

# CONNECTION IS PREVENTION



## SONOMA COUNTY MENTAL HEALTH SERVICES ACT (MHSA) FY 2024-2025 ANNUAL PLAN UPDATE WITH FY 2022-2023 PROGRAM REPORT



## **Update to the FY 2024-2025 MHSA Annual Update:**

As per CCR Title 9 Section 3315 Sonoma County Behavioral Health Division (BHD) is updating the current MHSA plan. Do to the housing needs of Full Service Partnership clients of all ages, BHD is changing the Transitional Age Youth (18-25 year olds) Housing Program to create housing support for all Full Services Partnership clients of all ages. This is a one time expense of \$2,300,000 in the FSP subcomponent of Community Services and Supports. These non-mental health services and supports funds can be used to assist FSP clients with the following expenses, as per CCR Title 9 Section § 3620.

Housing, including, but not limited to:

- Rent Subsidies
- Housing Vouchers
- House Payments
- Residence in a Drug/Alcohol Rehabilitation Program
- Transitional and Temporary Housing
- Cost of Health Care Treatment
- Cost of Treatment of Co-Occurring Conditions, such as substance Abuse

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# County Compliance Certification

## MHSA COUNTY COMPLIANCE CERTIFICATION

County: Sonoma

Local Mental Health Director	Program Lead
Name: Dr. 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	

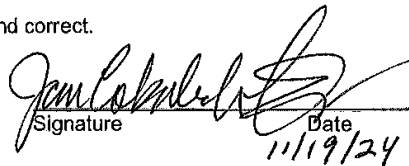
I hereby certify that I am the official responsible for the administration of county mental health services in and for said county and that the County has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this annual 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 November 5, 2024.

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.

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

  
Signature Date  
11/19/24

County: Sonoma

Date: 11-19-24

# County Fiscal Accountability Certification

Enclosure 1

## MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION<sup>1</sup>

County/City: SONOMA

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

<p align="center"><b>Local Mental Health Director</b></p> <p>Name: <u>Dr. Jan Cobaleda-Kegler</u></p> <p>Telephone Number: <u>(707) 565-5157</u></p> <p>E-mail: <u>jan.cobaleda-kegler@sonoma-county.org</u></p>	<p align="center"><b>County Auditor-Controller / City Financial Officer</b></p> <p>Name: <u>Erick Roeser</u></p> <p>Telephone Number: <u>707-565-3295</u></p> <p>E-mail: <u>erick.roeser@sonoma-county.org</u></p>
<p>Local Mental Health Mailing Address:</p> <p>Sonoma County DHS-Behavioural Health Division                  2227 Capricorn Way, Suite 203                  Santa Rosa, CA 95407</p>	

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 11-19-24  
 Signature Date

I hereby certify that for the fiscal year ended June 30, 2023, 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 1/22/2024 for the fiscal year ended June 30, 2023. I further certify that for the fiscal year ended June 30, 2023, 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)

Erick Roeser Nov 19, 2024  
 Signature Date

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

## MESSAGE FROM THE BEHAVIORAL HEALTH DIRECTOR



Dear MHSa Community Members and Supporters

I would like to welcome you to Sonoma County Behavioral Health Services Division's Mental Health Services Act (MHSa) Annual Program and Expenditure Plan update for FY 2024—2025. Fiscal year 2024-2025 will mark the second year of our current MHSa Three-Year Plan, FY 2023 to 2026. This annual update continues the work initiated in the Three-Year Plan; and introduces several new projects we plan to provide to the community.

My heartfelt thanks to all who have contributed to and participated in our Community Program Planning Process and numerous stakeholder group meetings. Working together we will build healthy, resilient, and responsive systems of care that support our clients, families, and staff.

Sonoma County is recovering from a series of traumas experienced over the past several years; devastating fires, floods, as well as a global COVID pandemic. Our workforce and the community we serve have been impacted. The need for Behavioral Health (BH) services has increased and there remains much work to do. We continue to work on strengthening and expanding our networks of care to serve our most vulnerable clients, repair our traumatized system, and build a community of practice. A commitment to trauma informed care threads through this annual update as we prioritize system transformation with initiatives begun in the first year of the Three Year Plan:

- Increasing staffing at critical access and entry points in our system of care.
- Developing a comprehensive training program for staff and contractors to improve our skills and the services we provide our clients.
- Building out a continuum of housing supports for our most vulnerable clients.

Some new initiatives you will find in this annual update:

- We plan to add a Homeless Services Full Service Partnership(FSP) with Housing Supports to expand services for unhoused BH clients.
- We plan to Initiate an RFP to contract with a provider to house Transition Age Youth(TAY) FSP clients in temporary and/or permanent supported housing for 6-20 TAY youth, ages 18 to 25.
- We will implement a Suicide Prevention Strategic Plan developed by our ***Life Worth Living Suicide Prevention Alliance***.
- We want to include the wisdom of lived experience in the services we provide by launching an RFP for Peer and Family Support Services to support our new BH School Partnership Program, known as CAPE, Crisis Assessment Prevention & Education.

This plan embodies the spirit of MHSa, soon-to-be BHSA: wellness, collaboration, recovery, and healing practices. I am deeply grateful for the supports that MHSa/BHSA provides our communities and for all the work that all of you do.

Warm regards,

*Jan Cobaleda-Kegler*

BH Division Director





**Melissa Ladrech**  
MHSA Coordinator



**Fabiola Espinosa**  
MHSA Analyst



*Meet Our Team*  
MHSA SONOMA



**Lisa Nosal**  
Cultural Responsiveness,  
Inclusion & Training Coordinator



**Iridian Onofre**  
Senior Office Assistant

# EXECUTIVE SUMMARY

## PURPOSE OF THIS DOCUMENT

As per the California Welfare and Institutions Code (WIC) Title 9, Section 3310 the Sonoma County 2024-2025 Mental Health Services Act (MHSA) Annual Update Plan provides stakeholders with:

- The Annual Update and Expenditure Plan for Fiscal Year (FY) 2024-2025.
- The Annual Program Report for FY 22-23 includes the activities, services, program descriptions and outcomes of the programs funded through MHSA for FY 22-23.

## 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 24-25, it is estimated that over \$3 billion in MHSA funds will be collected statewide, and it is estimated that Sonoma County will receive over \$30 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.



WELLNESS • RECOVERY • RESILIENCE

In 2024 Governor Newsome spear headed efforts to modernize MHSA. California voters passed Proposition 1: Behavioral Health Services Act (BHSA), in March 2024. Sonoma County is working in partnership with the state to implement BHSA. The law dictates that major changes will be phased in over several years, and the County has started to work with stakeholders to ensure that the changes will successfully serve our clients.

Proposition 1 has two major components:

1. Changes the Mental Health Services Act (MHSA) that was passed by voters in 2004, with a focus on how the money from the Act can be used. The new funding allocations become effective July 1, 2026.

- Prop 1 makes no changes to the amount of money collected through the MHSA (now BHSA) tax, but the money would be used differently.



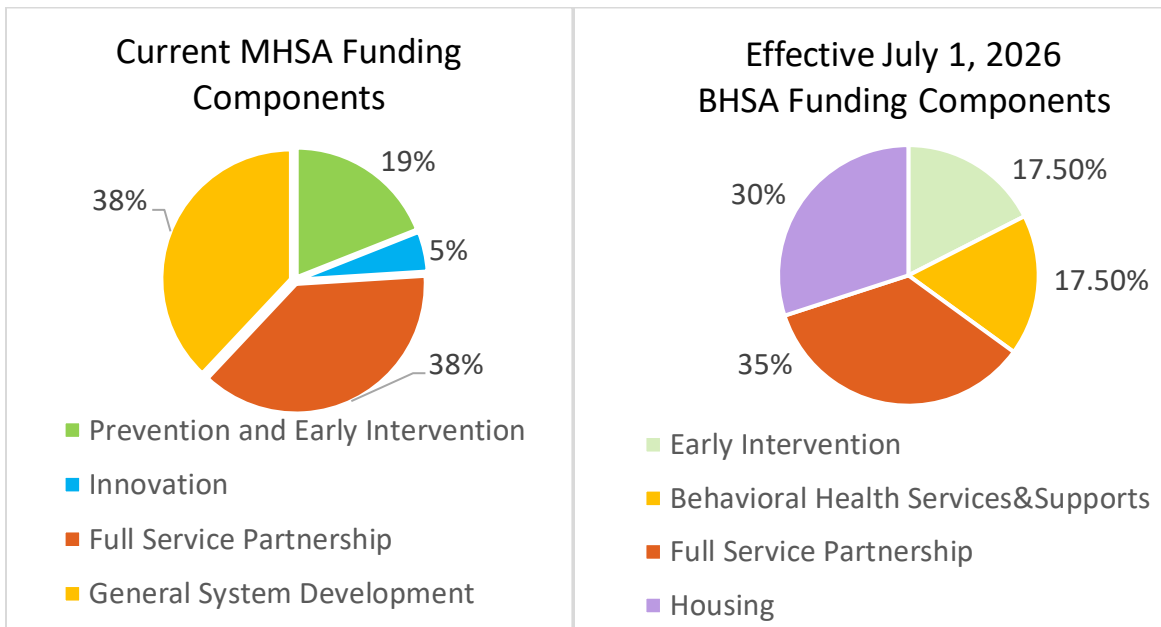
- Prop 1 will change how counties can use BHSAs to allow counties to use the funds to treat substance use disorders.
- BHSAs create a new requirement that 30% of funds allocated to Sonoma County must be spent on housing interventions for people with behavioral health challenges.
- Counties will not receive additional funding under Prop 1 for services previously funded by MHSA; therefore, less money will be available for non-housing services under BHSAs. There will be fewer resources for prevention programs, outpatient mental health treatment, and outreach efforts.



2. Approves a \$6.4 billion bond to build more places for mental health care and drug or alcohol treatment and more housing for people with mental health, drug, or alcohol challenges.

Bond funding will finance the building of new bricks and mortar infrastructure to house and treat county behavioral health clients. Many of Sonoma County’s behavioral health clients are receiving treatment despite not having permanent housing or shelter, and being able to provide more of our clients a safe space to live while they receive treatment is a welcome opportunity to build on the many paths to recovery.

**The charts below illustrate the funding components of MHSA and BHSAs:**



For FY 2024-2025 the county will continue to implement the current MHSA regulations. 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)<sup>1</sup>

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.

<sup>1</sup> 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.

**Capital Facilities and Technological Needs (CFTN)<sup>2</sup>**

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

**DRAFT FY 24-25 MHSA CHANGES & IMPACTS**

The following table highlights additions and substantial changes to MHSA funded programs from the FY 23-26 Three-Year Program Plan and Expenditure Plan (FY 23-26 Three-Year Plan) to the FY 24-25 Plan Update and Expenditure Plan (FY 24-25 Plan Update).

**Draft FY 24-25 MHSA Changes and Impacts**

Changes	Impacts
<b>Community Services and Supports</b>	
<b>Full Service Partnership (FSP) teams:</b>	
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.	
<p><b>Full Service Partnership (FSP) Team for Unhoused Adults:</b> This FSP will serve adults who are homeless or at risk of being homeless with serious mental health challenges. This program is budgeted at \$1,700,000 annually.</p>	<p>The addition of this FSP team will provide wrap around, intensive recovery oriented behavioral health services and housing support for 75 individuals. The FSP team will collaborate with clients to attain the client’s goals.</p>
<p><b>Transitional Age Youth (TAY) Housing Program:</b> The Behavioral Health Division will conduct a Request for Proposal (RFP) to contract with a provider to house TAY Full Service Partnership (FSP) clients. The RFP will consist of funds to secure a house or facility and provide supportive services. The FY 24-25 is budgeted at \$2,300,000, and there will be on going annual expenses of \$300,000.</p>	<p>This facility will provide temporary and/or permanent supported housing for a total of 6-20 Transition Age Youth (18-25 year olds) Full Service Partnership clients.</p>
<b>Prevention and Early Intervention (PEI)</b>	
<p><b>Peer and Family Support Services</b> will work in conjunction with the new Behavioral Health School Partnership program. Funding the Peer and Family Support Services of this program is budgeted at \$200,000 annually.</p>	<p>The Peer and Family Support Services is an Early Intervention program that will support 50-100 young people in accessing peer support from available community organizations, provide a safe space to talk about mental health symptoms in a non-judgmental setting, assist youth in learning about available options for treatment, if desired, and assist youth in navigating mental health treatment systems.</p>

<p><b>Seneca WRAP Program:</b> Seneca WRAP Program: This Early Intervention program will provide services for children and youth who are involved in foster care, the juvenile justice system, and/or who are at risk of out of home placement or psychiatric hospitalization. MHSA will provide \$500,000 annually for this program.</p>	<p>The addition of this Seneca WRAP program will serve 73 children (0-15 years old) and 32 youth (16-25 year olds). The program encourages coordination among agencies, disciplines, and communities to enhance outcomes for youth and families. WRAP services aim to prevent children and youth from going to higher levels of care by increasing resilience and recovery, teaching positive coping skills to youth, and improving caregiver ability to successfully support the youth in their care. WRAP services are designed to be short term, intensive interventions lasting 6 – 12 months.</p>
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Photo above: from May 2024's May is Mental Health Matters Month Healing Circle event in Healdsburg, CA



Santa Rosa is the county's most populous city with 177,181 people (U.S. Census Bureau, 2022 estimate) , and it is home to over one-third of county residents. Santa Rosa is also the County seat, including the offices of the Department of Health Services, Behavioral Health Division's (DHS-BHD) main campus. Beyond Santa Rosa, the major population centers are Petaluma (pop. 58,652) and Rohnert Park (pop. 44,326) to the south, and Windsor to the north (pop. 25,789). (U.S. Census Bureau, 2022 estimates) 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, along the coast and for those without a personal vehicle to access other areas in the county.

In 2022, 60.6% of residents identified as White, non-Hispanic with 28.9% identifying as Hispanic or Latinx, the County's largest and fastest growing minority population.<sup>5</sup> The County's poverty rates vary significantly by ethnicity with disparities affecting the Latinx community in particular. While Hispanic or Latinx residents represented almost 30% of the population, this group accounted for 40% of Sonoma County's Medi-Cal beneficiaries in 2021.<sup>6</sup> Additionally, there are an estimated 27,000 undocumented residents in the County. Of those, 12,000 or 44% are estimated to speak English less than "very well," suggesting possible linguistic isolation for this population.<sup>7</sup> Individuals who are undocumented and/or linguistically isolated 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 Lytton Band of Pomo Indians. Native Americans make up only 2.3% of the County's total population and about 1% of Medi-Cal beneficiaries. According to US Census, in 2022 the Asian/Native Hawaiian/Pacific Islander population represented 5.4% of the total population and African American/Blacks represented 2.2%. Although these percentages are relatively small, the diverse 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 21.9% (rate of 55.5% growth). The share of population that is 0-4 years old decreased from 5.8% in 2010 to 4.65 in 2022 as did the 5 – 9 year -old population, from 19% to 16.5% for the same years.<sup>8</sup> This data trend has serious

<sup>5</sup> USA Facts, Our Changing Population: Sonoma County, California. <https://usafacts.org/data/topics/people-society/population-and-demographics/our-changing-population/state/california/county/sonoma-county/>

<sup>6</sup> 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>

<sup>7</sup> Profile of the Unauthorized Population, Sonoma County, CA. Migration Policy Institute. <https://www.migrationpolicy.org/data/unauthorized-immigrant-population/county/6097>

<sup>8</sup> USA Facts, Our Changing Population: Sonoma County, California. <https://usafacts.org/data/topics/people-society/population-and-demographics/our-changing-population/state/california/county/sonoma-county/>



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 has increased to \$99,266 (U.S. Census Bureau, est. 2022), and the percentage of County residents living in poverty has decrease slightly from 9.1% to 8.9% in the past year. The unemployment rate has ticked up a bit in the past year, reported at 4.2% in March 2024 by the Labor Market Information Division, California Employment Development Department.

In 2021, 61.4% of the housing units in Sonoma County were occupied by their owner.<sup>9</sup> The remaining 38.6% of the population has encountered increasing rents over the past five years. Overall, median asking rents in Sonoma County have increased by 20% between 2021 and 2023.<sup>10</sup> This rent burden disproportionately impacts Black and Latino residents.

## MEDI-CAL BENEFICIARIES AND THRESHOLD LANGUAGES

In calendar year 2021, the number of people eligible for Medi-Cal in Sonoma County was reported at 129,764 according to the most recent External Quality Report released on FY 2022-23.<sup>11</sup> The report states that 3,227 beneficiaries were served by the Mental Health Plan. However, the overall penetration rate is low, at 2.49% as compared to the statewide average of 4.34%. Examining the penetration rate of those eligible as compared to those served by race/ethnicity are illustrated in the following table:

Race/Ethnicity	Annual Eligible	Beneficiaries Served	PR MHP	PR State
African-American	2,058	108	5.25%	7.64%
Asian/Pacific Islander	4,038	56	1.39%	2.08%
Hispanic/Latino	51,799	665	1.28%	3.74%
Native American	1,260	34	2.70%	6.33%
Other	34,294	1,037	3.02%	4.25%
White	36,315	1,327	3.65%	5.96%
Total	129,764	3,227	2.49%	4.34%

The penetration rate is lower than statewide in every race/ethnicity category. However, there has been a positive upward trend in penetration rate for African-American, Native Americans and Asian/Pacific Islanders since 2020.

The threshold language continues to be Spanish with 33.3% of unduplicated Medi-Cal enrollees in Sonoma County declaring Spanish as their primary language. California’s Department of Health Care Services (DHCS) defines “Threshold Language” as a language identified as the primary language, as

<sup>9</sup> *ibid*

<sup>10</sup> State of Housing in Sonoma County, Generation Housing, 2023.

<sup>11</sup> FY 2022-23 Medi-Cal Specialty Behavioral Health External Quality Review, Sonoma Final Report. Behavioral Health Concepts, Inc. February 2023.

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%

## COMMUNITY PROGRAM PLANNING PROCESS



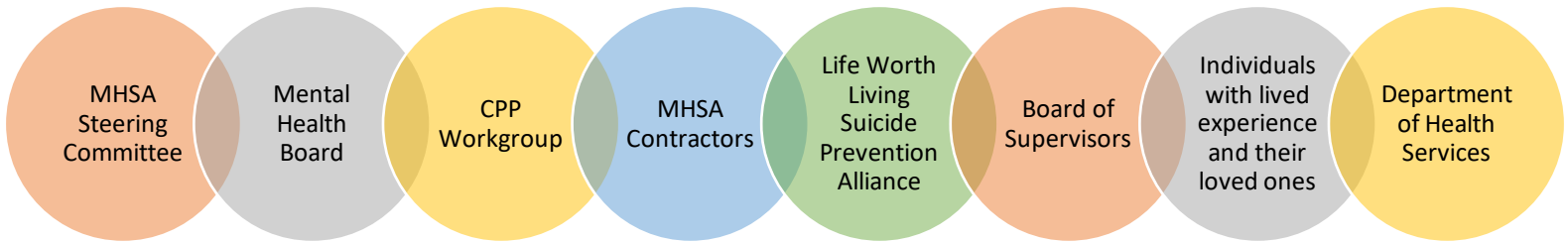
### COMMUNITY PROGRAM PLANNING WORKGROUP

Over the years, Sonoma County has refined the system and structure for the Mental Health Services Act (MHSA) Community Program Planning Process (CPPP) as a basis for developing the Three-Year Program and Expenditure Plans, Annual Plan Updates and other MHSA initiatives including Innovation proposals.

This structure is anchored by the MHSA Steering Committee 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. The CPPP also utilizes the Community Program Planning (CPP) Workgroup, Department of Health Services, Cultural Responsiveness Committee, Mental Health Board, Board of Supervisors, individuals with lived experience, family members, MHSA

contractors, mental health providers, community committees, and all other stakeholders.

The chart below illustrates the Stakeholder groups.



## 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, law enforcement, housing, veterans, 0-5 year olds and their caregivers, transitional age youth, and LGBTQ+.

The Steering Committee has a total of 29 members after conducting a recruitment in 2023. New members are provided in-depth training covering MHSA history and regulations, Sonoma’s CPPP, current expenditure plan, MHSA funded programs, and expectations for participation. Sonoma County offers stipends to participants that are not attending meetings as part of their job to encourage full participation.

In FY 2023-2024 the Steering Committee engaged in timely discussions about mental health in the county, assessed the FY 22-23 Listening Session Report, reviewed the Life Worth Living Suicide Prevention Alliance activities, and learned about SB 326: Behavioral Health Services Act.

The MHSA Steering Committee meeting minutes 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 members for 2023-2024 are listed in the table below:**

Name	Representation
Allison Murphy	0-5 year olds, mothers and caregivers
Amanda Lopez	Veterans Affairs
Amy Ramirez	Healthcare
Angie Dillon-Shore	First Five (0-5 year olds)
Becky Ennis	Mental Health provider, family member

Christy Davila	Mental Health Provider
Dory Escobar	Community Health Consultant, DEI Expert
Ellisa Reiff	Disabilities
Erika Klohe	Provider, lived mental health experience, family member
Fabiola Espinosa	MHSA Analyst, Family member, Latina
Fletcher Skerrett	Law Enforcement
Jan Cobaleda-Kegler	Behavioral Health Director
Jeane Erlenborn	Education, transition age youth
Julie Kawahara	MHSA Consultant and DEI Expert
Katie Bivin	Youth and Behavioral Health School Partnership
Kathy Smith	Family member
Kimi Barbosa	Positive Images, LGBTQI+
Lisa Nosal	Cultural Responsiveness, Inclusion & Training Coordinator
Mandy Corbin	Education
Maricarmen Reyes	Family member, Latina
Mary-Frances Walsh	Family member, NAMI
Matt Perry	Law Enforcement
Melissa Ladrech	MHSA Coordinator, Family Member
Michael Gause	Ending Homelessness
Michael Johnson	Mental Health Board, lived mental health experience
Michael Schemmel	Law Enforcement, Coroner's Office
Paula Glodowski Valla	Human Services Department
Renee Alger	0–5-year-olds and caregivers, Family member
Robin Phoenix	Lived mental health experience, Homeless Services
Saskia Garcia	Provider, family member, lived mental health experience
Wardell Anderson	Probation, African American

The Steering Committee convened four times in FY 2023-2024. The dates and topics of the meetings are in the chart with all the stakeholder meetings on page 26.

**COMMUNITY PROGRAM PLANNING WORKGROUP**

A powerful force leading CPPP is the 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.

When the CPP Workgroup was established in 2020, it was determined that the purpose of the 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 Updates. More specifically, the CPP Workgroup established the following goals:



Expand the community’s knowledge of the public mental health system, specifically MHSA funded programs and services.



Strengthen community partnerships and relationships with diverse representation.



Expand and strengthen partnership and relationships with consumers and family members.



Increase the engagement of community representatives in existing and emerging CPP opportunities.

**CPP Workgroup members:**

Name	Representation/Organization
Barbosa, Kimi	Positive Images LGBTQI +
Escobar, Dory	Community Health Consultant, DEI Expert
Espinosa, Fabiola	MHSA Analyst, Family Member
Erlenborn, Jeane	Education, transition age youth
Garcia, Saskia	Sonoma Connect
Gutierrez, Angelina	Sonoma County Indian Health Project
Johnson, Michael	Mental Health Board, lived experience
Kawahara, Julie	MHSA Consultant, DEI Expert, family member
Klohe, Erika	Provider, lived mental health experience, family member
Ladrech, Melissa	MHSA Coordinator, family member
Manieri, Stephanie	Latino Service Providers
Murphy, Meghan	Provider
Onofre, Iridian	MHSA Senior Office Assistant
Reynolds, Michael	Mental Health Board, lived experience
Rogers, Michele	0–5-year-olds and caregivers
Rogers, Tina	CPP Listening Session co-facilitator
Swan, KT	Mobile Crisis Response, lived experience, family member
Turner, Lee	Community Baptist Collaborative

The CPP Workgroup was aware that most of the stakeholder input was from current clients, individuals, and organizations involved that were already involved with the Behavioral Health Division. The Workgroup wanted to expand the stakeholders to include voices that MHSA

hadn't heard from in the past.

In 2022, the CPP Workgroup decided to conduct Listening Sessions with diverse populations that have been historically unserved and underserved.

CPP Listening Sessions Project Phases:



The workgroup selected 16 populations to find out more about their perceptions of local mental health support and services, what services are available, and what is still needed.

<b>FY 2022-2023</b>	<b>FY 2023-2024</b>
African American/Black	African American/Black Youth
Asian American/Pacific Islander	Agricultural Workers
Latinx Youth (immigrant & US-born)	Asian American/Pacific Islander Youth
Latinx Adults (immigrant) – Sonoma Valley	Indigenous (central County)
Latinx Adults (immigrant) – Cloverdale	Indigenous (coastal)
Latinx Adults (low-wage earners) – Guerneville	People with Physical Disabilities
LGBTQIA	Transitional Age Youth
Older Adults	Unhoused Adults

Within these populations, individuals and organizations were identified by Dory Escobar, the Listening Session consultant. The consultant and CPP Workgroup members identified co-facilitators for the selected populations. Once the seventeen co-facilitators were identified, they participated in an orientation and a comprehensive training. The co-facilitators are compensated with a stipend for attending trainings, outreach, and conducting the listening sessions. An outline of this training is illustrated in the following table:

Orientation	Facilitation Training
<ul style="list-style-type: none"> <li>○ Project Overview &amp; Context</li> <li>○ MHSA 101</li> <li>○ Listening Session Groups</li> <li>○ Health &amp; Safety</li> <li>○ Role of Co-facilitators</li> <li>○ Administrative Tasks/Forms</li> <li>○ Team Meetings</li> <li>○ Zoom Tips</li> </ul>	<ul style="list-style-type: none"> <li>○ Guiding Principles</li> <li>○ Listening Session Questions</li> <li>○ Participant Recruitment</li> <li>○ Facilitation Skills</li> <li>○ Sessions Planning &amp; Prep</li> <li>○ Interpretation of Results</li> <li>○ Developing Recommendations</li> </ul>



Photo above: Healing circle in Healdsburg for May is Mental Health Matters month in 2024.

The listening session questions used were adapted from the California Mental Health Services Oversight & Accountability Commission for Transitional Age Youth listening sessions that were conducted in 2022. The co-facilitators found that the questions were very relevant to each one of the populations being engaged. The Sonoma County MHSA listening sessions co-facilitators used the following questions for this project:

The image displays seven listening session questions arranged in a grid. The first row contains three boxes: a blue box on the left, a light blue box in the middle, and a teal box on the right. The second row contains three green boxes. The third row contains a single, wider green box centered below the other two rows.

What are the most critical mental health needs of people in your community today?	Has the need for support increased, decreased, or stayed the same in the past year compared to previous years?	How and where do people find that support? What barriers do they face in trying to get the help they need?
Who often gets overlooked when it comes to making mental health services available to your community?	Which types of organizations do folks go to when in need of mental health support or services and why?	What are the most important characteristics of an organization that advocates for and serves the behavioral health needs of your community?
What else should we know about the mental health needs of people in your community?		

Qualitative data was captured through transcripts of the audio recordings of the listening sessions, along with co-facilitator notes. A review of the transcripts revealed emerging themes in each listen session, as well as themes that were common to several or all the groups. A simple thematic table was composed for each listening session, followed by a identification of common themes. As a community-based participatory project, the engagement of community representatives to serve as listening session co-facilitators was key.



## Key Takeaways:



Themes found across culturally specific listening sessions include:

- Culturally aware and relevant services
- Cultural norms and stigma
- Increased mental health concerns including isolation, depression and stress
- Intergenerational trauma
- Racism and discrimination
- Formal and informal peer support



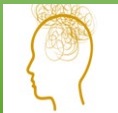
Facilitators who are representative of the listening session participants are at increased risk of experiencing and conflating primary and secondary trauma and need ongoing support.



Social isolation, stress, anxiety, and depression increased in recent years in all populations represented in the project. Participants identified the pandemic, fires, interpersonal violence, racism, and recent political divisiveness as contributing factors.



There is a need for greater access to services before the mental health concerns becomes a crisis, not only prevention, but widely available early intervention services for all income levels.



Intergenerational trauma is experienced in diverse populations in Sonoma County and is discussed or addressed to varying degrees and in different ways.



Culturally relevant peer support is critical, in some cases increased since the start of the pandemic and needs to be supported and expanded.



Decentralized (beyond Santa Rosa) and more culturally aware and relevant services and providers are needed to increase access and utilization by diverse populations.



Regardless of population, services need to be provided by organizations and individuals who are welcoming; authentically interested in and respectful of people's concerns, experiences, and perspectives; nonjudgmental; empathic; compassionate; and trustworthy.



In some cases, participants stated there are no services available in their community or in their preferred language when, in fact, there are. Regardless of that fact, their perception is of great importance and indicates a need for improved culturally aware and relevant outreach, education, and information about services and how to access them.

## Recommendations for Further Actions:



Provide support to trusted community-based organizations to sustain safe spaces like these listening sessions in the community.



Support cultural groups/organizations to build upon existing resources.



Organize some listening sessions with even more focused, specific cultural groups to promote greater affinity to build emotional and social safety and encourage participation.



Continue to support capacity building within Sonoma County's diverse cultural populations to facilitate dialogue about mental health and institutionalize their voice and influence within the MSHA system, structures, and processes.



Provide community education about intergenerational trauma and engage community representatives to provide more information.



Improve and increase culturally aware and relevant outreach, education, and information about services and how to access them.



Ensure that mental health services are not only linguistically appropriate, but culturally appropriate for the diversity within populations served.

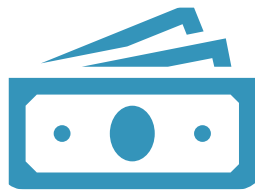


Expand facilitator's training on understanding the difference and interaction between primary and secondary traumatization.

### Progress on Recommendations:

Based on the recommendations of the listening sessions, the Division is working on two initiatives:

1. **Mini Grants:** The division planning on investing \$325,000 in mini grants with technical and administrative support from California Mental Health Authority (CalMHSA). CalMHSA assists county behavioral health departments in administering grants to local organizations for providing mental health early intervention services to their communities. These Time-Limited Community Driven Early Intervention grants can help to improve access to early intervention programs, linkages mental health resources, and culturally relevant healing and wellness activities to unserved and underserved groups.



\$250,000 can provide community-based organizations (CBOs) with technical assistance to develop Early Intervention Programs for historically unserved/ underserved/BIPOC/ LGBTQI+ communities. CBOs will need to apply for these funds, and it will be a competitive process.



\$75,000 is for inclusive culturally relevant supportive and healing community events for unserved/ underserved/BIPOC/ LGBTQI+ communities (i.e. healing circles, community wellness gatherings)

2. **Interactive digital Resource Map:** The Division is developing an interactive and bilingual behavioral health and basic needs resource map. The map will be posted on the division's website, and the map can also be printed out with a QR code that connects to the online map.

The dates and topics of the CPP meetings are in the chart with all the stakeholder meetings on page 26.

### STAKEHOLDER PARTICIPATION

The MHSA Stakeholder Meetings are developed with and co-facilitated by the members of the CPP Workgroup. One goal for stakeholder engagement is to build the capacity for community members to have a foundation of knowledge about Sonoma's MHSA planning and actively participate in promoting wellness and shaping access to quality services for a diverse population seeking mental health services.

These meetings are well attended, and the standard agenda includes a 30 minute briefing on

MHSA history and regulations, updates on programs, funding, and dedicated time for break-out sessions with discussions on current topics of interest, stakeholder feedback is documented and considered in future decision-making. Discussion questions have included:

- 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 from the group you represent?

The dates and topics of the meetings are in the chart below with all the stakeholder meetings.

**Overall Community Program Planning Process for Sonoma County’s MHSA Calendar:  
July 1, 2023 – June 30, 2024**

Date	Location	Stakeholder Group	Topics Discussed
Jul 6	Santa Rosa & Zoom	Life Worth Living: Suicide Prevention Alliance	<ul style="list-style-type: none"> <li>● Mission &amp; Guiding Principles</li> <li>● Suicide Prevention Month Activities</li> <li>● Means Safety – Resources</li> </ul>
Jul 26	Zoom	MHSA Contractors: Results Based Accountability – Turn the Curve	<ul style="list-style-type: none"> <li>● Coming Soon: Anti-Racist Results-Based Accountability</li> <li>● Turn the Curve example</li> <li>● Turn the Curve on your organization’s data</li> </ul>
Aug 1	Zoom	MHSA Innovation Contractors check-in	<ul style="list-style-type: none"> <li>● MHSA Updates</li> <li>● Innovation Project Updates</li> <li>● Annual Innovation Report Outline &amp; Timeline</li> </ul>
Aug 3	Santa Rosa & Zoom	Life Worth Living: Suicide Prevention Alliance	<ul style="list-style-type: none"> <li>● Charter</li> <li>● High Level Goals &amp; Next Steps</li> <li>● Strategic Planning</li> <li>● Suicide Prevention Month Activities</li> </ul>
Aug 9	Santa Rosa & Zoom	MHSA Steering Committee	<ul style="list-style-type: none"> <li>● FY 23-26 Three-Year Plan</li> <li>● Modernization of MHSA</li> <li>● Life Worth Living: So Co Suicide Prevention Alliance:</li> <li>● CPP Strategic Plan: Listening Sessions Update</li> </ul>
Sep 7	Zoom	Life Worth Living: Suicide Prevention Alliance	<ul style="list-style-type: none"> <li>● High Level Goals &amp; Strategic Planning</li> <li>● NAMI Suicide Prevention Efforts</li> </ul>

			<ul style="list-style-type: none"> <li>• Suicide Prevention Month</li> </ul>
Sep 10	Santa Rosa	All stakeholders and community members	<ul style="list-style-type: none"> <li>• Connection is Prevention: Suicide Prevention Event <ul style="list-style-type: none"> <li>○ Engaging workshops</li> <li>○ Interactive Activities</li> </ul> </li> </ul>
Sep 12	Santa Rosa & Zoom	CPP Workgroup	<ul style="list-style-type: none"> <li>• Review Listening sessions Report</li> <li>• Crossroads to Hope Peer Advisory Council</li> <li>• Suicide Prevention Month Events</li> </ul>
Oct 5	Zoom	Life Worth Living: Suicide Prevention Alliance	<ul style="list-style-type: none"> <li>• Supporting and Integrating with NAMI</li> <li>• Logo Development</li> <li>• Recap of Suicide Prevention Month Activities</li> </ul>
Nov 2	Zoom	Life Worth Living (LWL): Suicide Prevention Alliance	<ul style="list-style-type: none"> <li>• Review Spanish name for LWL</li> <li>• Suicide Remembrance Day events</li> <li>• Updates on Strategic Plan</li> </ul>
Nov 7	Santa Rosa	MHSA Annual Innovation Reports for Stakeholders	<ul style="list-style-type: none"> <li>• MHSA Updates</li> <li>• Annual Innovation Project Reports: <ul style="list-style-type: none"> <li>○ Early Psychosis - Learning Health Care Network</li> <li>○ Instructions Not Included: Dads Matter</li> <li>○ Nuestra Cultura Cura Social Innovations Lab</li> <li>○ New Parent TLC</li> <li>○ Unidos por Nuestro Bienestar</li> <li>○ Crossroads to Hope</li> </ul> </li> </ul>
Nov 8	Santa Rosa & Zoom	MHSA Steering Committee	<ul style="list-style-type: none"> <li>• Discussion Question</li> <li>• SB 326: Modernization of MHSA</li> <li>• Life Worth Living: So Co Suicide Prevention Alliance Update</li> </ul>
Nov 14	Sonoma Valley	Survivors of Suicide Remembrance Day	<ul style="list-style-type: none"> <li>• Viewing of Life Journeys Reclaiming Life After discussion</li> <li>• Update on Survivors of Suicide Group</li> <li>• 988 Information</li> <li>• Self-care ideas</li> </ul>
Nov 16	Santa Rosa	Survivors of Suicide Remembrance Day	<ul style="list-style-type: none"> <li>• Panelists</li> <li>• Update on Survivors of Suicide Group</li> <li>• 988 Information</li> <li>• Self-care ideas</li> </ul>
Nov 21	Santa Rosa & Zoom	Mental Health Board	<ul style="list-style-type: none"> <li>• Modernization of Mental Health Services Act</li> </ul>
Dec 7	Santa Rosa & Zoom	Life Worth Living: Suicide Prevention	<ul style="list-style-type: none"> <li>• LWL Logo Selection</li> <li>• 2023 Accomplishments</li> </ul>

		Alliance	<ul style="list-style-type: none"> <li>• Priorities for 2024</li> </ul>
Jan 4	Zoom	Life Worth Living: Suicide Prevention Alliance	<ul style="list-style-type: none"> <li>• Review December meeting minutes and plans for 2024</li> <li>• Review LWL Suicide Prevention Strategic Plan</li> </ul>
Feb 1	Santa Rosa & Zoom	Life Worth Living: Suicide Prevention Alliance	<ul style="list-style-type: none"> <li>• Review LWL Suicide Prevention Strategic Plan</li> <li>• 2024 Overnight Walk</li> <li>• Connection is Prevention Planning Group</li> </ul>
Feb 20	Santa Rosa & Zoom	Mental Health Board	<ul style="list-style-type: none"> <li>• Potential Impacts of Behavioral Health Services Act with Panel Discussion</li> </ul>
Mar 6	Santa Rosa & Zoom	MHSA Steering Committee	<ul style="list-style-type: none"> <li>• Discussion Question</li> <li>• May is Mental Health Matters Events</li> <li>• Connection is Prevention Suicide Prevention Month Event</li> <li>• Behavioral Health Services Act (BHSA) Timeline</li> </ul>
Mar 7	Zoom	Life Worth Living: Suicide Prevention Alliance	<ul style="list-style-type: none"> <li>• Sonoma County Annual Suicide Data Review</li> <li>• Annual Data Report for Strategic Plan</li> <li>• Behavioral Health School Based Program</li> <li>• Striving for Zero Conference Report</li> </ul>
Apr 10	Zoom	CPP Workgroup Planning	<ul style="list-style-type: none"> <li>• Reviewing Purpose of CPP</li> <li>• BHSA information</li> <li>• Recruiting more members</li> <li>• Stakeholder Committee meeting</li> </ul>
Apr 23	Santa Rosa & Zoom	CPP Workgroup	<ul style="list-style-type: none"> <li>• Behavioral Health Services Act (BHSA)</li> <li>• Listening sessions FY 23-24 Update</li> <li>• Planning Stakeholder Committee meeting</li> </ul>
May 1	Healdsburg	All stakeholders and community members	<ul style="list-style-type: none"> <li>• May is Mental Health Month Matters Community Event with Corazon <ul style="list-style-type: none"> <li>○ Community Healing Circle</li> </ul> </li> </ul>
May 2	Santa Rosa & Zoom	Life Worth Living: Suicide Prevention Alliance	<ul style="list-style-type: none"> <li>• Sonoma County Suicide Data Update</li> <li>• Strategic Plan Update</li> <li>• May is Mental Health Matters Month</li> </ul>
May 8	Santa Rosa & Zoom	MHSA Steering Committee	<ul style="list-style-type: none"> <li>• Discussion Question</li> <li>• FY 24-25 MHSA Plan Update</li> <li>• Behavioral Health Services Act (BHSA) Implementation Planning</li> </ul>

May 14	Petaluma	All stakeholders and community members May is Mental Health Month Matters	<ul style="list-style-type: none"> <li>• May is Mental Health Month Matters Community Event with Santa Rosa Junior College <ul style="list-style-type: none"> <li>○ Mindful Movement</li> </ul> </li> </ul>
May 15	Sonoma Valley	All stakeholders and community members May is Mental Health Month Matters	<ul style="list-style-type: none"> <li>• Community Event with La Luz <ul style="list-style-type: none"> <li>○ Mindful Guided Art Session</li> </ul> </li> </ul>
May 17	Guerneville	All stakeholders and community members	<ul style="list-style-type: none"> <li>• May is Mental Health Month Matters Community Event with West County Community Services <ul style="list-style-type: none"> <li>○ Mindful Guided Nature Walk</li> </ul> </li> </ul>
May 28	Santa Rosa	All stakeholders and community members	<ul style="list-style-type: none"> <li>• May is Mental Health Month Matters Community Event <ul style="list-style-type: none"> <li>○ Mindful Guided Art Session</li> </ul> </li> </ul>
May 29	Santa Rosa	MHSA Contractors	<ul style="list-style-type: none"> <li>• Anti-Racist Results Based Accountability Training for MHSA contractors</li> </ul>
Jun 6	Santa Rosa & Zoom	Life Worth Living: Suicide Prevention Alliance	<ul style="list-style-type: none"> <li>• Final Suicide Prevention Strategic Plan</li> <li>• Develop workgroups to implement plan</li> </ul>
Jun 18	Santa Rosa & Zoom	Stakeholder Committee	<ul style="list-style-type: none"> <li>• MHSA 101</li> <li>• Discussion Question</li> <li>• Behavioral Health Services Act (BHSA)</li> <li>• FY 24-25 MHSA Plan Update</li> <li>• Listening Session Update</li> </ul>
Jun 18	Santa Rosa & Zoom	Sonoma County Mental Health Board	<ul style="list-style-type: none"> <li>• Public Hearing on FY 24-25 MHSA Plan Update</li> </ul>
Aug 13	Santa Rosa & Zoom	Sonoma County Board of Supervisors	<ul style="list-style-type: none"> <li>• Review and approval of FY 24-25 MHSA Plan Update and Expenditure plan</li> </ul>

## LIFE WORTH LIVING: SONOMA COUNTY SUICIDE PREVENTION ALLIANCE



In 2022 Jan Cobaleda-Kegler, Behavioral Health Director, convened a time limited Suicide Prevention Alliance 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 from Striving for Zero Suicide Prevention Learning Collaborative Technical Assistance Team.

The coalition recruited members from a broad spectrum of community and government organizations that are concerned about suicide prevention. Members have participated in collaborative meetings, reviewing suicide related data, information gathering activities, and prioritization of activities.





**The Alliance has accomplished the following in FY 2023-2024:**

Developed the Alliance name: **Life Worth Living and logo**. Alliance name and logo were developed by Alliance members with lived mental health experience and enthusiastically adopted by the Alliance.

Hosted inaugural annual suicide prevention month event: **Connection is Prevention**

Hosted two **Survivors of Suicide Remembrance Events**

Developed draft **Sonoma County Suicide Prevention Strategic Plan**



**Pictured above:** Aztec dancers from Connection is Prevention, a suicide prevention event in 2023.

The table below lists the Life Worth Living Alliance members:

NAME	Organization/Representation
Alethea Larson	The Living Room, unhoused
Ali Soto	Sonoma County Office of Education, Transition Age Youth
Amanda Lopez	Veterans Affairs
April Reza	Sonoma County Office of Education, Transition Age Youth
Carly Memoli	Consultant
Christina Nihil	Buckelew, Suicide Prevention
Citlaly Martinez	Humanidad, Latinx
Cristian Gutierrez	Latino Service Providers, Latinx
Deepali Sansi	Buckelew, Suicide Prevention
Erika Klohe	Buckelew, lived experience, family member
Fabiola Espinosa	MHSA Analyst, family member
Fletcher Skerrett	Law Enforcement
Gabriel Kaplan	Public Health
Imelda Vera	Humanidad, Latinx
Jan Cobaleda-Kegler	Behavioral Health Division Director
Jeane Erlenborn	Santa Rosa Junior College, Transition Age Youth
Jenny Mercado	Department of Health Services, Epidemiology
Juan Torres	Humanidad, Latinx
Justin Haugen	Law Enforcement, Coroner's Office
Katie Bivin	Behavioral Health School Based Program and Medication Support Manager, youth
Leslie Petersen	Hanna Center, Sonoma Valley

Lisa Nosal	Cultural Responsiveness, Inclusion & Training Coordinator
Marikarmen Reyes	Family member, Sonoma Valley
Mary Champion	Sonoma County Office of Education
Mary-Francis Walsh	NAMI, family member
Meghan Murphy	Buckelew, Family Services Coordination
Melissa Ladrech	MHSA Coordinator, family member
Michael Johnson	Mental Health Board, lived experience
Michael Reynolds	Mental Health Board, lived experience
Michael Schemmel	Law Enforcement, Coroner's Office
Rebekah Pope	Sonoma County Office of Education
Sandra Black	Consultant
Sarahi Hernandez	Latino Service Providers, Latinx
Shelly Niesen-Jones	Kaiser, healthcare
Shriya Ambre	Buckelew, Suicide Prevention
Steve Diamond	Buckelew, Suicide Prevention
Susan Standen	Peer at large, lived experience

Special thank you to the Alliance's Strategic Plan Workgroup that drafted the Strategic Plan with input and feedback from the Alliance. The workgroup is listed below:

**The Sonoma County Suicide Prevention Strategic Plan Workgroup**

<b>Name</b>	<b>Organization</b>
Carly Memoli	Striving for Zero Learning Collaborative
Fabiola Espinosa	MHSA Analyst, family member
Mary Champion	Sonoma County Office Of Education

Mary-Francis Walsh	NAMI
Melissa Ladrech	MHSA Coordinator, family member
Michael Reynolds	Mental Health Board, West County Community Services, Lived experience
Rebekah Pope	Sonoma County Office of Education
Shelly Niesen-Jones	Kaiser

**ADDITIONAL STAKEHOLDER OUTREACH**

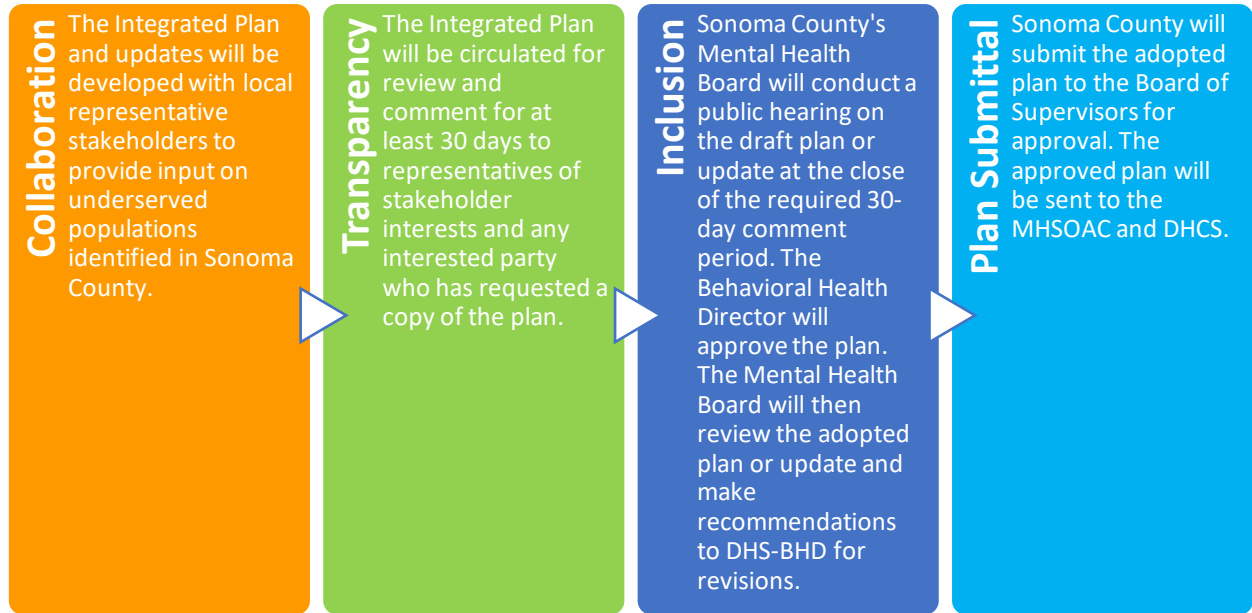
DHS-BHD also publishes an MHSA Newsletter, featuring relevant MHSA news, information, and events. The newsletter is produced every 3-4 months and is shared with a variety of community groups and stakeholders, including the Mental Health Board, Sonoma County Board of Supervisors, DHS-BHD program managers, and contractors. An archive of the newsletter PDFs is available on the MHSA website. People can subscribe to the email newsletter via the MHSA website at: [http://service.govdelivery.com/service/subscribe.html?code=CASONOMA\\_181](http://service.govdelivery.com/service/subscribe.html?code=CASONOMA_181)

See Appendix 3 on Page 341 for the MHSA newsletters distributed during FY 2023-2024.

**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 FY 2024-2025 MHSA Annual Plan Update and Expenditure Plan.

**Graphic: The Public Hearing Process**



Sonoma County’s Draft FY 2024-2025 MHSA Annual Plan Update and Expenditure Plan was posted and emailed for public review on September 17, 2024. DHS-BHD requested that stakeholders review the draft Three-Year Plan and submit comments and questions before October 15, 2024 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](mailto:MHSA@sonoma-county.org)

**FY 24-25 MHSA 30-DAY PUBLIC COMMENT RESULTS: Substantive Comments and Analysis**

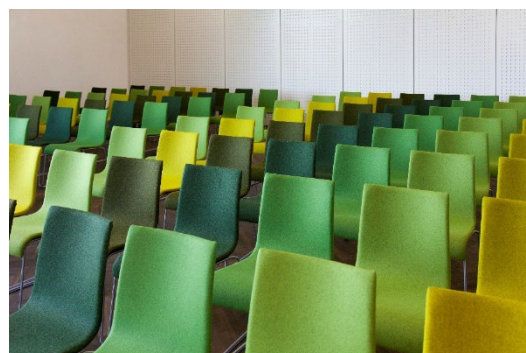
The 30-day public comment period for the FY 2024-2025 MHSA Annual Plan Update ended on October 15th at a public hearing hosted by the Mental Health Board. There were no substantive comments during the 30 day public comment period or the public hearing hosted by the Mental Health Board. The summary of the substantive comments is no comments were made. The analysis of any substantive recommendations is there were no substantive comments.



MHSA Annual Plan Update Distribution and/or Public Hearing Outreach to Stakeholders for 2024-2025

Date	Action
9/17	Post draft MHSA Plan on DHS, BHD, MHSA, and Mental Health Board web pages
9/17	Email Mental Health Board, MHSA Steering Committee, MHSA Stakeholder Committee, MHSA Contractors, and Staff Contact List with link to draft Plan
9/17	Send notice via email to 2000+ MHSA Update subscribers
10/15	Public Hearing with Mental Health Board and Stakeholders
10/15	Public Hearing with Mental Health Board and Stakeholders
11/5	Board of Supervisors reviews and finalizes MHSA Annual Plan Update

The FY 2024-2025 MHSA Annual Plan Update and Expenditure Plan was adopted by the Sonoma County Board of Supervisors **on November 5, 2024**. DHS-BHD sent the approved plan to DHCS and the MHSOAC to remain on file for review and evaluation purposes **on December 3, 2024**.



# SONOMA COUNTY'S FY 2024 – 2025 PROGRAM PLAN UPDATE

## MENTAL HEALTH SERVICES ACT (MHSA) FY 24-25 ANNUAL PLAN UPDATE

Sonoma County Department of Health Services, Behavioral Health Division (DHS-BHD) is pleased to present this Mental Health Services Act (MHSA) Annual Program Plan Update for Fiscal Year (FY) 2024-2025 (24-25) and this FY 24-25 Annual Plan is an update to the FY 2023-2026 Three Year Plan. The MHSA Annual Plan for FY 24-25 has been developed in collaboration with MHSA stakeholders as detailed in the Community Program Planning section on page 16. This Annual Plan Update (“The Plan”) describes MHSA funded programs including: the program purpose and the monies allocated to fund these programs. The program outcomes for FY 22-23 can be found in the FY 22-23 Program Report that follows the FY 24-25 Expenditure Plan. The content of this Program Plan includes:

- MHSA and Proposition 1: Behavioral Health Services Act
- Changes to The Plan from FY 23-26
- Expanded Medi-Cal Mobile Crisis Service
- Detailed description of MHSA programs and services planned for FY 23-24 by component:
  - Community Services and Supports (CSS) modifications
  - Prevention and Early Intervention (PEI) modifications
  - Innovation project updates
  - Workforce Education and Training (WET) Plan Update
  - Capital Facilities and Technology Needs (CFTN) Plan Update
- Update on No Place Like Home

### MHSA and Proposition 1: Behavioral Health Services Act

California’s Mental Health Services Act is funded by a one percent tax on personal annual incomes exceeding one million dollars. Also known as Proposition 63, this act, passed by California voters in 2004, provides mental health funding that is allocated into the following five components:

**Community Services and Supports** provides services for individuals with serious mental health challenges

**Prevention and Early Intervention** services for those at higher risk of developing a mental health challenge, unserved and underserved populations

**Innovative** programs to develop new approaches that increase access to unserved and/or underserved communities and improves the quality of services

**Workforce, Education and Training (WET)** 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.

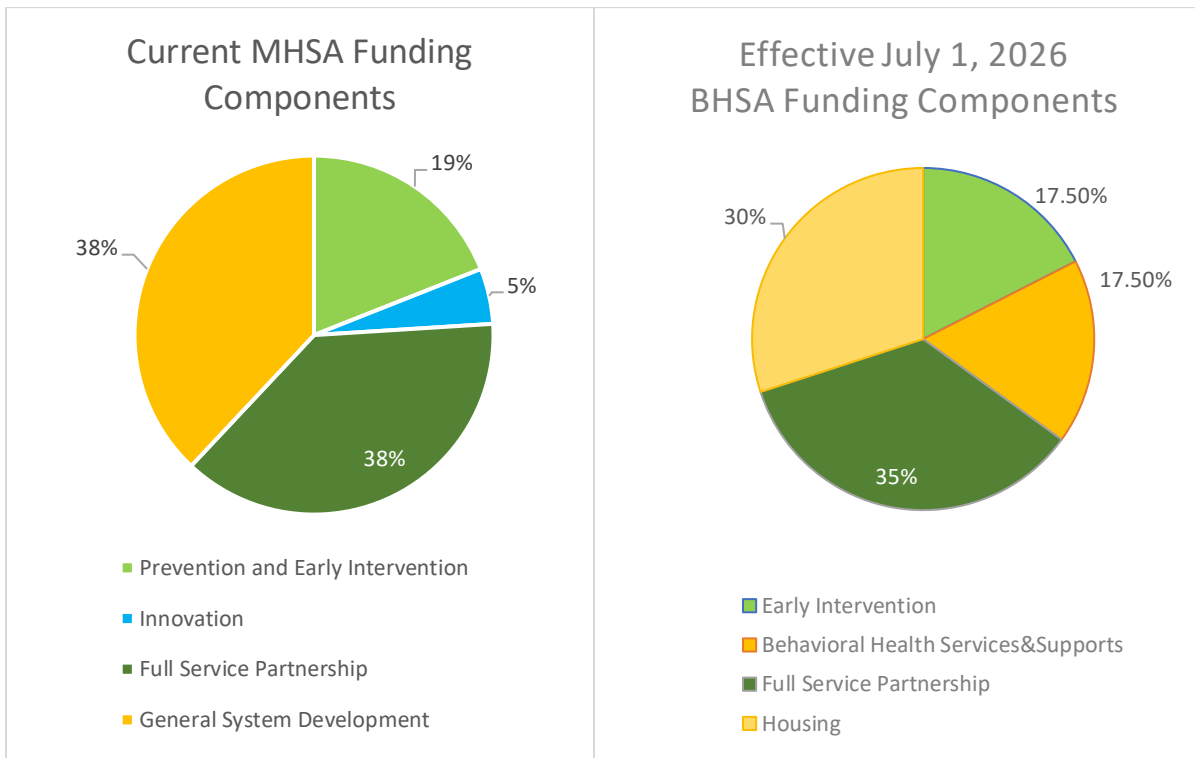
**Capital Facilities and Technology Needs** provides funding for building projects and increasing technological capacity to improve mental health service delivery

**Proposition 1:** This Proposition was on the California ballot in March 2024. The passage of Prop 1 has set into motion a significant level of change for the MHSAs funding stream and for County Behavioral Health Departments. Counties will have until July 1, 2026 to fully implement all of the changes that Proposition will create. Proposition 1 has two major components related to providing mental health care and drug and/or alcohol treatment to people, as well as addressing homelessness issues.

**This proposition will:**

- Change the MHSAs, with a focus on how the money from the act can be used. Under Prop 1 there is a wider service focus, that includes dedicated funding for housing and expanding the target population to include individuals with substance use only disorder diagnoses. The name of the act will be changed to the Behavioral Health Services Act (BHSA), because behavioral health is a term that is inclusive of individuals with both mental health challenges and/or substance use challenges. There are no additional funds available to fund the housing component or the additional target population. The County alongside our stakeholders will need to develop plans for enhancing some service areas such as Full Service Partnerships, and the County may also need to reevaluate services in other areas such as prevention, workforce, and outpatient treatment. Initial analysis and discussions for service changes have begun internally, and no decisions have been made at this time. Planning for BHSA implementation will take place with the subsequent FY 2026-2029 Three-Year Plan.
- Approves a \$6.4 billion bond to build more places for mental health care and drug or alcohol treatment.

The charts below illustrate the funding components of MHSAs and BHSA:





## Expanded Medi-Cal Mobile Crisis Service:

The Medi-Cal Mobile Crisis Service Benefit was developed by new California Department of Health Care Services requirements for counties to provide community-based mobile services to Medi-Cal beneficiaries experiencing a behavioral health crisis. This expanded MST aims to provide rapid response, individual assessment, and community-based stabilization to reduce the immediate risk of danger and subsequent harm and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement. The Counties Mobile Support Team (MST), which originated from an MHSAs Innovation project in 2008, has expanded services to dispatch the mobile crisis team 24 hours a day and seven days a week. MST is collaborating with the other local mobile crisis teams to provide complete coverage 24/7 through the county. Call 1-800-746-8181 to reach the mobile crisis hotline.

## Existing Mobile Crisis Teams



- inRESPONSE (Santa Rosa)
- SAFE (Petaluma)
- SAFE (Rohnert Park)
- SAFE (Cotati)
- SAFE (SSU)
- Mobile Support Team (County)

## SIGNIFICANT CHANGES TO THE FY 24-25 PLAN

As detailed in the FY 24-25 Expenditure Plan, the County estimates a fund balance of \$31 million. The fund balance accumulated due to the unpredictability of MHSAs funds that are based on the behaviors of about 76,000 individuals making over one million dollars a year. In addition to the fund balance the County is also estimating receiving \$30.5 million in FY 24-25. The Expenditure Plan details a total budget of \$47.7 million for FY 24-25, and this is the largest MHSAs budget the County has ever developed.

It is paramount to spend MHSAs funds within three years because MHSAs regulations (WIC Title 9 Section 5847) state that any funds allocated to a county that have not been spent within three

years shall revert to the state. The County has not reverted any MHSA funds since the Act's inception. However, BHSA does not state what will happen to County MHSA fund balances when BHSA is implemented. As the County anticipates the implementation of BHSA, and the lack of clarity in BHSA about the disposition of existing fund balance at the time of BHSA implementation, the County has decided to spend down fund balance. The additional funding is going towards contract increases with prescribers, Mobile Support Team expansion, new housing project and a new Full Service Partnership for unhoused individuals with serious mental health challenges.

### THE COMMUNITY SERVICES AND SUPPORT (CSS) PLAN FOR FY 24-25

Here are the significant changes and impacts to Community Services and Supports Programs for FY 24-25:

Changes	Impacts
<b>Community Services and Supports</b>	
<p><b>Full Service Partnership (FSP) teams:</b> 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.</p>	
<p><b>Full Service Partnership (FSP) Team for Unhoused Adults:</b> This FSP will serve adults who are homeless or at risk of being homeless with serious mental health challenges. This program is budgeted at \$1,700,000 annually.</p>	<p>The addition of this FSP team will provide wrap around, intensive recovery oriented behavioral health services and housing support for 75 individuals. The FSP team will collaborate with clients to attain the client's goals.</p>
<b>General System Development</b>	
<p><b>Transitional Age Youth (TAY) Housing Program:</b> The Behavioral Health Division will conduct a Request for Proposal (RFP) to contract with a provider to house TAY Full Service Partnership (FSP) clients. The RFP will consist of funds to secure a house or facility and provide supportive services. The FY 24-25 is budgeted at \$2,300,000, and there will be on going annual expenses of \$300,000.</p>	<p>This facility will provide temporary and/or permanent supported housing for a total of 6-20 Transition Age Youth (18-25 year olds) Full Service Partnership clients.</p>

## Sonoma County's FY 2024 – 2025 Three Annual Program Plan Update

The following table provides the estimated cost per client for FY 24-25 CSS Programs:

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
<b>Forensic Assertive Community Treatment (FACT) Team</b>	70	0	3	64	3	\$14,268
Includes the following programs:						
<ul style="list-style-type: none"> <li>County of Sonoma Department of Health Services Behavioral Health Division (DHS-BHD)</li> <li>Buckelew Programs - FACT - Independent Living Skills (ILS) [contractor]</li> <li>Buckelew Programs - FACT - Supplemental Patch for Unlicensed Supportive Housing Units [contractor]</li> </ul>						
<b>Family Advocacy, Stabilization &amp; Support Team (FASST)</b>	200	105	95	0	0	\$20,039
Includes the following programs:						
<ul style="list-style-type: none"> <li>DHS-BHD</li> <li>Seneca [contractor]</li> <li>Lifeworks [contractor]</li> <li>AFS Outpatient Services for FASST Clients</li> <li>TBD - RFP [contractor]</li> </ul>						
<b>Integrated Recovery Team (IRT)</b> DHS-BHD	150	0	0	135	5	\$13,415
<b>Older Adult Intensive Team (OAIT)</b> DHS-BHD	70	0	0	0	70	\$14,918
<b>Transition Age Youth (TAY) Team</b> DHS-BHD	70	0	70	0	0	\$44,965
Includes the following programs:						
<ul style="list-style-type: none"> <li>Buckelew Programs - TAY - Sonoma County Independent Living (SCIL) [contractor]</li> </ul>						

- TBD Housing [contractor]
- On The Move - VOICES [contractor]
- DHS- TAY Housing Program[contractor]

<b>Adult Full Service Partnership (AFSP)</b>						
DHS-BHD	100	0	0	100	0	\$11,882
Telecare ACT [contractor]	60	0	1	39	20	\$12,446
National Alliance on Mental Illness (NAMI) Sonoma County - Family-based Education, Advocacy and Support (FEAS) [contractor]	5529	20	2000	2514	995	\$39
WCCS - Interlink [contractor]	680	0	50	500	130	\$202
WCCS - Wellness & Advocacy Center [contractor]	100	0	5	65	30	\$1,043
WCCS - Russian River Empowerment Center [contractor]	40	0	5	25	10	\$1,761
WCCS - Petaluma Peer Recovery Center [contractor]	65	5	10	35	15	\$1,982
<b>Housing FSP Program</b>						
DHS- Homelessness Division [contractor]	75	0	15	50	10	\$22,667
<b>General Systems Development (GSD)</b>						
DHS-BHD Mobile Support Team (MST)	200	20	35	65	40	\$8,788
DHS-BHD Collaborative Treatment and Recovery Team (CTRT)	400	0	100	230	70	\$2,434

Buckelew Programs - CTRT System Navigation [contractor]	400	0	100	230	70	\$526
DHS-BHD Community Mental Health Centers	60	0	0	0	60	\$6,965
Council on Aging - Senior Peer Support [contractor]	80	0	0	0	80	\$1,485
WCCS - Senior Peer Counseling [contractor]	1300	0	150	800	350	\$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 - Crisis Support [contractor]	1565	0	266	1001	298	\$163
DHS-BHD Medication Support Services for Adult Programs	578	405	173	0	0	\$3,724
DHS-BHD Medication Support Services for Youth Programs	30	25	5	0	0	\$4,205
Alternative Family Services [contractor]	100	0	0	100	0	\$3333
Siyon Clinical Research [contractor]	100					\$6250
DHS - Homelessness Division [contractor]	50	0	10	35	5	\$46,000

### Outreach and Engagement (OE)

DHS-BHD Whole Person Care (WPC)	1406	0	56	984	366	\$844
Sonoma County Indian Health Project - Community Programs [contractor]	162	37	32	66	27	\$531

## PREVENTION AND EARLY INTERVENTION (PEI) PLAN FOR FY 24-25

Here are the significant changes and impacts to Community Services and Supports Programs for FY 24-25:

Changes	Impacts
<b>Prevention and Early Intervention (PEI)</b>	
<p><b>Peer and Family Support Services</b> will work in conjunction with the new Behavioral Health School Partnership program. Funding the Peer and Family Support Services of this program is budgeted at \$200,000 annually.</p>	<p>The Peer and Family Support Services is an Early Intervention program that will support 50-100 young people in accessing peer support from available community organizations, provide a safe space to talk about mental health symptoms in a non-judgmental setting, assist youth in learning about available options for treatment, if desired, and assist youth in navigating mental health treatment systems.</p>
<p><b>Seneca WRAP Program:</b> This Early Intervention program will provide services for children and youth who are involved in foster care, the juvenile justice system, and/or who are at risk of out of home placement or psychiatric hospitalization. MHSa will provide \$500,000 annually for this program.</p>	<p>The addition of this Seneca WRAP program will serve 73 children (0-15 years old) and 32 youth (16-25 year olds). The program encourages coordination among agencies, disciplines, and communities to enhance outcomes for youth and families. WRAP services aim to prevent children and youth from going to higher levels of care by increasing resilience and recovery, teaching positive coping skills to youth, and improving caregiver ability to successfully support the youth in their care. WRAP services are designed to be short term, intensive interventions lasting 6 – 12 months.</p>

## Sonoma County's FY 2024 – 2025 Three Annual Program Plan Update

The following table provides the estimated cost per client for FY 24-25 PEI Programs:

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 MHPA cost per person in FY 24-25
<b>PEI Programs - Prevention</b>						
Action Network [contractor]	264	124	55	53	32	\$241
Community Baptist Church Collaborative [contractor]	179	30	26	94	30	\$711
Sonoma County HSD- Older Adult Collaborative [contractor]	2926	0	0	0	2926	\$79
Sonoma County Indian Health Project [contractor]	28	9	6	10	3	\$1,516
<b>PEI Programs - Prevention &amp; Early Intervention</b>						
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
<b>PEI Programs - Early Intervention</b>						
BH Schools Partnership RFP [contractor]	65	30	35	0	0	\$3,077
Seneca WRAP [contractor]	105	73	32	0	0	\$4,762
Child Parent Institute (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
<b>PEI Programs - Stigma &amp; Discrimination Reduction</b>						
Santa Rosa Junior College [contractor]	468	0	378	80	10	\$453
<b>PEI Programs - Suicide Prevention</b>						
Bucklew Programs - North Bay Suicide Prevention Program [contractor]	2321	46	375	1600	300	\$73
<b>PEI Programs - Access and Linkage to Treatment</b>						
DHS-BHD Youth Access Team	434	338	96	0	0	\$3,350
DHS-BHD Adult Access Team	496	0	114	347	35	\$5,019
<b>PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness</b>						
Crisis Intervention Training (CIT) with Law Enforcement	30	0	2	26	2	\$1,008

## INNOVATION (INN) PLAN FOR FY 24-25

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.

**Brief descriptions of current Innovation projects can be found in the following pages:**

Category	Project Information
<b>Organization</b>	<b>Early Learning Institute</b>
<b>Project</b>	<b>Instructions Not Included (INI) - Dads Matter</b>
<b>Total Project Budget</b>	<b>\$689,360</b>



Category	Project Information
<b>Brief Description</b>	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.
<b>Innovation</b>	Makes a change to an existing practice in the field of mental health, including but not limited to application to a different population.
<b>Primary Purpose</b>	<ul style="list-style-type: none"> <li>• Increase access to unserved or underserved group.</li> <li>• Promote interagency collaboration related to Mental Health Services or supports.</li> </ul>
<b>Population to be served</b>	<ul style="list-style-type: none"> <li>• 450 first time Dads, likely working so weekend and evening hours will be offered.</li> <li>• Possible low-income, home renters, mid-20s to mid-30s in age</li> <li>• 54% estimated to be Spanish speaking in the home.</li> <li>• County-wide</li> </ul>
<b>Learning Goals</b>	<ol style="list-style-type: none"> <li>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.</li> <li>2. What key community resources (or lack thereof) are utilized by fathers based on results of their Edinburgh Postnatal Depression Scale (EPDS) screening?</li> <li>3. What key resources (or lack thereof) are utilized by father based on the results of their ACES screening?</li> <li>4. How can we best serve 1<sup>st</sup> time fathers, especially those who score low-average, or below-average on the Nurturing Skills Competency Scale (NSCS)?</li> </ol>
<b>Need in Sonoma</b>	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.



Category	Project Information
<b>Organization</b>	<b>First 5 Sonoma County</b>
<b>Project</b>	<b>New Parent TLC</b>
<b>Total Project Budget</b>	\$418,185
<b>Brief Description</b>	“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.
<b>Innovation</b>	Makes a change to an existing practice in the field of mental health, including by not limited to, application to a different population.
<b>Primary Purpose</b>	<ul style="list-style-type: none"> <li>• Increase access to unserved or underserved groups</li> <li>• Promote interagency collaboration related to Mental Health Services or supports</li> </ul> <p><i>New Parent TLC</i> 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. In addition, the project will promote community collaboration among nontraditional points of entry for individuals needing mental health support, developing a public health education movement encouraging possible policy change.</p>
<b>Population to be served</b>	<ul style="list-style-type: none"> <li>• Up to 100 childcare sites, seven faith communities, 3-5 large employers, and seven cosmetology providers to be trained</li> <li>• Reaching up to 500-2000 mothers and 250 fathers who are not engaged in any other parental/newborn home visiting program</li> <li>• Spanish-speaking, lower-income population, county-wide</li> </ul>
<b>Learning Goals</b>	<ol style="list-style-type: none"> <li>1. Does training nontraditional gatekeepers in Question Persuade Refer (QPR) model result in appropriate referrals for parental depression?</li> <li>2. Does training nontraditional gatekeepers in QPR model prevent parental suicide?</li> <li>3. Does training nontraditional gatekeepers in QPR model prevent infant exposure to ACEs as a result of untreated parental depression?</li> </ol>
<b>Need in Sonoma</b>	0-5 prevention and early intervention, unserved/underserved group (new fathers/mothers), suicide prevention



Category	Project Information
<b>Organization</b>	<b>Sonoma County Human Services Department, Adult and Aging Division in partnership with Santa Rosa Community Health Clinics</b>
<b>Project</b>	<b>Collaborative Care Enhanced Recovery Project (CCERP)</b>
<b>Total Project Budget</b>	\$999,558
<b>Brief Description</b>	Combines an established short-term intervention with 9-months of in-home case management, resulting in positive impacts for adults from 50 - 64 years old with depression.
<b>Innovation</b>	Makes a change to an existing practice in the field of mental health, including but not limited to application to a different population.
<b>Primary Purpose</b>	<ul style="list-style-type: none"> <li>• Increase access to unserved or underserved groups</li> <li>• Increase quality of mental health services, including better outcomes</li> <li>• Promote interagency collaboration related to Mental Health Services or supports</li> <li>• Increase access to mental health services</li> </ul>
<b>Population to be served</b>	<ul style="list-style-type: none"> <li>• Up to 225 clients, ages 50 - 64 years over three years</li> <li>• Focus on Latinx/Spanish speaking adults</li> <li>• Central Santa Rosa as in partnership with SRCH Lombardi, Vista and Brookwood campuses</li> </ul>
<b>Learning Goals</b>	<ol style="list-style-type: none"> <li>1. For adults 50 – 64 years old, whose depression symptoms improve with the existing 12-week Collaborative Care Model (CoCM) intervention, are these improvements sustained over the course of an additional nine-month case management period?</li> <li>2. For adults 50 – 64 years old, whose depression symptoms improve with the existing CoCM 12-week intervention plus 9-months of case management, is there an improvement in appropriate health care utilization?</li> <li>3. For Latinx/Spanish Speaking adults 50 – 64 years old who receive the CCERP intervention, are there sustained depression symptom improvements and improvements in appropriate health care utilization?</li> </ol>
<b>Need in Sonoma</b>	Addresses a population age group 50-64 years olds that is in the gap years (older than TAY, younger than elders) and at higher risk for suicide than the general population, and Latinx/Spanish Speaking (underserved group) with integrated health model combined with in-home case management. Suicide prevention for mature adults. (Note: 4 out of the 5 SMART Train suicide deaths in 2019 involved adults between the ages of 50-64)



Category	Project Information
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<b>Organization</b>	<b>On the Move/VOICES in partnership with La Plaza, Humanidad, Raizes Collective, Latino Service Providers, and North Bay Organizing Project</b>
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<b>Project</b>	Nuestra Cultura Cura Social Innovations Lab
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<b>Total Project Budget</b>	\$736,585
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<b>Brief Description</b>	A partnership of community organizations will engage a diverse cohort (The Team) from the Latinx communities to determine root causes of mental health stigma and inaccessibility for their communities. A facilitator will support the Team in determining a strategic direction with specific actions to address defined issues. Resources will be provided for the Team members by the various CBO partners.
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<b>Innovation</b>	Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
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<b>Primary Purpose</b>	<ul style="list-style-type: none"> <li>• Increase access to unserved or underserved groups</li> <li>• Increase quality of mental health services, including better outcomes</li> <li>• Promote interagency collaboration related to Mental Health Services or supports</li> <li>• Increase access to mental health services</li> </ul> <p>The Social Innovations Lab will create more culturally relevant mental health strategies that will reduce depression and anxiety and promote cultural protective factors.</p>
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<b>Population to be served</b>	<ul style="list-style-type: none"> <li>• The Team is composed of 20 diverse individuals from four communities: West County, Sonoma Valley, Healdsburg and Southwest Santa Rosa</li> <li>• Community engagement from a variety of sectors: Intergenerational, faith-based, artists, cultural practitioners, academics and research, public and nonprofit sectors</li> <li>• Reach up to 500 Spanish-speaking community members in four communities</li> </ul>
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<b>Learning Goals</b>	<ol style="list-style-type: none"> <li>1. What are the root cause of the unique mental health challenges faced by the Latinx community in Sonoma County?</li> <li>2. What culturally-specific interventions and language will reduce stigma around mental health among Latinos and increase cultural protective factors that lead to mental health?</li> <li>3. Can the current clinically-driven mental health system be influenced to adopt and fund culturally-specific experimental interventions deemed successful or promising?</li> </ol>
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<b>Need in Sonoma</b>	Lack of culturally responsive mental health services for Latinx/Spanish speakers; geographically based w/ localized services and improve low Latinx Mental Health Penetration Rate
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Category	Project Information
Organization	DHS-BHD, Felton, and Behavioral Health Outcomes Data Services (BHODS)
Project	Crossroads to Hope
Total Project Budget	\$2,500,000
Brief Description	Crossroads to Hope will provide transitional housing to individuals with serious mental health concerns who have been diverted from the criminal justice system. Peer support specialists with lived mental health and criminal justice involvement will provide supportive services to clients along with the DHS-BHD Mental Health Diversion team.
Innovation	Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite
Primary Purpose	<ul style="list-style-type: none"> <li>• Increase access to unserved or underserved groups</li> <li>• Increase quality of mental health services, including better outcomes</li> </ul>
Population to be served	<ul style="list-style-type: none"> <li>• 12-20 adults annually</li> <li>• Serves individuals with serious mental health concerns referred by probation and the courts</li> </ul>
Learning Goals	<ol style="list-style-type: none"> <li>1. Does providing peer supervised transitional housing with ACT reduce recidivism?</li> <li>2. Does supervised transitional housing with ACT reduce recidivism for diverted?</li> </ol>
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 needs.



Category	Project Information
Organization	DHS-BHD & California Mental Health Services Authority (CalMHSA)
Project	Semi-Statewide Enterprise Health Record
Total Project Budget	\$5,526,045
Brief Description	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. 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.
Innovation	Introduces a new practice or approach to the overall mental health system, including prevention and early intervention
Primary Purpose	<ul style="list-style-type: none"> <li>• Promotes interagency and community collaboration related to mental health services or supports or outcomes.</li> <li>• Increase quality of mental health services, including better outcomes.</li> </ul>
Population to be served	<ul style="list-style-type: none"> <li>• Serves Behavioral Health Care System clients and their families.</li> </ul>
Learning Goals	<ol style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>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.</li> </ol>
Need in Sonoma	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 modification, enhancement, implementation and maintenance of our EHR systems.

## Sonoma County's FY 2024 – 2025 Three Annual Program Plan Update

The following table provides the estimated cost per client for FY 24-25 INN Projects:

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
<b>Innovation Projects</b>						
Collaborative Care Enhanced Recovery Project (CCERP) aka Unidos Por Nuestro Bienestar - [Sonoma County Human Services Department]	10	0	0	0	10	\$7,156
Crossroads to Hope (Peer Program Provider) - Felton Institute	12	0	1	10	1	\$51,176
Instructions Not Included (INI) - Dads Matter [Early Learning Institute - contractor]	20	0	5	15	0	\$11,652
New Parent TLC - [First 5 Sonoma County - contractor]	40	0	5	30	5	\$4,234
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

## WORKFORCE, EDUCATION AND TRAINING (WET) PLAN FOR FY 24-25

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.”

### Cultural Responsiveness, Inclusion and Training Coordinator

The Sonoma County Behavioral Health Cultural Responsiveness, Inclusion & Training Coordinator (CRIT) 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 several 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 hopes to add a full-time clinical specialist role to support this program in the future.

The Cultural Responsiveness, Inclusion & 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	<ul style="list-style-type: none"><li>• Accreditation (BRN, CAMFT, CCAPP)</li></ul>
Career Pathways	<ul style="list-style-type: none"><li>• Pipeline Programs</li><li>• Career &amp; Internship Fairs</li></ul>



Staff Skill Development  
WET Activities

- Staff Development Trainings
- Strength 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
<ul style="list-style-type: none"><li>• Licensed Vocational Nurse (LVN)</li><li>• Licensed Psychiatric Technician (LPT)</li><li>• Registered Nurse (RN)</li><li>• Public Health Nurse (PHN)</li><li>• Nurse Practitioner (NP)</li><li>• Psychiatric Nurse Practitioner (PNP)</li></ul>	<ul style="list-style-type: none"><li>• Licensed Clinical Social Worker (LCSW)</li><li>• Licensed Marriage and Family Therapist (LMFT)</li><li>• Licensed Professional Clinical Counselor (LPCC)</li><li>• Licensed Educational Psychologist (LEP)</li></ul>	<ul style="list-style-type: none"><li>• Registered Alcohol Drug Technician (RADT)</li><li>• Certified Alcohol Drug Counselor I (CADC-I)</li><li>• Certified Alcohol Drug Counselor II (CADC-II)</li><li>• Licensed Advanced Alcohol Drug Counselor (LAADC)</li><li>• Licensed Advanced Alcohol Drug Counselor Supervisor (LAADC-S)</li></ul>

#### Career Pathways and Pipeline Program

The Cultural Responsiveness, Inclusion & Training Coordinator 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

As part of the Pipeline Program, the Cultural Responsiveness, Inclusion & Training Coordinator will participate in several community career events at both the high school and college level. Focus will be given to encouraging Latinx/Latine and bilingual students to consider Behavioral Health as a career option.

## Participating Universities:

Program Category	Participants
Nursing Programs	<ul style="list-style-type: none"><li>• Sonoma State University (SSU)</li><li>• Santa Rosa Junior College (SRJC)</li></ul>
Social Work Programs	<ul style="list-style-type: none"><li>• California State Long Beach</li><li>• San Francisco State University (SFSU)</li><li>• Humboldt State</li><li>• San Jose State University</li><li>• University of Southern California</li><li>• Berkeley</li></ul>
MFT Programs	<ul style="list-style-type: none"><li>• SSU</li><li>• University of San Francisco</li><li>• SFSU</li></ul>
Mental Health Worker Programs	<ul style="list-style-type: none"><li>• SSU</li><li>• SRJC</li></ul>
Peer Provider Programs	<ul style="list-style-type: none"><li>• Wellness and Advocacy Center</li><li>• Interlink Self-Help Center</li></ul>

## 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, Sonoma County hopes to add a full-time clinical specialist role to support this program in the future.



WET Activities	Trainings
Staff Skill Development	<ul style="list-style-type: none"> <li>• Staff Development Trainings</li> </ul>
Comprehensive training Program	<p>Evidence-Based Practices:</p> <ul style="list-style-type: none"> <li>• Strengths Model Care Management</li> <li>• Family Systems</li> <li>• EMDR</li> <li>• CBT for Psychosis</li> <li>• Cognitive Behavioral Social Skills Training</li> <li>• DBT</li> <li>• Trauma-Focused CBT</li> <li>• Assertive Community Treatment</li> <li>• Harm Reduction</li> <li>• Trauma Informed Systems</li> <li>• CBT for Depression</li> <li>• Seeking Safety</li> <li>• Peer-Based Supports (WRAP, Transformative Mutual Aid Practices)</li> <li>• Psychopharmacology for Non-Medical Staff</li> <li>• Motivational Interviewing</li> </ul>
Culturally Responsive Practices	<ul style="list-style-type: none"> <li>• Incorporating and working with peers in the workforce</li> <li>• Cultural humility</li> <li>• Special concerns for LGBTQIA+ clients</li> <li>• Adapting Evidence-Based Systems to Community Need, “Fidelity vs Fit”</li> </ul>

### Sonoma County’s FY 2024 – 2025 Three Annual Program Plan Update

The following table provides the estimated cost per client for FY 24-25 WET funded programs:

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
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### Capital Facilities and Technological Needs (CFTN)<sup>2</sup>

This component works towards the creation of facilities that are used for the delivery of MHS 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
SacValley MedShare [contractor]	Protected data exchange	Operates an electronic health information exchange.
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



## Sonoma County’s FY 2024 – 2025 Three Annual Program Plan Update

The following table provides the estimated cost per client for FY 24-25 CFTN funded programs:

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
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
SacValley MedShare[contract]	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

### NO PLACE LIKE HOME (NPLH) BACKGROUND

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.

### PURPOSE

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 need mental health services.

## 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



Playground at Orchard Commons



The picture above, of Caritas Homes, is the most recently completed 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.

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	<b>Sage Commons</b>	Santa Rosa	54	29	Single adults	Opened April 2022
Danco Communities	<b>Orchard Commons</b>	Santa Rosa	45	15	Families	Opened February 2023
Burbank Housing Development Corp.	<b>Caritas Homes</b> Phase 1 64 total units 22 NPLH with project based vouchers	Santa Rosa	128	30	Single adults, seniors, veterans, and families	Opened August 2023
Mid-Pen Housing	Petaluma Blvd. North	Petaluma	40	13	Single adults and small families	Opening in Fall 2024

### **Supportive Housing Services for NPLH Residents:**

The County, Sage Commons, Orchard Commons and Caritas Homes 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 in partnership with Danco, Burbank Housing and Catholic Charities 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 2024-2025

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A summary of Sonoma County's MHSAs estimated funding and expenditures for FY 2024 - 2025.

## MHSA Expenditure Plan for FY 24-25

### 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
<b>Estimated FY 2024/25 Funding</b>					
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					
Estimated Available Funding for FY 2024/25	39,933,506	15,306,360	3,668,380	1,899,680	971,357
<b>Estimated FY 2024/25 Expenditures</b>	35,884,258	7,468,474	2,092,162	1,262,847	926,188

<b>Estimated Local Prudent Reserve Balance</b>	
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

## FY 24-25 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
<b>FSP Programs</b>						
<b>Forensic Assertive Community Treatment (FACT) Team</b>						
County of Sonoma Department of Health Services Behavioral Health Division (DHS-BHD)	1,404,314	884,874	450,000			69,440
Bucklew Programs - FACT - Independent Living Skills (ILS) [contractor]	135,881	83,881	52,000			
Bucklew Programs - FACT - Supplemental Patch for Unlicensed Supportive Housing Units	30,003	30,003				
<b>Family Advocacy, Stabilization &amp; Support Team (FASST)</b>						
DHS-BHD	5,264,469	4,153,837	981,000			129,632
Seneca (SMHS for FASST Clients)[contractor]	200,000	53,781	146,219			
Lifeworks (SMHS for FASST Clients)[contractor]	100,000	26,891	73,109			
TBD - RFP [contractor] (SMHS for FASST Clients)	245,000	65,882	179,118			
TBD – AFS Outpatient Services for FASST clients	50,000	13,446	36,554			
<b>Integrated Recovery Team (IRT)</b>						
DHS-BHD	1,402,844	1,199,183	170,000			33,661
<b>Older Adult Intensive Team (OAIT)</b>						
DHS-BHD	1,191,712	1,044,228	110,000			37,484

Category/Program	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
<b>Transition Age Youth (TAY) Team</b>						
DHS-BHD	1,091,229	960,659	117,000			13,570
Bucklew Programs - TAY - Sonoma County Independent Living (SCIL) [contractor]	145,576	110,576	35,000			
TBD Housing [contractor]	164,500	123,130	41,370			
On The Move - VOICES [contractor]	253,154	253,154				
DHS- TAY Housing Program[contractor]	2,300,000	2,300,000				
<b>Adult Full Service Partnership (AFSP)</b>						
DHS-BHD	1,253,396	1,188,153	9,000			56,243
Telecare ACT [contractor]	1,493,488	746,744	746,744			
National Alliance on Mental Illness (NAMI) Sonoma County - Family-based Education, Advocacy and Support (FEAS) [contractor]	215,817	215,817				
WCCS - Interlink [contractor]	423,311	48,545				374,766
WCCS - Wellness & Advocacy Center [contractor]	726,822	709,143				17,679
WCCS - Russian River Empowerment Center [contractor]	176,135	176,135				
WCCS - Petaluma Peer Recovery Center [contractor]	79,268	79,268				
<b>Unhoused Program FSP</b>						
DHS- Homelessness Division [contractor]	1,700,000	1,700,000				
<b>Non-FSP Programs</b>						
<b>General Systems Development (GSD)</b>						
DHS-BHD Mobile Support Team (MST)	8,974,800	1,757,651	2,040,854			5,176,295
DHS-BHD Collaborative Treatment and Recovery Team (CTRT)	1,333,028	973,796	340,000			19,232
Bucklew Programs - CTRT System Navigation [contractor]	445,534	210,534	235,000			

DHS-BHD Community Mental Health Centers	2,756,307	2,089,420	640,000			26,887
Senior Peer Support [contractor TBD] -RFP	89,077	89,077				
Senior Peer Counseling [contractor TBD] - RFP	76,554	76,554				
Buckelew Programs Family Service Coordination [contractor TBD] - RFP	229,965	229,965				
Sonoma County Human Services Department (HSD) - Job Link [contractor]	33,750	33,750				
WCCS - Crisis Support [contractor]	10,611	10,611				
DHS-BHD Medication Support Services for Adult Programs	6,193,966	5,828,786	345,000			20,180
DHS-BHD Medication Support Services for Youth Programs	2,944,573	2,430,343	473,990			40,240
Alternative Family Services [contractor]	200,000	100,000	100,000			
Siyon Clinical Research [contractor]	1,250,000	625,000	625,000			
<b>Outreach and Engagement (OE)</b>						
DHS-BHD Whole Person Care (WPC)	1,703,179	1,186,790	451,000			65,389
Sonoma County Indian Health Project - Community Programs [contractor]	85,988	85,988				
<b>CSS Annual Planning</b>	640,158	605,765				34,393
<b>CSS Administration</b>	3,362,935	3,348,887				14,048
<b>CSS MHSA Housing Program Assigned Funds</b>	0	0				0
<b>Total CSS Program Estimated Expenditures</b>	50,411,355	35,884,258	8,397,958	0	0	6,129,139

## FY 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
<b>PEI Programs - Prevention</b>						
Action Network [contractor]	63,664	63,664				
Community Baptist Church Collaborative [contractor]	127,327	127,327				
Sonoma County Human Services Department - Older Adult Collaborative [contractor]	233,432	233,432				
Sonoma County Indian Health Project [contractor]	42,443	42,443				
<b>PEI Programs - Prevention &amp; Early Intervention</b>						
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				
<b>PEI Programs - Early Intervention</b>						
BH Schools Partnership RFP [contractor]	200,000	200,000				
Child Parent Institute (CPI) [contractor]	210,089	210,089				
La Luz [contractor]	48,618	48,618				
Early Learning Institute (ELI) [contractor]	46,687	46,687				
Seneca WRAP [contractor]	2,050,000	500,000	1,025,000	525,000		
<b>PEI Programs - Stigma &amp; Discrimination Reduction</b>						
Santa Rosa Junior College [contractor]	212,211	212,211				
<b>PEI Programs - Suicide Prevention</b>						

Bucklew Programs - North Bay Suicide Prevention Program [contractor]	169,769	169,769				
<b>PEI Programs - Access and Linkage to Treatment</b>						
DHS-BHD Youth Access Team	1,896,322	1,454,026	190,000			252,296
DHS-BHD Adult Access Team	3,587,169	2,894,503	462,000			230,666
OPTUM - MOU County of Contra Costa, Marin, San Mateo	150,000	150,000				
<b>PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness</b>						
Crisis Intervention Training (CIT) with Law Enforcement Personnel	30,250	30,250				
<b>PEI Annual Planning</b>	100,266	94,879				5,387
<b>PEI Administration</b>	563,136	560,936				2,200
<b>PEI Assigned Funds (CalMHSA Statewide PEI Project)</b>	172,673	172,673				
<b>Total PEI Program Estimated Expenditures</b>	10,161,023	7,468,474	1,677,000	525,000	0	490,549

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

<b>INN Programs</b>	<b>Estimated Total Mental Health Expenditures</b>	<b>Estimated INN Funding</b>	<b>Estimated Medi-Cal FFP</b>	<b>Estimated 1991 Realignment</b>	<b>Estimated Behavioral Health Subaccount</b>	<b>Estimated Other Funding</b>
Collaborative Care Enhanced Recovery Project (CCERP) aka Unidos Por Nuestro Bienestar - [Sonoma County Human Services Department]	71,558	71,558				
Crossroads to Hope (Peer Program Provider) - Felton Institute	614,108	614,108				
Instructions Not Included (INI) - Dads Matter [Early Learning Institute - contractor]	233,043	233,043				
New Parent TLC - [First 5 Sonoma County - contractor]	169,377	169,377				
Nuestra Cultura Cura Social Innovations Lab - [On The Move - contractor]	348,146	348,146				
Crossroads to Hope (Evaluation Consultant) - Behavioral Health Outcomes Data Services	13,830	13,830				
CalMHSA Electronic Health Record	642,100	642,100				
<b>INN Annual Planning</b>						
<b>INN Administration</b>						
<b>Total INN Program Estimated Expenditures</b>	2,092,162	2,092,162				



## 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
Cultural Responsiveness, Inclusion & Training Coordinator (CRITC)	444,723	444,723				
DHS-BHD WET Activities	500,000	500,000				
0.5 FTE Senior Office Assistant (SOA)	79,825	77,167				2,658
West County Community Services - Peer Education and Training [contractor]	147,926	147,926				
<b>WET Annual Planning</b>	15,426	14,597				829
<b>WET Administration</b>	78,773	78,434				339
<b>Total WET Program Estimated Expenditures</b>	<b>1,266,673</b>	<b>1,262,847</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>3,826</b>

## 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	777,000	777,000				
Avatar Electronic Health Record (EHR) - DHS staff	647	647				
SacValley MedShare [contractor]	23,000	23,000				
Sonoma Web Infrastructure for Treatment Services (SWITS) - FEI	2,200	2,200				
Data Collection and Reporting (DCAR) - AJW	38,875	38,875				
<b>CFTN Annual Planning</b>	15,426	14,597				829
<b>CFTN Administration</b>	70,208	69,869				339
<b>Total CFTN Program Estimated Expenditures</b>	927,356	926,188				1,168

**CONNECTION IS  
PREVENTION**



# **SONOMA COUNTY MENTAL HEALTH SERVICES ACT (MHSA)**

## **FY 2022 – 2023 ANNUAL PROGRAM REPORT**



# SONOMA COUNTY MHSA ANNUAL PROGRAM REPORT

Summary report and highlights from MHSA funded programs in FY 2022-2023



## Notes about the Data in the Report:

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.

**CONNECTION IS  
PREVENTION**



**SONOMA COUNTY MHSA ANNUAL  
COMMUNITY SERVICES AND SUPPORTS (CSS)  
PROGRAM REPORT**

**FY 2022 - 2023**



## 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 22-23, there were over unique clients served by Sonoma County FSPs.



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



FY 2022-2023 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:** 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/](http://www.sonomacounty.ca.gov/Health/Behavioral-Health/Adult-Services/Forensic-Assertive-Community-Treatment-Team/)

**Phone:** (707) 565-4850

**Program location:**  
12227 Capricorn Way, Suite 207  
Santa Rosa, CA 95407

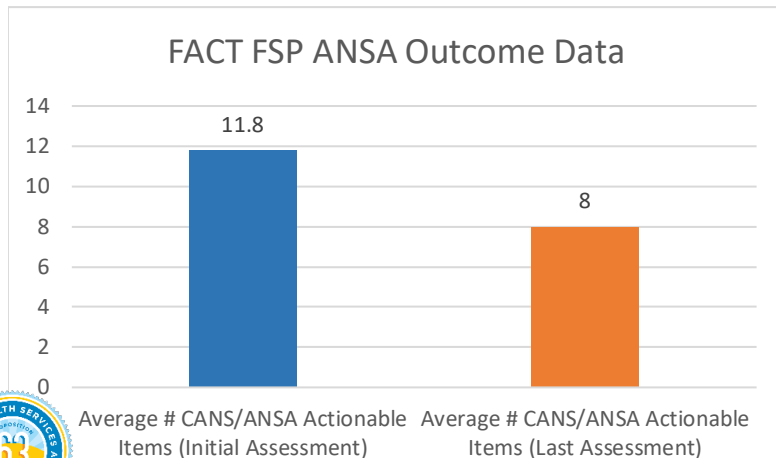
**PROGRAM DESCRIPTION:**

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 22-23, this program included contracted services from:

- Buckelew Programs – Independent Living Skills (ILS) (housing)
- Buckelew Programs – Supplemental Patch for Unlicensed Supportive Housing Units

**PERFORMANCE OUTCOMES & ACCOMPLISHMENTS:**

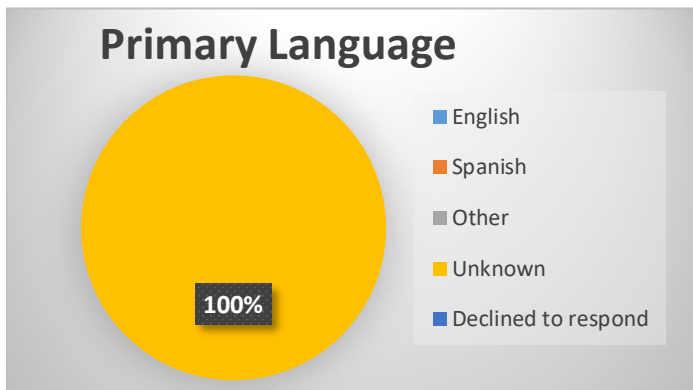
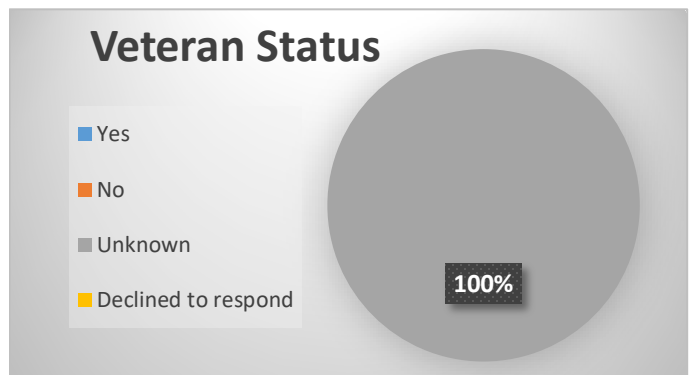
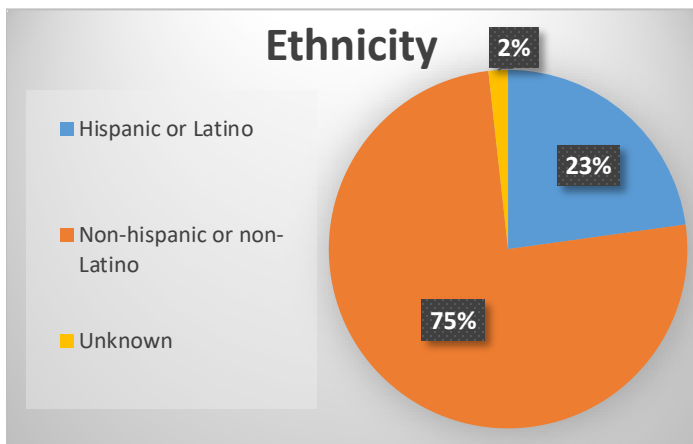
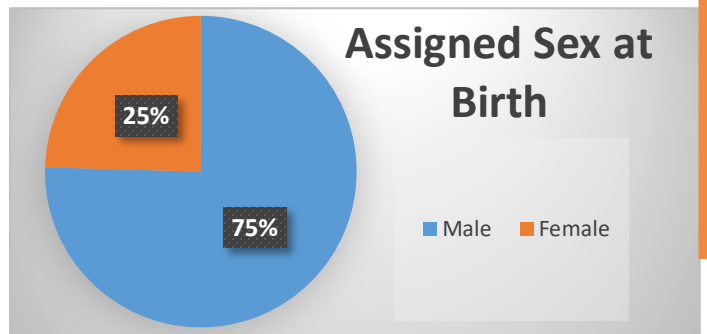
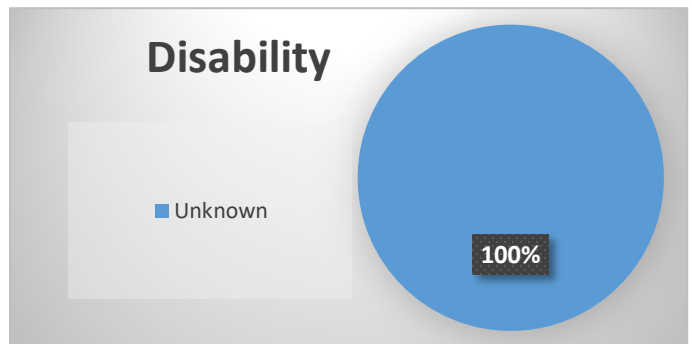
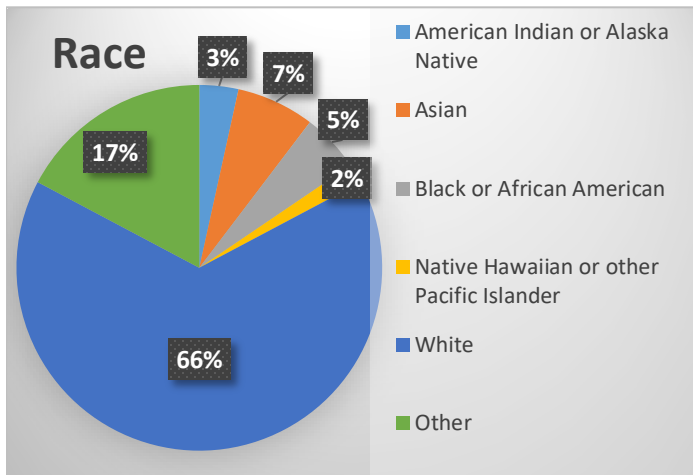
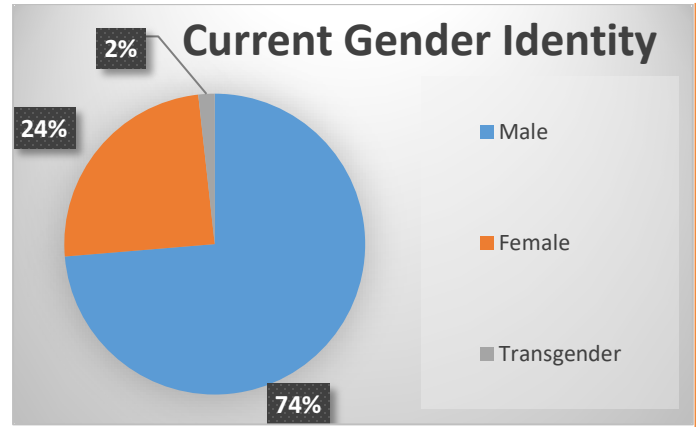
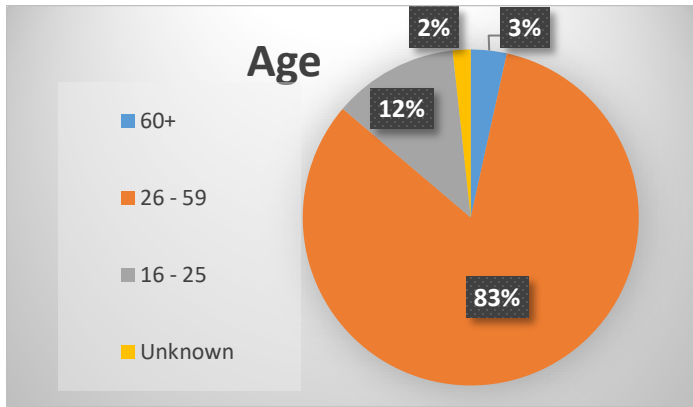


**FY 2022-2023  
PROGRAM STATISTICS**

- **Total number of unique clients served:** 58
- **Total unique clients that were also served by Buckelew FACT-ILS in FY 22-23:** 16



# FY 2022-2023 Program Demographics:





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



FY 2022-2023 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](http://www.sonomacounty.ca.gov/Health/Behavioral-Health/Youth-Services)  
**Phone:** (707) 565-4850  
**Program location:**  
 12227 Capricorn Way  
 Santa Rosa, CA 95407

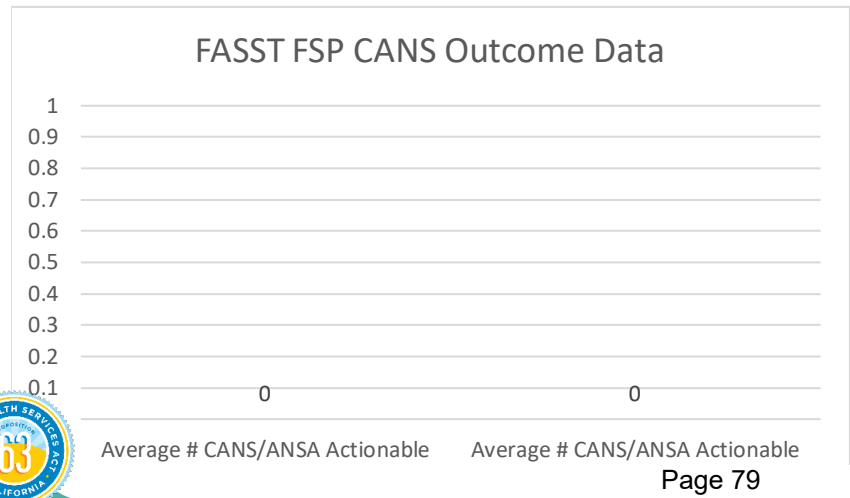
### PROGRAM DESCRIPTION:

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 22-23, this program included contracted services from:

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

### PERFORMANCE OUTCOMES & ACCOMPLISHMENTS:



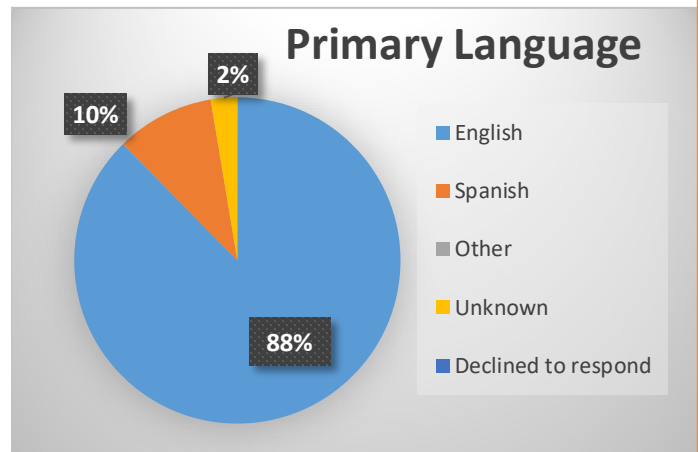
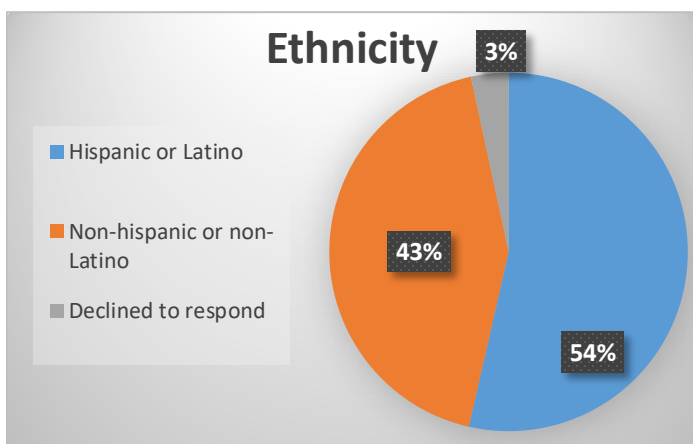
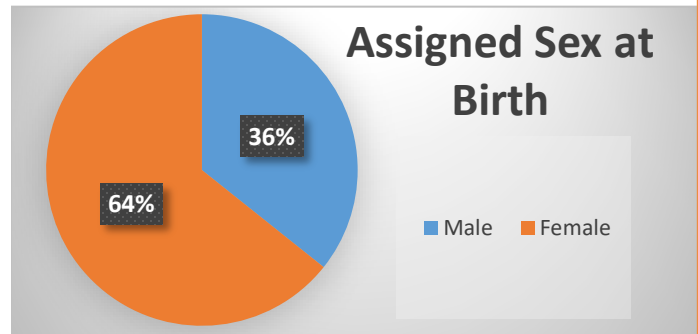
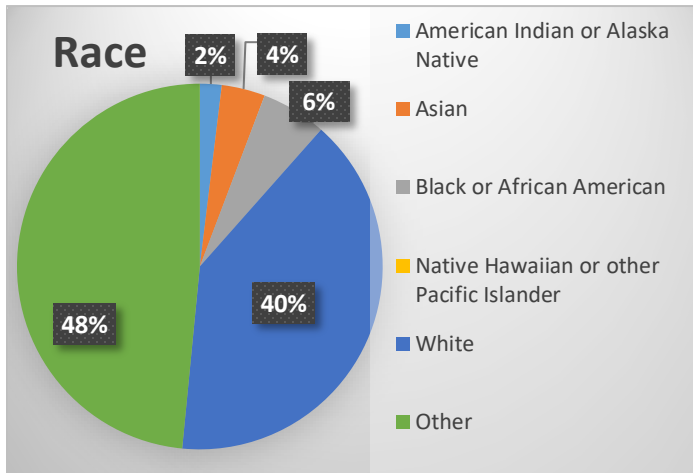
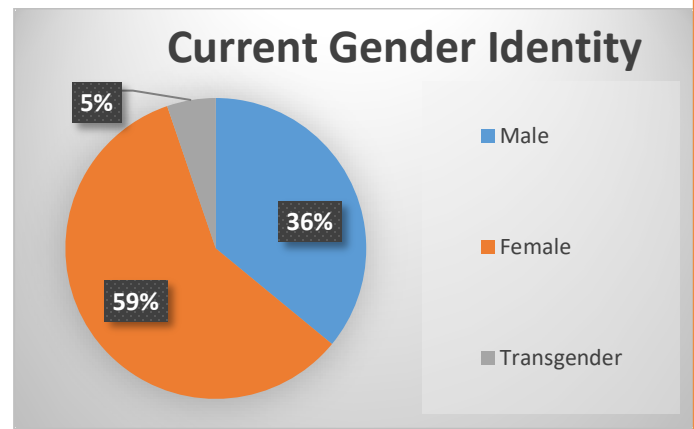
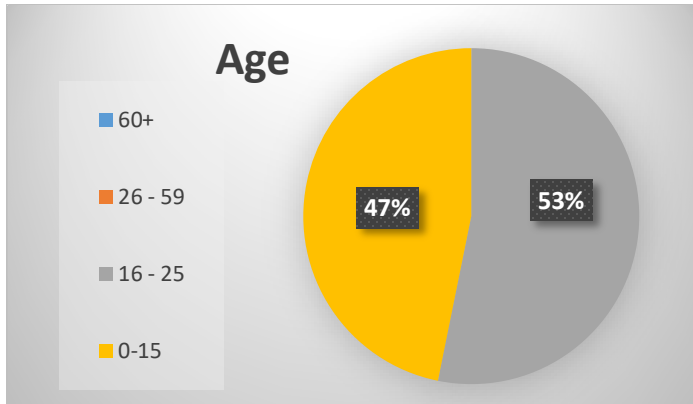
### FY 2022-2023 PROGRAM STATISTICS

- **Total number of unique clients served:** 363
- **Total unique clients that were also served by contracted providers in FY 22-23:** 187

\*No data available during this report period.



# FY 2022-2023 Program Demographics:



## DHS-BHD's Integrated Recovery Team (IRT)



FY 2022-2023 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

### 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.

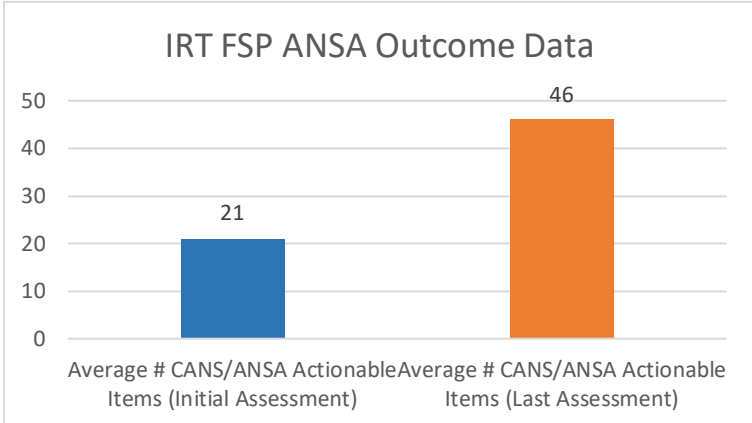
IRT uses an integrated treatment approach that addresses mental health and substance use conditions at the same time to ensure better overall health outcomes. Treatment focuses on the stages of change, utilizing a harm reduction approach, and motivational interviewing.

**Services include:** Pharmacological treatment, case management, self-help groups run by peers, family education, housing and employment services, and aftercare services.

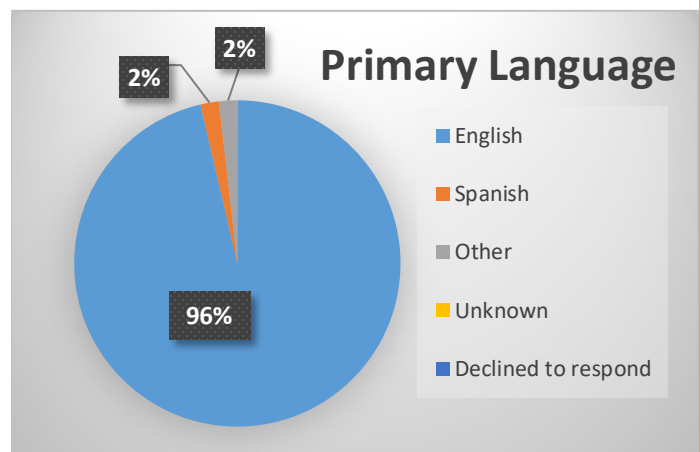
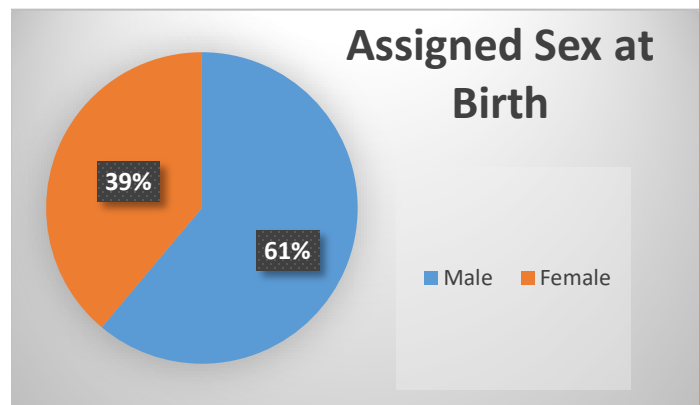
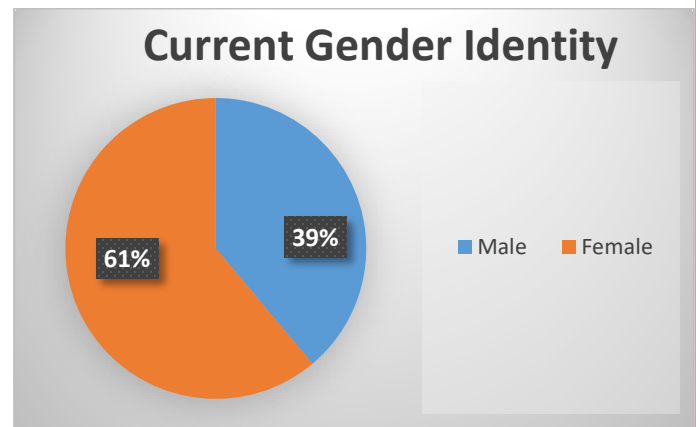
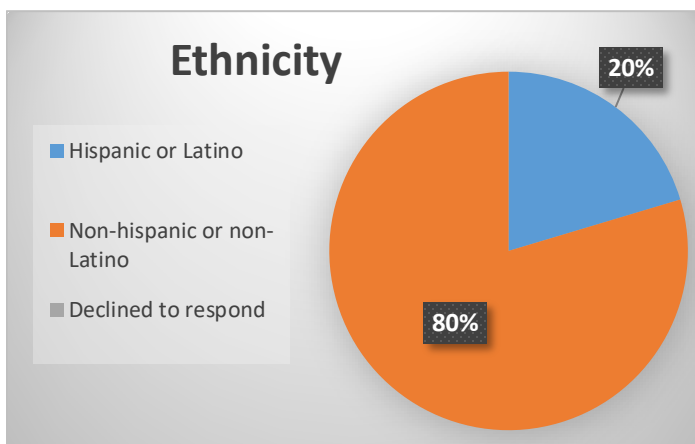
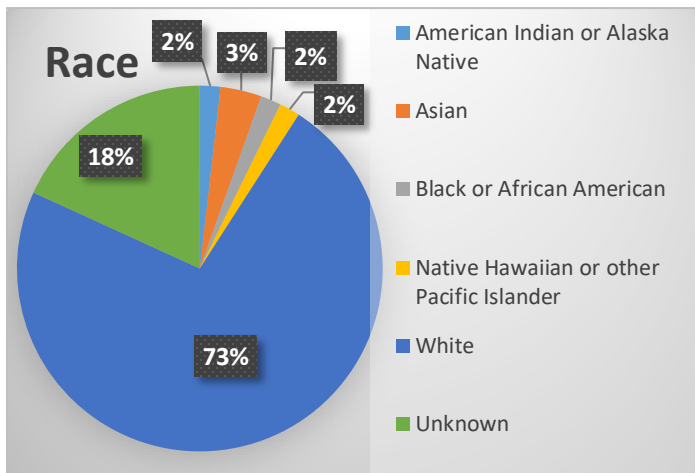
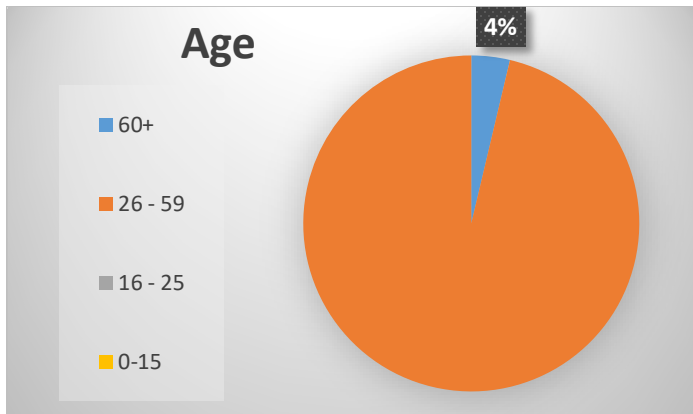
### FY 2022-2023 PROGRAM STATISTICS

- **Total number of unique clients served: 60**

### PERFORMANCE OUTCOMES & ACCOMPLISHMENTS:



# FY 2022-2023 Program Demographics:

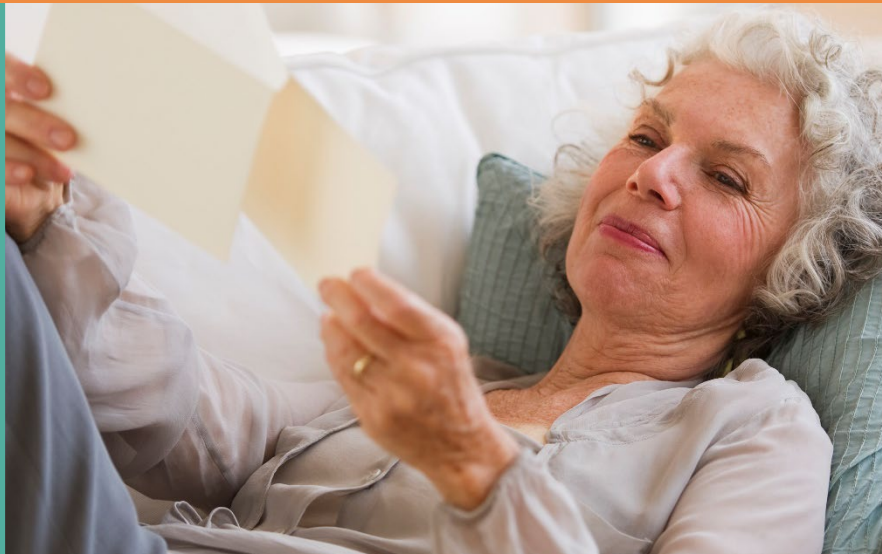


**DHS-BHD's  
Older Adult Intensive Team  
(OAIT)**



FY 2022-2023 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:** 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

**FY 2022-2023  
PROGRAM STATISTICS**

- **Total number of unique clients served: 61**

**PROGRAM DESCRIPTION:**

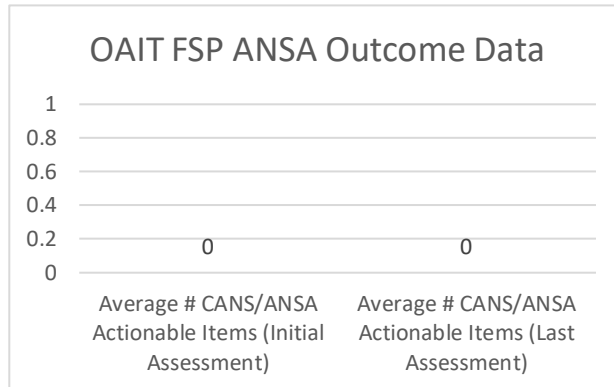
Sonoma County's Older Adult Intensive Team OAIT provides intensive, integrated services for older adults with serious mental illness coupled with more complex medical conditions requiring close coordination between mental health and primary or specialty medical providers. Includes contracted services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

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

**Services Include:**

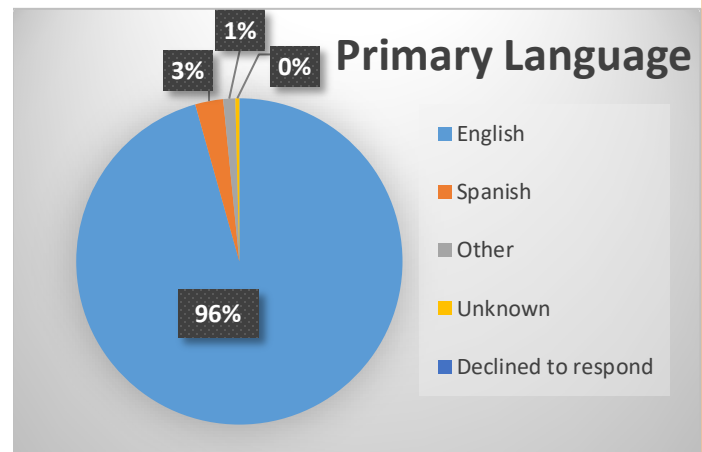
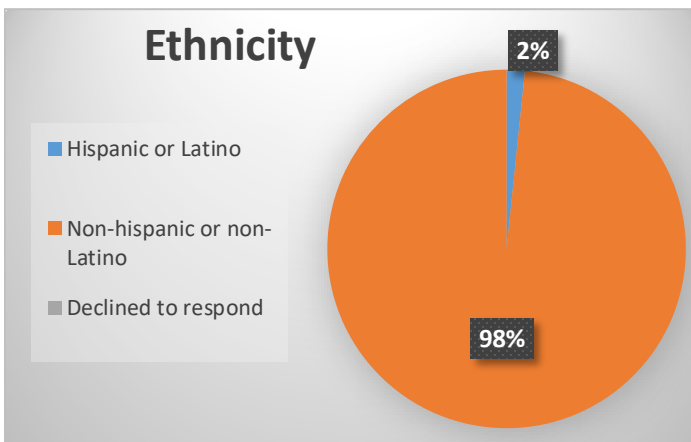
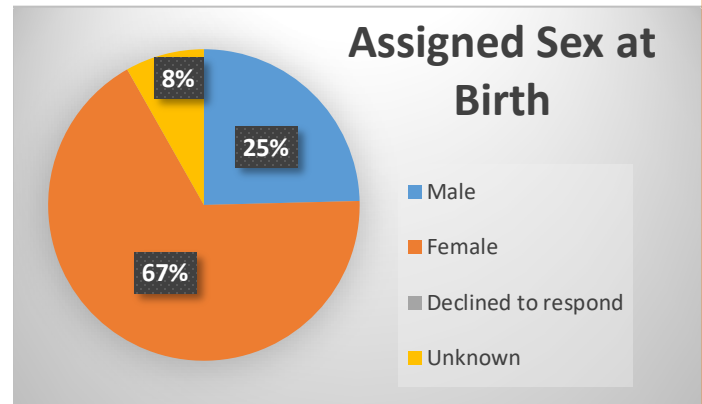
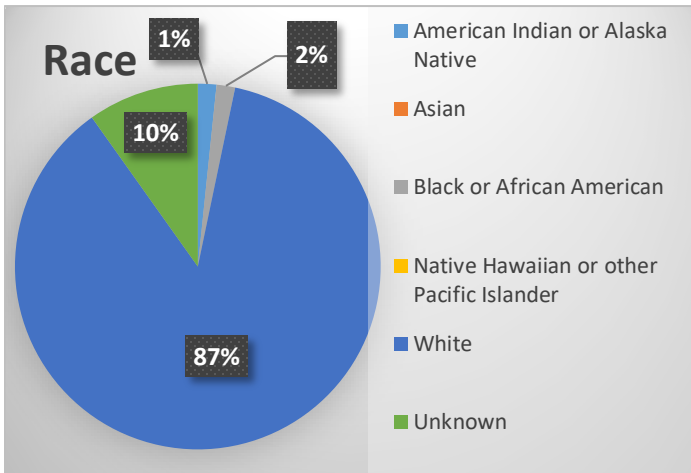
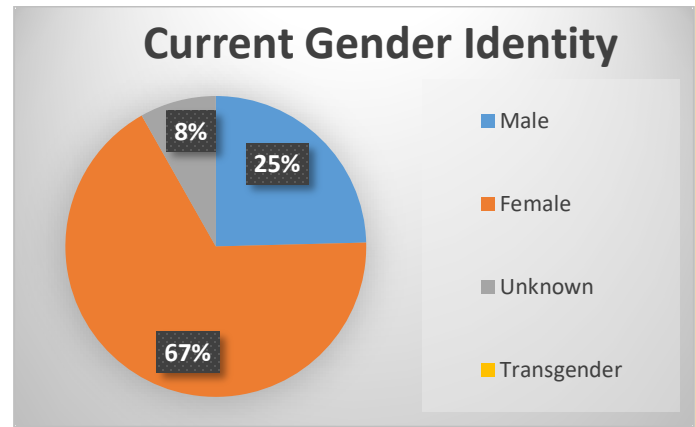
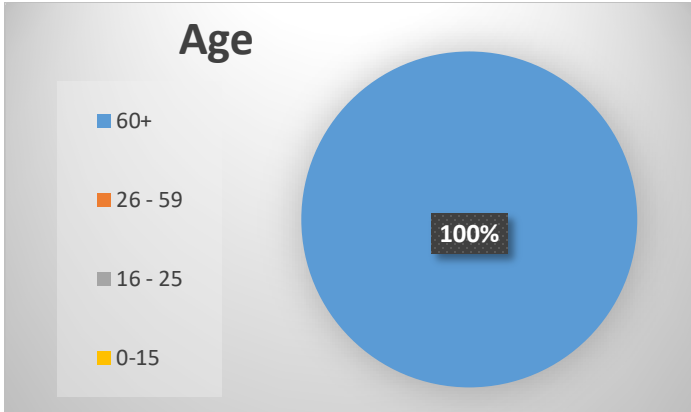
- Medication education, monitoring, and delivery.
- Case management.
- Referrals.
- Visiting clients when hospitalized (either medically or psychiatrically) and facilitating communications between the medical and psychiatric staff for care and follow-up planning.
- Transportation services, including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

**PERFORMANCE OUTCOMES & ACCOMPLISHMENTS:**



\*no data was available during reporting period

## FY 2022-2023 Program Demographics:



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



FY 2022-2023 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

### FY 2022-2023 PROGRAM STATISTICS

- **Total number of unique clients served: 59**

### 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.

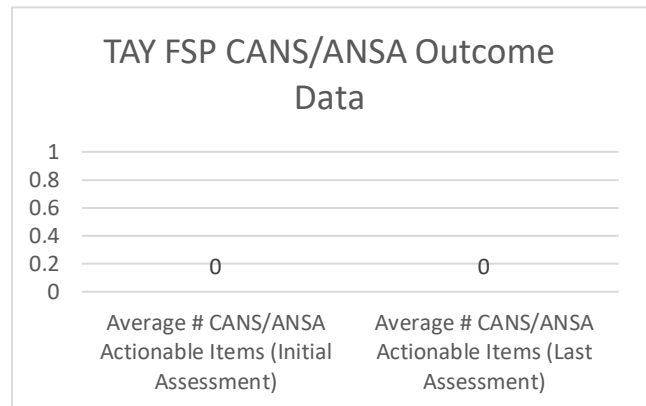
#### Includes contracted services from the following comm

- 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

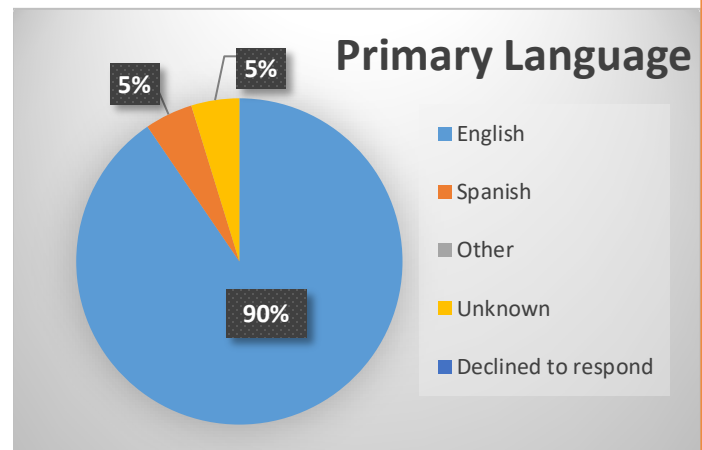
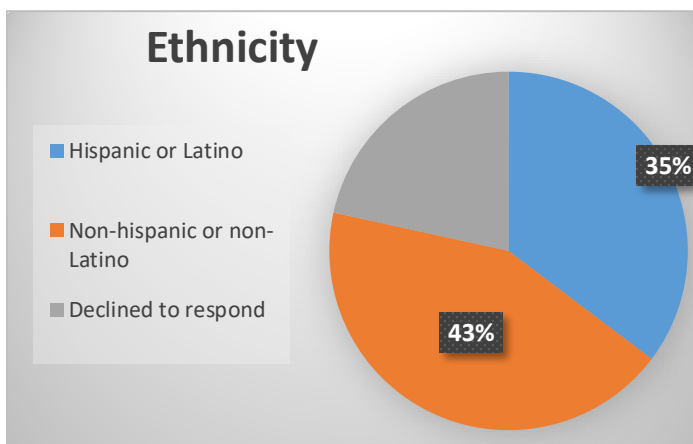
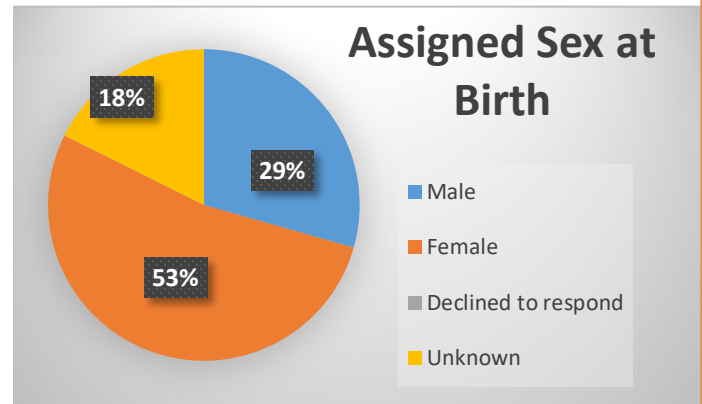
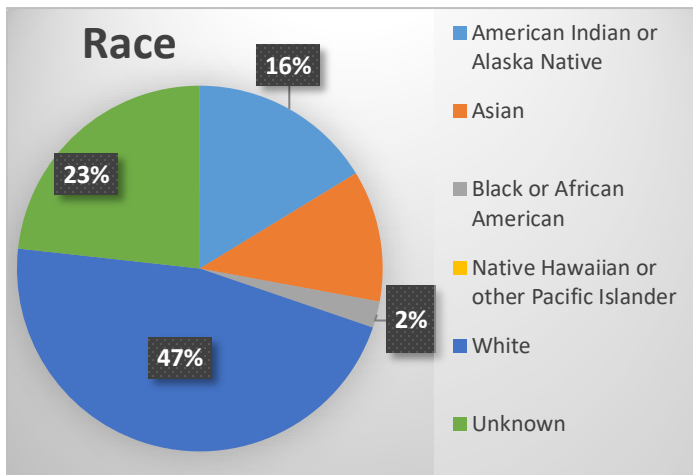
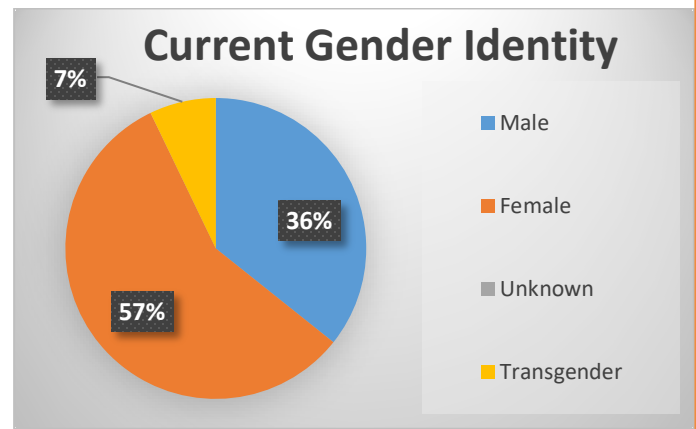
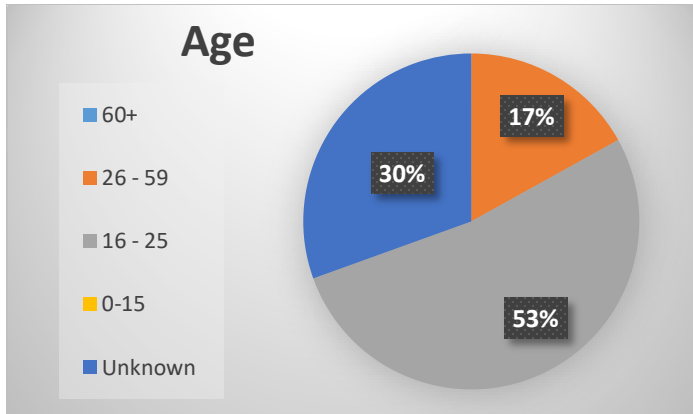
### PERFORMANCE OUTCOMES & ACCOMPLISHMENTS:



\*Data not available during reporting period



# FY 2022-2023 Program Demographics:





# SONOMA COUNTY MHSA ANNUAL PROGRAM REPORT FY 2022 - 2023

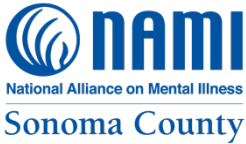
## COMMUNITY SERVICES AND SUPPORTS (CSS)

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.





# NAMI Sonoma County



FY 2022-2023 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:**

NAMI Sonoma County

**Population served:** Individuals and families affected by mental illness

**Website:** [www.namisoco.org](http://www.namisoco.org)

**Phone:** (866) 960-6264

**Program location:**

182 Farmers Lane #202  
Santa Rosa, CA 95405

**Social Media:**

@namisoco

@namisonoma

## FY 22-23 PERFORMANCE OUTCOMES:

<b>Encounters</b>	<b>6,396</b> Total Encounters <b>3,031</b> through Outreach
<b>Warmline</b>	<b>1,841</b> total contacts <b>739</b> new callers <b>60</b> referred by MST or YFS
<b>Support Groups (duplicated)</b>	<b>922</b> Connection attendees <b>602</b> Family Support Group attendees

## 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 increase their quality of life through education and support. NAMI program leaders use their lived experience and training to increase knowledge and understanding of mental illness. NAMI programs are free, offer practical skills, foster caring connections, decrease stigma, and build hope. NAMI strives to ensure that no one feels alone when faced with mental health challenges.

- ◆ **Warmline** (866-960-6264 | [info@namisoco.org](mailto:info@namisoco.org)): A starting place to find support, information, and resources that can help.
- ◆ **NAMI Family Support Groups:** For anyone who provides care and support to someone who lives with mental health challenges.
- ◆ **NAMI Connection 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 Homefront:** 6-week education program for those supporting an active-duty service member or veteran experiencing mental health challenges.
- ◆ **NAMI Peer-to-Peer:** 8-week education program for adults in recovery who live with mental health challenges.
- ◆ **NAMI Ending the Silence:** Presentation for youth, parents and school staff that shares 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 Youth & Family Services Team, inRESPONSE, and SAFE Teams.
- ◆ **QPR Suicide Prevention Training:** A concise training on how to talk to someone at risk of suicide, designed for both professionals and lay audiences.
- ◆ **Mental Health Speaker Presentations:** Expand awareness and understanding of mental health and community resources.

## PROGRAM TESTIMONIALS:

“NAMI programs have helped me see that we can make a difference for our loved ones.”

“NAMI Family Support Groups helped me understand that the symptoms of mental illness are separate from the person.”

“The NAMI Family-to-Family class is absolutely excellent. It provided a feeling of not being alone.”

“The NAMI Sonoma County Warmline made me feel immediately at ease and very supported.”

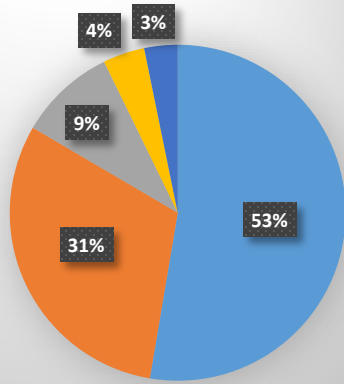
“NAMI Ending the Silence made learning about mental health understandable and the presenter’s experience relatable.”



# FY 2022-2023 Program Demographics:

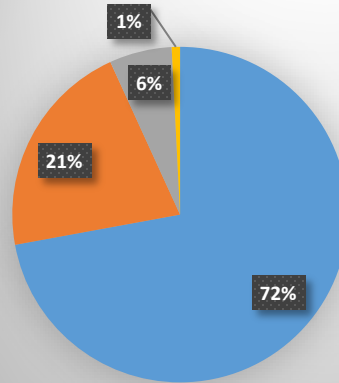
## Age

- 26 - 59
- 60+
- Unknown
- 16 - 25
- Declined to respond



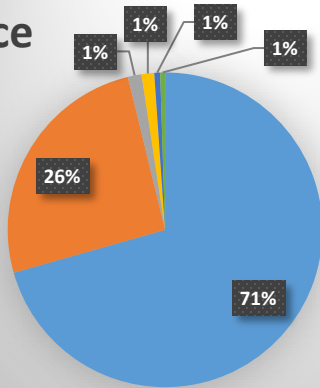
## Current Gender Identity

- Female
- Male
- Declined to respond
- Genderqueer



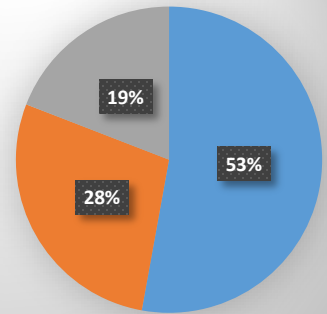
## Race

- White
- Unknown
- Black or African American
- Asian
- American Indian or Alaska Native
- Native Hawaiian or other Pacific Islander



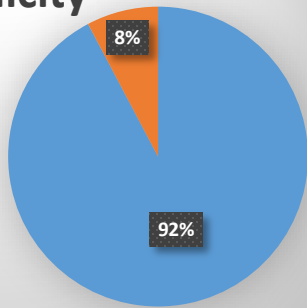
## Disability

- Unknown
- No
- Yes



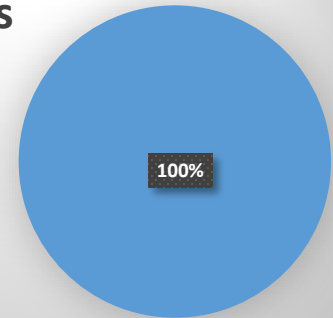
## Ethnicity

- Non-hispanic or non-Latino
- Hispanic or Latino



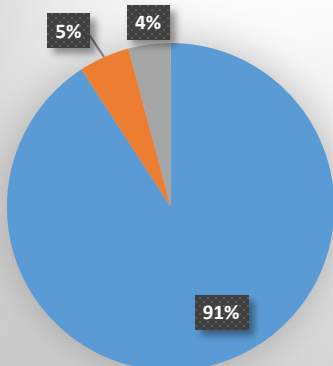
## Veteran Status

- Unknown



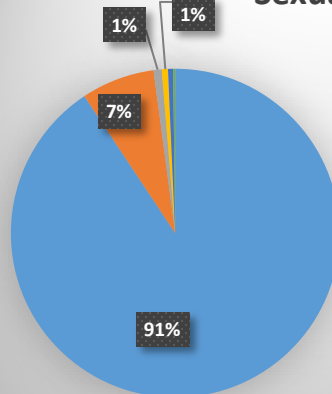
## Primary Language

- English
- Spanish
- Other



## Sexual Orientation

- Unknown
- Heterosexual or Straight
- Gay or Lesbian
- Bisexual
- Another sexual orientation
- Questioning or unsure





# Family Service Coordination Program at Buckelew Programs



FY 2022-2023 Service Category: i.e. Full Service Partnership Services, Outreach and Engagement Services or

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:** Buckelew Programs: Family Service Coordination

**Population served:** Sonoma County families and allies, supporting a loved one with a mental or behavioral health challenge.

**Website:**  
[www.buckelew.org/services/sonoma-county/family-services-coordination/](http://www.buckelew.org/services/sonoma-county/family-services-coordination/)

**Phone:** (707) 571-8452

**Program location:**  
2235 Mercury Way #107  
Santa Rosa, CA 95407

**Social Media:**  
[www.facebook.com/BuckelewPrograms](https://www.facebook.com/BuckelewPrograms)  
[www.instagram.com/BuckelewPrograms](https://www.instagram.com/BuckelewPrograms)

### PROGRAM DESCRIPTION:

The Family Service Coordination program works with families, friends, caregivers, and allies who are supporting an adult loved one with behavioral health challenges. FSC walks with families and allies through individualized and group support, system navigation, providing education about mental health and substance use challenges, connects individuals and families with community resources and supports, and reducing stigma through community education. All Family Service Coordination services are free of charge to anyone living in Sonoma County.

### PERFORMANCE OUTCOMES:

Family and Allies reported following:

- 89% of families have reported excellent or good understanding of Sonoma County’s Health System, i.e. how to access primary care, therapist, and psychiatrist.
- 95% of families reported accessing 1 or more resources for themselves.
- 97% of families reported accessing 2 or more resources for their loved one.
- “I have been trying to find support to assist my daughter for over a year now, after many phone calls and feeling like giving up, the Family Service Coordination program has given me a sense of hope in finding the help that my daughter and I needed” Anonymous Mother

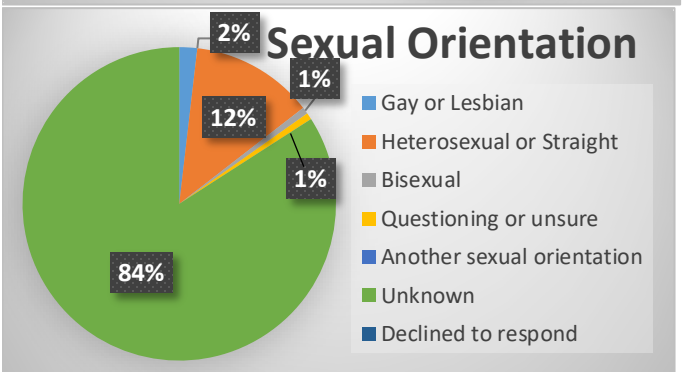
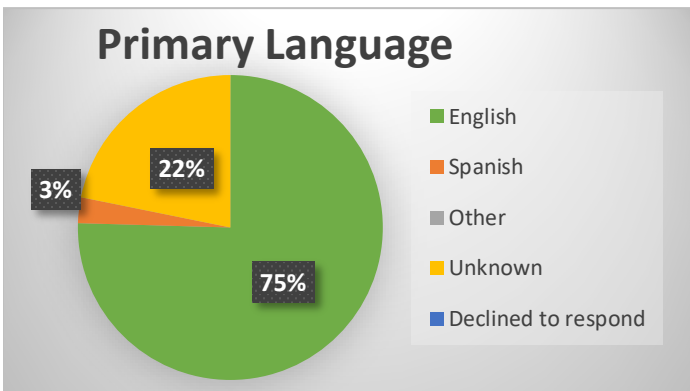
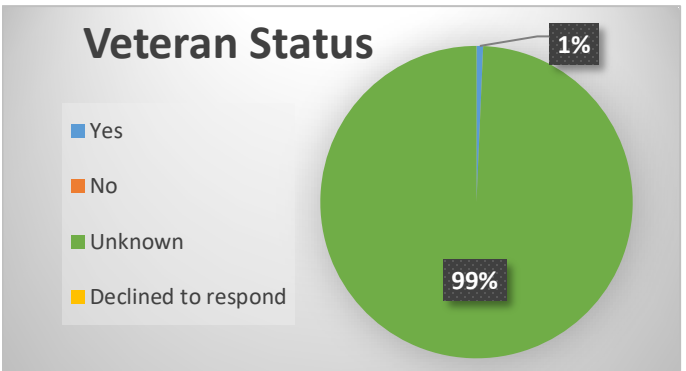
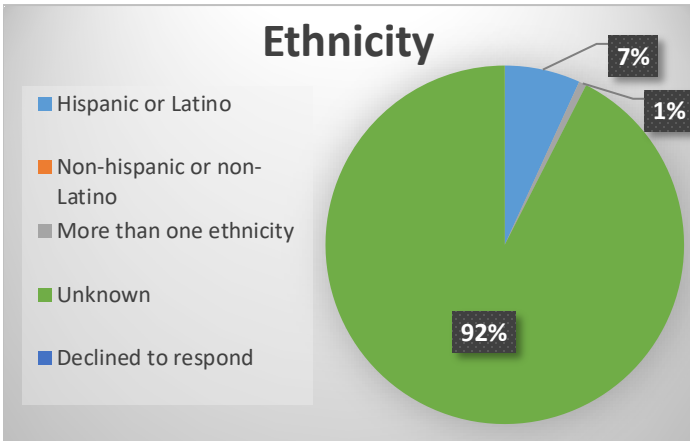
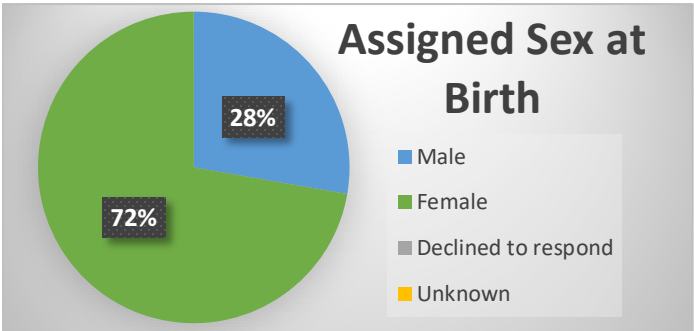
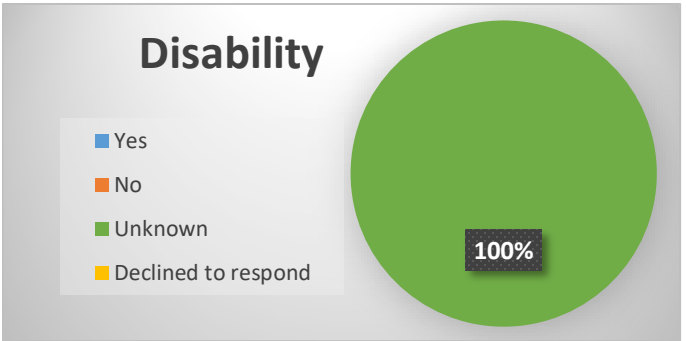
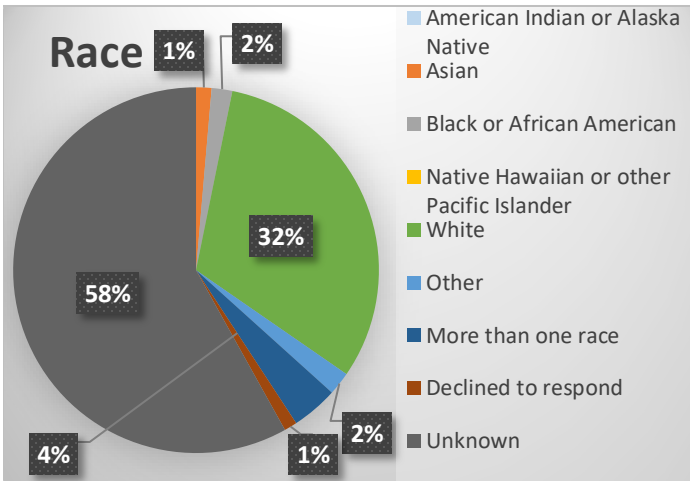
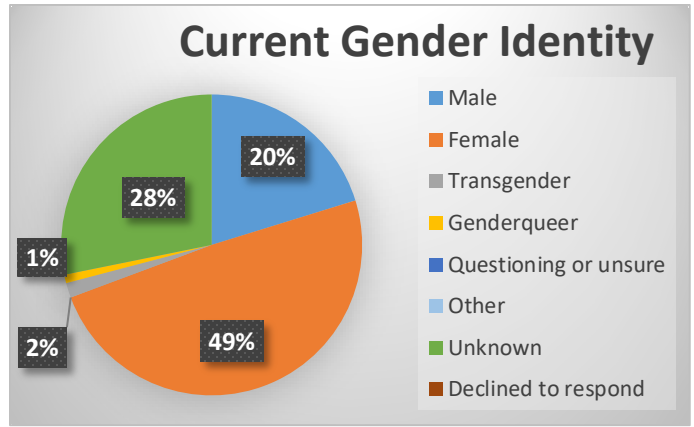
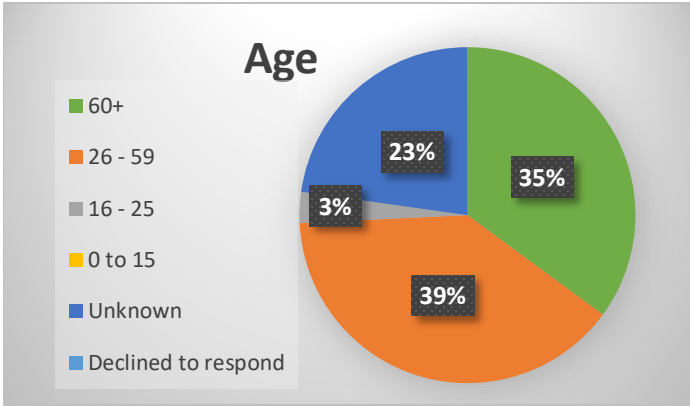
### FY 2022-2023

### PROGRAM STATISTICS

- **Total number of clients served:** 2,833
- **Total number of encounters:** 2,229
- **Approximate numbers reached through outreach:** 8,196



# FY 2022-2023 Program Demographics:





# VOICES Youth Center Alchemy Project



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:** Alchemy Project  
**Population served:** TAY youth (ages 18-26) involved with SCBH TAY team  
**Website:** [Voicesyouthcenter.org](http://Voicesyouthcenter.org)  
**Phone:** (707) 579-4327  
**Program location:**  
VOICES Youth Center  
714 Mendocino Ave.  
Santa Rosa, CA. 95401

### FY 2022-2023 PROGRAM STATISTICS

- **Total number of clients served:** 46
- **Total number of encounters:** 544
- **Approximate numbers reached through outreach:** 1,806

### PROGRAM DESCRIPTION:

VOICES Sonoma’s Alchemy Project is a comprehensive support program for youth experiencing severe mental health challenges that removes barriers to young people’s participation in mental health services by cultivating hope, relationships, stability and a sense of control over their lives. The goal of the Alchemy Project includes assisting youth in engaging and accessing appropriate mental health recovery programs, and, as applicable, obtaining a high school diploma or GED, stable housing, a source of income, a job and/or college attendance, supportive permanent relationships, and a plan for utilizing available community resources.

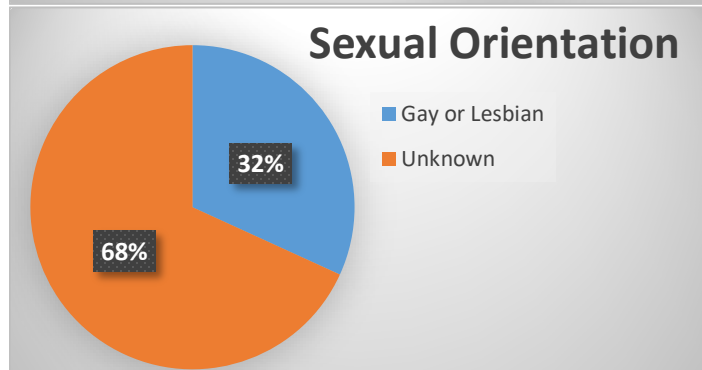
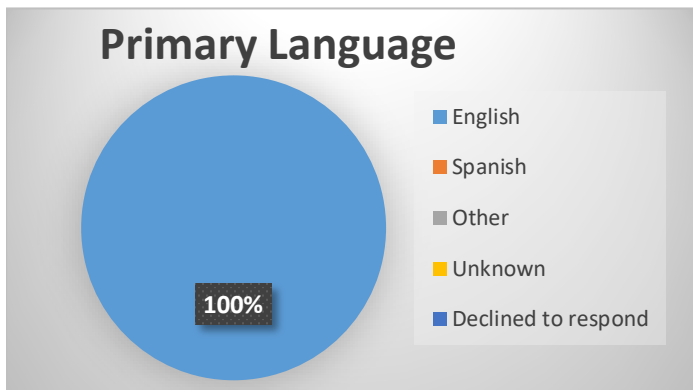
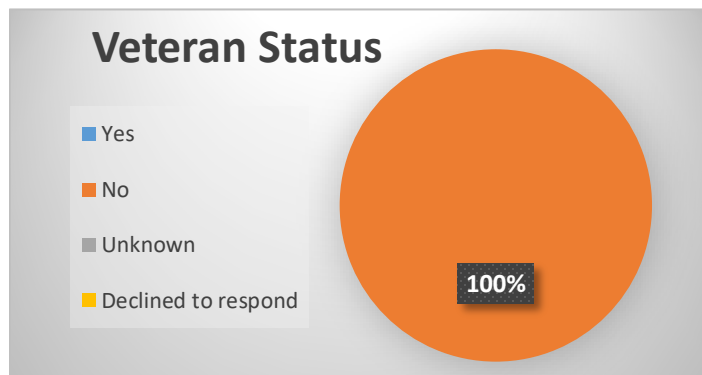
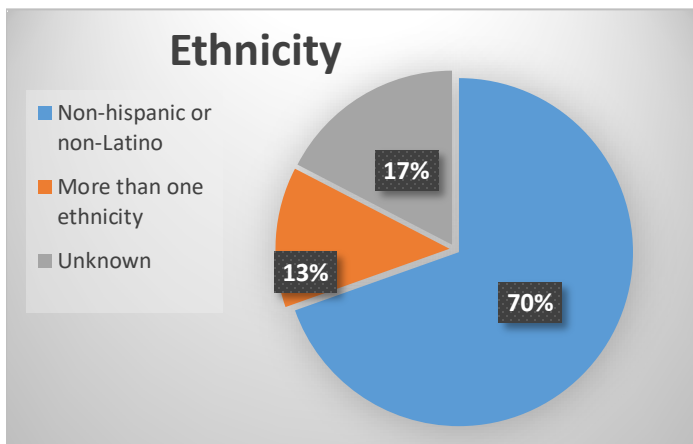
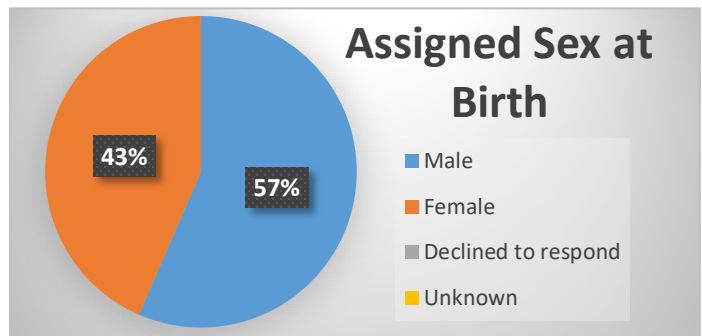
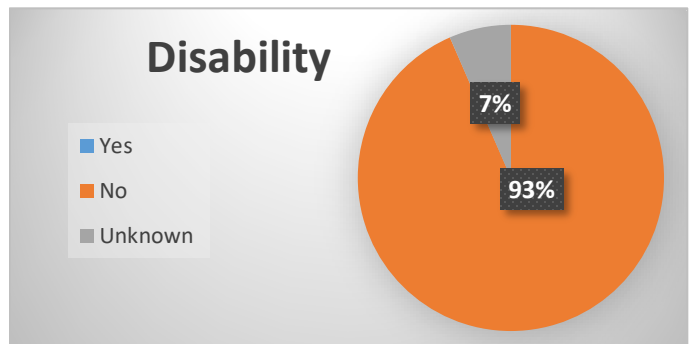
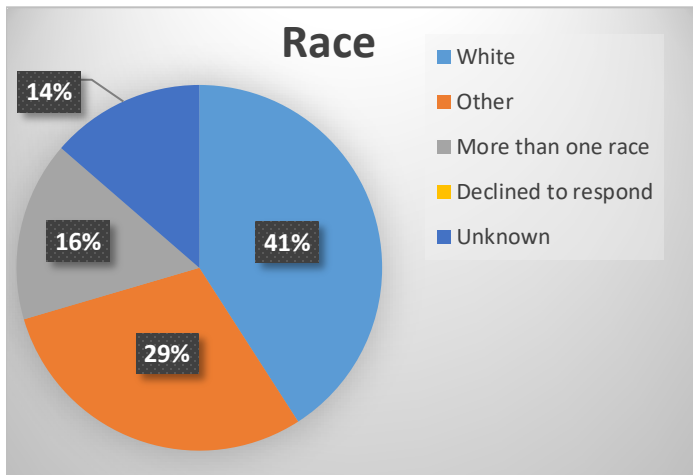
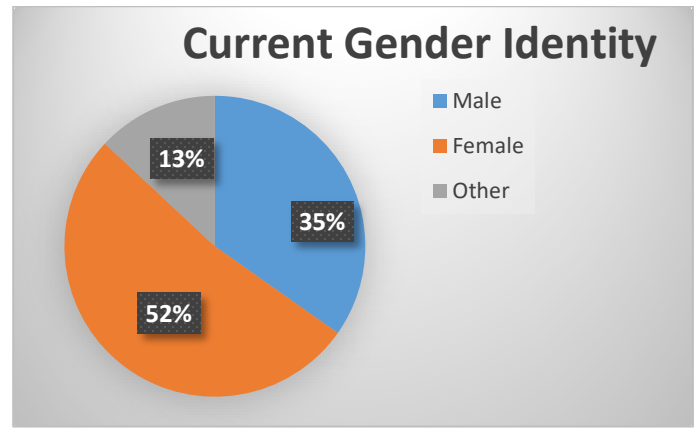
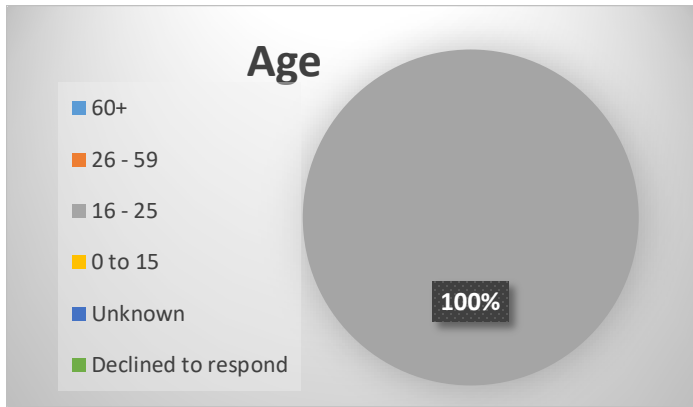
### PERFORMANCE OUTCOMES:

During the 22/23 service year, The Alchemy Project saw notable client outcomes in regard to mental health management (increase in clients going to doctor appointments, regular blood draws, attending therapy, and taking medications consistently), engaging in pro social events with peers (attending multiple monthly Alchemy outings, VOICES center workshops, and monthly community BBQs) and increased ADLs (maintaining employment, enrolling in school, and living independently). Over this year, 6 Alchemy youth maintained steady employment and another 9 youth maintained stable housing with support of The Alchemy Project. 100% of the youth reported feeling more seen and supported in their community, and enjoyed the social opportunities with peers. One reported feeling “safer” and “needing to go to the hospital less” with support from the Alchemy Project.

FY 2022-2023 Service Category: Full Service Partnership Services



# FY 2022-2023 Program Demographics:



# CONNECTION IS PREVENTION

## DHS-BHD's Mobile Support Team (MST)



FY 2022-2023 Service Category: General Service 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 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.

### PROGRAM INFORMATION

**Program Name:** Mobile Support Team (MST)

**Population 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

### FY 2022-2023 PROGRAM STATISTICS

- Total number of unique clients served: 267

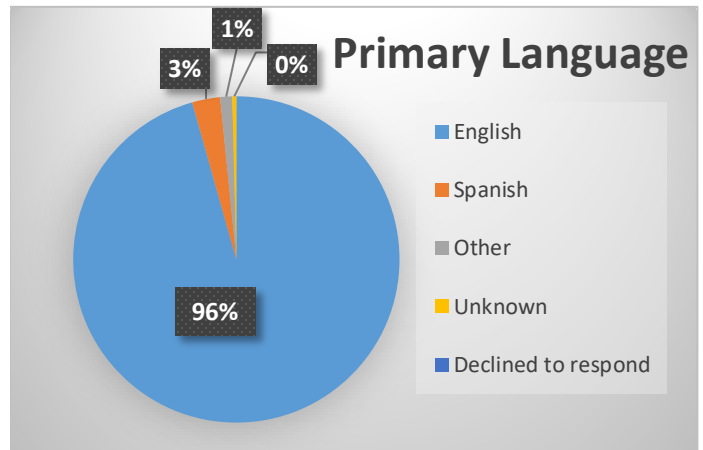
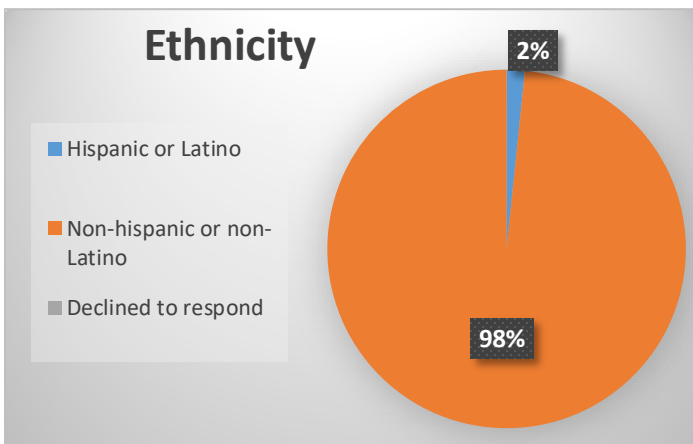
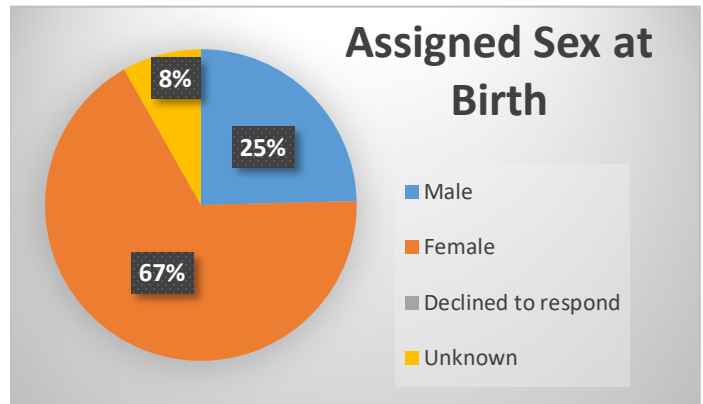
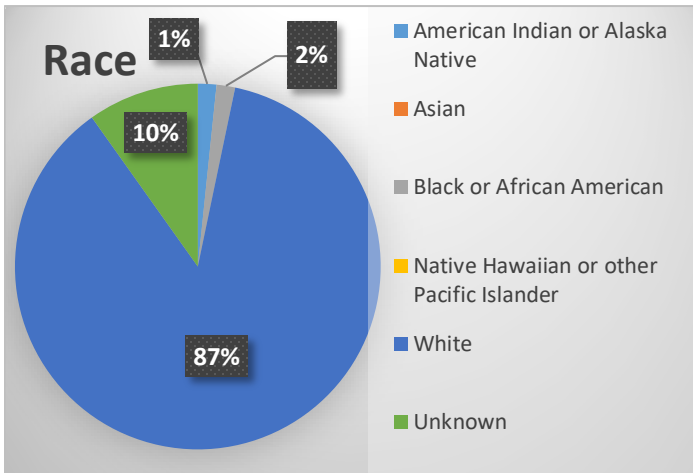
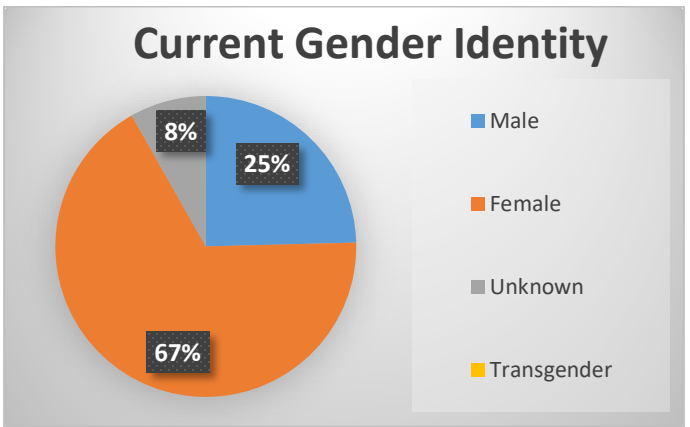
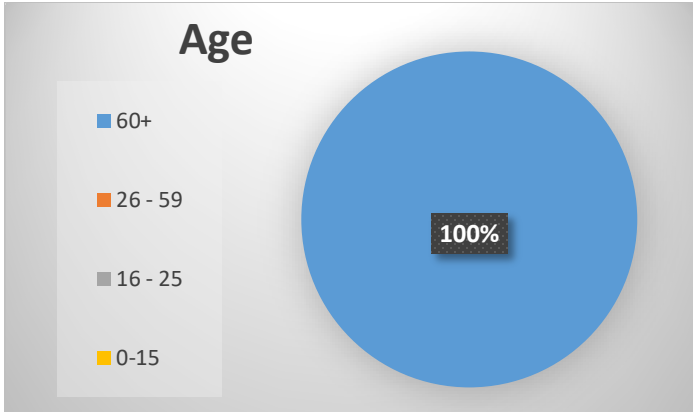
### PERFORMANCE OUTCOMES & ACCOMPLISHMENTS:

In progress





# FY 2022-2023 Program Demographics:



## DHS-BHD Collaborative Treatment and Recovery Team (CTRT)



FY 2022-2023 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:** 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

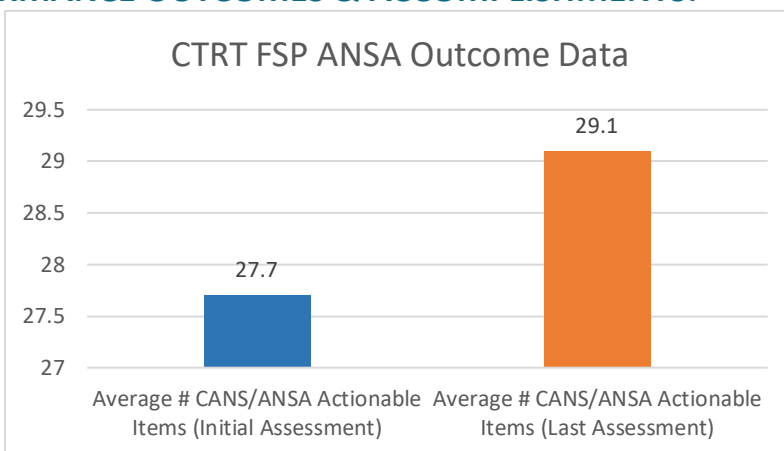
#### Program Goals:

- 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.

### 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.

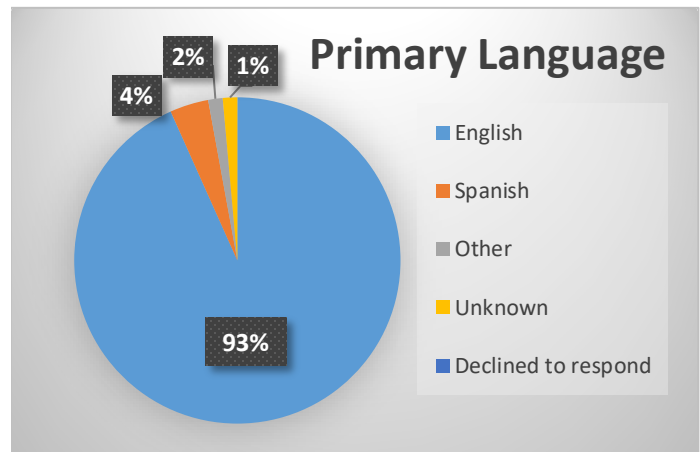
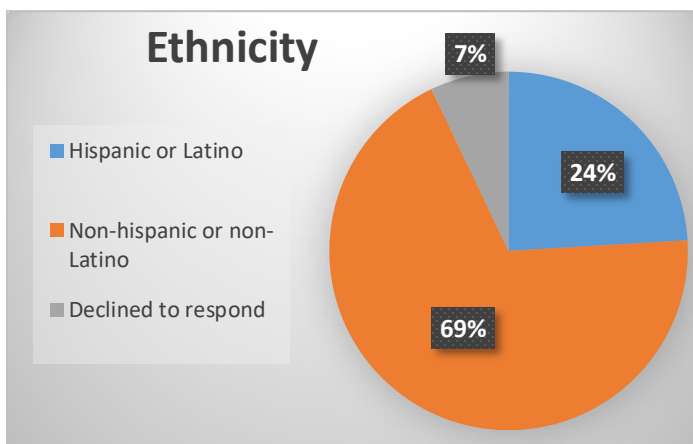
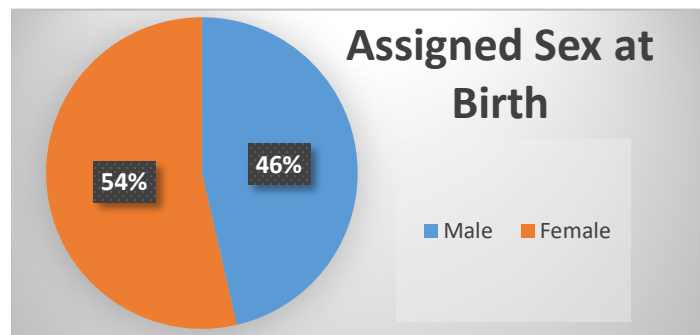
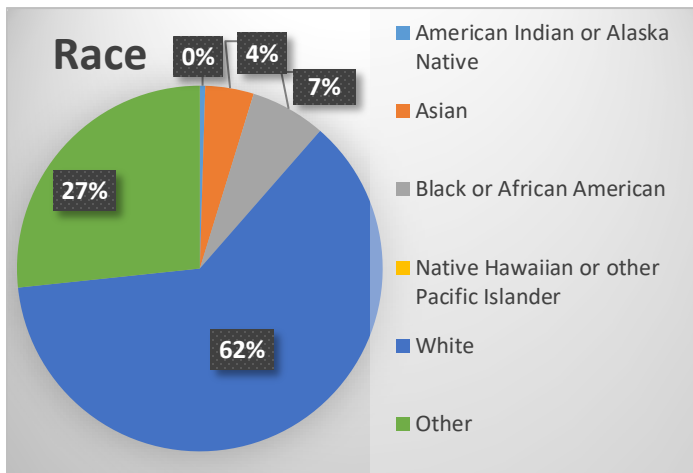
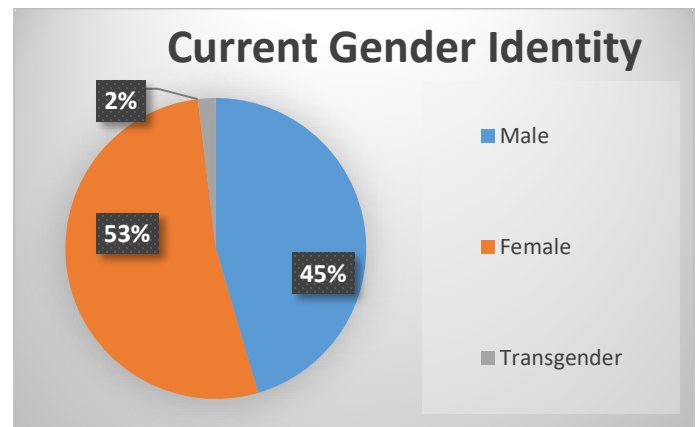
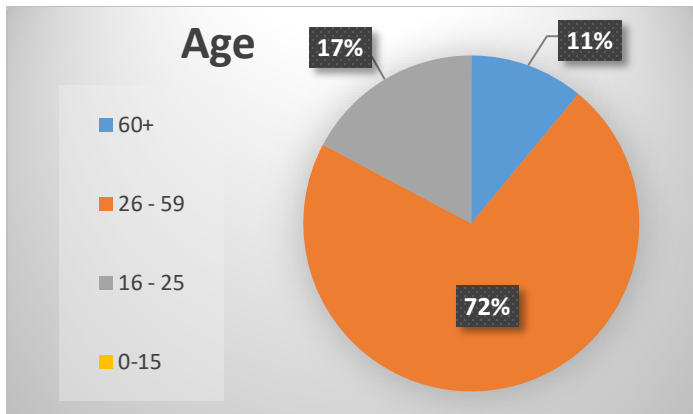
### PERFORMANCE OUTCOMES & ACCOMPLISHMENTS:



### FY 2022-2023 PROGRAM STATISTICS

- **Total number of unique clients served: 321**

## FY 2022-2023 Program Demographics:



**DHS-BHD**  
**Community Mental Health Centers (CMHCs)**



FY 2022-2023 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:** Community Mental Health Centers (CMHCs)  
**Population 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

For services call: (707) 565-6900

**FY 2022-2023 PROGRAM STATISTICS**

- **Total number of unique clients served: 298**

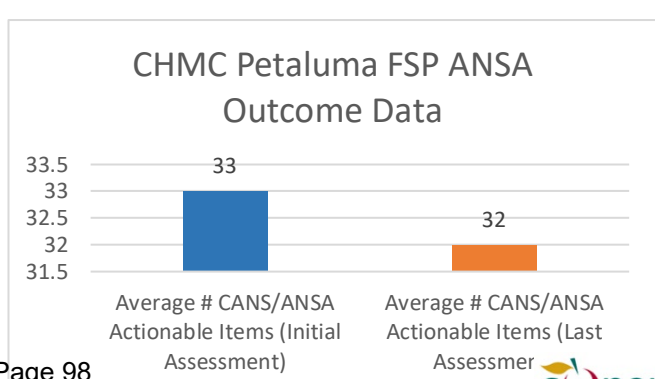
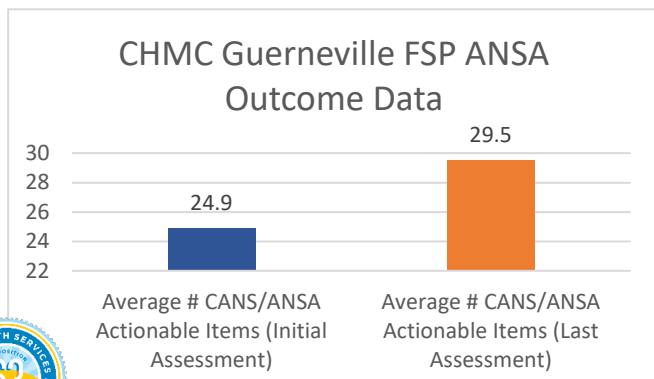
**PROGRAM DESCRIPTION:**

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:

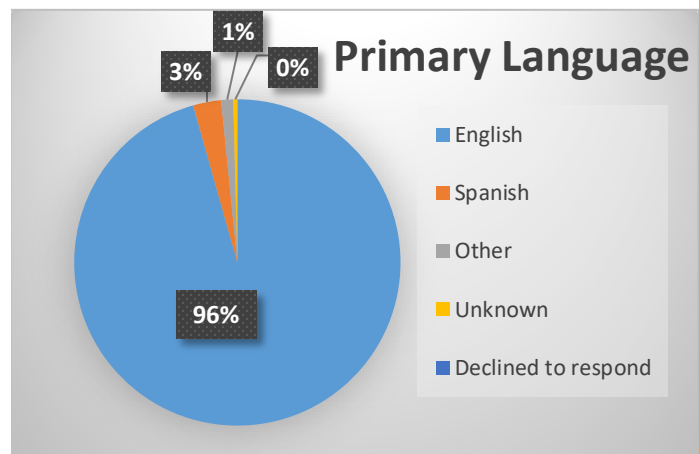
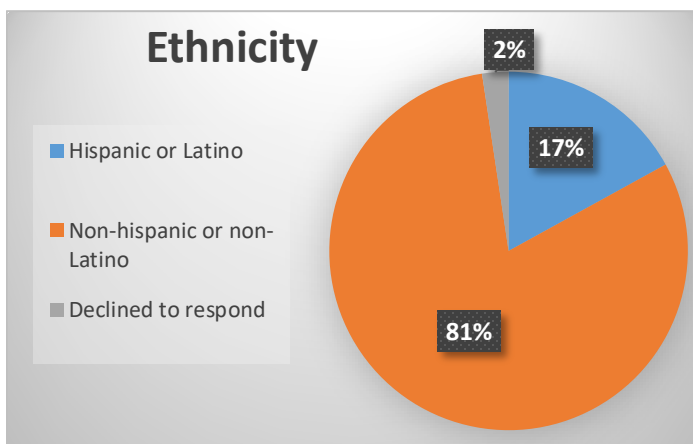
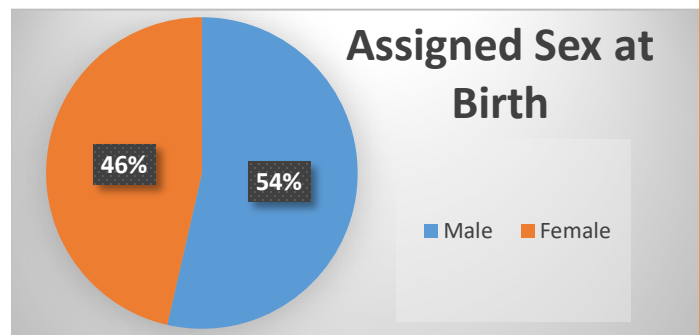
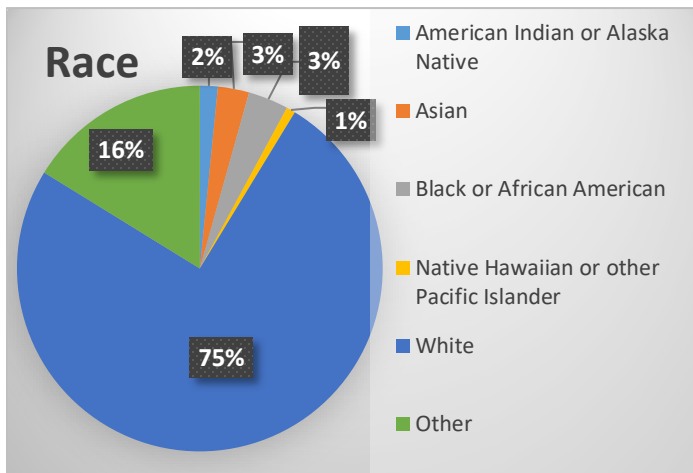
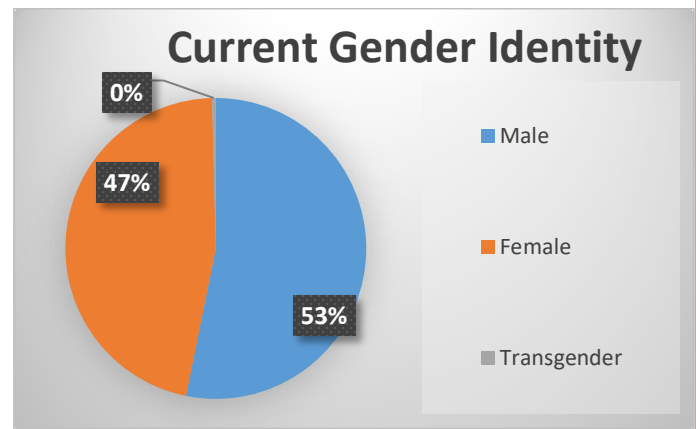
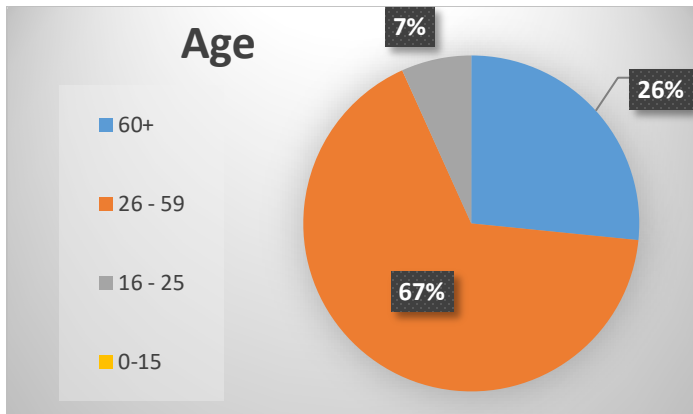
- Guerneville
- Cloverdale
- Petaluma
- Sonoma

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:**



# FY 2022-2023 Program Demographics:





## Council on Aging Senior Peer Support

CONNECTION IS PREVENTION

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](http://councilonaging.com)  
**Phone:** (707) 525-0143 x119  
**Program location:** Home Visits & 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 them “matches” over a 12-week session to offer emotional support, guidance and empathy.

### PERFORMANCE OUTCOMES:

Over the last two quarters, we faced significant challenges as we lost two Licensed Clinical Supervisors, which affected our ability to provide consistent support to our clients. To mitigate this, we partnered with an independent contractor who stepped in to meet with our volunteers. This partnership allowed us to maintain service continuity for our current clients during this transitional period. A month ago, we were pleased to welcome a new Licensed Clinical Social Worker (LCSW) to our team. Since then, our LCSW has initiated Senior Peer Support services with our volunteers, ensuring that we continue to meet the needs of our clients. Our data indicates that females and individuals aged 70-79 are the most in need of Senior Peer Support services. Furthermore, a significant number of our clients are living with disabilities, underscoring the importance of our support programs in enhancing their well-being and quality of life. We are committed to addressing these needs and are confident that, with our new LCSW and dedicated volunteers, we will continue to provide essential services to our senior community.

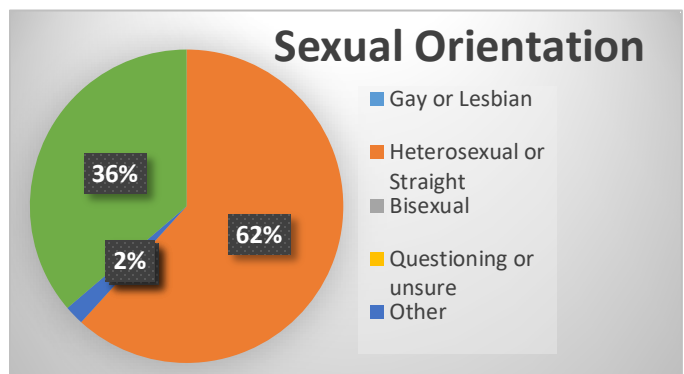
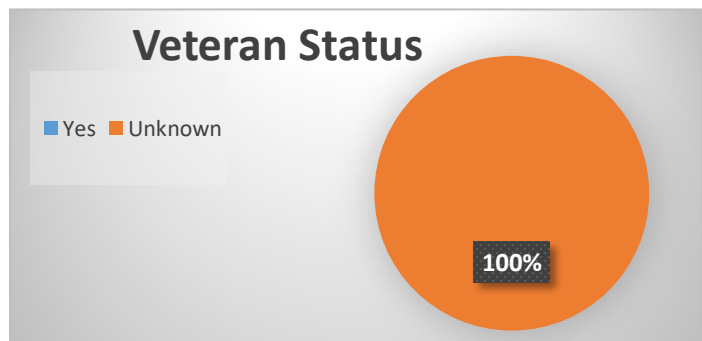
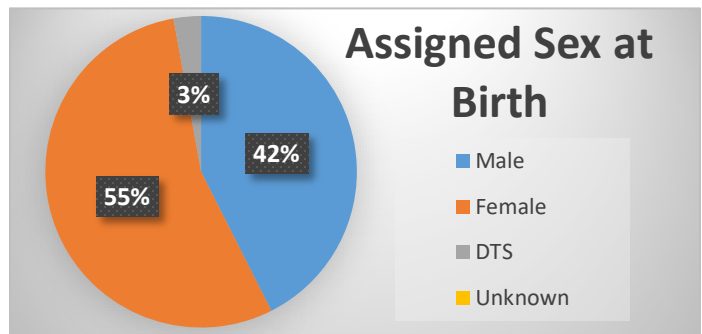
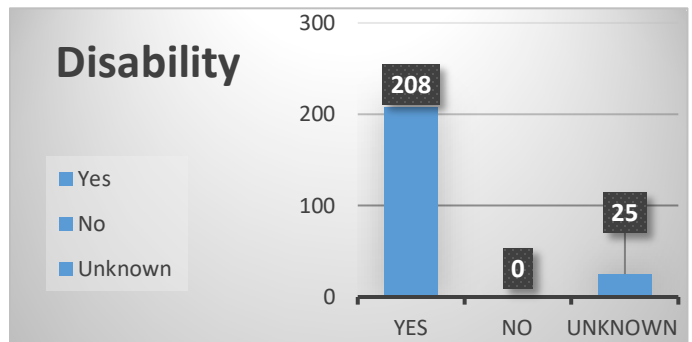
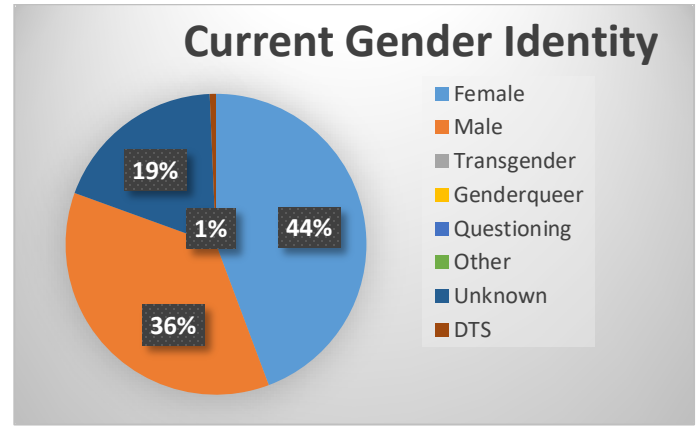
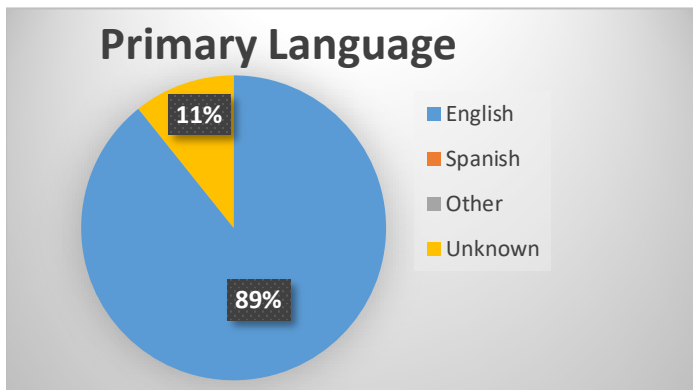
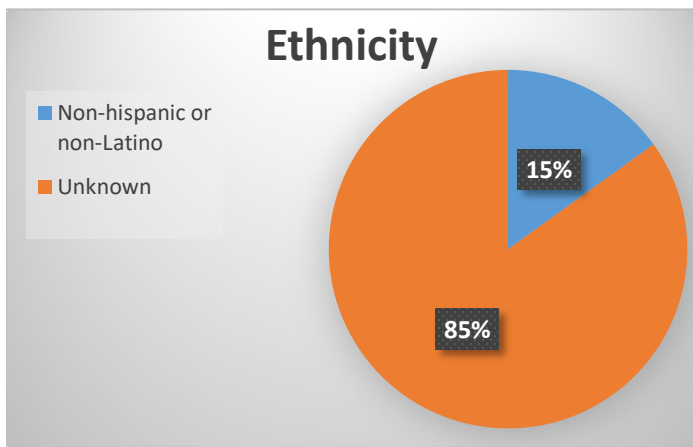
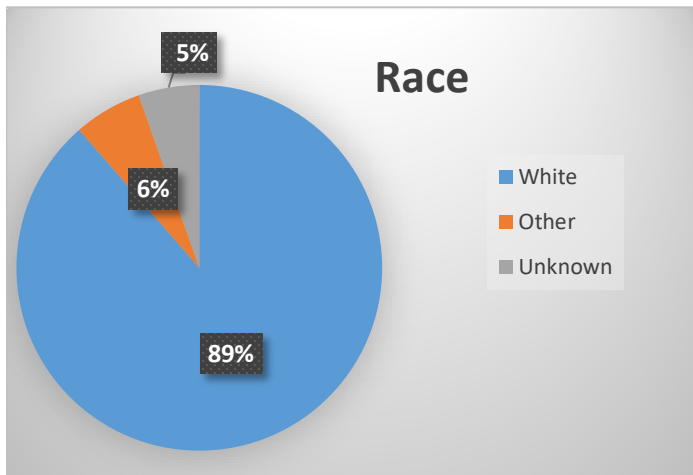
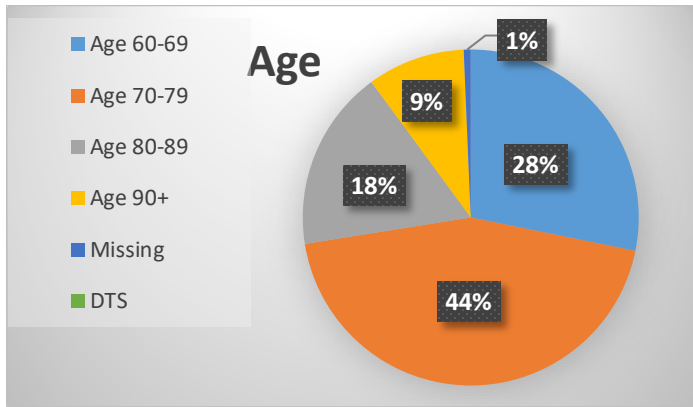
### FY 2022-2023

### PROGRAM STATISTICS

- **Total number of clients served: 173**
- **Total number of encounters: 149**
- **Approximate numbers reached through outreach: 250**



# FY 2022-2023 Program Demographics:





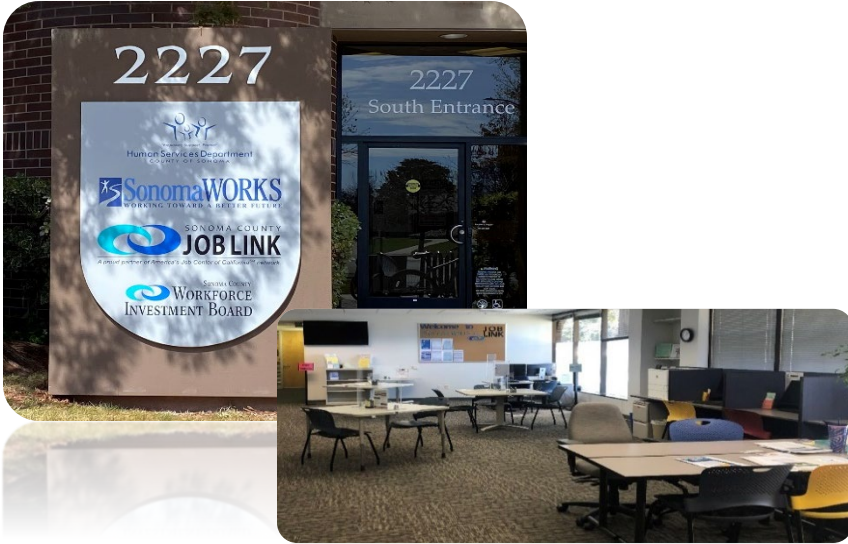
A proud partner of America's Job Center of California<sup>SM</sup> network.

# Sonoma County Job Link Program



FY 2022-2023 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:** Sonoma County Job Link  
**Population served:** Adults, Youth, and Employers in Sonoma County  
**Website:** [www.joblinksonoma.org](http://www.joblinksonoma.org)  
**Phone:** (707) 565-5550  
**Program location:** 2227 Capricorn Way, Ste 100 Santa Rosa, CA 95407  
**Social Media:**  
 Facebook: [@SonomaCountyJobLink](https://www.facebook.com/SonomaCountyJobLink)  
 Twitter: [@JobLinkSonoma](https://twitter.com/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.

### PERFORMANCE OUTCOMES:

During fiscal year 2022-2023, Job Link provided essential job search services to a wide range of job seekers in Sonoma County. Job Link had 1,159 customers who visited the One-Stop in person during that 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, 323 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 saw 10 individuals receive Job Link services.

Some of these individuals found employment and gained job readiness skills.

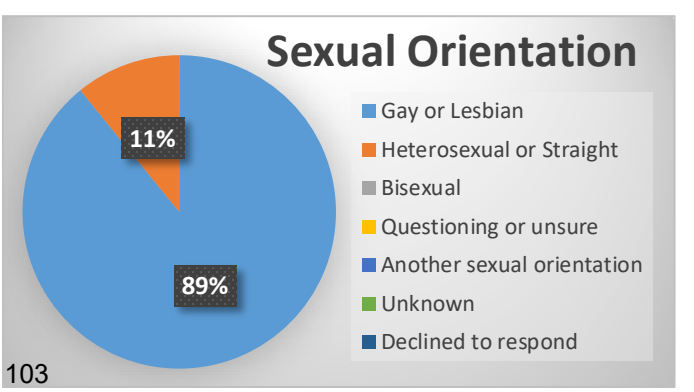
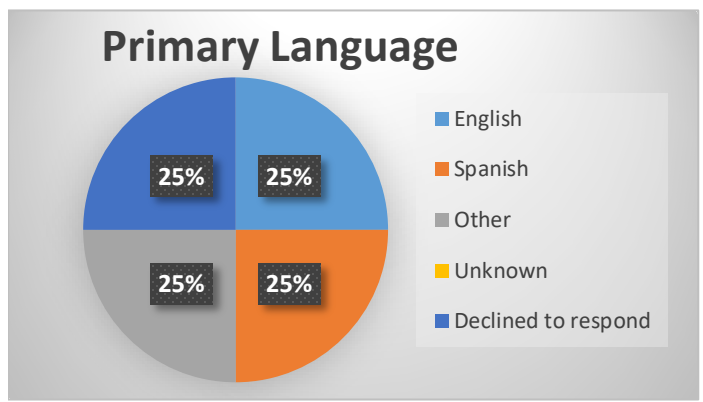
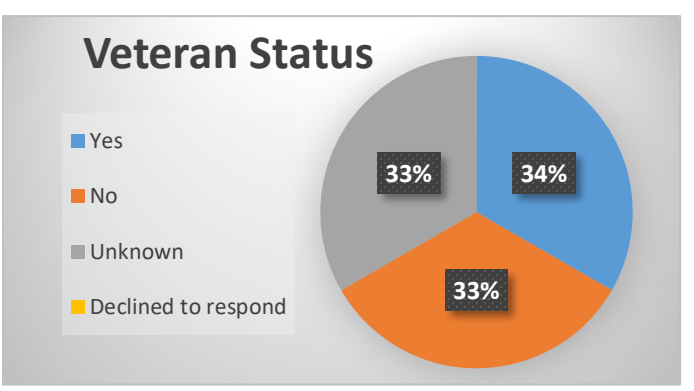
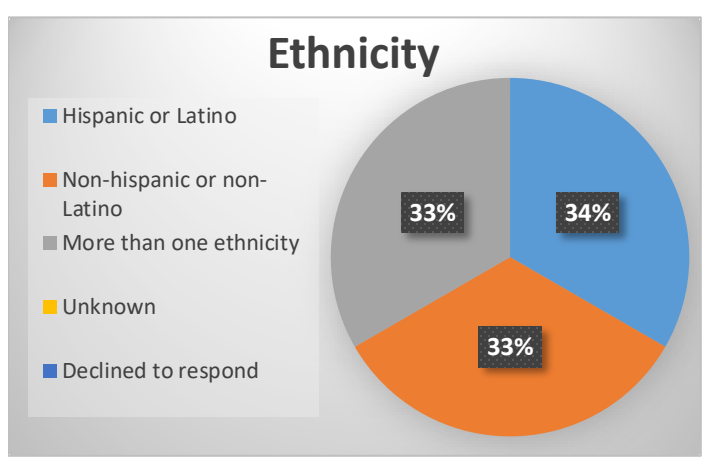
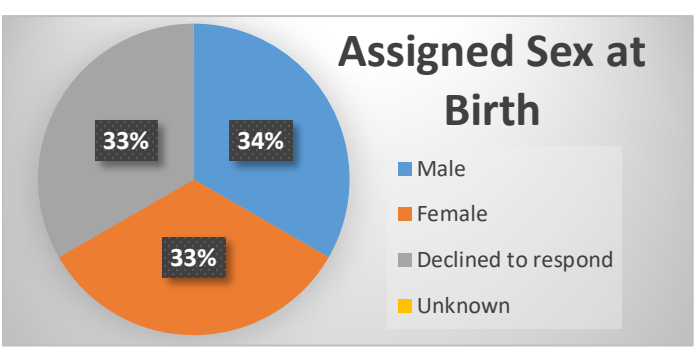
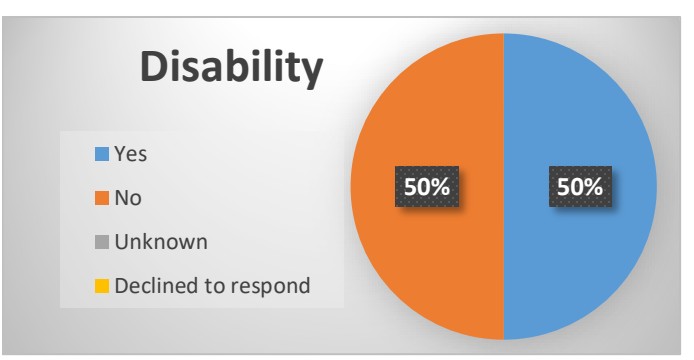
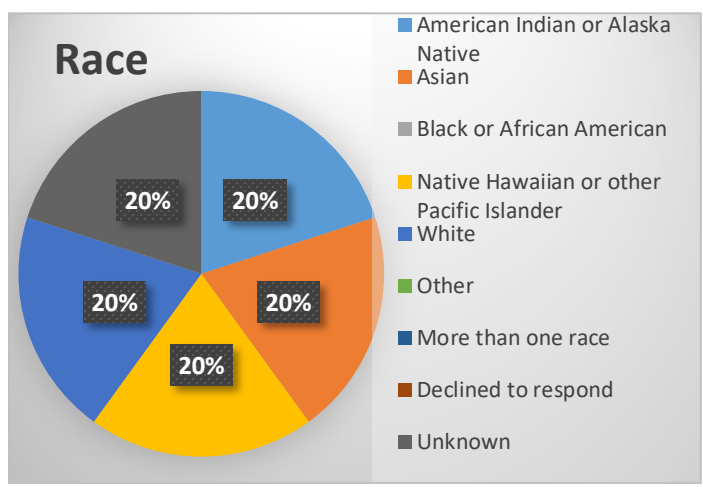
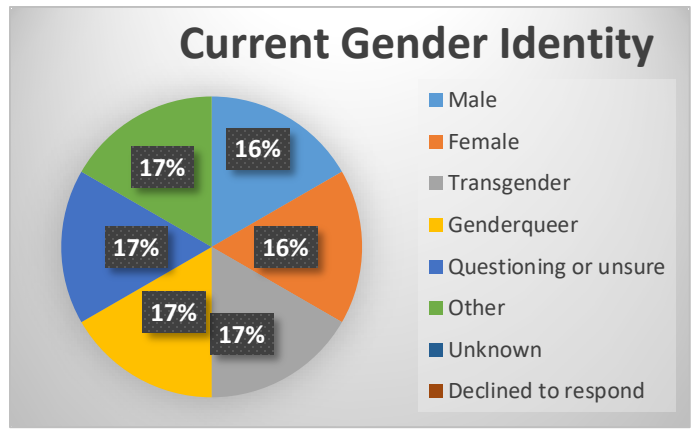
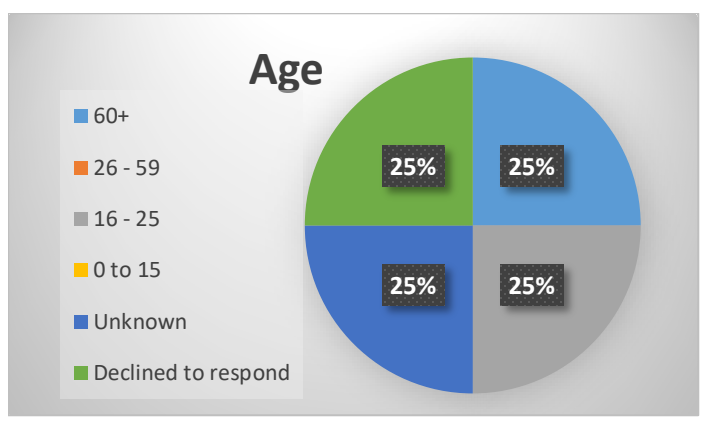
### FY 2022-2023 PROGRAM STATISTICS

- **Total number of clients served:** 12
- **Total number of encounters:** 48
- **Approximate numbers reached through outreach:** 679





## FY 2022-2023 Program Demographics:





## WCCS- Senior Peer Counseling



FY 2022-2023 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:** Senior Peer Counseling

**Population served:** Seniors 55+ in Sonoma County

**Website:** [www.westcountyservices.org](http://www.westcountyservices.org)

**Phone:** (707) 823-1640

**Program location:** 16390 Main Street  
Guerneville, CA 95446

**Social Media:** N/A

### FY 2022-2023

### PROGRAM STATISTICS

- **Total number of clients served: 107**
- **Total number of encounters: 510**
- **Approximate numbers reached through outreach: 700**

### 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 coping 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.

### PERFORMANCE OUTCOMES:

Our Senior Peer Counseling Program (SPC) has 25 dedicated and talented Senior volunteer counselors. The services we provide are vital to the at-risk seniors in our community. SPC's are a link for those that are isolated and struggling with depression. The services are mutually beneficial for the community and the volunteers themselves. The group of volunteers have built a supportive and cohesive community with one another. They choose to give of their time in this heartfelt way that also provides them meaning, purpose, and connection.

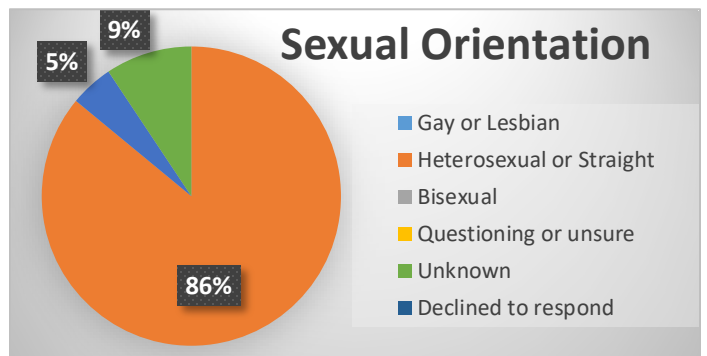
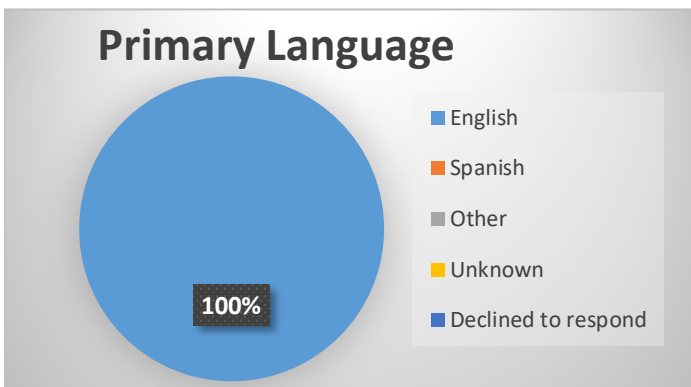
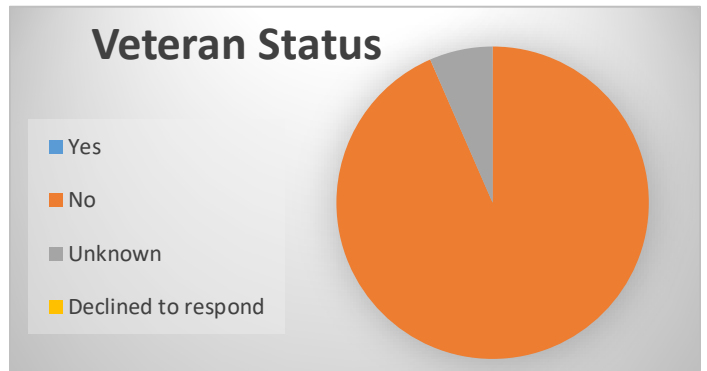
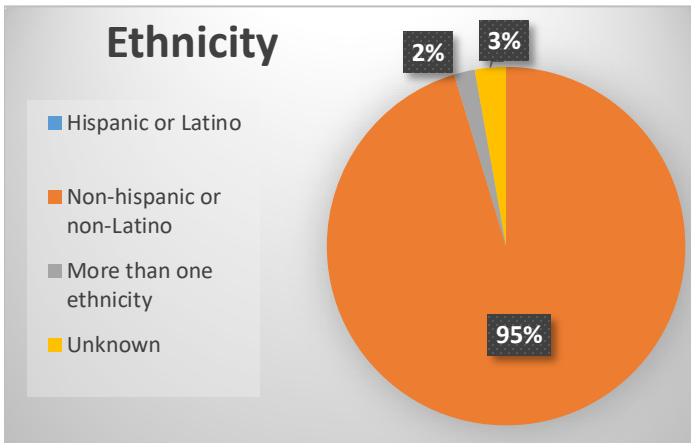
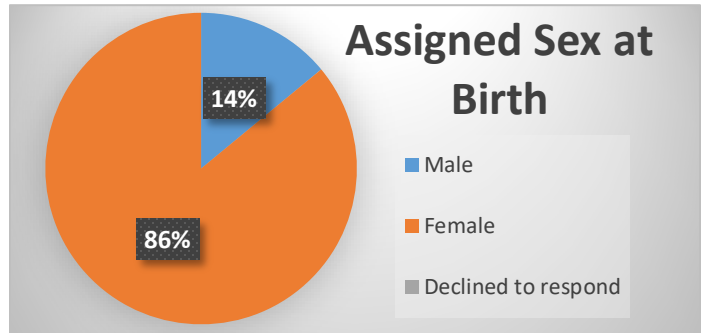
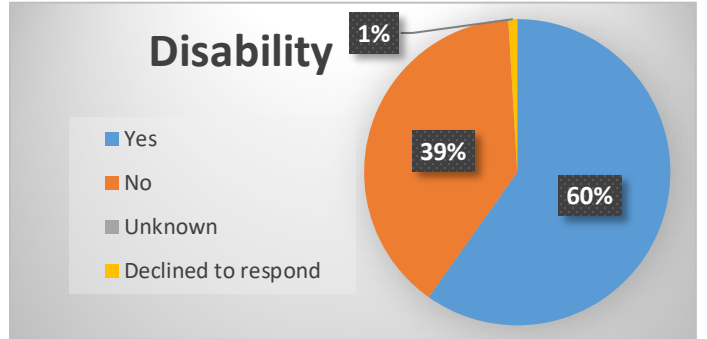
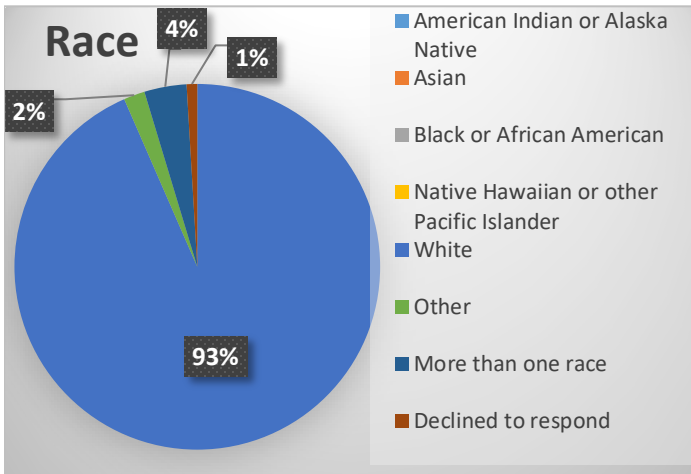
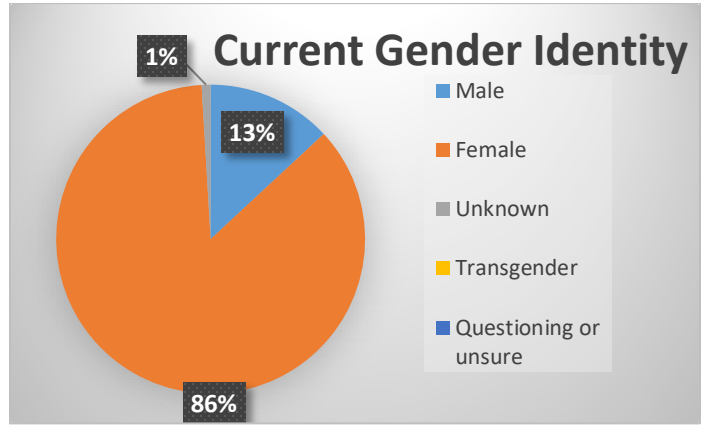
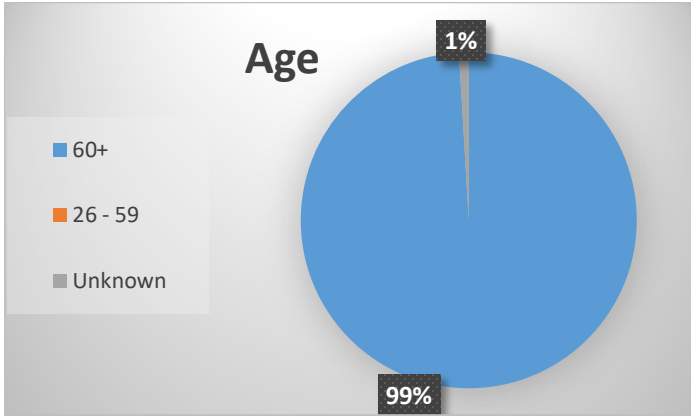
"Having a SPC my age was helpful as she understood my struggles and questions with health, aging, and finances. She really turned things around for me."

"My SPC was extremely supportive and encouraging. She was so compassionate of my issues. I felt like she really cared about me. I always felt supported even when she gently pushed me to try new things."

"I had no idea such a program was available and it's really valuable. Not only valuable for the clients, but for us as counselors. We are learning so much about ourselves through working with seniors — we are all navigating a lot of the same issues."



# FY 2022-2023 Program Demographics:





## WCCS Crisis Support

CONNECTION IS PREVENTION



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:** Crisis Support  
**Population served:** Adults and Families in Lower Russian River  
**Website:** [www.westcountyservices.org](http://www.westcountyservices.org)  
**Phone:** (707) 823-1640  
**Program location:** 16390 Main Street, Guerneville, CA 95446

### FY 2022-2023 PROGRAM STATISTICS

- **Total number of clients served: 65**
- **Total number of encounters: 151**
- **Approximate numbers reached through outreach:**

### PROGRAM DESCRIPTION:

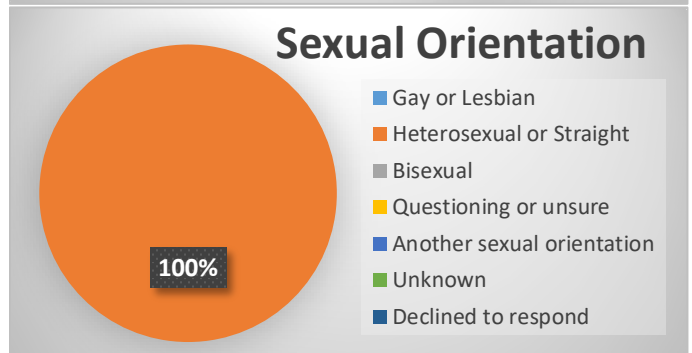
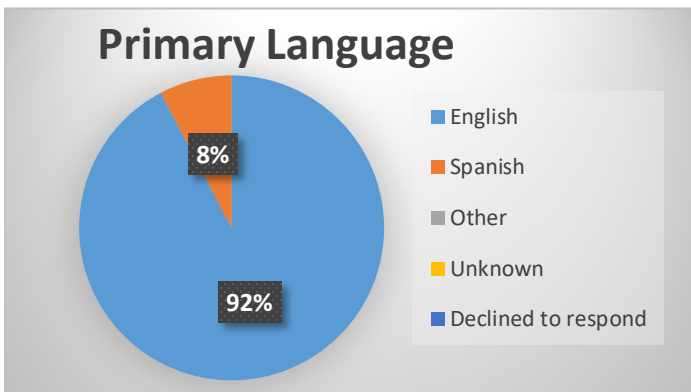
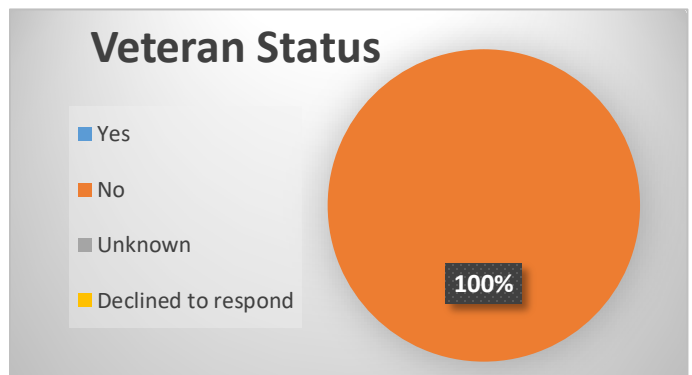
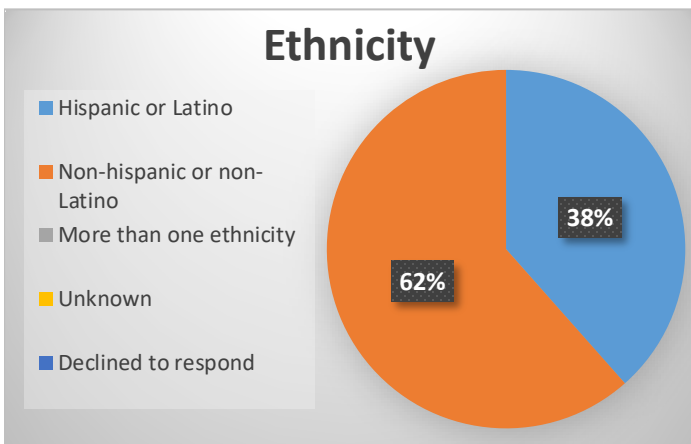
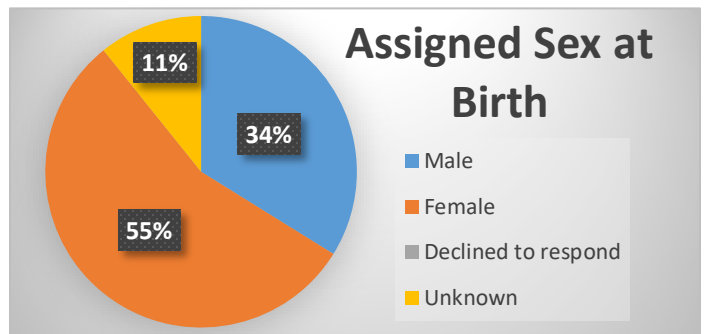
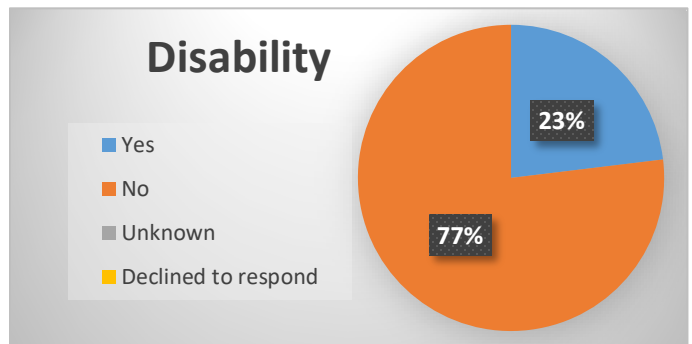
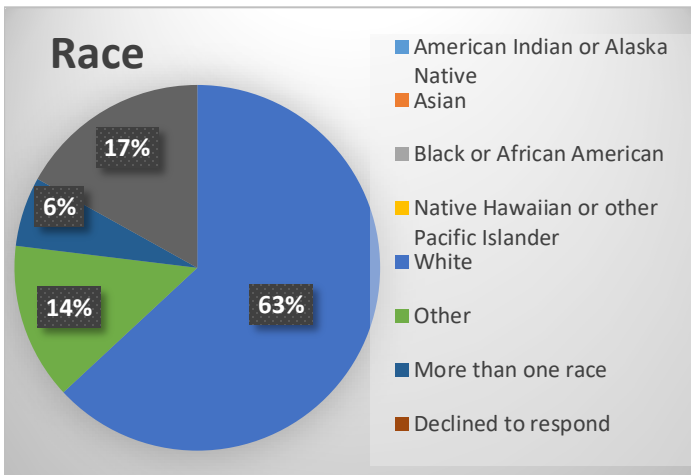
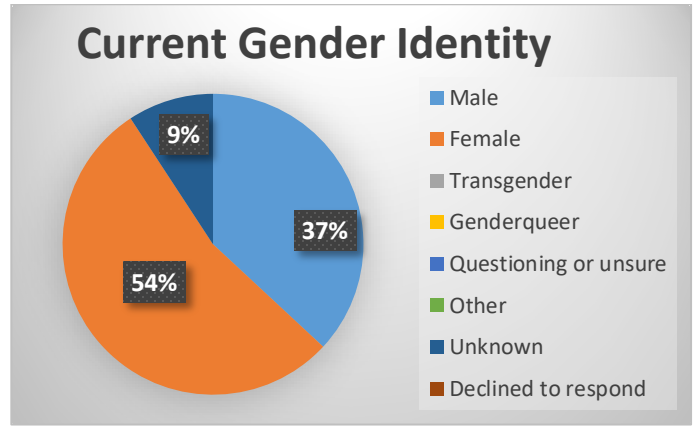
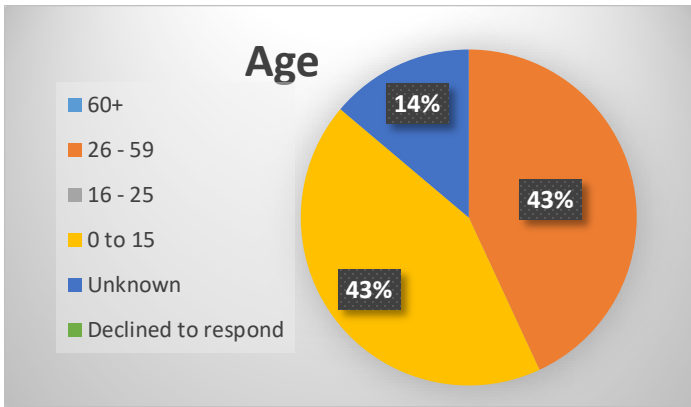
West County Community Services (WCCS) Crisis Support is offered through housing and resource counseling and resource referrals. Needs for individuals and families with children are assessed and prioritized. Immediate financial, food, clothing, and resource assistance are offered during meetings. Referrals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

### PERFORMANCE OUTCOMES:

Our agency is long standing and well known in our community. This year our Crisis Support Program met all the requests for services our clients ask of us. We form a kind and respectful partnership with our clients to meet their needs. Partnering our time with resources from other programs, we are able to provide our clients with valuable and essential basic needs.

We helped a single parent, family of 4 get into housing. Another family was on the waiting list for housing for 7 years. With our help in getting a deposit for this family, they were able to finally move into stable housing. A senior client secured housing for herself for the first time in 30 years with deposit help. We helped families secure clothing, shoes, car seats, and food. A senior was able to get her car repaired. We've given Christmas gifts to 32 families. We are a big heart, listening ear and Love in Action in our community.

# FY 2022-2023 Program Demographics:





# WCCS Russian River Empowerment Center



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:** Russian River Empowerment Center

**Population served:** Adults facing mental and/or behavioral health challenges

**Website:** [www.westcountyservices.org](http://www.westcountyservices.org)

**Phone:** (707)-823-1640 X207

**Program location:** 9925 Main St. Monte Rio CA 95462

**Social Media:** <http://www.facebook.com/THE.RREC>

### PROGRAM DESCRIPTION:

The Empowerment Center is a peer operated, self-help center sponsored by WCCS for people with chronic behavioral health challenges.

Our activities, classes, and groups are provided by our trained Peer staff who identify as having lived experience with mental health struggles.

We share what we have learned during our own individual journeys to support each other in strengthening our mental health.

### PERFORMANCE OUTCOMES:

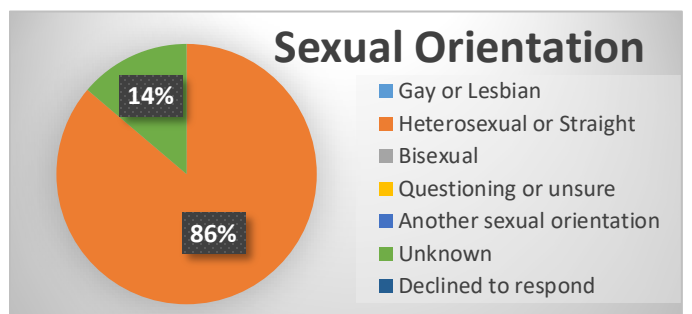
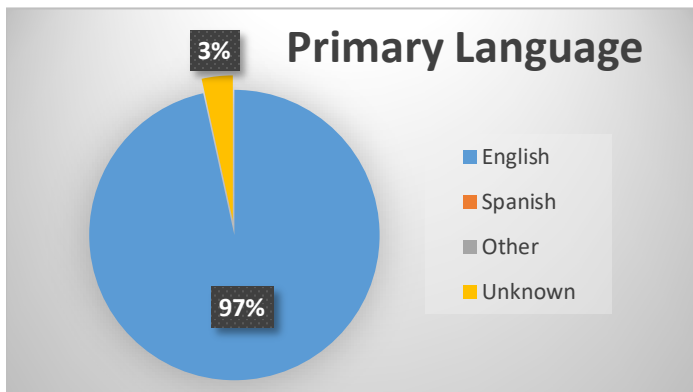
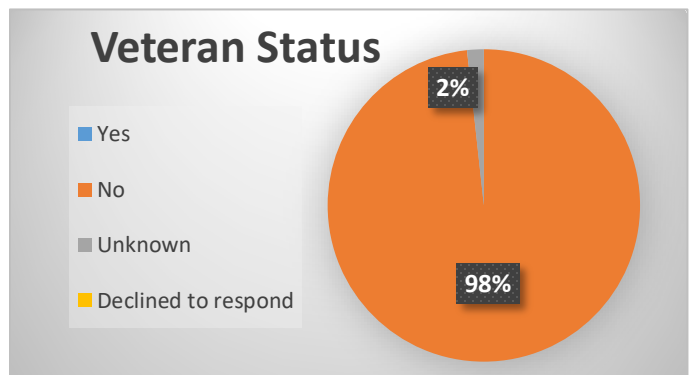
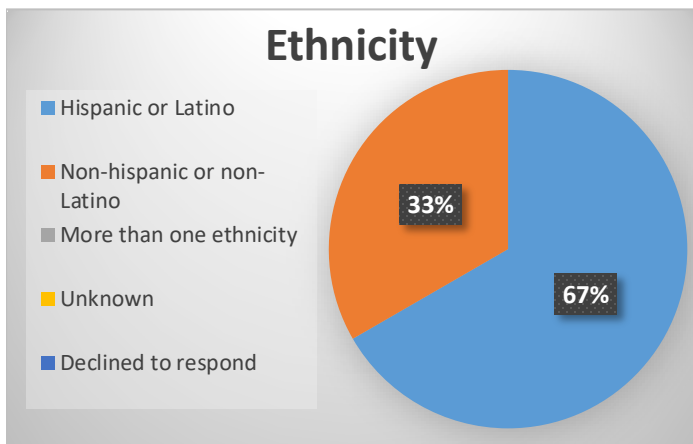
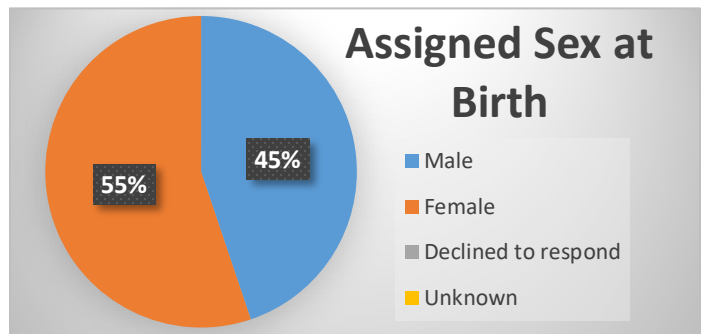
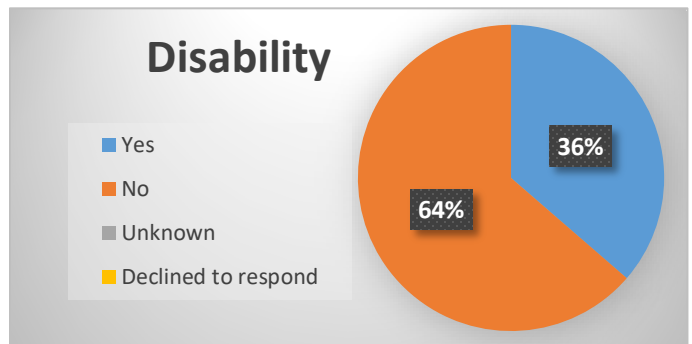
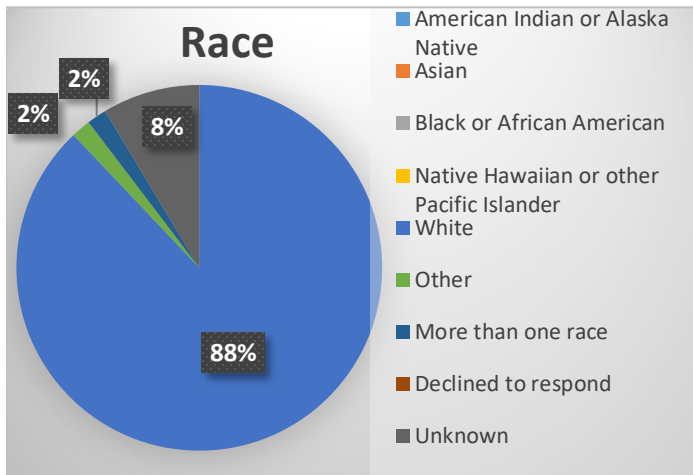
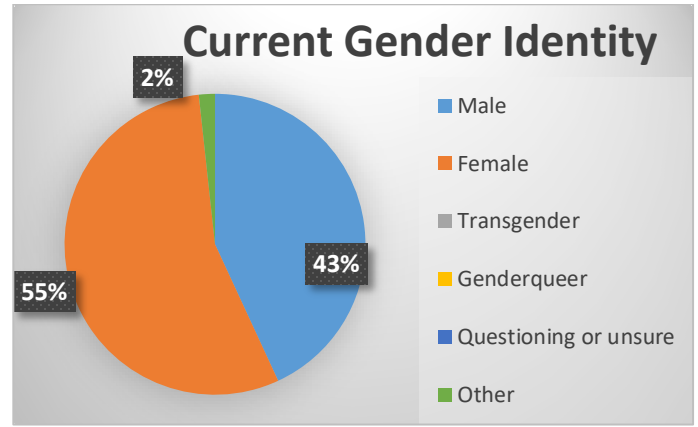
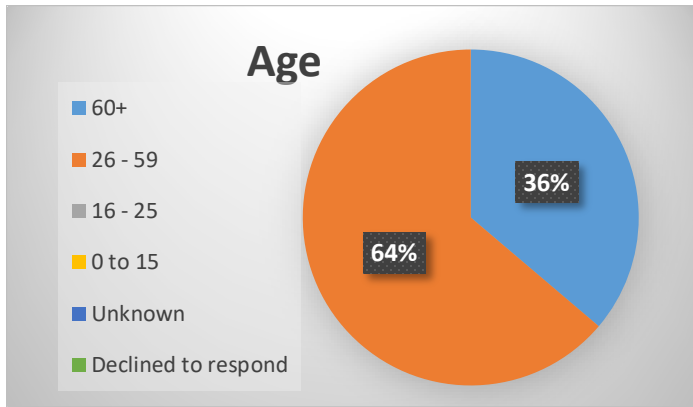
The Empowerment Center facilitates groups activities and workshops that provide opportunities to learn and build skills in particular areas of mental wellness. The Empowerment Center also provides a shuttle serviced and a warmline that offers support and resource information. It has been reported by members that participating in our offerings has assisted them with their mental health recovery and has also created an environment to interact with other members.

### FY 2022-2023 PROGRAM STATISTICS

- **Total number of clients served:** 58
- **Total number of encounters:** 880
- **Approximate numbers reached through outreach:** 830



## FY 2022-2023 Program Demographics:





# WCCS Petaluma Peer Recovery Center

CONNECTION IS  
PREVENTION



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:** Petaluma Peer Recovery Center (PPRC)

**Population served:**

Adults facing their mental and/or behavioral health challenges in the Petaluma area

**Website:** [westcountyservices.org](http://westcountyservices.org)  
[petalumapr.wordpress.com](http://petalumapr.wordpress.com)

**Phone:** (707) 565-1299

**Program location:** 5350 Old Redwood Highway; Suite 600, Petaluma, CA



**PROGRAM DESCRIPTION:** The Petaluma Peer Recovery Center (PPRC) is a peer run and managed program dedicated to empowering local adults with mental and/or behavioral health challenges through peer support and education. We provide a number of opportunities for connection including one-to-one and group support, monthly forums, socialization activities and help with resource navigation. We have instruments and art and craft supplies for group and individual creative pursuits. We offer in person support onsite and virtual support via Zoom as well as warmline services during our open hours on Mondays, Wednesdays and Thursdays.

### FY 2022-2023

### PROGRAM STATISTICS

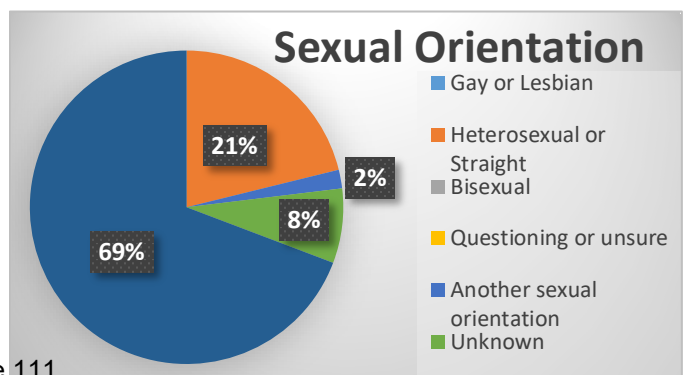
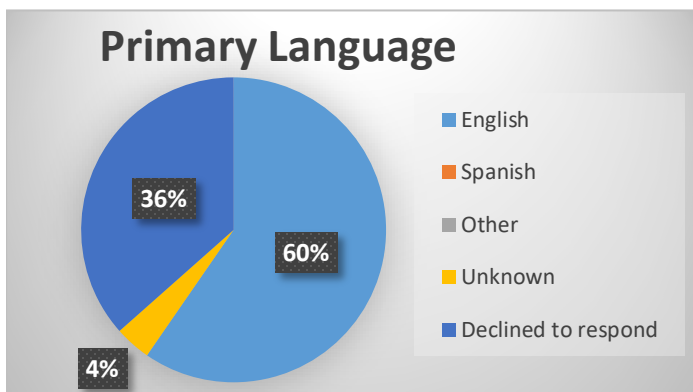
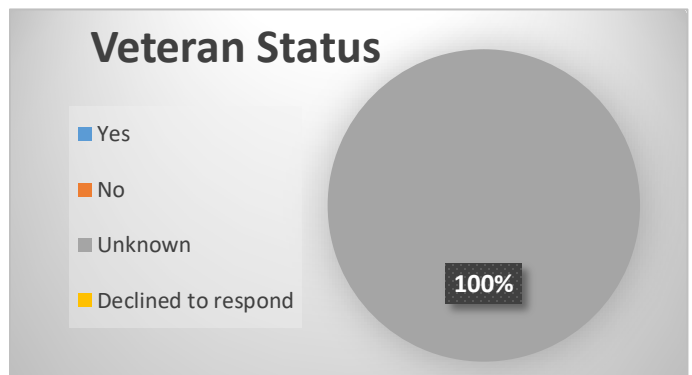
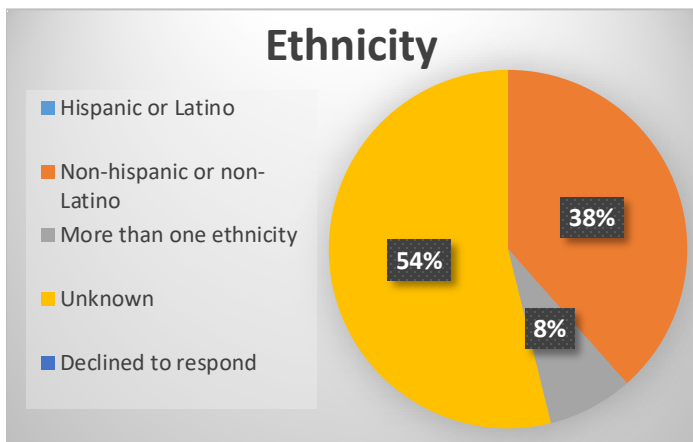
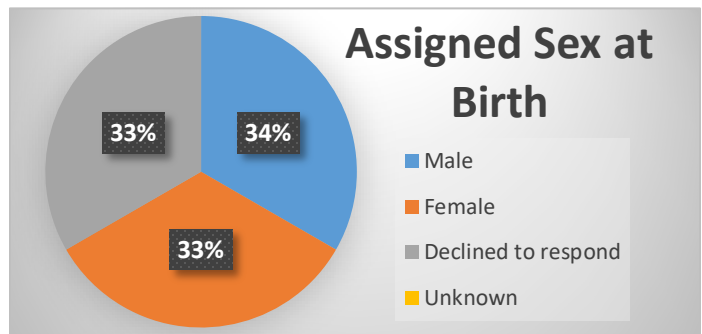
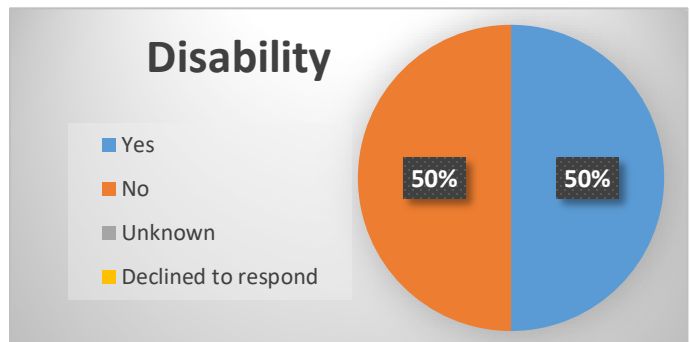
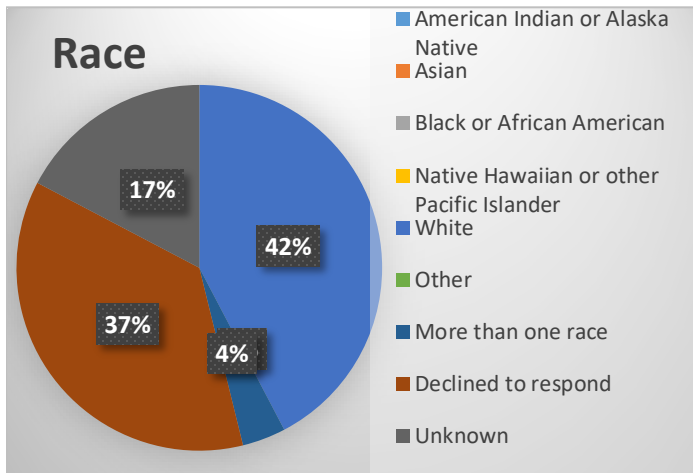
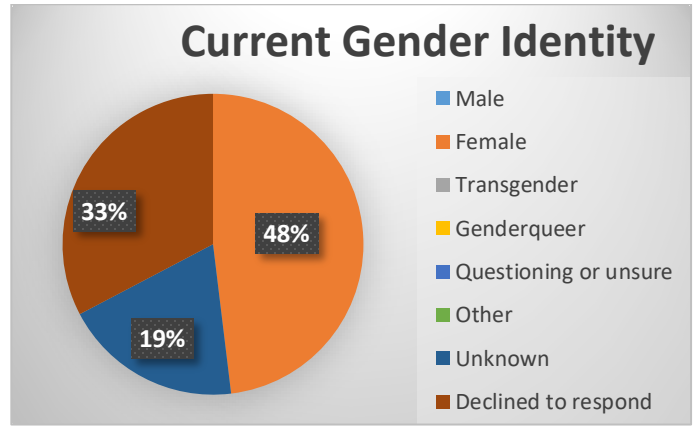
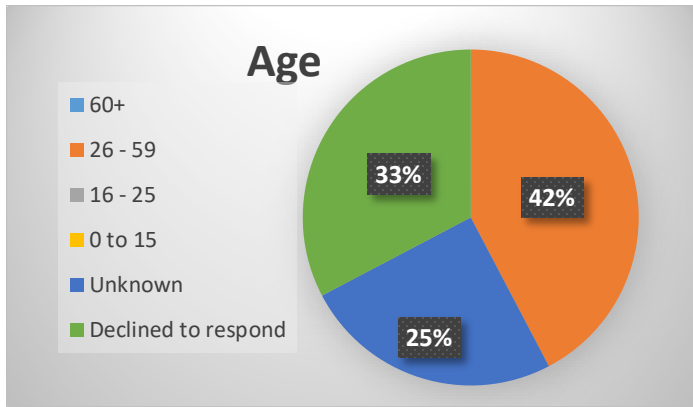
- **Total number of clients served:** 52
- **Total number of encounters:** 1801
- **Approximate numbers reached through outreach:** 820

**PERFORMANCE OUTCOMES:** Performance Measures included: Outreach Goal: 25 participants reached through Outreach – Actual: averaged 46 per month (22 emails and 24 warmline calls). Socialization Activities Goal: 25 Activities w/average of 2 participants – Actual: averaged 19 per month with 2 participants. We also provided an average of 25 one to one peer support sessions per month. We are grateful to have connected with the Studios at Montero now open in the neighborhood. We have been supporting Healthy Petaluma’s CHIPA workgroup and the Blue Zones Petaluma Project. Participant feedback included: "This is a good place to feel safe." "I appreciate how I can be honest here." "I don 't feel alone and I know that others have similar challenges." "I feel grateful to be able to gather with others with similar mental health challenges in community." "I feel happy that I can talk about anything." "This is a wonderful place." "PPRC is a godsend." "PPRC helps me feel like I am not alone." and I feel comfortable and in the environment here."





## FY 2022-2023 Program Demographics:



## DHS-BHD

# Medication Support Services for Adult Programs

**CONNECTION IS  
PREVENTION**



FY 2022-2023 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:** 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:**  
For services call: (707) 565-6900

### FY 2022-2023 PROGRAM STATISTICS

- **Total number of unique clients served: 252**

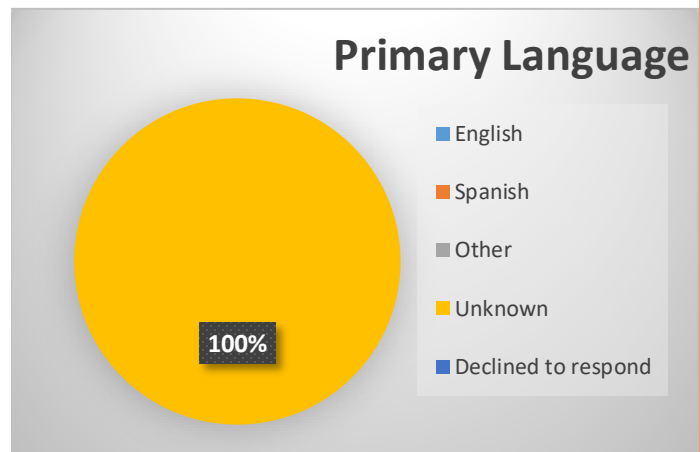
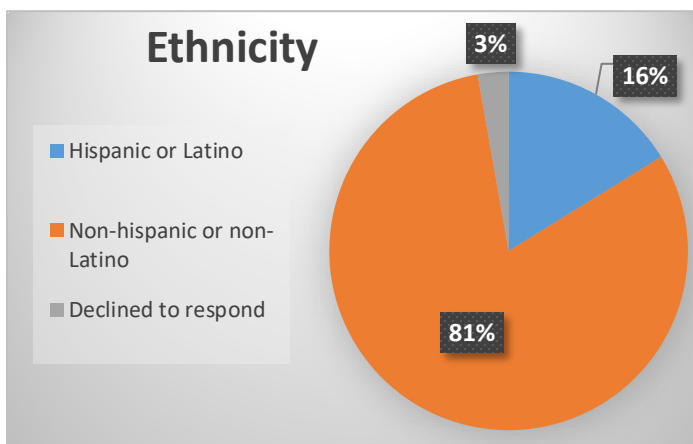
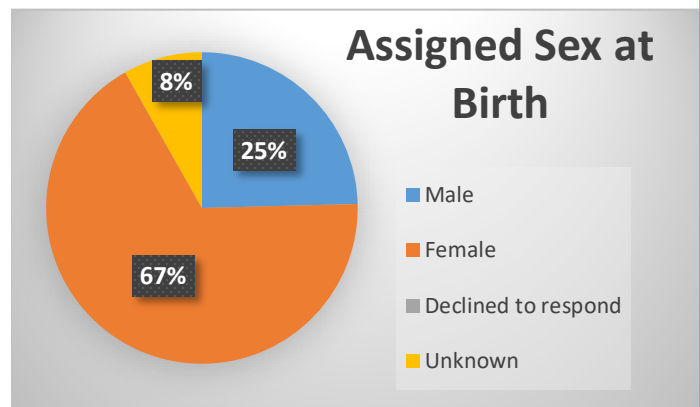
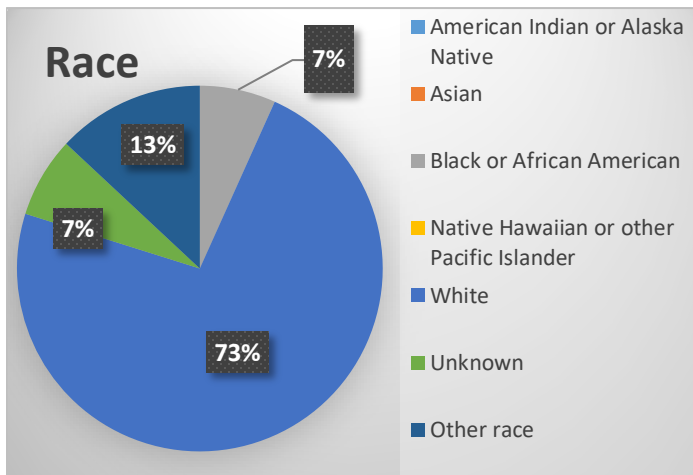
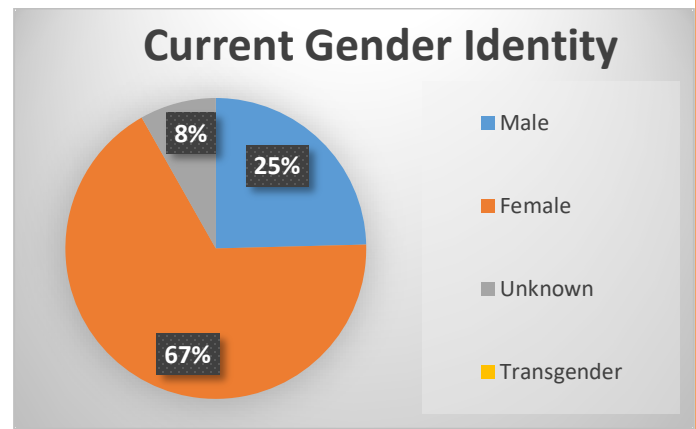
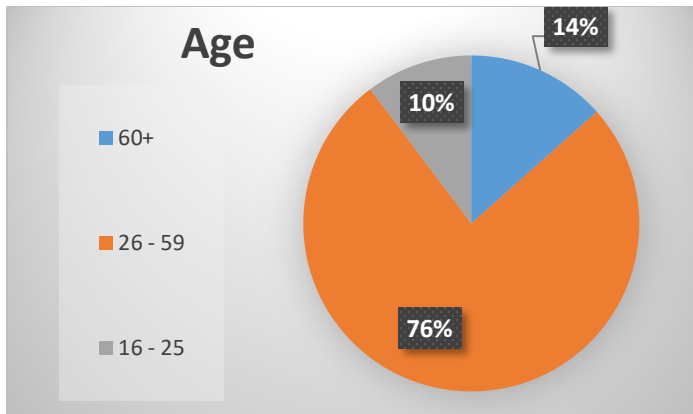
### PROGRAM DESCRIPTION:

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:



# FY 2022-2023 Program Demographics:



# DHS-BHD Medication Support Services for Youth Programs



FY 2022-2023 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:** 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:

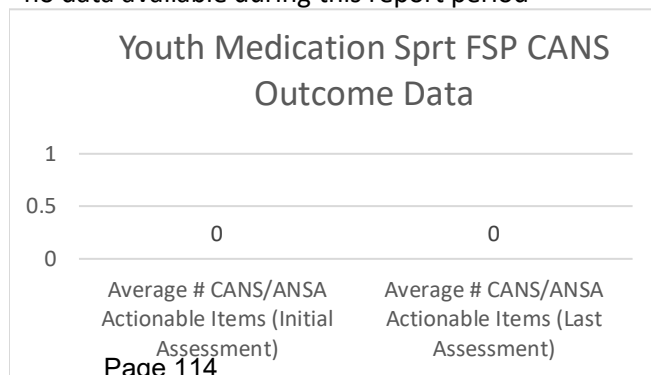
The Youth Medication Support Service (Youth Med Support) is a separate outpatient program which provides psychiatric and medication services to Sonoma County youth who meet Medi-Cal guidelines for Target Population. Clients are referred to Med Support from the SCBH Access team, after a thorough assessment 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.

### FY 2022-2023 PROGRAM STATISTICS

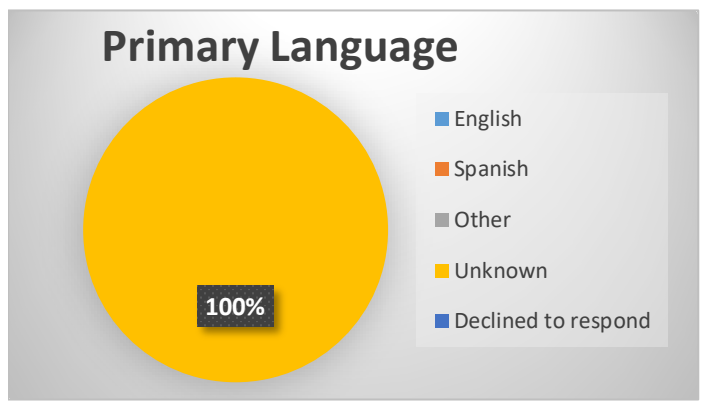
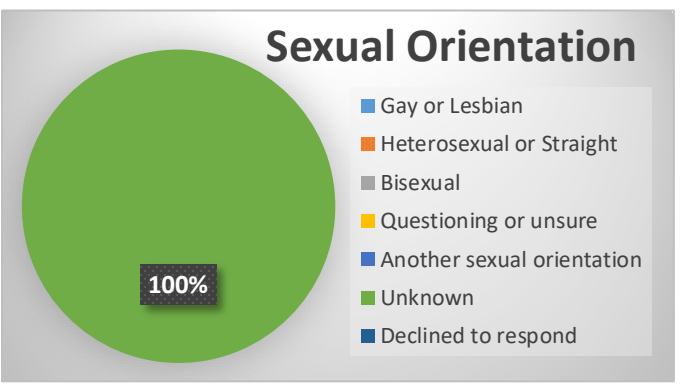
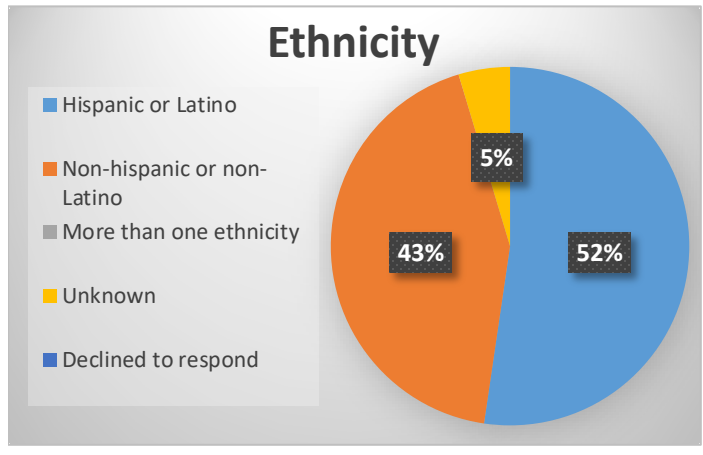
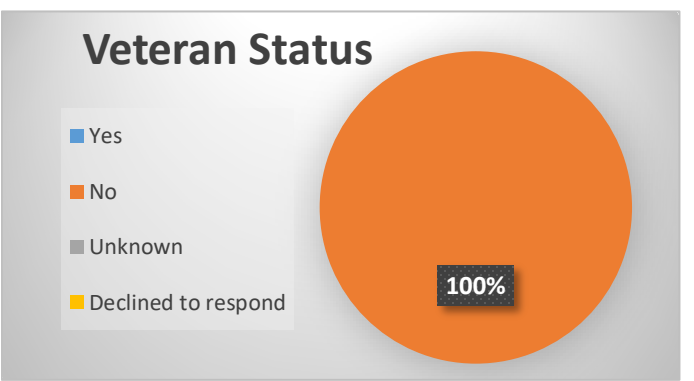
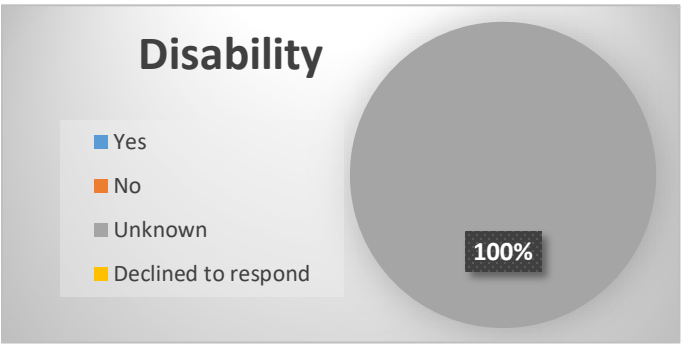
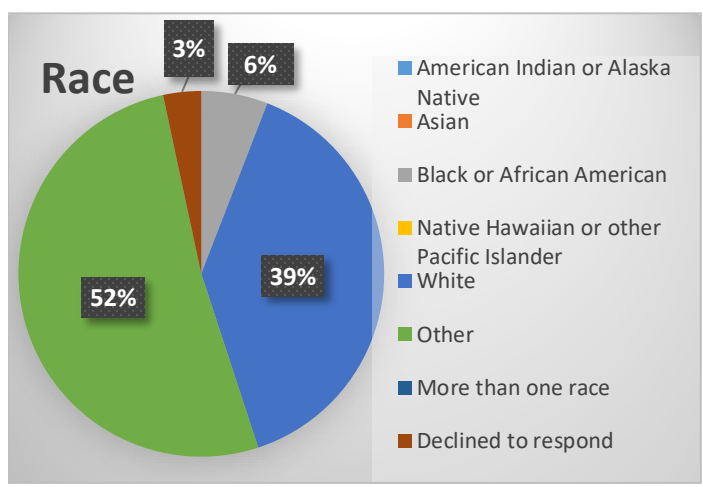
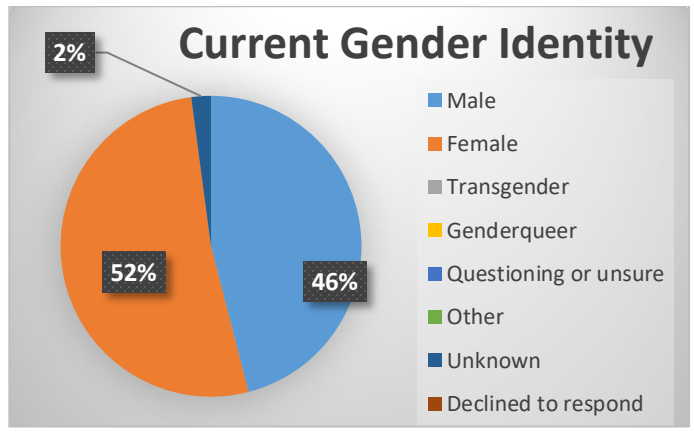
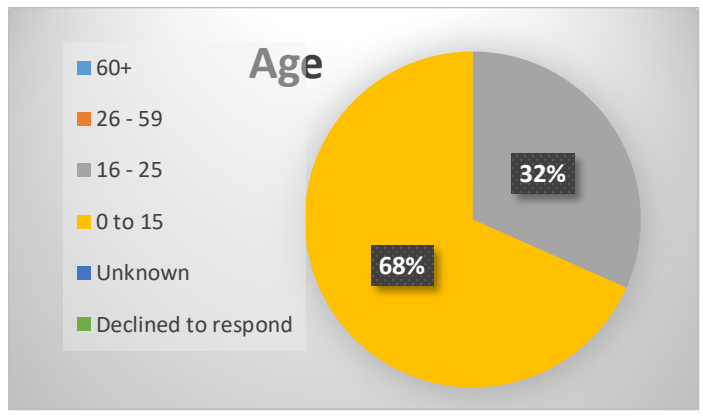
- **Total number of clients served: 237**

### PERFORMANCE OUTCOMES:

\*no data available during this report period



## FY 2022-2023 Program Demographics:





## Siyan Clinical Research



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:** The RAIN Project  
**Population served:** Adults age 18 and over who meet criteria, are current beneficiaries of Sonoma.  
**Website:** <https://siyanresearch.org>  
**Phone:** (707) 206-7268  
**Program location:**  
480 Tesconi Circle, Suite B, Santa Rosa, CA 95401

### FY 2022-2023 PROGRAM STATISTICS

- **Total number of clients served: 0**
- **Actual program will be starting in FY 23-24.**
- **No program demographics were available in FY 22-23.**

### PROGRAM DESCRIPTION:

Siyan Clinical Research, the non-profit division of Siyan Clinical Corporation, was created to fill service gaps in access to quality psychiatric care for vulnerable clients. As part of Siyan Clinical Research, the RAIN Project (Resources, Assessment, Intensive Case Management, Navigation) will deliver evidence-based therapeutic and rehabilitative mental health services to foster hope, recovery, and wellbeing for adults with Severe and Persistent Mental Illness (SPMI) in Sonoma County, who are not in need of the County’s Full Service Partnership (FSP) services. This program utilizes a culturally competent, multidisciplinary team approach with a commitment to “whatever it takes” via an integrated Recovery and Medical Model.

### PERFORMANCE OUTCOMES:

The goal of the RAIN project is to assist mental health consumers with serious and persistent mental illness to process clinical/therapeutic issues, develop new skills, or enhance current skills needed to improve their health and wellness, live a self-directed life, and strive to reach their full potential. Through this agreement, Contractor shall provide outpatient therapy, mental health rehabilitation services, targeted case management, and crisis intervention.

The program will start in FY 23-24 and services to be provided will be:

- Mental Health Services
- Crisis Intervention
- Targeted Case Management





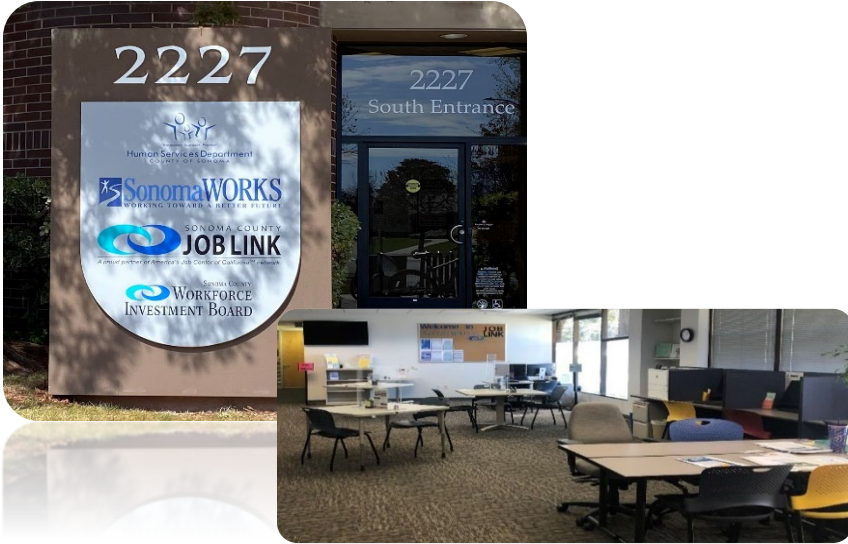
A proud partner of America's Job Center of California<sup>SM</sup> network.

# Sonoma County Job Link Program



FY 2022-2023 Service Category: i.e. Full Service Partnership Services, Outreach and Engagement Services or

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:**  
Sonoma County Job Link

**Population served:** Adults, Youth, and Employers in Sonoma County

**Website:** [www.joblinksonoma.org](http://www.joblinksonoma.org)

**Phone:** (707) 565-5550

**Program location:**  
2227 Capricorn Way, Ste 100  
Santa Rosa, CA 95407

**Social Media:**  
 [@SonomaCountyJobLink](https://www.facebook.com/SonomaCountyJobLink)  
 [@JobLinkSonoma](https://twitter.com/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.

### PERFORMANCE OUTCOMES:

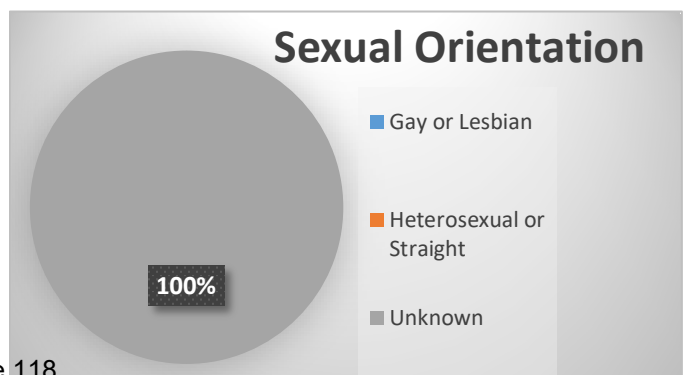
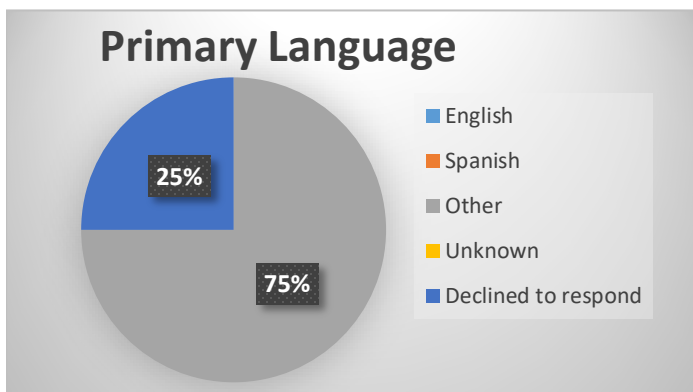
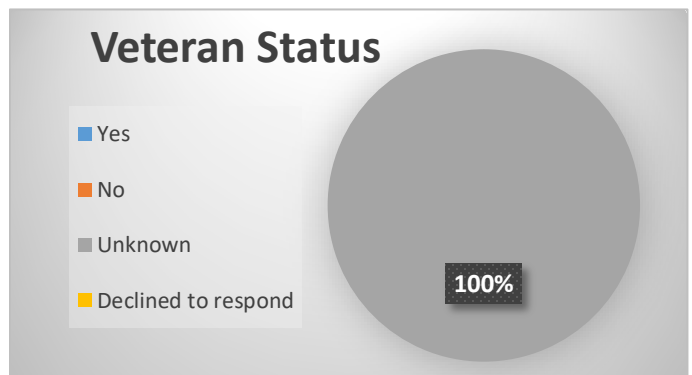
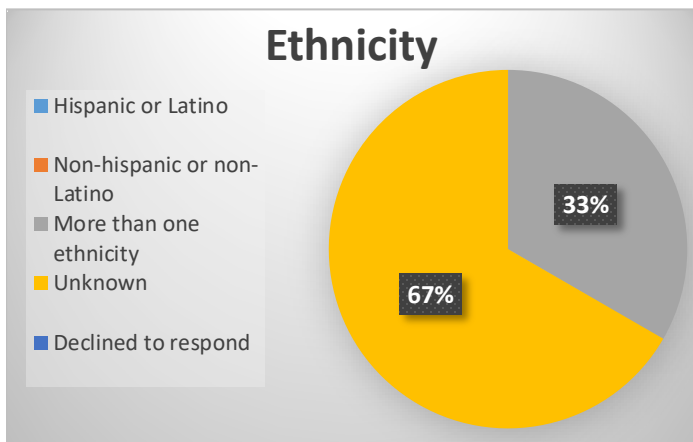
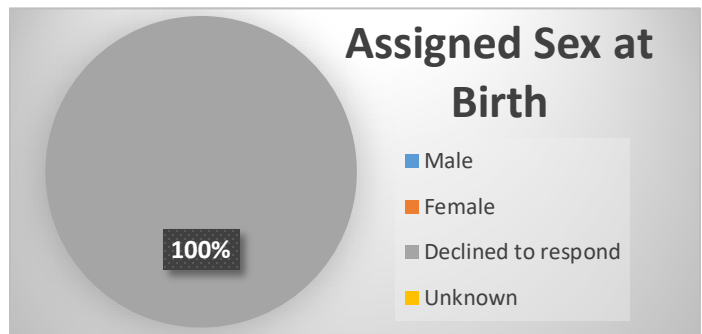
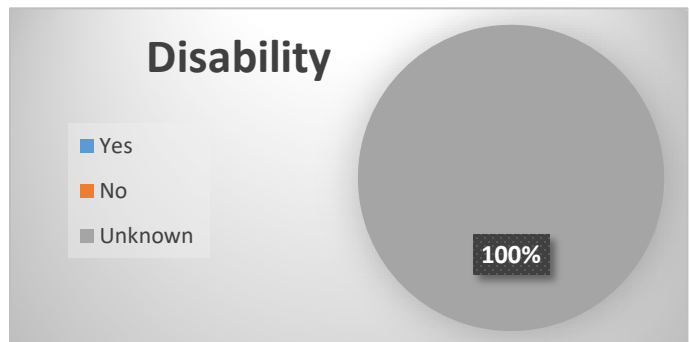
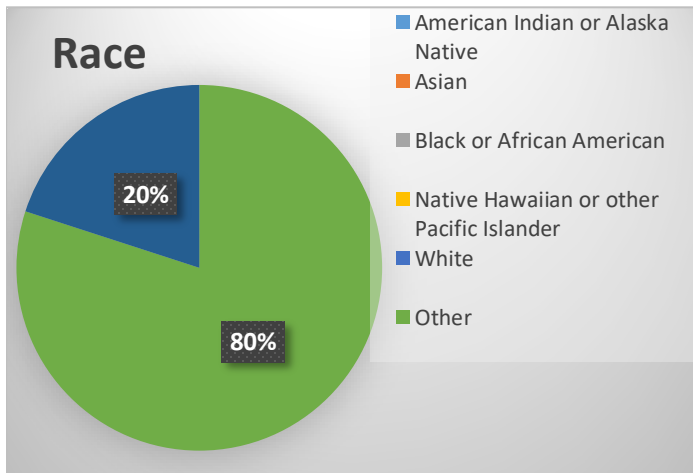
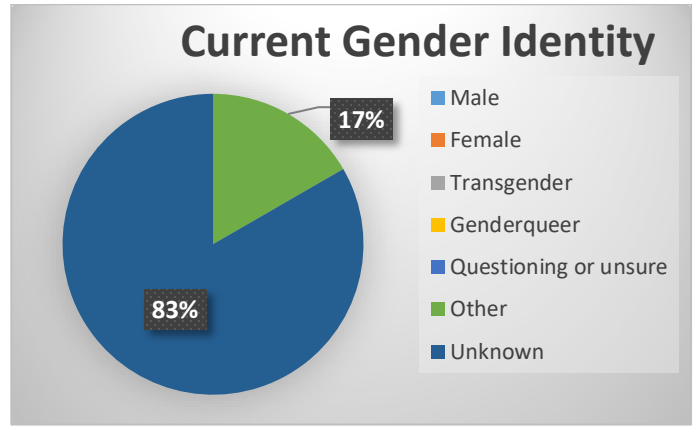
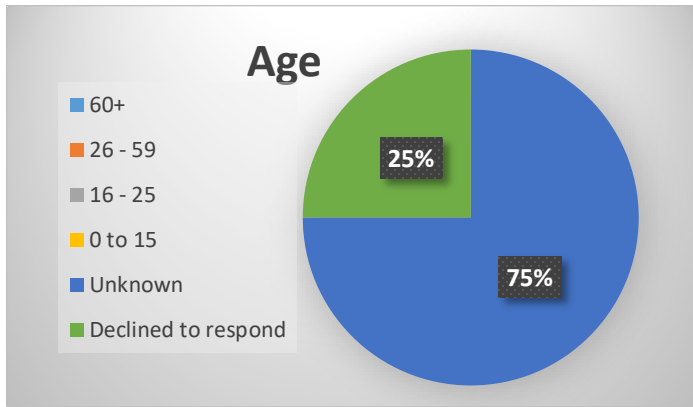
During fiscal year 2022-2023, Job Link provided essential job search services to a wide range of job seekers in Sonoma County. Job Link had 1,159 customers who visited the One-Stop in person during that fiscal year. The ability to once again offer in-person services allowed these visitors to access job 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, 323 participants were enrolled and received direct employment counseling and career services from Job Link counselors throughout the fiscal year. 83% of the Behavioral Health Division clients referred received Job Link services. Some of these individuals found employment, and gained job readiness skills.

### FY 2022-2023 PROGRAM STATISTICS

- **Total number of clients served:** 12
- **Total number of encounters:** 48
- **Approximate numbers reached through outreach:** 679



## FY 2022-2023 Program Demographics:







# Alternative Family Services (AFS)



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:** Alternative Family Services (AFS)  
**Population served:** Vulnerable youth, children, and families; age 0-21  
**Website:** [www.afs4kids.org](http://www.afs4kids.org)  
**Phone:** (707) 576-7700  
**Program location:** Sonoma County  
**Social Media:** (optional)

### FY 2022-2023 PROGRAM STATISTICS

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

AFS provides thoughtful and informed mental health services to vulnerable children and families. In June 2023, AFS partnered with MHSA to expand mental health services to reach more children and youth in need of support. Given the timeliness of this expansion, AFS did not receive referrals in the 22-23 FY, and is eager to provide services in the next fiscal year.

### PERFORMANCE OUTCOMES:

This program was in its early infancy in FY 2022-2023 and had not received referrals yet.



## 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.



## DHS-BHD's Whole Person Care (WPC)



FY 2022-2023 Service Category: Outreach and Engagement (OE)

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.

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

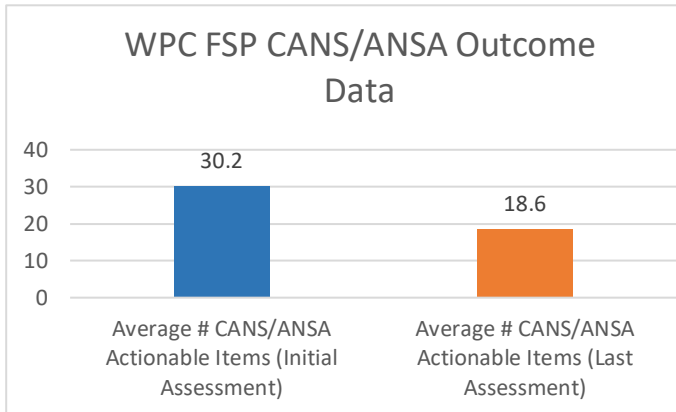
### PROGRAM INFORMATION

**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.

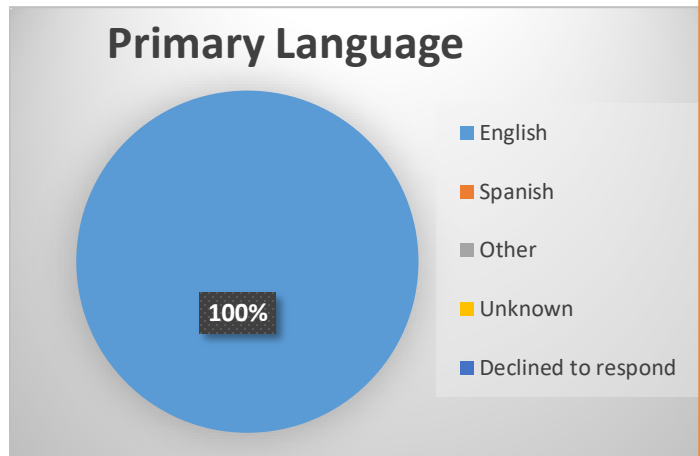
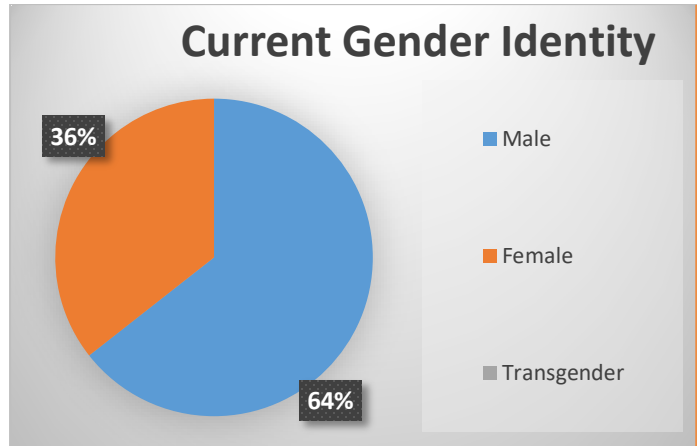
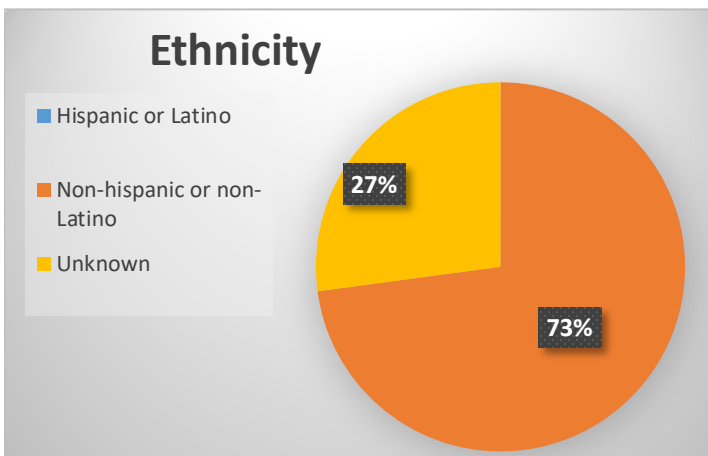
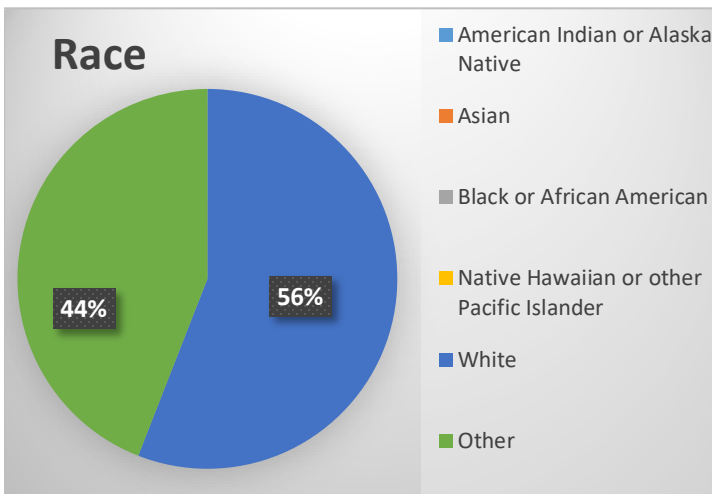
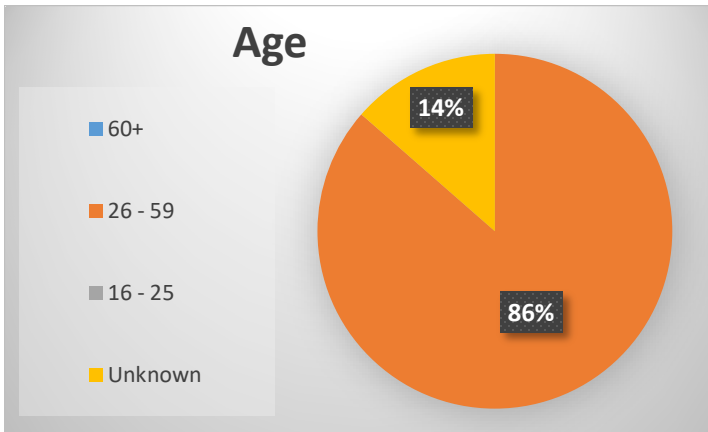
### FY 2022-2023 PROGRAM STATISTICS

- **Total number of unique clients served: 58**
- **Total number of encounters in FY 22-23: unknown**

### PERFORMANCE OUTCOMES:



## FY 2022-2023 Program Demographics:





# Sonoma County Indian Health Project, Inc.

## CONNECTION IS PREVENTION

FY 2022-2023 Service Category: i.e. Full Service Partnership Services, Outreach and Engagement Services or

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.



Art Therapy Activity with Teens and Kids

### PROGRAM INFORMATION

**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 (Facebook and Instagram)

### FY 2022-2023 PROGRAM STATISTICS

- **Total number of clients served:** 131
- **Total number of encounters:** 831
- **Approximate numbers reached through outreach:** N/A

### 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.

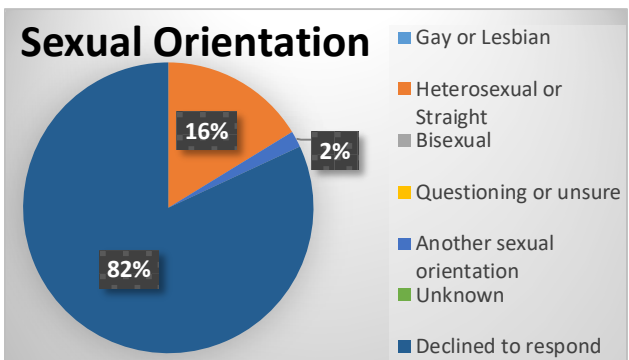
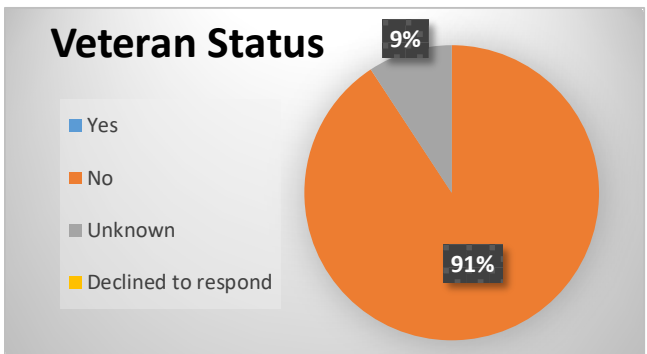
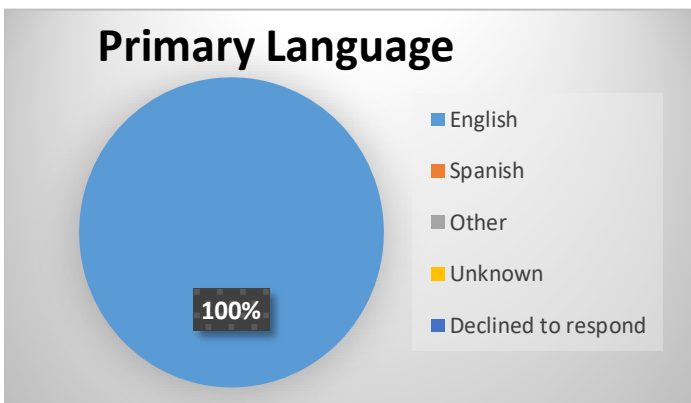
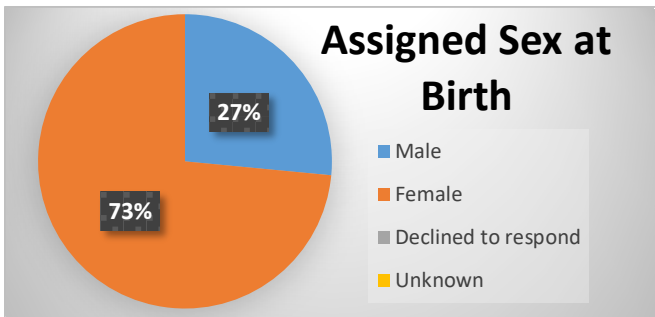
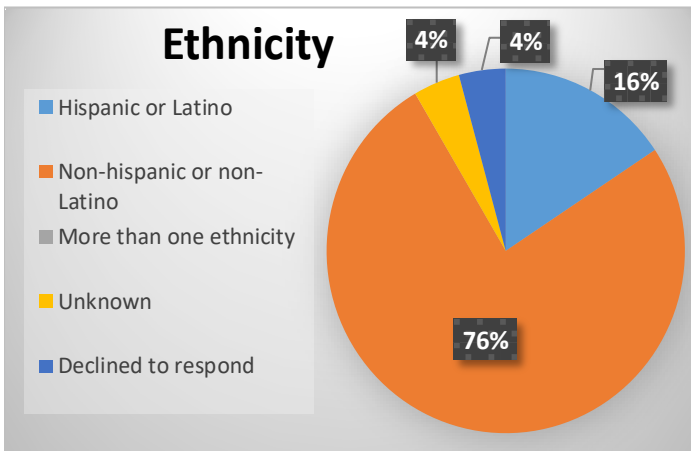
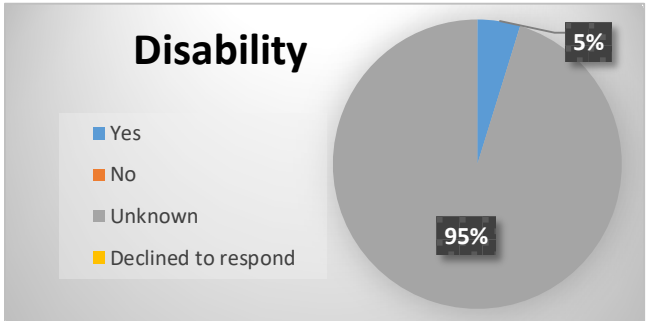
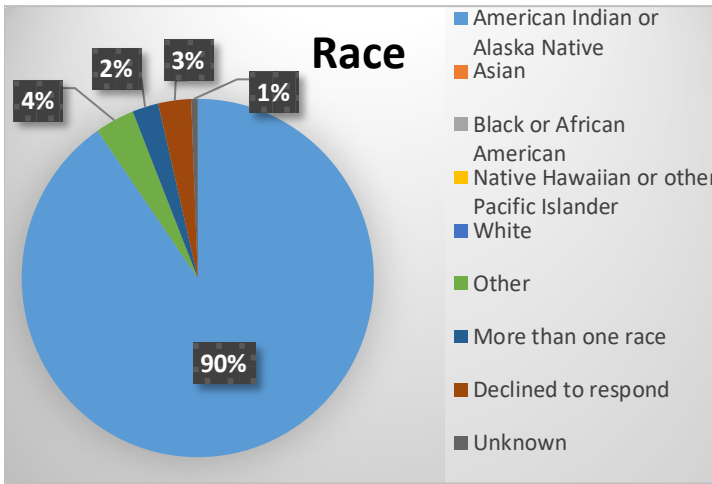
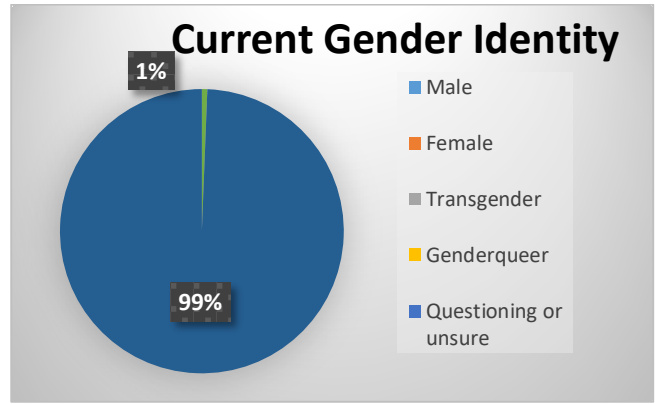
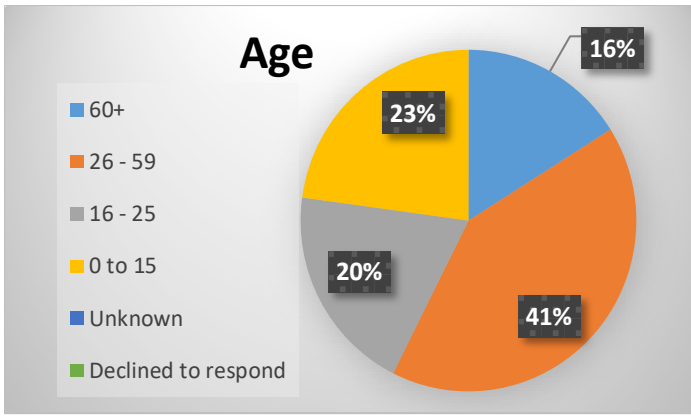
The Integrated Behavioral Health Provider identifies, treats, triages, and manages the care of individuals identified in the primary care department with a behavioral health need. This provider is also available for warm handoffs from primary care providers, on a same day basis, for brief problem-focused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

### PERFORMANCE OUTCOMES:

SCIHP's Integrated Behavioral Health Provider reports that 100 % of the clients continue to increase their ability to engage in positive coping strategies and manage symptoms related to their referral for services. Multiple clients have been successfully discharged from services due to meeting their goals. During a closing session one client stated that therapy has helped them feel more self-confident and independent.

Due to the increased need, this provider has added additional 30minute timeslots for short-term solution-based individual services. This has allowed us to increase the number of clients seen through our integration model. With these added timeslots we have seen a decrease in the number of clients on our waitlist and an increase in the number of appropriate referrals for long-term individual services through a more robust triage/assessment model.





**CONNECTION IS  
PREVENTION**



**SONOMA COUNTY MHSA ANNUAL  
PREVENTION & EARLY INTERVENTION (PEI)  
PROGRAM REPORT**

**FY 2022 - 2023**



# SONOMA COUNTY MHSA ANNUAL PROGRAM REPORT FY 2022 – 2023

## 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 pages 16-29 of the Sonoma MHSA Annual Plan Update 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 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.





## Action Network



FY 2022-2023 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 INFORMATION

**Program Name:** Name  
**Population served:** 0-65, underserved populations in NW Sonoma County  
**Website:** www.actionnetwork.net  
**Phone:** (707) 882-1691  
**Program location:** Northwest rural Sonoma County  
**Social Media:** IG @thecenter\_actionnetwork

### FY 2022-2023 PROGRAM STATISTICS

- **Total number of clients served:** 229
- **Total number of encounters:** 773
- **Approximate numbers reached through outreach:** 2000

### PROGRAM DESCRIPTION:

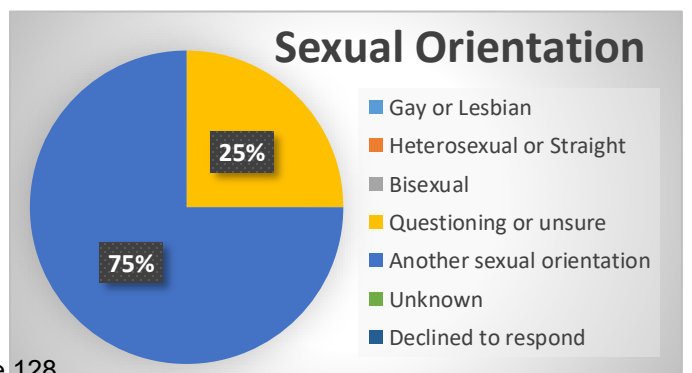
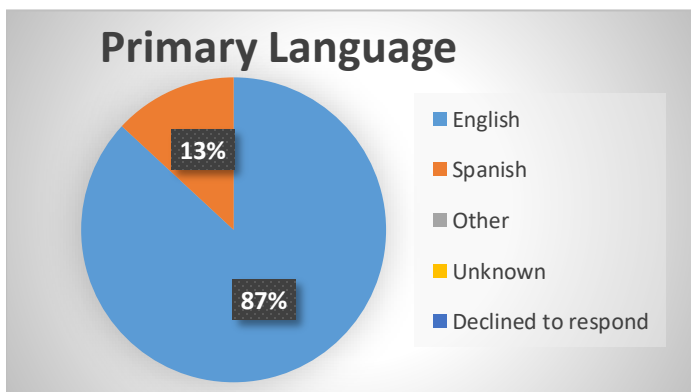
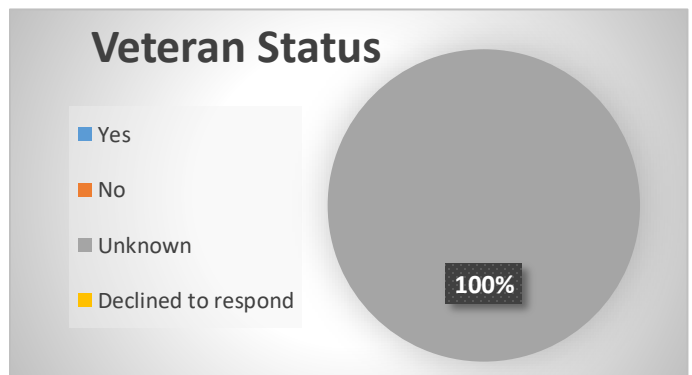
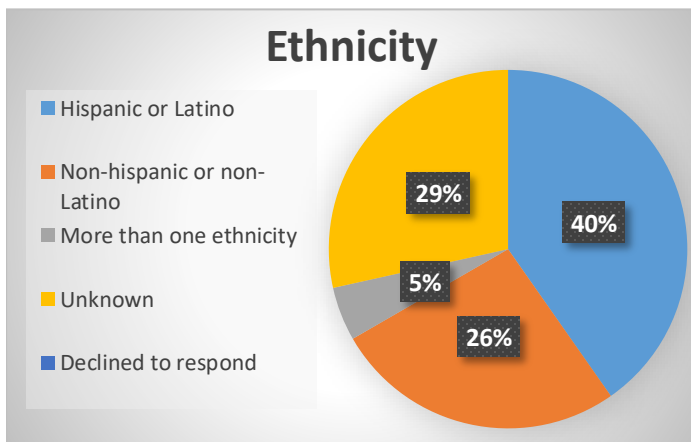
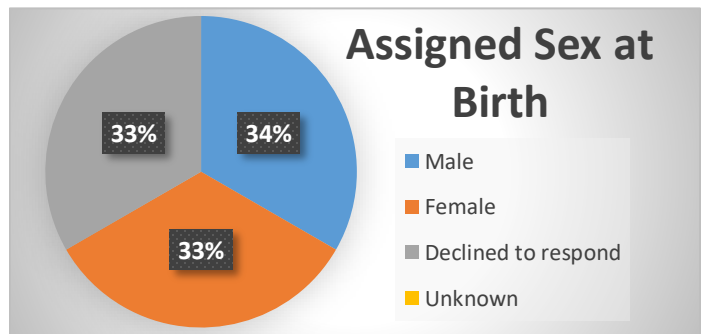
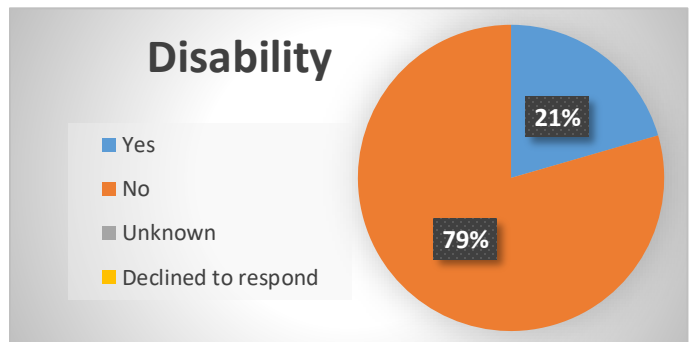
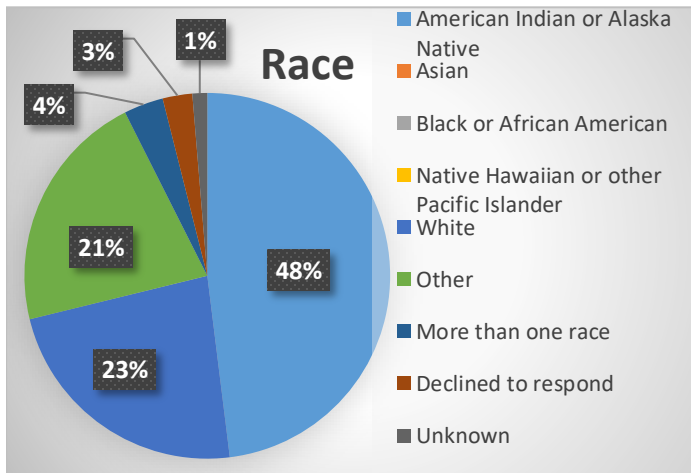
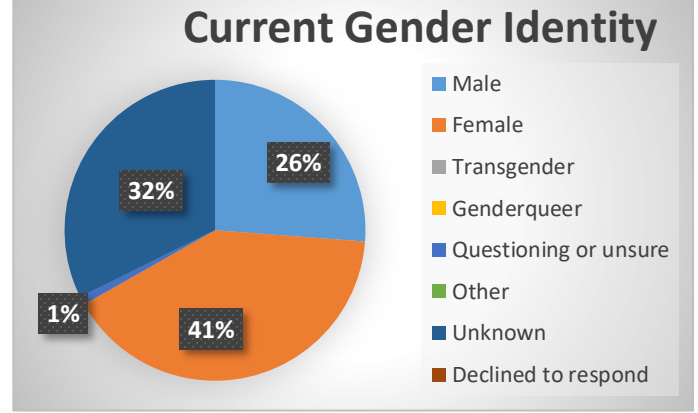
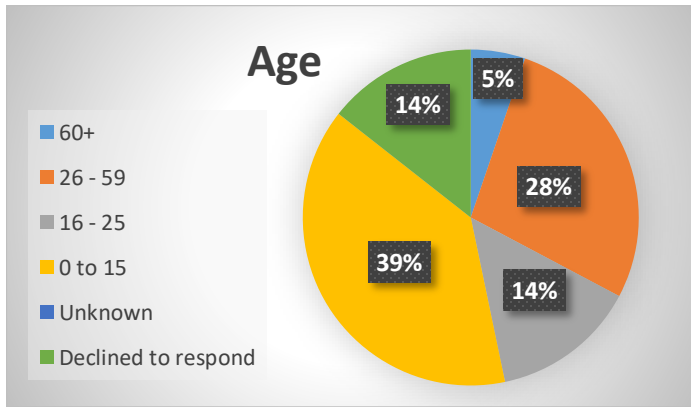
Outreach services to rural northern Sonoma County residents ages 0-65+. Action Network provides mobile outreach services to Kashia Rancheria on a bi-weekly basis delivering resources such as diapers & formula, clothing and personal hygiene supplies, food, grocery/gasoline vouchers, referrals for social services or other needs, and mental health check-ins to set gals with clients and track progress throughout the year. Bright Beginnings program served children ages 2.5-5 in a preschool and learning through play setting. High School students are served in the Arena District – the only option for high school in our service region. They receive prevention education, mental health check-ins, support groups on campus, and referrals, services, and appointments at the Teen Clinic coordinated by Action Network staff.

### PERFORMANCE OUTCOMES:

- 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 22-23.
- 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 continues with consistency, communication, and reliability.
- One client shared “I don’t know what I’d do without your help. Thank you for always showing up for my family.”



## FY 2022-2023 Program Demographics:





## Community Baptist Church Collaborative



FY 2022-2023 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 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 programming.

**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 these 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 INFORMATION**

**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

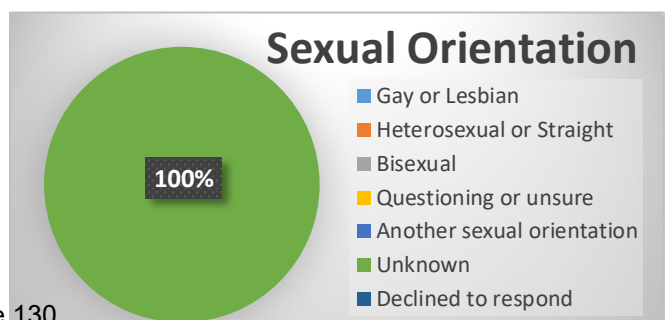
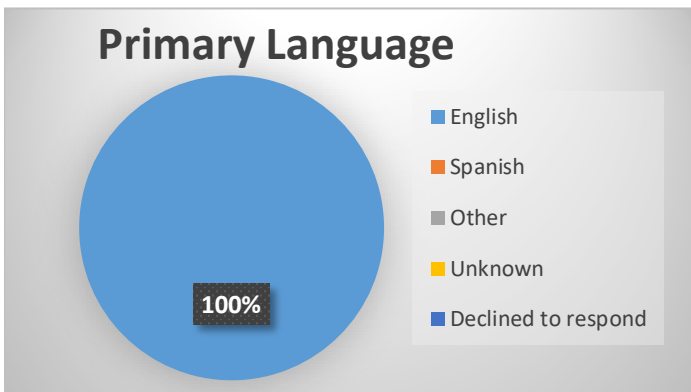
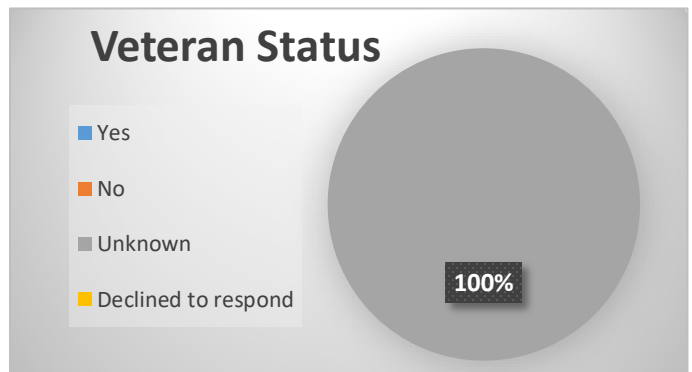
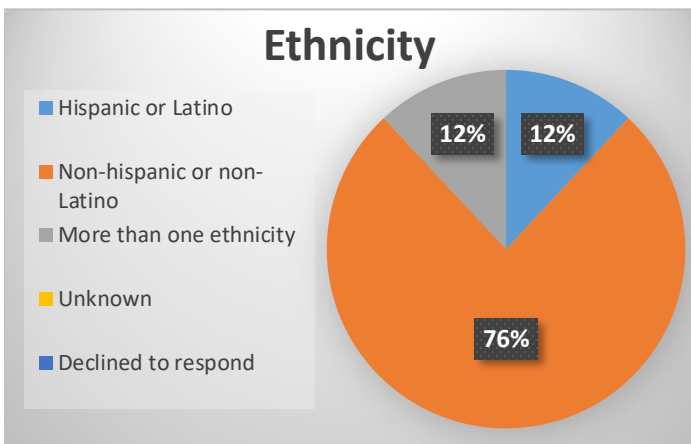
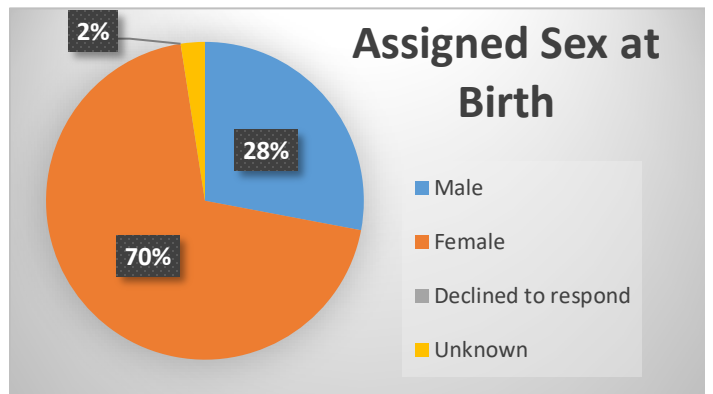
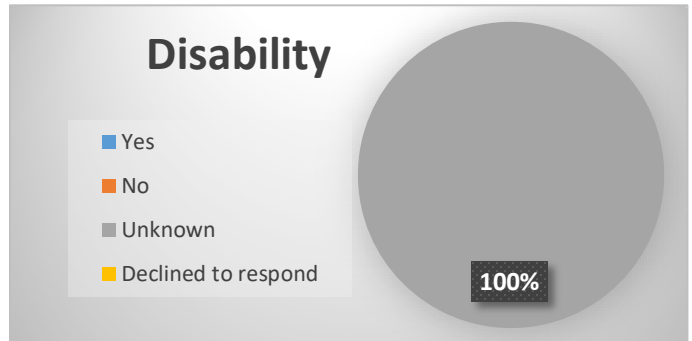
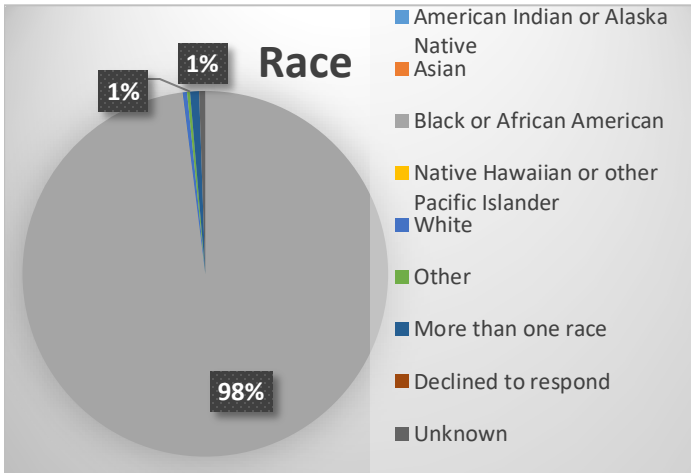
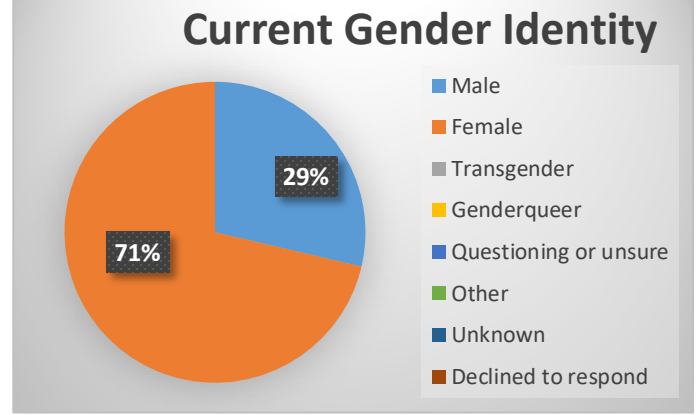
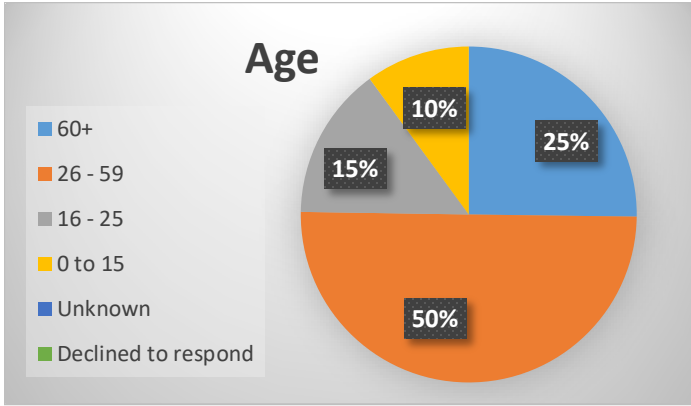
**FY 2022-2023 PROGRAM STATISTICS**

- Total number of clients served:** 56175
- Total number of encounters:** 4,350,430

**PROGRAM OUTCOMES:**  
 Not available at time of report



## FY 2022-2023 Program Demographics:





## Sonoma County Human Services Older Adult Collaborative Program



FY 2022-2023 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 INFORMATION

**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

### PROGRAM STATISTICS

- **Total number of clients served:** 2842
- **Total number of encounters:** 9919
- **Approximate numbers reached through outreach:** N/A



### 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

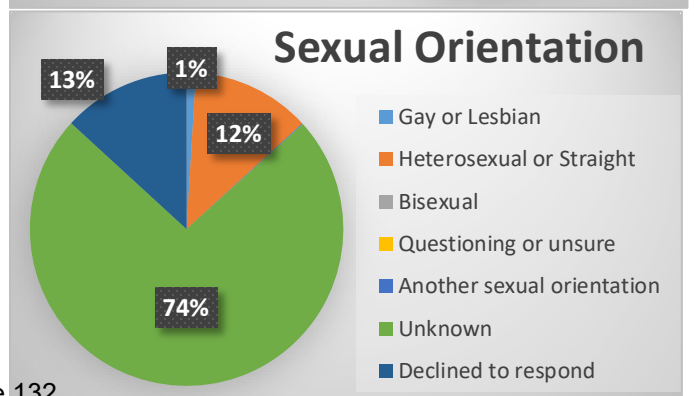
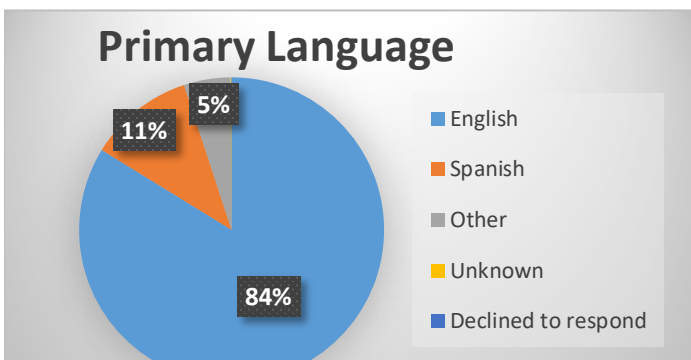
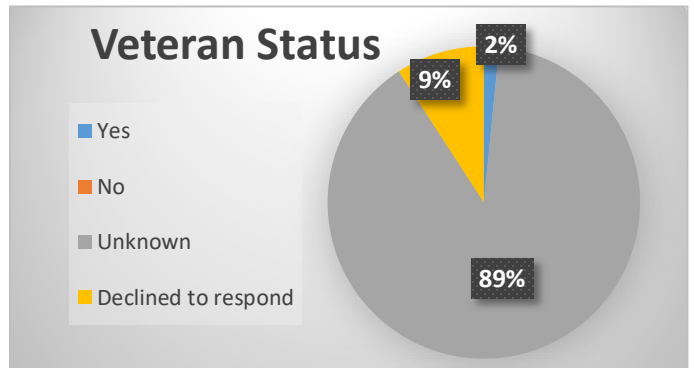
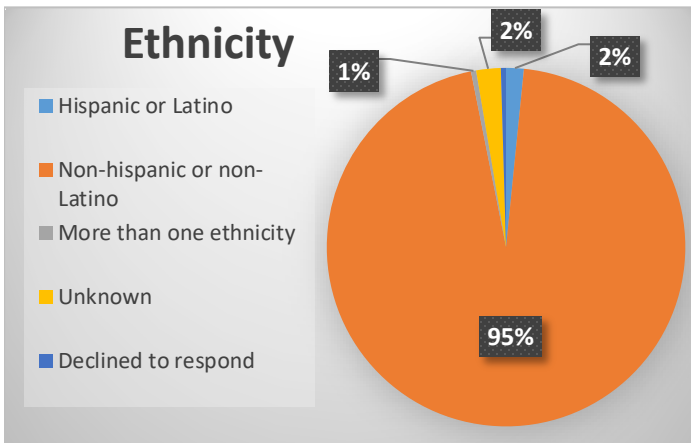
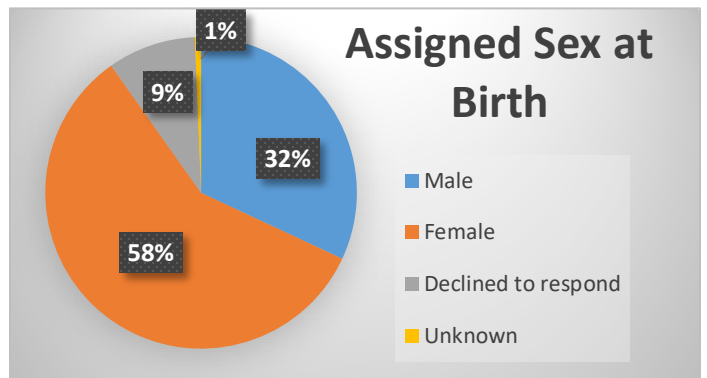
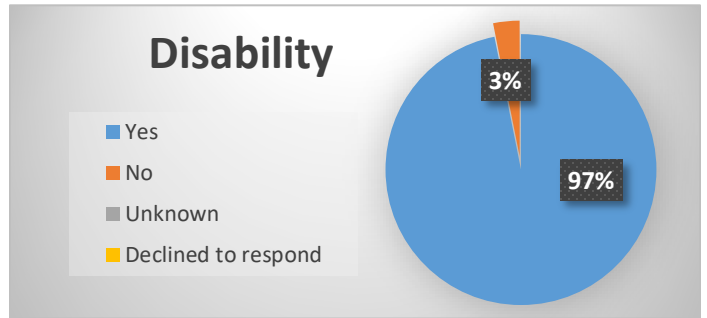
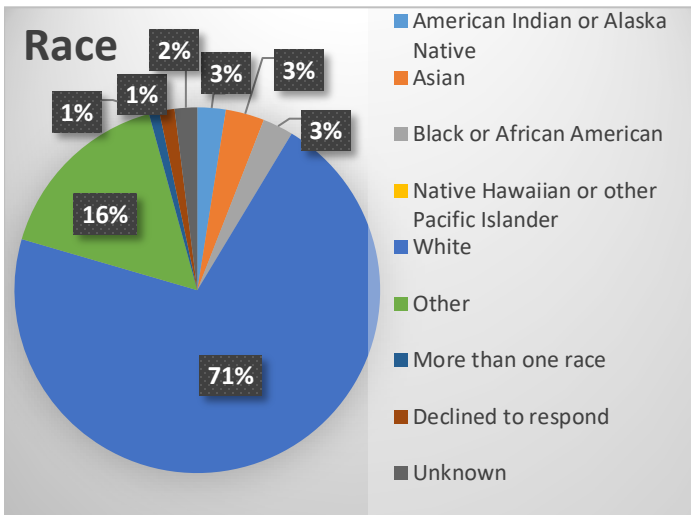
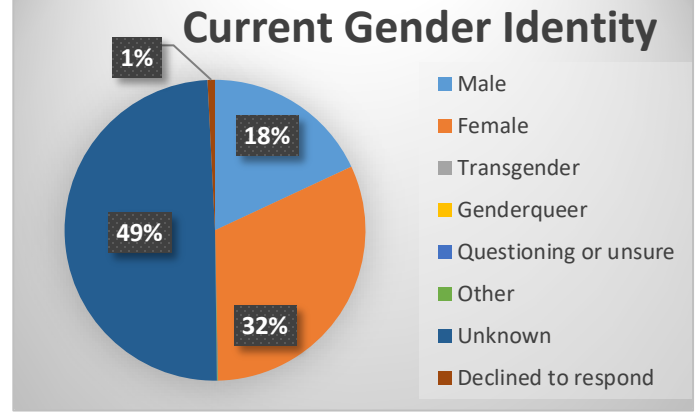
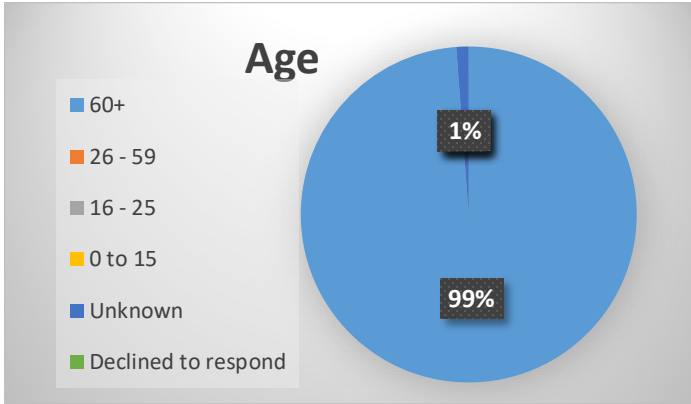
### PERFORMANCE OUTCOMES:

**Improvement in depression symptoms:** The number of older adults who showed improvement in depression symptoms (based on PHQ-9 scores) was **177** for the 2022-23 Fiscal Year.

**Other program highlights:** OAC partner agencies cumulatively offered older adults **1739** referrals to additional community resources during the 2021-22 fiscal year. In addition, **324** Mental Health Referrals were made.



## FY 2022-2023 Program Demographics:





# Sonoma County Indian Health Project's Gathering of Native Americans 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.

## 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.

## PROGRAM OUTCOMES & ACCOMPLISHMENTS:

Not available at time of report



## PROGRAM INFORMATION

**Program Name:** Gathering of Native Americans Program (GONA)

**Population served:** Native Americans, all ages in Sonoma County

**Website:** [www.scihp.org](http://www.scihp.org)

**Phone:** (707) 521-4550

**Program location:**  
144 Stony Point Road, Santa Rosa, CA 95401

## FY 2022-2023 PROGRAM STATISTICS

- **Total number of clients served:** 28
- **Total number of encounters:** 28

**PROGRAM OUTCOMES:**  
Not available at time of report

**FY 2022-2023  
Program Demographics:**

Not available during the time of this report due to staffing issues.





**LATINO**  
Service Providers

## Latino Service Providers

**CONNECTION IS 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 INFORMATION

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

### FY 2022-2023 PROGRAM STATISTICS

- **Total number of clients served:** 151
- **Total number of encounters:** 20,000
- **Approximate numbers reached through outreach:** 5,934

### PROGRAM DESCRIPTION:

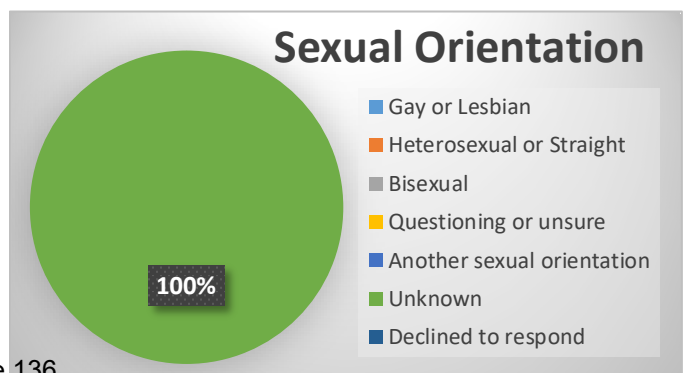
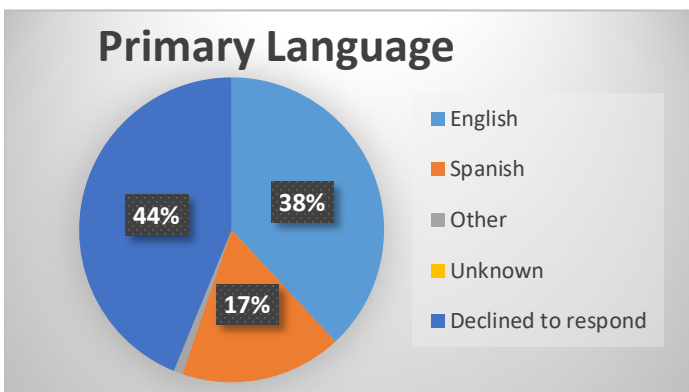
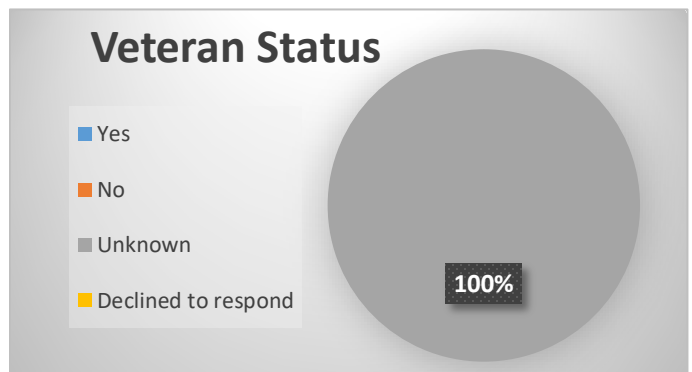
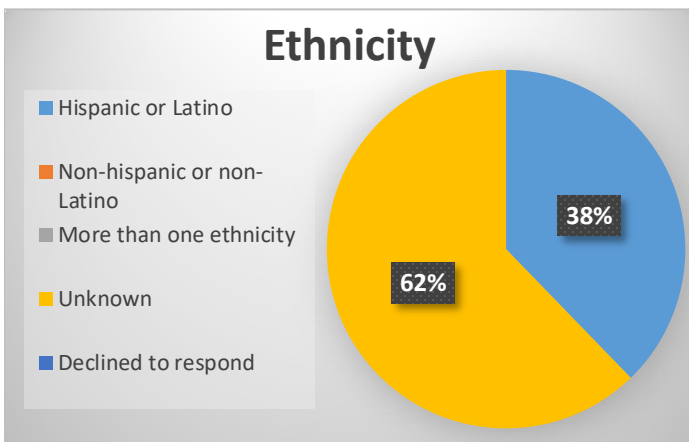
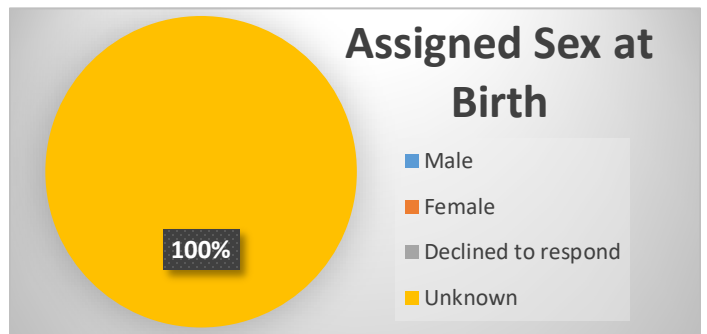
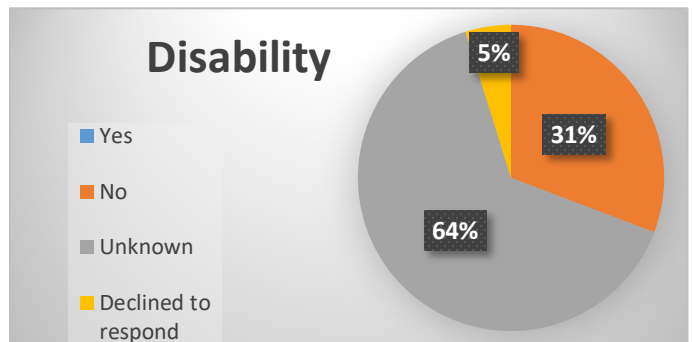
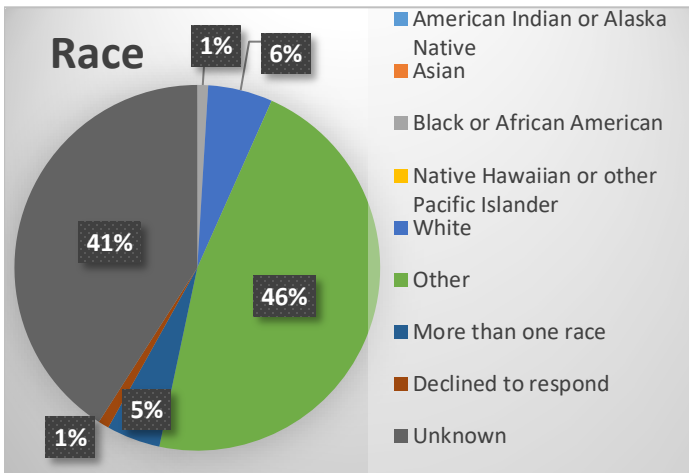
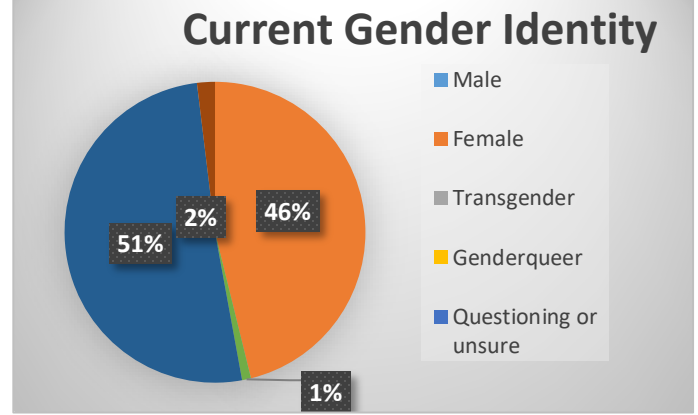
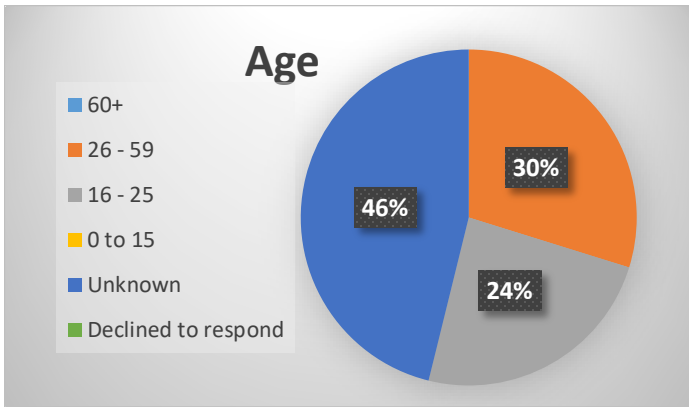
Latino Services Providers (LSP) is a community-based non-profit network organization whose mission is to be a bridge across generations for the Latinx community focusing on health, culture, and social issues. We do this by developing young leaders; building awareness and connections to community services,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

### PERFORMANCE OUTCOMES:

In the 2022-2023 fiscal year, Latino Service Providers (LSP) maintained their commitment to serving the Youth and the community. The Team continued to experience internal transitions and they are excited to share that Stephanie Manieri, previous Director of Programs, stepped into the Executive Director position in January. Under her guidance, LSP continued its longstanding collaboration with MHSA. The Youth Promotor team achieved significant milestones by recruiting and onboarding over 60 students from across Sonoma County. The Youth Promotor Internship Program aimed to actively involve the Latinx community in addressing health-related issues in the county and inspire the next generation of community health workers. These young advocates consistently engaged with the Latinx community, providing resources and information in a culturally and linguistically responsive manner. Collaborating with Youth Promotor students, the Community Engagement Team attended over 40 events, reaching out to the community. They also expanded their impact through 49 e-newsletters, offering free or low-cost resources to Sonoma County residents. The 2023 Stomp the Stigma event, organized by LSP Youth Promotor Students, saw the participation of over 150 individuals, successfully raising awareness about mental health through activities curated by the students. Latino Service Providers' unwavering commitment, coupled with dynamic leadership and the collaborative efforts of the Youth Promotor team, ensured a year of significant impact. As they continue to bridge gaps, foster community engagement, and promote mental health awareness, LSP remains a vital force in enhancing the well-being of Sonoma County residents.



## FY 2022-2023 Program Demographics:





## Positive Images



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:** Positive Images  
**Population served:** LGBTQIA+ Community  
**Website:** [www.posimages.org](http://www.posimages.org)  
**Phone:** (707) 568-5830  
**Program location:** 200 Montgomery Drive, Suite C, Santa Rosa CA 95404  
**Social Media:** IG @positiveimages  
 Facebook: PosImages  
 TikTok: @positive.images

### FY 2022-2023 PROGRAM STATISTICS

- **Total number of clients served:** 258
- **Total number of encounters:** 1347
- **Approximate numbers reached through outreach:** 7260

### PROGRAM DESCRIPTION:

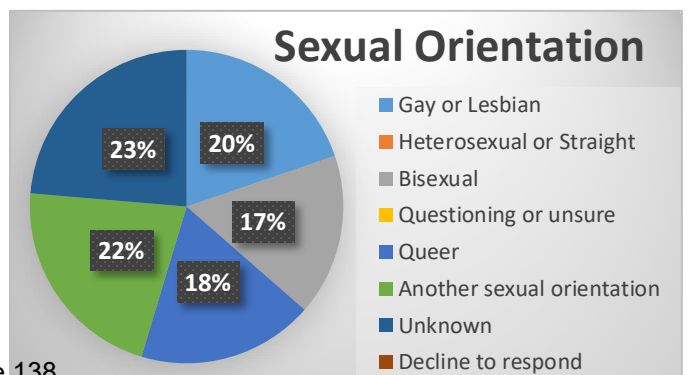
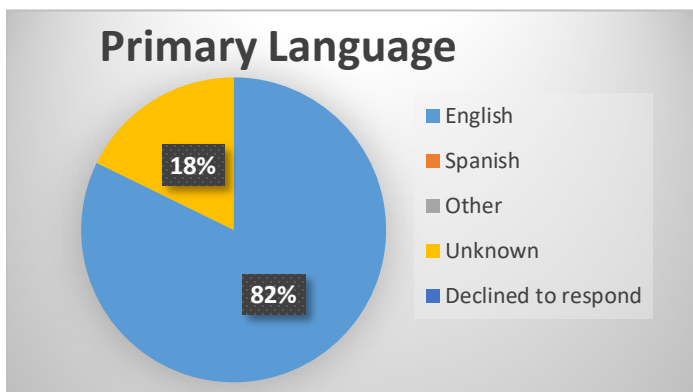
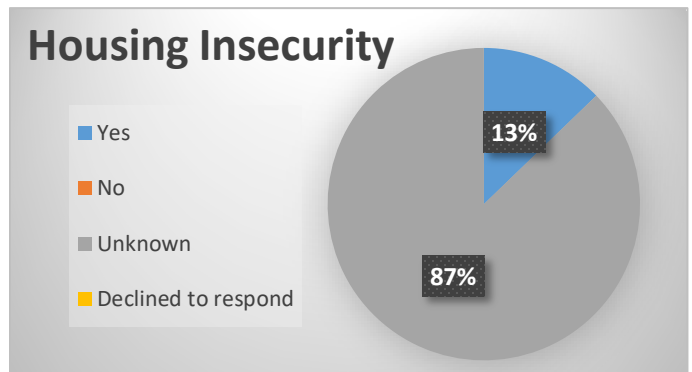
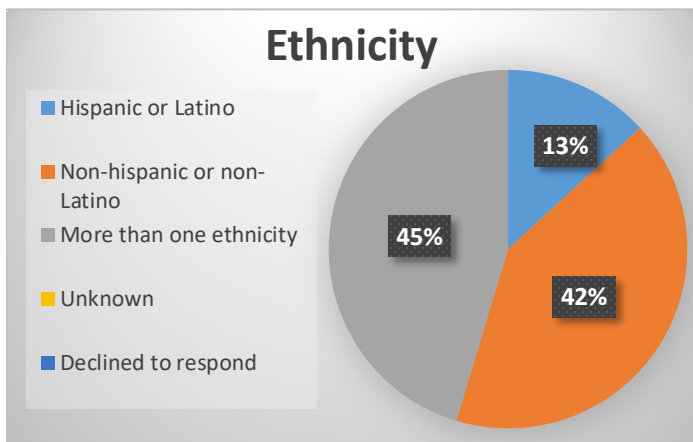
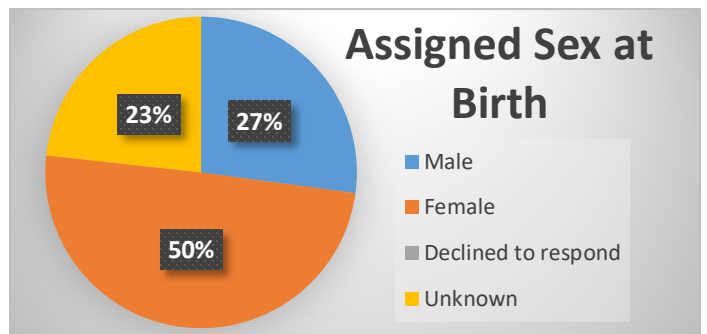
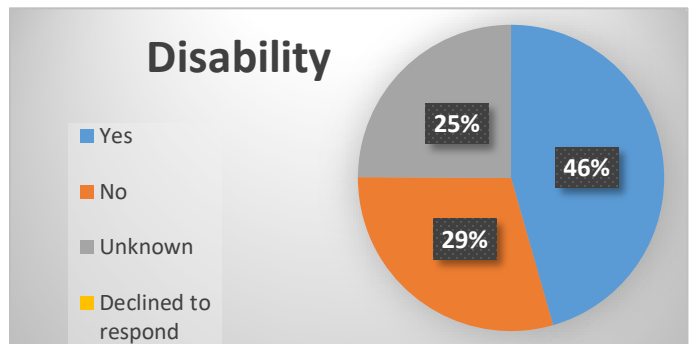
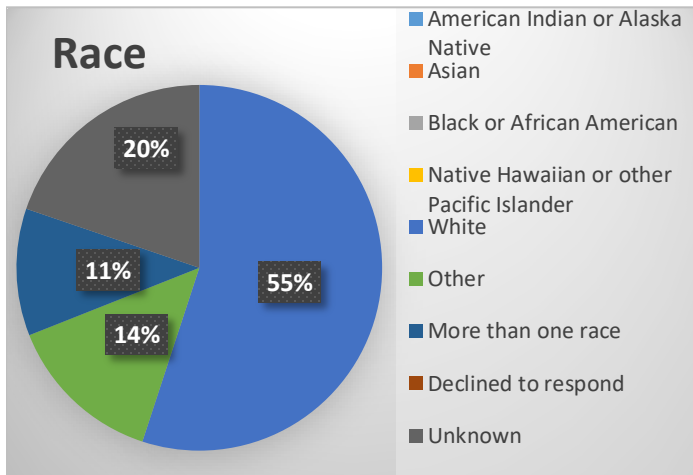
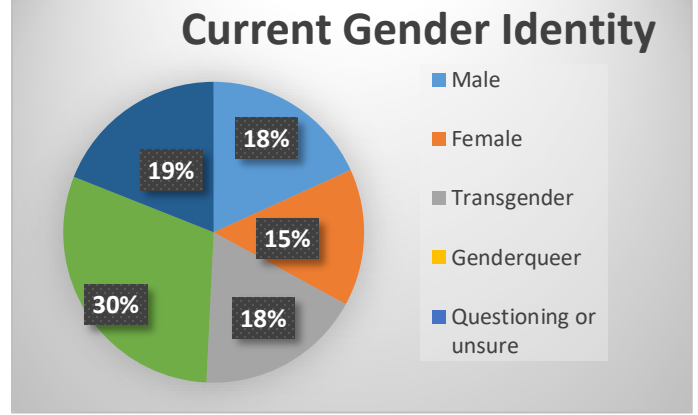
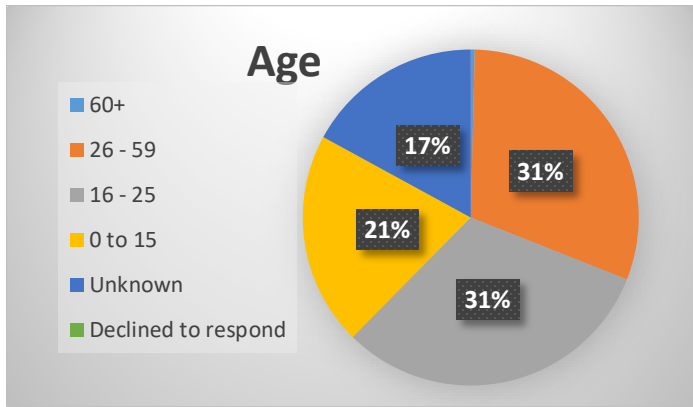
Positive Images is an LGBTQIA+ Community Center of Sonoma County. We provide support to the North Bay’s LGBTQIA+ population, with an emphasis on identities and individuals at the margins – including transgender and nonbinary individuals, LGBTQIA+ people of color, Latiné families, neurodivergent people, and disabled people. We are dedicated to providing essential services that encompass mental health support, advocacy, and education. Through Peer-Run Mental Health Support Groups, a Leadership Development Program, LGBTQIA+ Cultural Conscious 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:

Since Positive Images was established in 1990, we have been a cornerstone in our county, providing a safe, affirming, and welcoming space for the 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 2022-2023 Fiscal Year, our MHSA programs hosted 98 Peer-Run Mental Health Support Groups and 99 Leadership Development sessions, delivered 25 hours of Cultural Competency Trainings, and participated in 18 Outreach Events. Individuals who participate 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 2022-2023: *“These support groups have saved my life. I have been able to obtain valuable tools/skills, meet people that care about me, and find a family at PI.”* *“PI has offered me an open, friendly, and healthy community which is a rare and invaluable resource. I feel happy and much less lonely after meetings.”*



# FY 2022-2023 Program Demographics:



# SONOMA COUNTY MHSA ANNUAL PROGRAM REPORT FY 2022-2023

## 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.





Child Parent Institute

CONNECTION IS 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 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](http://www.calparents.org)

**Phone:** (707) 585-6108

**Program location:**  
3650 Standish Ave. Santa Rosa, CA

**Social Media:**  
[Facebook](#) | [Instagram](#) | [LinkedIn](#)  
[Twitter](#)

**FY 2022-2023 PROGRAM STATISTICS**

- **Total number of clients served:** 230
- **Total number of encounters:** 1146
- **Approximate numbers reached through outreach:** 22,304

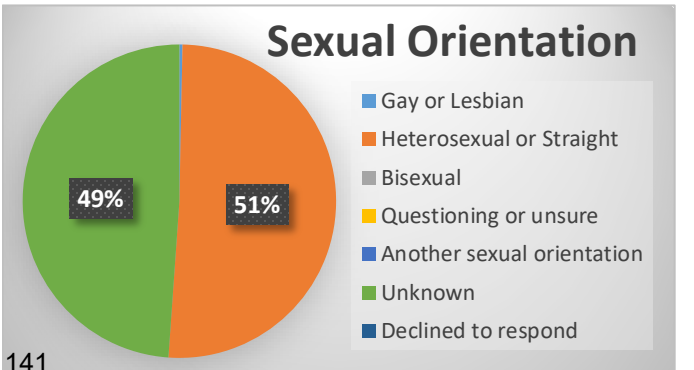
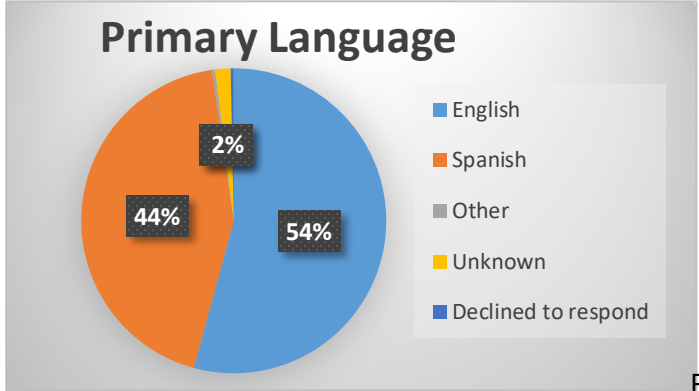
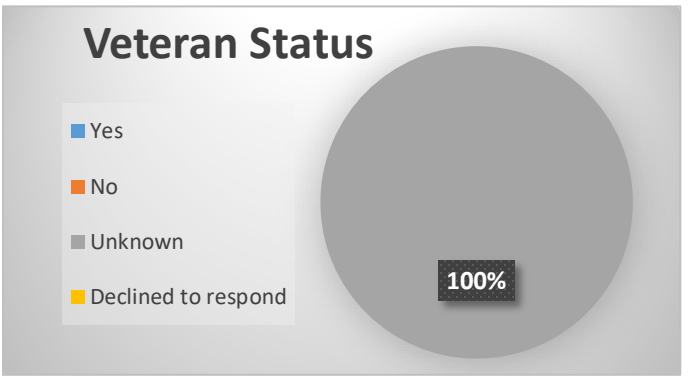
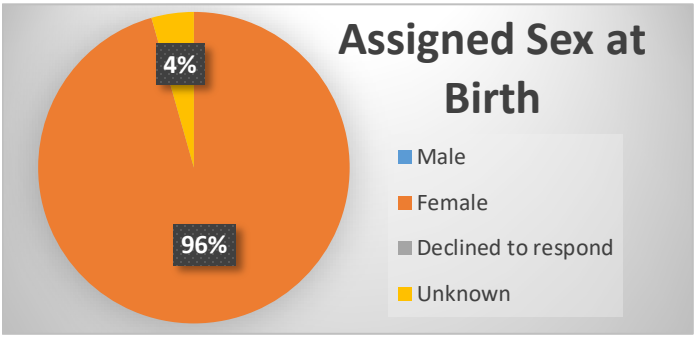
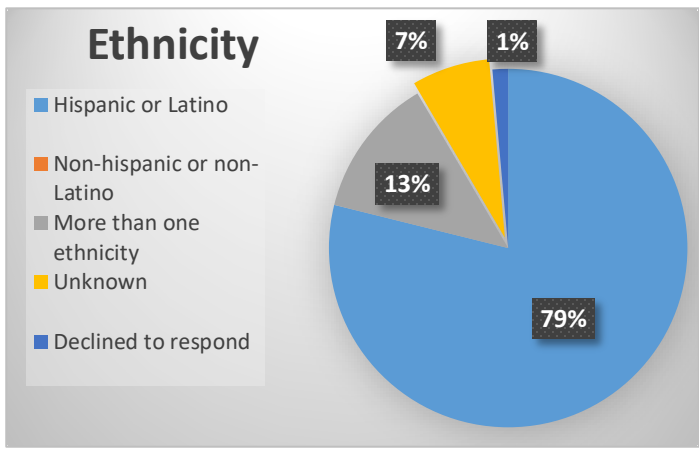
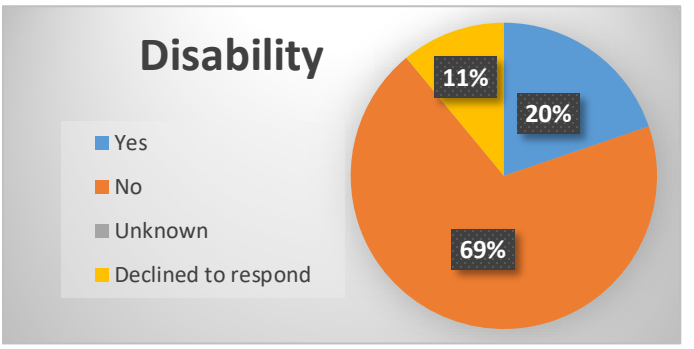
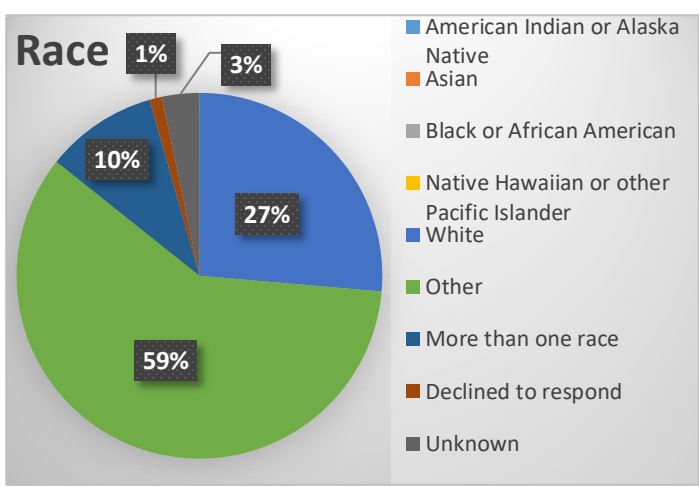
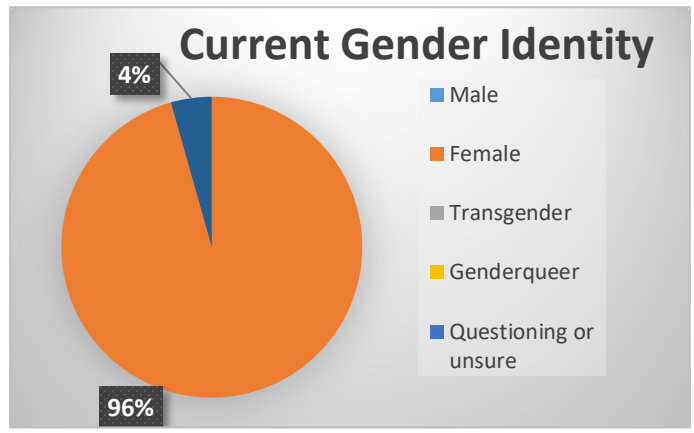
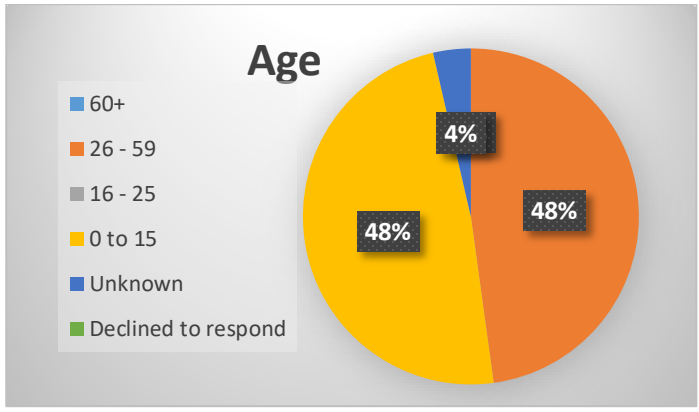
**PROGRAM DESCRIPTION:**

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.

**PROGRAM ACCOMPLISHMENTS:**

Carla is a young mother who accessed PMD therapeutic services at CPI through MHSA. She was referred to CPI by her healthcare provider after it was identified that after the birth of her daughter she was struggling with depression, feeling low energy, overwhelmed, and that she was not getting support from her partner at home. Carla's provider worked with her in her home, and using a structured curriculum, were able to address the things that were difficult for her. After 12 sessions, Carla reported she was able to consistently use the self-care skills she had learned, that she was able to be productive in how she used her time, and that she has been able to ask for help at home by communicating with her partner in an assertive manner instead of with frustration and anger. Although at intake she had scored in the clinical range for depression and anxiety symptoms, at close - her symptoms had reduced to the point that her scores were no longer in the clinical range.

# FY 2022-2023 Program Demographics:





# EARLY LEARNING INSTITUTE

CONNECTION IS 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 INFORMATION

**Program Name:** Watch Me Grow  
**Population served:** Children birth to 5 in Sonoma County  
**Website:** [www.earlylearninginstitute.com](http://www.earlylearninginstitute.com)  
**Phone:** (707) 591-0170  
**Program location:**  
 Serving All of Sonoma County  
 Services are offered in home, virtually or at the ELI center in Santa Rosa, based on family preference.

## PROGRAM DESCRIPTION:

Watch ME Grow is a unique program that provides free social emotional and developmental screenings to young children in Sonoma County. Parents learn valuable information about how to foster their child’s social and developmental skills and they learn about community programs, with referrals to services when needed. Anyone with concerns about a child is encouraged to call the WMG program. This is a “One Stop Shop” that will help parents and professionals navigate the various complex systems of care for children.

## PERFORMANCE OUTCOMES:

WMG Screeners completed 756 screenings for the year, 168% more than the funding target. 99% of the clients either had normal scores on their screening or were referred for further assessment. Of those that were referred on for further assessment, 95% were made within 5 business days. At the time of the first screening, about 48% of the parents report improved knowledge of early childhood mental health milestones, and this increases to 75% on future screenings. The majority of parents download the Learn the Signs, Act Early (LTSAE) developmental tracker App during the visits with the screener. Upon rescreen, many parents report that they looked at the app at least a couple of times. Online ASQ screenings dropped during the year. Many parents referred to WMG state that they preferred, instead, to have someone come and look at their child. One parent mentioned "no one has laid physical eyes on my child in two years. I just want someone to validate what I am seeing." 65% of the online screenings went on to have WMG screenings in person.

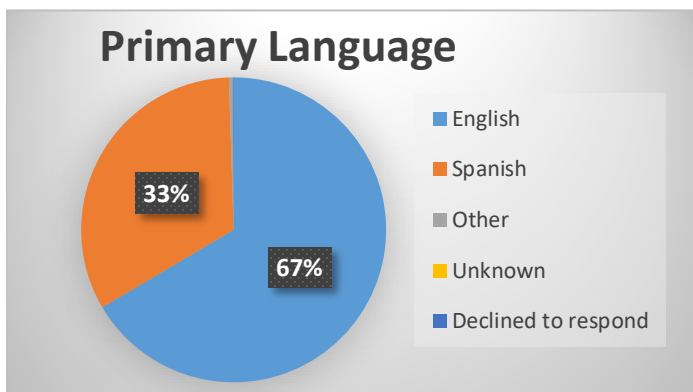
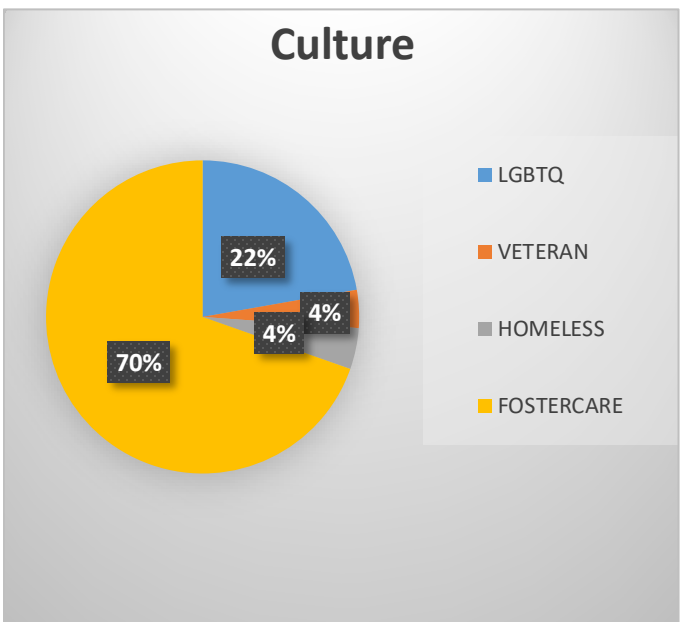
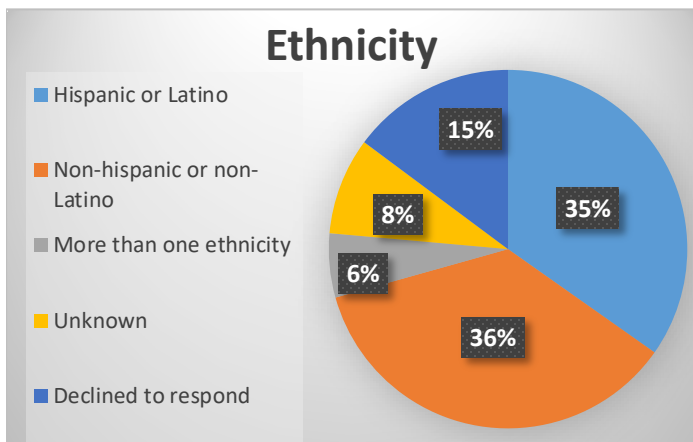
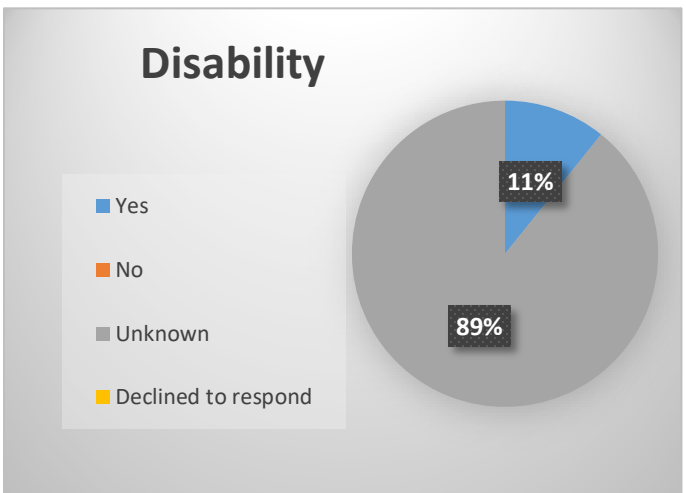
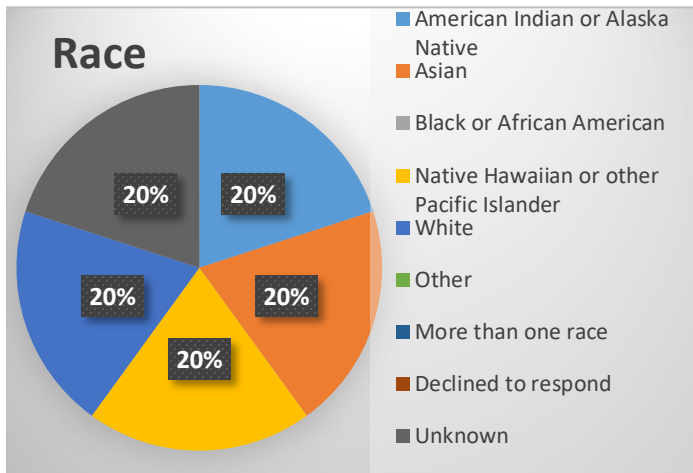
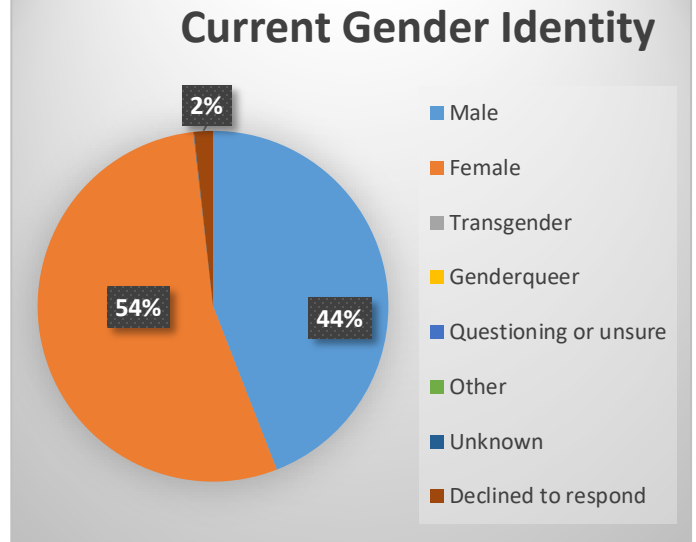
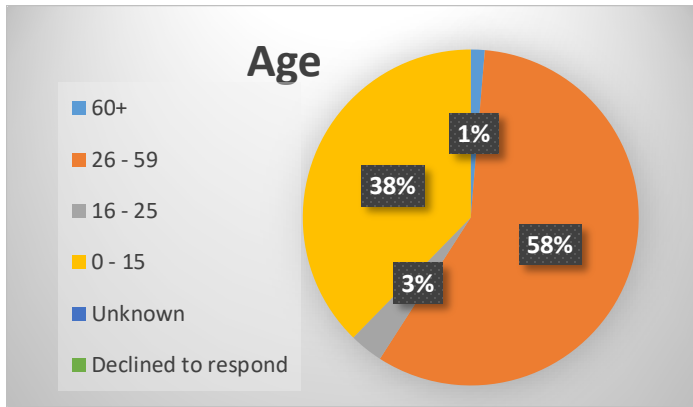
## FY 2022-2023 PROGRAM STATISTICS

- **Total number of clients served:** 756 screenings completed
- **Total number of encounters:** 806
- **Approximate numbers reached through outreach:** 40,000 via mailings, website hits, SM outlets and radio ads





# FY 2022-2023 Program Demographics:



# SONOMA COUNTY MHSA ANNUAL PROGRAM REPORT FY 2022 - 2023

## 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.



# La Luz Center Your Health, Your Community 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.



### PROGRAM INFORMATION

**Program Name:**  
Your community, Your Health /  
Tu Comunidad, Tu Salud

**Population served:**  
Latinos and low-income  
individuals and families

**Website:**  
[www.laluzcenter.org](http://www.laluzcenter.org)

**Phone:**  
(707) 938-5131

**Program location:**  
17560 Greger St.  
Sonoma, CA 95476

**Social Media:**  
 

### FY 2022-2023 PROGRAM STATISTICS

- **Total number of clients served: 331**
- **Total number of encounters: 1,324**
- **Approximate numbers reached through needs outreach: 4,501**
- **181 families referred, linked and guided through their mental health need.**

### PROGRAM DESCRIPTION:

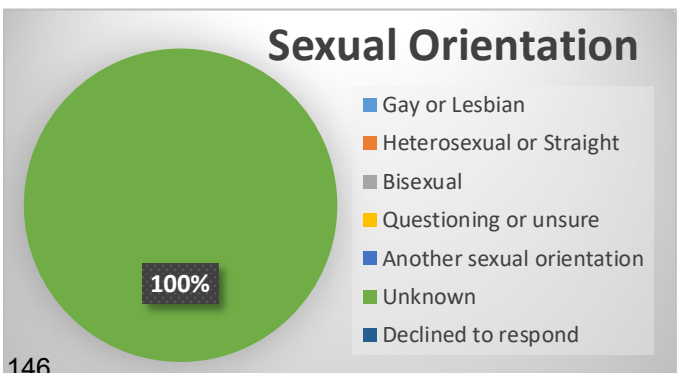
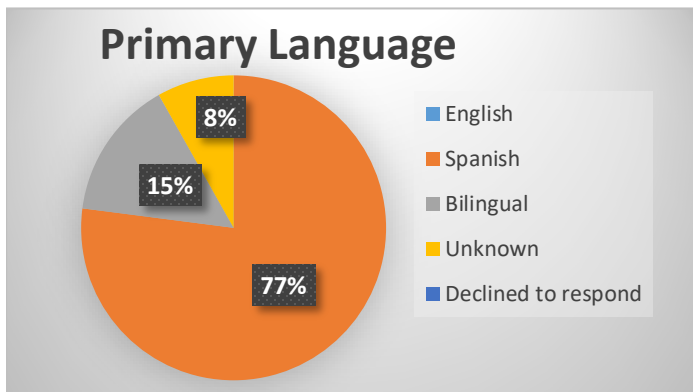
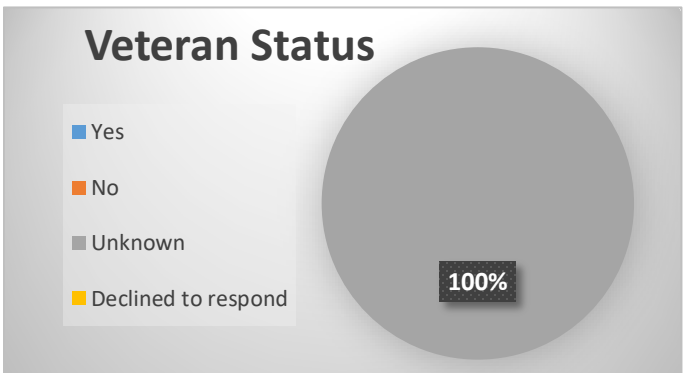
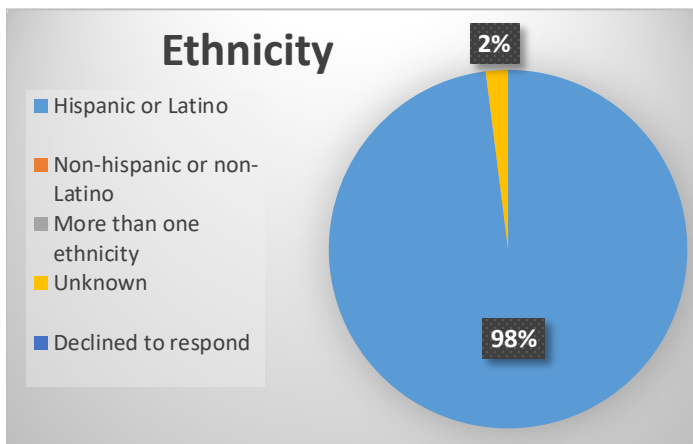
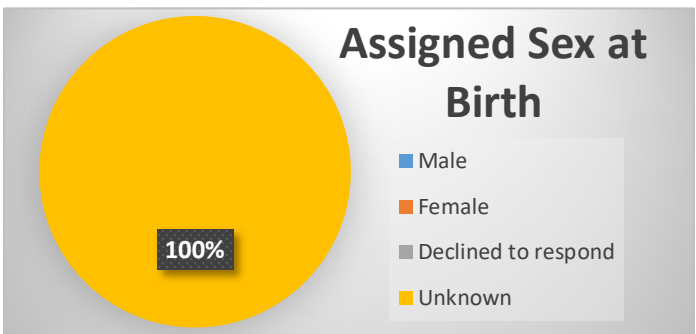
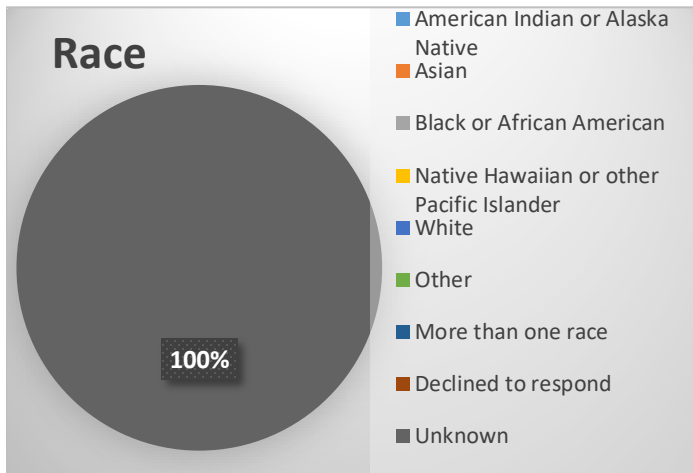
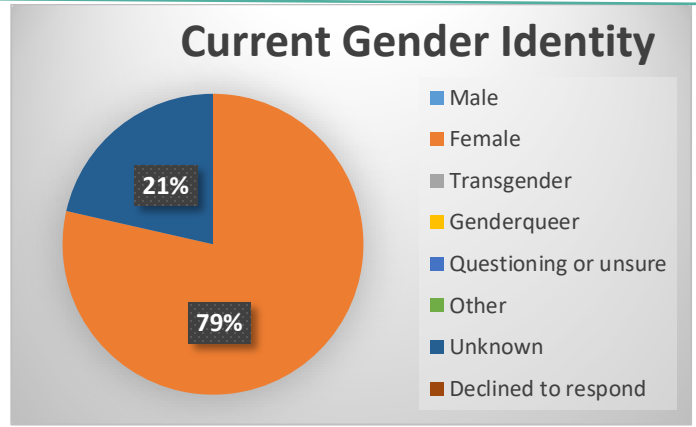
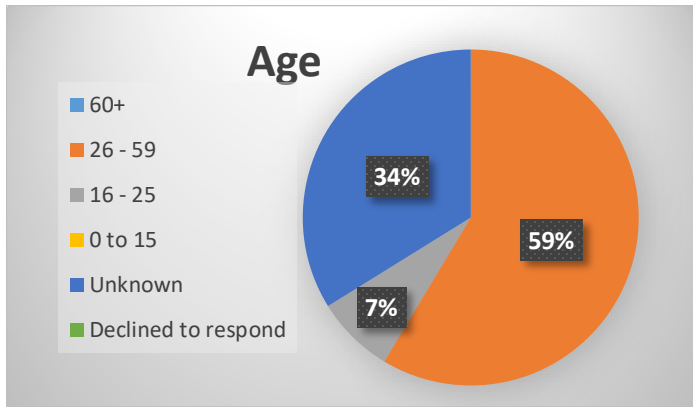
La Luz Center’s Your Community, Your Health/Tu Comunidad, Tu Salud addresses the mental health needs of the Sonoma Valley Latino community by working to reduce risk factors for developing a potentially serious mental illness, build protective factors and improve timely access to mental health services.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

- 93% of participants report feeling better off, post class participation.
- 89% of Your Health/Tu Comunidad, Tu Salud program participants reported increased confidence in their ability to manage their stress
- 44% of individuals reached by Promotoras received assistance and/or referrals to services.
- 72 % of clients attended 4+ wellness classes in a quarter.



# FY 2022-2023 Program Demographics:



## SONOMA COUNTY MHSA ANNUAL PROGRAM REPORT FY 2022 – 2023

### 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

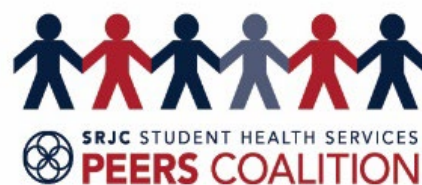
### Stigma & Discrimination

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.



**CONNECTION IS PREVENTION**

**SRJC Student Health Services, Mental Wellness Program**



FY 2022-2023 PEI Initiative: Stigma & Discrimination

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:** SRJC Student Health Services, Mental Wellness Program  
**Population served:** SRJC students with a focus on TAY (16-25)  
**Website:** [shs.santarosa.edu](https://shs.santarosa.edu)  
**Phone:** (707)527-4445

**Program location:**

<b>Santa Rosa</b>	1501 Mendocino Ave. Santa Rosa, CA 95401
<b>Petaluma</b>	680 Sonoma Mountain Pkwy, Petaluma, CA 94954

**Social Media:**

@srjcpeers  
 @ Student Health PEERS at SRJC

**FY 2022-2023**

**PROGRAM STATISTICS**

- **Total number of clients served: 501**
- **Total number of followers:**
  - 1,160 PEERS Instagram
  - 537 PEERS Facebook
- **Approximate numbers reached through outreach: 7966**

**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.

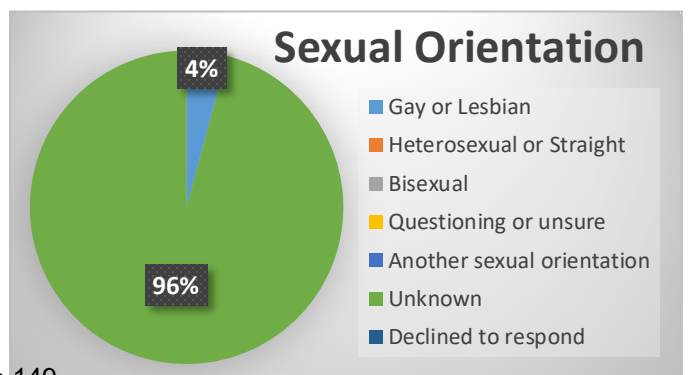
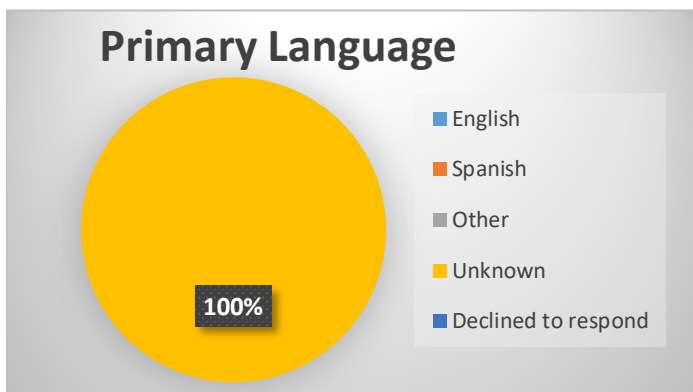
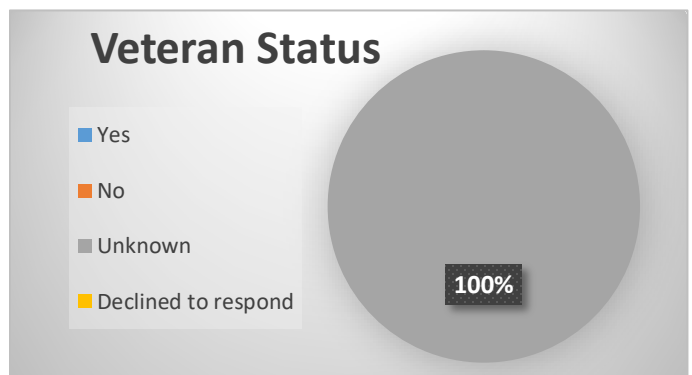
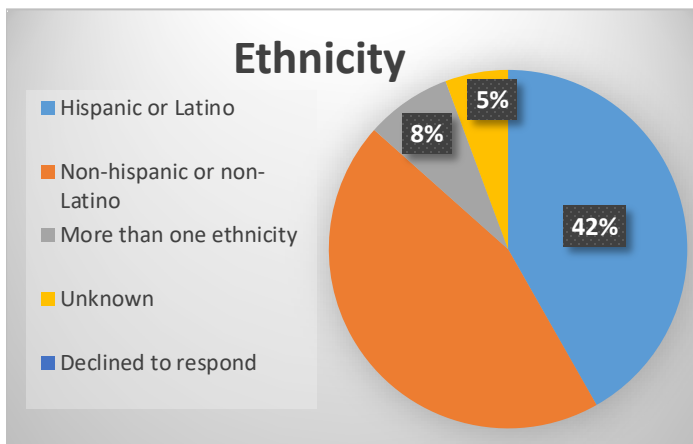
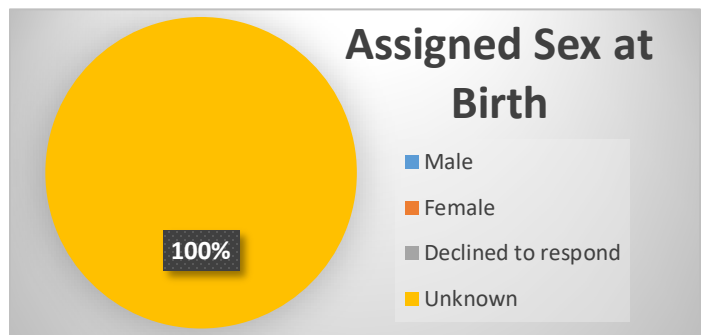
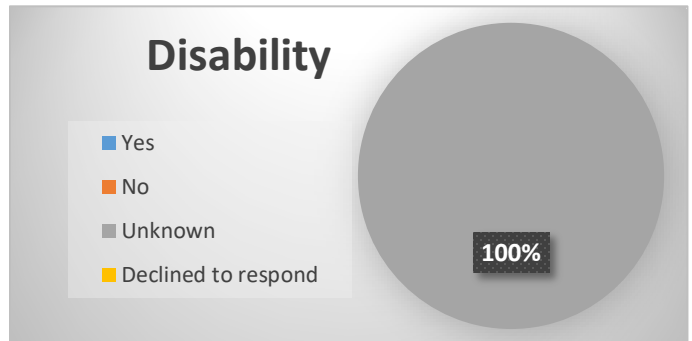
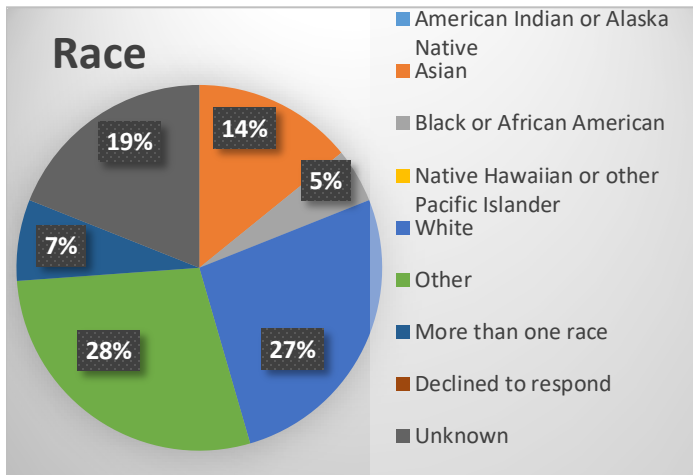
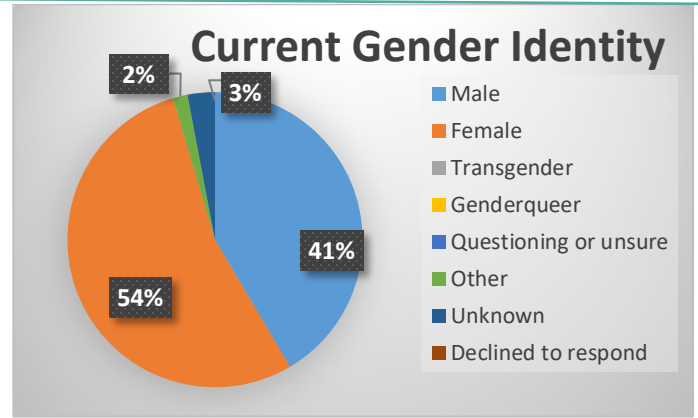
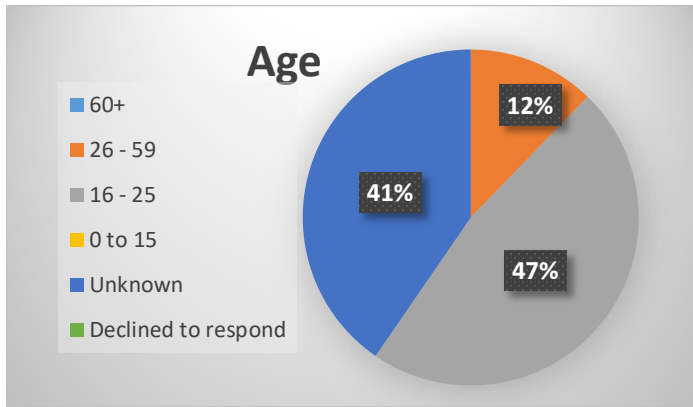
**PERFORMANCE OUTCOMES:**

The PEERS continued to work within the hybrid environment as more students returned to campus but many stayed remote. "There is Hope. A Conversation About Suicide Prevention in September had 50 in person attendees and 50 more joining via Zoom. This powerful panel included SRJC students and local mental health professionals. We continued this important conversation with QPR Trainings for staff and students, with 97% of attendees saying they would recommend to others. Some QPR feedback: Really amazing and beneficial training. Super critical to today's society/environment. Thank you for your time! Thank you for this training. I have a friend who has been giving me these signs and I have been wondering how to help them and ask them. This helped me a lot.

PEERS launched a bimonthly newsletter to update students on health and wellness events and resources on campus and in the community and continued outreach via social media. Through workshops, campus events, classrooms and more, PEERS reached almost 8,000 students @ SRJC.



# FY 2022-2023 Program Demographics:





# Crisis Intervention Training (CIT)



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:

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.

Crisis Intervention Training (CIT) conducted biannually with local law enforcement personnel.



### PROGRAM INFORMATION

**Program Name:** Crisis Intervention Training (CIT)

**Population served:** Law enforcement and emergency personnel

**Program location:** Sonoma County, CA

### FY 2022-2023 PROGRAM STATISTICS

- **Total number of clients served:** 52
- **Total number of encounters:** N/A
- **Approximate numbers reached through outreach:** N/A

### PERFORMANCE OUTCOMES:

- Law enforcement and emergency personnel gained knowledge, access to resources, tools, and connections to mental health providers to increase awareness and more effective ways to interact with our community.
- Law enforcement and emergency personnel visited and toured community-based organizations and mental health providers to help increase connections with staff and gain knowledge of these behavioral services and resources.

Demographics from FY 22-23 were not available during this reporting period.





# SONOMA COUNTY MHSA ANNUAL PROGRAM REPORT FY 2022 – 2023

## 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.





## DHS-BHD's Adult Access Team



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:** 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

### 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.

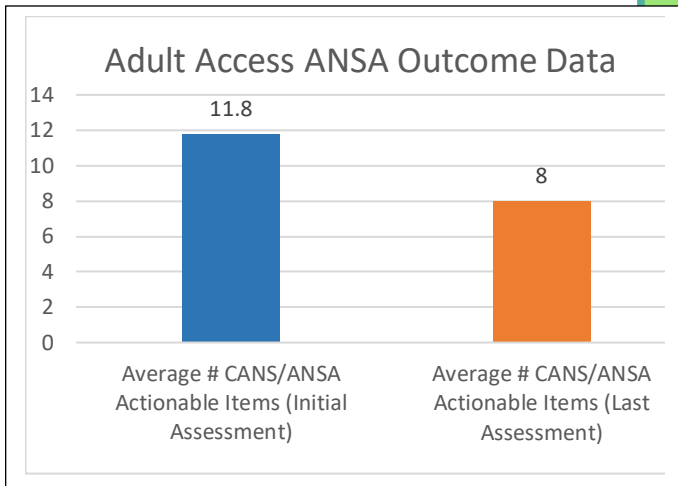
An Access Team Screener determines the level of need for mental health services, coordinates an assessment appointment and links individuals with community resources. The Access assessment is a series of questions to help determine how a client is functioning in an array of areas in their life and how 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.

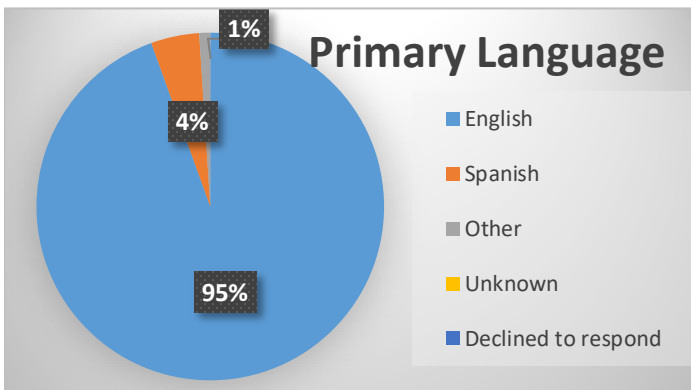
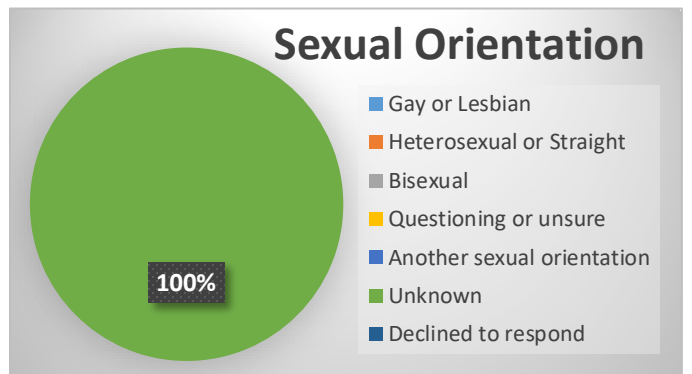
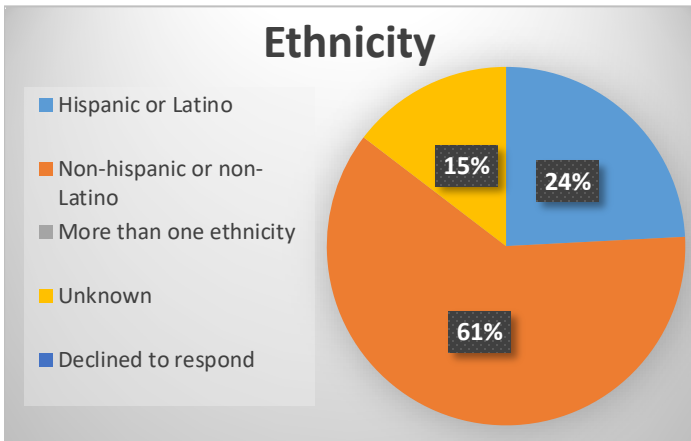
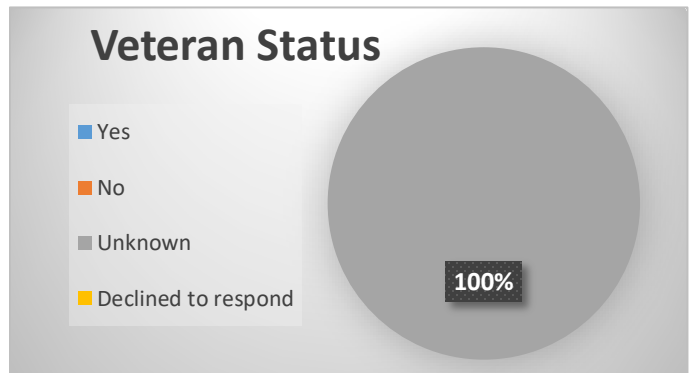
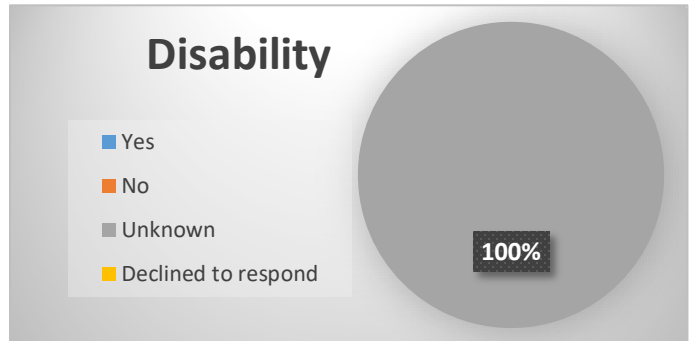
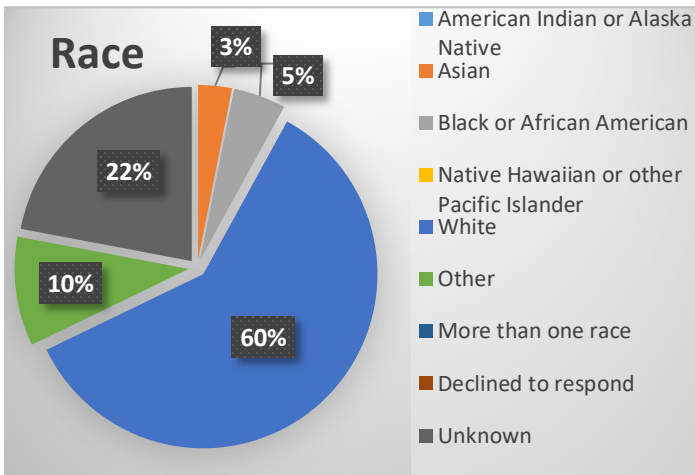
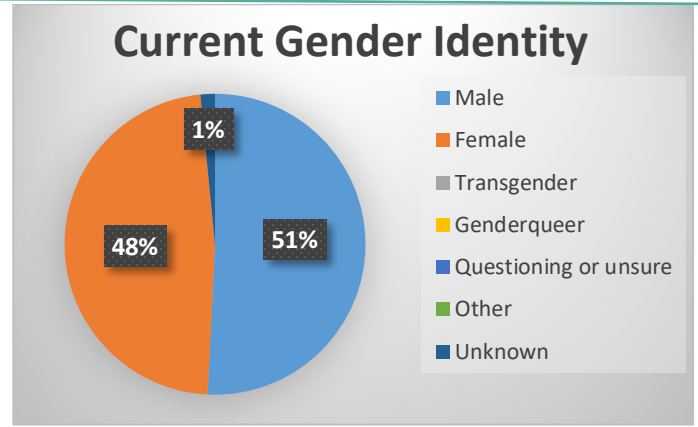
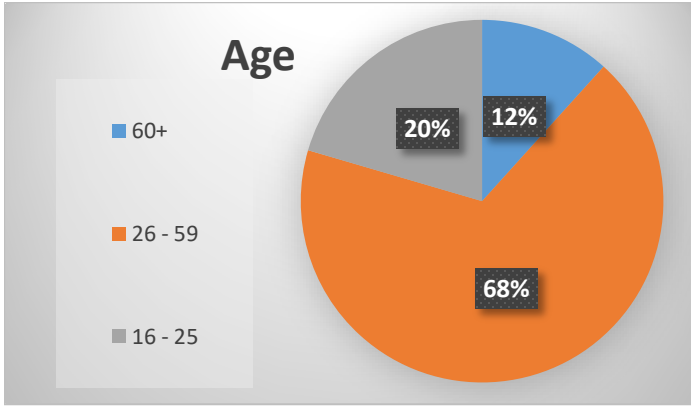


### FY 2022-2023 PERFORMANCE OUTCOMES:

- **Total number of clients served: 577**



## FY 2022-2023 Program Demographics:





## DHS-BHD's Youth Access Team



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:** Behavioral Health Division's Youth Access Team  
**Population served:** Sonoma County residents under the age of 18  
**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

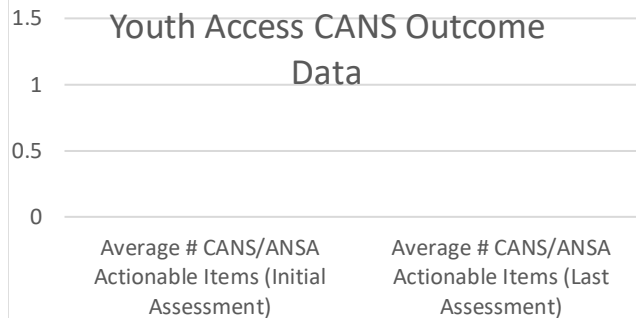
### PROGRAM DESCRIPTION & PROCESS:

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.

### FY 2022-2023 PERFORMANCE OUTCOMES:

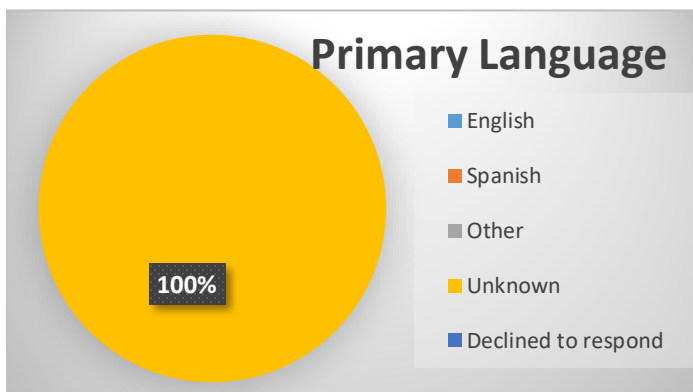
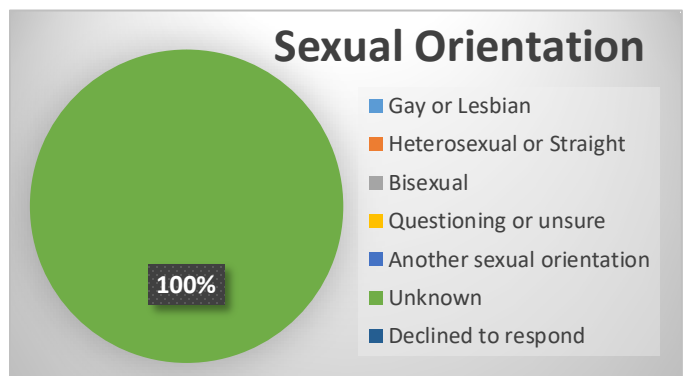
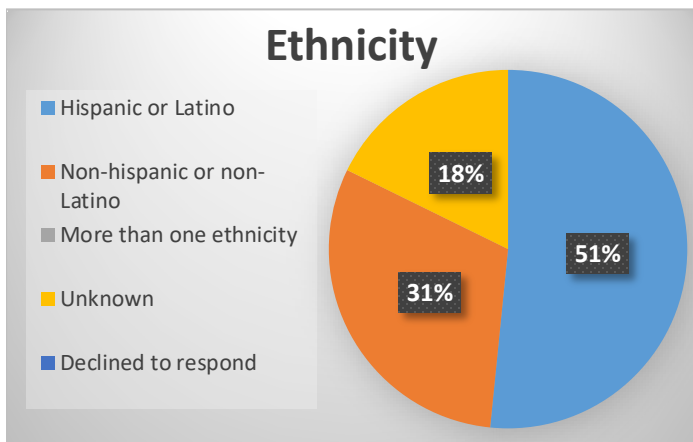
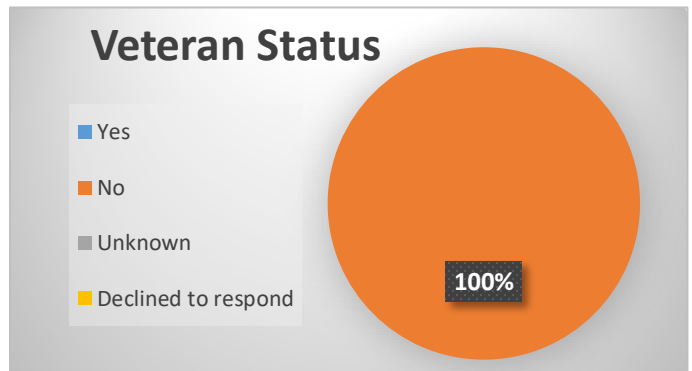
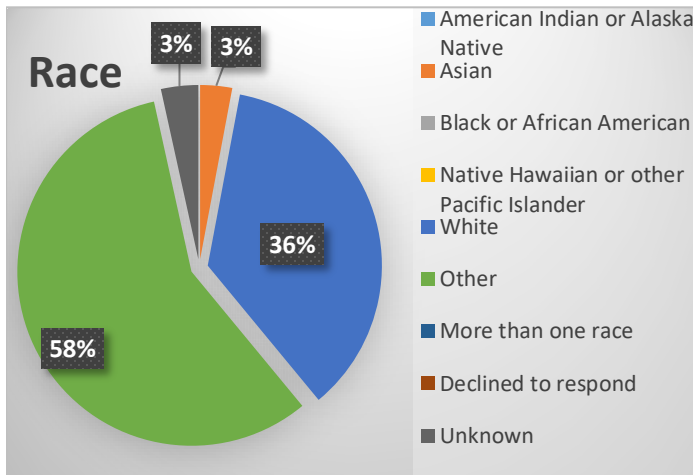
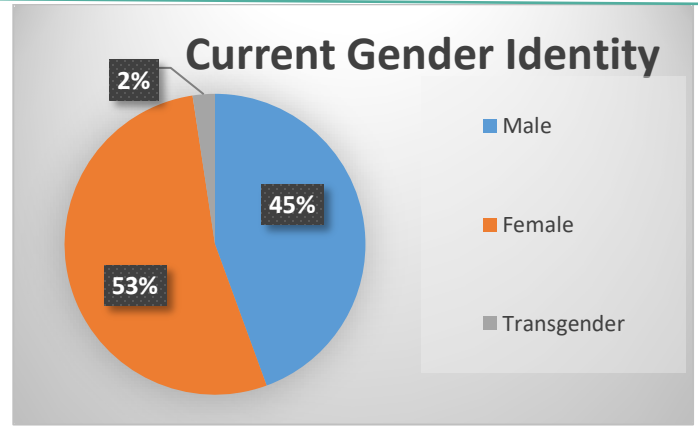
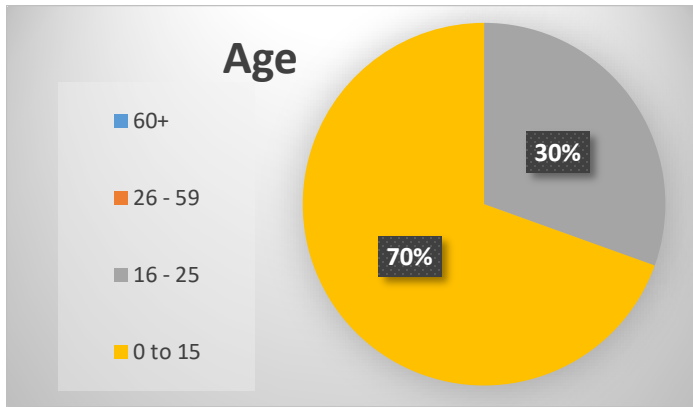
- **Total number of clients served: 237**



\*Data not available during this report.



# FY 2022-2023 Program Demographics:



## SONOMA COUNTY MHSA ANNUAL PROGRAM 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

### Suicide Prevention

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



CONNECTION IS PREVENTION

# Buckelew Programs' North Bay Suicide Prevention Program (NBSPP)



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 2022-2023 PROGRAM STATISTICS

- **Total number of clients served:** 2284 hotline contacts
- **Total number of encounters:** 6,703
- **Approximate numbers reached through outreach:** 5007

### 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.*

### PROGRAM INFORMATION

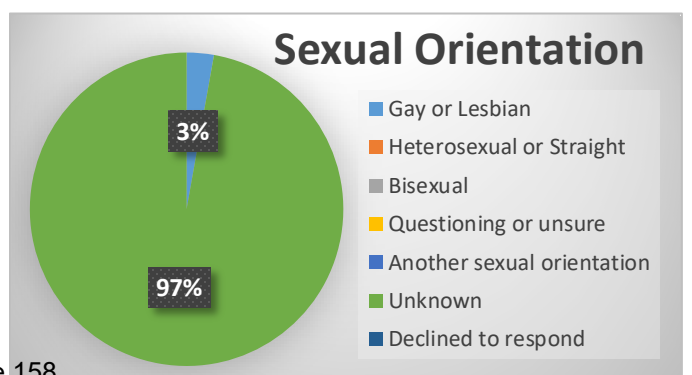
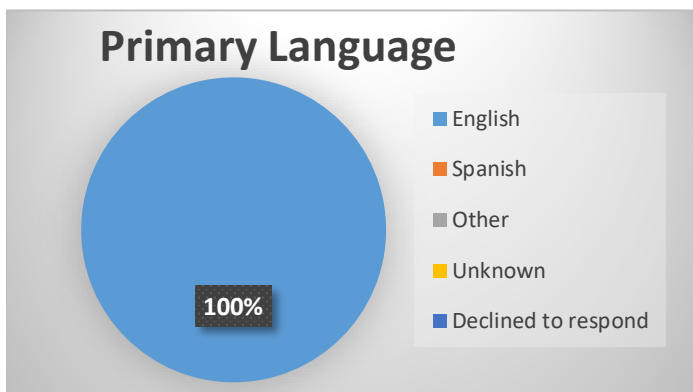
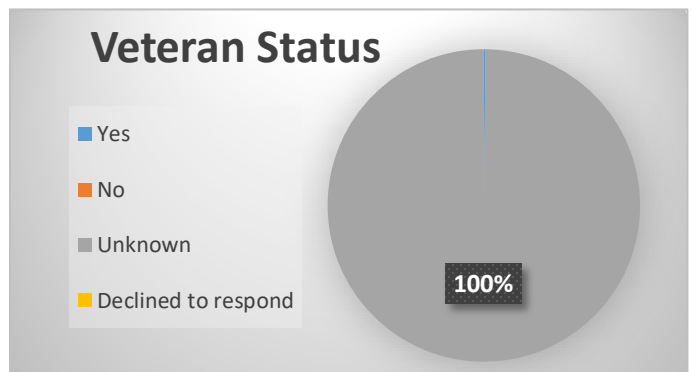
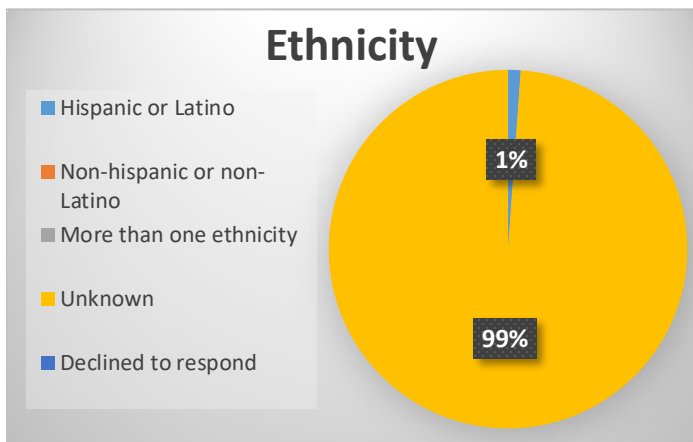
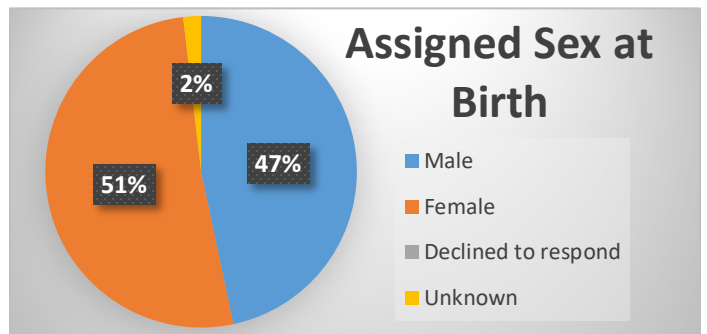
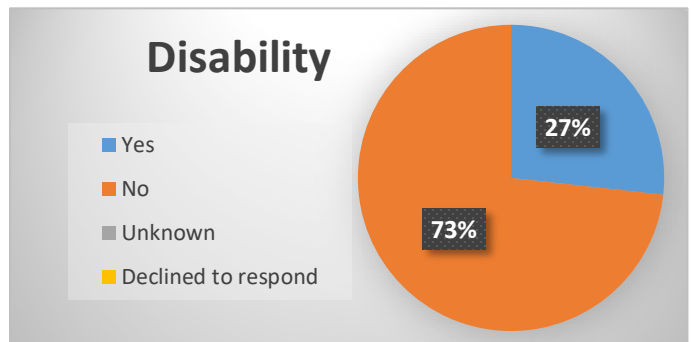
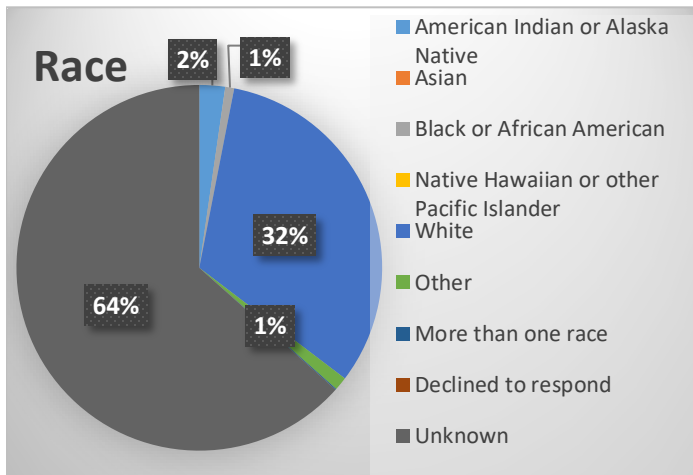
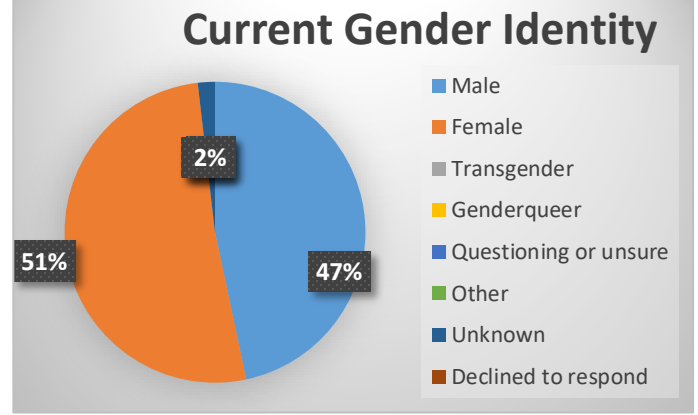
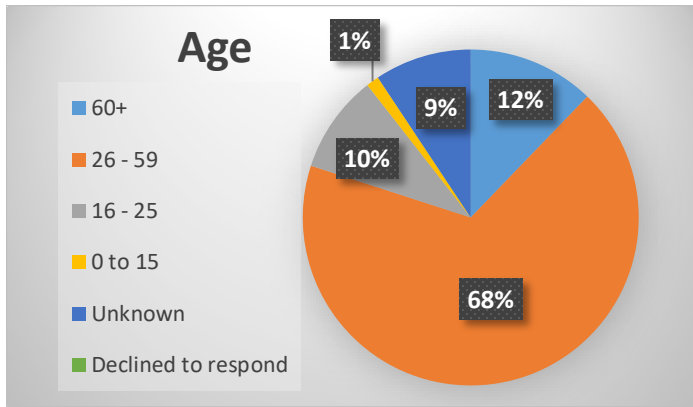
**Program Name:** Buckelew Programs  
**Population served:** All Ages in Sonoma County  
**Website:** www.buckelew.org  
**Phone:** (415) 457-6964  
**Program location:**  
 201 Alameda Del Prado, Novato, CA 94949

### PERFORMANCE OUTCOMES & PROGRAM ACCOMPLISHMENTS:

- In FY 22-23, program created new supervisor positions to support the team and program expansion
- 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.
- Program answer rate 91% and call volume increased over 30%
- Quote from a volunteer who became Volunteer/training coordinator: "The program saves lives and it's hard work. The staff need support to do the job well"
- Quote from a NBSPP caller: "The hotline helped me to not feel crazy. I needed that" – Jen (Alias for confidentiality)



# FY 2022-2023 Program Demographics:



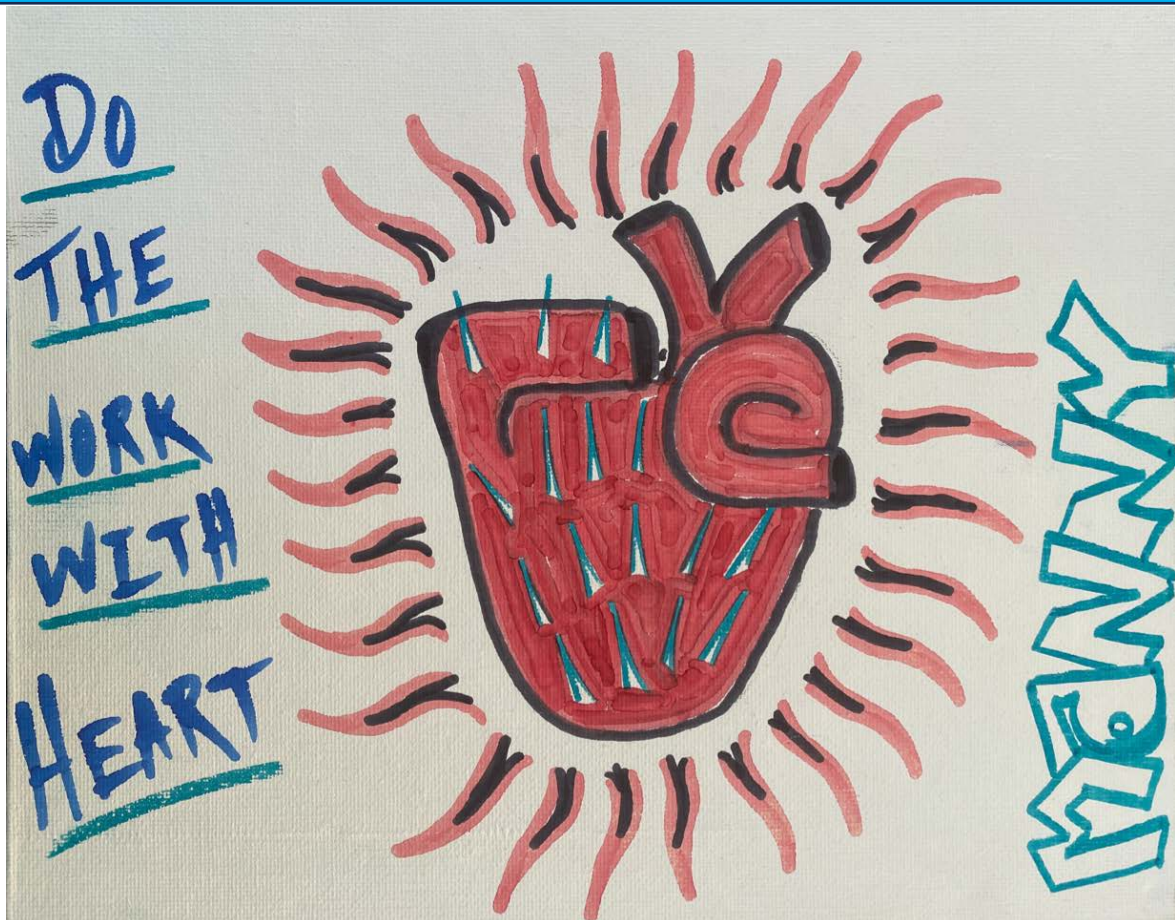


**CONNECTION IS  
PREVENTION**



**FY 2022 - 2023**

**SONOMA COUNTY MHSA  
ANNUAL REPORT ON INNOVATION  
PROGRAMS**



# SONOMA COUNTY MHSA ANNUAL PROGRAM REPORT FY 2022 – 2023

## 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 22-23, DHS-BHD had six projects funded through the Innovation component.



CONNECTION IS PREVENTION



# Early Psychosis Learning Health Care Network Project



FY 2022-2023 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 INFORMATION

**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 2022-2023 PROJECT OUTCOMES:

Please refer to FY 2022-23 Annual Innovation Report: Early Psychosis Learning Health Care Network on page 229 for a complete list of project outcomes.

### FY 2022-2023 PROJECT CHANGES:

Refer to FY 2022-23 Annual Innovation Report on page 229.



CONNECTION IS PREVENTION

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



Human Services Department  
COUNTY OF SONOMA



FY 2022-2023 INNOVATION PROJECT: Unidos Por Nuestro Bienestar

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 INFORMATION

**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

FY 2022-2023 PROJECT STATISTICS

- **Total number of clients served:** 14
- **Total number of new referrals:** 41

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 2022-2023 PROJECT OUTCOMES:

We served 14 unduplicated clients this project year, four completed the full 12-month Unidos program. Among these four clients:

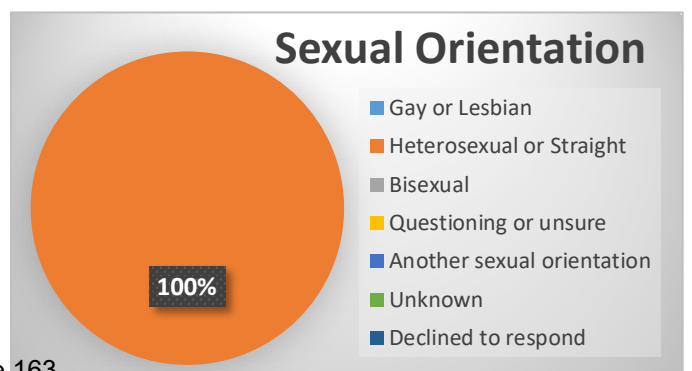
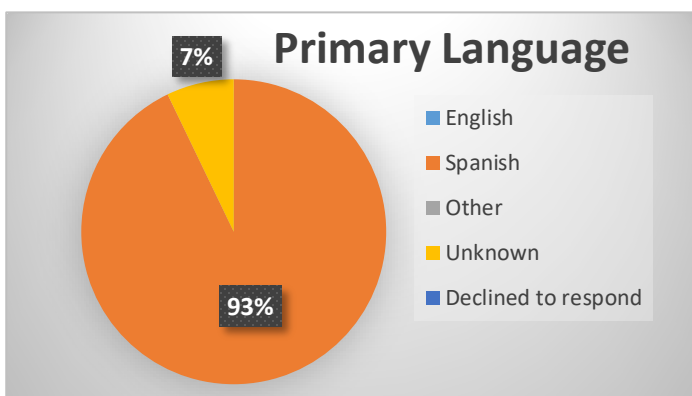
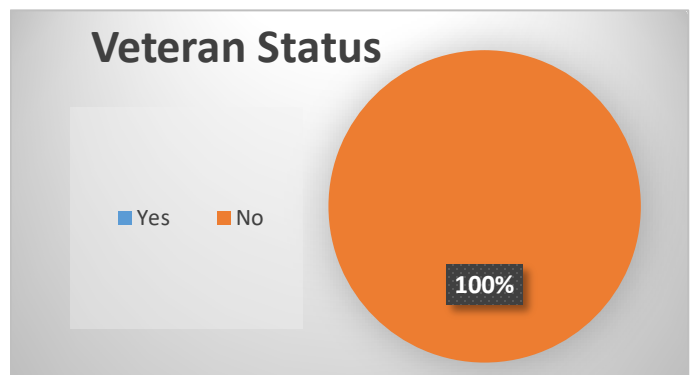
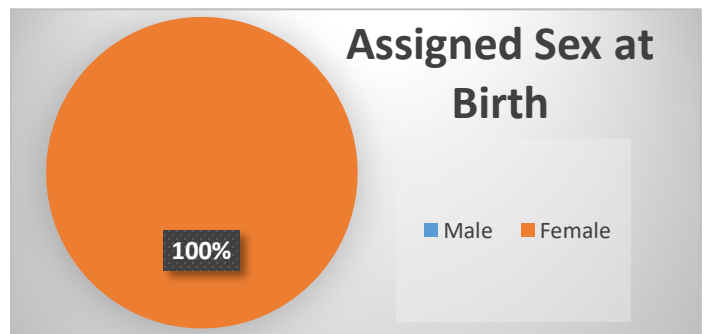
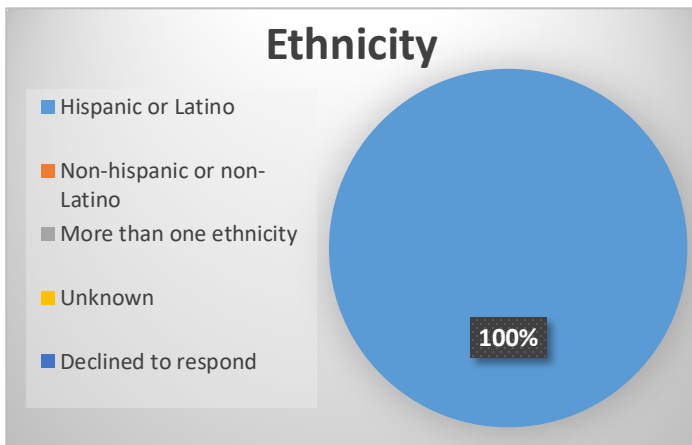
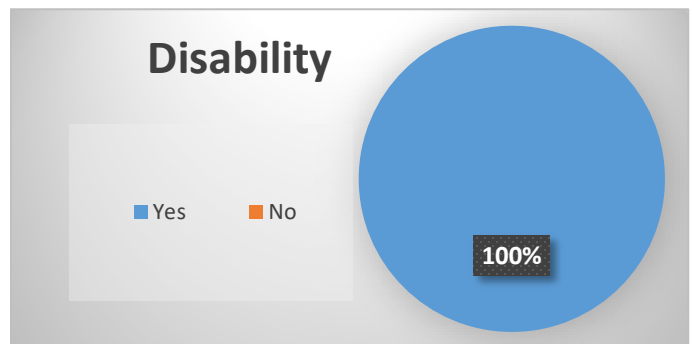
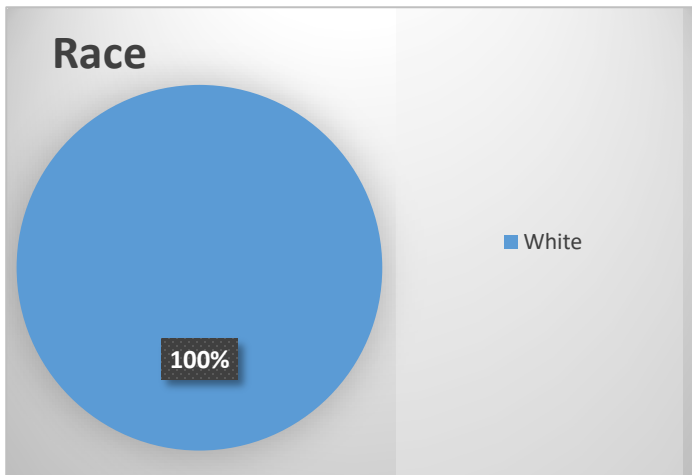
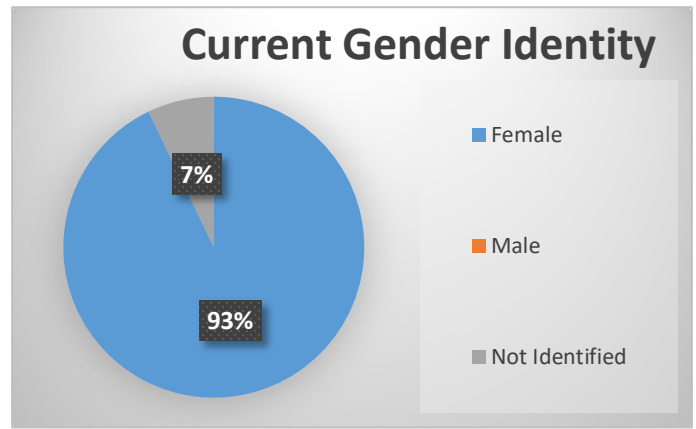
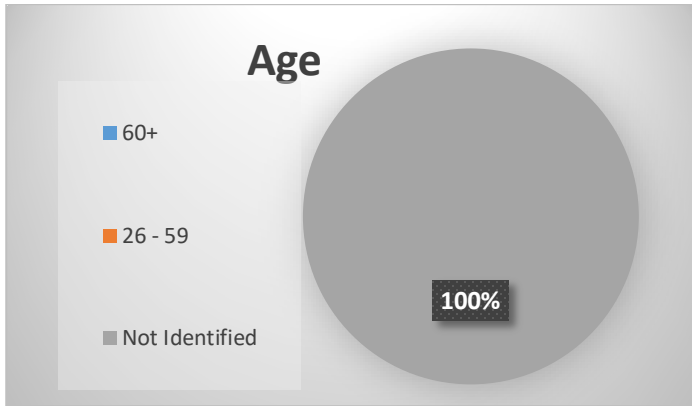
- All of them (100%) met the goals they established at enrollment to address their needs and improve their mental health status;
- Three of them (75%) demonstrated improvements in their depression symptoms as reflected in a 9- to 15-point decrease in PHQ9 score from program entry to exit; and
- The 2 client satisfaction surveys received from program completers revealed strong satisfaction with services and their case manager (a score of 25/25--see attached sample satisfaction survey).

FY 2022-2023 PROJECT CHANGES:

A project modification was submitted to address the implementation barriers detailed in the "Challenges" section of the FY 2022-2023 report. **To read the full FY 2022-2023 Innovation Project report go to page 203.**



# FY 2022-2023 Project Demographics:



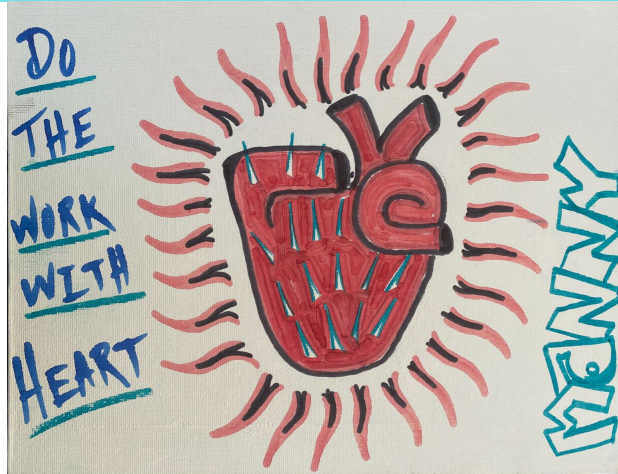


## Nuestra Cultura Cura Social Innovations Lab Project

CONNECTION IS PREVENTION

FY 2022-2023 INNOVATION PROJECT: Nuestra Cultura Cura Social Innovations Lab

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 INFORMATION

**Project Name:** Nuestra Cultura Cura Social Innovations Lab (NCC SIL)  
**Population served:** Insert info here (age range, geographic area, etc.)  
**Website:** [www.laplazanc.org](http://www.laplazanc.org)  
**Contact Info:** 1221 Farmers Lane Suite 200, Santa Rosa CA 95405  
 Phone: (707) 393-8700  
**Social Media:** Instagram - [@nuestra\\_cultura\\_cura](https://www.instagram.com/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 2022-2023

### PROJECT STATISTICS

- **Total number of clients served: 124**
- **Total number of encounters: 200**

### FY 2022-2023 PROJECT OUTCOMES:

The biggest success experienced during this reporting period was the launch of NCC SIL's offerings by holding a Caminata in Glen Ellen at Jack London State Park. This event provided an opportunity for the collective to come together to nurture well-being in Sonoma County. It provided an opportunity to co-create a space where community members felt connected, valued, and supported on their wellness journey. Through collaboration with communities and like-minded organizations, NCC SIL was able to build a culturally-rooted environment that celebrated diversity and honored the traditions, practices, and healing wisdom of different cultures. Through the Caminata, NCC SIL was able to: 1.) co-create inclusive spaces that honored and respected diverse cultural backgrounds; (2) promoted wellness practices rooted in the rich traditions of the Latine and Indigenous communities; (3) provided resources and support for individuals and their families on their journey to well-being; (4) and engaged in meaningful partnerships to strengthen community impact.

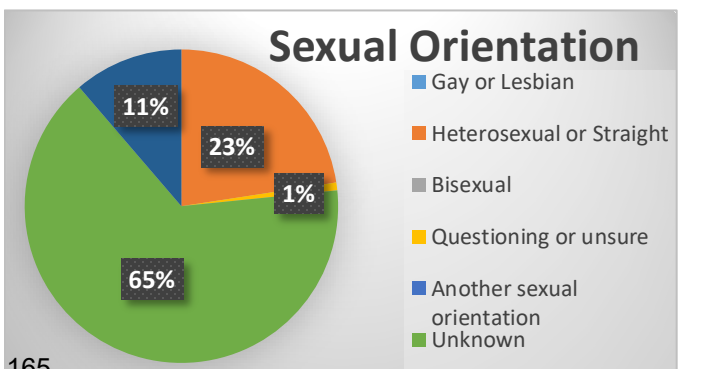
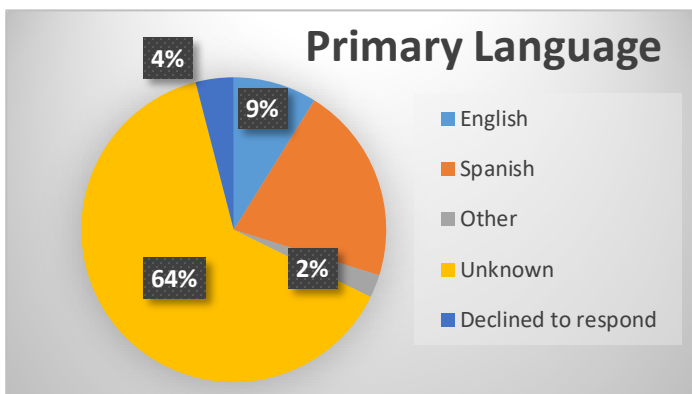
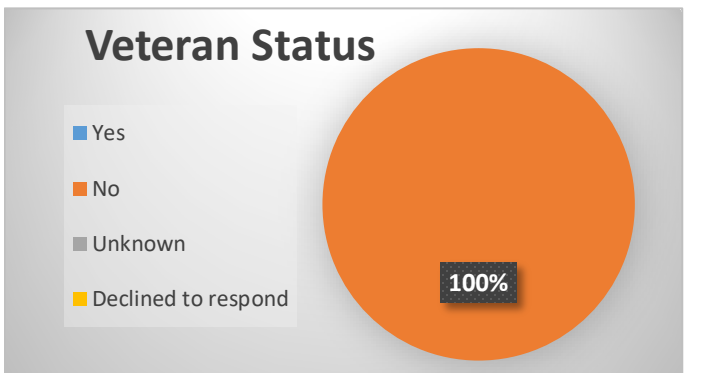
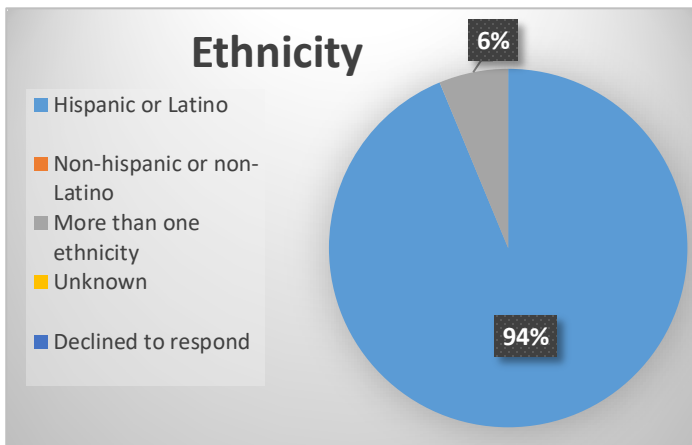
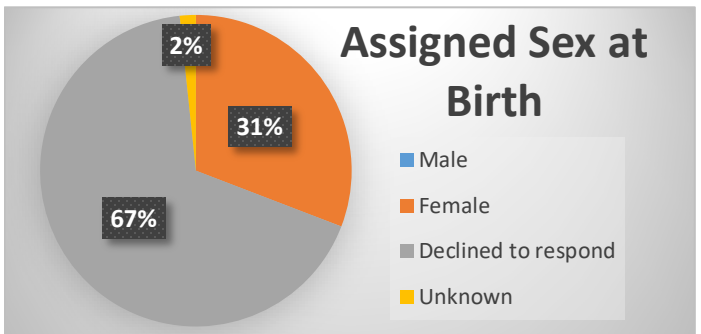
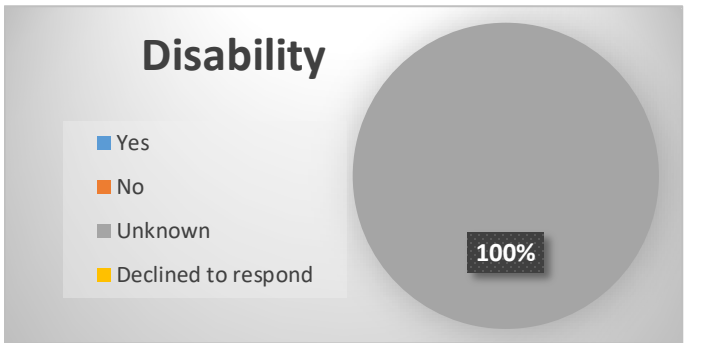
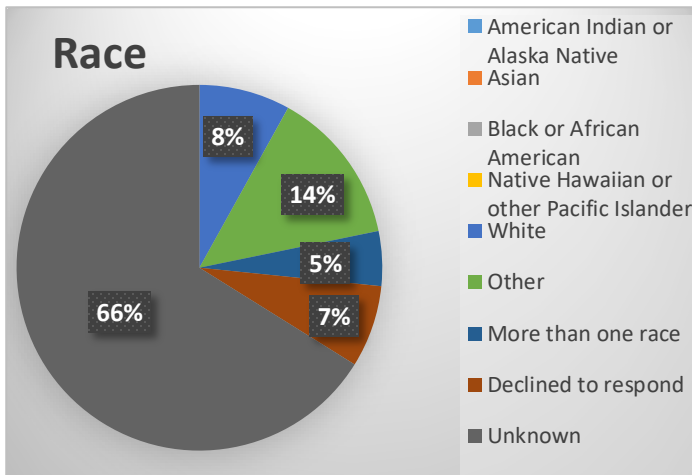
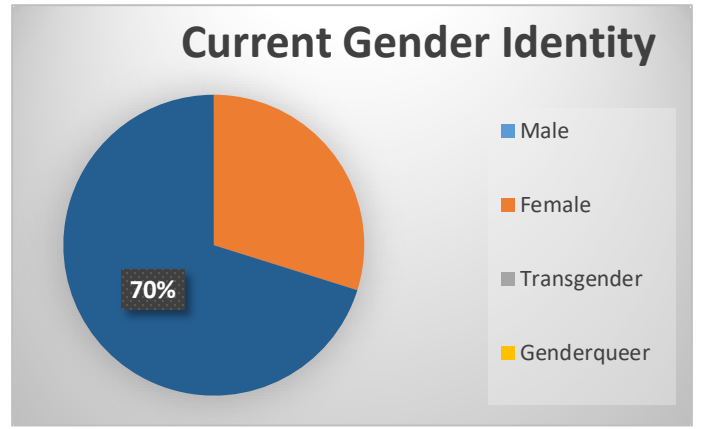
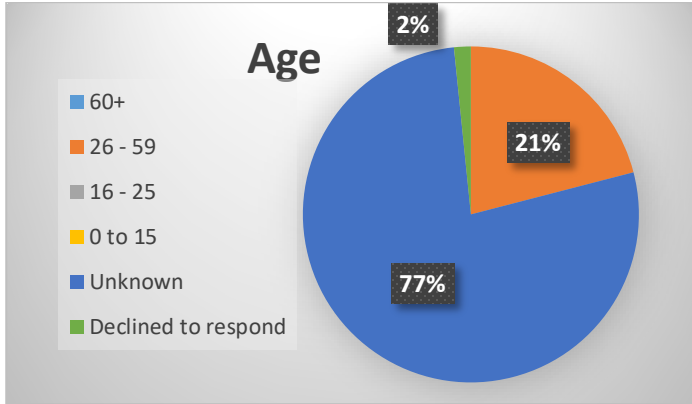
### FY 2022-2023 PROJECT CHANGES:

The biggest change made to the project was in the timeline of delivering the offerings. Given the challenges in coming together, the schedule to deliver community offerings was extended until the end of the calendar year (December 2023).

To read full FY 2022-2023 Innovation Project report go to page 176.



## FY 2022-2023 Project Demographics:



CONNECTION IS PREVENTION

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



FY 2022-2023 INNOVATION PROJECT: First 5 Sonoma County's New Parent TLC

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 INFORMATION

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

### FY 2022-2023 PROJECT STATISTICS

- In the 2022-2023 FY the project was still in the development stage.
- An advisory group was developed to provide feedback during the curriculum development

### FY 2022-2023 PROJECT OUTCOMES:

In the first year of the project, First 5 Sonoma County contracted with consultants to develop culturally responsive curriculum that was first 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 were mental health professionals who specialize in maternal mental health.

Also in the first year, a culturally responsive community advisory group was 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 were seven participants in 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.





## FY 2022-2023 Quotes from the Advisory 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



*“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.”*

-Parent with lived experience

## FY 2022-2023 PROJECT CHANGES:

One of the biggest changes to the program was the timeline of the curriculum development (as noted in the challenges section below). Since this is an innovative program, we worked with consultants to develop the Curriculum from scratch. The development of the curriculum with the consultants took longer than expected because of the convening of the Culturally Responsive Curriculum group which shaped and changed the content of the originally planned curriculum. Also, meetings with the three individuals from the child care, esthetician, and employer sectors make it clear that each curriculum would need to be curated to meet the needs of each population more than expected. With these realizations, First 5 Staff chose to focus on one sector curriculum at a time (first sector was child care). The creation of the Connector training binders, role play scripts, and outreach materials (including translation) also changed the timeline and will need to be specially curated for each sector. With all that being said, the curriculum/material development took twice as long as anticipated on the original Scope of Work.



CONNECTION IS PREVENTION

# Early Learning Institute's Instructions Not Included



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.



### PROGRAM INFORMATION

**Program Name:** Instructions Not Included

**Population served:** Families with an infant who are not enrolled in another HV program.

**Website:** [www.earlylearninginstitute.com](http://www.earlylearninginstitute.com)

**Phone:** (707) 591-0170

**Program location:**

Serving All of Sonoma County

Services are offered in home, virtually or at the ELI center in Santa Rosa, based on family preference.

### FY 2022-2023

### PROGRAM STATISTICS

- **Total number of clients served:** 756 screenings completed
- **Total number of encounters:** 806
- **Approximate numbers reached through outreach:** 40,000 via mailings, website hits, SM outlets and radio ads

### PROGRAM DESCRIPTION:

The Early Learning Institute's Instructions Not Included (INI) program provides up to 5, FREE home visits - or virtual visits if preferred, with a father/partner-friendly format. The experienced INI staff helps answer questions around infant development, adjusting to life as parents, infant safety, and social emotional well-being. Assistance is given for needed resources or referrals. INI will also provide information regarding the challenges associated with Perinatal Mood Disorder and resources available to help those who are struggling.

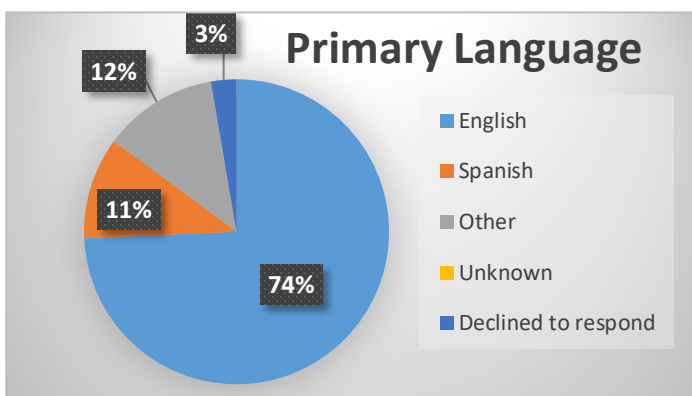
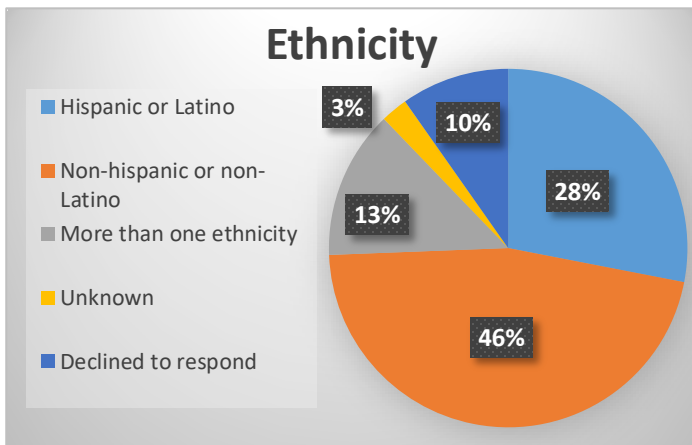
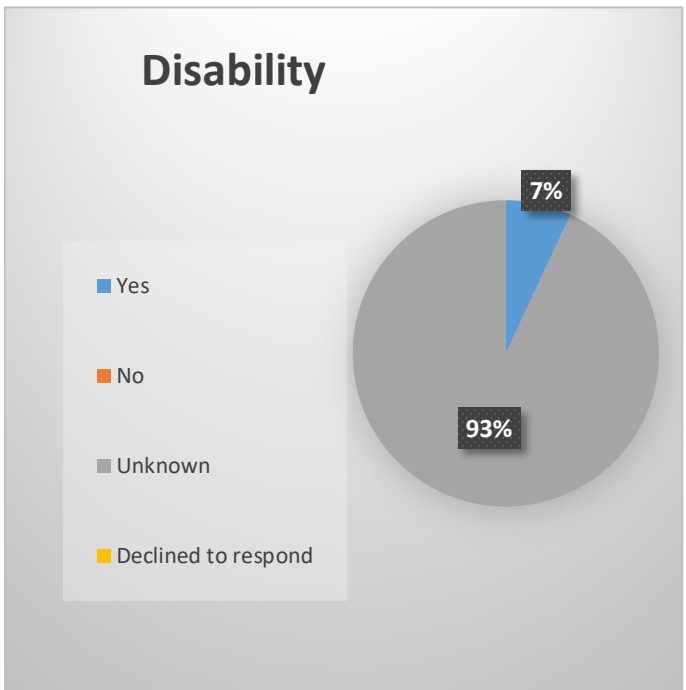
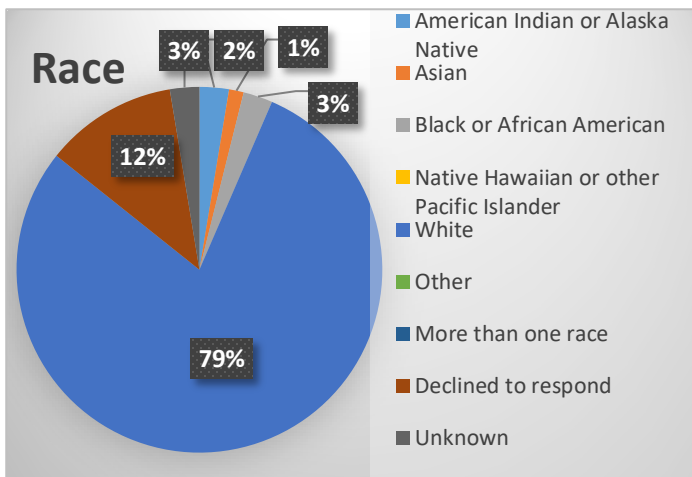
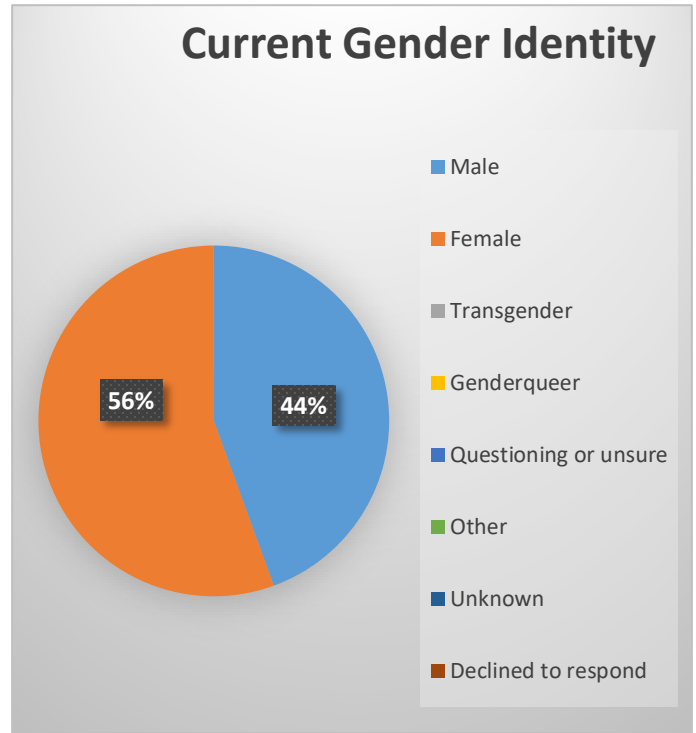
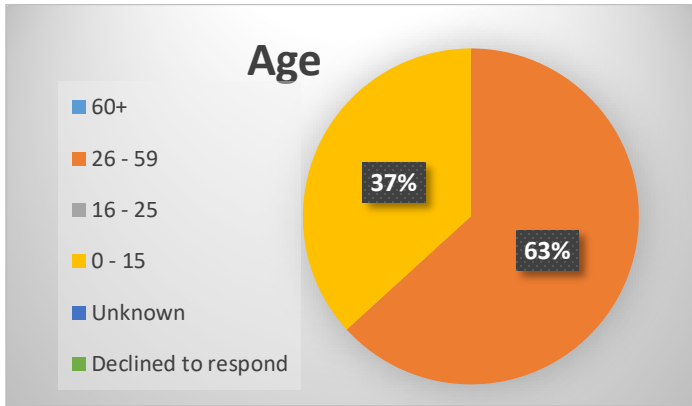
### FY 2022-2023 PERFORMANCE OUTCOMES:

Families participating in INI are reporting high satisfaction with the program and the information they are receiving. Though referrals were still low at the end of the FY 2022/2023, they were picking up significantly in Q4. 1 in 4 fathers screened for PPD scored high. Referrals for services were made and most reported they were able to get a therapist. None of the fathers/partners have refused the screenings, though fathers seem to want to do their screeners during their individual visit instead of with their partners. So far, none of the fathers have had high ACE scores, but some of the female partners and mothers have (+4 score) though most were already receiving supports around this or felt they had previously dealt with the issues. The majority of fathers/partners reported they were grateful to have the opportunity to ask questions one-to-one about child development and parenting. This increased their confidence and Knowledge. The ACE screening allowed for enriched conversations on how the family can work together as a team to address issues related to the scores.

To read full FY 2022-2023 Innovation Project report go to page 171.



# FY 2022-2023 Project Demographics:





## CalMHSA's Semi-Statewide Electronic Health Record Multi-County Collaborative 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.

### DESCRIPTION OF PROJECT:

This is a multi-county, scalable INN project that stems from a larger Semi-Statewide Enterprise Health Record (EHR) project CalMHSA is concurrently leading (the EHR Project). CalMHSA is partnering with 23 California counties – collectively responsible for 27% of the state's Medi-Cal beneficiaries – on the 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 in the future.

### FY 2022-2023 PROJECT OUTCOMES:

Sonoma County completed primary data conversion and migration for go-live date of 7/1/23. End-user staff training was completed and a Behavioral Health Informatics Analyst was hired to support the implementation of this project as a primary system admin for the new system, and primary training coordinator for on-boarding new staff. Sonoma has participated in multiple weekly collaboration and planning meetings with CalMHSA and other counties. Additionally, CalMHSA has provided ongoing TA pertaining to clinical needs, prescriber needs, billing set-up, reporting, and inpatient/residential functionality.

### FY 2022-2023 PROJECT CHANGES:

Sonoma County has requested changes to the participation agreement, these additions include one additional lab (LabCorp) and text reminders for appointments. The additional of the secondary lab options will facilitate improved care coordination by allowing for all lab interfaces within the same system. The text reminder feature will help reduce the incidence of no-shows for psychiatry and clinical appointments.

### PROJECT INFORMATION

**Project Name:** California Mental Health Services Authority (CalMHSA): Semi-Statewide Enterprise Health Record

**Project Goals:**  
This project focuses on transforming current EHR systems and processes counties use for the provision of behavioral health services. Accordingly, the number of individuals expected to be served annually is not estimated but instead this project focuses on quality, safety/privacy, satisfaction, and outcomes.

**Project Proposal:**  
<https://sonomacounty.ca.gov/Main%20County%20Site/Health%20and%20Human%20Services/Health%20Services/Documents/Behavioral%20Health/mental-health-services-act/Sonoma-County-MHSA-INN-Semi-Statewide-EHR-Proposal.pdf>



## FY 22-23 MHSA Innovation Annual Report

### Instructions Not Included

#### **Brief description of Project**

ELI's Instructions Not Included, (INI) is the first home visiting program in Sonoma County to target new fathers in a mental health focused fashion. INI is unique in that it includes the use of the Edinburgh Postnatal Depression Scale (EPDS with modified scoring for males) screening and ACE screening for dads. Referrals to INI come from Community Partners, Medical Professionals, and self-enrollment. Outreach is done at birthing classes, Obstetricians, MH partners and other places likely to be seen by new parents. INI home visitors conduct 5 home visits with fathers with 4 open to both parents, strategically placed to coincide with known vulnerable periods during an infant's first year of life:

- VISIT 1: 4-6 weeks after birth; sooner if requested. (Surveillance for PPD happens at this visit.)
- VISIT 2: 3-4 months after birth; (PPD screening tools are administered.)
- VISIT 3: 9 months after birth; (ACEs screening is given to both Caregivers)
- VISIT 4: 12 months after birth (ASQ is used to screen baby)
- Father Only Visit – 6 months after birth or earlier if requested by father.

#### **Problem Statement**

The primary problem this project wants to solve is the lack of screening and early identification of perinatal mood disorders in new fathers and a resulting lack of understanding of the magnitude of the problem in Sonoma County. Without this data, existing home visiting programs will continue to ignore the needs of new fathers and fail to engage them in the care of their child and partner from the very beginning.

#### **Learning Goals**

**The Following learning goals have been defined for Instructions Not Included:**

- 1) What percentage of new fathers are engaged in the INI home visiting program and complete both the PPD and ACEs screenings offered?
- 2) Identify the rate of paternal PPD in Sonoma County.
- 3) Identify availability of appropriate paternal PPD support, education and counseling resources in Sonoma County
- 4) Identify the rate of high ACE scores in new fathers in Sonoma County.
- 5) Identify availability of appropriate paternal ACE support, education and counseling resources in Sonoma County.
- 6) Identify the co-occurrence of paternal PPD and high ACE scores.

We will use what we find out to inform community partners as to how to increase support for partners, should that be needed. Data from this project may also inform child abuse prevention strategies as high ACE scores have been shown to correlate to more frequent use of corporal punishment from fathers.

### **Findings to date (preliminary)**

Since Instructions Not Included is ending its first year, and enrollment in the program was slow, there are not yet significant findings. However, preliminary data shows that most fathers/partners are attending all of the visits and they do want their separate visits – and most want it with our male counselor/home visitor when offered a choice. There has not been a high correlation of high ACE scores to high PMD scores – but the PMD scores have been in the moderate to concerning range. Referrals for PMD support for both moms, dads and other caregivers are well received but resources in Sonoma County are scarce and there are often wait lists or high copays, which is a burden on young families.

Additional findings indicate that INI home visitors need further and frequent training on mental health resources in Sonoma County as capacity, staffing and funding impact availability of services.

### **Evaluation data (if available), including outcomes and information about elements that are contributing to these outcomes.**

\* 100% of INI workforce ready to provide service by September 30, 2022 – Done and completed on time.

\*50% of participants in INI will have been referred by a community partner or medical provider. 70% of participants were referred by a community partner or medical provider.

•70% of families enrolled in INI will complete, or be on track to complete, all home visits in the series. 85% of families have completed or are on track to complete all their visits.

•50% of fathers enrolled in INI program will participate in all INI visits, including the PPD and ACEs screenings. – *statistics currently not available. Should have these in a couple of weeks.*

\*Identify the rate of paternal PPD in INI Participants. 28.5% of fathers screened had a high PPD score. Almost half of the father's are reporting high stress levels to the home visitors during the father's visits. The most common issue was feeling like they had to be strong when the mother or baby were crying, stressed or emotional. They said they felt like they had to hold it all together and take care of everyone. This came up even for those whose PMD score was low. The fathers reported relief in having another man that they could talk to about these feelings, without being judged. This common theme has the INI team thinking if we want to offer a father's group every quarter, where the dad's could make a toy for their child, or play a game of basketball, etc. and talk about "life as fathers."

\*Identify availability of appropriate paternal PPD support, education and counseling resources in Sonoma County, for INI participants - This is a work in progress across the three years of this program. However, antidotal reports from the fathers seeking MH support for PPD is that it is typically treated like generalized anxiety. One stated he felt patronized by his MD who said “all new fathers feel this way. It means you are normal.”

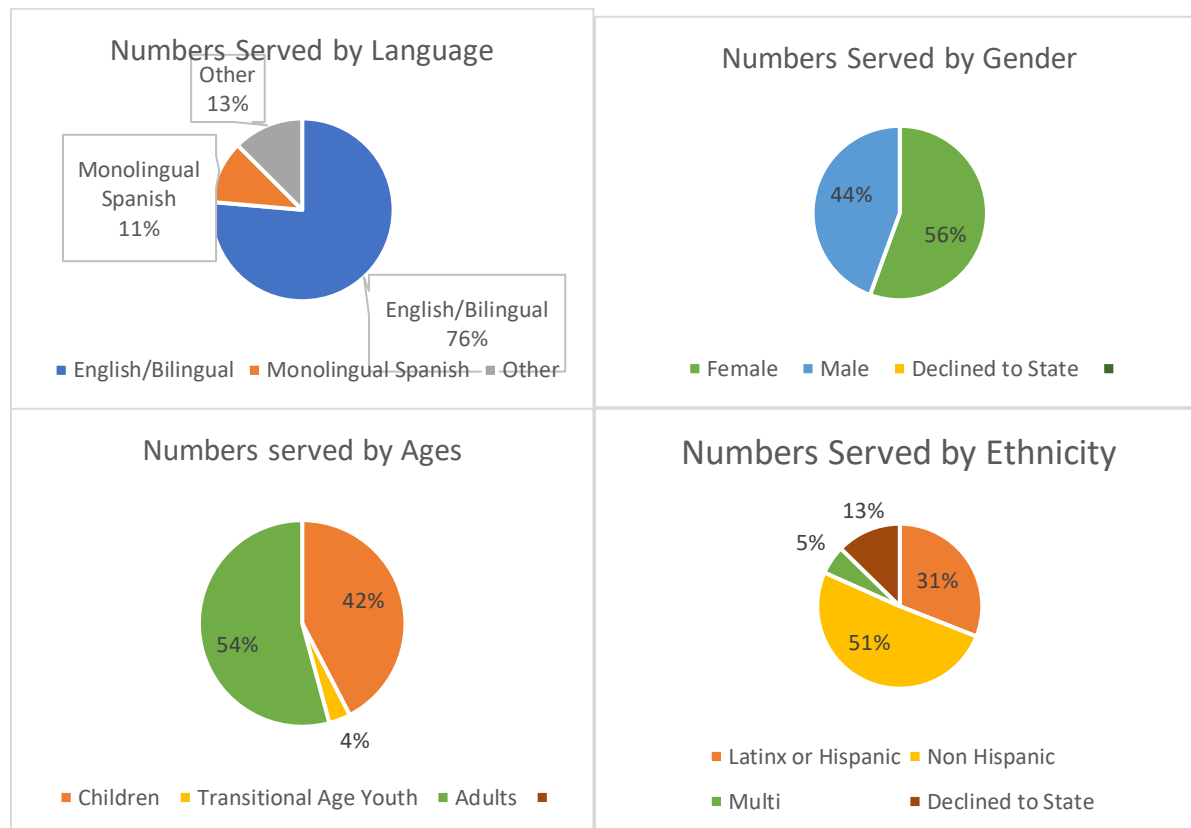
\*Identify the rate of high ACE scores in new fathers participating in INI. Surprisingly, none of the fathers have reported high ACE scores. 15% of their partners had high ACE scores.

\*Identify the co-occurrence of paternal PPD and high ACE scores. 0 co-occurrence as there are no high ACE scores. Very early in the program and numbers are small.

**Any changes that were made to the project during the reporting period and the reasons for the changes, including any changes in the timeline.**

- 1) Expanded the program eligibility criteria to all families in Sonoma County with a young infant, not just first time Caregivers. We did this to increase program access based on the referrals we were receiving. We also wanted to strategically increase number of families utilizing INI as a resource.
- 2) Extended the timeframe for enrollment in INI to increase access to the program. Referrals are now accepted for families with an infant up to 6 months of age, instead of 2 months of age.
- 3) Adapted timeframe for visits for late referrals to allow Caregivers to access all 5 visits if the family desires. We did this to increase the available screening data from later visits.
- 4) Allow the father screenings to be done when it is most comfortable for the fathers. One lesson we have learned during the first year of the program is that many fathers prefer to wait for the father visit to take the PPD and ACE's screenings. Reporting they want to stay and look strong so their spouse doesn't worry, while at the same time wanting help around areas they feel insecure about.

**Demographics from the reporting period:**

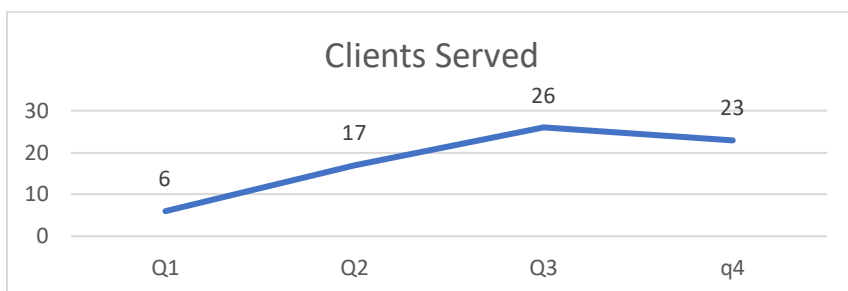


Instructions Not Included also served 4 individuals who identified as LGBTQ and 3 who identified as having disabilities in one or more categories, including deaf/hard of hearing.

## Successes



- INI seems to be finally taking off!



There has been a steady increase in referrals since January.

- Outreach for INI is also taking off! Efforts have included targeted social media posts (on Facebook and on Twitter) as well as email reminders to community partners through the “mail chimp” system. In the last quarter there have been 8 separate boosted posts, resulting in **over 200 views and/or “likes.”** 12 community partners have “shared” the information through their own social media outlets. Additionally, ELI has finalized a set of tools on our website that allows full language and disability access. All information can be automatically translated into the family’s home language. In the past few months, we’ve been invited to present the program at different organizations staff meetings, tabled, or passed out information at a variety of community events, done public service announcements, and posted on a variety of social media platforms over the last year. In the final quarter of fiscal year 22/23 we have done direct outreach at:
  - \* Mitote Food Park in Santa Rosa on four separate occasions
  - \* LGBTQ events and meetings throughout the county
  - \* Nurse Family Partnership staff meeting on 4/4/23
  - \* Sonoma County Children’s Museum, 4/13/23
  - \* Sonoma State Children’s Fair on 4/15/23
  - \* Community Resource Fair for Victims of Crime on 4/29/23
  - \* Teen Parent Connection staff meeting on 5/9/23
  - \* Reminder outreach to NICU nurse at Sutter Santa Rosa on 5/16/23



\* Shared INI information at the opening of Rohnert Park FRC on 6/8/23

\* Meeting with UCSF NICU nurse to discuss INI for clients they have from Sonoma County

- Important referrals have been made for Families. One referral was made for a baby based on the Newborn Behavioral Observation screening and that child received Early Start services. Two other children were referred for other children's programs and received the services. Five families were referred to WIC, Sonoma County 4C's program or for financial support services.
- ELI strives to keep our staff up to date on issues affecting our clients. The entire INI staff attend the Brazelton Touchpoints Center National Forum: All About Fathers and the Men in Children's Lives conference, May 2-5, 2023.

### **Brief Story**

Though it has taken INI longer than anticipated to gain traction, the families we have served have expressed extreme appreciation for the service, support, and referrals they received. Having these home visits helps families get the help they need, when and if they need it. One family in particular needed an extreme amount of help. When the mom made the appointment, she expressed a need for breastfeeding support and stated she felt her partner needed help understanding how hard the past few months had been on her since the baby's birth. The INI home visitor, Rosa, went out to see the family almost immediately, given the mother's level of distress. The initial visit ended up being over three hours as Rosa grew more and more concerned about the mother's emotional health. Mom said she was struggling to feed the baby and believed in her heart that this was not her baby – that this little boy was not the baby she gave birth to. No amount of reassurance from dad was helping. It was no surprise that mom tested high on the Edinburgh, showing high levels of postpartum depression. Rosa believed that mom was bordering on psychosis and urged both caregivers to seek immediate medical treatment. The mother was resistant but eventually put in a call to her physician who gave her an immediate appointment and started treatment for PPD. The family has since had two more appointments and though mom still has a lot of anxiety about her baby, she is doing better. Dad is participating in all the visits and is committed to learning as much as he can about helping the mom.

### **Challenges in implementation**

- Referrals to Instructions Not Included were very slow between July and January. We have been devoting a lot of staff time to increasing these numbers. You can see the increase in Q3 and Q4 and we are still seeing it in Q1 of 2023/2024.
- ELI's reputation in the community seems to be one challenge to implementation. A couple of referrals we had difficulty connecting with. When we finally reached them, they said they weren't sure they needed Instructions Not Included. The home visitor asked more questions and learned that both families knew of the Early Learning Institute and loved our reputation. They went on to state that they did not have developmental or social-emotional concerns about their baby, so they didn't want to take services from those that need them. Upon explaining the differences in the programs, the families were then eager to accept INI services.



HUMANIDAD  
Therapy & Education Services

NOVEMBER 2, 2023

# MHSA INNOVATIONS ANNUAL REPORT: FY 2022-2023



Artwork Created by NCC SIL Members During a Monthly Gathering



NCC SIL Altar (present at every gathering)

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# A Shared Vision with Intentionality

"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.**"

NCC SIL Participant Feedback



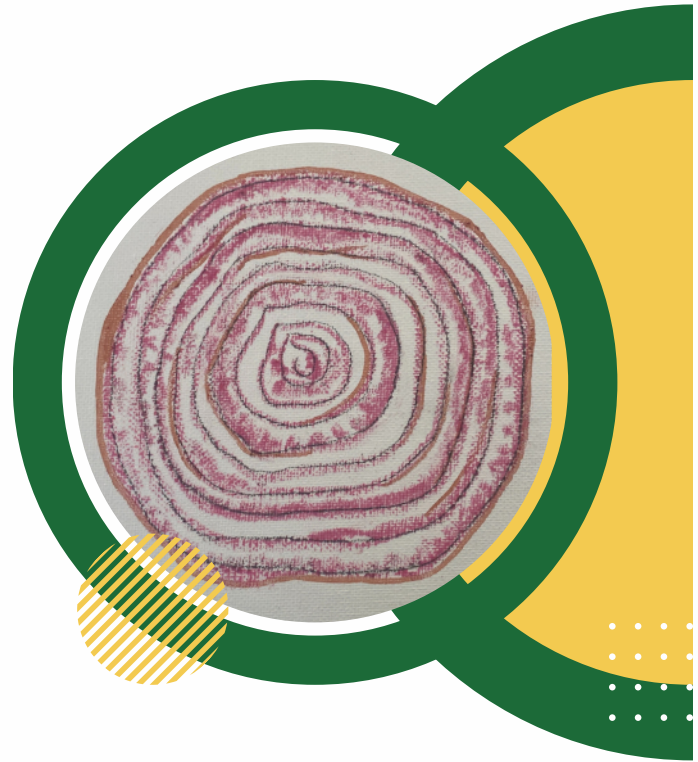
## Collaborating Partners

The Nuestra Cultura Cura Social Innovations Lab is made possible through collaboration with the five organizations.

In addition, to these partners, NCC SIL will invite cultural healers, individuals providing healing resources and services as defined by those they serve, to join the NCC SIL.

**NUUESTRA  
CULTURA CURA**

Social Innovations Lab





# MHSA ANNUAL REPORT: YEAR TWO

## 1. INTRODUCTION

**T**he 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 and alongside, our 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 2025. The following report presents data regarding Year Two 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 practitioners, 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 author is Cindy Berríos. Questions about this report can be directed to [cindy@onthemargins.us](mailto:cindy@onthemargins.us).

## RECOMMENDED CITATION

Berrios, C. (2023). MHSA Innovations Report 2023.

## 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 two, 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 where 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.

**Latino 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 strengths-based 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 poor 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.

The NCC SIL partners have created a variety of culturally-rich, non-clinical prevention and early intervention services designed for the Latinx population of Sonoma County. By engaging in community based participatory research, the partners have worked to develop and implement a minimum of three intervention strategies aimed at decreasing stigma, increasing cultural protective factors, and promoting access to appropriate mental health services. This research has been led by Sonoma County Latinx community members with lived mental health experiences. In an effort to learn about the communities' desires and aspirations, the Lab has authentically engaged the community

to collect information and analyze self-identified needs data in order to design and implement culturally relevant solutions. The Nuestra Cultura Cura project has relied on community defined evidence practices, which are innovative and culturally-rooted traditions designed by the communities they serve, and will ensure mental health equity by providing culturally and linguistically responsive prevention and early intervention services.

The learning goals outlined in the NCCSIL project are as follow:

- To understand what healing looks like for individual and the community as a whole
- To tap into cultural wealth and learn about existing healing practices
- To understand and deepen collective and individual healing practices

Additionally, NCC SIL is seeking to access culturally relevant prevention and early intervention mental health services for Latine community members who are underserved, unserved or inappropriately served. Innovations will continue to seek, recognize and understand strengths and skills of each person and acknowledge that when these strengths are brought together, communities can form a powerful collective.

## **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 is essential to continue to respond to the learning and relational needs of the collaborative. This commitment to centering relationships is an important component of ensuring the success and sustainability of the project. An additional and, quite significant finding, is that given the low numbers of members of the LGBTQIA2+ Community who attended NCC SIL's first community offering, it is clear that more targeted outreach is needed with and within that community in order for NCC SIL to truly create spaces of belonging rooted in cultural humility. While members of the Innovations Team understood that during the second year it would be important to start traveling, visiting, engaging, and connecting "out in the community," it is clear that a more target approach is necessary in order to meet NCC

SIL's goal 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

This quarter's sessions served as an opportunity to acknowledge the deep-rooted challenges that various communities face when it comes to accessing mental health services in Sonoma County. There was an overwhelming list of systemic and structural challenges that were named that have historically created many barriers. For example, language and culture continues to be a challenge, as well as not having sufficient and appropriate services offered to community members. This acknowledgment was integral in helping the collective to strategize and identify concrete tactics that would be utilized to address these barriers and increase access to services.

### Q2 FINDINGS

NCC SIL witnessed the challenges of the winter season, which was unexpected. Many participants found it difficult to attend scheduled monthly gatherings due to illness and holiday travel. There were a couple of sessions that were missing two to three members of the collective, which created a challenge in moving the project forward. However, the collective adapted and reached out directly to those who were unable to join to ensure that they were up to date with the information discussed in the larger group. This level of relational accountability and engagement with each other is deeply rooted in the core values of NCC SIL.

### Q3 FINDINGS

During this quarter, project facilitators and organizations realized the need to have an important conversation about commitment to the project and to the process of our work. The collective had to slow down and have deeper conversations and gain understanding about trauma informed care and healing-center care best practices, as it became clear that the individual toll of working both within traumatized organizations and with clients that have experienced multiple traumas (racialized trauma, immigration trauma, trauma of poverty, etc.) was impacting the ability of providers to participate fully in NCC SIL. Additionally, the collective explored different forms of power and how power can impact NCC SIL's work as a collaborative community and in the larger Sonoma

County community. These were essential pieces for NCC SIL to discuss in order to be able to continue the work ahead. Again, it became necessary to slow down and focus on the relationship before proceeding with the work. In other words, NCC SIL decided to pause in order to focus on connection before content. During this quarter, the collective also identified geographic locations that were in need of services and committed to moving away from being, "Santa Rosa Centric." For this reason, it was decided that the first NCC SIL offering, a Caminata led by Humanidad, would be held in Jack London State Park in Glen Ellen. Both the venue and geographic location were strategically selected in order to deliver programming in a historically underserved community and at a site that has not previously hosted the Latine community or many other communities of color.

## Q4 FINDINGS

This quarter saw the successful execution of NCC SIL's first community offering, a Caminata. The majority of community members who attended expressed an immense amount of gratitude for holding this gathering and expressed the need for more community gatherings, of this type, on a more consistent basis. The success of the Caminata solidified NCC SIL's commitment to continuing to provide culturally-rooted spaces of belonging.

## DEMOGRAPHIC INFORMATION

TABLE 1. Numbers Served

<b>NUMBERS SERVED</b>	<b>FISCAL YEAR JULY 2022- JUNE 2023</b>
Unduplicated or Unique	124
Total Numbers Served	124

TABLE 2. Age Group

<b>TOTAL NUMBERS SERVED BY AGE</b>	<b>FISCAL YEAR JULY 2022- JUNE 2023</b>
Children/Youth (0-15)	0
Transition Age Youth (16-25)	10
Adult (26-59)	26
Older Adult (60+)	7
Missing/Unknown	79
Declined to State	2
<b>TOTAL</b>	<b>124</b>



TABLE 3. Sex & Gender

<b>ASSIGNED SEX AT BIRTH</b>	<b>FISCAL YEAR JULY 2022- JUNE 2023</b>
Female	37
Male	7
Missing/Unknown	1
Declined to State	79
<b>TOTAL</b>	<b>124</b>

<b>CURRENT GENDER IDENTITY</b>	<b>FISCAL YEAR JULY 2022- JUNE 2023</b>
Female	37
Male	7
Transgender	0
Genderqueer	1
Questioning/Unsure	0
Other	0
Missing/Unknown	79
Declined to State	0
<b>TOTAL</b>	<b>124</b>

TABLE 4. Race

<b>TOTAL NUMBERS SERVED BY RACE</b>	<b>FISCAL YEAR JULY 2022- JUNE 2023</b>
American Indian or Alaska Native	3
Asian	0
Black or African American	0
Native Hawaiian or other Pacific Islander	0
White	10
Other	17
Multi	6
Missing/Unknown	79
Declined to State	9
<b>TOTAL</b>	<b>124</b>

TABLE 5. Ethnicity

<b>5A. TOTAL NUMBERS SERVED BY ETHNICITY (LATINO/X/E OR HISPANIC)</b>	<b>FISCAL YEAR JULY 2022- JUNE 2023</b>
Caribbean	1
Central American	0
Mexican/Mexican-American	37

Puerto Rican	0
South American	1
Other	2
Multi	4
TOTAL	45

<b>5B. TOTAL NUMBERS SERVED BY ETHNICITY (NON-HISPANIC/NON-LATINO/X/E)</b>	<b>FISCAL YEAR JULY 2022- JUNE 2023</b>
African	0
Asian Indian/South Asian	0
Cambodian	0
Chinese	0
Eastern European	0
European	0
Filipino	0
Japanese	0
Middle Eastern	0
Vietnamese	0
Other	0

Multi	3
TOTAL	3

<b>5C. TOTAL NUMBERS SERVED BY ETHNICITY (MORE THAN ONE ETHNICITY, DECLINED TO STATE, OR UNKNOWN)</b>	<b>FISCAL YEAR JULY 2022- JUNE 2023</b>
More than one ethnicity	3
Missing/Unknown	0
Declined to State	79
TOTAL	82

TABLE 6. Primary Language

<b>TOTAL NUMBERS SERVED BY PRIMARY LANGUAGE</b>	<b>FISCAL YEAR JULY 2022- JUNE 2023</b>
English	11
Spanish	26
Other	3
Missing/Unknown	79
Declined to State	5
TOTAL	124

TABLE 7. Culture

TOTAL NUMBERS SERVED BY CULTURE	FISCAL YEAR JULY 2022- JUNE 2023
LGBTQ	5
Veteran	0
Experiencing Homelessness	0
Individuals in Foster Care	0
Other	0
Missing/Unknown	0
Declined to State	0
TOTAL	5

TABLE 8. Medi-Cal Beneficiaries

TOTAL NUMBERS SERVED BY MEDICAL	FISCAL YEAR JULY 2022- JUNE 2023
Medi-Cal Beneficiaries	N/A
Missing/Unknown	N/A
Declined to State	N/A
TOTAL	N/A

TABLE 9. Sessions Offered by Program

TOTAL NUMBERS OF SESSION OFFERED BY PROGRAM	FISCAL YEAR JULY 2022- JUNE 2023
TOTAL	17

TABLE 6. Sexual Orientation

TOTAL NUMBERS SERVED BY SEXUAL ORIENTATION	FISCAL YEAR JULY 2022- JUNE 2023
Gay or Lesbian	0
Heterosexual or Straight	28
Bisexual	0
Questioning or Unsure	1
Queer	2
Other	0
Missing/Unknown	79
Declined to State	14
TOTAL	124

TABLE 10. Disability

TOTAL NUMBERS SERVED BY DISABILITY	FISCAL YEAR JULY 2022- JUNE 2023
------------------------------------	----------------------------------

No Disability	29
Communication Disability: Difficulty Seeing	1
Communication Disability: Difficulty hearing or speech	0
Communication Disability: Other	0
Intellectual or Mental Disability	0
Physical/Mobility	1
Chronic Health Condition	5
Other Disability	3
Declined to State	1
Missing/Unknown	0
TOTAL	40

## 9. PROJECT UPDATES

The biggest change made to the project was in the timeline of delivering the offerings. Given the challenges in coming together, the schedule to deliver community offerings was extended until the end of the calendar year (December 2023).

## 10. CHALLENGES IN IMPLEMENTATION

The biggest challenges to implementation have been scheduling and consistency. These two items have, and will continue to be, challenges due to organizing such a large group of individuals. In addition, operational challenges such as planning and preparation, communication between all partners and healers, and consistent messaging among all NCC SIL members were also experienced during this reporting period. Lastly, there were challenges in data collection after the first offering/community event. It was observed that close to eighty (80) people who attended NCC SIL's Caminata either left earlier than expected and/or decided not to fill out the evaluation survey. However, they did partake in many of the feedback art activities, which provided rich qualitative data. It should be noted that NCC SIL is actively working on addressing the items which posed challenges to improve for future gatherings.

## 11. SUCCESSES

The biggest success experienced during this reporting period was the launch of NCC SIL's offerings by holding a Caminata in Glen Ellen at Jack London State Park. This event provided an opportunity for the collective to come together to nurture well-being in Sonoma County. It provided an opportunity to co-create a space where community members felt connected, valued, and supported on their wellness journey. Through collaboration with communities and like-minded organizations, NCC SIL was able to build a culturally-rooted environment that celebrated diversity and honored the traditions, practices, and healing wisdom of different cultures. Through the Caminata, NCC SIL was able to: 1.) co-create inclusive spaces that honored and respected diverse cultural backgrounds; (2) promoted wellness practices rooted in the rich traditions of the Latine and Indigenous communities; (3) provided resources and support for individuals and their families on their journey to well-being; (4) and engaged in meaningful partnerships to strengthen community impact.



## 12. THE ROAD AHEAD

NCC SIL will continue to center relationships as the timeline for delivering community offerings progresses. Additionally, the collective will hold itself accountable for ensuring that it is being inclusive and intentional in its outreach to communities on the margins of society.

## **APPENDICES**



# Caminata con Humanidad

## En el parque de Jack London

Escanea el código QR para registrarte



<https://tinyurl.com/Caminata-Junio>

Sabado, 24 de Junio  
10:00am a 2:00 pm  
2400 London Ranch Rd,  
Glen Ellen, CA 95442  
**Estacionamiento gratuito para las personas que se registren**



**HUMANIDAD**  
Therapy & Education Services



**Botanical Bus**  
Bilingual mobile herb clinic

**IDALE**  
INTEGRATING DIVERSITY AND LEADERSHIP

GROUP NAME: **Grupo #3** ORGANIZING TOPIC: **Centro Cultural**

# ORGANIZING STRATEGY MAP

Using this worksheet you will identify your organizing objectives, tactics and the strategy you will need to actualize them.

**STEP 1: SET YOUR OBJECTIVE**

OBJECTIVE: We want to (change making action) \_\_\_\_\_ (what's the cause)  
 \_\_\_\_\_ (who is the audience)

**STEP 2: CHOOSE YOUR ORGANIZING TACTIC**

ORGANIZING TACTIC: What organizing tactic will you be using?  
**\* Tardeada, Quermes, Fiesta, Evento - Incorporando demostraciones de mesa.**

**STEP 3: ACTUALIZING YOUR TACTIC**

Content:  
 What content/collateral will you need to actualize your tactic?  
 - Pasar la voz (word of mouth) \* bilingue  
 - Social Media/Radio (KBOF) Spanish, Chinese, English  
 - Univision (T.V.) Public agencies  
 - Partnerships (organizaciones... etc.) - Service?  
 - Schools/escuelas

Delivery/Implementation:  
 What will you need to deliver/implement your content?  
 - Folletos | Posters (reach/timeline etc.)  
 - Dinero \$ (comida, espacio, actividades... etc.)  
 - Personal (Voluntarios)  
 - Lugar (parque, escuela, Salon Comunitario, iglesia... etc.)  
 - permisos - Documentation (photo/video, interviews)

**STEP 4: ASSET/RESOURCE MAPPING**

Existing & Needed Resources/ Assets: In this section you will revisit your items listed under content and delivery/implementation and use the below categories as a filter to identify what you need to actualize your items. (Example: if you wrote "logo" under "content" then using the "people" filter you might write "graphic designer" under logo. Then, you will indicate whether this is an (EXISTING) or (NEEDED) asset/resource.

- People (gifts, skills, capacities)
- Collectives/ Organizations/Businesses
- Funding
- Tools ( Social Media, Website)
- Venues/Location

**STEP 5: IDENTIFY WHO IS RESPONSIBLE**

Next, your collective will assign names of people/organizations of who will be responsible for the creation and/or implementation of each task under content & delivery/implementation.

**STEP 6: SET YOUR TIMELINES**

Next, your collective will assign achievable timelines/ dates for the creation and/or implementation of each task under content & delivery/implementation.

NCC SIL Community Offering Strategy Session

## **Name of Innovative 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**

In 2019, Sonoma County Human Services Department, Adult & Aging Division (A&A) and Santa Rosa Community Health (SRCH)-Lombardi Campus embarked on a partnership to deliver behavioral health care in a primary care setting (in coordination with social services delivered in the patient’s home) to Latinx patients with symptoms of depression ages 50+. The original project—conceived prior to the pandemic—entailed testing an innovative modification to an evidence-based depression intervention known as the Collaborative Care Model.

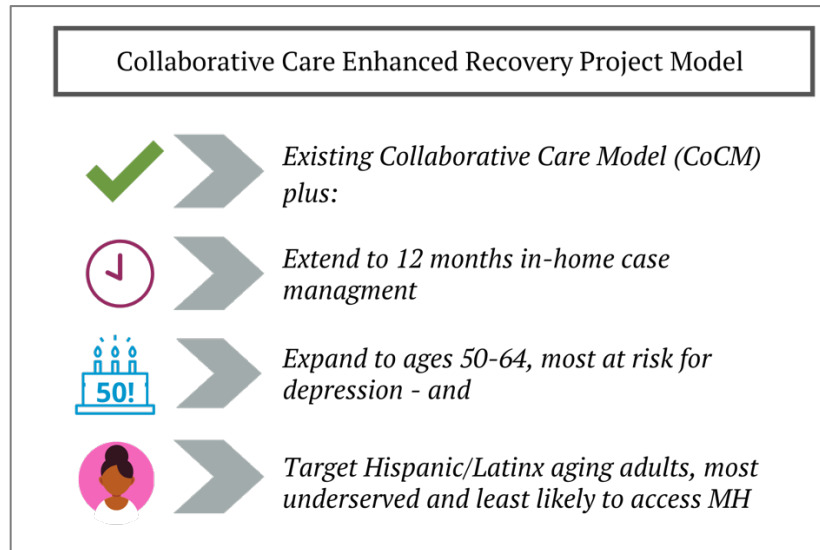
The Collaborative Care Model (aka CoCM) integrates physical and behavioral health services with the following key components: 1) brief care coordination between primary care and behavioral health care providers over a 12-week period that includes weekly multidisciplinary team meetings; 2) regular monitoring, 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 not show clinical improvement.

This innovation builds on A&A’s local experience since 2015 in delivering this model-of-care to low-income older adults ages 65 and over. A&A continues 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. A&A 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, A&A recognized that the efforts-to-date have not adequately supported the needs of the Latinx community.

The 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 in 2022 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 extended 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 were 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) proposed a pilot project to improve treatment for older adults struggling with depression. Unidos por Nuestro Bienestar is designed to 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' original learning goals entailed 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 2 Performance

The objectives for Project Year 2 and our progress toward achieving them are described below:

- 1) Deliver Unidos services to at least 105 unduplicated clients with a focus on Latinx clients

We continued to deliver services to 3 clients enrolled in Unidos in FY21-22, received 41 client referrals resulting in 13 new enrollments, closed 5 cases due to client health or other issues precluding their continued participation

- 2) Conduct project evaluation activities

Our formal project evaluation plan to inform program improvement activities included the following tools and administration protocol:

- Intake/Tracking Forms – Includes Care Plan and encounter/unable to reach/lost to follow-up/program exit records to support output and process measurements;

- PHQ9 – Administered at screening and at each client visit, and regularly tracked and plotted by the case manager to support sharing with client;
- Social Needs Screening Tool (adapted from the CMS Accountable Health Communities Health-Related Social Needs Screening Tool) – Administered at intake, 6 and 12 months to support client establishment/modification of goals and their achievement (Appendix A);
- Katz Index of Independence in Activities of Daily Living – Administered at intake, 6 and 12 months (Appendix B);
- Client Satisfaction Survey – Administered at 12 months (or at patient exit from program if served for  $\geq 6$  months with notation) (Appendix C); and
- Results-Based Accountability Measures – Measured by PHQ9, Client Satisfaction and Goal Achievement (Appendix D)

### 3) Implement quality improvements based on project evaluation results

Please refer to the “Changes” section for details on quality improvements instituted this project year to address challenges encountered in implementing the project as originally planned.

### 4) Develop first annual performance report and disseminate to key stakeholders

- We submitted our final Year 1 report in December 2022 and shared with our community internal and external partners.

## **Evaluation Data**

*(including outcomes and information about elements that are contributing to these outcomes)*

We served 14 unduplicated clients this project year, four completed the full 12-month Unidos program. Among these four clients:

- All of them (100%) met the goals they established at enrollment to address their needs and improve their mental health status;
- Three of them (75%) demonstrated improvements in their depression symptoms as reflected in a 9- to 15-point decrease in PHQ9 score from program entry to exit; and
- The 2 client satisfaction surveys received from program completers revealed strong satisfaction with services and their case manager (a score of 25/25--see attached sample satisfaction survey).

## **Changes**

**(specifically during the reporting period and the reasons for the changes, including any changes in the timeline)**

We submitted the following proposed project modification to the Sonoma County Department of Health Services/Behavioral Health Program in March/April 2023 to address the implementation barriers detailed in the “Challenges” session. Our workplan change is driven by our commitment to:



- 1) Preserve the original intent of our approved MHA Innovations project—to test an innovation to an evidence-based depression intervention—with primary care as the entry-point to the program;
- 2) Build on Sonoma County A&A and SRCH’s solid foundation of partnering to improve patients’ mental and overall health status; and
- 3) Demonstrate that integrating mental/behavioral healthcare in a primary care setting, augmented by coordinated and ongoing social services case management delivered in the clinic and in the patient’s home over a 12-month period, will yield sustained mental health improvements.

Our proposed solution entails the following:

Program Components:

**Integrated Mental/Behavioral Healthcare in Primary Care:** Preserve and build upon SRCH’s existing model of integrating mental and behavioral health within its primary care clinics.

- Embed the A&A social worker into the SRCH Lombardi clinic a minimum of 2 days per week to engage with primary care and/or behavioral health staff on potential referrals. Ideally, warm hand-offs of referred patients would occur during this on-site presence.

**Multi-Disciplinary Team (MDT):** Convene MDT meetings every 2 weeks that include SRCH primary care providers, behavioral health staff, other members of the SRCH team, the A&A social worker and A&A supervisor. SRCH primary care providers have regular and direct access to psychiatry consultation when needed for complex patients.

- SRCH will refer patients to the Unidos program during the MDT meeting. The A&A supervisor and A&A social worker will review new referrals and provide updates of existing patients during this MDT meeting. Case consultations will address how to proceed in a patient’s treatment and include any care-planning needs in the home that relate to the patient’s healthcare.

**Use of Patient Health Questionnaire 9 (PHQ-9):** Continue to administer the PHQ-9 to older adult patients (50+) and navigate those patients with a score of 5-18 to the A&A social worker (see below for range of individuals that benefit from the Healthy IDEAS intervention).

Interventions Used:

The A&A social worker utilizes two interventions with patients served by SRCH in the community (home).

- 1) The Linkages Case Management Intervention—a person-centered model that implements evidence-based motivational interviewing strategies and techniques. Through motivational interviewing, the A&A social worker engages the patient in their own care-planning needs by exploring readiness for change, identifying existing barriers to overcoming their goals, and developing potential solutions to meet those goals.

- SRCH patients who have been screened for depression (using the PHQ-9), referred to the Unidos program, AND indicate an interest to participate in a case management program to address needs in other areas of their lives, are appropriate for Linkages.
  - The A&A social worker will conduct a full needs assessment with patients in their home and engage them in a care-plan development conversation that includes goal-setting and breaking those goals down into smaller objectives that can reasonably be achieved within the 1-year program-enrollment period.
- 2) The Healthy IDEAS (Identifying Depression and Empowering Activities for Seniors) Intervention—an evidenced-based depression intervention embedded in an older adult case management program. Healthy IDEAS builds on the established client relationship to empower at-risk older adults to address depression and other basic care concerns so they can remain at home.
- The PHQ-9 depression score guideline for Healthy IDEAS enrollment is 5-14. We recommend the range of scores acceptable for enrollment be adjusted to 5-18 in order to reach a greater population who may benefit from this intervention.
  - The A&A social worker will implement this intervention within the Linkages Case Management intervention through regularly administering the PHQ-9 to the patient, delivering education on depression, making community referrals where possible to address symptoms of depression and by setting behavioral activation goals within the Linkages care plan.
  - The A&A social worker will share patient progress or significant decline on the Healthy IDEAS intervention at the bi-weekly MDT meetings to promote collaboration/care coordination.

**Demographics**

*(from the reporting period)*

Number of Unduplicated Clients Served: 14

Age:

26-59:	6
60+:	8

Gender Assigned at Birth:

Female:	13
Male:	1

Race:

American Indian/Alaska Native:	0
Asian:	0
Black/African American:	0
Native Hawaiian/Pacific Islander:	0

White:	12
Other:	2
Multi:	0
Ethnicity (Latinx/Hispanic):	
Caribbean:	0
Central American:	0
Mexican/Mexican American:	11
Puerto Rican:	0
South American:	2
Other:	1
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:	1
Spanish:	13
Other:	0
Culture:	
LGBTQ:	0
Veteran:	0
Homeless:	0
Individuals in Foster Care:	0
Other (Not Applicable):	0
Medi-Cal Beneficiaries:	9

## **Successes**

*(include pictures, quotes, stories, and other graphics)*

### **Exponential Benefits**

A Unidos client diagnosed with depression reported feelings of isolation that likely contributed to her mental health status. Although she lives with family, she expressed a deep desire for connecting with other Spanish-speaking women familiar with her culture. Together, the client and the Unidos social worker developed a case plan that included a goal of socialization. The Unidos case manager provided a list of local resources to the client, who used it to guide her finding social activities that would surround her with women of the same cultural background. She contacted these resources and began attending local events. Ultimately, the client found a community group where she has increased her socialization, connection and engagement in meaningful activities. Through monthly contacts, the client has worked on her own personal growth and continues to work on her case plan with support of her Unidos social worker. This experience not only provided tangible benefits to the client, but also opened this resource and opportunity to other Unidos clients with similar needs and goals.

### **Challenges in Implementation**

The pandemic significantly altered the environment in which we initiated our MHSA Innovations project (September 2021). Both SRCH and the Sonoma County A&A grappled with delivering services during the start-up period and into early 2023. Fluctuating conditions not only challenged our respective abilities to conduct 'business-as-usual,' they also demanded that we modify staffing patterns and responsibilities (while concurrently trying to fill project positions), adjust workflows, and essentially do more with reduced resources.

We served our first clients in Q4 of FY21-22, having filled the A&A Case Manager and several other SRCH Project Team positions (e.g., Lombardi Site Director). However, the service delivery model (including the client identification and referral process) was not launched according to our original plan due to the above-cited challenges. By the end of Q2 of FY22-23, we served 12 unduplicated clients, closed 3 of the cases, and received 32 referrals for individuals whose cases we closed primarily due to our inability to reach them to schedule an appointment. (Note that some of the referred patients were inappropriate for Unidos and were referred to other services while other patients moved or expressed disinterest in enrolling). This prompted us to consider how we may adjust our approach to gain traction with all of the key project personnel, the broader clinical healthcare provider team at SRCH and their eligible patients.

In January 2023, we invited the co-director of the University of Washington Advancing Integrated Mental Health Solutions (AIMS) Center (the CoCM developer) to address our Unidos team regarding the key model components and essential next steps for rebooting project implementation and optimizing its success. This meeting precipitated a deliberative process that yielded the project workplan changed described in the "Changes" section above.

Social Needs Screening Tool

Living Situation		
Question		
1. What is your living situation today?	<input type="checkbox"/> I have a steady place to live	<input type="checkbox"/> I am worried about losing it in the future <input type="checkbox"/> 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?	<input type="checkbox"/> (n/a)	<input type="checkbox"/> Pests such as bugs, ants, or mice <input type="checkbox"/> Mold <input type="checkbox"/> Lead paint or pipes <input type="checkbox"/> Lack of heat <input type="checkbox"/> Oven or stove not working <input type="checkbox"/> Smoke detectors missing or not working <input type="checkbox"/> Water leaks
Food		
3. Within the past 6 months, you worried that your food would run out before you got money to buy more.	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes <input type="checkbox"/> Often(+2)
Transportation		
4. Do you have reliable transportation to get to medical appointments, meetings, work or for getting things needed for daily living?	<input type="checkbox"/> Always	<input type="checkbox"/> Sometimes <input type="checkbox"/> 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?	<input type="checkbox"/> (n/a)	<input type="checkbox"/> electric <input type="checkbox"/> gas <input type="checkbox"/> oil <input type="checkbox"/> water <input type="checkbox"/> phone <input type="checkbox"/> internet
Safety		
6. Do you feel physically safe in your home?	<input type="checkbox"/> Always	<input type="checkbox"/> Sometimes <input type="checkbox"/> Never(+2)
7. Do you feel emotionally safe in your home?	<input type="checkbox"/> Always	<input type="checkbox"/> Sometimes <input type="checkbox"/> Never(+2)
Financial Strain		
8. How hard is it for you to pay for the very basics like food, housing, medical care, and heating?	<input type="checkbox"/> Not hard at all	<input type="checkbox"/> Very hard(+2) <input type="checkbox"/> Somewhat hard

Employment		
9. Do you need help finding or keeping a job?	<input type="checkbox"/> No	<input type="checkbox"/> 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?	<input type="checkbox"/> I don't need any help <input type="checkbox"/> I get all the help I need	<input type="checkbox"/> I could use a little more help <input type="checkbox"/> 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)	Dependence (0 Points)
	<b>NO</b> supervision, direction or personal assistance.	<b>WITH</b> supervision, direction, personal assistance or total care.
<b>BATHING</b> Points: _____	<b>(1 POINT)</b> Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	<b>(0 POINTS)</b> Need help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing
<b>DRESSING</b> Points: _____	<b>(1 POINT)</b> Get clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	<b>(0 POINTS)</b> Needs help with dressing self or needs to be completely dressed.
<b>TOILETING</b> Points: _____	<b>(1 POINT)</b> Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	<b>(0 POINTS)</b> Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
<b>TRANSFERRING</b> Points: _____	<b>(1 POINT)</b> Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable	<b>(0 POINTS)</b> Needs help in moving from bed to chair or requires a complete transfer.
<b>CONTINENCE</b> Points: _____	<b>(1 POINT)</b> Exercises complete self control over urination and defecation.	<b>(0 POINTS)</b> Is partially or totally incontinent of bowel or bladder
<b>FEEDING</b> Points: _____	<b>(1 POINT)</b> Gets food from plate into mouth without help. Preparation of food may be done by another person.	<b>(0 POINTS)</b> Needs partial or total help with feeding or requires parenteral feeding.
<b>TOTAL POINTS:</b> _____ <b>SCORING:</b> 6 = High ( <i>patient independent</i> )   0 = Low ( <i>patient very dependent</i> )		

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](http://www.hartfordign.org).

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## 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](http://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.

Kreševic, 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.



**Unidos Por Nuestro Bienestar – United for Our Health  
Client Survey**

**1. Meetings with my Unidos social worker helped me feel better. (circle one)**

Score



Strongly Agree      Agree      Neutral      Disagree      Strongly Disagree

5                      4                      3                      2                      1

**2. My Unidos social worker helped me identify my needs. (circle one)**



Strongly Agree      Agree      Neutral      Disagree      Strongly Disagree

5                      4                      3                      2                      1

**3. My Unidos social worker helped me set goals to address my needs. (circle one)**



Strongly Agree      Agree      Neutral      Disagree      Strongly Disagree

5                      4                      3                      2                      1

**4. My Unidos social worker connected me to resources that I used. (circle one)**



Strongly Agree      Agree      Neutral      Disagree      Strongly Disagree

5                      4                      3                      2                      1

**5. I would recommend this program to family and friends. (circle one)**



Strongly Agree      Agree      Neutral      Disagree      Strongly Disagree

5                      4                      3                      2                      1

Total:

**6. Any other comments?** \_\_\_\_\_  
\_\_\_\_\_

For office use only: Code - \_\_\_\_\_

Survey Period (check one) -  6 mo.     12 mo.     Other: \_\_\_\_\_

**Unidos Por Nuestro Bienestar – United for Our Health**  
**Client Survey**

**1. Las juntas con mi Trabajador/a Social Unidos me ayudaron a sentirme mejor. (seleccione uno)** Puntaje



Totalmente de acuerdo  
5

De acuerdo  
4

Neutral  
3

En desacuerdo  
2

Totalmente en desacuerdo  
1

**2. Mi Trabajador/a Social Unidos me ayudó a identificar mis necesidades. (seleccione uno)**



Totalmente de acuerdo  
5

De acuerdo  
4

Neutral  
3

En desacuerdo  
2

Totalmente en desacuerdo  
1

**3. Mi Trabajador/a Social Unidos me ayudó a establecer metas para atender mis necesidades.**



(seleccione uno)

Totalmente de acuerdo  
5

De acuerdo  
4

Neutral  
3

En desacuerdo  
2

Totalmente en desacuerdo  
1

**4. Mi Trabajador/a Social Unidos me conectó con recursos que utilicé. (seleccione uno)**



Totalmente de acuerdo  
5

De acuerdo  
4

Neutral  
3

En desacuerdo  
2

Totalmente en desacuerdo  
1

**5. Yo recomendaría este programa a familiares y amigos.( seleccione uno)**



Totalmente de acuerdo  
5

De acuerdo  
4

Neutral  
3

En desacuerdo  
2

Totalmente en desacuerdo  
1

Total:

**6. Algun otro comentario?** \_\_\_\_\_

\_\_\_\_\_

Para uso de la Oficina: Código - \_\_\_\_\_

Periodo de Encuesta(seleccione uno) -  6 ms.  12 ms.  Other: \_\_\_\_\_

**Unidos Por Nuestro Bienestar – United for Our Health**  
**Client Survey**

**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.	<b>How much do we do? (# of participants served, # of activities)</b> <ul style="list-style-type: none"> <li># of unduplicated clients</li> </ul>	<ul style="list-style-type: none"> <li>105 unduplicated clients per year</li> </ul>	<ul style="list-style-type: none"> <li>EHR patient registry</li> </ul>	<ul style="list-style-type: none"> <li>July 1- September 30</li> <li>October 1- December 31</li> <li>January 1- March 31</li> <li>April 1- June 30</li> </ul>	<ul style="list-style-type: none"> <li>October</li> <li>January</li> <li>April</li> <li>July</li> </ul>
	<b>How well do we implement the service? (Participant satisfaction, retention rates, cost)</b> <ul style="list-style-type: none"> <li>% 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)</li> </ul>	<ul style="list-style-type: none"> <li>50 % of unduplicated clients will meet their goals or exit the program at end of 12-month program)</li> </ul>	<ul style="list-style-type: none"> <li>EHR patient registry</li> </ul>	<ul style="list-style-type: none"> <li>July 1- September 30</li> <li>October 1- December 31</li> <li>January 1- March 31</li> <li>April 1- June 30</li> </ul>	<ul style="list-style-type: none"> <li>October</li> <li>January</li> <li>April</li> <li>July</li> </ul>
	<b>Are people better off? (#/% skill or knowledge, #/% attitude or opinion, #/% behavior, #/% circumstance/condition)</b> <ul style="list-style-type: none"> <li>% of unduplicated clients who exit the program and self-report mental health improvements</li> </ul>	<ul style="list-style-type: none"> <li>50% of unduplicated clients who exit the program will self-report improvements with their mental health</li> </ul>	<ul style="list-style-type: none"> <li>Client survey or questionnaire</li> </ul>	<ul style="list-style-type: none"> <li>July 1- September 30</li> <li>October 1- December 31</li> <li>January 1- March 31</li> <li>April 1- June 30</li> </ul>	<ul style="list-style-type: none"> <li>October</li> <li>January</li> <li>April</li> <li>July</li> </ul>

**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.

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Contractor

---

Contract Manager or  
Designee

---

Department RBA Lead



# New Parent TLC

Talk. Link. Confirm.  
Habla. Conecta. Confirma





## **I. Brief description of Project**

Sonoma County-wide MHSA Innovation project, New Parent TLC (Talk, Link, Confirm) employs 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 also aims to 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 a “Connector” 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 serve 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 second year of the project, the curriculum is being finalized, and outreach and training materials are being created and translated. The first set of training events is currently being scheduled for November 2023.

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. The culturally responsive community advisory group 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.

The First 5 program staff have all been trained in the New Parent TLC model. Of the trainers, four are bilingual Spanish speaking, and three trainers are monolingual English speaking trainers. The ratio of Spanish speaking trainers will allow for meeting the needs of the community and sufficient to hold at least 30% of the trainings in Spanish as planned.

### **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 the first year of the project, First 5 Sonoma County contracted with consultants to develop culturally responsive curriculum that was first 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 were mental health professionals who specialize in maternal mental health.

Also in the first year, a culturally responsive community advisory group was 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 were seven participants in 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 met monthly to review curriculum, with six monthly hour and a half meetings completed by the end of the reporting period, and additional meetings that continued into year two of the project. 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 included 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.

In the second year of the project, the curriculum development continued. There were multiple key informant interviews with potential connectors who represent each of the groups to inform the implementation of the training curriculum. The key information interviews were with one person per Connector group, so one child care provider, one employer with Amy’s Kitchen, and one hair dresser. Once the curriculum was thought to be finalized, First 5 Sonoma County started their training components of the grant. The first part of the training was to train the trainers which included First 5 Staff Members: two Program Coordinators, three Program Managers, and the Program Director. First 5 Staff participated in a four hour training facilitated by the consultants who created the curriculum. Some of the major findings that came out of the training was that there was more curriculum development that needed to take place and that some of the curriculum needed to be made into more interactive materials for the Connector training to be effective and utilize adult learning theories.

Another finding that came out of this year was the importance of including lived experiences in the curriculum and delivery of materials. It just so happened that two First 5 staff members had babies within the last year. Including the perspective of those staff members and having their fresh parenting perspective reshaped the curriculum to be more accessible and realistic.

Lastly, another finding from this year (although it was present in previous years) was that to do something right takes time and patience. With new parents involved in the process this year, the preciousness and delicate nature of this program was highlighted.



## **VI. Changes to Program**

One of the biggest changes to the program was the timeline of the curriculum development (as noted in the challenges section below). Since this is an innovative program, we worked with consultants to develop the Curriculum from scratch. The development of the curriculum with the consultants took longer than expected because of the convening of the Culturally Responsive Curriculum group which shaped and changed the content of the originally planned curriculum. Also, meetings with the three individuals from the child care, esthetician, and employer sectors make it clear that each curriculum would need to be curated to meet the needs of each population more than expected. With these realizations, First 5 Staff chose to focus on one sector curriculum at a time (first sector was child care). The creation of the Connector training binders, role play scripts, and outreach materials (including translation) also changed the timeline and will need to be specially curated for each sector. With all that being said, the curriculum/material development took twice as long as anticipated on the original Scope of Work.

## **VII. Challenges in implementation**

In the first year of the contract 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, including uncertainty about in-person training, which was the original plan.

Once the subcontract with the consultants was 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 process for the curriculum development took much longer than originally anticipated, as fully embracing the community voice was often 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.

In the second year, the current reporting period, the timeline is still a notable challenge. The development of curriculum for a pilot program is a living document that evolves as more trainings are conducted and more feedback is given on the materials and process. The curriculum has to be curated for three different populations and settings, which involved more specialized sections than originally anticipated. For example, an interaction between a child care provider and a parent may be brief (at a drop off or pick up) whereas an interaction with a hairdresser and their client may last for hours. This discrepancy in interactions changes how each sector might



approach the Talk, Link or Confirm aspect of the program, thus requiring extensive differences in approach for each sector.

Another challenge has been how to make sure harm is not created through secondary trauma for Connectors. The First 5 team recognized that not having concrete supports for Connectors could lead to trauma thus counteracting the positive work of New Parent TLC. Resources and a solid system for support and feedback has been under development to ensure Connectors are supported.

Lastly, with a pilot program, it can be hard to conceptualize the delivery of the materials to the target audience. The First 5 team has held several internal meetings to create and practice role plays and certain parts of the curriculum to ensure that the material is not only accessible, but that it upholds the spirit and feedback of the culturally responsive group. With all that being said, the depth of curriculum development and service delivery were underestimated in the original Scope of Work.

## **VIII. Successes**

In the first year, some success was that the curriculum was fully inclusive, and grounded in community voice and lived experience. Throughout the process, there were 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.

A humanistic approach to the curriculum development 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.



Successes in the second year include a fully developed curriculum translated to Spanish. Along with the Curriculum, First 5 Managers developed a comprehensive Child Care Connector training binder. The binder for the Child Care Connectors includes the slides with a notes section, a self-care guide, a page for them to plan how they will Confirm, flyers for doors and community boards, magnets, resource cards, and various other helpful handouts. All of the materials will be in English and Spanish. Throughout the curriculum “finalization” and materials development First 5 Staff met multiple times to discuss next steps but also to start practicing role plays and talking points.

Using the childcare connections mentioned in the first year successes, Staff has begun outreach for our first training which is scheduled for November 4th, and the second training (in Spanish) tentatively scheduled for November 18th.

As stated in the “Findings to Date” section, First 5 also had two Managers who had babies through this year of the project, and were vital in fully embracing the lived experience in real-time as the curriculum was being updated and revised. The depth of lived experience voice in this project has added significant value to the project. With all that being said, the quality of the product that was created exceeded anything that was envisioned in the beginning of the pilot program. The next steps will be to conduct the first two cohorts of child care provider Connector trainings, receive feedback via a survey, and then potentially adjust the curriculum again depending on feedback. We will also be shifting focus to the other two Connector sectors: Medium/large employers, and cosmetologists.

# Mental Health Services Act

*Collaborative Statewide Early Psychosis Program Evaluation*

*Annual Innovation Report:*

*Summary Report of the Activities of the LHCN*

*Fiscal Year 2022-2023*

Draft submitted November 13th, 2023

Prepared by:

University of California, Davis, San Francisco and San Diego

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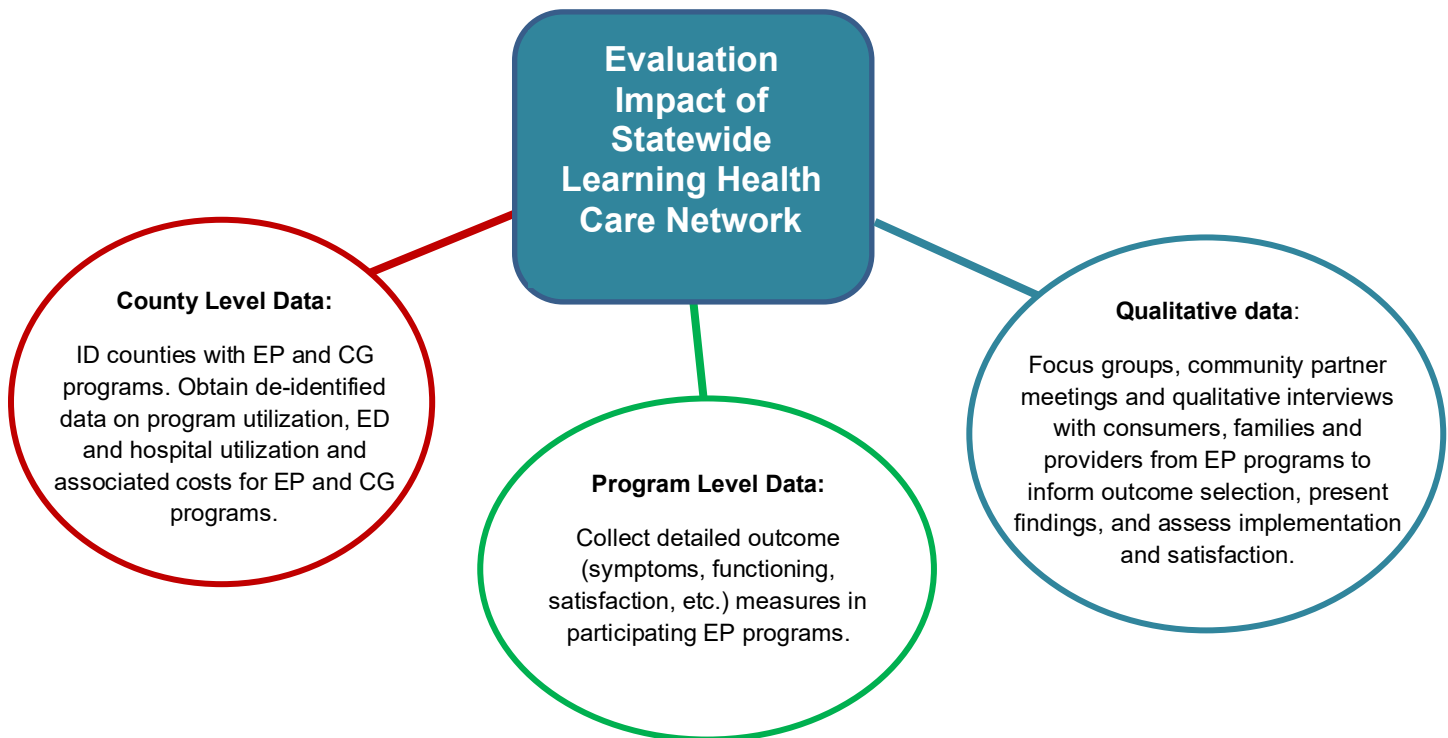
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## Background

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, Napa, Lake, and the Multi-County Collaborative (MCC) which includes Nevada, Mono, and Colusa Counties. 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, will bring consumer-level data to the providers' fingertips for real-time sharing with consumers, and allow 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 have been and continue to be 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 and

included Los Angeles, Solano, Orange, and San Diego counties. 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 were able to leverage 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. Since then, we have also had additional counties join EPI-CAL, including Napa, Stanislaus, Sonoma, Lake, Nevada, Mono, and Colusa. The overarching name of the project, which encompasses the LHCN and the NIH-funded components, is now “EPI-CAL.” In this report, 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).

The EPI-CAL team has made significant progress towards our goals outlined in the innovation proposal during the 22/23 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 FY2022/2023. 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.

- As soon as a contract is executed between UC Davis and a county to join the LHCN, our team initiates recruitment activities so that the counties’ community partners can participate in our biannual Advisory Committee Meeting. In the past fiscal year, the Multi-County Collaborative (Colusa, Mono, Nevada) and Lake County LHCN contracts were executed, and their respective EP programs joined EPI-CAL’s LHCN. Our team introduced the meeting to the EP program team and distributed flyers so that their community partners could be apprised of the upcoming LHCN meetings.
- 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.
- As each new program joins the Learning Health Care Network, our team holds a synchronous EPI-CAL introductory meeting with all team members at participating programs to introduce the project in detail. This past fiscal year, we had two new programs join and the LHCN and attend the introductory meeting. At this introductory meeting, providers and staff are invited to complete baseline questionnaires that assess provider and program variables as these variables are hypothesized to have an effect on the observed outcomes of clients in EP programs. We administer provider surveys that assess demographics, eHealth Readiness, Organizational Readiness for Change, Attitudes Toward Evidence Based Practice, Clinician Attitudes of Recovery and Stigma, Modified Practice Pattern Questionnaire, and Professional Quality Scale. This battery of questionnaires is termed the “baseline” surveys and have been designed to assess potential factors that could influence outcomes for EP consumers that are measured in the project.
- In the LHCN proposal, we proposed to ask clients and providers to complete self-report questionnaires in the pre-implementation period of the project. To examine adoption of a new technology in the EP program, we proposed to compare providers with respect to their reporting use of data to determine treatment choices at two timepoints, prior to Beehive implementation and after training in and using Beehive. Prior to Beehive implementation in each EP program, providers completed “pre-

implementation” surveys. We are now currently at the stage of the project where we want to evaluate change in these same variables after Beehive implementation. To do this, the same set of surveys are administered to EP programs who have sufficiently implemented Beehive in their program. During the past fiscal year, we have administered post-implementation surveys to three programs’ staff that meet the criteria for post-implementation.

- In the last year, we continued fidelity assessments in EPI-CAL LHCN clinics and by the end of the 22/23 FY we had completed a total of 17 fidelity assessments of programs in the LHCN. This included EPI-CAL LHCN county programs (San Diego, Solano, Orange, Sonoma, Los Angeles, Stanislaus, Sacramento, San Mateo, and Napa) as well as university programs (UCLA CAPPs, UCLA Aftercare, UCSD CARE, UCD EDAPT). 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, including new programs who have recently joined the LHCN, with a goal of completing them in the current 23/24 fiscal year.
- Since the EPI-CAL project began, our team has conducted a total of 20 fidelity assessments (this includes non-LHCN programs as well that are part of EPI-CAL through the training and technical assistance program). In the current report, we present aggregate results from fidelity assessments of EP programs in EPI-CAL, including data from both the CHRPS and FEPS. Amongst those where a full or formative assessment could be conducted, the mean FEPS-FS score was 3.86 out of 5. With the CHRPS, mean scores were slightly higher at 3.96 out of 5.
- 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.
- We conducted an interim analysis of Beehive enrollment, consumer demographics, data sharing preferences, and survey completion. The observed rate of enrollment across the LHCN is 412 clients across all diagnoses or 255 clients with a diagnosis that indicates FEP. There are an additional 258 clients who have been registered by the clinic in Beehive, but who have not engaged with Beehive by completing the EULA or starting their surveys. We found that a large majority of consumers (86%) opted in to sharing data for research purposes with UC Davis, and high completion rates of enrollment surveys (83%). 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.
- In the current report, we describe a detailed statistical analysis plan for outcomes data collected via Beehive.
- As a first step to assessing the successful implementation of the LHCN in EP programs across California, we assess preliminary data on feasibility and acceptability of LHCN app in all EP programs. To do this, we used a previously defined benchmark of enrollment of at least 70% of eligible participants and 50% of their available family members across the network as enrolled to meet our criteria as feasible and acceptable. We compare actual enrollment against this benchmark and summarize the results in this report.
- Over the last fiscal year, we have made a number of changes and improvements to Beehive based on feedback from programs and community partners. We summarize these changes in the current report.
- In order to finalize the data collection process for our county-level data evaluation component of the LHCN, we met with new LHCN counties to introduce our data collection process for obtaining county-level utilization and cost data for a retrospective 3-year timeframe for preliminary evaluation for both EP and comparator group (CG) programs. We have also continued to meet with all participating counties to refine the process as we receive data from each county.
- During the last fiscal year, 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, including each new LHCN county, and summarized it in a multicounty data table included in this report.

- During the last fiscal year, 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.

## **Current Project Goals**

The current document summarizes project activities for the LHCN for fiscal year 2022/2023. This includes the following project activities:

- 1. Recruit EP community partners for external Advisory Committee meeting*
- 2. Establish a stakeholder (community partner) advisory committee that will meet at least every 6 months.*
- 3. Complete baseline and pre-LHCN implementation questionnaires for new LHCN counties.*
- 4. Report on post-LHCN implementation questionnaires administered to program and county staff.*
- 5. Schedule EP program for fidelity assessment.*
- 6. Present results from fidelity assessments of EP programs.*
- 7. Provide training and implementation of outcomes measurement on app in non-pilot EP programs and progress of data collection in all EP programs.*
- 8. Submit report on LHCN enrollment and follow up completion rates for LHCN software application and dashboard in all EP Programs.*
- 9. Submit final data analysis plan for all data.*
- 10. Draft preliminary data on feasibility and acceptability of LHCN app in all EP programs.*
- 11. Subcontractor to make additional revisions to dashboard to include feedback from programs and community partners.*
- 12. Establish data collection process for obtaining county-level utilization and cost data for prior 3-year timeframe for preliminary evaluation for both EP and comparator group (CG) programs.*
- 13. Identification of county-level available data and data transfer methods, and statistical analysis methods selected for integrated county-level data evaluation.*
- 14. 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.*

### **1. Recruit EP community partners for external Advisory Committee meeting**

Once the contract for the LHCN between new counties and UC Davis was executed, the UC Davis team could start recruiting from each new county and program for the Advisory Committee. Our team sends program

leadership our LHCN Advisory Committee recruitment flyer for distribution within the program to recruit clients and family members who wished to participate in the Advisory Committee. During the past fiscal year, Lake County and the Multi-County Collaborative (MCC) of Nevada, Colusa, and Mono counties joined the LHCN. We had representation from both the MCC and Lake County at our most recent Advisory Committee meeting, including EP program leadership. We will continue to work with the program to include other stakeholders from Nevada, Mono, Colusa, and Lake Counties, such as a client or other family member.

## **2. 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.

*November 29<sup>th</sup>, 2022*

We held our first Advisory Committee meeting of the fiscal year on November 29th, 2022. The meeting was held remotely due to the continuing COVID-19 pandemic. During the meeting, we discussed recruitment and enrollment progress and challenges. Valerie Tryon gave a general overview of enrollment across the LHCN. While many programs are making progress using Beehive (i.e., enrolling clients and supporting completion of surveys), multiple 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 and considered ways in which programs could address these issues. Over the past six months, the rate of enrollment has improved significantly. The EPI-CAL team encouraged sites to keep up their pace of enrollment and make sure that surveys are also being completed. Sabrina Ereshefsky then gave a presentation summarizing how urgent clinical issue alerts are being addressed by clinic staff within Beehive. Her preliminary findings supported that the vast majority of urgent clinical issues are resolved within a few days. We received feedback from attendees at the meeting that they appreciated the integration of both client and support persons in risk assessment. Then, Mark Savill gave a presentation on the general analysis plan for the data collected via the LHCN project, with a particular focus on Beehive data. Variables of interest were prioritized during the extensive qualitative work done by our team in the first phase of the project. Functioning was a key area focus groups really cared about when discussing what outcomes to measure, whereas distal outcomes (homelessness, incarceration, mortality) may occur later than what is captured in many clinics' clientele. He elicited feedback from attendees to examine if we were considering the most important outcomes for our analysis. One attendee expressed interest in seeing a summary of the carceral data that is being collected via Beehive and said that this data may help us lobby the state for more urgent crisis response options.

Lindsay Banks then gave a brief presentation on fidelity assessment progress thus far, followed by a description of the duration of untreated psychosis (DUP) study by Rachel Loewy. Adrian Asbun reminded programs about an upcoming research opportunity for Spanish-speaking providers, family members, and clients. We then closed out the meeting by talking about how best to connect with programs for additional research opportunities as part of the larger EPINET and then proposed submitting a new innovation project to possibly examined long-term outcomes of clients in EP programs.

We recognize that we summarized a lot of information during this most recent Advisory Committee meeting and thus we sent a follow-up survey out after the meeting to give attendees an opportunity to provide additional feedback on the topics covered if they were not able to during the meeting.

*June 6<sup>th</sup>, 2023*

We held the second Advisory Committee meeting of the fiscal year on June 6<sup>th</sup>, 2023. The meeting was held remotely. During the meeting, we discussed recruitment and enrollment progress and challenges. Kathleen Nye gave a general overview of enrollment across the LHCN, including comparing enrollment today to the last progress report at the last Advisory Committee Meeting in November 2022. While there was a promising trajectory of enrollments in the second half of last year after having several meetings with individual programs, multiple programs' enrollment has now plateaued and several still have not integrated Beehive into their program to the degree necessary to achieve project aims. The EPI-CAL team encouraged sites increase the pace of enrollment and make sure that surveys are also being completed. Misha Carlson then gave a brief presentation on the DUP portion of the study, which is also contending with enrollment challenges. We discussed in the meeting that FEP enrollments seem to be particularly affected and asked programs to share their thoughts and experiences.

The next section of the meeting consisted of data presentations. Valerie Tryon presented preliminary data from Beehive, including data summarizing symptoms, quality of life, and functioning; these domains were selected for preliminary descriptive analysis because they were prioritized during the outcomes focus groups. Tara Niendam then gave a presentation on the how experiences of several adverse childhood experiences (ACEs) in individuals with early psychosis is associated with housing instability and suicidal ideation in our preliminary data collected in Beehive. This was particularly important to present to our committee because while we found that our EP teams noted the importance of trauma in contributing to outcomes during qualitative data collection, they did not see justice involvement or homelessness as key issues early in care but our data show that their clients do face these challenges both in their lifetime history and in the present to a lesser degree. ACEs and other social determinants are likely drivers of poor outcome in early psychosis and should be addressed in treatment. Then, Sabrina Ereshefsky gave a presentation on the importance of lived and living experience integration in early psychosis coordinated specialty care. Her data evaluated whether the presence of peers, individuals with lived and living experience with psychosis, and/or family advocates affected attitudes towards recovery and stigma. She found that there were generally high rates of recovery-oriented attitudes and low variability across programs, despite team composition, but that the CSC teams with persons with lived or living experience could reduce stigma and bias.

We had a guest speaker at this Advisory Committee Meeting. Christina McCarthy provided a presentation on One Mind at Work, an organization that seeks to have mental health workers improve the design of their workplaces to benefit individuals and teams and grow access to mental health services and support. Participants were invited to have people from each organization nominate a colleague to participate in One Mind at Work and the application was distributed after the meeting. Lastly, we ended the meeting by discussing preliminary renewal plans for the EPI-CAL R01 and proposed submitting a new innovation project to possibly examine outreach to improve enrollment in EP programs or examine long-term outcomes of clients in EP programs.

### **3. Complete baseline and pre-LHCN implementation questionnaires for new LHCN Counties**

We have a standardized process for every county that joins the Learning Health Care Network which starts with the EPI-CAL team meeting with EP program staff to introduce the EPI-CAL project and administer pre-



implementation surveys to program staff. As each new program joins the Learning Health Care Network, our team holds a synchronous EPI-CAL introductory meeting with all team members at participating programs to introduce the project in detail. At this introductory meeting, providers and staff are invited to complete baseline questionnaires that assess provider and program variables as these variables are hypothesized to have an effect on the observed outcomes of clients in EP programs. At the introductory meeting, we administer provider surveys that assess demographics, eHealth Readiness, Organizational Readiness for Change, Attitudes Toward Evidence Based Practice, Clinician Attitudes of Recovery and Stigma, Modified Practice Pattern Questionnaire, and Professional Quality Scale. This battery of questionnaires is termed the “baseline” surveys and have been designed to assess potential factors that could influence outcomes for EP consumers that are measured in the project.

This past fiscal year, we had two new programs join the LHCN, including Lake County Early Intervention Services (EIS) program and the multi-county collaborative hub and spoke EP program of Nevada, Mono, and Colusa counties (MCC). MCC staff and providers who attended our EPI-CAL Introductory meeting on December 9<sup>th</sup>, 2022 and Lake County Behavioral Health Services (LCBHS) staff and providers attended our EPI-CAL Introductory meeting on February 23<sup>rd</sup>, 2023. The EP program staff were approached to participate in research as part of the LHCN EPI-CAL project. During the meeting, staff signed consents to participate in research to complete our baseline questionnaires. Staff completed measures assessing their comfort with technology and readiness to implement eHealth. Additional questionnaires on organizational readiness for change, level of burnout and compassion satisfaction in their work as a helper, their attitudes about evidence-based practice, stigma related views toward psychosis and help-seeking, and their recovery-orientation were sent to EP program staff following that initial meeting, due a couple of weeks after the initial meeting. Their results will be incorporated into the statewide data on these measures.

In the LHCN proposal, we proposed to ask consumers and providers to complete self-report questionnaires in the pre-implementation period of the project. Consumers are asked to complete self-report questionnaires about insight into illness, perceived utility of the application, satisfaction with treatment, treatment alliance, and comfort with technology. We also have providers at each clinic complete questionnaires on Treatment Alliance, Use of Data in Care Planning, Perceived Effect of Use for the LHCN, and Comfort with Technology. In addition to the originally planned pre-implementation surveys, we have provider surveys that assess demographics, eHealth Readiness, Organizational Readiness for Change, Attitudes Toward Evidence Based Practice, Clinician Attitudes of Recovery and Stigma, Modified Practice Pattern Questionnaire, and Professional Quality Scale. This battery of questionnaires is termed the “baseline” surveys and have been designed to assess potential factors that could influence outcomes for EP consumers that are measured in the project. Therefore, the study team felt it was important to assess these factors for inclusion in the future analysis of outcomes data. Clinicians with eligible clients were approached about completing these additional pre-implementation surveys described above. At this time, one clinician from LCBHS has completed surveys about their clients. This clinician is working with our team to recruit clients from their program to participate as well, but no client has expressed interest at the time of this report. Our team is working closely with LCBHS staff to address concerns clients may have with participating in research activities.

#### **4. Report on post-LHCN implementation questionnaires administered to program and county staff.**

In the LHCN proposal, we proposed to ask clients and providers to complete self-report questionnaires in the pre-implementation period of the project. To examine adoption of a new technology in the EP program, we proposed to compare providers with respect to their reporting use of data to determine treatment choices at

two timepoints, prior to Beehive implementation and after training in and using Beehive. Prior to Beehive implementation in each EP program, providers completed “pre-implementation” surveys about their demographic information (age, sex, race, ethnicity) and professional characteristics (years of education, degree type) and completed questionnaires on their Treatment Alliance, Use of Data in Care Planning, Perceived Effect of Use for the LHCN, and Comfort with Technology. Clients are also asked to complete self-report questionnaires about insight into illness, perceived utility of the application, satisfaction with treatment, treatment alliance, and comfort with technology. Beehive training materials were implemented consistently across participating EP program, highlighting the utility of data to identify treatment goals and metrics of improvement during treatment planning, and provided guidance on client-centered ways to review data to monitor progress during treatment.

We are now currently at the stage of the project where we want to evaluate change in these same variables after Beehive implementation. To do this, the same set of surveys are administered to EP programs who have sufficiently implemented Beehive in their program. At this time, we have 11 provider-completed post-implementation survey packets completed across three participating EP programs (OC CREW, Kickstart, and Aldea Solano SOAR). These three programs were amongst the earlier programs to be trained to use Beehive in their program in the LHCN. We are continuing to recruit providers and clients from EP programs to complete these surveys once sufficient time has passed from initial Beehive implementation. These data will be used in analyses to assess changes in these variables prior to implementation of Beehive compared to after use of Beehive with clients in EP programs.

Additionally, our post-implementation analysis will include provider-rated “use of data in care” questions, which are intermittently presented to providers while they are reviewing a client’s data page in Beehive so that they may indicate 1) if the data was reviewed during a session with the client or family and, if yes, 2) how the data was used as part of care, such as “followed up by phone” or “scheduled follow up appointment,” or “no action taken.” These data use metrics allow analysis on rates of adoption and level of implementation of Beehive. Exploratory analysis will examine clinician expertise and training needed to effectively implement clinician review of client outcome data using Beehive at 80% of available time points.

## **5. Schedule EP program for fidelity assessment**

Each early psychosis clinic will undergo 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 are piloting a new scale under development designed to assess the components of care delivered to individuals with the diagnosis of CHR, known as the CHRPS-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, which started in November 2021. 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, each EP program site participates in an introductory meeting, in which an overview of the FEPS will be provided and the components of the evaluation will be 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.

At the end of the 2/23 FY, EP program fidelity assessments had been conducted for 17 programs in the LHCN. There are five remaining programs in the LHCN that need to complete their fidelity assessment. Of those, three are currently in progress, including the MCC multicounty collaborative, Stanford INSPIRE program, and UCSF Path program. Lake County Behavioral Health Services assessment is scheduled for Fall 2023. Kern County is the last remaining program, and finalizing their assessment is pending an executed LHCN contract with UC Davis.

## **6. Present results from fidelity assessments of EP programs**

This section includes preliminary findings from the fidelity assessments that have been conducted with EPI-CAL EP programs, including programs that are not currently in the LHCN but have received a fidelity assessment from our team through their participation in the EPI-CAL's training and technical assistance program. The majority of participating programs serve clients with both clinical high-risk syndrome (CHR) in addition to first episode psychosis (FEP). Therefore, most fidelity assessments were conducted using the First Episode Psychosis Services – Fidelity Scale (FEPS-FS) version 1.1 and a pilot version of the Clinical High Risk for Psychosis Services – Fidelity Scale (CHRPS-FS) (Addington, 2021). In this assessment Version FEPS-FS 1.1 was used, which includes additional items from the published 1.0 version related to discharge planning and the delivery of peer services. Additionally, given the widespread treatment of CHR clients within California CSC programs, and the inherent differences in the treatment approach between FEP and CHR, we have collaborated with the FEPS-FS 1.1 author to pilot a complimentary assessment tool that adapts some items of the FEPS-FS 1.1 to be appropriate for CHR care (i.e., the CHRPS-FS). These tools were developed to rate the degree to which the care mental health teams deliver adheres to the Coordinated Specialty Care Model (CSC; Heinssen et al., 2014) for clients with a first episode of Schizophrenia Spectrum Disorder and Clinical High Risk for Psychosis. The purpose of this fidelity assessment is to better understand the range and nature of services delivered by coordinated specialty care programs across the EPI-CAL network. Please see Table I for a detailed summary of the components that are assessed on the FEPS-FS 1.1 Scale. This differs slightly from the currently published scale with the inclusion of two additional items (items 36 and 37); one which focuses on the peer specialist role, and the second which focuses on transitions in care. These were added due to meet our state level clinical, policy and research priorities.

It is important to note that the findings come with multiple caveats:

- The field of early psychosis is a rapidly developing one, with evidence-base practices and recommendations evolving over time.

- While there is good evidence for coordinated specialty care leading to improved outcomes in early psychosis (i.e., Guo et al., 2010; Kane et al., 2016; Secher et al., 2015), understanding what the necessary specific components of coordinated specialty care are that leads to these improved outcomes, and how they should be optimally delivered, is in many cases still a matter of debate.
- The measure selected for use across the EPI-CAL network (the FEPS-FS v1.1), is one of multiple that exist. The FEPS-FS was selected due to the fact the tool is currently one of the most extensively used and validated in the field (Addington et al., 2020; Durbin et al., 2019)
- The FEPS-FS has been developed as an international standard, and so the tool has been designed to work across different systems of care. This may make high scores on some items much harder to achieve in the US due to the current structure of behavioral health service provision across the country.
- The ratings and the feasibility of meeting high-fidelity scores may vary widely depending upon the context in which the program is delivered. The FEPS-FS may include items where a high-fidelity score may be constrained by state, local, or insurance coverage decisions outside of the control of the specific program.

*Table 1: FEPS-FS 1.1 Components*

FEPS-FS 1.1			
1	Practicing team leader	20	Antipsychotic dosing within recommendations
2	Participant/provider ratio	21	Clozapine for medication-resistant symptoms
3	Services delivered by team	22	Patient psychoeducation
4	Assignment of case manager/ care coordinator	23	Family education and support
5	Psychiatrist caseload	24	Cognitive behavior therapy (CBT)
6	Psychiatrist role on team	25	Supporting Health
7	Weekly multi-disciplinary team meetings	26	Annual formal comprehensive assessment
8	Explicit diagnostic admission criteria	27	Services for patients with Substance Use Disorders
9	Population served	28	Supported employment (SE)
10	Age range served	29	Supported education (SEd)
11	Duration of FEP program	30	Active engagement and retention
12	Targeted Education to community groups	31	Patient Retention
13	Early Intervention	32	Crisis intervention services
14	Timely contact with referred individual	33	Communication between FEP and inpatient services
15	Family involvement in assessments	34	Timely contact after discharge from hospital
16	Comprehensive clinical assessment	35	Assuring Fidelity
17	Comprehensive psychosocial needs assessment	36	Peer support specialist role on team
18	Treatment / care plan after initial assessment	37	Transition in Care
19	Antipsychotic medication prescription		

The results of this assessment can be used in multiple ways. First, when combined with systematic data collection of client outcomes across multiple programs, fidelity assessments can be used to assess how variation in service delivery may impact client outcomes. Available data on which service components lead to specific outcomes could be used to advance the field of early psychosis care, and to advocate for potential changes in program funding and structure. Second, fidelity assessment can inform quality improvement efforts, highlighting individual areas of strengths and areas for improvement. Furthermore, it can enable individual clinics to review how their program compares to validated international standards and other programs in the state. Third, this information can be vital for county leadership and other key community partners to understand exactly what is being delivered by programs in a concrete, standardized format.

**Assessment Summary**

To date, we have completed assessments in 20 programs. Thirteen provide services for both FEP and CHR clients, four serve FEP only, and three serve clinical high risk only. Some of the assessed programs are well-established programs, but others are new and haven't even seen their first client yet. As a result, they do not have the sufficient service data to complete the health record abstraction necessary for the full fidelity assessment. To address this, in collaboration with the author of the FEPS-FS, Dr. Don Addington, we developed different levels of assessments, and operationalized rules around how to implement them. These included full assessments, formative assessments, and quality improvement (QI) assessments in cases where there were insufficient health record data to do a formal assessment. To meet criteria for a full fidelity assessment, the program must be delivering CSC services to EP clients two or more years and have five or more clients enrolled for at least one year and the time of the assessment. If those criteria are not met, the program may have a formative fidelity assessment if they have served ten or more clients ever, have at least five clients who have been enrolled for six months or more, and have supervision and defined admission criteria, assessment, and treatment approach. If the above criteria are not met, the program may have a simply quality improvement assessment in which their plan for program implementation in assessed by our team for consultation and feedback purposes.

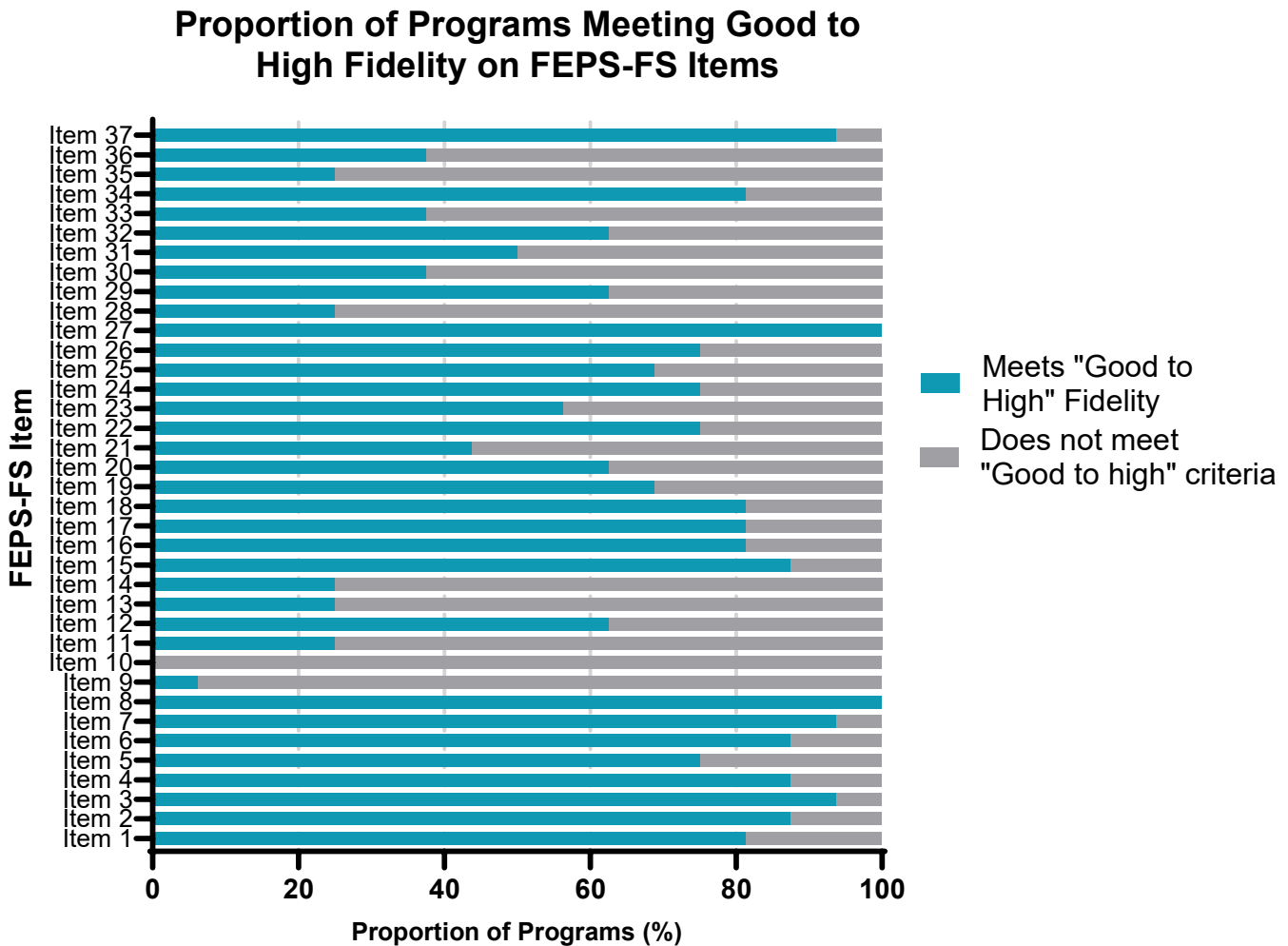
*Table II: Fidelity Assessment Characteristics*

<b>FEPS-FS n =17</b>				<b>CHRPS-FS n=16</b>			
<b>Assessment Types</b>				<b>Assessment Types</b>			
	Full	14	82.4%		Full	11	68.8%
	Formative	0	0.0%		Formative	1	6.3%
	QI	3	17.7%		QI	4	25.0%
<b>Program Type</b>				<b>Program Type</b>			
	Community	14	82.4%		Community	14	87.5%
	University	3	17.7%		University	2	12.5%
<b>Mean FEPS-FS Score*</b>		3.86	0.25	<b>Mean CHRPS-FS Score*</b>		3.96	0.32
<b>% Items good to high fidelity*</b>		66.6%	9.09	<b>% Items good to high fidelity*</b>		71.2%	8.15

For both FEPS and CHRPS, the full assessment was possible in the majority of programs. Amongst those

where a full or formative assessment could be conducted, the mean FEPS-FS score was 3.86 out of 5. Figure 2 shows a breakdown of the proportion of programs meeting good to high fidelity by each FEPS-FS item. With the CHRPS, mean scores were slightly higher at 3.96 out of 5.

Figure 2: Proportion of programs meeting good to high fidelity on FEPS-FS Items

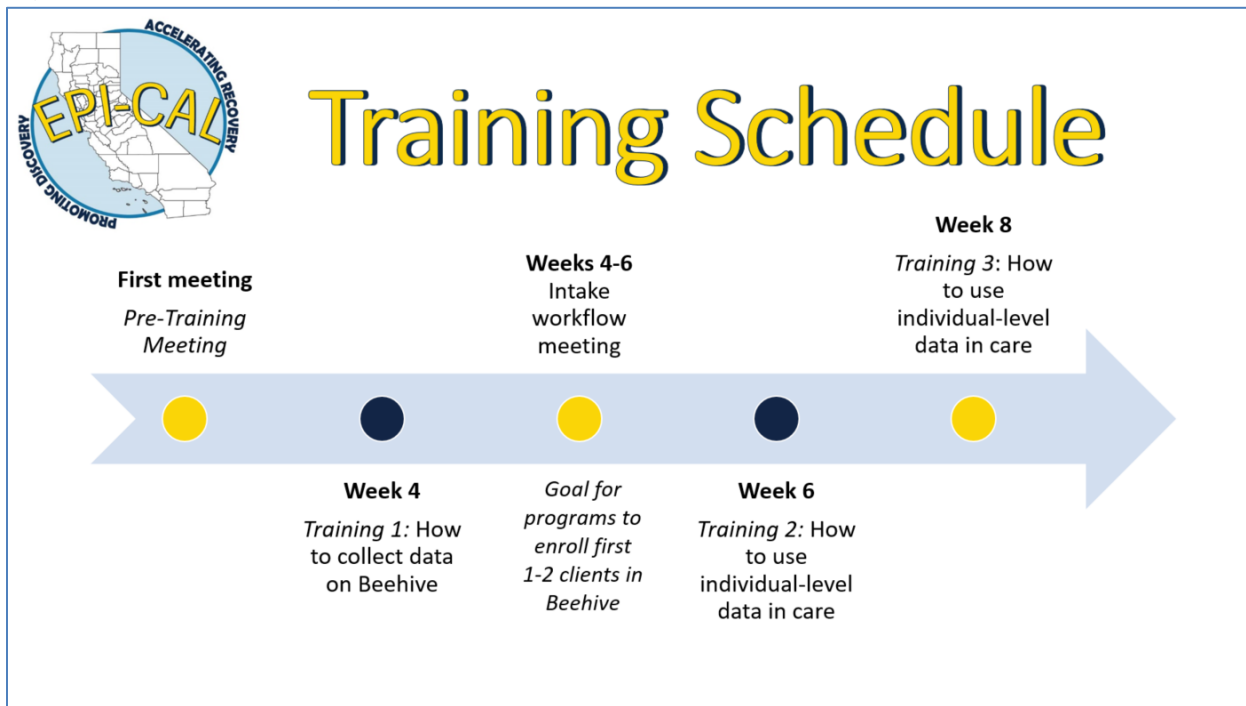


## 7. Provide training and implementation of outcomes measurement on app in non-pilot EP programs and progress of data collection in all EP programs

In our original LHCN proposal, we proposed in-person site visits to conduct the initial training for the Beehive application. However, due to the COVID-19 pandemic, we had to adjust our training plan and conduct the first training “site visits” 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 3: 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 2023. 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. We are also in the process of adding all of the training modules for Beehive trainings part 1 through 3 to a learning management system, Cornerstone, we all staff and providers from participating programs will be able to access asynchronous training materials. The planned release date for LHCN Cornerstone materials in at the end of June or early July.

Table III: EPI-CAL Site Training Completion

Site	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	7/13/2022	12/6/2022 & 6/13/2023
UCLA - Aftercare	7/29/21	9/1/2021	2/9/2022	5/20/2022	6/8/2023
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	10/28/2022	TBD
UCSD CARE	4/7/2022	5/23/2022	7/15/2022	9/30/2022	11/7/2022
Stanislaus LIFE PATH	2/23/2022	4/8/2022	5/10/2022	5/31/2022	9/22/2022
Stanford INSPIRE	3/21/2023	4/26/2023	5/23/2023	TBD	TBD
MCC	2/8/2023	3/9/2023 & 3/28/2023	4/7/2023	5/1/2023	6/9/2023
Lake County	4/21/2023	6/23/2023	TBD	TBD	TBD
<b>Totals</b>	<b>21</b>	<b>20</b>	<b>20</b>	<b>19</b>	<b>17</b>

### Pre-Training Meeting

The pre-training meeting is conducted between EPI-CAL staff, including the site’s assigned point person, site leadership, and a site IT representative. The purpose of this meeting is to introduce the training schedule and gather information to facilitate the first Beehive training. For example, the site leadership are invited to Beehive to create their accounts and 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). Site leadership complete their account registration ahead of the Part 1 training as they will be inviting all other program staff from their clinic to Beehive.

### 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 stakeholders 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 stakeholders, 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.

Figure 4: Training Agenda

## Training Agenda

- **Part A: Beehive Support**
  - Using Beehive Support Resources
- **Eula Video**
- **Part B: Training Tasks**
  - Task 1: Set up Clinic Admin accounts
  - Task 2: Set up Provider Accounts
- **Part C: Your Next Steps**
  - Goal 1: Set up Client and Support Person Accounts & Send Survey Weblinks
  - Goal 2: Check in with Clients and Support People (re: Completing Surveys)
  - Goal 3: Complete Clinician Data Entry

### *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/3E8hiEklvSQ>. (Spanish: <https://youtu.be/UgY7ZUhe-Fk> Vietnamese: <https://youtu.be/NqdC51TqGc0>). We developed the EULA video 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 5). 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 5: Training Checklist

TRAINING CHECKLIST	
<b>Tasks we completed together</b>	
<input checked="" type="checkbox"/>	<b>Task:</b> Set up Provider Accounts
<b>Goals for you to work on before our next training together</b>	
<input type="checkbox"/>	<b>Goal 1:</b> Set up Client & Support Person Accounts
<input type="checkbox"/>	<b>Goal 2:</b> Follow Up with Client & Support Person
<input type="checkbox"/>	<b>Goal 3:</b> Use our Support Resources

### 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 clients 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 stakeholder 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 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 6A) 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).

Figure 6: MCSI Example Graphs from Beehive

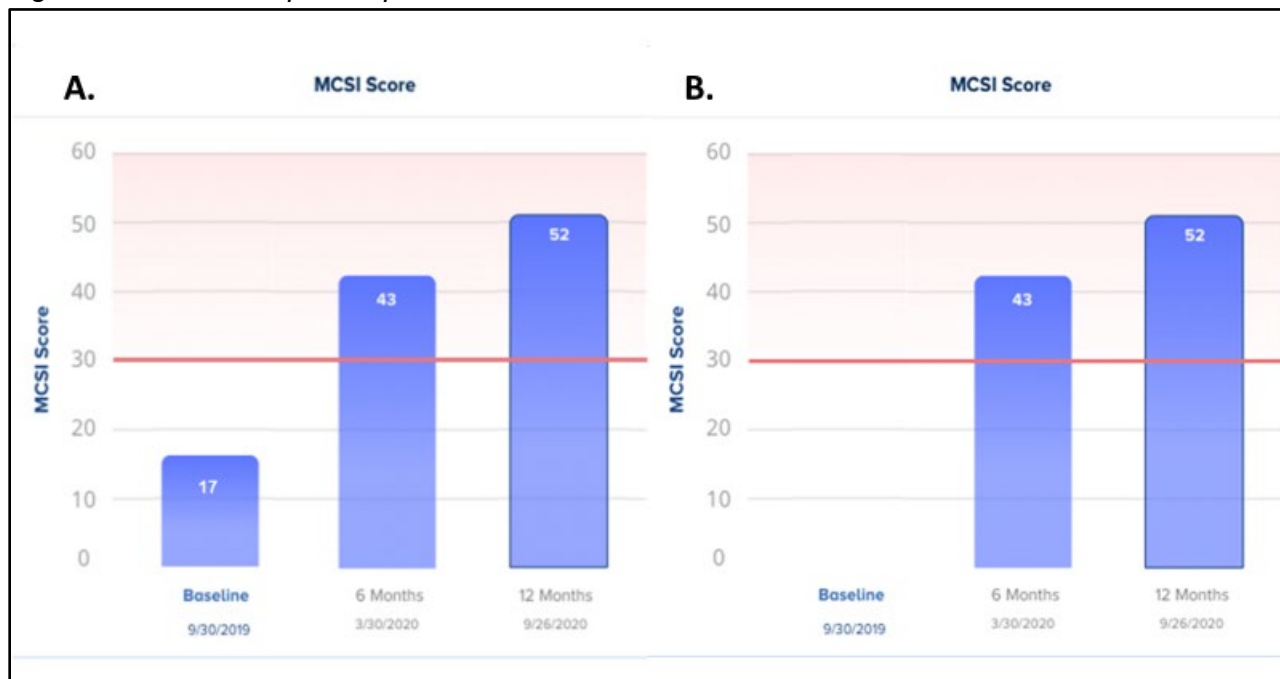


Figure legend: A. Representation of data showing increasing trend in MCSI symptom severity; B. Representation of how missing data (shown here at baseline) impacts the visualization

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 site 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 stakeholders 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. 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.

#### 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 client'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 clients?"). 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 client 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.

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 client 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 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 or in-person for sites that have resumed in-office operations.

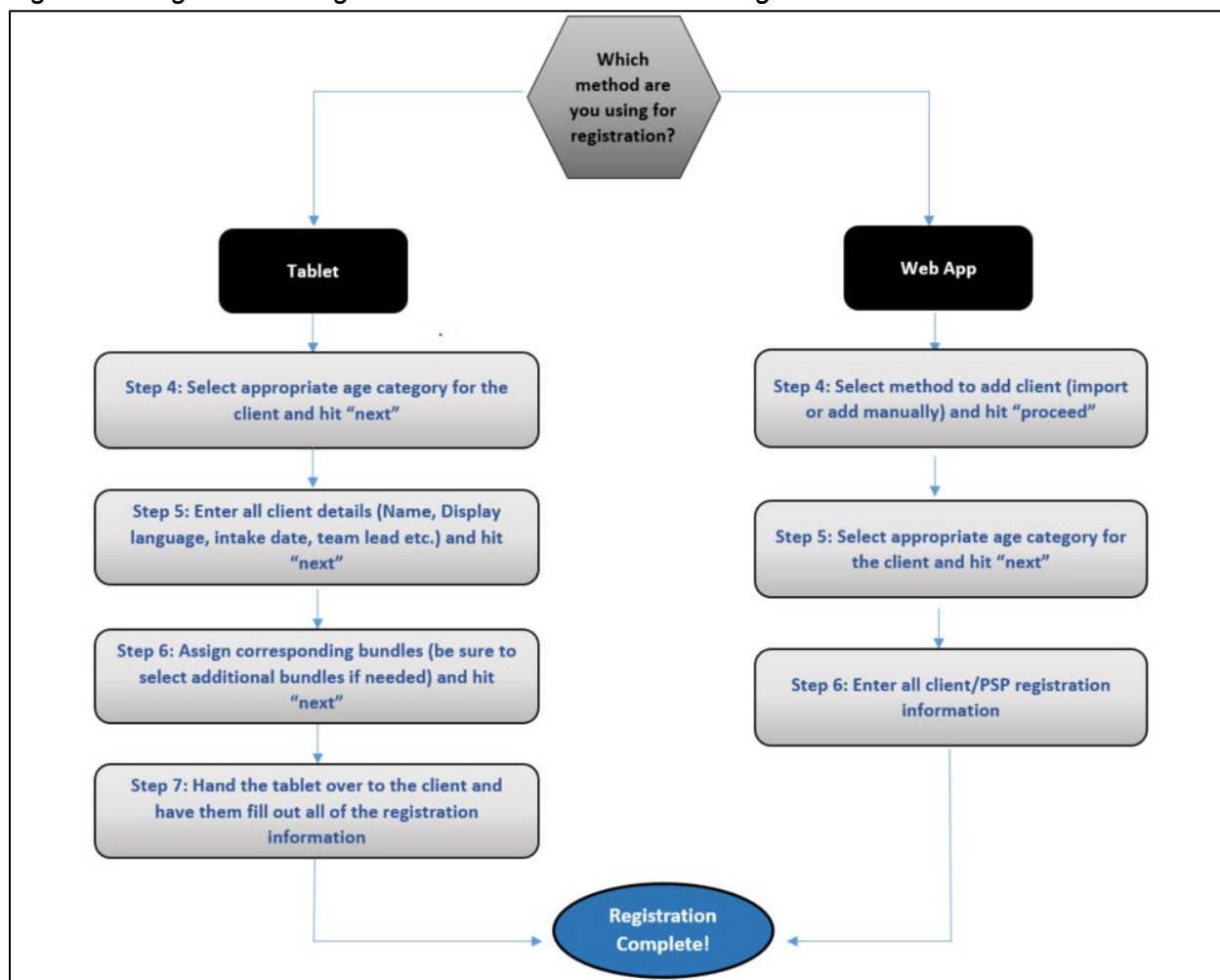
Point persons will also respond to ad hoc requests from the program for technical support and troubleshooting. For example, if a program experiences a bug or glitch while using Beehive, they are told to contact their point person who can help to troubleshoot or escalate this report.

Tablet Training

The Beehive application is available as both a web application and on tablets (i.e. iOS application). The tablet application is intended for clients who are receiving in-person services in the clinic or in the community. Due to the prevalence of telehealth and low incidence of in-person appointments, most sites did not plan to use the tablet application at the time of their initial core trainings. The EPI-CAL team developed a standalone tablet training to offer to sites on-demand whenever needed.

The tablet training covers the differences between registering clients and administering surveys on the iOS app as compared to the web application. It also covers several iOS app specific features such as the client individual check-in and group check-in features.

Figure 7: Diagram showing workflow differences in client registration based on environment



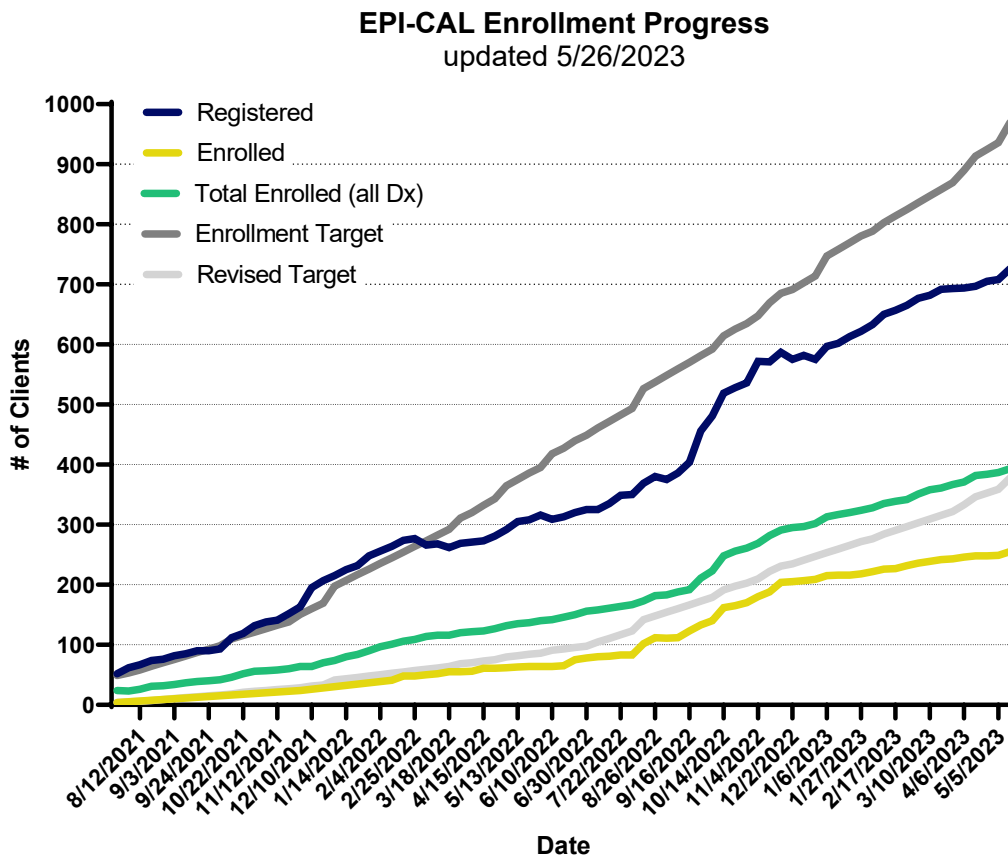
In the past year, only three programs have asked for this tablet training (OC CREW, San Mateo Felton, and Stanislaus LIFE Path). Other sites chose not to schedule a synchronous training, but rather have relied on the training materials and resource guide as they have begun to use the iOS application. We will continue to offer the live tablet training as needed, or refer staff to our asynchronous training materials.

## 8. Submit report on LHCN enrollment and follow up completion rates for LHCN app in all EP programs

### LHCN Overview

Figure 8 shows the LHCN Progress towards EPI-CAL Enrollment targets through May 26, 2023. Clients are considered enrolled if they have completed the Beehive EULA and agreed to share their data with UC Davis for use in research. If clients 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 969 individuals enrolled (solid dark gray line in figure below). In summer of 2022 we worked with sites to create a revised enrollment target (light gray line) based on observed rates of enrollment up to that point. The observed rate of enrollment across the LHCN is 412 clients across all diagnoses (green line in figure below) or 255 clients with a diagnosis that indicates FEP, (the yellow line in figure below). There are an additional 258 clients who have been registered by the clinic in Beehive (dark 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 clinics may not yet have all active clients registered) and allows us to see what possible enrollment across the network could be.

Figure 8: LHCN Progress Towards EPI-CAL Enrollment Targets



Figures 9-10 show a site-by-site breakdown of the proportion of individuals who agreed to data sharing with UC Davis for research purposes as of May 26, 2023. Figure 9 shows all registered clients, regardless of EULA completion status. Hence this figure shows the room for growth if sites support clients to complete their EULA in Beehive if those clients agree to data sharing.

Figure 9: Proportion of Data Sharing with UCD for Research by Site

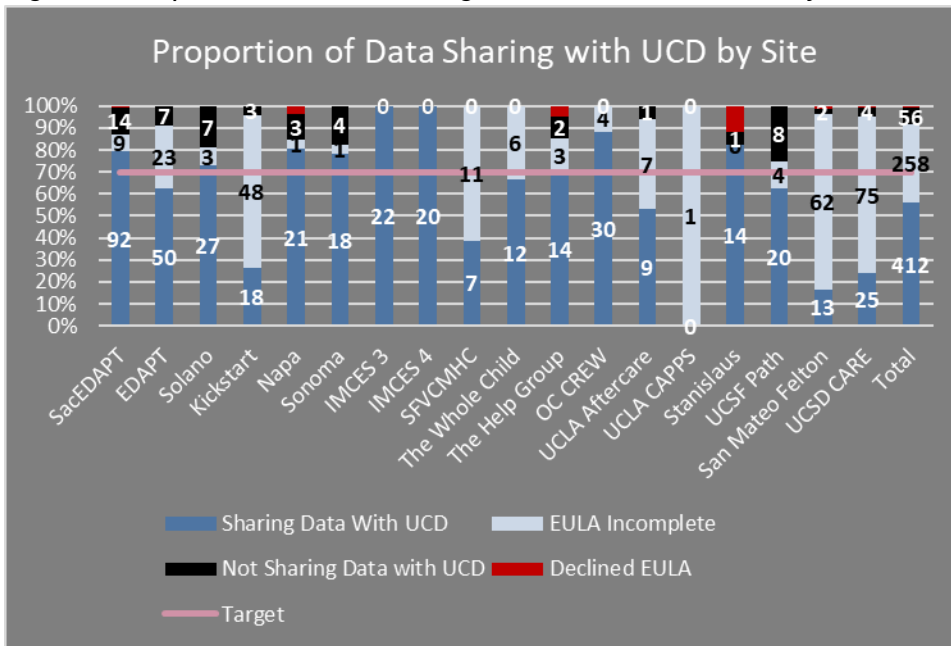
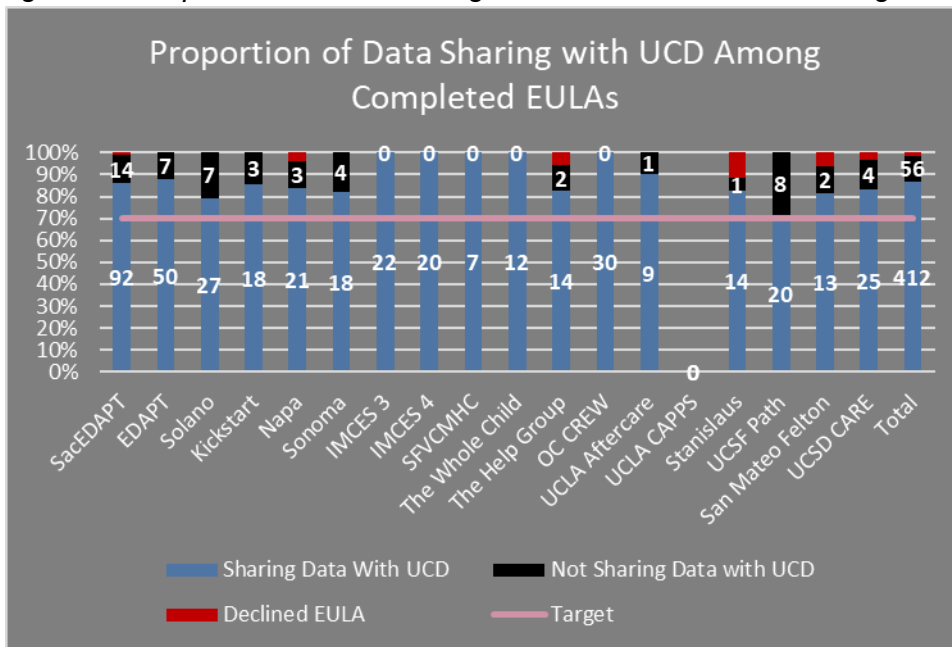


Figure 10 shows the proportion of data sharing choices made by those clients who have completed their EULA in Beehive. We can see that some sites on this graph do not have a bar at all because they do not have any clients who have been registered in Beehive.

Our goal is that 70% of active clients at each site agree to use Beehive and share their data for research purposes. When considering all clients 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. When considering all enrolled clients across the LHCN, 86% of clients have agreed to share their data with UC Davis and 83% of clients agreed to share their data with NIH for research purposes.



Figure 10: Proportion of Data Sharing with UCD for Research among Completed EULAs

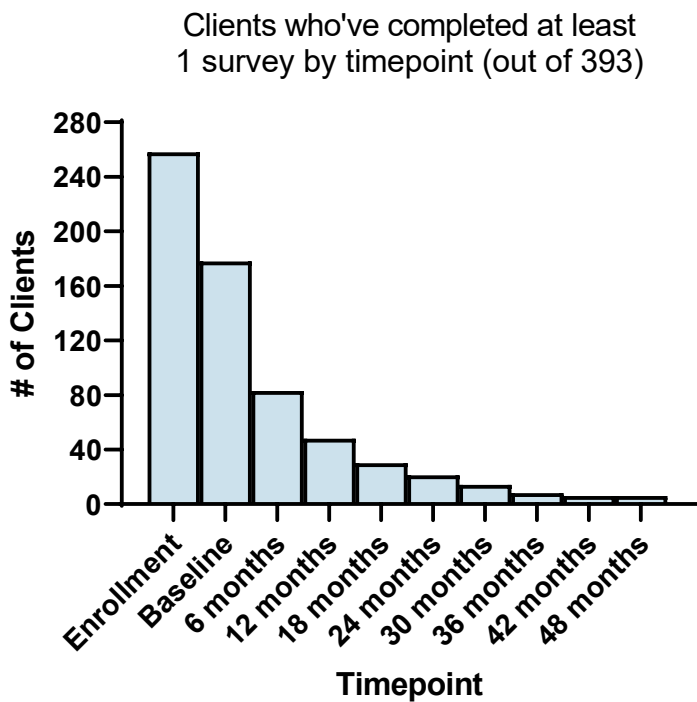


Progress of data collection in all EP programs

As of May 26, 2023, 18 EPI-CAL clinics have registered 733 clients in Beehive. Of those 733 clients who have been registered, 63% (n=468) have completed their Beehive EULA and are considered to be enrolled in Beehive. Of those who have completed their EULA, 83% (n=393) have agreed to share their de-identified data with NIH and 86% percent (n=412) have agreed to share their de-identified data with UCD.

Figure 11 shows network-level survey completion rates by time point as of May 26, 2023. Note that all clients are able to complete enrollment surveys regardless of when in their treatment they are enrolled. Clients are not able to complete some survey windows (e.g., baseline) if they are enrolled later in treatment. Some clients have completed surveys at more than one time point. Of the 468 clients who have been enrolled in Beehive, 88% (n=413) have completed at least one survey in Beehive.

Figure 11: Survey Completion Rates Across EPI-CAL Network



Here we report demographic information that is completed at registration, which is a subset of the demographic questions that are asked in Beehive (Table IV). Complete demographic information, including all required PEI fields, are administered via a required client-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 “<2%”, respectively. If there were 0 individuals who endorsed a response option in the demographic surveys, the category is not represented on Table IV (e.g., Genderqueer/gender non-conforming in the gender category); we will continue to add categories to each demographic variable if there are ≥1 individuals in each respective category.

Table IV: Demographic Data from all Participating EPI-CAL Clinics

EPI-CAL Combined Demographics, n =413 (through 5/26/2023)		
Display Language	N	%
English	402	97%
Spanish	9	2%
Missing	<5	<2%
Age	N	%
<12	<5	<2%
12-17	157	38%
18-23	182	44%
≥24	72	17%

<b>Sex at Birth</b>	<b>N</b>	<b>%</b>
Female	202	49%
Male	206	50%
Intersex	<5	<2%
None of these describe me	<5	<2%
Prefer not to respond	<5	<2%
<b>Gender</b>	<b>N</b>	<b>%</b>
Female	176	43%
Male	192	46%
Non-binary	16	4%
Transgender	6	1%
Questioning or unsure of gender identity	<5	<2%
Other	5	1%
Prefer not to say	14	3%
Missing	<5	<2%
<b>Pronouns</b>	<b>N</b>	<b>%</b>
He/Him	173	42%
She/Her	149	36%
They/Them	19	5%
Other	<5	<2%
Missing	68	16%
<b>Race</b>	<b>N</b>	<b>%</b>
African/African American/Black	49	12%
Asian	44	11%
American Indian/Alaskan Native	<5	<2%
Hispanic/Latinx Only	139	34%
White/Caucasian	10	2%
More than one race	149	36%
Unsure/Don't Know	9	2%
Prefer not to say	<5	<2%
Missing	<5	<2%
<b>Ethnicity</b>	<b>N</b>	<b>%</b>
No - I do not identify as Hispanic/Latinx	208	50%
Yes - I identify as Hispanic/Latinx	153	37%

Unsure/Don't know	48	12%
Missing	<5	<2%

Additionally, providers are asked to enter a client's diagnosis when they register individuals in Beehive, which is reported in Table V. 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 "<2%", respectively. 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). There is also a section for those individuals for which their FEP or CHR status is not yet confirmed. This reflects the wide range of psychosis diagnoses that are served by the EP clinics represented in this sample.

*Table V: Client Diagnoses from all Participating EPI-CAL Clinics*

<b>EPI-CAL Combined Diagnoses, n = 413 (through 11/28/22)</b>	<b>N</b>	<b>%</b>
Clinical High Risk (CHR)		
Attenuated Psychosis Symptoms	26	6%
Genetic Risk and Deterioration Syndrome (GRDS)	<5	<2%
Other	52	13%
First Episode Psychosis (FEP)		
Substance Induced Psychotic Disorder with onset during intoxication	<5	<2%
Mood disorders with psychotic features	47	11%
Schizoaffective Disorder (Bipolar or Depressive Type Combined)	29	7%
Schizophrenia	50	12%
Schizophreniform Disorder	6	1%
Delusional Disorder	<5	<2%
Brief Psychotic Disorder	<5	<2%
Other Specified Schizophrenia Spectrum Disorder	14	3%
Unspecified Psychosis	48	12%
Other FEP	58	14%
CHR or FEP Status Not Confirmed		
Anxiety Disorders*	23	6%
Mood Disorders*	30	7%
Other Diagnoses*	11	3%
Not enough Information	<5	<2%
Missing	35	8%

*\*Individuals may be counted more than once for these diagnoses*

## 9. Submit final data analysis plan for all data

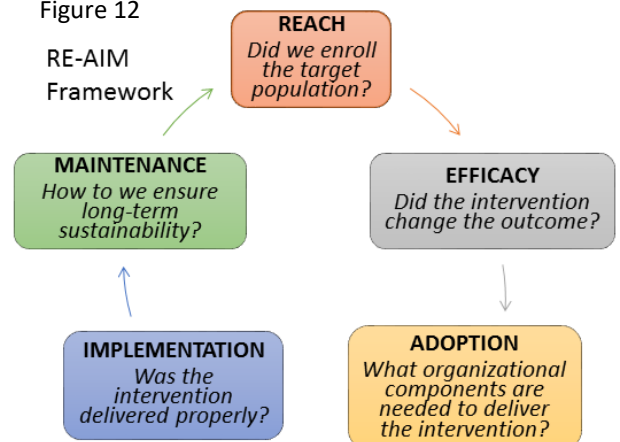
As a reminder, this project contains data collected via three components: program-level data, county-level data, and qualitative data (Figure 1). The county data analysis plan was described in prior deliverables. While we describe some qualitative analysis here, much of the qualitative data analysis was described in prior deliverables, including “Provide qualitative report on ongoing issues and suggestions on the app/dashboard from EP program staff and other community partners; including results of focus groups.”

Therefore, this analysis plan will focus on client data collected via Beehive, including client self-report data, data from the primary support person for the client, and clinician rated data. The majority of the data is designed to be collected longitudinally, i.e., at baseline and then every six months of treatment thereafter. For our purposes, baseline is associated with a client’s intake date, not when they are enrolled in Beehive. Therefore, any reference to “baseline” is referring to the client’s intake date or start in their program regardless of their interaction with Beehive, and “enrollment” is referring to when the client was enrolled in Beehive, which occurs after intake. There are several variables that are only assessed at enrollment in Beehive, including multiple items that are assessed if they occurred over the client’s lifetime. For example, clients are asked in the “EPI-CAL Baseline Only Questions” survey if they have ever, in their lifetime, experienced any legal interaction. Then, on follow-up surveys, clients are asked every 6 months thereafter if they have had legal involvement in the past 6 months. Therefore, the legal experiences variables represent variables that is assessed initially as a single lifetime variable and then longitudinally for more recent involvement. All clients are able to complete enrollment surveys regardless of when in their treatment they are enrolled. Clients are not able to complete some survey windows if they are enrolled later in their treatment (e.g., client enrolled at 6 months would complete the enrollment and 6-month bundle but would not be able to complete the baseline bundle). Please see Table VI for a list of all data domains collected in Beehive. This table outlines whether a domain is rated only at enrollment or longitudinally, and also indicates who completes the survey. Who rates the data will also be included as a variable in the analysis as we want to differentiate between information that is client self-report or clinician rated.

RE-AIM provides a conceptual framework to facilitate the translation of research to clinical practice. We will use this framework to examine the real-world impact of the proposed core battery and Beehive based on five dimensions (Figure 12): 1) Reach – the number and representativeness of the participants who use Beehive; 2) Efficacy – the impact of the intervention on specific outcomes; 3) Adoption – proportion and representativeness of people and places that adopt the intervention; 4) Implementation – quality and consistency of intervention delivery in real-world settings; and 5) Maintenance – long term outcomes of the intervention and its sustainability over time. This implementation research framework provides structure to examine initial impact of the project.

Prior to analysis, we will complete descriptive summaries for all data collected in Beehive, including client and clinician demographics, survey completion for each survey at each timepoint, and survey scores for quantitative measures. The distribution and completeness of each analysis variable will be examined to

Figure 12



determine appropriateness of different statistical methods. Availability of within-person longitudinal data will be reviewed to determine whether longitudinal or cross-sectional approaches are most appropriate. Descriptive summaries will be generated for each clinic individually as well as network wide.

*Table VI: Beehive Surveys by Timepoint and Respondent Type*

Respondent	Measure	Timepoint	
		Enrollment	Every 6 months (including Baseline)
Client	Registration Demographics	1*	0*
Client	EPI-CAL Baseline Only Questions	1	0
Client	Primary Caregiver background	1	0
Client	Adverse Childhood Experiences (ACES)	1	0
Client	Demographics & Background	0	1
Client	Education	0	1
Client	Employment and Related Activities	0	1
Client	Social Relationships	0	1
Client	SCORE-15	0	1
Client	Legal Involvement and Related	0	1
Client	Substance Use	0	1
Client	Medications	0	1
Client	Intent to Attend and Complete Treatment Scale	0	1
Client	Modified Colorado Symptom Index	0	1
Client	Questionnaire about the Process of Recovery (QPR)	0	1
Client	Life Outlook	0	1
Client	Hospitalizations	0	1
Client	Life Events Checklist (LEC-5) & PTSD Checklist for DSM-5 (PCL-5)	0	1
Client	Child and Adolescent Trauma Screen (CATS)	0	1
Clinician	Pathways to Care	1	0
Clinician	Diagnosis and DUP	0	1
Clinician	Family Involvement	0	1
Clinician	Risk to Self/Others	0	1
Clinician	Health	0	1
Clinician	Medications	0	1
Clinician	Service Use	0	1
Clinician	Functioning	0	1
Clinician	Symptoms	0	1
PSP *	Baseline Only Questions	1	0
PSP	Demographics & Background	0	1
PSP	Legal Interactions & Related	0	1
PSP	SCORE-15	0	1
PSP	Burden Assessment Scale	0	1
PSP	Modified Colorado Symptom Index	0	1

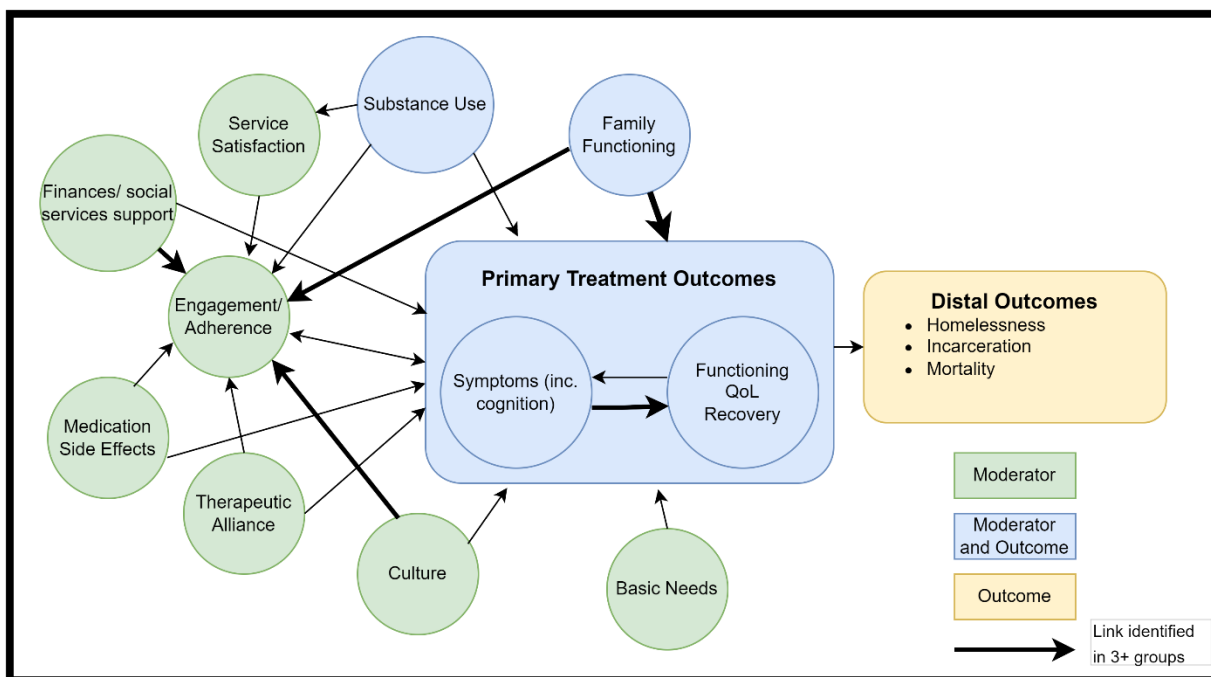
PSP	Medications	0	1
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\* PSP = Primary support person; 0 = not available; 1 = available

First, we will examine is whether we achieved adequate enrollment in Beehive (*Reach*). We will examine this using descriptive statistics to see if at least 70% of eligible participants, who are representative of the target population based on current program demographics, and 50% of their available family members, across the network were enrolled and completed at least one survey timepoint. To approximate the number of total clients eligible for enrollment, we will pull the total census number from each programs' completed fidelity assessment and program-level core assessment battery (PL-CAB). Data on of the number of available family members is available in Beehive and we are able to assess whether a primary support person (PSP) has completed enrollment and any additional surveys. Survey data analysis procedures for clustered data (treating early psychosis programs as clusters) will summarize characteristics of enrolled clients who complete enrollment and at least one longitudinal assessment. Enrollment rates (with 95% confidence interval) will be computed for 1) all eligible clients and 2) potentially available family members. For the latter, we will report, for the denominator of eligible clients with available family members, what proportion of those clients had at least one family member complete a baseline or 6-month assessment.

Through the extensive qualitative work that was completed in the first phase of this project (Figure 13), a variety of key outcomes were identified by our program, client and family workgroups. As described in the qualitative results from the Outcomes Focus groups, psychiatric symptoms, quality of life, and functioning were prioritized as key outcomes by all types of respondents and our analysis will center on these domains. Initially, as we continue to enroll and gather longitudinal data, our analyses will provide repeated cross-sectional assessment of these outcomes, with preliminary analyses of client's longitudinal trajectories when possible. As the longitudinal dataset grows, to account for the hierarchical structure of the data (nesting of measurements from clients, who are nested within clinicians within EP programs) and for continuous, binary, and count outcomes, generalized linear mixed models will be used to estimate the adjusted effects of exposures of interest on the key outcomes of interest, including quality of life, functioning, and recovery. Regression models will include independent variables (specified as fixed-effect terms) that operationalize relevant clinician metrics

Figure 13: Moderators and Outcomes of Interest



along with a parsimonious set of other clinician- and client-level covariates, in order to statistically adjust for confounders. Relevant clinician metrics may include clinician demographic information collected at registration, such as degree level, years working with this specific population, and other demographic variables. Random effects will be specified for sites, with additional effects specified for clinician and clients' effects if either/both improve model fit, according to Schwarz Information Criterion.

Next, we will examine *efficacy* of measurement-based care, comparing adjusted mean differences in baseline to 12-month change in psychotic symptom severity between groups defined by clinician metrics available from Beehive. When examining group-level differences, it is important to note that there is not a "Beehive" and "not Beehive" group of clients; all clients are assigned to the Beehive group and thus any analysis cannot examine the effect of Beehive use in treatment compared to a typical control group. Instead, clients will be classified according to the timeliness of clinician assessment of the client's Beehive data; the primary clinician metric will be a binary indicator for whether clinician accessed the patient's data within two weeks of surveys being completed. Exploratory metrics will include time spent reviewing Beehive data and whether the clinician reported that Beehive data impacted treatment plan. Our primary analysis will estimate impacts on mean baseline to 12-month changes in psychotic symptom severity, with separate regression models built for each of the primary and exploratory operationalizations of the Beehive clinician-usage metrics described above. Estimations of timepoint-specific changes (e.g. from baseline to 12-months) could either be done by computing the specific change score and using it as a dependent variable in a regression or, when data from other timepoints is also available, by analyzing the available data from each patient at each of multiple timepoints and including in the regression models terms for time, comparison group, and the interaction, to enable estimating timepoint-specific effects. When baseline data are available for a given outcome, we have opted to use regression approaches that pertain to estimating mean changes from baseline (e.g., a difference in differences type approach) instead of with baseline-adjusted mean differences at follow-up (e.g. an ANCOVA-type strategy) because our study is nonrandomized (Van Breukelen, 2006). Psychotic symptom severity data is available from both the client self-report Modified Colorado Symptom Index and a clinician-rated symptom measure, either the Brief Psychotic Rating Scale (BPRS) or the COMPASS-10. To address attrition, we will use multiple imputation to impute follow-up assessment scores and change scores based on them.

To assess the *maintenance* of measurement-based care via Beehive, we will assess timepoint-specific changes in psychotic symptom severity for each of the half-yearly assessment timepoints during the first 24 months, with the primary analysis based on a time-varying indicator for any endorsement of "impact on treatment plan" as a time-varying independent variable. We will also use data from the barriers and facilitator interviews to examine client-, provider- and program-level barriers to enrollment and completion. Separate models will be fit for each of the primary and alternative operationalization of Beehive clinician-usage metrics as the exposure variable of interest.

To examine *Adoption*, we will compare providers with respect to their reporting use of data to determine treatment choices at two timepoints, prior to Beehive implementation and after training in and using Beehive. To assess *Implementation*, we will examine if EP providers use Beehive in direct care with clients for at least 50% of completed assessments. Prior to Beehive implementation in each EP program, providers completed "pre-implementation" surveys about their demographic information (age, sex, race, ethnicity) and professional characteristics (years of education, degree type) and completed questionnaires on their 1) beliefs about the utility of data in care planning and 2) skills in discussing data with clients. Beehive training materials were implemented consistently across participating EP program, highlighting the utility of data to identify treatment goals and metrics of improvement during treatment planning, and provided guidance on client-centered ways to review data to monitor progress during treatment. For post-implementation analysis of use of data in care,



we will use provider-rated “use of data in care” questions, which are intermittently presented to providers while they are reviewing a client’s data page in Beehive so that they may indicate 1) if the data was reviewed during a session with the client or family and, if yes, 2) how the data was used as part of care, such as “followed up by phone” or “scheduled follow up appointment,” or “no action taken.” These data use metrics allow analysis on rates of adoption and level of implementation of Beehive. We will use a mixed effects regression model with robust standard errors to estimate site- and provider-adjusted pre-to-post differences in the proportion of client sessions where client-level data was used. The regression model will include fixed effects for site and a binary indicator for post-implementation and random effects for providers. If convergence can be obtained, we will use a linear link with a binomial variance. Otherwise, we will use a linear-normal model, relying on the robust variance estimator to correct for heteroscedasticity. Exploratory analysis will examine clinician expertise and training needed to effectively implement clinician review of FEP participant outcome data using Beehive at 80% of available time points.

To identify barriers and facilitators to Beehive implementation, our team is in the process of completing semi-structured qualitative interviews with clients and providers. Client-, provider- and program-level implementation barriers will be identified through analyses of qualitative data. Stratified purposeful sampling was and will continue to be used to recruit participants across clinics where Beehive adoption and implementation has been both high and low, and with clients who have and have not received data-integrated care. The data will be analyzed using an inductive approach to thematic analysis to identify data-driven themes to explain aspects of a phenomenon. Multiple coding will be adopted, and where possible, service users and providers will be involved in developing the topic guide and reviewing the data analysis and interpretation. Our goal is to have a total of 30 interviews completed by the Spring of 2023.

In addition to the program-level data described here, we also collected project data via fidelity assessments, program surveys, and the PL-CAB. Each program has completed a fidelity assessment to determine the components of coordinated specialty care (CSC) provided using the First Episode Psychosis Services Fidelity Scale (FEPS-FS), a standardized measure of fidelity to EP program best practices. Similar to the fidelity assessments, program surveys and the PL-CAB assess various components offered through the CSC program, program census, and staffing. The data from these other sources may also be used to inform the analysis of the program-level data described above.

Future analyses seek to examine the other relevant outcomes and moderators identified in Figure 13. Specifically, outcomes like homelessness, incarceration, and mortality are critically important for individuals with psychosis, but were not prioritized during the qualitative work given that these outcomes are not frequently observed in during the early course of illness. Therefore, these outcomes will be described for each of the programs, but not incorporated into statistical analyses for the purposes of the current report. Instead, we may need longer-term follow up data of those that transition out of the clinic and these domains have been identified as a priority for future work.

## **10. Draft preliminary data on feasibility and acceptability of LHCN app in all EP programs**

One of our primary metrics to evaluate the feasibility and acceptability of the Beehive application in EP programs it to examine is whether we achieved adequate enrollment in Beehive. We examined this using a previously defined benchmark of enrollment of at least 70% of eligible participants, who are representative of the target population based on current program demographics, and 50% of their available family members, across the network were enrolled. To approximate the number of total clients eligible for enrollment, we have

asked the programs to provide us with their current total census number. This was compared to clients currently enrolled in Beehive, and not including clients who have been discharged from Beehive. Clients must have completed their EULA to be considered enrolled. For the purposes of the preliminary analysis, we are only considering individuals who have agreed to share data with UCD as “enrolled”, but clients can decline this option and still use their data within their program for clinical purposes. Data on the number of available family members is available in Beehive and we are able to assess whether a primary support person (PSP) has completed enrollment. Just like clients, primary support persons are not considered enrolled unless they have agreed to share data with UCD. Clients and support persons can make different choices regarding their data sharing permissions, i.e., a client can decline to share their data for research purposes while a support person can opt in. For the purpose of the preliminary feasibility analysis, we are only examining what proportion of enrolled clients also have an enrolled PSP, acknowledging that there may be more enrolled PSPs whose corresponding client opted out of data sharing. Programs who have not begun enrollment are not included in this analysis (Lake County, MCC, and Stanford INSPIRE).

*Table VII: Preliminary client and PSP Beehive enrollment*

<b>Program Name</b>	<b>Current Census</b>	<b>Currently Enrolled</b>	<b>% Enrolled</b>	<b>Clients with an enrolled PSP</b>	<b>% with a Primary Support Person</b>
UCD SacEDAPT	25	29	116%	17	59%
UCD EDAPT	61	35	59%	20	57%
Solano SOAR	11	8	73%	4	50%
Napa SOAR	17	14	82%	9	64%
Sonoma SOAR	18	15	83%	5	33%
Kickstart Pathways	95	4	4%	3	75%
LAC- IMCES 3	11	17	154%	3	18%
LAC - IMCES 4	28	17	61%	4	24%
LAC - SFVCMHC	18	6	33%	1	17%
LAC- The Whole Child	34	12	35%	3	25%
LAC- The Help Group	19	13	68%	9	69%
OC CREW	42	16	38%	3	19%
San Mateo Felton	70	13	19%	3	23%
UCLA - Aftercare	21	9	43%	5	56%
UCLA - CAPPS	45	0	0%	0	0%
UCSF PATH	100 <sup>1</sup>	20	20%	4	20%
UCSD CARE	244	23	9%	2	9%
Stanislaus LIFE PATH	8	7	86%	3	43%

<sup>1</sup> Updated census not provided; estimate from program-level survey used.

As described in Table VII, there is quite a bit of variability across programs in the proportion of the program’s census that are enrolled in Beehive (mean = 55%, range = 0-154%). Two programs have more clients enrolled in Beehive than currently in their program, indicating they have clients who have been discharged from the program but not Beehive. EPI-CAL point persons are working with the sites to make sure they discharge clients from Beehive in a timely manner moving forward. Five of the participating programs meet or exceed the previously defined benchmark of 70% of eligible clients are enrolled. There was also extensive variability in the number of PSPs enrolled in Beehive across the programs as well (mean = 37%, range = 0-75%). Seven of the participating programs meet or exceed the previously defined benchmark of 50% of PSPs enrolled in Beehive.

The heterogeneity of enrollment across sites supports the need for the qualitative barriers and facilitators interviews to understand the issues that sites are facing. Future analyses will examine survey data from clients in more detail, and survey data analysis procedures for clustered data (treating early psychosis programs as clusters) will summarize characteristics of enrolled clients who complete enrollment and at least one longitudinal assessment.

## 11. Subcontractor to make additional revisions to dashboard to include feedback from programs and community partners.

Over the last fiscal year, we have made a number of changes and improvements to Beehive based on feedback from programs and community partners. Annual penetration testing (“pentesting”) was conducted in June of 2022 and May 2023. Results from the first annual testing of the fiscal year changes to Beehive (release date of 8/25/2022) in order to maintain compliance with increasing security standards. Results of the pentesting from May 2023 resulted in changes to Beehive in our current fiscal year and are not summarized in the current report. Table VIII summarized changes made to Beehive over the last fiscal year. Please see the table below for more detail.

*Table VIII: Changes to Beehive Implemented over the Fiscal Year 22/23*

Date	Changes to Beehive
7/8/2022	<ul style="list-style-type: none"> <li>• Performance updates (e.g., increased efficiency in application to reduce loading times) at login</li> <li>• Allow user to be logged into web browser and iOS app at the same time to prevent disruption in client survey completion</li> <li>• Added a link from Beehive dashboard to Beehive resource guide</li> <li>• Added a modal which shows survey expiration date when user hovers over survey due date</li> <li>• Added email notifications for urgent clinical issues</li> </ul> Alphabetized user dropdowns by first name
7/22/2022	<ul style="list-style-type: none"> <li>• Added in-App notifications for urgent clinical issues</li> </ul> Added ability for users to manage their email notifications (e.g. users can turn off email notifications if desired)
8/25/2022	<ul style="list-style-type: none"> <li>• Group Admin (i.e. program leadership) are notified of screen-shots taken on the iOS app</li> <li>• Users see a reminder not to share PHI without client’s written permission when taking screenshots on the iOS app</li> <li>• Updated password policy (does not apply to SSO-users)</li> <li>• Added “change password” functionality</li> </ul>

	Added One-Time Password timeouts (e.g., user can request OTP for a maximum of 3 times before they are locked out for 15 minutes, user can enter an invalid OTP a maximum of 5 times before they are locked out for 15 minutes).
9/14/2022	<ul style="list-style-type: none"> <li>Improved workflow for editing client data (e.g. summary page shows all registration information, user can jump to sections for editing purposes, user may save and close at any screen of client's profile when editing registration information)</li> </ul> <p>Updates to weblink distribution frequency (reduction in frequency in response to longer survey windows)</p>
10/03/2022	<ul style="list-style-type: none"> <li>Performance updates (e.g. increased efficiency in application to reduce loading times) during survey completion</li> <li>Added email notification when clients use "ask for help" feature</li> </ul> <p>Updated survey reports so that free text responses to "other (please specify)", for example, are treated as a separate variable</p>
10/14/2022	<ul style="list-style-type: none"> <li>Performance updates (e.g. increased efficiency in application to reduce loading times) throughout application</li> </ul> <p>Added an OTP cool down to prevent users from requesting a new OTP before the first OTP has had time to arrive</p>
11/21/2022	<ul style="list-style-type: none"> <li>Performance updates (e.g. increased efficiency in application to reduce loading times) on survey results and client data view page</li> <li>Update to client registration feature: allowing users to save registration before it is completed to finish later</li> </ul> <p>Added two additional response options to question asked when resolving urgent clinical issues based on user free-text responses from the past year</p>
12/23/2022	<ul style="list-style-type: none"> <li>Weblink &amp; OTP emails and text will be delivered to clients and support persons in their chosen display language (e.g., Spanish, Vietnamese)</li> <li>Added an option for "no weblink" to "Weblink Delivery Method" in response to request from LHCN programs</li> <li>Added an option to indicate when support persons decline to provide DOB in response to request from LHCN programs</li> <li>Report file names generated by Beehive will include more detail, including survey name and relevant clinics in the report, in response to request from LHCN programs</li> <li>To address request from LHCN programs, added in notifications relevant to track outstanding surveys: in-app survey notifications and weekly digest email</li> </ul>
01/23/2023	<ul style="list-style-type: none"> <li>Launch of Vietnamese (CA threshold language) translations for Beehive interface (e.g., EULA video, all navigation text) &amp; client &amp; support person surveys</li> </ul>
02/13/2023	<ul style="list-style-type: none"> <li>Added mobile phone validation and verification for client and support person weblinks</li> </ul>
03/13/2023	<ul style="list-style-type: none"> <li>In response to feedback from LHCN programs, gave provider-level users permission to close client episodes. Prior to this update, this permission was restricted to admin users only</li> <li>To support LHCN programs administer surveys to clients remotely, added an indication of the phone or email that OTP has been sent to</li> <li>In response to request from LHCN programs, added in a "download as PDF" option on client surveys so that surveys may be easily included in medical record or for other reporting purposes</li> </ul>

03/31/2023	<ul style="list-style-type: none"> <li>Performance updates (i.e., increased efficiency in application to reduce loading times) while loading data (e.g., client data view, survey results, clinic aggregate data)</li> </ul>
6/15/2023	<ul style="list-style-type: none"> <li>Arabic is available as a display language for Beehive interface (e.g., EULA video, navigation buttons). Survey translations not yet available because EPI-CAL team needs time after this language becomes available in production to enter them.</li> <li>Lengthened time before OTP expires from 5 minutes to 15 minutes to respond to institutional email screening procedures at sites which were slowing down email receipt and not delivering OTP before it would expire</li> </ul>

## 12. Establish data collection process for obtaining county-level utilization and cost data for prior 3-year timeframe for preliminary evaluation for both EP and comparator group (CG) programs

We have previously reported on our data collection process in past annual reports. However, we continue to work on the data collection process as new counties join the LHCN. During the last annual year, we continued to have follow-up meetings with the counties that are involved in retrospective data collection (Los Angeles, San Diego, Orange, Solano, Stanislaus, and Napa). We held a series of initial meetings with the EP program staff and county staff to address the collection of the county-level utilization and cost data for the prospective evaluation for both EP and comparator group (CG) programs (Los Angeles, San Diego, Orange, Solano, Stanislaus, Napa, and Lake). We identified EP program information, including a description of clients served, billing codes for each service, funding sources, and staffing personnel during the retrospective period. Meetings were also held with the county data analysts to discuss details about the data extraction. We reviewed all data elements that will be needed to define the EP and CG sample, including historical diagnostic and utilization data for both groups (January 1st, 2013- December 31st, 2016). We reviewed data categories, elements, and sources for utilization and cost to determine a) which services are provided in the county, and b) which data elements are available to be shared for the analysis. Any follow-up meetings with county data analysts are scheduled on an ongoing basis.

Lake and Kern counties will only be participating in the second phase of the evaluation, the prospective period, because their EP programs were not established until after the date range of the first evaluation phase concluded. In addition, Lake County will have a phase two timeframe that begins later due to the establishment of their EP program in 2022. Their prospective period will be January 1st, 2022- June 30th, 2024. This will allow for their EP program to have served more clients and collected service data for two and a half years for the prospective analysis.

### Data Collection Process

The retrospective data extraction procedures have been completed for Los Angeles, Orange, and San Diego, and are in progress for Solano, Stanislaus, and Napa counties. The prospective data extraction procedures are in progress for San Diego, Los Angeles, Orange, Solano, Stanislaus, Napa, and Lake counties. The county data analysts have been asked to identify all clients served by the EP program for the retrospective period dates between January 1st, 2017 – December 31st, 2019, and the prospective period dates between January 1st, 2020 – June 30th, 2022, with an exception for Lake County. For the retrospective period, this includes individuals who started services with the EP program between January 1st, 2017 – December 31st, 2019 and excludes any individuals who received services from the EP program prior to January 1st, 2017. For prospective period this includes individuals who started services with the EP program between January 1st,

2020-June 30th, 2022 and excludes any individuals who received services from the EP program prior to January 1st, 2020. The county data analyst will send the list of clients to the EP program manager, who will then confirm the list of clients as new clients as of January 1st, 2017 – December 31st, 2019 (for retrospective period, if applicable) and January 1st, 2020-June 30th, 2022 (for prospective period) and identify whether they were: 1) clinical high risk (CHR) and enrolled in treatment; 2) first episode psychosis (FEP) and enrolled in treatment; 3) assessed and referred out during January 1st, 2017 – December 31st, 2019 (retrospective) or January 1st, 2020-June 30th, 2022 (prospective); or 4) other, with reason (e.g., incorrectly assigned to EP program in EHR or claims data). They will also add any individuals missed and repeat above 1-3 categorization, if necessary. They will also send any available data elements that are not available in the county EHR and claims data to the county data analyst, who will integrate them into the dataset. These data elements may include information on intake forms, such as regional center involvement and referral information, or other data elements. The county data analyst will integrate these data elements into the dataset and assign an ID to replace medical record numbers (MRN), names, and other identifying information, then save the key in order to create a limited dataset (dates and zip code included). The county data analyst will be sent a username and password to login to a secure UC Davis GoAnywhere portal, whereby each county can upload their county data securely and will not be able to access any other county's data.

We formally requested this information when we met with each county. A summary of what we asked for is described below for the retrospective and prospective periods, respectively.

#### *Retrospective*

We are requesting a limited dataset for all individuals served in the specified EP Program between these dates: January 1st, 2017 – December 31st, 2019. Data elements requested include: 1) all diagnoses (psychiatric, substance use, physical health) and dates of diagnoses; 2) year and month of birth (not date); 3) demographics, including: race; ethnicity; sex; gender; gender identity; sexual orientation; living arrangement (housing status); US military information/ veteran status; primary language; foster care/adoption; zip code; insurance status (i.e., insurance type); education level; marital status; and employment status; and 4) all county behavioral health services utilized, including: i) all outpatient mental health services; ii) all other mental health services including but not limited to (and as available): inpatient; crisis residential; crisis stabilization; urgent care; long-term care; forensic services and jail services; referral(s) from EP program to other services; law enforcement contacts; justice system involvement; and regional center involvement. For each service, each county will check for these data elements and include as available: service/procedure code; location code, facility code; date; EBP/supported service code; charge description; and service duration/minutes. We also requested a data dictionary from each county.

Based on our preliminary analysis of the data from Los Angeles, Orange, San Diego, and Solano counties, we determined that we also need historical diagnostic and service utilization data going back to January 1st, 2013 for both EP and CG clients. This will allow us to improve the comparability of individuals in the CG group with those in the EP group by either, a) appropriately matching individuals from the CG group to individuals in the EP group or b) weighting clients by their predicted pre-period probability of being observed in the EP program during the study period. Therefore, all counties also received this additional request:

We are now requesting to extend our service utilization data request for the EP group to the four years prior to our active period (January 1st, 2017 – December 31st, 2019), going back to January 1st, 2013.

#### *Prospective*

We are requesting a limited dataset for all individuals served in the specified EP Program between these dates: January 1st, 2020 – June 30th, 2022. Data elements requested include: 1) all diagnoses (psychiatric,

substance use, physical health) and dates of diagnoses; 2) year and month of birth (not date); 3) demographics, including: race; ethnicity; sex; gender; gender identity; sexual orientation; living arrangement (housing status); US military information/ veteran status; primary language; foster care/adoption; zip code; insurance status (i.e., insurance type); education level; marital status; and employment status; and 4) all county behavioral health services utilized, including: i) all outpatient mental health services; ii) all other mental health services including but not limited to (and as available): inpatient; crisis residential; crisis stabilization; urgent care; long-term care; forensic services and jail services; referral(s) from EP program to other services; law enforcement contacts; justice system involvement; and regional center involvement. For each service, each county will check for these data elements and include as available: service/procedure code; location code, facility code; date; EBP/supported service code; charge description; and service duration/minutes. We also requested a data dictionary from each county.

Based on our preliminary analysis of the data from Los Angeles, Orange, San Diego and Solano counties, we determined that we also need historical diagnostic and service utilization data going back to January 1st, 2016 for both EP and CG clients. This will allow us to improve the comparability of individuals in the CG group with those in the EP group by either, a) appropriately matching individuals from the CG group to individuals in the EP group or b) weighting clients by their predicted pre-period probability of being observed in the EP program during the study period. Therefore, all counties also received this additional request:

We are now requesting to extend our service utilization data request for the EP group to the four years prior to our active period (January 1st, 2020 – June 30th, 2022), going back to January 1st, 2016.

### **13. Identification of county-level available data and data transfer methods, and statistical analysis 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 also examine services and costs associated with similar individuals served elsewhere in each county. We continue to work on harmonizing and integrating data across all LHCN counties in order to perform these analyses.

Specifically, in each county we identified an early psychosis (EP) group consisting of individuals served by the early psychosis program. We also identified a comparator group (CG), consisting of individuals with EP diagnoses, within the same age group, who entered standard care outpatient programs during that same time period. This analysis focuses on data from Los Angeles, San Diego, Orange, Napa, Stanislaus, Lake, and Solano counties. Inclusion of Kern County is pending an executed contract. 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 1st, 2017 – December 31st, 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 1st, 2020 – June 30th, 2022).

Lake and Kern counties will only be participating in the second phase of the evaluation, the prospective period, because their EP programs were not established until after the date range of the first evaluation phase concluded. In addition, Lake County will have a phase two timeframe that begins later due to the establishment of their EP program in 2022. Their prospective period will be January 1st, 2022-June 30th, 2024. This will allow for their EP program to have served more clients and collected service data for two and a half years for the prospective analysis.

For each county, our team held meetings with the EP program managers and the county data analysts. The meetings with the program managers discussed services provided by the EP program, description of clients

served, staffing specifics and billing 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 clients (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. The discussion included time-periods for which the LHCN team will request data, description of the clients from EP programs and how similar clients served elsewhere in the county will be identified, services provided by each program, other services provided in the county to the EP clients (i.e., hospitalization, crisis stabilization, 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. Each meeting has been described in detail in the call log provided in the deliverables. 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 IX).

*Table IX. Multicounty Program Services and Billing Information*

County	San Diego	Orange	Solano	Napa	Stanislaus	Los Angeles	Lake
<b>Program Name</b>	Kickstart	OC CREW	Aldea SOAR	Aldea SOAR	LIFE Path	CAPPS	Early Intervention Services (EIS)
<b>Clients Served</b>	FEP, CHR	FEP	FEP, CHR	FEP, CHR	FEP, CHR	CHR+	FEP and CHR
<b>Census</b>	140-160	42	26	15-Oct	Current 10-15, cap 40	60	30
<b>Length of Services</b>	(+/-) 2 yrs	2 - 4 yrs	(+/-) 2 yrs	(+/-) 2 yrs	2 yrs	2 years (case by case)	2-4 years
<b>Inclusion - Ages</b>	Ages 10-25	Ages 12-25	Ages 12-30	Ages 8-30	Ages 14 - 25	Ages 12-25	15-25 y/o
<b>Inclusion - Diagnoses</b>	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	CHR - based on SIPs, must have at least positive symptom score of 3-6.	Any type of psychoses, but not required.
<b>Inclusion - Insurance</b>	Medi-Cal, Uninsured	None	Medi-Cal, Uninsured	Medi-Cal, Private, Uninsured	Medi-Cal, Private, Uninsured	Medi-Cal only	Medi-Cal, uninsured, Medicare. We are only contracted with Medi-Cal and Medicare. We bill all other insurances,



County	San Diego	Orange	Solano	Napa	Stanislaus	Los Angeles	Lake
							but we are out-of-network.
<b>Inclusion - Duration of Psychosis</b>	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;	No longer than 30 days since onset	First break within last 2 years.
<b>Exclusion - Cognition</b>	IQ < 70 - Case by case discretion	IQ < 70	IQ < 70	IQ < 70	IQ < 70, Substance induced psychosis, psychosis due to medical conditions including TBI	IQ below 70	IQ <70
<b>Exclusion - Diagnoses</b>	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		Primary diagnosis of substance abuse	Primary substance use disorder
<b>Exclusion - Other</b>	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	Nothing beyond Specialty Health Services exclusions	We exclude when they are non-Specialty Mental Health Services.
<b>Assessments - Billing Codes</b>	10	90899-6 (H2015)	90791	10	10	90791	H2015 HE(SmartCar

County	San Diego	Orange	Solano	Napa	Stanislaus	Los Angeles	Lake
							e), 100 (Anasazi).
<b>Assessments - Provider type</b>	Clinicians	Clinician: master's level BHCI, BHCII, psychiatrist	Therapist; clinical supervisor	Therapist	LPHA	MD/DO, PA, PhD/PsyD (Licensed or Waivered), SW (Licensed, Registered or Waivered), MFT (Licensed, Registered or Waivered), NP or CNS (Certified), PCC (Licensed or Registered), Student professionals in these disciplines with co-signature*	Waivered Clinicians, LPHA, physician, nurse, case manager (other qualified provider).
<b>Assessments - Notes</b>	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 conservators hip evaluation, disability assessment, or eval for med services by telephone		Initial, Annual/ Periodic	Initial, periodic	n/a	Case managers provide screenings. Anasazi is the old electronic healthcare record. SmartCare has been utilized since 3/1/2023.

**14. 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 of Deliverable for Annual Report*

*Prospective Data Analysis*

Over the last fiscal year, we continued to meet with each county that has already submitted data from the retrospective period (Los Angeles, Orange, San Diego, and Solano) to review and finalize 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 client-level outcomes. Based on these pieces of information, we determined that the 2.5 year period of January 1, 2020 – June 30<sup>th</sup>, 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. That would allow for stakeholder feedback and a final analysis completed by June 2024 (see Table X). 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 December 2022.

**Table X. Proposed Timeline for Prospective Data Pull**

<b>County</b>	<b>Preliminary analysis due date</b>	<b>Length of time required for County to receive data</b>	<b>Data available by this date</b>
Solano	June 2023	3 months	<b>Sept 2022</b>
Orange	September 2023	10 – 11 months for charge data	<b>May 2023</b>
LA	June 2024	3 months for charge data DHS Hospital data - 6 months other hospitals - 30 days	<b>Jan 2023</b>
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 <b>Oct 2022</b> , Optum data available December 2023

Due to Covid-related delays in Beehive implementation (e.g., staffing shortages in county programs, reduced program censuses across the network), we do not expect to complete integrated analyses with sufficient statistical power by the end of the award period, but we do expect to conduct pilot analyses integrating client-level data from Beehive with county data.

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. We will confirm this timeline with Napa and Stanislaus counties after we complete the retrospective data analysis with them.

**Retrospective Data Request for Napa County**

During the last project period, we held a series of meetings with the EP program staff and county staff to address collection of the county-level utilization and cost data for the prior 3-year timeframe for Napa County.

We identified EP program information, including description of clients served, billing codes for each service, funding sources and staffing personnel during the retrospective period. Meetings were also held with the county data analysts to discuss details about the data extraction. The discussion included the time-period, January 1, 2017 – December 31, 2019, for which the LHCN team will formally request data. We reviewed all data elements that will be needed to define the EP and Comparator Group (CG) sample, including historical diagnostic and utilization data for both groups (Jan 2013-Dec 2016). We reviewed data categories, elements and sources for utilization and cost to determine a) which services are provided in the county and b) which are available to be shared for the analysis. Follow-up meetings with county data analysts have been scheduled.

#### *Follow-up to Preliminary Retrospective Data Analysis*

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, 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.

In the prior 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, as well as our central team, which has delayed project coordination and data extraction.

Over the last fiscal year, we have continued to meet with counties with clarifying 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 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 client, 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. For Napa County, they observed that the existing agreement between the county and UC Davis only covered de-identified data when it should have a described a limited dataset for the county data analysis. To make sure data sharing was covered appropriately, UC Davis drafted a data use agreement (DUA) covering all data elements to be shared between the county and the university as part of the EPI-CAL project. The draft DUA is currently under review by Napa County’s compliance department. Finally, we asked each county to provide us with clients’ episode of care end dates for those clients who may have ended their services since the data was originally extracted.

#### *Follow-up of preliminary analysis of service utilization data*

After completion of the last report, 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 client 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 prior Deliverables 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 client 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 client-level characteristics. However, we know clients 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 clients 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. 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 client to predict the probability we later observe them in the EP group during the study period by modeling selection into the EP group. Each client 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 clients 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 clients. We are also working closely with Solano County to obtain inpatient service utilization data for the specific CG clients 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 submitted the formal data requests on June 13<sup>th</sup>, 2022 for Stanislaus and May 26<sup>th</sup>, 2022 for Napa.

### Cost Analysis

We presented a preliminary analysis comparing the EP and CG groups in San Diego County on service utilization and related costs data as an example of the cost comparisons in the last annual report. Due to the challenges outlined above, we were not yet able to integrate or analyze cost data from Solano, Orange, and Los Angeles County. We have not yet received cost data from Napa or Stanislaus Counties. We are confident that the cost comparison analysis, along with a finalized comparison analysis of service utilization, will be completed for the deliverable due December 2023.

### *Sample and Methods*

We identified clients who initiated services in the San Diego EP program, “Kickstart,” from January 1, 2017 to December 31, 2019, and a comparison group of clients who were using outpatient services during the same time period. We identified Kickstart clients who first enrolled in the programs between January 1, 2017 and December 31, 2019. We limited the sample to clients 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 clients with private insurance, due to an inability to capture all of their services in the public claims system, and clients 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 clients with program staff who confirmed that these were past or current clients who had enrolled in services, and were identified as either First Episode Psychosis (FEP) or Clinical High Risk (CHR). FEP clients 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 clients have subthreshold symptoms, defined roughly as having a SOPS score of 3-5.

We identified a comparison group (CG) of clients 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 clients with private insurance, clients who received a diagnosis of intellectual disability, and clients 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 client 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 clients in the Kickstart program, of whom 104 were FEP and 197 were CHR, and 687 likely FEP clients in the CG (Table XI). Mean age in the FEP group was 18.3 years (SD=2.8) and the largest percentage of clients 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 clients 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 clients ages 21 and over (N=294, 43%). The FEP group had the largest percentage of clients who were male (N=73, 70%). The distribution of race/ethnicity was similar across the groups.

Table XII shows the mean number of services in the year prior and year post enrollment for Kickstart clients and in the year prior and year post the index outpatient visits for CG clients, 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 XIII 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 XIV 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 clients 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 XV 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 clients 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 XVI 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 clients enrolled in Kickstart had higher outpatient service use, visits, and costs than a comparable group of adolescent and young adult clients who were receiving services in standard outpatient programs. Services, visits, and costs were greater for clients with FEP than clients who were CHR. We did not find significant differences in psychiatric inpatient or emergency services use in the year following enrollment. However, since Kickstart clients 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 XI: Demographic Characteristics of Youth Clients 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+	19 (18%)	16 (8%)	294 (43%)	
<i>Gender N (%)</i>				P=.006
Male	73 (70%)	108 (55%)	368 (54%)	
Female	31 (30%)	89 (45%)	319 (46%)	
<i>Race/Ethnicity N (%)</i>				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 XII: Mean Annual Services Use, 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 XIII: 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 XIV: 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 XV: 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 XVI: Mean Annual Costs of Outpatient 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	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 fiscal year, we will finalize our analysis of 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 clients enrolled in the EP program were included as a comparison group in the current analysis, these clients 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 clients in both groups, as described previously. This will ensure that the CG group only contains clients most likely to have a first episode of psychosis, allowing for a more accurate comparison between FEP clients in the EP and CG groups on service utilization and related costs data.

**Discussion and Next Steps**

Discussion

Over this last fiscal year, the team has continued to meet each of the goals that were set to out for this project period. In addition to completing Deliverables laid out in our original Innovation plan timeline, the EPI-CAL team has also continued to bring in new counties to the multi-county collaborative to expand our Learning Health Care Network of EP programs. Through creating a Learning Health Care Network, all parties hope to have a larger impact on mental health services than any one county or program can create on their own. While the project has experienced some delays and challenges during the initial COVID-19 pandemic, the team works closely with counties and programs to adapt and adjust to the post-pandemic mental health landscape. 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 the original LHCN counties and are in the process of completing the Beehive training series for our newest LHCN county programs, including Lake County and the multi-county collaborative (MCC) programs. We are continuing to collect data on the core outcomes battery for the EPI-CAL project with 19 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, printing survey results to PDF, accessing the Beehive resource guide in the application, as well as modify our training approach based on constructive feedback from programs, including creating a testimonials slide from users of Beehive that describe the benefits of using Beehive thus far from real clinic users. We are in the process of

workshopping additional changes to the application, including the ability for clinics to edit data after survey completion as well as creating additional visualizations for more surveys for both client and clinic entered data.

We have also begun some of our planned feasibility analyses for the LHCN. While we have been monitoring LHCN enrollment and survey completion since EP programs began implementation of Beehive in their programs, we have just begun to assess whether current enrollment is meeting our pre-defined enrollment goals (70% of eligible clients enrolled in Beehive). Our preliminary analyses shows that a subset of programs are meeting this goal, and we are using our ongoing barriers and facilitators interviews to examine factors that are influencing enrollment across programs differently and contributing to the heterogeneity of enrollment that we observe in the LHCN.

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 Spring 2023.

We are in the process of procuring the final datasets in order to complete the integrated cost and utilization data for all counties. This has taken longer than originally expected given staffing shortages and problem solving needed to harmonize variables across counties. Over the next project period, we hope to gather the final datasets from all counties.

#### Next Steps

In the next fiscal year, we will conclude fidelity assessments with EPI-CAL programs and meet with county and program leadership to provide detailed feedback on fidelity results. At the end of FY 22/23, 17 LHCN EP programs (20 total programs as part of EPI-CAL) have completed a fidelity assessment and there are only five remaining fidelity assessments to complete, three of which were in progress. We will also continue and complete training new EP programs from both the LHCN and larger EPI-CAL network. 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. We are collecting informal data on these factors via regular check-in meetings with programs, as well as through a qualitative research approach by examining barriers and facilitators to Beehive implementation through interviews with EP program participants. While we first focused on interviewing providers and staff over the last fiscal year, our efforts will shift to recruiting clients to elicit their feedback about using Beehive in the current fiscal year.

Over the next fiscal year, the LHCN team expects to receive and review data for both EP program and CG clients 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 clients, 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 clients in the EP programs and CG groups from Napa and Stanislaus counties.

This 23/24 fiscal year is the last project year for many of the counties and programs that were part of the

original multi-county collaborative innovation plan and therefore our team in working to prepare a report that summarizes the overall progress of the LHCN to date. This report will include a summary of qualitative data that has been collected over the course of the project, outcomes data collected via Beehive, and a multi-county integrated analysis of cost and utilization data. The report will be prepared for review by our county and program partners, and we hope to have other community partners provide feedback on the overall success and challenges of implementing a Learning Health Care Network of EP Programs in California.

## 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 clients.

### 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 clients 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 clients into the Electronic Health Record
    4. How do you complete assessments or other paperwork for people who are in need of interpretive services?
  - ii. At what stage in the workflow would Beehive registration fit best?/When would you register clients 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)?
  - iii. Which staff member(s) will complete registration?
  - iii. When would client 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 client to EULA/surveys on intake day?
- b. Integration of Beehive

*(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)*

2. 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?
3. What roles on team currently complete data-entry? (QM, Clinic Coordinator, Clinicians)
4. How do you access/view data after it is entered?
5. 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 clients about completing their surveys?
  - ii. Entering clinician-entered data for each client?
  - 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 (clients & 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 client & 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 client'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 client's experiences?
- 
- Additional Discussion Questions
5. Does either survey help you understand the other survey better?
6. Think about the different roles in the clinic and how they might use this data differently
  - a. How might a family advocate or peer partner use this information compared to a clinician?
  - b. How might a prescriber use this information compared to a case manager?

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## CLIENT Surveys

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- Employment And Related Activities.....*
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- Questionnaire About The Process Of Recovery (“Staying Well Questionnaire”)*
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- Intent To Attend And Complete Treatment Scale (“Treatment”).....*
- Hospitalizations.....*
- Shared Decision Making Questionnaire (Sdm-Q-9) (“Shared Decision Making”).....*

### **EPI-CAL TRAUMA ADULT (“STRESSFUL LIFE EXPERIENCES”) .....**

- Life Events Checklist (LEC-5) & PTSD Checklist for DSM-5 (PCL-5) (“Stressful Life Experiences”).....*

### **EPI-CAL TRAUMA CHILD (“STRESSFUL LIFE EXPERIENCES”)**

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**EPI-CAL PSP LIFE QUESTIONS (“MY LIFE”) .....**

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*PSP: Score 15 (“Family”).....*

*Burden Assessment Scale (“Family Impact”) .....*

**EPI-CAL PSP EXPERIENCES QUESTIONS (“THEIR EXPERIENCES”) .....**

*PSP: Legal Involvement And Related (“Legal Involvement And Related”)*

*PSP: Modified Colorado Symptom Index (Mcsi) (“Personal Experiences Inventory”) .....*

*PSP: Medications (“Medications”).....*

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# County of Sonoma



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Semi-Statewide Enterprise Health Record

Multi-County Collaborative INN Project

Annual Innovative Project Report

*Reporting Period: July 1, 2022 – June 30, 2023*

*Project Period: November 17, 2022 - November 16, 2027*

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## Project Overview and Local Need

### 1. Please describe this Innovation project and its purpose.

This is a multi-county, scalable INN project that stems from a larger Semi-Statewide Enterprise Health Record (EHR) project CalMHSA is concurrently leading (the EHR Project). CalMHSA is partnering with 23 California counties – collectively responsible for 27% of the state’s Medi-Cal beneficiaries – on the 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 in the 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. This approach also facilitates data sharing between counties for patient treatment and payment purposes as patients move from one county to another.
- **Collective Learning and Scalable Solutions:** Moving from solutions developed within individual counties to a semi-statewide cohort 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 the EHR are being re-designed (e.g., clinical documentation and Medi-Cal claiming), while data exchange and interoperability with physical health care — toward improving care coordination and client outcomes — are being both required and supported by the State.
- **Lean and Human-Centered:** Engaging with experts in human-centered design to reimagine the clinical workflow in a way that reduces “clicks” (the documentation burden), increases client safety and natively collects outcomes.
- **Interoperable:** Typically, county behavioral health has, in response to state regulations, developed documentation that is out of alignment with data exchange standards. We are reimagining the clinical workflow so critical information about the people we serve is formatted in a way that will be interoperable (standardized and ready to participate in key initiatives like health information exchanges).

### 2. Please describe how this project makes a change to an existing practice in the field of mental health, including but not limited to application to a different population.

This project will meet the general requirements by making a change to an existing practice in the field of mental health, specifically, the practice of documentation of care provision in an EHR that meets the needs of the county’s workforce and the clients they serve.

### 3. Please describe how this project impacts your County’s local need(s):

## Progress Update and Identified Changes

### **1. Please describe your project progress from the date of approval by the Mental Health Services Oversight and Accountability Commission (MHSOAC) through June 30, 2023.**

Sonoma County completed primary data conversion and migration for go-live date of 7/1/23. End-user staff training was completed between 6/5/23 and 6/15/23. Trista Carr, Behavioral Health Informatics Analyst, was hired to support the implementation of this project as a primary system admin for the new system, and primary training coordinator for on-boarding new staff. Sonoma has participated in multiple weekly collaboration and planning meetings with CalMHSA and other counties. Additionally, CalMHSA has provided ongoing TA pertaining to clinical needs, prescriber needs, billing set-up, reporting, and inpatient/residential functionality.

### **2. Has your county experienced any changes in project implementation and/or local need since the submission of your Appendix for MHSOAC approval? What is/are the reason(s) for this/these change(s)?**

Sonoma County has requested changes to the participation agreement, these additions include one additional lab (LabCorp) and text reminders for appointments. The additional of the secondary lab options will facilitate improved care coordination by allowing for all lab interfaces within the same system. The text reminder feature will help reduce the incidence of no-shows for psychiatry and clinical appointments.

### **3. How does this change/these changes noted in #2 above impact or modify your project plan and/or timeline?**

N/A

## CalMHSA's Internal Evaluation and Qualitative Analysis of the State of Electronic Health Records Across California Counties

During this project period, CalMHSA partnered with IDEO, a global design and research company with over 40 years of consulting experience working in social and government sectors. IDEO was uniquely positioned to assist CalMHSA based on their strong focus on capacity building and creating new, strategized approaches to previously unsolved problems. CalMHSA, at the request of participating counties, sought to create a semi-statewide EHR system, built according to the needs of the user, that not only meets documentation and regulatory requirements, but also integrates provider needs for transparent communication, augments support for decision-making and best practices and, through increased efficiency, reduces staff burnout and improves workforce retention.

IDEO conducted interviews with over 50 county staff from participating county agencies, primarily focused on outpatient psychiatry services, to better understand different users' interactions and needs within an EHR. The staff interviewed included doctors, nurses, social workers, and peer counselors. Sonoma County had 101 users participate in these interviews. IDEO also met with EHR experts and analogous experts, such as digital storytellers, data visualization scientists, and behavioral scientists to draw inspiration for what was possible for this future EHR vision. They also conducted an in-depth

analysis of the transitional EHR, SmartCare, to better understand what could be leveraged versus what would need to be customized to achieve the goals as stated above.

**Some key needs identified from these interviews included:**

- An improved EHR design that allows for a holistic view of patient data rather than siloed across different areas of the software
- Better facilitation of record keeping and sharing across the platform
- Improved utilization of automaticity and intentional pauses as moments to accurately capture structured data to reduce redundancy, disseminate key information and promote best practices while maintaining flexibility and trust amongst users
- Transparent dialogue and a disruption of bias patterns in the software so the data entered can promote equitable outcomes and care

## Evaluation Data/Learning Goals/Project Aims

CalMHSA contracted with the RAND Corporation during this project period to conduct a comprehensive evaluation of the project. To ensure a systematic evaluation of the migration to the new EHR platform, RAND is employing two measurement approaches: 1) a pre-post user survey, 2) pre-post task-based usability testing. RAND selected evidence based EHR metrics grounded in measurement science that are precise, reliable and valid.

The goal of the pre-post user survey is to measure user experience and satisfaction of existing EHRs and the new EHR across all participating counties. This pre-phase of the survey was administered during this project period and prior to the “go-live” implementation of the new EHR system. It was sent to all EHR users in participating counties (see Exhibit 1 for Pre-Survey User Data). The survey (see Exhibit 2) included outcome measures such as the Post-Study System Usability Questionnaire (PSSUQ), satisfaction with EHR attributes, satisfaction with specific tasks in the EHR, and likelihood of recommending the EHR. The PSSUQ is a 16-item standardized questionnaire that originated from the IBM project called System Usability Metrics in 1988. This standardized tool allows for a single metric to be calculated as an average of the 16 items, which provides a reliable measure that can be compared to other studies that have used the tool. The tasks included in the survey were also based on the most common use cases across different role types (e.g., prescribers, medical staff, licensed clinicians, non-licensed providers and administrators).

The goal of the pre-post task-based usability testing is to obtain objective measures of EHR usage and burden (as measured by the length of time required to complete specific, common tasks in the EHR) before and after the migration to the new EHR. The pre-phase of this usability testing was conducted from May 30, 2023, to June 30, 2023, and included 30 prescribers and licensed clinicians in the select counties who opted to participate. The usability tests asked each participant to complete three tasks in a simulated EHR environment with simulated client scenarios. Tasks included creating an assessment/evaluation and progress note for a new client visit, reviewing a chart for an existing client and creating a progress note for a return client visit. The outcome metrics included task completion rate,

time on task, errors and post-task satisfaction. These usability tests complement the user survey to provide objective measures of the EHRs in a controlled environment.

The post-phase of the survey and task-based usability testing will likely occur in approximately January/February 2024 to allow users to become accustomed to the new EHR platform. The optimal time to conduct a post-migration assessment is when users have established stable and sustainable behaviors, which has typically been three to six months after implementation. The post-survey will also address the original learning goals and project aims regarding quality, safety/privacy, satisfaction and outcomes.

Overall, the evaluation will eventually allow for an assessment of how the transition to the new EHR resulted in changes to usability and user satisfaction.

<b>Learning Goals/Project Aims</b>
<b>Quality</b> <ul style="list-style-type: none"><li>▪ Comprehensiveness of client care</li><li>▪ Efficiency of clinical practice</li><li>▪ Interactions within the health care team</li><li>▪ Clinician access to up-to-date knowledge</li></ul>
<b>Safety/Privacy</b> <ul style="list-style-type: none"><li>▪ Avoiding errors (i.e., drug interaction)</li><li>▪ Ability to use clinical data for safety</li><li>▪ Personal and professional privacy</li></ul>
<b>Satisfaction</b> <ul style="list-style-type: none"><li>▪ Ease of use</li><li>▪ Clinician’s stress level</li><li>▪ Rapport between clinicians and clients</li><li>▪ Client’s satisfaction with the quality of care they receive</li><li>▪ Interface quality</li></ul>
<b>Outcomes</b> <ul style="list-style-type: none"><li>▪ Communication between clinicians and staff</li><li>▪ Analyzing outcomes of care</li><li>▪ System usefulness</li></ul>



- Information quality

Future annual reports will include status updates on the above learning goals and project aims.

## Program Information for Individuals Served

This project focuses on transforming current EHR systems and processes counties use for the provision of behavioral health services. Accordingly, we have not estimated the number of individuals expected to be served annually. As noted previously, the participating counties in the Semi-Statewide Enterprise Health Record project are collectively responsible for serving the population of Medi-Cal beneficiaries who need specialty mental health and/or substance use disorder treatment services among approximately 27% California’s Medi-Cal beneficiaries, or among approximately 4,000,000 people.

Regarding specific project information on individuals to served, this project focuses on transforming the current EHR system and the processes California counties use for the provision of behavioral health services rather than directly testing an innovative approach to service delivery.

## Budget and Annual Expenditures

**Total dollar amount expended during the reporting period on this Innovative Project:**

<b>Total Annual Budget Amount from Proposal (2022)*</b>	<b>Actual FY 22-23 INN Expenditures</b>	<b>Actual FY 22-23 Medi-Cal Expenditures</b>	<b>Actual FY 22-23 Realignment Expenditures</b>	<b>Actual FY 22-23 Other Expenditures</b>
\$1,038,189.84	\$1,691,333.19	\$0	\$0	\$0

\*Proposal listed budget in calendar year versus fiscal year.

**Total dollar amount expended during the reporting period for administration of this project:**

<b>Total Annual Budget Amount from Proposal (2022)</b>	<b>Actual FY 22-23 INN Expenditures</b>	<b>Actual FY 22-23 Medi-Cal Expenditures</b>	<b>Actual FY 22-23 Realignment Expenditures</b>	<b>Actual FY 22-23 Other Expenditures</b>
\$0	\$0	\$0	\$0	\$0

Total dollar amount expended during the reporting period for the evaluation of this project:

Total Annual Budget Amount from Proposal (2022)	Actual FY 22-23 INN Expenditures	Actual FY 22-23 Medi-Cal Expenditures	Actual FY 22-23 Realignment Expenditures	Actual FY 22-23 Other Expenditures
\$250,000	\$250,000	\$0	\$0	\$0

FY 22-23 total Expenditures compared to Estimates from Proposal:

Description	FY 22-23 Total	7 Year Estimates (includes Innovation & CFTN funding) from Proposal
Participant Instance Installation	\$250,000	\$250,000.00
System Acquisition Fee	\$95,484.83	\$115,353.02
Initial Development Fee (Customization and Security)	\$95,484.83	\$115,353.02
Discretionary Development Budget	\$95,484.83	\$115,353.02
Professional Services Implementation	\$738,461.52	\$8,000,000.00
SmartCare Patient Portal Implementation	\$2,400.00	\$2,400.00
SmartCare IP/Residential Implementation	\$7,500.00	\$7,500.00
SmartCare OE/EMAR Implementation	\$18,000.00	\$18,000.00
SmartCare Pharmacy Interface Implementation	\$15,000.00	\$15,000.00
SmartCare Pyxis Interface Implementation	\$0.00	\$0.00
SmartCare Lab Interface Implementation	\$15,000.00	\$0.00
SmartCare HIE / MCO Interface via FHIR Implementation	\$12,000.00	\$12,000.00
High Availability Cloud Infrastructure Implementation	\$0.00	\$12,000.00
Disaster Recovery Implementation	\$6,000.00	\$6,000.00
SmartCare CalMHSA Package	\$63,475.20	\$2,997,440.00
SmartCare Rx Prescribers Subscription	\$13,395.20	\$487,968.00
SmartCare Patient Portal Subscription	\$165.60	\$25,024.00
SmartCare IP/Residential Subscription	\$2,875.00	\$97,750.00
SmartCare OE/EMAR Subscription	\$2,875.00	\$97,750.00
SmartCare Pharmacy Interface Subscription	\$575.00	\$19,550.00
SmartCare Pyxis Interface Subscription	\$0.00	\$0.00
SmartCare HIE / MCO Interface via FHIR	\$575.00	\$19,550.00
SmartCare Add-On Hosting Storage Subscription	\$0.00	\$68,000.00
High Availability Cloud Infrastructure Subscription	\$0.00	\$380,800.00

<b>Disaster Recovery Subscription</b>	\$3,456.00	\$163,200.00
<b>SmartCare Lab Interface Subscription</b>	\$488.76	\$0.00
<b>Annual %3 Fee Increase - Subscription</b>	\$2,636.42	\$0.00

## Exhibit 1 – Pre-Survey User Data

### 1. User Roles

- a. 96 prescribers
- b. 121 prescriber med staff
- c. 730 clinician LPHA
- d. 723 non-LPHA
- e. 1081 admin
- f. 17 other
- g. 157 no response

### 2. Users by County (Please note: Counties participating in the Multi-County INN project are noted with an "\*" below)

- a. Colusa - 5
- b. Contra Costa - 6
- c. Fresno - 290
- d. Glenn - 29
- e. Humboldt\* - 67
- f. Imperial\* - 189
- g. Kern - 585
- h. Kings\* - 44
- i. Lake - 74
- j. Marin - 29
- k. Mono\* - 16
- l. Placer\* - 103
- m. Sacramento - 303
- n. San Benito\* - 20
- o. San Joaquin\* - 165
- p. San Luis Obispo - 119
- q. Siskiyou\* - 27
- r. Sonoma\* - 101
- s. Stanislaus - 104
- t. Tulare\* - 232
- u. Ventura\* - 299
- v. Other - 9
- w. Did not respond - 89

## Exhibit 2 – Pre-Survey Questions

### Usability and Satisfaction Metrics

**A. PSSUQ: On a scale between "Strongly Disagree" and "Strongly Agree," please rate the following statements (1 - Strongly Disagree to 7 - Strongly Agree).**

1. Overall, I am satisfied with how easy it is to use this system.
2. It was simple to use this system.
3. I was able to complete the tasks and scenarios quickly using this system.
4. I felt comfortable using this system.
5. It was easy to learn to use this system.
6. I believe I could become productive quickly using this system.
7. The system gave error messages that clearly told me how to fix the problems.
8. Whenever I made a mistake using the system, I could recover easily and quickly.
9. The information provided with this system was clear.
10. It was easy to find the information I needed.
11. The information was effective in helping me complete the tasks and scenarios.
12. The organization of information on the system screens was clear.
13. The interface of this system was pleasant.
14. I liked using the interface of this system.
15. The system has all the functions and capabilities I expect it to have.
16. Overall, I am satisfied with this system.

**B. Based on your experience, please indicate how satisfied you are with the way your EHR performs on the following items (1 - Very Dissatisfied to 5 - Very Satisfied, NA).**

1. Ability to use the EHR without needing IT or additional support
2. Supports delivery of quality healthcare
3. Interactions within the care team
4. Amount of time spent in the EHR
5. Your stress level
6. Rapport between providers and clients
7. Data privacy and security
8. Access to up-to-date information
9. Usefulness of alerts
10. Comprehensiveness of client care
11. Efficiency of clinical practice
12. Avoiding errors (such as overlooking a drug interaction, selecting the wrong intervention or scheduling the wrong service time)
13. Amount of information presented on each screen
14. Amount of data entry required
15. Response time (i.e., speed of system response or loading time)
16. Reliability (i.e., system performs correctly every time)
17. Costs of providing care
18. Inclusivity or adequacy of demographic data fields

**C. Based on your experience, how satisfied are you with the way your EHR allows you to perform the following tasks? (1 - Very Dissatisfied to 5 - Very Satisfied, NA)**

1. Review progress notes
2. Obtain and review lab results
3. Obtain and review imaging or test results

4. Review past and current medications or prescriptions
5. Identify allergies
6. Update medication lists
7. Enter a progress note with all relevant service indicators (e.g., person contacted, contact type, place of service, service intensity, etc.)
8. Create and maintain problem lists
9. Customize templates
10. Prevent providers from signing a document if required fields are not complete
11. Link a new episode or admission record to previous care coordination activities
12. Enable documentation of social determinants of health (SDOH) or Z-codes
13. Bill for services in a timely manner
14. Complete a psychosocial assessment or screening
15. Enter new outpatient lab orders
16. Enter orders for other tests
17. Add/renew/discontinue prescriptions
18. Receive drug interaction or dosage error alerts when writing prescriptions
19. Receive drug allergy alerts when writing prescriptions
20. Prevent other adverse events
21. Schedule appointments
22. Manage a closed-loop referral process (i.e., make a referral to an outside entity and track if the referral was completed)
23. Manage client caseload (e.g., identify people at risk or those who have not engaged in services in the last 60 days)
24. Run reports on metrics across your client network (e.g., number of clients dealing with homelessness, timeliness to treatment, number of referrals, etc.)
25. Analyze outcomes of care
26. Send quality measures to other entities (e.g., preventive screening rates)
27. Facilitate continuity of care and follow-up across organizations or providers
28. Communicate with clients electronically
29. Generate documents in my client's preferred language

**D. How likely are you to recommend this EHR to a colleague? (0-to-10-point scale)**

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

## SONOMA COUNTY MHSA ANNUAL PROGRAM REPORT FY 2022 – 2023

### 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 MHSA  
ANNUAL REPORT ON CAPITAL FACILITIES  
AND TECHNOLOGICAL NEEDS (CFTN)**



# SONOMA COUNTY MHSA ANNUAL PROGRAM REPORT FY 2022 – 2023

## 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 22-23, 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



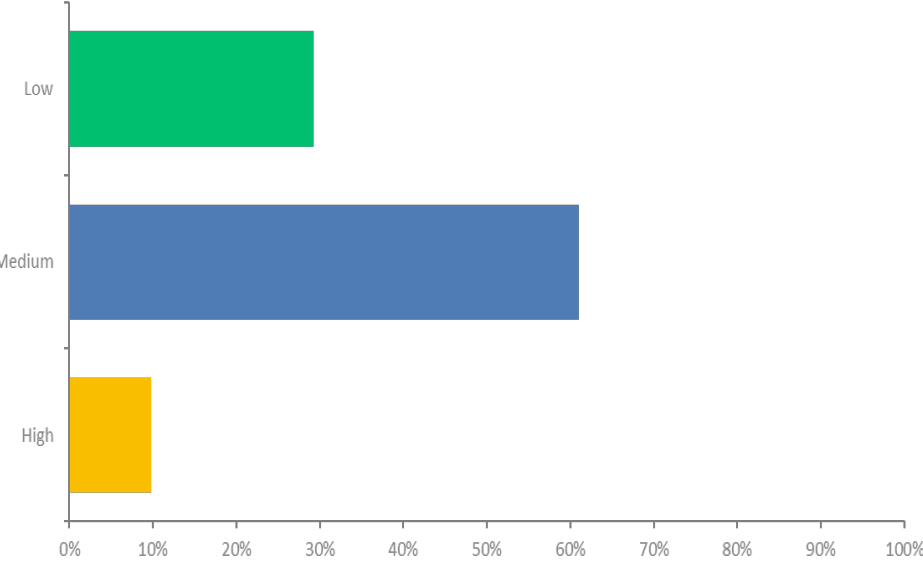


# SRJC QPR Outcome Data 2022-2023

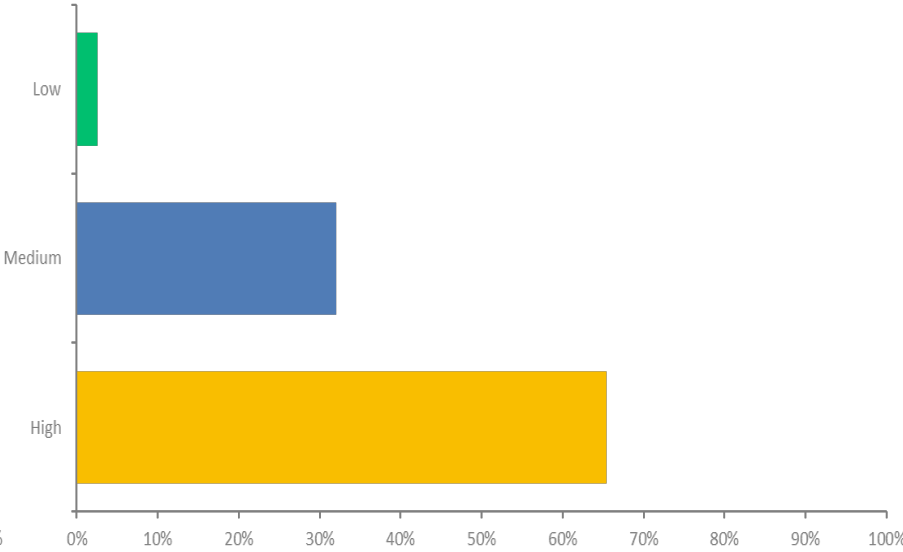
# How would you rate your knowledge of suicide in the following area?

## Facts concerning suicide prevention:

Pre Training

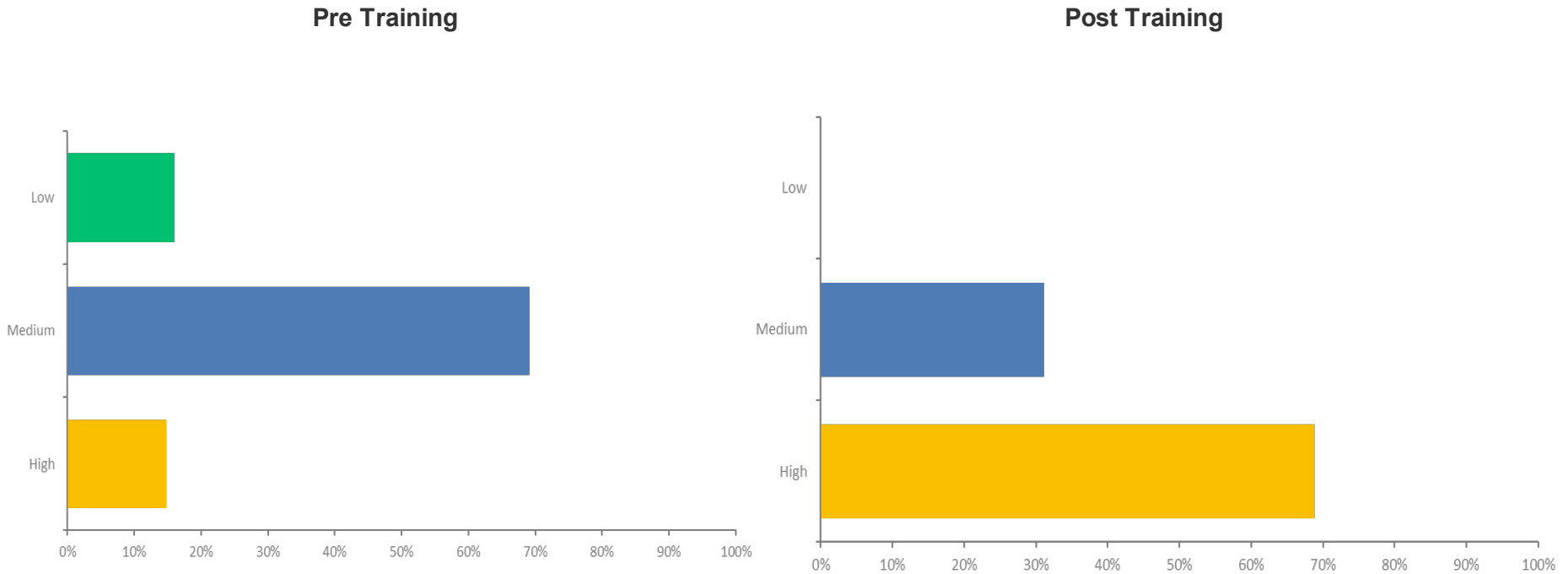


Post Training



# How would you rate your knowledge of suicide in the following area?

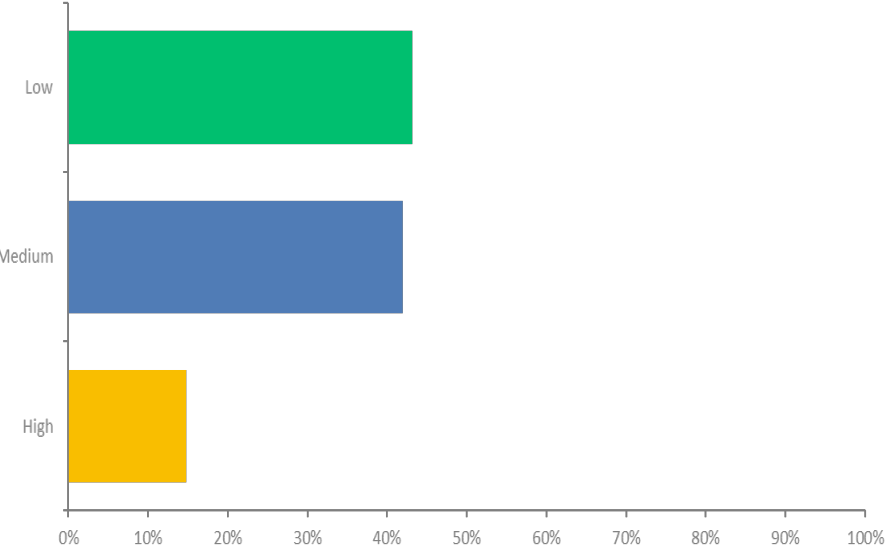
## Warning signs of suicide:



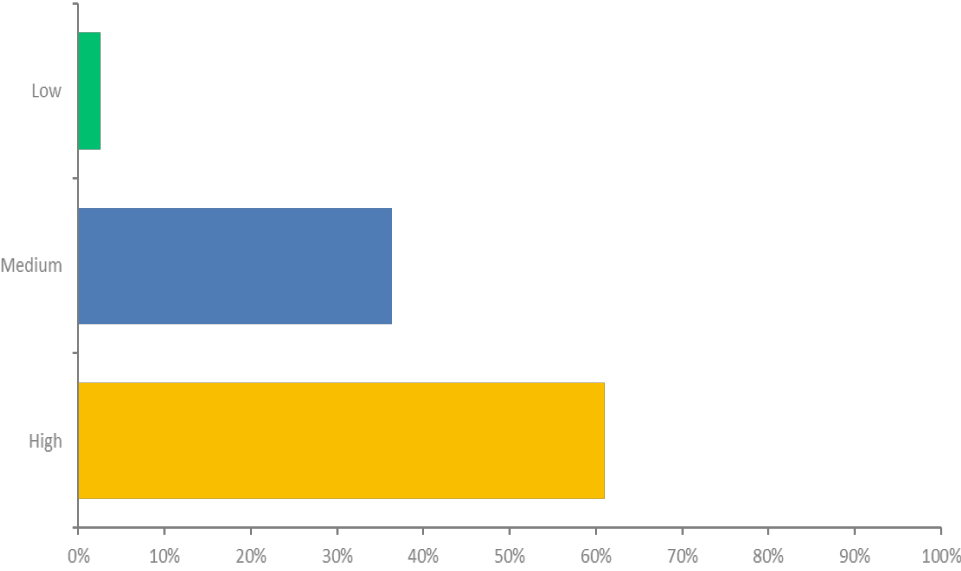
# How would you rate your knowledge of suicide in the following area?

## How to ask someone about suicide:

Pre Training



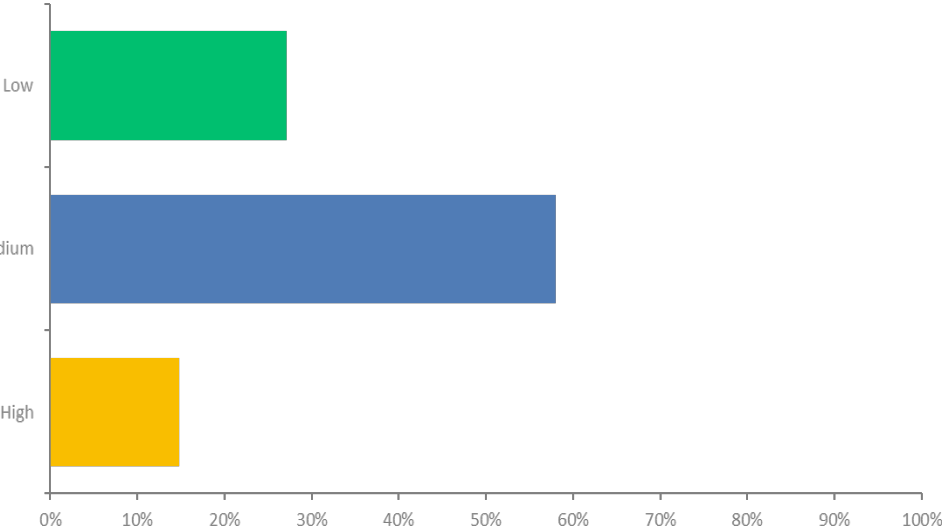
Post Training



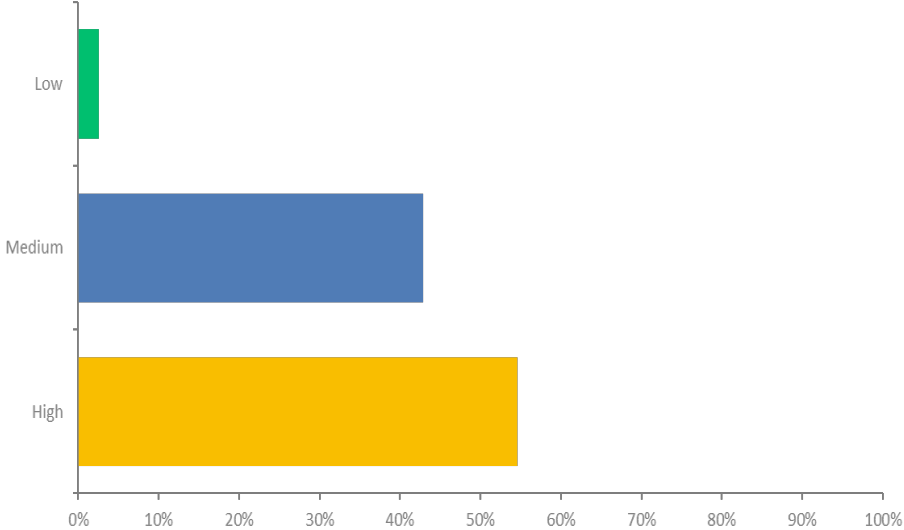
# How would you rate your knowledge of suicide in the following area?

## Persuading someone to get help:

Pre Training



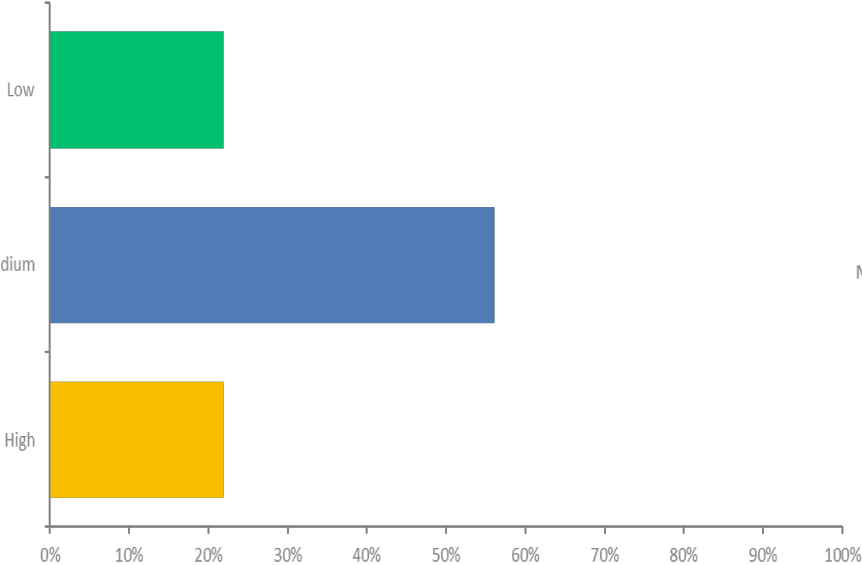
Post Training



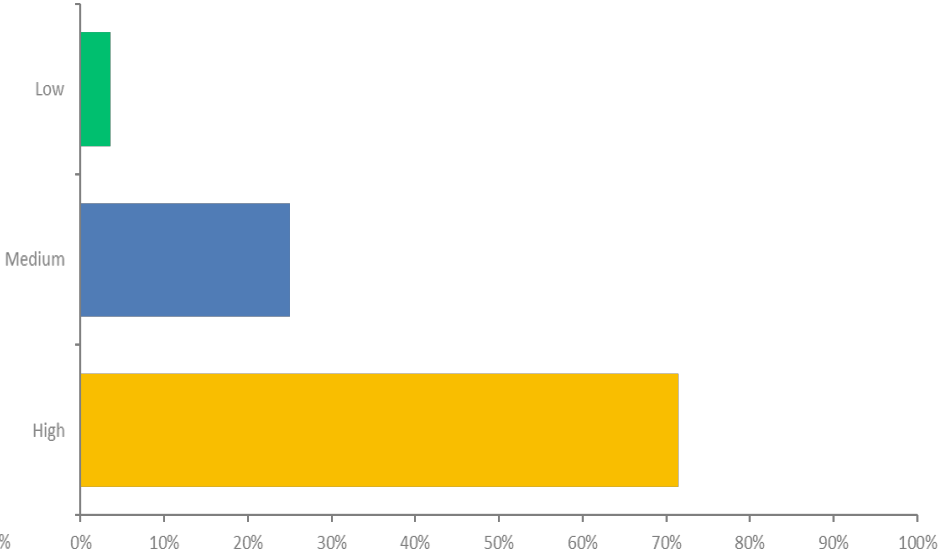
# How would you rate your knowledge of suicide in the following area?

## How to get help for someone:

Pre Training



Post Training

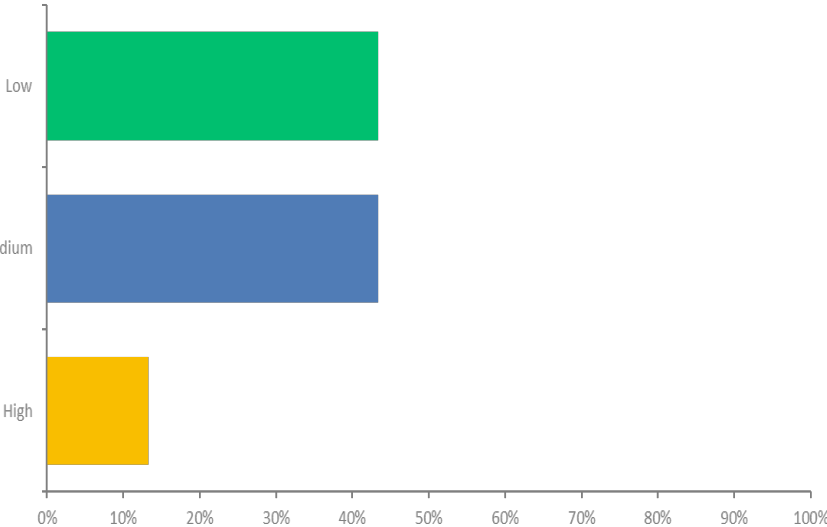




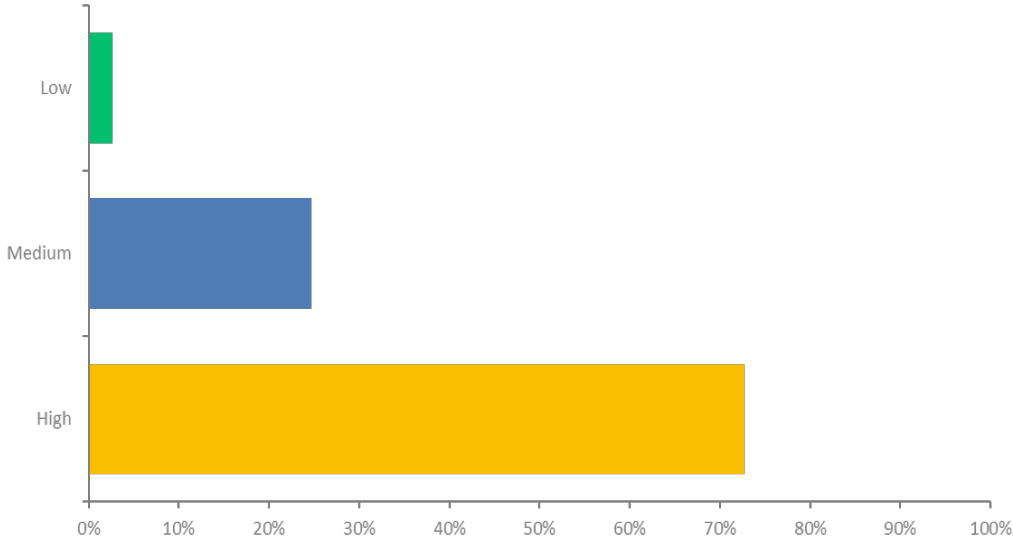
# How would you rate your knowledge of suicide in the following area?

## Information about local resources for help with suicide:

Pre Training

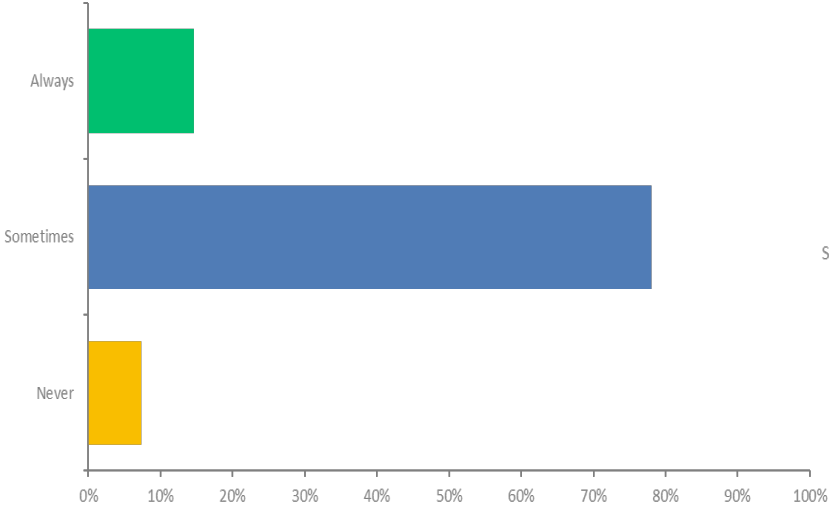


Post Training

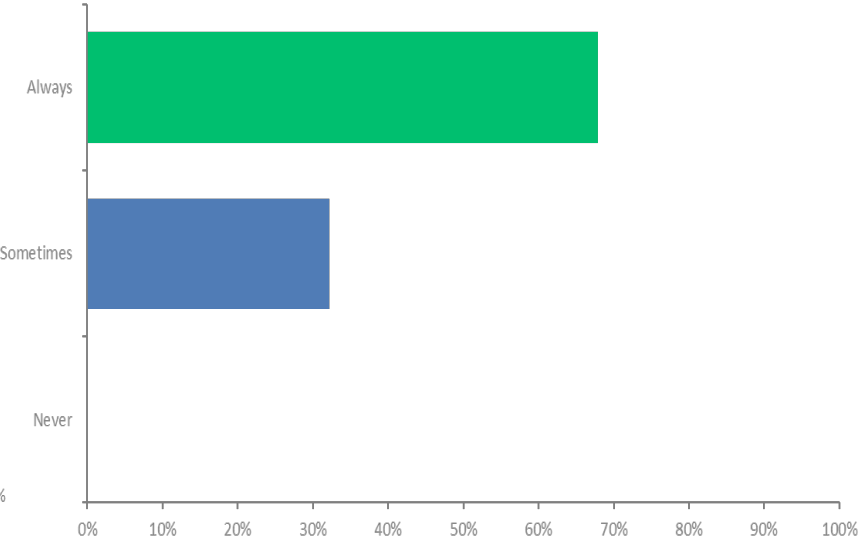


# Do you feel likely to ask someone if they are thinking of suicide?

Pre Training

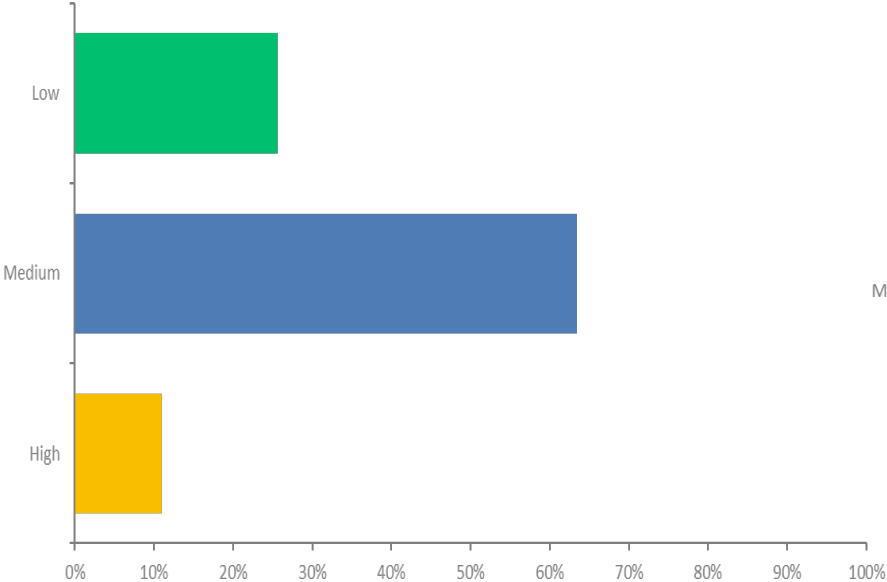


Post Training

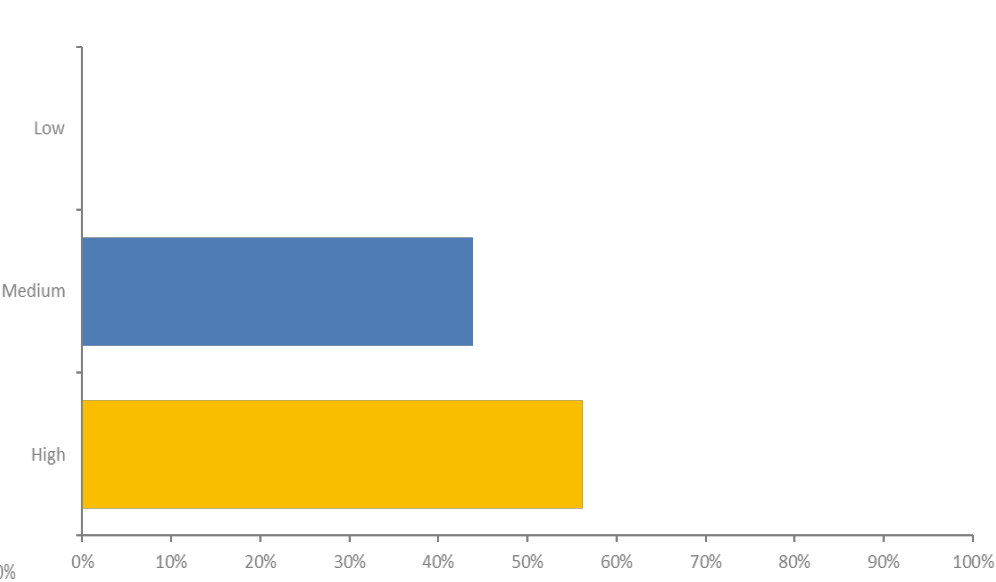


# Please rate your level of understanding about suicide and suicide prevention:

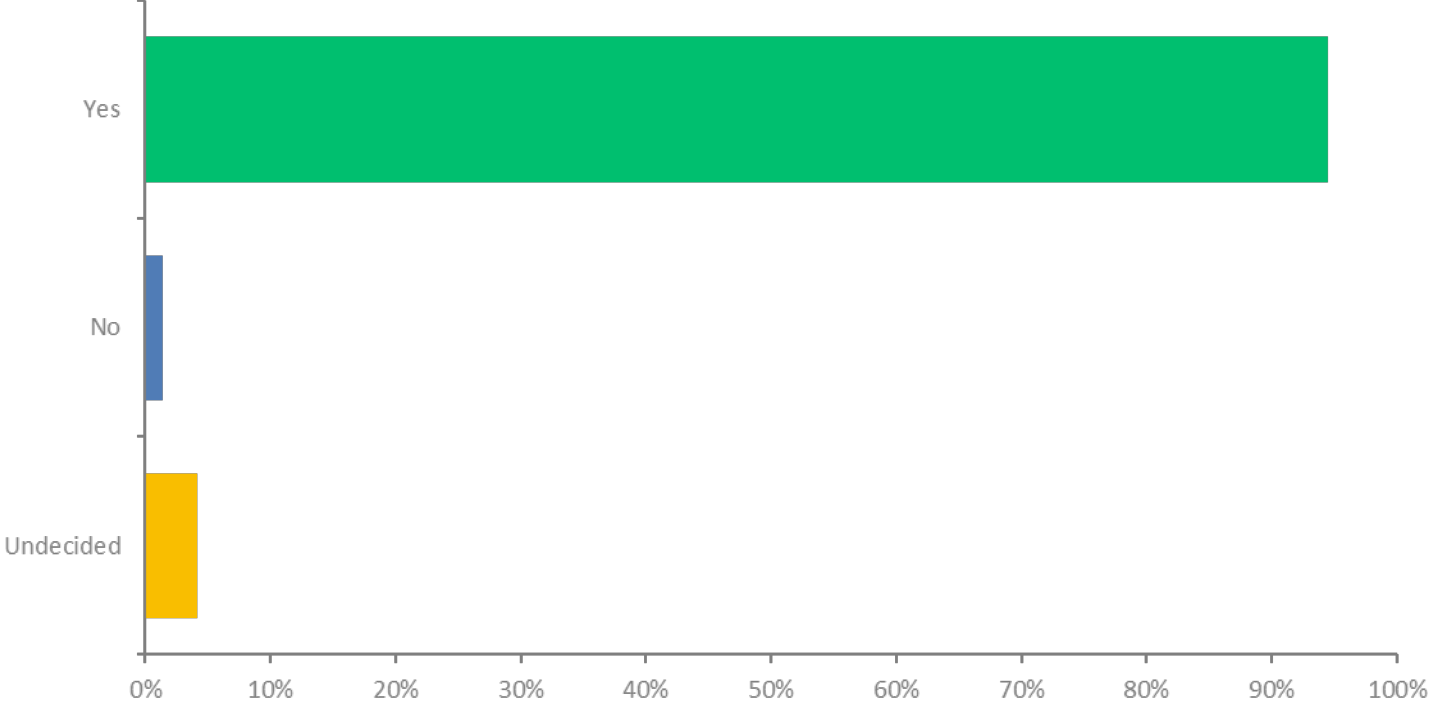
Pre Training



Post Training



# Would you recommend QPR training to other?



# Sonoma County MHSA Listening Sessions

## FY 2022-2023 Annual Report



**Prepared for Sonoma County Department of Health Services,  
Behavioral Health Division**

**by Coaction Institute**

**July 2023**



**Coaction Institute**

## Acknowledgements

This project is the result of the innovative efforts of Sonoma County's Mental Health Services Act Community Program Planning Workgroup, who went above and beyond in the development of a strategic plan to deepen engagement with the County's diverse communities experiencing mental health inequities. In bringing that plan to life, the heart and soul of the project lies with the community leaders and activists who stepped forward as co-facilitators to engage their communities in these important conversations. We would like to recognize their hard work and thank them for their contributions to the effort:

- For African American/Black residents: Mina Newman, Tina Rogers,
- For Asian American/Pacific Islanders: Grace Villafuerte, Jerry Thao
- For immigrant and US-born Latinx youth and adults: Isabel Lopez, Renee Saucedo, Maricarmen Reyes, Dalya Amador, Mar Rivas, Victoria Amador, Oscar Lopez, Chelene Lopez
- For LGBTQIA residents: Chelsea Kurnick, Celeste Austin
- For Older Adults: Mina Newman
- Contributing to facilitator conversations and planning: Madonna Feather Cruz

We would also like to thank the community partners who supported the co-facilitators in their outreach and provided logistical support, including Hanna Center, La Familia Sana, Latino Service Providers, Positive Images, Providence-Santa Rosa Memorial Hospital, Santa Rosa Junior College, and West County Community Services' Senior Center.

Sonoma County's MHSA Listening Sessions coordinating team includes Melissa Ladrech, MHSA Coordinator, Fabiola Espinosa, MHSA Analyst, Julie Kawahara, MHSA Consultant, and Dory Escobar, Executive Director of Coaction Institute. The project also had the support of Saoirse McCormack, MPH Candidate at the University of San Francisco.

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## Background

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. 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. State legislation requires that each County establish Community Programming Planning (CPP) specific to Mental Health Services Act (MHSA) funding. The CPP recognizes that community members are critical partners in creating an equitable community practice that inspires a cultural shift 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. Sonoma County's CPP Workgroup's 2022 Strategic Plan expanded upon its original mandate to establish a process whereby these community voices are elevated and incorporated into MHSA program planning.

The [Sonoma County] Office of Equity states that *“Equity is an outcome whereby you can’t tell the difference in critical markers of health, well-being, and wealth by 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.

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:

Transformation:	Information:	Education:	Representation:	Participation:	Consideration:
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.	We have the right to full transparency in our public mental health system.	We have the right to fully understand the meaning and implications of facts and data relevant to our public mental health system.	We have the right to competent and adequate representation when important decisions are made in our public mental health system.	We have the right to shape policy and meaningfully participate in all important programming and funding decisions in our public mental health system.	We have the right to submit grievances <sup>1</sup> to our public mental health system, to have our grievances acknowledged, and to receive thorough and timely responses to our grievances.

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. The CPP's vision is that all people from various cultural backgrounds and languages have accessible opportunities to influence how MHSAs 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 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 MHSAs.

The Sonoma County CPP's mission is to 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 should be demonstrated by policies, procedures and program outcomes of the community service programs funded by the MHSAs plan. The following values guide the CPP's efforts:

- 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 and 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 MHSAs 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.**

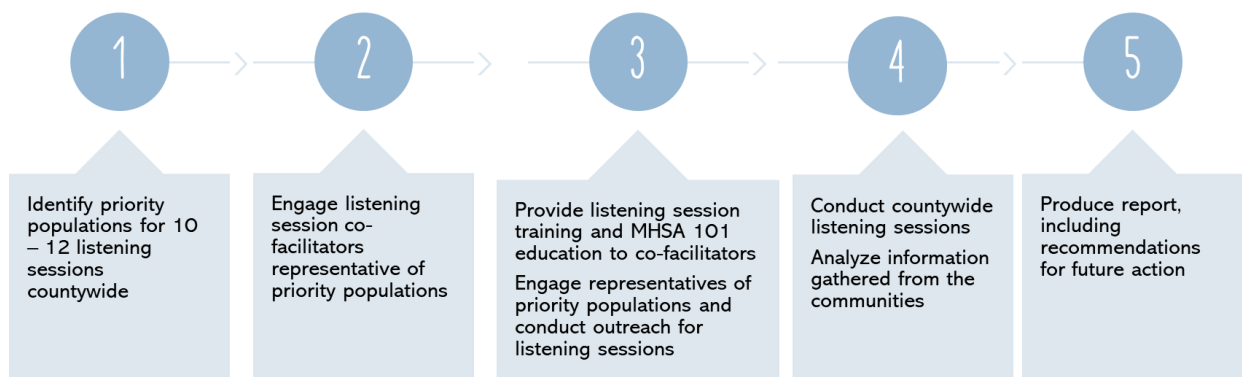
The CPP established the following goals in January 2022:

-  **Expand and strengthen the community's knowledge of the public mental health system, specifically MHSAs funded programs and services.**
-  **Expand and strengthen community partnerships and relationships with diverse representation.**
-  **Expand and strengthen partnership and relationships with consumers and family members.**
-  **Increase the engagement of community representatives in existing and emerging CPP opportunities. The listening sessions were particularly focused on achieving this goal, as described below.**

## Project Process

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.

This project took place in five phases:



Phase I focused on identifying the populations most likely to experience inequities in mental health status and access to and utilization of mental health services and programs. It became clear that it would be impossible to engage in one year with all the people whose voices needed to be heard, and so a two-year plan was developed. Some of the population groups were still quite diverse and the team recognizes the benefits of both targeted groups with strong affinity and more diverse groups that still share some identity. Multiple listen sessions with Latinx residents were planned for FY 2022-2023 given the size of and diversity within that population in Sonoma County and the unmet needs and mental health inequities identified in recent local assessments. During Phase I of the project the following population groups were prioritized for engagement over two years:

FY 2022-2023	FY 2023-2024 (provisionally planned)
African American/Black	African American/Black Youth
Asian American/Pacific Islander	Agricultural Workers
Latinx Youth (immigrant & US-born)	Asian American/Pacific Islander Youth
Latinx Adults (immigrant) – Sonoma Valley	Indigenous (central County)
Latinx Adults (immigrant) – Cloverdale	Indigenous (coastal)
Latinx Adults (low-wage earners) – Guerneville	People with Physical Disabilities
LGBTQIA	Transitional Age Youth
Older Adults	Unhoused Adults

During Phase II of the project, with recommendations from the CPP members and support from community-based organizations, fifteen residents representing the priority populations for FY22-23

were recruited to work in pairs as co-facilitators. During Phase III the co-facilitators received orientation about MHSA, including its history, purpose and structures on state and County levels. This was followed by training for the listening sessions, which included the following topics:

Project Orientation

- Project Overview & Team Building
- FY22-23 Listening Session Groups
- Health & Safety for In-Person Activities
- Co-Facilitator Expectations
- Review of Administrative Forms
- Team Meetings Overview and Scheduling
- Zoom Tips

Facilitator Training

- Introduction
- Guiding Principles
- Listening Session Questions
- Participant Recruitment
- Facilitation Skills
- Planning and Preparation of Listening Sessions
- Interpretation of Input & Recommendations
- Understanding Secondary Traumatization

The listening session questions used were an adaptation of those developed by the California Mental Health Services Oversight & Accountability Commission for Transitional Age Youth listening sessions conducted in 2022. Upon review, the co-facilitators found that they were relevant to each one of the populations to be engaged. The only modifications made to the question was to translate them for the Spanish-speaking groups. The Sonoma County MHSA listening sessions co-facilitators used the following questions for this project:

<b>What are the most critical mental health needs of people in your community today?</b>	<b>Has the need for support increased, decreased, or stayed the same in the past year compared to previous years?</b>	<b>How and where do people find that support? What barriers do they face in trying to get the help they need?</b>
<b>Who often gets overlooked when it comes to making mental health services available to your community?</b>	<b>Which types of organizations do folks go to when in need of mental health support or services and why?</b>	<b>What are the most important characteristics of an organization that advocates for and serves the behavioral health needs of your community?</b>
	<b>What else should we know about the mental health needs of people in your community?</b>	

After completing the training, the co-facilitators planned their listening sessions and worked with community partners to conduct targeted outreach to potential participants. Each listening session was limited to a maximum of fifteen participants, to ensure that the listening sessions would be comfortable and safe spaces, and that every voice in the room could be heard. In addition to recruitment, co-facilitators addressed all the logistical issues for their sessions. Groups were conducted fully in English or in Spanish, and though initially considered in the project, language interpretation was unnecessary. Food and stipends were provided to the participants to thank them and recognize the value of their contributions and this, too, was planned during Phase III. Monthly facilitation team meetings began during Phase III and continued through Phase IV to monitor progress, celebrate successes, troubleshoot challenges, and process what the co-facilitators were hearing from the communities.

The listening sessions were conducted during Phase IV. The sessions were audio-recorded to ensure that the participants' input was not lost. Before launching into the dialogue, participants in each session were presented with the purpose and process of the listening session and asked for their verbal consent for participation in the session and for the audio recording. One hundred percent of the participants gave their consent to participate and to be recorded. In the case of the Latinx Youth listening session, a written consent form for parents of minors was explained and obtained by the facilitators.

The final phase of the project for FY 2022-2023, Phase V, was the analysis and interpretation of the data collected in Phase IV, as well as formulation of recommendations made by the facilitation team to the Sonoma County MHSA CPP and MHSA Coordinator for future project implementation. Periodic updates were provided throughout the project to Sonoma County's MHSA Steering Committee and the CPP.

Qualitative data was captured through transcripts of the audio recordings of the listening sessions, along with facilitator notes taken during their sessions. A review of the transcripts revealed emerging themes in each listen session, as well as themes that were common to several or all the groups. A simple thematic table was composed for each listening session, followed by a identification of common themes. As a community-based participatory project, the engagement of community representatives to serve as listening session facilitators was key and they were trained and supported to lead their own groups. In some cases, technical issues, and lack of experience in documenting listening sessions led to incomplete or missing transcripts. So, some data has been supplemented with notes of listening session facilitators and observers and is included as a paraphrase of what was said by participants.

## Findings

The facilitation team reviewed and discussed the results of the data analysis, using the following questions to guide their discussion:

### Triggering Issues

- What issues seemed to be particularly triggering for participants or generated strong feelings or opinions?
- What ideas do you have about why this might be?

### Frequent Themes

- Why do you think that one theme may appear more often than another?

- How does that compare with what you might expect?

### Related Themes

- In what ways are themes related, influence each other, or interact?

### Unique Concerns

- What issues seemed to be of great importance to some participants, even if they were not mentioned by many others?
- How might these still be addressed?

## Summary of Findings

Tables with the raw data from each listening session can be found in the appendix of this report. A summary of findings heard across listening sessions is presented below.

### Increase in mental health concerns

Increasing social isolation and loneliness were mentioned as a priority concern throughout the listening sessions. This is congruent with national trends and the recent declaration of loneliness as a public health crisis in the United States. Isolation is associated with increased stress, anxiety, and depression. While social isolation became a greater problem during the COVID-19 pandemic, it did not begin with it. Intimate partner or family violence, loss of loved ones, sustained unemployment, political divisiveness and other issues can also lead to isolation and increase a person's risk for the mental health issues associated with it. Listening session participants expressed concern in particular for the increased isolation of children, youth, and older adults during the pandemic.

Participants in all the listening sessions noted an increase in stress and depression among their community members. Speakers associated the increase with natural disasters and the pandemic, which exacerbated and made more visible existing issues.

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*“The need increased quite a bit due to all the social issues not only historically that we’ve endured, but [also] the most recent four to five years.”*

*“Everything’s happening at the same time. Social isolation, stress, and depression have increased a lot.”*

*“When the world stopped people had time to look at themselves and become aware of their depression.”*

*“Social isolation leads to loneliness and are triggers for mental health crises.”*

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## Age-specific mental health needs

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*“Youth are having emotional crises and there aren’t enough therapists in schools. Teachers should have QPR training to understand what’s behind behavior problems to support and not label students.”*

*“[There’s a] constant overload and misinformation that hits older adults harder and causes secondary trauma and stress.”*

---

Listening session participants identified children and youth and older adults as being particularly vulnerable to mental health issues and in need of specialized attention. Concerns raised included the heightened risk for isolation among these age groups that increased during the COVID-19 pandemic.

## Impact of racism and discrimination on mental health

Racism and other forms of discrimination occur on systemic, institutional, and interpersonal levels; and each one negatively impacts mental health. It communicates to certain populations that their lives and concerns are of lesser value than those of the majority. Experiencing discrimination directly and indirectly is traumatizing, increases isolation, and can lead to mental health concerns. Every population group engaged in this project identified discrimination as a significant threat to mental health and wellbeing.

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*“Mostly white dominated spaces people of color can be very intimidating and entering spaces can feel really uncomfortable.”*

*“Asian Americans don’t necessarily show up as any significant demographic on any reports regarding mental health or health services, etc., so it plays into that myth of the model minority where we don’t need mental health services.”*

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## Influence of cultural and familiar norms on mental health

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*“Some people don’t know how to say I have an issue. Being an African American male, asking for help [isn’t] something that comes easily for me to ask for help. Because that would mean something’s wrong.”*

*“[There are] cultural taboos against talking about mental health. We weren’t raised to communicate, and that’s the basis of everything.”*

*“I grew up in a family system where no one talked about how they felt or knew how to manage their emotions and feelings. We don’t talk about it. You just buckle up and you move forward.”*

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Mental health concerns are not openly discussed in many cultures, with the implication being that the individual is “crazy,” or in some way defective. Asking for help is seen as a sign of weakness for not only the person in need, but by extension for the entire family or cultural group as well. Cultural and familiar norms that impede acknowledging and addressing mental health concerns were mentioned in nearly all the listening sessions.

## Relationship between housing status and mental health

Listening session participants pointed to the lack of access to stable and affordable housing as a significant risk factor for mental health in Sonoma County. Unhoused residents were identified as some of the most vulnerable to mental health disturbances and whose mental health concerns are often not considered or sufficiently addressed by the system. It was noted that there can be a cyclical relationship between housing instability and mental health problems, each one potentially exacerbating the other.

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*"Housing and just basic survival is a constant mental health stressor, especially in Sonoma County."*

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## Need for sensitive and culturally aware and relevant services

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*"We want people that we can trust... the most important characteristic for me when it comes to care is being culturally responsive, having people that look like us, that understand us."*

*"Some providers or organization staff don't seem sincerely interested, like they're just doing their jobs. Can feel intimidating, dismissive, or condescending. Makes it hard for people already having a hard time asking for help. Need providers to be nonjudgmental, authentically interested in me and my story."*

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Participants shared concerns about deficiencies in culturally aware and relevant mental health services and agency staff. Barriers cited included lack of Spanish-speaking providers and support staff, culturally relevant outreach materials and information about how to maneuver the system, as well as education about mental health-related topics. Likewise, many participants reported a lack of sensitivity to the needs of those seeking services, regardless of their cultural identity.

## Need for improved access to services

In addition to the cultural or linguistic barriers noted above, the following barriers to access to mental health services that were also noted in the listening sessions: affordability, long waiting lists, lack of transportation to services, inconvenient hours, and lack of easily accessible information about services available.

Participants in all the listening sessions conducted outside of Santa Rosa addressed the need for decentralized services to help overcome these obstacles.

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*"I have healthcare, cannot get into a mental health professional, have been on a waiting list for like eight months. So even individuals that have health care or benefits not able to utilize them."*

*"I think it's very important that our county have resources go to people. And this is something that has been a little bit of a shift. We can no longer keep having people go to the services. The services have to go to the people."*

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## Intergenerational Trauma

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*“We have that generational trauma. It’s in our DNA and comes out in adaptive behaviors that we learn and get passed on from generation to generation without you even knowing that you’re passing on that trauma, because it’s something that we use to protect ourselves.”*

*“Parents have trauma, war, trauma, evacuation trauma, whatever trauma it is. That plays out in families, and nobody says anything.”*

Participants spoke about the experience of intergenerational trauma in their families and communities and about its influence on their mental health. Unresolved trauma experienced by previous generations can repeat and be expressed in generations that follow. Traumas associated with racism or other forms of discrimination, interpersonal or socio-political violence, migration experiences, natural disasters, or other causes can be internalized and expressed as anger, irritability, anxiety, sleep disturbances, and mistrust and inability to bond with others.

## Value of formal and informal peer support

Participants noted that a person’s mental health status does not depend exclusively on access to professional service providers. Throughout the listening sessions, they spoke of the importance of formal and informal peer support to promote and restore mental health. Each group highlighted the importance of emotionally safe spaces such as the listening sessions as a way to support each other and, in that way, also themselves. They frequently asked how these spaces could be sustained and in two communities, Cloverdale and the Sonoma Valley, community partners have already stepped up to help make that happen.

*“Peer support groups get together and they’re not in denial about their situation or their condition. They’re just saying this is how we cope; how we can live the best life we can live. how to become more selfless to one another and carry this conversation that we’re having here outside in everyday life to other people and help other people just talking.”*

*“I’m not a trained therapist, but I’m able to reach out to people who tend to reach out to me because I’m around their age and they are more comfortable with me talking about their problems...there’s not always a format where we can talk about this openly in a safe space with other folks. How do you create more spaces for these conversations to occur?”*

*“We need more spaces like this. Can we meet again?”*

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## Key Takeaways



Themes found across culturally specific listening sessions include:

- Culturally aware and relevant services
- Cultural norms and stigma
- Increased mental health concerns including isolation, depression and stress
- Intergenerational trauma
- Racism and discrimination
- Formal and informal peer support
- Access to services
- Decentralized services



Facilitators who are representative of the listening session participants are at increased risk of experiencing and conflating primary and secondary trauma and need ongoing support.



Social isolation, stress, anxiety, and depression increased in recent years in all populations represented in the project. Participants identified the pandemic, fires, interpersonal violence, racism, and recent political divisiveness as contributing factors.



Stigma and cultural or familial traditions can impede accessing help when needed. This is common to different cultural groups. Each one identifies it as an issue unique to them, suggesting that along with cultural-specific spaces for dialogue and mutual support on mental health, intergroup dialogue would also be supportive of building connectedness and mutual support.



More culturally aware and age-specific outreach and community education about available services is needed.



There is a need for greater access to services before the mental health concerns becomes a crisis, not only prevention, but widely available early intervention services for all income levels.



Intergenerational trauma is experienced in diverse populations in Sonoma County and is discussed or addressed to varying degrees and in different ways.



Culturally relevant peer support is critical, in some cases increased since the start of the pandemic and needs to be supported and expanded.



Decentralized (beyond Santa Rosa) and more culturally aware and relevant services and providers are needed to increase access and utilization by diverse populations.



Regardless of population, services need to be provided by organizations and individuals who are welcoming; authentically interested in and respectful of people's concerns, experiences, and perspectives; nonjudgmental; empathic; compassionate; and trustworthy.



In some cases, participants stated there are no services available in their community or in their preferred language when, in fact, there are. Regardless of that fact, their perception is of great importance and indicates a need for improved culturally aware and relevant outreach, education, and information about services and how to access them.

## Recommendations for Further Action



Provide support to trusted community-based organizations to sustain safe spaces like these listening sessions in the community.



Support cultural groups/organizations to build upon existing or create welcoming and safe culturally aware and representative centers to foster connectedness and provide information about resources.



Organize some listening sessions with even more focused, specific cultural groups to promote greater affinity to build emotional and social safety and encourage participation.



Continue to support capacity building within Sonoma County's diverse cultural populations to facilitate dialogue about mental health and institutionalize their voice and influence within the MSHA system, structures, and processes.



Provide community education about intergenerational trauma and engage community representatives to provide information about culturally aware and relevant ways to dialogue about and address it.



Improve and increase culturally aware and relevant outreach, education, and information about services and how to access them.



Ensure that mental health services are not only linguistically appropriate, but culturally appropriate for the diversity within populations that speak the same language.



Expand facilitator's training on understanding the difference and interaction between primary and secondary traumatization, protective factors, and when to reach out for support to address secondary trauma when facilitating listening session.



Ensure 1:1 support as needed to listening session facilitators from someone trained and experienced in secondary trauma.

# APPENDIX 1

## FY22-23 MHSA Listening Sessions Themes

### African Americans/Blacks

Themes	Illustrative Quotes
Person-centered care	we need to be more what I want to say more directive to the person is specific basically. And so that means you're going to have to get to know that person to develop a plan that's going to work for them and is what I might need is different than what somebody else would need. And so I think that's something that should be highlighted moving forward when we're thinking about mental health. That is not a cookie cutter situation. It has to be specific.
Culturally aware and responsive services	more cultural culturally responsive therapists... we want people that we can trust and understand our stuff... we have to actually love the people that we're interacting with. the most important characteristic for me when it comes to care, not just mental health care, all care because we also have issues with our medical system is being culturally responsive...don't put us in a bucket and say, Oh, you're just like everybody else, because they have been very detrimental to our population. When we go in for medical care...they just ignore us and they just brush us off. So being culturally responsive, having people that look like us that understand us, that is one of the main characteristics that needs to go into mental health and whatever other services need to be compassionate ,,have grace and mercy... we need an African American Resource Center... We need to be at these meetings when all of this stuff and I'm no, I'm not allowed. But a lot of times I've had meetings. I'm the only one black there. But this is what I'm making those decisions. And so and I mentioned it to him, we have to be at these meetings and we know that these meetings by the time we hear about it's already made... we need more black people's on these committees.
Respectful culturally aware treatment of unhoused people with untreated mental illness	...my uncle died on the streets with schizophrenia....they kicked him out of the shelters... the police the way they address them... that needs to be they need to be trained on how to address African Americans who have mental health issues or conditions.
Physical health, spirituality, and the arts as mental health	Those also have to be talked about because you just can't talk about mental health without also talking about what you're putting inside your body... your spirit, and your soul. All of those things go into mental health...research has been done to show the positive effects of music and dance and just being physical overall, as a part of that their counseling.
Increased and improved outreach to increase use of services	You see, people have a hard time with the stigma with mental health, or how it's looked at or how you look at it. How can we make it more accessible and engaging in and more informing for our people to go in and get some help? before it becomes a crisis?... we have to really be able to encourage our folks to take that step. So, we do have a lot of things here in Sonoma County. But a lot of times I hear people complain or talk about something, they don't know where to go. And so usually for mostly bills and nonprofits and so forth, they'll tell you go sign up online. And so that's just one mode of signing up. And that's not the only way people should be able to sign up. So, we have to really look at meeting people where they are in order for them. To get the service that they need. ...in the hospitals they used to have a someone who was a, like if you had cancer they would would meet with the counselor. And then they would tell you these are your this is what you can do. This is where and then that would be a they will give you this little book here. This is everything you

Themes	Illustrative Quotes
	need to know about how you can get treatment for cancer. And that's something that I think we should also have as well are like a little magnet that you can put on your frigerator these are all the numbers that you can call that they can, you know send out for that kind of thing, but definitely older people need.
Normalizing looking for help, challenge cultural norms, reduce stigma	being an African American man, that was one of my biggest issues, someone trying to diagnose me, you know, I may be just, you know, rambunctious, and all of a sudden it's got a name, you give it a name. So now I'm pigeonhole. So mental health isn't always pigeon. Is it always mental health? You know, so what do we have available? That could not diagnose them but a person can go first of all feel comfortable with saying I had an issue? Maybe I'm the only one that has a problem with their I have an issue. Maybe some people don't know how to say I have an issue, because asking for help. Being an African American man. I could say that that's not something that comes easily for me to ask for help. Because that would mean something's wrong.
Mental health promoting youth activities	I think a lot of kids nowadays, well, for the younger people, they got ADHD, so that they need something for themselves to do and if they like they, they might run around and get in trouble and then they're further, like, ostracized from the community. And that can lead to like going into other activities more and then further deteriorating their mental health. So if we just have something for people to do, like the young people do get into that's positive. I think that it'll be a great positive effect on the community.
Intergenerational trauma	We have that generational trauma. And it's in our DNA. And that comes out in certain ways of adaptive behaviors. That we learn and get passed on from generation to generation without you even knowing that you're passing on that trauma, because it's something that we use to protect ourselves. But that could also be your kryptonite. You know, something that was useful at one time is not any cannot be useful now, in this day and age. So really being able to have conversations where people can look at these ideas.
Trauma-informed care	I think that a lot of times when you grow up with trauma that like anxiety stress, just negative self-talk and stuff can feel so normal that you're not even aware that you maybe are depressed because it has been around in your family or it's just normal to be in that environment. And I think that it's important that everybody who's going to receive help have an advocate there that is separate that because if you're in a state of trauma and you whether it be up elder or dealing with law enforcement or needing to talk about something that is very personal and you don't feel necessarily you can trust somebody that you're going to be in sort of a state of shock, so you might not be able to clearly express what you need. And I think that it's important for any organization or for anybody who's working in, in like social services to be mindful of that. And gentle and compassionate like if we're saying so yeah, be mindful about like lifetime trauma.
Connectedness	We need to have more discussion and more talking more communicating, more connectedness as a people... We need to talk to each other. And we have to have compassion... We just got to do it. We just got to come together. Because look at the ancestors. Look what they did.
Perinatal mental health support	I think that every woman who's going to have a baby should have there should be a proactive outreach to offer her mental health services.
Improved access to needed services	I have healthcare, cannot get into a mental health professional, have been on a waiting list for like eight months, right? So even individuals that have health care or benefits not able to utilize them... access for seniors who are at a certain age and a certain mindset is that also prevents them from accessing care if they don't have somebody who's an advocate.

Themes	Illustrative Quotes
Need to increase prevention activities	So how do we help people who are going over the edge? How do we make it more attractive to not do certain things and have alternatives? You know, how is social media driving this ship? You know, and how social media seems to be perpetuating and disconnecting us from each other. So we have to start, continue to do stuff like this.
Increased mental health concerns	The need is increased by quite a bit, just due to all the social issues not only historically that we've endured, but the most recent four to five years has caused a significant increase in everyone's mental health. ...It is increased across the country since the isolation caused by the pandemic. And a lot of it is not recognized because people are suffering and there's not they're not categorized as suffering. A lot of people suffer in silence
Peer support (formal and informal)	peer support groups. They get together and they're not in denial about their situation or their condition. They're just saying we this is how we cope with. This is how we can live the best life we can live and then like you said, Those who support people, they need support to that. Yeah, this is this is new territory. So I was just saying support for each other, peer support for each other for those who don't think Yeah, and so so that they can go to a place and feel like that I'm being heard or being seen This is great. And we're here to talk and we're here to come together and talk right so how do we come my two biggest thing is how to become more selfless to one another and carry this conversation right that we're having here. How do we carry outside in this everyday life in normal life?... how do we carry a conversation outside of here to chat to other people and help our other people just talking and saying hey, like, you know, this is what I know or this is why, what I can do or you're dealing with this problem.
Foster system support	I want to say that my mother and I have both been in the foster system. And as black youth in Sonoma County. I feel like some of some of my success has been due to being in foster care because they have looked at me like, oh, you're a black man. So you might need more help than what this white boy might meet? Because they can see my skin color. I might get downplayed a little bit so they might actually try and help me and I feel like I don't know what it's like for other people in foster systems like, for being white. However, I know for being black in Sonoma County. They somewhat do try and help you. So yeah, and the transitional housing program I'm in it has helped me a lot very much.
Racism and discrimination	But I think that you could work differently with black males because we may come up in different upbringings. And it may look at certain things that you do may be looked at as different from your elders in the black community, as opposed to like the white community...what I've seen is when we take young black men to like Aurora mental hospital, or the hospital, especially if they're like large bodied, you know, darker complected especially if they got like dreads or tattoos. They're definitely like stigmatized at the door. And there's racist intake workers. You got racist like security guards. They just messed up the whole vibe, trying to bring someone in and there's like no oversight on that, so that's been a big barrier
Decentralized services	I think it's very important that our county put resources to go to people. And this is something that has been a little bit of a shift. We can no longer keep having people go to the services. The services have to go to the people. We have a lot of black population that live out in Floresville in Guerneville. And the access to internet and those areas are is very limiting. So it has to be having some satellite buildings throughout our county and say we will be in your area on this day go to the people so we have to push our government to go to the people we can no longer keep having everybody come to Santa Rosa to get the care because last we heard the waiting list is long. So they need to start pushing it out to the outer areas of Sonoma

Themes	Illustrative Quotes
	County and getting to where the people are. That's just not for our population. That's for every population because everyone is having the same issue where they say come to Santa Rosa. This is the hub of where our services are. Our services need to go to our public in our community,

**Asian American / Pacific Islanders (Hawaiian, Hmong, Filipino, Chinese, Japanese)**

Themes	Illustrative Quotes
Culture clash as mental health issue	Coming from Asian communities, we tend to immerse ourselves in family and culture, and think of us as part of a community instead of somebody who could go out there and make your individual mark in the world. So, I think those create mental health conflict right there, for a lot of us since a lot of us are trapped in low paying jobs, no advancement, because you're busy just trying to get ahead. So that would be one of the issues I would pinpoint is the family culture, the culture clash, basically.
Substance use	There's so much oppression, there's substance abuse, there's a lot of people who are coping through alcoholism and things like that, but we don't go back to why people are using it. And so, it's more accepted, unintentionally, that will people use to cope.
Cultural norms, stigma	I grew up in a family system where no one talked about how they felt or knew how to manage their emotions and feelings. Their only goal was to learn how to speak English, learn how to communicate with people, and put food on the table. We don't talk about it. You just buckle up and you move forward in my family. I'm aggressive. I'm expressive. I'm a hugger. I wear my emotions on my sleeve as y'all can see. But the majority of my family is like, Oh, we don't talk about it. We just move forward like this is life and you move forward...I knew I had numerous health issues, depression, and everything, but I didn't really know about it until I was in college. There was the encouragement to go talk to a therapist. That's where I really started to learn about mental health wellbeing.
Intergenerational trauma	I think about my parents, survivors of war. They had to bring all that trauma here and continue culture and country. How do you deal with all of that? Parents have trauma, war, trauma, evacuation trauma, whatever trauma it is. That plays out in families, and nobody says anything. When I talk about them being born in internment camps and intergenerational trauma, they disassociate like they're gone. Like, they cannot hold that conversation. So I have to be very gentle in how I talk about things and not make it about them, but about the larger community. I grew up with a lot of racism in the area, and they just can't go there. Like you weren't to do your post World War II children, like you had to be facing racism, like constantly on a day-to-day basis, and they just don't talk about it.
Culturally aware and relevant care	What does mental health mean for our AAPI community? Bringing awareness and having folks who understand our community, someone who can connect with our elders and talk about mental health; being able to connect and translate because we have our communities who are still suffering to this day. You don't see a lot of people who look like you, that you can relate to. And so, within the mental health community and even thinking about getting the services, I would say that it can be intimidating. You don't know if people are going to judge you. Because of the culture here. It's very different. Change needs to happen. We need to direct this funding in ways where's it going to make that difference. Having hotlines absolutely helped you in that moment, knowing that the person on the other line is going to be someone who is of same culture to you.

Themes	Illustrative Quotes
	<p>if someone asked me, where can you go and get mental health services for the AAPI community, I'm like, Where would I direct them? I couldn't answer that question. There needs to be a network where you just tap it wherever point to have full access to services, no matter what type of services they are, that are generated for API. So that when somebody does ask, they can get culturally relevant care. Developing a whole generation that ties back into self-efficacy and mental health and confidence and building a healthier community. And then you're empowering others to do the same thing, when they may have come with their trauma, and they're bringing everything that they come with. empowering others to be able to take that leap and maybe do something and fill in their career path thinking, Oh, I never thought I would do this or be here or you know what I mean, but then it gives them that, that avenue. Sometimes I don't want to just be the Asian American worker, you know, the only one. At the same time, I do want to make a difference, and it's going to help the other people that come behind me, but it's just costing, it's tiring sometimes. It is exhausting.</p>
<p>Housing and homelessness</p>	<p>Housing and just basic survival even if they're working full time, in college, just trying to find affordable housing and pay all their bills is a constant mental health stressor, especially in Sonoma County. Where I live, I see a lot of homeless people. And yeah, there's their mental state. It goes beyond that--it's not being addressed that they're a human being. That's really overlooked. And yeah, we need good doctors and so forth, but it's beyond that also because a person doesn't always just need to be medicated, they need to find the root of the problem.</p>
<p>Connectedness</p>	<p>[We need] but more places to connect with other people in this group. How do you create more spaces for these conversations to occur? The first and most significant step for me is having the space to talk with other Asian Americans. Because being in Sonoma County versus maybe being somewhere like San Francisco, I'm hardly in a room with that many more Asian Americans, much less have the space to talk about this safely and openly, without like worrying about offending somebody. We have such overlapping experiences even though we might come from so many different backgrounds. Like exactly what we're doing now. It's just being in a circle and just talking about stuff, a private and safe space. this would be awesome with all because you're Asian American, and we were just talking about, like, our mental health and things that we go through day to day. So like, that would be my ideal. So safety, and, you know, have these resources be more obvious</p>
<p>Informal and formal peer support</p>	<p>Family really ties into the health of Asian Americans. I know that a lot from experience and also talking to other people. I'm not a trained therapist, but I'm able to reach out to people who tend to reach out to me because I'm around their age and they are more comfortable with me talking about their problems. As Asian American Pacific Islanders growing up, you just inherently know this stuff, a there's not always a format where we can talk about this openly in a safe space with other folks. How do you create more spaces for these conversations to occur? And for support groups? In some ways? Maybe that's a service that could be available? If we had more representation for our community, that would help normalize the conversation. Because there really isn't just a space for us to be able to have that.</p>
<p>Youth services needs</p>	<p>I feel like there should be like, I don't know, some sort of like center or like shelter, where there is access to in person therapy, and some sort of protection. Where parents aren't allowed to step in or intervene. We have</p>

Themes	Illustrative Quotes
	very good counseling at school right now. There's a lot more money that's gone into mental health and emotional wellbeing; but there's not connection with county services or city services, and everyone's trying to do the same thing somehow. Schools really need to be transformed into community schools, that's where the kids are. We're doing things in silos and we have to combine and do it together.
Racism and discrimination	My parents might be [assume] that if a white person is serving this service, or whatever it is, they might think it's higher quality. Asian Americans don't necessarily show up as any significant demographic on any reports regarding mental health or health services, etc., so it plays into that myth of the model minority where we don't need mental health services. It's invisibility. Some folks think we're doing so well, and they're like, Oh, y'all are having all the privileges of white folks. And so, we you don't really need this and you and you're not accessing these services, so you must not need them. There's racism within the Asian American community, for sure. we internalize those frameworks and so It doesn't escape us. Some of the immigrant mentality too, is internalized racism.

### Latinx Adults (Immigrant and US-born – multiple sessions and communities)

Themes	Illustrative Quotes
Culturally aware and relevant services	Need more Spanish-speaking providers and staff and Spanish-speaking therapists in schools. Having services in Spanish isn't enough, we come from different places and different cultures (Mexico, Central American, urban, rural, etc.). There are cultural differences, regional linguistic differences that can still get in the way of understanding even if someone technically speaks Spanish. Even if you speak English, you don't necessarily want to talk about your experience in English. It may not help in the same way. Need people who understand me. Not enough services for the indigenous people from Oaxacan, Spanish is their second language.
Access to services	There are very limited mental health services in Spanish in the Guerneville area. In all communities, there are wait lists and it can be hard to get an urgent appointment, especially for services in Spanish. Sometimes can't get help until it's a crisis. Necessary paperwork can be intimidating and there isn't always staff to help fill it out. Like to enroll in Medi-Cal. Some people can't read or write and sometimes the staff is rude to them. There's a lot of paperwork to fill out and costs can be high, especially for medications. If someone asks for something they don't provide, organizations should give out information about other places they can go to get the help they need. These days you need access to technology and the internet to get services, not everyone does or knows how to use them.
Increased mental health concerns	Needs have increased and intensified since COVID and natural disasters. Everything's happening at the same time. Social isolation and depression have increased a lot.
Increased bullying of children and youth	Those being bullied skip or refuse to go to school, experience social isolation, stress, and depression. Parents aren't always informed about it by the schools. Sometimes bullying is based on gender, language, or race.
Multi-generational families	Families caring for older adults in the house need mental health support.
Youth service needs	School counselors focus on academics and not mental health. Youth are having emotional crises and there aren't enough therapists in schools. Need programs about body image and to build self-esteem. Need parenting and parent-support programs. Kids are over-stimulated from too much screentime and electronics.



<b>Themes</b>	<b>Illustrative Quotes</b>
Need for more sensitive providers	Sometimes providers don't listen, minimize problems. Providers and staff need to have empathy and truly care about the people who come to them for help. Need to make sure that their words and their body language is respectful.
Racism and discrimination	The system discriminates against the homeless and against Latinx.
Formal and informal peer support	By listening to others, we also learn about ourselves. We need to show empathy for others. Need to build trust through solidarity. Social support is important, so we don't get sick from stress. I find support opening up to friends.
Housing and homelessness	Housing is not affordable, so families have to live with a lot of people in the same house.
Cultural norms, stigma	Cultural taboos against talking about mental health. We weren't raised to communicate, and that's the basis of everything. Latino men don't access mental health services due to machismo.
Education about mental health	Need to educate the community more about mental health issues like stress and depression, when is it normal and when is it a problem. Parents need to learn how to listen and talk to our kids.
Decentralized services	It's hard and expensive to have to go to Santa Rosa for services. Transportation is a problem if don't have your own, buses don't run a lot.
Connectedness	We need more spaces like this. Can we meet again? Need to strengthen relationship and show solidarity between indigenous Oaxacans and other Latinx (Spanish-speaking) Latinx in the community.

### Latinx Youth (Immigrant and US-born)

<b>Themes</b>	<b>Illustrative Quotes</b>
Challenged cultural and familial norms, stigma	Immigrant parents don't acknowledge mental health issues... I wish there was more services confidential services because I didn't want to go, but I felt ashamed...Need to teach parents not to judge their children when they ask for help.
Increased depression among youth	When the world stopped people had time to look at themselves and become aware of their depression. Got worse due to isolation during pandemic. After pandemic, mental health issues are more acknowledged and visible, talk about it more.
Increased stress and anxiety among youth	I know a lot of people are like stressed about like the way or I mean I know some people are kids you know scary fires...COIVD... losing people like at school shootings...First generation students are under a lot of pressure to do well at school...Children of undocumented parents have to hide, fear family separation.
Need for more resources for school-based mental health services	And then like you don't really get like to me personally I've talked to as many teachers like because I feel so comfortable with them and I'll tell them about like my own like mental health struggles or like what I'm struggling with in school and they don't get paid for that they don't get paid to therapists and sometimes I feel bad because I'm doing that to them but like at the same time I don't know who else to talk to you...We need advocacy for more mental health services at schools and increase awareness of what's available. Teachers leaving because it's overwhelming to act as therapist or deal with acting out students...can't focus on teaching.... Teachers should have QPR training to understand what's behind behavior problems to support and not label students.
Need for culturally aware and relevant services	to learn about culture and as opposed to someone who learn about it, read about it. experience being able to connect with someone who went through something similar. I feel like we should have like a lot more Latino or

Themes	Illustrative Quotes
	<p>different cultural background as a therapist because they will understand not only their own culture but other cultures as well when they tell them that they can't do a certain thing because of their family they run the risk of getting spied on gonna say pretty much in mostly white dominated spaces but people of color it can be very intimidating like art and entering spaces can feel really uncomfortable especially like when your skin color is darker than like sort of your white counterparts you know so yeah I feel like more representation and like every aspect of like school workplace hospitals just like me but not many spaces where white people feel the most comfortable. Would be cool to have cultural affinity groups at schools.</p> <p>Hard to form bond with therapist when there's a cultural clash, need someone with shared experiences (not just something they learned about).</p>
Intergenerational trauma	<p>I feel like the more like people have children the more they they put their own trauma, their own generational trauma onto the children and they create that cycle of trauma and trauma and trauma. And I feel like parents who seek their own health not just teenagers, I feel like parents should have their own therapist and they should receive help and just have someone to listen to them and give them advice entitled, like good parents. I know that there's not going to be like, the best parent out there. Everyone makes mistakes. We all make mistakes, but I feel like parents put that much trauma onto their children and they and I know that they don't need to.</p>
Migration-related trauma	<p>if you're undocumented once your life before that it's not really much but crossing the crossing the border in itself, that's going to bring a country because of violence such as in the coming year and potential relationships, say their separation of families ex military. Domestic Violence, that's tomorrow. And I've seen this firsthand people in a family like both of these things and then go through them alone</p>
Education about mental health	<p>People need to learn how to regulate emotions, how to manage the transition from middle school to high school...Need to learn about healthy vs. abusive relationships and substance use, especially alcohol and vaping...Need more education about racism and affect on mental health.</p>
Increased community support	<p>Seeing more support available recently in the community, more youth involved in mental health support for Latinx population. Positive shift, destigmatizing and unlearning/learning. Still a struggle, but hopeful direction...Nonprofit, community-based organizations, school-based organizations like MECCHA, teen clinics provide good services, affordable, accessible, help build connection with therapist.</p> <p>Need more sessions like this one.</p>
Need improved access to services	<p>Need safe rides to confidential youth services so don't have to tell their parents they're going...Hard to find the right therapist and limited number of therapists available...Found a great outpatient therapist but had to quit when insurance ran out, too expensive....Denied services at large service provider, on waiting list for two years because told that others need more urgent help, my problems "not bad enough."</p>
Characteristics of good mental health support	<p>Patience, empathy, trust, compassion, non-judgmental, confidential, safe, space to be your authentic self and to grow, open to different kinds of people and experiences. Take youth seriously, don't minimize what we say.</p>

**LGBTQ+**

Themes	Illustrative Quotes
Culturally aware and relevant services	<p>More trained providers of mental health services trained to understand the needs of our community, especially transgender people. There are so many factors that affect people within the gay community that kind of just lead to</p>

Themes	Illustrative Quotes
	<p>disastrous mental health crisis. dealing with homelessness and that can come with addiction and then other mental health issues.</p> <p>Some people that want crisis services may not want to go into the crisis stabilization unit because they're very concerned that they're going to get misgendered or that they're going to get bullied in some way about their gender identity. So, they're concerned about accessing those services.</p> <p>Mental health services were kind of difficult for me to find because I'm not out [about being trans] at home. So, I'm doing the Zoom meetings through Positive Images in my room, but I mean, anybody could overhear that.</p> <p>People of color get overlooked when seeking out mental health services. Because with the intersections of all the people in the [SRJC] multicultural center, there is like some people have like other backgrounds who like aren't necessarily like so tolerant towards gay people. And it's like, when you kind of have that exposure, you don't necessarily get to create boundaries for a safe space, it can get very intimidating for some people.</p> <p>All the staff, at every level, is culturally competent and diverse in all kinds of ways, including Spanish- speaking, neurodivergent-attuned. And that they prominently promote and advertise their LGBTQ+ services and attitudes. That is super important, otherwise people won't go.</p> <p>We need to make is encouraging young people and specifically young people of color to get training and to pursue a career in mental health because there's a dearth of people of color in the mental health industry, businesses, or services.</p>
Formal and informal peer support	<p>Support groups or places that folks can come and talk about some of the stuff. I hear a lot from older adults that they don't have any place that they can go and access community support, like a support group. If someone's 50 to 65 they may feel like they don't want to go to the senior center. You know, that could feel kind of stigmatizing. They might rather just have brunches with organizations doing different community things for them.</p> <p>People don't come to the SRJC Intercultural Center necessarily in crisis mode looking for therapy or instant support, just looking to find a community before—and I think that's kind of the pre-stages of getting to a harsher mental state where you're kind of looking for community, but then when you don't necessarily find it, you get to that point of deep isolation and self-hatred more because you're not able to find that community.</p>
Connectedness	<p>When I first moved here, I was looking for the Gay and Lesbian Center in Santa Rosa. People didn't know what I was talking about. There does seem to be a couple of strong—like this—at least a couple of places to be able to come together and talk.</p> <p>I think that any kind of community events, you know, from like Positive Images' days at the park or the Translife picnics, to a lot of events that other groups are doing throughout community are important preventatively for mental health. So, I think just having those places that people can go and people can find community is super important.</p> <p>community is vital to helping strengthen the mental health of gay people here in Sonoma County. But I think there's also a sense of dread with community events, I believe, at least in my instance. Because sometimes it feels, I think, the way that gay community events are presented in time, is that they are just a shining star that just kind of goes away as soon as it's over, because there's not a continuous momentum that builds up after the event. It's like you peak and then you go back down, and then you peak again when there's a next event and then you just go back down. It's like, "Okay, when's the next event? When's the next time I get to see gay people? When's the next time I get to feel like a real person?"</p>

Themes	Illustrative Quotes
Need increased and improved outreach and information	County needs a central number for LGBTQ+ people to call or text for resources that's really well advertised. Because I think people are just out there going, "I don't know who to call or where to reach out to."
Expanded or new services	<p>A suicide prevention hotline that accepts texts. The county really needs to have a DBT group for people. Maybe a lot of you don't know what that is. It's a kind of therapy that's very, very helpful for people in a lot of mental distress and emotional strain. I can't believe that the county does not offer any DBT groups.</p> <p>Need a community center. I think that's a huge gap in our local community. There's not a place that everyone can just find on the internet and be like, "Oh, that's the place to go to where I hook up with you know, all the resources I need."</p>
More sensitive, prepared providers	<p>I used to call the phone line a lot when I was like, 18-17, just bawling my eyes out. To me it was like the people on the other end of the call just weren't readily equipped to address the issues that I was coming forward with. It was just kind of like, "Oh, yeah, like just stay on the line," –kind of a guilt trippy kind of "stay on the line" thing. Need to have more people better equipped to like deal with our mental health needs.</p> <p>And unbiased workers who will listen first, try to piece together what happened later. Hopefully there's some kind of sensitivity training for the people that work in these places to make sure they're unbiased. Make sure when they see patients, they are presumed honest until proven dishonest. "You are lying," should never be the first thought.</p>
Stigma and discrimination	<p>Whether it has to do with mental health stigma or being part of our [LGBTQIA+] group stigma.</p> <p>I think that if our local institutions including Sonoma County governments, Santa Rosa city governments, if we could get lots more really public statements in support, and, you know, "Here's what we think about all these laws that are being passed." That would be super helpful to people's mental health.</p> <p>So much of our mental health in this community comes from social acceptance and non-acceptance, right? So I think a huge factor in our mental health comes from general social advocacy for laws, protection, rights, and education of cis people and het people—however that can happen. I just don't want that to get lost, because even though it seems separate, our mental health depends so much on advocacy and activism.</p>
Increased stressors	<p>There's a lot more storms, a lot more droughts. The storms last so much longer. Fires, snows, hails. It's more concentrated every time a really bad thing happens in the weather.</p> <p>I believe that the need for support is increased especially because of all of the anti-trans bills that have started ramping up like this year and this past year, there's been something like there's been a couple hundred across the country, and that really weighs on the community.</p> <p>The shift from COVID out of COVID has been difficult for individuals. It just has this kind of unique flavor of people almost forget how to socialize and how to be in community and it ends up kind of a little stressful, so I've noticed that in the past year as people have started to kind of emerge. Eight of 13 people here have lost someone they cared about to COVID or know somebody or are somebody who has had serious physical health effects or mental health effects from COVID.</p>
Need for improved access to services	I sort of hate to say it, but I typically find this support when I get 5150ed, which is not a great way to find your support. And, when that happens, yeah, then people reach out to me. Maybe. Or maybe not. But it'd be nice to get more support before I get to that very, very, very low place. Sometimes have to be very, very desperate before you get any help.

Themes	Illustrative Quotes
	Once you're not poor anymore, the state will stop helping you with a lot of vital services that if you tried to pay for it by yourself, it'd be thousands upon thousands of dollars. So they would take your money, make you poor again, and then you qualify again or something. Barriers to care include lack of low-fee and competent therapists, and not having LGBTQ-friendly and safe transitional housing.
Housing and homelessness	I think a lot of people who get overlooked are people from the homeless community here too in Sonoma County. Especially like within the gay homeless community. I feel like a lot of the resources available are only available to you if you have the funds to spend on them. And that is really hard to come by if you are homeless. I think there is just like a very harsh stigma with like trying to address the needs of like homeless gay youth here in Sonoma County too.
Physical activity as mental health	If I won the lottery, I would open a gym for people with mental health issues. I've found when I have gotten exercise, it helps, but it's hard to always motivate myself to get there. I think it's easier if you're part of a gym because then you get more support, you know, than if you're just like, "Okay, I'm gonna go for a walk." I'd open a gym and then I'd have bus rides to get people to and from the gym.
Depression and suicidal ideation	As seen through suicidal ideation, anxiety, depression, the list goes on. A lot of the people that I've encountered within the gay community are very strong, silent sufferers with a mental health until they get to that breaking point of like, "Do I live? or—" making the choice of like, "do I live or do I want to kill myself?" No matter how well put together you think someone is, it's like "Whoops." It's like a dominoes effect. It just crumbles. I don't know. It's tough.

**Older Adults (West County)**

Themes	Illustrative Quotes
Increased loneliness and isolation	Social isolation leads to loneliness and are triggers for mental health crises.
Negative influence of social media	Harder and harder to determine what's true in social media and news, constant overload and misinformation. Hits older adults and isolated people even harder. Causes secondary trauma and stress.
Complex trauma	COVID; difficult political climate and divisions; increased isolation; witnessing deaths from disease, fires, floods; increased intolerance and polarization compound the individual traumas.
Housing crisis and homelessness	Fires increased existing housing crisis and homelessness. Being unhoused (not getting basic needs met) can lead to mental health problems and vice versa. Unhoused need more services. Need more stable, affordable housing.
Problems with accessing services	Barriers to accessing needed services include location, lack of transportation, costs, limited hours, lack of availability/waiting lists. Need more insurance accepted at clinics and more free services. Lower Russian River area is unique and needs services located here. Need phone support to know where to go for help.
Need for more sensitive providers	Some providers or organization staff don't seem sincerely interested, like they're just doing their jobs. Can feel intimidating, dismissive, or condescending. Makes it hard for people already having a hard time asking for help. Need providers to be nonjudgmental, authentically interested in me and my story.
Patient education and advocacy	People need to learn how to shop for a therapist, and to prepare for and to build resilience for the therapy process. Need to be encouraged and taught

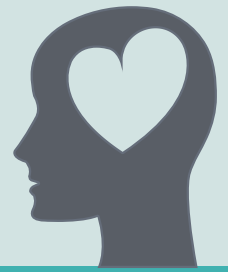
Themes	Illustrative Quotes
	<p>how to provide feedback about services provided and have it validated. Need advocates, because not everyone has the ability or confidence to advocate for themselves.</p>
<p>Formal and informal peer support</p>	<p>Support groups are powerful; help me and let me help others; shared vulnerability. Can find support in the community, talking to friends, to store clerks, anyone that I have an authentic relationship with. Need more qualified peer support specialists.</p>

# 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

## Take Action For Suicide Prevention

Know the Signs • Find the Words • Reach Out



Thriving At All Ages

[suicideispreventable.org](http://suicideispreventable.org)



Funded by counties through the Mental Health Services Act (Prop 63)

- **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](http://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](http://www.suicideispreventable.org) for more information.

## Be a Part of Our Suicide Prevention Efforts!

## Sonoma County Warmly Welcomes New Director!

### 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
  - **Bucklelew'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@bucklelew.org](mailto:Nicolen@bucklelew.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 Bucklelew** 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@Bucklelew.org](mailto:SOSinfo@Bucklelew.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** - Joint Sonoma County's Behavioral Health Division in partnership with Bucklelew 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.



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](mailto: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.



### 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**



There is hope.



**988** SUICIDE & CRISIS LIFELINE



# 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 or learn about

### 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](https://www.TakeAction4MH.com).



## 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

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](https://www.CalHOPEConnect.org).

**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 which is not only a great whole body workout, but is also a stress reducer, builds confidence, and it's also a good way to meet others and build connections which is known to improve mental health.

To learn more about La Luz Center please visit: [www.laluzcenter.org](http://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!



**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.



- |           |              |          |
|-----------|--------------|----------|
| Action    | Intervention | Services |
| Care      | Kindness     | Sonoma   |
| Community | Mental       | Support  |
| Health    | MHSA         | Take     |
| Hope      | Prevention   | Wellness |
|           | Self         | Winter   |

**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.

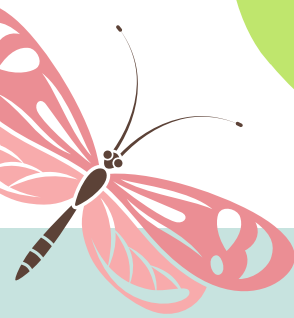
**WHEN:** Thursday, February 16, 2022  
1:00pm - 3:00pm  
**WHERE:** Zoom

To attend, please email [MHSA@sonoma-county.org](mailto: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](#).

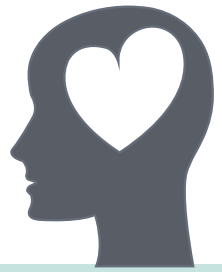


# Sonoma County

## MENTAL HEALTH SERVICES ACT

# Newsletter

MAY 2023 | 52ND EDITION



## May is Mental Health Matters Month!

### Safe Spaces for Mental Health

Take a moment to consider your surroundings. Do you feel safe? Do you have access to health care and grocery stores? Does your home support you, both physically and mentally?

This Mental Health Matters Month, challenge yourself to look at your world and how different factors can affect your mental health.

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. However, when it seems like the world is working against you, your mental health can suffer.

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

- **Work toward securing safe and stable housing:** This can be challenging, but there are a few things you can try, such as reaching out to state/local agencies to secure housing, removing safety hazards in the home, or finding another space (such as a community center or friend's home) where you can get the comfort you are missing at home.
- **Focus on your home:** Consider keeping your space tidy, sleep-friendly, and well-ventilated. Surround yourself with items that help you feel calm and positive.
- **Create bonds with your neighborhood and community:** Get to know the people living around you, join or start neighbors-helping-neighbors groups, and support local businesses to challenge gentrification.
- **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.

If you're taking steps to improve your surroundings but are still struggling with your mental health, you may be experiencing signs of a mental health condition. Take a free, private screening at [mhascreening.org](https://mhascreening.org) to help you figure out what is going on and determine next steps.

You can also call, text or chat 988 to reach trained crisis counselors who can help people experiencing suicidal, substance use, and/or mental health crisis. People can also dial 988 if they are worried about a loved one who may need crisis support.

### MHSA Contractor Spotlight: LSP Youth Promotores

The LSP Promotores Program is an exciting opportunity for young people to make a difference in their community while learning valuable skills



and gaining experience. This program is designed to empower youth to become leaders in their community by promoting mental health awareness, emergency preparedness, housing advocacy, and environmental education.

One of the key focuses of the LSP Promotores Program is mental health. Mental health challenges are a pandemic on their own, especially within the Latino community. The stigma surrounding mental health can prevent individuals from seeking help and support. The Promotores Program aims to de-stigmatize mental health and increase awareness of mental health resources in the Latino community. Youth promotores work on projects such as self-care, suicide prevention, teen dating violence, and substance abuse, among other important topics.

Another track in the Promotores Program is Promotores Preparados, which focuses on emergency preparedness. This track is intended to inform the Latino community on the importance of being prepared for emergencies by creating culturally and linguistically appropriate educational materials and leading discussions around emergency preparedness. The goal is to increase community resilience and improve mental health outcomes after a disaster.

*Promotores de vivienda* is another track in the program, which focuses on housing advocacy. Youth promotores work on projects related to housing, city planning, and civic engagement.

Continued on page 2.

If you or someone you know needs support now, call or text 988 or chat [988lifeline.org](https://988lifeline.org)



## LSP Youth Promotors (Cont'd from page 1)

The goal is to increase civic participation of the Latino community in housing policy and inform the community of the intersection between these issues and mental health wellbeing.

Lastly, Promotores verdes is a track focused on environmental education and climate science resources. Youth promotores work towards raising awareness about climate change and mental health wellbeing, with the goal of increasing the number of Latino community members who take proactive steps to address it.



The LSP Promotores Program is a fantastic opportunity for young people to get involved in their community and make a difference. By joining the program, youth are not only gaining valuable skills and experience, but also working towards overcoming stigma surrounding mental health and educating their community on

important topics such as emergency preparedness, housing advocacy, and climate change.

Benjamin Rosel, a 22-year-old youth promotor, is a shining example of the positive impact that the LSP Promotores Program can have on young people. Through the program, he was able to guide virtual sessions on mental health during the pandemic and create self-care kits for those struggling in isolation. He shared his personal struggles with mental health after his mother's cancer diagnosis in 2016, and he was determined to make a difference in the Latino community's understanding and acceptance of mental health. Through the program, he discovered his passion for psychology and now works for a local nonprofit. The LSP Promotores Program is funded by the CA Department of Public Health and the Sonoma County DHS-BHD Mental Health Services Act (MHSA).



Become a leader in your community, join the LSP Promotores program today! Visit: <https://latinoserviceproviders.org/youth-promotores/> to learn more about this fantastic opportunity and make a positive impact on people's lives.

## Sonoma County's MHSA Three Year Update & Report!



Read Sonoma County's MHSA Plan Update for FY 2023-2026 and Program Report for FY 2021-2022, which will be posted soon on the DHS-BHD website [HERE](#).

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. There will be two public hearings hosted by Sonoma County's Mental Health Board on May 16, 2023 at 5pm and another on June 20, 2023 at 5pm.

For more details on how to attend the Mental Health Board Meetings click [HERE](#).

## CELEBRATE MENTAL HEALTH MONTH!

**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](#) or scan to access Sonoma County's May 2023 Mental Health Matters Month Community Calendar.



Community Events for May 2023 - Mental Health Matters Month	
<p><b>1. Community Events for May 2023 - Mental Health Matters Month</b></p> <p><b>1.1. Community Events for May 2023 - Mental Health Matters Month</b></p> <p><b>1.2. Community Events for May 2023 - Mental Health Matters Month</b></p> <p><b>1.3. Community Events for May 2023 - Mental Health Matters Month</b></p> <p><b>1.4. Community Events for May 2023 - Mental Health Matters Month</b></p> <p><b>1.5. Community Events for May 2023 - Mental Health Matters Month</b></p> <p><b>1.6. Community Events for May 2023 - Mental Health Matters Month</b></p> <p><b>1.7. Community Events for May 2023 - Mental Health Matters Month</b></p> <p><b>1.8. Community Events for May 2023 - Mental Health Matters Month</b></p> <p><b>1.9. Community Events for May 2023 - Mental Health Matters Month</b></p> <p><b>1.10. Community Events for May 2023 - Mental Health Matters Month</b></p>	<p><b>2. Community Events for May 2023 - Mental Health Matters Month</b></p> <p><b>2.1. Community Events for May 2023 - Mental Health Matters Month</b></p> <p><b>2.2. Community Events for May 2023 - Mental Health Matters Month</b></p> <p><b>2.3. Community Events for May 2023 - Mental Health Matters Month</b></p> <p><b>2.4. Community Events for May 2023 - Mental Health Matters Month</b></p> <p><b>2.5. Community Events for May 2023 - Mental Health Matters Month</b></p> <p><b>2.6. Community Events for May 2023 - Mental Health Matters Month</b></p> <p><b>2.7. Community Events for May 2023 - Mental Health Matters Month</b></p> <p><b>2.8. Community Events for May 2023 - Mental Health Matters Month</b></p> <p><b>2.9. Community Events for May 2023 - Mental Health Matters Month</b></p> <p><b>2.10. Community Events for May 2023 - Mental Health Matters Month</b></p>

## Modernizing Our Behavioral Health System

The Mental Health Services Act (MHSA) has fundamentally changed how we deliver mental health care in California. For those with the most serious and persistent needs, the MHSA requires every county in the state to offer a core set of services through a program called Full-Service Partnerships (FSP) that today helps provide wraparound services and the least restrictive level of care with access to peer providers and community services. Today over 80,000 Californians are enrolled in FSP programs.

Today, MHSA funds 30% of the state's mental health system. But the MHSA has never undergone full scale reform. Since its initial passing in 2004, the Affordable Care Act and parity laws have significantly shifted the landscape and the governor sees this as the time to modernize MHSA to account for expanded coverage under Medi-Cal. Governor Newsom's proposed reforms include:

- 1. Require counties to dedicate 30% (roughly \$1 billion annually) to pay for housing and other community-based residential solutions** to provide an ongoing source of funding for new and existing housing and residential settings that are responsive to the diverse needs across the state.
- 2. Focus funding on Full-Service Partnerships and other services for the most seriously ill**, prioritizing community services and supports while including prevention and early intervention and infrastructure investments such as for capital and workforce.
- 3. Require counties to bill Medi-Cal for all reimbursable services** in accordance with Medicaid State Plan and applicable waivers, to further stretch scarce dollars and leverage MHSA to maximize federal funding for services.
- 4. Include those with substance use disorders** who can be served by MHSA funding, broadening the target population to include more people who need support.
- 5. Improve county accountability and increase transparency** updating the Three-Year County Plan requiring counties to create comprehensive behavioral health plans, and move the Mental Health Services Act Oversight and Accountability Commission under the California Health & Human Services Agency, to increase coordination and outcomes.

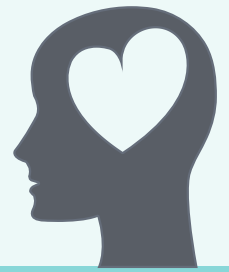
For questions and inquiries regarding Newsom's proposal, please email [BehavioralHealthTaskForce@chhs.ca.gov](mailto:BehavioralHealthTaskForce@chhs.ca.gov).

# Sonoma County

## MENTAL HEALTH SERVICES ACT

# Newsletter

SEPTEMBER 2023 | 53RD EDITION



## September is SUICIDE PREVENTION MONTH

### Suicide Prevention is Everyone's Business

Most of us have been touched by the tragedy of suicide. We may have lost someone close to us or been moved by the loss of someone we may have never met. When a suicide happens, those left behind often experience deep shock. Even if they knew the person was struggling, they may not have expected suicide would be the result. However, many people who find themselves in a suicide crisis can and do recover. We all have a role to play in suicide prevention. There are actions you can take right now to support yourself and those around you:

- **Know the Signs:** Most people who are considering suicide show some warning signs or signals of their intentions. Learn to recognize these warning signs and how to respond to them by visiting the Know the Signs web site ([www.suicideispreventable.org](http://www.suicideispreventable.org)).
- **Find the Words:** If you are concerned about someone, ask them directly if they are thinking about suicide. This can be difficult to do, but being direct provides an opportunity for them to open up and talk about their distress and will not suggest the idea to them if they aren't already thinking about it. The "Find the Words" section of the Know the Signs web site ([www.suicideispreventable.org](http://www.suicideispreventable.org)) suggests ways to start the conversation.
- **Reach Out:** You are not alone in this. Before having the conversation, become familiar with some resources to offer to the person you are concerned about. Visit the Reach Out section of the Know the Signs web site ([www.suicideispreventable.org](http://www.suicideispreventable.org)) to identify where you can find help for your friend or loved one.

The Know the Signs campaign is one of several statewide initiatives funded by counties through the voter-approved Mental Health Services Act (Prop 63). These efforts are administered by the California Mental Health Services Authority (CalMHSA) and are part of the Take Action for Mental Health Campaign.

To find local services and supports, visit the Reach Out section of the Know the Signs resources page where you will find California statewide and national resources as well as links to resources in your county: [www.suicideispreventable.org](http://www.suicideispreventable.org)

**Prevention Works.** Many people who feel suicidal don't want to die. If they can get through the crisis, treatment works. There are programs and practices that have been specifically developed to support those who are in a suicide crisis. The Suicide Prevention Resource Center hosts a registry of 160 programs, practices and resources for suicide prevention. You can learn more about them by visiting <https://sprc.org/>

### Help is available

The Suicide Prevention Lifeline (1-800-273-8255- TALK) or 988 (call, text or chat) offers 24/7 free and confidential assistance from trained counselors. Callers are connected to the nearest available crisis center. The Lifeline is also available in Spanish, and for veterans or for those concerned about a veteran, by selecting a prompt to be connected to counselors specifically trained to support veterans.



# Suicide Prevention Events in September

# Sonoma County Launches New Innovative Residential Housing Program!

**DETALLES**

**DOMINGO**  
10 DE SEPTIEMBRE 2023

Old Courthouse Sq.  
Santa Rosa, CA 95407  
10:00am - 1:00pm

**¡Acompáñanos!**

**CONEXIÓN ES PREVENCIÓN**

**LA CONEXIÓN ES PREVENCIÓN CON COMUNIDAD**

GRATIS Y TODOS ESTÁN INVITADOS

RECURSOS DE LA COMUNIDAD  
TALLERES INTERESANTES  
ACTIVIDADES INTERACTIVAS  
HABILIDADES DE AUTOCUIDADO

Van y se parte de esta enriquecedora experiencia y descubre cómo fomentar las conexiones puede ser la clave para prevenir problemas de salud mental. Juntos, prosperemos y creamos una comunidad más fuerte y solidaria.

10:00am - 10:30am Ceremonia de apertura  
10:30am - 10:50am Palabras de apertura  
10:50am - 11:00am Taller de Habilidades Mente-Cuerpo  
11:00am - 11:30am Hablar de la vida: masculina abierta  
11:30am - 11:45am Comentarios del mediador  
11:45am - 12:00pm Taller de planes de atención anticipada  
12:00pm - 12:15pm Presentación comunitaria\*  
12:15pm - 12:30pm Taller de Habilidades Mente-Cuerpo\*  
12:30pm - 1:00pm Palabras de Cierre / Ceremonia "Se Despedirá"

PARA MÁS INFORMACIÓN CONTACTA:  
MELISSA.LADRECH@SONOMA-COUNTY.ORG

Check out the community events, trainings, support groups and more happening this September in Sonoma County for suicide prevention awareness month!

We've put together a list of the events [HERE](#).

**EVENT DETAILS**

**SUNDAY**  
10 SEPTEMBER 2023

Old Courthouse Sq.  
Santa Rosa, CA 95407  
10:00am - 1:00pm

FREE & OPEN TO ALL

**CONEXIÓN IS PREVENCIÓN**

**LA CONEXIÓN ES PREVENCIÓN WITH COMMUNITY**

COMUNIDAD INTERACTIVAS  
TALLERES INTERESANTES  
ACTIVIDADES INTERACTIVAS  
HABILIDADES DE AUTOCUIDADO

Engaging Workshops  
Self-Care Skills

Van y se parte de esta enriquecedora experiencia y descubre cómo fomentar las conexiones puede ser la clave para prevenir problemas de salud mental. Juntos, prosperemos y creamos una comunidad más fuerte y solidaria.

10:00am - 10:15am Opening Ceremony  
10:15am - 10:30am Opening Remarks  
10:30am - 10:50am Mind-Body Skill Workshop  
10:50am - 11:00am Speak Life: Open Mic  
11:00am - 11:30am Mid-Day Remarks  
11:30am - 11:45am Advance Care Plan Workshop  
11:45am - 12:00pm Speak Life: Open Mic  
12:00pm - 12:15pm Community Presentation\*  
12:15pm - 12:30pm Mind-Body Skills Workshop\*  
12:30pm - 1:00pm Closing Remarks / Ceremony \*En Español

PARA MÁS INFORMACIÓN CONTACTA:  
MELISSA.LADRECH@SONOMA-COUNTY.ORG

DHS-BHD is excited to announce the launch of MHSa's Innovation Project: Crossroads to Hope (C2H)! C2H will help individuals with justice involved backgrounds and a mental health illness to build a supportive network, gain healthy life skills, get connected to community resources, and establish long-term stable housing.



C2H's transitional housing program opened its doors in July 2023. This peer-led and client centered program will provide 24/7 support. Felton Institute works collaboratively with DHS-BHD as the contracted peer service provider offering onsite case management services and programming for up to six months.

Click [HERE](#) to read Crossroads to Hope's Innovation Proposal.

## A Life Worth Living – Sonoma County's New Suicide Prevention Alliance

A group of dedicated mental health leaders and community representatives in Sonoma County have formed a new alliance with a mission to work collaboratively to create a community where anyone impacted by suicide is supported when and where they need it. According to the California Department of Public Health report, Sonoma County's three-year average age-adjusted suicide death rate for 2020 through 2022 was 38% higher than the average rate in California. The Alliance's vision to co-create a life worth living, helping one another safely navigate crises, and find support when needed, hopes to reduce Sonoma County's suicide rate.

The goals of this new alliance are to:

- Connect, collaborate, and build relationships
- Draft and circulate Sonoma County's Suicide Prevention Strategic Plan
- Identify needs and available resources in our community
- Implement strategic plan goals, objectives, and activities, in partnership with community and service providers
- Engage community members, stakeholders, and partners in planning and taking action

To learn more about A Life Worth Living: Suicide Prevention Alliance or to get involved email [Melissa.Ladrech@sonoma-county.org](mailto:Melissa.Ladrech@sonoma-county.org).

## MHSa Community Program Planning: Listening Sessions Report

Sonoma County's MHSa Community Program Planning Workgroup helped organize listening sessions with diverse communities experiencing mental health inequities. The listening sessions were co-facilitated by our consultant, Dory Escobar and trained community leaders to engage communities in important conversations. The findings and summary report will be presented on September 12, 2023 from 2pm to 4pm via Zoom and you are invited to attend! Email [MHSa@sonoma-county.org](mailto:MHSa@sonoma-county.org) for Zoom link.

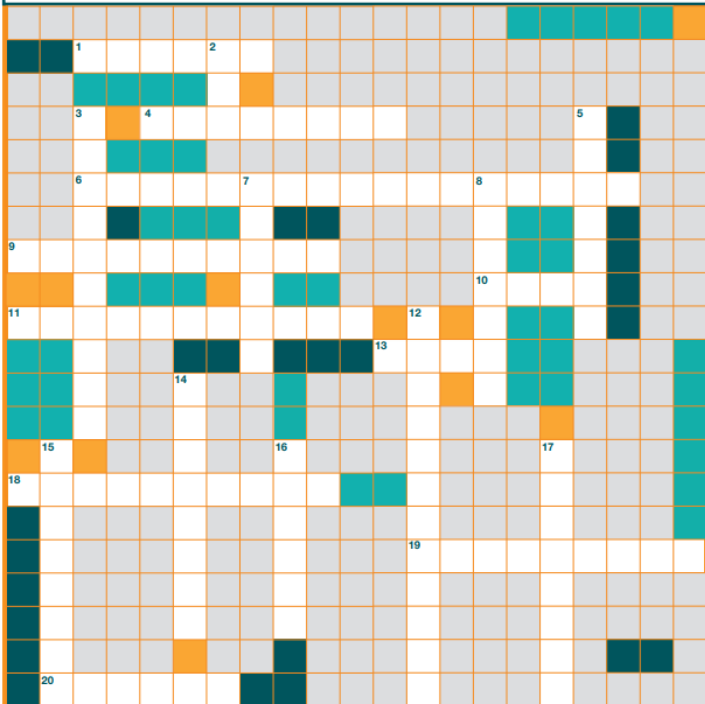
Join us on Sunday, September 10th for suicide prevention awareness day at Santa Rosa's Old Courthouse Square. Connect with others through art, mindfulness activities, words of affirmation and local community resources. Click [HERE](#) for flyer in English. Click [HERE](#) for flyer in Spanish.



Sonoma County's MHSa Three-Year Plan for FY 2023-2026 has been updated and is available on the DHS-BHD website [HERE](#).

## Know the Signs. Find the Words. Reach Out.

### Crossword Puzzle



#### Across

1. The skills and strategies that children and youth gain through \_\_\_-emotional learning can increase protective factors and decrease risk factors associated with suicide
4. Conscious act one takes in order to promote their own physical, mental, and emotional health
6. Personal or environmental characteristics that help protect people from suicide
9. Promoting connectedness and teaching coping and problem-solving skills are \_\_\_ strategies
10. \_\_\_ isn't always obvious
11. If you are concerned about someone, giving away \_\_\_ is a warning sign to look for
13. Securely storing prescription medications and firearms can help keep a person \_\_\_
18. Warning sign characterized by the act of not wanting to communicate or be around other people
19. Suicide Prevention Week is in this month
20. Changes in \_\_\_ and sleeping patterns are warning signs for suicide

#### Down

2. We can \_\_\_ prevent suicide
3. \_\_\_ is not a necessary part of aging
5. Talking about feeling hopeless or having no reason to live is a \_\_\_ sign
7. Before starting a conversation with someone you are concerned about have a list of \_\_\_ resources
8. The causes of suicide are \_\_\_
12. Indications that someone may be in danger of suicide, either immediately or in the near future
14. Asking someone about suicide does not \_\_\_ the likelihood of suicide
15. The national suicide prevention \_\_\_ is a 24/7 toll-free, confidential hotline available to anyone in suicidal crisis or emotional distress
16. Being connected to \_\_\_ and community support can decrease suicidal thoughts and behaviors
17. If you are concerned about someone, ask \_\_\_ about suicide

# Community Events for May 2023 - Mental Health Matters Month

## Action Network's Community Clothing Rack and Children's Clothing Drive

May 1st – May 31st, 2023 (Monday – Friday, 10am – 4pm)

**LOCATION:** 200 Main Street Point Arena, CA, 95468

Action Network will be hosting a Community Clothing Rack and children's clothing drive throughout May.

For more information please call [707-882-1691](tel:707-882-1691) or email [info@actionnetwork.info](mailto:info@actionnetwork.info)

## Community Mental Health Forum presented by Supervisors + Department of Health Services

Tuesday, May 2nd, 2023

**TIME:** 9:00am-3:00pm

**LOCATION:** Finley Community Center - 2060 West College Avenue in Santa Rosa

**REGISTRATION LINK:** <https://www.eventbrite.com/e/community-forum-on-mental-health-tickets-598602495177>

A community conversation discussing crisis services, suicide prevention, substance use disorder treatment services, & workforce development.

## Interlink Self-Help Center Event

Tuesday, May 2nd, 2023

**TIME:** 11:30am-1:30pm

**LOCATION:** 1033 4th St, Santa Rosa, CA 95404

Tie Dye Event, for more information call: [\(707\) 546-4481](tel:707-546-4481)

## SRJC's Mental Health Pop-Up Event in Petaluma

Tuesday, May 2, 2023

**TIME:** 12pm -2pm

**LOCATION:** SRJC in Petaluma-At the Farmers Market next to the Student Engagement/Success Center

Silent zen-zone and other un activities for SRJC students.

For more information visit [www.shs.santarosa.edu](http://www.shs.santarosa.edu)

## SRJC's Mental Health Pop-Up Event in Santa Rosa

Wednesday, May 3, 2023

**TIME:** 11am- 1pm

**LOCATION:** Bertolini Quad

Silent zen-zone and other un activities for SRJC students.

For more information visit [www.shs.santarosa.edu](http://www.shs.santarosa.edu)

## Free Suicide Prevention: QPR Community Gatekeeper Training

Wednesday, May 3rd, 2023

**TIME:** 1:30-3:00pm

**LOCATION:** SCOE - 5340 Skylane Boulevard, Santa Rosa, CA 95403)

**REGISTER:** [http://bit.ly/QPR\\_SCOE](http://bit.ly/QPR_SCOE)

## "The Wisdom of Trauma" Film Screening & Panel Discussion

Thursday, May 4th, 2023

**TIME:** 1:00pm-4:30pm

**LOCATION:** Glaser Center

Representatives from many organizations will provide information & resource for local wellness-oriented services. At 2pm we will be hosting a screening of Garbor Mates film "The Wisdom of Trauma, which will then be followed by a panel discussion. This event is free and open to the public.

For more information please contact Micheal Reynolds Peer Programs Coordinator: [707-889-1901](tel:707-889-1901) or [michael.reynolds@westcountyservices.org](mailto:michael.reynolds@westcountyservices.org).

## SCBH Family Education & Support Group

Monday, May 8th, 2023

**LOCATION:** Zoom

Monthly support group to increase understanding of nature of mental illness.

**CONTACT:** Buckelew's FSC Team at [707-494-0762](tel:707-494-0762) or [NicoleN@Buckelew.org](mailto:NicoleN@Buckelew.org) for Zoom link.

## Potluck Gathering for those who serve our community

Tuesday, May 9th, 2023

**TIME:** 3:00pm-6:00pm

**LOCATION:** RSVP to Kiahna Bell [KiahnaB@buckelew.org](mailto:KiahnaB@buckelew.org) or [707-780-7236](tel:707-780-7236)

Food gathering & short presentation by Susan Standen on the benefits of using recovery-oriented language in our work. Includes a small-group "thought exercise" as a discussion topic to help us learn ways to think about and re-phrase common medical-model statements.

## Screening of "Crooked Beauty" at Interlink Self-Help Center

Wednesday, May 10th, 2023

**TIME:** 12:00pm-1:00pm

**LOCATION:** 1033 4th St, Santa Rosa, CA 95404

Join us for a screening of "Crooked Beauty." For more information please call [\(707\) 546-4481](tel:707-546-4481).



**Cannabis and Adolescent Well-Being: A Conversation for Families**

**Wednesday, May 10th, 2023**

**TIME:** 4:00pm-5:30pm

**LOCATION:** Zoom

An organization dedicated to serving as the national leader in cannabis use prevention for young people.

For more information or for the Zoom link contact Kiahna Bell at [707-780-7236](tel:707-780-7236) or [KiahnaB@buckelew.org](mailto:KiahnaB@buckelew.org)



**Wellness & Advocacy Center**

**Wednesday, May 17th, 2023**

**TIME:** 1:00pm-3:00pm

**LOCATION:** 2245 Challenger Way #104, Santa Rosa, CA 95407

Mental Health Toolbox- Sharing different tools we have acquired that help us in everyday life.

For more information call [707-565-7800](tel:707-565-7800)



**Interlink Self-Help Center Event**

**Wednesday, May 17th, 2023**

**TIME:** 1:00pm-2:00pm

**LOCATION:** 1033 4th St, Santa Rosa, CA 95404

Writing Group: Reflections on Recovery. For more information please call [\(707\) 546-4481](tel:707-546-4481)



**Latino Service Provider's Monthly Meeting held by Youth Promotores**

**Thursday, May 18th, 2023**

**TIME:** 12:00pm-1:30pm

**LOCATION:** 1000 Apollo Way, Santa Rosa, CA 95407

Join us to learn about LSP's Youth Promotores program, an opportunity to network and get connected to other resources.

**CONTACT:** Alayza Cervates: [acervantes@latinoserviceproviders.org](mailto:acervantes@latinoserviceproviders.org)



**Stomp the Stigma**

**Saturday, May 20th, 2023**

**TIME:** 12:00pm-4:30pm

**LOCATION:** Santa Rosa Fairgrounds

Join LSP's Youth Promotores for their 4th annual event to promote mental health awareness and resources available to students in Sonoma County. Free live music, dance, workshops, food and community.

**CONTACT:** Alayza Cervates [acervantes@latinoserviceproviders.org](mailto:acervantes@latinoserviceproviders.org) for more information



**Community Baptist Church Collaborative Mental Health Conference**

**Saturday, May 20th, 2023**

**TIME:** 11:00am-1:00pm

**LOCATION:** Community Baptist Church – 1620 Sonoma Ave., Santa Rosa, CA 95405

The Community Baptist Collaborative is hosting their 7th annual Mental Health Conference featuring Devonderia Sanchez LMFT, who will discuss "Mental Health and the African American Community."

Please RSVP by email to Honor Jackson: [honorjackson1121@comcast.net](mailto:honorjackson1121@comcast.net)



**SOS: Allies for Hope**

**Wednesday, May 10th, 2023**

**TIME:** 7:00pm-8:30pm

**LOCATION:** Zoom for zoom link contact [SOSinfo@Buckelew.org](mailto:SOSinfo@Buckelew.org)

Monthly peer-to-peer group, we share strategies and skills for coping with the complex issues surrounding the loss. Introduction by Buckelew Programs, presented by Richard Von Feld, PsyD of Panaptic, an organization dedicated to serving as the national leader in cannabis use prevention for young people."



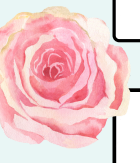
**Petaluma Education and Support Groups**

**Thursday, May 11th, 2023**

**TIME:** 4:00pm-5:30pm

**LOCATION:** Zoom, contact [NicoleN@Buckelew.org](mailto:NicoleN@Buckelew.org) for zoom link

A monthly education and support group to increase understanding of the nature of mental illness



**Bike4Buckelew: Access to Mental Healthcare for All**

**Saturday, May 13, 2023**

**TIME:** 8:00am-2:00pm

**LOCATION:** Miwok Meadows, China Camp State Park

Festivities will include organized mountain bike trail rides and guided hikes for every level, followed by a party in the woods with fabulous food, live entertainment and more. Fun for all ages!

**REGISTER:** <https://buckelew.salsalabs.org/bike4buckelew2023/index.html>



**Inspiration Through Empathy**

**Monday, May 15th, 2023**

**TIME:** 9:30am-11:30am

**LOCATION:** Zoom, contact Kiahna [BellKiahnaB@buckelew.org](mailto:KiahnaBell@buckelew.org) for zoom link

A Recovery-Model approach to burnout, compassion fatigue, and increasing mental health needs in our community.



[Petaluma Peer Recovery Center's Events](#)

**Monday, May 22nd, 2023**

**TIME:** 11:30am-12:30pm

**LOCATION:** 5350 Old Redwood Hwy N #600, Petaluma, CA 94954

MH Month Bingo w/ Prizes for more information please call (707) 565-1299

[Interlink Self-Help Center Event](#)

**Wednesday, May 24th, 2023**

**TIME:** 12:00pm-2:00pm

**LOCATION:** 1033 4th St, Santa Rosa, CA 95404

Screening of "Healing Voices" for more information please call (707) 546-4481

[Interlink Self-Help Center Event](#)

**Friday, May 26th, 2023**

**TIME:** 1:30-3:00pm

**LOCATION:** 1033 4th St, Santa Rosa, CA 95404

Sharing Recovery Resources. For more information please call (707) 546-4481

[Creating Safe Space for Mental Health through Connection](#)

**Tuesday, May 30th, 2023**

**TIME:** 3:00pm-6:00pm

Hear stories of lived mental health experience with a provider panel and community circle.

**REGISTER:** <https://www.eventbrite.com/e/creating-safe-space-for-mental-health-through-connection-tickets-619421956747>

[Petaluma Peer Recovery Center's Event](#)

**Wednesday, May 31st, 2023**

**TIME:** 10:30am-12:30pm

**LOCATION:** 5350 Old Redwood Hwy N #600, Petaluma, CA 94954

Screening of "Healing Voices" for more information please call (707) 565-1299

[Interlink Self-Help Center Event](#)

**Wednesday, May 31st, 2023**

**TIME:** 12:00pm-2:00pm

**LOCATION:** 1033 4th St, Santa Rosa, CA 95404

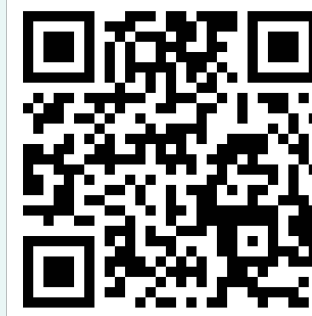
MH Month Bingo w/ Prizes

For more information call: 707-565-7800

**MAY IS  
MENTAL  
HEALTH  
MONTH**

**TAKE SOME TIME TO  
LOOK AROUND, LOOK WITHIN**

**MHANATIONAL.ORG/MAY**



Scan me!

**988 SUICIDE & CRISIS  
LIFELINE**

**24/7 CALL, TEXT, CHAT**

# May 2023

## Mental Health Matters Month



SUN

MON



















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28	29	30 	31 			

## **Creado un Espacio Seguro para la Salud Mental a Través de la Conexión** *Panel y Circulo de la Comunidad*

Se les invita a reunirse con nosotros en comunidad. Colectivamente, hemos pasado por mucho en los últimos años. Nos estaremos reuniendo para escuchar historias de experiencias vividas con un panel de proveedores y un círculo comunitario.

Se le dará la oportunidad de unirse al círculo comunitario. Tenemos un maravilloso panel de proveedores que se han ofrecido a compartir sus experiencias con nosotros. El espacio del círculo comunitario será limitado. La participación en el círculo no es necesaria en absoluto.

Comenzaremos con una oración de apertura de Madonna Feather Cruz y introducción con Jan Cobaleda-Kegler, Directora de Salud del Comportamiento del Condado de Sonoma. Kenia Leon, Directora de Programas, Programas de Sonoma y Erika Klohe, Directora Regional de Salud del Comportamiento, Buckelew serán las co-facilitadores. Tendremos un panel de proveedores comunitarios, ejercicio de conexión a tierra, círculo comunitario y compartiremos una comida juntos.

*¡Esperamos verlos a todos!*



*~ Reunamonos Juntos ~*

30 de mayo, 2023

3:00- 6:00pm

2060 W College Ave

Finley Center, Santa Rosa Ca

Por favor regístrese: <https://CreatingSpaceForMH.eventbrite.com>.

¡Tendremos interpretación al español en el evento y compartiremos el folleto pronto!

We will have Spanish interpretation at the event & flier to share soon!



## Adriana Arrizon

(ella)

Directora Ejecutiva

Health Action Together

Adriana Arrizon

[aarrizon@hatogether.org](mailto:aarrizon@hatogether.org)

Adriana tiene más de 20 años de experiencia en los sectores de salud pública y comunitaria en Alameda, Stanislaus, Marin y el condado de Sonoma. Hija de trabajadores agrícolas migrantes y criada por un guerrero de la justicia social: su abuela. Adriana entiende que son las conexiones auténticas y significantes las que impulsan el cambio, y que la vitalidad de una comunidad depende en gran medida de que sus miembros estén plenamente comprometidos y sean participantes activos en su propio bienestar. La experiencia de Adriana incluye el desarrollo, implementación y evaluación de programas de salud culturalmente receptivos. Adriana ha trabajado en salud materna e infantil, cuidado a temprana edad y educación, manejo de respuesta a desastres, participación comunitaria y cívica, coordinación de sistemas sociales y de salud, y desarrollo de políticas. Adriana se convirtió en Consultora de Lactancia Certificada Internacional en el 2010 para abordar las desigualdades del sistema de salud en la comunidad latina en el condado de Sonoma. A Adriana le gusta caminar, entretener a sus amigos y aprender a ver el mundo a través de los ojos de sus dos hijos.



## Teresa Bowman,

(ella)

Directora de Servicios del Uso  
de Sustancias

Programa Buckelew

Teresa Bowman

[TeresaB@buckelew.org](mailto:TeresaB@buckelew.org)

Teresa es nativa del condado de Marin y comenzó su carrera como adulta joven, justo después de graduarse de Tamalpais High School. Continuó su carrera con un título en negocios de Heald's Business College en San Francisco, y más tarde completó el programa de Estudios de Alcohol y Drogas de UC Berkeley para convertirse en una Especialista Certificada en Adicciones. En 1999, Teresa cofundó el Centro de Recuperación Helen Vine, también conocido como "The Vine", y se desempeñó como su Directora Ejecutiva, un papel que continúa desempeñando.

Como Directora Ejecutiva del Centro de Recuperación Helen Vine, Teresa fue galardonada con el Premio Humanitario Martin Luther King, Jr. en 2005. En 2011 The Vine se fusionó con el Programa Buckelew. Teresa ha sido fundamental para supervisar la adopción del tratamiento basado en la evidencia en The Vine y, en 2020, la adición de dos residencias sobrias críticamente necesarias.

Hoy, Teresa supervisa los Servicios de Uso de Sustancias de Buckelew y sigue dedicada a trabajar con sus colegas y personal para continuar expandiendo los servicios de tratamiento de trastornos concurrentes de Buckelew.



**Madonna (Feather) Cruz**

(ella)

[madonnafeather@yahoo.com](mailto:madonnafeather@yahoo.com)

MaDonna (Feather) Cruz, llamada así por su tía MaDonna Thunder Hawk, nació en Ukiah, California. MaDonna es un miembro inscrito de la reserva india de Round Valley, en Covelo, CA, y por parte de su padre Lakota Sioux. MaDonna actualmente se desempeña como Presidenta del Comité de Educación Indígena con el Distrito Escolar de la Ciudad de Santa Rosa, Directora de la radio KBBF, BOD a Ya-Ka- AMA Indian Education and Development, Inc., y miembro asesor de la comunidad para el proyecto Auntie's and Uncle's Eagle Council con Sonoma County Indian Health Project.



**Lisa Diaz-McQuaid,**

(ella)

Defensora de Víctimas de la  
Trata de Personas

Cofundador de Redemption  
House of the Bay Area

[info@redemptionhouseofthebayarea.org](mailto:info@redemptionhouseofthebayarea.org)

Lisa nació y creció en Santa Rosa, California. Ella es una sobreviviente de abuso sexual infantil y como adulta una sobreviviente de violencia doméstica, agresión sexual, tráfico laboral y trata de personas. Lisa encontró curación y la recuperación de su pasado y quiere ayudar a otros a lo largo de sus caminos de curación y descubrimiento de la autoestima, el amor propio, la libertad y el empoderamiento.

Lisa es miembro del Grupo de Trabajo contra la Trata de Personas del Condado de Sonoma y sirve en la junta como "experta en sobrevivientes de la trata" que representa a Redemption House of the Bay Area. Lisa es miembro de la mesa directiva de 'Raizes Collective' empoderando a nuestra comunidad latina a través del arte, la cultura y la educación ambiental. Lisa es miembro de varios otros grupos, iniciativas y recibió muchos premios por su servicio en la comunidad.



**Sean Kelson** (Tu eliges)

Gerente de Programa del  
Centro Interlink Self-Help

[sean.kelson@westcountyservices.org](mailto:sean.kelson@westcountyservices.org)

Sean Kelson es gerente de programas en West County Community Services y supervisa el Centro de ayuda propia de Interlink y el Centro de Recuperación de Compañeros de Petaluma. Sean ha trabajado como proveedor para compañeros por más de 15 años. Como consultor y empleado de la agencia, Sean ha proveído entrenamiento, divulgación y charlas motivacionales al personal, participantes y las agencias, en reuniones y en las calles. El celo y la capacidad de Sean para aprender, abogar y compartir información sobre la atención informada sobre el trauma, la valoración de la diversidad y la conciencia de cuándo podemos perder de vista la humanidad de otra persona, está informada por su experiencia vivida, basada en la esperanza y la recuperación.



**Kenia Leon**, (Ella)

Director del Programa, Sonoma  
Bucklew Programs

[Kenial@Bucklew.org](mailto:Kenial@Bucklew.org)

Bicultural, bilingüe hija de inmigrantes, soy una defensora apasionada con una fuerte ética de trabajo que está motivada para crear un cambio en nuestro mundo. Como terapeuta matrimonial, familiar e infantil y Consejero Clínico Licenciado en Alcohol y Drogas, mi objetivo es proporcionar atención competente, efectiva y basada en la fortaleza a nuestras poblaciones más marginadas. Centrada en la comunidad y orientada al sistema, trabajo a través de un lente de justicia restaurativo para mejorar el acceso a/y dentro de nuestro sistema de atención de salud mental.



## Jennifer Vargas

(ella)

inResponse System Navigator

Buckelew Programs

[JenniferV@buckelew.org](mailto:JenniferV@buckelew.org)

Jennifer Vargas es Navegadora de Sistemas en inRESPONSE, el equipo de respuesta a crisis de salud mental de Santa Rosa. Siendo mexicoamericana de primera generación, se esfuerza por tener un impacto positivo en la comunidad en la que creció, a través de su experiencia vivida en salud mental y su formación académica en psicología chicana. En su tiempo libre, a Jennifer le encanta bailar e ir a la playa.



## Erika Klohe

(ella)

Directora Regional

Sonoma/Napa

Buckelew Programs

[erikak@buckelew.org](mailto:erikak@buckelew.org)

Erika Klohe, es mamá, abuela, madrina, hija, hermana, amiga y tiene experiencia vivida. Ella es una trabajadora social clínica con licenciatura, con muchos años de experiencia trabajando en la comunidad brindando servicios directos y desarrollando asociaciones en todo el condado de Sonoma. Gran parte de su trabajo se ha centrado en el análisis de barreras y desafíos, y ha apoyado el establecimiento de prácticas compartidas que aumentan el acceso al cuidado.

Erika es una firme defensora de los servicios culturalmente diversos, orientados a la recuperación, informada sobre el trauma y humanistas. Ella tiene muchos años de experiencia trabajando con los más vulnerables de nuestra comunidad, incluyendo: poblaciones nativas y latinas, personas sin hogar, personas mayores, LGBTQI, aquellos involucrados en el sistema de justicia penal, jóvenes en transición y desatendidos y sus familias.

# En Asociación Juntos Con



## What is connection according to Brené Brown?

"I define connection as the energy that exists between people when they feel seen, heard, and valued; when they can give and receive without judgment; and when they derive sustenance and strength from the relationship." – Dr. Brené Brown



## **Creado un Espacio Seguro para la Salud Mental a Través de la Conexión** *Panel y Círculo Comunitario*

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Adriana Arrizon

[aarrizon@hatogether.org](mailto:aarrizon@hatogether.org)

Adriana tiene más de 20 años de experiencia en los sectores de salud pública y comunitaria en Alameda, Stanislaus, Marin y el condado de Sonoma. Hija de trabajadores agrícolas migrantes y criada por una guerrera de la justicia social: su abuela. Adriana entiende que son las conexiones auténticas y significantes las que impulsan el cambio, y que la vitalidad de una comunidad depende en gran medida de que sus miembros estén plenamente comprometidos y sean participantes activos en su propio bienestar. La experiencia de Adriana incluye el desarrollo, implementación y evaluación de programas de salud culturalmente receptivos. Adriana ha trabajado en salud materna e infantil, en el cuidado a temprana edad y educación, manejo de respuesta a desastres, participación comunitaria y cívica, coordinación de sistemas sociales y de salud, y desarrollo de políticas. Adriana se convirtió en Consultora de Lactancia Certificada Internacional en el 2010 para abordar las desigualdades del sistema de salud en la comunidad latina en el condado de Sonoma. A Adriana le gusta caminar, entretener a sus amigos y aprender a ver el mundo a través de los ojos de sus dos hijos.



## Teresa Bowman,

(ella)

Directora de Servicios del Uso  
de Sustancias

Programa Buckelew

Teresa Bowman

[TeresaB@buckelew.org](mailto:TeresaB@buckelew.org)

Teresa es nativa del condado de Marin y comenzó su carrera como adulta joven, justo después de graduarse de Tamalpais High School. Continuó su carrera con un título en negocios de Heald's Business College en San Francisco, y más tarde completó el programa de Estudios de Alcohol y Drogas de UC Berkeley para convertirse en una Especialista Certificada en Adicciones. En 1999, Teresa cofundó el Centro de Recuperación Helen Vine, también conocido como "The Vine", y se desempeñó como su Directora Ejecutiva, un papel que continúa desempeñando.

Como Directora Ejecutiva del Centro de Recuperación Helen Vine, Teresa fue galardonada con el Premio Humanitario Martin Luther King, Jr. en 2005. En 2011 The Vine se fusionó con el Programa Buckelew. Teresa ha sido fundamental para supervisar la adopción del tratamiento basado en la evidencia en The Vine y, en 2020, la adición de dos residencias sobrias críticamente necesarias.

Hoy, Teresa supervisa los Servicios de Uso de Sustancias de Buckelew y sigue dedicada a trabajar con sus colegas y personal para continuar expandiendo los servicios de tratamiento de trastornos concurrentes de Buckelew.



**Madonna (Feather) Cruz**

(ella)

[madonnafeather@yahoo.com](mailto:madonnafeather@yahoo.com)

MaDonna (Feather) Cruz, llamada así por su tía MaDonna Thunder Hawk, nació en Ukiah, California. MaDonna es un miembro inscrito de la reservación india de Round Valley, en Covelo, CA, y por parte de su padre Lakota Sioux. MaDonna actualmente se desempeña como Presidenta del Comité de Educación Indígena con el Distrito Escolar de la Ciudad de Santa Rosa, Directora de la radio KBBF, BOD a *Ya-Ka- AMA Indian Education and Development, Inc.*, y miembro asesor de la comunidad para el proyecto *Auntie's and Uncle's Eagle Council con Sonoma County Indian Health Project*.



**Lisa Diaz-McQuaid,**

(ella)

Defensora de Víctimas de la  
Trata de Personas

Cofundador de Redemption  
House of the Bay Area

[info@redemptionhouseofthebayarea.org](mailto:info@redemptionhouseofthebayarea.org)

Lisa nació y creció en Santa Rosa, California. Ella es una sobreviviente de abuso sexual infantil y como adulta una sobreviviente de violencia doméstica, agresión sexual, tráfico laboral y trata de personas. Lisa encontró curación y la recuperación de su pasado y quiere ayudar a otros a lo largo de sus caminos de curación y descubrimiento de la autoestima, el amor propio, la libertad y el empoderamiento.

Lisa es miembro del Grupo de Trabajo contra la Trata de Personas del Condado de Sonoma y sirve en la junta como "experta en sobrevivientes de la trata" que representa a *Redemption House of the Bay Area*. Lisa es miembro de la mesa directiva de '*Raizes Collective*' empoderando a nuestra comunidad latina a través del arte, la cultura y la educación ambiental. Lisa es miembro de varios otros grupos, iniciativas y recibió muchos premios por su servicio en la comunidad.



**Sean Kelson** (Tu eliges)

Gerente de Programa del  
Centro Interlink Self-Help

[sean.kelson@westcountyservices.org](mailto:sean.kelson@westcountyservices.org)

Sean Kelson es gerente de programas en *West County Community Services* y supervisa el Centro de ayuda propia de *Interlink* y el Centro de Recuperación de Compañeros de Petaluma. Sean ha trabajado como proveedor para compañeros por más de 15 años. Como consultor y empleado de la agencia, Sean ha proveído entrenamiento, divulgación y charlas motivacionales al personal, participantes y las agencias, en reuniones y en las calles. El celo y la capacidad de Sean para aprender, abogar y compartir información sobre la atención informada sobre el trauma, la valoración de la diversidad y la conciencia de cuándo podemos perder de vista la humanidad de otra persona, está informada por su experiencia vivida, basada en la esperanza y la recuperación.



**Kenia Leon**, (Ella)

Director del Programa, Sonoma  
Bucklew Programs

[Kenial@Bucklew.org](mailto:Kenial@Bucklew.org)

Bicultural, bilingüe hija de inmigrantes, Kenia es una defensora apasionada con una fuerte ética de trabajo que está motivada para crear un cambio en nuestro mundo. Como terapeuta matrimonial, familiar e infantil y Consejero Clínico Licenciado en Alcohol y Drogas, su objetivo es proporcionar atención competente, efectiva y basada en la fortaleza a nuestras poblaciones más marginadas. Centrada en la comunidad y orientada al sistema, trabaja a través de un lente de justicia restaurativo para mejorar el acceso a/y dentro de nuestro sistema de atención de salud mental.



## Jennifer Vargas

(ella)

inResponse System Navigator

Buckelew Programs

[JenniferV@buckelew.org](mailto:JenniferV@buckelew.org)

Jennifer Vargas es Navegadora de Sistemas en inRESPONSE, el equipo de respuesta a crisis de salud mental de Santa Rosa. Siendo Mexicana de primera generación, se esfuerza por tener un impacto positivo en la comunidad en la que creció, a través de su experiencia vivida en salud mental y su formación académica en psicología chicana. En su tiempo libre, a Jennifer le encanta bailar e ir a la playa.



## Erika Klohe

(ella)

Directora Regional

Sonoma/Napa

Buckelew Programs

[erikak@buckelew.org](mailto:erikak@buckelew.org)

Erika Klohe, es mamá, abuela, madrina, hija, hermana, amiga y tiene experiencia vivida. Ella es una trabajadora social clínica con licenciatura, con muchos años de experiencia trabajando en la comunidad brindando servicios directos y desarrollando asociaciones en todo el condado de Sonoma. Gran parte de su trabajo se ha centrado en el análisis de barreras y desafíos, y ha apoyado el establecimiento de prácticas compartidas que aumentan el acceso al cuidado.

Erika es una firme defensora de los servicios culturalmente diversos, orientados a la recuperación, informada sobre el trauma y humanistas. Ella tiene muchos años de experiencia trabajando con los más vulnerables de nuestra comunidad, incluyendo: poblaciones nativas y latinas, personas sin hogar, personas mayores, LGBTQI, aquellos involucrados en el sistema de justicia penal, jóvenes en transición y desatendidos y sus familias.

# En Asociación Juntos Con



## ¿Qué es la conexión según Brené Brown?

“Yo defino conexión como la energía que existe entre las personas cuando se sienten vistas, escuchadas y valoradas; cuando pueden dar y recibir sin juicio; y cuando obtienen sustento y fortaleza de la relación”. – Dra. Brene Brown

## Sonoma County September 2023 Suicide Prevention Events

Date/Time	Name of Event	Location	Sponsoring Organization	Audience / Cost	Registration	Contact Info
9/5/2023 11am-2pm	Walk in the Light @ The Lakes	Wellness Advocay Center, Santa Rosa	WCCS	Open to All Free Event	No Registration	<a href="mailto:Danette.alander@westcountyservices.org">Danette.alander@westcountyservices.org</a> <a href="tel:707-565-7800">707-565-7800</a>
9/10/2023 10am-1pm	Connection is Prevention	Old Courthouse Square, Santa Rosa	DHS-BHD and WCCS	Open to All Free Event	No Registration	Iridian Onofre <a href="mailto:Iridian.Onofre@sonoma-county.org">Iridian.Onofre@sonoma-county.org</a> (707) 565-4854
9/12/2023 11am	What is QPR? A presentation	Wellness Advocay Center, Santa Rosa	WCCS	Open to All Free Event	No Registration	<a href="mailto:Danette.alander@westcountyservices.org">Danette.alander@westcountyservices.org</a> <a href="tel:707-565-7800">707-565-7800</a>
9/23/2023 9am	Out of the Darkness Walk	Sonoma State University, Rohnert Park	AFSP	Open to All Free Event	Please Follow the link <a href="https://supporting.afsp.org/index.cfm?fuseaction=donorDrive.event&amp;eventID=9103">https://supporting.afsp.org/index.cfm?fuseaction=donorDrive.event&amp;eventID=9103</a>	Email: <a href="mailto:sonomacountyoutofthedarkness@gmail.com">sonomacountyoutofthedarkness@gmail.com</a> Phone: 707-480-8272
9/25/2023 3pm-5pm	QPR Suicide Prevention Training	SCOE	SCOE	Ages 12+ Free Event	Please Follow the link: <a href="https://docs.google.com/forms/d/e/1FAIpQLScJDXJZUfvaYac-dQcAlOjCzbbGIqce8TKnMok_eTRnRgtBLg/viewform">https://docs.google.com/forms/d/e/1FAIpQLScJDXJZUfvaYac-dQcAlOjCzbbGIqce8TKnMok_eTRnRgtBLg/viewform</a>	Mary Champion <a href="mailto:mchampion@scoe.org">mchampion@scoe.org</a>
9/26/2023 9am-11am	QPR Suicide Prevention Training	SCOE	SCOE	Ages 12+ Free Event	Please Follow the link: <a href="https://docs.google.com/forms/d/e/1FAIpQLScJDXJZUfvaYac-dQcAlOjCzbbGIqce8TKnMok_eTRnRgtBLg/viewform">https://docs.google.com/forms/d/e/1FAIpQLScJDXJZUfvaYac-dQcAlOjCzbbGIqce8TKnMok_eTRnRgtBLg/viewform</a>	Mary Champion <a href="mailto:mchampion@scoe.org">mchampion@scoe.org</a>
9/26/2023 12pm-2pm	Lethal Means Safety Counseling	Finley Center, Santa Rosa	DHS-BHD and VA		Creating link	Iridian Onofre <a href="mailto:Iridian.Onofre@sonoma-county.org">Iridian.Onofre@sonoma-county.org</a> (707) 565-4854

**EVENT DETAILS**

**SUNDAY**  
10 SEPTEMBER 2023

Old Courthouse Sq,  
Santa Rosa, CA 95407  
**10:00am - 1:00pm**



**FREE &  
OPEN TO  
ALL!**

**Share Hope Together**  
FOR SUICIDE PREVENTION

**KNOW THE SIGNS. FIND THE WORDS. REACH OUT.**

SUICIDE PREVENTION WEEK: SEPTEMBER 10TH - 16TH, 2023  
WORLD SUICIDE PREVENTION DAY: SEPTEMBER 10TH, 2023



**Join Us!**



**CONNECTION IS PREVENTION  
WITH COMMUNITY**

**THE POWER OF  
CONNECTION:**

10:00am - 10:15am	Opening Ceremony
10:15am - 10:30am	Opening Remarks
10:30am - 10:50am	Mind-Body Skill Workshop
10:50am - 11:00am	Speak Life: Open Mic
11:00am - 11:15am	Mid-Day Remarks
11:15am - 11:45am	Advance Care Plan Workshop
11:45am - 12:00pm	Speak Life: Open Mic
12:00pm - 12:15am	Community Presentation*
12:15pm - 12:30pm	Mind-Body Skills Workshop*
12:30pm - 1:00pm	Closing Remarks / Ceremony

**\*En Español**

- ◆ **COMMUNITY  
RESOURCES**
- ◆ **ENGAGING  
WORKSHOPS**
- ◆ **INTERACTIVE  
ACTIVITIES**
- ◆ **SELF-CARE  
SKILLS**

Come be a part of this enriching experience and discover how fostering connections can be the key to preventing mental health challenges. Together, let's thrive and create a stronger, more supportive community.



FOR MORE INFORMATION, CONTACT:  
MHSA@SONOMA-COUNTY.ORG



## DETALLES

# DOMINGO

10 DE SEPTIEMBRE 2023

Old Courthouse Sq,  
Santa Rosa, CA 95407

10:00am - 1:00pm



## EL PODER DE LA CONEXIÓN

10:00am - 10:15am	Ceremonia de apertura
10:15am - 10:30am	Palabras de apertura
10:30am - 10:50am	Taller de Habilidades Mente-Cuerpo
10:50am - 11:00am	Hablar de la vida: micrófono abierto
11:00am - 11:15am	Comentarios del mediodía
11:15am - 11:45am	Taller de planes de atención anticipados
11:45am - 12:00pm	Hablar de la vida: micrófono abierto
12:00pm - 12:15am	Presentación comunitaria*
12:15pm - 12:30pm	Taller de Habilidades Mente-Cuerpo*
12:30pm - 1:00pm	Palabras de Clausura / Ceremonia <b>*En Español</b>

PARA MÁS INFORMACIÓN CONTACTE:  
MHSA@SONOMA-COUNTY.ORG

GRATIS Y  
ABIERTO A  
TODOS

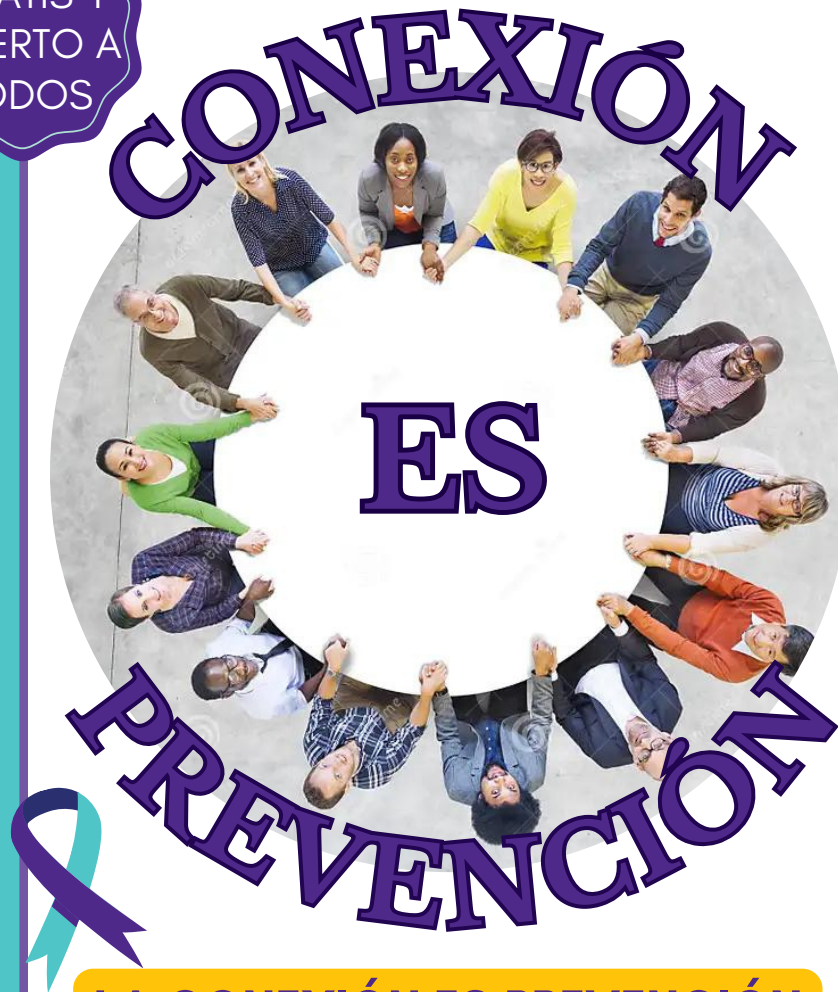
Share Hope Together  
FOR SUICIDE PREVENTION

KNOW THE SIGNS. FIND THE WORDS. REACH OUT.

SUICIDE PREVENTION WEEK: SEPTEMBER 10TH - 16TH, 2023  
WORLD SUICIDE PREVENTION DAY: SEPTEMBER 10TH, 2023



## ¡Acompáñanos!



## LA CONEXIÓN ES PREVENCIÓN CON COMUNIDAD

- ◆ **RECURSOS DE LA COMUNIDAD**
- ◆ **TALLERES INTERESANTES**
- ◆ **ACTIVIDADES INTERACTIVAS**
- ◆ **HABILIDADES DE AUTOCUIDADO**

Ven y sé parte de esta enriquecedora experiencia y descubre cómo fomentar las conexiones puede ser la clave para prevenir problemas de salud mental. Juntos, prosperemos y creemos una comunidad más fuerte y solidaria.



## Sonoma County Behavioral Health Division

### Free Staff Development Training

**\* This Training is for all direct service staff that develop safety plans with clients having thoughts of suicide. \***

## “Lethal Means Safety Counseling and Lock Box Distribution”

[You MUST register for this class!](#)

**2.0 CEs provided for LCSWs, LMFTs, Registered Associates LPCCsm LEPs, RNs, and AODS Counselors**

This will be a two hour (2.0 CEs) in-person presentation with time for questions and discussion. With the option of attending virtually.

Lethal Means Safety Counseling (LMSC) is an evidence-based intervention intended to promote the safety of a person in suicidal crisis or in anticipation of a crisis. LMSC facilitates collaborative discussion to assist a person with increasing time and distance between their suicidal intent and their ability to access lethal means. This training will explain the importance of addressing means safety as part of suicide prevention and how the implementation of LMSC can enhance suicide prevention efforts in your own community.

#### **Objectives: Participants will be able to**

1. List two elements of Lethal Mental Safety Counseling
2. Identify the most common method involved in death by suicide.
3. Describe the average duration of a suicidal crisis.
4. Identify two ways that reducing access to lethal means can prevent suicide.

**September 26, 2023**

Tuesday, 12:00pm – 2:00pm

Finley Community Center Person Auditorium

2060 West College Avenue

Santa Rosa, CA 95401

#### **Course Schedule:**

12:00pm – 12:10pm	Introduction
12:10pm – 1:00pm	Research and support for Lethal Means Safety
1:00pm – 1:45pm	Counseling How to become an effective Lethal Means
1:45pm – 2:00pm	Safety Counselor Summary, Wrap-up & Questions

**Presenter:** Dr. Anna Harrison

**Please register using one of the following links:**

<https://lethal-means-safety-counseling-lockbox-distribution.eventbrite.com> **(In-Person)**

[https://sonomacounty.zoom.us/webinar/register/WN\\_aWNspVDNTEGP0y9TJ9h2zg](https://sonomacounty.zoom.us/webinar/register/WN_aWNspVDNTEGP0y9TJ9h2zg) **(Virtual)**

**CE Certificates after completion of the course.**

**Contact: BH-Training [BH-Training@sonoma-county.org](mailto:BH-Training@sonoma-county.org) for more information, ADA requests, grievances or if you are unable to attend.**

Course meets the qualifications for 2 hours of continuing education credit for LMFTs, LCSWs, LPCCs and/or LEPs as required by the California Board of Behavioral Sciences.

The Sonoma County Behavioral Health Division is approved by the California Association of Marriage and Family Therapists to sponsor continuing education for LMFTs, LCSWs, & LPCCs. Sonoma County Behavioral Health Division maintains responsibility for this program/course and its content. Provider Number 135030, Exp. 02/01/2024.

This course has been approved by California Board of Registered Nursing, **B.R.N Provider No. 10298** expires 5/31/2024.

Provider approved by CCAPP-EI, Provider Number 4N-05-565-1122 for 2 CEs.

## REMEMBRANCE & HEALING CONVERSATION FOR THOSE IMPACTED BY SUICIDE

*This day of hope and healing is often very powerful to attendees affected by suicide loss. Many loss survivors who attend and participate in Survivor Day events find a deep connection with others who have had similar experiences, developing a new understanding of their grief with the realization that they are not alone.*



**LOSS FROM SUICIDE IS LIKE NO OTHER LOSS...**

HANNA CENTER  
17000 Arnold Drive, Sonoma CA

NOV  
14

**4 PM - 6 PM**

2023

**ADDITIONAL INFORMATION**

[MHPA@SONOMA-COUNTY.ORG](mailto:MHPA@SONOMA-COUNTY.ORG)

**988** SUICIDE & CRISIS  
LIFELINE





# REMEMBRANCE & HEALING CONVERSATION FOR THOSE IMPACTED BY SUICIDE

*This day of hope and healing is often very powerful to attendees affected by suicide loss. Many loss survivors who attend and participate in Survivor Day events find a deep connection with others who have had similar experiences, developing a new understanding of their grief with the realization that they are not alone.*



**LOSS FROM SUICIDE IS LIKE NO OTHER LOSS...**

**NORTH COAST BUILDERS EXCHANGE**

1030 APOLLO WAY, SANTA ROSA CA

NOV

16

2023

**3:00 PM - 5:00 PM**



Registration link: [HTTPS://TINYURL.COM/RZ8VUYWF](https://tinyurl.com/rz8vuywf)

**SCAN CODE TO**

**REGISTER** Page 370

**988** SUICIDE & CRISIS  
**LIFELINE**





## Fiscal Year 2022-2023 Sonoma County Impact Statement

### *The PEI Project: Achieving More Together to Support Californians*

California counties collectively pool local Prevention and Early Intervention (PEI) funds through the California Mental Health Services Authority (CalMHSA) to support the ongoing implementation of the PEI Project at a Statewide level. The PEI Project is a collection of campaigns which seek to expand the awareness of mental health needs and supports, reduce stigma, prevent suicides, and teach individuals how to achieve mental wellness. These campaigns are: Know the Signs, Directing Change, and Each Mind Matters (EMM). The EMM campaign was the original stigma reduction campaign and primarily focused on reducing stigma around mental health. The EMM campaign was an early trailblazing effort in stigma reduction. Following the direction of the CalMHSA Board of Directors, CalMHSA staff sought to reimagine the next iteration of the PEI Project towards one that is building off the work done by EMM to move California into a new phase of Taking Action. The *Take Action for Mental Health* campaign helps individuals learn how to Take Action for the mental health of themselves and those around them through three pillars: Check In, Learn More, and Get Support.

### *Strategies of the PEI Project in FY 22/23*

Funding to the PEI Project supported programs such as:

- Continued production, promotion, and dissemination of the *Take Action for Mental Health* campaign's materials and messages
- Providing technical assistance and outreach to Members contributing to the PEI Program
- Providing mental health and suicide prevention trainings to diverse audiences
- Engaging youth through the Directing Change program
- Strategizing on evaluation and best practices with RAND Corporation

### *Statewide achievements in FY 22/23*

The effects of the Statewide PEI Project go beyond county lines. Influencing all Californians in the message of *Take Action for Mental Health* is critical for creating a culture of mental wellness and wellbeing regardless of where individuals live, work or play. Key statewide achievements of the Statewide PEI Project in FY 2022-2023 include:

- Take Action 4 Mental Health disseminated physical and digital materials for May is Mental Health Month, Suicide Prevention Week and Month in September, National Rural Health Day, Winter Wellness, and Student Athlete Suicide Prevention
  - See more on pages 3-9
- Directing Change Hope & Justice Held Seven Topics for Monthly Submissions
  - See more on pages 10-12
- The Suicide Prevention Technical Assistance Team conducted two statewide webinars
  - See more on page 13

CHECK IN

LEARN MORE

GET SUPPORT





- The Suicide Prevention Technical Assistance team conducted regular meetings with PEI contributing counties throughout the year to provide technical assistance and resource navigation.
  - See more on page 13

*People under the age of 25 that were served through this Program and Disclaimer*

CalMHSA is unable to provide an exact number, however, based on the funded programs it is estimated that around 65% of services of this program are provided to individuals under 25 (as defined by Title 9 Regulations). For context, the program estimates are below:

- Directing Change: estimated at 95% under 25 years old
- Social Marketing: estimated at 55% under 25 years old
- Training and Technical Assistance: estimated at 55% under 25 years old
- Evaluation: 51%

CHECK IN

LEARN MORE

GET SUPPORT





May is Mental Health Matters Month Toolkit + Reporting Data

- [Link to Items](#)

# Physical Toolkit

**Included:** Resource booklets distributed in English and Spanish, recipes cards for wellness and self-care, green ribbons, pop-It keychains, wristbands, and toiletry kits!



Keychain + Wristband



Toiletry Kit



Green Ribbons



Your Mental Wellness Plan / Tu plan de bienestar mental



Wellness + self-care recipe cards

CHECK IN

LEARN MORE

GET SUPPORT





# Digital Toolkit

**Included:** 2023 Proclamation, web banners, eblasts, social media kit, Spotify playlist, digital versions of the resource books and recipe cards, billboard, and radio script.



Web banners



Digital billboard



Spotify playlist



2023 Proclamation

# Digital Toolkit



CHECK IN

LEARN MORE

GET SUPPORT







# Influencers

Partnered with mental health advocates to share their mental health stories and *Take Action* resources, and to encourage Californians to do the same.



**Amber Dee**  
@blackfemaletherapists



**Juan Acosta**  
@juanacosta\_



**Anysa & Amaya Gray**  
@grayytwins



**Owin Pierson**  
@owinpierson

# Media

Promoted *Take Action* campaign through paid media to extend reach across the state and target specific audiences.

**Ads included:** Facebook, Instagram, Twitter, Google Search, display, Eblasts, podcasts, and Spotify.



CHECK IN

LEARN MORE

GET SUPPORT





Take Action had more than  
**14,589,320 touchpoints**  
 with Californians throughout May

<b>12,499,906</b> paid media reach	<b>1,817,716</b> influencer post reach	<b>252,720</b> total toolkit materials distributed	<b>10,521</b> IG live event views	<b>8,457</b> organic social media reach
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Take Action had more than  
**5,611,261 touchpoints\***  
 with Californians in priority populations throughout May

<b>2,031,976</b> paid media reach to AAPI & Black/African American audiences	<b>1,930,507</b> paid media reach to LMI counties	<b>1,620,978</b> eblasts to AAPI & Black/African American audiences	<b>27,800</b> total toolkit materials distributed to LMI counties
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[CHECK IN](#)

[LEARN MORE](#)

[GET SUPPORT](#)





## How Californians took action

131,486

sessions on the  
*Take Action* website  
over 27X month over month

99,527

views of the Mental  
Health Matters  
Month landing page

13,514

resources were  
downloaded  
over 9X month over month

59,474

engagements on  
influencer posts

10,521

IG live views

5X

social engagement  
month over month

CHECK IN

LEARN MORE

GET SUPPORT



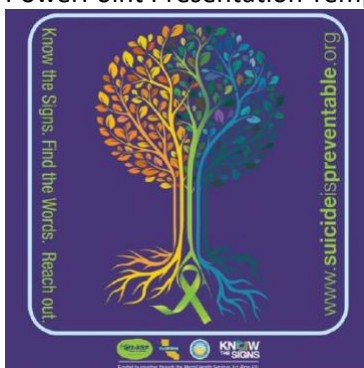
7





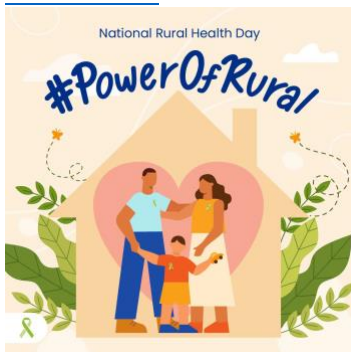
*Suicide Prevention Activation Kit – September 2022: Take Action for Suicide Prevention: Thriving at all Ages*

- Talking Points and Data Briefing 2022, SPW Overview and Activity Guide, Activity Challenge Tip Sheet, Video Conferencing Backgrounds, Poster, Banner, Proclamation, Daily Emails, PSA Scripts, Social Media Written Post Guides & Posts, Drop-in Articles, Older Adult Suicide Prevention 101 PowerPoint Presentation Template, Older Adult Billboard and Brochure



*National Rural Health Day “#PowerofRural”*

- Social Media Files and Drop-in Article
- [Link to Items](#)



*Winter Wellness Digital Toolkit*

- Eblasts, Resource Cards, and Social Media Files for December 2022 and January 2023
- [Link to Items](#)

CHECK IN

LEARN MORE

GET SUPPORT





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](https://www.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](https://www.CalHOPEConnect.org).**

*Student Athlete Suicide Prevention Digital Toolkit*

- Tip Sheet for Parents, Social Media Files, Roadmap for Student Athletes, Roadmap for Coaches, Roadmap for School Administrators, Pocket Card, Poster, Flyer
- [Link to Items](#)

**How to Take Action for Suicide Prevention**

**If you, or someone you know, are experiencing or talking about:**

- Wanting to stop living
- Not seeing reasons to live
- Feelings of guilt, shame, or being a burden to others
- Having a sense of emptiness, hopelessness, or being trapped
- Periods of extreme sadness, anxiety, agitation, or rage
- Unbearable emotional or physical pain

Call or text **988**, or chat at **988Lifeline.org** to connect to help 24/7

CHECK IN

LEARN MORE

GET SUPPORT





### *Directing Change Hope & Justice*

- Directing Change Hope & Justice Held Seven Monthly Topics range over the following throughout the year:
  - September 2022: “Find Your Anchor”
    - Total entries: 148 (Hope: 33, Justice: 11, Monthly Prompt: 104)
  - October 2022: “What is Your Word?”
    - Total entries: 90 (Hope: 20, Justice: 5, Monthly Prompt: 60)
  - November 2022: “Mental Health Heroes”
    - Total Entries: 73 (Hope: 16, Justice: 2, Monthly Prompt: 55)
  - December 2022 and January 2023: “What are your hopes for 2023?”
    - Total entries: 41 (Hope: 12, Justice: 3, Monthly Prompt: 26)
  - February 2023: “More Than One”
    - Total entries: 89 (Hope: 15, Justice: 3, Monthly Prompt: 58, RUHS Substance Use: 13)
  - April 2023: “Celebrate Earth Day”
    - Total entries: 45 (Hope: 8, Justice: 1, Monthly Prompt: 36)
  - May 2023: “Take Action for Mental Health”
    - Total entries: 63 (Hope: 2, Justice: 1, Monthly Prompt: 60)

### *Suicide Prevention Technical Assistance Team*

The Suicide Prevention TA Team held two statewide webinars:

- “Reclaiming 2SQT+ (Two-spirit, Queer and Trans) Youth Thriving: An Intersectional, Anti-racist and Radical Love Approach to Suicide Prevention”
  - Total number of participants: 292
  - Total counties represented: 35
- “Understanding the Complexity of Prolonged Stress and Addressing the Impacts on Parental and Child Wellbeing”
  - Total number of participants: 131
  - Total counties represented: 21

The Suicide Prevention TA Team met with Sonoma County through FY 22-23 about the following:

- *The YSM TA Team coordinated the delivery of Know the Signs bilingual pens to staff at Sonoma County. (YSM, 10.28.22)*



**Sonoma County Department of Health Services  
Behavioral Health Division  
Cultural Competency Plan 2023**

Send Word and PDF to [MCBHD-CCPR@dhcs.ca.gov](mailto:MCBHD-CCPR@dhcs.ca.gov) by December 31, 2023.

**Name of County:** Sonoma County

**Name of County Mental Health Director:** Jan Cobaleda-Kegler, Psy.D.

**Name of Contact:** Lisa Nosal, LMFT

**Contact's Title:** Cultural Responsiveness, Inclusion & Training Coordinator

**Contact's Unit/Division:** Department of Health Services, Behavioral Health Division

**Contact's Phone Number:** (707) 565-1293

**Contact's Email:** [lisa.nosal@sonoma-county.org](mailto:lisa.nosal@sonoma-county.org)

CHECKLIST OF THE 2010 CULTURAL COMPETENCY PLAN REQUIREMENTS  
CRITERIA

- ✓ [CRITERION 1:](#) COMMITMENT TO CULTURAL COMPETENCE
- ✓ [CRITERION 2:](#) UPDATED ASSESSMENT OF SERVICE NEEDS
- ✓ [CRITERION 3:](#) STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC MENTAL HEALTH DISPARITIES
- ✓ [CRITERION 4:](#) CLIENT/FAMILY MEMBER/COMMUNITY COMMITTEE: INTEGRATION OF THE COMMITTEE WITHIN THE COUNTY MENTAL HEALTH SYSTEM
- ✓ [CRITERION 5:](#) CULTURALLY COMPETENT TRAINING ACTIVITIES
- ✓ [CRITERION 6:](#) COUNTY'S COMMITMENT TO GROWING A MULTICULTURAL WORKFORCE: HIRING AND RETAINING CULTURALLY AND LINGUISTICALLY COMPETENT STAFF
- ✓ [CRITERION 7:](#) LANGUAGE CAPACITY
- ✓ [CRITERION 8:](#) ADAPTATION OF SERVICES

## Criterion 1: Commitment to Cultural Competence

Sonoma County's Department of Health Services, Behavioral Health Division (DHS- BHD), is committed to meeting the cultural and linguistic needs of our community, for individuals from all racial, ethnic, cultural, and linguistic backgrounds, not just to attain individual health outcomes but also to ensure health equity for the thousands of community members seeking services. This endeavor is reflected in our mission, philosophy, policies, and procedures throughout our mental health system.

Most importantly, DHS-BHD develops data-informed strategic plans based on community engagement and client utilization. The identification of behavioral health disparities, vulnerable populations, emerging trends, and barriers to services is an ongoing quality improvement plan that involves a complex process of examining systemwide data, seeking consumer satisfaction and feedback, assuring regulatory compliance, and balancing budgets.

Holding true to Mental Health Services Act (MHSA) values, our system is driven by clients and family members, focused on wellness and resilience, and philosophically aligned with the belief that recovery is possible. Providing culturally responsive and linguistically appropriate services is central to these values.

### I. County Mental Health System commitment to cultural competence. The county shall have the following available on site during the compliance review

A. Copies of the following documents are available to ensure the commitment to cultural and linguistic competence services are reflected throughout the entire system:

1. [Mission Statement](#);
2. [Statements of Philosophy](#);
3. [Strategic Plans](#);
4. [Policies and Procedure Manuals](#);
5. [Other Key Documents](#) (Public reports, such as the Annual Quality Improvement Work Plans and corresponding Evaluations by fiscal year);

### II. County recognition, value, and inclusion of racial, ethnic, cultural, and linguistic diversity within the system

A. Provide a copy of the county's CSS plan that describes practices and activities that demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, linguistic, and other relevant small county cultural communities with mental health disparities.

MHSA has provided Sonoma County the opportunity to enhance new partnerships and to strengthen continuing partnerships with community-based organizations. Sonoma County continues to expand the inclusion of consumers, family members, and unserved and underserved populations in the planning and implementation of mental health activities, programs, and services. Consequently, Sonoma County residents now have a more accessible, integrated, comprehensive, and compassionate mental health system of care. At the foundation for the development of this system of care, Sonoma County continues to be driven by the following MHSA Guiding Principles:



- **Community collaboration:** Individuals, families, agencies, and businesses work together to accomplish a shared vision.
- **Cultural responsiveness:** Adopting behaviors, attitudes, and policies that enable providers to work effectively in cross-cultural situations.
- **Client and family driven system of care:** Adult clients and families of children and youth identify needs and preferences that result in the most effective services and supports.
- **Focus on wellness, including recovery and resilience:** People diagnosed with a mental illness are able to live, work, learn, and participate fully in their communities.
- **Integrated service experiences:** Services for clients and families are seamless; clients and families do not have to negotiate with multiple agencies and funding sources to meet their needs.

DHS-BHD has established a system and structure for a community-engaged planning process as a basis for developing the Three-Year Program and Expenditure Plans and inclusive actions taken under MHSA governance. This structure is anchored with an MHSA Steering Committee and includes the Cultural Responsiveness Committee, the Community Program Planning (CPP) Process Workgroup, and the Mental Health Board. Furthermore, additional outreach and engagement is made through related but independent community committees and advisory councils, such as First 5 Sonoma County and Health Action Sonoma County. The California Code of Regulations, Title 9, states that counties must ensure that stakeholders reflecting the diversity of the demographics of the county, including but not limited to geographic location, age, gender, and race/ethnicity, have the opportunity to participate in the CPP process (CCR § 3300).

The commitment to an open and inclusive process is seeded throughout the MHSA committees that are convened by Sonoma County DHS-BHD. The following guiding principles are adhered to in membership and practice:

- Inclusive and representative
- Transparent and easy for all participants to understand
- Collaborative and in partnership with consumers, families, and the community
- Broad participation from diverse groups throughout Sonoma County within a safe space for expression of diverse perspectives
- Culturally responsive

The most recent draft of the [Sonoma County MHSA Program and Expenditure Plan Update FY 2023-2026 with FY 2020-21 Annual Report](#) contains the CSS Program Plan and Community Program Planning Process (CPPP) to date.

B. [A one-page description addressing the county’s current involvement efforts and level of inclusion with the above identified underserved communities on the advisory committee.](#)

As noted in the section preceding, DHS-BHD works with stakeholders through established MHSA Steering Committee, Cultural Responsiveness Committee, and the Community Program Planning Workgroup. In addition, DHS-BHD has had various ad hoc interactions with the peer community, community at-large, industry groups such as Health Action Sonoma, law enforcement, First 5, and other coalitions throughout the year. DHS-BHD has consciously

monitored the representation of committee stake holders against the county’s demographic make-up. The following chart provides an overview of stakeholder engagement opportunities that have been instituted into regular practice.

<b>Committee/Board</b>	<b>Open, appointed or elected</b>	<b>Composition of members</b>	<b>Number of seats</b>	<b>Meeting Frequency</b>
MHSA Stakeholders	Open to the public	Consumers and family members 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.	Undefined	Bi-annually
MHSA Steering Committee	Application and selection process managed by the MHSA Coordinator and Department of Health Services, Behavioral Health Division administration	Members represent the following: <ul style="list-style-type: none"> <li>· Clients</li> <li>· Families of clients</li> <li>· Providers of mental health, substance use, and social services</li> <li>· Persons with disabilities</li> <li>· Education field</li> <li>· Health care</li> <li>· Law enforcement</li> <li>· Veterans and/or representatives</li> <li>· College-age youth</li> <li>· Other advocates</li> <li>· Individuals from diverse cultural and ethnic groups</li> </ul>	20-25 seats	Quarterly
Community Program Planning Workgroup	Combination of voluntary and appointed	MHSA Steering Committee members, Stakeholders	4-8 members	Monthly or as determined by members
Equity Steering Committee	Appointed	Sonoma County Behavioral Health Division employees, and a Department of Health Services equity liaison, who have extensive foundational training in anti-racism and equity through the Sonoma County and Department of Health Services offices of equity	7 members	Monthly or as determined by members
Cultural Responsiveness Committee (on hold, restarting soon)	Combination of voluntary and appointed	Contractors, Mental Health Board, Individuals and/or family members of individuals with lived experience, Equity Steering Committee members, MHSA Steering Committee members, Stakeholders, BHD staff	Up to 12 members	Bi-annual or as determined by members
Life Worth Living Coalition (Suicide Prevention)	Combination of voluntary and appointed	Contractors, individuals and/or family members with lived experience, BHD staff, law enforcement, educational organizations,	Currently 18 members	Monthly or as determined by members

		public health, and members of other organizations and fields as needed		
Peer Advisory Council	Voluntary	Individuals with lived experience; BHD director; BHD Cultural Responsiveness, Inclusion & Training Coordinator	Currently 10 members	Monthly or as determined by members
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 5:00 p.m. Check <a href="#">calendar</a> .
Board of Supervisors	Elected		5 district representatives	Weekly on Tuesday at 8:30 a.m.

C. Share lessons learned on efforts made on the items A and B above and any identified county technical assistance needs. Information on the county’s current MHSA Annual Plan may be included to respond to this requirement.

**Description of the Stakeholder Community Planning Process (CPP)**

The Sonoma County 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 to 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.

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 cofacilitators to design and implement an inquiry within their own communities. 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. Listening sessions were then conducted over a three-month period and all participants were provided with a stipend for their attendance.

The qualitative data was 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.

### **Innovation Projects Focused on Underserved Populations**

Several innovation projects funded through MHSA in Sonoma County have a specific focus on engagement with underserved populations.

Organization/Project Name	Focus and Funding
On the Move/Nuestra Cultura Cura Social Innovation	Community defined practices for mental health in the Latino/x community A total of \$736,584 MHPA funding is being allocated for the 3-year Innovation project.
Early Learning Institute/Instructions Not Included, Dads Matter	Screening and supporting new parents, inclusive of non-birth parent (fathers and partners). A total of \$689,860 MHPA funding is being allocated for the 3-year Innovation project.
Crossroads to Hope	Expanding access to community mental health, substance use disorder, and trauma treatment as an alternative to incarceration, by developing facility space for both housing and service delivery to individuals who are being diverted to the community from the County jail. A total of \$560,379 is allocated for three fiscal years.
Sonoma County Human Services Department/ Collaborative Care Enhanced Recovery Project (CCERP)	Case management for older adults 50+ years with an emphasis on Spanish speaking population. A total of \$998,558 MHPA funding is being allocated for the 3- year Innovation project.
First 5 Sonoma County/ New Parent TLC	Training gatekeepers to refer new parents, with a specific focus on LGBTQ+ parents and Spanish language. A total of \$394,586 MHPA funding is being allocated for the 3-year Innovation project.

**Peer Advisory Council**

Our Peer Advisory Council is a new committee, which has met for about six months and is still in planning stages for its structure and goals. Designed to increase peer access to the Behavioral Health Director, the committee is facilitated by the Cultural Responsiveness, Inclusion & Training Coordinator. We are “moving at the speed of trust,” working to repair and rebuild institutional relationships that have been strained in the past, and we are incorporating values of participatory decision-making to move against typical hierarchical structures that can impede relationships. We are currently working to define mission, membership, authority, and scope, recognizing that the voices of people with lived experience should be central in our planning of behavioral health treatment services.

**III. Each county has a designated Cultural Competence/Ethnic Services Manager (CC/ESM) person responsible for cultural competence**

Sonoma County’s title for this position is Cultural Responsiveness, Inclusion, and Training Coordinator. This position reports to and has direct access to the Behavioral Health Director regarding issues related to the racial, ethnic, cultural, and linguistic populations within the county and the DHS-BHD workforce.

A. Detail who is designated the county’s CC/ESM responsible for cultural competence and who promotes the development of appropriate mental health services that will meet the diverse needs of the county’s racial, ethnic, cultural, and linguistic populations.

The Cultural Responsiveness, Inclusion, and Training Coordinator position is held by Lisa Nosal, LMFT. She is responsible for ensuring behavioral health services are provided in a culturally appropriate and responsive manner to the diversity of our clientele. This involves participation in several cross-cutting areas in DHS-BHD. That includes:

- Policy Development: ensuring division policies are nondiscriminatory and inclusive.
- Workforce, Education, and Training: developing a workforce pipeline to diversify the incoming behavioral health workforce that includes participation in the development of strategies related to recruitment, hiring, on-boarding, training, support, and retention practices and ensuring the current DHS-BHD 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, administrative, and other staff performance.
- Participation in the Sonoma County Department of Health Services Equity Circle.

Sonoma County DHS-BHD uses the California Behavioral Health Directors Association (CBHDA) April 2016 *Framework for Advancing Cultural, Linguistic, Racial & Ethnic Behavioral Health Equity in County and Local Behavioral Health Services* as the basis for the implementation of CC-ESM responsibilities.

In addition, the Behavioral Health Division identified priority areas for FY 21-22 that will drive the cultural competency goals for the remainder of the fiscal year and into the next.

FY 22-23 Goals	Details	Activities
I. Restart the Cultural Responsiveness Committee (CRC)	The monthly CRC meetings were suspended pending new leadership, the hire of the CRIT Coordinator, and the establishment and training of the DHS Equity Circle.	The BHD Equity Steering Committee will serve as the advisory board for the re-establishment of the Cultural Responsiveness Committee, connecting it to existing systems in at the Department and County levels.
II. Implement a Trauma-Informed Systems division transformation project	A trauma-informed system requires a foundation in cultural humility and equity. By creating structures that emphasize equity, resiliency, collaboration, safety, empowerment, and an understanding of the effects of trauma and stress, BHD will create better conditions for fostering diversity, equity, inclusion, and belonging for both staff and clients.	Working with Trauma Transformed, a Bay Area clearinghouse that promotes and trains trauma-informed systems, BHD is providing staff training, leadership learning, organizational assessment, and transformation of policies, practices, and protocols.
III. Oversee a staff training program to reduce racial, ethnic, cultural and linguistic mental health disparities and on the topics identified in the last staff Cultural Competence survey. Implement annual minimum standard for mandatory cultural competency training for all Division staff.	12 hours of all-staff training in FY2023-2024 will be devoted explicitly to cultural responsiveness and cultural humility trainings, and 30 additional hours of training have major components focusing on cultural responsiveness and equity. Additionally, Quality Management and Leadership staff for both BHD and contracted providers will receive six hours of training in Anti-Racist Results-Based Accountability.	All-staff training explicitly focused on cultural responsiveness will include: <ul style="list-style-type: none"> <li>• Cultural Humility</li> <li>• Anti-Racism</li> <li>• Gender-Inclusive Language &amp; Treatment</li> </ul> All-staff training with major components of cultural responsiveness include: <ul style="list-style-type: none"> <li>• Harm Reduction (multiple trainings)</li> <li>• Trauma Informed Systems</li> </ul>

<p>IV. Institute strategies to diversify and support a diverse behavioral health workforce at all levels of DHS-BHD.</p>	<p>Conduct pipeline activities to both encourage behavioral health career pathways and to support promotional opportunities.</p> <p>Implement recruitment, hiring, development, support, and retention strategies that support workforce diversification.</p>	<p>Work with local universities to create a formal pipeline program.</p> <p>Using Trauma Transformed principles and systems and additional training from The Management Center and other equity-forward organization, increase management and supervisory capacity for supporting a diverse workforce.</p> <p>As part of both BHD leadership and the DHS Equity Circle, work with both groups to create an inaugural Health Equity Plan for the department to guide and support ongoing work for diversity, equity, inclusion, and belonging for both staff and clients.</p>
<p>V. Implement strategies to support increasing services to the Latinx/Latine community</p>	<p>Work with the Quality Improvement Manager to increase Latinx/Latine access to specialty mental health services. Identify supports to improve services from a cultural perspective and experience.</p>	<p>Participate on QI Performance Improvement Project workgroup</p> <p>Identify resources and supports for Latinx/Latine beneficiaries and their families that support treatment and recovery.</p> <p>Attend regional and statewide CC/ESM meetings for TA exchange on strategies and best practices.</p>



VI. Responsible for development and implementation of Cultural Competency Plan (CCP) for DHS-BHD	Review and develop the planning, policy, compliance, and evaluation of system and services to affect change and improvement to equity measures.	Attend Quality Improvement Committee (QIC), and MHSA Steering Committee to assist in development of a culturally responsive division and recommend actions for policy and practice adaptations.  Work with DHS Office of Equity to develop Health Equity Steering Plan for the department.
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#### IV. Identify budget resources targeted for culturally competent activities

A. Evidence of a budget dedicated to cultural competence activities which may include, but not be limited to the following:

1. Budget amount allocated for Interpreter and translation services

Currently, Sonoma County BHD has \$166,192 budgeted for interpreter and translation services through Language Link (spoken language) and Communique (American Sign Language).

2. Reduction of racial, ethnic, cultural, and linguistic mental health disparities

Allocations in the FY 2023-24 budget for the Sonoma County Behavioral Health Division, to reduce disparities and increase equity system-wide.

Budget Allocation Description	FY 23-24
Cultural Responsiveness, Inclusion & Training Coordinator (1 FTE)	\$251,500
Support staff (0.5 FTE)	\$16,908
West County Community Services – Peer Education and Training	\$147,926
DHS-BHD Workforce Education & Training Activities	\$400,000

3. Budget amount allocated towards outreach, community engagement and prevention to racial and ethnic county-identified target populations

Priority Population	Organization(s)	FY 23-24
Latinos/x	Latino Service Providers, La Luz	\$148,739
Latinos/x	Innovation: New Parent TLC/Unidos	\$537,192
Native Americans	Sonoma County Indian Health Project	\$42,443
Black/African Americans	Community Baptist Church Collaborative	\$127,327

4. Budget for culturally appropriate mental health clinical services

Priority Population	Organization(s)	FY 23-24
Latinos/x	On the Move	\$233,154
Latinos/x	Buckelew and UC Davis, Early Psychosis Learning Healthcare Collaborative Network/ TAY Spanish Speaking Community	\$129,699
Latinos/x	La Luz	\$50,402
Native Americans	Sonoma County Indian Health Project	\$85,988

5. If applicable, financial incentives for culturally and linguistically competent providers, non-traditional providers, and/or natural healers.

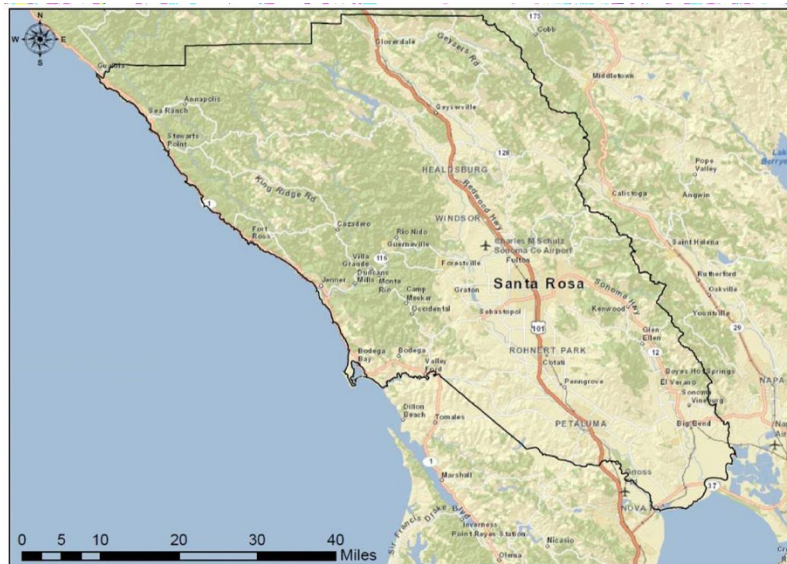
The County of Sonoma has personnel policies that provide for a differential pay increase above the employee's base hourly rate if the position requires at least 10% of the employee's work time to be used in a bilingual English/Spanish capacity. This differential was recently split into two levels, with additional pay added for employees who tested as "fluent" in Spanish. The current policy states that the employee shall be entitled to an additional \$1.15 per hour for basic bilingual skills and an additional \$1.50 per hour for fluent bilingual skills.

## Criterion 2: Updated Assessment of Service Needs

A population assessment is necessary to identify the cultural and linguistic needs of the County and to determine/confirm emerging population(s) of need. This assessment is also critical in designing and planning for the provision of culturally responsive and effective mental health services.

### I. General Population

- A. Provide a description of the county's general population by race, ethnicity, age, gender, and other relevant small county cultural populations. The summary may be a narrative or as a display of data (other social/cultural groups may be addressed as data is available and collected locally). If appropriate, the county may use MHSA Annual Update Plan data here to respond to this requirement.



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.<sup>1</sup> 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. The County seat and DHS-BHD's main campus are 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).<sup>2</sup> 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.

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.<sup>3</sup> The

<sup>1</sup> U.S. Census Bureau. (2020). Quick Facts, Sonoma County, California.

<sup>2</sup> Ibid.

<sup>3</sup> USAFacts, Our Changing Population: Sonoma County, California, <https://usafacts.org/data/topics/peoplesociety/population-and-demographics/our-changing-population/state/california/county/sonoma-county>

County's poverty rates vary significantly by ethnicity with disparities affecting the Latinx/Latine community in particular. While Latinx/Latine residents were over a quarter of the population, this group accounted for 40% of Sonoma County's Medi-Cal beneficiaries in 2021.<sup>4</sup> Additionally, there are an estimated 27,000 undocumented residents in the County.<sup>5</sup> Of those, 12,000 or 44% are estimated to speak English less than "very well," suggesting possible linguistic isolation for this population.<sup>6</sup> 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 Lytton Band of Pomo Indians. Native Americans make up 0.7% of the County's total population<sup>7</sup> and about 1% of Medi-Cal beneficiaries. According to USAfacts, in 2021 the Asian population composed 4.4% of the total population and African American/Blacks were 1.7%. Cultural and language differences can reduce access as well as the quality of services available—particularly for individuals in small communities and 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 five to 19 year-old age group decreased the most, dropping from 19% to 14% (rate of 10.4% decline) between 2010 and 2021.<sup>8</sup> 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, 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.

While Sonoma County continues to recover from the COVID-19 pandemic and devastating fires and floods 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 that began in 2020, have transformed the lives of many Sonoma

<sup>4</sup> 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>

<sup>5</sup> Profile of the Unauthorized Population: Sonoma County, Migration Policy Institute. <https://www.migrationpolicy.org/data/unauthorized-immigrant-population/county/6097>

<sup>6</sup> Ibid, English Proficiency

<sup>7</sup> USAFacts, Our Changing Population: Sonoma County, California, <https://usafacts.org/data/topics/peoplesociety/population-and-demographics/our-changing-population/state/california/county/sonoma-county>

<sup>8</sup> Ibid.

County residents. Sonoma County experienced a net 3.3% decrease in population from 2017 to 2021.<sup>9</sup>

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 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 rise 13 feet above flood stage to 45.4 feet in Guerneville, 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 decreased, supply chain impaired, and workforce compromised. The estimated Gross Regional Product (GRP) lost \$6.157 billion from 2020 to 2023, and the estimated loss of employers by 2023 is 6.9%.<sup>10</sup> 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 nine 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.

COVID-19, the fires, and the flood have impacted Sonoma County economically and have also brought mental health impacts across the county. Forty percent 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.<sup>11</sup> 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

<sup>9</sup> Ibid.

<sup>10</sup> 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](https://sonomaedb.org/Microsites/Economic%20Development%20Board/Documents/Archive/_Documents/Reports/_2020/Economic-Impacts-from-COVID19-Sonoma-County-Report.pdf)

<sup>11</sup> Sonoma County Department of Health Services, Epidemiology and Assessment Unit. (2019)

several pandemic related consequences, such as closures of universities and 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, in which 71% reported “feeling anxious about their future” due to disruptions in their lives and cited it as 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% of families and 57% 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.<sup>12</sup>

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 LGBTQIA+ youth; almost 70% reported feeling so sad or hopeless almost every day that they stopped doing some usual activities, compared to just over 25% of straight youth (Kids Data, 2020).

## **II. Medi-Cal population service needs (Use current CALEQRO data if available.)**

A. Summarize the following two categories by race, ethnicity, language, age, gender, and other relevant small county cultural populations:

### **1. The county’s Medi-Cal population**

Over one fourth (130,665) of the population is eligible for Medi-Cal (DHCS, 2022), and 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:

<sup>12</sup> 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-SonomaCounty.pdf>

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 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%

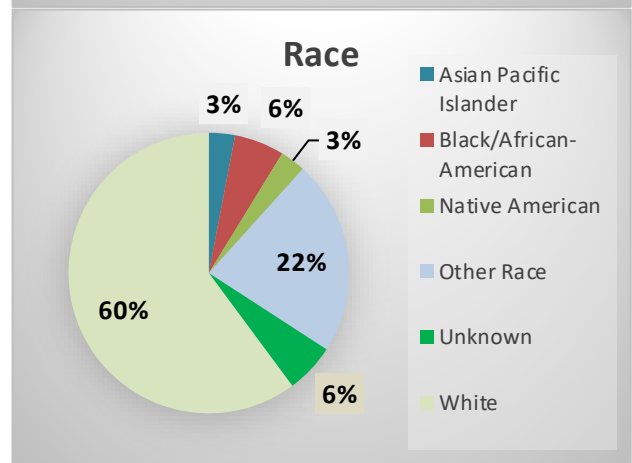
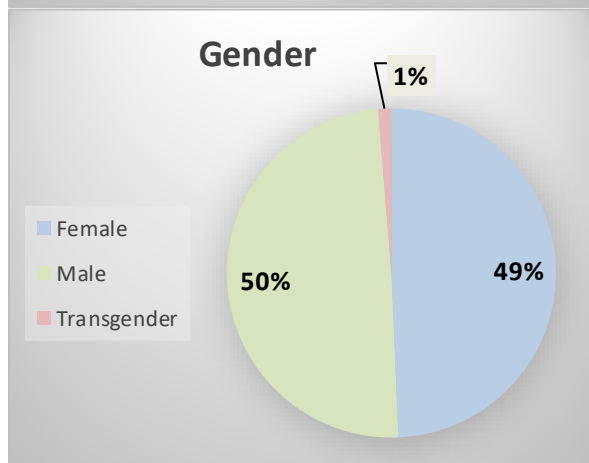
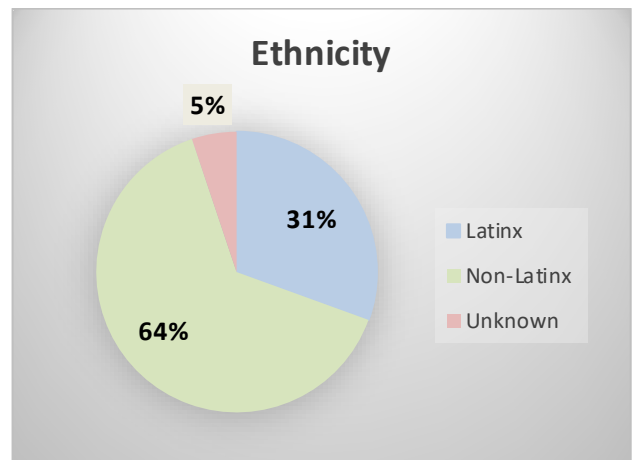
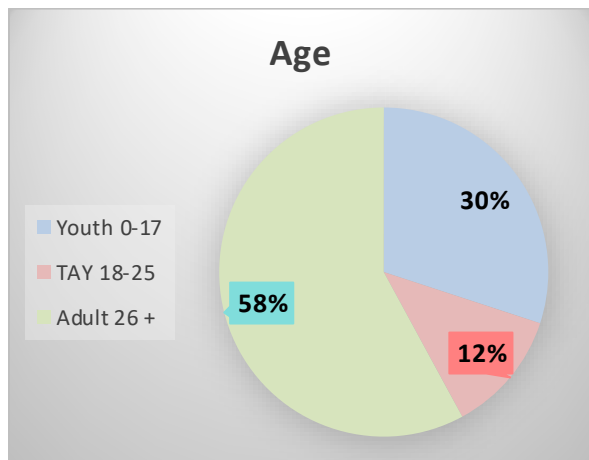
## 2. The county's client utilization data

Figures taken from Sonoma County's Annual Quality Assessment and Performance Improvement Work Plan Evaluation for Fiscal Year 2021-2022

### FY 21-22 DEMOGRAPHICS MHP BENEFICIARIES SERVED

AGE	UNIQUE BENEFICIARIES	PERCENT
Youth (0-17)	1,038	30.04%
TAY (18-25)	416	12.04%
Adult (26+)	2,001	57.92%
<b>RACE</b>		
Asian Pacific Islander	104	3.01%
Black/African American	199	5.76%
Native American	101	2.92%
Other Race	776	22.46%
Unknown	197	5.70%
White	2,078	60.14%
<b>ETHNICITY</b>		
Latinx	1,055	30.54%
Non-Latinx	2,222	64.31%
Unknown	178	5.15%

<b>GENDER</b>		
Female	1,704	49.29%
Male	1,705	49.35%
Transgender	46	1.30%
<b>GRAND TOTAL</b>	<b>3,455</b>	<b>100%</b>



B. Provide an analysis of disparities as identified in the above summary. This can be a

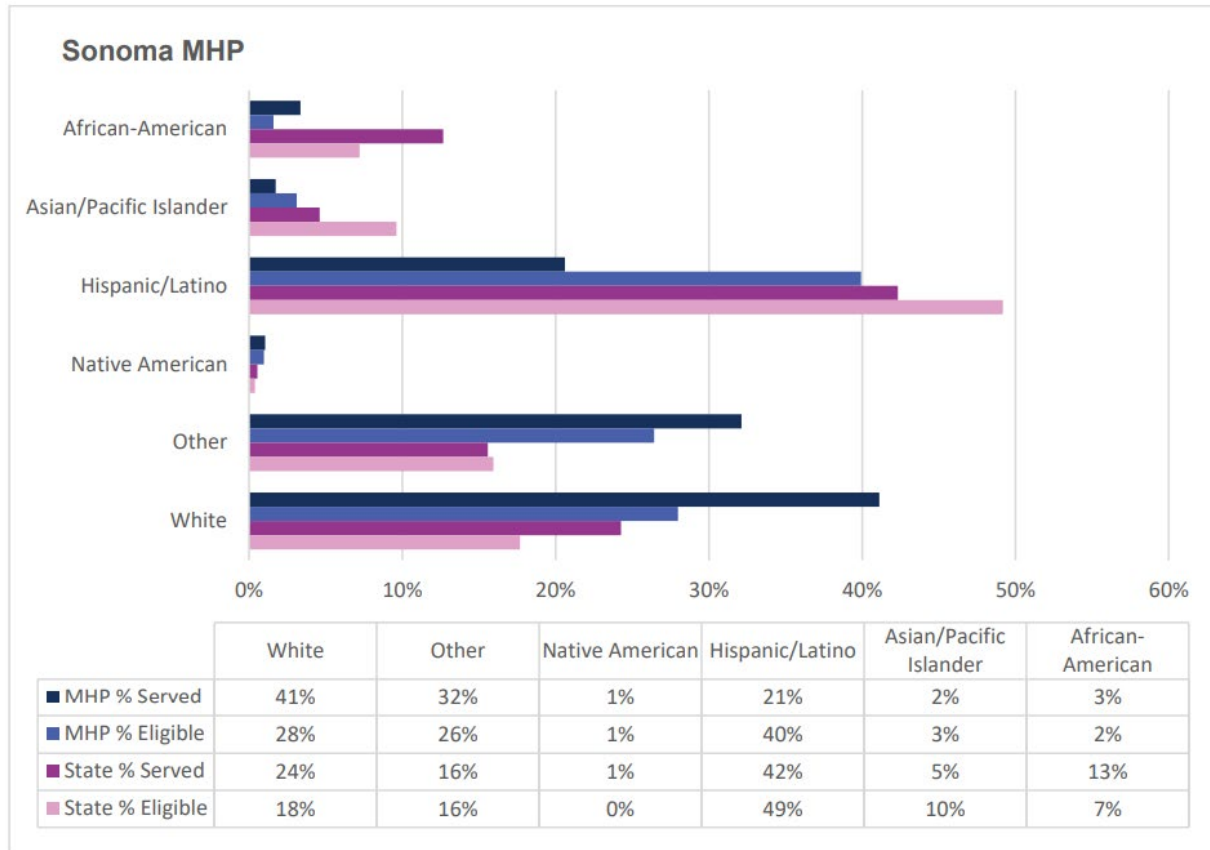


narrative discussion of the data. Data must support the analysis.

## Race/Ethnicity

From the Sonoma MHP EQRO Final Report for FY 2022-23:

**Figure 1: Race/Ethnicity for MHP Compared to State CY 2021**



**Table 5: Threshold Language of Medi-Cal Beneficiaries Served in CY 2021**

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percentage of Medi-Cal Beneficiaries Served by the MHP
Spanish	400	12.40%

Threshold language source: Open Data per BHIN 20-070

The EQRO report stated, “Similar to the pattern seen statewide, White beneficiaries are disproportionately overrepresented among beneficiaries served relative to the Medical eligible population, whereas Hispanic/Latino beneficiaries are underrepresented.” Of note, Sonoma County’s recent data analysis shows a much smaller percentage of clients with “Other” racial identity than the EQRO report (22% vs. 32%), with only 5.15% falling into the “unknown” category of Latinx versus non-Latinx. Sonoma County’s Quality Improvement team undertook a project to investigate the medical records of clients whose ethnicity was listed as “Other” or “Unknown” to determine if incomplete data entry had obscured the client’s race or ethnicity in the medical record (e.g., clients who were first admitted to Crisis Stabilization during an acute psychiatric emergency and thus could not provide reliable demographic data), and to correct those charts when that had happened.

Using Sonoma County’s most recent numbers, we see that the percentage of Latinx/Latine beneficiaries served is 30.54% for fiscal year 2021-2022. As the percentage of Latinx/Latine Medi-Cal eligible population in Sonoma County is 40%, Sonoma County has improved but still falls below where we should be. Similarly, the percentage of clients served in Spanish (12.4%) falls greatly below the percentage of Medi-Cal beneficiaries whose primary language is Spanish (33.3%). (The data clean-up seems to have removed the gap for Asian/Pacific Islander beneficiaries, and other identified racial categories are proportionate in service percentage and population percentage.)

While this closing gap shows promise for Sonoma County BHD intervention efforts, more work is needed and has been prioritized to achieve health equity for Sonoma County’s Latinx/Latine population.

**Age**

From the Sonoma MHP EQRO Final Report for Fiscal Year 2022-2023:

**Table 4: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Age, CY 2021**

Age Groups	Annual Eligibles	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	13,072	78	0.60%	1.08%	1.96%
Ages 6-17	31,269	894	2.86%	4.41%	5.93%
Ages 18-20	7,025	212	3.02%	3.73%	4.41%
Ages 21-64	66,838	1,833	2.74%	4.11%	4.56%
Ages 65+	11,561	210	1.82%	2.26%	1.95%
<b>Total</b>	129,764	3,227	2.49%	3.67%	4.34%

While Sonoma County shows a lower penetration rate in all categories than both similar sized counties and the statewide average, the difference is fairly uniform across all age categories. The outlier for underserved populations is the 0-5 age range. This gap points to a need to continue strengthening our relationships with prenatal and perinatal healthcare providers and supports.

Interestingly, the smallest gaps are in the Ages 18-20 and Ages 65+ populations, two populations that tend to be at high risk for mental health concerns and behaviors. This points to strengths in coalition-building with community partners and in service delivery that we can continue to build on.

**III. 200% of Poverty (minus Medi-Cal) population and service needs**

- A. Summarize the 200% of poverty (minus Medi-Cal population) and client utilization data by race, ethnicity, language, age, gender, and other relevant small county cultural populations.

The following tables are made available by the CA Department of Health Care Services. These tables demonstrate mental health and alcohol and other drug prevalence estimates.

These tables are available to all California counties. To review the complete report, follow the following link:

<https://www.dhcs.ca.gov/provgovpart/Documents/CaliforniaPrevalenceEstimates.pdf>

Estimates of Need for Mental Health Services for Sonoma County – SMI Definition Children and Youth in Households below 200% poverty				Estimates of Need for Mental Health Services for Sonoma County – SMI Definition Adults in Households below 200% poverty			
Total Pop	Cases	Pop	Percent	Total Pop	Cases	Pop	Percent
Total Population	8,858	105,332	8.41	Total Population	8,858	105,332	8.41
Youth Total	2,553	29,326	8.7	Adult Total	6,305	76,006	8.71
<b>AGE</b>				<b>AGE</b>			
00-05	982	11,292	8.7	18-20	172	5,374	3.2
06-11	839	9,625	8.71	21-24	646	9,005	7.17
12-17	732	8,409	8.71	25-34	1,612	15,730	10.25
<b>GENDER</b>				35-44	1,437	11,862	12.12
Male	1,274	14,524	8.77	45-54	1,253	10,669	11.75
Female	1,279	14,902	8.64	55-64	707	9,261	7.63
<b>ETHNICITY</b>				65+	477	14,104	3.38
White - NH	748	8,570	8.73	<b>GENDER</b>			
African American - NH	63	702	9.04	Male	2,331	34,176	6.82
Asian - NH	92	1,073	8.6	Female	3,974	41,830	9.5
Pacific Islander - NH	6	69	8.83	<b>ETHNICITY</b>			
Native - NH	22	241	9.12	White - NH	3,869	42,589	9.08
Other - NH	0	0	0	African American - NH	140	1,446	9.66
Multi - NH	84	955	8.82	Asian - NH	100	2,850	3.49
Hispanic	1,537	17,716	8.68	Pacific Islander - NH	7	151	4.47
				Native - NH	89	766	11.64
				Other - NH	0	0	0
				Multi - NH	148	1,690	8.78
				Hispanic	1,952	26,515	7.36
				<b>MARITAL STATUS</b>			
				Married	1,575	26,175	6.02
				Sep/Wid/Div	2,594	24,469	10.6
				Single	2,153	25,362	8.42
				<b>EDUCATION</b>			
				Grades 00-11	2,154	26,976	7.98
				HS Graduate	3,541	40,124	8.82
				College Graduate	610	8,906	

B. Provide an analysis of disparities as identified in the above summary. This can be a narrative discussion of the data. Data must support the analysis.

According to the data cited above, non-Hispanic Native Americans, African Americans, and multi-racial populations are disproportionately represented in estimated need. This data is supported by Sonoma County’s capacity assessments and identification of priority populations.

**IV. MHSA Community Services and Supports (CSS) population assessment and service needs**

A. From the county’s approved CSS plan, extract a copy of the population assessment and summarize population and client utilization data by race, ethnicity, language, age, gender and other relevant small county cultural populations.

The utilization by Medi-Cal beneficiaries by age, race, ethnicity, and gender are below, and beneficiaries by geographical area follow.

<b>AGE</b>	<b>UNIQUE BENEFICIARIES</b>	<b>PERCENT</b>
<i>Youth (0-17)</i>	1,038	30.04%
<i>TAY (18-25)</i>	416	12.04%
<i>Adult (26+)</i>	2,001	57.92%
<b>RACE</b>		
<i>Asian Pacific Islander</i>	104	3.01%
<i>Black/African American</i>	199	5.76%
<i>Native American</i>	101	2.92%
<i>Other Race</i>	776	22.46%
<i>Unknown</i>	197	5.70%
<i>White</i>	2,078	60.14%
<b>ETHNICITY</b>		
<i>Latinx</i>	1,055	30.54%
<i>Non-Latinx</i>	2,222	64.31%
<i>Unknown</i>	178	5.15%
<b>GENDER</b>		
<i>Female</i>	1,704	49.29%
<i>Male</i>	1,705	49.35%
<i>Transgender</i>	46	1.30%
<b>GRAND TOTAL</b>	<b>3,455</b>	<b>100%</b>

# GEOGRAPHIC LOCATION OF MHP BENEFICIARIES SERVED

## North 7.04%

City	# of Clients
Cloverdale	71
Fulton	3
Geyserville	9
Healdsburg	58
Windsor	102

## Central 58.08%

City	# of Clients
Santa Rosa	2006

## East 4.63%

City	# of Clients
Glen Ellen	14
Kenwood	4
Sonoma	142

## Coastal 0.32%

City	# of Clients
Bodega Bay	5
Jenner	4
Sea Ranch	2

## West County 6.20%

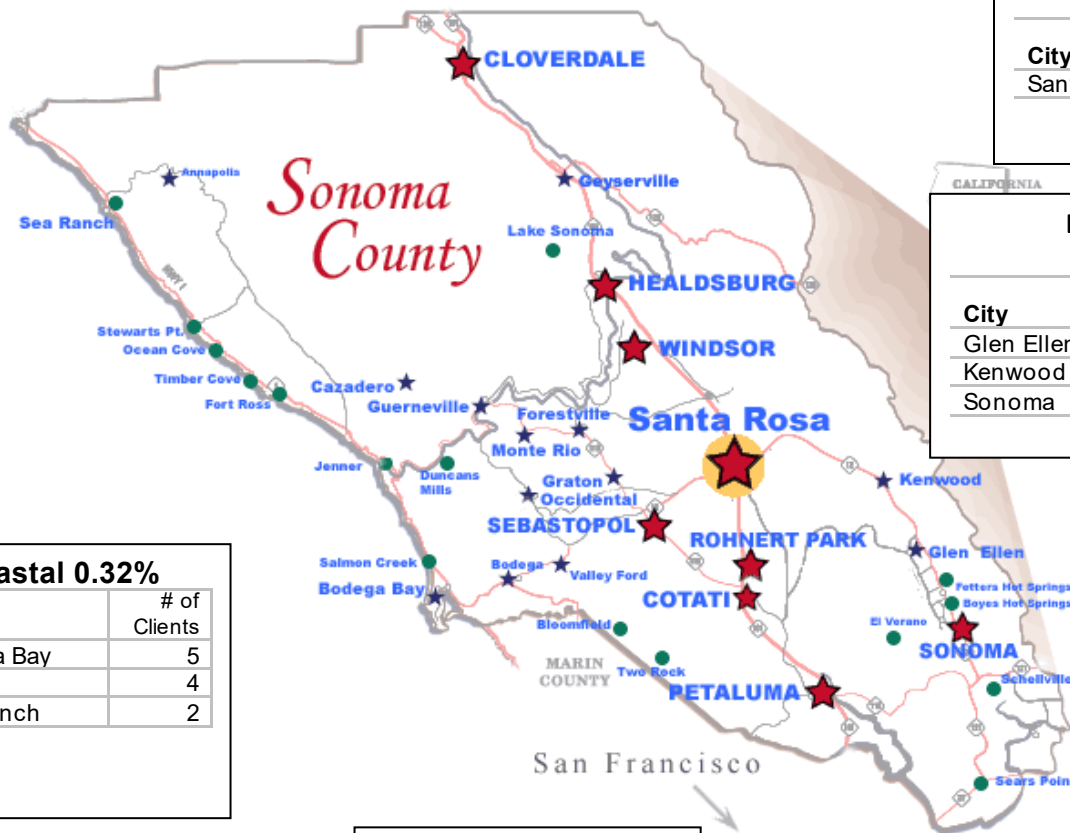
City	# of Clients
Camp Meeker	1
Cazadero	2
Forestville	26
Graton	2
Guerneville	62
Monte Rio	8
Occidental	2
Rio Nido	3
Sebastopol	108

## South 16.21%

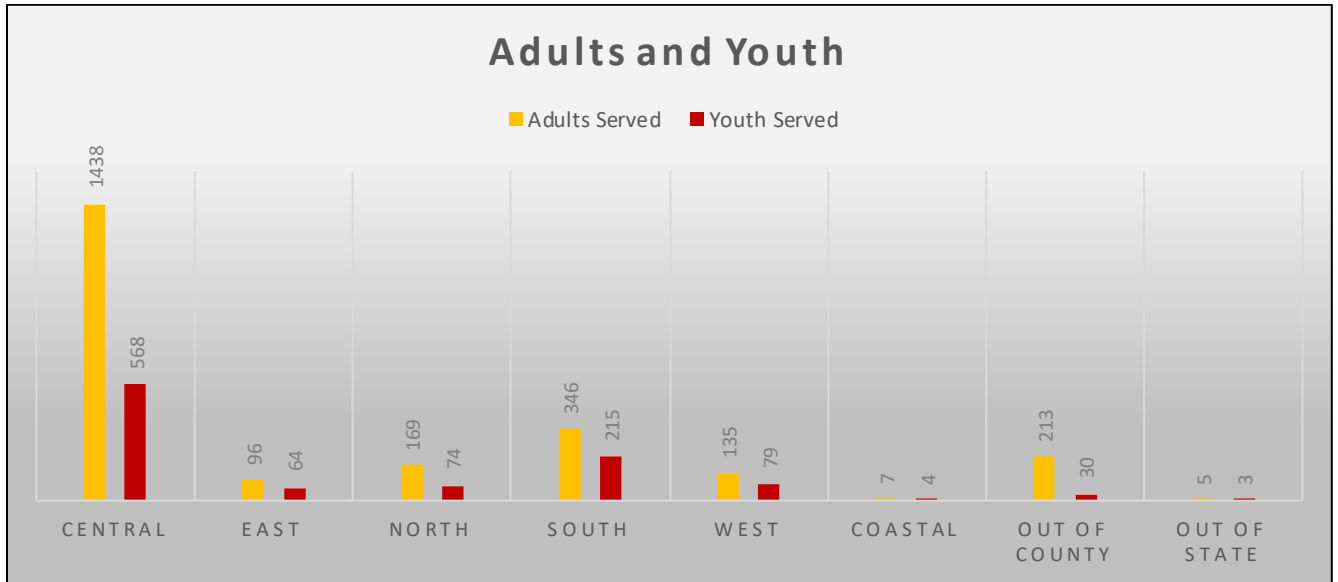
City	# of Clients
Cotati	52
Penngrove	18
Petaluma	244
Rohnert Park	247

## Out of County 7.27%

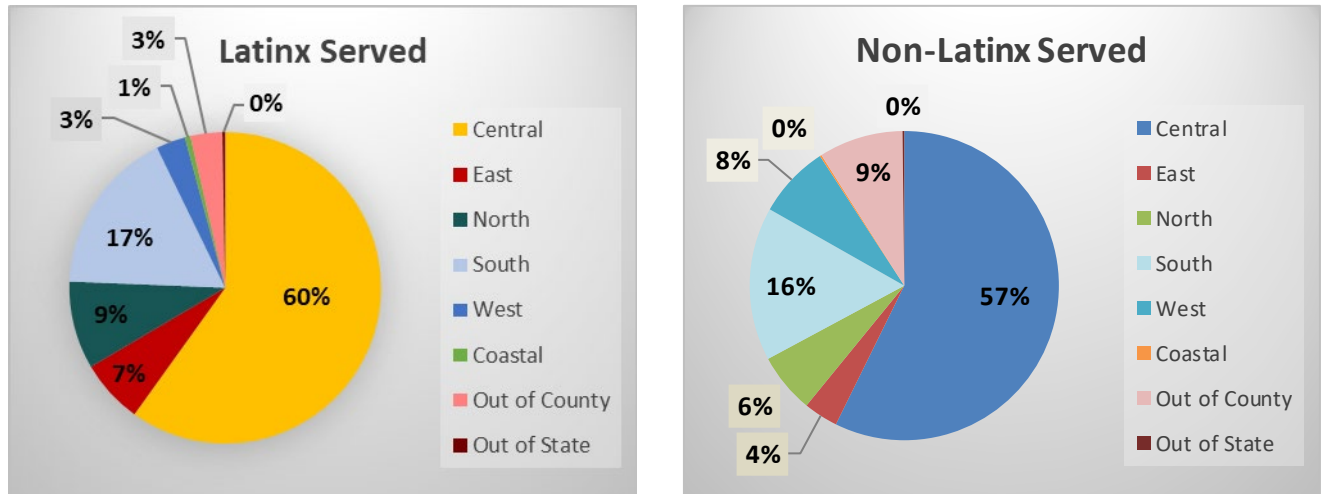
City	# of Clients
Out of County	243
Out of State	8



## AGE GROUP MHP BENEFICIARIES BY REGION OF RESIDENCE



## ETHNICITY OF MHP BENEFICIARIES BY REGION OF RESIDENCE



B. Provide an analysis of disparities as identified in the above summary. This can be a narrative discussion of the data. Data must support the analysis.

The ethnicity analysis of beneficiaries served revealed a growing trend seen in previous years. Latinx/Latine clients are significantly more likely to be served in the Youth System of Care—approximately 51% of the youth served in FY21-22 identified as Latinx, versus 22% for adults. Regarding this year’s growth in youth services, the majority of that growth (68%) was attributed to increases in Latinx/Latine youth served. In FY20-21, 417 Latinx/Latine youth were served, whereas a total of 525 Latinx/Latine youth were served in FY21-22. Finally, in terms of region of residence, Latinx/Latine beneficiaries are less likely to live in the West County area, and somewhat more likely to live in the East, North, and Central/Santa Rosa areas.

In every region of the county, the number of youth served increased. The total number of youth served (1,038) increased by 18% over last fiscal year, while the number of Transitional Age Youth (TAY) (416) decreased by 20%. Adults served (2,001) decreased by 4% in comparison to last year. A higher percentage of youth served resided in the southern part of Sonoma County. Twenty-one percent of youth (215) lived in South Sonoma County, versus 16% (66) for TAY and 14% (280) for adults. As consistent in previous years, adults were over three times more likely to be served out-of-county than youth.

The 2023 MHSA Capacity Assessment Report found that 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. 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, including 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, Latinx/Latine adult clients were underrepresented in the adult system, while Latinx/Latine 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.

## **V. Prevention and Early Intervention (PEI) Plan: The process used to identify the PEI priority populations**

A. Describe which PEI priority population(s) the county identified in their PEI plan and describe the process and rationale used by the county in selecting them. PEI Plan sections should be used to respond to priority populations identified by the county.

Most recently, the MHSA Work Plan Summaries for the Integrated Plan for PEI have prioritized the following populations:

- Latinx/Latine
- African Americans
- Native Americans
- LGBTQIA+ youth and Older Adults
- 0-5 year olds and their caregivers

These culturally underserved groups were identified and validated through a variety of data sources, including the 2019 Sonoma County Capacity Assessment and FY 2020- 23 MHSA Three-year Program and Expenditure Plan; 2018-2020 EQRO data reports; documented meetings with stakeholders, MHSA Steering Committee, Mental Health Board and Health Action Chapters.

## Criterion 3: Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities

### I. List the target populations with disparities your county identified in Medi-Cal and all MHSa components (CSS, WET, and PEI)

A. Briefly describe the process and rationale the county used to identify and target the population(s) (with disparities) in its PEI population.

The FY 2020-2023 MHSa Three-Year Planning Process and preceding Capacity Assessment validated the populations most at-risk and in need of PEI services:

- Native Americans
- Latinx/Latine
- African/Black Americans
- LGBTQIA+

### II. Then list disparities in each of the populations (Medi-Cal, CSS, WET, and PEI).

#### **Latinx Community (Medi-Cal, CSS, WET and PEI)**

The County has had a low Latinx/Latine penetration rate in clinical services for the past several years. The County is working toward increasing both access to mental health services for Latinx/Latine clients and improving the cultural responsiveness of services for Latinx/Latine clients.

While the County offers behavioral health services for the Latinx/Latine community, targeted opportunities were limited. Recent listening sessions, conducted as part of the MHSa Community Program Planning process, identified the following concerns from Sonoma County Latinx/Latine populations:

- Culturally aware and relevant services
- Access to services
- Increased mental health concerns
- Increased bullying of children and youth
- Multi-generational families and their needs
- Youth service needs, increased depression/anxiety/stress among youth
- Need for more sensitive providers
- Racism and discrimination
- Need for formal and informal (i.e., peer) support
- Housing and homelessness
- Cultural taboos and stigma
- Education about mental health
- Need for geographically diverse services
- Need for community connectedness
- Need for more school-based services
- Intergenerational trauma
- Migration-based trauma



### **Native American Communities (PEI, WET, Medi-Cal)**

The Native American population has access to the Sonoma County Indian Health Project (SCIHP), a Community Health Center that provides behavioral health, medical, dental, and other wellness related services predominantly to Native Americans in Sonoma. However, SCIHP is underutilized, likely due to mental illness stigma within the target population and limited culturally specific programs in remote geographic areas. As with the Latinx/Latine community, this could be leading Native American individuals with behavioral health needs to over rely on crisis services, as the majority of Native American consumers went to the CSU in fiscal years 2018-2019. As mentioned previously, Native American consumers were also overrepresented in locked long-term residential treatment. In fiscal year 2018-2019 they made up 7% of program episodes compared to only 2% of the MHSA population.

MHSA listening sessions with Indigenous groups in central Sonoma County and coastal Sonoma County are scheduled for fiscal year 2023-2024 to continue work on identifying and then addressing barriers and challenges, and building on community strengths.

### **LGBTQIA+ Youth and Young Adults (PEI, WET, CSS, Medi-Cal)**

A recent survey conducted by a local nonprofit, Positive Images focused on learning more from the community of LGBTQIA+ youth (14-18 years) and young adults (18-30 years). The sample of over 100 respondents reported that up to 24% were nonbinary or transgender. This population continues to report that they are challenged with finding both healthcare and mental health services that support them in their identity and in meeting their health needs. Sixty-eight percent of the respondents reported that they had utilized mental health services in the past year. Furthermore, this population reported that 79% had received a diagnosis of depression, 77% of anxiety, 41% of PTSD, and 26% of ADD/ADHD. The most striking finding was that 25% had called the suicide hotline at least once in their life, and 4% had called more than three times in their life.

Sonoma County's most recent Consumer Perception Survey noted that the number of other-gender respondents increased significantly and dramatically for youth. Approximately 25% of all youth surveys were completed by youth who identified as "other" gender, a 300% increase over the previous year. While the finding corresponds to Positive Image's survey results, the increase indicates that trans and gender-expansive behavioral health clients are either more comfortable disclosing their gender identity to their mental healthcare providers, or that more people from this community are seeking behavioral healthcare services with DHS-BHD.

A recent MHSA listening session for LGBTQIA+ people in Sonoma County identified the following concerns:

- Lack of culturally aware and relevant services, including fear of misgendering
- Need for both formal and informal (i.e., peer) support
- Need for community connectedness
- Need for increased and improved outreach and information
- Expanded mental health services
- Need for more sensitive, prepared providers
- Stigma and discrimination
- Increased stressors (natural disasters, national and local politics, Covid)
- Need for improved access to services beyond crisis services
- Housing and homelessness

- Physical activity and its relationship to mental wellbeing
- Depression and suicidal ideation

**III. Then list strategies for the Medi-Cal population as well as those strategies identified in the MHA plans (CSS, WET, and PEI) for reducing those disparities described above.**

**Latinx/Latine Community**

Latino Service Providers (LSP) was founded in 1989 by Latino leaders in education, government, and the social service sectors. LSP currently comprises over 1,600 members from neighborhood and community groups, mental health programs, public and private health service providers, education, law enforcement, immigration and naturalization agencies, social service agencies, community-based organizations, city and county governments, criminal justice systems, and the business community. The mission of LSP 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.

In 2021, PEI funds were opened to public bid to identify new approaches for prevention and early intervention for Latinx/Latine community members. Funding was shifted to support Youth Promotores who are bilingual and bi-cultural providing education and resources to both youth and adults in school and community settings. This model was initially funded and evaluated utilizing State MHA funding administered by the Office of Health Equity, California Department of Health Services. In addition, PEI funding was allocated to a Latinx/Latine-serving organization in Sonoma Valley, reaching a geographical population in the eastern region of the county that was previously underserved.

In the fall of 2019, the County started to collaborate on a new MHA Innovation Project, *Nuestra Cultura Cura: A community-based Social Innovations Lab*. The County has worked closely with local CBOs On the Move and La Plaza Latinx. This project specifically focuses on the unique cultural needs of the Latinx/Latine community surrounding mental health, as a means to raise awareness, reduce stigma, and increase access to mental health support.

La Plaza is set apart from traditional mental health programs by pairing clinical, therapy-based services with traditional mental health practices and cultural experiences that empower the Latinx/Latine community to recognize their own ability to heal. By providing a welcoming cultural approach, La Plaza creates a bridge for Latinx/Latine community members to access clinical services when needed. As a specific Innovations project, the *Nuestra Cultura Cura* Social Innovations Lab and its prototype strategies will create and promote a welcoming setting that will reduce mental health stigma, create appropriate, culturally based wellness activities, and provide a bridge to a variety of mental health resources. This Innovation Project was initiated in FY 2022-23.

**African-American/Black Community**

The Community Baptist Collaborative is focused on reducing mental health disparities in the African-American/Black population by increasing protective factors, building community, and decreasing mental health stigma. Projects include:

- Village Project: A weekly program for children ages 8-13 using a faith-based curriculum that focuses on character building.
- Saturday Academy: A weekly program that features topics of importance to youth of the

church and the community.

- Safe Harbor Project: Facilitated by African American peers that represent an at-risk population to assist people in dealing with “life-disrupting” events, and to provide education, support, and referral using music therapy, gardening, etc.

### **Native American Community**

The Aunties and Uncles Project through Sonoma County Indian Health Project reduces mental health disparities in the local Native American communities by increasing access to mental health services through:

- Reducing mental health stigma and decreasing suicide through a “Community Defined Evidence Practice” of Culture as Prevention
- Providing community wellness gatherings (e.g. Gathering of Native Americans, GONA) to reinforce culture and intergenerational relationships as a protective factor
- Provide youth support and cultural and leadership education

The Aunties and Uncles Program receives both county PEI funding and State MHSA funding from the Office of Equity, California Department of Health Services. An evaluation of the program was conducted from 2018 to 2020. The primary focus of this evaluation was to measure changes in attitudes, knowledge, and behaviors among the Native population that reduce risk for or early onset of mental illness. The methodology employed a mixed-methods approach, collecting both quantitative and qualitative data, focused on both process and outcome. The evaluation reported the following findings:

- Post-AUP intervention, 90% of survey respondents felt that talking about emotions is important to Native youth compared to only 68% in the pre-survey results.
- Native youth seek out those who they trust, who are non-judgmental, have lived experiences, and have wisdom. For the majority, Native youth feel supported by adults to succeed (school, career), but don't feel as strongly that adults listen or will talk to them when they are struggling emotionally.
- 60% of the participants stated that suicide remained a taboo subject that is difficult to talk about among community members.
- Over half of the AUP participants (56%) reported improvements in mental health status, specifically with depression and anxiety.
- The value of cultural identity and recognition that culture is prevention was expressed by GONA and focus group participants. Specifically, intergenerational relationships, learning from elders, and being with other Native Americans were the most frequently repeated themes.
- Over two-thirds of TAY post-survey respondents stated feeling satisfied with their family life, that they were doing better in school and/or work, that they were better able to cope when things go wrong, and that they were better at handling daily life.
- Respondents to the Herth Hope Index signified having a positive outlook toward life (85%) and having short and/or long-term goals (81%). Finally, over 95% reported feeling that their life has value and worth.

### **LGBTQIA+ Youth Community**

Positive Images is an agency in Sonoma County serving the unique needs of lesbian, gay, bisexual, transgender, queer, intersex, asexual, and otherwise marginalized gender/sexual identified populations, with an emphasis on identities and individuals at the margins. Their LGBTQIA+ Community Center hosts multiple weekly support groups, a youth leadership

development program, mentorship opportunities, an LGBTQIA+ Library, resource and referral station, and a Transformation Station. Positive Images offers a warm, welcoming, and affirming environment for young people to explore their individual identities, develop leadership skills, and contribute to our collective community. Positive Images staff lead LGBTQIA+ Cultural Competency Trainings and presentations that educate the greater community focusing on human connection, compassion, and inclusion.

Positive Images envisions a Sonoma County where all LGBTQIA+ people are valued, compassionate community members, creating a just society.

### **Older Adult Collaborative**

The Older Adult Collaborative (OAC) comprises the primary senior services agencies in Sonoma County and is led by the Sonoma County Human Services Department, Adult & Aging Services Division. The community based, non-profit members serving older adults in their respective communities are:

- Council on Aging (COA)
- Petaluma People Services (PPSC)
- West County Community Services (WCCS)

The OAC utilizes Healthy IDEAS (Identifying Depression and Empowering Activities for Seniors), a prevention and early intervention evidence-based model, to reduce depression and suicide among older adults throughout Sonoma County by:

- Administration of a depression screening by both licensed experience professionals and peer/volunteers who are supervised by licensed professionals
- Referral of case-managed clients to counseling and psychotherapy for those older adults identified as at risk for depression

## **IV. Then discuss how the county measures and monitors activities/strategies for reducing disparities.**

DHS-BHD uses a community driven Continuous Quality Improvement (CQI) model as part of our community planning process. Continuous Quality Improvement is the complete process of identifying, describing, and analyzing strengths and problems, and then testing, implementing, learning from, and revising solutions. Sonoma County BHD staff and managers monitor performance outcomes with contractors, working with them to make necessary adjustments in real time, in the effort to realize more effective programs, services, and activities.

Sonoma County is also moving to implement Anti-Racist Results-Based Accountability (AR-RBA) training for contracted and staff quality improvement and director-level staff, supported by a more in-depth AR-RBA training for DHS Equity Circle members. We hope AR-RBA's focus on "targeted universalism" can further reduce racial, ethnic, and other disparities.

### **Cultural Responsiveness Survey**

Every three years, a division-wide Cultural Responsiveness (CR) Survey is conducted to identify disparities, assess cultural responsiveness needs of the staff and provide insight into future training and system planning (reflected in the Workforce Education and Training Plan) for DHS-BHD. Three levels of staff are requested to take the survey to address differing scopes of work and interactions with the communities served: Management, Clinical, and Administrative staff.

The following standardized tools are used to collect information:

- California Brief Multicultural Competence Scale (CBMCS)
- Contra Costa County Mental Health Division Cultural Competency Assessment Tool
- Sonoma County Mental Health Administrative Staff Cultural Assessment Tool

The last survey was completed in December 2020 and included only selected behavioral health staff and contractors, not just from those providing services in specialty mental health, but along the mental health services continuum—prevention, early intervention, treatment, and recovery—not specifically focused on staff of the Mental Health Plan. It also does not include substance use disorders staff or contractors. While this survey does provide DHS-BHD with some information, it does not reflect an accurate picture of the behavioral health division staff as a whole nor can the data be compared with previous surveys.

In December 2020, an email was sent out inviting behavioral health staff, contractors, and community members to participate in the CR Survey. A link to a survey monkey was sent in the email and the survey closed in February 2021. (No survey was conducted in 2023; the survey will be repeated in 2024.) Below reflects the characteristics and responses from that survey:

- 165 individuals responded
- 64.6% or 104 respondents identified Sonoma County Department of Health Service Behavioral Health Division as their place of work, specifically:

ANSWER CHOICES	RESPONSES	
Adult Services	26.83%	44
YFS/FASST/TAY Services	20.12%	33
Crisis/Outreach Services	13.41%	22
BH Administration	9.15%	15
Not Applicable	30.49%	50
TOTAL		164

- 35.40% or 57 respondents identified as contract service provider of DHS-BHD.
- 74.55% stated they were White, and 11.73% reported they were of Hispanic or Latino ethnicity.
- Only 1.82% stated they spoke Spanish as a primary language.
- 8.59% stated they were bisexual, 5.52% stated they were gay or lesbian, and 3.68% stated they were queer.
- 33.33% stated they had lived experience with mental health challenges.
- 62.11% were clinicians, 26.71% were management, and 11.18% were administrative support.
- Survey questions regarding working with a non-English speaking client varied from 76% feeling that they knew what to do if a caller (on phone) speaks a language different than theirs to only 52% stating they had training on how to use translation services and could access translation services from their work station.
- Only 42.5% reported feeling confident that they could get interpreter support within 15 minutes of recognizing client need.
- Regarding a level of awareness about multicultural issues, a higher percentage of survey respondents reported they had awareness of racial challenges in society

(96.7%) and institutional barriers that affected their clients (98%).

- However, the more specific the questions were regarding diverse groups (LGBTQ+, seniors) and the intersectionality of groups (low-income vs. high income Puerto Ricans), the lower the confidence level staff had regarding their knowledge and ability to work effectively with those groups.
- There was a significant recognition that the organization's staffing did not represent the populations of the broader geographic community being served. Only 22% felt that the organization represented the community and 39% felt that the organization did not.
- Survey respondents felt less confident that the overall service delivery system was effective in providing culturally appropriate and linguistically proficient mental health services to the ethnic, racial, and cultural groups served.
- Although, not necessarily representative of all staff, the overall sentiment of survey respondents indicated that ongoing cultural training, discussions, and refining practices is warranted to better serve Sonoma County residents.

### **Capacity Assessment Report**

The Sonoma County MHSA Capacity Assessment Report released in 2023 made the following recommendations:

- 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.
- 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.
- 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.
- 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.
- 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.

### **Consumer Perception Survey**

In June 2022 DHS-BHD administered the Consumer Perception Survey. The goal of this survey is to collect data for the federal National Outcome Measures (NOMs) required by the Substance Abuse and Mental Health Services Administration (SAMHSA). Receipt of federal Community Mental Health Services Block Grant funding is contingent upon the submission of this data.

Counties are required to conduct the survey and submit data per §3530.40 of Title 9 of the California Code of Regulations. Section 3530.40 of Title 9 of the California Code of Regulations requires that semi-annual surveys be conducted (May and November). However, beginning in 2020, the Department of Health Care Services (DHCS) cancelled one of the survey periods due to the implementation of a system shift in submission processes.

DHCS has contracted with the University of California Los Angeles (UCLA) to scan and process the submitted forms and aggregate the data, once the counties have mailed the surveys. There are a total of four surveys for consumer populations:

- Adults
- Older Adults
- Youth
- Family/Parents of Youth

The surveys contain items in the form of statements that consumers rate. These responses are aggregated into the following categories:

Adults and Older Adults	Youth and Family
General Satisfaction	General Satisfaction
Perception of Access	Perception of Access
Perception of Participation in Treatment Planning	Perception of Participation in Treatment Planning
Perception of Quality and Appropriateness	Perception of Outcomes of Services
Perception of Outcomes of Services	Perception of Social Connectedness
Perception of Social Connectedness	Perception of Cultural Sensitivity
Perception of Functioning	Perception of Functioning

**V. Share what has been working well and lessons learned through the process of the county’s development and implementation of strategies that work to reduce disparities (within Medi-Cal, CSS, WET, and PEI).**

Despite the challenges faced by county over the past several years (budget crisis, firestorms, COVID), DHS-BHD has managed to gain ground on re-establishing the MHSA Steering Committee and corresponding community engagement in community planning, relevant committees and changes in cultural responsiveness of service delivery in PEI, WET, CSS, and Medi-Cal. This community engagement is the primary key that provides diverse experiences and perspectives shaping processes and decision-making.

Furthermore, engaging community members provides for a level of accountability and momentum that could not be achieved if the County were working in isolation. Adopting a Community-Based Participatory Research practice is challenging but rewarding and sustainable. For example, it may not be possible for BHD to hire a workforce that is equally representative of the community in gender, ethnicity, age, or life experience, but engaging a diverse community constituency to serve in various capacities within the mental health system is an achievable goal.

## **Criterion 4: Client/Family Member/Community Committee: Integration of the Committee with the County Mental Health System**

### **I. The county has a Cultural Competence Committee, or similar group that addresses cultural issues, has participation from cultural groups, that is reflective of the community, and integrates its responsibilities into the mental health system.**

- A. If so, briefly describe the committee or other similar group (organizational structure, frequency of meetings, functions, and role). If the committee or similar group is integrated with another body (such as a Quality Improvement Committee), the inclusive committee shall demonstrate how cultural competence issues are included in committee work.

Due to an extended staff vacancy in the Ethnic Services Manager (now the Cultural Responsiveness, Inclusion & Training Coordinator) role, as well as DHS structural changes in creating a DHS Office of Equity and then recruiting and training a DHS Equity Circle, the BHD Cultural Responsiveness Committee has been placed on hold in an effort to ensure that when it restarts, the committee aligns with and can leverage and build on the work done at the departmental level and at the county level.

A Sonoma County Office of Equity was established in August 20, 2020, followed by the establishment of a Department of Health Services Office of Equity in May 2022. Each office also created a core team of equity champions across its administrative division who have received and continue to receive extensive training in antiracism and equity. The champions in the Department of Health Services, called the DHS Equity Circle, have begun initial training and planning with DHS leadership to create a Health Equity Action Plan, scheduled to be completed in 2024. This plan will focus both on serving the community and on creating workplace conditions in which diverse employees can thrive.

While these structural changes are taking place, and while planning for the revamped Cultural Responsiveness Committee continues, the equity champions within the Behavioral Health Division have formed the Behavioral Health Equity Steering Committee, which began meeting monthly in the summer of 2023.

The BHD Equity Steering Committee comprises six Behavioral Health employees and one liaison from the DHS Office of Equity. The Cultural Responsiveness, Inclusion & Training Coordinator chairs the committee. The group membership is 43% Latinx/Latine, 14% White, 29% mixed race, and 14% Middle Eastern/North African. Several members are immigrants. At least two members identify as part of the LGBTQIA+ community. The committee contains both direct-service providers and administrative staff, from multiple job classifications.

The BHD Equity Steering Committee reports to the DHS Equity Circle and DHS Office of Equity, and, as Chair, the Cultural Responsiveness, Inclusion & Training Coordinator reports to the Behavioral Health Division Director. Eventually, this committee will serve as an advisory panel to the Cultural Responsiveness Committee, which we hope to resume in 2024.

Of note, a workgroup for a Quality Improvement project focusing on Latinx access to services will likely be moved under the Cultural Responsiveness Committee in order to better coordinate with the Office of Equity and the forthcoming Health Equity Action Plan for the Department of Health Services.



**Quality Improvement Committee (QIC)**

The Cultural Responsiveness, Inclusion & Training Coordinator regularly attends the monthly Quality Improvement Committee (QIC) meetings. The purpose of QIC is to oversee and be involved in quality improvement activities including policy issues, reviewing and evaluating results of QI activities, instituting needed QI actions, and following up on QI processes. Furthermore, QIC is one venue for community participation of the MHSA Community Planning Process. QIC members identify community issue related to mental illness resulting from lack of community services and supports, including any issues identified during the implementation of MHSA, analyze the mental health needs in the community, and identify and re-evaluate priorities and strategies to meet those mental health needs.

The areas of responsibility for the QIC are to monitor and review consumer relations/outcomes, develop and review the annual QI work plan, review data and work plan activities, and monitor performance improvement projects, including the Cultural Responsiveness Committee.

B. If so, briefly describe how the committee integrates with the county mental health system by participating in and reviewing MHSA planning process.

The Cultural Responsiveness, Inclusion & Training Coordinator attends QIC, MHSA Steering Committee, and MHSA CPP Workgroup. She facilitates the BHD Equity Steering Committee and will facilitate the Cultural Responsiveness Committee (CRC). She will be kept apprised of the MHSA planning processes.

## Criterion 5: Culturally Competent Training Activities

### I. The county system shall require all staff and shall invite stakeholders to receive annual cultural competence training.

A. The county shall develop a three-year training plan for required cultural competence training that includes the following: (The county may submit information from the county's WET plan provisions for training. The county shall describe how training efforts are integrated and can reasonably be expected to create and maintain a culturally competent workforce).

1. Steps the county will take to provide required cultural competence training to 100% of their staff over a three-year period.

The overall goal of division-wide staff development trainings for fiscal year 23-24 is to establish solid clinical frameworks for evidence-based practices that will improve client outcomes, increase staff efficacy and sustainability, and build foundational skills and mindsets on which BHD can build going forward.

Trainings in cultural humility, equity and anti-racism, and working with trans and gender-expansive populations will be required for all clinical staff, and open to contracted staff, in the spring of 2024. Trainings will be recorded so that staff who are not available on the day of the live training, including new staff, can access the trainings. Additionally, the County of Sonoma is working to create a required online equity and anti-racism training for all employees. (DHS-BHD's equity and anti-racism training will be adapted from that training and would fulfill the County requirement.)

2. How cultural competence has been embedded into all trainings.

All trainings are required to have at least one specific cultural competence goal. Staff report on their perceptions of how well the presenter(s) achieved that goal on each evaluation. The staff-development training series for fiscal year 23-24 is explicitly focused on important foundational skills for cultural responsiveness.

3. A report list of annual training for staff, documented stakeholder invitation. Attendance by function to include: Administration/Management; Direct Services, Counties; Direct Services, Contractors, Support Services; Community Members/General Public; Community Event; Interpreters; Mental Health Board and Commissions; and Community-based Organizations/Agency Board of Director, and if available, include if they are clients and/or family members.

The following chart documents the cultural competency training offered in the past year.

DATE	TITLE	LENGTH (HOURS)	PRESENTER(S)	AUDIENCE
2/2/2023	Monolingual English-Speaking Providers Who Use Interpreters	7	Dr. Jana Spalding, MD, CPSS; National Latino Behavioral Health Association	SCBH Staff

3/29/2023 & 3/30/2023	Intensive Skill-Building Curriculum for Bi-Lingual Clinical Staff	12	Dr. Jana Spalding, MD, CPSS; National Latino Behavioral Health Association	SCBH Staff
9/7/23	Trauma-Informed Systems 101	4	Paula Gonzalez, ASW; Trauma Transformed	SCBH Staff and Contractors
10/19/23	Trauma-Informed Systems 101	4	Paula Gonzalez, ASW; Trauma Transformed	SCBH Staff and Contractors
11/15/23	The Spirit of Harm Reduction	3	Maurice Byrd, LMFT; Harm Reduction Therapy Center	SCBH Staff and Contractors, community partners
12/13/23	Harm Reduction 101	3	Maurice Byrd, LMFT; Harm Reduction Therapy Center	SCBH Staff and Contractors, community partners

B. Annual cultural competence trainings topics shall include, but not be limited to the following:

1. Cultural Formulation;
2. Multicultural Knowledge;
3. Cultural Sensitivity;
4. Cultural Awareness; and
5. Social/Cultural Diversity (Diverse groups, LGBTQ, SES, Elderly, Disabilities, etc.).
6. Interpreter Training in Mental Health Settings
7. Training Staff in the Use of Mental Health Interpreters

### **Workforce, Education, and Training Plan (WET)**

DHS-BHD endeavors to provide a comprehensive workforce education and training program that supports diversity, equity, and inclusion and has both staff training and professional development opportunities available to all staff. WET programming provides workforce training and development opportunities for DHS-BHD staff, contractors, providers, clients/consumers, and family members. Through system-wide workforce training and development initiatives, WET aims to create and sustain a diverse, culturally responsive, and clinically effective workforce that provides the best possible care for Sonoma County communities.

The current fiscal year staff development training program is below.

#### September & October: Trauma-Informed Systems

##### *Objective*

To increase workplace satisfaction for staff and service satisfaction for clients

##### *Background*

Due to years of natural disasters (floods and fires), the Covid-19 pandemic, chronic clinical vacancies, and high turnover, all while staff continued providing service to the community, Sonoma County Department of Health Services, Behavioral Health Division, has remained in “crisis mode” for so long that it has started to dictate ways in which we serve clients, treat each

other, and design systems. Our contract with Trauma Transformed, which includes a division-wide training in “Trauma-Informed Systems 101” (one in-person, one virtual) will help us move out of crisis mode and toward creating healing environments, policies, and practices that mitigate the impact of stress and trauma for our clients, workforce, and all of us impacted by systems.

*Description of Training*

Sonoma County Behavioral Health and designated Homeless Services and network staff will participate in foundational TIS 101 workshops designed to:

- Understand effects of stress and trauma on individual, community, and organizational level.
- Learn the six core principles of trauma informed care and two to three strategies for applying these principles to practices.
- Learn strategies to develop organizational resilience and trauma-informed, equity-centered responses.

*Evidence to Support its Use*

Trauma-Informed Systems work through Trauma Transformed has been shown to increase job happiness and satisfaction, as well as client practice (e.g., more staff days on the job, greater client satisfaction, and reduced grievances and discipline). The United States Substance Abuse and Mental Health Services Administration (SAMHSA) includes Trauma-Informed Care in Behavioral Health Services as a Treatment Improvement Protocol (TIP), which are the products of a systematic and innovative process that brings together clinicians, researchers, program managers, policymakers, and other Federal and non-Federal experts to reach consensus on state-of-the-art treatment practices. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements, and are considered a consensus on best practices.

*Place in the Series*

By focusing on trauma-informed systems and trauma-informed care as our foundation, we create and encourage skills for listening, collaboration, cooperation, and shared values. These skills will remain foundational to the entire fiscal year’s training series.

*DHS Strategic Plan Integration*

<b>Goal Three</b>	<b>Objective One</b>	<b>Strategy One</b>
The Department of Health Services is a high achieving, high functioning organization	Build a highly competent, effective, and engaged workforce	Promote and support staff well-being and engagement
<b>DHS Value: Excellence</b>		

November, December & January: Harm-Reduction Therapy

*Objective*

To increase clinical expertise in helping clients reduce substance use and other risky activities

*Background*

Sonoma County has the second highest rate of overdoses in the Bay Area. Drug overdose deaths increased dramatically from 2016 to 2021 in Sonoma County, driven by opioids, with 87% of those deaths involving fentanyl. In May, members of the DHS-BHD Sentinel Events Committee requested division-wide clinical trainings to address recent client overdoses. Harm-

reduction therapy was identified as the federal and state best practice for addressing substance use, and the Harm Reduction Therapy Center (HRTC) in San Francisco was identified as a national leader in harm reduction and dual-diagnosis training for clinicians.

### *Description of Training Series*

HRTC will provide three trainings:

- Spirit of Harm Reduction: The history of Harm Reduction and its purpose, development, and use with people that use drugs and other risky behaviors.
- Harm Reduction 101: Harm-Reduction Therapy and its clinical applications in working with people who are using drugs and also have a mental health diagnosis.
- Substance/Drugs Use: Education on the different classifications of drugs and their impact on the brain and behavior. Understanding the connection between drug use and mental health.

### *Evidence to Support its Use*

At the federal level, the Biden-Harris Administration has identified harm reduction as a federal drug policy priority. SAMHSA describes harm reduction as “an evidence-based approach that is critical to engaging with people who use drugs and equipping them with life-saving tools and information to create positive change in their lives and potentially save their lives.” Harm-reduction strategies are shown to substantially reduce HIV and Hepatitis C infection among people who inject drugs, reduce overdose risk, enhance health and safety, and increase by five-fold the likelihood of a person who injects drugs to initiate substance use disorder treatment. In line with this, harm reduction is one of the four strategic priorities of the U.S. Department of Health and Human Services (HHS) Overdose Prevention Strategy.

At the state level, the harm-reduction framework is required by our MHPA Full-Service Partnerships, as described by the *Full Service Partnership Tool Kit*. Skills in harm-reduction therapy are also a required part of licensure as a mental-health therapist in California; clinical interventions to reduce harm are a required competency for Marriage and Family Therapist and Clinical Social Worker licensure. Providing support and training in harm-reduction therapy is therefore a supervisory ethical requirement for our system of care.

Harm-reduction therapy is supported at the federal and state level as the standard of care for clients who have issues with substance use.

### *Place in the Series*

Harm-reduction therapy strategies build on the previous training series, trauma-informed care, by offering client-centered supportive intervention shown to decrease substance use. They will also provide a framework for further clinical skill development in future years to address risk behaviors like suicidal behavior, hoarding, and self-harm.

*DHS Strategic Plan Integration*

<b>Goal Two</b>	<b>Objective One, Strategy One</b>	<b>Objective Two, Strategy One</b>
Individuals, families, and communities access high quality and coordinated services for health, recovery, well-being, and self-sufficiency	Increase access to safety net services by strengthen coordination of services with emphasis on high-need residents	Improve community-wide capabilities to strengthen Public and Behavioral Health infrastructure by prioritizing and implementing core Public and Behavioral Health services
<b>DHS Values: Equity, Excellence</b>		

March, April & May: Cultural Humility & Cultural Responsiveness

*Objective*

To increase our clinical and professional skills in building and maintaining strong multicultural working relationships

*Background*

In the summer of 2020, the Sonoma County Board of Supervisors created the Sonoma County Office of Equity and took a meaningful step to recognize and celebrate our powerful role in unseating racial inequity in our communities. In January 2021, the Board approved a five-year strategic plan, which includes a Racial Equity and Social Justice pillar. The pillar is made up of specific goals and objectives that will lead to normalizing, organizing, and operationalizing a new way of seeing our challenges, conducting analysis, and implementing new policies to ensure a workforce reflective of the community we serve and to achieve racial equity in County service provision.

“Cultural humility involves an ongoing process of self-exploration and self-critique combined with a willingness to learn from others. It means entering a relationship with another person with the intention of honoring their beliefs, customs, and values. It means acknowledging differences and accepting that person for who they are,” according to Katherine Yeager and Susan Bauer-Wu, who brought the concept forward in 2013.

Dr. Gloria Morrow was identified as a leading trainer in cultural humility through her trainings on the topic through the California Institute for Behavioral Health Solutions (CIBHS), a behavioral health consultancy for County MHPs. Other trainings that may be included in this series are to be coordinated with the Sonoma County Core Equity Team, DHS Equity Circle, and Translife, a Sonoma County trans-focused training organization.

By focusing on cultural humility as well as cultural responsiveness, DHS-BHD will work toward greater inclusion for staff and clients, better understanding of historical and current inequity, and developing tools for addressing disparities.

*Description of Training Series*

Dr. Morrow’s training, similar to her training for CIBHS, will introduce the integration of two powerful concepts, “Building the Beloved Community” and “Cultural Humility,” as a strategy for preparing the environment for providing culturally responsive services and helping marginalized clients to heal from racism-related trauma.

### *Learning Objectives:*

- Identify at least three ways that racism-related trauma impacts the mental, physical, and spiritual well-being of marginalized clients.
- List at least three principles of the Beloved Community, and its rationale for effectively meeting the overall health and well-being of those we serve, especially those from marginalized communities.
- List at least three threats to building the beloved community.
- Identify at least three components of cultural humility and its role in building the beloved community.
- Identify at least three strategies for becoming culturally humble.
- Identify at least three strategies for Building the Beloved Community through Cultural Humility.
- List three ways staff can become more culturally responsive in creating an environment that embodies the principles of diversity, equity, and inclusion.
- Identify at least five strategies for staff to practice self-compassion.

Two additional trainings still being explored would bring in the trainings developed by the County Core Equity Team, with a focus on equity and anti-racism, and by the Translife Conference, with a focus on trans and gender-expansive populations.

### *Evidence to Support its Use*

Cultural competency or responsiveness trainings are required as part of our mandate from DHCS and are monitored during our Triennial audits. Using the framework of cultural humility decenters the idea of “normal populations” and “marginalized populations” and allows us all to examine our experiences, identities, and beliefs so that we may better develop partnerships with others.

Bringing in training from the Sonoma County Core Equity Team would continue to further the Sonoma County Five-Year Strategic Plan Racial Equity and Social Justice Pillar, in which Objectives 2 and 4 are to invest in an ongoing and continually developing racial-equity learning program, including understanding the distinction between institutional, structural, interpersonal, and individual racism, for County leadership and staff and to develop a shared understanding of key racial and equity concepts across the County and its leadership.

Clinical training in working with trans populations has been requested often by DHS-BHD staff and would also address new state legislative requirements that will soon be enacted around TGI training for behavioral health professionals.

### *Place in the Series*

By placing cultural humility and responsiveness after the mini-series on trauma-informed systems and harm reduction therapy, our staff will have developed and practiced skills in listening, self-reflection, and curiosity that will provide a strong base for discussion topics of race and culture that can often be charged or difficult. Starting the series with cultural humility will introduce ways they can bring these skills to these topics, and then Core Equity and TGI healthcare trainings will provide further opportunities to use and develop their growing awareness.

*Sonoma County Five-Year Strategic Plan Integration*

<b>Pillar: Racial Equity and Social Justice</b>		
<b>Goal One:</b> Foster a County organizational culture that supports the commitment to achieving racial equity.	<b>Objective 2:</b> Invest in an ongoing and continually developing racial equity learning program, including understanding the distinction between institutional, structural, interpersonal, and individual racism, for County leadership and staff by end of 2021.	<b>Objective 4:</b> Develop a shared understanding of key racial equity concepts across the County and its leadership.
<b>Goal Two:</b> Implement strategies to make the County workforce reflect County demographic across all levels.	<b>Objective 2:</b> Implement countywide strategies to recruit, hire, develop, promote and retain County employees of color, produce an annual report card assessing progress, and update strategies as needed.	
<b>Sonoma County Value: Equity</b>		

**II. Counties must have a process for the incorporation of Client Culture Training throughout the mental health system.**

- A. Evidence of an annual training on Client Culture that includes a client’s personal experience inclusive of racial, ethnic, cultural, linguistic, and relevant small county cultural communities. Topics for Client Culture training are detailed on page 18 of the CCPR (2010) from DMH Information Notice 10-02.
- B. The training plan must also include, for children, adolescents, and transition age youth, the parent’s and/or caretaker’s, personal experiences with the following:
  - 1. Family focused treatment;
  - 2. Navigating multiple agency services; and
  - 3. Resiliency

In the past, Sonoma BHD has conducted annual trainings with a diverse panel of peers (individuals with lived experiences of mental health challenges). This panel has been diverse in gender, ethnicity, age, ability and other factors that influence the person’s experience. A more concerted effort needs to be made to outreach to the Latinx community and increase TAY representation on this panel. Due to staffing vacancies in the training coordinator role, this training has not been schedule for fiscal year 2023-2024, but will be given high priority in the upcoming fiscal year, as part of a hoped-for series on SAMHSA’s recovery model and recovery-oriented care. Future guidance given to panelists will ask them to share their experiences in accessing treatment, navigating multiple agencies, quality of treatment including client-centered and family-focused approaches, and their ability to increase resiliency for greater positive outcomes.



Required trainings held in the past were responsive to both staff surveys and input from community providers. Peer panels and Latinx/Latine focused staff development has been a mainstay of the annual training plan(s). Moving forward, DHS-BHD will use multiple strategies to ensure staff receive trainings that will continue to include bringing together all staff via Zoom or in person, and with the use of the Relias learning management system that has just been rolled out, staff will have access to trainings that are tailored specifically for their job, or a particular population making cultural competency training more relevant to their particular work.

## **Criterion 6: County's Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff**

### **I. Recruitment, hiring, and retention of a multicultural workforce from, or experienced with, the identified unserved and underserved populations**

The Sonoma County DHS-BHD Workforce Education and Training (WET) plan seeks to realize some of the Organizational Excellence and Racial Equity and Social Justice goals of the Sonoma County Board of Supervisors approved a Five-Year Strategic Plan (2021-26), with specific focus on the goals of:

- Fostering an organizational culture in DHS-BHD that supports the commitment to achieving racial equity
- Implementing strategies to diversify the behavioral health workforce to ensure representation the behavioral health workforce reflect the County demographics at all levels of the organization
- Becoming an employer of choice with a diverse workforce that reflects our community and with a positive work culture that results in engaged and developed employees

Specifically, DHS-BHD is using MHSA funds to develop and implement a WET program designed to enhance the public behavioral health workforce with programs and activities that shall address workforce shortages and deficits to:

1. Conduct outreach, recruit, hire, employ, train and develop, retain, and create promotional opportunities for individuals who share the racial/ethnic, cultural, and/or linguistic characteristics of behavioral health service consumers seeking to work in the public behavioral health system.
2. Recruit, hire, employ, train, and create promotional opportunities for people with lived experience and their family members in DHS-BHD.
3. Educate the public behavioral health system workforce on incorporating culturally responsive, clinically appropriate evidence-based and community-defined practices that align with the general standards for the implementation of State Drug Medi-Cal and the Mental Health Plan.

Informing this section is also feedback received by staff regarding DHS-BHD's priorities. In the Fall of 2021, DHS-BHD went through a process to set the priorities for entire division. Some of the stated priorities will be addressed, in whole or in part, in this WET plan. These relevant areas include:

1. Developing wraparound service capacity for people with dual diagnosis
2. Diversification of the workforce
3. Developing paths for promotion for non-licensed staff
4. Increasing support for bilingual staff
5. Providing onboarding training for new staff
6. Providing ongoing training for existing staff
7. Investing in leadership and management training
8. Creating more efficient responses to assist with job performance issues

These activities and strategies constitute ongoing goals and activities within the division. The

Cultural Responsiveness, Inclusion & Training Coordinator is working closely with staff to provide supports for guidance for implementation of these activities and strategies.

A significant investment in workforce retention is our trauma-informed systems transformation project. This project is focused on improving workplace culture, specifically by focusing on management and leadership and developing their skills in leading a diverse, supportive, trauma-informed workplace. Cultural humility and responsiveness is one of the pillars of a trauma-informed system, and will be foundational to all parts of this systems improvement. The Cultural Responsiveness, Inclusion & Training Coordinator is the main coordinator for this effort, further ensuring integration, rather than competition, between trauma-informed changes and equity work. DHS-BHD is in the process of an organizational assessment (Tools for Trauma-Informed Worklife) to help identify, and then target, areas of concern for employees regarding organizational culture.

Additionally, the DHS Equity Circle has begun initial training and planning with DHS leadership to create a Health Equity Action Plan, scheduled to be completed in 2024. This plan will focus both on serving the community and on creating workplace conditions in which diverse employees can thrive.

### **Current Behavioral Health Workforce Demographics**

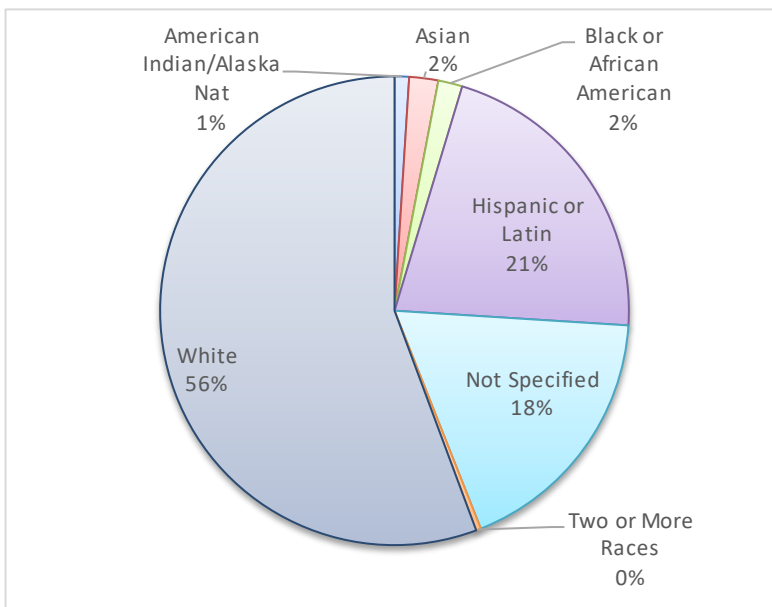
In order to focus on efforts to diversify DHS-BHD's workforce, the first step is to review the needs within DHS-BHD. To do so, data was collected about the current workforce racial and ethnic demographics to look for where there may be some areas for improvement. This information provides DHS-BHD with a starting point for conducting outreach, recruiting, hiring, and employing individuals who share the racial/ethnic, cultural, linguistic, gender, and/or sexual orientation characteristics of our behavioral health services.

The Sonoma County Five-Year Strategic Plan provides the context for its departments to inform policies and projects to prioritize over the next five years. Sonoma County chose to focus a strategic pillar on Racial Equity and Social Justice. The Board states, "Sonoma County's collective well-being and prosperity are impacted by significant racial inequities. By focusing on racial equity and social justice within the Strategic Plan, the Board of Supervisors can begin to institutionalize equity and address disparate impacts on people of color both internally and as an organization and in the community." Data shows that the greatest disparities occur along racial and socio-economic lines. If Sonoma County wants to start closing those gaps, we have to start there. Research and best practices nationally show that successful equity program begin with a focus on race. This sort of "targeted universalism" allows the development of a framework that centers the people most likely to be affected by disparities in ways that have been shown to improve conditions for people in all categories, including sexual orientation and gender.

For purposes of the Workforce, Education, and Training plan, DHS-BHD has also prioritized reviewing DHS-BHD's gender and sexual orientation workforce statistics to assist in making workforce decisions.

Sonoma County Human Resources provided the information about DHS-BHD's current workforce in the tables below. There are 300 employees.

Race and Ethnicity	BH Workforce		Sonoma County	
	#	%	Residents 13	Medi-Cal Beneficiaries
American Indian/Alaska Native	3	1%	2.3%	1%
Asian (alone)	6	2%	5%	3.1%
Native Hawaiian or other Pacific Islander (alone)	-	-	0.4%	
Black or African American	5	1.7%	2.2%	1.6%
Hispanic or Latinx/Latine	64	21.3%	28.9%	40%
White	167	55.7%	85.7%	27.7%
White (alone, not Hispanic or Latinx)	-	-	60.6%	-
Two or More Races	1	0.3%	4.4%	-
Unspecified/Not Reported	54	8%	-	26.7%

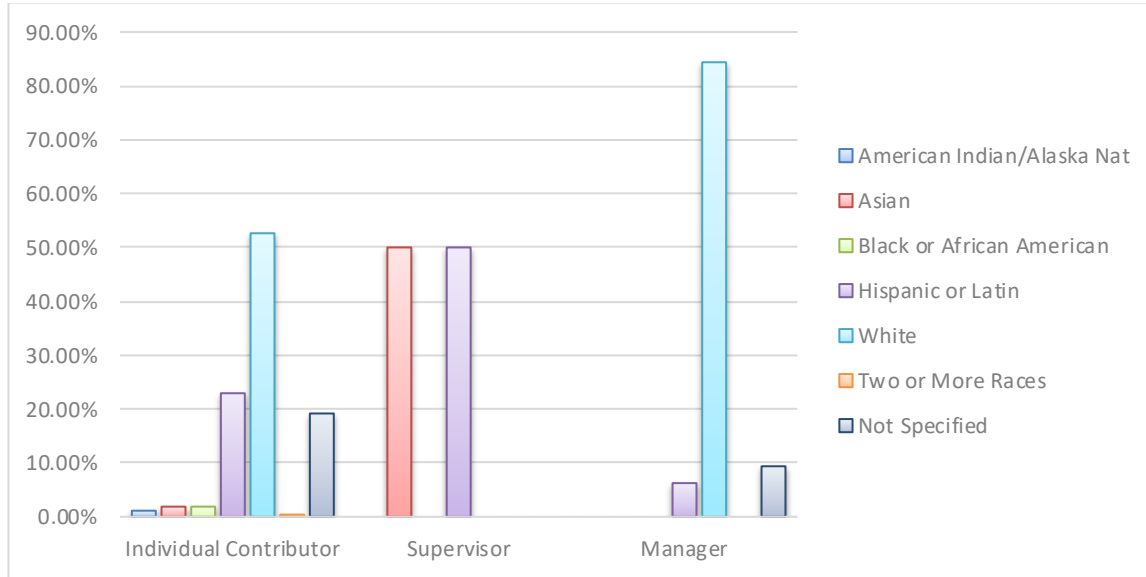


Data from these two charts indicates that DHS-BHD's entire workforce is underrepresented for Hispanic or Latinx/Latine staff, as compared to both the general population and especially to Medi-Cal eligibility. Reducing the disparity in representation continues to be a high priority in staff recruitment for the Division.

### Behavioral Health Workforce by Job Class and Race/Ethnicity

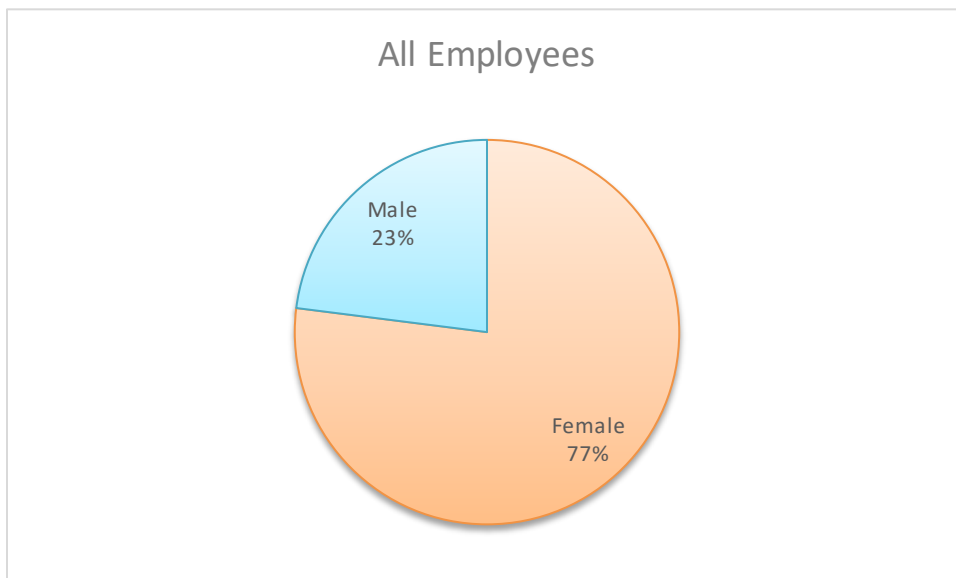
When presented by reporting level, the racial and ethnic disparities in the Sonoma County Behavioral Health workforce become more stark. Based on the most recent data from the Sonoma County Human Resources Department, White employees are 84.4% of the 32 total managers in the division, with only 6.3% Latinx/Latine and 9.4% unspecified. While Latinx/Latine and Asian employees each constitute 50% of the supervisors in the division, please note that there are only two supervisor-level positions in total.

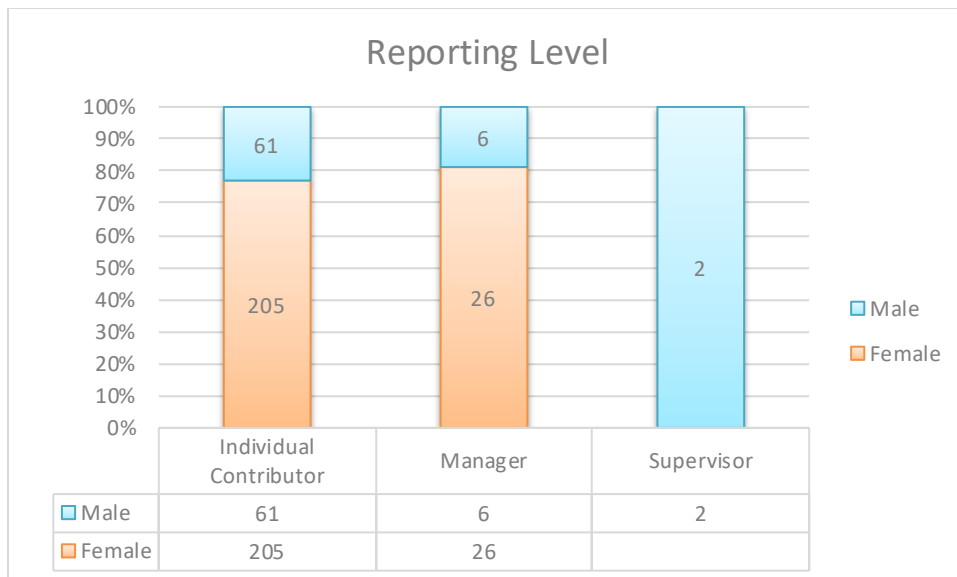
Reporting Level	American Indian / Alaska Native	Asian	Black/African American	Hispanic or Latinx / Latine	White	Two or More Races	Not Specified
Individual Contributor	1.1%	1.9%	1.8%	23%	52.6%	0.4%	19.2%
Supervisor	0%	50%	0%	50%	0%	0%	0%
Manager	0%	0%	0%	6.3%	84.4%	0%	9.4%



## Gender

When considering gender balance in the workforce, it is most important to consider power and position in the current existing workforce, the gender make-up of management relative to its workforce, who tops the pay scales, and opportunities for advancement. Upon hire, the County asks gender identity of its incoming staff. Unfortunately, the County only provides two categories, male and female as options.





Data from these this chart indicates:

- 81.3% of DHS-BHD management staff is female.
- 77% of all non-management Division staff are female.

### Sexual Orientation and Gender Expression

Gary Gates, a researcher at UCLAs Williams Institute, a think tank on sexual-orientation law, who based his findings on data from the US Census Bureau’s 2008 American Community Survey, reported that the Santa Rosa Metropolitan Area (“in effect Sonoma County”) was second “most gay” population in the nation, with 7.63 gay couples per 1,000 households, a rate 56 percent greater than the national average.<sup>14</sup> Unfortunately, information about sexual orientation is not a category collected of new hires into the workforce of Sonoma County. Nor is this information collected for Medi-Cal beneficiaries or consistently for DHS-BHD clients.

People who identify as lesbian, gay, bisexual, transgender, intersex, asexual, or otherwise queer often face social stigma, discrimination, prejudice, denial of civil and human rights, abuse, harassment, victimization, social exclusion, and family rejection. Because of these stressors, people in the LGBTQIA+ communities are at risk for various behavioral health issues. A National Institute of Health study further found that although sexual orientation discrimination alone was not significantly associated with substance use disorders, sexual orientation discrimination in combination with racial/ethnic or gender discrimination—and racial/ethnic discrimination alone—was associated with greater odds of substance use.<sup>15</sup>

O’Brien et al, in “Mapping the Road to Equity: The Annual State of LGBTQ Communities Report, 2018,” report that according to town hall meetings in California, a sizable proportion of therapists are not adequately trained or even willing to serve trans clients, and several trans people spoke of their difficulties in finding therapists who could provide the much-needed quality support.<sup>16</sup> This discomfort points to the need both for more training and also for

<sup>14</sup> Out4MentalHealth Sonoma County Mental Health Fact Sheet. <https://californialgbtqhealth.org/wp-content/uploads/2021/06/Sonoma-Task-Force-Fact-Sheet-Final-1.pdf>

<sup>15</sup> Sean Esteban McCabe, PhD, MSW, Wendy B. Bostwick, PhD, MPH, Tonda L. Hughes, PhD, RN, Brady T. West, MA, and Carol J. Boyd, PhD, MSN The Relationship Between Discrimination and Substance Use Disorders Among Lesbians, Gay, and Bisexual Adults in the United States, *American Journal of Public Health*; 2010 October; 100(10): 1946–1952. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2937001/>

<sup>16</sup> O’Brien, R.P., Walker, P.M., Poteet, S.L., McAllister-Wallner, A., & Taylor, M. (2018). Mapping the road to equity: The

recruiting LGBTQIA+, specifically trans, therapists.

## **Recruitment and Hiring**

Data regarding the current behavioral health workforce demonstrates the ongoing need to diversify is urgent and necessary. Over the previous years, DHS-BHD engaged in many efforts to diversify its workforce through innovative recruitment strategies including educational and employment pipeline opportunities. Previous outreach efforts of Latinx/Latine individuals into the behavioral health division workforce included a contract with a local non-profit, Latino Service Providers (LSP). Between 2015 through 2018, DHS-BHD contracted with LSP to assist, under the direction of the WET Coordinator, in the development of strategies for recruiting, assist with applying, and providing ongoing support for retaining behavioral health workforce. These activities included:

- Use print, radio, television, and social media targeting the Spanish-speaking Latinx/Latine community in recruitment strategies.
- Maintain a website for recruitment of bilingual Spanish, bicultural Latinx/Latine staff for DHS-BHD workforce.
- Participate in the North Bay Collaborative meetings
- Participate in the annual behavioral health career symposium in partnership with Sonoma County school districts.
- Support bilingual Spanish-speaking, bicultural Latinx/Latine applicants to apply for the behavioral health division positions.

The current contract with LSP provides for support and training of bilingual Youth Promotores in mental health. Many of these young adults expressed interest in pursuing a career in behavioral health, and in fiscal years 2021-2022 and 2022-2023, BHD has hosted interns from LSP in the MHSA coordinator's office and on the mental health treatment teams.

The Division will continue to coordinate with the County and Health Services Department Human Resources to identify best practices<sup>17</sup> for successful recruitment of a diverse workforce, with special attention to bilingual Spanish-speaking, bicultural Latinx/Latine individuals.

Managers have the lead role in recruiting, interviewing, and hiring a diverse workforce. It is the hiring manager in partnership with the Cultural Responsiveness, Inclusion & Training Coordinator who will shepherd the process by defining the role, getting input from the team, and weighing all the evidence to make a final decision.

## **Hiring**

Current data for the Behavioral Health workforce demographics demonstrates a significant shortage of bilingual Spanish speaking, bicultural Latinx/Latine workforce in comparison to the number of bilingual Spanish speaking, bicultural Latinx/Latine Medi-Cal beneficiaries in Sonoma County. As a specialty provider, and in keeping with the Sonoma County Board of Supervisor's Five-Year Strategic Plan, it is vital that DHS-BHD implement strategies to diversify the behavioral health workforce to ensure the behavioral health workforce reflects the County demographics at all levels of the organization.

annual state of LGBTQ communities, 2018. Sacramento, CA: #Out4MentalHealth Project.

<sup>17</sup> GEM. (December 7, 2021). Think Diversity is a "Pipeline Problem"? Look to Your Process Instead. [Blog Post] Retrieved from <https://www.gem.com/blog/diversity-hiring-pipeline-problem>

## **Behavioral Health Clinician Intern Job Classifications**

In 2012, DHS-BHD made a strategic decision to make systemic changes to its job classification and management structure as a recruitment strategy. This strategy set DHS-BHD aside from other organizations, making DHS-BHD a desirable place to work for newly graduated behavioral health clinicians. The strategy involved creating new job classification of Behavioral Health Clinical Intern positions for individuals to practice clinical work while gaining the supervised experience necessary to sit for the licensing exam. DHS-BHD also created the Clinical Specialist position to ensure oversight and accountability for the work of the Behavioral Health Clinician job classification.

Individuals who possess a graduate degree in counseling and/or social work, are registered with the CA Board of Behavioral Science Examiners, and need to gain the mandatory hours of qualifying supervised professional experience in order to take and pass the requisite law and ethics exam can be hired as Behavioral Health Clinical Interns. The Behavioral Health Clinical Interns practice under the licensure of their Clinical Supervisor. Once the Behavioral Health Clinician Intern completes their clinical hours, any other prerequisites, takes and passes their licensing exam, and is in good employment standing, they receive an automatic promotion to a Behavioral Health Clinician. The Behavioral Health Clinical Intern has three years to complete all prerequisites to obtain licensure.

This structure has historically been successful to recruit bicultural and bilingual staff. However, DHS-BHD has recognized that staff of color, particularly bilingual, bicultural Latinx/Latine staff, have experienced difficulty passing the licensing exam in the time allotted to do so. In 2017, DHS-BHD began tracking the licensing and certification process of Behavioral Health Clinical Interns to identify whether there was a propensity of DHS-BHD's staff of color having difficulty passing their licensing exam within the three-year timeframe. Data in 2017 indicated that 50% of the individuals having difficulty passing the exam were people of color. At that time, the WET Coordinator instituted a number of strategies to assist these individuals to pass their exams. These activities included providing exam preparation groups, and one-on-one coaching as well as guiding the candidates to use their staff development funds to purchase study materials. Because of these efforts, in 2018, the number of Behavioral Health Clinical Interns of color who had not passed their exam dropped to 36%.

Currently, the Cultural Responsiveness, Inclusion & Training Coordinator, who is a licensed Marriage and Family Therapist (LMFT), with the assistance of Clinical Specialists from the Quality Assessment & Performance Improvement (QAPI) team, facilitate multiple clinical supervision groups each week, with a focus not only on clinical feedback on current cases but also exam preparation. Additionally, BHD's new contract with Motivo, via CalMHSA, has diversified the pool of clinical supervisors available for both group and individual supervision. While BHD has started by using Motivo supervisors to fill a gap in LCSW supervision (versus LMFT supervision), future opportunities exist to increase access to bilingual, bicultural supervisors.

- A. [Extract and attach a copy of the Mental Health Services Act \(MHSA\) workforce assessment submitted to DHCS for the Workforce Education and Training \(WET\) component.](#) **Rationale:** Will ensure continuity across the County Mental Health System.

The Workforce Education and Training program supports the mission of the Sonoma County Behavioral Health Division to promote recovery and wellness of Sonoma County residents. BHD embraces a recovery philosophy that promotes the ability of a person with mental illness and/or substance use disorders to live a meaningful life in a community of his or her choosing, while striving to achieve his or her full potential. The principles of a recovery-



focused system include:

- Self-direction
- Individualized and person-centered care
- Empowerment and shared decision-making
- Holistic approach that encompasses mind, body, spirit, and community
- Strengths-based
- Peer-support
- Focus on respect, responsibility, and hope

BHD fosters a collaborative approach by partnering with clients, consumers, family members, and the community to provide high quality, culturally responsive services.

BHD Workforce Education and Training goals are:

- To provide staff with high quality education and training that promotes and endorses the mission of the Behavioral Health Division.
- To contribute to the development and maintenance of a culturally competent workforce, including individuals with client and family member experience who are capable of providing client- and family-driven services that promote wellness, recovery, and resilience.
- To teach and promote evidence-based and evidence-informed practices leading to measurable, values-driven outcomes in support of the Quality Improvement Workplan for the Behavioral Health Division.
- To encourage career development and increase job satisfaction by supporting the growth and refinement of a skillful workforce.
- To create and promote community outreach and training opportunities that encourage community stakeholder collaborations and facilitate forums for discussion and education around locally relevant behavioral health topics and needs.

In response to the QI Work plan and the Cultural Competence Plan, the Staff Development Training Series provides annual trainings on a core set of skills to support staff in refining and using skills in trauma-informed care and systems, harm reduction therapy, and cultural humility and responsiveness.

**B. Compare the WET Plan assessment data with the general population, Medi-Cal population, and 200% of poverty data.**

The WET Plan assessment agrees with known shortages of Spanish-speaking, culturally diverse providers, particularly Latinx/Latine staff to help match our Medi-Cal client base demographics. In addition, the plan calls for increasing the number of people with lived experience in the public mental health system workforce.

C. Provide a summary of targets reached to grow a multicultural workforce in rolling out county WET planning and implementation efforts.

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

Changes	Impacts
Workforce, Education and Training	
<p><b>Comprehensive Training Program:</b> 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.</p>	<p>The addition of a Comprehensive training program can improve client outcomes, DHS-BHD program efficacy, improve staff retention and staff recruitment.</p>

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 (now the Cultural Responsiveness, Inclusion & Training Coordinator) to oversee this mission. The Sonoma County Behavioral Health Cultural Responsiveness, Inclusion & Training Coordinator 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.

The Cultural Responsiveness, Inclusion & 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	<ul style="list-style-type: none"> <li>• Accreditation (BRN, CAMFT, CCAPP)</li> </ul>
Career Pathways	<ul style="list-style-type: none"> <li>• Pipeline Programs</li> <li>• Career &amp; Internship Fairs</li> </ul>
Staff Skill Development	<ul style="list-style-type: none"> <li>• Staff Development Trainings</li> </ul>
WET Activities	<ul style="list-style-type: none"> <li>• 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.</li> </ul>

### 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

- Licensed Vocational Nurse (LVN)
- Licensed Psychiatric Technician (LPT)
- Registered Nurse (RN)
- Public Health Nurse (PHN)
- Nurse Practitioner (NP)
- Psychiatric Nurse Practitioner (PNP)

#### CAMFT

- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Educational Psychologist (LEP)

#### CCAP

- 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 Cultural Responsiveness, Inclusion & Training Coordinator 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.

Currently, the Cultural Responsiveness, Inclusion & Training Coordinator, who is a licensed Marriage and Family Therapist (LMFT), with the assistance of Clinical Specialists from the Quality Assessment & Performance Improvement (QAPI) team, facilitate multiple clinical supervision groups each week, with a focus not only on clinical feedback on current cases but also exam preparation for pre-licensed clinicians.

While Sonoma hoped to increase Peer Support Specialist services throughout the system of care, BHD was unable to fund additional FTE positions. Plans are continuing to create full-time roles for peers, and in the meantime BHD is working with West County Community Services (WCCS), a Sonoma County non-profit with programs including senior services, employment, housing, youth programs, behavioral health, and crisis counseling services. WCCS currently operates peer recovery programs throughout Sonoma County and offers a peer support specialist certification training. Participants learn active listening, emotional literacy, communication skills, cultural responsiveness, ethics and confidentiality, boundaries and self-care, trauma and addiction support, recovery and resilience, crisis intervention, suicide prevention, peer advocacy, and system transformation. As part of the training, peers have an opportunity to practice these skills in placements, including the Behavioral Health Division. The Behavioral Health division is working closely with West County Community Services to create opportunities for placement of individuals with lived experience who are considering a career in the public behavioral health workforce.

As part of the Pipeline Program, the Cultural Responsiveness, Inclusion & Training Coordinator will participate in several community career events at both the high school and college level. Particular focus will be given to encouraging Latinx/Latine and bilingual students to consider Behavioral Health as a career option.

### Participating Universities

Program Category	Participants
Nursing Programs	<ul style="list-style-type: none"> <li>• Sonoma State University (SSU)</li> <li>• Santa Rosa Junior College (SRJC)</li> </ul>
Social Work Programs	<ul style="list-style-type: none"> <li>• California State Long Beach</li> <li>• San Francisco State University (SFSU)</li> <li>• Humboldt State</li> <li>• San Jose State University</li> <li>• University of Southern California</li> <li>• Berkeley</li> </ul>
MFT Programs	<ul style="list-style-type: none"> <li>• SSU</li> <li>• University of San Francisco</li> <li>• SFSU</li> </ul>
Mental Health Worker Programs	<ul style="list-style-type: none"> <li>• SSU</li> <li>• SRJC</li> </ul>

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 hopes to add a full-time clinical specialist role to support this program in the future.

WET Activities	Trainings
Staff Skill Development	<ul style="list-style-type: none"> <li>• Staff Development Trainings</li> </ul>
Comprehensive Training Program	<p>Evidence-Based Practices:</p> <ul style="list-style-type: none"> <li>• Strengths Model Care Management</li> <li>• Family Systems</li> <li>• EMDR</li> <li>• CBT for Psychosis</li> <li>• Cognitive Behavioral Social Skills Training</li> <li>• DBT</li> <li>• Trauma-Focused CBT</li> <li>• Assertive Community Treatment</li> <li>• Harm Reduction</li> <li>• Trauma Informed Systems</li> <li>• CBT for Depression</li> <li>• Seeking Safety</li> <li>• Peer-Based Supports (WRAP, Transformative Mutual Aid Practices)</li> <li>• Psychopharmacology for Non-Medical Staff</li> <li>• Motivational Interviewing</li> </ul>
Culturally Responsive Practices	<ul style="list-style-type: none"> <li>• Incorporating and working with peers in the workforce</li> <li>• Cultural humility</li> <li>• Special concerns for LGBTQIA+ clients</li> <li>• Adapting Evidence-Based Systems to Community Need, “Fidelity vs Fit”</li> </ul>

D. Share lessons learned on efforts in rolling out county WET implementation efforts.

- BHD has lost a number of bilingual staff over the past several years and is challenged by the competition among the county's healthcare system.
- BHD leadership must support managers to attend to recruiting, interviewing, hiring, onboarding, training, and developing and supporting strategies that promote diversity in the workforce needs to attend to its hiring practice as well.

E. Identify county technical assistance needs.

DHS-BHD does not have any identified TA needs at this time.

## Criterion 7: Language Capacity

### I. Increase bilingual workforce capacity

A. Evidence of dedicated resources and strategies counties are undertaking to grow bilingual staff capacity, including the following: (Counties shall document the constraints that limit the capacity to increase bilingual staff.)

1. Evidence in the Workforce Education and Training (WET) Plan on building bilingual staff capacity to address language needs.

Continuous efforts are made by the County to recruit and retain bilingual staff to more accurately reflect the diversity of Sonoma County, specifically focused on the Latinx/Latine and Spanish-speaking community. A significant development worth noting is the establishment of a countywide Office of Equity on August 20, 2020, followed by the establishment of a Department of Health Services Office of Equity in May 2022. Each office also created a core team of equity champions across its administrative division who have received and continue to receive extensive training in antiracism and equity; the champions within the Behavioral Health Division constitute the Behavioral Health Equity Steering Committee, which began meeting in the summer of 2023. The champions in the Department of Health Services, called the DHS Equity Circle, have also begun initial training and planning with DHS leadership to create a Health Equity Action Plan, scheduled to be completed in 2024. This plan will focus both on serving the community and on creating workplace conditions in which diverse employees can thrive.

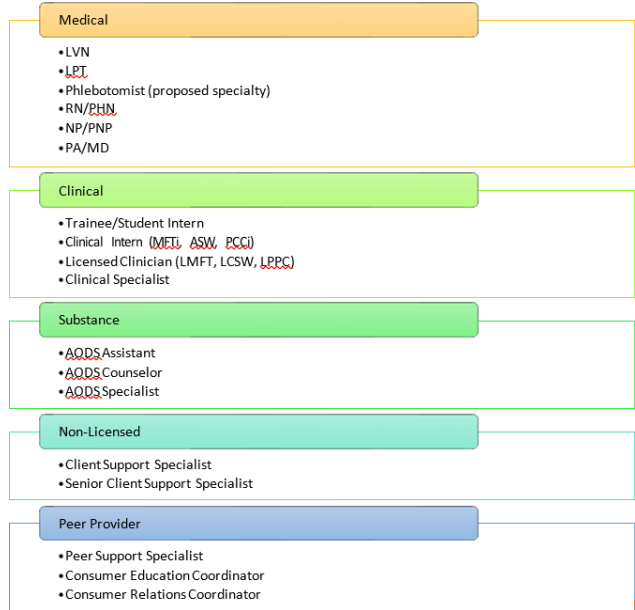
While not explicitly focused on bilingual capacity, BHD's trauma-informed systems transformation project is focused on improving workplace culture, specifically by focusing on management and leadership and developing their skills in leading a diverse, supportive, trauma-informed workplace. Cultural humility and responsiveness is one of the pillars of a trauma-informed system, and will be foundational to all parts of this systems improvement. The Cultural Responsiveness, Inclusion & Training Coordinator is the main coordinator for this effort, further ensuring integration, rather than competition, between trauma-informed changes and equity work. BHD is in the process of an organizational assessment (Tools for Trauma-Informed Worklife) to help identify, and then target, areas of concern for employees regarding organizational culture.

The County of Sonoma has personnel policies that provide for a differential pay increase above the employee's base hourly rate if the position requires at least 10% of the employee's work time to be used in a bilingual English/Spanish capacity. This differential was recently split into two levels, with additional pay added for employees who tested as "fluent" in Spanish. The current policy states that the employee shall be entitled to an additional \$1.15 per hour for basic bilingual skills and an additional \$1.50 per hour for fluent bilingual skills.

As of the most recent data provided by Sonoma County Human Resources, there are 52 bilingual employees in BHD, staffing the three categories of Management, Administrative, and Clinical.

## Career Ladders

The Cultural Responsiveness, Inclusion & Training Coordinator will support the development of promotional opportunities with career tracks to support a Grow-Your-Own Model from entry-level intern/student through supervision and management. This includes formalizing an Internship & Traineeship program, expanding the Peer-Provider program, providing clinical support to pre-licensed and paraprofessional staff, and providing management-level training and support.



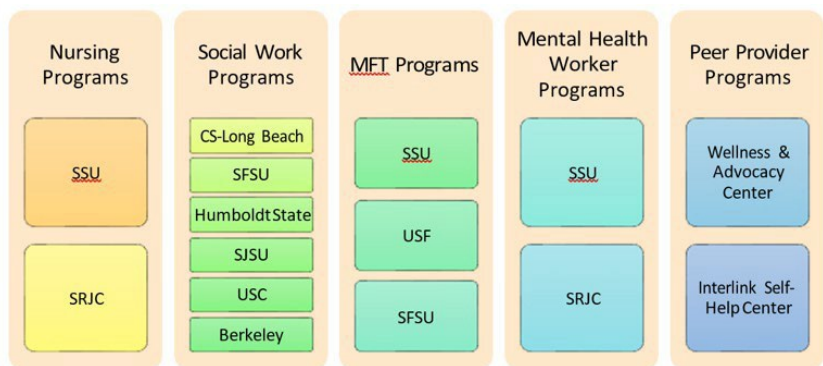
## Internships & Pipeline Programs

To increase and diversify the clinical workforce, BHD works with local universities to assist staff in obtaining clinical licensure and to develop pipeline programs with participating post-secondary schools and universities. The purpose of the pipeline program is to cultivate interest in healthcare careers, particularly in hard-to-fill areas with high-risk, underserved populations. Additionally, the pipeline program preserves diversity in the workforce and reduces health disparities for the consumers. The Cultural Responsiveness, Inclusion & Training Coordinator plans and participates in several community career events at both the high school and college level. Particular focus is given to encouraging Latinx/Latine and bilingual students to consider Behavioral Health as a career option.

BHD is currently working toward allowing peer providers who are still in training through West County Community Services to volunteer in our programs in order to gain experience working with clients and to help BHD ensure that its programs are centering the needs and voices of clients.

## Career & Internship Fairs

The Cultural Responsiveness, Inclusion & Training Coordinator, in coordination with Sonoma County Human Resources, engages in outreach through internship and career fairs at Santa Rosa Junior College, Sonoma State University, and University of San Francisco.



As part of a push to reduce our staff vacancy rate, Sonoma County held its first ever Behavioral Health Job Fair on site in November 2023, which resulted in five job offers for clinical staff.

## Community Health Workers and Pro Promotores

Community health workers and *promotores* (CHW/PPs) have been part of the health care landscape in the United States for decades. Payers and providers increasingly recognize their essential role in supporting people with complex medical and social and behavioral health



needs. The roles that CHW/Ps fill vary widely, including helping individuals navigate the complicated health care system, connecting them to resources to address their social needs, and accompanying them to visits with health providers. Whatever role they play, the work of CHW/Ps is characterized by a deep connection to their community and the lived experience that they share with their clients. They can draw on their knowledge of available resources and the social networks that define their communities, bridging geographic and cultural gaps between the health care system and consumers. CHW/Ps' shared life experience can provide an essential human connection between health care providers and the patients they serve. The behavioral health division is interested in engaging CHW/Ps to build and diversify its behavioral health workforce.

Latino Service Providers (LSP) is a non-profit organization in Sonoma County that works with the community partners to exchange information to increase awareness of available resources, access to programs and services, enhance interagency communication, and promote development within the Latinx/Latine community. LSPs Youth Promotor Internship program seeks to address the mental health inequities in the Latinx/Latine community by meaningfully engaging Latinx/Latine youth in issues related to mental health in the Latinx/Latine community by training youth as community health workers in hopes of inspiring them to seek a career in public behavioral health. As of July 1, 2022, LSP has trained over 150 youth promotores and retained alumni over the years.

BHD is in its second year of hosting pro promotores interns, who have worked with both administrative and the clinical staff to learn about how mental health services are provided in county settings. Additionally, the Department of Health Services has recently hired a Health Program Manager to oversee Community Health Workers at a department level, and BHD is excited to explore ways in which the CHWs may be able to support our behavioral health clients.

2. Updates from Mental Health Services Act (MHSA), Community Service and Supports (CSS), or WET Plans on bilingual staff members who speak the languages of the target populations.

As of March 2023, the Behavioral Health Division (BHD) had the following positions filled by bilingual Spanish speaking staff in the following job classifications.

Position	Bilingual Staff
AOD Counselor I	1
AOD Counselor II	6
AOD Intake Interviewer	1
AOD Specialist	1
Clinical Specialist	1
Clinician	9
Clinician Intern	7
FNP/PA	1
Health Program Manager	1
Nurse	1
Office Assistant II	2
Senior Client Support Specialist	8
Senior Office Assistant	12
Social Services Worker	1

3. Total annual dedicated resources for interpreter services in addition to bilingual staff.

In addition to the staffing referenced above, BHD uses Language Link for spoken languages and Communicate for American Sign Language.

**II. Provide services to persons who have Limited English Proficiency (LEP) by using interpreter services.**

- A. Evidence of policies, procedures, and practices for meeting clients' language needs, including the following:

1. A 24-hour phone line with statewide toll-free access that has linguistic capability, including TDD or California Relay Service, shall be available for all individuals. **Note:** The use of the language line is viewed as acceptable in the provision of services only when other options are unavailable.

Within the BHD Beneficiary Handbook, Sonoma County has an acknowledgement of nondiscrimination and a corresponding policy addressing access to services in languages other than English and formats that are accessible to people with different abilities. The BHD policy is to use a bilingual staff member to provide interpretation services whenever needed. Sonoma County BHD has a 24-hour phone line that is answered by a live person. If bilingual staff are unavailable, BHD uses other resources to provide interpretation. These other resources include:

- CTS Language Link
- CA RELAY TDD

- Least preferable are language lines. Consider use of new technologies such as video language conferencing as resources are available. Use new technology capacity to grow language access.

Sonoma BHD does not solely rely on language lines, though that is one tool to support access to individuals who have limited English proficiency. In addition, BHD has interpreter services on contract and is always seeking to hire a diverse multilingual staff to serve the community. Since the beginning of the Covid-19 pandemic, staff providing telehealth services have expanded their use of video language conferencing.

- Description of protocol used for implementing language access through the county's 24-hour phone line with statewide toll-free access including staff training protocol.

Sonoma County BHD Mental Health Policy MHP-8, "Linking Non-English-Speaking Beneficiaries to Behavioral Health Services and Use of Interpreters" (see Attachment A), provides the protocols to implement language access at no cost, 24 hours a day, seven days a week.

Furthermore, multilingual signage is provided at all BHD county lobbies and at the entryways to contracted providers.

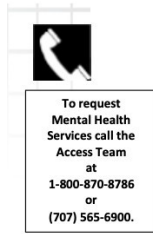
- Evidence that clients are informed in writing in their primary language, of their rights to language assistance services.

Contained in the Sonoma County [Mental Health Plan Beneficiary Handbooks](#) provided to all consumers/beneficiaries is a multilingual notice informing them of their right to access services in their primary language, free of charge. This notice is located on the first two pages of the handbook.

- Evidence that the county/agency accommodate persons who have LEP by using bilingual staff or interpreter services.

The Sonoma MHP EQRO Final Report for Fiscal Year 2022-23 shows that nearly one in eight beneficiaries served in the MHP speak Spanish.

## OTHER LANGUAGES AND FORMATS



### Other Languages

You can get this Beneficiary Handbook and other materials for free in other languages. Call Sonoma County Behavioral Health (SCBH). The call is toll free: 1-800-870-8786.

### Other Formats

You can get this information for free in other auxiliary formats, such as Braille, 18-point font large print, or audio. Call SCBH. The call is toll free: 1-800-870-8786.

### Interpreter Services

You do not have to use a family member or friend as an interpreter. Free interpreter, linguistic, and cultural services are available 24 hours a day, 7 days a week. To get this handbook in a different language or to get interpreter, linguistic, and/or cultural help, call SCBH. The call is toll free: 1-800-870-8786.

## NONDISCRIMINATION NOTICE

Discrimination is against the law. SCBH follows state and federal civil rights laws. SCBH does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation. SCBH provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact SCBH between Mondays through Fridays: 8am – 5pm. Or, if you have difficulty hearing or speaking, please call TYY: 711.



Call Sonoma County Behavioral Health Plan (SCBH) at 1-800-870-8786. SCBH is here Monday through Friday: 8AM-5PM. The call is free. Or visit online at <https://sonomacounty.ca.gov/health/behavioral-health/medi-cal-informing-materials>

**Table 5: Threshold Language of Medi-Cal Beneficiaries Served in CY 2021**

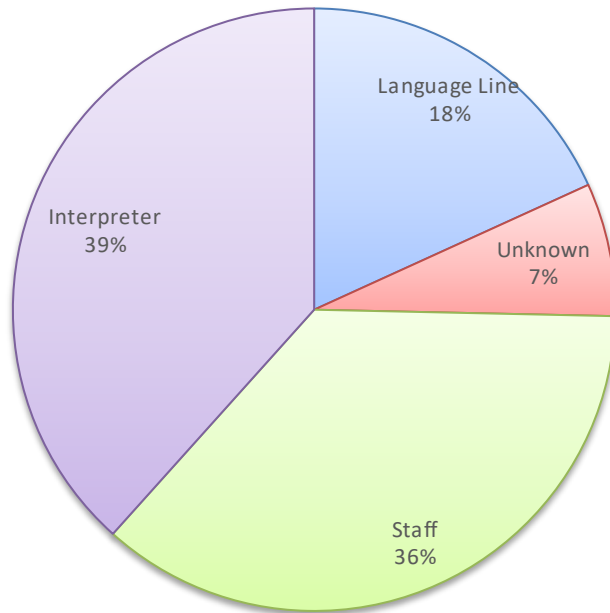
Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percentage of Medi-Cal Beneficiaries Served by the MHP
Spanish	400	12.40%
Threshold language source: Open Data per BHIN 20-070		

Data from Sonoma County’s most recent Network Adequacy Certification Tool show a total of 1022 clinical services provided in non-English languages from July 1, 2022, through March 31, 2023.

Service Description	Encounters
ASSESSMENT	41
ASSESSMENT NON CLAIMABLE	3
COLLATERAL	89
COLLATERAL NON CLAIMABLE	5
CRISIS INTERVENTION	2
CRISIS INTERVENTION NON CLAIMABLE	3
CSU NON MEDI-CAL CLAIMABLE	19
ECM Encounter	1
ECM Outreach Telehealth	1
EM MED SUPPORT OFFICE Time Based Est CLT	390
EM MED SUPPORT OFFICE Time Based New CLT	28
INDIVIDUAL THERAPY	1
INDIVIDUAL THERAPY NON CLAIMABLE	17
MEDICATION SUPPORT NON EM	153
PLAN DEVELOPMENT	18
PLAN DEVELOPMENT NON CLAIMABLE	2
REHABILITATION SERVICES INDIVIDUAL	74
TARGETED CASE MANAGEMENT	158
TARGETED CASE MGMT NON CLAIMABLE	8
TELEHEALTH ASSESSMENT	7
TELEHEALTH PLAN DEVELOPMENT	1
TELEHEALTH TARGETED CASE MANAGEMENT	1
<b>Grand Total</b>	<b>1022</b>

While the Avatar electronic health record did not capture which language was used, it does show whether an interpreter was used, the clinical staff member spoke the required language, or the Language Line was used.

Clinical Services Provided in Non-English Languages  
July 1, 2022 - March 31, 2023



The tables below show Language Line utilization for July 1, 2022, through March 31, 2023, for the 24/7 Access Line, for face-to-face encounters, and for telehealth services:

Language Line Use – 24/7 Access Line	
Language	Encounters
Arabic	
Armenian	
Cambodian	
Cantonese	
Farsi	
Hmong	
Korean	
Mandarin	
Other Chinese	
Russian	1
Spanish	56
Tagalog	
Vietnamese	3
American Sign Language (ASL)	
Burmese	
German	1
Punjabi	1
Tigrinya	2

<b>Language Line Use – Face to Face</b>	
<b>Language</b>	<b>Encounters</b>
Arabic	
Armenian	
Cambodian	
Cantonese	
Farsi	
Hmong	
Korean	
Mandarin	
Other Chinese	
Russian	
Spanish	23
Tagalog	
Vietnamese	5
American Sign Language (ASL)	

<b>Language Line Use – Telehealth</b>	
<b>Language</b>	<b>Encounters</b>
Arabic	
Armenian	
Cambodian	
Cantonese	
Farsi	
Hmong	
Korean	
Mandarin	
Other Chinese	
Russian	
Spanish	343
Tagalog	
Vietnamese	
American Sign Language (ASL)	
Burmese	2
Tigrinya	1

- D. Share historical challenges on efforts made on the items A, B, and C above. Share lessons learned.

Records show that in FY 20-21, the number of calls taken by the Language Line diminished as bilingual staffing and availability increased. This is an obvious cause and effect, that the more bilingual staffing is available, the less reliance on the Language Line is needed. In the data above, Language Line was used only 18% for clinical services in non-English languages, and bilingual staff or interpreters were used 75% of the time.

The goal of maintaining bilingual staffing is challenged by the fact that the BHD is in direct competition for a bilingual workforce with other health systems such as Kaiser Permanente, Sutter Health, St. Joseph's Health, and the community clinics throughout Sonoma County.

- E. Identify county technical assistance needs. (DMH is requesting counties identify language access technical assistance needs so that DMH may aggregate information and find solutions for small county technical assistance needs.)

At this time, there are no technical assistance needs identified.

### **III. Provide bilingual staff and/or interpreters for the threshold languages at all points of contact.**

- A. Evidence of availability of interpreter (e.g. posters/bulletins) and/or bilingual staff for the languages spoken by community.

As noted in earlier in this document, Sonoma County DHS-BHD Mental Health Policy MHP-8, "Linking Non-English-Speaking Beneficiaries to Behavioral Health Services and Use of Interpreters" (Attachment A), provides the protocols to implement language access at no cost, 24 hours, seven days a week. In addition, information for all language access is found on the first pages of the Beneficiary Handbook given to all consumers. Finally, as stated in Mental Health Policy MHP-21, "Required Informing Materials and Translation of written Documents" (Rev. 5-20-19), posters are required to be prominently displayed in the lobbies of BHD offices and posted by contractors providing mental health services to Medi-Cal beneficiaries. (See Attachment B).

- B. Documented evidence that interpreter services are offered and provided to clients and the response to the offer is recorded.

As seen in Criterion 7, II.C. above, 1022 clinical services in language other than English were provided and documented between July 1, 2022, and March 31, 2023.

- C. Evidence of providing contract or agency staff that are linguistically proficient in threshold languages during regular day operating hours.

As of March 2022, BHD had 52 positions filled by bilingual Spanish-speaking staff.

Because the competition for attracting and retaining skilled workers has increased significantly, particularly for health professionals and for bilingual candidates, Sonoma County provides bilingual pay to certified bilingual staff working in specific, bilingual designated positions. In order to receive this premium, staff must meet the established job qualifications and also meet

the County's bilingual certification requirements. This differential was recently split into two levels, with additional pay added for employees who tested as "fluent" in Spanish. The current policy states that the employee shall be entitled to an additional \$1.15 per hour for basic bilingual skills and an additional \$1.50 per hour for fluent bilingual skills.

D. Evidence that counties have a process in place to ensure that interpreters are trained and monitored for language competence (e.g., formal testing).

Bilingual skill testing is conducted by Sonoma County Human Resources (HR). The following process is used to test bilingual (English/Spanish) skills:

- The Department Head or Designee determines the level of proficiency (basic/fluent) required to perform the duties of the position:
  - Basic: the ability to verbally communicate in English and Spanish effectively, conversationally proficient. The individual will speak only, and work will be limited to providing verbal information to clients and to the public. They will not translate text or transcribe verbal communications.
    - Example: an Office Assistant or Receptionist primarily assists the public by answering questions, such as the location of another building, the restroom, locating an appropriate form, etc.
  - Fluent: the ability to speak, read, write, and translate between English and Spanish, at a highly proficient level. Translation is defined as the process of translating words or text from one language into another. This level is used for positions where employees may have a higher degree of interaction with and responsibility to the public or clients.
    - Example: a Social Service Worker primarily assigned to work in a courtroom setting, in which their clients need verbal information translated from English to Spanish.
- The Department submits a certified/complete Bilingual Proficiency Exam Request Form to HR.
- HR schedules the individual(s) for the next available exam session.
  - "No Shows" and last-minute cancellations will not be automatically rescheduled.
- HR tests the examinee(s) at the level requested by the Department.
  - Basic: This exam has 7 work-related exam questions. Exam Raters may allow some mixed language use and can simplify the questions to aid the examinee in understanding and responding to the questions. Speech may not be grammatically correct. The Raters will assess the examinee's ability to understand and use a common vocabulary, handle day-to-day verbal communication, and determine whether the examinee can be easily understood by a monolingual person.
  - Fluent: This exam has 3 sections: conversational, oral reading/translation, and a writing performance exercise. At this highly proficient level, the examinee is expected to fully comprehend and correspond in both English and Spanish. With the understanding that specialized terms in their area of responsibility will be learned on the job, Exam Raters assess



the examinee's command of language to determine their ability to perform the duties of the position.

- Within approximately one week of the exam:
  - If the candidate has passed the exam, HR will send exam results to the examinee, HR Liaison, and Payroll Clerk. This formal notice is viable for the duration of the examinees' employment with the County of Sonoma and should be placed in their personnel file.
  - If the candidate has failed the exam, HR will notify the HR Liaison and Payroll Clerk to discuss applicable next steps. After that conversation has occurred HR will send results to the examinee, HR Liaison, and Payroll Clerk.

#### **IV. Provide services to all LEP clients not meeting the threshold language criteria who encounter the mental health system at all points of contact.**

A. Policies, procedures, and practices that include the capability to refer, and otherwise link, clients who do not meet the threshold language criteria (e.g., LEP clients) who encounter the mental health system at all key points of contact, to culturally and linguistically appropriate services.

As noted earlier, the Beneficiary Handbook and corresponding policies clearly provide for language access through bilingual staffing, language interpreters, or the Language Line (last resort) for all aspects of the continuum of care. In addition, materials translated into the threshold language of Spanish are available to all staff.

B. Provide a written plan for how clients who do not meet the threshold language criteria, are assisted to secure, or linked to, culturally and linguistically appropriate services.

The MHP maintains a policy to ensure that all client and MHP contact providers link non-English speaking clients to culturally and linguistically competent mental specialty mental health services regardless of language spoken. Sonoma County's Mental Health Policy MHP-8, "Linking Non-English-Speaking Beneficiaries to Behavioral Health Services and Use of Interpreters," (see Attachment A) explains the process.

C. Policies, procedures, and practices that comply with the following Title VI of the Civil Rights Act of 1964 (see page 27) requirements:

1. Prohibiting the expectation that family members provide interpreter services;
2. A client may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services; and
3. Minor children should not be used as interpreters.

Sonoma County's Mental Health Policy MHP-8, "Linking Non-English-Speaking Beneficiaries to Behavioral Health Services and Use of Interpreters," clearly states the three policy positions above. Please see Attachment A.

#### **V. Required translated documents, forms, signage, and client informing materials**

A. Culturally and linguistically appropriate written information for threshold languages, including the following, at minimum:

1. Member service handbook or brochure;
2. General correspondence;
3. Beneficiary problem, resolution, grievance, and fair hearing materials;
4. Beneficiary satisfaction surveys;
5. Informed Consent for Medication form;
6. Confidentiality and Release of Information form;
7. Service orientation for clients;
8. Mental health education materials, and
9. Evidence of appropriately distributed and utilized translated materials.

As noted previously, Spanish is the only threshold language for Sonoma County. The Mental Health Plan Member Service Handbook is published in English and Spanish and kept on file for regular review, updating, and access by staff on a common computer drive. Forms, including Informed Consent and Release of Information, are generated through the semi-statewide electronic health record, SmartCare, and are available in Spanish. In addition, consumers/beneficiaries can access all documents in English and Spanish on the County's website:

[https://sonomacounty.ca.gov/Main%20County%20Site/Health%20and%20Human%20Services/Health%20Services/Documents/Behavioral%20Health/\\_Documents/Beneficiary-Handbook-with-Taglines-rem.pdf](https://sonomacounty.ca.gov/Main%20County%20Site/Health%20and%20Human%20Services/Health%20Services/Documents/Behavioral%20Health/_Documents/Beneficiary-Handbook-with-Taglines-rem.pdf)

- B. Documented evidence in the clinical chart, that clinical findings/reports are communicated in the clients' preferred language.

BHD conducts quarterly chart audits and is required to include one chart for a client who prefers Spanish (threshold language) for services.

- C. Consumer satisfaction survey translated in threshold languages, including a summary report of the results (e.g., back translation and culturally appropriate field testing).

Each year, DHS-BHD administers the Consumer Perception Survey in May. This survey is offered in English and Spanish. The goals of this survey are to collect data for the federal Nation Outcome Measures (NOMs) required by the Substance Abuse and Mental Health Services Administration (SAMHSA). Receipt of federal Community Mental Health Services Block Grant funding is contingent upon the submission of this data. The Consumer Perception Survey is a state issued and controlled survey, and the BHD cannot change labels, age categories, or wording of questions. The Quality Improvement Manager summarized the results and made the following recommendations:

### **2022 Consumer Perception Survey Summary and Recommendations**

Satisfaction with services varied between the four population groups surveyed. For adults, satisfaction increased across all domains relative to the previous year. Given the large sample size of adult respondents (160), this finding is a substantive one. One possible explanation for the increase in satisfaction could be related to the network's return to more in-person service offerings starting in 2022. This explanation is also supported by higher rates of satisfaction with adult social connectedness, in comparison to the two previous COVID-pandemic years. A separate exploration of service data from 2021 and 2022, focusing specifically on the location type of service, will help shed more light on this theory.

Of all four groups analyzed, youth had lowest overall satisfaction scores. Youths and families experienced two years of declining general satisfaction rates, which was most pronounced in both the outcome and perception of functioning domains. Ratings on satisfaction with social connectedness continued to decrease for youth; however, they were slightly better for families. A promising strength for both youth and families, evident in three years' worth of satisfaction data, pertains to consistently high satisfaction with the cultural appropriateness of youth services. Youth and families consistently score this among the highest domains.

The analysis of satisfaction by gender, ethnicity, and race is complicated by low sample sizes in all but the adult groups. Several observations are worth making, however. First, the number of other-gender respondents increased significantly and dramatically for youth. Approximately 25% of all youth surveys were completed by youth who identified as "other" gender, a 300% increase over the previous year. This finding suggests that youth serving programs may benefit from extra training and resources to support youth and families for which gender identity issues are emergent.

Finally, a complex and somewhat contradictory finding relates to satisfaction for mixed-race or multi-racial beneficiaries. Satisfaction scores tended to be below the minimum satisfaction threshold for mixed race adults and youth. By contrast in parents/families who identified their children as mixed race, satisfaction scores were higher. Furthermore, while mixed race had low satisfaction scores generally, they showed high satisfaction with the cultural appropriateness of services. This pattern suggests that while consumers find staff respectful of their cultural identity, the program or service model itself may be less effective in meeting the needs of this group. Further investigation and consideration of practice interventions and approaches that have an evidence base in mixed-race populations is warranted and recommended.

D. Report mechanisms for ensuring accuracy of translated materials in terms of both language and culture (e.g., back translation and culturally appropriate field testing).

The standard practice for Sonoma County BHD is to have translated documents proofread by at least two bilingual staff to ensure accuracy and accessibility.

E. Report mechanisms for ensuring translated materials are at an appropriate reading level (6th grade). Source: Department of Health Services and Managed Risk Medical Insurance Boards.

To monitor readability and access for those needing an appropriate reading level, documents are proofread by utilizing Word options in the software to show readability statistics. This application will provide a Flesch-Kincaid Grade Level for the selected content.

## Criterion 8: Adaptation of Services

### I. Client driven/operated recovery and wellness programs

A. List client-driven/operated recovery and wellness programs and options for consumers that accommodate racially, ethnically, culturally, and linguistically specific diverse differences.

Sonoma County is seeking to build on four client-driven/operated recovery and wellness programs provided under the auspices of West County Community Services:

- Wellness and Advocacy Center, Santa Rosa
- Interlink Self-Help Center, Santa Rosa
- Petaluma Peer Recovery Program, Petaluma
- Russian River Empowerment Center, Guerneville

In addition, Positive Images, a MHS A PEI funded program for the LGBTQIA+ community, uses a peer-based and peer-led socio-educational model with support groups, social activities, community education, and activism.

### II. Responsiveness of mental health services

A. Documented evidence that the county/contractor has available, as appropriate, alternatives and options that accommodate individual preference, or cultural and linguistic preferences, demonstrated by the provision of culture-specific programs, provided by the county/contractor and/or referral to community-based, culturally-appropriate, non-traditional mental health provider.

As required, Sonoma County provides a [Provider Directory](#) to all new clients, which has descriptive information regarding types of services available, populations served, and/or linguistic capabilities. DHS-BHD develops contracts with a number of community-based organizations who provide non-traditional mental health services.

The following chart illustrates the contractors and their focus in working with specific populations that are traditionally underserved.

Agency / Population Focus	Interpretation & Translation	Disparities Reduction	Outreach & Engagement	Culturally Appropriate Mental Health Services
Latino Service Providers/ Latinx		X	X	X
Sonoma County Indian Health Project/ Native Americans		X	X	X
Positive Images / LGBTQIA+		X	X	X
Community Baptist Church Collaborative / African Americans		X	X	X

Santa Rosa Community Health Centers/ Communities of Color		X	X	X
Alliance Health Center/ Latinx	X	X	X	X
West County Health Services/LGBTQII		X	X	X
Alexander Valley Health Center/Latinx	X	X		

- B. Evidence that the county informs clients of the availability of the above listing in their member services brochure. If it is not already in the member services brochure, the county will include it in their next printing or within one year of the submission of their CCPR.

DHS-BHD provides each beneficiary/consumer with the DHCS required Guide to Medi-Cal Mental Health Services in either English or Spanish. Also, both documents can be found on the County’s website:

<https://sonomacounty.ca.gov/health-and-human-services/health-services/divisions/behavioral-health/contractor-resources/medi-cal-informing-materials>

- C. Counties have policies, procedures, and practices to inform all Medi-Cal beneficiaries of available services under consolidation of specialty mental health services.

DHS-BHD Mental Health Policy MHP-21, “Required Informing Materials and Translation of Written Documents,” states that DHS-BHD and its contracted providers will provide to all beneficiaries written informing materials that are critical to obtaining Specialty Mental Health Services at the first face- to-face contact and/or upon request. In addition, informing materials will be displayed in the lobbies of all county-owned/operated programs and contract provider programs. (See Attachment B.)

- D. Evidence that the county has assessed factors and developed plans to facilitate the ease with which culturally and linguistically diverse populations can obtain services. Such factors should include:

1. Location, transportation, hours of operation, or other relevant areas

BHD’s Access team is located within the main Behavioral Health Campus at The Lakes business complex in Santa Rosa. Clinical services, including crisis and peer services, are co-located and centralized to provide easier access. In addition, a main bus line has a stop in front of BHD complex. This Behavioral Health Campus is located in the southern section of Santa Rosa and is close to the heart of the Latinx/Latine community, known as Roseland, where many Medi-Cal beneficiaries reside. This area is also accessible to many parts of Sonoma County given its proximity to the major highways. DHS-BHD also maintains clinics in the outlying areas of Sonoma, Petaluma, Guerneville, and Cloverdale to provide easier access for clients living in the east, south, west, and north areas of the county.

Since the Covid pandemic in 2020, BHD has also expanded the use of virtual clinical services to augment in-person services, which can help alleviate transportation issues.

Hours of operations are generally 8am-5pm, Monday through Friday. Our five Full Service Partnerships provide services to clients beyond those hours, as needed, including weekends. We also have several options for after-hours services. Optum provides after-hours phone coverage to provide information and referrals, and our screening team is generally available until 7pm on weekdays. Our Crisis Stabilization Unit and our Crisis phone line provide services 24 hours a day, seven days a week. Our Mobile Support Team currently operates 11am to 7pm and will soon expand to offer 24/7 coverage.

2. Adapting physical facilities to be accessible to disabled persons, while being comfortable and inviting to persons of diverse cultural backgrounds (e.g., posters, magazines, décor, signs)

All county-owned facilities have access for people with disabilities. Many locations have upgraded their waiting rooms to be more client-centered, culturally inclusive, and inviting.

3. Locating facilities in settings that are non-threatening and reduce stigma, including co-location of services and /or partnerships, such as primary care and in community settings. (The county may include evidence of a study or analysis of the above factors, or evidence that the county program is adjusted based upon the findings of their study or analysis.)

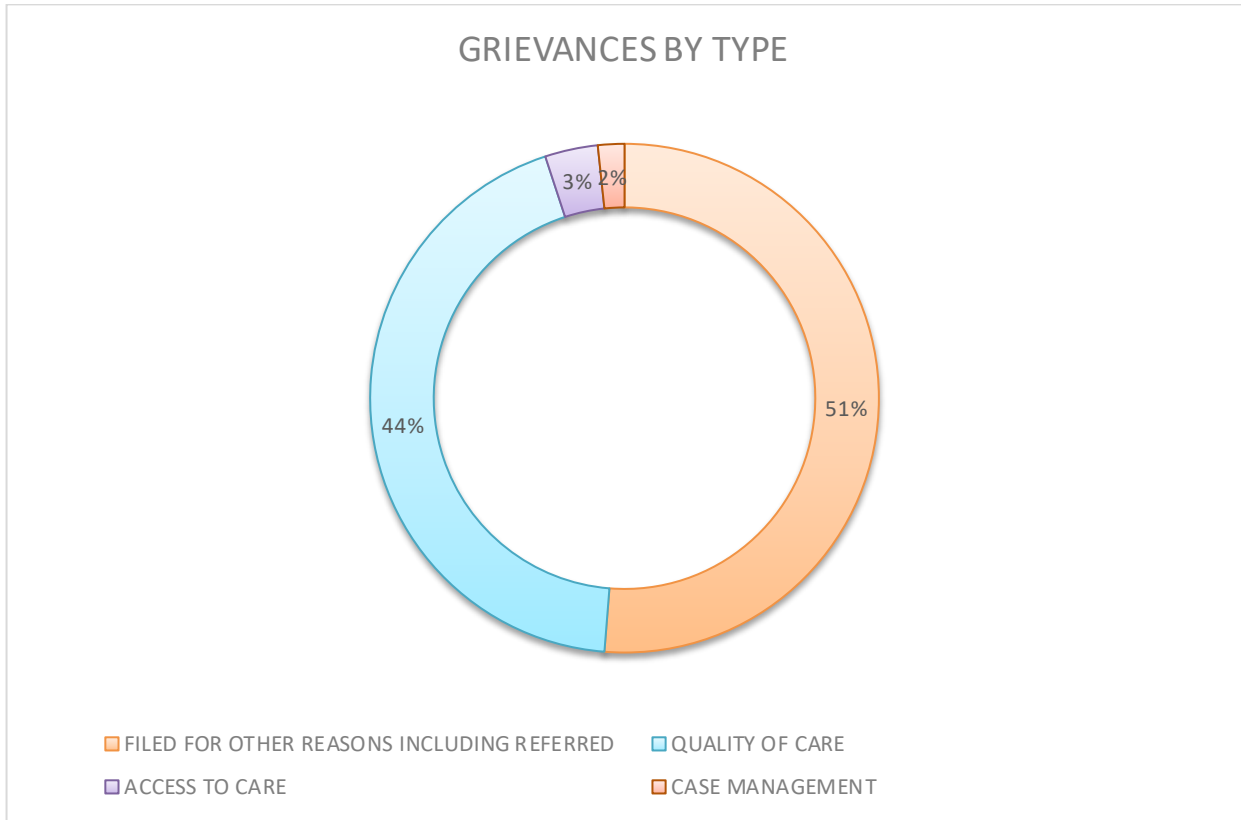
As part of the MHSA planning process, in order to provide more services to the Latinx/Latine population, it was decided to co-locate services as much as possible with the community health centers (FQHCs and Sonoma County Indian Health Project). In addition, BHD has a variety of community-based nonprofits that provide an array of prevention, early intervention, and clinical services in locations that are accessible to the populations intended to be served and in an appropriate cultural setting.

### III. Quality Assurance

- A. Grievances and Complaints: Provide a description of how the county mental health process for Medi-Cal and non-Medi-Cal client Grievance and Complaint/Issues Resolution Process data is analyzed and any comparison rates between the general beneficiary population and ethnic beneficiaries.

Prominently displayed in the Beneficiary Handbook and on the County's DHS-BHD website is a statement of Client Rights and guidelines to file a grievance in English and Spanish. DHS-BHD records all Medi-Cal Beneficiary grievances and appeals filed through the fiscal year. In FY 2022-23, a total of 119 grievances were filed resulting in 119 "Resolved" (per DHCS, a grievance is "resolved" when it has reached completion and been closed by the Plan), 27 Active (still pending or in process as of June 1st), and 16 cases referred (to the source of grievance). Grievances are reviewed quarterly and/or annually by the Quality Assurance Manager to determine if trends and patterns warrant a policy review or development, provider credentialing review, training implications, or other quality improvement concerns. A new Behavioral Health Grievance and Discrimination Grievance Policy has gone into effect for FY 23-24 that incorporates both Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) grievances, including discrimination grievances. An updated Grievances Procedure with the addition of Discrimination Grievances has gone into effect as well.

The chart below summarizes the types of grievances filed.



# Attachment A



# COUNTY OF SONOMA

## DEPARTMENT OF HEALTH SERVICES

### BEHAVIORAL HEALTH DIVISION: MENTAL HEALTH SERVICES

ISSUE DATE: 11/25/2002	POLICY NO: MHP - 08
REVISION DATE: 03/02/2020	POLICY NAME: <b>Linking Non-English Speaking Beneficiaries to Behavioral Health Services and Use of Interpreters</b>
APPROVED BY: <hr/> Behavioral Health Services Director	REFERENCE/AUTHORITY: <ol style="list-style-type: none"><li>1. MHP Contract, Exhibit A, Attachment I, MHP Contract, Attachment 11, Item 3</li><li>2. CCR 1810.410</li><li>3. DMH Information Notice 10-17</li></ol>

### **POLICY:**

The Sonoma County Department of Health Services, Behavioral Health Division (DHS-BHD), Mental Health Plan (MHP) maintains a policy to ensure that all beneficiaries and MHP contracted providers are informed about specialty mental health services (SMHS) offered by the MHP and have procedures in place to link Non-English speaking beneficiaries to culturally and linguistically competent providers.

Beneficiaries will have access to culturally and linguistically competent staff or interpreters at all key points of contact and in all DHS-BHD programs. All oral interpretation and sign language services will be provided free of charge to all MHP beneficiaries.

It is the policy of the MHP to use a DHS-BHD county-certified bilingual staff member who speaks the primary language of the person seeking treatment whenever possible. It is expected that DHS-BHD programs will assist each other in this regard to provide essential language services whenever possible. Furthermore, it is the policy to not use family members to interpret for the beneficiary, or for the beneficiary to interpret for the family; except at the request of the beneficiary, and only when the beneficiary has been informed of the availability of free interpreter services and declines these services.

## PROCEDURE:

### I. Definitions

- A. **Beneficiary:** Individuals who receive SMHS provided by the MHP.
- B. **Key points of contact:** Common points of access to SMHS from the MHP, including but not limited to the MHP's 24-hour toll-free line, the Beneficiary Grievance and Appeals Process, MHP contract providers, or any other central access locations established by the MHP.
- C. **Threshold language:** A language that has been identified as the primary language, as indicated on the Medi-Cal eligibility Data System (MEDS) of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area.

### II. Standards for Linking Non-English Speaking Beneficiaries to SMHS

- A. Key points of contact, such as the Access Team, Crisis Stabilization Unit (and other MHP program locations), will have posted a notice in English and Spanish that beneficiaries have a right to free language assistance services, including sign language services, and how to access these services. Beneficiaries with LEP are informed of these rights and how to access services by the use of interpreters.
- B. A statewide toll-free telephone number will be available 24 hours a day, 7 days a week, with language capability in all languages spoken by beneficiaries of the County.
- C. For beneficiaries who are deaf or hearing-impaired, a telephone communication device for the deaf (TTY machine) will be used [TTY: 711].
- D. See ***MHP – 21 Required Informing Materials and Translation of Written Documents*** policy for requirements concerning written document formatting, translation, and threshold languages.

### III. Use of Bilingual Staff and Interpreters

- A. When there is no clinical staff member who can speak the beneficiary's preferred language, it is the policy of the MHP to use county-certified, bilingual staff as interpreters to assist beneficiaries and staff in providing mental health services for those beneficiaries who do not speak English, or have LEP capability.
- B. Whenever possible, and when practical, attempts should be made to use County-certified, bilingual clinical staff for clinical services. This is especially important when providing an initial assessment, discontinuing a 5150 detention, or for evaluating any high-risk situations, including homicide or suicide ideation.
- C. If county-certified, bilingual clinical staff are not available, County-certified, bilingual clerical staff may be used.
- D. Telephone calls: When it has been determined that a caller needs an interpreter,

the staff receiving the call should make all efforts to find either a County-certified bilingual staff member in their program with the necessary language skills, or use the SCBH designated language line vendor to request a telephone interpreter for interpretive services (see attached instructions).

- E. Face-to-Face interviews: When setting up a face-to-face meeting with a beneficiary, it is incumbent upon the staff to ascertain the need for an interpreter, and arrange for one prior to the meeting. This includes beneficiaries who are deaf/hearing-impaired and need sign-language interpretative services. Allow sufficient time for the meeting to ensure adequate interpretation. Medication services appointments are to be extended for additional time to ensure a thorough clinical assessment.
- F. If the staff member involved with the beneficiary does not speak the beneficiary's preferred language, then the staff member should consult with their Health Program Manager (HPM) regarding the use of another County-certified bilingual team member who does speak the beneficiary's preferred language to either provide the service, or to provide interpretation.
- G. If there is no other county-certified bilingual staff member available within that team, then it is permissible to seek help from DHS-BHD staff from outside of that team. Staff should inform their HPM of their need.
- H. The HPM may contact another HPM to request the use of County-certified bilingual staff supervised by this HPM.
- I. The requesting HPM should make a determination as to the level of service needed, and should be as specific as possible regarding:
  - 1. The acuity of the situation (e.g. emergency vs: urgent vs. regular appointment)
  - 2. The type of service necessary (clinical vs. administrative)
  - 3. The nature of the relationship requested (e.g. clinical or administrative)
- J. If no county-certified bilingual staff member is available to provide interpretive services, then a MHP designated vendor for interpretive services may be used to assist in providing the service. (see attached list of vendors.)
- K. If using a contracted vendor, it is advisable to give them as much notice of the meeting as possible.

#### **IV. Use of an Interpreter when conducting a Face-to-Face Interview**

- A. Pre-Interview and Interview
  - 1. Staff should instruct interpreter as to the nature of the meeting prior to the interview. Review topics to be covered and any potentially sensitive topics;
  - 2. Provide for additional length of session time;
  - 3. Review seating arrangements. Whenever possible, the interpreter should sit (slightly behind and to the side of the beneficiary);
  - 4. The interpreter should interpret everything spoken by either party;

5. Staff should instruct the beneficiary "do not say anything that you do not want to be interpreted";
6. The interpreter should always ask for clarification from the clinician and the beneficiary if something is not clear;
7. Pay attention to nonverbal cues and impact of culture.

**B. Post-Interview**

1. Review session to see if there are any areas of concern that were not discussed or any areas that may still be unclear;
2. Clarify cultural factors, beliefs, behaviors that could influence assessment and diagnosis;
3. Discuss issues that may have been difficult or problematic for the interpreter;
4. Discuss planning for future sessions as appropriate.

**C. Family Member Interpretation**

1. A family member shall not be allowed to interpret for the beneficiary, nor should the beneficiary be allowed to interpret for or to the family;
2. Except at the request of the beneficiary, and only when the beneficiary has been informed of the availability of free interpreter services and declines these services;
3. The reasons for using a family member to interpret must be documented in the progress note, including the offer to utilize free interpreter services and the beneficiary's decline of such services.
4. Minor children should not be used as interpreters.
5. Family members shall never be used to interpret when evaluating someone to discontinue a 5150 detention, or for evaluation of any high risk situation, including evaluation of suicidal or homicidal ideation.

**V. Documentation and Claiming for Services**

- A.** Documentation of a beneficiary's preferred language other than English must be entered in the Initial Assessment and in the individual Progress Note, and whether the service provided was in a language other than English and if so, whether an interpreter was used.
1. If an interpreter is used, the Progress Note should include who provided the interpretation, and what language was spoken. If the staff member conducted the session in a different language, the Progress Note should reflect what language was spoken.

2. Documentation that interpreter services are offered to the beneficiary and the beneficiary's response to the offer is documented in the Progress Note.
- B. The staff member providing interpretative services does not claim for interpretative services. For example- if a county-certified, bilingual staff member provides interpretative services for beneficiary at the request of another staff member, only the requesting staff member is allowed to claim for services provided.
- C. Translation and Interpretative services are non-reimbursable and cannot be claimed to Medi-Cal.

**SCBH FORMS:**

1. MHS 403 Free Language Assistance Poster (English & Spanish)
2. Behavioral Health Services Staff Available for Bilingual Interpretation List
3. <http://sc-intranet/dhs/bh-policies.htm>

**ATTACHMENTS:**

1. Instruction sheet: How to Request Interpretation Services with CTS Language Link
2. CTS Account Number Codes by SCBH PROGRAM list
3. Communique ASL Interpreter Request Form

# **Attachment B**

# COUNTY OF SONOMA

## DEPARTMENT OF HEALTH SERVICES

### BEHAVIORAL HEALTH DIVISION: MENTAL HEALTH SERVICES

ISSUE DATE: 03/31/2017	POLICY NO: MHP-21
REVISION DATE: 05/20/2019	POLICY NAME: <b>Required Informing Materials and Translation of Written Documents</b>
APPROVED BY: _____ Behavioral Health Services Director	REFERENCE/AUTHORITY: <ol style="list-style-type: none"><li>1. Code of Federal Regulations, Title 42, §438.10</li><li>2. Code of Federal Regulations, Title 45, §92.8</li><li>3. California Code of Regulations, Title 9, Chapter 11, §1810.360 and §1810.410</li><li>4. Department of Health Care Services (DHCS), Mental Health Substance Use Disorders Services Information Notice NO.: 18-020 and 18-043</li><li>5. DHCS-Sonoma County Behavioral Health Mental Health Plan Contract 17-94619</li><li>6. 81 Federal Register Volume 81, Issue 96 31375, Nondiscrimination in Health Programs and Activities</li></ol>

#### POLICY:

The Sonoma County Behavioral Health Division (SCBH) and its contracted providers will provide to all Medi-Cal beneficiaries served by the Sonoma County Mental Health Plan (MHP) written informing materials that are critical to obtaining Specialty Mental Health Services (SMHS). Informing materials will be provided to Medi-Cal beneficiaries at the first face-to-face contact and upon request. Additionally, informing materials will be displayed in the lobbies of all MHP county-owned/operated programs and contracted provider programs. Electronic versions of informing materials will be available on the SCBH website.

Informing materials will be available in Sonoma County's threshold languages and upon request, alternative formats will be available to beneficiaries at no cost and in a format that the beneficiary can easily understand. Upon request, oral and alternative interpretation of informing materials will be provided; this includes the availability of auxiliary aids and services, such as TTY/TDY and American Sign Language. Language Assistance Taglines and a Non-Discrimination Notice shall be included in all informing materials, and posted in MHP county-owned/operated programs and contracted provider programs.

#### Definitions:

Sonoma County's *threshold languages* are English and Spanish. This means that these languages have been identified as the primary language of either 3,000 Medi-Cal beneficiaries or 5% of the beneficiary population, whichever is lower, in the County geographic area. Thus, all written informing materials are available in English and Spanish.

*Informing materials* include, but are not limited to, program literature that is critical to assisting beneficiaries in accessing mental health services, explain the beneficiary problem resolution and fair hearing process, and identify beneficiary rights and protections.

*Alternative formats* for written materials include, but are not limited to, large print or oral interpretation/audio format. The MHP readily has large print formats available and other formats (e.g., audio, braille) will be provided upon request.

*Language Assistance Taglines* is a notification explaining the availability of written or oral translation and includes the toll-free and TTY/TDY telephone number of the MHP's customer service unit. This notification is written in English, large-print (18-point font), and the top 16 non-English languages spoken by individuals with Limited English Proficiency.

*Non-Discrimination Notice* is a notification that the MHP must comply with non-discrimination and accessibility requirements.

## **PROCEDURE:**

### I. Informing Materials Provided to all Medi-Cal Beneficiaries

The following documents must be provided to beneficiaries at the first face-to-face contact with them and upon request:

- A. *Guide to Medi-Cal Mental Health Services Handbook*
- B. *Sonoma County MHP Provider Directory*
- C. *HIPAA Provider's Notice of County Privacy Practices*
- D. *Client Rights and Grievance/Appeal Process and Form*-with County addressed envelope
- E. *Your Right to Make Decisions About Medical Treatment-Advanced Directive* brochure (adult service providers only)
- F. *Early & Periodic Screening, Diagnosis & Treatment Including Therapeutic Behavioral Services* brochure (for providers of youth - up to age 21 years)

***NOTE: An acknowledgement of receipt must be obtained from all beneficiaries who are offered the identified informing materials (Use MHS 115-Consent for Treatment).***

### II. Informing Materials Postings for Medi-Cal Provider Lobbies

The following documents must be readily available in the lobbies of all Medi-Cal certified provider sites:

- A. *Guide to Medi-Cal Mental Health Services Handbook*
- B. *Sonoma County Mental Health Plan Provider Directory*
- C. *HIPAA Provider's Notice of County Privacy Practices*
- D. *Client Rights and Grievance/Appeal Process and Form* with County addressed envelopes
- E. *Your Right to Make Decisions About Medical Treatment-Advanced Directive* brochure (adult service providers only)
- G. *Early & Periodic Screening, Diagnosis & Treatment Including Therapeutic Behavioral Services* brochure (for providers of youth - up to age 21 years)
- F. *Free Language Assistance Services* (Taglines)
- G. *Point to Your Language*
- H. *Consumer Notification of Licensing Boards*



- I. *Mental Health Patients' Rights* Poster (for Residential Treatment and other 24-hour treatment facilities)
- J. *Request for Change of Service Provider*
- K. *Non-Discrimination Notice*

### III. Translation of Written Materials

SCBH staff and contractors will provide to Medi-Cal beneficiaries, informing materials in Sonoma County's threshold languages (English and Spanish) and in Large print (18-point font) format.

When applicable, SCBH staff will also ensure that other SCBH documents are translated into threshold languages, or provided in alternative formats upon request. For this purpose, SCBH contracts with a language interpretation and translation service (See policy *MHP 08-Linking Non-English Speaking Beneficiaries to Mental Health Services and Use of Interpreters*).

- A. Requests for written translation of formal SCBH documents are to be e-mailed to the Mental Health Plan Quality Assurance Manager (MHP-QA Manager) for review and authorization.
  - i. Less formal document translation, such as a single letter to a client during the course of treatment, may be translated by SCBH bilingual staff without going through the MHP-QA Manager (SCBH maintains a list of bilingual staff).
    - a. In these cases, review of the document by at least one other bilingual staff person is recommended before distribution of the document.
- B. Either the contracted language service or the identified bilingual staff person provides translation into Latin American Spanish, the type of Spanish that is most relevant to the County's Spanish-speaking clients.
- C. To ensure both accuracy of translation and cultural appropriateness, upon receipt of a translated document, the MHP-QA Manager will request review of the document by at least one bilingual SCBH staff member, who will notify the MHP-QA Manager of any recommended edits.
  - i. Any edits will be made by Quality Assurance (QA) staff before the document is released for use by SCBH and/or MHP contracted provider.
- D. With previously published SCBH documents, if an error in translation is identified; if content is deemed culturally insensitive for any reason; or if a document must be adapted to be accessible to persons with limited reading proficiency, the MHP-QA Manager will make necessary modifications/edits by adhering to the abovementioned review and approval process prior to re-release of the document.

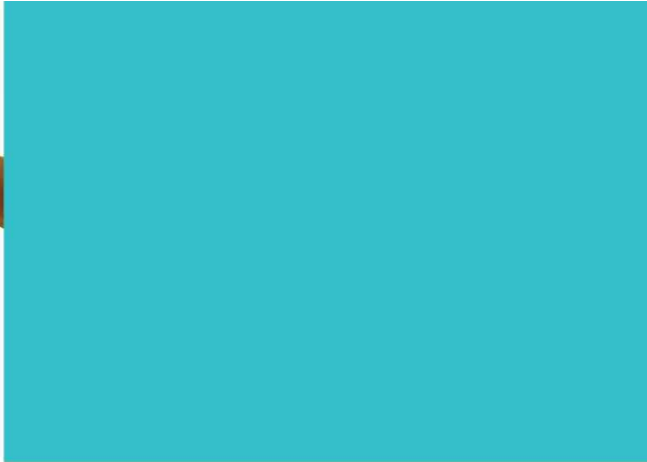
- E. When a revised document becomes available, QA staff will inform all applicable SCBH staff and/or MHP contracted providers of the change and request that any outdated documents be discarded and replaced by the revised version.
  - i. QA staff will save the current document in a shared folder on the SCBH network for all staff to access and archive the outdated document.
  - ii. QA staff will update the SCBH website with the revised document.

**FORMS/BROCHURES:**

1. *Guide to Medi-Cal Mental Health Services Handbook*
2. *Sonoma County Mental Health Plan Provider Directory*
3. *HIPAA Provider's Notice of County Privacy Practices*
4. *MHS 406-Client Rights and Grievance/Appeal Process and Form* with County addressed envelopes
5. *MHS 157-Your Right to Make Decisions About Medical Treatment-Advanced Directive* brochure (adult service providers only)
6. *Early & Periodic Screening, Diagnosis & Treatment Including Therapeutic Behavioral Services* brochure (for providers of youth - up to age 21 years)
7. *MHS 162-Free Language Assistance Services* (Taglines)
8. *Point to Your Language*
9. *MHS 402-Consumer Notification of Licensing Boards*
10. *MHS 400-Mental Health Patients' Rights* Poster (for Residential Treatment and other 24-hour treatment facilities)
11. *MHS 109-Request for Change of Service Provider*
12. *MHS 158-Non-Discrimination Notice*
13. *MHS 115-Consent for Treatment*

**ATTACHMENTS:**

1. Medi-Cal Informing Materials available online at:  
<http://www.sonoma-county.org/health/publications/medi-calinforming.asp>



LIFE WORTH LIVING

VIVA LA VIDA

Alianza para la Prevencion del Suicidio del Condado de Sonoma  
Sonoma County Suicide Prevention Alliance

# Sonoma County Suicide Prevention Strategic Plan

**2024 - 2029**

## Dedication

This strategic plan is dedicated to residents of Sonoma County who have been touched by suicide: through experiencing suicidal thoughts, by a suicide attempt, as a loss survivor, or as a provider of care and support for individuals impacted by suicide. Together, we can make a difference by preventing the tragedy of suicide in our community as well as helping one another to create a life worth living.

## You Are Not Alone

Please remember that help is available through local and national resources. If you or someone you care about is in emotional distress or thinking about suicide, help and support are available from a wide variety of services. For help identifying local resources, call 211.



The next pages have many of these services, focused on helping our community members safely navigate a crisis and find support.

Contact us: [Life-Worth-Living-Suicide-Prevention@sonoma-county.org](mailto:Life-Worth-Living-Suicide-Prevention@sonoma-county.org)

# Sonoma County Crisis Resources

## **988: Suicide Prevention & Crisis Lifeline (Answered locally by Buckelew Programs)**

Call or text 988 from any phone in the U.S.

Chat online at [www.988lifeline.org](http://www.988lifeline.org)

Free, confidential, 24 hours a day, 7 days a week;

TTY: 1-800-799-4889



## **Sonoma County Mobile Support Team (MST)**



Call 1 800-746-8181 to talk to our 24 hour a day, 7 days a week call center staff who can connect you with an in field crisis response team if needed.

The MST is staffed by licensed mental health clinicians, certified substance abuse specialists, post-graduate registered interns, mental health consumers, and family members.

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, crisis intervention, support, and referrals to medical and social services as needed. Follow-up services are provided by community members with personal mental health experience to help link community members to ongoing support.

## **Sonoma County Behavioral Health - Crisis Stabilization Unit & Crisis Line:**

**707-565-4970**



2225 Challenger Way Santa Rosa, CA 95407  
The Crisis Stabilization Unit (CSU) provides 24 hours, 7 day-a-week crisis intervention, assessment, medication, and up to 23 hours of supportive care for individuals in an acute mental health crisis. Services are available for children, youth, adults, and their families. Referrals are made to Crisis Residential Services or inpatient mental health facilities for those needing a higher level of psychiatric inpatient care.

**Substance Use Treatment Services - County of Sonoma Treatment Services for Adults:**  
<https://sonomacounty.ca.gov/health-and-human-services/health-services/divisions/behavioral-health/services/substance-use-disorder-services/adult-sud-treatment>

**Substance Use Disorder Provider Directory:**  
<https://sonomacounty.ca.gov/health-and-human-services/health-services/divisions/behavioral-health/services/substance-use-disorder-services/adult-sud-treatment>

**ADDITIONAL RESOURCES:**

For teens, call **TEEN LINE** at **800-852-8336** or text TEEN to **839863**

For transgender people, call the **Trans Lifeline** at **877-565-8860**

For Veterans, dial **988 and then press 1** or text **838255**

For law enforcement personnel, call the **COPLINE** at **800-267-5463**

For other first responders, call the **Fire/EMS Helpline** at **888-731-FIRE (3473)**

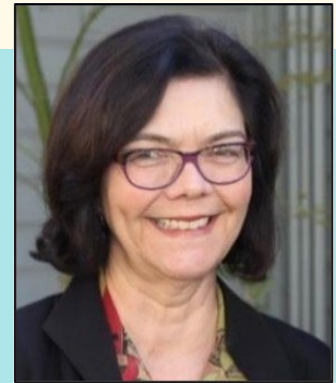
For non-emergency emotional support, call **Peer-Run Warmline** at **855-845-7415** or chat online at: [mentalhealthsf.org/peer-run-warmline](https://mentalhealthsf.org/peer-run-warmline)



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## A Letter from the Sonoma County Department of Health Services, Behavioral Health Division Director



Dear Residents of Sonoma County,

In Sonoma County, we are struggling as a community with a public mental health crisis. A global pandemic, preceded by several devastating fires and floods, traumatized, and impacted our communities. Our increasing suicide rates are a part of this somber trend. In response, Sonoma County Behavioral Health Services Department invited community members, stakeholders, and service providers to join us in creating the “Life Worth Living: Sonoma County Suicide Prevention Alliance” which, in turn, developed this Suicide Prevention Strategic Plan.

Our goal with this strategic plan is to reduce suicides and suffering while building meaningful connections for our community; helping one another to find reasons for hope, healing, and connection. The Life Worth Living Alliance includes a wide variety of people from our community, dedicated to reducing suicides by offering hope to those of every culture, gender, and socioeconomic group across their lifespans. It is with deep appreciation to the Alliance that we thank them for their dedication to this cause and their tenacity during this process. Their input and collaborative spirit have made this possible. We believe that “connection is prevention”. Together we can create positive change. We know that by offering support and connection to those struggling with depression and suicidal thoughts, we can prevent suicide. The strategic aims and related activities in this plan were developed by reviewing local data, and examining local resources, strengths, and gaps, as well as stakeholder surveys. Our strategies are also aligned with California’s Strategic Plan for Suicide Prevention, *Striving for Zero*.

The Life Worth Living Alliance’s purpose is to promote help and hope to everyone at risk or affected by suicide, understanding that this touches each of our lives. It is our hope that this strategic plan will help support the efforts of the Alliance and make a meaningful impact on the communities we serve.

Thank you.

Sincerely,

*Jan Cobaleda-Kegler*

Jan Cobaleda-Kegler, PsyD, LMFT  
Behavioral Health Division Director  
Sonoma County Department of Health Services



## Call to Action: All of Us Must Play a Role in Suicide

Organizations and individuals throughout Sonoma County are invited to join our collective effort to combat suicide and its devastating consequences. With the support and partnership of individuals, agencies, and organizations, we can prevent suffering and suicide, together. No single individual, organization or sector can succeed alone in putting the strategies in this strategic plan into action. We invite all community members to look at this plan to see where they fit in, and we hope that you will be inspired to get involved and take action to create a suicide-safer community.

At work, at home, at school, and in our community -- anyone and everyone can help:

- **Learn the warning signs of suicide and steps to take if you are concerned for yourself or someone you care about.**
  - For more information visit: [www.suicideispreventable.org/](http://www.suicideispreventable.org/)
  - If you notice signs of suicide, talk to the person about your concerns and ask directly: "Are you thinking about suicide or feeling that life may not be worth living?" Communicating openly about suicide and asking about suicide has been shown to be lifesaving. It encourages people to seek help, promotes a sense of belonging, and connects people to care.
  - Encourage someone who is thinking of suicide to call the Suicide & Crisis Lifeline at 988 or reach out to another resource. You can also call 988 to learn more about how to help.
- **Use best practice language.** Whether you are a member of the media, designing a brochure, posting on social media, or simply conversing with a friend on suicide-related matters, you can help reduce the negative impact of stigma around suicide by following best practices:
  - Read about language and stigma in this plan and work to apply these principles in your daily life. Visit <https://theactionalliance.org/messaging> or <https://suicidepreventionmessaging.org/>.
  - Help educate others in your community, workplace, school, and home life about stigma and person-first language.
- **Promote, support, and participate in suicide prevention training and presentations.**

- **Support suicide prevention in the workplace.**

- Strive for personnel, paid time off, and employee assistance policies and practices that promote employee and workplace behavioral health before, during, or after a crisis.
- Provide and/or promote employee and manager training on suicide prevention, intervention, and means safety.
- Prepare your workplace to be able to respond to a suicide attempt or loss by developing awareness of community resources that can be shared with employees.
- Normalize conversations about behavioral health; promote awareness of helpful resources such as 988, the National Suicide & Crisis Lifeline.

- **Reduce access to lethal means for suicide.**

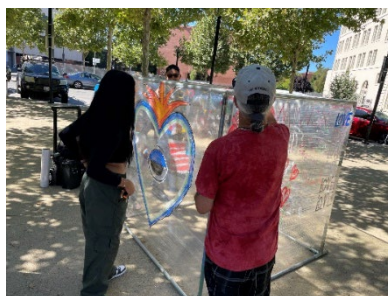
Means safety is about limiting a person’s access to means by which they may cause themselves harm. This is a practical, lifesaving approach to prevent suicide by making the environment safer for someone who is or may become suicidal, as well as after a suicide attempt.

- Participate in Counseling on Access to Lethal Means or other trainings for means safety.
- Visit **[strivingforsafety.org](https://strivingforsafety.org)** to learn more about means safety steps anyone can take, including:
  - Keeping medications securely stored; disposing of unused, unwanted, or expired medications.
  - Reviewing the steps to respond to a suspected drug overdose.
  - Keeping guns securely stored and learning about local laws/options for firearm storage outside the home.

- **Get involved in the Life Worth Living: Sonoma County Suicide Prevention Alliance.**

This Alliance is open to the public and meets regularly to coordinate suicide prevention efforts across Sonoma County, advance best practices, support implementation of this strategic plan, and host community awareness events.

To learn more, email: [Life-Worth-Living-Suicide-Prevention@sonoma-county.org](mailto:Life-Worth-Living-Suicide-Prevention@sonoma-county.org)



Participants in the 1<sup>st</sup> Annual Connection is Prevention Event in September 2023.

# LIFE WORTH LIVING: SONOMA SUICIDE PREVENTION ALLIANCE CHARTER



The Life Worth Living Alliance: Sonoma County Suicide Prevention Alliance (Life Worth Living Alliance) is a County-wide initiative funded by the Sonoma County Board of Supervisors and led by the Department of Health Services, Behavioral Health Division. The group forming this alliance began meeting in the fall of 2022 and continues to meet monthly, organizing special events and ongoing activities throughout the year. The heart of the group is its strong collaboration with key community partners, including broad representation and involvement from community stakeholders and service providers. The group includes community members with lived experience (individuals with behavioral health challenges and suicidal ideation and attempts), County staff, community organizations, education, behavioral health providers, Veterans Affairs, and public partners across key settings. Everyone in Sonoma County is invited and encouraged to share feedback and contribute ideas to planning and implementing the Alliance's suicide prevention efforts.

## **MISSION:**

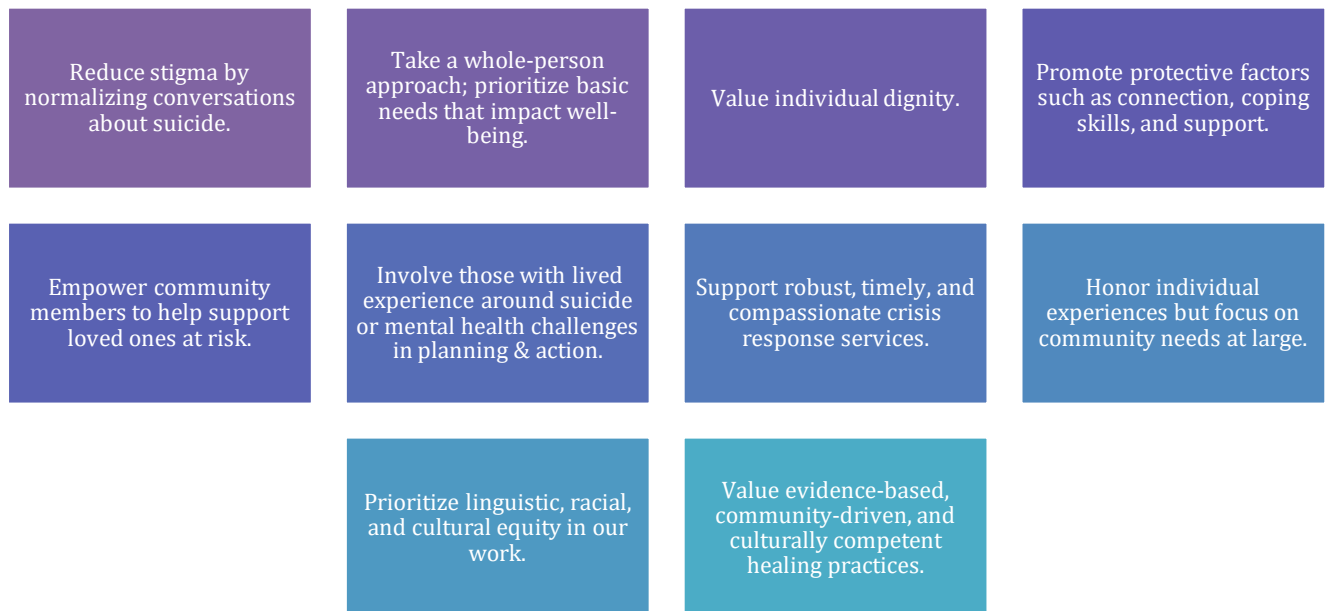
Work collaboratively to create a community where anyone impacted by suicide is supported when and where they need it. We envision a community with robust and diverse supports, where members feel connected to others and strive to help one another to build a life worth living.

## PURPOSE:



## GUIDING PRINCIPLES:

While striving to prevent suicide, we also want to support our fellow community members in helping one another to create a life worth living, to safely navigate crises, and to find support. To do this, we aim to follow these principles our work:



## WORKING AGREEMENTS:

- To make our work effective, equitable, and harmonious
- Respect different opinions and value all contributions and feedback.
- Accept that agreement and consensus on every detail isn't a requirement.
- Respect what the group and the community as a whole wants/needs.
- Commit to and follow a structured process for our meetings.
- Respect each person's different experience(s), learning, and comfort level.
- Encourage authenticity and connection.
- Engage in brave and honest conversations to bring about meaningful change.
- Acknowledge that we do not all share all the same values and priorities.
- Promote individual self-care and encourage each other to seek support when needed.

In addition to the Strategies outlined in the Plan, the Alliance will work to:

- Maintain an alliance that represents the diversity of our community; provide leadership to establish and continue partnerships necessary to reduce suicidal behavior.
- Prioritize input from individuals with life experience around suicide ideation, attempts, and loss; strive to ensure that planning processes are accessible to them.
- Identify ways to integrate existing suicide prevention, intervention, and survivor supports into local programs and activities. Aim to prioritize collective impact and avoid duplicating efforts.

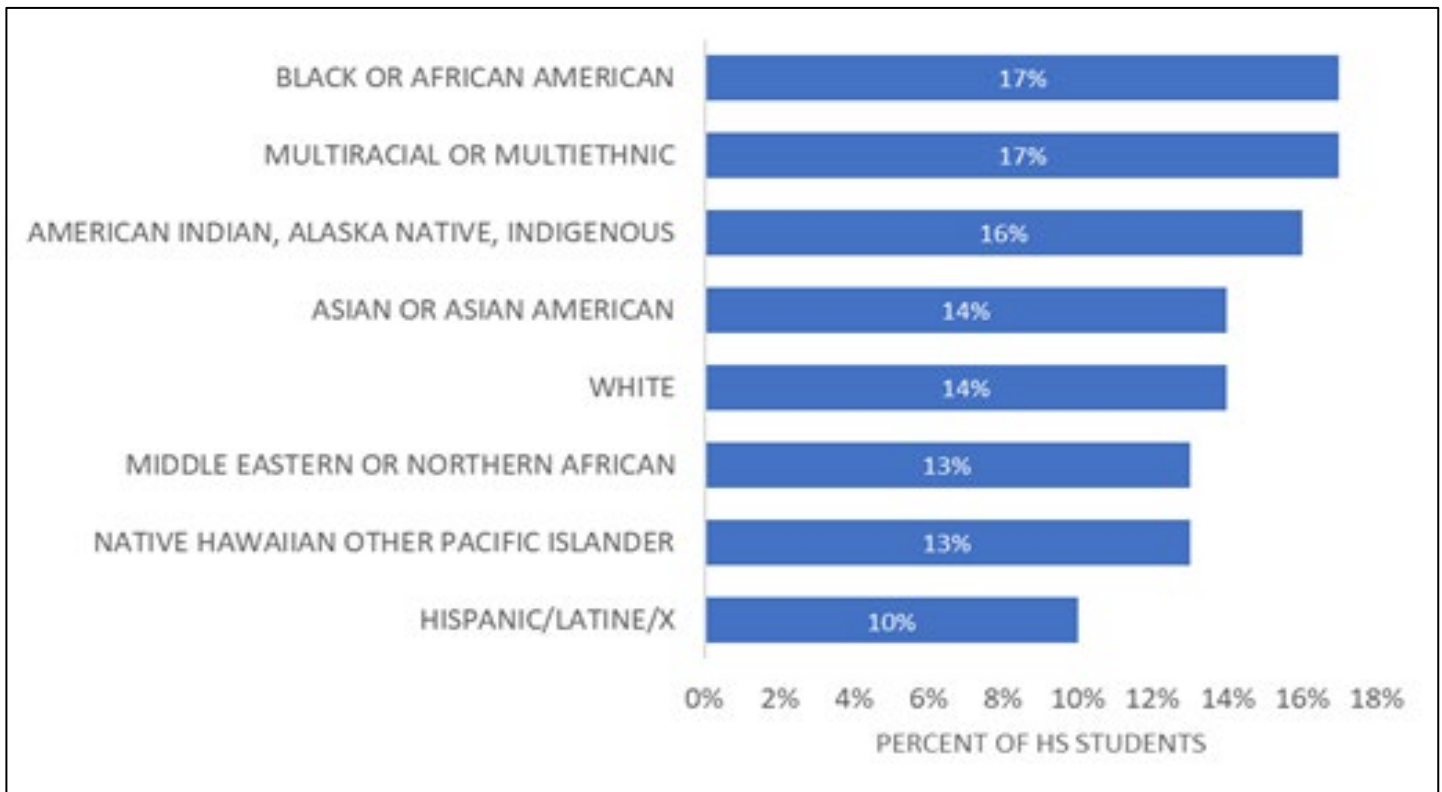
## Why Diversity, Equity, and Inclusion Matter in Suicide Prevention

The values of Diversity, Equity, and Inclusion (DEI) are particularly relevant to developing a plan to prevent suicide, as specific populations are disproportionately impacted by suicide. Socio-economic challenges, discrimination, and policies rooted in racism, place these groups at higher risk for behavioral health conditions that may escalate, leading to suicidal behaviors.

The County Board of Supervisors unanimously approved a proclamation to designate racism as a public health crisis in 2024, placing racial equity at the forefront of county policies and services<sup>1</sup>. This declaration came at a time in which county data indicate that suicidal ideation and death by suicide is on the rise in Sonoma County for African/Black Americans, Latinx, and LGBTQ+ populations.

<sup>1</sup> Press Democrat, "Generations of Systemic Harm – Sonoma County Declares Racism Public Health Crisis", March 12, 2024.

The 2018-2022 Youth Truth Survey revealed that a higher percentage of African American/Black, Multiracial, and Native American/Indigenous youth in Sonoma County reported experiencing suicidal ideation compared with their peers. When the data on suicide ideation was examined further, by sexual orientation and gender/transgender, the percentage of self-reported suicide ideation was even higher.



According to the Youth Truth survey, 28-30% of students who self-reported suicide ideation identified as gay, lesbian, or bi-sexual. Transgender and non-binary youth represented even larger percentages (39% and 34%) of self-reported suicidal ideation.

Another troubling trend, documented by the California Department of Health Care Access and Information, reported the overall rate for **non-fatal emergency room visits** in Sonoma County doubled in the five-year period (2016-2021), from 225 to 473 per 100,000. Sonoma County's rate is also significantly higher than the state rate of 277 per 100,000.

**Rates for non-fatal emergency room visits with suicide ideation** have also risen. This is concerning for the African American/Black, White, and Hispanic/Latinx communities, as their rates doubled or nearly doubled since 2016. However, rates for **non-fatal emergency room visits for suicide attempts** decreased for African American/Blacks while rates for Whites and Hispanic/Latinx trended slightly upward.

Concerningly, the number of deaths by suicide among Hispanic/Latinx people in Sonoma County more than doubled between 2016 and 2022 (from 7 deaths in 2016 to 16 deaths in 2022). These deaths were predominantly among males, between the ages of 25 – 44, a trend observed throughout California.

The County Department of Health Services – Behavioral Health Division has partnerships with several community organizations that serve the Hispanic/Latinx, African American/Black, and Indigenous communities through an array of behavioral health prevention, early intervention, and/or treatment programs, including:

- Community Baptist Collaborative
- County of Sonoma Human Service Department - *Unidos Por Nuestro Bienestar*
- La Luz
- Latino Service Providers
- On the Move - *Nuestra Cultura Cura*
- Sonoma County Indian Health Project - Aunties and Uncles & Community Programs

In 2023, the Behavioral Health Division conducted a series of ten Listening Circles to learn more about the behavioral health needs of county residents. Four sessions were held with Hispanic/Latinx community members (including immigrant- and U.S.-born youth and adults) in Sonoma Valley, Cloverdale, and Guerneville, as well as LGBTQ+, African American/Black, and Asian community members. The key findings of the Listening Sessions were that these community members identified discrimination as a significant threat to behavioral health and wellbeing. They noted an increase in stress and depression linked to the multiple natural disasters, the 2020 pandemic, and the rising cost of living. In addition, isolation and loneliness were mentioned as a high-need priority and most participants said they were not aware of behavioral health support services.



## HOW TO USE THIS PLAN

Community members (individuals, families, and organizations) and service providers are encouraged to use this plan as a guide to actions they can take to help prevent suicide in Sonoma County.

**Background:** Explains why a comprehensive approach to suicide prevention, intervention, and postvention, is needed to make meaningful and sustainable change.

**Data:** Shows the impact of suicide on Sonoma County residents, including population groups that are disproportionately impacted by suicide, helping identify where prevention efforts should be focused.

**Strategies & Activities:** Provides an overview of prioritized prevention efforts and considerations for their implementation; community members, organizations and service providers are encouraged to focus on aspects of most interest and/or relevance to them.

**A note on language:** The alliance values the lived experience and choices of all people, regardless of age, sex, gender identity, sexual orientation, race, ethnicity, religion, disability, geographic location, or socioeconomic circumstances. To reflect this, an effort was made to use inclusive, person-first language throughout this plan. Despite these efforts, specific terminology or language may be unintentionally offensive or stigmatizing to some individuals or populations. Language is subjective, and the meaning and use of language changes over time.



The plan's terminology is intended to reduce stigma faced by communities and populations disproportionately impacted by suicide. Our hope is to communicate in a manner that reflects a vision for a collective, inclusive, and respectful approach to suicide prevention in our community.

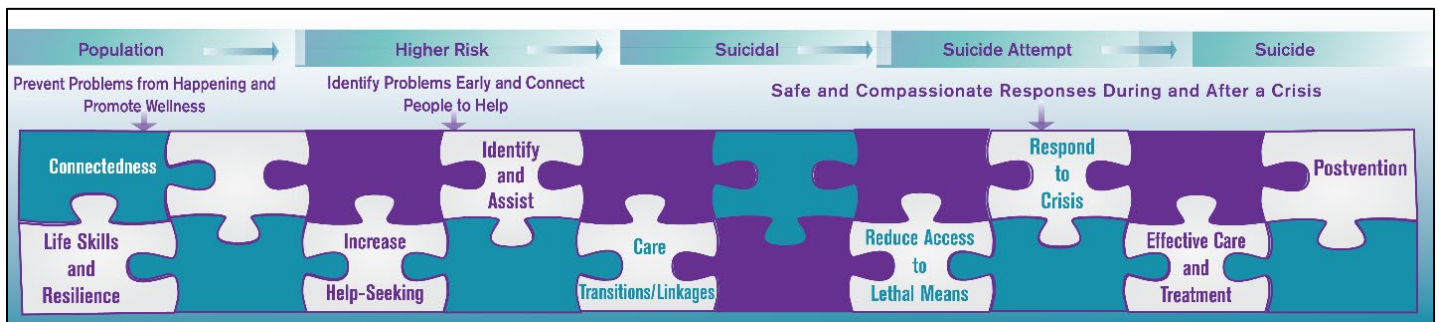
*Supervisor Chris Coursey presenting a Proclamation to our Behavioral Health Division Director Jan Cobaleda-Kegler for Suicide Prevention*



## Background: Why a Comprehensive Approach to Suicide Prevention is Needed

**Public Health Model:** Suicide is a complex public health problem involving many factors. Effective suicide prevention requires a combination of strategies at the individual, community, and population levels to prevent problems from occurring in the first place and to provide access to effective care and support when problems do occur. Programs that have taken this approach to suicide prevention have demonstrated reductions in suicidal behaviors, as well as other negative outcomes.

**The Suicidal Crisis Path Model:** This approach to suicide prevention offers a framework (see below) for conceptualizing the different stages of suicide as a public health problem, from strategies to prevent a crisis in the first place to after-care following a suicide attempt or death. It helps align suicide prevention strategies and considerations with each stage along this crisis pathway. <sup>2</sup>



In the graphic above, the Suicide Crisis Path is paired with the nine strategies adapted from the Suicide Prevention Resource Center. Each can be advanced through an array of possible activities (i.e., programs, policies, practices, and services).

**Social Ecological Model:** The Social Ecological Model helps to systematically consider the different levels of influence that contribute to an individual's health behaviors. Within this model, there are interactions between individual, interpersonal, organizational, community, and public policy factors that influence risk, as well as factors that prevent suicidal behavior. The model helps when identifying and describing how factors at multiple levels impact the possible risk of suicide.

<sup>2</sup> Based on *Suicide Prevention Resource Center Comprehensive Approach to Suicide Prevention and the Suicidal Crisis Path Model* developed by Lezine, D.A. & Whitaker. N.J., published in *Fresno County's Community-Based Suicide Prevention Strategic Plan, 2018*



Graphic above: Social Ecological Model.

## Building Shared Knowledge about Suicide

### Definitions:

Definitions and key concepts for prevention of suicidal behaviors reflect a broad continuum of risk and include: desire to die; suicidal ideation; suicide attempt planning; suicide attempt; and death by suicide. The Centers for Disease Control and Prevention (CDC) uses the term **self-directed violence** to describe a range of violent behaviors that can be fatal or non-fatal, suicidal, or non-suicidal; suicide itself is defined as “death caused by self-directed injurious behavior with any intent to die as a result of the behavior.”

**Behavioral Health:** Behavioral health includes the emotions and behaviors that affect your overall well-being. Behavioral health services include both mental health and substance use.

**Crisis Lines:** Provide immediate support and facilitate referrals to medical and mental health care, and community support services. Trained crisis counselors provide support and promote problem-solving and coping skills via phone, text or online chat for individuals experiencing emotional or psychological distress.

**Continuity of Care/Follow-Up Supports:** The weeks and months following a suicide attempt are frequently ones with elevated risk, in particular the days following discharge and before outpatient visits are scheduled. Additionally, as many as half of initial follow-up behavioral health appointments are not completed. Follow-up interventions, also known as “postvention,” are implemented after discharge from a hospital emergency department, hospital, or other behavioral health crisis care setting. Along with attempt or loss survivor support groups, and access to clinicians trained in suicide risk, postvention strategies that have shown promise in preventing future suicide attempts.

**Crisis Residential Services:** Provides voluntary, community-based care for individuals who have experienced a behavioral mental health crisis; a less-restrictive, supportive alternative to psychiatric hospitalization. Staff often include peer support specialists with lived experience of mental illness, including suicide thoughts or attempts.

**Crisis Stabilization Services:** Provides short-term care (up to 23 hours) for individuals in an acute behavioral health crisis; makes referrals to crisis residential or inpatient psychiatric facilities for those needing longer-term inpatient care.

**Interrupted Suicide Attempt:** self-directed potentially injurious behavior effort to with any intent to die that is stopped by the person attempting self-harm, or by another individual prior to fatal injury. This can occur at any point during the act, such as after the initial thought or after the behavior has started.

**Mobile Crisis Teams:** Provide de-escalation, assessment, and connections to care or support services for individuals experiencing a behavioral health crisis, wherever the individual is at (home, school, work or in the community). Their main objectives are to provide a timely response, assess the individual’s needs and when possible, resolve the immediate crisis situation when more intensive care is not needed.

**Preparatory Acts:** Preparation toward making a suicide attempt, taken before potential

for harm has begun. This can include any action beyond a verbalization or thought, such as purchasing a firearm or preparing for one's death by suicide by giving away belongings.

**Self Harm or Non-suicidal self-injury** is behavior that is self-directed and deliberately results in injury or the potential for injury to oneself, with no evidence - implicit or explicit - of suicidal intent.

**Suicide Attempt:** a non-fatal, self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury and starts with the first action taken with any intent of suicide.

**Suicidal Ideation:** Having some desire to die or thinking about engaging in suicidal behavior. Suicidal ideation can be passive or active. If active, it may include: a method without intent to die or plan; a method and intent to die, but no plan; or a method, intent, and plan.

**Warm Lines:** Provide mental health support and/or resource information, often staffed by individuals with lived experience, but not intended for emergency situations.

## The Role of Stigma in Suicide Prevention

Stigma refers to negative attitudes and beliefs about people with behavioral health needs, which may include mental health conditions, substance use disorders, or co-occurring substance use and behavioral health challenges. The severity of needs range from mild to moderate emotional or psychological distress to diagnosable illnesses and disorders.

Stigma not only discourages people from seeking professional help, but also can prevent individuals, families, and communities from connections with meaningful support. Stigma also impacts the reporting and recording of suicidal behaviors, including the circumstances leading up to a suicide (such as a previous attempt or death by suicide in the family). Consequently, prevention efforts are stymied by the underreporting of suicidal behavior.

Stigmatizing language that this strategic plan took care to avoid includes phrases such as: *committed* suicide; *successfully* completed suicide, *suicidal* person, *unsuccessful* or *failed* suicide attempt, and *mentally ill*.

### **Language Matters**

*The suicide prevention community* is trying to clarify the ways we all refer to actions related to suicide to better support help-seeking behavior among those that are at risk. Historically, it has been commonplace to describe someone ending their own life as the individual having “committed suicide.” Consider what first comes to mind when you hear the word “commit?” Crime? Sin? Just the use of the word “commit” can carry an enormous amount of stigma and shame, preventing people from reaching out for the support they need.

Instead, it is recommended to use “died by suicide.” This phrase can’t be distorted and simply states the fact without placing shame or guilt on the individual or survivors of suicide loss. Another phrase to consider is “successful” versus “unsuccessful” to describe suicide attempts. There is no success or failure when it comes to suicide. These events should simply be referred to as a suicide death or a suicide attempt.

Through small changes in our own thinking and language, and through use of safe and effective messaging practices, we can all become leaders in changing the conversation about suicide in our communities, for the better.

### **Effective Messaging:**

When it comes to suicide prevention, the terms, phrases and words we use can have a significant impact on the way messages are received. Messages, delivered through person-to-person conversations, presentations, data reports, outreach materials, etc. can encourage someone to seek help and reach out, or they can push people further from the support they need.

It is recommended to always evaluate any information you are sharing through a safety lens. Ask yourself: If a vulnerable individual who is thinking about suicide hears your conversation or sees your outreach materials, video, remarks or media coverage, how will it make them feel? Will it encourage them to feel hopeful and seek help, or will it increase their feelings of pain? How will your message be received by individuals who have lost a loved one to suicide?

The following guidelines are adapted from the Action Alliance on Suicide Prevention Framework for Successful Messaging (<https://suicidepreventionmessaging.org/>):

- Educate the audience on warning signs and, if appropriate, different ways people can get involved in local suicide prevention efforts.
- Use person-first language. For example, use **someone experiencing thoughts of suicide**; don't use suicidal.
- Focus on prevention and hope by using images and words that show people being supported, not suffering alone.
- Explain the complexity of suicide and avoid oversimplifying. It's natural to want to answer the "why" involved in a suicide, but there is usually not one event that is "the cause" of a suicide attempt or death.
- When discussing "risk factors" it is important to also include "protective factors" such as positive supports, connections, access to treatment and services, peers, equitable and anti-racist policies, and systems.
- Avoid sharing information about or images of means (e.g. weapons or medications) that could be used during a suicide attempt.
- Always provide a suicide prevention resource such as a crisis line.

## Myths and Misconceptions

Myths and misconceptions about suicide also hinder prevention efforts. Below are common examples of these myths and the facts associated with each, based on research.

**MYTH:** Most suicides are impulsive and happen without warning.

**FACT:** Over 70 percent of people who die by suicide communicated their plans to someone, prior to death. Planning, including obtaining the means by which to attempt suicide and identifying a location, often happens well before the attempt. Most suicides

are preceded by warning signs, such as communicating the desire to die, having no reason to live, or feeling like being a burden.

**MYTH:** People who want to die are determined and there is no changing their minds.

**FACT:** Over 90 percent of people who were interrupted during a suicide attempt do not go on to die by suicide at another location or by other methods.

Research suggests that those at risk for suicide often show great ambivalence about the desire to die or live and express a high degree of suffering. The accounts of attempt-survivors suggest that many people are relieved to have lived through an attempt and regain their desire to live. This fact highlights the opportunity to intervene by separating a person at risk from lethal means for a suicide attempt.

**MYTH:** Talking about suicide with a person at risk will plant the seed for thoughts of suicide, increasing risk.

**FACT:** Communicating openly about suicide and asking about risk has been shown to be lifesaving. It encourages people to seek help, promotes a sense of belonging, and connects people to care.



## Risk Factors, Protective Factors, and Warning Signs

**Protective Factors** are characteristics, including the absence of risk factors, that may make suicidal behavior more likely to occur. These may include connectedness to community, culture, spirituality or faith, and problem-solving skills, as well as access to health care, behavioral health care, social support, and the safe storage of lethal means such as guns and medications. Follow-up connections made by service providers and caregivers, after care for suicidal behavior or an attempt, are another form of protective factor.

**Protective factors** exist at many levels: individual, interpersonal, organizational, community, and in the form of public policy. They include but are not limited to the following:

- Life skills, especially during stressful events and life changes (including problem-solving and coping skills, ability to adapt to change)
- Coping skills and resource acquisition after previous suicidal behavior
- Cultural or religious beliefs that prohibit or discourage suicide
- High self-esteem and sense of worth
- Strong quality of life and sense of life purpose
- High sense of belongingness
- Connectedness to family or family of choice
- Genuine support from family or family of choice
- Relationships that affirm sexual orientation and gender identity
- Access to effective, affirmative health and behavioral health care
- Connectedness to neighborhood, community, or social group
- Religious affiliation or spiritual community membership



**Left Pic:** Danza Azteca group blessing at the 1st Annual Connection is Prevention Event in September 2023.

**Right Pic:** Artwork with hopeful and positive messages, created by participants at Connection is Prevention event.





**Risk Factors** are characteristics that, based on data, may make suicidal behavior more likely to occur, while protective factors are characteristics that make suicidal behavior less likely.

Suicide prevention efforts are effective when they target high-risk settings or risk factors that can be modified, such as by increasing screening and access to services for depression and other needs. Risk can be elevated during times of acute or lasting transition, such as a job loss, marital status change, hospitalization, housing change, and military service discharge or post-service-deployment. Risk appears to be additive – the more factors, the higher the risk – and it cuts across demographic, economic, social, and cultural boundaries.

Major risk factors for suicide are prior suicide attempt; substance use disorder; mood disorder, such as depression; access to lethal means; and physical health needs.

**Suicide risk factors** exist across the individual, interpersonal, organizational, community, and public policy level, including and not limited to:

- Prior suicide attempt(s)
- Thoughts of suicide with intent and planning (especially intense, pervasive, difficult-to-control thoughts); perceiving few reasons for living
- Demographic factors (male sex, indigenous or white ethnicity, middle to older age)
- Unmet acute or persistent physical health and behavioral health needs, including chronic pain, disability, substance use, and mood disorders
- Access to lethal means and gun ownership, especially having unlocked guns in the home
- Social isolation and low sense of belongingness
- Unstable mood or sleeping patterns, including insomnia and nightmares
- Hospitalization or incarceration
- Financial or employment problems
- End of a relationship or marriage, including by death or divorce
- Relationship dissatisfaction and problems, including abuse, unstable, or conflictual relationships
- Lack of access to appropriate and affirmative health and behavioral health care
- Disconnection from culture and cultural practices
- Cultural beliefs or institutions that promote social isolation
- Sensationalistic media coverage, especially for youth
- Behavioral health stigma and discrimination

**Warning Signs** are behaviors that *may* indicate acute risk for suicide. The behaviors below cannot predict a suicidal behavior, but they are important to be aware of. Suicide warning signs can also look different for different individuals and may be subtle.

Speaking directly with the person, sharing the behaviors you are noticing, and asking if they are related to thoughts of suicide are powerful steps everyone can take.

If you notice the signs above in yourself or another person, please do not wait. Reach out for help by calling or texting 988, the National Suicide and Crisis Lifeline (available 24/7 365 days a year).

**Warning signs may include:**

- Communicating a wish to die or plans to attempt suicide
- Having thoughts of suicide that are intense, pervasive, or difficult to control
- Looking for a way to kill oneself, such as searching online or obtaining a gun
- Giving away possessions
- Drafting notes indicating intent or desire for suicide
- Communicating feeling hopeless, having no reason to live
- Communicating feelings of guilt, shame, or self-blame
- Communicating feelings of being trapped or in unbearable pain
- Communicating being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly or engaging in risky activities
- Insomnia, nightmares, and irregular sleeping
- Withdrawing or feeling isolated
- Communicating or exhibiting anxiety, panic or agitation
- Appearing sad or depressed or exhibiting changes in mood
- Showing rage or uncontrolled anger or communicating seeking revenge

## Using Data for Effective Suicide Prevention Planning

A comprehensive approach to suicide prevention requires telling a comprehensive story about suicide and suicide prevention in our communities. Data is one source of information that helps support: a common understanding of the problem, develop long term goals for suicide prevention, and set priorities. Everything cannot be changed at once; however, gathering, reviewing, and taking consideration of local data allows us to:

- Provide context to local issues of suicide
- Dispel misconceptions and raise awareness about how suicide impacts us all
- Focus effort where the problem is most severe
- Identify risk and protective factors in order to select interventions
- Persuade funders, policy and decisionmakers to invest in and prioritize suicide prevention efforts
- Evaluate and measure change over time

### **The Limitations of Data**

Data does not tell the entire story and can be biased based on the design of research or in its analysis. Data has been used to perpetuate inequalities, leaving out groups who may be disproportionately impacted by suicide or other negative public health outcomes. When used for the purpose of advancing inclusion and equity, data can also be a powerful tool to help us get a more complete view of what is needed for suicide prevention.

By pairing data with deep listening, we can get answers to important questions, like "Who is not at the table? Whose voice is not yet being heard?" Additionally, resource mapping of programs, trainings, services, supports, and community strengths and needs can help us assess what can be built on and what gaps need to be filled.

### **Data on Progress and Programs**

In addition to local data on suicide and suicide related behavior, the Alliance is dedicated to sharing information that shows how Sonoma residents are seeking help and helping one another to navigate suicidal crises and find support. In the future, this information will be a component of our annual report on suicide prevention in Sonoma County. Highlights of recent successes include:

### **QPR (Question, Persuade, Refer) Suicide Prevention Training through Sonoma County Office of Education:**

- From August 2022 to May 2023, 3,127 residents were trained in QPR (Question, Persuade, Refer) suicide prevention training through Sonoma County Office of Education; (this includes 2,300 students, 394 educators, and 43 community members).
- Trainings were provided at 9 high schools, 4 middle schools, and 2 continuation schools
- Staff trainings were provided at 11 schools, with parent nights in English and Spanish in 2 districts

### **In 2022-2023, Sonoma County Office of Education's Behavioral Health and Wellbeing team also provided:**

- Individual counseling (over 300 students), crisis counseling, and classroom lessons across 20 school districts.
- Teacher consultation and professional development focusing on equitable and healing-centered practices (Youth Mental Health First Aid, suicide risk screening, supporting school-based youth mental health, supporting LGBTQ youth, trauma-responsive classroom interventions etc.) provided to over 2,000 educators, school based mental health providers, school counselors, parents, and community members.
- 16 youth-focused events supporting 670 students including a Youth Advisory Council.
- Three Latino Service Providers *Pro Promotores* interns were trained to host peer listening sessions on youth mental health topics. The synthesized student responses and shared recommendations during a *Conversations in Community* event for over 500 educators and community members, before introducing speaker Dr. Nadine Burke Harris.

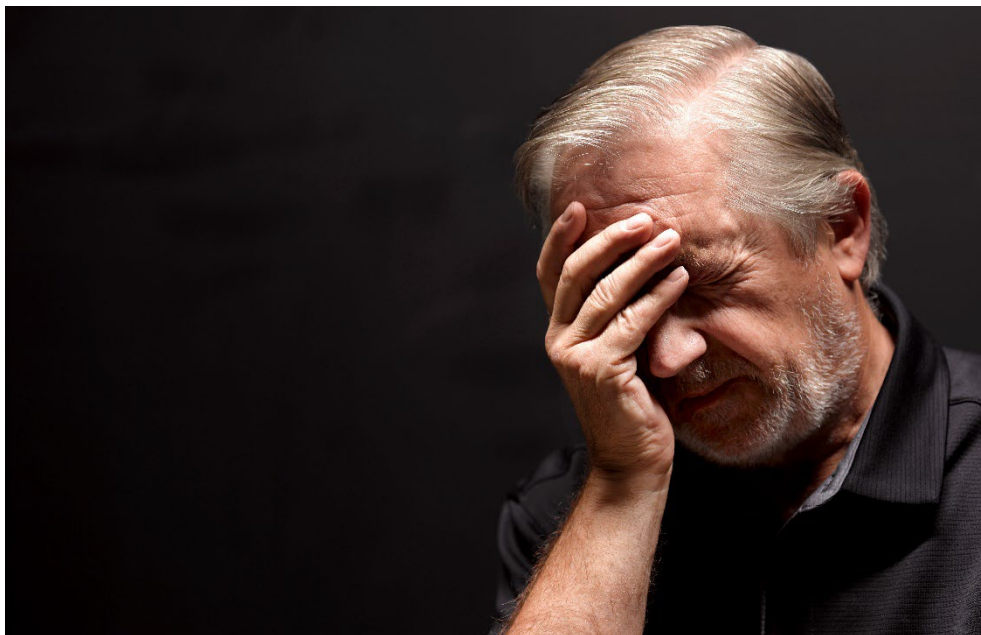
### **Sonoma County Suicide Prevention Alliance: Life Worth Living (through 2024):**

- The coalition recruited members from a broad spectrum of community and government organizations that are concerned about suicide prevention. Members have participated in collaborative meetings, reviewing suicide related data, information sharing, and collaborative planning.
- Developed the Alliance name, charter, and logo. Alliance name and logo were developed by Alliance members with lived mental health experience.
- Participated in statewide Striving for Zero Strategic Planning Learning Collaborative
- Hosted inaugural annual suicide prevent month event: Connection is Prevention
- Hosted two Survivors of Suicide remembrance events
- Developed draft Sonoma County Suicide Prevention Strategic Plan

## Local Suicide Related Data

Three main sources of statistical data are available that can support prevention planning:

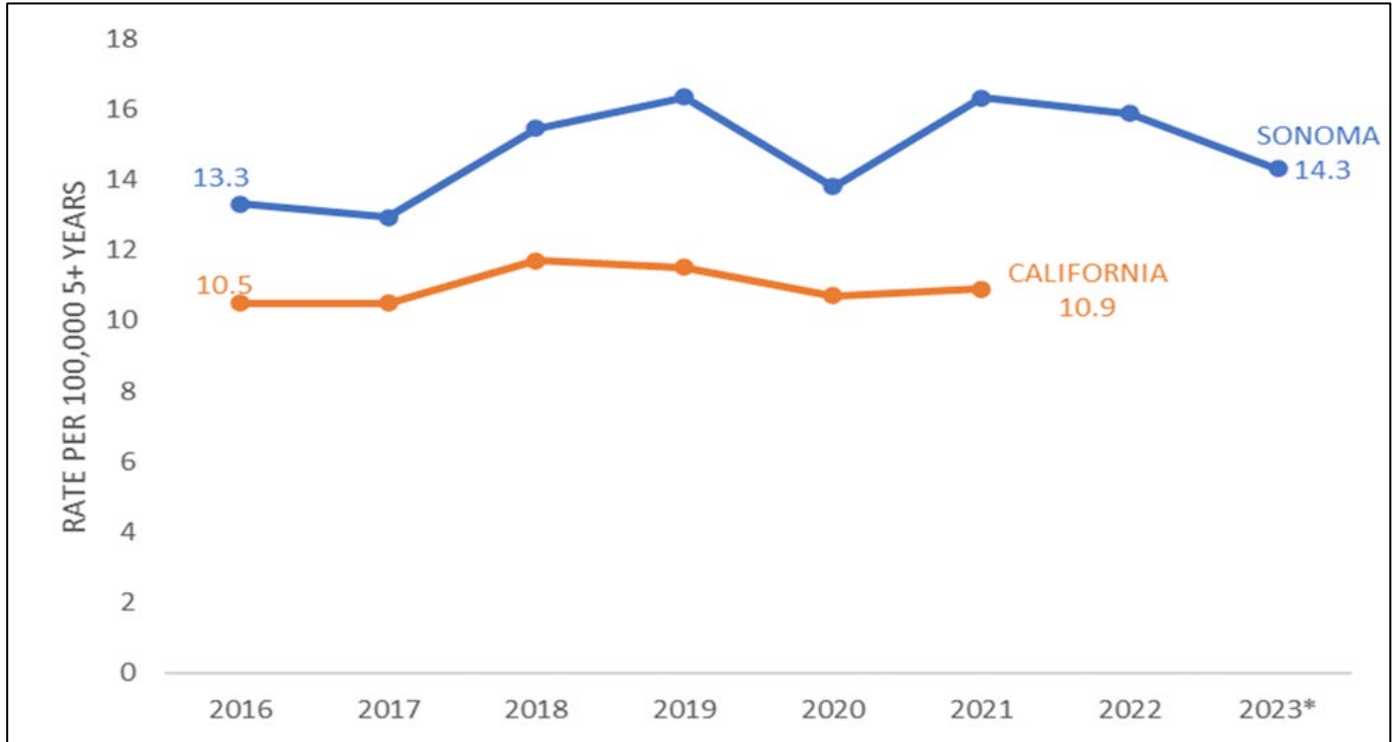
- **Mortality** refers to deaths that were confirmed to be suicide. Occasionally, deaths that may have been suicide are not reported as such because the coroner or medical examiner is not able to establish suicidal intent. In many jurisdictions, the threshold, or criteria to meet classification for a suicide is very high. Sources for this data include Coroners/Medical Examiners and public health and vital statistics agencies.
- **Morbidity** refers to nonfatal, *intentional* self-injuries. It is important to note that there are many hurdles to overcome for intentional injuries and suicide attempts to be recorded correctly such as (1) disclosure by patient, (2) recording by medical team, and (3) accurate or appropriate injury classification code assigned in a data system by staff. This data is helpful to gain an understanding of the prevalence of suicide attempts, but it is important to note that the actual number of suicide attempts in a community is likely to be higher, as this data does not include attempts that were not treated medically, sources include hospitals and Emergency Departments.
- **Suicidal ideation** refers to thinking about or wanting to take one's own life. Typically, this is self-reported data that is gathered through risk assessment or screening tools administered by health care or other providers or from surveys administered by phone or within specific settings, such as schools.



## Suicide Deaths

### Suicide Deaths in Sonoma County

**Table 1:** (Suicide death rates, people 5 years and older, 2016-2023).<sup>3</sup>



\*Rates are preliminary and are age-adjusted to the 2000 US standard

Each year in Sonoma County about 73 people 5 years and older die by suicide. The suicide death rate in Sonoma County is significantly higher than the California rate and appears to be increase while the state rate remains relatively flat.

While suicide can impact anyone, certain populations are at disproportionate risk. For example, Sonoma County data from 2016-2023 shows that suicide death rates are<sup>4\*</sup>:

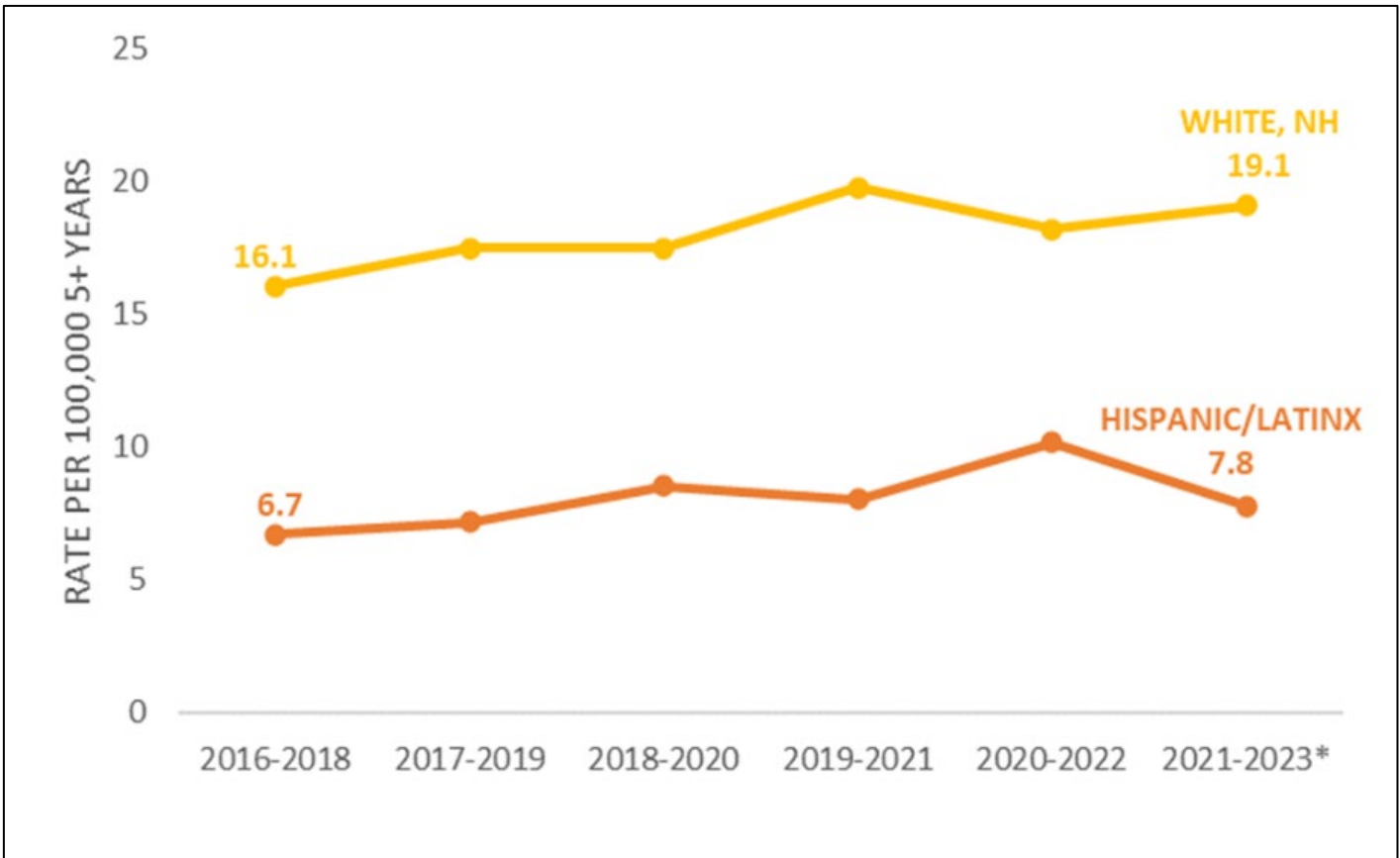
- Higher and increasing among men while decreasing among women.
- Increasing for adults aged 35-44 and over 75 years and decreasing among adults ages 55-64 years.
- Higher among persons experiencing homelessness.

<sup>3</sup> Source: California Department of Public Health, California Comprehensive Death File, 2016-2023; note that as of this publication 2023 data is preliminary)

<sup>4</sup> \*Data not Shown

### Suicide death rates by race/ethnicity

**Table 2:** (Suicide death rates by race/ethnicity, people 5+ years, 2016-2023).<sup>5</sup>



\*Rates are preliminary and are age-adjusted to the 2000 US standard population  
Source: CDPH, CCDF, 2016-2023

The suicide death rate remains higher among White, non-Hispanic people in Sonoma County and continue to increase. The suicide death rate among Hispanic/Latinx people in the county has also increased with the number of deaths from suicide more than doubling from 2016 to 2022.

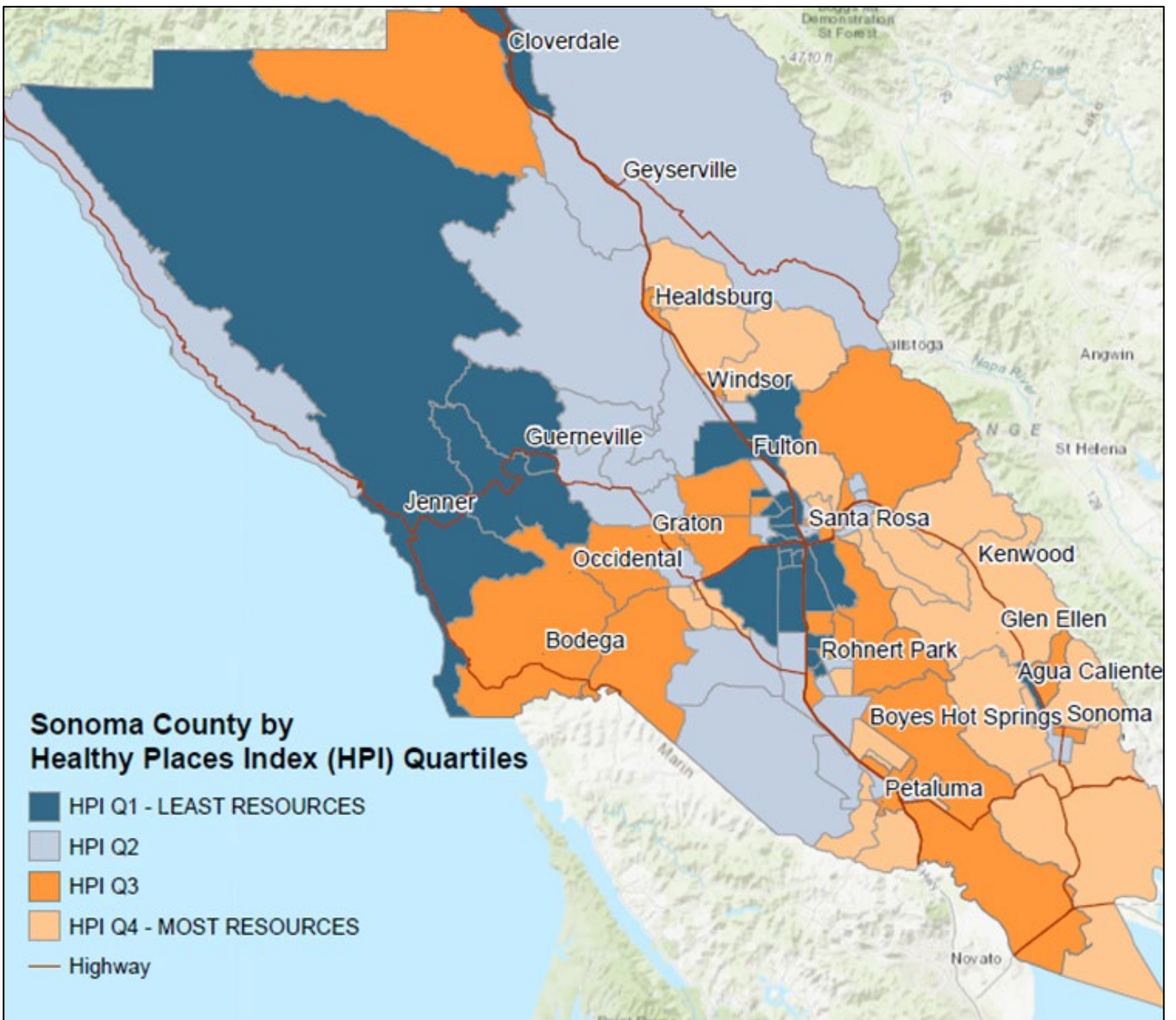
<sup>5</sup> Source: California Department of Public Health, California Comprehensive Death File, 2016-2023; note that as of this publication 2023 data is preliminary)

### Suicide death rates by availability of resources

The Healthy Places Index is a measure of the social and economic resources in a geographical area that are needed to support health and wellbeing.

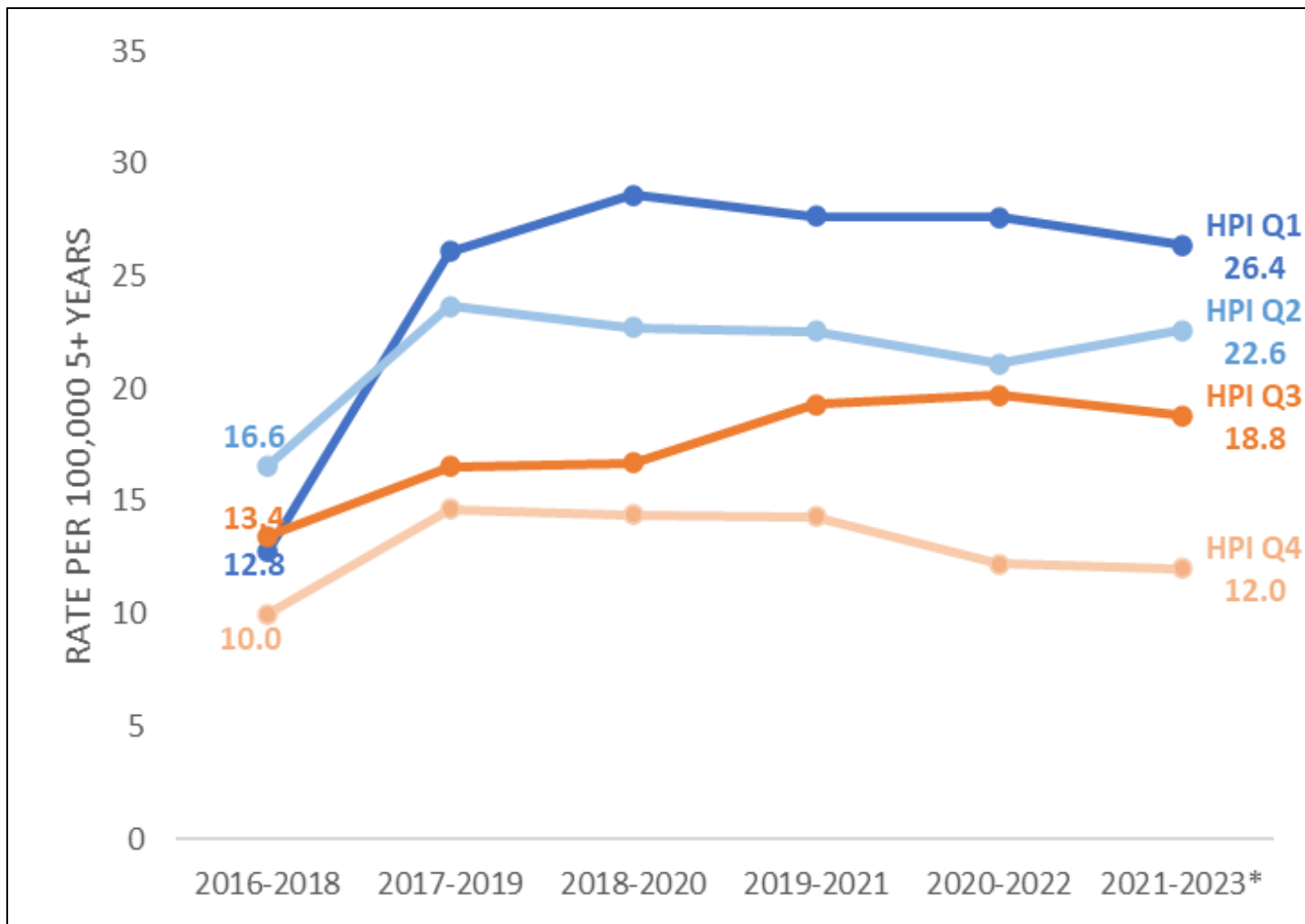
This measure assigns a score to each census tract in the state based on the amount of social and economic resources the residents of these areas have. Lower quartile areas have the fewest resources and higher quartile areas have the most resources.

**Table 3:** Suicide death rates by availability of resources in different parts of Sonoma County (Healthy Places Index Quartile, people 5 years and older, 2016-2023)





**Table 4:** (Suicide death rates by HPI Quartiles, people 5+ years, 2016-2023)<sup>6</sup>.

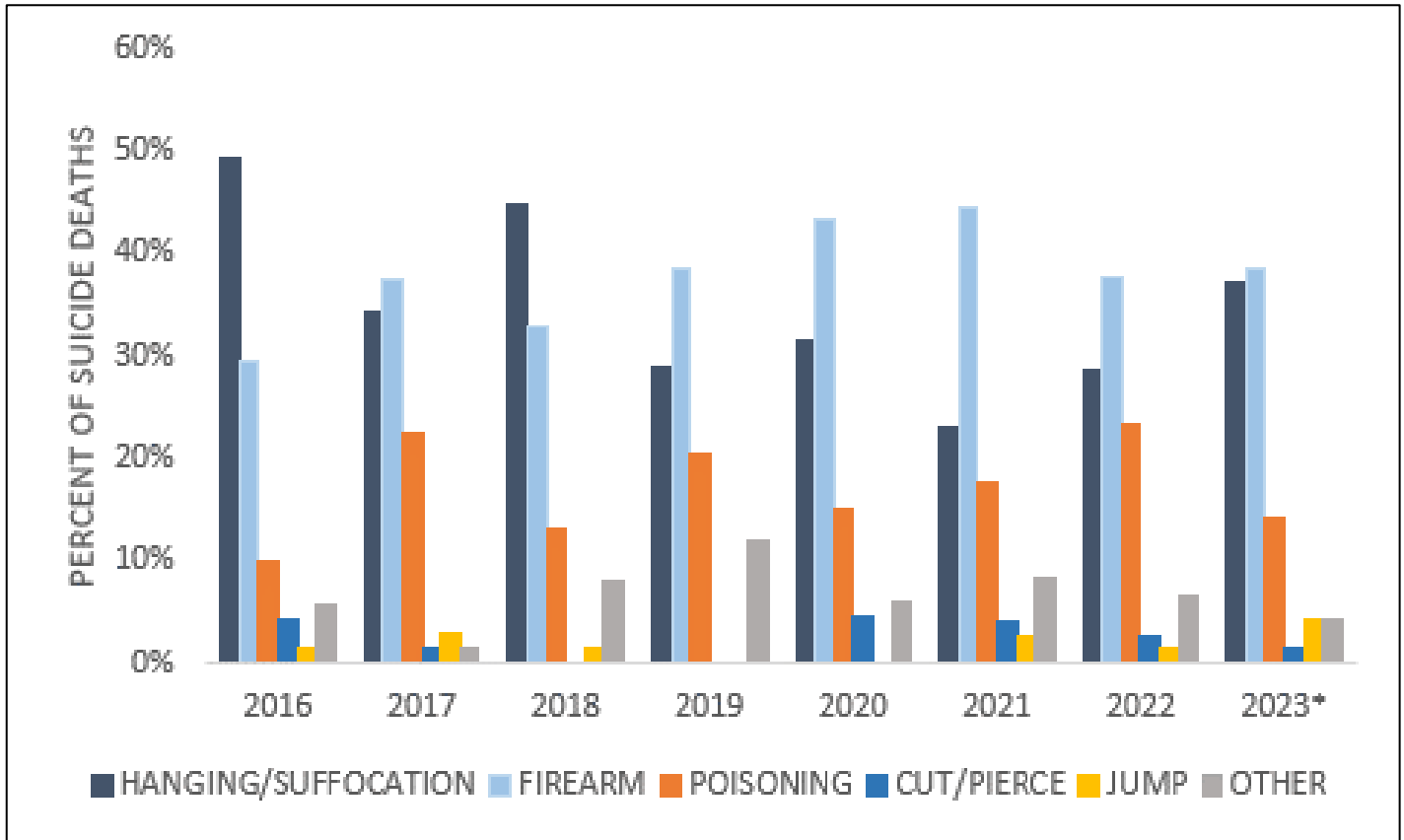


Suicide death rates are **highest** among people living in the **lowest resourced census tracts** (HPI quartile 1) and have increased at a steeper rate than for other, more resources areas.

<sup>6</sup> Source: California Department of Public Health, California Comprehensive Death File, 2016-2023; note that as of this publication 2023 data is preliminary)

## Suicide deaths by method

**Table 5:** (Suicide deaths by method 2016-2023 Sonoma County)<sup>7</sup>



From 2016-2023, suicide deaths by hanging/suffocation and firearms were most common, with fluctuations in other categories.

The means that are used in a suicide attempt may have a significant impact on whether the person survives. Information about suicide means can help inform our local means safety strategies and activities.

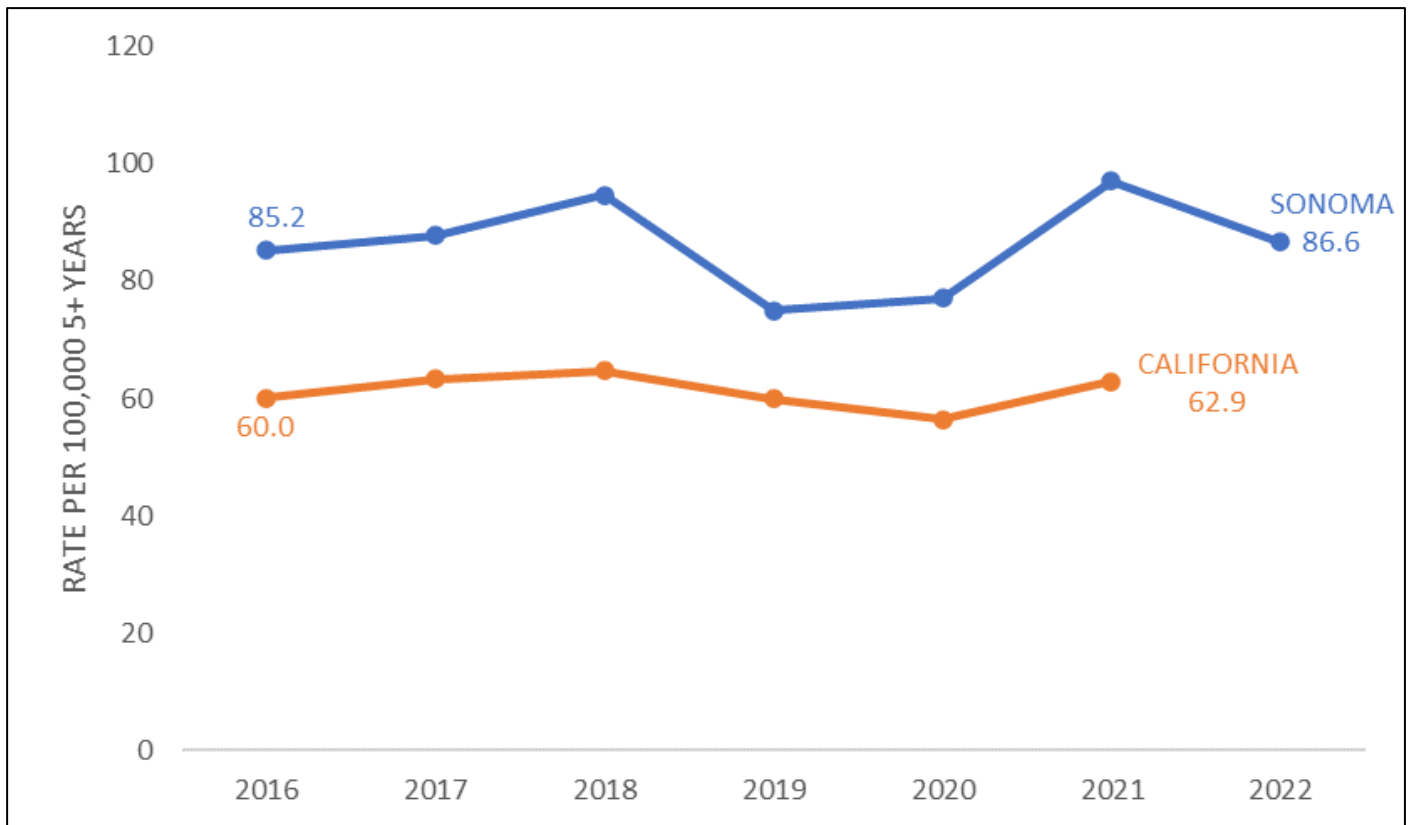
To learn more about means safety for everyone, please visit <https://strivingforsafety.org/>.

<sup>7</sup> Source: California Department of Public Health, California Comprehensive Death File, 2016-2023; note that as of this publication 2023 data is preliminary)

## **Self-Harm and Suicide Attempts**

### **Emergency Department visit rates for non-fatal self-harm**

**Table 6:** ED visit rates for non-fatal self-harm/suicide attempt, people 5+ years, Sonoma County and California, 2016-2022.<sup>8</sup>



The Emergency Department (ED) visit rate for non-fatal self-harm in Sonoma County is higher than the state rate.

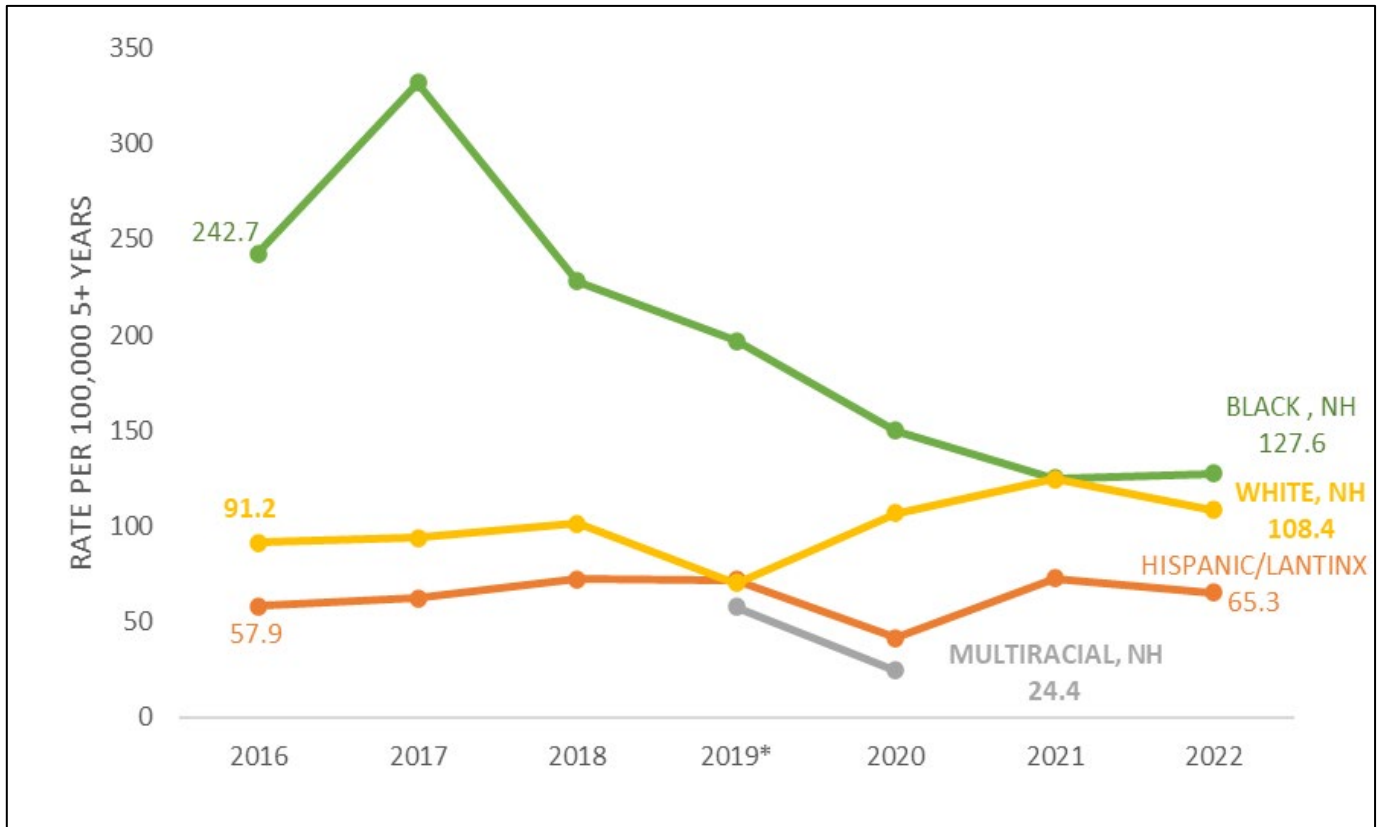
Just as certain populations may experience disproportionate risk for suicide, non-fatal self-harm or suicide attempt data shows certain groups of individuals have, on average, higher rates. It is worth noting that the groups disproportionately represented in non-fatal self-harm or suicide attempt data are different than those for suicide death. This includes the following differences\*:

- Rates are higher among females than males.
- The age group with the highest rates is young adults aged 10-24 years.
- The most common means for self-harm is cutting/piercing, followed by poisoning.

<sup>8</sup> J Source: CA HCAI, CA ED Visit Data, 2016-2022

## Emergency Department visit rates for non-fatal self-harm by race/ethnicity

**Table 7:** ED visit rates for non-fatal self-harm/suicide attempt by race/ethnicity, people 5+ years, Sonoma County and California, 2016-2022.<sup>9</sup> *Note: Race classifications changed to include multiracial.*



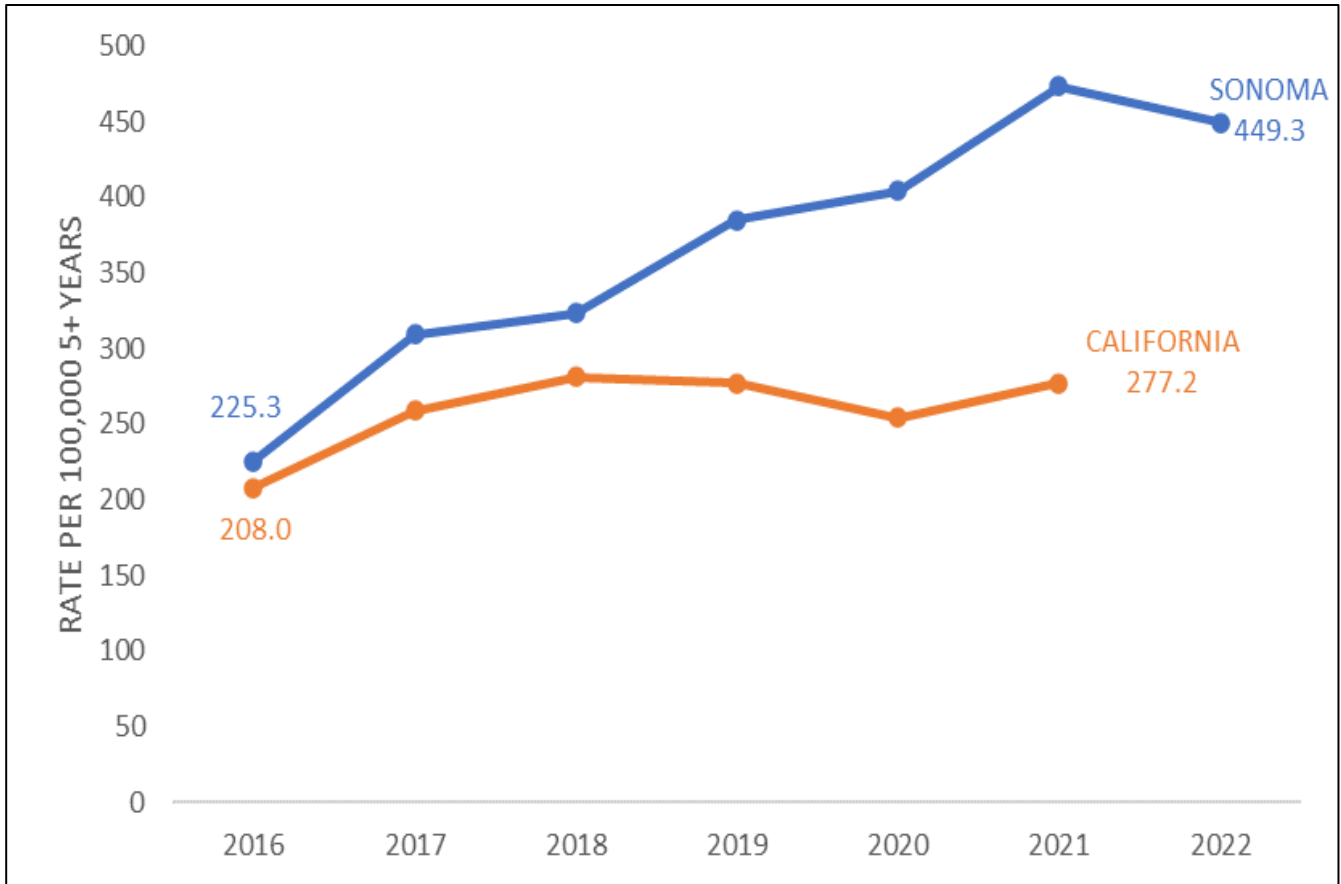
Emergency Department visit rates for non-fatal self-harm/suicide attempts have increased among Hispanic/Latinx people in Sonoma County. Rates among Black people in Sonoma County decreased by more than 50% in the past 6 years.

<sup>9</sup> Source: CA HCAI, CA ED Visit Data, 2016-2022

## Self-Reported Suicidal Ideation

### Emergency Department self-reported suicide ideation rates

**Table 8:** ED visit rates with suicide ideation, people 5+ years, Sonoma County and California, 2016-2022.<sup>10</sup>



Suicide ideation is increasing throughout the state. Sonoma County ED visit rates with suicide ideation have almost doubled in the past 7 years, a much steeper increase than for California.

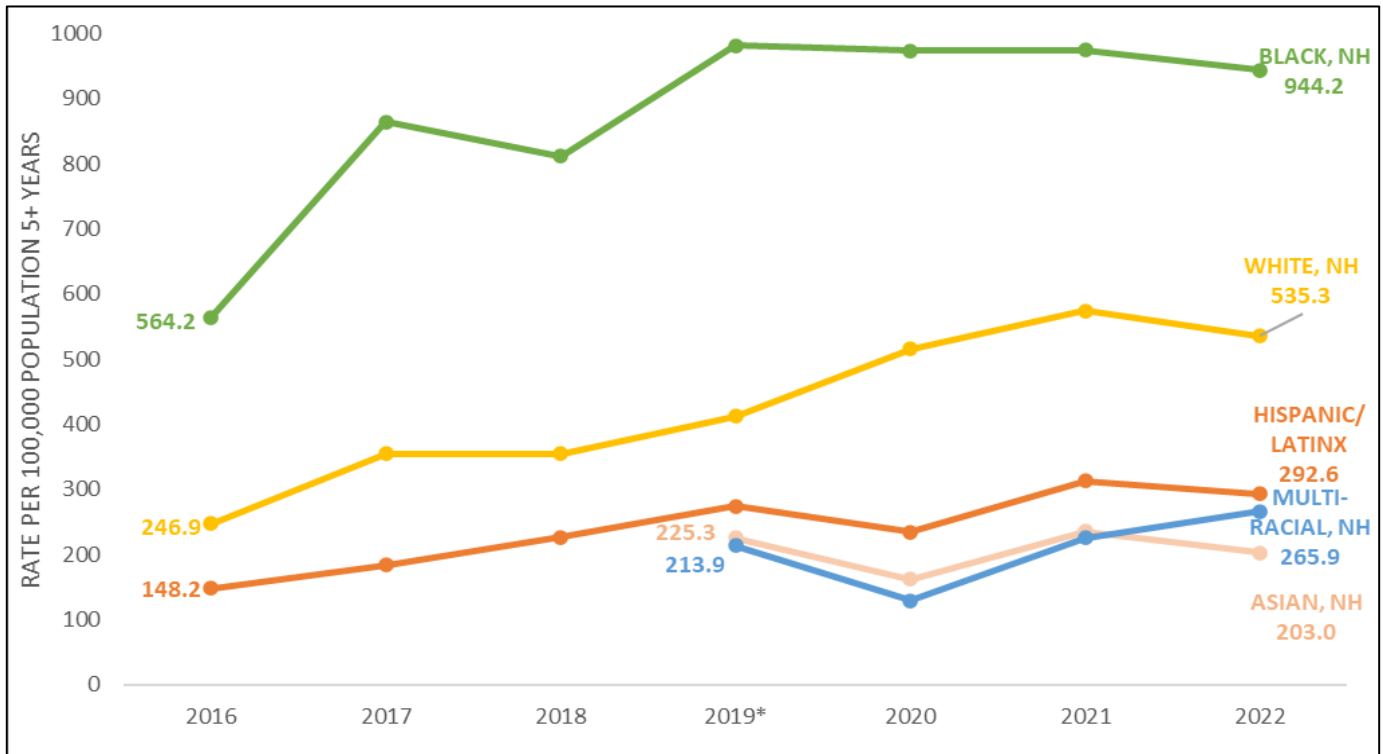
Between 2016-2022, the rate for ED visits with suicide ideation in Sonoma County:

- Doubled for both males and females.
- Was highest among youth ages 10-18 years, but has increased among most age groups, particularly children aged 5-14 years

<sup>10</sup> Source: CA HCAI, CA ED Visit Data, 2016-2022

## Emergency Department Self-reported suicide ideation rates by race/ethnicity

**Table 9:** ED visit rates with suicide ideation by race/ethnicity, people 5+ years, Sonoma County and California, 2016-2022<sup>11</sup>; Note: Race classifications changed to include multi-racial and disaggregated Asian/Pacific Islander

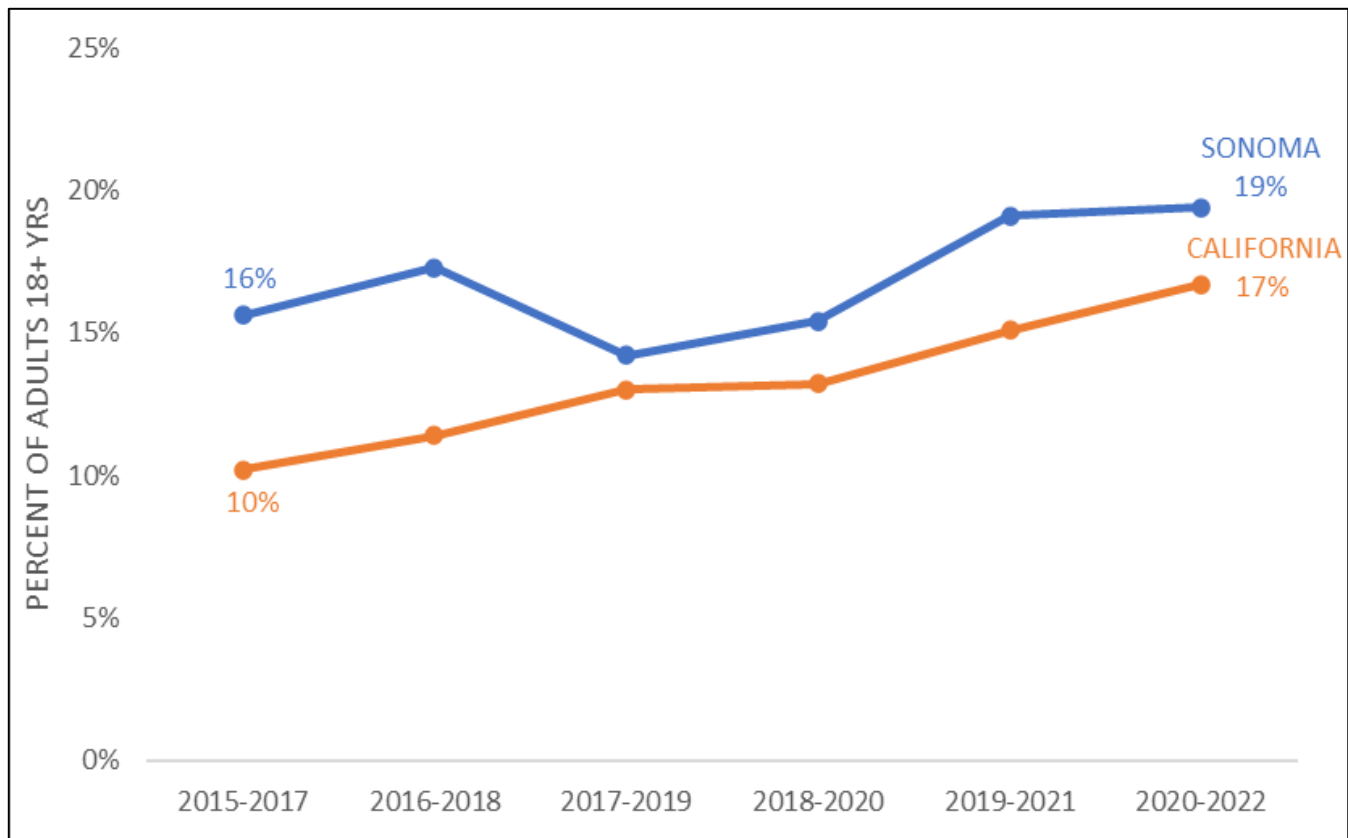


Between 2016-2022, the rate increased for most race/ethnic groups, doubled for Black, White, and Hispanic/Latinx residents, and was significantly higher among Black residents in Sonoma County, compared to any other racial/ethnic group.

## Suicide Ideation among adults

<sup>11</sup> Source: CA HCAI, CA ED Visit Data, 2016-2022

**Table 10:** Percent of adults 18 years and over that reported they ever seriously thought about attempting suicide (California Health Interview Survey, 2015-2022)<sup>12</sup>



The prevalence of self-reported suicidal ideation is higher in in Sonoma County than in California as a whole and is trending towards an increase:

- Self-reported suicidal ideation is increasing for both males and females.
- Prevalence is higher among Black, Multiracial/multiethnic, American Indian or Alaska Native and Indigenous youth than among their peers.
- The percent of adults who report suicide ideation has increased in the past 6 years, while the percent of students who report seriously considering attempting suicide has held relatively steady.

However, the prevalence of suicide ideation among students varies drastically by sexual orientation, gender identity, and transgender status, including the following:

<sup>12</sup> Source: California Health Interview Survey 2015-2022

- Bisexual and gay or lesbian students were more than three times as likely to report suicide ideation than straight students (30% compared to 8%);
- Non-binary or gender non-conforming students were about three times more likely to report suicide ideation than male or female identifying students (34% compared to 9% for males and 14% for females); and,
- Transgender students were more than three times more likely to report suicide ideation than students who don't identify as transgender (39% compared to 11%).

### **Using Data to Inform Suicide Prevention**

Obtaining and reviewing data can help us answer these and other questions to inform our work:

- Who is attempting suicide?
- Who is dying by suicide?
- How long does it take for survivors of suicide loss to access support?
- What care transitions exist? How well are these working? What can be improved?
- What community strengths can support suicide prevention efforts? What are the gaps?

Together with our community program, education, and public health partners, the Life Worth Living Alliance will:

- Develop a plan to collect local data around suicide ideation, attempts, loss, and help-seeking.
- Develop a consistent way to review and discuss this data to inform our efforts.
- Use this data to produce and distribute a public-facing annual report to inform community members and partners on local suicide trends, as well as prevention progress.

### **The Core of the Suicide Prevention Strategic Plan:**



## Strategies, Objectives, and Activities

This strategic plan organizes the major goals and action items into a three-tiered structure:

- **Strategies** are longer-term priorities to guide the Life Worth Living Alliance and community partners in carrying out the mission of preventing deaths by suicide in the county.
- **Objectives** are core goals in policy implementation, program development, cross-systems collaboration, and community outreach and engagement. Objectives are intended to be collaborative efforts among public agencies, community-based organizations, service providers, and community members. For each objective, there is a list of **recommended partners** whose participation can help advance progress.
- **Activities** are programs, services, collaborative ventures, and planning efforts undertaken to meet objectives.
- In addition, each strategy includes **performance measures** that can be used to measure progress towards goals.



*Left: Danza Azteca performing at the 1st Annual Connection is Prevention Event in September 2023.*

## Sonoma County's Core Strategies At-A-Glance



**Strategy 1:** Increase visibility and accessibility of behavioral health support and treatment resources.

**Strategy 2:** Enhance connectedness and protective factors at the individual, family, and community level.

**Strategy 3:** Provide culturally responsive, evidence-based and/or best practice suicide prevention trainings and education to Sonoma County residents

**Strategy 4:** Empower community members and service providers to use lethal means safety information and strategies to create safe environments for themselves and others.

**Strategy 5:** Assist behavioral health providers to develop uniform policies and procedures to screen for suicide risk and connect to care in the least restrictive setting possible.

**Strategy 6:** Promote effective suicide-related care and follow-up supports for individuals at high risk and their families.

**Strategy 7:** Connect suicide loss survivors to timely and effective resources and supports.

**Strategy 1: Increase visibility and accessibility of behavioral health support and treatment resources.**

Because of the stigma surrounding suicide, individuals experiencing suicidal ideation often do not volunteer their thoughts to caregivers. Individuals with thoughts of suicide need to be asked directly about suicidal thoughts to disclose their thoughts. Uniform suicide screening across healthcare systems can enable early intervention for suicidal behavior.

Many individuals who die by suicide have had recent contact with their healthcare providers before their deaths, yet they did not receive linkage to behavioral healthcare.

To bridge this gap, the Life Worth Living Alliance recommends the establishment of community guidelines that create visible, easily accessible pathways to access services for those at risk of suicide. These include: a centralized online behavioral health / crisis support resource hub, provider referral networks, and best practice protocols for 988 and 911 dispatchers. Additionally, it is imperative that local media be aware of best practices for reporting on suicide to improve awareness of community resources and reduce the possibility of contagion suicides.

**Strategy 1: Increase visibility and accessibility of behavioral health support and treatment resources.**

**Short-Term Goal:** Develop and disseminate a web-based behavioral health / crisis support community resource map by July 1, 2025.

**Objectives:**

- 1.1: Develop a suicide prevention awareness campaign that destigmatizes suicide, encourages behavioral health help-seeking, and promotes messaging that suicide is preventable.
- 1.2: Ensure that public messaging about suicide prevention is provided in a variety of modalities and languages to reach diverse community populations.
- 1.3: Plan outreach and engagement activities that raise public awareness of behavioral health resources.
- 1.4: Raise awareness of disparities in accessing behavioral health resources and identify strategies to remedy disparities.

**Recommended Activities:**

- Build a community behavioral health/crisis support resource map.
- Seek input from diverse community members/groups and behavioral health providers on creating an effective public awareness campaign.
- Develop a public awareness campaign centered around this community resource map.
- Evaluate reach of public awareness campaign annually.

**Potential Partners:**

- Sonoma County Behavioral Health
- Buckelew Suicide Prevention Hotline
- 211 / Findhelp.org
- Libraries
- Hospitals & Healthcare Systems
- Behavioral Health Providers
- Federally Qualified Community Health Centers
- Community-based Behavioral Health Organizations
- Local Farmer's Markets
- Community Health/Wellness Fairs
- School Districts
- Faith-based communities
- Law Enforcement Agencies
- Community Foundations
- Chambers of Commerce
- Board of Supervisors
- City Councils
- Sonoma County Indian Health
- Veterans Administration & Support Services

**Potential Performance Measures:**

- Number of unique individuals visiting the Suicide Prevention page on the Behavioral Health Website.
- Number of clicks based on analytics of the Suicide Prevention page on Behavioral Health Website.
- Number of respondents that report increase in awareness of suicide prevention resources.

## Strategy 2: Enhance connectedness and protective factors at the individual, family, and community level.

According to one predominant theory of suicide, known as the Interpersonal Theory for Suicide, three components must align to predict risk for suicide or a serious suicide attempt: thwarted belongingness, perceived burdensomeness, and acquired capability for lethal self-injury. Thwarted belongingness is described as a state of “unmet need to belong.” Both the theory and extensive research indicate that *people have a fundamental need to belong* and that, when that need is thwarted, it increases risk.

This theory is backed by a comprehensive study published in 2023 by the U.S. Surgeon General, titled *Our Epidemic of Loneliness and Isolation: The U.S. Surgeon General’s Advisory on the Healing Effects of Social Connection and Community*. In this study Surgeon General Dr. Vivek H. Murthy lays out the clear evidence for how our lack of connection is leading to a mental and physical health epidemic.

Perhaps the most notable statement in the report relates directly to suicidality and self-harm: ***“Social isolation is arguably the strongest and most reliable predictor of suicidal ideation, attempts, and lethal suicidal behavior among samples varying in age, nationality, and clinical severity.”***

Surgeon General Murthy goes on to say *“We are called to build a movement to mend the social fabric of our nation. It will take all of us - individuals and families, schools and workplaces, health care and public health systems, technology companies, governments, faith organizations, and communities... It will require reimagining the structures, policies, and programs that shape a community to best support the development of healthy relationships.”*

While businesses, organizations, and agencies are essential in the efforts to reduce suicidality through stronger community connection, individual relationships and connections are the key to combating loneliness and isolation.

**Strategy 2: Enhance connectedness and protective factors at the individual, family, and community level.**

**Short-Term Goal:**

By July 1, 2026, there will be a 20% increase of activities and programs that promote protective factors in place.

**Objectives:**

2.1: Raise awareness of the importance and impact of connection as a protective factor and component of wellness.

2.2: Empower and equip community members and organizations with resources, opportunities, and tools to build and strengthen connections.

2.3: Identify and promote services that build resilience and positive attachments between children, youth, their families, older adults, and social supports in their community.

2.4: Promote communication and connection of organizations and agencies across diverse settings and communities to strengthen and widen the network of support.

**Recommended Activities:**

- Host annual Connection is Prevention Wellness Fair
- Host central web resource ([connectionisprevention.com](http://connectionisprevention.com))
- Develop a "Connection is Prevention" public awareness campaign
- Promote and support school-based initiatives to increase awareness of support
- Promoting connection opportunities for Resource Providers
- Faith-based Mental Health Summit

**Potential Partners:**

- Board of Supervisors
- City Councils
- Municipal Advisory Committees
- Sonoma County Libraries
- Sonoma County Regional and City Parks
- Health Care Providers and Clinics
- Behavioral Health Clinicians
- Peer Service Providers
- Mobile Crisis Support Teams
- Schools, Colleges and Universities
- Youth Organizations
- Foster Care Organizations
- Faith-based Communities
- Community Based Organizations
- Recovery Organizations
- Santa Rosa Junior College and Sonoma State University
- Media Outlets, including print and radio

**Potential Performance Measures:**

- Baseline survey
- Youth Truth Survey
- Number of schools, community organizations, and other entities participating in Suicide Prevention Week and Month activities (annual count)

**Strategy 3: Provide culturally responsive, evidence-based and/or best practices suicide prevention trainings and education to Sonoma County residents.**

In Sonoma County, there is widespread community interest in suicide prevention training and education programs. There are many evidence-based suicide prevention trainings available for service providers, behavioral health practitioners, and community members. Some providers in the county already offer these trainings. This strategic aim includes coordinating these local efforts, strengthening coordination across trainers and settings, and expanding offerings as needed.

Training that is available for gatekeepers and wider audiences of community members will equip Sonoma residents with the skills and knowledge to initiate conversations about suicide, to recognize the warning signs of suicide, and to provide initial support to those who may be contemplating suicide.

We envision a future where suicide prevention trainings are as common in workplaces and community settings as first aid trainings, where suicide prevention is routinely and regularly discussed in school and community settings, and where the right community members have the right training to provide help to their clients, loved ones, and fellow community members. A community trained to recognize the signs of suicide and offer knowledge of support services will significantly increase collective protective factors and the sense of connectedness.





**Strategy 3: Provide culturally responsive, evidence-based and/or best practices suicide prevention trainings and education to Sonoma County residents.**

**Short-Term Goal:**

By July 1, 2025, Sonoma will implement a comprehensive Suicide Prevention Training Plan.

**Objectives:**

3.1: Convene stakeholders with subject matter expertise to develop a culturally responsive Suicide Prevention Training Plan.

3.2: Develop a request for proposal and identify a contractor to implement and coordinate the training plan, which incorporates existing trainers and organizations providing trainings throughout Sonoma County.

3.3: Advocate for ongoing training and support for service providers on best practices for culturally competent suicide risk assessments, management, intervention, means safety, and ongoing care for individuals at risk of suicide.

**Recommended Activities:**

Form Training Subcommittee and identify lead via Request for Proposals (RFP):

- Map and identify existing evidence-based and best practice trainings
  - QPR
  - Mental Health First Aid
  - Youth Mental Health First Aid
  - Columbia Suicide Severity Rating Scale (C-SSRS)
  - Stanley-Brown Safety Plan
  - Risk Assessment
  - Counseling on Access to Lethal Means
- Map and identify existing trainers and training resources and needs
- Identify trainings to address populations disproportionately impacted by suicide
- Develop and facilitate collaborative of trainers; includes incorporating suicide prevention trainings being conducted by organizations in the County.
- Train agencies, organizations, businesses, family members, and community members that work with groups disproportionately affected by suicide (as prioritized by data) to recognize signs of suicide, utilize means safety strategies, and appropriately intervene.

### **Potential Partners:**

- Life Worth Living (LWL) Alliance
- Training Providers:
  - NAMI (National Alliance on Mental Illness) Sonoma County
  - Sonoma County Office of Education
  - Behavioral Health Division
  - Veterans Administration
  - SRJC
  - Buckelew
  - Kaiser
- Key Settings or Partners to Participate In Trainings:
  - Sonoma State University

### **Potential Performance Measures:**

- Number of individuals trained
- Pre- and post- training questionnaires re: change in knowledge of warning signs
- Survey measuring community awareness of suicide prevention resources.



**Strategy 4: Empower community members and service providers to use lethal means safety information and strategies to create safe environments for themselves and others.**

Suicide prevention efforts often focus on why people attempt suicide and aim to reduce suicidal thoughts and attempts. However, how a person attempts suicide—in particular, the method used—can determine whether those individual lives or dies.

Suicidal behavior is often method-specific, and a person's choice of means is driven by multiple factors. These factors are critical because crises involving suicidal behavior tend to be short-term and transient and are characterized by ambivalence about the wish to die or stay alive. Reducing access to lethal means has proven to be one of the most effective and evidence-based strategies for suicide prevention. The Harvard T.H. Chan School of Public Health's Means Matter campaign emphasizes the six key points of understanding why means reduction efforts important:

- **Many suicide attempts occur with little planning during a short-term crisis.** While some suicides are the result of deliberate planning, many people who attempt or die by suicide decide to do so in an hour or less of consideration. Reducing access to common lethal means can deter some individuals from impulsive suicidal self-directed violence.
- **Intent alone does not determine whether or not an attempt will be lethal; means also matter.** Reducing easy access to highly lethal methods of suicide can save lives, especially among individuals with a high intent to die by suicide during brief episodes.
- **90% of people who make a suicide attempt will not go on to die by suicide in their lifetime<sup>48</sup>.** The high rate of long-term survival among survivors of a suicide attempt support the understanding that many suicidal crises are short-lived, even if there are underlying, longer-term factors behind shorter-term crises
- **Access to firearms is a risk factor for suicide.** Scientifically validated studies have unilaterally demonstrated that access to firearms is associated with increased suicide risk in the United States
- **Reducing access to lethal means saves lives.** Research demonstrates the effectiveness of efforts in lethal means reduction, in the United States and internationally. Combined with

practices that reduce the likelihood that individuals experience behavioral health crises, lethal means reduction is critical to preventing suicide.

**Strategy 4: Empower community members and service providers to use lethal means safety information and strategies to create safe environments for themselves and others.**

**Short-Term Goal:**

By July 1, 2026, there will be a 30% increase of community member awareness about means safety.

**Objectives:**

4.1: Establish a Means Safety Implementation Workgroup to partner with stakeholders in key community settings and implement strategies.

4.2: Develop and utilize means safety messaging campaigns and distribute practical tools and resources to empower community members.

**Recommended Activities:**

- Review data to inform efforts.
- Consult with key stakeholders to map existing activities
- Distribution of personal safes, cable/trigger locks, and other practical tools
- Public campaigns for means safety messaging
- Identify and promote existing means safety training

**Potential Partners:**

- Firearm ownership associations and retailers
- Pharmacists
- Opioid or SA/SUDS providers or coalitions
- Law enforcement
- Hospitals and Health Care organizations
- Veterans Administration
- Vet Connect
- Professional mental health associations

**Potential Performance Measures:**

- Number of lockboxes distributed.
- Number of individuals trained in Counseling on Access to Lethal Means

**Strategy 5: Assist behavioral health care settings to develop uniform procedures to screen for suicide risk and connect to care in the least restrictive setting possible.**

Screening tools can identify people at risk for suicide, warning signs, risks, and appropriate interventions. Crisis and support services can assist with assessing suicide risk and connection to available services that benefit the diverse range of people in need of help.

The Columbia-Suicide Severity Rating Scale (C-SSRS) along with the Stanley and Brown Safety Planning Intervention prioritize evaluation of the intensity of suicidal ideation as well as evaluation of suicidal behavior.

The greatest utility of a safety plan is connecting individuals to community support and care providers in the least restrictive setting.

These tools used in combination are considered best practices. The tools utilize a person-centered, collaborative, and transparent approach. Therefore the Alliance advocates for the adoption of the C-SSRS and Stanley Brown Safety Planning Intervention in behavioral health and community settings.

Learn more about the Columbia Suicide Severity Rating Scale and Safety Planning Intervention by visiting <https://cssrs.columbia.edu/> and <https://suicidesafetyplan.com/>.

**Strategy 5: Assist behavioral health care settings to develop uniform procedures to screen for suicide risk and connect to care in the least restrictive setting possible.**

**Short-Term Goal:**

Survey and assess the use of the CSSRS and Stanley and Brown Safety Plan in behavioral health settings throughout Sonoma County by July 1, 2025.

**Objectives:**

5.1: Map and evaluate the continuum of crisis services available through private and public resources and identify strengths and gaps.

5.2: Promote the use of best practices in suicide risk assessment and management for those who screen positive for risk in health, behavioral health, education, and criminal justice settings.

5.3: Promote clear methods of collaboration and communication between crisis service providers and other systems of care.

**Recommended Activities**

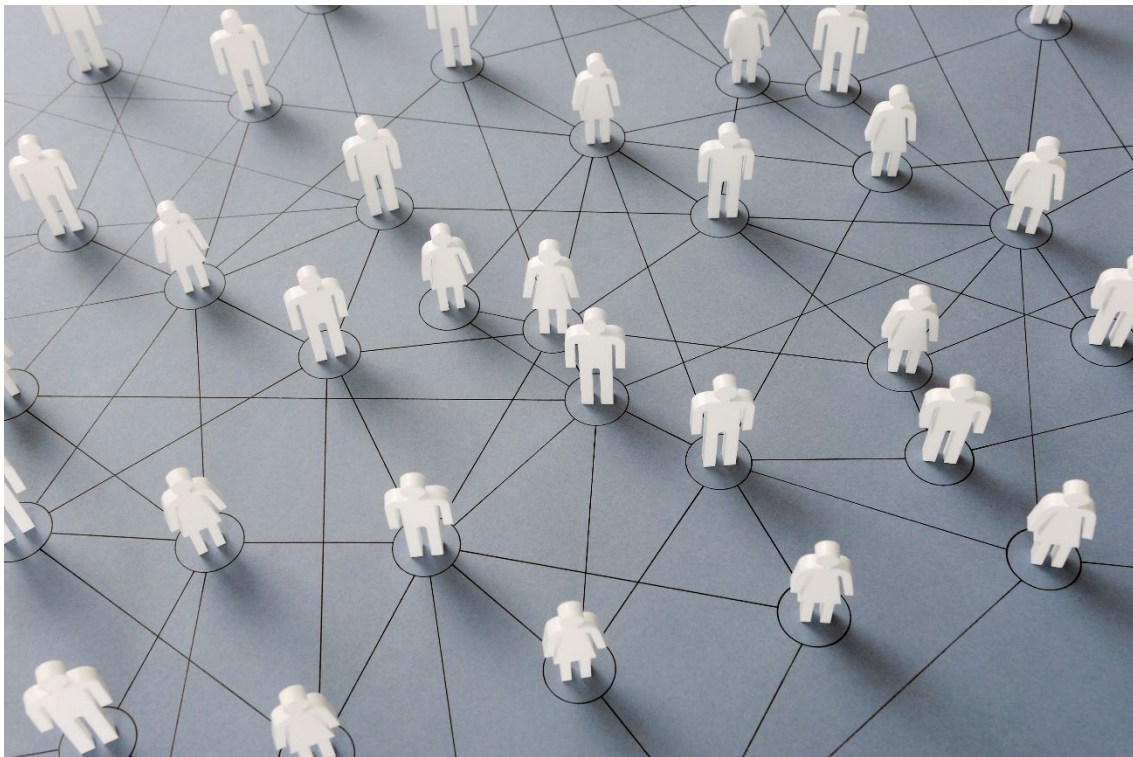
- Survey, System Resources
- Disseminate information on available crisis services resources to health, and behavioral healthcare partners.
- Convene crisis service providers regularly to share information, build collaboration, and identify/address gaps.
- MOUs or other information-sharing agreements
- Provide or support training on the Columbia Suicide Severity Rating Scale (C-SSRS), Stanley Brown Safety Plan, and other evidence-based tools.

**Potential Partners:**

- Behavioral Health
- Hospitals
- Community Clinics
- Crisis Stabilization Unit
- Mobile Crisis Support Teams
- Redwood Empire Association of Marriage and Family Therapists
- Redwood Empire - National Association of Social Workers
- Redwood Psychological Association
- Sonoma State - Nursing and MH MA Programs

### **Potential Performance Measures:**

- Number of individuals enrolled in trainings on using the CSSRS and Stanley and Brown Safety Plan
- Number of individuals that successfully completed the CSSRS and Stanley and Brown Safety Plan training
- Percentage of individuals that reported confidence in using the CSSRS and Stanley and Brown Safety Plan following the training



**Strategy 6: Promote effective suicide-related care and follow-up supports for individuals after a suicidal crisis.**

Best practices research indicates that implementing “bridge” or “transition” services within and between service providers and clinics can significantly increase the likelihood that a patient will link to outpatient care.

Ideally timely services and supports are available to people experiencing suicidal behavior, especially attempted suicides. Behavioral health and substance providers need to be equipped to help those at risk and trained to deliver care that reflects best practices. For example, low-cost, high-impact post hospitalization postcards and referral services are effective strategies for preventing future suicidal behavior and must be a standard component of aftercare following hospital or emergency department discharge.

**Strategy 6: Promote effective suicide-related care and follow-up supports for individuals at high risk and their families.**

**Short-Term Goal:** Develop resources to support individuals after a suicidal crisis by July 1, 2026.

**Objectives:**

- 6.1: Include information, education, and training resources on best practices for supporting an individual at high risk of suicide in the online resource map
- 6.2: Promote safe behavioral health discharge practices and transition of care for individuals at high risk of suicide and their loved ones.
- 6.3 Establish a postcard distribution project for individuals following a suicidal crisis

**Recommended Activities:**

- Identify and create resources to support individuals after a suicidal crisis.
- Advocate conducting warm hand-offs when a client is transitioning between providers.
- Create content for postcards to send to individuals following a suicidal crisis.



**Potential Partners:**

- Inpatient and outpatient physical health and behavioral health providers
- Schools, Colleges, and Universities
- Faith based communities

**Potential Performance Measures:**

- Number of hospitals, clinics, and providers that implement standardized follow-up contact procedures.
- Number of clients who were sent caring postcards following discharge.
- Number of schools that implement standard reentry protocols for returning students

**Strategy 7: Connect suicide loss survivors to timely and effective resources and supports.**

It can be traumatic for Individuals who experience a loved one's death by suicide. In addition to grief stemming from the loss, survivors of suicide loss frequently experience complicated emotions, including shame, guilt, anger, resentment, loss, and sadness. For many, the first few weeks and months after a death are filled with details and practical considerations. The deeper impacts may not be felt for months, or even years. Long term suicide loss survivors report intermittent and recurring periods of worsening grief.

It is estimated that approximately 50% of people will experience a suicide loss at some point in their life. Supportive interventions conducted after a suicide, also known as postvention, can reduce negative effects of exposure to suicide and facilitate the process of healing from a suicide loss.

Postvention includes the range of supports and services a community offers as an intentional response after a suicide death has occurred. Strategies range from immediate response after a death to options for ongoing support. The goal is to promote healing and support to individuals, groups and communities impacted by a suicide death. Many suicide loss

survivors benefit from connecting with others who have experienced a suicide loss to share strategies for coping and healing.

**Strategy 7: Connect suicide loss survivors to timely and effective resources and supports.**

**Short-Term Target:** Develop LOSS outreach materials (for referral by providers) and packet of support resources for survivors and distribute to community providers by 2025.

**Objectives:**

- 7.1: Identify resources to support survivors of suicide loss in healing and finding support.
- 7.2: Raise awareness of and promote access to existing loss survivor supports.
- 7.3: Create opportunities for connection and healing amongst loss survivors.

**Recommended Activities**

- Map out existing grief and suicide loss support resources.
- Host one annual event in November to raise awareness regarding suicide loss.
- Develop and distribute culturally responsive bereavement resources.
- Promote community postvention planning in key community settings.

**Potential Partners:**

- Peers/those with lived experience of suicide loss
- Sheriff's Office, Coroners Office, Law Enforcement Chaplaincy (unexpected tragedy)
- Bay Area Chapter American Foundation of Suicide Prevention
- First responders
- Funeral directors
- Faith-based communities
- Buckelew - Survivors of Suicide (SOS) online
- NAMI (National Alliance on Mental Illness)
- Behavioral Health provider organizations
- Sonoma County Resiliency Collaborative
- County Office of Education

**Potential Performance Measures:**

- Suicide loss support resources distributed
- Number of people who attend survivor support meetings or events
- Number of individuals receiving supportive services for processing suicide loss



## From Planning to Implementation

Creating a strategic plan results in change when the strategies, objectives, and goals in the plan are implemented, evaluated, and adapted over time to meet the shifting needs of the community. Success depends on supportive partnerships with and active participation from a wide range of individuals, agencies, and organizations.

Following the adoption of the Sonoma County Suicide Prevention Strategic Plan, the Life Worth Living: Sonoma County Suicide Prevention Alliance, along with Sonoma County Behavioral Health and community partners, will use an implementation framework to develop action plans and next steps for each area, as well as to refine how progress and success will be measured and reported in each Annual Report.

If you are interested in getting involved or would like more information, please contact:

[Life-Worth-Living-Suicide-Prevention@sonoma-county.org](mailto:Life-Worth-Living-Suicide-Prevention@sonoma-county.org)



*Members of the Alliance sharing a meal, successes, and ideas at the December 2023 Potluck.*

## With Gratitude

Thank you to our Suicide Prevention Alliance membership for your compassion, dedication, and care in creating this plan to guide and support our local activities.

At the time of publish, these individuals represented the membership of the Life Worth Living: Sonoma County Suicide Prevention Alliance:

Name	Organization/Representation
Alethea Larson	The Living Room, unhoused
Ali Soto	Sonoma County Office of Education, Transition Age Youth
Amanda Lopez	Veterans Affairs
April Reza	Sonoma County Office of Education, Transition Age Youth
Carly Memoli	Consultant
Christina Nihil	Buckelew, Suicide Prevention
Citlaly Martinez	Humanidad
Cristian Gutierrez	Latino Service Providers
Deepali Sansi	Buckelew, Suicide Prevention
Erika Klohe	Provider, Buckelew, lived experience, family member
Fabiola Espinosa	MHSA Analyst, family member
Fletcher Skerrett	Law Enforcement
Gabriel Kaplan	Public Health
Imelda Vera	Humanidad
Jan Cobaleda-Kegler	Behavioral Health Division Director
Jeane Erlenborn	Santa Rosa Junior College, Transition Age Youth

Jenny Mercado	Department of Health Services, Epidemiology
Juan Torres	Humanidad, provider
Justin Haugen	Law Enforcement, Coroner's Office
Katie Bivin	Behavioral Health School Based Program and Medication Support Manager, youth
Leslie Petersen	Hanna Center
Lisa Nosal	Cultural Responsiveness, Inclusion & Training Coordinator
Marikarmen Reyes	Family member
Mary Champion	Sonoma County Office of Education
Mary-Francis Walsh	NAMI, family member
Meghan Murphy	Buckelew, Family Services Coordination
Melissa Ladrech	MHSA Coordinator, family member

Michael Johnson	Mental Health Board, lived experience
Michael Reynolds	West County Community Services, lived experience
Michael Schemmel	Law Enforcement, Coroner's Office
Rebekah Pope	Sonoma County Office of Education
Sandra Black	Consultant
Sarahi Hernandez	Latino Service Providers
Shelly Niesen-Jones	Kaiser, healthcare, provider
Shriya Ambre	Buckelew, Suicide Prevention
Steve Diamond	Buckelew, Suicide Prevention
Susan Standen	Peer at large, lived experience

### The Sonoma County Suicide Prevention Strategic Plan Workgroup

We would also take this opportunity to highlight the Strategic Plan Workgroup that diligently and tirelessly drafted the Strategic Plan with input and feedback from the Alliance.

Name	Organization
Carly Memoli	Consultant, Striving for Zero Learning Collaborative
Fabiola Espinosa	Sonoma County Department of Health Services, Behavioral Health Division
Mary Champion	Sonoma County Office of Education
Mary-Francis Walsh	NAMI
Melissa Ladrech	Sonoma County Department of Health Services, Behavioral Health Division
Michael Reynolds	West County Community Services
Rebekah Pope	Sonoma County Office of Education
Shelly Niesen-Jones	Kaiser

## APPENDIX A – GUIDING DOCUMENTS AND REPORTS

The following resources include recommendations and resources to support communities in creating and using strategic plans and cooperative efforts for suicide prevention. The Life Worth Living: Sonoma County Suicide Prevention Alliance referred to many of these in the creation of this plan.

**Transforming Communities:** Key elements for the implementation of comprehensive community-based suicide prevention published by the National Action Alliance for Suicide Prevention:

[www.theactionalliance.org/sites/default/files/transformingcommunitiespaper.pdf](http://www.theactionalliance.org/sites/default/files/transformingcommunitiespaper.pdf)

**National Guidelines for Child and Youth Behavioral Health Crisis Care:**

<https://store.samhsa.gov/product/national-guidelines-child-and-youth-behavioral-health-crisis-care/pep22-01-02-001>

**Preventing Suicide: A Technical Package of Policy, Programs, and Practices:**

[www.cdc.gov/violenceprevention/pdf/suicidetechnicalpackage.pdf](http://www.cdc.gov/violenceprevention/pdf/suicidetechnicalpackage.pdf)

**Striving for Zero, California’s Strategic Plan for Suicide Prevention – Mental Health Services Oversight and Accountability Commission:**

[https://mhsoac.ca.gov/sites/default/files/Suicide%20Prevention%20Plan\\_Final.pdf](https://mhsoac.ca.gov/sites/default/files/Suicide%20Prevention%20Plan_Final.pdf)

**Striving for Zero Learning Collaborative Resource Page:**

<https://mhsoac.ca.gov/initiatives/suicide-prevention/collaborative/>

**National Action Alliance for Suicide Prevention:** <https://theactionalliance.org/>

**The 2018 CDC Vital Signs report:** [www.cdc.gov/vitalsigns/suicide/index.html](http://www.cdc.gov/vitalsigns/suicide/index.html)

[https://www.citinternational.org/resources/Best%20Practice%20Guide/CIT%20guide%20desktop%20printing%202019\\_08\\_16%20\(1\).pdf](https://www.citinternational.org/resources/Best%20Practice%20Guide/CIT%20guide%20desktop%20printing%202019_08_16%20(1).pdf)

**Community Readiness Manual on Suicide Prevention in Native Communities:**

[https://www.samhsa.gov/sites/default/files/tribal\\_tta\\_center\\_2.3.b\\_commreadinessmanual\\_final\\_3.6.14.pdf](https://www.samhsa.gov/sites/default/files/tribal_tta_center_2.3.b_commreadinessmanual_final_3.6.14.pdf)

**Know the Signs – California Mental Health Service Authority:**

<https://www.suicideispreventable.org/>

**Roadmap to the Ideal Crisis System:** [https://www.thenationalcouncil.org/wp-content/uploads/2022/02/042721\\_GAP\\_CrisisReport.pdf](https://www.thenationalcouncil.org/wp-content/uploads/2022/02/042721_GAP_CrisisReport.pdf)

**One Size Does Not Fit All: Making Suicide Prevention and Interventions Equitable for Diverse Communities:**

<https://www.suicideispreventable.org/events.php>

**Community Program Planning Listening Session Report 2023**

**Crisis Now:** <https://crisisnow.com/>

**CIT-Crisis Intervention International**