration. SAMHSA's Working Definition of Recovery. PEP12-RECDEF, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2012.*

SAMHSA's 10 Guiding Principles of Recovery[3]

SAMHSA developed 10 Guiding Principles of Recovery essential to recovery from a behavioral health issue. These principles promote healing and positivity during one's recovery journey.

Hope
Hope is the catalyst of the recovery process. People can and do overcome internal and external challenges, barriers, and obstacles. Hope is fostered by peers, family members, providers, and allies.

Person-Driven
Recovery is based on self-determination and self-direction. Clients define their own life goals and unique paths towards these goals. They exercise choice over services and treatments.

Many Pathways
Recovery occurs via many pathways. It is highly personalized and may include different treatments, services, and supports. The recovery process is not linear and may involve setbacks.

Holistic
Recovery encompasses the whole life, including mind, body spirit, and community.

Peer Support
Recovery is supported by peers and allies. Peers encourage one another and provide a vital sense of belonging, supportive relationships, valued roles, and community.

Relational
Recovery is supported through relationships and social networks. Positive relationships help clients engage in new roles, achieve a greater sense of belonging, and find new strategies for change.

[3] *Substance Abuse and Mental Health Services Administration. SAMHSA's Working Definition of Recovery. PEP12-RECDEF, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2012.*

Culture
Recovery is culturally based and influenced. Culture or background keys in determining a person's unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet each individual's unique needs

Addresses Trauma
Recovery is supported by addressing trauma. Trauma is often a precursor to or associated with mental health challenges and related issues/ Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.

Strengths/Responsibility
Recovery involves individual, family, and community strengths and responsibility. Individuals, families, and communities have strengths and resources that serve as a foundation for recovery.

Respect
Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems—including protecting their rights and eliminating discrimination—are crucial in achieving recovery. There is a need to acknowledge that taking steps towards recovery may require great courage. Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in one's self are particularly important.

SAMHSA's 4 Major Dimensions of Recovery
Through the Recovery Support Strategic Initiative, SAMHSA has delineated four major dimensions that support a life in recovery:

Health
Overcoming or managing one's disease(s) or symptoms—for example, abstaining from the use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction challenge—and for everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing.

Home
A stable and safe space to live

Purpose
Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society

Community
Relationships and social networks that provide support, friendship, love, and hope.

Recovery in Mental Health and Substance Use

Mental health and substance use prevention and treatment services are becoming more integrated under the single category of "behavioral health". These services have historically had different definitions of recovery that predate this merger. Each arose from shared understandings of the nature of illness reinforced over time within their respective fields, and the systems, institutions, paradigms, and consumer cultures that grew up around these fields

The culture is different!

Mental Health Culture	Substance Use Culture
Psychosocial factors, social determinants, trauma	Individual behaviors, personal decisions
Mental illness is something that happens to you	Substance misuse is something you cause to happen
"You are product of your environment"	"You are a product of your choices and actions"
"Client/Consumer"	"Addict/User"

The traditional approach to substance misuse treatment and recovery falls somewhere between the Medical Model and Recovery Model. SAMHSA's Working Definition of Recovery applies equally to mental health and substance misuse challenges. These recovery principles, concepts, and definitions are universal in that recovery-oriented services focus on clients' individual goals, strengths, challenges, and barriers, not their diagnosis.

Recovery Resources

The 4 Pillars of Recovery

Self-Determination

SAMHSA's Working Definition of Recovery Principles

What is a Recovery Oriented Approach

Recovery-Ready Workplace Resource Hub

Recovery Friendly Workplace Toolkit

Workplace Mental Health Toolkit

What Health Providers and Organizations Need to Know about Wellness

Bell Seal for Workplace Mental Health

Stages of Change

Motivational Interviewing, A Theory for Change (client-centered)

The Peer Role and Recovery Model

Peer support is a system of giving and receiving non-clinical assistance to achieve long-term recovery from severe psychiatric, traumatic, or substance use challenges.

How is Peer Support Different?

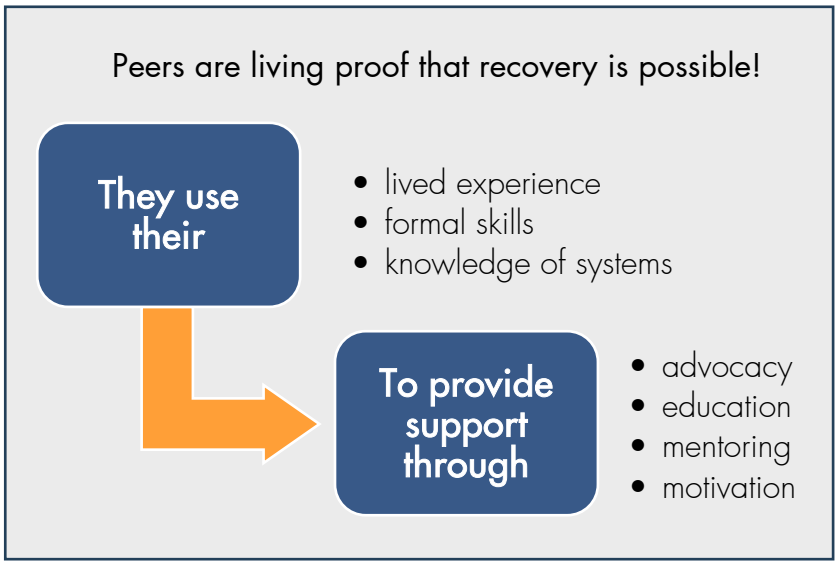
The primary distinction between Peer Support services and other behavioral health services is that Peers draw upon their personal Lived Experience and experiential knowledge in their approach to helping others. It is a relationship of equals. Peer support is grounded in the fact that there are many pathways to recovery and that progress is determined based on a client's achievement of self-defined goals.

Peers share their Lived Experience with others experiencing a similar life challenge. They **use** their Lived Experience to create an authentic connection and **model** how they overcame their challenge(s) to **inspire** and **motivate** others who are now going through it. Peers must have the same Lived Experience as the clients they are serving.

1. Lived Experience of a specific life challenge
   a. Consumers: Having a behavioral health condition
   b. Family Members: Caring for someone with a behavioral health condition
2. Lived Experience of overcoming this life challenge
   a. Consumers: Recovering from a behavioral health condition
   b. Family Members: Achieving resiliency and self-care

Peers can play many roles in supporting people living with behavioral health challenges, such as:

- Support groups
- Peer counseling
- Advocacy
- Personal plan creation
- Wellness Recovery Action Plan
- Health education/navigation
- Engagement
- Socialization
- Cultural brokerage
- Service referrals
- Systems navigation
- Benefits
- Crisis intervention
- Develop natural supports **The Peer Formula**



Peer Support Services can be provided in a variety of programs and settings, including but not limited to:

- Community Outreach
- Phone Bank/Call Centers
- Wellness Centers
- Outpatient Clinics | Multidisciplinary Teams
- Mobile Crisis Response
- Respite Centers
- Emergency Rooms
- Inpatient, Hospitals
- Correctional Facilities

Evidence shows Peer Support reduces:[4]

- Number of admissions and days spent in hospitals
- Use of acute services (e.g., ERs/detox centers)
- Substance use
- Depression and demoralization
- Average service costs per person

Evidence shows Peer Support increases:

- Time in the community
- Engagement in outpatient treatment
- Active involvement in care planning and self-care
- Hope, quality of life, and satisfaction with life
- Rates of family reunification
- Social functioning
- Chances for long-term recovery

[4] *Consumer-Operated Services Evidence-Based Practices (EBP) KIT, http://store.samhsa.gov/shin/content/SMA11-4633CD-DVD/TheEvidence-COSP.pdf, SAMHSA, 2011*

California's Medi-Cal Peer Support Specialist Certification[5]

Peers became eligible for certification in California with the with the passage of SB 803 in 2020. SB 803 recognized Certified Medi-Cal Peer Support Specialists (CMPSS) as a distinct Medi-Cal provider type. It also established that Peer Support Specialist Services delivered by CMPSS workers to Medi-Cal clients were eligible for federal reimbursement.

Establishing the MPSS certification in California has potential to improve the workplaces for Peers. Certification provides the following benefits:

- Legitimizes Peer Support Services
- Elevates the role of Peer Support workers
- Creates a distinct category of paraprofessionals that can collectively advocate for better pay, benefits, and working conditions
- Improves effectiveness of services and supports:
  - Diversifies behavioral health workforce
  - Expands availability of Peer services (and job opportunities for consumers)
  - Provides consistent core competencies, education standards, code of ethics, and scope of practice/services for Peer professionals
- Generates greater revenue for services that already exist

Initial Certification Requirements

To seek Certification as Medi-Cal Peer Support Specialist an individual must meet the following qualifications:

1. Be at least 18 years of age.
2. Possess a high school diploma or equivalent degree.
3. Be self-identified as having experience with the process of recovery from a mental health or substance use challenge, either as a consumer of these services or as the parent, caregiver or family member of a consumer.
4. Be willing to share their experience.
5. Have a strong dedication to recovery.
6. Agree, in writing, to adhere to the Code of Ethics.
7. Successfully complete the 80-hour training requirements for a peer support specialist through a CalMHSA-approved training entity.
8. Pass the certification examination.

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[5] *California Legislative Information,* ***SB-803 Mental health services: peer support specialist certification, 2020,*** *https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB803*

Core Competencies for California Medi-Cal Peer Support Specialists:

1. The concepts of hope, recovery, and wellness.
2. The role of advocacy.
3. The role of consumers and family members.
4. Psychiatric rehabilitation skills and service delivery, and addiction recovery principles, including defined practices.
5. Cultural and structural competence trainings.
6. Trauma-informed care.
7. Group facilitation skills.
8. Self-awareness and self-care.
9. Co-occurring disorders of mental health and substance use.
10. Conflict resolution.
11. Professional boundaries and ethics.
12. Preparation for employment opportunities, including study and test-taking skills, application and résumé preparation, interviewing, and other potential requirements for employment.
13. Safety and crisis planning.
14. Navigation of, and referral to, other services.
15. Documentation skills and standards.
16. Confidentiality.
17. Digital literacy.

SAMHSA's Foundational Principles of Peer Support

Core Competencies for peer workers reflect certain foundational principles identified by members of mental health and substance use recovery communities. These are:

- Recovery-Oriented: Peer workers hold out hope to those they serve, partnering with them to envision and achieve a meaningful and purposeful life. Peer workers help those they serve identify and build on strengths and empower them to choose for themselves, recognizing that there are multiple pathways to recovery.
- Person-Centered: Peer recovery support services are always directed by the person participating in services. Peer recovery support is personalized to align with the specific hopes, goals, and preferences of the individual served and to respond to specific needs the individuals has identified to the peer worker.
- Voluntary: Peer workers are partners or consultants to those they serve. They do not dictate the types of services provided or the elements of recovery plans that will guide their work with peers. Participation in peer recovery support services is always contingent on peer choice.
- Relationship Focused: The relationship between the peer worker and the peer is the foundation on which peer recovery support services and support are provided. The relationship between the peer worker and peer is respectful, trusting, empathetic, collaborative, and mutual.
- Trauma Informed: Peer recovery support utilizes a strengths-based framework that emphasizes physical, psychological, and emotional safety and creates opportunities for survivors to rebuild a sense of control and empowerment.

Peer Support Services[6]

The State defines Peer Support Services provided by CMPSS workers as culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower beneficiaries through strength-based coaching, support linkages to community resources, and to educate beneficiaries and their families about their conditions and the process of recovery.

Peer Support Services include the following service components:

- Educational Skill Building Groups: Providing a supportive environment in which beneficiaries and their families learn coping mechanisms and problem-solving skills in order to help the beneficiaries achieve desired outcomes.
- Engagement: Peer Support Specialist-led activities and coaching to encourage and support beneficiaries to participate in behavioral health treatment.
- Therapeutic Activity: A structured non-clinical activity provided by a Peer Support Specialist to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the beneficiary's treatment to attain and maintain recovery within their communities.

Certified Medi-Cal Peer Support Specialists are able to bill for Peer Services using two Procedure Codes:

- Behavioral Health Prevention Education Services (Educational Skill Building Groups – see description above)
- Self-Help/Peer Services (Engagement and Therapeutic Activities – see description above)

A Peer Support Specialist MAY NOT:

1. Practice outside of their scope of competence.
2. Engage in any services requiring a license.
3. Have a dual relationship with a recipient of services.

[6] *Department of Health Care Services, Behavioral Health Information Notice 22-026, 2022*

Training for Areas of Specialization[7]

There are four (4) areas of specializations for certified Medi-Cal Peer Support Specialists. These specializations focus on additional training that build on the knowledge, skills, and abilities of Medi-Cal Peer Support Specialists.

CalMHSA does not endorse training in areas of specialization as a stand-alone training nor taking these trainings prior to the 80-hour core competency training.

Parent, Caregiver, Family Member Peer

Parent, Caregiver, Family Member Peer plays a critical role in the wellbeing of the families they serve. The Peer-to-Peer relationship focuses on the relationship between the parents, caregivers, and/or family member's support on behalf of the person in care.

The specialization training for Medi-Cal Peers Support Specialist covers the following core competencies:

1. Professional Responsibilities
2. Systems Knowledge and Navigation
3. Resources and Natural Supports
4. Wellness and Resiliency
5. Effecting Change

Additional Information: Parent, Caregiver, Family Member Peer Training Curriculum | Specialization Training

Peer Services in Crisis Care

Peer Services in Crisis Care can complement clinical services and help individuals in crisis. The inclusion of peer support workers in crisis care helps facilitate a trauma-informed response and recovery oriented and strengths-based approaches.

Following are the three categories and their core competencies for peer services for in-crisis care:

Prevention:

1. Pathways to Crisis
2. Prevention, De-Escalation, and Crisis Resolution
3. Engagement and Resource Connection / Navigation
4. Person-Centered Trauma-Informed
5. Co-occurring disorders of mental health and substance use

[7] *California Mental Health Services Authority (CALMHSA), Training for Areas of Specialization, https://www.capeercertification.org/specialization-training/*

During Crisis:

1. Conflict Resolution
2. Person-Centered Trauma-Informed
3. Co-occurring disorders of mental health and substance use
4. Crisis and special populations

Post-Crisis / Recovery / Ongoing Peer Support:

1. Crisis planning and support
2. Self-awareness and self-care

Additional Information: Crisis Care Training Curriculum | Specialization Training

Peer Services for Unhoused

Peer Services for Unhoused can complement clinical services and help individuals who are unhoused or may become unhoused. Individuals and/or families may have unique behavioral health challenges and/or co-conditions. Peer support specialists with experience being unsheltered or unhoused offer a unique perspective in supporting others meet their needs, including behavioral health, housing support, and health conditions.

Following are the core competencies for Specialization – Peer Services for Unhoused:

1. Application of Lived Experience
2. Empowerment and Promotion of Recovery
3. Co-Occurring Disorders: Mental Health and Substance Use Disorders
4. Special Populations and Cultural Considerations
5. Trauma Informed Care
6. Self-Awareness and Self-Care
7. Conflict Resolution
8. Professional boundaries and ethics
9. Safety and crisis planning
10. Systems and Resource Navigation

Additional Information: Curriculum for Working with Persons Unhoused | Specialization Training

Peer Services for Justice Involved

The experience with the criminal justice system can impact an individual's life in many ways and it is best understood by individuals who have similar lived experience. Peers may support individuals with linking to services that address their behavioral health needs and preventing further involvement in the criminal justice systems and ease reentry into their community after incarceration.

Following are the core competencies for Specialization Peer Services for Justice Involved:

1. Application of Lived Experience
2. Role of Advocacy
3. The role of consumers and family members
4. Engagement Skills and Interventions
5. Cultural Responsiveness
6. Trauma Informed Support
7. Self-Awareness and Self-Care
8. Co-occurring disorders of mental health and substance use
9. Professional Boundaries and Ethics
10. Safety and Crisis Planning
11. Community Reintegration Support
12. Recidivism Risk Factors

Additional Information Curriculum for working with Justice Involved | Specialization Training

Specialization areas were determined by the Department of Health Care Services (DHCS).[8]

Any supplemental areas of specialization must be approved by DHCS. A Medi-Cal Peer Support Specialist Certification Program (CalMHSA) may add supplemental areas of specialization at their own discretion; however, they must first submit the curriculum and core competencies for the area of specialization to DHCS by May 1 prior to the start of the State Fiscal Year (SFY) (July 1 – June 30) in which the area of specialization will start. Medi-Cal Peer Support Specialist Certification Programs are the only entities that can submit curriculum and core competencies for a supplemental area of specialization. This process will occur every SFY for any new areas of specialization.

[8] *Department of Health Care Services, Behavioral Health Information Notice 22-061, 2022*

Qualifications for Supervisors of Peer Workers[9]

Individuals considering peer support specialist supervision work must meet one of the following option qualifications:

Option 1

- Have a Medi-Cal Peer Support Specialist Certification; and
- Have two (2) years of experience working in the behavioral health system; and
- Have completed an approved supervisory training.

Option 2

- Be a non-peer behavioral health professional, including registered or certified substance use disorder counselor; and
- Have worked in the behavioral health system for a minimum of two (2) years; and
- Have completed an approved supervisory training.

Option 3

- Have a high school diploma or general equivalency degree (GED)
- Have four (4) years of behavioral health direct service experience. May include peer services.
- And have completed an approved supervisory training.

If a Medi-Cal Peer Support Specialist's supervisor is not also a **Behavioral Health Professional** as defined in BHIN 22-026, the Medi-Cal Peer Support Specialist must also provide services under the direction of a Behavioral Health Professional who meets the qualifications in the previous slides.

A **Behavioral Health Professional** must be licensed, waivered, or registered in accordance with applicable State of California licensure requirements and be listed in the California Medicaid State Plan as a qualified provider of SMHS, DMC, or DMC-ODS.

Medi-Cal Peer Support Specialist Supervisors must take the CalMHSA Peer Support Supervisory training within 60 days of beginning to supervise a Medi-Cal Peer Support Specialist. Supervisors must take the DHCS-approved Peer Support Supervisory training at least once.

Peer Supervisor Training and Requirements can be found at https://www.capeercertification.org/supervisor-training.

[9] *Department of Health Care Services, Behavioral Health Information Notice 22-018, 2022*

Workforce Integration Challenges

Peer Support services are growing as an evidence-based practice to help people with behavioral issues. Peer support services provide several benefits. Peers provide hope that recovery is possible and that others can recover from them as well. They also provide real-world evidence that treatments work. As a result, more people may choose to access services. Finally, peers also act as role models for how to access behavioral health care services and overcome behavioral health conditions (Department of Behavioral Health and Intellectual Disability Services for the City of Philadelphia, 2023)[10].

Traditional behavioral health systems often experience challenges with incorporating peers. These include lack of preparation, lack of understanding, lack of support, lack of advocacy and structural barriers:

Lack of Preparation

Public behavioral health organizations have been hiring more peer support workers since the Mental Health Services Act (MHSA) was passed in 2004. The Act required counties to establish peer support and family education services to satisfy the needs and preferences of clients and their families (Welfare and Institutions Code § 3610(b)). It also mandated that public behavioral health organizations provide equal job opportunities to peers belonging to diverse racial/ethnic, cultural, and linguistic backgrounds as the clients they serve.

Although there was a mandate for county agencies to integrate peers into the workforce, many agencies were not prepared for it. Most agencies recruited peers based solely on their willingness to share their personal lived experiences, without providing any training or education on how to use their experiences to help others. Additionally, many agencies did not have well-defined performance expectations for peers, and rarely provided adequate onboarding, orientation, and training to familiarize them with their roles and responsibilities.

Lack of Understanding

As mentioned in the previous section, many behavioral health agencies are still rooted in the traditional behavioral health medical model. Peers bring with them a background in the recovery model. While these two models can work in concert with one another, recovery principles are frequently not reinforced throughout workplace practices. Non-peer staff and supervisors may react with hostility and mentalism. They assign tasks that no one else wants to do.

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[10] *https://dbhids.org/wp-content/uploads/2024/02/PSToolkit-2023.pdf*

Lack of Support

It is common for peers to lack ongoing guidance and support related to their job duties and peer identities. To share common workplace experiences, strengthen their professional identities, and learn new job skills, peers must interact with one another regularly. Unfortunately, many peers do not have mentors or role models within their organizations and are not provided with opportunities to seek them out in professional settings. As a result, if peers are struggling in their roles and their supervisors do not understand their needs, they often feel isolated and alone.

Lack of Advocacy and Structural Barriers

In workplaces where peer leadership roles are non-existent and peers are limited to their assigned programs without representation in management or a say in important decisions, their needs often go unaddressed. Peers often feel that their workplace leaders don't advocate for their interests, so their pay, benefits, and working conditions remain stagnant.

Moreover, there are additional structural barriers in the form of county personnel and risk management departments that refuse to alter standard hiring practices for peer positions. Institutionalized stigma also plays a role in treating peer staff differently, prohibiting them from accessing client data, walling them off from important activities and information, and treating identification as a peer as a black mark when applying for other positions.

Organization Change to Successfully Integrate Peers

SAMHSA developed recommendations for integrating peer support workers into traditional behavioral health settings. To successfully integrate peers, it is important to follow some guidelines:[11]

1. The process should be done slowly and methodically while working with staff to introduce the change.
2. Agencies should hire more than one peer in a program.
3. Peers should make living wages.
4. Peers should report directly to a high-level administrative staff member, allowing challenges to be addressed quickly so that the peer, and incorporation of peers, can be successful.

When planning for organizational transformation consider all aspects of your organization. Commit to proper onboarding of peers and making necessary changes to welcome and support them as vital contributors. Examples of organizational aspects to assess.

- Organization policies and procedures
- Workforce development practices
- Communication methods
- Peer staff training and education
- Data collection, outcomes, and performance management,

Laying the Foundation

- Engage community members using peers and providers to provide information and education.
- Involve stakeholders by maintaining an open dialogue throughout the transformation process.
- Establish the mission, vision, and values of the system.
- Establish and infuse recovery-oriented values by developing outcomes directly related to recovery.
- Raise awareness about recovery-oriented systems by publishing and sharing information.
- Bring in experts to provide education, training, ongoing support, and technical assistance related to the transformation process.
- Change policies and administrative structures to reflect the inclusion of peers and the adoption of recovery-oriented services.
- Identify and implement recovery, treatment, and recovery-oriented evidence-based practices.

[11] *Equipping Behavioral Health Systems & Authorities to Promote Peer Specialist/Peer Recovery Coaching Services, SAMHSA, 2014*

Policy

- Modify policies to foster the inclusion of peers in the workforce.
- Review and modify policies that pose barriers to employment, education, and housing.
- Adopt a recovery-oriented mission, vision, and values within key government agencies and organizations involved in the system.
- Adapt existing policies and practices to have recovery-oriented language.
- Develop policies and practices that promote recovery principles and modify policies and practices that inhibit recovery.
- Create policies that shift services and support from an acute care delivery model to a model that fosters quality of life and wellness.

Workforce Development

- Incorporate peers as equal and essential workforce participants in all aspects of system development.
- Develop the workforce by raising awareness about the role of peer support workers and recovery-oriented services.
- Develop strategic plans with areas of responsibility assigned to increase accountability for actions and outcomes.
- Develop a performance improvement framework with providers and peers to improve their knowledge of and competencies in delivering recovery-oriented services.
- Foster team building and collaborative opportunities.
- Clearly define staff roles and responsibilities.
- Create and nurture learning environments.
- Build resiliency and promote the health and wellness of staff to prevent burnout.

Peer Leadership

- Clearly define peer roles, drawing on existing evidence-based practices related to peer support services.
- Develop evaluation tools and other methods of providing coaching and helpful feedback to peer staff.
- Provide ongoing training and education to peers to foster leadership skills.
- Fund and develop peer-run programs to educate and train peer providers.
- Establish opportunities for peers to take meaningful leadership roles and achieve career advancement.
- Retrain and educate the workforce to understand and respect the role of peer providers.
- Establish pay scales that acknowledge the value of lived experience in the workforce.
- Create campaigns to educate and reverse workplace stigma around peers with lived experience.

Research and Outcomes

- Create a mechanism for peers and people in recovery to define outcomes and train people to understand them.
- Ensure data collected captures desired recovery outcomes.
- Increase the accessibility of data by using creative ways to share the information (e.g., fact sheets, intranets, podcasts).
- Establish new data systems that are integrative to create concurrent monitoring and data collection.
- Increase funding for research into recovery-oriented practices and peer-provided services.

Core Competencies for Agencies Employing Peer Support Workers

In recent years, US behavioral health systems have shifted towards more recovery-oriented approaches for mental health and substance use conditions. Yet, it is insufficient to only offer recovery-oriented services. Instead, the entire service delivery system must be recovery-oriented.

The following are core competencies that help organizations develop a recovery-oriented system and ensure the success of peer-provided services:

1. A recovery-oriented work culture that values the unique contributions of peers;
2. Dedicated and influential workplace leaders committed to peer-provided services;
3. Supportive managers and supervisors willing to coach peer staff;
4. High-quality ongoing training and individual mentoring for peers;
5. Adequate oversight, evaluation, and feedback for peer positions;
6. Clearly defined peer roles and genuine opportunities for career advancement;
7. Collaborative working relationships amongst all staff, peer and non-peer;
8. Workplace infrastructure that supports continuity and growth of peer programs;
9. Regular opportunities for peer employees to interact with one another;
10. Flexible workplace policies and procedures; and
11. An open learning environment.

These core competencies are explained in greater detail in the following pages.

Competency 1: A Recovery-Oriented Work Culture that Values Peers

Highlights

- Recovery Orientation
- Person-Centered
- Client-Driven
- Strengths-Based
- Work Culture
  - Shared attitudes, beliefs, and behaviors of employees of an organization
  - Influenced by leadership, managers, procedures, and people
- Recovery-Oriented Work Culture
  - Encourages individuality
  - Promotes accurate and positive portrayals of psychiatric disability
  - Uses the language of hope and possibility
  - Offers a variety of options for treatment, rehabilitation, and support
  - Helps people develop valued social roles, interests, and hobbies
  - Effectively engages stakeholders
  - Encourages user participation in advocacy activities

What is it?

Work culture is the values and practices shared by employees of an organization, program, or team. These include shared attitudes, beliefs, behaviors, and identities. It's "the way we do things around here." Work culture drives employee engagement, productivity, and performance. Leadership, managers, procedures, and people all influence work culture.

California mental health programs receiving MHSA funds are required to provide recovery-oriented services. Recovery orientation is more than a slogan or the latest buzzword. It is a governing philosophy that drives everything a program says and does. It is observable in the program's actions, goals, values, attitudes, and outcomes. There are three criteria programs must have to meet the definition of "recovery-oriented":

- Person-Centered (not illness-centered)
- Client-Driven (not professionally-driven)
- Strengths-Based (not deficits-based)

Organizations with successful peer programs have a work culture rooted in recovery-oriented principles. These agencies appreciate the unique contributions of peers. They also recognize the benefits of peer support. Their organizational culture infuses recovery concepts at every level, not only in services. Recovery principles are throughout organizational policies, processes, and procedures. Supervisor styles also reflect a recovery orientation.

Why it Matters

Recovery is not just about treating illness. It's also about helping individuals improve their lives as a whole. The public mental health system has been using the Medical Model as the standard for mental health services. However, the MHSA aimed to encourage providers to adopt the Recovery Model and do "whatever it takes" to help individuals achieve and maintain recovery, and not stick to the usual way of doing things. Programs that are not truly recovery-oriented are unlikely to succeed. Such programs won't be able to help peers to grow professionally. This is frustrating and can lead to disengagement, poor performance, greater rates of disability, and higher turnover among the staff.

Assess Your Organization's Competencies and Work Culture

- Is leadership informed about the history of the consumer movement and new developments?
- Do all of your employees – from leadership to clerical – understand and embrace basic recovery concepts?
- Are key recovery principles integrated into your program's services?
- Does everyone in your agency treat clients with dignity, respect their autonomy, and empower them to make their own choices?
- Do you offer a wide variety of services, including those that are non-clinical and strengths-based?
- Are you collecting and measuring recovery-based outcomes?

Included Tools and Handouts

- How Recovery-Oriented is Your Workplace? (p. 47)
- Recovery Infographic (p. 48)

Additional Resources Recovery-Oriented Services

A Recovery Culture Progress Report

Creating, Leading, and Sustaining a Culture Centered in Recovery and Resilience

MHA Village – Dr. Mark's Writings

SAMHSA's Working Definition of Recovery: 10 Guiding Principles of Recovery

Competency 2: Dedicated and Influential Leaders

Highlights

- Dedicated Leaders
  - Have integrity
  - Are devoted to an ideal, cause, or goal
- Influential Leaders
  - Affect others' actions, behaviors, and opinion
- Help employees understand:
  - What they need to do
  - How their work contributes to the organization
  - Whether there are impending changes
- Dedicated and Influential Leaders
  - Take full responsibility
  - Have difficult conversations
  - Have a "Hands On" philosophy
  - Don't be hypercritical or micro-manage
  - Commit time and resources
  - Hold people accountable
  - Communicate expectations clearly and early on
  - Outline clear/reasonable plans and timetables to achieve goals

What is it?

Successful mental health organizations in California are led by influential and dedicated individuals who are committed to peer-provided services. These leaders are known for their unwavering commitment to an ideal, goal, or cause, and have the ability to shape and influence the behavior, actions, and opinions of others.

- Establish the mission, vision, and values of the system.
- Identify and implement recovery, treatment, and recovery-oriented evidence-based practices.
- Change policies and administrative structures to reflect the inclusion of peers and the adoption of recovery-oriented services.
- Bring in experts to provide education, training, and ongoing support, and technical assistance related to the transformation process.
- Involve stakeholders by maintaining an open dialogue throughout the transformation process.
- Establish and infuse recovery-oriented values by developing outcomes directly related to recovery.
- Raise awareness about recovery-oriented systems by publishing and sharing information.
- Engage community members using peers and providers to provide information and education.

Such leaders have a realistic grasp of their power and responsibility to serve and strive to ensure that everyone on the team has access to the tools they need to get the job done right.

Why it Matters

Successful peer programs rely on more than just the competence of their peer support workers. Leaders are responsible for laying the foundation for peer-support integration, so leadership directly determines how well a peer program can be run. Optimal performance management and supervision strategies are necessary to ensure the alignment of peer core competencies, best practices, organizational vision, and values.

Dedicated and influential leaders can increase employee morale, resiliency, and trust while decreasing employee frustration and conflict by actively engaging with the organization and its team. To ensure a successful program, it's important to have quality leadership. Without it, workplace burnout, disengagement, and performance challenges can arise. These issues can negatively impact work productivity and the integration of peer-provided services in California's PBHS.

Assess Program Leadership

- What types of leadership are most effective for your peer programs?
- Are program leaders actively seeking peer perspectives?
- Do your leaders have a clear vision to strengthen and sustain peer employment?
- Does leadership consistently promote peer employment/ inclusion?
- Does upper management value the contribution of peers?
- Are there designated peer positions that participate in management team meetings, program planning, quality improvement, system transformation, etc.?

Included Tools and Handouts

Analyzing Leadership Challenges: Root Cause Analysis (p. 49)

Additional Resources: Dedicated and Influential Leadership

Equipping Behavioral Health Systems & Authorities to Promote Peer Specialist/Peer Recovery Services

Innovative Ways to Utilize Consumer/Peer-Run Organizations in SOAR

Peer Support Toolkit

Pillars of Peer Support: Transforming Mental Health Systems of Care through Peer Support Services

Working Well: Leading a Mentally Healthy Business

Competency 3: Supportive Managers and Supervisors Willing to Coach

Highlights

- Being Supportive
  - Providing empathy, encouragement, assistance
  - Can include physical, professional, emotional, intellectual, and financial support
- Coaching
  - Supporting someone in achieving a specific goal by providing training and guidance
  - Methods
    - Focusing on here- and now-needs and accomplishments
    - Close observation
    - Impartial and non-judgmental feedback on performance

What is it?

Managers and supervisors of successful peer programs are supportive and willing to coach peer staff. Supportive managers provide empathy, and encouragement, advocacy and assist their peer staff in achieving a specific personal or professional goal by providing training and guidance. This may include focusing on a peer support worker's here-and-now needs and accomplishments, close observation, impartial and non-judgmental feedback on job performance.

Supervision is one form of support, but support goes beyond just that. It can take a variety of forms – physical, professional, emotional, intellectual, and financial.

The term coaching typically refers to helping others improve, develop, learn new skills, find success, achieve aims, and manage change and challenges. Supportive managers and supervisors are willing to coach and seek to understand their peer staff's psychological and mental health concerns and respond appropriately as needed.

Supportive managers are not disrespectful to peers and are not critical. They work to understand their employee's capacities and avoid non-constructive feedback. In addition, they avoid contradictory behaviors. For example, they don't create a stressful situation (e.g., setting tight deadlines) and then try to provide emotional support. They also avoid poor problem-solving, ineffective performance monitoring, and spending too long checking on progress (e.g., long team meetings, lack of interest in employees' ideas or work).

Why it Matters

Employers may provide a foundation of support, but employees keep it running. Recovery-oriented work culture thrives when everyone takes responsibility, especially supervisors. Supervisors maintain a recovery-oriented culture by leading by example, taking initiative, and building a support network. Peers stay focused and determined over time and through difficulties when they have proper support and coaching. These also help them do their jobs more quickly, effectively, and comfortably.

When peer support workers perceive a lack of support from their organization, it can lead to increased absenteeism, withdrawal behaviors, conflict, strain, turnover, loss of productivity, increased costs, and a greater risk of accidents, incidents, and injuries.

The more peer support workers feel they have psychological support, the greater their job attachment, job commitment, job satisfaction, job involvement, positive work moods, desire to remain with the organization, organizational citizenship behaviors, and job performance.

Assess Your Program's Support and Coaching Systems

- Do your supervisors provide enough support during times of need?
- Are your managers familiar with the concept of coaching and how to coach effectively?
- Consider providing extra support to peers when they:
  - Are new
  - On special occasions

Included Tools and Handouts

Agency Policies and Practices that Address the 13 Psychosocial Risk Factors at Work (p. 52)

Resources: Supportive Managers Willing to Support

Accommodations Ideas for Mental Health Impairments

Guarding Minds @ Work

Psychological Health and Safety: An Action Guide for Employers

JAN Workplace Accommodation Toolkit: Building Your Inclusive Workplace

Pillars of Peer Support Services – Summit 6: Peer Specialist Supervision

Competency 4: High-Quality Ongoing Training and Mentoring for Peers

Highlights

- High-Quality On-Going Training
  - Continuous and enhances staff skills, capabilities, and knowledge
  - Organizational training on work culture and managerial competencies
  - Training on technical and behavioral skills for peers
  - Training may require special educational materials
  - Administered by expert and confident trainers
  - Improves mentorship relationships
- Individual Meeting
  - Enhances less experienced persons' broad skills for future personal or professional development
  - Can solidify trainings

What is it?

Ongoing training and individual mentoring of peer staff is essential to the success of agencies that employ peer support workers. High-quality ongoing training is continuous. It accomplishes more than just the enhancement of skills, capabilities, and knowledge of employees doing a particular job.

High-quality training:

- is data-driven and research-based
- has content that is suitable and engaging (e.g., training on the work culture and managerial competencies for leaders)
- has content that enables learners to internalize and "own" their learning
- is in an appropriate environment with minimal interruptions (e.g., one-on-one, classroom-style, online, on-the-job, hands-on, etc.).
- has specific materials that are provided to learners
- is administered by expert and confident trainers who inspire, entertain, counsel, and even push back to make peers think.

Individual mentoring is a relationship-based support tool. In the mentoring relationship, the more experienced person enhances the other person's skills to help with development. Effective mentors provide ongoing personalized, compassionate, problem-solving support while monitoring peer milestones. At the same time, they show a visible concern for their own physical and psychological health.

Why it Matters

The quality and consistency of employee training are crucial factors in the effective development of skills, knowledge, and attitudes of peers. High-quality training enhances peers' technical and behavioral skills and leads to increased professional development and output. Peers need more from trainers than speaking skills. No longer can trainers rest on their technical know-how to engage and affect learners. An organization's training process molds the thinking of team members. When employees are well-trained, they are more efficient and productive. They also have higher morale, need less supervision, and are more eligible for promotion.

Individual mentorship meets many of peers' workplace needs for appreciation, belonging, flexibility, purpose, recognition, respect, and support. Job engagement and productivity soar when employers meet these workplace needs.

Assess Your Program's Training and Mentoring Capabilities

- Design and develop training after asking several key questions:
  - What are the expected results?
  - What behaviors are needed to achieve those results?
  - What knowledge, skills, and attitudes are needed to affect the desired behaviors?
  - Are enough questions being asked before learning objectives are solidified?
  - Are your peers' workplace needs met by the work they do?

Resources: High-Quality Training and Mentoring

Core Competencies for California Medi-Cal Peer Support Specialists

California Peer Specialist Training Programs

California Peer Specialist Specialization Training Programs

Wellness Recovery Action Plan (WRAP) Seminars and Training

Whole Health Action Management Training

WISE University: Medi-Cal Peer Support Specialist Certification Program

Competency 5: Oversight, Evaluation, and Feedback for Peer Positions

Highlights

- Oversight
  - Watchful management of an operation or process
- Peer Evaluation
  - Incorporate core principles and values of peer support
  - Assess peers' skill levels in the 12 core competencies
  - Include organizational vision and values
- Feedback
  - Reinforce expectations
  - Clarify and prevent misunderstandings
  - Uncover unique strengths and motivators
- Adequate Oversight, Evaluation, and Feedback
  - Delineates how to collect and measure program outcomes
  - Increases employee engagement, morale, pride, and willingness to make extra effort when required
  - Decreases cynicism

What is it?

Adequate oversight, evaluation, and feedback of peer positions are essential to the ongoing success of peer-provided services. Oversight consists of regulatory supervision and watchful management of an operation or process. Evaluation is an assessment, or a judgment, about the amount, number, or value of something. Feedback consists of information about reactions to a product and/or a person's performance of a task. It is used as a basis for improvement. Successful agencies use all three of these tools to conduct research and discover outcomes of their peer-based programs. To guide the use of these valuable tools, these agencies:

- Create a mechanism for peers and people in recovery to define outcomes and train people to understand them;
- Ensure data collected captures desired recovery outcomes;
- Increase the accessibility of data by using creative ways to share the information (e.g., fact sheets, intranets, podcasts);
- Establish new data systems that are integrative to create concurrent monitoring and data collection;

- Conduct frequent (weekly, biweekly, or monthly) check-ins with peers and non-peer staff to determine how things are going, explore potential issues, and prevent future challenges;
- Increase funding for research into recovery-oriented practices and peer-provided services.

Why it Matters

Although the MHSA requires organizations to hire peers, it does not say how PBHS employers should achieve this mandate. There is no guidance or oversight from any statewide authority related to the integration of peers. There is no official entity evaluating or monitoring the integration of peers into the PBHS workforce.

Organizations need incentives, pressures, clear guidelines, and easy access to free help to successfully integrate peers. PBHS employers can access support and technical assistance to help them plan for the inclusion of peers. They can also seek or guide them through the correction of past mistakes.

Furthermore, proper oversight, evaluation, and feedback can provide data to uphold and identify the benefit of peer support work as an evidence-based practice.

Assess Your Program's Oversight, Evaluation, and Feedback Practices

- Peer Supervision
- Performance expectations
- Performance Evaluation
- Policies to address performance issues
- Data security protocols
- Documentation and record-keeping requirements

Included Tools and Handouts

- Recommended Peer Onboarding Procedures (p. 60)
- Supervisor Checklist for Peer Supporters(p. 63)
- Sample Peer Support Specialist Self-Assessment (p. 65)
- Collaborative Workplan (p. 68)

Resources: Oversight, Evaluation, and Feedback

Consumer Operated Services: Evaluating Your Program

Cultural Competency in Mental Health Peer-run Programs and Self-help Groups: A Tool to Assess and Enhance Your Services

Pillars of Peer Support Services – Summit 6: Peer Specialist Supervision

Toolkit for Evaluating Adult Community Services and Supports Programs

Toolkit for Evaluating Peer Respites

Competency 6: Clearly Defined Roles and Opportunities to Advance

Highlights

- Clearly-Defined Roles
  - Role easily and accurately perceived and interpreted
  - Non-peer staff have an understanding of the peer role
- The Peer Role
  - Lived experience of recovery is necessary
  - Core competencies and best practices
  - Prioritizing client's interests
  - Non-clinical and non-judgmental
  - Maintain ethics and boundaries
  - Sharing recovery stories
  - Advocate
  - Model recovery and inspire hope
  - Educate others
  - Personal and professional growth
- Examples of Advancement Opportunities
  - Peer Program Lead/Coordinator/ Supervisor/Manager
  - Patients' Rights Advocate
  - Client Advocate/Liaison
  - Cultural Competency Team
  - Quality Improvement Team
  - WET Team
  - MHSA (BHSA) Coordinator

What is it?

Organizations that offer the most stable and resilient peer programs have clearly defined peer roles and offer genuine opportunities for career advancement.

When peer roles are clearly defined, the functions of a peer support worker are easily and accurately perceived and interpreted. Effective employers understand the peer role before designing peer jobs and writing job descriptions. They understand that peers can provide a variety of services, including but not limited to:

- facilitating support groups
- peer counseling
- advocacy
- personal plan creation
- health education/navigation
- cultural brokerage
- services referrals
- system navigation
- benefits/healthcare acquisition
- crisis intervention
- engagement activities

Competent employers also understand that while the lived experience of recovery is necessary in the peer role, it is not enough. Nor does it ensure employee success. These employers incorporate recognized core competencies and best practices into peer job descriptions. Peers receive training and are encouraged to:

- Understand the principles of peer support and key recovery concepts.
- Model recovery at all times.
- Maintain appropriate interpersonal boundaries.
- Educate others about their roles.
- Review their job descriptions.

Workplaces that offer genuine opportunities for career advancement are those that provide authentic and sincere chances for employment, promotion, development, and improvement. In effective peer support work environments, peers receive real encouragement and support in developing their job skills and are exposed to a range of internal and external opportunities to enhance their competencies and prepare for potential future positions.

Why it Matters

Role confusion is one of the most common challenges in the successful integration of peer-provided services. Organizations that have not yet hired peers, or have a flawed integration of peers, may experience cooptation, and mishandling of transitions (e.g., from recipient to provider of services, client to coworker, and acquaintance to mentor). Peers become bored when they do not understand or are not challenged by their work. Their well-being and job performance also suffer. When peers' job duties are clear and relevant to peer roles, organizations can avoid or overcome role confusion.

Peer development opportunities increase goal commitment, organization commitment, job satisfaction, and the sentiment that the organization truly cares.

Assess Your Program's Peer Roles and Opportunities

- What program(s) will peers work in?
- Who will supervise peers?
- What duties will peers perform?
- What potential barriers to integration exist?
- Does your agency offer advancement for peers?
- What long-term growth and development exists for peer programs?

Included Tools and Handouts

- Sample Job Announcement/ Description (p. 54)

Lived Experience Requirements

Population Served	Lived Experience Required
Adult Mental Health Clients/Consumers (18+)	"Must have personal lived experience of recovery from a mental health challenge."
Family Members of Adult Consumers (18+)	"Must have personal lived experience as a close family member or caretaker providing direct support to an adult with a mental health challenge."
Parents/Caregivers of Children & Youth (≤ 17)	"Must have personal lived experience as a parent or primary caregiver providing direct support to a child or youth with an emotional, mental, or behavioral health challenge."
Transition Age Youth (16-24)	"Must be between the ages of 18-(24) and have personal lived experience of resiliency or recovery from a mental health challenge."

Resources: Defined Roles and Opportunities to Advance

California Core Competencies for Peer Support Specialists
Code of Ethics for Certified Medi-Cal Peer Support Specialists
Development of Peer Specialist Roles: A Literature Scoping Exercise
Emerging Practices in Employment of Persons in Recovery in the Mental Health Workforce
Ethical Guidelines for the Delivery of Peer-based Recovery Support Services
How to Create Meaningful Roles for Peer Providers in Integrated Healthcare
Living Wage Calculator for Sacramento County, California
National Practice Guidelines for Peer Supports
National Survey of Compensation Among Peer Support Specialists
Peer Involvement and Leadership in Early Intervention in Psychosis Services: From Planning to Peer Support and Evaluation
Peer Specialists in Mental Health Services: Workplace Integration and Outcomes
SAMHSA Core Competencies for Peer Workers in Behavioral Health Services
What do peer support workers do? A job description

Competency 7: Peer and Non-Peer Staff Collaboration

Highlights

- Collaborative Working Relationships
  - Relationship of equals
  - Clearly defined roles
- Peer and Non-Peer Staff
  - Are equal and essential
  - Are responsible and accountable
  - Make up a team
  - Need clearly-defined roles
  - Learn together
  - Strive to remain resilient and well
  - Aim to understand and learn from conflict
  - Acknowledge fallibility and invite contribution
  - Model curiosity and ask questions

Breaking it Down: What is it?

Healthy organizations with peer-provided services cultivate collaborative working relationships amongst all peer and non-peer staff. Collaboration exists when multiple people communicate and work together to achieve the same goal, and is present in programs where:

- Peers are incorporated as equal and essential workforce participants in all aspects of system development.
- The workforce is developed and aware of the role of peer support workers and recovery-oriented services.
- Strategic plans with areas of responsibility increase accountability for actions and outcomes.
- A performance improvement framework with improves knowledge of and competencies in delivering recovery-oriented services.
- Team building and collaborative opportunities are fostered.
- Staff roles and responsibilities are clearly defined.
- Learning environments are created and nurtured.
- The resiliency, health, and wellness of staff prevent burnout.
- Conflicts are framed as opportunities for understanding and learning.
- Fallibility is acknowledged and contribution is invited ("I may miss something and would appreciate any feedback you may have").
- Curiosity is modeled and many questions are asked.

Absent in collaborative work environments are various types of threatening behavior, abuse, physical attacks, harassment, and bullying.

The Bigger Picture: Why it Matters

The saying that "people don't quit companies, they quit people," rings true for many groups and individuals.

According to a survey run by Mental Health America National, two of the top five factors attributed to employee satisfaction are based on positive relationships with co-workers and immediate supervisors. Three of the top five common challenges for peers in the workplace involve stigma, isolation, and stressful working conditions.

When peers and non-peer staff collaborate, there is an exchange of social support that enhances coping capacities (e.g., work demands are perceived to be more manageable), reduces the severity of stress, and acts as a buffer between work demands and psychological and physical health and wellbeing. Collaboration in the workplace has positive effects on health, well-being, job satisfaction, perceptions of fairness, attitudes, morale, and teamwork. It also leads to a greater interest in personal development, engagement in problem resolution, enhanced staff relationships, reduction in sick leave, and reduction in turnover.

Try this

- Assess Your Program's Collaborative Relationships
  - Do non-peer staff understand the value of peer-provided services?
  - Do all employees feel like they fit in?
  - Are employees respectful and considerate in their interactions with one another, as well as with customers/clients/members, vendors, and the public?
  - Does workplace communication move toward practical resolutions rather than just highlighting and reinforcing work issues?
  - Does your workplace proactively prevent and address workplace threats, attacks, and other relationship-based issues?
- Work with Existing Staff
  - Explain the peer role
  - Explain the employer competencies
  - Share your vision for the role and program
  - Gather input and generate buy-in
  - Address and dispel common myths related to peers in the workplace

Resources: Peer and Non-Peer Staff Collaboration

Peers and Clinicians Together

Mental Health Consumer Providers: A Guide for Clinical Staff

Interprofessional Mentoring Guide

Competency 8: Infrastructure that Supports Growth of Peer Programs

Highlights

- Workplace Infrastructure
  - Organizational structure needed for the operation of an agency or program
  - Personnel/risk management understands the purpose and value of peer support
- Continuity
  - Unbroken, consistent existence over some time
- Growth
  - Development from a lower or simpler form to a higher or more complex form
  - Evolution
  - Expansion
- Examples of Peer Programs
  - Drop-in centers or spaces
  - Peer support groups
  - Skills-development programs
  - Camps or retreats
  - Self-help groups
  - Peer educator training programs
  - Mobile crisis/support teams
  - Call centers

Breaking it Down: What is it?

In a well-run mental health organization, workplace infrastructure supports the continuity and growth of its peer programs. Peer programs survive and thrive when the an agency's organizational structure has:

- Clearly defined peer roles that draw on existing evidence-based practices related to peer support services;
- Evaluation tools and other methods of providing coaching and helpful feedback to peer staff;
- Ongoing training and education that foster peers' leadership skills;
- Funding for and development of peer-run programs to educate and train peer providers;
- Opportunities for peers to take meaningful leadership roles and achieve career advancement;
- Training and education that helps the workforce understand and respect the role of peer providers;

- Established pay scales that acknowledge the value of lived experience in the workforce;
- Campaigns to educate and reverse workplace stigma around peers with lived experience; and
- Appropriate, fair, and timely acknowledgment and appreciation of peers' efforts (e.g., financial compensation, celebrations, recognition of years served, milestones reached).

Underlying all these components is the importance of safety in the workplace. A physically and psychologically safe and healthy workplace promotes workers' physical and mental well-being. The workplace does not harm employee's physical or mental health in negligent, reckless, or intentional ways. Managers in these workplaces take appropriate action to protect the physical and mental safety of their employees.

The Bigger Picture: Why it Matters

Peer programs need healthy environments to flourish. If a workplace does not promote engagement, continuity, and growth throughout its infrastructure, it may see marked psychological and medical consequences. This includes greater employee turnover, counterproductive behavior, and withdrawal behaviors that could lead to a collapse, eradication, or discontinuation of its programs. In addition, if employees and others perceive a workplace's conditions as unsafe, ambiguous, inconsistent, and/or unpredictable, these perceptions can undermine stakeholder, consumer, and public confidence in the organization and reduce funding opportunities needed to sustain and grow programs.

Resources: Infrastructure that Promotes the Growth of Peer Programs

Creation of the Pillars of Peer Support Services: Transforming Mental Health Systems of Care

DIMENSIONS: Peer Support Program Toolkit

Peer Services Toolkit: A Guide to Advancing and Implementing Peer-run Behavioral Health Services

Perspectives on the Evolution and Future of Peer Recovery Support Services

Pillars of Peer Support: Expanding the Role of Peer Support Services in the Mental Health Systems of Care and Recovery

The Peer Provider Workforce in Behavioral Health: A Landscape Analysis

Competency 9: Regular Opportunities for Peers to Interact

Highlights

- Regular Opportunities to Interact
  - It recurs and happens often
  - Happen in predictable and/or equal intervals
  - Facilitated by peer staff
- Interactions between Peer Employees
  - Coming together
  - Communicating
  - Troubleshooting/problem-solving
  - Acting reciprocally
  - Share knowledge and experience
  - Affect each other
  - Network of mentors

Breaking it Down: What is it?

Effective and healthy mental health agencies ensure there are regular opportunities for peer employees to interact with one another. Regular opportunities are those that are recurring and happen often, usually in predictable and/or equal intervals. Interactions take place when peers come together, communicate, act reciprocally, and have an effect on each other.

Regular interactions may consist of daily check-ins, weekly meetings, monthly conference calls, webinars, or annual team-building events that present opportunities for peer employees to engage with one another.

The Bigger Picture: Why it Matters

When peer employees do not have frequent contact with each other, isolation, cooptation, and dilution of the peer role tend to occur. The dilution of the peer role and cooptation lead to a "professionalization" of the peer role. Peer employees adopt values, attributes, and styles associated with clinical providers. They drift toward traditional, medical practices and becoming "mini-clinicians." When peers are brought into the "legal, ethical, and clinical cultural framework" of treatment organizations, they experience acculturation and, through that process, surrender the very attributes that recommended their participation in behavioral health systems of care to begin with.

In one survey, 77% of peer staff working in treatment organizations reported that they provide treatment services at a much higher rate than those working in peer organizations. 85% of peer staff working in treatment organizations reported receiving training intended to increase their knowledge of the treatment methods used in the organizations in which they work, while only 50% of peer staff working in peer

organizations reported the same. This suggests that peer staff working in treatment organizations may be perceived as "helpers," and of secondary status to treatment professionals, rather than providers of a separate set of services. This is reinforced by the fact that peer staff working in treatment organizations are much more likely to work part-time than their counterparts working in peer organizations.

When peer employees are allowed to regularly interact with other peer employees within their team or department and/or other programs and agencies, they are more likely to maintain a strong peer identity, reduce isolation, and build a sense of belonging. This has a direct impact on their commitment to tasks, sense of role clarity, and collaborative effectiveness. They also retain motivation to continue to tell their story, use recovery language rather than clinical language, advocate for client and family member interests, and refrain from using their position with clients and family members to push a clinical agenda.

Try this

- Assess Your Program's Opportunities for Peer Employee Interactions

  To address isolation, ask:
  - Is there enough support for the peer role?
  - Do peers find support from peers in their team or department or other programs and agencies?
  - Are peers encouraged to participate and asked to share their opinions?
  - Do peers participate in group activities and community events?
  - Do peers have mentoring and/or networking opportunities?

  To address cooptation, ask:
  - Are there 2+ peers per program?
  - Have peers developed a strong peer identity?
  - Is there reinforcement and support for the peer role?
  - Are peers supervised by peers to emphasize the non-professional nature of the services they provide?
  - Does a career ladder exist for peers?
  - Are clinical or treatment staff educated on the peer role?

Resources: Regular Opportunities for Peers to Interact

Sacramento County Peer Support Specialist Committees

California Association of Peer Professionals

National Association of Peer Supporters

WISE Peer Staff Professional Development Group

Competency 10: Flexible Workplace Policies and Procedures

Highlights

- Policies
  - A set of guiding principles to help with decision-making
- Procedures
  - Methods used to express policies in the day-to-day operations of an agency
- Flexible Policies and Procedures
  - Can be easily changed according to a given situation
  - Can bend easily without undermining an agency's purpose
  - Can lead to opportunities for professional development and career advancement
- Examples of Flexible Workplace Practices
  - Variable start and finish times and days worked
  - Ability to work from home
  - Ability to work part-time
  - Discretionary leave
  - Ability to arrange work to regulate tasks to meet work demands.

Breaking it Down: What is it?

California's effective mental health programs have flexible workplace policies and procedures. The flexibility helps attract and keep talented valued employees. Flexibility raises morale and job satisfaction, improves productivity, and reduces stress or burnout. Policies are clear, simple statements of how an agency intends to conduct its business, services, or actions. They provide a set of guiding principles to help with decision-making. Procedures are more specific. They outline the methods used to express policies in the daily operations of the agency. Policies and procedures influence and determine all major decisions, actions, and activities of an agency. They are the boundaries on which employees can make choices. Additionally, flexible workplace policies and procedures are often changeable according to a given situation. They can bend without breaking meaning or purpose.

Mental health programs demonstrate flexible policies and procedures when they:

- Modify policies to foster the inclusion of peers.
- Adopt recovery-oriented mission, vision, and values within key government agencies and organizations.

- Review and modify policies that pose barriers to employment, education, and housing for people who have mental health conditions and/or criminal justice histories.
- Adapt existing policies and practices to have recovery-oriented language.
- Develop policies and practices that promote recovery principles and modify policies and practices that inhibit recovery.
- Recognize and accommodate all employees' need for balance between work demands, family, and personal life.

The Bigger Picture: Why it Matters

Employers who recognize the effectiveness of peer-provided services and the importance of work-life balance tend to understand the necessity for greater flexibility in the workplace. In California's public mental health system, peers often find themselves in marginally employed positions and struggle to earn a living wage, which limits their career advancement. The current approaches often do not address the systemic impediments to peer job placement, which highlights the need for flexibility to explore more opportunities, become responsive to change, signal diversity in the workplace, successfully integrate and engage peers, and evolve peer programs effectively.

Try this

- Assess Your Program's Flexibility
  - How does your agency regard change?
  - Does your agency make all the internal changes necessary to integrate peers as quickly as possible?
  - Do workplace changes benefit both the agency and employee(s) and result in superior outcomes?
  - Is the consumer/family member voice incorporated into policy, planning, and decision-making?
  - Does the agency understand workplace laws and legal requirements related to peer employment?
  - Does the agency's hiring process prevent the hiring of qualified peer staff?

Resources: Flexible Policies and Procedures

JAN Workplace Accommodation Toolkit

Creating Mental Health-Friendly Workplace

Workplace Flexibility: Information and Options for Small Businesses

Toolkit for Employing Individuals with Lived Experience Within the Public Mental Health Workforce

Employer Best Practice Guidelines for the Return to Work of Workers on Mental Disorder–Related Disability Leave

Workplace Research: National Study of Employers

How We Rewrote Our Company's Mental Health Policy

Competency 11: An Open Learning Environment

Highlights

- Open Learning Environments
  - Learner-centered
  - Individuals choose what's important
  - The needs of the learner are determined by the learner
  - May incorporate
    - Classroom teaching
    - Interactive learning
    - Work-related education and training
    - Various cultures and ecologies
    - Community
    - Open educational resources
  - Can foster psychological protection for employees
  - Student-directed

Breaking it Down: What is it?

The most competent agencies in California's PBHS foster open learning environments. Open learning environments are "rooted in learner-centered design principles and highlight activities and contexts that 'support the individual's efforts to understand what he or she determines to be important' (Hannafin et al. 1994, p. 48)."

Open learning involves, but is not limited to:

- classroom teaching methods
- approaches to interactive learning
- the cultures and ecologies of learning communities, and the development and
- formats in work-related education and training
- use of open educational resources

While there is no agreed-upon, comprehensive definition of open learning, the central focus is on the "needs of the learner as perceived by the learner."

Open learning environments emphasize self-directed learning. They provide guidance and support strategies to help students engage in open-ended problem-solving. Case studies show that open learning is an innovation used across academic disciplines, professions, social sectors, and national boundaries. It is also used in business, higher education institutions, and collaborative initiatives between institutions.

Agencies with open learning environments present open-ended activities and invite new people, materials, ideas, and values to flow into their workplace environments.

The Bigger Picture: Why it Matters

A climate of openness, characterized by exploration, risk-taking, and tolerance, elevates an individual as a worker and as a person. It opens opportunities for an agency to continuously transform for the better. Employees learn and grow when they feel their beliefs are free to change as they expand their understanding and perspective.

Providing diverse opportunities for employees to enhance their skills and knowledge leads to higher engagement and growth. Employees are also better equipped for potential future roles within the agency. Ongoing support in developing interpersonal, emotional, and job skills positively affects organizational health and individual employee well-being. This can also reduce organizational costs and improve work context (Simon Fraser University).

An open learning environment can foster psychological protection for employees. It allows them to feel able to put themselves on the line, ask questions, seek feedback, report mistakes and challenges, or propose a new idea without fearing negative consequences to themselves, their job, or their career

Try this

- Assess Your Program's Learning Environment
  - Are training and other learning opportunities in your workplace formalized and taken seriously?
  - Are you aware of the different learning styles of your employees?
  - Can current learning opportunities in your workplace be enhanced and/or broadened?
  - Are employees who successfully learn new skills and abilities recognized? Does this encourage others to follow suit?
  - Shared learning enables agencies to increase their staff quickly and solve challenges more efficiently. Do individuals in your agency work together, or learn individually?

Resources: An Open Learning Environment

Is Yours a Learning Organization?

Cultivating a Learning Culture Within Your Organization

Bridging the Gap: Building a Learning Environment in the Workplace

Supporting Workplace Learning: A background paper for IES Research Network Members

Developing a Learning Culture in Nonprofit Organizations

Strategies for Cultivating an Organizational Learning Culture

Tools and Handouts

Integrating Peer Services into the Public Behavioral Health System

SAMPLE RECOVERY SELF-ASSESSMENT FOR PROVIDER

The Recovery Self-Assessment (RSA) is a 36-item measure designed to gauge the degree to which programs implement recovery-oriented practices. It is a self- reflective tool designed to identify strengths and target areas of improvement as agencies and systems strive to offer recovery-oriented care. The RSA contains concrete, operational items to help program staff, persons in recovery, and significant others to identify practices in their behavioral health agency that facilitate or impede recovery. Download the full five-page Recovery Self-Assessment for Providers.

Please rate how accurately the following statements describe the activities, values, policies, and practices of your program.

The mental health system I work in and people I work with …	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not Applicable	Don't Know
Staff make a concerted effort to welcome people in recovery and help them to feel comfortable in this program.							
This program/agency offers an inviting and dignified physical environment (e.g., the lobby, waiting rooms, etc.).							
Staff encourage program participants to have hope and high expectations for their recovery.							
Program participants can change their clinician or case manager if they wish.							
Program participants can easily access their treatment records if they wish.							
Staff do not use threats, bribes, or other forms of pressure to influence the behavior of program participants.							

Handout: RECOVERY SELF-ASSESSMENT FOR PROVIDERS
(O'Connell, Tondora, Kidd, Stayner, Hawkins, and Davidson (2007))

RECOVERY

Is defined as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

ATTACHMENT D

4 MAJOR DIMENSIONS

- HEALTH
- HOME
- PURPOSE
- COMMUNITY

1 in 4 ADULTS experience a mental illness in any given year - Benjamin G. Druss

50% of ADULTS will experience a mental illness in their lifetime. - PsychCentral

2 million children, adults and seniors in California are affected by a potentially disabling mental illness every year. - MHSA

10 GUIDING PRINCIPLES

01 HOPE
02 PERSON-DRIVEN
03 MANY PATHWAYS
04 HOLISTIC
05 PEER SUPPORT
06 RELATIONAL
07 CULTURE
08 ADDRESSES TRAUMA
09 STRENGTHS/RESPONSIBILITY
10 RESPECT

LANGUAGE

Language has the power to stigmatize and demean or respect and uplift. Some people who receive mental health or substance abuse services use the term "consumer" to refer to themselves and others, while others prefer to be called "survivors". Some people now prefer the term "peer", while others simply prefer to be referred to as a "person" or a "person who receives services".

Words that stigmatize, demean and pathologize and invite discrimination:	Words that uplift us; that recognize and respect our share humanity and strength:
Manipulation	Survival Mode: Overwhelmed and Trying to Get Needs Met
Low Functioning	Coping
Case, Patient, Client, Consumer	Person Receiving Cervices; Person
Decompensating	Becoming Ill; Things Are Breaking Down
Non-Compliant (or Compliant)	Idependent, Autonomous, Taking Personal Responsibility
Frequent Flyer	Trying to Get It Right, Giving Lots of Opportunities to Help
Unmotivated	Not Ready, Not Hopeful
"A _____." (Fill in the blank with any diagnosis)	"A person who has been given the diagnosis of _____"
Depressed	Sad
Symptomatic	Experience Big Feelings; Intense Feelings
Grandiose	Thinking Big; Expressing Hopes and Dreams; Ambitious
Cutter	Expressing Pain Through Self-Harm

PEER SUPPORT

WHAT IS A PEER?

A peer is a peer when he/she self-identifies as a peer and is willing to share his/her lived experiences with others. – SAMHSA

WHAT IS PEER SUPPORT?

The process of giving and receiving encouragement and assistance to achieve long-term recovery. Peers offer emotional support, share knowledge, teach skills, provide practical assistance, and connect people with resources, opportunities, communities of support, and other people. – SAMHSA

The federal **Centers for Medicare and Medicaid Services (CMS)** recognizes peer support services as an evidence-based model of care and notes it is an important component in a state's delivery of effective mental health and substance use disorder treatment. – SB614

PEER PROVIDERS IN CALIFORNIA WHO PROVIDE INDIVIDUALIZED SUPPORT, COACHING, FACILITATION, AND EDUCATION TO CLIENTS WITH MENTAL HEALTH CARE NEEDS AND SUBSTANCE USE DISORDER. - SB614

Peer Support Services are described as being non-clinical and recovery-focused (White, 2006). "Non-Clinical" refers to the fact that peers do not offer professional servies, make assessments, or dispense expert opinions. There is not a power differential in the relationship—or, if there is one, it is diminished compated to the customary professional-client relationship. "Recovery-focused" means that peer support services target recovery outcomes such as improved health and wellness, an increased success and satisfaction in a range of community settings such as work, home, and school, instead of merely focusing on symptom reduction. Peers/coaches are strengths-based and focus on the relationship that they have with the person striving to achieve recovery (Mead, 2003; White, 2006).

NorCal MHA Mental Health America
W·I·S·E OSHPD

ANALYZING LEADERSHIP CHALLENGES: ROOT CAUSE ANALYSIS

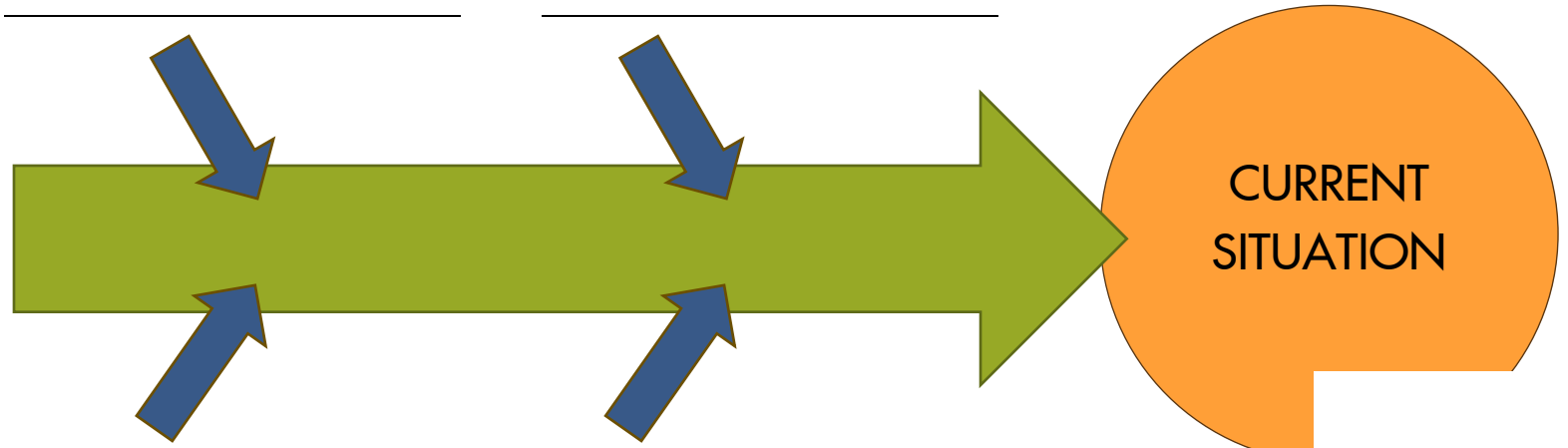
To effectively address a leadership challenge, you have to determine its root causes.

1. Assess the Current Situation
    - Provide a summary of the current situation
2. Determine Root Causes

    Identifying root causes enables you to see the obstacles that you need to address
    - Order and group the causes that are responsible for the current situation (Environment, People, Policies, Processes, and Procedures)
    - Start with the first major categories and then details
    - Each major cause can be further analyzed by asking "why"
3. Develop an Action Plan
    - The root causes are used as a basis for designing appropriate interventions
    - The action plan that you make should be designed to address these root-causes and not the symptoms.

POLICIES

PROCESSES AND PROCEDURES



PEOPLE

ENVIRONMENT

Analyzing Leadership Challenges				
Current Situation:				
Causes				
	Causes	Why	Details	Proposed Action/Intervention
Environment				
People				
Policies				
Processes & Procedures				

AGENCY POLICIES AND PRACTICES THAT ADDRESS THE 13 PSYCHOSOCIAL RISK FACTORS AT WORK

According to Guarding Minds at Work (2009-2020), there are 13 organizational factors shown to have the greatest impact on organizational health, the health of individual employees, and organizational costs, including the way work is carried out and the context in which work occurs. These psychosocial factors support certain basic human needs at that can be reasonably addressed at work (e.g., dignity, respect, security, integrity, autonomy, and organizational justice, etc.,) (Guarding Minds at Work, 2024). In addition, employees in a psychologically healthy workplace are more productive and sustainable.

Psychological Support
Coworkers and supervisors are supportive of employees' psychological and mental health concerns and respond appropriately as needed.

Positive Organizational Culture
People in the workplace demonstrate trust, honesty, and fairness, and my organization values the mental and physical health of all employees.

Clear Leadership and Expectations
Workplace leaders are effective; they communicate expectations clearly and help employees know what they need to do, how their work contributes to the organization, and whether there are impending changes.

Civility and Respect
Employees are respectful and considerate in their interactions with one another, as well as with customers/clients/members and the public.

Good Psychological Job Fit
Employees possess the technical skills and knowledge necessary for their particular positions as well as the psychological skills and emotional intelligence (self-awareness, impulse control, persistence, self-motivation, empathy, and social deftness) to do their jobs.

Growth and Development
Employees receive ongoing encouragement and support in the development of their interpersonal, emotional, and job skills. The workplace provides a range of internal and external opportunities for employees to develop their competencies and prepares them for possible future positions.

Recognition and Reward
The workplace offers appropriate acknowledgment and appreciation of employees' efforts in a fair and timely manner. Employees are fairly compensated for their work and employee or team celebrations are frequently held to recognize years served and/or milestones reached.

Involvement and Influence
Employees are included in discussions about how their work is done and how important decisions are made. They are given opportunities for involvement related to their specific job, the activities of their team or department, or issues involving the organization as a whole.

Workload Management
The tasks and responsibilities given to employees can be accomplished within the time available. Employees have enough work to remain productive but not so much that they are constantly overwhelmed. Employees have the resources (time, equipment, support) to do their work well.

Employee Engagement
Employees enjoy and feel connected to their work and are motivated to do their job well. Employees can relate to and are committed to, the overall success and mission of the agency.

Work-Life Balance
The organization recognizes the need for balance between the demands of work, family, and personal life. The workplace offers sufficient flexibility to minimize work-life conflict and allow employees to accomplish the non-work tasks necessary in their daily lives.

Psychological Protection
Employees feel able to put themselves on the line, ask questions, seek feedback, report mistakes and challenges, or propose a new idea without fearing negative consequences to themselves, their job, or their career. The workplace actively promotes emotional well-being among employees while taking all reasonable steps to minimize threats to employee mental health.

Physical Safety
The workplace has adequate policies, procedures, and training regarding workplace safety, and responds swiftly and appropriately to incidents or situations identified as risks, and demonstrates concern for employees' physical safety.

Learn more about Guarding Minds at Work and there library of free tools at
https://www.workplacestrategiesformentalhealth.com/resources/guarding-minds-at-work

SAMPLE PEER SUPPORT SPECIALIST JOB DESCRIPTION

PEER SUPPORT SPECIALIST

JOB CLASSIFICATION: FULL TIME, NON-EXEMPT | **ASSIGNED WORKSITE:** SACRAMENTO, CA

POSITION OVERVIEW

{Agency Name} has an immediate opening for a {full-time/part-time} {Job Title}. This position is employed by {Agency Name}. Under the supervision of {Agency Name's} {Supervisor/Manager Title}, the {Job Title} uses their personal lived experience of wellness, resilience, and recovery to provide peer mentoring and emotional support, wellness/recovery planning, education, linkage, and referrals to public behavioral health clients. {Job Title} must possess thorough knowledge of available resources in Sacramento County and be capable of supporting others using strengths-based, recovery-focused approaches. This is a fast-paced work environment where new tasks unexpectedly arise and priorities frequently shift, so organization, effective time management, personal flexibility, internal motivation, and a sense of humor are also essential. Employees in this position will be required to maintain Medi-Cal Peer Support Specialist Certification.

Due to the nature of Peer Support Services, this position must be held by someone with personal lived experience { of recovery from a behavioral health challenge/as the primary caretaker of an adult, child, or youth with complex mental or behavioral health needs }. Qualified individuals who have received public behavioral health services in any California county, are bilingual/bicultural, or identify as members of traditionally underserved populations (BIPOC, LGBTQ+, veterans, immigrants/refugees, former foster youth, experience with houselessness or justice system involvement, etc.) are strongly desired. Fluency in Spanish or another threshold language is also desired.

MINIMUM QUALIFICATIONS

- Personal lived experience {of recovery from a behavioral health challenge/as the primary caretaker of an adult, child, or youth with complex mental or behavioral health needs}
- A high school diploma or its equivalent, plus:
  - Medi-Cal Peer Support Specialist Certification that is current and in good standing; or
  - Completion of at least 40 hours of structured peer support education/training and at least 1,000 hours of work experience providing peer support services, or
  - At least two years or 2,500 hours of work experience providing peer support services
- A current and valid Class "C" California Driver License
- Immediate access to reliable personal transportation throughout the workday
- Auto insurance coverage that meets the minimum legal requirements in California
- Ability to perform all of the Job Duties for this position, with or without a reasonable accommodation
- Ability to meet all of the Physical and Mental Requirements for this position
- Any combination of training, education, and experience necessary to perform the Job Duties for this position, and likely to provide the required Knowledge and Abilities described herein
- Willingness to undergo a criminal background screening, if offered this position

JOB DUTIES

Core Responsibilities

- Provides individual peer support, information and referrals, mentoring, and advocacy skills to {clients/youth/families} receiving services from Sacramento County's Department of Behavioral Health Services
- Assesses the unique challenges faced by each {client/youth/family}; assists {clients/youth/families} in successfully completing their recovery programs
- Provides mentoring and/or coaching to {clients/youth/families} by helping {clients/youth/families} set recovery goals, develops individual recovery plans, solves challenges directly related to recovery, and provides encouragement, motivation and support to {clients/youth/families} seeking to establish or strengthen their recovery
- Facilitates {client/youth/family} access to benefits, entitlements, education supports, and resources including SSI and/or Medi-Cal Services, safe housing, job readiness training and/or job placement services, and community-based supports to assist {clients/youth/families} with meeting individual recovery needs
- Helps {clients/youth/families} navigate the formal and informal behavioral health treatments system and identify and articulate what they need; teaches {clients/youth/families} to advocate for their own needs, such as access to care and appropriate discharging planning
- Assists {clients/youth/families} in building or maintaining personal support networks; helps {clients/youth/families} in developing social skills needed to maintain positive interpersonal relationships
- Encourages {clients/youth/families} to identify and engage in meaningful leisure activities, social activities, and/or hobbies that support their recovery goals and reflect their unique cultural identities
- Provides recovery-oriented group activities and/or educational groups for {clients/youth/families} to share personal stories and engage in collective problem-solving with peers and expand personal skills sets

Advocacy, Outreach, and Engagement

- Works with a team to carry out varied and important duties within the areas of peer support and self-help services through advocacy, outreach, and engagement
- Uses personal experience to establish credibility, maximize {client/youth/family} voice and choice in services, and gives their perspective in the operation and development of program services
- Elevates the role of {clients/youth/families} and makes recommendations regarding behavioral health policy and practices
- Provides outreach services to unserved and underserved individuals and families
- Plans and provides feedback related to support groups, workshops, conferences and other coordinated efforts to improve mental health services in Sacramento County
- Reviews existing and proposed {client/youth/family} programs/services and participates in the development of new programs and resources

Other Responsibilities

- Maintains confidentiality at all times in accordance with Federal, State, County, and agency standards
- Documents contacts and services provided in alignment with the County's requirements

- Conducts data collection, satisfaction surveys, and other activities to measure program outcomes
- Advocates for {clients/youth/families} on the program and system levels to maximize {clients/youth/families} voice and choice in services, and improved access to resources and needed supports
- Represents {clients'/youth/families'} interests at various meetings with leadership, clinicians, staff, and partner agencies
- Offers their own experience-based perspectives in the development, implementation, and operation of services, providing important feedback on {clients'/youth/families'} perceptions, needs, and concerns
- Attends meetings, trainings, and community outreach events required by {Agency Name} or the County
- Provides outreach to individuals and families from traditionally unserved and underserved communities to engage them in services and encourage them to participate in programming and policy decisions
- Participates in local behavioral health policy discussions and program planning activities
- Formulates recommendations to improve behavioral health policies and practices
- Serves on advisory committees, oversight bodies, and policy-making panels
- Plans and coordinates trainings, meetings, and events
- Delivers presentations and educational content to various audiences
- Follows all {Agency Name} and County policies, procedures, and safety protocols
- Represents {Agency Name} values of individual and community empowerment, advocacy, wellness, recovery, inclusiveness, and cultural humility at all times
- Performs all other duties, as assigned

REQUIRED KNOWLEDGE, SKILLS, AND ABILITIES

Knowledge:

- The Consumer Movement and core principles of the recovery model, peer support, personal wellness, self-help, shared power and decision-making, client-directed services, trauma-informed and person-centered care, culturally- and linguistically-responsive services, and strengths-based approaches
- The structure and function of California's PBHS and key elements, values, and goals of the MHSA (BHSA)
- The complex network of public and private behavioral health service providers in Sacramento County, including community- and recovery-based resources and culture-specific providers and programs
- The unique challenges and disparities faced by traditionally un-, under-, and inappropriately-served groups in addressing their behavioral health needs and accessing appropriate services
- Methods and techniques of effective peer support, including use of strengths-based language, recovery-oriented communication, and motivational interviewing techniques
- Basic professional norms, business etiquette, and expectations for appropriate workplace behavior, performance, and communications
- Proper spelling, grammar, and punctuation in written communications
- Medi-Cal documentation and billing standards for Certified Medi-Cal Peer Support Specialists

- HIPAA privacy and security rules, and other basic requirements for safeguarding confidential information
- The following computer functions/operations: email, word processing, presentations, data entry, internet-based research, downloading and saving files, document retrieval and organization, conversion of file types, use of virtual meeting platforms

Skills:

- Collaboration and Teamwork Intermediate
- Reading Comprehension Intermediate
- Written Communication Intermediate
- Oral Communication Intermediate
- Emotional Intelligence and Empathy Advanced
- Planning and Organization Advanced
- Accuracy and Attention to Detail Intermediate
- Peer Support/Recovery Modeling Intermediate
- Digital Literacy and Technology Intermediate
- Documentation and Record Keeping Intermediate

Abilities:

- Display self-awareness and capacity for personal development
- Collaborate with a wide range of organizations, groups, professions, and individuals from different educational, economic, and cultural backgrounds
- Demonstrate culturally-sensitive and appropriate interaction
- Model effective coping techniques and communication skills
- Use language that is non-clinical and non-judgmental
- Treat clients as equals, share power and decision-making with them, and respect their personal choices
- Creatively help clients develop their own natural supports and solve their own challenges
- Recognize and avoid language/behaviors that others may interpret as rescuing, fixing, coercing, or shaming
- Apply self-help and peer support principles and techniques to challenges and issues
- Maintain confidentiality and appropriate interpersonal boundaries with clients and colleagues
- Display professionalism in appearance, language, and conduct
- Prioritize tasks and assignments in response to changing needs and competing interests
- Work with minimal oversight and instruction
- Comprehend and follow directions; seek clarification and additional information when needed
- Successfully manage responsibilities and deadlines
- Stay focused on tasks until satisfactorily completed
- Remain productive, calm, and focused in a hectic work environment
- Pay close attention to detail; complete work with minimal typos, errors, and omissions
- Accept guidance and constructive feedback without becoming defensive
- Take personal responsibility for actions, decisions, results, and outcomes
- Initiate conversations, address challenges directly, and implement effective solutions to maintain positive working relationships with clients, families, coworkers, and partner agencies
- Act in clients' and {Agency Name's} best interests while remaining responsive to the County's needs
- Perform common computer functions/operations: email, word processing, spreadsheets, presentations, data entry, internet-based research, digital file management, conversion of file types

- Utilize the following applications or their equivalents with proficiency: Microsoft Office products (Word, Excel, PowerPoint), G Suite (e.g., Gmail, Google Calendar, Google Drive), Zoom, Electronic Health Records software
- (Desired) Speak with clients in any of the following languages: Spanish, Arabic, Cantonese, Hmong, Russian, or Vietnamese

PHYSICAL AND MENTAL REQUIREMENTS

The frequencies listed below are based on estimated annual averages. Actual frequencies may vary. Regularly: daily/ongoing; Often: 1-2 times/week; Occasionally: 1-2 times/month; Rarely: 1-2 times/year

The person is this position is required to:

- Regularly perform all of the Job Duties for this position, with or without a reasonable accommodation
- Regularly apply the Required Knowledge, Skills, and Abilities for this position
- Regularly work {#} hours per day and {#} hours per week, {Days of the week} between {Hours of the day}
- Regularly work onsite at an office co-located with Sacramento County
- Occasionally work additional hours, as program needs dictate
- Often drive to/from various locations in the Sacramento area
- Often attend meetings, activities, and events held both virtually and in-person
- Rarely travel overnight to attend conferences, trainings, and events held in distant locations
- Regularly use a computer, the internet, electronic equipment, and digital devices
- Regularly perform substantial typing
- Regularly sit or remain stationary for most of the workday
- Regularly write notes or otherwise document and organize important information
- Regularly communicate clearly and effectively with others, both orally and in writing
- Regularly read, analyze, summarize, and organize information from a variety of sources
- Regularly explain concepts to individuals with varied levels of education and understanding
- Regularly perform basic math calculations (counting, adding, subtracting, multiplying, dividing, averaging)
- Regularly manage distractions and interruptions; maintain focus and productivity throughout the workday
- Regularly make decisions and engage in ongoing problem-solving
- Regularly maintain resilience and utilize effective coping techniques in response to work-related stressors
- Regularly address issues, problems, and challenges with their Manager or Lead, as soon as they arise

SUCCESS CRITERIA/PERFORMANCE MEASURES

- Adherence to {Agency Name's} rules, policies, and procedures
- Relationships with manager, lead, coworkers, {Agency's Name} and County staff, and other collaborative partners
- Productivity and number of clients served

- Timeliness and accuracy of documentation
- Work quality
- Client engagement and satisfaction levels
- Positive client outcomes
- Attendance and punctuality
- Demonstrated understanding of, and adherence to, the Recovery Model of care, core recovery concepts, and peer support principles
- Consistent modeling of hope, wellness, recovery, and resiliency
- Familiarity with local services and supports
- Mastery of Core Competencies for Certified Medi-Cal Peer Support Specialists
- Adherence to the Medi-Cal Code of Ethics for Peer Support Specialists
- Maintenance of Medi-Cal Peer Support Specialist Certification
- Participation in continuing education courses and professional development opportunities
- Enthusiasm, engagement, and willingness to take on special tasks, assignments, and projects
- Demonstrated leadership qualities and personal/professional growth

RECOMMENDED PEER ONBOARDING PROCEDURE (NOT ALL MAY APPLY)

Pre-Selection

- ☐ Review core competencies for Certified Medi-Cal Peer Support Specialists (CMPSS)
- ☐ Review core competencies for agencies employing peers (See pages 22-45 of this Toolkit)
- ☐ Determine duties and activities peer will perform; create/revise job description
  - See DHCS Service Components for CMPSS
  - See program's Scope of Work
- ☐ Prepare existing agency staff (information, training, discussions, etc.)
- ☐ Determine the onboarding and orientation process, including any required training
- ☐ Develop and disseminate job/volunteer announcements and employment/volunteer applications
- ☐ Review applications and select interview candidates
  - Check CalMHSA CMPSS Certification Registry to confirm Certification status (if applicable)
- ☐ Convene a hiring panel and conduct interviews; select a candidate
- ☐ Verify employment with the selected candidate's two most recent employers.
- ☐ Verify at least two of the selected candidate's professional references.
- ☐ Contact selected candidate to offer employment contingent upon the outcome of the background check
- ☐ Monitor New Hire's response to informal job offer email. If New Hire counters offered salary or any other terms of employment, work with HR Manager or appropriate personnel to determine best course of action.
- ☐ Conduct a background check and ensure the applicant passes
  - California Megan's Law Website
  - Live Scan Website – Background Check (or applicable background check)
  - DMV Driver's Records Request Website
- ☐ Monitor status of background check. If problematic information arises, work with HR Manager or appropriate personnel to determine the best course of action.

Post-Selection

- ☐ Work with HR Manager or appropriate personnel to finalize the New Hire's start date
- ☐ Review peer job description or volunteer activities; plan how responsibilities will be delegated, reporting structure, and communications procedures
- ☐ Notify team of hiring decision and start date; determine staff participation in onboarding process
- ☐ Refine Training Plan
- ☐ Make logistical preparations for onboarding
  - Schedule
  - Workspace
  - Telephone access
  - Computer access/email account
  - Building access (keys, badges, access codes, etc.) and parking
- ☐ Gather resources and materials relevant to the position and prepare an orientation binder
  - Contract scope of work/deliverables and budget
  - Program- or County-specific rules, policies, and procedures
  - Program-specific forms, templates, and other program materials
  - Performance expectations, position- or program-specific practice guidelines, and other relevant materials for performance of position/job duties

Post-Hire: Within the First 10 Days of Employment

- ☐ Send email to entire team welcoming New Hire.
- ☐ Introduce New Hire to the rest of the team, show them their desk, and give them a tour of their new work area.
- ☐ Conduct agency-specific orientation, covering:
  - The organization's history, mission, vision, and values
  - Current services and programs and how peer role fits into existing structure
  - Program's mission, purpose, and Scope of Work
  - How things are done (important policies and procedures)
  - Who peer works with, reports to, how information is shared, and how performance is evaluated
  - If embedded in another agency's facility, the nature of the program's relationship with agency, reporting structure, and chain of command for internal employees
  - Data security protocols
  - Documentation and record-keeping requirements, including how to complete common forms
- ☐ Enroll employee in any required training programs (i.e. Mandated Reporter Training, Medi-Cal Peer Support Specialist Certification Training, etc.)

Post-Hire: Within the First 30 Days of Employment

- ☐ Meet with New Hire to review their job description, supervision forms, and performance evaluation template to ensure New Hire understands agency and program expectations for their position.

- ☐ Meet with New Hire to determine how things are going with the job and work environment to identify potential challenges and prevent future employment issues. For example:
  - What do you like about the position and this agency?
  - What's going well?
  - What could be going better?
  - Do you have enough, too much, or too little to do?
  - What, if anything, do you not understand about your position or our agency?
  - Who do you talk to when you have questions about work? Do you feel comfortable asking?
  - Are we clearly communicating our expectations to you?
  - How are you getting along with your coworkers/non-peer staff?
  - How do you see yourself developing in this role?
  - What are your professional goals and how can we help you accomplish them?

- ☐ Conduct occasional check-ins with non-peer staff to determine how things are going, explore potential issues, and prevent future challenges. Questions for non-peer staff may include:
  - Do you understand the peer role? What questions do you still have?
  - What's going well?
  - What could be going better?
  - How are you getting along with peer(s)?

- ☐ Enroll the peer into additional trainings if needed:

- ☐ Ensure peer has frequent contact with other peers to prevent cooptation and dilution of the peer role

Supervisor Checklist for Peer Supporters

This checklist is intended for use by supervisors of people in the role of peer supporter/peer specialist. It will help supervisors support the unique contribution of peer supporters. It will also help determine if the peer supporter is remaining peer, or drifting into clinical culture.

The supervisor can use this checklist to structure supervision of the peer supporter. It will help determine if key job responsibilities are being performed. Remember, peer supporters are not junior clinicians. They have a unique job and function, which is captured in the checklist below:

Remaining Peer

☐ When working with program participants, the peer supporter keeps the focus on learning together, rather than assessing problems and prescribing help?

☐ The peer supporter is skilled in sharing relevant personal experiences in-the-service-of supporting program participants' self-discovery/recovery/wellness?

☐ The peer supporter seeks to understand program participants' evolving understanding of "what happened to me" which often involves non-traditional, non-clinical meaning making?

☐ The peer supporter's program notes and verbal communication to clinicians are peer-centric and do not include overtly clinical language. Specifically, communication does not include common clinical idioms (e.g. diagnosis, low functioning, manipulative, decompensating, suicidal, etc.) and does not attribute motive to behavior (triangulating, manipulative, sabotaging, help-seeking-rejecting, etc.)?

☐ The peer supporter is networking with other peer supporters via mentoring, training, conferences, publications, web-forums, etc. The peer supporter is not isolated from others in similar peer roles?

☐ Check for signs of "drift" from the role of peer supporter:

- ☐ Is the peer supporter adopting clinical language and terms in verbal or written communication?
- ☐ Is the peer supporter reluctant to share lived experience with participants and families?
- ☐ Is the peer supporter telling/advising what to do?
- ☐ Is the peer supporter performing assessments such as determination of suicide risk?
- ☐ Is the peer supporter making decisions for program participants?
- ☐ Is the peer supporter inviting program participants to co-produce or review notes in the record?

Influencing Organizational Culture

☐ The peer supporter is not being "siloed" as the only voice of self-discovery/recovery/wellness in the org?

☐ What are the peer supporter's impressions/observations of the culture shift that is occurring on the team/org?

☐ What are the peer supporter's experience(s) of micro-aggression and role conflict at work?

☐ Are the peer supporter's opinions carefully considered in the clinical decision-making process?

☐ (If applicable) Does the peer supporter feel free to express diverse cultural/ethnic and socioeconomic identities, sexual orientation/gender identification and do they experience respect in the workplace?

2016 Pat Deegan PhD & Associates, LLC - To inquire about use, please contact pat@patdeegan.com

This work was originally developed in collaboration with Sascha DuBrul MSW and Iruma Bello PhD for Peer Specialists working in OnTrackNY

Supervisor Checklist for Peer Supporters

Team/Organizational Communication

☐ The peer supporter speaks up during meetings in an effort to respectfully present non-clinical perspectives and understandings. For instance, at times he/she may speak from human rights, feminist or social justice perspectives?

☐ The peer supporter demonstrates the ability to communicate the peer framework respectfully to clinicians both verbally and in writing?

☐ The peer supporter works collaboratively with clinicians, as needed, to help participants achieve goals?

Connection

☐ The peer supporter facilitates connection with program participants and family members (if applicable)?

☐ The peer supporter facilitates connection with probation officers, primary care physicians, etc. (if applicable)?

Relationship Building

☐ The peer supporter develops authentic peer-2-peer relationships with program participants?

☐ The peer supporter shares personal experiences with participants?

☐ The peer supporter role models self-discovery/recovery/healing for program participants?

Embraces Alternate Frameworks of Understanding

☐ The peer supporter is open and willing to follow program participants' evolving understanding of the meaning of "what happened to me"?

Advocacy

☐ The peer supporter invites program participants to attend clinical meetings to advocate for their interests?

☐ The peer supporter rehearses and helps program participants to prepare for self-advocacy?

☐ The peer supporter speaks up at clinical meetings to advocate for alternative, non-clinical understandings of the experience of mental illness and self-discovery/recovery/wellness?

Co-Creating Support and Wellness Tools

☐ The peer supporter has mapped community resources, peer resources and natural supports available to all citizens in the community?

☐ The peer supporter has assisted program participants in developing Personal Medicine and Power Statements as directed by the program participant?

☐ The peer supporter provides decision support and discovery of options as directed by the program participant?

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SAMPLE PEER SUPPORT SPECIALIST SELF-ASSESSMENT: CORE COMPETENCIES

Download the full Peer Support Specialist Self-Assessment.

PEER SUPPORT SPECIALIST SELF-ASSESSMENT: CORE COMPETENCIES

About This Assessment

This self-assessment is a tool to assist you in reflecting on your own peer worker competencies.

Here are the possible outcomes of using the Peer Worker Self-Assessment:

- Identify your strengths as a peer worker
- Identify competencies that need to be developed
- Make a plan to develop your competencies
- Use the information to build a career development plan
- Use the information in supervision
- Become an objective observer of yourself at work

Because this assessment is only to help you improve in your work and advance your career, feel free to complete this assessment as honestly as you can to get the most benefit. There are no wrong answers.

Peer Worker Information

1. Date _____
2. Name _____
3. How long have you worked here? _____
4. Is this your first time completing this self-assessment? ☐ Yes ☐ No
5. If no, when was your last self-assessment? _____
6. What are your professional goals? _____
7. What do you think you do well at work? _____

_____

_____

8. What do you think you need to improve on? _____

_____

_____

_____

SELF-ASSESSMENT OF CORE COMPETENCY

On the following pages, review and rate yourself on how well you currently demonstrate the identified competencies. In addition to self-assessment rating, you can note examples that show why you rated yourself this way, what gets in the way of doing some competencies well, and what types of training would be helpful to improve where needed.

Peer Core Competencies – Category I: The Concept of Hope, Recovery and Wellness

This category of competencies emphasizes peer workers' ability to initiate and develop ongoing relationships with program clients. These competencies include interpersonal skills, knowledge about wellness, resilience, and recovery from behavioral health conditions and attitudes consistent with a recovery orientation.

Skills that can be assigned to this core competency:

- Knows the ten guiding principles of recovery as defined by the federal Substance Abuse and Mental Health Services Administration (SAMHSA)
- Knows the five stages in the recovery process, what is helpful and not helpful at each stage and the role of peer support services at each stage of the recovery process
- Knows the difference between focusing on the symptoms of mental health and substance use challenges and focusing on their impact on individuals and families
- Knows the role of peer support services at each stage of the recovery process
- Knows the difference between treatment goals and recovery goals
- Understands the role of culture in recovery
- Understands the peer experience
- Defines the concept of a wellness-focused approach to recovery
- Applies principles of empowerment
- Uses a strengths-based approach
- Demonstrates non-judgmental behavior
- Addresses internal and external stigma
- Is trauma informed
- The ability to promote hope, the potential for change, and personal empowerment
- The ability to identify the beliefs and values an individual holds that support and enrich their recovery
- The ability to foster individual choice and self determination
- The ability to identify the beliefs and values an individual holds that works against their recovery
- The ability to establish and maintain healing relationships based on mutuality, respect, acceptance, compassion, open and honest communication, active listening, and cultural humility
- Promotes a wellness-focused approach to recovery
- Demonstrates consistent support to individuals during times of wellness as well as during challenging times

Rating Scale

Based on the information on the previous page, rate yourself on how well you currently demonstrate Core Competency One – The Concept of Hope, Recovery and Wellness and its associated skills. In addition to self-assessment rating, you can note examples that show why you rated yourself this way, what gets in the way of doing some competencies well, and what types of training would be helpful to improve where needed.

I do this very well all the time.	I do this well most of the time.	I can do this well under the right circumstances.	I cannot do this well yet.	I do not know how to do this.	This is not applicable to my work.

Explain why you rated yourself this way using examples or scenarios from your work:

What do you think gets in the way of doing this competency well? (Check all that apply)

☐ N/A—I already do this well ☐ I don't know how to do this ☐ I've never seen anyone do it ☐ I don't have opportunities to practice this ☐ I don't have the confidence to do this

Improving Peer Core Competencies – Category I: The Concept of Hope, Recovery and Wellness

In this category, you assessed your competencies in the area of Providing support. What additional help or training would be beneficial to you to strengthen these competencies? Check all that apply.

☐ N/A—I don't need help ☐ Read more about this on my own ☐ Attend a webinar
☐ More help from supervisor ☐ Watch someone else do this at work ☐ Participate in training
☐ Other: _____

PEER SUPPORT SPECIALIST SELF-ASSESSMENT: CORE COMPETENCIES
Adapted from SAMHSA's *Core Competencies for Peer Workers in Behavioral Health Services – Peer Worker Self-Assessment*

COLLABORATIVE WORK PLAN TEMPLATE

Collaborative Work Plans, or Performance Improvement Plans, are often used when traditional feedback methods aren't working. The plans can be used to avoid disciplinary action. They may incorporate principles of Nonviolent Communication to explore unresolved feelings and unmet needs to determine the root of an issue. Collaborative Work Plans help to identify specific objectives and mutual responsibilities. Download the Collaborative Work Plan Guide for questions to help explore employee needs.

CHECK LIST FOR CREATING A COLLABORATIVE WORK PLAN

DEVELOPMENT PLAN: THE BASICS	YES	NO
Employee is making satisfactory overall progress in their position.		
Employee understands their role within the organization.		
Employee understands their job description and responsibilities.		
Employee understands how to perform their tasks and job duties.		
Employee has access to the necessary information, resources, materials, and equipment to adequately perform their job duties.		
Employee understands the expectations and standards of performance applicable to their position.		
Employee understands how work is assigned and duties are delegated.		
Employee understands how information is shared and how to have their questions answered.		
Employee understands how people work together on their team, who to rely upon, and who is relying upon them.		
Employee understands how their work is monitored and evaluated.		
Employee understands the timeframes and deadlines applicable to their position and is given adequate time to complete tasks and assignments.		
Employee knows who to turn to for guidance and support.		
Employee knows how to address problems if they arise.		
Employee understands the organization's purpose, mission, and values.		

SAMPLE COLLABORATIVE WORK PLAN

Employee _____ Manager _____

Plan Start Date _____

Plan End Date _____

I. Overview

The purpose of this Collaborative Work Plan is to address both your current work performance and adherence to organizational rules and policies, and to jointly identify areas in which you may need additional support.

To this end, we will collaborate in examining each of the following:

- Identifying performance issues
- Clarifying [AGENCY]'s expectations
- Exploring your workplace needs and areas in which support is necessary
- Exploring your own contribution to your success at work
- Exploring prevention of future issues
- Scheduling of subsequent meetings to monitor progress and offer additional support
- Setting duration of plan period and conditions for expiration

II. Background Information

[NAME], you were hired by [AGENCY] on or around [DATE], as a [POSITION]. In this role, you are required to [PRIMARY DUTIES]. In addition, you are expected to model recovery and provide guidance and mentorship to the clients we serve. Over the past [LENGTH OF TIME], you have demonstrated personal growth, organizational achievement, and have shown tremendous value in your role. You have been loyal to clients' interests and to our program's vision and goals. You are sincerely committed to [AGENCY]'s mission, hold team members in high regard, and care deeply for the clients we serve. You regularly go over and above your duties to better serve clients and in helping them to meet their recovery goals. You have demonstrated a passion for ongoing learning and personal development. We appreciate your talents and abilities and are fortunate to count you as an employee of our organization. [FEEL FREE TO TAILOR THIS PARAGRAPH AND TO LIST OTHER SPECIFIC ACHIEVEMENTS/TALENTS HERE.]

Recently, [DESCRIBE WHAT YOU HAVE NOTICED – OBSERVABLE BEHAVIORS, JUST THE FACTS. BE VERY OBJECTIVE AND NON-JUDGMENTAL IN DESCRIBING THE PERFORMANCE OR BEHAVIORAL PROBLEMS].

III. IDENTIFICATION OF PERFORMANCE ISSUES

[EMPLOYEE], what is going on for you? What do we need to know?

IV. Your Needs

[EMPLOYEE], what do you personally need to be successful at work?

Practical Needs

Process Needs

Person Needs

And what else? (In particular, what are the barriers to your success? What do you need to feel more empowered? What do you need to build better relationships with your coworkers?)

V. Your Contribution

[EMPLOYEE], what will you personally do to contribute to your own success at work?

VI. Prevention of Future Issues

Immediate Steps

[DESCRIBE IMMEDIATE CHANGES THAT MUST TAKE PLACE NOW – WHAT YOU ARE IMPOSING. THEN ALLOW ROOM FOR THE EMPLOYEE TO MAKE HIS/HER OWN IMMEDIATE COMMITMENTS. LIST ALL FOLLOW UP/ACTION ITEMS FOR BOTH YOU AND THE EMPLOYEE HERE.]

[EMPLOYEE], how will we know if this Plan is working?

[EMPLOYEE], how will we know if this Plan is working?

[EMPLOYEE], what will we do if either of us realizes we neglected to include something in this Plan?

[EMPLOYEE], exactly how would you like us to communicate to you if we notice a change in your behavior or performance that needs to be addressed? What words would you prefer us to use, and how would you like us to initiate the conversation with you?

VII. Subsequent Meetings

[EMPLOYEE], we will meet once every [TIME PERIOD] for [NUMBER] minutes to discuss this Plan, other barriers to your success, and any new issues that may arise.

Day: _____

Time: _____

VIII. Plan Expiration

This Plan is scheduled to expire on [EXPIRATION DATE]. Nevertheless, we may extend this Plan if you experience new challenges or require additional support beyond [EXPIRATION DATE].

Employee Acknowledgement

I acknowledge this Collaborative Work Plan was created jointly with [AGENCY]'s management, and I was given an opportunity to provide input and feedback in the creation of this Plan.

Employee Signature
(retain a copy for your records)

Date

Manager Acknowledgement

I acknowledge this Collaborative Work Plan was created jointly with the affected employee, and I have given this employee an opportunity to provide input and feedback in the creation of this Plan.

Manager Signature
(retain a copy for your records)
Submit original to HR

Date

ADDITIONAL RESOURCES

Peer Certification

- Medi-Cal Peer Support Specialist Certification Program
- Certification Registry: Medi-Cal Peer Support Specialist Certification
- Core Competencies for Certified Medi-Cal Peer Support Specialists
- Code of Ethics for Certified Medi-Cal Peer Support Specialists
- Training Providers: Medi-Cal Peer Support Specialist Certification Training
- Early Implementation of California's Peer Support Specialist Certification Program
- SAMHSA's National Model Standards for Peer Support Certification

Evidence of Impacts of Peer Support

- A systematic review and meta-analysis of randomized controlled trials of peer support for people with severe mental illness
- Addition of Peer Support Workers to Improve Patient Outcomes & Reduce Costs
- Consumer-Operated Services Evidence-Based Practices (EBP) KIT
- Contributions of Peer Support to Health, Health Care, and Prevention: Papers from Peers for Progress
- Evidence Base for Peer Support Services
- Global Evidence for Peer Support: Humanizing Health Care
- Making the Case for Peer Support
- Peer Support in Behavioral Health: The Evidence is In!
- Peer Support in Mental Health Care: Is it good value for money?
- Peer Support: Research and Reports
- Peer-Delivered Wellness Recovery Services: From Evidence to Widespread Implementation
- The Benefits of Family Peer Support Services: The Evidence

Integrated Systems

- Call to Action: Integrating Peer Support in Prevention and Health Care Under the Affordable Care Act
- Meaningful Roles for Peer Providers in Integrated Healthcare: A Guide
- Peer Models and Usage in California Behavioral Health and Primary Care Settings
- Peer Workers in the Behavioral and Integrated Health Workforce: Opportunities and Future Directions

Peer Integration

- Deflection and Pre-Arrest Diversion: Integrating Peer Support Services
- Incorporating Peer Support Into Substance Use Disorder Treatment Services
- Integration of Peer Specialists Working in Mental Health Service Settings
- Integrating Peer Recovery Support Services into Substance Use-Related Crisis Care: A Brief for States
- Key Considerations for Integrating Peer Support Staff in Behavioral Health Organizations
- Peer Specialists in Mental Health Services: Workplace Integration and Outcomes
- The Peer Provider Workforce in Behavioral Health: A Landscape Analysis

Population Specific

- Effectively Employing Young Adult Peer Providers: A Toolkit
- Experts by Experience: Peer Support and its Use with the Homeless
- Family Peer Support: An Emerging Workforce
- Peer Services in Crisis Care
- Peer Support for People with Substance Use Disorders
- Peer Support Roles in Criminal Justice Settings
- Peer Support Specialists' Unique Contribution to Veterans' Health

Psychological Health and Safety

- Guarding Minds at Work: Assess and Address Psychological Health and Safety in Your Workplace
- Mental Health - Psychosocial Risk Factors in the Workplace
- Recovery Friendly Workplace Toolkit
- Recovery-Ready Workplace Resource Hub
- Workplace Development Tips: A Resource Kit for the Alcohol and Other Drugs Field
- Workplace Health and Well-being - Comprehensive Workplace Health and Safety Program

Supervision and Evaluation

- (Required) Supervision of Peer Workers Training
- Evaluating Peer Programs
- Guidebook for Peer Support Program Self-Evaluation: Practical Steps and Tools
- National Practice Guidelines for Peer Specialists and Supervisors
- Performance Measurement in Peer Support Services
- Supervision of Peer Workers
- Supervision of Peer Workers TA Resources
- Supervisor of Peer Workers Self-Assessment

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CAL VOICES
ADVOCACY · RECOVERY · PEER SUPPORT

SACRAMENTO COUNTY

The Certified Peer Support Specialist Leadership Liaison Program is a collaborative program of Cal Voices and Sacramento County Department of Health Services, Division of Behavioral Health Services, funded through the voter-approved Proposition 63, the Mental Health Services Act.

PERMANENT SUPPORTIVE HOUSING

MHSA PORTFOLIO CATALOG

SACRAMENTO COUNTY BEHAVIORAL HEALTH SERVICES DIVISION

REV. 3/2025

ARDENAIRE

1960 Ethan Way, Sacramento, 95825

PROPERTY DESCRIPTION

- ✓ Opened in 2008
- ✓ Acquisition and rehabilitation
- ✓ 53 units; 19 MHSA units
- ✓ Four 2-story apartment buildings
- ✓ Property features community room
- ✓ 1- & 2- Bedroom units

PARTNERS

- ✓ Mercy Housing
- ✓ Sacramento Housing and Redevelopment Agency
- ✓ Sacramento County Behavioral Health Services
- ✓ Mercy Housing California Resident Services
- ✓ Mercy Services Corporation

MARTIN LUTHER KING VILLAGE

3900 47th Avenue, Sacramento, 95824

PROPERTY DESCRIPTION

- ✓ Opened in 2008
- ✓ New construction
- ✓ Single story, cottage and duplex units
- ✓ 80 units; 30MHSA units (this will grow to 39 units as future vacancies become MHSA units)
- ✓ Property features community room with kitchen
- ✓ 1 bedroom units

PARTNERS

- ✓ Mercy Housing California
- ✓ Sacramento Housing and Redevelopment Agency
- ✓ Sacramento County Behavioral Health Services

YWCA

1122 17th Street, Sacramento, 95814

PROPERTY DESCRIPTION

- ✓ Opened in 2009
- ✓ Preservation and rehabilitation of residential hotel units
- ✓ City designated landmark building in downtown Sacramento
- ✓ Affordable housing provided at this location since 1932
- ✓ 31 units; 3 MHSA units
- ✓ Single Room Occupancy
- ✓ Large main floor rooms available for community use

PARTNERS

- ✓ YWCA
- ✓ Sacramento Housing and Redevelopment Agency
- ✓ Sacramento County Behavioral Health Services

BOULEVARD COURT

5321 Stockton Blvd, Sacramento, 95820

PROPERTY DESCRIPTION

- ✓ Opened in 2011
- ✓ Redevelopment of existing hotel
- ✓ Aligned with Five Year Redevelopment Implementation Plan for Stockton Boulevard Redevelopment Area
- ✓ Two story walk-up building
- ✓ 74 units; 25 MHSA units (this will grow to 36 units as future vacancies become MHSA units)
- ✓ Property features community space, computer room, lounge, therapy and counseling offices, basketball court / recreation area
- ✓ Studio & 1 Bedroom Units

PARTNERS

- ✓ Mercy Housing
- ✓ Sacramento Housing and Redevelopment Agency
- ✓ Sacramento County Behavioral Health Services
- ✓ Mercy Housing California Resident Services
- ✓ Mercy Housing Management Group

FOLSOM OAKS

809 Bidwell St, Folsom, 95630

PROPERTY DESCRIPTION

- ✓ Opened in 2011
- ✓ New construction
- ✓ Four residential apartment buildings
- ✓ Smallest property in portfolio at 20 units; 5 MHSA units
- ✓ Property features community room, tot lot play area
- ✓ Nearby amenities include shopping, banks, schools and parks within ½ mile of site
- ✓ Public transportation conveniently located
- ✓ 2- & 3-bedroom units

PARTNERS

- ✓ TLCS, Inc. (dba Hope Cooperative)
- ✓ Sacramento Housing and Redevelopment Agency
- ✓ Sacramento County Behavioral Health Services

MUTUAL HOUSING AT THE HIGHLANDS

6010 34th Street, North Highlands, 95660

PROPERTY DESCRIPTION

- ✓ Opened in 2011
- ✓ New construction
- ✓ Located in Mather/McClellan Redevelopment Area in North Highlands neighborhood
- ✓ 90 units; 33 MHSA units
- ✓ Units feature porch or patio
- ✓ Property features community room and kitchen, computer room, conference room
- ✓ Studio, 1- & 3-bedroom units

PARTNERS

- ✓ Sacramento Mutual Housing Association
- ✓ Sacramento Housing and Redevelopment Agency
- ✓ Sacramento County Behavioral Health Services
- ✓ Mutual Housing Management

7TH AND H

720 7th Street, Sacramento, 95814

PROPERTY DESCRIPTION

- ✓ Opened in 2012
- ✓ Preservation and rehabilitation of historical property / existing SRO
- ✓ Mixed use development includes ground floor health clinic and retail space
- ✓ Located in downtown Sacramento
- ✓ Largest property in portfolio with 150 affordable units; 34 MHSA units (this will grow to 74 units as future vacancies become MHSA units)
- ✓ Studio & 1 Bedroom Units
- ✓ Well served by public transportation, walking distance to Amtrak station
- ✓ Extensive common space amenities include large community room, conference and meeting rooms, lounges, patios, and second floor rooftop deck

PARTNERS

- ✓ Mercy Housing
- ✓ Sacramento Housing and Redevelopment Agency
- ✓ Sacramento County Behavioral Health Services
- ✓ Mercy Housing California Resident Services
- ✓ Mercy Housing Management Group

STUDIOS AT HOTEL BERRY

729 L. Street, Sacramento, 95814

PROPERTY DESCRIPTION

- ✓ Opened in 2012
- ✓ Preservation, renovation, and modernization of Single Room Occupancy residential hotel units
- ✓ Mixed use development includes ground floor retail space
- ✓ Conveniently located in downtown Sacramento
- ✓ 106 units; 10 MHSA units
- ✓ Property features resident lounge, community room with kitchen, computer lab
- ✓ Studio units

PARTNERS

- ✓ Jamboree Housing Corporation
- ✓ Sacramento Housing and Redevelopment Agency
- ✓ Sacramento County Behavioral Health Services
- ✓ Quality Management Group

THE COURTYARDS ON ORANGE GROVE

3425 Orange Grove Ave, North Highlands, 95660

PROPERTY DESCRIPTION

- ✓ Opened in 2020
- ✓ Adaptive reuse of existing motel
- ✓ 92 units; 20 MHSA units (this will grow to 45 units as future vacancies become MHSA units)
- ✓ Property features counseling and therapy offices, group meeting rooms, resident lounge, commercial kitchen, computer workstations, dog run, community garden and BBQ area
- ✓ Studio & 1 bedroom units

PARTNERS

- ✓ Mercy Housing
- ✓ Sacramento Housing and Redevelopment Agency
- ✓ Sacramento County Behavioral Health Services
- ✓ Mercy Housing California Resident Services
- ✓ Mercy Housing Management Group

LOS MOLINOS

7789 La Mancha Way, Sacramento, 95823

PROPERTY DESCRIPTION

- ✓ Opened in 2021
- ✓ Acquisition and conversion of 124 room extended stay hotel
- ✓ First Homekey Program development in portfolio; funded with federal Coronavirus Relief Funds
- ✓ Located in southern Sacramento
- ✓ 100 units; 40 MHSA units
- ✓ Property features common spaces and outdoor amenities
- ✓ Studio units

PARTNERS

- ✓ Mercy Housing
- ✓ Sacramento Housing and Redevelopment Agency
- ✓ Sacramento County Behavioral Health Services
- ✓ Mercy Housing California Resident Services
- ✓ Mercy Housing Management Group

VISTA NUEVA

140 Promenade Circle, Sacramento, 95814

PROPERTY DESCRIPTION

- ✓ Opened in 2022
- ✓ Stabilized housing and services for families and their children as well as transitional age youth
- ✓ Located in North Natomas
- ✓ 117 units; 15 MHSA units
- ✓ Second Round Homekey Program development
- ✓ Family-friendly amenities include a community center, playground, pet area and swimming pool
- ✓ Studio, 1- & 2-bedroom units

PARTNERS

- ✓ Jamboree Housing
- ✓ Sacramento Housing and Redevelopment Agency
- ✓ Sacramento County Behavioral Health Services

CENTRAL SACRAMENTO STUDIOS

1114 H Street, Sacramento, 95814

PROPERTY DESCRIPTION

- ✓ Opened 2023
- ✓ Acquisition and renovation of operating hotel
- ✓ Located in downtown Sacramento
- ✓ Second Round Homekey Program development
- ✓ Amenities include a community garden and recreational area for residents
- ✓ 93 units; 15 MHSA units
- ✓ Studio units

PARTNERS

- ✓ The Danco Group
- ✓ Sacramento Housing and Redevelopment Agency
- ✓ Sacramento County Behavioral Health Services
- ✓ LifeSTEPS Resident Services

MUTUAL HOUSING ON THE BOULEVARD

7351 Stockton Blvd, Sacramento, 95823

PROPERTY DESCRIPTION

- ✓ Opened 2023
- ✓ New construction
- ✓ Second Round No Place Like Home Project
- ✓ Multi-family rental housing
- ✓ 127 units; 50 No Place Like Home units
- ✓ Property features indoor play area, computer room, picnic and BBQ area, sports court, community garden, outdoor movie area
- ✓ Designed with universal design principles for persons of all abilities
- ✓ Site designed to incorporate crime prevention through environmental design and safety
- ✓ 1-, 2-, & 3-Bedroom Units

PARTNERS

- ✓ Stockton Boulevard Mutual Housing LLC
- ✓ Sacramento Housing and Redevelopment Agency
- ✓ Sacramento County Behavioral Health Services
- ✓ Mutual Housing Management

SUNRISE POINTE

7424 Sunrise Blvd, Citrus Heights, 95610

PROPERTY DESCRIPTION

- ✓ Opened in 2023
- ✓ Acquisition and development
- ✓ 1st Round No Place Like Home Project
- ✓ 47 units; 22 No Place Like Home units
- ✓ Units feature private deck and patio spaces
- ✓ Amenity space includes large multi-purpose rooms, afterschool program area and conference rooms
- ✓ Property features outdoor lounge area, tot-lot, outdoor BBQ and picnic area, half basketball court
- ✓ 1-, 2-, & 3-Bedroom Units

PARTNERS

- ✓ Jamboree Housing Corporation
- ✓ TLCS, Inc. (dba Hope Cooperative)
- ✓ Quality Management Group
- ✓ Sacramento Housing and Redevelopment Agency
- ✓ Sacramento County Behavioral Health Services

VILLA JARDIN / CORAL GABLES

49, 63, and 81 Coral Gables Court, Sacramento, CA 95822

PROPERTY DESCRIPTION

- ✓ Opened in 2023
- ✓ Rehabilitation of 44 units (Villa Jardin) and new construction of 38 units (Coral Gables)
- ✓ Located in south Sacramento
- ✓ 82 units; 15 MHSA units
- ✓ Family-friendly amenities include a community center, playground and after school program
- ✓ 1- & 2-bedroom units

PARTNERS

- ✓ John Stewart Company
- ✓ Sacramento Housing and Redevelopment Agency
- ✓ Sacramento County Behavioral Health Services

THE SAINT CLARE AT CAPITOL PARK

1125 9th Street, Sacramento, 95814

PROPERTY DESCRIPTION

- ✓ Opened in 2024
- ✓ Preservation, rehabilitation, and conversion of historic Capitol Park Hotel
- ✓ Largest remaining Single Room Occupancy under residential hotel ordinance
- ✓ 1st Round No Place Like Home Project
- ✓ Transit Oriented Development in downtown Sacramento
- ✓ Mixed use development with 5,000 square feet of commercial ground floor storefront/ restaurant space
- ✓ 134 units; 65 No Place Like Home units
- ✓ Studio Units

PARTNERS

- ✓ Mercy Housing
- ✓ Sacramento Housing and Redevelopment Agency
- ✓ Sacramento County Behavioral Health Services
- ✓ Mercy Housing California Resident Services
- ✓ Mercy Housing Management Group

AUBURN OAKS (PIPELINE)

7501 Sunrise Blvd, Citrus Heights, 95601

PROPERTY DESCRIPTION

- ✓ Acquisition and renovation of senior living facility
- ✓ MHSA funding
- ✓ 88 Units; 30 MHSA Units
- ✓ Senior housing

PARTNERS

- ✓ TLCS, Inc. (dba Hope Cooperative)
- ✓ Sacramento Housing and Redevelopment Agency
- ✓ Sacramento County Behavioral Health Services

DONNER FIELD SENIOR APARTMENTS (PIPELINE)

4501 9th Avenue, Sacramento, 95818

PROPERTY DESCRIPTION

- ✓ New construction
- ✓ Senior housing
- ✓ 67 units; 17 MHSA units
- ✓ Planned property features community building, computer room, covered community porch, bike parking, picnic and BBQ area, community garden, outdoor movie area
- ✓ 1-bedroom units

PARTNERS

- ✓ Eden Housing
- ✓ Sacramento Housing and Redevelopment Agency
- ✓ Sacramento County Behavioral Health Services

HOPE LANDING (ARDEN STAR) (PIPELINE)

1413 Howe Avenue, Sacramento, 95825

PROPERTY DESCRIPTION

- ✓ Acquisition and rehabilitation
- ✓ 124 Units; 30 MHSA units
- ✓ Senior housing
- ✓ Property features community center, outdoor gathering space, pet area, and pool
- ✓ Studio & 1 bedroom units

PARTNERS

- ✓ The John Stewart Company
- ✓ TLCS, Inc. (dba Hope Cooperative)
- ✓ Sacramento Housing and Redevelopment Agency
- ✓ Sacramento County Behavioral Health Services

MADISON SQUARE STUDIOS (SUPER 8) (PIPELINE)

4317 Madison Avenue, Sacramento, 95825

PROPERTY DESCRIPTION

- ✓ Acquisition and rehabilitation
- ✓ Units feature private bathroom and kitchenette
- ✓ 118 Studio Units; 15 MHSA units
- ✓ Property features community kitchen, basketball court, pickle ball court, pet area and pool
- ✓ Studio units

PARTNERS

- ✓ Danco Communities
- ✓ Sacramento Housing and Redevelopment Agency
- ✓ Sacramento County Behavioral Health Services
- ✓ Danco Property Management
- ✓ Lutheran Social Services of Northern California

ON BROADWAY (PIPELINE)

1901 Broadway, Sacramento, 95814

PROPERTY DESCRIPTION

- ✓ Acquisition and development; demolition of existing vacant office building
- ✓ 4th Round No Place Like Home Project
- ✓ Mixed use development
- ✓ Located in midtown Sacramento
- ✓ Two 5-story buildings
- ✓ 140 Units; 37 No Place Like Home Units
- ✓ Conveniently located near Oak Park Community Center, Brooks Truits Park, Midtown District
- ✓ Green-certified Transit Oriented Development
- ✓ Property features community commons center, exterior courtyards, play structures, bike parking
- ✓ 1-, 2-, and 3-bedroom units

PARTNERS

- ✓ EAH Housing
- ✓ Sacramento Housing and Redevelopment Agency
- ✓ Sacramento County Behavioral Health Services

POWELL'S LANDING (RODEWAY INN) (PIPELINE)

25 Howe Avenue, Sacramento, 95826

PROPERTY DESCRIPTION

- ✓ Acquisition and renovation of operating motel
- ✓ Homekey funding
- ✓ 70 Units; 30 MHSA Units
- ✓ Property features include kitchenettes in all units, pet area, community room and gathering areas.
- ✓ Studio units

PARTNERS

- ✓ John Stewart Company
- ✓ TLCS, Inc. (dba Hope Cooperative)
- ✓ Sacramento Housing and Redevelopment Agency
- ✓ Sacramento County Behavioral Health Services

SEQUOIA HOTEL (PIPELINE)

911 K St, Sacramento, CA 95814

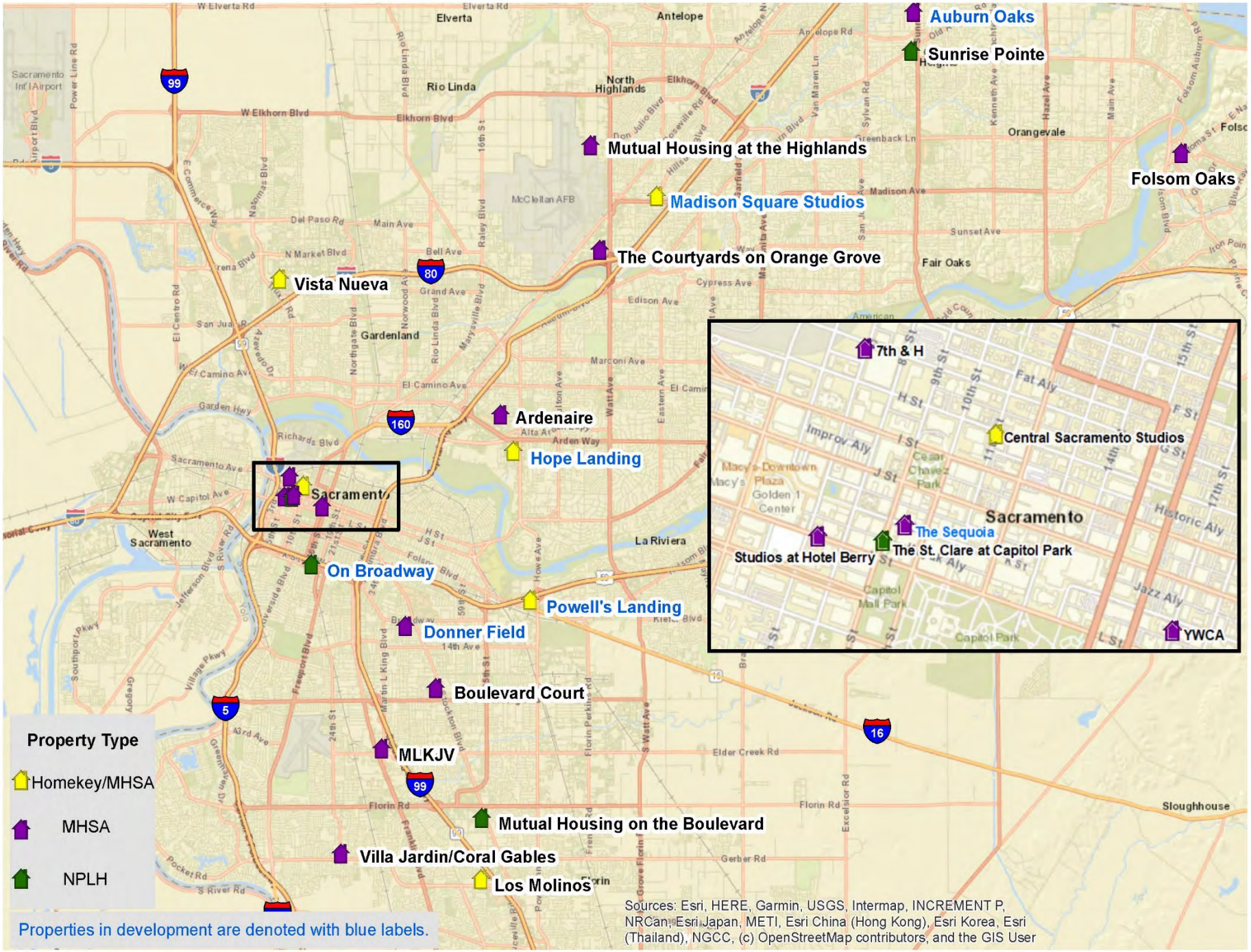
PROPERTY DESCRIPTION

- ✓ Preservation and rehabilitation of historical property / existing SRO
- ✓ 88 Units; 16 MHSA Units
- ✓ Property features include computer room, laundry room, bike storage and community room
- ✓ Studio units

PARTNERS

- ✓ John Stewart Company
- ✓ TLCS, Inc. (dba Hope Cooperative)
- ✓ Sacramento Housing and Redevelopment Agency
- ✓ Sacramento County Behavioral Health Services

MAP OF PORTFOLIO



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Sacramento County Community Driven Time Limited Prevention and Early Intervention Grant Program

AUGUST 2024

Annual Program Report Reporting Period: July 2023 - June 2024

CalMHSA
California Mental Health Services Authority

Table of Contents

PROGRAM SUMMARY 3
PEI PRIORITIES 4
Access and Linkage to Mental Health Services and Community Resources
Address Mental Health Needs and Promote Mental Health and Well-Being
Reduce the Stigma Associated with Mental Health and Wellness Through Engagement of Diverse Communities
DATA ANALYSIS 8
Overview
DEMOGRAPHIC DATA HIGHLIGHTS.....8
PROGRAM HIGHLIGHTS.....10
Youth and Transition Age Youth (TAY) Programs
Older Adults Age 55+
Refugee Populations
RECOMMENDATIONS 12
Challenges in Community Engagement Strategies, Building Equitable Programs
Challenges in Grant Management and Budgeting
Challenges in Data Submission
GRANTEE CONTACT SHEET 13

PROGRAM SUMMARY

The Sacramento County Community-Driven Prevention and Early Intervention (PEI) Grant Program supports a grassroots approach to helping communities reduce stigma and increase prevention of mental health crises in Sacramento County's diverse communities. The program goal is to build community capacity and address the mental health needs of marginalized communities by promoting mental health and well-being, increasing mental health services, and reducing stigma associated with mental health through culturally and linguistically congruent outreach. The program also emphasizes community engagement activities within the county's most vulnerable, underserved, and unserved populations.

CalMHSA collaborated with Sacramento County to implement the second funding cycle of the grant program. Grants focus on community-based organizations (CBOs) that are staffed by and serve diverse communities. Twenty-seven recipients received awards ranging from $10,000 up to $425,000, with program terms starting July 1, 2023, and ending as late as May 30, 2026.

CalMHSA provided administrative and program implementation support to awardees through contract execution, program orientations and trainings on contract requirements, review of policies and procedures for contract deliverables, data collection, funding cycles, payment distribution, and general program requirements. To help improve oversight of program data collection, CalMHSA introduced the Salesforce data management system, assisting awardees with access to and use of the data system. CalMHSA also recommended survey frequency and distribution techniques and provided training on MHSA data collection requirements for PEI programs.

CalMHSA also:

- Met with awardees monthly
- Managed contracts
  - Develop, execute, and monitor contracts with awardees ensuring they have developed program plans that clearly outlines the programs target population, engagements strategies, outreach, data collection protocol, goals, and the lasting community impact of the program.
- Provided ongoing program support and technical assistance
- Facilitated workshop and training opportunities, including:
  - A four-part learning collaborative series on Trauma-Responsive and Attachment-Focused Care provided by Crisis and Recovery Enhancement (CARE)
  - A webinar on Promoting Immigrant Health: Equitable Data and Community Engagement and Zero Suicide Academy through the California Department of Public Health

Awardees used the first year of the funding term to implement programs that incorporate a holistic and Peer-led approach, hiring culturally inclusive staff, developing outreach strategies, creating data collection protocols, and engaging with community partners. Awarded CBOs worked to meet their communities where they were by providing free community outreach events such as:

- Mental wellness fairs
- Sporting events
- Art therapy groups
- Music therapy groups
- Barbershop talks
- Community Sunday dinners
- Healing circles

- Sound baths
- Physical fitness sessions (e.g., yoga, meditation, breathing techniques)
- Sewing circles
- Support groups
- Educational webinars

Awardees embedded mental health education and resources in each event by partnering with other community-based and county partners to offer information on additional, longer-term support services and resources. Sacramento County Community-Driven PEI grant program data collection reported that awardees supported county communities ranging from youth and older adults to refugee communities and ethnic/racially diverse communities. Of those served, 22.8% were from the Black/African American community, and 40.7% were from the Latiné/x community. During the reporting period, 1,000 events were facilitated; at those events, 71.87% of community members in attendance had no prior mental or behavioral health symptoms. Of the 5,659 surveyed, 16% reporting being a member of the LGBTQIA+ community.

The most frequently spoken languages were:

- English, 47.86%
- Spanish, 36.46%
- Farsi, 12.09%

The most served age groups were:

- 55+, 32%
- Youth and TAY ages 0-25, 27.24%

PEI PRIORITIES

Prevention and Early Intervention (PEI) programs are legislatively required to support access and linkage to mental health services, address mental health needs and promote mental health and well-being, and reduce stigma associated with mental health and wellness through community engagement, as required by the Mental Health Services Act (MHSA). Awardees in Round 2 addressed each aspect of PEI, as listed below.

Access and Linkage to Mental Health Services and Community Resources

Participants of awarded programs come from diverse populations who are at a higher risk of severe symptoms of untreated mental illness and prolonged suffering. Many face language and literacy barriers; 50% of participants who received services in this reporting period mentioned another language other than English as their primary language. Finding support services in multiple languages and to serve recipients of different cultural backgrounds, sexual orientations, and other underrepresented communities is often challenging. Awarded programs created services that best fit their target populations. Programs leveraged their community connectedness to create direct pathways that reach those populations, which allowed them to engage their communities in mental health and wellness awareness through a grassroots, community-driven, peep-to-peer approach that created openness among community members to receiving mental health services. The efforts resulted in 24,165 individuals being served, of that 90.9% reported being more aware of how access to community services and support resources. Individuals surveyed 84.7% reporting that the services they received reflected their cultural beliefs, preferences, and values.

In addition to the high demand for mental health support services, communities shared the need to access additional services that support the reduction of socioeconomic disparities. Workforce and education support were integrated into services provided as economic inflation continued to rise and financial challenges intensified daily stressors; 585 participants were referred to education and employment services. Awardees developed community resource guides for service providers that meet their communities' demographic needs and link them to mental health services. Additionally, awardees-built partnerships with community-based partners to create a direct referral system and expand their provider network.

The examples below illustrate the types of events and partnerships awardees established to promote access and linkage to their targeted audiences.

- ONTRACK, Program Resources' Soul Space program provides unhoused individuals with 1:1 support by providing linkage services to housing/shelter, mental health and AOD services, crisis intervention, social services, food disparity, and Medi-Cal services. ONTRACK provided 90 individuals with linkage and referral services in this reporting period.

- Healthy Community Forum for the Greater Sacramento Region dba Sacramento Covered (SC) Community Health Worker (CHW) program assists individuals being released from Sacramento County Main Jail with coordinating post release plans. Post release plans provide care coordination by linking clients to Medi-Cal/CalAIM enrollments, CalFresh assistance, referrals to mental health/Alcohol and other Drugs (AOD)/Motivational Enhancement Therapy (MET), health care services, ID vouchers, transportation, phone assistance, and shelter referrals. SC's Community Café has continued success in providing recently released and unhoused individuals with a place to meet with the CHW, stay out of the elements, have basic needs met, and enjoy a cup of coffee. CHW also provide clients with transportation to initial probation check-ins, AOD and mental health respite services appointments, and temporary shelter service.

Address Mental Health Needs and Promote Mental Health and Well-Being

Awarded CBOs attended events relevant to their target populations and where their communities gathered, using community centers, places of worship, parks, temporary housing locations, schools, and public events to provide education on the importance of mental health and wellness.

The examples below illustrate the types of events and partnerships awardees established to promote mental health and well-being to their targeted audiences.

- Iu Mien Community Services facilitated weekly lunchtime classroom sessions to students attending Hiram Johnson High School. The classroom sessions are a combination of mental health education, community resources, and fun activities that keep youth engaged. Session topics included mental wellness, self-care tips, coping skills, suicide prevention, and help-seeking behaviors.

- Musical Instruments N' Kids Hands implemented the weekly Music Science Group after school program at Bowling Green McCoy Charter Academy in South Sacramento for youth ages 8-12 who were referred to the program due to behavioral and educational challenges. The after-school program provided them with social and emotional support through a holistic approach that incorporates personalized home visits, promotes mental well-being, offers a creative outlet for self-expression, and vital skills and support systems.

The curriculum component addresses emotional challenges, effective anger management, expressing emotions through songwriting, and fostering therapeutic outlets for processing feelings. The goal is to empower youth to navigate challenges and lead healthier, more productive lives, and achieve overall mental wellness. For the nine-month academic year, five students were awarded student of the month and two were invited to speak at their sixth-grade promotion.

- The Greater Sacramento Urban League (GSUL) implemented the bi-weekly Cut to the Chase barbershop group therapy program. Group sessions are designed for Black men and boys to discuss everyday challenges and barriers that come with being a Black male in America. Early in the program, GSUL expressed challenges in getting participants to initially attend because of the traditional taboos associated with mental health and Black males, such as being seen as less manly or weak by expressing emotion and/or trauma, the lack of cultural representation in mental health, and the mistrust or fear of treatment creating feelings of embarrassment and shame. GSUL found that once an individual attends at least one session, they understand that the format, content, and approach are not the traditional model of mental health services and are encouraged to return for additional sessions. The program has grown and expanded to the Cut to the Chase, Queens for focuses on Black women and girls, facilitated at local beauty salons and focused on the trauma and experiences of being a Black woman in America. From the success of the program, GSUL was invited to speak at the National Urban League's Health Equity Summit on the work it has done to support of Black communities in Sacramento

Reduce the Stigma Associated with Mental Health and Wellness Through Engagement of Diverse Communities

Awarded CBOs developed program models that decolonize mental wellness by creating curricula that accommodate diverse populations and support reducing mental health stigma within each target population. Program models are a blend of peer-to-peer support groups, 1:1 case management, and community presentations. Support group topics include breaking generational traumas, toxic stress, emotional impacts of being a person of color in America, school stress and bullying, how to raise teens in a new country, and signs of mental illness and substance use among youth.

The examples below illustrate the types of events and partnerships awardees established to reduce the stigma associated with Mental Health and Wellness through engagement of diverse populations.

- The Sacramento LGBT Center facilitated 152 ongoing support groups and workshops that enhance the mental health and well-being of LGBTQIA+ Black and Latin/x/è youth residing in South Sacramento, Black queer and transgender adults, parents, and LGBTQIA+ older adults. Group participants of the parents' support group have shared that the peer-to-peer led groups have improved their relationship with transgender family members due to the group's support of gender-affirming resources and tools. Other group participants have expressed that the group has helped them to manage their daily life stressors, which in turn helps them to feel less lonely.

- Be Love Holistic implemented the Be Love Holistic and Wellbeing: Healing from Prenatal and Postpartum Trauma and Loss project. The project offers wellness activities that incorporate mental and physical health to women who experienced perinatal loss. Activities include monthly healing circling circles that blend yoga and hip-hop step aerobics, music and movement therapy, emotional freedom techniques, sound baths, mindful meditation, plant-based food education, and holistic healing education. Be Love Holistic provided 68 women suffering from prenatal trauma and loss with peer-to-peer support services. Of the 68 women served 84.42% were African American/Black, with 85.29% between the ages of 26-54. 95% reported that this program has helped them with finding services and support.

- East Bay Asian Youth Center (EBACY) facilitated two cohorts of the Peer Advocates program during this fiscal year; 130 youth participated between both cohorts. Participating students attend Luther Burbank, Hiram Johnson, and Grant High School. The youth meet collectively weekly at EBACY's South Sacramento location. Discussion topics include how to access mental health resources, digital storytelling, mentorship, building healthy relationships, and linkage to clinical care if needed. Participant outcomes provided by EBACY show that 98% of youth agreed that their participation in the Peer Advocates program has helped them learn new information about youth mental illnesses; 88% agree that the program helped them learn new information about the causes and harms of stigma associated with mental illness; 89% agree the program supported them in learning new information about mental illness and substance abuse prevention; and 97% feel that youth can work together to improve their community.

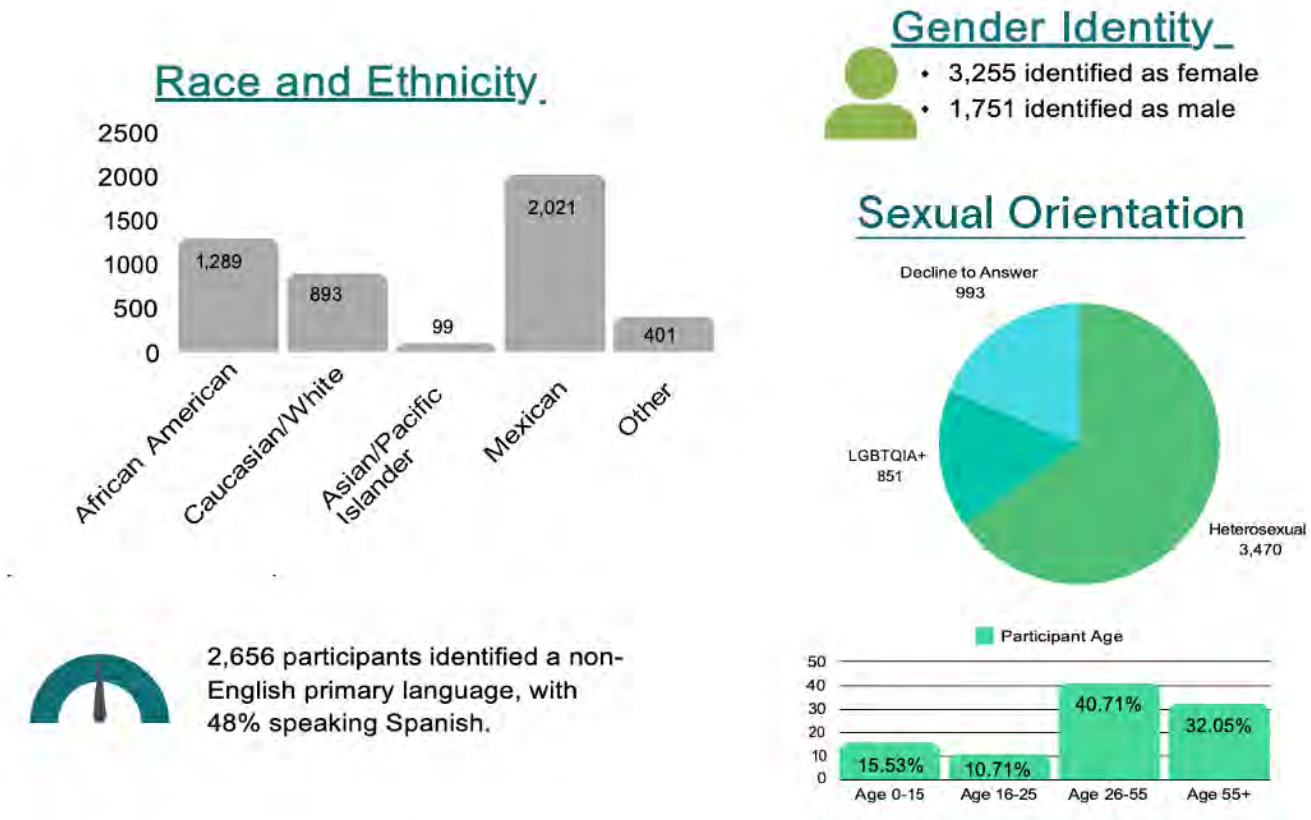
DATA ANALYSIS

Overview

Awardees collected participant demographic, satisfaction, and linkage and referral data, using CalMHSA's Salesforce data collection management system. The data management system was implemented in this reporting period as a quality improvement process that supports community-based organizations in meeting MHSA PEI data reporting requirements, alleviating some of the collection barriers that were seen in the first cycle of the grant program. Awardees can share a survey link, create a QR code, print for translation into languages other than English, and/or use an iPad/tablet/computer at time of service. If awardees utilize the print/hard-copy version of the form, that data must be entered by their staff on a monthly basis. CalMHSA has provided group and individual training on how to use and administer the survey form and collection platform.

Populations served by awarded programs were cautious with providing personal information for governmental use. Multigenerational traumas stem from the primary usage of demographic data to create systemic barriers for communities of color. In efforts to reduce fears and expand data collection, awardees have used this barrier to open conversations on why the data is collected and how it is used to improve services provided to underrepresented communities — empowering participants in the data collection and ensuring they feel heard.

DEMOGRAPHIC DATA HIGHLIGHTS



DATA ANALYSIS

Satisfaction and Linkage Highlights

CATEGORY	DATA/OUTCOME	PERCENTAGE
Knowledge of Community Supports	4.1K participants reported they are more aware of the community services available and how to access them for themselves or family	
Crisis Intervention	3.8K participants reported that the services they received kept them safe.	
Linkage to Community Services and Resources	4,255 participants have a better knowledge of how to find and access support services and resources.	
Participant Satisfaction	4,383 participants reported that they would return for services if needed for themself or a family member.	

PROGRAM HIGHLIGHTS

In the 2023-24 fiscal year, 24,165 participants were served through activities facilitated by awardees. The select programs highlighted in this section provided services to youth, older adult, and refugee populations. These populations are typically hard to reach and providing them with prevention and early intervention services is especially important. Each agency provided community-centered activities to each of the highlighted populations. Communities learned about resources and engaged in conversations that reduce the stigma and discrimination associated with mental health and wellness.

Youth and Transition Age Youth (TAY) Programs

During this reporting period, nine programs provided youth services. Youth participated in activities that include classroom pop-ups, after school support groups, youth workshops, and mentorship programs. Agencies provided caregiver workshops on youth mental health topics that include recognizing the signs of mental illness and/or substance use, effective communication, and linkage to youth services. Below is an example of the types of services and activities awardees provided to support efforts of reducing stigma and discrimination associated with mental health.

- Project Optimism implemented the Project Optimism Mentoring Sessions (POMS) across 10 schools in the San Juan and Folsom Cordova Unified School Districts. The POMS youth mentor team facilitated weekly after school activities at participating campuses that incorporated diverse topics that included, but were not limited to, identity development, mental health and wellness, anti-bullying, social competencies, cultural awareness, interpersonal skills, empathy, peaceful conflict resolution, and academic success. Project Optimism extended support to student parents and caregivers through weekly parent support groups that offered resources for self-care and recognizing the signs in youth, as well as discussions on how to engage youth in achieving mental wellness.

Older Adults Age 55+

During this reporting period, two programs provided older adult focused support services. Older adult communities participated in activities that include support groups, workshops, and community classes on self- care, isolation reduction, nutrition, and mental wellness. The examples below illustrate the types of services and activities awardees provided to support efforts of reducing stigma and discrimination associated with mental health.

- La Familia Counseling Center provided group support to Spanish speaking older adults within their target population. Participants discussed topics such as merging physical health and mental health, nutrition, and reducing loneliness and isolation.

- Agile Group facilitated monthly Wellness Wednesday support groups that focused on older adults in the Black community. The support group provides participants and their families with additional emotional support to elders as they enter the next phase of life. The program aims to remove the stigma surrounding mental health issues in traditionally marginalized communities by providing a space that is welcoming and comfortable to allow conversations on mental wellness among multigenerational households, offering support and in need of resources.

Refugee Populations

There are four awardees serving refugee populations in this funding cycle. These programs offered many resources, such as temporary housing assistance, health and mental wellness support services, and assistance in securing the appropriate status and documents to receive the support services needed. In support of services listed above, awardees utilize outreach opportunities, peer-to-peer support groups, and 1:1 case management to achieve the overall goal of access to care and cultural awareness. Below are some examples of the services that were provided.

- Lao Family Community Development (LFCD) implemented the Sacramento Health and Well- Being (HWB) project, a culturally and linguistically sensitive PEI program that offers a series of support services to newly resettled refugee populations. HWB offers Chai and Chat peer-led support groups that give Afghan women a safe place to discuss sensitive topics and experiences like positive parenting, postpartum concerns, depression, marriage, family issues and support, and cultural and religious challenges. LFCD offered community workshops that covered mental wellness topics and socialization skills. In an effort to provide a high level of support, LFCD provided individuals with 1:1 case management support that assists clients with navigation of and access to mental health services, referrals to language-appropriate counseling, translation and interpretation services, and linkage to many social service resources.

- International Rescue Committee (IRC) facilitated Refugee 101/Cultural Competency trainings to school staff, community partners, physicians, health care professionals and Sacramento State social work students. The orientation provided individuals who support newly resettled refugees with cultural education on discrimination, microaggressions, and the traumatic experiences refugees have faced. The goal of the training is to reduce negative interactions by educating service providers so they can better understand, empathize with, and treat clients with culturally relevant practice

RECOMMENDATIONS

In an effort to support grantees in their request to receive additional training on community engagement strategies and grant management, CalMHSA recommends the following.

Challenges in Community Engagement Strategies, Building Equitable Programs

Awarded CBOs continue to discuss in their individual monthly Technical Assistance meetings building more equitable programs that benefit their target populations with lasting impact. Awardees are looking for new and innovative ways to outreach and engage with their communities. CalMHSA has provided awardees with training opportunities as listed in the program summary. Recommendations to support awardees with this need are:

1. Establish opportunities for community organizations to participate in free training on community engagement and building equitable programs.

2. Share community networking opportunities.

3. Recommend events outside of regular outreach, such as sporting events, concerts, art events, farmers markets and street fairs, and various places communities gather in order to meet community members where they are.

Challenges in Grant Management and Budgeting

Another challenge that awarded CBOs have expressed is the need to better understand grant management and program budgeting. Many of these organizations are small, grassroots, newly established organization, and/or new to grant funding. Recommendations to support awardees with this need include:

1. Establish opportunities for community organizations to receive grant management and fiscal trainings.

2. Incorporate Grants 101 trainings in established individual monthly technical assistance, to include:

    - How to apply for a grant
    - Where to search for grant opportunities
    - How to create a budget
    - Administrative and/or overhead fees, and how to include them in grant budget

Challenges in Data Reporting

Data collection within the communities served through the Sacramento County Community-Driven Time-Limited PEI program continues to be a barrier. Populations served by awarded programs are cautious with providing person information for governmental use. Multigenerational trauma stem from the primary usage of data to create systemic barriers for communities of color. An additional ongoing barrier within data collection is literacy and language translations. As a response, in fiscal year 2024/2025 Sacramento County provided MHSA approved survey forms in the seven threshold languages (see below) . Recommendations to awardees are;

- Flexibility in administering the survey:
    - QR coding
    - Utilize peers and community health workers to support participants in completing the

survey form in the seven threshold languages.
    - Arabic
    - Chinese
    - Farsi
    - Hmong
    - Russian
    - Spanish
    - Vietnamese
- Incentives for survey completion i.e., gift card, meal tickets, etc.
- Require an internal data collection process as one of the program deliverables.
- Continued conversations with awardees still struggling in the data collection to support their target population and communities in feeling empowered through data collection.

Sacramento County Time-Limited Community Driven Prevention and Early Intervention (PEI) Grant Program, Round II

Grantee Contact Sheet

Fiscal Year 2023-24

Program Details:

The Sacramento County Division of Behavioral Health Services (BHS), through Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) component funding and in collaboration with California Mental Health Services Authority (CalMHSA) implemented a second round of the Time-Limited Community-Driven Grant Program. Round II awarded $10 million in grants to 27 local community-based organizations with awards up to $425,000.

Program Objective:

The Sacramento County Time-Limited Community-Driven PEI Grant Program is intended to build community capacity by addressing the mental health needs of communities by promoting mental health and wellness, increasing mental health services, and reducing stigma associated with mental health and wellness through cultural and linguistic congruent programs and activities that serve diverse communities.

	Organization and Grant Amount:	Contact Information:	Grant Term:	Population Served:	Program Description:
1	Agile group $182,700	Michael Craft Program Director mcraft@agilegroup.us (916) 670-2932	July 1, 2023 – May 31, 2026	African American Older Adults	The goal of the **Aging Gracefully** program facilitated by Agile Group is to create a safe space to discuss mental health as well as the issues that come with aging within the African American community. The program will provide the opportunity to engage their target population along with their families to provide additional emotional support to their elders as they enter the next phase of life. Efforts will include helping to remove the stigma surrounding mental health issues in traditionally marginalized communities by providing a space that is welcoming and comfortable to allow conversations on mental wellness among mutigenerational households. Agile Group will facilitate weekly Wellness Wednesday support groups, A Life Worth Living – Sharing Memoir Journaling and Kitchen Table Talks, modeled after old school Sunday dinners.
2	Be Love Holistic $133,909	Teah Hairston Program Director & Lead Facilitator beloveholistics@gmail.com (916) 201-4255 www.beloveholistic.com	July 1, 2023 – May 31, 2026	Black women ages 18-55 who have experienced prenatal and/or postpartum trauma or loss	**Be Love Holistic Wellbeing: Hearing from Prenatal and Postpartum Trauma & Loss** project will facilitate Sister Circles composed of holistic health and wellbeing activities to provide recovery support for Black women who have experienced prenatal/perinatal loss and early infant demise. Participants will be educated about history, risks, and causes and prevalence of and solutions to maternal health issues. Participants will learn

	Organization and Grant Amount:	Contact Information:	Grant Term:	Population Served:	Program Description:
					tools and strategies to prevent and/or intervene in prolonged suffering caused by pregnancy loss/early infant demise. Be Love Holistic will provide local resources to raise awareness and reduce stigma and discrimination related to accessing mental health support for maternal health issues.
3	CA Black Women's Health Project $425,000	Sonya Young Aadam CEO sonya@cabwhp.org (310) 412-1828 www.cabwhp.org	July 1, 2023 – May 31, 2026	African American/Afro-Latina/Afro Caribbean TAY populations	California Black Woman's Health Project's (CABWHP) program **Black-TAY Mentally Mobilized** is part of a college-going, Black youth-centered sister/brother circle community capacity building program. CABWHP will design, host, and evaluate a series of culturally infused mental health focused convenings, trainings, and safe spaces that support transitional age youth (TAY) to find balance, mitigate stress, and come together to tend to their hearts, minds, souls, and communities.
4	CalVoices $424,653	Maksim Tsymbal Program Manager sacmap@calvoices.org (916) 366-4668 www.calvoices/sacmap	July 1, 2023 – May 31, 2026	BIPOC and 2S+/LGBTQ+	The **SacMap** Project provides an online resource directory where Sacramento County community members can find behavioral health programs and services available to them. The site focuses on programs that do not require a formal referral, and many are available at no cost. SacMap will provide in-person and virtual workshops to educate and inform people about substance use and mental health challenges, and the many services and support available to them, both within the County and other

	Organization and Grant Amount:	Contact Information:	Grant Term:	Population Served:	Program Description:
					resources they can access regardless of their place of residence.
5	Coffee and Conversations Foundation $425,000	Patrice Tevis LMFT patricetevis@gmail.com (916) 217-0934	July 1, 2023 – May 31, 2026	English speaking youth, teens, and families	**Project Soar** program goal is to provide mental health education classes to increase target audience understanding of mental illness and to reduce the stigma associated with mental health conditions. In addition, the program will offer educational games and activities for children, youth, and their families to enhance academic and life skills, and to promote positive community engagement.
6	East Bay Asian Youth Center $402,336.45	David Kakishiba Executive Director junji@ebayc.prg (510) 533-1092 x25 www.ebayc.org	July 1, 2023 – May 31, 2026	Southeast Asian youth	**Peer Advocates** is a Peer Support & Leadership Development program designed to strengthen protective factors including self-awareness/self-efficacy, relationships with positive peers and adults, and build a connection with youth attending target schools and within the community of low-income, high-need Southeast Asian youth. The program model will use an activity engagement, activity-based curriculum that integrates healing circles, behavioral health education, peer-to-peer outreach, and participatory action research to achieve the overall program goal.
7	Greater Sacramento Urban League $425,000	Jahmese Williams, PhD Executive VP jwilliams@gsul.org (916) 286-8600 www.gsul.org	July 1, 2023 – May 31, 2026	Black Men & Women-specifically Del Paso Heights and Oak Park residents	**The Cut to the Chase** project will focus on improving mental health as a social determinant of health impacting Black men and women in Del Paso Heights and Oak Park. As they are often the site of candid conversation and informal

	Organization and Grant Amount:	Contact Information:	Grant Term:	Population Served:	Program Description:
					resource sharing among African Americans, GSUL will partner with barbershops and beauty salons as the sites for participants receiving mental health support. By removing barriers to mental health support, this project will promote innovative service delivery, advance health equity, and provide mental health support and services. Cut to the Chase will address community disparity by merging professional mental health support and peer support.
8	Health Education Council $425,000	Amanda Bloom, MPH Director of Programs and Impact abloom@healthedcouncil.org (916) 556-3344 www.healthedcouncil.org	July 1, 2023 – May 31, 2026	Latin/x/e, Black and Afghan communities	**The Hub** will provide culturally and linguistically tailored prevention and intervention services for members of the Latinx/e, Black, and Afghan communities, working to reduce stigma and discrimination associated with seeking mental health services and/or being diagnosed with a mental illness. The project will train diverse residents as Community Mental Health Navigators, equipping them with skills to talk about mental health in their community and link other community members to resources. The project will also provide space and funding support for culturally and linguistically responsive support groups and community classes that decrease mental health stigma by providing a safe space to learn and talk about mental health in culturally responsive ways.

	Organization and Grant Amount:	Contact Information:	Grant Term:	Population Served:	Program Description:
9	Healthy Community Forum for the Greater Sacramento Region dba Sacramento Covered $425,000	Kyle Stefano VP of Clinical Programs kstefano@sacramentocovered.org (916) 956-2626 www.sacramentocovered.org	July 1, 2023 – May 31, 2026	Individuals returning to the community following incarceration, particularly those with mental health needs and complex social needs	Sacramento Covered **Community Health Worker Reentry Program** will build community capacity for Behavioral Health care coordination and navigation services for individuals returning to the community following incarceration. A key component of this work is screening, and referral into CalAIM program for eligible clients. Sacramento Covered will collaborate with the Sacramento County Jail to connect clients to services to address their unique needs and goals.
10	International Rescue Committee $425,000	Dima Al Ayderous Grants Coordinator Dima.alayderous@rescue.org (916) 482-0120 www.rescue.org/sacramento	July 1, 2023 – May 31, 2026	Sacramento County refugee populations	International Rescue committee's **Community Wellness Program** will provide mental health services, outreach, and engagement activities the support Sacramento County refugee and special immigrant visa holder populations who are newly resettled in the county. Services implemented under this program will assist with reducing the stigma associated with mental health services, address mental health needs within the community, and increase access to wellbeing resources. Services and resources will be provided in Ukrainian, Russian, Spanish, Pashto and/or Dari.

	Organization and Grant Amount:	Contact Information:	Grant Term:	Population Served:	Program Description:
11	Iu Mien Community Services $237,193.80	Susan Saechao Executive Director contact@iumiencommunityservices.org (916) 383-3083 www.unitediumien.org	July 1, 2023 – May 31, 2026	API youth from refugee or immigrant families	**Seek Act Embrace** Youth Club will invite Asian Pacific Islander students, or any student attending Hiram W. Johnson High School who would like to be a part of a club to learn about mental health through fun and engaging activities during their lunch time. The overall goal is to help students recognize early signs of mental health related issues and how to navigate and access support resources.
12	Justice Teams Network $425,000	Annie Banks Network Director annie@justiceteams.org (510) 631-4353 www.justiceteams.org	July 1, 2023 – May 31, 2026	Sacramento County communities of color	Through this project, **Mental Health First: Building Alternatives, Growing Our Network,** Justice Teams Network will expand upon the healing justice-based festival held in May 2022 as part of round 1 funding by the Sacramento County Time-Limited Community-Driven PEI grant program. Program expansion will include: (1) introduce and provide training to over hundreds of community members in non-carceral crisis response, (2) host a conference to convene leading practitioners to share issues, best practices, and collectively navigate pathways forward that provide community-based pathways to safety and crisis response, and (3) produce and publish a report based on this convening on the power of community alternatives to create safe and thriving communities to be released at follow-up virtual summit in year three.

	Organization and Grant Amount:	Contact Information:	Grant Term:	Population Served:	Program Description:
13	La Familia Counseling Center $425,000	Jessie Armenta, LMFT Clinical Director JessieA@lafcc.org (916) 210-8773 www.lafcc.org	July 1, 2023 – May 31, 2026	Immigrant and refugee populations	La Familia's program, **Resilient Sacramento** will serve the culturally diverse populations of Sacramento. The program will focus on immigrant and/or refugee populations. The program goal is to increase their wellness and awareness of mental health conditions, through outreach, cultural activities, workshops, trainings, and other opportunities that address barriers and help them create wellness and be part of a Resilient Sacramento Community.
14	Lao Family Community Development, Inc. $424,999	Mai Quach Director of Programs Global Career Development Facilitator mquach@lfcd.org (510) 533-8850 www.lfcd.org	July 1, 2023 – May 31, 2026	Immigrant and refugee population	Lao Family Community Development will implement a culturally and linguistically sensitive PEI programs that utilize personal case management, comprehensive participant assessments, individual care plans, and evidence-based educational workshops, peer support groups, social gathers and linkage and resources to increase clients access to mental health treatment and health care.
15	Mental Health California $425,000	Kristene (K.N) Smith CEO kn@mentalhealthca.org (916) 288-2466 www.mentalhealthca.org	July 1, 2023 – May 31, 2026	Males of color	**The Brother Be Well** Graphic Novels and Educational Materials Series is a digital, limited series of eight (8) overcoming-themed graphic novels and educational materials aimed at high school and college-aged males of color. The series promotes storytelling around ACEs, trauma, anxiety, depression, and substance use coupled by strength based, resilience themes to educate and

	Organization and Grant Amount:	Contact Information:	Grant Term:	Population Served:	Program Description:
					inspire in a new medium, now and into the future.
16	Musical Instruments n' Kids Hands $134,143.60	Marcus Wright Program Director marcus@musicsciencegroup.com (216) 903-3756 www.musicsciencegroup.com	July 1, 2023 – June 30, 2024	Youth ages 12-19	**Musical Instruments 'N Kids' Hands'** awarded program **Music Science Group** primary service will provide educational programming and enrichment activities that positively impact underserved students, including students who do not pursue a career in music. The goals of Musical Instruments 'N Kids' Hands include, but are not limited to: • Improved grades and test scores, especially in math and science, • Increased self-esteem and confidence, • Development of teamwork skills, • Improved social skills, and • Higher graduation rates
17	NAMI, Sacramento $422,778.10	David Bain Executive Director david@namisacramento.org (916) 890-5467 www.namisacramento.org	July 1, 2023 – May 31, 2026	LGBTQIA+, Veterans, and BIPOC Communities	NAMI, Sacramento will utilize peer led support groups and community education classes, to support those living with mental health conditions and their families to improve their quality of life. The program will also provide community presentations on mental health and resources to help reduce the stigma associated with living with a mental illness that offer information and the hope that there is a life in mental health recovery.
18	Nation's Finest $425,000	Kendra Barter Chief Program Officer kbarter@nationsfinest.org (916) 407-5694 www.nationsfinest.org	July 1, 2023 – May 31, 2026	At-risk veterans and their families	Nations Finest, **Veteran Mental Health Outreach, Education and Prevention Initiative** will conduct county-wide outreach to locate veterans and family members in need of mental

	Organization and Grant Amount:	Contact Information:	Grant Term:	Population Served:	Program Description:
					health referrals, and those who could benefit from educational materials and information about suicide prevention, and discrimination reduction. In addition, Nations Finest will host at least one community event each quarter. Events will include two sporting events, three educational seminars, four art therapy groups and three mental health resource fairs.
19	ONTRACK, Program Resources $424,376.56	Madalyn Rucker Executive Director mcrucker@getontrack.org (916) 285-1805 www.ontrackconsulting.org	July 1, 2023 – May 31, 2026	African American Communities	**Soul Space** is a community-defined best practice serving African Americans who are unserved or underserved in traditional behavioral health, health, social service, and justice systems. Soul Space will provide mental health supports, case management/empowerment advocacy, culturally congruent support groups, life skills workshops, and community education open to all residents of Sacramento County.
20	Opening Doors, Inc. $424,990	Analee Villapando Director of Programs analee@openingdoorsinc.org (916) 492-2591 x203 www.openingdoorsinc.org	July 1, 2023 – May 31, 2026	Refugee Populations	Opening Doors Inc., **Community Mental Health Navigation Program project** goal is to engage 140 Opening Doors clients to enhance their connectedness with topics that support mental health through community workshops and clinical mental health support by providing linkage and referral services to therapy service provided by partner community-based organizations who also support refugee populations.
21	Project Optimism	Kyari Cail Operations Coordinator	July 1, 2023 – May 31, 2026	Underserved 4th-12th grade students.	**Project Optimism Mentoring Sessions (POMS)**

	Organization and Grant Amount:	Contact Information:	Grant Term:	Population Served:	Program Description:
	$260,549.07	kcail@projectoptimism.org (916) 621-7406 www.projectoptimism.org			is a school-based intervention program tailored for historically marginalized and unserved 4th-12th grade scholars. Assessments will be conducted throughout the term of the program, while developing and facilitating enriching activities that will be conducted weekly by Youth Mentors that focus on various topics, but not limited to, identity development, mental health and wellness, and academic success.
22	Public Health Institute-Center for Collaborative Planning $425,000	Connie Chan Robinson Executive Director connie@connectccp.org (916) 498-6960 www.connectccp.org	July 1, 2023 – May 31, 2026	Students attending Job Corps	The Center for Collaborative Planning will partner with Sacramento Job Corps and other community stakeholders to provide outreach, education, resource referral, and advocacy to bolster the mental health fitness of its student population. The proposed project seeks to reduce stigma and promote help seeking behaviors so that young people are primed for academic and economic success and untouched by school failure and unemployment, two key consequences of untreated mental illness.

	Organization and Grant Amount:	Contact Information:	Grant Term:	Population Served:	Program Description:
23	Sacramento LGBT Center $425,000	Karen Kurasaki Grant & Program Sustainability Manager grants@saccenter.org (916) 442-0182 x132 www.saccenter.org	July 1, 2023 – May 31, 2026	LGBTQIA+ Black and Latinx/e populations residing in South Sacramento	Sacramento LGBT Center's program **SaQ Bridges** to Equitable Care aims to improve mental health and wellness among LGBTQIA+ Black and Latinx/e individuals in South Sacramento by creating activities and services that support mental health stigma reduction and creates bridges to affirming care in the Sacramento Region.
24	Sacramento Youth Center $422,985.50	Raquel Shipp Executive Director raquel@sacyouthcenter.org (925) 698-9121 www.sacyouthcenter.org	July 1, 2023 – May 31, 2026	Youth and TAY ages 14-24	Sacramento Youth Center will build intentional connections between community-and school-based programs as well as existing systems providing youth mental health services and resources. Sacramento Youth Center seeks to directly engage 250 youth in peer mentoring programs, achieve an extended reach of 2,500 through youth-led peer mentoring activities, and engage 4 young people (ages 17+) as peer interns. The goal of the Project is to engage youth as change agents to promote mental health and wellness for themselves, peers, and families by building capacity for youth peer mental health and wellness support programs. Sacramento Youth Center will partner with PRO Youth and Families (PRO) to develop a continuum of opportunities for youth to engage in peer-to-peer support programs and connect to pathways for behavioral/mental health careers.

	Organization and Grant Amount:	Contact Information:	Grant Term:	Population Served:	Program Description:
25	Sac Youth Mental Health $176,341	Staci Anderson Pro Youth and Families, President & CEO stacia@proyouthandfamilies.org (916) 576-3300 www.proyouthandfamilies.org	July 1, 2023 – May 31, 2026	Teen's age 14-19	**Sac Youth Mental Health** program goal is to continue their efforts to engage teens in topics that promote mental wellness and reduces stigma among youth. Proposed activities and events include a youth mental health conference, mental health film screenings and discussions, classroom and community pop-up events, webinars, and creating lasting partnerships with other Sacramento youth organizations.
26	Safe Black Space $424,791	Dr. Kristee Haggins Safe Black Space President safeblackspace@gmail.com (530) 683-5101 www.safeblackspace.org	July 1, 2023 – May 31, 2026	Black people across the Sacramento County region	Safe Black Space intends to continue to offer African-centered, culturally affirming support services as provided in round 1 of the Sacramento County Time-Limited Community-Driven PEI grant opportunity, while developing more robust new programs for Round 2. Safe Black Space will expand their reach to additional communities and target populations, resume their highly effective in-person healing circles, and include new programming such as African Drum Circles and Book Study Groups. Safe Black Space will hire additional staffing to deepen these offerings in order to increase capacity and expand the positive impact across Sacramento's Black community.
27	World Relief $422,140.61	Mark Dandeneau, MSW Regional Director mdandeneau@wr.org (916) 626-0827 www.worldrelief.org/sacramento/	July 1, 2023 – May 31, 2026	Refugee and immigrant populations	World Relief's **Immigrant and Refugee Mental Wellness Project** will fill a service gap by enhancing support services for refugees and immigrants that

	Organization and Grant Amount:	Contact Information:	Grant Term:	Population Served:	Program Description:
					promote overall wellness, reduce the stigma and discrimination associated with seeking behavioral health services, and decrease suicide by: Embedding prevention and early intervention psychosocial education information into existing training programs. Program services will include: 1) identify and reduce disparities 2) address barriers and improve support services 3) destigmatize mental health and improve knowledge of mental health services, and 4) provide county specific linkage and referral services.

Mental Health Services Act
Annual Prevention and Early Intervention Program and Evaluation Report
Fiscal Year 2023-2024

The Sacramento County Department of Health Services, Behavioral Health Services (BHS) has an array of Mental Health Services Act (MHSA) funded Prevention and Early Intervention (PEI) programs designed to serve the unserved and underserved communities in the County. The PEI programs range from outreach and engagement services to early identification and intervention for individuals experiencing early signs of psychosis.

In FY 2023-2024, PEI Suicide Prevention and Early Intervention programs served 79,713 and outreached to over 47,000 individuals by providing individual outreach and participating in 677 community events and disseminating information to over 10,000 additional individuals.

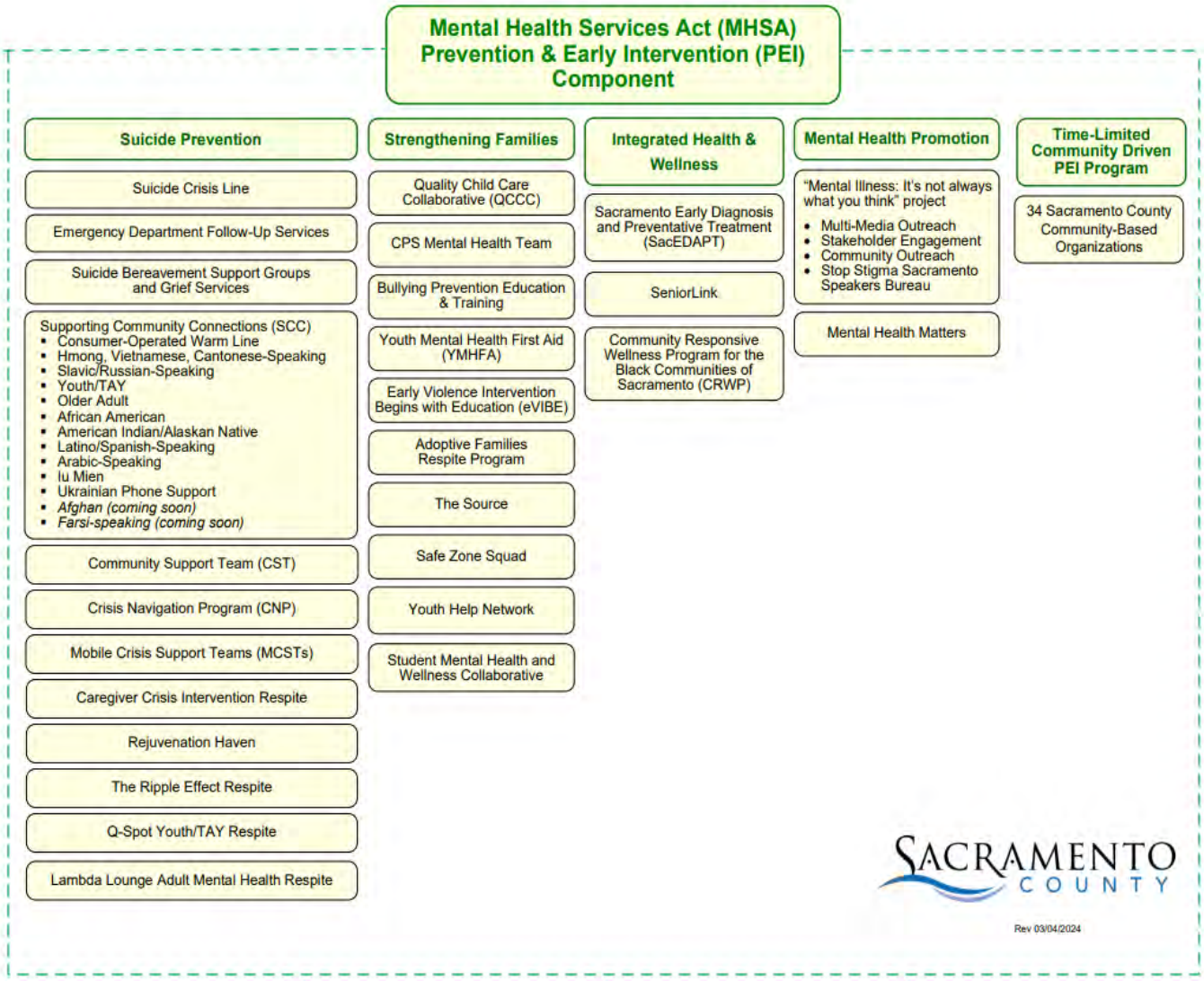
The Strengthening Families program served 7,373 individuals and offered prevention trainings and information to over 13,000 students, parents/caregivers, education staff, and other stakeholders.

The Integrated Health and Wellness program served 2,054 and outreached and distributed information to 1,901 individuals.

The Mental Health Promotion program "Mental Illness: It's not always what you think" project utilizes television, radio, social media and print material to advertise across the Sacramento area. In FY 2023-24, there were 6,163,960 impressions from the radio, 649 TV ads for a total of 6,712,106 impressions, 17 print ads, 34,291,209 impressions from outdoor ads and 21,863,540 impressions from online and mobile ads. Extra media events (Mental Health Awareness Month, Black History Month, and other holidays) garnered more than 5,409,955 additional impressions. Social Media impressions included over 61,000 from Instagram and 787,000 from Facebook. To date, The Stop Stigma Sacramento website (www.StopStigmaSacramento.org) has collected emails and has disseminated information to 518 people as well as 49,000 visits to the site and 110,000 page views. As of the end of FY 2023-24, the project's Stop Stigma Sacramento Speakers Bureau had 270 individuals trained, of which 37 actively participated and shared their personal stories 138 times at 64 events (40 in person and 24 virtual) with a total audience attendance of 2,913 individuals. The Speakers Bureau also participated in 36 in-person tabling events that included over 15,300 attendees. The Mental Health Matters television viewership was over 25,000 views and YouTube channel had over 1,000.

The time limited PEI programs engaged 6,835 individuals.

The diagram below depicts the range of PEI programs the County offered in FY 2023-2024.



Suicide Prevention and Education Program

Ages Served: Children, TAY, Adults, Older Adults

The Suicide Prevention and Education Program consists of:

- Suicide Crisis Line
- Emergency Department Follow-Up Services
- Suicide Bereavement Support Groups and Grief Services
- Supporting Community Connections (SCC)
- Community Support Team (CST)
- Crisis Navigation Program (CNP)
- Mobile Crisis Support Teams (MCSTs)
- Mental Health Respite Programs
    - Caregiver Crisis Intervention Respite
    - Rejuvenation Haven
    - The Ripple Effect
    - Q-Spot Youth/TAY Respite
    - Lambda Lounge Adult Mental Health Respite

Suicide Crisis Line

Program Type: PEI Suicide Prevention

Program Description: Administered by WellSpace Health, the 24-hour nationally accredited telephone crisis line, National Suicide Prevention Lifeline (now known as the 988 & Suicide Crisis Lifeline), that utilizes professional and trained volunteer staff to provide suicide prevention and crisis services to callers of all ages at risk of suicide. In addition to in-person phone response, program services also include a 24/7 Suicide Crisis Line chat and text response feature.

Number Served: In FY 2023-2024, 67,339 calls were made to the Suicide Crisis Line.

Suicide Crisis Line Demographics:

Characteristic	N=67,339	%
Age Group		
Children/Youth (0-15)	1,420	2.1%
TAY (16-25)	7,573	11.3%
Adults (26-59)	13,441	20.0%
Older Adults (60+)	5,093	7.6%
Unknown/Not Reported	39,812	59.1%
Ethnicity		
Hispanic or Latino	2,045	3.0%
Non-Hispanic/Non-Latino	8,429	12.5%
Other	390	0.6%
More than one ethnicity	647	1.0%
Unknown/Not Reported	55,828	82.9%
Race		
White	4,657	6.9%
Black or African American	1,596	2.4%
Asian	2,030	3.0%
American Indian or Alaska Native	91	0.1%
Native Hawaiian or other Pacific Islander	55	0.1%
More than one race	647	1.0%
Other	2,435	3.6%
Unknown/Not Reported	55,828	82.9%
Primary Language		
English	58,099	86.3%
Spanish	69	0.1%
Vietnamese	5	<0.1%
Cantonese	17	<0.1%
Russian	18	<0.1%
Hmong	9	<0.1%
Arabic	5	<0.1%
Farsi	0	<0.1%
Other	93	<0.1%
Unknown/Not Reported	9,024	13.4%

Sexual Orientation		
Heterosexual or Straight	1,672	2.5%
Gay or Lesbian	143	0.2%
Bisexual	86	0.1%
Questioning or unsure	24	<0.1%
Queer	46	0.1%
Another sexual orientation	51	0.1%
Unknown/Not Reported	65,317	97.0%
Current Gender Identity		
Female	31,482	46.8%
Male	28,526	42.4%
Transgender	258	0.4%
Genderqueer	49	0.1%
Questioning or unsure	29	<0.1%
Another gender identity	64	0.1%
Unknown/Not Reported	6,931	10.3%
Veteran Status		
Yes	207	0.3%
No	67,132	99.7%
Unknown/Not Reported	0	0.0%

Suicide Crisis Line – Satisfaction Survey Results:

Satisfaction Survey Item	N=481	%
I felt less distress at the end of the hotline call, than I did at the beginning.		
Strongly Agree	335	69.6%
Agree	94	19.5%
Undecided	23	4.8%
Disagree	10	2.1%
Strongly Disagree	10	2.1%
Not Applicable	9	1.9%
I felt the crisis counselor understood what I was going through.		
Strongly Agree	360	75.0%
Agree	63	13.1%
Undecided	31	6.5%
Disagree	8	1.7%
Strongly Disagree	10	2.1%
Not Applicable	8	1.7%
I am likely to call again if I need help.		
Strongly Agree	372	77.5%
Agree	55	11.5%
Undecided	24	5.0%
Disagree	9	1.9%
Strongly Disagree	13	2.7%
Not Applicable	7	1.5%

Emergency Department Follow-Up Services

Program Type: PEI Suicide Prevention

Program Description: Administered by WellSpace Health, brief individual follow-up and support services to consenting individuals seen at Sutter Medical Center Emergency Department (ED), Dignity San Juan Medical Center ED, and University of California Davis Medical Center (UCDMC) ED who have attempted suicide and are at high-risk for suicide.

Number Served: In FY 2023-2024, 120 unduplicated individuals were served.

ED Follow-Up Services Demographics:

Characteristic	N = 120	%
Age Group		
Children/Youth (0-15)	6	5.0%
TAY (16-25)	16	13.3%
Adults (26-59)	53	44.2%
Older Adults (60+)	31	25.8%
Unknown/Not Reported	14	11.7%
Ethnicity		
Hispanic or Latino	10	8.3%
Non-Hispanic/Non-Latino	25	20.8%
Other	0	0.0%
More than one ethnicity	5	4.2%
Unknown/Not Reported	80	66.7%
Race		
White	12	10.0%
Black or African American	11	9.2%
Asian	2	1.7%
American Indian or Alaska Native	0	0.0%
Native Hawaiian or Other Pacific Islander	0	0.0%
More than one race	5	4.2%
Other	10	8.3%
Unknown/Not Reported	80	66.7%
Primary Language		
English	12	10.0%
Spanish	0	0.0%
Vietnamese	0	0.0%
Cantonese	1	0.8%
Russian	0	0.0%
Hmong	0	0.0%
Arabic	0	0.0%
Farsi	0	0.0%
Other	0	0.0%
Unknown/Not Reported	107	89.2%

Sexual Orientation		
Heterosexual or Straight	0	0.0%
Gay or Lesbian	0	0.0%
Bisexual	0	0.0%
Questioning or unsure	0	0.0%
Queer	0	0.0%
Another sexual orientation	1	0.8%
Unknown/Not Reported	119	99.2%
Current Gender Identity		
Female	12	10.0%
Male	12	10.0%
Transgender	3	2.5%
Genderqueer	0	0.0%
Questioning or unsure	0	0.0%
Another gender identity	0	0.0%
Unknown/Not Reported	93	77.5%
Veteran Status		
Yes	1	0.8%
No	119	99.2%
Unknown/Not Reported	0	0.0%

Emergency Department Follow-up Services – Satisfaction Survey Results:

Satisfaction Survey Item	N=17	%
I was contacted within 48 hours of discharge from the emergency room.		
Strongly Agree	16	94.1%
Agree	0	0.0%
Undecided	1	5.9%
Disagree	0	0.0%
Strongly Disagree	0	0.0%
Not Applicable	0	0.0%
This program helped me remain Safe from suicide after discharge.		
Strongly Agree	13	76.5%
Agree	2	11.8%
Undecided	2	11.8%
Disagree	0	0.0%
Strongly Disagree	0	0.0%
Not Applicable	0	0.0%
The Follow-up Specialist I spoke with during follow-up calls was professional and empathetic.		
Strongly Agree	16	94.1%
Agree	1	5.9%
Undecided	0	0.0%
Disagree	0	0.0%
Strongly Disagree	0	0.0%
Not Applicable	0	0.0%
My knowledge and awareness of community based and online resources improved as a result of this follow-up program.		
Strongly Agree	9	52.9%
Agree	8	47.1%
Undecided	0	0.0%
Disagree	0	0.0%
Strongly Disagree	0	0.0%
Not Applicable	0	0.0%
I would recommend the ED Suicide Prevention Follow-up program to others if needed.		
Strongly Agree	13	76.5%
Agree	3	17.6%
Undecided	0	0.0%
Disagree	1	5.9%
Strongly Disagree	0	0.0%
Not Applicable	0	0.0%

Suicide Bereavement Support Groups and Grief Services

Program Type: PEI Suicide Prevention

Program Description: Administered by Friends for Survival, staff and volunteers directly impacted by suicide provide support groups, phone support, and other services designed to encourage healing for those coping with a loss by suicide.

Number Served: In FY 2023-2024, Friends for Survival served 39 individuals. This is reflected in the table below.

Suicide Bereavement Support Groups and Grief Services Demographics:

Characteristic	N=39	%
Age Group		
Children/Youth (0-15)	0	0.0%
TAY (16-25)	0	0.0%
Adults (26-59)	32	82.1%
Older Adults (60+)	7	17.9%
Unknown/Not Reported	0	0.0%
Ethnicity		
Hispanic/Latino	0	0.0%
Non-Hispanic/Non-Latino	39	100.0%
Other	0	0.0%
More than one ethnicity	0	0.0%
Unknown/Not Reported	0	0.0%
Race		
White/Caucasian	20	51.3%
Black/African American	1	2.6%
Asian	2	5.1%
American Indian/Alaska Native	0	0.0%
Native Hawaiian/Other Pacific Islander	0	0.0%
More than one race	3	7.7%
Other	4	10.3%
Unknown/Not Reported	9	23.1%

Primary Language		
English	37	94.9%
Spanish	0	0.0%
Vietnamese	0	0.0%
Cantonese	0	0.0%
Russian	0	0.0%
Hmong	0	0.0%
Arabic	0	0.0%
Farsi	0	0.0%
Other	0	0.0%
Unknown/Not Reported	2	5.1%
Sexual Orientation		
Heterosexual/Straight	26	66.7%
Gay/Lesbian	0	0.0%
Bisexual	0	0.0%
Questioning/Unsure	0	0.0%
Queer	0	0.0%
Another sexual orientation	1	2.6%
Unknown/Not Reported	12	30.8%
Gender Identity		
Female	27	69.2%
Male	5	12.8%
Transgender	0	0.0%
Genderqueer	0	0.0%
Questioning/Unsure	0	0.0%
Another gender identity	0	0.0%
Unknown/Not Reported	7	17.9%
Veteran Status		
Yes	0	0.0%
No	39	100.0%
Unknown/Not Reported	0	0.0%

Information and Referral: Friends for Survival submitted 529 Information and Referral Log forms.

Suicide Bereavement Support Groups and Grief Services – Satisfaction Survey Results:

Satisfaction Survey Item	(%)
The services I received or group(s) I attended helped me in these areas:	
Finding services and supports	96.8%
Feeling less lonely	95.6%
Managing my daily life stressors	94.0%
Keeping myself safe	93.1%
Managing a crisis	93.2%
I'll use these skills to help with:	
Finding services and supports	97.6%
Feeling less lonely	96.4%
Managing my daily life stressors	94.9%
Keeping myself safe	93.1%
Managing a crisis	91.8%

Satisfaction Survey Item	N=135	%
I am more aware of community services and supports that can help me or others in my family as a result of the services I received or group I attended.		
Strongly Agree/Agree	120	88.9%
Undecided	6	4.4%
Disagree/Strongly Disagree	3	2.2%
Not Applicable	4	3.0%
Unknown/Not Reported	2	1.5%
I learned skills from the services I received or groups that I attended that I use each day or share with others.		
Strongly Agree/Agree	119	88.1%
Undecided	4	3.0%
Disagree/Strongly Disagree	4	3.0%
Not Applicable	8	5.9%
Unknown/Not Reported	0	0.0%
I would come back again if I needed help for myself or others in my family.		
Strongly Agree/Agree	128	94.8%
Undecided	3	2.2%
Disagree/Strongly Disagree	0	0.0%
Not Applicable	2	1.5%
Unknown/Not Reported	2	1.5%
As a result of he services I received or groups I attended, I know how to get help if I knew someone who is considering suicide, harming themselves or if I felt suicidal or like harming myself.		
Strongly Agree/Agree	121	89.6%
Undecided	5	3.7%
Disagree/Strongly Disagree	0	0.0%
Not Applicable	8	5.9%
Unknown/Not Reported	1	0.7%

I felt the services I received reflected my cultural beliefs, preferences, and values which made me feel respected.		
Strongly Agree/Agree	119	88.1%
Undecided	4	3.0%
Disagree/Strongly Disagree	1	0.7%
Not Applicable	10	7.4%
Unknown/Not Reported	1	0.7%

Supporting Community Connections (SCC)

Program Type: PEI Improving Timely Access to Services for Underserved Populations

Program Description: A constellation of community based agencies working collaboratively throughout the County to provide culturally and linguistically appropriate suicide prevention support services designed to increase access to and linkage with needed services; improve self-reported life satisfaction and well-being; reduce risk factors and enhancement of protective factors; diversion from crisis services or decreased need for crisis services; decreased suicide risk; increased knowledge of available resources and supports; and enhanced connectedness and reduced isolation. Each program is specifically tailored to meet the needs of their respective communities. The communities served and community-based agencies are listed below:

- Afghan Community – Administered by Refugee Enrichment and Development Association (REDA)
- African American Community – Administered by A Church for All: The Living Room
- American Indian/Alaskan Native Community – Administered by Sacramento Native American Health Center (SNAHC)
- Arabic-Speaking Community – Administered by REDA
- Consumer-Operated Warmline – Administered by Cal Voices
- Farsi-Speaking Community – Administered by REDA
- Hmong, Vietnamese, Cantonese-Speaking Communities – Administered by Asian Pacific Community Counseling (APCC)
- Latino/Spanish-Speaking Community – Administered by La Familia Counseling Center (LFCC)
- Iu-Mien Community – Administered by Iu-Mien Community Services (IMCS)
- Older Adult – Administered by LFCC
- Slavic/Russian-Speaking Community – Administered by Slavic Assistance Center
- Ukrainian Support Line – Administered by Slavic Assistance Center
- Youth/Transition Age Youth (TAY) – Administered by Children's Receiving Home

Number Served: In FY 2023-2024, SCC agencies served a total of 7,593 individuals (duplicated count).

SCC Demographics:

Characteristic	Afghan (N=207)		African American (N=246)		Arabic-Speaking (N=173)		Cantonese, Vietnamese, & Hmong-Speaking (N=350)		Consumer Operated Warmline (N=277)		Farsi-Speaking (N=74)		Iu-Mien (N=355)		Native American (N=271)		Older Adults (N=155)		Russian-Speaking/Slavic (N=286)		Spanish-Speaking/ Latino (N=648)		Ukrainian Support Line (N=4275)		Youth/TAY (N=276)		Total (N=7593)	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Age Group																												
Children/Youth (0-15)	12	5.8%	27	11.0%	5	2.9%	0	0.0%	0	0.0%	4	5.4%	79	22.3%	44	16.2%	0	0.0%	0	0.0%	0	0.0%	5	0.1%	23	8.3%	199	2.6%
TAY (16-25)	38	18.4%	46	18.7%	23	13.3%	8	2.3%	16	5.8%	15	20.3%	14	3.9%	47	17.3%	0	0.0%	29	10.1%	27	4.2%	1071	25.1%	252	91.3%	1,586	20.9%
Adults (26-59)	153	73.9%	117	47.6%	123	71.1%	183	52.3%	237	85.6%	52	70.3%	65	18.3%	135	49.8%	50	32.3%	166	58.0%	463	71.5%	2794	65.4%	1	0.4%	4,539	59.8%
Older Adults (60+)	4	1.9%	56	22.8%	21	12.1%	159	45.4%	24	8.7%	3	4.1%	197	55.5%	42	15.5%	103	66.5%	91	31.8%	155	23.9%	405	9.5%	0	0.0%	1,260	16.6%
Unknown/Not Reported	0	0.0%	0	0.0%	1	0.6%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	3	1.1%	2	1.3%	0	0.0%	3	0.5%	0	0.0%	0	0.0%	9	0.1%
Ethnicity																												
Hispanic/Latino	1	0.5%	9	3.7%	0	0.0%	1	0.3%	40	14.4%	0	0.0%	11	3.1%	88	32.5%	145	93.5%	1	0.3%	635	98.0%	0	0.0%	102	37.0%	1,033	13.6%
Non-Hispanic/Non-Latino	206	99.5%	237	96.3%	173	100.0%	348	99.4%	237	85.6%	74	100.0%	343	96.6%	182	67.2%	9	5.8%	285	99.7%	12	1.9%	4275	100.0%	174	63.0%	6,555	86.3%
More than one ethnicity	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Unknown/Not Reported	0	0.0%	0	0.0%	0	0.0%	1	0.3%	0	0.0%	0	0.0%	1	0.3%	1	0.4%	1	0.6%	0	0.0%	1	0.2%	0	0.0%	0	0.0%	5	0.1%
Race																												
American Indian/Alaska Native	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.4%	0	0.0%	0	0.0%	130	48.0%	2	1.3%	0	0.0%	2	0.3%	0	0.0%	2	0.7%	137	4.1%
Asian	0	0.0%	3	1.2%	1	0.6%	337	96.3%	11	4.0%	0	0.0%	307	86.5%	13	4.8%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	9	3.3%	681	20.5%
Black/African American	0	0.0%	222	90.2%	0	0.0%	0	0.0%	18	6.5%	0	0.0%	6	1.7%	12	4.4%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	98	35.5%	356	10.7%
More than one race	3	1.4%	4	1.6%	8	4.6%	9	2.6%	7	2.5%	9	12.2%	31	8.7%	74	27.3%	0	0.0%	117	40.9%	0	0.0%	0	0.0%	50	18.1%	312	9.4%
Native Hawaiian/Other Pacific Islander	0	0.0%	1	0.4%	0	0.0%	0	0.0%	1	0.4%	0	0.0%	2	0.6%	1	0.4%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2	0.7%	7	0.2%
Other	204	98.6%	5	2.0%	119	68.8%	0	0.0%	28	10.1%	65	87.8%	8	2.3%	23	8.5%	142	91.6%	166	58.0%	637	98.3%	0	0.0%	51	18.5%	1,448	43.6%
Unknown/Not Reported	0	0.0%	8	3.3%	44	25.4%	2	0.6%	152	54.9%	0	0.0%	1	0.3%	5	1.8%	5	3.2%	0	0.0%	4	0.6%	0	0.0%	2	0.7%	223	6.7%
White/Caucasian	0	0.0%	3	1.2%	1	0.6%	2	0.6%	59	21.3%	0	0.0%	0	0.0%	13	4.8%	6	3.9%	3	1.0%	5	0.8%	4275	100.0%	62	22.5%	4,429	4.6%
Primary Language																												
English	0	0.0%	244	99.2%	0	0.0%	2	0.6%	271	97.8%	0	0.0%	124	34.9%	256	94.5%	10	6.5%	0	0.0%	14	2.2%	0	0.0%	276	100.0%	1,197	15.8%
Spanish	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2	0.7%	0	0.0%	0	0.0%	3	1.1%	143	92.3%	0	0.0%	631	97.4%	0	0.0%	0	0.0%	779	10.3%
Vietnamese	0	0.0%	1	0.4%	1	0.6%	168	48.0%	0	0.0%	0	0.0%	3	0.8%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	173	2.3%
Cantonese	0	0.0%	0	0.0%	0	0.0%	25	7.1%	0	0.0%	0	0.0%	0	0.0%	1	0.4%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	26	0.3%
Russian	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	286	100.0%	0	0.0%	0	0.0%	0	0.0%	286	3.8%
Hmong	0	0.0%	0	0.0%	0	0.0%	154	44.0%	0	0.0%	0	0.0%	3	0.8%	1	0.4%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	158	2.1%
Arabic	1	0.5%	0	0.0%	165	95.4%	0	0.0%	1	0.4%	0	0.0%	0	0.0%	2	0.7%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	169	2.2%
Other	206	99.5%	1	0.4%	5	2.9%	1	0.3%	0	0.0%	74	100.0%	223	62.8%	1	0.4%	0	0.0%	0	0.0%	1	0.2%	0	0.0%	0	0.0%	512	6.7%
Unknown/Not Reported	0	0.0%	0	0.0%	2	1.2%	0	0.0%	3	1.1%	0	0.0%	2	0.6%	7	2.6%	2	1.3%	0	0.0%	2	0.3%	4275	100.0%	0	0.0%	4,293	56.5%
Sexual Orientation																												
Heterosexual/Straight	207	100.0%	127	51.6%	134	77.5%	347	99.1%	85	30.7%	74	100.0%	303	85.4%	178	65.7%	146	94.2%	286	100.0%	639	98.6%	0	0.0%	87	31.5%	2,613	34.4%
Gay/Lesbian	0	0.0%	15	6.1%	0	0.0%	0	0.0%	4	1.4%	0	0.0%	0	0.0%	5	1.8%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	12	4.3%	36	0.5%
Bisexual	0	0.0%	3	1.2%	0	0.0%	0	0.0%	3	1.1%	0	0.0%	3	0.8%	6	2.2%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	24	8.7%	39	0.5%
Questioning/Unsure	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.4%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	17	6.2%	18	0.2%
Queer	0	0.0%	2	0.8%	0	0.0%	0	0.0%	1	0.4%	0	0.0%	0	0.0%	4	1.5%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	120	43.5%	127	1.7%
Another sexual orientation	0	0.0%	0	0.0%	9	5.2%	3	0.9%	5	1.8%	0	0.0%	4	1.1%	21	7.7%	0	0.0%	0	0.0%	2	0.3%	0	0.0%	8	2.9%	52	0.7%
Unknown/Not Reported	0	0.0%	99	40.2%	30	17.3%	0	0.0%	179	64.6%	0	0.0%	45	12.7%	56	20.7%	9	5.8%	0	0.0%	7	1.1%	4275	100.0%	8	2.9%	4,708	62.0%
Gender Identity																												
Female	65	31.4%	150	61.0%	85	49.1%	178	50.9%	127	45.8%	34	45.9%	239	67.3%	180	66.4%	117	75.5%	147	51.4%	496	76.5%	2412	56.4%	99	35.9%	4,329	57.0%
Male	142	68.6%	64	26.0%	88	50.9%	172	49.1%	52	18.8%	40	54.1%	111	31.3%	67	24.7%	36	23.2%	139	48.6%	149	23.0%	1861	43.5%	119	43.1%	3,040	40.0%
Transgender	0	0.0%	2	0.8%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	4	1.5%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	25	9.1%	31	0.4%
Genderqueer	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2	0.7%	2	0.0%
Questioning/Unsure	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2	0.7%	2	0.0%
Another gender identity	0	0.0%	2	0.8%	0	0.0%	0	0.0%	2	0.7%	0	0.0%	0	0.0%	7	2.6%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	27	9.8%	38	0.5%
Unknown/Not Reported	0	0.0%	28	11.4%	0	0.0%	0	0.0%	96	34.7%	0	0.0%	5	1.4%	13	4.8%	2	1.3%	0	0.0%	3	0.5%	2	0.0%	2	0.7%	151	2.0%
Veteran Status																												
Yes	0	0.0%	2	0.8%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	6	2.2%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	8	0.1%
No	207	100.0%	244	99.2%	173	100.0%	350	100.0%	277	100.0%	74	100.0%	355	100.0%	265	97.8%	155	100.0%	286	100.0%	648	100.0%	0	0.0%	276	100.0%	3,310	43.6%
Unknown/Not Reported	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	4275	100.0%	0	0.0%	4,275	56.3%

SCC Outreach: The SCC programs are required to provide outreach to the underserved communities for which they served. The agencies attend many community events throughout the year to educate their communities around suicide and mental illness.

Number Served - Outreach: In FY 2023-2024, the SCC programs attended 598 community events and had direct contact with 32,281 individuals.

Demographics: Due to the nature of the outreach events, demographics were not collected.

SCC - Information and Referral: The SCC programs provide information and referrals to individuals in the community. These individuals may or may not receive ongoing services through the SCC program.

Number Served: In FY 2023-2024, the SCC programs disseminated information and made referrals to 10,931 individuals. Note: due to the nature of the data collection, this is not an unduplicated count.

SCC Programs	N	%
Afghan	70	0.6%
African American	24	0.2%
Arabic-Speaking	1,559	14.3%
Cantonese/Vietnamese/Hmong-Speaking	57	0.5%
Consumer Operated Warmline	4,057	37.1%
Farsi-Speaking	2	0.0%
Native American	4	0.0%
Older Adults	103	0.9%
Russian-Speaking/Slavic	94	0.9%
Spanish-Speaking/Latino	4,961	45.4%
Total	**10,931**	**100.0%**

SCC – Satisfaction Survey Results:

Satisfaction Survey Item	Afghan	African American	Arabic-Speaking	Cantonese, Vietnames, & Hmong-Speaking	Consumer Operated Warmline	Farsi-Speaking	Iu-Mien	Native American	Older Adults	Russian-Speaking/ Slavic	Spanish-Speaking/ Latino	Youth/TAY
	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)
The services I received or group(s) I attended helped me in these areas:												
Finding services and supports	82.8%	100.0%	100.0%	100.0%	100.0%	87.0%	99.8%	95.8%	100.0%	98.9%	99.7%	100.0%
Feeling less lonely	43.5%	98.5%	91.5%	100.0%	99.2%	69.6%	99.0%	93.7%	97.8%	100.0%	99.3%	95.2%
Managing my daily life stressors	73.3%	100.0%	95.8%	100.0%	100.0%	83.3%	98.1%	92.3%	99.6%	98.9%	99.8%	100.0%
Keeping myself safe	96.4%	100.0%	90.5%	100.0%	100.0%	91.3%	98.0%	92.5%	99.6%	100.0%	99.8%	100.0%
Managing a crisis	73.1%	99.2%	98.0%	100.0%	100.0%	73.9%	95.4%	89.7%	99.1%	98.9%	99.5%	100.0%
I'll use these skills to help with:												
Finding services and supports	89.3%	100.0%	100.0%	100.0%	100.0%	88.0%	99.3%	97.0%	99.6%	98.9%	99.8%	96.0%
Feeling less lonely	70.8%	99.2%	94.4%	100.0%	100.0%	82.6%	99.5%	94.6%	98.7%	100.0%	99.7%	95.2%
Managing my daily life stressors	85.7%	99.3%	98.1%	100.0%	100.0%	87.5%	98.2%	94.9%	99.6%	98.9%	99.7%	95.5%
Keeping myself safe	82.1%	99.2%	92.1%	100.0%	100.0%	91.7%	98.4%	94.5%	99.1%	100.0%	99.7%	100.0%
Managing a crisis	82.1%	97.7%	98.0%	100.0%	100.0%	78.3%	96.0%	93.7%	98.7%	98.9%	99.3%	100.0%

Note 1: The denominator varies for each question, as not all questions were applicable to every participant who submitted a survey.
Note 2: Satisfaction Survey results were unavailable at time of Annual Update posting for Ukrainian Support Line program.

Satisfaction Survey Item	Afghan (N=31)	African American (N=135)	Arabic-Speaking (N=65)	Cantonese, Vietnamese, & Hmong-Speaking (N=129)	Consumer Operated Warmline (N=134)	Farsi-Speaking (N=26)	Iu-Mien (N=645)	Native American (N=675)	Older Adults (N=236)	Russian-Speaking/ Slavic (N=95)	Spanish-Speaking/ Latino (N=597)	Youth/TAY (N=27)
	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)
I am more aware of community services and supports that can help me or others in my family as a result of the services I received or group I attended.												
Strongly Agree/Agree	90.3%	97.8%	92.3%	100.0%	97.0%	96.2%	96.9%	91.1%	98.7%	98.9%	99.0%	88.9%
Undecided	3.2%	0.7%	1.5%	0.0%	0.7%	0.0%	1.2%	1.6%	0.8%	1.1%	0.3%	11.1%
Disagree/Strongly Disagree	0.0%	0.7%	0.0%	0.0%	0.0%	3.8%	0.0%	0.3%	0.4%	0.0%	0.3%	0.0%
Not Applicable	0.0%	0.0%	4.6%	0.0%	1.5%	0.0%	1.7%	7.0%	0.0%	0.0%	0.3%	0.0%
Unknown/Not Reported	6.5%	0.7%	1.5%	0.0%	0.7%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%
I learned skills from the services I received or groups that I attended that I use each day or share with others.												
Strongly Agree/Agree	93.5%	96.3%	92.3%	100.0%	97.8%	92.3%	83.6%	88.6%	98.3%	97.9%	99.2%	96.3%
Undecided	0.0%	0.0%	0.0%	0.0%	0.0%	3.8%	11.0%	3.7%	1.3%	1.1%	0.5%	3.7%
Disagree/Strongly Disagree	0.0%	0.0%	1.5%	0.0%	0.0%	3.8%	0.0%	0.3%	0.4%	0.0%	0.0%	0.0%
Not Applicable	0.0%	1.5%	4.6%	0.0%	1.5%	0.0%	5.3%	7.3%	0.0%	1.1%	0.3%	0.0%
Unknown/Not Reported	6.5%	2.2%	1.5%	0.0%	0.7%	0.0%	0.2%	0.1%	0.0%	0.0%	0.0%	0.0%
I would come back again if I needed help for myself or others in my family.												
Strongly Agree/Agree	90.3%	98.5%	90.8%	100.0%	99.3%	84.6%	94.9%	89.5%	99.2%	97.9%	99.3%	96.3%
Undecided	0.0%	0.0%	0.0%	0.0%	0.0%	11.5%	2.9%	2.2%	0.4%	2.1%	0.2%	3.7%
Disagree/Strongly Disagree	3.2%	0.0%	0.0%	0.0%	0.0%	3.8%	0.2%	0.4%	0.4%	0.0%	0.2%	0.0%
Not Applicable	0.0%	0.0%	7.7%	0.0%	0.0%	0.0%	1.9%	7.6%	0.0%	0.0%	0.3%	0.0%
Unknown/Not Reported	6.5%	1.5%	1.5%	0.0%	0.7%	0.0%	0.2%	0.3%	0.0%	0.0%	0.0%	0.0%
As a result of he services I received or groups I attended, I know how to get help if I knew someone who is considering suicide, harming themselves or if I felt suicidal or like harming myself.												
Strongly Agree/Agree	87.1%	97.8%	86.2%	100.0%	94.0%	92.3%	56.0%	85.3%	97.9%	98.9%	98.8%	92.6%
Undecided	3.2%	0.7%	0.0%	0.0%	1.5%	3.8%	12.7%	2.4%	0.4%	0.0%	0.2%	3.7%
Disagree/Strongly Disagree	3.2%	0.0%	0.0%	0.0%	0.7%	3.8%	0.0%	0.7%	1.3%	1.1%	0.5%	0.0%
Not Applicable	0.0%	0.0%	12.3%	0.0%	3.0%	0.0%	31.0%	11.3%	0.4%	0.0%	0.3%	0.0%
Unknown/Not Reported	6.5%	1.5%	1.5%	0.0%	0.7%	0.0%	0.3%	0.3%	0.0%	0.0%	0.2%	3.7%
I felt the services I received reflected my cultural beliefs, preferences, and values which made me feel respected.												
Strongly Agree/Agree	90.3%	97.8%	86.2%	100.0%	98.5%	92.3%	95.2%	88.9%	97.5%	98.9%	99.0%	92.6%
Undecided	3.2%	0.0%	3.1%	0.0%	0.0%	3.8%	2.0%	2.8%	0.8%	1.1%	0.2%	7.4%
Disagree/Strongly Disagree	0.0%	0.7%	0.0%	0.0%	0.0%	3.8%	0.2%	0.3%	1.3%	0.0%	0.3%	0.0%
Not Applicable	0.0%	0.0%	9.2%	0.0%	0.7%	0.0%	2.0%	7.7%	0.4%	0.0%	0.3%	0.0%
Unknown/Not Reported	6.5%	1.5%	1.5%	0.0%	0.7%	0.0%	0.6%	0.3%	0.0%	0.0%	0.2%	0.0%

Community Support Team (CST)

Program Type: PEI Access and Linkage to Treatment

Program Description: The CST provides culturally responsive triage, crisis intervention, linkages to community supports, outreach and education regarding suicide prevention to support Sacramento County children, youth, transition age youth (TAY), adults, and older adults experiencing mental health challenges. The CST program staffing consists of BHS Clinicians and Mental Health Counselors and Cal Voices Peer and Family Specialists who respond to individuals struggling to link to mental health services.

The CST engages and builds bridges between family members, individuals, natural supports systems, and community resources or services. The CST provides education, resources, and connections to services for individuals and their caregivers, loved ones and other natural supports. The goal of CST is to provide culturally and linguistically responsive services while promoting recovery, resiliency and well-being resulting in decreased use of crisis services and/or acute care hospitalization services; decreased risk for suicide; increased knowledge of available resources and supports; and increased personal connection and active involvement within the community.

Number Served: In FY 2023-2024, the CST BHS Clinicians and Mental Health Counselors served a total of 922 individuals. Note: all individuals are served by BHS Clinicians and Mental Health Counselors, but not all are served by CST Cal Voices Peer and Family Specialists. The numbers below are duplicated across components, if a client was served in by both BHS and Cal Voices team members.

CST Demographics:

Characteristic	N=922	%
Age Group		
Children/Youth (0-15)	66	7.16%
TAY (16-25)	164	17.79%
Adults (26-59)	423	45.88%
Older Adults (60+)	269	29.18%
Unknown/Not Reported	0	0.0%
Ethnicity		
Hispanic or Latino	92	10.0%
Non-Hispanic/Non-Latino	311	33.7%
Other	0	0.0%
More than one ethnicity	0	0.0%
Unknown/Not Reported	519	56.3%
Race		
White	208	22.6%
Black or African American	100	10.8%
Asian	43	4.7%
American Indian or Alaska Native	4	0.4%
Native Hawaiian or other Pacific Islander	8	0.9%
More than one race	87	9.4%
Other	40	4.3%
Unknown/Not Reported	432	46.85%

Primary Language		
English	571	61.9%
Spanish	14	1.5%
Vietnamese	4	0.4%
Cantonese	0	0.0%
Russian	0	0.0%
Hmong	2	0.2%
Arabic	0	0.0%
Farsi	1	0.1%
Other	16	1.7%
Unknown/Not Reported	314	34.1%
Sexual Orientation		
Heterosexual or Straight	201	21.8%
Gay or Lesbian	8	0.9%
Bisexual	10	1.1%
Questioning or unsure	7	0.8%
Queer	0	0.0%
Another sexual orientation	0	0.0%
Unknown/Not Reported	696	75.5%
Current Gender Identity		
Female	216	23.4%
Male	175	19.0%
Transgender	1	0.1%
Genderqueer	1	0.1%
Questioning or unsure	1	0.1%
Another gender identity	4	0.4%
Unknown/Not Reported	524	56.8%
Veteran Status		
Yes	0	0.0%
No	128	13.9%
Unknown/Not Reported	794	86.1%

Crisis Navigation Program (CNP)

Program Type: PEI Access and Linkage to Treatment

Program Description: Administered by BACS, provides brief community-based navigation services for individuals recently involved in crisis services as a result of their mental illness. Navigators provide 24 hours / 7 days a week care coordination, advocacy, peer engagement, system navigation, and linkage to services for individuals living with serious mental illness who are homeless, at-risk of homelessness, and/or may have a co-occurring substance use disorder. The Crisis Navigation Program (CNP) serves children, youth, TAY, adults, and older adults with the goal of reducing unnecessary hospitalizations and incarcerations, as well as mitigating unnecessary expenditures of law enforcement. The CNP program focuses primarily on the needs of those coming into contact with the hospital system and inpatient psychiatric hospitals.

Number Served: In FY 2023-2024, the CNP served a total of 870 unduplicated individuals.

CNP Demographics:

Characteristic	N=870	%
Age Group		
Children/Youth (0-15)	15	1.7%
TAY (16-25)	115	13.2%
Adults (26-59)	624	71.7%
Older Adults (60+)	115	13.2%
Unknown/Not Reported	1	0.1%
Ethnicity		
Hispanic or Latino	136	15.6%
Non-Hispanic/Non-Latino	454	52.2%
Other	0	0.0%
More than one ethnicity	0	0.0%
Unknown/Not Reported	280	32.2%
Race		
White	274	31.5%
Black or African American	164	18.9%
Asian	34	3.9%
American Indian or Alaska Native	18	2.1%
Native Hawaiian or Other Pacific Islander	8	0.9%
More than one race	62	7.1%
Other	78	9.0%
Unknown/Not Reported	232	26.7%

Primary Language		
English	715	82.2%
Spanish	25	2.9%
Vietnamese	0	0.0%
Cantonese	1	0.1%
Russian	1	0.1%
Hmong	0	0.0%
Arabic	0	0.0%
Farsi	2	0.2%
Other	8	0.9%
Unknown/Not Reported	118	13.6%
Sexual Orientation		
Heterosexual or Straight	396	45.5%
Gay or Lesbian	18	2.1%
Bisexual	26	3.0%
Questioning or unsure	2	0.2%
Queer	0	0.0%
Another sexual orientation	3	0.3%
Unknown/Not Reported	425	48.9%
Current Gender Identity		
Female	300	34.5%
Male	307	35.3%
Transgender	9	1.0%
Genderqueer	1	0.1%
Questioning or unsure	0	0.0%
Another gender identity	7	0.8%
Unknown/Not Reported	246	28.3%
Veteran Status		
Yes	0	0.0%
No	0	0.0%
Unknown/Not Reported	870	100.0%

CNP – Satisfaction Survey Results:

Survey Item	N = 420	%
As a result of the services I receive from the program, I am more aware of community services and supports that are available and how they can help me or others in my family.		
Strongly Agree	243	57.9%
Agree	156	37.1%
Undecided	19	4.5%
Disagree	0	0.0%
Strongly Disagree	0	0.0%
Missing	2	0.5%
As a result of the services I receive from the program, I know how to access Mental Health support for myself or others in my family.		
Strongly Agree	230	54.8%
Agree	168	40.0%
Undecided	22	5.2%
Disagree	0	0.0%
Strongly Disagree	0	0.0%
Missing	0	0.0%
As a result of the services I receive from the program, I know how to keep myself and/or others safe in times of crisis.		
Strongly Agree	213	50.7%
Agree	173	41.2%
Undecided	32	7.6%
Disagree	1	0.2%
Strongly Disagree	0	0.0%
Missing	1	0.2%
As a result of the services I receive from the program, I feel more empowered and hopeful.		
Strongly Agree	217	51.7%
Agree	163	38.8%
Undecided	32	7.6%
Disagree	3	0.7%
Strongly Disagree	0	0.0%
Missing	5	1.2%
I feel the program staff that I work with listen to me.		
Strongly Agree	286	68.1%
Agree	123	29.3%
Undecided	8	1.9%
Disagree	1	0.2%
Strongly Disagree	0	0.0%
Missing	2	0.5%
I feel the services I receive from the program reflect my cultural beliefs, preferences and values.		
Strongly Agree	225	53.6%
Agree	138	32.9%
Undecided	53	12.6%
Disagree	4	1.0%
Strongly Disagree	0	0.0%
Missing	0	0.0%

Mobile Crisis Support Teams (MCSTs)

Program Type: PEI Access and Linkage to Treatment

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

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

Number Served: In FY 23/24, the MCST served a total of 859 unduplicated individuals in the community.

MCST Demographics:

Characteristic	N=859	%
Age Group		
Children/Youth (0-15)	70	8.1%
TAY (16-25)	141	16.4%
Adults (26-59)	418	48.7%
Older Adults (60+)	160	18.6%
Unknown/Not Reported	70	8.1%
Ethnicity		
Hispanic or Latino	113	13.2%
Non-Hispanic/Non-Latino	353	41.1%
Other	0	0.0%
More than one ethnicity	0	0.0%
Unknown/Not Reported	393	45.8%

Race		
White	347	40.4%
Black or African American	124	14.4%
Asian	14	1.6%
American Indian or Alaska Native	8	0.9%
Native Hawaiian or Other Pacific Islander	17	2.0%
More than one race	23	2.7%
Other	70	8.1%
Unknown/Not Reported	256	29.8%
Primary Language		
English	618	71.9%
Spanish	9	1.0%
Vietnamese	0	0.0%
Cantonese	0	0.0%
Russian	4	0.5%
Hmong	0	0.0%
Arabic	0	0.0%
Farsi	1	0.1%
Other	5	0.6%
Unknown/Not Reported	222	25.8%
Sexual Orientation		
Heterosexual or Straight	286	33.3%
Gay or Lesbian	10	1.2%
Bisexual	13	1.5%
Questioning or unsure	6	0.7%
Queer	0	0.0%
Another sexual orientation	0	0.0%
Unknown/Not Reported	544	63.3%
Current Gender Identity		
Female	219	25.5%
Male	223	26.0%
Transgender	8	0.9%
Genderqueer	1	0.1%
Questioning or unsure	2	0.2%
Another gender identity	3	0.3%
Unknown/Not Reported	403	46.9%
Veteran Status		
Yes	18	2.1%
No	350	40.7%
Unknown/Not Reported	491	57.2%

MCST Satisfaction Survey Results:

MCST (CIT Unit) Satisfaction Survey Item	N=42	%
As a result of Mobile Crisis Support Team (CIT Unit), I am more aware of community services and supports that are available, and how they can be accessed.		
Strongly Agree	20	47.6%
Agree	12	28.6%
Undecided	1	2.4%
Disagree	5	11.9%
Strongly Disagree	3	7.1%
Not Applicable/Declined to Answer	1	2.4%
As a result of Mobile Crisis Support Team response, I have reengaged with my treatment providers or supports.		
Strongly Agree	18	42.9%
Agree	7	16.7%
Undecided	4	9.5%
Disagree	1	2.4%
Strongly Disagree	4	9.5%
Not Applicable/Declined to Answer	8	19.0%
The MCST/CIT unit listened and responded to my needs.		
Strongly Agree	26	61.9%
Agree	10	23.8%
Undecided	2	4.8%
Disagree	0	0.0%
Strongly Disagree	3	7.1%
Not Applicable/Declined to Answer	1	2.4%
As a result of the services the MCST/CIT Unit provided, I feel more empowered and hopeful.		
Strongly Agree	15	35.7%
Agree	14	33.3%
Undecided	3	7.1%
Disagree	3	7.1%
Strongly Disagree	4	9.5%
Not Applicable/Declined to Answer	3	7.1%
I felt the program staff were respectful and helpful.		
Strongly Agree	27	64.3%
Agree	10	23.8%
Undecided	0	0.0%
Disagree	1	2.4%
Strongly Disagree	4	9.5%
Not Applicable/Declined to Answer	0	0.0%
As a result of the Mobile Crisis Support Team, I was linked to resources that were a support to me.		
Strongly Agree	20	47.6%
Agree	10	23.8%
Undecided	2	4.8%
Disagree	2	4.8%
Strongly Disagree	5	11.9%
Not Applicable/Declined to Answer	3	7.1%

MCST (CIT Unit) Satisfaction Survey Item	N=42	%
Please mark whom you had contact with on the CIT Unit:		
MCST Counselor/Officer Team	20	47.6%
MCST Counselor	5	11.9%
MCST Officer/Deputy	9	21.4%
MCST Peer Navigator	3	7.1%
Don't know or remember	0	0.0%
Not answered	11	26.2%
Type of contact with the MCST Unit:		
Provided support to me when I was in crisis	24	57.1%
Responded to a call for my family member	15	35.7%
Clinician or Officer/Deputy called me to check in on how I was doing after a crisis situation	10	23.8%
Clinician called after an incident with Law Enforcement	5	11.9%

Note: Percentages equal greater than 100%, as clients are able to select more than one answer when applicable.

MCST (CIT Unit) Client Satisfaction Survey Question	N=844	%
Survey Completion Outcome		
Completed	42	5.0%
Declined or Didn't Return Survey	437	51.8%
Declined MCST Services	0	0.0%
No Contact	100	11.8%
Whereabouts Unknown	265	31.4%

Note: Whereabouts Unknown includes clients who could not be reached due to no address in Avatar

Mental Health Respite Programs

Program Type: PEI Improving Timely Access to Services for Underserved Populations

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

- **Caregiver Crisis Intervention Respite Program:** Administered by Del Oro Caregiver Resource Center, helps decrease hospitalizations due to mental health crises of family caregivers of dementia patients. The program provides respite care, family consultation, home visits and an assessment with a master's level clinician to develop a care plan focused on services, supports and wellness. The program serves adult caregivers of all age groups with the majority of caregivers being in the 60+ age range.
- **Rejuvenation Haven:** Administered by Wind Youth Services, provides mental health respite care to youth/TAY ages 13-25 years old experiencing overwhelming stress due to life circumstance and homelessness. Services may be accessed via drop-in center or with a pre-planned visit and include screening, planning, crisis intervention, life skills workshops, health screenings, groups, crisis counseling, and case management.
- **The Ripple Effect:** Administered by A Church for All, provides respite services to unserved and underserved adults ages 18 and older, with emphasis on people of color (POC) and lesbian, gay, bisexual, transgender, and/or questioning (LGBTQ) at risk of or experiencing a mental health crisis. Services include screening, supportive services, individual and group support, linkage to other services, peer supports, other crisis response services, and community outreach activities. The Ripple Effect promotes community connection and other supportive resources, so participants leave experiencing less stress than when they arrived. Participants may return to utilize respite services as needed.
- **Q Spot Youth/Transition Age Youth (TAY) Respite Program**: Administered by Sacramento LGBT Community Center, provides drop-in mental health respite care and supportive services to unserved and underserved youth/TAY ages thirteen (13) through twenty-three (23) who identify as LGBTQ. In addition, support groups are provided with a range of topics, including but not limited to: anti-bullying, coming out, healthy relationships, and life skills development. Q-Spot program offers LGBTQ+ youth community with peers and staff with the same lived experience, which is critical to improving their mental health.
- **Lambda Lounge Adult Mental Health Respite Program:** Administered by Sacramento LGBT Community Center, provides drop-in mental health respite care designed to prevent an acute mental health crisis from occurring, as well as suicide prevention support services to unserved and underserved adults and older adults who identify as LGBTQ. The program offers a variety of support groups focused on mitigating risk factors, building healthy relationships, health, and wellness, etc.

Number Served: In FY 2023-2024, the respite programs served a total of 1,971 individuals in the community.

Respite Programs Demographics:

Characteristic	Caregiver Crisis Intervention Respite		Rejuvenation Haven		The Ripple Effect		Lambda Lounge		Q-Spot		Total	
	N=83	%	N=846	%	N=246	%	N=245	%	N=551	%	N=1,971	%
Age Group												
Children/Youth (0-15)	0	0.0%	6	0.7%	10	4.1%	9	3.7%	54	9.8%	79	4.0%
TAY (16-25)	1	1.2%	125	14.8%	16	6.5%	8	3.3%	333	60.4%	483	24.5%
Adults (26-59)	22	26.5%	0	0.0%	149	60.6%	110	44.9%	4	0.7%	285	14.5%
Older Adults (60+)	60	72.3%	0	0.0%	32	13.0%	18	7.3%	1	0.2%	111	5.6%
Unknown/Not Reported	0	0.0%	715	84.5%	39	15.9%	100	40.8%	159	28.9%	1,013	51.4%
Ethnicity												
Hispanic or Latino	15	18.1%	21	2.5%	19	7.7%	26	10.6%	48	8.7%	129	6.5%
Non-Hispanic/Non-Latino	68	81.9%	105	12.4%	187	76.0%	119	48.6%	344	62.4%	823	41.8%
Unknown/Not Reported	0	0.0%	720	85.1%	40	16.3%	100	40.8%	159	28.9%	1,019	51.7%
Race*												
American Indian or Alaska Native	2	2.4%	2	0.2%	11	4.5%	4	1.6%	8	1.5%	27	1.4%
Asian	10	12.0%	1	0.1%	3	1.2%	3	1.2%	5	0.9%	22	1.1%
Asian Indian	0	0.0%	0	0.0%	0	0.0%	2	0.8%	3	0.5%	5	0.3%
Black or African American	8	9.6%	37	4.4%	57	23.2%	21	8.6%	39	7.1%	162	8.2%
Mexican	0	0.0%	1	0.1%	11	4.5%	3	1.2%	4	0.7%	19	1.0%
Native Hawaiian/Pacific Islander	0	0.0%	0	0.0%	6	2.4%	4	1.6%	8	1.5%	18	0.9%
White	50	60.2%	28	3.3%	107	43.5%	22	9.0%	89	16.2%	296	15.0%
Other	13	15.7%	43	5.1%	37	15.0%	40	16.3%	64	11.6%	197	10.0%
Unknown/Not Reported	0	0.0%	745	88.1%	40	16.3%	146	59.6%	331	60.1%	1,262	64.0%
Primary Language												
English	83	100.0%	82	9.7%	121	49.2%	75	30.6%	107	19.4%	468	23.7%
Non-English	0	0.0%	0	0.0%	5	2.0%	2	0.8%	3	0.5%	10	0.5%
Unknown/Not Reported	0	0.0%	764	90.3%	120	48.8%	168	68.6%	441	80.0%	1,493	75.7%
Sexual Orientation												
Gay or Lesbian	2	2.4%	7	0.8%	4	1.6%	18	7.3%	41	7.4%	72	3.7%
Heterosexual or Straight	80	96.4%	42	5.0%	190	77.2%	22	9.0%	22	4.0%	356	18.1%
Bisexual	1	1.2%	20	2.4%	4	1.6%	12	4.9%	48	8.7%	85	4.3%
Questioning or unsure	0	0.0%	1	0.1%	0	0.0%	5	2.0%	6	1.1%	12	0.6%
Queer	0	0.0%	0	0.0%	0	0.0%	1	0.4%	7	1.3%	8	0.4%
Another sexual orientation	0	0.0%	18	2.1%	0	0.0%	9	3.7%	46	8.3%	73	3.7%
Unknown/Not Reported	0	0.0%	758	89.6%	48	19.5%	178	72.7%	381	69.1%	1,365	69.3%

Current Gender Identity												
Male	17	20.5%	28	3.3%	104	42.3%	32	13.1%	33	6.0%	214	10.9%
Female	66	79.5%	30	3.5%	100	40.7%	9	3.7%	18	3.3%	223	11.3%
Transgender	0	0.0%	3	0.4%	0	0.0%	8	3.3%	33	6.0%	44	2.2%
Genderqueer	0	0.0%	1	0.1%	0	0.0%	1	0.4%	7	1.3%	9	0.5%
Questioning or unsure	0	0.0%	0	0.0%	0	0.0%	3	1.2%	2	0.4%	5	0.3%
Another gender identity	0	0.0%	24	2.8%	0	0.0%	14	5.7%	78	14.2%	116	5.9%
Unknown/Not Reported	0	0.0%	760	89.8%	42	17.1%	178	72.7%	380	69.0%	1,360	69.0%
Veteran Status												
Yes	6	7.2%	0	0.0%	4	1.6%	3	1.2%	1	0.2%	14	0.7%
No	77	92.8%	131	15.5%	203	82.5%	142	58.0%	391	71.0%	944	47.9%
Decline to answer	0	0.0%	715	84.5%	39	15.9%	100	40.8%	159	28.9%	1,013	51.4%

Note: numbers are unduplicated by program, but not in total. Some individuals could have been seen by multiple programs.

Satisfaction Survey Results – Caregiver Crisis Intervention:

Caregiver Crisis Intervention Satisfaction Survey Item	N=170	%
The services I received or group(s) I attended helped me in these areas:		
Finding services and supports	160	100.0%
Feeling less lonely	155	96.7%
Manage my daily life stressors	110	99.0%
Keeping myself safe	110	99.0%
Managing a crisis	130	99.0%
I'll use these skills to help with…		
Finding services and supports	154	100.0%
Feeling less lonely	143	98.6%
Manage my daily life stressors	159	100.0%
Keeping myself safe	112	99.1%
Managing a crisis	142	99.2%
I am more aware of community services and supports that can help me or others in my family as a result of the services I received or group I attended.		
Strongly Agree/Agree	160	94.1%
Undecided	5	2.9%
Disagree/Strongly Disagree	0	0.0%
Not Applicable	5	2.9%
I learned skills from the services I received or groups that I attended that I use each day or share with others.		
Strongly Agree/Agree	129	75.8%
Undecided	9	5.2%
Disagree/Strongly Disagree	1	0.5%
Not Applicable	31	18.2%
I would come back again if I needed help for myself or others in my family.		
Strongly Agree/Agree	162	95.2%
Undecided	2	1.5%
Disagree/Strongly Disagree	0	0.0%
Not Applicable	6	3.3%
As a result of the services I received or group(s) I attended, I know how to get help if I knew someone who is suicidal or if I felt suicidal.		
Strongly Agree/Agree	128	75.2.%
Undecided	5	2.9%
Disagree/Strongly Disagree	1	0.5%
Not Applicable	36	21.2%
I felt the services I received reflected my cultural beliefs, preferences, and values which made me feel respected.		
Strongly Agree/Agree	158	92.9%
Undecided	6	3.5%
Disagree/Strongly Disagree	0	0.0%
Not Applicable	6	3.5%

Satisfaction Survey Results – Adult Mental Health Respite Programs (The Ripple Effect and Lambda Lounge)**:**

Adult Respite Program Satisfaction Survey Item	The Ripple Effect		Lambda Lounge	
	N=809	%	N=32	%
The services I received or group(s) I attended helped me in these areas				
Finding services and supports	754	96.4%	24	100.0%
Feeling less lonely	700	92.3%	23	92.0%
Manage my daily life stressors	722	95.1%	25	92.6%
Keeping myself safe	718	95.4%	24	100.0%
Managing a crisis	715	94.8%	20	95.2%
****I'll use these skills to help with…***				
Finding services and supports	758	96.4%	26	92.9%
Feeling less lonely	810	99.1%	23	92.0%
Manage my daily life stressors	720	95.2%	23	92.0%
Keeping myself safe	717	95.7%	25	92.6%
Managing a crisis	716	95.9%	23	88.5%
I am more aware of community services and supports that can help me or others in my family as a result of the services I received or group I attended.				
Strongly Agree/Agree	747	93.8%	25	83.3%
Undecided	45	5.7%	3	10.0%
Disagree/Strongly Disagree	4	0.5%	2	6.7%
Unknown	0	0.0%	0	0.0%
I learned skills from the services I received or groups that I attended that I use each day or share with others.				
Strongly Agree/Agree	681	86.3%	22	81.5%
Undecided	103	13.1%	3	11.1%
Disagree/Strongly Disagree	4	0.5%	2	7.4%
Unknown	0	0.0%	0	0.0%
I would come back again if I needed help for myself or others in my family.				
Strongly Agree/Agree	764	95.6%	29	96.7%
Undecided	32	4.0%	1	3.3%
Disagree/Strongly Disagree	4	0.5%	0	0.0%
Unknown	0	0.0%	0	0.0%
As a result of the services I received or group(s) I attended, I know how to get help if I knew someone who is suicidal or if I felt suicidal.				
Strongly Agree/Agree	264	84.6%	18	69.2%
Undecided	117	14.7%	6	23.1%
Disagree/Strongly Disagree	6	0.8%	2	7.7%
Unknown	0	0.0%	0	0.0%

I felt the services I received reflected my cultural beliefs, preferences, and values which made me feel respected.				
Strongly Agree/Agree	762	95.6%	23	76.7%
Undecided	33	4.1%	7	23.3%
Disagree/Strongly Disagree	3	0.4%	0	0.0%
Unknown	0	0.0%	0	0.0%
I would like this program or group to expand in order to provide more access and/or services.				
Strongly Agree/Agree	760	95.5%	27	93.1%
Undecided	31	3.9%	2	6.9%
Disagree/Strongly Disagree	2	0.3%	0	0.0%
Unknown	0	0.0%	0	0.0%

*The denominator varies for each question, as not all questions were applicable to every person who submitted a survey.

Satisfaction Survey Results – Youth Mental Health Respite Programs (Rejuvenation Haven and Q Spot)**:**

Youth Respite Program Satisfaction Survey Item	Rejuvenation Haven		Q Spot	
	N= 45	%	N= 624	%
This visit helped me make connections with others or feel less alone.				
Completely True	24	53.3%	403	64.6%
Mostly True	7	15.6%	107	17.1%
A Little True	5	11.1%	74	11.9%
Not at All	0	0.0%	7	1.1%
Not Applicable	6	13.3%	0	0.0%
Decline to Answer	3	6.7%	33	5.3%
I felt accepted and heard by staff.				
Completely True	25	55.6%	441	70.7%
Mostly True	7	15.6%	90	14.4%
A Little True	5	11.1%	56	9.0%
Not at All	1	2.2%	5	0.8%
Not Applicable	5	11.1%	0	0.0%
Decline to Answer	1	2.2%	32	5.1%
I know where to start if I need resources.				
Completely True	25	55.6%	417	66.8%
Mostly True	8	17.8%	107	17.1%
A Little True	4	8.9%	61	9.8%
Not at All	1	2.2%	8	1.3%
Not Applicable	6	13.3%	0	0.0%
Decline to Answer	1	2.2%	31	5.0%

This helped me improve my emotional/physical wellness in some way.				
Completely True	22	48.9%	392	62.8%
Mostly True	7	15.6%	106	17.0%
A Little True	4	8.9%	75	12.0%
Not at All	2	4.4%	7	1.1%
Not Applicable	8	17.8%	2	0.3%
Decline to Answer	2	4.4%	42	6.7%
If I didn't come to the center today, I probably would have gone to ...				
Emergency Room	1	2.2%	4	0.6%
A Psychiatric Hospital	5	11.1%	15	2.4%
Jail	0	0.0%	16	2.6%
A Shelter	6	13.3%	98	15.7%
Friends or Family	8	17.8%	127	20.4%
Home	5	11.1%	67	10.7%
Outside	17	37.8%	227	36.4%
Other	3	6.7%	45	7.2%
Decline to Answer	0	0.0%	25	4.0%

Mental Health Respite Programs – Outreach

Number Served: In FY 2023-2024, The Ripple Effect attended 79 community events. At these events, they made direct contact with 1,779 individuals. Further, all respite programs made a total of 15,493 individual contacts and 1,327 group contacts.

Demographics: Due to the nature of the outreach events, demographics were not collected.

Program	Individual Direct Contacts		Group Direct Contacts		Events		Estimated # of Event Participants	# of Direct Contacts at Events
	#	%	#	%	#	%	#	#
The Ripple Effect	1,589	10.3%	268	20.2%	79	100.0%	7,614	1,779
Lambda Lounge	1,171	7.6%	2	0.2%	0	0.0%	N/A	N/A
Q Spot	4,038	26.1%	902	68.0%	0	0.0%	N/A	N/A
Rejuvenation Haven	8,695	56.1%	155	11.7%	0	0.0%	N/A	N/A
Total	**15,493**	**100.0%**	**1,327**	**100.0%**	**79**	**100.0%**	**7,614**	**1,779**

Strengthening Families Program

Ages Served: Children, TAY, Adults, Older Adults

The Strengthening Families Program consists of:

- Quality Childcare Collaborative (QCCC)
- CPS Mental Health Team
- Bullying Prevention Education and Training Program
- Youth Mental Health First Aid
- Early Violence Intervention Begins with Education (eVIBE)
- Adoptive Families Respite Program
- The Source
- Safe Zone Squad
- Youth Help Network
- Student Mental Health and Wellness Collaborative

Quality Childcare Collaborative (QCCC)

Program Type: PEI Prevention

Program Description: QCCC is a collaboration between Behavioral Health Services (BHS), Child Action, Sacramento County Office of Education (SCOE), and other partners. This collaborative leverages First 5 funding to provide behavioral health consultations to preschools and early childcare learning environments for children, birth through age five (5). Consultations are designed to increase teacher awareness about the meaning of behavior and to provide strategies to ensure the success of the child while in a childcare and/or preschool setting. Support and education are also available for parents.

Number Served: In FY 2023-2024, 577 unduplicated caregivers and teachers utilized QCCC.

QCCC Demographics:

Characteristic	N=577	%
Age Group		
Children/Youth (0-15)	28	4.9%
TAY (16-25)	3	0.5%
Adults (26-59)	18	3.1%
Older Adults (60+)	0	0.0%
Unknown/Not Reported	528	91.5%
Ethnicity		
Hispanic or Latino	4	0.7%
Non-Hispanic/Non-Latino	18	3.1%
Other	0	0.0%
More than one ethnicity	13	2.3%
Unknown/Not Reported	542	93.9%
Race		
White	19	3.3%
Black or African American	10	1.7%
Asian	0	0.0%
American Indian or Alaska Native	0	0.0%
Native Hawaiian or Other Pacific Islander	0	0.0%
More than one race	5	0.9%
Other	7	1.2%
Unknown/Not Reported	536	92.9%
Primary Language		
English	40	6.9%
Spanish	5	0.9%
Vietnamese	0	0.0%
Cantonese	0	0.0%
Russian	0	0.0%
Hmong	0	0.0%
Arabic	2	0.3%
Farsi	0	0.0%
Other	3	0.5%
Unknown/Not Reported	527	91.3%

Sexual Orientation		
Heterosexual or Straight	15	2.6%
Gay or Lesbian	1	0.2%
Bisexual	0	0.0%
Questioning or unsure	0	0.0%
Queer	0	0.0%
Another sexual orientation	0	0.0%
Unknown/Not Reported	561	97.2%
Current Gender Identity		
Female	30	5.2%
Male	20	3.5%
Transgender	0	0.0%
Genderqueer	0	0.0%
Questioning or unsure	0	0.0%
Another gender identity	0	0.0%
Unknown/Not Reported	527	91.3%
Veteran Status		
Yes	0	0.0%
No	50	8.7%
Unknown/Not Reported	527	91.3%

QCCC Satisfaction Survey Results:

General Survey Item	N=3	%
The consultant suggested and modeled appropriate strategies		
Very Satisfied	1	33.3%
Satisfied	1	33.3%
Neutral	0	0.0%
Unsatisfied	0	0.0%
Very Unsatisfied	1	33.3%
The consultant provided support and guidance to provider in implementing and maintaining strategies		
Very Satisfied	1	33.3%
Satisfied	1	33.3%
Neutral	1	33.3%
Unsatisfied	0	0.0%
Very Unsatisfied	0	0.0%
The consultant helped providers manage a crisis situation		
Very Satisfied	1	33.3%
Satisfied	0	0.0%
Neutral	0	0.0%
Unsatisfied	0	0.0%
Very Unsatisfied	1	33.3%
Missing	1	33.3%

The consultant made recommendations for strategies to improve classroom environment		
Very Satisfied	1	33.3%
Satisfied	0	0.0%
Neutral	0	0.0%
Unsatisfied	0	0.0%
Very Unsatisfied	1	33.3%
Missing	1	33.3%

Parent Survey Item	N=1
The consultant helped the child care center to be more responsive to the child needs	
Strongly Agree	1
Agree	0
Neutral	0
Disagree	0
Strongly Disagree	0
The consultant help improve the quality of the childcare center	
Strongly Agree	1
Agree	0
Neutral	0
Disagree	0
Strongly Disagree	0
You feel you learned strategies that helped you accomplish what you wanted or needed	
Strongly Agree	1
Agree	0
Neutral	0
Disagree	0
Strongly Disagree	0

Child-Specific Survey Item	N=3	%
The consultant consulted with teacher/director regarding observations		
Very Satisfied	0	0.0%
Satisfied	2	66.7%
Neutral	0	0.0%
Unsatisfied	0	0.0%
Very Unsatisfied	1	33.3%
The consultant suggested appropriate strategies (i.e. transition times, snack time, etc.)		
Very Satisfied	1	33.3%
Satisfied	1	33.3%
Neutral	0	0.0%
Unsatisfied	0	0.0%
Very Unsatisfied	1	33.3%

The consultant trained provider on strategies to use with related behavioral concern		
Very Satisfied	1	33.3%
Satisfied	0	0.0%
Neutral	1	33.3%
Unsatisfied	0	0.0%
Very Unsatisfied	1	33.3%
The consultant developed home-based strategies to help parents address child's challenging behaviors		
Very Satisfied	0	0.0%
Satisfied	1	33.3%
Neutral	1	33.3%
Unsatisfied	0	0.0%
Very Unsatisfied	1	33.3%
The consultant made recommendations for strategies to improve classroom environment		
Very Satisfied	1	33.3%
Satisfied	0	0.0%
Neutral	0	0.0%
Unsatisfied	0	0.0%
Very Unsatisfied	1	33.3%
Missing	1	33.3%
The consultant helped providers manage a crisis situation		
Very Satisfied	0	0.0%
Satisfied	1	33.3%
Neutral	0	0.0%
Unsatisfied	0	0.0%
Very Unsatisfied	1	33.3%
Missing	1	33.3%

CPS Mental Health Team

Program Type: PEI Improving Timely Access for Underserved Populations

Program Description: The CPS Mental Health Team is a collaborative program with Child Protective Services (CPS) supporting the mental health needs of children within the Child Welfare system. The program serves children and youth, birth through age 20 and aligns with the implementation of Continuum of Care Reform and the requirement that a Child and Family Team (CFT) is provided to all children entering the Child Welfare system. The program's Behavioral Health Services (BHS) clinicians complete the Child and Adolescent Needs and Strengths (CANS) tool and provide mental health consultation informing the CFT meeting process and CPS case planning. This completed CANS assessment represents a shared vision of the child and family in collaboration with the CFT. Clinicians also participate in the CFT to identify supports, mental health referrals, and other services needed to achieve permanency, enable the child to live in the least restrictive family setting, and promote normal childhood experiences.

Number Served: In FY 2023-2024, 574 children, 0-20 years of age, received mental health screenings.

CPS Mental Health Team Demographics:

Characteristic	N=574	%
Age Group		
Children/Youth (0-15)	479	83.4%
TAY (16-25)	47	8.2%
Adults (26-59)	47	8.2%
Older Adults (60+)	1	0.2%
Unknown/Not Reported	0	0.0%
Ethnicity		
Hispanic or Latino	54	9.4%
Non-Hispanic/Non-Latino	124	21.6%
Other	0	0.0%
More than one ethnicity	0	0.0%
Unknown/Not Reported	396	69.0%
Race		
White	72	12.5%
Black or African American	81	14.1%
Asian	3	0.5%
American Indian or Alaska Native	0	0.0%
Native Hawaiian or Other Pacific Islander	3	0.5%
More than one race	46	8.0%
Other	25	4.4%
Unknown/Not Reported	344	59.9%

Primary Language		
English	243	42.3%
Spanish	8	1.4%
Vietnamese	0	0.0%
Cantonese	0	0.0%
Russian	2	0.3%
Hmong	0	0.0%
Arabic	0	0.0%
Farsi	1	0.2%
Other	5	0.9%
Unknown/Not Reported	315	54.9%
Sexual Orientation		
Heterosexual or Straight	121	21.1%
Gay or Lesbian	1	0.2%
Bisexual	7	1.2%
Questioning or unsure	9	1.6%
Queer	0	0.0%
Another sexual orientation	0	0.0%
Unknown/Not Reported	436	76.0%
Current Gender Identity		
Female	133	23.2%
Male	81	14.1%
Transgender	0	0.0%
Genderqueer	0	0.0%
Questioning or unsure	0	0.0%
Another gender identity	1	0.2%
Unknown/Not Reported	359	62.5%
Veteran Status		
Yes	0	0.0%
No	120	20.9%
Unknown/Not Reported	454	79.1%

Bullying Prevention Education and Training Program

Program Type: PEI Prevention

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

Number Served: The total number of people participating in the Bullying Prevention Program FY 2023-2024 was 12,804. Of those, there were:

Staff Trained: 2,816
Youth Served: 9,459
Parents served: 529

Demographics: Unavailable due to program design.

Youth Mental Health First Aid

Program Type: PEI Outreach for Increasing Early Signs of Mental Illness

Program Description: YMHFA is administered by Sacramento County Office of Education (SCOE) to increase the number of school staff and caregivers receiving YMHFA training.
Program objectives include learning about the signs of mental health challenges for youth and typical adolescent development. The program will teach a five-step action plan for how to help youth in both crisis and non-crisis situations.

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

Number Served: 326 adults were trained in YMHFA in FY 2023-2024

Demographics: Unavailable due to program design.

Early Violence Intervention Begins with Education (eVIBE)

Program Type: PEI Outreach for Increasing Early Signs of Mental Illness

Program Description: Administered by the Sacramento Children's Home, uses universal and selective evidence-based prevention approaches to target children and youth ages six (6) to eighteen (18) and their family members/caregivers to improve social skills, increase protective factors, prevent youth violence, and reduce or eliminate family conflict.

Number Served: In FY 2023-2024, 1,962 unduplicated individuals were served.

eVIBE Demographics:

Characteristic	N=1,962	%
Age Group		
Children/Youth (0-15)	1847	94.1%
TAY (16-25)	40	2.0%
Adults (26-59)	48	2.4%
Older Adults (60+)	1	0.1%
Unknown/Not Reported	26	1.3%
Ethnicity		
Hispanic or Latino	820	41.8%
Non-Hispanic/Non-Latino	735	37.5%
Other	0	0.0%
More than one ethnicity	0	0.0%
Unknown/Not Reported	407	20.7%
Race		
White	281	14.3%
Black or African American	207	10.6%
Asian	272	13.9%
American Indian or Alaska Native	13	0.7%
Native Hawaiian or other Pacific Islander	41	2.1%
More than one race	374	19.1%
Other	578	29.5%
Unknown/Not Reported	196	10.0%
Primary Language		
English	1456	74.2%
Spanish	155	7.9%
Vietnamese	12	0.6%
Cantonese	21	1.1%
Russian	12	0.6%
Hmong	3	0.2%
Arabic	3	0.2%
Other	63	3.2%
Unknown/Not Reported	237	12.1%

Sexual Orientation		
Heterosexual or Straight	33	1.7%
Gay or Lesbian	0	0.0%
Bisexual	5	0.3%
Questioning or unsure	0	0.0%
Queer	0	0.0%
Another sexual orientation	0	0.0%
Unknown/Not Reported	1924	98.1%
Current Gender Identity		
Female	981	50.0%
Male	955	48.7%
Transgender	1	0.1%
Genderqueer	0	0.0%
Questioning or unsure	0	0.0%
Another gender identity	0	0.0%
Unknown/Not Reported	25	1.3%
Veteran Status		
Yes	0	0.0%
No	0	0.0%
Unknown/Not Reported	1962	100.0%

eVIBE Parent Satisfaction Survey Results:

Too Good For Violence Grade Survey	Yes		Not Sure		No	
3-8 Parent Survey #1 (N=874)	***N***	***%***	***N***	***%***	***N***	***%***
Have you and your student had a conversation about TGFV-SP and/or eVIBE?	614	70.3%	96	11.0%	155	17.7%
Do you think that the TGFV-SP program is helping your student develop healthy strategies to manage their emotions?	653	74.7%	59	6.8%	150	17.2%
Do you think that the TGFV-SP program is promoting your student's positive interactions with peers and/or family members?	599	68.5%	150	17.2%	110	12.6%
Grade 3-8 Parent Survey #2 (N=787)	***N***	***%***	***N***	***%***	***N***	***%***
Have you and your student had a conversation about TGFV-SP and/or eVIBE?	577	73.3%	85	10.8%	115	14.6%
Do you think that the TGFV-SP program is helping your student develop healthy strategies to manage their emotions?	548	69.6%	187	23.8%	41	5.2%
Do you think that the TGFV-SP program is promoting your student's positive interactions with peers and/or family members?	580	73.7%	164	20.8%	29	3.7%

High School Parent Survey (N=41)	*N*	*%*	*N*	*%*	*N*	*%*
Have you and your teenager had a conversation about TGFV-SP and/or eVIBE?	19	46.3%	5	12.2%	17	41.5%
Has your teenager talked about setting goals recently?	28	68.3%	3	7.3%	10	24.4%
Has your teenager practiced the decision-making model (Stop, Think, Act, Reflect)?	22	53.7%	11	26.8%	8	19.5%
Do you think that the TGFV-SP program is helping your teenager develop healthy strategies to manage their emotions (anger, sadness, excitement)?	24	58.5%	14	34.1%	3	7.3%
Do you think that the TGFV-SP program is promoting your teenager's positive interactions with peers and/or family members?	26	63.4%	12	29.3%	3	7.3%

Nurturing Parenting Program Survey (N=27)	Agree or Strongly Agree		Neutral		Disagree or Strongly Disagree	
	N	*%*	*N*	*%*	*N*	*%*
I am better able to problem solve within my family by utilizing my nurturing parenting skills.	26	96.3%	0	0.0%	1	3.7%
I have learned new nurturing skills (self-care, managing stress & behavior, empathy, etc.) to build nurturing relationships with myself and my family.	26	96.3%	0	0.0%	1	3.7%
My family and I have more tools to successfully resolve conflicts or disagreements.	24	88.9%	2	7.4%	1	3.7%
I am able to communicate more effectively with my family.	22	81.5%	4	14.8%	1	3.7%
I have experienced a positive change within my family relationships because of the NPP services.	23	85.2%	2	7.4%	1	3.7%
I have learned about available community resources.	22	81.5%	4	14.8%	1	3.7%

Adoptive Families Respite Program

Program Type: PEI Prevention

Program Description: Administered by Capital Adoptive Families Alliance, this respite program provides temporary relief for adoptive families caring for children with complex mental health issues. Eligible families must live in or have adopted from Sacramento County. The respite model includes planned respite during drop off events, summer camp, and recreational activities.

Number Served: In FY 2023-2023, 423 children and their families utilized this respite service. Note: Demographics are not unduplicated because the same children and their families may have utilized respite services more than once in the year.

Adoptive Families Respite Demographics:

Characteristic	N= 423	%
Age Group		
Children/Youth (0-15)	187	44.2%
TAY (16-25)	45	10.6%
Adults (26-59)	178	42.1%
Older Adults (60+)	11	2.6%
Unknown/Not Reported	2	0.5%
Ethnicity		
Hispanic or Latino	90	21.3%
Non-Hispanic/Non-Latino	333	78.7%
Other	0	0.0%
More than one ethnicity	0	0.0%
Unknown/Not Reported	0	0.0%
Race		
White	221	52.2%
Black or African American	77	18.2%
Asian	5	1.2%
American Indian or Alaska Native	12	2.8%
Native Hawaiian or other Pacific Islander	0	0.0%
More than one race	57	13.5%
Other	41	9.7%
Unknown/Not Reported	10	2.4%
Primary Language		
English	423	100.0%
Spanish	0	0.0%
Vietnamese	0	0.0%
Cantonese	0	0.0%
Russian	0	0.0%
Hmong	0	0.0%
Arabic	0	0.0%
Farsi	0	0.0%
Other	0	0.0%
Unknown/Not Reported	0	0.0%

Sexual Orientation		
Heterosexual or Straight	291	68.8%
Gay or Lesbian	34	8.0%
Bisexual	17	4.0%
Questioning or unsure	38	9.0%
Queer	1	0.2%
Another sexual orientation	0	0.0%
Unknown/Not Reported	42	9.9%
Current Gender Identity		
Female	238	56.3%
Male	142	33.6%
Transgender	9	2.1%
Genderqueer	0	0.0%
Questioning or unsure	0	0.0%
Another gender identity	8	1.9%
Unknown/Not Reported	26	6.1%
Veteran Status		
Yes	6	1.4%
No	415	98.1%
Unknown/Not Reported	2	0.5%

Satisfaction Survey Results – Adoptive Families Respite:

Adoptive Families Respite Program Satisfaction Survey Item	N =118	%
As a result of the services I received or group(s) I attended, I know how to get help if I knew someone who is suicidal or if I felt suicidal.		
Strongly Agree/Agree	71	60.17%
Undecided	16	13.56%
Disagree/Strongly Disagree	0	0.00%
N/A	31	26.27%
I felt the services I received reflected my cultural beliefs, preferences, and values which made me feel respected.		
Strongly Agree/Agree	108	91.53%
Undecided	3	2.54%
Disagree/Strongly Disagree	0	0.00%
N/A	7	5.93%
I had a decrease in stress.		
Strongly Agree/Agree	117	99.15%
Undecided	1	0.85%
Disagree/Strongly Disagree	0	0.00%
N/A	0	0.00%
I have an increase in well-being.		
Strongly Agree/Agree	116	98.31%
Undecided	1	0.85%
Disagree/Strongly Disagree	0	0.00%
N/A	1	0.85%
I have an increased feeling in my ability to cope.		
Strongly Agree/Agree	112	94.92%
Undecided	1	0.85%
Disagree/Strongly Disagree	0	0.00%
N/A	5	4.24%

The Source

Program Type: PEI Improving Timely Access to Services for Underserved Populations

Program Description: Administered by Sacramento Children's Home, The Source provides a 24 hours per day, 7 days per week, 365 day per year call center providing immediate phone response, mobile in-person/face-to-face crisis intervention, triage services, mediation, follow-up support, and information and referral. The Source is available to all youth up to age 26 and their families, inclusive of current and former foster youth and foster parents/caregivers who are experiencing crisis or emotional or behavioral distress that, without immediate support, risks disruption to the current living situation. Services include peer mentoring, youth and family engagement, support and advocacy, and temporary relief for youth and/or foster parents/ caregivers.

To be relevant to affected youth, the program also provides outreach and information via a dedicated website, text, video conferencing, and popular social media and apps. Opportunities are provided for youth to participate in normative and developmentally appropriate activities.

Number Served: In FY 2023-2024, The Source served a total of 2247 unduplicated individuals. Due to the program design, demographics could not be collected on all served.

The Source Demographics:

Characteristic	N=80	%
Age Group		
Children/Youth (0-15)	63	78.8%
TAY (16-25)	17	21.3%
Adults (26-59)	0	0.0%
Older Adults (60+)	0	0.0%
Unknown/Not Reported	0	0.0%
Ethnicity		
Hispanic or Latino	18	22.5%
Non-Hispanic/Non-Latino	51	63.8%
Other	0	0.0%
More than one ethnicity	0	0.0%
Unknown/Not Reported	11	13.8%
Race		
White	24	30.0%
Black or African American	25	31.3%
Asian	0	0.0%
American Indian or Alaska Native	0	0.0%
Native Hawaiian or other Pacific Islander	1	1.3%
More than one race	19	23.8%
Other	3	3.8%
Unknown/Not Reported	8	10.0%

Primary Language		
English	78	97.5%
Spanish	2	2.5%
Vietnamese	0	0.0%
Cantonese	0	0.0%
Russian	0	0.0%
Hmong	0	0.0%
Arabic	0	0.0%
Farsi	0	0.0%
Other	0	0.0%
Unknown/Not Reported	0	0.0%
Sexual Orientation		
Heterosexual or Straight	33	41.3%
Gay or Lesbian	3	3.8%
Bisexual	3	3.8%
Questioning or unsure	7	8.8%
Queer	0	0.0%
Another sexual orientation	0	0.0%
Unknown/Not Reported	34	42.5%
Current Gender Identity		
Female	35	43.8%
Male	25	31.3%
Transgender	2	2.5%
Genderqueer	2	2.5%
Questioning or unsure	1	1.3%
Another gender identity	2	2.5%
Unknown/Not Reported	13	16.3%
Veteran Status		
Yes	0	0.0%
No	56	70.0%
Unknown/Not Reported	24	30.0%

Note: No satisfaction surveys were completed for The Source during FY23/24.

Safe Zone Squad

Program Type: PEI Improving Timely Access to Services for Underserved Populations

Program Description: Administered by Sacramento County Office of Education (SCOE), Safe Zone Squad (SZS) provides mental health crisis and triage services to students, ages 11 to 14, at two (2) identified middle school campuses. SZS program provides and coordinates mental health support services, including crisis intervention services, listening circles, skills development, psychoeducation, stress/crisis management, parent/caregiver trainings, and restorative mediation. These services are delivered by a two-person team comprised of a Youth Advocate and a Safe Zone Coach (mental health counselor). The team provides mental health screenings to students who are referred and identifies and provides appropriate levels of support and linkages to mental health services and/or other community resources. Program outcomes include enhancing school success, reducing stigma, improving relationships, and reducing unnecessary psychiatric hospitalizations.

Number Served: Safe Zone Squad served 1332 children within the school, but no students were referred for higher level services within our system. The schools did not provide demographic information for those served within the school.

Youth Help Network

Program Type: PEI Improving Timely Access to Services for Underserved Populations

Program Description: Capital Star's Youth Help Network (YHN) program offers free short-term peer support for all 16- to 25-year-olds in Sacramento County regardless of insurance. YHN's Youth Advocates have personal experience with mental health and other challenges that youth face. YHN services include health navigation, peer support, mental health assessment, housing resources, job readiness, education, essential needs, and more.

Number Served: In FY 2023-2024, the Youth Help Network served a total of 258 individuals.

YHN Demographics:

Characteristic	N=258	%
Age Group		
Children/Youth (0-15)	1	0.4%
TAY (16-25)	257	99.6%
Adults (26-59)	0	0.0%
Older Adults (60+)	0	0.0%
Unknown/Not Reported	0	0.0%
Ethnicity		
Hispanic or Latino	47	18.2%
Non-Hispanic/Non-Latino	108	41.9%
Other	0	0.0%
More than one ethnicity	0	0.0%
Unknown/Not Reported	103	39.9%
Race		
White	52	20.2%
Black or African American	119	46.1%
Asian	6	2.3%
American Indian or Alaska Native	3	1.2%
Native Hawaiian or other Pacific Islander	2	0.8%
More than one race	24	9.3%
Other	20	7.8%
Unknown/Not Reported	32	12.4%
Primary Language		
English	197	76.4%
Spanish	3	1.2%
Vietnamese	0	0.0%
Cantonese	0	0.0%
Russian	0	0.0%
Hmong	0	0.0%
Arabic	0	0.0%
Farsi	0	0.0%
Other	0	0.0%
Unknown/Not Reported	58	22.5%

Sexual Orientation		
Heterosexual or Straight	127	49.2%
Gay or Lesbian	12	4.7%
Bisexual	24	9.3%
Questioning or unsure	2	0.8%
Queer	0	0.0%
Another sexual orientation	1	0.4%
Unknown/Not Reported	92	35.7%
Current Gender Identity		
Female	65	25.2%
Male	47	18.2%
Transgender	13	5.0%
Genderqueer	0	0.0%
Questioning or unsure	0	0.0%
Another gender identity	14	5.4%
Unknown/Not Reported	119	46.1%
Veteran Status		
Yes	0	0.0%
No	41	15.9%
Unknown/Not Reported	217	84.1%

YHN Satisfaction Survey: Satisfaction is rated on a four-point Likert-type scale. The scores range from 4 (Completely True) to 1 (Not at All). A mean score of 2.50 and above is considered satisfied.

Satisfaction Survey Results:

Satisfaction Survey Items	July-Sept 23 (N=20)		Oct-Dec 23 (N=30)		Jan-Mar 24 (N=15)		Apr-Jun 24 (N=17)	
	Mean	% Agree	Mean	% Agree	Mean	% Agree	Mean	% Agree
1 – This visit helped me make connections with others, or feel less alone	3.50	83.3%	3.45	75.0%	3.83	96.7%	4.00	100.0%
2 – I felt accepted and heard by staff	3.64	92.9%	3.65	90.0%	3.93	100.0%	4.00	100.0%
3 – I know where to start if I need resources	3.55	88.1%	3.55	85.0%	3.87	96.7%	4.00	100.0%
4 – This helped me improve my emotional/physical wellness in some way	3.51	82.9%	3.50	80.0%	3.80	93.3%	4.00	100.0%

Student Mental Health and Wellness Collaborative

Program Type: PEI Improving Timely Access to Services for Underserved Populations

Program Description: The Student Mental Health and Wellness Collaborative was initially created in 2009 by a small group of stakeholders who came together to discuss a common vision and desired results for the role of schools in creating a comprehensive countywide system of prevention and early intervention to promote the mental health and academic success of children from birth to high school completion.

The purpose of the collaborative is to bring together mental health professionals, educators, and other system partners to collaborate with the goal of developing, improving, and maintaining supports for student mental health and wellness. The collaborative was charged with developing a plan for a comprehensive approach to coordinating mental health services in educational settings.

Numbers Served: During the 2023-24 fiscal year, the Collaborative met quarterly and consists of over 473 members with an average of 40-50 participants per meeting.

Integrated Health and Wellness Program

Ages Served: Children, TAY, Adults, Older Adults

The Integrated Health and Wellness Project consists of:

- SacEDAPT (Early Diagnosis and Preventative Treatment)
- SeniorLink
- Community Responsive Wellness Program (CRWP)

SacEDAPT (Early Diagnosis and Preventative Treatment)

Program Type: PEI Early Intervention

Program Description: Administered by UC Davis, Department of Psychiatry, SacEDAPT focuses on individuals aged 12 to 30 identified as experiencing early onset of a serious mental illness or emotional disturbance with psychotic features. SacEDAPT uses a nationally recognized treatment model utilizing an inter-disciplinary team of physicians, clinicians, support staff, consumers, and family advocates to provide assessment, early identification, and treatment of the onset of psychosis. The program provides culturally and linguistically responsive psychiatric support, case management, peer support, and access to treatment, including transportation. The program also engages in outreach services throughout Sacramento County, with a particular focus on underserved populations.

Number Served: In FY 2023-2024, 137 unduplicated clients were served.

SacEDAPT Demographics:

Characteristic	N=137	%
Age Group		
Children/Youth (0-15)	43	31.4%
TAY (16-25)	85	62.0%
Adults (26-59)	9	6.6%
Older Adults (60+)	0	0.0%
Unknown/Not Reported	0	0.0%
Ethnicity		
Hispanic or Latino	49	35.8%
Non-Hispanic/Non-Latino	66	48.2%
Other	0	0.0%
More than one ethnicity	0	0.0%
Unknown/Not Reported	22	16.1%
Race		
White	38	27.7%
Black or African American	35	25.5%
Asian	10	7.3%
American Indian or Alaska Native	1	0.7%
Native Hawaiian or other Pacific Islander	0	0.0%
More than one race	28	20.4%
Other	23	16.8%
Unknown/Not Reported	2	1.5%

Primary Language		
English	123	89.8%
Spanish	9	6.6%
Vietnamese	0	0.0%
Cantonese	0	0.0%
Russian	2	1.5%
Hmong	1	0.7%
Arabic	0	0.0%
Farsi	0	0.0%
Other	2	1.5%
Unknown/Not Reported	0	0.0%
Sexual Orientation		
Heterosexual or Straight	102	74.5%
Gay or Lesbian	6	4.4%
Bisexual	13	9.5%
Questioning or unsure	4	2.9%
Queer	0	0.0%
Another sexual orientation	0	0.0%
Unknown/Not Reported	12	8.8%
Current Gender Identity		
Female	56	40.9%
Male	69	50.4%
Transgender	5	3.6%
Genderqueer	1	0.7%
Questioning or unsure	1	0.7%
Another gender identity	3	2.2%
Unknown/Not Reported	2	1.5%
Veteran Status		
Yes	0	0.0%
No	0	0.0%
Unknown/Not Reported	137	100.0%

SeniorLink

Program Type: PEI Prevention

Program Description: Administered by El Hogar, SeniorLink provides community integration support for adults aged 55 and older who are demonstrating early signs of isolation, anxiety and/or depression. Para-professional Advocates outreach to individuals in their homes or other community-based settings based on the participant needs. Program services include home visits, collaboration with and linkage to health care providers, socialization opportunities, transportation, service coordination, advocacy, information and referral, skills-building groups, and liaison to community services.

Number Served: In FY 2023-2024, 253 unduplicated older adults were served.

SeniorLink Demographics:

Characteristic	N=253	%
Age Group		
Children/Youth (0-15)	0	0.0%
TAY (16-25)	0	0.0%
Adults (26-59)	7	2.8%
Older Adults (60+)	186	73.5%
Unknown/Not Reported	60	23.7%
Ethnicity		
Hispanic or Latino	18	7.1%
Non-Hispanic/Non-Latino	160	63.2%
Other	0	0.0%
More than one ethnicity	0	0.0%
Unknown/Not Reported	75	29.6%
Race		
White	88	34.8%
Black or African American	65	25.7%
Asian	7	2.8%
American Indian or Alaska Native	3	1.2%
Native Hawaiian or other Pacific Islander	3	1.2%
More than one race	2	0.8%
Other	14	5.5%
Unknown/Not Reported	71	28.1%
Primary Language		
English	185	73.1%
Spanish	1	0.4%
Vietnamese	0	0.0%
Cantonese	3	1.2%
Russian	0	0.0%
Hmong	1	0.4%
Arabic	0	0.0%
Farsi	0	0.0%
Other	1	0.4%
Unknown/Not Reported	62	24.5%

Sexual Orientation		
Heterosexual or Straight	165	65.2%
Gay or Lesbian	7	2.8%
Bisexual	1	0.4%
Questioning or unsure	0	0.0%
Queer	0	0.0%
Another sexual orientation	4	1.6%
Unknown/Not Reported	76	30.0%
Current Gender Identity		
Female	155	61.3%
Male	35	13.8%
Transgender	2	0.8%
Genderqueer	0	0.0%
Questioning or unsure	0	0.0%
Another gender identity	0	0.0%
Unknown/Not Reported	61	24.1%
Veteran Status		
Yes	10	4.0%
No	0	0.0%
Unknown/Not Reported	243	96.0%

SeniorLink – Outreach

Number Served: In FY 2023-2024, the program outreached to 139 unduplicated older adults.

SeniorLink Outreach Demographics:

Characteristic	N = 139	%
Age Group		
Children/Youth (0-15)	0	0.0%
TAY (16-25)	0	0.0%
Adults (26-59)	8	5.8%
Older Adults (60+)	128	92.1%
Unknown/Not Reported	3	2.2%
Ethnicity		
Hispanic or Latino	11	7.9%
Non-Hispanic/Non-Latino	117	84.2%
Other	0	0.0%
More than one ethnicity	0	0.0%
Unknown/Not Reported	11	7.9%

Race		
White	62	44.6%
Black or African American	43	30.9%
Asian	9	6.5%
American Indian or Alaska Native	4	2.9%
Native Hawaiian or Other Pacific Islander	3	2.2%
More than one race	0	0.0%
Other	11	7.9%
Unknown/Not Reported	7	5.0%
Primary Language		
English	172	123.7%
Spanish	5	3.6%
Vietnamese	1	0.7%
Cantonese	1	0.7%
Russian	1	0.7%
Hmong	17	12.2%
Arabic	0	0.0%
Other	2	1.4%
Unknown/Not Reported	6	4.3%
Sexual Orientation		
Heterosexual or Straight	129	92.8%
Gay or Lesbian	1	0.7%
Bisexual	1	0.7%
Questioning or unsure	0	0.0%
Queer	0	0.0%
Another sexual orientation	4	2.9%
Unknown/Not Reported	4	2.9%
Current Gender Identity		
Female	104	74.8%
Male	33	23.7%
Transgender	1	0.7%
Genderqueer	0	0.0%
Questioning or unsure	0	0.0%
Another gender identity	0	0.0%
Unknown/Not Reported	1	0.7%
Veteran Status		
Yes	6	4.3%
No	1	0.7%
Unknown/Not Reported	132	95.0%

Community Responsive Wellness Program

Program Type: PEI Improving Timely Access to Services for Underserved Populations

Program Description: The Community Responsive Wellness Program (CRWP) is administered by Sierra Health Foundation: Center for Health Program Management and provides culturally relevant outreach, engagement, and prevention services to Sacramento County African American/Black Community (AABC) residents within Sacramento County of all ages and genders who have experienced or have been exposed to trauma with special consideration given to children, youth, and Transition Age Youth (TAY). Through the program, four (4) community partner programs provide culturally responsive trauma-informed services to AABC members. Along with the administrative support provided by The Center, these partner programs employ staff members with shared cultural background and lived experience to provide culturally relevant outreach, engagement, and supportive services to AABC members. The program provides outreach and engagement activities including sharing program information, education about the Medi-Cal healthcare system, and linkage assistance to Medi-Cal resources for eligible individuals. The program also offers a variety of services to AABC members including resource navigation, linkage and referral to needed services, and supportive services (e.g. supportive counseling, coaching/skills building training, healing circles, support groups, crisis intervention, community education about mental health/substance use issues and the impacts of trauma and Adverse Childhood Experiences (ACE) on community members).

Number Served: In FY 2023-2024, the CRWP programs served 1,664 individuals.

CRWP Demographics:

Characteristic	Improve Your Tomorrow (N=51)		ONTRACK Program Resources, Inc. (N=26)		Roberts Family Development Center (N=654)		Rose Family Creative Empowerment Center (N=933)		Total (N=1664)	
	N	%	N	%	N	%	N	%	N	%
Age Group										
Children/Youth (0-15)	29	56.9%	0	0.0%	128	19.6%	204	21.9%	361	21.7%
TAY (16-25)	22	43.1%	5	19.2%	95	14.5%	134	14.4%	256	15.4%
Adults (26-59)	0	0.0%	17	65.4%	362	55.4%	498	53.4%	877	52.7%
Older Adults (60+)	0	0.0%	4	15.4%	66	10.1%	97	10.4%	167	10.0%
Unknown/Not Reported	0	0.0%	0	0.0%	3	0.5%	0	0.0%	3	0.2%
Ethnicity										
Hispanic or Latino	4	7.8%	2	7.7%	82	12.5%	150	16.1%	238	14.3%
Non-Hispanic/Non-Latino	42	82.4%	24	92.3%	562	85.9%	774	83.0%	1402	84.3%
Other	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
More than one ethnicity	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Unknown/Not Reported	5	9.8%	0	0.0%	10	1.5%	9	1.0%	24	1.4%

Characteristic	Improve Your Tomorrow (N=51)		ONTRACK Program Resources, Inc. (N=26)		Roberts Family Development Center (N=654)		Rose Family Creative Empowerment Center (N=933)		Total (N=1664)	
	N	%	N	%	N	%	N	%	N	%
Race										
White/Caucasian	0	0.0%	0	0.0%	51	7.8%	83	8.9%	134	8.1%
Black/African American	42	82.4%	22	84.6%	455	69.6%	576	61.7%	1095	65.8%
Asian	0	0.0%	0	0.0%	1	0.2%	38	4.1%	39	2.3%
American Indian/Alaska Native	0	0.0%	0	0.0%	8	1.2%	12	1.3%	20	1.2%
Native Hawaiian/Other Pacific Islander	0	0.0%	0	0.0%	2	0.3%	4	0.4%	6	0.4%
More than one race	9	17.6%	3	11.5%	19	2.9%	12	1.3%	43	2.6%
Other	0	0.0%	1	3.8%	37	5.7%	100	10.7%	138	8.3%
Unknown/Not Reported	0	0.0%	0	0.0%	81	12.4%	108	11.6%	189	11.4%
Primary Language										
English	51	100.0%	26	100.0%	576	88.1%	928	99.5%	1581	95.0%
Spanish	0	0.0%	0	0.0%	0	0.0%	1	0.1%	1	0.1%
Vietnamese	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Cantonese	0	0.0%	0	0.0%	0	0.0%	1	0.1%	1	0.1%
Russian	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Hmong	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Arabic	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Farsi	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Other	0	0.0%	0	0.0%	1	0.2%	0	0.0%	1	0.1%
Unknown/Not Reported	0	0.0%	0	0.0%	77	11.8%	3	0.3%	80	4.8%
Sexual Orientation										
Heterosexual or Straight	47	92.2%	26	100.0%	372	56.9%	925	99.1%	1370	82.3%
Gay or Lesbian	1	2.0%	0	0.0%	6	0.9%	2	0.2%	9	0.5%
Bisexual	0	0.0%	0	0.0%	25	3.8%	1	0.1%	26	1.6%
Questioning or unsure	0	0.0%	0	0.0%	5	0.8%	0	0.0%	5	0.3%
Queer	0	0.0%	0	0.0%	2	0.3%	1	0.1%	3	0.2%
Another sexual orientation	1	2.0%	0	0.0%	37	5.7%	1	0.1%	39	2.3%
Unknown/Not Reported	2	3.9%	0	0.0%	207	31.7%	3	0.3%	212	12.7%
Gender Identity										
Female	0	0.0%	20	76.9%	441	67.4%	614	65.8%	1075	64.6%
Male	48	94.1%	6	23.1%	194	29.7%	316	33.9%	564	33.9%
Transgender	0	0.0%	0	0.0%	1	0.2%	0	0.0%	1	0.1%
Genderqueer	1	2.0%	0	0.0%	1	0.2%	0	0.0%	2	0.1%
Questioning or unsure	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Another gender identity	0	0.0%	0	0.0%	4	0.6%	1	0.1%	5	0.3%
Unknown/Not Reported	2	3.9%	0	0.0%	13	2.0%	2	0.2%	17	1.0%
Veteran Status										
Yes	1	2.0%	2	7.7%	0	0.0%	0	0.0%	3	0.2%
No	50	98.0%	24	92.3%	654	100.0%	933	100.0%	1661	99.8%
Unknown/Not Reported	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%

CRWP – Information and Referral:

Number Served: In FY 2023-2024, the CRWP programs gave information and referrals to 1,762 individuals. Note: due to the nature of the data collection, this is not an unduplicated count.

CRWP Programs	N	%
Improve your tomorrow	5	0.3%
ONTRACK Program Resources, Inc.	52	3.0%
Roberts Family Development Center	9	0.5%
Rose Family Creative Empowerment Center	1,696	96.3%
Total	**1,762**	**100.0%**

CRWP – Satisfaction Survey Results:

Satisfaction Survey Item	Improve Your Tomorrow (N=38)	ONTRACK Program Resources, Inc. (N=28)	Roberts Family Development Center (N=15)	Rose Family Creative Empowerment Center (N=65)	Total (N=146)
	(%)	(%)	(%)	(%)	(%)
The group I attended helped me find services and supports.					
Yes	89.5%	100.0%	100.0%	63.1%	80.8%
No	2.6%	0.0%	0.0%	6.2%	3.4%
Not Applicable	7.9%	0.0%	0.0%	29.2%	15.1%
Unknown/Not Reported	0.0%	0.0%	0.0%	1.5%	0.7%
The group I attended helped me manage my daily life stressors.					
Yes	86.8%	89.3%	93.3%	69.2%	80.1%
No	5.3%	0.0%	6.7%	7.7%	5.5%
Not Applicable	7.9%	7.1%	0.0%	23.1%	13.7%
Unknown/Not Reported	0.0%	3.6%	0.0%	0.0%	0.7%
The group I attended helped me heal from trauma.					
Yes	57.9%	82.1%	100.0%	58.5%	67.1%
No	15.8%	0.0%	0.0%	10.8%	8.9%
Not Applicable	26.3%	14.3%	0.0%	29.2%	22.6%
Unknown/Not Reported	0.0%	3.6%	0.0%	1.5%	1.4%
The group I attended helped me learn more about trauma and race-based stress.					
Yes	78.9%	85.7%	93.3%	60.0%	73.3%
No	5.3%	0.0%	6.7%	10.8%	6.8%
Not Applicable	15.8%	10.7%	0.0%	27.7%	18.5%

Satisfaction Survey Item	Improve Your	ONTRACK Program	Roberts Family Development	Rose Family Creative	Total (N=144)

	Tomorrow (N=35)	Resources, Inc. (N=28)	Center (N=15)	Empowerment Center (N=66)	
	(%)	(%)	(%)	(%)	(%)
I am more aware of community services and/or have learned skills that can help me or others in my family or community as a result of the services I received or group I attended.					
Strongly Agree/Agree	85.7%	96.4%	93.3%	83.3%	87.5%
Undecided	5.7%	0.0%	0.0%	7.6%	4.9%
Disagree/Strongly Disagree	2.9%	0.0%	0.0%	0.0%	0.7%
Not Applicable	5.7%	0.0%	6.7%	9.1%	6.3%
Unknown/Not Reported	0.0%	3.6%	0.0%	0.0%	0.7%
I learned skills from the services I received or groups that I attended that I use each day or share with others.					
Strongly Agree/Agree	82.9%	89.3%	93.3%	81.8%	84.7%
Undecided	8.6%	0.0%	0.0%	6.1%	4.9%
Disagree/Strongly Disagree	2.9%	0.0%	0.0%	0.0%	0.7%
Not Applicable	5.7%	7.1%	6.7%	12.1%	9.0%
Unknown/Not Reported	0.0%	3.6%	0.0%	0.0%	0.7%
As a result of the services I received, I learned more about and have a better understanding of trauma/race-based stress.					
Strongly Agree/Agree	82.9%	85.7%	93.3%	74.2%	80.6%
Undecided	2.9%	0.0%	0.0%	6.1%	3.5%
Disagree/Strongly Disagree	2.9%	0.0%	0.0%	1.5%	1.4%
Not Applicable	11.4%	10.7%	6.7%	18.2%	13.9%
Unknown/Not Reported	0.0%	3.6%	0.0%	0.0%	0.7%
As a result of the services I received, I know more about mental health conditions.					
Strongly Agree/Agree	77.1%	96.4%	93.3%	71.2%	79.9%
Undecided	11.4%	0.0%	0.0%	9.1%	6.9%
Disagree/Strongly Disagree	2.9%	0.0%	0.0%	3.0%	2.1%
Not Applicable	8.6%	0.0%	6.7%	16.7%	10.4%
Unknown/Not Reported	0.0%	3.6%	0.0%	0.0%	0.7%
As a result of the services I received, I feel more satisfied with my life and well-being.					
Strongly Agree/Agree	88.6%	96.4%	93.3%	83.3%	88.2%
Undecided	2.9%	0.0%	0.0%	1.5%	1.4%
Disagree/Strongly Disagree	2.9%	0.0%	0.0%	1.5%	1.4%
Not Applicable	5.7%	0.0%	6.7%	13.6%	8.3%
Unknown/Not Reported	0.0%	3.6%	0.0%	0.0%	0.7%
As a result of the services I received, I know more about the resources and supports that are available to me.					
Strongly Agree/Agree	77.1%	96.4%	93.3%	81.8%	84.7%
Undecided	11.4%	0.0%	0.0%	4.5%	4.9%
Disagree/Strongly Disagree	2.9%	0.0%	0.0%	1.5%	1.4%
Not Applicable	8.6%	0.0%	6.7%	12.1%	8.3%
Unknown/Not Reported	0.0%	3.6%	0.0%	0.0%	0.7%
I felt the services I received reflected my cultural beliefs, preferences, and values which made me feel respected.					
Strongly Agree/Agree	82.9%	100.0%	93.3%	77.3%	84.7%
Undecided	5.7%	0.0%	0.0%	6.1%	4.2%
Disagree/Strongly Disagree	2.9%	0.0%	0.0%	3.0%	2.1%
Not Applicable	8.6%	0.0%	6.7%	13.6%	9.0%
Unknown/Not Reported	0.0%	0.0%	0.0%	0.0%	0.0%

Mental Health Promotion Program

Ages Served: Children, TAY, Adults, Older Adults

Mental Health Promotion Program consists of:

- Mental Illness: It's not always what you think Project
- Mental Health Matters

Mental Illness: It's not always what you think Project

Program Type: PEI Stigma and Discrimination Reduction

Program Description*:* Since June of 2011, the Division of Behavioral Health Services (BHS), in partnership with Edelman, a communication marketing agency, and Division of Public Health, developed and coordinated a multi-media stigma and discrimination reduction project titled the "Mental Illness: It's not always what you think" Project. FY 2023-2024 marked the twelfth year of this project. The project's target audiences include:

- Residents who primarily speak Arabic, Cantonese, Hmong, Russian, Spanish, or Vietnamese
- Residents who primarily speak English and identify as Black/African American, Latino, American Indian/Alaska Native, Older Adult, or young adults
- Residents who primarily speak English and self-identify as Lesbian, Gay, Bisexual, Transgender and Gender Diverse, and Questioning (LGBTQ) communities.

The goal of the project is to reduce the stigma and discrimination associated with mental illness that keeps many from seeking support and treatment by promoting messages of wellness, hope and recovery, dispelling myths and stereotypes surrounding mental illness, and fundamentally altering negative attitudes and perceptions about mental illness and emotional disturbance. The project aims to reduce stigma and discrimination by engaging diverse communities and the general public through culturally relevant mental health information and education. The project has multiple components:

- Multi-Media Outreach that encompasses a heavy advertising campaign across multiple mediums (such as radio, TV, online and outdoor ads)
- Social Media accounts on Facebook, Instagram, and Twitter
- Microsite – www.StopStigmaSacramento.org
- Stakeholder Engagement that includes engaging community organizations and members in project activities
- Collateral Material – offering free program materials to stakeholder organizations and community members
- Community Outreach Events
- Research – engaging with and incorporating feedback from community members and leaders to recalibrate, update and tailor messaging and materials that reflect each specific target audience
- Stop Stigma Sacramento Speakers Bureau – speakers share their personal stories of hope and inspiration at speaking events

Numbers reached through the projects' multimedia components:

Radio Ads:
Radio advertisements featuring campaign messages ran at various times on numerous stations from July 2023 – June 2024 Overall, radio ads delivered more than 6,163,960 impressions (of note: in-language radio placements were made, but impressions are not available for those placements).

The project ran the 30-second spots in Spanish, Vietnamese, Russian, English, Iranian and Hmong, sharing messages of hope, wellness and recovery and encouraging listeners to learn more by visiting the project's website.

Overall, 4,308 radio advertisements ran. These placements were featured on 16 music-focused, multicultural and in-language radio stations, including, KHYL (Rhythmic AC), KSEG (classic rock), KSFM (contemporary hits), KKDO (alternative), KDEE (Audience: African American), KRCX (Audience: Hispanic), KXSE (Audience: Hispanic), KFSG (Audience: Vietnamese, Russian), KEFM (Audience: Russian) and KJAY (Audience: Hmong), KYMX (Adult contemporary), KNCI (country), KVMX (Audience: Spanish), KUDL (Adult contemporary).

Television Ads:
Television advertisements supporting the campaign messages and branding ran at various times on numerous stations from July 2023 – June 2024. Overall, 649 TV spots ran, and there was a total of 6,712,106 impressions delivered from the television ads.

Print Ads:
Print advertising ran in eight local publications, including: Thang Mo (Audience: Vietnamese-speaking), Sac Cultural Hub (Audience: Black and African American), Sacramento Observer (Audience: Black and African American), Diaspora (Audience: Russian-speaking), Word and Deed (Audience: Russian-speaking), Outword Magazine (Audience: LGBTQ+), the Crescent (Audience: Arabic) and d'Primeramano (Audience: Spanish-speaking). Overall, 17 print ads or editorials ran in these publications, featuring real stories, often translated in language, that shared real experiences and tips.

Outdoor Ads:
Outdoor advertising ran from July 2023 – June 2024. Advertising included bus tails, digital billboards, airport boards and premiere panels. In total, these paid placements garnered an estimated 34,291,209 impressions.

Online and Mobile Ads:
Digital and mobile advertisements supporting the campaign ran from July 2023 – June 2024. Overall, online and mobile ads garnered 21,863,540 impressions (slightly up from 16,250,236 impressions in the previous fiscal year) with a cost per click of $1.87.

Impressions by Age Demographic:
18-25: 28% of total impressions; 5,400,231 (up 4% from last year)
26-59: 50% of total impressions; 9,696,430 (up 4% from last year)
60+: 22% of total impressions; 4,231,805 (down 8% from last year)

Clicks by Age Demographic:
18-25: 26% of total impressions; 13,483
26-59: 47% of total impressions; 24,592
60+: 27% of total impressions; 13,816

Digital Advertising: Click-Through Rates By Advertisement:
The following images include screenshots of each digital advertisement and the click through rate. A click is when a user engages in an advertisement and follows the link. The click through rate is found by calculating clicks divided by impressions.

For example:
1,000 people viewed the ad (1000 impressions)
4 people clicked on the ad (4 clicks)
= 0.4% Click Rate

General Audience

.19%

.28%

.23%

.18%

Older Adult

.50%

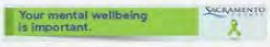
.92%

1.38%

1.18%

LGBTQ

.25%



.49%

.63%

.26%

Transgender

.40%

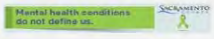
1.14%

1.05%

Native American

.58%

.27%



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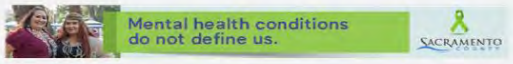
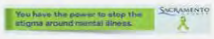


.26%

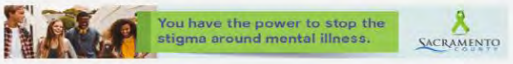
TAY

.41%

.72%



.70%



.89%

African American

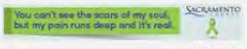
.23%

.19%

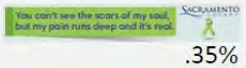
.24%

.26%

.24%



.39%



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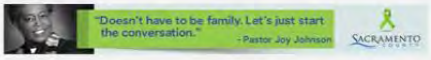

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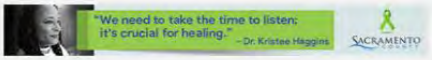

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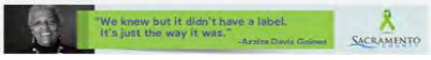
.32%



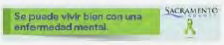
.45%

In-Language Audience

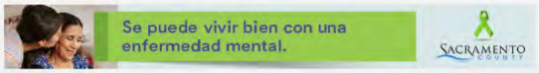
Spanish

.18%

.36%



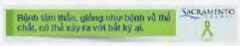
.45



.21%

Vietnamese

.11%



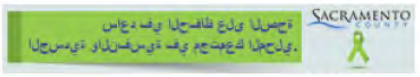
.46%

.35%

.25%

Arabic

.06%



.31%

.53%

.17%

.10%

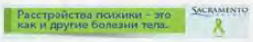
.34%

.51%

.16%

Russian

.13%



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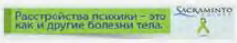

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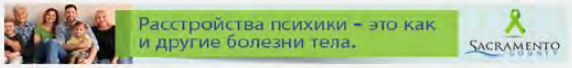


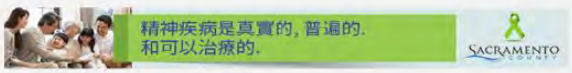
.21%

Cantonese

.18%

1.03%

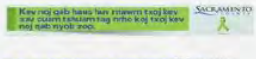
3.22%



1.33%

Hmong

.40%



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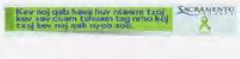

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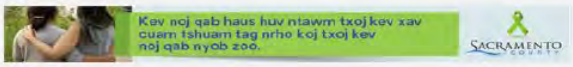


1.04%

Added Value Items:

- Crossings TV: Hmong interview aired in Sacramento on May 26th, May 27th, & May 28th
- CBS: Health Watch Sponsorship
- Fox: Studio 40Live interview aired on 5/29 x30 spots on Antenna Station NTXL
- Clear Channel: Airport Baggage Claim added value spots 1,277; Digital Bulletins 1 Bonus Board; 12 paid Premiere Pannels ran 14 plus ran for an additional week
- Lamar: 11 Bus Tail Posted for 35 additional days & x54 Bus interior cards posted for an additional 25 days
- Sacramento Cultural Hub: Bonus editorial piece
- Outword Magazine: Bonus editorial piece
- Sac Observer: Bonus editorial piece
- KVMX: 30-minute Spanish interview aired on July 30th
- Audacy: Mental health PSA interview aired on May 19th on KSEG, KUDL, KKDO, KIFM, KRXQ and KSFM

(7) Earned Media:

Edelman's media experts conducted strategic outreach to local and regional media to promote various project activities, Speakers Bureau stories and milestones within the community throughout the year.

The list below represents the 11 earned (non-paid) placements and corresponding impressions secured between July 1, 2023 and June 30, 2024. The majority of media outreach took place around timely observances and key milestones, such as Mental Illness Awareness Week, Black History Month, and the holidays. The project was included in key local news publications garnering more than 5,409,955 total impressions. Impressions are defined as any interaction with a piece of content.

Date	Title	Outlet	Impressions/ Audience
Radio			
12/19/2023	Holiday Blues	KTSE/KFBK	144,940
Online/Print			
8/24/2023	Prepare Students for a Mentally Strong School Year	Carmichael Times	7,000
2/13/2024	Ajna Glisic Of Sacramento County Department of Behavioral Health: Five Things I Wish Someone Told Me When I Was First Diagnosed With Mental Illness	Authority Magazine	500,000
3/18/2024	Wounded Healer	Sacramento Observer	50,000

Date	Title	Outlet	Impressions/ Audience
5/21/2024	How arts in the Sacramento region can improve our health	Sacramento News & Review	13,184
5/23/2024	'We can get through it together': Sacramento art exhibit puts spotlight on mental health	KCRA Online	1,892,840
TV Broadcast			
7/20/2023	Minority Mental Health Month	Univision	10,000
8/20/2023	Back to school and mental health: Tips for parents, students	ABC 10	879,151
9/25/2023	Suicide Awareness Month	Univision	10,000
10/17/2023	Mental Illness Awareness Week	Univision	10,000
5/23/2024	Mental Health Awareness Month Art Exhibit	KCRA	1,892,840

(8) Social Media and Microsite:

To support the project's stakeholder and media outreach efforts and engage with key audiences, the team continually updated the www.StopStigmaSacramento.org microsite, as well as Instagram, Facebook and X (previously Twitter) pages.

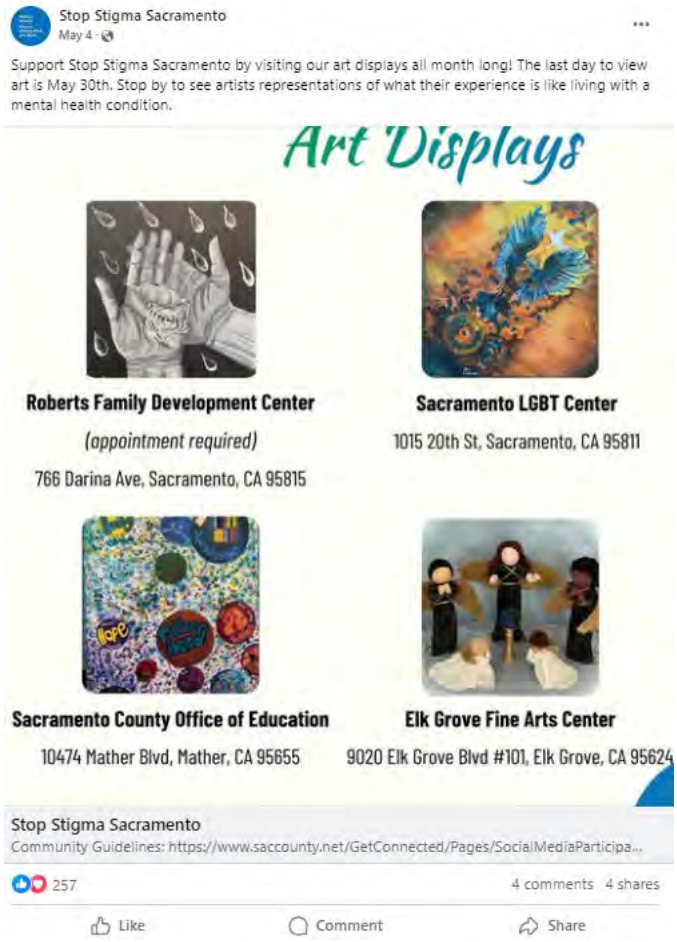
Instagram posts generated a total of 61.7K impressions*, down from 183.9K, while Facebook posts saw an increase, reaching 787K impressions, up from 214.8K. The drop in Instagram impressions from previous years is likely due to ongoing algorithm changes and the oversaturation of Reels on the platform. Audience insights on X are no longer available, and other analytics features are evolving under Elon Musk's leadership as CEO.

**Impressions are the number of times the project's content is displayed.*

Facebook:

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

- The page currently has 9,531 likes, slightly up from 9,478 likes from last year's EOY report and reached 787,030 people last year.
    - 82.4% of people who like the page are women, while 17.6% are men. (Of note, these metrics are binary, and we acknowledge that not all of our followers will identify with either of these genders. These metrics are supplied to us by Facebook.)
    - The highest demographic of women Facebook followers were aged 65+, representing 22.8% of female followers. The same is true for men, with 4.7% of male followers being age 65+.



    - The highest performing post was published on May 4, 2024.and promoting the project's art displays for Mental Health Awareness Month. The post reached 3,996 people. The post also received 265 post clicks and engagements.

X:

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

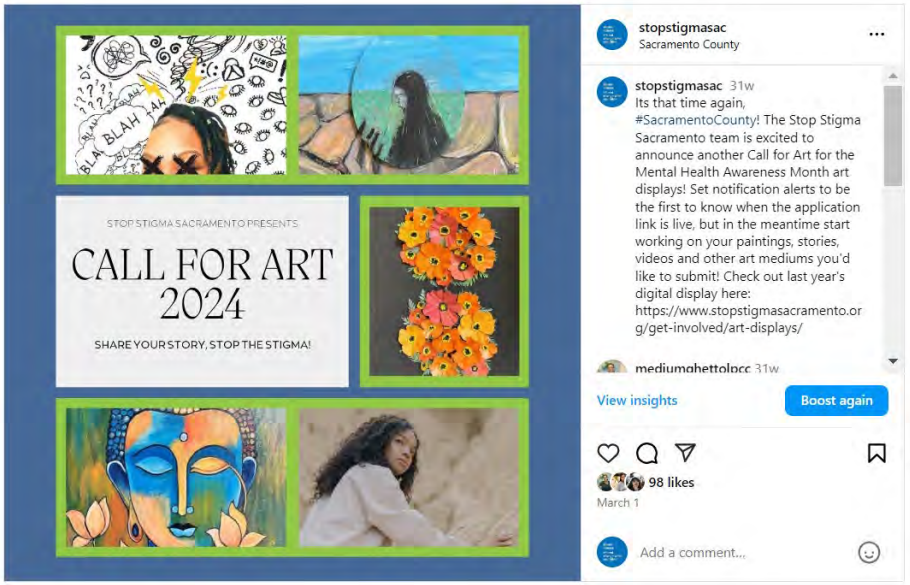
- The page has 1,056 followers, down from 1,086 followers noted last year.
- The top performing tweet was published on May 10, 2024, and promoted Stop Stigma Sacramento art displays at the Sacraments LGBTQ Center for Menal health Awareness month. It generated 425 impressions.

- **Note: Audience insights are no longer available on Twitter, and other analytics features are changing since Elon Musk has become CEO of Twitter/X.*

Instagram:

The team launched the project's Instagram account in October 2020, and since then, it has grown exponentially. To date:

- The page currently has 1.1K followers, up from 993, and reached 61.7K people in the last fiscal year.
- 82% of people who follow the page are women, while 18% are men.
- A majority of our audience live in Sacramento, Carmichael, and Citrus Heights.
- The highest-performing post was a call for art published during Mental Health Awareness Month. The post reached 2,639 people. The post also received 98 likes, 43 saves and 29 shares.



Microsite:

The project microsite, www.StopStigmaSacramento.org, serves as a public, online resource that provides supportive messaging, community event details, Speakers Bureau information, and more.

In September 2020, the team launched a refreshed version of the site, which has been continuously updated since then. Key features include community-specific webpages with tailored, in-language messaging for 13 target audiences. These audiences include residents who primarily speak Arabic, Cantonese, Hmong, Russian, Spanish, Vietnamese, and now Farsi, as well as those who speak English and identify as Black/African American, Latino, American Indian/Alaska Native, older adults, young adults, or members of the LGBTQ+ community. The microsite also hosts a library of mental health stories from Speakers Bureau members, conversation tips to help people reach out to someone struggling with mental health (available in each target language), a blog with posts from community leaders and Speakers Bureau members, and a list of vetted community resources and partners for support.

Engagement

To date, 518 people have submitted their email addresses through the site to receive project updates, up from 493 people in total last year.

Analytics (July 1, 2023 – June 30, 2024)

Note: *Google Analytics required a transition to a new measurement platform. Therefore, the below metrics reflect website traffic and insights from April 1, 2023).*

- Total website visits: 49K (up from 43K in the previous year).
- Unique page views: 110K
- The most popular page was the General Community page, with 7K page views.

  - Blog Landing Page 6K
  - LGBTQ Community Page 5K
  - Cantonese Speaking Community Page 4K
  - Spanish Speaking Community Page 3.5K
  - Vietnamese Speaking Community Page 3K
- Paid search generated the most page views, while direct, organic search and social media trailed behind.

Plot rows | Search... | Rows per page: 10 | Go to: 1 | 1-10 of 137

	Page path and screen class	Views	Active users	Views per active user	Average engagement time per active user	Event count All events	Key events All events	Total revenue
	Total	70,552 100% of total	49,137 100% of total	1.44 Avg 0%	15s Avg 0%	198,587 100% of total	0.00	$0.00
1	/	10,675	7,837	1.36	17s	32,938	0.00	$0.00
2	/communities/general-community/	6,696	5,870	1.14	7s	19,454	0.00	$0.00
3	/about/blog/	6,664	5,132	1.30	2s	18,179	0.00	$0.00
4	/communities/lgbtq/	4,593	3,393	1.35	4s	12,541	0.00	$0.00
5	/communities/漢語/	4,450	4,294	1.04	0s	13,153	0.00	$0.00
6	/communities/espanol/	3,529	3,241	1.09	3s	10,636	0.00	$0.00
7	/communities/tieng-viet/	3,082	2,516	1.22	2s	8,641	0.00	$0.00
8	/communities/african-american-black-community/	3,054	2,926	1.04	1s	8,943	0.00	$0.00
9	/services/	2,376	1,665	1.43	42s	5,430	0.00	$0.00
10	/communities/русский/	2,331	2,194	1.06	1s	6,828	0.00	$0.00

(9) Stop Stigma Sacramento Speakers Bureau:

Sacramento County Public Health continued to coordinate the Stop Stigma Sacramento Speakers Bureau in FY 2023-2024. The Stop Stigma Sacramento Speakers Bureau is funded by the Sacramento County Division of Behavioral Health Services through the voter approved Proposition 63, Mental Health Services Act (MHSA).

The “Mental Illness: It’s not always what you think” project was initiated by Sacramento County Department of Health Services/ Division of Behavioral Health Services (DHS/BHS) to:

- Reduce stigma and discrimination
- Promote mental health and wellness
- Inspire hope for people and families living with mental illness

The Stop Stigma Sacramento Speakers Bureau is operated by the Health Education Unit of Sacramento County Public Health.

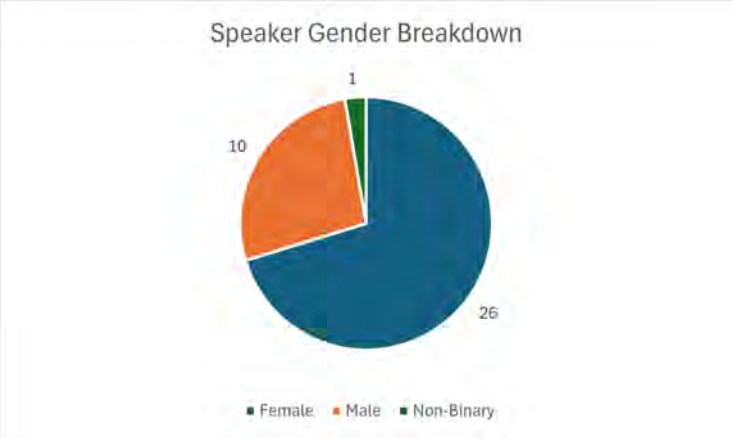
At the close of FY 2023-2024, the Stop Stigma Sacramento Speakers Bureau had trained 224 speakers, of whom 37 were actively speaking (participated in at least one tabling or speaking event) during the most recent fiscal year. We continued to recruit potential speakers via the StopStigmaSacramento.org webpage as well as at speaking and tabling events. This year extra effort was made to recruit speakers from project target demographics, including the Ukrainian- and Farsi-speaking communities. We received 12 potential speaker applications during FY 2023-2024, resulting in 6 active speakers.

The Speakers Bureau participated in 64 speaking events. Of these events 24 were virtual (37.5%) and 40 were in person (62.5%).

The Speakers Bureau participated in 36 in-person tabling events. Tabling events continue to be an excellent avenue for both speaking event and speaker recruitment.

*For a full list of speaking events please see the table at the end of the report. *

In FY 2023-24, Stop Stigma Sacramento Speakers Bureau speakers shared their personal stories 138 times at 64 events with a total audience attendance of over 2,913 individuals. 36 Tabling Events exposed to the project to over 15,300 attendees.



The Speakers Bureau maintained 37 active speakers during FY 2023-2024. Speakers were considered active if they participated in at least one speaking or tabling event during the FY. The Speakers Bureau brought on 6 new active speakers during the 2023-2024 FY. Our active speaker gender makeup consists of 26 females, 10 males, and 1 non-binary speaker. The Speakers Bureau continues to understand the need for more male and gender non-conforming speakers and will make this a top priority in FY 2024-2025.

Practice Sessions

Practice sessions continued to be an integral part of the Speakers Bureau during FY 2023-2024. Practice sessions were offered at least weekly and allowed both new and experienced speakers to practice and develop their presentations, meet and maintain contact with other speakers, and provide support and feedback to one another. During FY 2023-2024, 20 hours of practice sessions were performed. Practice sessions allowed program staff to preview and shape speaker presentation content to assure that it was consistent with the program goals and content guidelines.

Speakers Bureau Sponsored Events and Affiliated Activities

Community Events

In FY 2023-2024, the Speakers Bureau attended 36 tabling events and exposed to the project to over 15,300 attendees. The Bureau continued to attend general population community events, but also prioritized on participating in community events that focused on project target populations. Examples include the Exceptional Woman of Color Gala (African American/Black), Coming Out Day (LGBTQ & Transgender & Gender Non-Conforming) and Hmong University Student Association Culture Show (Hmong) to name a few. Tabling in these communities allowed the Speakers Bureau to share the message of mental wellness and build trust with community members. At these tabling events the Speakers Bureau shared mental health resources, passed out applications to join the Bureau, and networked for potential speaking events.

Speakers Bureau Coffee Chats

During FY 2023-2024 Coffee Chats were implemented to boost speaker engagement and allow project staff to conduct informal satisfaction check-ins.

Coffee Chats were hosted at the Starbucks on N Street in Midtown Sacramento. The site was chosen due to its central location and proximity to public transportation.

The Speakers Bureau hosted 6 Coffee Chats from December 2023-June 2024 (December (x2), February, March, April, June), which were attended by 10 unique speakers. The chats were held at various times to encourage participation, including before and after normal working hours.

The coffee chats were well received and have become a cherished monthly tradition. The chats also allow for newer speakers to network with experienced speakers, obtain advice on their stories, and hear about other stigma-reduction opportunities.

The Speakers Bureau plans to continue hosting Coffee Chats monthly or bi-monthly as budget allows.

Speaker Newsletter

A quarterly Speaker Newsletter was developed during the 2023-2024 FY in order to keep speakers up to date with Speakers Bureau related information. The speaker newsletter was sent to the 37 active speakers, as well as project staff. The newsletter was met with a positive response from speakers.

Two quarterly newsletters were published during FY 2023-2024. One in April 2024, and another in July 2024.

Newsletter content included:

- Upcoming Events (Coffee Chats, Trainings)
- Gift Card Increases
- Speaker Spotlights
- Speaker Media Involvement
- Upcoming O&T and Practice Sessions

As well as project contact information and speaker and event requests.

According to Mailchimp, the April newsletter had a 70.5% open rate with a 11.4% click rate, and the July newsletter had a 75% open rate with a 6.7% click rate. Content the speakers clicked on included the practice session schedule, new speaker application, the Stop Stigma Sacramento blog posts, and speaker media highlights.

Journey of Hope Art Event

The Journey of Hope art event was revitalized in FY 2023-2024. The reception will be held on October 5, 2024, with the exhibit being shown Wednesday-Sunday, October 2nd-31st, 2024.

Journey of Hope is a collaborative art event that pairs stories and poems of mental health with local artists who use the story as inspiration for an original art piece which are displayed through the month of October. Journey of Hope will consist of 65 participants and will feature 33 unique art pieces. All 33 writers participating in Journey of Hope 2024 have lived experience with mental illness.

In FY 2023-2024, special attention was paid to making the event more diverse and inclusive. The reception and exhibit will be held at The Gallery by We Are Sacramento which is an independent Art Gallery located in the lively Uptown District of Old North Sacramento. The Gallery is owned and operated by a coalition of BIPOC artists and business owners who share a deep love for Sacramento's art community and a passion. In an effort to improve recruitment for future shows, demographics of participants were collected for the first time in FY 2023-2024. Finally, headshots and bios were requested from participants in order to showcase the diversity of artists and writers.

The project leadership will work with the Journey of Hope committee and Edelman Public Relations to recruit and represent a diverse community for a Journey of Hope that will be relatable to a larger percentage of the community.

Mental Health Matters

Program Type: PEI Stigma and Discrimination Reduction

Program Description: Administered by Cal Voices, is a monthly television talk show, produced by mental health consumers and their family members, that highlights issues relating to mental health. The show also promotes and informs the community about available local resources, community events, and activities relating to mental health and wellness. Mental Health Matters℠ airs the first Saturday, at 7pm, every month on channel 17 for Sacramento area Comcast and local television subscribers and channel 14 for U-verse subscribers. Mental Health Matters shows are also accessible anytime on the Mental Health Matters' YouTube channel, www.youtube.com/@CalVoicesMHM.

In FY 2022-2023, television viewership was approximately 25,000 and YouTube viewership was 795. Demographics are unavailable due to program design.

Time-Limited Community Driven PEI Grants Program

Ages Served: Children, TAY, Adults, Older Adults

The Time-Limited Community Driven PEI Grants focus on the following PEI priorities:

- Childhood trauma prevention and early intervention to deal with the early origins of mental health needs
- Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs
- Culturally Competent and linguistically appropriate prevention and intervention
- Strategies targeting the mental health needs of older adults

Number Served: In FY 2023-24, 6,835 unduplicated clients were served across programs. Note: demographics were not collected on all programs due to the program design.

Characteristic	Agile Group		Be Love Holistic		Cal Voices		CA Black Women's Health Project		Coffee and Conversations Foundation		East Bay Asian Youth Center		Greater Sacramento Urban League		Health Education Council		Total	
	N= 107	%	N= 68	%	N= 119	%	N= 14	%	N= 218	%	N= 134	%	N= 53	%	N= 120	%	N= 833	%
Age Group																		
Children/Youth (0-15)	1	0.9%	0	0.0%	0	0.0%	0	0.0%	28	12.8%	45	33.6%	1	1.9%	0	0.0%	75	9.0%
TAY (16-25)	2	1.9%	1	1.5%	9	7.6%	1	7.1%	45	20.6%	88	65.7%	2	3.8%	0	0.0%	148	17.8%
Adults (26-59)	56	52.3%	64	94.1%	82	68.9%	10	71.4%	112	51.4%	1	0.7%	44	83.0%	117	97.5%	486	58.3%
Older Adults (60+)	48	44.9%	3	4.4%	28	23.5%	3	21.4%	33	15.1%	0	0.0%	6	11.3%	3	2.5%	124	14.9%
Unknown/Not Reported	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Ethnicity																		
Hispanic or Latino	4	3.7%	1	1.5%	20	16.8%	0	0.0%	17	7.8%	28	20.9%	0	0.0%	32	26.7%	102	12.2%
Non-Hispanic/Non-Latino	97	90.7%	61	89.7%	90	75.6%	14	100.0%	171	78.4%	99	73.9%	49	92.5%	87	72.5%	668	80.2%
Other	0	0.0%	0	0.0%	0	0.0%	0	0.0%	29	13.3%	0	0.0%	0	0.0%	0	0.0%	29	3.5%
More than one ethnicity	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Unknown/Not Reported	6	5.6%	6	8.8%	9	7.6%	0	0.0%	0	0.0%	7	5.2%	4	7.5%	1	0.8%	33	4.0%
Race																		
White	2	1.9%	0	0.0%	39	32.8%	0	0.0%	5	2.3%	1	0.7%	0	0.0%	9	7.5%	56	6.7%
Black or African American	101	94.4%	65	95.6%	32	26.9%	14	100.0%	181	83.0%	12	9.0%	52	98.1%	1	0.8%	458	55.0%
Asian	1	0.9%	0	0.0%	15	12.6%	0	0.0%	7	3.2%	89	66.4%	0	0.0%	1	0.8%	113	13.6%
American Indian or Alaska Native	1	0.9%	2	2.9%	2	1.7%	0	0.0%	10	4.6%	0	0.0%	0	0.0%	0	0.0%	15	1.8%
Native Hawaiian or other Pacific Islander	0	0.0%	0	0.0%	0	0.0%	0	0.0%	3	1.4%	0	0.0%	0	0.0%	0	0.0%	3	0.4%
More than one race	0	0.0%	0	0.0%	4	3.4%	0	0.0%	1	0.5%	0	0.0%	0	0.0%	0	0.0%	5	0.6%
Other	2	1.9%	0	0.0%	20	16.8%	0	0.0%	6	2.8%	32	23.9%	0	0.0%	106	88.3%	166	19.9%
Unknown/Not Reported	0	0.0%	1	1.5%	7	5.9%	0	0.0%	5	2.3%	0	0.0%	1	1.9%	3	2.5%	17	2.0%
Primary Language																		
English	105	98.1%	68	100.0%	108	90.8%	14	100.0%	202	92.7%	112	83.6%	53	100.0%	2	1.7%	664	79.7%
Spanish	0	0.0%	0	0.0%	1	0.8%	0	0.0%	3	1.4%	5	3.7%	0	0.0%	34	28.3%	43	5.2%
Vietnamese	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2	1.5%	0	0.0%	0	0.0%	2	0.2%
Cantonese	0	0.0%	0	0.0%	2	1.7%	0	0.0%	0	0.0%	4	3.0%	0	0.0%	0	0.0%	6	0.7%
Russian	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Hmong	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	9	6.7%	0	0.0%	0	0.0%	9	1.1%
Arabic	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Other	2	1.9%	0	0.0%	8	6.7%	0	0.0%	11	5.0%	2	1.5%	0	0.0%	84	70.0%	107	12.8%
Unknown/Not Reported	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2	0.9%	0	0.0%	0	0.0%	0	0.0%	2	0.2%
Sexual Orientation																		
Heterosexual or Straight	99	92.5%	55	80.9%	81	68.1%	13	92.9%	139	63.8%	98	73.1%	5	9.4%	95	79.2%	585	70.2%
Gay or Lesbian	0	0.0%	0	0.0%	5	4.2%	1	7.1%	2	0.9%	7	5.2%	0	0.0%	0	0.0%	15	1.8%
Bisexual	1	0.9%	6	8.8%	7	5.9%	0	0.0%	8	3.7%	9	6.7%	0	0.0%	0	0.0%	31	3.7%
Questioning or unsure	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Queer	0	0.0%	5	7.4%	2	1.7%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	7	0.8%
Another sexual orientation	2	1.9%	2	2.9%	8	6.7%	0	0.0%	36	16.5%	2	1.5%	0	0.0%	24	20.0%	74	8.9%
Unknown/Not Reported	5	4.7%	0	0.0%	16	13.4%	0	0.0%	33	15.1%	18	13.4%	48	90.6%	1	0.8%	121	14.5%
Current Gender Identity																		
Female	79	73.8%	68	100.0%	91	76.5%	14	100.0%	144	66.1%	67	50.0%	14	26.4%	1	0.8%	478	57.4%
Male	28	26.2%	0	0.0%	23	19.3%	0	0.0%	68	31.2%	61	45.5%	34	64.2%	119	99.2%	333	40.0%
Transgender	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.7%	0	0.0%	0	0.0%	1	0.1%
Genderqueer	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Questioning or unsure	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Another gender identity	0	0.0%	0	0.0%	4	3.4%	0	0.0%	1	0.5%	2	1.5%	0	0.0%	0	0.0%	7	0.8%
Unknown/Not Reported	0	0.0%	0	0.0%	1	0.8%	0	0.0%	5	2.3%	3	2.2%	5	9.4%	0	0.0%	14	1.7%
Veteran Status																		
Yes	7	6.5%	1	1.5%	3	2.5%	1	7.1%	5	2.3%	0	0.0%	2	3.8%	0	0.0%	19	2.3%
No	100	93.5%	67	98.5%	116	97.5%	13	92.9%	213	97.7%	134	100.0%	51	96.2%	120	100.0%	814	97.7%
Unknown/Not Reported	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%

Characteristic	Healthy Community Forum for the Greater Sacramento		International Rescue Committee		Iu Mien Community Services		Justice Teams Network		La Familia Counseling Center		Lao Family Community Development, Inc.		Mental Health California		Musical Instruments n' Kids Hands		Total	
	N= 446	%	N= 92	%	N= 187	%	N= 3	%	N= 1,816	%	N= 441	%	N= 2	%	N= 8	%	N= 2,995	%
Age Group																		
Children/Youth (0-15)	0	0.0%	4	4.3%	129	69.0%	0	0.0%	1	0.1%	50	11.3%	0	0.0%	8	100.0%	192	6.4%
TAY (16-25)	38	8.5%	20	21.7%	58	31.0%	0	0.0%	21	1.2%	64	14.5%	0	0.0%	0	0.0%	201	6.7%
Adults (26-59)	390	87.4%	61	66.3%	0	0.0%	2	66.7%	618	34.0%	315	71.4%	2	100.0%	0	0.0%	1,388	46.3%
Older Adults (60+)	18	4.0%	7	7.6%	0	0.0%	1	33.3%	1,176	64.8%	12	2.7%	0	0.0%	0	0.0%	1,214	40.5%
Unknown/Not Reported	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Ethnicity																		
Hispanic or Latino	90	20.2%	18	19.6%	37	19.8%	3	100.0%	1,784	98.2%	6	1.4%	0	0.0%	6	75.0%	1,944	64.9%
Non-Hispanic/Non-Latino	347	77.8%	63	68.5%	138	73.8%	0	0.0%	24	1.3%	434	98.4%	2	100.0%	2	25.0%	1,010	33.7%
Other	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
More than one ethnicity	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Unknown/Not Reported	9	2.0%	11	12.0%	12	6.4%	0	0.0%	8	0.4%	1	0.2%	0	0.0%	0	0.0%	41	1.4%
Race																		
White	166	37.2%	37	40.2%	21	11.2%	0	0.0%	10	0.6%	101	22.9%	0	0.0%	0	0.0%	335	11.2%
Black or African American	161	36.1%	3	3.3%	59	31.6%	0	0.0%	3	0.2%	0	0.0%	0	0.0%	2	25.0%	228	7.6%
Asian	12	2.7%	19	20.7%	3	1.6%	0	0.0%	8	0.4%	0	0.0%	0	0.0%	0	0.0%	42	1.4%
American Indian or Alaska Native	9	2.0%	0	0.0%	54	28.9%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	63	2.1%
Native Hawaiian or other Pacific Islander	0	0.0%	0	0.0%	8	4.3%	0	0.0%	1	0.1%	0	0.0%	0	0.0%	0	0.0%	9	0.3%
More than one race	4	0.9%	2	2.2%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	6	0.2%
Other	72	16.1%	22	23.9%	38	20.3%	3	100.0%	1,763	97.1%	340	77.1%	2	100.0%	4	50.0%	2,244	74.9%
Unknown/Not Reported	22	4.9%	9	9.8%	4	2.1%	0	0.0%	31	1.7%	0	0.0%	0	0.0%	2	25.0%	68	2.3%
Primary Language																		
English	437	98.0%	66	71.7%	168	89.8%	0	0.0%	24	1.3%	2	0.5%	0	0.0%	3	37.5%	700	23.4%
Spanish	6	1.3%	7	7.6%	8	4.3%	3	100.0%	1,781	98.1%	6	1.4%	0	0.0%	5	62.5%	1,816	60.6%
Vietnamese	0	0.0%	0	0.0%	2	1.1%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2	0.1%
Cantonese	1	0.2%	0	0.0%	2	1.1%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	3	0.1%
Russian	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Hmong	1	0.2%	0	0.0%	2	1.1%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	3	0.1%
Arabic	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Other	1	0.2%	18	19.6%	3	1.6%	0	0.0%	7	0.4%	433	98.2%	2	100.0%	0	0.0%	464	15.5%
Unknown/Not Reported	0	0.0%	1	1.1%	2	1.1%	0	0.0%	4	0.2%	0	0.0%	0	0.0%	0	0.0%	7	0.2%
Sexual Orientation																		
Heterosexual or Straight	420	94.2%	59	64.1%	92	49.2%	3	100.0%	1,798	99.0%	22	5.0%	0	0.0%	0	0.0%	2,394	79.9%
Gay or Lesbian	5	1.1%	1	1.1%	11	5.9%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	17	0.6%
Bisexual	8	1.8%	2	2.2%	25	13.4%	0	0.0%	0	0.0%	1	0.2%	0	0.0%	0	0.0%	36	1.2%
Questioning or unsure	0	0.0%	0	0.0%	13	7.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	13	0.4%
Queer	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Another sexual orientation	0	0.0%	8	8.7%	12	6.4%	0	0.0%	17	0.9%	418	94.8%	1	50.0%	0	0.0%	456	15.2%
Unknown/Not Reported	13	2.9%	22	23.9%	34	18.2%	0	0.0%	1	0.1%	0	0.0%	1	50.0%	8	100.0%	79	2.6%
Current Gender Identity																		
Female	86	19.3%	55	59.8%	103	55.1%	2	66.7%	1,298	71.5%	239	54.2%	1	50.0%	0	0.0%	1,784	59.6%
Male	355	79.6%	30	32.6%	52	27.8%	1	33.3%	518	28.5%	202	45.8%	1	50.0%	0	0.0%	1,159	38.7%
Transgender	0	0.0%	1	1.1%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.0%
Genderqueer	0	0.0%	0	0.0%	1	0.5%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.0%
Questioning or unsure	0	0.0%	0	0.0%	6	3.2%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	6	0.2%
Another gender identity	0	0.0%	0	0.0%	13	7.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	13	0.4%
Unknown/Not Reported	5	1.1%	6	6.5%	12	6.4%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	8	100.0%	31	1.0%
Veteran Status																		
Yes	15	3.4%	0	0.0%	0	0.0%	0	0.0%	7	0.4%	0	0.0%	0	0.0%	0	0.0%	22	0.7%
No	431	96.6%	92	100.0%	187	100.0%	3	100.0%	1809	99.6%	441	100.0%	2	100.0%	8	100.0%	2,973	99.3%
Unknown/Not Reported	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%

Characteristic	NAMI, Sacramento		Nation's Finest		ONTRACK, Program Resources		Opening Doors, Inc.		Project Optimism		Public Health Institute - Center for Collaborative Planning		Sacramento LGBT Center		Sacramento Youth Center		Total	
	N= 144	%	N= 180	%	N= 140	%	N= 104	%	N= 585	%	N= 39	%	N= 171	%	N= 61	%	N= 1,424	%
Age Group																		
Children/Youth (0-15)	0	0.0%	0	0.0%	0	0.0%	4	3.8%	585	100.0%	0	0.0%	7	4.1%	18	29.5%	614	43.1%
TAY (16-25)	2	1.4%	0	0.0%	29	20.7%	23	22.1%	0	0.0%	39	100.0%	75	43.9%	42	68.9%	210	14.7%
Adults (26-59)	95	66.0%	0	0.0%	104	74.3%	76	73.1%	0	0.0%	0	0.0%	76	44.4%	0	0.0%	351	24.6%
Older Adults (60+)	47	32.6%	0	0.0%	7	5.0%	1	1.0%	0	0.0%	0	0.0%	13	7.6%	0	0.0%	68	4.8%
Unknown/Not Reported	0	0.0%	180	100.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	1.6%	181	12.7%
Ethnicity																		
Hispanic or Latino	9	6.3%	0	0.0%	10	7.1%	87	83.7%	135	23.1%	12	30.8%	20	11.7%	13	21.3%	286	20.1%
Non-Hispanic/Non-Latino	126	87.5%	0	0.0%	115	82.1%	13	12.5%	419	71.6%	21	53.8%	101	59.1%	33	54.1%	828	58.1%
Other	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
More than one ethnicity	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Unknown/Not Reported	9	6.3%	180	100.0%	15	10.7%	4	3.8%	31	5.3%	6	15.4%	50	29.2%	15	24.6%	310	21.8%
Race																		
White	103	71.5%	0	0.0%	0	0.0%	3	2.9%	77	13.2%	10	25.6%	79	46.2%	0	0.0%	272	19.1%
Black or African American	9	6.3%	0	0.0%	129	92.1%	3	2.9%	309	52.8%	14	35.9%	33	19.3%	41	67.2%	538	37.8%
Asian	19	13.2%	0	0.0%	0	0.0%	10	9.6%	16	2.7%	2	5.1%	13	7.6%	10	16.4%	70	4.9%
American Indian or Alaska Native	1	0.7%	0	0.0%	7	5.0%	0	0.0%	8	1.4%	4	10.3%	8	4.7%	0	0.0%	28	2.0%
Native Hawaiian or other Pacific Islander	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.6%	2	3.3%	3	0.2%
More than one race	0	0.0%	0	0.0%	0	0.0%	0	0.0%	14	2.4%	0	0.0%	16	9.4%	0	0.0%	30	2.1%
Other	4	2.8%	0	0.0%	2	1.4%	7	6.7%	77	13.2%	5	12.8%	0	0.0%	7	11.5%	102	7.2%
Unknown/Not Reported	8	5.6%	180	100.0%	2	1.4%	81	77.9%	84	14.4%	4	10.3%	21	12.3%	1	1.6%	381	26.8%
Primary Language																		
English	144	100.0%	0	0.0%	140	100.0%	12	11.5%	569	97.3%	36	92.3%	160	93.6%	60	98.4%	1,121	78.7%
Spanish	0	0.0%	0	0.0%	0	0.0%	85	81.7%	7	1.2%	0	0.0%	2	1.2%	0	0.0%	94	6.6%
Vietnamese	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Cantonese	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Russian	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Hmong	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Arabic	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Other	0	0.0%	0	0.0%	0	0.0%	7	6.7%	7	1.2%	0	0.0%	8	4.7%	1	1.6%	23	1.6%
Unknown/Not Reported	0	0.0%	180	100.0%	0	0.0%	0	0.0%	2	0.3%	3	7.7%	1	0.6%	0	0.0%	186	13.1%
Sexual Orientation																		
Heterosexual or Straight	94	65.3%	0	0.0%	123	87.9%	9	8.7%	94	16.1%	17	43.6%	20	11.7%	46	75.4%	403	28.3%
Gay or Lesbian	13	9.0%	0	0.0%	0	0.0%	0	0.0%	1	0.2%	2	5.1%	43	25.1%	0	0.0%	59	4.1%
Bisexual	7	4.9%	0	0.0%	7	5.0%	0	0.0%	0	0.0%	5	12.8%	25	14.6%	4	6.6%	48	3.4%
Questioning or unsure	2	1.4%	0	0.0%	0	0.0%	0	0.0%	2	0.3%	2	5.1%	17	9.9%	1	1.6%	24	1.7%
Queer	2	1.4%	0	0.0%	0	0.0%	0	0.0%	10	1.7%	0	0.0%	17	9.9%	0	0.0%	29	2.0%
Another sexual orientation	15	10.4%	0	0.0%	2	1.4%	0	0.0%	1	0.2%	8	20.5%	31	18.1%	3	4.9%	60	4.2%
Unknown/Not Reported	11	7.6%	180	100.0%	8	5.7%	95	91.3%	477	81.5%	5	12.8%	18	10.5%	7	11.5%	801	56.3%
Current Gender Identity																		
Female	94	65.3%	0	0.0%	110	78.6%	52	50.0%	315	53.8%	15	38.5%	33	19.3%	31	50.8%	650	45.6%
Male	26	18.1%	0	0.0%	22	15.7%	20	19.2%	268	45.8%	18	46.2%	27	15.8%	29	47.5%	410	28.8%
Transgender	1	0.7%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	42	24.6%	0	0.0%	43	3.0%
Genderqueer	2	1.4%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	5	2.9%	0	0.0%	7	0.5%
Questioning or unsure	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	2.6%	4	2.3%	0	0.0%	5	0.4%
Another gender identity	15	10.4%	0	0.0%	7	5.0%	0	0.0%	2	0.3%	5	12.8%	42	24.6%	0	0.0%	71	5.0%
Unknown/Not Reported	6	4.2%	180	100.0%	1	0.7%	32	30.8%	0	0.0%	0	0.0%	18	10.5%	1	1.6%	238	16.7%
Veteran Status																		
Yes	2	1.4%	0	0.0%	3	2.1%	0	0.0%	0	0.0%	0	0.0%	3	1.8%	0	0.0%	8	0.6%
No	142	98.6%	0	0.0%	137	97.9%	104	100.0%	585	100.0%	39	100.0%	168	98.2%	61	100.0%	1,236	86.8%
Unknown/Not Reported	0	0.0%	180	100.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	180	12.6%

Characteristic	Sac Youth Mental Health		Safe Black Space		World Relief		Total	
	N= 1,315	%	N= 76	%	N= 192	%	N= 1,583	%
Age Group								
Children/Youth (0-15)	0	0.0%	0	0.0%	0	0.0%	0	0.0%
TAY (16-25)	0	0.0%	4	5.3%	3	1.6%	7	0.4%
Adults (26-59)	0	0.0%	59	77.6%	154	80.2%	213	13.5%
Older Adults (60+)	0	0.0%	13	17.1%	35	18.2%	48	3.0%
Unknown/Not Reported	1,315	100.0%	0	0.0%	0	0.0%	1,315	83.1%
Ethnicity								
Hispanic or Latino	0	0.0%	1	1.3%	0	0.0%	1	0.1%
Non-Hispanic/Non-Latino	0	0.0%	74	97.4%	192	100.0%	266	16.8%
Other	0	0.0%	0	0.0%	0	0.0%	0	0.0%
More than one ethnicity	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Unknown/Not Reported	1,315	100.0%	1	1.3%	0	0.0%	1,316	83.1%
Race								
White	0	0.0%	0	0.0%	149	77.6%	149	9.4%
Black or African American	0	0.0%	73	96.1%	0	0.0%	73	4.6%
Asian	0	0.0%	0	0.0%	0	0.0%	0	0.0%
American Indian or Alaska Native	0	0.0%	1	1.3%	0	0.0%	1	0.1%
Native Hawaiian or other Pacific Islander	0	0.0%	0	0.0%	0	0.0%	0	0.0%
More than one race	0	0.0%	1	1.3%	0	0.0%	1	0.1%
Other	0	0.0%	0	0.0%	43	22.4%	43	2.7%
Unknown/Not Reported	1,315	100.0%	1	1.3%	0	0.0%	1,316	83.1%
Primary Language								
English	0	0.0%	76	100.0%	0	0.0%	76	4.8%
Spanish	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Vietnamese	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Cantonese	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Russian	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Hmong	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Arabic	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Other	0	0.0%	0	0.0%	192	100.0%	192	12.1%
Unknown/Not Reported	1,315	100.0%	0	0.0%	0	0.0%	1,315	83.1%
Sexual Orientation								
Heterosexual or Straight	0	0.0%	59	77.6%	0	0.0%	59	3.7%
Gay or Lesbian	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Bisexual	0	0.0%	2	2.6%	0	0.0%	2	0.1%
Questioning or unsure	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Queer	0	0.0%	5	6.6%	0	0.0%	5	0.3%
Another sexual orientation	0	0.0%	8	10.5%	1	0.5%	9	0.6%
Unknown/Not Reported	1,315	100.0%	2	2.6%	191	99.5%	1,508	95.3%
Current Gender Identity								
Female	0	0.0%	51	67.1%	171	89.1%	222	14.0%
Male	0	0.0%	14	18.4%	0	0.0%	14	0.9%
Transgender	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Genderqueer	0	0.0%	1	1.3%	0	0.0%	1	0.1%
Questioning or unsure	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Another gender identity	0	0.0%	8	10.5%	0	0.0%	8	0.5%
Unknown/Not Reported	1,315	100.0%	2	2.6%	21	10.9%	1,338	84.5%
Veteran Status								
Yes	0	0.0%	1	1.3%	0	0.0%	1	0.1%
No	0	0.0%	75	98.7%	192	100.0%	267	16.9%
Unknown/Not Reported	1,315	100.0%	0	0.0%	0	0.0%	1,315	83.1%

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RAND CalMHSA California Mental Health Services Authority

Evaluation Report

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Evaluation of the California Multi-County Full Service Partnership Innovation Project

Serious mental illness (SMI), as defined by the Substance Abuse and Mental Health Services Administration, pertains to individuals age 18 and older who either presently have or have experienced within the past year a diagnosable mental, behavioral, or emotional disorder leading to functional impairment that hinders or restricts major life activities.[1] In 2019, 3.9 percent of adults in California experienced an SMI,[2] with higher prevalence among Californians with the lowest incomes.[3] Beyond income, another barrier to sustained wellness and recovery for individuals with SMI is co-occurring substance use disorders, creating complex needs for treatment.

California's Full Service Partnership (FSP) programs aim to address these barriers. FSP programs began as an effort to provide comprehensive and integrated care for people with SMI with the goal of reducing hospitalizations, justice involvement, and homelessness.[4] FSP programs provide comprehensive, recovery-oriented services and share a philosophy of individualized care, often employing intensive case management or assertive community treatment, a community-based service delivery model for people living with severe and persistent mental illness.[5] Some of the FSP programs are directly

KEY FINDINGS

- The initial cohort of six counties participating in the California Multi-County Full Service Partnership (FSP) Innovation Project successfully developed standardized definitions for key populations served, as well as common process and outcome metrics. A subset of the counties succeeded in developing program step-down and graduation guidelines, improved data collection processes, and referral guidelines or processes.
- After the initial development of planned changes to the FSP programs, the extent of on-the-ground implementation and sustainment varied by county and by innovation area.
- Outcomes for FSP participants improved during the first 12 months of involvement. Participants experienced reduced psychiatric inpatient admissions, increased stable housing, and decreased judicial system involvement.
- Improvement in individuals' outcomes increased after participation in the FSP Innovation Project, suggesting that the project facilitated improved quality of care.

operated by counties, while many are provided by nonprofit human services organizations contracted by counties.

FSP programs are funded by the Mental Health Services Act (MHSA), enacted by California voters in 2004 and generated through a 1 percent tax on annual personal income exceeding $1 million. The MHSA seeks to enhance the state's behavioral health system. The MHSA uses a comprehensive approach to better serve individuals and families dealing with serious mental health issues.[6] Community Services and Support constitutes one of the five funding components of the MHSA and encompasses three service categories, one of which constitutes FSP programs.[7]

FSP programs first began as a result of advocacy efforts in California; in 1999, legislation passed to support four pilot projects that funded comprehensive and integrated care for individuals who were at high risk of becoming unhoused, involvement with the justice system, and hospitalization.[8] As of 2021, more than 60,000 individuals were enrolled in FSP programs throughout California, and FSP programs represented a $1 billion annual investment in public funds.[9] There are various types of FSP programs, and each is designed for different age groups and subpopulations, as determined by each county and contracted provider within the county. This approach results in wide variations among FSP program design and eligibility across the state. Typically, people who are eligible for FSP programs have an SMI, are unhoused or at risk of being unhoused, are involved or at risk of being involved with the criminal justice system, and have had frequent visits to the emergency department.[10]

The fundamental principle of FSP programs is to do "whatever it takes" to partner with individuals on their paths to wellness or recovery. FSP programs can provide support beyond mental health services and integrated treatment; the programs can also assist with housing, employment, and education. FSP program services are designed to be as accessible as possible: They are culturally and linguistically appropriate, allow flexibility in terms of service delivery location (e.g., at home or in the community), and employ informal sources of care, such as peer and caregiver support groups. Some unique aspects of FSP programs are provider partnerships with participants and their families in the design of a treatment plan, a low staff-to-participant ratio, around-the-clock access to care, and a team-based approach that provides comprehensive and personalized care to each individual served.

In 2020, the Mental Health Services Oversight and Accountability Commission, the California Mental Health Services Authority (CalMHSA), and an initial group of six counties launched the California Multi-County FSP Innovation Project in partnership with Third Sector, a nonprofit organization that provides technical assistance to the public sector. In collaboration with Third Sector and one another, six counties established a collaboration model that fostered peer learning and county cooperation to enhance FSP programs. Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura counties initially participated in the project, with additional counties joining later. The FSP Innovation Project identified commonalities and differences among FSP programs and practices across counties to inform the design of FSP program innovations.

Third Sector conducted a landscape assessment to gather contextual information in 2020, then worked with the counties on implementation and sustainability of innovations in 2021. Overarching goals of the FSP Innovation Project were identifying a shared understanding of FSP's core components, improving consistency across FSP programs, and developing or enhancing operational processes that are data driven and outcome oriented. To this end,

Abbreviations

CalMHSA	California Mental Health Services Authority
CI	confidence interval
DBH	department of behavioral health
DCR	Data Collection and Reporting System
EHR	electronic health record
FSP	Full Service Partnership
KET	Key Event Tracker
MHSA	Mental Health Services Act
PAF	Partnership Assessment Form
SMI	serious mental illness

Third Sector provided all participating counties with technical assistance in defining key populations and in tracking process and outcome measures and metrics. In addition to these two core innovations, counties chose which additional innovations to work on, according to their individual needs. To this end, Third Sector also provided technical assistance on other topics that varied by county—including defining eligibility for FSP program services, developing criteria to be used to establish that individuals maintained eligibility for services (i.e., the reauthorization process), improving data collection processes, and developing guidelines for enrolling individuals into FSP programs or referring them to other programs. Table 1 shows the types of innovations the counties chose to work on.

This report covers the original six counties, whose locations represent the major regions of California, from Siskiyou County on the northern border of the state to Ventura County and San Bernardino County in Southern California (Figure 1). The participating counties also represent the range of populations in the state, from rural (Siskiyou County) to urban (Sacramento County).

CalMHSA contracted with RAND to conduct an independent, objective evaluation of the Multi-County FSP Innovation Project. RAND is a nonprofit and nonpartisan policy research organization that has extensive experience evaluating California's mental health programs.[11] The RAND team's evaluation examined the period directly following innovation implementation at the end of 2021 through 2023. We conducted a mixed-methods evaluation, with qualitative and quantitative components. The qualitative evaluation collected and analyzed data from semistructured, qualitative interviews with representatives from the participating counties, including department of behavioral health (DBH) leadership, FSP program administrators, and FSP program providers. The interviews focused on the strengths and weaknesses of the FSP Innovation Project, any impacts interviewees noticed in their programs, challenges that arose during the FSP Innovation Project, perceived sustainability of the work, and lessons learned across the counties. The quantitative component analyzed electronic health records (EHRs) and program data to examine the impact of FSP programs on participant outcomes and whether this

TABLE 1
Innovation Activities

Innovation Activity	Definition	Number of Participating Counties
Defining key populations	Standardize the definition of key populations served by FSP programs (e.g., individuals experiencing homelessness)	6
Defining and tracking outcome and process metrics	Identify standardized measures and metrics for tracking what services individuals receive and key health outcomes	6
Step-down (graduation) guidelines	Define stability and recovery indicators as criteria for FSP program graduation	5
Service requirements	Develop minimum FSP program service requirements to adopt as official guidance	3
Reauthorization process	Standardize the processes for reauthorizing FSP program enrollment for those who do not meet step-down criteria	2
Eligibility guidelines	Revise county-specific eligibility guidelines for enrollment in FSP programs	2
Data collection processes	Streamline existing processes or develop new ways of collecting data that can inform care decisions	2
Referral guidelines	Create a standardized FSP program referral form that captures key data	1
Referral and enrollment processes	Create a specific referral and enrollment process for youth FSP programs	1

FIGURE 1

The Six Counties Participating in California's FSP Innovation Project

impact changed over time as a function of participating in the FSP Innovation Project. In this report, we present the evaluation methodology, key findings, and conclusions from qualitative and quantitative analyses, followed by an overarching conclusion.

Qualitative Evaluation: Findings from Interviews

Qualitative interviews were used to answer evaluation questions regarding the implementation and impact of the Multi-County FSP Innovation Project, including strengths and weaknesses, perceived effects, barriers and facilitators, and lessons learned. We also inquired about the sustainability of the changes implemented.

Methods

Sampling and Recruitment

RAND worked with county points of contact to identify potential participants in the qualitative interviews. We requested that these people provide contact information for two groups of individuals: (1) county DBH leadership (i.e., individuals who could speak to how the FSP Innovation Project changed practices and about the strengths and weaknesses of the project) and (2) contracted providers (i.e., individuals who could speak to the impact of the FSP Innovation Project on providers and potentially on individuals served). Points of contact were not given a specific number of individuals to identify in each category, as counties varied in terms of the number of individuals in each of these two roles.

A member of the evaluation team reached out to potential participants via email up to five times to try to schedule an interview. The RAND team conducted 31 semistructured qualitative interviews about the FSP Innovation Project. The qualitative interview sample included 31 completed interviews involving DBH leadership and administrators (n = 14) and FSP providers (n = 17) across the participating counties. The team interviewed between five and eight people from Fresno, Sacramento, Ventura, and Siskiyou counties, and the team spoke with one to four people from San Bernardino and San Mateo counties. An additional 18 key informants were contacted via email up to five times and did not respond to the interview request.

Measures and Metrics

The RAND evaluation team developed a semistructured interview protocol that guided our discussions with participants; it was based on key goals of the FSP Innovation Project, outlined in Table 1. Specifically, the interview protocol covered new activities and changes made as part of the FSP Innovation Project, the implementation process, and any impacts the changes had on staff and for the populations they serve. We also discussed challenges to implementation and lessons learned, sustainability of the new activities, and strengths and weaknesses of the FSP Innovation Project.

Procedures

All of our evaluation procedures were approved by RAND's Human Subjects Protection Committee. Before conducting interviews, we obtained verbal consent from our interviewees. All of our interviews were conducted virtually via Zoom for Government, which is a RAND-approved secure platform for conducting qualitative interviews. Interviewers also received verbal consent to audio record interviews for note-taking purposes. Interviewers took detailed notes during the interview in a Microsoft Excel abstraction form designed based on the interview questions in our interview protocol and then went back to listen to recorded interviews as necessary to fill in the matrix with any important missing details.

In cases in which interviewees asserted that no changes were made as a result of the FSP Innovation Project (n = 2), our protocol was to ask about each activity and change in the interview protocol to ensure that we were not missing important details. With these interviews, we noted that no new changes were reported as the outcome of the interview.

Data Analysis

To analyze the data, our team used the abstraction form described above to pull out recurring themes across the interviews. After each interview, the interviewer filled out the form with the respondent's

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comments related to each topic covered. This method helped outline implementation changes across each county. The abstraction matrix also described implementation barriers and facilitators, the status of implementation changes, findings about sustainability of the changes, and opinions on the FSP Innovation Project overall. The RAND evaluation team used the abstraction spreadsheet for a rapid thematic analysis.[12] Each interviewee filled in their abstraction form, and one other interviewer read the notes to confirm interview results. Major findings were identified by RAND evaluators. Discussion among all team members was used to resolve disagreement about the findings. This method helped highlight implementation changes, challenges, facilitators, and lessons learned.

Results

We identified several broad themes about the strengths and challenges associated with the FSP Innovation Project. In this section, we first describe the accomplishments of the FSP Innovation Project, overall and in terms of the targeted innovation areas. We then discuss lessons learned from implementation, including implications for the overall sustainability of the interventions. We conclude with a summary of findings identified in the interviews.

Impact of the FSP Innovation Project

County leadership worked with Third Sector to identify areas to focus on for implementing interventions (see Table 1). All six participating counties committed to defining key populations and defining and tracking process and outcome metrics. In addition, counties selected a few additional interventions to implement locally based on their priorities. Five of the counties were working on step-down or graduation guidelines. Three addressed service requirements. Two counties focused on eligibility guidelines. Two counties worked on reauthorization processes. Two addressed improving their data collection processes, and one of them also worked on addressing referral guidelines. One county worked on its referral and enrollment processes for youth FSP programs.

Interviewees were asked to share their perspectives on strengths of the FSP Innovation Project and share what changes or new activities they undertook. Across participating counties, four key strengths of the FSP Innovation Project emerged. Information about these key strengths is presented below, followed by impact within the targeted areas of the project.

The Multi-County FSP Innovation Project Helped Reinforce the Program's Mission

FSP programs are designed to provide comprehensive health and social services to support individuals experiencing severe symptoms of SMI and having significant practical needs (e.g., people experiencing homelessness) across California. Some interviewees highlighted how participating in the FSP Innovation Project reminded county leadership, administrators, and providers of exactly what the FSP policies and regulations are and underscored the impor-

tance of focusing on mechanisms that best support their counties' most-vulnerable FSP recipients (e.g., strengths-based models of care). One leadership interviewee discussed the importance of achieving clarity "across the spectrum, from executives down to staffing to now know what an FSP means, what it entails, and what it should look like," as a strength of the project. **Participation reminded counties of their FSP programs' mission.** For example, one administrator remarked that FSP programs should "foster independence and [help individuals served] connect to their community" so that those in the program can ultimately utilize "the lowest level of care possible. . . . [The project was] a reminder to everybody that that's what we're doing."

The Multi-County FSP Innovation Project Facilitated Collaboration Across and Within County FSPs

Representatives from almost all counties spoke to the importance of the **knowledge sharing across and within counties** that was fostered by the FSP Innovation Project. One county administrator stated, "I think we had a lot of really good dialogue in the FSP Innovation Project, and it was great to talk to other counties and see how they were problem-solving. So, I think the information sharing" was a strength. Interviewees from two counties attributed this collaboration to the effective facilitation of the FSP Innovation Project by Third Sector. Within counties, a few interviewees specifically mentioned positive collaboration with providers. One provider shared that they "loved that the project got provider feedback" and that this feedback led to an end product for graduation guidelines. One FSP leader reported that a major accomplishment of the FSP Innovation Project was bringing together county leaders, FSP providers, and individuals served to design innovations. Another noted that such engagement increased FSP provider buy-in related to innovations.

The Multi-County Innovation Project Achieved Buy-in from Leadership, Administrators, and Providers on the Benefits of Increased Standardization and a Population-Based Approach to FSP Planning

Half of the participating counties specifically noted that a strength of the FSP Innovation Project was **increased standardization** (e.g., language, practices, and forms) related to FSP service provision. In general, interviewees reported that increased standardization would help FSP services be delivered to those with the highest level of need in a timely manner by ensuring that programs' capacities are not used up by those with less intensive service needs. One person in a leadership role shared that the project "provided a lot of clarity," and they "think that's had an impact" on developing clearer guidelines. One interviewee noted that increased standardization created an opportunity to serve larger portions of the population. They explained that, prior to standardization, it was easy to focus solely on individual-level needs rather than looking at what best serves the population overall. Creating a standard approach allows room for the diversity of different individuals who might benefit from FSP services, including those across both rural and urban localities.

"I think we had a lot of really good dialogue in the FSP Innovation Project, and it was great to talk to other counties and see how they were problem-solving. So, I think the information sharing" was a strength.

The guidelines developed were an "amazing outcome" of the FSP Innovation Project.

Third Sector Staff Were Helpful Facilitators for the Multi-County FSP Innovation Project, but Participants Felt That Project Processes Could Be More Efficient

Project participants identified several ways that **technical assistance from Third Sector was helpful** throughout the project. Some saw "value [in] . . . putting multiple subject-matter experts together and pulling on all their ideas to strategize." Others reported that they appreciated Third Sector's facilitation style. One county administrator said, "Third Sector was a pleasure to work with. They were both welcoming and noninvasive." Participants reported that Third Sector "did a good job of making the big group smaller" by identifying and connecting programs with similar goals and challenges. Others reported that Third Sector summarized and disseminated information that helped them process information shared by subject-matter experts and in discussions.

At the same time, some interviewees reported the process of developing innovations via the FSP Innovation Project could have been more efficient. Many interviewees commented on the pace and timing of the FSP Innovation Project. Some found that "repetition, a lack of clarity, [and] a lack of direction" during project meetings prevented important steps and slowed decisions about innovations. One interviewee described the process as "pretty slow moving" but noted that the project gained momentum once participants understood relevant program details. A different interviewee reported that they had hoped that the time invested in the FSP Innovation Project would have resulted in a "final product that we can use, . . . [such as] tool[s] that can support [project] work." Another interviewee suggested that inviting key decisionmakers and clarifying the roles of project participants may have improved the effectiveness of the project. That interviewee shared that it "would have been good to have one person per county who was the ultimate decider. It was difficult to have good final product [decided on by] committee."

Project Accomplishments by Targeted Innovation Activities

Table 1 provided an overview of the innovation activities targeted by one or more participating counties. In this section, we describe their accomplishments in each of these areas, in turn.

Defining Key Populations

Counties collaborated successfully to define six key populations for eligibility and outcomes tracking, using the best practices of the California Institute for Behavioral Health Solutions—a behavioral health consultancy with expertise in California systems of care—to aid their process.[13] The participating counties acknowledged that the absence of standardized definitions for their populations created difficulties in understanding who is eligible for FSP programs. Additionally, it was challenging to assess the effectiveness of programs across counties because their definitions do not always align. For instance, one county may consider living in a motel as stable housing, while another county may classify it as a form of homelessness—relevant to both key populations and outcome metrics (see the next section).

One county discussed the need to update guidelines for defining its key populations, noting that the guidelines developed were an "amazing outcome" of the FSP Innovation Project. Another county emphasized the importance of reminding its team to focus on its target population through a behavioral health lens. Although many individuals in the county have needs that the program can assist with, it is crucial to determine whether the FSP program is the appropriate program for them to participate in or whether better-suited programs exist that can also connect them to necessary resources, thus ensuring that the right participants are enrolled in the FSP programs.

One leadership interviewee noted, "We are now safeguarding this program for those who really need it." Ultimately, **the FSP Innovation Project aided in providing clarity and specificity around populations served** for the counties that prioritized this metric.

Defining and Tracking Outcome and Process Metrics

In this targeted innovation activity, the counties made efforts to improve their outcome and process metrics, with dedicated endeavors toward cross-county standardization and staff retraining. **The counties successfully identified common process metrics**, such as the number of encounters for services—for example, individual therapy, group therapy, rehabilitation services, medication management, case management, and flex funding provided to support housing. **Counties also established key outcome metrics**, including increased stable housing, reduced justice system involvement, reduced utilization of psychiatric services, and increased social connectedness.

Interviews revealed that most of the data needed to inform the cross-county metrics were already collected as part of standard FSP care and statewide requirements, so few changes to data collection and tracking processes were needed. However, the brief social connectedness measure required additional data collection—which most counties were not able to immediately implement. An interviewee also noted that the social connectedness measure "is sustainable and gives qualitative insight to case managers." Although most of the data already existed, it was not easy to pull them in a consistent manner that enabled examination of common metrics using the data. To this end, a Third Sector contractor worked with counties to develop a template that all counties could integrate into their processes, drawing on the common metrics identified through the FSP Innovation Project. Each county could upload its data and receive the same output for its outcome metrics.

Step-Down (Graduation) Guidelines

Overall, the FSP Innovation Project's **efforts to define graduation and step-down guidelines were successful**, with all five of the counties that engaged in this targeted innovation activity establishing revised guidelines. Three of the five participating counties reported successfully establishing and implementing common step-down guidelines as part of the innovation process. The other two counties shared that they developed guidelines but had yet to implement them. The impact of these guidelines appeared to vary across the counties. Leadership at one county described this process as "smoothing out the edges" around what graduation and stepping down looks like for their participants and that the multi-county work groups were helpful for developing definitions and gaining clarity around graduation.

Two of the interviewed counties identified best practices for graduation guidelines through a collaborative process between FSP program providers and county mental health departments. One county noted that the primary impact of these discussions was to increase awareness that FSP participants should not be indefinitely enrolled in FSP programs. An FSP program provider from another county described an increased effort to track progress and increase the number of graduations since being involved in those discussions. Similarly, another FSP provider reported that because of the FSP Innovation Project, the clinic spends time in staff meetings discussing participants and the frequency of contact to determine whether they could be eligible for a different program. The providers ask the question, "Does this person need us?" If not, "Do we have other, better-suited options for this client?"

Counties facilitated on-the-ground implementation of the new guidelines using such strategies as incorporating step-down criteria into provider contracts as optional guidelines, developing a training for providers and poster-sized guidelines to share with all agencies, developing and implementing a graduation binder, and offering a transition program prior to graduation. A county noted that the graduation binder was a small change that improved the step-down process and helped their participants "feel more hopeful. This binder shows them their journeys and the successes they have accomplished."

Service Requirements

Three counties worked to develop minimum requirements for services offered by FSP programs. The impact of this effort was mixed, with varying outcomes and efforts across the three participating counties. One member of county leadership reported that their county successfully established a set of mandatory FSP service requirements, which included psychotherapy. Another county representative explained that service requirements depend on local context and priorities and could include the percentage of field-based services, the availability of telehealth options, housing services, employment services, and peer supports. The third county did not discuss any innovations made to service requirements during our interviews. The low number of participating counties makes it challenging to interpret interview findings on service requirement innovation goals.

Reauthorization Process

Two counties worked to standardize the processes for reauthorizing FSP enrollment for those who do not meet step-down criteria. Again, the impact of the FSP Innovation Project was mixed for this targeted innovation activity. One county revised its reauthorization processes. This county collaborated closely with its providers and mentioned the need for good communication between leadership and providers when discussing precarious changes, such as reauthorizations, and emphasized that the goal of reauthorization is to build capacity in programs by ensuring that the right individuals get reauthorized and others are appropriately assessed for readiness to step down. The county has its FSP providers "submit info about why someone is in the program each year" to assess their reauthorization and explained that it is working with FSP programs to "help them see the impact of discharge." The other county did not report implementing changes to its reauthorization process. As above, it is challenging to interpret these findings, because only two counties targeted the reauthorization process as part of the FSP Innovation Project.

Eligibility Guidelines

Two counties worked to revise county-specific eligibility guidelines for enrollment in FSP programs. **Both counties successfully established FSP eligibility guidelines, and representatives reported that their work on FSP eligibility criteria was beneficial to their counties.** One interviewee discussed gaining "clarity" around eligibility guidelines for their programs. The individual discussed developing an improved and more clearly targeted population. The FSP Innovation Project helped streamline eligibility guideline processes. The other county discussed gaining clarity around the definitions of *homelessness* and *medical necessity*. Representatives were able to review the eligibility guidelines of other counties through the project and adjust some of their eligibility criteria. One interviewee shared that their "county developed very detailed guidelines."

Data Collection Processes

Two counties **successfully streamlined existing data collection processes or developed new ways of collecting data that can inform care decisions**. Representatives from one county shared that they developed a universal referral form in a centralized location so that participant-specific information can be assessed quickly as needed. They noted developing processes to collect data at multiple points so that participant goals can be recorded and assessed over time. An interviewee explained that "it takes a whole team to stay consistent in collecting information" and that "it helps us. It helps the client, and it helps the tracking system." Representatives from the other county described using the Level of Care Utilization System (LOCUS) form and score sheet and adding these data to their caseload tracking.

Representatives from one county explained that implementation is still in development and noted that it was too early to measure impact, and representatives from the other county said that their implementation is complete but did not mention any notable impact during the interview.

Referral Guidelines

One county aimed to create a standardized FSP referral form that captures key data. This county reported that it **successfully developed both paper and online referral forms and created revised referral processes**. The referral form included a checklist with referral criteria and the required referral processes.

Interviewees described the implementation process as ongoing and thus impact is not yet known.

Referral and Enrollment Processes

One county **successfully developed a referral and enrollment process for youth FSP programs**. First, the county reviewed referrals and noticed a lack of standardization across providers. The county "worked with providers to narrow down information needed" and implemented this feedback into its process. The county then established a revised process for reviewing the eligibility of referred youth for enrollment in FSP programs. It developed a checklist for use by DBH staff to support the screening process for program entry. The county also worked to train referring providers on the requirements for admission to youth FSP programs to reduce the number of inappropriate referrals that require screening.

Lessons Learned About the Implementation and Sustainment of Multi-County FSP Innovation Project Changes

The qualitative interviews conducted as part of this evaluation revealed several lessons related to the implementation and impact of the FSP Innovation Project.

Shared decisionmaking between FSP leaders and program staff facilitated implementation. Interviews highlighted the importance of including providers in the shared decisionmaking process. Some interviewees reported that engaging FSP providers in implementing innovations was generally well received by providers because the engagement was collaborative in nature and not punitive. Some credited Third Sector for working "so closely with providers throughout the process [that] the rollout of new policies and procedures went smoothly, with no pushback." Similarly, others reported that collaboration between FSP leaders and providers prevented implementation delays. For example, one county received feedback that the providers using a newly developed step-down tool found it to be helpful, especially because the providers helped co-design the product. Interviews revealed that it was important to communicate early and often with the providers who will be responsible for implementing new policies and guidelines. Those counties that had more provider input seemed to have an easier road to implementation.

Co-designing and implementing a countywide standardized referral form helped some counties improve their communication, participant data collection, and care coordination. One county worked collaboratively with its FSP program providers in reviewing each program's referral forms to identify common elements and reach a consensus on the most-essential items for inclusion in the final standardized referral form to be used by all FSP program providers. This co-design process highlighted the importance of communication between FSP leaders and FSP providers, as well as among FSP providers. This communication resulted in consensus about standard data elements in the referral form, despite program differences. One county reported that a paper-copy version of this standardized referral form had been implemented, although the online version of the form had not yet been incorporated into the county's EHR system. An interviewee noted, "It is so helpful to have something like this in place for care coordination." An interviewee from another county reported that the standardized form was very similar to the one that was previously used in their county, so the county did not expend resources on implementing a revised form. This example suggests that a shared decisionmaking process can facilitate implementation by easing the adoption of FSP Innovation Project innovations, increasing the spread of systems that work across counties, and reducing effort spent implementing unnecessary changes.

Some FSP providers reported insufficient dissemination of the innovations and training on how to implement them. Some counties took different approaches to disseminating innovations and training FSP staff. One county included the innovations it created for step-down criteria as a recommendation in its FSP provider contracts. The county also produced email notifications, informational posters, and provider trainings that were designed to disseminate information about project innovations. Interviews suggested that these dissemination materials were not sufficient to create changes among FSP staff. Some provider interviewees reported being unaware of FSP innovations, including step-down guidelines.

Overall, workforce recruitment and retention may be a critical factor in the successful implementation and sustainment of efforts associated with the FSP Innovation Project.

Other provider interviewees shared that counties did not follow up after the initial email announcement introducing these guidelines and resources.

Interviews revealed that FSP staff and providers require additional training on innovations developed during the FSP Innovation Project. One county's representatives discussed the need for additional funding to provide training around the new interventions and processes. A different county's representatives explained that staff were trained to ask about social connectedness, but the uptake had been inconsistent and challenging. Another county's representatives noted that "guidelines have been shared but we still need to work on developing trainings to ensure uniform implementation and uptake." Overall, both county leadership and providers discussed the need for training to understand and implement the innovations.

Some structural and contextual factors inhibited the implementation of innovations developed as part of the Multi-County FSP Innovation Project. Some interviewees reported challenges in making changes to **information technologies** to correspond with the innovations in defining and tracking FSP outcomes. For example, some counties noted that incompatibilities between state- and county-data EHR systems resulted in workflow problems and redundancies.

Workforce shortages were cited as a barrier to the implementation of the FSP Innovation Project. These shortages were reported by county administrators and FSP providers and appeared to be exacerbated during the COVID-19 pandemic. Two interviewees discussed spending months trying to fill positions in their FSP programs, which prevented them from implementing new processes or procedures related to the programs because they did not have the adequate staff to train and implement the changes. For example, one county developed a new referral and enrollment process that required county staff to review incoming participant referrals. A preexisting staffing shortage resulted in delays in the review process. As a result, this county reassigned county staff to conduct these reviews, taking these staff away from work on other important projects. Another county reported that staffing shortages were a barrier to implementing FSP service requirements because county FSPs did not have the bandwidth to meet these requirements. Other interviewees highlighted burnout as a significant workforce issue that is a barrier to sustaining innovations from the FSP Innovation Project, with some being reluctant to ask more of strained staff. Overall, **workforce recruitment and retention** may be a critical factor in the successful implementation and sustainment of efforts associated with the FSP Innovation Project.

Participants in the FSP Innovation Project also suggested that the sustainment of project efforts would be influenced by larger policy and program changes in California. Interviews revealed that impending statewide changes to mental health care financing and health department recordkeeping preceded or coincided with intended changes proposed by the FSP Innovation Project. In multiple interviews, respondents reported concerns about dealing with the possible impact of statewide payment reform at the same time that they were implementing FSP innovations. Program administrators and providers also reported that changes in their countywide EHR platform may also create strains that disrupt the sustainment of efforts associated with the FSP Innovation Project. Staff reported feeling that they

had lower capacity to implement changes developed by the FSP Innovation Project because they focused resources on preparing for these other wide-scale changes. One county leader pointed out that "implementation of something like this has to be timed really well" to prevent contextual factors from disrupting progress.

Early Lessons Learned About the Impact of Innovations

Innovations developed as part of the Multi-County FSP Innovation Project increased adherence with guidelines on the enrollment, retention, and graduation of individuals served. A major focus of the FSP Innovation Project was the standardization of criteria used to determine which individuals served were eligible for FSP services. In general, interviews with county leaders and FSP providers indicated that the innovations designed as part of the FSP Innovation Project have resulted in changes to the enrollment, retention, and graduation practices used by FSPs. Broadly, the interviews suggested that FSP services are more consistently reserved for people who have the highest severity of mental health symptoms and co-occurring vulnerabilities related to housing instability, frequent hospitalization, and interactions with the criminal justice system. FSP providers shared that there is a high demand for services for people who do not meet this overall criterion but that the innovation process resulted in higher levels of adherence to enrollment, retention, and graduation guidelines. One interviewee noted that some individuals served "want housing but don't want to engage in any form of treatment. We have to remind the [individuals served] and referring parties that we are not a housing program; it is only one component of our program." Several county leaders and providers reported that the FSP Innovation Project resulted in collaborative audits of the census of individuals served to ensure that they met criteria for FSP services. Stated differently, **the FSP Innovation Project resulted in changes to ensure that the high-intensity services provided by FSP programs are reserved for the most-vulnerable individuals served**.

These innovations also created unintended service gaps. Refining enrollment criteria to ensure that FSP programs are provided only to those with severe symptoms resulted in an unintended gap in services for those with moderately severe symptoms. For example, one county reported that youth ages 0–5 with moderately severe symptoms had previously been served by a county FSP program. After changes to enrollment guidelines, these youth were no longer eligible for FSP and instead were placed on waiting lists for other programs. This county reported that families of children with moderately severe symptoms now struggle to find providers trained in evidence-based practices to care for these children. More broadly, several interviewees reported that these changes to enrollment created problems in connecting individuals with care in a timely manner.

Interviews revealed a similar issue associated with innovations in graduation criteria. One interviewee stated that the "lack of [an] intermediate step

The interviews suggested that FSP services are more consistently reserved for people who have the highest severity of mental health symptoms and co-occurring vulnerabilities related to housing instability, frequent hospitalization, and interactions with the criminal justice system.

Improvements in adherence to FSP enrollment, reauthorization, and graduation criteria created a dilemma for programs that lacked alternative practical supports for those who did not meet FSP enrollment criteria and for those who were ready for graduation from FSP programs.

between [the FSP] level . . . [and lower levels of care] . . . makes implementation of graduation difficult. It feels like a big leap" for individuals who received intensive support from FSPs to transfer to typical outpatient treatment. Other interviewees reported that they had difficulty finding lower-intensity services that had availability to enroll those individuals who graduated from FSPs. Some FSP providers reported that individuals served were hesitant to lose the long-standing, trusting relationships that they developed with FSP providers and to establish relationships with new providers upon meeting graduation criteria. Some providers reported that they took steps to fill the gap created by the FSP Innovation Project. For example, some reported that they supported individuals served through the transition to new providers and remained in contact with them until they were engaged in appropriate lower-level care. FSP providers reported that they took these steps to ensure that individuals who graduate from FSPs do not experience a relapse in the severity of their symptoms as a result of transitioning to a lower level of care.

FSP administrators and providers reported that programs had historically offered services to those who did not meet criteria for FSP programs to more easily provide participants with housing, transportation, and financial support. Improvements in adherence to FSP enrollment, reauthorization, and graduation criteria created a dilemma for programs that lacked alternative practical supports for those who did not meet FSP enrollment criteria and for those who were ready for graduation from FSP programs. For example, FSP providers pointed out that when individuals served by FSP programs experience improvements in their mental health and functioning, they may still need housing support. One service provider said, "We can refer [individuals served] back to DMH [the Department of Mental Health—i.e., a DBH], but they can't afford to spend $1,400 to $1,500 on an apartment, because that is all of their income." Many reported that these individuals served could lose vital housing and transportation supports if they are referred to a lower-intensity level of care.

Representatives from some counties reported that they faced policy and administrative barriers to addressing the practical needs of individuals who did not qualify for or who graduated from FSP programs. FSP administrators reported that, with the exception of FSP funding, policies create separate pools of funding for mental health services and housing services. Interviewees reported that one county had housing funds for program participants but faced administrative barriers in using these funds. One leader reported that the "biggest change is around our . . . use of basic-needs funding. There was a lot of underutilization of those funds. . . . We are waiting on fine tuning some stuff with our fiscal department to be able to use" this funding more efficiently. **Policy changes may be needed to increase access to practical and financial supports for people who do not meet enrollment criteria for, or who graduate from, FSP programs.**

FSP administrators and providers advocated further development of a full continuum of care to mitigate service gaps caused by improved adherence to FSP criteria. FSP programs that had good access to a full continuum of care that spanned low- to high-acuity services reported fewer gaps in services for people who did not qualify for FSP services or who were ready for graduation from an FSP program. FSP providers described a need for a care continuum in which individuals served could work with a single provider while receiving more or less intensive care based on their needs. Individuals served would benefit because they would not be required to switch providers when they moved across different levels of care. Developing a full continuum of care may also address concerns about supportive housing and transportation needs for individuals served (see the previous section). Additionally, having a full a continuum of care within a given provider organization would facilitate more rapidly increasing the intensity of services for individuals served when their symptoms or circumstances changed. For example, when discussing criteria that disallow the reauthorization of services to people who have not attended an FSP appointment, one interviewee said, "I would always fear that, at the 60-day mark, we discharge [an individual served by an FSP program who has engaged in care], and a week later they are hospitalized and have to be reenrolled" and experience a delay in receiving services. Organizations that offered FSP services as part of a full continuum of care could avoid delays in transitioning individuals to both higher- and lower-acuity services.

Discussion

Interviews with county staff and FSP providers highlighted important interventions that were implemented across the six participating counties. **Counties successfully developed standardized definitions for key populations:** individuals experiencing homelessness, those with justice system involvement, and those at risk of experiencing homelessness and justice system involvement. This standardization will help create clarity around eligibility for programs and the effectiveness of FSP programs. **All counties successfully identified common process and outcome metrics**, which can be used to measure the success of their programs and facilitate cross-county conversations about FSP processes and outcomes. Several **counties succeeded in creating step-down and graduation guidelines to clarify when program participants are ready to move to a lower level of care and free up FSP capacity** for those who need the services. With respect to innovations pursued by a small number of counties, two counties successfully implemented improved data collection processes and two others reported changes in referral guidelines or referral and enrollment processes. Counties varied in the extent to which they implemented standardized service requirements and reauthorization processes.

After the initial development of innovations, there were variations in the sustained success of implementation efforts, with some counties reporting little on-the-ground implementation of the processes designed in the innovation projects and others sharing success stories with implementation and confidence in sustainability over time. **Involving providers in the changes seemed to facilitate the successful implementation of innovations.**

Findings suggest that **increased provider training may facilitate on-the-ground implementation of the innovations**. It will also be important for future innovation projects to **address step-down options** for those who do not require FSP-level care, in light of concerns about service gaps as an unintended consequence of increased attention to enrollment and graduation criteria. These gaps in care cannot be fully addressed by the Multi-County FSP Innovation Project, but they contributed to concerns for the ongoing sustainability of the successfully made changes.

Quantitative Evaluation: Findings from Patient Data

The quantitative component of the evaluation analyzed EHR and program data to answer evaluation questions about (1) the impact of FSP programs on participant outcomes and (2) whether this impact changed over time as a function of Multi-County FSP Innovation Project participation. We conducted a pre-post comparison of key outcomes for 2,555

FSP program participants, looking at changes within individuals served over time.

Methods

Study Data

We evaluated the effectiveness of FSP programs on improving participant outcomes by comparing data that covered the year prior to a participant's enrollment in an FSP program with data covering the first 12 months after enrollment to assess whether outcomes improved after enrollment. Our analyses relied on two primary data sources: the MHSA FSP Data Collection and Reporting System (DCR) and EHRs from the counties' DBHs. The DCR system includes the Partnership Assessment Form (PAF), which is completed when a participant enrolls in an FSP program; the Quarterly Assessment Form (3M), completed every three months of participation; and the Key Event Tracker (KET) data that contain records for each change in a participant's housing, employment, or education. The EHR data identify each time a service is provided to an FSP participant and includes the type of service and the date on which it was provided.

We also evaluated the potential impact of a county's participation in the FSP Innovation Project by comparing changes in FSP participant outcomes prior to the start of the project with outcomes after the project ended.

The FSP Innovation Project's design and implementation phase with the first cohort of counties took place from October 2020 through October 2021, and we requested DCR and EHR data for all FSP participants who enrolled at any time from July 1, 2019, through October 31, 2023.

Outcome Metrics

The outcome metrics selected for the FSP Innovation Project were associated with the success of FSP programs and were carefully aligned with the primary objectives of the DBHs and FSP programs. The metrics were selected by participating counties through a collaborative process guided by Third Sector (Table 2). The outcomes were to increase stable housing, reduce the utilization of inpatient psychiatric services, reduce justice system involvement, and increase social connection.

We assessed the impact of FSP participation on these outcomes by comparing their values in the year prior to enrollment to the first year of participation. All outcome metrics with the exception of social connection were tracked in the DCR data. Data for the 12 months prior to enrollment were captured on the PAF through a series of items that covered housing status, inpatient psychiatric admissions, and arrests.

TABLE 2

Outcome Metrics Selected by the FSP Innovation Project

Outcome Metric	Definition
Days of stable housing	The number of days during the 12 months pre- and postenrollment that a participant experienced stable housing in a home in which they hold the lease or share in the rent or mortgage, with adult family members, or in a single-room occupancy (must hold lease)
Number of mental health inpatient admissions	The number of times during the 12 months pre- and postenrollment that a participant was admitted to a psychiatric hospital or general hospital to receive psychiatric care
Number of mental health inpatient days for those with an admission	The number of days during the 12 months pre- and postenrollment that a participant with an admission experienced in psychiatric hospitals or general hospitals to receive psychiatric care
Ever arrested (yes or no)	Was the participant arrested during the 12 months pre- and postenrollment?
Number of arrests for those with at least one	How many times was the participant arrested during the 12 months pre- and postenrollment?
Social connectedness (Likert scale, never to always)	How often did the participant get the social and emotional support they needed during the 12 months pre- and postenrollment?

NOTE: DCR PAF and KET data are used to compute all but social connectedness. Counties planned to add social connectedness to the 3M assessment, but we did not receive any data that included this measure.

These items had the following structure: "How many times in the past 12 months did you live with a family member?" and "How many days during the past 12 months did you live with a family member?"

The 12 months prior to a participant's enrollment was the only period covered by items in the PAF, so we created outcome metrics before and after enrollment that covered 12 months. Data for the first 12 months of participation after enrollment were captured in the KET. Even though data included enrollment through October 2023, we limited our study to participants who enrolled July 2019 through October 2022 to observe a complete 12 months of FSP participation. For participants who enrolled through October 2022, we used KET data through October 2023 to compute the outcomes following enrollment.

Counties agreed to add a measure of social connection as part of the FSP Innovation Project, but adding a new measure was challenging, and the counties were unable to implement this during the data collection period we examined. Therefore, we were unable to assess the impact of FSPs on social connection.

Service Utilization

FSP participants commonly receive case management, rehabilitation, medication management, and psychotherapy, among other services. We used EHR data to count the number of each type of service FSP participants utilized during the first 12 months of their enrollment and then used these counts to evaluate whether there is an association between utilization of these services and outcomes for FSP participants. FSP participants received services after enrollment, so we did not have EHR service data for the time prior to enrollment. We were unable to discern a causal relationship between receiving services and participant outcomes because we could only observe both, without differentiation, during the same period.

Although our outcome metrics were consistently coded in the DCR data, there was variation in how counties recorded services. The DCR assessments and KET data were specified by the state. Counties were able to add a few measures of their own (such as social connection), but the existing measures were coded the same. There was no such consistency in the EHR data because of differences in how counties coded their services and in EHR providers. We reviewed service codes in the EHR data we received and classified them into the following categories:

- case management
- individual therapy
- group therapy
- medication management
- rehabilitation services.

Housing services were not separately identified from case management in most counties' EHRs. Consequently, we used case management services rather than housing services as a predictor of housing outcomes.

Statistical Models

To estimate the association between FSP participation and changes in outcomes, we compared each of the outcomes in Table 2 for the 12 months *prior* to FSP enrollment with the first 12 months of FSP participation. This model answered the question, "Did FSP participants demonstrate improvement before versus after participation?" In other words, did they get better over time?

We estimated models with a pre-post structure:

$$Y_{it} = m_0 + m_1 post_{it} + m_2 y2020_i + m_3 y2021_i + m_4 y2022_i + \varepsilon_{it},$$

where Y_{it} is the outcome for participant i in time period t (pre-post), $post_{it}$ is an indicator for the first 12 months after enrollment in an FSP program, and $y2020_i$–$y2022_i$ are indicators for the year in which participant i enrolled. The coefficient estimate, m_1, is our estimate of the association between participation in an FSP program and each outcome. We included calendar-year indicators to control for state-level external effects, such as state policies or societal changes, that could also influence the outcomes. For instance, a statewide initiative about housing could inadvertently affect the housing stability outcomes for FSP participants, and the COVID-19 pandemic could affect service utilization. By controlling for these external factors, the model seeks to isolate the effect of FSP participation from other statewide changes. We did not include county indicators to

Participants experienced an average increase of 128 days of stable housing in the first year of FSP participation. The total number of psychiatric admissions decreased on average by 2.5 admissions.

keep the focus on the general effect of FSP participation rather than on comparing performance across different counties. This approach aligns with the report's goal of evaluating the statewide effectiveness of FSP programs, assuming that a program's influence on outcomes is consistent across California. We used maximum likelihood to estimate the association and cluster standard errors by county and participant identification number to account for the hierarchical structure of the data.

To estimate the association between FSP service utilization and participant outcomes, we focused on the first 12 months of FSP participation and regressed each outcome on the number of times a participant received each type of service:

$$Y_i = m_0 + m_1 casemanagement_i + m_2 individualtherapy_i + m_3 grouptherapy_i + m_4 rehabservices_i + m_5 medicationmanagement_i + m_6 y2020_i + m_7 y2021_i + m_8 y2022_i + \varepsilon_i,$$

where Y_i is the outcome for participant i, each of the five service types represent the count of services received by participant i during the first 12 months of FSP participation, and $y2020_i$–$y2022_i$ are indicators for the year in which participant i enrolled. The coefficient estimates, m_1–m_5, are the estimates for how the intensity and type of services provided by FSPs are associated with participant outcomes. We used maximum likelihood to estimate the association and cluster standard errors by county to account for the hierarchical structure of the data.

To estimate the association between a county's participation in the FSP Innovation Project starting October 2021 and potential changes in FSP participant outcomes, we compared each FSP participant's outcomes before and after enrollment in a program and added an indicator that identifies when that enrollment occurs in months after the start of the FSP Innovation Project. This model answers the question, "Is participation in the FSP Innovation Project associated with greater improvement in outcomes over time?"

We estimated models with a pre-post structure and included a term that captures the interaction between the first 12 months of FSP participation (*post* from our equation above) and the year of enrollment after the end of FSP Innovation Project (November 2021 through October 2022):

$$Y_{it} = m_0 + m_1 post_{it} + m_2 post_{it} X innovation_t + m_3 y2020_i + m_4 y2021_i + y m_5 y2022_i + \varepsilon_{it},$$

where Y_{it} is the outcome for participant i in time period t (pre-post enrollment in an FSP program). As in the previous equation, $post_{it}$ is an indicator for the first 12 months after enrollment in an FSP program. The interaction term, $post_{it} X innovation_t$, is the interaction between the first 12 months after enrollment in an FSP program for a participant and the end of county participation in the FSP Innovation Project. This term captures moderation of the FSP program effect—whether the effect increases or decreases as a function of FSP Innovation Project participation. The terms $y2020_i$–$y2022_i$ are indicators for the year in which participant i enrolled. The coefficient estimate, m_2, is our estimate of the incremental association between participation in an FSP program and each outcome after the end of the FSP Innovation Project.

The forms of the models depend on the distributions of the outcomes. The number of days of stable housing and the length of stay for psychiatric admissions are distributed normally and use linear models to estimate these associations. The number of psychiatric admissions is a count of relatively rare events and has an excess of zeros, so we used zero-inflated negative binomial models to estimate these associations.[14] Whether a participant is arrested is a yes-no outcome. We used a common approach in modeling outcomes of this form and estimated this association with a logit model. We reported the average marginal effect, or the average effect in the population of FSP participants of a change in the variable of interest on the outcome.

Results

Data Description

We received DCR data for 2,555 FSP participants enrolled from July 2019 through October 2022, across six participating counties. We needed each participant's PAF record to identify outcomes prior to enrollment in an FSP program, and we received PAF records for 2,143 (84 percent) of the participants, so our analyses are based on this subgroup of participants. To identify outcomes during FSP participation, we needed both the DCR KET data on key events, such as changes in housing status, and the EHR data. Among the participants we analyzed, 69 percent had at least one event record, and 88 percent had at least one EHR record.

KETs are completed only when a key event occurs, such as a change in housing status. The absence of a KET form is meant to indicate that there was no change to record, and we analyzed the data assuming that this was accurate (i.e., no KET indicated no event). However, a limitation to this data collection method is that we could not definitively distinguish between whether the individual served did not experience any events or whether they experienced an event but a form was not completed. However, we think that if there are missing data, the evaluation findings are unlikely to be affected in a systematic manner.

Association Between Changes in Outcomes and Participation in FSPs

FSP participants experienced significant improvement on average for all of the outcomes we evaluated, except length of stay in a psychiatric inpatient setting (Table 3). The changes reported in the last column on the table represent the average change after controlling for the year of enrollment in an FSP. Participants experienced an average increase of 128 days of stable housing in the first year of FSP participation (95 percent confidence interval [CI]: 120 to 136 days), compared with the 12 months prior to enrollment. Both the likelihood of being arrested (–26 percent; 95 percent CI: –23 percent to –29 percent) and the number of arrests (–0.5, 95 percent CI: –0.2 to –0.8) among those with any arrest decreased on average for FSP participants. The total number of psychiatric admissions decreased on average by 2.5

TABLE 3

Change in Participant Outcomes from One Year Prior to Enrollment in an FSP Program and One Year Postenrollment

Outcome Metric	Average During Year Preenrollment	Average During Year Postenrollment	Change in Average Value After Controlling for Year of Enrollment[a]
Number of days of stable housing	120.6	248.8	128.2***
Ever arrested (%)	31.0	5.1	–26.4***
Number of arrests for those with at least one	1.8	1.4	–0.5**
Number of psychiatric inpatient stays	1.6	0.1	–2.5***
Length of stay for those with an admission (days)	55.6	41.0	–15.3

NOTE: * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

[a] Estimated difference in outcomes (postenrollment – preenrollment) for FSP participants based on a regression model controlling for year of enrollment. The values reported in this table are the marginal effects from the model estimates based on the maximum likelihood, with standard errors clustered at the county and participant levels.

admissions (95 percent CI: –1.7 to –3.3), but the average annual length of stay for those who had at least one admission did not change significantly.

Service Utilization

Table 4 summarizes utilization by FSP participants of key services during the first 12 months following their enrollment. Case management was the most common service, utilized by 94 percent of FSP participants, with an average of 22 services or roughly once every two weeks. Rehabilitation services were also utilized an average of 22 times during the year by 84 percent of participants. Most participants (82 percent) utilized medication management services, and fewer than half (41 percent) utilized individual or group therapy. It is possible that participants received case management as part of rehabilitation or medication management services, and it also possible that participants received additional services during a visit that were coded as case management.

Association Between Service Utilization and Changes in Outcomes

Service utilization is associated with each of the outcomes we evaluated (Table 5). Each use of therapy by an FSP participant is associated with an average decrease of 0.009 arrests (95 percent CI: –0.0001 to –0.016), an average decrease of 0.01 psychiatric inpatient admissions (95 percent CI: –0.0004 to –0.01), and an average decrease of one day in the length of stay for those who were admitted (95 percent CI: –0.7 to –1.3). Medication management utilization is

TABLE 4

Summary of Key Service Utilization in the 12 Months Following Participant Enrollment in an FSP Program

Service	Enrollees with Any (%)	Average Number of Services	Minimum	Median	Maximum
Therapy	40.6	4.9	0	0	183
Medication management	82.4	9.1	0	5	114
Rehabilitation services	84.4	22.2	0	13	281
Case management	93.6	21.9	0	13	265
Any of above types of services	100.0	59.7	1	44	416

TABLE 5

Estimated Difference in Participant Outcomes Associated with Amount of Service Utilization

Services	Days of Stable Housing	Any Arrests? (%)	Number of Arrests Among Those with Any	Number of Psychiatric Inpatient Admissions	Length of Stay (Days) for Those with an Admission
Therapy	–0.1	–0.2	–0.009*	–0.01**	–1.0**
Medication management	1.4***	–0.2***	–0.02*	–0.001*	0.4
Rehabilitation services	0.8*	–0.1***	0.02***	–0.0	–0.3
Case management	–0.6*	0.1***	–0.001	0.001*	0.3*

NOTE: The estimated change is based on regression model controlling for year of enrollment. The values reported in this table are the marginal effects from the model estimates based on maximum likelihood with standard errors clustered at the county level. The statistically significant values are in shaded cells.

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

associated with increased days of stable housing (1.4 days, 95 percent CI: 1.0 to 1.8), decreased likelihood of arrest (–0.2 percent, 95 percent CI: –0.1 percent to –0.3 percent) and the number of arrests (–0.02, 95 percent CI: –0.001 to –0.04), and decreased psychiatric admissions (–0.001, 95 percent CI: –0.00004 to –0.002). Rehabilitation service utilization is associated with increased stable housing (0.8 days, 95 percent CI: 0.1 to 1.5), decreased likelihood of arrest (–0.1 percent, 95 percent CI: –0.04 percent to –0.3 percent), and *increased* number of arrests among those with at least one (0.02, 95 percent CI: 0.01 to 0.04).

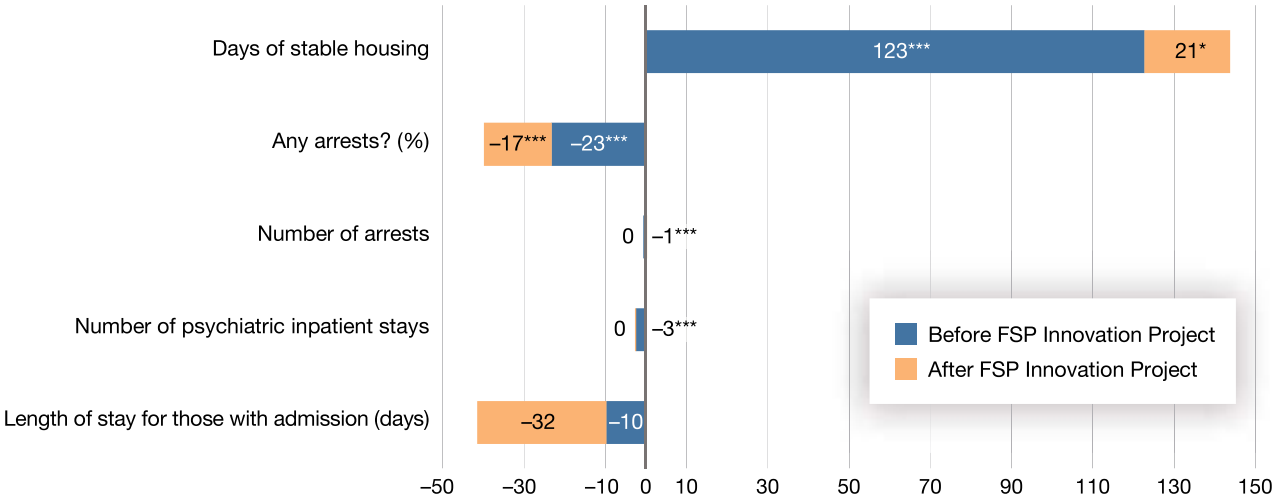
Case management utilization is associated with a *decrease* in the number of days of stable housing (–0.6 days, 95 percent CI: –0.01 to –1.1) and *increased* likelihood of arrest (0.1 percent, 95 percent CI: 0.07 percent to 0.12 percent). These counterintuitive associations highlight the challenges in interpreting these results. It is possible that increased case management causes declines in some outcomes, but it is also possible (and more likely) that more-complex FSP participants with worse outcomes on average utilize more case management. We were unable to distinguish among the possible causal relationships and can only estimate an association.

Association Between County Participation in the FSP Innovation Project and FSP Program Outcomes

We examined outcomes for FSP participants who enrolled prior to the FSP Innovation Project with those who enrolled from November 2021 through October 2022, examining their data through October 2023. **FSP participants who enrolled after the start of the FSP Innovation Project experienced greater improvement in two of the outcomes we evaluated than participants who enrolled prior to the project** (Figure 2). The total length of the two-color bars in Figure 2 represents the estimated change in outcomes for those who enrolled after the FSP Innovation Project began. The blue section of the bar represents the estimated change for enrollees who enrolled prior to the FSP Innovation Project, and the orange section represents the difference in the change for enrollees who enrolled after it began. After counties began participating in the FSP Innovation Project, the days of stable housing increased an additional 21 days (95 percent CI: 2.7 to 39.1) for their FSP participants. The likelihood of arrest decreased by an additional 17 percentage points (95 percent CI: –7 percent to –26 percent). There were significant decreases in

FIGURE 2

Estimated Change in Participant Outcomes Associated with a County's Participation in the FSP Innovation Project



NOTE: The estimated change is based on a regression model controlling for year of enrollment. The values reported in this figure are the marginal effects from the model estimates based on the maximum likelihood, with standard errors clustered at the county and participant levels.

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

After counties joined the FSP Innovation Project, the improvement in outcomes increased for their FSP participants.

the number of arrests and the number of psychiatric inpatient admissions prior to the FSP Innovation Project, but there was no significant change in this pattern after counties began participating. The additional change in psychiatric inpatient length of stay after participating is not significant.

Discussion

Outcomes for FSP participants improved during the first 12 months of participation relative to the 12 months prior to participation: **Participants experienced increased stable housing, decreased justice system involvement, and reduced psychiatric inpatient admissions.** The amount of FSP services that participants utilize is associated with changes in outcomes, but we were unable to determine whether associations are causal because our data lack a control group. In most cases, utilizing more services yielded improvements in outcomes, but utilization of case management is associated with fewer days of stable housing and an increase in the likelihood of arrests. This may be because more-complex cases that would otherwise have much worse outcomes require more case management. Nonetheless, FSP participants experienced improved outcomes on average, and the provision of most services is associated with improvement.

We found that **after counties joined the FSP Innovation Project, the improvement in outcomes increased for their FSP participants**. This finding suggests that the FSP innovations might have led to changes in the quality of care that the individuals served received or to changes in the appropriateness of the population that FSP programs serve. The qualitative data indicated that counties' identification of common metrics might have led to more-consistent use of measurement-based care, which could improve quality of care and, in turn, outcomes. At the same time, several counties succeeded in establishing guidelines for readiness to graduate from FSP programs and move to a lower level of care; this innovation might have increased capacity for individuals at the higher level of need that FSP programs are intended to serve. These higher-need individuals may be more likely to experience significant change in response to FSP participation.

Conclusion

Overall, there is evidence that the Multi-County FSP Innovation Project led to improvements in processes and outcomes among the first cohort of six participating counties. Counties worked with each other and Third Sector to successfully implement standardized definitions, measures and metrics, guidelines, and processes necessary to improve program implementation. However, there was considerable variation in the extent to which innovations were implemented on the ground and sustained after the initial innovation development and implementation period was over. Nonetheless, **we found evidence that FSP participants experienced improved outcomes in key areas, including stable housing, justice system involvement, and psychiatric hospitalizations, and that these improvements increased after counties participated in the FSP Innovation Project**. We cannot definitively attribute these improvements in outcomes to the project, but our findings may suggest that there was improved quality of care or improved targeting of FSP programs to those most in need of these high-intensity services.

Given the initial successes of the FSP Innovation Project and the lessons learned about its implementation and impacts, it may be helpful to expand the innovations to additional counties across the state—with attention to such issues as need for provider training in the innovations and step-down care options.

Notes

[1] Substance Abuse and Mental Health Services Administration, "Mental Health and Substance Use Disorders."

[2] Substance Abuse and Mental Health Services Administration, "Mental Health and Substance Use Disorders."

[3] California Health Care Foundation, *Mental Health Care in California*.

[4] Mental Health Services Oversight and Accountability Commission, *Report to the Legislature on Full Service Partnerships*.

[5] Title IV-E Prevention Services Clearinghouse, "Assertive Community Treatment."

[6] California Department of Health Care Services, "Mental Health Services Act."

[7] California Department of Health Care Services, "MHSA Components."

[8] Mental Health Services Oversight and Accountability Commission, *Report to the Legislature on Full Service Partnerships*.

[9] Third Sector, *California Multi-County Full Service Partnership Innovation Project*.

[10] Mental Health Services Oversight and Accountability Commission, *Report to the Legislature on Full Service Partnerships*.

[11] RAND Corporation, "Publications."

[12] Vindrola-Padros and Johnson, "Rapid Techniques in Qualitative Research."

[13] California Institute for Behavioral Health Solutions, homepage.

[14] Cameron and Trivedi, *Microeconometrics*.

References

California Department of Health Care Services, "Mental Health Services Act," webpage, undated. As of February 9, 2024:
https://www.dhcs.ca.gov/services/mh/Pages/MH_Prop63.aspx

California Department of Health Care Services, "MHSA Components," webpage, undated. As of February 9, 2024:
https://www.dhcs.ca.gov/services/MH/Pages/MHSA-Components.aspx

California Health Care Foundation, *Mental Health Care in California: Waiting for Care*, July 2022. As of February 9, 2024:
https://www.chcf.org/wp-content/uploads/2022/07/MentalHealthAlmanac2022.pdf

California Institute for Behavioral Health Solutions, homepage, undated. As of February 15, 2024:
https://www.cibhs.org/

Cameron, A. Colin, and Pravin K. Trivedi, *Microeconometrics: Methods and Applications*, Cambridge University Press, 2005.

Mental Health Services Oversight and Accountability Commission, *Report to the Legislature on Full Service Partnerships*, January 25, 2023. As of February 9, 2024:
https://mhsoac.ca.gov/wp-content/uploads/SB-465-Report-to-the-Legislature_approved_ADA.pdf

RAND Corporation, "Publications," webpage, undated. As of February 15, 2024:
https://www.rand.org/health-care/projects/calmhsa/publications.html

Substance Abuse and Mental Health Services Administration, "Mental Health and Substance Use Disorders," webpage, last updated June 29, 2023. As of February 9, 2024:
https://www.samhsa.gov/find-help/disorders

Third Sector, *California Multi-County Full Service Partnership Innovation Project: Progress Report*, March 2021. As of February 9, 2024:
https://www.thirdsectorcap.org/wp-content/uploads/2021/03/Multi-County-FSP-INN-Progress-Report_March-2021.pdf

Title IV-E Prevention Services Clearinghouse, "Assertive Community Treatment," webpage, last reviewed April 2023. As of February 9, 2024:
https://preventionservices.acf.hhs.gov/programs/483/show

Vindrola-Padros, Cecilia, and Ginger A. Johnson, "Rapid Techniques in Qualitative Research: A Critical Review of the Literature," *Qualitative Health Research*, Vol. 30, No. 10, August 2020.

About This Report

This report describes the evaluation of the California Multi-County Full Service Partnership Innovation Project. Mental Health Service Act (MHSA) innovation projects seek to promote innovations that improve mental health outcomes for individuals and communities.

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CalMHSA is an organization of county governments working to improve mental health outcomes for individuals, families, and communities. Prevention and early intervention programs implemented by CalMHSA are funded by counties through the voter-approved MHSA (Prop. 63). Prop. 63 provides the funding and framework needed to expand mental health services to previously underserved populations and all of California's diverse communities.

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MHSA FY 2025-26 Annual Update Acronym List

AA/B/AD	African American/Black/African Descent
AABHPHS	Arthur A. Benjamin Health Professions High School
ABC	Augmented Board and Care
AI/AN/I	American Indian/Alaskan Native/Indigenous
API	Asian and Pacific Islander
APSS	Adult Psychiatric Support Services
ARISE	Sacramento Adults Recovering in Strengths-Based Environment
ART	Adult Residential Treatment
AU	Annual Update
BACS	Bay Area Community Services
BH-CONNECT	Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment
BHREC	Behavioral Health Racial Equity Collaborative
BHSA	Behavioral Health Services Act
BHS	Behavioral Health Services
BHCSC	Behavioral Health Crisis Services Collaborative
CalAIM	California Advancing and Innovating Medi-Cal
CalMHSA	California Mental Health Services Authority
CANS	Child and Adolescent Needs and Strengths
CAPS	Child and Adolescent Psychiatric Services
CBO	Community Based Organization
CF	Capital Facilities
CFT	Child and Family Team
CJSP	Community Justice Support Program
CNP	Crisis Navigation Program
CORE	Community Outreach Recovery Empowerment
CPPP	Community Program Planning Process
CPS	Child Protective Services
CPS-LLP	Certified Peer Specialist – Leadership Liaison Program
CRC	Mental Health Crisis Respite Center
CRP	Crisis Residential Program

MHSA FY 2025-26 Annual Update Acronym List

CRWP	Community Responsive Wellness Program for the Black Communities of Sacramento
CSEC	Commercially Sexually Exploited Children
CSET	Consultation, Support, and Engagement Teams
CSS	Community Services and Supports
CST	Community Support Team
CWC	Community Wellness Center
CWRT	Community Wellness and Response Team
DHCS	California Department of Health Care Services
DMC-ODS	Drug Medi-Cal Organized Delivery System
DPS	Department of Personnel Services
ED	Emergency Department
EDFU	Emergency Department Follow Up
EHR	Electronic Health Record
FIT	Flexible Integrated Treatment
FSP	Full Service Partnership
FY	Fiscal Year
GONA	Gathering of Native Americans
GSD	General System Development
HBC	Housing and Benefits Coordinator
HCAI	Department of Health Care Access and Information
HEART	Homeless Engagement and Response Team
HR	Human Resources
IMCS	Iu Mien Community Services
INN	Innovation
ISA	Integrated Services Agency
JJDTP	Juvenile Justice Diversion and Treatment Program
L/LX/LE/H	Latino/Latinx/Latine/Hispanic
LFCC	La Familia Counseling Center
LGBTQ+	Lesbian, gay, bisexual, transgender, questioning or queer, and others
LRP	Loan Repayment Program

MHSA FY 2025-26 Annual Update Acronym List

MCST	Mobile Crisis Support Teams
MHFA	Mental Health First Aid
MHP	Mental Health Plan
MHSA	Mental Health Services Act
MHSA SC	Mental Health Services Act Steering Committee
MHSOAC	Mental Health Services Oversight and Accountability Commission
MHTC	Mental Health Treatment Center
MHUCC	Mental Health Urgent Care Clinic
MST	Multi-System Team
NPLH	No Place Like Home
NPP	Nurturing Parent Program
OASIS	Outpatient Assisted Services & Integrated Supports
PEI	Prevention & Early Intervention
PSH	Permanent Supportive Housing
PSS	Peer Support Services
PTSD	Post-Traumatic Stress Disorder
QCCC	Quality Child Care Collaborative
QPR	Question, Persuade, Refer training
REDA	Refugee Enrichment & Development Association
RPC	Respite Partnership Collaborative
SB	Senate Bill
SCC	Supporting Community Connections
SCH	Sacramento Children's Home
SCOE	Sacramento County Office of Education
SHRA	Sacramento Housing and Redevelopment Agency
SMHC	Senior Mental Health Counselors
SMRT	The Source Mobile Response Team
SNAHC	Sacramento Native American Health Center
SOAR	Sacramento Outreach Adult Recovery
SUD	Substance Use Disorder

MHSA FY 2025-26 Annual Update Acronym List

SUPT	Substance Use Prevention and Treatment
SZS	Safe Zone Squad
TAY	Transition Age Youth
TICRT	Trauma Informed Culturally Responsive Treatment
TN	Technological Needs
TWC	Transcultural Wellness Center
UCD	University of California, Davis
UCDMC	University of California, Davis Medical Center
WET	Workforce Education and Training
WIC	Welfare and Institution Code
YAG	Youth Advisory Group
YDF	Youth Detention Facility
YHN	Youth Help Network
YMHFA	Youth Mental Health First Aid