Welcome and Overview
Myel Jenkins, Sierra Health Foundation Program Officer, welcomed RPC members and guests. She reviewed changes to the meeting schedule (refer to www.sierrahealth.org/rpc for RPC meeting schedule).

Introductions and Warm Up
Participants shared their experience of what makes collaboration successful and reflected on how to bring those elements to the RPC.

Perspectives on Mental Health Crisis in Sacramento County: Why Respite and Community Collaboration as a Response

This panel provided context and background for RPC members on the impact of mental health crisis in Sacramento County. Panel members represent a variety of perspectives:
- Dorian Kittrell, crisis service provider,
- Leslie Napper, lived mental health experience, and
- Michaele Beebe, family/caregiver

Panelists addressed two main questions:
1. Why is it important to offer respite in response to mental health crisis in order to reduce hospitalization?
2. Why do you think a community-driven collaborative process is needed to address mental health crisis and reduce hospitalization?

Dorian Kittrell, Director of Sacramento County Mental Health Treatment Center (MHTC), provided background on the reduction of crisis services over time and how that reduction has impacted the types of care available in the county.

Before the fiscal crisis, the MHTC provided a one-stop shop for crisis stabilization. In 2009-2010, approximately 9,600 clients were served. Of those, 3,100 received services within a few hours such as
referrals, support with medications or just a person to talk to. The other 6,500 received up to 23 hours of outpatient crisis stabilization services. Of those 6,500, about half were referred to in-patient services – mostly in hospital psychiatric departments. In Fiscal Year (FY) 2011, with cuts to crisis stabilization services, hospitalizations increased to approximately 4,000. In FY 2012, it is anticipated that the hospitalization number will rise again.

Dorian points out that professional and peer provided respite services are more humane and consumer friendly, as well as less expensive than inpatient services. The RPC has an opportunity to build pre-crisis services such as respite services.

A community-driven collaborative process is needed to overcome the tendency to work in “silos” and increase understanding of the issues facing both in-patient and out-patient service providers, especially in a climate of dwindling resources.

Leslie Napper consulted adult consumers to solicit their opinion on the need for respite services in response to mental health crisis. Clients stressed their fear of locked facilities, which can prevent them from seeking help and, in turn, lead to declining conditions and possible suicide attempts. The availability of respite services without a required referral would allow consumers to access care quickly with more direct services. They also note that respite services would be less expensive, closer to home and help them progress in their improvement more than hospitalization. Clients like the idea that they will have someone just like them to greet them when they show up for services. Additionally, respite services would reduce the burden on hospital staff, allowing them to work more closely with critically ill patients.

A community-driven approach is important because coordination is a key to patient success and can lead to more partnerships that provide direct referrals, for example, to employment and housing. Clients point out that if the services are properly administered, a community approach will serve clients where they live, work, and play so that when they stabilize, they can more easily re-integrate into community life. Hospitals and business are part of the community and should be part of the solutions. They hope that respite centers will identify clients who may be in crisis and help them through crisis; provide primary services or referrals to address the whole person; help avoid 5150s; and help clients navigate systems.
Michael Beebe works for Children’s Receiving Home in Sacramento and brings a perspective of family and caregivers, whom she consulted to gather ideas about respite services. Respite services provided for children and parents separately would provide a much needed “time out” from each other, an opportunity to understand each other’s perspectives, and support to express feelings in a safe environment. Additionally, whole person care, education about adolescent mental health problems, and more specific education about preventing physical harm during crisis would be helpful.

A community-driven, collaborative approach can provide a wider range of personalized, mutual support than any one entity. As one parent says, “Recovery started when I found a parent who could relate.” Additionally, the community knows what it needs, what areas to concentrate resources in, and can leverage existing resources.

Questions and Reflections
Some common themes observed include: hope, trust of community, a willingness to address mental health challenges in non-clinical settings, and the potentially powerful impact of respite services to improve outcomes and lower human and financial costs. Members point out that the need for in-patient services increased when crisis intervention services were cut.

Q: Budgets are continually cut, is there any hope out there or any respite for financial stress? It’s a guess how much more will be cut. Often services are mandated without sufficient funds to implement. DBHS will begin some crisis stabilization services with AB 109 funds, but it will be limited to referrals from ERs. The RPC needs to consider a continuum of care from pre-crisis to post-crisis to ensure the options aren’t only hospitalization or respite.

Q: Can you tell us about Community Support Teams? The CST directs people to resources, provides telephone services or sometimes a visit. The team contacts all patients discharged from psychiatric facilities to encourage them to attend their first outpatient appointment.

Q: Is there a plan for giving respite providers training or tools to be able to support the patient/caregiver? The RPC can create that opportunity and it should dovetail with existing efforts, for example by leveraging funds such as MHSA workforce training dollars.

Q: What does respite look like for an adult? There is no one model. It could be someone to stabilize medication or to talk to when someone might feel suicidal, but doesn’t want to go to the hospital. It might be a hot shower, a meal, and rest. If a client comes to a respite center and needs more services, hopefully there are trained staff to make appropriate referrals. When an adult with mental
health issues comes to a respite center, it also provides a break for the caregivers and/or staff at board and care facilities or at home. Respite is not just an activity center. Consumers want a little more intensive care and a place they can feel safe.

The RPC and guests discussed ideas and implications, then shared highlights from their conversations (see sidebar).

### RPC Membership/Engaging Missing Perspectives

To continue the initial conversation about stakeholder representation, RPC members examined the completed member stakeholder matrix and identified gaps in representation/perspectives, including: Law Enforcement, Transition Age and LGBTQ Youth, Latinos, Asian Pacific Islanders, Native Americans, Eastern European, Dual Diagnosed consumers and Veterans.

The RPC then considered whether to recruit new members with these perspectives now or wait until January 2013 (end of first phase). After discussing a range of perspectives, there was consensus to wait until January to recruit new members, including law enforcement, which was a stakeholder group of particular concern to a significant number of RPC members. However, members want to engage missing perspectives through other means to inform their work during Phase I.

### RPC Membership Change

Guy Klopp, Child Welfare system partner representative, is unable to participate for several weeks. In his absence, his colleague, Stephen Wallach, is attending RPC meetings as a guest to ensure this perspective is represented. Sierra Health and DBHS proposed that Stephen Wallach participate as an RPC member while Guy is on leave. The RPC decision was unanimous agreement that Steven should take the seat until Guy can return. This raised the question of RPC alternates in general and there was a request to add this to a future agenda.
Dinner and Presentation: Grant Making Considerations
Myel introduced the elements that will need to be in the Request for Proposals that the RPC will develop over the next few months. She also reviewed the timeline and questions for RPC consideration (see PowerPoint and handouts for details). During the presentation, a show of hands indicated the number of RPC members with experience in grant writing (about half) and reviewing applications (about a third). Members were asked to review the Innovation Plan.

Parking Lot
- Ways to engage missing perspectives in the RPC’s work (May 22)
- Exploring possibilities for alternates – about half of RPC members think this is important (May 22)
- Exploring how to have a big impact, be inclusive and support innovative work (May 14)