Sonoma County
Mental Health Services Act (MHSA)
FY2016-2019 Capacity Assessment

Prepared by:

Resource Development Associates

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Sonoma County Mental Health Services Act (MHSA) FY2016-2019 Capacity Assessment Report

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This report was developed by Resource Development Associates under contract with Sonoma County's Department of Health Services Behavioral Health Division (DHS-BHD).

About Resource Development Associates

Resource Development Associates (RDA) is a consulting firm based in Oakland, California, that serves government and nonprofit organizations throughout California as well as other states. Our mission is to strengthen public and non-profit efforts to promote social and economic justice for vulnerable populations. RDA supports its clients through an integrated approach to planning, grant-writing, organizational development, and evaluation.

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- Latino Service Providers (LSP)
- National Alliance on Mental Illness (NAMI)
- Positive Images
- Redwood Community Health Coalition
- Santa Rosa City Schools
- Santa Rosa Community Health
- Social Advocates for Youth (SAY)
- Sonoma County Indian Health Project (SCIHP)
- Sonoma County Office of Education
- St. Joseph Health
- Sutter Health
- Telecare
- Veterans Service Office
- VOICES Sonoma
- Wellness and Advocacy Center
- West County Services

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Introduction

Sonoma County's Behavioral Health Division (BHD) of the Department of Health Services (DHS) is pleased to present the following Mental Health Services Act (MHSA) Capacity Assessment Report. This report is intended to provide a comprehensive analysis of Sonoma's MHSA-funded system of care and community needs, and contribute to the development of the Three-Year MHSA Program and Expenditure Plan for fiscal year 2020-2023. This assessment presents DHS-BHD and the community with a deeper understanding of the underlying dynamics of the County's behavioral health system and suggests recommendations in order to develop actionable and feasible strategies and approaches to further strengthen Sonoma's public mental health system of care. The findings presented in this report were identified and prioritized with the involvement and participation of diverse stakeholders across the County.

Sonoma County Overview

Sonoma County has a population of 499,942 people across a region of 1,576 square miles.[1] While most residents in the County have economic security, about 10% of the population have an income below the Federal Poverty Level (FPL).[2] With the high cost of living in the County, there are likely additional residents without the ability to meet their basic needs (i.e., food, clothing, shelter, transportation, health care, etc.). One in four County residents (122,962) were enrolled in Medi-Cal in 2018 with an income at or below 138% FPL.[3] These residents rely on the County for support with a number of social services and health care needs, including mental health services for individuals with serious mental illness.

Santa Rosa, the County's most populous city with 177,586 people, is home to over one-third of county residents, the County seat, and the Behavioral Health Division (DHS-BHD) main campus.[4] Beyond Santa Rosa, the main population centers are Petaluma (population 61,917) and Rohnert Park (population 43,753) to the south, and Windsor to the north (population 27,849).[5] **Sonoma is geographically dispersed** with limited public transit and bicycle and pedestrian infrastructure. It can therefore be challenging for individuals living in more rural areas and those without a personal vehicle. This is particularly true for residents enrolled in Medi-Cal and can make it difficult to access services, some of which are only available in Santa Rosa.

[1] U.S. Census Bureau. (2018). *Quick Facts, Sonoma county, California*. Retrieved from https://www.census.gov/quickfacts/fact/table/sonomacountycalifornia
[2] U.S. Census Bureau. (2018). *Quick Facts, Sonoma county, California*.
[3] California Department of Health Services (2018). *Medi-Cal Enrollees and Beneficiaries Served in CY 2018 by Race/Ethnicity.*
[4] U.S. Census Bureau. (2018). *Quick Facts, Santa Rosa city, California*. Retrieved from https://www.census.gov/quickfacts/fact/table/santarosacitycalifornia/
[5] U.S. Census Bureau. (2018). *Quick Facts, Petaluma city, California; Rohnert Park city, California; Windsor town, California.* Retrieved from https://www.census.gov/quickfacts/fact/table/petalumacitycalifornia,rohnertparkcitycalifornia,windsortowncalifornia/

In 2018, **87% of residents identified as White with 27% identifying as Hispanic or Latinx**, the County's largest minority population.[6] The County's poverty rates vary significantly by ethnicity with disparities affecting the Latinx community in particular. While Hispanic or Latinx residents were about a quarter of the population, this group accounts for over 40% of Sonoma County's Medi-Cal beneficiaries in 2018.[7]

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.[8] Native Americans make up just over 2% of the County's total population and about 1% of Medi-Cal beneficiaries.[9]

Over 25% of Sonoma households speak a language other than English at home, of which about 19% speak Spanish – the County's only threshold language.[10] **About 11% of residents speak English less than "very well,"** suggesting possible linguistic isolation for this population.[11] Additionally, there are an estimated 38,500 undocumented residents in the County.[12] Individuals that are undocumented and/or linguistically isolated may experience unique challenges accessing medical, transportation, and social services. If services are limited by language, it can reduce access as well as the quality of services available – particularly for individuals with lower levels of income.

The County's major industries include agriculture, healthcare, hospitality, and manufacturing. The top employers are Kaiser Permanente, Sutter Medical Center of Santa Rosa, St. Joseph Health System, and Graton Resort & Casino.[13] Like many California counties, Sonoma was severely affected by the economic recession that began in 2008. The unemployment rate jumped to over 11% in 2010, but has since dropped to just over 3%.[14] Today, just over 9% of County residents live in poverty, about half of California's rate of 19%.[15] The median household income is $71,796.[16]

While many Sonoma residents have bounced back after the recession, **rising housing costs continue to be a key driver of economic instability**. Over 50% 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

[6] U.S. Census Bureau. (2018). *Quick Facts, Sonoma county, California*.
[7] California Department of Health Services (2018). *Medi-Cal Enrollees and Beneficiaries Served in CY 2018 by Race/Ethnicity.*
[8] County of Sonoma. (2019). *Tribal affairs.* Retrieved from http://sonomacounty.ca.gov/CAO/Public-Reports/Legislative-Program/Tribal-Affairs/
[9] U.S. Census Bureau. (2018). *Quick Facts, Sonoma county, California*. Retrieved from https://www.census.gov/quickfacts/fact/table/sonomacountycalifornia
[10] U.S. Census Bureau, American Fact Finder. (2018). *Occupied housing units, 2013-2017 American Community Survey 5-year estimates*. Retrieved from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_5YR_B25106&prodType=table
[11] U.S. Census Bureau. (2018). *Selected social characteristics on the United States, California.* Retrieved from https://data.census.gov/cedsci/table?d=ACS%205-Year%20Estimates%20Data%20Profiles&table=DP02&tid=ACSDP5Y2017.DP02&y=2017&g=0400000US06_0500000US06097&lastDisplayedRow=146
[12] Hayes, J. & Hill, L. (2017). *Undocumented immigrants in California.* Retrieved from https://www.ppic.org/content/pubs/jtf/JTF_UndocumentedImmigrantsJTF.pdf
[13] County of Sonoma. (2019). *Industry sectors.* Retrieved from http://sonomaedb.org/Why-Sonoma-County/Industry-Sectors/
[14] State of California, Employment Development Department. (2019). *Sonoma county profile*. Retrieved from https://www.labormarketinfo.edd.ca.gov/cgi/databrowsing/localAreaProfileQSResults.asp?selectedarea=Sonoma+County&selectedindex=49&menuChoice=localAreaPro&state=true&geogArea=0604000097&countyName=
[15] U.S. Census Bureau. (2018). *Quick Facts, Sonoma county, California*.
[16] U.S. Census Bureau. (2018). *Quick Facts, Sonoma county, California*.

their household income on rent or mortgage).[17] Historic chronic underbuilding of housing created a disparity between supply and demand and limited the growth potential of the County's economy.[18] Housing costs and underbuilding have the greatest impact on individuals and families with less financial security or who are experiencing home instability, furthering disparities already present.

Economic challenges in Sonoma were exacerbated by the 2017 Sonoma Complex Fires and the recent 2019 Kincade Fire. The 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.[19] Approximately 2.5% of Sonoma's total housing units were lost in the fires, leading the County to require a total of 26,000 new units by 2020 to account for employment growth, fire losses, and overcrowding.[20] The County was better-prepared for the Kincade Fire and, fortunately, it was less impactful. However, the fire burned over 77,000 acres, forced almost 200,000 people to evacuate, and affected the County for weeks.[21]

The fires also had enduring mental health impacts across the County. **The Sonoma community experienced individual and collective trauma, with 40% of households reporting traumatic experiences** such as being separated from a family member or suffering a significant disaster-related illness or injury.[22] Some experienced quality of life changes associated with post-traumatic stress disorder, depression, and anxiety. Fifty-nine percent of households reported at least one member experienced anxiety and/or fear and 24% reported at least one member experienced depression or hopelessness.[23] Vulnerable populations, such as individuals enrolled in Medi-Cal and those with a serious mental illness, are disproportionately impacted by these events as they add to their cumulative trauma. The County saw an increase in the number of people seeking mental health assistance as a result of the fires, many for the first time. Sonoma County BHD deployed over 120 staff to provide services, resources, and act as Disaster Workers, and the County was subsequently awarded disaster relief grants and funds to support mental health assistance and training activities.[24]

In fiscal years 2017-2018 and 2018-2019, Sonoma Department of Health Services, including BHD, faced a significant budget deficit. [25] To address the issue, the Sonoma DHS-BHD engaged in a system redesign, a hiring freeze and general reduction in staff levels, program cuts, and the elimination of some MHSA contracts.[26] The type and amount of services the County was able to provide were impacted, unfortunately during a time of higher need in the County. Moving forward the County intends to more conservatively estimate revenues and expenditures in the MHSA expenditure plans, and the DHS budget

[17] U.S. Census Bureau. (2018). *Quick Facts, Sonoma county, California*.
[18] Beacon Economics. (2018). *Sonoma county complex fires: Housing and fiscal impact report*. Los Angeles, CA: Thornberg, Kleinhenz, & Meux.
[19] Epidemiology and Assessment Unit. (2019*). 2018 Sonoma county rapid needs assessment*. [PowerPoint slides].
[20] Beacon Economics. (2018).
[21] Alexander, K. (2019, November2). Sonoma's Kincade Fire was different – no one died. Here's why. *San Francisco Chronicle*. Retrieved from https://www.sfchronicle.com
[22] Epidemiology and Assessment Unit. (2019).
[23] Epidemiology and Assessment Unit. (2019*).*
[24] Epidemiology and Assessment Unit. (2019*).*
[25] Sonoma County DHS-BHD. (2019). *MHSA 2018-2019 Plan Update & Annual Update for 2016-2017*. Sonoma, CA.
[26] Sonoma County DHS-BHS. (2019).

more broadly, to account for financial shortfalls and ensure sufficient funds exist to pay for planned programming.[27]

California's Public Mental Health System

The public mental health system is designed to provide specialty mental health services to individuals who have Medi-Cal or are otherwise uninsured and have significant mental health needs. In California, each county administers a mental health plan (MHP), which provides coverage for medically necessary mental health services; counties also administer the Mental Health Services Act funding. Both Medi-Cal and MHSA are operated under contract from the California Department of Health Care Services (DHCS). Services provided by MHPs can include rehabilitative mental health services, psychiatric inpatient hospital services, targeted case management, psychiatrist services, psychologist services, supplemental specialty mental health services, and more. Mental health specialists, such as psychiatrists, psychologists, licensed clinical social workers, licensed marriage and family therapists, or peer support providers, provide these services to consumers. **Medi-Cal will reimburse counties for up to 50% of these services**, however, there are restrictions on this reimbursement and not all of the services provided by counties will be reimbursed. Counties remain responsible for providing these services to their Medi-Cal population, even if they are not reimbursed. The other main source of funding for these services is the Mental Health Services Act.

Mental Health Services Act (MHSA)

The Mental Health Services Act (MHSA), Proposition 63, was approved by California voters in 2004 to expand and transform the public mental health system. **MHSA represented a statewide movement toward a better coordinated and more comprehensive system of care for those with serious mental illness** (SMI). In addition, MHSA defined an approach to the planning and the delivery of mental health services that are embedded in the MHSA values (see Figure 1).

[27] Sonoma County DHS-BHS. (2019).

MHSA is funded through a one percent tax on individual annual income exceeding one million dollars. California counties receive MHSA allocations from the state, which typically make up **about 50% of a county's behavioral health budget.** Counties determine how to distribute these funds at the local level through a Community Program Planning (CPP) process which culminates in a three-year plan.

Figure 1: MHSA Values

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

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

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

Additionally, MHSA intends to serve individuals who are historically unserved or underserved by the public mental health care system.[28]

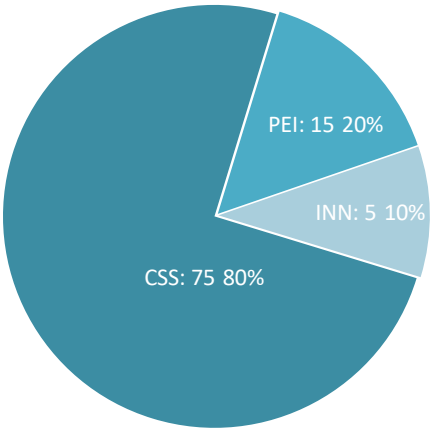
- **Unserved individuals** are defined as "individuals who may have serious mental illness and/or serious emotional disturbance and are not receiving mental health services. Individuals who may have had only emergency or crisis-oriented contact with and/or services from the County may be considered unserved."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

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

MHSA funding is distributed across three funding categories[29] to support all facets of the public mental health system throughout the lifespan of consumers and their needs (see Figure 2).

- **Community Services and Supports (CSS):** Outreach and direct services for children, TAY, adults and older adults with the most serious mental health needs. At least 51% of CSS funds must be dedicated to Full Service Partnerships.
- **Prevention and Early Intervention (PEI):** Services promoting wellness and the prevention of mental health issues. Early intervention services screen for and intervene in early signs of mental health disorders. At least 51% of PEI money must fund programs for children and TAY consumers (birth to 25-years-old).
- **Innovation (INN):** Funding to test new approaches that may improve access, collaboration, and/or service outcomes for un-, under-, and inappropriately served populations. INN provides funding for 3-5 years per innovative practice.

Figure 2. MHSA Allocation Percentages for California Counties



MHSA Capacity Assessment

This capacity assessment is required by MHSA as part of California counties' Program and Expenditure Plans, for Annual Updates and Three-Year Plans. The County must conduct and submit an assessment of the mental health needs in the community for those who qualify for MHSA services. In particular, the County shall identify the number of consumers across age groups by gender, race/ethnicity, and other demographics and use these findings to analyze any population disparities.[30] Stakeholders and community members should be included in both the MHSA assessment and planning process.

In the fall of 2019, the Sonoma County DHS-BHD hired Resource Development Associates (RDA) to assess the effectiveness, structure, quality, and impact of their MHSA-funded system of care. A primary purpose of this assessment is to prepare for and inform the upcoming Community Program Planning (CPP) process for the Three-Year MHSA Program and Expenditure Plan 2020-2023. The assessment team was tasked with exploring the current landscape of MHSA-funded services and what has been accomplished, and the opportunities to address service gaps and remaining community needs.

The resulting report describes DHS-BHD's capacity assessment process, provides a review of the needs identified and prioritized via inclusive stakeholder outreach and engagement activities, and proposes recommendations to support a robust mental health system based in wellness and recovery. This assessment includes the following sections:

[29] Counties also received a one-time allocations of Workforce Education & Training and Capital Facilities & Technology Needs funds to be spent by FY 2017-18.
[30] WIC § 3300.

- **Overview of the capacity assessment process,** data collection activities that took place in the County from July 2019 through November 2019, and analytical methods. DHS-BHD's assessment process built upon the meaningful involvement and participation of mental health consumers, family members, County staff, providers, and many other stakeholders.
- **Description of Sonoma County's public mental health system** including MHSA components and the two service systems – Youth and Family Services and Adult and Older Adult Services. The consumer populations served by these systems and programs are presented as well.
- **Assessment of mental health needs and current capacity** that identifies both strengths and opportunities to improve the mental health service system in Sonoma County. The findings and recommendations presented here will be used by DHS-BHD in their upcoming MHSA service plan for fiscal year 2020 – 2023.

Sonoma County's MHSA Capacity Assessment Process

Sonoma County's DHS-BHD hired Resource Development Associates (RDA), a consulting firm with mental health planning expertise, to assess the effectiveness, structure, quality, and impact of its MHSA-funded Continuum of Care in June 2019. RDA's assessment was supported by DHS-BHD personnel, including Bill Carter, Behavioral Health Division Director; Melissa Ladrech, Mental Health Services Act (MHSA) Coordinator and Workforce, Education and Training (WET) Coordinator; Bruce Robbins, Program Planning and Evaluation Analyst; Julie Kawahara, MHSA Planning consultant; and the MHSA Steering Committee and Capacity Assessment Subcommittee. The capacity assessment process was divided into three phases: 1) Project Launch and Discovery, 2) Data Collection and Analysis, and 3) Reporting and Dissemination. Figure 3 lists the activities included in each phase.

Figure 3. Capacity Assessment Process

Phase I Project Launch and Discovery	Phase II Data Collection and Analysis	Phase III Reporting and Dissemination
• Kick-off Meeting • Context and Background Information Gathering • Systems of Care Mapping • Preliminary Impressions • Capacity Assessment Subcommittee Meetings	• Focus Groups and Interviews Survey • Consumer and Service Utilization Data Analysis • Financial Analysis • Capacity Assessment Subcommittee and Steering Committee Meetings	• Initial Findings Presentation to Capacity Assessment Subcommittee • MHSA Capacity Assessment Report • Presentation to Steering Committee

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

Capacity Assessment Methods

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

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

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

Project Launch and Discovery

RDA embarked on a process of initial data gathering activities to build a foundation of knowledge and materials from which to guide the assessment process and specific areas of inquiry. RDA first developed a shared understanding of the project's vision, goals, and work plans, and gathered further background knowledge on the landscape of the MHSA-funded system of care. Activities during this phase included meeting with DHS-BHD staff, reviewing existing reports and documentation, and conducting three key informant interviews with DHS-BHD leadership and stakeholders' familiar with behavioral health services in the County. RDA met with DHS-BHD staff from each system of care to map the existing services and discuss the processes that support access, engagement, and participation in mental health services as well as transitions between these programs.

MHSA Committee Meetings: RDA began this process by meeting with the County's MHSA Steering Committee and MHSA Capacity Assessment Subcommittee. Twenty-five members were selected, representing diverse populations and age groups throughout the geographical regions of Sonoma County, for the MHSA Steering Committee through an application process in December 2018. In June 2019, the MHSA Steering Committee formed the Capacity Assessment Subcommittee to support the development and implementation of the Sonoma County Capacity Assessment for the 2020-2023 Three-Year Planning Process. Members of these committees are listed in Table 1.

Table 1. Committee Member List and Organization Affiliation

Name	Organization	Committee
Clay Brookfield	Santa Rosa Junior College, PEERS	Steering & Subcommittee
Mechelle Buchignani	Sonoma County Sheriff's Office	Steering
Gene Calhoun	VOICES Sonoma	Steering
Stephanie Chandler	Redwood Community Health Coalition	Steering & Subcommittee
Mandy Corbin	Sonoma County Office of Education	Steering

Name	Organization	Committee
Brandon Cutting	Sonoma County Sheriff's Office	Steering
Christy Davila	West County Community Services	Steering
Angie Dillon-Shore	First 5 Sonoma County	Steering & Subcommittee
Michael Gause	Sonoma County Community Development Commission	Steering
Ozzy Jimenez	Healdsburg Forever, an affiliate CFSC, Positive Images	Steering
Erika Klohe	St. Joseph Health	Steering & Subcommittee
Melissa Ladrech	Sonoma County Behavioral Health Division	Steering
John Mackey	Kaiser Permanente	Steering & Subcommittee
Debbie Mason	Healthcare Foundation Northern Sonoma County	Steering
Alison Murphy	Mothers Care	Steering
Ernesto Olivares	California Violence Prevention Network	Steering & Subcommittee
Matt Perry	Probation Department	Steering
Selena Polston	Sonoma County DHS/HPPE Division	Steering
Jill Ravitch	District Attorney's Office	Steering
Ellisa Reiff	North Bay Regional Center	Steering
Kurt Schweigman	Sonoma County Indian Health Project	Steering & Subcommittee
Kathy Smith	Mental Health Board	Steering
Susan Standen	Independent contractor (has contract w/ GIRE)	Steering
Angela Struckmann	County of Sonoma Human Services Department	Steering
Jacquelyn Torres	Sonoma County Health Action Council, Sustainable Sonoma, City of Sonoma	Steering
Sam Tuttelman	Family Member	Steering & Subcommittee

RDA convened meetings with both committees to introduce the project, share information about the assessment process and goals, and discuss the various opportunities for stakeholder engagement. Throughout the project, RDA met and consulted with the MHSA Capacity Assessment Subcommittee, who provided additional support engaging with the community and validating initial findings.

Context Interviews: RDA staff conducted three interviews with members of DHS-BHD leadership and on the Mental Health Board (MHB) in the County. These interviews provided an understanding of the types and levels of services in each system of care, the process for accessing and transitioning between programs, and the resources for mental health available in the County.[31] The purpose of these interviews was to learn about the landscape of mental health services from a high-level as well as historical perspective. The interviews were used as a tool to facilitate discussion of changes to the system, impacts

[31] See Appendix for a complete list of interview questions.

of recent events in the County and DHS-BHD, conceptualize gaps and needs of the current system, and any potential or planned modifications to the current system. Interviews were conducted with:

- Bill Carter, Director of Behavioral Health Division
- Kathy Smith, Local Mental Health Board member
- Susan Castillo, Health Program Manager

Document Review: In addition to the firsthand data collected through Focus Groups and Key Informant Interviews, RDA conducted a review of existing County documents to supplement insights gained through stakeholder engagement activities.

Discussion Groups with County Staff and Systems Mapping: RDA staff conducted discussion groups with key County staff from each system of care to discover ways in which the existing mental health system could be strengthened to better support consumers with the highest levels of mental health need. Participants were asked to reflect on what works well in the current system, mental health service gaps, how consumers move through the system, level of care determination, and recommendations for what they would like to see in an ideal system. DHS-BHD staff who participated in these meetings were:

Table 2. DHS-BHD Staff Discussion Participants

Name	Position
Helene Barney	Adult Access, Residential, Transportation, Transitional Recovery, and Hospital Liaison Program Manager
Katie Bivin	Youth Access, Youth Medication Support, and Youth Outpatient Program Manager
Bill Carter	Behavioral Health Division Director
Amy Colville	Older Adult Team and Integrated Recovery Team Manager
Kimia Ghassemy	Family Advocacy Stabilization & Support Team and Transitional Age Youth Team Manager
Amy Howard	Former Adult Criminal Justice System Support Manager
Phyllis King	Foster Youth and Juvenile Justice Program Manager
Melissa Ladrech	MHSA Coordinator
Cruz Lopez	Whole Person Care Manager
Sid McColley	Adult Services Section Manager
Stephanie Meyler	Crisis Stabilization Unit Manager
Kathleen Spence	Community Mental Health Centers Manager

Findings from this discussion group supported RDA's creation of maps of the Youth and Adult systems of care (see Figure 10 and Figure 12).

Based on all of the information gathered during this phase, RDA prepared a list of key areas to focus on during the subsequent data collection and analysis phase. RDA's preliminary impressions were presented

to the Capacity Assessment Subcommittee and DHS-BHD leadership.[32] The context and understanding of Sonoma's mental health system led to the following refined and targeted questions:

- How do consumers **move through the system**? Why do some appear to be "stuck"?
- Which consumers are using **acute and residential services**? How does this compare to other counties?
- What is the **staffing model** of providers? How does that affect consumers and resources?
- Which populations are **underrepresented** in the system? Are these voices being heard?

Data Collection and Analysis

RDA used a mixed-methods approach (i.e., both qualitative and quantitative data collection tools) to conduct the capacity assessment, which maximizes validity by allowing for the examination of the same phenomenon in different ways (e.g., triangulation).[33] RDA utilized data from multiple sources, including document review, interviews, focus groups, surveys, electronic health records data, and financial data. Utilizing a mixed-method approach provided RDA the flexibility to fill in gaps in the available information, to use triangulation to strengthen the validity of estimates, and to provide different perspectives on complex, multi-dimensional phenomena. [34]

Data Collection

The data collection process included the following components:

Consumer and Service Utilization Data: RDA collected data from DHS-BHD on consumers who received DHS-BHD services during the three-year period from July 1, 2016- June 30, 2019. Consumer information, including demographics, was collected to describe the specialty mental health population in Sonoma County. Programmatic and service information was collected to identify which services and levels of care were being utilized by consumers. Service data also included financial information on County expenditures and Medi-Cal reimbursement. These data were obtained through the County's electronic health record, Avatar, as well as Sonoma Web Infrastructure for Treatment Services and MHSA Quarterly Reports from contracted providers.

Countywide Survey: To include input from a wide range of stakeholders, particularly those who would not be able to attend the in-person focus groups, RDA designed and administered a community survey. The survey ran from September 23rd – November 16th, 2019 and was available in both English and Spanish. This anonymous survey included both closed- and open-text questions to gather data on respondents' demographics and relationships to MHSA services; perceptions of program quality, appropriateness for community need, timeliness, accessibility, and staffing; and thoughts regarding outstanding community mental health needs, population-specific needs, service strengths, and service weaknesses or areas for

[32] See Appendix for the presentation slide deck.
[33] Frechtling, J., & Sharp, L. (1997). *User-friendly handbook for mixed method evaluations*. National Science Foundation. Retrieved from http://www.nsf.gov/pubs/1997/nsf97153/start.htm
[34] Bamberger, B., Rao, R., & Woolcock, M. (2010). *Using mixed methods in monitoring and evaluation*. The World Bank,p. 11. Retrieved from: http://www-wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2010/03/23/000158349_20100323100628/Rendered/PDF/WPS5245.pdf

growth. The survey was available online, where most participants responded, and in paper form at various community locations including DHS-BHD waiting areas and mental health peer resource centers in the County. RDA established and maintained the online survey and related database via a secure online platform, Survey Gizmo, and DHS-BHD distributed and collected paper surveys from physical locations and submitted them to RDA for data entry and analysis.

Focus Group Discussions and Key Informant Interviews: To gather a more in-depth understanding of program activities, community impact, perceived service strengths, weaknesses, and outstanding mental health needs, RDA convened ten focus groups and conducted seven interviews with key informants. DHS-BHD, the MHSA Steering Committee, and Capacity Assessment Subcommittee worked with RDA to generate a list of potential groups and individuals using the key stakeholder groups identified in MHSA regulations.[35] DHS-BHD leadership, staff from local community-based organizations, and committee members conducted recruitment for the focus groups, making special efforts to reach target populations and communities throughout Sonoma County. Focus groups were advertised to providers and community leaders via emails explaining the purpose of the meetings. DHS-BHD connected RDA with the key informants with RDA conducting further outreach to each individual via email. To better understand the differences between the consumer and provider experience with the mental health system of care, RDA created unique focus group and interview protocols for each of these groups.[36]

Summarized in the tables below are the list of organizations that participated in a focus group or key informant interview and the population they represent in the community.

Table 3. Community Focus Group Participants by Organization Type

Focus Group Population	Host Organization/Meeting	Total Participants
Adult consumers	Wellness and Advocacy Center	9
Older adult consumers	Wellness and Advocacy Center	2
Family members	National Alliance on Mental Illness (NAMI)	7
Homeless consumers	Committee on the Shelterless (COTS)	15
TAY population	VOICES	6
Latinx community	Latino Service Providers (LSP)	9
Parents of youth consumers	Social Advocates for Youth (SAY)	1
Justice Stakeholders	Community Corrections Partnership	15
Behavioral health providers	Child Parent Institute (CPI)	6
Healthcare service providers	St. Joseph Health	7

[35] Per the MHSOAC, WIC § 5848 states that each Annual Update shall be developed with local stakeholders, including: Adults and seniors with severe mental illness; Families of children, adults, and seniors with severe mental illness; Providers of services; Law enforcement agencies; Education; Social services agencies; Veterans; Representatives from veterans organizations; Providers of alcohol and drug services; Health care organizations; Other important interests (e.g., individuals served or targeted by Prevention and Early Intervention (PEI) services and individuals expected to benefit from INN projects). CCR § 3300 further includes: Representatives of unserved and/or underserved populations and family members of unserved/underserved populations, as defined in CCR § 3200.300 and CCR § 3200.310; Stakeholders that reflect the diversity of the demographics of the county, including but not limited to, geographic location, age, gender, and race/ethnicity; Clients with serious mental illness and/or serious emotional disturbance, and their family members.

[36] See Appendix for the protocols.

Table 4. Community Key Informant Interview Participants by Organization Type

Participant	Organization	Population Represented
Sean Boland	Wellness and Advocacy Center	Adult and older adult consumers
Eric Lofchie	Santa Rosa City Schools	Students and school staff
Mark Orlando	Veterans Service Office	Veterans
Alison Whitemore	Sonoma County Indian Health Project	Native American community
Jessica Carroll	Positive Images	LGBTQ+ community
Christy Davila	West County Services	Outlying Areas – Consumers
Stephanie Chandler	Redwood Community Health Coalition	Outlying Areas – Providers

Data Analysis

RDA triangulated quantitative and qualitative findings to identify trends in the strengths, needs, challenges, and opportunities of the behavioral health system. RDA conducted causal analysis by first identifying challenges and then exploring potential root causes or facilitator of challenges. This process was iterated multiple times to thoroughly investigate the overall needs of the behavioral health system.

RDA employed a multi-dimensional framework for analyzing, interpreting, and synthesizing findings at the system, program, and individual levels. RDA used **system-level** analysis to synthesize findings and identify trends related to the broader system, including the MHSA structure, local culture and history, stewardship, and integration of service provision across the system. RDA analyzed data related to specific programs to identify findings at the **program-level,** including trends related to population served, provision of behavioral health services, and challenges and opportunities observed in specific programs. RDA employed a **consumer-level** perspective to identify and describe trends related to consumer experience of care and utilization of services, including trends related to population characteristics and how consumers access services, navigate the behavioral health system, and move through different levels of care. **This multi-pronged approach allowed RDA to conduct targeted data collection and analysis in order to investigate specific emerging trends, resulting in a comprehensive understanding of the needs of the system at multiple levels.**

To analyze the quantitative data (e.g., consumer and service utilization data, financial data, and survey responses), RDA used descriptive statistics to examine frequencies and ranges. These data were analyzed at both the consumer- and episode-level as well as aggregated to the program and system levels. RDA analyzed service and consumer data from July 2016 to June 2019 to describe service utilization trends in the DHS-BHD system of care. After understanding these trends, RDA further examined the quantitative data to assess:

- **Length of stay**: RDA determined the length of each episode and compared lengths across similar programs to identify trends. These were also compared to expected lengths of stay for those programs and any overstays were highlighted.
- **Transition between programs**: In order to understand how clients move through levels of care, particularly for crisis and residential services, RDA examined consumers' next episodes following particular programs.

- **High utilizers**: RDA identified consumers as high utilizers if they had four or more CSU visits.
- **Service costs**: RDA analyzed service costs through the billable and unbillable expenses identified at the service level. Total billable and unbillable costs were determined by program and fiscal year. The potential lost revenue (i.e., the amount of unbillable services which could potentially have been reimbursed through Medi-Cal) was also calculated by program and year.

For each of these analyses, RDA then analyzed service utilization and consumer profile data to characterize the consumer population and identify trends in their service utilization patterns (e.g., Did a particular population represent a significant proportion of overstays at the CSU?). Additionally, the survey data were analyzed to understand how the majority of consumers, their loved ones, providers, and community respondents viewed the services available in the County.

This needs assessment is centered on fiscal year 2018-2019 and provides a snapshot of behavioral health service provision trends. RDA examined data from fiscal year 2016-2017 and 2017-2018 and found similar patterns over these three years. **Most data presented in this report is from fiscal year 2018-2019,** as it represents the most up-to-date data and reflects for many recent changes in the County and Behavioral Health Division (e.g., Complex Fires, budget challenges).

To analyze the qualitative data, RDA transcribed the focus group and key informant interview (KII) participant responses, and used **content analysis to create and analyze emerging themes**. Content analysis refers to a process by which qualitative data is systematically classified and coded. Themes from the focus groups and KIIs were analyzed, along with the open-text responses to the Countywide survey, to identify the commonalities and differences in consumer and provider experiences. In order to acknowledge the different participant experiences of consumers and providers with the mental health system of care, RDA first grouped these themes separately and then compared across perspectives.

Once each data source was analyzed, RDA reviewed the findings collectively as a team to understand where there were multiple data sources suggesting a similar finding and there was disagreement prompting additional analysis to fully understand. Multiple internal meetings were held to synthesize findings from multiple angles, as described above. During team meetings, team members discussed specific findings and trends, indicated the source of information, method of data collection, limitations of methodology, relevant time frame, specific population to which the finding relates, and the context of the finding.

As the assessment team began to formulate findings for each research question, emerging themes were identified that led to additional questions and points for further research. This iterative process of data analysis was repeated throughout this project: sharing findings, allowing findings and questions to emerge from the data, and going back to the data to explore these questions. The emerging set of findings were discussed and iterated with DHS-BHD and the Capacity Assessment Subcommittee for further validation and refinement. **This iterative process produced a comprehensive study with multiple layers of analyses and findings.**

Reporting and Dissemination

Throughout the capacity assessment, RDA worked closely with key stakeholders to present, confirm, and refine data and findings as necessary. At the conclusion of the capacity assessment process, RDA shared the preliminary findings in a presentation to the Capacity Assessment Subcommittee and DHS-BHD leadership on December 12, 2019 for validation and refinement. RDA conducted a further presentation to the MHSA Steering Committee on January 6, 2020. Concurrently, RDA drafted and then finalized this Capacity Assessment Report.

Limitations

As with any research project, there are limitations that need to be acknowledged. Although RDA used extensive data collection techniques and robust mixed-methods analyses, the underlying findings are dependent on the data available. Data collected for this report did present some challenges and limitations.

Sonoma County DHS-BHD collects consumer and program information through a number of different datasets. For this capacity assessment, RDA collected data from three – Electronic Health Record (EHR), Sonoma Web Infrastructure for Treatment Services (SWITS), and Quarterly Reports. Avatar is the County's EHR, which captures the majority of service and consumer data. SWITS is the database for additional services, mainly substance use disorder programs, and consumer details. DHS-BHD contracted providers complete reports on the services they delivered and consumers they engaged every quarter. These reports are presented in mainly narrative format without detailed consumer information due to the nature of these programs (mainly prevention and early intervention or peer providers).

It was not possible for RDA to link consumers across these datasets. The information presented in this report therefore concentrates on Avatar data due to the comprehensiveness of the dataset and the focus of this capacity assessment. This dataset posed an additional limitation as the County changed EHRs during the three years for which RDA obtained data. Therefore, it was necessary for RDA to link episodes across EHRs. It must be noted that certain demographic information was not available for all consumers when analyzing this data. At least 15% of consumers had some missing information, such as housing status.

Qualitative data collections (e.g., focus groups and interviews) were limited by the difficulty of accessing hard-to-reach populations. RDA employed multiple data collection methods to address this anticipated challenge. However, certain groups may still be underrepresented in the data collected.

Some recent changes to the mental health system in Sonoma County may not be represented in this assessment's findings. In particular, DHS-BHD redesigned the Youth and Family system, which created a Youth Access team and moved transitional age youth (TAY) away from the Adult and Older Adult system. The system maps presented in this report reflect this redesign, however, the time-period from which quantitative data was collected took place prior to many of these changes being implemented. Whenever

possible, these changes were noted in the capacity assessment in order to present a historical and current perspective of the findings.

The data collection process for this report was also impacted by the Kincade Fire, which burned from October 23 to November 6, 2019. The fire burned over 70,000 acres, destroyed over 350 structures, and caused widespread evacuations throughout the County.[37] Additionally, there were significant power outages during this time, which caused further instability and, in some cases, displacement. Thankfully, the fire's impact was much less severe than that of the previous Complex Fires of 2017. However, the progress of the capacity assessment was impacted with many focus groups being canceled and delays in connecting with the Sonoma community. To account for the lost time, RDA rescheduled all canceled focus groups for later dates and extended the survey to allow for further community involvement and representation after the Kincade Fire.

Stakeholder Participation

The capacity assessment process included a variety of stakeholders reflective of the geographic and cultural diversity of Sonoma County including groups listed in MHSA regulations and the Welfare and Institution Code. [38] This included representatives from the following groups:

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

The capacity assessment process leveraged a number of existing meetings whenever possible, including the Community Corrections Partnership monthly meeting and the local National Alliance on Mental Illness chapter's weekly drop-in family member support group.

Overall, **550 people participated in the capacity assessment** – 77 attended focus groups, 447 completed the survey, 16 engaged in system of care discussions, and 10 participated in interviews. There were 302

[37] California Department of Forestry & Fire Protection. (2019, November 20). *Kincade Fire*. Retrieved from https://www.fire.ca.gov/

[38] Per the MHSOAC, WIC § 5848 states that each Annual Update shall be developed with local stakeholders, including: Adults and seniors with severe mental illness; Families of children, adults, and seniors with severe mental illness; Providers of services; Law enforcement agencies; Education; Social services agencies; Veterans; Representatives from veterans organizations; Providers of alcohol and drug services; Health care organizations; Other important interests (e.g., individuals served or targeted by Prevention and Early Intervention (PEI) services and individuals expected to benefit from INN projects). CCR § 3300 further includes: Representatives of unserved and/or underserved populations and family members of unserved/underserved populations, as defined in CCR § 3200.300 and CCR § 3200.310; Stakeholders that reflect the diversity of the demographics of the county, including but not limited to, geographic location, age, gender, and race/ethnicity; Clients with serious mental illness and/or serious emotional disturbance, and their family members.

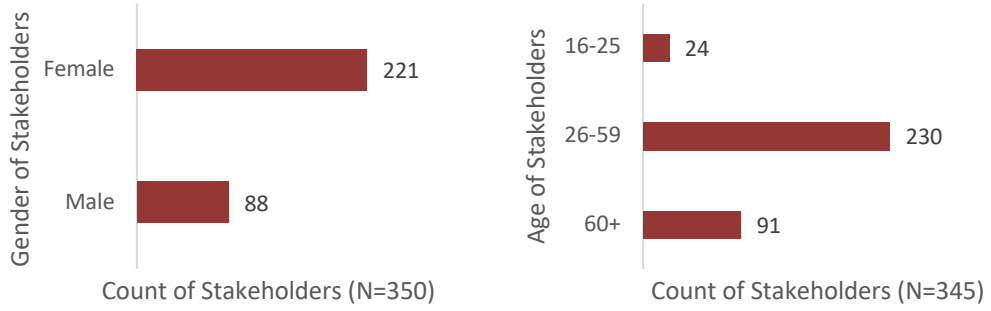
community surveys completed in their entirety, including demographic forms, and 145 completed partially. Fifty-nine focus group participants at least partially completed demographic forms and all key informant interviewees fully completed demographic forms. Table 5 presents the total number of participants in each activity. Demographic information presented here represents all stakeholders who completed that question in the demographic form. Therefore, the number of respondents may differ across the figures and information presented below.

Table 5. Data Collection Activities and Participants

Activity	Date	Total Participants
Preliminary Context Interviews	August – September, 2019	3
System of Care Discussions	August 2019	16
Key Informant Interviews	September – October 2019	7
Focus Groups	October – November, 2019	77
Community Survey	September 23 – November 16, 2019	447
Total Participants		**550**

Of the stakeholders for which demographic data was available, **64% were aged 26-59**, 25% were aged 60 or older, and 7% were 16-25 years of age. **Sixty-three percent of community stakeholders identified as female** and 25% identified as male. Additionally, **68% identified as White/Caucasian** and 16% as Hispanic/Latino, 10% of whom were Mexican/Mexican-American/Chicano.[39] **Most capacity assessment participants lived in Santa Rosa (54%)**, followed by Petaluma (9%), Rohnert Park (7%), and Sebastopol (7%).

Figure 4. Number of Stakeholders Participating in Capacity Assessment by Gender and Age

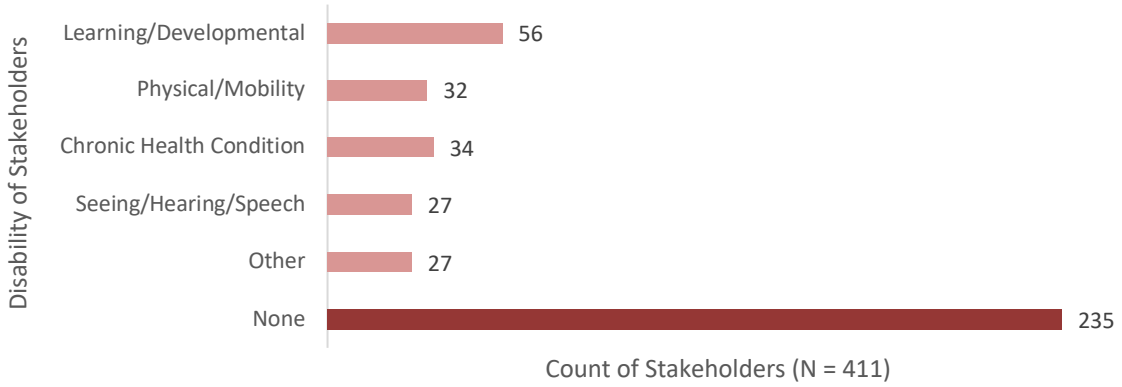


As part of Sonoma County's data collection efforts to reach minority and underrepresented populations, stakeholder participation demographic forms included questions regarding gender identity and sexual orientation as well as veteran and disability status.[40] **Sixty-two percent of stakeholders identified as heterosexual or straight**, 18% declined to answer, and 7% each identified as either bisexual or gay or

[39] Other responses were excluded due to the small number of individuals to protect participant confidentiality.
[40] See Appendix for a copy of the demographic form.

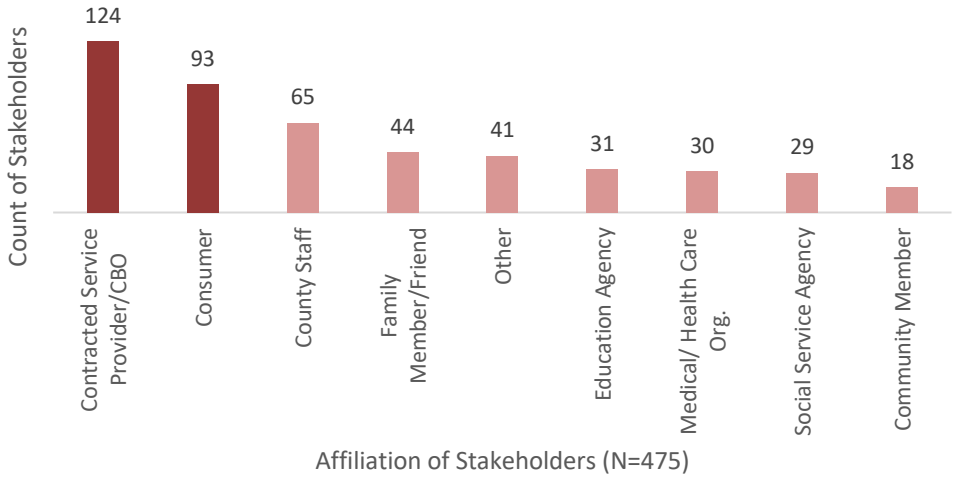
lesbian. **Eighty-nine percent of community stakeholders did not identify as veterans**. Fourteen percent reported a mental (i.e., learning disability, developmental disability, dementia) disability; 8% each reported a physical/mobility disability or chronic health condition; and 7% each reported difficulty seeing, hearing, or having speech understood; or another disability.

Figure 5. Number of Stakeholders Participating in Capacity Assessment by Type of Disability



Among the various stakeholder groups represented in the annual update process, **the largest group identified as community members (26%)**, followed by behavioral health services consumers (20%), and County staff (14%). However, when combined, **consumers and their family members or friends made up the largest proportion of participants (29%)**. As displayed in Figure 6, 9% each identified as having another connection to behavioral health services, 7% were affiliated with an education agency, and 6% each were affiliated with either a social service agency or medical or health care organization.[41]

Figure 6. Number of Stakeholders Participating in Capacity Assessment by Affiliation



[41] Another connection to behavioral health services, or other, includes law enforcement and veteran organizations.

Sonoma County Behavioral Health System

Sonoma County offers a variety of MHSA-funded mental health services for children, transition age youth, adults, and older adults. The County public behavioral health system, through the Behavioral Health Division (DHS-BHD), is intended to support the crisis and general mental health needs of individuals with severe mental illness who are on Medi-Cal, uninsured, or otherwise cannot afford services on their own. Services are provided directly by DHS-BHD or through partnerships with community based agencies. Dedicated services are available for youth and families, adults, and older adults. Services include assessment, case planning and management, crisis intervention, medication support, therapy, rehabilitation, full service partnership, and assertive community treatment.

The following section explores MHSA-funded services in Sonoma and the County's behavioral health system of care more broadly. First, the County's MHSA-funded system and its components are described. Then, the public mental health system of care is presented with an overview and map of the Youth and Adult systems. Finally, the process for accessing and receiving services is discussed along with consumer information.

MHSA in Sonoma

Community Services and Support

Community Services and Supports (CSS) allow for the provision of all necessary mental health services for children with severe emotional disturbances and adults with serious mental illness. CSS funds the following service categories:

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

There are 12 CSS initiatives in Sonoma County. They utilize peer and clinical providers to identify, assess, and serve individuals experiencing mental health problems throughout the lifespan. The following table provides an overview of the CSS-funded services.

Table 6. Summary of Sonoma County's CSS Programs in Fiscal Year 2018-2019

Program Name	Category	Target Age	Description
Forensic Assertive Community Treatment (FACT)	Full Service Partnership	18-59	Community-based treatment as an alternative to incarceration
Family Advocacy, Stabilization & Support (FASST)	Full Service Partnership	5-18	Family-centered wraparound specialty mental health services
Integrated Recovery Team (IRT)	Full Service Partnership	26-59	Multidisciplinary teams that provide intensive field-based specialty mental health services for adults with co-occurring substance use and mental health disorders
Older Adult Team	Full Service Partnership	60+	Intensive, integrated services for older adults with serious mental illness, coupled with more complex medical conditions requiring coordination between the mental health and medical providers.
Transition Age Youth	Full Service Partnership	18-25	Mental health services, intensive case management, housing and employment support services, and independent living skills
Adult Full Service Partnership	Full Service Partnership	26-59	Multidisciplinary teams that provide intensive field-based specialty mental health services
Peer and Family Programs	General Systems Development	All	Peer centers and education, support, and advocacy for families impacted by SMI
Collaborative Treatment and Recovery Team	General Systems Development	26-59	Care coordination, case management, systems navigation and outpatient therapy
Mobile Support Team	General Systems Development	26-59	Behavioral health professionals provide field-based support to law enforcement officers responding to behavioral health crises.
Community Mental Health Centers	Outreach and Engagement	26-59	Regionally-based outpatient specialty mental health services
Outreach and Engagement	Outreach and Engagement	All	Reach, identify, and engage individuals and communities that are unserved or underserved by the mental health system
Whole Person Care	Outreach and Engagement	26-59	Outreach and engagement and intensive case management

Prevention and Early Intervention

Prevention and Early Intervention (PEI) efforts in Sonoma County were designed to introduce a continuum of services across the lifespan to prevent or intervene early in mental health issues, with particular focus on serving unserved and underserved community members. The County's PEI initiatives work towards this goal by bringing together diverse approaches to address many facets of mental illness in the

community. The primary PEI approach focuses on activities that prevent the development of mental illness or intervene during the early stages of onset.

- **State-Wide Promotion** (optional): A pool of PEI funds between 38 counties that supports the ongoing implementation of the Statewide PEI Project, Each Mind Matters: California's Mental Health Movement, which amplifies efforts to reduce stigma and discrimination and prevent suicides across the state.
- **Prevention:** Reduces the risk for developing a potentially serious mental illness (SMI) and builds protective factors. Activities can include universal prevention strategies geared towards populations who may be more at risk of developing SMI.
- **Early Intervention:** Treatment and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence with a goal to lessen the severity and duration of mental illness.
- **Access and Linkage to Treatment:** Activities to connect children, adults and seniors with severe mental illness as early in the onset of these conditions as practicable, to medically necessary care and treatment.
- **Stigma and Discrimination Reduction:** Direct activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services, which can include training and education, campaigns, and web-based resources.
- **Suicide Prevention:** Organized activities that prevent suicide as a consequence of mental illness, which can include trainings and education, campaigns, suicide prevention networks, capacity building programs, culturally specific approaches, survivor-informed models, screening programs, suicide prevention hotlines, or web-based suicide prevention resources.
- **Outreach for Increasing Recognition of Early Signs of Mental Illness:** Outreach services to families, employers, primary care health care providers, law enforcement, and others to recognize early signs of potentially severe and disabling mental illness.

There are 14 PEI initiatives in Sonoma County. Many are targeted towards specific age groups across the lifespan and run by contracted community-based service providers. Table 7 summarizes DHS-BHD's PEI programs.

Table 7. Summary of Sonoma County's PEI Programs in Fiscal Year 2018-2019

Program Name	Category	Target Age	Description
California Mental Health Services Authority (CalMHSA)	State-Wide Promotion	All	Trainings, presentations, and other efforts to reduce stigma and discrimination and prevent suicide
Action Network - Across Ages and Cultures	Prevention	All	Substance use and violence prevention coalition that provides education, direct support services, and advocacy to strengthen diverse individuals and communities

Program Name	Category	Target Age	Description
Sonoma County Indian Health Project -Aunties & Uncles	Prevention	All	Reduces mental health disparities among the local Native American communities by increasing access to mental health services
Community Baptist Church Collaborative	Prevention	All	Reduces mental health service disparities among the local African American population by decreasing stigma
Latino Service Providers of Sonoma County	Prevention	All	Information on activities and resources that promote economic stability, educational success, housing, legal services, healthcare, and mental health services and stigma reduction
Positive Images	Prevention	12-24	Programs and services that help youth, service providers, and the public develop positive, healthy, and life affirming behaviors and views of personal expression of gender identity and sexual preference
Human Services Dept. - Older Adult Collaborative	Prevention	60+	Utilizes Healthy IDEAS, a prevention and early intervention evidence-based model, to reduce depression and suicide
0-5 Collaborative: Child Parent Institute, Early Learning Institute, and Petaluma People Services	Early Intervention	0-5	Services that aim to reduce risk factors, build protective factors and skills, and increase support for families with children ages 0 to 5
Youth Access Team	Access and Linkage to Treatment	0-18	Improves access to mental health treatment by determining the appropriate level of care and creating service linkages
Adult Access Team	Access and Linkage to Treatment	18+	Improves access to mental health treatment by determining the appropriate level of care and creating service linkages
SRJC - People Empowering Each Other to Realize Success	Stigma & Discrimination Reduction	18-25	Promotes mental health and reduces stigma on campus through orientations, first year experience courses, online screenings, educational content, and trainings
Buckelew Programs - North Bay Suicide Prevention Program	Suicide Prevention	All	24/7 suicide prevention and crisis telephone counseling to people in distress and/or their family and friends

Innovation

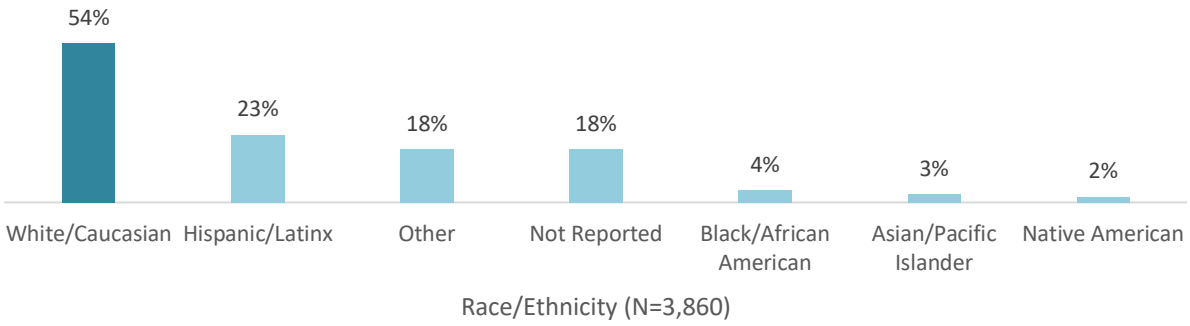
Innovation projects are designed to increase mental health care access for underserved groups, increase the quality of services, and promote interagency collaboration through innovative new approaches. INN programs may introduce new mental health practices that have never been done before, change an

existing mental health practice, or introduce a new application of a promising practice that has been successful in non-mental health contexts. Sonoma County is currently in the Community Planning Process with stakeholders and the community to identify new Innovation projects with an Innovation Subcommittee overseeing the process.

System of Care

The Sonoma County behavioral health system offers services across the spectrum of mental health severity, from high-intensity crisis and residential treatment to maintenance-focused community-based programs. In fiscal year 2018-2019, the system **directly served almost 4,000 unique consumers** and reached an additional 10,000 consumers through peer, prevention and early intervention, and outreach services.[42] During this time, **the majority of BHD consumers were White/Caucasian** (54%), followed by Hispanic (23%), and other (18%). Race and ethnicity data was not reported for 18% of consumers.

Figure 7. Race/Ethnicity of DHS-BHD Consumers in Fiscal Year 2018-2019[43]



Sonoma County Consumers FY 18-19

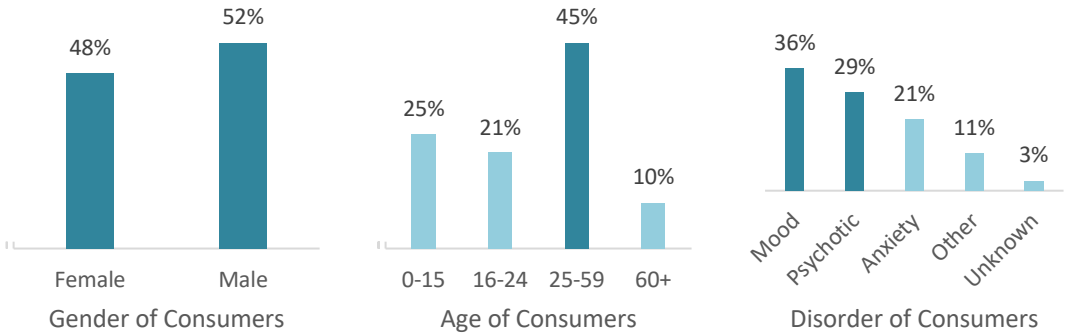
Consumers Served: **3,860**

Expenses: **$93,561,935**

MHSA-funded services have allowed for **individuals of all ages** to access necessary and intensive mental health services to promote recovery and increased quality of life. The majority of DHS-BHD consumers were **adults between the ages of 25 and 59**, followed by children ages zero to 15, transition age youth ages 16-24, and older adults aged 60 or older. The service population was **evenly split across genders**, with 48% of consumers identifying as female and 52% identifying as male in fiscal year 2018-2019. MHSA services also supported consumers with a variety of diagnosis. During that period the **majority of consumers were diagnosed with a mood or psychotic disorder**, followed by anxiety, other, or unknown disorders. Figure 8 presents this demographic information for consumers during fiscal year 2018-2019.

[42] Data from these programs is limited as most programs do not track details on the individuals they engage. These numbers represent estimates and are likely double-counting individuals.
[43] Ethnicity is reported separately from race, therefore the numbers in this figure do not sum to 100%.

Figure 8. Gender, Age, and Disorder of DHS-BHD Consumers in Fiscal Year 2018-2019, N=3,680



There exists a high level of need among consumers in Sonoma compared to other California counties. Many residents used crisis services through the Crisis Stabilization Unit (CSU), inpatient hospitals, and emergency departments. In fiscal year 2018-2019, about 2,000 consumers went to the **Crisis Stabilization Unit (CSU) over 2,500 times**, and many stayed longer than the expected 24-hour period. Similarly, about one-fourth and up to more than half of **adult consumers stayed longer than expected in unlocked short-term and long-term residential treatment programs**. Stakeholders also noted that there was **a high prevalence of serious mental illness in the jails**, with over 40% of inmates having a mental health issue.

Additionally, the California External Quality Review Organization (CalEQRO), Behavioral Health Concepts (BHC), found a **high level of psychotic disorder (29%) among Medi-Cal beneficiaries in Sonoma County** compared to California residents overall (16%).[44] The County also has a large proportion of people who are unhoused. The 2019 Point-in-Time Homeless County found that **2,951 individuals were unhoused, 21,000 individuals were unstably housed, there was an almost 20% increase in the number of youth experiencing homelessness**, and there was a significant increase in the number of people living in vehicles.[45] Some housing data was available through DHS-BHD, however, over a third of consumers did not report their residency limiting the validity of analysis using this data. Stakeholders throughout this assessment did not a perceived increase in the homeless population overall and within DHS-BHD consumers.

The higher level of need could be due to a variety of factors and the interplay between them, including the series of fires over the past several years, growing income inequality, the severe housing shortage, and the growing number of people who are unhoused. It is challenging for existing services and providers to meet these increasing demands, resulting in a greater number of people with mental health needs seeking crisis intervention, being incarcerated, and being placed in services out-of-County. Providers termed this a **"vicious cycle" where those in crisis end up in the emergency room or at the CSU where they may be discharged without a referral for follow-up services and end up back in these facilities or incarcerated**. This high level of need places a strain on both consumers and the mental health system.

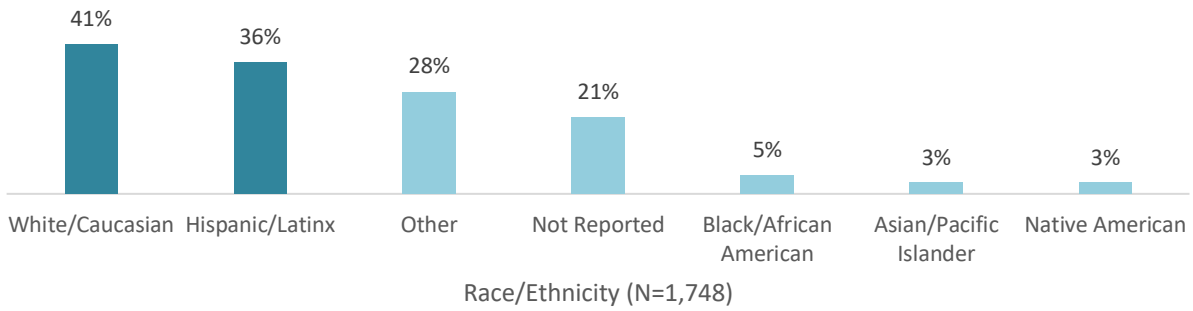
[44] CalEQRO, BHC. (2019). FY 2018-19: Medi-Cal specialty mental health external quality review: Sonoma MHP final report. Emeryville, CA.
[45] Home Sonoma County. (2019). Sonoma County 2019 Point-in-Time Homeless Count Shows Reduction in Countywide Homelessness. Retrieved from https://sonomacounty.ca.gov/CDC/Press-Releases/Sonoma-County-2019-Point-in-Time-Homeless-Count-Shows-Reduction-in-Countywide-Homelessness/

However, given the high number of prospective consumers, Sonoma County is likely engaging in an effective screening process at Access, whereby strong and consistent decision-making tools are used to identify and treat only those with severe and moderate mental illness, determine medical necessity, and make level of care determinations for initial service access and authorization.

Youth and Family Services

In order to effectively address the high level and diversity of needs amongst County residents, Sonoma's behavioral health division is divided into two systems of care – Youth and Family Services serves children and youth ages zero to 18 and Adult and Older Adult Services serves adults and older adults age 25 and older. In fiscal year 2018 – 2019, **Youth and Family Services served 1,748 unique consumers. The majority were White/Caucasian (41%)**, followed by Hispanic (36%), and Other (28%). Race/ethnicity information was unknown for 21% of consumers.

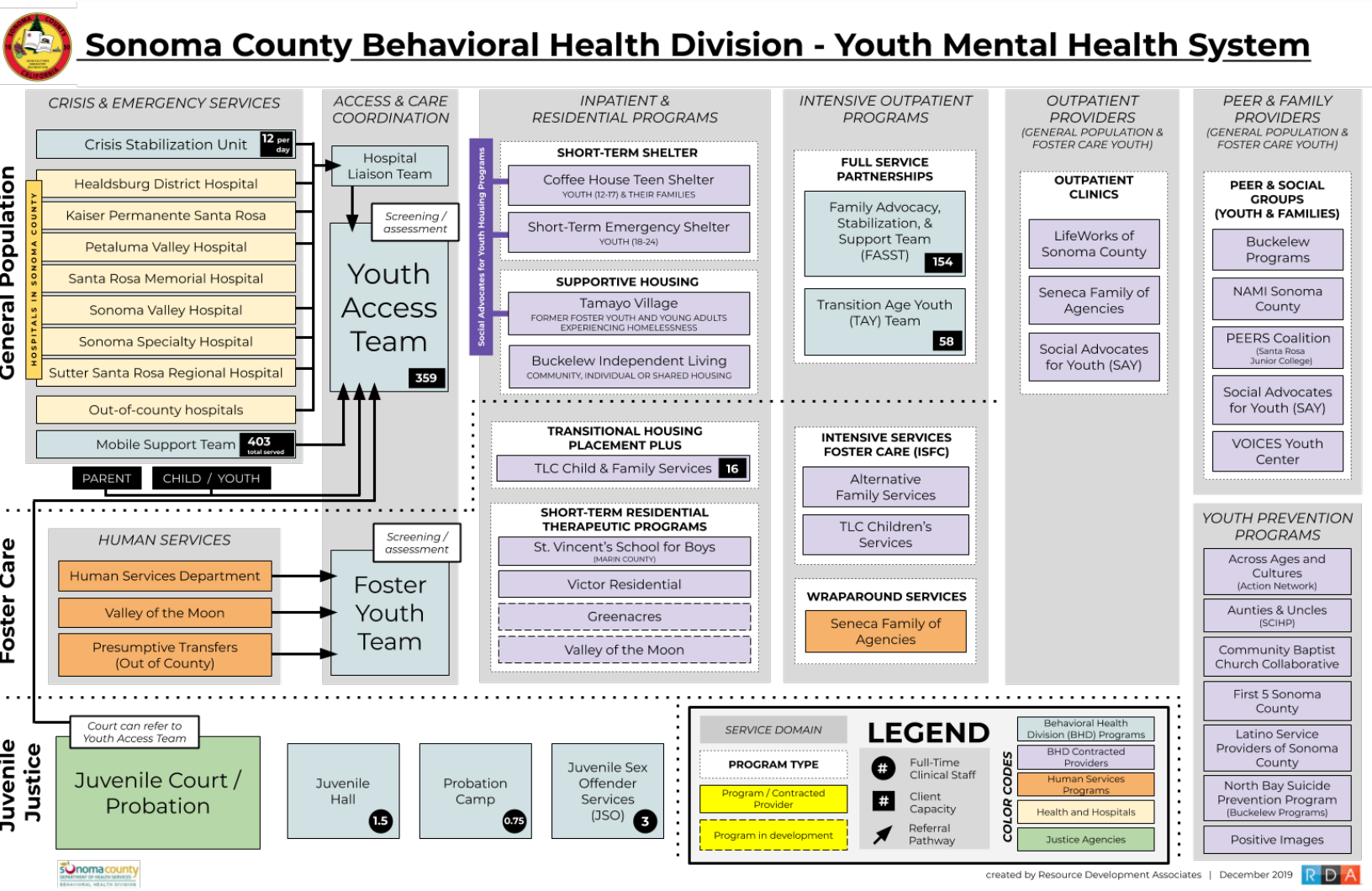
Figure 9. Race/Ethnicity of Youth and Family DHS-BHD Consumers in Fiscal Year 2018-2019[46]



Overall, the Youth and Family Services system is well set-up to provide services to children and transitional age youth. There are also dedicated teams of justice department and foster care staff who provide important service connections. The system is currently undergoing a transitional period, after restructuring and developing new contracts with providers. The County's mental health system for youth and families is captured in the following map:

[46] Ethnicity is reported separately from race, therefore the numbers in this figure do not sum to 100%.

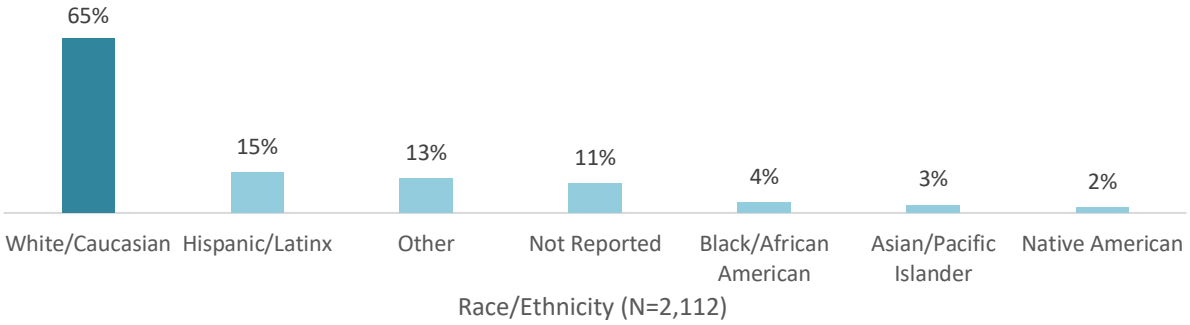
ure 10. Sonoma County Youth and Family Mental Health System



Adult and Older Adult Services

In fiscal year 2018–2019, **Adult and Older Adult Services served 2,112 unique consumers. The majority were White/Caucasian (65%)**, followed by Hispanic (13%), and Other (11%). Race/ethnicity information was unknown for 15% of consumers.

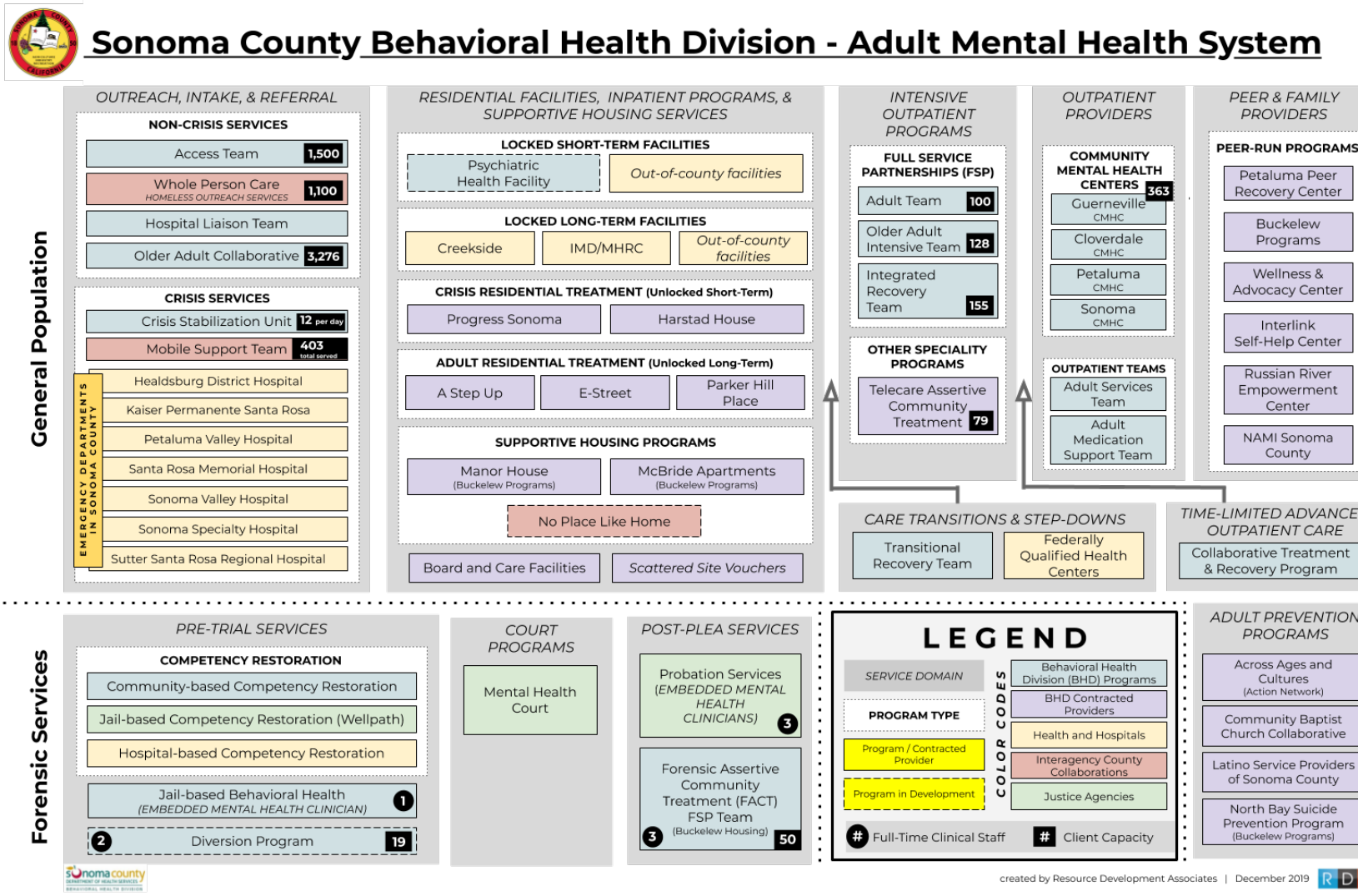
Figure 11. Race/Ethnicity of Adult and Older Adult DHS-BHD Consumers in Fiscal Year 2018-2019[47]



The Adult and Older Adult Services system has many beneficial programs and services available. A high proportion of crisis and residential beds are available, and although budget challenges led to a reduction in CSU beds, the planned 16-bed PHF opening in 2020 will soon allow the system to serve additional consumers. The County's mental health system for adults and older adults is captured in the following map:

[47] Ethnicity is reported separately from race, therefore the numbers in this figure do not sum to 100%.

ure 12. Sonoma County Adult and Older Adult Mental Health System



Accessing Care

Points of Entry

As depicted in the youth and family and adult systems maps above, individuals can enter and receive behavioral services through a variety of paths. Sonoma County's comprehensive treatment opportunities vary from intensive residential treatment to more informal prevention services. Regardless of individual demographics and the services consumers ultimately access, individuals enter the system through two main points of entry – crisis services and the Access Teams.

Crisis Services

A Crisis Stabilization Unit serves children, youth, adults, and older adults. It provides 24 hour-a-day, seven days-a-week crisis intervention, assessment, medication, and supportive care for individuals experiencing an acute mental health crisis. In fiscal year 2018-2019, **the CSU served consumers in 2,643 episodes, the majority of whom were ages 26 to 69 (60%)** or 16 to 24 (25%) and identified as white (43%) or Hispanic/Latinx (18%). If a crisis happens in the field, the County's Mobile Support Team; staffed by licensed mental health clinicians, certified substance abuse specialists, post-graduate registered interns, mental health consumers, and family members; is deployed to assist law enforcement officers in supporting the individual in crisis. Individuals needing a higher level of care can also be referred to hospitals. As the CSU is co-located with Access, described below, an assessment can be completed while a consumer stabilizes.

Access Teams

In non-crisis situations, the Access Team is the first point of contact for individuals requesting mental health services. Access Teams exist for adults and youth, with the latter divided into general youth and foster youth populations. Initial service requests come from the client, family, acute hospitals, or health centers and are typically made by phone, in-person, or fax. The Access Team ensures individuals meet the income threshold and uses structured decision-making tools to assess their level and type of need. Based on the results, consumers are then referred to requisite County services, community health centers, and/or contracted services.

In fiscal year 2018-2019, **Access Teams served 890 individuals** – the Adult Access Team served 665 people and the Foster Youth Access Team served 222 people. The Foster Youth Team provides services to address the mental health needs of foster youth, working in conjunction with Human Services Department staff and community partners as part of a multi-disciplinary team.

Previously, youth accessed services through the same access team as adults or were assessed by a contracted provider. However, a Youth Access Team was created in 2019 to provide dedicated assessment services for youth through DHS-BHD. In fiscal year 2018-2019, **22% percent of consumers served by the**

Adult Access team were ages 16 to 25, indicating that a significant proportion of youth receive Access services through the adult program. A new development in fiscal year 2019-2020 was availability of drop-in assessment through Access Teams. With same-day assessments available, the County hopes to increase timely access to services and treatment for consumers.

Receiving Services

Sonoma County offers services for youth and adults with mental health needs across the acuity spectrum. Service intensity decreases as consumers travel through the system, depicted from left to right on the youth and adult system maps (Figure 10 and Figure 12).

Residential Programs

Inpatient or other residential programs offer the highest level of care. Short-term programs typically last for fourteen days and long-term programs usually last six to nine months. Residential and housing options are available to clients receiving specialty mental health services and are offered in collaboration with community providers. Youth services include unlocked, short-term programs and both short-term and transitional housing placements. All of these facility-based treatments offer individuals the opportunity to stabilize and prepare for community discharge. Additionally, to further support acute behavioral health needs in the community, the County is planning to open a 16-bed Psychiatric Health Facility (PHF) in 2020. This locked unit will provide assessment, stabilization, and recovery-focused and trauma-informed services to predominantly Medi-Cal eligible individuals aged 18 to 64 years. Transition teams, including the Transitional Recovery Team and the Collaborative Treatment and Recovery Program, also exist to support adults transitioning from residential programs to community-based treatments.

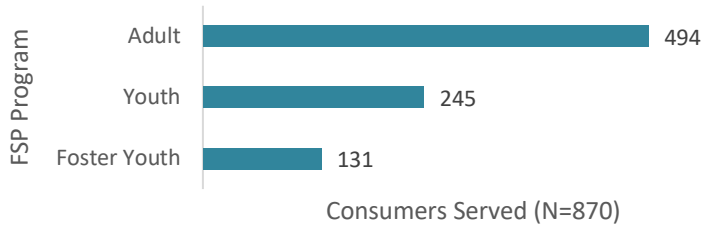
In fiscal year 2018-2019, **youth residential programs served 31 individuals and youth housing programs served 187 individuals.** Adult services included locked short and long-term programs, unlocked short and long-term programs, and supportive housing programs. In fiscal year 2018-2019, **adult residential programs served 643 individuals and adult housing programs served 401 individuals**. As with the CSU, approximately 15% of consumers receiving treatment in adult short-term unlocked and long-term locked and unlocked programs during that time were transition age youth ages 16 to 20. Additionally, **Black and Native American consumers were overrepresented in long-term residential programs** – in fiscal year 2018-2019 Black consumers made up 8% of locked and 7% of unlocked long-term residential program episodes compared to 4% of the general MHSA population, while Native American consumers made up 7% of locked long-term residential program episodes compared to only 2% of the MHSA population.

Outpatient Programs

A variety of community-based outpatient services exist for individuals with severe and persistent mental illness who can remain in the community while enrolled in a program. Intensive outpatient programs include intensive services for foster youth (ISFC), youth wraparound services, and Full Service Partnerships (FSPs), including Assertive Community Treatment (ACT). FSPs are multidisciplinary teams that provide intensive field-based specialty mental health services targeted at specific populations with a service

commitment of doing "whatever it takes," and include teams dedicated to family advocacy, stabilization, and support (FASST); transition age youth (TAY); adults with co-occurring mental health and substance use disorders, and older adults. In fiscal year 2018-2019, **FSP programs served 870 individuals.** These consumers are presented in Figure 13 by program category.

Figure 13. Number of Individuals in FSP Programs by Type in Fiscal Year 2018-2019



ISFC addresses the mental health needs of foster youth in Sonoma County, working in conjunction with Human Services Department staff and community partners as part of a multi-disciplinary team. Youth wraparound services engage cross-sector partners to offer family centered, individualized, and culturally relevant and strength based support. Individuals requiring less intensive care have access other outpatient services, including community mental health centers and service and medication teams for adults and clinics for youth.

DHS-BHD also provides less intensive outpatient services through clinics and teams for both youth and adults. Clinics, including the community mental health centers (CMHCs), provide mental health services, medication support, crisis intervention, and case management for consumers. These programs served **consumers in 5,142 episodes in fiscal year 2018-2019**. Most services are located in Santa Rosa with a focus on maintenance and medication. For these individuals, clinicians may conduct case management and provide some therapeutic services, but direct outpatient therapy for this population is limited.

The CMHCs mainly provide targeted regional access for underserved populations. Each center collaborates with community- based providers, law enforcement agencies, and local Federally Qualified Health Centers to offer culturally and linguistically relative services for specific racial and ethnic groups and individuals who are unhoused. Centers are located in the communities of Guerneville, Cloverdale, Petaluma, and Sonoma. The four dispersed sites allow staff to meet consumers where they are and engage with individuals in outlying regions beyond Santa Rosa.

Justice Services

Justice services exist for both youth and adults. Juvenile justice programs include juvenile hall, probation camp, and juvenile sex offender services, which **collectively served individuals in 172 episodes during fiscal year 2018-2019**. During this period, Hispanic youth were overrepresented in youth justice programs (42%) compared to the broader MHSA population (35%). Adults are referred to Forensic Services, which are specialty services intended to help individuals who present a risk to the public as determined by the

court. Services are available at pre-trial, in court, and post-plea. The Forensic Assertive Community Treatment (FACT) Team offers one of the more robust programs, a full-service partnership that works with a probation officer to provide community-based specialty mental health services to people referred through Mental Health Court. **In fiscal year 2018-2019, 1,282 adults engaged in justice initiatives.**

Peer-Run Programs and Prevention Programs

Sonoma offers peer-run programs for youth, adults, and families. The County sponsors four peer run self-help centers for adults that **collectively see about 750 consumers per month**. Additionally, there are peer support groups for youth and family members. These drop-in groups are led by trained peers and provide a safe, confidential space for mental health consumers and loved ones to share challenges and gain support. Goodwill Industries, which runs the peer centers, offers a highly regarded peer training program creating a large group of certified peer providers in the County.

The County also has prevention programs for children, youth, adults, older adults, family members and the community. These services are offered in community-based settings and are intended to increase mental health awareness and understanding or prevent mental health crises or more severe episodes. Some of these services, such as Whole Person Care, also provide referrals to Access. Prevention, early intervention, and outreach services are presented on the system maps, but are not discussed in detail in this report as the focus is on direct consumer programs.

Capacity Assessment Findings

Sonoma County's Behavioral Health Division (DHS-BHD) hired Resource Development Associates (RDA) to conduct a capacity assessment of the mental health needs in the community for those accessing MHSA-funded services. The purpose of the project was to explore structure, process, and resources in Sonoma County's public mental health system. The capacity assessment team performed a variety of data collection activities, engaging with stakeholders and the community throughout, in an effort to answer the following research questions:

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

The findings of Sonoma County's MHSA capacity assessment are presented below, reflecting the perspectives of a variety of mental health stakeholders combined with a robust analysis of available data. When reviewing these findings, it is important to note the social and economic challenges that have affected the behavioral health needs of the community and impacted Sonoma County's ability to address those needs. The Complex Fires and the recent Kincade Fire led to an increase in the number of people seeking services for traumas associated with these events. In addition, the budget deficit during fiscal years 2017-2018 and 2018-2019 affected the amount and types of services that the County could provide. These events have made it particularly challenging to serve a community that has a high level of mental health acuity.

This capacity assessment found that Sonoma's public mental health system was, overall, well setup with the appropriate services at suitable capacity for the population. Consumers were by-in-large satisfied with the services they received and providers were dedicated to supporting consumers' recovery. However, the culture and internal system dynamics created a lack of movement through the system and increased costs to both consumers and the County. By prioritizing lived experience, adjusting the staffing model, and improving utilization review, DHS-BHD can decrease crisis service utilization and manage service costs.

Sonoma County's Behavioral Health Division has been particularly receptive and open to the findings and recommendations from this capacity assessment. Many changes are already being implemented by the County with others planned for the near future. The willingness of DHS-BHD to actively address the challenges presented here, even prior to this report being finalized, demonstrates the dedication of the County to supporting consumers' recovery by continually working to improve the services available.

Barriers to Access

The programs available as well as consumers' satisfaction with those services were key strengths of Sonoma's public mental health system. While there were a variety of programs across levels of care, some stakeholders noted difficulties accessing appropriate and timely services. Notable challenges from consumers, their loved ones, providers, and community members included knowing and navigating the programs and services available, accessing timely care, and limited service availability for some populations. When enrolled in programs, consumers and their family members appreciated the services received and, in particular, the community praised services from peer providers.

System Entry and Appointments

> "Our system of care is hard to access, once connected people feel their loved one has support, but getting people engaged with a program is a challenge."
>
> – Provider

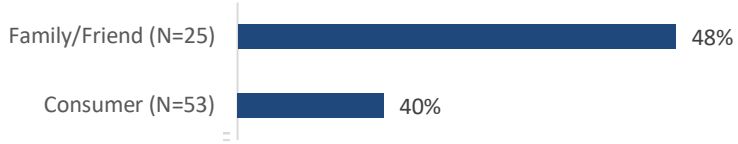
Some family members reported feeling "lost" at the initial stage of their loved one's mental illness. They were often leading the process, but were unsure if they should seek services and did not know who to ask for support with such a major decision. Sometimes this resulted in **waiting to seek help until their loved one experienced a crisis**, which they felt could be prevented by having more education about mental illness and information on the resources available. For those that knew they wanted to access services, many reported not knowing where to go to learn about Sonoma County's behavioral health system generally, or specific services and providers. Some stakeholders reported taking a long time to figure out what steps to take to help their loved one, and noted the adverse emotional impact of not being able to provide immediate support.

Providers also had limited knowledge of the full system of services and programs, which made it more difficult to refer consumers to appropriate services as well as collaborate with other providers. Stakeholders noted that the budget changes, staff turnover, changing programs, and restructures increased this uncertainty and made it difficult to establish connections that could facilitate stronger collaboration between the County and community partners.

> "There is a lot of need and it can take a really long time to get an appointment."
>
> – Community Member

Almost 50% of loved ones and 40% of consumers felt it was difficult to get an appointment when needed (Figure 14). Both groups cited long wait times leading up to initial appointments and long periods between appointments. Some family and friends also noted that due to the dynamic nature of some mental illnesses, by the time appointments arrived their loved ones no longer wanted or needed that service. Additionally, almost 20% of consumers reported that the most challenging part of their mental health needs is the long wait times for appointments. The long wait times can be particularly difficult for those with high acuity, who may often need an immediate intervention.

Figure 14. Percent of Friends/Family and Consumers who Found it Not at All True or a Little Bit True that it was Easy to Get an Appointment



Increased Utilization of Crisis Services

The service delays described above may have led to an increased use of crisis services. In fiscal year 2018-2019, about **50% of all DHS-BHD consumers accessed the CSU**. About 2,000 consumers went to the CSU over 2,600 times, which accounted for 25% of all episodes during that period. **Forty-one percent of CSU episode resulted in a consumer staying longer than the expected 24-hour period** and a tenth of individuals stayed for over 72-hours. Across fiscal years 2016-2019, CSU stays cost an average of $2,852 per person per day and a total of $45,125,866. Expenses during fiscal year 2018-2019 were almost $20 million. Conversations with providers highlighted concerns about the amount of funds the County spends and the overutilization of crisis services. They emphasized the gap in services due to the reduction of beds at the CSU and the resulting high reliance on emergency departments and health centers to treat individuals in crisis. A Psychiatric Health Facility (PHF) will open in this year and should help provide more space as well as move consumers from the CSU.

Crisis Stabilization Unit FY 18-19

2,643 episodes
2,100 consumers

Expenses:
$19,554,811

"We spend the most on crisis services. If we did more prevention and education we could prevent people from needing those services."

– Provider

The Sonoma County behavioral health system also experienced **high utilization of locked, long-term residential treatment facilities**. There were 162 episodes in fiscal year 2018 -2019, among whom 38% (61) stayed for longer than the expected nine months and 30% stayed for over one year. The total service cost during that period was $8,084,042. Overstays in residential facilities and other programs may have created service delays for new consumers, potentially leading them to rely more heavily on crises services in the absence of more long-term stabilizing opportunities.

Consumer Service Satisfaction

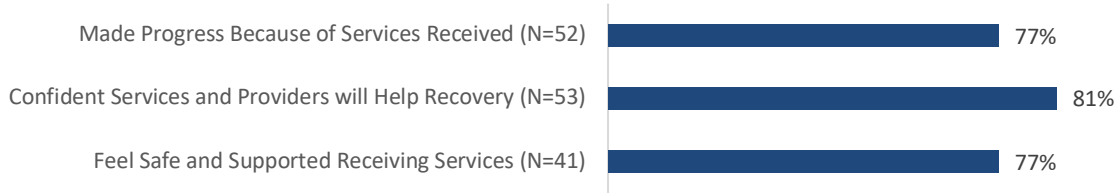
Despite challenges with access, once consumers got into care **the majority of people were satisfied with the behavioral health services they received**. About 75% of stakeholders felt that it was very or mostly true that the mental health services they or their loved one received were helpful and almost 85% felt that it was very or mostly true that mental health services were focused on the belief that they or their

loved one could get better. Stakeholders also reported many positive things they or their loved one experienced as a result of behavioral health services, including better relationships with family, friends, children, and others; being connected to assistance for basic needs (e.g., income, housing, food); and engagement in meaningful/productive activities including a job, school, or volunteer work.

Figure 15. Stakeholders Who Found it Very or Mostly True They or Their Loved One was Satisfied with Mental Health Services

Additionally, over 75% of consumers surveyed stated that it was very or mostly true that they felt **safe and supported** receiving mental health services, felt confident that services and providers would **help them recover**, and **made progress** because of the services they received.

Figure 16. Consumers Who Found it Very or Mostly True They were Satisfied Receiving Services



Stakeholders emphasized that the case manager, counselor, or other **provider** they or their love one worked with **was dedicated, caring, and supportive**. Many discussed wonderful relationships that went above and beyond their expectations. This commitment was further demonstrated in conversations with providers, who expressed feeling driven to support their community. Their dedication and enthusiasm was particularly commendable, given the challenges these providers experience over the last few years.

> "The counseling services here are amazing. I have never had to fight to get them to go to counseling here."
>
> – Parent of consumer

Many stakeholders emphasized the effectiveness of programs focused on prevention and education, such as the wellness centers, support groups, and other peer support services. Providers noted that wellness centers allowed people to receive services within their communities in spaces that were comfortable and accessible, while consumers felt that the centers brought people together and promoted healing and recovery. Consumers also noted the variety of support groups, including those at Positive Images and the Wellness and Advocacy Center, which they appreciated being able to self-select into based on experience and age.

In addition to prevention and education efforts, stakeholders felt positively about many other behavioral health services. They noted that the **Mobile Support Team** effectively helped law enforcement respond to mental health crises in the field. Consumers found **Buckelew's housing support and counseling services** to be particularly helpful. Stakeholders also emphasized the utility of the **new Sonoma County Behavioral Health campus** in Santa Rosa, where they could access many necessary services at a convenient location.

Peers Providers

Stakeholders, particularly consumers, consistently expressed praise for peer providers and programs. They noted that peers offered a different dynamic and level of care than could be achieved by clinicians or staff alone, and that **support from individuals with lived experience was empowering**. Stakeholders also reported that peers were uniquely positioned to effectively engage in community outreach efforts, particularly among groups less familiar or comfortable with mental health issues and services.

> "Peer services were life-changing."
>
> – Consumer

Sonoma County has a number of successful and beneficial peer support programs where consumers have access to peer-led services, including group discussion, classes, individual support, and more. **An estimated 750 individuals accessed peer-run centers in the County** and additional individuals accessed these providers through other support groups and organizations such as National Alliance Mental Illness and Buckelew Programs.[48] Peer-run centers, operated through Goodwill Industries in five locations, saw an average of just over 2,000 people per quarter in fiscal year 2017-2018. Unfortunately, these peer centers were no longer funded by MHSA or DHS-BHD in 2018-2019 due to budget challenges. The Board of Supervisors agreed to fund the centers for two years, however there is still a sense of uncertainty for both consumers and peer providers about the long-term stability of these services.

These peer programs clearly provided an important and positive service to the County, however, **almost all peer providers were located in discrete programs rather than integrated within DHS-BHD programs**. Consumers, as well as providers, expressed an interested in having peer-led programs at all levels of care. Doing so could more strongly align Sonoma's services with MHSA values, particularly Client & Family Driven Services and Community Collaboration. Additionally, integrated peer providers embody recovery and what is possible for consumers, which can create a culture and mindset shift throughout the system.

> "Peer services were life-changing."
>
> – Consumer

Movement through the System

Dedicated providers in Sonoma County offered supportive programs to consumers and worked to ensure they continued to receive beneficial services. Because of the barriers to access described above as well as consumer satisfaction with programs, consumers often became "stuck" in certain services and had longer

[48] Due to the nature of these programs, detailed information on consumers who access these programs is not available.

than expected stays. Many services were backlogged without the necessary care transitions expected based on recovery and changing needs. This limited consumers' ability to recover as well as available capacity in these programs. The County is currently undergoing an improvement of their utilization management and review, which will help to ensure consumers are in the appropriate services.

Service Overstays

Consumers across the system were participating in services for longer than expected periods. Stakeholders noted that consumers overstayed in programs because it was difficult to get connected to appropriate services. This led consumers and providers to be less willing to "give up" the services they were currently receiving for fear that they would be unable to regain access in the future. As a result, **FSPs, the CSU, and residential treatment facilities were often at capacity** and providers were unsure where to transfer consumers. These "overstays" increased the costs to the County while also decreasing the availability of these services for other consumers.

> "Connecting people with mental health services can be confusing, not a lot of options when we do discharge."
>
> – Provider

Given the high level of mental health acuity in Sonoma, it was particularly important that people received the appropriate level and amount of services to support their own treatment as well as create space for other consumers. While there are certainly consumers who will require longer than typical enrollment in programs and facilities, it is the goal of a recovery-focused system to move consumers to lower levels of care when appropriate. In an effort to improve access to care and service transitions, **the County adopted a drop-in Access Clinic** in hopes of connecting people to appropriate services before they experience a crisis.

In Sonoma County, stay lengths for many services, particularly those intended to be short-term and temporary, extended beyond recommended timelines. In fiscal year 2018-2019, the median stay length for adults in unlocked short-term residential (CRT) programs was 16 days, two days longer than the expected maximum stay of two weeks. Almost **60% of episodes lasted for 14 days or more, with 15% (396) of consumers staying over 30 days**. Fifteen percent of consumers were transitional age youth between the ages of 16 and 25.

At the CSU, the median stay length was one day, however in fiscal year 2018-2019, 27% of episodes lasted two days or more, with some episodes lasting for months. Over the last three years, the **total potential lost revenue from overstays was $14,069,893**. The CSU is intended to support individuals experiencing acute mental health crises, and stays for longer than 24 hours could indicate challenges transferring to the next level of care or accessing more long-term maintenance services. There were a small portion of high utilizers, 6% of CSU consumers, who accounted for about 30% of all CSU episodes. This population may present unique challenges and require more intensive services.

Table 8. Facility Stay Lengths in Fiscal Year 2018-2019

Facility	Expected Stay Length	Overstay Episodes	Median Stay Length
CSU	<24 hours	41% (1,094)	1 day
CRT	14 days	58% (228)	16 days
ART	6-9 months	22% (19)	6 months

Episodes also lasted longer than expected for some consumers in long-term treatment programs as shown in Table 8. While the expected stay length for long-term residential treatment was six to nine months, in fiscal year 2018-2019, **38% of episodes in locked facilities and 22% of episodes in unlocked (ART) facilities lasted for nine months or more.** Adult residential treatment services are designed for persons who are able to take part in programs in the general community, but who, without the support of counseling, as well as the therapeutic community, would be at risk of returning to the hospital. Without such treatment, individuals are more likely to be hospitalized more frequently and be hospitalized for longer lengths of time. The lack of adult residential treatment options (locked and unlocked facilities) in Sonoma may have led some individuals to stay in psychiatric settings for extended periods of time and to experience increased rates of relapse once back in the community.

Many consumers' length of stay in FSP programs was also longer than expected (Figure 17). While the median stay length in fiscal year 2018-2019 for adults in FSP programs was just under one year, **11% of consumers remained in a program for longer than five years and 4% for longer than 10 years**. While consumers stayed in these programs, the level of service consumers received was of a lower intensity than expected. **Over 35% of FSP consumers did not receive an hour of service per week**, on average, throughout their enrollment in an FSP program in fiscal year 2018-2019. Only 40% of consumers had an average of at least two services and one hour of service per week. Many consumers were not stepping down from these programs as expected and the lower level of engagement may play a role in this.

Overview of Full Service Partnerships

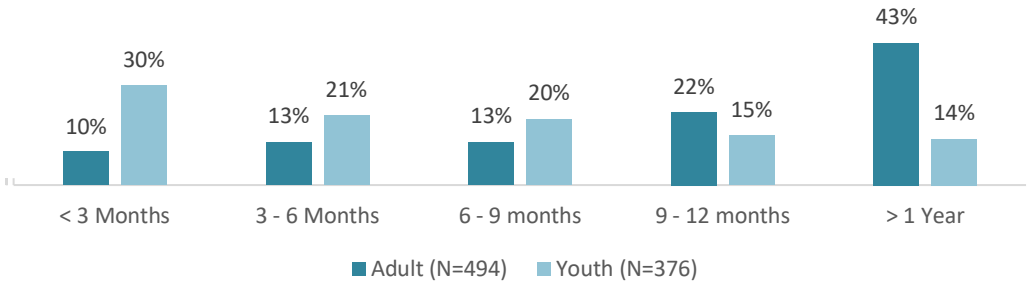
Target Population
People with the most serious mental illness who are un- or under-served and at risk of or experiencing incarceration, hospitalization, or homelessness.

Goal
To interrupt the cycle of jail, hospitalization, and homelessness for people with serious mental illnesses and support their recovery in the community using a "whatever-it-takes" approach

Frequency & Intensity of Services
Individuals should engage in services at least once a week for a minimum of 1-2 hours per encounter.

Clinical Services	Non-Clinical Services
• Mental health treatment, including alternative and culturally specific • Peer support • Wellness Centers • Needs Assessment • ISSP development • Crisis intervention/ stabilization	• Supportive services to obtain employment, housing, education, and health care • Family education • Case management • Respite care • Wrap-around services to children

Figure 17. Adult and Youth FSP Stay Length in Fiscal Year 2018-2019



Additionally, there appeared to a **reluctance from providers to step down consumers** due to difficulty in regaining access to services if necessary and the amount of work necessary, given their high caseloads. The County's clinician-heavy staffing in programs may have also contributed to implicit bias and benign stigma within the system. Unconscious associations or beliefs may have influenced providers decisions to keep consumers in programs longer. In the future, widespread integration of peers into clinical programs could help balance assumptions and recommendations based on education and training alone. As programs, including FSPs, are now fully staffed, creating a shift with a focus on recovery and system movement should be less complicated.

Ongoing Service Determinations, Delays, and Misaligned Levels of Care

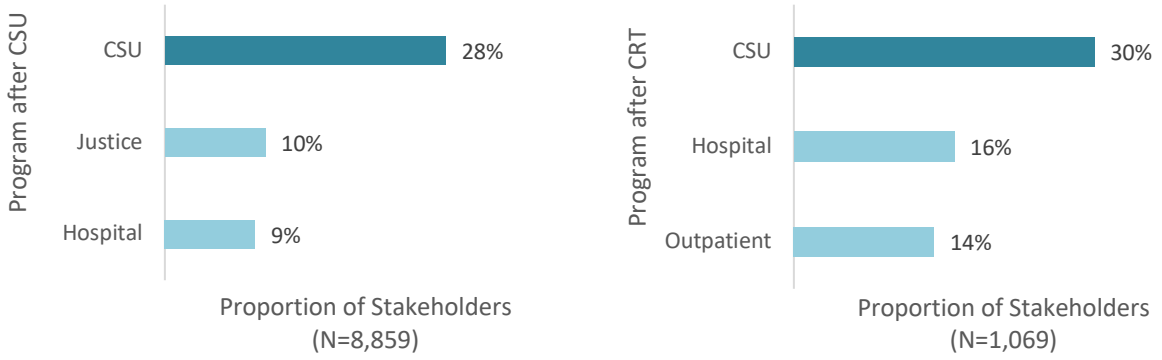
While there were many consumers "stuck" in programs, these overstays were not consistent. **Some consumers remained in services for longer than expected while others were not referred to subsequent treatment opportunities**. It was unclear if structured decision-making tools were used to support the reauthorization of ongoing services, but there appeared to be a lack of standardization in the reauthorization process. Some of these decisions, may have been more subjective and potentially influenced by implicit bias and/or benign stigma – although providers strove to effectively meet the needs of consumers, unconscious associations or beliefs may have influenced their decisions. As a result, individuals received services as they were referred to them and/or they were made available, not necessarily based on assessed need and risk.

> "I'm not sure why County Behavioral Health keeps graduating me out [of services] while friends of mine have been clients for 23 years."
>
> – Consumer

In addition to overstaying in certain programs, without efficient service transitions **some consumers also delayed services or cycled in and out of the same levels of care**. This increased the likelihood of crisis, hospitalization, and incarceration, and reduced psychosocial and recovery opportunities. Providers noted concerns supporting consumers' transfers and making referrals to other agencies. Stakeholders also did not know where to go for more minor, less severe mental health challenges. This led some to wait to seek support until the individual was at a crisis point.

Once in crisis, stakeholders heavily relied on the CSU for assistance. After CSU services, care transitions were misaligned for some consumers. Those who went on to receive additional services after the CSU were most likely to return to the CSU (28%) or engage in justice (10%) or hospital (9%) services. This was also true for consumers engaged in unlocked short-term residential treatment. After going to the CRT, consumers who went on to receive additional services were most likely to go to the CSU (30%) or hospital (16%). Stakeholders noted the need for more locked residential treatment facilities that support the transition from stabilization to recovery by providing a lower level of long-term care. Many also reflected that **if consumers had access to services for less severe mental health issues and/or were engaged in extended interventions they would less frequently utilize more costly crisis and short-term services.**

Figure 18. Consumers' Next Episode After the CSU or CRT



Currently, there is a lack of oversight in place to assess if a client needs to be "stepped up or down", or if a client is in the appropriate level of care. The lack of a standardized process results in limited oversight of clients' care and decreases the County's ability to manage capacity and demand to ensure that those with the highest level of need receive services. By developing a County-led level of care determination process with clear policies and procedures for how consumers move through the system, providers would be better equipped to make objective referrals. With greater oversight from the County, DHS-BHD programs and contracted providers would have clear expectations regarding referrals, enrollments, and when to "step up" or "step down" consumers. The County could then focus on quality assurance and utilization management, while providers focus on ensuring consumers are getting the services and care they require. The County has already begun measures to improve flow and access, including focusing on quality assurance, developing new contracts with providers, and restructuring the Youth and Family System. By continuing and building upon these efforts, DHS-BHD can further support consumers' recovery, improve cost-effectiveness, and further support providers.

> "Biggest gap is the availability of services and resources. I receive tons of calls every day from people looking for services."
>
> – Provider

Further exacerbating the issue of movement through the system were the recent budget challenges for DHS-BHD. **Budget issues have led to staff shortages and higher caseloads for providers**, which contributes to burnout and staff turnover. High caseloads has also led to the perception of a lower quality of care due to provider's inability to devote enough time to each client. Staff turnover and the DHS-BHD hiring freeze also resulted in some consumers changing providers throughout their continuum of care, which they found disengaging and discouraging from further accessing services. The lack of transparency in recent years regarding budget decisions has also caused fear amongst staff that they were going to lose their jobs. This fear led to a further distrust in the system and for some to leave the County altogether. Recent fires, power outages, and a worsening housing crisis have also increased the number of consumers trying to access mental health care, further impacting the system's capacity to appropriately serve this population. **During fiscal year 2019-2020, DHS-BHD programs and services became fully staffed, which should improve caseloads and services provided for consumers.**

> "We need to address the increase in staff turnover at the County, especially with case managers, social workers, and nurses."
>
> – Provider

Despite challenges with service transitions, providers noted that **strong collaborations exist amongst community partners**. Stakeholders identified the Community Corrections Partnership (CCP), Collaborative of Trans-Affirming Therapists, and Redwood Community Health Coalition (RCHC) as particularly effective. The CCP brings various justice stakeholders together to develop program and funding recommendations focused on public safety, reducing recidivism, and offender rehabilitation, including issues related to mental illness. The Collaborative of Trans-Affirming Therapists was developed in response to the lack of appropriate providers for the LGBTQ+ community, particularly for Trans-identifying consumers. Organizations like Positive Images highlight the importance of this group, as they can refer consumers to any providers within the collaborative with confidence. Finally, the RCHC provides a forum for collaboration amongst County health centers across the County. Stakeholders shared that the RCHC is currently looking at the continuum of care and discussing how to improve care coordination and transition of services. **Providers voiced an interest in creating more collaborations to holistically support consumers across the system**.

> "The RCHC allows for great communication between health centers, very forward-thinking and collaborative."
>
> – Provider

Spirit and Intention of MHSA

Sonoma County has intentionally incorporated MHSA values across its behavioral health system. The collaborations discussed above are a strong example as well as the restructuring of the Youth and Family system of care. Stakeholders also noted that DHS-BHD has been more transparent regarding budgets and plans, which has helped to build trust and support from the community. However, the County could continue to grow within MHSA spirit and intention by further implementing the MHSA values of:

- Wellness, Recovery, and Resilience

- Cultural Competence
- Client & Family Driven Services
- Integrated Service Experience
- Community Collaboration

Adhering to and integrating these values could improve movement through the system and foster more inclusive, community-driven services. As mentioned previously, the MHSA values of Client & Family Driven Services and Community Collaboration could be strengthened by integrating peer providers within DHS-BHD programs and reducing opportunities for benign stigma and implicit bias. The values of Community Collaboration and Cultural Competence could also be more deeply applied through additional stakeholder collaboration and enhanced services for underserved populations. DHS-BHD's new targeted recruit of those with lived experience to MHSA committees and their incorporation into this capacity assessment demonstrate the County's commitment to community involvement.

Stakeholder Participation

> There is a need to "increase genuine engagement with community members and other stakeholders. It appears many changes…are made without engaging the community."
>
> – Provider

In addition to integrating peers into clinical services, stakeholders highlighted both improvements and opportunities for growth with community participation in other areas. Many noted the County has been more transparent in recent years. Budget issues, combined with changing leadership, encouraged **more communication and collaboration among community partners and the County.** Providers were appreciative of the increased transparency on decisions regarding the budget and the increase in opportunities to participate in the process. Stakeholders and consumers alike described how the loss of services, changing providers, and organizational barriers to access diminished their trust in the system in past years, but acknowledged that this now seems to be changing for the better. **By inviting stakeholders and the community to the table when making budget decisions and continuing to remain transparent about these changes, the County is able to better allocate funding for services and maintain a level of trust with the community.**

Stakeholders were invited to be part of the MHSA process in a number of different venues, including the MHSA Steering Committee through an application process, and the MHSA Stakeholder Committee, which is open to the public. In addition, the community, including the groups highlighted in the Capacity Assessment section above, participated fully in the capacity assessment with the encouragement and outreach of DHS-BHD. However, there appeared to be **limited involvement in the planning and oversight process from consumers and those with lived experienced,** youth and parents of minor children, and older adults and seniors. While diverse in terms of organizations, most membership of the MHSA committees were individuals who participated on behalf of an employer.

DHS-BHD began a new application process for the Steering Committee in January 2020. The County will conduct a targeted recruitment to encourage greater participations from those underrepresented,

particularly individuals with lived experience. Having this perspective well represented will ensure the community's input throughout the process. Additionally, those with lived experience can help to combat any benign stigma or implicit bias that may exist in these committees.

Underserved Populations

Certain populations experienced service limitations and barriers to access within Sonoma's behavioral health system. Cultural competence is an MHSA value, and while the County has made efforts to reach some un- and underserved populations, deeper and more targeted efforts are possible. DHS-BHD is aware of the limited penetration rates from the Latinx community and is actively working on furthering their cultural competency and developing more culturally specific services.

Latinx/Hispanic Community

While the County offered some behavioral health services for the Latinx/Hispanic community, opportunities were limited. Although this group makes up about 30% of the County's general population and over 40% of Sonoma's Medi-Cal population, **only 23% of DHS-BHD consumers were of Hispanic ethnicity**. Table 9 lists the percent of various Sonoma County population groups identified as Hispanic or Latinx. As noted previously, in fiscal year 2018 – 2019, the system directly served almost 4,000 consumers, the majority of which were White/Caucasian.

There was a notable contrast in the youth and adult populations served. **Latinx/Hispanic consumers made up just over a tenth of adult consumers while they made up over one third of youth consumers.** Interestingly, over 21% of consumers served by the Adult Access Team identified as Hispanic, almost double the proportion of Sonoma's broader consumer population. It is unclear why these individuals were not connected to subsequent services.

Table 9. Sonoma County Latinx/Hispanic Population in 2019

Sonoma County Latinx/Hispanic Population	Percent of Population
In County	27%
Medi-Cal	42%
Consumers	23%
Adult Consumers	13%
Youth Consumers	36%

Latinx/Hispanic youth, on the other hand, were overrepresented in a variety of programs. They made up 45% of episodes in general outpatient programs (e.g. therapy, medication support, etc.), 44% of episodes in youth FSP program, and 42% of episodes in youth justice programs compared to 35% in the general youth DHS-BHD population. There may be greater services available for Latinx/Hispanic youth or they may be more likely to access services due to less barriers either from language or stigma.

> "She happens to speak Spanish and now provides those services in Spanish, but she's not actually trained to do so."
> – Community Member

Both consumers and providers noted difficulties accessing or supplying services in Spanish. While about one fifth of consumers identified as Hispanic, very few services were offered in Spanish. Many reported a need for a greater quantity and variety of high-quality services in Spanish that accept consumers regardless of citizenship status. Stakeholders noted that the lack of culturally competent and bilingual staff resulted in the Hispanic community accessing a lower level of care than others or being deterred from accessing care altogether. For example, when monolingual Spanish-speakers tried to access counseling services oftentimes they were only offered education or wellness opportunities due to the lack of in-county bilingual clinicians. Service limitations were particularly true for undocumented residents, who had limited access to facilities that were often over capacity and inconsistent in quality.

> "We have the bilingual staff that…do [the] program…because they speak Spanish, not because they have the mental health training."
> – Provider

Limited services in Spanish and culturally relative to Sonoma's Latinx/Hispanic population may have led to increased use of higher level services. During fiscal year 2018-2019, a high proportion of Latinx consumers went to the CSU, though slightly less than consumers overall. While accessing the appropriate level of care may have been a problem for this community, Sonoma is working to address this issue. **The County is currently exploring a possible MHSA Innovation project that would create culturally-specific interventions for the Latinx/Hispanic population.**

LGBTQ+ and Native American Communities

Services were also limited for Native American communities and individuals who identify as LGBTQ+. Effective PEI programs exist for both of these groups. Positive Images, for example, acts as an access point for individuals who identify as LQBTG+ prior to being connected to further services. The Native American population has access to the Sonoma County Indian Health Project (SCIHP), a Community Health Center that provides behavioral health, and other, services predominantly to Native Americans in Sonoma. However, SCIHP is underutilized, likely due to stigma within the target population and limited culturally specific programs.

As with the Latinx/Hispanic 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.

Stakeholders also emphasized **challenges finding comfortable, culturally/socially appropriate services for LGBTQ+ and Native American consumers**. Further engagement of the MHSA values of community

collaboration and culturally competency specific to these communities could support deeper integration of relative services into Sonoma's behavioral health system.

System Cost

The challenges of receiving appropriate levels of care at the necessary time discussed above harm consumers' ability to recover as well as result in a more expensive behavioral health system in Sonoma County. These barriers can lead to higher use of crisis and acute mental health services, which are more expensive than lower levels of care and not always covered by Medi-Cal. Additionally, consumers remaining in programs longer than necessary increases the expenses for those individuals, some of which cannot be reimbursed, as well as limits the space available for other consumers, which increases necessity for crisis services. This cycle unfortunately perpetuates itself, increasing costs to consumers' recovery and DHS-BHD.

Consumer overstays at the CSU were particularly expensive for the County. Medi-Cal will reimburse CSU stays up to 24 hours, but anything over a day is unable to be reimbursed by Medi-Cal. As these services were unbillable, the County was not only reasonable for the total expense of these additional days, but also lost potential revenue from other consumers who may have remained in these facilities for the appropriate amount of time. Total CSU expenses for fiscal year 2018-2019 were almost $20 million with about $7 million of those expenses reimbursable through Medi-Cal. **Consumer overstays at the CSU resulted in over $12,500,000 unbillable services and a potential revenue loss of over $6 million.** Unbillable expenses at the CSU made up almost 40% of all unbillable DHS-BHD services and over 60% of the CSU's total costs for services.[49]

Longer term acute and high level services were also costly for the County and were not reimbursable through Medi-Cal.[50] As the county mental health plan, DHS-BHD is responsible for funding these services. In fiscal year 2018-2019, there were 162 locked inpatient episodes with a total service cost over $8 million. There were over 450 episodes for board and care facilities, many of which were augmented out-of-county programs, costing the County over $10 million. While many of these services were necessary and appropriate, the high utilization of these more acute and more expensive services placed a financial burden on DHS-BHD. Given the barriers to access, it is possible that some of these episodes could be avoided if consumers were able to access appropriate treatment sooner.

The County's high reliance on clinicians potentially adds to this lack of movement and further increases system costs. Clinicians are valuable and necessary staff members for any behavioral health program with many counties struggling to hire enough clinicians to support their services. Sonoma's DHS-BHD is

> "Sometimes, our biggest obstacle is the system itself."
>
> – Provider

[49] Non-treatment housing services, such as board and cares, made up the next largest proportion (33%) of unbillable services. None of these services qualify for Medi-Cal reimbursement.
[50] Some services may potentially be reimbursable through Medi-Cal, but almost all service costs were paid by County without reimbursement.

fortunate to not have this problem with dedicated and substantial clinical staffing. However, clinicians are expensive to staff and in Sonoma were often undertaking tasks better suited for a non-clinical staff member such as peer provider or mental health worker. **Having the appropriate staffing balance could not only decrease system costs, but also shift the culture by promoting recovery and stepping down of services.**

Sonoma's current mental health system is stuck with a cycle that leads to increased crisis and acute services and higher costs for the County. Rather than creating new programs, DHS-BHD would benefit from changing the process and approach of the system internally.

Conclusion and Recommendations

Overall, Sonoma's public mental health system is structured well with beneficial services at suitable capacity for the population. The County's providers are dedicated to supporting their clients resulting in high satisfaction from consumers in their services. With appropriate programs and committed providers, Sonoma's mental health system has a strong foundation which the Behavioral Health Division (DHS-BHD) is continuing to build upon.

Despite these strengths, the capacity assessment found some challenges and barriers within the system. In particular, there was limited and inconsistent movement of consumers through the system which increased services costs for DHS-BHD and potentially inhibited consumers' recovery. This report outlined the following areas for improvement:

- There are barriers preventing or delaying access to appropriate mental health services.
- Consumers are getting "stuck" in programs, which impacts their ability to recovery.
- Those with lived experience could be better integrated into programs and MHSA planning.
- Some populations are underserved, particularly the Latinx community.
- These factors lead to a more expensive system.

Based on these findings, recommendations focus on improving the internal structure and culture of the County's mental health system. RDA would recommend that DHS-BHD implement or continue the following:

- **Standardize the reauthorization process for continued program enrollment with increased utilization review from the County.** This oversight and structured process would increase consumers' movement through the system thereby ensuring consumers have access to the appropriate services to support their recovery. It will also decrease subjectivity that can arise through implicit bias and benign stigma.
- **Integrate peers into programs and explore creating a more balanced staffing model.** Peer providers bring their lived experience into their work, which promotes a recovery focus and decreases benign stigma. By integrating peers and other non-clinical staff, the County can create a more comprehensive staffing model that provides both increased support to consumers and decreased costs for DHS-BHD.
- **Increase representation from those with lived experience in all aspects of the MHSA process.** As with peers, consumers and family members provide a unique and necessary perspective for guiding these community-based mental health programs. Greater involvement from these groups would keep the process grounded in support of consumers, their recovery, and the community's needs.
- **Develop culturally competent services for underserved communities, particularly Latinx individuals.** By increasing culturally specific treatment programs, DHS-BHD will provide more

appropriate and beneficial services to currently un- and underserved populations in the County. There is a clear need to increase the services available in Spanish, but it is also necessary to ensure that these services are offered in a culturally appropriate and competent way for the communities being served.

The County has been receptive to the findings and recommendations presented in this capacity assessment report. Some improvements suggested above are already taking place and others are being planned for future implementation. Recent and planned changes from DHS-BHD include:

- Complete staffing across programs and new contracts with providers
- Drop-in assessment services through Access
- Increased DHS-BHD oversight and utilization review
- Culturally appropriate Latinx innovation project
- Targeted recruitment for MHSA committees

By improving movement through the mental health system, prioritizing lived experience within programs and the MHSA process, and developing more culturally competent services for underserved populations; DHS-BHD will be able to stop the cycle leading consumers to crisis services and increased service costs.

Appendices

Appendix 1. Sonoma County MHSA Needs Assessment Focus Group Protocol (Consumer Experience)

Date	
FG Type/Size	
Location	
Facilitator	

Introduction

Thanks for making the time to join us today. My name is _____ and this is _____. We are with a consulting firm called Resource Development Associates and we are here to help Sonoma County with a needs assessment that will inform the upcoming MHSA Three-Year Program & Expenditure Plan. I will be facilitating our talk today and _____ will take notes, but we won't be attaching your names to anything that is said. We hope you will feel comfortable sharing candidly about your experiences, but please let me know if there is anything you don't want us to document. We respect your anonymity.

The purpose of the MHSA 3-Year Program & Expenditure Plan is to capture and document the community's vision for services to address mental health issues. More specifically, the Mental Health Services Act aims to strengthen the public mental health system that many individuals and communities rely on, especially underserved communities. We are holding several focus groups throughout Sonoma County to better understand the mental health needs in the community.

We're here today to hear from you. This is your process and your opportunity to make your voice heard about what is working well, what isn't working well, and what you feel is needed. We know there have been changes and upheavals in the last few years, [depending on the audience mention: fires, budget changes, new leadership, etc.], and we want to learn how these changes have affected you.

This is your conversation, but part of my job as facilitator is to help the discussion go smoothly and make sure that everyone has a chance to say what's on their mind in a respectful way. We have a few guidelines to help us do that. Please:

- Put your phone on silent and don't text
- Engage in the conversation – this is your meeting!
- Limit "side conversations" or "cross talk" so that everyone can hear what is being said
- And remember, there are no "wrong" or "right" opinions: please share your opinions honestly and listen with curiosity to understand the perspective of others

Focus Group Guide

Introductions

We know you could be spending your time anywhere, so we are interested to hear your name and what you're hoping to accomplish or contribute today.

Service & Program Experience

1. Think about your experiences with Sonoma County mental health services and programs.
    a. What services or programs are you apart of?
    b. Overall, what has your experience been with these services?

2. What has been the most helpful or positive when receiving these services?
    Prompt: staff, location, hours, ease of access

3. What has been the most difficult or challenging when receiving these services?
    Prompt: staff, location, hours, ease of access

Service & Program Changes

4. With the changes in the last few years, [depending on the audience mention: fires, budget changes, new leadership, etc.], how have these events impacted your services?
    a. What improvements in services have you experienced, if any?
    b. Have you experienced any decline or increased issues with services?
    Prompt: hours of operations, timely appointments, crisis support, interactions with law enforcement when dealing with a crisis, coordination of services

Recommendations and Needs

5. What would you recommend to improve Sonoma's mental health services?
    a. What would make the process of receiving services easier? More supportive?
    b. Are there services you wish existed? What services do people need but are not available?
    Prompt: psychiatry, wellness programs, residential programs, age or cultural group-specific programs

6. Considering the discussion we've just had, what's the most important issue or most significant mental health care need in Sonoma County?
    a. Who needs help and isn't getting it? Whose needs are not being met?
    b. What gaps remain in the system?
    c. What would be helpful to address this?

7. Is there anything else you would like to add before we conclude this discussion

Appendix 2. Sonoma County MHSA Needs Assessment Focus Group Protocol (Provider Experience)

Date	
FG Type/Size	
Location	
Facilitator	

Introduction

Thanks for making the time to join us today. My name is _____ and this is _____. We are with a consulting firm called Resource Development Associates and we are here to help Sonoma County with a needs assessment that will inform the upcoming MHSA Three-Year Program & Expenditure Plan. I will be facilitating our talk today and _____ will take notes, but we won't be attaching your names to anything that is said. We hope you will feel comfortable sharing candidly about your experiences, but please let me know if there is anything you don't want us to document. We respect your anonymity.

The purpose of the MHSA 3-Year Program & Expenditure Plan is to capture and document the community's vision for services to address mental health issues. More specifically, the Mental Health Services Act aims to strengthen the public mental health system that many individuals and communities rely on, especially underserved communities. We are holding several focus groups throughout Sonoma County to better understand the mental health needs in the community.

We're here today to hear from you. This is your process and your opportunity to make your voice heard about what is working well, what isn't working well, and what you feel is needed. We know there have been changes and upheavals in the last few years, [depending on the audience mention: fires, budget changes, new leadership, etc.], and we want to learn how these changes have affected you.

This is your conversation, but part of my job as facilitator is to help the discussion go smoothly and make sure that everyone has a chance to say what's on their mind in a respectful way. We have a few guidelines to help us do that. Please:

- Put your phone on silent and don't text
- Engage in the conversation – this is your meeting!
- Limit "side conversations" or "cross talk" so that everyone can hear what is being said
- And remember, there are no "wrong" or "right" opinions: please share your opinions honestly and listen with curiosity to understand the perspective of others

Does anyone have any questions before we begin?

Focus Group Guide

Introductions

To get started, I'd like to begin with introductions. Please share:

- Your name and organization
- What you are hoping to accomplish or contribute today

Current System of Care

1. Tell us about your/your agency's role in mental health services or working with people with mental health needs.
    a. What services do you provide?
    b. Who do you collaborate and coordinate services with (i.e. other providers, law enforcement, schools)?

2. How do you typically first become aware that an individual might need mental health services?
    a. How do people access your services? How does the referral process work?
    b. Is it working well? What could be improved?

3. What has been the most helpful or positive when providing these services?
    Prompt: addressing the needs of consumers, coordination/collaboration, referrals, capacity

4. What has been the most difficult or challenging when providing these services?
    Prompt: addressing the needs of consumers, coordination/collaboration, referrals, capacity

Service & Program Changes

5. With the changes in the last few years, [depending on the audience mention: fires, budget changes, new leadership, etc.], how have these events impacted the mental health system?
    a. What improvements have you experienced, if any?
    b. What increased challenges have you experienced, if any?
    Prompt: coordination of services, capacity, staff resources

Needs and Recommendations

6. Think about your community and the mental health needs in Sonoma.
    a. Where are there gaps in the system? What services are so full that you need more?
    b. Who is not being served? Who may be falling through the cracks?
    c. What is getting in the way of certain populations needs being met?
    d. What would be helpful to address these issues?

7. Considering the discussion we've just had, what's the most important issue or most significant mental health care need in Sonoma County?

Thank you

Appendix 3. Sonoma County MHSA Needs Assessment Consumer & Community KII Protocol

Date	
Name	
Title	
Agency/Dept./Org.	
Telephone #	
Interviewer	

Introduction

Hello, my name is _____ [and this is _____] from Resource Development Associates. Is now still a good time to talk?

Thank you for taking the time to talk with ME/US. I/WE work for a consulting firm called Resource Development Associates and we have partnered with Sonoma County to develop a capacity assessment that will inform the upcoming MHSA Three-Year Program & Expenditure Plan. The purpose of the MHSA 3-Year Program & Expenditure Plan is to capture and document the community's vision for services to address mental health issues.

For the capacity assessment, we are looking at the current mental health system in Sonoma County, its strengths, and its challenges. The purpose of this interview is to understand how [YOUR GROUP] and the community overall participates in Sonoma's Mental Health System, what is working well, and where there are areas for improvement. Please feel free to ask for clarification about any questions I ask, or to add information you believe is relevant.

This conversation will take approximately 45-60 minutes. As we are going through the interview, I/WE will be typing notes. We will be using the information from these interviews, our focus groups, and data collection in our analysis of Sonoma's Mental Health System. While your name will not be attached to the answers you provide in the interview, because of your affiliation in the County, it may be possible to identify you as the source of certain information. We hope you will feel comfortable sharing candidly about your experiences, but please let me know if there are any sensitive comments that you would like us to be especially careful about when writing up the summary of the conversation.

Do you have any questions before we begin?

Interview Guide

Introductions

We know you could be spending your time anywhere, so we are interested to hear your involvement with the Sonoma's Mental Health System and what you're hoping to accomplish or contribute today.

Service & Program Experience

8. Think about your [OR YOUR GROUP'S] experiences with Sonoma County mental health services and programs.
    a. What services or programs are you apart of?
    b. Overall, what has your experience been with these services?

9. What has been the most helpful or positive when receiving these services?
    Prompt: staff, location, hours, ease of access

10. What has been the most difficult or challenging when receiving these services?
    Prompt: staff, location, hours, ease of access

Service & Program Changes

11. With the changes in the last few years, [depending on the audience mention: fires, budget changes, new leadership, etc.], how have these events impacted your services?
    a. What improvements in services have you [OR YOUR GROUP] experienced, if any?
    b. Have you [OR YOUR GROUP] experienced any decline or increased issues with services?
    Prompt: hours of operations, timely appointments, crisis support, interactions with law enforcement when dealing with a crisis, coordination of services

Recommendations and Needs

12. What would you recommend to improve Sonoma's mental health services?
    a. What would make the process of receiving services easier? More supportive?
    b. Are there services you wish existed? What services do people need but are not available?
    Prompt: psychiatry, wellness programs, residential programs, age or cultural group-specific programs

13. Considering the discussion, we've just had, what's the most important issue or most significant mental health care need in Sonoma County?
    a. Who needs help and isn't getting it? Whose needs are not being met?
    b. What gaps remain in the system?
    c. What would be helpful to address this?

14. Is there anything else you would like to add before we conclude this discussion?

Thank you!

Appendix 4. Sonoma County MHSA Needs Assessment Provider and Professional KII Protocol

Date	
Name	
Title	
Agency/Dept./Org.	
Telephone #	
Interviewer	

Introduction

Hello, my name is _____ [and this is _____] from Resource Development Associates. Is now still a good time to talk?

Thank you for taking the time to talk with ME/US. I/WE work for a consulting firm called Resource Development Associates and we have partnered with Sonoma County to develop a capacity assessment that will inform the upcoming MHSA Three-Year Program & Expenditure Plan. The purpose of the MHSA 3-Year Program & Expenditure Plan is to capture and document the community's vision for services to address mental health issues.

For the capacity assessment, we are looking at the current mental health system in Sonoma County, its strengths, and its challenges. The purpose of this interview is to understand how [YOUR GROUP] and the community overall participates in Sonoma's Mental Health System, what is working well, and where there are areas for improvement. Please feel free to ask for clarification about any questions I ask, or to add information you believe is relevant.

This conversation will take approximately 45-60 minutes. As we are going through the interview, I/WE will be typing notes. We will be using the information from these interviews, our focus groups, and data collection in our analysis of Sonoma's Mental Health System. While your name will not be attached to the answers you provide in the interview, because of your affiliation in the County, it may be possible to identify you as the source of certain information. We hope you will feel comfortable sharing candidly about your experiences, but please let me know if there are any sensitive comments that you would like us to be especially careful about when writing up the summary of the conversation.

Do you have any questions before we begin?

Interview Guide

Introductions

I'd like to begin with learning about you and your position in Sonoma's Mental Health System of Care.

- Your name and organization
- How are you involved in the MH System?

Current System of Care

8. Tell us about your/your agency's role in mental health services or working with people with mental health needs.
    a. What services do you provide?
    b. Who do you collaborate and coordinate services with (i.e. other providers, law enforcement, schools)?

9. How do you typically first become aware that an individual might need mental health services?
    a. How do people access your services? How does the referral process work?
    b. Is it working well? What could be improved?

10. What has been the most helpful or positive when providing these services?
    Prompt: addressing the needs of consumers, coordination/collaboration, referrals, capacity

11. What has been the most difficult or challenging when providing these services?
    Prompt: addressing the needs of consumers, coordination/collaboration, referrals, capacity

Service & Program Changes

12. With the changes in the last few years, [depending on the audience mention: fires, budget changes, new leadership, etc.], how have these events impacted the mental health system?
    a. What improvements have you experienced, if any?
    b. What increased challenges have you experienced, if any?
    Prompt: coordination of services, capacity, staff resources

Needs and Recommendations

13. Think about your community and the mental health needs in Sonoma.
    a. Where are there gaps in the system? What services are so full that you need more?
    b. Who is not being served? Who may be falling through the cracks?
    c. What is getting in the way of certain populations needs being met?
    d. What would be helpful to address these issues?

14. Considering the discussion we've just had, what's the most important issue or most significant mental health care need in Sonoma County?

Appendix 5. Sonoma County MHSA Needs Assessment Context KII Protocol

Date	
Name	
Title	
Agency/Dept./Org.	
Telephone #	
Interviewer	

Introduction

Hello, my name is _____ [IF ANOTHER PERSON IS ON THE CALL/ATTENDING] and this is _____ from Resource Development Associates. Is now still a good time to talk?

Thank you for taking the time to talk with ME/US. I/WE work for a consulting firm called Resource Development Associates and we have partnered with Sonoma County to develop a capacity assessment that will inform the upcoming MHSA Three-Year Program & Expenditure Plan. The purpose of the MHSA 3-Year Program & Expenditure Plan is to capture and document the community's vision for services to address mental health issues.

For the capacity assessment, we are looking at the current mental health system in Sonoma County, it's strengths, and its challenges. At this early phase of this work, the purpose of this interview is to provide an overview of the Sonoma County system and to understand the context and history of the system's development. Please feel free to ask for clarification about any questions I ask, or to add information you believe is relevant.

This conversation will take approximately 45-60 minutes. As we are going through the interview, I/WE will be typing notes. We will be using the information from these interviews, our focus groups, and data collection in our analysis of Sonoma's Mental Health System. While your name will not be attached to the answers you provide in the interview, because of your affiliation in the County, it may be possible to identify you as the source of certain information. We hope you will feel comfortable sharing candidly about your experiences, but please let me know if there are any sensitive comments that you would like us to be especially careful about when writing up the summary of the conversation.

Do you have any questions before we begin?

Interview Guide

Introductions

To get started, I'd like to begin with learning about you and your position in Sonoma's Mental Health System of Care.

- Your name and organization
- How are you involved in the MH System?

Current System of Care

15. Can you provide an overview of the mental health system in Sonoma County?
    a. What services are available?
    b. Who has access to these services?
    c. How does the MH system and the Behavioral Health Department work with the community? With other social service agencies?

16. What would you say are the MH system's primary strengths? [bring out their positive thoughts]
    a. Are there specific programs or services that are performing particularly well?
    b. What factors lead to these successes?
    c. Are these new successes or are these long-standing strengths?

17. What would you say are the MH system's primary challenges?
    a. Are there specific programs or services that are not meeting the community's needs?
    b. What factors lead to these issues?
    c. Are these new issues or are these long-standing challenges?

Historical and Future System

18. There have been a number of changes that have taken place in Sonoma County and the behavioral health system in the last five years. What is your perspective on these changes?
    a. How do you think these changes have gone? How have these changes affected the Behavioral Health Department?
    b. How has the conversation changed in the County as a result?
    c. What turned out to be a positive change? What would you do again?
    d. What has been an issue or challenge because of these changes? What would you have done differently?

19. Are there are other historical factors that contributed to the design of current MH system?
    a. Thinking of last five to ten years, what changes have taken place?
    b. What events have taken place in Sonoma that have affected the MH system?
20. What changes are planned or currently taking place within the MH system?

a. What is the impetus for these changes?
b. What is your hope for how these changes will affect the MH system?
c. What has been tried in the past?

Needs and Recommendations

21. Think about your community and the mental health needs in Sonoma.
    a. Where are there gaps in the system? What services are so full that you need more?
    b. Who is not being served? Who may be falling through the cracks?
    c. What is getting in the way of certain populations needs being met?
    d. What would be helpful to address these issues?

22. Considering the discussion we've just had, what's the most important issue or most significant mental health care need in Sonoma County?

Thank you!

Appendix 6. Consumer Focus Group Flyer

SONOMA COUNTY BEHAVIORAL HEALTH

CONSUMER FOCUS GROUPS

WE WANT TO HEAR FROM YOU!

THURSDAY, OCT. 24TH

WELLNESS AND ADVOCACY CENTER

2245 Challenger Way #104
Santa Rosa, CA 95407

Tell us about your experiences receiving mental health services in Sonoma County! Your ideas will help shape your county's future behavioral health services.

REFRESHMENTS AND A GIFT CARD WILL BE PROVIDED!

ADULT CONSUMERS	OLDER ADULT CONSUMERS
AGES 26-59	AGES 60+
12:30PM TO 1:30PM	2:00PM TO 3:00PM

IF YOU CANNOT ATTEND, PLEASE TAKE OUR SURVEY

http://sgiz.mobi/s3/Imperial-Survey

Local Health Authority

For more information, contact
gmartinez@resourcedevelopment.net

RDA

Appendix 7. Provider Focus Group Flyer

SONOMA COUNTY BEHAVIORAL HEALTH

PROVIDER FOCUS GROUP

WE WANT TO HEAR FROM YOU!

Tell us about your experiences with Sonoma County's Behavioral Health system! Your ideas will help shape your county's future mental health services.

REFRESHMENTS WILL BE PROVIDED!

When: Wednesday, October, 30th 2019
What Time: 9:00-10:00AM
Who: Health Care Professionals
Where: St. Joseph Health
Rohnert Park, 1450 Medical Center Drive
Rohnert Park, CA 94928

IF YOU CANNOT ATTEND, PLEASE TAKE OUR SURVEY

http://sgiz.mobi/s3/Sonoma-MHSA-Survey

Sonoma County Department of Health Services Behavioral Health Division

For more information, contact gmartinez@resourcedevelopment.net

RDA

Appendix 8. Focus Group Sign-in Sheet

Name	I want to receive MHSA Emails (Circle One)	Email Address (If you would like to receive MHSA communication)
	Yes / No	
	Yes / No	
	Yes / No	
	Yes / No	
	Yes / No	
	Yes / No	
	Yes / No	
	Yes / No	
	Yes / No	
	Yes / No	
	Yes / No	
	Yes / No	
	Yes / No	

Appendix 9. Sonoma County Behavioral Health Consumer and Family Survey

Sonoma County Behavioral Health has partnered with Resource Development Associates (RDA) to develop a capacity assessment that will inform the upcoming MHSA Three-Year Program & Expenditure Plan. The purpose of the MHSA Three-Year Program & Expenditure Plan is to capture and document the community's vision for services to address mental health issues.

If you have access to a computer or are not a behavioral health consumer or family member of a consumer, we encourage you to take this survey online at:

http://sgiz.mobi/s3/Sonoma-MHSA-Survey

This survey is anonymous. Only RDA will see your response and they will combine your response with others' responses to inform the capacity assessment.

1. **What is your relationship to Sonoma County Behavioral Health?**
   - ☐ I am a consumer of behavioral health services
   - ☐ I am a loved one of a consumer of behavioral health services

2. **What services have you or your loved one received in the past year? Check all that apply.**
   - ☐ Outpatient Treatment (e.g., therapy, case management, medication)
   - ☐ Peer Self-Help Center (e.g., The Wellness and Advocacy Center, Russian River Empowerment Center)
   - ☐ Crisis or Emergency Mental Health Services (e.g., CSU, Urgent Care)
   - ☐ Residential Treatment (e.g., Progress Sonoma, Parker Hill Place)
   - ☐ Court-involved Services (e.g., FACT)

3. **What do you like best about you or your loved one's mental health services?**
   - ☐ I or my loved one has better relationships with family, friends, children, and others
   - ☐ I or my loved is engaged in meaningful/productive activities including a job, school or volunteer work
   - ☐ I or my loved one is connected to assistance for their basic needs (e.g., income, housing, food)
   - ☐ I or my loved one can resolve existing legal problems and stay out of the legal system
   - ☐ I or my loved one is less likely to need acute services for risk of harm to self or others
   - ☐ I or my loved one can better manage substance use problems
   - ☐ I or my loved one can better take care of daily needs (e.g., clothing, bathing, eating, etc.)
   - ☐ Other: _____

4. **What is the most challenging part of you or your loved one's mental health services?**

☐ I or my loved one don't know where to go for services or the location of services is not convenient

☐ I have or my loved one has to wait a long time to get an appointment

☐ Providers do not discuss treatment options with me or my loved one

☐ Medication does not work for me or my loved one

☐ I or my loved one feel uncomfortable seeking mental health services

☐ I or my loved one feel that services lack cultural responsiveness or appropriateness

☐ Other: _____

5. **How true are the following statements about you or your loved one's experience in <u>getting access to mental health services</u>?**

Obtaining Services	**Not at all true**	**A little bit true**	**Mostly true**	**Very true**	**Don't Know or N/A**
I or my loved one know who to **<u>call</u>** for mental health services.	☐	☐	☐	☐	☐
I or my loved one know where to **<u>go</u>** for mental health services.	☐	☐	☐	☐	☐
I or my loved one feel comfortable seeking mental health services.	☐	☐	☐	☐	☐
It is easy to get an appointment when I or my loved one need one.	☐	☐	☐	☐	☐
The services I or my loved one receive are at a convenient location.	☐	☐	☐	☐	☐
Please explain or elaborate on your answers above:					

6. **How true are following statements about you or your loved one's <u>experience receiving mental health services</u>?**

Effectiveness of Services	**Not at all true**	**A little bit true**	**Mostly true**	**Very true**	**Don't Know or N/A**
I believe the mental health services I or my loved one receive are helpful.	☐	☐	☐	☐	☐
I am confident that the services and providers will help my or my loved one's recovery.	☐	☐	☐	☐	☐
When receiving mental health services, I or my loved one feel safe and supported.	☐	☐	☐	☐	☐
Services are focused on the belief that I or my loved one can get better.	☐	☐	☐	☐	☐
Please explain or elaborate on your answers above:					

7. **How true are the following statements about you or your loved one's <u>experiences with mental health providers</u>?**

Provider Communication	**Not at all true**	**A little bit true**	**Mostly true**	**Very true**	**Don't Know or N/A**
I or my loved one feel respected by the mental health team.	☐	☐	☐	☐	☐
I or my loved one trust that any information provided to the mental health team is kept confidential.	☐	☐	☐	☐	☐
I or my loved one is included in the treatment planning.	☐	☐	☐	☐	☐
My or my loved one's family are included in the mental health treatment.	☐	☐	☐	☐	☐
Services are sensitive to my or my loved one's culture or ethnicity.	☐	☐	☐	☐	☐
Services are available in the language I or my loved one want to use.	☐	☐	☐	☐	☐
Please explain or elaborate on your answers above:					

8. **How true are the following statements about you or your loved one's satisfaction with mental health services and providers?**

Satisfaction	Not at all true	A little bit true	Mostly true	Very true	Don't Know or N/A
I or my loved one have made progress because of the services received.	☐	☐	☐	☐	☐
The mental health team is available when I or my loved one need help.	☐	☐	☐	☐	☐
I am satisfied with the mental health services available for myself or my loved one.	☐	☐	☐	☐	☐
Please explain or elaborate on your answers above:					

9. **Based on your experience, what are the greatest strengths of the Sonoma County mental health system? Please choose three strengths.**
   - ☐ Services work well together across providers and programs
   - ☐ Services are coordinated with other systems (e.g., justice, child welfare, etc.)
   - ☐ Services are driven by consumers and their families
   - ☐ Diversity and language of providers/staff reflect the diversity of the population they serve
   - ☐ Services engage and educate the community
   - ☐ Services utilize a peer workforce in a meaningful way
   - ☐ Service providers understand consumer needs
   - ☐ Services have improved in quality over time
   - ☐ Crisis services are available to everyone who needs them
   - ☐ Services and referrals are right for consumer needs
   - ☐ Services are easy to access (e.g., ease of getting appointments, convenient locations/times)
   - ☐ Services help the people with the greatest needs
   - ☐ People with less severe needs can get services quickly
   - ☐ Other: _____

10. **Based on your experience, what are the greatest needs of the Sonoma County mental health system? Please choose <u>three</u> needs.**
    - ☐ Services do not work well together across providers and programs
    - ☐ Services are not coordinated with other systems (e.g., justice, child welfare)
    - ☐ Services are not driven by the consumers and their families
    - ☐ Diversity and language of providers/staff does not reflect the diversity of population served
    - ☐ Services do not engage and educate the community
    - ☐ Services do not utilize a peer workforce in a meaningful way
    - ☐ Service providers do not understand consumer needs
    - ☐ Services have decreased in quality over time
    - ☐ Crisis services are not available to everyone who needs them
    - ☐ Services and referrals are not right for consumer needs
    - ☐ Services are hard to access (e.g., difficult to get appointments, inconvenient locations/hours)
    - ☐ Services do not help the people with the greatest needs
    - ☐ People with less severe needs cannot get services quickly
    - ☐ Other: _____

11. **What is your top recommendation to improve the Sonoma mental health system? Please only list your primary suggestion.**

12. Do you have any additional comments you would like to add?

DEMOGRAPHICS FORM

1. What is your connection to behavioral health services?
   - ☐ Consumer of Behavioral Health Services
   - ☐ Family Member of Consumer of Behavioral health Services
   - ☐ County Government Agency
   - ☐ Contracted Service Provider or Community-Based Organization
   - ☐ Law Enforcement
   - ☐ Education Agency
   - ☐ Social Service Agency
   - ☐ Veteran Organization
   - ☐ Medical or Health Care Organization
   - ☐ Community Member
   - ☐ Other:

     _____

2. What is your primary language? (Please select one)
   - ☐ Arabic
   - ☐ Armenian
   - ☐ Cambodian
   - ☐ Cantonese
   - ☐ English
   - ☐ Farsi
   - ☐ Hmong
   - ☐ Korean
   - ☐ Mandarin
   - ☐ Other Chinses
   - ☐ Russian
   - ☐ Spanish
   - ☐ Tagalog
   - ☐ Vietnamese
   - ☐ Prefer not to answer

3. Please indicate your age range:
   - ☐ Under 16
   - ☐ 16-25
   - ☐ 26-59
   - ☐ 60 and older
   - ☐ Prefer not to answer

4. What is your race? (Check all that apply)
   - ☐ American Indian or Alaska Native
   - ☐ Asian
   - ☐ Black or African American
   - ☐ Native Hawaiian or Other Pacific Islander
   - ☐ White
   - ☐ Other
   - ☐ Prefer not to answer

5. What is your ethnicity? (Check all that apply)
   - ☐ Caribbean
   - ☐ Central American
   - ☐ Mexican/Mexican-American/Chicano
   - ☐ Puerto Rican
   - ☐ South American
   - ☐ Other Hispanic or Latino
   - ☐ African
   - ☐ Asian Indian/South Asian
   - ☐ Cambodian
   - ☐ Chinese
   - ☐ Eastern European
   - ☐ European
   - ☐ Filipino
   - ☐ Japanese
   - ☐ Korean
   - ☐ Middle Eastern
   - ☐ Vietnamese
   - ☐ Other Non-Hispanic or Non-Latino
   - ☐ Prefer not to answer

6. Please indicate your gender assigned at birth:
   - ☐ Female
   - ☐ Male
   - ☐ Prefer not to answer

7. Please indicate your current gender identity:
   - ☐ Female
   - ☐ Male
   - ☐ Transgender
   - ☐ Genderqueer
   - ☐ Questioning or unsure of gender identity
   - ☐ Another gender identity
   - ☐ Prefer not to answer

8. Please indicate your sexual orientation:
   - ☐ Gay or Lesbian
   - ☐ Heterosexual or Straight
   - ☐ Bisexual
   - ☐ Questioning or unsure of sexual orientation
   - ☐ Queer
   - ☐ Another sexual orientation
   - ☐ Prefer not to answer

9. Are you a veteran of the United States military?
   - ☐ Yes
   - ☐ No
   - ☐ Prefer not to answer

10. Please indicate your disability status:
    - ☐ Difficulty seeing
    - ☐ Difficulty hearing, or having speech understood
    - ☐ Mental (i.e., learning disability, developmental disability, dementia)
    - ☐ Physical/mobility domain
    - ☐ Chronic health condition
    - ☐ Other disability
    - ☐ No disability
    - ☐ Prefer not to answer

11. Which zip code do you live in?
    _____

Appendix 10. Sonoma County Behavioral Health Provider Survey

1. **What services does your organization or program provide? Check all that apply.**
   - ☐ Outpatient Treatment (e.g., therapy, case management, medication)
   - ☐ Peer Self-Help Center (e.g., The Wellness and Advocacy Center, Russian River Empowerment Center)
   - ☐ Crisis or Emergency Mental Health Services (e.g., CSU, Urgent Care)
   - ☐ Residential Treatment (e.g., Progress Sonoma, Parker Hill Place)
   - ☐ Court-involved Services (e.g., FACT)

2. **Where in Sonoma County do you provide services? (check all that apply)**
   - ☐ North County
   - ☐ East County
   - ☐ Santa Rosa
   - ☐ South County
   - ☐ West County

3. **What is one area you feel your organization or program excels at or provides the best care in?**
   - ☐ Cultural competency
   - ☐ Awareness and education about mental health and recovery
   - ☐ Coping skills and strategies to manage mental health symptoms
   - ☐ Competence to support living independently
   - ☐ Strategies for healthy relationships with friends and families
   - ☐ Ability to meet all basic self-care needs independently like hygiene, cooking, and managing finances
   - ☐ Other: _____

4. **What is one area you think your organization or program could improve or is missing from your services?**
   - ☐ Less time-consuming hiring process
   - ☐ Less stringent educational requirements
   - ☐ More competitive salaries compared to other counties
   - ☐ Affordable living situations for staff close to work
   - ☐ Bilingual providers
   - ☐ Shorter wait times for clients
   - ☐ Other: _____

5. How true are the following statements about the services that your organization or program provides?

Services Available	Not at all true	A little bit true	Mostly true	Very true	Don't Know or N/A
The services my organization or program provides are useful to our clients.	☐	☐	☐	☐	☐
My organization or program is able to keep our clients engaged in our services for as long as they need them.	☐	☐	☐	☐	☐
The services my organization or program provide focus on the belief that our clients can get better.	☐	☐	☐	☐	☐
Please explain or elaborate on your answers above:					

6. How true are the following statements about the resources available to your organization or program?

Staff Resources	Not at all true	A little bit true	Mostly true	Very true	Don't Know or N/A
My organization or program is able to recruit and retain the staff necessary to meet our clients' needs.	☐	☐	☐	☐	☐
I have enough time to provide my clients with the services they need.	☐	☐	☐	☐	☐
My organization or program offers the services that our clients need.	☐	☐	☐	☐	☐
My organization or program provides services in the language that our clients wish to use.	☐	☐	☐	☐	☐
Please explain or elaborate on your answers above:					

7. How true are the following statements about your organization's or program's communication with clients and other agencies?

Communication	Not at all true	A little bit true	Mostly true	Very true	Don't Know or N/A
My organization or program works together with our clients to make decisions about their services.	☐	☐	☐	☐	☐
My organization or program works with our clients' families to support their recovery.	☐	☐	☐	☐	☐
My organization or program is able to connect our clients to other services they need in Sonoma County.	☐	☐	☐	☐	☐
I believe the County works well with my organization or program to best meet the needs of our clients.	☐	☐	☐	☐	☐
I believe other providers work well with my organization or program to best meet the needs of our clients.	☐	☐	☐	☐	☐
Please explain or elaborate on your answers above:					

8. How true are the following statements about your satisfaction with mental health services from your organization or program and in Sonoma County?

Satisfaction	Not at all true	A little bit true	Mostly true	Very True	Don't Know or N/A
I believe Sonoma County has the mental health services necessary to meet the community's needs.	☐	☐	☐	☐	☐
I am confident in my organization's or program's ability to help our clients' recovery.	☐	☐	☐	☐	☐
I am satisfied with the working environment at my organization or program.	☐	☐	☐	☐	☐
Please explain or elaborate on your answers above:					

9. Based on your experience, what are the greatest strengths of the Sonoma County mental health system? Please choose <u>three</u> strengths.

☐ Services work well together across providers and programs
☐ Services are coordinated with other systems (e.g., justice, child welfare, etc.)
☐ Services are driven by consumers and their families
☐ Diversity and language of providers/staff reflect the diversity of the population they serve
☐ Services engage and educate the community
☐ Services utilize a peer workforce in a meaningful way
☐ Service providers understand consumer needs
☐ Services have improved in quality over time
☐ Crisis services are available to everyone who needs them
☐ Services and referrals are right for consumer needs
☐ Services are easy to access (e.g., ease of getting appointments, convenient locations/times)
☐ Services help the people with the greatest needs
☐ People with less severe needs can get services quickly
☐ Other: _____

10. Based on your experience, what are the greatest needs of the Sonoma County mental health system? Please choose <u>three</u> needs.

☐ Services do not work well together across providers and programs
☐ Services are not coordinated with other systems (e.g., justice, child welfare)
☐ Services are not driven by the consumers and their families
☐ Diversity and language of providers/staff does not reflect the diversity of population served
☐ Services do not engage and educate the community
☐ Services do not utilize a peer workforce in a meaningful way
☐ Service providers do not understand consumer needs
☐ Services have decreased in quality over time
☐ Crisis services are not available to everyone who needs them
☐ Services and referrals are not right for consumer needs
☐ Services are hard to access (e.g., difficult to get appointments, inconvenient locations/hours)
☐ Services do not help the people with the greatest needs
☐ People with less severe needs cannot get services quickly
☐ Other: _____

11. **What is your top recommendation to improve the Sonoma mental health system? Please only list your primary suggestion.**

12. **Do you have any additional comments you would like to add?**

DEMOGRAPHICS FORM

1. What is your connection to behavioral health services?
   - ☐ Consumer of Behavioral Health Services
   - ☐ Family Member of Consumer of Behavioral health Services
   - ☐ County Government Agency
   - ☐ Contracted Service Provider or Community-Based Organization
   - ☐ Law Enforcement
   - ☐ Education Agency
   - ☐ Social Service Agency
   - ☐ Veteran Organization
   - ☐ Medical or Health Care Organization
   - ☐ Community Member
   - ☐ Other: _____

2. What is your primary language? (Please select one)
   - ☐ Arabic
   - ☐ Armenian
   - ☐ Cambodian
   - ☐ Cantonese
   - ☐ English
   - ☐ Farsi
   - ☐ Hmong
   - ☐ Korean
   - ☐ Mandarin
   - ☐ Other Chinses
   - ☐ Russian
   - ☐ Spanish
   - ☐ Tagalog
   - ☐ Vietnamese
   - ☐ Prefer not to answer

3. Please indicate your age range:
   - ☐ Under 16
   - ☐ 16-25
   - ☐ 26-59
   - ☐ 60 and older
   - ☐ Prefer not to answer

4. What is your race? (Check all that apply)
   - ☐ American Indian or Alaska Native
   - ☐ Asian
   - ☐ Black or African American
   - ☐ Native Hawaiian or Other Pacific Islander
   - ☐ White
   - ☐ Other
   - ☐ Prefer not to answer

5. What is your ethnicity? (Check all that apply)
   - ☐ Caribbean
   - ☐ Central American
   - ☐ Mexican/Mexican-American/Chicano
   - ☐ Puerto Rican
   - ☐ South American
   - ☐ Other Hispanic or Latino
   - ☐ African
   - ☐ Asian Indian/South Asian
   - ☐ Cambodian
   - ☐ Chinese
   - ☐ Eastern European
   - ☐ European
   - ☐ Filipino
   - ☐ Japanese
   - ☐ Korean
   - ☐ Middle Eastern
   - ☐ Vietnamese
   - ☐ Other Non-Hispanic or Non-Latino
   - ☐ Prefer not to answer

6. Please indicate your gender assigned at birth:
   - ☐ Female
   - ☐ Male
   - ☐ Prefer not to answer

7. Please indicate your current gender identity:
   - ☐ Female
   - ☐ Male
   - ☐ Transgender
   - ☐ Genderqueer
   - ☐ Questioning or unsure of gender identity
   - ☐ Another gender identity
   - ☐ Prefer not to answer

8. Please indicate your sexual orientation:
   - ☐ Gay or Lesbian
   - ☐ Heterosexual or Straight
   - ☐ Bisexual
   - ☐ Questioning or unsure of sexual orientation
   - ☐ Queer
   - ☐ Another sexual orientation
   - ☐ Prefer not to answer

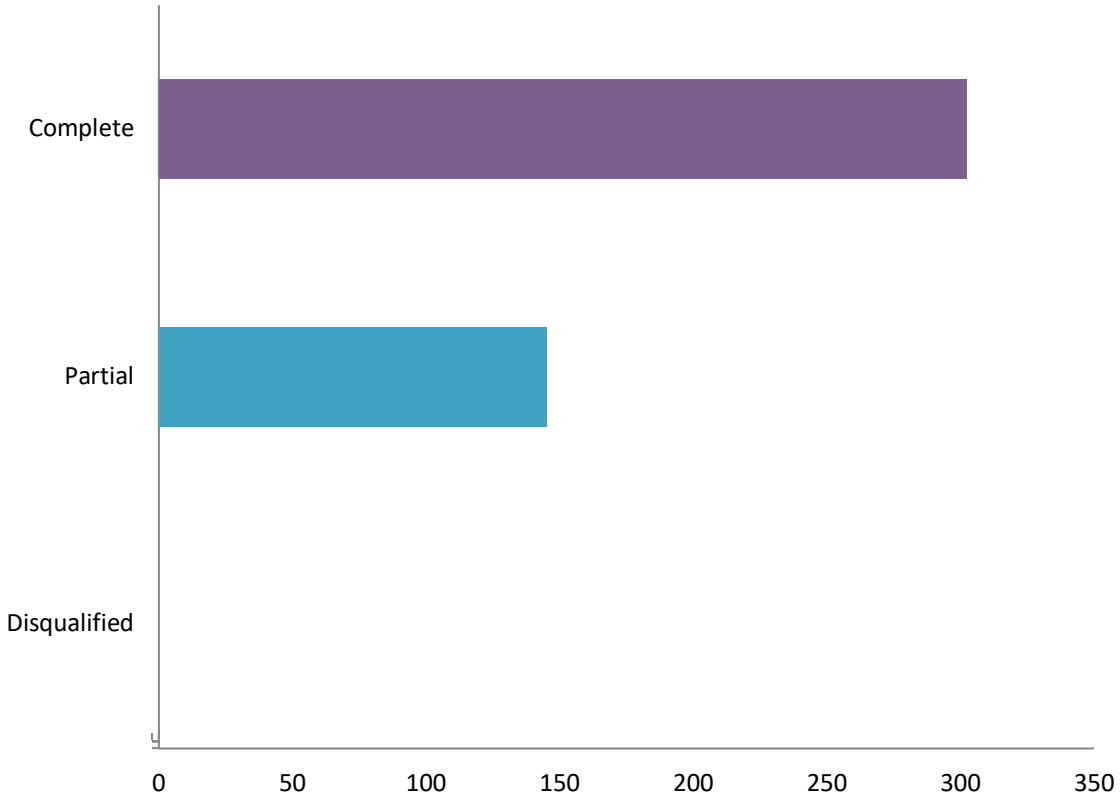
9. Are you a veteran of the United States military?
   - ☐ Yes
   - ☐ No
   - ☐ Prefer not to answer

10. Please indicate your disability status:
    - ☐ Difficulty seeing
    - ☐ Difficulty hearing, or having speech understood
    - ☐ Mental (i.e., learning disability, developmental disability, dementia)
    - ☐ Physical/mobility domain
    - ☐ Chronic health condition
    - ☐ Other disability
    - ☐ No disability
    - ☐ Prefer not to answer

11. Which zip code do you live in?
    _____

Appendix 11. Open Text Survey Responses from the Sonoma County MHSA Capacity Assessment Survey

Response Statistics



	Count	Percent
Complete	302	67.6
Partial	145	32.4
Disqualified	0	0
Totals	447	

What is your connection to Behavioral Health Services?

Other (open text responses):
private practice
AODS
Acute Hospital Care Coordination
Behavioral health advocate
Catholic Charities
Colleague at SRJC
Community Based Organization
Consumer, Family Member, Community Member and Peer Provider
Consumer; Family Member; Peer Support Specialist
private practice
Contract with BH and subcontract for services, no direct services provided through our agency
County staff with autism, that previously worked in Private disabled care homes.
Homeless Service Agency
I'm in 2 categories, a parent of a consumer of SCBH services, peer provider
Labor Rep for BHD members
Medical street outreach team
private practice
Peer support in a drop in peer run self-advocacy center
Peer support specialist
SUD Provider

School employee, school health
Senior Peer Counselor Volunteer
Substance Abuse
consultant
county staff, family member of son,Detox employee
non profit organization
peer suport person
school
student
volunteer
volunteer with SAY

What do you like best about your loved one's mental health services?

Other (open text responses):
Didn't like having personal items taken away after being 51/50ed- so that in itself is a desire to not have to repeat
I would like to check off several of these. They are ALL very important. FACT has given my son his life back, out of jail, dealing with addiction, basic needs met, etc.
It's a terrible, understaffed system
My loved one has better relationships with family, friends, children, and others My loved one is engaged in meaningful/productive activities including a job, school or volunteer work // My loved one has better relationships with family, friends, children, and others My loved one is engaged in meaningful/productive activities including a job, school or volunteer work
My loved one is a minor.. The only good thing is My loved one has a great local psychiatrist.
We are still working on getting services established
We have lived thru a nightmare with the services here in Sonoma County. One is better off homeless to get the full care needed. I don't get it.
have kept loved one on an even keel
my loved one is now spirally down mentally
nothing "liked best"
• My loved one has better relationships with family, friends, children, and others • My loved one is connected to assistance for my basic needs (e.g., income, housing, food) • My loved one is less likely to need acute services for risk of harm to self or others • My loved one can better manage substance use problems • My loved one can better take care of daily needs (e.g., clothing, bathing, eating, etc.)

What is the most challenging part of your loved one's mental health services?

Other (open text responses):
Cost of services
Lack of appropriate housing options.
Lack of hospital beds in proximity to Sonoma County
Managing
My loved one has to wait a long time to get an appointment // My loved one feels uncomfortable seeking mental health services
My loved one is a minor. Most challenging is finding a peer support group therapy for adolescents with private heath insurance (NOT KAISER) - very difficult to find a therapist who accepts private insurance (NOT KAISER). I hear lots of talk but don't see many options.
My loved one killed himself because the cops wouldn't take him to the CSU
No complaints. A nurse comes to my sons house to give the injection that lasts 3 months.
Previously, just getting him in a helpful situation, getting the service he needed, was a challenge.
Providers do not discuss treatment options with me
Services take a long time to be offered and when they do its always limited by money not by the actual benefit of the individual
This survey isn't helpful.I can't pick more than one item! Family not contacted after two weeks at Aurora, family member had no idea what was going on
has had to go out of county for needed services
is not covered by insurance and makes too much to be on medical
poor diagnostic and therapeutic skills

How true are the following statements about your loved one's experience in getting access to mental health services? - comments

Response:
Inadequate hospitals in Sonoma County who know how to deal with Behavioral Health concerns.
My answer pertains to her psychiatrist only - which is covered by private insurance (not kaiser)
My son has been in the FACT program for 3.5 years, his services are centrally located to the Buckalew housing where he lives. This program and housing has saved his life.
could not find a doctor who would take on new clients. When he did they were not very involved in his recovery
He does not believe he needs and help
When my Loved one is in a downward spiral they do not think to call their metal health provider. I take time off work to drive them to a crisis appointment. Then it takes weeks to be seen again because the system is so backed up. By the time the next appointment comes around my loved one does not want to go.
Services are difficult to arrange, difficult to get family member to cooperate with, and are largely ineffective.
After being hospitalized, my son gets help in Guerneville and knows who to call for any questions.
He knows that he got help at CSU His case worker was very helpful in making sure he got appointments when needed
It takes months to be seen and they don't have the right dosage for refills.
my loved one does not understand who does what so he ties to get services and quits when it becomes difficult, which is often as folks who manage the services have differing messages depending upon who is answering the question
We cannot find a psychiatrist who can take him and no counselors were available when he was in crisis. Went to horrible facility off Sebastopol road to wait for a bed and was taken to Saint Helena facility which is now closed.

Previously he knew some of the places to call, but it was very challenging to wait or to be told he wasn't in a 51/50 situation so he didn't qualify for help.
My daughter had to wait almost a year to receive outpatient treatment. Once there she did amazingly well but the support that she was supposed to get upon release has really been lacking and it's almost been a month since she was released.

How true are the following statements about your loved one's experience receiving mental health services? - comments

Response:
Inadequate
Pertains to her psychiatrist only
He does share with his family. Due to HIPPA we are not in the loop
I have sat in appointments with my loved one and I felt rushed and I was not the one in crisis.
Available mental health professionals have only seen my family member at infrequent times, without good support or follow-up.
My son finally got on a med that works. He doesnt mind seeing his psychiatrist Dr. Erlich.
His experience was positive so he has some confidence that it is helpful
there has been several times when my loved one reached out about his bipolar to his provider without any referral or further discussion about next steps for treatment
Group sessions are not helpful. One session does not make a dent.
My son finally got the help he needed only after being incarcerated. I had always hoped this wouldn't be the way but in the end it was.
Also explains mental health good fortune.
When we actually receive the services they are pretty good but the issue is the large delay in actually getting the services.

How true are the following statements about your loved one's experiences with mental health providers? - comments

Response:
When client is not honest it's hard to know what is fact or fiction.
My family member speaks English. Language is not a barrier.
While in jail for "being mentally ill" my sons treatment was inhumane, but after several periods in jail he finally got a team of people who help him and respect him. My son is an adult and shares a little bit of info. While in jail however, we were not included and were excluded from everything that was happening
He didn't give us any reason to think he wasn't treated with dignity He signed release papers for us to communicate with caregivers which was extremely helpful.
he's Caucasian so he is lucky that way, the mental health services folks are great but the system is so understaffed that it just doesn't work
The FACT program has been excellent for my son. It has turned his life around. I can't thank them enough.
My loved one is included. Appropriate but I'd like to be more included in big changes like housing changes. Not my decision but informed.

How true are the following statements about your loved one's satisfaction with mental health services and providers? - comments

Response:
Private hospital because client had good insurance provided best results.
Like I said, he's dead now. It wb nice if the avail;able services were better funded. I know the County is TRYING to do the right thing, there just isn't enough money to go around.
From her psychiatrist services only.
Available services are only provided at infrequent intervals. (Once or twice a month)
My son is now kind, calm and responsible.
He has been able to remain stable for over a year now
We have struggled tremendously in getting my daughter the services she needs. We were told nothing was available and it wasn't until I took legal action over a period of almost a year that slowly finally services were provided.

What do you like best about your mental health services?

Other (open text responses):
All of the above
All of the above and support with medications
All of the response options
• I have better relationships with family, friends, children, and others • I am engaged in meaningful/productive activities including a job, school or volunteer work • I am connected to assistance for my basic needs (e.g., income, housing, food) • I am less likely to need acute services for risk of harm to self or others • I can better manage substance use problems • I can better take care of daily needs (e.g., clothing, bathing, eating, etc.)
All of the above; Good program is helping me a lot
I am connected to assistance for my basic needs (e.g., income, housing, food); I can resolve existing legal problems and stay out of the legal system; I am less likely to need acute services for risk of harm to self or others; I can better manage substance use problems; I can better take care of daily needs (e.g., clothing, bathing, eating, etc.)
I am engaged in meaningful/productive activities including a job, school or volunteer work; I can better take care of daily needs (e.g., clothing, bathing, eating, etc.)
I feel uncomfortable seeking mental health services; I am connected to assistance for my basic needs (e.g., income, housing, food); I am less likely to need acute services for risk of harm to self or others
I have better relationships with family, friends, children and others. I can better manage substance use problems. I can better take care of daily needs (e.g., clothing, bathing, eating, etc.)
I have better relationships with family, friends, children, and others // I am engaged in meaningful/productive activities including a job, school or volunteer work // I am less likely to need acute services for risk of harm to self or others // I can better manage substance use problems // I'm able to get my medication and see a psychiatrist
I have better relationships with family, friends, children, and others; I am engaged in meaningful/productive activities including a job, school or volunteer work; I am connected to assistance

for my basic needs (e.g., income, housing, food); I am less likely to need acute services for risk of harm to self or others
I have better relationships with family, friends, children, and others; I am engaged in meaningful/productive activities including a job, school or volunteer work; I am engaged in meaningful/productive activities including a job, school or volunteer work
I have better relationships with family, friends, children, and others; m connected to assistance for my basic needs (e.g., income, housing, food)
Options 1-5
Peer support
• I am connected to assistance for my basic needs (e.g., income, housing, food) •I can resolve existing legal problems and stay out of the legal system • I can better manage substance use problems • I can better take care of daily needs (e.g., clothing, bathing, eating, etc.)

What is the most challenging part of your mental health services?

Other (open text responses):
I don't know where to go for services or the location of services is not convenient; I feel uncomfortable seeking mental health services
I don't know where to go for services or the location of services is not convenient. I have to wait a long time to get an appointment. I feel that services lack cultural responsiveness or appropriateness.
I don't know where to go for services or the location of services is not convenient; I have to wait a long time to get an appointment; Providers do not discuss treatment options with me; I feel that services lack cultural responsiveness or appropriateness
I don't know where to go for services or the location of services is not convenient; Providers do not discuss treatment options with me; I feel uncomfortable seeking mental health services
I don't like transferring to a new case manager or doctor with no notice
I feel that services lack cultural responsiveness or appropriateness - pathologizing and diagnosing is required and this is misguided and harmful. This thinking even contaminates and undermines Peer Support and erodes self esteem
I feel uncomfortable seeking mental health services; Do not feel listened to
I have a problem with one of my medications
I have to wait a long time to get an appointment; Medication related
I'm in recovery I'm doing well
None of the above
Not applicable
Providers do not discuss treatment options with me // I feel uncomfortable seeking mental health services // I feel that services lack cultural responsiveness or appropriateness
Waiting times
lack of enough psychiatrists that are in-person, not telemedicine

providers are numerous, their skill level varies greatly
• I don't know where to go for services or the location of services is not convenient • I have to wait a long time to get an appointment • Providers do not discuss treatment options with me • Medication does not work for me // Places not safe // TAR not submitted in a timely manner so I did not get the meds I needed
• I don't know where to go for services or the location of services is not convenient • I have to wait a long time to get an appointment • Providers do not discuss treatment options with me • Medication does not work for me •I feel that services lack cultural responsiveness or appropriateness

How true are the following statements about your experience in getting access to mental health services? - comments

Response:
All services not avalable at some sites. Information on services need triage by provider at times to refer. Specialzed needs may be unmet. More providers and groups needed.
The services help me stay out of crisis, but I am still in a great emotional pain affecting my quality of life in a very negative way. I am not sure how to get more help. Maybe more help isn't available?
The only Mental Health Hospital is Aurora in Santa Rosa. This Hospital does absolutely nothing for treatment. The staff is rude and threatening including the Psychologists. They only hold you there so they can collect on your medical insurance. So no treatment at all is better than going to that fraudulent "Mental Heath Hospital". It is NOT a safe place.
I don't have a counselor and need one, tried to get one in the past but they wouldn't see me because of my severe diagnosis.
have to wait a long time in access team to see a psychiatrists even though I have been hospitalized twice in 2 months; in past, not sure why county behavorial health keeps graduating me out while friends of mine have been clients for 23 years
Able to locate crisis services/OP services. However communication with case manager for some issues are confusing
I know where to go for help but it is a hard decision to make
I am uncertain on how I can receive mental health help. Like how to get help for depression.
I come here or the Novato Community Center. I ask people in the area.
Once connected by referral by my primary care doctor, my therapist has been very helpful in describing available services.
It is true
Wait long time to see doctor
Appropriate mental health service would be peer-run, non-pathologizing, and voluntary. "Open dialogue" would be practiced instead of the deluded disease model

If I need to see a psychologist I haven't asked my psychiatrist who I would see
Interlink rocks!

How true are the following statements about your experience receiving mental health services? - comments

Response:
More providers needed, hard to get appointments on consistant weekly basis for individual work.
My personal Psychologist goes above and beyond regarding my Mental Health. The alleged Health Service Providers do not exist. Certainly not in the aforementioned Aurora Medical Insurance Fraud Hospital.
would like to see more services to improve quality of life ---- like supported employment or going to SRJC; more recovery focused and empowerment
Dig improvement w/ OP services but am often rushed or judged
I do not know how to get better with pills. I feel supported and I think I will get better.
When I get help it's the best service ever.
I receive a visual satisfaction from functioning here but I need more
Transport can be scary
But this is because they include things like bodywork, acupuncture, and a therapist outside of Sonoma County Behavioral Health.
My needs do not perfectly match services which I have so far tried.
I believe the program works very well. I need to continue working on recovery
Peer-hosted service (Wellness Center) is ok but somewhat compromised because of the hierarchical management structure and medical model system it functions within
Services with the psychiatrist during the last five years is better than the prior five years when I was seeing a different psychiatrist
Wellness and Advocacy and Interlink are great
Some mental health experiences were harmful and/or abusive

How true are the following statements about your experiences with mental health providers? - comments

Response:
There are no legitimate Mental Health Services in this area.
Very supportive yet resistant to client life improvements
My doctors respect me they said why to take medication.
Everything is explained perfectly
Fear of bus transport
Outside of SCBH, yes.
I'm an English speaker.
I am always respected here at PPIC
Very focused team approach to the problem
Their work ethics could be a little better

How true are the following statements about your satisfaction with mental health services and providers? - comments

Response:
Satisfied with my own Psychologist ONLY! There are no Mental Health Services in the Sonoma County Area. The Wellness & Advocacy Center in Santa Rosa specializes in working more with the Homeless, not Mental Health Patients.
again more psychiatrist are needed; also when I was at CSU the staff were not very helpful; at night time they were on their computers or socializing w/ each other; I have complained many times about this; they are paid a lot of money and they do not work very much at night
Need professional services. Must lean better advocacy for services.
I cannot talk to my mental health provider when I have a panic attack
Everything is wonderful here
allowing my anxiety to go
I think there should be more centers like this in other communities
Except for CSU, which was NOT helpful.
The services that I have received so far have been helpful.
I need to keep coming back for recovery
I have been hammered more than helped by crisis intervention teams and psychiatry, even "therapy." We need peer led, peer run alternatives at all levels of care including crisis intervention as well as education about what works and what doesn.t
Peer

How true are the following statements about the services that your organization or program provides? - comments

Response:
We are only able to provide services to consumers while they are incarcerated and cannot provide any aftercare or transitional services
While leadership and staff focus on the belief that our clients can get better, a few key providers of services still have not subscribed to a recovery-oriented approach.
We provide treatment in a home setting that offers support for our client's and allows them to be stable with their conditions.
The staff and volunteers in our Peer programs and crisis program work hard at providing a variety of opportunities for community members to work on their own Mental Health.
We work on prevention of MH needs for young children.
Some services / activities required are not needed for some clients. Tendency to one size fits all approach
My agency maintains that no youth should be rejected from our services for the behaviors they were referred for thus, we are always holding hope for more positive outcomes.
I work with probationer's
We provide 1:1, group, psychiatry, and consultation services to the community - many of whom would otherwise have no access to therapy or support
The Wellness and Advocacy Center is place for education and understanding which works well for all that utilize it's opportunities
Peer to Peer Services are all inclusive in our setting at Wellness and Advocacy
We strive to provide our clients with skills that will help them recover long after they graduate our programs.
Our most at risk Clients are often the ones to drop out of services.
Our program uses the principles of social rehabilitation to provide a recovery environment that meets each person where they're at.

Peer counseling via family service agency Has been a huge success in helping Behavioral cases thru 1:1 counseling Weekly for 12 was AND it is free. We handle most clients. Vicki & Melissa (our excellent supervisors Help in selection and case review. Our + results have been consistent and We have helped our clients lead more With purpose or just be with them and Give compassion.
The Services we provide encourage clients to set and reach goals while they learn Independent Living Skills, Coping Skills, Social Skills, and Medication Management. We believe all clients can continue to learn and grow throughout life.
An increase in inappropriate referrals and a push from the county to move people out of programs before they are ready both contribute to difficulties preventing recidivism.
Our population is chronic adults. We see improvements, but they are mostly small. Most beneficial is helping them find the level of care they need moving forward.
We offer a huge array of tools for cl to learn to be more self-sufficient, clean and sober and build on pro-sicla skils
We are a positive team, looking out to empower the clients in their recovery.
Services are time-limited (12 wks). Useful to clts. as we provide practical and clt. focused support. Some clt. lack any motivation to change, but most do and follow through on goals they make.
Staff varies in their belief that our clients can get better.
I educate an audience of one residential treatment facility each month, and also run a sole proprietorship that pays owner, me, nothing in providing de-stigma, hope for clients to get better, and for intellectual and private property concerns advocacy.
The nature of short-term brief therapy means that clients need to be referred for longer-term therapy.
Our program gives imported support and information to help clients solve their issues
LPS Conservatorship provides the safety for the individual with the treatment needs under the Superior Court .
Our focus is in on helping to reduce mental health stigma and assisting those who need resources obtain them and keep them until they are satisfied.

We provide crisis stabilization for clients when they are unable to maintain in the outpatient continuum. what we need is more group services and contact with case managers who have too heavy caseloads and cannot attend to high need/often acute clients.
We provide timely psychotherapy and are services are covered by most insurance companies
I run an education presentation at a Crisis Clinic one time a month, and do de-stigma and treatment presentations as needed the rest of the months.
Medication stabilization Teaching coping skills Discharge planning Connecting patients to referral sources
We are a FQHC, providing integrated medical and BH. We are able to effectively manage mild to moderate care of patients, but not SPMI. We have no other sufficient psychiatric support in our area (and SCBH is very limited in what they are providing)
Some patients have progressive neurodegenerative conditions, so focus on maintenance of independence and qol
God's Grace is a behavioral base program. We provide an excellent care to our clients who are psychologically, physically challenged.
Our organization provides peer/recovery-based, trauma-informed advocacy & system navigation. All employees are peers.
we feel that that program participants, for the most part, can learn how to manage their symptoms and make use of available resources
Our service is crisis stabilization. Our influence is short term only. We have minimal influence in long term care.
We tailor our services to assist clients with their immediate needs.
In connection with our training, our agency prepares us to best meet our client's where they are and support them to the best of our ability.
this has been observed by me since I have been employed here since 2004
Client engagement long-term is challenging due to extenuating life circumstances and social-emotional stressors

The agency that I work for strongly beliefs in the abilities of the people, youth, and families that we work to support.
Our center is peer run and peer driven so we give services that our peers need. We do regular focus groups to ensure we are keeping current with peer needs. At the center we emphasize the fact that recovery is possible.
diverse clientele w/several over utilizers that would benefit from long acting injectable / mandated medication compliance / drug rehab programing.
My program does not itself provide services, but connects clients to a wide array of services in Sonoma County Behavioral Health, as well as providing immediate needs support.
Services focus too much on crisis and not enough on prevention/skills
The lack of an overall strategy to deal with $ shortfalls, understaffing. Misalignment of resources/mission.
Effective to address emergency situations but not very effective for people who are fragile though not 5150 criteria.
SCBH does not have enough staff or contracts with enough community based organizations to provide comprehensive services to meet the needs of all our beneficiaries.
program is tied in with probation requirement, therefore there is some incentive to participate
MH appts for foster children get backlogged. More transportation availability is needed at VMCC.
We allow the opportunity for clients to move from locked settings back to the community. With licensed board and care and co-located specialty mh clinic. It all works well to support the highest needs with the highest supports.
My group does not provide services, but connects clients to services. My group believes that the services to which we connect clients will help those clients get better.
Our organization provides a number of services depending on the needs of our clients, and providers are well informed about additional resources available, as needed.

How true are the following statements about the resources available to your organization or program? - comments

Response:
It has been challenging to retain staff with the pay scale we have available through our contracts.
We have over 50% bilingual/bi-cultural staff. We have some staff that speak French as well.
Staffing cuts have impacted the ability of the program to meet needs in the most effective, sensitive, and beneficial way possible.
housing for families needs to be addressed, as well as services for staff to become bilingual.
There is only one place to send male clients for SUDS Turning Point, It is overcrowded and understaffed. Often there is drug use there that goes on all too often. We need another choice for residential treatment.
I would like to be able to use my time at work to learn more about the different cultures Develop ways with the cultures to educate and understand different peoples needs.
We need to be able to take time during our daily schedule to focus on learning foreign languages and sign language.
We do all we can to ensure that the resources we offer to our clients are ones that our clients need.
We can always benefit from more time, more funding, and more diverse and bilingual staffing
We are not able to provide our staff with a competitive salary which makes it hard to find and retain good staff
While we have never reached a point where clients needs have not been met, there are many additional activities and services that I would love to provide if/when we have the additional staff to make it possible.
Budgetary restrictions restrict the ability to provide a competitive wage, especially for bilingual workers.
We are unable to recruit/maintain staff. We do not have enough staff to do the individual work our clients need regularly.
We are assisting with the intentions of meeting cls where they are and helping them in building on strengths; staffing can be difficult; the persons are not looking to work in this field.

Paperwork available in Spanish, but I truly believe that there needs to be a better system then just interpreters by phone if needed. In person available interpreters are always a better way for everyone to be on the same page
Considerable turnover due cost of living in this area. Could always use more time, but have to keep limit of 12 visits in mind.
needs improvement
Our office is the legal component for MI in the community. Our office works collaboratively with SC BH.
our focus is around the latino community, where we can meet the language needs for our clients. we also focus on retention for our staff.
We have no or very little ability to provide Therapy because of no funding/contract set up with the County
We are a FQHC, providing integrated medical and BH. We are able to effectively manage mild to moderate care of patients, but not SPMI. We have no other sufficient psychiatric support in our area (and SCBH is very limited in what they are providing). We are severely understaffed in BH to meet the needs of high level of care patients
We lose staff constantly and we are never fully staffed because we cannon retain staff.
We often need to get interpreters, but this doesn't help with a long term stay.
We have access to interpreters and currently 1 staff member available for spanish speaking only evaluations
Our staff who has been in our program for 10-15 years are trained to deal in a very difficult situations. We have educational program every year to prepare them in a difficult and challenging behaviors.
We do not yet have bi-lingual employees, so we utilize interpreters to serve our bi-lingual clients. This adds an element of complication to providing services that we intend to solve in the future with linguistically/culturally diverse employees. Our peer-run organization is in development.
In the context of providing short term stabilization services. Language is an issue, especially Spanish. Need more clinicians with the ability to speak Spanish. We use interpretation services when needed.
Staff are asking for transfer and not enough staff for client's needs
More bilingual therapist needed

Budget cuts make point number 1 challenging
Hiring seems to be a consistent barrier because of the expansion and needs of our referring partners. We work to support this need and continue to make strides to better meet our clients.
same as above
Our center has had a little difficulty staying fully staffed.
We could be better at having outside resources to refer more clients to
Depends on shift re: language issues. Services often straddle legal / mental health / substance use issues + homelessness. So many crossroads and not enough services to serve any one appropriately.
There is significantly more need than our staff can accommodate.
Understaffed
more suitable and affordable housing
First a note of my involvement. Psychiatrist in outpatient dual diagnosis (drugs/major mental illness. I retired in 2018. Staffing was always a problem. Slow process, bureaucratic. More doctors staffing week below an optimum.
There is adequate time to make a competent decision as to imminent danger but little to no time for assisting in stabilization.
Residential staff is tough to recruit in Santa Clara County and Monterey County. Competing with Soledad Prison and in SC County every one!
I do not personally provide services. We are currently a bit short staff, but hope to resolve that in the coming weeks.

How true are the following statements about your organization's or program's communication with clients and other agencies? - comments

Response:
County often under or not represented at events. The County's representation and management of the budget crisis deteriorated clients' abilities to meet their needs and their ability to trust any one or any thing, particularly the County
The 4 programs we have that are MHSA funded have been threatened to have severe budget cuts or complete elimination for the past 2 years. This is extremely stressful for the members utilizing services, and also the staff. Staff have quit and found other, more stable jobs because of this reason.
We are often not able to connect our clients into County services when needed.
Client impairment at times impacts their ability to meaningfully take part in their treatment planning, i.e. active relapse that client(s) do not want to address.
It is mostly true and not very true due to lack of resources.
Outpatient treatment is good with CHD. Residential treatment is completely sub-par.
I don't need too.
I'm hoping with more outreach from resources in the community we can get funding continually to fill the drastic need for peer services.
We strive to give our clients as much decision as possible in their treatment.
Sometimes, our biggest obstacle is the system itself. It is very disconnected and often staffed with burned-out or under-trained folks.
There has been a lot of turnaround within SCBH making it difficult to coordinate care as needed.
There is an occasional lapse in communication between department heads and primary service coordinators, which can result in PSCs not getting vital info about their clients, and our program not receiving timely responses to issues that arise.
Work closely with county case-managers. Communication is a mixed bag.

There is always room for improvement for all providers to work better as a bigger team. Medical vs mental health still needs more work on working towards whole person care
HIPPAA precludes family involvement for mentally ill
Always work with clts. goal. Families are often not available. Quite often link clt. to other county services.
I work three agencies in Sonoma County mental health as a peer provider. I never landed the RFP contract that I designed(3 of them) for client based services upon my source perspective design of Prop 63 AS genesis designer of the Mental health Services Act.
SCBH has had a difficult time over the past few years with the case management .
Therapy is a big piece that is missing
I would like to see better continuum of care with the FQHC's directly from CSU
Arranging appointments and transportation to services outside of Cloverdale is difficult for the MH population. The patients are not capable of following through with SCMH Access referrals many times over the phone. Therefore they are dropped before getting their needs addressed
Receive positive feedback and ongoing referrals
It is our Program's goal to make sure all clients needs are met. They are given a freedom to make choices in life. We want to make sure they Thrive.
Great services are based on trusting relationships in all contexts: between providers and clients; between provider colleagues with and on behalf of shared clients. Consistent time and care invested in relationships yields high quality services.
Again, there are limitations r/t our function as a short term crisis stabilization service.
Just one nurse working for a program of 218 clients with about 45 injections monthly, no possibilities for overtime and no extra nurse hired.
SCBH has had multiple challenges with staffing which has created many problems for clients and staff. No one knows who to access for assistance, clients are not notified of changes, and many have ended up without meds or services that are vital for their well being. There is often a lack of communication with providers about what a client needs or how best to assist a client and collaboration is seldom offered by SCBH.

I feel confident in my organization's ability to equip us to meet the needs of our clients. We do work well with partners and more effort can be put on interfacing more with direct care staff.
same as above
County engagement is lacking and not prioritized. County engagement is not responsive, engaging, and doesn't provide opportunities for our clients to succeed.
I don't think the County values the peer run self-help movement.
Every county program is impacted and unable to keep up with demand. This will only increase, as more and more become homeless, or cannot access healthcare or substance use disorder services.
My perception is that clients' lives are improved by contact with our program staff.
Need more shelter and affordable housing These are two services we offer and we don't have enough or any at all
As an out-of-county provider we heavily rely on the intensive case managers to support linkages back to Sonoma County services. Including locating closer to home housing options.
All my group does is connect clients and their families to other services, both with County and other providers. These services generally meet the needs of our clients.

How true are the following statements about your satisfaction with mental health services from your organization or program and in Sonoma County? - comments

Response:
The constant concern of potential funding cuts on mine and other programs has resulted in a less satisfactory working environment
The uncertainty of funding, that would close programs creates a challenging work environment for all.
Needed: Expanded Mobile Crisis Team for outlying areas; Early Psychosis & SMI Programs for TAY; Co-Occurring Disorder Treatment Services; Drug Medi-Cal
A learning curve has been created by staff reductions. Learning to provide amended services with less support.
It is mostly true and not very true due to lack of resources.
Non-profits should learn to work together to possibly form a network of good communication. The focus should be more related to the greater need for understanding within this wealthy community.
Sonoma county does it's best to meet the needs of all the community members but struggles due to overwhelming demands.
Sonoma County is not meeting the needs of our clients.
We need more services in Sonoma County, specifically tied to housing needs.
There is a massive population that is consistently neglected when it comes to mental health services in Sonoma County. Housing is extremely limited, and many clients are not provided the care that is needed to maintain stability in the community unless they are conserved. The Crisis Stabilization unit is underfunded and has too few beds for the population of the county, and the Case Managers appear stretched too thin between clients- which allows people to slip through the cracks. The organization I work for does everything they can with the support of County Case Managers to insure clients receive the best care possible, but I feel like much more is needed for the clients who are not able to make it into the extremely limited number of program beds in the county.
I feel that the bare bones are there, but we have an increase in mental health population that requires a matching increase in programs to meet the needs of the community.

There are not enough service for mental health clients. Mostly long-term supportive housing. The management company I work for spends most of it's time trying to stay open instead of serving the clients. They want to expand the services the offer instead of effectively utilizing the resources they have.

There are not enough funds allocated or staff positions or salary reviews. No facilities to put people who need services,

I believe Sonoma County has not enough mental health services necessary to meet the community's needs.

I need pay, the income and credit needs to reach the mental health services act designer and Gregg Jann was the source of this legislation.

It is my hope for the SCBH restructure provides for the needs of the community. It is my understanding that we are loosing beds in our CSU which not positive momentum.

Sonoma County needs to develop mental heath services such as groups, individual TX INSIDE the county not through outside agencies. The county cannot afford those services supposedly and what ends up happening is there is a lack of solid preventative care because it's deemed too expensive. Crisis services are more expensive as are hospitalizations because we don't have accessible drug/alcohol treatment to meet the need of the meth tox'd community who are often back in CSU chronically.

My own part time work at an affiliated partner is for source perspective design of taxes, treatment, and tips as the main advocate and creator of the funding mechanism of the tax act for welfare codes of the Prop 63 Mental Health Services Ace of CA Fall 2004. I deserve my money paid in full as I have tried for Credit and Income from the Mental Health Directors, and State Senators and Legislators in person, and in letters to legislators, and on my sole proprietors advocacy content of Patient Rights and Recognition of Business Rights and Civil Rights proponent.

The medical and BH staff are doing their best to address the needs of the SPMI patients at this clinic. We do not have sufficient psychiatric services from Partnership plans or from county services in this area. We address and then refer many MH crisis situations that then do not receive ongoing services. Access referral are not being completed into care, likely due to patient's inability to follow through with the requirements.

We like our office space

It is important to our organization to support the needs of our client. We have house Psychiatrist and Primary doctors who are on board in helping our clients with health and Psychological needs.

Mental health services in Sonoma County have been decimated over the last two years of budget crisis. The impact to the most vulnerable peer/clients (aka "consumers") has been immense and devastating, particularly among thousands of mental health-impacted people in the homeless population. The safety net has been basically looted in ways that are short-sighted and very endangering to a huge number of people in our community. :-(
I believe that all of county mental health services are under-funded and under-staffed.
Overwhelmed with work and micro management
While we are currently busy with the hiring process, my organization is working to help meet this need with intention. I feel that the county is on track to meet the mental health needs of the community.
There are many services that our county doesn't provide including transportation for youth and families. We need more bilingual providers in each field. I also feel that families need respite options to support placement and mental health.
more need in areas of cultural sensitivity and spirituality. important to native people
My experience has been that connecting to services through our Access line can be challenging for Spanish speaking families.
The County needs to spend more money to facilitate the growing number of peers in Sonoma County.
More requirements without appropriate supervision/oversight to implement them. County appears to be playing whack-a-mole with issues re: funding streams, staffing, etc.
Sonoma County offers a good array of mental health services, but not in sufficient quantity to meet the community's needs. There are many more people who need services than County staff available to help them. But Sonoma County definitely helps those people whom it is able to serve.
More services providing medi-cal beds for drug and alcohol. More services to offer homeless. More medical supported therapy
Not applicable to me right now
Relationships amongst staff and immediate supervisor is good but the overall environment is quite stressful and despairing as the resources available to our clients in particular ongoing therapy options, residential drug treatment and housing is quite limited.

Staff have too many clients on their case loads to be very effective in meeting client treatment goals and needs.
Runaways and substance use by foster youth at VMCC are a concern. Also more placement opportunities are needed in a more timely way.
There are always exceptions to my group and the County's ability to help everyone. I am not a regular County employee, so do not derive as much benefit from my job as others in my working environment.

How true are the following statements about your satisfaction with mental health services from your organization or program and in Sonoma County? - comments

Response:
My organization is resourceful in connecting patients to the services they need, and we are able to get people connected to some of those services, so long as they're not required to go through the County system to get there. There is also a large gap in being able to provide a fully robust, integrated service to patients across the spectrum of severity. There is virtually 0% access for MediCal beneficiaries seeking IOP or PHP programming.
It's a little bit true because I've seen the same People with SEVERE mental illness using/abusing the system for decades and there's is little to no improvement in these people's mental health.
We have a very high rate of success helping our clients
The County direct services is in need of reorg to assist with delivery of MH services since this population is the moderate to severe. The significance is the County has training budget to train staff to work with severe mentally ill as opposed to most CSO
I find the Wellness and Advocacy Center very important and healing as I come here five days a week. Case management is just next door and doctors offices near. I have my PhD in sociology and studied with the Army and Coast Guard. I find friendship that have been encouraging sine they opened in 2007. There are a variety of activities and people understand me here and are very special.
Latinx and older adults are underserved. Not bilingual(Spanish)/bicultural clinicians. Not enough private clinicians a who accept MediCal
Feels like a growing need for mental health services (for mild/moderate as well as severe mental health challenges/illness), while the capacity to serve individuals experiencing mental health challenges/illness (especially severe/acute mental illness) continues to decline.
Mental health services is not available to adult and elderly population.
the largely unfair burden of dealing with impaired members of the community on the county campus has fallen to our department - homeless, addicted, mentally ill. We have no budget for "security" and are told by leadership (BOS et al) to "get these people off of the property". Our very limited staff do what they can to connect the people in need via 2-1-1, but it takes hours, and no one from human services has ever made any attempt to work with us on this issue.

The mental health facilities in Sonoma County are not adequate to meet the client load they receive. This is creating "frequent flyers" that are 51/5250'd at CSU, obtain brief aftercare, and then drop through the cracks because case managers and transitional facilities are overloaded. These clients then stop taking their meds, are taken back to CSU, and the whole cycle starts again.
Not enough Infant Mental Health professionals or staff that is well trained to serve severe MH issues with 0-5 age group. Accessibility to MH is a long process and some families need services immediately. The shortness of services or not enough ex: 1x every 2 weeks instead of weekly visits or the services are cut short- 6 months instead of a year or longer. Not enough psycho-dynamic - long term services that are needed.
There has been some confusion and lack of access for the families I work with lately since funding was cut and providers changed in the 0-5 age range.
As peer volunteers we are referred to clients who need therapy.
Takes long time for processing service request for my clients
I see people falling through the cracks every day, especially if they do not want to engage in services but no longer have the capacity to understand the consequences of their decision to refuse services.
the most severely ill clients need services that are unavailable to them. more ACT program slots and the ACT program needs to be beefed up since they no longer have a psychiatrist that goes out into the field to see clients who won't come in. This results in clients not receiveing medications they need to remain stable and stay out of the IMD/conservatorship. Also, we need more supervised housing situations. I believe that, with the right supervised housing (with MED management on site), many of the clients living in board and care could now be living in their own or shared apartments. I have seen this occur in other counties in California.
Generally we refer our 18-22 year old special needs students to the North Bay Regional Center.
Schools have fewer and fewer resources as a direct result of fewer funds available for services.
While my classroom has many resources (SEL curriculum, mindful practices, & classroom counselor) to help TK-2 graders with mental health issues, we are not equipped to help the families (which are often the cause of the issues in my students)
It is my experience that it takes a full court response to advocate on behalf of students we serve with mental health needs to research resources, make calls, and communicate the urgency of need. Most

recently a young, homeless, adult, special education student, with an intellectual disability and a recent diagnosis of psychosis was released from multiple hospitals to his own devices with newly prescribed medication. He came back to school and didn't feel well because he did not understand his meds and took too much. A fews days later he was suicidal again and re-hospitalized. Aurora was going to release him to the streets with all his meds. It took a coordinated effort of School professionals to track down the right people to advocate for the student and he was moved to housing with mental health support. Without us dropping everything we were doing to address this concern, he would be on the streets. Services are too difficult to understand and access.
We need inpatient and residential services
I work with young mothers who experience mild to moderate depression and anxiety, sometimes related to PMD, but often a condition developed due to their own childhood trauma and exacerbated by becoming a new mother. The number of culturally competent resources available do not meet the need, and both the women and their babies suffer for it.
IO put mostly true due to time, monetary and other outside limits
Most of my students are young & non verbal. Parents are expected to follow through with services. If parents don't, teachers are limited in where to get help for non verbal students.
Difficult to get open communication with Mental Health services and how the school can support family and children as they access care.
Not enough resources for the agencies to help the mental ill population.
More resources are needed within many of the medical insurance providers in Sonoma County
I am confident in my agency's ability to meet youth and families' mental health needs, however based on experience there are other agencies that don't always collaborate well with my agency
It is difficult to identify and direct students to the correct service people. Seems most are told to call another number for information.
Psychiatrist shortage, substance abuse residential care shortages.
Sonoma County does not have nearly enough MH providers to meet the needs of the community.
I understand the local efforts to ensure mental health is accessible to our communities. However, the organization I worked for has limited access, as only those who pay a health service fee can schedule

appointments. Clients that don't pay, are referred to community agencies. By design of my agency more than 6,000 clients don't have access to mental services. As such, I am not confident in my organization's ability to serve the needs of our clients.
With all of the recent trauma in our county / high cost of living/ limited housing- anxiety-stress-depression have skyrocketed
It's more a matter of access and how long it takes to get into the system.
Accessing mental health services through county behavioral health is confusing and cumbersome even for other professionals trying to connect persons to services. It also seems that when the connection is finally made, the answer is a no, or the needed services are not available, or not available because the person is not medi-cal eligible.
There are very few Mental Health resources in the area and one of the largest resources, Kaiser Permanente, is being sued for its lack of even adequate care for those who need the help- like a class action lawsuit for millions of dollars.
We work with clients with severe mental illness and there is little being done to support them

Based on your experience, what are the greatest strengths of the Sonoma County mental health system? Please choose up to three strengths.

Other (open text responses):
A wide variety of services are available in Sonoma County
Coordination with other systems is improving.
County leadership and service line leaders are responsive to requests for assistance in coordinating care for patients when there is an urgency.
Crisis services are available, but personnel providing these services need improvement in empathy and communication with family members.
For the Spanish speaking residents mental services are limited.
Gregg Jann still plugs away at his provision of services trying for Income and Credit that he so richly deserves for source perspective design of the funding mechanism of the Mental health Services
Hard to define strengths right now while SCBH is trying to rebuild itself
I can't find more
I can't in all honesty say any of these are strengths currently.
I can't pick one area that doesn't need significant improvement Countywide.
I don't believe the County MH system serves our client's needs well at all other than medication management.
I don't consider any of the above to be strengths of our current system.
I hope we get to a place where I could choose more things in this section with a good conscience
It is NOT a system of care.
No strengths except good people trying to help
None
None of the Above

None of the above
None of the above. Even my general practitioner says he has no resources to refer us to.Ambulance took my son to the wrong facility adding miles and cost to the service.
Nope
Not impressed with County Mental Health's ability to meet the needs of the mild to moderate needs of patients or the severely and persistently mentally ill.
Online uniqueness of Jannda.com and his IP fights for advocacy within legal profession and medical model adjustments getting articulated in Peer Support Specialist Training currently
Peer services are great
People are working their best understaffed
People with less severe needs can get services
Services utilize a peer workforce in a meaningful way. Service providers understand consumer needs.
Services work well together across providers and programs Services engage and educate the community Services utilize a peer workforce in a meaningful way Services are easy to access (e.g., ease of getting appointments, convenient locations/times) Easy access is best for me and everyone
Services work well together across providers and programs Services are coordinated with other systems (e.g., justice, child welfare, etc.) Services are driven by consumers and their families Diversity and language of providers/staff reflect the diversity of the population they serve Services engage and educate the community Services utilize a peer workforce in a meaningful way
Services work well together across providers and programs; Services are driven by consumers and their families; Services have improved in quality over time; Crisis services are available to everyone who needs them
Staff these days seem to get it and care, which is a great improvement
Support of fellow staff
They are trying to make improvements
This system's strengths are impoverished in a dire way.

We do good work within the constraints of the system in place
based on my experience there have been no strenghts for quite some time. Services have been cut and there are not enough staff
currently its been hard for children and families to get into services with systems that were in placed changed. Its hard to see families who are still on wait-list or haven't gotten call backs at the 1 month marker.
many caring staff who want to make a difference
passionate hard working staff
strong and dedicated staff
there is some hope at peer-staffed centers and in the peer support model for people to make helpful connections and heal from the harm caused by pathologizing, disease-model psychiatry and pharmaceutical interests but even this part of mental health services is tainted by the medical model
unable to choose any of these for having this experience in the outlying area
• Services are coordinated with other systems (e.g., justice, child welfare, etc.) •Diversity and language of providers/staff reflect the diversity of the population they serve • Services engage and educate the community • Services utilize a peer workforce in a meaningful way • Service providers understand consumer needs • Services have improved in quality over time • Crisis services are available to everyone who needs them • Services and referrals are right for consumer needs • Services are easy to access (e.g., ease of getting appointments, convenient locations/times) • People with less severe needs can get services quickly
• Services work well together across providers and programs • Service providers understand consumer needs • Services have improved in quality over time • Crisis services are available to everyone who needs them • Services and referrals are right for consumer needs • Services are easy to access (e.g., ease of getting appointments, convenient locations/times) • Services help the people with the greatest needs • People with less severe needs can get services quickly
• Services work well together across providers and programs • Services are coordinated with other systems (e.g., justice, child welfare, etc.) • Services are driven by consumers and their families • Diversity and language of providers/staff reflect the diversity of the population they serve • Services

engage and educate the community •Services utilize a peer workforce in a meaningful way • Services have improved in quality over time •Services help the people with the greatest needs
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Based on your experience, what are the greatest needs of the Sonoma County mental health system? Please choose up to three needs.

Other (open text responses):
All of the above
County fails to meet even the basic federal mandates for SMHS
Credit and Income need to reach Gregg Jann for desiging the tax act mechanism of the MHSA CA '04
Housing
I have had challenges scheduling appointments for own family needs. Through my insurance plan. Therefore, I cannot relate or give you an honest answer to the choices above,
I've had people 'released' from county services and sent to my clinic with no paperwork or contact from County
Lack of providers/services available
Lack of psych beds - CSU decreased # of beds to 12
More anxiety prevention groups
More responsive public agency
None
None of these is true
Our experience was positive with getting the help he needed.
Patient Rights
People with more severe cognitive needs can not get help
Services are not coordinated with other systems (e.g., justice, child welfare); Services are not driven by the consumers and their families; Services do not engage and educate the community; Crisis services are not available to everyone who needs them; I think the community needs to be more informed about the spectrum of issues that mental health issues covers (ie DV abuse, addiction, elder/disabled abuse)

Services do not work well together across providers and programs // Services have decreased in quality over time // Services are hard to access (e.g., difficult to get appointments, inconvenient locations/hours) // You have providers but services you actually get are limited
Services do not work well together across providers and programs Services are not coordinated with other systems (e.g., justice, child welfare) Services are not driven by the consumers and their families Diversity and language of providers/staff does not reflect the diversity of population served Services do not engage and educate the community Services do not utilize a peer workforce in a meaningful way Services are hard to access (e.g., difficult to get appointments, inconvenient locations/hours) Services do not help the people with the greatest needs Actually providing services to the people that really need it
Services have decreased, increased case loads, telehealth instead of face to face MD visits, drug/alcohol treatment
There do not seem to be enough Psychologists in Sonoma county. It was difficult for me to find one, and he is always fully booked for the next month.
families are overwhelmed and do not have time or energy to access services
housing
lack of sufficient prevention and early intervention services
more ACT to prevent conservatorship from being needed
not enough peer or clinical staff and peer services have not been valued (cutting some then threatening to cut most)
prevention and/or stigma reduction
• Services do not work well together across providers and programs • Services are not driven by the consumers and their families • Diversity and language of providers/staff does not reflect the diversity of population served • Services do not utilize a peer workforce in a meaningful way • Service providers do not understand consumer needs • Crisis services are not available to everyone who needs them • Services and referrals are not right for consumer needs • Services are hard to access (e.g., difficult to get appointments, inconvenient locations/hours) • People with less severe needs cannot get services quickly

What is your top recommendation to improve the Sonoma mental health system? Please only list your primary suggestion.

Response:
Increase crisis beds
Transparently and collaboratively engage the community
Integration of resources across the continuum of care and service providers.
hire more qualified employees at the line staff level
Reliable and sufficient funding to retain staff and supportive resources to fully support our clients wherever they are.
Integrate consumer voice into planning
Engage community based providers to meet the basic needs of those with specialty mental health services needs. Exceed statewide average penetration rates for EPSDT SMHS (as identified in the DHCS POS reports)
Have more inpatient beds available. Have better psychiatric emergencies available. Improve referrals to residential service providers. Improve the augmented patch funds for service providers. The current rate is pathetic and this probably is the main reason no one wants to have a facility that serves folks with mental health conditions. There is no way to provide anything but basic services for client's residing in residential settings. Why not have social activities available for client's who would not only benefit from increased social events but would love to have more social acuities available to them. Back in the day when there was day services on Chanate the client's had a safe place to spend their days.
Increase genuine engagement with community members and other stakeholders. It appears many changes to the MHSA service plan are made without engaging the community in violation of the MHSA.
Increase the integration of services within the community health organizations to allow patients to remain within their medical home regardless of symptom severity.
not a clue, keep on trying again.
Address the issues raised by the Grand Jury.

It is impossible to get high needs patients into SCBH. I have even called the CSU letting them know I have to send a patient in total crisis and being told they don't have space. Unacceptable.
Continue funding cost efficient Peer Programs, and crisis response programs for youth & community members in greatest need.
Expand Mobile Crisis Team to outlying areas; contract with local org's to provide the psychotherapeutic services not available to county clients; Build evidence based practice for serving (or contracting out) services for TAY youth who are having early psychosis, first break or Bipolar Disorder.
Impeach Donald Trump
More prevention services that target the 2 Gen approach.
Better provider funding.
Focus on the LGBTQ Community mental health
Expand peer recovery services and programs to offer more preventative care and decrease the need for crisis services and offer ongoing support.
County run psychiatric hospital, more housing, a jail discharge planning team that works with clients for several months in custody and when they are transitioning out of custody.
Streamline billing and documentation processes.
address housing for families. If families do not have adequate space, mental health for the youth of the community will continue to deteriorate. A family of 4 living in a studio with abuse involved is unacceptable and will only lead to more complex problems within their community. it impacts most life domains.
Trained hospital staff unlike experience received at Santa Rosa Memorial Hospital.
More streamline coordination and collaboration across contracted agencies and systems
Employ peers throughout the County system!
residential rehabilitation programs, both mental health and dual Dx.
More staffing and better access to services and less wait time for clients needing the resources.

You need to go back to the way it was. I used to be able to have a mental health asser go out to Homeless camps and asses my clients on the spot do the paperwork and have them in the system right away. Your new system sucks.
There needs to be greater funding for all mental health programs, and those that are in place should not have to be concerned about begin cut.
Supervised senior peer counseling by text/email
Get more funding rather than less and less
Need more psychiatrists, more access to care, better coordination of care with primary care
Provide individual services to SMI and their families instead of the deep dependence on CBO. At the very least work in collaboration and provide training to bring CBO into scope of practice and to ensure the expertise is with those in the CBO's with County contracts.
Funding! Your proposals for funding or de-funding the MHSA money favored expensive County programs while prposing to cut or de-fund consumer run programs. Only County run programs were given increases in funding.
single-contact centralized source for consumer info/referrals with case worker assigned to followup on whether services are provided that meet consumer's need
Better financial management and oversight including staffing and implementing priority to Urgent needs such as risk assessment and holds/hospitalization workflows
Put Peers in all areas of involvement that require recovery tools and follow-through with services. Peer related.
More money spent on preventative strategies v. crisis/hospital/conservatorships Housing!!
Make easier access to appointments with psychiatrist.
Provide services to the client's and families that need them upon assessment rather than waiting for a crisis.
More staff. More group work groups. More education, outreach and information os services. More consumer information.

Need to have more beds at the Crisis Unit for Clients. Right now we have a 12 person que to get a bed at the CSU.
Shift more and more clinicians to therapy, groups, assessment, and crisis services and away from case management. Hire less clinicians to do case management and save more money and be able to have MORE staff.
More community based services which are more cost effective
Adequate staffing in all departments
We need more housing for this population and a quicker turn around for appointments and services
More providers to meet the needs of the community and more bilingual/bicultural clinicians.
Improve ease of access for consumers. Navigating a confused and burnout system does not promote wellness for persons who are already in crisis.
To lower salary amounts so that more money goes to the population rather than the employee.
Use peer consumers to help defray costs and provide much needed support for our clients.
Clients need more supportive homes that fit their specific needs- Residential Facilities, and Supportive Living homes need to be appropriately funded and utilized.
More acute service programs for low-functioning clients, allowing beds in programs to be utilized by clients with the appropriate level of functioning for the program.
More supportive housing. Permanent support and long term residential treatment.
accessing in the field and transportation
To improve the Sonoma mental health system would be to continue to educate in Peer Support as there are classes here at the Wellness and Advocacy Center. Sometimes people are homeless because they want to drink and use drugs. I have worked through four programs and am now in proper housing. The Wellness Center is a good place and I am happy that they stayed open. More funding for the Wellness Center and Sonoma County Behavioral Health would be a suggestion as they are many programs, groups, art, music, computer lab.
More staff, more doctors and extend peer recovery services instead of cutting programs

Communications is key, for example pretty sure the findings of this survey will never be shared.
Not a rushed system, real help, placement and availability to therapy long term. Plus housing!!!
Collaborate and cooperate with other County departments, and with service providers--sometimes it's more important to be at the table than to insist sitting at the head of the table.
Support (not terrorize) peers and peer services that are clearly working, helpful, crucial and save money.
Build on peer programs and the Recovery model they advocate and represent rather than trying to dismantle them.
Continue to work on improving coordination of services across agencies/programs in order to more effectively leverage the resources that are available.
Increase mental health services ie: therapy. Seniors do not drive. They need access to mental health services at home. Research shows meds and therapy is effective treatment. Stop cutting jobs and moving BH staff around. My client has seen 3 psychiatrists within past year and that is traumatizing.
better departmental outreach and partnership
Increase the number of mental health therapists for longer term psychotherapy and quicker response to crises.
Coordinate care between medical and mental health staff. Meet clients where they are, for example homebound clients at home. Meet clients at home.
Peer Providers as County employees permanent job class.
I think that in order to make a difference there would need to be a lot more money put into mental health services. It will be financially punitive initially, but should eventually even out as there becomes less demand for crisis services. More transitional housing would be a great place to start, and potentially even more crisis residential units. Also a higher number of case managers/advocates with a lower client load would be ideal.
Increase 0-5 infant mental health professionals that are bilingual and monolingual. For many reasons-children who have been through severe trauma need professionals to support them who know what they are doing. Drug exposed babies, sexually abused, severe physical abuse, domestic violence exposure and children who have been at immigration camps/refugees etcs any kind of trauma. 0-5 children need professionals that are able to support them within the appropriate time for their healing to take place

whether it takes 6 months or longer of services not just short term and the ability for them to return based on needs. Change the way that crisis units are handled- folks who are on a 5150 should not be put on an area that appears to be "drunk tank" for folks who are on a crisis. They should be taken care of my providing 1-1 counseling immediately and during the time they are on a 5150 hold, instead on just putting on a room with other who are having a psychosis, psychotic break, suicidal etc. Some people call to get help and instead get more traumatized or are just given medication. There needs to be a holistic approach to treating individuals who are dealing with a crisis.
Rebuild mental health residential facilities (locked).
Greater access to mental health care, regardless of level of acuity.
Continued mental health education.
Pay Jann Demystifying Affects for consumer provider who designed the MHSA Ca '04 and made our mental health system what it is today.
More prevention and stigma reduction would be good.
Better clarity and communication with community partners/referring agencies in order to provide easier access for people who may have less urgent seeming needs.
Reduce mental health stigma!
Subsidize counseling by paying for organizations to hire more staff to meet needs.
more peers in the workplace and more hours to peer services
Get recovered or recovering clients more involved in the recovery system and pay them equitably with other providers.
(disclaimer, some of this may apply to my medical benefits, not SC directly.)Common medical things are very easy to deal with in Sonoma county, but when I was looking for mental help, it was very difficult to get access to online. I could find help phone numbers and temp programs, but finding a permanent psychologist was difficult. For people like me with social difficulties, we don't really want to be forced to call a live person as I had to do to get answers and an appointment. If we could do it all online, it would be much less stressful. But again, this may have just been sutter, not SC.
The amount of staff available to the large number of people who need their services is inadequate

Incorporate trained peers in front-line services.
Ensure funding for peer run services as these services assist in holistic ways ; they reduce hospitalization, jail stays and emergency room visits for mental health needs.
Close the Aurora Mental Health Facility. Open one that is actually going to provide care and treatment and respect patient's rights.
Intervention while incarcerated.
Support and options for all Insurances
Have peer services available after work hours.
getting services to the homeless who have mental health challenges.
To provide more availability for those seeking assistance prior to the moment it becomes a Crisis.
The system needs to coordinate consistently with the parts of the community that should be viewed as partners. This includes homeless shelters, transitional shelters, and day programs not currently part of the mental health system universe.
Expand access to services.
more competitive salaries would result in more highly competent staff
Increase ACT services (like the old Sonoma ACT, not the new watered-down one). And have the ACT services have showers/light meals to attract the homeless mentally ill to drop in.
On the isolated Redwood Coast we need more funding to do the appropriate outreach for prevention and early intervention.
More peer employment
More community-based peer-driven education and community to clinical linkages. There are many individuals who do not access services because of fear and stigma. We need to bridge this gap.
Accessibility for people that do not have severe mental health issues
more inclusion of peers employed at County Mental Health; peer to peer services are cost-effective, prevent suicides, and encourage consumers to give back to their communities in meaningful ways

Language, cultural understanding, free services.
I think that the service providers should be better educated about meeting the needs of students with developmental disabilities (students in my classroom). There is a significant lack of understanding in this population's diverse needs.
Legislature needs to significantly increase money for mental health services.
Bring back case management to out-of-county clients so they still feel connected to their home county.
We need to hire more staff.
New leadership, hard working and dedicated to more than a paycheck.
Wrap around services where counselors working with students in schools can work with parents in homes.
Create a seamless, one-stop, clearing house with a live person to address all mental health needs, coordinated with the different programs and services that can address the needs. In the middle of a crisis people should easily be able to know who to call for help.
Invest in the clinics to expand and improve their mental health services.
Create a collaborative environment between management and line staff where employees are involved in changes. This could help not only the programs function better but also lower employee turnover.
Hire more clinicians, decrease caseloads, consider group tx modalities
we need more residential and inpatient services
Quicker appointments.
Increase outpatient mental health services and have county day treatment and intensive outpatient
focus some portion of prevention/ early intervention funds and services on proven upstream intervention activities with families who have children under 5 years old
Would be nice to provide a mobile shower program. So many of our homeless with mental health needs, need a shower.
Pay Gregg Jann credit and Income for designing the tax act and making it possible with creating the funding mechanism.

Because of the steep decrease in staff, there aren't enough people to do the work required, which means people constantly fall thru the system cracks. We have more people in crisis and more families who need support, and no services to help. Plus there is very limited engagement with families who play a vital role in supporting these clients.
out reach to community - starting with schools. A source guide with all organizations resources
Better resources for family members who are the primary caregiver
Have times available when parents are not working
More therapists in more locations throughout the county
Increase staffing to reduce case loads and prevent burnout.
Don't assume only verbal child experience trauma or have mental health issues. Non verbal children with lower cognitive functioning also have negative experiences. They are not able to verbalize but body language, emotional outbursts, behaviors etc can indicate help processing an experience is needed.
Do you remember what mental health services were like in the 1980's? What happened?
Individuals with severe mental health problems (chronic) require a much greater commitment from society. These people require ongoing oversight by trained professionals, intensive support, and ongoing provision of resources. Family members can not do this alone. The County needs to step up and do more!!!
Create more awareness of services available and how to access them. Decrease wait times for patients when scheduling appointments. Develop an online referral system for outside providers. Update website/app and offer online scheduling, resources that are easy to access.
I would recommend a robust behavorial health court, where the regular court system is omitted.
Increase the number of psych beds available in Sonoma County
Hire more County staff and use fewer contractors
SPMI clients from outlying areas need more support from Access team when referrals are made. Then increased case management support for client s receiving services (including meeting basic needs-disability income applications, housing, and day programs)
coordination/education across a multidisciplinary team such as working with school districts.

When clients are released from services and told to f/u somewhere, there needs to be communication with the new provider (written and verbal if possible).
Increase the budget so more staff can be hired. That way more services can be delivered to consumers and in a more timely manner
Access to quality psychotherapy for children, teens and families.
more services including therapy needed
Follow up with the referring agency or personnel so they can be assured that some type of service or intervention is being provided.
increase its capacity
Keep up the good work. I think it was extremely helpful to be able to communicate with care providers so I would say make sure consumers are always given the opportunity to sign release papers even if they don't bring it up
Make the cost more affordable.
Moor funding is needed in all aspects of the mental ill crisis we are seeing today, not only in our own region but nation wide as well.
We need enough staff to provide the services in a timely manner.
I think it would be most beneficial to the youth and their families in our community if the Sonoma County Department of Health in general worked more closely together and collaborated with the local school districts more.
Improve communication among providers to create a stronger system of care.
We need to continue to focus on mental health in the work place and recognize the health impacts of stress on everyone due to climate change and the stresses of school, parenting, work and scarcity of resources
More integration of community services is needed -- an LGBT organization should be able, for instance, to easily connect LGBT homeless people to a shelter or motel vouchers.
Increase county-provider partnerships

none
There is a need for more providers within the county.
Create an early psychosis program for people and their families
Top recommendation- to improve collaboration amongst all county mental health agencies, and to reduce any stigmas that may exist between different service providers
increase capacity
The Health Department and County Administrator MUST comprehend the crucial, essential NEED for robust mental health stakeholder system FUNDING---EVERY fiscal cycle. Tens of thousands of lives are at stake. They must STOP balancing our broken county budget on the backs of the most vulnerable kids, teens, adults, seniors and families in Sonoma County...without even comprehending that this is what they are doing. In addition, the terror and suffering caused over the last two years by these massive threats to essential programs and already meager MH dollars is simply massive. Consumers end up in harmful crisis and suicide; providers caught in the tsunami of need vs. lack of support endure stress levels that rival those we all endured during the 2017 fire disaster. This is not hyperbole. I have heard this language from dozens of local mental health providers, both peer and conventional. :-(It has been just devastating for all of us.
Increase information about how to initially access the mental health system
Regional Center more involved in helping parents w/the mental health challenges of having a child w/special needs.
We all need access to each others records in an easily accessible electronic system.
Create more short term and long term treatment and housing for those in mental health crisis. Jail should not be the primary housing option
More funding
Establish better communication pathways between programs and buildings that are related or close to eachother
Management has to start making decision to relieve overwhelmed staff and make decision centered on client needs and not budget

More covered providers that can see clients when they are not in active crisis(preventative/maintenance)
Greater access and understanding that early treatment (in childhood and or early after trauma) can improve health in long run
Housing
More board and cares that are able to work with adults with SPMI.
Reduce the challenges/obstacles for CBO's to partner is providing quality, local services
Allow more agencies and private practice clinicians to provide services
More collaboration; treat providers as partners not enemies; communicate changes; provide emergency beds for the most acute clients.
Provide resources to the community health centers at their sites, where patients access care. Mentally ill patients cannot access services easily and the problem is worse in remote parts of the county.
- Utilize programs that are not that busy/stretched thin to help with other programs. - Invest in staff to avoid retention. - Less specialization of staff; for example, Access: everyone should be able to do screens and assessments. - Improve crisis services; increase staff; find safe placements for conservatees.
Increase workforce of quality, trained MH professionals
Increase collaboration between Partnership Health Plan mental health services and other organizations.
I think that more focus needs to be placed on how to better triage care for high risk client's. Client's who are high risk get help however, it has been my experience that it takes time to get services moving. Further, it will be good to place some focus on the accessibility of services for all community members.
There is a lack of available housing for mental health clients , there needs to be more support for the current board and care facilities, and more follow up with communication from case managers to board and care operators
my recommendation would be to coordinate care across all providers ~ I know that the new system was created to plug folks in to services and manage their care but this is not working and folks who work within the system to help do not all have the same answers to questions, it becomes confusing for folks trying to get care and they quit since they are so vulnerable in the first place
willingness to conserve gravely disabled adults

Need for a specific crisis handling location other than the emergency room. Reasonable on going help until the person can function rather than intensive care in a hospital. My family member lost everything to medical expenses and now has even fewer choices without his private medical insurance no longer affordable and is on MediCal. I am willing to pay out of pocket for a psychiatrist, but cannot find one who is taking new patients.
While I feel that programs and community partners do struggle in their collaboration at times, I think there is some strengths existing already, they just need some improvement. I also feel that our service providers to not reflect the cultural makeup and diversity of the communities we serve and I think that is a direct reflection of a systemic failure.
Increase individual therapy access
need for more cultural sensitivity
Increase collaboration between systems, increase ease of service between organizations, increase connection with community resources for crisis response
Do not cut back all the prevention and early intervention programming. We will pay more for it down the line if we do.
More funding for more providers at a more reasonable rate.
Increase the amount of housing offered to consumers with mental health diagnosis and not just those with severe problems.
As an individual with a mental health background and a graduate degree in counseling psychology, my recommendation is to make mental service accessible to the diversity make up of our community,
Making acute beds available for actively suicidal individuals.
prevention and/or stigma reduction
Greater access
Bilingual and diverse staff Easier process to access care
Higher wages for workers in the field of peer support.
Awareness of programs

To increase the resillience of our children and adult populations with extensive exposure to porgrams like the Mind/Body resilliency workshops.
To have better access for clients and more ability to meet more often. Clients need to be seen more that 1 time a month
Hire staff to address needs/access to care.
Adequately staff programs with right sized caseloads. Appropriately using extra help to provide coverage for gaps in caseload sizes.
Involve family and educate learn how to communicate with doctors to get needs met
Help advocate for clients that need resources. Also have more emphasis on peer driven services for recovery
Bus tickets are not routinely offered by staff or office personnel. They are always needed and always appreciated. Have always waited to get appointments in many instances too long in between.
I think CSU's suicide/5150 ward is punitive, and following the outdated medical model, and may just ensure that those wanting suicide will avoid the authorities and handle things themselves.
Work harder to keep family together
People don't know how to get help
Open early or stay later
< y agenda should not be stressing me out
1) Cell phone classes and government issue 2) Outreach and public awareness
For those in need of services to be able to easily access services in a timely fashion.
More collaboration and better services to meet the individual needs of clients
Acquire more resources - funding and staff - to be able to help a larger population than currently being served.
Add staffing to lower levels of care
Stronger focus on prevention and early intervention.

My top recommendation would be to improve communication and services to meet the needs of all community members, and diversifying its current practices.
Transparency about the available services and how to access them.
Housing more resources for homeless; shelters access to drug and alcohol treatment, via medi-cal more outside medical therapist more assistance from county and city supervisor
My sense is that the County reduced the physician component of the treatment teams overall. From what I hear from former colleagues, the doctors are quite separated from the team/support staff, less doctor time. A physician/psychiatrist a very necessary part of the treatment team of the more seriously ill patients. A team is a necessary component of treatment of these patients.
Peer Support Specialists everywhere, at every level of service: ERs, inpatient psych, mobile support, warm line, outreach, family services... everywhere! And not asked to be junior clinicians or do "charting" that conflicts with Recovery Model principles!
Residential treatment for drugs and alcohol, weekly counselling, housing
Crisis Intervention
Increase staff to increase timely access to services
There needs to be caring, easy-to access Health Services, 100x the amount that is available now.
IMO, the best Improvement would be to find a way to better serve people who are not in acute need of mental health care but are impaired enough that they cannot function well day to day. Perhaps the best way to do that would be to provide them with a living space either temporarily or semi-permanently where Healthcare professionals would come to work to treat them.
Sonoma County Board of Supervisors must allocate more funds for Behavioral Health programs, both for treatment and for prevention/education. The Behavioral Health Division is very understaffed.
Increase the dynamic of brining services to clients
Make all services accessible to consumers in a simple and timely manner.
More staff hiring, less management hiring
More money for more staff and in-patient facilities is needed.

Greater provider collaboration and ease of service delivery to mental health clients in a residential substance abuse program; clients fall through the cracks and there is not a good collaborative system integration between substance abuse to mental health
Improve on the time it takes to get services and also on the actual services that the county provides. As I mentioned earlier, I had to take legal action to get my daughter the services she actually needed because we were told the county didn't provide the services that she needed. Even now after all the legal stuff we have gone through i can't get her to be able to see her eating disorder doctor because the county has spent over a month negotiating a contract with him and in the meantime my daughter is the one that suffers.
More hours more days I would like to come here Sat and Sunday would be very effective
Scrap it and start from scratch. New mid managers and a real client driven program.
Increase education for the community as a whole to facilitate knowledge of services available and how to access them.
A group for people on the autism spectrum scale
More for improvement of client's needs - improve for better housing and more chance to get a job (on the job training)
Make a drastic change modeled after successful system like the Open Dialogue model as practiced in W. Lapland Finland where people truly heal from psychosis with only infrequent, usually temporary use of medication
Budget to hire more mental health clinicians, we are highly needed in this community.
Increased staff and more beds for clients in need.
It would be better to see my psychiatrist once a month instead of once every two months. It's hard to get appointments
More peer services
People with severe mental health issues really have a hard time getting services. There are too many hoops to jump through. The process needs to be more simple and easy to do and understand
All great! Thanks!

more use of peer driven work
Services need to be more comprehensive and include - immediate housing, medications if needed, and support sessions. Without this trinity people fall between the cracks and decompensate. They loose hope and die. Also I hear a lot asking for transporation (bus passes) Maybe mental health clients like college students can get a free monthly bus card and additional transport if necessary. Housing and support is essential (like Buckelew). Ongoing support. Not diversion, oppression. You have service providers but benefits are not making it to consumers.
It is hard to get an appointment to see a doctor, too few doctors
Recovery programs such as arts(?) or community access programs med classes and transportation! med. skrcomphrus
1. Outreach 2. Housing hard to decide
I am not sure. I am grateful for help.
More psychiatrists and case workers
Just to be understanding of people's story and situation

Do you have any additional comments you would like to add?

Response:
FYI, On the next page where it says "What is your race? (Check all that apply)" you can only choose one which is why I chose to not answer. If I can't choose both, I choose none. (same thing with the ethnicity question) Disability status does not say check all that apply, and if I can't check all that are relevant, I check other
Take the advice of of the consumers and Mental Health Board into consideration when making policy and budget decisions
Integrate care: Katie A services School based MH services Primary care/behavioral health care integration Trauma Informed care
It appears the county is not utilizing MHSA effectively as services have decreased in availability and quality over the last 3-4 years. It appears CAPE was terminated 2 years ago although continued to be a feature of the MHSA until recently. Reduction in crisis services in favor of supplementing other areas is a grave error and represents a clear misunderstanding of the community's needs.
Work towards filling the gap in the middle by establishing a network of services aimed at the patients who float in and out of the bubble of moderate to severe symptoms. This would be best facilitated through a shared partnership with other community stakeholders.
nope
I have found it frustrating to work with the County. There are often not clear messages about who to talk to around a specific issue. The Step-Up and Step-Down process has continually changed and has not been consistently effective.
Impeach Donald Trump
No
Peer Services are the most cost effective aspect of our Mental Health System, as they are staffed by volunteer and professional Peer Support Specialists. They save the county money by existing as an alternative to more expensive services such as crisis units, emergency rooms, and psychiatric hospitals. Studies found a 32% reduction of involuntary hospitalizations for people receiving peer run respite

services (Bergeson, 2013). They keep people out of perpetual crisis and off of the streets and invite them into true healing, support and growth.
Stop contracting out and reducing beds/services!
Emergency services net is stretched.
More county funded services for Behavioral Health. Use to have art and therapy groups before budget cuts.
It is shameful the way SCBH got rid of its peer workforce. This needs to be rectified!
There are simply not enough resources available within the community (i.e. more mental health programs needed, housing, etc.)
The Whole Person Care Project has not helped in the way that we had expected. There needs to be more mental health crisis beds.
Please make it easier for my clients who are windsor to cloverdale bring help right to them.
Nl
MHSA money was intended for consumers, and not for Social Workers.
budgets for mental health services commensurate with those that provide support for physical health services
It is hard to trust that sending people to county services will actually help them get their needs met. Many patients that return to clinic felt why are underserved by the county, that staff are overworked and there are too few options for treatment
no
None
Community presentations and viedo.
Using Licensed staff to do case management is an inefficient and expensive use of resources.

I believe the County does the best they can with what they have to work with. The staff at the Crisis Stabalization Center are excellent and have difficult jobs serving the growing need.
None.
Contracting agencies need more money to provide the quality services that our clients deserve. It's frustrating to hear about county staff getting raises when our staff makes barely above minimum wage and our houses are falling apart.
More PSCs and doctors, allowing clients to meet with their case management team in person, and when services are needed.
Psychiatric services need expanding.
As the wellness center is part of my recovery plan; I have done a full WRAP plan and have told my story in front of a group.
More services please, with no more scares of losing funding.
Never do what you did last year, proposing to cut peer services, not listing them to be on the add back list, especially at such a late date, and then name it a transparent process built on community trust.
Seems negligent that DHS/BHD held back $1mil MHSA Innovation Grant funds in FY18/19 when badly needed so DHS could now fund data base infrastructure work. The budget process has been very flawed in terms of community engagement until just recently.
Stop outsourcing jobs. Take care of BH staff so that they stay and provide quality care. It is unbelievable Barbie decided to cut jobs right after fires, and now hiring. It's like a schizo love/hate DV relationship.
Great need to home therapy services. Coordinate with social services agencies with a ROI to keep people safe at home.
There are some amazing people working in mental health in this county!
There is also a need for a "hand-off" system in placed when the MH services are over- connecting folks with community partners- community based programs that offer socialization etc.
I don't understand why the threshold for 5150 is so high. My kid threatened to kill himself, but MCS was not called, nor was he taken to CSU. He was dead the next day. What more proof do the cops need that

a person is a danger to themselves or others? It kinda sucks that the family member has to die for that to become "known," because by then it is obviously too late.
MHSA money is intended for clients, not for social workers.
I really appreciate the EAP program through the county. The 6 free visits turned into a permanent thing for me. Thank you.
The in adequacy of staff and service programs of all kinds to low income and senior individuals Greatly impacts the degree of mental health issues.
We need more services for people who need help but are considered moderate sufferers of mental health problems.
Pass mental health sales tax, educate community on the system of care in community forums -share real information about program values not just statistics.
The Mental Health Services truly need an overhaul, where you are not just placed in a facility that keeps you on a 51/50 hold or longer and then provides absolutely no treatment. Yelling at patients and refusing to let them see their visitors is NOT appropriate.
Drug diversion program vs incarceration.
More options for Peer support groups for adolescents are needed. If not a Kaiser member but have insurance -where are adolescent peer groups held? And Aurora is not the answer because they have been very poor in following up with those in need or crisis!
No
no
It is a difficult balance, however, many people call our office and state they are not able to get the assistance they need for their loved one, and fear the worst.
I cannot stress that coordination with a variety of service providers is essential to minimizing the trauma that is experienced daily.
The people who work in Behavioral Health try their best to do their best inside a broken system of care. The system must change to meet the needs of consumers, especially those near crisis or in crisis.

i am saddened to see that CSU is losing beds. that, coupled with the lack of inpatient beds, will have it's toll on the community, despite what leadership says
You may want to visit the MHA Village in Long Beach CA to look at what we could really do to keep our consumers living in the community in Sonoma County.
In general, mental health services are comprehensive and inclusive
Bilingual Community Health Workers who are trained as peer leaders to use evidence-based assessment tools to screen for unmet BH needs within underserved populations would be a key solution.
The responsibility to provide culturally responsive mental health services to the community has historically been placed on local non-profits. MHSA dollars should keep supporting these efforts to ensure consistent delivery of services and community defined practices.
the complete elimination of MHSA funding this year for peer services is unacceptable; Peer and family involvement is written into the MHSA law; also, preferential hiring of "friends" -- what Mike Kennedy did --- is so unethical and should not be tolerated
I wish service providers worked more openly with educators and teachers (of their clients).
Increased money to mental health services would help with, drug addiction, homelessness, crime, etc.
No. 3 does not have an option for out-of-county providers that serve Sonoma County clients. I am unsure if given the survey the out-of-county clients would even know how to respond to this questions about geographical location.
The whole place seems to be mismanaged and has poor morale. I'd clean house starting with mid mangers. They've been there too long to not have responsibility in the dysfunction.
Free parenting classes for adults with mental health issues that have children in the school system
There needs to be more resources so there are not waiting lists for critical services, such as transitional mental housing.
More overnight care for people in need.
Please think about working more collaboratively with your public health partners who are experts in early childhood, upstream prevention.

I am extremely thankful for the FACT program and the employees/support staff. Jo Iniger (sp?) is an angel and is core to helping my son be successful. The prompt services offered to the clients during the horrific Tubb's fire were above excellent. The judges and probation officers that hold the clients accountable are incredible. It has not been easy, but it has given our family a new lease on life.
I need the credit and income richly soon, and for person and for my own company at Jannda.com for Jann Demystifying Affects.
its nearly impossible to figure out how the system works. This forces families to go outside the system to get the client's needs met. People frequently can't access basic services. Plus the decrease in crisis services has caused chaos throughout the county as people end up in ERs where they are just released, and our police and sheriffs are unable to do their jobs when confronted by people in crisis.
When working with families not only have late times available when they are not working but have childcare available as well
Cutting down the beds at CSU has been extremely detrimental across the whole county and has led to a backup of 5150's in local hospitals that prevent people from getting medical care in a timely manner.
No
.
We closed down our mental health institutions - and now our streets and our jails are our mental health facilities for our most vulnerable people. Shame on us all.
I think there has been a lot of progress.
Sid McColley and Stephanie Meyler have attended our Sutter Jail/CSU collaborative meetings and are very engaged. Very much appreciate working with them.
County DHS needs to focus on how to reduce or minimize the "churn" of staff constantly leaving. The BHD will never stabilize until that issue is resolved.
Unfortunate that Sonoma County has been lacking in providing necessary care for the SPMI population. The funding and management of this agency needs to be improved tremendously. Look at how the agency was run historically (prior 2000) for an effective model.

Services are fragmented. There is little support for people in the continued recovery from a psychiatric disorder. There needs to be the ability to access mental health services at all levels of need.
No
We need to pay people competitively so that they will want to work for the county and stay here.
Both a lot of room, and great potential for growth.
none
no
I think there needs to be more intentionality for youth and families to receive intensive services as needed, regardless of a clinician's hesitancy or personal opinions about such services. There is a need for a higher level of care for some families, and I think oftentimes it takes too long for families to receive such services, which contributes to placement disruptions.
The above, expressed again, with a broken heart.
Parent support, especially for Dads. Also, help w/financial stress as it gets worse if you have a child w/special needs.
We need to address loneliness as a de-stabilizer among those with mental illness.
Family support
Denying contracts to agencies that are providing quality services is harmful to clients
No
None
manage fiscal issues and stop cutting services
More mental health facilities would reduce many of society's other problems such as crime,domestic violence, poverty, homelessness, and overcrowded hospitals.

Continuity of care is crucial for clients receiving mental health services. I feel removing the red tape and road blocks would better serve our clients (i.e, being open with multiple MediCal billing agencies simultaneously, rather than discontinuing with one provider in order to transition to another agency).
too much beurocracy
It took me 2 years to figure out how to utilize the Access Team with insurance and getting an appointment for my son. And, there should be mental health assessment from the mobile team 24 hours a day, not just after 2 pm.
Have those insurers who provider care, e.g., Kaiser Permanente have enough available care for those with suicidal ideation.
The BCARE group at SRJC is a fantastic resource for the SRJC community!
Many programs are understaffed and morale is low. Difficult to retain quality employees in this environment.
Mental health is important
- Make med clinic services more accessible - Better services by eligibility workers for services
I feel as a mental health service user my time becomes everyones time to watch s it does not blow that should be fixed 50/59 but don't know how to start.
Please don't make me do what I fear
Crisis services outside to 101 corridor at all times. Mental health crisis's do not adhere to a 1p to 5p rule.
I know resources and staff are stretched thin, I wish there was more funding and staff available.
In my experience, it is not easy to navigate resources or to connect with specific individuals in specific departments.
There appears to be limited coordination among agencies that serve families that are not also identified for needs by local social services.
As county mental health workers, we are asked to offer and provide services that we don't have. Frustrating for the public and outreach

The only ways I have gotten mental health services that are actually helpful is either through the peer centers and the fact I have enough income to pay for providers outside SCBH.
no
Everything in this county seems to be designed to work against people in general. New housing developments can pay their way out of providing even reasonable housing prices, jobs are not supportive and don't match the local and state economy, and when these things affect peoples' mental health, they can't even get access to help for that. Everyone is surprised that crime rate is going up, that people are jumping in front of the Smart Train, and are becoming homeless, but with lack of any kind of support- well expcet for the "pillar of out community" the Joe Rodota bike trail (as stated in a Press Democrat article). Everything is driven towards consumerism with the least amount of actual support, and at least there could be helpful Mental Health services available to people.
Not at this time.
The quality of life in Sonoma County is suffering, in part, because of the deteriorating level behavioral health services.
It is difficult and confusing trying to enroll clients in services, and most of our clients do not want the services that are being offered although they do want mental health support
People and the help they need should be the driving force not the money...
More hours More times Sat and Sunday Please this will help a lot
I enjoy attending the peer center and wished they were open more days of the week and longer hours
More peer to peer programs and support - I go to Wellness Center - with people like me - socializing
The rate of serious disability due to mental illness has drastically increased since the adoption of the medical model and ubiquitous overuse of psychotropic medication here in the USA. Elsewhere, where drugs aren't used so much people get better. Learn from what works. Take courage and truly change this sick system that is stealing people's mental health and making huge profits for big pharma.
We should find an alternative placement for Conservatees rather than them living at CSU.

The process to get services is too complicated. People with severe issues can't do it and they aren't getting the help they need. The process needs to be more simple and easy.
Yes - ever think about incorporating MH into law enforcement more. Yes you have a mobile team - but really they are not helpful. Also what about outreach MH workers who go in pairs or accompanied by plain clothes officers into encampments. Homeless mentally ill clients do not go into shelters because they are dangerous, toxic, places where people die or get hurt. Most people I know what to work. Also what about creating a day labor agency for MH clients. We have them for immigrants. What about a day labor, where people can earn food cards, gift cards, gym memberships. This can be done through MH outreach services.
Overall love what I see happening
No

Appendix 12. Sonoma County Behavioral Health Services Data Request for the MHSA Capacity Assessment

Description: The tables below list the data requested for every consumer who received Sonoma County Behavioral Health funded services during the three-year period from July 1, 2016 – June 30, 2019. Consumer information will be used to describe the specialty mental health population in Sonoma County. Programmatic and service information will be used to identify which services and levels of care are being utilized by consumers. Financial information will be used to assess the potential for cost savings across the entire system of care.

Table 10. Data Requested from Avatar Electronic Health Record (EHR)
Time Frame Requested: July 1, 2016 – June 30, 2019

Domain	Categories	Variables
Consumer Information	Identifying Info.	Medical Record Number
		Client Name
	Demographic Info.	Date of Birth
		Gender
		Race
		Ethnicity
		Primary Language
		Housing Status or Living Situation (e.g., stable housing, homeless, shelter, transitional housing, etc.)
		Insurance Status/Type (e.g., Medi-Cal, Medicare, private, uninsured)
	Clinical Diagnoses	Mental Health diagnosis code and description
		Substance use disorder diagnosis [if available]
Outpatient Mental Health and Substance Use Service Information	Identifying Info.	Medical Record Number
		Client Name
	Service Episode Info.	Episode Number
		Program Name (e.g., FSP, Access Team, etc.)
		Episode Open Date
		Episode Close Date
	Service Encounter Info.	Service Code and Description (e.g., therapy, case management, etc.)
		Date of Service
		Service Location (e.g., field, office, telephone, etc.)
		Service Length (minutes)
		Service Charges/Cost
Crisis Stabilization Unit Service Information	Identifying Info.	Medical Record Number
		Client Name
	Referral and Location Info.	Referral Source (e.g., law enforcement agency, SCBHD, etc.)
		Transport to CSU (e.g., walk-in, law enforcement transport, ambulance transport)
		Location of MST (e.g., zip code or city)
	5150 Hold Info.	5150 Hold Placed

Domain	Categories	Variables
		Reason for 5150 Hold (e.g., danger to self, danger to others)
	Medical Clearance Info.	Medical Condition
		Medical Clearance Request (e.g., requested, not requested)
		Medical Clearance Status (e.g., cleared, not cleared)
		Medical Clearance Location (e.g., St. Joseph, Sutter, etc.)
	Service Episode Info.	Episode Admission Date and Time
		Episode Discharge Date and Time
		Episode Length (minutes/hours)
		Discharge disposition (e.g., psychiatric hospitalization, referred to FSP, etc.)
	Service Encounter Info.	Service Code and Description (e.g., crisis intervention, assessment, etc.)
		Date of Service
		Service Location (e.g., field, office, telephone, etc.)
		Service Length (minutes)
		Service Charges/Cost
Residential Placement Information (Both in-County and out-of-County)	Identifying Info.	Medical Record Number
		Client Name
	Episode Info.	Episode Number
		Level of Care (e.g., Board and Care, Crisis Residential Unit, etc.)
		Program Name (e.g., Parker Hill Place, Creekside, E Street, etc.)
		Episode Admission Date
		Episode Discharge Date
		Episode Length (days)
		Service Charges/Cost [if available]
Psychiatric Inpatient Information (Both in-County and out-of-County)	Identifying Info.	Medical Record Number
		Client Name
	Episode Info.	Episode Number
		Level of Care (e.g., Psychiatric Hospital, Psychiatric Health Facility, etc.)
		Program Name (e.g., Aurora Santa Rosa Hospital, Crestwood Psychiatric Health Facility, etc.)
		Episode Admission Date
		Episode Discharge Date
		Episode Length (days)
		Service Charges/Cost [if available]

Table 11. Data Requested from Sonoma Web Infrastructure for Treatment Services (SWITS)
Time Frame Requested: July 1, 2016 – June 30, 2019

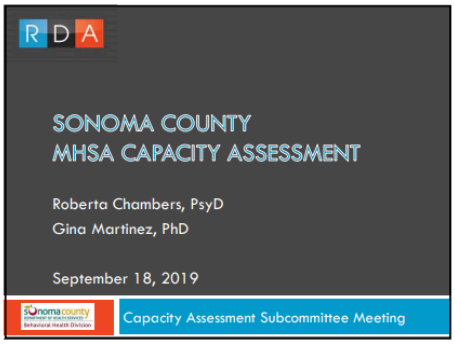
Domain	Categories	Variables
Consumer Information	Identifying Info.	Medical Record Number
		Client Name
	Demographic Info.	Date of Birth
		Gender
		Race
		Ethnicity
		Primary Language
		Housing Status or Living Situation (e.g., stable housing, homeless, shelter, transitional housing, etc.)
		Insurance Status/Type (e.g., Medi-Cal, Medicare, private, uninsured)
	Clinical Diagnoses	Mental Health diagnosis code and description
		Substance use disorder diagnosis
Service Information (Outreach and Engagement programs, other MHSA programs not included in Avatar)	Identifying Info.	Medical Record Number
		Client Name
	Service Episode Info.	Episode Number
		Program Name (e.g., FSP, Access Team, etc.)
		Episode Open Date
		Episode Close Date
	Service Encounter Info.	Service Code and Description (e.g., therapy, case management, etc.)
		Date of Service
		Service Location (e.g., field, office, telephone, etc.)
		Service Length (minutes)
		Service Charges/Cost
Mobile Support Team Service Information	Identifying Info.	Medical Record Number
		Client Name
	Referral and Location Info.	Referral Source (e.g., law enforcement agency, family, etc.)
		Location of MST (e.g., zip code or city)
	Service Episode Info.	Episode Start Date and Time
		Episode End Date and Time
		Episode Length (minutes/hours)
		Discharge disposition (e.g., 5150 placed, referred to Access, etc.)
		Transportation, if applicable (e.g., CSU, Sutter, etc.)
	Service Encounter Info.	Service Code and Description (e.g., crisis intervention, assessment, etc.)
		Service Length (minutes)
		Service Charges/Cost

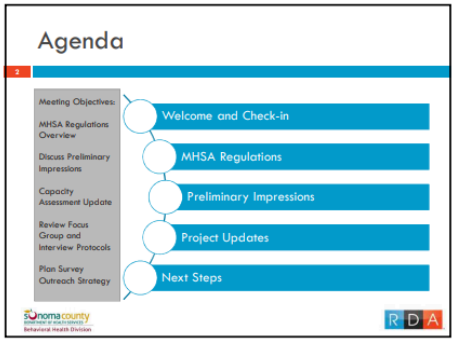
Table 12. Data Requested from Quarterly Reports
Time Frame Requested: July 1, 2016 – June 30, 2019
[in spreadsheet format, if possible, and full report documents]

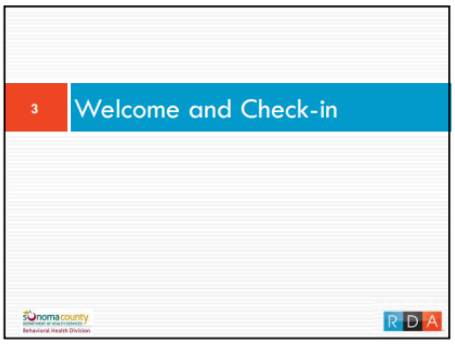
Domain	Categories	Variables
Consumer Information By Program	General Info.	Program Name (e.g., Wellness and Advocacy Center, Petaluma Peer Recovery Project, etc.)
		Number of Consumers (per quarter)
	Number of Consumers by Demographic Info.	Gender
		Race
		Ethnicity
		Primary Language
		Housing Status or Living Situation (e.g., stable housing, homeless, shelter, transitional housing, etc.)
		Insurance Status/Type (e.g., Medi-Cal, Medicare, private, uninsured)
Program Information	Program Info.	Number of Peers (per quarter)
		Number of other staff (per quarter)
	Service Info.	Service Description (e.g., peer counseling, art group, etc.)
		Number of Times offered (per quarter)
		Number of Consumers (per quarter)
		Service Charges/Cost (by service or program per quarter)

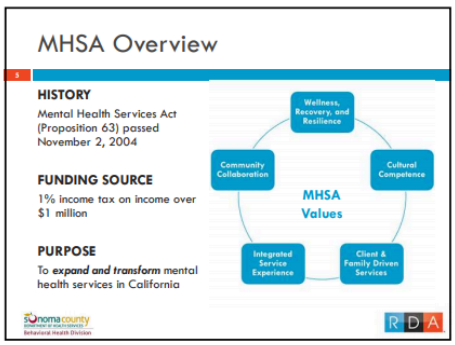
Appendix 13. MHSA Capacity Assessment Preliminary Impressions

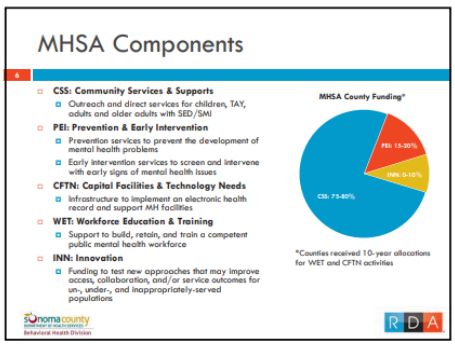
Sonoma County MHSA Steering Committee
Meeting 9/9/2019











MHSA CSS Regulations

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- Assessment of Mental Health Needs: The County shall assess and submit a narrative analysis of the mental health needs of unserved, underserved/inappropriately served, and fully served county residents who qualify for MHSA services.
  - The analysis shall identify the number of older adults, adults, transition age youth and children/youth by gender, race/ethnicity and primary language.
  - The assessment data used shall include racial/ethnic, age, and gender disparities.
- Identification of Issues: The County shall submit a list of community mental health issues resulting from lack of mental health services and supports, as identified through the Community Program Planning Process required by Section 3300.

8 Preliminary Impressions

Acute and Residential Services

- There may be a higher than expected number of consumers placed out of county.
- The ratio of CRT and ART beds appears high.
- A 16-bed Psychiatric Health Facility is planned that will likely influence this dynamic.

Behavioral Health Staffing Model

- County programs rely heavily on clinical staff.
- There are fewer peer professionals and MHRWs than expected, and peer support is predominantly provided in discrete programs.
- This may increase the total cost per person, limit Medi-Cal reimbursement, and reduce opportunities for cross-training and shared learning.

Movement through System

- Consumers may be getting "stuck" and not progressing through the Mental Health System.
- This may limit consumers' progress and de-incentivize wellness and recovery.
- It may also limit the County's ability to maximize Medi-Cal reimbursement.

MHSA Stakeholders

- It may be useful to "refresh" the MHSA stakeholder group.
- There appears to be an underrepresentation of:
  - Individuals with lived experience
  - Transitional age youth and parents of minor children
  - Older adults and seniors
- Few committee members are voluntary (i.e. unpaid, don't participate as a part of their employment).

13 Capacity Assessment Updates

Subcommittee Updates?

Capacity Assessment

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Phase I Project Launch and Discovery	Phase II Data Collection and Analysis	Phase III Reporting and Dissemination
Kick-off Meeting	Focus Groups and Interviews	Findings Presentation and Feedback
Context and Background Information Gathering	Survey	MHSA Capacity Assessment Report
Systems of Care Mapping	Quantitative Data	
Preliminary Impressions	Data Analysis and Initial Findings	

July-Aug | Aug-Oct | Nov-Dec

Key Informant Interviews

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Stakeholder Group		Contact
Professionals	Peer Provider	Sean Boland, Wellness and Advocacy Center
	School Districts	Eric Lofchie, Santa Rosa City Schools
		Mental Health Clinical Supervisor
Local Community Groups	Veterans and Veterans Organizations	Mark Orlando, HSD Veterans Resource Officer
	Native American Tribal Communities	Alison Whitmore, SCIHP
	LGBTQ+ Community	Jessica Carrol, Positive Images

- All scheduled for the next two weeks

Focus Groups

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Stakeholder Group		Contacts
Lived Experience	Transitional-aged Youth	VOICES and SAY
	Adult Consumers	Peer Support Centers (Wellness Center, Interlink, Petaluma Peer Recovery, Russian River Empowerment Services)
	Older Adult Consumers	Older Adult Collaborative, OAIT, Council on Aging, and PPSC
	Parents of Minor Children	SAY
	Family Members of Adult Consumers	NAMI, Buckelew, and interested contacts
Professionals	Service Providers (Mental Health, AOD, CBOs, Social Services & Peer Providers)	Buckelew, Telecare, Peer Support Centers Seneca, SAY, and ELI
	Health Care Organizations	FQHCs, Kaiser, St. Joseph, Sutter, Emergency Depts, Dr. Bernard-Pearl
	Law Enforcement and Criminal Justice Agencies	Attend existing cross-department meeting
Local Community Groups	Latinx Community	Latino Service Providers and Action Network
	Individuals Experiencing Homelessness	Catholic Charities Shelter (Sam Jones Hall)
	Outlying Regions	Conference call with: La Luz, Petaluma Healthcare, RCHC, WCCS

Data Collection Activities

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Protocols

- Guide discussions with key topics and questions
- Questions missing on protocols?
- Potential issues that may arise?

Survey

- Questions finalized; Translation to Spanish this week
- Outreach plan to community?
- Location of hard copies for consumers and family members?

Next Steps

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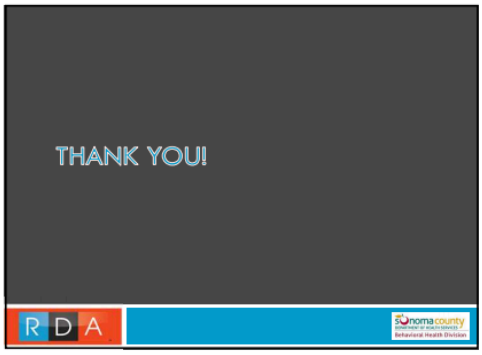
- **September**
  - Community Survey Opens
  - Key Informant Interviews
- **October**
  - Focus Group Events
  - Data Analysis
- **November**
  - Drafting Capacity Assessment
  - Subcommittee Presentation
- **December**
  - Steering Committee Presentation
  - Capacity Assessment Report


THANK YOU!