Safe Spaces
FOR MENTAL HEALTH

SONOMA COUNTY MENTAL HEALTH SERVICES ACT (MHSA)

FY 2023-2026

Three-Year Plan & Expenditure Plan
with FY 2021-2022 Annual Report

MENTAL HEALTH SERVICES ACT PROPOSITION 63 CALIFORNIA

WELLNESS • RECOVERY • RESILIENCE

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

SONOMA COUNTY CALIFORNIA AGRICULTURE INDUSTRY RECREATION

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MHSA COUNTY COMPLIANCE CERTIFICATION

County: SONOMA

Local Mental Health Director	Program Lead
Name: Jan Cobaleda-Kegler	Name: Melissa Ladrech
Telephone Number: 707 565-5157	Telephone Number: 707 565-4909
E-mail: Jan.Cobaleda-Kegler@sonoma-county.org	E-mail: Melissa.Ladrech@sonoma-county.org
County Mental Health Mailing Address: Sonoma County DHS,Behavioral Health Division 2227 Capricorn Way, Suite 203 Santa Rosa, CA 95407	

I hereby certify that I am the official responsible for the administration of county mental health services in and for said county and that the County has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this annual update, including stakeholder participation and nonsupplantation requirements.

This annual update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft annual update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on December 12, 2023.

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

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

Jan Cobaleda-Kegler
Local Mental Health Director/Designee (PRINT)

Jan Cobaleda-Kegler 12/20/23
Signature Date

County: Sonoma

Date:

Enclosure 1

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: SONOMA

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

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Jan Cobaleda-Kegler	Name: Erick Roeser
Telephone Number: 707-565-5157	Telephone Number: 707-565-3295
E-mail: jan.cobaleda-kegler@sonoma-county.org	E-mail: erick.roeser@sonoma-county.org
Local Mental Health Mailing Address: Sonoma County DHS-Behavioral Health Division 2227 Capricorn Way, Suite 203 Santa Rosa, CA 95407	

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.

Jan Cobaleda-Kegler
Local Mental Health Director (PRINT)

Jan Cobaleda-Kegler 1-3-24
Signature Date

I hereby certify that for the fiscal year ended June 30, 2022, 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 1/13/2023 for the fiscal year ended June 30, 2022. I further certify that for the fiscal year ended June 30, 2022, 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.

Erick Roeser
County Auditor Controller / City Financial Officer (PRINT)

Signature 1/2/24
Date

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

Message from the Behavioral Health Director

Dear MHSA Dear MHSA Community Members and Supporters

I would like to welcome you to Sonoma County Behavioral Health Division's (SCBHD) Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan for fiscal years 2023 through 2026. I am very excited to share this with you. Thank you to all who have contributed and participated in our Community Program Planning process and numerous stakeholder group meetings. Working together we can build healthy, resilient, and responsive systems of care that support our clients, their families, and our staff.

Our mental health is a precious thing. In Sonoma County we are currently struggling with a public mental health crisis. A global COVID pandemic preceded by several devastating fires and floods has left our community traumatized and in pain. We are stressed and trying to recover from the collective numbness of this sequence of challenging events. Our clients feel this; our staff as well. In Sonoma County, while the need for Behavioral Health services has increased, our workforce has experienced the debilitating effects of high turnover rates effecting recruitment and retention resulting in a staff vacancy rate of 28%.

In spite of these challenges, our staff have continued to provide outstanding service and supports to our clients and their families. I am deeply moved and inspired repeatedly by their dedication and resilience. Our system, although weakened, continues to do the work we were created to do. Embodying the transformational recovery philosophy of MHSA, our programs continue to provide accessible, community-based mental health services to all our clients. And our programs need support. We need to strengthen and expand our net to continue to serve our most vulnerable clients, repair our traumatized system, and build a community of practice and healing.

Commitment to trauma informed care is central in this 2023-2026 MHSA Three Year Plan. This commitment threads through our plan as we prioritize system transformation with several initiatives:

- Increasing staffing at critical access and entry points in our system of care to increase timeliness and improve access to care to those we serve. We want to engage with those who need care as early as possible and connect them to the services they need as swiftly as we can.
- Developing a comprehensive training program for staff and contractors which will improve our skills and the services we provide our clients. This will also support staff retention.
- Continue to build out a continuum of housing supports for our most vulnerable clients.

These are a few of several proposals you will find in this Three-Year Plan that embody the spirit of MHSA: wellness, integration, collaboration, recovery, and healing practices. I am deeply grateful for the supports and services that MHSA brings to our system and, most significantly, for all the work that all of you in our community provide to our clients. I am hopeful that by working together we can build healthy, resilient, caring, and safe communities and restore wellness to our mental health system.

Warm regards,

Jan Cobaleda-Kegler

Jan Cobaleda-Kegler, BH Division Director

Meet our MHSA team

Jan Cobaleda-Kegler
Behavioral Health Director

Melissa Ladrech
MHSA Coordinator

Lisa Nosal
Ethnic Services, Inclusion & Training Coordinator

Fabiola Espinosa
MHSA Anaylst

Executive Summary

Purpose of this Document

As per the California Welfare and Institutions Code (WIC) Title 9, Section 331 the Sonoma County 2023-2026 Mental Health Services Act (MHSA) Three-year Plan provides stakeholders with:

- The Three-Year Plan and Expenditure Plan for Fiscal Years (FY) 2023-2026.
- The Annual Program Report for FY 21-22 that includes the activities, services, and programs funded through MHSA and the program outcomes for FY 21-22.

History of MHSA

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA), placing a one percent tax on personal income above $1 million to be used to expand mental health services. In FY 23-24, it is estimated that over $3 billion in MHSA funds will be collected statewide, and it is estimated that Sonoma County will receive over $33 million. MHSA funds are not guaranteed, and the amount of MHSA funds that the County of Sonoma Department of Health Services Behavioral Health Division (DHS-BHD) receives varies each year.

The passage of Proposition 63 created the first opportunity in many years for California to increase funding, personnel, and other resources to support county mental health programs and monitor progress toward statewide goals for:

Youth	Transition Age Youth	Adults	Older Adults	Families

The MHSA addresses a broad continuum of prevention, early intervention, service needs, and the necessary infrastructure, technology and training elements that will effectively support this system.

MHSA challenges communities throughout California to utilize MHSA resources to support the transformation of our mental health systems.

The Five Components of MHSA

MHSA consists of five funding components, each of which addresses specific goals for priority populations, key community mental health needs, and age groups that require special attention. The programs and services of this report will be presented in the context of these components.

Community Services and Supports (CSS) – ***76%*** *of MHSA funds*

Provides funds for direct services to individuals with severe mental illness. There are three subcomponents under CSS:

- **Full Service Partnerships (FSPs)** provide wrap-around services or "whatever it takes" services to clients with the most serious mental health impairments. *(A **majority** of CSS funds are to be expended on FSPs.)*
- **General System Development (GSD)** provides funds to improve the mental health service delivery system.
- **Outreach and Engagement (OE)** is designed to reach, identify, and engage unserved individuals and communities in the mental health system and reduce disparities.

Prevention and Early Intervention (PEI) – ***19%*** *of MHSA funds*

Targets individuals of all ages prior to the onset of mental illness.

Innovation (INN) – ***5%*** *of MHSA funds*

Funds new approaches that increase access to unserved and/or underserved communities, promotes interagency collaboration, and improves the quality of services.

Workforce, Education and Training (WET)[1]

Provides funding to improve and build the capacity of the mental health workforce to meet the needs of unserved and underserved populations, and provide linguistically and culturally relevant services.

Capital Facilities and Technological Needs (CFTN)[2]

Provides funding for building projects and increasing technological capacity to improve mental health service delivery.

FY 23-26 MHSA Changes and Impacts

The following table highlights additions and substantial changes to MHSA funded programs from the FY 22-23 Annual Plan Update and Expenditure Plan (FY 22-23 Plan Update) to the FY 23-26 Three-Year Plan and Expenditure Plan (FY 23-26 Plan).

[1] Pursuant to WIC 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.
[2] Ibid.

FY 23-26 MHSA Changes and Impacts

Changes	Impacts
6% Cost of Living Adjustment (COLA) increase for MHSA Contractors (across all components) $434,050. This is a change to CSS, PEI and WET contractors.	Contractors have been providing high quality services while their expenses have been increasing. This COLA will assist contractors that received across the line budget cuts in 2017 and have been impacted by recent inflation so they can continue to provide high quality and effective services for DHS-BHD clients.
Community Services and Supports	
Telecare, Sonoma ACT: Telecare will be added to the Adult Full Service Partnership (AFSP) team. This is an annual increase in spending of $1,493,488.	The addition of Telecare, Sonoma ACT to the AFSP team will increase capacity and improve timeliness.
General System Development	
Discontinue funding for Support Our Students (SOS): SOS will no longer be funded to provide interns to the Mobile Support Team. The annual cost of the program is $212,672, and $79,672 was funded with MHSA.	SOS was unable to provide the Mobile Support Team (MST) with clinicians that meet the new state guidelines for mobile support units. The Division will recruit clinicians directly for MST.
Additional Senior Client Support Specialists for Collaborative Treatment and Recovery Team (CTRT). Three Senior Client Support Specialists will be added to the CTRT program. This is an annual increase of $513,000.	The addition of three Senior Client Specialists to CTRT will increase the capacity of CTRT which will enable CTRT to provide case management for more clients and improve timeliness and access to serves.
Prevention and Early Intervention (PEI)	
Care Navigator for Medication Assisted Treatment (MAT): A Care Navigator in the position of Senior Client Support Specialist will engage clients at the early stages of medication assisted treatment for opioid use disorder initiated at Santa Rosa Community Health. This is an annual increase in spending of $171,000.	The Care Navigator will provide wraparound support (transportation, case management, outreach, and engagement) to address barriers that clients experience when on new medications, which are intended to replace Heroin, Fentanyl, Oxycodone, etc. This will improve access to services, client engagement and contribute to clients moving towards recovery.
Workforce, Education and Training (WET)	
Comprehensive Training Program: The comprehensive training program will be focused on addressing the impairments of the primary diagnoses that DHS-BHD clients experience. All trainings will be evidence based or best practices, and the trainings are designed for clinical staff, senior client support specialist, including peer support staff. This is an increase of $400,000 annually.	The addition of a Comprehensive training program can improve client outcomes, DHS-BHD program efficacy, improve staff retention and staff recruitment.

Introduction

MHSA Background

The Mental Health Services Act (MHSA) creates local mental health systems that are client and family member driven, focused on wellness and resiliency, hold a vision in which recovery is possible, and deliver culturally competent and linguistically appropriate services. MHSA aims to facilitate change along a continuum of care that helps identify emerging mental illness and prevents it from becoming severe, to providing treatment for children, transition age youth, adults, and older adults through supporting mental health recovery.

Since the passage of MHSA in 2004, the County of Sonoma Department of Health Services Behavioral Health Division (DHS-BHD) has undertaken an ongoing, robust community planning process for each MHSA component. The process began in FY 05-06 to plan for the implementation of the Community Services and Supports (CSS) component of MHSA. In FY 06-07, Sonoma County, along with community stakeholders, began to identify Workforce, Education and Training (WET) needs. In FY 07-08, the MHSA housing plan was funded. In FY 09-10, the Prevention and Early Intervention (PEI) Community Planning Process began. In FY 10-11, Sonoma's Capital Facilities and Technology Needs (CFTN) plan was finalized; and in FY 11-12, the initial plan for Innovation was finalized.

Each of these planning processes involved countless stakeholders throughout Sonoma County. The stakeholders participated in various capacities, such as in community planning meetings, as questionnaire respondents, advisory committee members, focus group participants, request for proposal review panels, etc. These processes required a tremendous commitment of time and skill that demonstrates the thought and care that went into each plan. These plans have ultimately resulted in the development of essential programs, activities, and services that make up Sonoma County's current behavioral health continuum of care.

MHSA Today

Today, Sonoma County has a well-developed behavioral health system of care. It has been implemented in phases and now runs as a full continuum of care. MHSA services, activities, and programs are reviewed and approved by Sonoma County stakeholders each year. For more information on programs and services taking place during FY 21-22, please see the Annual Program Report section of this document on Page 100.

MHSA has provided Sonoma County the opportunity to enhance new partnerships and to strengthen continuing partnerships with community-based organizations and has supported inclusion of the voices of more clients, family members, and unserved and underserved populations in the planning and implementation of mental health activities, programs, and services. Therefore, Sonoma County residents now have a more accessible, integrated, comprehensive, and compassionate behavioral health system of care. The system of care was founded on and continues to develop in concert with the MHSA Guiding Principles cited below:

MHSA defines four client age groups to reflect the different mental health needs associated with a person's age, and counties are directed to provide age-appropriate services for each:

- **Children:** 0-15 years
- **Transition Age Youth** (TAY): 16-25 years
- **Adults:** 26-59 years
- **Older Adults:** 60 years and older

Additionally, MHSA intends to serve individuals who are historically unserved or underserved by the public mental health care system. The California Code of Regulations defines these individuals as follows:

- **Unserved.** "Individuals who may have serious mental illness and/or serious emotional disturbance and are not receiving mental health services. Individuals who may have had only emergency or crisis-oriented contact with and/or services from the County may be considered unserved."
- **Underserved.** "Individuals who have been diagnosed with a serious mental illness and/or serious emotional disturbance and are receiving some services but are not provided the necessary or appropriate opportunities to support their recovery, wellness, and/or resilience."

Sonoma County recognizes the historical disparities in access and quality of care that additional populations in the county have experienced, thus including them into the unserved and underserved definition. One common factor that contributes to these disparities is language barriers which prohibit people from engaging in services available only in English. Cultural backgrounds also influence individuals' experiences of mental health treatment; some practices are more effective to engage people in services or provide effective treatment for one culture than for others. Additionally, individuals experiencing poverty, individual and institutional discrimination based on race, ethnicity, gender identity, or sexual orientation may be more likely to face difficulty navigating the system of care. Finally, lack of transportation, geography and location affect access and utilization of services.

The theme for this year's plan is Safe Spaces for Your Mental Health. In an often challenging world, having a safe space to go to is incredibly important for maintaining good mental health. A safe space is a place—physical or virtual—you can go to relax and recharge. A judgment-free zone where you can let your guard down and truly be yourself.

On the cover four of the Division's MHSA funded programs that offer safe spaces for mental health are highlighted: Positive Images, VOICES, West County Community Services Wellness and Advocacy Center. You can find more information about these programs on pages 99.

988 SUICIDE & CRISIS LIFELINE

If you or someone you know
needs support now,
call or text **988**
or
chat **988lifeline.org**

Your surroundings impact your mental health, and it is important to take a moment to consider your surroundings. Do you feel safe? Does your home support you, both physically and mentally? Where a person is born, lives, learns, works, plays, and gathers, as well as their economic stability and social connections, are part of what is called "social determinants of health" (SDOH). The more these factors work in your favor means you are more likely to have better mental well-being.

There are steps you can take to change your space and protect your well-being.

- Make your place a stress-free sanctuary: Consider keeping your space tidy, sleep-friendly, and well-ventilated. Surround yourself with items that help you feel calm and positive. Put up pictures of people you love and play some of your favorite music.
- Finding spaces (such as a community center or peer wellness centers) where you can be safe and comfortable.
- Try a traditional support group
- Create bonds with your neighborhood and community: Get to know the people living around you, join or start neighbors' groups.

- Connect with nature: Hike in a forest, sit in a city park, bring a plant inside, or keep the shades open to absorb natural light.

The world around us can be both positive and negative – bringing joy and sadness, hope and anxiety. Everyone can build a life worth living in a safe space.

Learn more with Mental Health America's 2023 Mental Health Month toolkit, which provides free, practical resources, such as how an individual's environment impacts their mental health, suggestions for making changes to improve and maintain mental well-being, and how to seek help for mental health challenges. Go to https://mhanational.org/mental-health-month to learn more.

Description of Sonoma County

Sonoma County, located within the San Francisco Bay Area, about 45 minutes north of San Francisco has a population of 488,863 people across a region of 1,576 square miles.[3] A large, urban-rural county with 76 miles of Pacific Ocean coastline, Sonoma County is known for its Mediterranean climate that supports an agricultural industry including vineyards producing world class wine. In addition to agriculture, the County's major industries include healthcare, hospitality, and manufacturing. The top employers are Kaiser Permanente, Sutter Medical Center of Santa Rosa, St. Joseph Health System, and Graton Resort & Casino.

Santa Rosa is the county's most populous city with 178,127 people (U.S. Census Bureau, 2020) and is home to over one-third of county residents, and that is why the County seat, including the Department of Health Services, Behavioral Health Division's (DHS-BHD) main campus is located in Santa Rosa. Beyond Santa Rosa, the main population centers are Petaluma (population 59,776) and Rohnert Park (population 44,390) to the south, and Windsor to the north (population 26,344). (U.S. Census Bureau, 2020) Sonoma County is geographically dispersed with limited public transportation and bicycle and pedestrian infrastructure which can make it challenging for individuals living in more rural areas and those without a personal vehicle.

[3] U.S. Census Bureau. (2020). Quick Facts, Sonoma County, California.

In 2021, 61.5% of residents identified as White, non-Hispanic with 28.3% identifying as Hispanic or Latinx, the County's largest and fastest growing minority population.[4] The County's poverty rates vary significantly by ethnicity with disparities affecting the Latinx community in particular. While Hispanic or Latinx residents were over a quarter of the population, this group accounted for 40% of Sonoma County's Medi-Cal beneficiaries in 2021.[5] Additionally, there are an estimated 27,000 undocumented residents in the County.[6] Of those, 12,000 or 44% are estimated to speak English less than "very well," suggesting possible linguistic isolation for this population.^7 Individuals who are undocumented and/or linguistically isolated may experience unique challenges accessing medical, transportation, and social services.

The County is also home to five federally recognized Native American tribes, including the Cloverdale Rancheria of Pomo Indians of California, the Dry Creek Rancheria Band of Pomo Indians, the Federated Indians of Graton Rancheria, the Kashia Band of Pomo Indians of the Stewarts Point Rancheria, and the

[4] USAFacts, Our Changing Population: Sonoma County, California, https://usafacts.org/data/topics/people-society/population-and-demographics/our-changing-population/state/california/county/sonoma-county

[5] California Department of Health Care Services (2018). Medi-Cal Enrollees and Beneficiaries

https://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal-Certified-Eligibles.aspx

[6] Profile of the Unauthorized Population: Sonoma County, Migration Policy Institute. https://www.migrationpolicy.org/data/unauthorized-immigrant-population/county/6097

[7] Ibid, English Proficiency

Lytton Band of Pomo Indians. Native Americans make up only .7% of the County's total population[8] and about 1% of Medi-Cal beneficiaries. According to USAfacts, in 2021 the Asian population represented 4.4% of the total population and African American/Blacks represented 1.7%. Although these percentages are relatively small, culture and language differences can reduce access as well as the quality of services available—particularly for individuals with lower levels of income.

Finally, Sonoma County is aging. The 65+ age group was the fastest growing between 2010 and 2021 with its population increasing from 14% to 21.1% (rate of 51.1% growth). The 5 to 19 age group decreased the most dropping from 19% to 14% (rate of 10.4% decline) between 2010 and 2021.[9] This data trend has serious implications for service delivery needs for the elderly and economic impacts for school districts. The intersectionality of race, age, economics, language spoken, and gender have deep implications on access to housing, services, and healthcare.

Sonoma County's median household income is $91,607 (U.S. Census Bureau, est. 2021), however this is in contrast to the 9.1% of County residents living in poverty. Sonoma County's unemployment rate peaked at 14.5% in April 2020. The rate has since then decreased to just over 3.6% for February 2023 as reported by the Labor Market Information Division, California Employment Development Department.

Medi-cal Beneficiaries and Threshold Languages

Over one fourth (130,665) of the population is eligible for Medi-Cal. (DHCS, 2022) 7.8% of the population has an income below the Federal Poverty Level (FPL). California External Quality Review Organization (CalEQRO), BHC Behavioral Health Concepts, reports that Sonoma County's average monthly unduplicated number of Medi-Cal enrollees by Race/Ethnicity and language during Calendar Year 2021 are as follows:

Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees	% Enrollees
White	36,206	27.7%
Latinx/Hispanic	52,228	40%
Asian/Pacific Islander	4,014	3.1%
Black/African American	2,054	1.55%
American Indian or Alaska Native	1,244	0.95%
Not Reported	34,919	26.7%
Total	130,665	100%

The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently. California's Department of Health Care Services (DHCS) Behavioral Health Information Notice 20-07 reports Spanish as a threshold language for Sonoma County. DHCS defines "Threshold Language" as a language identified as the primary language, as

[8] USAFacts, Our Changing Population: Sonoma County, California, https://usafacts.org/data/topics/people-society/population-and-demographics/our-changing-population/state/california/county/sonoma-county
[9] Ibid.

indicated on the Medi-Cal Eligibility Data System (MEDS), of 3,000 beneficiaries or 5% of the beneficiary population – whichever is lower – in an identified geographic area, per Title 9, CCR Section 1810.410 (a)(3).

Language	Average Monthly Unduplicated Medi-Cal Enrollees	% Enrollees
English	84,554	64.7%
Spanish	43,478	33.3%
Other/Unknown	2,633	2%
Total	130,665	100%

While Sonoma County continues to recover from the COVID-19 pandemic and devastating fires from the past five years, rising housing costs continue to be a key driver of economic instability. Over 60% of Sonoma County residents who rent their homes and over 30% of residents who own their homes experience housing-cost burden (i.e., spend 30% or more of their household income on rent or mortgage). Historic chronic underbuilding of housing created a disparity between supply and demand and limited the growth potential of the County's economy. Housing costs and underbuilding have the greatest impact on individuals and families with less financial security or who are experiencing home instability.

The severe wildfire seasons of 2017, 2019 and 2020, combined with the flood of 2019 and the Covid-19 pandemic of 2020-2022 have transformed the lives of many Sonoma County residents. Sonoma County experienced a net 3.3% decrease in population from 2017 to 2021.[10]

The 2017 Complex Fires burned over 112,000 acres, destroyed over 5,000 homes, and took 24 lives. One in six households reported lost wages or employment and one in ten households reported an increase in housing or rent costs as a direct result of the fires. In

[10] Ibid.

2019 an atmospheric river brought up to 20 inches of rain to Sonoma County over three days. The heavy rains caused the Russian River to raise 13 feet above flood stage to 45.4 feet in Guernevillle which resulted in the worst flood event in Sonoma County in 24 years. The flood impacted Russian River communities including Guerneville, Jenner, Rio Nido, Monte Rio, Sebastopol, and Healdsburg. Over 40 people were rescued, 3,600 residents were evacuated and 8,000 were without power. Additionally, more than 2,000 homes and businesses were flooded, with 527 structures damaged and 31 declared uninhabitable due to flood damage. The flood impacted 578 businesses, totaling $35 million in damages.

After the flood in 2019, came the largest wildfire to burn in Sonoma County the Kincade Fire, which was also the largest fire of the 2019 California wildfire season. The Kincade Fire burned over 77,000 acres in Geyserville, Windsor, and Healdsburg and resulted in the evacuation of 90,000 residents. The fire destroyed 174 homes and 200 additional structures, including winery facilities.

The impact of COVID-19 is challenging to quantify in lives lost, jobs lost, businesses closed, revenue down, supply chain impaired and workforce compromised. The estimated Gross Regional Product (GRP) lost $6.157 Billion from 2020-2023 and the estimated loss of employers by 2023 is estimated at 6.9%.[11] The industries that were most impacted were lower wage earners in retail, hospitality, and tourism. However, even strong economic sectors were impacted including construction, education, and healthcare. The Sonoma County Economic Development Board projects that the long-term impacts depend on housing market (in)stability, ability to continue to build more housing, longer spell of unemployment and subsequent pressure on non-profit and public programs, and the potential outmigration of lower-wage workers.

In the midst of the COVID-19 pandemic, California experienced rare thunderstorms in August of 2020, which sparked 376 fires across the state. Two of those fires occurred in Sonoma County: the Walbridge Fire and the Meyers Fire. In total, the Walbridge and Meyers Fires destroyed 298 structures, including 150 residences and 9 motor homes. A third major fire of 2020 started in September – the Glass Fire. The Glass fire burned over 67,484 acres and destroyed 1,555 structures, including 334 homes in Sonoma County. Approximately 2.5% of Sonoma's total housing units were lost in the 2017 fires, leading the County to require a total of 26,000 new units by 2020 to account for employment growth, fire losses, and overcrowding.

[11] *Economic Impacts of COVID-10 on Sonoma County Economy,* August 2020. Sonoma County Economic Development Board.
https://sonomaedb.org/Microsites/Economic%20Development%20Board/Documents/Archive/_Documents/Reports/_2020/Economic-Impacts-from-COVID19-Sonoma-County-Report.pdf

COVID-19, the fires, and the flood have impacted Sonoma County economically, and have also brought mental health impacts across the county. 40% of households in Sonoma County reported individual and collective trauma experiences, such as being separated from a family member or suffering a significant disaster-related illness or injury.[12] In a poll conducted by the Kaiser Family Foundation, 45% of Americans said the virus and pandemic had a negative effect on their mental health. Young adults have experienced several pandemic related consequences, such as closures of universities, high schools and loss of income, which may contribute to poor mental health. In May of 2020, YouthTruth conducted a survey with more than 5,000 Sonoma County high school students with 71% reporting "feeling anxious about their future" due to disruptions in their lives was the number one barrier to distance learning. Prior to the pandemic, young adults were already at higher risk of poor mental health and substance use disorder, though many did not receive treatment.

During the 2020-21 academic year, YouthTruth conducted another survey with a total of almost 30,000 respondents: 18,366 high school students, 8,954 parents, and 1,996 school staff from 56 participating school in Sonoma County. Seventy-three percent of school staff, 72 percent of families and 57 percent of students reported that the pandemic had meaningfully affected their lives. Furthermore, of the nearly 2,000 school staff surveyed, 35% stated that they've seriously considered moving out of the area due to concerns of cost of living, wildfires, housing issues and job availability.

The pandemic has also disproportionately affected the education and health of communities of color, low-income families and families living in remote geographic areas of the county. Sixty-three percent of high school students surveyed reported at least one obstacle to learning, including feeling depressed, stressed, or anxious. In addition, barriers included distractions at home, family responsibilities and limited or no internet access.[13]

Non-Hispanic Black adults (48%) and Hispanic or Latinx adults (46%) are more likely to report symptoms of anxiety and/or depressive disorder than Non-Hispanic White adults (41%). Historically, these communities of color have faced challenges accessing mental health care. The pandemic also disproportionately affected LGBTQ+ youth; almost 70 % reported feeling so sad or hopeless almost every day that they stopped doing some usual activities, compared to just over 25 percent of straight youth. (Kids Data, 2020)

[12] Sonoma County Department of Health Services, Epidemiology and Assessment Unit. (2019)
[13] Leading Through Listening: Student & Community Voices in Sonoma County, 2020-21, YouthTruth. http://youthtruthsurvey.org/wp-content/uploads/2021/05/YouthTruth-Leading-through-Listening-in-Sonoma-County.pdf

Community Program Planning Process (CPPP)

Over the years, Sonoma County has refined the system and structure for the Mental Health Services Act (MHSA) Community Program Planning Process (CPPP) to be more inclusive with depth of inquiry into various demographic populations that are still experiencing mental health disparities and due to lack of appropriate services or barriers to accessing services. This system of community engagement is foundational for informing the Three-year Program and Expenditure Plans and Plan Updates. A major component that is leading CPPP is the newly formed Community Program Planning (CPP) Workgroup, a subcommittee of the MHSA Steering Committee. The CPP Workgroup is comprised of MHSA Steering Committee members and other stakeholders from the community at-large. The MHSA Steering Committee continues to be the anchor for the overall CPP process and adheres to the California Code of Regulations (CCR) § 3200.270 and CCR § 3200.300 to ensure that stakeholders reflect the diversity of the county's demographics, including, but not limited to geographic location, age, gender, and race/ethnicity.

MHSA Steering Committee

The current composition of the MHSA Steering Committee includes representation from individuals with lived experience, family members, the Mental Health Board, education, health, criminal justice and law enforcement, housing and community development, veterans and LGBTQ+.

The Steering Committee has a total of 24 members after conducting a recruitment in FY 2022-23. Standard protocol to become a member of the MHSA Steering Committee includes an application reviewed and vetted by the MHSA Coordinator to assure diverse representation. New members are provided in-depth training covering MHSA regulations, CPPP, current expenditure plans and programs, and expectations for participation. To assure full

participation, Sonoma County offers stipends to cover transportation or loss of work time to attend quarterly meetings. Minutes for past MHSA Steering Committee meetings can be found on the Sonoma County Department of Health Services, Behavioral Health Division MHSA website at: https://sonomacounty.ca.gov/health-and-human-services/health-services/divisions/behavioral-health/about-us/mental-health-services-act

MHSA Steering Committee past and current members for 2020-23 are listed in the table below. Included in the table are description of status, committee participation and representation. Sixteen members resigned in 2021-22 and nine new members joined in 2022.

Name	Status and Subcommittee	Representation
Claudia Abend	Resigned 2022	Lived mental health experience, family member
Wardell Anderson	New member 2022	Probation, African American
Mechelle Buchignani		Sheriff Dept, LGBTQ+
Jessica Carroll	CPP Workgroup, Resigned 2022	LGBTQ+, lived mental health experience
Stephanie Chandler	Capacity Assessment, Innovation, Resigned 2022	Healthcare
Sophie Marie Clifford	Resigned 2022	Lived mental health experience, Latina, LGBTQ+, provider
Mandy Corbin		Education
Brandon Cutting	Resigned 2021	Law Enforcement
Christy Davila		MH Provider
Angie Dillon-Shore	Capacity Assessment	First Five, 0-5, LGBTQ+
Becky Ennis	New member 2022	MH provider, Education, family member
Jeane Erlenborn		Education, Transition age youth
Fabiola Espinosa	MHSA Analyst	Family member, Latina
Saskia Garcia	CPP Workgroup	Provider, family member, Lived mental health experience
Paula Glodowski Valla		Human Services
Cynthia Kane Hyman	CPP Workgroup, Resigned 2022	Education
Ozzy Jimenez	Resigned 2021	LGBTQ+, Latino, business, philanthropy
Michael Johnson	New member 2022	Mental Health Board, lived mental health experience
Erika Klohe	CPP Workgroup, Innovation	Provider, lived mental health experience, family member
Melissa Ladrech	MHSA Coordinator	Family member
Kenia Leon	New member 2022	Provider, lived mental health experience, family member, Latina
Amanda Lopez	New member 2022	Veterans
John Mackey	Resigned 2022	Veterans, Healthcare
Claire McDonell		Family member, TAY, Education

Shannon McEntee	Resigned 2022	Lived mental health experience, TAY
Michael Merchen	New member 2021	Sheriff
Allison Murphy		0-5
Ernesto Oliveras	Capacity Assessment, Resigned 2022	Latino, Social Services
Nubia Padilla	CPP workgroup, New member 2022	Latina, MH provider, TAY
Matt Perry	Resigned 2021	Law Enforcement
Robin Phoenix	New member 2022	Lived mental health experience, Homeless Services
Amy Ramirez	New member 2022	Health
Ellisa Reiff		Disabilities
Maricarmen Reyes	New member 2022	Family member, Latina
Kate Roberge	CPP Workgroup	Lived mental health experience, Peer, Workforce, Disabilities
Kurt Schweigman	CPP workgroup, Capacity Assessment, Innovation, Resigned 2022	Native American, Healthcare, SA\MH Provider
Kathy Smith	Innovation, CPP Workgroup	MH Board, family member
Susan Standen	Innovation, CPP Workgroup	Lived mental health experience, "Peer at large"
Angela Struckmann	Resigned 2022	Family member, Social Services
Katie Swann	CPP Workgroup, Resigned 2022	Family member, LGBTQ+, TAY, MH Provider
Sam Tuttleman	Innovation, Capacity Assessment, Resigned 2021	Family member
Carol West	CPP Workgroup, resigned 2022	Peer provider, Community Health Worker, lived mental health experience

During the fiscal years (FY), 20-21, 21-22 and 22-23 much was accomplished despite the challenges that the COVID-19 pandemic presented. The following are highlights for each corresponding fiscal year.

FY 2020-21

- Recommendation to enhance peer staffing in FSP programs.
- Monitoring the submission, review, and approval of four innovation projects submitted to the MHSOAC. Further development of approved Early Psychosis program and preliminary development of Crossroads to Hope, a diverse program integrating peers into short-term housing with treatment.
- Presentation and discussion on SB803, AB2112 and AB2265.
- Decision to include community members at-large on the Community Program Planning Workgroup to increase diversity and representation.
- Conduct RFP process for PEI funding. Established PEI workgroup to develop recommendations on PEI local priorities, support development of RFP process and

corresponding public documents, evaluation criteria and review and rating of submitted proposals. Recommendation for eleven awards totaling $1,330,000.

Top scoring PEI RFP proposals:

Population Focus	MHSA PEI Program Type(s)	Organization	Funding Award
African Americans	Prevention	Community Baptist Church	$120,000.00
Native Americans	Prevention	Sonoma County Indian Health Project	$40,000.00
Geographically Isolated	Prevention	Action Network	$60,000.00
LGBTQIA+	Prevention and Early Intervention	Positive Images	$102,000.00
Latinx	Early Intervention and Prevention	La Luz	$33,000
		Latino Service Providers	$107,000
Children Aged 0-5 (and their families)	Early Intervention	La Luz	$46,000
		Child Parent Institute (CPI)	$198,000
		Early Learning Institute	$44,000
Transition Age Youth (ages 16-25)	Stigma and Discrimination Reduction	Santa Rosa Junior College	$200,000
General Population	Suicide Prevention	Buckelew	$160,000

- Mental Health Board hosted the public hearing for MHSA FY 21- 22 Annual Update and Expenditure Plan and the FY 19-20 MHSA Program Report

FY 2021-22

- Supporting organization and systems ongoing adaptation to COVID-19 pandemic impacts.
- Discussed implementing Results Based Accountability into MHSA contracts.
- Support CPP Workgroup in recruiting new members and developing a strategic plan with recommendation for listening sessions to be planned and implemented in 2022. Funding identified to support project and solicitation for consultant to lead process is initiated.
- Development, public review and input to the Annual Plan Update FY 22-23 and Program Report for FY 19-20
- Introduction to Capacity Assessment, solicitation of consultant to lead process.
- Appointment of Behavioral Health Director.
- Mental Health Board hosted the public hearing for MHSA FY 22- 23 Annual Update and Expenditure Plan and the FY 20-21 MHSA Program Report

FY 2022-23

- Retained consulting firm, RDA, to lead Capacity Assessment process. Presentation to MHSA Steering Committee on process and deliverables. Engagement of stakeholders.

- Retained consultant, Dory Escobar, to lead Listening Sessions for CPPP workgroup strategic plan. Briefing with MHSA Steering Committee. Differentiate Listening Sessions from Capacity Assessment focus groups.
- Provide update on Suicide Prevention Coalition work and solicit input on goals for the Suicide Prevention Strategic Plan
- Input on housing needs: supported permanent and transitional housing
- Received feedback on FY 23-26 Three-Year Program Plan and Expenditure Plan, including Capacity Assessment.
- Not yet completed: Mental Health Board hosted the public hearing for MHSA FY 23-26 Three Year Program Plan and Expenditure Plan and the FY 21-22 MHSA Program Report

Community Program Planning Workgroup

As noted earlier, the Community Program Planning Workgroup was established in August of 2020. The general purpose of the CPP Workgroup is to support community engagement of local stakeholders to obtain input on the development of the county's MHSA Three-year plans and annual program updates. More specifically, the members of the CPP Workgroup were tasked with the following:

1. Identify and conduct outreach to stakeholders for community engagement.
2. Support the distribution of MHSA Plans and Updates upon public release.
3. Co-facilitate the annual Stakeholder meeting: encourage stakeholders to provide relevant input on key system considerations, review MHSA Plan and Updates and provide input through public channels.
4. Develop cost-effective methods of community engagement.
5. Report back to the MHSA Steering Committee, Mental Health Board, and any other governing bodies as necessary.
6. Report back to the engaged stakeholder communities on how their input resulted in changes to MHSA plans, programs and/or budgets.

In 2021, during the second year of the pandemic and stay-at-home orders, CPP Workgroup general meetings shifted to focus on preparing for the Request for Proposal (RFP) process for MHSA Prevention, Early Intervention Services (PEI). Members from the CPP Workgroup were joined by additional community members to form the MHSA PEI RFP Stakeholder group. This group met five times from January – April. The MHSA PEI RFP Stakeholders were instrumental in defining populations of interest for prevention and early intervention services, analyzing the data to recommend funding categories and shaping language of the RFP solicitation. In addition, CPP workgroup members supported community outreach, distribution of the RFP, and community education on the funding opportunity.

In the fall of 2021, the CPP Workgroup developed a Strategic Plan that defined their Mission, Vision, and Values. In addition, priority actions were determined and shaped into a workplan that ultimately recommended a series of listening sessions that are place-based within communities of color and other communities that still experience mental health disparities

based on age, geography, gender, or other characteristics. This Strategic Plan was shared with the MHSA Steering Committee and DHS-BHD leadership with a final adoption in January 2022. The Community Program Planning Strategic Plan is on page 539.

Funding of $150,000 was identified to implement the listening sessions in FY 2022-23 with the support of a facilitator. A community-based participatory research model is employed by identifying co-facilitators within populations of interest and building capacity for co-facilitators to design and implement an inquiry within their own communities. The following graphic describes this process beginning with the identification of priority populations to engage, recruiting and training of co-facilitators from those communities, designing and implementing the listening sessions, analyzing data and producing annual reports with key findings.

CPP Listening Sessions Project Phases:

From August to October of 2022, the CPP Workgroup determined twelve populations that were of interest to engage for inquiry into their perceptions of appropriate mental health support and services, what is available and what is still needed.

- Latinx Immigrant Adults
  - Sonoma Valley
  - Low-Wage Earners
  - North County Farmworkers and/or their Families
- Latinx US-Born Adults
- Latinx Youth
- African Americans
- Local Indigenous People
- Asian American Pacific Islanders
- People with Disabilities
- Older Adults
- LGBTQI

- Unhoused Women

Within these populations, individuals and organizations were identified by the facilitator and CPP Workgroup members for the role of co-facilitator. Seventeen co-facilitators were identified and participated in orientation and a comprehensive training. These co-facilitators are compensated with a stipend for both attending training and conducting outreach and the listening sessions. An outline of this training is illustrated below.

Orientation	Facilitation Training
○ Project Overview & Context ○ Listening Session Groups ○ Health & Safety ○ Role of Co-facilitators ○ Administrative Tasks/Forms ○ Team Meetings ○ Zoom Tips	○ MHSA 101 ○ Guiding Principles ○ Listening Session Questions ○ Participant Recruitment ○ Facilitation Skills ○ Sessions Planning & Prep ○ Interpretation of Results ○ Developing Recommendations

Listening sessions were then conducted over a three-month period and all participants were provided with a stipend for their attendance.

Date	Population
3/16/23	Older Adults
3/29/23	Spanish-speaking, low-income Latinx
4/2/23	Asian American Pacific Islander
4/8/23	Asian American Pacific Islander
4/10/23	African American
4/22/23	LGBTQIA+
4/27/23	Spanish-speaking Latinx immigrants
4/30/23	Latinx-Youth
5/18/23	African American Adults
TBD	Indigenous Adults
	Additional Sessions will be scheduled

The qualitative data will be analyzed with co-facilitators and CPP Workgroup members in July of 2023. The project will culminate with a listening session report containing findings and recommendations that will be utilized by the County for shaping future programming for the MHSA system of care. This report will be disseminated back to the community of participants, stakeholders, Mental Health Board, MHSA Steering Committee and DHS-BHD leadership.

Stakeholder Participation

Stakeholders, defined as anyone in the community who may have an interest in mental health services, specifically MHSA funded mental health services, are provided opportunities to learn about funding and programming and provide input to influence decisions regarding MHSA services. The following

opportunities are available to the community on a regular basis, and notifications are sent to a mailing list of over 2000 emails.

1) Stakeholder meeting
    a. Annually
    b. MHSA orientation
    c. MHSA updates
    d. Community discussion on current topic of interest
    e. Co-facilitated by CPP Workgroup members
2) Public hearings hosted by the Mental Health Board on Three-year Program and Expenditure Plans
    a. Every three years
3) Public hearing hosted by the Mental Health Board on Annual Plan Updates and prior year's Plan Report
    a. Annually
4) Mental Health Board meetings
    a. Monthly

One goal for stakeholder engagement is to build the capacity for community members to have a foundation of knowledge and actively participate in promoting wellness and shaping access to quality services for a diverse population seeking mental health services. An example of this is, the listening sessions sponsored by the CPP workgroup will be engaging co-facilitators in a deep and meaningful process. These individuals may be interested in joining the MHSA Steering Committee in the future. Their diversity of experiences, connection to their communities and knowledge about MHSA and mental health would provide valuable perspectives and contributions to enhancing the MHSA system of care.

Stakeholder Meetings

As noted previously, the MHSA Stakeholder Meetings are developed with and co-facilitated by the members of the CPP Workgroup. These meetings are well attended, and the standard agenda includes a 30 minute briefing on MHSA history, regulations, updates on program and funding, and dedicated time for break-outs with discussions on current topics of interest, stakeholder feedback that is documented and considered for future decision-making. Discussions questions have included:

- What are the successes and challenges with our mental health systems that your have observed over the past year?
- How do we get more engagement and diversity in our stakeholder group?
- How do we create a safe space for diversity in this stakeholder group?
- What is working well in the Sonoma County Behavioral Health System?
    - What would you like to see more of?
- What is not working well in the Sonoma County BHS?
    - What are the top three changes you would like to see?
- What is the most effective or best way to get input for the group you represent?

Overall Community Program Planning Process for Sonoma County's MHSA Programs
Calendar: July 2020 – June 2023

Date	Location	Stakeholder Group	Topics Discussed
7/6/20	Virtual	MHSA Steering Committee	MHSA Update, Findings from DHCS MHSA Site Review, Innovation Projects
8/12/20	Virtual	CPP workgroup	Establishing workgroup charter, MHSA orientation and community planning processes
9/16/20	Virtual	CPP workgroup	Review Innovation projects, Capacity Assessment and Three-Year Program and Expenditure Plan
10/14/20	Virtual	MHSA Steering Committee	MHSA budget delay due to fires and pandemic, Innovation updates, CPP update, Discussion about the impact of Covid on the CBOs in respect to mental health and wellness
11/18/20	Virtual	CPP Workgroup	MHSA Updates, Planning Stakeholder Meetings, PEI RFP process
12/14/20	Virtual	Mental Health Board Public Hearing on MHSA Program Plan Update and Expenditure Report, All Stakeholders,	Budget Update and impacts on MHSA Expenditure Plan, Innovation Update, Community Program Planning Process, Overview of Four Innovation Proposals
12/15/20	Virtual	CPP Workgroup	PEI RFP process and CPP member engagement
1/7/21	Virtual	MHSA PEI RFP Stakeholders	MHSA and PEI regulations and programs, RFP process,
1/13/21	Virtual	MHSA Steering Committee	PEI RFP process, role of CPP Workgroup, MHSA Updates, review data including Capacity Assessment, population data and funding availability,
1/14/21	Virtual	MHSA PEI RFP Stakeholders	Determine priority populations and funding allocations
1/21/21	Virtual	MHSA PEI RFP Stakeholders	RFP content, Evaluation criteria for proposals, schedule, and outreach
3/9/21	Virtual	PEI RFP Bidder's Conference	Review PEI solicitation with interested community providers and interested stakeholders
4/13/21 & 4/22/21	Virtual	PEI RFP Evaluation panel	Orientation for scoring PEI proposals, review of scores and develop recommendation for funding
5/27/21	Virtual	Stakeholder Meeting	MHSA orientation and update, PEI RFP process, discussion
5/11/21	Virtual	MHSA Steering Committee	Pandemic impacts, FY 2021-22 MHSA Budget review, FY 2021-22 MHSA Annual Program Plan and Expenditure Report, Updates on PEI RFP and Innovation projects
8/5/21	Virtual	CPP Workgroup	Drafting CPP Strategic Plan, Debrief Stakeholder meeting, plan for MHSA Steering Committee
8/11/21	Virtual	MHSA Steering Committee	CPP Workgroup update, Stakeholder meeting, presentation from panel of individuals with lived mental health experience, MHSA updates

10/21/21	Virtual	CPP Workgroup	CPP Strategic Plan, Proposal for funding of Strategic Plan, Recruiting for CPP members
11/4/21	Virtual	CPP Workgroup	Planning for Steering Committee and Stakeholder meetings, Edits to Strategic Plan and Funding Plan
11/4/21	Virtual	Mental Health Board Public Hearing on MHSA Program Plan Update and Expenditure Report, All Stakeholders	Reviewed the MHSA FY 21- 22 Annual Update and Expenditure Plan and the FY 19-20 MHSA Program Report Public comments
11/10/21	Virtual	MHSA Steering Committee	DEI discussion, MHSA Updates, Reviewed Public Hearing for Plan Update and Report, CPP Workgroup update
12/2/21	Virtual	CPP Workgroup	Finalize Strategic Plan and Funding Plan, Develop agenda for Stakeholder meeting, MHSA Updates, CPP recruitment of new members
12/7/21	Virtual	Board of Supervisors, all stakeholders	Reviewed and approved FY 22-21 Plan Update, Expenditure Plan, and FY 19-20 Program Report
2/3/22	Virtual	CPP Workgroup	Adopt Strategic Plan, Finalize Funding plan, Planning for Stakeholder meeting in Feb
2/9/22	Virtual	MHSA Steering Committee	Discussion on ongoing impact of COVID-19, Capacity Assessment discussion, CPP Workgroup update, MHSA updates, DEI update
2/17/22	Virtual	Stakeholder Meeting	DEI discussion, CPP Workgroup Update on listening sessions, MHSA Updates,
3/15/22	Virtual	CPP Workgroup	Debrief Stakeholder meeting, Actions related to Strategic Plan listening sessions – recruiting facilitator
4/7/22	Virtual	CPP Workgroup	Discussion on DEI and creating safe spaces, Listening Session update, discussed new INN project: Semi-Statewide Electronic Health Record (EHR)
5/11/22	Virtual	Steering Committee	Reviewed California Reducing Disparities Project, requested feedback on FY 22-23 Annual Plan Update and Expenditure Plan and Program Report for FY 19-20 discussed new INN project: Semi-Statewide Electronic Health Record (EHR)
5/17/22	Virtual	Mental Health Board Public Hearing on MHSA Program Plan Update and Expenditure Report, All Stakeholders	Highlights of the MHSA Program Plan Update & Expenditure Plan for 2022-2023, Summary of Changes from Last Year's Plan, Expenditure Plan, Highlights of the MHSA Annual Program Report for 2020-2021
5/22/22	Virtual	CBO CalAIM Stakeholder Meeting	Many CBOs indicated a desire to participate in the semi-statewide EHR project to increase interoperability and efficiency of care coordination. They identified challenges that multi-county CBOs encounter when attempting

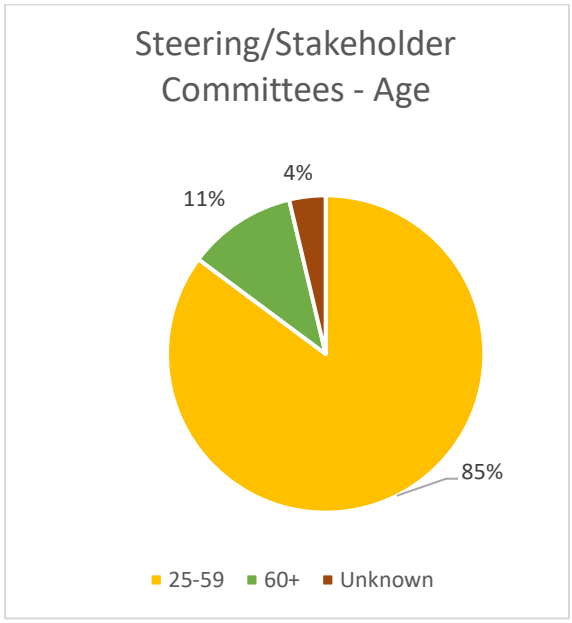
			to interface with different county EHRs. They stated their need for support from the County on implementation and requested inclusion in the project. They were invited to the Quality Improvement Committee as the forum to continue discussions on CalAIM changes and EHR project updates.
5/26/22	Virtual	Department of Health Services Leadership	Department Director, Tina Rivera, reviewed and approved moving forward with Semi-Statewide Electronic Health Record (EHR), including the budget and the risks and benefits associated with the project.
6/15/22	Hybrid: Santa Rosa and virtual	CPP Workgroup	Revisit group norms, Implementation of Strategic Plan and develop solicitation for consultant facilitator
6/20/22	Virtual	Posted on Behavioral Health Website and notified over 2000 MHSA stakeholders via the MHSA listserv	No comments were received about the posting of Semi-Statewide Electronic Health Record (EHR) The Steering Committee, CPP Workgroup and MHB were provided with the proposal to review.
7/19/22	Virtual	Mental Health Board Public Hearing	Public comments supported the Semi-Statewide Electronic Health Record (EHR) project, there were no substantive comments.
7/20/22	Hybrid: Santa Rosa and virtual	CPP Workgroup	Introduction of Listening Session facilitator, Preliminary conversation re: priority populations, Plan for MHSA Steering Committee meeting
8/10/22	Virtual	MHSA Steering Committee	Introduction of new members, BHD Director update, Cal-AIM, FY 2019-22 Capacity Assessment, and consulting firm RDA, CPP Listening Sessions, reviewed the Semi-Statewide Electronic Health Record (EHR)
8/16/22	Hybrid: Santa Rosa and virtual	CPP Workgroup	Capacity Assessment and RDA, Process, and priority populations for Listening Sessions
9/6/22	Hybrid: Santa Rosa and virtual	CPP Workgroup	Capacity Assessment process and input, Populations for listening sessions, Planning for Stakeholder meeting
9/13/22	Hybrid: Santa Rosa and virtual	Board of Supervisors	Revied and approved the Semi-Statewide Electronic Health Record (EHR)

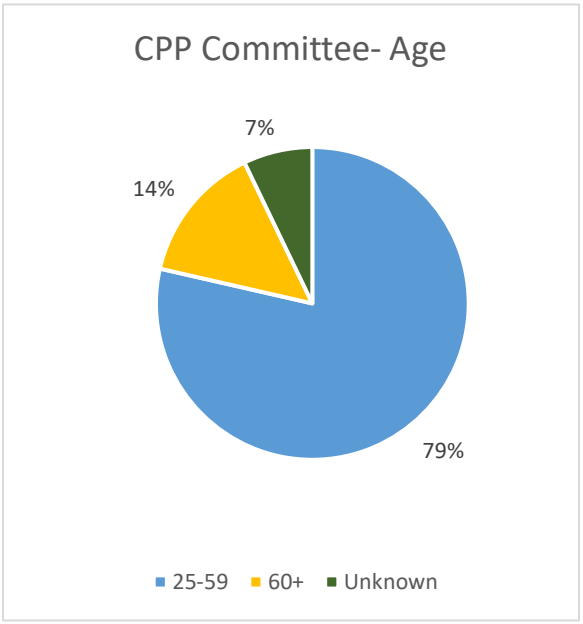
9/21/22	Hybrid: Santa Rosa and virtual	CPP Workgroup	Finalize priority populations for listening sessions, upcoming process, and calendar
10/5/22	Hybrid: Santa Rosa and virtual	CPP Workgroup	Listening session update, Capacity Assessment update, differentiate Capacity Assessment focus groups from CPP listening sessions
11/9/22	Virtual	MHSA Steering Committee	Capacity Assessment update, FY 2023-26 Budget update, Innovation, Listening Session update
11/17/22	Hybrid: Santa Rosa and virtual	Mental Health Services Oversite and Accountability Commission (MHSOAC)	The MHSOAC approved Sonoma County's Semi-Statewide Enterprise Health Record System Improvement Innovation Project on November 17, 2022, up to the amount of $4,420,447.54 in Innovation funding over five (5) years
12/7/22	Hybrid: Santa Rosa and virtual	CPP Workgroup	Listening session recruitment of co-facilitators and training plan, Capacity Assessment survey and focus groups, MHSA update
1/24/23	Hybrid: Santa Rosa and virtual	Board of Supervisors, all stakeholders	Reviewed and approved FY 23-22 Plan Update, Expenditure Plan, and FY 20-21 Program Report
2/1/23	Hybrid: Santa Rosa and virtual	CPP Workgroup	Listening session update, MHSA update
2/8/23	Virtual	MHSA Steering Committee	Introduction of Ethnic Services, Inclusion and Training Coordinator, Sonoma Suicide Prevention Coalition Update and discussion on recommended service needs, Capacity Assessment preliminary findings, CPP listening session update
3/7/23	Hybrid: Santa Rosa and virtual	Stakeholder Meeting	MHSA orientation, Review DEI input, Discussion on MH challenges and successes in service delivery, FY 2023-26 Three-year Program Plan development, Sonoma Suicide Prevention Coalition report, CPP listening session update
5/10/23	Virtual	MHSA Steering Committee	Discussed FY 23-26 Three-Year Plan and Expenditure Plan adjustments, reviewed and discussed the Governor's Announcement about the Modernization of MHSA and focus on Housing and provided an update on the CPP Listening Sessions.
5/16/23	Hybrid: Santa	Mental Health Board on MHSA Program Plan	MHSA Overview, Mental Health Funding review, discussed draft MHSA FY 23-26 Program Plan

	Rosa and virtual	Update and Expenditure Report, All Stakeholders	and Expenditure Plan Expansion, No Place Like Home Update and review of MHSA FY 21-22 Annual Report
5/17/23	Virtual	Measure O Stakeholders	MHSA Overview, Mental Health Funding review, discussed draft MHSA FY 23-26 Program Plan and Expenditure Plan Expansion, No Place Like Home Update and review of MHSA FY 21-22 Annual Report
6/20/23	Hybrid: Santa Rosa and virtual	Mental Health Board Public Hearing on MHSA Program Plan Update and Expenditure Report, All Stakeholders	MHSA Overview, Mental Health Funding review, discussed draft MHSA FY 23-26 Program Plan and Expenditure Plan Expansion, No Place Like Home Update and review of MHSA FY 21-22 Annual Report
7/18/23	Hybrid: Santa Rosa and virtual	Board of Supervisors	Review Three Year Plan for approval

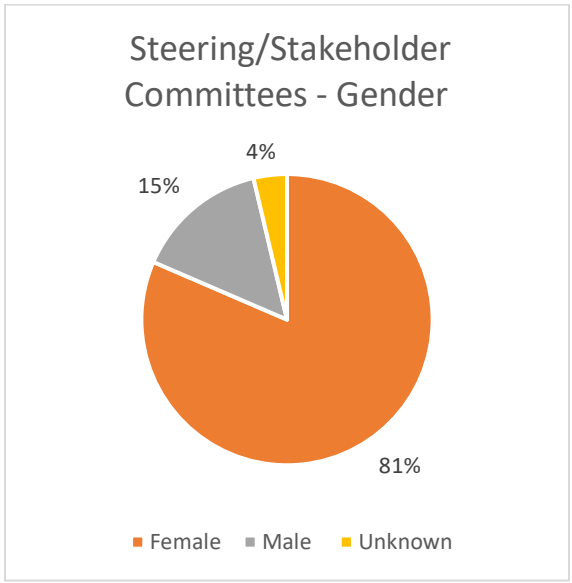
Sonoma County MHSA Steering, Stakeholder, and CPP Committee Demographics

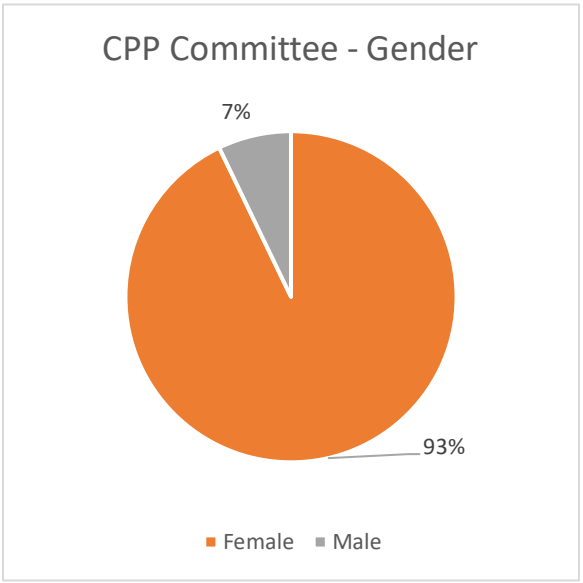
Age





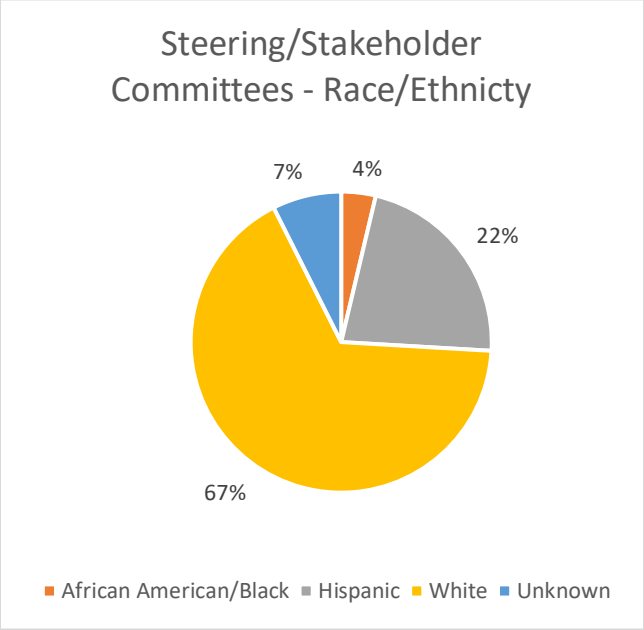
Gender

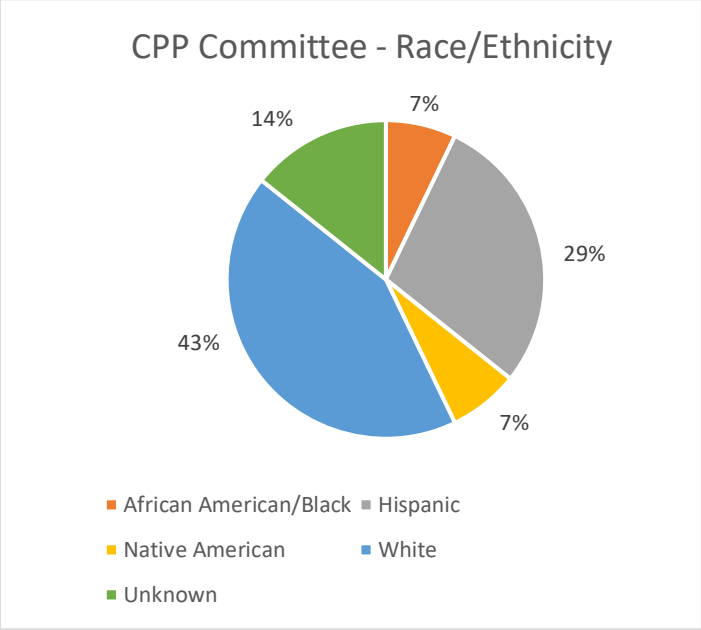




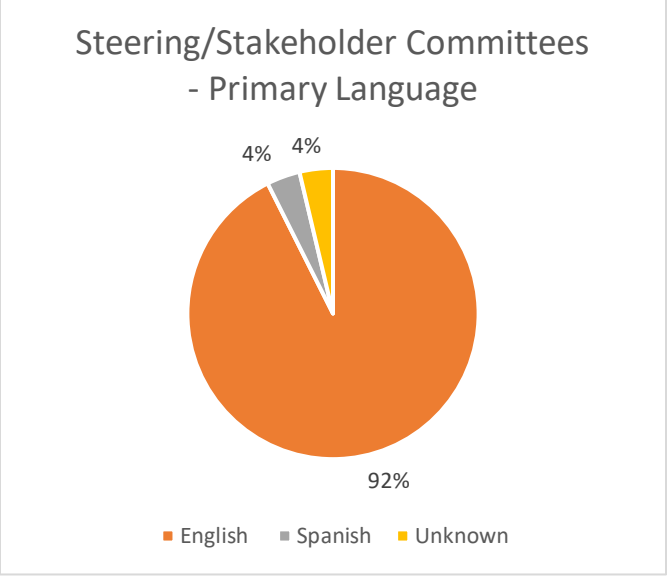
Sonoma County MHSA Steering, Stakeholder, and CPP Committee Demographics (cont'd)

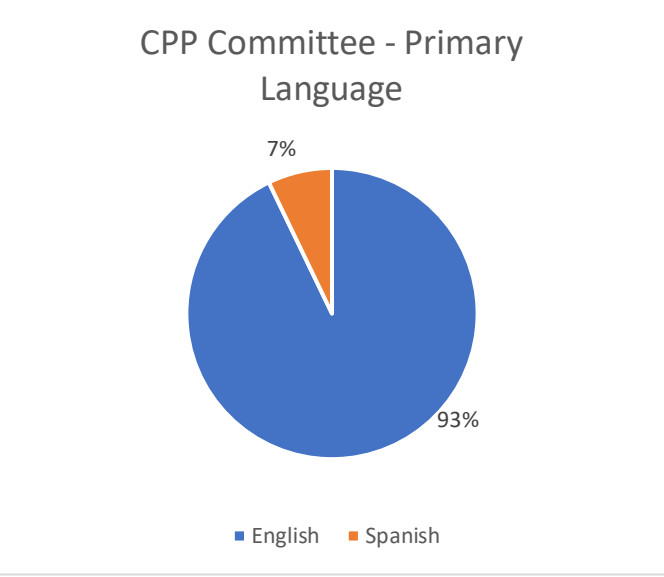
Race/Ethnicity





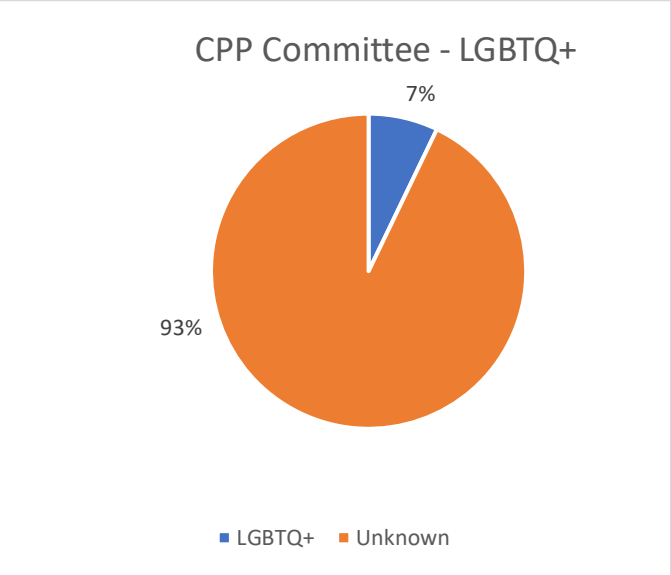
Primary Language





Sonoma County MHSA Steering, Stakeholder, and CPP Committee Demographics (cont'd)

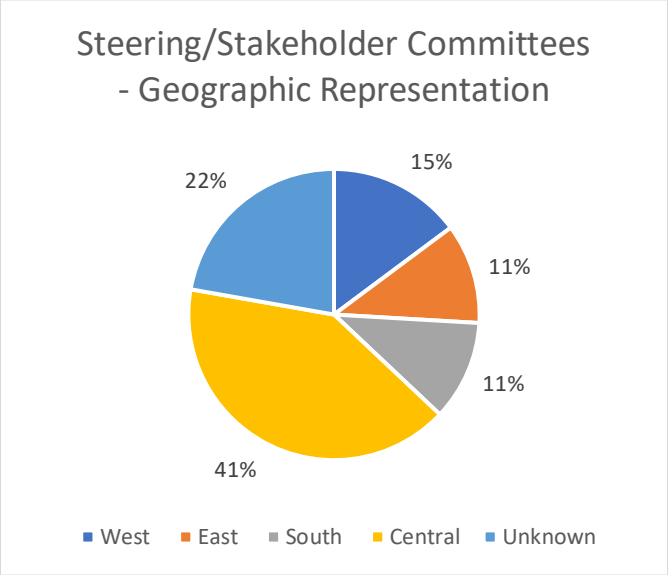
LGBTQ+

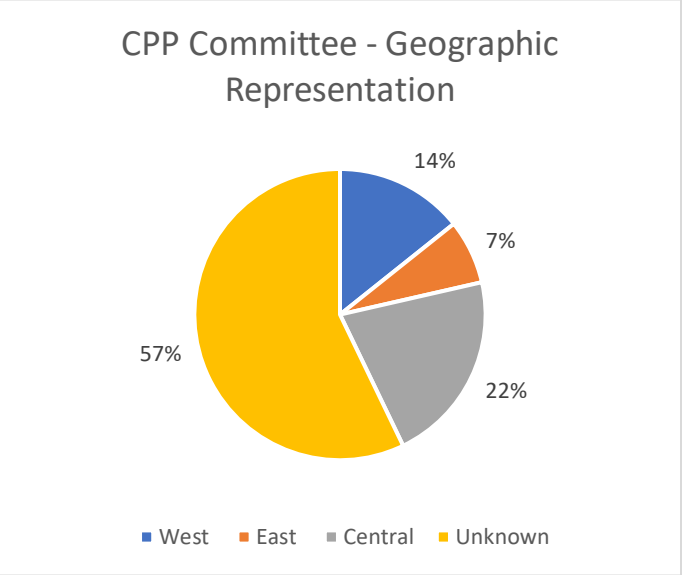


Veteran Status

Sonoma County MHSA Steering, Stakeholder, and CPP Committee Demographics (cont'd)

Geographic Representation





Innovation Development: Semi-Statewide Enterprise Health Record System Improvement Innovation Project

In 2022, Sonoma County Behavioral Health utilized 3 primary recordkeeping systems (Avatar, SWITS, and DCAR) to manage clinical documentation, mandated data reporting, and billing/claiming (primarily Medi-Cal). The FY 21-22 contract amounts for these systems totals of $857,701, $91,970, and $34,500, respectively.

Sonoma County, like many California Counties, has struggled with implementing Federal and State requirements with our current EHR vendors and systems. The Division has minimal resources to administer our systems, and lack technical expertise in the areas of modification, enhancement, implementation, and maintenance of our EHR systems.

The Division's efforts over the years to implement Avatar has been challenging and expensive, and there have been significant delays with project timelines and deliverables. SWITS provides a basic system that has been used for over a decade. As we move towards implementing the Drug Medi-Cal Organized Delivery System (DMC-ODS), SWITS will require significant and expensive upgrades, changes to configuration, and enhancements to comply with the various regulatory requirements associated with DMC-ODS.

The Division has been unsuccessful with implementing the use of Avatar with our community-based organizations, which provide approximately 40% of our mental health services. As a result, we have continued to use the CANS/ANSA Data Collection and Reporting (DCAR) System to track and submit required CANS/ANSA outcomes data.

On 5/24/22, the Quality Assessment Performance Improvement (QAPI) section facilitated a CBO CalAIM stakeholder meeting to provide an overview of anticipated system changes, and conduct 3 listening sessions (Adult MH Providers, Youth MH Providers, Substance Use Disorder service providers). CBO attendees included Program Directors, Clinical Directors, Quality Management Teams, and Billing/Claiming Teams. Many CBOs indicated a desire to participate in the semi-statewide EHR project to increase interoperability and efficiency of care coordination. They identified challenges that multi-county CBOs encounter when attempting to interface with different county EHRs. They stated their need for support from the County on implementation and requested inclusion in the project. They were invited to the Quality Improvement Committee as the forum to continue discussions on CalAIM changes and EHR project updates.

Sonoma County Behavioral Health Division has prioritized this project over other identified challenges because implementing a Semi-Statewide Electronic Health Record (EHR) that meets the new CalAIM requirements will address many of the barriers discussed in this proposal by providing the following:

- User friendly EHR system that reduces staff time spent on data input, and can assist with retaining staff
- CBO direct entry and interface with the county EHR
- Consolidation of the three current EHR platforms into one centralized system
- Compliance with CalAIM requirements on payment reform, policy changes, and data exchange
- Client Portal interface capability, which will increase client access and transparency

Community Program Planning Process for the Semi-Statewide Enterprise Health Record System Improvement Innovation Project, AKA SmartCare:

Date	Committee	Feedback
4/7/22	MHSA Community Program Planning (CPP) Workgroup	One CPP Workgroup member stated that she supported the plan since it was being designed to help retain staff and allow staff to focus on clients and spend less time on entering data.
5/11/22	MHSA Steering Committee	One member stated that she was an intern at the county and Avatar, the county's current EHR, was very difficult and time consuming to use. She was very excited about the project.
5/22/22	CBO CalAIM Stakeholder Meeting	Many CBOs indicated a desire to participate in the semi-statewide EHR project to increase interoperability and efficiency of care coordination. They identified challenges that multi-county CBOs encounter when attempting to interface with different county EHRs. They stated their need for support from the County on implementation and requested inclusion in the project. They were invited to the Quality Improvement Committee as the forum to continue discussions on CalAIM changes and EHR project updates.

5/26/22	Department of Health Services Leadership	Department Director, Tina Rivera, reviewed the proposal, including the budget and the risks and benefits associated with the project. After reviewing all of the data the Department Director approved moving forward with the project.
6/20/22	Posted on Behavioral Health Division Website and notified over 2000 MHSA stakeholders via the MHSA listserv	No comments were received about the posting. The Steering Committee, CPP Workgroup and MHB were provided with the proposal to review.
6/22/2022	Quality Improvement Committee (QIC)	Announcement of upcoming changes through CalAIM and inclusion of additional members of QIC
7/19/2022	Mental Health Board Public Hearing	One member was very interested in the client portal capacity that the new EHR is planned to have. This member stated how important a client portal is to transparency.
7/26/22	Quality Assessment and Performance Improvement Section Meeting	Announced plans to collaborate with CalMHSA and other counties to implement new semi–State-wide EHR. Received requests for further details about system and support for implementing new, improved system.
7/27/22	Quality Improvement Committee	Focused discussion of CalAIM and EHR Project. Participants identified the importance of meaningful participation from peers and family members in the project.
8/10/2022	MHSA Steering Committee	One member had questions about the use of CFTN funds and how the county was funding Avatar. Avatar and the County staff are currently both being funded by CFTN.
9/13/2022	Sonoma County Board of Supervisors Meeting	Agenda item detailing EHR plan and receiving approval to enter into Participation agreement with CalMHSA for development and implementation.
11/17/22	Mental Health Services Oversite and Accountability Commission (MHSOAC)	The MHSOAC approved Sonoma County's Semi-Statewide Enterprise Health Record System Improvement Innovation Project on November 17, 2022, up to the amount of $4,420,447.54 in Innovation funding over five (5) years

Suicide Prevention Coalition:

In 2022 the new Behavioral Health Director convened a time limited Suicide Prevention Coalition to develop a Sonoma County Suicide Prevention Strategic Plan. Because Sonoma County has a suicide rate that is significantly higher than the state average, Sonoma is being provided technical assistance by Carly Memoli, Consultant and Subject Matter Expert with Striving for Zero Suicide Prevention Learning Collaborative Technical Assistance Team administered by Your Social Marketer, Inc.

The coalition recruited members from a broad spectrum of community and government organizations that are concerned about suicide prevention. Workgroup members will be asked to participate in collaborative meetings, review suicide related data, contribute to information gathering activities, prioritization of activities, and contribute to writing/editing of draft report. The table below lists the names, organizations, and sectors of coalition meetings.

Name	Organization	Sector
Amanda Lopez	Veterans Affairs	Veterans
Erika Klohe	Buckelew	Behavioral Health
Fabiola Espinosa	DHS-BHD	Behavioral Health
Jan Cobaleda-Kegler	DHS-BHD	Behavioral Health
Jeane Erlenborn	Santa Rosa JC	TAY/Education
Mandy Corbin	SCOE	Education
Mary-Frances Walsh	NAMI	Family Support
Mechelle Buchignani	Sherriff Department	Law Enforcement
Melissa Ladrech	DHS-BHD	Behavioral Health
Sang Shin	Kaiser	Mental Health
Steve Diamond	North Bay Suicide Prevention	Suicide Prevention
Saskia Garcia	Sonoma Connect	Community Health
Gabriel Kaplan	Public Health	Public Health
Michael Reynolds	West County Community Services	Peers, lived experience
Leslie Petersen	Hanna Center	Behavioral Health, Youth
Maricarmen Reyes	N/A	Family Member
Susan Standen	N/A	Peers, lived experience

Since the inception of the Suicide Prevention Coalition five meetings have been held. The meetings are generally held monthly, and the members engage in robust discussion. The table below contains the dates and topics of coalition meetings.

Dates	Agenda Items
10/13/22	Introductions Striving For Zero Collaborative Describing the issue of Suicide in Sonoma County including data
12/01/22	Developing a timeline and plan for 2023 Resource Mapping & Survey
2/9/23	Recap of Fall 2022 Meetings Presentation/Q&A with County Coroner & Sheriff Key Dates & Planning Timeline
3/6/23	Resource Mapping & Survey Results Preview for April: Focus on supports after an attempt
4/6/23	Goal setting Survey Results Develop Mission and Guiding Principles

	Focus on Youth presentation by Sonoma County Office of Education Goal setting Survey

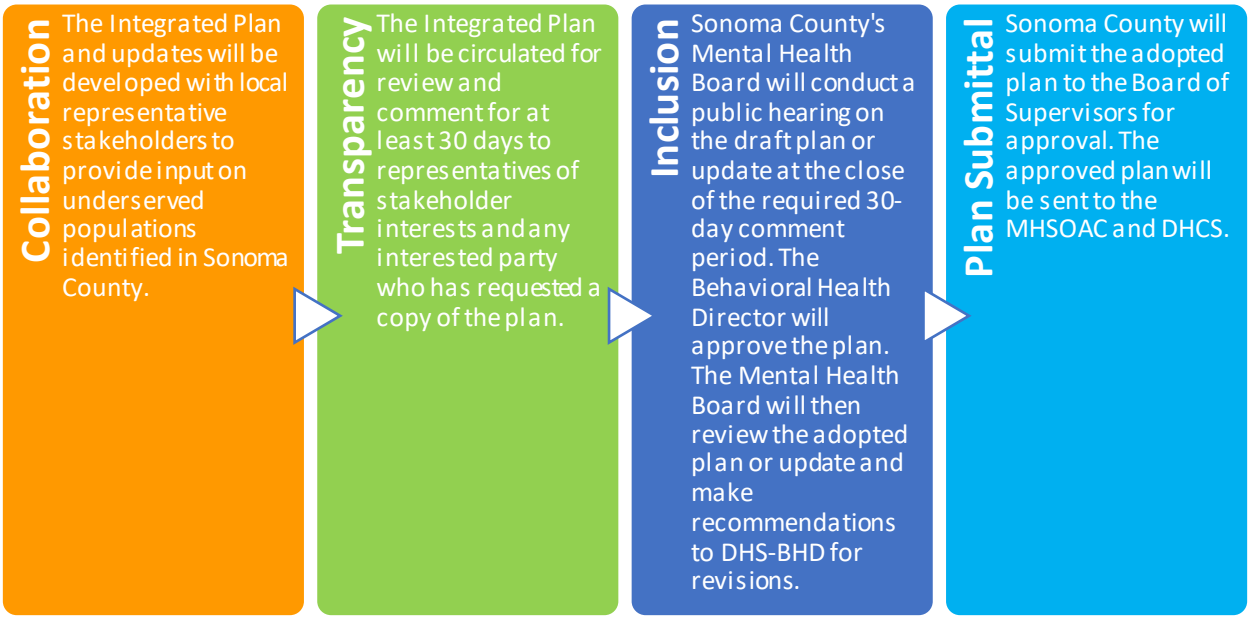
Additional Stakeholder Outreach

DHS-BHD also publishes an MHSA Newsletter, featuring relevant MHSA news, information, and events. A hard copy version of the newsletter is produced every 3-4 months and is shared with a variety of community groups and stakeholders, including the Mental Health Board, Sonoma County Board of Supervisors, DHS-BHD program managers, and contractors. An archive of the newsletter PDFs is available on the MHSA website. An email version of the newsletter is produced and sent out every 3-4 months. People can subscribe to the email newsletter via the MHSA website at:
http://service.govdelivery.com/service/subscribe.html?code=CASONOMA_181
See Appendix 9 on Page 523 for the MHSA newsletters distributed during FY 22-23.

The Public Review and Public Hearing Process

Per Title 9, CCR Section 3315, Sonoma County has conducted a local review process for the community to review and comment on the MHSA Three-Year Program and Expenditure Plan.

Graphic 1: The Public Hearing Process



Sonoma County's Draft MHSA Three-Year Program and Expenditure Plan was posted and emailed for public review on April 14, 2022. DHS-BHD requested that stakeholders review the draft Three-Year Plan and submit comments and questions before May 16, 2023 to:

Melissa Ladrech, LMFT, MHSA Coordinator

Sonoma County Department of Health Services
Behavioral Health Division
2227 Capricorn Way, Suite 207
Santa Rosa, CA 95407 or email at: MHSA@sonoma-county.org

The draft MHSA Three-Year FY 23-26 Plan was posted and distributed via email to skakeholders on May 22, 2023. The 30-day comment period culminated in a final public hearing for the MHSA Three-Year Plan FY 23-26 on June 20, 2023 at the Mental Health Board meeting. There were no substantive recommendations received during the 30 day comment period or public hearing for the County's FY 23-26 Plan, and there were no changes made to the plan.

MHSA Three-Year Plan Distribution and/or Public Hearing Outreach to Stakeholders for 2020

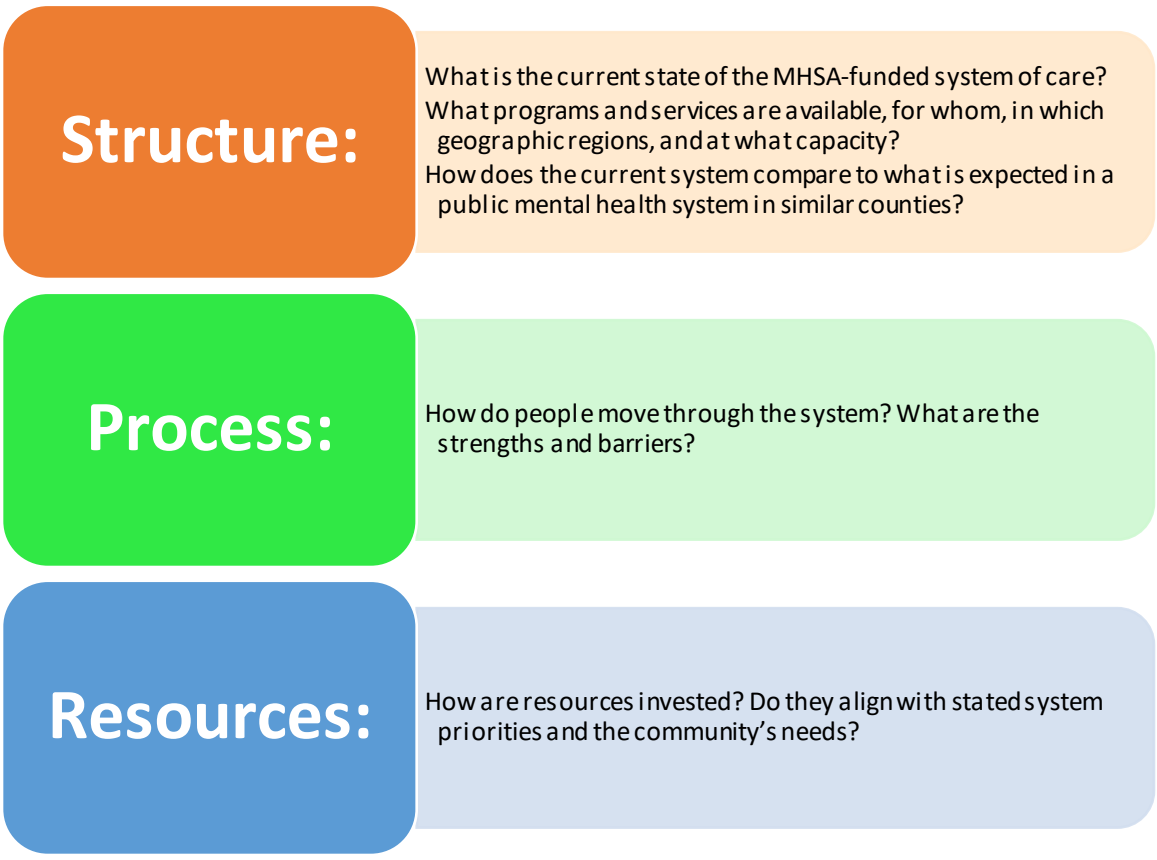
Date	Action
5/22/23	Post draft MHSA Plan on DHS, BHD, MHSA, and Mental Health Board web pages
5/22/23	Email Mental Health Board, MHSA Steering Committee, MHSA Stakeholder Committee, MHSA Contractors, and Staff Contact List with link to draft Plan
5/22/23	Send notice via email to 2000+ MHSA Update subscribers
6/20/23	Public Hearing with Mental Health Board and Stakeholders
8/29/23	Board of Supervisors reviews and adopts final MHSA Three-Year Plan

Capacity Assessment Summary for FY 2019 - 2022

Summary of the Fiscal Years 2019-2022 Sonoma County DHS-BHD Capacity Assessment
(The complete FY 2019-2022 Sonoma County DHS-BHD Capacity Assessment is in the appendix on page 200)

Background

Sonoma County Department of Health Services - Behavioral Health Division (DHS-BHD) has partnered with Resource Development Associates (RDA) to conduct a Mental Health Services Act (MHSA) Capacity Assessment for fiscal years 2019-2022. This report is intended to provide a comprehensive analysis of Sonoma's MHSA-funded system of care and community needs and contribute to the development of the Three-Year MHSA Program and Expenditure Plan for fiscal years 2023-2026. This assessment presents a deeper understanding of the underlying dynamics of the County's behavioral health system and suggests recommendations to further strengthen Sonoma's public mental health system of care.
To evaluate Sonoma's MHSA-funded system of care, the capacity assessment focused on three core questions



To answer these questions, RDA Consulting collected data between August and December 2022 via:

- community survey
- focus groups
- key informant interviews

to understand strengths, challenges, and gaps in the system of care from community and system leaders, clients, family members, providers, and other partners. In addition, RDA Consulting conducted a background document review and secondary analysis of administrative data and quarterly reports

supplied by the County's MHSA-funded partners. These analyses informed this final capacity assessment report.

Capacity Assessment Findings

Structure of the Sonoma County Behavioral Health System of Care

Sonoma's BHD is comprised of Youth and Family Services and Adult and Older Adult Services. Clients ages 0-17 are served by Youth and Family Services and clients ages 18 and older are served by Adult and Older Adult Services. Services for Transition Age Youth (TAY), ages 16-24, are integrated into the Youth and Family Services, but TAY clients 18 and older can also access Adult Services.

Clients may enter the behavioral health system in a variety of ways and through different channels, depending on whether a client is an adult or youth, and whether they need crisis or non-crisis services. The two primary entry points are the Adult Access or Youth Access Teams and crisis services, which is available to all age groups. Once a client enters the system, regardless of whether they are youth or adult, there are a variety of services available that address different needs. The continuum of services ranges from the highest level of care, such as inpatient or other residential programs, to less intensive levels of care, including outpatient and prevention programs. The continuum of care also includes services that aid in care transitions and "stepping down" from more intensive levels of care. Lastly, the system of care also includes services in the Forensic System that serves justice-involved individuals.

Population served

In fiscal year 2021-2022, 3,484 unique individuals were served by Sonoma County BHD, with a total of 2,378 clients served by Adult and Older Adult Services, 1,154 clients served by Youth and Family Services, and 65 clients served by TAY services. 14 The racial and ethnic makeup of clients was like that of the County, with a majority of clients identifying as White and about a quarter identifying as Hispanic/Latinx. Most clients were between the ages of 26 and 59, and the majority were diagnosed with psychotic disorders and mood disorders, such as schizophrenia, bipolar disorder, anxiety, depressive disorders, and trauma related disorders. Almost half of all clients entered the system through the Access Teams and crisis services, and after entry, most clients utilized outpatient services. Analysis of client demographics across programs identified certain groups being over- and/or under-represented in the system of care. Notably, Hispanic/Latinx adult clients were underrepresented in the adult system, while Hispanic/Latinx youth were over-represented in the youth system of care, specifically within general outpatient programs and youth justice services, compared to the Medi-Cal- eligible population of Sonoma County. Other groups, such as Black and Native American clients were also found to be overrepresented in unlocked residential programs.

Process

People move through the mental health system in Sonoma County in a variety of ways. RDA used primary and secondary data to understand the process through which clients access services and receive services, and the strengths and barriers of the system. Sonoma BHD has also faced several significant challenges before and since the previous Capacity Assessment, described in interviews conducted with BHD leadership, clients, and providers. Changes have had both positive and negative impacts on the overall BHD system, described below.

[14] Some clients accessed more than one system of care; therefore, the sum of clients served by the adult system of care, youth system of care, and TAY system of care is greater than the total unique clients served.

Accessing services

Most clients surveyed indicated that they knew who to call and where to go for mental health services and were comfortable seeking mental health services. However, only half of clients said that services were at a convenient location, and only one in five said it was easy to get an appointment when needed. Long wait times and difficulty accessing services was a consistent challenge that was raised by clients and loved ones in both quantitative and qualitative data.

Participating in and providing services

A clear strength highlighted by clients in their experience with the mental health system was with providers themselves. Two thirds of clients and loved ones surveyed agreed that the mental health services they or their loved one received are helpful, and three quarters said they felt respected by the mental health team. Many positives and strengths highlighted by clients were mirrored by providers, who expressed confidence in their organizations' abilities to help clients' recovery and keep clients engaged for as long as they needed services. Providers also rated collaboration among agencies as a significant strength, despite acknowledging room for improvement. Overall, when providers and clients were asked similar questions about service provision, providers ranked services more positively than did clients.

Areas for improvement in service provision noted by clients included more involvement of clients and loved ones in their treatment planning. Clients also indicated that crisis services not being available to everyone was a top need in the system, which is consistent with other findings about long wait times, not enough CSU beds and more availability of other types of high-intensity services. Overall, client satisfaction with services was relatively low.

Movement through the system

Ideally, clients who are accessing services within the Sonoma BHD system can be "stepped up" or "stepped down" to different services according to their level of needs in a timely manner. However, in many cases, clients are staying longer than expected in high levels of care, contributing to higher costs, higher caseloads for providers, and longer wait times for clients.

In the CSU, there were 972 episodes in FY 2021-2022, and the median length of stay was one day, but the mean length of stay was 2.5 days, with 44% of episodes lasting two or more days. This indicates a slowdown in the system where clients are hindered from being transferred to more appropriate levels of care after stabilization, and this is consistent with findings around long wait times for other levels of care.

For unlocked short-term residential services, approximately half of episodes lasted for longer than the recommended length of stay, with the mean length of stay (15 days) just exceeding the recommended maximum stay (14 days). For unlocked long-term residential services, three quarters of clients stayed for less than maximum recommended amount of time (6-9 months). For both unlocked short-term and unlocked long-term residential services, staying beyond the expected length of stay does represents challenges in movement through the system, indicating clients may not be receiving the most appropriate level of care in a timely manner.

In addition to the CSU and unlocked short- and long-term services, Sonoma BHD's Full Service Partnerships (FSPs) play an integral role in moving clients through the system and engaging clients in intensive, team-based, and culturally appropriate services in the community. In FY 2021-2022, the adult FSP teams had 263 total episodes, with a mean "length of stay" or period of client engagement of

approximately 1 year and 10 months. The youth FSP team had 626 total episodes and a mean length of engagement of 11 months. 15 This timeframe, for both the adult and youth FSP teams, encompasses how long a client engages with the FSP program to ensure they are connected with appropriate services, as FSPs are committed to doing "whatever it takes."

Positive systemic changes

A variety of strengths of the mental health system and successes of the last several years were highlighted in conversations with BHD staff and partners. Community engagement through bodies like the MHSA Community Program Planning (CPP) Workgroup has been key in implementing MHSA, and additional funding through sources such as Measure O has helped fill some programmatic system needs. Creative responses to the COVID-19 pandemic, including new solutions to the housing crisis and an increase in access to telehealth were seen as positive changes coming out of an overall challenging situation. Staff in general, including peer providers, were highlighted as core strengths of Sonoma's mental health services, and were lauded for their compassion, dedication, and respect for clients.

System-wide and external challenges

Budget cuts from 2017-2019 forced BHD to reduce mental health services to core services only, reducing preventative care. This meant that more clients needed to utilize higher levels of care, which is more expensive than preventative care and more challenging to transition out of, meaning that clients sometimes remain in higher levels of care longer than needed. This created a cycle in which more funding must be dedicated to intensive care services.

The need for mental health services has increased County-wide because of the collective trauma of multiple devastating fires, the COVID-19 pandemic, seasonal flooding, and the related amplification of other hardships, including economic instability, increased unemployment inflation, and school closures. Simultaneously, the County has an ongoing challenge of understaffing, with high rates of turnover and difficulty in both recruitment and retention of staff. For the providers who remain, high caseloads have an impact on provider burnout and the quality of services they can provide.

The County has areas of strengths and limitations that impact the County's ability to meet the needs of the County's racially and ethnically diverse populations. The strengths include new leadership that is committed to improving representation of racially and ethnically diverse, especially Latino representation. The leadership includes a new Behavioral Health Director and a newly appointed Ethnic Services, Inclusion and Training Coordinator.

The County is also dedicating resources to a performance improvement project on Latinx Mental Health Access, and the MHSA CPP Workgroup listening sessions are designed to learn more about how we can meet the needs of the County's racially and ethnically diverse populations. The County is working very closely with Human Resources and community partners to recruit racially and ethnically staff that mirror the County's clients. Additionally, the Department is collaborating with the Board of Supervisors to discuss increasing wages for the workforce.

There are several barriers, some mentioned above, to developing a workforce that mirrors our clientele and meets the needs of the County's racially and ethnically diverse clients including:

- A behavioral health workforce shortage in the County, state and nationwide
- A shortage of Spanish/English Bilingual behavioral health workers throughout the state

.

- The County's wages for behavioral health workers are lower than other neighboring counties and other providers in the county

Insufficient housing has been an increasing problem in the last several years, with an increase in the number of people experiencing homelessness since the beginning of the pandemic. In addition, budget cuts in recent years have resulted in reduced capacity to support individuals with severe mental illness (SMI) moving from a higher level of care into supportive housing. Improved coordination between departments and programs, including those addressing SUD and homelessness, would be helpful, to support clients with co-occurring SMI and other challenges, including SUD, homelessness, and significant medical conditions.

Services are scarcer in more rural areas, and telehealth increases access for some but remains a challenge for those with limited internet access or computer literacy. Finally, significant health disparities exist across various populations; providing more culturally and linguistically appropriate services was identified as a potential gap.

Resources

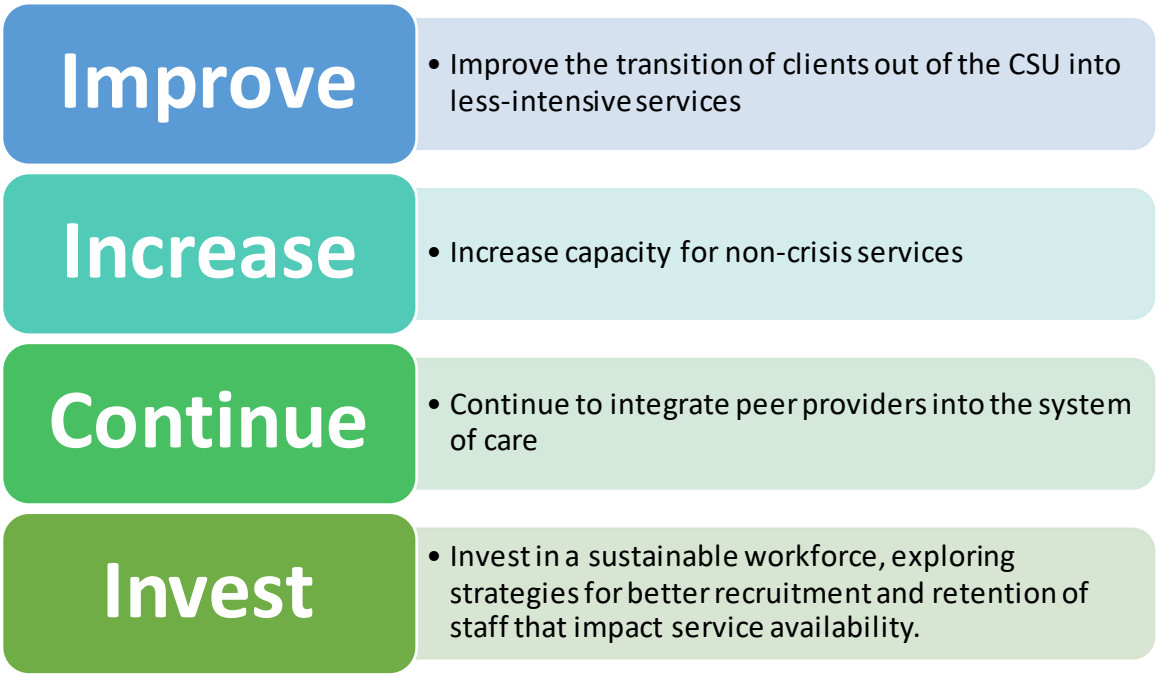
Available data provided the price of each service rendered for both claimable and non-claimable services. The price of services, when added together across all services rendered in FY 21-22, indicates how much Sonoma County BHD could have claimed if all services were claimable. Thus, this is considered Sonoma County BHD's "Potential Revenue." Overall, in the 2021-2022 fiscal year, potential revenue of all services rendered (both claimable and non-claimable) totaled $66.6 million. One-third of the potential revenue of all services rendered was non-claimable, for a total of $22.5 million of non-claimable services and $44.2 million of claimable services. In all, an average of $20,000 was spent per person on 3,454 unique clients.

Most of the potential revenue was related to adult services ($51 million) followed by youth services ($13 million) and TAY services ($3 million). Per person, potential revenues were highest for adult services ($21,373 per person), followed by TAY services ($20,106). The potential revenue of services for youth ages 0-18 was significantly lower per client, at $11,358.

Programs that had high levels of non-claimable costs included adult board and care ($6.7 million total, all non-claimable), adult residential services ($4.6 million claimable and $5.1 million non-claimable), and the CSU ($3.8 million claimable and $9.0 million non-claimable). The $9.0 million of non-claimable CSU costs were related to CSU overstays.

The challenges of receiving appropriate levels of care at the necessary time, such as those related to CSU overstays discussed above, result in a more expensive behavioral health system in Sonoma County. These barriers can lead to higher use of crisis and acute mental health services, which are more expensive than lower levels of care and not always covered by Medi-Cal.

Recommendations



1. **Improve the transition of clients out of the CSU into less-intensive services,** to reduce the amount of time that clients stay in the CSU and to provide clients with a better environment for recovery.
2. **Increase capacity for non-crisis services**, including outpatient therapy, to reduce wait times for appointments and help prevent clients from escalating needs that may turn into crises. Increased capacity for non-crisis services may also help alleviate overstays in the CSU by providing clients who have been stabilized with more options for appropriate levels of care.
3. **Continue to integrate peer providers into the system of care.** Services provided by peer providers and those with lived experience are highly valued by the community, serve a large number of clients, and may help reduce the burden of services on other cadres of providers.
4. **Invest in a sustainable workforce**, exploring strategies for better recruitment and retention of staff that can alleviate the high levels of staff turnover and understaffing, which impact service availability.

Sonoma County's FY 2023 - 2026

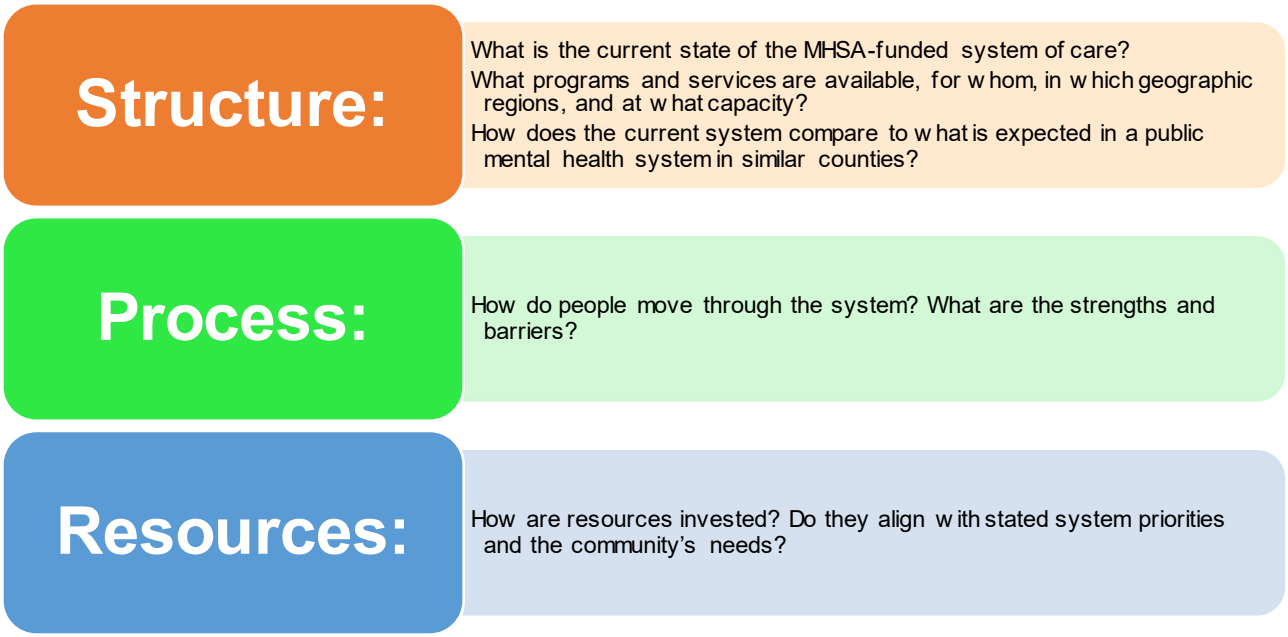
Sonoma County Department of Health Services, Behavioral Health Division (DHS-BHD) is pleased to present this Mental Health Services Act (MHSA) Program Plan for Fiscal Years 2023-2026. The MHSA Program Work Plan for FYs 23-26 has been developed in collaboration with MHSA stakeholders as detailed in the Community Program Planning section on page 25. This Program Plan includes:

- Context for FY 23-26 Three Year Plan
- Behavioral Health Funding in California
- Key recommendations and significant changes for FY 23-26
- Detailed description of MHSA programs and services planned for FY 22-23 by component:
    - Community Services and Supports (CSS) modifications
    - Prevention and Early Intervention (PEI) modifications
    - Innovation project updates
    - Workforce Education and Training (WET) FY 19-20 Plan Update
    - Capital Facilities and Technology Needs (CFTN) FY 19-20 Plan Update
- Update on No Place Like Home

Context for FY 23-26 Three Year Plan

As DHS-BHD approaches this next three-year cycle, fiscal years (FY) 2023-2026 it is important to look back at the challenges and strengths of the system of care. Our community has experienced fires, floods, and all the ramifications of the Covid 19 pandemic over the past three years. To reflect and learn from the recent challenges and strengths the Division has partnered with Resource Development Associates (RDA) to conduct a Mental Health Services Act (MHSA) Capacity Assessment for fiscal years 2019-2022. This Capacity Assessment in conjunction with stakeholder feedback provides a comprehensive analysis of Sonoma's MHSA-funded system of care and community needs, and it serves as a foundation to the development of the FY 23-26 Three-Year MHSA Program and Expenditure Plan.

To evaluate Sonoma's MHSA-funded system of care, the capacity assessment focused on three core areas of inquiry regarding the structure, process, and resources of DHS-BHD.

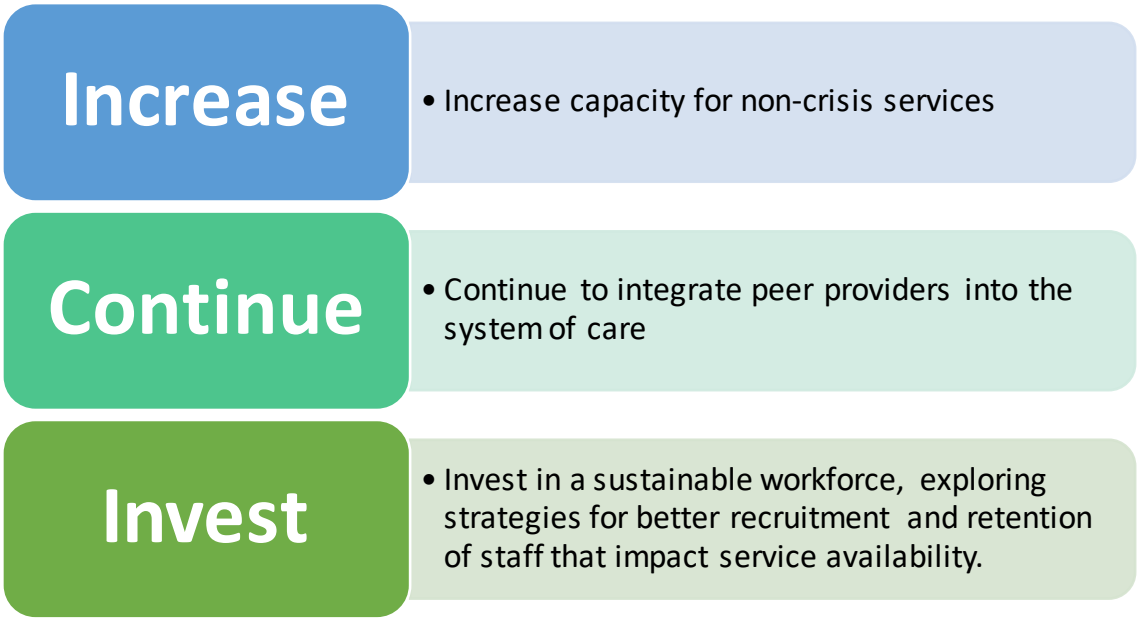


To answer these questions, RDA Consulting collected data between August and December 2022 via:

- community survey
- focus groups
- key informant interviews

to understand strengths, challenges, and gaps in the system of care from community and system leaders, clients, family members, providers, and other partners. In addition, RDA Consulting conducted a background document review and secondary analysis of administrative data and quarterly reports supplied by the County's MHSA-funded partners. These analyses informed this final capacity assessment report which is in appendix 1 on pp 199, and there is a summary of the Capacity Assessment on page 43.

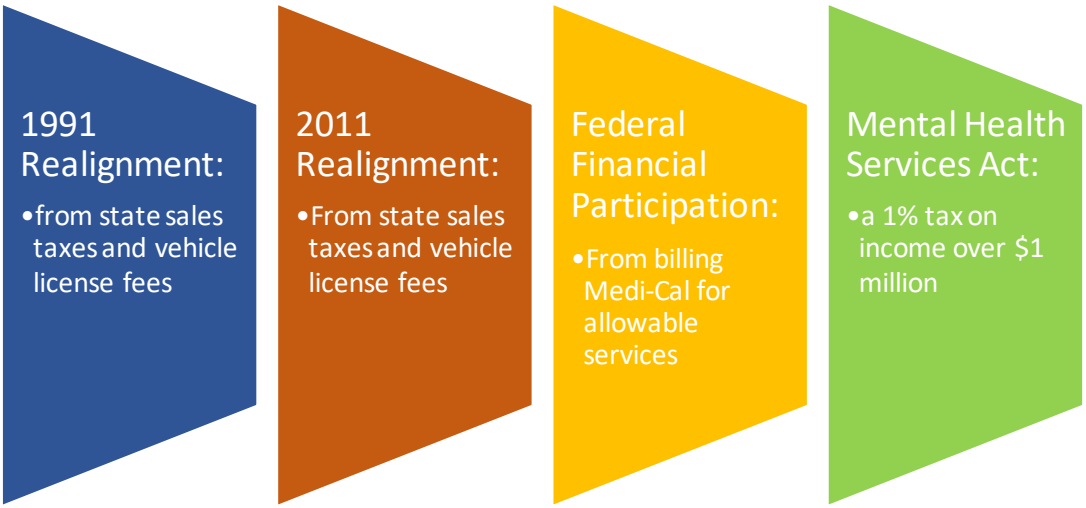
The key recommendations of the Capacity Assessment Report are below:

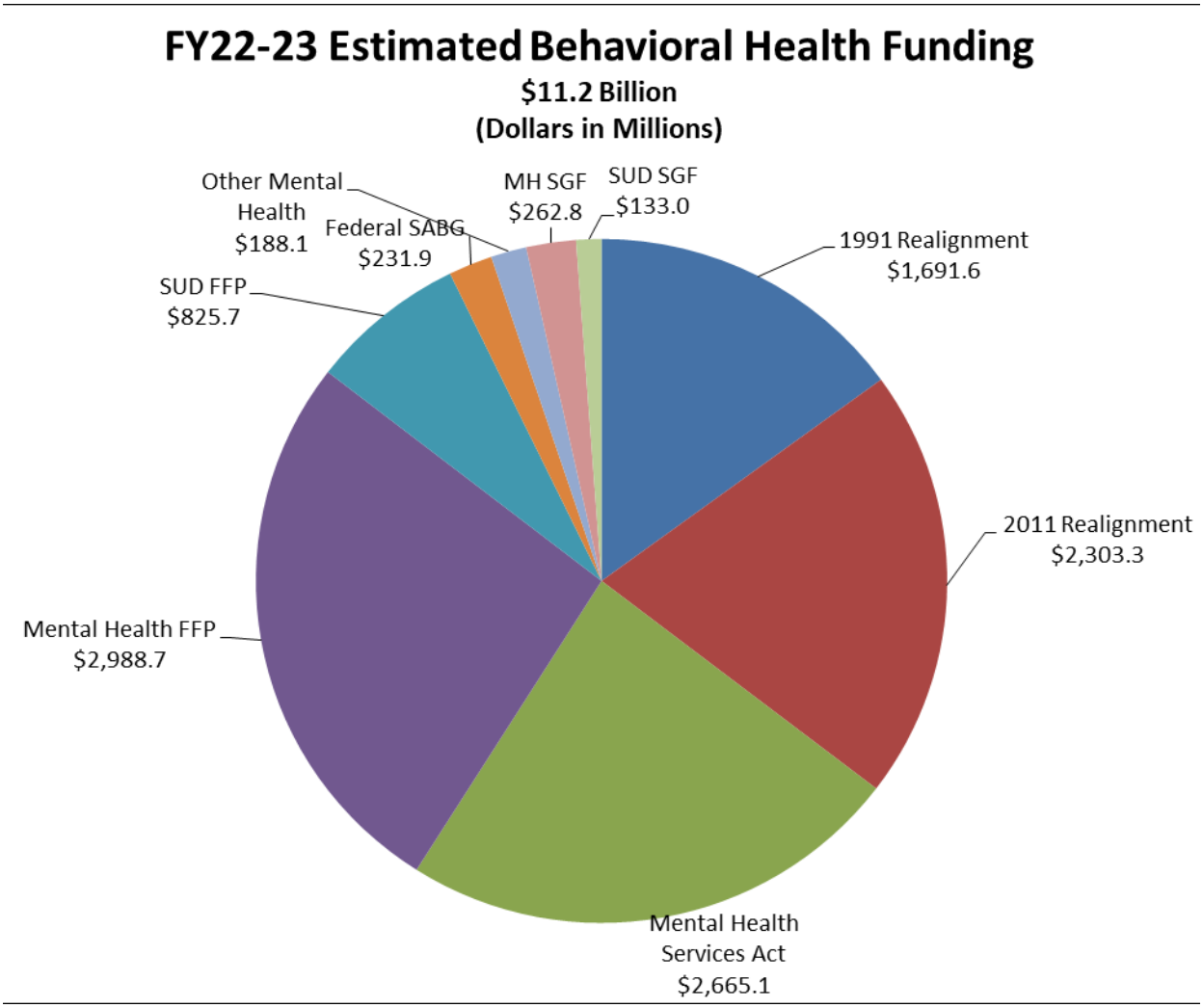


The MHSA FY 23-26 Three-Year Plan addresses two of the key recommendations, and the Division's financial resources play an enormous role in the Division's ability to respond to the recommendations along with the potential MHSA Modernization. Therefore MHSA funding and Modernization of MHSA will be reviewed.

Behavioral Health Funding in California

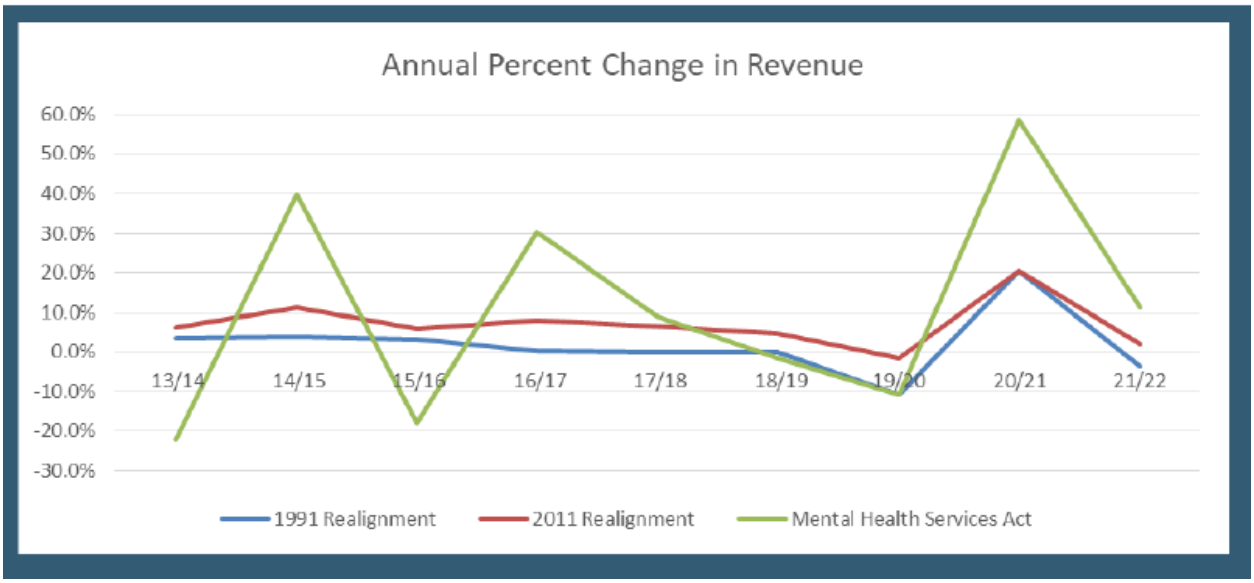
Counties in California receive state funding to provide behavioral health services, and there are four primary sources:





Of these four state funding sources, MHSA is the most volatile and unpredictable source of funding, as demonstrated in the chart below. The annual MHSA distributions vacillates from minus 20% to additional 60%.

MHSA



distributions are unpredictable because they are based on the behaviors of only 76,000 individuals in California that make

over $1,000,000 annually. The volatility of the MHSA funds makes it very difficult to plan on the use of funds. In fiscal years 2017-2020 Sonoma received an average of $21.8 million in annual MHSA distributions from the state. In fiscal year 20-21 the annual MHSA distribution dramatically and suddenly increased to $33 million, which is a 57% increase. This level of MHSA distributions continued in FY 21-22. However in FY 22-23 Sonoma received approximately $10,000,000 less of MHSA distributions than anticipated and budgeted.

Additionally, Governor Newsome has announced plans to "Modernize MHSA" which may have an impact on future MHSA distributions and how counties are allowed to spend MHSA funds if California voters pass this initiative on March 5, 2024. If the initiative passes Sonoma will need to be in a position redirect 30% of funds to housing. Please see website for additional information: https://www.dhcs.ca.gov/services/Documents/Modernizing-Our-Behavioral-Health-System.pdf

The context for the Modernization of MHSA is:

- MHSA will be 20 years old in 2024
- Unspent MHSA dollars and increasing MHSA revenue
- Other aspects of the Behavioral Health System are changing
- Counties support more flexibility is spending components
- Governor's focus on reducing homelessness

Plans to Modernize MHSA:

Authorize New General Bond $3-$5B for March 2024 ballot	Modernize MHSA for March 2024 ballot	Statewide Enhancement of Fiscal Transparency & Accountability Entire Behavioral Health System
• Fund unlocked community behavioral health supportive residential settings including for individuals with serious mental health challenges and homeless vets	• Themes around the need to update the Act and prioritize spending for the most vulnerable and references to homeless encampments	• Increased accountability across all public and private payers for behavioral health

Stakeholder and Capacity Assessment recommendations and significant changes for FY 23-26

The Capacity Assessment, stakeholder input and increased MHSA distributions have set the stage for targeted expansion of programing and staff to improving the lives and outcomes of the Division's clients:

Stakeholder & Capacity Assessment Recommendation	Plan to Address the Recommendation	FY 23-26 Annual Funding	MHSA Component
Increase capacity for non-crisis services.	• Add 3 Senior Client Support Specialists to Collaborative Treatment and Recovery Team	• $513,000	• CSS
	• Add 1 Care Navigator for Medication Assisted Treatment	• $171,000	• PEI
	• 6% Cost of Living Increase for MHSA Contractors	• 434,050	• CSS, PEI & WET
Invest in a sustainable workforce, exploring strategies for better recruitment and retention of staff.	• Comprehensive Evidence Based Training Program	• $400,000	• WET
TOTAL		$1,518,050	

The Community Services and Support (CSS) Plan for FY 23-26	
Community Services and Supports	
Full Service Partnership (FSP) teams: The FSP teams provide wrap-around services to clients in our system of care with the most serious mental health impairments and the majority of the Community Services and Supports funds must be allocated to the FSP teams.	
Changes	**Impact**
Telecare, Sonoma ACT: Telecare will be added to the Adult Full Service Partnership (AFSP) team. This is an annual increase in spending of $1,493,488.	The addition of Telecare, Sonoma ACT to the AFSP team will increase capacity and improve timeliness.
Additional Senior Client Support Specialists for Collaborative Treatment and Recovery Team (CTRT). Three Senior Client Support Specialists will be added to the CTRT program. This is an annual increase of $513,000.	The addition of three Senior Client Specialists to CTRT will increase the capacity of CTRT which will enable CTRT to provide case management for more clients and improve timeliness and access to serves.
General System Development	
Eliminating Support Our Students (SOS): SOS will no longer be funded to provide interns to the Mobile Support Team. The annual cost of the program is $212,672, and $79,672 was funded with MHSA.	SOS was unable to provide the Mobile Support Team (MST) with interns that meet the new state guidelines for mobile support units require. The Division will directly recruit clinicians for MST.

Sonoma County's FY 2023 – 2026 Three Year Program Plan

The following table provides the estimated cost per client for FY 23-24:

Provider/Program	Estimated # to be served in FY 23-24	Children and Youth (0-15)	Transition Age Youth (16 - 25)	Adults (25-59)	Older Adults (60+)	Estimated MHSA cost per person in FY 23-24
Forensic Assertive Community Treatment (FACT) Team	70	0	3	64	3	$13,366
County of Sonoma Department of Health Services Behavioral Health Division (DHS-BHD)						
Buckelew Programs - FACT - Independent Living Skills (ILS) [contractor]						
Buckelew Programs - FACT - Supplemental Patch for Unlicensed Supportive Housing Units						
Family Advocacy, Stabilization & Support Team (FASST)	200	105	95	0	0	$16,996
DHS-BHD						
Seneca (SMHS for FASST Clients)						
Lifeworks						
Social Advocates for Youth - Individuals Now						
Integrated Recovery Team (IRT)	150	0	0	135	5	$5,580
DHS-BHD						
Older Adult Intensive Team (OAIT)	70	0	0	0	70	
DHS-BHD						
Transition Age Youth (TAY) Team	70	0	70	0	0	$15,228
DHS-BHD						
Buckelew Programs - TAY - Sonoma County Independent Living (SCIL) [contractor]						
SAY - Tamayo Village [contractor]						
On The Move - VOICES [contractor]						
Adult Full Service Partnership (AFSP)	100	0	0	100	0	$26,126
DHS-BHD						
Telecare ACT [contractor]	60	0	1	39	20	$24,891
General Systems Development (GSD)						

National Alliance on Mental Illness (NAMI) Sonoma County - Family-based Education, Advocacy and Support (FEAS) [contractor]	5529	20	2000	2514	995	$39
DHS-BHD Mobile Support Team (MST)	200	20	35	65	40	$5,587
DHS-BHD Collaborative Treatment and Recovery Team (CTRT)	400	0	100	230	70	$2,659
Buckelew Programs - CTRT System Navigation [contractor]						
DHS-BHD Community Mental Health Centers	300	0	35	225	40	$5,409
Council on Aging - Senior Peer Support [contractor]	60	0	0	0	60	$1,485
WCCS - Senior Peer Counseling [contractor]	80	0	0	0	80	$957
Buckelew Programs - Family Service Coordination [contractor]	1300	0	150	800	350	$177
Sonoma County Human Services Department (HSD) - Job Link [contractor]	15	0	2	12	1	$2250
WCCS - Interlink [contractor]	240	0	20	170	50	$202
WCCS - Wellness & Advocacy Center [contractor]	680	0	50	500	130	$1,038
WCCS - Russian River Empowerment Center [contractor]	100	0	5	65	30	$1,761
WCCS - Petaluma Peer Recovery Center [contractor]	40	0	5	25	10	$1,982
WCCS - Crisis Support [contractor]	65	5	10	35	15	$163
DHS-BHD Medication Support Services for Adult Programs	1565	0	266	1001	298	$3,194
DHS-BHD Medication Support Services for Youth Programs	578	405	173	0	0	$3,688
Alternative Family Services [contractor]	30	25	5	0	0	$8,333
Siyan Clinical Research [contractor]	100	0	0	100	0	$12,500
Outreach and Engagement (OE)						
DHS-BHD Whole Person Care (WPC)	1406	0	56	984	366	$555
Sonoma County Indian Health Project - Community Programs [contractor]	162	37	32	66	27	$531

The following table provides the estimated cost per client in FY 24-25:

Provider/Program	Estimated # to be served in FY 24-25	Children and Youth (0-15)	Transition Age Youth (16 - 25)	Adults (25-59)	Older Adults (60+)	Estimated MHSA cost per person in FY 24-25
Forensic Assertive Community Treatment (FACT) Team	70	0	3	64	3	$13,366
County of Sonoma Department of Health Services Behavioral Health Division (DHS-BHD)						
Buckelew Programs - FACT - Independent Living Skills (ILS) [contractor]						
Buckelew Programs - FACT - Supplemental Patch for Unlicensed Supportive Housing Units						
Family Advocacy, Stabilization & Support Team (FASST)	200	105	95	0	0	$16,996
DHS-BHD						
TBD - RFP [contractor]Current vendor is Seneca (SMHS for FASST Clients)						
TBD - RFP [contractor]Current vendor is Lifeworks (SMHS for FASST Clients)						
TBD - RFP [contractor]Current vendor is Social Advocates for Youth - Individuals Now (SMHS for FASST Clients)						
Integrated Recovery Team (IRT)	150	0	0	135	5	$5,580
DHS-BHD						
Older Adult Intensive Team (OAIT)	70	0	0	0	70	$11,351
DHS-BHD						
Transition Age Youth (TAY) Team	70	0	70	0	0	$15,228
DHS-BHD						
Buckelew Programs - TAY - Sonoma County Independent Living (SCIL) [contractor]						
SAY - Tamayo Village [contractor]						

On The Move - VOICES [contractor]						
Adult Full Service Partnership (AFSP)	100	0	0	100	0	$26,125
DHS-BHD Telecare ACT [contractor]	60	0	1	39	20	$24,891
General Systems Development (GSD)						
National Alliance on Mental Illness (NAMI) Sonoma County - Family-based Education, Advocacy and Support (FEAS) [contractor]	5529	20	2000	2514	995	$40
DHS-BHD Mobile Support Team (MST)	200	20	35	65	40	$5,587
DHS-BHD Collaborative Treatment and Recovery Team (CTRT)	400	0	100	230	70	$2,054
Buckelew Programs - CTRT System Navigation [contractor]	300	0	35	225	40	
DHS-BHD Community Mental Health Centers	60	0	0	0	60	$5,409
Council on Aging - Senior Peer Support [contractor]	80	0	0	0	80	$1,485
WCCS - Senior Peer Counseling [contractor]	90	0	0	0	90	$957
Buckelew Programs - Family Service Coordination [contractor]	15	0	2	12	1	$177
Sonoma County Human Services Department (HSD) - Job Link [contractor]	240	0	20	170	50	$2,250
WCCS - Interlink [contractor]	680	0	50	500	130	$202
WCCS - Wellness & Advocacy Center [contractor]	600	0	100	400	100	$1,038
WCCS - Russian River Empowerment Center [contractor]	100	0	12	63	25	$1,761
WCCS - Petaluma Peer Recovery Center [contractor]	65	5	10	35	15	$1,982
WCCS - Crisis Support [contractor]	10	0	1	8	1	$163
DHS-BHD Medication Support Services for Adult Programs	578	405	173	0	0	$3,194
DHS-BHD Medication Support Services for Youth Programs	30	25	5	0	0	$3,688

Alternative Family Services [contractor]	100	0	0	100	0	$8,333
Siyan Clinical Research [contractor]						$12,500
Outreach and Engagement (OE)						
DHS-BHD Whole Person Care (WPC)	1406	0	56	984	366	$555
Sonoma County Indian Health Project - Community Programs [contractor]	162	37	32	66	27	$531

The following table provides the estimated cost per client in FY 25-26:

Provider/Program	Estimated # to be served in FY 25-26	Children and Youth (0-15)	Transition Age Youth (16 - 25)	Adults (25-59)	Older Adults (60+)	Estimated MHSA cost per person in FY 25-26
Forensic Assertive Community Treatment (FACT) Team	70	0	3	64	3	$12,366
County of Sonoma Department of Health Services Behavioral Health Division (DHS-BHD)						
Buckelew Programs - FACT - Independent Living Skills (ILS) [contractor]						
Buckelew Programs - FACT - Supplemental Patch for Unlicensed Supportive Housing Units						
Family Advocacy, Stabilization & Support Team (FASST)	200	105	95	0	0	$16,996
DHS-BHD TBD - RFP [contractor]Current vendor is Seneca (SMHS for FASST Clients) TBD - RFP [contractor]Current vendor is Lifeworks (SMHS for FASST Clients)						
TBD - RFP [contractor]Current vendor is Social Advocates for Youth - Individuals Now (SMHS for FASST Clients)						
Integrated Recovery Team (IRT)	150	0	0	135	5	$5580
DHS-BHD						
Older Adult Intensive Team (OAIT)	70	0	0	0	70	$11,351
DHS-BHD						
Transition Age Youth (TAY) Team	70	0	70	0	0	$15,228
DHS-BHD						
TBD - RFP [contractor]						

TBD - RFP [contractor]						
TBD - RFP [contractor]						
Adult Full Service Partnership (AFSP)	100	0	0	100	0	$26,127
DHS-BHD						
Telecare ACT [contractor]	60	0	1	39	20	$24,891
General Systems Development (GSD)						
National Alliance on Mental Illness (NAMI) Sonoma County - Family-based Education, Advocacy and Support (FEAS) [contractor]	5529	20	2000	2514	995	$40
DHS-BHD Mobile Support Team (MST)	200	20	35	65	40	$5,587
DHS-BHD Collaborative Treatment and Recovery Team (CTRT)	400	0	100	230	70	$6,215
TBD - RFP [contractor]	TBD	TBD	TBD	TBD	TBD	TBD
DHS-BHD Community Mental Health Centers	60	0	0	0	60	$1,485
TBD - RFP [contractor]	TBD	TBD	TBD	TBD	TBD	TBD
TBD - RFP [contractor]	TBD	TBD	TBD	TBD	TBD	TBD
TBD - RFP [contractor]	TBD	TBD	TBD	TBD	TBD	TBD
Sonoma County Human Services Department (HSD) - Job Link [contractor]	240	0	20	170	50	$2,250
TBD - RFP [contractor]	TBD	TBD	TBD	TBD	TBD	TBD
TBD - RFP [contractor]	TBD	TBD	TBD	TBD	TBD	TBD
TBD - RFP [contractor]	TBD	TBD	TBD	TBD	TBD	TBD
TBD - RFP [contractor]	TBD	TBD	TBD	TBD	TBD	TBD
TBD - RFP [contractor]	TBD	TBD	TBD	TBD	TBD	TBD
DHS-BHD Medication Support Services for Adult Programs	1565	0	266	1001	298	$3,194
DHS-BHD Medication Support Services for Youth Programs	578	405	173	0	0	$3,688
Alternative Family Services [contractor]	30	25	5	0	0	$8,333
Siyan Clinical Research [contractor]	100	0	0	100	0	$12,500
Outreach and Engagement (OE)						
DHS-BHD Whole Person Care (WPC)	1406	0	56	984	366	$61
TBD - RFP [contractor]	TBD	TBD	TBD	TBD	TBD	TBD

Prevention and Early Intervention (PEI) Plan for FY 2023 - 2026

Prevention and Early Intervention (PEI) Plan for FY 23-26	
Changes	**Impacts**

Prevention and Early Intervention (PEI)	
Care Navigator for Medication Assisted Treatment (MAT): A Care Navigator in the position of Senior Client Support Specialist will engage clients at the early stages of medication assisted treatment for opioid use disorder initiated at Santa Rosa Community Health. This is an annual increase in spending of $171,000.	The Care Navigator will provide wraparound support (transportation, case management, outreach, and engagement) to address barriers that clients experience when on new medications, which are intended to replace Heroin, Fentanyl, Oxycodone, etc. This will improve access to services, client engagement and contribute to clients moving towards recovery.

The following table provides the estimated cost per client in FY 23-24:

Provider/Program	Estimated # to be served in FY 23-24	Children and Youth (0-15)	Transition Age Youth (16 - 25)	Adults (25-59)	Older Adults (60+)	Estimated MHSA cost per person in FY 23-24
PEI Programs - Prevention						
Action Network [contractor]	264	124	55	53	32	$241
Community Baptist Church Collaborative [contractor]	179	30	26	94	30	$711
Sonoma County Human Services Department - Older Adult Collaborative [contractor]	2926	0	0	0	2926	$79
Sonoma County Indian Health Project [contractor]	28	9	6	10	3	$1,516
PEI Programs - Prevention & Early Intervention						
La Luz [contractor]	460	60	40	307	53	$77
Latino Service Providers of Sonoma County [contractor]	268	0	65	143	60	$424
Positive Images [contractor]	196	37	60	62	37	$552
PEI Programs - Early Intervention						
Child Parent Insititute (CPI) [contractor]	311	130	30	130	21	$676
La Luz [contractor]	460	60	40	307	53	$106
Early Learning Institute (ELI) [contractor]	1646	662	65	900	19	$28
PEI Programs - Stigma & Discrimination Reduction						
Santa Rosa Junior College [contractor]	468	0	378	80	10	$453
PEI Programs - Suicide Prevention						
Buckelew Programs - North Bay Suicide Prevention Program [contractor]	2321	46	375	1600	300	$73

PEI Programs - Access and Linkage to Treatment						
DHS-BHD Youth Access Team	434	338	96	0	0	$3,226
DHS-BHD Adult Access Team	496	0	114	347	35	$3,706
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness						
Crisis Intervention Training (CIT) with Law Enforcement Personnel	30	0	2	26	2	$994

The following table provides the estimated cost per client in FY 24-25:

Provider/Program	Estimated # to be served in FY 24-25	Children and Youth (0-15)	Transition Age Youth (16 - 25)	Adults (25-59)	Older Adults (60+)	Estimated MHSA cost per person in FY 24-25
PEI Programs - Prevention						
Action Network [contractor]	264	124	55	53	32	$241
Community Baptist Church Collaborative [contractor]	179	30	26	94	30	$711
Sonoma County Human Services Department - Older Adult Collaborative [contractor]	2926	0	0	0	2926	$79
Sonoma County Indian Health Project [contractor]	28	9	6	10	3	$1,516
PEI Programs - Prevention & Early Intervention						
La Luz [contractor]	460	60	40	307	53	$77
Latino Service Providers of Sonoma County [contractor]	268	0	65	143	60	$424
Positive Images [contractor]	196	37	60	62	37	$552
PEI Programs - Early Intervention						
Child Parent Insititute (CPI) [contractor]	311	130	30	130	21	$676
La Luz [contractor]	460	60	40	307	53	$106
Early Learning Institute (ELI) [contractor]	1646	662	65	900	19	$28
PEI Programs - Stigma & Discrimination Reduction						
Santa Rosa Junior College [contractor]	468	0	378	80	10	$453
PEI Programs - Suicide Prevention						
Buckelew Programs - North Bay Suicide Prevention Program [contractor]	2321	46	375	1600	300	$73

PEI Programs - Access and Linkage to Treatment						
DHS-BHD Youth Access Team	434	338	96	0	0	$3,226
DHS-BHD Adult Access Team	496	0	114	347	35	$3,706
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness						
Crisis Intervention Training (CIT) with Law Enforcement Personnel	30	0	2	26	2	$994

The following table provides the estimated cost per client in FY 25-26:

Provider/Program	Estimated # to be served in FY 25-26	Children and Youth (0-15)	Transition Age Youth (16 - 25)	Adults (25-59)	Older Adults (60+)	Estimated MHSA cost per person in FY 25-26
PEI Programs - Prevention						
TBD - RFP [contractor]	TBD	TBD	TBD	TBD	TBD	TBD
TBD - RFP [contractor]	TBD	TBD	TBD	TBD	TBD	TBD
TBD - RFP [contractor]	TBD	TBD	TBD	TBD	TBD	TBD
TBD - RFP [contractor]	TBD	TBD	TBD	TBD	TBD	TBD
PEI Programs - Prevention & Early Intervention						
TBD - RFP [contractor]	TBD	TBD	TBD	TBD	TBD	TBD
TBD - RFP [contractor]	TBD	TBD	TBD	TBD	TBD	TBD
TBD - RFP [contractor]	TBD	TBD	TBD	TBD	TBD	TBD
PEI Programs - Early Intervention						
TBD - RFP [contractor]	TBD	TBD	TBD	TBD	TBD	TBD
TBD - RFP [contractor]	TBD	TBD	TBD	TBD	TBD	TBD
TBD - RFP [contractor]	TBD	TBD	TBD	TBD	TBD	TBD
PEI Programs - Stigma & Discrimination Reduction						
TBD - RFP [contractor]	TBD	TBD	TBD	TBD	TBD	TBD
PEI Programs - Suicide Prevention						
TBD - RFP [contractor]	TBD	TBD	TBD	TBD	TBD	TBD
PEI Programs - Access and Linkage to Treatment						
DHS-BHD Youth Access Team	434	338	96	0	0	$3,226
DHS-BHD Adult Access Team	496	0	114	347	35	$3,706
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness						
Crisis Intervention Training (CIT) with Law Enforcement Personnel	30	0	2	26	2	$994

Innovation (INN)

Novel, creative and/or ingenious mental health practices/approaches that are expected to contribute to learning, which are developed within communities through a process that is inclusive and representative, especially of unserved and underserved individuals. Innovation pilot programs are time limited, and MHSA regulation (9 CCR § 3910.010) requires that the end date is not more than five years from the start date of the Innovative Project.

DHS-BHD is pleased to report that four of the five projects that were developed with the CPP process received Mental Health Services Oversight and Accountability (MHSOAC) approval and one project received conditional approval. One of the approved projects was implemented in FY 20-21, and the remaining four will be implemented in FY 21-22. DHS-BHD is also developing an additional Diversion Transitional Housing Innovation proposal with key stakeholders. The table below lists the County's Innovation programs.

Brief descriptions of the Innovation projects in the chart below can be found on pages XX, and the description of SmartCare Electronic Health Record is on page 37.

The following table provides the estimated cost per client in FY 23-24:

Provider/Project	Estimated # to be served in FY 23-24	Children and Youth (0-15)	Transition Age Youth (16 - 25)	Adults (25-59)	Older Adults (60+)	Estimated MHSA cost per person in FY 23-24
Innovation Projects						
Collaborative Care Enhanced Recovery Project (CCERP)aka Unidos Por Nuestro Bienestar - [Sonoma County Human Services Department]	10	0	0	0	10	$42,131
Crossroads to Hope (Peer Program Provider) - Felton Institute	12	0	1	10	1	$50,637
Early Psychosis Learning Health Care Network (EP LHCN) - [Buckelew/Aldea - contractor]	12	2	10	0	0	$6,233
Early Psychosis Learning Health Care Network (EP LHCN) - [UC Davis - contractor]	N/A	N/A	N/A	N/A	N/A	N/A
Instructions Not Included (INI) - Dads Matter [Early Learning Institute - contractor]	20	0	5	15	0	$11,960
New Parent TLC - [First 5 Sonoma County - contractor]	40	0	5	30	5	$2,897
Nuestra Cultura Cura Social Innovations Lab - [On The Move - contractor]	N/A	N/A	N/A	N/A	N/A	N/A
Crossroads to Hope (Evaluation Consultant) - Behavioral Health Outcomes Data Services	N/A	N/A	N/A	N/A	N/A	N/A

CalMHSA Electronic Health Record	N/A	N/A	N/A	N/A	N/A	N/A

The following table provides the estimated cost per client in FY 24-24:

Provider/Project	Estimated # to be served in FY 24-25	Children and Youth (0-15)	Transition Age Youth (16 - 25)	Adults (25-59)	Older Adults (60+)	Estimated MHSA cost per person in FY 24-25
Innovation Projects						
Collaborative Care Enhanced Recovery Project (CCERP)aka Unidos Por Nuestro Bienestar - [Sonoma County Human Services Department]	10	0	0	0	10	$4,000
Crossroads to Hope (Peer Program Provider) - Felton Institute	12	0	1	10	1	$53,460
Instructions Not Included (INI) - Dads Matter [Early Learning Institute - contractor]	20	0	5	15	0	$11,108
New Parent TLC - [First 5 Sonoma County - contractor]	40	0	5	30	5	$1,500
Nuestra Cultura Cura Social Innovations Lab - [On The Move - contractor]	N/A	N/A	N/A	N/A	N/A	N/A
Crossroads to Hope (Evaluation Consultant) - Behavioral Health Outcomes Data Services	N/A	N/A	N/A	N/A	N/A	N/A
CalMHSA Electronic Health Record	N/A	N/A	N/A	N/A	N/A	N/A

The following table provides the estimated cost per client in FY 25-26:

Provider/Project	Estimated # to be served in FY 25-26	Children and Youth (0-15)	Transition Age Youth (16 - 25)	Adults (25-59)	Older Adults (60+)	Estimated MHSA cost per person in FY 25-26
Innovation Projects						
Crossroads to Hope (Peer Program Provider) - Felton Institute	12	0	1	10	1	$50,637
Crossroads to Hope (Evaluation Consultant) - Behavioral Health Outcomes Data Services	N/A	N/A	N/A	N/A	N/A	N/A
CalMHSA Electronic Health Record	N/A	N/A	N/A	N/A	N/A	N/A

Sonoma County's FY 2023 – 2026 Three Year Program Plan

Category	Information
Organization	Early Learning Institute

Category	Information
Project	Instructions Not Included (INI) - Dads Matter
Total Project Budget	$689,360
Brief Description	Home visiting program for first time fathers combining three curricula: Promoting First Relationships, Partners for a Health Baby, and Nurturing Fathers with enhancements from Dad's Matter, Adverse Childhood Experiences (ACEs) and depression screening and lessons learned from National Father's Initiative.
Innovation	Makes a change to an existing practice in the field of mental health, including but not limited to application to a different population.
Primary Purpose	• Increase access to unserved or underserved group. • Promote interagency collaboration related to Mental Health Services or supports.
Population to be served	• 450 first time Dads, likely working so weekend and evening hours will be offered. • Possible low-income, home renters, mid-20s to mid-30s in age • 54% estimated to be Spanish speaking in the home. • County-wide
Learning Goals	1. What 3-5 key strategies are most effective in the engagement of fathers to participate in and complete visits 1-5 of the INI home visitation program? 2. What key community resources (or lack thereof) are utilized by fathers based on results of their Edinburgh Postnatal Depression Scale (EPDS) screening? 3. What key resources (or lack thereof) are utilized by fathers based on the results of their ACES screening? 4. How can we best serve 1st time fathers, especially those who score low-average, or below-average on the Nurturing Skills Competency Scale (NSCS)?
Need in Sonoma	Home visiting programs for first time mothers are prevalent in Sonoma County and demonstrated positive outcomes. However, no programs address or support the screening for mental health of first-time fathers. Addresses 0-5-year-old prevention (intergenerational ACEs), and suicide prevention.

Sonoma County's FY 2023 – 2026 Three Year Program Plan

Category	Information
Organization	DHS-BHD and Felton
Project	Crossroads to Hope
Total Project Budget	$560,379
Brief Description	The County of Sonoma proposes to expand access to community mental health, substance use disorder, and trauma treatment as an alternative t o incarceration, by developing facility space for both housing and service delivery to individuals who are being diverted to the community from the County jail. This facility will include space for six transitional housing beds and include peer support services to encourage a milieu of recovery and self-determination. The facility will also house two Assertive Community Treatment (ACT) teams that will provide services to individuals in the transitional housing facility, as well as other individuals in the community.
Innovation	Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite
Primary Purpose	• Increase access to unserved or underserved groups • Increase quality of mental health services, including better outcomes
Population to be served	• 12-20 adults annually • Serves individuals with serious mental health concerns referred by probation and the courts
Learning Goals	1. Does providing peer supervised transitional housing with ACT reduce recidivism? 2. Does supervised transitional housing with ACT reduce recidivism for diverted?
Need in Sonoma	The County has seen a significant increase in the number of individuals with mental health and substance use issues entering the criminal justice system in recent years. County jail data for 2017 showed that 479 inmates (45.5% of the jail population) were mental health involved. In 2018, this number increased to 513, (46.5%). The most recent figure for April 17, 2019, indicates 520 inmates (47%) are involved with mental

Workforce, Education and Training (WET) Plan for FY 2023 - 2026

Workforce, Education and Training (WET) Plan for FY 23-26

Pursuant to WIC 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."

Changes	Impacts
Workforce, Education and Training (WET)	
Comprehensive Training Program: All the trainings selected for the program will be focused on addressing the impairments of the primary diagnoses that DHS-BHD clients experience. All trainings will be evidence based or best practices for the impairments and diagnoses, and the trainings are designed for clinical staff, senior client support specialist, including peer support staff. This is an increase of $400,000 annually.	The addition of a Comprehensive training program can improve client outcomes, DHS-BHD program efficacy, improve staff retention and staff recruitment.

The goal of the WET component is to develop and retain a diverse, engaged, and clinically excellent workforce. Our WET program provides training for staff and contracted agencies to promote culturally responsive and clinically appropriate interventions to promote community wellness and staff development. At the end of 2022, the Division hired an Ethnic Services, Inclusion, and Training Coordinator to oversee this mission.

Ethnic Services, Inclusion, and Training Coordinator

The Sonoma County Behavioral Health Ethnic Services, Inclusion, and Training Coordinator (ESITC) position is responsible for ensuring behavioral health services are provided in a culturally responsive manner to the diversity of our clientele, and that our diverse staff are supported and respected in their work. This oversight involves participation in a number of cross-cutting areas in the division including:

- Policy Development: ensuring division policies are nondiscriminatory and inclusive.
- Workforce, Education, and Training: diversifying the incoming behavioral health workforce and supporting its ability to care for diverse clients, including developing strategies for recruitment, hiring, on-boarding, training, support, and retention practices and ensuring the current behavioral health workforce is appropriately attending to the needs of our diverse clientele.
- Program Design and Development: participation in program design and development to control for bias and ensure equity and cultural relevance in service provision.
- Leadership Development: Strengthening management and administrative performance.

Workforce, Education, and Training Activities

- The goal of our Workforce, Education, and Training (WET) Activities is to create and maintain a robust comprehensive training program, including evidence-based clinical practices and culturally responsive frameworks, to make Sonoma County Behavioral Health an attractive place to work and to promote wellness and meaning for our diverse clients. To better support these goals, WET will add a full-time clinical specialist role to support this program.

The Ethnic Services, Inclusion, and Training Coordinator will manage training programs and community events to further DHS-BHD's goals in the following Domains: System Level Support, Career Pathways and Pipeline Program, Staff Skill Development, and Workforce Diversification.

Domain	Programs/events/goals
System Level Support	• Accreditation (BRN, CAMFT, CCAPP)
Career Pathways	• Pipeline Programs • Career & Internship Fairs
Staff Skill Development	• Staff Development Trainings
WET Activities	• Strengths Model Care Management: an evidence-based practice demonstrating positive outcomes in the areas of psychiatric hospitalization, competitive employment, education, and a range of quality of life indicators.

System Level Support

Accreditation

The Division will continue to maintain accreditation through the Board of Registered Nursing (BRN), the California Association of Marriage and Family Therapists (CAMFT) and California Consortium of Addiction Programs and Professionals (CCAPP) for the license types listed below, and provides Continuing Education Units (CEUs) for these license types:

BRN	CAMFT	CCAPP
•Licensed Vocational Nurse (LVN) •Licensed Psychiatric Technician (LPT) •Registered Nurse (RN) •Public Health Nurse (PHN) •Nurse Practitioner (NP) •Psychiatric Nurse Practitioner (PNP)	•Licensed Clinical Social Worker (LCSW) •Licensed Marriage and Family Therapist (LMFT) •Licensed Professional Clinical Counselor (LPCC) •Licensed Educational Psychologist (LEP)	•Registered Alcohol Drug Technician (RADT) •Certified Alcohol Drug Counselor I (CADC-I) •Certified Alcohol Drug Counselor II (CADC-II) •Licensed Advanced Alcohol Drug Counselor (LAADC) •Licensed Advanced Alcohol Drug Counselor Supervisor (LAADC-S)

Career Pathways and Pipeline Program

The ESITC will continue the Internship and Traineeship program to assist staff in obtaining clinical licensure and to develop pipeline programs with participating universities. This includes a Group Clinical Supervision and Educational Outreach Events.

Pipeline Program

The ESITC will participate in several community career events at both the high school and college level. Particular focus will be given to encouraging Latino and bi-lingual students to consider Behavioral Health as a career option.

Participating Universities

Program Category	Participants
Nursing Programs	• Sonoma State University (SSU) • Santa Rosa Junior College (SRJC)
Social Work Programs	• California State Long Beach • San Francisco State University (SFSU) • Humboldt State • San Jose State University • University of Southern California • Berkeley
MFT Programs	• SSU • University of San Francisco • SFSU
Mental Health Worker Programs	• SSU • SRJC

Workforce, Education, and Training Activities

The goal of our Workforce, Education, and Training (WET) Activities is to create and maintain a robust comprehensive training program, including evidence-based clinical practices and culturally responsive frameworks, to make Sonoma County Behavioral Health an attractive place to work and to promote wellness and meaning for our diverse clients. To better support these goals, WET will add a full-time clinical specialist role to support this program.

WET Activities	Trainings
Staff Skill Development	• Staff Development Trainings
Comprehensive training Program	Evidence-Based Practices: • Strengths Model Care Management • Family Systems • EMDR

	• CBT for Psychosis • Cognitive Behavioral Social Skills Training • DBT • Trauma-Focused CBT • Assertive Community Treatment • Harm Reduction • Trauma Informed Systems • CBT for Depression • Seeking Safety • Peer-Based Supports (WRAP, Transformative Mutual Aid Practices) • Psychopharmacology for Non-Medical Staff • Motivational Interviewing
Culturally Responsive Practices	• Incorporating and working with peers in the workforce • Cultural humility • Special concerns for LGBTQIA+ clients • Adapting Evidence-Based Systems to Community Need, "Fidelity vs Fit"

The following programs and activities will be funded through WET in FY 23-26:

Program/Project	Estimated # to be served in FY 23-24	Children and Youth (0-15)	Transition Age Youth (16 - 25)	Adults (25-59)	Older Adults (60+)	Estimated MHSA cost per person in FY 23-24
Ethnic Services, Inclusion and Training Coordinator	N/A	N/A	N/A	N/A	N/A	N/A
DHS-BHD WET Activities	N/A	N/A	N/A	N/A	N/A	N/A
0.5 FTE Senior Office Assistant (SOA)	N/A	N/A	N/A	N/A	N/A	N/A
West County Community Services - Peer Education and Training [contractor]	79	0	0	49	30	$1,872

Program/Project	Estimated # to be served in FY 24-25	Children and Youth (0-15)	Transition Age Youth (16 - 25)	Adults (25-59)	Older Adults (60+)	Estimated MHSA cost per person in FY 24-25
Ethnic Services, Inclusion and Training Coordinator	N/A	N/A	N/A	N/A	N/A	N/A
DHS-BHD WET Activities	N/A	N/A	N/A	N/A	N/A	N/A

0.5 FTE Senior Office Assistant (SOA)	N/A	N/A	N/A	N/A	N/A	N/A
West County Community Services - Peer Education and Training [contractor]	79	0	0	49	30	$1,872

Program/Project	Estimated # to be served in FY 25-26	Children and Youth (0-15)	Transition Age Youth (16 - 25)	Adults (25-59)	Older Adults (60+)	Estimated MHSA cost per person in FY 25-26
Ethnic Services, Inclusion and Training Coordinator	N/A	N/A	N/A	N/A	N/A	N/A
DHS-BHD WET Activities	N/A	N/A	N/A	N/A	N/A	N/A
0.5 FTE Senior Office Assistant (SOA)	N/A	N/A	N/A	N/A	N/A	N/A
West County Community Services - Peer Education and Training [contractor]	79	0	0	49	30	$1,872

Capital Facilities and Technological Needs (CFTN) Plan for FY 2023 - 2026

Capital Facilities and Technological Needs (CFTN)[2]

This component works towards the creation of facilities that are used for the delivery of MHSA services to mental health clients and their families, or for administrative offices. Funds may also be used to support an increase in peer-support and consumer-run facilities, development of community-based settings, and the development of a technological infrastructure for the mental health system to facilitate the highest quality and cost-effective services and supports for clients and their families.

In 22-23 DHS-BHD implemented the SmartCare Innovation project. Eventually SmartCare will be the only electronic health record for the division. During the next 5-7 years as each phase of SmartCare is implemented, the division will be reducing the use of Avatar, SWITS and DCAR. It is estimated that the division will need to maintain Avatar through 2029 to ensure a seamless transition. The following projects will be funded through CFTN in FY 23-26:

Provider	Project	Description
NetSmart	Avatar Electronic Health Record (EHR)	Implementing fully integrated Electronic Health Record
FEI	Sonoma Web Infrastructure for Treatment Services (SWITS)	Database for tracking demographics and outcomes

A.J. Wong, Inc.	Data Collection Assessment and Reporting (DCAR)	Database for client CANS (Child and Adolescent Needs and Strengths) and ANSA (Adult Needs and Strength Assessment) assessments, reassessment and closing assessments
DHS-BHD	Avatar Electronic Health Record (EHR) - DHS staff	DHS-BHD staff to administer Avatar

Program/Project	Estimated # to be served in FY 23-26	Children and Youth (0-15)	Transition Age Youth (16 - 25)	Adults (25-59)	Older Adults (60+)	Estimated MHSA cost per person in FY 23-26
Avatar Electronic Health Record (EHR) - Netsmart	N/A	N/A	N/A	N/A	N/A	N/A
Avatar Electronic Health Record (EHR) - DHS staff	N/A	N/A	N/A	N/A	N/A	N/A
Sonoma Web Infrastructure for Treatment Services (SWITS) - FEI	N/A	N/A	N/A	N/A	N/A	N/A
Data Collection and Reporting (DCAR) - AJW	N/A	N/A	N/A	N/A	N/A	N/A

No Place Like Home

Background Information

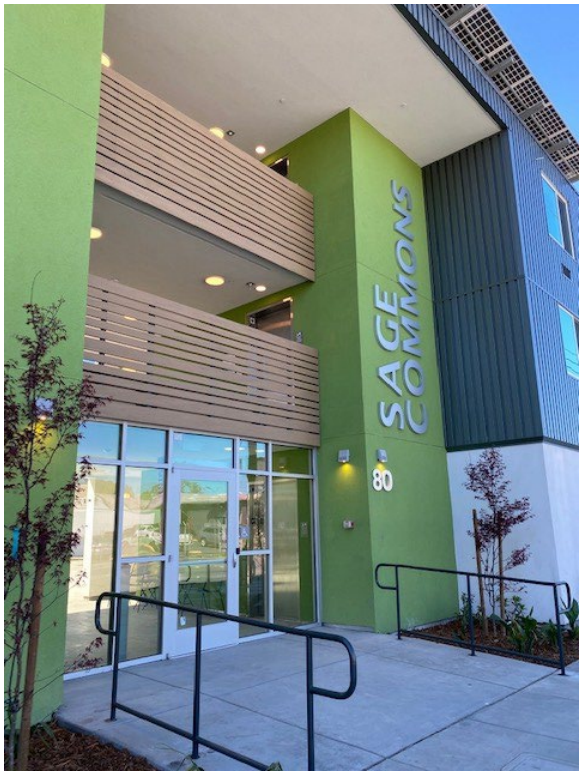
On July 1, 2016, Governor Brown signed landmark legislation enacting the No Place Like Home (NPLH) program to dedicate up to $2 billion in bond proceeds to invest in the development of permanent supportive housing for persons who need mental health services and are experiencing homelessness, chronic homelessness, or who are at risk of chronic homelessness. The bonds are repaid by funding from the Mental Health Services Act (MHSA). In November 2018 voters approved Proposition 2, authorizing the sale of up to $2 billion of revenue bonds and the use of a portion of Proposition 63 taxes for the NPLH program.

The purpose of NPLH is to acquire, design, construct, rehabilitate, or preserve permanent supportive housing for persons who are experiencing homelessness, chronic homelessness or who are at risk of chronic homelessness, and who experience serious mental health illness.

Population to be Served

Adults with serious mental illness; or children with severe emotional disorders and their families; and persons who require—or are at risk of requiring—acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a mental disorder with symptoms of psychosis, suicidality, or violence and who are homeless, chronically homeless, or at risk of chronic homelessness.

The definition of "at risk of chronic homelessness" includes persons who are at high risk of long-term or intermittent homelessness, including persons with mental illness exiting institutionalized settings with a history of homelessness prior to institutionalization, and transition age youth experiencing homelessness or with significant barriers to housing. For more information about NPLH please follow this link: https://www.hcd.ca.gov/grants-funding/active-funding/nplh.shtml



NPLH in Sonoma County

The picture on the left, of Sage Commons is the first NPLH funded project in Sonoma County to open and provide supportive housing for the population to be served. The table below, provided by Sonoma's Community Development Commission, lists the NPLH projects in Sonoma County. Sage Commons opened in 2022, and Orchard Commons, which is for families, opened in 2023.

Playground at Orchard Commons

Caritas Homes are open and occupied.

The table below provides additional information on the NPLH projects including the sponsor, name of the project, total units, designated NPLH units, the target population for the units, and current status.

Project Sponsor	Project Name	Project City	Total Project Units	NPLH Units	Population	Current Status
Danco Communities	**Sage Commons**	Santa Rosa	54	29	Single adults and small families	Opened April 2022
Danco Communities	**Orchard Commons**	Santa Rosa	45	15	Families	Opened February 2023
Burbank Housing Development Corp.	**Caritas Homes**	Santa Rosa	128	30	Single adults, seniors, veterans, and families	Opened 2023
Burbank Housing Development Corp.	**Petaluma River Place Apartments**	Petaluma	50	15	TBD	Opening Fall 2023
Mid-Pen Housing	**Petaluma Blvd. North**	Petaluma	40	15	TBD	TBD

Supportive Housing Services for NPLH Residents:
The County, Sage Commons and Orchard Commons are providing supportive housing services for NPLH residents to help ensure that residents can make a smooth transition from no housing, temporary or insecure housing into long-term permanent housing.

DHS-BHD is providing supportive services to individuals who have been certified as eligible prospective tenants in NPLH-funded units. These services focus on three areas:

1. Move-In Process
2. Ongoing Tenancy and Lease Violation Intervention
3. Eviction Prevention

Move-In Process

- Assist the NPLH tenants with the leasing process.
- Meet with incoming tenants at the time of move-in.
- Orient new tenants to the services available on-site and provide them with information on community resources.
- Offer tenants the opportunity to participate in supportive services and receive mental health services.

Ongoing Tenancy

- Conduct needs assessments, develop recovery focused service plans, and establish appropriate linkage to community-based services such as health care, child care, alcohol and other substance use treatment, education and/or employment services, self-help groups, and other services essential for achieving and maintaining independent living.
- Provide mental health services including assessment, individual and group therapy, rehabilitative groups, case management, crisis intervention, medication support, and psychiatric services as needed and agreed upon by the NPLH tenant.
- Facilitate community-building activities for NPLH tenants when possible (i.e., educational workshops, trainings, garden projects, support groups, discussion groups, volunteer opportunities) to establish peer support systems.

Lease Violation Interventions and Eviction Prevention

- Help NPLH tenants to understand and meet their obligations with respect to NPLH tenant agreements and community rules.
- Establish plans to help tenants obtain the appropriate support and services they need to maintain their permanent housing in times of crisis.

EXPENDITURE PLAN

FY 2023-2026

A summary of Sonoma County's MHSA estimated funding and expenditures for FY 2023-2026.

MHSA Expenditure Plan for FY 23-24

FY 23-24 Estimated Funding and Expenditures Summary

Category/Program	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs
Estimated FY 2023/24 Funding					
Estimated Unspent Funds from Prior Fiscal Years	25,892,760	9,178,767	3,097,819	0	0
Estimated New FY 2023/24 Funding	23,194,606	5,798,651	1,528,970		
Transfer in FY 2023/24a	(1,946,657)			974,519	972,138
Access Local Prudent Reserve in FY 2023/2024					
Estimated Available Funding for FY 2023/24	47,140,709	14,977,418	4,626,789	974,519	972,138
Estimated FY 2023/24 Expenditures	27,530,772	5,469,709	2,487,379	974,519	972,138

Estimated Local Prudent Reserve Balance	
Estimated Local Prudent Reserve Balance on June 30, 2023	944,981
Contributions to the Local Prudent Reserve in FY 2023/24	0
Distributions from the Local Prudent Reserve in FY 2023/24	0
Estimated Local Prudent Reserve Balance on June 30, 2023	944,981

FY 23-24 Estimated Community Services and Supports (CSS) Funding and Expenditures

Category/Program	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
Forensic Assertive Community Treatment (FACT) Team						
County of Sonoma Department of Health Services Behavioral Health Division (DHS-BHD)	1,462,880	835,123	534,541			93,216
Buckelew Programs - FACT - Independent Living Skills (ILS) [contractor]	135,881	83,478	52,403			
Buckelew Programs - FACT - Supplemental Patch for Unlicensed Supportive Housing Units	30,086	16,985	13,101			
Family Advocacy, Stabilization & Support Team (FASST)						
DHS-BHD	4,903,917	3,092,144	1,736,853			74,921
Seneca [contractor]	200,000	111,979	88,021			
Lifeworks [contractor]	100,000	57,179	42,821			
Social Advocates for Youth - Individuals Now [contractor]	245,000	137,948	107,052			
Integrated Recovery Team (IRT)						
DHS-BHD	1,297,631	837,023	437,455			23,153
Older Adult Intensive Team (OAIT)						
DHS-BHD	1,072,274	794,562	260,656			17,056
Transition Age Youth (TAY) Team						
DHS-BHD	923,596	625,472	277,571			20,553
Buckelew Programs - TAY - Sonoma County Independent Living (SCIL) [contractor]	146,576	73,288	73,288			
SAY - Tamayo Village [contractor]	164,500	114,026	50,474			

On The Move - VOICES [contractor]	253,154	253,154				
Adult Full Service Partnership (AFSP)						
DHS-BHD	1,146,099	1,119,104				26,995
Telecare ACT [contractor]	1,493,488	1,493,488				
Non-FSP Programs						
General Systems Development (GSD)						
Family-based Education, Advocacy and Support (FEAS) [contractor TBD] - RFP	215,817	215,817				
DHS-BHD Mobile Support Team (MST)	3,413,593	1,117,344				2,296,249
DHS-BHD Collaborative Treatment and Recovery Team (CTRT)	1,159,464	821,713	327,770			9,981
Buckelew Programs - CTRT System Navigation [contractor]	445,534	242,048	203,486			
DHS-BHD Community Mental Health Centers	2,578,526	1,622,674	850,158			105,694
Senior Peer Support [contractor TBD] -RFP	89,077	89,077				
Senior Peer Counseling [contractor TBD] - RFP	76,554	76,554				
Family Service Coordination [contractor TBD] - RFP	229,965	229,965				
Sonoma County Human Services Department (HSD) - Job Link [contractor]	33,750	33,750				
WCCS - Interlink [contractor]	423,311	48,545				374,766
WCCS - Wellness & Advocacy Center [contractor]	726,822	726,822				
WCCS - Russian River Empowerment Center [contractor]	176,135	176,135				
WCCS - Petaluma Peer Recovery Center [contractor]	79,268	79,268				
WCCS - Crisis Support [contractor]	10,611	10,611				
DHS-BHD Medication Support Services for Adult Programs	5,564,206	4,998,099	516,020			50,087

Category/Program	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
DHS-BHD Medication Support Services for Youth Programs	2,643,550	2,131,466	473,990			38,094
Alternative Family Services [contractor]	250,000	125,000	125,000			
Siyan Clinical Research [contractor]	1,250,000	1,250,000				
Outreach and Engagement (OE)						
DHS-BHD Whole Person Care (WPC)	1,745,260	780,112	952,730			12,418
Sonoma County Indian Health Project - Community Programs [contractor]	85,988	85,988				
CSS Annual Planning	254,176	242,370				11,806
CSS Administration	2,698,437	2,673,410				25,027
CSS MHSA Housing Program Assigned Funds	4,875	4,875				0
Total CSS Program Estimated Expenditures	37,730,000	27,530,772	6,998,389	0	0	3,200,839

FY 23-24 Estimated Prevention and Early Intervention (PEI) Funding and Expenditures

Category/Program	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						
Action Network [contractor]	63,665	63,665				
Community Baptist Church Collaborative [contractor]	127,327	127,327				
Sonoma County Human Services Department - Older Adult Collaborative [contractor]	233,432	231,483				1,949
Sonoma County Indian Health Project [contractor]	42,443	42,443				
PEI Programs - Prevention & Early Intervention						
La Luz [contractor]	35,206	35,206				
Latino Service Providers of Sonoma County [contractor]	113,533	113,533				
Positive Images [contractor]	108,228	108,228				
PEI Programs - Early Intervention						
Child Parent Institute (CPI) [contractor]	217,800	217,800				
La Luz [contractor]	50,402	50,402				
Early Learning Institute (ELI) [contractor]	48,400	48,400				
PEI Programs - Stigma & Discrimination Reduction						
Santa Rosa Junior College [contractor]	212,211	212,211				
PEI Programs - Suicide Prevention						
Buckelew Programs - North Bay Suicide Prevention Program [contractor]	169,769	169,769				
PEI Programs - Access and Linkage to Treatment						
DHS-BHD Youth Access Team	1,796,106	1,399,968	284,842			111,296
DHS-BHD Adult Access Team	2,550,671	2,009,112	301,549			240,010
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness						
Crisis Intervention Training (CIT) with Law Enforcement Personnel	30,250	29,830				420
PEI Annual Planning	39,811	37,962				1,849
PEI Administration	412,576	408,656				3,920
PEI Assigned Funds (CalMHSA Statewide PEI Project)	172,673	172,673				
Total PEI Program Estimated Expenditures	6,415,544	5,469,709	586,391	0	0	359,444

FY 23-24 Estimated Innovation (INN) Funding and Expenditures

INN Programs	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Collaborative Care Enhanced Recovery Project (CCERP)aka Unidos Por Nuestro Bienestar - [Sonoma County Human Services Department]	421,309	421,309				
Crossroads to Hope (Peer Program Provider) - Felton Institute	607,639	607,639				
Early Psychosis Learning Health Care Network (EP LHCN) - [Buckelew/Aldea - contractor]	74,799	74,799				
Early Psychosis Learning Health Care Network (EP LHCN) - [UC Davis - contractor]	54,900	54,900				
Instructions Not Included (INI) - Dads Matter [Early Learning Institute - contractor]	239,206	239,206				
New Parent TLC - [First 5 Sonoma County - contractor]	115,883	115,883				
Nuestra Cultura Cura Social Innovations Lab - [On The Move - contractor]	246,732	246,732				
Crossroads to Hope (Evaluation Consultant) - Behavioral Health Outcomes Data Services	23,800	23,800				
CalMHSA Electronic Health Record	703,111	703,111				
INN Annual Planning						
INN Administration						
Total INN Program Estimated Expenditures	2,487,379	2,487,379				

FY 23-24 Estimated Workforce, Education and Training (WET) Funding and Expenditures

WET Programs	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Ethnic Services, Inclusion and Training Coordinator	251,500	251,500				
DHS-BHD WET Activities	500,000	500,000				
0.5 FTE Senior Office Assistant (SOA)	16,908	4,844				12,064
West County Community Services - Peer Education and Training [contractor]	147,926	147,926				
WET Annual Planning	6,125	5,841				284
WET Administration	65,011	64,408				603
Total WET Program Estimated Expenditures	987,470	974,519				12,951

FY 23-24 Estimated Capital Facilities and Technological Needs (CFTN) Funding and Expenditures

CFTN Programs/Projects	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Avatar Electronic Health Record (EHR) - Netsmart	857,701	857,701				
Avatar Electronic Health Record (EHR) - DHS staff	3,397	3,397				
Sonoma Web Infrastructure for Treatment Services (SWITS) - FEI	2,200	2,200				
Data Collection and Reporting (DCAR) - AJW	38,875	38,875				

CFTN Annual Planning	6,125	5,841				284
CFTN Administration	64,727	64,124				603
Total CFTN Program Estimated Expenditures	973,025	972,138				887

MHSA Expenditure Plan for FY 2024-2025

FY 24-25 Estimated Funding and Expenditures Summary

Category/Program	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs
Estimated FY 2024/25 Funding					
Estimated Unspent Funds from Prior Fiscal Years	19,609,937	9,507,709	2,139,410	0	0
Estimated New FY 2024/25 Funding	23,194,606	5,798,651	1,528,970		
Transfer in FY 2024/25a/	(2,871,037)			1,899,680	971,357
Access Local Prudent Reserve in FY 2024/25	0	0			
Estimated Available Funding for FY 2024/25	39,933,506	15,306,360	3,668,380	1,899,680	971,357
Estimated FY 2024/25 Expenditures	27,525,898	5,469,709	1,699,537	979,680	971,357

Estimated Local Prudent Reserve Balance	
Estimated Local Prudent Reserve Balance on June 30, 2024	944,981
Contributions to the Local Prudent Reserve in FY 2023/24	0
Distributions from the Local Prudent Reserve in FY 2023/24	0
Estimated Local Prudent Reserve Balance on June 30, 2025	944,981

* 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 24-25 Estimated Community Services and Supports (CSS) Funding and Expenditures

	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
Forensic Assertive Community Treatment (FACT) Team						
County of Sonoma Department of Health Services Behavioral Health Division (DHS-BHD)	$1,462,880	$835,123	$534,541	$0	$0	$93,216
Buckelew Programs - FACT - Independent Living Skills (ILS) [contractor]	$135,881	$83,478	$52,403	$0	$0	$0
Buckelew Programs - FACT - Supplemental Patch for Unlicensed Supportive Housing Units	$30,086	$16,985	$13,101	$0	$0	$0
Family Advocacy, Stabilization & Support Team (FASST)						
DHS-BHD	$4,903,917	$3,092,143	$1,736,853	$0	$0	$74,921
Seneca [contractor]	$200,000	$111,979	$88,021	$0	$0	$0
Lifeworks [contractor]	$100,000	$57,179	$42,821	$0	$0	$0
Social Advocates for Youth - Individuals Now [contractor]	$245,000	$137,948	$107,052	$0	$0	$0
Integrated Recovery Team (IRT)						
DHS-BHD	$1,297,631	$837,023	$437,455	$0	$0	$23,153
Older Adult Intensive Team (OAIT)						
DHS-BHD	$1,072,274	$794,562	$260,656	$0	$0	$17,056
Transition Age Youth (TAY) Team						
DHS-BHD	$923,596	$625,472	$277,571	$0	$0	$20,553
Buckelew Programs - TAY - Sonoma County Independent Living (SCIL) [contractor]	$146,576	$73,288	$73,288	$0	$0	$0
SAY - Tamayo Village [contractor]	$164,500	$114,026	$50,474	$0	$0	$0

	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
On The Move - VOICES [contractor]	$253,154	$253,154	$0	$0	$0	$0
Adult Full Service Partnership (AFSP)						
DHS-BHD	$1,146,099	$1,119,104	$0	$0	$0	$26,995
Telecare ACT [contractor]	$1,493,488	$1,493,488	$0	$0	$0	$0
Non-FSP Programs						
General Systems Development (GSD)						
Family-based Education, Advocacy and Support (FEAS) [contractor TBD] - RFP	$215,817	$215,817	$0	$0	$0	$0
DHS-BHD Mobile Support Team (MST)	$3,413,593	$1,117,344	$0	$0	$0	$2,296,249
DHS-BHD Collaborative Treatment and Recovery Team (CTRT)	$1,159,464	$821,713	$327,770	$0	$0	$9,981
Buckelew Programs - CTRT System Navigation [contractor]	$445,534	$242,048	$203,486	$0	$0	$0
DHS-BHD Community Mental Health Centers	$2,578,526	$1,622,674	$850,158	$0	$0	$105,694
Senior Peer Support [contractor TBD] -RFP	$89,077	$89,077	$0	$0	$0	$0
Senior Peer Counseling [contractor TBD] - RFP	$76,554	$76,554	$0	$0	$0	$0
Family Service Coordination [contractor TBD] - RFP	$229,965	$229,965	$0	$0	$0	$0
Sonoma County Human Services Department (HSD) - Job Link [contractor]	$33,750	$33,750	$0	$0	$0	$0
WCCS - Interlink [contractor]	$423,311	$48,545	$0	$0	$0	$374,766
WCCS - Wellness & Advocacy Center [contractor]	$726,822	$705,999	$0	$0	$0	$20,823
WCCS - Russian River Empowerment Center [contractor]	$176,135	$176,135	$0	$0	$0	$0
WCCS - Petaluma Peer Recovery Center [contractor]	$79,268	$79,268	$0	$0	$0	$0
WCCS - Crisis Support [contractor]	$10,611	$10,611	$0	$0	$0	$0

	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
DHS-BHD Medication Support Services for Adult Programs	$5,564,206	$4,998,099	$516,020	$0	$0	$50,087
DHS-BHD Medication Support Services for Youth Programs	$2,643,550	$2,131,466	$473,990	$0	$0	$38,094
Alternative Family Services [contractor]	$250,000	$250,000	$0	$0	$0	$0
Siyan Clinical Research [contractor]	$1,250,000	$1,250,000	$0	$0	$0	$0
Outreach and Engagement (OE)						
DHS-BHD Whole Person Care (WPC)	$1,745,260	$780,112	$952,730	$0	$0	$12,418
Sonoma County Indian Health Project - Community Programs [contractor]	$85,988	$85,988	$0	$0	$0	$0
CSS Annual Planning	$254,176	$242,370	$0	$0	$0	$11,696
CSS Administration	$2,698,437	$2,673,410	$0	$0	$0	$44,548
CSS MHSA Housing Program Assigned Funds	$0	$0	$0	$0	$0	$0
Total CSS Program Estimated Expenditures	$37,725,126	$27,525,898	$6,998,389	$0	$0	$3,200,839

FY 24-25 Estimated Prevention and Early Intervention (PEI) Funding and Expenditures

Category/Program	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						
Action Network [contractor]	$63,664	$63,664	$0	$0	$0	$0
Community Baptist Church Collaborative [contractor]	$127,327	$127,327	$0	$0	$0	$0
Sonoma County Human Services Department - Older Adult Collaborative [contractor]	$233,432	$231,483	$0	$0	$0	$1,949
Sonoma County Indian Health Project [contractor]	$42,443	$42,443	$0	$0	$0	$0
PEI Programs - Prevention & Early Intervention						
La Luz [contractor]	$35,206	$35,206	$0	$0	$0	$0
Latino Service Providers of Sonoma County [contractor]	$113,533	$113,533	$0	$0	$0	$0
Positive Images [contractor]	$108,228	$108,228	$0	$0	$0	$0
PEI Programs - Early Intervention						
Child Parent Institute (CPI) [contractor]	$210,089	$210,089	$0	$0	$0	$0
La Luz [contractor]	$48,618	$48,618	$0	$0	$0	$0
Early Learning Institute (ELI) [contractor]	$46,687	$46,687	$0	$0	$0	$0
PEI Programs - Stigma & Discrimination Reduction						
Santa Rosa Junior College [contractor]	$212,211	$212,211	$0	$0	$0	$0
PEI Programs - Suicide Prevention						
Buckelew Programs - North Bay Suicide Prevention Program [contractor]	$169,769	$169,769	$0	$0	$0	$0
PEI Programs - Access and Linkage to Treatment						
DHS-BHD Youth Access Team	$1,796,106	$1,399,968	$284,842	$0	$0	$111,296
DHS-BHD Adult Access Team	$2,448,316	$1,906,757	$301,549	$0	$0	$240,010
OPTUM - MOU County of Contra Costa, Marin, San Mateo	$104,605	$104,605	$0	$0	$0	$0

PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness						
Crisis Intervention Training (CIT) with Law Enforcement Personnel	$30,250	$29,830	$0	$0	$0	$420
PEI Annual Planning	$42,873	$40,882	$0	$0	$0	$1,991
PEI Administration	$412,576	$408,656	$0	$0	$0	$4,221
PEI Assigned Funds (CalMHSA Statewide PEI Project)	$172,673	$172,673	$0	$0	$0	$0
Total PEI Program Estimated Expenditures	$6,415,544	$5,469,709	$586,391	$0	$0	$359,444

FY 24-25 Estimated Innovation (INN) Funding and Expenditures

INN Programs	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Collaborative Care Enhanced Recovery Project (CCERP)aka *Unidos Por Nuestro Bienestar* - [Sonoma County Human Services Department]	$40,000	$40,000	$0	$0	$0	$0
Crossroads to Hope (Peer Program Provider) - Felton Institute	$641,520	$641,520	$0	$0	$0	$0
Instructions Not Included (INI) - Dads Matter [Early Learning Institute - contractor]	$222,165	$222,165	$0	$0	$0	$0
New Parent TLC - [First 5 Sonoma County - contractor]	$60,000	$60,000	$0	$0	$0	$0
Nuestra Cultura Cura Social Innovations Lab - [On The Move - contractor]	$70,000	$70,000	$0	$0	$0	$0

Crossroads to Hope (Evaluation Consultant) - Behavioral Health Outcomes Data Services	$23,800	$23,800	$0	$0	$0	$0
CalMHSA Electronic Health Record	$642,052	$642,052	$0	$0	$0	$0
INN Annual Planning	$0	$0	$0	$0	$0	$0
INN Administration	$0	$0	$0	$0	$0	$0
Total INN Program Estimated Expenditures	$1,672,125	$1,672,125	$0	$0	$0	$1,809

FY 24-25 Estimated Workforce, Education and Training (WET) Funding and Expenditures

WET Programs	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Ethnic Services, Inclusion and Training Coordinator	$251,500	$251,500	$0	$0	$0	$0
DHS-BHD WET Activities	$500,000	$500,000	$0	$0	$0	$0
0.5 FTE Senior Office Assistant (SOA)	$16,908	$4,844	$0	$0	$0	$12,064
West County Community Services - Peer Education and Training [contractor]	$153,356	$153,356	$0	$0	$0	$0
WET Annual Planning	$6,125	$5,841	$0	$0	$0	$284
WET Administration	$64,742	$64,139	$0	$0	$0	$603
Total WET Program Estimated Expenditures	$992,631	$979,680	$0	$0	$0	$12,951

FY 24-25 Estimated Capital Facilities and Technological Needs (CFTN) Funding and Expenditures

CFTN Programs/Projects	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Avatar Electronic Health Record (EHR) - Netsmart	$857,701	$857,701	$0	$0	$0	$0
Avatar Electronic Health Record (EHR) - DHS staff	$3,397	$3,397	$0	$0	$0	$0
Sonoma Web Infrastructure for Treatment Services (SWITS) - FEI	$2,200	$2,200	$0	$0	$0	$0
Data Collection and Reporting (DCAR) - AJW	$38,875	$38,875	$0	$0	$0	$0
CFTN Annual Planning	$6,125	$5,841	$0	$0	$0	$284
CFTN Administration	$63,946	$63,343	$0	$0	$0	$603
Total CFTN Program Estimated Expenditures	$972,244	$971,357	$0	$0	$0	$887

MHSA Expenditure Plan for FY 25-26

FY 25-26 Estimated Funding and Expenditures Summary

Estimated FY 2025/26 Funding	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs
Estimated Unspent Funds from Prior Fiscal Years	12,407,607	9,836,651	1,968,843	0	0
Estimated New FY 2025/26 Funding	23,194,606	5,798,651	1,528,970		
Transfer in FY 2025/26a/	(2,858,973)			1,887,616	971,357
Access Local Prudent Reserve in FY 2025/26	0	0			
Estimated Available Funding for FY 2025/26	32,743,240	15,635,302	3,497,813	1,887,616	971,357
Estimated FY 2025/26 Expenditures	27,525,898	5,469,709	1,273,985	979,949	972,138
Estimated FY 2025/26 Unspent Fund Balance	5,217,343	10,165,593	2,223,828	0	0

Estimated Local Prudent Reserve Balance	
Estimated Local Prudent Reserve Balance on June 30, 2025	944,981
Contributions to the Local Prudent Reserve in FY 2025/26	0
Distributions from the Local Prudent Reserve in FY 2025/26	0
Estimated Local Prudent Reserve Balance on June 30, 2026	944,981

* 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 25-26 Estimated Community Services and Supports (CSS) Funding and Expenditures

Category/Program	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
Forensic Assertive Community Treatment (FACT) Team						
County of Sonoma Department of Health Services Behavioral Health Division (DHS-BHD)	1,462,880	835,123	534,541	0	0	93,216
Buckelew Programs - FACT - Independent Living Skills (ILS) [contractor]	135,881	83,478	52,403	0	0	0
Buckelew Programs - FACT - Supplemental Patch for Unlicensed Supportive Housing Units	30,086	16,985	13,101	0	0	0
Family Advocacy, Stabilization & Support Team (FASST)						
DHS-BHD	4,903,917	3,092,144	1,736,853	0	0	74,921
Seneca [contractor]	200,000	111,979	88,021	0	0	0
Lifeworks [contractor]	100,000	57,179	42,821	0	0	0
Social Advocates for Youth - Individuals Now [contractor]	245,000	137,948	107,052	0	0	0
Integrated Recovery Team (IRT)						
DHS-BHD	1,297,631	837,023	437,455	0	0	23,153
Older Adult Intensive Team (OAIT)						
DHS-BHD	1,072,274	794,562	260,656	0	0	17,056
Transition Age Youth (TAY) Team						
DHS-BHD	923,596	625,472	277,571	0	0	20,553
TBD - RFP [contractor]	146,576	73,288	73,288	0	0	0
TBD - RFP [contractor]	164,500	114,026	50,474	0	0	0
TBD - RFP [contractor]	253,154	253,154	0	0	0	0

Adult Full Service Partnership (AFSP)						
DHS-BHD	1,146,099	1,119,104	0	0	0	26,995
Telecare ACT [contractor]	1,493,488	1,493,488	0	0	0	0
Non-FSP Programs						
General Systems Development (GSD)						
National Alliance on Mental Illness (NAMI) Sonoma County - Family-based Education, Advocacy and Support (FEAS) [contractor]	215,817	215,817	0	0	0	0
Family Service Coordination [contractor TBD] - RFP	3,413,593	1,117,344	0	0	0	0
DHS-BHD Mobile Support Team (MST)	1,159,464	821,713	0	0	0	2,296,249
DHS-BHD Collaborative Treatment and Recovery Team (CTRT)	445,534	242,048	327,770			9,981
CTRT System Navigation [contractor TBD] - RFP	2,578,526	1,622,674	203,486	0	0	0
DHS-BHD Community Mental Health Centers	89,077	89,077	850,158	0	0	105,694
Senior Peer Support [contractor TBD] -RFP	76,554	76,554	0	0	0	0
Senior Peer Counseling [contractor TBD] - RFP	229,965	229,965	0	0	0	0
Sonoma County Human Services Department (HSD) - Job Link [contractor]	33,750	33,750	0	0	0	0
Interlink [contractor TBD] - RFP	423,311	48,545	0	0	0	374,766
Wellness & Advocacy Center [contractor TBD] - RFP	726,822	705,999	0	0	0	0
Russian River Empowerment Center [contractor TBD] - RFP	176,135	176,135	0	0	0	0
Petaluma Peer Recovery Center [contractor TBD] - RFP	79,268	79,268	0	0	0	0
Crisis Support [contractor TBD] - RFP	10,611	10,611	0	0	0	0
DHS-BHD Medication Support Services for Adult Programs	5,564,206	4,998,099	516,020	0	0	50,087
DHS-BHD Medication Support Services for Youth Programs	2,643,550	2,131,466	473,990	0	0	38,094
Alternative Family Services [contractor]	250,000	250,000	125,000	0	0	0
Siyan Clinical Research [contractor]	1,250,000	1,250,000	625,000	0	0	0

Outreach and Engagement (OE)						
DHS-BHD Whole Person Care (WPC)	1,745,260	780,112	952,730	0	0	12,418
Sonoma County Indian Health Project - Community Programs [contractor]	85,988	85,988	0	0	0	0
CSS Annual Planning	254,176	242,370	0	0	0	11,806
CSS Administration	2,698,437	2,673,410	0	0	0	25,027
CSS MHSA Housing Program Assigned Funds	0	0	0	0	0	0
Total CSS Program Estimated Expenditures	37,725,126	27,525,898	6,998,389	0	0	3,200,839

FY 25-26 Estimated Prevention and Early Intervention (PEI) Funding and Expenditures

Category/Program	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						
TBD - RFP [contractor]	63,664	63,664	0	0	0	0
TBD - RFP [contractor]	127,327	127,327	0	0	0	0
TBD - RFP [contractor]	233,432	231,483	0	0	0	1,949
TBD - RFP [contractor]	42,443	42,443	0	0	0	0
PEI Programs - Prevention & Early Intervention						
TBD - RFP [contractor]	35,206	35,206	0	0	0	0
TBD - RFP [contractor]	113,533	113,533	0	0	0	0
TBD - RFP [contractor]	108,228	108,228	0	0	0	0
PEI Programs - Early Intervention						
TBD - RFP [contractor]	210,089	210,089	0	0	0	0
TBD - RFP [contractor]	48,618	48,618	0	0	0	0
TBD - RFP [contractor]	46,687	46,687	0	0	0	0

PEI Programs - Stigma & Discrimination Reduction						
TBD - RFP [contractor]	212,211	212,211	0	0	0	0
PEI Programs - Suicide Prevention						
TBD - RFP [contractor]	169,769	169,769	0	0	0	0
PEI Programs - Access and Linkage to Treatment						
DHS-BHD Youth Access Team	1,796,106	1,399,968	284,842	0	0	111,296
DHS-BHD Adult Access Team	2,448,316	1,906,757	301,549	0	0	240,010
OPTUM - County of Contra Costa, Marin, San Mateo	104,605	104,605	0	0	0	0
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness						
Crisis Intervention Training (CIT) with Law Enforcement Personnel	30,250	29,830	0	0	0	420
PEI Annual Planning	39,811	37,962	0	0	0	1,991
PEI Administration	412,576	408,656	0	0	0	4,221
PEI Assigned Funds (CalMHSA Statewide PEI Project)	172,673	172,673	0	0	0	0
Total PEI Program Estimated Expenditures	6,415,544	5,469,709	586,391	0	0	359,444

FY 25-26 Estimated Innovation (INN) Funding and Expenditures

INN Programs	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Crossroads to Hope (Peer Program Provider) - Felton Institute	607,639	607,639	0	0	0	0
Crossroads to Hope (Evaluation Consultant) - Behavioral Health Outcomes Data Services	23,800	23,800	0	0	0	0
CalMHSA Electronic Health Record	642,546	642,546	0	0	0	0
INN Annual Planning						0
INN Administration	0	0	0	0	0	0

Total INN Program Estimated Expenditures	1,273,985	1,273,985	0	0	0	0

FY 25-26 Estimated Workforce, Education and Training (WET) Funding and Expenditures

WET Programs	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Ethnic Services, Inclusion and Training Coordinator	251,500	251,500	0	0	0	0
DHS-BHD WET Activities	500,000	500,000	0	0	0	0
0.5 FTE Senior Office Assistant (SOA)	16,908	4,844	0	0	0	12,064
West County Community Services - Peer Education and Training [contractor]	153,356	153,356	0	0	0	0
WET Annual Planning	6,125	5,841	0	0	0	284
WET Administration	65,011	64,408	0	0	0	603
Total WET Program Estimated Expenditures	992,900	979,949	0	0	0	12,951

FY 25-26 Estimated Capital Facilities and Technological Needs (CFTN) Funding and Expenditures

CFTN Programs/Projects	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Avatar Electronic Health Record (EHR) - Netsmart	857,701	857,701	0	0	0	0
Avatar Electronic Health Record (EHR) - DHS staff	3,397	3,397	0	0	0	0

Sonoma Web Infrastructure for Treatment Services (SWITS) - FEI	2,200	2,200	0	0	0	0
Data Collection and Reporting (DCAR) - AJW	38,875	38,875	0	0	0	0
CFTN Annual Planning	6,125	5,841	0	0	0	284
CFTN Administration	64,727	64,124	0	0	0	603
Total CFTN Program Estimated Expenditures	973,025	972,138	0	0	0	887

SONOMA COUNTY MHSA ANNUAL PROGRAM REPORT FY 2021 - 2022

SONOMA COUNTY MHSA ANNUAL PROGRAM REPORT

Summary report and highlights from MHSA funded programs in FY 2021-2022

Notes about the Data in the Report:

Data De-identifaction

In order to ensure the protection of personally identifiable information, some data in this section of the report have been suppressed or "masked" to prevent re-

identification (e.g. "Data suppressed due to small cell counts", "Multiple categories") as per California Department of Health Care Services (DHCS) Data De-identification Guidelines.

CANS/ANSA Outcome Data

The CANS and ANSA are comprehensive standardized, easy-to-use assessment tools which provide multi-system partners with understandable information about an individual's needs and strengths. The data set includes aggregated CANS/ANSA scores from the beginning of the reporting period to the end of the reporting period for each county run CSS and PEI program.

SONOMA COUNTY MHSA ANNUAL CSS PROGRAM REPORT

SONOMA COUNTY MHSA ANNUAL PROGRAM REPORT FY 2021 - 2022

COMMUNITY SERVICES AND SUPPORTS (CSS)

Programs provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

FULL-SERVICE PARTNERSHIP PROGRAMS (FSPs)

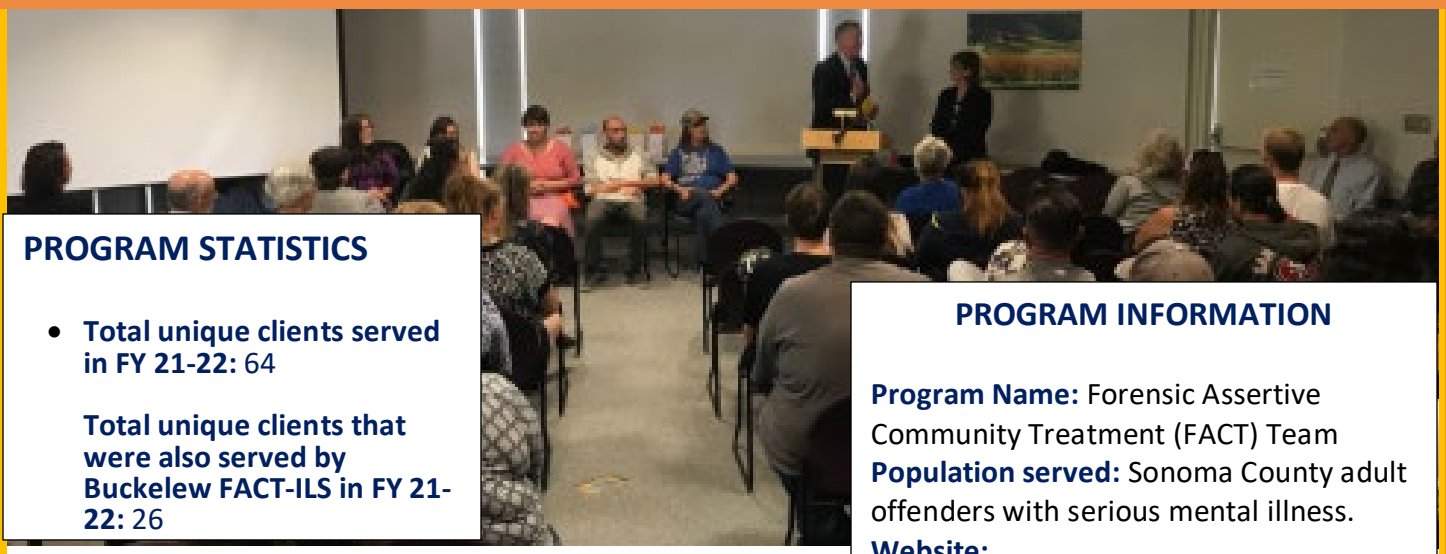
Full-Service Partnership programs are designed specifically for children who have been diagnosed with severe emotional disturbances and for transition age youth, adults and seniors who have been diagnosed with a severe mental illness that would benefit from an intensive service program.

The foundation of FSPs is utilizing a "whatever it takes" approach to help individuals on their path to recovery and wellness. FSPs embrace client-driven services and supports, with each client choosing services based on individual needs. Unique to FSP programs are a low staff-to-client ratio, a 24/7 crisis availability, and a team approach that is a partnership between mental health staff and consumers. Embedded in Full-Service Partnerships is a commitment to deliver services in ways that are culturally and linguistically responsive and appropriate.

In FY 21-22, there were over ___unique clients served by Sonoma County FSPs.

DHS-BHD's Forensic Assertive Community Treatment (FACT) Team

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.



PROGRAM STATISTICS

- **Total unique clients served in FY 21-22:** 64

  Total unique clients that were also served by Buckelew FACT-ILS in FY 21-22: 26

PROGRAM INFORMATION

Program Name: Forensic Assertive Community Treatment (FACT) Team
Population served: Sonoma County adult offenders with serious mental illness.
Website: www.sonomacounty.ca.gov/Health/Behavioral-Health/Adult-Services/Forensic-Assertive-Community-Treatment-Team/
Phone: (707) 565-4850
Program location:
2227 Capricorn Way, Suite 207
Santa Rosa, CA 95407

PROGRAM DESCRIPTION:

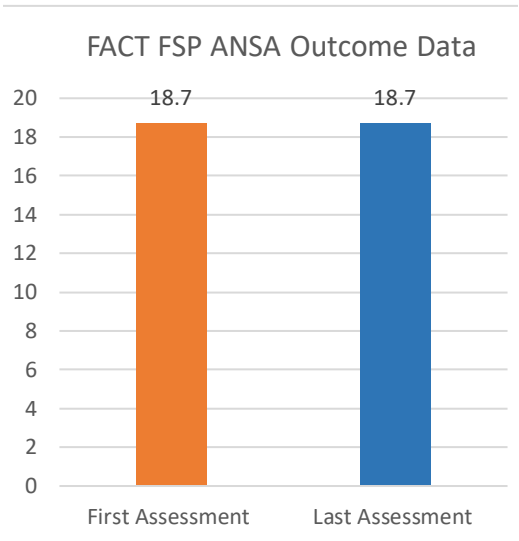
Sonoma County Department of Health Services' Behavioral Health's Forensic Assertive Community Treatment Team (FACT) serves adult offenders with Serious Mental Illness (SMI) by providing a community-based treatment team as an alternative to incarceration.

In FY 21-22, this program included contracted services from:

- Buckelew Programs – Independent Living Skills (ILS) (housing)

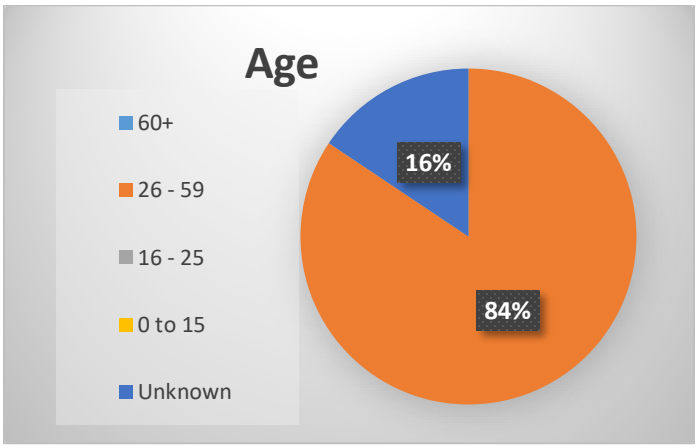
PERFORMANCE OUTCOMES & ACCOMPLISHMENTS:

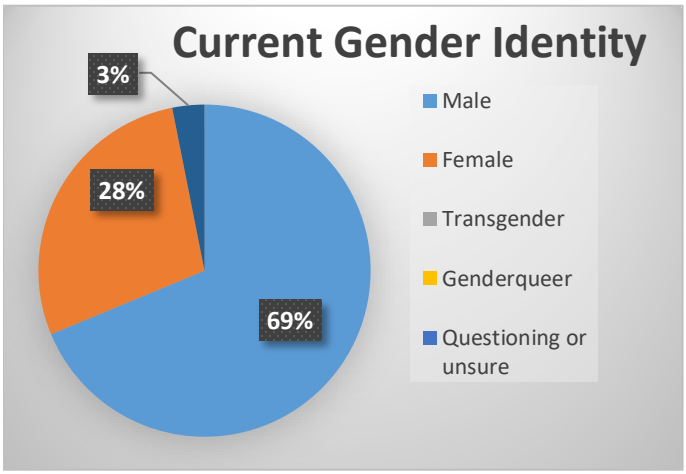
- The FACT program launched an aftercare element of our program to support recently graduated clients by providing ongoing ACT level of care even though probation requirements had been successfully completed. 7 clients took part of this aftercare option during FY 21-22
- Clients demonstrated tremendous resiliency as they endured long wait times to enter communal housing or access other community services due to ever changing protocols brought on by the COVID 19 pandemic. Clients persevered continuing to focus on their own recovery despite losing some of their peers to the fentanyl crisis.
- Despite not having the ability to hold graduation ceremonies due to social distancing protocols that limit large gatherings, the FACT team saw 14 clients graduate from court ordered treatment.
- Of the 64 clients who were served in the FACT program, 42 clients received assistance in locating stable housing in the community (transitional, permanent, short-term shelter, board, and care placement, etc.).

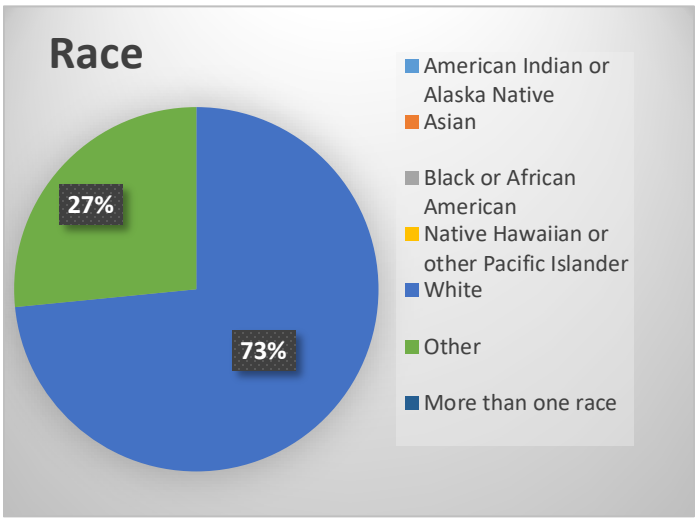


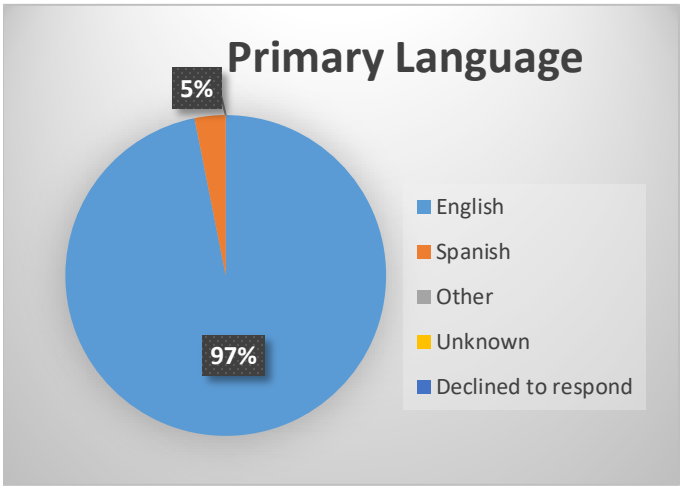
See pg.100 for an explanation of CANS/ANSA

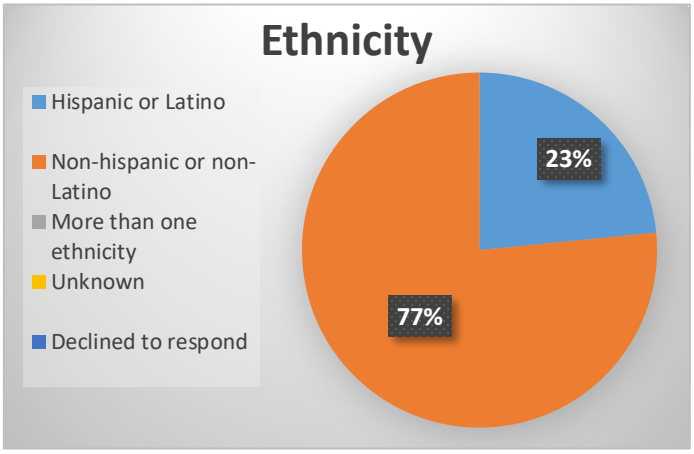
FY 2021-2022 Program Demographics:











DHS-BHD's Family Advocacy, Stabilization and Support Team (FASST)

sonoma county DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

Service Category: Full-Service Partnership Services

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM INFORMATION

Program Name: Family Advocacy, Stabilization and Support Team (FASST)
Population served: Sonoma County youth ages 5-18.
Website: www.sonomacounty.ca.gov/Health/Behavioral-Health/Youth-Services
Phone: (707) 565-4850
Program location:
2227 Capricorn Way, Suite 207
Santa Rosa, CA 95407

PROGRAM DESCRIPTION:

FASST is an intensive enrollee-based program that serves high-risk Seriously Emotionally Disturbed (SED) children (ages 5-18) who have not responded to traditional levels of service.

In FY 21-22, this program included contracted services from:

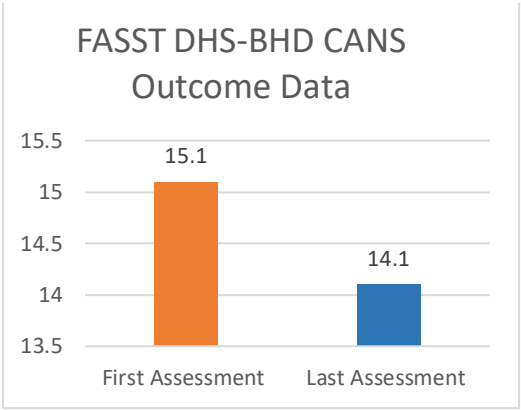
- Seneca, Lifeworks, and Social Advocates for Youth (SAY)

PERFORMANCE OUTCOMES & PROGRAM ACCOMPLISHMENTS:

FY 21-22 Client Success Story: A female youth became a FASST client in 2018. Client experienced early trauma and abandonment from biological parents and was adopted at 6 months old. Client was struggling with daily outbursts, anger control, depression, anxiety, suicidal thoughts, and self-harm. Client was failing her classes and not attending school.

Client started participating in weekly therapy, utilizing the skills that she learned to cope with strong emotions and manage behaviors. Client utilized therapeutic Behavioral Services through a YFS contract agency. Client learned healthy communication to express her strong emotions in the moment. Client worked with providers to figure out the right school program for her and attended Pivot Charter and received her high school diploma.

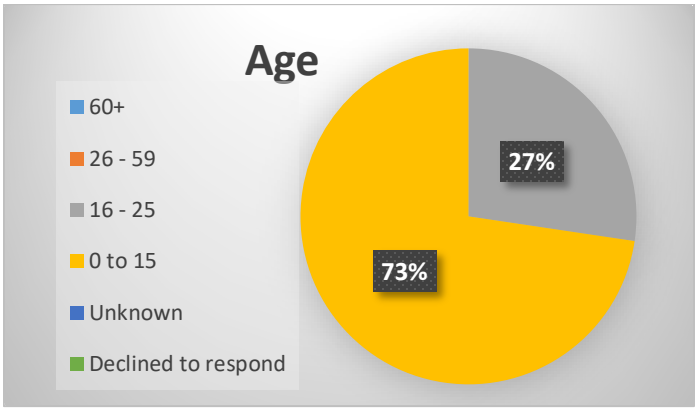
Thanks to the FASST program, the Client is currently working full time and started Lytle's Beauty College in the Spring 2023. Client met her treatment goals and is excited for her future in becoming a Theater and Entertainment Make-up artist. Client is excited for her future and has the confidence and skills to manage difficult emotions and early trauma.

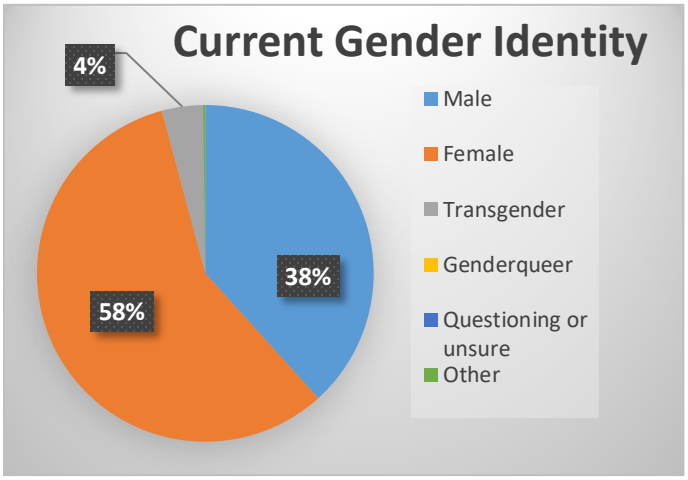


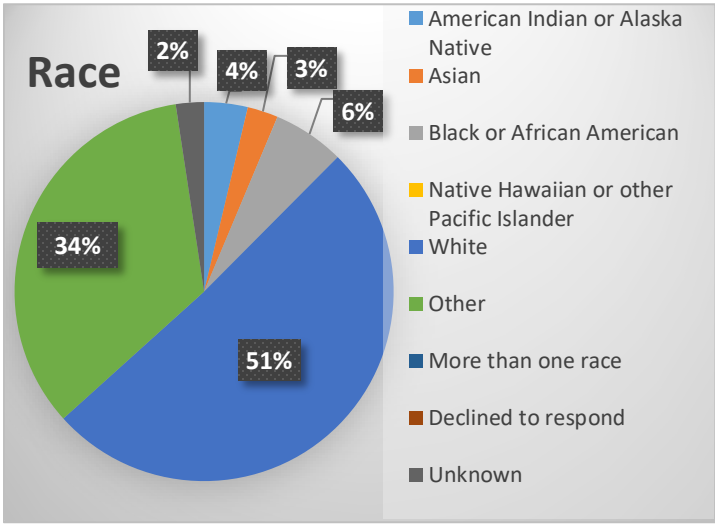
See pg.100 for an explanation of CANS/ANSA

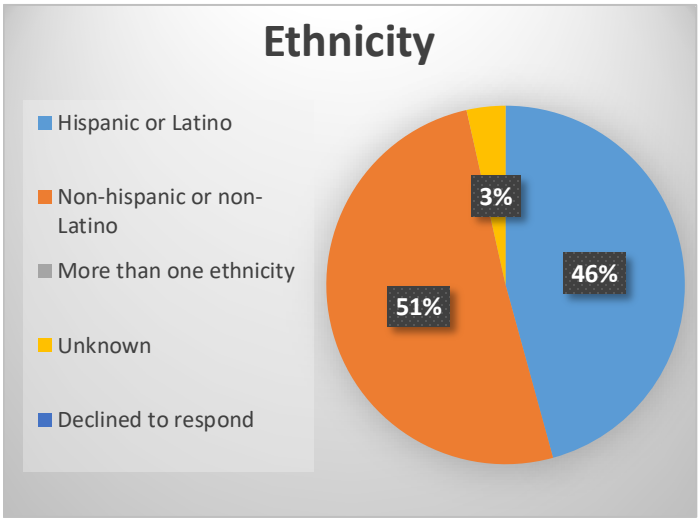
Total number of clients served in FY 21-22: 457

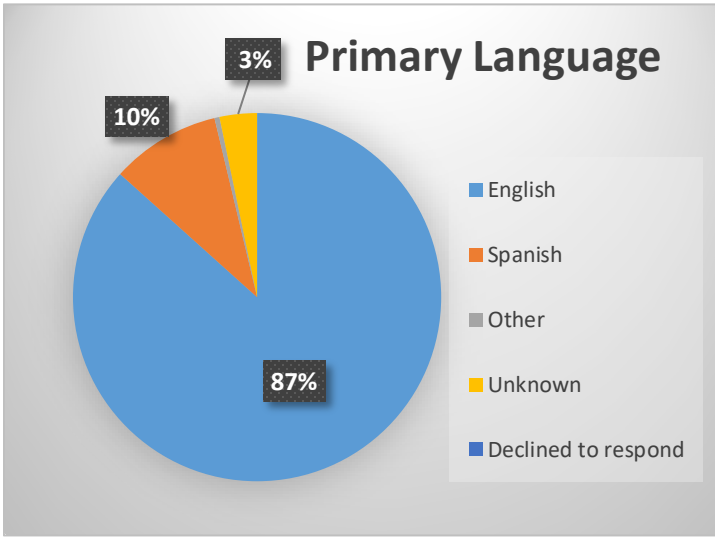
FY 2021-2022
Program Demographics:











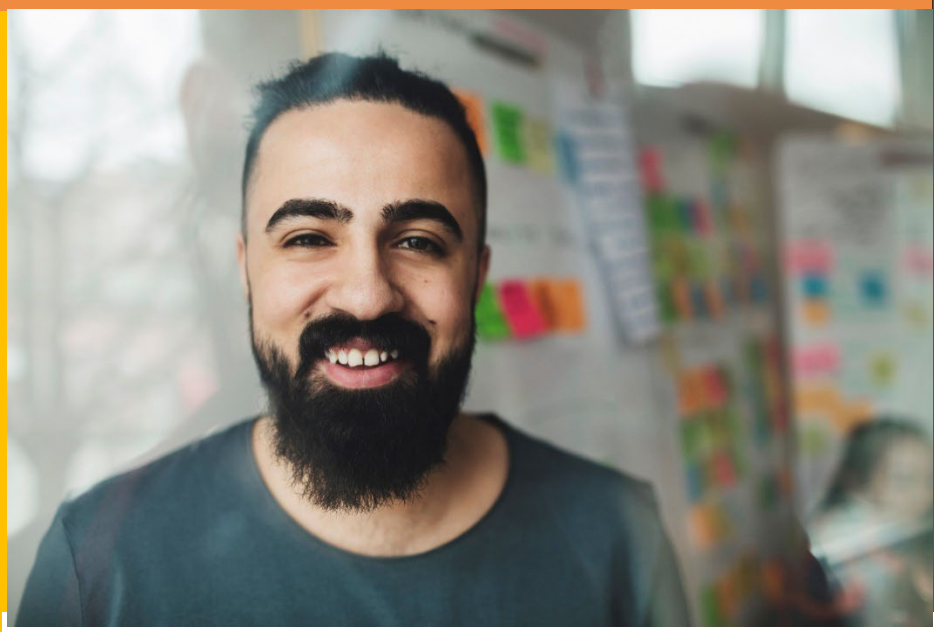
DHS-BHD Integrated Recovery Team (IRT)

Sonoma County's Safe Spaces FOR MENTAL HEALTH

Sonoma county DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

Service Category: *Full Service Partnership Services*

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.



PROGRAM INFORMATION

Program Name: Integrated Recovery Team (IRT)
Population served: Sonoma County adults with serious mental illness and substance use disorders
Website: https://sonomacounty.ca.gov/Health/Behavioral-Health/Integrated-Health-Team
Phone: (707) 565-4850, however, to request mental health services call: (707) 565-6900
Location:
2227 Capricorn Way, Suite 207
Santa Rosa, CA 95407

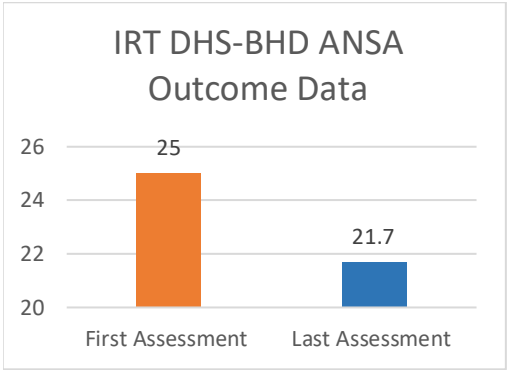
PROGRAM DESCRIPTION:

Sonoma County's Integrated Recovery Team (IRT) serves adults with serious and persistent mental illness and co-occurring substance use disorders, who currently do not receive comprehensive services.

IRT uses an integrated treatment approach that addresses mental health and substance use conditions at the same time to ensure better overall health outcomes. Treatment focuses on the stages of change, utilizing a harm reduction approach, and motivational interviewing. Services include: pharmacological treatment, case management, self-help groups run by peers, family education, housing and employment services, and aftercare services

PERFORMANCE OUTCOMES & ACCOMPLISHMENTS:

- Two additional bilingual staff members were added to the program in FY 21-22; one to help with scheduling and clerical tasks and one to help as a case manager.
- An estimated 50 clients were transported to Psychiatry appointments at our clinic allowing them to be seen in person for assessment and prescriptions related to their Mental Health diagnosis.
- 2 clients received intervention services that allowed them to stay in their housing
- 7 clients who were previously homeless were referr to Sage Commons and received their own new low income apartments.

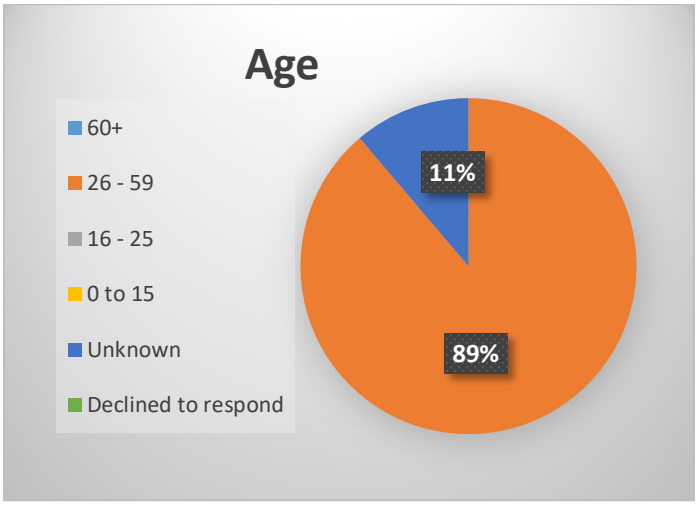


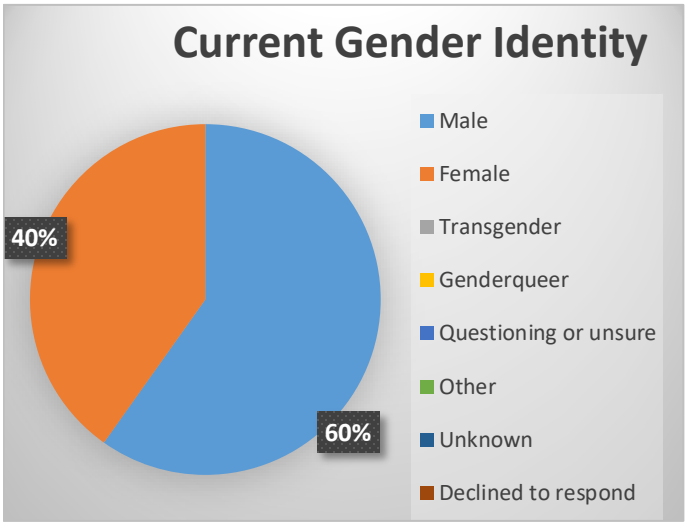
See pg.100 for an explanation of CANS/ANSA

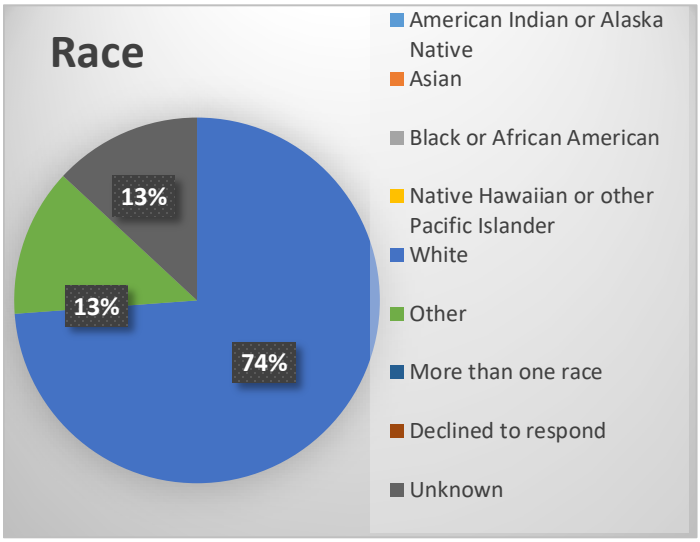
Total number of clients served in FY 21-22: 107

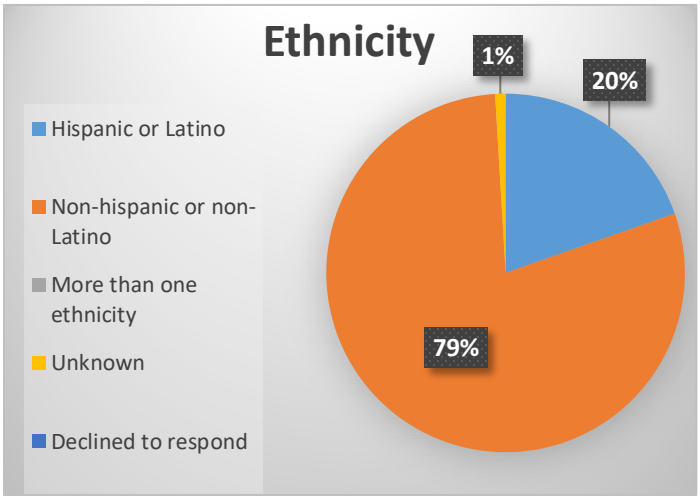
WELLNESS • RECOVERY • RESILIENCE

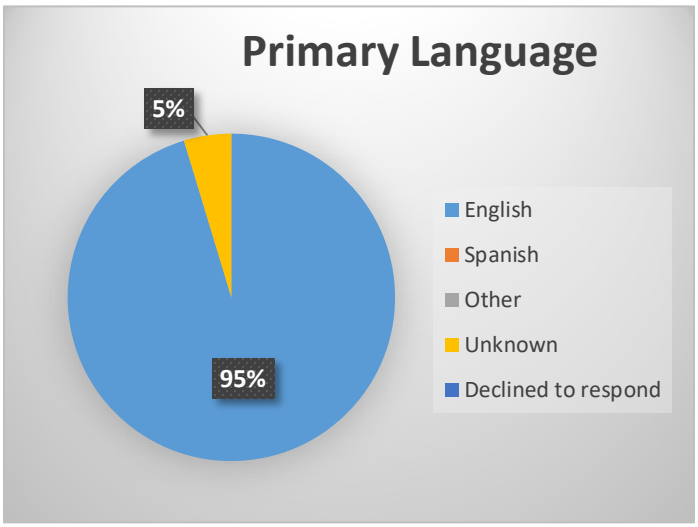
FY 2021-2022
Program Demographics:





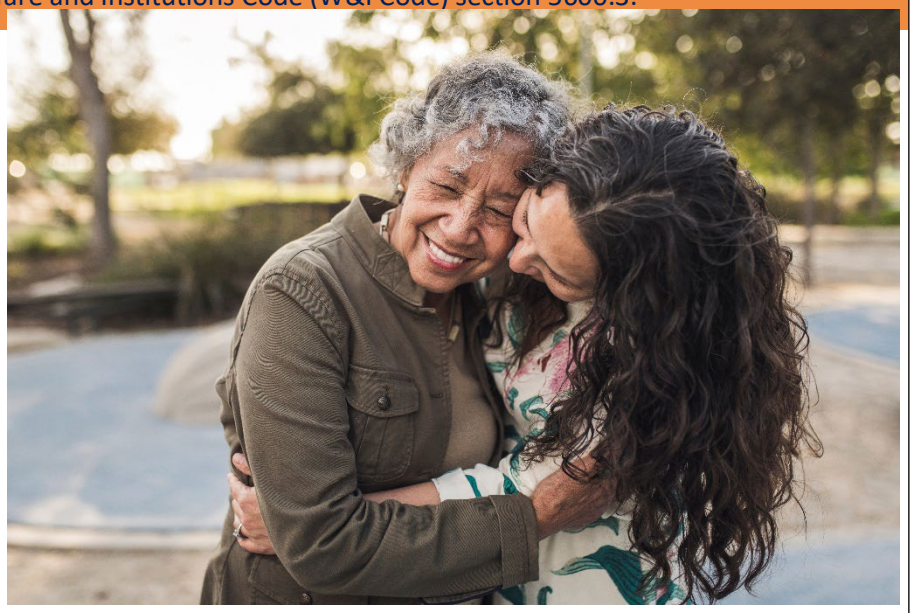






DHS-BHD's Older Adult Intensive Team (OAIT)

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.



PROGRAM INFORMATION

Program Name: Older Adult Intensive Team (OAIT)

Population served: Sonoma County adults ages 60 and older with serious mental illness coupled with more complex medical conditions requiring close coordination between mental health and primary or specialty medical providers.

Website: https://sonomacounty.ca.gov/Health/Behavioral-Health/Older-Adult-Team

Phone: (707) 565-4850, however, to request mental health services call: (707) 565-6900

PROGRAM DESCRIPTION:

Sonoma County's Older Adult Intensive Team OAIT provides intensive, integrated services for older adults with serious mental illness coupled with more complex medical conditions requiring close coordination between mental health and primary or specialty medical providers. Includes contracted services from the following community partners:

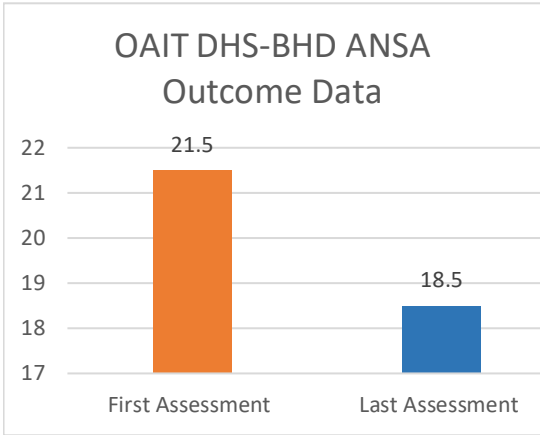
- West County Community Services – Senior Peer Counseling
- Council on Aging – Senior Peer Support

Services include:

- Medication education, monitoring, and delivery.
- Case management.
- Referrals.
- Visiting clients when hospitalized (either medically or psychiatrically) and facilitating communications between the medical and psychiatric staff for care and follow-up planning.
- Transportation services, including attending important doctor's appointments, having routine laboratory work, and participating in community-offered services to reduce isolation.

FY 21-22 PERFORMANCE OUTCOMES:

Total number of clients served: 68

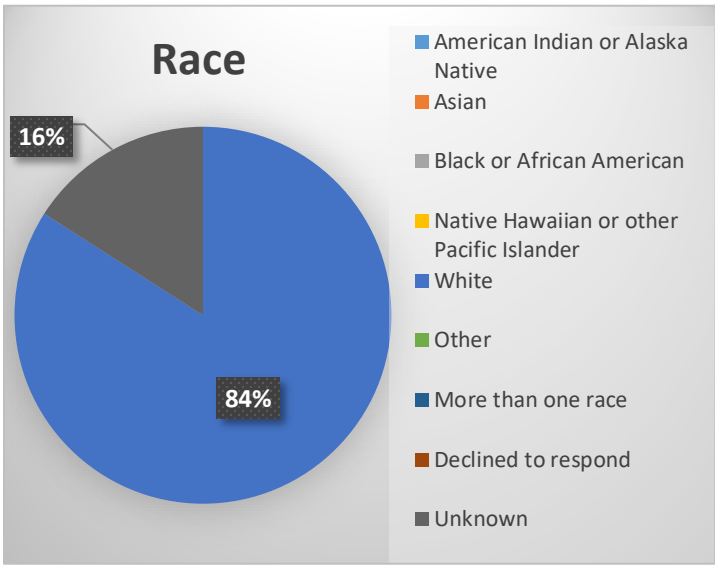


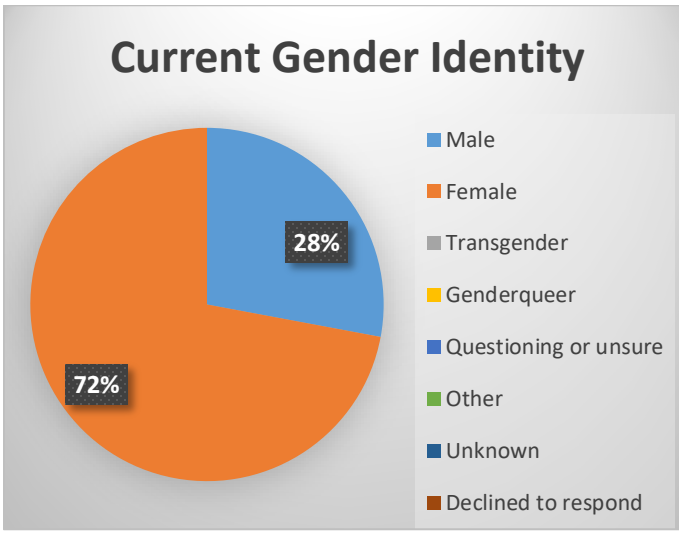
See pg.100 for an explanation of CANS/ANSA

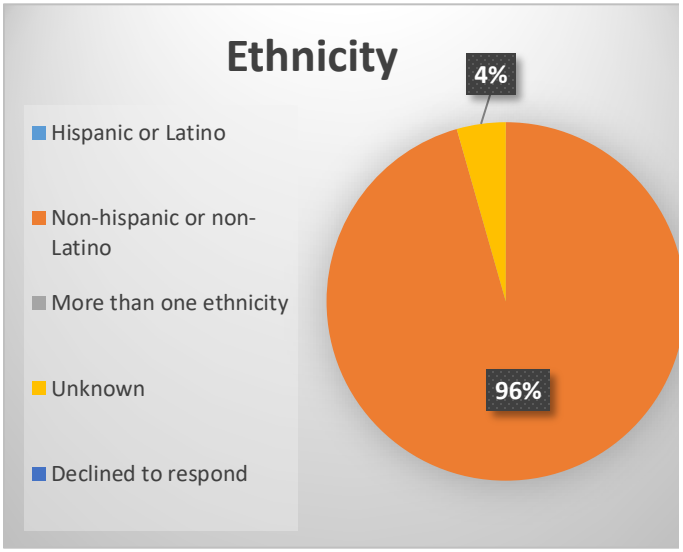
FY 21-22 PROGRAM OUTCOMES & ACCOMPLISHMENTS:

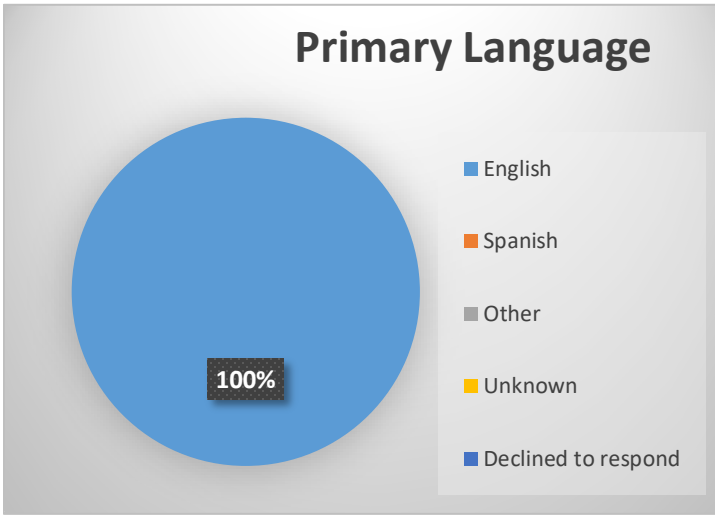
- One bilingual/bicultural staff member was added to the program in FY 21-22 to help clients with scheduling and administrative tasks and to help create a comfortable and inclusive environment.
- An estimated 50 clients were transported to Psychiatry appointments at our clinic allowing them to be seen in person for assessment and prescriptions related to their Mental Health diagnosis.
- 3 clients received intervention services that allowed them to stay in their housing
- The OAIT program allowed 3 clients to step down from skilled nursing facilities into community housing.
- 3 clients who were previously homeless were referred to Sage Commons and received their own new low-income apartments.

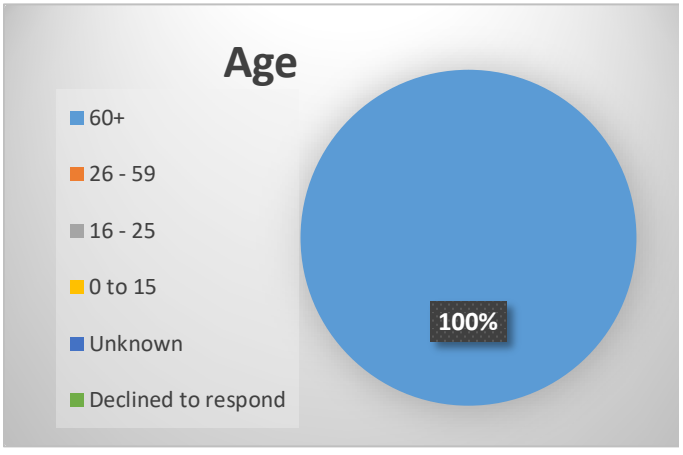
FY 2021-2022 Program Demographics:











Sonoma County's Safe Spaces FOR MENTAL HEALTH

DHS-BHD's Transition Age Youth (TAY) Team

sonoma county DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

Service Category: Full Service Partnership Services

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM INFORMATION

Program Name: Transition Age Youth (TAY) Team
Population served: Sonoma County youth ages 18-25 diagnosed with a serious and persistent mental illness and their families.
Website: https://sonomacounty.ca.gov/Health/Behavioral-Health/Transition-Age-Youth-Team/
Phone: (707) 565-4850, however, to request mental health services call: (707) 565-6900

PROGRAM DESCRIPTION:

Sonoma County's TAY Team is an intensive, integrated service program for Transition Age Youth (ages 18-25), providing mental health services, intensive case management, housing support services,
and independent living skills.

Individuals are:

- Aging out of children's mental health services, and are at risk of homelessness, hospitalization, or incarceration.
- Aging out of Child Welfare.
- Leaving placement.
- Experiencing First Episode Psychosis.

Includes contracted services from the following community partners:

- Buckelew Programs – Sonoma County Independent Living (TAY-SCIL) (housing)
- Social Advocates for Youth (SAY) – Tamayo Village
(housing)
- VOICES Youth Center (peer support and mentoring)

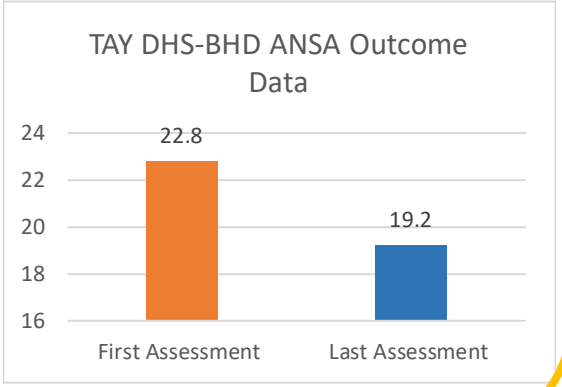
Services include:

- Mental health services
- Intensive case management
- Housing and employment support services
- Independent living skills

PERFORMANCE OUTCOMES

Total unique clients served in FY 21-22: 66

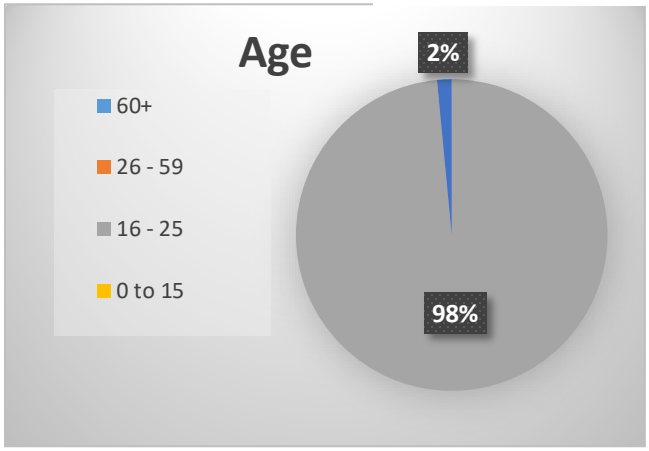
- **Total unique clients that were also served by Buckelew TAY-SCIL in FY 21-22: 23**
- **Total unique clients that were also served by SAY Tamayo Village in FY 21-22: 15**
- **Total unique clients that were also served by VOICES in FY21-22: 46**
- **Total unique clients that were also served by Sonoma County Behavioral Health in FY 21-22: 66**

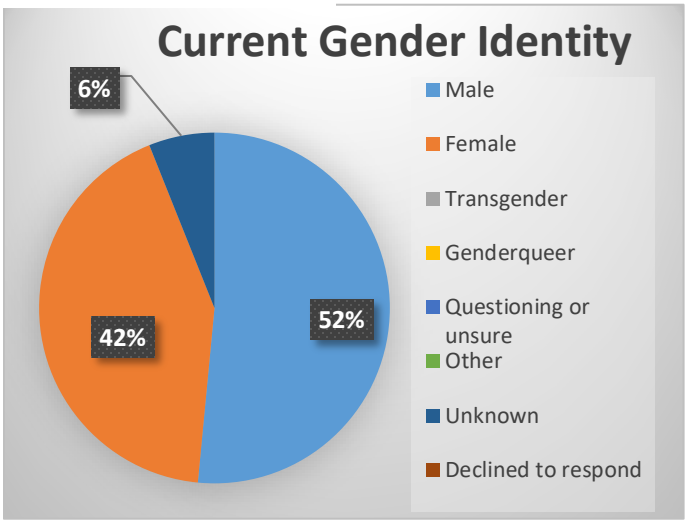


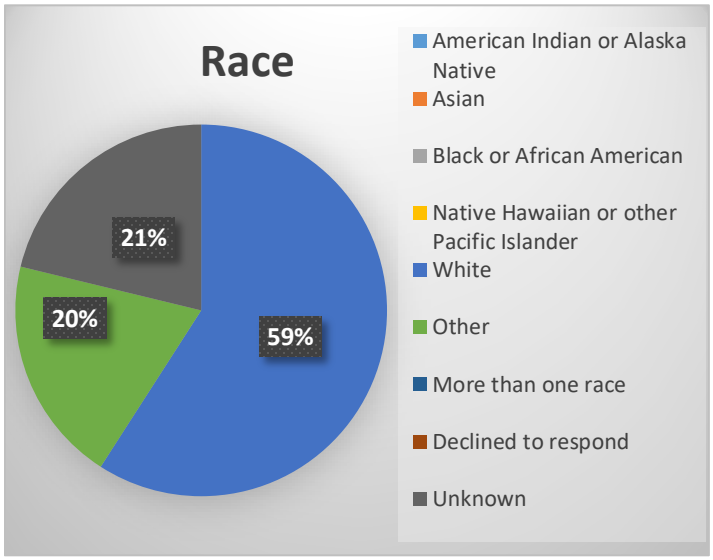
See pg.100 for an explanation of CANS/ANSA

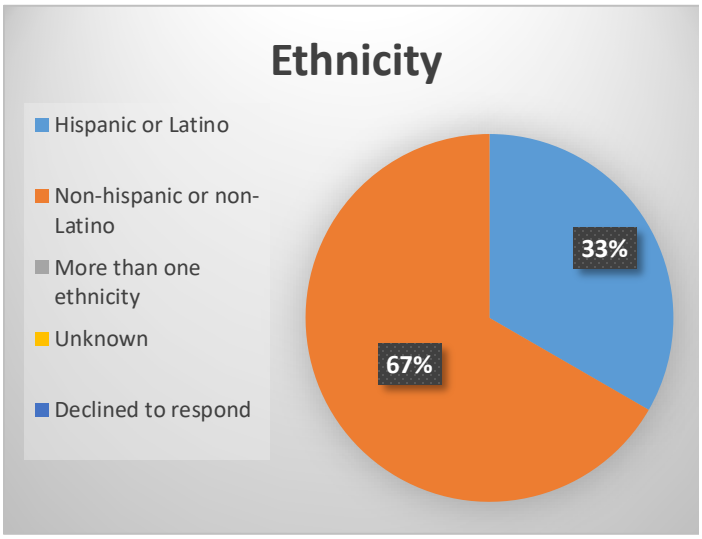
WELLNESS • RECOVERY • RESILIENCE

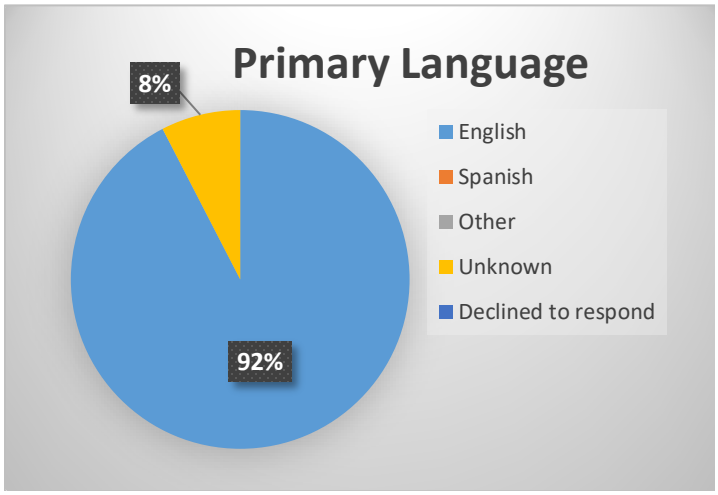
FY 2021-2022
Program Demographics:











"I do want to talk about being in Tay. Tay saved my life I think. During Covid you guys were the only ones who would check in on me. You didn't forget me. You taught me how deal with my brother and be a better person."

-TAY client

FY 21-22 PROGRAM OUTCOMES/ACCOMPLISHMENTS:

- A client came to TAY conserved, had been homeless at one point, multiple hospitalizations, extremely terrorized by auditory hallucinations, difficulty maintaining good relationships (family included), failed attempts with housing options, even struggled with incontinence at one point… but within the last two-ish years they have been stable, they have housing, they go to weekly social events with one of our community partners, they are volunteering and working towards one day working. Family relationships have improved. They are doing really good!
- 66 clients were served in FY 21-22

DHS-BHD's Adult Full Service Partnership (AFSP)

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM INFORMATION

Program Name: Adult Full Service Partnership (AFSP)

Target Population: adults from 26-59 years old with severe and persistent mental illness and at risk of institutionalization, homelessness, incarceration, or psychiatric in-patient services

PROGRAM STATISTICS & PERFORMANCE OUTCOMES

AFSP was scheduled to begin services in FY 21-22, but was unable to meet this goal due to the pandemic and staffing issues.

PROGRAM DESCRIPTION:

AFSP is a new FSP which will provide intensive services for adults from 26-59 years old with severe and persistent mental illness and at risk of institutionalization, homelessness, incarceration, or psychiatric in-patient services. Every AFSP client will participate in the development of a treatment plan focused on wellness and recovery. Low caseloads of no more than 20 clients will be maintained.

The AFSP team is made up of mental health professionals who work in partnership with the clients they serve to explore individual mental health wellness and recovery using a "whatever it takes" approach to case management. The treatment team is available to provide crisis services to the client, and services can be provided to individuals in their homes, the community, and other locations. Peer and caregiver support are available. Embedded in Full-Service Partnerships is a commitment to deliver services in ways which are culturally and linguistically competent and appropriate.

COMMUNITY SERVICES AND SUPPORTS (CSS)

Programs provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

General Systems Development (GSD)

A service category of the CSS component used to improve the County's mental health service delivery system for all clients and/or to pay for specified mental health services and supports for clients, and/or when appropriate their families.

Sonoma County's Safe Spaces FOR MENTAL HEALTH

NAMI Sonoma County

NAMI National Alliance on Mental Illness Sonoma County

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM DESCRIPTION:

As the local affiliate of the National Alliance on Mental Illness (NAMI), we help individuals affected by mental health conditions, and the family members who support them, to build a better quality of life through education and support. NAMI program leaders use their lived experience and training to raise awareness and increase knowledge and understanding. NAMI programs are free, offer practical skills, foster caring connections, decrease stigma, and build hope, so that no one feels alone when faced with mental health challenges.

- **Warmline** (866-960-6264 | info@namisoco.org): A starting place to find support, information, and resources that may help.
- **NAMI Family Support Groups:** For family members and friends supporting a loved one with serious mental health challenges.
- **NAMI Connection Recovery Support Groups:** For adults in recovery who live with mental health challenges.
- **NAMI Family-to-Family:** 8-week education program for family members of adults living with serious mental health challenges.
- **NAMI Basics:** 6-week education program for those caring for a child or adolescent experiencing mental health symptoms.
- **NAMI Ending the Silence:** Presentation for youth about mental health facts, statistics, warning signs, and steps to seeking help.
- **Family Support Referrals:** Follow-up outreach to family members referred by Sonoma County Behavioral Health Mobile Support Teams, or the Youth & Family Services Team.
- **QPR Suicide Prevention Training:** A concise training about how to question, persuade, and refer someone who may be suicidal.
- **Mental Health Speaker Presentations:** Talks from local experts on mental health topics and community services.

PROGRAM IMFORMATION

Program Name:
NAMI Sonoma County
Population served: Individuals and families affected by mental illness
Website: www.namisoco.org
Phone: (866) 960-6264
Program location:
182 Farmers Lane #202
Santa Rosa, CA 95405
Social Media:
@namisonoma
@namisoco

PERFORMANCE OUTCOMES:

Encounters	**5,529** Total Encounters **2,589** through Outreach
Warmline	**3,500** total contacts **693** new callers **137** referred by MST or YFS
Support Groups (duplicated)	**715** Connection attendees **490** Family Support Group attendees

PROGRAM TESTIMONIALS:

"**NAMI Sonoma County** programs literally helped to save my life and the life of my loved one."

"Thank you for keeping this organization available. **NAMI Sonoma County is a treasure**..."

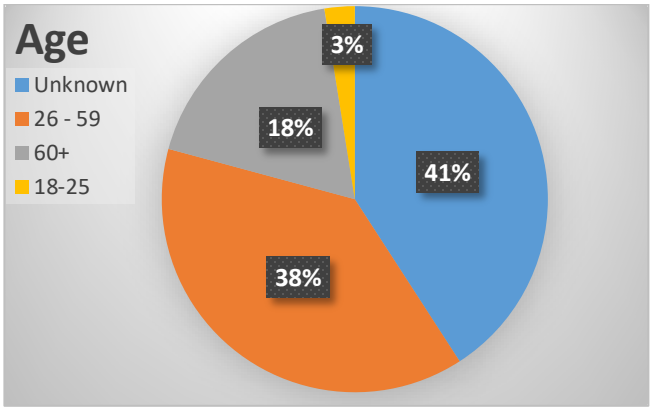
"On the **Warmline,** I could feel the understanding and compassion NAMI had for my family and loved one. Hope is so important!"

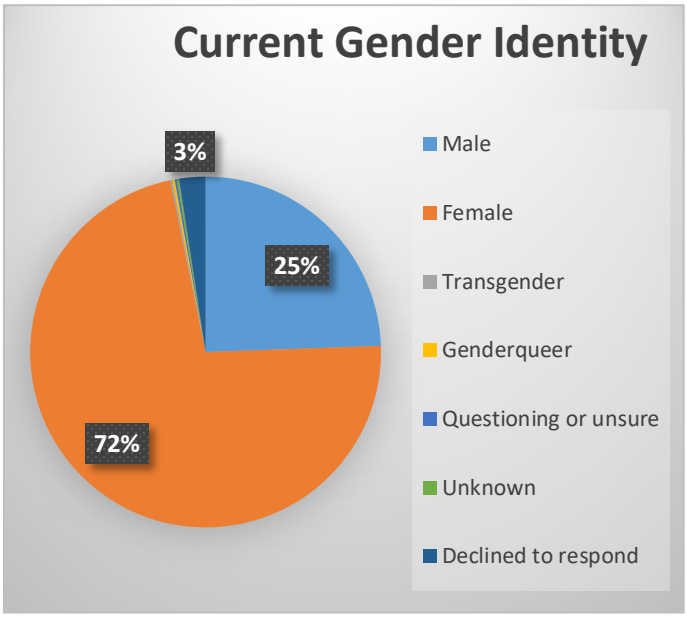
"I wish I had **NAMI Ending the Silence** when I was younger and struggling with my mental health."

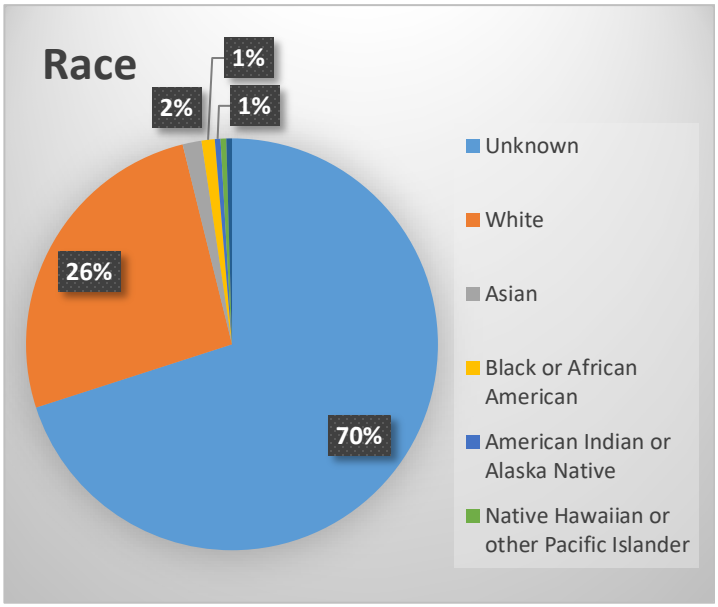
"**NAMI Family Support Group** helped me set boundaries and take care of myself when my young adult son was struggling. I cannot thank NAMI enough."

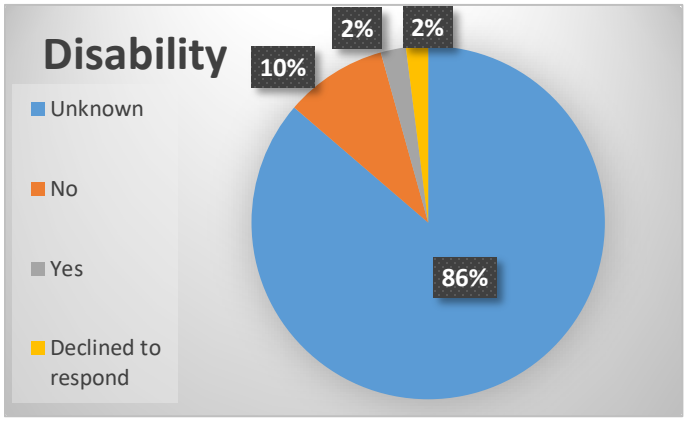
Sonoma County DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

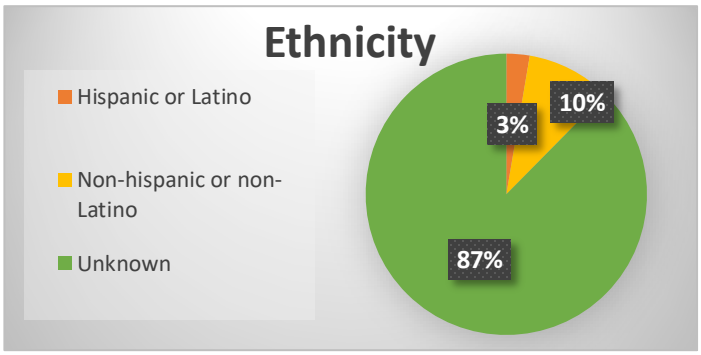
FY 2021-2022 Program Demographics:

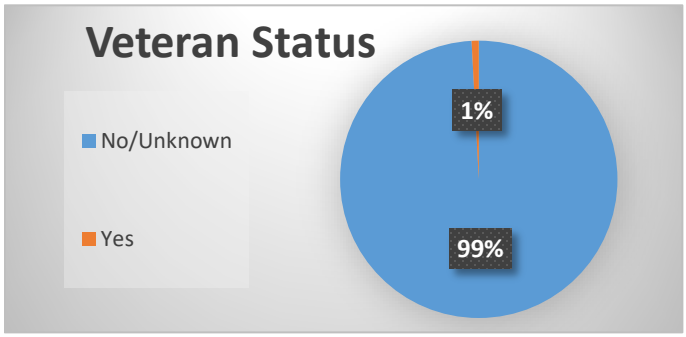


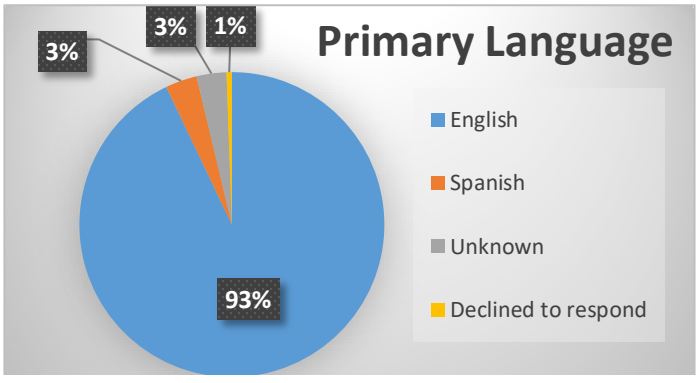


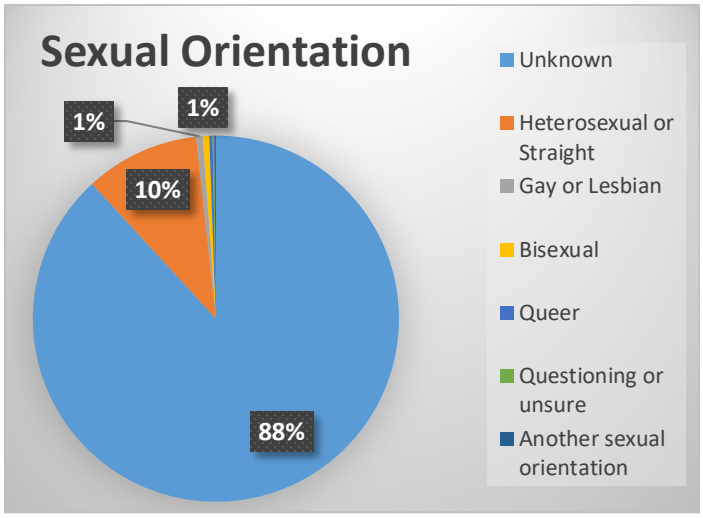












Sonoma County's Safe Spaces FOR MENTAL HEALTH

MHSA Component: Community Services & Supports (CSS)

Buckelew Program's Family Service Coordination (FSC) Program

FY 2021-2022 Service Category: General System Development

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM IMFORMATION

Program Name: Buckelew Programs: Family Service Coordination
Population served: Sonoma County Families and allies, supporting a loved one with mental and behavioral health challenges.
Website: www.buckelew.org/services/sonoma-county/family-services-coordination/
Phone: (707) 571-8452
Program location:
2330 Northpoint Parkway, Santa Rosa CA 95407
Social Media:
www.facebook.com/FamilyServiceCoordination/ www.instagram.com/BuckelewPrograms

PROGRAM DESCRIPTION:

The Family Service Coordination program works with family members and allies of adults with mental and behavioral health challenges. FSC walks with families and allies through individualized and group support, system navigation, outreach providing education about mental illness, reducing stigma, and connecting family and allies with community resources and supports. All Family Service Coordination services are free of charge to residents in Sonoma County.

PERFORMANCE OUTCOMES: FY 2021-2022

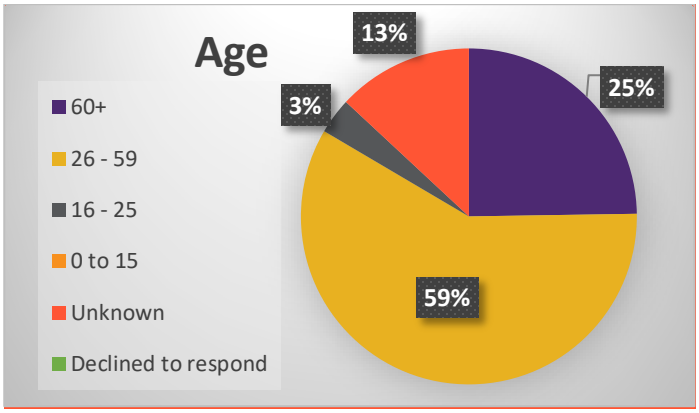
- **Total number of clients served: 1301**
- **Total number of encounters: 2334**
- **Number reached through outreach: 3187**

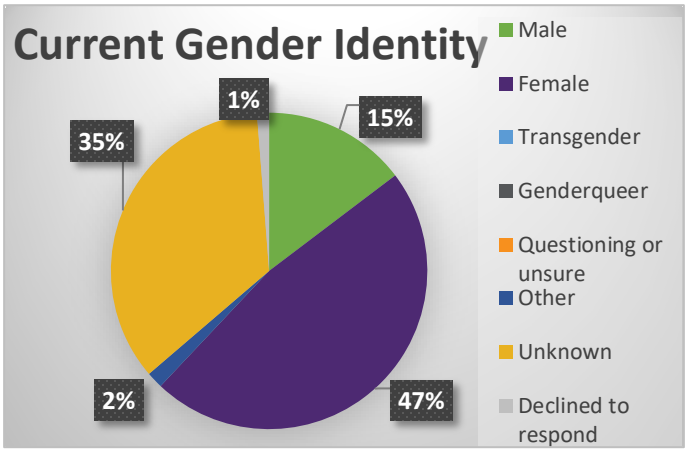
PERFORMANCE OUTCOMES & ACCOMPLISHMENTS:

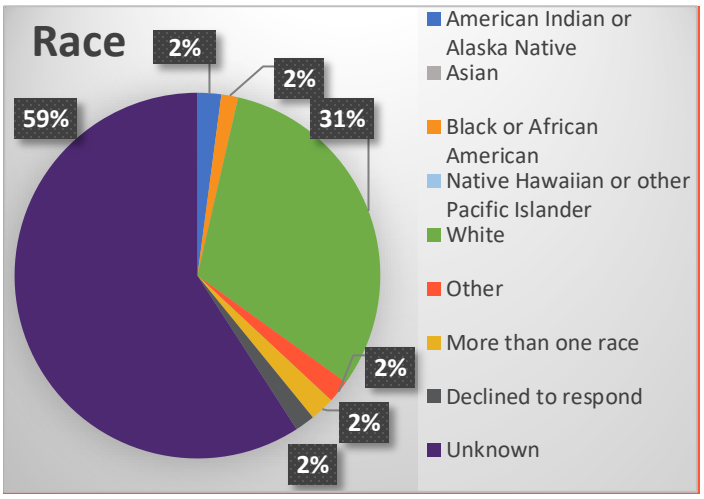
- 100% of families reported excellent or good understanding of what mental health services are available, how to access those services, and a general understanding of the limitations of the mental health system.
- 100% of families strongly agree or agree that they have a sense of increased hope and empowerment for their family member's well-being.

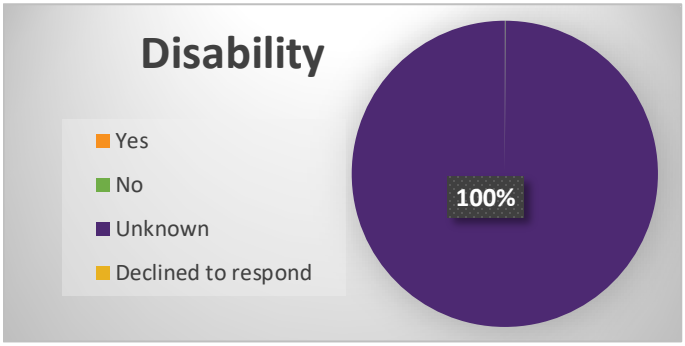
"FSC has helped me a lot. They have given me undivided attention and I feel like I belong. I get resources to help my loved one and they tell me where to go, and who to call. I feel very supported and cared about. Everyone is very personable, and I have gained a lot of knowledge about resources. Everybody is attentive and good about sending me things in the mail." – FSC Client

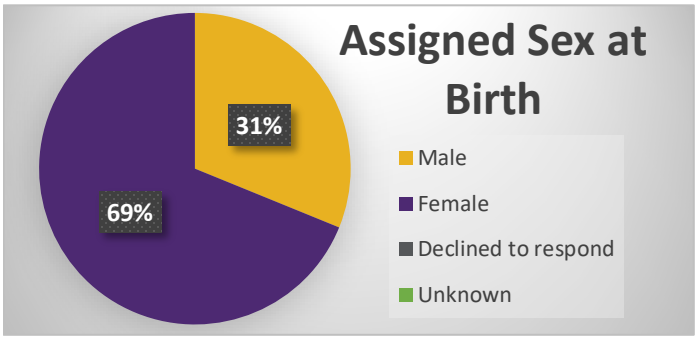
FY 2021-2022 Program Demographics:

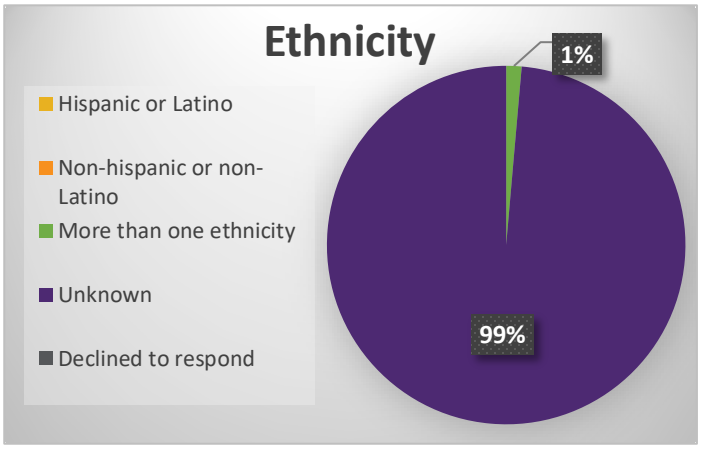


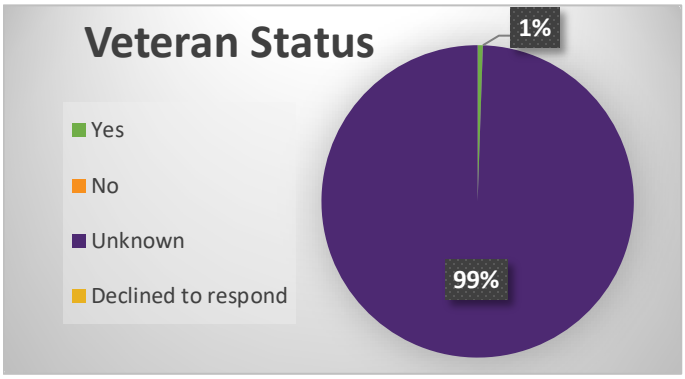


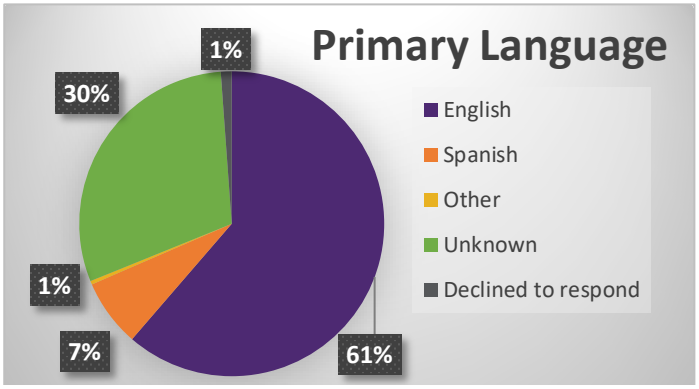


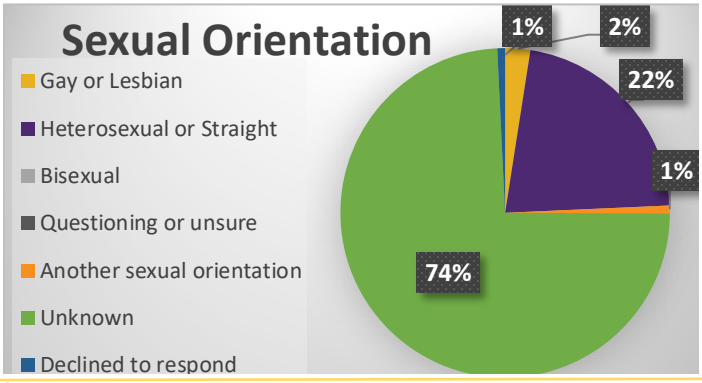












DHS-BHD's Mobile Support Team (MST)

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM DESCRIPTION:

Sonoma County's Mobile Support Team (MST) is a partnership with the Santa Rosa Police Department, Sebastopol Police Department, Cotati Police Department, Rohnert Park Police Department, Petaluma Police Department, Santa Rosa Junior College District Police, and the Sonoma County Sheriff's Office, and Support Our Student (SOS) MST Interns. MST provides field-based support to requesting law enforcement officers responding to a behavioral health crisis.

We are staffed by licensed mental health clinicians, certified substance abuse specialists, post-graduate registered interns, mental health consumers, and family members who:

- Receive specialized field safety training by law enforcement partners.
- Are available during peak activity hours and days as informed by ongoing data review and coordination with law enforcement agencies.
- Participate in law enforcement shift briefings to maintain open communication.

When MST responds and the scene is secured, staff provides mental health and substance use disorders interventions to individuals experiencing a behavioral health crisis, including an evidence-based assessment that assists in determining if the individual should be placed on an involuntary hold.

MST provides crisis intervention, support, and referrals to medical and social services as needed.

Follow-up services are provided to help link community members to ongoing care and treatment to mitigate future crisis.

PROGRAM INFORMATION

Program Name: Mobile Support Team (MST)

Areas served: Santa Rosa, Windsor, Rohnert Park, Cotati, Petaluma, Sonoma Valley, Guerneville (Triage Grant funded service area), Forestville (Triage Grant funded service area), Sebastopol (Triage Grant funded service area)

Website:
https://sonomacounty.ca.gov/Health/Behavioral-Health/Community-Response-and-Engagement/Mobile-Support-Team

Phone: (707) 565-4850
To request services: (707) 565-6900

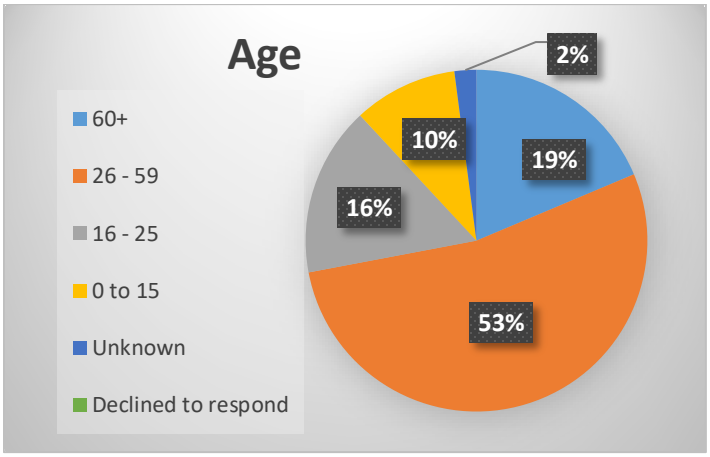
PERFORMANCE OUTCOMES

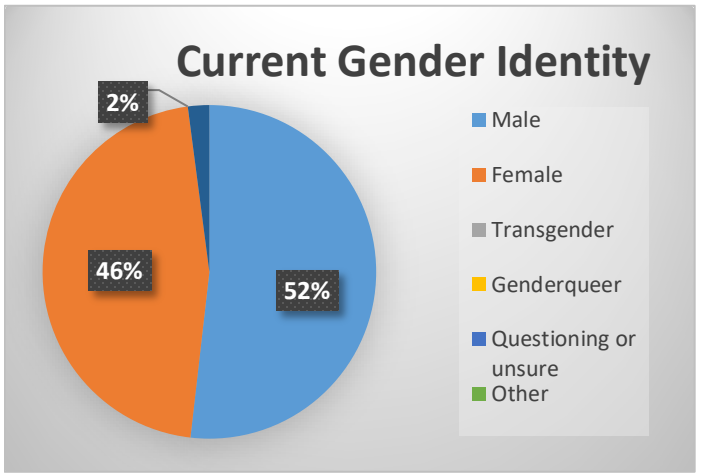
- **Total unique clients served by MST in FY 21-22: 193**
- **Total number of encounters conducted by MST in FY 21-22: 433**

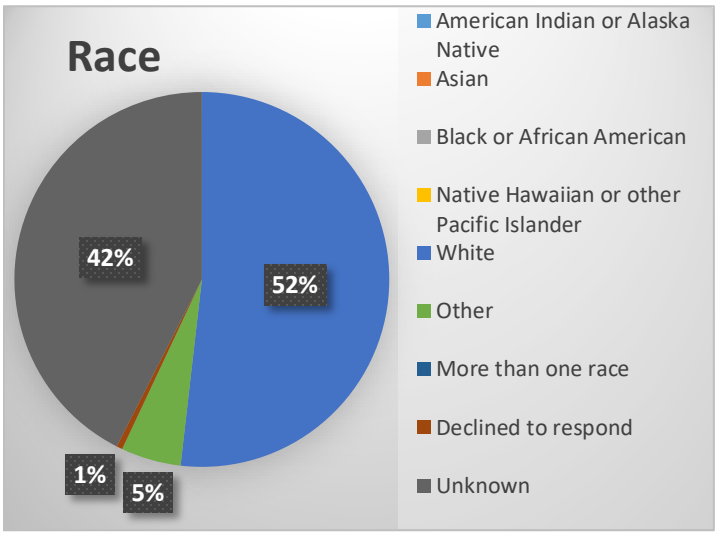
PROGRAM GOALS

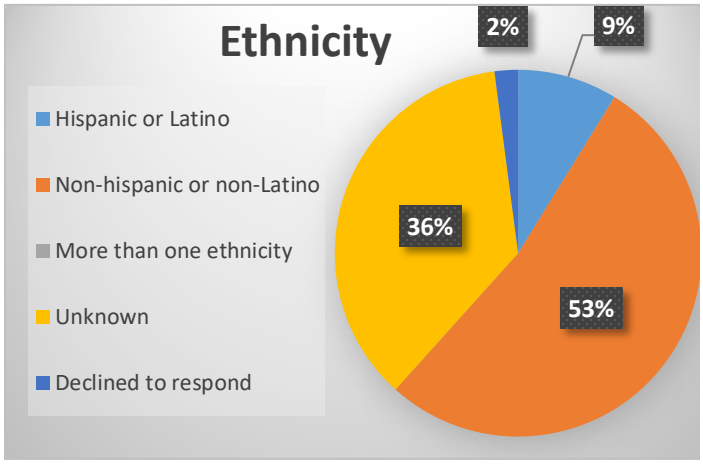
- Promote the safety and emotional stability of community members experiencing behavioral health crises.
- Minimize further deterioration of community members experiencing behavioral health crises.
- Help community members experiencing crises to obtain ongoing care and treatment.
- Prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate.

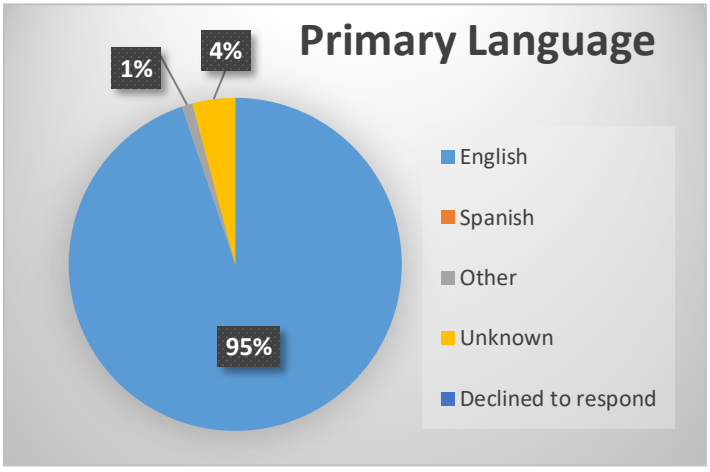
FY 2021-2022
Program Demographics:

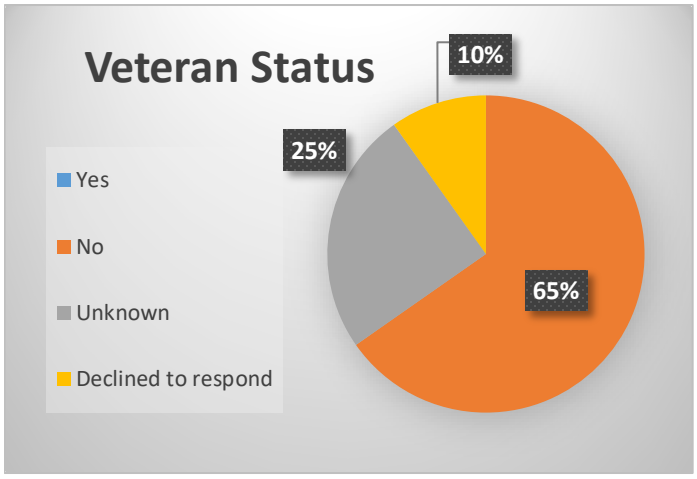












Sonoma County's Safe Spaces FOR MENTAL HEALTH

DHS-BHD Collaborative Treatment and Recovery Team (CTRT)

sonoma county DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

Service Category: General System Development

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM IMFORMATION

Program Name: DHS-BHD Collaborative Treatment and Recovery Team (CTRT)

Population served: Adults in Sonoma County who are new to behavioral health services.

For services call: (707) 565-6900

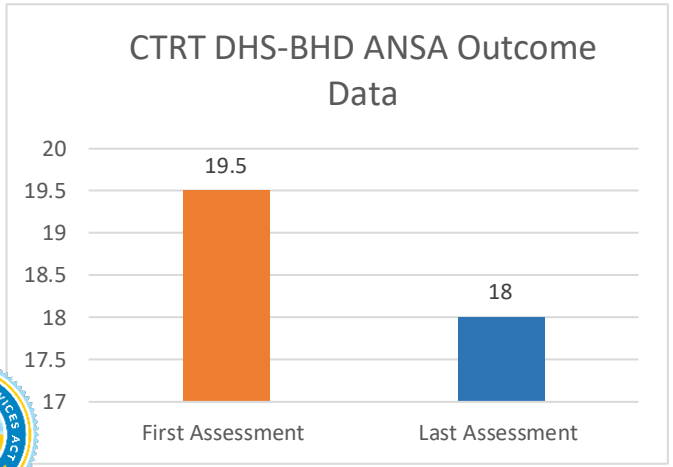
PROGRAM DESCRIPTION:

DHS-BHD Collaborative Treatment and Recovery Team CTRT's goal is to empower adult individuals who are new to behavioral health services by assisting them to gain competencies in system navigation, access to community resources and supports and providing education about mental illness. This team works in concert with Buckelew's CTRT, embodying a collaborative and recovery-oriented approach.

PROGRAM GOALS

- Engage clients in obtaining independent housing from homelessness.
- Assists clients with the creation of a safety plan.
- Refer clients to Buckelew Programs for assistance with understanding and navigating the Mental Health System on their own.

PERFORMANCE OUTCOMES:

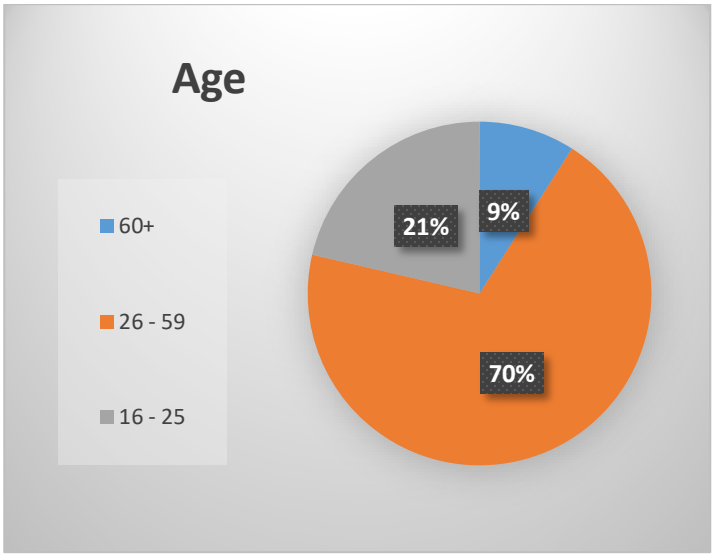


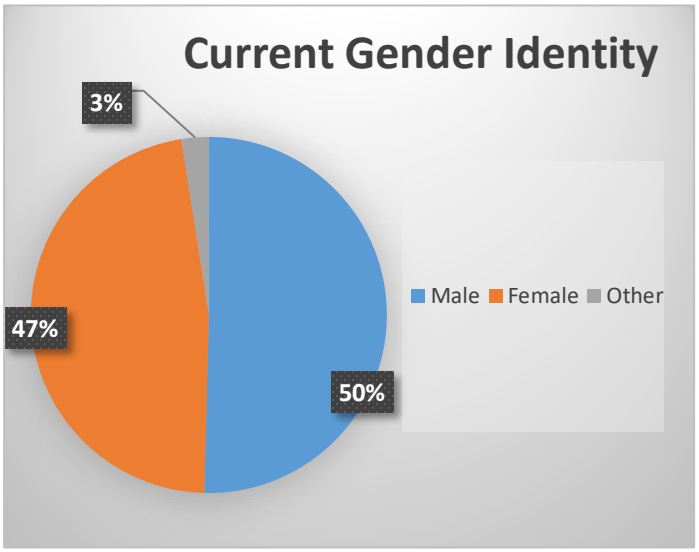
Total number of clients served in FY 21-22: 365

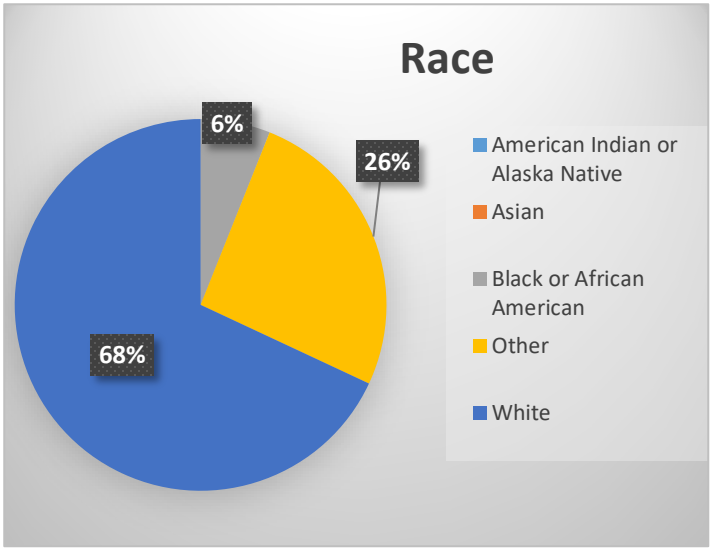
See pg.100 for an explanation of CANS/ANSA

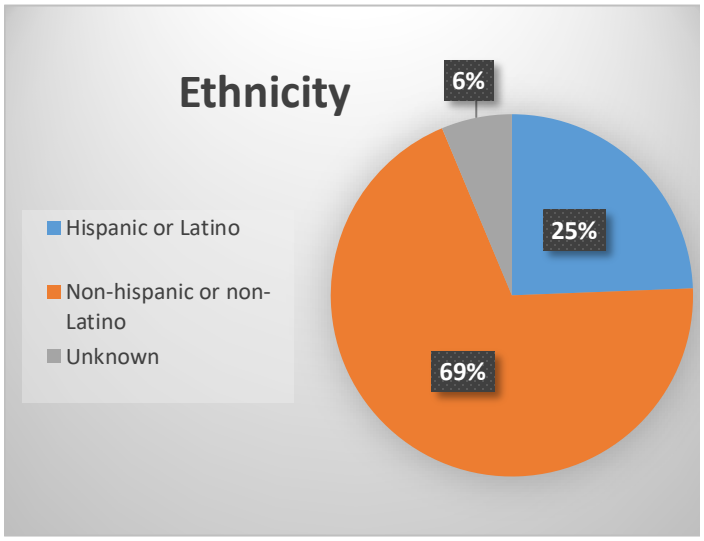
WELLNESS • RECOVERY • RESILIENCE

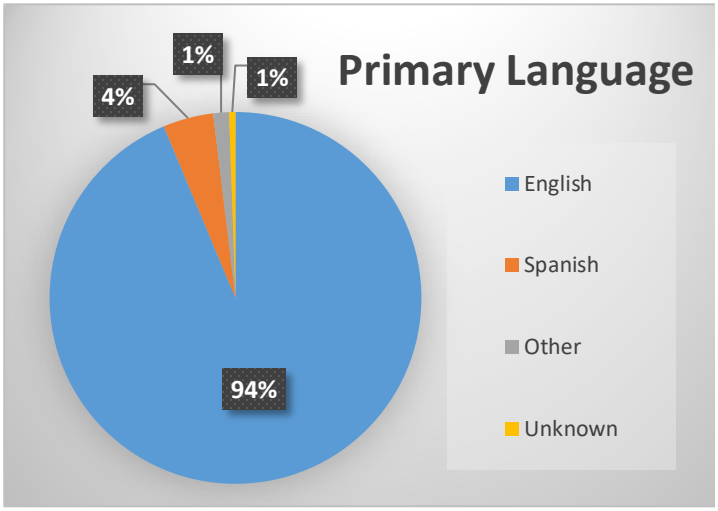
FY 2021-2022
Program Demographics:







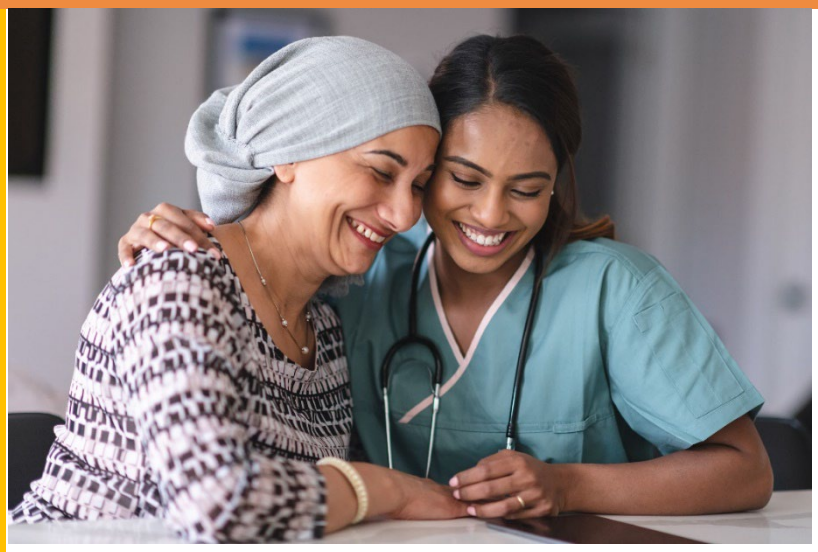




DHS-BHD Community Mental Health Centers (CMHCs)

sonoma county DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.



PROGRAM INFORMATION

Program Name: Community Mental Health Centers (CMHCs)
Areas served: Sonoma County adults living in four regionally-based areas of: Guerneville, Cloverdale, Petaluma, and Sonoma
Website: https://sonomacounty.ca.gov/Health/Behavioral-Health/Community-Mental-Health-Centers
Phone: (707) 565-4850
To request services: (707) 565-6900

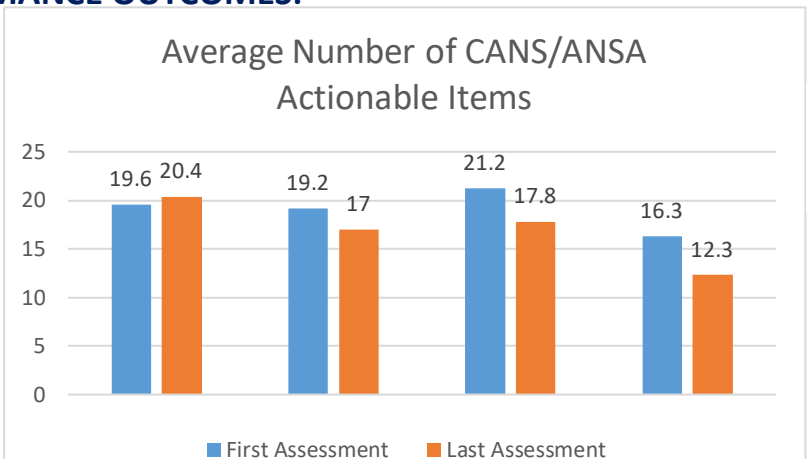
PROGRAM DESCRIPTION:

The Community Mental Health Centers (CMHCs) are primarily aimed at providing access for underserved populations, including providing culturally and linguistically appropriate services to locally underserved racially and ethnically diverse communities, and homeless individuals with mental illness, in four regionally-based areas of Sonoma County:

- Guerneville
- Cloverdale
- Petaluma
- Sonoma

The service teams are linked to the larger adult systems of care but focus on providing services and supports in the smaller communities where they are located. Services are available through collaborations between each CMHC and community-based providers, law enforcement agencies, and local Federally Qualified Health Centers (FQHCs).

PERFORMANCE OUTCOMES:

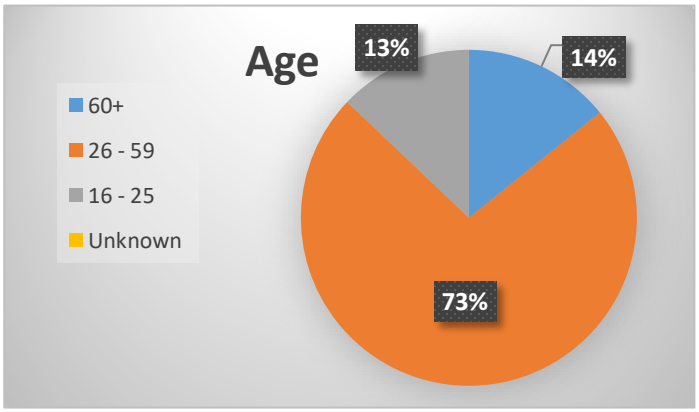


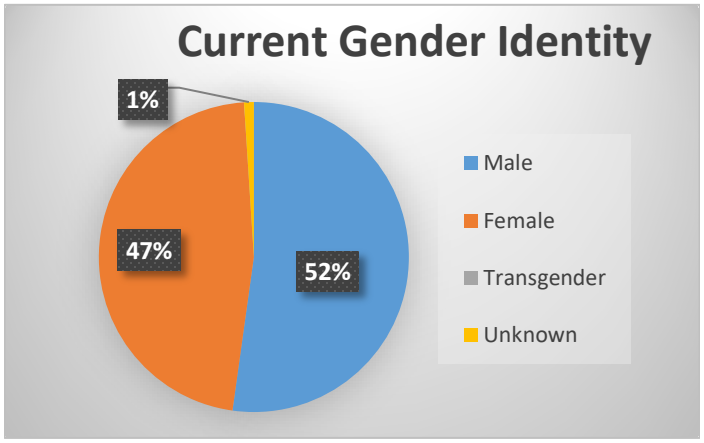
Total unique clients served by CMCH in FY 21-22: 295

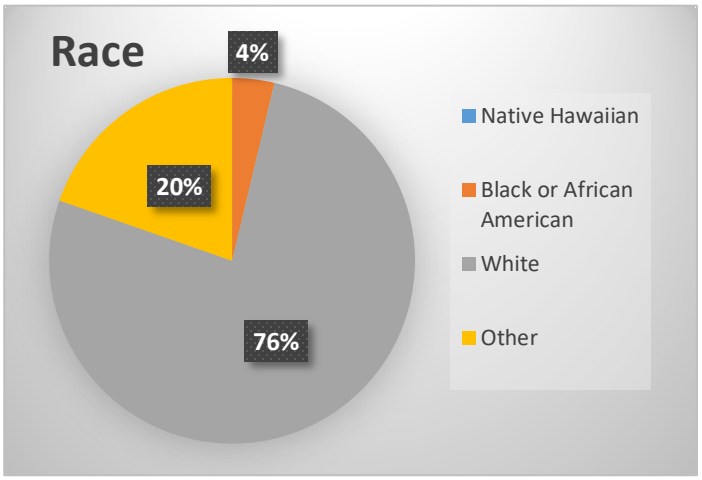
See pg.100 for an explanation of CANS/ANSA

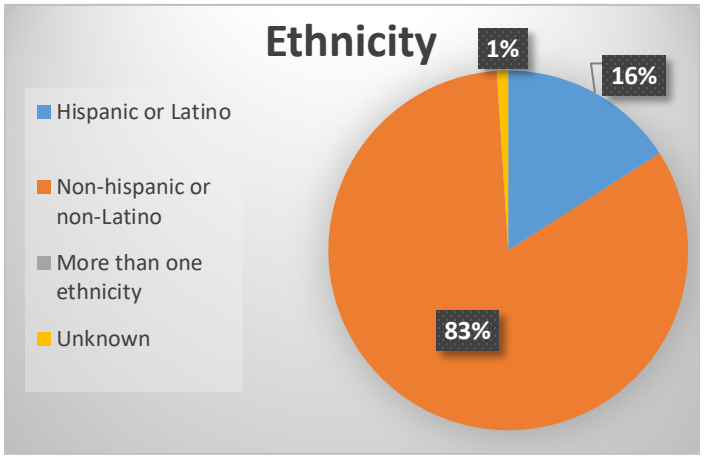
WELLNESS • RECOVERY • RESILIENCE

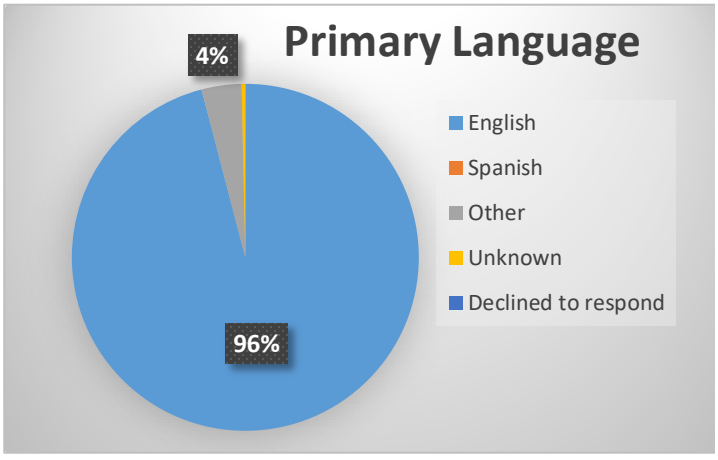
FY 2021-2022
Program Demographics:











Sonoma County's Safe Spaces FOR MENTAL HEALTH

MHSA Component: Community Services & Supports (CSS)

Council on Aging Senior Peer Support

council on aging

Service Category: General System Development

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM INFORMATION

Program Name:
Council on Aging
Senior Peer Support
Population served: Sonoma County Adults, age 60+
Website: councilonaging.com
Phone: (707) 525-0143 x125
Program location:
Home Visits and Community Locations
Social Media: Facebook, Twitter:
@councilonaging.sonoma
@SonomaCOA

PROGRAM DESCRIPTION:

The Senior Peer Support program offers confidential, no-cost support to older adults in Sonoma County who are experiencing mental health challenges related to aging. Community volunteers who have faced similar concerns receive training and supervision from a licensed mental health professional and are "matched" with a peer confronting mood disorder, the death of a spouse, the stress of an illness, isolation from family and friends, or other life transitions. Volunteers visit with their "matches" over a 12-week session to offer emotional support, guidance and empathy.

- **Total number of clients served:**
  55 Clients
  13 Volunteers
- **Total number of encounters:**
  660
- **Approximate numbers reached through outreach:**
  8000

PERFORMANCE OUTCOMES & PROGRAM ACCOMPLISHMENTS:

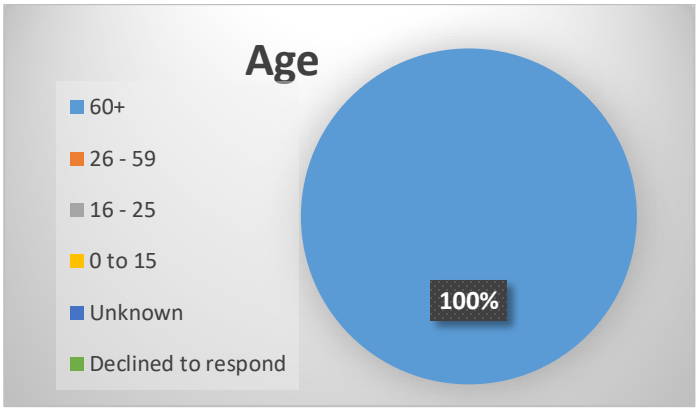
- **100% of SPC clients set a goal of decreased isolation.**
- **75% of those who set a goal of decreased isolation showed improvement.**
- **66% of SPC clients showed improvement on a post program PHQ-9.**

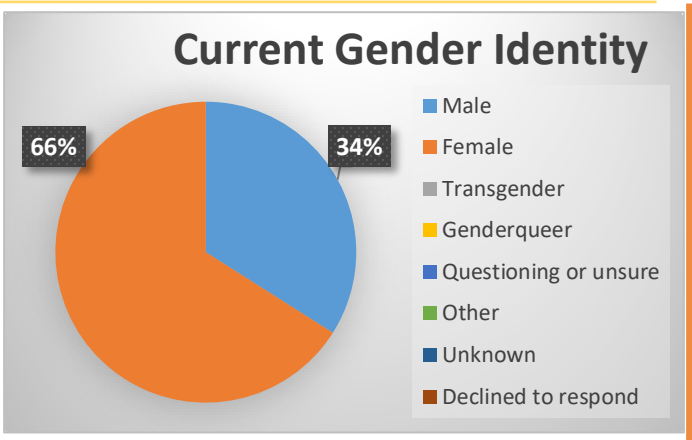
"Thank you for being who you are and providing a safe and supportive space."
"I just want to say that I am really grateful to have been a part of the group and it put me out into the world. I think it's a great program!" -COA SPC Client

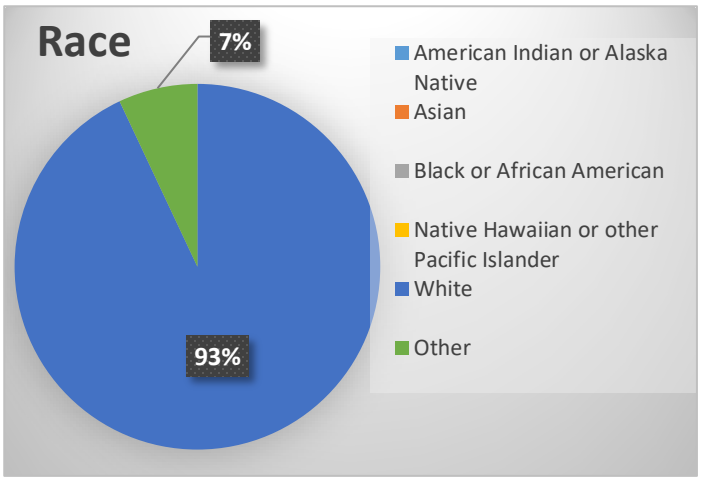
MENTAL HEALTH SERVICES ACT PROPOSITION 63 CALIFORNIA
WELLNESS • RECOVERY • RESILIENCE

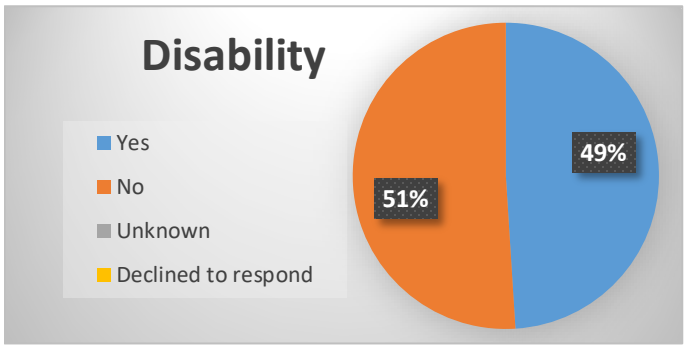
sonoma county DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

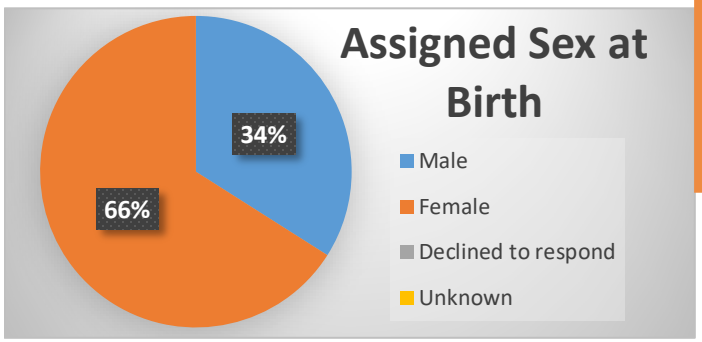
FY 2021-2022 Program Demographics:

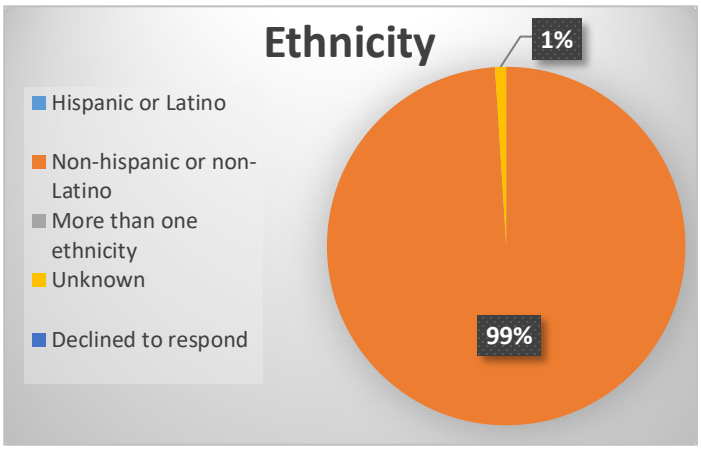


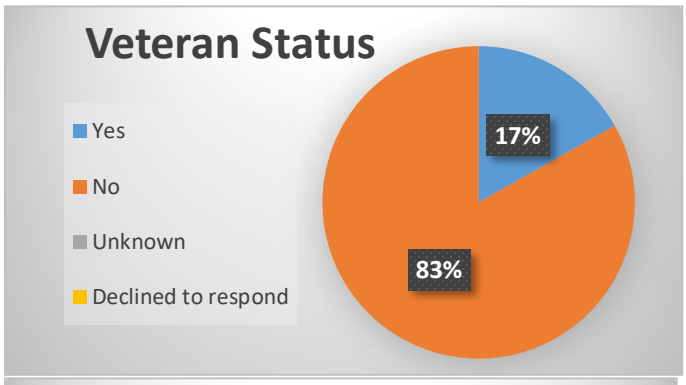


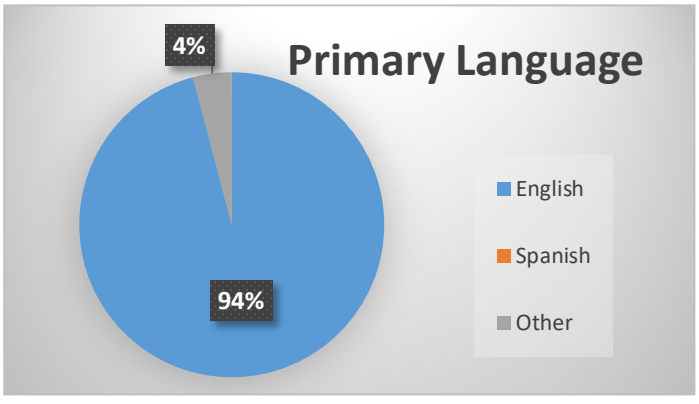


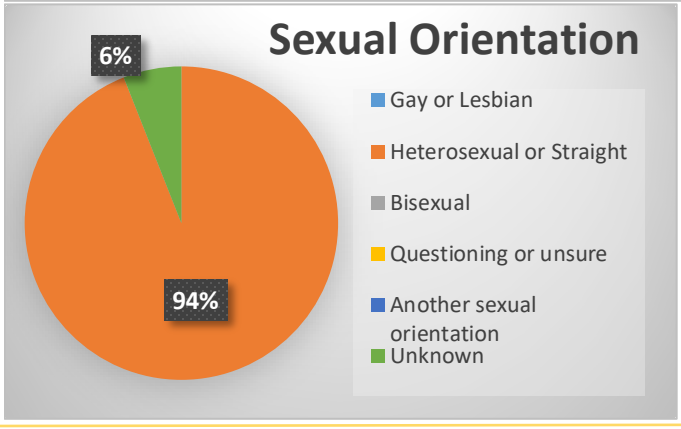












Sonoma County's Safe Spaces FOR MENTAL HEALTH

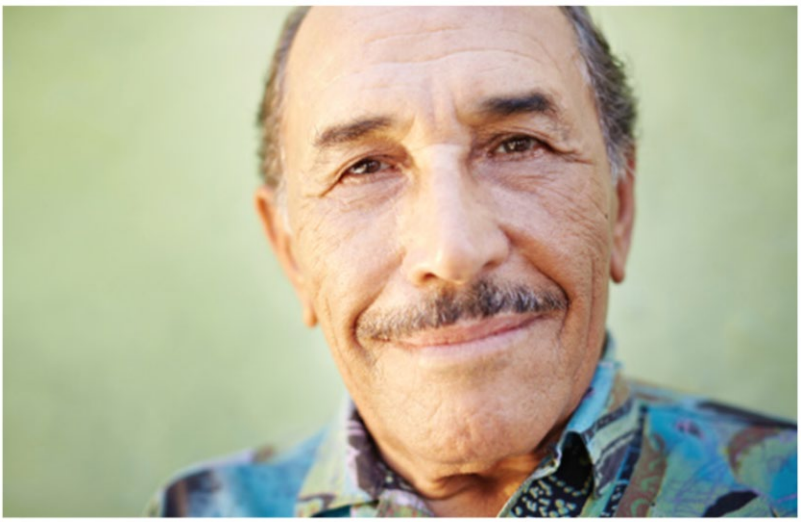
MHSA Component: Community Services & Supports (CSS)

West County Community Services Senior Peer Counseling Program

WCCS West County Community Services

FY 2021-2022 Service Category: General System Development

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.



PROGRAM IMFORMATION

Program Name: WCCS Senior Peer Counseling Program
Population served: Adults ages 55+ throughout Sonoma County
Website: www.westcountyservices.org/senior-peer-counseling-older-adults-collaborative
Phone: (707) 827-1640 ext. 301
Program location: Santa Rosa, CA
Social Media: N/A

PROGRAM DESCRIPTION:

Senior Peer Counseling is supportive counseling (not therapy) between two people who have something in common. Our Senior Peer Counselors provide goal-oriented counseling on a short-term basis to address problems and life adjustments. Emphasis is on developing copies skills and expanding one's knowledge and use of resources. The program strives to reach at-risk seniors before they experience crisis, helping them to remain self-sufficient, independent, and out of the institutional care system. WCCS works with clients to instill hope and promote wellness through providing in home peer support as well as groups accessibly located in different areas of the county. Volunteer Senior Peer Counselors are caring individuals who offer listening and support to help other seniors share concerns, and gain a healthier perspective and better emotional balance. 12 sessions of supportive counseling is offered free of cost.

FY 2021-2022 PROGRAM STATISTICS

- **Total number of clients served:** 80
- **Total number of encounters:** 502
- **Approximate numbers reached through outreach:** Unknown

PERFORMANCE OUTCOMES & ACCOMPLISHMENTS:

- WCCS provided 80 clients with Senior Peer Counseling services in FY 21-22. About half were seen in groups, and about one-third were provided with one-one services.
- Quotes from clients in FY 21-22:

"I had a wonderful experience with my SPC. I am a queen of procrastination and my counselor helped me with this issue. I am very thankful for the help and referrals my SPC gave me." – SPC Client

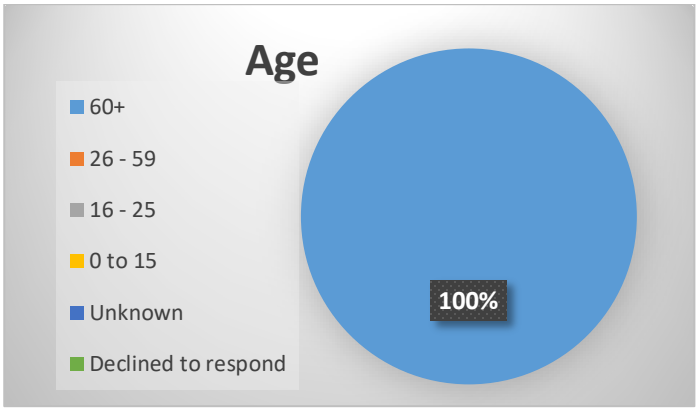
"Let me give 5 stars to the counseling program and 5 stars for 12 wonderful sessions. My counselor was attentive, patient, and truly constructive in assisting me with my issues. I am truly grateful for this program." – SPC Client

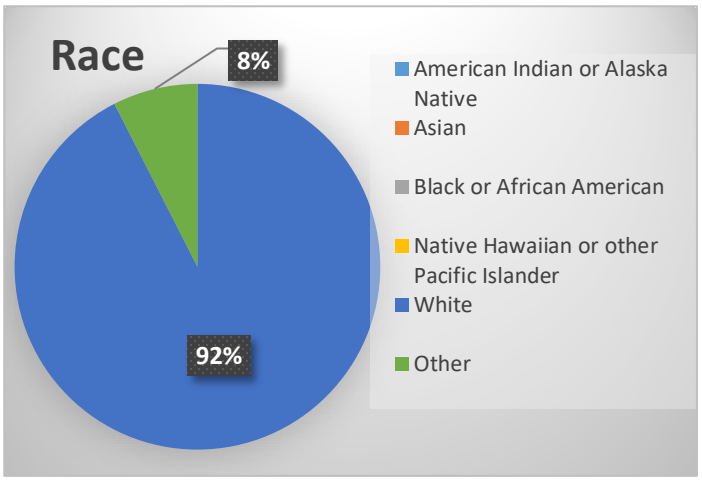
"My SPC was thoughtful, positive, and helpful in a difficult time. Excellent program! Thank you." – SPC Client

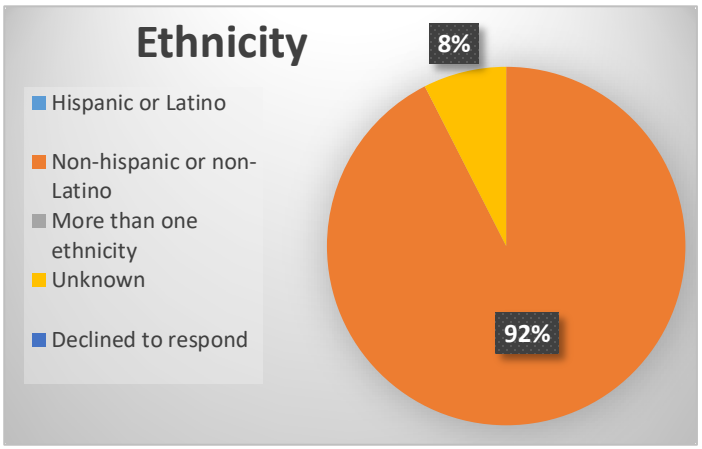
"My counselor brought so much to the table. Excellent listening skills, profound wisdom, encouragement that was so needed. A boatload of real life tools for my future. Most of all, she brought love, compassion and understanding and her wealth of knowledge is amazing. She is a real treasure!" – SPC Client

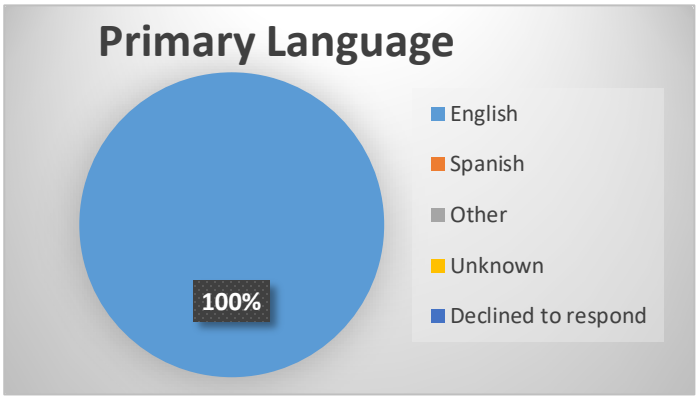
Sonoma County DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

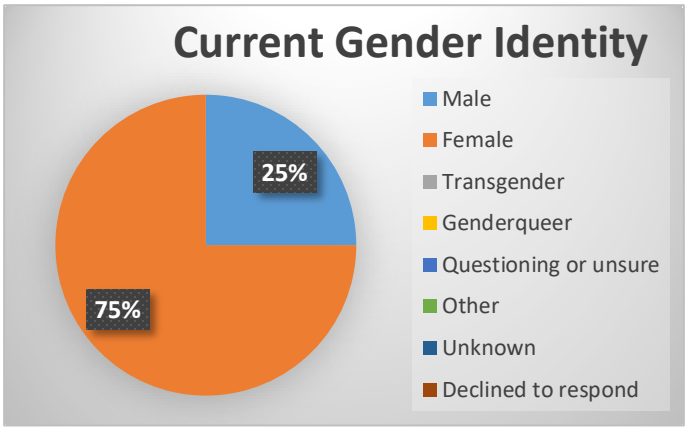
FY 2021-2022 Program Demographics:

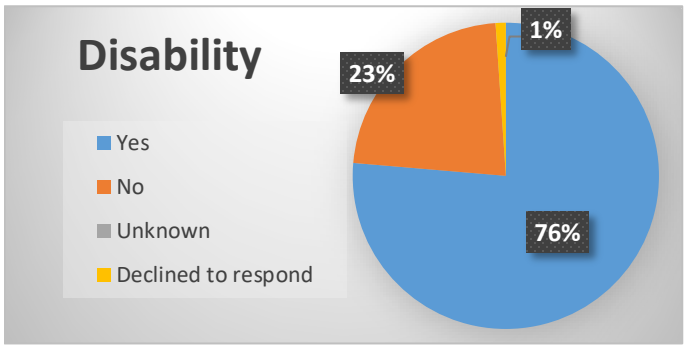


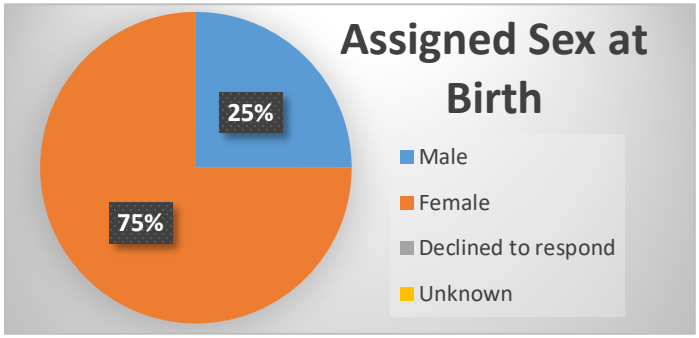


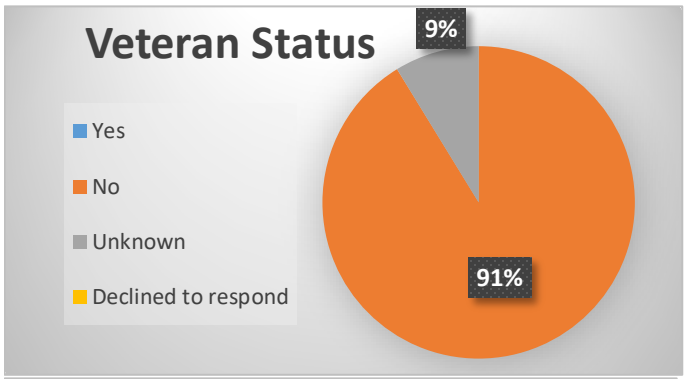


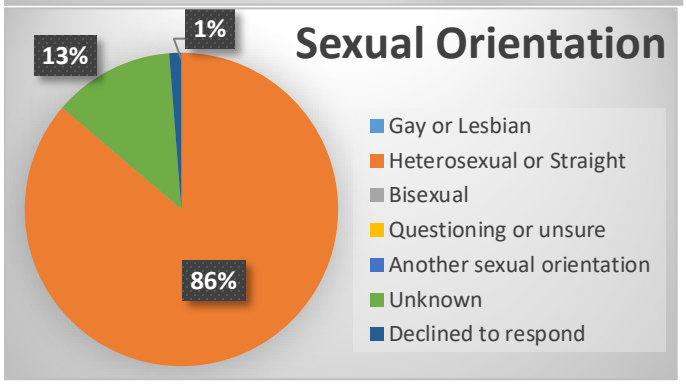












Sonoma County's Safe Spaces FOR MENTAL HEALTH

MHSA Component: Community Services & Supports (CSS)

Sonoma County Job Link Program

SONOMA COUNTY JOB LINK
A proud partner of America's Job Center of California℠ network.

Service Category: *General System Development*

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM IMFORMATION

Program Name:
Sonoma County Job Link
Population served: Adults, Youth, and Employers in Sonoma County
Website:
www.caljobs.joblinksonoma.org
Phone: (707) 565-5550
Program location:
2227 Capricorn Way, Ste 100
Santa Rosa, CA 95407
Social Media:
@SonomaCountyJobLink
@JobLinkSonoma

PROGRAM DESCRIPTION:

Sonoma County Job Link/AJCC is a One-Stop Career Center comprised of multiple Workforce Service Providers and Partners working together connecting Job Seekers, Employers, and the Community to create a thriving Sonoma County economy. Job Link provides employment services including a Resource Center; Computer Lab; and Navigators and Counselors who assist with resume and interview prep, help with education and training, finding a job, or starting a career.

PROGRAM STATISTICS

- **Total number of clients served:** 10 who were counted as individuals with serious mental illness.
- **Total number of encounters:** 50
- **Approximate numbers reached through outreach:** 284

PERFORMANCE OUTCOMES & ACCOMPLISHMENTS:

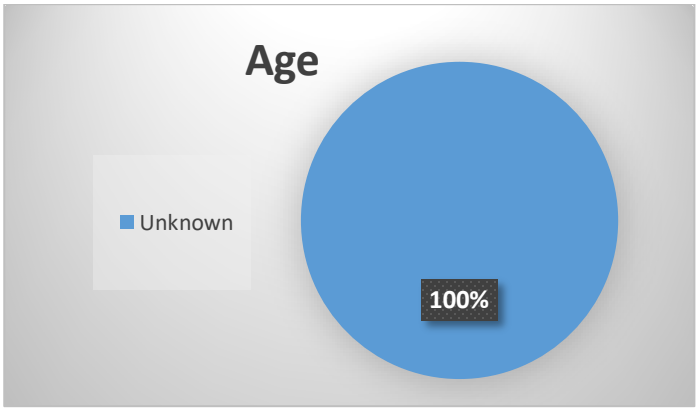
During fiscal year 2021-2022, many services continued to be impacted by the COVID-19 pandemic with more visitors than the previous year. Job Link had 600+ customers who visited the One-Stop in person during that fiscal year, up from only 100+ visitors in the prior fiscal year. The ability to once again offer in-person services allowed these visitors to access job postings, workshops, use the computer lab, obtain information for resources from our navigators, and be connected to other agencies such as EDD, DOR, etc. In addition to these in-person services, over 500 participants were enrolled and received direct employment counseling and career services from Job Link counselors throughout the fiscal year.

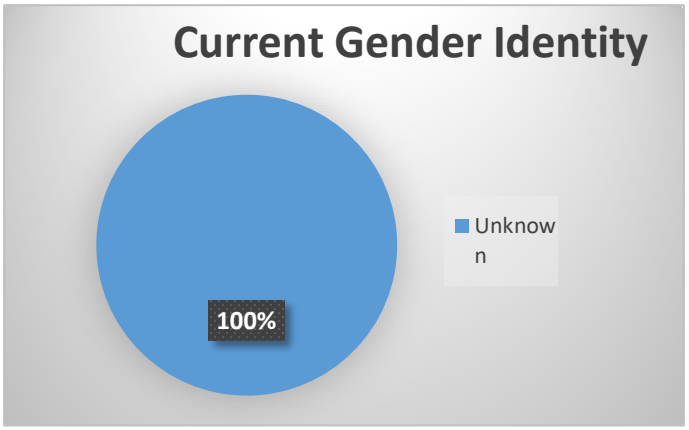
- Job Link's referral process to obtain referrals from the Behavioral Health Division specifically for individuals with serious mental illness was also refreshed in May 2021 and outreach was enhanced resulting in over 250 individuals learning about the services.
- The number Sonoma County Behavioral Health clients served in FY 21-22 increased from FY 20-21 from 3 clients in FY 20-21 to 10 clients served by Job Link's program.in FY 21-22.

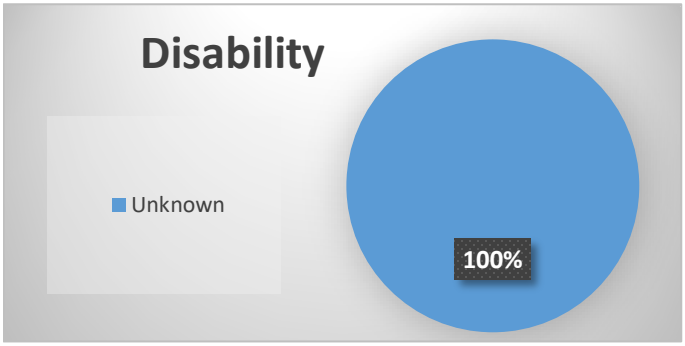
MENTAL HEALTH SERVICES ACT PROPOSITION 63 CALIFORNIA

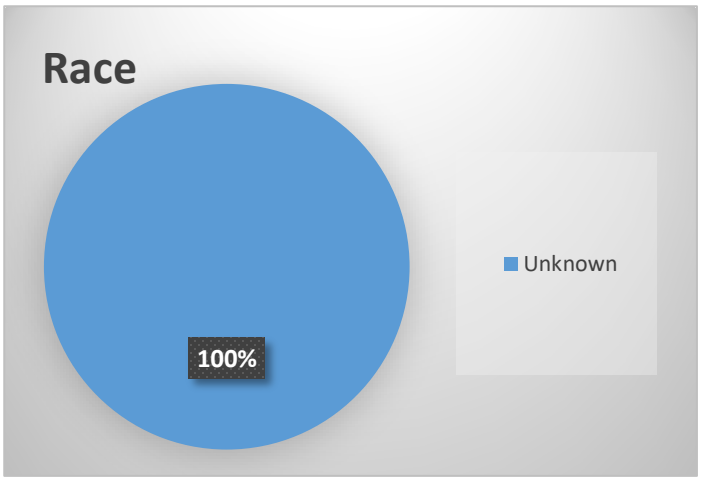
sonoma county DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

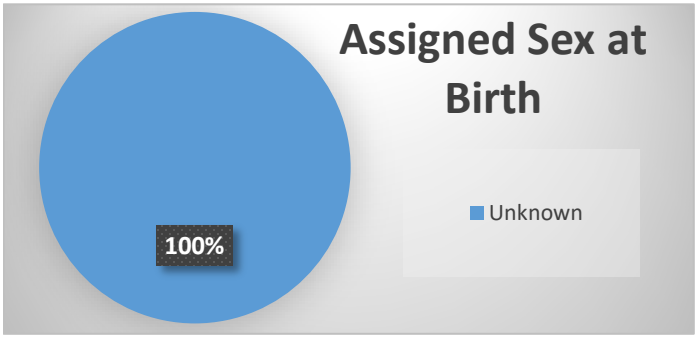
FY 2021-2022
Program Demographics:

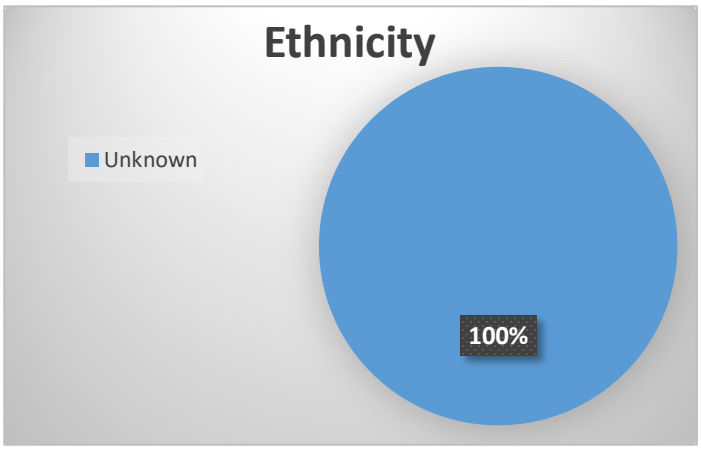


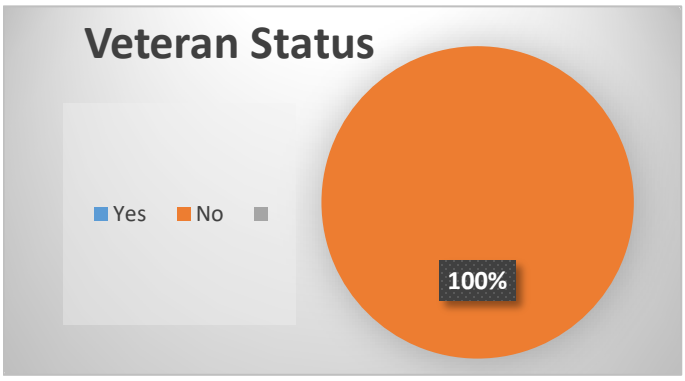


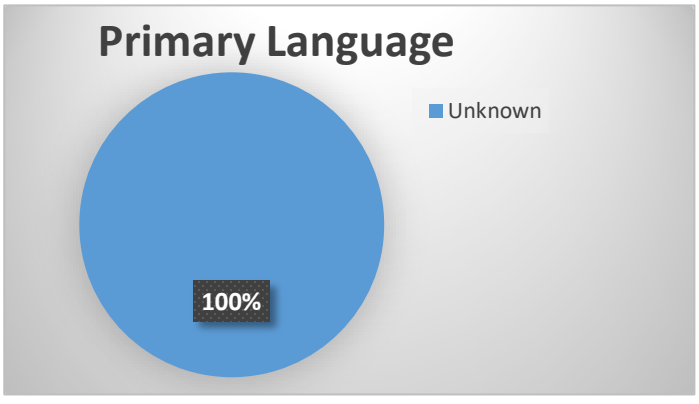


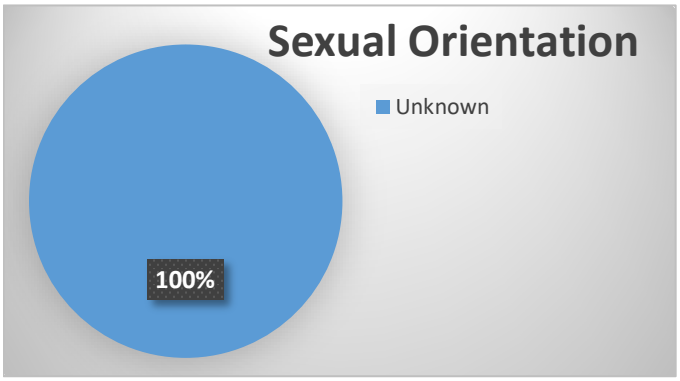












Sonoma County's Safe Spaces FOR MENTAL HEALTH

MHSA Component: Community Services & Supports (CSS)

West County Community Services Crisis Support Program

WCCS West County Community Services

FY 2021-2022 Service Category: General System Development

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM IMFORMATION

Program Name: Crisis Support
Population served: Adult Individuals & Families in the Lower Russian River Community
Website: https://westcountyservices.org/
Phone: (707) 823-1640
Program location: Lower Russian River
Social Media: N/A

PROGRAM DESCRIPTION:

West County Community Services (WCCS) Crisis Support is offered through housing and resource counseling and resource referrals. Needs for individuals and families with children are assessed and prioritized. Immediate financial, food, clothing, and resource assistance are offered during meetings. Referrals for ongoing local support resources are identified and offered. The Counselor assists in filling out and submitting Season of Sharing applications.

FY 2021-2022 PROGRAM STATISTICS

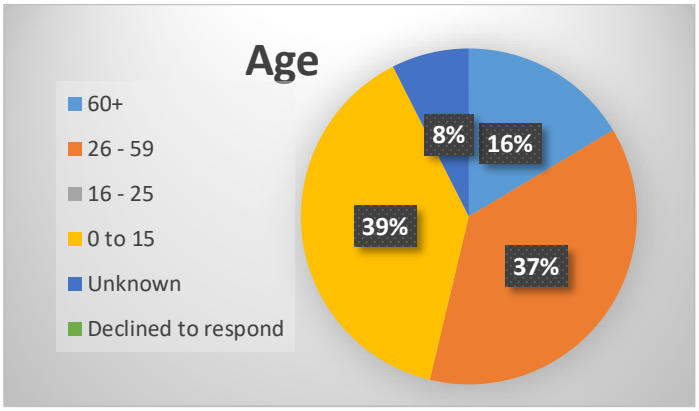
- **Total number of clients served:** 67
- **Total number of encounters:** 109
- **Approximate numbers reached through outreach:** 38

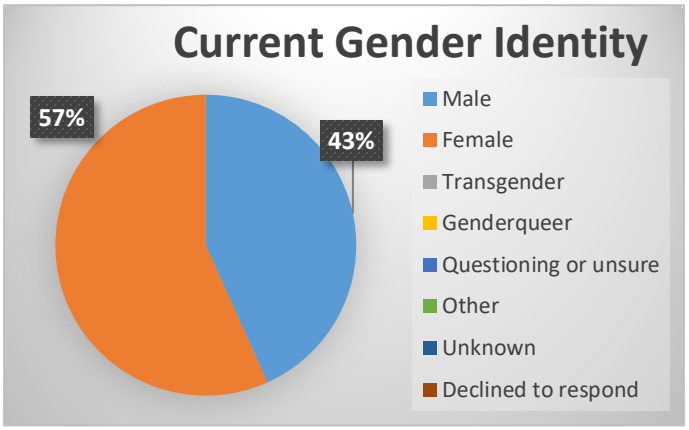
PERFORMANCE OUTCOMES & PROGRAM ACCOMPLISHMENTS:

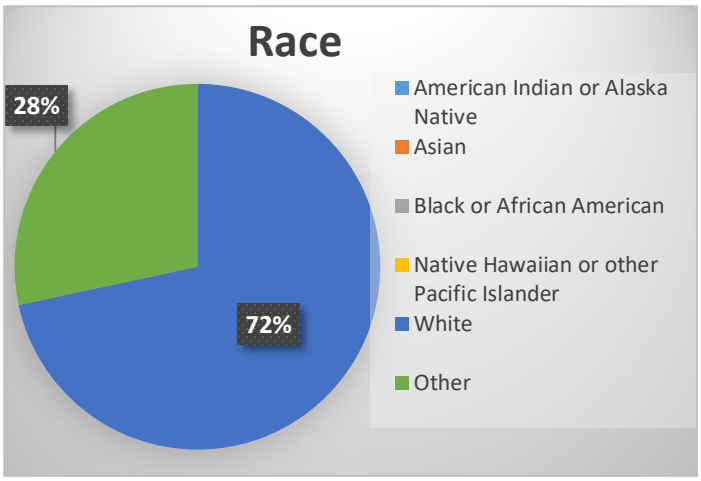
- In FY 21-22 WCCS Crisis Support Program met 100% of the requests for services from their clients.
- WCCS Crisis Support Program provided 10 families with food boxes and gift cards in FY 21-22.
- WCCS Crisis Support Program provided 5 families with clothing and shoes in FY 21-22.
- In FY 21-22, 25 families were given birthday gifts and Christmas gifts to help lift their spirits.
- WCCS is a big heart, listening ear and Love in Action in our community.
- WCCS forms a kind and respectful partnership with their clients to meet their needs. Seven families were able to be housed through their collaboration with Season of Sharing. Three of those were leaving domestic violence. Here is a quote from a mother who was helped get into a safe home. "You've sent me and my daughter a lifeline in a very dark and confusing time. You've given me hope and made it possible to start a (much needed) new chapter in a safe home." – WCCS Client

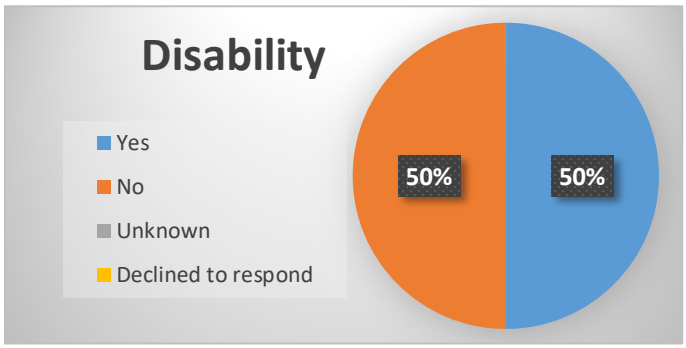
Sonoma County DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

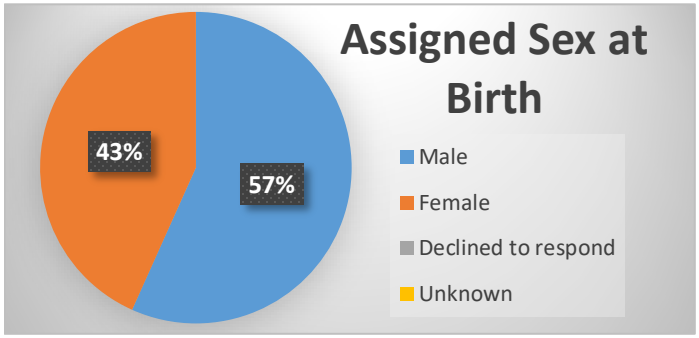
FY 2021-2022 Program Demographics:

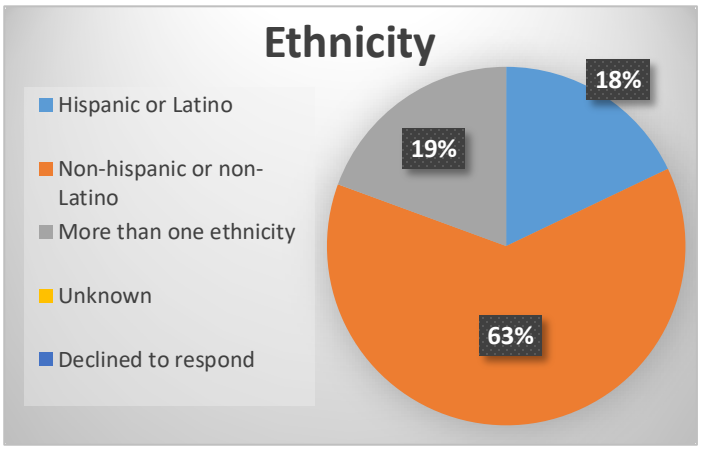


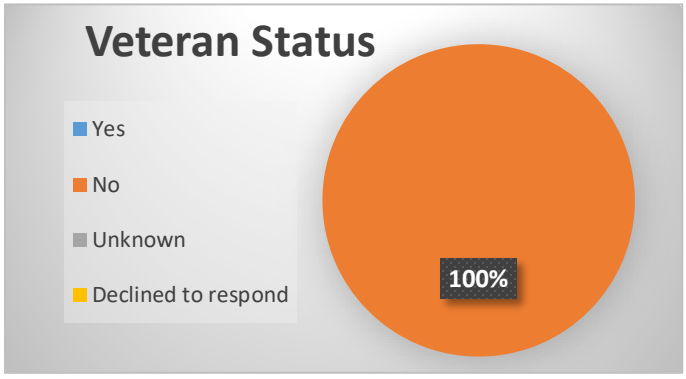


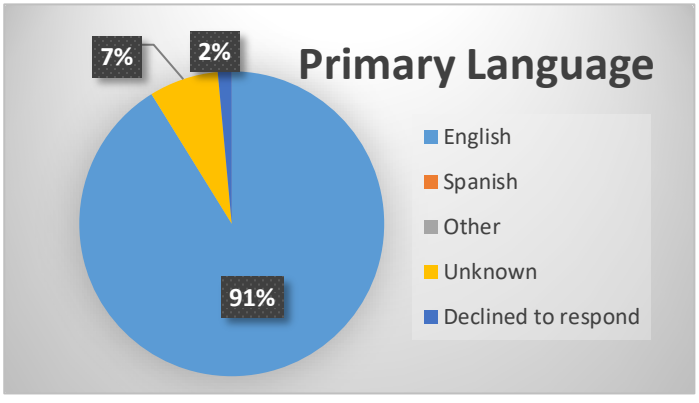


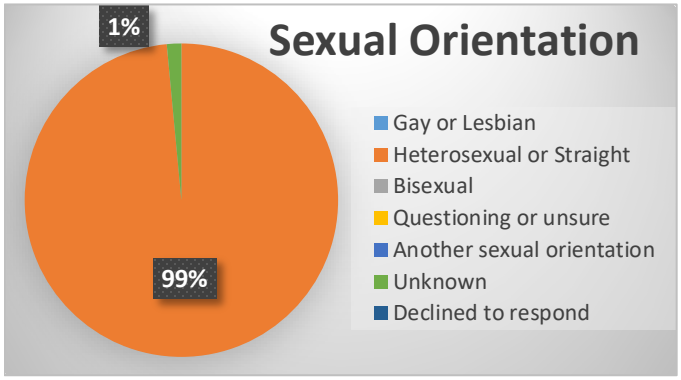












DHS-BHD Medication Support Services for Adult Programs

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM IMFORMATION

Program Name: DHS-BHD Medication Support Services for Adult Programs

Population served: Adults (18 years and older) in Sonoma County who meet Medi-Cal guidelines for Target Population. Clients must be referred through the Access team after an Adult Needs and Strengths Assessment.

Phone: (707) 565-6900

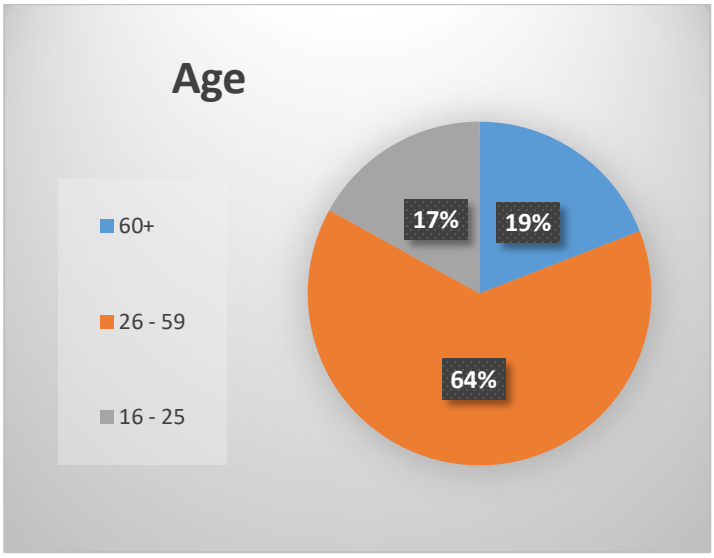
PROGRAM DESCRIPTION:

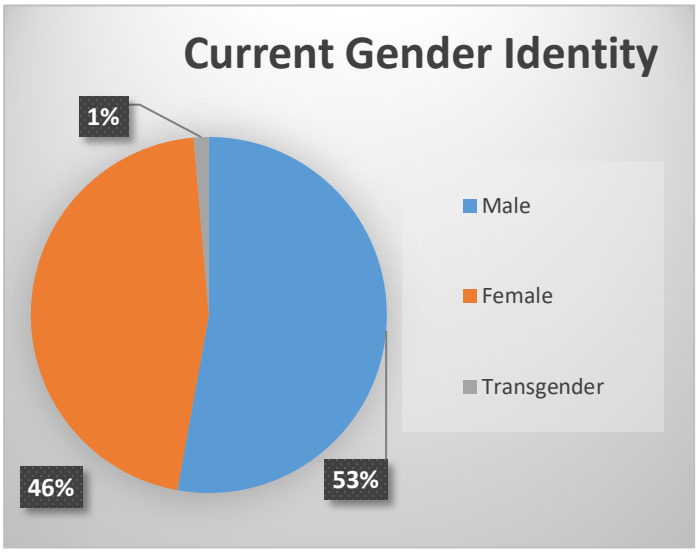
Describe The Adult Medication Support Service (Med Support) provides psychiatric and medication services to residents of Sonoma County who meet Medi-Cal guidelines for Target Population. Clients are referred to Med Support from the SCBH Access team, after a thorough assessment using the Adult Needs and Strengths Assessment has shown that the client requires this level of care. Med Support clients are linked to psychiatric services and receive psychiatric assessments and treatment, including psychiatric RN support, medication management, monitoring, and coordination. In cases where the Med Support clients are open to other SCBH mental health programs, Med Support staff coordinates care as necessary with the client's primary SCBH case manager. Periodically, staff from the Med Support program may provide other specialty mental health services, including case management, mental health services, and crisis intervention on an as needed basis.

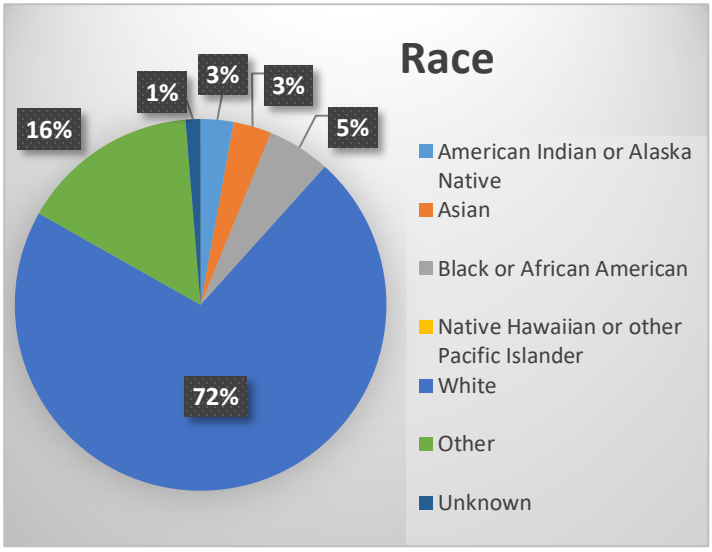
PERFORMANCE OUTCOMES:

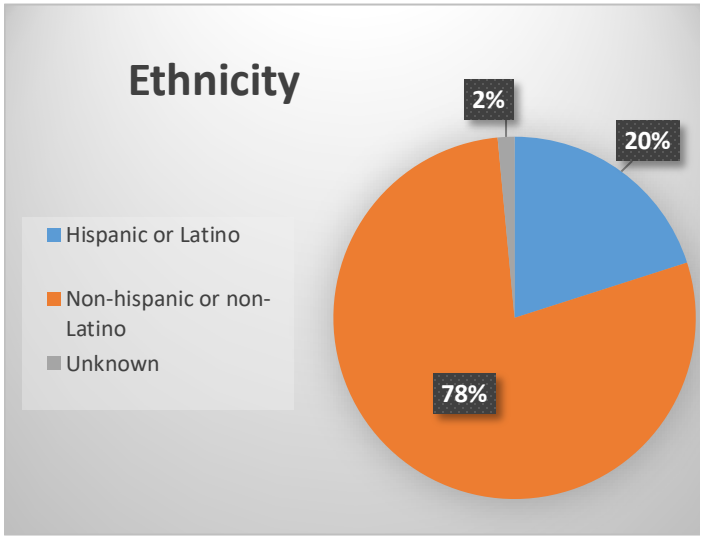
- **Total number of clients served in FY 21-22: 1565**
- Average Number of CANS/ANSA Actionable Items data was not available from FY 21-22

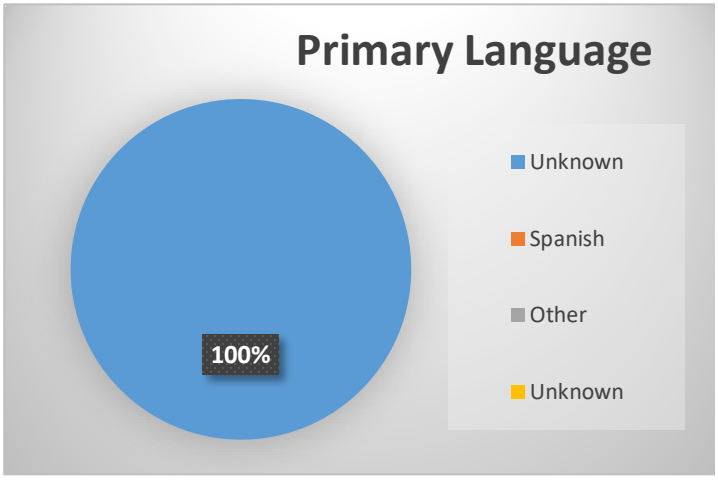
FY 2021-2022
Program Demographics:











Sonoma County's Safe Spaces FOR MENTAL HEALTH

FY 2021-2022 Annual MHSA Program Report
MHSA Component: Community Services & Supports (CSS)

DHS-BHD Medication Support Services for Youth Programs

sonoma county DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

Service Category: *General System Development*

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM IMFORMATION

Program Name: DHS-BHD Youth Medication Support Service (Youth Med Support)

Population served: Youth in Sonoma County who meet Medi-Cal guidelines for Target Population. Clients must be referred through the Access team after a Child and Adolescent Needs and Strengths (CANS).

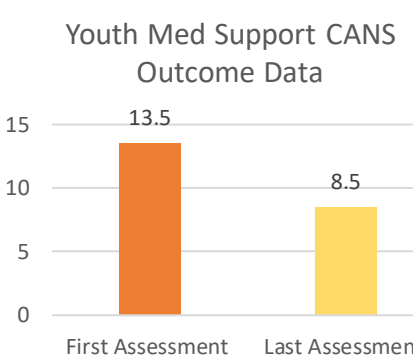
Phone: (707) 565-6900

PROGRAM DESCRIPTION

The Youth Medication Support Service (Youth Med Support) is a separate outpatient program which provides psychiatric and medication services to Sonoma County youth who meet Medi-Cal guidelines for Target Population. Clients are referred to Med Support from the SCBH Access team, after a thorough assessment using the Child and Adolescent Needs and Strengths (CANS) has shown that the client requires this level of care. Youth Med Support clients are linked to psychiatric services and receive psychiatric assessments and treatment, including psychiatric RN support, medication management, monitoring, and coordination. In cases where the Youth Med Support clients are open to other SCBH mental health programs, Youth Med Support staff coordinates care as necessary with the youth's primary SCBH case manager. Periodically, staff from the Youth Med Support program may provide other specialty mental health services, including case management, mental health services, and crisis intervention on an as needed basis.

PERFORMANCE OUTCOMES:

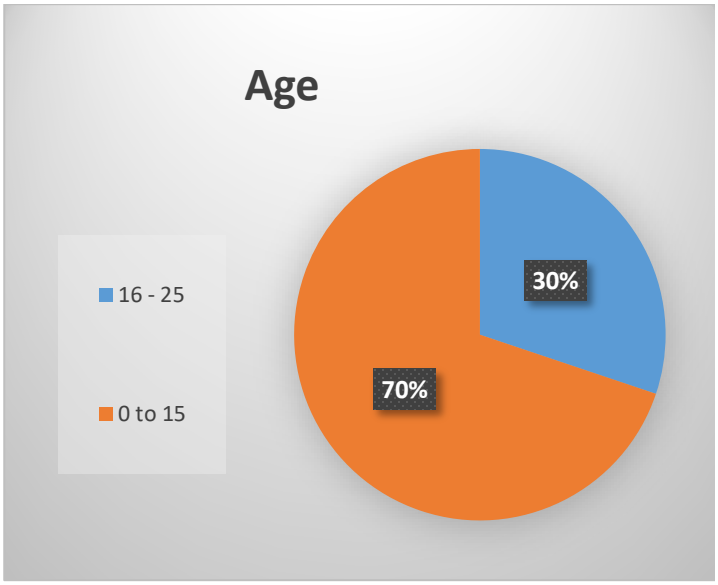
- **Total number of clients served in FY 21-22:** 578

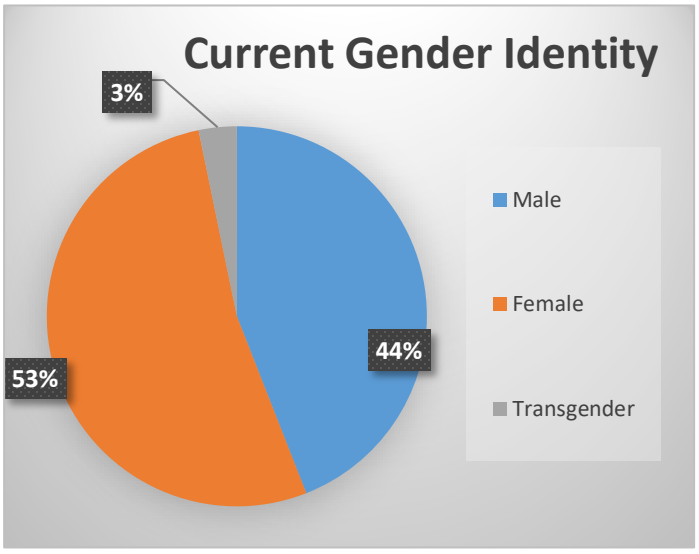


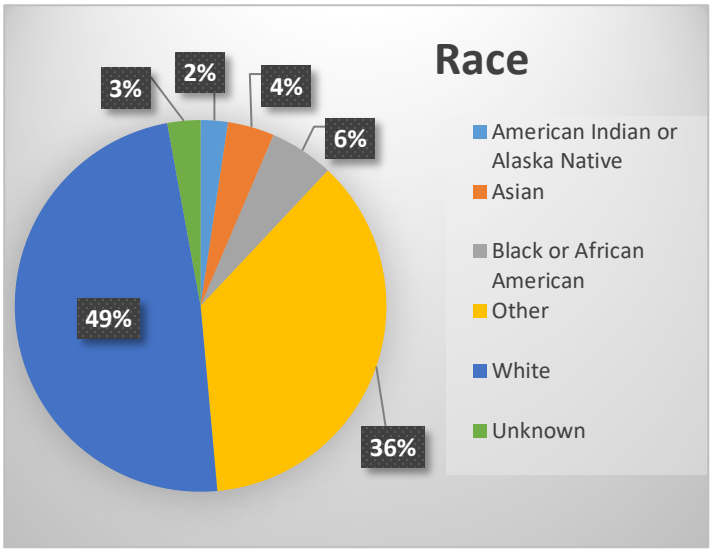
See pg.100 for an explanation of CANS/ANSA

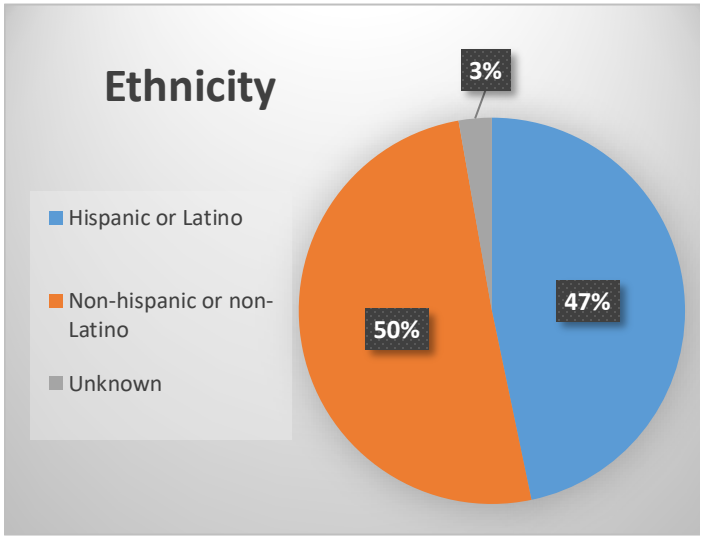
WELLNESS • RECOVERY • RESILIENCE

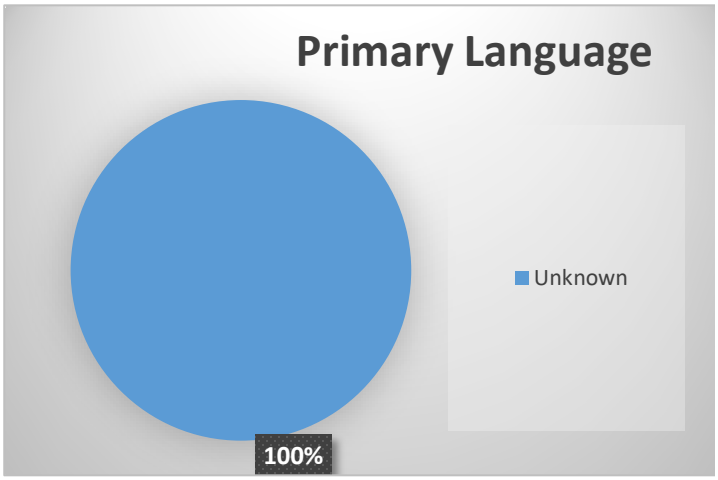
FY 2021-2022
Program Demographics:











Telecare Sonoma ACT

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM IMFORMATION

Program Name: Sonoma ACT
Population served: Adults ages 18 and older who have been diagnosed with a serious mental illness and meet specific criteria or need for intensive level of services.
Website: https://www.telecarecorp.com/sonoma-act
Phone: (707) 568-2800
Program location:
327 College Avenue Santa Rosa, CA 94501

PROGRAM DESCRIPTION:

At Sonoma ACT we are available to provide wrap-around services 24/7 to support our members in living in the community successfully. We meet people where they are, and are here to support individuals in feeling better, stronger, and taking positive steps towards the things that matter in their lives. We believe recovery is possible with the right plan in place. Our multi-disciplinary team includes licensed Clinical Director, nurse, peer support staff, substance use specialist, case managers, nurse practitioner, and psychiatrist.

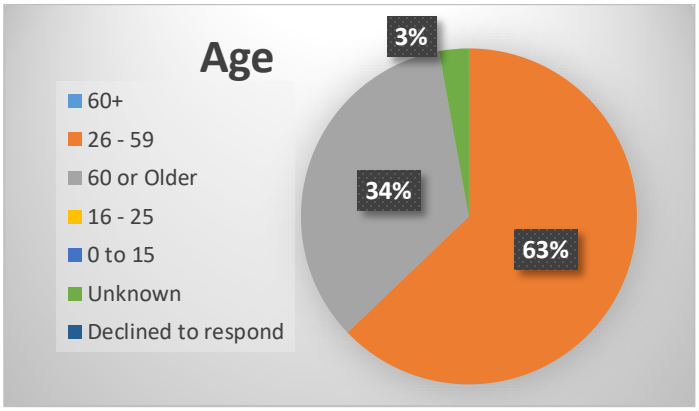
FY 2021-2022 PROGRAM STATISTICS

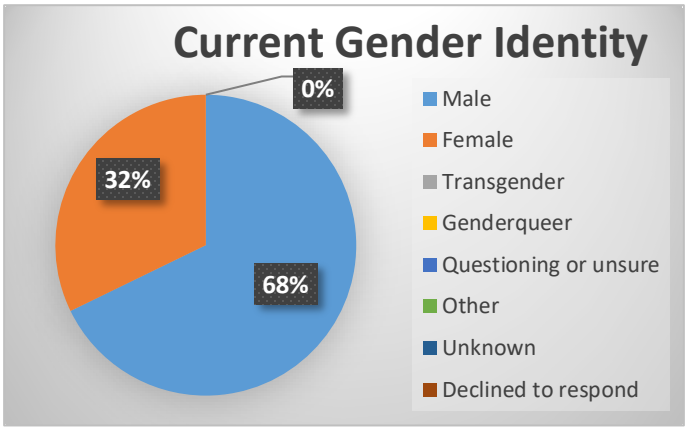
- **Total number of clients served:** 66
- **Total number of encounters: 5,732**

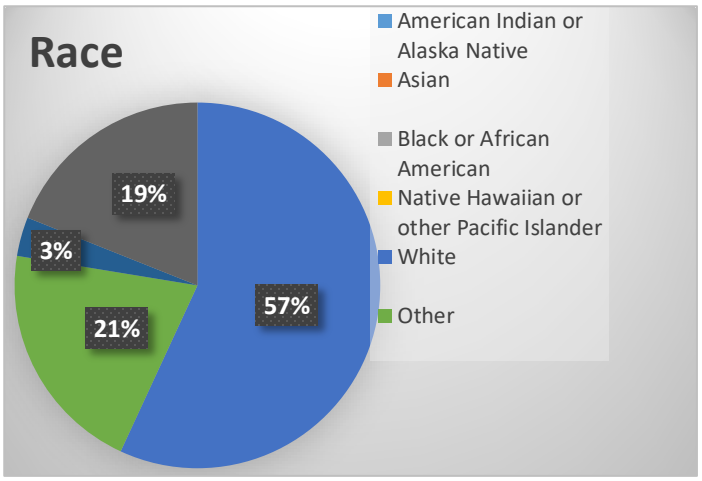
PERFORMANCE OUTCOMES & PROGRAM ACCOMPLISHMENTS:

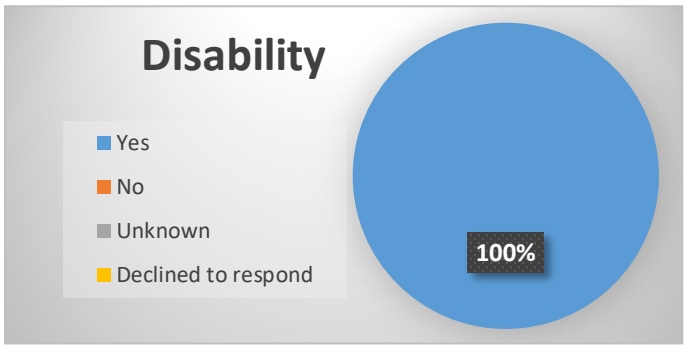
During FY 21-22, the Sonoma ACT program ensured members had access to COVID-19 vaccinations and boosters. In the previous FY, Telecare Sonoma ACT was able to report an 87% vaccination rate. We're proud of the continued efforts to match and exceed this number. Furthermore, towards the end of the FY 22, many of the 1:1, in-person services had been restored and active planning was underway for weekly groups to reconnect our members for a sense of community. This was especially important for those members who were reporting feeling isolated and cut off from their peers. Engaging housing services for the homeless remained a high priority and 93% of the Telecare Sonoma ACT members were stably housed.

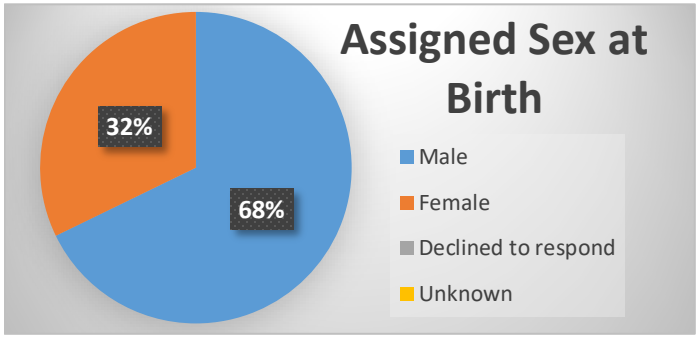
FY 2021-2022 Program Demographics:

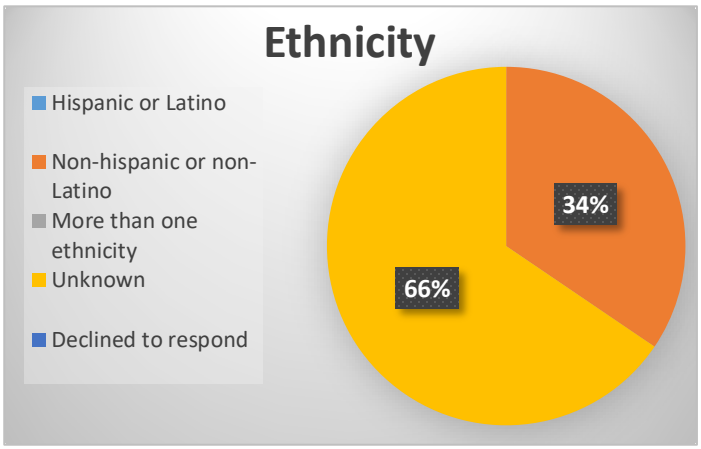


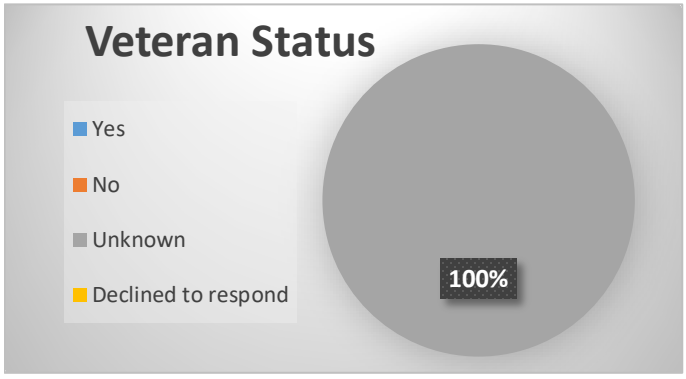


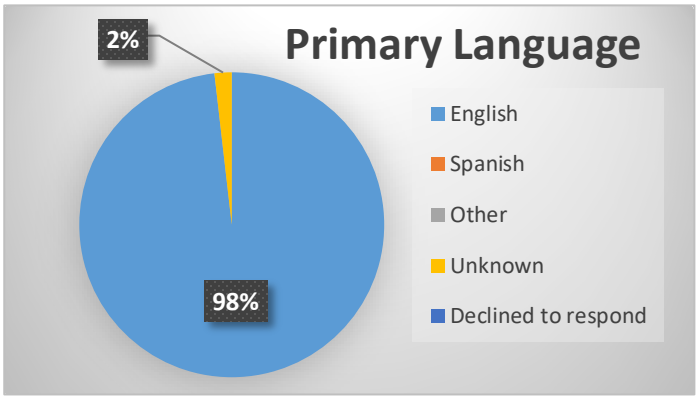


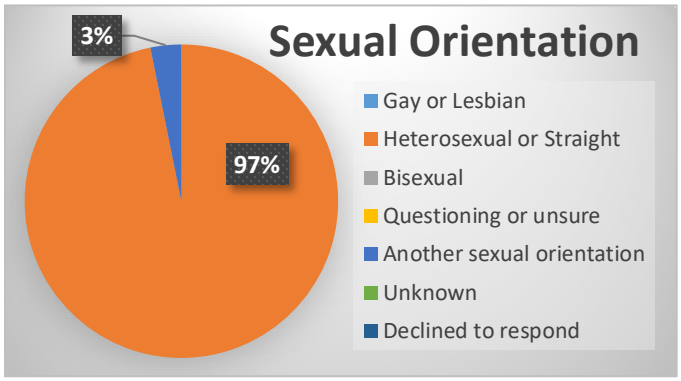












COMMUNITY SERVICES AND SUPPORTS (CSS)

Programs provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

Outreach and Engagement (OE)

A service category of the CSS component used to fund activities to reach, identify, and engage unserved individuals and communities in the mental health system and reduce disparities identified by the County.

Sonoma County's Safe Spaces FOR MENTAL HEALTH

MHSA Component: Community Services & Supports (CSS)

Sonoma County Indian Health Project's Community Program

Service Category: *Outreach and Engagement Services*

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM IMFORMATION

Program Name: Sonoma County Indian Health Project, Inc.
Population served: Native Americans, all ages, residing in Sonoma County
Website: www.scihp.org
Phone: (707) 521-4550
Program location:
144 Stony Point Road
Santa Rosa, CA 95401
Social Media: Sonoma County Indian Health Project, Inc (Facebook)

PROGRAM DESCRIPTION:

Sonoma County Indian Health Project Inc. (SCIHP) provides psychotherapy services in an integrated system of care to Native American individuals of all ages residing in Sonoma County. SCIHP's Integrated Behavioral Health Provider is embedded in the medical department and serves as a key member of primary care team, consulting on the treatment of individuals with a behavioral health need. This provider offers clinical case management and therapy services, and referrals to additional services and resources, both onsite and elsewhere in the community.

The Integrated Behavioral Health Provider identifies, treats, triages, and manages the care of individuals identified in the primary care department with a behavioral health need. This provider is also available for warm handoffs from primary care providers, on a same day basis, for brief problem-focused interventions.

PERFORMANCE OUTCOMES & PROGRAM ACCOMPLISHMENTS:

- The Integrated Behavioral Health Provider provided therapy services to 162 Native American individuals in 2021-2022.
- Services were further enhanced in with the hire of an additional therapist, psychologist, and Behavioral Health Director in 2022. These providers have made tremendous progress in increasing access to behavioral health services, improving communication and collaboration across departments and ensuring that providers and community members have access to our full continuum of culture-based behavioral health prevention and treatment programs offered at SCIHP and by partners serving our tribal community.

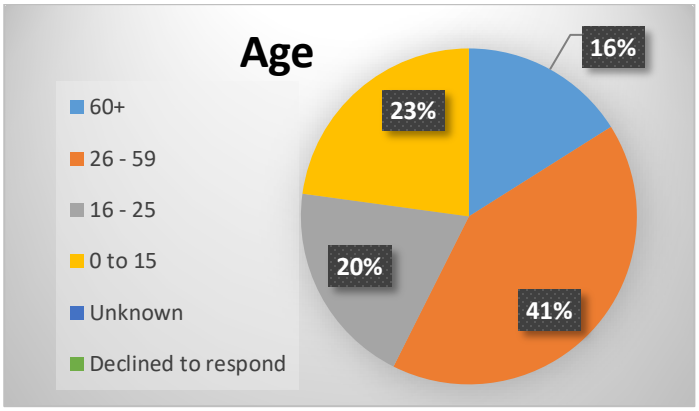
- **Total number of clients served:** 162
- **Total number of encounters:** 628
- **Approximate numbers reached through outreach:** 42

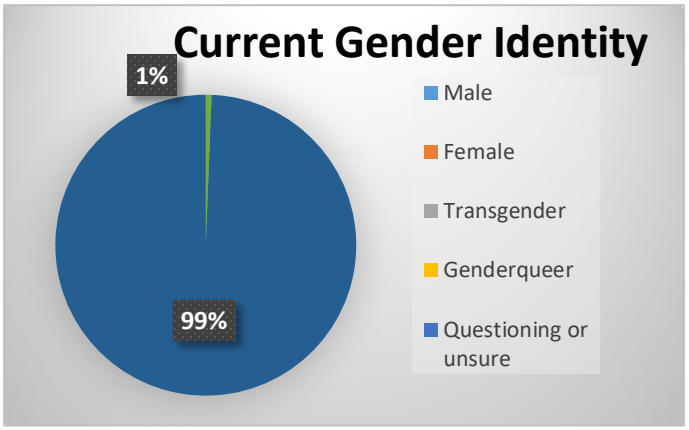
MENTAL HEALTH SERVICES ACT PROPOSITION 63 CALIFORNIA

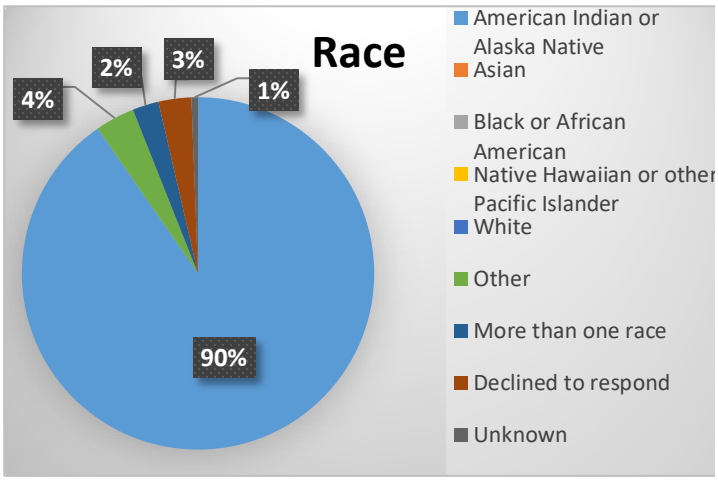
WELLNESS • RECOVERY • RESILIENCE

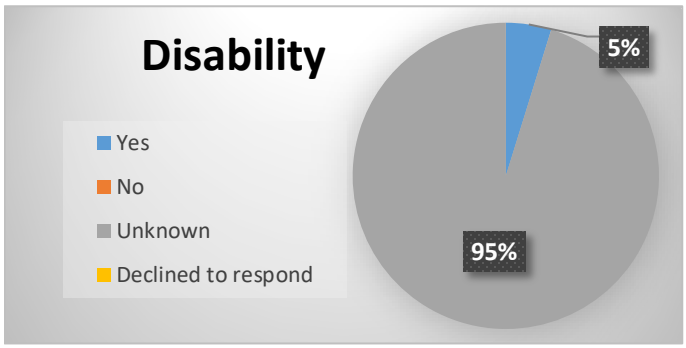
sonoma county DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

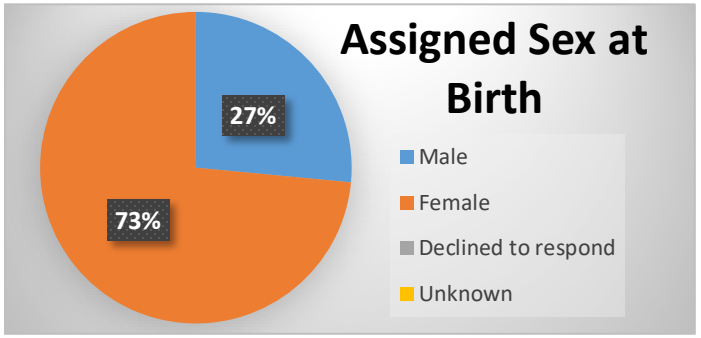
FY 2021-2022 Program Demographics:

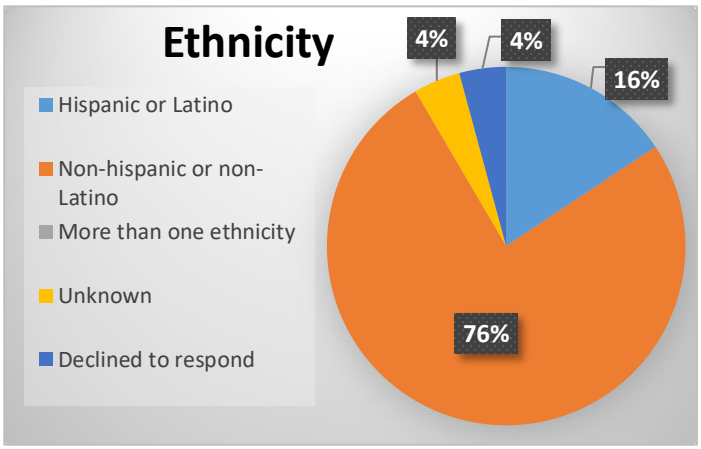


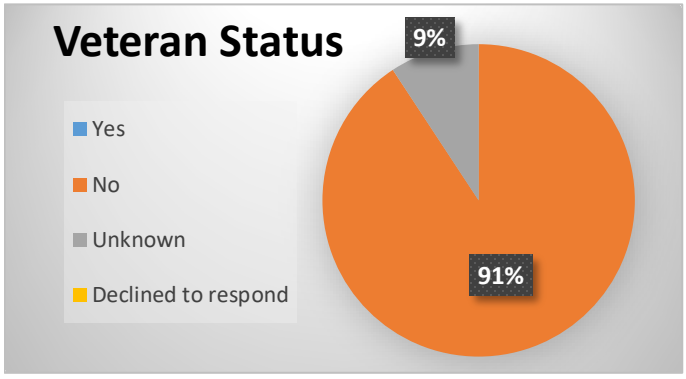


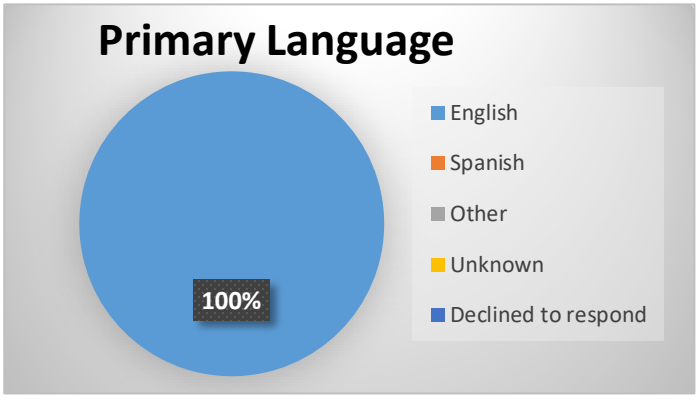


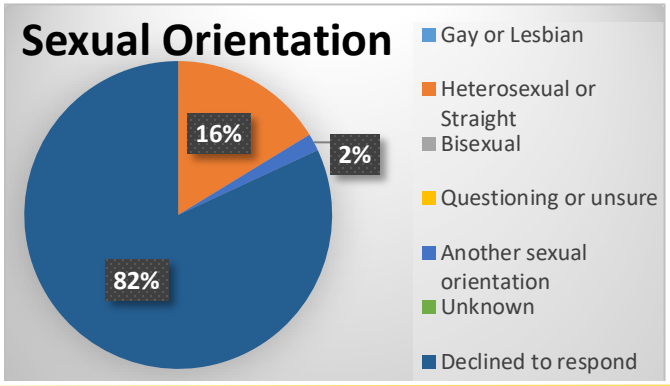












DHS-BHD's Whole Person Care (WPC)

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM DESCRIPTION:

Sonoma County's Whole Person Care (WPC) program includes outreach and engagement services, short term recuperative care services, and intensive case management services. Outreach and engagement services center around identifying clients, building trust, providing informed consent and collecting clients' data sharing permissions, completing comprehensive assessments and screenings to identify medical, behavioral health, social service, housing needs and eligibility for intensive care management services.

PROGRAM INFORMATION

Program Name: Whole Person Care (WPC)
Population served: Sonoma County residents who are experiencing homelessness or at-risk of homelessness and have a mental health condition with a chronic physical health condition.
Phone: (707) 565-4811, referral form required.

Placed-based outreach and engagement teams are strategically located throughout Sonoma County in high-density cities, as well as geographically remote, and typically underserved, areas to find and enroll participants in the field. WPC Pilot staff also actively partner with and take referrals from community partners, who typically encounter potential WPC's target population, such as:

- Hospitals, community health centers, emergency departments
- Local law enforcement agencies, jail, probation
- Community-based service organizations
- Shelters, supportive low-income housing projects, medical respite programs Self-refer into the program

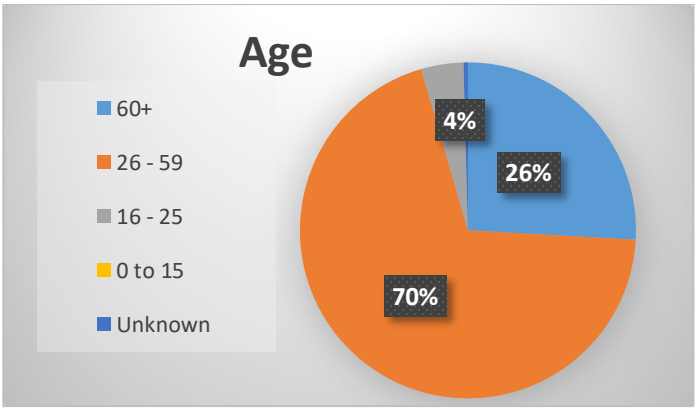
PERFORMANCE OUTCOMES

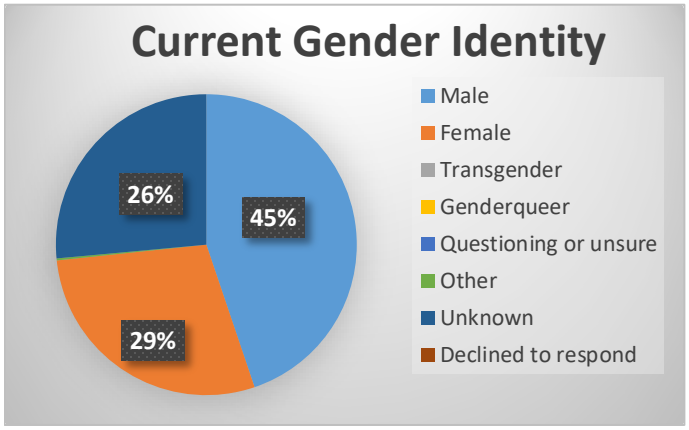
- **Total number of clients served in FY 21-22:** 1,406
- **Total number of encounters in FY 21-22:** 9,738
- **CANS/ANSA data was not available in FY 21-22.**

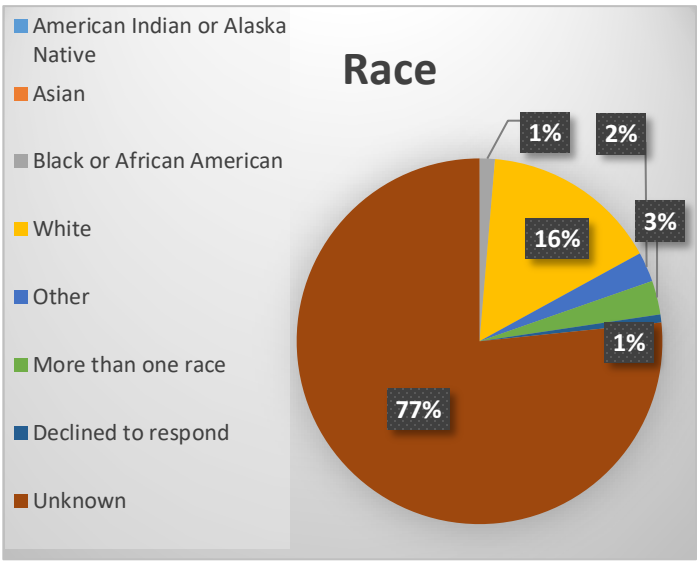
See pg.100 for an explanation of CANS/ANSA

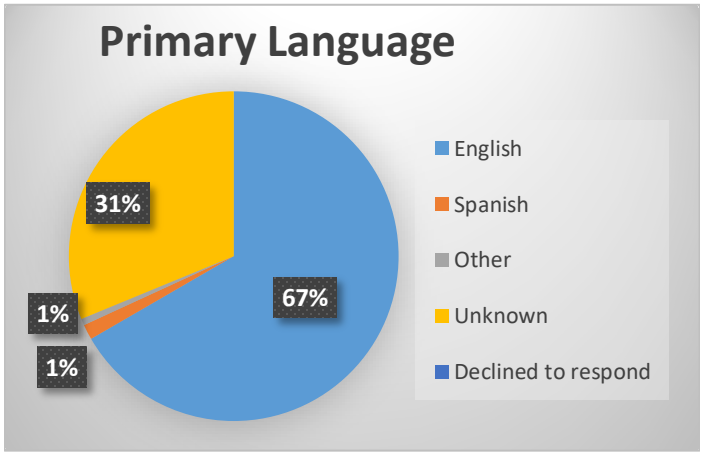
WPC Success Story:
A 28-year-old client in need of shelter, food and financial resources was enrolled into WPC. His case manager helped move him from a trail encampment into a trailer shelter where he was able to stay throughout the winter. During his stay there, he was connected to clothing, food resources, a local clinic to get his medical needs met, referred to a local support group for LGBTQI folks, and assisted in finding a full-time job. He was able to save enough money for a rent deposit on a room and signed a one-year lease. His case manager provided him with budgeting worksheets and helped him come up with a financial plan to keep his housing. On the day he moved out of the trailer shelter, he sent a message to his case manager stating the following, "Thank you so much for believing in me when no one else did. I could not have done this without your help and it means a lot to me that you didn't let me push you away when I was miserable on the inside". He continues to work with his case manager regarding some medical issues he has been having, but he is stable, housed, and is seeking a promotion at work soon.

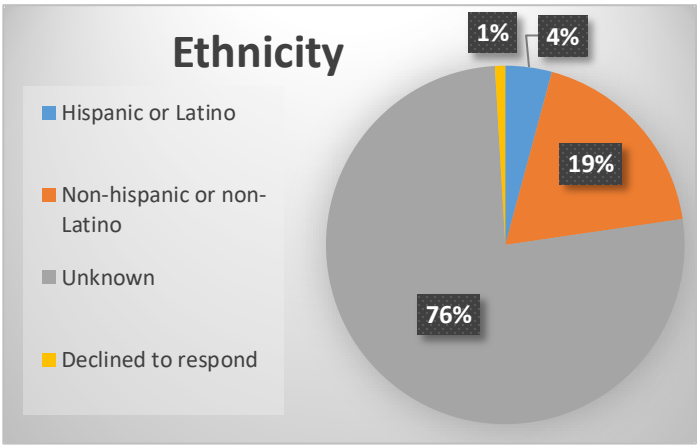
FY 2021-2022
Program Demographics:

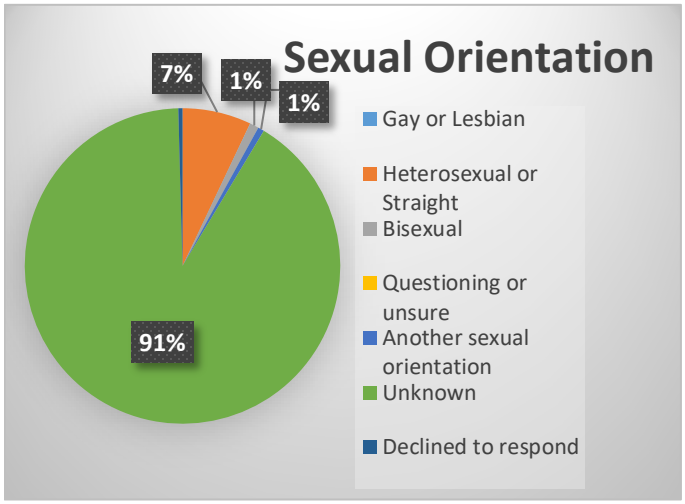












"Getting this help has been a huge win for me! People finally listened when you started coming to my appointments and at least now I have money to take better care of myself and my daughter. Thank you so much for everything you helped me with".

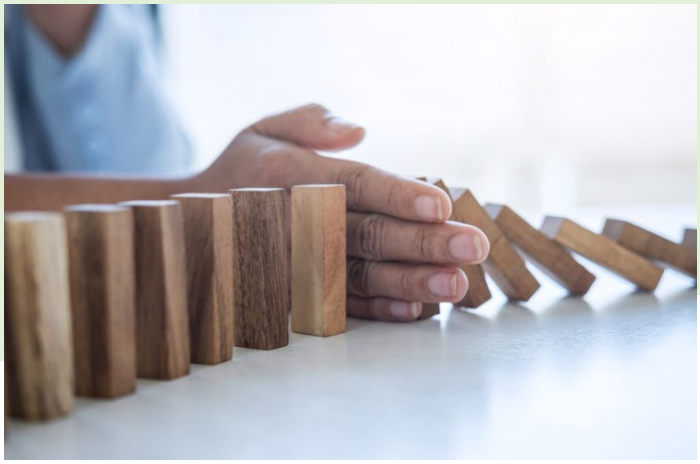
– WPC Client

SONOMA COUNTY MHSA ANNUAL PEI REPORT FY 2021-2022

Prevention and Early Intervention (PEI)

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:

- Suicide Incarcerations
- School failure or dropout
- Unemployment
- Prolonged suffering
- Homelessness
- Removal of children from their homes



On page 33 of the Sonoma MHSA Three-Year Plan there is description of how the County ensures that staff and stakeholders are involved in the Community Program Planning process, informed about, and understand the purpose and requirements of the Prevention and Early Intervention Component required by Title 9 California Code of Regulations, Section 3300.

Additionally, in the same section there is a description of how the County's meaningfully involves community stakeholders in all phases of the Prevention and Early Intervention Component of the Mental Health Services Act, including program planning and implementation, monitoring, quality improvement, evaluation, and budget allocations.

Prevention

A set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. The goal of this Program is to bring about mental health including reduction of the applicable negative outcomes listed in Welfare and Institutions Code Section 5840, subdivision (d) as a result of untreated mental illness for individuals (see page 106) and members of groups or populations whose risk of developing a serious mental illness is greater than average and, as applicable, their parents, caregivers, and other family members.

Sonoma County's Safe Spaces FOR MENTAL HEALTH

MHSA Component: Prevention and Early Intervention (PEI)

ACTION NETWORK - FAMILY RESOURCE CENTER

FY 2021-2022 PEI Initiative: Prevention

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, homelessness, removal of children from their homes, and prolonged suffering.

PROGRAM IMFORMATION

Program Name: Prevention Services
Population served: 0-65 Northern Sonoma Coastal Region
Website: www.actionnetwork.net
Phone: (707) 882-1691
Program location: Mobile Services to N. Sonoma Coast, Horicon School
Social Media:
IG: @thecenter_actionnetwork
FB: Act Net (profile)
@actionnetworkthecenter (page)

PROGRAM DESCRIPTION:

Action Network provides mobile outreach services to Kashia Rancheria on a bi-weekly basis delivering resources such as diapers & formula, food, food/fuel vouchers, and mental health check-ins to set goals with clients and track progress through the year. The Bright Beginnings program located at Horicon Elementary School provides a space for parents with children 0-5 to socialize, learn and play together and are introduced to school environment. Parents receive regular Triple P meetings regarding behavioral or developmental concerns. Staff can then make appropriate referrals for the family, assist with paperwork, and follow up on goals and progress. High school students are also served in the school system with prevention education, mental health check-ins and support groups on campus and after school.

FY 2021-2022 PERFORMANCE OUTCOMES:

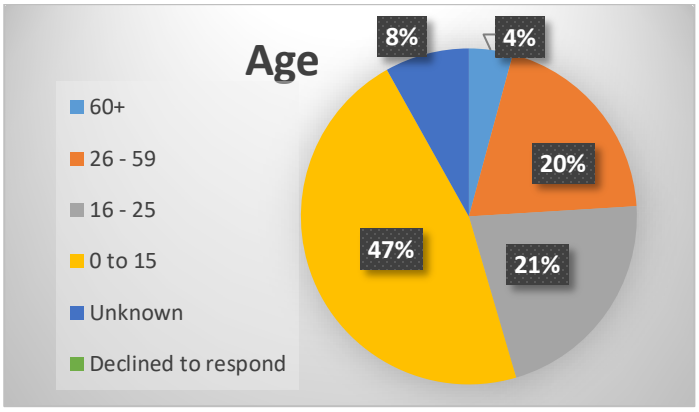
- **Total number of clients served:** 264
- **Total number of encounters:** 912
- **Approximate numbers reached through outreach:** 3375

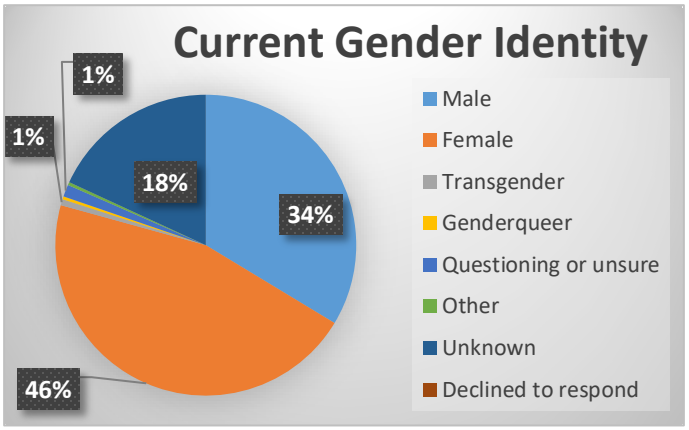
PERFORMANCE OUTCOMES & PROGRAM ACCOMPLISHMENTS

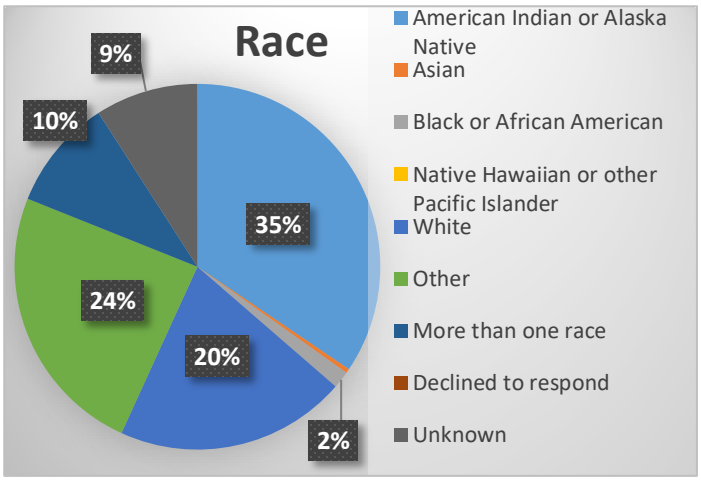
- 100% of Mobile Outreach services met the needs of families that are some of the most underserved in Sonoma County at the Kashia Rancheria in FY 21-22.
- 100% of mental health check-ins are woven into every visit and being able to see the family home and current state of living, allows staff to respond and deliver in a meaningful way.
- One on one relationship building has taken a long time but with consistency, families begin to rely on resource delivery from Action Network staff. The most important aspect of this program is listening to the needs the families are expressing, consistently showing up and clear communication regarding goals and follow up.
- One client shared, "You've shown up for us and we see you are the kind of people we can trust," reiterating the importance of building relationships across ages and cultures.

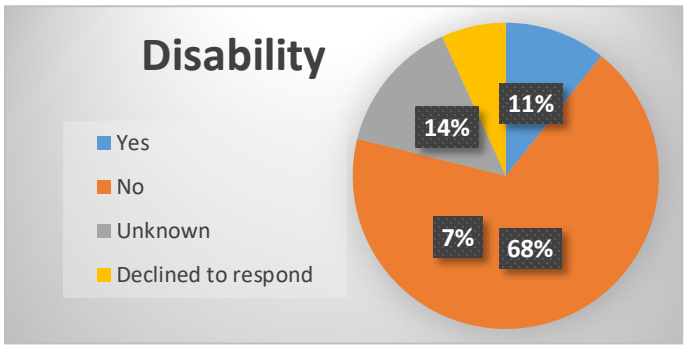
WELLNESS • RECOVERY • RESILIENCE

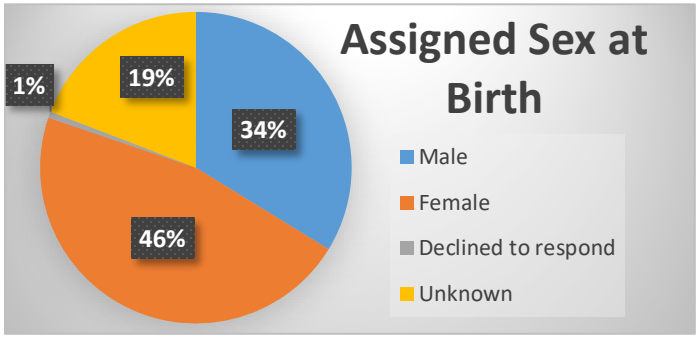
FY 2021-2022 Program Demographics:

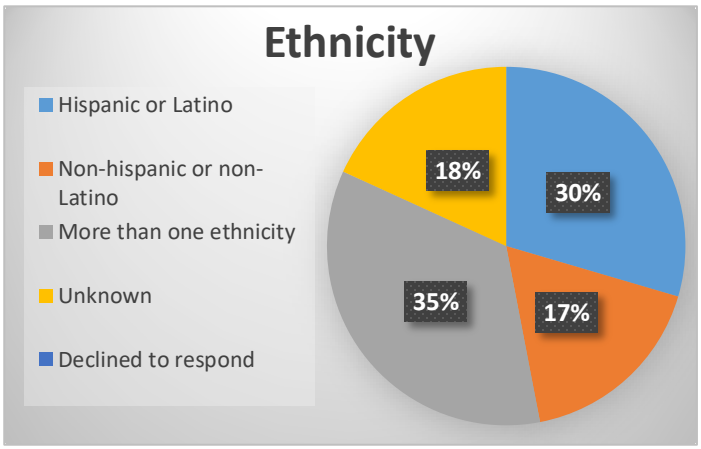


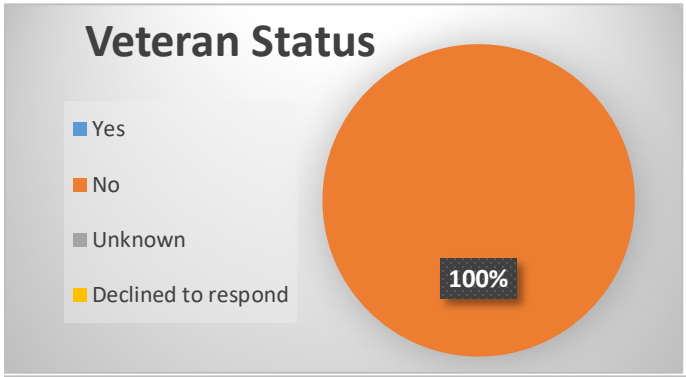


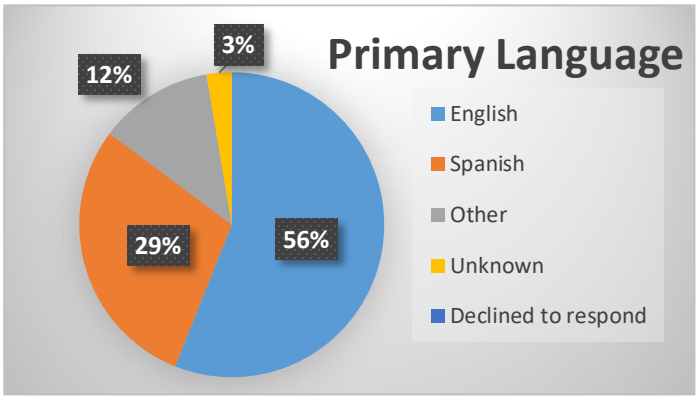


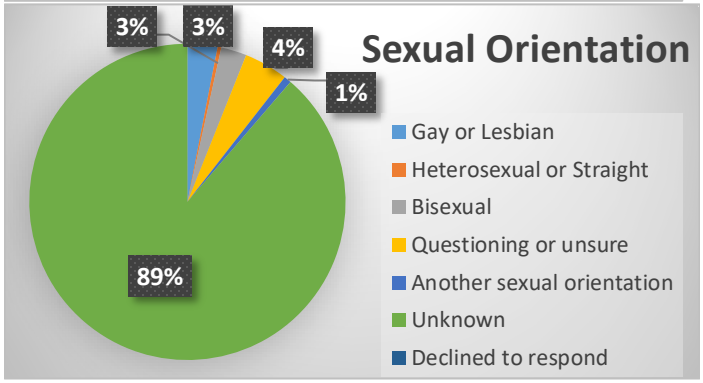












Sonoma County's Safe Spaces FOR MENTAL HEALTH

MHSA Component: Prevention and Early Intervention (PEI)

Community Baptist Church Collaborative

CBC COLLABORATIVE

FY 2020-2021 PEI Initiative: Prevention

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, homelessness, removal of children from their homes, and prolonged suffering.

PROGRAM DESCRIPTION:

Community Baptist Church Collaborative goals are to increase awareness of mental health issues and resources in the broader community and specifically within the African American Community. Community Baptist Church Collaborative addresses the associated risk factors of stigma, inadequate information regarding mental health issues, lack of trust for mainstream services and lack of acceptable mental health service for the African American community in Sonoma County with the following programs:

"[The men's mental health retreat helped me] realize how I had shut my sister out of my life for the last ten years because of how she treated our parents. I should make the connection again. " -J.N.

THE VILLAGE PROJECT AND SATURDAY ACADEMY are weekly programs for children ages 7-11 (Village Project) and 12-18 (Saturday Academy) using faith –based curriculum that focuses on character building and resiliency. Topics include perseverance, leadership, African American history, and representation in the bible, as well as physical and mental health topics. An additional support many of the participating youth receive is mentoring and tutoring.

SAFE HARBOR PROJECT provides events and activities to increase well-being, reduce stress, and increase community building using music, sound and vibro-acoustic techniques. In addition, Safe Harbor Project provides significant outreach concerning mental health to African American and other residents. Safe Harbor Project launched a 24/7 internet radio station (KSHP Mood Music) with music intended to increase wellbeing, Public Service Announcements, interviews, speakers, and other mental health related information. Once in-person programs are viable, SHP will continue KSHP; host at least 4 large events each year at African American cultural events, health and wellness fairs, and other venues; and provide music and programing.

MENTAL HEALTH TRAINING AND SPEAKER SERIES hosts 4 events each year to reduce stigma, increase mental health awareness and appropriate help seeking, and increase the cultural competency of the mental health system. Our staff, leaders, mentors, and volunteers attend theses trainings, as well as others interested in the wellbeing of the African American community. Events will include QPR training regarding suicide prevention, the annual African American Mental Health Conference, annual Martin Luther King celebration and annual Juneteenth festival of which Safe Harbor Project is a sponsor.

PROGRAM IMFORMATION

Program Name: CBC Collaborative
Population served: Sonoma County's broader community and specifically within the African American Community.
Phone: (707) 546-0744
Program location:
1620 Sonoma Ave, Santa Rosa, CA

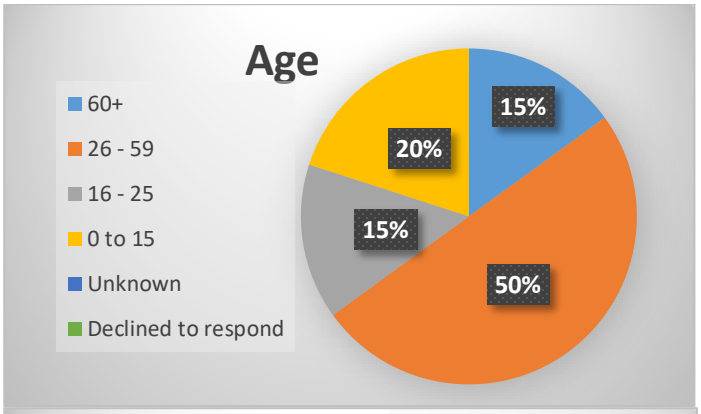
FY 2021-2022 PERFORMANCE OUTCOMES

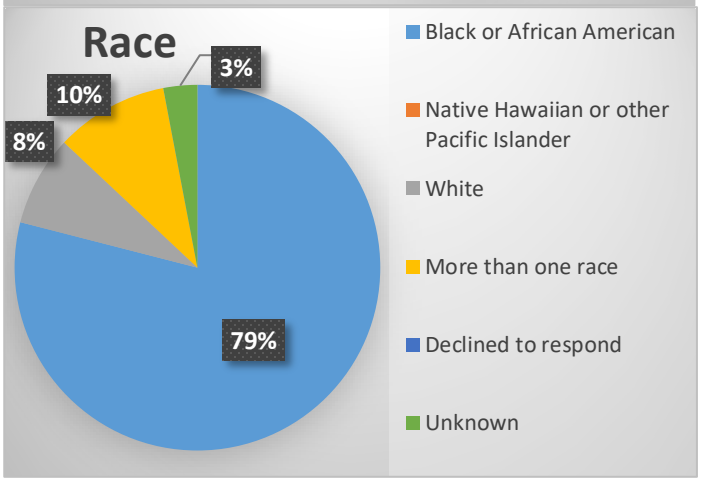
Total number of clients served: 179

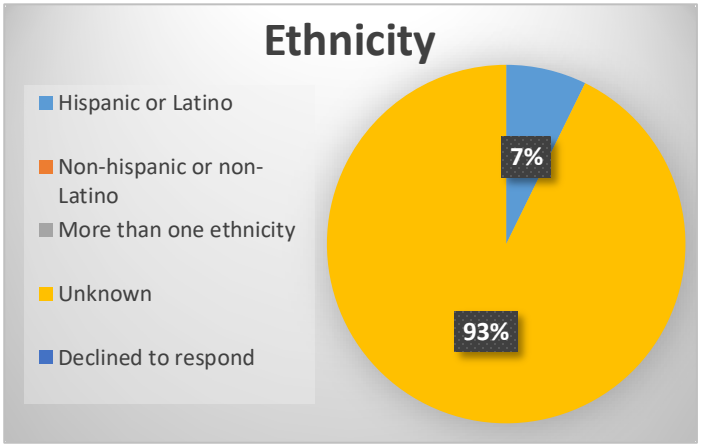
- **Approximate numbers reached through outreach:** 211,508
- 100% of mental health training attendees found the presentation on mental health to be excellent or very good.
- 70% of Saturday Academy students improved their grades by at least half a grade level.

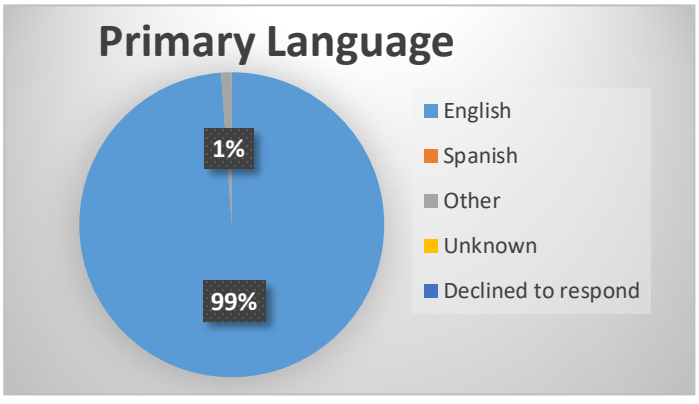
sonoma county DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

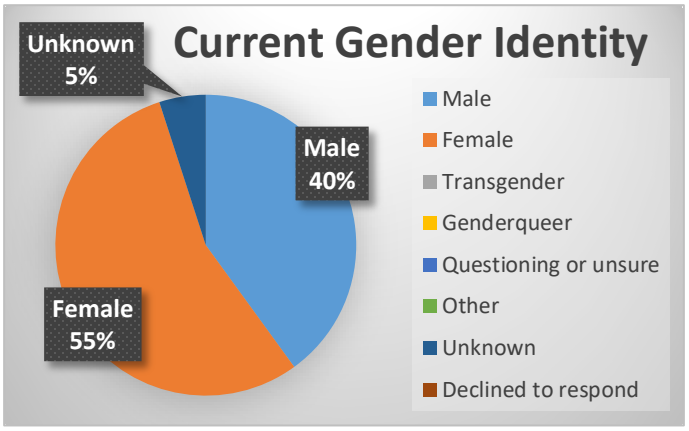
FY 2021-2022 Program Demographics:

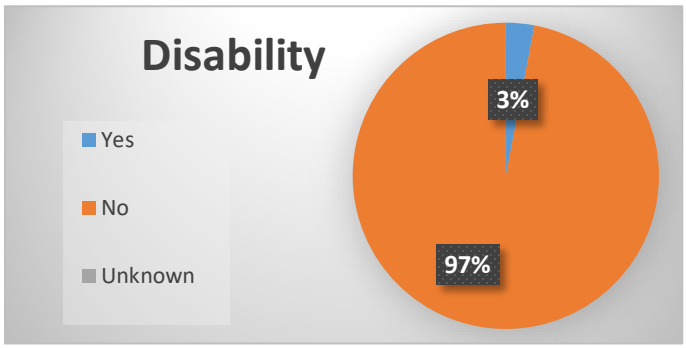


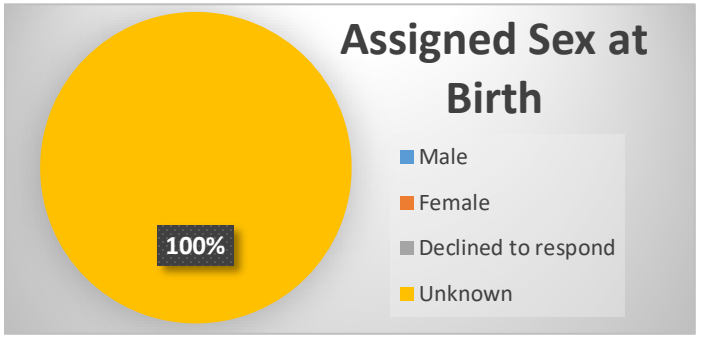


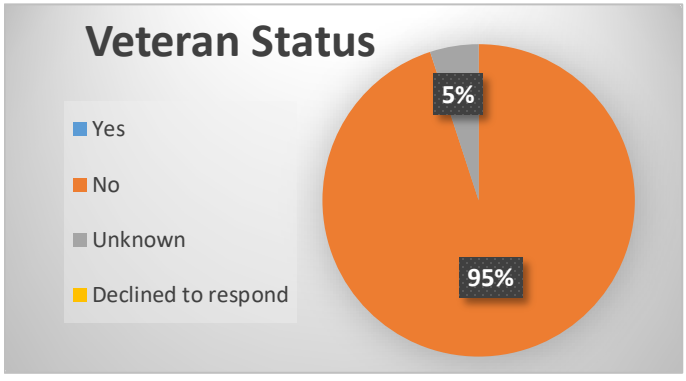


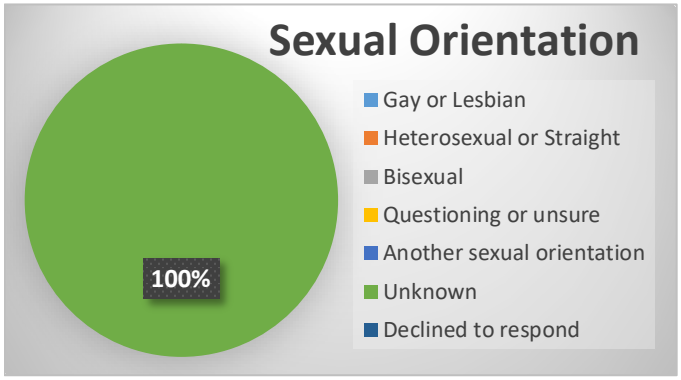












Sonoma County's Safe Spaces FOR MENTAL HEALTH

MHSA Component: Prevention and Early Intervention (PEI)

Sonoma County Indian Health Project's Gathering of Native Americans Program (GONA)

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, homelessness, removal of children from their homes, and prolonged suffering.

GONA Facilitators

PROGRAM IMFORMATION

Program Name: Gathering of Native Americans Program (GONA)
Population served: Native Americans, all ages in Sonoma County
Website: www.scihp.org
Phone: (707) 521-4550
Program location:
144 Stony Point Road
Santa Rosa, CA 95401

PROGRAM DESCRIPTION:

The GONA Project offers presentations and workshops, trainings, gatherings, and cultural events that bring together our Native community with a focus on cultural strengths and behavioral health wellness. The purpose of the Gathering of Native Americans (GONA) and curriculum is to reduce mental health disparity in our local Native American communities by increasing access to mental health services by:

1) Mental health stigma reduction and decreasing suicide through community-based awareness campaigns and education (utilizing community wellness gatherings and community outreach) The GONA focuses on the following four themes: belonging, mastery, interdependence, and generosity.

2) Providing GONA events which support healing, encourages and guides community discussion about mental wellness, and helps communities build capacity for Native Americans who are at risk.

FY 2021-2022 PROGRAM STATISTICS

- **Total number of clients served:** 28
- **Total number of encounters:** 28
- **Approximate numbers reached through outreach:** 1000

PROGRAM OUTCOMES & ACCOMPLISHMENTS:

100% of Participants communicated very positive feedback, including:

What did you enjoy most about the GONA?

- "I loved having a GONA space where all members of families could attend - children, adults, elders, and even orphans (like me!). It's such a good mix of contributions when a spectrum of voices get to speak, and I think it's really beneficial when we all get to contribute to each others' self esteem.
- "The stories. I especially liked analyzing together the meaning of the different relatives we get to learn from."

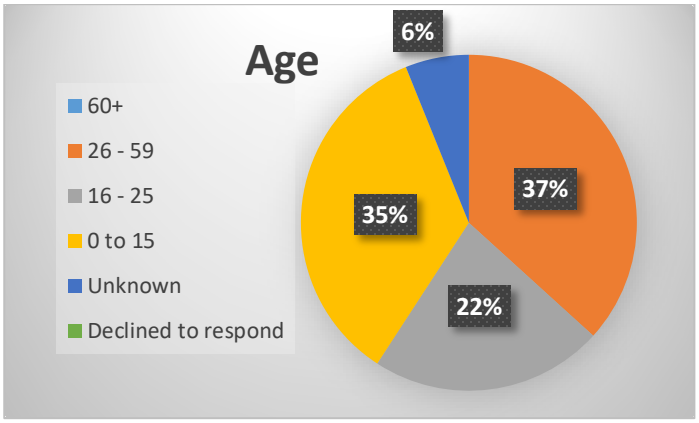
How did you and your family members feel at the end of the GONA?

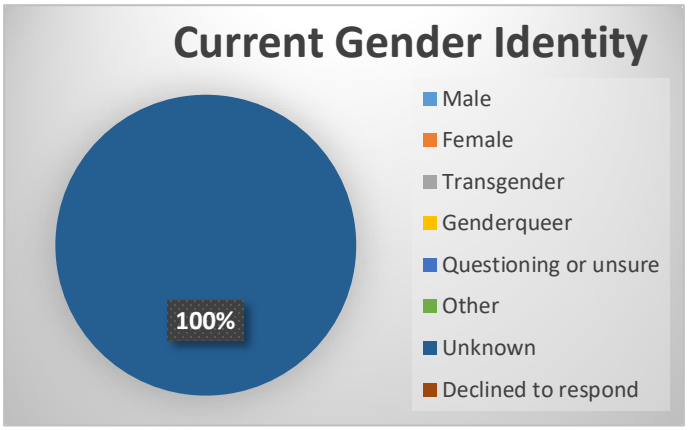
- "Affirmed, welcomed, related, confident, hopeful"
- "We felt we belonged."

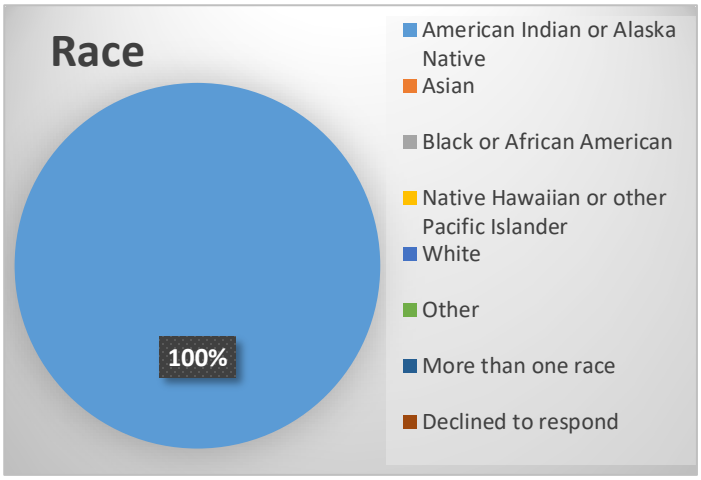
WELLNESS • RECOVERY • RESILIENCE

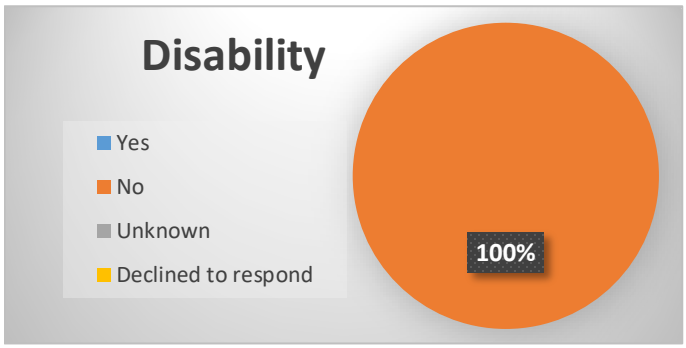
sonoma county DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

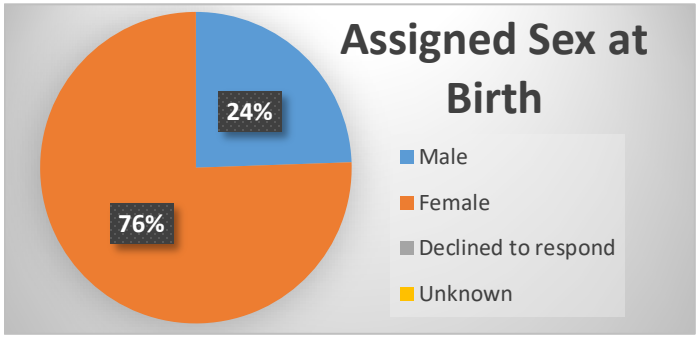
FY 2021-2022 Program Demographics:

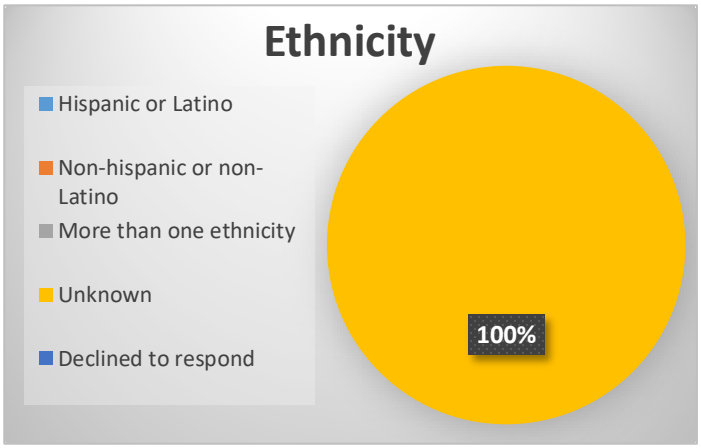


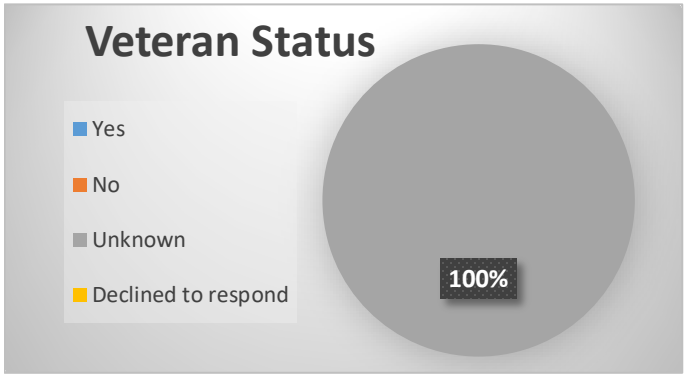


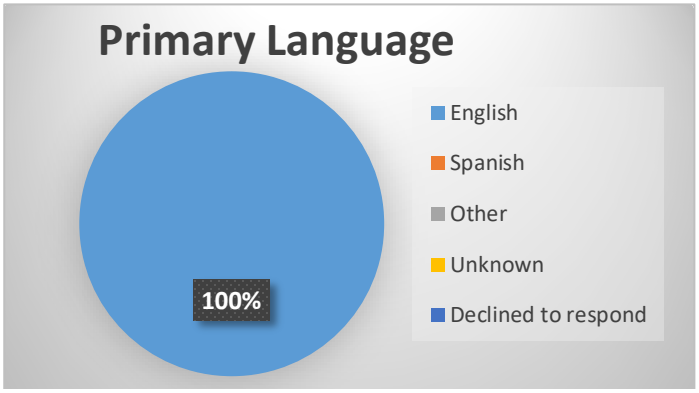


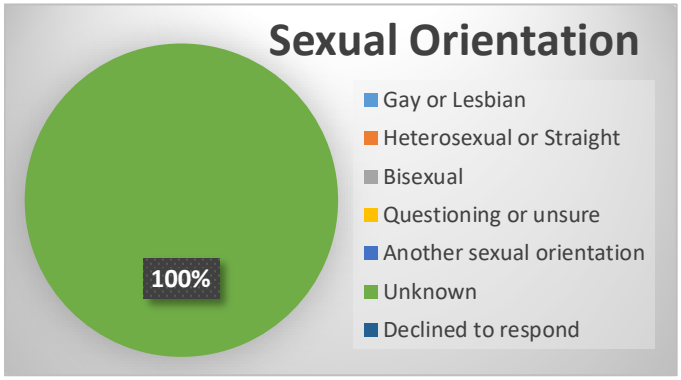












Sonoma County's Safe Spaces FOR MENTAL HEALTH

MHSA Component: Prevention and Early Intervention (PEI)

Sonoma County Human Services Older Adult Collaborative Program

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, homelessness, removal of children from their homes, and prolonged suffering.

"Empower, Support, Protect"
Human Services Department
COUNTY OF SONOMA

council on aging
living better, together.

PETALUMA PEOPLE SERVICES CENTER

WEST COUNTY COMMUNITY SERVICES

PROGRAM IMFORMATION

Program Name:

Sonoma County Human Services: OLDER ADULT COLLABORATIVE
Reducing Depression in Older Adults

Population served: Older Adults (60+)
Phone: (707) 565-6465
Program location:
Sonoma County, CA

FY 2021-2022 PERFORMANCE OUTCOMES

- **Total number of clients served:** 2926
- **Total number of encounters:** 6825
- **Approximate numbers reached through outreach:** 0

PROGRAM DESCRIPTION:

The **Older Adult Collaborative (OAC)** is a four-agency collaborative between Sonoma County Human Services Department (Adult & Aging Division), Council on Aging, Petaluma People Services Center, and West County Community Services.

These member agencies are the primary providers of older adult services in Sonoma County. The OAC initiative incorporates depression screening, education, and early intervention into existing older adult programming such as case management and nutrition programs. OAC utilizes the evidence-based depression intervention Healthy IDEAS (Identifying Depression & Empowering Activities for Seniors), while also referring clients to mental health services and community resources as needed.

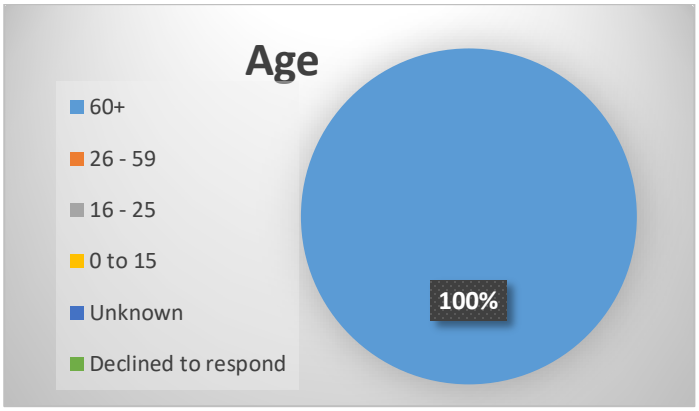
PERFORMANCE OUTCOMES & PROGRAM ACCOMPLISHMENTS:

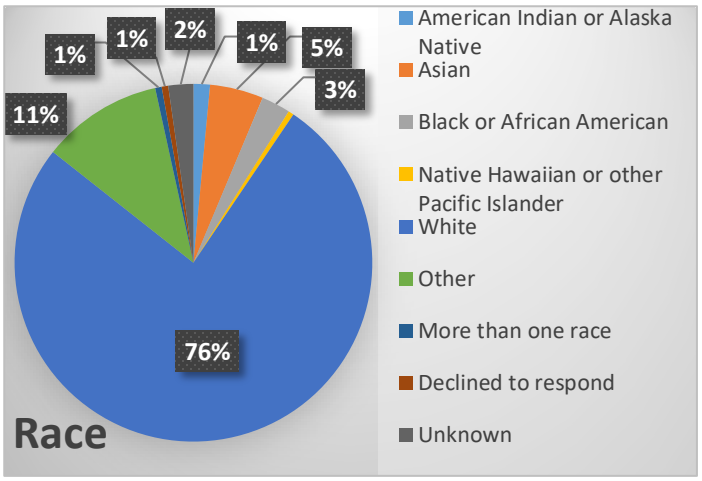
Improvement in depression symptoms: 262 older adults who participated in the OAC program in 2021-22 fiscal year showed improvement in depression symptoms (based on PHQ-9 scores).

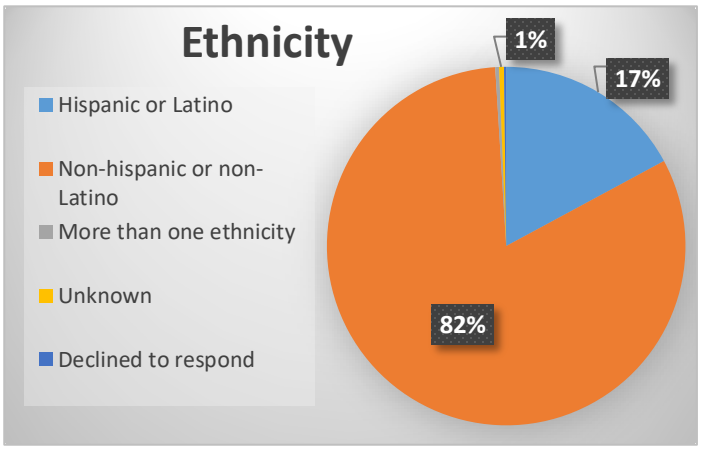
Other program highlights: OAC partner agencies cumulatively offered older adults **1600** referrals to additional community resources during the 2021-22 fiscal year. OAC partner agencies continued to refine their screening processes to gain more engagement, resulting in almost **20% increase in screenings** over the previous fiscal year.

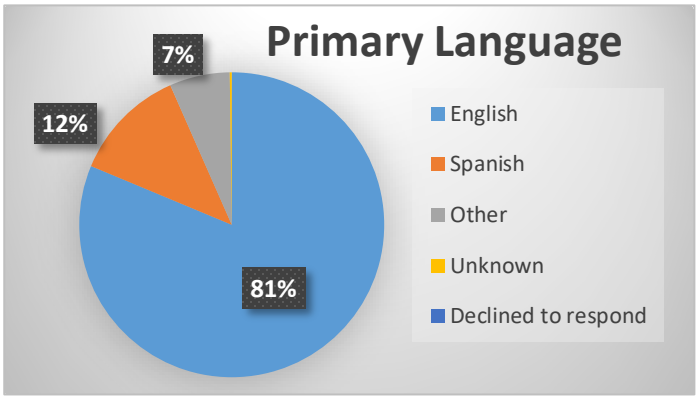
sonoma county DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

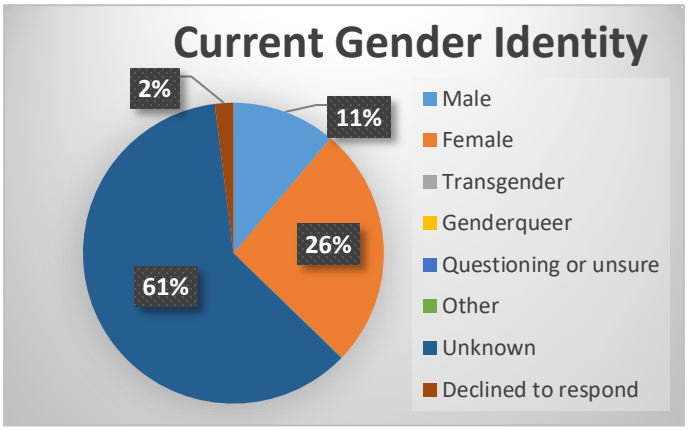
FY 2021-2022 Program Demographics:

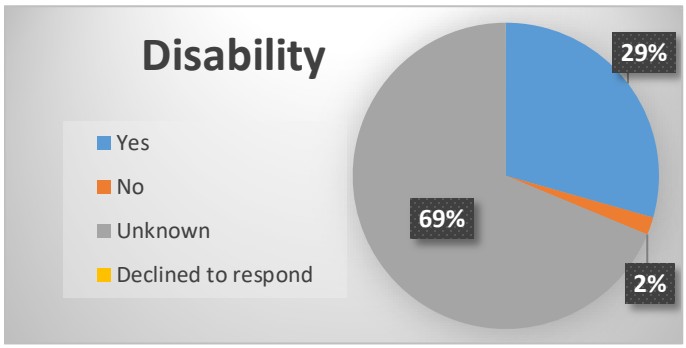


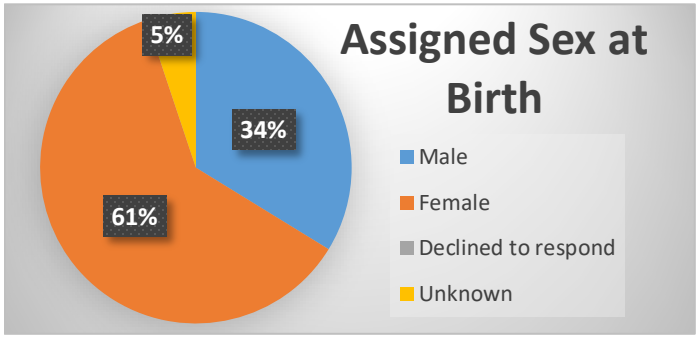


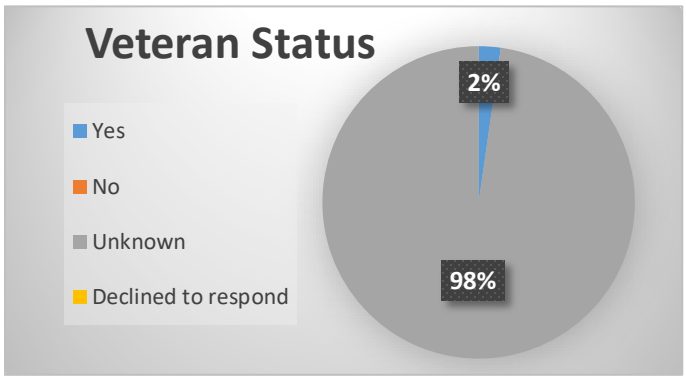


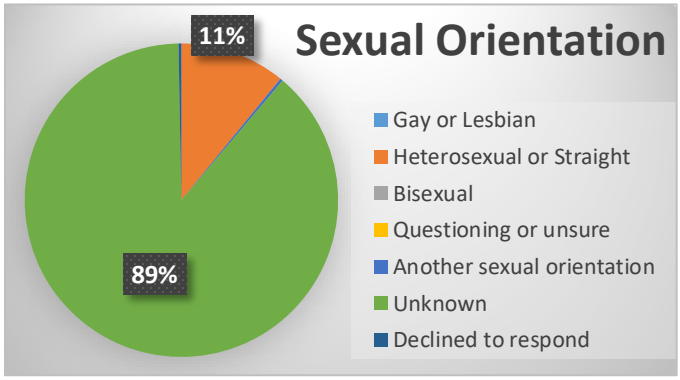












Prevention and Early Intervention (PEI)

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:

- Suicide Incarcerations
- School failure or dropout
- Unemployment
- Prolonged suffering
- Homelessness
- Removal of children from their homes

Early Intervention

A set Treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the applicable negative outcomes listed in Welfare and Institutions Code Section 5840, subdivision (d) that may result from untreated mental illness.

Sonoma County's Safe Spaces FOR MENTAL HEALTH

MHSA Component: Prevention and Early Intervention (PEI)

Child Parent Institute

FY 2021-2022 PEI Initiative: Early Intervention

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, homelessness, removal of children from their homes, and prolonged suffering.

PROGRAM INFORMATION

Program Name: Prevention Early Intervention
Population served: Families with children 0-5 in Sonoma County at risk for mental health issues.
Website: www.calparents.org
Phone: (707) 585-6108
Program location:
3650 Standish Ave. Santa Rosa, CA
Social Media:
Facebook | Instagram | LinkedIn
Twitter

FY 2021-2022 PROGRAM OUTCOMES

- **Total number of clients served:** 311
- **Total number of encounters:** 1,122
- **Approximate numbers reached through outreach:** 12,143

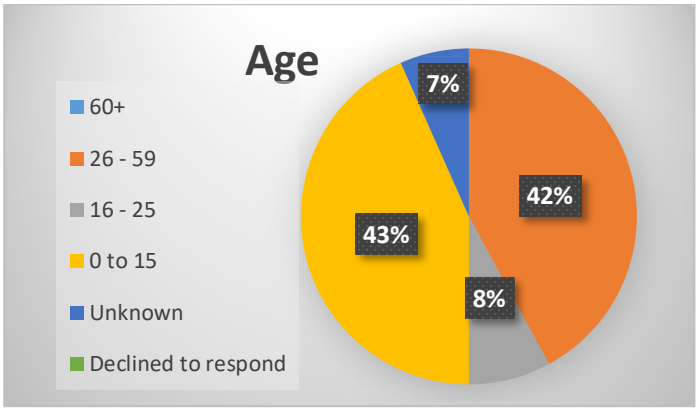
PROGRAM DESCRIPTION:

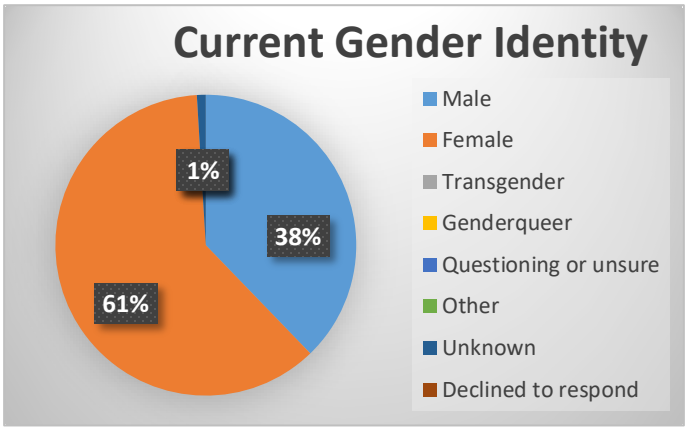
CPI's programs and services are trauma-informed, community-focused, evidence-based, and merited as best practice. We specialize in serving children and families from prenatal to age 5 in parent education and therapeutic supports. CPI's programs are dedicated to prevention and early intervention and are founded on the belief that with culturally-competent, strength-based services, families can successfully overcome many barriers associated with mental illness.

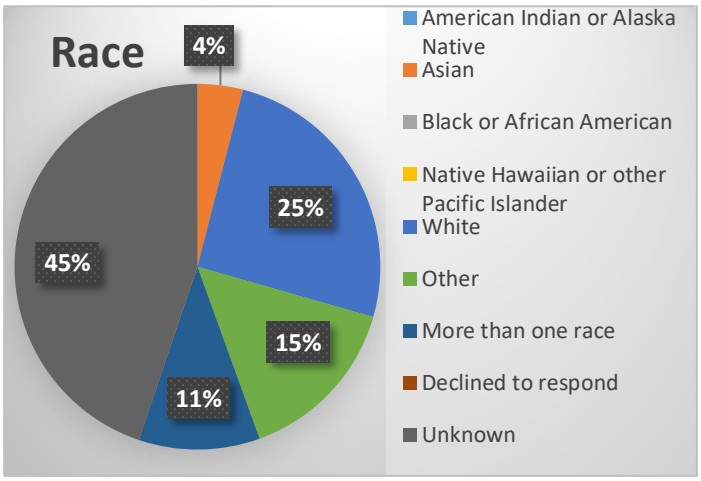
PERFORMANCE OUTCOMES & PROGRAM ACCOMPLISHMENTS:

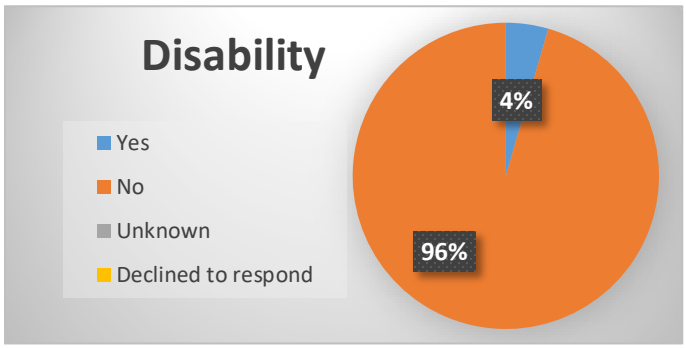
- 80% of CPI participants who completed services successfully reported feeling an increase in parent/caregiver confidence in parenting skills and an increase in parent knowledge of social, emotional and behavioral issues impacting young children.
- 100% of mothers who were previously at risk of or experiencing perinatal mood disorders and successfully completed the CPI counseling program, self-reported feeling that they had met their goals and/or were no longer bothered by symptoms of depression and anxiety.
- CPI Success Story from FY 21-22: CPI served parents through their in-home parenting education program whose communication difficulties created disparities in their parenting styles. Their three-year-old was starting to hit them and display tantrums. A Parent Educator met with them in their home to teach them positive parenting and child management skills. With practice, they were able to focus on their communication and their child's needs. Both Parents said that working with a parent educator helped them to communicate better with each other, and to understand their daughter's behavior and guide her instead of getting into fights over their different ways of handling behavior. Both parents made time to spend as a family and as they improved their communication they noticed their three-year old's tantrums decreased in number and intensity. These parents improved their ability to work together and reported feeling less stressed and more patient with one another and with their daughter.

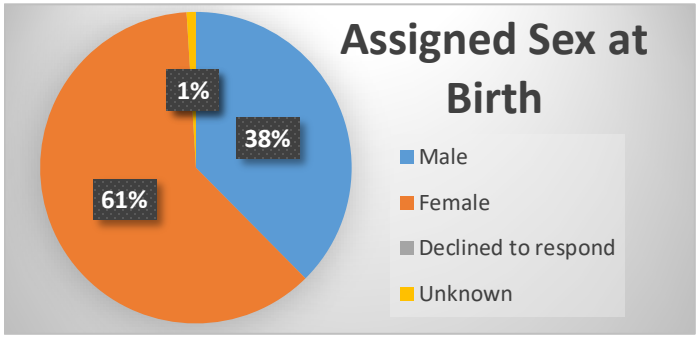
FY 2021-2022 Program Demographics:

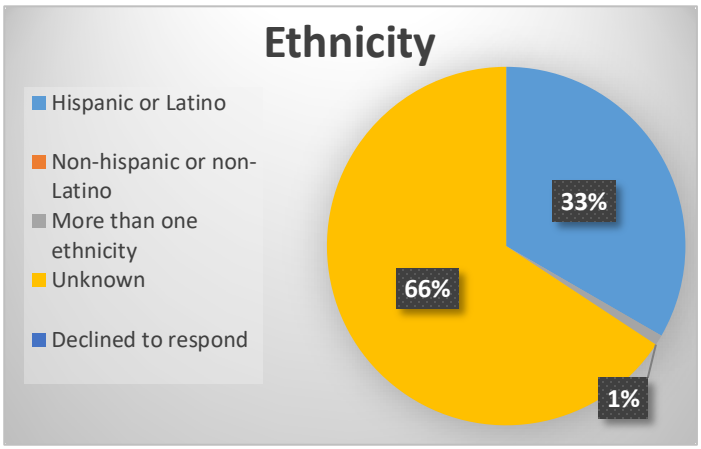


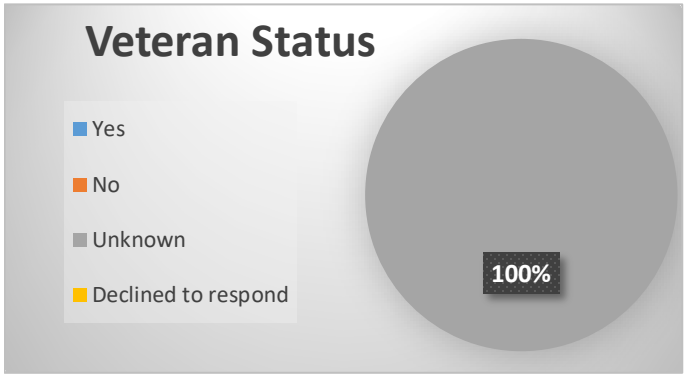


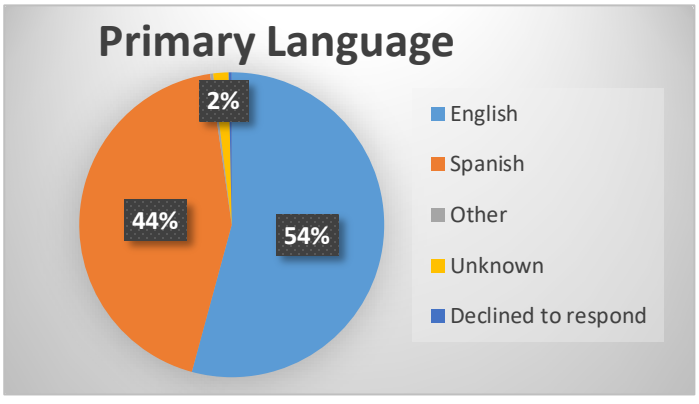


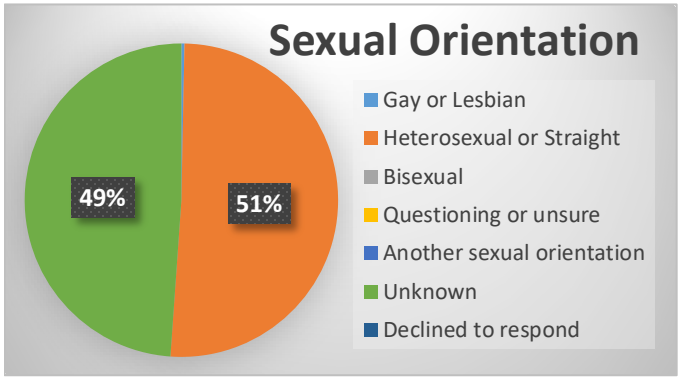












Sonoma County's Safe Spaces FOR MENTAL HEALTH

MHSA Component: Prevention and Early Intervention (PEI)

Early Learning Institute (ELI)'s Watch Me Grow Program

eli early learning institute

*FY 2021-2022 **PEI Initiative:** Early Intervention*

The Watch Me Grow (WMG) program provides social and developmental screenings to children in Sonoma County from 2 through age 5 and not yet in Kindergarten. WMG staff connects families to services in the community, and will make referrals to mental health or developmental services as needed to assist the family.

PROGRAM IMFORMATION

Program Name: Watch Me Grow
Population served: Children birth to 5 in Sonoma County
Website: www.earlylearninginstitute.org
Phone: (707)591-0170
Program location:
311 Professional Center Drive, Rohnert Park, Ca 94928
Services are offered in home, virtually or at the ELI center, based on family preference.

PROGRAM DESCRIPTION:

Watch ME Grow is a unique program that provides social emotional and developmental screenings to young children in Sonoma County. WMG Staff makes referrals to mental health or developmental services as needed to assist the family. Parents learn valuable information about how to foster their child's social and developmental skills. Families learn about community programs, with referrals to services available when needed. Professionals are encouraged to call the WMG program if they have a concern about a child. This is a "One Stop Shop" for developmental and social-emotional concerns for young children in Sonoma County.

FY 2021-2022 PROGRAM STATISTICS

Total number of clients served: 1646 children and their families.

Total number of encounters: 1650

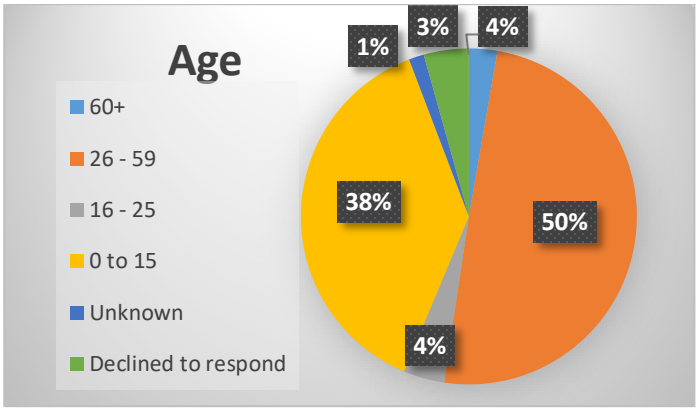
Approximate numbers reached through outreach: ELI Facebook page has over 3000 followers. Radio ads reached will over 50,000 families.

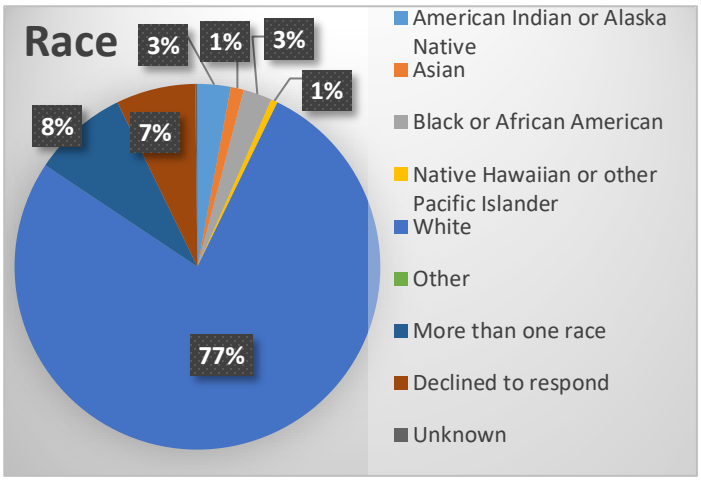
PERFORMANCE OUTCOMES & ACCOMPLISHMENTS:

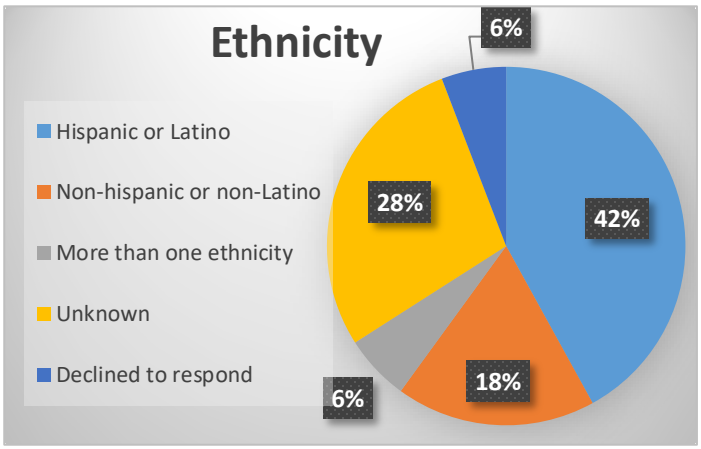
- In this fiscal year, ELI was able to complete 686 mental health and developmental screenings for Sonoma County children ages 2-5. This includes children in Foster care placement, an enormously vulnerable population.
- 864 children and their families have received Navigation services, referral support and/or case management, including follow up support for all online screenings.
- More than ever before, parents seem eager to have the human connection that comes with in-person services and WMG has been there for them. 77% of parents served report improved knowledge of early childhood mental health milestones.
- WMG received the following comments from parents screened:
  - "I haven't felt like anyone truly understood my child until this screening. Up till now, people have only assessed him via video visits and they did not seem to see the same things we see. You have taken the time to come and actually interact with him and get to see him as we do."
  - "The other people who tried to help us, just gave us new numbers to call. We have called 3 different agencies and you are the first agency to take our referral."

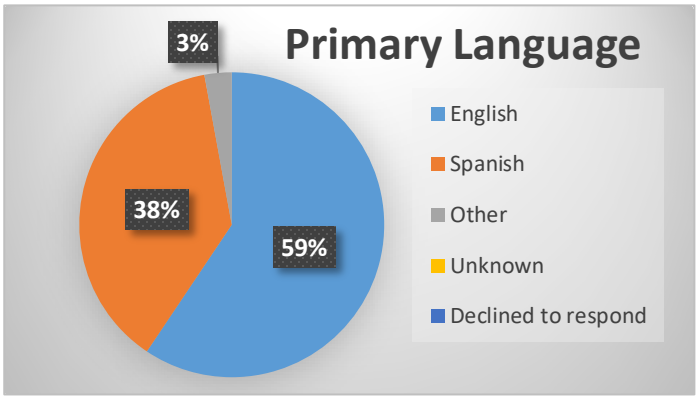
Sonoma county DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

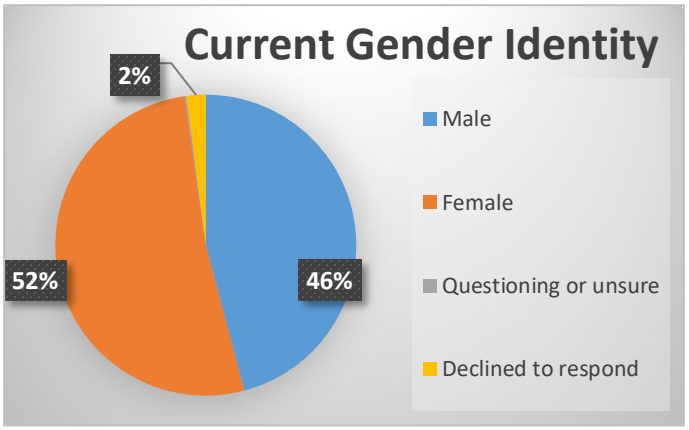
FY 2021-2022 Program Demographics:

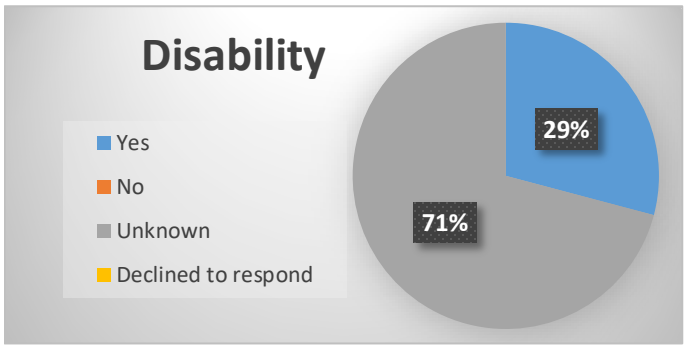


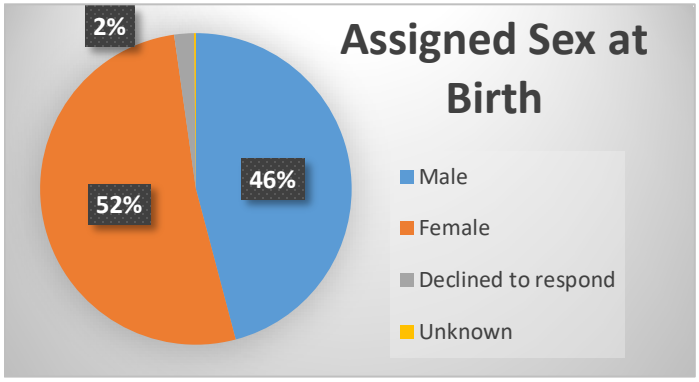


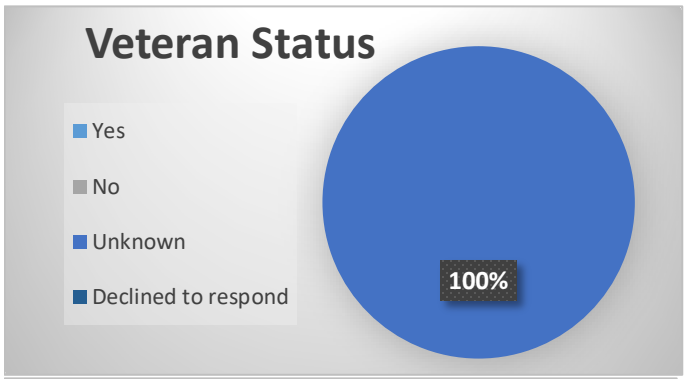


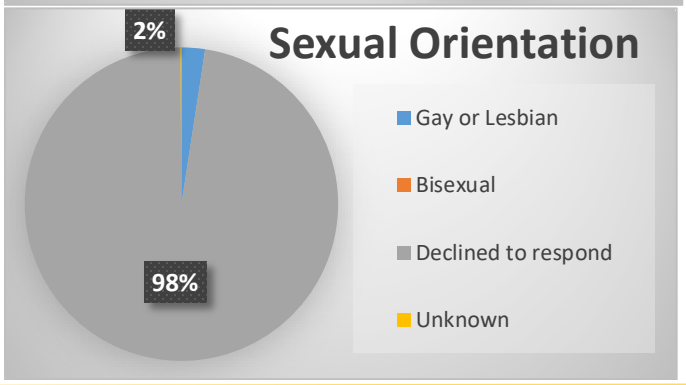












Prevention and Early Intervention (PEI)

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:

- Suicide Incarcerations
- School failure or dropout
- Unemployment
- Prolonged suffering
- Homelessness
- Removal of children from their homes

Prevention & Early Intervention

A set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. The goal of this Program is to bring about mental health including reduction of the applicable negative outcomes listed in Welfare and Institutions Code Section 5840, subdivision (d) as a result of untreated mental illness for individuals and members of groups or populations whose risk of developing a serious mental illness is greater than average and, as applicable, their parents, caregivers, and other family members.

A set Treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the applicable negative outcomes listed in Welfare and Institutions Code Section 5840, subdivision (d) that may result from untreated mental illness.

Sonoma County's Safe Spaces FOR MENTAL HEALTH

MHSA Component: Prevention and Early Intervention (PEI)

La Luz Center's Your Health/ *Tu Comunidad, Tu Salud* Program

LA LUZ Strengthening Community

FY 2021-2022 **PEI Initiative:** *Prevention & Early Intervention*

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, homelessness, removal of children from their homes, and prolonged suffering.

PROGRAM DESCRIPTION:

La Luz Center's Your Community, Your Health/Tu Comunidad, Tu Salud addresses the mental health needs of the Sonoma Valley Latino community by working to reduce risk factors for developing a potentially serious mental illness, build protective factors and improve timely access to mental health services.

With the assistance of our community health workers, known as Promotoras, we share valuable resources and information regarding mental health in a culturally sensitive manner, in addition to referring the community to our internal wellness programming classes and to our trusted partners for 1:1 and group therapy. Our program is designed to prevent the onset of stress, anxiety, and depression through education and wrap-around model. For support and the latest free classes or workshops please call 707-938-5131.

PERFORMANCE OUTCOMES & PROGRAM ACCOMPLISHMENTS

- 87% of Your Health/*Tu Comunidad, Tu Salud* program participants reported increased confidence in their ability to manage their stress
- 100% of *Luchadoras* reported knowledge of mental health issues and ways to connect community members to the *Tu Salud* program.
- 32% of individuals reached by *Luchadoras* received assistance and/or referrals to services.
- In FY 21-22, La Luz helped train 10 *Luchadoras* to increase their knowledge of mental health and knowledge of ways to connect community members to *Tu Salud.*
- 61 % of clients attended 4+ wellness classes in a quarter.

PROGRAM IMFORMATION

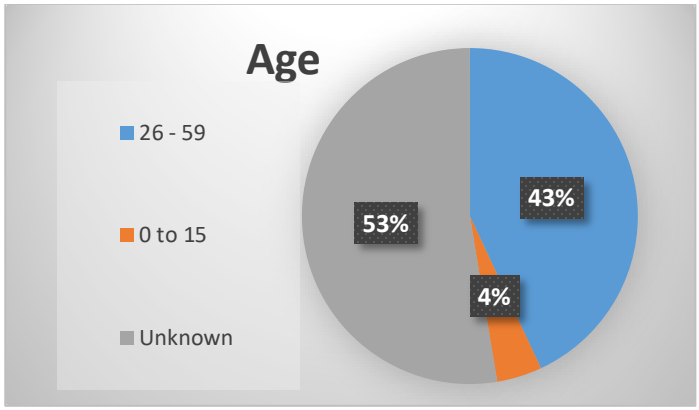
Program Name:
Your community, Your Health / *Tu Comunidad, Tu Salud*
Population served:
Latinos and low-income individuals and families
Website:
www.laluzcenter.org
Phone:
(707) 938-5131
Program location:
17560 Greger St.
Sonoma, CA 95476
Social Media:
@Laluzcenter

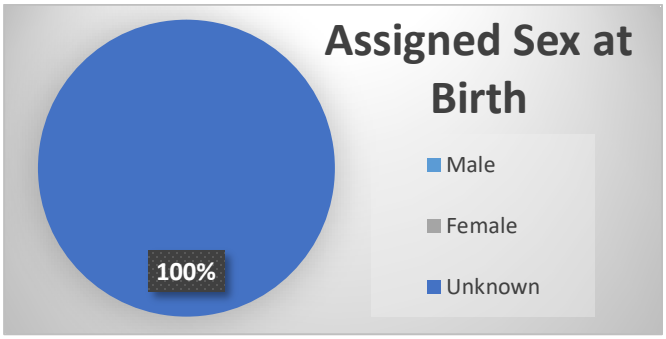
FY 2021-2022 PERFORMANCE OUTCOMES:

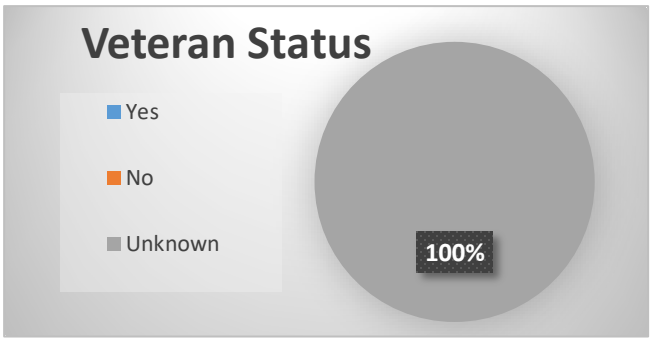
460 Total number of clients served
3,199 Community members reached via Promotora's outreach
72 Unique wellness class participants

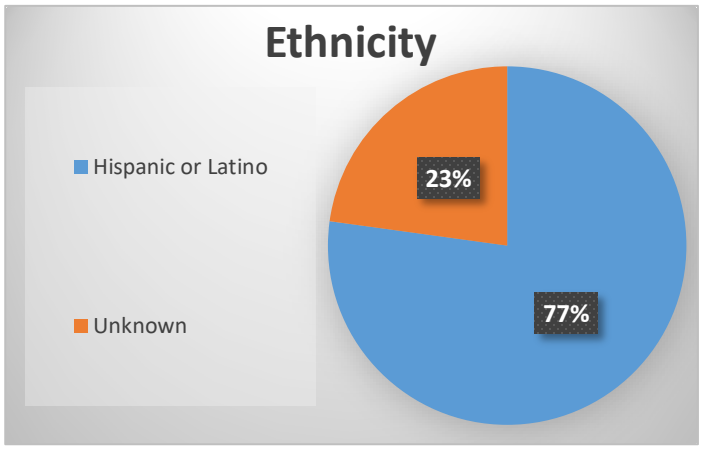
Weekly drop-in Spanish Wellness classes
Yoga: Wednesday 5pm
Zumba: Mon, Tue, Thu 6pm
HIIT Fitness: Friday 5:30pm

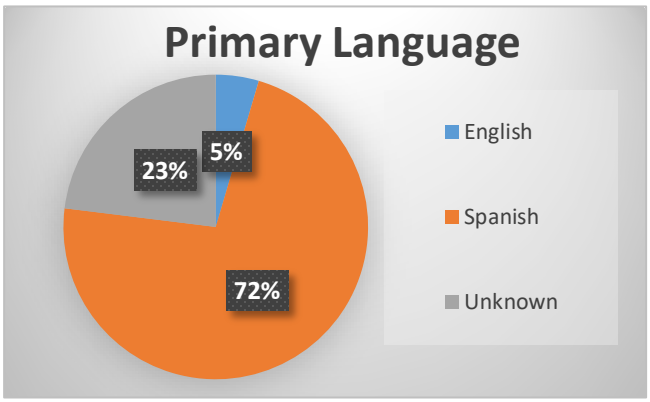
FY 2021-2022 Program Demographics:

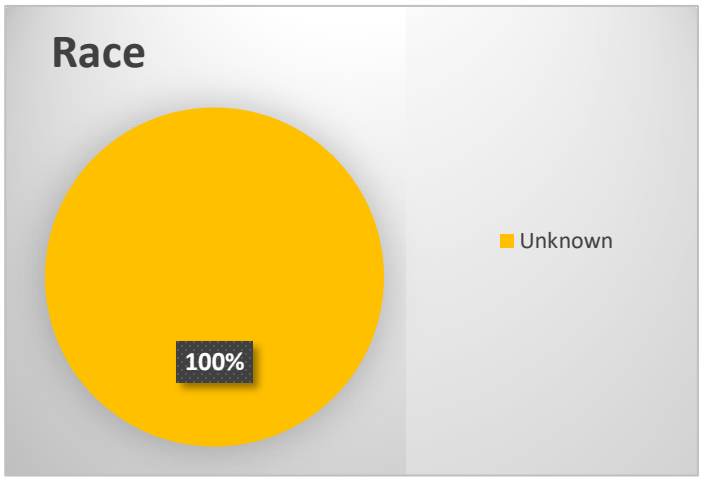


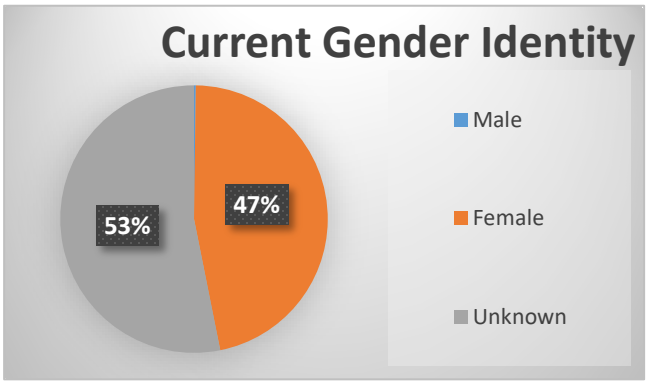


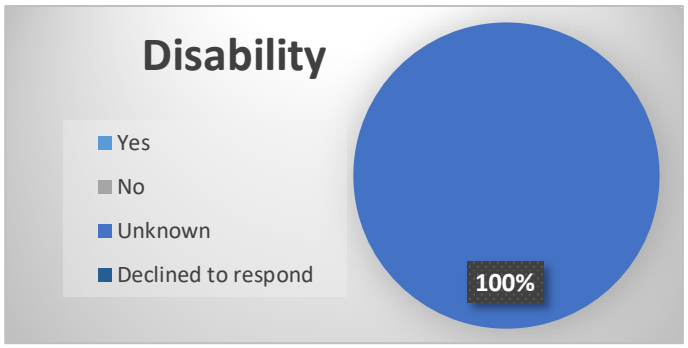


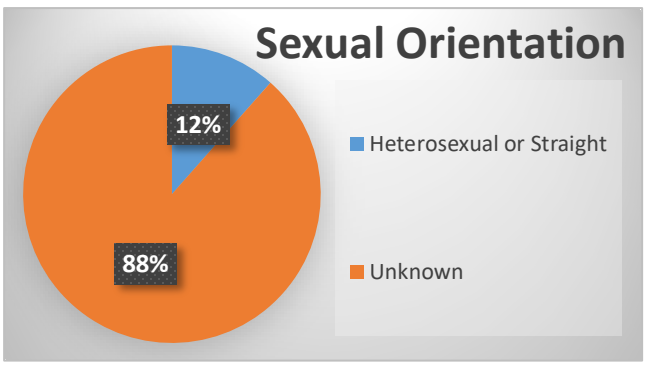












Sonoma County's Safe Spaces FOR MENTAL HEALTH

MHSA Component: Prevention and Early Intervention (PEI)

Latino Service Providers

LATINO Service Providers

FY 2021-2022 PEI Initiative: Prevention & Early Intervention

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, homelessness, removal of children from their homes, and prolonged suffering.

PROGRAM IMFORMATION

Program Name: Latino Service Providers
Population served: Latinx population and allies in Sonoma County.
Website: www.latinoserviceproviders.org
Phone: (707) 837-9577
Program location: 1000 Apollo Way Suite #185, Santa Rosa, CA 95407
Social Media: @LatinoServiceProviders @LSPyouthpromotres

PROGRAM DESCRIPTION:

Latino Services Providers (LSP) is a community-based non-profit network organization whose mission is to be a bridge across generations for the Latinx community focusing on health, culture, and social issues. We do this by: developing young leaders; building awareness and connections to community services; and advocating for equity across race and ethnicity.

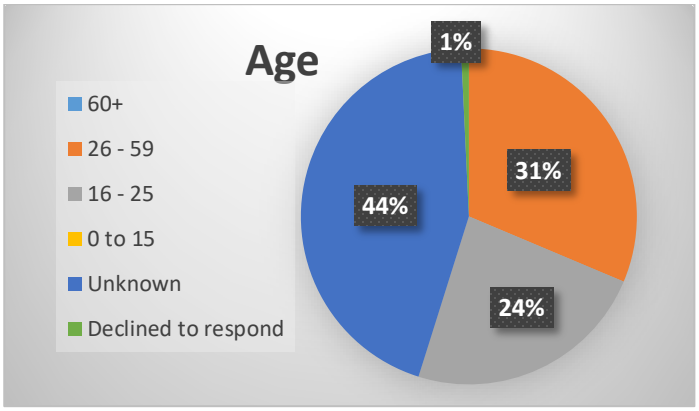
FY 2021-2022 PROGRAM OUTCOMES:

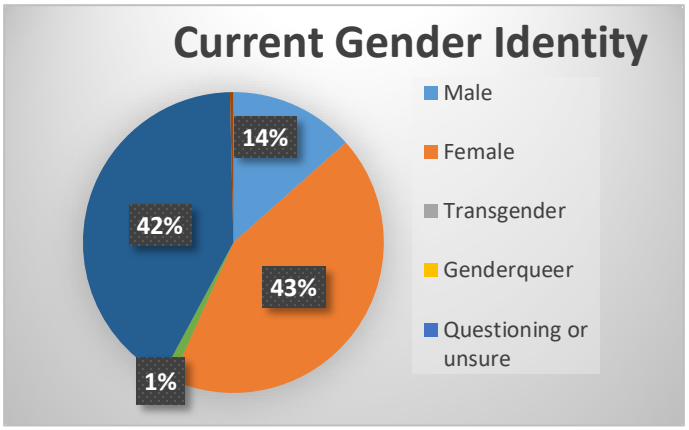
- **Total number of clients served:** 268
- **Total number of encounters:** 22,876
- **Approximate numbers reached through outreach:** 7,500

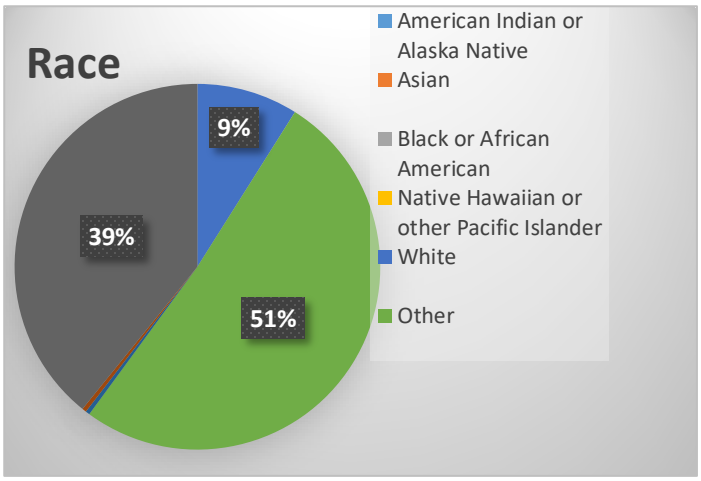
PERFORMANCE OUTCOMES & ACCOMPLISHMENTS:

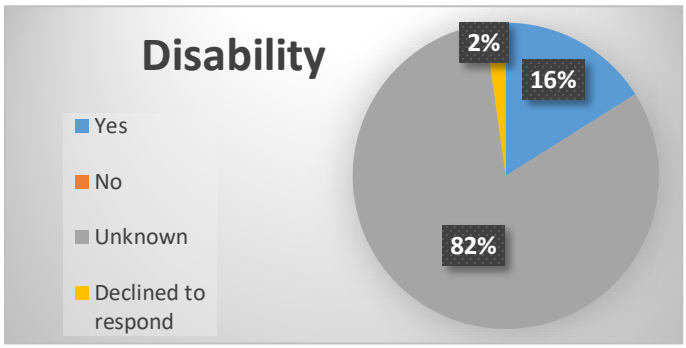
During the 2021-2022 fiscal year, Latino Service Providers experienced a change in leadership and employee development. Latino Service Providers hired a total of four additional hires, two of which were hired to support the Youth Promotor internship program and the other two to support the Community Engagement team. COVID-19 continued to heavily affect our communities which led staff to find creative ways to support the community at large alongside trusted community partners. Latino Service Providers hosted a total of 10 virtual monthly meetings that reached 268 attendees. To equitably share more resources, LSP disseminated 51 bilingual newsletters and attended over 40 community events. LSP approximately served 150 people at Stomp the Stigma, an annual event led by Latino Service Providers in collaboration with LSP Youth Promotores (YP) and several Sonoma County mental health service organizations. The goal of this event is to promote mental health awareness, resources, and an opportunity to practice self-care. Aside from the work being done through MHSA, LSP has had the opportunity to grow the Youth Promotor program to a total of 47 students who are working towards destigmatizing mental health in their communities through different avenues such as advocating for equitable housing, learning, and educating the community about environmental education, and the importance of emergency preparedness. The goal of the Youth Promotor Internship Program is to meaningfully engage the Latinx community on issues that impact health outcomes in Sonoma County and inspire the future community health workforce. YP frequently engage with the Latinx community, offer resources and information in Spanish and English, and are culturally responsive. At the end of the YP program, 60% reported to be very knowledgeable and 37% said they were moderately knowledgeable about mental health. This is significant compared to only 5% at the beginning who said they were very knowledgeable and 35% said they were moderately knowledgeable.

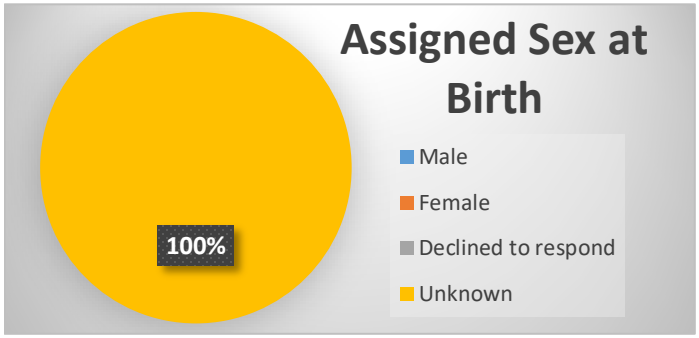
FY 2021-2022 Program Demographics:

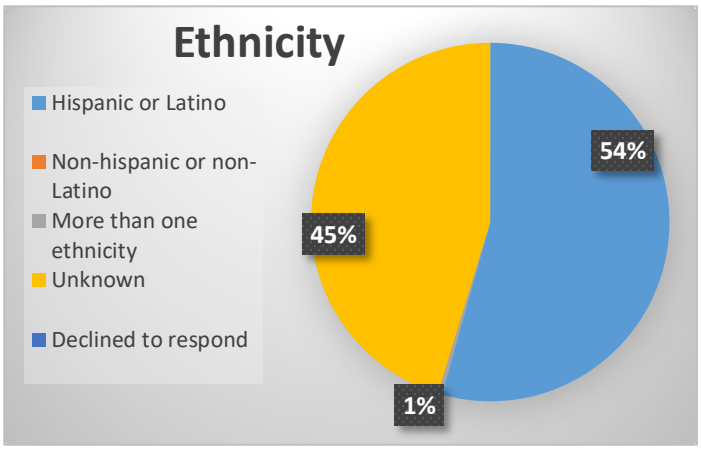


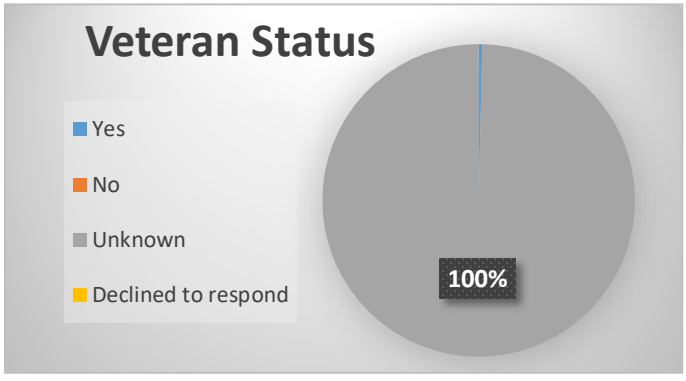


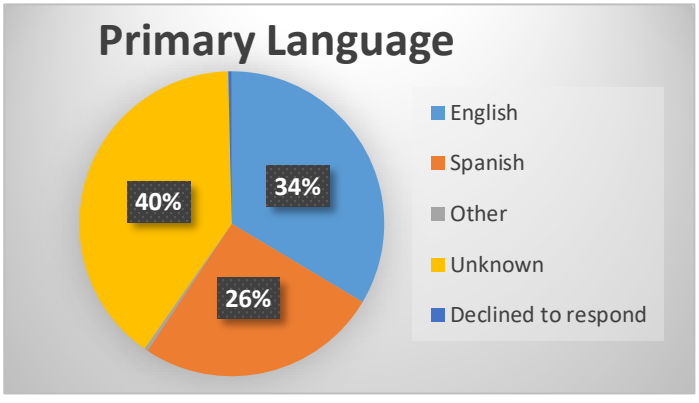


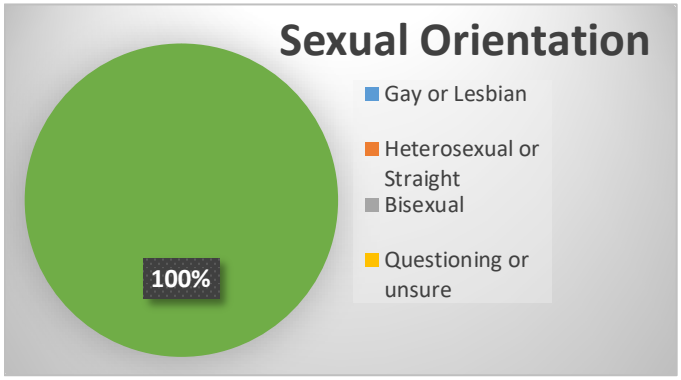












Sonoma County's Safe Spaces FOR MENTAL HEALTH

MHSA Component: Prevention and Early Intervention (PEI)

Positive Images

POSITIVE IMAGES

FY 2021-2022 PEI Initiative: Prevention & Early Intervention

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, homelessness, removal of children from their homes, and prolonged suffering.

FY 2021-2022 PROGRAM OUTCOMES

- **Total number of clients served:** 196
- **Total number of encounters:** 1,001
- **Approximate numbers reached through outreach:** 9,244

PROGRAM IMFORMATION

Program Name: Positive Images
Population served: LGBTQIA+ Community
Website: www.posimages.org
Phone: (707) 568-5830
Program location:
200 Montgomery Drive, Suite C
Santa Rosa, CA, 95404
Social Media:
Instagram: @positiveimages
Facebook: PosImages

PROGRAM DESCRIPTION:

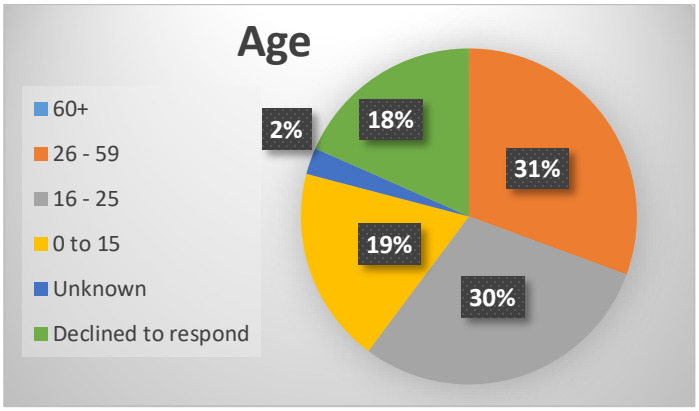
Positive Images (PI) is a LGBTQIA+ community center that provides support to Sonoma County's LGBTQIA+ population, with an emphasis on identities and individuals at the margins. We envision a Sonoma County where all LGBTQIA+ people are valued, compassionate community members, building a just and equitable society. Through Peer-Run Mental Health Support Groups, a Leadership Development Program, LGBTQIA+ Cultural Competency Trainings, Resources and Referrals to affirming behavioral health resources, and Community Outreach and Engagement Activities, our programs are designed to reduce risk factors for developing a serious mental illness, build protective factors, as well as address and promote recovery.

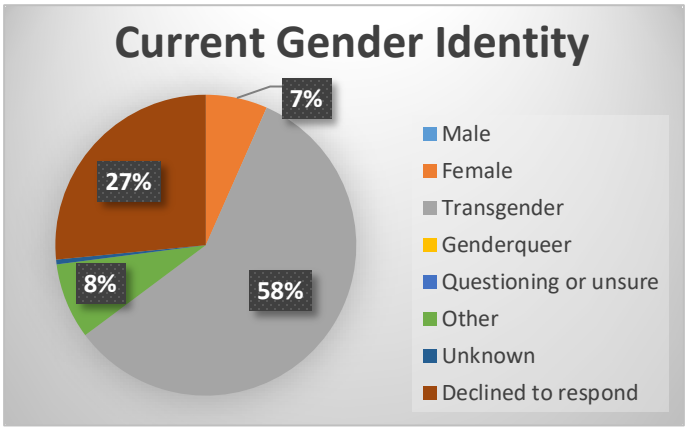
PERFORMANCE OUTCOMES & PROGRAM ACCOMPLISHMENTS:

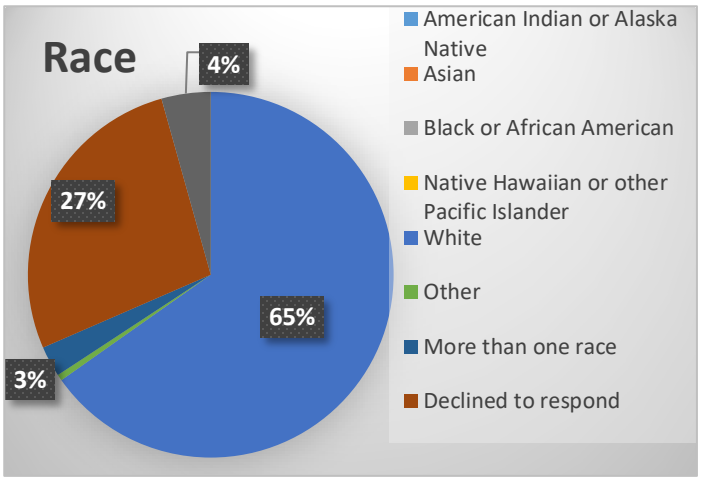
Since Positive Images was established in 1990, we have been a cornerstone in our county, providing a safe, affirming, and welcoming space for the historically and systemically underserved and underrepresented LGBTQIA+ community. Over the last three decades, PI has served thousands of community members and has been instrumental in building, developing, and nurturing a strong and resilient local LGBTQIA+ community.

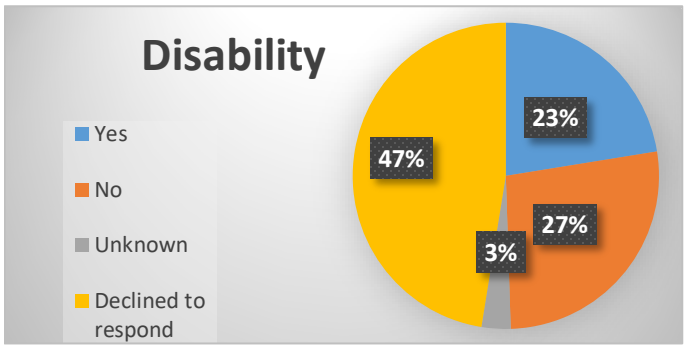
- In the 2021-2022 Fiscal Year, our MHSA programs hosted 95 Peer-Run Mental Health Support Groups and 94 Leadership Development sessions, delivered 21 hours of Cultural Competency Trainings, and participated in 13 Outreach Events.
- 100% of Individuals who participated in our programs consistently report increased feelings of connectedness, life satisfaction, self-acceptance, self-esteem, and self-advocacy.
- The following are quotes from participants in 2021-2022:
  "I feel super lucky to have found such an incredible group of amazing people who make me feel loved, supported, and a little less alone."
  "As a parent of a transgender child, I value your efforts in educating parents, schools, children, and administrators, and helping to create (hopefully) a more accepting world."

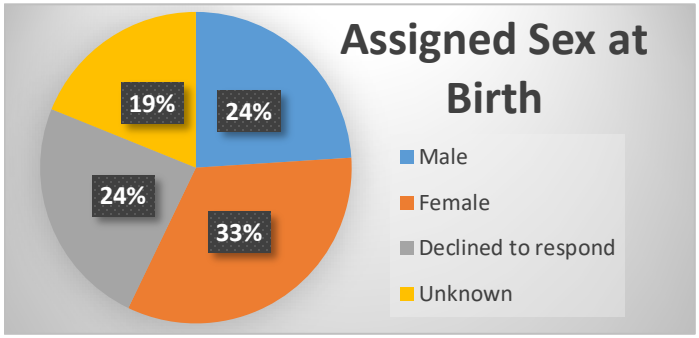
FY 2021-2022 Program Demographics:

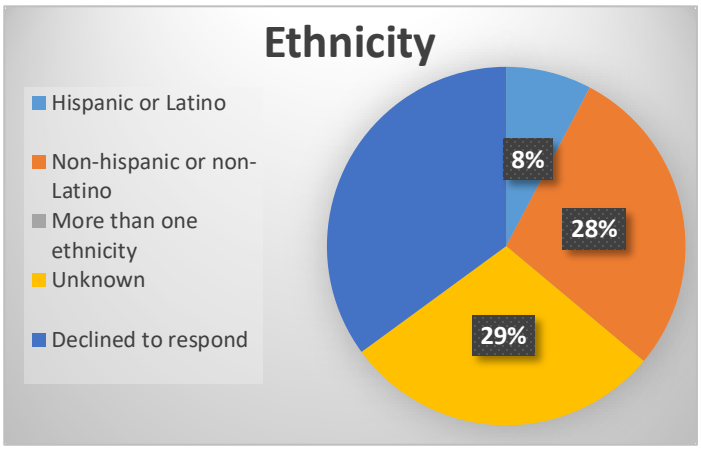


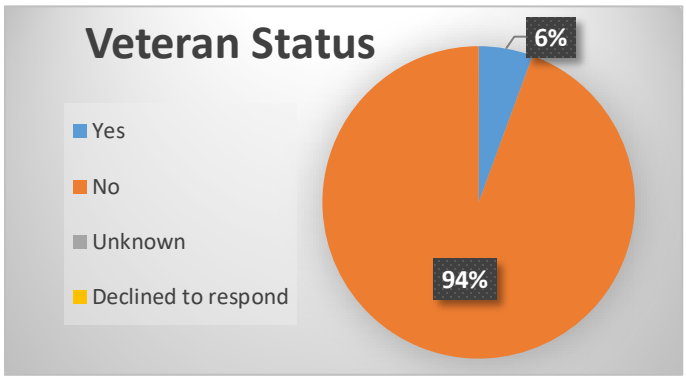


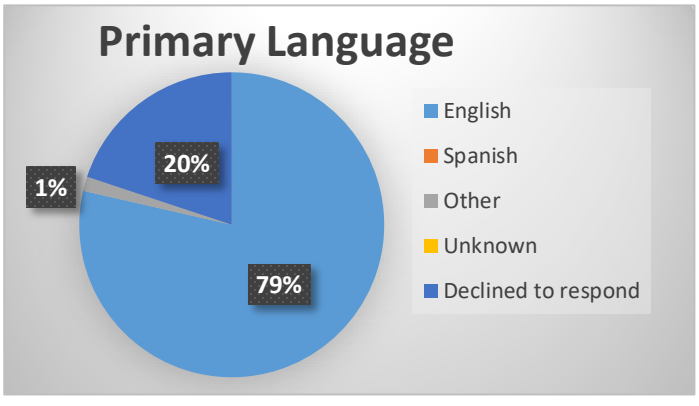


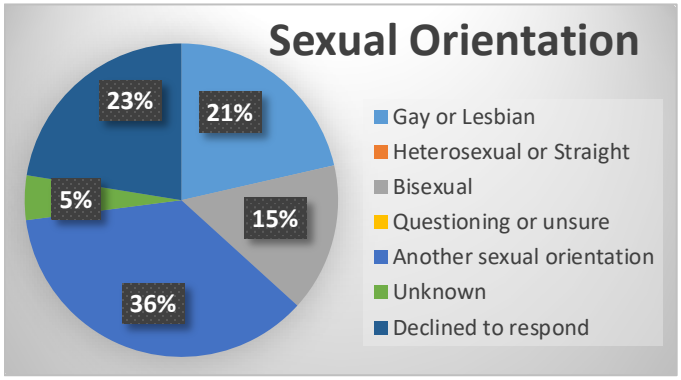












Prevention and Early Intervention (PEI)

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:

- Suicide Incarcerations
- School failure or dropout
- Unemployment
- Prolonged suffering
- Homelessness
- Removal of children from their homes

Stigma & Discrimination

The County's direct activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families.

Sonoma County's Safe Spaces FOR MENTAL HEALTH

MHSA Component: Prevention and Early Intervention (PEI)

Santa Rosa Junior College (SRJC) Student Health Services Mental Wellness Program

SRJC STUDENT HEALTH SERVICES PEERS COALITION

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, homelessness, removal of children from their homes, and prolonged suffering.

PROGRAM IMFORMATION

Program Name: SRJC Student Health Services, Mental Wellness Program

Population served: SRJC students of all ages with mental health concerns.

Website: shs.santarosa.edu

Phone:

Santa Rosa	(707) 527-4445
Petaluma	(707) 778-3919

Program location:

Santa Rosa	1501 Mendocino Ave. Santa Rosa, CA 95401
Petaluma	680 Sonoma Mountain Pkwy, Petaluma, CA 94954

Social Media:

@srjcpeers

@ Student Health PEERS at SRJC

PROGRAM DESCRIPTION:

The Mental Wellness Program at SRJC uses a comprehensive approach to promote mental health and reduce stigma on campus. Faculty trainings on recognizing and responding to students with mental health challenges, QPR suicide prevention workshops, mental health presentations in classrooms and orientations, PEER led workshops and drop-in groups, social media, online mental health screenings and outreach events are strategies used to ensure that the SRJC community knows that Mental Health Matters.

FY 2021-2022 PROGRAM OUTCOMES

Education # of students & staff	**103** Classroom and Club presentations **250** PEERS Workshops **115** QPR Training
Outreach	**444** online mental health screening **415** students contacted a Campus Events
Social Media # of followers	**1,160** PEERS Instagram **537** PEERS Facebook

PERFORMANCE OUTCOMES & ACCOMPLISHMENTS:

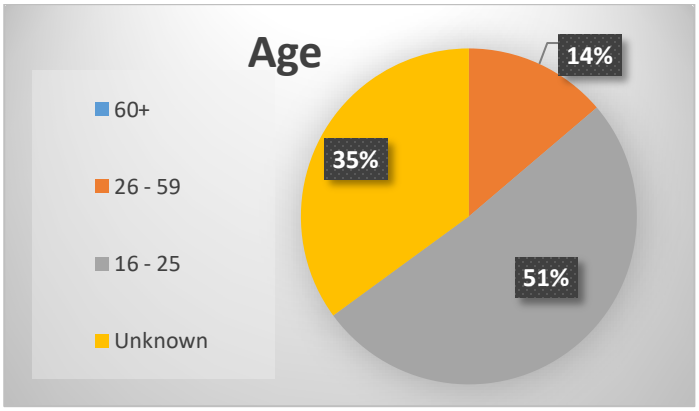
SRJC campuses were still very quiet during this year as most instruction was remote and services being offered online during the COVID pandemic.

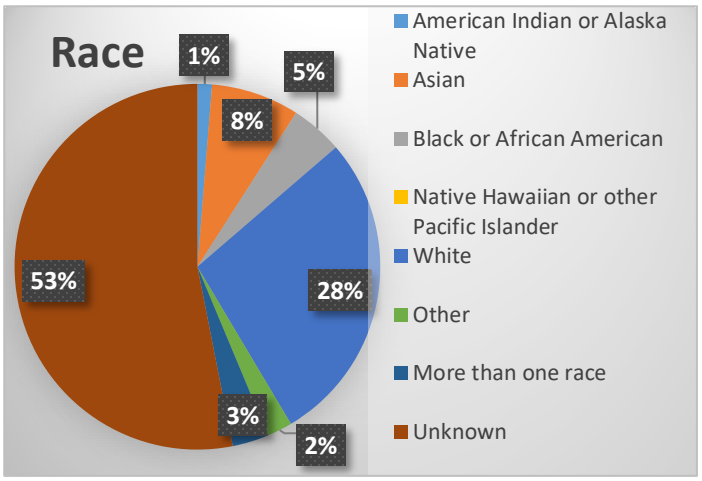
- The PEERS adapted to creating community online and offered Well-Being Wednesday drop-in groups twice a month for students to connect in a safe space.
- PEERS also collaborated with the Intercultural Center and Queer Resource Center to offer workshops via Zoom on a variety of mental health issues. Staff successfully adapted QPR and Mental Health First Aid Trainings to be offered via Zoom.
- As campus slowly opened up in the Spring, PEERS created the above pictured street mural on Earth Day which was on display for 6 months.
- PEERS worked with Latino Service Providers to host Stomp out the Stigma at SRJC in May 2022.

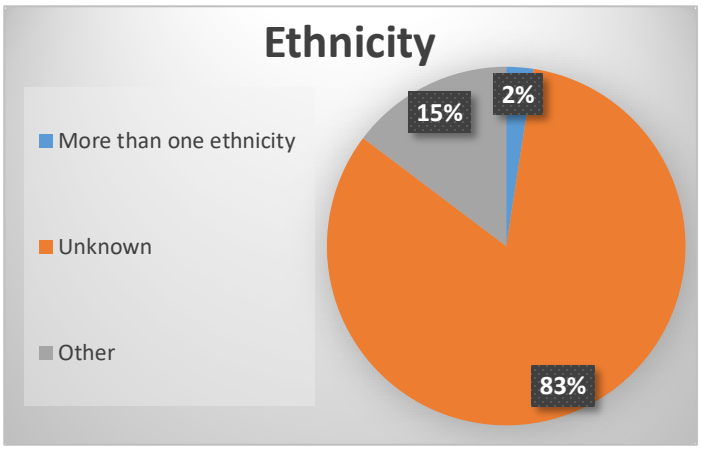
FY 2021-2022 PEI Initiative: Stigma & Discrimination Reduction

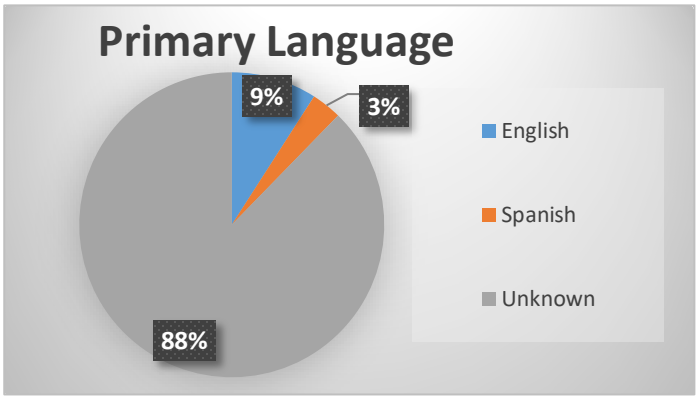
sonoma county DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

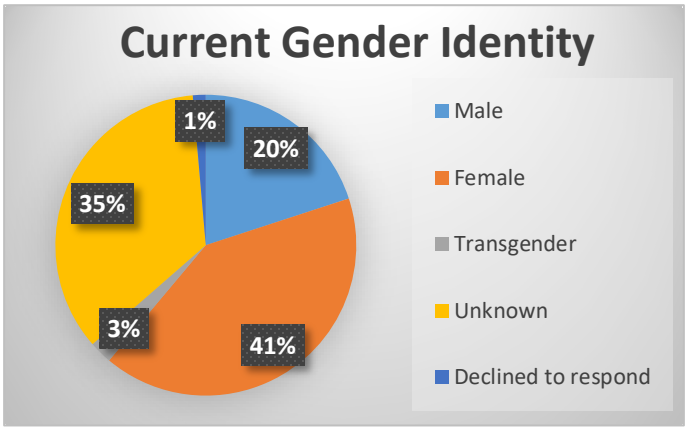
FY 2021-2022 Program Demographics:

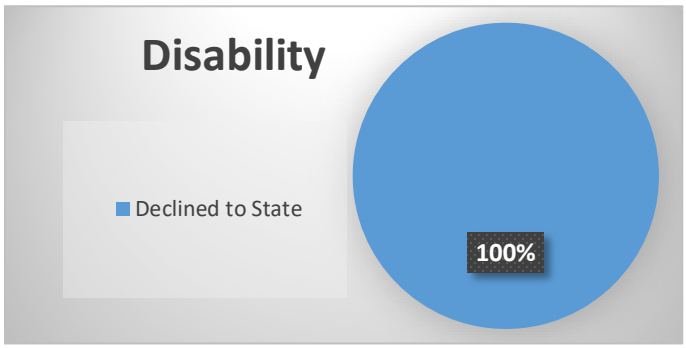


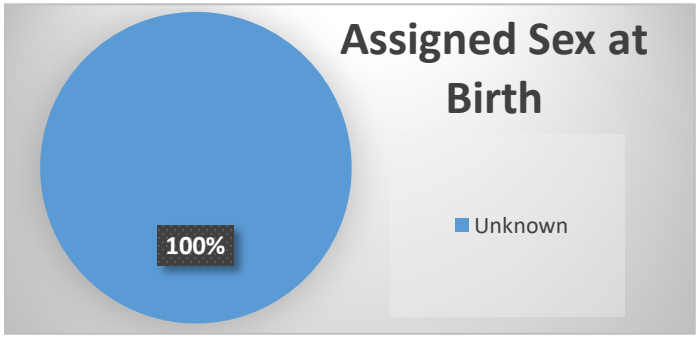


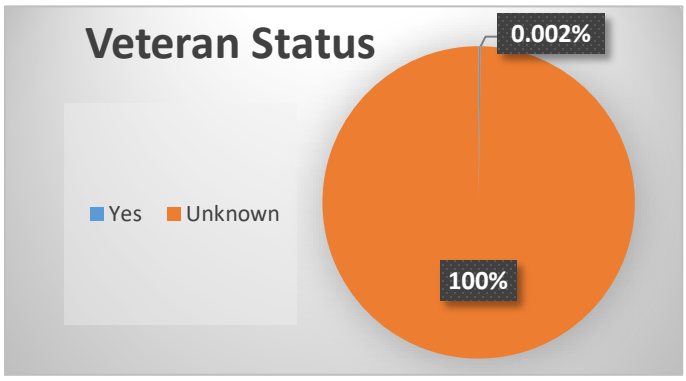


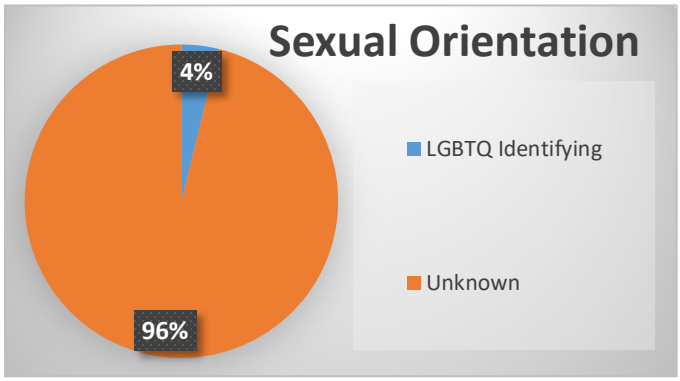












Prevention and Early Intervention (PEI)

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:

- Suicide Incarcerations
- School failure or dropout
- Unemployment
- Prolonged suffering
- Homelessness
- Removal of children from their homes

Access and Linkage

A set of related activities to connect children with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, and adults and seniors with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, as early in the onset of these conditions as practicable, to medically necessary care and treatment, including, but not limited to, care provided by county mental health programs.

Sonoma County's Safe Spaces FOR MENTAL HEALTH

MHSA Component: Prevention and Early Intervention (PEI)

DHS-BHD's Adult Access Team

Sonoma County DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

FY 2020-2021 PEI Initiative: Access and Linkage

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, homelessness, removal of children from their homes, and prolonged suffering.

PROGRAM DESCRIPTION & PROCESS:

Sonoma County - Behavioral Health Division's Adult Access Team is the first contact for anyone requesting mental health services. Anyone can self-present to the Access team and request services; this can be accomplished by calling or walking into the offices at 2225 Challenger Way. This process is outlined on the website. The Access Team is available 24 hours a day 7 days a week to answer any questions and to start the intake process.

Clients can also be referred to the Access Team as a step-up in care from any of the County's Federally Qualified Health Centers, or via discharge from a psychiatric hospital. DHS-BHD monitors all clients in psychiatric hospitals that are Sonoma County residents and are provided with an Access assessment within 7 business days of their hospital discharge.

An Access Team Screener determines the level of need for mental health services, coordinates an assessment appointment and links individuals with community resources. The Access assessment is a series of questions to help determine how a client is functioning in an array of areas in their life and how their ability to function is impaired by their mental health symptoms. The Adult Access Team uses the Adult Needs and Strengths Assessment (ANSA) to determine the level of services needed. The client is placed on a team based on this information. While the client waits to be placed with a long-term case manager and on a team, the Access Team provides light case management, which is mostly emergency based. This may involve getting a client into housing or doing crisis intervention.

A warm hand off between the Access clinician and the long-term clinician is provided to the client within 7 days after being placed on a team. All follow up services are provided by the new case manager once the client is on a team, this allows the Access Team to focus on providing assessments to other individuals who need services.

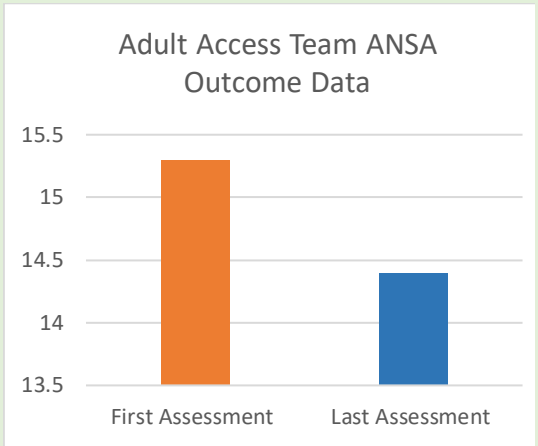
PROGRAM IMFORMATION

Program Name: Behavioral Health Division's Adult Access Team
Population served: Sonoma County residents 18 of age and over
Website: https://sonomacounty.ca.gov/health-and-human-services/health-services/divisions/behavioral-health/services/accessing-mental-health-services
Phone: (707) 565-6900 or (800) 870-8786
Program location:
2225 Challenger Way
Santa Rosa, CA 95407

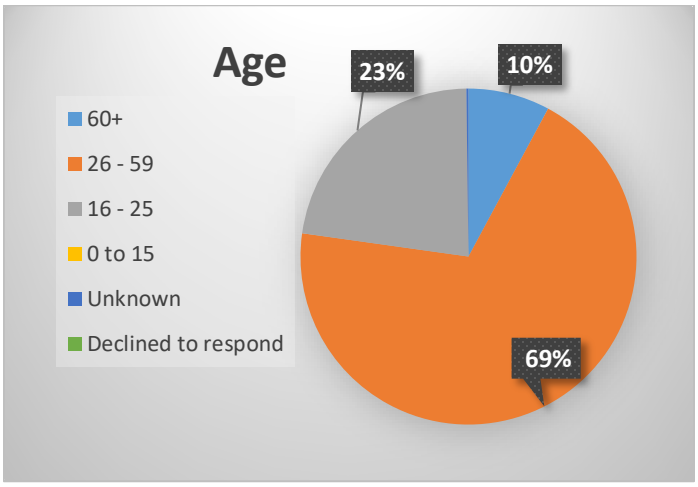
FY 2021 – 2022 PERFORMANCE OUTCOMES:

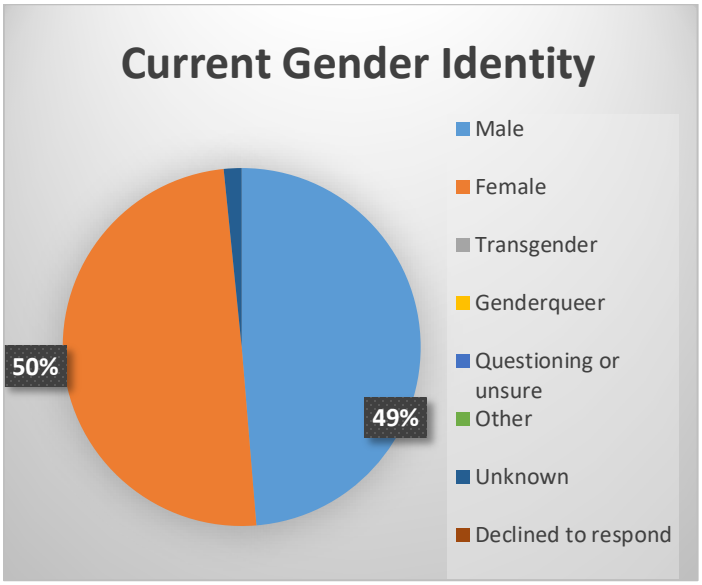
Total unique clients who received an assessment through the Adult Access Team in FY 21-22: **496**

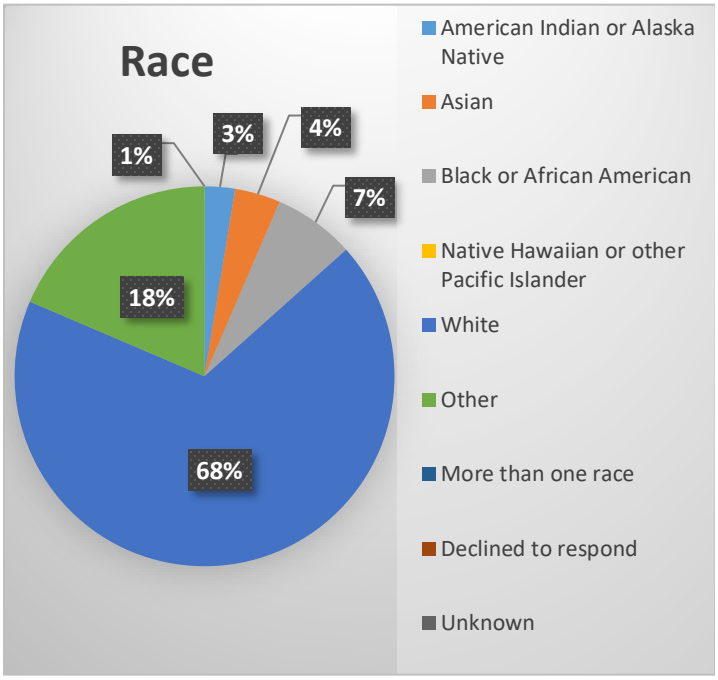
See pg.100 for an explanation of CANS/ANSA

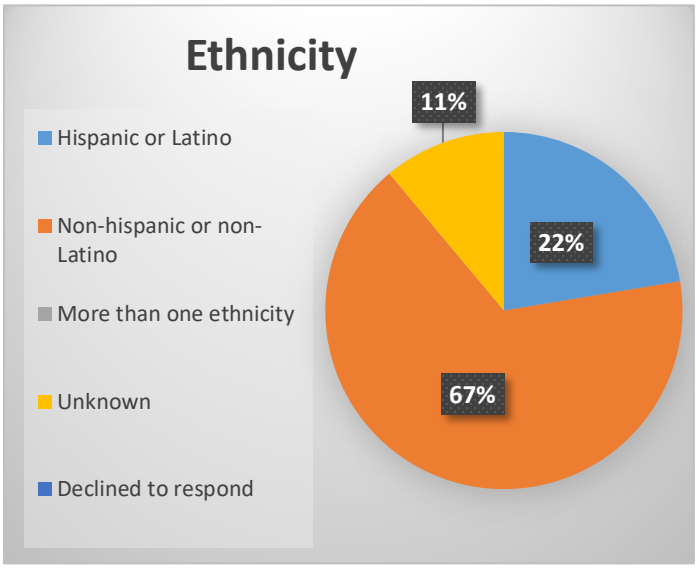


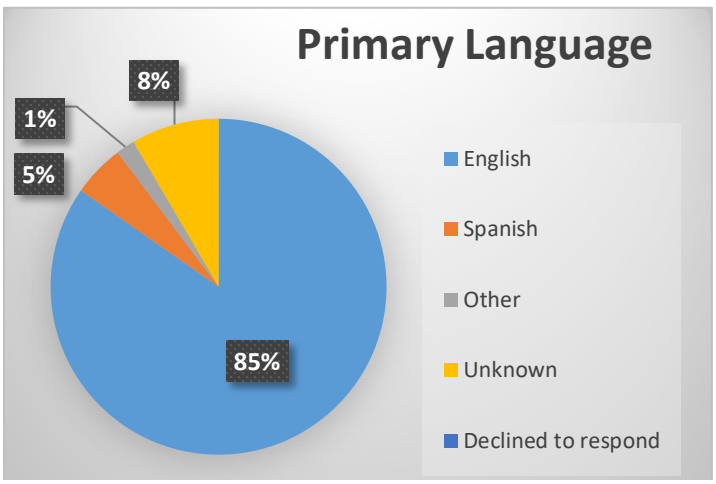
FY 2021-2022
Program Demographics:











Sonoma County's Safe Spaces FOR MENTAL HEALTH

MHSA Component: Prevention and Early Intervention (PEI)

DHS-BHD's Youth Access Team

Sonoma County DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

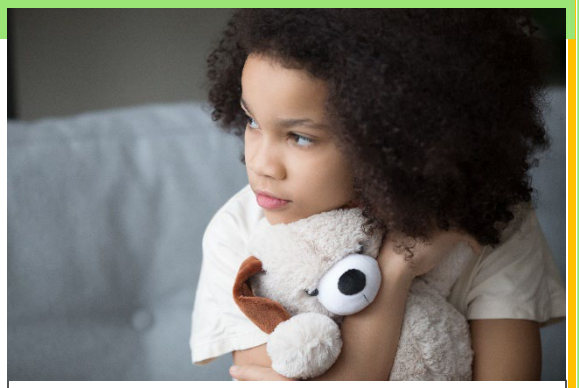
FY 2020-2021 PEI Initiative: Access and Linkage

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, homelessness, removal of children from their homes, and prolonged suffering.

PROGRAM DESCRIPTION & PROCESS:

Department of Health Services, Behavioral Health Division (DHS-BHD)'s Youth Access Team is the first contact for youth and families who are requesting mental health services. Referrals are primarily received through psychiatric hospitals and managed care providers, including Federally Qualified Health Centers (FQHC). Youth and families can request mental health services for themselves or a child by calling the Main Access line at 707-565-6900. DHS-BHD screening staff will provide a screening to determine if the individual will be assessed through DHS-BHD or their FQHC. The primary purpose of the initial screening is to determine where an individual will be assessed, and the assessment with a Youth Access clinician determines where they will receive treatment. Youth Access clinicians provide assessment, information about additional services, and referrals to mental health services for beneficiaries up to age 20.

DHS-BHD Youth and Family Services (YFS) uses the California CANS 50, which is a multi-purpose tool that supports decision making, including level of care and service planning. If an individual/family qualifies for Specialty Mental Health Services (SMHS), the individual/family will be connected to a YFS treatment team for mental health services. If the individual/family doesn't qualify for SMHS, the individual/family will be treated at the FQHC. Individual/families are encouraged to exercise choice and specify preferences, including service delivery language and gender of service provider. Case management services can be delivered by DHS-BHD Youth and Family Services staff or contracted Community-Based Organizations. Once the individual/family qualifies for SMHS, a DHS-BHD YFS provider will follow their case and coordinate care until discharged from services.

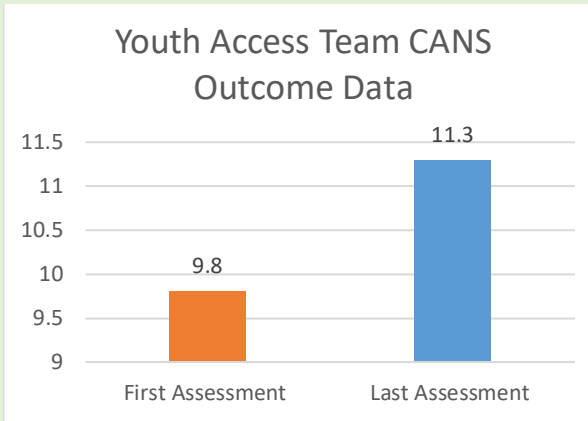


PROGRAM IMFORMATION

Program Name: Behavioral Health Division's Youth Access Team
Population served: Sonoma County residents 18 of age and over
Website: https://sonomacounty.ca.gov/health-and-human-services/health-services/divisions/behavioral-health/services/accessing-mental-health-services
Phone: (707) 565-6900 or (800) 870-8786
Program location:
2225 Challenger Way
Santa Rosa, CA 95407

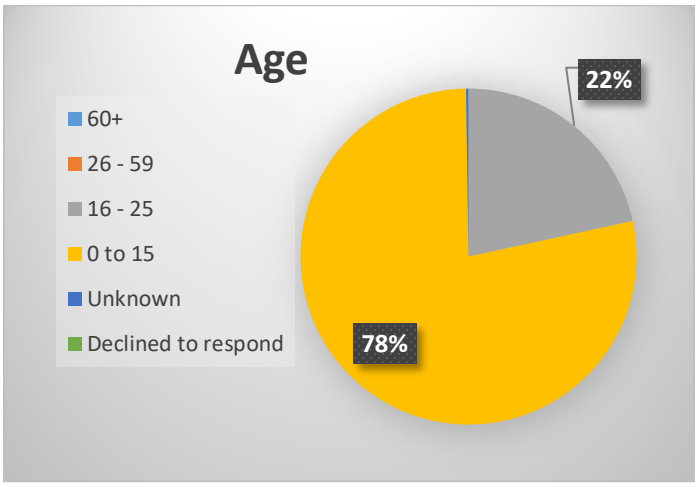
FY 2021 – 2022 PERFORMANCE OUTCOMES:

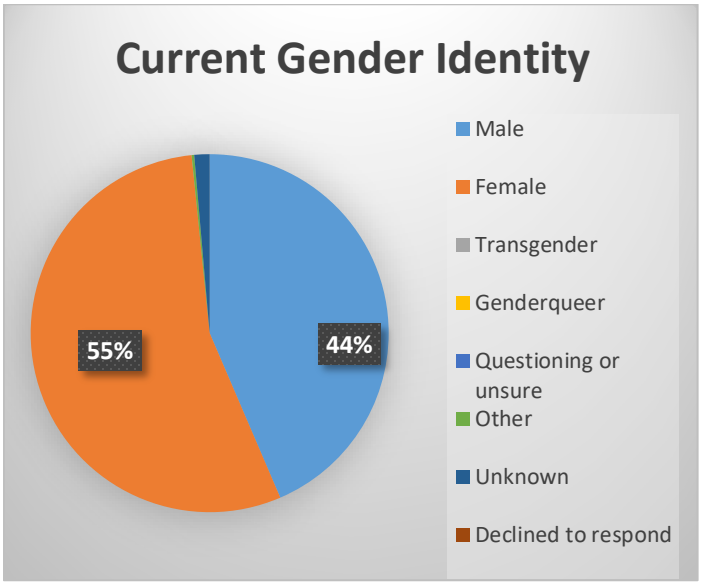
Total unique clients who received an assessment through the Youth Access Team in FY 21-22: **434**

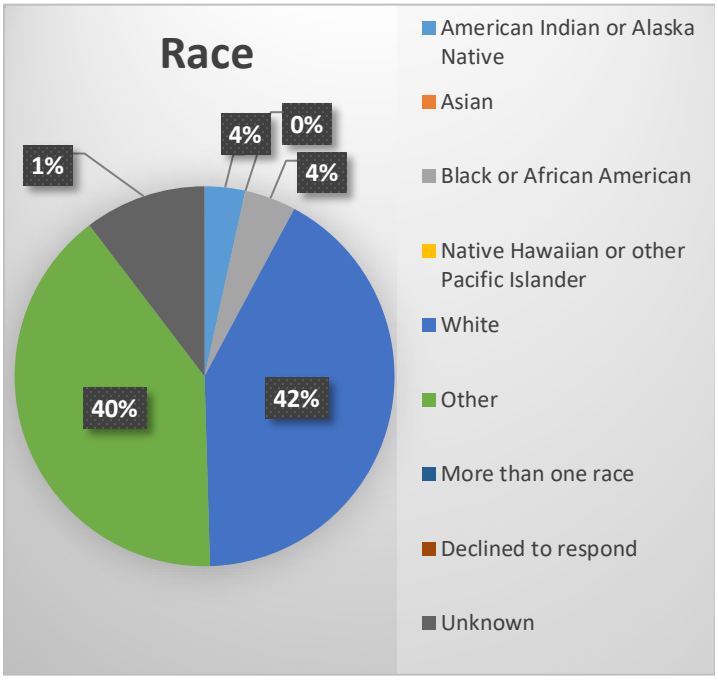


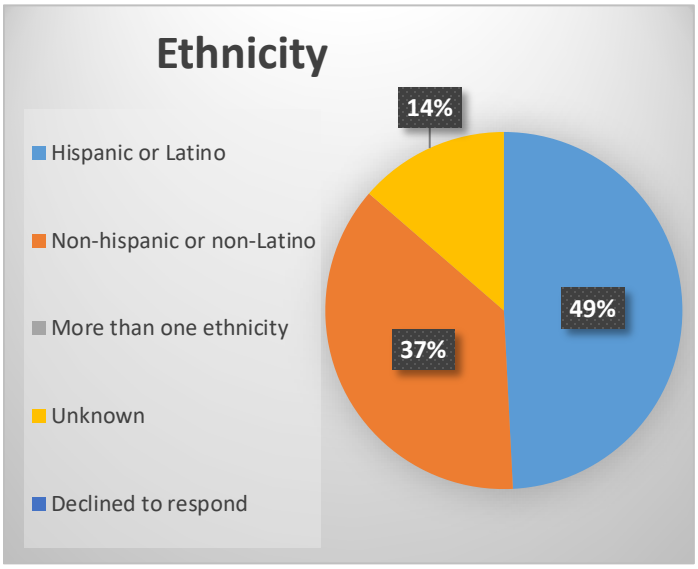
See pg.100 for an explanation of CANS/ANSA

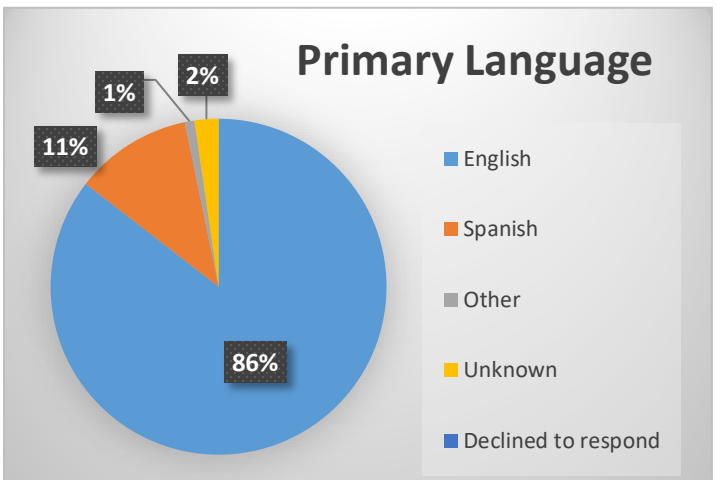
FY 2021-2022
Program Demographics:











Prevention and Early Intervention (PEI)

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:

- Suicide Incarcerations
- School failure or dropout
- Unemployment
- Prolonged suffering
- Homelessness
- Removal of children from their homes

Suicide Prevention

Organized activities that the County undertakes to prevent suicide as a consequence of mental illness.

Sonoma County's Safe Spaces FOR MENTAL HEALTH

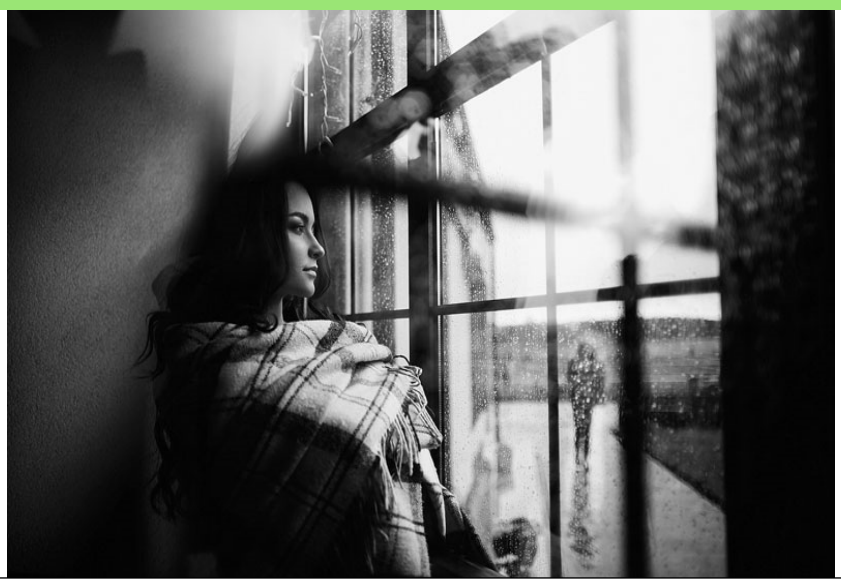
MHSA Component: Prevention and Early Intervention (PEI)

Buckelew Programs' North Bay Suicide Prevention Program (NBSPP)

Buckelew Programs

*FY 2021-2022 **PEI Initiative:** Suicide Prevention*

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, homelessness, removal of children from their homes, and prolonged suffering.



PROGRAM IMFORMATION

Program Name: Buckelew Programs
Population served: All Ages in Sonoma County
Website: www.buckelew.org
Phone: (415) 457-6964
Program location:
201 Alameda Del Prado, Novato, CA 94949

PROGRAM DESCRIPTION:

Suicide Prevention Program responds to callers on the Suicide Prevention Hotline and 988 crisis line and provides de-escalation, safety planning, referrals to resources, and linkage to crisis intervention services including mobile crisis and 911 on an as-needed basis. The outreach staff engage in community Suicide Prevention training, special events to raise awareness of services and resources, and distribution of informational materials regarding services and support.

* *Some call data is not collected due to system limitations. There is a new system identified that will collect language demographics in the future.*

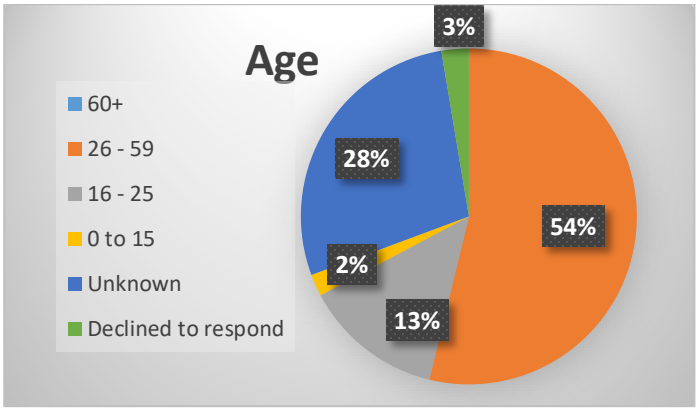
FY 2021-2022 PROGRAM OUTCOMES

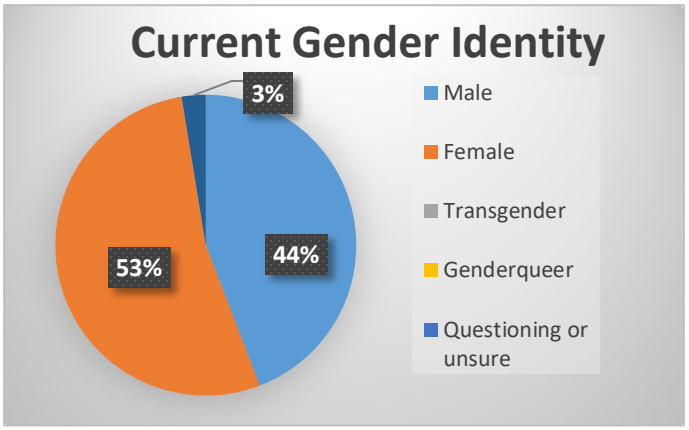
- **Total number of clients served:** 2321
- **Total number of encounters:** 2072
- **Approximate numbers reached through outreach:** 486 directly, 5007 brochures and cards distributed

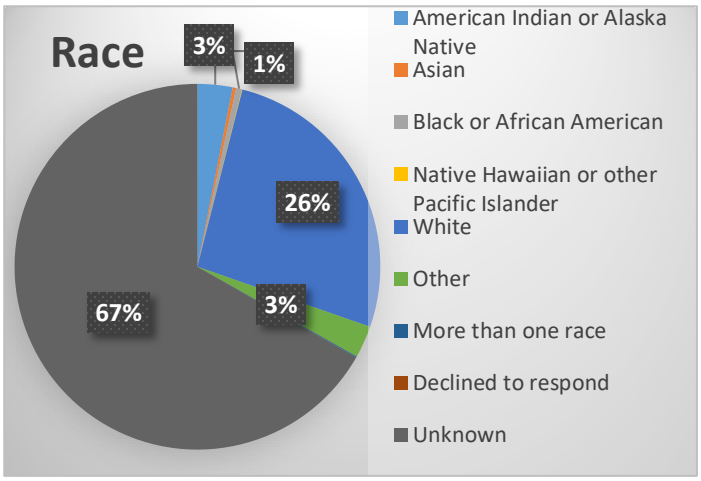
PERFORMANCE OUTCOMES & PROGRAM ACCOMPLISHMENTS:

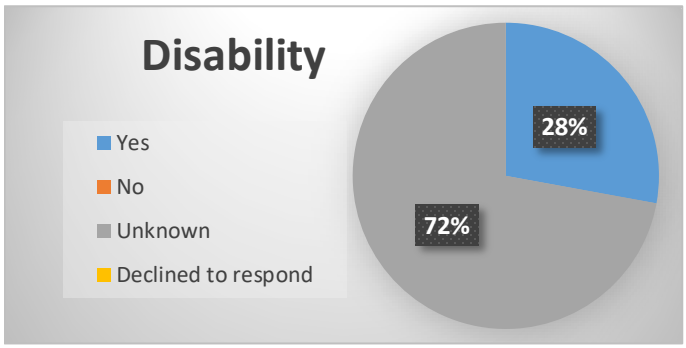
- In FY 21-22, Buckelew's North Bay Suicide Prevention Program (NBSPP) was able to hire 5 full-time staff members and had 2-3 volunteers move into employee positions including community outreach coordinator and part-time hotline counselor.
- Buckelew's NBSPP was able to hire two additional bilingual staff members who are increasing our capacity to support callers in need in various languages.
- A Team Leader and an Assistant Program Director were hired in FY 21-22.
- Quote from a volunteer who became a staff member in FY 21-22: "This program has given me the best job I've ever had and I am so grateful to be able to be in this program and support the community" – Chris.
- Quote from a NBSPP caller: "I got what I needed in the call that I made. It may not seem like much, but it saved my life that night" – Joe (Alias for confidentiality)

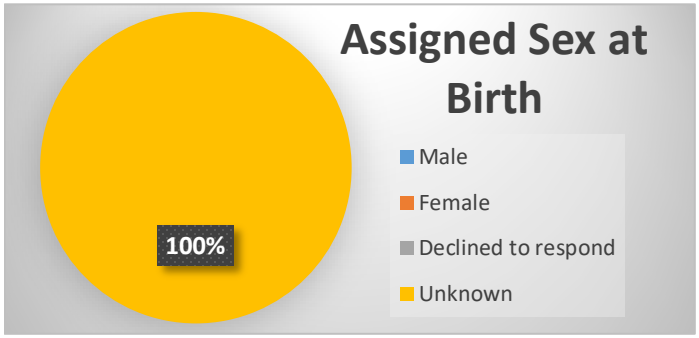
FY 2021-2022 Program Demographics:

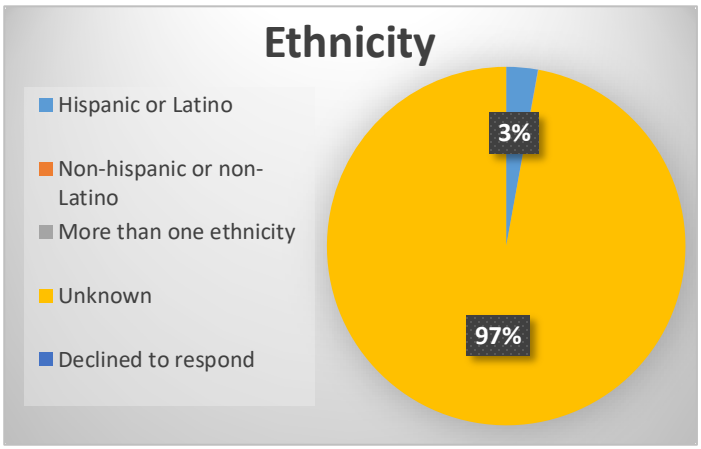


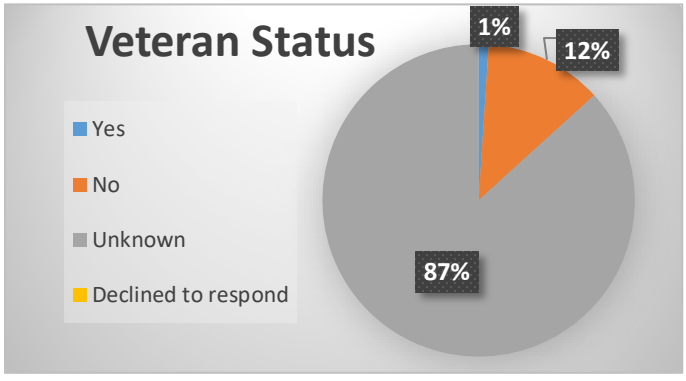


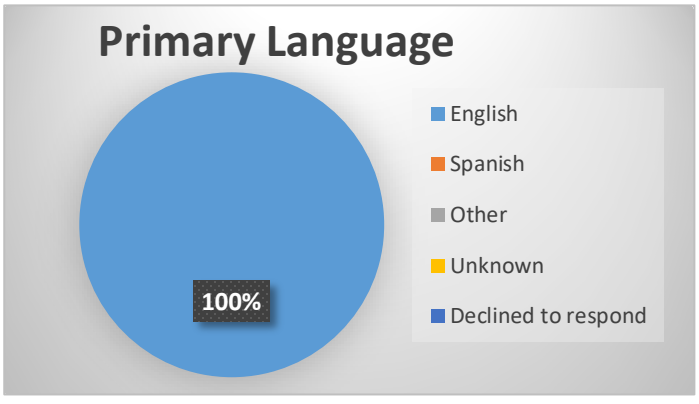


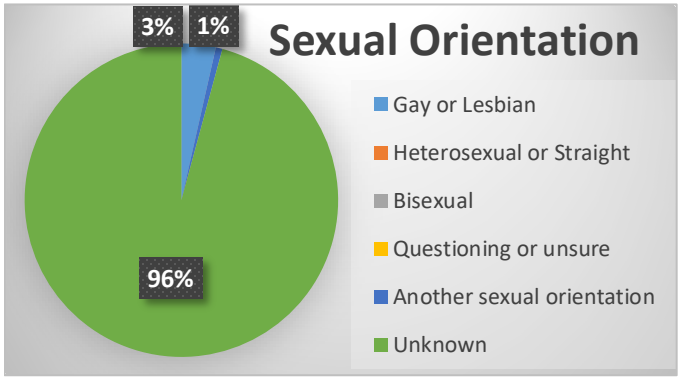












Prevention and Early Intervention (PEI)

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:

- Suicide
- Incarcerations
- School failure or dropout
- Unemployment
- Prolonged suffering
- Homelessness
- Removal of children from their homes

Outreach for Increasing Recognition of Early Signs of Mental Illness

A process of engaging, encouraging, educating, and/or training, and learning from potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness

For the PEI Outreach for Increasing Recognition of Early Signs of Mental Illness strategy the County provides the evidence based Crisis Intervention Training (CIT) for Law Enforcement personnel.

CIT was postponed for FY 21-22 due to the pandemic. The County will continue offer training to first responders in FY 22-23.

SONOMA COUNTY MHSA ANNUAL REPORT ON INNOVATION PROGRAMS

Innovation (INN)

Novel, creative and/or ingenious mental health practices/approaches that are expected to contribute to learning, which are developed within communities through a process that is inclusive and representative, especially of unserved and underserved individuals.

In FY 21-22, DHS-BHD had four projects funded through the Innovation component. For a list of Innovation projects that were in development and are being implemented in FY 22-23, see page 38.

Sonoma County's Safe Spaces FOR MENTAL HEALTH

MHSA Component: Innovation (INN)

Early Psychosis Learning Health Care Network Project

UC DAVIS UNIVERSITY OF CALIFORNIA

ALDEA

Buckelew Programs Healthier Lives. Stronger Communities.

FY 2020-2021 INNOVATION PROJECT: Early Psychosis Learning Health Care Network

The INN component funds projects designed to test time-limited new or changing mental health practices that have not yet been demonstrated as effective. The purpose of the INN component is to infuse new, effective mental health approaches into the mental health system, both for the originating county and throughout California. These projects may focus on increasing access to underserved groups, increasing the quality of services including measurable outcomes, promoting interagency and community collaboration, or increasing access to mental health services.

DESCRIPTION OF PROJECT:

Early Psychosis Learning Health Care Network (EP LHCN) is the first treatment program specifically for youth psychosis in Sonoma County. This project will be part of the Statewide Early Psychosis Learning Collaborative (a Mental Health Services Oversight and Accountability Commission's [MHSOAC] Incubator Project) as approved by the MHSOAC. Buckelew, Aldea and the University of California at Davis are collectively leading this project.

PROJECT IMFORMATION

Project Name: Early Psychosis Learning Health Care Network

Population served: Youth and adults ages 12 – 30 who have onset of psychosis within the past two years or attenuated psychotic symptoms or recent deterioration in youth with a parent/sibling with psychotic disorder.

Website:
https://www.aldeainc.org/services/behavioral-health/the-elizabeth-morgan-brown-center

Phone Number:
(707) 224-8266

Location: 2300 Northpoint Pkwy
Santa Rosa, CA 95407

FY 21-22 PERFORMANCE OUTCOMES:

Please refer to FY 2021/22 Annual Innovation Report: Early Psychosis Learning Health Care Network on page 318 for a complete list of project outcomes.

FY 2021-2022 PROJECT CHANGES:

Refer to FY 2021/22 Annual Innovation Report on page 318.

Sonoma County DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

WELLNESS • RECOVERY • RESILIENCE

Sonoma County's Safe Spaces FOR MENTAL HEALTH

MHSA Component: Innovation (INN)

First 5 Sonoma County's New Parent TLC (Talk, Link, Confirm) Project

FIRST 5 sonoma county

The INN component funds projects designed to test time-limited new or changing mental health practices that have not yet been demonstrated as effective. The purpose of the INN component is to infuse new, effective mental health approaches into the mental health system, both for the originating county and throughout California. These projects may focus on increasing access to underserved groups, increasing the quality of services including measurable outcomes, promoting interagency and community collaboration, or increasing access to mental health services.

DESCRIPTION OF PROJECT:

Sonoma County-wide MHSA Innovation project, New Parent TLC (Talk, Link, Confirm) will employ a gatekeeper training model similar to the evidence-based model QPR (Question, Persuade, Refer) to identify signs, and intervene early with new parent mental health issues that may otherwise go unaddressed, ultimately preventing suicide. As a secondary outcome, New Parent TLC will also prevent the exposure of infant Adverse Childhood Experiences (ACEs) resulting from parental depression and the associated disruption of optimal infant/toddler brain development. The model increases access to mental health services to underserved groups including new parents of all types: biological, non-biological, adoptive, gay, or straight (Beck, 2014). New Parent TLC promotes interagency and community collaboration related to mental health services with the innovative model that engages childcare providers, cosmetology service providers, and employees of medium to large places of employment as peers, as "connectors," (formally known as "gatekeepers") with a robust outreach method to raise awareness of new parental depressive symptoms, and helps get parents linked to mental health services by initiating the conversation (Talk), providing culturally appropriate referrals to parental mental health services (Link), and following-up with the parent to confirm they have accessed services (Confirm).

PROJECT IMFORMATION

Project Name: New Parent TLC
Population served: "Connectors" Child Care Providers, Cosmetology Service Providers, and peers at large places of employment
Website: first5sonomacounty.org
Contact Info: 5340 Skylane Blvd. Santa Rosa, CA 95403. 707.522.2020
Social Media: facebook.com/SonomaFirst5

FY 2021-2022 PROJECT STATISTICS

- **In the 2021-2022 FY the project was still in the curriculum development stage.**
- **Connectors were not trained in the first year of implementation**

FY 2021-2022 PERFORMANCE OUTCOMES:

In fiscal year 2021-2022 the project was just getting started, and Connectors had not yet been trained. The overall project learning goals include evaluating referrals by each group of Connectors: Child Care Providers, Cosmetology Service Providers, and Peers at larger places of employment to understand if this model is more effective with a certain population of Connectors, or if it works universally. Another learning goal is to evaluate the experiences of the parents experiencing depressive symptoms, the trained Connectors, and the service providers in the early relational health system of care who work with the parents who are referred. A qualitative evaluation of their experiences will help identify factors that contribute to completed linkages to services and barriers to successful linkages.

To read full FY 2021-2021 Innovation Project report go to page 401.

sonoma county DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

WELLNESS • RECOVERY • RESILIENCE

FY 2021-2022 Project Demographics:

The primary population to be served with this project are "Connectors," which will include groups of child care providers, cosmetology service providers, and employees of medium to large places of employment as peers. When training begins, approximately 30% of the training groups will be facilitated in Spanish to match the demographics of Sonoma County. At the end of the first year, the project is still in the curriculum development phase, and no connectors have been trained to date.

In the curriculum development phase, a culturally responsive community group was established to inform the curriculum development process and ensure the curriculum and training implementation for the community is inclusive, and representative of Sonoma County parents. This includes birthing parents, non-birthing parents, heterosexual parents and parents who are part of the LGBTQIA2s+ community. In addition, the curriculum is culturally responsive for

English speaking parents and Spanish speaking parents in Sonoma County. The culturally responsive community advisory group includes members of organizations to represent the Latinx and LGBTQIA2s+ parental communities, with organizations represented including Positive Images, Latino Service Providers, Postpartum Support Center, North Bay LGBTQI Families, and participants with lived experience.

FY 2021-2022 PROJECT CHANGES:

The original plan included in-person trainings for Connectors. At this time, Zoom trainings are being scheduled, as there are still challenges and health risks with in-person trainings.

***Participants of the Culturally Responsive Curriculum Advisory Group provided the following statements about their participation in the group*:**

"Participating in the Culturally Responsive Curriculum Group was a very positive experience. Each time I joined this group, I felt empowered to share my perspective and my ideas with the group. The facilitators did an amazing job inviting each of our voices into the conversation and Jenni and Allison showed us respect each time by showing us how they implemented our opinions and feedback. This group was truly special because it finally felt like we weren't just another equity group to check off a box, our voices mattered. I am excited to see this program reach our communities."

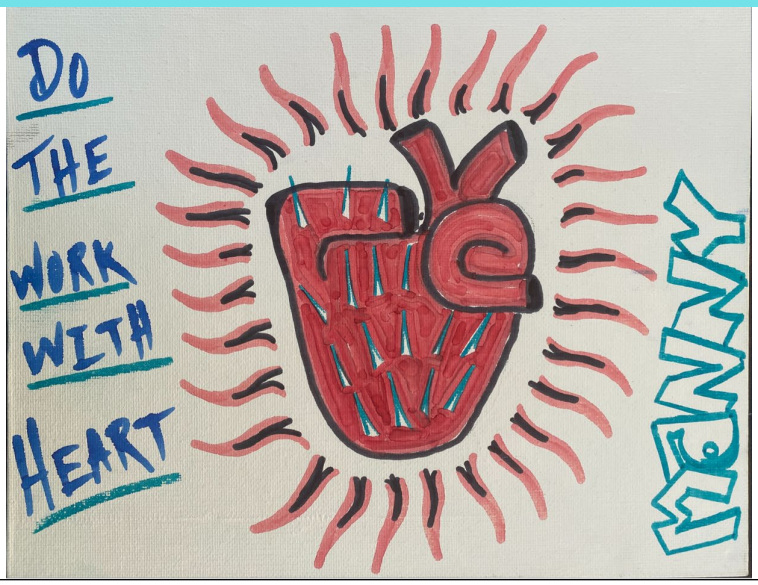
-Alayza Cervantes, Community Engagement Manager at Latino Service Providers

Sonoma County's Safe Spaces FOR MENTAL HEALTH

MHSA Component: Innovation (INN)

Nuestra Cultura Cura Social Innovations Lab Project

The INN component funds projects designed to test time-limited new or changing mental health practices that have not yet been demonstrated as effective. The purpose of the INN component is to infuse new, effective mental health approaches into the mental health system, both for the originating county and throughout California. These projects may focus on increasing access to underserved groups, increasing the quality of services including measurable outcomes, promoting interagency and community collaboration, or increasing access to mental health services.



PROJECT IMFORMATION

Project Name: Nuestra Cultura Cura Social Innovations Lab (NCC SIL)
Population served: Insert info here (age range, geographic area, etc.)
Website: www.laplazancc.org
Contact Info: 1221 Farmers Lane Suite 200, Santa Rosa CA 95405 Phone: (707) 393-8700
Social Media: Instagram - @nuestra_cultura_cura

DESCRIPTION OF PROJECT:

Innovations Project is a project designed to support processes and practices that envision a more equitable, trauma-response, and culturally-rooted team. The innovations Team consists of practitioners from La Plaza, Latino Service Providers, Humanidad, the North Bay Organizing Project, and the Botanical Bus. The Project moved away from the Innovations traditional model of attending to team and community deficiencies. Instead, it focused on the Innovation's Team and community shared goals, strengths, assets, and resilience.

FY 2021-2022 PROJECT STATISTICS

- **Total number of clients served: 12**
- **Total number of encounters:** 9 community gathers with the 12 clients served

FY 2021-2022 PERFORMANCE OUTCOMES:

NCC SIL acknowledged that a greater impact to our Sonoma County Latinx Community may be achieved together, yet understand that without the trust, buy-in, accountability, healthy conflict and follow through, of partner agencies our efforts will fail. Therefore, it was determined that year one would be a planning and relationship, rapport and community building year for the collective. However, NCC SIL also committed to outreach and community engangement to recruit healers and community members to get involved with the innovation project.

FY 2021 - 2022 PROJECT CHANGES:

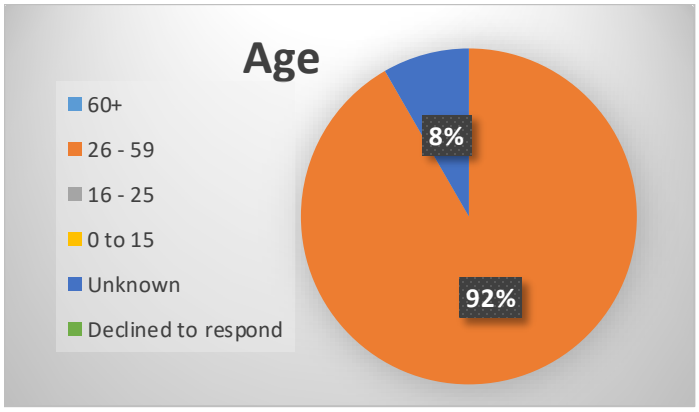
Initially, Raizes Collective was invited to join as a partner. However, they decided not to proceed with participation in the project due to other internal obligations. The collective then invited The Botanical Bus was invited because they had pre-existing relationships with the participating organizations. They are also aligned with NCC SIL's mission and vision regarding healing and wellbeing. Utilizing a democratic process, NCC SIL's participating organizations voted anonymously to invite Botanical Bus to Join the project.

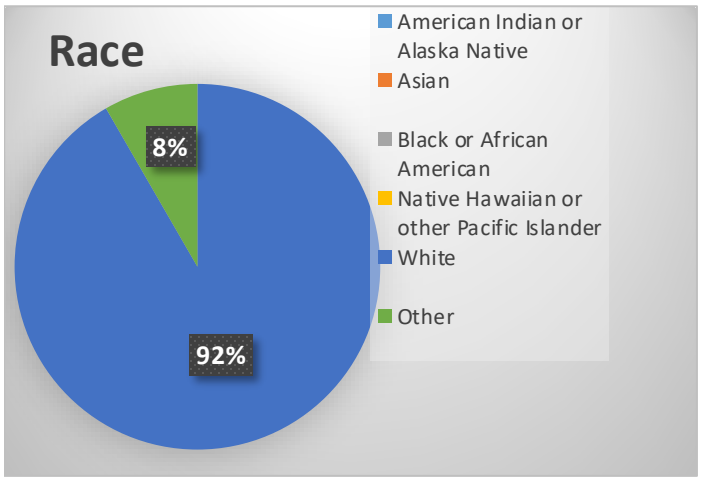
To read full FY 2021-2021 Innovation Project report go to page 407.

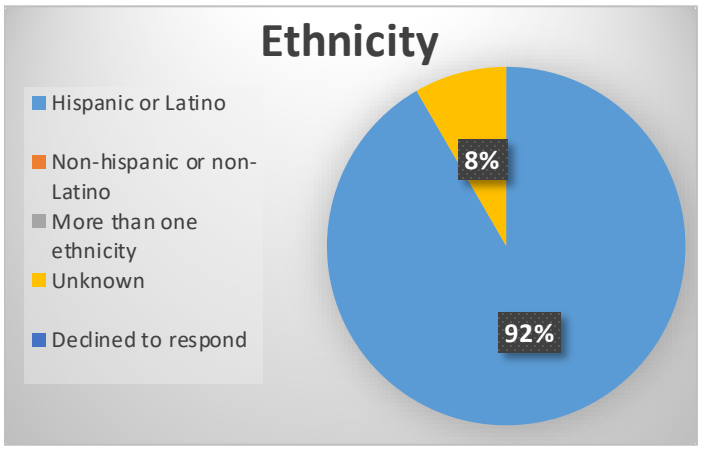
sonoma county DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

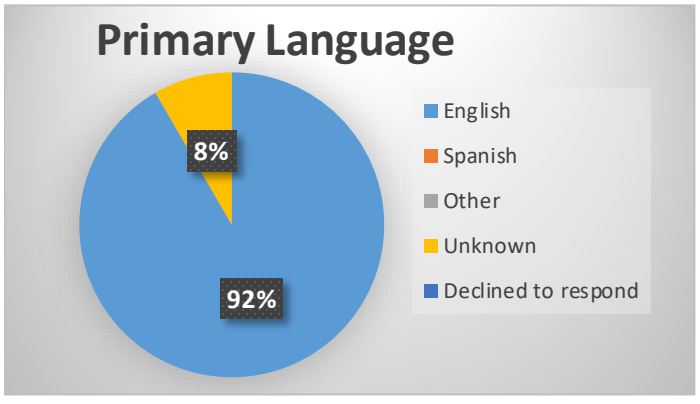
WELLNESS • RECOVERY • RESILIENCE

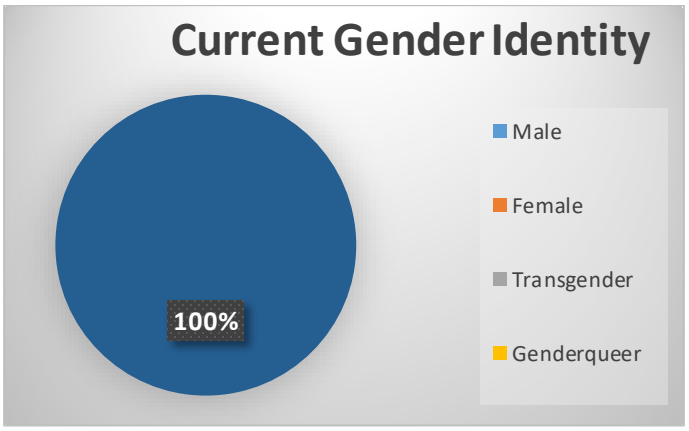
FY 2021-2022 Project Demographics:

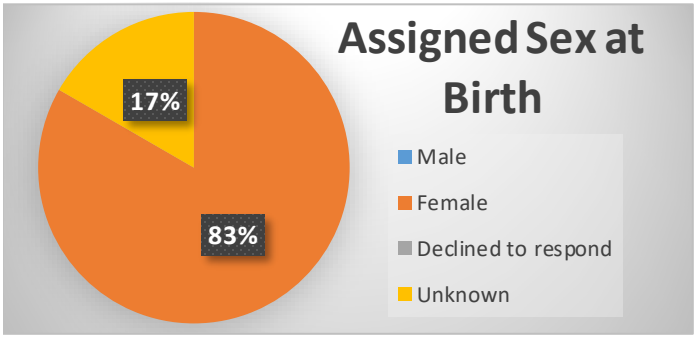


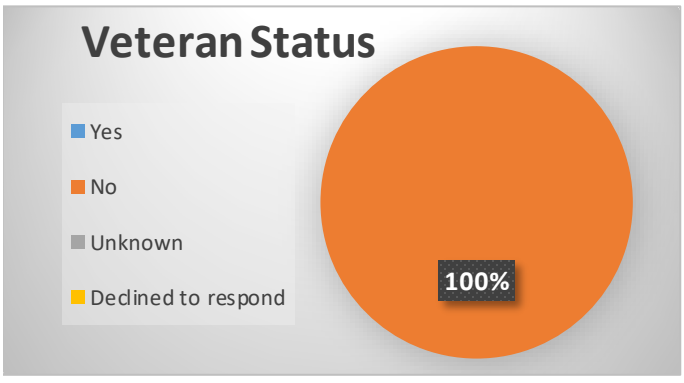


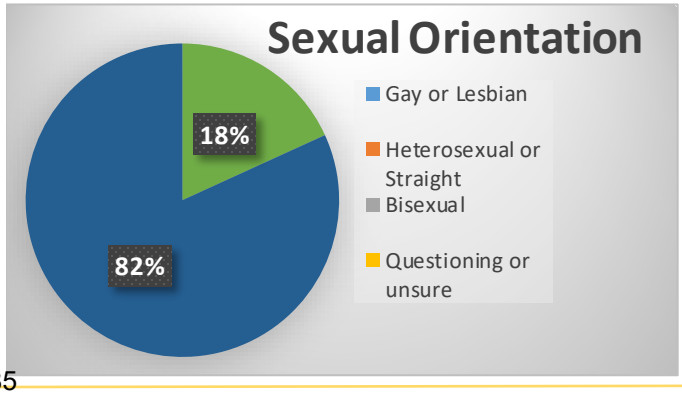












Sonoma County's Safe Spaces FOR MENTAL HEALTH

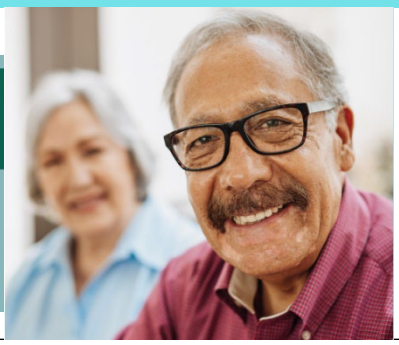
MHSA Component: Innovation (INN)

Sonoma County Human Services' Unidos Por Nuestro Bienestar (formally CCERP) Project

"Empower, Support, Protect" Human Services Department COUNTY OF SONOMA

Santa Rosa COMMUNITY HEALTH All of us. For all of you.

The INN component funds projects designed to test time-limited new or changing mental health practices that have not yet been demonstrated as effective. The purpose of the INN component is to infuse new, effective mental health approaches into the mental health system, both for the originating county and throughout California. These projects may focus on increasing access to underserved groups, increasing the quality of services including measurable outcomes, promoting interagency and community collaboration, or increasing access to mental health services.



PROJECT IMFORMATION

Project Name: Unidos Por Nuestro Bienestar (aka 'Unidos')
Population served: Latinx older adults age 50+ served at Santa Rosa Community Health in Roseland
Contact Info: 707-547-2220

DESCRIPTION OF PROJECT:

Sonoma County Human Services Department, Adult & Aging Division (A&A) and Santa Rosa Community Health (SRCH)-Lombardi Campus is testing an innovative modification to an evidence-based depression intervention known as the Collaborative Care Model (CoCM). CoCM integrates physical & behavioral health services through: 1) brief care coordination between primary care and behavioral health care providers over a 12-week period; 2) regular monitoring, treatment and case management including home visits and phone check-ins; & 3) systematic psychiatric caseload reviews and consultation for clients who do not show clinical improvement. The Unidos project intentionally engages Latinx patients ages 50+ served @ SRCH and adds 9 months of case management services to the initial 3 months of Collaborative Care for a 1-year intervention.

FY 2021-2022 PROJECT STATISTICS

- **Total number of clients served:** 3
- **Total number of encounters:** 20
- **Approximate numbers reached through outreach:** 24

FY 2021-2022 PERFORMANCE OUTCOMES:

In our first year of operations, Unidos por Nuestro Bienestar:

- Assembled a team of clinicians and administrators who meet regularly and are committed to the project's aims and making progress.
- Hired and onboarded a community-based organization (CBO) bilingual and bicultural social worker;
- Selected the measures, developed intake instruments and created promotional materials;
- Crafted a baseline workflow that continues to evolve as SRCH staff positions are filled; and
- Received 24 client referrals, 3 of whom were fully enrolled, 11 pending and 7 closed.

FY 2021-2022 PROJECT CHANGES:

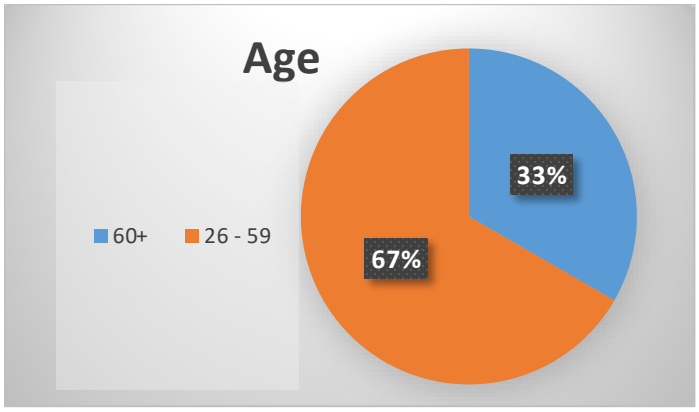
Project name was changed from Collaborative Care Enhanced Recovery Project (CCERP) to Unidos por Nuestro Bienestar – United for Our Wellness (aka 'Unidos') in the spirit of engaging the population-of-focus for this initiative—Hispanic/Latinx clients served at SRCH.

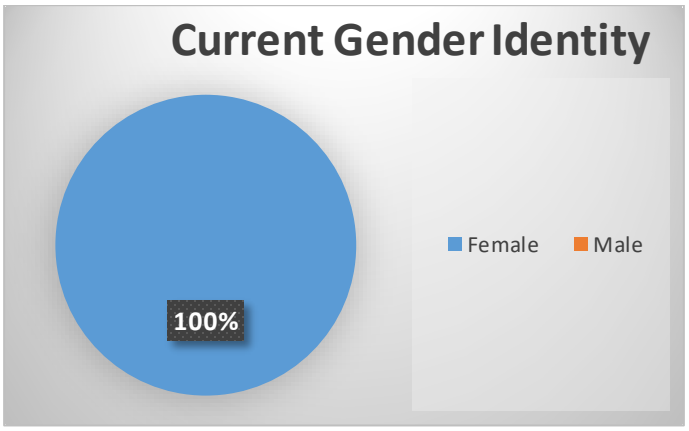
To read full FY 2021-2021 Innovation Project report go to page 424.

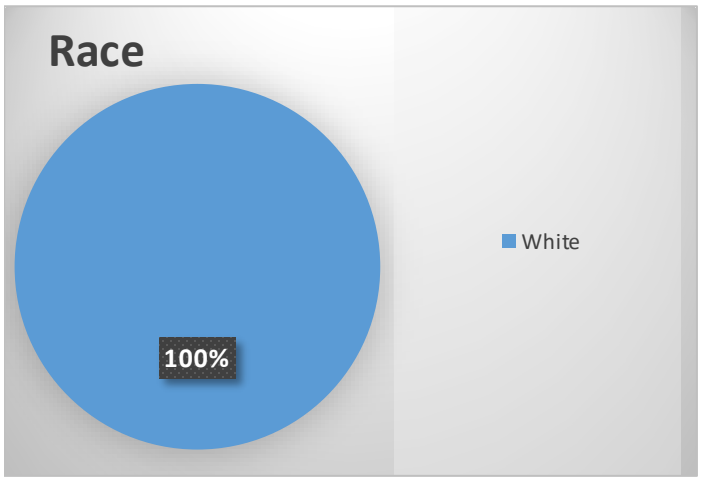
WELLNESS • RECOVERY • RESILIENCE

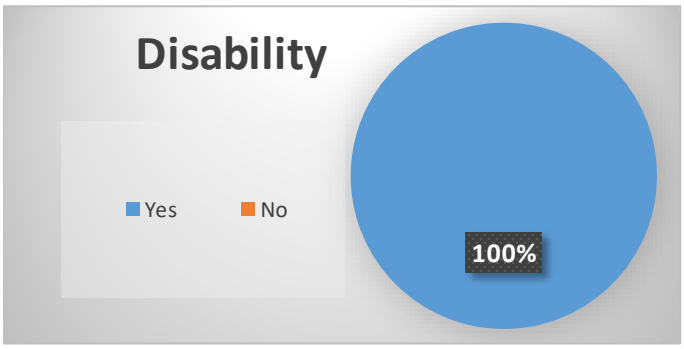
sonoma county DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

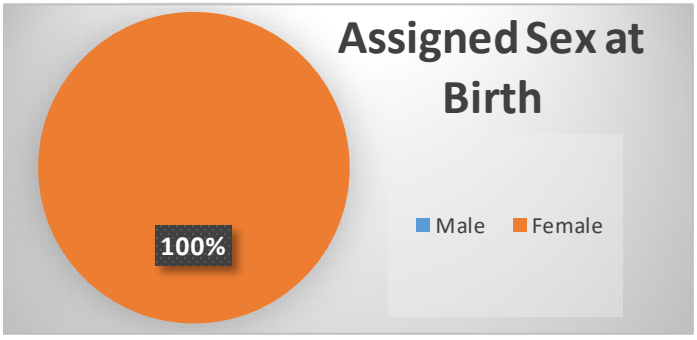
FY 2021-2022 Project Demographics:

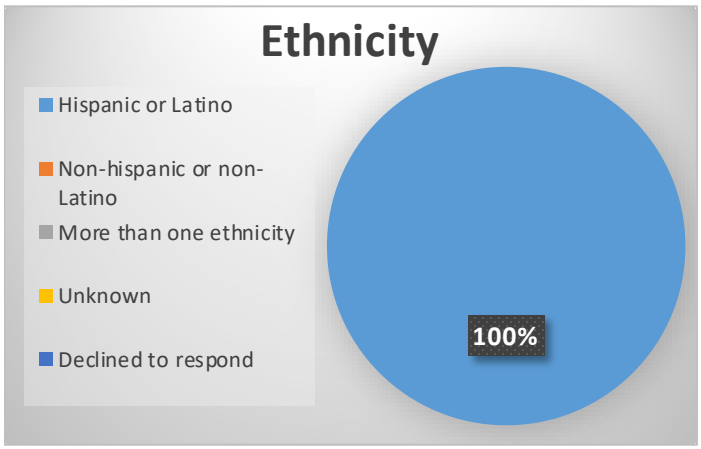


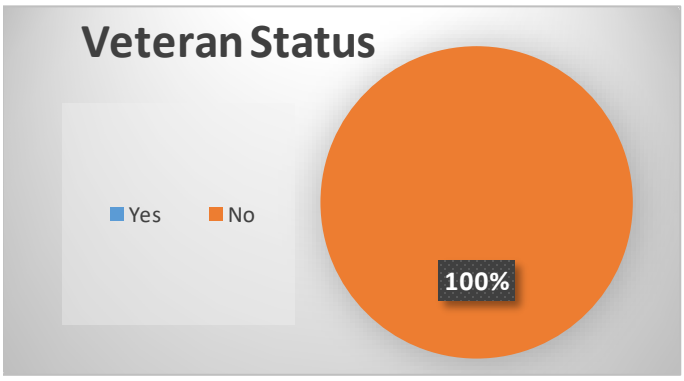


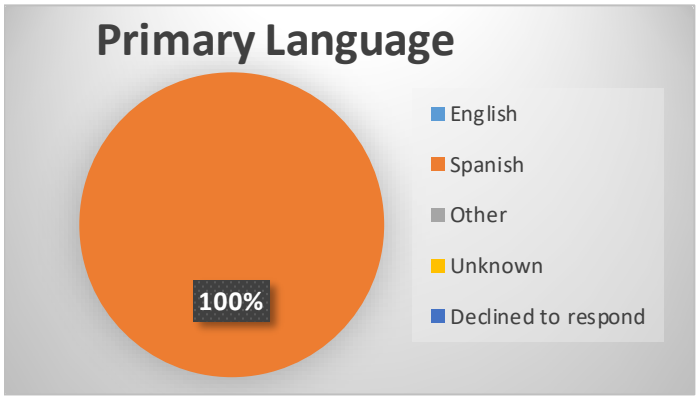


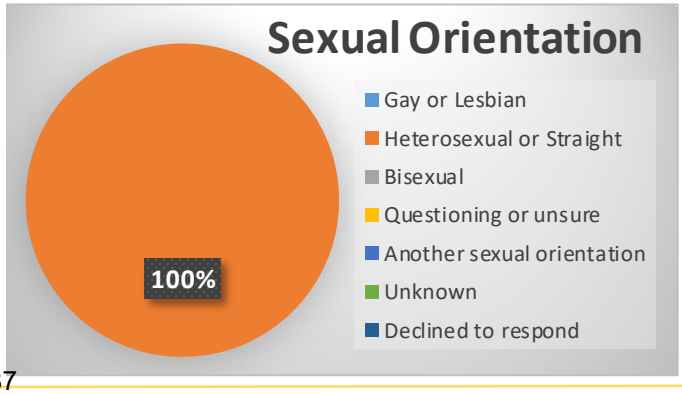












SONOMA COUNTY MHSA ANNUAL REPORT ON WORKFORCE EDUCATION AND TRAINING (WET)

Workforce Education and Training (WET)

The goal of the WET component is to develop a diverse workforce. Individuals with lived mental health experience and DHS BHD staff and contractors are given training to promote wellness and other positive mental health outcomes. WET funds are also used to promote and expand the cultural responsiveness of DHS BHD.

Sonoma County's Safe Spaces FOR MENTAL HEALTH

MHSA Component: Community Services & Supports (CSS)

West County Community Services' Peer Education and Training Program

WCCS West County Community Services

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

FY 2021-2022 Service Category: Workforce, Education & Training

PROGRAM IMFORMATION

Program Name: WCCS Peer Education and Training Program
Population served: Adults in Sonoma County
Website: www.westcountyservices.org
Phone: (707) 565-7807
Program location:
2245 Challenger Way, Ste #104
Santa Rosa, CA 95405

PROGRAM DESCRIPTION:

The Peer Education and Training (PET) program seeks to transform the mental health system to a more recovery-oriented model based on a Peer model of support. PET provides education and training to those with lived mental health experience, or Peers, who are seeking to become Peer Support Specialists.
In addition, PET provides presentations and trainings on Peer services to a variety of public and private mental health organizations to promote understanding and inclusion of Peer Support throughout the continuum of care network.

FY 2021-2022 PROGRAM STATISTICS

- **Total number of clients served:** 79
- **Total number of encounters:** 424
- **Approximate numbers reached through outreach:** 450

PERFORMANCE OUTCOMES & ACCOMPLISHMENTS:

The Peer Education and Training (PET) program successfully navigated the numerous challenges related to the health crisis and its elimination of onsite training. Our program adapted and moved forward to an online platform that allowed for the ongoing delivery of the class. This change has allowed for participation in classes by those who may have otherwise been able to participate due to transportation challenges, which has eliminated a barrier to equity. In addition, we have increased outreach efforts substantially by developing presentations which we have provided for a variety of agencies.

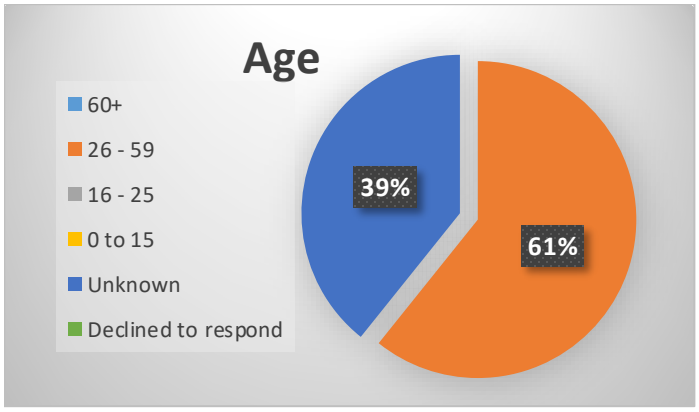
The PET program has undergone a renovation process, due to the retirement of the long-time Program Manager. We elicited feedback from participants of the program, staff within the program as well as Peer Center Managers and community partners. We have strengthened the program through creating relationships with additional organizations for Internship opportunities as well as developing new training presentations for a variety of audiences.

WELLNESS • RECOVERY • RESILIENCE

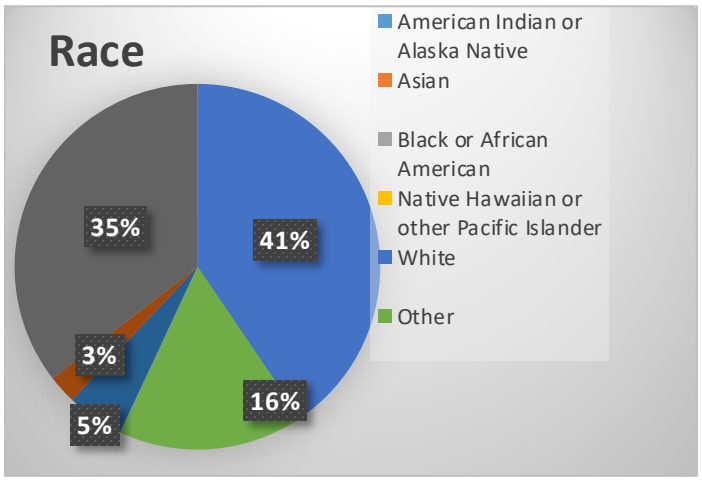
sonoma county DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

FY 2021-2022 Program Demographics:

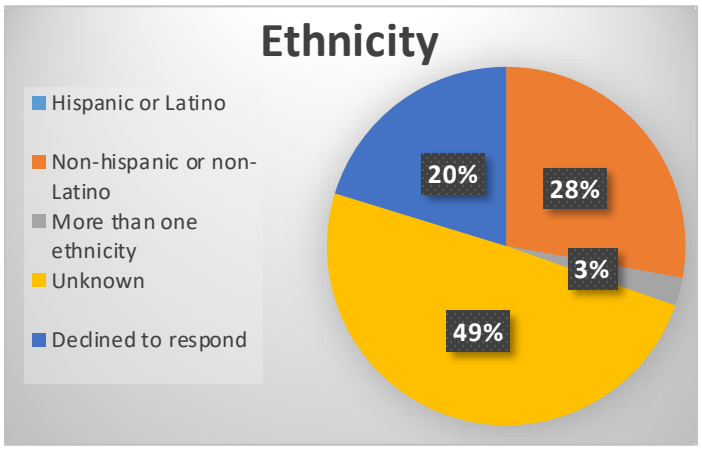
Age



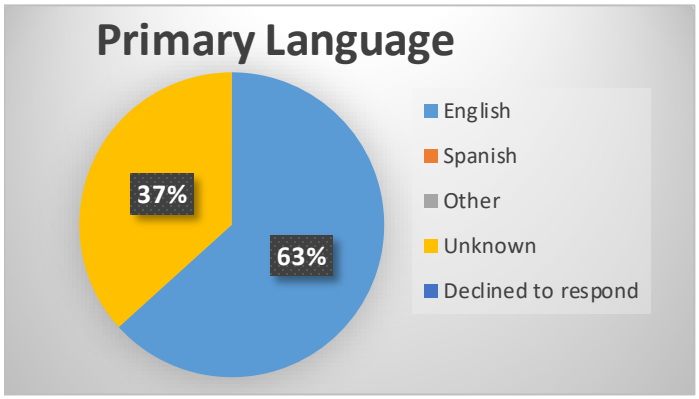
Race



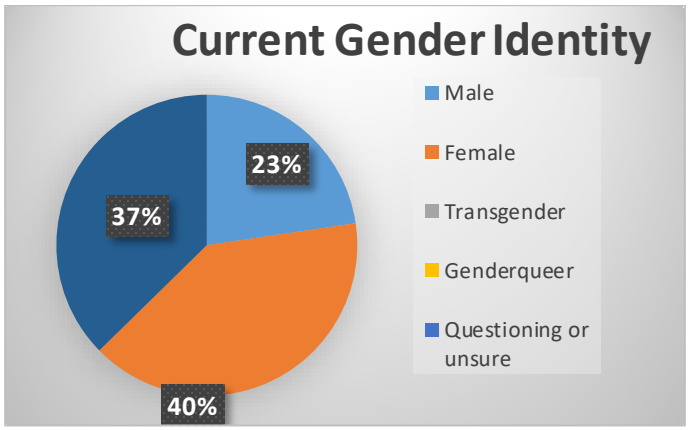
Ethnicity



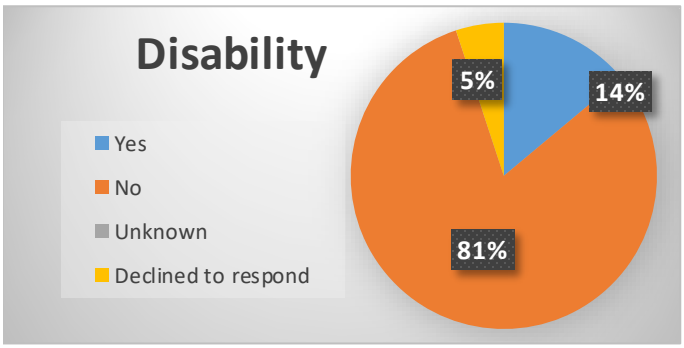
Primary Language



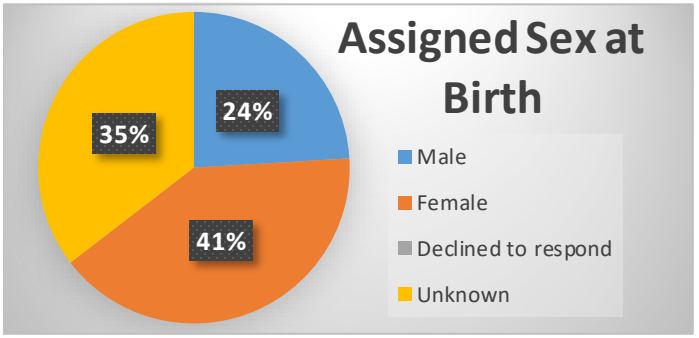
Current Gender Identity



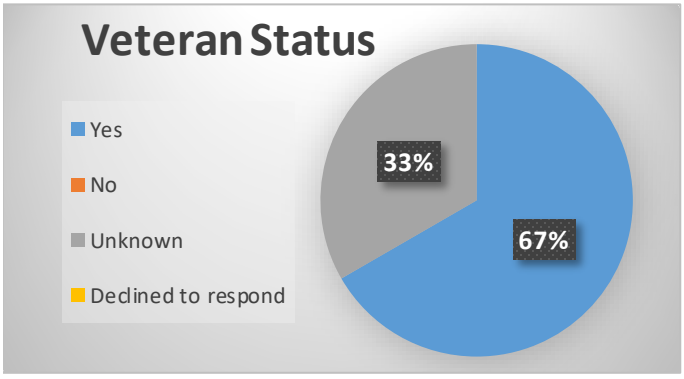
Disability



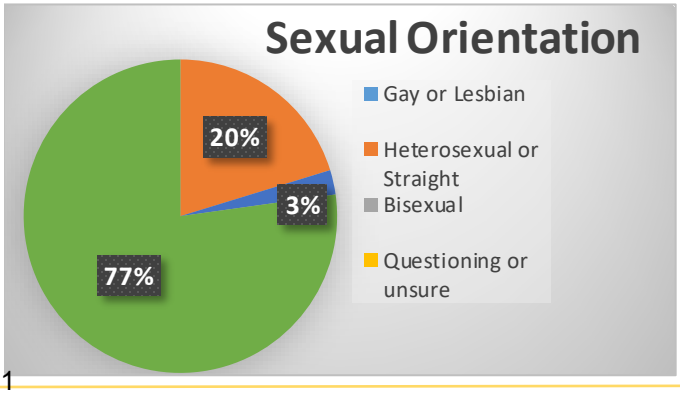
Assigned Sex at Birth



Veteran Status



Sexual Orientation



Sonoma County Department of Health Services, Behavioral Health Division
Workforce Education and Training (WET) Report for Fiscal Year 2021-2022

West County Community Services – Peer Education and Training (PET) Program

The Peer Education and Training (PET) Program provides workforce development opportunities with a peer perspective to support system transformation and a recovery vision that is consumer-driven and holistic in its services and supports.

PET collaborates with the community to create awareness of opportunities for involvement in transformation activities to increase knowledge of, and participation in the development and provision of mental health services. Additionally, the program recruits, engages, supervises and supports consumers as volunteers and interns in mental health agencies and organizations. PET provides education, employment, promotion of mental health system transformation through peer participation in quality improvement activities, and expands awareness of mental health recovery to all segments of the mental health community.

DHS-BHD Workforce Education and Training (WET) Activities

In FY 21-22, the WET Coordinator managed two training programs and community events to further DHS-BHD's goals in the following Domains: System Level Support and Staff Skill Development, and Workforce Diversification. Due to the pandemic, County participated in fewer community events.

Domain	Programs/events/goals
System Level Support	• Accreditation (BRN, CAMFT, CCAPP)
Staff Skill Development	• Staff Development Trainings

System Level Support

Accreditation

At the onset of FY 20-21, BHD maintained accreditation through the Board of Registered Nursing (BRN), the California Association of Marriage and Family Therapists (CAMFT) and California Consortium of Addiction Programs and Professionals (CCAPP) for the license types listed below, and provides Continuing Education Units (CEUs) for these license types:

BRN	CAMFT	CCAPP
•Licensed Vocational Nurse (LVN) •Licensed Psychiatric Technician (LPT) •Registered Nurse (RN) •Public Health Nurse (PHN) •Nurse Practitioner (NP) •Psychiatric Nurse Practitioner (PNP)	•Licensed Clinical Social Worker (LCSW) •Licensed Marriage and Family Therapist (LMFT) •Licensed Professional Clinical Counselor (LPCC) •Licensed Educational Psychologist (LEP)	•Registered Alcohol Drug Technician (RADT) •Certified Alcohol Drug Counselor I (CADC-I) •Certified Alcohol Drug Counselor II (CADC-II) •Licensed Advanced Alcohol Drug Counselor (LAADC) •Licensed Advanced Alcohol Drug Counselor Supervisor (LAADC-S)

Career Pathways and Pipeline Program

The WET Coordinator continued the Internships and Traineeship program to assist staff in obtaining clinical licensure and to develop pipeline programs with participating universities. This included a Licensure Support Program, Group Clinical Supervision, and Educational Outreach Events.

Participating Universities

Program Category	Participants
Nursing Programs	• Sonoma State University (SSU) • Santa Rosa Junior College (SRJC)
Social Work Programs	• California State Long Beach • San Francisco State University (SFSU) • Humboldt State • San Jose State University • University of Southern California • Berkeley
MFT Programs	• SSU • University of San Francisco • SFSU
Mental Health Worker Programs	• SSU • SRJC
Peer Provider Programs	• Wellness and Advocacy Center • Interlink Self-Help Center

Staff Skill Development:

The WET program offered over 20 trainings to promote professional development. The topics include: Patient Rights, Cultural Responsiveness, Substance Abuse, Law and Ethics and Suicide Risk Assessment.

Staff Development Trainings:

DATE	***TITLE***	***TIME***	***PRESENTER(S)***	***AUDIENCE***
Sept 2, 2021	5150 – Review of 5150's and Other Legal Holds in Mental Health	2.0	Bill SmithWaters & Frank SmithWaters; SmithWaters Group	*SCBH, Healdsburg District Hosp, Buckelew*
Sept 9, 2021	AMSR: Assessing & Managing Suicide Risk	6.5	Melissa Ladrech, LMFT: Serina Sanchez LMFT	*SCBH Staff*
Sept. 10, 2021	QPR Gatekeeper	6.0	Melissa Ladrech, LMFT	*SCBH Staff and community partners*
Sept 24, 2021	5150 – Review of 5150's and Other Legal Holds in Mental Health	2.0	Bill SmithWaters & Frank SmithWaters; SmithWaters Group	*SCBH, Sonoma Valley Hosp, Sutter, VA*
Nov 5, 2021	5150 – Review of 5150's and Other Legal Holds in Mental Health	2.0	Bill SmithWaters & Frank SmithWaters; SmithWaters Group	*SCBH, Wellpath, SSU, SSU-CAPS, Healdsburg District Hosp*
Nov 12, 2021	5150 – Review of 5150's and Other Legal Holds in Mental Health	2.0	Bill SmithWaters & Frank SmithWaters; SmithWaters Group	*Santa Rosa Behavioral Health Hosp (SRBHH)*
Dec 2, 2021	5150 – Review of 5150's and Other Legal Holds in Mental Health	2.0	Bill SmithWaters & Frank SmithWaters; SmithWaters Group	*Kaiser-SRO, Sonoma Valley Hosp*
Dec 9, 2021	5150 – Review of 5150's and Other Legal Holds in Mental Health	2.0	Bill SmithWaters & Frank SmithWaters; SmithWaters Group	*Kaiser-Petaluma, Wellpath, Sonoma Valley Hosp, SCBH*
Dec 10, 2021	5150 – Review of 5150's and Other	2.0	Bill SmithWaters & Frank SmithWaters;	*Santa Rosa Behavioral Health Hosp (SRBHH)*

	Legal Holds in Mental Health		SmithWaters Group	
Dec 15, 2021	5150 – Review of 5150's and Other Legal Holds in Mental Health	2.0	Bill SmithWaters & Frank SmithWaters; SmithWaters Group	*SSU-CAPS, SCBH*
Jan 3, 2022	5150 – Review of 5150's and Other Legal Holds in Mental Health	2.5	Bill SmithWaters & Frank SmithWaters; SmithWaters Group	*Crestwood PHF*
Jan 13, 2022	5150 – Review of 5150's and Other Legal Holds in Mental Health	2.0	Bill SmithWaters & Frank SmithWaters; SmithWaters Group	*Kaiser - Petaluma*
Jan 20.2022	5150 – Review of 5150's and Other Legal Holds in Mental Health	2.0	Bill SmithWaters & Frank SmithWaters; SmithWaters Group	*Kaiser – Santa Rosa, Buckelew, Sutter, VA*
Jan 31, 2022	5150 – Review of 5150's and Other Legal Holds in Mental Health	2.0	Bill SmithWaters & Frank SmithWaters; SmithWaters Group	*Crestwood PHF*
Mar 23, 2022	Staff Development: Law & Ethics	6.0	Linda Garrett	*SCBH clinicians and RNs*
May 4th and 18th, 2022	Cannabis & MH Professional Training "Cannabis & Mental Health: A Training for Clinicians" "Brief Intervention and Motivational Interviewing Skills to address Cannabis Use: A Training for Clinicians"	2.0 each class	Sarah Ferraro Cunningham, PsyD, Co-Founder Panaptic; Richard Von Feldt, PsyD, Co-Founder, Panaptic	*County BH staff and community* *mental health professionals: Behavioral/Mental health providers, substance use providers, social workers, school-based counselors.*
April 25-29, 2022	inRESPONSE training:	None	Community Peers, Erika Klohe, Wendy Tappon, Wendy Wheelwright, Nubia Padilla, Susan Standen, Drew Crawford, Mary-Frances Walsh,	*inRESPONSE team members*

			Melissa Struzzo, Meghan Murphy, Melissa Ladrech, Stephanie Merrida, Todd Finnemore, Sarada Oglesby	
May 10, 2022	5150 Training	2.0	The SmithWaters Group	*SCBH staff, VA, Memorial ED staff*
May 17, 2022	5150 Training	2.0	The SmithWaters Group	*SCBH staff, VA, Memorial ED staff*
May 19, 2022	5150 Training	2.5	The SmithWaters Group	*SCBH staff, Memorial ED staff, Seneca*
May 24, 2022	AMSR	6.5	Melissa Ladrech	*SCBH staff and community partners*
May 26, 2022	5150 Training	2.5	The SmithWaters Group	*SCBH staff, VA, Memorial ED staff*

SONOMA COUNTY MHSA ANNUAL REPORT ON CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

Capital Facilities and Technological Needs (CFTN)

Works towards the creation of facilities that are used for the delivery of MHSA services to mental health clients and their families, or for administrative offices. Funds may also be used to support an increase in peer-support and consumer-run facilities, development of community-based settings, and the development of a technological infrastructure for the mental health system to facilitate the highest quality and cost-effective services and supports for clients and their families.

In FY 21-22, the following projects were funded under the CFTN component:

Provider	Project	Description
NetSmart	Avatar electronic health record (EHR)	Implementing fully integrated Electronic Health Record
FEI	Sonoma Web Infrastructure for Treatment Services (SWITS)	Database for tracking demographics and outcomes
A.J. Wong, Inc.	Data Collection Assessment and Reporting (DCAR)	Database for client CANS (Child and Adolescent Needs and Strengths) and ANSA (Adult Needs and Strengths Assessment) assessments, reassessment and closing assessments

Appendices

Sonoma County Mental Health Services Act (MHSA)

Capacity Assessment Report

RDA CONSULTING

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

Sonoma County Mental Health Services Act (MHSA)

Capacity Assessment Report

This report was developed by Resource Development Associates under contract with Sonoma County Department of Health Services Behavioral Health Division.

Resource Development Associates, 2023

RDA CONSULTING

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Executive Summary

Background

Sonoma County Department of Health Services - Behavioral Health Division (DHS-BHD) has partnered with Resource Development Associates (RDA) to conduct a Mental Health Services Act (MHSA) Capacity Assessment for fiscal years 2019-2022. This report is intended to provide a comprehensive analysis of Sonoma's MHSA-funded system of care and community needs and contribute to the development of the Three-Year MHSA Program and Expenditure Plan for fiscal years 2023-2026. This assessment presents a deeper understanding of the underlying dynamics of the County's behavioral health system and suggests recommendations to further strengthen Sonoma's public mental health system of care.

To evaluate Sonoma's MHSA-funded system of care, the capacity assessment focused on three core questions:

1. **Structure:** What is the current state of the MHSA-funded system of care? What programs and services are available, for whom, in which geographic regions, and at what capacity? How does the current system compare to what is expected in a public mental health system in similar counties?
2. **Process:** How do people move through the system? What are the strengths and barriers?
3. **Resources:** How are resources invested? Do they align with stated system priorities and the community's needs?[1]

To answer these questions, RDA Consulting collected data between August and December 2022 via a community survey, focus groups, and key informant interviews to understand strengths, challenges, and gaps in the system of care from community and system leaders, clients, family members, providers, and other partners. In addition, RDA Consulting conducted a background document review and secondary analysis of administrative data and quarterly reports supplied by the County's MHSA-funded partners. These analyses informed this final capacity assessment report.

Capacity Assessment Findings

Structure of the Sonoma County Behavioral Health System of Care

Sonoma's BHD is comprised of Youth and Family Services and Adult and Older Adult Services. Clients ages 0-17 are served by Youth and Family Services and clients ages 18 and older are served by Adult and Older Adult Services. Services for Transition Age Youth (TAY), ages 16-24, are integrated into the Youth and Family Services, but TAY clients 18 and older can also access Adult Services.

Clients may enter the behavioral health system in a variety of ways and through different channels, depending on whether a client is an adult or youth, and whether they need crisis or non-crisis services. The two primary entry points are the adult or youth Access Teams and crisis

[1] See limitations on p. 23.

services, which are available to all age groups. Once a client enters the system, regardless of whether they are youth or adult, there are a variety of services available that address different needs. The continuum of services ranges from the highest level of care, such as inpatient or other residential programs, to less intensive levels of care, including outpatient and prevention programs. The continuum of care also includes services that aid in care transitions and "stepping down" from more intensive levels of care. Lastly, the system of care also includes services in the Forensic System that serve justice-involved individuals.

Population served

In fiscal year 2021-2022, 3,484 unique individuals were served by Sonoma County BHD, with a total of 2,378 clients served by Adult and Older Adult Services, 1,154 clients served by Youth and Family Services, and 65 clients served by TAY services.[2] The racial and ethnic makeup of clients was similar to that of the County, with a majority of clients identifying as White and about a quarter identifying as Hispanic/Latinx. Most clients were between the ages of 26 and 59, and the majority were diagnosed with psychotic disorders and mood disorders, such as schizophrenia, bipolar disorder, anxiety disorders, depressive disorders, and trauma related disorders. Almost half of all clients entered the system through the Access Teams and crisis services, and after entry, most clients utilized outpatient services. Analysis of client demographics across programs identified certain groups being over- and/or under-represented in the system of care. Notably, Hispanic/Latinx adult clients were underrepresented in the adult system, while Hispanic/Latinx youth were over-represented in the youth system of care, specifically within general outpatient programs and youth justice services, compared to the Medi-Cal- eligible population of Sonoma County. Other groups, such as Black and Native American clients were also found to be overrepresented in unlocked residential programs.

Process

People move through the mental health system in Sonoma County in a variety of ways. RDA used primary and secondary data to understand the process through which clients access services and receive services, and the strengths and barriers of the system. Sonoma BHD has also faced several significant challenges before and since the previous Capacity Assessment, described in interviews conducted with BHD leadership, clients, and providers. Changes have had both positive and negative impacts on the overall BHD system, described below.

Accessing services

Most clients surveyed indicated that they knew who to call and where to go for mental health services and were comfortable seeking mental health services. However, only half of clients said that services were at a convenient location, and only one in five said it was easy to get an appointment when needed. Long wait times and difficulty accessing services was a consistent challenge that was raised by clients and loved ones in both quantitative and qualitative data.

Participating in and providing services

A clear strength highlighted by clients in their experience with the mental health system was with providers themselves. Two thirds of clients and loved ones surveyed agreed that the mental health services they or their loved one received are helpful, and three quarters said they felt respected by the mental health team. Many positives and strengths highlighted by clients were

[2] Some clients accessed more than one system of care; therefore, the sum of clients served by the adult system of care, youth system of care, and TAY system of care is greater than the total unique clients served.

mirrored by providers, who expressed confidence in their organizations' abilities to help clients' recovery and keep clients engaged for as long as they needed services. Providers also rated collaboration among agencies as a significant strength, despite acknowledging room for improvement. Overall, when providers and clients were asked similar questions about service provision, providers ranked services more positively than did clients.

Areas for improvement in service provision noted by clients included more involvement of clients and loved ones in their treatment planning. Clients also indicated that crisis services not being available to everyone was a top need in the system, which is consistent with other findings about long wait times, not enough CSU beds and more availability of other types of high-intensity services. Overall, client satisfaction with services was relatively low.

Movement through the system

Ideally, clients who are accessing services within the Sonoma BHD system can be "stepped up" or "stepped down" to different services according to their level of needs in a timely manner. However, in many cases, clients are staying longer than expected in high levels of care, contributing to higher costs, higher caseloads for providers, and longer wait times for clients.

In the CSU, there were 972 episodes in FY 2021-2022, and the median length of stay was one day, but the mean length of stay was 2.5 days, with 44% of episodes lasting two or more days. This indicates a slowdown in the system where clients are hindered from being transferred to more appropriate levels of care after stabilization, and this is consistent with findings around long wait times for other levels of care.

For unlocked short-term residential services, approximately half of episodes lasted for longer than the recommended length of stay, with the mean length of stay (15 days) just exceeding the recommended maximum stay (14 days). For unlocked long-term residential services, three quarters of clients stayed for less than maximum recommended amount of time (6-9 months). For both unlocked short-term and unlocked long-term residential services, staying beyond the expected length of stay does represent challenges in movement through the system, indicating clients may not be receiving the most appropriate level of care in a timely manner.

In addition to the CSU and unlocked short- and long-term services, Sonoma BHD's Full Service Partnerships (FSPs) play an integral role in moving clients through the system and engaging clients in intensive, team-based, and culturally appropriate services in the community. In FY 2021-2022, the adult FSP teams had 263 total episodes, with a mean "length of stay" or period of client engagement of approximately 1 year and 10 months. The youth FSP team had 626 total episodes and a mean length of engagement of 11 months.[3] This timeframe, for both the adult and youth FSP teams, encompasses how long a client engages with the FSP program to ensure they are connected with appropriate services, as FSPs are committed to doing "whatever it takes."

Positive systemic changes

A variety of strengths of the mental health system and successes of the last several years were highlighted in conversations with BHD staff and partners. Community engagement through bodies like the MHSA Community Program Planning (CPP) Workgroup has been key in implementing MHSA, and additional funding through sources such as Measure O has helped fill

some programmatic system needs. Creative responses to the COVID-19 pandemic, including new solutions to the housing crisis and an increase in access to telehealth were seen as positive changes coming out of an overall challenging situation. Staff in general, including peer providers, were highlighted as core strengths of Sonoma's mental health services, and were lauded for their compassion, dedication, and respect for clients.

System-wide and external challenges

Budget cuts from 2017-2019 forced BHD to reduce mental health services to core services only, reducing preventative care. This meant that more clients needed to utilize higher levels of care, which is more expensive than preventative care and more challenging to transition out of, meaning that clients sometimes remain in higher levels of care longer than needed. This created a cycle in which more funding must be dedicated to intensive care services.

The need for mental health services has increased County-wide as a result of the collective trauma of multiple devastating fires, the COVID-19 pandemic, seasonal flooding, and the related amplification of other hardships, including economic instability, increased unemployment, inflation, and school closures. Simultaneously, the County has an ongoing challenge of understaffing, with high rates of turnover and difficulty in both recruitment and retention of staff. For the providers who remain, high caseloads have an impact on provider burnout and the quality of services they can provide.

Insufficient housing has been an increasing problem in the last several years, with an increase in the number of people experiencing homelessness since the beginning of the pandemic. In addition, budget cuts in recent years have resulted in reduced capacity to support individuals with severe mental illness (SMI) moving from a higher level of care into supportive housing. Improved coordination between departments and programs, including those addressing SUD and homelessness, would be helpful, to support clients with co-occurring SMI and other challenges, including SUD, homelessness, and significant medical conditions.

Services are scarcer in more rural areas, and telehealth increases access for some but remains a challenge for those with limited internet access or computer literacy. Finally, significant health disparities exist across various populations; providing more culturally and linguistically appropriate services was identified as a potential gap.

Resources

Available data provided the price of each service rendered for both claimable and non-claimable services. The price of services, when added together across all services rendered in FY 21-22, indicates how much Sonoma County BHD could have claimed if all services were claimable. Thus, this is considered Sonoma County BHD's "Potential Revenue." Overall, in the 2021-2022 fiscal year, potential revenue of all services rendered (both claimable and non-claimable) totaled $66.6 million. One-third of the potential revenue of all services rendered was non-claimable, for a total of $22.5 million of non-claimable services and $44.2 million of claimable services. In all, an average of $20,000 was spent per person on 3,454 unique clients.

Most of the potential revenue was related to adult services ($51 million) followed by youth services ($13 million) and TAY services ($3 million). Per person, potential revenues were highest for adult services ($21,373 per person), followed by TAY services ($20,106). The potential revenue of services for youth ages 0-18 was significantly lower per client, at $11,358.

Programs that had high levels of non-claimable costs included adult board and care ($6.7 million total, all non-claimable), adult residential services ($4.6 million claimable and $5.1 million non-claimable), and the CSU ($3.8 million claimable and $9.0 million non-claimable). The $9.0 million of non-claimable CSU costs were related to CSU overstays.

The challenges of receiving appropriate levels of care at the necessary time, such as those related to CSU overstays discussed above, result in a more expensive behavioral health system in Sonoma County. These barriers can lead to higher use of crisis and acute mental health services, which are more expensive than lower levels of care and not always covered by Medi-Cal.

Recommendations

1. **Improve the transition of clients out of the CSU into less-intensive services,** to reduce the amount of time that clients stay in the CSU and to provide clients with a better environment for recovery.
2. **Increase capacity for non-crisis services**, including outpatient therapy, to reduce wait times for appointments and help prevent clients from escalating needs that may turn into crises. Increased capacity for non-crisis services may also help alleviate overstays in the CSU by providing clients who have been stabilized with more options for appropriate levels of care.
3. **Continue to integrate peer providers into the system of care.** Services provided by peer providers and those with lived experience are highly valued by the community, serve a large number of clients, and may help reduce the burden of services on other cadres of providers.
4. **Invest in a sustainable workforce**, exploring strategies for better recruitment and retention of staff that can alleviate the high levels of staff turnover and understaffing, which impact service availability.
5. **Explore the reasons behind over- and under-representation of specific populations** in mental health services and in justice-related services to better understand possible service gaps and bias in the treatment of mental illness.

Introduction

Sonoma County Department of Health Services, Behavioral Health Division (DHS-BHD) has partnered with Resource Development Associates (RDA) to conduct a Mental Health Services Act (MHSA) Capacity Assessment for the period of fiscal years 2019-2022. This capacity assessment is intended to provide a comprehensive analysis of Sonoma's MHSA-funded system of care and community needs and contribute to the development of the Three-Year MHSA Program and Expenditure Plan for fiscal years 2023-2026.

This report presents results from qualitative and quantitative data collection and analysis for this project, conducted in August through December of 2022. RDA Consulting conducted data collection via a community survey, focus groups, and key informant interviews in order to understand strengths, challenges, and gaps in the system of care from community and system leaders, clients, family members, providers, and other partners. In addition, RDA Consulting conducted a background document review and secondary analysis of administrative data and quarterly reports supplied by the County's MHSA funded partners. These analyses informed this final capacity assessment report.

Sonoma County Overview

Sonoma County has a population of 485,887 people across a region of 1,576 square miles.[4] While most residents in the County have relative economic security, about 9% of the population have an income below the Federal Poverty Level (FPL).[5] With the high cost of living in the County, which has a median income of $91,607,[6] there are likely additional residents without the economic ability to meet their basic needs (i.e., food, clothing, shelter, transportation, health care, etc.). More than one in four (28%) of County residents (138,932) were eligible for Medi-Cal in 2022 with an income at or below 138% FPL.[7] These residents rely on the County for support with a number of social services and health care needs, including mental health services for individuals with serious mental illness.

Santa Rosa, the County's most populous city with 176,938 people, is home to over one-third of county residents, and holds the County seat and the main campus of the Department of Health Services, Behavioral Health Division (DHS-BHD).[8] Beyond Santa Rosa, the main population centers are Petaluma (population 59,403) and Rohnert Park (population 44,411) to the south, and Windsor (population 26,039) to the north.[9] Sonoma is geographically dispersed with limited

[4] U.S. Census Bureau. (2022). *Quick Facts, Sonoma County, California*. Retrieved from https://www.census.gov/quickfacts/fact/table/sonomacountycalifornia

[5] U.S. Census Bureau. (2022). *Quick Facts, Sonoma County, California*. Retrieved from https://www.census.gov/quickfacts/fact/table/sonomacountycalifornia

[6] U.S. Census Bureau. (2022). *Quick Facts, Sonoma County, California*. Retrieved from https://www.census.gov/quickfacts/fact/table/sonomacountycalifornia

[7] California Department of Health Services (2022). Medi-Cal Certified Eligibility by Month of Eligibility and Race/Ethnicity. Retrieved from: https://data.chhs.ca.gov/dataset/medi-cal-certified-eligibles-tables-by-county-from-2010-to-most-recent-reportable-month/resource/29a8f949-5c12-4e42-92db-39fa5ea12b8e

[8] U.S. Census Bureau. (2022). *Quick Facts, Santa Rosa City, California*. Retrieved from https://www.census.gov/quickfacts/fact/table/santarosacitycalifornia

[9] U.S. Census Bureau. (2022). *QuickFacts Windsor town, California; Rohnert Park city, California; Petaluma city, California.* Retrieved from: https://www.census.gov/quickfacts/fact/table/windsortowncalifornia,rohnertparkcitycalifornia,petalumacitycalifornia

public transit or bicycle and pedestrian infrastructure. It can therefore be challenging for individuals living in more rural areas and those without a personal vehicle to get around.

In 2022, 86% of residents identified as White with 28% identifying as Hispanic or Latinx, the County's largest minority population.[10] The County's poverty rates vary significantly by ethnicity, with disparities affecting the Latinx community in particular. While Hispanic or Latinx residents were about a quarter of the population, this group accounts for nearly 40% of Sonoma County's Medi-Cal beneficiaries in 2022.[11]

The County is also home to five federally recognized Native American tribes, including the Cloverdale Rancheria of Pomo Indians of California, the Dry Creek Rancheria Band of Pomo Indians, the Federated Indians of Graton Rancheria, the Kashia Band of Pomo Indians of the Stewarts Point Rancheria, and the Lytton Band of Pomo Indians.[12] Native Americans make up just over 2% of the County's total population and about 1% of Medi-Cal beneficiaries.[13]

Over 26% of Sonoma households speak a language other than English at home, of which about 20% speak Spanish – the County's only threshold language.[14] About 11% of residents speak English less than "very well," suggesting possible linguistic isolation for this population.[15] Individuals that are undocumented and/or linguistically isolated may experience unique challenges accessing medical, transportation, and social services. Language barriers may have a negative impact on access to services and the quality of services available.

The County has endeavored to hire additional Spanish/English Bilingual staff by keeping continuous recruitments for Spanish/English bilingual positions and offering a pay differential, but there are a low number of bilingual mental health providers in the County. Therefore, despite persistent efforts to hire bilingual staff, the County has a limited number of staff that are bilingual in Spanish/English, see table below:

Table 1: Bilingual DHS-BHD staff by job categories

DHS-BHD Staffing Category	Number of Bi-lingual staff	
	Basic	Fluent
Behavioral Health Clinician	6	3
Behavioral Health Clinical Intern	3	0
Nurse	1	0
AOD Counselors (all categories)	2	1
Senior Client Support Specialists	5	2
Senior Office Assistants	6	2

[10] U.S. Census Bureau. (2022). *Quick Facts, Sonoma County, California*. Retrieved from https://www.census.gov/quickfacts/fact/table/sonomacountycalifornia

[11] California Department of Health Services (2022). Medi-Cal Certified Eligibility by Month of Eligibility and Race/Ethnicity. Retrieved from: https://data.chhs.ca.gov/dataset/medi-cal-certified-eligibles-tables-by-county-from-2010-to-most-recent-reportable-month/resource/29a8f949-5c12-4e42-92db-39fa5ea12b8e

[12] County of Sonoma. (2022). Tribal affairs. Retrieved from http://sonomacounty.ca.gov/CAO/Public-Reports/Legislative-Program/Tribal-Affairs/

[13] U.S. Census Bureau. (2022). *Quick Facts, Sonoma County, California*.

[14] U.S. Census Bureau. (2022). *Language Spoken at Home, 2017-2021 American Community Survey 5-year estimates.* Retrieved from: https://data.census.gov/table?q=+sonoma+county+california&tid=ACSST5Y2021.S1601

[15] U.S. Census Bureau. (2022). *Selected Social Characteristics in the United States, 2017-2021 American Community Survey 5-year estimates.* Retrieved from: https://data.census.gov/table?g=0500000US06097&y=2021&d=ACS+5-Year+Estimates+Data+Profiles

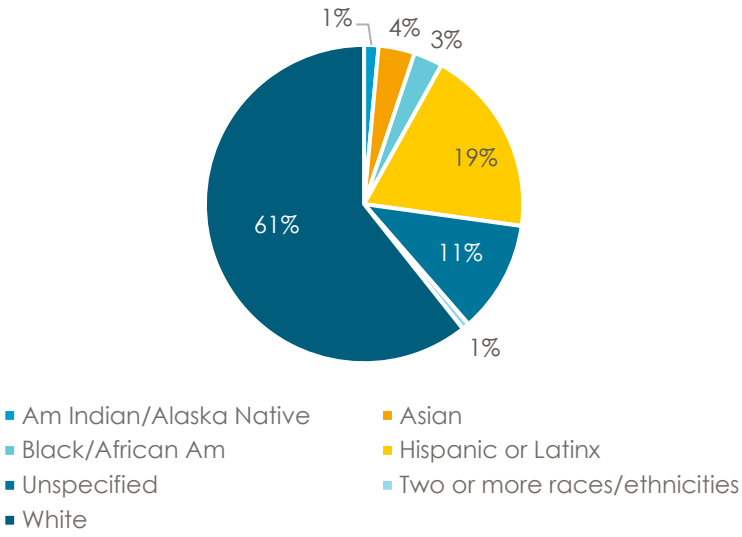
In 2022, Sonoma County Human Resources provided the information below about DHS-BHD's current workforce. At the time of the survey, there were 273 Behavioral Health Staff.

Table 2: Race and ethnicity of DHS-BHD workforce, county residents, and Medi-Cal beneficiaries

Race and Ethnicity	BH Workforce		Sonoma County	
	#	%	Residents	Medi-Cal Beneficiaries[8]
American Indian/Alaska Native	4	1%	2.3%	1%
Asian (alone)	10	4%	4.8%	3.2%
Native Hawaiian or other Pacific Islander (alone)	-	-	.4%	
Black or African American	8	3%	2.1%	1.7%
Hispanic or Latinx	52	19%	28.3%	40.8%
Unspecified	31	11%	-	-
Two or More Races	2	1%	4.3%	-
Other	-	-	-	23.7%
White	165	61%	86.1%	29.5%

Data from Table 2 indicates that DHS-BHD's entire workforce is underrepresented for Hispanic or Latino as compared to both the general population and Medi-Cal eligibility. Reducing the disparity in representation continues to be a high priority in staff recruitment for the Division.

Figure 1: DHS-BHD Workforce by Ethnicity



The County has areas of strengths and limitations that impact the County's ability to meet the needs of the County's racially and ethnically diverse populations. The strengths include new leadership that is committed to improving representation of racially and ethnically diverse, especially Latino representation. The leadership includes a new Behavioral Health Director and a newly appointed Ethnic Services, Inclusion and Training Coordinator. The County is also dedicating resources to a performance improvement project on Latinx Mental Health Access, and the MHSA CPP Workgroup listening sessions designed to learn more about how we can meet the needs of the County's racially and ethnically diverse populations. The County is working very closely with Human Resources and community partners to recruit racially and ethnically staff that mirror the County's clients. Additionally, the County is collaborating with the Board of Supervisors to increase wages for the workforce.

There are serval barriers, some mentioned above, to developing a workforce that mirrors our clientele and meeting the needs of the County's racially and ethnically diverse clients including:

- A behavioral health workforce shortage in the County, state and nationwide
- A shortage of Spanish/English Bilingual behavioral health workers throughout the state
- The County's wages for behavioral health workers are lower than other neighboring counties and other providers in the county

COVID-19 in Sonoma County

On March 18th, 2020, the Health Officer of Sonoma County issued a Shelter in Place order in order to slow the spread of COVID-19 in the county.[16] As of January 2023, the county has seen almost 113,000 documented cases of COVID-19 in all, and a total of 532 deaths due to the virus countywide.[17] People identifying as Hispanic/Latinx have been disproportionately affected by the pandemic in Sonoma County; members of this community account for 43% of all the cases countywide but, as stated earlier, make up 28% of the overall population of the county.[18] The Native American/Alaska Native and Native Hawaiian and other Pacific Islander populations are also disproportionately affected by COVID-19 in Sonoma County, as together they make up 0.9% of the population, but account for 2% of the total cases in the county.[19]

Nearly three years into the COVID-19 pandemic, the negative mental health impacts of the pandemic and its many related outcomes (social isolation, economic uncertainty) have been widely acknowledged throughout the United States and globally, both on youth and adults. These mental health impacts, in addition to the physical impacts of the virus, have disproportionately affected communities which were already disadvantaged in our society (i.e., people living with disabilities, people with mental illness, communities who are economically disadvantaged).[20] This creates additional strains on public mental health services, such as those provided by Sonoma BHD.

California's Public Mental Health System

California's Public Mental Health System

The public mental health system in California is designed to provide specialty mental health services to individuals who have Medi-Cal or are otherwise uninsured and have significant mental health needs. In California, each county administers a mental health plan (MHP), which provides coverage for medically necessary mental health services; counties also administer the MHSA funding. Both Medi-Cal and MHSA are operated under contract from the California Department of Health Care Services (DHCS). Services provided by MHPs can include rehabilitative mental health services, psychiatric inpatient hospital services, targeted case management, psychiatrist services, psychotherapy services, supplemental specialty mental health services, and more. Mental health specialists, such as psychiatrists, psychologists, licensed clinical social workers, licensed marriage and family therapists, or peer support providers, deliver

[16]County of Sonoma (2020) *Health Officer Orders County Residents Shelter in Place*. Retrieved from: https://sonomacounty.ca.gov/health-officer-orders-county-residents-shelter-in-place
[17]County of Sonoma Emergency Readiness, Response and Recovery (2023) *Sonoma County Coronavirus Data at a Glance*. Retrieved from: https://socoemergency.org/emergency/novel-coronavirus/
[18] County of Sonoma Emergency Readiness, Response and Recovery (2023) *Sonoma County Coronavirus Cases*. Retrieved from: https://socoemergency.org/emergency/novel-coronavirus/coronavirus-cases/
[19] County of Sonoma Emergency Readiness, Response and Recovery (2023). *COVID-19 Case Data*. Retrieved from: https://experience.arcgis.com/experience/1edbb41952a8417385652279305e878d/page/Race-%2F-Ethnicity/
[20] Panchal, Nirmita, et al (2021). *The Implications of COVID-19 for Mental Health and Substance Use*. Retrieved from: https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

these services to clients. Medi-Cal will reimburse counties for up to 50% of these services, however, there are restrictions on this reimbursement and not all of the services provided by counties will be reimbursed. Counties remain responsible for providing these services to their Medi-Cal population, even if they are not reimbursed. The other main sources of funding for these services are the Mental Health Services Act and Realignment.

Spirit and Intention of MHSA

The Mental Health Services Act, Proposition 63, was approved by California voters in 2004 to expand and transform the public mental health system. **MHSA represented a statewide movement toward a better coordinated and more comprehensive system of care for those with Serious Mental Illness** (SMI). In addition, MHSA defined an approach to the planning and the delivery of mental health services that are embedded in the MHSA values (see Figure 2).

Figure 2: MHSA Values

MHSA is funded through a one percent tax on individual annual income exceeding one million dollars. California counties receive MHSA allocations from the state, which typically make up **about 25-30% of a county's behavioral health budget.** Counties determine how to distribute these funds at the local level through a Community Program Planning (CPP) process which culminates in a three-year plan.

MHSA provides increased funding, personnel, and other resources to support county mental health programs. The Act supports a variety of prevention, early intervention, and service needs, as well as the necessary technology, infrastructure, and training. MHSA calls upon local county behavioral health departments to **transform their public mental health system and engage in a community-driven process to provide more effective treatment.** MHSA provides a unique opportunity for counties to continue developing their public mental health systems with and in support of individuals who have limited resources and a high level of need.

MHSA defines four client age groups to reflect the different mental health needs associated with a person's age, and counties are directed to provide age-appropriate services for each:

Children: 0-15 years
Transition Age Youth (TAY): 16-25 years
Adults: 26-59 years
Older Adults: 60 years and older

Additionally, MHSA intends to serve individuals who are historically unserved or underserved by the public mental health care system.[21]

> **Unserved individuals** are defined as "individuals who may have serious mental illness and/or serious emotional disturbance and are not receiving mental health services. Individuals who may have had only emergency or crisis-oriented contact with and/or services from the County may be considered unserved."
> **Underserved individuals** are defined as "individuals who have been diagnosed with a serious mental illness and/or serious emotional disturbance and are receiving some services but are not provided the necessary or appropriate opportunities to support their recovery, wellness, and/or resilience."

MHSA funding is distributed across three funding categories to support all facets of the public mental health system throughout the lifespan of clients and their needs.

> **Community Services and Supports (CSS):** Outreach and direct services for children, TAY, adults, and older adults with the most serious mental health needs. The majority of CSS funds must be dedicated to Full Service Partnerships (FSPs).
> **Prevention and Early Intervention (PEI):** Services promoting wellness and the prevention of mental health issues. Early intervention services screen for and intervene in early signs of mental health disorders. The majority of PEI money must fund programs for children and TAY clients (birth to 25-years-old) and their caregivers.
> **Innovation (INN):** Funding to test new approaches that may improve access, collaboration, and/or service outcomes for un-, under-, and inappropriately served populations. INN provides funding for up to five years per innovative practice.

MHSA Services in Sonoma County

Sonoma County offers youth and adults a broad array of behavioral health services through a combination of those provided directly by Sonoma County BHD and those provided through BHD contracted agencies. Services include crisis response and stabilization, inpatient and outpatient services, case management, assessments, mobile services, residential services, community treatment, among many others. Broadly, Sonoma County BHD tends to directly provide higher levels of behavioral health support and use contracted providers for less intensive services.

Services provided by the county are supported both through MHSA funding, which makes up about 25% of the county's behavioral health budget, as well as other funding sources. All county services are represented in the youth and adult systems maps, including those supported by MHSA funding. MHSA-funded services specifically are comprised of three categories: Community Services and Support (CSS), Prevention and Early Intervention (PEI), and Innovation (INN).

[21] "Unserved" and "Underserved" are defined in California Code of Regulations, Title 9. Rehabilitative and Development Services, Division 1. Department of Mental Health, Chapter 14. Mental Health Services Act, Sections 3200.300 and 3200.310

Community Services and Supports

Community Services and Supports (CSS) allow for the provision of all necessary mental health services for children with severe emotional disturbances and adults with serious mental illness. There are 13 CSS programs in Sonoma County. They utilize peer and clinical providers to identify, assess, and serve individuals experiencing mental health problems throughout the lifespan. Table 3 shows all CSS programs, with a description. CSS funds the following service categories:

Full Service Partnerships (FSP): FSP seeks to engage children with severe emotional disturbances and adults with serious mental health challenges into intensive, team-based, and culturally appropriate services in the community.
General System Development (GSD): GSD works to develop and operate programs to provide mental health services to individuals across the lifespan who require or are at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention.
Outreach and Engagement (OE): OE services Identify those in need, reach out to target populations, and connect those in need to appropriate treatment.

Table 3: Community Services and Supports Programs, 2022-2023

Program Name	Category	Target Age	Description
Adult Full Service Partnership	Full Service Partnership	26-59	Multidisciplinary teams that provide intensive field-based specialty mental health services
Family Advocacy, Stabilization & Support (FASST)	Full Service Partnership	0-18	Family-centered wraparound specialty mental health services. This program includes services from the County, Seneca, Lifeworks and Social Advocates for Youth (SAY).
Forensic Assertive Community Treatment (FACT)	Full Service Partnership	18+	Community-based treatment as an alternative to incarceration
Integrated Recovery Team (IRT)	Full Service Partnership	18+	Multidisciplinary teams that provide intensive field-based specialty mental health services for adults with co-occurring mental health and substance use disorders
Older Adult Team	Full Service Partnership	60+	Intensive, integrated services for older adults with serious mental illness, coupled with

Program Name	Category	Target Age	Description
			more complex medical conditions requiring coordination between the mental health and medical providers. This program includes services from the County and West County Community Services and Council on Aging.
Transition Age Youth	Full Service Partnership	18-25	Mental health services, intensive case management, housing and employment support services, and independent living skills. This program includes services from the County, Buckelew Programs, Social Advocates for Youth, and VOICES.
Alternative Family Services	General Systems Development	0-15 16-18	Provides therapeutic treatment for youth clients.
Collaborative Treatment and Recovery Team	General Systems Development	26-59	Care coordination, case management, systems navigation and outpatient therapy. This program includes services from Buckelew.
DHS-BHD Foster Youth Team	General Systems Development	0-15 16-25	Case management, care coordination, and therapeutic treatment for foster youth clients.
DHS-BHD Medication Support Services for Adult Programs	General Systems Development	18+	Provides psychiatric services for adult clients
DHS-BHD Medication Support Services for Youth Programs	General Systems Development	0-15 16-25	Provides psychiatric services for youth clients
Mobile Support Team	General Systems Development	All	Behavioral health professionals provide field- based support to law enforcement officers responding to behavioral health crises. This program includes

Program Name	Category	Target Age	Description
			services from Support Our Students.
Peer and Family Programs	General Systems Development	All	Peer centers and education, support, and advocacy for families impacted by SMI. This program includes services from West County Community Services.
Sonoma County Job Link	General Systems Development	16+	Employment, education, and career services.
Community Mental Health Centers	Outreach and Engagement	18+	Regionally-based outpatient specialty mental health services
Whole Person Care	Outreach and Engagement	18+	Outreach and engagement to homeless individuals with SMI , short term recuperative care services, and intensive case management
Sonoma County Indian Health Project - Community Programs	Outreach and Engagement	18+	Provision of health care for all Indians of Sonoma County. Services are provided in a manner which is sensitive to the culture and traditions of the local Indian Tribes.

Prevention and Early Intervention (PEI)

Prevention and Early Intervention (PEI) efforts in Sonoma County were designed to introduce a continuum of services across the lifespan to prevent or intervene early in mental health issues, with particular focus on serving unserved and underserved community members. The County's PEI initiatives work towards this goal by bringing together diverse approaches to address many facets of mental illness in the community. The primary PEI approach focuses on activities that prevent the development of mental illness or intervene during the early stages of onset. There are 15 PEI programs funded by MHSA in Sonoma County. Table 4 includes the full list of PEI programs.

State-Wide Promotion (optional): A pool of PEI funds between 38 counties that supports the ongoing implementation of the Statewide PEI Project, Each Mind Matters: California's Mental Health Movement, which amplifies efforts to reduce stigma and discrimination and prevent suicides across the state.

Prevention: Reduces the risk for developing a potentially serious mental illness (SMI) and builds protective factors. Activities can include universal prevention strategies geared towards populations who may be more at risk of developing SMI.

Early Intervention: Treatment and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence with a goal to lessen the severity and duration of mental illness.
Access and Linkage to Treatment: Activities to connect children, adults and seniors with severe mental illness as early in the onset of these conditions as practicable, to medically necessary care and treatment.
Stigma and Discrimination Reduction: Direct activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services, which can include training and education, campaigns, and web-based resources.
Suicide Prevention: Organized activities that prevent suicide as a consequence of mental illness, which can include trainings and education, campaigns, suicide prevention networks, capacity building programs, culturally specific approaches, survivor-informed models, screening programs, suicide prevention hotlines, or web-based suicide prevention resources.
Outreach for Increasing Recognition of Early Signs of Mental Illness: Outreach services to families, employers, primary care health care providers, law enforcement, and others.

Table 4: Prevention and Early Intervention Programs, 2022-2023

Program Name	Category	Target Age	Description
California Mental Health Services Authority (CalMHSA)	State-Wide Promotion	All	Trainings, presentations, and other efforts to reduce stigma and discrimination and prevent suicide
Action Network - Across Ages and Cultures	Prevention	All	Provides bi-lingual, culturally effective services to parents and other family members of children on the remote Sonoma Coastline.
Community Baptist Church Collaborative	Prevention	All	Reduces mental health service disparities among the local African American population by decreasing stigma through various programs.
Human Services Dept. - Older Adult Collaborative	Prevention	60+	Utilizes Healthy IDEAS, a prevention and early intervention evidence-based model, to reduce depression and suicide
Sonoma County Indian Health Project -Aunties & Uncles	Prevention	All	Reduces mental health disparities among the local Native American communities by increasing access to mental health services

Program Name	Category	Target Age	Description
La Luz Center	Prevention & Early Intervention; Early Intervention	All	Uses Your Community, Your Health/*Tu Comunidad, Tu Salud* program to address the mental health needs of the Sonoma Valley Latinx community providing no-cost culturally and linguistically competent health and wellness services.
Latino Service Providers of Sonoma County	Prevention & Early Intervention	All	Provides information on activities and resources that promote economic stability, educational success, housing, legal services, healthcare, and mental health services and stigma reduction among the Latinx community. Trains ten Youth *Promotores* and two Youth Promotor Leaders to promote mental health information and resources in the Latinx community.
Positive Images	Prevention & Early Intervention	12+	Programs and services that help youth, service providers, and the public develop positive, healthy, and life affirming behaviors and views of personal expression of gender identity and sexual preference.
Child Parent Institute (CPI)	Early Intervention	0-5 and their caregivers	Services that aim to reduce risk factors, build protective factors and skills, and increase support for families with children ages 0 to 5. Program focuses on children at risk for mental illness and for women identified with Perinatal Mood Disorder. Services include risk assessment/screening, case management, parent education (Triple P Parenting) and brief psychotherapy.
Early Learning Institute (ELI)	Early Intervention	0-5 and their caregivers	Provides social-emotional screenings and navigation for children 0-5 years of age and individual therapeutic interventions to promote developmental education and support to young children and their families.

Program Name	Category	Target Age	Description
Santa Rosa Junior College (SRJC) – People Empowering Each Other to Realize Success	Stigma & Discrimination Reduction	16+	Promotes mental health and reduces stigma on campus through orientations, first year experience courses, online screenings, educational content, and trainings
Buckelew Programs - North Bay Suicide Prevention Program	Suicide Prevention	All	24/7 suicide prevention and crisis telephone counseling to people in distress and/or their family and friends
Adult Access Team	Access and Linkage to Treatment	18+	Improves access to mental health treatment by determining the appropriate level of care and creating service linkages
Youth Access Team	Access and Linkage to Treatment	0-18	Improves access to mental health treatment by determining the appropriate level of care and creating service linkages
Crisis Intervention Training (CIT) with Law Enforcement Personnel	Outreach for Increasing Recognition of Early Signs of Mental Illness	18+	Trainings for law enforcement and community members to recognize signs and symptoms of mental illness and how to effectively intervene when a crisis occurs.

Innovation

Innovation (INN) projects are designed to increase mental health care access for underserved groups, increase the quality of services, and promote interagency collaboration through innovative new approaches. INN programs may introduce new mental health practices that have never been done before, change an existing mental health practice, or introduce a new application of a promising practice that has been successful in non-mental health contexts. In 2020, Sonoma County underwent a Community Planning Process with stakeholders and the community to identify new Innovation projects, with an Innovation Subcommittee overseeing the process. This process resulted in five new Innovation projects, each of which are summarized in Table 5.

Table 5: Innovation Programs, 2022-2023

Project Name	Target Age	Time frame	Project Summary
Early Psychosis Learning Health Care	12-25	5 year project (started March 2021)	Elizabeth Morgan Brown One Mind ASPIRE Program of Sonoma County's EP LHCN is the first treatment program specifically for youth with First Episode Psychosis in Sonoma

Project Name	Target Age	Time frame	Project Summary
Network (EP LHCN)			County. This project is a collaboration between UC Davis, Aldea and Buckelew and is also part of the Statewide Early Psychosis Learning Collaborative (a Mental Health Services Oversight and Accountability Commission's [MHSOAC] Incubator Project).
Instructions Not Included (INI) - Dads Matter	All	3 year project (started Sept 2021)	Instructions Not Included (INI) - Dads Matter is operated by Early Learning Institute. This is a home visiting program for first time fathers combining three curricula: Promoting First Relationships, Partners for a Health Baby, and Nurturing Fathers with enhancements from Dad's Matter, Adverse Childhood Experiences (ACEs) and depression screening and lessons learned from National Father's Initiative.
New Parent TLC	18+	3 year project (started August 2021)	New Parent TLC operated by First 5 Sonoma County seeks to address the lack of screening, identification, and necessary referrals for parents with unidentified and untreated parental depression from pregnancy through the first 12-months after birth. "Gatekeeper" training for early intervention of maternal and paternal mental health issues, preventing progression of more serious depression and/or suicide by parents and reducing the exposure of infant ACEs resulting from parental depressions and associated disruption of optimal infant brain development. To promote community collaboration among nontraditional points of entry for individuals needing mental health support, developing a public health education movement encouraging possible policy change.

Project Name	Target Age	Time frame	Project Summary
Unidos Por Nuestro Bienestar (formerly Collaborative Care Enhanced Recovery Project (CCERP))	50-64	3 year Project (Started November 2021)	Unidos Por Nuestro Bienestar is led by HSD's Older Adult Division combines an established short-term intervention with an additional 9- months of in-home case management, resulting in positive impacts for adults from 50 - 64 years old with depression.
Nuestra Cultura Cura Social Innovations Lab		3 year project (Started 2021)	Nuestra Cultura Cura Social Innovations Lab operated by On the Move in partnership with community leaders: A partnership of community organizations will engage a diverse cohort from the Latinx communities to determine root causes of mental health stigma and inaccessibility for their communities. Facilitators support the team in determining a strategic direction with specific actions to address defined issues. Resources are be provided for team members by the various CBO partners. The Social Innovations Lab will create more culturally relevant mental health strategies to reduce depression and anxiety and promote cultural protective factors.

Sonoma County's MHSA Capacity Assessment Process

Sonoma County's DHS-BHD hired Resource Development Associates (RDA), a consulting firm with mental health planning expertise, to assess the effectiveness, structure, quality, and impact of its MHSA-funded Continuum of Care in August 2022. RDA's assessment was supported by DHS-BHD personnel, including Melissa Ladrech, Mental Health Services Act (MHSA) Coordinator; Fabiola Espinosa, Program Planning and Evaluation Analyst; Julie Kawahara, MHSA Planning consultant; and the MHSA Steering Committee and Community Program Planning (CPP) Workgroup.

The capacity assessment provided the community with many opportunities to share their experiences with the Sonoma mental health system to ensure that any recommendations made in this assessment were community-driven and responsive to their needs. Stakeholders across the County had an opportunity to express their opinion of the current Sonoma mental health systems and their suggestions for future improvements.

Capacity Assessment Methods

The assessment team carried out a set of information-gathering activities, engaging stakeholders and the community throughout the process to ensure that the assessment reflected their experiences and suggestions. From the data collected, RDA conducted a mixed-methods analysis of qualitative and quantitative data to understand the successes, challenges, and gaps of Sonoma's public mental health system. Three priority questions guided the capacity assessment:

> **Structure:** What is the current state of the MHSA-funded system of care? What programs and services are available, for whom, in which geographic regions, and at what capacity? How does the current system compare to what is expected in a public mental health system in similar counties?
>
> **Process:** How do people move through the system? What are the strengths and barriers?
>
> **Resources:** How are resources invested? Do they align with stated system priorities and the community's needs?

Throughout the assessment process, the RDA team used an iterative approach, refining questions and findings throughout the assessment. The approach was also multi-level, assessing trends and findings at the system-, program-, and individual-level. This framework allowed RDA to identify trends and synthesize findings across the County system and ensure validity with targeted questions and refinement of findings. Assessment activities are described in detail below and corresponding materials and handouts are included in the Appendix.

Project Launch

Document Review

To inform RDA's approach to the key informant interviews and community data collection activities, RDA reviewed the 2019 MHSA Capacity Assessment final report as well as several other relevant documents:

- 2019 final presentation (slides) provided to the Steering Committee
- Tools and internal documents used during the development of the 2018-2019 MHSA Capacity Assessment
- Sonoma County's MHSA Three Year Program and Expenditure Plan for 2020-2023
- The Sonoma County BHD Cultural Competency Plan for FY 21-22
- Sonoma County MHSA Program and Expenditure Plan Update for FY 2022-2023 with FY 2020-2021 Annual Report
- The "Leading Through Listening: Student & Community Voices in Sonoma County" 2020-2021 Youth Truth Student Survey
- FY 2021-2022 Medi-Cal Specialty Behavioral Health External Quality Review, Sonoma Final Report

Context-setting Key Informant Interviews

Three initial key informant interviews (KIIs) were conducted in August 2022 to better understand the overall BHD system of care in Sonoma County. Appendix 1, Table 11 provides the full list of participants who took part in a KII.

System Mapping discussions

To develop maps of the adult and youth systems of care, RDA facilitated two separate discussion sessions in August 2022 with BHD staff who work with adult mental health services and youth mental health services. For each discussion, RDA relied on the systems maps developed for the 2019 capacity assessment as a starting point to understand how clients move through the systems of care, identify areas that have changed, and explore how the maps may be updated and improved for accuracy and clarity. Table 12 in Appendix 1 provides the full list of participants who took part in the systems mapping discussions for the adult and youth systems of care.

Data Collection & Analysis

RDA used a mixed-methods approach (i.e., both qualitative and quantitative data collection tools) to conduct the capacity assessment, which maximizes validity by allowing for the examination of the same phenomenon in different ways (e.g., triangulation).[22] RDA utilized data from multiple sources, including document review, interviews, focus groups, surveys, electronic health records data, and financial data. Utilizing a mixed-method approach provided RDA the flexibility to fill in gaps in the available information, to use triangulation to strengthen the validity of estimates, and to provide different perspectives on complex, multi-dimensional phenomena.[23]

Data Collection

The data collection process included the following components:

Consumer and Service Utilization Data

RDA collected data from DHS-BHD on consumers who received DHS-BHD services during the three-year period from July 1, 2019- June 30, 2022. Client information, including demographics, was collected to describe the specialty mental health population in Sonoma County. Programmatic and service information was collected to identify which services and levels of care were being utilized by consumers. Service data also included financial information on County expenditures and Medi-Cal reimbursement. These data were obtained through the County's electronic health record, Avatar, as well as Sonoma Web Infrastructure for Treatment Services and MHSA Quarterly Reports from contracted providers.

Countywide Survey

To include input from a wide range of stakeholders, particularly those who would not be able to attend the in-person focus groups, RDA designed and administered a community survey. The survey ran from October 6 - November 8, 2022 and was available in both English and Spanish. This anonymous survey included both closed- and open-text questions to gather data on respondents' demographics and relationships to MHSA services; perceptions of program quality, appropriateness for community need, timeliness, accessibility, and staffing; and thoughts regarding outstanding community mental health needs, population-specific needs, service strengths, and service weaknesses or areas for growth. The survey was available online, with paper flyers including a QR code at various community locations including DHS-BHD waiting

[22] Frechtling, J., & Sharp, L. (1997). User-friendly handbook for mixed method evaluations. National Science Foundation. Retrieved from http://www.nsf.gov/pubs/1997/nsf97153/start.htm

[23] Bamberger, B., Rao, R., & Woolcock, M. (2010). Using mixed methods in monitoring and evaluation. The World Bank. Retrieved from: http://www-wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2010/03/23/000158349_20100323100628/Rendered/PDF/WPS5245.pdf

areas and mental health peer resource centers in the County. RDA established and maintained the online survey and related database via a secure online platform, Alchemer.

Focus Group Discussions and Key Informant Interviews:

To gather a more in-depth understanding of program activities, community impact, perceived service strengths, weaknesses, and outstanding mental health needs, RDA convened ten focus groups and conducted seven interviews with key informants. DHS-BHD, the MHSA Steering Committee, and CPP worked with RDA to generate a list of potential groups and individuals using the key stakeholder groups identified in MHSA regulations. DHS-BHD leadership, staff from local community-based organizations, and committee members conducted recruitment for the focus groups, making special efforts to reach target populations and communities throughout Sonoma County. Focus groups were advertised to providers and community leaders via emails explaining the purpose of the meetings. DHS-BHD connected RDA with the key informants with RDA conducting further outreach to everyone via email. To better understand the differences between the consumer and provider experience with the mental health system of care, RDA created unique focus group and interview protocols for each of these groups. The organizations that hosted or participated in focus groups and key informant interviews, and the populations they represented in the community, are listed in Table 13 and 14 in Appendix 3.

Community Survey

There were 236 community surveys completed in their entirety, and 185 partially completed.[24] Figure 3 through Figure 9 show the demographic and role breakdowns of the survey respondents who responded to these questions.

[24] "Complete" surveys include respondents who went through to the "thank you" page, but this includes individuals who indicated they were neither providers nor clients nor loved ones and were routed out of the survey. Additionally, not all respondents answered all questions, so n's for individual questions vary.

Figure 4: Categories of survey respondents (n=297)

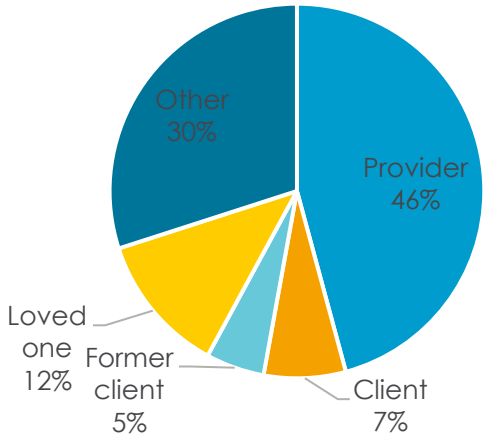


Figure 3: Provider respondents, by agency type (n=103)

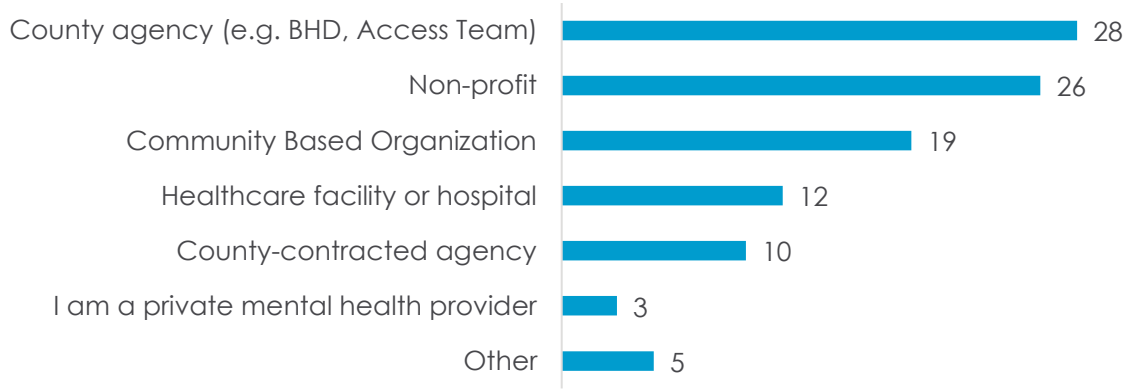


Figure 5: Survey respondents, by race (n=121)

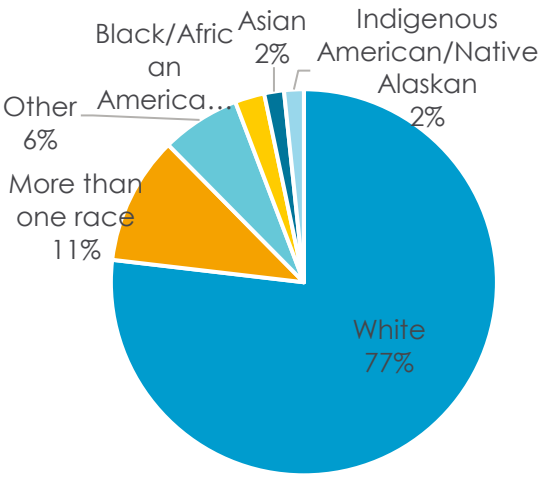


Figure 6: Survey respondents, by ethnicity (n=114)

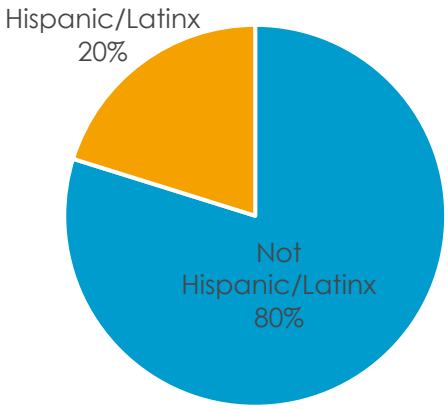


Figure 8: Survey respondents, by gender identity (n=132)

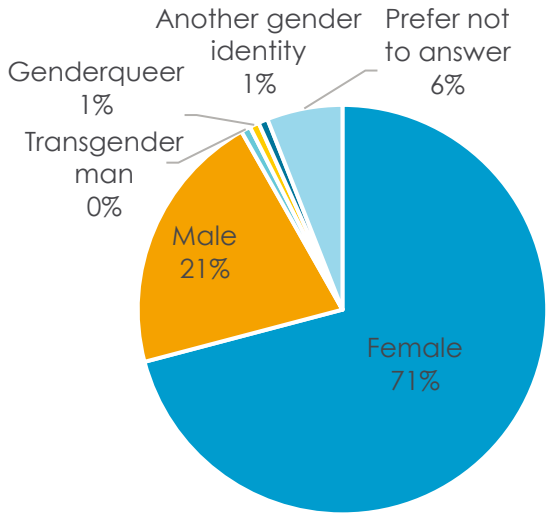


Figure 9: Survey respondents, by sexual orientation (n=132)

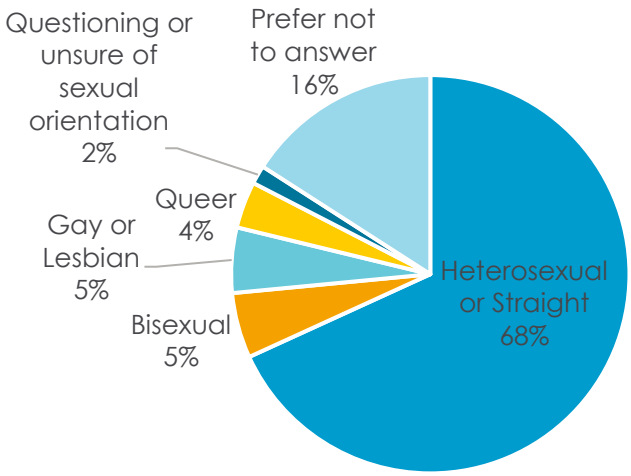
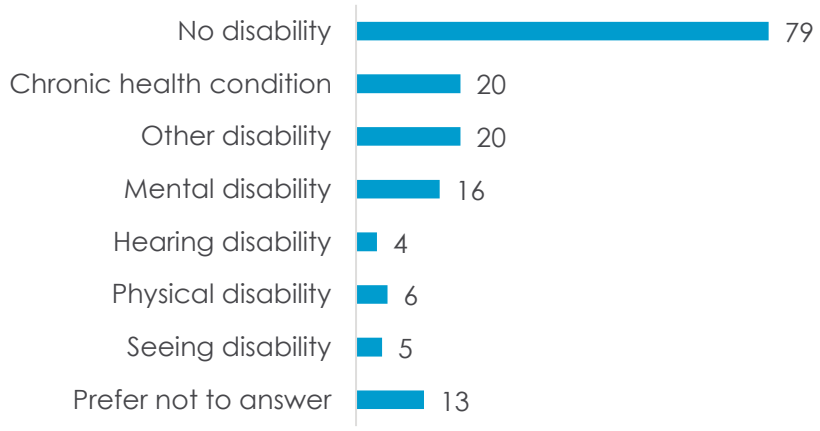


Figure 7: Survey respondent types of disabilities identified (n=131)



5%
were veterans

96%
spoke English at home

30%
identified as having at least one disability

Stakeholder Participation

The capacity assessment process included a variety of stakeholders reflective of the geographic and cultural diversity of Sonoma County including groups listed in MHSA regulations and the Welfare and Institution Code.[25] This included representatives from the following groups:

[25] Per the MHSOAC, WIC § 5848 states that each Annual Update shall be developed with local stakeholders, including: Adults and seniors with severe mental illness; Families of children, adults, and seniors with severe mental illness; Providers of services; Law enforcement agencies; Education; Social services agencies; Veterans; Representatives from veterans organizations; Providers of alcohol and drug services; Health care organizations; Other important interests (e.g., individuals served or targeted by Prevention and Early Intervention (PEI) services and individuals expected to benefit from INN projects). CCR § 3300 further includes: Representatives of unserved and/or underserved populations and family members of unserved/underserved populations, as defined in CCR § 3200.300 and CCR § 3200.310; Stakeholders that

- Adults and Seniors with Lived Experience
- Family Members
- DHS-BHD staff, managers, and senior leadership
- Community Mental Health Service Providers
- Law Enforcement Agencies
- Education Agencies
- Social Service Agencies
- Veterans and Veterans Organizations
- Providers of Alcohol and Drug Services
- Health Care Organizations

The capacity assessment process leveraged several existing meetings whenever possible, including the Community Corrections Partnership monthly meeting and the local National Alliance on Mental Illness chapter's weekly drop-in family member support group. Overall, 484 people participated in the capacity assessment – 35 attended focus groups, 421 participated in the survey, 15 engaged in system of care discussions, and 13 participated in interviews.

Limitations

Although RDA used extensive data collection techniques and robust mixed-methods analyses, the underlying findings are dependent on the data available, which have some limitations.

Sonoma County DHS-BHD collects client and program information through several different datasets for different program and service types. For this capacity assessment, RDA collected data from the County's Electronic Health Record (EHR) system, Avatar, which captures the majority of service and client data but does not collect data from contracted providers. DHS-BHD contracted providers submit quarterly reports on the services they deliver, and clients served. However, client data in these reports are aggregated and limited detail is available. Thus, the information presented in this report concentrates on Avatar data as the most comprehensive of all client data sources available.

While seeing how resources are spent in the system is an important part of a comprehensive capacity assessment, the financial data that is available in Avatar only shows a small part of the overall costs of the system. This available data does tell a comprehensive story about how much services could be billed for in the CSU and other programs, and the analysis of that information is included in Appendix 8. As for the cost of services, or the expenses incurred by Sonoma BHD for services rendered, that data was not readily available at the time of analysis and therefore not included in this report.

The community survey had a lower than desired total response rate, among clients and loved ones, with only approximately 30 complete responses. Thus, the client perspectives presented from the community survey are representative of an important but small portion of clients and loved ones who access services.

reflect the diversity of the demographics of the county, including but not limited to, geographic location, age, gender, and race/ethnicity; Clients with serious mental illness and/or serious emotional disturbance, and their family members.

RDA attempted to facilitate a focus group with Hispanic/Latinx clients, and with parents of youth clients, but was unable to recruit participants to either one, thus, there is a lack of qualitative data from these two groups in our assessment.

Lastly, as is with many data collection efforts, selection bias is a limitation. RDA conducted focus groups with a variety of provider and client groups, and it is possible that those with particularly negative or positive outlooks on services/programs were more inclined to participate in data collection than other providers or clients within Sonoma's system of care. In addition, there may be selection bias caused by the fact that those who know how to access services may also have been more likely to know of and access the survey, and community members who face challenges accessing mental health services or are under-represented in mental health services are also likely under-represented in the survey. Selection bias can therefore impact the generalizability of findings and should be considered when interpreting results.

Capacity Assessment Findings

The Sonoma County behavioral health system offers services across the spectrum of mental health severity, from high-intensity crisis and residential treatment to maintenance-focused community-based programs. In fiscal year 2021-2022 (July 1, 2021 to June 30, 2022), the system **directly served almost 3,500 unique clients** and reached an estimated 8,000 clients through peer, prevention and early intervention, and outreach services.[26]

This section describes the findings from the data collection process described above, including system mapping sessions, key informant interviews, focus groups, a community survey, and electronic health records. The findings are structured around the three priority questions for the MHSA Capacity Assessment, pertaining to the structure and population served, the process by which clients access and receive care, and the resources invested.

Structure of the Sonoma County Behavioral Health System

Regardless of funding source or type of program, clients move through the County's behavioral health system according to their needs and interest in services. The sections below describe the services available to clients and how they move within them. The services described are depicted visually in the systems maps shown in Figure 10 and Figure 11.

Adult and Youth Systems of Care

Points of Entry

Clients may enter the behavioral health system in a variety of ways, including through self-referral or referral by a family member, through Mobile Service Teams, hospitals, or a variety of other channels. Points of entry into the system of care differ based on whether the client is an adult or youth, and whether they need crisis or non-crisis services. The BHD provides a range of services, from locked inpatient facilities to peer-run prevention programs via an integrated

[26] Data from these programs is limited. These numbers represent estimates and are likely double-counting individuals who accessed multiple services.

network of BHD in-house programs, contracted providers in the community, and connections with services in other county departments.

Crisis Referral Channels for Adults

If an adult is experiencing a crisis, they may self-refer or be referred by a friend or family member to the Crisis Stabilization Unit (CSU), run by Sonoma County BHD. If they present to one of the County's seven hospital emergency departments, the hospital can refer them to the CSU; similarly, the client may be referred through a federally qualified health center (FQHC). If a mobile crisis intervention team (i.e., the Sonoma County-run Mobile Support Team or Santa Rosa's inRESPONSE team) or the police respond to a client in crisis, they may also refer the client to the CSU. Additionally, clients may be referred to the CSU from the jail.

Non-Crisis Referral Channels for Adults

Adults who are not in crisis may enter the system by referral to the Access Team through many of the same channels described above: self-referral or referral by a friend or family member; referral by a FQHC where they are receiving care; or by the Hospital Liaison Team from one of the County hospitals. The Whole Person Care team, the Older Adult Collaborative, or staff at the jail may refer clients as well. The Access Team provides an assessment of the appropriate level of care for the client and provides connections to service teams or providers.

Youth Referral Channels

Youth under age 18 entering the system of care may be referred to the Youth Access Team via the Crisis Stabilization Unit, hospitals, FQHCs, Mobile Support Teams, or Juvenile Court. They may also self-refer or be referred by family members. If they are being referred from the Psychiatric Health Facility, the Hospital Liaison Team refers them to the Youth Access Team. The Foster Youth Team accepts referrals from the Human Services Department, Children's shelter, and out-of-county transfer. Youth in the Foster Care System may also self-refer or be referred by their foster families.

Transition Age Youth

Transition Age Youth (TAY), defined in the MHSA as people between the ages of 16 and 25, are a group with needs which often differ from those of younger youth or older adults. The Sonoma BHD system offers some programs specifically targeted to this age group and tailored to their unique needs. These programs are all included on the Youth System Map, though some youth 18 years old and older are referred to these by the Adult Access Team. TAY may also and often do access adult services as well as those geared specifically to TAY.

Inpatient and Housing-based Services

Adult inpatient services within the system of care include locked short-term and long-term facilities, which include the BHD-run Psychiatric Health Facility, as well as residential treatment programs, which are run through four community-based providers under contracts with the County. Contracted providers and County inter-agency collaborations also offer Supportive Housing, Board and Care Facilities, and Scattered Site Vouchers for housing. Youth have access to four short-term shelters, seven supportive housing programs, one transitional housing program, and six short-term therapeutic programs provided by organizations contracted by BHD. The Human Services Department is in development for a new short-term therapeutic housing site for youth.

Care Transitions and Intensive Outpatient Services

Adult clients in need of care transitions and step-down services may access these through the BHD's Transitional Recovery Team, which provides extended support and oversight to clients who are in the process of community discharge, as well as through the number of FQHCs in the county. Intensive Outpatient Programs provided through the BHD include three Full-Service Partnerships (FSPs), all of which offer an interdisciplinary approach to intensive outpatient treatment. These include the Adult Team, the Older Adult Intensive Team (for those 60 years of age or older), and the Integrated Recovery Team (for those with substance use disorder or other co-occurring disorders). BHD also contracts with Telecare Assertive Community Treatment (TACT) to provide intensive case management for adults with SMI in Sonoma County. The Collaborative Treatment and Recovery Program provides time-limited outpatient care coordination, case management, systems navigation, and outpatient therapy, and includes services through Buckelew Programs.

Youth may access FSP services through the Family Advocacy, Stabilization, and Support Team (FASST), and young adults between the ages of 16-24 can access FSP services through the TAY Team. FSP services are also available to youth through BHD Medication Support Services, Alternative Family Services and TLC Children's Services. Seneca Family of Agencies offers wraparound services to youth.

Outpatient and Prevention Programs

Outpatient mental health services are provided to adults through the four Community Mental Health Centers (CMHC) in Sonoma County: Cloverdale, Guerneville, Petaluma, and Sonoma Valley. The four CMHCs focus on underserved populations in their respective geographies, as well as services for adults with co-occurring substance use disorders. Additional outpatient services are available through the BHD's Adult Services Team and Adult Medication Support Team. The BHD also provides culturally specific and peer-run prevention programs via contracts with 11 community-based organizations and other partners.

Three outpatient clinics in the County system serve youth under 18, and one (Interlink) serves young adults ages 18-24. Peer, social, and family groups are offered to youth through eight different contracted organizations. BHD also supports youth via the Youth Medications Team. Three culturally specific providers serve both adults and youth in Sonoma County, and there are two others, Aunties & Uncles and Positive Images, which primarily focus on youth services. Additional programs, including Early Learning Institute, Child Parent Institute and North Bay Suicide Prevention Program (Buckelew Programs), offer age-based services to youth.

Forensic System Programs

BHD services are available to adults and youth in various phases of the legal system, including pre-trial, in court, and post-plea. For adults, there is a BHD-run Diversion Program. There are three competency restoration programs available to adults in Sonoma County, including the Community-Based Competency Restoration provided through the BHD. There is also a justice agency and a hospital-based competency restoration program. BHD offers a full service partnership program to adults with involvement in the justice system through the Forensic Assertive Community Treatment (FACT) FSP Team. For youth, juvenile justice programs include juvenile hall, probation camps, and juvenile sex offender services.

Figure 10: Adult Mental Health System Map

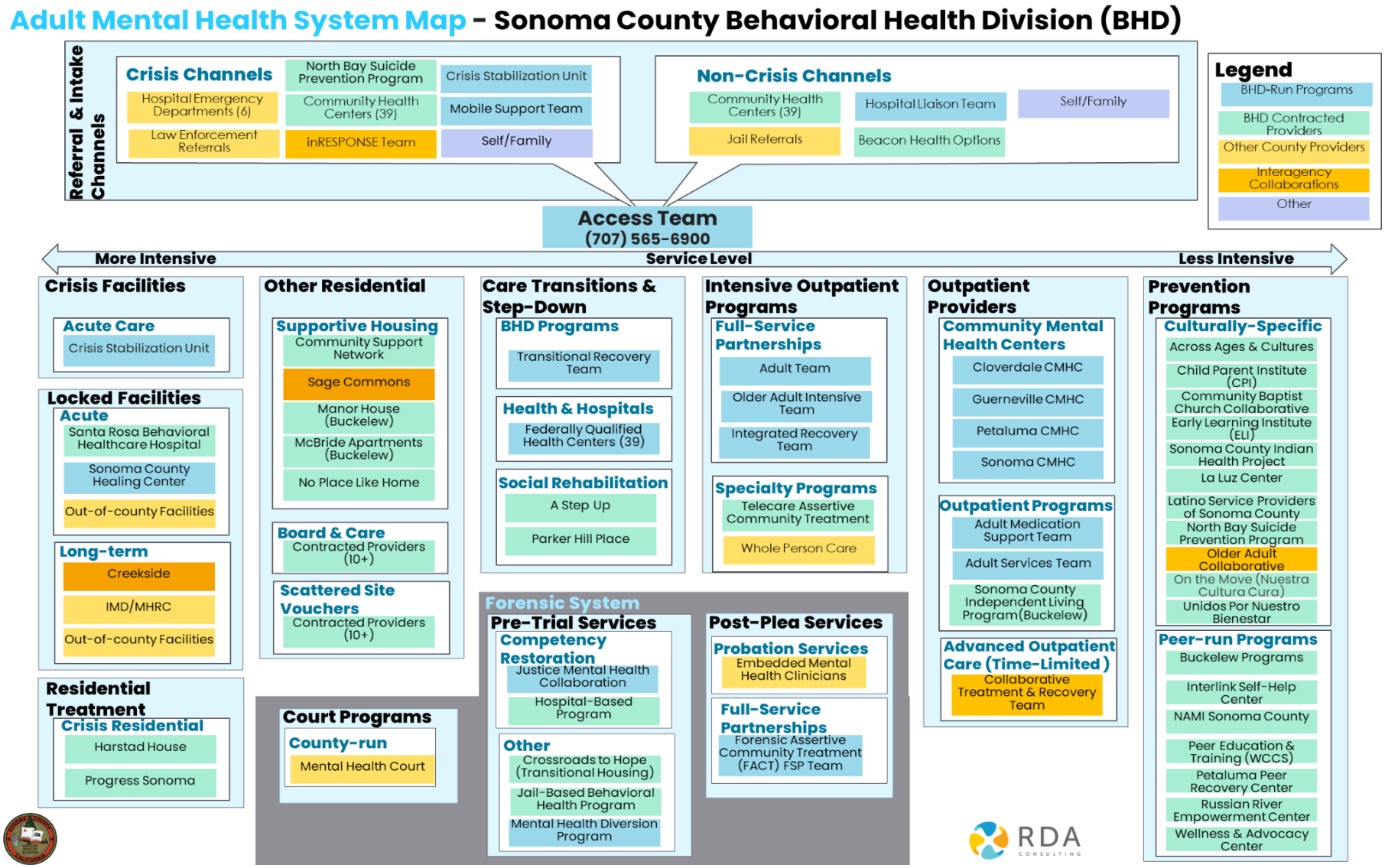
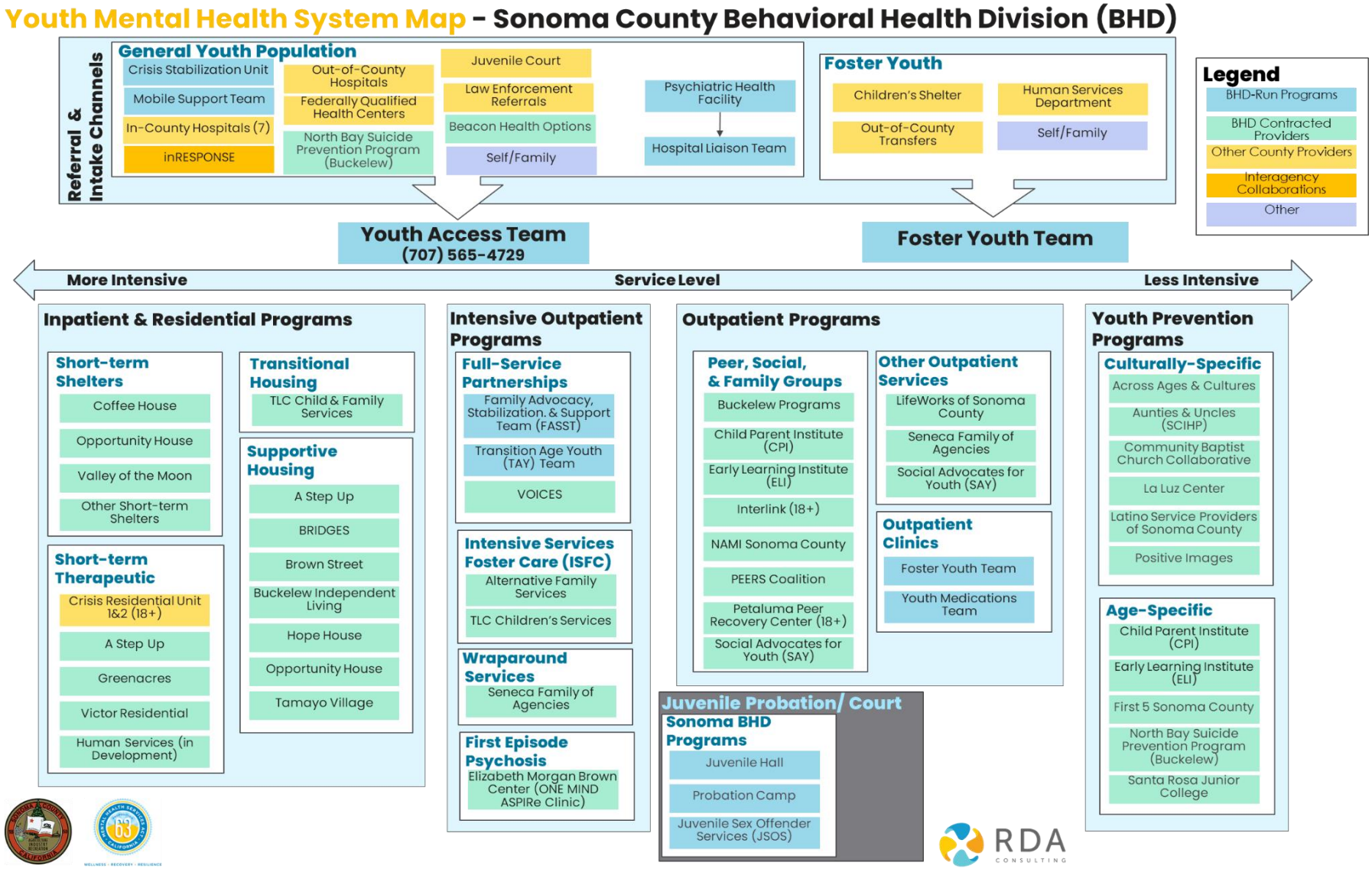


Figure 11: Youth Mental Health System Map



Demographics of Population Served

As shown in Figure 12 and Figure 13, **the majority of the 3,484 unique BHD clients who accessed services during fiscal year 2021-2022 were White (59%) and not Hispanic/Latinx (63%)**, followed by those identifying as another race not listed (22%). Smaller proportions of clients identified as Black or African American (6%), American Indian/Native Alaskan (3%), Asian/Asian American (3%), or Native Hawaiian or Pacific Islander (<1%). When asked their ethnicity, about a quarter of clients identified as Mexican or Mexican American (19%) or another Hispanic/Latinx identity (9%). Race and ethnicity data was not reported for almost 10% of clients. The racial and ethnic makeup of BHD clients is similar to that of Sonoma County, with a majority of residents identifying as White and a little more than a quarter (28%) identifying as Hispanic or Latinx, the county's largest minority population.

Figure 12: Race of total individuals served, FY 21-22 (n=3,181)[27]

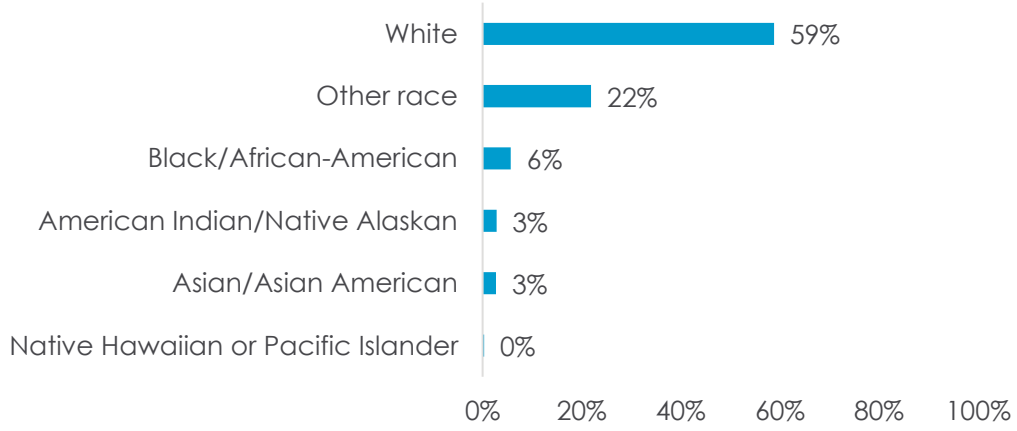
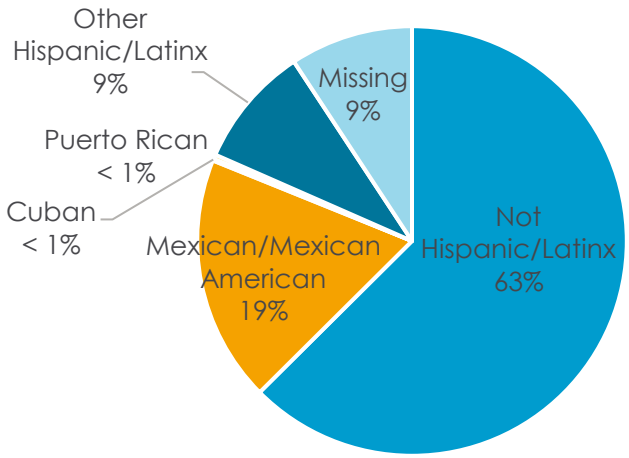


Figure 13: Ethnicity of total individuals served, FY 21-22 (n=3,454)



[27] Excluding missing/blank entries

MHSA-funded services have allowed for individuals of all ages to access necessary and intensive mental health services to promote recovery and increased quality of life. As displayed in Figure 14, **the majority of DHS-BHD clients were adults between the ages of 26 and 59**, followed by children ages zero to 15, TAY ages 16-25, and older adults aged 60 or older. The service population was almost evenly split across genders (Figure 15), with 49% of clients identifying as female and 49% identifying as male in fiscal year 2021-2022. The remaining 1% of clients identified as another gender identity.

Figure 14: Age groups of total individuals served, FY 21-22 (n=3,453)

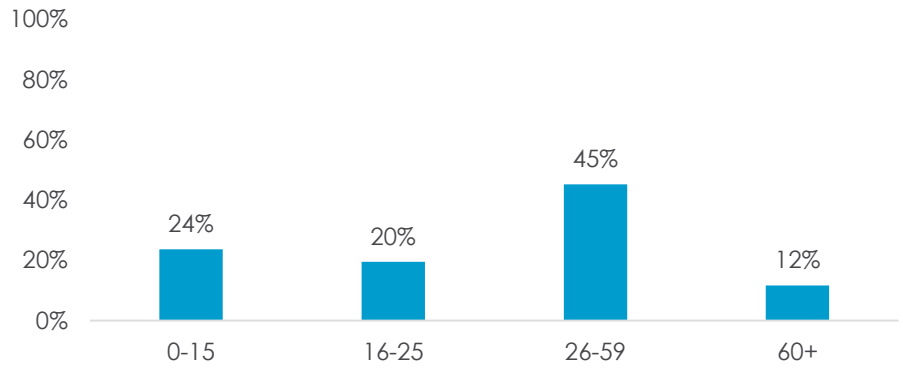
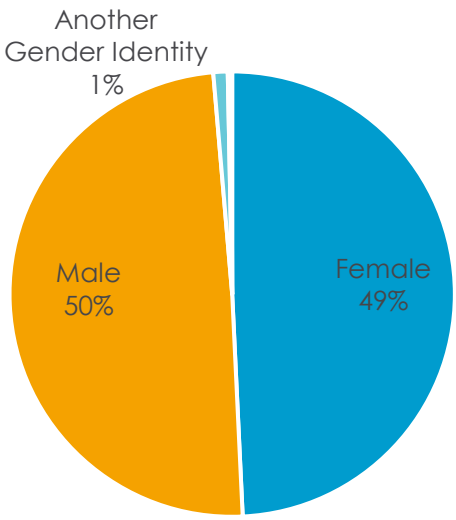


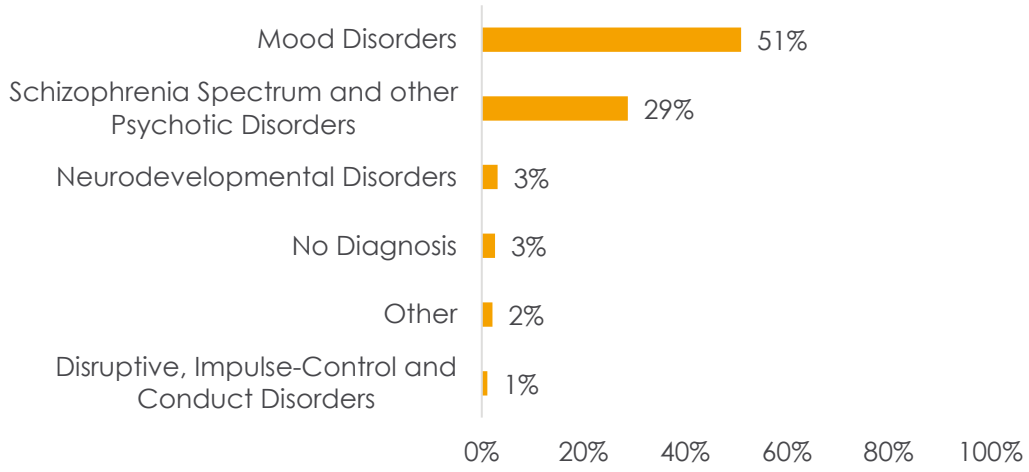
Figure 15: Gender identity of total individuals served, FY 21-22 (n=3,454)



MHSA services also supported clients with a variety of diagnoses. During that period, **half of clients were diagnosed with a mood disorder,** such as anxiety disorders, depressive disorders, stress and trauma related disorders, and others. The second most common category of diagnosis was schizophrenia spectrum and other psychotic disorders (29%). Less than 5% of clients were diagnosed with neurodevelopmental disorders or having a disruptive, impulse-control, and conduct disorder diagnosis. A very small portion of clients did not have a diagnosis of any kind in their records (3%). The breakdown of primary diagnosis among DHS-BHD clients can be found in Figure 16. A majority of schizophrenia disorder diagnoses (67%) were among

those ages 26-59, while mood disorder diagnoses were more evenly split across age groups. Moreover, the majority of neurodivergent disorder diagnoses (78%) were among those under the age of 15 (data not shown).

Figure 16: Diagnosis of total individuals served, FY 21-22 (n=3,692)[28]



Adult and Older Adult Services

In fiscal year 2021–2022, **Adult and Older Adult Services served 2,378 unique clients. The majority were White (65%)**, followed by another category (15%) (Figure 17). Only about 20% of clients in the adult system of care identified as Mexican/Mexican American or Other Hispanic/Latinx (data not shown), although this group makes up about 30% of total DHS-BHS clients and 40% of Sonoma's adult Medi-Cal beneficiaries. During the past fiscal year, approximately 12% of clients served by the Adult and Older Adult system of care were TAY.

Youth and Family Services

In fiscal year 2021-2022**, Youth and Family Services served 1,154 unique clients. The largest group identified as White (45%),** followed by another category (37%) (Figure 17). Almost half of clients in the Youth system of care identified as Latinx, including Mexican/Mexican American (30%) or Another category Hispanic/Latinx (16%) (data not shown). There is a notable contrast in the proportion of youth and adult system populations served who identify as Latinx: Hispanic/Latinx clients made up about 20% of clients in the adult system of care while they made up almost half of clients in the youth system of care. This trend was also seen within specific programs, with Hispanic/Latinx youth making up close to half of all episodes for general outpatient programs and about 40% of total clients served by youth justice-related services.

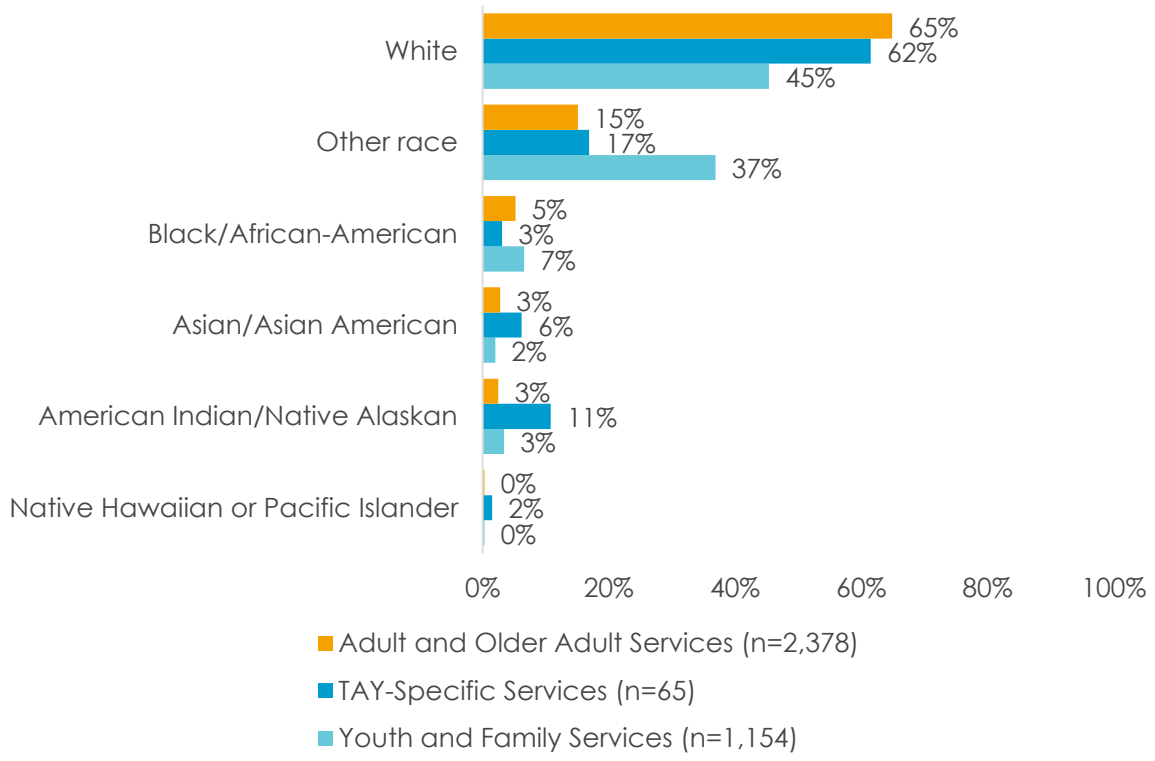
Transition Age Youth (TAY) Specific Services

Moreover, 65 unique clients were served by TAY-specific services, which falls within the Youth and Family section. Over half of clients utilizing TAY-specific services identified as

[28] Individuals can have multiple diagnoses. Thus, the total number of diagnoses is greater than the total number of clients.

White/Caucasian (62%) and over a third of clients identified as Latinx, including Mexican/Mexican American (23%) or Other Hispanic/Latinx (9%).

Figure 17: Race of individuals served by adult and older adult services, TAY-specific services, and youth and family services, FY 21-22



Process

Points of Access

As depicted in the youth and family and adult systems maps (Figure 10 and Figure 11), individuals can enter and receive behavioral services through a variety of paths. Regardless of individual demographics and the services clients ultimately access, individuals enter the system through two main points of entry – the Access Teams and crisis services. In fact, almost half of all clients enter the system through these two primary channels.

Access Teams

In non-crisis situations, the Access Team is the first point of contact for individuals requesting mental health services. Access Teams exist for adults and youth, with the latter comprised of general youth and foster youth populations.

In fiscal year 2021-2022, **Access Teams served 1,068 individuals** – the Adult Access Team served 467 individuals, the Youth Access Team served 415 individuals, and the Foster Youth Access Team served 186 individuals. Previously, youth accessed services through the same access team as adults or were assessed by a contracted provider. The Youth Access Team was created in

2019 to provide dedicated assessment services for youth through DHS-BHD. In fiscal year 2021-2022, **23% of clients served by the Adult Access team were TAY.**

Crisis Services

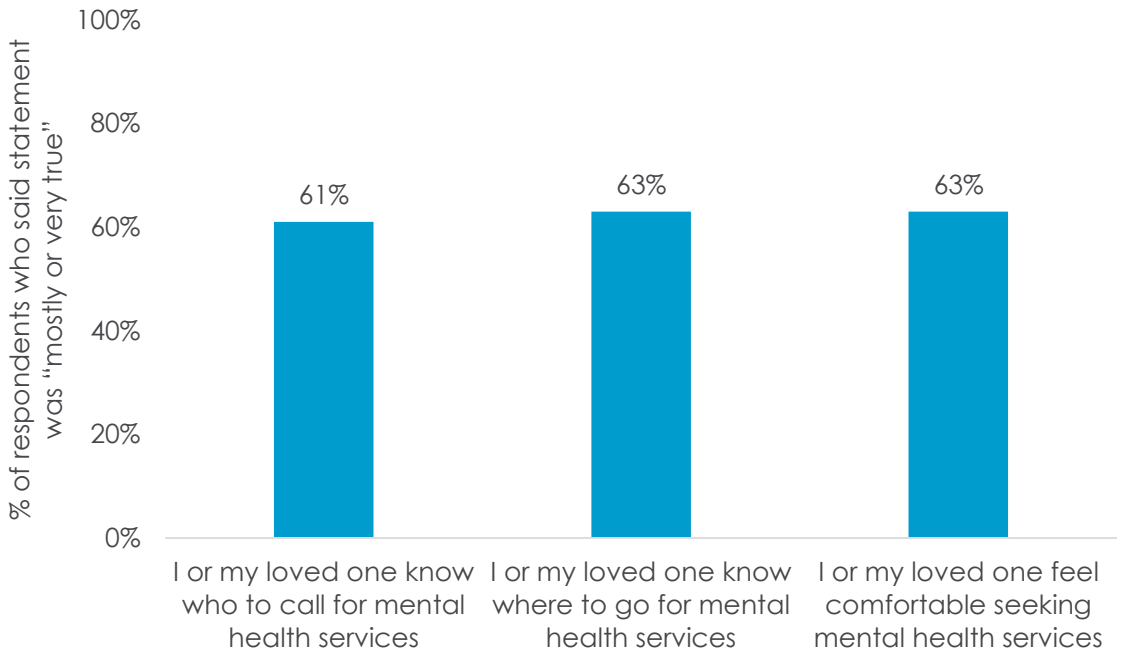
The Crisis Stabilization Unit serves people of all ages, including children, TAY, adults, and older adults. It provides 24 hour-a-day, seven days-a-week crisis intervention, assessment, medication, and supportive care for individuals experiencing an acute mental health crisis. In fiscal year 2021-2022, **the CSU served 640 unique clients in 972 episodes**, the majority of whom were ages 26 to 59 (67%) or 16 to 25 (22%) and identified as White/Caucasian (55%) and not Hispanic/Latinx (57%). About 20% of CSU clients identified as Mexican/Mexican American or Other Hispanic/Latinx, and for another 20% of CSU clients, no race or ethnicity was recorded.

Successes and challenges accessing services

Providers and clients were asked about positive aspects and challenges of accessing various types of services.

Nearly two thirds of clients and their loved ones who responded to the survey said that they knew who to call and where to go for mental health services, and that they or their loved one felt comfortable seeking mental health services (Figure 18). Among providers, two thirds said they thought that client wait times for services were reasonable (66%) (data not shown), indicating that providers do not perceive the delay in services to be as large of a problem as do clients.

Figure 18: Positive aspects of accessing services (client perspectives) (n=35-36)

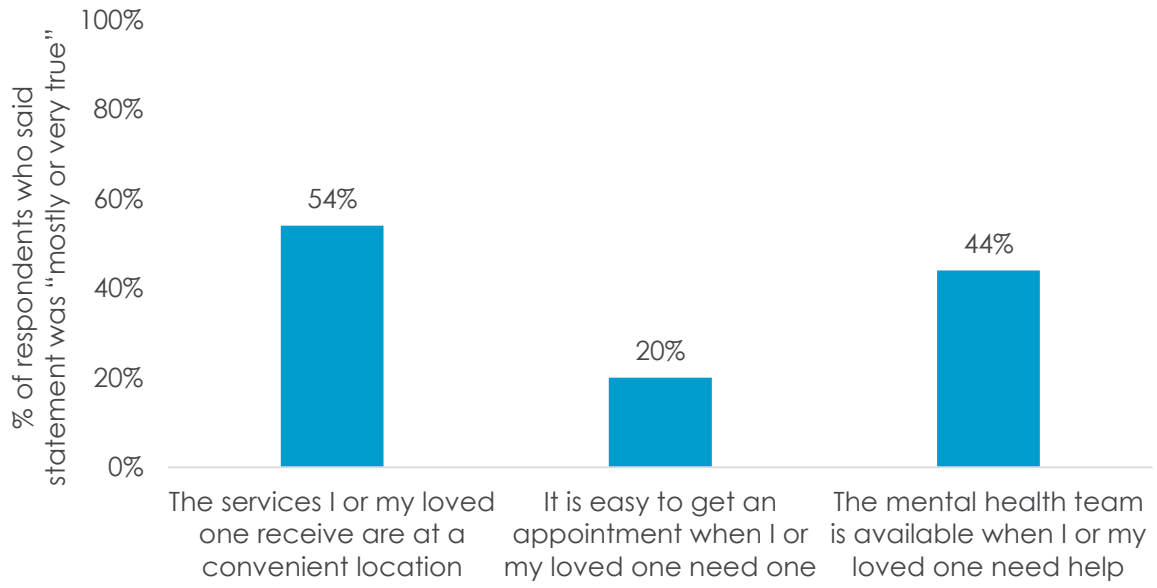


However, only half of clients said that services were at a convenient location, and only one in five (20%) said it was easy to get an appointment when needed (Figure 19). Fewer than half of clients (44%) agreed with the statement that "the mental health team is available when I or my loved one need help", and when asked to rank the most challenging aspects of receiving

services, the top two challenges identified by clients were long wait times for appointments and not knowing where to go for services or services not being convenient. This mirrors findings among providers and BHD leadership about insufficient availability of services and understaffing leading to challenges meeting demand in a timely manner.

> *"Sometimes, loved ones have to wait weeks for an appointment." - Survey Respondent*

Figure 19: Challenging aspects of accessing services (client perspectives) (n=35-36)



Participating in and providing services

Once clients have entered the mental health system, Sonoma County offers services for children, TAY, and adults with mental health needs across the acuity spectrum (Table 6).

Table 6: Total number of clients served by adult and older adult services, TAY-specific services, and youth and family services (n=597)[29]

Service Type	Total Served
Adult	2,378
TAY	65
Youth	1,154

[29] TAY are formally served by Youth and Family Services, but there are instances when this group is served by the Adult and Older Adult system of care. Thus, there are instances of "double counting" across the adult, TAY, and youth services because some TAY clients (and some youth) were sometimes serviced by the adult system of care.

Adult and Older Adult Services

The Adult and Older Adult system of care includes a variety of services, such as residential programs, community-based outpatient services for those with severe and persistent mental illness, supportive housing options, and justice-related services (Table 7).

Table 7: Total unique clients served by adult and older adult services, FY 21-22[30]

Program	Total Served
Adult Outpatient	1,975
Adult Residential	617
Adult Board and Care	263
Adult Justice Services	87

Inpatient or other residential programs offer the highest level of care. Residential and housing options are available to clients receiving specialty mental health services and are offered in collaboration with community providers. Adult residential services include locked long-term programs, unlocked short- and long-term programs, and supportive housing programs.

In fiscal year 2021-2022, short-term unlocked programs (Crisis Residential Treatment or "CRT") were the most widely utilized type of residential care, serving 235 individuals. Locked long-term programs served 130 individuals, followed by adult supportive housing programs (101 individuals), and unlocked long-term programs (Adult Residential Treatment or "ART") served 63 individuals. It is important to note that stakeholder interviews highlighted insufficient supportive housing programs as a gap in services.

A majority of clients served by both unlocked (CRT and ART) and locked programs (long term care - LTC) were White (63%, 83%, and 72% respectively) and between the ages of 26 and 59 (63%, 87%, and 69% respectively). About a quarter of clients receiving treatment in adult short-term unlocked (CRT) and long-term locked programs were TAY. **Black or African American clients and Native American clients were overrepresented in unlocked residential programs.** Black and African American clients were overrepresented in short-term unlocked residential programs (CRT) – while making up only 5% of the total number of clients served by the adult system of care, Black/African American clients made up 14% of total clients served by CRT and 8% of CRT program episodes. Similarly, Native American clients were overrepresented in long-term unlocked residential programs (ART) – Native American clients made up almost 5% of total ART clients and 5% of ART episodes, compared to slightly less than 3% of the total number of clients served by the adult system of care.

A variety of community-based outpatient services exist for individuals with severe and persistent mental illness who can remain in the community while enrolled in a program. The primary type of outpatient program available to adults are FSPs, which are multidisciplinary teams that provide intensive field-based specialty mental health services targeted at specific populations. **In fiscal year 2021-2022, 224 clients were served by Adult FSP programs.**

[30] Individual clients may access more than one category of services and thus may be counted more than once in this table.

Adults who present a risk to the public as determined by the court are referred to Forensic Services, which are available at pre-trial, in court, and post-plea. The Forensic Assertive Community Treatment (FACT) Team offers one of the more robust programs, an FSP that works with a probation officer to provide community-based specialty mental health services to people referred through Mental Health Court. Additionally, DHS-BHD also provides a Mental Health Diversion Program. **In fiscal year 2021-2022, 87 adults engaged in justice initiatives.**

DHS-BHD also provides outpatient services through clinics, including the community mental health centers (CMHCs), which provide mental health services, medication support, crisis intervention, and case management for clients. **CMHCs served 289 clients in fiscal year 2021-2022.** The majority of clients were adults ages 26+, but these services were also available to and utilized by TAY. In fact, 31 CMHC clients were TAY in fiscal year 2021-2022, making up 11% of clients. Centers are located in the communities of Guerneville, Cloverdale, Petaluma, and Sonoma Valley. The four dispersed sites allow staff to meet clients where they are and engage with individuals in outlying regions beyond Santa Rosa.

Youth and Family Services

The Youth and Family system of care offers similar services as those for Adult and Older Adult clients, with services that address a spectrum of needs. Youth have access to outpatient and residential programs, as well as justice-related programs offered by DHS-BHD (Table 8).

Table 8: Total unique clients served by youth and family services, FY 21-22[31]

Program	Total Served
Youth Outpatient	1,133
Youth Residential	82
Youth Justice Programs	58

Youth residential services include unlocked, short-term programs and both short-term and transitional housing placements. As with adult residential services, all of these facility-based treatments offer individuals the opportunity to stabilize and prepare for community discharge. In fiscal year 2021-2022, **youth residential programs served 82 individuals**.

As shown in Table 8, **over 1,000 youth were served through outpatient programs**, which includes intensive outpatient programs, such as intensive services for foster youth (ISFC), youth wraparound services, and FSPs. The FSP multidisciplinary team available to youth is the Family Advocacy, Stabilization, and Support Team (FASST). **In fiscal year 2021-2022, 473 individuals were served through Youth FSP programs and only four were served through the Foster Youth FSP Programs.**

Juvenile justice programs include juvenile hall, probation camp, and juvenile sex offender services. However, data was only available for juvenile hall, which **served 58 individuals in 65 episodes during fiscal year 2021-2022.** Of these 58 individuals, 23 (40%) identified as Latinx.

[31] Individual clients may access more than one category of services and thus may be counted more than once in this table.

Transition Age Youth (TAY) Services

Transition Age Youth (TAY), or those between the ages of 16-25, is a group that often overlaps with the Youth and Adult systems of care, with 16 and 17 year olds able to access services for children and youth, and 18-25 year olds able to access Adult services. However, there are a few programs that are specific to TAY in the County (Table 9).

Table 9: Total unique clients served by TAY-specific services, FY 21-22

Program	Total Served
TAY Outpatient	65
TAY Supportive Housing	13

In fiscal year 2021-2022, 65 unique individuals were served through TAY-specific services. All 65 clients were served by TAY FSP programs, which are also the only providers of supportive housing services for this age group. All 13 clients that accessed supportive housing services were also enrolled in the TAY FSP programs.

Peer-Run Programs and Prevention Programs

Sonoma offers peer-run programs for youth, adults, and families. The County sponsors eight peer run self-help programs across the region that **collectively served almost 8,000[32] clients in fiscal year 2021-2022**, serving approximately 1,700 clients in quarter four of fiscal year 21-22.

Strengths and challenges receiving services

Strengths

A clear **strength highlighted by clients in their experience with the mental health system was with providers themselves**. Two thirds of clients and loved ones surveyed agreed that the mental health services they or their loved one received are helpful, and three quarters said they felt respected by the mental health team. Clients were also highly confident (82% agreed) that information they shared with providers would be kept confidential (Figure 20). When asked to rank the best aspects of mental health services, clients and their loved ones highlighted better abilities to take care of daily needs, better connection to basic needs like housing and food, and better relationships with family, friends, and others. When asked to rank the greatest strengths of the mental health system, clients indicated that services have improved over time, services included staff and peers who have lived experience with mental health challenges, and clients and families have input into services.

"His family is blessed to know he is safe and in an environment that he can make changes to progress to a positive lifestyle when he is ready and will learn how to access the right support services waiting for him."

- Survey Respondent

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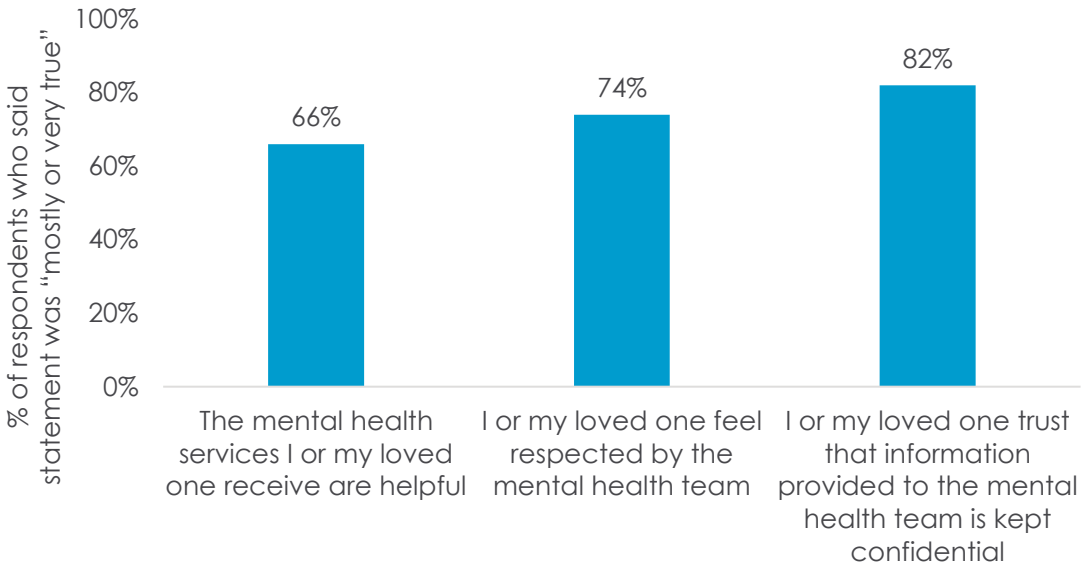
[32] This number is a sum of all unique clients from each peer-run program, which means that there may be duplicates as some individuals may access services from multiple peer-run programs within the same fiscal year.

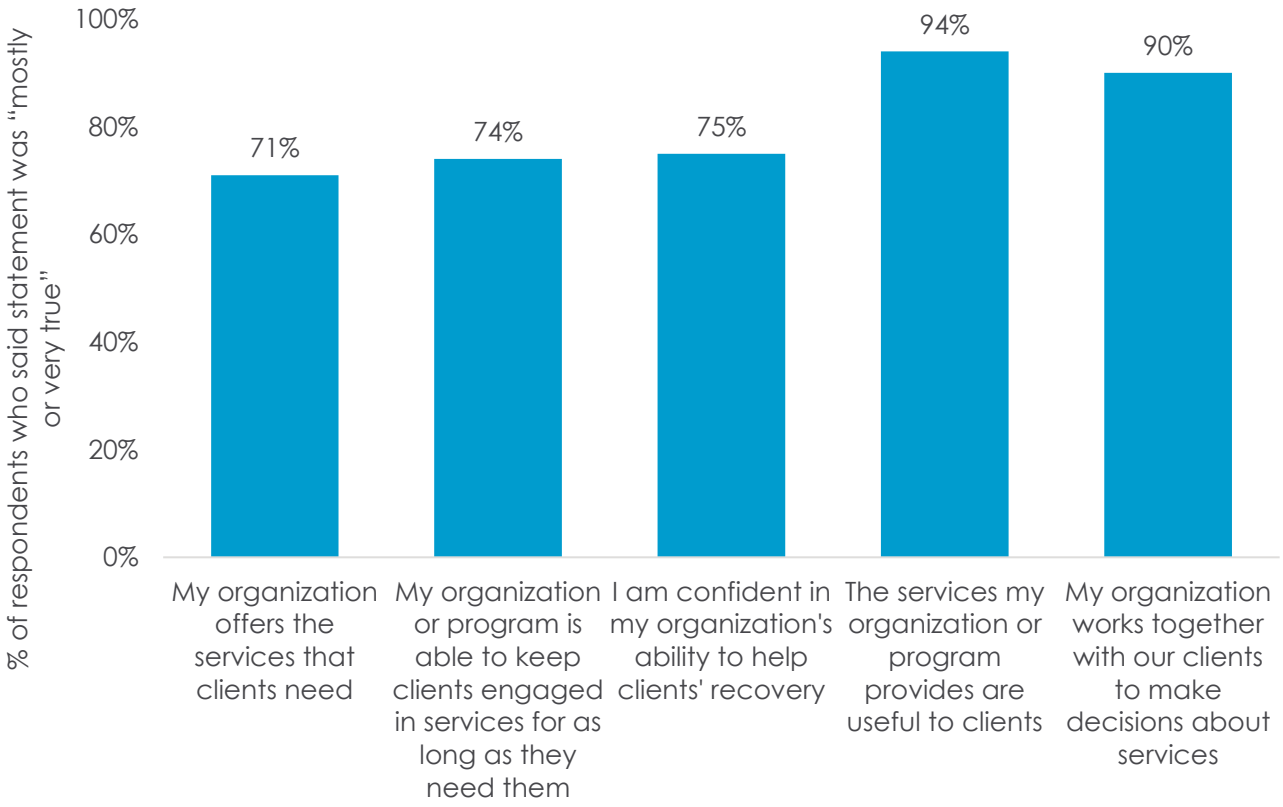
Figure 20: Positive aspects of receiving services (client perspectives) (n=33-35)



Many of the same strengths and positives highlighted by clients were mirrored by providers. Providers largely agreed that their organizations were able to offer clients the services they needed, were able to keep clients engaged in services for as long as they needed them and were confident in their organizations' abilities to help clients' recovery (Figure 21). When asked what their programs excel at, providers highlighted teaching coping skills and strategies to manage mental health symptoms, awareness and education about mental health and recovery, and crisis response services. The greatest strength of the mental health system identified by providers was that service providers understand client needs.

> *"With the team we do have, I believe we are providing thorough services to our youth, with special emphasis on social interaction, independent living skills, coping skills, and individual and specific care for each client's needs."*
>
> *- Survey Respondent*

Figure 21: Positive aspects of providing services (provider perspectives) (n=97-100)



Providers also rated **collaboration among agencies and providers as being a significant strength** and an important aspect of care, even while acknowledging in interviews and focus groups that there was room for improvement. Indeed, the second ranked "greatest strength" of the mental health system according to providers was that services and providers communicate with each other and collaborate on clients' care.

When providers and clients were asked similar questions, **providers ranked services more highly than did clients.** For example, while 94% of providers agreed with the statement that "the services my organization or program provides are useful to clients", only 66% of clients agreed that "the mental health services I or my loved one receive are helpful". Similarly, while 90% of providers said it was mostly or very true that "my organization works together with our clients to make decisions about services," only 65% percent of clients said it was mostly or very true that "I or my loved one is included in treatment planning." "Clients and families have input into services" was also the third highest ranked strength of the mental health system by clients. While these are overall positive responses from both providers and clients, it may indicate that there is a disconnect in perceptions between clients and providers of what meaningful engagement in services and treatment plans means.

Areas for improvement in service provision

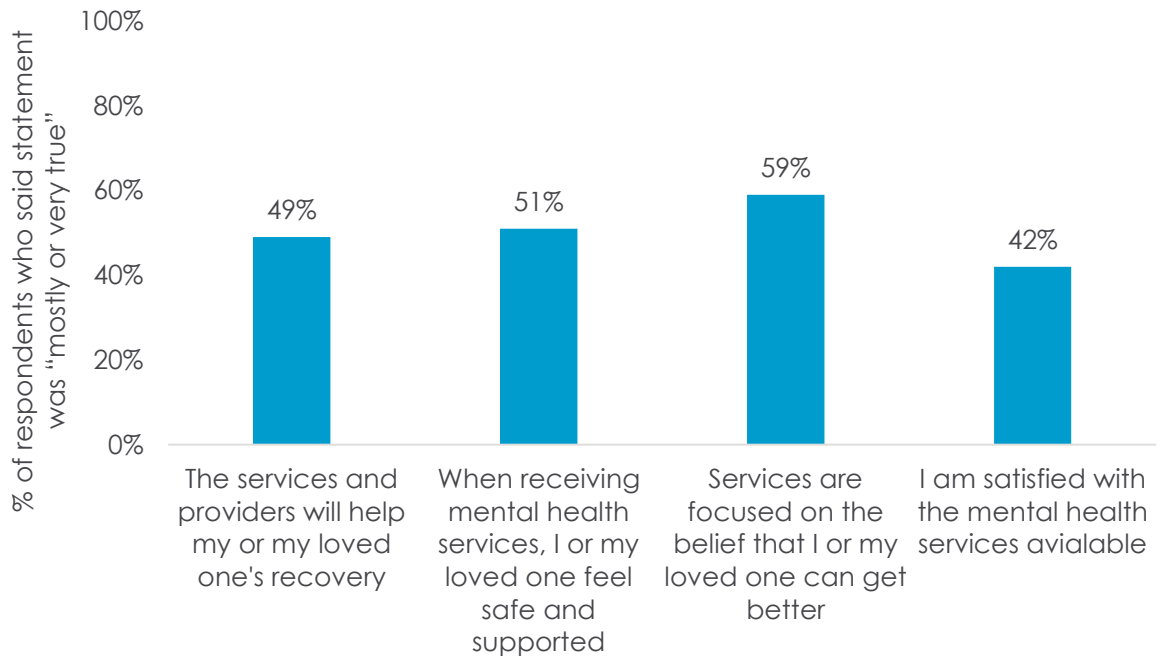
As noted above, inclusion of clients and loved ones in their treatment planning was highlighted as a strength in services among both clients and providers. However, the findings on this point were nuanced, as it was also noted as an area for improvement by many. When asked about

the most challenging aspects of receiving services, "providers do not support me or my loved one in understanding my/their treatment options" was the third challenge, ranked after long wait times and not knowing where to go for services. These findings are not necessarily contradictory, but rather indicate that clients overall feel very strongly about the importance of being included in their treatment plans, and both those who felt this was successful and those who felt this needed improvement highlighted this as an important aspect of their care.

When asked what the greatest needs were of the Sonoma mental health system, the **top need identified by clients was that crisis services were not available to everyone**. This may in part be reflective of earlier findings about long wait times, limited CSU beds and limited other high-level services. The second greatest need identified was that services are difficult to access (difficult to get appointments or inconvenient location and hours) and the third was that services and providers do not communicate with each other or collaborate on my/my loved one's care. Given that collaboration was a strength highlighted by providers, it may indicate that the collaboration behind the scenes among providers is not being understood and felt by clients in the way their services are delivered, or that collaboration is strong but there continues to be room for improvement.

Overall, **client satisfaction with services was relatively low.** Only half of clients indicated they believed the services and providers will help their or their loved one's recovery, and only half indicated that they feel safe and supported when receiving mental health services (Figure 22). Fewer than two-thirds said they felt services were focused on the belief that they or their loved one could get better, and overall, **only 42% of clients stated that they were satisfied with mental health services.**

Figure 22: Challenging aspects of receiving services (client perspectives) (n=34-36)



Movement through the System

Ideally, clients who are accessing services within the Sonoma BHD system can be "stepped up" or "stepped down" to different services according to their level of needs, which would support clients' recovery and reduce costs by providing clients the level of care they need and shifting clients out of crisis or intensive services as soon as appropriate. While there are certainly clients who will require longer than typical enrollment in programs and facilities, it is the goal of a recovery-focused system to move clients to lower levels of care when appropriate. While this may occur in many cases, clients also often stay longer than expected in high levels of care, and services are often full to capacity. These two factors combined contributed to high caseloads for providers and longer wait times for clients.

Length of stay

While service "overstays" only have a direct impact on claimable vs non-claimable costs for the CSU, there are also recommended lengths of stays for unlocked short term and unlocked long-term facilities. For CSU, an individual is expected to stay for less than 24 hours before being released and moved into other types of services if needed. For unlocked short-term services, the recommended length of stay should be 14 days or less, while for unlocked long-term services, a client may stay for 6 to 9 months.

As shown in

Table 10, the median length of stay for the CSU was one day, but the mean length of stay was 2.5 days, and 44% of episodes (431 total episodes, out of 972) lasted two or more days.[33] The maximum length of stay recorded for any individual in the CSU was 62 days. Episodes that extend for several days or more indicate a significant block in the system.

Table 10: Length of stay in select programs

Service type	Recommended maximum length of stay	Median length of stay FY21-22	Mean length of stay[34]	% of episodes greater than recommended duration (n)
CSU	<24 hours	1 day	2.5 days	44% (431)
CRT	14 days	15 days	17 days	51% (185)
ART	180-270 days (6-9 months)	143 days (4.7 months)	156 days (5.2 months)	25% (17)

For unlocked short-term residential services (CRT), the recommended length of stay is approximately two weeks. The median and mean length of stays in CRT were close to this recommended length (17 days and 15 days, respectively), but just over half of CRT episodes (51%, or 185 episodes) lasted for longer than the recommended 14 days (

Table 10). In addition, the length of stay was calculated as of the end of the fiscal year (6/30/2022) for clients who were in CRT services at that time, so stays beyond the end of the

[33] Avatar data does not contain time of entry or exit so calculations of greater or less than 24 hours were approximated with entry and exit date.

[34] Length of stay was calculated from admit date to discharge date or to end of fiscal year (6/30/2022), whichever occurred first. For clients who remained beyond 6/30/2022, their length of stay may have been longer than what was calculated based on available data.

fiscal year were not captured. The true mean length of stay may therefore be higher than what the data reflect.

For unlocked long-term residential services (ART), the recommended length of stay is approximately six to nine months, allowing clients a greater period of time to stabilize and move toward more independent living. Three quarters of clients stayed in ART services for less than the full recommended amount of time, indicating clients had appropriate supports and step-down services as they transitioned to lower levels of care and that there may have been fewer bottlenecks in service transfers at this level of care, compared to crisis and more acute services. The median length of stay was just under five months, while the mean length of stay was just over five months (

Table 10). Only one in four episodes lasted longer than nine months. Similar to the CRT, stays beyond the end of the fiscal year were not captured and the true mean length of stay may be higher than what the data reflect.

In addition to the CSU and unlocked short- and long-term services, Sonoma BHD's Full Service Partnerships (FSPs) play an integral role in moving clients through the system. FSPs are multidisciplinary teams that provide intensive field-based specialty mental health services targeted at specific populations (children with severe emotional disturbances and adults with serious mental health challenges). FSPs work to engage clients in intensive, team-based, and culturally appropriate services in the community and are committed to doing "whatever it takes" to ensure clients are connected with appropriate services.[35] In FY 2021-2022, the adult FSP teams (Integrated Recovery Team, Older Adult Intensive Team, and the Forensic Assertive Community Treatment Team [FACT Team]) documented 263 total episodes, with an average period of client engagement of approximately 1 year and 10 months. The youth FSP team, The Family Advocacy, Stabilization and Support Team (FASST), had 626 total episodes and a mean length of engagement of 11 months.[36]

Systematic and Programmatic Changes in Sonoma County

Sonoma BHD has faced a number of significant challenges before and since the previous Capacity Assessment, described in interviews conducted with BHD leadership, clients, and providers. Changes have had both positive and negative impacts on the overall BHD system.

Positive changes

A variety of strengths of the Mental Health system and successes of the last several years were highlighted in conversations with BHD staff and partners. Overall, the implementation of MHSA services and funding is seen as having contributed to a positive direction for mental health services over more than a decade. More people with mental health needs have been covered over time, and there is significant ongoing support from the mental health board and the community. **Community engagement** was reported to be strong in the early days of MHSA, then to have receded somewhat, and more recently to have been reenergized through the CPP Workgroup.

[35] Department of Health Services Behavioral Health Division. (n.d.). *Mental Health Services for adults*. County Of Sonoma. Retrieved February 28, 2023, from https://sonomacounty.ca.gov/health-and-human-services/health-services/divisions/behavioral-health/services/adult-services

While funding challenges continue to exist, the passage of "Measure O" in 2020 has provided **additional funding that has helped backfill some funding gaps** and paid for some needed initiatives. Housing remains a major challenge, and funding from No Place Like Home has begun to make strides. The COVID-19 pandemic also forced Sonoma, like many other counties, to be **creative with housing solutions** and begin experimenting with innovative models such as hotels, which may have long-term benefits in terms of expanding the types of solutions Sonoma can explore to support people experiencing homelessness.

COVID-19 also forced the BHD system to become more flexible in the way services were provided, increasing accessibility of virtual services, which expanded the reach and convenience of services for many. Providers and BHD leadership also noted that there was a greater acknowledgement community-wide of mental health challenges and collective trauma in the wake of COVID-19 and several serious wildfires that impacted the community. This greater awareness of mental health needs led to increasingly compassionate care, and a greater appreciation for the work that mental health and peer providers do. The dedication, respect for clients, and increasing shift toward human-centered and trauma-informed services of **staff were highlighted as core strengths** of Sonoma's mental health services. Specific programmatic strengths include **peer programs**, which continued despite overall budget cuts due to strong community advocacy around their importance. **Recent turnover at the executive level for BHD is seen as both a challenge and a strength**, with a new team bringing renewed energy, focus, and outside experience that can be applied to the Sonoma County system.

So much of it seems so sterile and distant, but I've seen it shifting in the past 10 years. People are much more informed by their lived experience, more compassionate, and it's safer, working with peers in the system. We need to really value that…"

- Provider KII

System-wide and external challenges

Budget cuts in 2017, 2018 and 2019 forced BHD to reduce mental health services to core services only. This meant that more clients needed to utilize higher levels of care, which is more expensive than preventative care and more challenging to transition out of, meaning that clients sometimes remain in higher levels of care longer than needed. This creates a cycle in which more funding must be dedicated to intensive care services to respond to the demand, further straining the budget. While funding has since increased, it has been an ongoing process for the system to rebuild its preventative and less-intensive services.

Need for mental health services has increased as Sonoma County (and more broadly, the state, country, and world) experienced the **collective trauma of the devastating COVID-19 pandemic** coupled with an amplification of other types of hardships, including economic instability, increased unemployment, inflation, and school closures. Students of all ages suffered significant socio-emotional harm due to extended isolation, on top of learning loss, and the widespread need for additional mental health services as students recover is widely acknowledged. For adults as well, the collective trauma and hardship has had a significant impact on mental

health. Moreover, various providers and types of services were forced to close physical locations and services, or reduce capacity, due to pandemic restrictions.

Even as the need for mental health services increased, **understaffing** of programs is an ongoing challenge, with **high rates of turnover and difficulty in both recruitment and retention.** Fires, floods, and COVID-19 have forced staff away from their primary responsibilities to respond to emergencies, further stretching available services and contributing to burnout. While Sonoma County's experiences generally align with the recruitment and retention challenges that exist statewide, pay for mental health professionals in Sonoma County is low relative to the cost of living and that of other counties, exacerbating the challenges. Indeed, only 6% of providers surveyed agreed that it was "mostly or very true" that there are affordable living situations for staff close to work and rising inflation in 2021 and 2022 was perceived to be contributing to this problem. Fewer than half agreed that "my organization is able to recruit and retain the staff necessary to meet clients' needs", and only one third of providers agreed that "my organization has sufficient staff" (Figure 23).

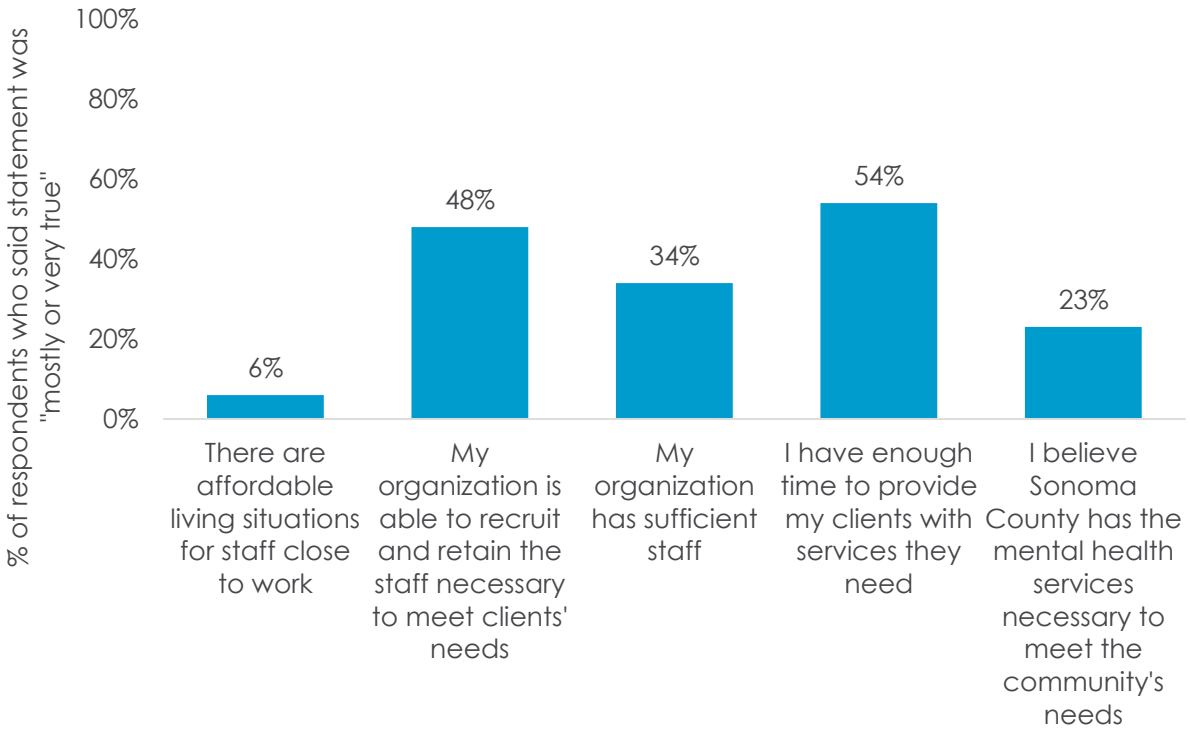
At least one major mental health provider has closed in recent years, and multiple substance use disorder providers have closed as well. As a result of staffing challenges, there are not enough outpatient counselors to support existing mental health and substance use disorder (SUD) needs. While "Measure O" and other funding sources are filling some gaps, much of the funding is reserved for new or innovative programs and does not solve the **ongoing need for more outpatient providers**. Finally, basic therapy is a significant need in the community, particularly for those who cannot pay out of pocket and/or do not have private insurance. There are an insufficient number of providers who provide therapy, and access for clients relying on Medi-Cal is particularly challenging.

"It's been hard for folks in the County BH system to do quality work because their caseloads are so big."

- Provider KII

As a result of all of these challenges, only one in four providers surveyed agreed with the statement "I believe Sonoma County has the mental health services necessary to meet the community's needs." For the providers who remain, high caseloads have an impact on provider burnout and quality of services: just over half of providers surveyed agreed that "I have enough time to provide my clients with the services they need."

Figure 23: Staffing challenges (provider perspective) (n=99-100)



Insufficient housing is a problem that has grown in the last several years, with the number of individuals experiencing homelessness increasing. Existing challenges have been exacerbated by COVID-19, inflation, and fires that destroyed thousands of homes in 2017 and 2018. Preliminary results from the 2022 Sonoma County Point in Time (PIT) count found that 2,893 residents are experiencing a form of homelessness, which is a five percent increase from the last count in 2020 prior to the COVID-19 pandemic (no count was taken in 2021).[33] This increase is a change from the steady downward trend in homelessness Sonoma County had been experiencing since 2011, which had a PIT count of 4,539.[37] In addition, budget cuts in recent years resulted in **reduced capacity to support individuals with SMI moving from a higher level of care into supportive housing**, as well as reducing the availability of housing itself. Further coordination between SUD, mental health, and the homeless division is needed to support people who are transitioning into supportive housing.

"We have to get better at whole person care. We cannot separate SUD and mental wellness care! If someone has an SUD that is a mental health diagnosis, so we need to treat it that way."

[37] Sonoma, Bay Area counties release preliminary homelessness count statistics. (2022, May 16). Sonoma County. Retrieved September 15, 2022, from https://sonomacounty.ca.gov/sonoma-bay-area-counties-release-preliminary-homelessness-count-statistics

- Provider FG

Telehealth, which significantly expanded in response to COVID-19, is helpful for some in accessing services (especially those in rural areas who may have to drive long distances to access services) but is challenging for others to navigate internet access, computer literacy, and the less-personal dynamic of providing and receiving services over a screen rather than in-person. Finally, the availability of a safe and confidential location for clients to hold virtual visits was a challenge that emerged from interviews.

Sonoma is a medium sized county, with its population center in Santa Rosa. Outside the center of the County, **services are limited in more rural areas**. While BHD staff reported that Petaluma and East County are doing well in terms of available services, North County has fewer available options.

Finally, **significant health disparities exist across various populations**. While the Human Development Index has increased among White and Hispanic Sonoma residents, the HDI has decreased among the Black and African American community.[38] Youth services were highlighted as a significant need in the county, particularly as the mental health of young people has suffered during the pandemic. While strides have been made in connecting Latinx clients to mental health services and three quarters of providers stated that their organization provides services in the language that clients wish to use (data not shown), culturally and linguistically appropriate services was also noted as a potential gap, and burnout was noted as being acute among bilingual staff due to the demand for their services.

"Bilingual folks who speak Spanish are burnt out, there's burnout in general for folks, even if they're not bilingual. Short staffing makes us operate more at the crisis level rather than at the preventative level."

- Provider KII

Upcoming Changes

In addition to the changes of the last several years, there are many changes on the horizon for BHD in Sonoma County, perceived by stakeholders as both positive and negative.

Positive Upcoming Changes

CalAIM is rolling out and is perceived to be overall a positive development that will streamline services and improve flexibility. CalAIM will reduce the regulatory and paperwork burden on providers, thus allowing more time and capacity to provide direct services, and potentially encouraging more therapists in the community to provide services to Medi-Cal patients. **A new**

[38] Lewis, Kristen. *A Portrait of Sonoma County: 2021 Update*. New York: Measure of America, Social Science Research Council, 2021.

electronic health records system to be launched in 2023 is also anticipated to streamline services and improve data sharing.

The county jail is building a new mental health unit which is intended and planned to be a more therapeutic place to house incarcerated individuals with mental needs than the existing unit and will ideally contribute to more recovery-focused services.

Multiple new and expanded services are in the works: there is an active Request for Proposals for a new residential facility and a new case management facility, which are anticipated to lower caseloads for existing case managers. The county is also applying for funding to create a crisis residential facility for children, a SUD and outpatient residential facility, a sobering and resource center for adults, pre-crisis services, and a small peer-run residential facility. There is a potential plan to develop a short-term residential treatment program (STR-TP) in the Valley of the Moon Children's Shelter, and to develop a campus in collaboration with Marin County that would serve foster youth, using Continuum of Care (COC) Reform funding. Additional potential funding streams for expanded programs include CA Healthcare Facility Financing Grants. Sonoma County is also working to develop a regional approach to supporting and treating specific target populations, such as those with severe eating disorders.

Upcoming Challenges

The controversial passing of Care Court was largely perceived by Sonoma BHD staff as a problematic new program. This program will force people to accept services, taking an approach that is neither evidence-based nor expected to be effective. If counties are not effective in reaching the required Care Court objectives, they may be subject to sanctions. Many stakeholders are concerned about its potential for punitiveness for both clients and for the County.

Resources

Resource expenditures and system priorities

The challenges of receiving appropriate levels of care at the necessary time impair clients' ability to recover as well as result in a more expensive behavioral health system in Sonoma County. These barriers can lead to higher use of crisis and acute mental health services, which are more expensive than lower levels of care and not always covered by Medi-Cal. Additionally, clients remaining in programs longer than necessary increases the expenses for those individuals, and limits the space available for other clients, which increases necessity for crisis services. This cycle unfortunately perpetuates itself, increasing costs to clients' recovery and DHS-BHD. While crisis and acute mental health care services are necessary, greater investment in lower levels of care and prevention services could contribute to better client outcomes as well as reduce system costs by providing clients care that could prevent them from reaching crisis.

Conclusion

Overall, Sonoma's DHS-BHD has faced significant challenges, both internal and external, over the last several years, and has had significant successes and improvements as well.

The impact of the **COVID-19 pandemic** on Sonoma residents' collective mental health and demand for mental health services as well as on service and provider availability cannot be overstated, and will have resounding impacts for years to come, just as it has and will state- and nation-wide. **Understaffing** was one of the most significant challenges highlighted by stakeholders, exacerbated by the pandemic, inflation, and high cost of living in Sonoma County. This has contributed to **long wait times and difficulty accessing services** for many clients. Providers, clients, and loved ones alike agreed that **crisis services and less intensive preventive services were insufficient** for the existing demand. Many **clients spend longer than ideal in high-intensity services, particularly the CSU**. Finally, gaps for specific populations were highlighted as needs within the County, including youth, monolingual Spanish-speaking Sonoma residents, and adults with co-occurring disorders such as mental illness and substance use disorders or older adults with significant physical and mental health needs,

On the other hand, Sonoma BHD was praised by providers, clients, and loved ones for their **creative and flexible response to the pandemi**c, increasing service availability through telehealth and other ways where possible. Clients largely gave **positive feedback on the providers with whom they engaged**, expressing appreciation for services received. P**eer providers in particular were noted as an essential cadre,** and providers were lauded for demonstrating empathy and compassion in services rendered. There is acknowledgement that **service availability and quality has overall improved over time**, and that collaboration among providers and agencies, in particular between SUD and BHD, is improving.

Recommendations

Based on the findings of this capacity assessment, RDA Consulting has the following recommendations to continue the positive trend in Sonoma's BHD system of care.

1. **Improve the transition of clients out of the CSU into less-intensive services,** to reduce the amount of time that clients stay in the CSU.
2. **Increase capacity for non-crisis services**, including outpatient therapy, to reduce wait times for appointments and help prevent clients from escalating needs that may turn into crises. Increased capacity for non-crisis services may also help alleviate overstays in the CSU by providing clients who have been stabilized with more options for appropriate levels of care.
3. **Continue to integrate peer providers into the system of care.** Services provided by peer providers and those with lived experience are highly valued by the community, serve a large number of clients, and may help reduce the burden of services on other cadres of providers.
4. **Invest in a sustainable workforce**, exploring strategies for better recruitment and retention of staff that can alleviate the high levels of staff turnover and understaffing, which impact service availability.
5. **Explore the reasons behind over- and under-representation of specific populations** in mental health services and in justice-related services to better understand possible service gaps and bias in the treatment of mental illness.

Acknowledgements

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Appendices

Appendix 1: Stakeholder Participants in Capacity Assessment

Table 11: Context Setting Key Informant Interview Participants

Name	Role
Kathy Smith	Current member and former Chair of County Mental Health Board
Jan Cobaleda-Kegler and Michele Bowman	Division Director for Behavioral Health Services & Administrative Services Officer for BHD
Sid McColley	Acute and Forensic Section Manager for DHS

Table 12: System Mapping Session Participants

Name	Role
Adult System Mapping Discussion	
Wendy Wheelwright	Adult Services Section Manager for BHD
Tracie Wishart-Barnes	Health Program Manager for Access Team and Collaborative Treatment & Recovery Team (CTRT)
Dez Ohlstrom	Health Program Manager for Whole Person Care
Elizabeth Storm	Program Manager for Community Mental Health Centers
Melissa Struzzo	SUD Services Section Manager for BHD
Fabiola Espinosa	MHSA Analyst for BHD
Helene Barney	Client Care Manager for Crisis Stabilization Unit and Hospital Liaison Team
David Evans	Health Program Manager for Adult Forensic Program
Eric Acuna	Psychiatric Nurse overseeing nurses in Operation Clinic
Amy Colville	Program Manager for Older Adult and Adult Integrated Recovery Team
Charlie Alarie	Client Care Manager for Crisis Stabilization Unit
Youth System Mapping Discussion	
Karin Sellite	Section Manager for Youth & Family Services
Christy Booth	Clinical Specialist for Youth Access Team
Katie Bivin	Health Program Manager for Counseling, Youth Medication Clinic, and Youth Access Team
Sarah Pilgrim	Health Program Manager for Child & TAY FSP Team
Fabiola Espinosa	MHSA Analyst for BHD

Table 13: Focus Groups

Population[39]	Host/organizing Organization	Total Participants
Older Adult Clients	DHS-BHD Older Adult Team (in-person)	4
Homeless Clients	Committee on the Shelterless (COTS) (in-person)	4
TAY Clients	VOICES (virtual)	6
Black/African American Providers	Sonoma County Quality Assessment and Performance Improvement; Buckelew Programs (virtual)	4
Behavioral Health Providers	Buckelew Programs (virtual)	7
Healthcare Service Providers	St Joseph Health (virtual)	5
Justice Stakeholders	Community Corrections Partnership (virtual)	5

Table 14: Key Informant Interviews

Participant	Organization	Population Represented
Sean Kelson	Interlink Self-Help Center	Adult & older adult consumers
Mary Champion	Sonoma County Office of Education	Students and school staff
Amanda Lopez	Veterans Affairs	Veterans
Dean Hoaglin	Sonoma County Indian Health Project	Native American Community
Jessica Carroll	Positive Images	LGBTQ+ Community
Christy Davila	West County Community Services	Outlying Areas - Consumers
Thaïs Mazur	Live Action Network	Outlying Areas - Providers
Nicole Navidad	Buckelew Programs	Asian American and Pacific Islanders

[39] Several attempts were made to conduct focus groups with Latinx clients and with parents or family members of youth clients; however, BHD, RDA, and partner organizations were unsuccessful in recruiting participants for these focus groups.

Appendix 2: Survey results

Table 15: Likert Scale Survey Results

Questions in which clients and providers were asked whether they believed the statement was not at all true, somewhat true, mostly true, or very true.	n	% who said statement was "mostly true" or "very true"
Accessing Services – Positive Aspects		
Services are available in the language I or my loved one want to use.	34	79%
I or my loved one feel comfortable seeking mental health services.	35	63%
I or my loved one know where to go for mental health services.	35	63%
I or my loved one know who to call for mental health services.	36	61%
Accessing Services – Challenging aspects		
Services are culturally responsive to me or my loved one.	34	59%
The services I or my loved one receive are at a convenient location.	35	54%
I or my loved one have made progress because of the services received.	36	47%
The mental health team is available when I or my loved one need help.	36	44%
It is easy to get an appointment when I or my loved one need one.	35	20%
Participating in Services – Positive aspects		
I or my loved one trust that information provided to the mental health team is kept confidential.	33	82%
I or my loved one feel respected by the mental health team.	34	74%
The mental health services I or my loved one receive are helpful.	35	66%
I or my loved one is included in my/their treatment planning.	34	65%
Participating in services – Challenging aspects		
Services are focused on the belief that I or my loved one can get better.	34	59%
When receiving mental health services, I or my loved one feel safe and supported.	35	51%
The services and providers will help my or my loved one's recovery.	35	49%
I am satisfied with the mental health services available.	36	42%
My or my loved one's family are included in my/their mental health treatment.	34	32%
Staffing – Positive aspects		

Questions in which clients and providers were asked whether they believed the statement was not at all true, somewhat true, mostly true, or very true.	n	% who said statement was "mostly true" or "very true"
My organization has the right mix of staff positions (e.g. mental health professionals, peer providers, etc).	100	61%
Staffing – Challenging aspects		
I have enough time to provide my clients with the services they need.	100	54%
My organization is able to recruit and retain the staff necessary to meet clients' needs.	99	48%
A less time-consuming hiring process would improve my organization's staffing situation.	100	46%
My organization has sufficient staff.	99	34%
I believe Sonoma County has the mental health services necessary to meet the community's needs.	100	23%
Less stringent staff educational requirements would improve my organization's staffing situation.	97	19%
There are affordable living situations for staff close to work.	100	6%
Providing services – Positive aspects		
The services my organization or program provides are useful to clients.	100	94%
My organization works together with our clients to make decisions about services.	98	90%
My organization or program is able to connect our clients to other services they need in Sonoma County.	100	76%
I am confident in my organization's ability to help clients' recovery.	100	75%
My organization or program provides services in the language that our clients wish to use.	100	74%
My organization or program is able to keep clients engaged in services for as long as they need them.	100	74%
I am satisfied with the working environment at my organization or program.	99	72%
My organization offers the services that clients need.	97	71%
I believe other providers work well with my organization or program to best meet the needs of our clients.	99	70%
Client wait times for services are reasonable.	100	66%
My organization or program works with our clients' families to support their recovery.	100	65%
Providing Services – Challenging aspects		
I believe the County works well with my organization or program to best meet the needs of our clients.	100	59%

Table 16: Ranking Survey Results

Questions in which clients and providers were asked to rank positive and challenging aspects of care	Top three responses
What is the most challenging part of you or your loved one's mental health services?	1. I have or my loved one has to wait a long time to get an appointment.
	2. I or my loved one don't know where to go for services or the location of services is not convenient.
	3. Providers do not support me or my loved one in understanding my/their treatment options.
What do you like best about you or your loved ones mental health services?	1. I or my loved one can better take care of daily needs (e.g., clothing, bathing, eating, etc.).
	2. I or my loved one is connected to assistance for their basic needs (e.g., income, housing, food).
	3. I or my loved one has better relationships with family, friends, children, and others.
Based on your experience, what are the greatest strengths of the Sonoma County mental health system?	1. Services have improved in quality over time.
	2. Services include staff and peers in providing care who have lived experience with mental health challenges themselves or with family members.
	3. Clients and families have input into the services we/they receive.
Based on your experience, what are the greatest needs of the Sonoma County mental health system?	1. Crisis services are not available to everyone who needs them.
	2. Services are hard to access (e.g., difficult to get appointments, inconvenient locations/hours).
	3. Services and providers do not communicate with each other or collaborate on my/my loved ones' care.[40]
Based on your experience, what are the greatest strengths of the Sonoma County mental health system?	1. Service providers understand client needs.
	2. Services and providers communicate with each other and collaborate on clients' care.
	3. Clients and families have input into the services they receive.
Based on your experience, what are the greatest needs of the Sonoma County mental health system?	1. Services are hard to access (e.g., difficult to get appointments, inconvenient locations/hours).
	2. Crisis services are not available to everyone who needs them.
	3. People with less severe needs cannot get services quickly.

[40] There was a four-way tie for third most highlighted need.

Appendix 3: Client Data Collection Tools

Sonoma County MHSA Needs Assessment Consumer & Community KII Protocol

Date	
Name	
Title	
Agency/Dept./Org.	
Telephone #	
Interviewer	

Introduction

Hello, my name is _____ [and this is _____] from Resource Development Associates. Is now still a good time to talk?

Thank you for taking the time to talk with ME/US. I/WE work for a consulting firm called Resource Development Associates and we have partnered with Sonoma County to develop a capacity assessment that will inform the upcoming MHSA Three-Year Program & Expenditure Plan. The purpose of the MHSA 3-Year Program & Expenditure Plan is to capture and document the community's vision for services to address mental health issues.

For the capacity assessment, we are looking at the current mental health system in Sonoma County, its strengths, and its challenges. The purpose of this interview is understand how [YOUR GROUP] and the community overall participates in Sonoma's Mental Health System, what is working well, and where there are areas for improvement. Please feel free to ask for clarification about any questions I ask, or to add information you believe is relevant.

This conversation will take approximately 45-60 minutes. As we are going through the interview, I/WE will be typing notes. We will be using the information from these interviews, our focus groups, and data collection in our analysis of Sonoma's Mental Health System. While your name will not be attached to the answers you provide in the interview, because of your affiliation in the County, it may be possible to identify you as the source of certain information. We hope you will feel comfortable sharing candidly about your experiences, but please let me know if there are any sensitive comments that you would like us to be especially careful about when writing up the summary of the conversation. We will be recording today's conversation so that we can use the generated transcript for our notes, but the recording will not be shared with anyone.

Do you have any questions before we begin?

Interview Guide

Introductions

We know you could be spending your time anywhere, so we are interested to hear your involvement with the Sonoma's Mental Health System and what you're hoping to accomplish or contribute today.

Service & Program Experience

1. Think about your [OR YOUR GROUP'S] experiences with Sonoma County mental health services and programs.
    a. What services or programs have you taken part in?
    b. Overall, what has your experience been with these services?

2. What has worked the best or been the most positive when receiving these services?
    Prompt: staff, location, hours, ease of access

3. What has been the most difficult or challenging when receiving these services?
    Prompt: staff, location, hours, ease of access

Service & Program Changes

4. With the changes in the last few years, [depending on the audience mention: COVID-19, fires, budget changes, new leadership, etc.], how have these events impacted your services?
    a. What improvements in services have you [OR YOUR GROUP] experienced, if any?
    b. Have you [OR YOUR GROUP] experienced any decline or increased issues with services?

    Prompt: hours of operations, timely appointments, crisis support, interactions with law enforcement when dealing with a crisis, coordination of services

Recommendations and Needs

5. What would you recommend to improve Sonoma's mental health services?
    a. What would make the process of receiving services easier? More supportive?
    b. Are there services you wish existed? What services do people need but are not available?

    Prompt: psychiatry, wellness programs, residential programs, age or cultural group-specific programs

6. Considering the discussion, we've just had, what's the most important issue or most significant mental health care need in Sonoma County?
    a. Who needs help and isn't getting it? Whose needs are not being met?
    b. What gaps remain in the system?
    c. What would be helpful to address this?

7. Is there anything else you would like to add before we conclude this discussion?

Thank you!

Sonoma County MHSA Needs Assessment Focus Group Protocol (Client Experience)

Date	
FG Type/Size	
Location	
Facilitator	

Introduction

Thanks for making the time to join us today. My name is _____ and this is _____. We are with a consulting firm called Resource Development Associates and we are here to help Sonoma County with a needs assessment that will inform the upcoming MHSA Three-Year Program & Expenditure Plan. I will be facilitating our talk today and _____ will take notes, but we won't be attaching your names to anything that is said. We hope you will feel comfortable sharing candidly about your experiences, but please let me know if there is anything you don't want us to document. We respect your anonymity. We will be recording today's conversation so that we can use the generated transcript for our notes, but the recording will not be shared with anyone.

The purpose of the MHSA 3-Year Program & Expenditure Plan is to capture and document the community's vision for services to address mental health issues. More specifically, the Mental Health Services Act aims to strengthen the public mental health system that many individuals and communities rely on, especially underserved communities. We are holding several focus groups throughout Sonoma County to better understand the mental health needs in the community.

We're here today to hear from you. This is your process and your opportunity to make your voice heard about what is working well, what isn't working well, and what you feel is needed. We know there have been changes and upheavals in the last few years, including but not limited to COVID-19 and wildfires [depending on the audience mention: budget changes, new leadership, etc.], and we want to learn how these changes have affected you.

This is your conversation, but part of my job as facilitator is to help the discussion go smoothly and make sure that everyone has a chance to say what's on their mind in a respectful way. We have a few guidelines to help us do that. Please:

- Turn your video on if able/comfortable
    - *If in person*: turn your phone on silent and please refrain from having side conversations
- Engage in the conversation – this is your meeting!
- And remember, there are no "wrong" or "right" opinions: please share your opinions honestly and listen with curiosity to understand the perspective of others

As we wrap up the discussion, I'm going to share a link to a survey that is an additional way for you to share your thoughts. Please take a few minutes to fill out the survey as well.

Does anyone have any questions before we begin?

Focus Group Guide

Introductions

We know you could be spending your time anywhere, so we are interested to hear your name and what you're hoping to accomplish or contribute today.

Service & Program Experience

1. Think about your experiences with Sonoma County mental health services and programs.
    a. What services or programs are you or have you been a part of in the last year or two?
    b. Overall, what has your experience been with these services?

2. What has worked the best or been the most positive when receiving these services?
    Prompt: staff, location, hours, ease of access

3. What has been the most difficult or challenging when receiving these services?
    Prompt: staff, location, hours, ease of access

    Prompt: are there services you have needed and been unable to receive?

Service & Program Changes

4. With the changes in the last few years, [depending on the audience mention: COVID-19, fires, budget changes, new leadership, etc.], how have these events impacted your services?
    a. What improvements in services have you experienced, if any?
    b. Have you experienced any decline or increased issues with services?
    Prompt: hours of operations, timely appointments, crisis support, interactions with law enforcement when dealing with a crisis, coordination of services

Recommendations and Needs

5. What would you recommend to improve Sonoma's mental health services?
    a. What would make the process of receiving services easier? More supportive?
    b. Are there services you wish existed? What services do people need but are not available?
    Prompt: psychiatry, wellness programs, residential programs, age or cultural group-specific programs

6. Considering the discussion we've just had, what's the most important issue or most significant mental health care need in Sonoma County?
    a. Who needs help and isn't getting it? Whose needs are not being met?
    b. What gaps remain in the system?
    c. What would be helpful to address this?
7. Is there anything else you would like to add before we conclude this discussion?

Thank you!

Condado de Sonoma MHSA Protocolo de Grupo de Enfoque de Evaluación de Necesidades (experiencia del cliente)

Date	
FG Type/Size	
Location	
Facilitator	

Introduction

Gracias por hacer el tiempo para reunirse hoy con nosotros. Mi nombre es _____ y este es _____. Estamos con una firma de consultoría llamada Resource Development Associates y estamos aquí para ayudar al Condado de Sonoma con una evaluación de necesidades que se informará el próximo Programa de Tres Años y Plan de Gastos de MHSA. Yo facilitaré nuestra charla de hoy y _____ tomará notas, pero no adjuntaremos sus nombres a nada de lo que se diga. Esperamos que se sienta cómodo compartiendo con franqueza sobre sus experiencias, pero por favor infórmeme si hay algo que no quiera que documentemos. Respetamos su anonimato. Grabaremos la conversación de hoy para que podamos usar la transcripción generada para nuestras notas, pero la grabación no se compartirá con nadie.

El propósito del Programa y Plan de Gastos de 3 Años de MHSA es captar y documentar la visión de la comunidad sobre los servicios que abordan los problemas de salud mental. Más específicamente, la Ley de Servicios de Salud Mental tiene como objetivo fortalecer el sistema público de salud mental del que dependen muchas personas y comunidades, especialmente las comunidades menos atendidas. Estamos llevando a cabo varios grupos de enfoque a través del condado de Sonoma para comprender mejor las necesidades de salud mental en la comunidad.

Hoy estamos aquí para saber de usted. Este es su proceso y su oportunidad para lograr que su voz se escuche sobre lo que está funcionando bien, lo que no está funcionando bien, y lo que usted siente que se necesita. Sabemos que ha habido cambios y trastornos en los últimos años, incluidos, entre otros, el COVID-19 e incendios forestales [dependiendo de la mención de la audiencia: cambios presupuestarios, nuevos liderazgos, etc.] y queremos conocer cómo te han afectado estos cambios.

Esta es su conversación, pero parte de mi trabajo como facilitador es ayudar a que la discusión transcurra sin problemas y asegurarme de que todos tengan la oportunidad de decir lo que tienen en mente de una manera respetuosa. Tenemos algunas pautas para ayudarnos a lograr eso. Por favor:

- Encienda su video si puede/si está cómodo.
- Participe en la conversación: ¡esta es su reunión!
- Y recuerde, no hay opiniones "incorrectas" o "correctas": por favor, comparta sus opiniones honestamente y escuche con curiosidad para entender la perspectiva de los demás.

¿Alguien tiene alguna pregunta antes de comenzar?

Presentaciones

Sabemos que podría estar pasando su tiempo en cualquier lugar, por lo que hoy estamos interesados en escuchar su nombre y lo que espera lograr o contribuir.

Experiencia en servicios y programas

1. Piense en sus experiencias con los servicios y programas de salud mental del Condado de Sonoma.
    a. ¿En qué servicios o programas participa o ha participado en el último año o dos?
    b. En general, ¿cuál ha sido su experiencia con estos servicios?
2. ¿Qué ha funcionado mejor o ha sido lo más positivo a la hora de recibir estos servicios?

    Sugerencia: personal, ubicación, horarios, facilidad de acceso
3. ¿Cuál ha sido lo más difícil o desafiante al recibir estos servicios?

    Sugerencia: personal, ubicación, horarios, facilidad de acceso

    Sugerencia: ¿hay servicios que ha necesitado y no ha podido recibir?

Cambios en el servicio y el programa

4. Con los cambios en los últimos años, [dependiendo de la mención de la audiencia: el COVID-19, incendios, cambios presupuestarios, nuevos liderazgos, etc.], ¿Cómo han afectado estos eventos a sus servicios?
    a. ¿Qué mejoras en los servicios ha experimentado, si las ha experimentado?
    b. ¿Ha experimentado alguna disminución o aumento de los problemas con los servicios?

    Sugerencias: horas de operaciones, citas oportunas, apoyo en crisis, interacciones con la policía cuando se trata de una crisis, coordinación de servicios.

Recomendaciones y necesidades

5. ¿Qué recomendaría para mejorar los servicios de salud mental de Sonoma?
    a. ¿Qué haría que el proceso de recepción de servicios fuera más fácil? ¿Más solidario?
    b. ¿Hay servicios que desea que existieran? ¿Qué servicios necesitan las personas, pero no están disponibles?

    Sugerencias: psiquiatría, programas de bienestar, programas residenciales, programas específicos de edad o grupo cultural
6. Teniendo en cuenta la discusión que acabamos de tener, ¿cuál es el problema más importante o la necesidad de atención de salud mental más importante en el condado de Sonoma?

a. ¿Quién necesita **ayuda** y no la está recibiendo? ¿Las necesidades de quienes no se están satisfaciendo?

b. ¿Qué lagunas existen aún en el sistema?

c. ¿Qué sería útil para abordar esto?

7. ¿Hay algo más que le gustaría agregar antes de concluir esta discusión?

¡Gracias!

Sonoma County Behavioral Health Client and Family Survey

Sonoma County Behavioral Health has partnered with RDA Consulting to develop a capacity assessment of mental health services that will inform the upcoming MHSA Three-Year Program & Expenditure Plan. The purpose of the MHSA Three-Year Program & Expenditure Plan is to capture and document the community's vision for services to address mental health issues.

If you have access to a computer or are not a behavioral health consumer or family member of a consumer, we encourage you to take this survey online at:

https://survey.alchemer.com/s3/7034583/Sonoma-County-Behavioral-Health-Community-Survey

This survey is confidential. Only RDA will see your response and they will combine your response with others' responses to inform the capacity assessment. If you complete the survey, you will have the choice of being entered to win a $20 gift card as a thank you for your time. We are asking for your name and address in order to send you the gift card if you win; your information will not be shared with anyone else.

Do you consent to participate in this survey?

☐Yes

☐No

Note: If you do not consent, please **do not** fill out the rest of the survey. Thank you for your time.

1. **What is your relationship to Sonoma County Behavioral Health?**
   ☐ I am a client of behavioral health services in Sonoma County (meaning, I have received Behavioral Health Services from Sonoma County in the past 12 months)

   ☐ I am a loved one of a client of behavioral health services in Sonoma County

   ☐ I am a former client of behavioral health services in Sonoma County (I have received services previously but none in the last 12 months)

   ☐ I am a mental health provider or professional (If you are a provider, please **go to the online survey** linked above and complete the provider survey)

   ☐ I have a different relationship to Sonoma County Behavioral Health

   Please specify: _____ (If you have a different relationship to Sonoma BHD, please **do not** fill out the rest of the survey. Thank you for your time.)

2. **How long have you or your loved one been receiving services from Sonoma Behavioral Health?**
   ☐ Less than 1 year

   ☐ 1-2 years

   ☐ 3-5 years

☐ 6-10 years

☐ More than 10 years

3. **What services have you or your loved one received in the past year? Check all that apply.**
   ☐ Outpatient Treatment (e.g., therapy, case management, medication)

   ☐ Peer Self-Help Center (e.g., The Wellness and Advocacy Center, Interlink, Petaluma Peer Recovery Center, Russian River Empowerment Center)

   ☐ Crisis or Emergency Mental Health Services (e.g., CSU, Urgent Care)

   ☐ Residential Treatment (e.g., Progress Sonoma, Parker Hill Place)

   ☐ Court-involved Services (e.g., FACT)

4. **What do you like best about you or your loved one's mental health services? Check all that apply, labeling the most important benefit as "1" and other applicable benefits in descending order (2, 3, 4, etc).**
   ☐ I or my loved one has better relationships with family, friends, children, and others

   ☐ I or my loved is engaged in meaningful/productive activities including a job, school or volunteer work

   ☐ I or my loved one is connected to assistance for their basic needs (e.g., income, housing, food)

   ☐ I or my loved one can resolve existing legal problems and stay out of the legal system

   ☐ I or my loved one is less likely to need crisis services for risk of harm to self or others

   ☐ I or my loved one can better manage substance use problems

   ☐ I or my loved one can better take care of daily needs (e.g., clothing, bathing, eating, etc.)

   ☐Other: _____

5. **What is the most challenging part of you or your loved one's mental health services? Check all that apply, labeling the biggest challenge as "1" and other applicable challenges in descending order (2, 3, 4, etc).**
   ☐ I or my loved one don't know where to go for services or the location of services is not convenient

   ☐ I have or my loved one has to wait a long time to get an appointment

   ☐ Providers do not support me or my loved one in understanding my/their treatment options

☐ Medication does not work for me or my loved one

☐ I or my loved one feel uncomfortable seeking mental health services

☐ I or my loved one feel that services lack cultural responsiveness or appropriateness

☐ Other: _____

6. **How true are the following statements about you or your loved one's experience in <u>getting access to mental health services</u>?**

Obtaining Services	**Not at all true**	**A little bit true**	**Mostly true**	**Very true**	**Don't Know or N/A**
I or my loved one know who to **<u>call</u>** for mental health services.	☐	☐	☐	☐	☐
I or my loved one know where to **<u>go</u>** for mental health services.	☐	☐	☐	☐	☐
I or my loved one feel comfortable seeking mental health services.	☐	☐	☐	☐	☐
It is easy to get an appointment when I or my loved one need one.	☐	☐	☐	☐	☐
The services I or my loved one receive are at a convenient location.	☐	☐	☐	☐	☐
Please explain or elaborate on your answers above:					

7. **How true are the following statements about you or your loved one's <u>experience receiving mental health services</u>?**

Effectiveness of Services	**Not at all true**	**A little bit true**	**Mostly true**	**Very true**	**Don't Know or N/A**
I believe the mental health services I or my loved one receive are helpful.	☐	☐	☐	☐	☐

I am confident that the services and providers will help my or my loved one's recovery.	☐	☐	☐	☐	☐
When receiving mental health services, I or my loved one feel safe and supported.	☐	☐	☐	☐	☐
Services are focused on the belief that I or my loved one can get better.	☐	☐	☐	☐	☐
Please explain or elaborate on your answers above:					

8. **How true are the following statements about you or your loved one's <u>experiences with mental health providers</u>? Mental health providers can include psychiatrists, case managers, therapists, counselors, crisis response providers, or outreach providers.**

Provider Communication	**Not at all true**	**A little bit true**	**Mostly true**	**Very true**	**Don't Know or N/A**
I or my loved one feel respected by my/their mental health team.	☐	☐	☐	☐	☐
I or my loved one trust that any information provided to my/their mental health team is kept confidential.	☐	☐	☐	☐	☐
I or my loved one is included in my/their treatment planning.	☐	☐	☐	☐	☐
My or my loved one's family are included in my/their mental health treatment.	☐	☐	☐	☐	☐
Services are culturally responsive to me or my loved one.	☐	☐	☐	☐	☐
Services are available in the language I or my loved one want to use.	☐	☐	☐	☐	☐
Please explain or elaborate on your answers above:					

Provider Communication	Not at all true	A little bit true	Mostly true	Very true	Don't Know or N/A

9. **How true are the following statements about you or your loved one's <u>satisfaction</u> with mental health services and providers? Mental health providers can include psychiatrists, case managers, therapists, counselors, crisis response providers, or outreach providers.**

Satisfaction	Not at all true	A little bit true	Mostly true	Very true	Don't Know or N/A
I or my loved one have made progress because of the services received.	☐	☐	☐	☐	☐
The mental health team is available when I or my loved one need help.	☐	☐	☐	☐	☐
I am satisfied with the mental health services available for myself or my loved one.	☐	☐	☐	☐	☐
Please explain or elaborate on your answers above:					

10. **Based on your experience, what are the greatest strengths of the Sonoma County mental health system? Please choose <u>three</u> strengths.**

☐ Services and providers communicate with each other and collaborate on my/my loved ones' care.

☐ Services are coordinated with other systems (e.g., justice, child welfare, etc.)

☐ Clients and families have input into the services we/they receive.

☐ Diversity and language of providers/staff reflect the diversity of the population they serve

☐ Services engage and educate the community

☐ Services include staff and peers in providing care who have lived experience with mental health challenges themselves or with family members.

☐ Service providers understand client needs

☐ Services have improved in quality over time

☐ Crisis services are available to everyone who needs them

☐ Services and referrals are right for client needs

☐ Services are easy to access (e.g., ease of getting appointments, convenient locations/times)

☐ Services help the people with the greatest needs

☐ People with less severe needs can get services quickly

☐ Other: _____

11. **Based on your experience, what are the greatest needs of the Sonoma County mental health system? Please choose <u>three</u> needs.**

☐ Services and providers do not communicate with each other or collaborate on my/my loved ones' care

☐ Services are not coordinated with other systems (e.g., justice, child welfare)

☐ Clients and families do not have input into the services we/they receive

☐ Diversity and language of providers/staff does not reflect the diversity of population served

☐ Services do not engage and educate the community

☐ Services do not include staff and peers in providing care who have lived experience with mental health challenges themselves or with family members.

☐ Service providers do not understand client needs

☐ Services have decreased in quality over time

☐ Crisis services are not available to everyone who needs them

☐ Services and referrals are not right for client needs

☐ Services are hard to access (e.g., difficult to get appointments, inconvenient locations/hours)

☐ Services do not help the people with the greatest needs

☐ People with less severe needs cannot get services quickly

☐ Other: _____

12. **What is your top recommendation to improve the Sonoma mental health system? Please only list your primary suggestion.**

13. **Do you have any additional comments you would like to add?**

1. What is your connection to behavioral health services?
   - ☐ Client of Behavioral Health Services
   - ☐ Family Member of Client of Behavioral health Services
   - ☐ County Government Agency
   - ☐ Contracted Service Provider or Community-Based Organization
   - ☐ Law Enforcement
   - ☐ Education Agency
   - ☐ Social Service Agency
   - ☐ Veteran Organization
   - ☐ Medical or Health Care Organization
   - ☐ Community Member
   - ☐ Other: _____

2. What is your primary language? (Please select one)
   - ☐ Arabic
   - ☐ Armenian
   - ☐ Cambodian
   - ☐ Cantonese
   - ☐ English
   - ☐ Farsi
   - ☐ Hmong
   - ☐ Korean
   - ☐ Mandarin
   - ☐ Other Chinese language
   - ☐ Russian
   - ☐ Spanish
   - ☐ Tagalog
   - ☐ Vietnamese
   - ☐ Other
   - ☐ Prefer not to answer

3. Please indicate your age range:
   - ☐ Under 16
   - ☐ 16-25
   - ☐ 26-59
   - ☐ 60 and older
   - ☐ Prefer not to answer

4. What is your race? (Check all that apply)
   - ☐ American Indian or Alaska Native
   - ☐ Asian
   - ☐ Black or African American
   - ☐ Native Hawaiian or Other Pacific Islander
   - ☐ White
   - ☐ Other
   - ☐ Prefer not to answer

5. What is your ethnicity? (Check all that apply)
   - ☐ Hispanic or Latino
   - ☐ Not Hispanic or Latino
   - ☐ Prefer not to answer

6. Please indicate your gender identity:
   - ☐ Female
   - ☐ Male
   - ☐ Transgender woman
   - ☐ Transgender man
   - ☐ Genderqueer
   - ☐ Questioning or unsure of gender identity
   - ☐ Another gender identity
   - ☐ Prefer not to answer

7. Please indicate your sexual orientation:
   - ☐ Gay or Lesbian
   - ☐ Heterosexual or Straight
   - ☐ Bisexual
   - ☐ Questioning or unsure of sexual orientation
   - ☐ Queer
   - ☐ Another sexual orientation
   - ☐ Prefer not to answer

8. Are you a veteran of the United States military?
   - ☐ Yes
   - ☐ No
   - ☐ Prefer not to answer

9. Please indicate your disability status: (select all that apply)
   - ☐ Difficulty seeing
   - ☐ Difficulty hearing, or having speech understood
   - ☐ Mental (i.e., learning disability, developmental disability, dementia)
   - ☐ Physical/mobility domain
   - ☐ Chronic health condition
   - ☐ Other disability
   - ☐ No disability
   - ☐ Prefer not to answer

10. Which zip code do you live in?
    _____

Please provide your name and address:

First name: Last name:

Street: City:

State: Zip Code:

Would you like to be entered into a raffle to win a $20 gift card as a thank you for your time?

☐ Yes

☐ No

Encuesta de Salud del Comportamiento del condado de Sonoma para Clientes y sus Familiares

La Divisíon de Salud del Comportamiento del condado de Sonoma (SCBH) se ha asociado con Resource Development Associates (RDA) para desarrollar una evaluación de capacidad de servicios de salud mental que informará el próximo Programa de Tres Años de MHSA y Plan de Gastos. El propósito del Programa de Tres Años de MHSA y el Plan de Gastos es capturar y documentar la visión de la comunidad cuando se trata de servicios para abordar problemas de salud mental.

Si usted tiene acceso a una computadora o no es un cliente de servicios de salud mental o un miembro de la familia de un cliente, le recomendamos que realice esta encuesta en la computadora en la página:

https://survey.alchemer.com/s3/7034583/Sonoma-County-Behavioral-Health-Community-Survey

Esta encuesta es confidencial. Solo RDA verá su respuesta y combinará su respuesta con las respuestas de otros para informar la evaluación de la capacidad. Si completa la encuesta, tendrá la opción de participar en un sorteo para ganar una tarjeta de regalo de $20 como agradecimiento por su tiempo. Le pedimos su nombre y dirección para enviarle la tarjeta de regalo si gana; su información no será compartida con nadie más.

¿Usted acepta participar en esta encuesta?

☐Sí

☐No

Nota: Si no da su consentimiento, **no complete la encuesta.** Gracias por su tiempo.

1. **¿Qué es su relación con la Divisíon de Salud del Comportamiento del condado de Sonoma?**
   ☐ Soy un cliente de servicios de salud del comportamiento del condado de Sonoma (o sea, recebi servicios de Salud del Comportamiento del condado de Sonoma en los últimos 12 meses)

   ☐ Soy un ser querido de un cliente de servicios de salud del comportamiento

   ☐ Soy un ex cliente de servicios de salud conductual en el condado de Sonoma (he recibido servicios anteriormente, pero ninguno en los últimos 12 meses)

   ☐ Soy un proveedor o profesional de salud mental (Si usted es un proveedor, por favor **vaya a la línea** arriba para la encuesta de proveedores, y complete la forma.)

   ☐ Tengo una relación diferente con la Divisíon de Salud del Comportamiento del condado de Sonoma

   Por favor especifique: _____ (Si tiene una relación diferente, **no complete la encuesta.** Gracias por su tiempo.)

2. **¿Desde hace cuánto tiempo ha estado usted o su ser querido recibiendo los servicios de la Divisíon de Salud del Comportamiento del condado de Sonoma?**
   ☐ Menos que un año

   ☐ 1-2 años

   ☐ 3-5 años

   ☐ 6-10 años

   ☐ Más que 10 años

3. **¿Qué servicios recibió usted o su ser querido el año pasado? Marque todas las opciones que correspondan.**
   ☐ Tratamiento ambulatorio (por ejemplo, Terapia, manejo de casos, medicación)

   ☐ Centro de Autoayuda entre Pares (por ejemplo, el Centro de Bienestar y Advocacia, Interlink, Petaluma Peer Recovery Center, el Centro de Empoderamiento de Russian River)

   ☐ Servicios de Salud Mental de Crisis o Emergencia (por ejemplo, CSU, Atención de Urgencia)

   ☐ Tratamiento residencial (por ejemplo, Progress Sonoma, Parker Hill Place)

   ☐ Servicios involucrados en la corte (por ejemplo, FACT)

4. **¿Qué es lo que más le gusta a usted o a su ser querido de los servicios de salud mental? Marque todos los que correspondan, enumerando el beneficio más importante como "1" y otros beneficios aplicables en orden descendiente (2, 3, 4, etc.).**
   ☐ Yo o mi ser querido tenemos mejores relaciones con familiares, amigos, niños y otras personas.

   ☐ Yo o mi ser querido participamos en actividades significativas / productivas que incluyen un trabajo, escuela o trabajo voluntario.

   ☐ Yo o mi ser querido estamos conectados a asistencia para las necesidades básicas (por ejemplo, ingresos, vivienda, comida)

   ☐ Yo o mi ser querido podemos resolver problemas legales existentes y mantenerse fuera del sistema legal

   ☐ Es menos probable que yo o mi ser querido necesite servicios de crisis por riesgo de daño a sí mismo u otros

   ☐ Yo o mi ser querido puede manejar mejor los problemas de uso de sustancias

   ☐ Mi ser querido puede atender mejor las necesidades diarias (por ejemplo, ropa, bañarse, comer, etc.)

   ☐ Otro: _____

5. **¿Cuál es la parte más difícil de los servicios de salud mental para usted o su ser querido? Marque todas las que correspondan, enumerando la mayor dificultad como "1" y las demás dificultades aplicables en orden descendiente (2, 3, 4, etc).**

☐ Yo o mi ser querido no sabe a dónde ir para recibir servicios o la ubicación de los servicios no es conveniente

☐ Yo o mi ser querido tiene que esperar mucho tiempo para obtener una cita

☐ Los proveedores no me apoyan a mí o a mi ser querido para comprender mis/sus opciones de tratamiento

☐ La medicación no funciona para mí o mi ser querido

☐ Yo o mi ser querido se siente incómodo buscando servicios de salud mental

☐ Yo o mi ser querido siente que los servicios faltan la capacidad de ser culturalmente receptivos o apropiados

☐ Otro: _____

6. **¿Que verdaderas son las siguientes declaraciones sobre la experiencia de usted o de su ser querido para obtener acceso a los servicios de salud mental?**

Obteniendo Servicios	**Nada cierto**	**Un poco cierto**	**Mayor-mente cierto**	**Muy cierto**	**No se o no es aplicable**
Yo se o mi ser querido sabe a quién llamar para recibir servicios de salud mental.	☐	☐	☐	☐	☐
Yo se o mi ser querido sabe a dónde ir para recibir servicios de salud mental.	☐	☐	☐	☐	☐
Yo me siento o mi ser querido se siente cómodo buscando servicios de salud mental.	☐	☐	☐	☐	☐
Es fácil obtener una cita cuando yo o mi ser querido la necesita.	☐	☐	☐	☐	☐
Los servicios que yo recibo o mi ser querido recibí están en una ubicación conveniente.	☐	☐	☐	☐	☐
Por favor explique sus respuestas anteriores:					

7. **¿Que verdaderas son las siguientes declaraciones sobre la experiencia de su ser querido al recibir servicios de salud mental?**

Effectiveness of Services	**Nada cierto**	**Un poco cierto**	**Mayor-mente cierto**	**Muy cierto**	**No se o no es aplicable**
Creo que los servicios de salud mental que yo recibo o mi ser querido recibe son útiles.	☐	☐	☐	☐	☐
Estoy seguro de que los servicios y proveedores ayudarán a mi recuperación o la de mi ser querido.	☐	☐	☐	☐	☐
Cuando recibe servicios de salud mental, yo me siento o mi ser querido se siente seguro y apoyado.	☐	☐	☐	☐	☐
Los servicios se enfocan en la creencia de que yo o mi ser querido nos podemos mejorar.	☐	☐	☐	☐	☐
Por favor explique sus respuestas anteriores:					

8. **¿Que verdaderas son las siguientes declaraciones sobre usted o las experiencias de su ser querido con los proveedores de salud mental? Los proveedores de salud mental pueden incluir psiquiatras, administradores de casos, terapeutas, consejeros, proveedores de reacción ante crisis, o proveedores de alcance.**

Comunicación de Proveedores	**Nada cierto**	**Un poco cierto**	**Mayor-mente cierto**	**Muy cierto**	**No se o no es aplicable**
Yo me siento o mi ser querido se siente respetado por mi/su equipo de salud mental.	☐	☐	☐	☐	☐
Yo confío o mi ser querido confía en que toda la información proporcionada a mi/su equipo de salud mental se mantenga confidencial.	☐	☐	☐	☐	☐
Yo estoy o mi ser querido está incluido en la planificación de mi/su tratamiento.	☐	☐	☐	☐	☐

Comunicación de Proveedores	Nada cierto	Un poco cierto	Mayor - mente cierto	Muy cierto	No se o no es aplicable
Mi familia o la de mi ser querido está incluida en mi/su tratamiento de salud mental.	☐	☐	☐	☐	☐
Los servicios son culturalmente receptivos a mi o a mi ser querido.	☐	☐	☐	☐	☐
Los servicios están disponibles en el idioma que yo o mi ser querido queremos usar.	☐	☐	☐	☐	☐
Por favor explique sus respuestas anteriores:					

9. **¿Que verdaderas son las siguientes declaraciones sobre la satisfacción de usted o de su ser querido con los servicios y proveedores de salud mental? Los proveedores de salud mental pueden incluir psiquiatras, administradores de casos, terapeutas, consejeros, proveedores de reacción ante crisis, o proveedores de alcance.**

Satisfaction	Nada cierto	Un poco cierto	Mayor - mente cierto	Muy cierto	No se o no es aplicable
Yo o mi ser querido hemos progresado debido a los servicios recibidos.	☐	☐	☐	☐	☐
El equipo de salud mental está disponible cuando yo o mi ser querido necesitamos ayuda.	☐	☐	☐	☐	☐
Estoy satisfecho con los servicios de salud mental que estan disponibles para mi or mi ser querido.	☐	☐	☐	☐	☐
Por favor explique sus respuestas anteriores:					

10. **Según su experiencia, ¿cuáles son las mayores fortalezas del sistema de salud mental del condado de Sonoma? Por favor, elija <u>tres</u> puntos fuertes.**

☐ Los servicios y los proveedores se comunican entre sí y colaboran en el cuidado mío/de mis seres querido

☐ Los servicios se coordinan con otros sistemas (por ejemplo, justicia, bienestar infantil, etc.)

☐ Los clientes y las familias tienen facilidad para aportar en los servicios que ellos/yo recibo

☐ La diversidad y el idioma de los proveedores/personal reflejan la diversidad de la comunidad a la que sirven

☐ Los servicios involucran y educan a la comunidad

☐Los servicios incluyen personal y compañeros que prestan cuidados y que han vivido ellos mismos o miembros de la familia experiencias con dificultades de salud mental

☐ Los proveedores de servicios comprenden las necesidades del cliente

☐ Los servicios han mejorado en calidad con el tiempo

☐ Los servicios de crisis están disponibles para todos los que los necesitan

☐ Los servicios y referencias son adecuados para las necesidades del cliente

☐ Los servicios son de fácil acceso (por ejemplo, facilidad para obtener citas, ubicaciones / horarios convenientes)

☐ Los servicios ayudan a las personas con mayores necesidades

☐ Las personas con necesidades menos severas pueden obtener servicios rápidamente

☐ Otro: _____

11. **Según su experiencia, ¿cuáles son las mayores necesidades del sistema de salud mental del condado de Sonoma? Por favor, elija <u>tres</u> necesidades.**

☐ Los servicios y los proveedores no se comunican entre sí y colaboran en el cuidado mío/de mis seres querido

☐ Los servicios no están coordinados con otros sistemas (por ejemplo, justicia, bienestar infantil)

☐ Los clientes y las familias no tienen facilidad para aportar en los servicios que ellos/yo recibo

☐ La diversidad y el idioma de los proveedores/personal no reflejan la diversidad de la comunidad a la que sirven

☐ Los servicios no involucran y educan a la comunidad

☐ Los servicios no incluyen personal y compañeros que prestan cuidados y que han vivido ellos mismos o miembros de la familia experiencias con dificultades de salud mental

☐ Los proveedores de servicios no entienden las necesidades del cliente

☐ Los servicios han disminuido en calidad con el tiempo

☐ Los servicios de crisis no están disponibles para todos los que los necesitan

☐ Los servicios y referencias no son adecuados para las necesidades del cliente

☐ Es difícil acceder a los servicios (por ejemplo, Citas difíciles, ubicaciones / horarios inconvenientes)

☐ Los servicios no ayudan a las personas con mayores necesidades

☐ Las personas con necesidades menos severas no pueden obtener servicios rápidamente

☐ Otro: _____

12. **¿Cuál es su principal recomendación para mejorar el sistema de salud mental de Sonoma? Por favor solo enumere su sugerencia principal.**

13. ¿Tiene algún comentario adicional que le gustaría agregar?

1. ¿Cuál es su conexión con los servicios de salud mental?

   - ☐ Cliente de servicios de salud del comportamiento
   - ☐ Miembro de la familia o amigo del cliente de servicios de salud del comportamiento
   - ☐ Agencia del gobierno del condado
   - ☐ Proveedor de servicios contratado u organización comunitaria
   - ☐ Cumplimiento de la ley
   - ☐ Agencia de Educación
   - ☐ Agencia de Servicios Sociales
   - ☐ Organización de Veteranos
   - ☐ Organización médica o de atención de la salud
   - ☐ Miembro de la comunidad
   - ☐ Otro: _____

2. ¿Cual es su idioma principal? (Por favor, seleccione uno)

   - ☐ Arábica
   - ☐ Armenio
   - ☐ Camboyano
   - ☐ Cantonés
   - ☐ Inglés
   - ☐ Farsi
   - ☐ Hmong
   - ☐ Coreano
   - ☐ Mandarín
   - ☐ Otros idiomas chinos
   - ☐ Ruso
   - ☐ Español
   - ☐ Tagalo
   - ☐ Vietnamita
   - ☐ Otro (por favor especifique):
   - ☐ Prefiero no responder

3. Por favor indique su rango de edad:

   - ☐ Menos de 16 años
   - ☐ 16-25
   - ☐ 26-59
   - ☐ 60 o mas
   - ☐ Prefiero no responder

4. ¿Cuál es su raza? (Marque todo lo que corresponda)

   - ☐ Indio Americano o Nativo de Alaska
   - ☐ Asiático
   - ☐ Negro o Afroamericano
   - ☐ Nativo de Hawai u otra isla del Pacífico
   - ☐ Blanco
   - ☐ Otro (por favor especifique): _____
   - ☐ Prefiero no responder

5. ¿Cuál es su origen étnico? (Marque todo lo que corresponda)

   - ☐ Hispano/a o Latino/a
   - ☐ No Hispano/a o Latino/a
   - ☐ Prefiero no responder

6. Por favor indique su identidad de género actual:
   - ☐ Femenino
   - ☐ Masculino
   - ☐ Mujer Transgénera
   - ☐Hombre Transgénero
   - ☐ Genderqueer
   - ☐ Cuestionar o no estar seguro de la identidad de género
   - ☐ Otra identidad de genero
   - ☐ Prefiero no responder

7. Por favor indique su orientación sexual:
   - ☐ Gay o Lesbiana
   - ☐ Heterosexual
   - ☐ Bisexual
   - ☐ Cuestionar o no está seguro de la orientación sexual.
   - ☐ Queer
   - ☐ Otra orientación sexual
   - ☐ Prefiero no responder

8. ¿Eres un veterano del militar de los Estados Unidos?
   - ☐ Si
   - ☐ No
   - ☐ Prefiero no responder

9. Por favor indique su estado de discapacidad: (Marque todo lo que corresponda)
   - ☐ Dificultad para ver
   - ☐ Dificultad para oír o para entender el habla.
   - ☐ Mental (es decir, discapacidad de aprendizaje, discapacidad del desarrollo, demencia)
   - ☐ Dominio físico /movilidad
   - ☐ Condición de salud crónica
   - ☐ Otra discapacidad
   - ☐ Sin discapacidad
   - ☐ Prefiero no responder

10. ¿En qué código postal vives? _____

Por favor proporcione su nombre y dirección

Primer nombre:

Sobrenombre:

Calle:

Ciudad:

Estado:

Código postal:

¿Le gustaría participar en una rifa para ganar una tarjeta de regalo de $20 como agradecimiento por su tiempo?

☐Si

☐No

Appendix 4: Provider/Professional Data Collection Tools

Sonoma County MHSA Capacity Assessment

Initial Context KII Protocol

Date	
Name	
Title	
Agency/Dept./Org.	
Telephone #	
Interviewer	

Introduction

Hello, my name is _____ [IF ANOTHER PERSON IS ON THE CALL/ATTENDING] and this is _____ from Resource Development Associates. Is now still a good time to talk?

Thank you for taking the time to talk with ME/US. I/WE work for a consulting firm called Resource Development Associates (and we have partnered with Sonoma County to develop a capacity assessment that will inform the upcoming MHSA Three-Year Program and Expenditure. The purpose of the MHSA 3-Year Program and Expenditure Plan is to capture and document the community's vision for services to address mental health issues.

For this capacity assessment, we are looking at the current mental health system in Sonoma County, its strengths, and its challenges. At this early phase of this work, the purpose of this interview is to provide an overview of the Sonoma County system of care, get your initial input on the strengths, challenges, and gaps of this system, and for context about changing needs and service adaptations in response to both wildfires and COVID-19. Please feel free to ask for clarification about any questions I ask, or to add information you believe is relevant.

This conversation will take approximately 45-60 minutes. As we are going through the interview, I/WE will be typing notes, and I'll be recording so that we can use the automated transcript for additional records. We will be using the information from these interviews, upcoming focus groups and community interviews, and data collection in our analysis of Sonoma's Mental Health System. While your name will not be attached to the answers you provide in the interview, because of your affiliation in the County, it may be possible to identify you as the source of certain information. We hope you will feel comfortable sharing candidly about your experiences, but please let me know if there are any sensitive comments that you would like us to be especially careful about when writing up the summary of the conversation.

Do you have any questions before we begin?

Interview Guide

Introductions

To get started, I'd like to begin with learning about you and your position in Sonoma's Mental Health System of Care.

- Your name and organization
- How are you involved in the MH System?

Current System of Care

1. Can you provide an overview of the mental health system of care in Sonoma County?
    a. What services are available?
    b. Who has access to these services?
    c. How does the MH system and the Behavioral Health Department work with the community? With other social service agencies, such as SUD, the carceral system, and others?

2. What would you say are the MH system's primary strengths? [bring out their positive thoughts]
    a. Are there specific programs or services that are performing particularly well?
    b. What factors lead to these successes?
    c. Are these new successes or are these long-standing strengths?

3. What would you say are the MH system's primary challenges?
    a. Are there specific programs or services that are not meeting the community's needs?
    b. What factors lead to these issues?
    c. Are these new issues or are these long-standing challenges?

Historical and Future System

4. What changes taken place in Sonoma County and the behavioral health system in the last five years? What is your perspective on these changes?
    a. How do you think these changes have gone? How have these changes affected the Behavioral Health Department?
    b. How has the conversation changed in the County as a result?
    c. What turned out to be a positive change? What would you do again?
    d. What has been an issue or challenge because of these changes? What would you have done differently?
    e. What do you think has changed as a result of the last capacity assessment and three year plan?

5. Are there are other historical factors that contributed to the design of current MH system?

a. Since the last capacity assessment in 2019, how have the wildfires and COVID-19 impacted needs and/or the MH system?
b. What other events have taken place in Sonoma over the last five to ten years that have affected the MH system?

6. What changes are planned or currently taking place within the MH system?
    a. What is the impetus for these changes?
    b. What is your hope for how these changes will affect the MH system?
    c. What has been tried in the past?

Needs and Recommendations

7. Think about your community and the mental health needs in Sonoma.
    a. Where are there gaps in the system? What services are so full that you need more?
    b. Who is not being served? Who may be falling through the cracks?
    c. What is getting in the way of certain populations needs being met?
    d. What would be helpful to address these issues?

8. Considering the discussion we've just had, what's the most important issue or most significant mental health care need in Sonoma County?

Thank you!

Sonoma County MHSA Capacity Assessment

Adult System of Care Systems Map Discussion Protocol

Date:	
Name(s):	
Title(s):	
Agency/Dept./Org.	
Telephone #:	
Facilitator(s):	

Introduction

Hello, my name is _____ [and this is _____] from Resource Development Associates. Is now still a good time to talk?

Thank you for taking the time to talk with ME/US. I/WE work for a consulting firm called Resource Development Associates and we have partnered with Sonoma County to develop a capacity assessment that will inform the upcoming MHSA Three-Year Program & Expenditure Plan. The purpose of the MHSA 3-Year Program & Expenditure Plan is to capture and document the community's vision for services to address mental health issues.

As part of the capacity assessment, we are mapping the existing services and processes involved in Sonoma County's adult mental health system of care. The purpose of this discussion is to understand this system of care, including how consumers access and move through the system, how appropriate levels of care are determined, data management, how care coordination and transitions occur, as well as strengths and challenges of the system. We hope that the next hour will be an iterative discussion of these topics, so please feel free to ask for clarification about any questions asked or to add information you believe is relevant. We will be typing notes as we go and will use them to inform the systems map that we ultimately create for this capacity assessment.

Do you have any questions before we begin?

Discussion Guide

Introductions

I'd like to begin with learning about you and your position in Sonoma's MH System of Care.

1. What is your name, title, and the organization you work for?
2. How are you involved in the MH system?

Access, Movement, and Coordination within the System of Care

We'd like to now walk through different service domains within the current MH system of care and discuss consumer access and movement through each of them. **We also want to make**

distinctions, if possible, between supports available as part of the *broader system of care* in the county versus the *MHSA-funded* system of care.

3. In what ways do consumers commonly become involved in or connect with the system of care?
4. Can you talk about what **crisis services and supports** are available within the county system of care?
    a. Operated by the county or private? MHSA-funded or not?
    b. If MHSA-funded, do you know what component? (Community Services and Support; Prevention and Early Intervention, or other?)
    c. How do consumers access and obtain these services?
    d. Can you describe common consumer trajectories within these agencies?
    e. How are appropriate levels of care determined?
5. Can you talk about what options are available for **inpatient and residential services** in the system of care?
    a. Operated by the county or private? MHSA-funded or not?
    b. If MHSA-funded, do you know what component? (Community Services and Support; Prevention and Early Intervention, or other?)
    c. How do consumers access and obtain these services?
    d. Can you describe common consumer trajectories within these agencies?
    e. How are appropriate levels of care determined?
6. Can you discuss the **Full Service Partnership programs** within the county system of care?
    a. Operated by the county or private? MHSA-funded or not?
    b. How do consumers access and obtain these services?
    c. Can you describe common consumer trajectories within these agencies?
    d. How are appropriate levels of care determined?
7. What options are available for **outpatient and intensive outpatient services** in the system of care?
    a. Operated by the county or private? MHSA-funded or not?
    b. If MHSA-funded, do you know what component? (Community Services and Support; Prevention and Early Intervention, or other?)
    c. How do consumers access and obtain these services?
    d. Can you describe common consumer trajectories within these agencies?
    e. How are appropriate levels of care determined?
8. How do different service agencies coordinate care and transitions for consumers (e.g., when consumers move from inpatient to outpatient service providers)?
    a. What **transitional or step-down supports** exist? How do they fit into the system of care?
9. How does the **SUD system of care** interact with or feed into the MH system of care?
    a. Can you discuss some specific examples?
    b. What kind of formal collaboration exists between MH and SUD systems of care?
    c. What kind of informal collaboration exists?
    d. How does "no wrong door" play out for someone in need of both MH and SUD services?
10. What agencies (if any) within the system of care…

    a. Integrate peer and/or family-based services?
    b. Incorporate culturally specific services?
    c. Focus on serving older adults?
11. What other key agencies or domains (if any) exist within the current system of care that we haven't yet discussed? How do they fit into the system?
    a. Are there agencies or providers that are newer or in development?

Data Management

12. What is your understanding of how data are managed and shared across agencies or levels of care within this system?

Strengths, Challenges, and the "Ideal" System

13. In your view, what are the biggest strengths of the current adult system of care?
14. What are the biggest challenges?
15. Where do you think clients may fall through the cracks in the current system of care?
16. What elements or characteristics would be needed to create an "ideal" system of care in the county?
17. What changes do you think need to be made to improve the system?

Thank you!

Sonoma County MHSA Capacity Assessment

Youth System of Care Systems Map Discussion Protocol

Date:	
Name(s):	
Title(s):	
Agency/Dept./Org.	
Telephone #:	
Facilitator(s):	

Introduction

Hello, my name is _____ [and this is _____] from Resource Development Associates. Is now still a good time to talk?

Thank you for taking the time to talk with ME/US. I/WE work for a consulting firm called Resource Development Associates and we have partnered with Sonoma County to develop a capacity assessment that will inform the upcoming MHSA Three-Year Program & Expenditure Plan. The purpose of the MHSA 3-Year Program & Expenditure Plan is to capture and document the community's vision for services to address mental health issues.

As part of the capacity assessment, we are mapping the existing services and processes involved in Sonoma County's **youth** mental health system of care. The purpose of this discussion is to understand this system of care, including how consumers access and move through the system, how appropriate levels of care are determined, data management, how care coordination and transitions occur, as well as strengths and challenges of the system. We hope that the next hour will be an iterative discussion of these topics, so please feel free to ask for clarification about any questions asked or to add information you believe is relevant. We will be typing notes as we go and will use them to inform the systems map that we ultimately create for this capacity assessment. / ASK ABOUT RECORDING

Do you have any questions before we begin?

Discussion Guide

Introductions

I'd like to begin with learning about you and your position in Sonoma's MH System of Care.

1. What is your name, title, and the organization you work for?
2. How are you involved in the MH system?

Access, Movement, and Coordination within the System of Care

We'd like to now walk through different service domains within the current MH system of care and discuss consumer access and movement through each of them. **We also want to make**

distinctions, if possible, between supports available as part of the *broader youth system of care* in the county versus the *MHSA-funded* youth system of care.

3. In what ways do youth consumers commonly become involved in or connect with the system of care?
4. Can you talk about what **crisis services and supports** are available within the youth system of care?
    a. Operated by the county or private? MHSA-funded or not?
    b. If MHSA-funded, do you know what component? (Community Services and Support; Prevention and Early Intervention, or other?)
    c. How do youth access and obtain these services?
    d. Can you describe common trajectories within these agencies?
    e. How are appropriate levels of care determined?
5. Can you talk about what options are available for **inpatient and residential services** in the youth system of care?
    a. Operated by the county or private? MHSA-funded or not?
    b. If MHSA-funded, do you know what component? (Community Services and Support; Prevention and Early Intervention, or other?)
    c. How do youth access and obtain these services?
    d. Can you describe common trajectories within these agencies?
    e. How are appropriate levels of care determined?
6. Can you discuss the **Full Service Partnership programs** within the youth county system of care?
    a. Operated by the county or private? MHSA-funded or not?
    b. How do youth access and obtain these services?
    c. Can you describe common trajectories within these agencies?
    d. How are appropriate levels of care determined?
7. What options are available for **outpatient and intensive outpatient services** in the system of care?
    a. Operated by the county or private? MHSA-funded or not?
    b. If MHSA-funded, do you know what component? (Community Services and Support; Prevention and Early Intervention, or other?)
    c. How do youth access and obtain these services?
    d. Can you describe common trajectories within these agencies?
    e. How are appropriate levels of care determined?
8. What **youth prevention programs** exist within the system of care for children?
    a. Operated by the county or private? MHSA-funded or not?
    b. How do youth access and obtain these services?
    c. Can you describe common trajectories within these agencies?
    d. How are appropriate levels of care determined?
9. How do different service agencies coordinate care and transitions for youth (e.g., when consumers move from inpatient to outpatient service providers)?
    a. What **transitional or step-down supports** exist? How do they fit into the system of care?
10. What agencies (if any) within the system of care…
    a. Integrate peer and/or family-based services?

b. Incorporate culturally specific services?

11. What other key agencies or domains (if any) exist within the current system of care that we haven't yet discussed? How do they fit into the system?
    a. Are there agencies or providers that are newer or in development?

Data Management

12. What is your understanding of how data are managed and shared across agencies or levels of care within this system?

Strengths, Challenges, and the "Ideal" System

13. In your view, what are the biggest strengths of the current youth system of care?
14. What are the biggest challenges?
15. Where do you think youth may fall through the cracks in the current system of care?
16. What elements or characteristics would be needed to create an "ideal" system of care in the county?
17. What changes do you think need to be made to improve the system?

Thank you!

Sonoma County MHSA Needs Assessment Provider/Professional KII Protocol

Date	
Name	
Title	
Agency/Dept./Org.	
Telephone #	
Interviewer	

Introduction

Hello, my name is _____ [and this is _____] from Resource Development Associates. Is now still a good time to talk?

Thank you for taking the time to talk with ME/US. I/WE work for a consulting firm called Resource Development Associates and we have partnered with Sonoma County to develop a capacity assessment that will inform the upcoming MHSA Three-Year Program & Expenditure Plan. The purpose of the MHSA 3-Year Program & Expenditure Plan is to capture and document the community's vision for services to address mental health issues.

For the capacity assessment, we are looking at the current mental health system in Sonoma County, its strengths, and its challenges. The purpose of this interview is to understand how [YOUR GROUP] and the community overall participates in Sonoma's Mental Health System, what is working well, and where there are areas for improvement. Please feel free to ask for clarification about any questions I ask, or to add information you believe is relevant.

This conversation will take approximately 45-60 minutes. As we are going through the interview, I/WE will be typing notes. We will be using the information from these interviews, our focus groups, and data collection in our analysis of Sonoma's Mental Health System. While your name will not be attached to the answers you provide in the interview, because of your affiliation in the County, it may be possible to identify you as the source of certain information. We hope you will feel comfortable sharing candidly about your experiences, but please let me know if there are any sensitive comments that you would like us to be especially careful about when writing up the summary of the conversation. We will be recording today's conversation so that we can use the generated transcript for our notes, but the recording will not be shared with anyone.

Do you have any questions before we begin?

Interview Guide

Introductions

I'd like to begin with learning about you and your position in Sonoma's Mental Health System of Care.

- Your name and organization
- How are you involved in the MH System?

Current System of Care

1. Tell us about your/your agency's role in mental health services or working with people with mental health needs.
    a. What services do you provide?
    b. Who do you collaborate and coordinate services with (i.e. other providers, law enforcement, schools)?
2. How do you typically first become aware that an individual might need mental health services?
    a. How do people access your services? How does the referral process work?
    b. Is it working well? What could be improved?
3. What has been the most helpful or positive when providing these services?
    Prompt: addressing the needs of consumers, coordination/collaboration, referrals, capacity
4. What has been the most difficult or challenging when providing these services?
    Prompt: addressing the needs of consumers, coordination/collaboration, referrals, capacity

Service & Program Changes

5. With the changes in the last few years, [depending on the audience mention: COVID-19, fires, budget changes, new leadership, etc.], how have these events impacted the mental health system?
    a. What improvements have you experienced, if any?
    b. What increased challenges have you experienced, if any?
    Prompt: coordination of services, capacity, staff resources

Needs and Recommendations

6. Think about your community and the mental health needs in Sonoma.
    a. Where are there gaps in the system? What services are so full that you need more?
    b. Who is not being served? Who may be falling through the cracks?
    c. What is getting in the way of certain populations' needs being met?
    d. What would be helpful to address these issues?
7. Considering the discussion we've just had, what's the most important issue or most significant mental health care need in Sonoma County?

Thank you!

Sonoma County MHSA Needs Assessment Focus Group Protocol (Provider Experience)

Date	
FG Type/Size	
Location	
Facilitator	

Introduction

Thanks for making the time to join us today. My name is _____ and this is _____. We are with a consulting firm called Resource Development Associates and we are here to help Sonoma County with a needs assessment that will inform the upcoming MHSA Three-Year Program & Expenditure Plan. I will be facilitating our talk today and _____ will take notes, but we won't be attaching your names to anything that is said. We hope you will feel comfortable sharing candidly about your experiences, but please let me know if there is anything you don't want us to document. We respect your anonymity. We will be recording today's conversation so that we can use the generated transcript for our notes, but the recording will not be shared with anyone.

The purpose of the MHSA 3-Year Program & Expenditure Plan is to capture and document the community's vision for services to address mental health issues. More specifically, the Mental Health Services Act aims to strengthen the public mental health system that many individuals and communities rely on, especially underserved communities. We are holding several focus groups throughout Sonoma County to better understand the mental health needs in the community.

We're here today to hear from you. This is your process and your opportunity to make your voice heard about what is working well, what isn't working well, and what you feel is needed. We know there have been changes and upheavals in the last few years, [depending on the audience mention: fires, budget changes, new leadership, etc.], and we want to learn how these changes have affected you.

This is your conversation, but part of my job as facilitator is to help the discussion go smoothly and make sure that everyone has a chance to say what's on their mind in a respectful way. We have a few guidelines to help us do that. Please:

- Turn on your video if you're able to and comfortable doing so
    - *If in person*: turn your phone on silent and please refrain from having side conversations
- Engage in the conversation – this is your meeting!
- And remember, there are no "wrong" or "right" opinions: please share your opinions honestly and listen with curiosity to understand the perspective of others

Does anyone have any questions before we begin?

Focus Group Guide

Introductions

To get started, I'd like to begin with introductions. Please share:

- Your name and organization
- A brief (1 min) overview of the services your agency provides or the role they play in working with people with mental health needs

Current System of Care

1. How do you typically first become aware that an individual might need mental health services?
    a. How do people access your services? How does the referral process work?
    b. Is it working well? What could be improved?

2. What has worked the best or been the most positive when providing these services?
    Prompt: addressing the needs of consumers, coordination/collaboration, referrals, capacity

3. What has been the most difficult or challenging when providing these services?
    Prompt: addressing the needs of consumers, coordination/collaboration, referrals, capacity

Service & Program Changes

4. With the changes in the last few years, [depending on the audience mention: fires, budget changes, new leadership, etc.], how have these events impacted the mental health system?
    a. What improvements have you experienced, if any?
    b. What increased challenges have you experienced, if any?
    Prompt: coordination of services, capacity, staff resources

Needs and Recommendations

5. Think about your community and the mental health needs in Sonoma.
    a. Where are there gaps in the system? What services are so full that you need more?
    b. Who is not being served? Who may be falling through the cracks?
    c. What is getting in the way of certain populations needs being met?
    d. What would be helpful to address these issues?

6. Considering the discussion we've just had, what's the most important issue or most significant mental health care need in Sonoma County?

Thank you!

Sonoma County Mental Health Provider Survey

1. **What type of organization or agency do you work for?**
   - ☐ County agency (e.g. BHD, Access Team)
   - ☐ Community Based Organization
   - ☐ County-contracted agency (e.g. Progress Sonoma, Buckelew)
   - ☐ Healthcare facility or hospital
   - ☐ Non-profit
   - ☐ I am a private mental health provider
   - ☐ Other (Please specify)

2. **What services does your organization or program provide? Check all that apply.**
   - ☐ Outpatient Treatment (e.g., therapy, case management, medication)
   - ☐ Peer Self-Help Center (e.g., The Wellness and Advocacy Center, Russian River Empowerment Center)
   - ☐ Crisis or Emergency Mental Health Services (e.g., CSU, Urgent Care)
   - ☐ Residential Treatment (e.g., Progress Sonoma, Parker Hill Place)
   - ☐ Court-involved Services (e.g., FACT)

3. **Where in Sonoma County do you provide services? (check all that apply)**

☐ North County
☐ South County
☐ East County
☐ West County
☐ Santa Rosa

4. **What is one area you feel your organization or program excels at or provides the best care in?**

☐ Cultural competency
☐ Awareness and education about mental health and recovery
☐ Coping skills and strategies to manage mental health symptoms
☐ Competence to support living independently
☐ Strategies for healthy relationships with friends and families
☐ Ability to meet all basic self-care needs independently like hygiene, cooking, and managing finances
☐ Crisis response services
☐ Other: _____

5. **How true are the following statements about the <u>services</u> that your organization or program provides?**

Services Available	**Not at all true**	**A little bit true**	**Mostly true**	**Very true**	**Don't Know or N/A**
The services my organization or program provides are useful to our clients.	☐	☐	☐	☐	☐
My organization or program is able to keep our clients engaged in our services for as long as they need them.	☐	☐	☐	☐	☐
The services my organization or program provide focus on the belief that our clients can get better.	☐	☐	☐	☐	☐
Client wait times for services are reasonable.					
Please explain or elaborate on your answers above:					

6. **How true are the following statements about the staffing and <u>resources</u> available to your organization or program?**

Staff Resources	Not at all true	A little bit true	Mostly true	Very true	Don't Know or N/A
My organization or program is able to recruit and retain the staff necessary to meet our clients' needs.	☐	☐	☐	☐	☐
My organization has sufficient staff.					
My organization has the right mix of staff positions (e.g. MH professionals, peer providers, etc)					
A less time-consuming hiring process would improve my organization's staffing situation.					
Less stringent staff educational requirements would improve my organization's staffing situation.					
There are affordable living situations for staff close to work					
I have enough time to provide my clients with the services they need.	☐	☐	☐	☐	☐
My organization or program offers the services that our clients need.	☐	☐	☐	☐	☐
My organization or program provides services in the language that our clients wish to use.	☐	☐	☐	☒	☐
Please explain or elaborate on your answers above:					

7. **How true are the following statements about your organization's or program's <u>communication</u> with clients and other agencies?**

Communication	Not at all true	A little bit true	Mostly true	Very true	Don't Know or N/A
My organization or program works together with our clients to make decisions about their services.	☐	☐	☐	☐	☐
My organization or program works with our clients' families to support their recovery.	☐	☐	☐	☐	☐

Communication	Not at all true	A little bit true	Mostly true	Very true	Don't Know or N/A
My organization or program is able to connect our clients to other services they need in Sonoma County.	☐	☐	☐	☐	☐
I believe the County works well with my organization or program to best meet the needs of our clients.	☐	☐	☐	☐	☐
I believe other providers work well with my organization or program to best meet the needs of our clients.	☐	☐	☐	☐	☐
Please explain or elaborate on your answers above:					

8. **How true are the following statements about your <u>satisfaction</u> with mental health services from your organization or program and in Sonoma County?**

Satisfaction	Not at all true	A little bit true	Mostly true	Very True	Don't Know or N/A
I believe Sonoma County has the mental health services necessary to meet the community's needs.	☐	☐	☐	☐	☐
I am confident in my organization's or program's ability to help our clients' recovery.	☐	☐	☐	☐	☐
I am satisfied with the working environment at my organization or program.	☐	☐	☐	☐	☐
Please explain or elaborate on your answers above:					

9. **Based on your experience, what are the greatest strengths of the Sonoma County mental health system? Please choose <u>three</u> strengths.**
   ☐ Services and providers communicate with each other and collaborate on clients' care
   ☐ Services are coordinated with other systems (e.g., justice, child welfare, etc.)
   ☐ Clients and families have input into the services they receive

☐ Diversity and language of providers/staff reflect the diversity of the population they serve
☐ Services engage and educate the community
☐ Services include staff and peers in providing care who have lived experience with mental health challenges themselves or with family members.
☐ Service providers understand client needs
☐ Services have improved in quality over time
☐ Crisis services are available to everyone who needs them
☐ Services and referrals are right for client needs
☐ Services are easy to access (e.g., ease of getting appointments, convenient locations/times)
☐ Services help the people with the greatest needs
☐ People with less severe needs can get services quickly
☐ Other: _____

10. Based on your experience, what are the greatest needs of the Sonoma County mental health system? Please choose <u>three</u> needs.

☐ Services and providers do not communicate with each other or collaborate on clients' care

☐ Services are not coordinated with other systems (e.g., justice, child welfare)

☐ Clients and families do not have input into the services they receive

☐ Diversity and language of providers/staff does not reflect the diversity of population served

☐ Services do not engage and educate the community

☐ Services do not include staff and peers in providing care who have lived experience with mental health challenges themselves or with family members

☐ Service providers do not understand client needs

☐ Services have decreased in quality over time

☐ Crisis services are not available to everyone who needs them

☐ Services and referrals are not right for client needs

☐ Services are hard to access (e.g., difficult to get appointments, inconvenient locations/hours)

☐ Services do not help the people with the greatest needs

☐ People with less severe needs cannot get services quickly

☐ Other: _____

11. **What is your top recommendation to improve the Sonoma mental health system? Please only list your primary suggestion.**

12. **Do you have any additional comments you would like to add?**

1. What is your connection to behavioral health services?
   - ☐ Client of Behavioral Health Services
   - ☐ Family Member of Client of Behavioral health Services
   - ☐ County Government Agency
   - ☐ Contracted Service Provider or Community-Based Organization
   - ☐ Law Enforcement
   - ☐ Education Agency
   - ☐ Social Service Agency
   - ☐ Veteran Organization
   - ☐ Medical or Health Care Organization
   - ☐ Community Member
   - ☐ Other: _____

2. What is your primary language? (Please select one)
   - ☐ Arabic
   - ☐ Armenian
   - ☐ Cambodian
   - ☐ Cantonese
   - ☐ English
   - ☐ Farsi
   - ☐ Hmong
   - ☐ Korean
   - ☐ Mandarin
   - ☐ Other Chinese language
   - ☐ Russian
   - ☐ Spanish
   - ☐ Tagalog
   - ☐ Vietnamese
   - ☐ Other
   - ☐ Prefer not to answer

3. Please indicate your age range:
   - ☐ Under 16
   - ☐ 16-25
   - ☐ 26-59
   - ☐ 60 and older
   - ☐ Prefer not to answer

4. What is your race? (Check all that apply)
   - ☐ American Indian or Alaska Native
   - ☐ Asian
   - ☐ Black or African American
   - ☐ Native Hawaiian or Other Pacific Islander
   - ☐ White
   - ☐ Other
   - ☐ Prefer not to answer

5. What is your ethnicity? (Check all that apply)
   - ☐ Caribbean
   - ☐ Central American
   - ☐ Mexican/Mexican-American/Chicano
   - ☐ Puerto Rican
   - ☐ South American
   - ☐ Other Hispanic or Latino
   - ☐ African
   - ☐ Asian Indian/South Asian
   - ☐ Cambodian
   - ☐ Chinese
   - ☐ Eastern European
   - ☐ European
   - ☐ Filipino
   - ☐ Japanese
   - ☐ Korean
   - ☐ Middle Eastern
   - ☐ Vietnamese
   - ☐ Other Non-Hispanic or Non-Latino
   - ☐ Prefer not to answer

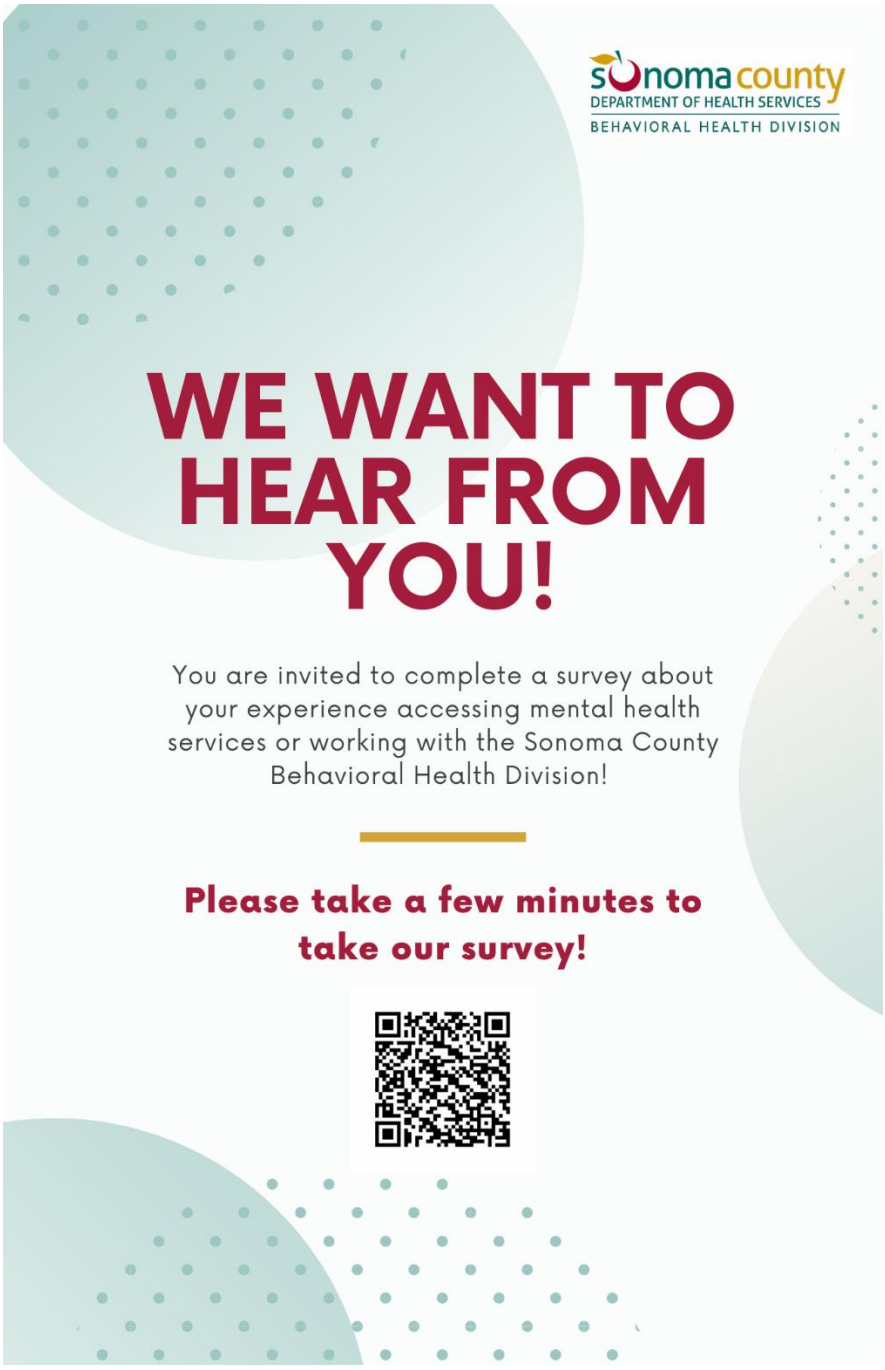
6. Please indicate your current gender identity:
   - ☐ Female
   - ☐ Male
   - ☐ Transgender woman
   - ☐ Transgender man
   - ☐ Genderqueer
   - ☐ Questioning or unsure of gender identity
   - ☐ Another gender identity
   - ☐ Prefer not to answer

7. Please indicate your sexual orientation:
   - ☐ Gay or Lesbian
   - ☐ Heterosexual or Straight
   - ☐ Bisexual
   - ☐ Questioning or unsure of sexual orientation
   - ☐ Queer
   - ☐ Another sexual orientation
   - ☐ Prefer not to answer

8. Are you a veteran of the United States military?
   - ☐ Yes
   - ☐ No
   - ☐ Prefer not to answer

9. Please indicate your disability status (select all that apply)
   - ☐ Difficulty seeing
   - ☐ Difficulty hearing, or having speech understood
   - ☐ Mental (i.e., learning disability, developmental disability, dementia)
   - ☐ Physical/mobility domain
   - ☐ Chronic health condition
   - ☐ Other disability
   - ☐ No disability
   - ☐ Prefer not to answer

Appendix 5: Recruitment Materials




sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION
QUEREMOS ESCUCHAR DE USTED!
¡Está invitado a completar una encuesta sobre su experiencia al acceder a los servicios de salud mental o de trabajar con la División de Salud del Comportamiento del Condado de Sonoma!
¡Tómese unos minutos para completar nuestra encuesta!


sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION
WE WANT TO HEAR FROM YOU!
Join us for a focus group about your experience accessing mental health services or working with the Sonoma County Behavioral Health Division!
Friday, October 21st
4-5pm | Seneca
101 Wikiup Drive Santa Rosa 95403
Receive a $25 gift card for participating!
If interested, contact Paulina Hatfield
phatfield@rdaconsulting.com


sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION
WE WANT TO HEAR FROM YOU!
Join us for a focus group to discuss the strengths and challenges of the mental health system and your experience working with the Sonoma County Behavioral Health Division!
Clients and family members invited to join!
Receive a $25 gift card for participating!
If interested, contact Paulina Hatfield
phatfield@rdaconsulting.com


sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION
QUEREMOS ESCUCHAR DE USTED!
¡Únase a nosotros para una discusión de grupo sobre su experiencia en La Luz y el acceso a otros servicios de bienestar/salud mental en el Condado de Sonoma!
Lunes 21 de Noviembre
6-7pm | Zoom
¡Reciba una tarjeta de regalo de 25 dólares por participar!
Si está interesado, utiliza el código QR para inscribirte

Appendix 6: Data Pull Request

Sonoma County Behavioral Health Services Data Request for the MHSA Capacity Assessment

Description: The tables below list the data requested for every consumer who received Sonoma County Behavioral Health funded services during the three-year period from July 1, 2019 – June 30, 2022. Consumer information will be used to describe the specialty mental health population in Sonoma County. Programmatic and service information will be used to identify which services and levels of care are being utilized by consumers. Financial information will be used to assess the potential for cost savings across the entire system of care.

Table 1. Data Requested from Avatar Electronic Health Record (EHR) Time Frame Requested: July 1, 2019 – June 30, 2022

Domain	Categories	Variables
Consumer Information	Identifying Info.	Medical Record Number
		Client Name
	Demographic Info.	Date of Birth
		Gender
		Race
		Ethnicity
		Primary Language
		Housing Status or Living Situation (e.g., stable housing, homeless, shelter, transitional housing, etc.)
		Insurance Status/Type (e.g., Medi-Cal, Medicare, private, uninsured)
	Clinical Diagnoses	Mental Health diagnosis code and description
		Substance use disorder diagnosis [if available]
Outpatient Mental Health and Substance Use Service Information	Identifying Info.	Medical Record Number
		Client Name
	Service Episode Info.	Episode Number
		Program Name (e.g., FSP, Access Team, etc.)
		Episode Open Date
		Episode Close Date
	Service Encounter Info.	Service Code and Description (e.g., therapy, case management, etc.)
		Date of Service
		Service Location (e.g., field, office, telephone, etc.)
		Service Length (minutes)
		Service Charges/Cost
Crisis Stabilization Unit Service Information	Identifying Info.	Medical Record Number
		Client Name
	Referral and Location Info.	Referral Source (e.g., law enforcement agency, SCBHD, etc.)
		Transport to CSU (e.g., walk-in, law enforcement transport, ambulance transport)
		Location of MST (e.g., zip code or city)
	5150 Hold Info.	5150 Hold Placed

	Medical Clearance Info.	Reason for 5150 Hold (e.g., danger to self, danger to others)
		Medical Condition
		Medical Clearance Request (e.g., requested, not requested)
		Medical Clearance Status (e.g., cleared, not cleared)
		Medical Clearance Location (e.g., St. Joseph, Sutter, etc.)
	Service Episode Info.	Episode Admission Date and Time
		Episode Discharge Date and Time
		Episode Length (minutes/hours)
		Discharge disposition (e.g., psychiatric hospitalization, referred to FSP, etc.)
	Service Encounter Info.	Service Code and Description (e.g., crisis intervention, assessment, etc.)
		Date of Service
		Service Location (e.g., field, office, telephone, etc.)
		Service Length (minutes)
		Service Charges/Cost
Residential Placement Information (Both in-County and out- of-County)	Identifying Info.	Medical Record Number
		Client Name
	Episode Info.	Episode Number
		Level of Care (e.g., Board and Care, Crisis Residential Unit, etc.)
		Program Name (e.g., Parker Hill Place, Creekside, E Street, etc.)
		Episode Admission Date
		Episode Discharge Date
		Episode Length (days)
		Service Charges/Cost [if available]
Psychiatric Inpatient Information (Both in-County and out- of-County)	Identifying Info.	Medical Record Number
		Client Name
	Episode Info.	Episode Number
		Level of Care (e.g., Psychiatric Hospital, Psychiatric Health Facility, etc.)
		Program Name (e.g., Aurora Santa Rosa Hospital, Crestwood Psychiatric Health Facility, etc.)
		Episode Admission Date
		Episode Discharge Date
		Episode Length (days)
		Service Charges/Cost [if available]

Table 2. Data Requested from Sonoma Web Infrastructure for Treatment Services (SWITS)

Time Frame Requested: July 1, 2019 – June 30, 2022

Domain	Categories	Variables
Consumer Information	Identifying Info.	Medical Record Number
		Client Name
	Demographic Info.	Date of Birth
		Gender
		Race
		Ethnicity
		Primary Language
		Housing Status or Living Situation (e.g., stable housing, homeless, shelter, transitional housing, etc.)
		Insurance Status/Type (e.g., Medi-Cal, Medicare, private, uninsured)
	Clinical Diagnoses	Mental Health diagnosis code and description
		Substance use disorder diagnosis
Service Information (Outreach and Engagement programs, other MHSA programs not included in Avatar)	Identifying Info.	Medical Record Number
		Client Name
	Service Episode Info.	Episode Number
		Program Name (e.g., FSP, Access Team, etc.)
		Episode Open Date
		Episode Close Date
	Service Encounter Info.	Service Code and Description (e.g., therapy, case management, etc.)
		Date of Service
		Service Location (e.g., field, office, telephone, etc.)
		Service Length (minutes)
		Service Charges/Cost
Mobile Support Team Service Information	Identifying Info.	Medical Record Number
		Client Name
	Referral and Location Info.	Referral Source (e.g., law enforcement agency, family, etc.)
		Location of MST (e.g., zip code or city)
	Service Episode Info.	Episode Start Date and Time
		Episode End Date and Time
		Episode Length (minutes/hours)
		Discharge disposition (e.g., 5150 placed, referred to Access, etc.)
		Transportation, if applicable (e.g., CSU, Sutter, etc.)
	Service Encounter Info.	Service Code and Description (e.g., crisis intervention, assessment, etc.)
		Service Length (minutes)
		Service Charges/Cost

Table 3. Data Requested from Quarterly Reports

Time Frame Requested: July 1, 2019 – June 30, 2022

[in spreadsheet format, if possible, and full report documents]

Domain	Categories	Variables
Consumer Information By Program	General Info.	Program Name (e.g., Wellness and Advocacy Center, Petaluma Peer Recovery Project, etc.)
		Number of Consumers (per quarter)
	Number of Consumers by Demographic Info.	Gender
		Race
		Ethnicity
		Primary Language
		Identify as LGBTQ
		Identify as Veteran
		Identify as Homeless
		Individuals in Foster Care
		Medi-Cal Beneficiaries
Program Information	Program Info.	Number of Peers (per quarter) *(if available)*
		Number of other staff (per quarter) *(if available)*
	Service Info.	Service Description (e.g., peer counseling, art group, etc.)
		Number of Times offered (per quarter) *(if available)*
		Number of Consumers (per quarter)
		Service Charges/Cost (by service or program per quarter) *(if available)*

Appendix 7: Acronyms

Abbreviation	Definition
ART	Adult Residential Treatment
BHD	Behavioral Health Division
CMHC	Community Mental Health Centers
COTS	Committee on the Shelterless
CPP	Community Program Planning
CRT	Crisis Residential Treatment
CSS	Community Services and Supports
CSU	Crisis Stabilization Unit
CTRT	Collaborative Treatment & Recovery Team
DHCS	Department of Health Care Services
DHS	Department of Health Services
DHS-BHD	Department of Health Services - Behavioral Health Division
EHR	Electronic Health Record
FACT	Forensic Assertive Community Treatment
FASST	Family Advocacy, Stabilization, and Support Team
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FSP	Full Service Partnership
INN	Innovation
ISFC	Intensive Services for Foster Youth
KII	Key Informant Interview
LTC	Long-Term Care Facilities
MHP	Mental Health Plan
MHSA	Mental Health Services Act
PEI	Prevention and Early Intervention
PIT	Point in Time
SMI	Serious Mental Illness
STR-TP	Short-Term Residential Treatment Program
SUD	Substance Use Disorder
TACT	Telecare Assertive Community Treatment
TAY	Transition Aged Youth

Appendix 8: Resources

Overall, in the 2021-2022 fiscal year, potential revenue of all services rendered (both claimable and non-claimable) totaled $66,628,238 on all services for all 3,454 unique clients served (**Error! R eference source not found.**). One-third of all services rendered were non-claimable, for a total of $22.5 million in non-claimable services and $44.2 million in claimable services. Overall, an average of nearly $20,000 was spent per person, ranging from $0 (services for which there was no charge) to $682,907 for one high-utilizing individual. Moreover, the median price of services per person was $9,848, meaning that for half of clients, services amounted to less than $9,848.

The majority of potential revenue was related to adult and older adult services ($50.8 million) followed by youth and family services ($12.9 million) and TAY-specific services ($2.9 million) (**Error! R eference source not found.**). Per person, service prices were highest for adult services ($21,373 per person), followed by TAY services ($20,106). The price of services for youth ages 0-18 were significantly lower per client, at $11,358.

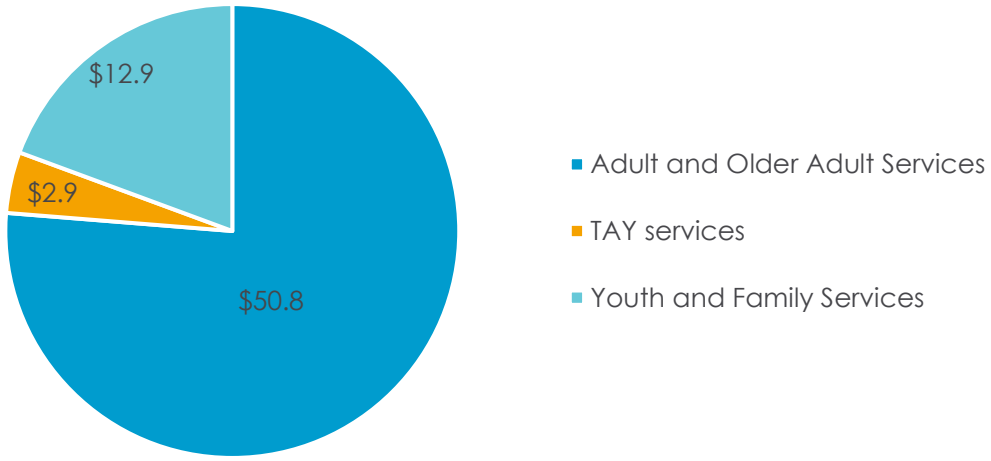
Table 17: Potential revenue for all services, by service type

Service	Potential Revenue	Average per person
Adult and older adult services (total)	$50,823,841	$21,373
TAY-specific services (total)	$2,935,543	$20,106
Youth and family services (total)	$12,868,855	$11,358
All services (total)	$66,628,238	$19,291

Programs that had high levels of non-claimable costs included adult board and care, adult residential services, and the CSU. Together, these three service categories accounted for more than 90% of non-claimable costs. Adult board and care services amounted to a total of $6.7 million worth of services, none of which is claimable, and which amounted to nearly one third of all non-claimable costs. Adult residential services added up to a total of $9.7 million dollars' worth of services, split between claimable ($4.6 million) and non-claimable ($5.1 million) costs. The $5.1 million non-claimable adult residential costs were associated with 148 episodes of locked inpatient facilities (long-term care facilities, or LTC). The CSU amounted to $9.0 million of non-claimable costs and is discussed in more detail below.

For unlocked short-term residential services (CRT) there were a total of 360 episodes among 235 unique clients, amounting to $2.5 million dollars' worth of services, 100% of which was claimable. For unlocked long-term residential services, there were a total of 69 episodes during the fiscal year among 63 unique clients, totaling $1.6 million, 100% of which was claimable.

Figure 24: Total potential revenue of all services rendered, by type (in millions)



CSU claimable and non-claimable services

The **CSU is overall one of the most expensive types of services provided by DHS-BHD and totaled nearly $13 million in fiscal year 21-22** (**Error! Reference source not found.**). However, Medi-Cal will o nly reimburse CSU stays up to 20 hours, with the remaining four hours within the first 24 being non-claimable, and anything over 24 hours considered an overstay and therefore also non-claimable.

Mental Health Services Act

Collaborative Statewide Early Psychosis Program Evaluation

Annual Innovation Report:

Summary Report of the Activities of the LHCN

Fiscal Year 2021-2022

Draft submitted November 7, 2022

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Prepared by:

University of California, Davis, San Francisco and San Diego

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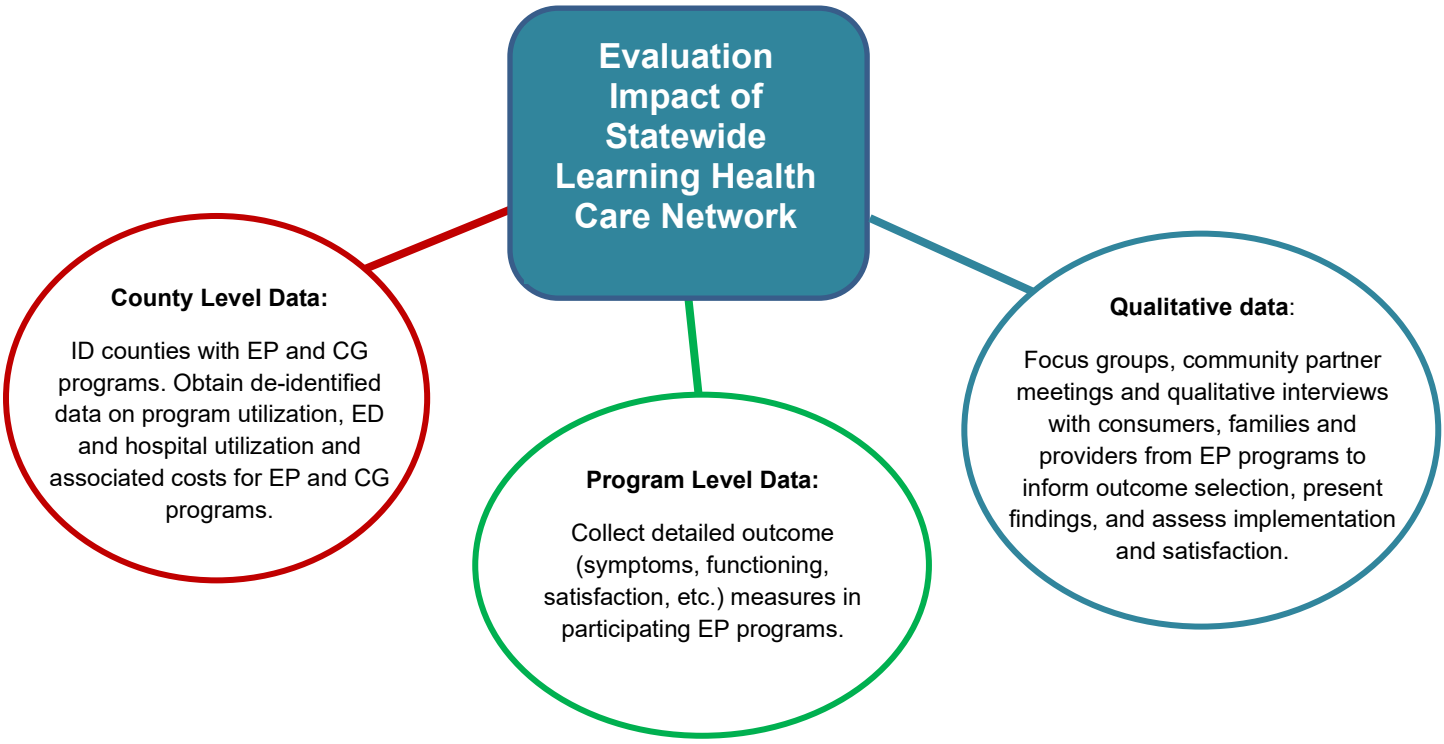
Background

Multiple California counties in collaboration with the UC Davis Behavioral Health Center of Excellence received approval to use Innovation or other Prop 63 funds to develop infrastructure for a sustainable learning health care network (LHCN) for early psychosis (EP) programs. Of those counties with approved funding, the following counties have processed and executed contracts between their behavioral health services departments and UC Davis: San Diego, Solano, Sonoma, Los Angeles, Orange, Stanislaus, and Napa. One Mind has also contributed $1.5 million in funding to support the project. This Innovation project seeks to demonstrate the utility of the network via a collaborative statewide evaluation to assess the impact of the network and these programs on the consumers and communities that they serve. This project, led by UC Davis in partnership with UC San Francisco, UC San Diego, University of Calgary and multiple California counties, brings consumer-level data to the providers' fingertips for real-time sharing with consumers, and allows programs to learn from each other through a training and technical assistance collaborative. This Statewide EP Evaluation and LHCN propose to 1) increase the quality of mental health services, including measurable outcomes, and 2) introduce a mental health practice or approach that is new to the overall mental health system. The project must comply with the regulatory and funding guidelines for evaluation as stipulated by the applicable Mental Health Services Act (MHSA) funding regulations, contract deliverables, and best practices.

There are three components to the data collected for the LHCN: County Level, Program Level, and Qualitative data (Figure 1). The protocol for collecting each component has been reviewed by an Institutional Review Board (IRB) and approved before commencement of data collection. Further, aspects of the data design has been shaped by the input of community partners, including mental health consumers, family members, and providers.

Figure 1. Three Components of the Evaluation Associated with the Statewide LHCN.



This project was approved for funding using Innovation Funds by the MHSOAC in December of 2018. The California Early Psychosis Learning Health Care Network (LHCN) represents a unique partnership between the

University of California, multiple California counties, and One Mind to build a network of California early psychosis (EP) programs. We leveraged this initial investment to obtain additional funding from the National Institutes of Health (NIH) in 2019, which enabled six university and two county early psychosis programs to join and also linked the California network to a national network of EP programs, including UCSF PATH, UCSD CARE, UCLA Aftercare & CAPPS, Stanford Inspire, San Mateo Felton BEAM UP/(re) MIND, UC Davis EDAPT and SacEDAPT programs. The overarching name of the project, which encompasses the LHCN and the NIH-funded components, is now “EPI-CAL.” In this and future reports, we will refer to the LHCN only when describing components of the project that are specific to the LHCN evaluation (e.g., county data analysis).

Our EPI-CAL team has made significant progress towards our goals outlined in the innovation proposal during the 21/22 fiscal year, which are summarized in the current report.

Executive Summary

The purpose of this document is to provide the EP LHCN Mental Health Services Act (MHSA) Annual Innovation Report to review EP LHCN goals accomplished during FY2021/2022. This report will include summaries and status updates on the infrastructure of the LHCN, steps taken towards implementation, and barriers that have been identified over the course of the last fiscal year. While the counties involved in the EP LHCN may be at different stages in the process, the overarching LHCN is moving forward as planned.

- Prior to beginning activities for the LHCN, UC Davis had to have an executed contract with each of the participating counties so each party could mutually agree to a scope and terms of work. As of June 2022, UC Davis had executed contracts with Solano, San Diego, Los Angeles, Orange, Sonoma, Napa and Stanislaus counties. The Multi-County Collaborative (Colusa, Mono, Nevada) and Lake County LHCN contracts were under review at the time of June 2022. This represents two additional executed contracts (Napa and Stanislaus), and two new contracts under review for the past fiscal year. In addition to existing LHCN counties, Kern County has received approval to join the LHCN in May of 2022. We are working together to execute their contract before officially beginning activities in their county program.
- We have held two LHCN Advisory Committee meetings in the last fiscal year, which was comprised of a county representative from each participating county, a clinical provider from each participating EP program, and consumers and family members who have been or are being served by the participating programs. We will continue to hold Advisory committee meetings on a bi-annual basis and summarize meetings activities in our deliverables and annual reports.
- In the last year, we began fidelity assessments in EPI-CAL/LHCN clinics. We conducted a total of ten fidelity assessments across EPI-CAL clinics, including four LHCN county programs (San Diego, Solano, Orange, and Napa). We have submitted fidelity assessment reports to each program and met with individual program leadership to discuss their fidelity assessment results. We have scheduled fidelity assessments for all remaining participating programs in the LHCN network with an executed contract, with a goal of completing them in the current 22/23 fiscal year.
- In the past year, we continued implementation of the Beehive application in EPI-CAL/LHCN clinics, which has included extensive training and site-specific support. We have refined our training approach and have completed Beehive training in several participating EPI-CAL programs.
- After an initial enrollment period in pilot EP programs, we did an interim analysis of consumer demographics, data sharing preferences, and survey completion. We found that a large majority of consumers (83%) opted in to sharing data for research purposes with UC Davis, and high completion rates of enrollment surveys (80%). We will shift our focus in the future to higher survey completion rates, as we know that while the vast majority of consumers have completed some self-report surveys, not many have completed the full EPI-CAL bundle of surveys for each time point.
- LHCN enrollment progress is summarized in this report through the FY2021/2022. The goal was to have at least 405 individuals enrolled by the end of the FY21/22 . However, the observed rate of enrollment across the LHCN is 145 consumers. Due to the discrepancy in observed and expected

enrollment, we have focused on addressing barriers to enrollment in the current FY and have offered additional support to programs, where feasible. It is important to note that there were an additional 142 consumers who have been registered by the clinic in Beehive, but who have not engaged with Beehive by completing the End User License Agreement (EULA) or starting their surveys. Therefore, one of the points of intervention we have asked programs to focus on in enrolling their registered consumers.

- The needs and preferences of EP programs and the institutions of which they are a part have driven the design of Beehive. In this report, we summarize some of the recent revisions made to Beehive based on our EP program partner feedback. For example, security requirements of counties and institutions have led to increases in the security of Beehive. Feedback from users at EP Programs have identified several aspects of the application that could be improved to increase compatibility with their existing workflows and facilitate implementation of this novel technology.
- We report our preliminary findings from our interviews with EP community partners about the barriers and facilitators to implementing a LHCN into EP treatment programs.
- During the last FY, we have finalized methods for multi-county-integrated evaluation of costs and utilization data. The proposed analysis focuses on consumer-level data related to program service utilization, other outpatient services utilization, crisis/ED utilization, and psychiatric hospitalization and costs associated with these utilization domains during two time periods: 1) the three years prior to implementation of the LHCN in the EP programs to harmonize data across counties and account for potential historical trends, and 2) for the 2.5 year period contemporaneous with the prospective EP program level data collection via Beehive.
- During the last FY, our team continued to hold meetings with the EP program managers and the county data analysts for each participating LHCN county to identify county-level available data and data transfer methods. We discussed services provided by the EP program, description of consumers served, staffing specifics and billings codes for each service. We also reviewed details of funding sources, staffing levels during certain time-periods and other types of services provided for specific types of consumers (i.e., foster care). We have discussed time-periods for which the LHCN team will request data, description of the consumers from EP programs and how similar consumers served elsewhere in the county will be identified, services provided by each program, other services provided in the county to the EP consumers (i.e., hospitalization, crisis stabilization and substance use treatment), and data transfer methods. Our research team has gathered all the information from each program/county and summarized it in a multicounty data table included in this report.
- During the last FY, our team finalized our plan and timeline for working with counties to support infrastructure to access final round of county-level cost and utilization data for EP and CG programs. One goal of this analysis was to provide a preliminary demonstration of the proposed method for accessing data regarding EP programs and CG groups across California. The secondary goal was to analyze service utilization and costs associated with those services across counties. Over the last FY, we successfully completed our primary goal and the first part of our secondary goal (service utilization comparison). We were unable to complete the cost comparison analysis due to the complexity of the data required to be harmonized across counties and the variety of data sources.
- In this report, we provide our preliminary findings on cost and utilization data from a single county. At this time, we did not have enough data to complete a multi-county integrated evaluation of costs and utilization data. However, our progress is summarized and plans for the multi-county analysis is described in this report.

Current Project Goals

The current document summarizes project activities conducted for the LHCN during the FY2021/22. This includes the following project activities:

1. Establish a community partner advisory committee that will meet at least every 6 months. Please note that our team is swiftly moving away from using the term “stakeholder” as it holds a violent connotation for Indigenous communities. We are now using the term “community partner” instead.

2. Schedule for EP program fidelity assessments and provide results from fidelity assessments of EP programs

3. Provide training and implementation of outcomes measurement on app in non-pilot EP programs, detailing training of EP program staff in data collection

4. Outline plan for training EP program staff from non-pilot programs on app implementation and outcomes measurement

5. Get preliminary results on program-level data from 2 pilot EP programs, including interviews with EP programs to understand barriers and facilitators to app implementation

6. Monitor enrollment and follow up completion rates for LHCN app in all EP programs

7. Submit report on LHCN enrollment and follow up completion rates for LHCN software application and dashboard in all EP Programs

8. Subcontractor to revise dashboard to include feedback from programs and community partners

9. Gather feedback from interviews with EP community partners about experience in EP treatment programs

10. Finalize methods for multi-county-integrated evaluation of costs and utilization data from preliminary multi-county integrated evaluation

11. Identification of county-level available data and data transfer methods, and statistical methods selected for integrated county-level data evaluation

12. Deliver a plan and timeline for working with counties to support infrastructure to access final round of county-level cost and utilization data for EP and CG programs.

13. Provide findings on cost and utilization data from preliminary multi-county integrated evaluation, identification of problems and solutions for county-level data analysis

1. Establish a community partner advisory committee that will meet at least every 6 months

The Advisory Committee for the LHCN is comprised of a county representative from each participating county, a representative of each participating EP program, and up to five consumers and five family members who have been, or are being served, by EP programs. This committee is co-led by Bonnie Hotz, family advocate from Sacramento County. Recruitment for the Advisory Committee is ongoing, and we have confirmed membership with multiple community partners. These include past consumers, family members, clinic staff and providers. Even though we have already held several Advisory Committee meetings, we continue to distribute flyers to all participating clinics, as their contracts are coming through, to make sure the Advisory Committee is open to all LHCN member clinics. In FY2021/22 , we held Advisory Committee meetings on December 15th, 2021 and June 10th, 2022.

November 15th 2021 Meeting

We held the first Advisory Committee meeting of the fiscal year on November 15th, 2021. The meeting was held remotely due to the COVID-19 pandemic. During the meeting, we introduce two new programs to the LHCN Committee, including Napa and Stanislaus Counties, who recently executed their contract with UC Davis. Dr. Loewy provided a brief update on the county data analysis progress, including reaching a milestone of collecting all initial services data from participating counties. Lindsay Banks then provided an update on the fidelity assessments thus far, as our team has conducted our first assessment with the Kickstart program of

San Diego. Hope Graven, program director of Kickstart, described the fidelity assessment experience from the program perspective.

A large part of the most recent meeting was providing an update on Beehive training progress, including the stage at which each program is at in their training goals and the barriers to implementing Beehive in EP programs thus far. Kali Cowden-Sherwood, a therapist from the Solano SOAR program, gave her perspective on what has been going well and what barriers she has experienced with using Beehive in a clinical setting. Common barriers included the time commitment to getting consumers set up in Beehive, as well as problem solving technical issues with consumers in real time. However, many of these issues are no longer present if the consumer is completing surveys in person on the tablet.

After summarizing training progress in LHCN/EPI-CAL programs, Kathleen Nye also summarized changes that were implemented in Beehive in response to user feedback, such as revising the dashboard layout and modifying clinic-entered survey layout. Upcoming changes to be implemented based on user feedback include lengthening the survey windows and enabling consumers to complete their EULA before their intake date. Dr. Karina Muro then provided an update on Spanish materials available in Beehive, and plans for supporting EP program staff in providing Beehive services in Spanish to consumers and their parents. One of the supports includes a training on Cultural Considerations and Working with Latinx Families that Dr. Muro will lead in December, 2021.

Peer advocates that usually attend the LHCN Advisory Committee meeting were not able to attend this time around. The peer voice is very important to the LHCN progress, so our team will make a greater effort to increase peer partner participation in future Advisory Committee meetings.

June 10th, 2022 Meeting

We held the most recent Advisory Committee meeting on June 10, 2022. The meeting was also held remotely. During the meeting, we discussed recruitment and enrollment progress and challenges. Kathleen Nye gave a general overview of the status of training and enrollment across the LHCN. While many programs are making progress using Beehive (i.e., enrolling consumers and supporting completion of surveys), as many programs have not integrated Beehive into their program to the degree necessary to achieve project aims. We discussed in the meeting that there are many reasons for this. For example, Lindsay Banks presented initial impressions from the barriers and facilitators interviews which have begun at sites who have been using Beehive consistently.

The next part of the meeting consisted of three breakout rooms, facilitated by EPI-CAL research team members, to brainstorm solutions to the challenges identified in the barriers and facilitators interview. The three topics for the breakout rooms were 1) Incorporating Beehive in Care, 2) Consumer Engagement, 3) Training & Beehive Learning Curve. The purpose of these groups was to hear from the EPI-CAL network what solutions they think would work best for them. To this end, each group was asked to identify two to three concrete and actionable solutions to address challenges and barriers associated with each discussion topic.

After the breakout rooms, the final portion of the meeting was devoted to debriefing in a large group discussion. Each breakout group shared their discussion and solutions with the larger group.

The Training & Beehive Learning Curve group shared that hands-on, one-on-one trainings have been helpful to reinforce concepts discussed in the large all-team Beehive core trainings. The group agreed that both live trainings and recordings of those trainings are important to engage different members of the team. Due to the large turnover at most programs, there is a need to retrain staff across multiple programs at regular intervals. One solution for this that was proposed is to offer network-wide trainings for new staff. There was agreement that having materials to reference alongside asynchronous training or to reference after a training is helpful

(e.g., Beehive Resource Guide), and that sites would like more materials to support their usage of Beehive, such as one-page instruction sheets for certain workflows in Beehive. Beehive office hours where individuals can drop-in and ask questions in a group setting was another proposed solution. Finally, group participants agreed it would be helpful to have more guidance on creating increased buy-in for consumers when clinicians are introducing Beehive. Currently, the EPI-CAL team has created scripts and flyers for this purpose, but the group agreed they would like to hear more from the other breakout rooms about additional solutions to this issue.

The Consumer Engagement group included our peer and family partners in attendance at the advisory committee meeting. One solution proposed for providers is understanding that the process for engaging each consumer will be somewhat unique and tailored to that individual. Flexibility is needed. For example, if the day the team planned to introduce Beehive seems to be a day where the consumer is very overwhelmed or symptomatic, the team can choose not to introduce on that day but should try to re-introduce another time. One family partner shared the importance of reminding consumers and families why this information is important in care. Some family members may not understand the relevance of questions about health history, for example. Explaining the relevance of certain questions and domains could increase buy-in. One peer shared the importance of including peers in clinical roles due to the powerful connection that peers can form with consumers. If a peer shares a message about why Beehive is important, that may mean more to a consumer. Similarly, the importance of reminding individuals that this application—and all the questions in it—were developed in collaboration with peers and family members across the state and include the things they thought were important was discussed.

The Incorporating Beehive Into Care group shared details about the barriers they have experienced and possible solutions for each. One challenge is that clinical teams are having trouble integrating Beehive into their existing process. Lack of resources and limited time when teams are short staffed is a huge barrier. Possible solutions for this are: 1) to create a specific policy for adding Beehive into the intake procedure, 2) for leadership to ensure that clinical teams have time set aside for Beehive use and learning, 3) and to consider collecting the minimum necessary information. Another barrier is that use of Beehive is a shift in usual practice, and a possible solution for this is increasing visual reminders about Beehive. One program leader shared that use of Beehive on the tablets was helpful for staff to become more familiar with Beehive. A clinician and supervisor shared that they might benefit from a Beehive flyer which could be a reminder to use Beehive. It was also mentioned from several different attendees that engaging Beehive and using Beehive in-person has been more successful than engaging consumers remotely via telehealth. To conclude the Advisory Committee meeting, Dr. Tara Niendam addressed that the change to practice needed to integrate Beehive into care is difficult, and we are all working hard to make the changes needed. To that end, closing remarks also addressed the need for program leadership to make the space and time for their program staff to learn and use Beehive.

2. Schedule EP program fidelity assessments and provide results from fidelity assessments of EP programs

Each early psychosis clinic undergoes a fidelity assessment to determine their adherence to evidence-based practices for first-episode services using a revised version of the First Episode Psychosis Services Fidelity Scale (FEPS-FS). The FEPS-FS represents a standardized measure of fidelity to EP program best practices (Addington et al., 2016; First Episode Psychosis Services Fidelity Scale: (FEPS-FS 1.0), 2015). The FEPS-FS was developed using an international expert consensus method, focused on six domains: (1) population-level interventions and access, (2) comprehensive assessment and care plan, (3) individual-level intervention, (4)

group-level interventions, (5) service system and models of intervention, and (6) evaluation and quality improvement. The FEPS-FS has been recently revised to meet the agreed upon standards of EP care in the US and allow large-scale fidelity evaluation. Additionally, most programs within EPI-CAL also provide services to individuals with the clinical high-risk syndrome (CHR), for whom evidence-based best practice differs from FEP care in a number of respects. Consequently, to provide a program assessment that most accurately represents the care delivered, alongside the FEP-FS, we will be piloting a new scale under development designed to assess the components of care delivered to individuals with the diagnosis of CHR, known as the CHRP-FS.

Each EP program will participate in an assessment of EP program components using the revised FEPS-FS/CHRPS-FS, which will be completed via web-based teleconference. The fidelity assessment will be used to identify program strengths and possible areas for improvement, which can serve an important driver to improving early psychosis care delivered in EP programs in the LHCN. Additionally, the ability to evaluate the impact of service-level factors on consumer-level outcomes collected by Beehive will provide us with important new insights into what particular components of the EP program of care are associated with improved outcomes in different domains. These findings can then be disseminated across the network (and beyond), further informing care and shaping service delivery.

Assessments are completed in groups of 2-6 programs per quarter, starting in November 2021 until December 2022. Assessments are completed by trained clinical staff with expertise in early psychosis care and supported by evaluation administrative and research staff. Prior to the assessment taking place, the assessors and administrative/research support staff undergo a two-day training to go through the manual and conduct a mock site visit based on real cases. Prior to the evaluation, EP program sites participate in an introductory meeting, in which an overview of the FEPS is provided and the components of the evaluation are discussed. The assessments are conducted in consultation with Don Addington, M.D. from the University of Calgary, author of the FEPS-FS and CHRPS-FS scales.

As of June 30th, 2022 (the time period summarized in this report), EP program fidelity assessments have been initiated or completed for ten EPI-CAL programs: Orange County OC CREW (November 29 - December 3, 2021), San Diego Kickstart (November 1-5, 2021), Aldea SOAR Solano (January 17-21, 2022), San Mateo Felton (April 18, 2022), UCLA CAPPS (April 18-22, 2022), SacEDAPT (May 23-27, 2022), EDAPT (June 6-10, 2022), UCLA Aftercare (June 6-10, 2022), Aldea SOAR Napa (June 13-17, 2022), and UCSD CARE (June 20-24, 2022). The five LACDMH programs are scheduled for the third quarter of 2022 (July, August, September), and Stanislaus LIFE Path program, and Aldea SOAR Sonoma programs are schedule for the fourth quarter of 2022 (October, November, December).

Eight fidelity assessments have been completed using the First Episode Psychosis Service – Fidelity Scale (FEPS-FS) and the Clinical High Risk for Psychosis Service—Fidelity Scale (CHRPS-FS). The FEPS-FS includes 37 items, resulting in a score range from 37 to 185 and the CHRPS-FS includes 32 items, resulting in a score range from 32 to 160. All item scores range from 1 to 5, with an item score of ‘4’ indicating good fidelity, and a score of ‘5’ indicating high fidelity. In the completed assessments, FEPS-FS scores range from 129 to 154 and CHRPS-FS scores range from 108 to 136. Nine assessments are currently in progress with expected completion by the end of the calendar year.

Notably, these tools have been developed as an international standard, so achieving high fidelity scores may be constrained by state, local, or insurance coverage decisions outside of the control of the specific program. With that in mind, frequent low scoring items include population served (all clinics scored 1) and age ranged served (all clinics scored 1).

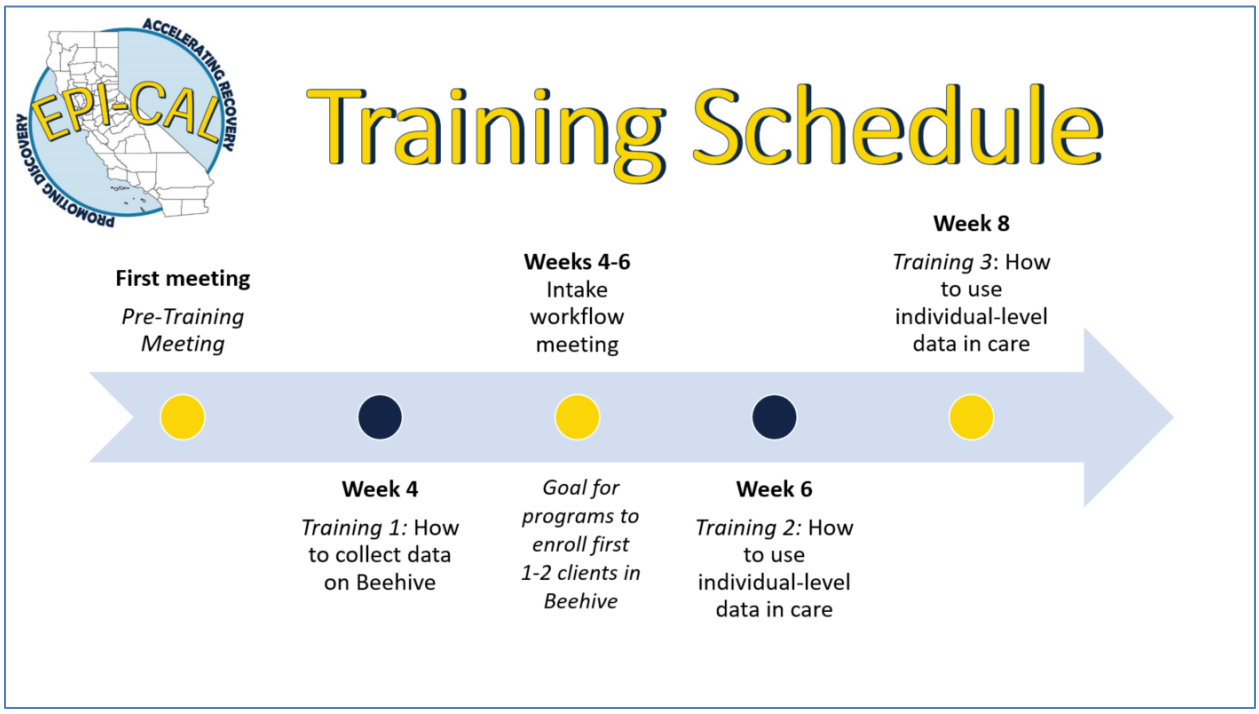
There is notable heterogeneity across programs (FEPS-FS mean score range: 3.36 – 4.16, CHRPS-FS mean score range: 3.48 –4.39). All clinics had over 50% of items at good or high fidelity. Particular heterogeneity can be found in items such as clozapine administration (interquartile range (IQR): 1-5), the delivery of supported employment (IQR: 1-3) and education services (IQR: 1-5), active engagement and outreach (IQR: 1-5), patient retention (IQR: 1-5), the involvement of peers in care (IQR: 1-4), and communication between the CSC team and inpatient services (IQR: 1-4).

3. Provide training and implementation of outcomes measurement on app in non-pilot EP programs, detailing training of EP program staff in data collection

In our original LHCN proposal, we proposed in-person visits to each program to conduct the core training for the Beehive application. However, due to the COVID-19 pandemic, we had to adjust our training plan and conduct the core trainings remotely.

The core trainings begin with a pre-training meeting with leadership at the program to discuss which program staff members would be designated as providers, group analysts, or group and clinic admin in Beehive (roles described below), as well as to cover topics around integrating Beehive into their current data collection system. Next, we conducted a training series consisting of a pre-training meeting with program leadership to introduce the training plan, three training sessions to introduce Beehive to each program (Part 1, Part 2, and Part 3), and an intake-workflow meeting with key clinic staff to understand clinic workflow and brainstorm how to best implement Beehive within their program context.

Figure 2: Beehive Training Schedule



Our remote trainings began with our pilot programs in March 2021. In June 2021, we began to onboard non-pilot programs, starting with the Los Angeles County PIER programs. See table below for all core trainings conducted through June 2022. Note that booster trainings (for entire program or for individuals at the program) have also been conducted in addition to the core trainings and are not included on the table below.

Table 1: EPI-CAL Program Training Completion

Program	Pre-Training	Training 1	Intake Workflow	Training 2	Training 3
UCD SacEDAPT	3/10/2021	3/22/2021	3/10/2021	4/5/2021	6/14/2021
UCD EDAPT	3/10/2021	3/22/2021	3/10/2021	4/5/2021	6/14/2021
Solano SOAR	3/18/2021	3/22/2021	3/29/2021	4/12/2021	6/7/2021
Napa SOAR	7/23/2021	8/19/2021	10/21/2021	10/14/2021	12/2/2021
Sonoma SOAR	8/24/2021	9/29/2021	10/21/2021	10/14/2021	12/2/2021
Kickstart Pathways	3/24/2021	3/31/2021	6/8/2021	4/14/2021	7/28/2021
LAC- IMCES 3	5/10/2021	6/21/2021	8/11/2021	11/10/2021	12/8/2021
LAC - IMCES 4	5/10/2021	6/21/2021	8/11/2021	11/10/2021	12/8/2021
LAC - SFVCMHC	5/11/2021	6/18/2021	7/19/2021	11/18/2021	12/9/2021
LAC- The Whole Child	5/13/2021	6/17/2021	7/21/2021	11/23/2021	1/25/2022
LAC- The Help Group	5/14/2021	6/14/2021	8/10/2021	11/29/2021	1/5/2022
OC CREW	7/13/2021	8/12/2021	8/23/2021	10/13/2021	12/8/2021
San Mateo Felton	7/14/2021	10/20/2021	12/9/2021, 4/27/2022, & 5/16/2022	7/13/2022	TBD
UCLA - Aftercare	7/29/21	9/1/2021	2/9/2022	5/13/2022	TBD
UCLA - CAPPS	9/23/2021	11/22/2021	2/1/2022	5/3/2022	TBD
UCSF PATH	9/21/2021	5/6/2022	5/25/2022	7/8/2022	TBD
UCSD CARE	4/7/2022	5/23/2022	7/15/2022	9/30/2022	TBD
Stanislaus LIFE Path	2/23/2022	4/8/2022	5/10/2022	5/31/2022	9/22/2022
Stanford INSPIRE	TBD	TBD	TBD	TBD	TBD
Totals	**18**	**18**	**17**	**14**	**12**

Pre-Training Meeting

The pre-training meeting is conducted between EPI-CAL staff, including the program's assigned point person, program leadership, and a program IT representative. The purpose of this meeting is to introduce the training schedule and gather information to facilitate the first training. For example, the program leadership are invited to Beehive to test network compatibility (e.g., ensure that invite emails are not blocked by institution, ensure that program staff can access web application). The IT representative is engaged as needed to resolve technical issues (e.g., add beehive email address to approved senders list).

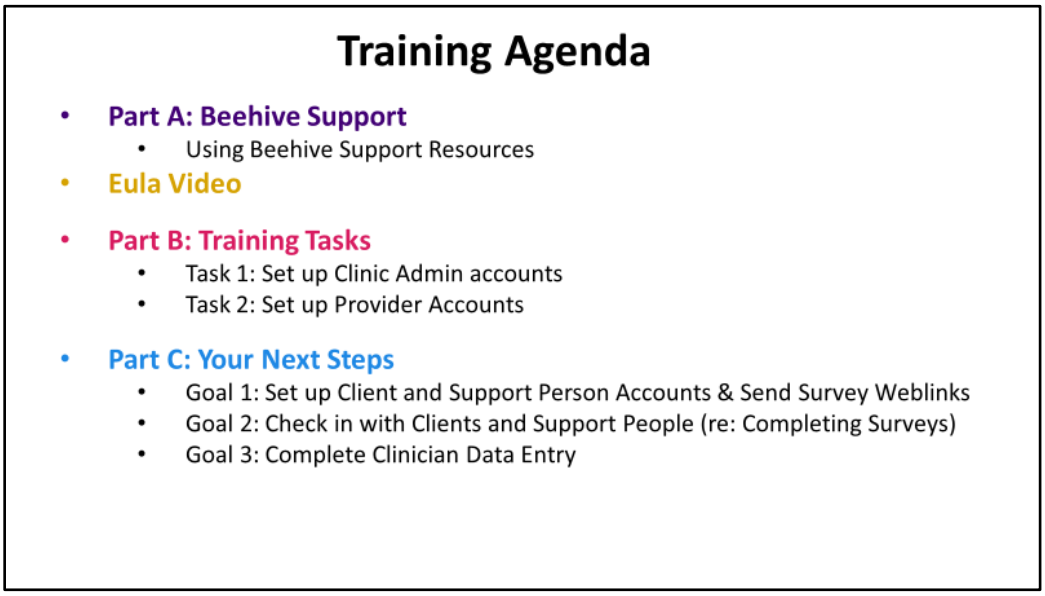
Part 1 Training

The general outline for the first training is as follows:

1. Re-introduction to the EPI-CAL project, including the overarching purpose and goals of data collection via Beehive
2. Presentation on the value of Beehive and data collection
3. Beehive Application training session (see Figure 3)

Presentation- "The Value of Beehive and Data Collection"
An EPI-CAL team member, Leigh Smith, Ph.D., gives a brief presentation that first focuses on how Beehive was developed using input from community partners and providers. Next, she provides a historical example of data collection that led to significant innovation in health care by giving a brief vignette of John Snow's work with the Cholera outbreak in London in 1854. She then draws parallels between Snow's work and how Beehive was designed, focusing on a meaningful connection between providers and community partners, a holistic approach to data collection, and prioritization of record keeping through automation and data consolidation. After, she speaks about Beehive's power to facilitate dialogue between providers and consumers, and within/between clinics, through reports provided by the Beehive team or generated within Beehive. Dr. Smith covers the purpose of participating in a Learning Health Care Network (LHCN), and how valuable information collection can be in informing treatment. Finally, she emphasizes the ability of Beehive's data collection in shaping care by illustrating how over a million points of data can be generated if each of the 18 EPI-CAL clinics enrolled 80% of their consumers and completed the baseline and two follow-up surveys in the first year. If Dr. Smith cannot attend in person, she has a recorded version of this presentation which is shown.

Figure 3: Training Agenda



Part A: Using Beehive Support Resources
We provide all EP program staff with the link to our detailed resource guide, accessed here: https://sites.google.com/view/beehiveguide/home

The resource guide was created so that EP program staff may reference, in detail, how to use the Beehive application and complete the tasks reviewed during the training. This includes: Creating Clinic or Group Admin Account & Inviting them to Beehive, Accepting Beehive Invite & Completing Registration, and Adding a Provider and Inviting them to Beehive. The resource guide also provides information on how to complete the "homework" that was assigned during the first training, including Adding a Consumer & Support Person and Completing Clinician Data Entry.

End User License Agreement (EULA) Video
We show the EULA video to all EP program staff for two reasons: 1) to streamline the registration process for staff during the training (as all users watch this video as part of the registration process), and 2) to orient them to what consumers and families also see when they first access the Beehive system. The EULA video can be

accessed here: https://youtu.be/3E8hiEkIvSQ. The Spanish EULA video is available here: https://youtu.be/UgY7ZUhe-Fk. The EULA video was developed through focus groups with EPI-CAL community partners (consumers, family members and providers) to ensure that core aspects of Beehive (e.g., security, consent and data sharing) were clear to users. The EULA video describes what Beehive is and how it is part of the EPI-CAL project, the purpose of Beehive, how data is shared and stored, and users' options for data sharing. Every new user of Beehive will be presented with the EULA video before making their data sharing choices.

Part B: Training Tasks: Setting up Clinic Admin/Provider Accounts and Registering Consumers
There are three main types of accounts in Beehive; each account is associated with the ability to complete certain actions in the Beehive system in line with that person's job duties:

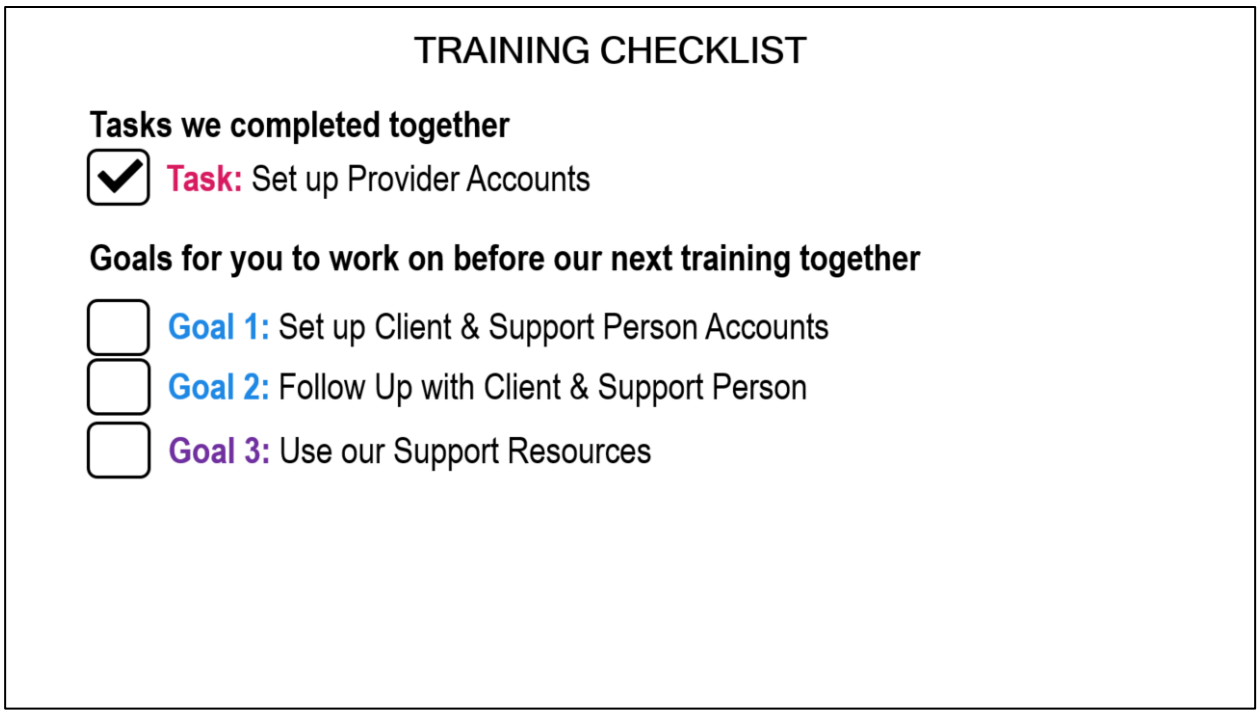
- Group Admin account: For program-level staff members who provide supervision and administrative support across clinics within a particular group – for example, a Group Admin is a person whose position includes oversight of activities at more than one clinic.
- Clinic Admin account: For staff members who provide supervision and administrative support within a specific clinic in a group.
- Provider account: For staff members providing direct services to consumers in a particular clinic, for example therapists, prescribers, and peer support specialists.

There is a general hierarchical structure to the relationship between these account types, such as who can invite new users and who can download data from Beehive.

The first training task is to set up Clinic Admin and Provider accounts in Beehive. For the initial Part 1 trainings, EPI-CAL staff created Group and Clinic Admin accounts prior to the first training meeting and sent those specific users their invitations during the live training (for trainings of non-pilot programs, EPI-CAL staff assist all admin users to register at the pre-training meeting). Once participants with Clinic Admin-level accounts accept their invitations and completed the registration process, EPI-CAL staff guide them through creating provider-level accounts for their staff and inviting those staff to complete registration in Beehive. For programs utilizing a Single Sign-On (SSO) authentication scheme, the EPI-CAL staff also walk them through the process to log in through their institution.

Part C: Next Steps
Once all providers conclude the registration process, EPI-CAL staff demonstrate the process of registering a consumer and their support persons. Next, the survey collection timeline is introduced. Baseline surveys are available for four months after the consumer's intake date. After baseline, follow up surveys are sent, which are due every 6 months from baseline will open two months prior to the due date and close four months after the due date. Next, the process for consumers and primary support persons to complete/request help to complete surveys is shown, along with the steps to manually resend surveys. Participants are then given the goal to register two consumers and their support persons (if applicable) in Beehive, and have the consumers complete their surveys before the next training session (see Figure 4). These consumers can be at any point in treatment when they are enrolled in Beehive. A Beehive consumer introductory script is provided to support the program staff in talking about Beehive to potential participants.

Figure 4: Training Checklist



Intake Workflow Meeting

After the Part 1 Training, EPI-CAL staff, including the program's point person, meet with the program's key staff involved in intakes. The purpose of this meeting is to understand the program's current workflow to facilitate a smooth transition to implementing Beehive. Once EPI-CAL team have a basic understanding of the program's intake process, they ask questions to operationalize how Beehive will be integrated into this process (e.g., "Who will be responsible for registering consumers in Beehive?"). They may offer suggestions or ideas based on what has worked at other programs. The goal of this meeting is to create an initial plan for the program to introduce Beehive into their current workflow. Please see Appendix I for a template of the questions asked at the intake workflow meeting.

Part 2 Training

The second Beehive training focuses on how providers can utilize individual level data in care. The Beehive team introduces the EPI-CAL Core Assessment Battery (CAB), including its domains and how these domains were selected from community partner input. Next, the trainer presents two surveys from the EPI-CAL CAB: the Modified Colorado Symptom Index (MCSI) and the Questionnaire about the Process of Recovery (QPR). Then, the trainer shows participants where to find consumer data in Beehive. The trainer then demonstrates how to present the data visualizations available in Beehive and asks the group what clinical questions or concerns the sample visualizations elicit from them. Participants then participate in small group exercises focused on example data visualizations of the MCSI with the goals of 1) exercising their data comprehension skills and 2) practicing using data to explore a consumer's story.

During small group exercises, an example consumer's MCSI scores are displayed, and participants are prompted to discuss the "story" that could be illustrated by this data set. For example, providers are presented with a graph in which MCSI scores are going up over time (indicating more frequent and/or distressing symptoms; Figure 5A) and then asked to interpret possible situations that could be leading to these data trends for this sample consumer. After providers correctly identify that the example consumer is experiencing an increase in frequency and/or number of symptoms, they are asked how they might use this information in treatment (e.g., modify the consumer's treatment plan to help reduce the frequency of these symptoms,

engage new treatment techniques to reduce these symptoms, request psychiatry consultation to review medication).

Figure 5: MCSI Example Graphs from Beehive

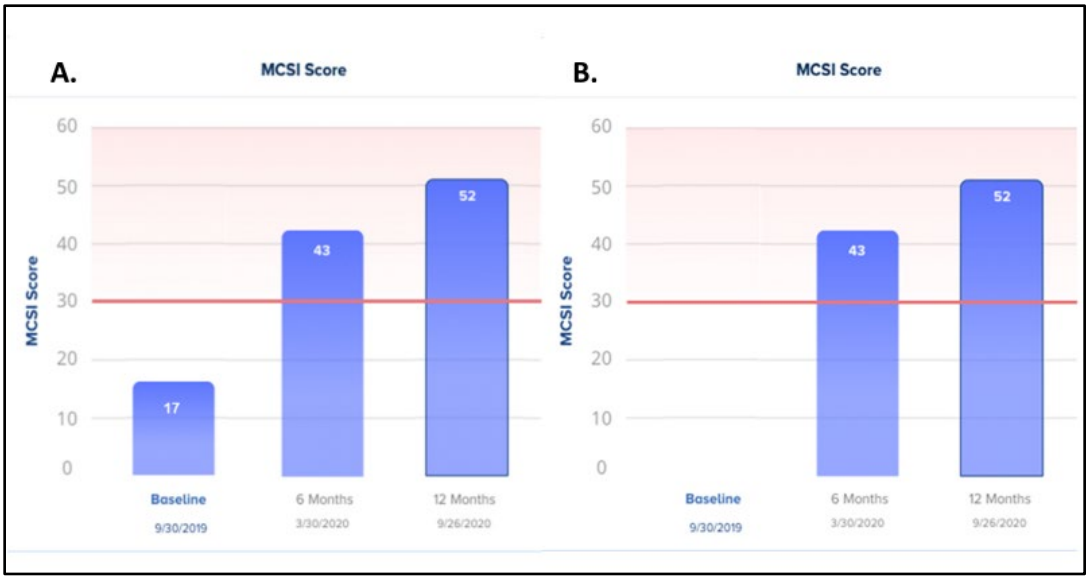


Figure legend: A. Representation of data showing increasing trend in MCSI symptom severity; B. Representation of how missing data (shown here at baseline) impacts the visualization

After these exercises conclude, small groups reconvene back into the larger group, with a member from each group presenting their group's discussion/findings to the rest of the program as a whole. As each small group has different themes and discussions that come up during the exercises, the larger group discussion is meant to help to broaden participants' understanding of data interpretation.

Next, the training details the types of urgent clinical issues that are currently tracked by Beehive, including "Risk to self", "Risk to others", "Risk of homelessness," and "Plan to stop taking medication". These issues were identified during focus groups with EP program community partners as critical moments for intervention during treatment. The training team also explains where each one of these alerts can be triggered within the assessment battery. Importantly, we stress that Urgent Clinical Issues in Beehive are not a replacement for each clinic's standard risk management procedures; instead, Beehive can be used as an additional tool to inform their standard risk management approaches. We also cover how to resolve urgent clinical issues using the responses programmed into Beehive (i.e., "Modified treatment plan", "Conducted risk assessment" or "Sent for emergency care") as appropriate for these alerts.

To conclude the training, the trainer introduces the "Data Use in Care" question pop up and its different response options (see Figures 6 and 7 below). This pop-up appears intermittently when a user leaves a page on Beehive which displays consumer's data. It asks the user whether they reviewed the data with the consumer or family and then asks them how the data impacted treatment. These response options are the same as the response options programmed into the urgent clinical issues – the training team intentionally takes the approach of presenting these two Beehive features together to help maximize participant comprehension. These data will contribute to a data-driven understanding of Beehive's impact (e.g., whether and how staff use data as part of treatment) on the participating programs of the LHCN.

Figure 6: Data Use in Care Question 1

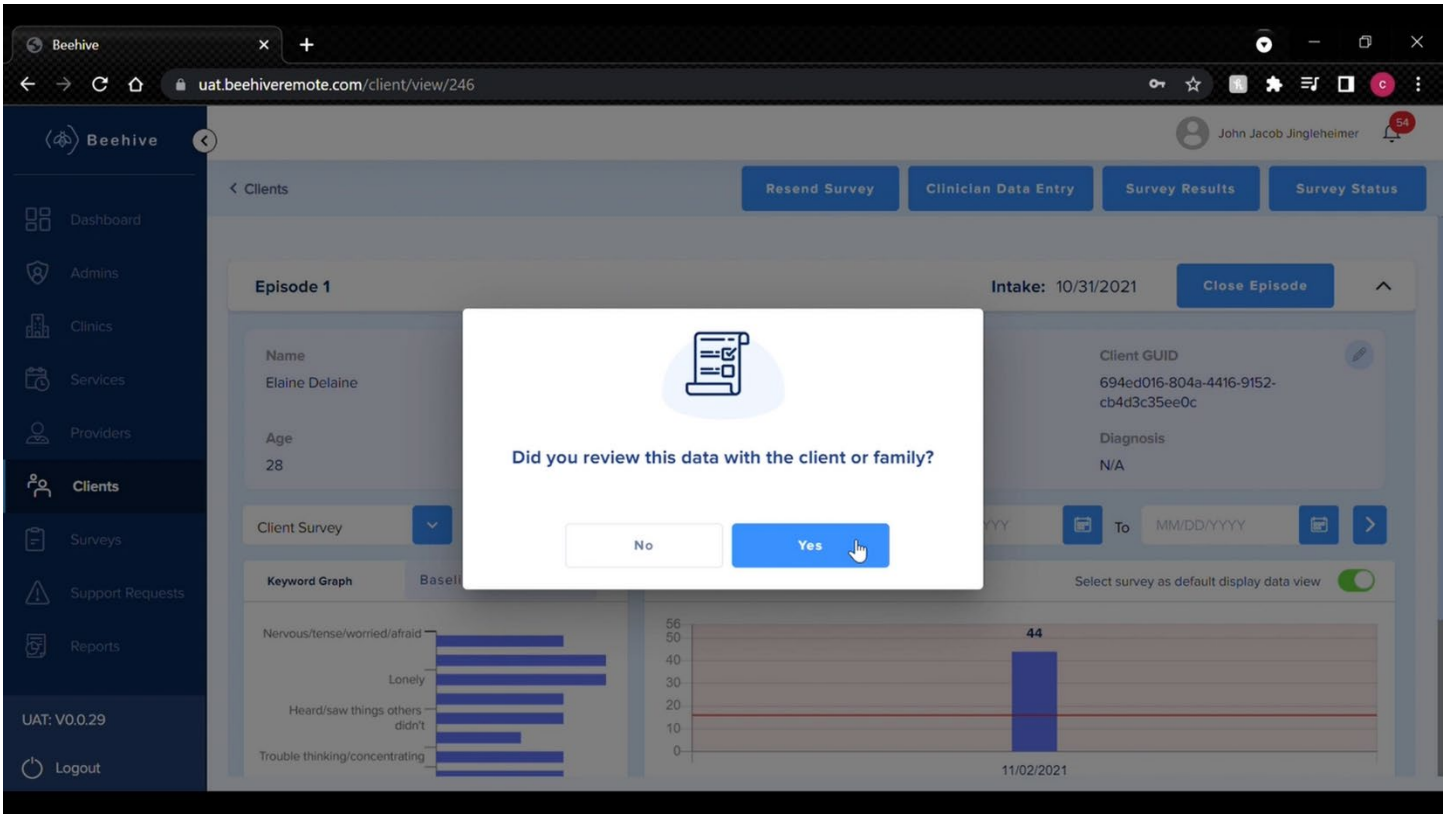
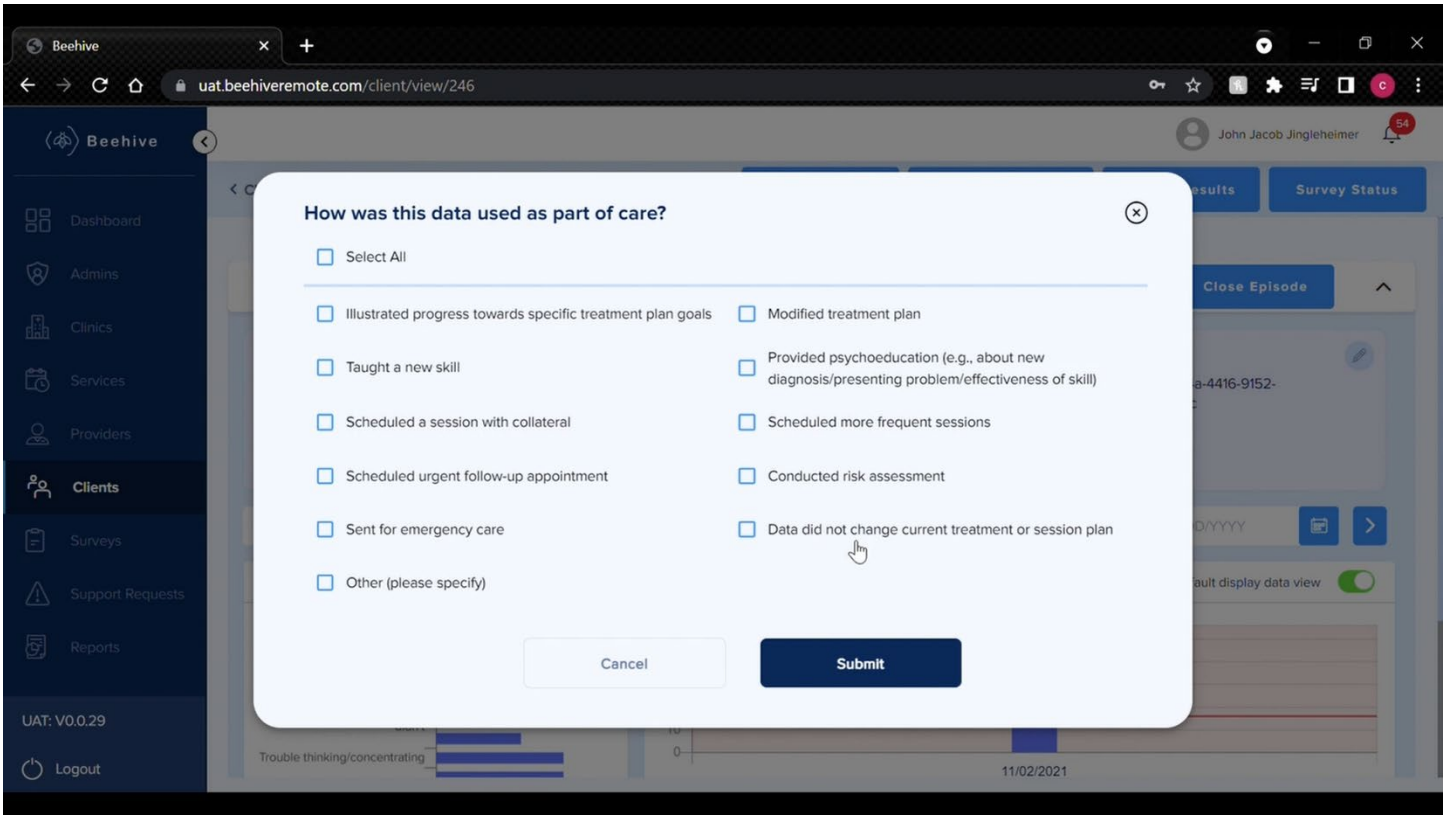


Figure 7: Data Use in Care Question 2



Data-Entry Workflow Meeting

After the Part 2 Training, EPI-CAL staff, including the program's point person, meet with the program leadership. The purpose of this meeting is to help the program create a reasonably sustainable plan for completing clinic-entered data about each consumer's clinical outcomes in Beehive. EPI-CAL team will ask question to understand whether there is an existing data-entry workflow in place as well as which roles on the teams are involved in the process. Once EPI-CAL team have an understanding of the program's existing data-entry workflow, they ask questions to operationalize how Beehive will be integrated into this process (e.g., "Who will be responsible for entering clinic-entered data for consumers?"). They may offer suggestions or ideas based on what has worked at other programs. The goal of this meeting is to support the program to create an initial plan to complete clinic-entered surveys about key consumer outcomes. This should include a plan for which team members will monitor and track completion and which team members will enter the data. Please see Appendix II for a template of the questions that will be asked as part of the data-entry workflow meeting.

This workflow meeting has been added as an iterative update to the core training series based on experience working with initial programs. Our team has identified that programs often need support to operationalize this workflow in their program, so we have added this as a meeting to the core training series. Because this is a recent edition, we have not conducted it at any program yet but are reaching out to programs to schedule.

Part 3 Training

Part 3 training revolves around applying and expanding the data interpreting skills gained in Part 2 training, with actual data from consumers that was collected after the last (Part 2) training. During Part 3 training, participants are oriented on how to input and view Clinic-entered data and how to assign additional surveys to consumers, and how to close and re-open consumer episodes in Beehive.

Part 3 training also familiarizes participants to two more measures included in the Core Assessment Battery: the SCORE-15 and the Burden Assessment Scale (BAS). These measures were selected because they both capture quantifiable scores on domains (family impact and family burden, respectively) that were identified as high priorities by EP community partners during EPI-CAL outcomes focus groups. These measures were chosen for this training as, like the Modified Colorado Symptom Index and Questionnaire on the Process of Recovery covered in Part 2 Training, they are scored measures which are visualized in Beehive.

Next, participants are split into small groups, and given a globally unique identifier (GUID) of a consumer that receives services at their clinic and has completed surveys in Beehive. This is to ensure that each small group has real-world data to interpret. At the beginning of the small group, an EPI-CAL team member orients the group to a worksheet which includes training activities and discussion questions about finding, interpreting, and using consumer data as part of care. As these trainings require participants to examine their consumer's data (i.e., PHI), EPI-CAL training team members are only present for the beginning of the small group exercise to introduce the activity, but they leave prior to any discussion or sharing of PHI. EPI-CAL staff encourage each participant to take an active role within the small group: note taker, screen sharer, delegate to report during large group debrief, etc. Each small group uses the small group worksheet (Appendix III) to guide their time in the small group.

After the small group exercise, participants rejoin the larger group to share their findings. After each small group has presented their findings with the rest of the groups as a whole, the EPI-CAL team facilitates a large group discussion which encourages participants to look for trends and assess what they could mean. After encouraging pattern recognition of common patterns in the data, the training team encourage participants to view their consumer's data through this analytical lens and demonstrate how their treatment plans could benefit from this approach.

Implementation Support After Initial Beehive Trainings

Each program has an EPI-CAL staff point person to provide regular check-ins to provide training and implementation support. The point persons are introduced during pre-training and the Beehive training series. Initially, we request weekly meetings or calls with key program staff (as determined by the program). At these meetings, point persons can help programs troubleshoot issues and support staff with accessing resources and learning to use Beehive.

In addition to regular check-ins with key program staff, point persons may also provide booster trainings to individuals at the program or to groups of program staff. These may be conducted remotely via web conferencing. More recently we have begun to visit sites in-person as initially proposed and planned prior to COVID-19 in-person meeting restrictions.

Point persons will also respond to ad hoc requests from the program for technical support and troubleshooting. For example, if a program experiences a bug or glitch while using Beehive, they are told to contact their point person who can help to troubleshoot or escalate this report.

4. Outline plan for training EP program staff from non-pilot programs on app implementation and outcomes measurement

Our team has learned a great deal from the initial Beehive trainings regarding the most efficient way to approach training for non-pilot EP programs. One of the consistent messages was that the initial trainings were too fast paced for many users. Another major learning opportunity was that we did not have enough time to sufficiently cover all the content we had planned in each session. Therefore, instead of breaking out the initial trainings into two 2-hour sessions, we have revised our training plan to include at least three 2-hour sessions for the introduction to Beehive for non-pilot programs as well as provide a fourth training to cover additional content for admin staff (see Figure 2: Beehive Training Schedule). We will continue to incorporate any changes and feedback from additional trainings into all future trainings, as we view improvement of our training approach as an iterative process. One change we implemented to save time during Part 1 training was to register all admin users (Clinic and Group Admin) during the pre-training meetings so that we only had to register the remaining providers during the first training. This has saved a substantial amount of time in subsequent Part 1 trainings thus far. We have also broken out into small groups to register providers during Part 1 training so several people can be registered in parallel, which has also saved time.

Another important piece of information we learned from these first trainings was the need to meet with each program's IT department ahead of time to make sure that emails/server requests from Beehive are not blocked by their organization's network security protocols. For example, Solano Aldea SOAR had delays in the first training because the emails from Beehive were being quarantined. While we were able to work with IT to unblock these emails, we will meet with IT ahead of time and test the sign-up email process in the pre-training meeting with leadership to avoid the delays during the training in the future. Additionally, meetings with site IT to ensure Beehive's ability to properly communicate with its servers through site networks will be conducted. Thus far, we have modified our pre-training approach with five additional programs in preparation from their training and were able to verify ahead of time that Beehive emails would not be blocked during Beehive training.

We have also identified the need to understand more about each program's intake process so that we may customize our training and support approach to each program's existing clinical workflow. To better understand each program's unique process, we now schedule an additional "Intake Workflow Meeting" with programs between their Part 1 and 2 training to collect information and meet with intake coordinators from each program

to understand data collected during phone screen and intake, and how and where Beehive consumer registration and surveys will fit into their existing process.

Additionally, the team has updated the training material to reflect changes based on each program's needs and how their feedback is incorporated into the application. A multitude of training videos and slides that were accurate earlier in the year have required updating. As the Beehive application continues to evolve, the training team will continue to ensure our training materials will follow.

We have also found that providing more live demonstrations of Beehive features has been helpful during the trainings. Many of the materials that were originally covered in pre-recorded videos during prior trainings are now administered as a live demonstration. Additionally, we provide more information during breakout rooms as we find smaller group sizes to be more amenable for training purposes. Please see Table 1 for an up-to-date list of all Beehive trainings provided thus far through June 30th, 2022.

5. Get preliminary results on program-level data from 2 pilot EP programs, including interviews with EP programs to understand barriers and facilitators to app implementation.

Preliminary results on program-level data from 3 pilot EP programs

After our initial trainings with EDAPT/SacEDAPT and Solano SOAR Aldea programs in March 2021, programs began enrolling consumers into Beehive. Kickstart in San Diego County had also started enrolling consumers in Beehive a few months after the initial launch. Basic demographic information is collected via phone screen and entered into Beehive by clinic staff when initially registering a consumer and their support persons. All consumers had to complete the EULA before being presented with surveys. When consumers complete the EULA, they indicate whether they want to share their data with UC Davis and/or the NIH for research purposes beyond using Beehive for the purpose of their clinical care. Their choices are explained in detail in the EULA video. Our goal is to have 70% of consumers agree to share their data with UC Davis and NIH.

For this annual report, we are reporting on data collected in those three pilot programs up through December 3rd, 2021 for those who agreed to share their data with UC Davis. After that date, we started summarizing enrollment and survey completion rates for all participating programs, which can be found in the section below titled Submit report on LHCN enrollment and follow up completion rates for LHCN software application and dashboard in all EP Programs. One hundred and twenty-five consumers were registered in Beehive across the three pilot clinics, and of those, 66 completed their EULA indicating their data sharing permissions. Of those who completed their EULA, 55 consumers agreed to share their data with UC Davis (83%). Therefore, in the current report, we are reporting demographic data for those 55 individuals across three clinics who have registered in Beehive, completed their EULA, and agreed to share data with UC Davis. It is important to note that clinic staff register consumers and invite them to Beehive. Consumers complete their registration and then have the ability to complete surveys. So, if someone has been registered in Beehive, it does not necessarily mean that they have completed any of the outcomes surveys available in Beehive.

Here we report demographic information that is completed at registration, which is a subset of the demographic questions that are asked in Beehive (Table 2). Complete demographic information, including all required PEI fields, are administered via a required consumer-entered Beehive survey. For any cell that has an N less than 5 individuals, this data was masked and both the N and proportion cells were updated with "<5" and "<9%", respectively. If there were 0 individuals who endorsed a response option in the demographic surveys, the category is not represented on Table 2 (e.g., intersex under Sex at Birth); we will continue to add categories to each demographic variable if there are ≥1 individuals in each respective category.

Table 2: Preliminary Demographic Data from Beehive Pilot Testing

SacEDAPT, Solano SOAR, and Kickstart Combined Demographics (through 12/3/21)		
Display Language	**N**	**%**
English	55	100%
Age	**N**	**%**
12-17	18	33%
18-23	27	49%
≥24	10	18%
Sex at Birth	**N**	**%**
Female	26	47%
Male	29	53%
Gender	**N**	**%**
Female	21	38%
Male	27	49%
Non-binary	<5	<9%
Questioning or unsure of gender identity	<5	<9%
Prefer not to say	<5	<9%
Pronouns	**N**	**%**
He/Him	27	49%
She/Her	22	40%
They/Them	<5	<9%
N/A	<5	<9%
Race	**N**	**%**
African/African American/Black	13	24%
Asian	<5	<9%
American Indian/Alaskan Native	<5	<9%
Hispanic/Latinx Only	14	25%
White/Caucasian	13	24%
More than one race	8	15%
Other	<5	<9%
Prefer not to say	<5	<9%
Ethnicity	**N**	**%**
No - I do not identify as Hispanic/Latinx	32	58%
Yes - I identify as Hispanic/Latinx	16	29%
Prefer not to say	<5	<9%
Unsure/Don't know	6	11%

Additionally, providers are able to enter a consumer's diagnosis when they register individuals in Beehive, which is reported in Table 2. In the same manner as the table above, cells with less than 5 individuals were masked and both the N and proportion cells were updated with "<5" and "<9%", respectively. For most

diagnostic categories, except Schizoaffective disorder and mood disorders with psychotic features, there were less than 5 individuals per cell. Diagnoses are grouped according to two classes of early psychosis: 1) individuals who are deemed to be at clinical high risk for psychosis (CHR), and 2) individuals who have experienced psychotic level symptoms (First Episode Psychosis, FEP). This reflects the wide range of psychosis diagnoses that are served by the EP clinics represented in this sample.

Table 3 Consumer Diagnoses from Beehive Pilot Testing

Diagnosis	N	%
Clinical High Risk (CHR)		
Attenuated Psychosis Symptoms	<5	<9%
First Episode Psychosis (FEP)		
Substance Induced Psychotic Disorder with onset during intoxication	<5	<9%
Mood disorders with psychotic features	6	11%
Schizoaffective Disorder (Bipolar or Depressive Type Combined)	11	20%
Schizophrenia	<5	<9%
Schizophreniform Disorder	<5	<9%
Unspecified Psychosis	5	9%
CHR or FEP Status Not Confirmed		
Anxiety Disorders	<5	<9%
Missing	25	45%

When consumers finish registration in Beehive, they then have access to Beehive surveys. After registration is complete, Beehive makes three surveys available for completion: Adverse Childhood Experiences (ACES), primary caregiver background, and questions about other lifetime experiences as well as a static demographics information (see EPI-CAL Enrollment Life Questions, see Table 4 and Figure 9). If a consumer is in a survey window (e.g., at intake or six months), Beehive makes available 15 additional surveys that assess various community partner-chosen outcomes including family functioning, education, social relationships, demographics and background, medications, and symptoms (see Table 4). These surveys are presented in different bundles that are grouped based on subject matter and/or timing of the surveys (i.e., whether they receive the survey just at enrollment, or at enrollment and every six months thereafter). EPI-CAL enrollment and required bundles are automatically assigned to every consumer who registers in Beehive. However, each individual clinic also has the option of assigning addition surveys if they choose to do so. The current data only include EPI-CAL enrollment and required bundles.

Table 4 EPI-CAL Enrollment and Required Survey Bundles

Bundle Name	Survey Name	Bundle Timing
EPI-CAL Enrollment Life Questions	EPI-CAL Enrollment Life Questions	Enrollment only
	Adverse Childhood Experiences (ACES)	
	Primary Caregiver Background	
EPI-CAL Experiences Bundle	Life Outlook	

	Questionnaire About the Process of Recovery (QPR)	Every 6 months, including intake
	Modified Colorado Symptom Index (MCSI)	
	Substance Use	
	Legal Involvement and Related	
EPI-CAL Treatment bundle	Intent to Attend and Complete Treatment Scale	Every 6 months, including intake
	End of Survey Questions	
	Hospitalizations	
	Shared Decision Making (SDM)	
	Medications	
EPI-CAL Life Bundle	SCORE-15	Every 6 months, including intake
	Demographics and Background	
	Social Relationships	
	Employment and Related Activities	
	Education	

When enrolled at intake, consumer and identified support persons can be registered in Beehive by clinic staff. Beehive will then prompt them to complete registration, review the EULA, and choose data sharing permissions. Beehive then shows them the surveys that are available for them to complete within each bundle (see Figure 8 below). Respondents can choose which surveys they wish to complete in the order they wish to complete them.

Figure 8: Survey Window Timing

Example Survey Window Timing for a Consumer with Intake on April 1

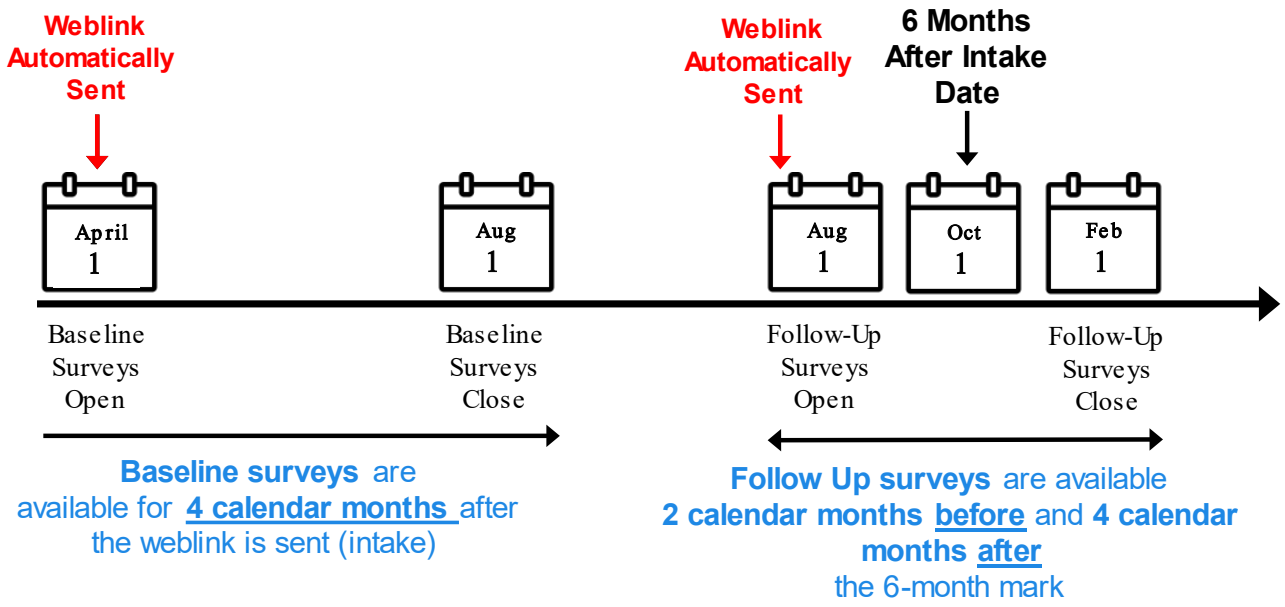
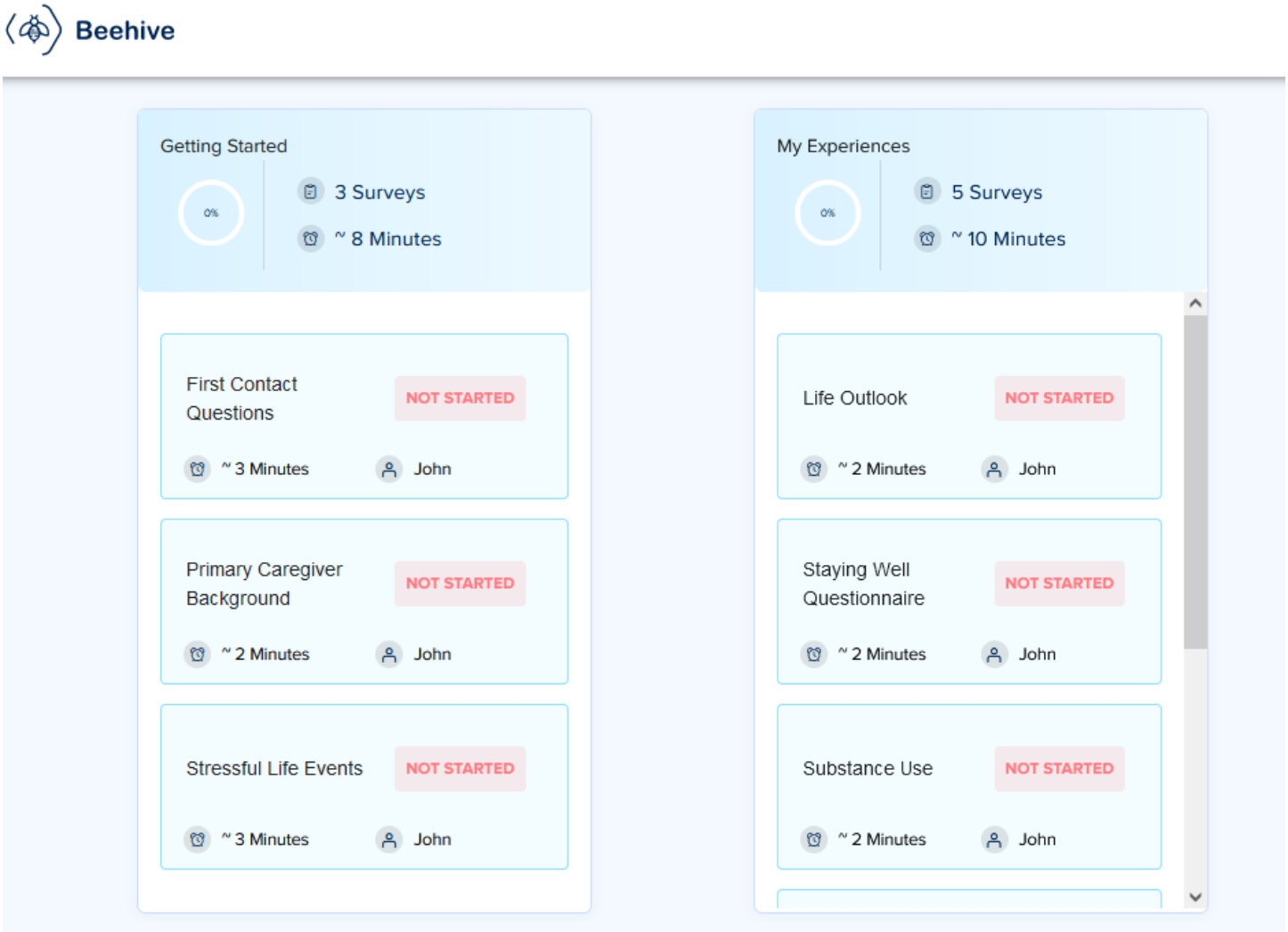


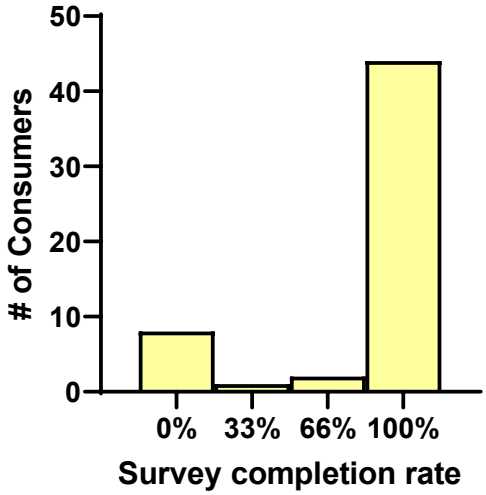
Figure 9: Subset of Surveys Available for Consumer to Complete at Baseline



During the initial phase of Beehive roll out, we asked clinics to enroll consumers and support persons who were already engaged in EP care. When these active consumers are enrolled, Beehive prompts them to complete registration, review the EULA, choose data sharing permissions, and complete enrollment surveys. If they are within the active 6-monthly survey window, they are also able to complete the EPI-CAL required bundles.

At this time, we are reporting the survey completion rate from 55 consumers on the three available enrollment surveys (EPI-CAL Enrollment Life Questions, “Getting Started,” Figure 9) because some consumers were enrolled outside of survey windows and thus were not presented with the remaining 15 surveys. The distribution of survey completion is reported in Figure 10. Survey completion rate ranges from 0-100%, with 80% of individuals completing all three enrollment surveys. The point person at each clinic site will track survey completion and inform clinic staff if there are consumers who are not completing their surveys so that the clinic staff may check in and provide support to ensure survey completion.

Figure 10: Preliminary Survey Completion Rate for Enrollment Surveys



Exploration of barriers and facilitators to implementation of the Beehive system
Results from additional barrier and facilitator interviews in the past fiscal year are summarized below.

6. Monitor enrollment and follow up completion rates for LHCN app in all EP programs

EPI-CAL staff monitor enrollment progress and symptom survey completion for LHCN across all EP programs in LHCN on a weekly basis. The following metrics are monitored and visualized:

- Beehive registrations
- Beehive enrollments (i.e., consumers with a completed EULA)
- Opt-ins for data sharing with UCD and/or NIH for research purposes
- Completion of Modified Colorado Symptom Index (MCSI) at Baseline, 12 month, and 24 months.

Please find the report on recent data for these metrics in the deliverable: Submit report on LHCN enrollment and follow up completion rates for LHCN software application and dashboard in all EP Programs in study.

While reviewing these figures each week, the team discusses observed barriers for sites which are enrolling at a rate below the average LHCN enrollment rate. EPI-CAL team will also discuss solutions or interventions to address barriers. This may include developing additional trainings, making changes to Beehive application, reaching out to the program to ask what additional support they may need and brainstorm solutions, etc. Even when barriers are outside the scope of EPI-CAL project, (e.g., program turnover, dedication of program staff efforts), the team will still attempt to understand how we can accommodate the program given their needs at that moment.

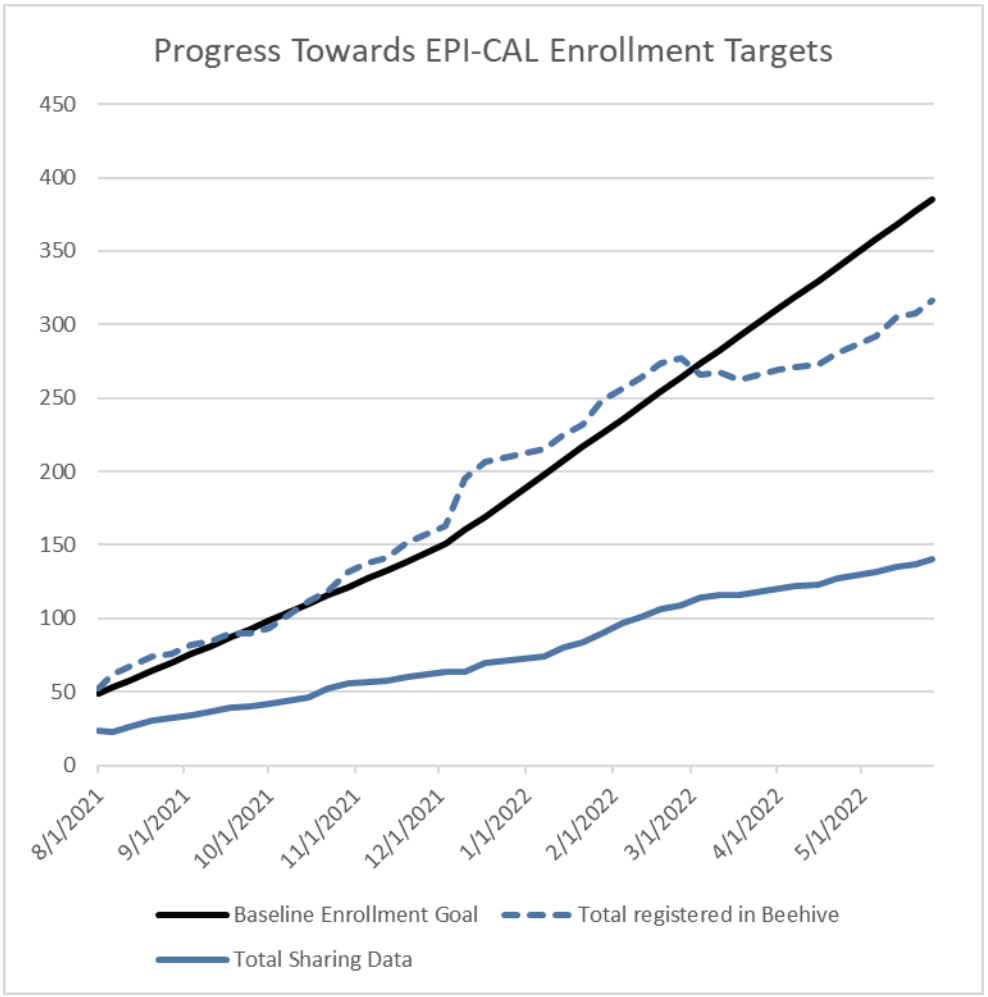
The EPI-CAL team also discusses the facilitators for sites which are enrolling above the average LHCN enrollment rate. EPI-CAL staff develop strategies to disseminate facilitators among all LHCN sites. For example, we noticed that sites who distribute the effort of Beehive implementation across their team, rather than relying on one or two people to carry the weight of implementation, have better rates of enrollment and survey completion. We now strongly recommend this distributed model during our workflow meetings with sites. We have also noticed that sites using the tablet (rather than the weblink) have been more successful in enrolling consumers. We are now encouraging all sites to use the tablet as much as they can.

7. Submit report on LHCN enrollment and follow up completion rates for LHCN software application and dashboard in all EP Programs

LHCN Overview

Figure 11 shows the LHCN Progress towards EPI-CAL Enrollment targets as of June 10, 2022. Consumers are considered enrolled if they have completed the Beehive EULA and agreed to share their data with UC Davis for use in research. If consumers do not allow their data for use in research, but agree to use Beehive as part of clinical care, their data may be used for quality management or quality assurance purposes only. The goal at this point in the project was to have 405 individuals enrolled (endpoint of black line in figure below). The observed rate of enrollment across the LHCN is 145 consumers (solid blue line in figure below). There are an additional 142 consumers who have been registered by the clinic in Beehive (dashed blue line in figure below), but who have not engaged with Beehive by completing the EULA or starting their surveys. We monitor the number of registered individuals because it serves as a proxy for program census (however we know that most clinics do not yet have all active consumers registered) and allows us to see what possible enrollment across the network could be.

Figure 11: LHCN Progress Towards EPI-CAL Enrollment Targets



Figures 12-13 show a site-by-site breakdown of the proportion of individuals who agreed to data sharing with UC Davis for research purposes as of June 10, 2022. Figure 12 shows all registered consumers, regardless of

EULA completion status. Hence this figure shows the room for growth if sites support consumers to complete their EULA in Beehive if those consumers agree to data sharing.

Figure 12: Proportion of Data Sharing with UCD for Research by Site

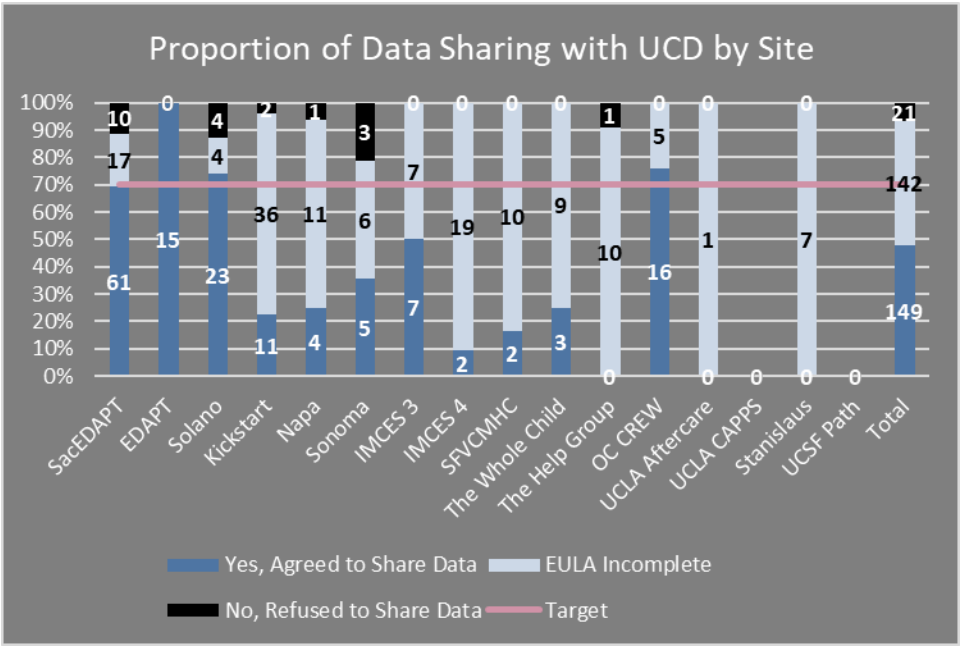


Figure 13 shows the proportion of data sharing choices made by those consumers who have completed their EULA in Beehive. We can see that some sites on this graph do not have a bar at all because they do not have any consumers who have completed the Beehive EULA.

Our goal is that 70% of active consumers at each site agree to use Beehive and share their data for research purposes. When considering all consumers known to EPI-CAL (i.e., all those registered in Beehive), we can see that only a few sites are meeting this metric. However among those individuals who have actually engaged with Beehive and completed the EULA, we are exceeding our target across the network, and at most sites individually as well. We are seeing rates of data sharing closer to 90% when considering all enrolled consumers across the LHCN.

Figure 13: Proportion of Data Sharing with UCD for Research among Completed EULAs

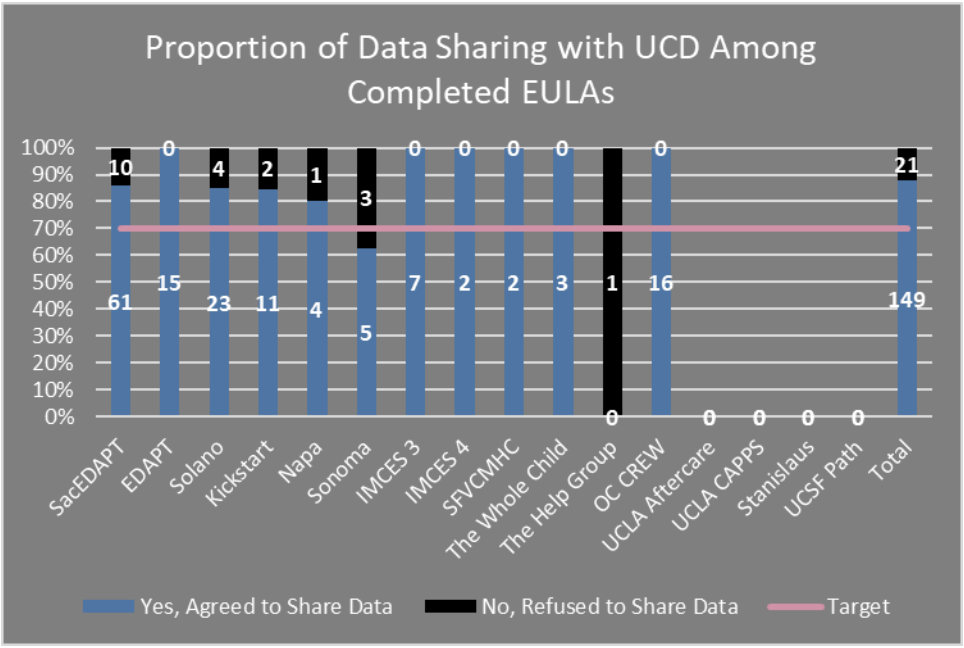
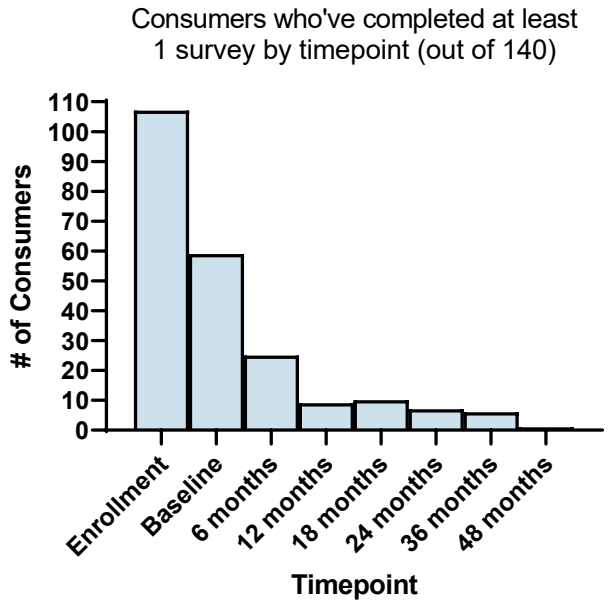


Figure 14 shows network-level survey completion rates by time point as of May 26, 2022. Note that all consumers are able to complete enrollment surveys regardless of when in their treatment they are enrolled. Consumers are not able to complete some survey windows (e.g., baseline) if they are enrolled later in treatment. Some consumers have completed surveys at more than one time point. Seventy-six percent of enrolled consumers (n=107) have completed at least one enrollment survey.

Figure 14: Survey Completion Rates Across EPI-CAL Network



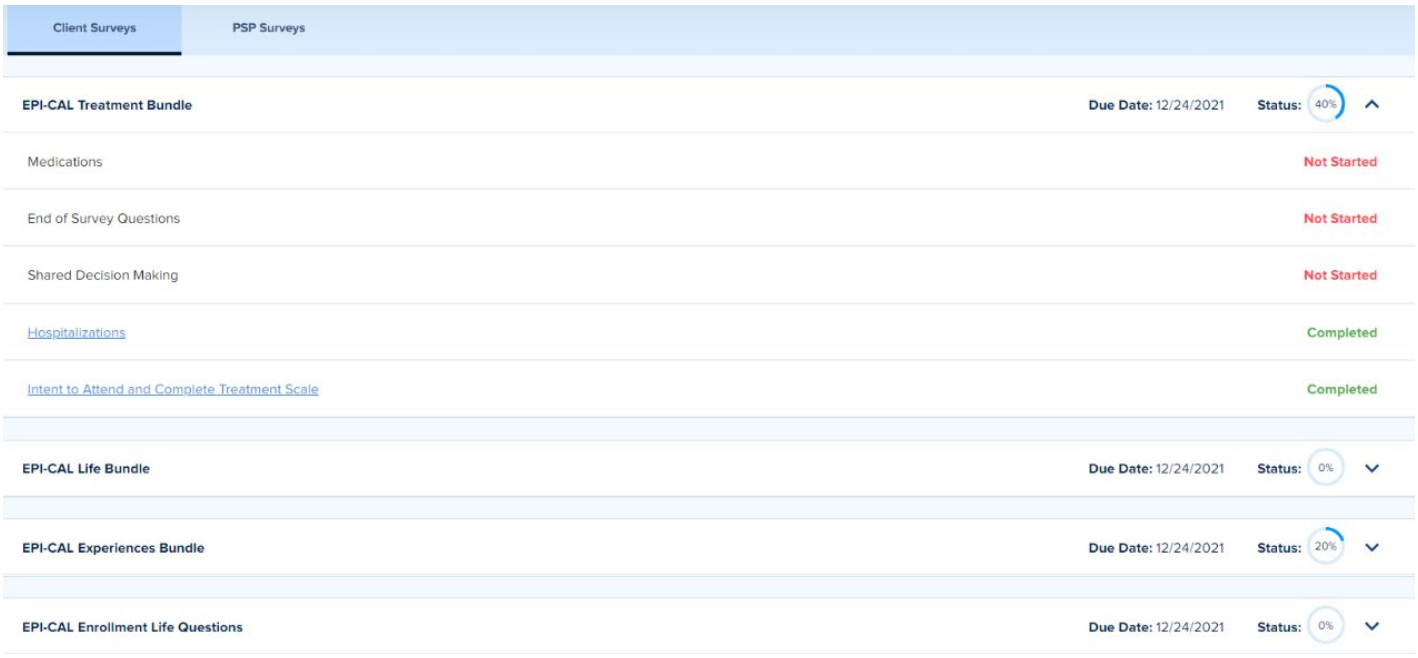
8. Subcontractor to revise dashboard to include feedback from programs and community partners

As Beehive has been designed for EP Programs, the needs and preferences of EP programs and the institutions of which they are a part have driven the design of Beehive. Security requirements of counties and institutions have led to increases in the security of Beehive. Feedback from users at EP Programs has identified several aspects of the application that could be improved to increase compatibility with their existing workflows and facilitate implementation of this novel technology.

Notably, pentesting was conducted by Azacus.io Cybersecurity on the Beehive application as a security requirement for several programs. Penetration testing, or pentesting, is a simulated hack to test the security of a system. Azacus.io conducted pentesting on both the web and iOS applications between June 21, 2021 and July 3, 2021. Azacus.io delivered the results of pentesting to the EPI-CAL team on July 12, 2021. All issues of vulnerability that were identified in the testing were addressed by the developers. On September 10, 2021, Azacus.io completed a retest of the application that proved all identified vulnerabilities had been fixed.

User feedback has also contributed to the development of Beehive. For example, Beehive users at EP programs noted that the process to determine survey progress for an individual consumer using the weblink solution to answer surveys was cumbersome. The EPI-CAL team gathered feedback on this issue and designed a “Survey Status” page in the application which allows the user to view the gestalt of survey completion for both consumers and primary support persons (Figure 15). It also allows the user to drill down into the survey completion for each survey and quickly review survey results by simply clicking on the name of the completed survey. The “survey status” page is a tool for Beehive users at EP programs to monitor survey completion more easily and thus support consumers and support persons to complete both the EPI-CAL battery and any additional program-specific surveys.

Figure 15: Survey Status Screen



Beehive users at beta programs also provided feedback that it was not easy to tell when a consumer had new data to review or to monitor an individual consumer’s survey completion. The EPI-CAL team designed two solutions for this which have since been implemented in Beehive. The first solution was to add an icon to the consumer list on the dashboard which indicates when there is data which has not been reviewed by the consumer’s treatment team lead (green dot on Data icon in Figure 16). The second solution was to make

survey names in dropdowns bolded when they have not yet been reviewed (Figure 17). These features aim to facilitate a clinician's review of their consumers' data by highlighting what remains to be reviewed. Thus far, user feedback from our beta sites has proved invaluable to improving the usability of Beehive in a clinical setting, and we hope to continue to elicit user feedback at non-pilot sites to examine if these changes are sufficient to address previous usability concerns.

Figure 16 : New Data Icon (green dot) on Consumer List, shown in Test Clinic

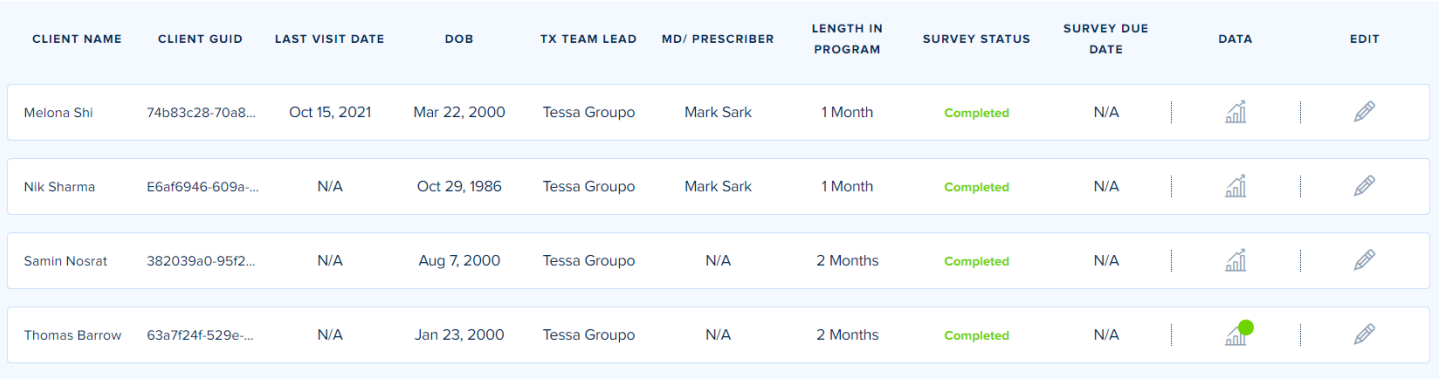
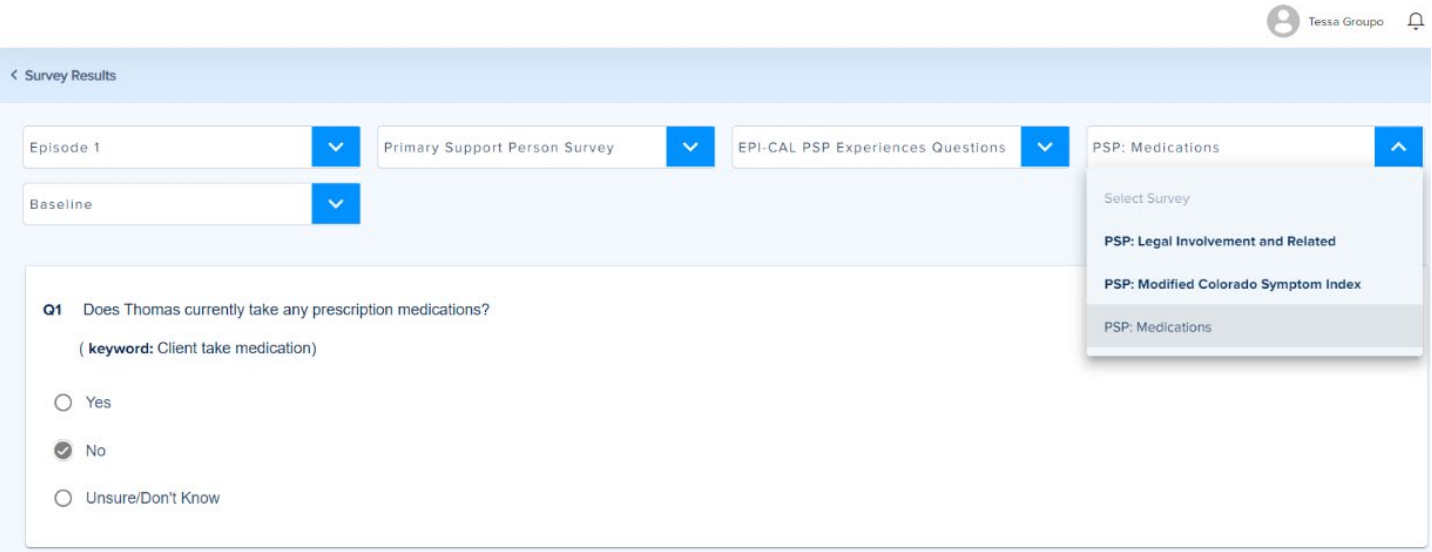


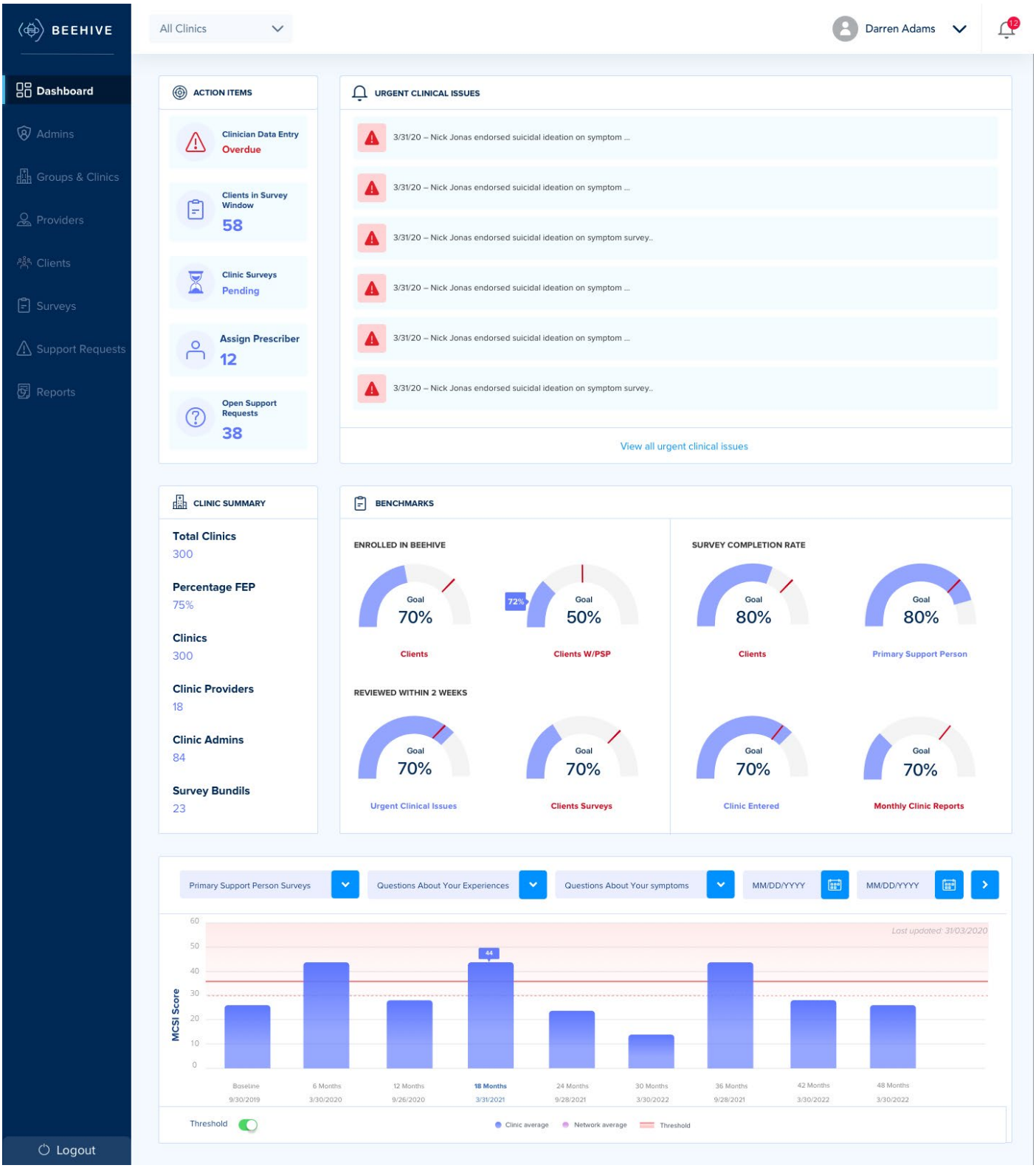
Figure 17 : Newly answered surveys in bold in dropdowns



The Beehive dashboard was also redesigned with input from programs. The goal of the dashboard is to provide users with the information that is of the highest priority for them when using Beehive. However, feedback from beta users indicated that they weren't sure what was most important, and the dashboard seemed busy. With this in mind, the dashboard was redesigned to reduce visual noise. The color scheme was simplified, with red being used sparingly for the most important information. The widgets above the fold of the web page are those that would require the user to act (e.g., urgent clinical issues and action items). Other widgets which are more informational in nature (e.g., benchmarks, clinic summary, and aggregate data widgets) were moved lower. Designs and mock-ups were presented to community partners across programs, including non-pilot programs, for their feedback and approval before implementing in Beehive. EP program community partners said that they liked the placement of the urgent clinical issues widget. They also said they

liked the curved progress bars in the Enrollment widget as they are more visually appealing, compared to straight-bar options that we presented as alternatives. In general, community partners said they thought the information on the new dashboard was easy to digest and their direct feedback was used to update specific design choices in the current dashboard (Figure 18).

Figure 18: Updated Beehive Dashboard



Another common theme of feedback from beta users was that the clinician data-entry was burdensome because it only included one question per page. This design of one question per page was intended to reduce the amount of information presented to consumers completing surveys in Beehive, but clinic users did not have the same needs. Due to the design of Beehive, it is not feasible from a resource perspective to allow more than one question per page. If future modifications in Beehive allow multiple questions to be presented in the clinic user view, we will work to incorporate this change. In the meantime, a new question type, matrix tables, was designed in Beehive so that EP program users could enter multiple data fields per page.

To prioritize community partner preferences and needs, the EPI-CAL team has implemented a system of formally gathering user feedback before planning each sprint series with the developers. A survey was sent out to all beta sites to solicit their feedback to prioritize the issues and ideas they had reported over the beta testing period. Respondents were asked if they were willing to participate in discussions with the Beehive project manager to provide qualitative information to help determine the best method of implementation for prioritized features. The issue prioritized by all respondents who had been using Beehive in their clinic was that survey windows were too short. The Beehive project manager met with individuals from each beta site to discuss their previous workflow around data collection and present possible Beehive solutions around this issue. EPI-CAL staff then used this information to determine the best length for Beehive survey windows moving forward.

Another feature that was adjusted based on community partner feedback is the availability of the EULA video. Several programs have indicated it would be helpful to be able to complete the Beehive EULA process prior to the consumer's intake. We changed Beehive so that the EULA process can be completed up to 15 days in advance of the intake date entered in Beehive.

Moving forward, we will continue to implement this method of gathering community partner feedback before each sprint series. Any program who has completed Beehive core training and begun to use Beehive in their program will be given the opportunity to contribute to the process of prioritizing changes and development to Beehive.

9. Gather feedback from interviews with EP community partners about experience in EP treatment programs.

This section includes the preliminary findings from our interviews with EP community partners about the barriers and facilitators to implementing a Learning Health Care Network into EP treatment programs.

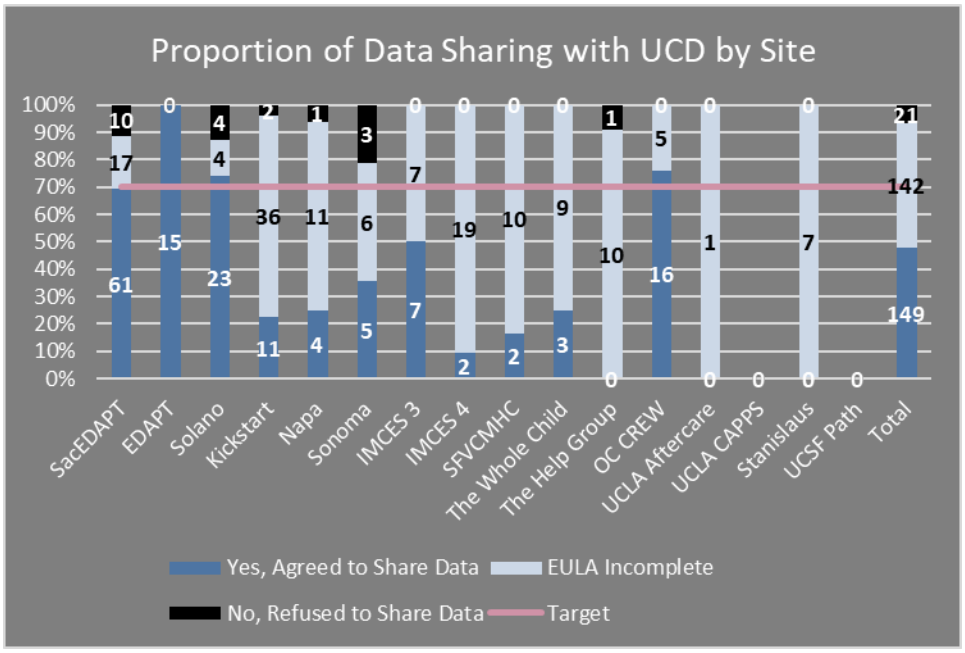
The interview guide was developed by the qualitative lead, with input from the rest of the research team. Once a first draft was completed the interview was submitted to the LHCN advisory group and further modified based on community partner feedback. The interview guide is structured to explore provider experiences related to each component of Beehive implementation, including enrolling consumers into the application, consenting and other steps prior to consumers inputting data, the data inputting process itself, and then incorporating Beehive and the data in care. Finally, provider experiences of training and ongoing support were explored. The aim of the interviews was to understand potential barriers to effective implementation of Beehive at each step of the process, potential solutions either considered or implemented to address these challenges, and facilitators to effective implementation. In keeping with the principles of a Learning Health Care Network, the aim was to disseminate these experiences across the EPI-CAL clinical to encourage cross program learning. Prior to recruitment, the interview guides were reviewed and approved by the UC Davis IRB.

Potential participants were identified through the help of our EPI-CAL clinic point persons. Following identification, the point person would introduce the potential participant to the interviewer via email so that the

interviewer could introduce the study. If the potential participant agreed to take part, a time would be scheduled to go through the consent process, payment form, and if the participant consents, complete the interview all via a zoom call. Interviews lasted one hour, and participants received a $30 gift card or check for participating.

All interviews took place between March 10, 2022 and March 29, 2022 with the exception of one interview that took place on May 3, 2022. Participants were clinical staff at the four specified clinics and identified as having the following roles: Clinical Supervisor, Clinician, Peer, Case Manager, Clinic Coordinator, Bilingual program coordinator, and Director. Nine providers across four clinics (Solano, EDAPT, SacEDAPT, and OC CREW) were interviewed. These sites were selected based on the relatively high degree of engagement with the Beehive platform, as evidenced by Figure 19. The rationale for this selection process was two-fold: 1) at programs in the earlier stage of Beehive implementation, there was a concern that providers may have insufficient exposure to the platform to be able to provide a detailed account of using the tool, and 2) the plan was to initially explore Beehive implementation in sites that have most successfully implemented the platform, allowing for the collection of data that may be helpful to other programs. Going forwards, we aim to expand recruitment of providers across all sites to develop a more comprehensive experience of Beehive implementation across the whole EPI-CAL network.

Figure 19: Proportion of Data Sharing with UCD for Research by Site



Preliminary findings centered on five prominent domains: training, enrollment workflow, clinical utility, the learning curve, and consumer engagement in surveys. Regarding training, preliminary results suggest clinics would like more trainings and refreshers, especially for new hires and when changes to the system happen. Additionally, participants highlighted the importance of hands-on and practice-oriented trainings. Next, participants discussed challenges with the flow of the initial meetings and procedures surrounding enrolling consumers into beehive, consenting, completing the EULA, completing initial surveys and the intake assessment. The most cited problems were technical challenges with the EULA video that were exacerbated by the remote set up due to the COVID-19 pandemic, and not having enough time for consumers to complete initial surveys before their intake assessment. More interviews are needed to understand if recent changes to the application have resolved these issues, and if it is experienced network wide. Some participants elicited concern regarding the current lack of clinical utility in beehive, attributable in part due to the inconsistency of data collection. Next, we have been looking into the learning curve to understanding beehive, which seems to

differ for more experienced clinicians and staff to newer team members. More data is needed to reach saturation for this topic and will be updated in a later report. Lastly, participants have been sharing innovative ways to improve consumer engagement in surveys, such as gift card incentives, making completing a survey a game, and having a case manager or other staff sit with consumers as they complete surveys.

More interviews with staff at additional clinics as well as consumer interviews are needed to fully understand the barriers and facilitators to implementing a LHCN into EP programs. Additionally, it is important to note that Beehive is continuously evolving through feedback, and challenges expressed in March may not be reflective of current progress. These preliminary findings highlight a brief snapshot of experiences for a small group of staff at a particular stage of implementation. We will continue to collect data to get a more cohesive picture.

10. Finalize methods for multi-county-integrated evaluation of costs and utilization data

The proposed analysis is based on pilot work conducted in Sacramento County, scaled to multiple counties (Niendam et al., 2016). It focuses on consumer-level data related to program service utilization, other outpatient services utilization, crisis/ED utilization, and psychiatric hospitalization and costs associated with these utilization domains during two time periods: 1) the three years prior to implementation of project tablet in the Early Psychosis (EP) programs (e.g., Jan 2017 – Dec 2019), to harmonize data across counties and account for potential historical trends, and 2) for the 2.5 year period contemporaneous with the prospective EP program level data collection via the tablet (Jan 2020 - June 2022). Below, we describe the data extraction and analysis plans for the first time period.

Early Psychosis (EP) sample
First, all individuals entering the EP programs January 1, 2017 – December 31, 2019 will be identified using County Electronic Health Record (EHR) data. This list will be cross-referenced with the County EP program(s) to identify those individuals who received treatment versus only eligibility assessment and referral to another service. *We will restrict the comparison to individuals diagnosed with first-episode psychosis (FEP), and not include those at Clinical High-Risk (CHR) for psychosis, due to an inability to reliably identify individuals with CHR in the comparator group.*

Comparator Group (CG) sample
We will compare the utilization and costs of the FEP participants in EP programs to utilization and cost among a group of FEP individuals with similar demographic and clinical characteristics who do not receive care in the EP program during the same timeframe in the same County. FEP individuals meeting the same eligibility criteria for the EP program (e.g., FEP diagnoses, within the same age group) who enter standard care outpatient programs in the County during that same time period will be identified as part of the comparator group (CG). First, we will identify all FEP individuals meeting these criteria receiving any outpatient services who are not served in the EP program. The Comparator Group (CG) was defined as 1) any individual seen in outpatient mental health services between January 1st, 2017 - December 31st, 2019; 2) age as of first date of service during this period: 12 years 0 days – Less than 26 years 0 days; and 3) any primary psychosis diagnosis during this period. We also requested that the counties submit a dataset of prior diagnoses and service utilization for the period of January 1, 2013 – December 31, 2017. This will allow us to correctly identify individuals with “first episode psychosis” (FEP) for our sample. This is defined as individuals who received a psychotic disorder diagnosis within two years of their index service date. The index service date is the first outpatient service associated with a primary psychotic disorder diagnosis in the study period.

Service Utilization

Next, data will be requested from the County EHR on all services received by individuals in the EP programs and all services for members of both groups including 1) any non-EP outpatient services; 2) inpatient services and 3) crisis/ED services. As possible, we will also work with other systems identified by EP programs as having service use data not otherwise captured in the County EHR (e.g., databases of other EP program services; private inpatient hospitalizations not billed to the County; non-billable services, etc.). We have identified these potential additional sources of data in expert interviews with program directors and senior program staff to date and will investigate their availability once groups are defined.

Costs

Costs per unit of service will be assigned to each type of service. We will work with county staff to identify the most accurate source of cost data. This may include internal financial accounting systems, contracts, cost reports, or published rates. We will determine whether to apply a single cost across all services (by type of service) or to apply costs that are county or provider specific. We will include billable and non-billable services. Outcomes will be calculated per month to account for varying lengths of time receiving services during the active study period. Additional details on outcomes and cost data sources are described in Table 5 below.

Table 5. Outcomes, Sources of Outcome Data, and Methods to Determine Costs Associated with Outcomes

Potential Outcomes of Interest	Sources of Data on Relevant Outcomes	Levels of Analysis	Sources of Cost Data associated with Outcomes
COUNTY LEVEL DATA VARIABLES			
Inpatient hospitalization for mental health concerns	• County hospitalization records	• Number/proportion of individuals hospitalized per group • Number of hospitalizations per consumer • Duration of each hospitalization (days) • Total duration of hospitalizations (days) per consumer	• Daily rate paid by County • Daily rate Medi-Cal reimbursement
Emergency Department or Crisis stabilization	• County crisis stabilization unit records	• Number/proportion of individuals with crisis visits per group • Number of visits, per consumer • Duration of each visit (hours) • Total duration (hours) of all visits, per consumer	• Hourly rate paid by County
Outpatient service utilization	• Service unit records by outpatient program from County *Examples:* • Assessment • Case management • Group Rehab • Group Therapy • Individual Rehab • Individual Therapy	• Service type • Number of service units (minutes)	• Contract service unit rates

	• Family Therapy • Plan Development • Medication management • Collateral Services • Crisis Intervention		

Statistical Methods

Multi-County Analysis
The data will be harmonized on demographics, diagnoses, and service types across all participating LHCN counties, for EP and CG groups, then merged into a single dataset for our primary analyses. This combined, multi-county dataset will provide increased statistical power, allowing for a richer set of controls and error structure without compromising efficiency.

Analysis of Sample Characteristics
Student T-tests and Pearson Chi-square (or Fisher's exact) tests will be used to compare unadjusted group differences in demographic characteristics (e.g., age, sex, race, ethnicity, etc.) between the individuals in the EP and CG groups. Both unadjusted and adjusted analyses will be used to examine group differences in clinical characteristics at time of index service such as primary diagnosis, as well as the duration of enrollment.

Analysis of Outpatient Service, Day Service/Crisis Stabilization, and 24-Hour/ Inpatient Psychiatric Hospitalization Data
All service data outcomes will be analyzed with a simple empirical equation: the independent variable is regressed on a county-specific fixed effect, an epoch-specific fixed effect, an indicator taking 1 for the EP group and 0 otherwise, a set of interactions between the EP group indicator and each epoch allowing the effect of the EP program to vary over time, and a set of individual-specific controls - measured at intake - consisting of sex, ethnicity, race, and primary language. We will use all demographic variables that were available and harmonized across all counties in time for this preliminary analysis. Standard errors will be always clustered at the individual-level because repeated measures of the same outcome for the same individual are correlated, and we are interested in describing individual-level differences. Further processing of the data will allow the addition of other individual-specific controls and clinic-specific effects to the empirical equation to account for other sources of confounding variation. These will be included in future analyses.

Total outpatient service time (in minutes) of all outpatient services and total minutes of each service type (e.g., medication management, individual therapy, group therapy, rehab services), and time per month will be analyzed by estimating the empirical equation described above with negative binomial regression for count data to determine if outpatient service use differs between the EP and CG samples.

Data related to individuals' use of Day Service/Crisis Stabilization, and 24-Hour/ Inpatient Psychiatric Hospitalization Data usage will be examined using multiple measurements based on the study period: 1) a binary indicator for whether the individual had ever been hospitalized; 2) a binary indicator for whether the individual had ever utilized crisis services; 3) number of hospitalizations per month; 4) number of crisis visits per month; and 5) mean duration of hospitalizations (i.e., length of stay [LOS]) in days; 6) mean LOS for Day/Crisis services (hours); 7) total duration of hospitalizations per month; and 8) total duration of Day/crisis services per month. Data for (1) and (2) will be analyzed by estimating the empirical equation described above with multiple logistic regression. Data for (3), (4), (7), and (8) will be analyzed by estimating the empirical equation described above with negative binomial regression for count data. Data for (5) and (6) will be

analyzed by estimating the empirical equation described above with linear regression. These various methods will allow us to determine whether each respective outcome differed between the EP and CG samples.

Data transfer methods
While data transferred between EP program staff and County data analysts within the same County may be identifiable, all information will be de-identified and provided with a unique numeric ID before being submitted to the UCD evaluation team. Data will be shared through an encrypted and password protected SFTP server, which is housed on UCD secure servers. Counties will not have access to any identifiable data from the other counties. Counties receive instructions for uploading their data to the secure SFTP server. Each county is given a unique login and is able to securely login into the SFTP portal and upload their data directly to the UCD servers. Once we receive the data, we confirm with the county that all the information was received.

11. Identification of county-level available data and data transfer methods, and statistical methods selected for integrated county-level data evaluation

One component of the LHCN project is to identify and describe the services and related costs for individuals served by the EP programs in each county. We will also examine services and costs associated with similar individuals served elsewhere in each county. We will harmonize and integrate data across all LHCN counties in order to perform these analyses.

Specifically, in each county we will identify an early psychosis (EP) group consisting of individuals served by the early psychosis program. We will also identify a comparator group (CG), consisting of individuals with EP diagnoses, within the same age group, who enter standard care outpatient programs during that same time period. This analysis focuses on data from Los Angeles, San Diego, Orange, Napa, Stanislaus, and Solano counties. For this component of the project, the evaluation has two phases: 1) the three years prior to the start of this project (e.g., January 1, 2017 – December 31, 2019) to harmonize data across counties and to account for potential historical trends and 2) for the 2.5-year period contemporaneous with the prospective EP program level data collection (January 1, 2020 – June 30, 2022).

For each county, our team held meetings with the EP program managers and the county data analysts. The meeting with the program managers discussed services provided by the EP program, description of consumers served, staffing specifics and billings codes for each service. A follow-up meeting was held with each county to review details of funding sources, staffing levels during certain time-periods and other types of services provided for specific types of consumers (i.e., foster care). Meetings were held with the county data analysts to discuss details about the data the county will be pulling for the LHCN team during the next annual period. The discussion included time-periods for which the LHCN team will request data, description of the consumers from EP programs and how similar consumers served elsewhere in the county will be identified, services provided by each program, other services provided in the county to the EP consumers (i.e., hospitalization, crisis stabilization and substance use treatment), and data transfer methods. We have met with the program managers and data analysts from all LHCN counties with active contracts and have scheduled follow-up meetings with the data analysts as necessary. Our research team has gathered all of the information from each program/county and summarized it in meeting notes and a multicounty data table. For the purposes of this report, we have provided a sample of the data collected from each county (see Table 6).

Table 6. Multicounty Program Services and Billing Information

County	**San Diego**	**Orange**	**Solano**	**Napa**	**Stanislaus**
Program Name	Kickstart	OC CREW	Aldea SOAR	Aldea SOAR	LIFE Path

County	San Diego	Orange	Solano	Napa	Stanislaus
Consumers Served	FEP, CHR	FEP	FEP, CHR	FEP, CHR	FEP, CHR
Census	140-160	42	26	10-15	Current 10-15, cap 40
Length of Services	(+/-) 2 yrs	2 - 4 yrs	(+/-) 2 yrs	(+/-) 2 yrs	2 yrs
Inclusion - Ages	Ages 10-25	Ages 12-25	Ages 12-30	Ages 8-30	Ages 14 - 25
Inclusion - Diagnoses	Any type of psychoses (NOS) but not required, SIPs score of 6	FEP	CHR diagnosis or FEP within 2 yrs	All Psychotic D/Os (within 2 yrs of meeting dx criteria) & CHR diagnosis	Psychotic d/os within 1 year of meeting dx criteria including affective, & CHR diagnosis
Inclusion - Insurance	Medi-Cal, Uninsured	None	Medi-Cal, Uninsured	Medi-Cal, Private, Uninsured	Medi-Cal, Private, Uninsured
Inclusion - Duration of Psychosis	First psychotic symptoms within 2 yrs	First psychosis within 2 yrs	First psychosis within 2 yrs	First psychotic episode within 2 years; Attenuated psychosis of any duration	First episode within 2 years;
Exclusion - Cognition	IQ < 70 - Case by case discretion	IQ < 70	IQ < 70	IQ < 70	IQ < 70, Substance induced psychosis, psychosis due to medical conditions including TBI
Exclusion - Diagnoses	Case by case discretion: Medical diagnosis that better explains symptoms; substance use	No substance use or medical condition that better explains symptoms	Substance dependence would not allow to participate in treatment – refer to substance abuse treatment, Head injury or medical condition	Substance dependence would not allow to participate in treatment – refer to substance abuse treatment, Head injury or medical condition	
Exclusion - Other	Qualitative Judgement call: Physically aggressive, sexually inappropriate, safety issues	Not received counseling prior for psychotic disorder in the last 24 months	Qualitative Judgement call: Physically aggressive, sexually inappropriate, safety issues	Qualitative Judgement call: Physically aggressive, sexually inappropriate, safety issues	Qualitative: requires 24 hour care/higher level; staff/peer safety issues

County	San Diego	Orange	Solano	Napa	Stanislaus
Assessments - Billing Codes	10	90899-6 (H2015)	90791	10	10
Assessments - Provider type	Clinicians	Clinician: master's level BHCI, BHCII, psychiatrist	Therapist; clinical supervisor	Therapist	LPHA
Assessments - Notes	Behavioral Health assessment and HRA (high risk assessment)	Code 90899-6 for each of multiple sessions leading up to intake completion; Same code for psychiatrist completing conservatorship evaluation, disability assessment, or eval for med services by telephone		Initial, Annual/ Periodic	Initial, periodic
Targeted case management - Billing Codes	50	90899-1 (T1017)	T1017	50	50
Targeted Case Management - Provider Type	All direct service staff: clinical team, OT, Peer Support or EES. As well as medical team (NP, Psychiatrist, or LVN)	BHCI, BHCII, psychiatrist, Mental Health Specialist, Psychiatrist, Behavioral Health Nurse, Mental Health Worker	Therapist, family partner; Medical director or PNP	Therapist, Family Partner/ Peer Case Manager	Clinician, Behavioral Health specialist
Targeted Case Management - Notes	Monitoring progress toward goals - information gathered from schools and parents	A variety of services can be billed under case management as long as they referred to coordination of care, monitor service delivery and linkage access to community services.	Examples: Therapist discusses consumer with PNP or Family Partner; Therapist or Family Partner discusses consumer need for housing with Caminar; Therapist facilitates consumer's transition to a new service upon	Linkage to Resources; SEE support	Linkages, evaluate other program/resource progress; verify progress

County	San Diego	Orange	Solano	Napa	Stanislaus
			completion of program		
Group Psychotherapy - Billing Codes	35	90849 (H2015)	H2017	31 or 35 (Peer & MFG); Non-Bill (FSG)	38, 36
Group Psychotherapy - Provider Type	Clinician, Peer Support Specialist, Education Employment Specialist, OT	BHCI, BHCII, Mental Health Specialist, Behavioral Health Nurse	Therapist, Family Partner	Therapist, Family Partner/ Peer Case Manager	Clinician, Behavioral Health Specialist, Family Advocate
Group Psychotherapy - Notes	10 different groups offered. Collateral services billed 8-15 to capture other support specialist for any group with multiple facilitators	Group Psych-multifamily	Group rehab	Multi-Family Group, Family Support Group, Peer Group(s) for Adolescents & Adults	Multi-Family Group, Social Skills/Life Skills Group

12. Deliver a plan and timeline for working with counties to support infrastructure to access final round of county-level cost and utilization data for EP and CG programs

Overview

The County Data evaluation of the LHCN project examines the services and costs associated with individuals treated in Early Psychosis (EP) programs across several California counties in comparison to the services and associated costs for a comparator group (CG) of similar individuals treated in other outpatient clinics representing “standard care,” during a concurrent time frame in the same community. The primary goal of this component, submitted December 2021 to the counties in the last report, was to provide a preliminary demonstration of the proposed method for accessing data regarding EP programs and CG groups across California. The secondary goal was to analyze service utilization and costs associated with those services across counties.

Over the last fiscal year, we successfully completed our primary goal and the first part of our secondary goal (service utilization comparison). We were unable to complete the cost comparison analysis due to the complexity of the data required to be harmonized across counties and the variety of data sources. Nearly all programs and counties, as well as our central team, have been impacted by staff shortages due to unfilled positions and redeployment of staff during the COVID-19 pandemic, which has delayed project coordination and data extraction.

Over the last fiscal year, we have continued to meet with counties to clarify questions about received cost and utilization data, and to troubleshoot issues related to incomplete or unclear data elements. In these meetings, we requested that each county provide us with contracts and budgets for their EP programs as a way to account for non-billable activities and other unaccounted-for costs of running the program. Further, we worked with counties to obtain actual costs per service, per consumer, rather than reimbursement amounts or fixed costs per unit of service, as these have differed. In our efforts to thoroughly balance EP and CG groups, we decided to request historical data for the EP group from each county and have worked to modify data use agreements as necessary. Finally, we asked each county to provide us with consumers' episode of care end dates for those consumers who may have ended their services since the data was originally extracted.

Summary of preliminary analysis of service utilization data

During the fiscal year, the County Data evaluation team focused on addressing the limitations of the preliminary analysis of service utilization data. This effort is composed of three main activities: 1) improving the harmonization of variables across counties and the detection of episodes of care, 2) addressing missingness in county data, and 3) addressing selection bias into EP programs.

The County Data evaluation team is reviewing CG and EP group data to identify ways to improve the harmonization of data across the counties in the evaluation. This exercise will allow us to fully leverage the diversity of our service-level data. Additionally, we are working closely with county staff to improve how we detect consumer episodes of care in the data. Accurate identification of episodes of care are crucial to accurately measuring service utilization in both the CG and EP groups, improving the credibility and rigor of our estimates of the effects of EP programs.

Subsequent descriptive analyses of county-level service data after the previous analysis revealed substantial variation in the number of variables with missing values across counties, as well as the degree to which data is missing within each county's data. The county data evaluation team is exploring the extent of missingness in the data from each group in each county, as well as the extent to which missingness is correlated with a consumer belonging to the CG group. Once the team has a clear understanding of missing data in our sample, we will explore solutions and determine the extent to which missingness is a limitation of the evaluation.

The preliminary analysis of service utilization data provided comparisons between the CG and EP group adjusted for a small initial set of observable consumer-level characteristics. However, we know consumers are not randomly assigned to the EP group, so even adjusted analyses still suffer from selection bias. This selection bias arises from the likelihood that consumers in the EP group differ systematically from those in the CG group such that they were a priori more likely to have been members of the EP group. For example, many EP programs exclude serious substance use disorders (SUD) on a case-by-case basis, but SUD severity is difficult to discern from the diagnostic data obtained for the comparator group. Hence, a rigorous comparison of the EP and CG groups should correct for this selection bias. To address selection bias, the county data evaluation team is implementing a generalized version of propensity score weighting, using augmented inverse probability weighting (AIPW) with Lasso covariate selection. The principal idea behind this method is to leverage historical data from each consumer to predict the probability we later observe them in the EP group during the study period by modeling selection into the EP group. Each consumer is then "weighted" by the

inverse of this predicted probability, which statistically approximates random assignment of EP care. While powerful, the propensity score weighting method is dependent on the evaluation team's ability to accurately predict the "true" probability a person is observed in the EP group. Lasso, a machine learning technique, allows us to find the best selection model within the available data. The combination of these methods will allow the evaluation team to correct for selection bias to the best of the data's ability. Correcting for selection bias makes the comparison of the EP and CG groups as close to "apples-to-apples" as possible.

In addition to methodological improvements, the county data evaluation team is working with county staff to extract additional data required for the analytic methods. We requested historical data for consumers in our county EP groups to be used in the weighting methodology described above. LA county staff were able to identify previously unavailable service data for 24-hour service categories for all consumers. We are also working closely with Solano county to obtain inpatient service utilization data for the specific CG consumers selected for our comparison. We are also working with two new counties that will contribute data to these combined utilization analyses, Napa and Stanislaus. We have met with both county and program staff to discuss the process for this element of the project and will submit our formal data requests to them shortly.

Cost Analysis

In this report, we present a preliminary analysis comparing the EP and CG groups in San Diego County on service utilization and related costs data. Due to the challenges outlined above, we were not yet able to integrate or analyze cost data from Solano County, Orange County, and Los Angeles County. We are confident that the cost comparison analysis, along with a finalized comparison analysis of service utilization, will be completed for the next deliverable, due December 2022.

Sample and Methods

We identified consumers who initiated services in the San Diego EP program, "Kickstart," from January 1, 2017 to December 31, 2019, and a comparison group of consumers who were using outpatient services during the same time period. We identified Kickstart consumers who first enrolled in the programs between January 1, 2017 and December 31, 2019. We limited the sample to consumers ages 12-25 who did not have a diagnosis of psychosis (ICD-10 codes F20, F22, F23, F25, F28, F29, F31.2, F31.5, F31.64, F32.3 F33.3) greater than two years before enrollment (through October, 2008). We excluded consumers with private insurance, due to an inability to capture all of their services in the public claims system, and consumers who received a diagnosis of intellectual disability (ICD-10 codes F70-F79, ICD-9 codes 317-319), to harmonize the sample with our other counties' exclusion criteria.

We shared a list of Kickstart consumers with program staff who confirmed that these were past or current consumers who had enrolled in services, and were identified as either First Episode Psychosis (FEP) or Clinical High Risk (CHR). FEP consumers have threshold psychosis symptoms defined as having a Psychosis Syndrome on the Structured Interview for Prodromal Syndromes (SIPS), roughly corresponding to a score of 6 for Positive Symptoms on the Scale of Prodromal Symptoms (SOPS). CHR consumers have subthreshold symptoms, defined roughly as having a SOPS score of 3-5.

We identified a comparison group (CG) of consumers with likely FEP ages 12-25 who received an outpatient mental health service in San Diego County between January 1, 2017 and December 31, 2019, and who had a first diagnosis of psychosis (same diagnoses as above) within two years prior to their first service during this time period. We defined the first outpatient service during January 1, 2017 to December 31, 2019 as the index outpatient visit. We similarly excluded consumers with private insurance, consumers who received a diagnosis of intellectual disability, and consumers with a diagnosis of psychosis greater than two years before the index outpatient visit.

We summarized service use over 365 days prior and 365 days following enrollment in Kickstart or the index outpatient visit. Outpatient services included case management, crisis intervention, medication management, and mental health services including rehabilitation and therapy. We defined a visit as a unique day receiving services. We summarized psychiatric admissions including admissions to psychiatric hospitals, admissions to psychiatric units of acute care hospitals, and admissions to crisis residential facilities; and psychiatric emergency services including the emergency psychiatric unit and mobile psychiatric emergency response teams. We also summarized costs of outpatient mental health services covered by Medi-Cal, California's Medicaid program.

We estimated the numbers of services and visits during the year using negative binomial regression models. We estimated the probabilities of having a psychiatric inpatient admission and of using psychiatric emergency services using logistic regression models. We estimated costs using a generalized linear model with a gamma distribution and a log link function. In each model, we included covariates for age, gender, and race/ethnicity (included as indicator variables for Black and Latino), along with indicator variables for FEP and CHR. We calculated standardized estimates for each outcome using the estimated coefficients to generate predicted values for each consumer in the sample as if they were alternately assigned to each group: FEP, CHR, and CG. The standardized mean is the mean of the predicted values across the sample. We calculated standard errors using the non-parametric bootstrap, and significance values using non-parametric permutation.

Results

We identified 301 consumers in the Kickstart program, of whom 104 were FEP and 197 were CHR, and 687 likely FEP consumers in the CG (Table 7). Mean age in the FEP group was 18.3 years (SD=2.8) and the largest percentage of consumers was 15-17 years (N=51, 49%). Mean age was lower among the CHR group (16.5 years, SD=2.8), due to a large percentage of consumers under age 15 (N=63, 32%). Mean age was highest among the CG (19.5 years, SD=4.0), due to a large percentage of consumers ages 21 and over (N=294, 43%). The FEP group had the largest percentage of consumers who were male (N=73, 70%). The distribution of race/ethnicity was similar across the groups.

Table 8 shows the mean number of services in the year prior and year post enrollment for Kickstart consumers and in the year prior and year post the index outpatient visits for CG consumers, as well as the difference in services from pre to post. Service use was highest for the FEP group in both the pre and post periods, followed by CHR and CG. The FEP group also had the greatest increase in services from pre to post (45.7, SE=6.6), followed by CHR (24.0, SE=3.1) and CG (12.3, SE=1.8).

Table 9 shows the mean number of visits in the year prior and year post enrollment or index outpatient visit and the difference between years. Visits were highest for the FEP group in both the pre and post periods, followed by CHR and CG. The FEP group also had the greatest increase in visits from pre to post (32.5 SE=4.2), followed by CHR (17.5, SE=1.9) and CG (8.9, SE=1.1).

Table 10 shows probabilities of psychiatric admission in the pre and post periods and the change in probability of admission from the pre to post period. The CG had the highest probability of admission in the pre period, when 14.4% (SE=1.3) of consumers had admissions. The rate of psychiatric admission was similar among FEP and CG, but slightly lower among the CHR group in the post period. As a result, the FEP group had the greatest increase in probability of admission with an 18.1 (SE=4.7) percentage point increase from pre to post.

Table 11 shows the probabilities of using psychiatric emergency services. The CG had the highest probability of emergency service use in the pre period, when 12.4% (SE=1.5) of consumers used services. The rate of emergency service use was similar among FEP and CG, but slightly lower among the CHR groups in the post

period. As a result, the FEP group had the greatest increase in emergency service use with a 25.3 (SE=4.5) percentage point increase from pre to post.

Table 12 shows Medi-Cal reimbursed outpatient mental health services. Outpatient costs were similar in the year prior to enrollment or index outpatient visit. In the post period, costs were greatest among FEP ($9,711, SE=$910) followed by CHR ($6,334, SE=$451) and CG ($4,620, SE=$272). As a result, outpatient costs increased the most among FEP, followed by CHR and CG.

Summary

Youth consumers enrolled in Kickstart had higher outpatient service use, visits, and costs than a comparable group of adolescent and young adult consumers who were receiving services in standard outpatient programs. Services, visits, and costs were greater for consumers with FEP than consumers who were CHR. We did not find significant differences in psychiatric inpatient or emergency services use in the year following enrollment. However, since Kickstart consumers had lower use of these services in the pre period, they appear to have greater increases in use from the pre to post period.

Table 7: Demographic Characteristics of Youth Consumers of Kickstart and a Comparison Group

	First Episode Psychosis	**Clinical High Risk**	**Comparison Group**	**P-value for difference across groups**
N	104	197	687	
Age N (%)				P<.001
Age <15	9 (9%)	63 (32%)	113 (16%)	
Age 15-17	51 (49%)	88 (45%)	161 (23%)	
Age 18-20	25 (24%)	30 (15%)	119 (17%)	
Age 21- 25	19 (18%)	16 (8%)	294 (43%)	
Gender N (%)				P=.006
Male	73 (70%)	108 (55%)	368 (54%)	
Female	31 (30%)	89 (45%)	319 (46%)	
Race/Ethnicity N (%)				P=.002
Non-Latino White	23 (22%)	39 (20%)	158 (23%)	
Black	14 (13%)	19 (10%)	66 (10%)	
Latino	57 (55%)	118 (60%)	325 (47%)	
Other	4 (4%)	16 (8%)	60 (9%)	
Unknown	6 (6%)	5 (3%)	78 (11%)	

Table 8: Mean Annual Services Use (Individual Visits, Even if Received on the Same Day), Standardized by Demographic Characteristics, in the Year Prior and Year Post Enrollment

	First Episode Psychosis	Clinical High Risk	Comparison Group	P-value for difference across groups
Pre	19.4 (3.9)	17.8 (2.5)	15.3 (1.4)	<.0001
Post	65.1 (5.5)	41.8 (2.7)	27.6 (1.5)	<.0001
Difference	45.7 (6.6)	24.0 (3.1)	12.3 (1.8)	<.0001

Table 9: Mean Annual Visits, Standardized by Demographic Characteristics, in the Year Prior and Year Post Enrollment

	First Episode Psychosis	Clinical High Risk	Comparison Group	P-value for difference across groups
Pre	12.4 (2.2)	11.5 (1.4)	10.6 (.9)	<.0001
Post	44.9 (3.5)	29.0 (1.7)	19.5 (.9)	<.0001
Difference	32.5 (4.2)	17.5 (1.9)	8.9 (1.1)	<.0001

Table 10: Mean Annual Probability of Psychiatric Inpatient Admission, Standardized by Demographic Characteristics, in the Year Prior and Year Post Enrollment

	First Episode Psychosis	Clinical High Risk	Comparison Group	P-value for difference across groups
Pre	5.4 (2.2)	3.8 (1.4)	14.4 (1.3)	.0002
Post	23.4 (4.3)	17.1 (2.8)	24.8 (1.6)	.095
Difference	18.1 (4.7)	13.3 (3.1)	10.3 (2.1)	<.001

Table 11: Mean Annual Probability of Use of Psychiatric Emergency Services, Standardized by Demographic Characteristics, in the Year Prior and Year Post Enrollment

	First Episode Psychosis	Clinical High Risk	Comparison Group	P-value for difference across groups
Pre	4.4 (1.9)	6.6 (1.8)	12.4 (1.5)	.011
Post	29.7 (4.3)	18.3 (2.7)	23.1 (1.6)	.075
Difference	25.3 (4.5)	11.7 (3.1)	10.8 (2.0)	.010

Table 12: Mean Annual Costs of Outpatient Services (in USD), Standardized by Demographic Characteristics, in the Year Prior and Year Post Enrollment

	First Episode Psychosis	Clinical High Risk	Comparison Group	P-value for difference across groups
Pre	3606 (785)	3264 (484)	2915 (316)	.490
Post	9711 (910)	6334 (451)	4620 (272)	.001
Difference	6105 (1186)	3070 (640)	1704 (420)	.041

Future Analyses

During the next deliverable period, we will examine service utilization across the entire retrospective period (January 1, 2017 – December 31, 2019) rather than comparing services received during the year prior and the year post program enrollment. In addition, outcomes will be calculated as unique outpatient services accounting for varying durations of active treatment. We will also expand the scope of the cost analysis. Currently, costs are limited to the amounts paid for Medi-Cal reimbursable mental health outpatient services. In the next period, we will consider the costs incurred to the County for all outpatient services, including those services that are not reimbursable by Medi-Cal. We will also consider additional service types including inpatient and crisis residential, and the emergency psychiatric unit and the psychiatric emergency response team.

Although CHR consumers enrolled in the EP program were included as a comparison group in the current analysis, these consumers will be excluded from future planned analyses as they cannot be reliably identified for the comparator group using standard diagnostic codes. We will also refine the exclusion criteria for the CG group based on diagnostic and service utilization history of the EP group as well as utilizing a weighting strategy for included consumers in both groups, as described previously. This will ensure that the CG group only contains consumers most likely to have a first episode of psychosis, allowing for a more accurate comparison between FEP consumers in the EP and CG groups on service utilization and related costs data.

Finally, future analyses will harmonize and integrate service utilization and related cost data from Orange County, Los Angeles County, Solano County, Stanislaus, and Napa counties.

Prospective Data Analysis

Over the last FY, we held a series of meetings with each county (Los Angeles, Orange, San Diego and Solano) to review the prospective data request. In these meetings, we discussed when claims data would become available for service utilization and estimating costs, as well as time needed for data extraction. Data availability ranged from 4-11 months after the service was billed. We also conferred with other LHCN team members about the timelines for program fidelity assessments to be completed and Beehive implementation to obtain consumer-level outcomes. We had originally planned for a prospective 3.5 year period contemporaneous to the EP program-level data collection; however, based on the projected time estimates to receive from the counties, we determined that the 2.5 year period January 1, 2020 – June 30th, 2022 would be best aligned with the goals of this analysis. This period will allow us to obtain service and cost data for all counties Jan 2020 - June 2022, then finish cleaning, harmonizing and integrating data for a preliminary analysis to be completed by December 2023. This aligns with the original preliminary analysis due dates for San Diego, Orange, Los Angeles, Napa, and Stanislaus counties, and is slightly delayed for Solano County, which had a due date for the preliminary analysis of June 2023. We will obtain community partner feedback and complete a final analysis by June 2024 (see Table 13). This aligns with the original plan for Los Angeles, Napa, and Stanislaus Counties, and is slightly delayed for Orange, San Diego, and Solano Counties which had a due date for the final analysis of December 2023. The process of harmonizing and integrating data for the

initial retrospective period has been incredibly useful and will allow us to do the same for the new service period much more quickly. This prospective period would include almost all program fidelity assessments, with the last assessment scheduled for September 2022.

Table 13. Proposed Timeline for Prospective Data Pull

County	Preliminary analysis due date	Length of time required for County to receive data	Data available by this date
Solano	June 2023	3 months	**Sept 2022**
Orange	September 2023	10 – 11 months for charge data	**May 2023**
LA	June 2024	3 months for charge data DHS Hospital data - 6 months other hospitals - 30 days	**Jan 2023**
San Diego	June 2023	3 months - for annual report, so that there will be enough time for clinic to input all data	CCBH data available end of **Oct 2022**, Optum data available December 2023

Due to Covid-related delays in Beehive implementation (e.g., staffing shortages in county programs, leadership and staff turnover, additional efforts associated with engaging consumers remotely), we expect to conduct pilot analyses integrating consumer-level data from Beehive. As described above, enrollment in Beehive has been delayed, providing insufficient statistical power by the end of the award period to conduct comprehensive integrated analyses of consumer-level outcomes with utilization and cost data. However, we plan to discuss the data needs for this analysis in detail with the counties during the next project period in order to complete these analyses in the post award period.

Further, in our meetings with program and county staff, we discussed any changes to the county EHR or billing and claims systems, changes in data elements collected during the new time period, or any other relevant changes to data availability. We met with Solano County on June 2, 2022; Los Angeles County on May 23, 2022; Orange County on May 19, 2022; and held conversations with San Diego County on May 23, 2022.

13. Provide findings on cost and utilization data from preliminary multi-county integrated evaluation, identification of problems and solutions for county-level data analysis

Overview of Deliverable

The County Data evaluation of the LHCN project examines the services and costs associated with individuals treated in Early Psychosis (EP) programs across several California counties in comparison to the services and associated costs for a comparator group (CG) of similar individuals treated in other outpatient clinics representing “standard care,” during a concurrent time frame in the same community. The primary goal of this component was to provide a preliminary demonstration of the proposed method for accessing data regarding EP programs and CG groups across California. The secondary goal was to analyze service utilization and costs associated with those services across counties.

For this report, we were able to successfully complete our primary goal and the first part of our secondary goal (service utilization comparison). We were unable to complete the cost comparison analysis due to the complexity of the data required to be harmonized across counties and the variety of data sources. Nearly all programs and counties have been impacted by staff shortages due to unfilled positions and redeployment of staff during the COVID-19 pandemic, which has delayed project coordination and data extraction. In this deliverable, we describe the cost data we have obtained to date, the cost data still needed, and the challenges and solutions relevant to this endeavor.

Description of Early Psychosis Programs Evaluated

Los Angeles County
The Los Angeles Center for Assessment and Prevention of Prodromal States (CAPPS) program is an early psychosis program serving consumers at clinical high risk for psychosis and consumers who have experienced a first episode of psychosis. The majority of assessment and treatment services offered at CAPPS are free of charge to the consumers. There were 6 CAPPS clinics in operation during the study period, January 1, 2017 – December 31, 2019.

Orange County
The Orange County Center for Resiliency, Education, and Wellness (OC CREW) is an early psychosis program serving consumers who have experienced a first episode of psychosis in the last 2 years. OC CREW provides screening and needs assessments, clinical case management, individual counseling and family services, psychiatric care, psychoeducational groups, referrals and linkages to community resources, and community education on “The First Onset of Psychosis.”

San Diego County
San Diego Kickstart is an early psychosis program serving consumers who are at clinical high risk for psychosis and those who have experienced a first episode of psychosis in the last 2 years. Kickstart aims to educate the community, treat youth, and assist families in preventing psychosis.

Solano County
Solano County Aldea provides early psychosis services through the Supportive Outreach and Access to Resources (SOAR) program. They serve consumers who are at clinical high risk for psychosis and those who have experienced a first episode of psychosis in the last 2 years. SOAR provides services based on the model of the UC Davis Early Diagnosis and Preventative Treatment Clinic. Components include community outreach and education, psychiatric medication management, individualized clinical case management, weekly psychoeducation and support groups, bi-monthly family and multi-family support groups, peer advocate support, and employment and education support.

Characteristics of each county program are detailed below in Table 14.

Table 14. EP Program Characteristics

County	Age Range Served	Duration of Services	Excluded Diagnoses
Los Angeles	Prior to March 2019: 16 – 25 March 2019 – present: 12 – 30	2 years	• medication-induced psychosis • psychosis due to a medical condition • intellectual disability
Orange	12 - 25	2 – 4 years	• delusional disorders • affective disorders

			• post-partum psychosis • substance-induced psychosis • substance use disorder • psychosis due to a medical condition • intellectual disability / IQ below 70
San Diego	10 - 25	1.5 years	• psychosis due to a medical condition • intellectual disability
Solano	Prior to June 2017: 12 – 25 June 2017 – present: 12 – 30	2 years	• psychosis due to a medical condition • intellectual disability • substance dependence.

Analytic Approach

This report presents: 1) descriptive analysis of the EP groups in San Diego, Los Angeles, Orange and Solano counties; 2) a preliminary comparison of the service utilization associated with individuals with first-episode psychosis (FEP) treated at the participating EP programs versus service utilization of a comparable group (CG) of individuals seen for usual outpatient care in the same counties, during the same time period; and 3) a description of cost data available to date from each county. The data were harmonized across counties for analysis, in order to obtain a larger sample size than any one county could contribute alone, allowing for more complex and robust statistical modeling with sufficient to detect even small differences between EP and CG groups.

EP Sample Description

All individuals entering the EP programs January 1, 2017 – December 31, 2019 were identified using county EHR data. County data analysts excluded individuals who received services from the EP program prior to January 1, 2017. This list was cross-referenced with the county EP program(s) to identify 1) those individuals who enrolled in the EP program and received treatment, and 2) those who received only eligibility assessment and referral to another service.

The EP programs also identified which consumers were diagnosed with a first episode of psychosis (FEP) and which were diagnosed with a clinical-high-risk for psychosis (CHR) syndrome. Programs differ in whether they serve one or both groups. If the designation was unknown, typically due to lack of program data, individuals were classified as FEP if they had documented psychotic disorder diagnoses (see Appendix IV). For the comparison analysis, the LHCN research team then applied the following additional inclusion criteria to harmonize EP samples across counties: 1) age 12-25, 2) FEP, 3) enrolled in the EP program (not assessed and referred out). None of the EP consumers had a diagnosed intellectual disability. We did not exclude any consumers based on substance use disorders.

Comparator Group (CG) Sample Description

The CG group was defined as individuals served in outpatient behavioral health treatment in each county for a first episode of psychosis during the period January 1, 2017 – December 31, 2019. County data analysts identified individuals from the EHR based on the following inclusion criteria: 1) seen in any mental health service between January 1, 2017 – December 31, 2019; 2) age as of first date of service during the study period from January 1, 2017 – December 31, 2019: 12 yrs 0 days – 25 years 355 days; 3) psychotic disorder diagnosis documented January 1, 2017 – December 31, 2019. The eligible diagnoses were based on the psychotic disorder diagnoses accepted by the EP programs, standardized across counties (diagnosis list in Appendix IV). We requested service data for an extended period of time (January 1, 2013 – December 31,

2019) in order to determine that there was no psychotic disorder diagnosis more than two years prior to their index outpatient service during the active study period. The "index service date" was defined as the first outpatient (non-FSP, when possible) service associated with an eligible diagnosis during the active study period (January 1, 2017 – December 31, 2019)

The LHCN research team then applied the following exclusion criteria to the CG group, in accordance with EP program criteria, to identify a cohort most likely experiencing FEP: 1) diagnosis of intellectual disability; 2) psychotic disorder diagnosis more than 2 years prior to the index service date during the active study period (January 1, 2017 – December 31, 2019); 3) first outpatient service during the active study period was a Full Service Partnership (FSP) OR consumer received FSP service in the two years prior to study period.

Data Sources Included in Analysis

Prior reports described a proposed set of outcomes of interest as well as potential data sources for those outcomes and their associated costs. However, as anticipated, limitations in data availability and data quality resulted in modification of the previously described analytic approach in some areas. Table 4 represents the final set of outcomes used in this analysis. All outcomes and data sources included from the methodology proposed in prior reports, as well as any differences between the proposed analysis and current analysis, are described in this section. Descriptions apply to all counties, except as noted.

Table 15. Outcomes

Finalized Outcomes of Interest	Levels of Analysis
Outpatient Services	• Service type • Number of service units (minutes)
Day Services/Crisis Stabilization	• Number/proportion of individuals with crisis visits per group • Number of visits, per consumer, per month • Duration of visit (hours) • Total duration (hours) of all visits, per consumer, per month
24-hour Services: **Psychiatric inpatient hospitalization, Residential**	• Number/proportion of individuals hospitalized per group • Number of hospitalizations per consumer, per month • Duration of hospitalization (days) • Total duration of hospitalizations (days) per consumer, per month

Description of Included Data Sources

Demographic Data

Consumer demographics were obtained from the EHR system from each county, based on the date of the first EP program or outpatient CG program service, when possible. Table 5 shows dates of demographic data used, by county. Demographic data obtained for the analysis includes age, zip code, race and/or ethnicity, sex, gender identity, sexual orientation, language, education level, currently enrolled in school, employment status, marital status, living arrangement, military service/veteran status, and insurance status. In order to account for differences in how these demographics were coded across counties, we harmonized the variables before integrating them into a single dataset. For example, each county had variations in the way they collected race data for consumers, with some counties having collected more detailed information than others. To

accommodate for the varying levels of data collected and enable analysis across counties, a harmonized race variable was created with six main race categories: White, Black/African American, Asian, American Indian/Alaska Native, Native Hawaiian/Other Pacific Islander, and Other. Race data from each county was then re-coded to fit into one of these high-level categories (e.g. 'Korean' would be re-coded as 'Asian') to account for the counties with more limited race data. Details regarding when the demographic variables were originally entered into each county EHR system are shown in Table 16 (below), and which variables were available for each county are described in Table 17.

For this analysis, we required "baseline" demographic data, that is, demographics as of the index service date. Due to differences between counties in collection date of demographic data, as well as likelihood of that particular variable changing over time, the final demographic variables used in this analysis were age, sex, and race/ethnicity.

Table 16: Demographic Data – Dates Used

County	Date used for Demographic Data	
	EP	CG
Los Angeles County	Demographics at first date of service in the program	Demographics at first service during study period (Jan 1, 2017 - Dec 31, 2019)
San Diego County	Demographics collected at first date of service in the program	Demographics at first service during study period (Jan 1, 2017 - Dec 31, 2019)
Orange County	Demographics collected at first date of service in the program	Demographics at first service during study period (Jan 1, 2017 - Dec 31, 2019)
Solano County	Demographics at first date of service in the program but can be updated at any time	Demographics at first service during study period (Jan 1, 2017 - Dec 31, 2019)

Table 17: Demographic Data – Availability by County

Data Element	**Availability by County**	**Additional Details**
Year and month of birth (not date)	SD - yes	
	OC - yes	
	Solano - yes	
	LA - yes	Year and month of birth was not available in the LA CG dataset, but rather, age at first service during the active study period.
Zip code	SD - yes	
	OC - yes	
	Solano - yes	
	LA - yes	LA provided 9-digit zip code; last 4 digits were removed to be consistent with 5-digit format of other counties.
Race	SD - yes	
	OC - yes	
	Solano - yes	
	LA - yes	LA collects race and ethnicity data as a combined variable and had to be re-coded into separate variables for harmonization across counties; endorsements of ethnicity only were re-coded as "unknown" for the harmonized race variable. "Multi" category for LA has been rolled up into "other" for harmonized race variable.

Ethnicity	SD - yes	
	OC - yes	2 items - Hispanic ethnicity and self-reported primary and secondary ethnicity
	Solano - yes	
	LA - yes	LA collects race and ethnicity data as a combined variable and had to be re-coded into separate variables for harmonization across counties.
Education level (highest level obtained)	SD - yes	
	OC - **no**	
	Solano - yes	
	LA - yes	
Education level (currently enrolled)	SD – yes	No "current education" variable across counties so variable was created using employment status variable (those who endorsed 'student' were coded as being currently enrolled in education)
	OC – no	
	Solano – yes	No "current education" variable across counties so variable was created using employment status variable (those who endorsed student were coded as being currently enrolled in education)
	LA – yes	No "current education" variable across counties so variable was created using employment status variable (those who endorsed student were coded as being currently enrolled in education)
Marital status	SD - yes	
	OC - **no**	
	Solano - yes	
	LA - yes	
Primary language	SD - yes	
	OC - yes	
	Solano - yes	
	LA - yes	
Insurance status (i.e., insurance type)	SD - yes	Three separate harmonized insurance variables were created: 1) Medi-Cal, 2) Medicare, 3) Private insurance.
	OC - yes	Three separate harmonized insurance variables were created: 1) Medi-Cal, 2) Medicare, 3) Private insurance.
	Solano - yes	Three separate harmonized insurance variables were created: 1) Medi-Cal, 2) Medicare, 3) Private insurance.
	LA - yes	Three separate harmonized insurance variables were created: 1) Medi-Cal, 2) Medicare, 3) Private insurance. We used the Medi-Cal claim variable from the LA EP services; this was not available for the LA CG datasets.
Employment status	SD - yes	
	OC - **no**	
	Solano - yes	
	LA - yes	
	SD - yes	

Living arrangement (housing status)	OC - yes	
	Solano - yes	
	LA - no	Data not available for EP group, included in CG data only.
Sex	SD - yes	
	OC - **no**	
	Solano - yes	
	LA - yes	
Gender identity	SD - yes	
	OC - yes	Variable for gender only, not gender identity. No trans category; only Male and Female. Therefore, some individuals in Male or Female category may be Transgender.
	Solano - yes	
	LA - **no**	
Sexual orientation	SD - yes	Intersex and transgender have been placed in the 'unknown' category as these are not sexual orientations. Deferred has been placed in prefer not to answer.
	OC - yes	
	Solano - yes	
	LA - **no**	
Military service / Veteran status	SD - yes	Indicates some affiliation with the military, does not necessarily indicate military status (e.g. Consumer self-reports that they or an immediate family member have served in the US Military).
	OC - yes	Indicates some affiliation with the military, does not necessarily indicate military status (e.g. Consumer self-reports that they or an immediate family member have served in the US Military).
	Solano - yes	Indicates some affiliation with the military, does not necessarily indicate military status (e.g. Consumer self-reports that they or an immediate family member have served in the US Military).
	LA - **no**	

Psychiatric Diagnoses

Baseline psychiatric diagnoses were obtained from the EHR systems for each county. They were selected as either the first diagnoses within the first 90 days a consumer was served after the index service date or the latest diagnosis before the index service date if no post-90-day diagnosis was found. Index diagnoses for FEP consumers in EP groups, and all CG group consumers were defined as either a primary psychotic disorder diagnosis or mood disorder with psychotic features, with other diagnoses possible for CHR consumers in EP groups (e.g. PTSD, anxiety disorders, autism), using an algorithm described in Appendix IV. As noted previously, classification of FEP and CHR were obtained from the EP programs. Service Dates

As described previously, we defined the index service date for individuals in the EP group as the first date of service at the EP program within the study period (January 1, 2017 – December 31, 2019). The index service date for individuals in the CG group was defined as the first date of outpatient service (non-FSP, when possible) associated with an eligible diagnosis within the study period (January 1, 2017 – December 31, 2019). The "last service date" was defined as the end of the episode of care related to the index service date. If the

episode of care start or end date was outside the active study period, the first or last service within the study period was used, respectively. The “duration of enrollment” was calculated as months between index and last service dates.

A unique feature of EP programs is their limited duration: most programs offer services for a maximum period of approximately 2 years. This focus on early intervention supports transitioning consumers to other services after a specific period of time and/or after treatment goals are met. It also allows new consumers to enter the program as others leave. General outpatient services have no limits on duration of treatment. Therefore, our analyses focus on the first 24 months of treatment for both groups. To account for variation in intensity of services and attrition over time, we defined service periods as index service date to 6 months, 7-12 months, 13-18 months, 19-24 months and 25 months+ (until last service date).

Outpatient Service Data
All contacts related to outpatient mental health services are recorded as part of the reimbursement process via service billing in each county. Clinical staff input all billable and non-billable services into the EHR systems through an electronic progress note that includes the date of service, type of service provided (defined by each county), and the time spent providing the service.

Billable service types examined include: Assessment, Case Management, Collateral, Crisis Intervention, Group Therapy, Individual Therapy, Medication Management, Plan Development, Rehabilitation, Supported Education and Employment services, Therapeutic Behavioral Services, Occupational Therapy, Peer Support, Administrative, Outreach, and Forensic, Lock Out, and Travel/Transportation.

Non-billable services were also compared as work conducted and no-show rates as indicators of engagement (see descriptions of all services in Appendix VI). Availability of service categories by county are detailed in Table 18.

Day Services/Crisis Stabilization Data
Individuals experiencing mental health exacerbation often receive treatment in mental health urgent care or crisis stabilization facilities, which are intended to resolve the mental health crisis and attempt to prevent hospitalization. All Day Services (under 24 hours) and Crisis Stabilization data utilized in the analysis includes: Crisis Stabilization, Day Treatment, and Day Rehabilitation. Data elements used in the analysis include: number of visits per individual in the sample, date of visit, and length of stay (hours).

24-Hour Services/Inpatient Psychiatric Hospitalization Data
Individuals experiencing more severe mental health exacerbation often receive treatment in inpatient psychiatric hospital settings. This includes California Welfare and Institutions Code §5150/§5585 72-hour involuntary psychiatric holds for adults and minors, respectively, and §5250 14-day involuntary psychiatric holds, the duration of which can vary depending on the severity of the individual’s needs, as well as all voluntary stays. All 24-hour services used in this analysis include: Inpatient Hospitalization, Residential Other, and Crisis Residential. We were able to obtain non-comprehensive services data from some private hospitals that bill the county, with the exception of Orange County, which submitted cost data for regional inpatient hospitalization. For 24-hour service data, data elements include number of visits per individual in the sample, dates of hospitalization, and length of stay.

Details regarding which services were available by county are shown in Table 7 below.

Table 18: Availability of services data by county

Broad Service Category	Service Subcategory	Los Angeles	San Diego	Orange	Solano

Outpatient Services (Mode 15)	Assessment	yes	yes	yes	yes
	Case Management	yes	yes	yes	yes
	Collateral	yes	yes	yes	yes
	Crisis Intervention	yes	yes	yes	yes
	Group Therapy	yes	yes	yes	yes
	Individual Therapy	yes	yes	yes	yes
	Medication Management	yes	yes	yes	yes
	Plan Development	yes	yes	**no**	yes
	Rehabilitation	yes	yes	yes	yes
	Supported Education and Employment	yes	**no**	**no**	**no**
	Therapeutic Behavioral Services	yes	**no**	yes	yes
	Occupational Therapy	**no**	**no**	**no**	**no**
	Peer Support	**no**	**no**	**no**	**no**
	Administrative	**no**	yes	yes	yes
	Outreach	**no**	yes	**no**	**no**
	Forensic Services	**no**	yes	**no**	**no**
	No Show	**no**	**no**	**no**	yes
	Lock Out Code	**no**	**no**	**no**	yes
	Transportation	**no**	yes	yes	yes
	Intensive Home-Based Services	yes	yes	yes	yes
	ECT	**no**	yes	**no**	**no**
	Outpatient – other	yes	**no**	**no**	**no**
Day Services (Mode 10)	Crisis Stabilization	**no**	yes	yes	yes
	Urgent Care	**no**	**no**	**no**	**no**
	Day Treatment	yes	yes	**no**	yes
	Day Rehabilitation	**no**	yes	**no**	**no**
	Day Services - other	yes	**no**	**no**	**no**
24-hour Services (Mode 5)	Inpatient Hospital	yes	yes	yes	**no**
	Residential Other	**no**	**no**	yes	yes
	Residential Rehabilitation	**no**	**no**	**no**	**no**
	Skilled Nursing Facility (SNF)	**no**	**no**	**no**	**no**
	Crisis Residential	**no**	yes	yes	yes

Other Mental Health Services

Other mental health services include Substance Use Services for Orange County, and any services that had insufficient information to classify into one of the other three categories. For example, some outpatient services provided by private organizations used codes indicating “Other mental health service” and a provider name. However, there were very few of these, and their impact on the analyses would be negligible. We will explore further during the next project period to see if we can resolve and services in this category.

Description of Unavailable Data Sources

Justice system and Regional Center services were unavailable for all counties. With the exception of Orange County, substance use services could not be obtained, as these records are kept separately from mental health services for privacy protection and require additional data use permissions.

Many consumers have hospital stays in private psychiatric hospitals both within and outside of their county of residence. Some counties track this data in separate databases, but we were unable to obtain and integrate this separate data for the current analysis. Furthermore, due to lack of available psychiatric inpatient beds across California, particularly for children, many consumers are placed out of county and require transportation over extensive distances that may not be adequately captured in our data.

Although the majority of EP consumers are publicly insured (e.g., Medi-Cal), San Diego Kickstart and Solano Aldea SOAR utilize MHSA, insurance contracts, and/or philanthropic funds to serve privately insured consumers. Some of these services are not billed to county systems, therefore, they are not represented in our data. Furthermore, services provided to privately insured consumers by other private providers (e.g., Kaiser Psychiatry) are not represented.

Table 7 summarizes individual subcategories of services that were unavailable for specific counties. This was due to either 1) lack of a specific type of service in that county; 2) service data being unable to specifically denote that service; 3) data for those services needing to be obtained separately and we could not yet do so, or 4) certain non-billed services not being tracked.

Statistical Methods

Multi-County Analysis
After harmonizing the demographics, diagnoses, and service types across all four counties, as well as EP and CG groups, the data were merged into a single dataset for our primary analyses. This combined, multi-county dataset provided increased statistical power, allowing for a richer set of controls and error structure without compromising efficiency.

Analysis of Sample Characteristics
Student T-tests and Pearson Chi-square (or Fisher's exact) tests were used to compare unadjusted group differences in demographic characteristics (e.g., age, sex, race, ethnicity, etc.) between the individuals in the EP and CG groups. Both unadjusted and adjusted analyses were used to examine group differences in clinical characteristics at time of index service such as primary diagnosis, as well as the duration of enrollment.

Analysis of Outpatient Service, Day Service/Crisis Stabilization, and 24-Hour/ Inpatient Psychiatric Hospitalization Data
All service data outcomes were analyzed with a simple empirical equation: the independent variable is regressed on a county-specific fixed effect, an epoch-specific fixed effect, an indicator taking 1 for the EP group and 0 otherwise, a set of interactions between the EP group indicator and each epoch allowing the effect of the EP program to vary over time, and a set of individual-specific controls - measured at intake - consisting of sex, ethnicity, race, and primary language. We used all demographic variables that were available and harmonized across all counties in time for this preliminary analysis. Standard errors were always clustered at the individual-level because repeated measures of the same outcome for the same individual are correlated, and we are interested in describing individual-level differences. Further processing of the data will allow the addition of other individual-specific controls and clinic-specific effects to the empirical equation to account for other sources of confounding variation. These will be included in future analyses.

Total outpatient service time (in minutes) of all outpatient services and total minutes of each service type (e.g., medication management, individual therapy, group therapy, rehab services) were analyzed by estimating the

empirical equation described above with negative binomial regression for count data to determine if outpatient service use differs between the EP and CG samples.

Data related to individuals' use of Day Service/Crisis Stabilization, and 24-Hour/ Inpatient Psychiatric Hospitalization Data usage were examined using multiple measurements based on the study period: 1) a binary indicator for whether the individual had ever been hospitalized; 2) a binary indicator for whether the individual had ever utilized crisis services; 3) number of hospitalizations per month; 4) number of crisis visits per month; and 5) mean duration of hospitalizations (i.e., length of stay [LOS]) in days; 6) mean LOS for Day/Crisis services (hours); 7) total duration of hospitalizations per month; and 8) total duration of Day/crisis services per month. Data for (1) and (2) were analyzed by estimating the empirical equation described above with multiple logistic regression. Data for (3), (4), (7), and (8) were analyzed by estimating the empirical equation described above with negative binomial regression for count data. Data for (5) and (6) were analyzed by estimating the empirical equation described above with linear regression. These various methods allowed us to determine whether each respective outcome differed between the EP and CG samples.

Results

The final cohort includes a sample of 506 individuals served by EP programs and 17,092 individuals from the CG group.

Clinical and Demographic Characteristics

Table 10 (Appendix V) summarizes baseline diagnostic and demographic information for the individuals from the EP and CG cohorts.

The EP sample had an average age of 17.0 years (standard deviation [SD] = 3.1 years), 59% of whom identified as male. Of those receiving treatment in the CG group, the mean age was 20.1 (SD=3.8 years), and 61% of them identified as male. The average age of CG individuals was significantly older than the average age of EP individuals in this sample (p<.001). No statistical difference in the distribution of sex was found.

The EP group included a significantly higher number of individuals who identified as Hispanic/Latino (56%) compared to the proportion of individuals from the CG clinics (44%, p<.001). In addition, a higher percentage of EP individuals identified as Caucasian (27%) compared to CG individuals (17%). However, a majority of CG individuals reported Unknown race (54%).

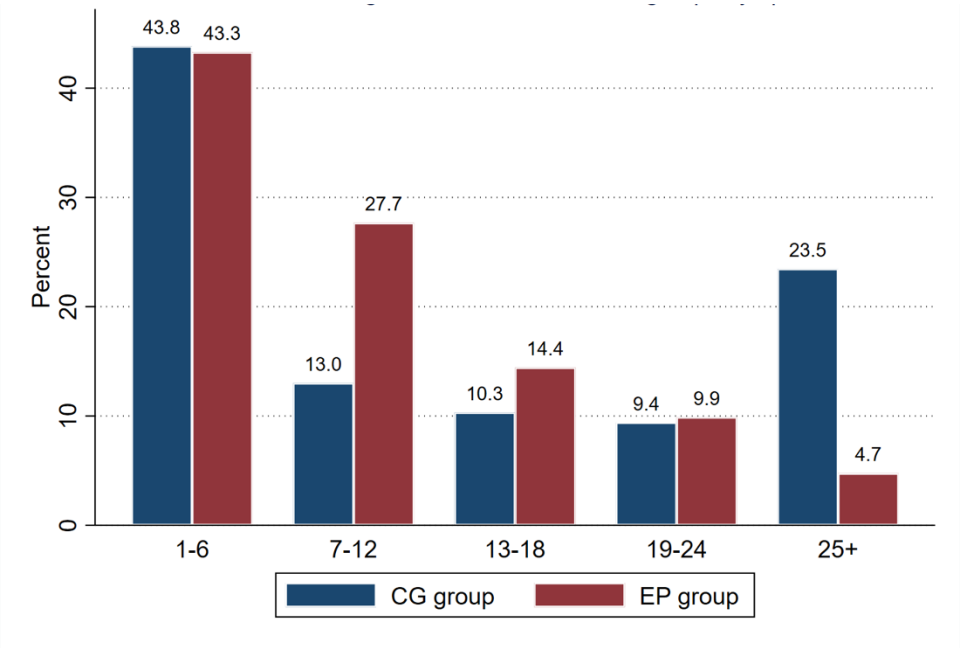
A higher proportion of individuals in the EP group had a Psychosis Spectrum disorder as the primary index diagnostic category compared to the CG group (EP Group: 80%; CG Group: 61%, p<.001). For both groups, Mood Spectrum disorders represented a smaller proportion of the primary diagnoses (EP Group: 6%; CG Group: 21%).

Service Utilization Characteristics

Duration of Enrollment

On average, individuals receiving treatment in both groups tended to remain in treatment for roughly one year (EP group: 11.1 months [SD=9.1], CG group: 12.2 months [SD=12.3]), but average duration of treatment was significantly higher for CG individuals (p<.05).

Figure 20. Percentage of consumers ending treatment within each time period



As shown in Figure 20, a roughly equal proportion of EP and CG individuals ended treatment within the first 6 months (43% and 44%, respectively). A greater proportion of EP individuals ended treatment between 7 and 12 months compared to CG consumers (28% vs. 13%, respectively). However, compared to EP individuals, a larger proportion of CG individuals ended treatment after they had received over 25 months of services (5% vs. 24%, respectively). For more information on differences in enrollment, see Appendix V – Table 20.

Outpatient Service Use

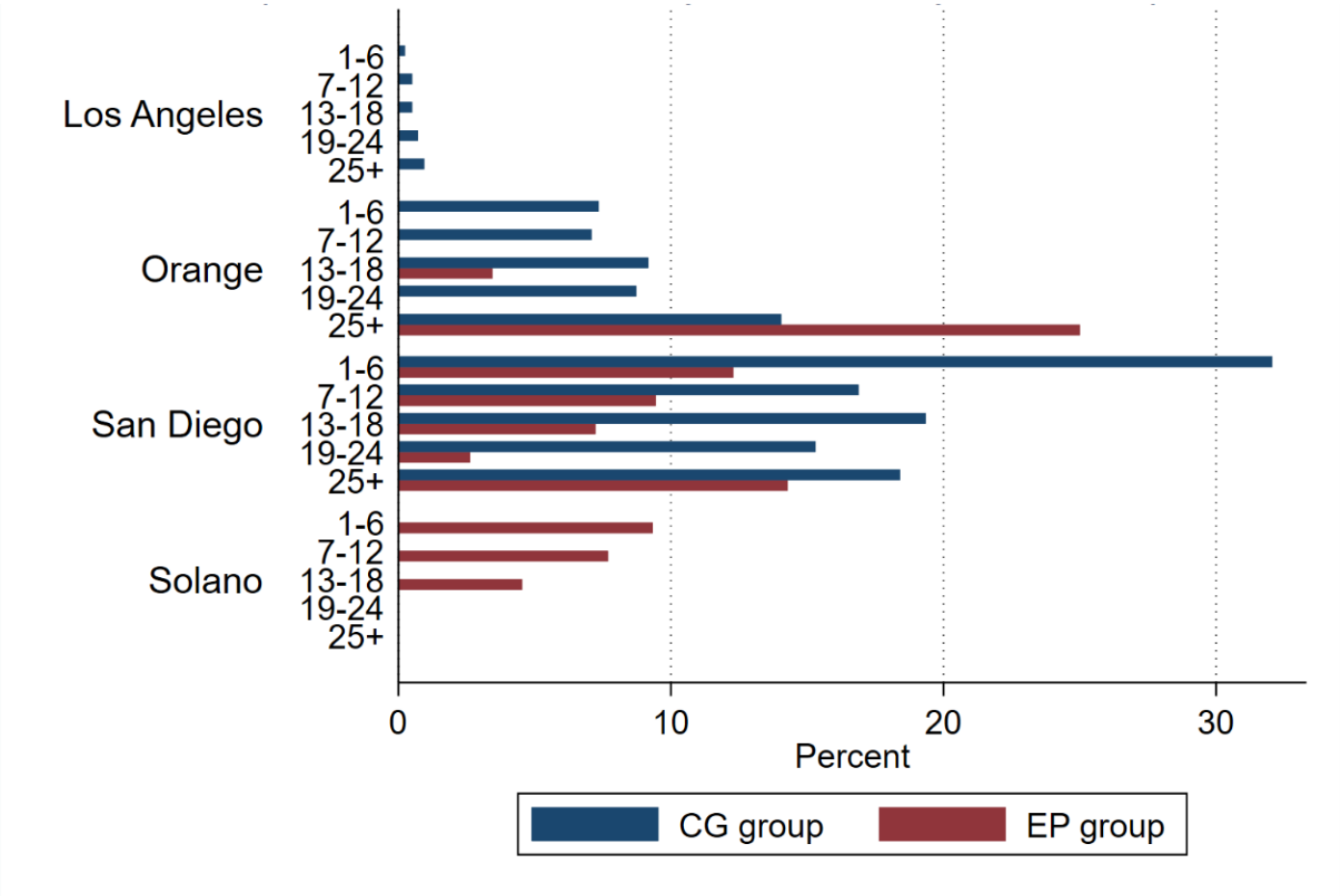
The EP and CG clinics offered similar types of outpatient services, including assessment, case management, collateral, crisis intervention, group therapy, individual therapy, medication support, plan development, and rehabilitation (see Appendix VI Service Code Definitions for descriptions of these services).

In examining the total minutes of outpatient services provided to individuals per month, those served in the EP group received significantly more minutes of service across all time points compared to the CG group (p<.001, see Appendix V – Tables 21A and 21B). When specific services are examined individually, the greatest difference is observed between groups in minutes of collateral, per person, per month (EP group: 140 minutes; CG group: 66 minutes) and individual therapy (EP group: 239 minutes; CG group: 188 minutes) per person.

Day Services

The use of day services was rare for both groups, as only 2.0% of EP and 4.7% of CG individuals received these services while enrolled in EP or general outpatient treatment (see Appendix V – Table 22). Calculated as the proportion of individuals with one or more visits, use of day services was greater in the CG group across all time points (p<.001). Further, the rate of day service visits was the highest among individuals that had been enrolled in treatment for 25 months or more (EP group: 3.3%; CG group: 5.7%, see Figure 21).

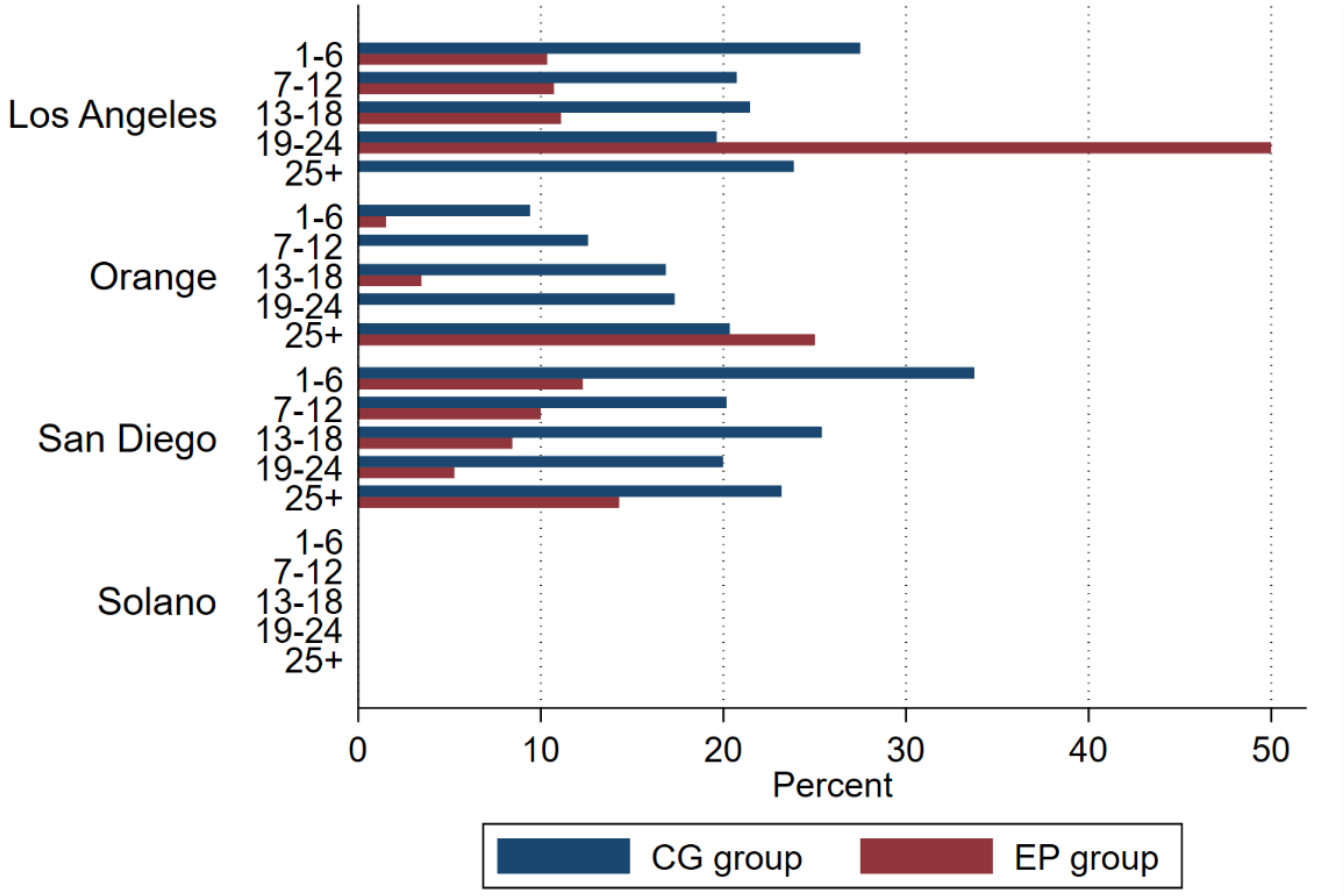
Figure 21. Proportion of consumers with at least one day service visit by time period by county



24-Hour Services/Inpatient Psychiatric Hospitalization Data

A significantly greater proportion of CG individuals experienced at least one 24-hour service or inpatient hospitalization during their enrollment compared to EP individuals (22.4% vs. 8.9%, $p<.001$; see Appendix V – Table 23). As shown in Figure 12, 24-hour services occurred most frequently during the first 6 months of treatment (EP group: 9.4%; CG group: 24.8%) and after 25 months of treatment (EP group: 17.0%; CG group: 23.7%), although we did not test these differences statistically. As noted previously, this data was unavailable for Solano County.

Figure 22. Proportion of consumers with at least one 24-hour service by time period by county



NOTE: Data not available for Solano County

Summary

Across all time periods, the total minutes of outpatient services per month was higher among EP individuals compared to CG individuals. However, the proportion of individuals in the EP group with one or more day services and/or 24-hour services/ inpatient hospitalizations was lower compared to the CG group.

Interpretations

Regarding duration of enrollment in treatment, the EP and CG groups are generally similar, with more EP consumers receiving 7-12 months of service, and the CG group having a substantial proportion of consumers who received longer-term treatment (25+ months), past the standard end-point of EP treatment at 24 months. In both groups, nearly half of the consumers received services for less than 6 months, which may represent challenges in engagement with this population, as well as the mobility of TAY youth, who may also have received services elsewhere.

The groups were both predominantly male, as is often typical in early psychosis clinical samples. There was a slightly older average age in the CG group, and more Hispanic/Latino consumers and Caucasian consumers in the EP group. This may reflect the focus of programs on outreach and staffing availability predominantly in English and Spanish. They identified as predominantly heterosexual across both groups. The results of this preliminary analysis are consistent with the intent of EP programs- to offer more intensive and evidence-based outpatient services in order to reduce the need for higher levels of care and to promote recovery. This is evident in the higher overall outpatient minutes for the EP group. Greater time spent in individual therapy likely

reflects the treatment models of the EP programs, which focus on CBT for psychosis or other similar forms of therapy. EP programs make a concerted effort to involve families of these transition age youth, reflected in the results of more collateral services than the CG group.

Similarly, the significantly greater proportion of CG individuals who had inpatient hospitalizations during the study period may demonstrate the effectiveness of early intervention in reducing hospitalization rates. Day services were so rare in both groups that we only analyzed the proportion of individuals with at least one service. Overall, these group differences are quite promising, although at this time, we cannot rule out differences in severity and needs between the EP and CG groups at baseline that could partly or fully explain the service utilization differences. As noted previously, access to hospitalization data may have been limited (e.g., by treatment outside county); however, these issues should have affected the EP and CG groups in a county similarly.

Limitations and Future Analyses

The primary goal of the current deliverable was to demonstrate the availability of service utilization and cost data that can be accessed and integrated across counties. Through this process, we identified a number of issues that require additional clarification for the final analysis. We will focus on these issues during the next project period:

Defining CG consumers

Identifying an equivalent comparison group relies upon identifying similar individuals to EP consumers. Given the lack of the CHR syndrome as a formal DSM or ICD diagnosis, we are unable to identify CHRs for comparison. Restricting our analysis to “first episode” psychosis, we were able to exclude CG individuals with recorded psychotic disorder diagnoses for more than 2 years prior to out active service period (the most common eligibility requirement for the EP programs). However, this does not rule out individuals who had psychosis but were not accurately diagnosed as such in health records. Due to factors such as the complexity of early psychosis diagnoses, lack of information about symptoms over time, and provider hesitance related to stigma about psychosis and serious mental illness, FEP consumers are often only diagnosed with a psychotic disorder in records after a substantial period of time with psychosis. Less stigmatizing disorders such as bipolar disorder, or those that represent only current symptoms, such as substance-induced psychosis are often used instead. Further, consumers who recently entered the county system, but were treated for psychosis outside the county prior to the service period, may not be appropriately excluded. Finally, as we explore comparisons of baseline characteristics of EP and CG consumers, we may use propensity score matching or a similar method in our final analysis.

Defining CG services

We attempted to compare services in specialized EP programs to usual outpatient care, or “treatment as usual.” These services vary greatly across counties and across child and adult systems of care, so that we may have inadvertently included other specialized programs that offer more intensive services as well. Finally, consumers were not randomized to treatment, so there may be systematic biases that influence whether consumers received services at the EP program or elsewhere that we cannot see in the data we obtained. We excluded CG consumers who were treated in FSPs for this reason, but we were only able to accurately identify all FSP programs in our data in San Diego and Orange Counties. This will be a focus of our work during the next project period.

Inpatient services

Our preliminary analysis only includes inpatient data for county hospitals and some private hospitals that bill the counties. Some counties maintain separate databases of inpatient hospitalizations, which we expect to receive in time for the final analysis.

Private insurance services
Some EP programs serve all residents of the county, regardless of insurance. This may include individuals who have private insurance, and therefore services outside the EP program would be within a private insurance or HMO network, which cannot be included in these data. We will work with programs and counties to make sure we are accurately identifying these individuals and may need to exclude them form the final analysis.

Non-billable services
In future analyses, we plan to analyze no-show and cancellation rates as measures of treatment engagement.

Missing service categories
Although there were very few services that could not be categorized, we will follow up to obtain additional information about either subcategories for which we have no services in a county or specific services that lack sufficient detail. We will also investigate additional sources of data to determine whether more day services and 24 hour services can be integrated into our dataset. We may limit the analysis where there remain discrepancies in availability of specific service types by county or by group.

Demographic factors
Due to time constraints, we were only able to fully harmonize and analyze a subset of demographic variables. For the next deliverable, we will examine the relationship of more demographic factors to our outcomes, including: sexual orientation, language, education level, employment status, marital status, housing status, military service/veteran status, foster care status, insurance status and zip code. We will also determine which values represent true "baseline" characteristics, and which may be outcomes, recorded at later time points in treatment.

Fiscal year
In the next period we will explore fiscal year as a factor impacting outcomes, given changes over time in both service categorization and reimbursement.

Description of Sources of Cost Data
The costs associated with each service type were requested from each county. For the purposes of this report, we will describe the cost data obtained thus far. Comparison of costs associated with service utilization in the EP and CG groups will be analyzed once all cost data have been received by the study team. Potential sources of cost data were identified for specific service types, as described in Table 9, below.

Table 9. Sources of Cost Data by Service Type

Service Type	Included Sources of Cost Data
Outpatient	Contract service unit rates
Day/Crisis Stabilization	Hourly rate paid by County
24-hour: Inpatient, Residential	Daily rate paid by County Daily rate Medi-Cal reimbursement Harmonized Average Statewide Rate

Los Angeles and Orange County were able to submit their cost data to the study team prior to the completion of this report. San Diego County provided several tables of cost rates for services; however, after review of the

submitted data, a revised cost data request was sent to the county seeking final costs attached to each service. Because final cost data from San Diego County are still pending, the present report describes the data sources that were received. Solano County also experienced delays in obtaining and submitting their cost data. Delays included more complex data sources and lack of IT support staff available to the county data analysts to be able to pull the requested data. Final details of specific cost data sources for San Diego and Solano County will also be included in the next deliverable.

Los Angeles County
Outpatient Service Use: Los Angeles County costs rates were attached to each service and included all service types. For outpatient services each cost rate was the total cost of the service and the service unit (recorded in minutes).

Day Services/Crisis Stabilization Data: Costs related to day services included total cost of the service and the service unit (recorded in minutes).

24-Hour Services/Inpatient Psychiatric Hospitalization Data: Costs related to 24-hour services include inpatient county hospitals, Fee-for-Service hospitals and County contracted providers. These costs include total cost of the service and cost per service unit (recorded in days).

Orange County

Outpatient Service Use: Costs related to outpatient service use were based on contract service rates. Each outpatient service included a service unit rate and number of service units (in minutes).

Day Services/Crisis Stabilization Data: Costs related to day services/crisis stabilization were based on contract service rates which included a service unit rate and number of service units (in minutes).

24-Hour Services/Inpatient Psychiatric Hospitalization Data: Costs related to 24-hour services were day rates which varied by contract. Inpatient/hospital stays include negotiated bed day rate for each HCA contracted acute inpatient facility. These rates are different from the general regional rates set by DHCS. Skilled Nursing Facility (SNF)/IMD rates were averaged and include a bed day rate. Crisis Residential rates include a day rate and charge for the medical services by the minute.

San Diego County
Outpatient Service Use: County interim cost rates for outpatient services per service unit (15 minutes, bill in one-minute increments). Published reimbursable cost rates and actual reimbursable cost rates for EP community services, including case management, mental health services, medication support, and crisis intervention.

Day Services/Crisis Stabilization Data: County interim rates for day services/crisis stabilization per service unit (in hours).

24-Hour Services/Inpatient Psychiatric Hospitalization Data: County interim rates per service unit (in days) for inpatient/hospital stays, crisis residential, and therapeutic foster care. Contracted inpatient hospital rates for adult and adolescent services, effective February 1, 2020. Regional rate, effective July 1, 2021, for non-contracted inpatient hospitals.

Statewide Sources of Cost Data
Across California, psychiatric inpatient beds are often unavailable, particularly for minors. Patients are placed at both county-run and private hospitals, in or out of county. Each county negotiates different day rates with each hospital. Due to this variability, we will use multiple sources of data to develop averaged rates statewide.

We will apply these cost rates to inpatient service utilization for both the EP and CG groups, across counties. Once we are able to review the day rates for residential services in each county, we may use the same harmonization method.

Discussion and Next Steps

Discussion

Over this last FY, the team has continued to work hard to meet each of the goals that were set to out for the project period. It should be noted that the LHCN represents one of the first collaborative university-county partnerships between the University of California, Davis, San Diego and San Francisco with multiple California counties to implement and expand an integrated Innovation project. Through this endeavor, all parties hope to have a larger impact on mental health services than any one county can create on their own. While the project has experienced some delays and many barriers due to the global COVID-19 pandemic, we are confident that we are making excellent progress at meeting our goals and catching up with the original planned timeline.

We have completed Beehive training with all of the original LHCN counties and are in the midst of training our newest LHCN county program, Stanislaus LIFE Path. We are continuing to collect data on the core outcomes battery for the EPI-CAL project with 18 programs. Based on feedback from users in these programs, we have continued to work with Beehive developers to make modifications to the application, such as extending survey windows, as well as modify our training approach based on constructive feedback from programs.

We have completed several fidelity assessments, and plan to complete those for all of our programs within the next few months. The next annual report will summarize the results from all participating programs.

As noted previously, we were able to successfully complete our primary goal for the retrospective county data analysis, to provide a preliminary demonstration of the proposed method for accessing data regarding EP programs and CG groups across California, and the first part of our secondary goal, to analyze service utilization and costs associated with those services across counties. However, we are still gathering additional data to inform a final analysis of the 2017-2019 period, which we expect to complete by December 2022.

While we were not able to integrate the cost data for all counties, we have described our cost analysis for San Diego County in section 9 above. We have obtained some cost data and are working with our county partners to obtain the remaining information. We are confident that the cost comparison analysis will be completed for the December 2022 deliverable.

Next Steps

In the next project period, we will continue to conduct fidelity assessments with EPI-CAL programs and meet with county and program leadership to provide detailed feedback on fidelity results. We will also continue and complete training of EP programs from both the LHCN and larger EPI-CAL network, especially as new programs join. As implementation of Beehive continues, we will elicit feedback from EP programs how to improve both the training process and Beehive itself via feedback surveys, regular check-ins from point people, and qualitative interviews. Our goal is to continue to improve Beehive in an iterative process and to incorporate community partner feedback so that Beehive be a useful data collection and visualization tool for the programs using it. We are also working with sites to understand why enrollments are not matching the original projections and to support them to increase the degree to which they are integrating Beehive into their standard practice.

Over the next project period, the LHCN team expects to receive and review data for both EP program and CG consumers and their service utilization data from Napa and Stanislaus counties for the retrospective data period January 1st, 2017 – December 31st, 2019. Upon receiving the data, we will review the submitted datasets and problem-solve with counties regarding any missing data elements, particularly other mental

health services received by EP program consumers, which may need to be retrieved from different sources. We will harmonize these data with the prior counties' and integrate them into the final dataset. We will also be requesting all related cost data for the services received by consumers in the EP programs and CG groups from Napa and Stanislaus counties.

In addition, for all counties participating in the county data component of the LHCN, meetings will be scheduled over the next several months with each county to review the details of the EP and CG retrospective data pulls, the cost data, and to problem-solve any issues that arise. We will then conduct the statistical analyses for individual counties and across the integrated dataset. In anticipation of the prospective data analysis, we have met with each county to discuss the timeline for obtaining their data and details of what will be included in the data pull. We will submit the formal data extraction requests in writing in July 2022, after we complete meetings with all relevant parties.

Another major goal of the next project period is to develop the final analysis plan for all LHCN data, with a particular focus on the consumer outcomes data collected via Beehive. This will integrate results from the fidelity assessments.

Appendix I: Intake Workflow Meeting Template

Our goal for this meeting: understand your intake workflow to help make transition to using Beehive at intakes smoother. Today we are focusing on how to integrate Beehive into your workflow, but remember (once Beehive is approved for use), you can also register existing consumers.

Questions

a. Current Intake process
    i. What is program's general intake workflow?
        1. Do you do phone screenings before scheduling an intake? (review template of phone screen to compare with Beehive registration fields)
        2. Do you currently have consumers complete surveys/paperwork with the intake appointment?
            i. Treatment consent, research consent, ROIs?
            ii. How are surveys administered?
            iii. When surveys they sent (e.g., prior to intake date, morning of intake date)?
        3. At what stage in the process do you register consumers into the Electronic Health Record
        4. How do you complete assessments or other paperwork for people who are in need of interpretive services?
b. Integration of Beehive
    i. At what stage in the workflow would Beehive registration fit best?/When would you register consumers into Beehive (takes about 15 minutes)
        1. In advance (Web app)? Is all of the information in registration already gathered? (see phone screen)
        2. Day of (tablet)?
    ii. Which staff member(s) will complete registration?
    iii. When would consumer complete the intake surveys (EPI-CAL battery takes about 45 minutes)?
        1. Do clinicians plan to use survey data as part of their intake assessment?
        2. Consider prioritization of surveys required for intake assessment
    iv. Which staff member(s) will orient consumer to EULA/surveys on intake day?

(As needed) demonstration of registration process

Appendix II: Data-Entry Workflow Meeting

1. **Questions to Understand Current Clinic Data** *(can skip if already asked at Intake Workflow meeting)*

    1. Is clinic already using a data-entry platform?
        i. If so what? (excel, EMR, redcap, in-house platform (ex. MHOMS)
        ii. Who designs the surveys on that platform?
        iii. Do you first enter data on a CRF prior to entry in this system?
    2. What roles on team currently complete data-entry? (QM, Clinic Coordinator, Clinicians)
    3. How do you access/view data after it is entered?
    4. Does your program have dedicated staff to analyze data?

2. **Questions about Integration of Beehive for Survey Completion**

    a. Who will be responsible for each of these items (one person? Each clinician for their caseload? Leadership?):
        i. Following up with consumers about completing their surveys?
        ii. Entering clinician-entered data for each consumer?
        iii. Monitoring urgent clinical issues? (our recommendation is that each clinician monitors their caseload)
    b. What level of support do you want with tracking survey completion (consumers & clinicians) and urgent clinical issues?
    c. Are there other surveys that your clinic wants to collect through Beehive?
        i. Standardized measures that are already built in: PSC-35, CATS-Guardian report
        ii. Other measures can also be entered-- our team needs to review first to ensure that we can design the surveys in Beehive
    d. Who is assessing COMPASS & GFS/GFR? Who is monitoring ACES to determine if additional survey should be assigned?
        i. We will want to make sure that they have completed the trainings for these trainings

Demonstration on how to access clinician-entered data, view survey status page (for consumer & PSP) as necessary

Appendix III: Beehive Part 3 Training Small-Group Worksheet

Beehive Part 3 Training Small Group

Identify a group note-taker and a person who will report back to the larger group

Survey 1 *(Identify a member of your group to screen share survey 1)*

1. Find one of the 3 measures we have introduced to you in trainings: **Modified Colorado Symptom Index** (MCSI), **Questionnaire on the Process of Recovery** (QPR), or **SCORE Index of Family Functioning and Change** (SCORE-15). Next answer the following questions about that survey:
    a. What is the global score?
    b. Is there a clinical threshold?
    c. Is there score severity shading? In which direction? What does that mean?
    d. Is the global score above or below the threshold? What does that mean?
    e. Which is the highest rated individual item(s)? What does that mean?
    f. Which is the lowest rated individual item(s)? What does that mean?

2. Discussion Questions
    a. How might you use this information in care?
    b. Are the survey responses consistent with your knowledge of the consumer's experiences?
    c. What questions do you have after viewing these surveys?

Survey 2-3 *(Identify a new member of your group to screen share survey(s) 2-3)*

3. Reference the Table of Contents for the EPI-CAL battery (next page). Find one to two additional surveys that you are interested in or that might answer the questions you have from the first survey.
    a. Is there a global score? (i.e. is this survey visualized?). If yes,
        i. Is there a clinical threshold?
        ii. Is there score severity shading? In which direction? What does that mean?
        iii. Is the global score above or below the threshold? What does that mean?
        iv. Which is the highest rated individual item(s)? What does that mean?
        v. Which is the lowest rated individual item(s)? What does that mean?
    b. If there is no visualization, remember you can view the survey responses by clicking the "survey results" button at the top left of the page

4. Discussion Questions
    a. How might you use this information in care?
    b. Are the survey responses consistent with your knowledge of the consumer's experiences?

5. Additional Discussion Questions
    a. Does either survey help you understand the other survey better?
    b. Think about the different roles in the clinic and how they might use this data differently
        i. How might a family advocate or peer partner use this information compared to a clinician?
        ii. How might a prescriber use this information compared to a case manager?

Appendix IV. Algorithm Used to Determine Index FEP Diagnoses

1. If present, the psychotic disorders listed below will always be the index diagnosis:

    - F20.0 Paranoid schizophrenia (ICD 9: 295.12)
    - F20.3 Undifferentiated schizophrenia (ICD 9: 295.15)
    - F20.81 Schizophreniform disorder (ICD 9: 295.21)
    - F20.9 Schizophrenia (ICD 9: 295.23)
    - F22 Delusional disorders (ICD 9: 295.25)
    - F23 Brief psychotic disorder (ICD 9: 295.30)
    - F25.0 Schizoaffective disorder, bipolar type (ICD 9: 295.32)
    - F25.1 Schizoaffective disorder (ICD 9: 295.33)
    - F25.9 Schizoaffective disorder, unspecified (ICD 9: 295.35)
    - F28 Other psychotic disorder not due to a substance or known physiological condition (ICD 9: 295.40)
    - F29 Unspecified psychosis not due to a substance or known physiological condition (ICD 9: 295.41)

2. If no psychotic disorder is present, these mood disorders with psychotic features will be the index diagnosis

    - F31.64 Bipolar disorder, current episode mixed, severe, with psychotic features (ICD 9: 295.82)
    - F31.5 Bipolar disorder, current episode depressed, severe, with psychotic features (ICD 9: 295.73)
    - F31.2 Bipolar disorder, current episode manic severe with psychotic features (ICD 9: 295.64)
    - F33.3 Major depression with psychotic features (ICD 9: 296.20)
    - F32.3 Major depressive disorder, single episode, severe with psychotic features (ICD 9: 296.06)

Appendix V. Cost and Utilization Data From Preliminary Multi-County Integrated Evaluation

Demographic Characteristics

Table 18. Demographics of Individuals included in Analysis

	Early Psychosis (N=506)		Comparator Group (N=17,092)			
	n	%	n	%	X^2	p-value
Sex						
Male	300	59%	10,345	61%	2.04	0.564
Female	206	41%	6,672	39%		
Other	-	0%	46	<1%		
Unknown	-	0%	7	<1%		
Gender Identity						
Male	288	57%	9,783	60%	407.99	<.001
Female	185	37%	6,391	39%		
Transgender	3	<1%	61	<1%		
Other	10	2%	33	<1%		
Prefer not to Answer	2	<1%	11	<1%		
Unknown	15	3%	6	<1%		
Sexual Orientation						
Heterosexual	232	69%	2,624	68%	51.40	<.001
Gay/ Lesbian	9	3%	86	2%		
Bisexual	31	9%	109	3%		
Other	16	5%	116	3%		
Prefer not to Answer	17	5%	324	8%		
Unknown	32	9%	577	15%		
Ethnicity						
No - Not Hispanic/Latino	205	41%	9,426	55%	62.57	<.001
Yes - Hispanic/Latino	285	56%	7,507	44%		
Unknown	16	3%	153	1%		
Race						
White	137	27%	2,894	17%	356.83	<.001
Black/African American	67	13%	2,791	16%		
Asian	32	6%	627	4%		
American Indian/Native Alaskan	4	1%	114	1%		
Native Hawaiian/Other Pacific Islander	4	1%	114	1%		
Other	140	28%	1,328	8%		
Unknown	122	24%	9,208	54%		
Language						
English	448	89%	14,361	89%	1.42	.702
Spanish	47	9%	1,463	9%		

Other	8	2%	292	2%		
Unknown	1	<1%	93	1%		
Education level						
Grade K-4	-	0%	739	9%	92.67	<.001
Grade 5 (completed elementary school)	41	12%	982	12%		
Grade 8 (completed middle school)	209	58%	3,027	38%		
Grade 12 (completed high school)	48	13%	856	11%		
Some college	32	9%	1,196	15%		
Completed college	2	1%	67	1%		
Graduate degree	2	1%	51	1%		
Prefer not to Answer	-	0%	14	<1%		
Unknown	24	7%	1,039	13%		
Employment Status						
Employed full time	8	2%	163	2%	51.83	<.001
Employed part time	30	7%	234	3%		
Student	280	65%	4,776	57%		
Unemployed, seeking employment	17	4%	311	4%		
Unemployed, not seeking employment	40	9%	1,551	18%		
Other	32	7%	596	7%		
Unknown	27	6%	782	9%		
Marital Status						
Single/ never married	396	97%	7,663	90%	22.39	<.001
Married	-	0%	95	1%		
Other	-	0%	46	1%		
Unknown	12	3%	698	8%		
Living Arrangement						
House/ apartment (No support required)	289	78%	3,634	63%	125.37	<.001
House/ apartment (Support required)	56	15%	346	6%		
Foster care	2	1%	91	2%		
Residential treatment	4	1%	271	5%		
Inpatient psychiatric hospital	-	0%	7	<1%		
Homeless	8	2%	785	14%		
Jail/ prison/ correctional facility/ juvenile hall	-	0%	198	3%		
Other	3	1%	134	2%		
Unknown	11	3%	325	6%		
Military Service/Veteran Status						
No	403	99%	4,612	99%	2.02	.155
Yes	5	1%	29	1%		
Diagnosis Category						
Psychosis Spectrum	405	80%	10,346	61%	84.47	<.001

Mood Spectrum	30	6%	3,618	21%		
Other	69	14%	2,646	16%		
Unknown	2	<1%	482	3%		

Table 19. Age of Individuals included in Analysis

	Early Psychosis		Comparator Group				
	Mean	**SD**	**Mean**	**SD**	***t***	***df***	**p-value**
Age	17.0	3.1	20.1	3.8	18.41	17596	<.001

Table 20. Proportion of Individuals Ending Treatment within each Time Period

	Early Psychosis		Comparator Group			
	n	**%**	**n**	**%**	**X^2**	**p-value**
≤6 months	219	43%	7,493	44%	162.14	<.001
7 to 12 months	140	28%	2,221	13%		
13 to 18 months	73	14%	1,762	10%		
19 to 24 months	50	10%	1,606	9%		
>25 months	24	5%	4,010	24%		
Total	506	100%	17,092	100%		

Service Utilization Characteristics

Outpatient Service Use

Table 21A. Total Minutes of Outpatient Services per Individual per Month

	Early Psychosis		Comparator Group			
	Mean	**95% CI**	**Mean**	**95% CI**	***z***	***p*-value**
Total minutes of outpatient services (per month)	452	417 - 488	296	290 - 302	8.63	<.001

Table 21B. Total Minutes of Outpatient Services per Individual per Month by Time Period

	Early Psychosis		Comparator Group			
	Mean	**95% CI**	**Mean**	**95% CI**	***z***	***p*-value**
≤6 months	537	493 - 582	287	281 - 292	11.11	<.001
7 to 12 months	455	403 - 508	305	297 - 314	5.58	<.001
13 to 18 months	433	375 - 491	313	302 - 323	4.02	<.001
19 to 24 months	321	261 - 380	299	288 - 309	0.71	.48
>25 months	297	218 - 377	285	274 - 297	0.29	.77

Table 21C. Total Minutes of Outpatient Services per Individual per Month by Service Type and Time Period

		Early Psychosis		Comparator Group			
		Total Minutes of Service per Individual per Month		**Total Minutes of Service per Individual per Month**			
		Mean	**95% CI**	**Mean**	**95% CI**	***z***	***p*-value**
Service date from enrollment	**Service Type**						
<6 months	**Assessment**	90	82 - 97	69	68 - 70	5.51	<.01
	Case Management	89	72 - 106	81	77 - 84	0.93	.35
	Collateral	139	121 - 157	62	60 - 65	8.44	<.01
	Crisis Intervention	66	49 - 83	125	121 - 128	-6.79	<.01
	Group Therapy	75	60 - 89	95	84 - 106	-2.37	.02
	Individual Therapy	238	215 - 260	171	165 - 176	6.00	<.01
	Medication Support	73	67 - 79	64	62 - 65	3.08	<.01
	Plan Development	47	42 - 52	48	46 - 50	-0.30	.76
	Rehabilitation	98	84 - 113	66	59 - 73	4.14	<.01

7-12 months	**Assessment**	44	36 - 53	59	56 - 63	-3.55	<.01
	Case Management	93	68 - 119	100	95 - 106	-0.52	.61
	Collateral	157	132 - 182	72	68 - 75	6.64	<.01
	Crisis Intervention	64	35 - 93	92	86 - 98	-1.86	.06
	Group Therapy	64	51 - 78	110	96 - 124	-4.94	<.01
	Individual Therapy	258	225 - 291	201	193 - 209	3.39	<.01
	Medication Support	64	57 - 71	55	54 - 57	2.34	.02
	Plan Development	39	31 - 46	53	50 - 56	-3.56	<.01
	Rehabilitation	106	89 - 122	79	68 - 89	2.59	.01
13-18 months	**Assessment**	50	37 - 64	60	57 - 63	-1.40	.16
	Case Management	69	50 - 88	105	99 - 111	-3.60	<.01
	Collateral	137	110 - 164	70	66 - 74	4.82	<.01
	Crisis Intervention	89	34 - 144	92	86 - 98	-0.10	.92
	Group Therapy	63	40 - 86	129	106 - 152	-4.12	<.01
	Individual Therapy	232	199 - 264	202	193 - 211	1.79	.07
	Medication Support	63	52 - 74	59	57 - 61	0.67	.50
	Plan Development	50	32 - 68	54	51 - 57	-0.43	.67
	Rehabilitation	108	84 - 132	80	69 - 92	1.94	.05
>19-24 months	**Assessment**	52	33 - 70	58	55 - 61	-0.66	.51
	Case Management	40	29 - 52	105	98 - 111	-9.59	<.01
	Collateral	132	92 - 172	67	63 - 72	3.15	<.01
	Crisis Intervention	58	50 - 66	81	74 - 87	-4.53	<.01
	Group Therapy	85	33 - 137	141	114 - 168	-1.88	.06

	Individual Therapy	222	181 - 264	198	189 - 208	1.13	.26
	Medication Support	68	53 - 83	59	57 - 61	1.18	.24
	Plan Development	44	22 - 66	49	46 - 52	-0.46	.65
	Rehabilitation	68	46 - 91	68	58 - 78	0.02	.98
25+ months	**Assessment**	57	30 - 84	46	43 - 48	0.82	.41
	Case Management	62	37 - 87	91	85 - 97	-2.21	.03
	Collateral	118	70 - 166	59	55 - 64	2.42	.02
	Crisis Intervention	66	-9 - 140	65	59 - 71	0.01	.00
	Group Therapy	97	85 - 109	124	100 - 147	-1.87	.06
	Individual Therapy	232	177 - 288	184	174 - 193	1.70	.09
	Medication Support	64	40 - 87	57	54 - 60	0.57	.57
	Plan Development	95	14 - 177	43	40 - 46	1.26	.21
	Rehabilitation	47	13 - 80	52	44 - 60	-0.29	.77

Day Service Use

Table 22. Day Services – Proportion of Individuals with One or More Visits

	Early Psychosis		Comparator Group			
Visit date from enrollment	**%**	**95% CI**	**%**	**95% CI**	***z***	***p*-value**
≤6 months	2.4%	0.017 - 0.032	5.0%	0.047 - 0.054	-6.24	<.001
7 to 12 months	1.8%	0.010 - 0.026	4.0%	0.036 - 0.044	-4.67	<.001
13 to 18 months	1.5%	0.004 - 0.025	4.7%	0.041 - 0.052	-5.43	<.001
19 to 24 months	0.4%	-0.003 - 0.011	4.2%	0.037 - 0.048	-8.33	<.001

>25 months	3.3%	-0.006 - 0.071	5.7%	0.050 - 0.064	-1.22	.222
Across All Time Periods	2.0%	0.014 - 0.026	4.7%	0.044 - 0.050	-7.93	<.001

24-Hour Service/Inpatient Hospitalization

Table 23. 24-Hour/ Inpatient Hospitalization Services – Proportion of Individuals with One or More Visits

	Early Psychosis		Comparator Group			
Visit date from enrollment	**%**	**95% CI**	**%**	**95% CI**	***z***	***p*-value**
≤6 months	9.4%	0.067 - 0.121	24.8%	0.242 - 0.255	-10.83	<.001
7 to 12 months	7.7%	0.044 - 0.109	19.5%	0.186 - 0.204	-7.00	<.001
13 to 18 months	7.1%	0.026 - 0.116	21.4%	0.204 - 0.225	-6.10	<.001
19 to 24 months	5.4%	-0.005 - 0.114	19.5%	0.184 - 0.207	-4.57	<.001
>25 months	17.0%	-0.014 - 0.353	23.7%	0.191 - 0.216	-0.72	.472
Across All Time Periods	8.9%	0.061 - 0.118	22.4%	0.224 - 0.250	-9.03	<.001

Appendix VI. Service Code Definitions

These definitions are based upon the Medi-Cal Billing Manual published in September 2019 by the State of California—Health and Human Services Agency Department of Health Care Services, Mental Health Services Division.

Medication Support
Psychiatric medication-related services provided by nurse or physician including obtaining informed consent linked to providing Medication Support Services activities; instructions in the use, risks and benefits of and alternatives for medication; and plan development related to Medication Support Services. This may include services to consumer, family and caregivers.

Assessment
A service activity designed to evaluate the current status of a consumer's mental, emotional, or behavioral health. Assessment includes but is not limited to the following: mental status determination, analysis of consumer's clinical history; analysis of relevant cultural issues and history and diagnosis. The Server may be gathering information from a variety of sources. Interactive complexity includes the need to manage high reactivity, emotions or behavior of participants that interferes/complicates implementation or delivery of treatment services. It also may include mandated reporting such as in situations involving abuse or neglect. May include the use of play equipment, other physical devices, and interpreter or translator services.

Collateral
A service activity to a significant support person in the consumer's life for the purpose of meeting the needs of the consumer in achieving the goals of the consumer plan. May include but is not limited to consultation and training of the significant support person(s) to assist in better understanding of mental illness. The consumer may or may not be present for this service activity.

Plan Development
A service activity that consists of development of consumer plans, approval of consumer plans, and/or monitoring of a consumer’s progress. Includes team meetings for these purposes. Whenever possible, consumer should be present for these activities.

Rehabilitation
Individual: A service activity provided to a consumer and may include the following: counseling, assistance in improving, maintaining, or restoring an individual's functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and/or medication education. If family or others are present, the focus of the session shall be on the consumer’s individual goals.

Group
A service activity provided to a group of individuals and may include the following: counseling, assistance in improving, maintaining, or restoring an individual's functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and/or medication education. This may include consumers with family (can be foster family) for example multi-family groups, consumers with consumers, or consumers with others.

Individual Therapy
Psychotherapy conducted with a consumer: includes insight-oriented, behavior modifying and/or supportive psychotherapy. If family or others are present, the focus of the session shall be on the consumer’s individual goals.

Group Session/Group Therapy
Psychotherapy conducted with a group of individuals. Interactions among members are considered to be insight-oriented, behavior modifying and/or supportive. This may include consumers with family (can be foster family) for example multi-family groups, consumers with consumers, or consumers with others.

Case Management/Brokerage (CMB)
Case management services provided to assist the consumer to access needed housing, medical, educational, social, prevocational, vocational, rehabilitative, alcohol or drug treatment, or other needed community services. Includes targeted case management services of monitoring the beneficiary's progress toward consumer plan goals and placement services.

Crisis Intervention
Response to an unplanned event enabling consumer to cope with a crisis while maintaining his/her status as a functioning community member to the greatest extent possible. Includes related components such as assessment, evaluation, collateral contacts and therapy. Crisis Intervention is only provided to the consumer or the consumer with family present.

Non-Billable Codes
No-Show (Missed Visit)

Cancelled by Consumer

Cancelled by Program

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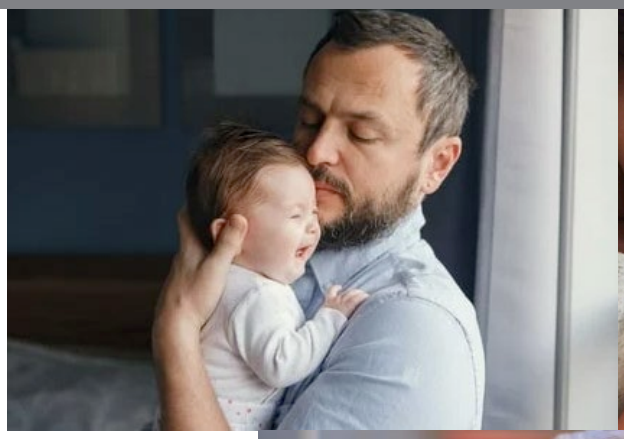
New Parent TLC

Sonoma County Innovation Poject

2021-2022 Annual Report

FIRST 5

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION



I. Brief description of Project

Sonoma County's MHSA Innovation project, New Parent TLC (Talk, Link, Confirm) will employ a gatekeeper training model similar to the evidence-based model QPR (Question, Persuade, Refer) to identify signs, and intervene early with new parent mental health issues that may otherwise go unaddressed, ultimately preventing suicide. As a secondary outcome, New Parent TLC will also prevent the exposure of infant Adverse Childhood Experiences (ACEs) resulting from parental depression and the associated disruption of optimal infant/toddler brain development. The model increases access to mental health services to underserved groups including new parents of all types: biological, non-biological, adoptive, gay, or straight (Beck, 2014). New Parent TLC promotes interagency and community collaboration related to mental health services with the innovative model that engages childcare providers, cosmetology service providers, and employees of medium to large places of employment as peers, as "connectors," (formally known as "gatekeepers") with a robust outreach method to raise awareness of new parental depressive symptoms, and helps get parents linked to mental health services by initiating the conversation (Talk), providing culturally appropriate referrals to parental mental health services (Link), and following-up with the parent to confirm they have accessed services (Confirm).

The project includes a culturally responsive curriculum development process with a community advisory group, training for a core team of trainers to implement the project, and community-wide training for groups of childcare providers, cosmetology service providers, and employees of medium to large places of employment. The community groups will be trained in the New Parent TLC (Talk, Link, Confirm) model, and become "Connectors" who will work in the community to identify parental mental health concerns, link the identified new parents with culturally appropriate resources, and follow-up to confirm the new parents have accessed services.

II. Demographics

The primary population to be served with this project are "Connectors," which will include groups of child care providers, cosmetology service providers, and employees of medium to large places of employment as peers. When training begins, approximately 30% of the training groups will be facilitated in Spanish to match the demographics of Sonoma County. At the end of the first year, the project is still in the curriculum development phase, and no connectors have been trained to date. Thus, no demographics of connectors are available during this reporting period.

In the curriculum development phase, a culturally responsive community group was established to inform the curriculum development process and ensure the curriculum and training implementation for the community is inclusive, and representative of Sonoma County parents.

This includes birthing parents, non-birthing parents, heterosexual parents and parents who are part of the LGBTQIA2s+ community. In addition, the curriculum is culturally responsive for English speaking parents and Spanish speaking parents in Sonoma County. The culturally responsive community advisory group includes members of organizations to represent the Latinx and LGBTQIA2s+ parental communities, with organizations represented including Positive Images, Latino Service Providers, Postpartum Support Center, North Bay LGBTQI Families, and participants with lived experience. There were two representatives of the LGBTQI+ population, one from the Latinx population, and two participants with lived experience.

III. Problem Statement

The primary problem that this project intends to address is 3-fold:

1. The high prevalence of postnatal mental health issues for new parents;
2. Postnatal mental health issues very often go unidentified, untreated and unmitigated;
3. Untreated parental mental health issues pose a significant risk of exposure to ACEs to thousands of Sonoma County children in the first year of life when the brain is most vulnerable to such exposure.

IV. Learning Goals

Learning Goal 1: What is the difference, if any, of the number of referrals for parents for services for parental depressive symptoms by trained connectors?

Sub-goal 1a: Is there a statistically significant difference in the rate of referrals between the three groups of childcare providers, cosmetology services providers, and coworkers/employees?

Learning Goal 2: What is the experience of parents experiencing depressive symptoms, trained connectors, and postpartum service providers who have participated in the New Parent TLC pilot project?

Sub-goal 2a: What factors contribute to completed linkages to services and a positive experience for parents, and trained connectors?

Sub-group 2b: What factors were identified as barriers for referrals made that were not successfully completed?

V. Findings to date (preliminary)

In Fiscal Year 21-22 (with a project start date of December 2021), First 5 Sonoma County contracted with consultants to develop a culturally responsive curriculum that will first be used to train the primary trainers of the project, and then for the primary trainers to train the connectors in the community. The curriculum development consultants are mental health professionals who specialize in maternal mental health.

Within this reporting period, a culturally responsive community advisory group was also developed to provide feedback during the curriculum development. The group was strategically developed to represent underrepresented demographics of parents in Sonoma County, to ensure inclusivity and belonging in the framework of the curriculum. There are currently seven participants on the culturally responsive community advisory group, from four different organizations including participants with lived experience, with the intention of inclusiveness for LGBTQIA2s+ and Latinx parents. The group meets monthly to review curriculum, with six monthly hour and a half meetings completed by the end of the reporting period. The curriculum is expected to be fully complete by the end of October 2022. Feedback from each session was implemented to update the train-the-trainer and connector training curriculum.

***Participants of the Culturally Responsive Curriculum Advisory Group provided the following statements about their participation in the group*:**

"Participating in the Culturally Responsive Curriculum Group was a very positive experience. Each time I joined this group, I felt empowered to share my perspective and my ideas with the group. The facilitators did an amazing job inviting each of our voices into the conversation and Jenni and Allison showed us respect each time by showing us how they implemented our opinions and feedback. This group was truly special because it finally felt like we weren't just another equity group to check off a box, our voices mattered. I am excited to see this program reach our communities."

-Alayza Cervantes, Community Engagement Manager at Latino Service Providers

"I'm heartened by the innovative NPTLC program. I've known new parents and care providers who faced serious mental health struggles but did not feel safe opening up to their partner or family. Training hair stylists—and other people to whom a new parent might open up—on how to recognize signs of these challenges and connect people to support is an excellent idea.
I'm grateful that First5 engaged me and other LGBTQIA+ community members to guide the curriculum toward being culturally relevant to- and acknowledging of queer and trans parents. Mainstream society's approach to parenthood is rooted in cisheteronormativity; for queer and trans parents, this can create and exacerbate feelings of isolation and other new parent mental health challenges."

-Chelsea Kurnick, Member of the Board of Directors for Positive Images

"This is a quick thank you to let you know of my appreciation for the opportunity to influence a program directed at postpartum mental health. The opportunity to have my experience heard and my ideas validated is important to me. I am pleasantly surprised and amazed to see an entire program grow from my thoughts. It is a life lesson in using my energy to speak up, and engage, in a process to try and make positive change.
My experience with postpartum depression left me aware there is a gap between the technical competence of the medical world and its ability to engage with patients. That lack of engagement

can come from the formality of the system, the lack of awareness of desperate patients, or from feeling the system isn't there to support your specific needs. I am hoping this new program will help alleviate the gap in the first two. And in another good life lesson, I see, through the great effort to build inclusiveness that this program is addressing the last as well.
-Greg Ludlam, Parent with lived experience

Some of the major findings to date throughout the curriculum development phase include a focus on inclusive language that is not gender specific. As an example, instead of referring to either a mother or a father, our curriculum refers to the birthing parent, or a non-birthing parent. Within the curriculum there is also intention in the area of calling out that when the gender specific terms are used, that it is only because there are direct quotes from a study. There was significant exploration about addressing parental stress that is related to traditional cultural norms, with a conscious decision to remove as many examples with stereotypes as possible.
In addition, the curriculum initially included significant background information specific to maternal mental health, but was eventually adapted to include parental mental health, with less gender specific examples, as they were irrelevant to identifying the signs, and providing a referral, which is the goal of the project.

On the horizon, there are key informant interviews with potential connectors who represent each of the groups to inform the implementation of the training curriculum, and then finalization of the curriculum around the end of October 2022. Additional feedback may be provided with the train-the-trainer model once the initial primary trainers have completed the training. Currently the project is around three to five months behind schedule with the curriculum development taking more time than initially anticipated. With that being said, the curriculum has not been approved yet and cannot be shared at this time.

VI. Challenges in implementation
Some of the notable challenges include the timeline. The contract execution was later than expected, which pushed back the timeline for the entire project. The contract delay also came after an extremely long proposal approval delay, through the pandemic and negotiations of details of the project. The combination of delays resulted in the need to reconfigure portions of the project to meet current needs before the project could fully launch.
Additional considerations have been discussed, as there is still uncertainty about in-person training, which was the original plan. At this time, trainings are planned for a Zoom format, but that may change through the project based on the potential for sufficient safety measures for in-person participation.

Once the consultants were in place, the curriculum development phase got off to a solid start with strong participation from the culturally responsive community advisory group. Through this process, the curriculum development has taken longer than originally anticipated, as fully embracing the community voice was at times time consuming, as the feedback came with rich

conversations and deep discussions to ensure inclusive language was being utilized consistently, and that the true vision of the project was moving forward.

With a current timeline approximately three to five months behind schedule, there is not an expectation to "catch up" as it is not realistic to schedule more trainings than originally planned. This may mean in the full scope of the project, there may be a reduced number of connectors trained by the end of the pilot period.

VII. Successes

Successes include a fully inclusive, strong curriculum that is grounded in community voice. Throughout the process, there have been additions to the original plan to include more community voice wherever possible. In addition to the originally planned culturally responsive community group for curriculum feedback, there were one-on-one key informant interviews added to provide specific feedback within each connector group of childcare providers, cosmetology service providers, and employees at medium to large places of employment. There was a humanistic approach to the curriculum development that resulted in multiple positive outcomes. Not only does the curriculum framework completely embrace and represent the parental communities of Sonoma County, but the culturally responsive group also shared many positive impacts based on their participation in the group. The participants felt their voices were heard and clearly represented throughout the curriculum, and the participants expressed interest in being a part of the process moving forward, as demonstrated in a quote above.

There has been time in this first phase for the primary trainers to prepare for their training within the next few months by having the time to proactively prepare their workloads to accommodate the time responsibility to participate in the initial training, learn the material, and fully prepare for implementation in the community. Within the early learning sector there has been opportunities for cross collaboration with partners in the childcare sector. Some of the other projects First 5 facilitates and funds have been great places to engage professionals in the childcare sector when information or feedback is needed, and it has helped that the relationship is already established as we prepare for large scale trainings in the near future.
Finally, there are already opportunities arising for potential expansions once the pilot project is complete. One additional area to expand includes infant and parent focused yoga classes, where the yoga instructors can be the next set of connectors.

ON THE MARGINS

NUESTRA CULTURA CURA LA PLAZA

LATINO Service Providers

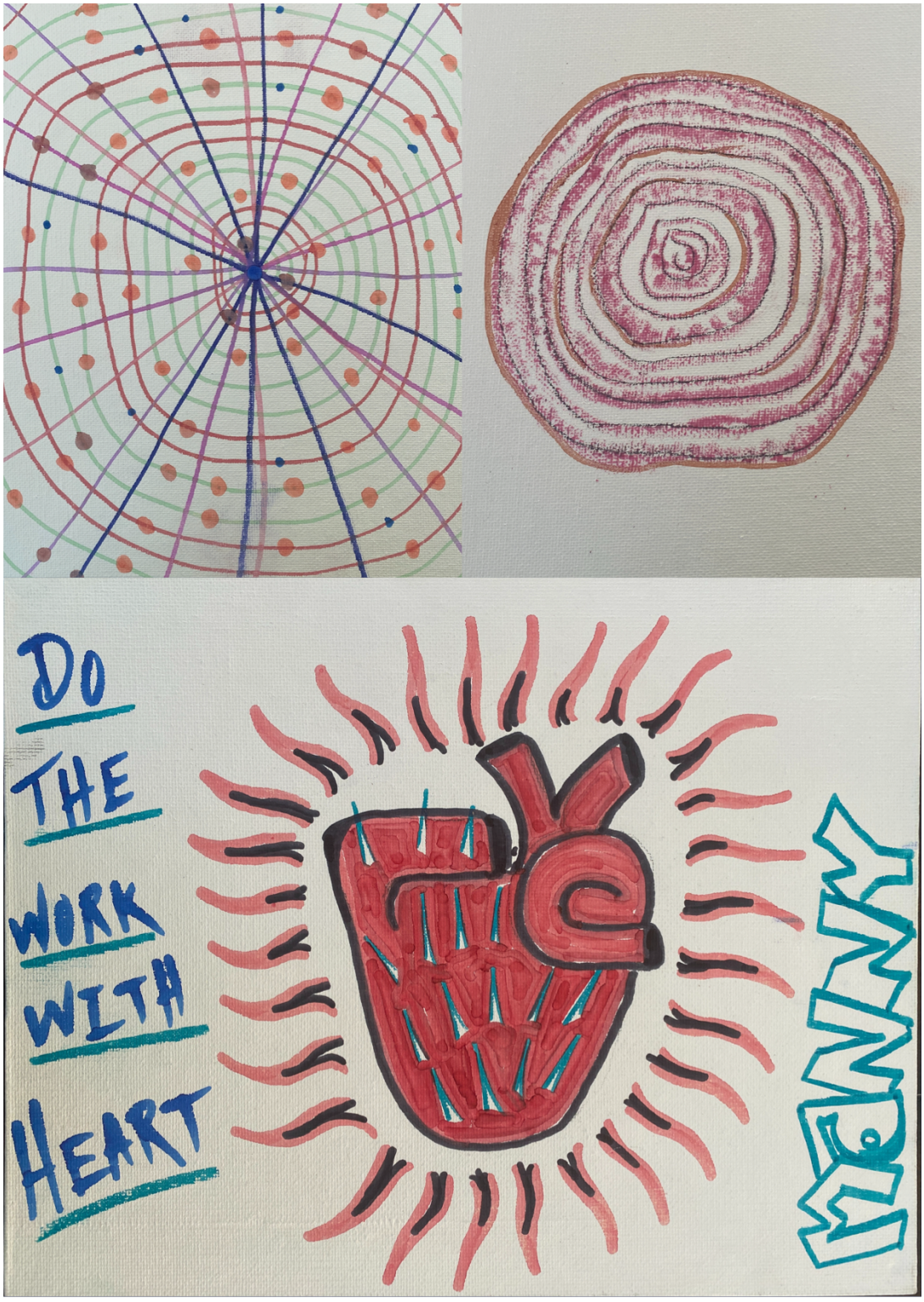
Botanical Bus
Bilingual mobile herb clinic

HUMANIDAD
Therapy & Education Services

OCTOBER 31, 2022

Appendix D

MHSA INNOVATION ANNUAL REPORT: FY 2021-2022



Art Work Created by NCC SIL Members

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2. Name of Project
3. Project Overview and Description
4. NCC SIL Collaborating Partners
5. Problem Statement
6. Learning Goals
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8. Evaluation Data & Outcomes
9. Project Updates
10. The Road Ahead

MHSA ANNUAL REPORT: YEAR ONE

1. INTRODUCTION

The converging pandemic of COVID-19 and racial injustice have increased our collective sense of urgency to more actively participate in systemic changes that address inequities and social determinants of health. In Sonoma County, the disproportionate toll this pandemic has had on individuals from disadvantaged communities serves as a clear indicator of the needed shifts in existing paradigms, including the ways in which organizations and individuals engage with, and provide services to, the Latinx Community.

Drawing from the framework developed by Social Lab expert and author Zaid Hassan, the *Nuestra Cultura Cura Social Innovations Lab* (NCC SIL) launched on October 1, 2021 and seeks to implement a culturally responsive approach to mental health services delivery in Sonoma County through a three year, multi-phase process, with a projected completion year of 2024. The following report presents data regarding Year One of the project.

ABOUT THIS REPORT

In 2022, Nuestra Cultura Cura Social Innovations Lab (NCC SIL) commissioned On the Margins, a collective of educators, mental health practitioners, health educators, artists and researchers who practice at the intersection of anti-racism, feminist theory and trauma responsive practices, to support the project by providing program evaluation and facilitation. This report was written for the Nuestra Cultura Cura Social Innovations Lab by On the Margins. The authors are Cindy Berríos and Danny Domínguez. Questions about this report can be directed to cindy@onthemargins.us or danny@onthemargins.us.

RECOMMENDED CITATION

Berríos, C. & Domínguez, D. (2022). MHSA Innovations Report.

2. NAME OF INNOVATION PROJECT

The name chosen for this project is Nuestra Cultura Cura Social Innovations Lab (NCC SIL).

3. PROJECT OVERVIEW AND DESCRIPTION

The Nuestra Cultura Cura Social Innovations Lab (NCC SIL) was created to support a unique collaboration of Latinx-led community-based mental health and cultural arts organizations. These organizations are a combination of formal and informal groups consisting of nonprofits, churches, civic organizations and clubs. Early discussions in the pre-planning phase were held with Latino Service Providers, Humanidad Therapy & Education Services, The North Bay Organizing Project and The Botanical Bus. In addition to these partners, NCC SIL invited cultural healers, individuals providing healing resources and services, as defined by those they serve, to join the NCC SIL. At the end of year one, five community organizations and five cultural healers comprised the NCC SIL partnership coordinated by On The Move.

4. NCC SIL COLLABORATING PARTNERS

The Nuestra Cultura Cura Social Innovations Lab is made possible through collaboration with the following project partners:

The Botanical Bus - The Botanical Bus is a bilingual mobile herb clinic that takes community-based action for health equity. They are driven by the proven success of the self-healing community model in which holistic health is empowered by the people and for the people. They meet their Latinx and Indigenous clients were they are - at vineyard worksites and family service center hubs - to provide upstream, culturally centered health services including massage, acupuncture, somatic therapy, diabetes prevention and care, clinical nutrition and herbalism. Their programs, led by Promotora Community Health Advocates, include farmworker clinics and wellness workshops.

Latinos Service Providers - Latino Service Providers (LSP) was founded in 1989, in response to helping the Latinx community in Sonoma County obtain knowledge and access to resources to enrich lives and help improve our communities. LSP works with community partners to engage, collaborate, and exchange valuable information; to increase awareness of available resources, access to programs and services; to influence public policy, delivery of services, enhance inter-agency communication; and to promote professional development within the Latinx community. The organization currently comprises over 1,400 members from a broad spectrum of the community, including a diverse group of individuals, community-based organizations and local businesses. Members come together to educate and network in support of the Latinx community, to improve access to healthcare, mental health services, education, legal support and other social services available in the area.

Humanidad Therapy & Education Services - Humanidad Therapy & Education Services' mission is to strengthen the lives of the Latinx community by increasing access and utilization of community mental health resources. They transcend barriers and reduce stigma by providing culturally proficient therapist training, inclusive community education, and bilingual therapy services. Humanidad envisions healthy and thriving communities where the stigma associated with mental health does not exist and all have access to quality and compassionate culturally sensitive therapy services.

North Bay Organizing Project - The North Bay Organizing Project (NBOP) is a grassroots, multiracial, and multi-issue organization comprised of over twenty-two faith, environmental, labor, student and community-based organizations in Sonoma County. NBOP seeks to build a regional power organization rooted in working class and minority communities in the North Bay: Uniting people to build leadership and grassroots power for social, economic, racial and environmental justice.

5. PROBLEM STATEMENT

Current services to address health, healing and wellness in the Latinx community are limited and those that are available are not rooted in cultural humility, awareness, or responsiveness. This service gap has led to a lack of access to historically marginalized and oppressed groups, which has impacted population health. In 2012, the UC Davis Center for Reducing Health Disparities, in collaboration with the California Department of

Mental Health, led an extensive process for identifying community- defined needs and strength based promising practices to reduce disparities in mental health as part of the California Reducing Disparities Project (CRDP). Their research confirms that current disparities in mental health care for Latinos are severe, persistent, and well documented. The Latinx community has less access to mental health services, are less likely to receive needed care, and are more likely to receive poor quality care when treated. The reasons range from poor access and quality of care, limited insurance coverage, ineffective communication between provider and patient, patients' lack of trust, doctors' assumptions about the distribution of disease and their inability to perceive severity among minorities, and low minority representation in the workforce with implications for health insurance coverage.

6. LEARNING GOALS

NCC SIL's learning goals are two-fold. First the project seeks to learn what additional knowledge can be gleaned about the unique challenges that inhibit Latino/x/e community members from accessing mental health services in Sonoma County. Second, it seeks to understand how culturally-specific interventions and language might improve the quality of mental health services for the Latino/x/e community.

7. FINDINGS TO DATE (PRELIMINARY)

NCC SIL found that in order to engage meaningfully, ensure successful implementation of the project and achieve its learning goals, it was essential to establish trust and rapport during year one with the collaborative first. For the team, this meant: (a) maintaining important communication among members between meetings; (b) starting all meetings with a check-in; (c) grounding themselves on their shared objective; (d) practicing active listening and open communication; (e) practicing shared responsibility; (f) relying on mutual support and communication; (g) practicing check-out rituals; (h) connecting work during monthly meetings; (i) and inviting new members to NCC SIL who can practice more intersectional identities. NCC SIL found that there was a desire to pursue the identified objective with varying degrees of shared responsibility between team members. There was a sentiment that more consistent participation in-between monthly meetings could help strengthen the team. To that end, the collaborative decided to create a shared calendar that was distributed to all members so that quarterly

community events can be held in the future. Members of the Innovations Team understand that during the second year it will be important to start traveling, visiting, engaging, and connecting "out in the community." In terms of long-term outcomes, NCC SIL's hope is for these "culturally-rooted spaces of belonging" to become a model that can be replicated across the county and beyond.

8. EVALUATION DATA & OUTCOMES

Q1 FINDINGS

NCC SIL acknowledged that a greater impact to the Sonoma County Latinx Community may be achieved together, yet understand that without the trust, buy-in, accountability, healthy conflict and follow through of partner agencies, efforts will fail. Therefore, it was determined that year one would be a planning and relationship, rapport and community building year for the collective. However, NCC SIL also committed to outreach and community engagement to recruit healers and community members to get involved with the Innovations Project.

Q2 FINDINGS

NCC SIL came to fully understand and appreciate the true value of process as it relates to building coalitions. As the project moved forward, the collective became aware that it needed to move away from a rush to produce a product and that the process of creation was equally as important as the final outcome.

Q3 FINDINGS

As the project continued to evolve, NCC SIL found that the integration of a facilitator has been extremely helpful for all NCC SIL participants. On the Margins was invited to join the project in February 2022.

Q4 FINDINGS

At the end of the first year, NCC SIL provided space for members in the collective to provide feedback about their experience thus far. Below are a few quotes that captured the process driven element of year one.

"As the executive director and cofounder of a new non-profit organization, the Innovations Project has provided me a safe space to connect with other organizational leaders. The space, committed to respect,

confidentiality, and acknowledgment of emotion, allows for the quieting of the inner-critic and freedom to envision new ways of working together. The intentional language and process that are integral to the Innovations Project supports me in cultivating like spaces of shared leadership, open communication and emotional support within my own organization and in the community."
-JB

"Being in community, with like minded people and people experiencing similar challenges as leaders, has provided me the opportunity to feel supported, reduced my concerns/anxiety and gave me the sense of belonging, which is very important for my mental health which translates to my physical health. As with any process, it took some time for me to find a tune. Once I discovered how powerful this experience is, it was just a matter of being present and to have an open mind to see and listen."
-NP

"I am so grateful for this space. I feel safe. I am not part of many safe spaces. This is unique and special for me. Something that has stuck out to me is being able to openly talk about systemic oppression and have opportunities for healing. This process has been scary, but exciting and freeing!"
-SM

DEMOGRAPHIC INFORMATION

TABLE 1. Numbers Served

NUMBERS SERVED	FISCAL YEAR JULY 2021- JUNE 2022
Unduplicated or Unique	12
Total Numbers Served	12

TABLE 2. Age Group

TOTAL NUMBERS SERVED BY AGE	FISCAL YEAR JULY 2021- JUNE 2022
Children/Youth (0-15)	0
Transition Age Youth (16-25)	1
Adult (26-59)	11

Older Adult (60+)	0
Missing/Unknown	0
Declined to State	0
TOTAL	12

TABLE 3. Sex & Gender

ASSIGNED SEX AT BIRTH	FISCAL YEAR JULY 2021- JUNE 2022
Female	11
Male	1
Missing/Unknown	0
Declined to State	0
TOTAL	12

CURRENT GENDER IDENTITY	FISCAL YEAR JULY 2021- JUNE 2022
Female	9
Male	2
Transgender	0
Genderqueer	1
Questioning/Unsure	0

Other	0
Missing/Unknown	0
Declined to State	0
TOTAL	12

TABLE 4. Race

TOTAL NUMBERS SERVED BY RACE	FISCAL YEAR JULY 2021- JUNE 2022
American Indian or Alaska Native	0
Asian	1
Black or African American	0
Native Hawaiian or other Pacific Islander	0
White	11
Other	0
Multi	0
Missing/Unknown	0
Declined to State	0
TOTAL	12

TABLE 5. Ethnicity

5A. TOTAL NUMBERS SERVED BY ETHNICITY (LATINO/X/E OR HISPANIC)	FISCAL YEAR JULY 2021- JUNE 2022
Caribbean	0
Central American	1
Mexican/Mexican-American	8
Puerto Rican	1
South American	1
Other	0
Multi	0
TOTAL	11

5B. TOTAL NUMBERS SERVED BY ETHNICITY (NON-HISPANIC/NON-LATINO/X/E)	FISCAL YEAR JULY 2021- JUNE 2022
African	0
Asian Indian/South Asian	0
Cambodian	0
Chinese	0
Eastern European	0

European	0
Filipino	0
Japanese	1
Middle Eastern	0
Vietnamese	0
Other	0
Multi	0
TOTAL	1

5C. TOTAL NUMBERS SERVED BY ETHNICITY (MORE THAN ONE ETHNICITY, DECLINED TO STATE, OR UNKNOWN)	FISCAL YEAR JULY 2021- JUNE 2022
More than one ethnicity	0
Missing/Unknown	0
Declined to State	0
TOTAL	0

TABLE 6. Primary Language

TOTAL NUMBERS SERVED BY PRIMARY LANGUAGE	FISCAL YEAR JULY 2021- JUNE 2022
English	11
Spanish	1
Other	0
Missing/Unknown	0
Declined to State	0
TOTAL	12

TABLE 7. Culture

TOTAL NUMBERS SERVED BY CULTURE	FISCAL YEAR JULY 2021- JUNE 2022
LGBTQ	2
Veteran	0
Experiencing Homelessness	0
Individuals in Foster Care	0
Other	0
Missing/Unknown	0

Declined to State	0
TOTAL	2

TABLE 8. Medi-Cal

TOTAL NUMBERS SERVED BY MEDI-CAL	FISCAL YEAR JULY 2021- JUNE 2022
Medi-Cal Beneficiaries	0
Missing/Unknown	0
Declined to State	0
TOTAL	0

TABLE 9. Sessions Offered by Program

TOTAL NUMBERS OF SESSION OFFERED BY PROGRAM	FISCAL YEAR JULY 2021- JUNE 2022
TOTAL	10

TABLE 6. Sexual Orientation

TOTAL NUMBERS SERVED BY SEXUAL ORIENTATION	FISCAL YEAR JULY 2021- JUNE 2022
Gay or Lesbian	0
Heterosexual or Straight	0

Bisexual	0
Questioning or Unsure	0
Queer	2
Other	0
Missing/Unknown	10
Declined to State	0
TOTAL	12

TABLE 10. Disability

TOTAL NUMBERS SERVED BY DISABILITY	FISCAL YEAR JULY 2021- JUNE 2022
No Disability	0
Communication Disability: Difficulty Seeing	0
Communication Disability: Difficulty hearing or speech	0
Communication Disability: Other	0
Intellectual or Mental Disability	0
Physical/Mobility	0
Chronic Health Condition	0

Other Disability	0
Declined to State	0
Missing/Unknown	12
TOTAL	12

9. PROJECT UPDATES

There was only one change that was made to the project during year one. Initially, Raizes Collective was invited to join as a partner. However, Raizes Collective decided not to proceed with their participation in the project due to other internal obligations. The collective then invited a new organization to join NCC SIL. The Botanical Bus was invited because they had pre-existing relationships with the participating organizations. The Botanical Bus is also aligned with NCC SIL's mission and vision regarding healing and wellbeing. Utilizing a democratic process, NCC SIL's participating organizations voted anonymously to invite Botanical Bus to join the project.

10. THE ROAD AHEAD

In Year Two of NCC SIL, each collaborating organization will work toward expanding the network by inviting community members who engage in healing practices. The vision is to co-create culturally rooted spaces of belonging for the Latinx community through a vast network of providers.

Name of Project

Current Name: Unidos por Nuestro Bienestar – United for Our Wellness (aka 'Unidos')
Former Name: Collaborative Care Enhanced Recovery Project (CCERP)
Start Date**:** 9/1/2021

Brief Description of Project

Sonoma County Human Services Department, Adult & Aging Division (A&A) and Santa Rosa Community Health (SRCH)-Lombardi Campus is partnering to test an innovative modification to an evidence-based depression intervention known as the Collaborative Care Model.

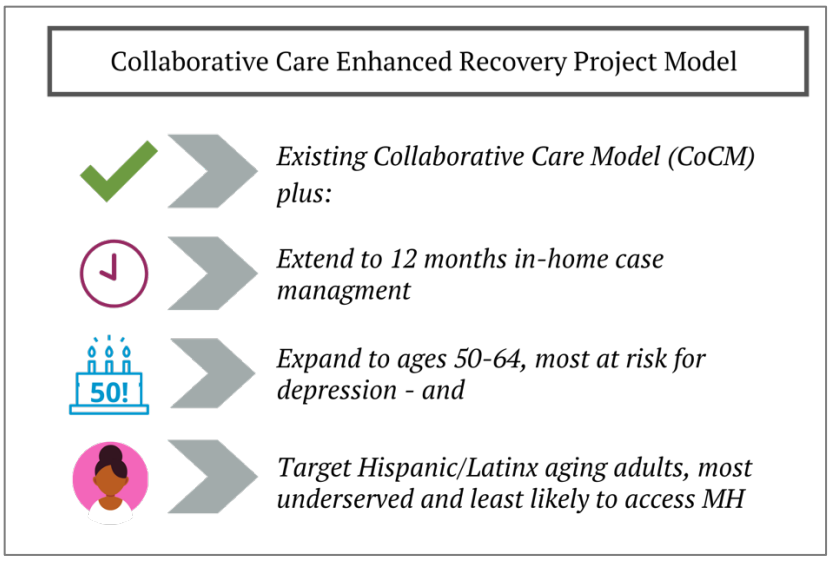
The Collaborative Care Model (aka CoCM) integrates physical and behavioral health services with the following key components: 1) brief care coordination between primary care and behavioral health care providers over a 12-week period that includes weekly multidisciplinary team meetings; 2) regular monitoring, treatment and case management (using validated clinical rating scales) that entail home visits at initiation and weeks 6 and 12 and phone check-ins at weeks 3 and 9; and 3) systematic psychiatric caseload reviews and consultation, as indicated, for clients who do now show clinical improvement.

Our innovation builds on our local experience since 2015 in delivering this model-of-care to low-income older adults ages 65 and over. We continue to collaborate with Petaluma Health Center in implementing CoCM with fidelity and recently completed a project to support its implementation at West County Health Centers in partnership with West County Community Services. We learned from these experiences not only that younger "senior" populations could benefit from this program, but also that 3 months is insufficient duration for the intervention to yield enduring benefits. In addition, we recognized that our efforts-to-date have not adequately supported the needs of the Latinx community.

Our project, now known as Unidos Por Nuestro Beinestar—United for our Wellness—or Unidos, for short, intentionally engages Latinx patients ages 50+ served @ SRCH and extends the case management period from 3 months to a full year. We changed our project name from Collaborative Care Enhanced Recovery Project (CCERP) to Unidos in the spirit of engaging the population-of-focus for this initiative). Coordinated care is provided by a bilingual/bicultural team comprised of primary and behavioral healthcare providers at the FQHC and a Sonoma County Adult & Aging social worker who is embedded at the health center and also conducts home and telephonic visits. Unlike the CoCM intervention, we also extend eligibility to those who screen positive for mild depression (vs. moderate depression) on the PHQ-9, as we have found that:

1) Clients often report their mental health status more favorably than it actually is until they develop trust with their provider, as stigma, taboo and shame about mental health deters disclosure (as observed in many cultures, including the Latinx community [https://www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions/Hispanic-Latinx]); and
2) Even those with mild depression benefit from the intervention.

Those diagnosed with severe persistent mental illnesses are referred to appropriate care.



Our goals are to reach 215 unduplicated individuals during the project period and demonstrate that:

- 50% of clients who show improved depression symptoms during the first 12-weeks will sustain these improvements over the following 9-month extended intervention period; and
- one-quarter of clients will increase their appropriate utilization of primary healthcare services

Problem Statement

Sonoma County as a whole is experiencing a profound demographic shift, mirroring that which is underway throughout the state and the nation, as the population ages and demand for behavioral health services grows among older adults. The percentage of Sonoma County's aging adults continues to grow faster than the US average and makes up a significantly larger share of the total population than the state average: 39.1% of the County's approximately 504,000 residents are over the age of 50, compared to 31.6% for the state. Further, the number of residents aged 60 and older is projected to increase by nearly 38% between 2015 and 2025.

Hispanic/Latino individuals also make up a growing proportion of Sonoma County's population: 27% of the County's population is Hispanic and 62.1% is white. Correspondingly, more than a quarter of County residents speak a primary language other than English, 77% of which is Spanish. Further, as the largest city in Sonoma County and the biggest urban center between San Francisco and Portland, Santa Rosa is home to a disproportionate share of low-income Sonoma County residents struggling with unaddressed mental health disorders, chronic disease, and contributing social determinants of health.

As the County faces an increasingly senior and Hispanic/Latino population; increases in depression, suicide and chronic health problems; disparities in culturally responsive treatment and access to care among low-income and Hispanic residents it concurrently poses significant challenges to the local mental health care system.

In response, the County of Sonoma Human Services Department (HSD) Adult and Aging Division (A&A) and Santa Rosa Community Health (SRCH) propose a pilot project to improve treatment for older adults struggling with depression. Unidos por Nuestro Bienestar will augment an established short-term

intervention model with longer-term, in-home case management and target it to the underserved Hispanic/Latinx population, resulting in positive and more equitable impacts on mental health, physical health, and quality of life for older adults with depression.

Learning Goals

Unidos' learning goals entail assessment of the following:

Learning Goal #1: The project's population impact via sustained patient outcomes by establishing whether extending the duration of home-based care management from 12 weeks to 12 months results in sustained improvement of depression symptoms over the course of the intervention period.

Learning Goal #2: The project's system impact via appropriate healthcare utilization, as indicators that clients are accessing optimal medical care that is preventive in nature and supports their overall physical and mental health.

Learning Goal #3: The effectiveness of this intervention for the Hispanic/Latinx population. SRCH serves a large population of Hispanic/Latinx adults. The goal of serving this population is to address the cultural barriers to serving Hispanic/Latinx adults with symptoms of depression.

Findings to Date (preliminary)

Year 1 Performance

The objectives for Project Year 1 and our progress toward achieving them are described below:

1) By the end of FY21-22, conduct project start-up activities

    a) Hire, onboard and train all project staff

        - Sonoma County Adult & Aging Division Personnel Team Assigned/Hired:
            - Adult & Aging Section Manager – Gary Fontenot (incumbent)
            - Linkages Program Supervisor – Sara Avery (incumbent)
            - Bilingual Care Manager – Cecelia Castaneda (joined the project 1/25/22)
            - Unidos Project Manager – CB Wohl (joined the project July 2021)

        - Santa Rosa Community Health (SRCH) Personnel Team Assigned/Hired:
            - Lombardi Behavioral Health Provider – Amanda Abud (incumbent)
            - Lombardi Mental Health Services Director – Susan Milam Miller (joined the project June 2022)
            - Lombardi Campus Medical Director Dr. Hannah Watson (incumbent)
            - Lombardi Campus Physician Champion – Dr. Laura Martin (incumbent)
            - Chief Medical Officer - Dr. Marie Mulligan (incumbent)
            - Lombardi Campus Interim Site Director – Jacki Leon (joined the project February 2022

- Lombardi Campus Assistant Director – Luis Gonzalez (joined the project February 2022)
- Psychiatric Consultant – Dr. Elizabeth Hegarty (incumbent)
- Quality & Data Director – Dr. Irene Balyut (incumbent)
- Grant Director – Annemarie Brown (incumbent)
- Chief Operating Officer – Gabriela Bernal (incumbent)
- Project Management Consultant – Carin Hewitt (joined the project September 2021)
- Remaining to be hired as of 6/30/22: RN Case Manager/Patient Navigator

o Created and refined operational workflow document (Appendix A) to guide and streamline project implementation and inform quality improvement efforts.

o Developed schedule for bimonthly internal and partnership administrative meetings as well as the weekly Multidisciplinary Team (MDT) meetings where the clinical personnel convene to discuss patient care/implement the collaborative care model.

b) Develop/refine the evaluation plan

o Affirmed existing and developed new screening/assessment tools for measuring intervention outputs/outcomes/impacts, including the schedule for administering each
- Intake/Tracking Forms – Includes Care Plan and encounter/unable to reach/lost to follow-up/program exit records
- PHQ – administered at screening, intake, every 3 weeks until week 12, then at 6, 9, and 12 months
- Social Needs Screening Tool (adapted from the CMS Accountable Health Communities Health-Related Social Needs Screening Tool) (Appendix B) – Administered at intake, 6 and 12 months
- Katz Index of Independence in Activities of Daily Living – Administered intake, 6 and 12 months (Appendix C)
- Client Satisfaction Survey – Administered at 6 and 12-months (or at patient exit from program with notation) (Appendix D)
- Results-Based Accountability Measures – (Appendix E)

c) Build queries/reports to track patient and program data

o Developed system for processing and reporting on Unidos process and outcome data

d) Develop bilingual materials for outreach, education and engagement

o Created bilingual outreach/education/engagement flier to promote program to eligible SRCH patients, family members, caregivers and target population residing in the health center's catchment area (attached)

2) Launch the enhanced CCERP interventions by Jan 1, 2022

a) Identify clients in target population

- Commenced identification and referral of patients Spring 2022. The referral sources included SRCH Primary & Behavioral Healthcare Providers and Sonoma County Adult & Aging's Linkages program. Of the 19 clients referred through the end of FY21-22, 3 were enrolled in the program, 10 were engaged via multiple contacts by the A&A Case Manager (averaging 5 often in-depth telephone encounters per client) and 6 were unresponsive to follow-up contact.

b) Deliver traditional CoCM depression intervention

- The Case Manager began delivering the intervention to clients via telephonic and home visits.

c) Begin providing long-term in-home care management services

- These activities will begin in Project Year 2, when the first group of clients have concluded the traditional 3-month CoCM program and transition to the innovative 9-month extended services period.

Changes to Date

1) We changed our project name from Collaborative Care Enhanced Recovery Project (CCERP) to Unidos por Nuestro Bienestar – United for Our Wellness (aka 'Unidos') in the spirit of engaging the population-of-focus for this initiative—Hispanic/Latinx clients served at SRCH.

2) We reduced the number of clients to be served through the entire project from 225 to 215 to reflect the late project initiation due to delayed contract execution and challenges with staff hiring/onboarding due to the pandemic.

3) Integrated 'Results-Based Accountability' (RBA) measures into our evaluation plan as required by Sonoma County for all of its contractors.

Demographics from the Reporting Period (please see MHSA regulations)

Number of Unduplicated Clients Served:	3
Age:	
26-59:	2
60+:	1
Gender Assigned at Birth:	
Female:	3
Male:	0

Race:

American Indian/Alaska Native:	0
Asian:	0
Black/African American:	0
Native Hawaiian/Pacific Islander:	0
White:	3
Other:	0
Multi:	0

Ethnicity (Latinx/Hispanic):

Caribbean:	0
Central American:	0
Mexican/Mexican American:	3
Puerto Rican:	0
South American:	0
Other:	0
Multi:	0

Ethnicity (Non-Hispanic/Non-Latinx)

African:	0
Asian Indian/South Asian:	0
Cambodian:	0
Chinese:	0
Eastern European:	0
European:	0
Filipino:	0
Japanese:	0
Korean:	0
Middle Eastern:	0
Vietnamese:	0
Other:	0
Multi:	0

Primary Language:

English:	0
Spanish:	3
Other:	0

Culture:

LGBTQ:	0
Veteran:	0
Homeless:	0
Individuals in Foster Care:	0
Other (Not Applicable):	3

Medi-Cal Beneficiaries: 3

Challenges in Implementation

We began our project in September 2021 following some contract delays. Start-up included regular meetings (1-2x per month) between key project personal from A&A and SRCH. However, building rapport coupled with launching a new project in the age-of-COVID is a complex undertaking. Waxing and waning case rates and economic conditions have affected the clinic's capacity, health safety considerations and both organizations' ability to fill essential staff vacancies. Bandwidth to fully learn and integrate a new care model, despite the best intentions, also has presented some barriers to implementation. Despite these challenges, we are well on our way and optimistic that the project's 2nd year will see more clients connected to Unidos and the data will show its positive impact.

Successes

We are happy to report that:

1) We have a solid team of clinician's and administrators who meet regularly and are committed to the project's aims and making progress.

2) We conducted a local CoCM partners' meeting with Petaluma Health Center that offered the SRCH team insights into the model's value and how best to operationalize it at their site.

3) We hired and onboarded our bilingual and bicultural social worker who has experience in medical social work, social services and mental health, formerly worked at UCSF and Marin Aging & Adult Services and is on the Petaluma Health Center Board.

4) Our measures have been selected, intake instruments developed and promotional materials designed and printed.
   Our measures include:
   a. PHQ-9
   b. Katz Index of Independence in Activities of Daily Living
   c. Social Needs Screening Tool based on CMS' Accountable Health Communities Health-Related Social Needs Screening Tool

5) We are working with the SRCH team to develop a template in their EHR where our social worker can enter key information that the primary care team would like ready-access to.

6) We crafted a baseline workflow that continues to evolve as SRCH staffing is filled.

7) Multidisciplinary Team Meetings and Administrative Meetings convene at least 2x per month to support care coordination and project management.

8) As of 6/30/22, 24 clients were referred, 3 were fully enrolled, 11 were pending and 7 were closed.

Appendix

Appendix A – Unidos Workflow

Appendix B – Social Needs Screening Tool

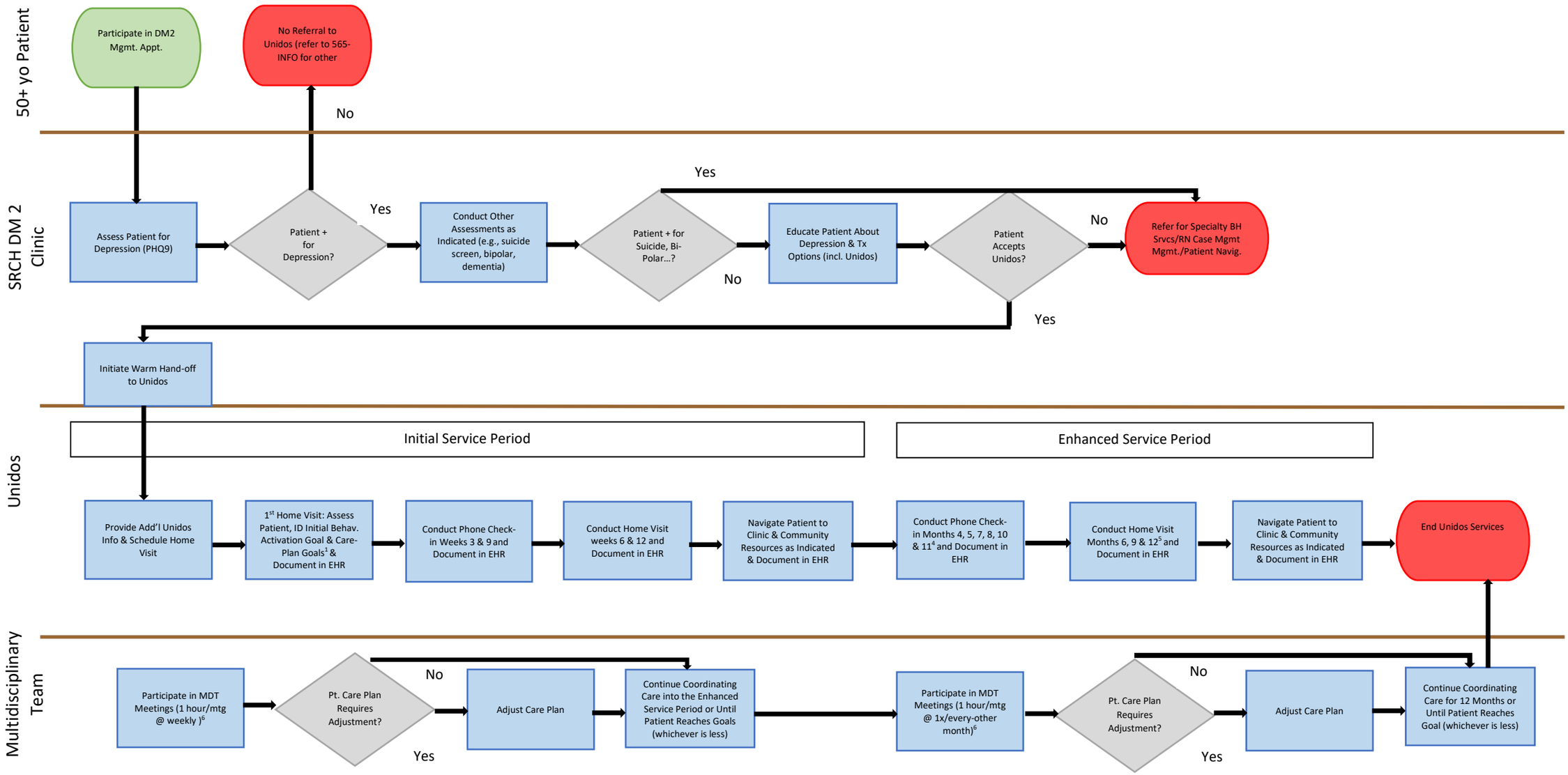
Appendix C – Katz Index of Independence in Activities of Daily Living

Appendix D - Unidos Client Satisfaction Survey

Appendix E – Unidos Results-Based Accountability Measures

Appendix F – Unidos Outreach/Education/Engagement Flier

SAMPLE Unidos WORKFLOW



[1] Initial Home Visit: PHQ9, Social Needs Screening Tool, Katz Index of Independence in Activities of Daily Living, MHSA Demographic Data, Behavioral Activation Goal(s), Care Plan

[2] Phone Check-ins Weeks 3 & 9: PHQ9, Behavioral Activation Goal(s) Progress, Care Plan Progress

[3] Home Visits Weeks 6 & 12: Home Visits tracking and measures identical to Weeks 3, & 9 Phone Check-ins

[4] Phone Check-ins Months 4, 5, 7, 8, 10 & 11: PHQ9, Care Plan Progress

[5] Home Visits Months 6, 9 & 12: PHQ9, Care Plan Progress; Addition: Social Needs Screening Tool, Katz Index of Independence in Activities of Daily Living Months 6 & 12

[6] MDT Meetings: Physician & Psychiatric Consultant join for the first half-hour

Comments/Questions

- "Lanes" are not uniformly labeled (some id an individual, others an organizational unit); need to update to reflect primary person(s) responsible to facilitate workflow adjustments as needed
- Patient education about depression and Unidos services should be delivered at the same time by the same person.
    - Depression care needs to start in primary care setting.
    - Co-locate Unidos worker at DM clinic; MAs perform the screens.
    - Patient hand-off to too many staff over a long period of time likely to lose interest and memory about the program's value/importance.
    - Patient may be more motivated with physician educates patient about depression.
- Implement new project name (to replace CCERP) that will support branding and promotion to the target population.
- Need to discuss PHQ2 & PHQ9
    - Is there a value to administering the PHQ2? Client interest may wane between administering PHQ2 & PHQ9.
    - Need to discuss score ranges on the PHQ9 to qualify patient for Unidos services. Under the UW model of collaborative care, symptoms need to be fairly significant to qualify. It seems that we may want to lower the bar for symptoms, but having numbers will help filter those that really need help with their depression and more likely to persist in the program.
- During enhanced service-delivery period, care manager continues to provide behavioral health services oversight (checking on behavior activation goal progress).
- Need to identify case manager's counterpart at the clinic who's committed at a patient-level to work as the case manager's clinical partner
    - Who's responsible for monitoring patient engagement and maintaining regular contact to promote persistence with program & adherence to treatment plan (e.g., if a patient misses a care manager appointment, who at the SRCH can administer the PHQ9?)
- Important to build in flexibility re: services provided by case manager over the phone and during a home visit.

Social Needs Screening Tool

Living Situation		
Question		
1. What is your living situation today?	☐ I have a steady place to live	☐ I am worried about losing it in the future ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park) (+2)
2. Think about the place you live. Do you have problems with any of the following?	☐ (n/a)	☐ Pests such as bugs, ants, or mice ☐ Mold ☐ Lead paint or pipes ☐ Lack of heat ☐ Oven or stove not working ☐ Smoke detectors missing or not working ☐ Water leaks
Food		
3. Within the past 6 months, you worried that your food would run out before you got money to buy more.	☐ Never	☐ Sometimes ☐ Often(+2)
Transportation		
4. Do you have reliable transportation to get to medical appointments, meetings, work or for getting things needed for daily living?	☐ Always	☐ Sometimes ☐ Never(+2)
Utilities		
5. In the past 6 months have any of the following services threatened to shut off services or have shut off services in your home?	☐ (n/a)	☐ electric ☐ gas ☐ oil ☐ water ☐ phone ☐ internet
Safety		
6. Do you feel physically safe in your home?	☐ Always	☐ Sometimes ☐ Never(+2)
7. Do you feel emotionally safe in your home?	☐ Always	☐ Sometimes ☐ Never(+2)
Financial Strain		
8. How hard is it for you to pay for the very basics like food, housing, medical care, and heating?	☐ Not hard at all	☐ Very hard(+2) ☐ Somewhat hard

Employment		
9. Do you need help finding or keeping a job?	☐ No	☐ Yes
Family and Community Support		
10. If for any reason you need help with day-to-day activities such as bathing, preparing meals, shopping, managing finances, etc., do you get the help you need?	☐ I don't need any help ☐ I get all the help I need	☐ I could use a little more help ☐ I need a lot more help (+2)
		Total= /35

Patient Name:_____ Date:_____
Patient ID #_____

Katz Index of Independence in Activities of Daily Living

Activities Points (1 or 0)	**Independence** (1 Point) **NO** supervision, direction or personal assistance.	**Dependence** (0 Points) **WITH** supervision, direction, personal assistance or total care.
BATHING Points: _____	**(1 POINT)** Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	**(0 POINTS)** Need help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing
DRESSING Points: _____	**(1 POINT)** Get clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	**(0 POINTS)** Needs help with dressing self or needs to be completely dressed.
TOILETING Points: _____	**(1 POINT)** Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	**(0 POINTS)** Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
TRANSFERRING Points: _____	**(1 POINT)** Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable	**(0 POINTS)** Needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE Points: _____	**(1 POINT)** Exercises complete self control over urination and defecation.	**(0 POINTS)** Is partially or totally incontinent of bowel or bladder
FEEDING Points: _____	**(1 POINT)** Gets food from plate into mouth without help. Preparation of food may be done by another person.	**(0 POINTS)** Needs partial or total help with feeding or requires parenteral feeding.

TOTAL POINTS: _____ **SCORING:** 6 = High (*patient independent*) 0 = Low (*patient very dependent*

Source:
try this: Best Practices in Nursing Care to Older Adults, The Hartford Institute for Geriatric Nursing, New York University, College of Nursing, www.hartfordign.org.

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From The Hartford Institute for Geriatric Nursing, New York University, College of Nursing

Issue Number 2, Revised 2007

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New York University College of Nursing

Katz Index of Independence in Activities of Daily Living (ADL)

By: Meredith Wallace, PhD, APRN, BC, Fairfield University School of Nursing, and Mary Shelkey, PhD, ARNP, Virginia Mason Medical Center

WHY: Normal aging changes and health problems frequently show themselves as declines in the functional status of older adults. Decline may place the older adult on a spiral of iatrogenesis leading to further health problems. One of the best ways to evaluate the health status of older adults is through functional assessment which provides objective data that may indicate future decline or improvement in health status, allowing the nurse to intervene appropriately.

BEST TOOL: The Katz Index of Independence in Activities of Daily Living, commonly referred to as the Katz ADL, is the most appropriate instrument to assess functional status as a measurement of the client's ability to perform activities of daily living independently. Clinicians typically use the tool to detect problems in performing activities of daily living and to plan care accordingly. The Index ranks adequacy of performance in the six functions of *bathing, dressing, toileting, transferring, continence, and feeding*. Clients are scored yes/no for independence in each of the six functions. A score of 6 indicates full function, 4 indicates moderate impairment, and 2 or less indicates severe functional impairment.

TARGET POPULATION: The instrument is most effectively used among older adults in a variety of care settings, when baseline measurements, taken when the client is well, are compared to periodic or subsequent measures.

VALIDITY AND RELIABILITY: In the thirty-five years since the instrument has been developed, it has been modified and simplified and different approaches to scoring have been used. However, it has consistently demonstrated its utility in evaluating functional status in the elderly population. Although no formal reliability and validity reports could be found in the literature, the tool is used extensively as a flag signaling functional capabilities of older adults in clinical and home environments.

STRENGTHS AND LIMITATIONS: The Katz ADL Index assesses basic activities of daily living. It does not assess more advanced activities of daily living. Katz developed another scale for instrumental activities of daily living such as heavy housework, shopping, managing finances and telephoning. Although the Katz ADL Index is sensitive to changes in declining health status, it is limited in its ability to measure small increments of change seen in the rehabilitation of older adults. A full comprehensive geriatric assessment should follow when appropriate. The Katz ADL Index is very useful in creating a common language about patient function for all practitioners involved in overall care planning and discharge planning.

MORE ON THE TOPIC:

Best practice information on care of older adults: www.ConsultGeriRN.org.

Graf, C. (2006). Functional decline in hospitalized older adults. *AJN*, *106*(1), 58-67.

Katz, S., Down, T.D., Cash, H.R., & Grotz, R.C. (1970) Progress in the development of the index of ADL. *The Gerontologist*, *10*(1), 20-30.

Katz, S. (1983). Assessing self-maintenance: Activities of daily living, mobility and instrumental activities of daily living. *JAGS*, *31*(12), 721-726.

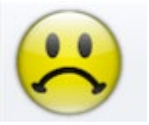
Kresevic, D.M., & Mezey, M. (2003). Assessment of function. In M. Mezey, T. Fulmer, I. Abraham (Eds.), D. Zwicker (Managing Ed.), *Geriatric nursing protocols for best practice* (2nd ed., pp 31-46). NY: Springer Publishing Co., Inc.

Mick, D.J., & Ackerman, M.H. (2004, Sept). Critical care nursing for older adults: Pathophysiological and functional considerations. *Nursing Clinics of North America*, *39*(3), 473-93.

1. **Meetings with Cecilia helped me feel better. (circle one)**





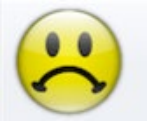


Strongly Agree Agree Neutral Disagree Strongly Disagree

2. **Cecilia helped me identify my needs. (circle one)**





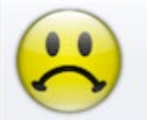


Strongly Agree Agree Neutral Disagree Strongly Disagree

3. **Cecilia helped me set goals to address my needs. (circle one)**







Strongly Agree Agree Neutral Disagree Strongly Disagree

4. **Cecilia connected me to resources that I used. (circle one)**





Strongly Agree Agree Neutral Disagree Strongly Disagree

5. **I would recommend this program to family and friends. (circle one)**





Strongly Agree Agree Neutral Disagree Strongly Disagree

6. **Any other comments?** _____

_____

Addendum 1: Results-Based Accountability Plan

The Results-Based Accountability (RBA) Plan may be periodically amended, as evidenced in writing and signed by all Parties. A written, signed RBA Plan, outlining specific performance measures, will constitute an addendum to this Scope of Work.

1. Program Information:

Organization: County of Sonoma's HSD & Santa Rosa Community Health Centers
Program Name: Collaborative Care Enhanced Recovery Project (CCERP)

1.1. Location and region where services are to be provided (location of where clients served live):

North county: ☒ South county: ☒ East county: ☒ West county: ☒
Central county: ☒

1.2 Language services will be provided in: English: ☒ Spanish: ☒ Other:

1.3 Client demographics for program, if available, check all that apply:

Race/Ethnicity: Hispanic/Latino ☒ White ☒ African American ☒ Asian/Pacific Islander ☒ Native American ☒

Other

Gender: Male ☒ Female ☒ Transgender Female to Male ☒ Transgender Male to Female ☒

Genderqueer/Gender non-binary ☒ Not Listed, please specify:

Age: 0-5 (children) ☐ 6-15 (youth) ☐ 16-25 (transition age youth) ☐
26-59 (adults) ☒ 60 and over (older adults) ☒

Other:

** For reporting purposes only*

2. Result Area:
Result (population accountability)
What population result does your program contribute to? The County has identified a list of results and population indicators for each Department. Add result(s) relevant to this procurement from the list.

2.1 Result: *All Sonoma County Residents Live a Long and Healthy Life*

3. Performance Measures for Program Year 2 –

List proposed activities that you plan to monitor with performance measures	***Program Performance Measures***	***Performance Measure Target***	***Data Collection Method***	***Data Reporting Cycle***	***Turn the Curve Frequency – (data review & action plan)***
Provide longer-term (12 months), in-home case management to adults aged 50+ who have two or more impairments with a goal of reducing depression, increasing targeted outreach to and engagement of Latinx and Spanish-speaking individuals, with an enhanced focus on culturally and linguistically appropriate care.	**How much do we do? (# of participants served, # of activities)** • # of unduplicated clients	• 105 unduplicated clients per year	• EHR patient registry	• July 1-September 30 • October 1-December 31 • January 1-March 31 • April 1-June 30	• October • January • April • July
	How well do we implement the service? (Participant satisfaction, retention rates, cost) • % of unduplicated clients who meet their goals and exit the program in a quarter (meet goals or exit the program at end of 12-month program)	• 50 % of unduplicated clients will meet their goals or exit the program at end of 12-month program)	• EHR patient registry	• July 1-September 30 • October 1-December 31 • January 1-March 31 • April 1-June 30	• October • January • April • July
	Are people better off? (#/% skill or knowledge, #/% attitude or opinion, #/% behavior, #/% circumstance/condition) • % of unduplicated clients who exit the program and self-report mental health improvements	• 50% of unduplicated clients who exit the program will self-report improvements with their mental health	• Client survey or questionnaire	• July 1-September 30 • October 1-December 31 • January 1-March 31 • April 1-June 30	• October • January • April • July

4. Reporting Requirements:

Contractor shall apply, document and report on performance measures and activities detailed in the RBA Plan. These documents may be modified at any time as agreed to in writing by both parties. Contractor shall report these data based on the timeline determined in the RBA Plan, and participate in Turn the Curve monitoring as defined in the RBA Plan. Contractor shall disaggregate the performance measures by demographics and geographic area for reporting when possible. Upon contract closeout, contractor shall report client demographics for program if available.

Contractor	Contract Manager or Designee	Department RBA Lead

unidos

POR NUESTRO BIENESTAR

El objetivo del programa es en apoyar a personas de 50 años o más, a mejorar su sentido de bienestar con atención colaborativa conjunto a su clínica de salud médica

Usted se siente o tiene:

- cansancio frecuente
- estado de ánimo bajo
- agobiado/ ogabiada
- dificultad en completar metas o quehaceres
- solo/ sola
- dificultad en casa con su familia

Con el apoyo del programa Unidos:

Obtenga 12 meses de asistencia y apoyo continuo de una trabajadora social con visitas en su hogar y de su equipo de salud de la clínica.

Hablaremos sobre obstàculos y buscaremos soluciones que se adapten a sus necesidades. Brindaremos conexiones a recursos tal como alimentos, transporte, y otros servicios.

Si estás interesado,
por favor hable con su proveedor médico
o llame al Centro de Salud Comunitario de Santa Rosa

707-547-2220

Santa Rosa COMMUNITY HEALTH

Human Services Department COUNTY OF SONOMA

unidos

POR NUESTRO BIENESTAR

United for Our Wellness

The goal of Unidos por nuestro bienestar is to help adults (50+) improve their sense of wellbeing through a collaborative care team approach

Have you been feeling:

- tired
- low mood
- overwhelmed
- challenges following through with tasks
- alone
- having difficulty at home

With the support of the Unidos care team:

Get 12 months of ongoing assistance and support from a home-visiting social worker and your health clinic team.

Talk through challenges and find solutions that work best for you and get connections to resources such as food, transportation and other benefits.

If you're interested,
please talk with your medical provider
or call Santa Rosa Community Health Center

707-547-2220

Human Services Department
COUNTY OF SONOMA

Santa Rosa COMMUNITY HEALTH

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

WELLNESS • RECOVERY • RESILIENCE

Sonoma County Prevention and Early Intervention Report For Fiscal Years 2018–2019 to 2020-2021

The MHSA regulations authorize funding for Prevention and Early Intervention (PEI) services, defined as programs that identify early mental illness, improve timely access to services for underserved, unserved and inappropriately served populations. In addition, these programs are designed to reduce negative outcomes from untreated mental illness, such as suicide, incarceration, school failure or dropping out, unemployment, homelessness and removal of children from homes.

In July 2018, Title 9, California Code of Regulations, were amended that increased reporting requirements for PEI programs. Newly required data elements included specific ethnic designations, veteran status, disabilities, sexual orientation, and gender at birth. Sonoma County's data system was not upgraded to include these additional data points until 2021, thus this report will not represent those demographic elements.

In fiscal years 2018-2021 Sonoma County funded a total of 12 Prevention and Early Intervention Programs. The numbers served by many of Sonoma's PEI programs decreased in 2020 due to the COVID 19 pandemic and the resulting social distancing. Many of the programs were able to make some changes in their services to accommodate the absence of in person interactions, however some programs have declining trends.

Sonoma County Department of Health Services, Behavioral Health Division Prevention and Early Intervention Programs:	
Prevention Programs	**Underserved/unserved Population Focus**
Action Network – Across Ages and Cultures	Rural Areas
Community Baptist Church Collaborative	African Americans
Latino Service Providers of Sonoma County	Latinx
Positive Images	LGBTQI+
Sonoma County Human Services Department – Older Adult Collaborative	Older Adults
Sonoma County Indian Health Project – Aunties and Uncles Program	Native Americans
Early Intervention Program	
Early Childhood Mental Health (0-5) Collaborative	
Outreach for Increasing Recognition of Early Signs of Mental Illness Program	
Crisis Intervention Team (CIT) with Law Enforcement Personnel	
Stigma and Discrimination Reduction Program	
Santa Rosa Junior College (PEERS) People Empowering Each Other to Realize Success	
Suicide Prevention Program	
Buckelew Programs – North Bay Suicide Prevention Program	
Access and Linkage to Treatment Programs	
Youth Access Team	
Adult Access Team	

Prevention Programs

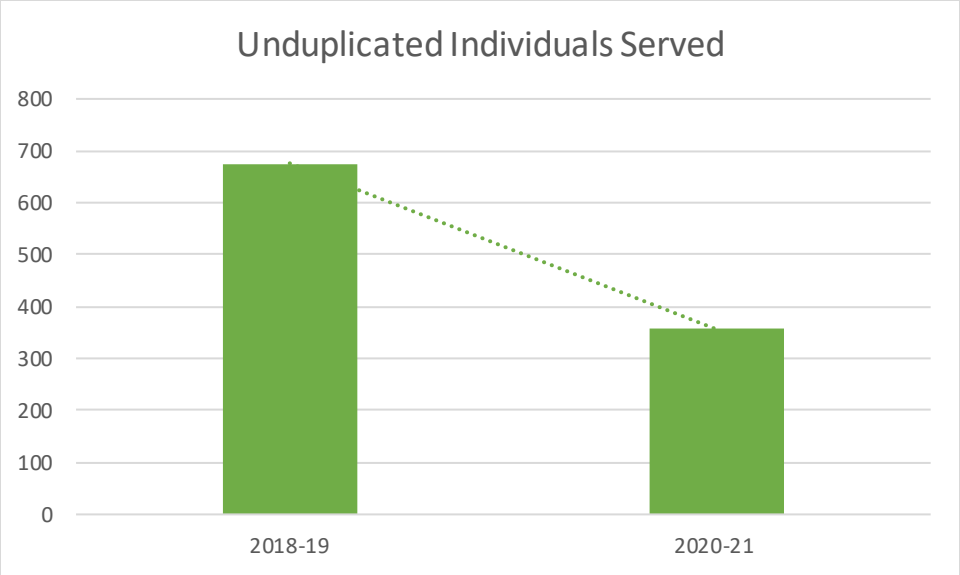
Sonoma County Prevention programs are a set of strategies and activities designed to reduce risk factors, build protective factors and reduce disparities in achieving mental health wellness. Risk factors include, but are not limited to, adverse childhood experiences, historical and repeated trauma, prolonged isolation, stressful family dynamics and living environments (domestic violence, substance abuse, homelessness), racism and social inequity, having a serious and/or chronic medical condition. Prevention strategies may be universal (public education campaigns) or targeted (population focused and culturally defined).

Prevention programs listed below include service descriptions, populations served and significant outcomes for three fiscal years: FY 18-19, FY 19-20, and FY 20-21.

Action Network – Across Ages and Cultures

Action Network aims to provide a Community Wellness approach in all support services and outreach. Youth and family services are woven together through in-home visits, distribution of resources, community events, mental health services and in-person, phone or zoom counseling. School-based and cross agency referrals help in identifying at-risk individuals. Building trust with consistent and reliable contact is key to continuing to serve remote communities. Program participants are at-risk and high-risk children, youth, adults, and seniors primarily from Native American Pomo Tribes, Latinx (English and Spanish speaking), Caucasian, and mixed heritage families living in Sonoma County.

Action Network – Across Ages and Cultures	2018-19	2019-20	2020-21
Unduplicated individuals served	676	287	356
At risk (prevention)	400 (duplicated)	N/A	422



Demographics for Action Network – Across Ages and Cultures			
Age	2018-19	2019-20	2020-21
0 to 15 years (children/youth)	17.8%	67.3%	5%
16 to 25 years (transition age youth)	0.7%	12.0%	32%
26 to 59 years (adult)	5.3%	18.5%	42%
60+ years (older adult)	76.2%	2.2%	21%
Declined to answer	-	-	-
Race			
American Indian or Alaska Native	-	17.0%	70%
Asian	-	-	-
Black or African American	-	-	-
Native Hawaiian or other Pacific Islander	-	-	-
White	82.0%	36.2%	26%
Hispanic	16.0%	37.4%	41%
Other	-	1.5%	2%
More than one race	1.8%	-	-
Declined to answer	0.3%	-	2%
Language			
English	85.5%	59.9%	64%
Spanish	14.5%	40.1%	29%
Other	-	-	-
Gender			
Male	30.5%	36.4%	59%

Female	68.3%	62.7 %	39%
Transgender	-	0.9%	1%
Declined to answer	1.2%	-	1%

Notable performance outcomes FY 2018-19:

- Mental Health First Aid Training attended by community members and nonprofit personnel.
- Over 400 home visits provided to seniors who are homebound. Educational programming for seniors included: Managing stress, Preventing Suicide, 10 Early Signs and Symptoms of Alzheimer's.

Notable performance outcomes FY 2019-20:

- Mental health screenings conducted for children, youth, and parents.
- Kashia Rancheria families received bi-monthly resources such as diapers, food, infant formula, warm clothing, hygiene products, fresh organic produce, and mental health check-ins.

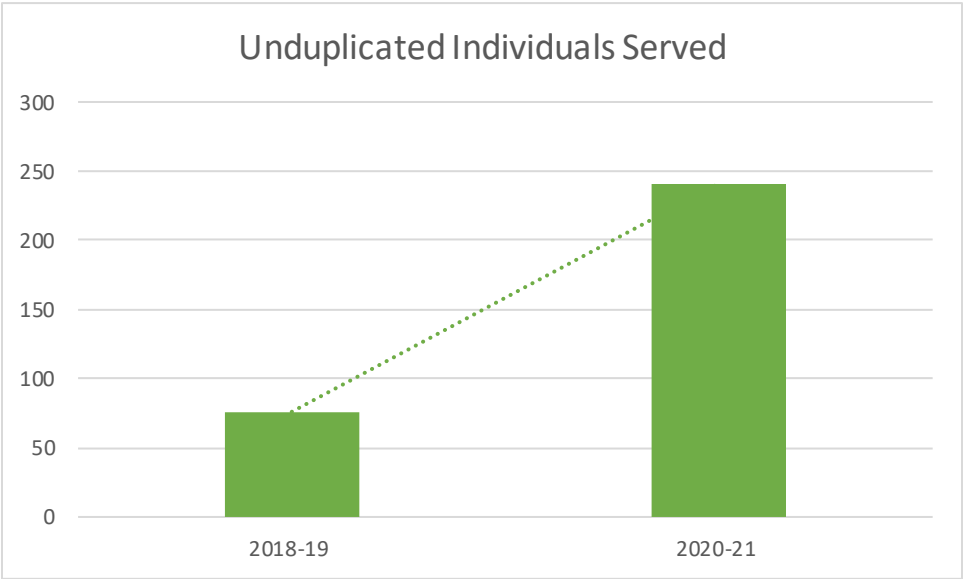
Notable performance outcomes for FY 2020-21:

- 25 households received bi-monthly services at Burbank Housing in Sea Ranch.
- Community Wellness Collaborative was established to support cross agency and school-based referrals for mental health.

Positive Images

Positive Images (PI) is a LGBTQIA+ community center which provides support to Sonoma County's LGBTQIA+ population with an emphasis on identities and individuals at the margins. We envision a Sonoma County where all LGBTQIA+ people are valued, compassionate community members building a just and equitable society. PI offers Peer-Run Mental Health Support Groups, a Leadership Development Program, LGBTQIA+ Cultural Competency Trainings, Resources and Referrals to affirming behavioral health resources, and Community Outreach and Engagement Activities. PI's programs are designed to reduce risk factors for developing a serious mental illness, build protective factors, as well as address and promote recovery.

Positive Images	2018-19	2019-20	2020-21
Unduplicated individuals served	76	269	241
At risk prevention (duplicated #)	6,125	2,391	2,065
Families by individual	1,995	N/A	N/A



Demographics for Positive Images			
Age	2018-19	2019-20	2020-21
0 to 15 years (children/youth)	17.0%	22.0%	25%
16 to 25 years (transition age youth)	22.5%	45.6%	32%
26 to 59 years (adult)	9.8%	26.1%	28%

60+ years (older adult)	2.7%	2.1%	-
Declined to answer	48.0%	4.2%	15%
Race			
American Indian or Alaska Native	0.5%	-	5%
Asian/Pacific Islander	1.1%	-	-
Black or African American	0.5%	-	-
White	33.3%	2.9%	65%
Hispanic/Latino	5.6%	29.2%	9%
More than one race	3.3%	-	21%
Other	0.6%	-	-
Declined to answer	55%	67.9%	-
Language			
English	16.0%	19.7%	100%
Spanish	-	12.4%	-
Other	6.5%	-	-
Declined to answer	77.4%	67.9%	-
Gender			
Male	4.5%	4.2%	-
Female	11.9%	17.4%	12%
Transgender	0.03%	-	60%
Other	-	2.7%	21%
Unknown	48.2%	15.3%	7%

Notable performance outcomes for FY 2018-19

- 1,626 individuals (duplicated) attended 50 Thursday night support groups.
- 83 individuals attended 21 Tuesday Tutoring sessions.
- 968 school, medical and law enforcement personnel attended educational trainings.
- 793 (duplicated) TAY participated in Leadership Team trainings.

Notable performance outcomes for FY 2019-20

- Over 100 TAY referred to Mental Health and other supportive services.

Notable performance outcomes for FY 2020-21

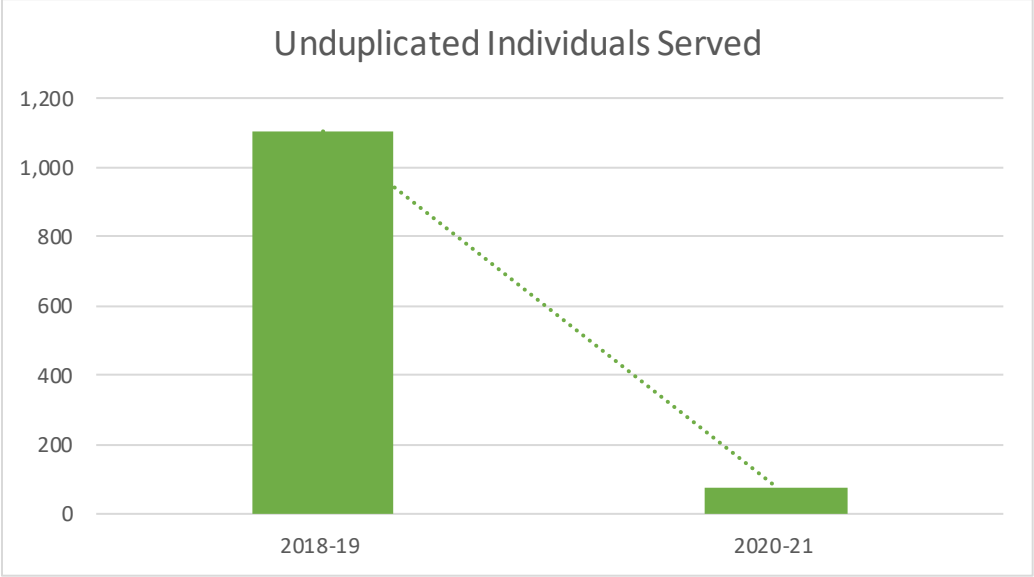
- Hosted 262 Peer-Run Mental Health support groups and 97 Leadership Development sessions.
- Conducted 15 community-wide LGBTQ+ cultural competency trainings.

Sonoma County Indian Health Project – Aunties and Uncles Program

The purpose of the Aunties and Uncles Project is to reduce mental health disparities in the local Native American communities by increasing access to mental health services by:

- Providing community-based awareness campaigns, promoting wellness and education through community and cultural gatherings.
- Providing the GONA (Gathering of Native Americans) Project that supports healing, encourages and guides community discussion about mental health wellness in a cultural context.

Sonoma County Indian Health Project – Aunties and Uncles Program	2018-19	2019-20	2020-21
Unduplicated individuals served	1,104	159	77
At risk (prevention)	N/A	N/A	2000



Demographics for Sonoma County Indian Health Project – Aunties and Uncles Program			
Age	2018-19	2019-20	2020-21
0 to 15 years (children/youth)	27.5%	18.9%	*49%*

16 to 25 years (transition age youth)	17.0%	-	-
26 to 59 years (adult)	-	-	41%
60+ years (older adult)	-	-	10%
Declined to answer	55.4%	81.1%	-
Race			
American Indian or Alaska Native	65.9%	-	100%
Asian	-	-	-
Black or African American	-	-	-
Native Hawaiian or other Pacific Islander	-	-	-
White	-	3.1%	-
Other	-	-	-
More than one race	-	-	-
Declined to answer	34.1%	96.9%	-
Language			
English	98.3%	3.8%	100%
Spanish	-	-	-
Other	1.7%	-	-
Declined to answer	-	96.2%	-
Gender			
Male	6.9%	-	37%
Female	9.1%	19.0%	63%
Declined to answer	84.0%	81.0%	-

Notable performance outcomes for FY 2018-19

- The annual Memorial Gathering on September 15 took place at Ya-ka-Ama Indian education Development Center with a total of 287 adults and children attending. The focus was to bring awareness of youth suicide and to offer resources to tribal community members. Pomo dance groups participated in offering healing traditional song and dance.
- A SafeTalk suicide prevention training for behavioral health staff was conducted by the California Indian Health Board.

Notable performance outcomes for FY 2019-2020

- After-School Program resumed in January for the 2019-2020 school year. This was held on Tuesdays and Thursday 2-5pm until Sonoma County's Shelter in place orders went into effect on March 18, 2020.
- Family Fun Night brought the community together to help support community members impacted by the October wildfires.

Notable performance outcomes for FY 2020-21

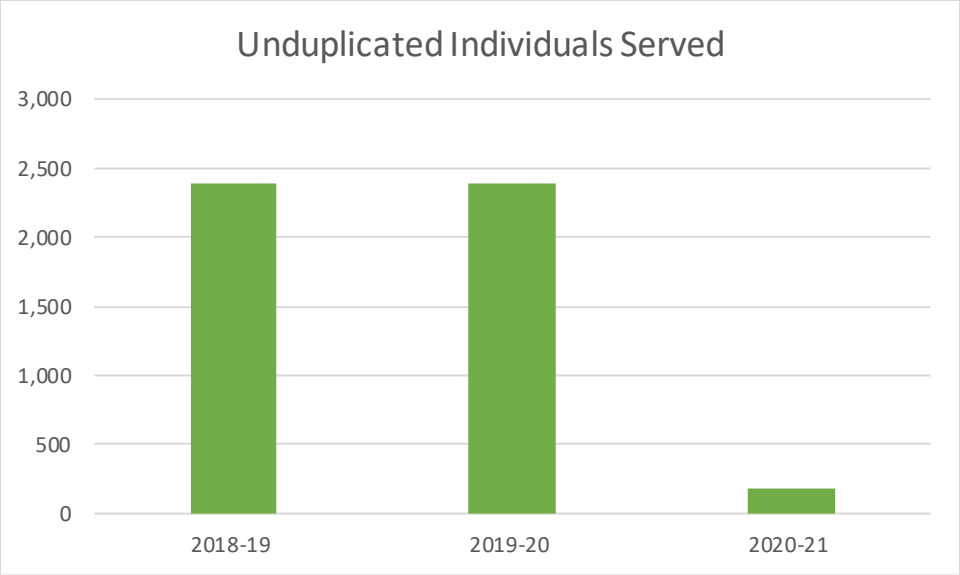
- Program shift to focus on delivery of Gathering of Native Americans (GONA) curriculum.
- Feedback from participants of GONA included appreciation for bringing family members together, meeting other Natives, and traditional storytelling.

Community Baptist Church Collaborative

Community Baptist Church Collaborative goals are to increase awareness of mental health issues and resources in the broader community and specifically within the African American Community. Community Baptist Church Collaborative addresses the associated risk factors of stigma, inadequate information regarding mental health issues, lack of trust for mainstream services and lack of acceptable mental health service for the African American community in Sonoma County with the following programs:

- Village Project and Saturday Academy: A weekly program for children ages 7-11 (Village Project) and 12 – 18 (Saturday Academy) using a faith- based curriculum that focuses on character building and resiliency. Additional support includes mentoring and tutoring.
- Rites of Passage: An eight month program predominantly for youth ages 14-18. This program uses adult mentors (civic and community leaders, elected officials, etc.) to provide youth with life skills to assist with a successful transition into adulthood. This program was not included in the FY 2020-21 contract.
- Safe Harbor Project: Provides events and activities to increase well-being , reduce stress, and increase community building through the use of music, sound and vibro-acoustic techniques. In 2020, Safe Harbor Project launched a 24/7 internet radio station (KSHP Mood Music) with music intended to increase wellbeing, Public Service Announcements, interviews, speakers, and other mental health related information. Once in-person programs are viable, SHP will continue KSHP; host at least 4 large events each year at African American cultural events, health and wellness fairs, and other venues; and provide music and programing.

Community Baptist Church Collaborative	2018-19	2019-20	2020-21
Unduplicated individuals served	2,390	2,390	179
At risk (prevention)	N/A	N/A	4750
Families by individual	220	N/A	-



Demographics for Community Baptist Church Collaborative			
Age	2018-19	2019-20	2020-21
0 to 15 years (children/youth)	28.2%	42.7%	21%
16 to 25 years (transition age youth)	24.9%	6.7%	19%
26 to 59 years (adult)	34.4%	34.1%	60%
60+ years (older adult)	12.6%	12.0%	-
Declined to answer	-	-	-
Race			
American Indian or Alaska Native	12.8%	1.9%	-
Asian	-	-	-
Black or African American	65.1%	75.2%	80%
Native Hawaiian or other Pacific Islander	-	-	-
White	9.2%	1.7%	8%
Hispanic/Latino	11.4%	1.5%	7%
More than one race	1.4%	0.5%	9%
Other	-	19.3%	-
Declined to answer	-	-	3%
Language			
English	97.9%	99.4%	99%
Spanish	2.1%	0.6%	-
Other	-	-	1%
Gender			
Male	43.2%	28.4%	35%
Female	56.8%	71.6%	60%
Respondents who declined to answer	-	-	5%

Notable Performance Outcomes for FY 2018-19

- QPR (Question, Persuade, Refer) suicide prevention training was conducted by the Saturday Academy program.
- 16 students completed the 8-month Rites of Passage program. The graduation ceremony was attended by 220 parents, friends and supporters. This was the 19th graduating class.
- Safe Harbor Project presented "Music as Relief" concerts for the 49th Annual Juneteenth Celebration, Black History Month, and Wellness Festival.

Notable Performance Outcomes for FY 2019-20

- Held annual Hallelujah night at skating rink and 75 youth and adults attended.

Notable Performance Outcomes for FY 2020-21

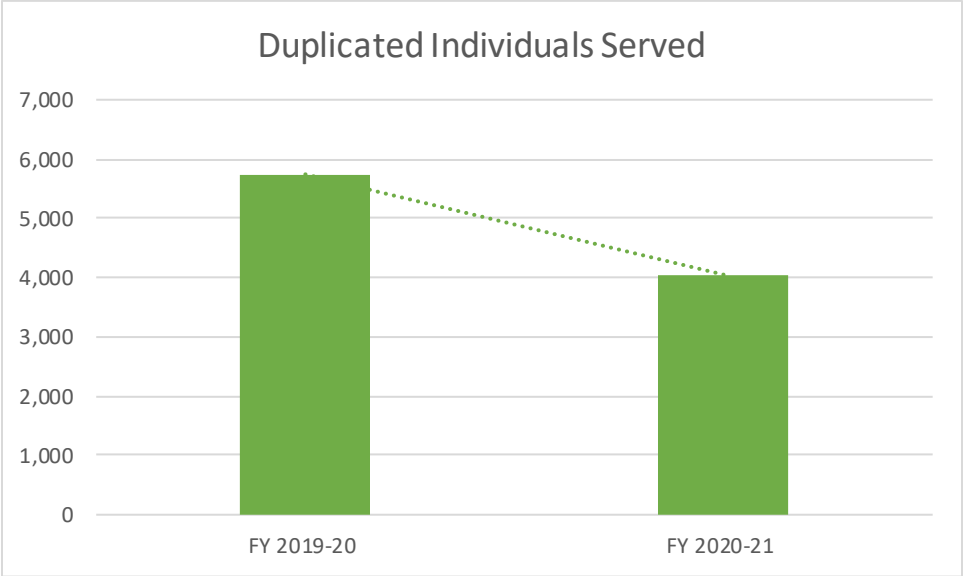
- Establishment of a program on KSHP Mood Music, a 24/7 internet radio station that provides music for well-being and mental health information and resources.

Latino Service Providers of Sonoma County (LSP)

The mission of Latino Service Providers is to serve and strengthen Latinx families and children by building healthy communities and reducing disparities in Sonoma County. LSP's vision is a community where Latinos are fully integrated by having equal opportunities, support, and access to services in the pursuit of a higher quality of life.

To reduce disparities in mental health, LSP utilizes a networking model among community providers to exchange information about activities and resources that will promote economic stability and educational success; increase access to healthcare, mental health, housing, and legal services; reduce the stigma associated with mental health issues; and to address other areas of interest for families throughout Sonoma County.

Latino Service Providers of Sonoma County	FY 2018-19	FY 2019-20	FY 2020-21
Duplicated individuals served	73,641	5,742	4,050
At risk (prevention)	N/A	N/A	208
Early onset (Early intervention)	N/A	N/A	N/A
Families by individual	N/A	N/A	N/A



Demographics for Latino Service Providers			
Age	2018-19	2019-20	2020-21
0 to 15 years (children/youth)	1.2%	-	-
16 to 25 years (transition age youth)	9.6%	17.5%	17%
26 to 59 years (adult)	25.7%	14.6%	14%
60+ years (older adult)	2.1%	-	1%

Declined to answer	61.4%	67.9%	68%
Race			
American Indian or Alaska Native	0.2%	-	-
Asian/Pacific Islander	0.9%	-	-
Black or African American	0.3%	-	-
White	28.6%	2.9%	-
Hispanic/Latino	57.4%	29.2%	28%
More than one race	1.8%	-	72%
Other	1.1%	-	-
Declined to answer	9.7%	67.9%	-
Language			
English	33.4%	19.7%	21%
Spanish	16.0%	12.4%	11%
Other	1.6%	-	-
Declined to answer	0.4%	67.9%	68%
Gender			
Male	20.3%	2.3%	72%
Female	71.7%	23.3%	28%
Declined to answer	8.0%	74.4%	-
Transgender	0.1%	-	-

Notable Performance Outcomes for FY 2018-19

- Conducted eleven 90-minute partnership meetings focused on raising awareness of and access to mental health programs and services for Latinx community members.
- Distributed 50 E-Newsletters (bicultural resource newsletters) resulting in over 80,000 impressions.

Notable Performance Outcomes for FY 2019-20

- Hosted eight community meetings for community providers focused on serving Latinx community members and disseminated 56 E-Newsletters.

Notable Performance Outcomes for FY 2020-21

- Expanded organizational capacity by adding two new staff members to the team to serve the community in response to wildfires and the COVID-19 pandemic.
- Leveraged additional funding (not County MHSA funds) to expand a Youth Promotor program focusing on mental health education and early intervention for the Spanish speaking community.

Sonoma County Human Services Department – Older Adult Collaborative

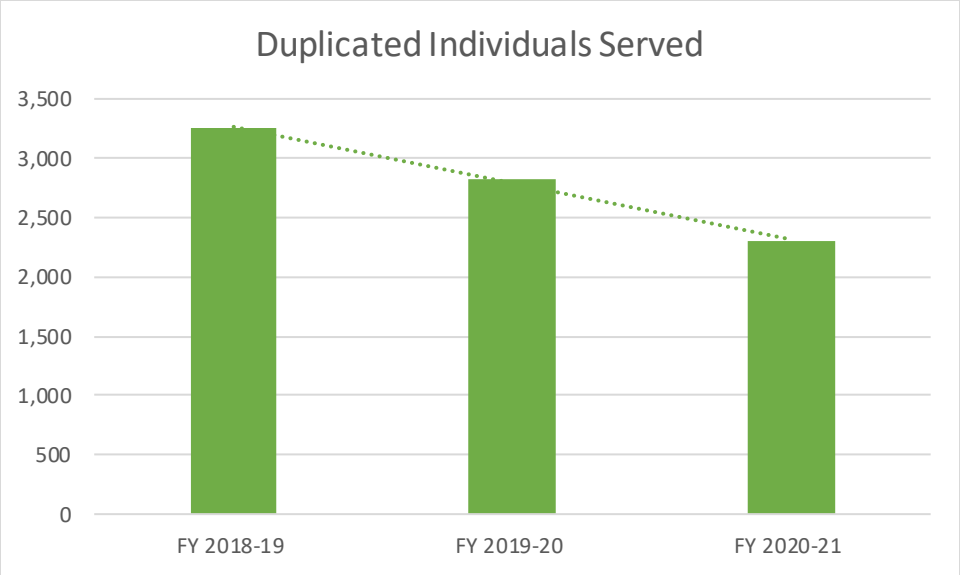
The Older Adult Collaborative (OAC) is led by the Sonoma County Human Services Department – Adult & Aging Services Division. The collaborative is comprised of community-based, non-profit members serving older adults in their respective communities:

- Council on Aging (COA)
- Petaluma People Services (PPSC)
- West County Community Services (WCCS)

Utilizing a prevention and early intervention evidence-based model, Healthy IDEAS (Identifying Depression and Empowering Activities for Seniors), the Collaborative reduces depression and suicide among older adults throughout Sonoma County by:

- Administering a depression screening by licensed experience professionals and supervised peer/volunteers.
- Referring older adults identified as at risk for depression to counseling and psychotherapy.

Sonoma County Human Services Department – Older Adult Collaborative	FY 2018-19	FY 2019-20	FY 2020-21
Duplicated individuals served	3,251	2,817	2,301
At risk (prevention)	1543	N/A	2,966
Early onset (early intervention)	279	N/A	3,680
Families by individual	N/A	N/A	N/A



Demographics for Older Adult Collaborative			
Age	2018-19	2019-20	2020-21
0 to 15 years (children/youth)	-	-	-
16 to 25 years (transition age youth)	-	-	-
26 to 59 years (adult)	-	-	-
60+ years (older adult)	99.7%	99.6%	100%
Declined to answer	0.3%	0.4%	-
Race			
American Indian or Alaska Native	1.5%	1.2%	2%
Asian	4.0%	3.6%	3%
Black or African American	2.9%	2.6%	3%
Pacific Islander	0.5%	-	2%
White	73.5%	73.3%	74%
Hispanic/Latino	13.0%	14.3%	12%
More than one race	0.6%	0.6%	1%
Other	3.1%	2.4%	2%
Declined to answer	0.8%	1.9%	1%
Language			
English	82.8%	86.8%	86%
Spanish	10.0%	11.5%	9%
Other	6.1%	-	4%
Declined to answer	1.13%	1.1%	1%
Gender			
Male	34.0%	33.3%	32%
Female	65.6%	66.2%	68%
Another gender identity	0.1%	-	-
Declined to answer	0.31%	0.4%	-

Notable Performance Outcomes for FY 2018-19

- Over 2,600 seniors were screened for depression, with 525 (19.5%) seniors having positive indicators for depression.
- 279 seniors were referred for mental health services and 1,543 seniors received home visits and phone calls for support.

Notable Performance Outcomes for FY 2019-20

- OAC partner agencies quickly pivoted during the COVID-19 pandemic to provide virtual services that reduced isolation of older adults while providing much needed continuation of services.

Notable Performance Outcomes for FY 2020-21

- 250 older adults showed improvements in depression symptoms based on pre- and post-PHQ9 scores.
- Purchased electronic tablets and set up a daily call program for easier access to services to this vulnerable population.

Early Intervention Programs

Early intervention programs address and promote recovery, including relapse prevention, and related functional outcomes for a mental illness early in its emergence through screening, treatment and other supportive services.

Early Childhood Mental Health (0-5) Collaborative

Sonoma County utilizes MHSA funds for the Early Childhood Mental Health (0-5) Collaborative to support early relational health by:

- Preventing and reducing the impact of **Adverse Childhood Experiences** (ACE's);
- Identifying **developmental and social-emotional concerns and delays**, and linking families to resources;
- Strengthening **parent-child relationships** and building parent's knowledge and skills; and
- Identifying and treating women with **perinatal mood and anxiety disorders** (PMDs).

The following community partners provide contracted services under the 0-5 Collaborative:

- **Child Parent Institute (CPI)**
- **Early Learning Institute (ELI)**
- **Petaluma People Services Center (PPSC)**

Each of these community-based partners has a role in providing a continuum of care through the implementation of an evidence-based parenting program, Triple P – Positive Parenting Program. Triple P gives parents simple and practical strategies to help them build strong, health relationships, confidently manage their children's behavior, and prevent problems from developing.

"Our focus has been on the population who have been afraid to come in to get the other services we offer. When they come in, we can tell them about all the things we do. Without the partnership we wouldn't be able to do the work. It's important to have those relationships. We receive a lot of referrals from [our Collaborative partners], which helps us connect with those other families we might miss otherwise." Child Parent Institute (0-5 Collaborative)

Child Parent Institute (CPI) participates in a community continuum of care, which includes screening, intervention, and support strategies, serves children and caregivers, and establishes a framework for success beyond a single program or strategy. CPI provides:

- Triple P (Positive Parenting Program) Level 2 Seminars.
- Levels 3, 4, and 5 (individual and group formats) in an in-home parent education format or at CPI or a community site.
- Enhanced services that include mental health consultations as needed.

Child Parent Institute (0-5 Collaborative)	FY 2018-19	FY 2019-20	FY 2020-21*
Duplicated individuals served	512	113	N/A
At risk (prevention)	69	N/A	N/A
Early onset (Early intervention)	N/A	N/A	N/A
Families by individual	N/A	N/A	N/A

Demographics for Child Parent Institute			
Age	2018-19	2019-20[1]	2020-21*
0 to 15 years (children/youth)	41.6%	38.5%	N/A
16 to 25 years (transition age youth)	12.3%	3.5%	N/A
26 to 59 years (adult)	29.3%	36.1%	N/A
60+ years (older adult)	1.0%	-	N/A
Declined to answer	-	21.4%	N/A
Race			
American Indian or Alaska Native	-	1.9%	N/A
Asian	-	0.5%	N/A

[1] This data reflects the 0-5 collaborative (CPI, ELI and PPSC) as a whole for FY 2019-20.

Black or African American	3.1%	1.4%	N/A
Pacific Islander	-	-	N/A
White	16.2%	34.8%	N/A
Hispanic/Latino	60.0%	48.9%	N/A
More than one race	4.1%	4.9%	N/A
Other	0.6%	1.9%	N/A
Declined to answer	16.0%	5.7%	N/A
Language			
English	45.3%	62.1%	N/A
Spanish	52.0%	36.7%	N/A
Other	1.2%	-	N/A
Declined to answer	1.6%	1.2%	N/A
Gender			
Male	42.0%	44.2%	N/A
Female	56.8%	55.8%	N/A
Another gender identity	-	-	N/A
Declined to answer	1.2%	-	N/A

Early Learning Institute (0-5 Collaborative)

The Early Learning Institute's Watch Me Grow (WMG) program serves families of children ages birth through five across Sonoma County by:

- Providing comprehensive screenings to at-risk children who would otherwise not receive them.
- Providing case management and referral assistance to families of children ages 0-5 for whom a screening identifies potential problems.

Early Learning Institute (0-5 Collaborative)	FY 2018-19	FY 2019-20	FY 2020-21
Duplicated individuals served	2,785	2,078	3,051
At risk (prevention)	406	320 est.	210
Early onset (Early intervention)	490	401 est.	550
Families by individual	2,785	N/A	N/A

Demographics for Early Learning Institute			
Age	2018-19	2019-20[2]	2020-21
0 to 15 years (children/youth)	37.6%	38.5%	35%
16 to 25 years (transition age youth)	5.1%	3.5%	4%
26 to 59 years (adult)	33.5%	36.1%	37%
60+ years (older adult)	21.1%	-	-
Declined to answer	2.8%	21.4%	23%
Race			
American Indian or Alaska Native	1.1%	1.9%	3%
Asian	0.6%	0.5%	1%
Black or African American	2.1%	1.4%	3%
Pacific Islander	-	-	.5%
White	33.6%	34.8%	36%
Hispanic/Latino	51.4%	48.9%	46%
More than one race	7.0%	4.9%	5%
Other	-	1.9%	.5%
Declined to answer	4.2%	5.7%	-

[2] This data reflects the 0-5 collaborative (CPI, ELI and PPSC) as a whole for FY 2019-20.

Language			
English	60.1%	62.1%	66%
Spanish	38.0%	36.7%	33%
Other	0.8%	-	1%
Declined to answer	0.3%	1.2%	-
Gender			
Male	47.8%	44.2%	45%
Female	52.1%	55.8%	55%
Another gender identity	-	-	-
Declined to answer	0.1%	-	-

Petaluma People Services (0-5 Collaborative)

Petaluma People Services Center (PPSC), in partnership with Petaluma City School District provides developmental and social-emotional screening for children in high-risk situations with no other access to screening, parent education, and mental health services to families of children 0-5.

Petaluma People Services Center (0-5 Collaborative)	FY 2018-19	FY 2019-20	FY 2020-21*
Duplicated individuals served	181	N/A	N/A
At risk (prevention)	N/A	N/A	N/A
Early onset (Early intervention)	N/A	N/A	N/A
Families by individual	181	N/A	N/A

Demographics for Petaluma People Services Center			
Age	2018-19	2019-20[3]	2020-21*
0 to 15 years (children/youth)	62.4%	38.5%	N/A
16 to 25 years (transition age youth)	1.1%	3.5%	N/A
26 to 59 years (adult)	36.5%	36.1%	N/A
60+ years (older adult)	-	-	N/A
Declined to answer	-	21.4%	N/A
Race			
American Indian or Alaska Native	-	1.9%	N/A
Asian	-	0.5%	N/A
Black or African American	-	1.4%	N/A
Pacific Islander	-	-	N/A
White	3.9%	34.8%	N/A
Hispanic/Latino	96.1%	48.9%	N/A
More than one race	-	4.9%	N/A
Other	-	1.9%	N/A
Declined to answer	-	5.7%	N/A
Language			
English	12.7%	62.1%	N/A
Spanish	85.6%	36.7%	N/A
Other	1.7%	-	N/A

[3] This data reflects the 0-5 collaborative (CPI, ELI and PPSC) as a whole for FY 2019-20.

Declined to answer	-	1.2%	N/A
Gender			
Male	45.9%	44.2%	N/A
Female	54.1%	55.8%	N/A
Another gender identity	-	-	N/A
Declined to answer	-	-	N/A

*Demographics for Child Parent Institute and Petaluma People Services Center were combined with Early Learning Institute for FY 2020-21.

Notable performance outcomes FY 2018-19

- 126 parents/caregivers attended Level 2 Triple P seminars and 86 parents/caregivers attended Level 3 Triple P seminars.
- Over 20 parents/caregivers receive Level 3 individual sessions and over 120 parents/caregivers received Level 4/5 individual sessions.

Notable performance outcomes FY 2019-20

- 359 parents/caregivers attended Triple P Levels 4/5 sessions focused on broad parenting skills training and intensive family intervention.

Notable performance outcomes FY 2020-21

- 246 parents/caregivers attended Triple P seminars (one or more levels).
- 56 parents/caregivers at risk of or experiencing perinatal mood disorders participated in individual counseling services and 100% of those participants showed improvement in depressive symptoms based on a pre- and post-PHQ9 screening.

Outreach for Increasing Recognition of Early Signs of Mental Illness Programs

Per MHSA PEI definition, "outreach" is a process of engaging, encouraging, educating, and/or training, and learning from potential responders about ways to recognize and respond effective to early signs of potentially severe and disabling mental illness. The potential responders my include families, employers, primary healthcare providers, school personnel, peers, cultural brokers, law enforcement personnel, emergency medical service providers, social service personnel, leaders of faith-based organizations, and child protective services. This program component can also be a strategy in the "prevention program component" of PEI.

In FY 2018-19 and FY 2019-20, this strategy was employed by the Older Adult Collaborative in the Prevention program component and the 0-5 Collaborative within the Early Intervention program component. (See descriptions on pages 16-17 and 19-25 of this report). In FY 20-21, Sonoma County allocated PEI funding to the Crisis Intervention Team as a designated program under this category of Outreach for Increasing Recognition of Early Signs of Mental Illness as noted below.

Crisis Intervention Team (CIT) with Law Enforcement Personnel

A key approach for crisis response is to develop strategies to train community members to recognize signs and symptoms of mental illness and how to effectively intervene when a crisis occurs.

The Sonoma County Sheriff's Office partnered with the County of Sonoma Department of Health Services Behavioral Health Division (DHS-BHD) to conduct the first Crisis Intervention Training (CIT) Academy for Law Enforcement. The 4-day (32-hour) training academy is designed to increase officers' skills to intervene with mental health consumers, individuals with substance use issues, and individuals in crisis. The CIT Academy goals are to:

- Ensure the safety of officers and civilians
- Increase officer understanding of mental illness
- Improve relationships with the community, particularly with mental health professionals, people with mental illness, and family members

Officers are trained to de-escalate potentially violent situations and ensure the safety and diversion of the mental health consumer to a treatment center. CIT trains law enforcement officers to become more adept at assisting mental health consumers, individuals with substance abuse issues, and individuals in crisis. CIT is useful in domestic violence cases and in contacts with youth, elderly citizens, and the general public.

CIT is conducted twice a year in April and October by specially trained law enforcement personnel, mental health professionals, mental health consumers and family advocates. The training is for a maximum of 30 personnel and includes identification of types of mental illness, verbal skills for de-escalation of potentially violent situations, specifics on suicide intervention, and a mental health system overview.

In FY 19-20, two probation officers were invited to join the Law Enforcement CIT. The probation officers found the training very valuable, and the participating officers recommend that all officers have the opportunity to participate in CIT.

Sonoma County Sample
Crisis Intervention Training Curriculum

Day 1

0800	0815	Opening
0815	0830	Introduction to Class
0830	1000	Major Mental Disorders (+video)
1000	1130	Personality Disorders
1130	1230	Lunch
1230	1330	Excited Delirium
1330	1515	PTSD in Returning Vets (+ video)
1515	1530	Local Veterans Resources
1530	1600	Adults w/ Dementia/ Alzheimer's
1600	1700	Family & Consumer Presentation

Day 2

0800	0900	Overview of the BH System
0900	1000	Co-occurring Disorders (BH & SUDS)
1000	1130	Homelessness
1130	1200	NAMI
1200	1300	Lunch
1300	1530	Site Visits and Student Exercise
1530	1700	Disability Awareness

Day 3

0800	0900	Children, Teens & TAY
0900	0945	Overview of Mobile Support Team
0945	1100	Suicide Prevention QPR (+video)
1100	1200	Positive Images
1200	1230	Review
1230	1330	Lunch
1330	1500	Cultural Competence – Implicit Bias
1500	1700	Crisis Communication Tactical Communication/Stress Management

Day 4

0800	0900	Suicide by Cop (+video)
0900	1000	PTSD for Officers
1000	1200	Legal Issues/ 5150's
1200	1300	Lunch
1300	1330	Communication Techniques Review & Simulator Training Scenarios
1330	1630	Role Plays
1630	1700	Graduation

Crisis Intervention Services	FY 2018-19	FY 2019-20	FY 2020-21*
Individuals served	N/A Not funded by PEI	N/A Not funded by PEI	Training not held due to pandemic

Due to the COVID-19 pandemic, CIT law enforcement services were not conducted in April 2020, October 2020, and April 2021. No data is available for those reporting period.

Stigma and Discrimination Reduction Program

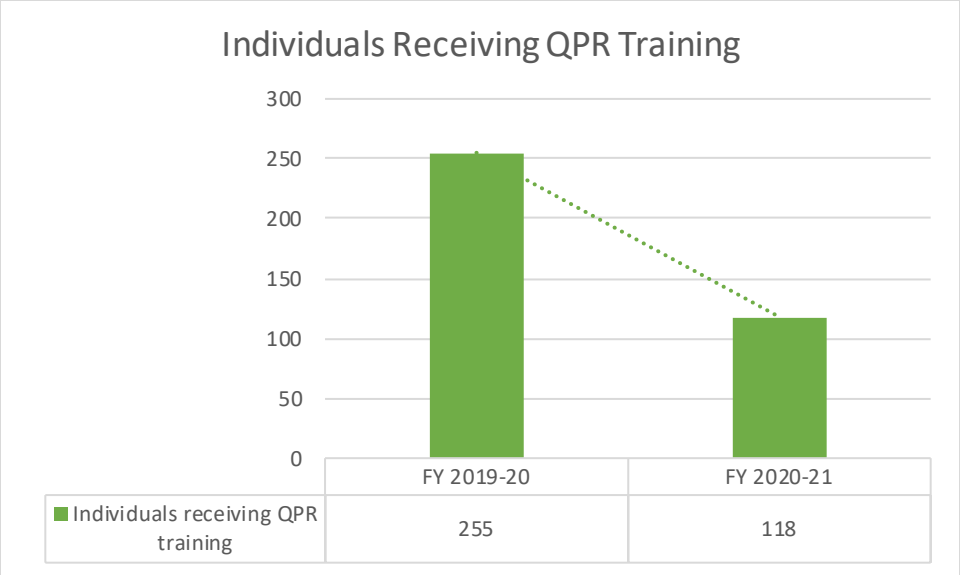
The County's direct activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families.

Stigma and Discrimination Reduction Programs may include social marketing campaigns, speakers' bureaus and other direct-contact approaches, targeted education and training, web-based campaigns, and efforts to encourage self-acceptance for individuals with a mental illness.

Santa Rosa Junior College (PEERS) People Empowering Each Other to Realize Success

People Empowering Each Other to Realize Success (PEERS) is based in the Santa Rosa Junior College (SRJC) Student Health Services department. PEERS uses a comprehensive approach to assist the college community in identifying and responding to students experiencing significant mental health problems, and to promote mental health and reduce stigma across the campus. Faculty trainings on recognizing and responding to students with mental health challenges, QPR suicide prevention workshops, mental health presentations in classrooms and orientations, PEER led workshops and drop-in groups, social media, online mental health screening and outreach events are strategies used to ensure that the SRJC community know that mental health matters.

Santa Rosa Junior College (PEERS) People Empowering Each Other to Realize Success	FY 2018-19	FY 2019-20	FY 2020-21
Individuals receiving QPR training	342	255	118
Individuals receiving education (duplicated)	1,346 students, 58 faculty and staff	799 students	1167 students, 218 faculty and staff



Demographics for SRJC PEERS			
Age	2018-19	2019-20	2020-21
0 to 15 years (children/youth)	0.2%	-	-
16 to 25 years (transition age youth)	49.5%	73.0%	35%
26 to 59 years (adult)	26.3%	24.0%	26%
60+ years (older adult)	2.9%	1.5%	-
Declined to answer	1.0%	1.5%	39%
Race			
American Indian or Alaska Native	1.8%	1.4%	2%
Asian	7.0%	5.9%	5%
Black or African American	4.9%	5.3%	4%
Pacific Islander	-	-	4%
White	34.3%	31.9%	50%
Hispanic/Latino	24.9%	39.8%	33%
More than one race	8.7%	14.4%	8%
Other	5.5%	-	4%
Declined to answer	12.8%	-	25%
Language			
English	64.0%	58.8%	45%
Spanish	7.0%	16.4%	12%
Other	3.7%	1.9%	1%
Multiple languages	0.8%	-	-
Declined to answer	24.7%	22.9%	42%
Gender			
Male	23.7%	30.5%	18%
Female	55.4%	66.1%	58%

Another gender identity	0.5%	2.3%	5%
Transgender	-	1.1%	4%
Declined to answer	0.3%	-	15%

Notable performance outcomes FY 2018-19

- Of 342 participants of QPR suicide prevention training, 91% increase their understanding about suicide and suicide prevention and 95% rated their knowledge in how to ask someone about suicide as medium or high.
- 267 students completed an online mental health screening for depression, anxiety, bi-polar disorder, eating disorders, PTSD and alcohol abuse.

Notable performance outcomes FY 2019-20

- 906 Student Health 101 Online magazine readers.
- 1,191 PEERS Instagram followers.

Notable performance outcomes FY 2020-21

- 295 on-line mental health screenings completed.
- 1151 student contacts at food distribution and vaccine clinics.
- 118 individuals participated in QPR suicide prevention training.

Suicide Prevention Program

Suicide prevention activities aim to reduce suicidality for specific individuals at risk within the general public. Activities may include targeted information campaigns, suicide prevention networks, survivor-informed models, screening programs, suicide prevention hotlines or web-based resources, training and education.

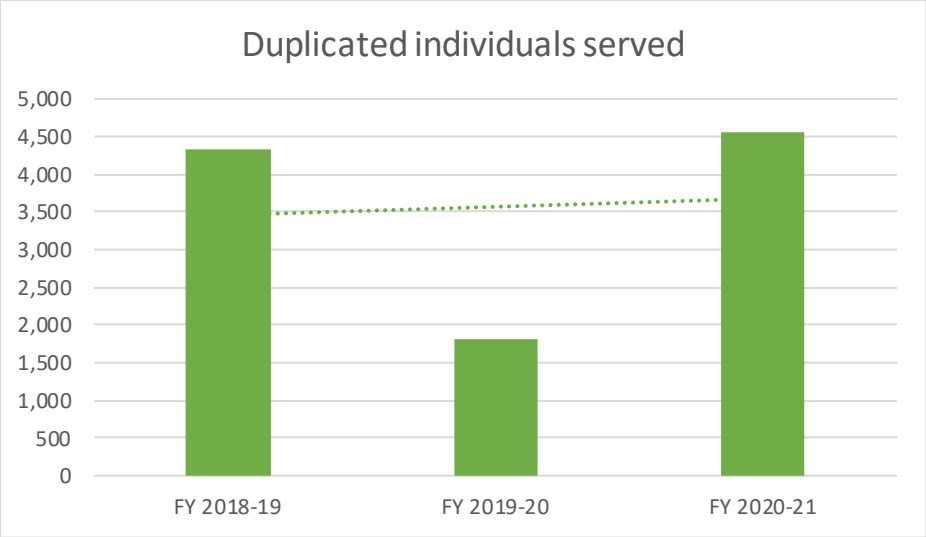
Buckelew Programs – North Bay Suicide Prevention Program

The North Bay Suicide Prevention (NBSP) Hotline of Sonoma County, a program of Buckelew Programs, provides 24/7 suicide prevention and crisis telephone counseling. The Hotline's highly trained and supervised phone counselors provide crisis prevention and intervention to people in distress and/or their family and friends.

Buckelew Programs Suicide Prevention Program provides support for callers who are experiencing suicidal ideation or are closely connected to individuals experiencing suicidal ideation. This support is provided through verbal de-escalation, safety planning, and/or ensuring access to resources, including emergency services or mobile crisis team intervention as needed. The program also provides community training to increase community awareness and provides a SOS (Survivors of Suicide) support group for community members who may need support following the loss of a loved one.

Accredited by the American Association of Suicidology, the Hotline has been part of the National Suicide Prevention Lifeline (a toll free national number that connects callers to their closest certified crisis line) since its inception in 2005. The NBSP Hotline responds to calls from Sonoma County made to the National Lifeline.

Buckelew Programs – North Bay Suicide Prevention Program	FY 2018-19	FY 2019-20	FY 2020-21
Duplicated individuals served	4,333	1,820	4,552
At risk (prevention)	3,997	N/A	3,600
Early onset (Early intervention)	12	N/A	N/A
Families by individual	355	N/A	N/A



Demographics for North Bay Suicide Prevention Program				
Age	2018-19	2019-20	2020-21	
0 to 15 years (children/youth)	3.4%	6.6%	-	
16 to 25 years (transition age youth)	10.8%	21.0%	11%	
26 to 59 years (adult)	47.4%	37.9%	25%	
60+ years (older adult)	23.8%	6.8%	35%	
Declined to answer	14.7%	27.8%	25%	
Race				
American Indian or Alaska Native	0.6%	-	20%	
Asian/Pacific Islander	0.5%	-	40%	
Black or African American	9.0%	1.0%	-	
White	27.3%	6.7%	20%	
Hispanic/Latino	1.3%	3.2%	34%	
More than one race	0.1%	-	33%	
Other	-	0.7%	-	
Declined to answer	61.1%	88.4%	-	
Language				
English	99.8%	99.6%	25%	
Spanish	-	0.4%	25%	
Other	-	-	25%	
Multiple languages	0.2%	-	-	
Declined to answer	-	-	25%	
Gender				
Male	34.7%	39.2%	16%	
Female	56.1%	59.1%	16%	
Transgender	8.1%	-	17%	
Another gender identity	0.05%	-	17%	
Declined to answer	1.0%	1.3%	17%	

Notable performance outcomes FY 2018-19

- 4,333 estimated calls with 1,861 estimated call from unique individuals.
- 12 voluntary rescues for emergency call form Sonoma Callers who were actively suicidal or in acute crisis and requested rescue.
- 2 NBSP Hotline training classes were conducted during the program year resulting in 13 new volunteers.

Notable performance outcomes FY 2019-20

- Held 3 counselor trainings with 13 participants, resulting in 5 new volunteers.
- Instituted 2 new techniques for training: Zoom in trainings to present information and facilitate discussions and roleplays.

Notable performance outcomes FY 2020-21

- The resulting impact of COVID-19 pandemic, staffing shortages and changes in the community's interactions, the program successfully engaged community partners to plan the nationwide transition to 988 hotline.
- Served more than 3,600 callers and supported those callers through de-escalation and/or development of safety plans without the need for on-site emergency intervention.

Access and Linkage to Treatment Programs

The Access and Linkage to Treatment Program connects children and/or adults with severe mental illness (WIC 5600.3) to medically necessary care and treatment. Programs may have a primary focus on screening, assessment, referral, telephone help lines and mobile response.

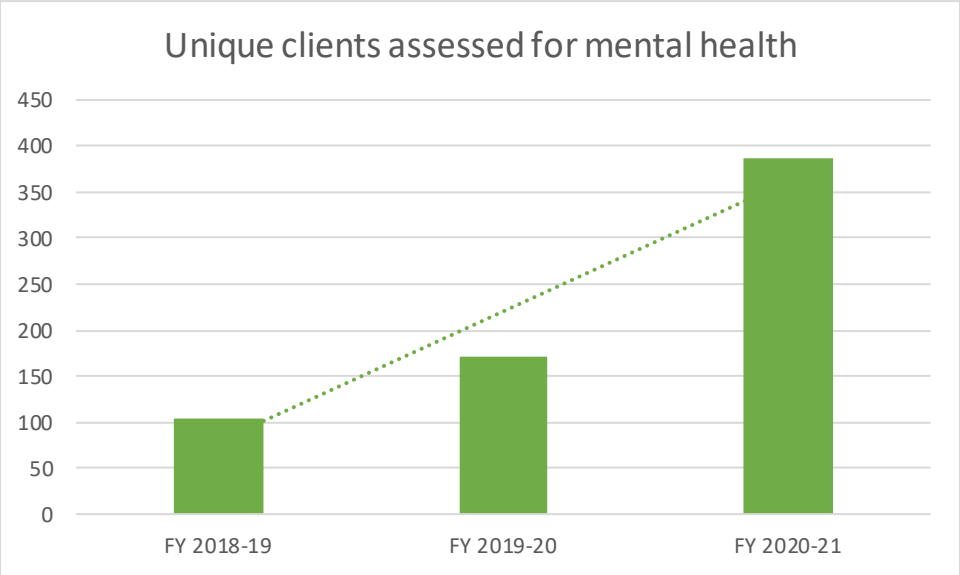
This program component is also a strategy that should be found in all prevention and early intervention programs under PEI funding. In addition, this strategy may be found in other MHSA program components.

Youth Access Team

In fiscal year 18-19, the Behavioral Health Division's Access Team was divided into two service programs, one servicing adults, Adult Access Team, and one servicing youth, Youth Access Team. The Youth Access Team, supported by PEI funds, improves access to mental health services for residents of Sonoma County under the age of 18. Individuals seeking care are able to quickly receive a mental health screening and, when needed, assessment and treatment planning and/or referral for appropriate levels of care to the network of mental health services available throughout the county. While the primary purpose of the Youth Access Team is to assist the Medi-Cal beneficiary into care, the Youth Access Team also provides links to other community resources for any caller.

Youth Access Team[4]	FY 2018-19	FY 2019-20	FY 2020-21
Unique clients assessed for mental health	104	170	387

[4] Data does not include # of mental health referrals, # of other referrals, # of individuals who followed through on the referral and engaged in treatment (at least once), average duration of untreated mental illness and average interval between the referral and participation in treatment.



Demographics for Youth Access Team			
Age	2018-19[5]	2019-20	2020-21
0 to 15 years (children/youth)	-	69.8%	77%
16 to 25 years (transition age youth)	-	30.2%	23%
26 to 59 years (adult)	-	-	-
60+ years (older adult)	-	-	-
Declined to answer	-	-	-
Race			
American Indian or Alaska Native	-	-	4%
Asian/Pacific Islander	-	-	-
Black or African American	-	5.9%	5%
White	-	41.2%	52%
Hispanic/Latino	-	42.4%	50%
More than one race	-	-	-
Other	-	4.1%	39%
Declined to answer	-	6.5%	1%
Language			
English	-	65.1%	81%
Spanish	-	3.0%	15%
Other	-	-	1%
Multiple languages	-	-	-
Declined to answer	-	32.0%	3%
Gender			

[5] Due to data collection issues, demographic information is not available for FY 2018-19 for Youth Access Team.

Male	-	42.6%	39%
Female	-	55.6%	59%
Transgender	-	-	-
Another gender identity	-	1.8%	2%
Declined to answer	-	-	-

Notable performance outcomes for FY 2018-19

- Youth Access Team phone clinicians screened 575 youth.
- Approximately 104 clients were clinically assessed by the Youth Access Team.

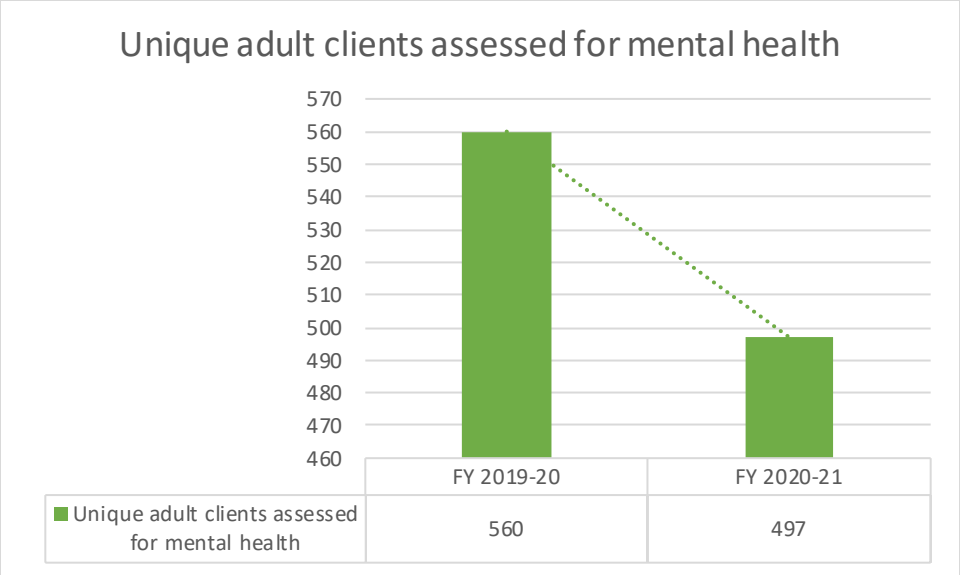
Adult Access Team

The Adult Access Team was funded by Community Services and Supports/General Systems Development prior to 2019-20. In FY 2019-20, PEI funds were allocated for the Adult Access Team to improve access to mental health services for adult residents of Sonoma County. Sonoma County - Behavioral Health Division's Adult Access Team is the first contact for requesting mental health services. They determine the level of need for mental health services, provide assessment, linkage, and information and referral for mental health services for adults.

The Adult Access Team improves access to mental health services for adult residents of Sonoma County. Individuals seeking care are able to quickly receive a mental health screening and, when needed, assessment and treatment planning and/or referral for appropriate levels of care to the network of mental health services available throughout the county. While the primary purpose of the Adult Access Team is to assist the Medi-Cal beneficiary into care, the Adult Access Team also provides links to other community resources for any caller.

Adult Access Team[6]	FY 2018-19	FY 2019-20	FY 2020-21
Unique clients assessed for mental health	N/A	560	497

[6] Data does not include # of mental health referrals, # of other referrals, # of individuals who followed through on the referral and engaged in treatment (at least once), average duration of untreated mental illness and average interval between the referral and participation in treatment.



Demographics for Adult Access Team			
Age	2018-19[7]	2019-20	2020-21
0 to 15 years (children/youth)	-	-	-
16 to 25 years (transition age youth)	-	23.8%	21%
26 to 59 years (adult)	-	68.6%	69%
60+ years (older adult)	-	7.7%	10%
Declined to answer	-	-	-
Race			
American Indian or Alaska Native	-	1.6%	3%
Asian/Pacific Islander	-	-	3%
Black or African American	-	6.6%	6%
White	-	52.5%	68%
Hispanic/Latino	-	18.0%	24%
More than one race	-	-	-
Other	-	16.8%	19%
Declined to answer	-	4.5%	1%
Language			
English	-	70.7%	87%
Spanish	-	3.2%	5%
Other	-	-	1%
Multiple languages	-	-	-
Declined to answer	-	26.1%	7%
Gender			
Male	-	52.7%	51%

[7] Demographic information is not available for FY 2018-19 for Adult Access Team under PEI reporting as the program component was supported by CSS/GSD program component funding.

Female	-	47.0%	47%
Transgender	-	-	-
Another gender identity	-	0.4%	-
Declined to answer	-	-	2%

Improve Timely Access to Services for Underserved Populations Program/Strategy

This program component (or strategy) aims to increase the extent to which and individual or family member from an underserved population has access to culturally and clinically appropriate services in a timely manner. Factors to be considered are location, transportation, hours available, language access, culturally relevant, physical accessibility, and convenient. Service delivery can be offered in non-traditional settings, such as churches, schools, shelters, family resource centers, health care settings and other community locations to improve desired outcomes.

Sonoma County does not have a dedicated program for improving timely access to services for underserved populations, but rather incorporates this objective as a strategy in many PEI and Innovation funded programs. The PEI programs that include this strategy are:

Action Network – Across Ages and Cultures
Community Baptist Church Collaborative
Latino Service Providers of Sonoma County
Positive Images
Sonoma County Human Services Department – Older Adult Collaborative
Sonoma County Indian Health Project – Aunties and Uncles Program

WELLNESS • RECOVERY • RESILIENCE

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

Sonoma County Innovation Plan Proposal

California Mental Health Services Authority (CalMHSA): Semi-Statewide Enterprise Health Record

California Mental Health Services Authority (CalMHSA):
Semi-Statewide Enterprise Health Record for Sonoma County

Innovation (INN) Project Name:	Semi-Statewide Enterprise Health Record
Total INN and CFTN Funding Requested:	$5,526,045
Duration of INN Project:	Five (5) Calendar Years: 2022-2026

Community Program Planning:

Dates Project Shared with Stakeholders:	May 11 and 17, 2022
Public Comment Period:	June 20, 2022- July 19, 2022
Mental Health Board Public Hearing Scheduled:	July 19, 2022
Scheduled for review by the County Board of Supervisors:	August 2, 2022

GENERAL REQUIREMENT AND PRIMARY PURPOSE

General Requirement

X	Introduces a new practice or approach to the overall mental health system, including prevention and early intervention
	Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
	Applies a promising community driven practice or approach that has been successful in non-mental health context or setting to the mental health system

Primary Purpose

	Increases access to mental health services to underserved groups
X	Increases the quality of mental health services, including measured outcomes
X	Promotes interagency and community collaboration related to mental health services or supports or outcomes
	Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Primary Problem

Behavioral Health Plans in California have had a limited number of options from which to choose when seeking to implement a new Electronic Health Record (EHR). The majority of EHR vendors develop products to meet the needs of the much larger physical health care market, while the few national vendors that cater to the behavioral health market have been disincentivized from operating in California by the many unique aspects of the California behavioral health landscape. This has resulted in the majority of county BHPs largely dissatisfied with their current EHRs, yet with few viable choices when it comes to implementing new solutions. The pervasive difficulties of 1) configuring the existing EHRs to meet the everchanging California requirements, 2) collecting and reporting on meaningful outcomes for all of the county BH services (including MHSA-funded activities), and 3) providing direct service staff and the clients they serve with tools that enhance rather than hinder care have been difficult and costly to tackle on an individual county basis.

Currently, EHRs have been identified as a source of burnout and dissatisfaction among healthcare direct service staff. EHRs, which were first and foremost designed as billing engines, have not evolved to prioritize the user experience of either the providers or recipients of care. The impact of this design issue is telling – an estimated 40% of a healthcare staff person's workday is currently spent in documenting encounters, instead of providing direct client care. This estimate does not consider the full breath of the BHP workforce, which relies on a wide diversity of provider types needed to respond to the Medi-Cal population.

Sonoma County Behavioral Health currently utilizes 3 primary systems (Avatar, SWITS, and DCAR) to manage clinical documentation, mandated data reporting, and billing/claiming (primarily Medi-Cal). Current FY 21/22 contract amounts for these systems totals of $857,701, $91,970, and $34,500, respectively.

Within the last year, CalMHSA has developed a plan to procure and administer a Semi-Statewide Electronic Health Record (EHR) for California Counties. The goal of CalMHSA's effort is to partner with the EHR Contractor and participating counties to configure a California-centric Enterprise Health Record that will then be implemented across multiple counties.

Sonoma County, like many California Counties, has struggled with implementing Federal and State requirements, in particular with our current EHR vendors and systems. The Division has minimal resources to administer our systems, and lack technical expertise in the area of modification, enhancement, implementation and maintenance of our EHR systems.

The Division's efforts over the years to implement Avatar has been challenging and expensive, and there have been significant delays with project timelines and deliverables. SWITS provides a basic system that has been used for over a decade. As we move towards implementing the Drug Medi-Cal Organized Delivery System (DMC-ODS), SWITS will require significant upgrades, changes to configuration, and

enhancements in order to comply with the various regulatory requirements associated with DMC-ODS.

The Division has been unsuccessful with implementing the use of Avatar with our community-based organizations, which provide approximately 40% of our mental health services. As a result, we have continued to use the CANS/ANSA Data Collection and Reporting (DCAR) System in order to track and submit required CANS/ANSA outcomes data.

California Advancing and Innovating Medi-Cal (CalAIM) changes target documentation redesign, payment reform and data exchange requirements bringing California BH requirements into greater alignment with national physical healthcare standards, thereby creating a lower-barrier entry to EHR vendors seeking to serve California. At the same time, the COVID-19 pandemic has increased the demand for behavioral health services, had disproportionately impacted communities of color, and has factored into the staggering workforce shortages faced by counties throughout California. BHPs need to foundationally revamp their primary service tool to meet the challenges and opportunities of this moment. BHPs, in partnership with CalMHSA are positioned to do just that through the Semi-Statewide EHR initiative. Clearly, this current moment provides both the opportunity and the imperative for counties to take a substantial leap forward with regard to EHRs.

In addition, CalAIM is a massive initiative requiring all California counties to implement various goals and milestones. With this comes several new requirements which will need to be addressed through updates and modification to each County's EHR such as payment reform, data exchange, and behavioral health policy changes (ie screening tools and clinical documentation).

***Proposed Solution*:** Sonoma County Department of Health Services, Behavioral Health Division Participates in the *Semi-Statewide Enterprise Health Record Project*

Sonoma County Behavioral Health Division is proposing to use MHSA Innovation (INN) and Capital Facility and Technology funds to contract and participate with California Mental Health Services Authority (CalMHSA) to implement a Semi-Statewide Electronic Health Record (EHR) that meets the new CalAIM requirements.

California Mental Health Services Authority (CalMHSA) is a Joint Powers of Authority (JPA), formed in 2009, for the purpose of creating a separate public entity to provide administrative and fiscal services in support of County Behavioral Health Departments. They serve California Counties in the dynamic delivery of behavioral health and supportive services by promoting efficiency, effectiveness, and enterprising among all 58 Counties. In response to CalAIM, CalMHSA has proposed a Semi-Statewide Electronic Health Record.

CalMHSA is currently partnering with 20+ California Counties – collectively responsible for over half of the state's Medi-Cal beneficiaries – to enter into a Semi-Statewide Enterprise Health Record project. This project is unique in that it engages counties to collaboratively design a lean and modern EHR to meet the needs of counties and the communities they serve both now and into the intermediate future. The key principles of the EHR project include:

- **Enterprise Solution**: Acquisition of an EHR that supports the entirety of the complex business needs (the entire "enterprise") of County Behavioral Health Plans.

- **Collective Activism**: Moving from solutions developed within individual counties to a semi-statewide scale allows counties to achieve alignment, pool resources, and bring forward scaled solutions to current problems, thus reducing waste, mitigating risk, and improving quality.

- **Leveraging CalAIM**: CalAIM implementation represents a transformative moment when primary components within an EHR are being re-designed (clinical documentation and Medi-Cal claiming) while data exchange and interoperability with physical health care towards improving care coordination and client outcomes are being both required and supported by the State.

Optimizing EHR platforms used by providers to meet their daily workflow needs can enhance their working conditions, increase efficiencies, and reduce burnout. This increased efficiency translates into more time to meet the needs of Californians with serious behavioral health challenges, while improving overall client care and increasing provider retention.

Additionally, the State has introduced new regulations that require a more sophisticated and customizable electronic health record. Centers for Medicare & Medicaid Services (CMS) announced that they had approved the California Department of Health Care Services' (DHCS') request for a five-year extension of its Medicaid section 1115 demonstration and a five-year extension of its Medicaid managed care section 1915(b) waiver. Both were scheduled to expire on December 31, 2021. The demonstration and managed care 1915(b) combination, re-named "California Advancing and Innovating Medi-Cal" (CalAIM), is a long-term commitment to transform and strengthen Medi-Cal, offering Californians a more equitable, coordinated, and person-centered approach to maximizing their health and life trajectory.

The INN project will have three (3) phases:

1) **Formative Evaluation**: Prior to implementation of the new EHR, the project will measure key indicators of time, effort, cognitive burden, and satisfaction while providers utilize their current or "legacy" EHR systems. The data collected by direct observation of staff workflows currently in use will then be assembled and analyzed using quantitative scales. Objective data for example, length of time

moving between screens, number of mouse clicks, and amount of time required, as well as subjective data to measure user satisfaction, will be incorporated into the evaluation process.

2) **Design Phase**: Based on data gathered from the initial phase, Human-centered design (HCD) experts will assist with identifying solutions to problems identified during the evaluation of the legacy products. This process will help ensure the needs of service providers, inclusive of licensed professionals, paraprofessionals, and peers, and in turn their clients, will be at the forefront of the design and implementation of the new EHR. In order to create as many efficiencies as feasible, the design phase will be iterative, to assure feedback from users and stakeholders is incorporated throughout the process.
3) **Summative Evaluation**: After implementation of the new EHR, the same variables collected during the Formulative Evaluation will be re-measured to assess the impact of the Design Phase interventions.

The HCD approach is supported by research and is a key component of this project. Enlisting providers' knowledge and expertise of their daily clinical operations in order to inform solutions in the Design Phase is vital to ensuring the new EHR is responsive to the needs of the BHP workforce as well as the clients they serve.

Project Management and Administration

- **CalMHSA**: CalMHSA will serve as the Administrative Entity and Project Manager. CalMHSA will execute Participation Agreements with each respective county, as well as contracts with the selected EHR Vendor and Evaluator.
- **Streamline Healthcare Solutions**: This vendor will be responsible for the development, implementation, and maintenance of the Semi-Statewide EHR.
- **RAND**: As the evaluation vendor, RAND will assist in ensuring the INN project is congruent with quantitative and qualitative data reporting on key indicators, as determined by the INN project. These indicators include, but may not be limited to, impacts of human-centered design principles with emphasis on provider satisfaction, efficiencies, and retention. In addition, RAND will subcontract with a subject matter expert in the science of human-centered design to ensure the project is developed in a manner that is most congruent to the needs of the behavioral health workforce and the diverse communities they serve.

Project Objectives

CalMHSA will partner with RAND to achieve the following preliminary objectives:

- **Objective I**: *Shared decision making and collective impact*. Over the course of the EHR project, RAND will evaluate stakeholder perceptions of and satisfaction with the decision-making process as well as suggestions for improvement.
- **Objective II**: *Formative assessment*. RAND will conduct formative assessments to iteratively improve the new EHR's user experience and usability during design, development, and pilot implementation phases. This will include:

    - A discovery process identifying key challenges that the new EHR is aiming to improve and establish strategic areas for testing (e.g., efficiency, cognitive load, effectiveness, naturalness, satisfaction).
    - Testing EHR usage with core workflows (e.g., writing progress notes; creating a new client records) as well as common case scenarios (e.g., potential client calls an "Access Center" for services, before or after hours; sending referrals to other agencies or teams) in order to identify opportunities for increased efficiencies / standardization.
    - Iterative testing and feedback of new EHR vendor's design (wireframes and prototypes) using agreed-upon scenarios, including interviews and heuristic evaluation workshops as appropriate.
    - Identifying performance indicators to gauge success, such as measures of efficiency (e.g., amount of time spent completing a task; number of clicks to access a needed form or pertinent client information), provider effectiveness, naturalness of a task, and provider cognitive load / burden and satisfaction.
- **Objective III**: *Summative assessment*. Conduct a summative evaluation of user experience and satisfaction with the new EHR compared to legacy EHRs, as well as a post-implementation assessment of key indicators.

Project Learning Goals

1. Using a Human Centered Design approach, identify the design elements of a new Enterprise Health Record to improve California's public mental health workforce's job effectiveness, satisfaction, and retention.

2. Implement a new EHR that is more efficient to use, resulting in a projected 30% reduction in time spent documenting services, thereby increasing the time spent providing direct client care.

3. Implement a new EHR that facilitates a client-centered approach to service delivery, founded upon creating and supporting a positive therapeutic alliance between the service provider and the client.

Budget

The amount of Sonoma County's MHSA Innovation (INN) funding is **$4,288,215.07** and the total amount of MHSA funding for the project over seven years is **$5,825,991.07.** The final two years of the project, calendar years 2027 and 2028, will be funded with Sonoma County's MHSA Capital Facilities and Technological Needs (CFTN) component.

Year	MHSA Funding Component	Amount
2022	INN	$1,038,189.84
2023	INN	$943,361.23
2024	INN	$768,888.00
2025	INN	$768,888.00
2026	INN	$768,888.00
2027	CFTN	$768,888.00
2028	CFTN	$768,888.00
	Total Innovation Funding	$4,288,215.07
	Total Cost Over 7 Years	**$5,825,991.07**

Fees:

Description	7 Year Total
One-Time Fees	$596,059.07
Implementation Fees	$872,900.00
Subscription Fees	$4,357,032.00

Description	Unit	Fee Type	7 Year Total
Timeline			
Participant Instance Installation	1	One-Time	$250,000.00
System Acquisition Fee	1	One-Time	$115,353.02
Initial Development Fee (Customization and Security)	1	One-Time	$115,353.02
Discretionary Development Budget	1	One-Time	$115,353.02
Professional Services Implementation	1	One-Time	$800,000.00
SmartCare Patient Portal Implementation	1	One-Time	$2,400.00
SmartCare IP/Residential Implementation	1	One-Time	$7,500.00
SmartCare OE/EMAR Implementation	1	One-Time	$18,000.00
SmartCare Pharmacy Interface Implementation	1	One-Time	$15,000.00

SmartCare Pyxis Interface Implementation	0	One-Time	$0.00
SmartCare HIE / MCO Interface via FHIR Implementation	1	One-Time	$12,000.00
High Availability Cloud Infrastructure Implementation	1	One-Time	$12,000.00
Disaster Recovery Implementation	1	One-Time	$6,000.00
SmartCare CalMHSA Package	800	Monthly	$2,997,440.00
SmartCare Rx Prescribers Subscription	60	Monthly	$487,968.00
SmartCare Patient Portal Subscription	4000	Monthly	$25,024.00
SmartCare IP/Residential Subscription	1	Monthly	$97,750.00
SmartCare OE/EMAR Subscription	1	Monthly	$97,750.00
SmartCare Pharmacy Interface Subscription	1	Monthly	$19,550.00
SmartCare Pyxis Interface Subscription	0	Monthly	$0.00
SmartCare HIE / MCO Interface via FHIR	1	Monthly	$19,550.00
SmartCare Add-On Hosting Storage Subscription	1000	Monthly	$68,000.00
High Availability Cloud Infrastructure Subscription	1	Monthly	$380,800.00
Disaster Recovery Subscription	1	Monthly	$163,200.00

Crossroads To Hope

Sonoma County Mental Health Services Act
FY 2021 - 2027 Innovation Proposal

MENTAL HEALTH SERVICES ACT · PROPOSITION 63 · CALIFORNIA

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

SONOMA COUNTY · 18 50 · CALIFORNIA REPUBLIC · AGRICULTURE INDUSTRY RECREATION · CALIFORNIA

WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

County Name: Sonoma County
Date submitted: September 17, 2021
Project Title: Crossroads to Hope
Total amount requested: $2,500,000 for FY 2021-27

Innovation Project Defined: As stated in California Code of Regulations, Title 9, Section 3200.184, an Innovation project is defined as a project that "the County designs and implements for a defined time period and evaluates to develop new best practices in mental health services and supports". As such, an Innovation project should provide new knowledge to inform current and future mental health practices and approaches, and not merely replicate the practices/approaches of another community.

SECTION 1: INNOVATION REGULATIONS REQUIREMENT CATEGORIES

GENERAL REQUIREMENT:

An Innovative Project must be defined by one of the following general criteria.
The proposed project:

- ☐ Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention
- ☐ Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- ☐ Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- ☑ **Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite**

PRIMARY PURPOSE:

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

- ☑ **Increases access to mental health services to underserved groups**
- ☑ **Increases the quality of mental health services, including measured outcomes**
- ☐ Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- ☐ Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

SECTION 2: PROJECT OVERVIEW

PRIMARY PROBLEM

What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community. Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county.

Sonoma County does not have any dedicated housing that provides supportive and recovery driven peer services for individuals with significant mental health and/or substance use disorders and criminal justice involvement. Instead, many individuals that have significant mental health and/or substance use disorders and criminal justice involvement that may be incompetent to stand trial are housed in the Sonoma County jails and do not receive supportive peer services and evidenced based treatment that will help them move towards recovery and away from criminal justice involvement.

At best, the jails can provide medications to stabilize acute mental health issues and keep the jail population safe. Recovery is difficult to achieve in such a setting. According to a report from the Bureau of Justice Statistics (BJS), more than half of those incarcerated in the United States have mental health issues. These individuals, says BJS, are more likely to have previous convictions and to serve a lengthier sentence than those who do not have mental health needs. Without treatment, mental health conditions can linger or worsen, increasing the likelihood of further involvement in the justice system.[1]

Sonoma County has seen a significant increase in the number of individuals with mental health and substance use issues entering the criminal justice system in recent years. County jail data for 2017 showed that 479 inmates (45.5% of the jail population) were receiving treatment for mental health concerns. In 2018 this number increased to 513, equal to 46.5% of the jail population. The most recent figure for April 17, 2019, indicates 520 inmates (47%) are involved with mental health services, with 246 (47.3%) of this group identified as having acute mental illness, and 117 (22.5%) determined to be seriously mentally ill.[2] In 2017, the Press Democrat published a series of investigative reports about the lack of psychiatric beds and the negative consequences for those individuals experiencing mild to severe mental illness in the local jails. Findings include:

- The number of inmates with severe mental illness diagnoses such as bipolar disorder and schizophrenia increased 60 percent to an average of 69 inmates a day in 2016, up from 43 in 2008.[3]
- Inmates found by the court to be "incompetent to stand trial" must be sent to a state psychiatric hospital to be treated until they are able to understand and face the charges

[1] "Addressing Mental Health in the Justice System", Richard Williams, National Conference of State Legislatures, Vol. 23, No. 31/August 2015.
[2] Data provided by the Sonoma County Sheriff's Department on 4/17/2019.
[3] "Jail is Largest Psychiatric Facility in Sonoma County", The Press Democrat, August 12, 2017.

against them. Because of the lack of bed space at the state's mental hospitals, inmates often wait up to three months or more for an opening.[4]

Recognizing that people with mental illness are over-represented in the local criminal justice system, Sonoma County held a two-day meeting (March 2018) of a Sequential Intercept Model planning process used by communities to assess the circumstances of people with behavioral health needs in the justice system and identify opportunities for linkages to services that can prevent deeper penetration into the criminal justice system. The County brought together over 40 stakeholders from multiple systems, including mental health consumers and professionals, substance abuse, law enforcement, pretrial services, courts, jails, community corrections, housing, health, social services, and family members to identify gaps, resources and opportunities for individuals with mental illness and co-occurring disorders in the criminal justice system. Among all of the alternative strategies, the highest number of participants named "Expand Housing with Supportive Services" as the top priority for the county.[5]

The challenges in transitioning from the jails to community is widely documented and includes finding and securing housing, re-entry into the labor market, and accessing public assistance.[6] For those who are transitioning from the criminal justice system back into the community at large, there is an overwhelming need for safe and stable housing that can enable them to begin or continue their recovery and prevent recidivism back into the criminal justice system. A two-year study conducted by Resource Development Associates states that individuals released from the criminal justice system have the highest recidivism rate in the first 90 days. The findings of this study conclude that appropriate services and supports during that critical period can reduce recidivism.[7] Even when treatment services are available, if an individual cannot identify a safe and stable residence they are significantly less likely to be successful in a jail diversion program. Securing long-term housing and/or a treatment program for individuals takes time and requires the active participation of the client. Providing access to immediate and safe transitional housing, offers a way to bridge the gap so that the client can be diverted from jail with needed supports, begin a treatment program, and have the time and assistance to locate long-term housing.

Local data highlights the difficulty of maintaining stable housing for those who have been engaged with the justice system. The 2018 Point in Time Homeless Count for Sonoma County identified a total of 2,996 homeless individuals. Of this population, 32% had spent at least one night in jail or prison in the previous 12 months, and 28% reported they were on probation or parole at the time of the survey. In addition, 35% of the total number of homeless were identified as having psychiatric or emotional conditions and 33% reported drug or alcohol abuse.[8]

Of the 1,379 individuals on probation in 2018, 180 (13%) were homeless or transient. In terms of unmet needs, a total of 153 (11%) probationers were identified as having housing, but not receiving needed mental health services. On the other hand, 46 (3%) were receiving mental health services but had unmet housing needs. Finally, 122 (9%) were lacking both housing and needed mental health services. This means that nearly a quarter of the total probation population

[4] Ibid
[5] Sequential Intercept Model Mapping Report for Sonoma County, CA; Policy Research Associates, Inc, March 20-21, 2018.
[6] "From prisons to communities: Confronting re-entry challenges and social inequality", American Psycological Association, March 2018.
[7] Sonoma County AB 109 Recidivism Analysis Report, Resource Development Associates, 2019.
[8] Sonoma County Homeless Census And Survey, 2018, p. 52.

was lacking either or both mental health and housing services.[9] As a result of changes to California sentencing policies that reduce the incentives for misdemeanants to participate in services, motivating individuals with misdemeanors to participate in treatment can be difficult. Housing is a significant incentive for this population, and the ability to offer housing to potential participants could contribute greatly to their willingness and ability to participate in treatment.

This was also a finding contained in Sonoma County's Housing Needs Assessment, April 2018. The Housing Needs Assessment report recommended the consideration of the types of supports and services needed for individuals with a history of incarceration. Given that survey respondents indicated difficulty with either securing housing upon their release or finding housing that was considered safe and secure, additional services and supports may be needed to help individuals secure housing upon their release from incarceration.[10]

Assuming transitional housing is available to those with severe mental health diagnoses and involved in the criminal justice system, appropriate and effective clinical and other support services need to be available for a successful re-entry and to establish a foundation for recovery. Interventions, such as "jail diversion" programs, have mixed results. Many incorporate legal leveraging in the form of reporting back to the courts to promote adherence to treatment and services, but this is a coercive and avoidance driven model. Instead, Sonoma County would like to address the challenge of providing a comprehensive program model for individuals who are severely mentally ill and re-entering the community from the criminal justice system.

Combining a healthy and solid transition from the criminal justice system to the community will not be solved by transitional housing alone, a supportive component staffed with peers, individuals with lived criminal justice, mental health and/or substance abuse experience can provide a trusting relationship for education, empowered recovery planning and successful connections with community resources. The Sonoma County MHSA FY 2016-19 Capacity Assessment articulates the finding that peer providers were exclusively located in discrete programs rather than integrated within DHS-BHD programs.[11] Consumers, as well as providers, participating in surveys and focus groups expressed having peer-led programs at all levels of care aligns with MHSA values and promotes a culture shift towards recovery with possible improved outcomes throughout the system of care. Research shows the effectiveness of peer support on many levels, including increasing engagement in treatment and recovery, promoting a sense of hope and self-empowerment, improving social functioning and overall quality of life, and decreasing hospitalizations.[12] Furthermore, having peer support embedded in programming is most effective if those peers have both lived experience with mental illness and criminal justice involvement. The experience with the criminal justice system impacts an individual's life in many ways and it is best understood by individuals who have experienced it.[13] Thus, the proposed Innovation Project, will establish a robust peer component in collaboration with the

[9] Data provided by the Sonoma County Department of Probation, 3/12/2019.
[10] Sonoma County Housing Needs Assessment, Harder + Company Community Research, April 2018.
[11] Sonoma County Mental Health Services Act FY 2016 – 19 Capacity Assessment, Resource Development Associates, January 2020.
[12] Davidson, L., Bellamy, C., Guy, K., & Miller, R. (2012). Peer support among persons with severe mental illnesses: A review of evidence and experience. *World Psychiatry, 11(2), 123-8.*
[13] Substance Abuse and Mental Health Services Administration, GAINS Center for Behavioral Health and Justice Transformation. (Aug 2017). Peer Support Roles in Criminal Justice Settings, A Webinar-Supporting Document.

delivery of clinical mental health services within a transitional housing environment has promising impact for an underserved population.

PROPOSED PROJECT

Describe the INN Project you are proposing. Include sufficient details that ensures the identified problem and potential solutions are clear. In this section, you may wish to identify how you plan to implement the project, the relevant participants/roles within the project, what participants will typically experience, and any other key activities associated with development and implementation.

A) Provide a brief narrative overview description of the proposed project.

The County of Sonoma (County) Innovations Project proposal is Crossroads to Hope (Crossroads). Crossroads will expand access to community-based treatment for individuals who have a severe mental health illness, with a possible substance use disorders who are eligible criminal justice diversion clients. Crossroads seeks to enhance a multi-modality approach for adult diversion clients who are determined to be at-risk for IST (Incompetent to Stand Trial) by adding intensive peer support services for up to 6 individuals at one time within a transitional housing environment. Innovation funding will add a peer support component consisting of a team of peer providers who will lead a holistic client-centered program including: recovery and wellness strategies, independent living skills, building a support network, accessing community resources, and establishing long-term stable housing. Peer providers will collaborate with clinicians to support client-driven recovery plans, facilitate educational and support groups, provide navigation for needed community services, and help support the overall well-being of the residents. Capacity will be for up to 12 - 20 clients annually. In addition, Crossroads will establish a Peer Advisory Council for the project and conduct a formative and outcome evaluation. This model is consistent with the recommendations stated in the MHSOAC's report, *Together We Can, Reducing Criminal Justice Involvement for People with Mental Illness*. Recommendation #3 contained in this report, specifically states that to reduce the backlog of individuals who are found to be or at risk of IST, state and local programs must maximize diversions from the criminal justice system.

The County recently secured funds[14] and is in contract to purchase a three-bedroom house with a second unit that will provide for six beds (transitional housing). In addition to the peer provider staffing, the residents will be supported by a clinical Assertive Community Treatment (ACT) team that will be on-site daily. The ACT team will provide intensive case management, individual, group and family/couples therapy. Education, psychiatry and medication evaluation and monitoring will be provided by a registered nurse. The ACT team will be funded through an already secured California Department of State Hospitals Felony Incompetent to Stand Trial contract.

[14] California Health Facilities Financing Authority – Community Services Infrastructure Grant Program, 2020

Crossroads is designed to provide a robust peer provider program within a short-term residential setting for diversion clients for up to six months. The transitional housing beds, the first dedicated for diversion clients in Sonoma County, will be an invaluable resource providing a safe, stable and supportive environment for clients to begin their journey of recovery. Peer providers, people with similar lived experience in mental health recovery and criminal justice involvement, will staff the residence serving a maximum of 6 individuals at one time. The peer support component will complement ACT clinical services by providing educational and emotional support, advocacy for self-determination, and connection to community-based services and other peer services.

By establishing a supportive community of peers, clinicians, and community resources, this innovative project seeks to increase the quality of mental health services for an underserved group and increase the interagency coordination with community groups and support systems. The Crossroads peer-enhanced model is designed to engage members of the target population by encouraging a high level of contact with peers who share lived experiences resulting in the development of strong, trustworthy, therapeutic relationships. Second, the model encourages clients to share their journey with their fellow peers as a basis for self-actualization and development of a meaningful recovery plan. This recovery plan will be grounded in a philosophy of self-determination and supported by the peers providing personal encouragement, relevant education and connections to community resources. Third, the model is multi-disciplinary, enabling the treatment team to draw upon multiple perspectives to support recovery. Finally, the provision of transitional housing serves as a safe and stable environment; a solid foundation to begin the recovery journey.

Peer support promotes a sense of understanding among those in recovery because they've collectively "been there," shared similar experiences and can model for each other a willingness to learn and grow. In peer support people come together with the intention of changing unhelpful patterns, getting out of "stuck" places, and building relationships that are respectful, mutually responsible, and potentially mutually transforming. Individuals may come to a peer support program because it feels safe and accepting. By sharing experiences and building trust, peers help each other move beyond their perceived limitations, old patterns and ways of thinking about mental health. This allows members of the peer community to try out new behaviors and move beyond the "illness culture" into a culture of health and ability.

Some models of therapy for mental illness focus on a series of problems or symptoms that lead the individual to feel different and alone, "othered", leaving them in relationships that are less than mutually empowering. These clients experience their illness as the driving factor to their lives and depend on professionals to interpret their everyday experiences. Peer support programs do not promote an "illness narrative" but rather look at how individuals have come to know what they know. This leads to a conversation and exploration on what else does the individual need to know and experience to move through the past and into the future. This transformative movement returns the power to the individual to open a new framework for problem solving and decision-making.

Eligible individuals will be identified through Sonoma County's Pretrial program process. The Department of Probation administers a Pretrial Risk Assessment Tool, Public Safety Assessment (PSA) to identify individuals who are appropriate for Pretrial diversion into community

placement. Additionally, the County's Department of Health Services, Behavioral Health Division (BHD) has a clinician embedded within the Pretrial process to conduct needs assessments and determine appropriate level of care for those individuals in custody who have mental health and/or substance use disorders. The clinician consults with clients about available treatment in the community and with consent, the clinician provides a warm handoff to services.

Once a client is deemed eligible for diversion, the Peer provider support team will meet with the client before he/she is scheduled for placement in the transitional housing facility. Peer providers will conduct an orientation and intake to assure the client is fully informed of the program model and evaluation and consents to participation. The ACT team will facilitate the development of personal recovery plans for each client. These plans will be a hybrid of traditional clinical approaches and a philosophy and practice of encouraging client self-determination, a pillar of the peer model. The traditional aspects of the model include the administration of the ANSA (Adult Needs and Strengths Assessment) to establish history, behavior and functionality at entry into the program (baseline). The ANSA will be re- administered between 6 – 9 months after the baseline assessment to compare any changes (outcome). Utilizing the results of ANSA, the development of the personal recovery plan will primarily be led by the client to define their desired goals and definition of success. This approach to recovery planning will be supported by the Peer Providers encouraging a practice of empowerment and self-determination. It is this blended approach to recovery that is innovative for a diversion population and will be studied in the project's process and evaluation.

Crossroads will hire up to 4.5 FTE peers who will staff the transitional housing 24 hours per day, seven days per week. Peer Providers support their peers both individually and in groups. Their responsibilities may include the following:

- Help clients create individual service plans based on recovery goals and steps to achieve those goals
- Use recovery-oriented tools to help clients address challenges
- Assist clients to build their own self-directed wellness plans
- Support clients in their decision-making
- Set up and sustain peer self-help and educational groups
- Share community resources supportive of recovery
- Advocate with clients for what they need
- Work within integrated health settings
- Support clients in crisis
- Share their personal stories of recovery with clients

Qualifications for peer providers will include lived experience (mental health challenges and/or in recovery from a substance use disorder, and prior involvement with the criminal justice system), verified peer training or two years of local peer experience, and familiarity with local resources. Sonoma County has offered peer training utilizing the Intentional Peer Support curriculum through local community-based organizations and instructors may be engaged to provide further staff support and professional development.

One standard recovery goal for all Crossroads clients will be to identify and secure long-term housing as the transitional housing is meant for up to a 6-month stay. The ACT clinical team will interface with the Sonoma County Housing Authority (SCHA), a member of the Sonoma Accessing Coordinated Care and Empowering Self Sufficiency (ACCESS) interdepartmental multidisciplinary team and other housing providers to identify long term supportive housing where Crossroads clients can be placed.

Additional recovery goals may include:

- Community connections: familial, social and recovery support
- Healthy living, including nutrition, exercise, stress reduction, spiritual development, self-care
- Engagement in workforce and/or education

Clients will receive education and support in these areas, opportunities to practice skills and establish connections that promote achievement of personal recovery plan goals. The peer support program at Crossroads will include a nutritionist to help with menu planning, shopping, and cooking demonstrations once per week, a yoga/meditation practitioner once per week, guest speakers and instructors, and opportunities for visits to the Santa Rosa Junior College, Wellness and Advocacy Center, Job Link, and recreational centers.

Peer providers will work in tandem with clinicians of the ACT team, probation officers and other providers of wrap around services. The multi-disciplinary team coordinates around a client-directed approach and actions, decisions and progress will be documented in case notes and periodic reports from the peer providers. Not to be confused with a residential therapeutic treatment center, Crossroads is transitional housing with supportive and clinical services for the residents of the house. Peers will not have the role of supervising residents nor addressing compliance issues.

To ensure that Crossroads maintains a peer recovery focus and that the program structure, policies, and procedures are supportive of the Peer Provider Team, a Peer Advisory Council will be established. This Peer Advisory Council will be comprised of peer providers from the community, family members and other stakeholders who are aligned with the intent and philosophy of the project. The role of the Peer Advisory Council is to expand the diversity of experience and views of the peer community in accordance with Community Program Planning processes. This group will meet regularly to review program and evaluation design, progress on implementation and review evaluation findings at annual benchmarks. Peer Advisory Council members will be compensated for attending meetings if not already compensated by their employer.

B) Briefly explain how you have determined that your selected approach is appropriate. For example, if you intend to apply an approach from outside the mental health field, briefly describe how the practice has been historically applied.

The added benefit and positive outcomes resulting from the integration of peer providers into mental health services is not a new concept. In fact, self-help groups for substance abuse and addiction have been around since the first Alcoholic Anonymous meeting started in 1935. Peer

support is instrumental in developing strong trusting relationships among those in early recovery. Sonoma County has a strong history of peer provider engagement to successfully engage consumers in community-based recovery models. In 1996, a group of individuals with lived experience established Interlink Self-Help Center, a peer managed and operated service promoting self-directed mental health recovery and wellness. This was the first formal organization funded by the County of Sonoma. Since then, Sonoma County has supported a variety of peer-led services including the Wellness Center, Petaluma Peer Recovery Center, Russian River Empowerment Center, Peer Education and Training Program, and the MST Peer Supports Project with MHSA funding.

Realizing the benefits of having peers both as advisors and providers in the mental health continuum of care, Sonoma County has continued to look for opportunities to strengthen and expand the peer role in service delivery. In June of 2016, a group of community stakeholders including consumers, peers, mental health providers and County representatives met to discuss the lack of services and supports for those who were on the precipice of a crisis. With limited beds at the Crisis Stabilization Unit (CSU), the group proposed a peer respite residential center. This proposal to provide immediate short-term housing staffed and led by peers would intervene prior to crisis and focus on wellness and recovery. Unfortunately, funding stalled and the project was not realized, but this effort set the stage for continued interest and determination for peer-led services and supports.

In the Sonoma County Capacity Assessment Report released in January 2020, community stakeholders praised peer providers and programs noting the effectiveness of engaging individuals into treatment and empowering a community of recovery that could not be achieved by clinicians alone.[15] The FY 2016-19 MHSA Capacity Assessment report continues to state that consumers, as well as providers, expressed support for peer-led programs at all levels of care. Integrating peer providers who embody recovery and what is possible for consumers is aligned with MHSA values and could create a cultural shift in the way mental health services are delivered throughout the system of care.

C) Estimate the number of individuals expected to be served annually and how you arrived at this number.

The proposed project will serve six individuals residing in Crossroad's transitional housing beds. Assuming a maximum stay of six months, with some clients that will transition to long-term housing earlier or chose to leave the program, it is anticipated that the program will be able to serve 12 to 20 clients each year. The diversion transitional housing beds will be an invaluable resource for serving the diversion population in the county, by helping clients to focus on their recovery plan, connect to treatment services, and re-engage with the community and needed resources. All alumni who complete the transitional housing phase and are still actively in recovery will be invited back to the Crossroads transitional house to participate in support groups, meetings with ACT clinicians, weekly community dinners, and select educational groups and activities.

[15] Sonoma County MHSA FY 2016-2019 Capacity Assessment, Research Associates Development, January 2020.

D) Describe the population to be served, including relevant demographic information (age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate).

The population to be served aligns with AB1810 and the criteria for Specialty Mental Health Services for the Department of Health Services, Behavioral Health. Individuals who are eligible for local Diversion services, include the following:

- Felons or Misdemeanants
- Individuals with a serious mental illness (SMI) as identified under AB1810
- Preference will be given to clients participating in the Mental Health Diversion Court who also have a diagnosis of:
    - Schizophrenia
    - Schizo-Affective Disorder
    - Bi-Polar Disorder
- At low or no-risk to public safety and the community
- Voluntarily seeks to participate in treatment, agreement to comply/consent
- Found to be ICST (Incompetent to Stand Trial) or At risk for ICST
- Significant relationship between Mental Health condition and charged offense
- Medi-Cal eligible

Crossroads will provide services to Spanish-speakers and has contracted ASL interpreters for the hearing impaired. The transitional housing will be welcoming to all gender identities.

RESEARCH ON INN COMPONENT

A) What are you proposing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

Sonoma County does not have any dedicated housing that provides supportive and recovery driven peer services for individuals with significant mental health and/or substance use disorders and criminal justice involvement. Instead, many individuals that have significant mental health and/or substance use disorders and criminal justice involvement that may be incompetent to stand trial are housed in the Sonoma County jails and do not receive supportive peer services and evidenced based treatment that will help them move towards recovery and away from criminal justice involvement.

The proposed project, Crossroads, is based upon a combination of evidenced-based approaches, including Housing First, Assertive Community Treatment (ACT) and peer support integration into mental health treatment and recovery processes. The innovation is combining those approaches into one program model to fully engage and support individuals in their early recovery with that is client driven and addresses the barriers to successful achievement of recovery goals.

The initial research question was whether there was a successful model serving individuals with mental illness having a criminal justice background with a robust peer provider program combined with a clinical team within a supportive housing model. Research for this project discovered existing models that combined housing with ACT and/or peer-led services for the homeless, but not for adult diversion clients. The New York based homeless project, Pathways' Housing First is focused on obtaining market rate housing with minimum rules. It is almost expected that there will be challenges in maintaining housing and that the policies and procedures need to be flexible and client-driven. Pathways incorporates five principals: 1). Housing First, 2) Consumer Choice and Self-Determination, 3) Recovery Orientation, 4) Individualized and Person Driven and 5) Social and Community Integration. These five principles have transformed many staff to think differently about their approaches and understanding of recovery, and simultaneously empowered clients to be open to new ways of thinking, acting and increase ownership of their actions in the context of recovery.

The Peer Wellness Program, a service component of Pathways to Housing is exclusively run and managed by peers with lived experience. The peer run model emphasizes empowerment, social inclusion and true collaboration. Furthermore, the service delivery model focuses on the whole person, offering an array of supportive services, including housing retention, employment, pursuing their education, securing entitlements, making social connections, criminal justice issues, reuniting with children and families, living healthier lifestyles, becoming financially informed, and dealing with trauma. Pathways to Housing does use similar evidence-based and promising practices including: Housing First, Supported Employment—IPS (Intentional Peer Support) model, Integrated Dual Disorder Treatment (IDDT), the Wellness Self-Management tool, and Assertive Community Treatment Model (ACT). However, this project is not a criminal justice diversion project focusing on the severely mentally ill who are at risk of being found incompetent to stand trial.[16]

Crossroads to Hope is different from Pathways to Housing in that Crossroads will have transitional beds open and dedicated to eligible individuals leaving the criminal justice system. Pathways relies on market housing available to the broader public. In Sonoma County, housing is sparse and competition for rentals is fierce. Clients could be waiting many months for housing and thus delay access to treatment and possibly impact motivation.

Another model closer to home in California is the Amity Foundation, located in Los Angeles County. The Amity Foundation has implemented a model of short-term supportive housing coupled with case management for diversion clients but does not integrate peers into the clinical service delivery model. Furthermore, the Department of Health Services' Office of Diversion and Reentry's program offers long-term (not transitional) supportive housing with intensive case management to Probationers. Additional diversion programs have been developed by LA's Office of Diversion and Reentry for individuals found to be incompetent to stand trial, but again does not incorporate peers into the recovery model. [17]

[16] "Peer Wellness Program and Pathways to Housing", Substance Abuse and Mental Health Services Administration, https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/peer-wellness-pathways-housing

[17] Health Services, Los Angeles County, Office of Diversion and Reentry, http://dhs.lacounty.gov/wps/portal/dhs/diversionandreentry/jcbd

B) Describe the efforts made to investigate existing models or approaches close to what you're proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.

With the support of MHSOAC staff, Sonoma County reviewed three additional Innovation Projects from Marin, Sacramento, and San Joaquin counties. Although Marin and Sacramento counties address the challenges in providing effective services for those involved with the criminal justice system, Marin takes a housing and holistic therapeutic approach and Sacramento is modifying their Child and Family team model to a forensic behavioral health multi-system team approach. Marin does incorporate one staff member with lived experience (peer), but does not build a strong peer provider program component as their centerpiece. Rather, Marin focuses on holistic health to address trauma within an exclusively female population.

San Joaquin is housing first focused for individuals experiencing mental illness and homelessness. San Joaquin's project does not incorporate a peer provider component at all.

Casting a wider net of research, a review of consumer-provided services (peer provider services) combined with Assertive Community Treatment (without housing) was conducted and identified 16 published studies. Findings were mixed, with evidence supporting consumer-provided services for improving (client) engagement. However, evidence was lacking for other outcomes, such as symptom reduction or improved quality of life.[18] The gaps in research indicate a lack of documentation and evaluation on a model that combines Housing First, Assertive Community Treatment with peer-led provider support for diversion clients from the criminal justice system. This innovation proposal for Crossroads to Hope would be an excellent model to measure impact and has promising benefits for those in the criminal justice system in Sonoma County and throughout California.

LEARNING GOALS/PROJECT AIMS

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the expansion of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the expansion of effective practices.

A) What is it that you want to learn or better understand over the course of the INN Project, and why have you prioritized these goals?

The first overarching goal for the program is to learn if a combined peer-provider model that is client centered and self-directed can be blended with a clinical approach that is often compliance focused and driven by the clinician. Furthermore, the County would like to understand the challenges and successes in that development process. The second and third goal is to

[18] A review of consumer-provided services on Assertive Community Treatment and intensive case management teams: Implication for future research and practice. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3117264/

understand if the peer provider programming is a significant factor on client engagement and achievement of treatment plan goals. The lessons learned from developing this blended model and outcomes can be used for future programming that integrates **peer providers** and self-empowered, self-directed recovery philosophies.

B) How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?

A literature review finds evidence that peer-led programs have value and positive impact on mental health recovery for individuals. But there is lacking evidence on **how** peer support specifically contributes to positive outcomes. In Sonoma County, peer-led programs are usually stand-alone programs and not integrated with a clinical model. Thus, the first learning goal will contribute to an understanding of best practices for the development of future peer integrated programs. The second and third learning goals provide additional information on the impact and specifically the cause and effect of the peer support team.

EVALUATION OR LEARNING PLAN

For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. Specifically, please identify how each goal will be measured and the proposed data you intend on using.

Crossroads to Hope enhances a model of transitional housing and clinical support with peer provider staffing and a robust peer-recovery program for improved outcomes for diversion clients. The County of Sonoma is planning to contract with RDA Consulting, a firm that has extensive knowledge of MHSA and experience in research and evaluation, including Innovation projects. The following learning goals are proposed for the Crossroads Innovation Project:

Learning Goal 1: How do peer providers and clinicians work together to create a treatment milieu that incorporates the principles of self-determination and choice for clients?

- What were the significant barriers to overcome in developing this model?
- What were the factors that helped overcome challenges and led to success?
- Are there professional development standards for peer providers that factor into the success of a blended treatment and support team? Contributing factors may include required qualifications for the position, certification, training, team support, mentorship, and supervision.

Learning Goal 2: How do the peer providers impact the diversion clients in their early engagement in recovery?

- What is the diversion clients' perception of value/benefit in receiving peer provider support and services?
- What is the peer providers' perception of value/benefit of their support and services?
- What is the ACT teams' perception of value/benefit of having peer provider support and services?

Learning Goal 3: How do peer providers impact the accomplishment of treatment goals among the diversion clients that complete the first 6 months at Crossroads?

- Are there specific activities that peers provide that are most beneficial to diversion clients' achievement of treatment goals and what are they?
- Are there other factors that influence the success of diversion clients' to achieve treatment goals? (i.e. amount of time spent with peer providers, qualities of peer providers)

METHODOLOGY

The evaluation team will commence their planning work in tandem with the peer provider organization and the Peer Advisory Council at a session(s) designed to define the theory of change (TOC) and identify the specific ways that peers may engage clients and support the achievement of recovery goals within the six-month intervention. This TOC will be the basis for the development of the evaluation plan. It is anticipated that the evaluation will consist of a mixed-methods data collection approach including both qualitative and quantitative data. In addition, the evaluation process will employ a community-based participatory research model, engaging the Peer Advisory Council in the design and implementation of the evaluation process; collection and analysis of the data; and development/dissemination of the final report to stakeholders in the community.

Learning Goal 1 is a formative evaluation. Documentation of team meetings with peer providers and ACT team members will be maintained with a focus on discussions related to the integration of peer-model principles of self-determination and client choice. The findings in the process documentation will be validated with an annual mixed-methods (qualitative and quantitative) questionnaire to be completed by the clinical/case management team and peer providers, key informant interviews and review of program documentation.

Learning Goal 2 is an outcome evaluation question measuring the impact of peer providers on the engagement from the perspective of the clients and peer providers. The specific measures are yet to be determined, but will consist of a pre-post measure(s). For example, a tool such as the Self-Sufficiency Matrix can be completed by a peer provider as an assessment based on interactions with the client. The Self-Sufficiency Matrix consists of 20 domains examining the status/outcomes of the individual's activities of daily living. This non-clinical assessment can be completed at entry and again at the 6-month exit from transitional housing. In addition to a standardized assessment tool, interviews will be conducted with a randomized convenience sample of clients, peer providers and clinical staff to collect qualitative data to triangulate and validate findings.

Learning Goal 3 is also an outcome evaluation question focusing on the effect that peer providers have on the achievement of client treatment goals. The theory of change developed by the evaluation team and peer providers will inform the specifics of how the peer provider support may influence and ultimately impact client recovery outcomes. Appropriate tools will be identified and may include the Adult Needs and Strengths Assessment (ANSA) to benchmark client changes in clinical status and achievement of recovery goals. The ANSA is a multi-use assessment tool that can be used for treatment planning, determining levels of care, measuring outcomes and serves as a communication tool. This assessment will be administered every six months. The ANSA will be administered upon entry into the program (baseline) to help inform and support the development of treatment goals. The ANSA will be re-administered a second time at 6-months, when the client is expected to exit transitional housing. Additional administration of the ANSA at 12, 18 and 24-months will be administered by the ACT team. The local evaluation team and Peer Advisory Council will continue to review ANSA data with the participant's consent at 12, 18 and 24 months. The evaluator will conduct statistical analysis of the ANSA data to determine if there is a correlation between the Crossroads interventions and longer-term client outcomes/status. These findings will be included in the annual and final Innovation Reports.

A qualitative database will be added to examine the peer provider support intervention and whether those activities contributed to the client outcomes. An example method of data collection might be interviews conducted with all clients at 6-months to determine what factors influenced client success. Interviews could consist of open-ended questions and allow the client to respond without prompts or direction. If needed, clients may be offered suggestions such as educational groups, housing, relationships with staff/peers/peer providers/probation officers, wrap around services, community connections, etc. This will be determined by the evaluation team, peer providers and Peer Advisory Council.

SECTION 3: ADDITIONAL INFORMATION FOR REGULATORY REQUIREMENTS

CONTRACTING

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

Sonoma County Department of Health Services (DHS) will solicit up to a five-year contract with a community-based organization to provide the peer-led services for the proposed term of the Innovation funding award. DHS will need to develop a request for proposals (RFP) to select an appropriate community-based provider for the peer provider component.

In addition, the County will seek an independent evaluator from the County's qualified contractor list to oversee the evaluation. Early discussions have been held with Resource Development Associates (RDA) based in Oakland, CA as to their interest and role as the local project evaluation team. RDA has indicated that they are very interested in evaluating this project, and they have provided the County with a cost estimate. RDA has decades of experience with MHSA funded programs, including Innovation Projects, Capacity Assessments, and Community Program Planning models.

The MHSA Coordinator and the Forensic Health Program Manager of the Sonoma County DHS BHD will share responsibility to monitor the progress of **Crossroads to Hope** and assure contract compliance per County and State regulations for both the program and the evaluation contractors. The County may provide technical support in program delivery and evaluation, fiscal reporting and program reporting to these contractors. Project coordination meetings will be held quarterly to establish expectations in reporting and to assure compliance with MHSA and regulations. In addition, the selected contractor will be expected to submit quarterly reports that include client demographics (as per MHSA INN regulations), program data, program progress and challenges, and invoices for services rendered.

The selected evaluation contractor will engage with the DHS Health Prevention, Planning and Evaluation Unit to ensure alignment with the overall evaluation of the Diversion project. The evaluation contractor will also meet with the MHSA Coordinator and the Forensic Health Program Manager with regular frequency (minimum quarterly) to facilitate and assure the evaluation is on track.

COMMUNITY PROGRAM PLANNING

In June of 2016, a group of community stakeholders including consumers, peers, mental health providers and County representatives met to discuss the lack of services and supports for those who were on the precipice of a crisis. With limited beds at the Crisis Stabilization Unit (CSU), the group proposed a peer respite residential center. This proposal to provide immediate short-term housing staffed and led by peers would intervene prior to crisis and focus on wellness and

recovery. Unfortunately, funding stalled and the project was not realized, but this effort set the stage for continued interest and determination for peer-led services and supports.

In March of 2018, Sonoma County held a two-day meeting of a Sequential Intercept Model planning process used by communities to assess the circumstances of people with behavioral health needs in the justice system and identify opportunities for linkages to services that can prevent deeper penetration into the criminal justice system. The County brought together over 40 stakeholders from multiple systems, including mental health consumers and professionals, substance abuse, law enforcement, pretrial services, courts, jails, community corrections, housing, health, social services, and family members to identify gaps, resources and opportunities for individuals with mental illness and co-occurring disorders in the criminal justice system. Among all of the alternative strategies, the highest number of participants named "Expand Housing with Supportive Services" as the top priority for the county.[19]

This was also a finding contained in Sonoma County's Housing Needs Assessment, April 2018. The Housing Needs Assessment report recommended the consideration of the types of supports and services needed for individuals with a history of incarceration and/or inpatient psychiatric services. Given that survey respondents indicated difficulty with either securing housing upon their release or finding housing that was considered safe and secure, additional services and supports may be needed to help individuals secure housing upon their release from inpatient psychiatric facilities or incarceration.[20]

In the Sonoma County Capacity Assessment Report released in January 2020, community stakeholders praised peer providers and programs noting the effectiveness of engaging individuals into treatment and empowering a community of recovery that could not be achieved by clinicians alone.[21] The 2019 MHSA Capacity Assessment report continues to state that consumers, as well as providers, expressed support for peer-led programs at all levels of care. Integrating peer providers who embody recovery and what is possible for consumers is not only aligned with MHSA values, but could create a cultural shift in the way mental health services are delivered throughout the system.

Specific to this innovation project, a few members and consultants from the Sonoma County Peer Council have been participating in the development and planning of Crossroads to Hope. Interviews with three peer providers who have lived mental health and criminal justice experience and two mental health providers at local mental health agencies were conducted in April and May 2020.

The chart below lists those individuals and their affiliations.

Name	Affiliation	Organization
Sean Bolan	Peer provider	Manager, Wellness and Advocacy Center
Sean Kelson	Peer provider	Manager, Interlink and Petaluma Peer Recovery Center

[19] Sequential Intercept Model Mapping Report for Sonoma County, CA; Policy Research Associates, Inc, March 20-21, 2018.
[20] Sonoma County Housing Needs Assessment, Harder + Company Community Research, April 2018.
[21] Sonoma County MHSA FY 2016-2019 Capacity Assessment, Research Associates Development, January 2020.

Kate Roberge	Peer provider	Consumer Affairs Coordinator, Wellness and Advocacy Center
Steven Boyd, LCSW	Clinician	Clinical Director to Napa and Sonoma Programs, Progress Foundation
Sid McColley, RN, CNS	County	Section Manager, Acute and Forensic Services Sonoma County Behavioral Health Services

In addition, the Crossroad to Hope Innovation proposal and program highlights have been presented to groups of MHSA Stakeholders at the meetings listed on the table below.

Date	Stakeholder Group
May 7, 2021	MHSA Community Program Planning Workgroup
May 11, 2021	MHSA Steering Committee
May 27, 2021	MHSA Stakeholder Meeting (comprised of a broad group of stakeholders)
September 13, 2021	Innovation Contractors
September 16, 2021	Prevention and Early Intervention Contractors
October 6, 2021	Community Services and Supports Contractors
October 14, 2021	DHS-BHD Staff
November 4, 2021	Mental Health Board

Thus far all of the comments received about the proposal from the various stakeholder groups have been positive and include the following themes.

- Creates transitional housing
- Helps individuals to develop skills that will promote their ability to get and keep permeant housing
- Diverts people with mental health concerns from jail
- Integrates supportive peer services to help individuals to move towards recovery

The 30-day public review period commenced on December 1, 2021 with the publication of the Crossroads to Hope application posted on the Department of Health Services Behavioral Health website and publicized in the MHSA newsletter, emailed to list of over 2000 on the MHSA listserv, stakeholders and contractors. The Mental Health Board hosted the public hearing on Crossroads on January 18, 2022. There were 18 attendees at the public hearing, and four individuals contributed comments in support of the project. The Board of Supervisors will review the proposal for approval on February 8, 2022.

Finally, a Peer Advisory Council specific to Crossroads will be re-convened to receive updates to the project's progress and provide input to the final design and implementation of the project's evaluation and program modifications.

MHSA GENERAL STANDARDS

Using specific examples, briefly describe how your INN Project reflects, and is consistent with, all potentially applicable MHSA General Standards listed below as set forth in Title 9 California Code of Regulations, Section 3320 (Please refer to the MHSOAC Innovation Review Tool for definitions of and references for each of the General Standards.) If one or more general standards could not be applied to your INN Project, please explain why.

A) Community Collaboration

The discussion of increasing peer providers in the continuum of mental health services for Sonoma County has been evolving over the past 8 years or more with a stakeholder group comprised of peers, family members, clients, criminal justice personnel, behavioral health clinicians and management in that has resulted the establishment of a variety of peer-led programs in the community and an application for funding for a Peer Respite program in 2018. The dialogue between peer providers (trained and certified) and behavioral health clinicians/management has been ongoing to improve and expand peer provider services in the system of care.

Crossroads to Hope is a model that incorporates a multi-disciplinary team comprised of consumers, mental health providers, law enforcement, housing and community-based organizations. Case conferences and meetings on program operations will held with frequent regularity, especially in the first year of the project. Furthermore, a Peer Advisory Council will be established for ongoing consultation and monitoring of this project which will assure a peer perspective and support for the peer providers.

B) Cultural Competency

The diversion clients coming from the local county jails will most likely represent the diversity of ethnic and racial demographics of the jail population. The model of client-driven and self-determination will address and hopefully prevent inherent biases of a western medical model. In addition, the Behavioral Health Division has a Cultural Responsiveness Committee that will receive updates on this project and make recommendations on policy and procedures to assure the services are free from racial, economic and gender biases.

C) Client-Driven

By adopting a philosophy and practice of self-directed recovery planning supported by a peer-led support model, Crossroads will identify and provide opportunities to assure that diversion clients are empowered to define their recovery goals, actions for achievement and definitions of success.

D) Family-Driven

As noted in the earlier value of "client-driven", if diversion clients have family members (defined by the client) whom they would like to involve in their recovery, those family members will be engaged in recovery planning and actions. In addition, family member representatives will be sought to participate in the Peers Advisory Council which will guide the development, engagement and evaluation of Crossroads.

E) Wellness, Recovery, and Resilience-Focused

The premise of peer-led services integrated into a more compliance oriented, illness-focused, clinical model will necessitate a transformation of how the team looks at recovery. The journey of people in recovery does not start with a recovery plan, but of telling and understanding how they got to where they are today and where they want to go and what they want to do. Practicing self-care leading to wellness and resilience is an ongoing process. The structures that will be in place to maintain the focus on wellness, recovery and resilience include: 1). Trained and supported Peer providers; 2). Informed and engaged Peer Advisory Council; and 3) Realized opportunities for staff-development and training.

F) Integrated Service Experience for Clients and Families

The Crossroads model is inter- and multi-disciplinary. In supporting diversion clients with transitional housing, a home-base is established whereby services can come to the clients rather than asking clients to work with traditionally siloed providers. Case conferences will provide the mechanism to further identify areas of integration and coordination to support a solid start to recovery.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

Explain how you plan to ensure that the Project evaluation is culturally competent and includes meaningful stakeholder participation.

As mentioned throughout this application, a Peer Advisory Council will be established to provide counsel and accountability to both the program and evaluation design and implementation. This Peer Advisory Council is reflected in the budget to offer stipends and cover expenses. The PAC will meet regularly with the MHSA Coordinator or designee to assure communication and continuity of policy and procedural practices. Documentation of these meetings will be maintained contributing to the formative evaluation and continuous improvement.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

A) **Briefly describe how the County will decide whether it will continue with the INN project in its entirety, or keep particular elements of the INN project without utilizing INN Funds following project completion.**

Determination of whether the program will continue after the end of the Innovation Period using other funding will be made through the Community Program Planning Process by analyzing data gathered that address the learning questions and additional outcome data including occupancy, cost-effectiveness and cost-savings to the larger community, client-feedback, and availability/prioritization of funding. Funding with MHSA Community Services and Supports (CSS) component will be considered. Also, the implementation of the California Advancing and Innovating Medi-Cal (CalAim) reforms will be continually monitored over the next five years and this is a potential be a source of funding this type of innovative whole person approach that addresses key social determinants of health. In addition, if successful outcomes are achieved through this innovative approach, the Probation department may be another potential funding source to continue this work.

B) Will individuals with serious mental illness receive services from the proposed project? If yes, describe how you plan to protect and provide continuity of care for these individuals upon project completion.

Crossroads will be serving individuals with serious mental illness and if the project is to terminate at the end of the five-year Innovation funding, the ACT clinical team will continue to support diversion clients while they are in the transitional housing as well as afterwards when they are in long-term housing. There will be no break in those clinical services.

COMMUNICATION AND DISSEMINATION PLAN

A) How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties? How will program participants or other stakeholders be involved in communication efforts?

The MHSA Coordinator will be primarily responsible for communicating the progress, results, and lessons learned to community stakeholders, including the County Mental Health Board, Board of Supervisors, MHSA Steering Committee, key Department Heads and other community leaders/stakeholders. The Peer Advisory Council and Crossroads clients will be invited to engage in the development of public materials, reports and presentations. In addition, clients may participate in testimonials at public hearings, conferences, or other key policy meetings.

In light of the MHSOAC Commission and State of California's interest in reducing the population of those with severe mental health conditions in the criminal justice system, Crossroads hold promise of an innovative, comprehensive and effective model that can be replicated in other counties throughout the state. Crossroads evaluation will document the formation and outcomes of the project for ease of replication.

B) KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.

- Mental Health Peer Providers
- Criminal Justice Diversion
- Innovative Mental Health Models

TIMELINE

A) Specify the expected start date and end date of your INN Project

B) Specify the total timeframe (duration) of the INN Project

C) Include a project timeline that specifies key activities, milestones, and deliverables by quarter.

Year 1			
April 2022	**July 2022**	**October 2022**	**January 2023**
• Contractor recruits Peer Providers, Peer Advisory Council • Convene kick-off meeting with ACT team, Peer Providers, law enforcement, evaluator • Establish policy and procedures for Crossroads • Refine roles and responsibilities of Peer Providers • Establish draft of evaluation protocols and instruments	• Enroll eligible clients for Crossroads, administer ANSA • Clients develop recovery plans • Peer providers implement educational curriculum, supportive services • Quarterly meeting with Peer Advisory Council • Establish evaluation protocols • Quarterly meetings with contractors, evaluator • Evaluator reviews evaluation protocols and data collection methods with peer providers	• Program operations refined • Quarterly meeting with Peer Advisory Council • Quarterly meetings with contractors, evaluator • Evaluator reviews data collection methods • Evaluator reviews evaluation protocols and data collection methods with Peer Advisory Council and providers	• Clients moving from transitional to long-term housing, administer ANSA • Survey administration for exiting clients and ACT team • Focus Group or key informant interviews for qualitative data collection • Quarterly meeting with Peer Advisory Council • Quarterly meetings with contractors, evaluator • Identify eligible clients for Crossroads, administer ANSA

Year 2 - 4			
April 2023 - 2025	July 2023-2025	October 2024 - 2026	January 2024 - 2026
• Clients develop recovery plans • Quarterly meeting with Peer Advisory Council • Quarterly meetings with contractors, evaluator	• Clients moving from transitional to long-term housing, administer ANSA • Survey administration for exiting clients and ACT team • Peer Advisory Council meeting • Meetings with contractors, evaluator • Identify eligible clients for vacancies in Crossroads, administer ANSA • Clients develop recovery plans	• Peer providers implement educational curriculum, supportive services • Quarterly meeting with Peer Advisory Council • Quarterly meetings with contractors, evaluator	• Clients moving from transitional to long-term housing, administer ANSA • Survey for exiting clients and ACT team • Focus Group or key informant interviews for qualitative data collection • Peer Advisory Council meeting • Meetings with contractors, evaluator • Identify eligible clients for Crossroads, administer ANSA • Clients develop recovery plans

Year 5			
April 2026	July 2026	October 2027	January 2027
• Peer providers implement educational curriculum, supportive services • Meetings with contractors, evaluator • Analyze first 2 years of evaluation, share findings with Peer Advisory Council	• Clients moving from transitional to long-term housing • Survey administration for exiting clients and ACT team • Peer Advisory Council meeting • Meetings with contractors, evaluator • Identify eligible clients for Crossroads • Begin disseminating preliminary findings from evaluation on impact, lessons learned to stakeholders, policy makers and funders	• Continued dissemination of preliminary findings from evaluation on impact, lessons learned to stakeholders, policy makers and funders • Determination of continued funding or termination of peer provider component of Crossroads • Peer Advisory Council meeting • Meetings with contractors, evaluator • On-going program implementation	• Clients moving from transitional to long-term housing, administer ANSA • Survey for exiting clients and ACT team • Focus Group or key informant interviews for qualitative data collection • Peer Advisory Council meeting • Meeting with contractors, evaluator • Identify eligible clients for Crossroads, administer ANSA • Clients develop recovery plans • Final evaluation report • Dissemination of final evaluation report to stakeholders, policy makers and interested members of the public

SECTION 4: INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

The next three sections identify how the MHSA funds are being utilized:

1. A) **BUDGET NARRATIVE** (Specifics about how money is being spent for the development of this project)
2. B) **BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY** (Identification of expenses of the project by funding category and fiscal year)
3. C) **BUDGET CONTEXT** (if MHSA funds are being leveraged with other funding sources)

BUDGET NARRATIVE

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project.

Personnel Costs:

Year 1

- **1 FTE Senior Peer Provider** (2080 hours) x $25 per hour = $52,000 prorated for 3 months (.25 of year).
- **2 FTE Peer Provider** (4160 hours) x $20 per hour = $83,200 prorated for 3 months (.25 of year).
- **1 FTE Relief Peer Provider**, 2080 hours x $20 = $41,600 prorated for 3 months (.25 of year).
- **Direct Costs:** Wages of 4 FTE Peer Providers x .33 (benefits, payroll taxes, insurance) = $58,344, prorated for 3 months (.25 of year).
- **Indirect Costs** are administrative expenses related to recruitment, administrative management of Peer Providers at 10% of contract with non-profit contractor. Year 1 is prorated for 3 months (.25 of year).

Year 2 – 5

- Each year, a proposed .03 Cost of Living increase is added to salaries if personnel is stable. Direct Cost of benefits, payroll taxes and insurance of .33 is consistent, as is Indirect Cost of .10 for non-profit contractor.

Direct Operating Costs (Years 1 and 5 are prorated)

- **Peer program costs include:** Supplies (workbooks, journals, art supplies) - $4000. Educational materials - $4000. Guest speakers - $3000. Field trips - $3000. Subscriptions - $2000.
- **Food** – Year 1 = $40,000 Estimated $300 - 334/person per month @ 10 – 12 people Year 3 - 5 and 3 included $5,000 increase per year.
- **Peer Advisory Council stipends** $2400 per year for (6 meetings per year, 8 participants, $50 per meeting). $600 for snacks/meals for meetings;
- **Peer training and professional development:** 4 x $500 = $2000
- **Transportation:** County pool car fees: $1500 per year. Bus passes for clients: $62.50 per month x 6 clients x 12 months = $4,500.
- **Housewares:** dishes, silverware, glasses, mugs, serving platters at $10,000 year 1 with replacement allowance at Year 3 - $2000 and Year 5 - $1000.
- **Household Expenses:** Consumable products, including cleaning supplies, toilet paper, paper towels, and maintenance supplies = $10,000
- **Utilities:** $5,500 per month including communications for the house and cellular for peer providers, IT, PGE, water, garbage
- **Building improvements:** $5,000 for repairs, maintenance on building and grounds
- **Client Educational Funds:** $24,000 - $2,000 per client x 12 annually for GED, computer classes, books, professional development
- **Office Expense:** $2000 per year for printer paper, ink, postage, stationary, supplies
- **Peer provider education and training:** $5,500 = $1,375 annually per peer provider x 4
- **Recreation:** $7,200 per year to promote wellness and self-care - Bicycles for house (4 x $500 = $2000), yoga ($100 per week x 52 weeks = $5,200)
- **Professional & Special Services:** $23,400 for nutritionist/chef at $75 per hour x 6 hours x 52 weeks. For nutritional guidance, menu planning and meal prep education.
- **Transportation:** $4,200 lease car with insurance and registration at $350 per month for peer providers to transport clients to court, medical appointments, and other important appointments.
- **Client travel:** $4,500 for bus vouchers. $62.50 per month x 6 clients x 12 months.
- **Gas, oil, maintenance on lease vehicle:** $3,000 per year
- **Rents & Leases:** $32,000 for first, last and deposit to support clients leaving transitional housing when needed.

Indirect Operating Costs:

- 10% to non-profit contract for administration of payments, managing house inventory and utilities, lease of vehicle.

Non-Re-occurring Costs

- Computers - $4,500: Five computers for clients and peer providers at $750 each and 2 printers at $325 each.

Consultant Costs:

- Evaluation Contractor (propose RDA to evaluate the program): Year 1: $47,000; Years 2-4: $11,750; and Year 3: $25,000

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*

EXPENDITURES								
PERSONNEL COSTS		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
1	Salaries	$44,200.00	$176,800.00	$182,104.00	$187,567.00	$193,194.00	$113,020.00	$896,885.00
2	Direct Costs	$14,586.00	$58,344.00	$60,094.00	$61,897.00	$63,754.00	$37,296.00	$295,971.00
3	Indirect Costs	$5,879.00	$23,514.00	$24,220.00	$24,946.00	$25,695.00	$15,031.00	$119,285.00
4	Total Personnel Costs	$64,665.00	$258,658.00	$266,418.00	$274,410.00	$282,643.00	$165,347.00	$1,312,141.00
OPERATING COSTS		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
5	Direct Costs	$30,759.00	$181,841.00	$191,300.00	$193,900.00	$194,900.00	$174,899.00	$967,599.00
6	Indirect Costs	$3,076.00	$18,184.00	$19,130.00	$19,390.00	$19,490.00	$17,490.00	$96,760.00
7	Total Operating Costs	$33,835.00	$200,025.00	$210,430.00	$213,290.00	$214,390.00	$192,389.00	$1,064,359.00
NON RECURRING COSTS		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
8	Computers for clients and peers	$4,500.00	$0.00	$0.00	$0.00	$0.00	$0.00	$4,500.00
9	Total Non-recurring costs	$4,500.00	$0.00	$0.00	$0.00	$0.00	$0.00	$4,500.00
CONSULTANT COSTS / CONTRACTS		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
10	Direct Costs	$47,000.00	$11,750.00	$11,750.00	$11,750.00	$11,750.00	$25,000.00	$119,000.00
11	Indirect Costs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
12	Total Consultant Costs	$47,000.00	$11,750.00	$11,750.00	$11,750.00	$11,750.00	$25,000.00	$119,000.00
OTHER EXPENDITURES		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
13	Total Other Expenditures	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
BUDGET TOTALS		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
Personnel (line 1)		$44,200.00	$176,800.00	$182,104.00	$187,567.00	$193,194.00	$113,020.00	$896,885.00
Direct Costs (add lines 2, 5 and 10 from above)		$92,345.00	$251,935.00	$263,144.00	$267,547.00	$270,404.00	$237,195.00	$1,382,570.00
Indirect Costs (add lines 3, 6 and 11 from above)		$8,955.00	$41,698.00	$43,350.00	$44,336.00	$45,185.00	$32,521.00	$216,045.00
Non-recurring costs (line 9)		$4,500.00	$0.00	$0.00	$0.00	$0.00	$0.00	$4,500.00
Other Expenditures (line 13)		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
TOTAL INNOVATION BUDGET		$150,000.00	$470,433.00	$488,598.00	$499,450.00	$508,783.00	$382,736.00	$2,500,000.00

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)								
ADMINISTRATION								
	Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**Total Budget**
1.	Innovative MHSA Funds	$103,000	$458,683	$476,848	$487,700	$497,033	$357,736	$2,381,000
2.	Federal Financial Participation							
3.	1991 Realignment							
4.	Behavioral Health Subaccount							
5.	Other funding*							
6.	**Total Proposed Administration**	$103,000	$458,683	$476,848	$487,700	$497,033	$357,736	$2,381,000
EVALUATION								
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**Total Budget**
1.	Innovative MHSA Funds	$47,000	$11,750	$11,750	$11,750	$11,750	$25,000	$119,000
2.	Federal Financial Participation							
3.	1991 Realignment							
4.	Behavioral Health Subaccount							
5.	Other funding*							
6.	**Total Proposed Evaluation**	$47,000	$11,750	$11,750	$11,750	$11,750	$25,000	$119,000
TOTAL								
C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**Total Budget**
1.	Innovative MHSA Funds	$150,000	$470,433	$488,598	$499,450	$508,783	$382,736	$2,500,000
2.	Federal Financial Participation							
3.	1991 Realignment							
4.	Behavioral Health Subaccount							
5.	Other funding*							
6.	**Total Proposed Expenditures**	$150,000	$470,433	$488,598	$499,450	$508,783	$382,736	$2,500,000

Sonoma County MENTAL HEALTH SERVICES ACT Newsletter

MAY 2022 | 49TH EDITION

Let's celebrate May is Mental Health Matters Month!

Every month should be a month we are paying attention to our mental health, right? But with May as Mental Health Matters Month, we have a special focus on getting the word out about what you can do to take action for your mental health and for everyone in our County!

You may already know that more than half of all Americans will experience a mental illness or disorder in their lifetime. And just about all of us have times when we feel stressed out, anxious, or down. When that happens to you or a loved one, do you know what to do? Recognizing that you or someone you know could use some support for your mental health is the first step. That means checking in with yourself regularly, and checking in with others to see if they may need help. Then you can take action to get support if it's needed.

Join us and people across California in taking the Take Action for Mental Health Pledge. This is a way to commit to ourselves and the people around us that mental health is a priority and that we will do what we can to support each other.

The Take Action for Mental Health Pledge says:

- I Pledge to Take Action for Mental Health
- I will Check In with myself to identify mental health needs.
- I will Learn More about mental health.
- I will Get Support for my own mental health and support the mental health of others.
- I will share this pledge with others to help them take action too!

Download the pledge and find more resources to help you Check In, Learn More, and Get Support on the Take Action for Mental Health website HERE.

If you are in distress, need emotional support, or are worried about a loved one, help is available.

24 HOUR HOTLINE
NORTH BAY SUICIDE PREVENTION HOTLINE OF SONOMA COUNTY
1 855 587 6373
Suicide Prevention • Crisis Intervention • Toll free

CBC TAKES ACTION FOR MENTAL HEALTH

Prior to the pandemic, Community Baptist Church Collaborative (CBC) hosted a variety of programs from "The Village Project and Saturday Academy" – a weekly faith-based learning program which focuses on character building and resiliency to "The Safe Harbor Project" featuring events and activities to increase well-being, reduce stress, and increase community building through music, sound, and vibro-acoustic techniques. They even held an annual "Mental Health Training and Speaker Series" which emphases on reducing stigma; increasing mental health awareness and cultural competency; and appropriate health seeking. However, the pandemic put a halt on in-person activities which lead CBC programs and events to a pause; making many sad during a time where services were even more critical.

Dr. Reverend Lee Turner, Honor Jackson, and James Coffee came together and found a way to keep the music alive and people connected. They created KSHP Mood Radio where people can just click and enjoy during times of uncertainty. They had heard about a radio station in Mendocino County and decided it was a worthwhile endeavor to offer our community during a time filled with worry and fear. With no prior radio experience, CBC took the initiative to learn the ropes. Thus, KSHP Mood Radio was born. It has grown to over 680 listeners in two years.

Continued on next page.

NEW MHSOAC GRANT AIMS TO IMPROVE LIVES THROUGH EARLY DIAGNOSIS AND TREATMENT

Nearly 100,000 adolescents and young adults experience their first psychotic episode each year in the United States. With half of all mental disorders manifesting by the age of 14 and 75 percent by the age of 24, the early detection and early intervention of psychosis can improve the lives of adolescents and young adults, significantly reducing the impact of mental health challenges.

The County of Sonoma is honored to receive Early Psychosis Intervention Plus (EPI Plus) funding through the Mental Health Services Oversight and Accountability Commission (MHSOAC). The County in partnership with Aldea aspires to help improve the lives of Sonoma County residents with mental health needs before those needs escalate and become severe or disabling.

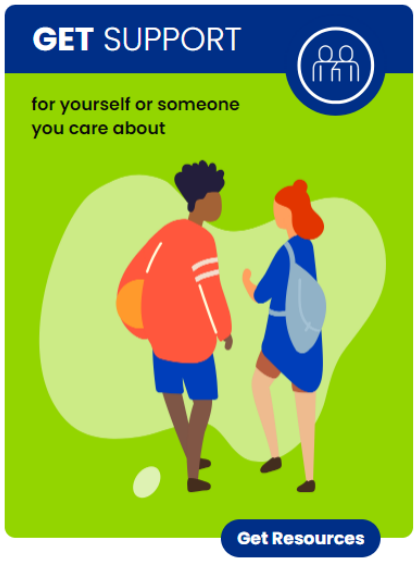
This program is offered through the Elizabeth Morgan Brown One Mind ASPIRe Clinic in Santa Rosa, CA. It aims to identify a coordinated specialty treatment approach, evidence-based therapies, family support, medication management, and recovery-oriented practices to address psychotic symptoms and promote resilience. Click HERE to learn more.

CBC TAKES ACTION FOR MENTAL HEALTH

(continued from page 1)

The station today plays 24 hours a day with a wide variety of music styles to offer, including tunes by some local musicians and James himself. The music—intended to increase wellbeing along with PSAs, interviews, speakers, and other mental health related information—can be reached through the MSHP Facebook group (https://www.facebook.com/kshpradio/) or directly on the internet by clicking HERE.

For more information on CBC's MHSA funded programs and events please email: honorjackson1121@comcast.net



Check out Sonoma County MHSA's Annual Update & Report!

Check out Sonoma County's MHSA Annual Plan Update for FY 22-23 and Program Report for FY 20-21, now posted on the DHS-BHD website!

This publication is brought to you by the County of Sonoma Department of Health Services Behavioral Health Division (DHS-BHD) and will be posted for at least 30 days prior to a public hearing hosted by Sonoma County's Mental Health Board on May 17, 2022 at 5pm. Click HERE to access the publication released on April 15th. For more details on how to attend the Mental Health Board Meeting on May 17th click HERE.

TAKE ACTION: COMMUNITY CALENDAR

May is Mental Health Matters Month, a time for Sonoma County to collectively raise awareness about mental health and wellness. We've put together a community calendar of events, activities and trainings to encourage people to **check in** virtually or in-person, **learn more** about mental health and the resources, and **get support** for yourself or others.

Click HERE to access Sonoma County's May 2022 Mental Health Matters Month Community Calendar.

Sonoma County MENTAL HEALTH SERVICES ACT Newsletter

SEPTEMBER 2022 | 50TH EDITION

September is SUICIDE PREVENTION MONTH

Thriving at All Ages

People of all ages benefit from some common tenets of wellness, but the specific ways that wellness and resilience are supported change through the life span. Building resiliency is important at all ages, and strategies can be tailored depending on what is enjoyable or accessible depending on your age. Throughout our communities many people are continuing to experience mental health challenges, trauma, burn-out and fatigue due to the prolonged impacts of the pandemic and natural disasters. To support Thriving At All Ages, Californians are encouraged to take action for suicide prevention by recognizing the importance of strengthening resiliency, protective factors, and physical and emotional wellness throughout the lifespan and at different life stages.

Effective strategies for suicide prevention must address the strengths, circumstances, and challenges of the different phases of life. Resiliency can be built at any age with attention to some common protective factors that promote wellness and are necessary to thrive:

- **Strong social support networks** where people can talk through their problems and feelings, ask for help and offer help and support to others.
- **Good physical health**, and when complications occur, finding the right health regimen to promote recovery and support wellness.
- **Access to primary care services** to promote health and catch problems early. Primary care is where many people go for wide variety of concerns and is a key setting for connecting people to appropriate services and supports.
- **Access to effective behavioral health care** reduces the risk and severity of illness and supports recovery. Counseling can help strengthen strategies for problem-solving and coping with stress.
- **Meaning and purpose** can be found in a variety of ways, but their sources often shift throughout life. Meaning and purpose can be found through work or hobbies, family life, learning and studying, and religion and spirituality. Meaning and purpose can also be found through helping others by volunteering and supporting important causes.
- **Self-care** is not a luxury; it is a necessity. Self-care is too often neglected, especially when other demands seem more pressing, or when changes limit access to what once worked for wellness. Many steps to self-care are simple, free, and can be done anywhere, even with only a few minutes of time.

"We need to find meaning and build a life worth living on a daily basis no matter what age we are."
- Julie Phillips, Professor of Sociology, Rutgers University

- **Attitudes about aging** have a significant impact on wellness, especially in later years. It is possible for people of all ages to thrive. Viewing aging as a developmental stage, with its own unique opportunities for growth, allows room for adaptation to life's changes and reasons for hope.

We all have a role to play in suicide prevention. Take action to support yourself and those around you by visiting **www.takeaction4MH.com** for more information.

Learn about the signs for suicide, finding the words to check-in with someone we are concerned about, and reaching out to resources. Visit **www.suicideispreventable.org** for more information.

sonoma county DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

County of Sonoma, Mental Health Services Act
2227 Capricorn Way, Suite 207
Santa Rosa, CA 95407
(707) 565-4850

Be a Part of Our Suicide Prevention Efforts!

Join Sonoma County's Suicide Prevention & Awareness Efforts!
Sonoma County Board of Supervisors adopted a gold resolution proclaiming the month of September 2022 as Suicide Prevention Month in Sonoma County. The following efforts to prevent suicide are scheduled for Suicide Prevention Month:

- **September 6th** 3:00pm - 4:30pm
  - **Buckelew's Virtual Community Resource Clinic** - Resource clinic via Zoom to help with understanding or assistance in accessing services for themselves or their loved one. Email Nicolen@buckelew.org or call 707-494-0762 to participate.
- **September 14th** 8:30am - 5:00pm
  - **Assessing and Managing Suicide Risk (AMSR)** - a free workshop for behavioral health professionals on assessing suicide risk, planning treatment, and managing the ongoing care of the at-risk client. Clinicians can earn 6.5 CEs and this training meets the BBS suicide assessment training requirements. This is an in-person only event. Click HERE for flyer with registration information.
- **September 14th & 28th** 7:00 pm - 8:30 pm
  - **SOS: Allies For Hope by Buckelew** Survivors of Suicide Bereavement Support Group (Virtual) is a non-clinical peer-to-peer group to share strategies and skills for coping with loss of a loved one to suicide and transitioning to a place of greater understanding and compassion for ourselves, for those with similar experiences, and those we have lost. Email SOSinfo@Buckelew.org or call: 415-492-0614 for more information.
- **September 21st** 12:30pm - 2:30pm
  - **Be Sensitive, Be Brave for Suicide Prevention Webinar** - infuses culture and diversity throughout a foundational workshop in suicide prevention. The workshop teaches community members to act as eyes and ears for suicidal distress and to help connect individuals with appropriate services. Click HERE to register.
- **September 29th** 4:00pm - 6:30pm, Finley Center
  - **"The S Word" Film Screening & Panel Discussion** - Join Sonoma County's Behavioral Health Division in partnership with Buckelew for a free in-person and virtual screening of "The S Word" documentary film. "THE S WORD" is a powerful feature documentary that puts a human face on suicide, a topic that has long been stigmatized and buried with the lives it has claimed. A panel discussion with resources will be available after the film. Click HERE for flyer.

New 988 - There is hope!

If you or someone you know is having thoughts of suicide or experiencing a mental health or substance use crisis, 988 provides **24/7 connection to confidential support**. There is Hope. **Just call or text 988 or chat 988lifeline.org**

Sonoma County Warmly Welcomes New Director!

Sonoma County welcomed Dr. Jan Cobaleda-Kegler as Department of Health Services Behavioral Health Division (DHS-BHD) Director in May! We are very pleased to have Dr. Cobaleda-Kegler onboard as she brings forty-six years of experience working in Behavioral Health treatment as an administrator, clinical supervisor, and provider committed to developing and providing services that are accessible, supportive, effective, and compassionate. She has worked with children, youth, adults, and families across a broad spectrum of community-based behavioral health treatment settings.

Prior to joining DHS-BHD, Dr. Cobaleda-Kegler served as Mental Health Program Chief for Contra Costa County Adult and Older Adult Behavioral Health Services where she dedicated herself to promoting the recovery and wellness of vulnerable adults and their families and to implementing numerous system improvements in an effort to improve the quality of care provided to clients. She also served as Program Manager in Contra Costa Children's System of Care, where she distinguished herself by developing and implementing training for staff across the division in Evidence Based Practices in the treatment of trauma, depression, co-occurring disorders, eating disorders, animal assisted therapy, and anxiety.

Peer Support Certification Scholarships Available!

Medi-Cal Peer Support Specialist certification is here! The Department of Health Care Services (DHCS) is offering scholarship opportunities, through CalMHSA, for peers who want to seek certification as Medi-Cal Peer Support Specialists. Sonoma County is now collecting names for local peers who want to apply for scholarships for certification. The scholarships cover the cost of the application, training, and exam. While individuals may apply on their own for certification, DHCS/CalMHSA scholarships are available only through this process.

To meet DHCS's definition of a peer, the individual must "self-identify as having experience with the process of recovery from mental illness or substance use disorder, either as a consumer of these services or as the parent, caregiver, or family member of a consumer" and must "be willing to share one's experience as a person with lived experience and recovery to help others." To meet certification requirements, the peer must also be at least 18 years old; have a high-school diploma, GED, or college degree; agree to adhere to the Medi-Cal Code of Ethics for Peer Support Specialists; and pass the state exam.

CalMHSA's Medi-Cal Peer Support Specialist Certification website has more background on California's work on peer certification and details about the scholarships.

If you live, work, or volunteer in Sonoma County and you want to apply for a certification scholarship, please contact Lisa Nosal at lisa.nosal@sonoma-county.org for information. The deadline for applying for a scholarship is September 16, 2022, and peers who are awarded scholarships must register for the exam by November 30, 2022.

Sonoma County MENTAL HEALTH SERVICES ACT Newsletter

DECEMBER 2022 | 51ST EDITION

Happy Holidays from Sonoma County's Behavioral Health Division!

REACH OUT FOR SUPPORT WITH MENTAL HEALTH DURING THE HOLIDAYS!

This season can be a joyful time of cozy get-togethers and generosity. It can also be a difficult time for people experiencing isolation, grief and loss, or those who live with anxiety or depression. Social and family expectations can also cause extra stresses and triggers.

How will you decide it's time to reach out? Consider first checking in with yourself to know if you're experiencing some or all of these signs of distress:

- Feeling sad, hopeless, or helpless
- Becoming anxious, worried, or overwhelmed all the time
- Being unable to focus on work or school
- Acting extremely moody or irritable
- Withdrawing from friends and activities
- Having difficulty coping with daily problems or stress
- Using more alcohol or drugs than usual or more often
- Drastically changing eating or sleeping patterns

If you're experiencing these, or similar signs, you are not alone. Learn more about identifying when you may need more mental health support. To take action for your own mental wellness, you can reach out to trusted friends, family, and other supportive people in your life. You can also call 988 the new three-digit number for mental health, substance use and suicidal crises, and talk with a phone counselor.

Here are some tips to help with winter blues:

Whatever you're feeling this season, it's important to check in on your mental health and the mental health of people around you.

Learn how to practice holiday self-care, and find support and resources for yourself and others, at TakeAction4MH.com.

If you or someone you know are depressed or thinking about suicide, **call or text the 988 Suicide & Crisis Lifeline or chat with CalHOPE Connect at CalHOPEConnect.org.**

MHSA CONTRACTOR SPOTLIGHT: LA LUZ CENTER

La Luz Center has been helping immigrants and families in the Sonoma Valley since 1985 when Ligia Booker, a Colombian philanthropist, learned that the families of vineyard workers had basic unmet needs like language skills and access to food, clothing and housing; assistance with medical, legal and financial issues presented more complicated, longer term challenges.

La Luz Center has grown and continues to develop new programs and resources to ensure residents in Sonoma Valley can improve their lives and strengthen their families by providing easily accessible services, effective programs, and culturally relevant mental health services.
Continued on page 2.

Take Action for Mental Health:

1. Exercise
2. Look for ways to enjoy social connections
3. Stick to a Sleep Routine
4. Queue Up a Stream of Laugh-Out-Loud Films
5. Warm Yourself Up With a Mug of Real Hot Cocoa
6. Give Yourself a Manageable Task to Accomplish
7. Find time for yourself
8. Don't Hesitate to See Your Healthcare Professional

sonoma county DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

County of Sonoma, Mental Health Services Act
2227 Capricorn Way, Suite 207
Santa Rosa, CA 95407
(707) 565-4850

CONTINUED FROM PAGE 1 – LA LUZ CENTER

In 2021 a contract was executed with La Luz and the County of Sonoma to provide MHSA Prevention and Early Intervention (PEI) services. PEI funds, "Your Community, Your Health/Tu Comunidad, Tu Salud" which helps address the mental health needs of the Sonoma Valley Latinx community providing no-cost culturally and linguistically competent health and wellness services.

One of the popular services available under MHSA at La Luz Center are Zumba classes. Zumba classes are a great whole body workout, stress reducer, confidence builder and a fun way to meet new people and make connections which is known to improve mental health.

To learn more about La Luz Center please visit: www.laluzcenter.org or call: 707- 938-5131

Looking for a mental health support group in Sonoma County? Housing resources? Other local resources? **Check out NAMI Sonoma County's Resource Directory HERE**. You are not alone, reach out for help!

Ways to learn more & get involved!

MHSA Stakeholder Committee

You are invited to attend our next virtual MHSA Stakeholder committee meeting. This meeting is open to anyone with an interest in Sonoma's Behavioral Health System of care. This meeting provides MHSA updates and current events and an opportunity to share your thoughts and ideas related to MHSA.

WHEN: Thursday, February 16, 2022
1:00pm - 3:00pm
WHERE: Zoom

To attend, please email MHSA@sonoma-county.org for Zoom link.

Sonoma County's Mental Health Board

You are also invited to attend Sonoma County's Mental Health Board meeting. This an advisory board empowered to listen to the concerns of our constituents and to help formulate policies that offer a consistent continuum of care for all those with mental health challenges. The Board advises the County Board of Supervisors on the Mental Health System of Care.

For date, time, and location of the next board meeting please visit the webpage HERE.

MHSA Winter Word Search

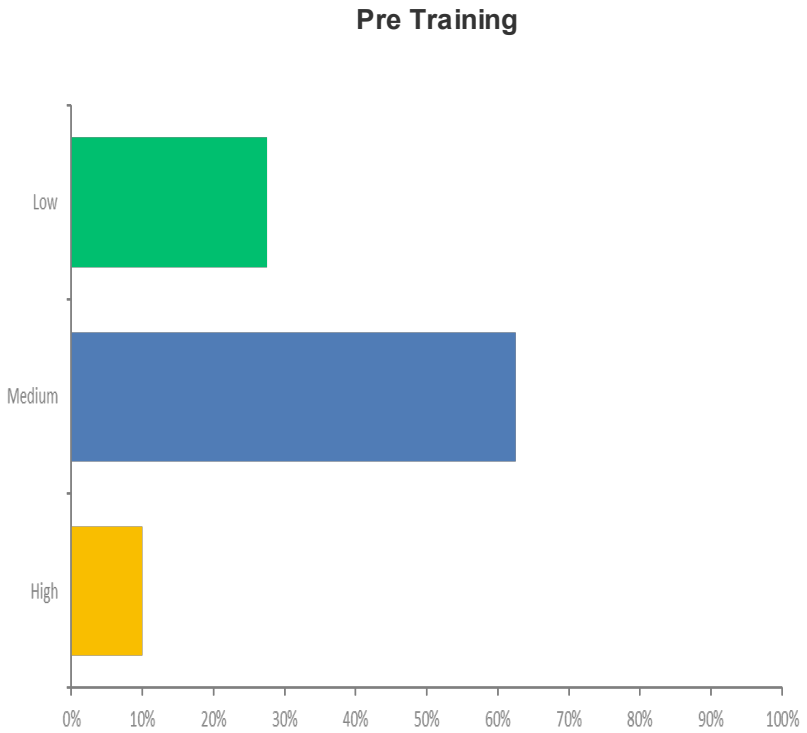
Find the word in the puzzle. Words can go in any direction. Words can share letters as they cross over each other.

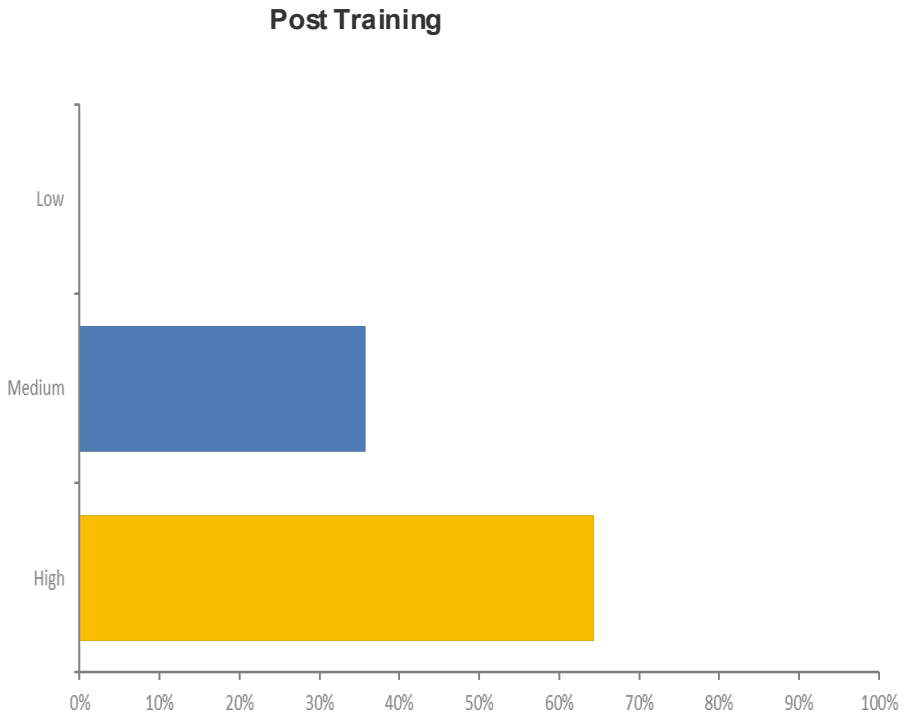
W	E	L	L	N	E	S	S	Q	S	R	E	X	Q	C
I	Z	S	J	K	M	O	Q	C	S	D	P	M	E	O
N	D	H	G	E	S	N	L	R	E	A	C	R	S	M
T	Q	E	N	E	U	O	F	E	N	D	D	W	N	M
E	W	T	L	S	P	M	N	F	D	Z	S	X	O	U
R	A	F	N	E	P	A	O	Z	N	C	X	F	I	N
L	A	B	I	R	O	D	I	H	I	X	A	E	T	I
X	J	A	Q	V	R	Q	T	A	K	E	S	R	N	T
I	S	S	N	I	T	Y	A	C	T	I	O	N	E	Y
H	O	P	E	C	P	M	V	M	A	Y	L	V	V	V
Z	T	J	U	E	H	N	O	K	I	J	K	B	R	L
J	C	L	C	S	H	K	N	T	G	T	F	Z	E	D
T	Z	R	A	V	G	C	N	M	G	V	W	H	T	A
P	R	E	V	E	N	T	I	O	N	G	A	E	N	R
A	J	W	P	I	H	E	X	U	D	U	C	U	I	F

Action
Care
Community
Health
Hope
Innovation
Intervention
Kindness
Mental
MHSA
Prevention
Self
Services
Sonoma
Support
Take
Wellness
Winter

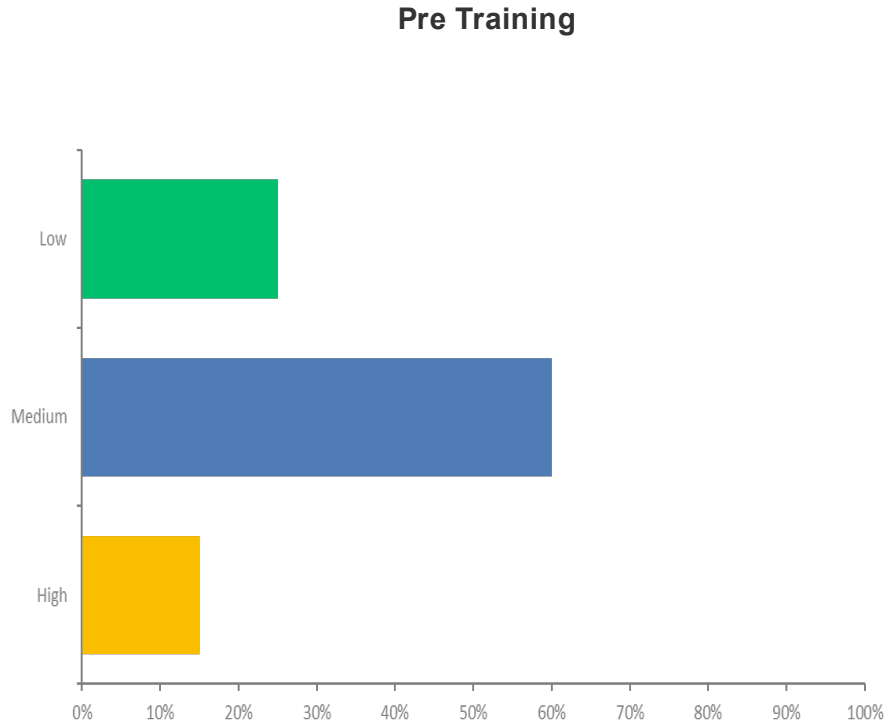
SRJC QPR Outcome Data 2021-2022

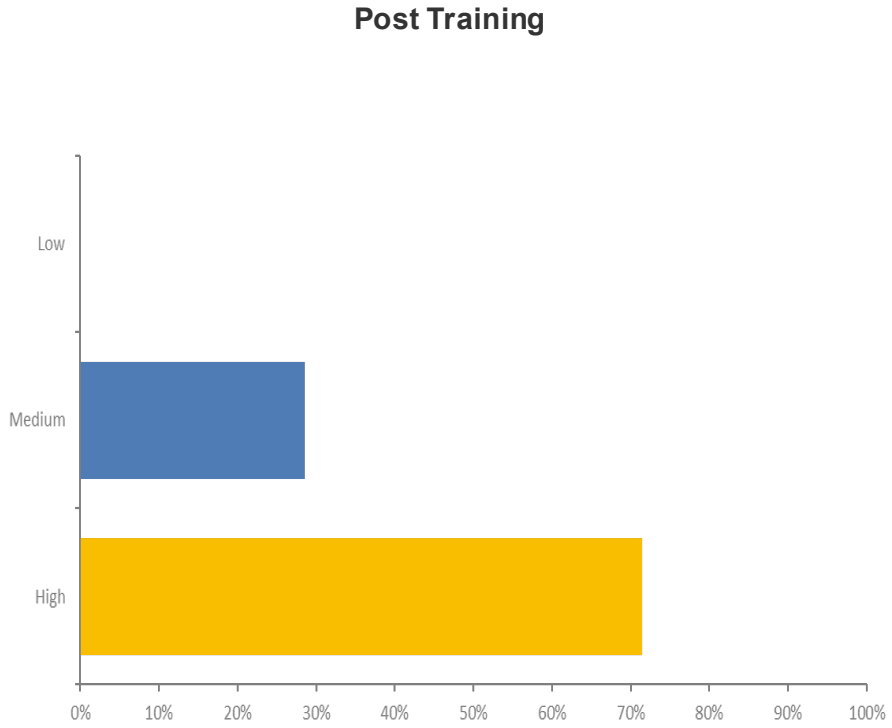
How would you rate your knowledge of suicide in the following area? Facts concerning suicide prevention:





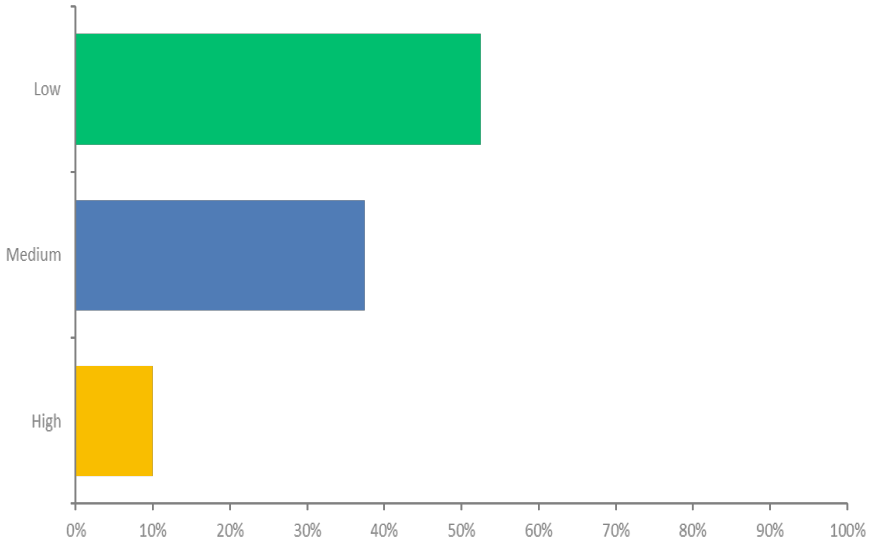
How would you rate your knowledge of suicide in the following area? Warning signs of suicide:



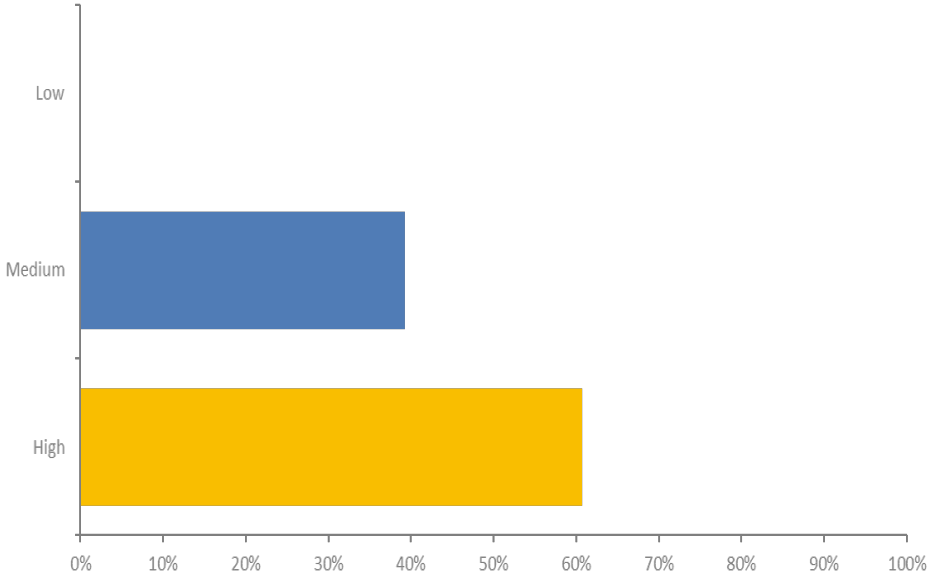


How would you rate your knowledge of suicide in the following area? How to ask someone about suicide:

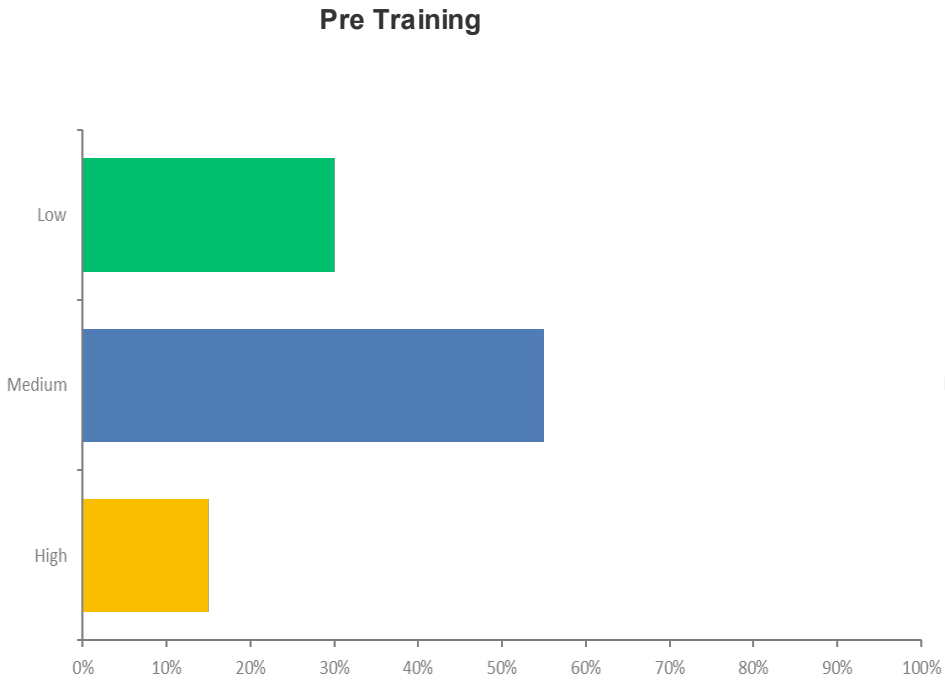
Pre Training

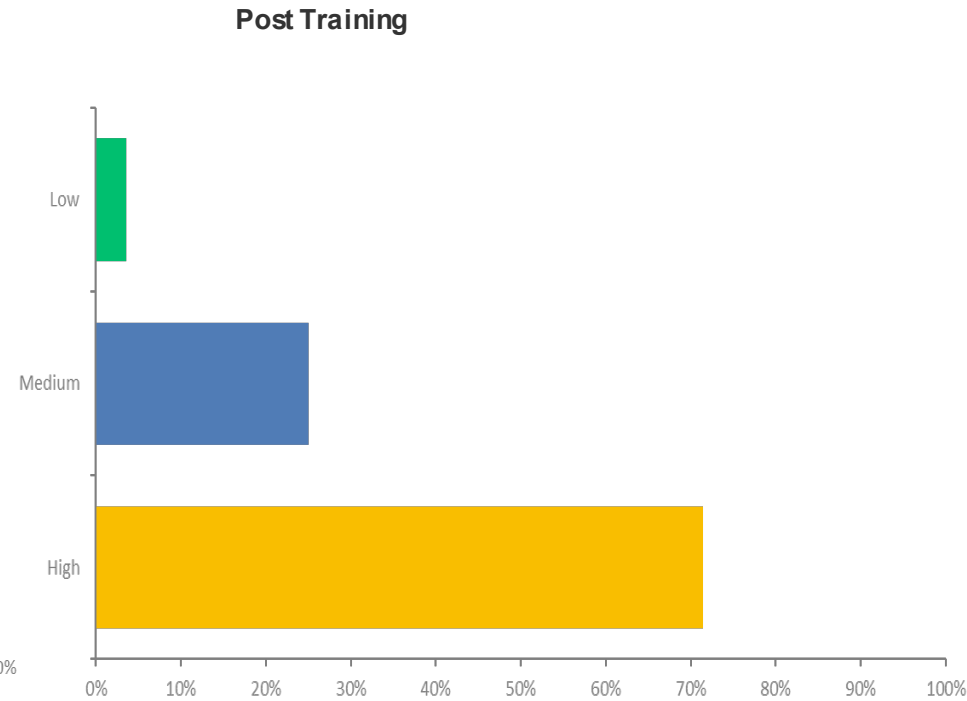


Post Training

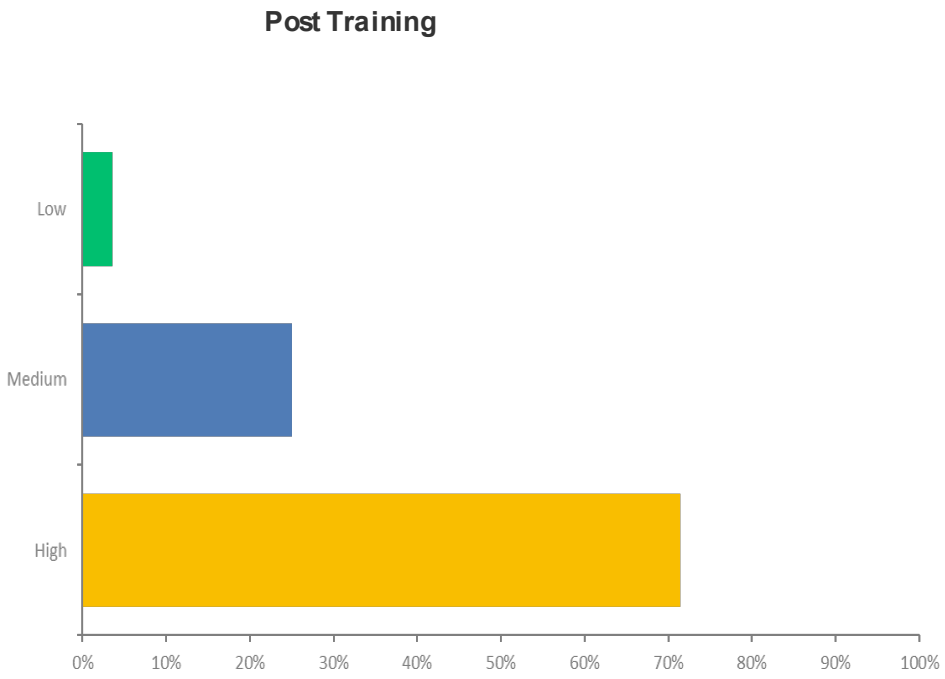


How would you rate your knowledge of suicide in the following area? Persuading someone to get help:

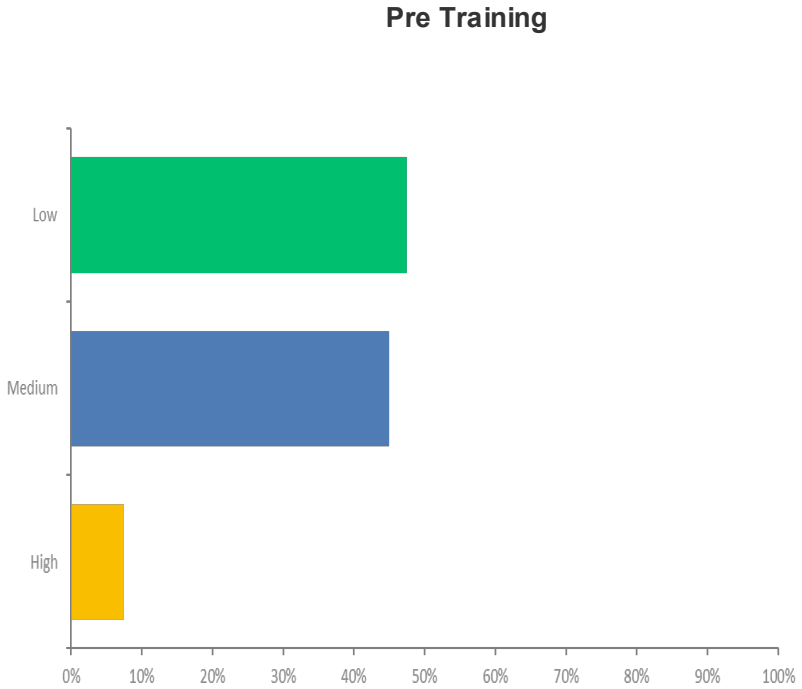


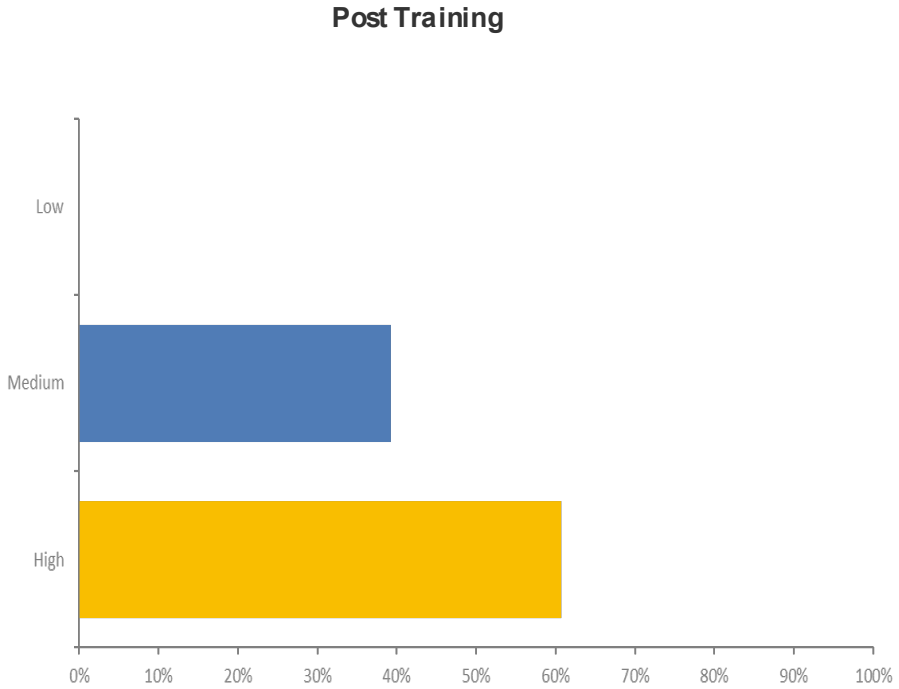


How would you rate your knowledge of suicide in the following area? How to get help for someone:

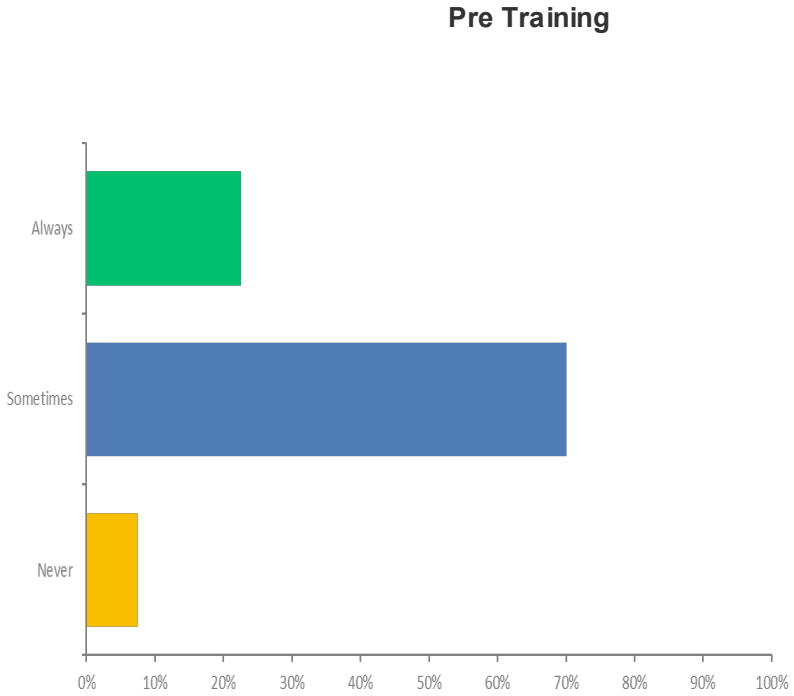


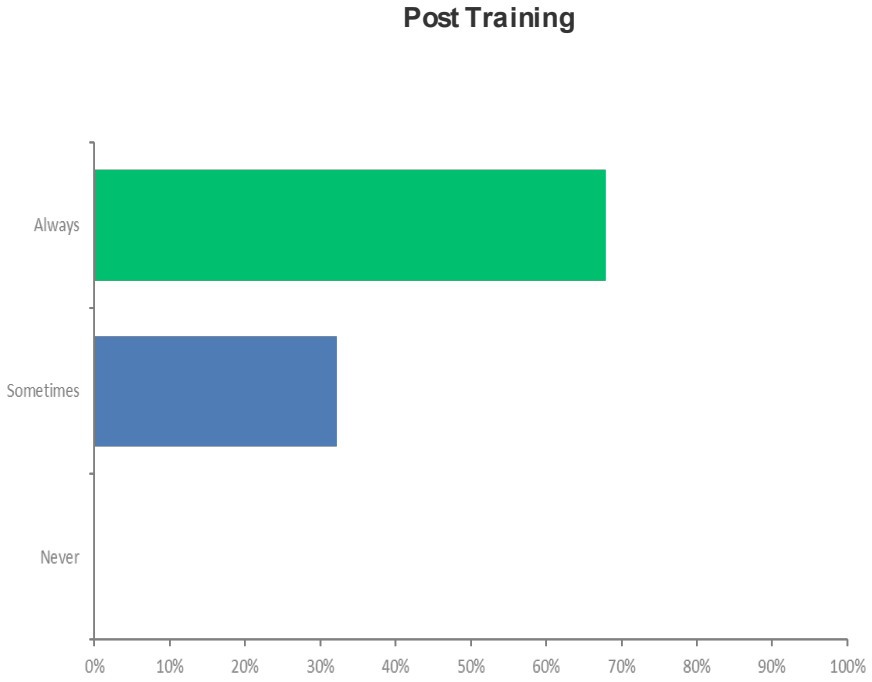
How would you rate your knowledge of suicide in the following area? Information about local resources for help with suicide:



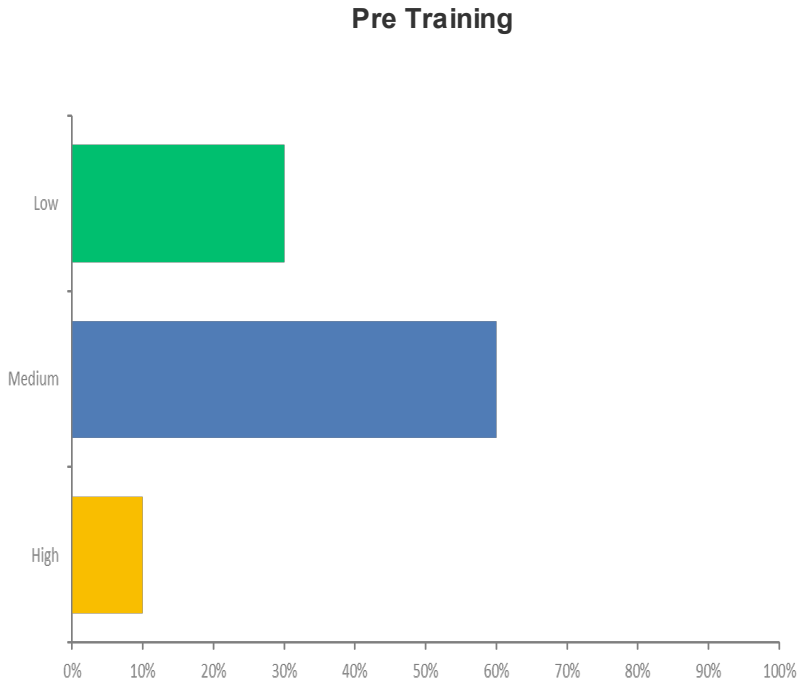


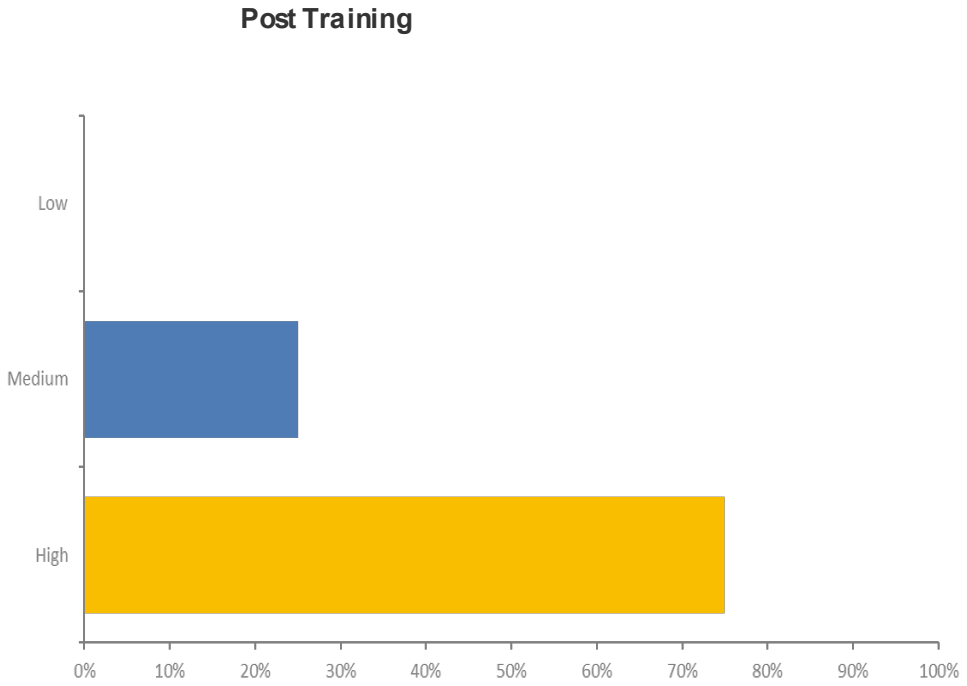
Do you feel likely to ask someone if they are thinking of suicide?



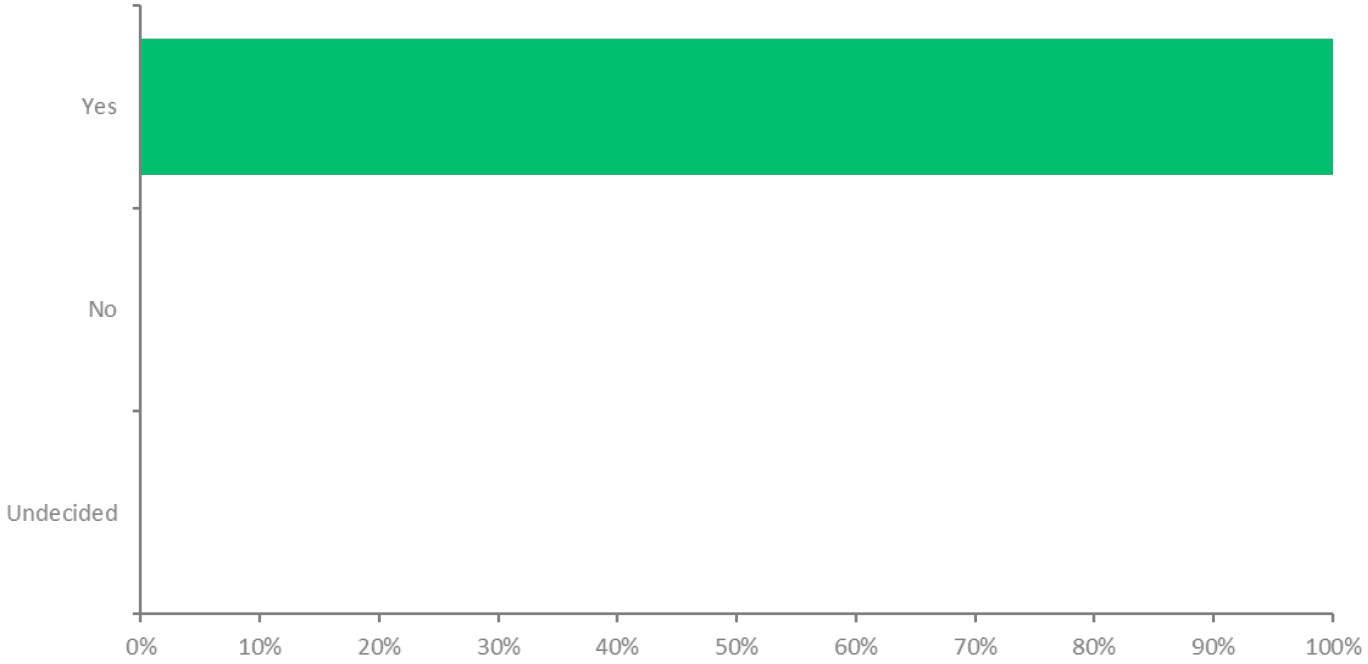


Please rate your level of understanding about suicide and suicide prevention:





Would you recommend QPR training to other?



Sonoma County MHSA Community Program Planning Workgroup

Strategic and Action Plan
January 2022

Introduction

In 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA established a one percent income tax on personal income over $1 million for the purpose of funding mental health systems and services in California. In an effort to effectively transform the mental health system, MHSA creates a broad continuum of prevention, early intervention, innovative programs, services, and infrastructure, technology, and training elements. Community Programming Planning (CPP) is specific to Mental Health Services Act (MHSA) funding.

The MHSA was designed to transform the public mental health system, not only through the generation of new revenue to fund the expansion of services, but also by requiring unprecedented levels of ongoing stakeholder input and involvement at all levels of public mental health policy, program planning, implementation, monitoring, quality improvement, evaluation, and budget allocations. WIC § 5848(a). Furthermore, the California Code of Regulations, Title 9 states that counties must ensure that stakeholders reflect the diversity of the demographics of the county, including, but not limited to, geographic location, age, gender, race/ethnicity, individuals with lived experience and family members have the opportunity to participate in the CPP process (CCR § 3300). Additional background information about MHSA can be found through Access California, a statewide consumer-led public mental health advocacy program of Cal Voices.

The benefits of having a structured Community Program Planning (CPP) model cannot be overstated. Public programs designed by and for the members of the community are more relevant, culturally-appropriate, promotes ownership and are oriented to cost-effectiveness. *Access California* lists the benefits of stakeholder engagement as follows:

- Better decision making
- More effective service delivery
- Greater community support
- Community development
- Renewal of local democracy
- Increased resources
- Increased engagement with services
- Increased cultural competence

Sonoma County MHSA Community Program Planning Workgroup

Incorporating Community-Based Participatory Research (CBPR) practices into a local community program planning process strengthens and assures that the voices of consumers, family members, and stakeholders are represented in decisions, actions, and results of the planning process. CBPR involves a partnership between researchers and community members in all aspects of the process: defining the research questions, deciding who participates, how the data is collected and analyzed, and determining how to share the findings. CBPR has been shown to provide an opportunity to build greater trust between institutions and the community, explore the depth of local knowledge and perceptions, empower community members toward self-determination, and improve health equity within a system of care.

Diversity, Equity, and Inclusion (DEI)

In August 2020, the Sonoma Board of Supervisors established the Office of Equity to focus on the immediate spike in COVID-19 cases within the Latinx community. However, this health indicator was just a tipping point within a series of apparent inequities experienced during the recent wildfires, floods, power-grid shut offs, and Stay-at-Home orders by communities of color, poverty and others that are often on the margins of mainstream society. The Office of Equity states that "Equity is an outcome whereby you can't tell the difference in critical markers of health, well-being, and wealthy be race or ethnicity, and a process whereby we explicitly value the voices of people of color, low income, and other underrepresented and underserved communities who identify Solutions to achieve that outcome."

In alignment, the Department of Health Services, Behavioral Health Division appointed a new DEI Development Manager to ensure division policies and practices are non-discriminatory and inclusive, promote the diversification of a behavioral health workforce, ensure equity and cultural relevance in program services, and strengthen management and administrative performance relative to DEI.

Stakeholder Bill of Rights

Access California has adopted and published a Stakeholder Bill of Rights to further their mission of advancing client and community empowerment through sustainable solutions. The Sonoma County Community Program Planning workgroup, comprised of stakeholders, has adopted the following statements as foundational guiding principles in developing a sustainable, inclusive community engagement plan responsive to MHSA and the broader public mental health system.

1. **Transformation:** We have the right to a public mental health system that embraces the Recovery Model of Care and is fully committed to all General Standards for programs and services set forth by the MHSA.

2. **Information:** We have the right to full transparency in our public mental health system.
3. **Education:** We have the right to fully understand the meaning and implications of facts and data relevant to our public mental health system.
4. **Representation:** We have the right to competent and adequate representation when important decisions are made in our public mental health system.
5. **Participation:** We have the right to shape policy and meaningfully participate in all important programming and funding decisions in our public mental health system.
6. **Consideration:** We have the right to submit grievances[1] to our public mental health system, to have our grievances acknowledged, and to receive thorough and timely responses to our grievances.

Current opportunities for community participation

Sonoma County currently has a structure in place that meets the minimum requirement for a Community Program Planning process. The table below lists the MHSA committees and governing boards with a brief description of the member composition.

Committee/Board	Open, appointed or elected	Composition of members	Number of seats	Meeting dates
Stakeholders of mental health services	Open to the public	Nonprofit providers of health, social services, criminal justice, education; Contractors and providers of the health department and behavioral health division; interested members of the public; consumers and family members	Undefined	Bi-annually
MHSA Steering Committee	Application and selection process managed by	Members must represent the following: · Clients and consumers	20-25 seats	Quarterly

[1] Sonoma County Behavioral Health Division has a Client Rights policy with a stated grievance procedure. https://sonomacounty.ca.gov/Health/Behavioral-Health/Medi-Cal-Informing-Materials/

Sonoma County MHSA Community Program Planning Workgroup

	the MHSA Coordinator and Behavioral Health administration	· Families of clients/consumers · Providers of mental health, substance use, and social services · Persons with disabilities, including providers · Education field · Health care · Law enforcement · Veterans and/or representatives from veterans' groups · College-age youth · Other interests (faith-based, aging and adult services, youth advocates) · Individuals from diverse cultural and ethnic groups		
MHSA Workgroup: Innovation, PEI, CSS, CPP	Combination of voluntary and appointed	MHSA Steering Committee members, Stakeholders	4 – 8 members	As needed workgroups
Mental Health Board	Appointed by Board of Supervisors	Member of the public vested in mental health services; Fifty percent of the Board membership shall be consumers or the family members of consumers who are receiving or have received mental health services. At least 20% of the total membership shall be consumers and at least 20% shall be family members of consumers.	16 members: 3 representatives for each of the 5 county districts and one Supervisor	Monthly, third Tuesday at 5p. Check calendar.
Board of Supervisors	Elected		5 district representatives	Weekly on Tuesday, 8:30a; check calendar

County Capacity Assessment

In addition to these regular meetings, the Sonoma County Behavioral Health Division conducts a Community-wide Capacity Assessment every three years to prepare for the development of the regulated Three-Year Program and Expenditure Plan. Counties in California have flexibility to conduct their capacity assessments to include specific elements of inquiry, however MHSA regulations (WIC § 330) require the identification of the number of consumers across age groups by gender, race/ethnicity, and other demographics compared against projected need and utilization to analyze population disparities.

The most recent MHSA 2016-2019 Sonoma County Capacity Assessment, provided the community with many opportunities to share their experiences with the Sonoma County mental health system in order to ensure that any recommendations made in this assessment were community-driven and responsive to their needs. Stakeholders in the county had opportunities to express their opinion of the current Sonoma County mental health system and their suggestions for future improvements through surveys, focus groups and key informant interviews.

The capacity assessment process included a variety of stakeholders reflective of the geographic and cultural diversity of Sonoma County including groups listed in MHSA regulations and the Welfare and Institution Code.[2] This included representatives from the following groups:

- Adults and Seniors with Lived Experience
- Family Members
- DHS-BHD staff, managers, and senior leadership
- Community Mental Health Service Providers
- Law Enforcement Agencies
- Education Agencies

[2] Per the MHSOAC, WIC § 5848 states that each Annual Update shall be developed with local stakeholders, including: Adults and seniors with severe mental illness; Families of children, adults, and seniors with severe mental illness; Providers of services; Law enforcement agencies; Education; Social services agencies; Veterans; Representatives from veterans organizations; Providers of alcohol and drug services; Health care organizations; Other important interests (e.g., individuals served or targeted by Prevention and Early Intervention (PEI) services and individuals expected to benefit from INN projects). CCR § 3300 further includes: Representatives of unserved and/or underserved populations and family members of unserved/underserved populations, as defined in CCR § 3200.300 and CCR § 3200.310; Stakeholders that reflect the diversity of the demographics of the county, including but not limited to, geographic location, age, gender, and race/ethnicity; Clients with serious mental illness and/or serious emotional disturbance, and their family members.

- Social Service Agencies
- Veterans and Veterans Organizations
- Providers of Alcohol and Drug Services
- Health Care Organizations

Overall, 550 people participated in the capacity assessment**:** 77 attended focus groups, 447 completed a community survey, 16 engaged in system of care discussions, and 10 participated in key informant interviews.

The next County capacity assessment is projected to occur in the summer of 2022 which will present a significant opportunity for the CPP workgroup to engage a broader representation of the community and assure a process that is diverse, equitable and inclusive.

Expanding the Scope of Sonoma County's Community Program Planning (CPP)

The purpose of the Sonoma County CCP workgroup is to establish a process whereby community voices are elevated and incorporated into MHSA program planning for the behavioral health system. This workgroup is comprised of a diverse group of individuals interested in developing strategies and taking action to engage a broader community than themselves.

Our Vision: All people from various cultural backgrounds and languages have accessible opportunities to influence how MHSA funding support behavioral health programs and services in a system of care that is people centered and community driven. Community members in Sonoma County are acknowledged as critical partners in creating an equitable community practice that inspires a cultural shift[3] in which the voices of people in Sonoma County from all backgrounds are heard, acknowledged, and **utilized** in creating a system of mental health care funded by MHSA.

[3] CPP Workgroup definition: accumulation of listening to marginalized voices, developing increased awareness, creating new beliefs, and demonstrating new behaviors over a period of time.

Sonoma County MHSA Community Program Planning Workgroup

Our Mission: Increase community input into program planning decision making by establishing regular, timely, meaningful, safe, culturally appropriate opportunities for (1) deep listening, (2) free exchange of ideas, and (3) determining action based on those ideas. Results will be demonstrated by action steps as illustrated by policies, procedures and program outcomes of the community service programs funded by the MHSA plan.

Our Values:

- Practice **deep listening**: Listen to learn, listen to understand, listen without judgement
- Be **strategic**: Leveraging community and financial resources, respond to opportunities expediently, plan for long-term impact
- Recognize and support community resilience: Encourage healthy communities to work collectively for greater impact, acknowledge historical trauma, **self-determination**
- Promote community voice in all decision making: **Respect**/ honor individual expertise about their needs and solutions, Focus on strengths and aspirations
- Act with transparency: Make the purpose, expectations, and impacts of stakeholder participation explicit.
- Be **inclusive**: Commit to diverse multicultural and unserved, underserved and inappropriately served populations, Share responsibility and accountability
- Utilize the MHSA principles as foundational guidance
- Build capacity of community members: advocate for meaningful stakeholder participation, promote public education and training in CPP activities
- Conduct multiple methods of outreach: Dedicate efforts to increase accessibility

Goals

1) Expand and strengthen the community's knowledge of the public mental health system, specifically MHSA funded programs and services.
2) Expand and strengthen community partnerships and relationships with diverse representation.
3) Expand and strengthen partnership and relationships with consumers and family members.
4) Increase the engagement of community representatives in existing and emerging CPP opportunities.

Sonoma County MHSA Community Program Planning Workgroup

Key Actions for 2022

- Refine objectives and messaging of CPP, including MHSA and financing of mental health services (MHSA, Block Grant, Realignment, MediCal, insurance)
- Expand list of stakeholders to increase diversity
- Support and improve existing opportunities for community engagement
- Identify and define additional opportunities for community engagement and input
- Develop community relationships, build, and expand network
- Develop outreach toolkit (Skills, resources, and workbook: Include Dialogue and Appreciative Inquiry, TING) (See Appendix)
- Host outreach and education events
- Conduct a series of community focus groups with trained co-facilitators from the communities we seek to engage.

Sonoma County MHSA Community Program Planning Workgroup

CPP Strategic Action Plan

Objective	Action	Partners	Resources	Timeline
Prepare for Outreach and Education campaign to inform the community about MHSA and opportunities for community participation, input Why are we doing this? • System transformation from top-down to shared decision making Is there a call to action? What is it? • Value the expertise of community members • Include community expertise in shared decision making	• Develop outreach materials (English/Spanish) • Develop educational materials (English/Spanish) • Refine and expand stakeholder list • Develop outreach plan to include social media, radio/tv, print and public presentations	MHSA PEI contractors, media partners	Consultant team to support development and implementation of outreach and engagement plan	May 2022 – July 2022

Sonoma County MHSA Community Program Planning Workgroup

Objective	Action	Partners	Resources	Timeline
Identify organizations for new partnerships, community participation and outreach	• Develop list of organizations to explore partnerships: NAMI, Health Action leadership and all local chapters, Sonoma Connect, Measure O, ARPA, CHW CARES Act funding, IOLERO, NBOP, Graton Day Labor Center, Homeless Action, SAVS, Housing is Healthcare Collaborative, School and Church-based events, Peer programs, Disability Service and Legal Center,	Recruit additional champions for workgroup that represent diversity in community, bi-lingual Spanish, other languages?	Workgroup brainstorming session	March - April 2022
Conduct Outreach and Education Campaign	• Host a minimum of five events in accessible geographic locations • Secure public radio, tv and newsprint interviews	Media outlets Diverse Community Based Organizations (CBO) to host outreach and education events	Consultant team to secure locations, set up interviews. Coordinate with CPP workgroup members	July/Aug 2022

Sonoma County MHSA Community Program Planning Workgroup

Objective	Action	Partners	Resources	Timeline
Prepare for community listening sessions (Collecting data/input)	• Define objectives: ○ Data that contributes to the needed changes for system of care • Recruit community members to help develop listening session protocols, questions • Train community members on facilitation, reflective listening, and recording • Draft questions, review with community, refine • Establish locations and other logistics • Advertise, outreach for community participation	MHSA PEI contractors, Community Partners	Stipend for training community co-facilitators Cost of materials Paid advertising/try to get pro-bono from news outlets Consultant team to provide support and guidance	July - Sept 2022
Conduct community listening sessions	• Conduct up to 12 community listening sessions	Community partners, community co-facilitators	Stipend for co-facilitators and recorders Rental of space, food, stipends for attendees	Aug – Sept 2022

Sonoma County MHSA Community Program Planning Workgroup

Objective	Action	Partners	Resources	Timeline
Publish results from Community Listening Sessions	● Draft findings ● Review findings with co-facilitators and other stakeholders ● Finalize report ● Distribute report and present at various meetings	MHSA contractors, stakeholder groups, Mental Health Board, Board of Supervisors, public forums	Paid consultant to draft findings from focus groups Review findings w/ CPP workgroup	Oct – Dec 2022

Sonoma County MHSA Community Program Planning Workgroup

Appendix of Supporting Materials for CPP workplan

Community Outreach Toolkit/Workbook

Deep Listening

Deep Listening, what is it: levels of listening (Video)

We have many opportunities to listen to people on a daily basis but to what degree are we truly listening? And what opportunities can present themselves when we do?

Inspired by the thinking of Otto Scharmer, we can break listening down into **four levels:** inner chatter, factual, empathic, and generative. The further down we go, the more powerful our conversations can become and the more impact we can have.

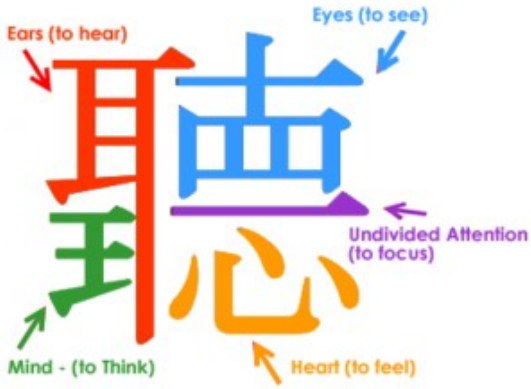
1. **Level 1** – Inner chatter - at this level we're more focused on listening to ourselves; our monkey brain takes over and we're really thinking about other things than the conversation. At best, we are only picking up information that confirms what we know already.
2. At **level 2**, we find the factual level of listening where we focus on the facts that are being stated in the conversation. It allows us to listen with an open mind to new information and change our opinions and views about a subject.

3. **At level 3** – empathic listening - we have the emotional story. This is where we go beyond ourselves and see the world through the eyes of the other which opens up more perspectives. To be at this level, it helps if we pay attention to congruence between the words and the way they are said.
4. Finally, at **level 4** we have generative listening. This is the deepest level of listening where we are able to connect with the narrator in a safe, optimistic, forward-looking manner, thereby opening up a wider field of possibilities.

Improving your listening is possible. Try these tips:

- Use mindfulness to calm the inner chatter in level 1
- Letting go of your agenda will help you move to Level 2 and 3
- Asking "what if" questions will help you get to Level 4

So, on what level of listening do you find yourself most often? Where do you aspire to be? And what steps will you take to get there?



"TING"

- Listening with **ears** - two ears one mouth listen twice as much as talking
- Listen with **eyes** - take note of body language and context. Nonverbal communication 70%
- Undivided **attention**-focus on the person you are listening to, quiet internal and external distractions
- Listen with your **mind**- be engaged
- Listen with your **heart-** feel the emotion of the person you are listening to. Be aware of the emotional response in yourself in response to what they are saying

The seven skills of dialogue are

1. Deep listening,
2. Respecting others,
3. Inquiry,
4. Voicing openly,
5. Balancing advocacy and inquiry,
6. Suspending assumptions & judgements
7. Reflecting

Appreciative Inquiry

Introduction to Appreciative Inquiry

Ap-pre'ci-ate, v. 1. valuing; the act of recognizing the best in people or the world around us; affirming past and present strengths, successes, and potentials; to perceive those things that give life (health, vitality, excellence) to living systems 2. to increase in value, e.g., the economy has appreciated in value. Synonyms: VALUING, PRIZING, ESTEEMING, and HONORING.

In-quire' (kwir), v., 1. the act of exploration and discovery. 2. To ask questions; to be open to seeing new potentials and possibilities. Synonyms: DISCOVERY, SEARCH, and SYSTEMATIC EXPLORATION, STUDY.

Appreciative Inquiry

The Core Principles of Appreciative Inquiry, which describe the basic tenets of the underlying Ai philosophy, were developed in the early 1990's by David Cooperrider and Suresh Srivastva (Cooperrider's advisor at Case Western Reserve University) and serve as the building blocks for all AI work. The five original principles are: Constructionist, Simultaneity, Anticipatory, Poetic, and Positive.