Santa Barbara County Department
Of Behavioral Wellness

Mental Health Services Act

Three-Year MHSA Plan Update
Fiscal Years 2017-2020

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Santa Barbara, CA
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countyofsb.org/behavioral-wellness

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MHSA COUNTY COMPLIANCE CERTIFICATION

County: Santa Barbara

Local Mental Health Director	Program Lead
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Local Mental Health Mailing Address: Santa Barbara County Department of Behavioral Wellness 300 N. San Antonio Rd. Santa Barbara, CA 93110	

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

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

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

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

Local Mental Health Director/Designee (PRINT) Signature Date

County: _____

Date: _____

Enclosure 1

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Santa Barbara

- [x] Three-Year Program and Expenditure Plan
- [ ] Annual Update
- [ ] Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Alice Gleghorn, PhD	Name: Theo Fallati, CPA, CPFO
Telephone Number: 805-681-5220	Telephone Number: 805-568-2100
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Local Mental Health Mailing Address: Santa Barbara County Department of Behavioral Wellness 300 N. San Antonio Rd, Santa Barbara, CA 93110	

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

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

Alice Gleghorn, PhD
Local Mental Health Director (PRINT)

Signature 5/18/17
Date

I hereby certify that for the fiscal year ended June 30, 2016, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated 8/26/16 for the fiscal year ended June 30, 2016. I further certify that for the fiscal year ended June 30, 2016, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

Theo Fallati, CPA, CPFO
County Auditor Controller / City Financial Officer (PRINT)

Signature Theo Fallati 5.23.17
Date

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

Executive Summary

During this coming 2017-2020 Mental Health Services Act (MHSA) Three Year Plan period, the Department of Behavioral Wellness will focus on continuing the enhancement and evolution of the many programs and initiatives launched during the last Three Year Plan period. The period of 2014/15 through 2016/17 was an ambitious and productive period for the Department, as it sought to implement recommendations from the consultant Tri-West Group's System Change initiative, as well as establish new facilities and operations made feasible by the grant awarded to the Department through the Investment in Mental Health Wellness Act of 2013 (California Senate Bill 82). For this three year period, with limited fiscal growth anticipated, continued uncertainty about the future of the federal Affordable Care Act and the expanded Medicaid funding it provides to the Department, and the need to anticipate mandatory contributions to the new MHSA No Place Like Home initiative, focusing on refining existing programs appears to be the most prudent manner for moving forward.

One significant Department goal for this three year planning process was to fulfill the objective of broad, diverse and inclusive stakeholder feedback and engagement to help direct the Department's efforts in program enhancement. With this in mind, as well as in response to feedback received over the last few years, the stakeholder planning process was significantly expanded. Under new leadership by the Department's Chief of Compliance, Celeste Andersen, four Community Stakeholder forums were held at locations across the County at different hours of the day to accommodate varied work schedules. In addition, 16 presentations were provided to individuals and groups participating in the Behavioral Wellness Commission's public hearings, the Department's Community Action Team meetings, Community Based Organization partner meetings, Department regional staff meetings, and all three community based Recovery Learning Centers.

Although participation in community planning can sometimes wane when funds are limited, the Department is gratified by the enthusiastic participation across these meetings, particularly comments from consumers in housing programs and the Recovery Learning Centers. Generally, stakeholders were receptive to the four proposals put forward by the Department:

- Operate a Transition Age Youth program as a Full Service Partnership;
- Reconsider the operations of the Justice Alliance Program;
- Increase programming at the Recovery Learning Centers;
- Further integrate the existing Treatment Teams into Levels of Care.

In addition, there was consistent stakeholder feedback that encouraged more outreach and education to the schools about existing mental health services for children from pre-school to high school age; continued collaboration with local health care providers for improved continuity of care between health care systems; and the importance of sustaining the Department's current programs. All of the feedback received through the stakeholder meetings can be found under Attachment 2 of the

Plan – Public Comments Submitted Prior to the Public Hearing. The Department hopes to incorporate many of the ideas shared through this process throughout the course of implementing this Three Year Plan.

New this year, where available, are program performance reports using data collected by the Department for Fiscal Year 2015-2016. The outcomes reported depend on the type of program. Psychiatric hospital admissions and incarcerations are reported for all programs. Higher intensity programs, such as Assertive Community Treatment (ACT), Residential Treatment and SPIRIT, have more detailed outcomes. In addition, children in the system are assessed with the Child and Adolescent Needs and Strengths Assessment (CANS); whereas, adults and transitional age youth are evaluated using the Milestones of Recovery Scale (MORS). The Department will continue to collect this data in the coming years, and intends to expanded data collection in some other critical areas.

More About the CANS and MORS Reports

Child and Adolescent Needs and Strengths (CANS)

The CANS is a multi-purpose tool developed for children's service professionals to identify current needs and strengths of the child and family, to support treatment planning, facilitate quality improvement and to monitor outcomes. Implementation of the CANS began mid-year FY14/15. The CANS is scored from zero (no evidence of a problem/well developed strength) to three (immediate or intensive action needed/no strength identified). Therefore, improvement on the CANS is evidenced by a decrease in scores. The CANS is organized into six primary domains:

1. Life Functioning	2. School	3. Child Strengths
4. Risk Behaviors	5. Behavioral/Emotional Needs	6. Caregiver Needs & Strengths

Milestones of Recovery Scale (MORS)

The MORS is an 8-item tool for identifying stage of recovery and is used to evaluate effectiveness in helping adults achieve recovery. Implementation of the MORS was completed in phases, beginning with ACT in July 2015. The adult outpatient, transitional-age youth and Community Supportive Service began in spring 2016. The MORS can also be utilized to assign consumers to appropriate levels of care, based on a person-centered assessment of where they are in their recovery process. Scores of 1-3 indicate extreme risk to high risk/engaged in treatment; 4-5 indicate poor coping and somewhat engaged in treatment; 6-8 indicate coping/rehabilitating and early or advanced recovery.

BACKGROUND

About the Mental Health Services Act

On November 2004, voters in the State of California passed Proposition 63, the Mental Health Services Act (MHSA), which was designed to expand and transform California's county mental health service system. The MHSA is funded by imposing an additional one percent tax on individual, but not corporate, taxable income in excess of 1 million dollars. Becoming law in January 2005, the MHSA represented another California legislative movement, begun in the 1990s, to provide better coordinated and more comprehensive care to those with serious mental illness, particularly in under-served populations. Additionally, MHSA has proven an effective vehicle for leveraging funding and developing integration; opportunities further enhanced through the implementation of the Affordable Care Act.

The keys to obtaining true system transformation and integration are to focus on the five principles outlined in the MHSA regulations:

1. Community Collaboration
2. Cultural Competence
3. Consumer- and Family Member-Driven System
4. Focus on Wellness, Recovery and Resilience
5. Integrated Services

To receive funding, Counties are required to develop three-year plans that are consistent with the requirements outlined in the Act. Counties are also obligated to collaborate with community stakeholders to develop plans that are consistent with the MHSA Principles.

County plans are to contribute to achieving the following goals:

• Safe and adequate housing, including safe living environments
• Reduction in homelessness
• A network of supportive relationships
• Timely access to needed help, including in times of crisis
• Reduction in incarceration in jails and juvenile halls
• Reduction in involuntary services, including reduction in institutionalization and out-of-home placements

MHSA applies a specific portion of funding to each of the five system-building components:

1. Community Services and Supports (CSS); (45%); $11.7M in FY 17-18
2. Prevention and Early Intervention (PEI); (20%); $3.8M in FY 17-18
3. Workforce Education and Training (WET); (10%); $14K in FY 17-18

4. Capital Facilities (Buildings) and Technological Needs (CF/TN); (10%); $108K in FY 17-18
5. Innovation. (5%); $1.5M in FY 17-18

In addition, 10% of the funding will be designated for community program planning and administration. For FY 17-18, $3.8M is available in this category.

CSS, PEI and Innovation categories have ongoing funding streams, although MHSA guidelines call for changing Innovation projects every few years. The CSS component consists of three funding categories: Outreach and Engagement, General System Development and Full Service Partnerships (FSPs). MHSA requires that counties allot at least 51% of CSS funds to Full Service Partnerships. MHSA similarly requires that 20% of total funds be allocated to PEI, and within that allocation, 51% of the funds be used for children and Transition Age Youth (TAY) services. The WET and CF/TN categories were intended to be time-limited and once expended are closed unless the County elects to transfer monies from the CSS funding stream into WET and/or CF/TN.

Funding for housing development has also been a separate stream of funds. This funding will be expended upon the completion of the Residences at Depot Street project in Santa Maria. However, the “No Place Like Home” initiative, in which Santa Barbara County intends to participate, will establish a new stream of funding for housing projects.

The FY 2017-18 MHSA Planning Process

More than 670 individual stakeholders were invited to participate in the county-wide stakeholder meetings. Approximately 100 individuals participated in the nineteen (19) stakeholder meetings. These included representatives from partner agencies, community organizations, advocates, Department staff, Commission members, as well as consumers, family members, and individuals from the community interested in learning more about the MHSA planning process.

The following stakeholder forums were convened:

• Behavioral Wellness Supervisor's Training	• March 2, 2017
• Behavioral Wellness Santa Maria Regional Staff Meeting	• March 8, 2017
• Behavioral Wellness Santa Barbara Regional Staff Meeting	• March 9, 2017
• Santa Barbara County Behavioral Wellness Commission	• March 15, 2017
• Behavioral Wellness Lompoc Regional Staff Meeting	• March 15, 2017
• CBO Coalition Quarterly Meeting	• March 16, 2017
• Transition Aged Youth (TAY) Meeting- SM, SB, Lompoc	• March 17, 2017
• NAMI's Public Policy Committee Meeting	• April 3, 2017
• Stakeholder Forum- Santa Barbara	• April 10, 2017
• Stakeholder Forum- Lompoc	• April 13, 2017
• Consumer and Family Member Advocacy Committee	• April 13, 2017
• Cultural Competence Action Team	• April 14, 2017
• Recovery Learning Center- Santa Barbara	• April 14, 2017
• Stakeholder Meeting-Santa Maria	• April 17, 2017
• Stakeholder Meeting- All Three Regions	• April 18, 2017
• Recovery Learning Center- Santa Maria	• April 21, 2017
• Recovery Learning Center- Lompoc	• April 24, 2017
• Children System of Care (CSOC) Action Team	• April 27, 2017
• Santa Barbara County Behavioral Wellness Commission	• April 27, 2017
• Santa Barbara County Behavioral Wellness Commission (Public Hearing)	• May 15, 2017

The 30-day review process was conducted from May 1st to June 1st, 2017 in partnership with the local Behavioral Wellness Commission. The draft FY 2017-2020 three-year MHSA Plan Update was e-mailed to nearly 670 stakeholders. It was also made available by postal mail upon request. In addition, the Plan update was posted

to the Department of Behavioral Wellness website on May 1, 2017. On May 15, 2017, the Behavioral Wellness Commission conducted a Public Hearing to review this plan.

Santa Barbara County Demographics

Santa Barbara County has a mountainous interior abutting several coastal plains on the West and South coasts of the county. The largest concentration of the population is on the Southern coastal plain, referred to as the "South Coast" – meaning the part of the County South of the Santa Ynez Mountains. This region includes the cities of Santa Barbara, Goleta, and Carpinteria, as well as the unincorporated areas of Hope Ranch, Summerland, Mission Canyon, Montecito and Isla Vista.

North of the mountains are the towns of Santa Ynez, Solvang, Buellton, and Lompoc; the unincorporated towns of Los Olivos and Ballard; the unincorporated areas of Mission Hills and Vandenberg Village; and Vandenberg Air Force Base, where the Santa Ynez River flows out to the sea. North of the Santa Ynez Valley are the cities of Santa Maria and Guadalupe, and the unincorporated towns of Orcutt, Los Alamos, Casmalia, Garey, and Sisquoc.

In the extreme Northeastern portion of the County are the small cities of Cuyama, New Cuyama, and Ventucopa. As of January 1, 2006, Santa Maria became the largest city in Santa Barbara County. (From *Wikipedia*, retrieved 7-19-16.)

Quick Facts, Santa Barbara County
United States Census Bureau

Population	
Population estimates, July 1, 2016, (V2016)	NA
Population estimates, July 1, 2015, (V2015)	444,769
Population estimates base, April 1, 2010, (V2016)	NA
Population estimates base, April 1, 2010, (V2015)	423,939
Population, percent change - April 1, 2010 (estimates base) to July 1, 2016, (V2016)	NA
Population, percent change - April 1, 2010 (estimates base) to July 1, 2015, (V2015)	4.9%
Population, Census, April 1, 2010	423,895
Age and Sex	
Persons under 5 years, percent, July 1, 2015, (V2015)	6.5%
Persons under 5 years, percent, April 1, 2010	6.5%
Persons under 18 years, percent, July 1, 2015, (V2015)	22.4%
Persons under 18 years, percent, April 1, 2010	23.1%
Persons 65 years and over, percent, July 1, 2015, (V2015)	14.3%
Persons 65 years and over, percent, April 1, 2010	12.8%
Female persons, percent, July 1, 2015, (V2015)	49.9%
Female persons, percent, April 1, 2010	49.8%
Race and Hispanic Origin	
White alone, percent, July 1, 2015, (V2015) (a)	85.8%
White alone, percent, April 1, 2010 (a)	69.6%
Black or African American alone, percent, July 1, 2015, (V2015)(a)	2.4%
Black or African American alone, percent, April 1, 2010 (a)	2.0%
American Indian and Alaska Native alone, percent, July 1, 2015, (V2015) (a)	2.2%
American Indian and Alaska Native alone, percent, April 1, 2010(a)	1.3%
Asian alone, percent, July 1, 2015, (V2015) (a)	5.8%
Asian alone, percent, April 1, 2010 (a)	4.9%
Native Hawaiian and Other Pacific Islander alone, percent, July 1, 2015, (V2015) (a)	0.2%

Native Hawaiian and Other Pacific Islander alone, percent, April 1, 2010 (a)	0.2%
Two or More Races, percent, July 1, 2015, (V2015)	3.6%
Two or More Races, percent, April 1, 2010	4.6%
Hispanic or Latino, percent, July 1, 2015, (V2015) (b)	44.8%
Hispanic or Latino, percent, April 1, 2010 (b)	42.9%
White alone, not Hispanic or Latino, percent, July 1, 2015, (V2015)	45.4%
White alone, not Hispanic or Latino, percent, April 1, 2010	47.9%
Population Characteristics	
Veterans, 2011-2015	24,098
Foreign born persons, percent, 2011-2015	23.0%
Housing	
Housing units, July 1, 2015, (V2015)	155,163
Housing units, April 1, 2010	152,834
Owner-occupied housing unit rate, 2011-2015	51.9%
Median value of owner-occupied housing units, 2011-2015	$465,300
Median selected monthly owner costs -with a mortgage, 2011-2015	$2,231
Median selected monthly owner costs -without a mortgage, 2011-2015	$536
Median gross rent, 2011-2015	$1,369
Building permits, 2015	1,082
Families and Living Arrangements	
Households, 2011-2015	142,713
Persons per household, 2011-2015	2.92
Living in same house 1 year ago, percent of persons age 1 year+, 2011-2015	79.5%
Language other than English spoken at home, percent of persons age 5 years+, 2011-2015	39.6%
Education	
High school graduate or higher, percent of persons age 25 years+, 2011-2015	79.6%
Bachelor's degree or higher, percent of persons age 25 years+, 2011-2015	32.2%
Health	
With a disability, under age 65 years, percent, 2011-2015	

	5.9%
Persons without health insurance, under age 65 years, percent	⚠ 15.5%
Economy	
In civilian labor force, total, percent of population age 16 years+, 2011-2015	63.6%
In civilian labor force, female, percent of population age 16 years+, 2011-2015	57.8%
Total accommodation and food services sales, 2012 ($1,000) (c)	1,428,929
Total health care and social assistance receipts/revenue, 2012 ($1,000) (c)	2,637,280
Total manufacturers shipments, 2012 ($1,000) (c)	4,157,565
Total merchant wholesaler sales, 2012 ($1,000) (c)	3,475,600
Total retail sales, 2012 ($1,000) (c)	4,853,808
Total retail sales per capita, 2012 (c)	$11,255
Transportation	
Mean travel time to work (minutes), workers age 16 years+, 2011-2015	19.1
Income and Poverty	
Median household income (in 2015 dollars), 2011-2015	$63,985
Per capita income in past 12 months (in 2015 dollars), 2011-2015	$30,589
Persons in poverty, percent	⚠ 15.6%

⚠ This geographic level of poverty and health estimates are not comparable to other geographic levels of these estimates

Some estimates presented here come from sample data, and thus have sampling errors that may render some apparent differences between geographies statistically indistinguishable.

The vintage year (e.g., V2015) refers to the final year of the series (2010 thru 2015).
Different vintage years of estimates are not comparable.

- **(a)** Includes persons reporting only one race
- **(b)** Hispanics may be of any race, so also are included in applicable race categories
- **(c)** Economic Census - Puerto Rico data are not comparable to U.S. Economic Census data

- **D** Suppressed to avoid disclosure of confidential information
- **F** Fewer than 25 firms
- **FN** Footnote on this item in place of data
- **NA** Not available
- **S** Suppressed; does not meet publication standards
- **X** Not applicable
- **Z** Value greater than zero but less than half unit of measure shown
- Retrieved from https://www.census.gov/quickfacts/table/HCN010212/06083 on 3/23/17.

PROGRAM UPDATES

Community Services and Supports (CSS)

The CSS programs in the General System Development category will be listed first, followed by Full Service Partnerships (FSPs).

CARES Mobile Crisis (General System Development) – Behavioral Wellness

Provider:	Behavioral Wellness
Estimated Funding FY 2017/18:	
Estimated Total Mental Health Expenditures:	$3,252,057
Estimated CSS Funding	$36,529
Estimated Medi-Cal FFP:	$1,857,800
Estimated 1991 Realignment:	$558,862
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$798,866

The Mobile Crisis Program serves adults and older adults (18 years +) experiencing a psychiatric crisis or mental health emergency in all three regions of Santa Barbara County. The Mobile Crisis Program substantially enriches crisis services, providing consumers appropriate alternatives to hospitalization whenever possible. The staffing for these programs includes Peer Recovery Specialists, Case Workers, Mental Health Practitioners, Psychiatric Technicians and Psychiatric Nurses.

Mobile Crisis staff members are guided by a recovery vision and attitude of outreach and collaboration in identifying intervention options. Staff members work closely with consumers, family members and friends to identify natural supports and strategies consistent with the culture and values of the individual and family. Teams in all three regions work closely with local law enforcement professionals and hospital staff. When feasible, they refer to the Crisis Stabilization Unit in South County and the Crisis Residential Treatment facilities in North or South Santa Barbara County, as an alternative to involuntary hospitalization at the Psychiatric Health Facility (PHF).

The Department of Behavioral Wellness has long identified improved responsiveness to crises as a priority. Mobile programs offer a range of expertise in staffing that enables the team to provide interventions to a diverse community. A multidisciplinary team includes medical staff availability to address medication issues that, if left unattended, may result in the need for emergency, involuntary care. The Countywide Mobile Crisis team is linked to both the Crisis Triage teams and the Access and Intake teams in the outpatient clinics in all three regions.

Due to a lower call volume in both North and West County, especially in the overnight hours, staffing was reallocated and a Standby system was put in place. During

traditionally slow hours between 11pm and 7am, both regions are covered by one staff, with a staff member on Standby if needed. This has allowed the teams to enhance services during busier day shifts and still meet the crisis needs of the community.

Now that all Crisis Programs (Mobile, Triage, Crisis Stabilization Unit, Crisis Residential Treatment and PHF) have co-existed for several years, they are beginning to function as an integrated Crisis System of Care, better able to address the needs of all consumers moving through the different levels of care in the Department. With greater access to voluntary crisis programs, the Department is better situated to meet the needs of consumers in crisis and reduce the need for inpatient hospitalization.

All three regions now co-locate their Mobile Crisis and Crisis Triage teams. Staff continue to cross train which has led to more flexible staff assignments and the ability to facilitate adequate coverage and seamless transitions for consumers. Similar cross training is planned for Nursing staff and Psych Techs in the CSU and PHF to also facilitate adequate coverage in those programs.

Program Challenges and Solutions

The challenges are greater in the Santa Barbara region. There are twice as many calls and crisis encounters in the South compared to the North and West regions. To resolve this, staffing has been allocated in attempt to meet the need. Another challenge is the need to improve the relationship/partnership with local hospitals, law enforcement, and outpatient clinics. The Department has increased opportunities for collaboration between these parties, improving dialogue and approaching problem solving in a team-based manner. These efforts will continue to be a priority in the coming years.

Program Performance (FY 15-16)

Crisis Services

	Unique Clients Served								
	Mobile Crisis			**Crisis Triage**			**SAFTY (child/youth)**		
	North	**South**	**West**	**North**	**South**	**West**	**North**	**South**	**West**
Age Group									
0-15	26	39	19	0	13	2	200	96	70
16-25	152	371	111	86	116	44	120	87	59
26-59	440	804	248	320	450	181	1	0	0
60+	92	171	51	48	66	28	0	0	0
Missing DOB	6	8	5	4	0	0	0	0	0
Total	***716***	***1,393***	***434***	***458***	***645***	***255***	***321***	***183***	***129***
Gender									
Female	373	590	229	234	303	134	188	102	76
Male	321	768	196	212	337	120	133	81	53
Unknown	22	35	9	12	5	1	0	0	0

Ethnicity									
White	45%	56%	62%	40%	55%	55%	22%	30%	26%
Hispanic	37%	17%	27%	43%	28%	33%	57%	42%	48%
African American	4%	4%	5%	4%	4%	9%	1%	2%	7%
Asian/Pacific Islander	0%	2%	0%	2%	2%	1%	1%	2%	1%
Native American	1%	1%	1%	>1%	1%	>1%	0%	1%	1%
Other/Not Reported	13%	20%	5%	11%	10%	2%	19%	23%	17%

A goal of the crisis service programs is to stabilize clients in the community with safety planning and other supportive services in order to avoid admitting clients to a psychiatric hospital. As can be seen below, most of the crisis programs were able to avoid hospitalizing clients, using hospitalization as a last resort.

Client Outcomes

Hospital Admission Avoidance	North	South	West
Mobile Crisis	72%	68%	76%
Crisis Triage	74%	45%	80%
SAFTY	88%		

New Heights (General System Development) – Behavioral Wellness

Provider:	Behavioral Wellness
Estimated Funding FY 2017/18:	
Estimated Total Mental Health Expenditures:	$2,004,808
Estimated CSS Funding	$ 6,280
Estimated Medi-Cal FFP:	$1,061,100
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$467,604
Estimated Other Funding:	$469,824

The New Heights program serves transition-age youth (TAY), ages 16-25, who require assistance for serious emotional conditions or severe mental illness. These young adults age out of the Department of Behavioral Wellness Children's System of Care at age 25 and are at risk for homelessness. The New Heights TAY program also serves consumers experiencing mental health and substance abuse conditions. The program model was developed using the Transition Age Youth Subcommittee Resource Guide as approved by the California Mental Health Directors' Association in May 2005 and the Transition to Independence Process (TIP) System Development and Operations Manual.

Program Challenges and Solutions

The challenges encountered have been the increased need to develop employment resources that are specific to the TAY population. TAY specific resources for TAY housing is also a challenge due to the lack of short-term housing resources. The Department has begun to develop partnerships with the State Department of Rehabilitation (DOR) and Work Force Development Board to address these issues.

The Department will continue to work with stakeholders to develop additional resources for TAY consumers, including a possible teen drop-in center and the development of additional TAY employment staff funded through DOR. The higher mental health needs for TAY have not currently been met within the New Heights program causing consumers to be transitioned to the adult ACT teams where they drop out or do not engage. Due to this, there is a need to develop a TAY Full Service Partnership (FSP) level of care to meet the needs of this age group within the Children's system of care. A TAY FSP is one of the new proposals being recommended by the Department as part of this Three-Year Plan.

Program Performance (FY 15-16)

New Heights-Transitional Age Youth

Unique Clients Served			
	New Heights		
	North	South	West
Age Group			
0-15	1	0	1
16-25	72	42	98
26-59	5	2	1
60+	0	0	0
Missing DOB	0	0	0
Total	***78***	***44***	***100***
Gender			
Female	37	27	68
Male	41	16	32
Unknown	0	1	0
Ethnicity			
White	33%	30%	30%
Hispanic	59%	50%	57%
African American	1%	2%	5%
Asian/Pacific Islander	4%	2%	1%
Native American	0%	0%	1%
Other/Not Reported	3%	16%	6%

Client Outcomes

Child & Adolescent Needs & Strengths Assessment (CANS) Age: 6-17 years	**Time Period**	**New Heights**
	Percent Improvement	
Life Functioning (e.g., ability to communicate and interact with families, communication, social functioning and health status)	Initial – 6-mo.	27% (n=8)
	6-mo.-12-mo.	19% (n=6)
Behavioral/Emotional Needs (e.g., symptoms of depression, anxiety, psychosis and other conditions)	Initial – 6-mo.	10% (n=8)
	6-mo.-12-mo.	12% (n=6)
Child Risk Behaviors (e.g., self-injury, suicidal behavior, bullying, and running away)	Initial – 6-mo.	42% (n=8)
	6-mo.-12-mo.	21% (n=6)
School (e.g., behavior, attendance and grades)	Initial – 6-mo.	0% (n=8)
	6-mo.-12-mo.	73% (n=6)
Caregiver Needs & Strengths (e.g., child supervision skills, family stress levels, residential stability, and caregiver physical/mental health status)	Initial – 6-mo.	0% (n=8)
	6-mo.-12-mo.	4% (n=6)
Child Strengths (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment)	Initial – 6-mo.	0% (n=8)
	6-mo.-12-mo.	19% (n=6)
Incarcerations/Juvenile Hall	11%	
Psychiatric Inpatient Care	7%	
Milestones of Recovery Scale Age: 18 years + (*clients open in FY15/16*)	Initial to 6-Month MORS (n=103): 38% showed improvement 42% remained stable 6-Month to 12-month MORS (n=80): 19% showed improvement 54% remained stable	

TAY clients that received the CANS (age less than 18 years) made the most progress in Life Functioning, Risk Behaviors and Child Strengths. The majority of clients that received the MORS (age 18-25 years) remained stable with MORS scores over time. Nearly 40% of clients in New Heights made the most progress in the first 6 months. Hospitalizations were kept at 7%, while 11% of the clients were incarcerated during FY15/16.

Partners in Hope: Recovery Learning Centers and Family Advocate (General System Development) – Mental Wellness Center and Transitions Mental Health Association

Partners in Hope is a peer-run program that provides peer support services to consumers and family members. The program supports Peer Recovery Specialists and Recovery Learning Communities (RLCs) in South, West and North County. There are three (3) Full Time Employees (FTE's), divided into 10 part-time positions, of which seven (7) have been filled for the past three years.

The goal of the RLCs is to create a vital network of peer-run supports and services that builds bridges to local communities and engages natural community supports. The RLCs are also supported by other Mental Health Services Act (MHSA) funds to provide technology access to participants. These include computer access and technology training and classes. There are currently three RLCs throughout the County, each located at pre-existing housing developments that include MHSA-funded units, including Garden Street Apartments in Santa Barbara, Home Base on G in Lompoc, and Rancho Hermosa in Santa Maria.

Partners in Hope primarily serves adults with severe mental illness, including those with co-occurring substance use disorders, at risk of admission to psychiatric care, and/or criminal justice involvement. Consumers may also be homeless or at risk of homelessness. The program is linguistically and culturally capable of providing services to Spanish-speaking consumers who represent a large under-served ethnic population in Santa Barbara County.

Partners in Hope also includes a Family Advocate in each region of the County. Family Advocates provide support to family members throughout the County. The family peer program is operated by two community-based organizations (CBOs): The Mental Wellness Center and Transitions Mental Health Association. At this time, both providers offer bilingual services to family members.

Santa Barbara Services:

In the past three years at the Mental Wellness Center's RLC, staffing has converted to all peer providers. This includes the program staff (Manager plus three specialists), a kitchen crew of three that provides seventy lunches daily, and computer laboratory and art room facilitators. An effort has been made to ensure that the staff reflects the ethnic distribution of the RLC members. In addition, the Santa Barbara RLC has developed multiple supported employment positions, especially around a Vintage Clothing Care Closet that has many benefits, including retail and stocking positions for RLC members to learn and practice employment skills that are in high demand in the community. The Closet provides gently used clothing and hygiene items, which are particularly useful for consumers who are homeless.

In addition to creating greater employment access both through in-house peer staff positions and through supported training opportunities, the Santa Barbara RLC promotes physical and mental health learning. Using groups and one-to-one dyads, Peer Specialists, RLC members, and ancillary workers meet with RLC members to recognize and manage symptoms, learn self-care, and practice recreational and social activities that are beneficial to their health. The Santa Barbara RLC schedules thirty to thirty-five group activities per week. The computer laboratory, which is physically a part of the RLC, averages 150 users per year.

2013-14, 2014-15, and 2015-16: 1,218 Unduplicated RLC Members and 31 Annually Unduplicated MHSA Tenants Served at Santa Barbara Site	
Age Group	Number of Unduplicated Persons Served
16-25	73
26-59	940
60+	236
Total	1,249
Cost per Consumer Cost per Visit	$801,000 for 3 years/1,249 people served = $641 cost per person served. 43,186 visits = $19/visit

*Data is from the Mental Wellness Center.

In Santa Barbara, the Family Advocate reaches out to both Spanish- and English-speaking audiences. The Family Advocate meets with adults or small groups individually to address questions about resources and systems navigation on behalf of family members who often have a serious mental illness. The Family Advocate presents current and accurate information that is hard to obtain in the community, and also demonstrates and encourages coping skills and attitudes in the family members. The Family Advocate includes modeling effective strategies that he or she has learned through lived experience as a family member. For the past three years, the Family Advocate has been meeting with more people yearly, culminating in meeting with 329 unduplicated people/family groups between July 1, 2015 and June 30, 2016.

The Family Advocate is a pivotal position at the Mental Wellness Center in that she/he performs community outreach and liaises with the local National Alliance on Mental Illness (NAMI) Chapter and other volunteers and service providers to create a network of support useful to people navigating mental health and related resources. The Family Advocate averages about four presentations monthly at community events to increase awareness of mental health and available resources. At the Santa Barbara site, three to four support groups for family members are scheduled regularly each week in the evenings. In addition, the NAMI Family to Family course is taught twice or thrice yearly, with about twenty participants per class. Monthly speaker presentations are hosted at the facility, and several other presentations are offered throughout the year on various topics of interest.

2013-14, 2014-15, and 2015-16: Unduplicated Persons Served by Family Advocate	
Age Group	Number of Unduplicated Persons Served
16-25	26
26-59	469
60+	385
Total	880
Cost per Consumer	$193,575 over three years/880 people served = $220 cost per person served

Lompoc and Santa Maria Services

Transitions - Mental Health Association (TMHA) has over 50% of staff in Santa Barbara County that are family members or have lived mental health experience. Additional strategies to increase access for peers have included part-time employment opportunities for consumers and family members in most Community-Based organizations.

TMHA has developed grant-funded programs to specifically engage the RLC membership and cultivate leadership and employment potential. TMHA CORPS (Career Opportunities in Recovery for Preventive Services), funded by the California Wellness Foundation, aims to outreach, enroll, train, and help place people with lived mental health experience and family members into the behavioral health workforce. LEAD (Lived Experience Advocacy Development), funded by the McCune Foundation, provides outreach to members of both the Lompoc and Santa Maria RLC's and recruits and trains individuals with lived experience of mental illness to develop an advocacy platform and presentation. The goal is to develop a new generation of community leaders, a group that is deeply invested in the cause of mental health advocacy and can accurately and empathically represent its peers in the process. Additionally, both the Lompoc and Santa Maria RLC's receive Community Development Business Grant funding from the cities in order to provide more food and outreach to members in the Latino community, respectively.

Partners in Hope served approximately 1,361 unduplicated individuals in Santa Maria and Lompoc during the past 3 years.

Age Group	Number of Unduplicated Persons Served - PIH
16-25	68 in Santa Maria and Lompoc
26-59	721 in Santa Maria and Lompoc
60+	572 in Santa Maria and Lompoc
Total	1,361 served in Santa Maria and Lompoc
Cost per Consumer	$283,694 three years/1,361 people served = $208.00 cost per person served*

The Recovery Learning Centers (RLC's) served approximately 1,340 unduplicated individuals in Santa Maria and Lompoc during the past 3 years.

Age Group	Number of Unduplicated Persons Served – RLC's
16-25	120 in Santa Maria and Lompoc
26-59	925 in Santa Maria and Lompoc
60+	295 in Santa Maria and Lompoc
Total	1,340 served in Santa Maria and Lompoc
Cost per Consumer Cost per Visit	$836,000 three years/1,340 people served = $624.00 cost per person served. 30,000 visits = $28.00/visit*

*Data is from quarterly narrative reports sent to the Department of Behavioral Wellness.

Program Challenges and Solutions

Peer services have been evolving in Santa Barbara County since the inception of the MHSA. The original Community Services and Support (CSS) Plan initially included three peer staff. Since that time, most MHSA programs have integrated peer staff into their teams. Peer services are quickly becoming an integral part of all service teams, and the RLC's are 100% peer run programs.

The increase in staff positions has provided additional opportunities for people with lived experience, and a number of peer staff have been hired in Civil Service positions. Additional strategies to increase access for peers have included part-time employment opportunities for consumers and family members using a Peer Expert Pool funded through Workforce Education and Training (WET). At the Santa Barbara site, consumers are encouraged to develop skills in house and transfer them into the community. This process involves selecting work that the consumers are comfortable with performing and which doesn't interfere with their government benefits and other supports. Again, peer support is proving valuable in navigating employment pathways.

The most significant challenge faced by the peer staff has been the lack of a well-defined career ladder. Professional standards have not been established with any degree of uniformity, although this is changing. Mental Health America has come up with a peer specialist credential program that may well serve as a model for other programs. Establishing professional standards will help define the steps of a career ladder. In addition, there is also a lack of mentors: there are few people with a lot of experience as peer providers that can closely help those entering the field. This, too, will change as the staff at the three sites gain more experience over time. Sharing their experience will be valuable to new staff.

The Family Advocate at the Santa Barbara site is facing decreased challenges in terms of stigma and lack of knowledge about mental health. This is indicated by the

increasing numbers of visits by care-giving family members, and the additional awareness-building events and opportunities that have been made available recently within the community. Still, these challenges do exist and continue to be a barrier to achieving better mental health for people who live here.

There is currently a lack of community awareness about existing MHSA-funded mental health services. While CBO staff attend community meetings and health fairs, present program and mental health information to other CBO's, health care providers, churches and Rotary Clubs, a continued and focused effort is needed. To that end, TMHA has paid for and published an annual insert in the North and Mid-County newspaper, “The Santa Maria Sun” which provides information about available mental health and local programs including Partners In Hope and the RLC's.”

Finally, there is a lack of consistent collaboration between the Department’s Outpatient Clinics and Community Based Organizations treatment providers working within the RLCs. Consumers continue to report that they do not wish to be “forever clients” of the system and would like to step down to RLC level of care but still have access to some clinical services. Consumers have reported in stakeholder meetings their desire to see Psychiatric services and low end counseling at the RLCs. This is another proposal the Department has included in this Three Year Plan.

Homeless Outreach Services – Behavioral Wellness, Good Samaritan, Transitions Mental Health Association

Provider:	Behavioral Wellness, Good Samaritan, Transitions Mental Health Association
Estimated Funding FY 2017/18:	
Estimated Total Mental Health Expenditures:	$594,007
Estimated CSS Funding	$370,114
Estimated Medi-Cal FFP:	$142,400
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$81,493

The expansion of Homeless Outreach services in all three regions during the last Three-Year Plan period has enhanced the mental health system’s ability to respond to long-term needs of persons with severe mental illness who are homeless or at-risk of homelessness, and who are not receiving adequate mental health services.

In North County the Department contracts with Transitions Mental Health Association for Homeless Outreach services, providing rapid access to mental health and substance use disorder treatment for residents of the Good Samaritan Shelter in Santa Maria. The Department also contracts for 4 shelter beds at the Good Samaritan

shelter for homeless mentally ill consumers. Potential consumers are screened and referred by the Department's Homeless Outreach workers.

In Lompoc, there is no stand-alone program for Homeless Outreach services. This is addressed with the referral and active outreach and contact by shelter staff to the Lompoc Crisis Triage team. Once a consumer is identified, he or she is entered into the electronic health record and engaged with Crisis Triage staff, including the Caseworker, Recovery Assistant, Licensed Clinician and Medical staff. Additionally, one Recovery Assistant and the Team Supervisor meet bi-monthly in collaboration with other service providers for housing challenges and placements.

In South County, due to a higher percentage of homeless individuals, staffing in this region was further enhanced. The Department currently has 2 full-time and one half-time Homeless Outreach workers. In addition to outreach and assertive outreach efforts, outreach staff provide mental health screenings and assessments to determine the presence of a mental illness or substance use disorder. This is done in a setting preferable to the potential consumer and therefore, many screenings or other clinical services are provided in the field.

The Department partners with community organizations that provide key services to homeless persons, including primary health, mental health, substance use, housing, and employment services providers. These include, but are not limited to: The Department of Public Health (Health Care for the Homeless Program), Cottage Hospital, the Santa Barbara Neighborhood Clinics, the Department of Social Services, Social Security, Legal Aid (benefits advocacy), the Santa Barbara Rescue Mission, the Salvation Army Hospitality House, PATH shelter, Catholic Charities, the City and County Housing Authorities, and Common Ground. Homeless Outreach staff and the Department maintain ongoing contact and carry out ongoing collaboration with the Central Coast Collaborative on Homelessness (C3H), an agency aimed at reducing the number of individuals experiencing homelessness in Santa Barbara County. C3H is a key partner in arranging / referring homeless consumers to the Department's outreach program.

The program expansions are consistent with the principles of MHSA, including a recovery and resiliency focus, creating a greater continuity of care and cultural competence. The Homeless Services program is providing extensive outreach and engagement services. Teams have also adopted strategies that meet the specific needs of homeless populations in each region. Teams also provide housing support and assistance, employment and education support, rehabilitation services and other necessary supports for families and individuals. The program model utilized is culturally and linguistically competent and appropriate: the only threshold language identified in Santa Barbara County is Spanish. Consequently, the goal has been to have 40% of direct service staff on this team and others be bilingual (Spanish/English) and bicultural. This team provided services to approximately 100 individuals per year.

Program Challenges and Solutions

The expansion of services in Santa Barbara County resulted in greater supports to chronically homeless individuals. An adjustment necessary in the South County region was providing supports and services to chronically homeless people housed in a new development offering 40 chronically homeless individuals long-term housing opportunities.

In other areas of the County, additional staff members were contracted to Community-Based Organizations. The Department has expanded collaboration with local shelters to provide support for consumers. In (North County), two staff persons were hired through a local provider and work with the local shelter. Ongoing partnership building and community collaboration will be essential to meet the challenges of the persistent needs of the homeless population.

Program Performance (FY 15-16)

Homeless Services

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	0	0	0
16-25	15	3	0
26-59	28	58	2
60+	0	12	0
Missing DOB	0	0	0
Total	***43***	***73***	***2***
Gender			
Female	36	30	1
Male	7	43	1
Unknown	0	0	0
Ethnicity			
White	28%	58%	50%
Hispanic	63%	24%	0%
African American	2%	19%	50%
Asian/Pacific Islander	0%	3%	0%
Native American	2%	1%	0%
Other/Not Reported	5%	5%	0%

Client Outcomes

	North	South	West
Incarcerations/Juvenile Hall	8%	18%	26%
Psychiatric Inpatient Care	4%	16%	11%
Milestones of Recovery Scale (*clients open in FY15/16*)	Initial to 6-Month MORS (n=33): 36% showed improvement 42% remained stable		

In the Homeless Services program, outreach is provided to approximately 300 clients per year. Nearly 120 clients were enrolled and connected to needed services including mental health services in FY15/16. A third of clients showed improvement on the MORS during the first 6 months. Hospitalization admissions were higher in South County, but overall, inpatient care was less than 16% County-wide. Clients served in West County had the highest incarceration rates (26%), followed by South County (18%) and North County (8%).

Co-Occurring Mental Health and Substance Use Outpatient Teams – Behavioral Wellness

Provider:	Behavioral Wellness
Estimated Funding FY 2017/18:	
Estimated Total Mental Health Expenditures:	$2,878,949
Estimated CSS Funding	$836,672
Estimated Medi-Cal FFP:	$1,105,920
Estimated 1991 Realignment:	$936,357
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$0

The Co-Occurring Outpatient Teams offer consumer-driven services and customize services based on individual needs. In the past three year stakeholder process, stakeholders' priorities were to focus on dual diagnosis rather than solely on the consumers' mental health needs. Accordingly, specialized outpatient Co-Occurring Teams are based in North, West and South County, and were designed for adults 18 and older. Consumers diagnosed with a severe mental illness and a co-occurring alcohol or other drug (Substance Use Disorder (SUD)) issue are identified for this specialized level of service. More specifically, this may include consumers who 1) have SUD-related legal issues, 2) have been recently discharged from a detoxification program, or 3) have a history of substance use.

All staff in the Adult Clinics have received training in selected evidence-based practices to ensure that they are co-occurring informed and competent. Evidence-based practices include Motivational Interviewing, Seeking Safety, and Cognitive Behavioral Therapy (CBT). Staff working on the Co-Occurring Teams utilizes a wide variety of treatment modalities in their treatment including weekly groups based on

"Living in Balance," for group facilitation, and 1:1 SUD coaching and counseling; Medication Assisted Treatment and linkage to medical or social detox facilities and sober living homes; and local Alcoholics Anonymous or Narcotics Anonymous groups. All of the Department's Psychiatrists have been trained and are able to provide Medication Assisted Treatment.

Program Challenges and Solutions

There is a lack of a comprehensive system of care for people in recovery in the community that results in consumers being displaced into jail, hospital, Emergency Rooms, the inpatient Psychiatric Health Facility, and other types of inpatient containment. As a solution, the Department continues to collaborate with community agencies in an attempt to bridge gaps in community system of care resources. Rehabilitative SUD treatments that are available locally are primarily for women, and there are not enough resources for men. However, the development of expanded Drug-Medi-Cal services through the Organized Delivery System (ODS) is expected to be implemented by the Department for Fiscal Year 2018-2019. The ODS will expand Substance Use Disorder referrals for co-occurring consumers throughout the system.

Program Performance (FY 15-16)

Behavioral Wellness: Adult Co-Occurring Teams

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	0	0	0
16-25	28	3	12
26-59	279	116	114
60+	9	21	6
Missing DOB	0	0	0
Total	***316***	***140***	***132***
Gender			
Female	182	64	94
Male	134	76	38
Unknown	0	0	0
Ethnicity			
White	50%	61%	55%
Hispanic	42%	27%	30%
African American	4%	4%	9%
Asian/Pacific Islander	1%	2%	2%
Native American	1%	0%	2%
Other/Not Reported	2%	6%	2%

Client Outcomes

	North	South	West
Incarcerations	18%	16%	11%
Psychiatric Inpatient Care	7%	16%	12%
Milestones of Recovery Scale (*clients open in FY15/16*)	Initial MORS to 6-Month MORS (n=230): 32% showed improvement; 48% remained stable 6-Month MORS to 12-month MORS (n=90): 20% showed improvement; 54% remained stable		

In the Co-Occurring programs, 32% of clients showed improvement during the first 6 months, with 20% improving in 1 year. Approximately half of the clients remained stable with MORS scores over time. Hospitalization admissions were avoided at high rates, 84% and above. Incarcerations were higher in North County than in South or West County, but overall were less than 20% County-wide.

Children Wellness, Recovery and Resiliency (WRR) Teams – Behavioral Wellness

Provider:	Behavioral Wellness
Estimated Funding FY 2017/18:	
Estimated Total Mental Health Expenditures:	$4,672,313
Estimated CSS Funding	$12,074
Estimated Medi-Cal FFP:	$2,486,690
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$2,173,549
Estimated Other Funding:	$0

The Wellness, Recovery and Resiliency (WRR) program for children is designed to serve consumers who have a higher level of function, those who may be stable and require a lower level of care, and those who may have graduation potential or successful step-down opportunities from clinics to a lower level of care or discharge from clinics. Services provided to consumers include:

- WRAP Services
- Focus on Prevention (3-4-50 Health Program) and healthy behaviors
- Skill building & retaining skills
- Vocational Rehabilitation services
- Empowerment and Self Reliance Skills
- Case Management

Services in WRR are provided based on a model of Team-Based Care (TBC). TBC is a multi-disciplinary approach in which all clinic/program members share joint responsibility in providing services, supports and treatment to consumers. Each

treatment team carries together an assigned caseload of consumers, and each team member – based on his/her role, expertise and scope of practice – contributes towards a consumer's success, recovery and goal achievement. Consumers therefore are receiving services that are coordinated and integrated while still individualized.

This team triages, evaluates, manages and treats all referrals from the community in collaboration with other specialty teams to ensure consumers are receiving the appropriate level of care. The WRR team provides evidence based, trauma informed treatment to children ranging from ages five through young adulthood. All treatment is customized and tailored to meet the individualized needs of each consumer as he/she works in collaboration with team members on treatment goals of mental health wellness and recovery. The team focuses on providing an array of services, including the following: individual, family and group therapy, behavioral treatment, intensive case management, psychiatric services and medication support. Team members can include any or all of the following: Mental Health Practitioners, Case Workers, a Psychiatric Technician, a Registered Nurse and a Psychiatrist.

A specialized service provided within the WRR program is the "Katie A" program. The services are provided in collaboration with the Department of Social Services' Child Welfare Services (CWS) program to screen, evaluate and identify any child with an open child welfare case to determine the acuity of their mental health needs and to provide them with the appropriate level of care. As indicated in the Core Practice Model, the Katie A Team strives to work within a team environment, with CWS, to build a culturally relevant and trauma informed system of support and services that is responsive to the strengths and underlying needs of families. The Katie A Team provides Intensive Care Coordination, Intensive Home Based Services, and Child and Family Team meetings in conjunction with all other core clinic support services. Team members can include any or all of the following: Mental Health Practitioners, Case Workers, a Psychiatric Technician, a Registered Nurse, and a Psychiatrist.

Program Challenges & Solutions:

One of the challenges is the recent changes in admission criteria implemented by the State in December 2016 within Children's services. The change in requirements impact Children services from accepting only moderate to severe consumers to more inclusive criteria. The new criterion includes consumers with mild to moderate and severe mental health needs for admission and treatment. Since these new lower level consumers are now being served, staffing resources, and timeliness to care have been impacted. The solution has led to an increased collaboration with the community in order to build additional resources and supports for consumers and families. Another challenge is not having developed designated Access staff in the Children System of Care in the previous MHSA plan. Not having Access staffing takes away from ongoing consumer care. Lastly, some of the Community Based Organization partner services are duplicating similar services within the County, and the level of care is not sufficiently defined. Due to these challenges the Department recognizes the likelihood that the current Children's programs will need to be restructured and the type of partnering re-considered.

Program Performance (FY 15-16)

Behavioral Wellness: Children's Wellness, Recovery and Resiliency Teams

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	258	152	154
16-25	89	98	54
26-59	1	2	0
60+	0	0	0
Missing DOB	1	2	1
Total	***349***	***254***	***209***
Gender			
Female	184	125	109
Male	162	129	100
Unknown	3	0	0
Ethnicity			
White	22%	18%	24%
Hispanic	71%	68%	64%
African American	3%	2%	5%
Asian/Pacific Islander	1%	2%	1%
Native American	0%	1%	1%
Other/Not Reported	3%	9%	5%

Client Outcomes

Child & Adolescent Needs & Strengths Assessment (CANS) Age: 6-17 years	**CANS Time Period**	**Percent Improvement**
Life Functioning (e.g., ability to communicate and interact with families, communication, social functioning and health status)	Initial – 6-mo.	20% (n=164)
	6-mo.-12-mo.	13% (n=142)
Behavioral/Emotional Needs (e.g., symptoms of depression, anxiety, psychosis and other conditions)	Initial – 6-mo.	22% (n=164)
	6-mo.-12-mo.	4% (n=142)
Child Risk Behaviors (e.g., self-injury, suicidal behavior, bullying, and running away)	Initial – 6-mo.	26% (n=164)
	6-mo.-12-mo.	0% (n=142)
School (e.g., behavior, attendance and grades)	Initial – 6-mo.	23% (n=164)
	6-mo.-12-mo.	0% (n=142)

Caregiver Needs & Strengths (e.g., child supervision skills, family stress levels, residential stability, and caregiver physical/mental health status)	Initial – 6-mo.		0.2% (n=164)
	6-mo.-12-mo.		0.1% (n=142)
Child Strengths (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment)	Initial – 6-mo.		9% (n=164)
	6-mo.-12-mo.		3% (n=142)
	North	**South**	**West**
Psychiatric Inpatient Care	4%	9%	3%

Adult Wellness and Recovery (WR) Teams - Behavioral Wellness

Provider:	Behavioral Wellness
Estimated Funding FY 2017/18:	
Estimated Total Mental Health Expenditures:	$3,089,753
Estimated CSS Funding	$736,263
Estimated Medi-Cal FFP:	$2,353,490
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$0

The Wellness and Recovery (WR) teams provide services to adults in a clinic setting, with some services provided in the community on an as-needed basis. All staff has been trained in relevant Evidenced-based Practices, including Cognitive-Behavioral Treatment and Trauma-Informed Care. Team members provide services in a variety of modalities including groups addressing trauma, depression and life skills. Groups related to improved health outcomes have been introduced. Consumers served in this team are also linked with services provided by the Department of Rehabilitation. A manual for Team-Based Care has been developed and implemented which articulates the roles and interactions for each team member and provision of services. In addition, case management services are always available to consumers to assist them with obtaining and maintaining housing, linking them to primary health care providers, and providing financial management support.

Program Challenges and Solutions

The WRR program was initially designed to serve consumers who are higher functioning and will be appropriate for step-down to a lower level of care. In practice, a different reality emerged due to a variety of factors: 1) the lack of step-down options available in the community, especially for Psychiatry, remains non-existent or very limited in all regions especially if the consumer has Medicare or Medicare/Medi-Cal insurance. Consumers who likely can step down remain at the clinic receiving services due to the lack of other treatment options; 2) a significant percentage of consumers who require on-going intensive services do not fit naturally into the specialized Co-Occurring or Medically Integrated Team, and by default remain in the

WRR team. The result of these barriers is that the WRR teams are comprised of consumers with a wide variety of diagnoses and treatment needs that stretches staff resources and impacts good consumer care.

Program Performance (FY 15-16)

Behavioral Wellness: Adult Wellness, Recovery & Resilience Teams

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	0	0	0
16-25	52	5	5
26-59	525	178	228
60+	76	56	35
Missing DOB	1	0	0
Total	***654***	***239***	***268***
Gender			
Female	366	130	154
Male	287	109	114
Unknown	1	0	0
Ethnicity			
White	45%	61%	56%
Hispanic	44%	26%	28%
African American	5%	6%	9%
Asian/Pacific Islander	3%	5%	4%
Native American	1%	>1%	1%
Other/Not Reported	2%	2%	2%

Client Outcomes

	North	**South**	**West**
Incarcerations	4%	4%	5%
Psychiatric Inpatient Care	6%	10%	6%
Milestones of Recovery Scale (*clients open in FY15/16*)	Initial MORS to 6-Month MORS (n=489): 27% showed improvement; 53% remained stable 6-Month MORS to 12-month MORS (n=172): 17% showed improvement; 60% remained stable		

In the Wellness, Recovery & Resiliency programs, nearly 80% of clients remained stable or improved over the course of 1 year of treatment. Hospitalization admissions were avoided at high rates, 90% and above, and approximately 5% of the clients were incarcerated during FY15/16.

HOPE Program – CALM, Santa Maria Valley Youth and Family Center

Provider:	CALM, Santa Maria Valley Youth and Family Center
Estimated Funding FY 2017/18:	
Estimated Total Mental Health Expenditures:	$1,020,000
Estimated CSS Funding	$0
Estimated Medi-Cal FFP:	$497,500
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$522,500
Estimated Other Funding:	$0

HOPE provides intensive in-home treatment to Foster Youth and their foster or kinship families. The goals are to maintain the stability of children in their homes and placements thereby reducing the necessity of multiple placements for a child. The program also focuses on working toward permanent placement through trauma-informed treatment for the youth and trauma informed parenting.

The CALM HOPE program covers the Santa Barbara and Lompoc regions. The HOPE Program in these regions is enhanced due to adjunct services funded through the Department of Social Services. These include Family Drug Treatment Court, the Intensive Family Reunification Program and the Trauma Informed Parenting Workshop series, all of which provide services to the youth's caregivers and have demonstrated a decrease in changes in placement and an increase in successful reunifications and adoptions.

Santa Maria Valley Youth and Family Center is the provider of HOPE service in the Santa Maria region (North County).

Program Challenges and Solutions

The annual caseloads for the HOPE Program are diminishing. It appears that with the implementation of the Katie A screening and referral process, fewer children in foster care are being referred to HOPE. For example, in FY13-14 ninety-four (94) referrals were received by the program, forty-two (42) referrals were made in FY 14-15, and thirty-four (34) in FY 15-16. Under current practice, these children have been referred to other programs that do not have the same experience and auxiliary services as the HOPE program that is specific to working with children in foster care. Fortunately the Trauma Informed Parenting Program is becoming more well-known County Wide. Referrals are now coming for foster, kinship and adoptive parents throughout Santa Barbara County regardless of the program through which the youth is being treated.

One challenge is related to broader system improvements. The current intensive in-home services may be consolidated in order to create a more comprehensive and seamless system. Therefore, HOPE and other services may be reconfigured in the upcoming year. This does not reflect a particular challenge for the program, but

rather, a system improvement under consideration. Changes to the State "Continuity of Care Reform" may also impact service due to new models introduced by the State.

Program Performance (FY 15-16)

HOPE

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	35	88	N/A
16-25	1	23	
26-59	0	0	
60+	0	0	
Missing DOB	0	0	
Total	***36***	***111***	
Gender			
Female	26	67	N/A
Male	10	44	
Unknown	0	0	
Ethnicity			
White	19%	22%	N/A
Hispanic	67%	57%	
African American	8%	5%	
Asian/Pacific Islander	6%	3%	
Native American	0%	3%	
Other/Not Reported	0%	10%	

Client Outcomes

	North	**South**
Incarcerations/Juvenile Hall	0%	0%
Psychiatric Inpatient Care	0%	3%
Out-of-Home Placement	0%	0%
Purposeful Activity (employed, school, volunteer)	100%	95%
Stable/Permanent Housing	100%	93%

Anka Crisis Residential Services North/South – Anka Behavioral Health

Anka Crisis Residential North

Provider:	Anka Behavioral Health
Estimated Funding FY 2017/18:	
Estimated Total Mental Health Expenditures:	$2,079,916
Estimated CSS Funding	$501,616
Estimated Medi-Cal FFP:	$1,154,200
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$424,100

Anka Crisis Residential South

Provider:	Anka Behavioral Health
Estimated Funding FY 2017/18:	
Estimated Total Mental Health Expenditures:	$926,739
Estimated CSS Funding	$228,239
Estimated Medi-Cal FFP:	$624,100
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$74,400

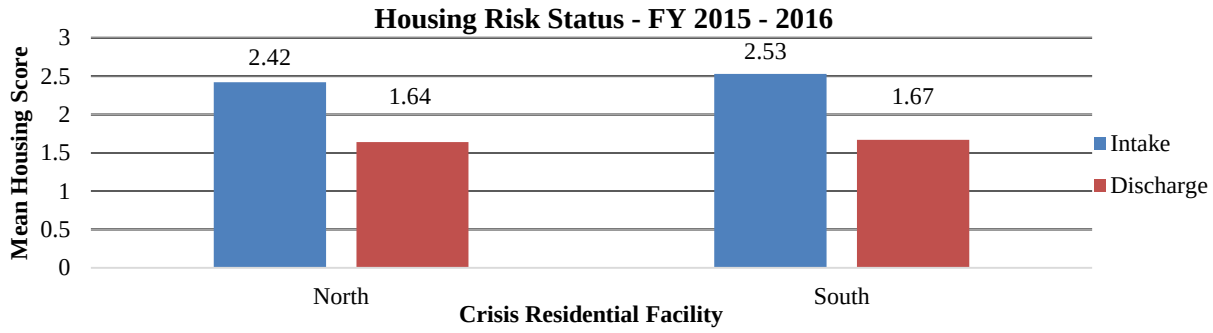
The Santa Barbara County Department of Behavioral Wellness offers voluntary residential recovery programs to clients in crisis in both North (Santa Maria) and South (Santa Barbara) County. The programs allow clients in crisis, who have a serious mental illness, to receive treatment from Mental Health Practitioners, Caseworkers, Peer Recovery Assistants, and Psychiatrists, while participating in various recovery programs. Clients can stay at either facility for up to 30 days at a time and have designated visitation hours. Residential crisis services aim to:

- provide an alternative to the hospital Emergency Department
- increase community-based services
- provide appropriate services in less restrictive environments
- provide post-crisis support and linkage to maintain stability and reduce recidivism

Program Challenges and Solutions

The primary objectives for Crisis Residential Treatment (CRT) programs are to reduce the client's active behavioral health symptoms and psychological distress. Using the Symptom Checklist and Triage Severity Scale as a measurement toll at intake and

discharge, significant improvements were reported at both North and South CRT facilities. Another primary objective for CRT staff is ensuring stable housing for clients upon discharge from CRT programs. Across all quarters evaluated, clients at both facilities consistently experienced significantly less homelessness at discharge than intake.



During the past year, the Santa Barbara and Santa Maria CRT program focus was to better collaborate and problem-solve with the County's Psychiatric Health Facility (PHF) , Crisis Stabilization Unit (CSU), Triage teams and other county resources with the goal of maximizing the bed occupancy at the CRT's. ANKA worked toward this goal by providing a driver to assist in the transportation of clients from the PHF and CSU to the CRT programs; and by working with their own staff to be more flexible with admission hours and working collaboratively with the County on challenging clients. Although ongoing effort by the parties is required for beds to be consistently full, progress was made with collaboration and problem-solving

Program Performance (FY 15-16)

Anka Crisis Residential

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	0	0	N/A
16-25	31	10	
26-59	160	97	
60+	13	11	
Missing DOB	0	0	
Total	***204***	***118***	
Gender			
Female	95	51	N/A
Male	109	67	
Unknown	0	0	

Ethnicity			
White	59%	67%	N/A
Hispanic	31%	20%	
African American	4%	4%	
Asian/Pacific Islander	1%	2%	
Native American	0%	1%	
Other/Not Reported	5%	6%	

Treatment Engagement: Client engagement in treatment, such as medication compliance and participation in therapeutic activities, is critical for stabilization and recovery. The target for engagement is 75%. In FY15/16, clinical staff reported that over 80% of clients were engaged in program services. Follow-up care beyond the CRT is an important component in helping clients maintain gains made toward recovery and preventing hospital or CRT admissions. Over 60% of clients are referred to an outpatient clinic setting for follow-up care in FY15/16.

Stable/Permanent Housing: The CRT program strives to develop a plan for stable/permanent housing by discharge for clients that are at risk for homelessness or are homeless. Program staff assess housing status and risk for homelessness at admission and discharge. In FY15/16, housing risk/homelessness among CRT clients was reduced by 33%.

Client Satisfaction with Services: Clients in North and South County strongly agree or agree that their treatment was satisfactory, and that services received were effective, efficient, accessible, and collaborative. Clients report that staff were "exceptionally helpful during this time of crisis", and "the classes were comforting and the knowledge was so good".

Staff Professional Quality of Life: The CRT employs peer and non-peer staff. As the CRT serves a population with intensive needs with a high number of peer staff, it was important that Anka monitor the wellbeing of their staff. Using the Professional Quality of Life Survey, job or work burnout, secondary traumatic stress (emotional duress from listening to another's trauma experience), and compassion satisfaction were assessed on all staff each quarter. Staff report high professional quality of life. Peer and non-peer staff report feeling pleasure and satisfaction from their work often/very often, and rarely experience burnout or secondary traumatic stress.

Behavioral Health Symptoms: Both clinician- and client-reported symptoms and psychological distress decreased by more than 50% in FY15/16 between intake and discharge from the CRTs. Clients reported being able to sleep better, a reduction in voices, and feeling as though they are human again and can contribute to society.

Inpatient Recidivism: In FY15/16, 83% of clients served the CRTs remained stable in the community and did not require hospitalization within 30 days of discharge from the CRT. These data suggest that the CRT successfully reduced mental illness symptoms, stabilized medication, and addressed other life functioning needs such as housing.

Medical Integration Program - Behavioral Wellness

Provider:	Santa Maria Valley Youth and Family Center
Estimated Funding FY 2017/18	
Estimated Total Mental Health Expenditures:	$1,948,969
Estimated CSS Funding	$208,519
Estimated Medi-Cal FFP:	$1,035,230
Estimated 1991 Realignment:	$705,220
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$0

The specialized Medical Integration teams in each region of the County serve persons with severe mental illness who also experience serious medical problems, including individuals who are 60 years of age and over. Teams address the complex needs of this population, including multiple medication management and the prevalence of significant physical and mental health conditions. In the past year, 386 consumers have been identified and assigned to these teams. With ongoing evaluation and program development the Teams learned that age alone was not a clinically appropriate determination for assignment to this program. Each consumer is now being assigned based on the existence of complex medical needs to ensure individualized treatment.

The Teams serve:

- Newly diagnosed individuals with chronic/severe health conditions;
- Persons with poorly managed health conditions;
- Individuals with multiple and complex health conditions;
- Persons with limited mobility and/or incapacities due to health conditions;
- Elderly and infirm people;
- Dually diagnosed individuals with a medical condition;
- Persons with infectious/chronic conditions;
- Persons with apparent health conditions that need to be connected with a primary care provider.

Forging new partnerships with primary care and substance use treatment providers is essential. In monthly meetings, each region is collaborating with the Public Health Department, Community Based Organizations (CBO's), other community health providers and service agencies to improve the care of mutual consumers and to develop seamless processes of referral. Services provided to consumers in the Medical Integration team are mostly medication support services and intensive case management services. Groups addressing pain management and healthy living (i.e. nutrition, exercise) also have been introduced.

The key measurements of the project include assessing the reduction in hospitalization and Emergency Room visits; potential reduction of service duplication; improvement in medication management; potential reduction of costs of primary and mental health care and improved quality of life.

- Reduction of hospitalization
  Consumer data will be collected to benchmark hospitalization and emergency room rates prior to program participation and will be compared to rates during the time of enrollment.

- Improvement in service coordination
  Specialized teams equipped to address co-occurring health and mental health conditions are designed to reduce the duplication of services, improve service coordination and medication management. A tool will be developed to measure progress in these areas.

- Reduction of long-term primary and mental health care costs
  Data analysis of Emergency Room visits and hospitalization will provide a partial measurement of this outcome. Data related to costs in services prior to enrollment will also assist in developing a comparative analysis.

- Improvement in quality of life
  Qualitative tools will be identified and utilized to determine if improvements have been made in this area.

Program Challenges and Solutions

This program was developed to serve older adults to now serving consumers with complex medical needs of all ages. The services have evolved to being a specialized area that requires a lot of collaboration with primary care and ongoing education and collaboration. This population requires intensive field-based medical and case worker services that exceeded the allocated staffing patterns**.** To address this issue, the Medical Integration teams were trained in team-based care so that responsibility for consumer care could be shifted away from individual caseloads to multi-disciplinary teams who could assist with multiple consumers. The teams have been very successful in integrating a team-based approach and have successfully adopted consumers into their new teams. However, ongoing refinement to this approach may require evolving into levels of care that include medical integration at all levels, being mindful that each program level will require a different level of coordination and services.
A 3-4-50 Health Program Manual and trainings have been developed and implemented including groups such as Rethink your Drink, movement, pain management, healthy eating, yoga, and walking to assist consumers with improving physical concerns which impact their mental health.

The original vision for the implementation of three specialized programs (Wellness Resilience Recovery, Medically Integrated Older Adult, and Co-Occurring Disorders) was for staff positions to be flexible. Fiscal structure didn't allow for staff movement which created stagnation of consumers in programs that no longer applied to them after specialized treatment was provided. Consumers naturally became attached to their originally assigned clinicians, but were reassigned to new clinicians when transferring from program to program. These transfers created ruptures in therapeutic relationships or a lack of fidelity to fiscal organizational structures when consumers were kept with the original clinician. In order to address these challenges, the Department envisions designing levels of care encompassing the specialty programs focusing on consumers' needs for services. This, in addition to Team Based Care will allow flexibility of staff to provide services at each level of care and at each program within the outpatient clinic site. This is a proposal being recommended in this Three Year Plan.

Program Performance (FY 15-16)

Behavioral Wellness: Medical Integration and Older Adult Teams

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	0	0	0
16-25	1	0	3
26-59	164	21	68
60+	113	72	22
Missing DOB	0	0	0
Total	***278***	***93***	***93***
Gender			
Female	181	57	65
Male	97	36	28
Unknown	0	0	0
Ethnicity			
White	59%	69%	57%
Hispanic	31%	20%	30%
African American	4%	8%	11%
Asian/Pacific Islander	3%	1%	1%
Native American	1%	0%	0%
Other/Not Reported	2%	2%	1%

Client Outcomes

	North	South	West
Incarcerations	3%	2%	3%
Psychiatric Inpatient Care	2%	8%	11%
Milestones of Recovery Scale	Initial MORS to 6-Month MORS (n=165):		

(*clients open in FY15/16*)	22% showed improvement; 60% remained stable 6-Month MORS to 12-month MORS (n=58): 10% showed improvement; 66% remained stable

Although, the majority of clients remained stable with MORS scores over time, it is important to consider additional outcome variables, such as incarcerations and hospitalizations, in evaluating the effectiveness of Behavioral Wellness services. Clients in the Medically Integrated/Older Adult programs successfully avoided hospitalizations at high rates, 89% and above, and approximately 3% of the clients were incarcerated during FY15/16.

Full Service Partnerships

About Full Service Partnerships:

Full Service Partnerships (FSPs) are one of three funding categories within the MHSA Community Services and Supports (CSS) funding component. MHSA Guidelines for FSPs require that these programs:

- *provide all necessary and desired appropriate services and supports* to consumers and families to achieve goals identified in their plans;

- provide each consumer an *individual service plan* that is person/child-centered and includes sufficient information to allow them to make informed choices about the services in which they participate;

- *maintain a single point of responsibility* – Personal Service Coordinators (PSCs) for adults – case managers for children and youth – with a caseload that is low enough so that: (1) their availability to the individual and family is appropriate to their service needs, (2) they are able to provide intensive services and supports when needed, and (3) they can provide the consumer served and/or family member considerable personal attention;

- *respond to consumers and family members 24 hours a day, 7 days a week* with PSCs, children's case managers or team members known to the consumer or family member;

- *respond to landlords and/or law enforcement* for transition age-youth, adults and older adults; for children and youth it must include the ability to respond to persons in the community identified by a child's family;

- be staffed with people *known to the consumer or family member to be culturally competent* and know the community resources of the consumer's racial/ethnic community;

- *provide direct service or linkages to all needed services or benefits as defined by the consumer and or family* in consultation with the PSC/case manager. This includes the capability of increasing or decreasing service intensity as needed.

Assertive Community Treatment (ACT): Santa Barbara, Lompoc and Santa Maria

Adult Assertive Community Treatment (ACT) programs for adults include Santa Maria ACT FSP (Provider: Telecare; capacity 100), Santa Barbara ACT FSP (Provider: Behavioral Wellness; capacity 100); Lompoc ACT FSP (Provider: Transitions Mental Health Association; capacity 100).

ACT is an evidence-based approach for helping people with severe mental illness, including those experiencing co-occurring conditions. ACT programs offer integrated treatment, rehabilitation and support services through a multidisciplinary team approach to transition-age youth and adults with severe mental illness at risk of homelessness. ACT seeks to assist consumers' functioning in major life domains.

Treatment includes early identification of symptoms or challenges to functioning that could lead to crisis, recognition and quick follow-up on medication effects or side effects, assistance to individuals with symptoms self-management and rehabilitation and support. Many consumers experience co-occurring mental health conditions and substance abuse disorders.

Lompoc ACT FSP

Provider:	Transitions-Mental Health Association
Estimated Funding FY 2017/18:	
Estimated Total Mental Health Expenditures:	$2,072,850
Estimated CSS Funding	$967,750
Estimated Medi-Cal FFP:	$1,105,100
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$0

Transitions Mental Health Association provides ACT services in Lompoc. As an ACT model program, the staff functions as a team and provide services for adults, older adults, and transitional age youth with serious and persistent mental illness. The team provides treatment, support and rehabilitation services in the community with a "whatever it takes" approach. Lompoc ACT is committed to reducing homelessness, hospitalizations, and incarceration and focuses on encouraging each individual's recovery and pursuit of a full, productive life.

From 2014-2017, services have been focused on supporting consumers moving further along in their recovery journeys. Emphasis has been placed on supporting individual goals of employment, education, and volunteer work, encouraging growth in these areas. Transitions Mental Health Association has been able to connect consumers with our own employment programs and employment opportunities at the Growing Grounds Farm and Recovery Learning Communities (RLC). ACT consumers have been employed at the farm, the RLC, as well as in-house paid job training positions.

Over the past three years, this program has also shifted its staffing pattern to employ more Master's Level clinical staff. This has resulted in more therapeutic offerings and group treatment options and has benefited the ACT population.

This team has provided services to over 100 unique consumers each of the last 3 fiscal years. As a result, in-patient hospitalizations have been reduced, employment and education participation has increased, and incarcerations have reduced as well.

- 95% of consumers have avoided incarceration
- 97.5% have avoided in-patient medical hospital stays
- 94% have remained in stable housing
- 15% are participating in work, volunteer activities, or pursuing educational goals

Santa Maria ACT FSP

Provider:	Telecare Corporation
Estimated Funding FY 2017/18:	
Estimated Total Mental Health Expenditures:	$2,730,665
Estimated CSS Funding	$945,175
Estimated Medi-Cal FFP:	$1,420,100
Estimated 1991 Realignment:	$365,390
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$0

Telecare Corporation provides contract Assertive Community Treatment (ACT) services to the Department of Behavioral Wellness in Santa Maria. Santa Maria ACT (SM ACT) employs the following Program Goals to fulfill consumer outreach objectives:

A. Build Relationships with consumers based on mutual trust and respect.

Consumers are in various stages of relationship development with staff and are connected to a variety of staff based on need and consumer preference. Each consumer has a point-person; however, emphasis is placed on development of relationships with the team as a whole, as well as this "primary" point-person.

Consumers interface with employment and co-occurring staff when this is a focus of treatment and/or is a barrier to the “hope and dream” for the consumer. Medical care is provided by the Department of Behavioral Wellness Psychiatrist and Nurses assigned to the team. Consumers involved with forensic systems are supported in Mental Health/Drug Court as well as Probation obligations. In 2015, the Team-Within-A-Team (team-based) approach to improving mutual relationships and individualized care was implemented:

1) Team A – This team is for those newly admitted to the program or those who are poorly coping, at risk for crisis, or minimally engaging. This team meets with consumers more than once a week.

2) Team B – Consumers in this team may be somewhat coping but are engaged in treatment or may be coping and actively working on rehabilitation. Consumers are seen at least once a week.

3) Team C – This team works with those who have achieved early recovery and are ready to graduate to the next level of recovery. The team focuses on community linkage and preparation for clinic services. Consumers are seen at least once a week with a gradual plan to reduce direct staff services to every other week in preparation for transition to outpatient clinic services.

Comprehensive reviews for each consumer are completed once a month to determine team placement. The Milestones of Recovery Scale (MORS) was implemented in 2015 and is utilized on the first Monday of the month for the prior month. Efforts are underway to be more inclusive of the consumer in this process and to physically have them present whenever possible in comprehensive planning meetings and treatment plan development. We are encouraging the consumer to be involved and take an active role in their own recovery.

B. Offer Individualized Assistance: Each consumer is assisted in the areas of medical and psychological health, housing, education, vocational readiness, interpersonal skills development, substance use, and family interactions as identified in a “problems” list. Goals, both short and long term, are prioritized by the consumer. Stages of recovery are addressed by the team to assist consumers in identifying barriers which the consumer may not connect to past or current failures in reaching their own hopes and dreams.

C. Provide a culture of recovery through Telecare’s Recovery-Centered Clinical Systems (RCCS) treatment modality

Admissions are voluntary and prioritized based on need of the consumer and the ability of the team to meet his or her needs. Each consumer has the right to fail or succeed based on their choices. The consumer drives recovery through staff support in the awakening of hopes and dreams. The recovery process involves gaining the knowledge to reclaim one’s power and achieve one’s desires by learning to make choices that bring strength rather than harm. Recovery involves living a meaningful life with the capacity to love and be loved.

No matter with which culture or cultures the consumer identifies, it is the goal of the program to recognize the unique differences, strengths, knowledge and

experiences of each person served. Inclusion into the community as an active, independent, healthy, and productive citizen is the program's goal.

70% of services are provided in the community and use natural supports whenever possible. Development of a broad support network is necessary for continued growth and achievement of life goals.

D. Provide continuity across time

Many of SM ACT's consumers have long-term relationships with team members. A "whatever-it-takes" approach is used to support each consumer in their recovery. Support is given when the following situations occur but is not limited to: medical care is needed; psychiatric crisis; being unable to make effective choices which thereby leads to risky behaviors; involved with forensic services; specialized group participation is needed (e.g. rape crises counseling); or when family issues occur beyond the ability of the consumer's skill to either problem solve, set limits, or re-establish connections. Services are provided 24/7/365 through a crisis line answered by a familiar staff ready to provide support.

E. Operate as a comprehensive, self-contained service.

All outpatient behavioral health services are provided by SM ACT. The team has a wide variety of experience and expertise. Linkage to community support while an individual is a consumer of SM ACT is part of the Full Service Program (FSP) wraparound service.

Program Challenges and Solutions

Between 2014-2017, SM ACT saw changes and challenges in various areas such as staffing, documentation, and available resources both internally and in the community. Changes implemented within Telecare and within the Department of Behavioral Wellness were also factors that impacted services at the program level. Positive changes for consumers are evidence by MHSA data for this reporting period:

- *Census*: Average census of 93 was maintained for the ACT program. An average census of 1 was maintained for the ACTOE program.

- *Incarceration*: 90% have never been incarcerated since enrollment. 4 out of 93 is the average of incarcerated members.

- *Psychiatric Admission:* 90% have never been psychiatrically hospitalized since enrollment. 2 out of 93 is the average of members psychiatrically hospitalized.

- *Physical Health Admission:* 96% have never been medically hospitalized since enrollment. 4 out of 93 is the average of members medically hospitalized.

- *Emergency room visits for physical health*: 95% have avoided emergency room visits for physical concerns since enrollment. 5 out of 93 is the average of members going to the emergency room for physical health reasons.

- *Stable Housing*: 87% have maintained stable housing since enrollment.

- *Vocational/Employment*: An average of 83 members have participated in a gainful activity (employment, school/vocational training, volunteer) since enrollment.

Santa Barbara ACT FSP

Provider:	Behavioral Wellness
Estimated Funding FY 2017/18:	
Estimated Total Mental Health Expenditures:	$2,642,267
Estimated CSS Funding	$1,872,307
Estimated Medi-Cal FFP:	$712,300
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$57,660

Santa Barbara ACT functions as a multi-disciplinary team, meeting every morning to review the status of all clients and develop the Daily Organizational Schedule. The Daily Organization Schedule enables the team to determine which services will be provided that day based upon consumer acuity and regular rehabilitation and medication support visits. ACT services are provided to transitional age youth (18-25); adults (26 to 59), and older adults (60 and over) with serious and persistent mental illness. The team recently transitioned to two teams, both of which provide all services as needed. Each team includes a Practitioner, Nurse, Case Manager, Vocational Rehabilitation Specialist, and a Recovery Assistant. Both teams report each morning on what happened during the last 24 hours, and work together to ensure that all consumers are seen as needed, including the option of teams crossing-over to support client needs and acuity. The team operates in a manner consistent with the ACT fidelity model, doing “whatever it takes” to ensure consumers are provided with case management, rehabilitation, therapy, and linkage to other supportive services in the community as needed. Santa Barbara ACT is committed to reducing homelessness, hospitalizations, and incarceration and focuses on providing all services using a recovery-based, client-centered approach

Program Challenges and Solutions

In the last several years, ACT programs have faced challenges related to fidelity compliance. Concerns related to fidelity and program consistency were addressed by conducting an in-depth fidelity review of all three ACT programs during this last three year period. The review tool used was the updated TM-ACT (The Tool for

Measurement of ACT) which has 47 items rated on a 5-point scale, as compared to the former DACTS (Dartmouth Assertive Community Treatment Scale).

Over the past three years, this ACT program has undergone a number of changes (e.g., changes in management, documentation practices, and team leadership), but has begun shifting to the fidelity model again. This includes completing comprehensive assessments in order to get to know the consumers as fully as possible, thus facilitating the development of a treatment plan based upon the consumers wishes and needs. The multi-disciplinary team meets as part of the Individual Treatment Team (ITT) to review the summaries of the assessments, and build the treatment plan to be reviewed again with the consumer for final review. This takes place within the first 30 days.

The team also shifted its staffing pattern to employ more Practitioner Interns and Volunteer Interns (Master's level staff), greatly increasing the ability to provide clinical services needed. This additional staff will assist the team in meeting consumers more to work on rehabilitation, leading to a reduction in hospital days and jail days. The ACT program is also working on developing more groups (Seeking Safety, Dialectical Behavior Therapy (DBT); physical health (wellness); and co-occurring groups) during this Three Year Plan period.

Program Performance (FY 15-16)

Assertive Community Treatment (ACT)

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	0	0	0
16-25	5	1	16
26-59	82	82	73
60+	28	30	23
Missing DOB	0	0	0
Total	***115***	***113***	***112***
Gender			
Female	50	49	56
Male	65	64	56
Unknown	0	0	0
Ethnicity			
White	68%	67%	61%
Hispanic	22%	20%	28%
African American	8%	4%	5%
Asian/Pacific Islander	1%	3%	4%
Native American	1%	0%	0%
Other/Not Reported	0%	6%	2%

Client Outcomes

	North	South	West
Incarcerations	3%	6%	8%
Psychiatric Inpatient Care	4%	15%	7%
Physical Health Hospitalization	4%	3%	6%
Physical Health Emergency Care	20%	1%	20%
Stable/Permanent Housing	88%	50%	91%
Purposeful Activity (employed, school, volunteer)	10%	8%	24%
Graduation to Lower Level of Care	74% of clients discharged went to a lower level of care	85% of clients discharged went to a lower level of care	87% of clients discharged went to a lower level of care
Milestones of Recovery Scale (*clients open in FY15/16*)	Initial MORS to 12-Month MORS: 19% showed improvement; 56% remained stable 12-Month MORS to 18-month MORS: 16% showed improvement; 70% remained stable		

Supported Community Services FSP: Pathpoint in Santa Barbara and Transitions Mental Health Association in Santa Maria

Supported Community Services (formerly known as Supported Housing) is a lower level Full Service Partnership (FSPs). There are currently two Supported Community Service Programs, one in Santa Maria and a second in Santa Barbara. These programs must be staffed with people known to the consumer or family member to be culturally competent and know the community resources of the consumer's racial/ethnic community.

Supported Community Services South (Santa Barbara) – PathPoint

Provider:	PathPoint
Estimated Funding FY 2017/18	
Estimated Total Mental Health Expenditures:	$1,211,746
Estimated CSS Funding	$450,341
Estimated Medi-Cal FFP:	$632,800
Estimated 1991 Realignment:	$70,945
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$57,660

PathPoint's Behavioral Health Division provides supportive housing services that assist individuals challenged with behavioral health diagnosis to live independently, be connected to community resources, and receive medical support & therapy support for dealing with symptoms that might interfere with daily living. Paths to Recovery (PTR) mobile team is PathPoint's MHSA funded Full Service Partnership providing Supported Housing services to individuals living in South Santa Barbara County. The PTR mobile team consists of a Psychiatrist, Nursing staff, Marriage & Family Therapists (and Interns), and Qualified Mental Health Rehabilitation Specialists with expertise in "lived experiences," substance recovery, mental illness, and vocational services. This mobile team fans out across the community each day to meet with PathPoint consumers served by PTR in the community, and helps them continue on the path to wellness. This aid takes the form of basic medical care (shots, medications, medical advice, etc.), psychological therapy, crisis and eviction prevention, and social and vocational skills training. Many persons enrolled in the PTR program live in PathPoint-operated, and HUD subsidized, properties in Santa Barbara. The most notable change in this MHSA funded program was the addition of a grant funded Registered Nurse (RN) to provide medical services. This RN was first funded from a Cottage Hospital grant in December 2014 but the RN was hired in 2015. The goal is to integrate health care and mental health care service. Below are the following most recent outcome goals:

Outcome 1: Reduction of Unnecessary Hospitalizations.

During this past six-month period, PTR had only 3 true emergencies that needed hospitalization out of a total of 45 consumers, compared to 4.75 per month or 57 per year in the six-month period prior to program implementation. Extrapolated over a one-year period, this rate amounts to a 13% chance of a consumer needing one emergency hospitalization per year; down from 81% prior to program implementation. This is an increase over the previous 6-months figure of 6.3% of enrolled consumers, but given that many of the consumers are now securely connected with medical services, those that request Mobile Nursing services have a higher likelihood of having a medical crisis.

Outcome 2: Increase in access to primary health care services.
Of the 45 consumers served these past six months, 10 of them – 22% – did not know who their doctors were. They were linked to their Primary Care Provider (PCP) and appointments were made for them. Again, 100% of consumers are now successfully connected to appropriate medical services.

Outcome 3: Increased understanding and competency in symptom self-management.
Of the 45 consumers seen by the PCP, 26 were able to manage their medical care/medications, following up with the PCP regularly and take their medications as prescribed. The rest of the consumers had medications delivered to them in weekly pill packs by their Case Managers, and one is assisted in packing her own pill pack by the Nurse. All consumers benefitted from an increased understanding and competency in symptom self-management after meeting with the Mobile Nurse. They followed through on self-care directions, connected with their PCP, tracked their appointments

and clearly understood the value of taking their medications appropriately. A portion of the consumers served are non-compliant with medical treatment, refuse to see a doctor, or don't care about their health due to mental illness or addiction, or for other reasons (such as low IQ, poor motivation, or other competing stressors) have a poor ability to understand/comprehend information.

Outcome 4: Reduction in levels of measureable pain and discomfort from medical conditions.
Out of the 45 consumers seen in this period, 10 complained of pain. Of these, 6 reported an improvement after either surgery or steroid injections. One still suffers from knee pain while waiting for knee surgery, while 3 continue to manage pain. While this group complains of pain or chronic pain issues, they feel that this is managed as well as possible under the circumstances.

Many of our consumers are not accurate reporters of pain. Some (due to their mental health impairments) are not very cognizant of their physical condition. Others over report pain – saying on a scale of 1-10 they are "15". Again, due to mental health impairments there is an over reporting – dramatization – of the physical condition perhaps due to paranoia.

Supported Community Services North (Santa Maria) – Transitions Mental Health Association

Provider:	Transitions-Mental Health Association
Estimated Funding FY 2017/18:	
Estimated Total Mental Health Expenditures:	$990,852
Estimated CSS Funding	$431,452
Estimated Medi-Cal FFP:	$559,400
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$0

Santa Maria Supported Community Services provides outpatient mental health treatment for adults and older adults with severe and persistent mental illness. The intensive treatment team helps individuals to recover and live independently within their community. Program participants are assisted in their efforts to gain the skills needed to make choices that reflect their own values, preferences, and goals; supports are developed to meet each person's needs and to empower each individual to attain their highest level of independence and recovery possible. Over the last 3 years this program has shifted the focus to each consumer's unique recovery journey. Staff and consumers work together to identify recovery goals and to develop a specific "road map" for each individual, with an overall goal of reaching a level of recovery that enables an individual to graduate from the program.

In the past two years additional Master's level clinical staff have been recruited and more therapeutic groups and individual therapy opportunities have been offered to consumers. Groups have focused on healthy relationships, self-care, stress management, coping skills, art therapy, co-occurring disorder support, and laughter therapy. Supportive Services has provided care for 119, 117, and 116 unique individuals in each of the past three fiscal years respectively. In the past three years, on average:

- 97.5% of consumers have avoided incarceration
- 97.5% of consumers have avoided in-patient psychiatric stays
- 97% have remained housed
- 10% have participated in employment, volunteer activities, or education

Program Performance (FY 15-16)

Community Supportive Services (*formerly Supported Housing*)

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	0	0	N/A
16-25	2	1	
26-59	99	79	
60+	35	37	
Missing DOB	0	0	
Total	***136***	***117***	
Gender			
Female	67	50	N/A
Male	69	67	
Unknown	0	0	
Ethnicity			
White	51%	76%	N/A
Hispanic	36%	10%	
African American	5%	8%	
Asian/Pacific Islander	6%	3%	
Native American	0%	1%	
Other/Not Reported	2%	2%	

Client Outcomes

	North	South
Incarcerations	2%	1%
Psychiatric Inpatient Care	2%	2%
Physical Health Hospitalization &	4%	3%

Physical Health Emergency Care	20%	8%
Stable/Permanent Housing	95%	96%
Purposeful Activity (employed, school, volunteer)	15%	17%
Graduation to Lower Level of Care	60% of clients discharged went to a lower level of care	85% of clients discharged went to a lower level of care
Milestones of Recovery Scale (*clients open in FY15/16*)	Initial MORS to 12-Month MORS: 30% showed improvement; 57% remained stable	

SPIRIT FSP Wraparound Services – Behavioral Wellness

Provider:	Behavioral Wellness
Estimated Funding FY 2017/18:	
Estimated Total Mental Health Expenditures:	$2,392,809
Estimated CSS Funding	$509,423
Estimated Medi-Cal FFP:	$880,184
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$968,202
Estimated Other Funding:	$35,000

This Full Service Partnership (FSP) for children and their families is an evidenced based, Wraparound program known as the SPIRIT TEAM, designed around the following MHSA core principles: consumer and family involvement and empowerment, culturally competent and appropriate services, integration into existing systems, collaboration and partnership and wellness and recovery.

The SPIRIT Team (capacity 75) operates in all three regions of the County as a specialized team that provides intensive, high frequency services to a disenfranchised, underserved population of consumers and families that have limited resources, failed to thrive with conventional treatment, and whose children are at risk for placement in Out Of County high level facilities.

The SPIRIT Team strives to implement services within a Wraparound model of treatment delivery focusing on engagement, plan development, plan implementation and transition. Consumers and families are involved at every level of the planning and treatment process aimed at achieving their family vision, hopes and dreams and wellness goals.

The SPIRIT team consists of the following: Mental Health Practitioner/Family Facilitator, Peer Parent Partner and a Child/Family Specialist. Teams serve consumers at a 1:15 ratio and ensure that care is available 24/7. This main team works alongside other outpatient teams which can include any or all of the following: Mental Health Practitioners, Case Workers, Psychiatric Technician, Registered Nurse and Psychiatrist. Together they provide a comprehensive array of services.

Program Challenges and Solutions:

SPIRIT Team services are designed to be high frequency and intensive to engage the most resistant and high needs consumers and families. At times these families with very limited resources and high social/ emotional needs struggle with transitioning out of SPIRIT's intensive supportive 24/7 care; they also struggle to maintain some of the necessary changes they learned during their involvement with SPIRIT. One reason that families are fearful and reluctant to end SPIRIT services and transition to a lower level of care is the lack of sufficient supportive resources in the community. It will be important to reconsider the existing programs across the spectrum including Community Based Organizations' programs, to better meet the needs for these families. This is a proposal that will be developed as part of this Three Year Plan.

Program Performance (FY 15-16)

SPIRIT

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	26	18	27
16-25	6	9	6
26-59	0	0	0
60+	0	0	0
Missing DOB	0	0	0
Total	***32***	***27***	***33***
Gender			
Female	15	11	15
Male	17	16	18
Unknown	0	0	0
Ethnicity			
White	16%	4%	18%
Hispanic	81%	89%	76%
African American	3%	4%	3%
Asian/Pacific Islander	0	4%	0%
Native American	0	0%	0%
Other/Not Reported	0	0%	3%

Client Outcomes

Child & Adolescent Needs & Strengths Assessment (CANS)	CANS Time Period	Percent Improvement

Age: 6-17 years			
Life Functioning (e.g., ability to communicate and interact with families, communication, social functioning and health status)	Initial – 6-mo.		21% (n=25)
	6-mo.-12-mo.		25% (n=17)
Behavioral/Emotional Needs (e.g., symptoms of depression, anxiety, psychosis and other conditions)	Initial – 6-mo.		17% (n=25)
	6-mo.-12-mo.		30% (n=17)
Child Risk Behaviors (e.g., self-injury, suicidal behavior, bullying, and running away)	Initial – 6-mo.		27% (n=25)
	6-mo.-12-mo.		42% (n=17)
School (e.g., behavior, attendance and grades)	Initial – 6-mo.		0% (n=25)
	6-mo.-12-mo.		29% (n=17)
Caregiver Needs & Strengths (e.g., child supervision skills, family stress levels, residential stability, and caregiver physical/mental health status)	Initial – 6-mo.		4% (n=25)
	6-mo.-12-mo.		2% (n=17)
Child Strengths (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment)	Initial – 6-mo.		5% (n=25)
	6-mo.-12-mo.		10% (n=17)
	North	**South**	**West**
Psychiatric Inpatient Care	23%	14%	16%

Forensic FSP (Justice Alliance) - Behavioral Wellness

Provider:	Behavioral Wellness
Estimated Funding FY 2017/18:	
Estimated Total Mental Health Expenditures:	$1,609,504
Estimated CSS Funding	$1,346,404
Estimated Medi-Cal FFP:	$263,100
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$0

Justice Alliance provides licensed mental health professionals in each region of the County to link persons involved with the legal system to wellness- and recovery-oriented services. The Justice Alliance program serves adults with severe mental illness in custody, out of custody and on probation or at risk of being in custody.

These individuals may have co-occurring substance abuse conditions. Many of the individuals assessed are un-served or under-served members of ethnically diverse populations, and in need of integrated and simultaneous mental health and substance abuse treatment.

Justice Alliance staff members work closely with the Court, Probation, Public Defender, District Attorney, Community-Based Organizations and other Department of Behavioral Wellness treatment teams to make treatment recommendations, facilitate access to treatment and provide follow-up progress reports to the Court and other appropriate parties. Justice Alliance staff are responsible for the initial ACT screening and disposition process. Staff members identify appropriate ACT consumers and ensure that consumers are placed in the appropriate regional ACT programs or Supported Housing Teams. When consumers do not qualify for ACT services, staff will refer consumers to the appropriate specialized outpatient teams such as Medical Integration, Co-occurring, or Wellness and Recovery.

In addition, Justice Alliance staff provide competency restoration services to misdemeanants found incompetent to stand trial, as well as providing case management to individuals receiving outpatient competency restoration services at newly established Alameda House and Cottage Grove housing facilities.

Program Challenges and Solutions

Since Justice Alliance does not have Rehabilitation/Case Worker staffing to fulfill its obligations to engage in case management and rehabilitation activities, Justice Alliance staff work closely with the Department's outpatient clinics to provide services. Without consistent rehabilitative services available, the Program's ability to provide ongoing services to individuals who are engaged in the criminal justice system is compromised. Finally, collaboration, linkage, and brokerage with other Departmental programs has at times, fallen short of expectations. Reconsidering the operations of the Justice Alliance Program is one of the proposals recommended in this Three Year Plan.

Program Performance (FY 15-16)

Justice Alliance

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	0	0	0
16-25	39	62	34
26-59	129	238	68
60+	6	25	2
Missing DOB	1	1	1
Total	***175***	***326***	***105***
Gender			
Female	71	75	39
Male	104	251	63
Unknown	0	0	3

Ethnicity			
White	40%	52%	42%
Hispanic	47%	25%	42%
African American	8%	6%	8%
Asian/Pacific Islander	2%	2%	0%
Native American	0%	1%	0%
Other/Not Reported	3%	14%	8%

Client Outcomes

	North	South	West
Incarcerations	51%	46%	66%
Psychiatric Inpatient Care	11%	21%	18%
Milestones of Recovery Scale (*clients open in FY15/16*)	Initial to 6-Month MORS (n=87): 38% showed improvement 40% remained stable		

In FY15/16, 38% of clients showed improvement on the MORS during the first 6 months. Hospitalization admissions were higher in South County, but overall, inpatient care was less than 21% county-wide. Incarcerations rates were high in all three programs, which is anticipated given the nature of the program.

Senate Bill 82 (S.B. 82)

California Senate Bill 82 (S.B. 82), the Investment in Mental Health Wellness Act of 2013, uses state MHSA funding to provide grants to counties. The Department of Behavioral Wellness received approximately $11 million in S.B. 82 funding. This funding supports Crisis Triage Teams in Santa Maria, Santa Barbara and Lompoc, a Mobile Crisis West team in Lompoc, a new Crisis Stabilization Unit in Santa Barbara and Santa Maria, and the Crisis Residential Facility in Santa Barbara and Lompoc.

A description of the enhanced crisis services made possible by S.B. 82 funding is included in this Plan update because all Department of Behavioral Wellness outpatient programs, regardless of funding source, are integrated through implementation of the guiding principles of MHSA and by using consistent evidence-based practices.

The Crisis System of Care and Recovery includes the following components:

- Access and Assessment teams, Santa Maria, Lompoc, Santa Barbara (funded by MHSA)
- Santa Maria and Santa Barbara Mobile Crisis Teams (funded by MHSA)
- Mobile Crisis West Team (funded by SB 82)
- CARES North Crisis Residential Facility (funded by MHSA)
- Crisis Triage Teams, Santa Maria, Lompoc, Santa Barbara (funded by SB 82)

- Crisis Stabilization Unit Santa Barbara and Santa Maria (funded by SB 82)
- Crisis Residential Facility Santa Barbara and Santa Maria (funded by SB 82)

Crisis Triage Teams (SB 82)

Provider:	Behavioral Wellness
Estimated Funding FY 2017/18:	
Estimated Total Mental Health Expenditures:	$3,396,690
Estimated CSS Funding	$0
Estimated Medi-Cal FFP:	$1,003,600
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$2,393,090

Based in all regions of the County, the Crisis Triage Teams focus on assisting individuals experiencing behavioral health crises who do not meet the criteria for involuntary hospitalization. Services include short-term interventions to promote wellness and recovery and helping individuals gain access to effective outpatient and crisis services. Consumer experiences are improved through a more seamless array of services designed to prevent future crises.
The program is intended to reduce costs associated with expensive inpatient and emergency room care by better serving people in the least restrictive manner possible, including those in a pre-crisis state and those discharged from a hospital. The field-based Triage workforce engages in proactive case management, peer support and clinical care before, during and after a behavioral health crisis. Follow-up services for individuals who have been hospitalized will be designed to reduce readmission.

Program Challenges and Solutions:

Due to difficulty creating flow within the Department's System of Care, there is limited capacity at the primary clinic sites to accept consumers who have been receiving services from the Triage Teams. Similarly, specialized programs throughout the system (such as the Co-Occurring and Wellness and Recovery Teams) have also led to bottlenecks within the Crisis Triage programs. Consumers have continued to receive services through the Crisis Triage program longer than intended. There is a need to reconsider the flow of services within the Department's programs so that consumers can move up or down within a continuum of care to receive needed services. This is a proposal being addressed in this Three Year Plan.

Crisis Stabilization Unit South (SB 82) - Behavioral Wellness

Provider:	Behavioral Wellness
Estimated Funding FY 2017/18:	
Estimated Total Mental Health Expenditures:	$2,750,133
Estimated CSS Funding	$634,417
Estimated Medi-Cal FFP:	$2,115,716
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$0

In January 2016 the Department of Behavioral Wellness opened the county's first Crisis Stabilization Unit (CSU) in Santa Barbara (South County). The Santa Barbara Crisis Stabilization Unit was partly funded through SB 82. The CSU provides a safe, nurturing short-term, voluntary emergency treatment option for individuals experiencing a behavioral health emergency. The program accommodates up to eight individuals daily for stays of up to 23 hours. The CSU is located on the County campus in Santa Barbara. The facility offers a semi-private intake and assessment space, a casual open common room with lounge chairs or day beds, wireless phone access, music headsets, laundry facilities, showers, secure storage and staff offices.

Staffing includes a Psychiatric Registered Nurse as well as a 24-hour on-call Psychiatrist who conducts on-site rounds morning and evening. The comfortable, non-clinical setting offers a calming, stable environment to help individuals move away from crisis. Services include assessments, peer counseling, referrals for continued treatment, emergency medications, nursing assessment and access to psychiatric consultation.

ANKA Crisis Residential South

The facility offers voluntary crisis residential services for up to 30 days and opened as Anka Santa Barbara Crisis Residential opened in July 2015. During this Three Year Plan period, available beds will increase from a current total of 8 to a total of 10 beds.

Please refer to information that appears in the Community Services and Supports (CSS) section of this plan for information on both Crisis Residential programs.

Mobile Crisis West

Data for this Lompoc-based addition to Mobile Crisis Services is included in the Mobile Crisis listing in the Community Services and Supports (CSS) section of the plan.

Prevention and Early Intervention (PEI)

Mental Health Education and Support to Culturally Under-Served Communities (Promotora Program) - La Casa de la Raza, Mental Wellness Center

Provider:	La Casa de la Raza, Mental Wellness Center
Estimated Funding FY 2017/18:	
Estimated Total Mental Health Expenditures:	$304,098
Estimated PEI Funding	$304,098
Estimated Medi-Cal FFP:	$0
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$0

This program mobilizes Community Mental Health Educators – known in the Latino community as *Promotoras* – from culturally underserved populations to address individual and family mental health and wellness needs. As trusted members of their community, Community Mental Health Educators assist with navigation and linkage to culturally and linguistically appropriate services. Information and guidance is provided through various culturally-adapted modes of engagement and outreach, including educational workshops, presentations in community-based locations (e.g. schools, churches) and support groups.

Through contracts with regional Community-Based Organizations (CBOs), the Department supports outreach and accessible services to several targeted populations, including Spanish speaking communities, indigenous Mexican communities (i.e. Mixtec, Zapotec) and Native American communities. These CBOs have effectively engaged underserved populations by employing culturally appropriate interventions in setting familiar and building trust and partnership within the community.

Community Health Centers of the Central Coast (CHCCC) is contracted to provide Community Mental Health Educators who connect with unserved or underserved communities in the Santa Maria, Guadalupe, and Lompoc areas of the County. Activities address multiple barriers to accessing services, such as those related to culture, language, transportation, location, stigma and institutional mistrust or fear. Specifically, CHCCC utilizes mobile clinics to reach remote outposts of the community to provide primary care access and mental health education and support. Furthermore, CHCCC has been successful in developing partnerships with local agricultural employers to gain access to migrant workers in the community. They also conduct ongoing radio and television outreach, education and anti-stigma efforts and have undertaken an annual health fair for migrant farmworkers. The health fair focuses on health and mental health support and information services. Many of the participants were Spanish- and Mixteco-speaking farm workers. Mental health and

educational services are delivered in a culturally informed primary care setting that promotes the integration of care.

In the Santa Barbara region, Casa de La Raza established ongoing Spanish speaking community groups called “Cafecitos” which served approximately 382 individuals from the community. Additionally, their other outreach efforts, including their work with the Family Resource Center, also reached approximately 1400 individuals and family members.

In addition, funding previously supported training in Mental Health First Aid provided by the Mental Wellness Center. The initial Mental Health First Aid component was intended to increase awareness and develop capacity for educational outreach in the community. At that time, only several individuals were trained to provide training. In the last several years, increased training opportunities have been provided through several state wide MHSA initiatives. These initiatives have created additional capacity and increased the number of organizations and individuals who can provide Mental Health First Aid. These training opportunities have also afforded a diverse group of individuals to be trained who specialize in providing outreach to Spanish speaking, Mixteco, and African American Communities.

PEI Early Childhood Mental Health (ECMH) - CALM, Santa Ynez Valley People Helping People, Santa Barbara County Education Office

Providers:	CALM, Santa Ynez Valley People Helping People, Santa Barbara County Education Office
Great Beginnings	
Estimated Funding FY 2017/18:	
Estimated Total Mental Health Expenditures:	$419,498
Estimated PEI Funding	$419,498
Estimated Medi-Cal FFP:	$0
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$0
Early Childhood Mental Health	
Estimated Funding FY 2016/17:	
Estimated Total Mental Health Expenditures:	$1,122,000
Estimated PEI Funding	$7,000
Estimated Medi-Cal FFP:	$700,000
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$415,000
Estimated Other Funding:	$0

The Early Childhood Mental Health (ECMH) Project addresses the needs of young children, currently prenatal to age five, and their families in Santa Barbara County within the following priority populations: trauma-exposed individuals, children and youth in stressed families, children and youth at risk for school failure, and under-served cultural populations. ECMH components build on existing services and programs throughout the County and support a community continuum of care that serves children and caregivers and supports a framework for success beyond a single program or strategy.

This Project addresses the needs of children who are not eligible or covered through other systems and helps parents navigate systems through enhanced referrals and support for follow-up. In-home support, health and development screening, parent education and skills training, psychotherapy, advocacy, resources and referrals, postpartum support groups and father outreach are provided.

There are three primary programs funded under this initiative. The programs are the following:

1) <u>The Great Beginnings - CALM</u>
   This program features a multidisciplinary team that uses a strengths-based approach to provide home and center-based services to low-income families of children prenatal to age five, with a specific focus on the Latino populations.
2) <u>ECMH Special Needs Counseling - Santa Ynez Valley People Helping People</u>
   The program provides services to low-income monolingual Spanish speaking children and families in the Santa Ynez Valley in Central County. Services are based at four school sites. Parents may access services in their neighborhood and in their homes. This component provides needed services in an area of the Central County where program resources are limited.

3) <u>CATCH – Santa Barbara County Education Office</u>
   The CATCH Program assisted preschoolers who exhibit challenging behaviors and do not qualify for special education. This program uses an evidence-based curriculum to train teachers and to support parents of preschoolers with challenging behaviors. This program accepts referrals for any “at risk” child exhibiting behavioral challenges. Services support children to be successful in their preschool setting. Direct support is also offered to other children in the school. Parent and teacher consultations are also provided.

   This program may be eliminated in the 2017-2018 Fiscal Year due to the Community Based Organization provider no longer offering these services. However there has been Stakeholder discussion about having another CBO provider assume operations because of the importance and value of these services to families and the community.

School-Based Prevention/Early Intervention Services for Children and TAY (START) - Family Service Agency, Council on Alcoholism and Drug Abuse

Providers:	Family Service Agency, Council on Alcoholism and Drug Abuse
Estimated Funding FY 2017/18:	
Estimated Total Mental Health Expenditures:	$492,705
Estimated PEI Funding	$230,665
Estimated Medi-Cal FFP:	$262,040
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$0

The Support, Treatment, Advocacy and Referral Team (START) program is provided by Family Service Agency (FSA) and the Council on Alcoholism and Drug Abuse (CADA). This program provides mental health assessment, screening and treatment, home visits, school collaborations, family interventions, linkage and education for children, transition-age youth (TAY) and families. A school-based program offers prevention and early intervention mental health services to students in Carpinteria public schools experiencing emotional and/or behavioral difficulties. This program supports children and youth who are uninsured and for whom mental health services would otherwise not be accessible. Approximately 68% are Latino, and many are uninsured. The program offers counseling, support, advocacy, treatment, and referrals, including services to individuals experiencing mental health and substance abuse challenges.

Program staff members work as a team with school staff and parents to address consumers' social-emotional development, prevent mental health and psychological problems from becoming acute, enhance the consumers' ability to adapt and cope with changing life circumstances, increase consumers' protective factors, and minimize risk factors. The (START) team assigned to schools includes experts in substance abuse and mental health prevention and treatment. START is available to provide intervention, referrals, programs, and services to intervene as early as possible to address learning, behavior, and emotional problems. START staff persons served 120 unduplicated individuals between July 1, 2015 and June 30, 2016.

Program Performance (FY 15-16)

START

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	N/A	98	N/A
16-25		22	
26-59		0	
60+		0	
Missing DOB		0	
Total		***120***	
Gender			
Female	N/A	59	N/A
Male		61	
Unknown		0	
Ethnicity			
White	N/A	28%	N/A
Hispanic		72%	
African American		1%	
Asian/Pacific Islander		0%	
Native American		0%	
Other/Not Reported		0%	

Client Outcomes

Child & Adolescent Needs & Strengths Assessment (CANS) Age: 6-17 years	**CANS Time Period**	**Percent Improvement**
Life Functioning (e.g., ability to communicate and interact with families, communication, social functioning and health status)	Initial – 6-mo.	15% (n=32)
	6-mo.-12-mo.	0% (n=37)
Behavioral/Emotional Needs (e.g., symptoms of depression, anxiety, psychosis and other conditions)	Initial – 6-mo.	11% (n=32)
	6-mo.-12-mo.	0% (n=37)
Child Risk Behaviors (e.g., self-injury, suicidal behavior, bullying, and running away)	Initial – 6-mo.	20% (n=32)
	6-mo.-12-mo.	0% (n=37)
School (e.g., behavior, attendance and grades)	Initial – 6-mo.	0% (n=32)
	6-mo.-12-mo.	0% (n=37)
Caregiver Needs & Strengths (e.g., child supervision skills, family stress levels, residential stability, and caregiver physical/mental health status)	Initial – 6-mo.	0% (n=32)
	6-mo.-12-mo.	0% (n=37)

Child Strengths (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment)	Initial – 6-mo.	0% (n=32)
	6-mo.-12-mo.	1% (n=37)
Psychiatric Inpatient Care	0%	
Incarcerations/Juvenile Hall	2%	

PEI Early Detection and Intervention Teams for Transition-Age Youth (TAY) – Behavioral Wellness

Providers:	Behavioral Wellness
Estimated Funding FY 2017/18:	
Estimated Total Mental Health Expenditures:	$1,397,819
Estimated PEI Funding	$327,215
Estimated Medi-Cal FFP:	$715,840
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$354,764
Estimated Other Funding:	$0

Early Detection and Intervention Teams for transition-age youth use evidence-based interventions for adolescents and young adults to help them achieve their full potential without the trauma, stigma, and disabling impact of a fully developed mental illness.

Three teams specialize in early detection and prevention of serious mental illness in Transition-Age Youth (TAY), ages 16-25. Teams are based in North County (Santa Maria), South County (Santa Barbara) and West County (Lompoc). The program serves TAY consumers who are at risk for serious mental illness, or were diagnosed within the past 12 months. The target population also includes individuals who are homeless and/or experiencing co-occurring mental health and substance abuse conditions. Youth are typically served for approximately one year.

Transition-age youth who require continued support receive the following services from the team, based on individual need:

- Care management;
- Crisis assessment and intervention;
- Housing services and supports;
- Activities of daily living support;
- Employment and educational support;
- Community integration;
- Peer and support services;
- Symptom assessment/self-management;
- Individual support;
- Substance abuse/co-occurring conditions support;

- Medication management;
- Coordination with primary care and other services.

The team continuously provides active outreach, engagement, and consultation to individuals involved in participants' lives, including family, school counselors/personnel, Probation officers and others, based on the principles and practices of supported education.

Program Challenges and Solutions

TAY youth struggle with a complex array of mental health issues coupled with social and economic challenges, and limited overall resources both personally and environmentally. The challenges for effective treatment for this population have been keeping TAY youth engaged in services, lack of substance abuse treatment resources, and the lack of specific TAY housing resources. Some solutions may be to develop a Full Service Partnership program for TAY that can increase field based, 24/7, outreach type of services for this group. This is one of the proposals of this Three Year Plan.

Program Performance (FY 15-16)

PEI Early Detection & Intervention

Unique Clients Served			
	PEI-TAY		
	North	South	West
Age Group			
0-15	1	3	2
16-25	73	51	21
26-59	3	0	0
60+	0	0	0
Missing DOB	0	0	0
Total	***77***	***54***	***23***
Gender			
Female	30	22	18
Male	46	32	5
Unknown	1	0	0
Ethnicity			
White	23%	26%	13%
Hispanic	70%	56%	70%
African American	1%	0%	9%
Asian/Pacific Islander	3%	4%	0%
Native American	0%	2%	4%
Other/Not Reported	3%	12%	4%

Client Outcomes

Child & Adolescent Needs & Strengths Assessment (CANS) Age: 6-17 years	Time Period	PEI-TAY
	Percent Improvement	
Life Functioning (e.g., ability to communicate and interact with families, communication, social functioning and health status)	Initial – 6-mo.	20% (n=12)
	6-mo.-12-mo.	11% (n=4)
Behavioral/Emotional Needs (e.g., symptoms of depression, anxiety, psychosis and other conditions)	Initial – 6-mo.	6% (n=12)
	6-mo.-12-mo.	15% (n=4)
Child Risk Behaviors (e.g., self-injury, suicidal behavior, bullying, and running away)	Initial – 6-mo.	0% (n=12)
	6-mo.-12-mo.	63% (n=4)
School (e.g., behavior, attendance and grades)	Initial – 6-mo.	33% (n=12)
	6-mo.-12-mo.	0% (n=4)
Caregiver Needs & Strengths (e.g., child supervision skills, family stress levels, residential stability, and caregiver physical/mental health status)	Initial – 6-mo.	0% (n=12)
	6-mo.-12-mo.	19% (n=4)
	Initial – 6-mo.	22% (n=12)
	6-mo.-12-mo.	7% (n=4)

Incarcerations/Juvenile Hall	8%
Psychiatric Inpatient Care	10%
Child Strengths (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment) **Milestones of Recovery Scale Age: 18 years + (*clients open in FY15/16*)**	Initial to 6-Month MORS (n=57): 25% showed improvement 49% remained stable 6-Month to 12-month MORS (n=34): 38% showed improvement 56% remained stable

TAY clients that received the CANS (under 18 years) made the most progress in Life Functioning, Risk Behaviors and Child Strengths. The majority of clients that received the MORS (age 18-25 years) remained stable with MORS scores over time. It is notable that while approximately half of the clients remained stable, 38% in PEI-TAY made progress between 6- and 12 months. Hospitalizations were kept at 10%, and 8% of the clients were incarcerated during FY15/16.

Safe Alternatives for Children and Youth (SAFTY) (Crisis Services) – Casa Pacifica

Provider:	Casa Pacifica
Estimated Funding FY 2017/18:	
Estimated Total Mental Health Expenditures:	$1,035,275
Estimated PEI Funding	$546,475
Estimated Medi-Cal FFP:	$488,800
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$0

Crisis services for children and youth were provided by Casa Pacifica through the Safe Alternatives for Treating Youth (SAFTY) mobile crisis response program, available to all Santa Barbara County youth up to the age of 21.

SAFTY provides children's crisis services in collaboration with CARES Mobile Crisis (Crisis and Recovery Emergency Services) teams. The SAFTY program is available 24 hours a day, seven days a week. SAFTY provides quick and accessible service to families by providing specialized crisis intervention, in-home support and linkage to county behavioral health or other appropriate services. By working in collaboration with the child's existing service providers, SAFTY seeks to keep children, youth and families safe in their homes and communities. SAFTY served 633 unduplicated individuals between July 1, 2015 and June 30, 2016.

Age Group	Number of Unduplicated Individuals Served
0-15	366
16-25	266
26-59	1
Total	633

Program Challenges and Solutions

SAFTY staffing is sometimes inadequate to handle multiple crises in different regions of the County, which continues to slow the response time and requires intervention by the CARES Mobile Crisis teams. To address surges in need and to keep response times reasonably prompt, the Department of Behavioral Wellness supports SAFTY moving to a per diem model, which allows rapidly deploying additional staff when the need is high. The implementation of expanded crisis services as described previously, including the Mobile Crisis Triage Teams, has helped to alleviate some of SAFTY's workload.

To date, some local hospitals continue to decline granting SAFTY hospital privileges. To avoid having CARES Mobile Crisis staff respond to all hospital emergency room calls with person's under 21 years of age, Mobile Crisis staff requested and are now

allowed to escort SATFY staff into the Emergency Departments. SAFTY staff conduct the 5150 evaluations with Mobile Crisis staff observing.

Access and Assessment Teams – Behavioral Wellness

Provider:	Behavioral Wellness
Estimated Funding FY 2017/18:	
Estimated Total Mental Health Expenditures:	$2,055,525
Estimated PEI Funding	$1,435,751
Estimated Medi-Cal FFP:	$306,740
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$313,034

Equitable and improved access to services is the single most urgent priority identified by County Stakeholders and the State. The implementation of a clear, simple, and consistent process for entry into the County behavioral health system is a high priority for many community members including the Department of Behavioral Wellness. Stakeholders have also identified the need to handle effectively the disposition and referral of consumers who do not meet medical necessity criteria for County behavioral health services. Creating a welcoming and integrated system of care and recovery has been a priority for the Department during this last Three Year Plan period, and continues to be a work in progress.

In FY 2016/2017, the Department restructured its operations to a centralized access approach, and an Access call center was developed. Access screeners handle calls from new consumers requesting services. Callers are screened for appropriate assignment to a level of care within the system. The access and assessment component handled by the three Access and Assessment teams now focuses on performing assessments on new consumers referred by the Access screeners, as well as initial assessments for walk-in consumers, and for hospital discharge appointments.

The specialized Access and Assessment Teams focus on access and assessment services, as well as appropriate disposition and referrals for consumers who do not meet the Department's criteria of Severe and Persistent Mental Illness. This team focuses on simplifying and improving access to care, reducing wait times, reducing barriers to receiving services, and increasing consistency throughout the County.

Assessments and referrals are customized to ensure that appropriate cultural and linguistic needs of each consumer are identified and accommodated. Furthermore, each team includes staff members who are bicultural and bilingual in the primary threshold language (Spanish).

Program Challenges and Successes

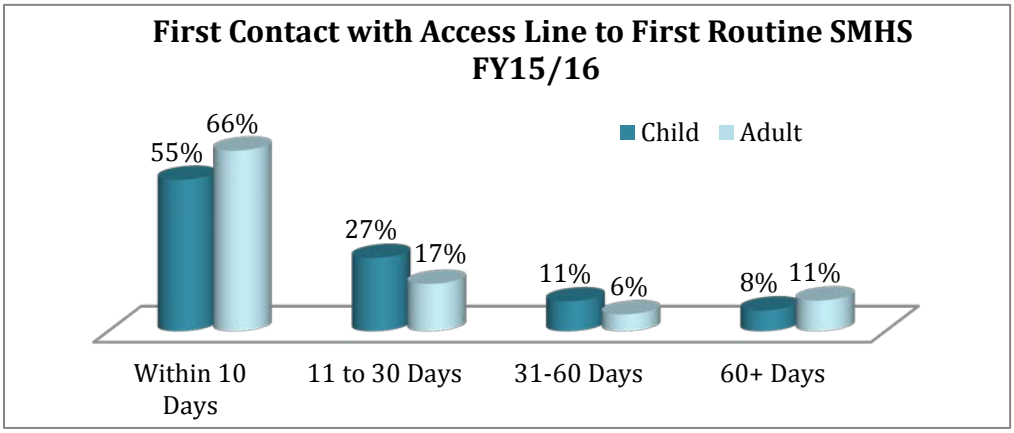
As the initial plan to deploy Access teams in each region rolled out, the Department learned that continued bottlenecks throughout the system led to the outcome of Access and Assessment staff providing ongoing treatment to consumers, making this staff less available for the specialized function of access and assessment, and also resulting in all clinic staff needing to conduct consumer intakes. To address this and the issue of consistency of consumer placement and dispositions, the Department centralized the Access call center within the Office of Quality Care Management by routing all Access calls to one place. Staff dedicated to this function were hired and trained. This allowed staff in each of the Adult Clinics (Santa Barbara, Lompoc, and Santa Maria) to conduct walk-in assessments, intake assessments and referrals. Each team in Santa Barbara, Lompoc, and Santa Maria is bicultural and bilingual. An Access template used to track timeliness has been implemented across the Department to monitor access improvements.

In the last Three Year Plan Stakeholder process, Access and Assessment staffing was not included for the Children's and TAY clinics. The same staff that are providing ongoing treatment to consumers respond to walk-ins and ongoing intake and assessment duties- causing an impact on the services for ongoing consumers.

Program Performance (FY 15-16)

In FY2015/16, the Access and Assessment Teams served 995 unduplicated individuals, providing assessments for services in behavioral health care.

Behavioral Wellness strives to have 100% of clients seen within 10 days of first contact with the 24-hour Access Line. The first service is generally an assessment, which is a Specialty Mental Health Service. The data indicate that more than half (55%) of children and two-thirds (66%) of adults were seen within 10 days of their call to the Access Line; 27% and 17% respectively were seen between 11-30 days; and another 11% of children and 6% of adults were seen between 31-60 days after the first call to the Access Line. In FY15/16, the average wait time for adults was 24 days and 20 days for children.



Innovation

Resiliency Interventions for Sexual Exploitation (RISE) Project

R.I.S.E (Resiliency Interventions for Sexual Exploitation), in its third year of Innovation funding, provides service to young woman victims of sex trafficking. Services are also offered to siblings and family members to decrease the chance of sibling involvement and increase the positive involvement of family members in promoting the recovery and reintegration of victims. Friends, families, service providers, and community members will be educated in how to recognize the signs of sex trafficking, and what to do if you suspect someone is in danger.

The program is committed to the restoration and empowerment of young females exposed to, or at risk of, sexual exploitation and trafficking. Through trauma-specific services, collaborative partnerships and community outreach, RISE works to restore and reintegrate survivors, eradicate sexual exploitation and reduce the stigma surrounding sexual trauma in Santa Barbara County. RISE is committed to promoting hope and resiliency in girls and young women, guiding them to be leaders in their pursuit of meaningful and enriching lives.

The RISE Project serves females aged 10-19 and their families; specifically targeting the underserved African-American, Asian/Pacific Islander, Latino, Native American/Tribal, and the LGBTQ girls who are “at risk” and vulnerable to exploitation. RISE also works with the community to identify risk factors that may put young women in jeopardy of sex trafficking.

These risk factors include:

- incarceration
- history of running away
- school expulsion
- multiple caregivers
- addiction
- associations with others involved in exploitation
- family history of sexual exploitation
- domestic violence
- gang involvement
- past sex trauma/child abuse/neglect/abandonment and out of home placement

The RISE Project is composed of integrated elements which include:

- Initial Intake and Exit Screenings, Survey’s & Assessments to collect/evaluate data to ensure program efficacy as well as provide compatible treatment interventions.
- Comprehensive & Inclusive Treatment Planning and Development including treatment team, youth, family/caretakers and other support persons.

- Trauma Informed Crisis Interventions 24/7 crisis interventions & referrals will be available through RISE & Community Partners.
- Biopsychosocial-Hierarchy of Needs supports focusing on wellness, resilience and recovery through evidenced based and best practice supports that attend holistically to the individual through a biological, social, psychological, spiritual, cultural, basic needs and environmental supports.
- Medication Support through a trauma-informed Psychiatrist.
- Linkage to strength and trauma based support and peer-driven resources.
- Advocates assisting youth in navigating legal, Child Welfare Services, School, Immigration and Mental Health systems etc.
- Monthly Multi-Disciplinary Treatment Team meetings with youth and family to review progress and problem-solve.
- Incentive Program (*Outreach, Welcome & Success Packs*) to celebrate effort/goal attainment, keeping youth engaged and assisting them in reaching their goals.
- Weekly Treatment Team Review Committee where youth are presented to a trained multi-agency team to determine appropriate treatment and supports, and assess progress/efficacy of treatment.

Program Challenges and Solutions

There has been a challenge in finding temporary and permanent safe shelter/placements for Commercially Sexually Exploited Children (CSEC) (under 18 victims/survivors of sexual exploitation) and Adult (18-24yo) survivors of sexual exploitation. Runaway and/or homelessness are the number one vulnerability factors that increase the likelihood of sexual exploitation. The Department is currently partnering with the Community Based Organization Uffizi Order, which is working specifically on finding safe and "homelike" shelter and placement options for CSEC. Together with Uffizi Order, RISE created a Sexual Exploitation Community Collaborative to involve community in shelter/placement solutions and funding.

New Senate Bill 855 mandates significant CSEC Administrative resources. Current RISE staffing is insufficient to meet the needs of growing caseloads and the lack of other community supports. In response to this challenge, the Department has partnered with Child Welfare Services, Probation, Public Health, both Rape Crisis Centers, and the District Attorney's Victim Witness Program to receive Tier II CSEC funds. This multi-disciplinary team will discuss possible CSEC administrative support through this collaborative. RISE has also been collaborating with the Victim Witness/District Attorney/Human Trafficking Task Force, which also is assisting with some of the SB855 Multi-Disciplinary Team/Treatment mandates.

The original estimated staffing configuration is insufficient for the needs of RISE clients. The Department has identified larger numbers of CSEC clients than expected, and the CSEC population's needs are higher and more complicated than expected. The RISE program has found it difficult to find staff with experience to meet the needs

of this particular population. One solution would be to expand the program or merge it into an existing Full Service Partnership in the coming three year period.

Program Performance (FY 15-16)

RISE (Resiliency Interventions for Sexual Exploitation Project)

	Unique Clients Served			
	North	**South**	**West**	**Out-of-County**
Age Group				
0-15	10	4	6	0
16-25	6	4	1	2
26-59	0	0	0	0
60+	0	0	0	0
Missing DOB	0	0	0	0
Total	***16***	***8***	***7***	***2***
Gender				
Female	16	8	7	2
Male	0	0	0	0
Unknown	0	0	0	0
Ethnicity				
White	6%	13%	42%	50%
Hispanic	82%	75%	29%	50%
African American	0%	0%	29%	0%
Asian/Pacific Islander	0%	0%	0%	0%
Native American	6%	0%	0%	0%
Other/Not Reported	6%	12%	0%	0%

Client Outcomes

Incarcerations/Juvenile Hall	4%
Psychiatric Inpatient Care	12%
Child & Adolescent Needs & Strengths Assessment (CANS) Age: 6-17 years	**Percent Change**
Life Functioning (e.g., ability to communicate and interact with families, communication, social functioning and health status)	8%
Behavioral/Emotional Needs (e.g., symptoms of depression, anxiety, psychosis and other conditions)	11%
Child Risk Behaviors (e.g., self-injury, suicidal behavior, bullying, and running away)	0%
School (e.g., behavior, attendance and grades)	0%

Caregiver Needs & Strengths (e.g., child supervision skills, family stress levels, residential stability, and caregiver physical/mental health status)	4%
Child Strengths (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment)	0%

Housing

The Department has worked to create a final housing development with these funds in partnership with local housing stakeholders. The MHSA Housing Program has supported major housing projects in each of the three largest cities in Santa Barbara County. Despite the number of units purchased, the Housing budget still retains more than half of its funding allocation. Currently there are 35 MHSA units funded throughout Santa Barbara County. Santa Maria is the site of four one-bedroom, six three-bedroom and two two-bedroom apartments. MHSA units in Santa Barbara and Lompoc are single occupancy.

Completed projects:

Garden Street Apartments, Santa Barbara
MHSA housing funds support ten affordable units for persons with mental illness in South County.

Homebase on G Street, Lompoc
MHSA housing funds support 13 affordable units for persons with mental illness in Central County.

Rancho Hermosa, Santa Maria
MHSA housing funds support 12 units, including family units, for persons with mental illness (four one-bedroom, six three-bedroom and two two-bedroom apartments) in North County.

Current Project: Residences on Depot Street, Santa Maria

On February 11, 2016, a proposal for a new MHSA Housing allocation was posted for 30-day public review. There were two comments submitted in support of this project. In partnership with the Santa Barbara County Housing Authority, a site has been secured for The Residences at Depot Street in the city of Santa Maria in North County. The proposed mixed population development is an 80-unit project with 35 MHSA units. Although this project was not selected for the first round of funding due to several other large competing projects, the County anticipates that the Depot Street project will be approved for the second round of funding to be finalized in June. Based on this new timeline, approvals for the project should be completed by September,

with the target of breaking ground in December 2017/January 2018. Instead of developing the project in phases as initially contemplated, the revised plan is to build all 80 units continuously from start to finish. The distribution of unit type is still under discussion but should include studios, one-bedroom, two-bedroom and three-bedroom units. Some units will be designated for homeless veterans.

The project will be supported by tax credits, other federal funds and MHSA. This development will use the remaining balance of Santa Barbara County's MHSA Housing funds.

The "No Place Like Home" Initiative

During the next three-year period, the State will launch the No Place Like Home initiative, established pursuant to AB 1618/1628. This Initiative will divert a portion of MHSA funds to provide $2 billion in bond proceeds for investment in the development of permanent supportive housing for persons who are living with a severe mental illness (SMI) or a co-occurring disorder. These individuals must be experiencing chronic homelessness, or are at-risk of chronic homelessness, or homelessness. The funding must be used for permanent supportive housing and utilize low barrier tenant selection practices that prioritize and offer flexible, voluntary, and individualized supportive services.

Counties may apply for funds as the sole applicant(s) if they are the development sponsor, or jointly with a developer as development sponsor, and must also make a commitment to providing mental health services and helping coordinate access to other community-based supportive services.

Santa Barbara County intends to participate fully in this initiative, including submitting proposals for both funding allocations:

1. Non-competitive funds based on county population of homeless (Santa Barbara County's estimated allocation: $2.7 million)

2. Competitive funds which may be awarded, after application and analysis, out of a pool of funds for medium sized counties.

Additionally, start-up or "technical assistance" (TA) funds will be available in the form of grants (Santa Barbara County's allocation is: $100,000).

The Department of Behavioral Wellness has had preliminary meetings with the leadership at Santa Barbara County Housing and Community Development, who will assist with notification of funding and vetting of potential development partners. Santa Barbara County intends to respond to the State's Request for Proposal when published, reported to be in April of 2018.

Workforce Education and Training (WET)

The Workforce Education and Training (WET) funding component was conceived to be time-limited; it is not a continuous source of funding like CSS, PEI and Innovation. To maximize the use of WET funding, we eliminated the position of WET Manager.

During the last three-year period, the savings were used to continue offering an annual Crisis Intervention Training (CIT) to law enforcement and to create part-time employment opportunities for graduates of the WET Peer Specialist Training through a Peer Expert Pool.

At this time, the WET funding has been expended. The costs associated with ongoing peer employment have been transferred to the CSS funding category.

Capital Facilities & Technological Needs (CF/TN)

Provider:	Behavioral Wellness and Mental Health Systems
Estimated Funding FY 2017/18:	
Estimated Total Mental Health Expenditures:	$108,088
Estimated CFTN Funding	$108,088
Estimated Medi-Cal FFP:	$0
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$0

Electronic Health Records Conversion

During the last three-year period, the Department successfully converted all outpatient clinics to an Electronic Health Record (EHR). During this next three-year period, the Department will finalize the conversion of paper records to electronic records in the inpatient Psychiatric Health Facility. Funding available in the CF/TN funding category will be fully expended upon the completion of this project.

New Proposals for this Three Year Plan

These proposals were introduced to Stakeholders for feedback and program development input during the Stakeholder public forums.

Proposal One: Operate the Transition Age Youth (TAY) Program as a Full Service Partnership

Currently the older TAY population (ages 18-24) may receive services as part of the adult ACT programs. This proposal would expand TAY services by establishing a separate FSP program that provides unique services to this population. The Department is set to execute a contract with the State Department of Rehabilitation that will provide the Department with additional resources to assist TAY with obtaining vocational rehabilitation services and employment support.

Leveraging this contract would enable the Department to expand the current amount of vocational rehabilitation and employment support offered to TAY. In addition, as part of the FSP program, the Department would offer field-based engagement services, housing support, 24/7 crisis support, and adopt a "whatever-it takes" approach to deliver needed services with the goal of moving these consumers to a lower level of care as expeditiously as possible.

Proposal Two: Reconsider Justice Alliance

Currently, Justice Alliance is a Full Service Partnership providing the following services:

- Outreach and engagement to consumers involved with the criminal justice system, including linkage to outpatient and ACT programs as appropriate;
- Present in court to provide mental health assessments to charged misdemeanants;
- Provides competency restoration services to individuals found Incompetent to Stand Trial (ISTs);
- Provides case management of criminally involved consumers.

The Department is working with the Courts, District Attorney's Office, Public Defenders Office, and law enforcement to reconsider how the Justice Alliance program is structured with the goal of enhancing support to criminally involved mental health consumers to reduce recidivism.

Proposal Three: Increase Programming at the Recovery Learning Centers

Use the Recovery Learning Centers more fully as part of the continuum of care, which would include:

- Provide Psychiatry & Medical staff time at the RLCs for medication support services;
- Increase clinical support on site;
- Enhance employment support on site;
- Enhance Peer support on site;
- Link with the Department's outpatient groups to facilitate client transitions to RLCs.

Proposal Four: Further Integrate the Existing Treatment Teams Into Levels of Care

Level 1- Consumer Run Centers	Level 2- Outpatient Wellness	Level 3- Field Capable/Moderate Clinical Services	Level 4- Moderate to High Service Intensify	Level 5- FSPs High Intensity Community Based
➢ Network Providers ➢ Recovery Learning Centers ➢ Medication Compliant ➢ Supportive Employment Services	➢ Minimal Maintenance ➢ Groups, Case Management, Individual Services ➢ Minimum Med Management ➢ Integrated MH/SUD/ Medical ➢ Supportive Employment Services	➢ Less intensive maintenance ➢ Step down from ACT/ Supportive Housing ➢ Community Based ➢ Integrated MH/SUD/ Medical ➢ Supportive Employment Services	➢ Step down from ACT with intensive services-field based, ACT-lite ➢ Supportive Housing Services ➢ Integrated MH/SUD/ Medical ➢ Supportive Employment Services	➢ ACT/Jail/ Homeless ➢ Difficulty accessing office services-outreach ➢ Field based services ➢ Integrated MH/SUD/ Medical ➢ Supportive Employment Services

SUPPORTING MATERIALS

Attachment 1: MHSA Budget Summaries
Attachment 2: Public Comments Submitted
Attachment 3: Behavioral Wellness Commission Meeting Agenda for Public Hearing
Attachment 4: Minutes of the Public Hearing
Attachment 5: Evidence of Santa Barbara County Board of Supervisors' Approval

Attachment 1
Proposed Budget Summaries

Budget Review by Funding Component

Mental Health Services Act Proposed Budget
Community Services and Supports (CSS)

	FY 2017-18				FY 2018-19				FY 2019-20			
Community Services and Supports (CSS) Programs	TOTAL MHSA Plan CSS Expenditures	CSS Funded	Medi-Cal FFP Funded	Realignment/ Grant/ Other Funded	TOTAL MHSA Plan CSS Expenditures	CSS Funded	Medi-Cal FFP Funded	Realignment/ Grant/ Other Funded	TOTAL MHSA Plan CSS Expenditures	CSS Funded	Medi-Cal FFP Funded	Realignment/ Grant/ Other Funded
Full Service Partnership (FSP)	13,650,693	6,522,852	5,572,984	1,554,857	13,638,064	6,755,758	5,327,449	1,554,857	13,910,825	6,895,298	5,433,998	1,581,529
Non-FSP	30,247,123	5,144,012	15,497,246	9,605,865	30,317,268	7,461,424	15,838,870	7,016,974	30,923,613	8,089,037	16,155,647	6,675,540
FSP Programs as % CSS Programs		*55.9%*				*47.5%*				*46.0%*		
CSS Administration Total	8,795,744	3,824,254	4,125,700	845,790	8,846,205	3,851,848	4,125,700	868,657	8,607,438	3,544,458	4,150,000	912,980
TOTAL CSS Programs Expenditures	52,693,560	15,491,118	25,195,930	12,006,512	52,801,537	18,069,030	25,292,019	9,440,488	53,441,877	18,528,793	25,739,645	9,170,048
Estimated Available Funding	52,693,560	15,491,118	25,195,930	12,006,512	49,714,885	14,982,378	25,292,019	9,440,488	50,012,852	15,103,158	25,739,645	9,170,048
Estimated remain / (deficit)	0	0	0	0	(3,086,652)	(3,086,652)	0	0	(3,429,024)	(3,425,635)	0	0

The following issues result in the $3.1M deficit reflected beginning in FY2018/19

1. Crisis Triage Grant of $2.4M will have been fully Exhausted; we may receive additional grant funding, so full expenses of Crisis Triage are still reflected (the department will cut the Triage program if no additional grant funds are allocated in order to balance budget)
2. No Place Like Home offset will be additional $560k lost revenue
3. Overall CSS expenses increase by $108k

Note that MHSA revenue projections from the state are currently estimated to be flat from FY1718-FY1819, so these flat estimates are used as the baseline for Estimated Available Funding

Also Note that while FSP % for FY2018/19 and FY2019/20 is currently below the 50% Minimum, this will be corrected once the Crisis Triage funding (or cuts) are known.

Budget Review by Funding Component

Mental Health Services Act Proposed Budget

Innovations (INN)

FY 2017-18					FY 2018-19				FY 2019-20			
Innovations (INN) Programs	TOTAL MHSA Plan INN Expenditures	MHSA INN Funded	Medi-Cal FFP Funded	Realignment/ Grant/ Other Funded	TOTAL MHSA Plan INN Expenditures	MHSA INN Funded	Medi-Cal FFP Funded	Realignment/ Grant/ Other Funded	TOTAL MHSA Plan INN Expenditures	MHSA INN Funded	Medi-Cal FFP Funded	Realignment/ Grant/ Other Funded
RISE	1,317,483	1,239,883	77,600	0	1,317,483	1,239,883	77,600	0	1,317,483	1,239,883	77,600	0
INN Administration	232,386	232,386	0		232,386	232,386	0		232,386	232,386	0	
Total INN Program Expenditures	1,549,869	1,472,269	77,600		1,549,869	1,472,269	77,600		1,549,869	1,472,269	77,600	
Estimated Avaialable Funding	1,549,869	1,472,269	77,600	-	1,549,869	1,472,269	77,600	-	1,549,869	1,472,269	77,600	-
Estimated remain / (deficit)	0	0	0	0	0	0	0	0	0	0	0	0

Budget Review by Funding Component

Mental Health Services Act Proposed Budget

Workforce, Education and Training (WET)

FY 2017-18					FY 2018-19				FY 2019-20			
Workforce, Education and Training (WET) Programs	**TOTAL MHSA Plan WET Expenditures**	**MHSA WET Funded**	**Medi-Cal FFP Funded**	**Realignment/ Grant/ Other Funded**	**TOTAL MHSA Plan WET Expenditures**	**MHSA WET Funded**	**Medi-Cal FFP Funded**	**Realignment/ Grant/ Other Funded**	**TOTAL MHSA Plan WET Expenditures**	**MHSA WET Funded**	**Medi-Cal FFP Funded**	**Realignment/ Grant/ Other Funded**
Peer Training	**13,779**	**13,779**	**0**	0	**0**	**0**	**0**	0	**0**	**0**	**0**	0
Southern Counties Regional Partnership	**1,035,367**	**0**	**0**	1,035,367	**1,035,367**	**0**	**0**	1,035,367	**1,035,367**	**0**	**0**	1,035,367
WET Administration	0	0	0	0	0	0	0	0	0	0	0	0
Total WET Program Expenditures	1,049,146	13,779	0	1,035,367	1,035,367	0	0	1,035,367	1,035,367	0	0	1,035,367
Estimated Avaialable Funding	**1,049,146**	**13,779**	**0**	**1,035,367**	**1,035,367**	**0**	**0**	**1,035,367**	**1,035,367**	**0**	**0**	**1,035,367**
Estimated remain / (deficit)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Budget Review by Funding Component

Mental Health Services Act Proposed Budget

Capital Facilities/Technological Needs (CFTN)

FY 2017-18					FY 2018-19				FY 2019-20			
Capital Facilities/Technological Needs (CFTN) Programs	TOTAL MHSA Plan CFTN Expenditures	MHSA CFTN Funded	Medi-Cal FFP Funded	Realignment/ Grant/ Other Funded	TOTAL MHSA Plan CFTN Expenditures	MHSA CFTN Funded	Medi-Cal FFP Funded	Realignment/ Grant/ Other Funded	TOTAL MHSA Plan CFTN Expenditures	MHSA CFTN Funded	Medi-Cal FFP Funded	Realignment/ Grant/ Other Funded
Capital Information Technology (CIT)	**108,088**	**108,088**	**0**	0	**0**	**0**	**0**	0	**0**	**0**	**0**	0
CFTN Administration	0	0	0	0	0	0	0	0	0	0	0	0
Total CFTN Program Expenditures	108,088	108,088	0	0	0	0	0	0	0	0	0	0
Estimated Avaialable Funding	**108,088**	**108,088**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Estimated remain / (deficit)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

MHSA Housing Fund

MHSA Housing Funds $2.3M: The California Department of Health Care Services (DHCS) Information Notice No. 16-025 dated June 9, 2016, providing counties the option to request the release of any future unencumbered MHSA Housing Program funds for local use.

- On February 28, 2017, this item went before the Board of Supervisors who approved and authorized the request.
- The funds are to be used to provide housing assistance to the MHSA target population.
- A separate Agency Fund has been set up for the MHSA funds to pass through select entities in accordance with MHSA (W&I Code Section 5892.5
    - (b) In addition, the use of these funds will be consistent with the 3-year MHSA plan.

Future Budget Challenges

Crisis Triage Grant Funding: current award to be expended by June 2018

- State may allocate another year of funding at current $2.4M, allowing the program to continue at current level
- If additional grant funding is not awarded, the program will be reduced to a sustainable level

No Place Like Home: Up to $1.4M of MHSA Allocation diverted

- FY1718 Estimate reflects $700k diverted for No Place Like Home
- FY1819 and FY1819 reflect the full $1.4M annual diversion

MHSA Prudent Reserve Fund Balance

	FY2017/18 Estimated Beginning Balance	FY 2017/18 Uses of Fund Balance	6/30/2018 Recommended Ending Balance
MHSA Prudent Reserve	2,023,113	-	2,023,113
Purpose of Fund	2,102,444	640,779	1,461,665
Total Fund Balance	**4,125,557**	**640,779**	**3,484,778**

- 'MHSA Prudent Reserve' account cannot be used to expand programs
- 'Purpose of Fund' account consists of unexpended Innovations funds
  In FY 2017/18 we estimate that we will use ~$641k of Innovations fund balance

Attachment 2:
Public Comments Submitted

SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

MHSA Plan Feedback Summary

Public Comments Submitted Between March 2 and April 27, 2017

Behavioral Wellness Supervisor's Training - March 2, 2017

Reviewed proposed dates for staff meetings and stakeholder presentations to discuss the MHSA Plan;
Reviewed 2016 budgets, and likelihood that no new funding would be available;
Scheduled presentations at staff regional meetings.

Santa Maria Regional Staff Meeting - March 8, 2017

Several staff indicated that client flow across the system is very problematic and needs to be improved. They also wanted to know how the MORS would be applied to the level of care design that is being proposed.
Staff indicated that Santa Maria already is implementing levels of care by assigning clients with highest need into designated teams.
Staff raise questions regarding Wellness Recovery & Resilience teams and feel they are simply a repository for difficult cases or cases that don't fit anywhere else.
Regarding the Recovery Learning Centers (RLCs), there should be higher intensity groups conducted on site as well as considerations to increase higher level vocational rehab and medication supported services. Additional recommendations included changing the RLC design so it includes clinical staffing.
The RLC needs to provide outreach to clients because the perception is that it is still like the Gate House.
RLC staff wanted a point person at Be Well to work with difficult participants. However, staff feel that it should be the RLC's responsibility to support clients attending.

Santa Barbara Regional Staff Meeting - March 9, 2017

With respect to creating more level of care programming, staff notes that there is a problem with establishing true levels of care services because there is insufficient supportive housing facilities to step clients down; Pathpoint rarely has available beds because they do not move clients on, back to the community. The Department should encourage Pathpoint to discharge clients from their program.
With respect to the level of care services, feedback was provided that Medi-Medi clients likely don't need to stay with the Department for services, but there is concern that there would not be a place for them to obtain their psychiatric medication – this would need to be addressed.
There has not been fidelity in the ACT model over the years; there have been lots of different versions of ACT implemented here. All Department staff should know what the ACT program is, so they understand how to properly utilize the program. All staff should know that clients are not intended to stay in the ACT programs for years – it is an intensive program that should be used to stabilize clients, provide them supports with the goal of eventually having them integrate back into the community.

The Children's Team Supervisor was supportive of an enhanced Transition Age Youth (TAY) program – possibly a TAY ACT program. The Child Psychiatrist was also supportive of expanded TAY services – however was concerned that services are compromised by the turnover of providers. Additional feedback was provided about the SPIRIT program, noting that this was a good program that needs more attention and support.
Questions arose about specific participation for the peers – how many opportunities will peers have to participate in the stakeholder process. A similar question was raised about the Latino population. Feedback was provided that there would be quite a few more stakeholder meetings so all could participate.

Lompoc Regional Staff Meeting - March 15, 2017

Feedback provided was specific to the need to fill positions and address issues of extra help. Participants expressed that it was very critical to transition experienced extra help staff into permanent positions.
Concerns shared related to level of care design because of the limited services in Lompoc; specifically, the lack of a Community Supportive Services Program. Although staff supported the concept of moving to a 3 to 4 tiered level of care system, there was some concern as to the limitations due to varied services by region.
Comments related to Transition Age Youth services included support for the increased focus on this population. However, staff wanted to know if extra help staff would be able to transition into permanent positions.
Staff wanted to know why Justice Alliance funding had to be moved to an FSP component.

Mental Health Commission Meeting - March 15, 2017

Refugio (Cuco) Rodriguez, Mental Health Services Act (MHSA) Division Chief presents PowerPoint on fiscal year 17-18 MHSA 3 year plan overview. The commission had an opportunity to ask questions in regards to the new process and how it will include Behavioral Wellness Commissioners as part of the planning process as instructed by CEO last year. Celeste Andersen, Chief of Compliance assures the Commission that this year the Department will present the information to a broad variety of forums including Action Teams, Regional Meetings, and cultural competency groups and outside providers among others suggested. Next month, a detailed MHSA plan update to this Commission will provide more content, budget programs, expected audience and expected results. Chair Byrne encouraged all Commissioners to participate in stakeholder events to be scheduled to voice their input, and requested that the Department provide a calendar listing all planned stakeholder events leading up to the final plan to be presented to the Board of Supervisors and agreed to keep this as a monthly agenda item until the plan is complete.

CBO Coalition Quarterly Meeting - March 16, 2017

We discussed having an MHSA presentation at the Recovery Learning Centers – Frank R. thought that this was a good idea and stated that he would coordinate these gatherings – after he coordinated the EQRO collaboration.

Tom Sodergren recommended having an MHSA presentation at the CSOC (Children's Action Team) – another good idea.

<u>Transition Age Youth (TAY) Full Service Partnership (FSP) Issues</u>:

Concerns were raised about whether there were enough TAY clients to support a TAY FSP. Also there is a concern when TAY clients age out of the system of which they are a part – then need to re-establish themselves in other programs, which can be a challenge.

Cuco Rodriguez noted that the goal is not to have the TAY clients transition to the adult system of care, but to receive adequate services in the TAY program so that they can return to the community and require fewer services. This is a different approach than thinking that intensive services will be required for a lifetime. The primary needs of the TAY populations are: housing and vocational rehab/work.

Telecare's ACT Program Manager confirmed that the TAY populations have different service needs. TAY naturally

separate themselves from the adult clients because TAY don't feel that they have a lot in common with the adults – they face different issues.

The conversation transitioned to budget matters. The CALM Director brought up the issue that less clients are attending clinic services in Santa Maria because they are afraid of immigration officials. There are lots of "no-shows" because people are afraid to leave their homes. JT Turner noted how in Europe, services are provided in clients' homes – professional staff go to the client instead of the other way around. There was some discussion of whether this approach would be viable in our system – and the concern that clinicians would connect with fewer clients because it takes more time to go house-to-house.

Transition Age Youth (TAY) Meeting SM, SB, Lompoc Staff - March 17, 2017

Lompoc staff wanted to know why they or other TAY staff were not consulted on the proposed design of the TAY Program. The program has not yet been designed, so there is opportunity for input still.
Concerns were raised in regards to the importance of transitioning extra help staff to full time status.
A request was made to include TAY staff in the design of the new FSP TAY Program and to ensure that the design also allowed for regional adaptations; related requests also included ensuring that the program model selected fostered independence in participants.
In regards to staffing, participants asked if there would be a funding shift from Justice Alliance to a TAY FSP Program and whether that would include increased staffing and additional program funding for program expenses.
In regards to FSP requirements, concerns were raised regarding the 24/7 hour coverage. A request was made to utilize Crisis Services and SAFTY to ensure coverage didn't impact turnover in the proposed TAY ACT Program.

NAMI's Public Policy Committee Meeting April 3, 2017

Question about how current funds for Transition Age Youth (TAY) are used, and how many teams exist currently. There are currently 2 TAY teams per region. One consideration is to make one of the TAY teams a separate ACT program. One of the TAY teams is a Prevention & Early Intervention (PEI) program funded in part by SAMSA – first episode psychosis is a big initiative for NAMI. There was discussion about the Mental Health Systems contract, and the fact that it was not renewed last year – there are problems with the organization in San Diego County, the County of origin. Another consideration is to use funding that had been allocated to the MHS contract to pay for additional staff to expand services.

Justice Alliance has received expanded money – there was a concern about Justice Alliance doing case management, since this was not the original intention for the program. Others thought that the idea of case management was a good thing. Some felt that Justice Alliance is disconnected from families; others asked what the Justice Alliance teams are doing in the courtroom all day. There are also issues with how individuals coming out of Justice Alliance are managed – there really isn't a warm hand-off to the mental health clinic. Sometimes, there are so many different teams involved – Triage, Justice Alliance, Clinic members, etc., that the individual isn't sure with whom to connect, and ends up not receiving treatment or being properly linked to services. There is also the problem of Justice Alliance trying to link a client with a clinic when the clinic is not ready to receive the client – so again there is a gap in service. Justice Alliance was supposed to connect clients to services, not provide services – Justice Alliance has moved away from that model. Warm hand-offs need to be improved – Peer Recovery Specialists would be great with this work; the Family Advocate in attendance also asked to let her know if there was not enough staff to help with the warm handoff, as she can provide assistance also.

Feedback on the last MHSA 3-Year plan – it was not clear which programs were FSPs; there were so many specialty programs that just became silos – which did not improve care and in some cases made services worse. It is good to see emphasis on continuity of care. This would be a good time to "tweek" the current programs.

One important concern is continuing the Assertive Outpatient Treatment program that was adopted as a pilot by the

Board Of Supervisors. With the budget shortage, there is concern that there may not be special funding coming from the General Fund anymore. Feedback was provided that AOT is working well within the ACT program, and there doesn't seem to be a reason why it cannot continue to operate in this fashion, even without additional funding.

The Department needs to communicate its vision – where is it going as a system?

Need to start the stakeholder process earlier.

Decisions need to be data driven – the Department "doesn't get it"/ or is not there yet.

Santa Barbara Stakeholder Forum April 10, 2017

Question: **Will a final proposed budget be presented?**
Celeste Andersen: I have been pushing for a budget. There will be a budget in the finalized 3 year plan.

Question: **Was last year's plan submitted to the state?**
Ana Vicuna: It seems it would have to be submitted or you don't get the funding.

Question: **Will the final plan demonstrate information about effectiveness of current programs?**
Celeste: We are working on that and I've asked for the MORs and CANS scores for the programs that are MHSA funded. We also have performance measures that are being provided and incorporated into the plan.

Question: In the past we learned that services weren't distributed across all populations equally. **Will we be able to include in the report the different groups who are receiving types of services?** Then we can examine how decisions are made relative to services provided and efficacy. It should be shown in MHSA planning who is receiving our services. Ethnic and racial groups should be listed in the plan.
Shereen Khatapoush: We looked at basic counts across the county by region and age. Now we are running data for gender and ethnicity. It will be included.

Feedback: Regarding the MHSA funding for Crisis Intervention Training (CIT) - You suggested that the Sheriff has a plan for that. Unfortunately it isn't funded. Supervisors need to step up and fund it. **The Department should consider providing MHSA funding for CIT programs**. The other thing is that I am concerned about the maintenance of the equipment at the Recovery Learning Centers. Computers fail on a regular basis. At the Mental Wellness Center, 8 of 10 computers are down and have been down for months. I am hoping additional MHSA funding goes to regular upkeep and maintenance of technology.
Celeste: This year the contracted providers will have this responsibility instead of our IT staff being responsible. We are aware there are problems with the computers not running well. The best solution is to transfer the funding directly to the CBO Providers and let them have control so they can pay for the computer technicians. This funding will be integrated into their respective contracts.

Question: **The programs you mentioned, did they come from previous analysis?**
Celeste: Many of these ideas were brought forward over time through various types of feedback. Some is our own analysis. Other ideas come from feedback from other partners. We have a lot of dialogue w/ the courts/public defenders/PHF, etc.

Question: **What about programs for Native American children and TAY?**
Ana: They are served regardless of ethnicity. We serve them all within the same timeframes.
Evan: We have identified them as the un-served population within the County. We are looking at data and determining how to make decisions about how to better serve these populations.

Question: In regards to the prevention aspect of MHSA, and in working with Probation, mental health staff try to address

the mental health needs of children on probation. They write grants and there are meetings. **But are we communicating enough w/ mental health? How is mental health working with Probation so that those kids locked up who need MH services are more part of an organized process and not a hap-hazard process which is what we seem to typically get**. We learn that their needs are not being directly addressed. **Are there MHSA founds that can be used to assist in this area?**
Ana: We are in Juvenile Hall and in the Camp. Behavioral Wellness is part of the racial/ethnic disparities grant. We partnered w/ Probation to see if we could help w/ the over representation of minorities w/ specific diagnoses. We have workgroups to develop a better trauma tool to use when we assess kids. We will be able to help Probation with doing a thorough assessment to make sure that children are served and assessed properly.
Feedback: There is still a void. We aren't reaching that population. It is not effective. Something is falling by the wayside. **Use MHSA funds to expand exploration of understanding what is being done in Juvenile Hall but not moving forward effectively.**
Ana: We still need to look at the data that is being provided. We are working to build these bridges. We want to link them to services. It is difficult to get these kids to voluntarily come to services. How do we serve clients that don't want to be served?
Feedback: Get the parents involved.
Ana: Strengthening Families starts this week. It works with parents and children. It is a huge endeavor to take on.
Shereen: Strengthening Families is an Evidenced Based Practice, one group for kids and one group for parents; we're providing food and childcare. We start tomorrow for 10 weeks.

Question: **Is the TAY program for ACT services going to be based at the Children's Clinic**?
Ana: Yes

Feedback: **Are there plans to hire more staff in South County to reflect such a huge area of need? Can we have 3 extra line staff here deal w/ everything down here**?
Ana: I can't speak to the hiring of staffing but we can put it as a suggestion.
Feedback: We need to have enough coverage. We don't have enough staff to cover the program.
Celeste: We know.

Feedback: Some of the things were accomplished during the last Three Year Plan, and I want to recognize this. The main thing I am interested in is the planning process. **If you want meaningful stakeholder involvement, you need to have stakeholders involved early in the development of the plan**. Do it before the plan is developed and presented to a group like this. Please involve us earlier. **The total transparency is important**. We need more information than what we are given. **We need to know costs**.
Celeste: Yes this is important to us as well. Ideally we will start doing the next round of Stakeholder meetings in the Fall of 2017 for early stakeholder participation.

Feedback: The original initiation and launch of the programs was very robust and conferences from people in the community participated. I want to speak for BeWell staff and contractors, **early involvement of staff is really important**. **A lot was done at top level management but there was a lack of communication w/ ground level staff**. Now we react to program implementation and feel we are not involved. We need to be involved in the process to make sure that we are doing what the state expects and what the plan expects.
Celeste: I agree. I love this stakeholder process to hear the input and what people think. I cannot speak to how things were structured in the past. I concur with your point. There is a lot of value to getting this information from the community.
Shereen: It's not too late to put forth your ideas. My sense is that it is fluid and changes over time. If you or colleagues you work with have a sense of something that is needed, please bring it forward at any time.
Feedback: Staff can't get release time to be here.
Shereen: Take the feedback forms to your staff.

Feedback: I am concerned about Justice Alliance. They are going to end up like CARES did – temporary clientele and a

huge caseload. **New programs are being developed w/o any fiscal description about the money we can spend**. Is something going to be cut to enhance new programing? What about the re-do of the clinics? Is it working? The clinic services have been transferred into MHSA funding. The other thing we haven't heard about is Medi-Cal reimbursement rates. Are projections being met? I don't know what the budget actuals are. I have heard that the '16-17 program did not get sent to the state. I don't know if I am in support of this. I am concerned about the level of care. Our clients depend on relationships. Moving people from one thing to another when they are doing better is a worry to me. They then have to change all of their relationships. I am concerned about this effort.
Ana: Levels of care – same staffing within all levels. It is not that they have new staffing. None of this has been worked out yet. We are forming work groups. We need feedback. It is not carved in stone. We do know that this topic keeps coming up. We need some kind of levels of care so that we know what kind of services that clients require. We don't have many staff.
Feedback: I am glad you want to have the step down of ACT teams.

Feedback: Regarding medical integration and older adult program: Please clarify the older adult program. Older adults perceive that there are not any mental health programs. **The plan has to include specific planning of geriatric populations.**
Celeste: Yes. Older adults are individuals who are 60 years of age or older, and we have programs to address their needs.

Feedback: Research about our clients perceived needs do exist.
Shereen: Yes. The county clinics and our CBO partners do a survey 2 xs per year in English and Spanish. There are 4 different surveys to get at the needs of the different populations.

Feedback: I'm impressed with all of the programs we have. Looking at the crisis teams, and having been around since its inception, I have witnessed how the program is useful and necessary for our high utilizers in an ongoing way. We need to have new programs looked at how to enhance resources so we can better serve clients. Warm handoffs from PHF. Crisis triage interfaces throughout our system. **We need more resources for Crisis teams in both North and South County**. It is imperative across all levels of care, especially repeat users in our system. I have seen how beneficial these services have been. It is vital.
Celeste: We will continue to augment the system and look for various funding sources in order to do that. We are conscious of this and don't want to bring in new programs that will sacrifice those programs that are working well.

Feedback: **Another issue – the CSU - most of that funding was SB82 but some MHSA, apparently it is still not working. The police and hospitals can't refer people because there is not enough staffing. What's happening? How is that being addressed?**
Celeste: Our CSU reimbursement rates are being increased to a much higher rate than in the past. There is an ongoing incentive to utilize the CSU. We are focusing on the effort to make all eight beds available this next fiscal year. We've shifted staffing to bring Mobile/Triage teams over to help support staffing at CSU.
Feedback: Why did you start a program if you didn't have funds to make it work?
Celeste: The issue is not about funding – it is about operations. It is a new program and providers considering the CSU as an available treatment option requires a new thought process. Utilization is slowly building momentum. We need to focus on level of comfort of the staff so that they can adequately serve the clients.
Ana: We also need to update our Polices & Procedures so that we know who the right people for the program are.

Feedback: CSU and Crisis Residential staff, does it include minors?
Ana: No
Feedback: **We don't want to send kids out of county for WIC 5585-** inpatient hospitalization.
Ana: We are looking at the data for this. We talked about developing a continuum of care for kids.
Feedback: Would this be part of MHSA funding?
Ana: I am not entirely sure but I don't think so.
Feedback: **What about kids outside of the justice system? Young people without Medi-Cal?**
Celeste: We have been looking into this. This is a good example.

Feedback: **Integrating into different levels of care calls for a robust discussion w/ line staff to get their input.** I hope this will take place with them. TAY youth emerging from Justice Alliance who are treatment resistant – do they meet the criteria for Laura's Law? **The techniques of engagement that have been successful w/ early Laura's Law program starts, can the Justice Alliance staff try to approach people using those engagement techniques?** TAY aged folks don't want to be diagnosed or treated.
Ana: We had one TAY go through an AOT.

Feedback: Since the process has a beginning and an end, we are all going to be faced with a dynamic environment of change. I am concerned with things being reimbursed by Medi-Cal. You need a task force to respond to the need for ongoing health care funding regarding the possible legal changes that will take place.
Celeste: Absolutely. We have not started a separate process but it is a great idea. We have not taken this approach yet. I know that California has a different mindset with a dedication to healthcare reform. There is a lot of motivation and dedication in our State for health care coverage that affords the residents of this State with some sense of insulation from what is happening at the Federal level. Inevitably, we could be impacted. So your idea is a good one. These dialogues are great. I love to get people involved.

Additional Comments Received:

- New programs to enhance resources for treatment of patients (crisis)
- Children specific crisis stabilization unit to prevent having to send them out of County/State
- Department should consider providing ongoing funds for CIT training
- American Indian TAY program(s)
- Use of MHSA funds for minority representation in Juvenile Systems (TAY)

Lompoc Stakeholder Forum April 13, 2017

- Pleased with Recovery Learning Center (RLC) progress.
- Ideas for RLC- Tobacco Cessation, Low Impact Exercise, Clinical Support, need for a program van or vehicle, donate county vehicles to RLC.
- RLC has helped "move me forward."
- Wraparound services and peers are important.
- A lot of people are served in the RLC- people participate.
- "I got a job and housing through the RLC, I am now a computer technician at the RLC"- client wouldn't be where she is today without the RLC.
- Because Bridge House is RLC, I wouldn't have anywhere to go. Client has now become a volunteer.
- RLC is important for career building. Discussion regarding future plans for the RLC computers – adding Adobe software products.
- Need more Path positions and would like to establish a Growing Grounds in Lompoc.
- Testimony about a consumer: "He was a mental health case worker with the ACT program, he got sick, needed support, and got an offer to work at Santa Maria RLC which gave him an opportunity to see people in recovery.
- Suggestion to go from ACT to SUD treatment and go back to ACT after SUD recovery.
- Support- someone needed help getting ID, documents, rehab to connect with family, time to do maintenance on self."
- Need more housing; manage wait list; must be specific as to who can access housing.
- "When I started seven years ago, there was a small staff. Now we have more staff to assist RLC clients which makes a big difference.
- TAY- CWS Case worker mentioned the need to have someone meet the clients where they are, the need for

housing, and expressed the importance of TAY clients talking to peers. Suggestion to focus on more services for TAY. A TAY parent shared his son was recently seen at the mental health clinic and it didn't seem to go well, parent is now aware of TAY services and the program is extremely beneficial and services are exceptional. There needs to be an easier way to find out about TAY services; another parent shared how she had to do research on her own in order to find out about the programs. Perhaps family members receiving TAY services could volunteer to spread the word regarding TAY at community events. Having evening hours available for TAY and perhaps adding the information to the Department's web page.

Consumer and Family Meeting Advocacy Committee April 13, 2017

- TAY Services- need specialized services- assumed this was already the case.
- Continuum of Care- Will Holman still provides services?
  Answer: Yes
- Some clients on medication regimens can't go to Holman.
  Answer: Might be able to receive services at Recovery Learning Centers.
- Peer Internships are great- Received training in Buellton-Want to get more training/how to access this kind of training?
  Answer: Should also consider the services available through the Workforce Investment Board as another potential resource.
- Will Promotoras continue to be part of continuum of care?
  Answer: Yes.
- Promatoras type of services should be imbedded into all services.
- Section 8 Housing suspended- how to get on list for housing.
  Answer: There is no way to get on a list for Section 8 housing at the moment; not aware of other options to get on lists.
- Hotel Riviera- now permanent not transitional housing- consumer now not considered homeless since has a room at the Hotel Riviera-how can she get better housing now?
  Answer: this sounds like a challenge.
  Friendship line- phone line for people to call for counseling services. Is there a chance that there can be funding for this service again? This would provide for Peer support in afternoons- could call and talk to someone.
  Answer: This sounds like a great idea.
- Shortage of psychiatrists.

Cultural Competence Action Team April 14, 2017

- How have we enhanced homeless outreach?
  Answer: Increased staffing through the SB-82 grant; partnering with C3H, Americore program.
  Do we have stats of numbers reached?
  Answer: Not here with us, but the data will be included in the final MHSA Plan.
- Crisis beds increased how and where?
  Answer: A Crisis Residential facility was established in Santa Barbara; we also opened a Crisis Stabilization Unit in Santa Barbara; there was enhanced staffing at the Crisis Residential Facility in Santa Maria. We will also be opening another Crisis Residential Facility in Santa Maria.
- How many beds will be there for children in SM?
  Answer: None. Ventura opened up an inpatient children's facility. We don't have the funding or staffing for this type of program at this time.
- Because of CARES, were children's services disregarded?
  Answer: No.
  Additional Response: Originally, when CARES North opened it was supposed to provide children's Crisis

Services. No one was aware of this.

- Santa Maria High School District representative- Working with schools that deal with kids' families and how ongoing needs continue to not be met; we have 6-8 counselors at every site and their feedback is that they don't have an understanding on how to connect kids with needed services. Maybe there needs to be a meeting so Behavior Wellness can outline services available.
  Answer: That is a great idea, and we have heard from other stakeholder groups that this type of communication with the schools is needed.
- CIT is it only for law enforcement? Will it expand to school staff?
  Answer: There is no plan to expand it to school staff at this time, but that is a good idea.
- Has Santa Maria Police Department received CIT training as well? Bring it up due to local situations that occurred in Santa Maria.
  Answer: Yes, they would have been included with the local police departments that were offered the training. Not sure if all officers receive this training, however.
- When looking at disbursement of resources-does the Department looks at equity, to where homeless reside or does the squeaky wheel get the grease? Suggesting that for transparency, should show data on needs. It keeps coming up that resources are not dispersed equitably. For example, Los Compadres uses low barrier tenant selection. Does this include undocumented?
  Answer: Undocumented individuals are considered part of the unserved and underserved populations; people receiving services from the Department must meet certain criteria regarding mental health needs or have co-occurring conditions, so services from Behavioral Wellness do have specific criteria.
- Who comprises the community development?
  Answer: County Housing Department; SB Housing Authority, HEART, C3H.
- How do decisions get made-Santa Maria tends to be left out of the loop.
  Answer: That is not intended.
- How is Justice Alliance being re-considered? Under MH program clients are supposed to stay for a year and must be Seriously and Persistently Mentally Ill (SPMI). – "Nothing specific in the slide."
  Answer: Correct – this is an open ended proposal. We are working with the Courts, District Attorney's Office, Public Defenders Office and other partners to consider how to better utilize Justice Alliance as a resource.
- Liked the idea of RLC enhancement- Great idea if it integrates back into level of care. What staffing needs to be present to provide good quality services?
  Answer: Psychiatry and Nursing support for medication management; peer and vocational rehabilitation services, and possibly some case management.
- Suggest use of old dormitory on the Camino Real campus for clients. Location is perfect.
- Key Objectives on Justice Alliance- new Justice Alliance MH provider. Work on finding out when clients go into Justice Alliance what medications they are already on. Reentry to connect to MH service, sober houses.
- Request for bilingual, bicultural staff.
- Anka-Community Care Licensing (CCL) rules keep clients out. CSU not stream lined- leadership issue -since Dr. Lundt left.
- Need to support stable staffing- people leaving due to pressures; less stability and continuity need to look at what is happening.
- Current teams are not clearly laid out with who is served where.
- Justice Alliance, if they do ACT type services, it's a duplication of service. They aren't really FSP. If they are to be ACT they need additional staffing.
  Answer: They are primarily linkage based to connect clients with ACT and Supported Housing programs.
- Trainings on Treatment Plans are more stigmatizing because they focus too much on impairments.

Additional Comments Received:

- Enhanced homeless services
- Show previous/present comparison of what is available

- FSP Services- All TAY
- Students need 6-8 counselors at all sites. Do not have a good idea of services available-better communication to schools; a meeting is needed.
- Santa Maria- Bonita School District/ and High School
- CIT for school personnel
- Disbursement of resources- Allocate based on needs
- Resources are not disbursed equally
- -No Place Like Home-Undocumented? Entitled to services-Undocumented parents/citizen children
- Who comprises community Development Leadership- Santa Maria excluded from the table.
  Justice Alliance- Very helpful services-makes a big difference.
- RLCs- accessibility of psych services-medical maintenance key-people could get there easier
- Partner with existing SNFS- don't want clients with mental illness.
- Need for RX pads-keep up with technology
- Get feedback from Justice Alliance on clients being arrested-maintain meds
- Release from Justice Alliance-linkage and planning-provide housing
- Request for more bilingual and bi-cultural staff
- Still challenges with ANKA and Crisis Stabilization Unit (CSU) admissions – community care licensing challenges.
- Stabilizing staff- why is staff leaving? Less continuity in the system.
  Need vision of what teams will look like.
- Justice Alliance – FSP should provide full ACT services- instead of linkage.

Santa Barbara Mental Wellness Center- Recovery Learning Center- April 14, 2017

Feedback**: More housing in Santa Barbara**/Goleta that provides help with meals (preparation, learning to cook), medication, and clothes washing. **More training/education** to help her become a better volunteer when working with kids.

Feedback: **Is there outreach to people transitioning out of foster care?**
Ana: We have a contract to serve children in the transition and the children are referred to us. All age groups are referred to us.

Feedback**: There needs to be mental health education in school systems.** There needs to be access at an early age. Mental Health services could be in schools in some way. They need to implement a system that can help a kid. We need more education about what services are available for children. People need to care about psychology within the community.

Feedback: There is more attention given to us at the MWC and I appreciate that. **The RLC resources are helpful**. The computer room is great. It is warm here. It helps when you have been away and come back in.

Feedback: **The Recovery Learning Community (RLC) staff is supportive**. They help us feel safe. They stop the drama.

Feedback: Re: No Place Like Home – There have been a lot of budget cuts in the past. They go right after mental health like a bloodhound after a fox. **Can they find a way to keep from cutting our funding?** We can't be cut like that. People end up homeless. The housing projects/Crisis Teams are a godsend to me.

Feedback: Tell **more about Psychiatry and Med Staff at the RLCs**. Is it for existing members? Would their Psychiatrist be here?

Ana: We would have the doctors and medical staff available to provide medication management at the RLC to reduce the need to have clients go to the clinics. Medication management clinics could be held several times a week at scheduled dates and times. We want to hear from you. We try to problem solve at the Department, but how do we work better together to support you clinically? Would it better serve you to have clinical services at the RLC sites?

Feedback: Pathpoint had supported housing here and a doctor saw the supported housing clients. It would be interesting to hear what the club members think about having a Psychiatrist on site. Would it be available to everyone or just a few people? Some club members are not in the County system. Would they get help? If you asked people: would they rather go out to Calle Real or would they like to have the clinical sessions at the RLC, they might like it, but will that change the way the club operates?

Feedback: People come to the RLC on our own schedules. It is hard for our clients to make regularly scheduled appointments.

Ana: We keep hearing people don't want to come out to Calle Real.

Feedback: My neighbors (who live here on Garden) would love it. They don't necessarily utilize the RLC services though.

Feedback: My concern would be where would there be available space for the Doctors. All the spaces downstairs are already full.

Feedback: It would be so convenient to have a doctor in this place. I don't want to go all the way out to Calle Real – two buses there and back. I would try to make the appointments.

Feedback: I've been seeing a doctor at CARES and now Calle Real. I go because I really need to go. If I know that I need something then I have to go. My question is, if you bring a doctor here, what doctor would it be? Would it be the doctor that I am already seeing? Would it be someone new?

Feedback: The thing about med staff time is that I think we could find a way to make it work in terms of space if we found a regular time. It would work best if there were appointments available but also drop in. There are a lot of people who come to the RLCs that would benefit from the walk in appointment. Need flexibility for walk ins.

Feedback: Sometimes at Pathpoint and Rehab, people are looking for jobs and it is hard to find them. The services don't help. We need to find another way to get access to jobs. The Dept. of Rehab does not help at all. **We need more supported employment**. A lot of people want it but don't have it.

Feedback: The Co-op project is going really well but is limited in terms of dollars.

Feedback: There are many people who tell me all the time that what they really need is supported employment. This is something people could really, really benefit from.

Feedback: I would benefit. I have mental health issues. I tried twice at the Dept. of Rehab and it did not work well. I need support. I can't as of yet get it together to go back to work.

Additional Comments Received:

- TAY- Need support for transitions out of Foster Care
- Schools- Mental Health education services available to kids who need help
- RLC's are so helpful. Nick is great at the RLC
- Busses a challenge to get to Calle Real
- Supported Employment is always needed.

Santa Maria Stakeholder Forum April 17, 2017

- No Place Like Home- $1.4 Million invested would get back a minimum of $2.7 Million for housing. There is still concern that this is not enough funding for developing the housing needed.
- Concern about Psychiatrists at Foster Road being replaced with Physician Assistants
- Concern about holding gardening and bowling groups and not offering PTSD groups.
- Peer advocate- Transitions Mental Health, programming for RLC, hopes it moves forward.
- Public Health representative mentioned that if Public Health can help in anyway let Michael Craft know. One concern, if TAY is FSP and Justice Alliance remains FSP that is a lot of staff having to be available 24/7.
- Need low barrier housing and having adequate support for clients.
- Need services for RLC
- Views of RLC used as part of community services - need additional funding included for more Peers.
- When MHSA Plan comes out, need to see more transparency, outcomes, accountability.

Additional Comments Received:

- Ongoing therapy for PTSD- regular meetings with doctor and clinician – wonderful group at clinic was cancelled. The person from clinic took over the meeting, and then group was transferred to RLCs, no support for PTSD at clinic. People have disintegrated/drinking/drugs/can't get out of bed.
- LEAD Project- Increase programming at RLCs
- Psycho/social factors often challenge; having landlords on board early
- RLCs Support- Place for individuals with mental illness
- Santa Maria RLCs- Community based operations
- Consider Incorporating Justice Alliance System
- Number of clients served

Regional Stakeholder Forum April 18, 2017 – Public Health Auditorium

Feedback: **Will the finished project have a budget**? I can't help but come back to this. SB82 is going to end. Grant funding is going to end. Then what?
Celeste: We are trying our best to make sure that we do not lose the money and that we use it in the best way that we can.
Feedback: I am concerned with the money. **Things are being expanded and there is not money to expand and keep what we have going already.**
Celeste: We have this in mind and it is our priority as well. We are not looking to expand programs during this three year period, but continue to enhance what we already have.

Feedback: **I am from Santa Ynez Valley Society St. Vincent De Paul and we have a lot of homeless people (around 100 by the river because we gave them jackets). What services will you provide in the Santa Ynez Valley?**
Celeste/Ana: We are doing a lot of homeless outreach in Santa Barbara. We know there needs to be services everywhere. This is the area served by Lompoc.
Feedback: **It would be nice if there were mental health services offered from time to time in Santa Ynez Valley**. It is difficult for homeless people to go to Lompoc. Sometimes the Buellton Senior Center has events that the homeless attend. I will give you the contact for the woman involved with homeless from the Buellton Senior Center.

Feedback: TAY programming as a FSP. What TAY services will remain in prevention/early intervention?
We serve a large number (around 250) of Native American TAY youth who are interested in culturally proficient programming, specifically in the prevention/early intervention area. We'd like to partner with existing services offered.

Feedback: Connecting our program (Community Health Center) for access and referral to you. We do a lot of screening/assessment in primary care. We can accommodate some Behavioral Health services. We can meet some needs in house. We have greater needs and we'd like to partner more. We partner w/ CALM. **We need greater awareness in our system about how we can partner with you.**
Ana: We want the same as you. We have the same goals as you. We need to have you connect with Amanda Pyper, Santa Barbara Regional Manager (who was in the room).

Feedback: **Request for more funding for field based engagement for TAY in order to connect with the community through activities that are ongoing and specific**. **Funds for: Gym membership. Sports games at the Colleges. Music/concerts at the colleges. Museums.** It would be nice to have funding to do these things again. We take advantage of free things and donations are no longer easily available.

Feedback: **The community needs to know what services are available**. I have been trying to find ways to be of help. One thing I did was pretend I had a family member who needs mental health services. I googled it online. The results were not heartening. It was very frustrating. Not only that but when you go to the websites it looks like you're in someone else's empire. It could be used much more constructively. **If you want to network, I would suggest that everyone links to each other's websites.** The link is there and not only that but it explains why it was there. Assume that you are absolutely new in the community and new to the problems of mental health. "I know nothing. I do not know who to call." See what happens when you try to Google it. **The websites should have a big obvious link that says "Go here if you need help."** They explain all their services but don't tell how to get services if you need help. We need to use specific wording, so that when people search mental health Santa Barbara, the appropriate services come up. We need to serve people w/ the greatest need. They have no way of figuring out who you are and where you are.

The stakeholder participants were asked their opinions about whether the Department of Behavioral Wellness should maintain its membership with CalMHSA and continue to pay dues. There was some discussion around the amount of the dues and what membership benefits entailed. In general, the stakeholder participants were surprised to learn that counties would have to join CalMHSA and didn't particularly agree that this was the best use for MHSA funds.

Santa Maria Recovery Learning Community April 21, 2017

- Space at RLC- would need to re-arrange office to make med support happen, but love the idea. Only space is maintenance people's space
- Clients work at RLC- Loves the idea of med support at RLC. Ease and knowledge of one stop shop would make it easier. More one on one.
- A lot of times, people want therapy-Clients disappointed when no one has a therapy degree, only support groups. Heard this need for the past 7 years. Therapy that is not short-term, even if an intern is getting supervised hours.
- I'm all for this enhanced clinic/ med support at RLC. Best idea to have stepped down.
- Could use special programs similar to Lompoc and San Luis Obispo – "Home Base"- volunteer Friendship Line. Transitions got a grant from San Luis Obispo. Need to put Friendship Line back in, was cut a couple months ago: costs were $40,000 per year, received 3000-4000 calls. County should pay versus grant. Start as volunteers then create minimum wage position 16 hours/week. A person at RLC did it for 6 months and enjoyed it.
- Clients working with the system plus getting paid-would like to see this again, "Internship" employment plus peer support- employment made all the difference. There also is an Americore worker – who does homeless outreach? Having someone such as a peer do outreach at the RLC; similar to Americore to navigate the system - someone

with experience.

- Daughter received service at Cottage Plus in SLO County- increase services for family members- Dialectical Behavioral Therapy classes or one on one therapy sessions.
- Plus run classes for Cognitive Behavioral Therapy/classes for families on psycho-education topics. Computer labs- friendly; good idea to provide money to RLCs directly to manage this on their own.
- "Status of the van since it was stolen and trashed?- "outings are what keep us sane"
- People who want to go back to work- supportive employment. Counselor versus therapist- cheaper to have a counselor- interns needing hours.
- Housing or Job for Justice Clients who have a criminal record.
- RLC staff visited orientation at Foster Rd. would like to have a social hour with Behavioral Wellness staff- good time of year for open house.
- Can Behavioral Wellness staff attend?

Lompoc Recovery Learning Community April 24, 2017

There was a discussion about Medication management at the RLC's. RLC Manager expressed that the center is a place where people don't have to talk about their mental illness. Clinical talk is usually held at the MH clinics. At the RLC people like to talk about their housing, employment and Wellness/ Recovery issues. Tina Wooton also expressed that other people have expressed the concern that the RLC is Peer run, and if clinical care is brought in, then that could change the dynamic of the Peer Run, Peer led, programing. There could be issues of programming changes, hierarchy, and control issues. There was also a discussion about billing and group billing at the RLC's.

There was a discussion about TAY services. One member expressed the need for more services such as game night, movie night and a need for more transportation.
Also, people come from Bridge House which is far away and the need for a van is crucial. The bridge that people have to cross doesn't have a bike or pedestrian lane and it can be dangerous when walking when cars are passing.

There was more talk about the need for the Lompoc RLC to have its own van. They have shared a van with the Santa Maria RLC, for several years, and with so many transportation issues presented daily it would be great if Lompoc RLC could have their own. Santa Maria's van was stolen so the Lompoc RLC doesn't have access to any van at this time. Celeste suggested other resources to acquire a van and Tina will contact the Sheriff's office to see if they have any auctions or impound sales.

The Lompoc RLC is a model RLC, per the members, and they like the collaborative effort that they have with the other RLC's. Steve stated that he hoped for more peer employment and that the Public Health department has peer navigators and expressed the need for more in Mental Health. There is a need for more peer employees in TAY and the Adult system.

Sandy shared that the cost of doing MH First Aid is a burden for some members and hopes for some free classes. The Lompoc RLC is in need of Art supplies. There was a discussion about digital art; some of the members were familiar with different software, which is appealing to many members especially the TAY group, but the need for all Art supplies is still there since Art is a huge piece for many for their recovery.

Summary:
Careful implementation of Med Management to the RLC's
TAY and Adult Employment
The need for a van
Art Supplies
Mental Health First Aid Support

Additional Comments Received:

- Stepping down from B. St. (Lompoc Adult) lost therapist-clinician - could help at RLC.
- Van–transportation helps get consumer to the RLC- Specially TAY age.
- There is concern that the RLC peer run program will be affected negatively by a hierarchy if doctors and nurses are imbedded within RLC.
- The goal is not for med staff to take over the RLC programming.
- Interest in TAY services for or within the RLC.
- 3-4-50 Health Program for RLC.

Children System of Care Action Team April 27, 2017

SELPA is concerned about youth who have been sent out of state for education/mental health services, who will be coming back to County after completing program. This TAY age youth will have aged out of mandatory education program – but there are no supports or services for him. He will not even have a place to stay upon his return from out of State placement. Will the TAY FSP be able to assist with housing for such an individual?

There is a great need for a children's residential facility in the County. Ventura County has this facility now, but it would be great if SB County had its own facility so families could easily visit and connect with their child. New legislation is making its way through the State Legislature that would provide further support for this type of program. Is this something SB County is investigating and could MHSA funding help support this program?

CALM staff expressed position that the PEI Early Childhood Mental Health Services should expand from 0-5 years of age to 0-8 years of age, since some 8 year olds still need the same level of support as a 5 year old; 5 years seems an arbitrary age limitation. Others seemed to agree.

SB County needs to have an improved vision of how to provide services to children at an earlier age. If there were robust programs available for the 0-5/pre-school age range, maybe we wouldn't be spending so much money on the older children and adults. Family issues need to be addressed earlier. Consider how to restructure families; provide improved support to families, including parenting skills and how to handle early childhood challenges; partner better with CWS; support improved functioning of the family, including addressing issues such as domestic violence and substance abuse while children are still young – not starting to address it when the child is already 8 or 9 years of age.

CWS representative shared that they are currently building a voluntary program, where parents that need help and support can request it through the In Home Intensive programs. There was also discussion about how Behavioral Wellness has partnered with CWS through the Katie A program.

There was discussion about the loss of the CATCH program, which worked with children who were expelled from pre-school. Not maintaining programs such as CATCH reinforces the idea that the County does not appreciate the importance of early intervention for children. Not sure where the funding for the program was going – the Department had reported that it was absorbing the money, but details were not available. There was discussion about CALM and other children's providers taking over the CATCH program.

The head of PHD's Pediatric services reported that problems should be identified and acted upon during early childhood screenings – the kids may not be having trouble yet, but at risk kids can be identified at this stage. ACE screening should begin at a young age, and can be performed by Pediatricians – this is happening at PHD and as well as Neighborhood Clinics. There was further discussion about how the ACE screening is currently used in the RISE program and at Juvenile Hall and has been a useful tool for them.

The two Pediatricians in the room were introduced to the Santa Maria Child Psychiatrist – it was interesting to observe that these doctors had not met previously, and were unaware of the extent of each other's respective work. Discussion ensued about the children's doctors from different specialties meeting together at intervals to discuss cases and enhance collaboration.

There is a lack of Psychiatric services in the community for consumers that need to be stepped down from the children's system of care

Final discussion point – without additional MHSA funding coming in, the Department cannot launch new programs, but we should be reconsidering how effective the current programs are and whether those programs need to be revamped or switched out for other programs. We should not be holding on to programs that are not achieving the goals that were intended. These types of discussions should continue beyond the MHSA Planning process.

Santa Barbara County Behavioral Wellness Commission April 27, 2017

Mental Health Services Act Planning and Stakeholder Process (Attachment 7a and 7b) Update – Celeste Andersen, Chief of Compliance presents the Commission with an outline (attachment 7b) of the 18 stakeholder presentations that have taken place county wide which also include proposed dates for the final presentation to BWC and the public hearing to receive comments on proposal. Also included, is June 20th as the date the plan presentation is to go before the Board of Supervisors to meet the State deadline.

Ms. Andersen references attachment 7a, *MHSA Planning* which is the PowerPoint that has been presented at stakeholder meetings. The presentation goes over the following; What is MHSA; Programs Established to Date; Community Services and Supports (CSS) – ongoing funding; Housing – One Time Funds; Prevention Early Intervention (PEI) – Ongoing Funding; Workforce Education and Training (WET) – One Time Funds; Innovation – Ongoing Funding – 3 Year Minimum; Capital Facilities/ Information Technology – One Time Funds; New Programs from the Last Three – Year Plan; Budget Data; No New MHSA Funding Identified at this Time; Proposal to Operate TAY as a Full Service Partnership; Proposal to Reconsider Justice Alliance; Proposal to Increase Programming at the Recovery Learning Centers; Proposal to Further Integrate the Existing Treatment Teams Into Levels of Care; Preparing for "No Place Like Home"; Utilization of "No Place Like Home" Funding; Funding Available for "No Place like Home"; Engagement in the "No place Like Home" Initiative; Community Input Makes a Difference – Feedback from the Last Three Year Plan.

Emma Godinez, Fiscal Manager reviewed the *Proposed Budget Summary* PowerPoint which addresses the following: Budget Review which is broken down by Funding Component (Community Services and Supports (CSS), Prevention and Early Intervention (PEI); Innovations (INN); Workforce, Education and Training (WET); Capital Facilities/Technology's Needs (CFTN); MHSA Housing Fund; Future Budget Challenges and Fund Balance.

After brief discussion, the Commission agreed to hold the MHSA Planning Presentation Update proposed on May 17th as part of the regular meeting. However, it was suggested that the meeting locations be changed to take place in a more public venue such as the Santa Maria and Santa Barbara Board of Supervisors conference rooms if available.

The Commission thanked Ms. Andersen and fiscal staff for the detailed and nicely prepared presentation.

MHSA Plan Posting Feedback Received from
May 1, 2017 to May 31, 2017

Email-Sent: Monday, May 01, 2017 3:48 PM

Message: As a member of this community I find it incredibly disheartening & disappointing the lack of interest & concern regarding accessibility to mental health services for the Latino population. There is not a bilingual LPHA available to assess Latino clients at CARES. Clients have gone there and told to go to Calle Real. The automatic response from administration who are NOT bilingual is "We have a language line & people need to use it." or the other response from administration is "I can go to any of our clinics & speak to someone in Spanish." Yes you can talk to an AOP staff who speaks Spanish but they can't do a risk assessment. The language line while isn't ideal it is available when there is no bilingual practitioner available. This shouldn't be the constant solution. At Calle Real there are 2 bilingual practitioners. There are no bilingual practitioners at CARES & there have been Spanish speaking clients DENIED to be seen there because of no availability of LPHA bilingual staff including a client who was suicidal. A solution to this issue have a bilingual LPHA at CARES.

Response: We appreciate your concern regarding access to mental health services for Spanish speaking individuals as well as all other non-English speakers. You are correct that for a period of time there was no Spanish speaking practitioner at the De la Vina location. In lieu of a Spanish speaking practitioner staff were instructed to use the available Language Line or contact our contracted live interpreter service for scheduled appointments. We are sorry to hear that some staff may not have followed this directive and we will address this issue with them.

After an extensive recruitment and interview process we are happy to announce that we have been able to hire a Spanish speaking practitioner at the De La Vina location who will be available to conduct screenings and assessments with Spanish speaking individuals 4 days out of the week. When this practitioner is not in the clinic, we will insure that the Language Line is utilized. Just yesterday afternoon a practitioner reported to me that he utilized the Language Line with a Spanish speaking consumer who arrived at the clinic as a walk-in. our Practitioner reported the language Line was easy to use and the interpreter did a good job.

Email- Sent: Wednesday, May 03, 2017 12:05 PM
First Name: Megan Last Name: Staudenraus Email: megan@casurvivorsspeak.org
Affiliation/Position Title: Program Manager, Survivors Speak

Message: I'm reaching out to share an upcoming CSEC 102 training opportunity on 5/17 and 5/18 in Santa Barbara.
The two-day "CSEC 102: Engagement Skills for Working with Commercially Sexually Exploited Children and Transitional Age Youth" training is led by a survivor and clinician training pair. Utilizing the unique perspective of a victim of sex trafficking as well as the clinical perspective, the training provides an overview of trauma, an overview of the stages of change model, information about AWOLing and peer recruitment, and strategies for prevention and intervention. The course is a follow up to the CSEC 101 course (available online) and is geared towards probation officers, social workers, clinicians, advocates, medical professionals, school personnel, and other professionals that serve youth, especially vulnerable youth populations.
Register here: https://www.eventbrite.com/e/csec-102-santa-barbara-county-tickets-33034536187
Please share with anyone interested, and feel free to contact me with any questions.

Best,
Megan Staudenraus
631-312-7944
casurvivorsspeak.org

Response: Behavioral Wellness promoted the training as response to the feedback provided.

Email- Sent: Tuesday, May 02, 2017 7:32 PM
First Name: Nathaniel Last Name: Tavani Email: ntava573@live.kutztown.edu

Message: Hello, My name is Nathaniel Tavani. I am currently about to graduate from Kutztown University with a BS in Psychology and minor in philosophy. I am interested in any type of job opportunities at your facility. I am particularly interested in the neurological and cognitive aspects of psychology and would love to use my use of this and other psychological methods to help others. Please let me know of any opportunities and how I should be able to apply.

Thank you,
Nathaniel Tavani

Response: This email was forwarded to the HR Manager and the Division Chief of Clinical Operations

Email- Friday, May 05, 2017 8:47 AM
First Name: Noel Last Name: Lossing Email: n.lossing@sbcsocialserv.org
Affiliation/Position Title: Child Welfare Services/Division Chief

Message: Santa Barbara County Child Welfare Services enthusiastically supports Proposal One: TAY Program Full Service Partnership. There is a tremendous need to expand services to the transitional age youth population which has historically been underserved.

Response: Thank you for your feedback.

Email- Sent: Monday, May 08, 2017 4:57 PM
First Name: Christine Last Name: Staricka Email: cstaricka@breastfeedla.org
Affiliation/Position Title: Education and Policy Program Manager, BreastfeedLA

Message: Good afternoon! I am writing to make sure you are aware of our upcoming seminar, Connected Care to Help Families Thrive: Breastfeeding, Maternal Mental Health, and the Community Circle. We are co-sponsoring this event with First 5 LA and it will be held at Valley Presbyterian Hospital in Van Nuys on May 25.
We are excited to bring Dr. Kathleen Kendall-Tackett here to LA, plus we will also have Joy Burkhard of 2020Mom, Helen O'Connor from LA County DPH, and many more panelists and community members. I am including the registration link for your convenience. We hope to see you there!

Registration: https://bflaconnectedcare.eventbrite.com/
Warmly, Christine
BreastfeedLA

Response: Behavioral Wellness promoted the training as response to the feedback provided.

Email: Sent: Wednesday, May 10, 2017 3:41 PM

Message:
Message: I support the use of PEI dollars currently going to SBCEO for CATCH to go to another agency to serve children with challenging behaviors in preschool.

Response: Thank you for your feedback. The Department is looking into this.

Email: Sent: Friday, May 19, 2017, 3:56pm
First Name: Kelly Last Name: Griffin Email: kgriffin@sbcbwell.org Affiliation/Position Title: Practitioner II

Message: MHSA plan for Lompoc TAY- We are in need for additional therapists and need our case managers' positions to be converted from extra help to permanent. We currently have 81 active PEI and New Heights TAY clients, with the majority of them needing intensive treatment and case management. Our current team is comprised of 2 therapists, and 2 extra help case managers that have been working as extra help for the past 11 months. In order retain are highly trained and experienced case managers, they need the assurance that their jobs are permanent. We serve 81 clients with a variety of treatment needs, psychosocial stressors, and severe impairments, in a community that has little resources. We have no Planned Parenthood, Social Security Administration, Food Bank, and have few community based organizations. The youth we serve include those that have experienced their first psychotic break, struggle with severe depression and suicide attempts, have little to no familial support systems, are high risk for continued psychiatric hospitalization or incarceration, and aging out of foster care.

Response: Thank you for your feedback. We are aware of the limited resources in Lompoc and investigating ways to expand resources to support the TAY FSP.

Email: Sent: Monday, May 22, 2017, 8:27am
First Name: Mayra Last Name: Ruiz Email: mruiz@co.santa-barbara.ca.us Affiliation/Position Title: case manager tay extra help

Message: I have worked with the TAY program for 8 years now. First with MHS then county this last year as an extra help position. My concern is that the case managers position are still extra help and that there is the possibility they may be cut. I believe these positions are crucial to our clients. Regardless if I am the one that stays on board or not I believe case managers positions should be made permanent. Working as extra help has been hard due to no sick time, benefits or vacation and does hurt morale. These youth are used to a level of care and without these positions it is not fair to them nor the therapist on the team. The youth deserve the level of care they have been receiving. Lompoc already has limited resources and without the case management services the youth would be cheated from their care. Case managers have the availability to focus on vital roles that these youth need and that the therapist don't have the time to focus on. TAY already has a large case load and without case mangers positions I don't see how TAY can continue to have the success that it has had.

Response: Thank you for your feedback. We acknowledge the current budget constraints and are looking for ways to bring on full time staff.

Brown Mail: Received 5/22/17
Name: Sara Scofield Affiliation: Behavioral Wellness

Message: Re: MHSA Funding Proposal the addition of Rehab Specialists for the 3 TAY teams – You did not involve

primary staff stakeholders who could have identified the specific vocational/pre-voc needs of teams. There is a misconception that there is currently no door to the Department of Rehab. This is not true, since throughout my tenure in the current Co-Op, we have strived with our DOR partner to serve the South County team and presently have at least half a dozen such individuals with open cases.

Response: Thank you for your feedback. Moving forward, we plan to include more staff input and invite our staff and stakeholders to attend the various MHSA Forums that will be held in the future, to voice their ideas and experience.

Brown Mail: Received 5/22/17
Name: Rosa Cepeda Affiliation: Behavioral Wellness

Message: What has worked so far is the idea of team based care meeting with staff to discuss plan of treatment for individual clients in which clinic staff are on the same page. The team based meetings could be shorter – 30 minutes. What has not worked and impacted the care of clients and has impacted the quality of treatment staff provided to clients was transferring clients from CARES South to Calle Real. This transition should have been gradual. A solution to this very problematic issue which resulted in delay in doctor appointments, clients running out of medications and an increase in crisis situations that could have been avoided with a gradual transfer. A solution to this issue would be to transfer the co-occurring and medical integration/older adults client and staff back to CARES. This would ease staff's sense of being overwhelmed (currently at Calle Real) and be able to provide care that clients deserve. Also, Santa Barbara Triage is short staffed at De La Vina and are in need of staff who are skilled in providing assessments, determining level of care, and providing referrals. A solution to this issue is to send the intake and assessment staff who are currently at Calle Real to De La Vina as De La Vina has more walk ins than Calle Real. Intake and assessment has a waivered psychologist and bilingual licensed MFT that would satisfy the language needs that are currently lacking at De La Vina.

Response: Thank you for your feedback. The Department is looking into this.

Letter Received 5/25/17
Name: Audra Strickland, Regional Vice President of the Hospital Association of Southern California recommending that the Department fund an involuntary CSU to address the significant gaps in involuntary services in the County. An excerpt from the letter states the following:

"However, this cavernous gap in involuntary services is not reflected in the MHSA report, identified as a significant problem, nor slated for any type of funding to reduce patient malingering. Hospitals would ask that the MHSA update reflect the true nature of the desperation associated with accessing emergency services and fund opportunities for these services to be provided locally – starting with an involuntary CSU.

A Crisis Stabilization Unit for those on involuntary holds has been raised with county staff for several years now as patient boarding hours have increased, the budget for out-of-county inpatient services has ballooned and community-based, outpatient services were favored over expansion of involuntary services. However, around other parts of the state, counties have successfully implemented this type of treatment opportunity with great success. In July of 2016, HASC provided extensive information to the County CEO's office and Behavioral Wellness regarding the benefits of an involuntary CSU. I have attached that letter for your reference.

Santa Barbara County has only 16 locked beds for those being held involuntarily because they are a danger to themselves, danger to others, or gravely disabled. Millions of dollars are spent annually to ship Santa Barbara residents to other counties to receive mental health treatment – treatment they could receive in the county if there was the will to do so.

Involuntary Crisis Stabilization Units (CSU) have been proven to address the needs of patients in a less restrictive

setting, by administering appropriate medications, connecting patients to county outpatient services, and eliminating the need for very costly inpatient treatment. As much as 75% of the population served at an involuntary CSU is diverted from inpatient care -- keeping patients near their support systems, reducing ambulance out-of-service time, serving patients efficiently in an appropriate setting, while saving substantial county resources."

Response: Thank you for this feedback. Opening an involuntary Crisis Stabilization Unit has been discussed by the Department in the past. The Department is currently focusing on utilizing all eight beds in its CSU during the coming three year plan period. Once the CSU is operating at full capacity, the Department can consider the need for additional CSU beds. The possibility of an involuntary CSU is not included in the MHSA Plan because MHSA funding may not be used to provide services in a locked facility.

Attachment 3:
Behavioral Wellness Commission Meeting Agenda for Public Hearing

County of Santa Barbara
Behavioral Wellness Commission
300 North San Antonio Road, Bldg. 3, Santa Barbara, CA 93110
TEL: (805) 681-5220 FAX: (805) 681-5262

Behavioral Wellness Commission (BWC) Special Meeting Agenda

The Santa Barbara County Behavioral Wellness Commission announces the Public Hearing for the MHSA Three Year Plan Update. The public is invited to attend to ask questions and offer feedback about the plan.

The Public Hearing will be held at the Santa Barbara Board of Supervisors Conference Room, 105 East Anapamu St., Fourth Floor, Santa Barbara. Videoconferencing will be offered in Santa Maria at the Santa Maria Board of Supervisors Conference Room, 511 East Lakeside Parkway Santa Maria, CA.

Interpretation Services will be provided. If you need language access, please let us know at least 72 hours prior to the event so we may schedule an interpreter. For more information or if you require interpretation services, please email Talia Lozipone, tlozipone@co.santa-barbara.ca.us

Time	Item	Presenter
3:30 pm	Roll Call	Karen Campos
3:31 pm	Establish Quorum	Sharon Byrne
3:32 pm	Welcome and Introductions	Sharon Byrne
3:40 pm	1.Mental Health Services Act (MHSA) Three Year Plan Update (Attachments 1a)	Celeste Andersen
4:00 pm	2. General Public Comment	Public Members
5:00 pm	3. Adjournment	All

"Writings that are a public record under Government Code § 54957.5(a) and that relate to an agenda item for open session of a regular meeting of the Behavioral Wellness Commission and that are distributed to the majority of the members of the Behavioral Wellness Commission less than 72 hours prior to that meeting shall be available for public inspection at Santa Barbara County Clerk of the Board at 105 E. Anapamu Street, 4th Floor in Santa Barbara, and also on the Behavioral Wellness website at: www.countyofsb.org/behavioral-wellness

Further Information Regarding Meetings:

Meeting Procedures

Members of the public are encouraged to attend and testify before the meeting participants on any matter appearing on the agenda.

Correspondence to the Behavioral Wellness Commission regarding items appearing on the agenda should be directed to Karen Campos, Department of Behavioral Wellness, 315 Camino Del Remedio, 2nd Floor, Santa Barbara CA 93110.

The schedule of the Behavioral Wellness Commission, meeting agendas, supplemental hearing materials and minutes of the Board meetings are available on the Department of Behavioral Wellness website at www.countyofsb.org/behavioral-wellness

Disability Access

American Sign Language interpreters, Spanish language interpretation and sound enhancement equipment may be arranged by contacting the Clerk of the Board of Supervisors by 4:00 p.m. three days prior to the meeting date. For information about these services please contact the Clerk of the Board at (805) 568-2240.

Attachment 4:
Minutes of the Public Hearing

Behavioral Wellness Commission Special Meeting
Wednesday, May 15, 2017
3:30 PM to 5:00 PM
Santa Barbara BOS Conf Room
Santa Maria BOS Conf Room
Meeting Minutes

Meeting Facilitator: Sharon Byrne, 4th District, Behavioral Wellness Commission Chair.

Department of Behavioral Wellness Staff: Alice Gleghorn, PhD, Director; **John Doyel,** Alcohol and Drug Program Administrator; **Karen Campos,** Behavioral Wellness Commission Program Administrator; **Celeste Andersen**, Chief of Compliance.

Roll Call: Commission Members Present: Jan Winter, 1st District; **Rod Pearson**, 1st District; **Sharon Rumberger**, 2nd District; **Judy Blue**, 2nd District; **Tom Franklin,** 3rd District; **Mary Richardson**, 3rd District; **Sharon Byrne**, 4th District, Chair; **Das Williams**, 1st District Supervisor

Commission Members Absent: Wayne Mellinger, 1st District; **Jeffery Moore**, 1st District; **Alicia Journey**, 2nd District; **Ruth Ackerman,** 2nd District (excused); **Ciara Wong**, 3rd District (excused); **Edwin Weaver**, 4th District (excused); **John Truman**, 5th District; **Ann Eldridge,** 5th District; **Charles Huffines**, 5th District (excused**).**

Establish Quorum: no quorum at this meeting.

Welcome and Introductions Chair Byrne welcomed everyone followed by self-introductions.

1. **Mental Health Services Act (MHSA) Three Year Plan Update (Attachment 1a) –** Celeste Andersen, Chief of Compliance provided a high level overview of the draft plan presented which contains detailed information on the following: MHSA Background; FY 2016-17 MHSA Planning Process; Santa Barbara County Demographics; Program Updates on all Programs under Community Services and Supports (CSS): Full Service Partnerships, S.B. 82 Enhanced Crisis Services, Prevention and Early Intervention (PEI), Innovation, Housing, Workforce Education and Training (WET), Capital Facilities and Technological Needs (CF/TN) and the 4 New Proposals for this Three- Year Plan along with Supporting Materials.

   Dr. Gleghorn addressed the request to the Department from the California Mental Health Services Authority (CalMHSA) to contribute $168,000 in Statewide prevention efforts, such as suicide awareness campaigns and stigma reduction initiatives. As Director of Behavioral Wellness, Dr. Gleghorn's role is to obtain approval from the community/stakeholders to contribute $168,000 to CalMHSA which funds would need to come out of current programs budgeted under the MHSA plan. Dr. Gleghorn asked for input from public/stakeholders as there would need to be further discussion to amend the MHSA plan to reflect the change before it is presented to the Board of Supervisors.

After discussion, the popular consensus was that the funds should be invested in the current programs they are already assigned to under the MHSA plan as those programs need to be the basis for addressing suicide risk and stigma prevention as well as assist the homeless or incarcerated mentally ill. Money would be well spent reaching people at the early stages.

2. **General Public Comment:**

- A program is needed that focuses on mentally ill homeless who reside in the Downtown Santa Barbara area and on Milpas St.
- Clarification was requested on the indicated 5 levels of care and on using the Recovery Learning Centers as part of the continuum of care.
- As the Department begins to collect quality data, the next obvious step (since resources are tight) would be to determine how to use that data to make decisions.
- A suggestion was made that the system needs access to more caseworkers who stay involved in a client's life once they are placed in housing and/or other services.

Feedback from Commission Members:

- As the RISE program becomes a collaborative effort, the hope is that those collaborating also contribute to the funding of this effort as the MHSA Plan funding is limited and it's an urgent need in our community.
- Juvenile Justice as an FSP sounds appropriate.
- Crisis services for Transition Age Youth (TAY) needs to be expanded.
- The Justice Alliance Program needs to focus on linking clients to services.
- Can Santa Barbara County consider a sales tax to benefit the homeless?

3. **Adjournment -** meeting adjourned 5:00 pm

Attachment 5:
Evidence of Santa Barbara County Board of Supervisors' Approval