SANTA BARBARA COUNTY
DEPARTMENT OF BEHAVIORAL WELLNESS

# MENTAL HEALTH SERVICES ACT

## DRAFT ANNUAL MHSA PLAN UPDATE
## FISCAL YEARS 2021-2022

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

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Art and photography provided by: Bridget Hochman, Amanda Kirk, and Danielle Denton

# County Compliance Certification

## MHSA County Compliance Certification

County: Santa Barbara

| Local Mental Health Director | Program Lead |
|---|---|
| Name: Pam Fisher, Psy.D<br>Telephone: 805-681-5161<br>Email: pfisher@co.santa-barbara.ca.us | Name: Lindsay Walter<br>Telephone: 805-681-5236<br>Email: lwalter@co.santa-barbara.ca.us |
| **County Mental Health Mailing Address:**<br>Santa Barbara County Department of Behavioral Wellness<br>300 N. San Antonio Road<br>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 statues of the Mental Health Services Act in preparing and submitting annual update, including stakeholder participation and nonsupplantation requirements.

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

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

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

Pam Fisher, Psy. D
Pam Fisher, Acting Director
Local Mental Health Director/Designee (PRINT)

Pam Fisher
Signature

County: Santa Barbara

Date: 06.17.2021

# County Fiscal Accountability Certification

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## MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County: Santa Barbara

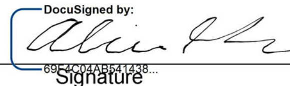
■ Three-Year Program and Expenditure Plan
Annual Update
Annual Revenue and Expenditure Report

| Local Mental Health Director | County Auditor-Controller/City Financial Officer |
|---|---|
| Name: Alice Gleghorn, Ph.D. | Name: Betsy Schaffer |
| Telephone Number: 805-681-5220 | Telephone Number: (805) 568-2100 |
| Email: agleghorn@co.santa-barbara.ca.us | Email: bschaffer@co.santa-barbara.ca.us |
| 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 other counties in future years.

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

DocuSigned by:



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| Alice Gleghorn, Ph.D. | | 6/9/2021 |
|---|---|---|
| Local Mental Health Director (PRINT) | Signature | Date |

I hereby certify that for the fiscal year ended June 30, 2020, 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 08/28/19 for the fiscal year ended June 30, 2019. I further certify that for the fiscal year ended June 30, 2020, the State MHSA distributions were recorded as revenues in the local MHS Fund; that CountylCity MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the CountylCity 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 the attached report is true and correct to the best of my knowledge.

DocuSigned by:

FE2388B572B0431...

| Betsy Schaffer, CPA, CPFO | | 6/15/2021 \| 4:12 |
|---|---|---|
| County Auditor/Controller/City Financial Officer (PRINT) | Signature | Date |

[1] Welfare and Instiutions Code Sections 5847(b)(9) and 5899(a)
Three-Year Program and Expenditure Plan, Annual Update and RER Certification (02/14/2013)

# Executive Summary

In the Fiscal Year (FY) 2020-23 Mental Health Services Act (MHSA) Three Year Plan, the Department of Behavioral Wellness (Department, BWELL, or Behavioral Wellness) committed to focusing on the continued enhancement and evolution of the many MHSA programs and initiatives launched in the past few years, while also outlining new proposals within Santa Barbara County MHSA programming. The FY 2021-22 MHSA Plan Update highlights progress achieved in the past year and plans for achieving new goals.

As a result of the COVID-19 Pandemic, the past year has proven that the Santa Barbara MHSA Behavioral Health network is resilient and adaptable while also showcasing the dramatic need for mental health and substance use treatment services throughout the community. The partnerships between the Department, community providers, and consumers were vital in ensuring individuals received care. The Department is thankful for our stakeholders who have been supporting us to ensure we deliver these necessary services and providing input on solutions to any barriers, such as staffing shortages from outbreaks, or virtual support groups when people couldn't meet in person.

The Department has continued to focus on the most prudent ways to deal with limited fiscal growth. Due to the initiation of mandatory contributions for the new MHSA No Place Like Home (NPLH) initiative passed by California voters in November 2018, continued focus on refining and augmenting existing programs while limiting new programs is the key fiscal strategy for continuance of all operations. The Department applied for a variety of new housing projects in 2020 and met the goal of creating 50 new permanent supportive housing units in County with newly awarded NPLH grant funds.

COVID-19 rapidly changed our way of being. The Department maintained essential Behavioral Health services with telehealth, reduced on-site locations, and expanded outreach coordination in the community as many people were in isolation. At time of publication, the Department is slowly transitioning to open more face-to-face services and concurrently assisting the County in COVID-19 relief activities, such as community behavioral health seminars and outreach events. Over the past year there were strains and concerns regarding MHSA funding as a result of the unknown impact on tax revenues from COVID-19. At this time, MHSA has not declined and the Governor's California budget projects MHSA growth in the coming year.

Beginning in July 2019, the Department commenced a robust MHSA Planning process for the new FY 2020-2023 Three-Year Plan. The Behavioral Wellness Commission supported creation of a planning group made of Commissioners, Department staff, Access Ambassadors, Peers, Family members, and Youth in the community. Two youth served as MHSA interns in development of the FY 2021-22 Plan Update, including assisting with communication ideas, drafting the plan, coordinating stakeholder meetings, and hosting Youth events. Additionally, the Planning team held over 17 meetings throughout the County virtually and in person, in three languages, and marketed the public events on a variety of social media platforms. The support from the community was overwhelmingly positive and feedback was received in various formats such as surveys, emails, photos, poems, and painted art.

Highlights from the year are: the creation of new housing developments including the opening of Depot Street in Santa Maria with 35 MHSA units, two youth MHSA State grant awards for expanding prevention services with collaboration with schools and specialized Early Psychosis programming, federal emergency grant funds for technology equipment for all outpatient MHSA clinic services to ensure telehealth capability with consumers in the community, and collaborating with the hospital network to initiate a new North County Crisis Stabilization Unit opening in winter of 2021 which will be partially funded by MHSA in FY 2022-23.

Based on input received during the 2020-2023 three-year planning process, the Department has four key proposals:

1. Implementation of expanded Youth-Focused Care and Youth-Driven Initiatives,
2. Increased utilization of Peer Services and integration of Peer Philosophies in the Department,
3. Expansion of Housing Developments and Support Services for those experiencing Homelessness; and
4. Integrating Whole Person Care practices throughout Outpatient programming.

Updates on these goals are included throughout the plan. In order to achieve these goals, Regional Partnerships and various Action Teams meet regularly to review barriers and implement solutions in key areas of focus for MHSA, including the proposals above. These teams' topics are: Adults' and Childrens' System of Care, Change Agents, Cultural Competence and Diversity, Crisis Services, Homeless Services, Housing, Peers, and Forensic Services. Action Team meetings are open to the Public for those interested in providing ongoing input and working on continuous quality improvement with Behavioral Wellness. Meeting notes are posted online in the monthly Director's report along with meeting locations and times for the following month. The Department will work with these teams and Community Partners to coordinate and establish these proposals in Santa Barbara County's Behavioral Health System.

*Santa Barbara on the California map*

## Performance Data Description

This year's plan update, where available, includes program performance reports using data collected by the Department for Fiscal Year 2019-20. As part of the plan update, the Department has committed to collect and report this data, and intends to continue to expand data collection in in upcoming years.

There were a few expansions to the performance metrics this year:

(1) ***Incarceration***. Incarceration data was derived by using a jail in/out report shared by the Sheriff's Department; thus, this only captures stays in Santa Barbara County Jail. Clients were matched to the jail census data through name and date of birth; therefore, it is likely a slight underreport due to names variations across systems. This data does not include juvenile hall stays, so it will underreport criminal justice involvement for transitional-age youth programs where some of their clients are under 18. We hope to be able to provide juvenile hall outcome data in the future.

(2) ***Crisis Services***. Crisis Services data was derived in the same way as inpatient psychiatric hospital admissions data; by cross-referencing the crisis services billed during a clients' admission to a program.

(3) ***Child and Adolescent Needs and Strengths (CANS)***. In moving to the new CANS version, the Department also changed how it examined clinical change on the CANS. See below for a more detailed description.

The outcomes reported depend on the type of program. Psychiatric hospital admissions during program admission are reported for all programs. Higher intensity programs, such as Full-Service Partnership (FSP) programs, have more detailed outcomes. The CANS and MORS continue to be administered as a way to monitor clinical acuity, needs, and strengths. Below is a description of each of the measurement tools used to determine outcomes in the children and adult systems of care.

**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. Due to a state mandated change, Santa Barbara County began using a new version of the CANS (CANS-50) in July 2018. This change in instrumentation made all existing CANS reports (such as compliance and outcomes) obsolete. In addition to changing versions, the CANS age range was also extended to age 20. This means that more transitional-age youth clients will receive a CANS.

The CANS-50 is organized into six primary domains (domains have changed slightly from the previous version of the CANS): *Life Functioning*, *Behavioral/Emotional Needs*, *Risk Behaviors*, *Cultural Factors*, *Caregiver Resources and Needs*, and *Child Strengths*. The Department did not present *Caregiver Resources and Needs* for these analyses because caregivers that are entered in the Caregiver A section often change across timepoints and are not currently tracked to allow for a matched comparison.

This year, the Department also examined CANS clinical change differently than in previous years. The data provided shows the percent change in the average number of *actionable needs* within a particular domain. On each item in the CANS, clients are rated a 0-3 on a Likert scale, with higher ratings indicating more serious problems, and a rating of 2 or 3 on an item to be considered an *actionable need*: 0 = no evidence; 1 = history

or suspicion, monitor; 2 = interferes with functioning, action needed; 3 = disabling, dangerous; immediate or intensive action needed. Therefore, improvement on the CANS is evidenced by a decrease in scores. Further, looking at the number of actionable needs over time is a meaningful measure of change.

As an example of this analytic method: At intake, the clients in a program had an average of three actionable needs per client in the 11-item *Life Functioning* domain. At six months, that matched group has an average of two actionable needs per client. This difference corresponds to a 33.3% decrease in their number of actionable needs in that domain. This method of analysis is more meaningful when there are more items in the domains and ratings are more normally distributed. Some scales, such as Cultural Factors, experience large percent differences between time points because the average number of actionable needs are so low that the average actionable needs have positive skew and a floor effect.

**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.

## 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 underserved 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 systematic transformation and integration are to focus on the five MHSA Guiding Principles that are outlined in the MHSA regulations.

The five MHSA Guiding Principles guide planning and implementation activities and are defined as such:

1. Cultural Competence-Services should reflect the values, customs, beliefs, and languages of the populations served and eliminate disparities in service access;
2. Community Collaboration- Services should strengthen partnerships with diverse sectors to help create opportunities for employment, housing, and education;
3. Client, Consumer, and Family Involvement- Services should engage clients, consumers, and families in all aspects of the mental health system, including planning, policy development, service delivery and evaluation;
4. Integrated Service Delivery- Services should reinforce coordinated agency efforts to create a seamless experience for clients, consumers and families; and
5. Wellness and Recovery- Services should promote recovery and resiliency by allowing clients and consumers to participate in defining their own goals so they can live fulfilling and productive lives.

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. During the three-year plan, a yearly plan update must be completed which is provided in this document.

County plans are to contribute to achieving the following goals:

- Safe and adequate housing, including safe living environments;
- Reduction in homelessness, such as a network of supportive relationships;
- Timely access to needed help, including in times of crisis;
- Reduction in incarceration in jails and juvenile halls; and
- Reduction in involuntary services, including 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); (79.3%); $23.0M in FY 21-22

2. Prevention and Early Intervention (PEI); (16.9%); $4.9M in FY 21-22
3. Workforce Education and Training (WET); (0.3%); $123K in FY 21-22
4. Capital Facilities (Buildings) and Technological Needs (CF/TN); (0.4%); $53K in FY 21-22
5. Innovation; (3.1%); $900K in FY 21-22

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 (FSP). 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 are a separate stream of funds. The "No Place Like Home" initiative established a new stream of funding for housing projects with implementation plans that have been completed throughout FY 2021-22 and upcoming years. Ongoing MHSA funding for Santa Barbara was diverted to the State and Santa Barbara County was awarded $2.56 million in non-competitive NPLH funding. Santa Barbara County has used the NPLH noncompetitive funding to fund housing units for people with a serious mental illness who are experiencing homelessness. These non-competitive funds have funded 13 units in Santa Maria at West Cox Cottages, 3 units in Santa Barbara at Hollister II in development, and are anticipated to fund 14 units in Lompoc at Cypress Studios.

Additionally, Santa Barbara County Housing Authority in conjunction with the Department of Behavioral Wellness has been awarded Competitive NPLH funding for an 18-unit housing project, Hollister Lofts, in Santa Barbara. Funding is available for competitive applications for housing at the State level through 2021-22.

## Community Program Planning Process for FY 2021-22 Plan Update

**Community Program Planning Process**

Pursuant to Welfare and Institutions Code (WIC) Section 5848(a), the Mental Health Services Act (MHSA) requires an inclusive and on-going Community Program Planning (CPP) process to gather input about experiences with MHSA Programs and the current mental health system. This allows for the Department to gauge the overall impact and effectiveness of such programs; to record recommendations for improvement of programs and processes; and to acknowledge feedback regarding future and/or unmet needs. Community Planning Process provides a structured process that the County uses in partnership with stakeholders in determining how best to improve existing programs and to utilize funds that may become available for the MHSA components.

**Components of Local Review of the MHSA 3-Year Program Plan**

The first step to creating a 1-year Plan Update is to solicit feedback from stakeholders throughout the County of Santa Barbara on what to include in the initial draft of the plan. Feedback is gathered through Department Action Team meetings on specific programs/needs, at hosted regional community stakeholder forums, in attendance of local community organization meetings with an awareness of mental health needs and engagement with regional key informants. In light of the COVID-19 Pandemic, feedback was obtained through online, virtual meetings and a Survey Monkey which was distributed to meeting attendees and interested community members who were unable to attend virtually.

Using the received feedback then guides the plan's initial draft. Once the plan is drafted, it must be published and circulated for 30 days. The draft plan is made available through various locations, online and by mail upon request. During this time, stakeholders are able to comment on the initial plan through emailing, calling, or writing MHSA Chief Lindsay Walter, or posting an "issue" on the Department's website for anonymous input.

Once the 30-day period is complete, the plan is presented to the Behavioral Wellness Commission at a public hearing on the proposed plan. This allows for public comment, testimony, and presentation. In order to enhance the transparency of the plan and aid the accessibility needs of the public; the Behavioral Wellness Commission has encouraged allowing the meeting to take place in a public building that is "less intimidating" for the public to join. Due to COVID-19, a virtual hearing.

After the hearing and review by the Behavioral Wellness Commission, the Commission votes on presenting the plan for adoption by the County Board of Supervisors. The plan is then sent to the County Board of Supervisors for approval. The hearing was on August 18, 2021.

Upon receipt of the plan, the Board of Supervisors reviews the plan and votes on whether to adopt it. Any significant recommended change to the plan, offered by the Board of Supervisors, requires a re-engagement of the stakeholder process.

Once all these steps are completed, and the Board of Supervisors adopts the plan, it is submitted to the Mental Health Services Oversight and Accountability Commission and the Department of Health Care Services for final approval by MHSA Chief, Lindsay Walter.

**Santa Barbara County's FY 2021-2022 MHSA Community Program Planning Process Schedule**

More than 1000 individual stakeholders were invited to participate in the county-wide stakeholder meetings. A total of 750+ individuals participated in the seventeen stakeholder meetings. including representatives from the Santa Barbara County Sheriffs, National Alliance on Mental Illness (NAMI), Pacific Pride, Just Communities, What Is Love, Santa Barbara Education Office, Lompoc Education Office, Santa Maria Education Office, Santa Ynez Tribal Health Clinic, Casa De La Raza, Casa Pacifica, Cottage Hospitals, Crestwood, Transitions Mental Health Association Santa Maria and Lompoc, Santa Maria School District, Good Samaritan Shelter, Community Health Center, Santa Barbara Independent, CALM, Los Alamos School, Community Action Commission and many more.

These Stakeholder meetings were all tailored to specific populations served in our Mental Health Systems, although anyone from the public was welcome to attend any meeting. Stakeholder meetings were hosted and specifically oriented to as many of our underserved/unserved populations as we could identify. Targeted stakeholder groups for meetings and in attendance included: Consumers and Families; LatinX populations; Migrant and Permanent Agricultural Workers, Mixteco communities; Homeless and At-Risk of Homeless Populations; LGBTQIA+ populations; TAY populations; College and High School students; Older populations; Rural communities; and Veterans. Additionally, this year, Project Heal coordinated an exit survey with Black and Religious community members during a vaccine clinic and a Survey Monkey was disseminated to all Department email distribution list and at all meetings for community feedback for those unable to attend meetings or wishing to provide online feedback.

The 30-day review process was conducted from July 17 to August 17, 2021 in partnership with the local Behavioral Wellness Commission. Additionally, the draft Mental Health Services Act FY 2021-2022 One-Year Plan Update was e-mailed to nearly 1000 stakeholders. It was available by postal mail on request, posted online and available in the Director's Report. The Behavioral Wellness Commission hosted a Public Hearing on August 18, 2021 and anticipate a Board of Supervisors Hearing on November 16, 2021. Finally, the Final plan update will be posted to the Department of Behavioral Wellness website and announced in the Director's Report.

For more information about the Community Planning Process or if you missed the opportunity to share input at any of named community planning sessions, you can always email, mail or call MHSA Chief, Lindsay Walter. Contact Information is MHSA Chief, Lindsay Walter, JD Email: lwalter@sbcbwell.org 315 Camino Del Remedio Santa Barbara, CA 93110 ☏: (805) 621-5236.

| Fiscal Years 2021-22 MHSA Community Program Planning Process Schedule | |
|---|---|
| **MHSA Planning Workgroup Meeting** | |
| Client Family Member Action Team – Workgroup 1 | 12/17/2020 |
| Peer Employee Forum – December | 12/17/2020 |
| Client Family Member Action Team – Workgroup 2 | 1/21/2021 |
| Leadership Team | 1/25/2021 |
| Community-Based Organization Collaborative | 2/3/2021 |
| Housing Empowerment Action and Recovery Team (HEART) | 2/10/2021 |
| Peer Employee Forum – March | 3/18/2021 |
| Client Family Member Action Team – Workgroup 3 | 2/18/2021 |
| **MHSA CPPP Sessions – Stakeholder Focus Groups Meetings** | |
| Client and Family Member Action Team (CFMAT) | 3/18/2021 |
| Cultural Competence and Diversity Action Team- Whole Person Care | 3/12/2021 |
| General Community Listening Session on MHSA Planning and Updates – Community Members in All Regions | 3/23/2021 |
| Children's System of Care (CSOC) – Community Based Organizations and Consumers | 3/25/2021 |
| National Alliance of Mental Illness (NAMI) Family Members – Housing and Homeless Service Focus | 3/25/2021 |
| Housing Empowerment Action and Recovery Team (HEART)- Housing and Homeless Service Focus | 4/14/2021 |
| Community-Based Organization Collaborative – Provider Community Focus on all Plan goals | 4/17/2021 |
| Spanish Speaking Session focusing on Underserved/Unserved Community in West County | 4/19/2021 |
| Project Heal of Santa Barbara – Vaccine Exit Survey with Black and Religious Community in South County | 4/24/2021 |
| Spanish Speaking Session focusing on LatinX Community and Family Members in South County | 5/11/2021 |
| **Transition- Aged Youth (TAY) Community and Consumer Listening Sessions** | |
| Behavioral Wellness Transition-Aged Youth Clients | 3/3/2021 |
| Community Session | 4/7/2021 |
| Virtual Game Night | 3/24/2021 |
| Spanish Session | 5/22/2021 |
| **Survey Monkey – Virtual MHSA Feedback Survey** | |
| Disseminated at all Stakeholder Session and to Department distribution list.<br><br>**Results:** The MHSA Planning Survey was distributed electronically via SurveyMonkey in English and Spanish, and was completed by stakeholders from March to May 2021. One hundred and thirty-two people responded to the survey; 24% of respondents took the Spanish survey. The English version took respondents on average 6.5 minutes complete and had an 84% completion rate. The Spanish version took respondents just over 8 minutes to complete and had a 71% completion rate. | March – May 2021 |

## MHSA Department Action Teams

Department Action Teams are continuous community planning and feedback meetings focused on topics of interest for stakeholders. The meetings are public and held regularly for ongoing collaboration with partners in Santa Barbara. Each team is highlighted below reflecting on activities from the year and contact information for those interested in participating in MHSA activities by attending these meetings.

**Children System of Care (CSOC)** provides information to schools, agencies, and the community on trauma-informed services available in the community with hosted discussions on MHSA-funded initiatives pertaining

to prevention and early intervention. For information on attending contact Tony Hollenbeck by email at: ahollenbeck@sbcbwell.org or call the department at: (805) 681-5220.

Throughout fiscal year 2020-21, CSOC has welcomed several new members and engaged in many lively discussions regarding how to best support children and families through MHSA funding, specifically during the COVID-19 pandemic. Presentations were given at various meetings including the RISE Project that discussed human trafficking and effective strategies of engagement and resources to support the community. CALM facilitated a discussion regarding ways to engage with and connect high-risk youth and families to services during COVID-19. Throughout the year, CSOC members worked hard to identify four primary areas of focus for the upcoming fiscal year: Access to Care & Engagement, Safety & Resilience, Criteria for Services, and Youth of Color. Members worked in sub-groups to discuss ways to enhance services and continually expressed the need for increased substance abuse support within wellness programs and integration of services for youth who have a dual diagnosis of mental health and substance abuse needs. The need for a youth advisory council has also been expressed by CSOC members and transition-age youth employees within the Behavioral Wellness Department have been invited to attend meetings to share their input.

**Consumer and Family Member Action Team (CFMAT)** seeks to advance recovery by strengthening the role of consumers and family members who work and volunteer in the public mental health system by ensuring that MHSA programs are client-led and family involved. Members from the Peer Action Team (PAT) collectively selected to merge with Client Family Member Advisory Team in December 2019 as a way to best support the delivery of action items without duplicating duties. For information on attending contact Maria Arteaga by email at: marteaga@sbcbwell.org or call the department at: (805) 681-5220

CFMAT members regularly shared and discussed Behavioral Wellness peer trainings and peer job opportunities as well as upcoming community events. Various presentations were given throughout the 2020-21 fiscal year including an 8-session Virtual Peer-to-Peer Education Program by NAMI and mindfulness relaxation techniques by Brock Travis, PhD. Lindsay Walter facilitated lively discussions regarding the MHSA Community Planning Process and many CFMAT members provided feedback and volunteered to be leads on peer initiatives including expanded Youth Focused and Youth Driven Initiatives, Increasing utilization of Peer Services and Integration of Peer Philosophies, Expansion of Housing Developments and Housing Support Services for those at Risk and Experiencing Homelessness, and Integrating Whole Person Care Philosophies through Outpatient Services. CFMAT members expressed an interest in having the Behavioral Wellness Commission include perspectives from Transition-Age Youth (TAY). Help@Hand provided multiple updates throughout the year to gather feedback from team members regarding digital literacy groups called “Appy Hours,” peer-run support groups at the PHF, and improving the transition between discharge and a client’s first follow-up appointment. To end the fiscal year, CFMAT hosted its first annual MHSA Peer Empowerment Conference on May 27th, 2021.

**Forensic Action Team** is a cross disciplinary group of individuals interested in addressing challenges at the intersection of the Behavioral Health and Criminal Justice systems. Behavioral Wellness organizes the team and facilitates discussions and problem-solving on topics related to people with mental illness who are also involved in the criminal justice system. The team is open to the public and seeks participation from a wide range of stakeholders, including but not limited to: the Superior Court, District Attorney, Public Defender, local law enforcement personnel, Probation Department, consumers, families, NAMI and other advocacy organizations. The team is co-chaired by Shana Burns. For more information contact Celeste Andersen by email at: candersen@sbcbwell.org or call the department at (805) 681-5220.

The Forensic Action Team Meeting seeks to connect a wide variety of leaders and stakeholders invested in cross-sector collaboration and ongoing systemic enhancements for services provided to criminal justice-involved juveniles and adults. Meetings occur monthly on the 4th Wednesday of each month from 1:30 P.M. – 3:30 P.M. (via Zoom)

Throughout 2020 and into 2021, the Forensic Action Team has been meeting monthly to discuss the Proposition 47 Jail Diversion grant, which offers law enforcement the option to divert intoxicated individuals from incarceration to a safe and therapeutic setting where they may be linked to substance abuse and/or mental health services, and the Assembly Bill 1810 Department of State Hospitals Felony Diversion grants, which promotes stabilization of individuals within their community rather than being sent to a state hospital. New COVID-19 laws regarding the early jail release process required a discussion about positive teamwork between Probation, Sheriff's Office, Public Defender, and Behavioral Wellness and changes that have been made in response to the COVID-19 health crisis. Partner updates regarding this health crisis were presented by the Behavioral Wellness Forensics Manager, Shana Burns, LMFT, and Justice Alliance Team Supervisor, Nicole Horne, LMFT, whose mission is to provide individualized intensive treatment for adults involved in the criminal justice system.

Meetings were well-attended and many included lively roundtables with a diverse group of stakeholders and forensic partners regarding the successes and challenges of Prop 47 and AB1810 and implemented programs such as: 1) Co-Response (Sherriff's Office and Behavioral Wellness mobile crisis collaboration); 2) CREDO 47 Sobering Center (Crisis, Recovery, Engagement, Diversion and Outreach) headed by Good Samaritan; and, 4) the Medication Assisted Treatment (MAT) induction services provided by the Alcohol and Drug Programs (ADP) division of the Department of Behavioral Wellness. Behavioral Wellness' partner, WellPath, highlighted their new Jail Based Competency Treatment (JBCT) program and were recognized by stakeholders for their valiant efforts and beneficial outcomes in building a separate unit in the Santa Barbara county jail to provide welcoming, individualized treatments for adults who would otherwise be sentenced to a state hospital for competency restoration due to the severity of their mental illnesses. This year ended with discussions regarding 2020 highlights and successes and visionary goals for 2021, including ideas regarding how to incorporate peers with lived experience into WellPath's discharge process for inmates.

**Housing, Empowerment, Action and Recovery Team (HEART)** was chartered to address the present and expanding housing and treatment crisis facing clients and potential participants of the Department of Behavioral Wellness in Santa Barbara County. The team has produced policies, launched MHSA programs such as No Place Like Home, and produced capital recommendations for incorporation into the budget and programs of Behavioral Wellness. For more information contact Laura Zeitz at lzeitz@sbcbwell.org or you can call the department at (805) 681-5220.

Throughout the fiscal year, HEART members planned and discussed the multitude of Housing programs that utilize MHSA funding including, but not limited to, the No Place Like Home (NPLH) Initiative, the Homeless Emergency Assistance Program (HEAP), the Community Corrections Partnership (CCP) Housing, and the Project Homekey State limited term program. Funding was secured for NPLH, making it possible to start construction of West Cox, a 13-unit housing development, and Hollister Lofts, an 18-unit housing development. HEART's current focus under NPLH includes applying for non-competitive funding for a 14-unit development in Lompoc. HEART has also worked hard to allocate funding for CCP Housing (MHRC pilot) and design a 16-bed housing development located at the former Methadone Clinic on Calle Real in Goleta, as well as assisting Crestwood in obtaining a certificate of occupancy for 34+ beds at the Champion Center in Lompoc. Under HEAP, there were 6 units on Depot Street, in addition to the 34 MHSA-funded units in Santa Maria that were

fully leased. Amid COVID-19 concerns, HEART members ensured that Depot Street residents were provided with telehealth services supported by Peer Personnel from Santa Maria clinic. Under Project Homekey, a hotel on B Street in Lompoc was rehabilitated and developed into 14 studio apartments that were fully leased by January 15th 2021. These units exclusively house homeless population with a serious mental illness.

**Cultural Competency and Diversity Action Team (CCDAT)** seeks to increase access to services for under-served populations, particularly in high poverty areas; increase the capacity of staff to work effectively with diverse cultural and linguistic populations; revise or develop policies on cultural competency and disparities to ensure relevance and consistency; develop strategies to address issues of cultural competency regarding staff preparation and client engagement; and improve the accuracy of clinical assessments for diverse clients. This action team serves as a platform to host and guide all MHSA programs. For more information contact Maria Arteaga at: marteaga@sbcbwell.org or Tony Hollenbeck at ahollenbeck@sbcbwell.org or you can contact the department at (805) 681-5220

Discussions centered on Behavioral Wellness' language assistance services and cultural competency trainings. CCDAT members made efforts to establish goals for the fiscal year such as narrating and translating recordings for those who speak Spanish, Mixteco, and American Sign Language to promote inclusive access to reduce mental health disparities. Another goal centered on increasing access and clarity of informing materials like brochures and signage so they reach a wide variety of communities. Members discussed social connectedness and technology use during COVID to ensure everyone has access to care and provided feedback for Help@Hand's digital literacy program. CCDAT is in collaboration with Santa Ynez Tribal Health Center to pilot an outpatient substance abuse program that integrates and reflects Native/Indigenous culture, tradition, and beliefs. Members also gave input on the Latinx and Indigenous Migrant Covid-19 Response Taskforce's Mental Health and Wellness Working Group. CCDAT members identified four primary goals in alignment with the Cultural Competency Action Plan: Language Access Services, Outreach & Engagement, Cultural Competency Training, and ADP Program (in collaboration with Santa Ynez Tribal Health Center). Within these goals, an additional intention of CCDAT is to incorporate MHSA's Whole Person Care initiative and develop resources that effectively demonstrates that.

**Crisis Action Team** seeks to improve timeliness to psychiatrist visits for adults in crisis; increase the quality and availability of transportation to support the quality and availability of transportation to support voluntary admissions to out-of-county LPS facilities; improve the continuum of crisis response services for children; ensure consistent awareness of the rights of individuals in psychiatric crises; and increase public awareness of psychiatric crisis services needs in Santa Barbara County. Crisis Action Team hosts discussions on MHSA funded programs that are built to serve people in crisis. For more information contact the department at (805) 681-5220.

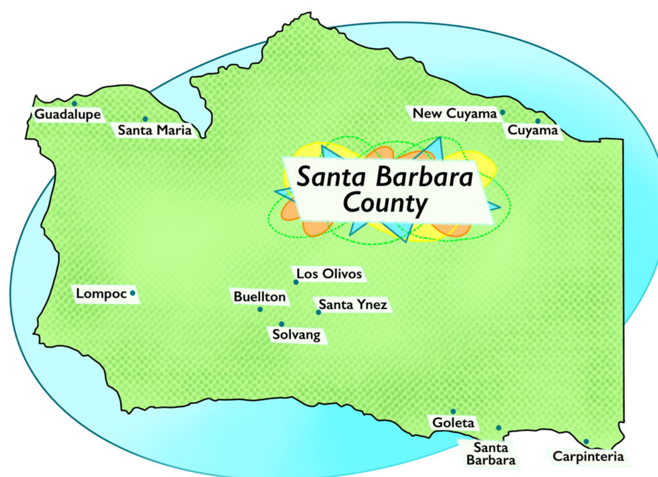
At the beginning of the fiscal year, Crisis Action Team was providing tremendous support and feedback for the expanded Co-Response Program Teams and the opening of the CREDO47 Stabilization Center, operated by Good Samaritan, on the main campus of Behavioral Wellness. This center is a jail diversion program that provides sobering services, diverts individuals from jail and potential repercussions of minor offenses, and connects individuals to drug and alcohol programs, housing, and other necessary services. Co-Response Teams were established in the North and South parts of the county and Crisis Action Team Members participating in the Co-Response program attended a two-day training led by the SB County Sheriff's Department. Since the COVID-19 Pandemic, efforts have been made to incorporate more telehealth crisis evaluations and outpatient nursing and Recovery Assistant staff have been cross-trained in anticipation of staffing shortages at the Psychiatric Health Facility (PHF). Crisis Action Team members voiced the need for improved

collaboration and communication in order to increase the number of individuals in the Emergency Departments that receive access to Behavioral Wellness services.

**Change Agent** seeks to improve the quality of care through continuous quality of care activities. For more information contact Pam Fisher at: pfisher@sbcbwell.org or you can contact the department at (805) 681-5220.

A main focus of Change Agents Action Team is to reduce wait time for urgent and crisis needs by creating a flow chart for Behavioral Wellness Administrative Office Professionals to better triage calls and to increase attendance by adding snacks for participants. During the COVID-19 Pandemic, Change Agents members discussed increasing safety within the clinics for staff and consumers and assisting onsite staff with the extra work they are experiencing due to the increasing need of telehealth staff. Members also recognized the need to increase access and attendance to telehealth groups and solve problems surrounding client IT issues. Appointment schedulers and reminders are being utilized in an effort to decrease the no-show appointment attendance rate.

## Santa Barbara County Demographics and Target Populations




Santa Barbara County has a mountainous interior abutting several coastal plains on the west and south coasts of the county. The largest concentration of 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, along with stretches of unincorporated area such as Noleta. North of the Santa Ynez range in the Santa Ynez Valley are the towns of Santa Ynez, Solvang, Buellton, 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 New Cuyama, Cuyama, and Ventucopa. As of January 1, 2006, Santa Maria has become the largest city in Santa Barbara County.
(Retrieved 6-21-2021 from Wikipedia)

**Quick Facts Santa Barbara County United States Census**

| **Population** | **446,449** |
|---|---|
| **Population estimates, July 1, 2019, (V2019)** | 446,499 |
| **Population estimates base, April 1, 2010, (V2019)** | 423,947 |

| | |
|---|---|
| **Population estimates base, April 1, 2010, (V2018)** | 000,000 |
| **Population, percent change - April 1, 2010 (estimates base) to July 1, 2019, (V2019)** | 5.3% |
| **Population, percent change - April 1, 2010 (estimates base) to July 1, 2018, (V2018)** | 0% |
| **Population, Census, April 1, 2010** | 423,895 |
| **Age and Sex** | |
| **Persons under 5 years, percent** | 6% |
| **Persons under 18 years, percent** | 22% |
| **Persons 65 years and over, percent** | 15% |
| **Female persons, percent** | 50% |
| **Race and Hispanic Origin** | |
| **White alone, percent** | 85% |
| **Black or African American alone, percent** | 2% |
| **American Indian and Alaska Native alone, percent** | 2% |
| **Asian alone, percent** | 6% |
| **Native Hawaiian and Other Pacific Islander alone, percent** | 0.3% |
| **Two or More Races, percent** | 3.8% |
| **Hispanic or Latino, percent** | 46% |
| **White alone, not Hispanic or Latino, percent** | 43% |
| **Population Characteristics** | |
| **Veterans, 2015-2019** | 21,027 |
| **Foreign born persons, percent, 2015-2019** | 23% |
| **Housing** | |
| **Housing units, July 1, 2019, (V2019)** | 159,246 |
| **Owner-occupied housing unit rate, 2015-2019** | 52% |
| **Median value of owner-occupied housing units, 2015-2019** | $577,400 |
| **Median selected monthly owner costs -with a mortgage, 2015-2019** | $2,364 |
| **Median selected monthly owner costs -without a mortgage, 2015-2019** | $634 |
| **Median gross rent, 2015-2019** | $1,643 |
| **Families & Living Arrangements** | |
| **Households, 2015-2019** | 145,856 |
| **Persons per household, 2015-2019** | 2.91 |
| **Living in same house 1 year ago, percent of persons age 1 year+, 2015-2019** | 80% |
| **Language other than English spoken at home, percent of persons age 5 years+, 2015-2019** | 40% |
| **Computer and Internet Use** | |
| **Households with a computer, percent, 2015-2019** | 92% |
| **Households with a broadband Internet subscription, percent, 2015-2019** | 87% |
| **Education** | |
| **High school graduate or higher, percent of persons age 25 years+, 2015-2019** | 80% |
| **Bachelor's degree or higher, percent of persons age 25 years+, 2015-2019** | 34% |
| **Health** | |
| **With a disability, under age 65 years, percent, 2015-2019** | 6% |
| **Persons without health insurance, under age 65 years, percent** | 11% |
| **Economy** | |
| **In civilian labor force, total, percent of population age 16 years+, 2015-2019** | 63% |
| **In civilian labor force, female, percent of population age 16 years+, 2015-2019** | 58% |
| **Total accommodation and food services sales, 2012 ($1,000)** | 1,428,929 |
| **Total health care and social assistance receipts/revenue, 2012 ($1,000)** | 2,637,280 |
| **Transportation** | |

| Mean travel time to work (minutes), workers age 16 years+, 2015-2019 | 20.5 |
|---|---|
| **Income & Poverty** | |
| **Median household income (in 2018 dollars), 2015-2019** | $74,624 |
| **Per capita income in past 12 months (in 2018 dollars), 2015-2019** | $36,039 |

Value Notes: 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., V2019) refers to the final year of the series (2010 thru 2019). *Different vintage years of estimates are not comparable.* https://www.census.gov/quickfacts/fact/table/santabarbaracountycalifornia/PST045219

**Community Planning Process and Prioritized Targeted Population Programming:**

The planning process resulted in stakeholders identifying all six populations as priorities:

1. Trauma Exposed Individuals
2. Individuals Experiencing Onset of Serious Psychiatric Illness
3. Children and Youth in Stressed Families
4. Children and Youth at Risk for School Failure
5. Children and Youth at Risk of/or Experiencing Juvenile Justice Involvement
6. Underserved Cultural Populations
7. Children and Youth at risk for substance use disorders

Additionally, due to the geographic vastness of the county, MHSA Programming also targets those unserved and underserved groups including:

1) Those community members in geographically isolated areas (such as Carpinteria, New Cuyama, Guadalupe, Santa Ynez), and
2) Those experiencing homelessness, because the new Ten-Year County Homeless Plan prepared for the No Place Like Home Initiative indicates increases in this population county-wide, and a large contingent of these individuals have underlying behavioral health and/or substance use concerns.

Additionally, Santa Barbara County completes the Network Adequacy Certification Tool (NACT) quarterly, but is changing to annually, as directed by Information Notice 18-011 and Information Notice 20-012. The NACT is used to determine if the County has enough outpatient Specialty Mental Health Services (SMHS) providers to serve the anticipated need of the County. This information is provided to the Department of Health Care Services (DHCS) and their feedback is provided and monitored if certain ratios aren't achieved.

The County has been given the followings ratios of provider to clients in four categories:

- Adult (21+) SMHS 1 provider to 85 clients,
- Adult (21+) Psychiatry 1 provider to 524 clients and Children (0-20),
- Children (0-20) SMHS 1 provider to 43 clients, and
- Psychiatry 1 provider to 323 clients.

Santa Barbara County has collected data from both our Behavioral Wellness Programs, as well as our Contracted Providers, to determine our anticipated needs, including our current staffing needs. The NACTs submitted for January 2020 and April 2020 show that Santa Barbara has successfully met the ratios provided by DHCS and has an adequate network of outpatient SMHS providers to meet the anticipated need for

services in our county. Overall, the County strives to ensure a complete network of care for all outpatient services, which are primarily funded in MHSA. This plan will outline each program and those targeted age group populations to ensure our network remains adequate and there is a focus toward the unserved and underserved in our Community.

# Program Updates

## Community Services and Supports and General System Development

Community Services & Support (CSS) is the largest component of the MHSA. CSS continues the commitment focused on community collaboration; cultural competence; client and family driven services and systems; wellness focus, which includes concepts of recovery and resilience; integrated service experiences for clients and families; and serving the un-served and underserved populations. CSS funds programming pertaining to General System Development (GSD), Full Service Partnerships (FSP), and Supported Community Services FSPs.

General Systems Development (GSD) focuses on the mental health service delivery system. GSD is used for: treatment, including alternative and culturally specific; peer support; supportive services to assist with employment, housing, and/or education; wellness centers; case management to access needed medical, educational, social, vocational rehabilitative or other services; needs assessment; individual Services and Supports Plans; crisis intervention/stabilization; family education; improving the service delivery system; and reducing ethnic/racial disparities.

MHSA funds the following General System development Programs: Crisis Services, New Heights, Partners in Hope, Homeless Outreach Services, Co-Occurring Mental and Substance Use Outpatient Teams, Children's' Wellness, Recovery and Resiliency (WRR) Teams, Adult Wellness and Recovery Outpatient (WR) Teams, Pathways to Well Being (HOPE), Crisis Residential Services North and South, Medical Integration Program, Adult Housing Support Services, and more.

## Crisis Services

| **Provider:** | **Behavioral Wellness** |
|---|---|
| **Estimated Funding FY 2021/22:** | |
| Estimated Total Mental Health Expenditures | $5,859,000 |
| Estimated CSS Funding | $ 155,800 |
| Estimated Medi-Cal FFP | $3,103,400 |
| Estimated 1991 Realignment | |
| Estimated Behavioral Health Subaccount | |
| Estimated Other Funding | $2,599,800 |
| Average Cost Per Consumer | $2,482 |
| Estimated Total of Consumers Served | 2,360 |
| Target Population Demographics Served | Children, TAY, Adults, Older Adults |

The Crisis Services program is operated by Behavioral Wellness; the staff in each county region perform the following functions:

1. Respond to all Access urgent calls. Crisis Services staff can respond in the field to urgent calls coming into the Access line, or the callers can be directed to come into the Crisis Services offices for services in the three regions.
2. Respond to law enforcement requests for outreach. Crisis Services staff build strong relationships with law enforcement and assist them in outreach to individuals in the community who appear to be struggling with severe mental health issues and are frequently calling 911 or being contacted by law enforcement in the field.
3. Respond to requests for services when an individual is evaluated for a 5150 but a hold is not written. Crisis Services staff work closely with the client to provide urgent follow-up services for these individuals with severe mental health issues who are not meeting criteria for a hold.
4. Assist current outpatient program clients when they are rapidly decompensating and are at risk of hospitalization. Crisis Services staff step in to provide very brief, intensive treatment, medication support and case management for core outpatient clinic clients when needed to prevent hospitalization.
5. Act as an access point for walk-in clients new to Behavioral Wellness or returning clients who are not currently open and can have more difficulty with engagement into services. Crisis Services staff are available to provide an initial assessment to determine if clients meet medical necessity for SPMI services and determine appropriate level of care in the system. The Crisis services staff outreach the clients and the Clients needing intensive stabilization will be served by Crisis Services staff for a short period of time (up to 30 days) before being transferred to an appropriate level of care.
6. Provide hospital discharge services to individuals being discharged from the Psychiatric Health Facility (PHF), Crisis Stabilization Unit (CSU), Telecare & Crestwood Behavioral Health CRT (Crisis Residential Facility), or out-of-county LPS facilities, to individuals who are new to Behavioral Wellness or to returning clients who are not currently linked to services.

Crisis Services staff are available to provide hospital discharge appointments and conduct initial assessments to determine if clients meet medical necessity for Severe and Persistent Mental Illness (SPMI) services and determine the appropriate level of care in the system. Also, Santa Barbara Crisis Services staff work closely with the CSU in the newly developed “crisis hub” in South County. The new Crisis Services location on the main Behavioral Wellness campus, next to the CSU and below the PHF, allows a closer working relationship between the different programs. A law enforcement “drop-off” location for individuals experiencing a mental health crisis is in the initial stages of development. Individuals are able to receive immediate evaluation to determine their need for in-patient hospitalization, stabilization in the CSU, or more rapid stabilization and return to the community with ongoing services and linkages to treatment by the Crisis Services Team members.

**Program Challenges and Solutions**

Primary challenges for crisis teams continue to be limited availability of LPS beds in-county and no adolescent LPS beds in county. Also, out of county LPS facilities are frequently full or for other reasons unable to accept BWELL referrals. In addition, with the onset of the COVID Pandemic, placement of individuals at LPS facilities became even more difficult due to a number of factors. LPS facilities had to intermittently close due to outbreaks in their facilities, and patients on LPS holds waiting placement in an LPS facility who tested positive for COVID were not able to be placed and had to sit out their holds in hospital emergency departments.

Our own PHF and Crisis Teams struggled with staffing issues throughout the year due to staff needing to quarantine because of testing positive or being exposed, or childcare issues related to school closings. In order to keep the Crisis Stabilization Unit (CSU) open even when floating the majority of their staff to the PHF, the department quickly trained all available outpatient nursing staff and Peer Recovery Assistants to work at the CSU. As CSU staff were pulled to the PHF to cover vacancies there, outpatient staff were pulled from their duties in the clinics and assigned to the CSU so CSU could remain open.

In addition, the COVID Pandemic caused intermittent closure of temporary shelters due to COVID outbreaks or staffing issues. With less shelter beds available, more individuals began experiencing mental health crises that couldn't be managed without a place to stay. Having less shelter bed options also made safety planning more difficult for individuals who were being evaluated for 5150 criteria.

Several measures were implemented to expand the crisis continuum in the county. The county received a Proposition 47 grant which among other things funded a sobering center and a Co-Response team. The sobering center, now called the CREDO 47 Center, was initially set up as a jail diversion program for individuals in the community who would otherwise have gone to jail for intoxication or being under the influence. With the Pandemic and less individuals out drinking, and the need to keep jail populations down, the CREDO 47 center pivoted to being a jail discharge center for individuals in need of substance use treatment. The Prop 47 grant also funded a Co-Response Team (Sheriff Deputy paired with a mental health clinician who respond to crisis calls in the community). Previously, we had been piloting a Co-Response team with no funding, so the grant assisted us in sustaining the program. In addition, the Sheriff's Department also secured a Byrne Jag grant which is currently funding two additional Co-Response teams. Both the Santa Barbara Police (SBPD) and Santa Maria Police Departments (SMPD) also became interested in the Co-Response model. The Department formed a partnership with SBPD and currently has a full-time team going with them. Behavioral Wellness is in the process of completing a Memorandum of Understanding (MOU) with the SMPD and hope to have a team going with them in the next few months. The Lompoc Police Department has also expressed interest in partnering with the department to create a Co-Response team. This potential partnership is currently in the discussion phase.

**Program Performance (FY 19-20)**

**Crisis Services**

| **Unique Clients Served** | | | | | |
|---|---|---|---|---|---|
| | **Adult Crisis Services*** | | | **Youth Crisis Services (SAFTY)^** | |
| | **North** | **South** | **West** | **North** | **South** |
| **Age Group** | | | | | |
| 0-15 | 28 | 27 | 14 | 356 | 184 |
| 16-25 | 127 | 241 | 125 | 242 | 122 |
| 26-59 | 463 | 618 | 394 | 0 | 0 |
| 60+ | 105 | 142 | 73 | 0 | 0 |
| Missing DOB | 2 | 0 | 1 | 0 | 0 |
| ***Total*** | **725** | **1,028** | **607** | **598** | **306** |
| | | | | | |
| **Gender** | | | | | |
| Female | 335 | 446 | 294 | 336 | 170 |
| Male | 382 | 582 | 313 | 261 | 134 |

| Missing/Other | 8 | 0 | 0 | 1 | 2 |
|---|---|---|---|---|---|
| | | | | | |
| **Ethnicity** | | | | | |
| American Indian or Alaska Native | 11 | 17 | 13 | 6 | 1 |
| Asian | 18 | 26 | 14 | 5 | 6 |
| Black or African American | 26 | 41 | 27 | 25 | 5 |
| Mixed Race | 23 | 183 | 18 | 4 | 13 |
| Native Hawaiian or Pacific Islander | 1 | 3 | 0 | 1 | 0 |
| White | 531 | 681 | 517 | 415 | 192 |
| Other/Not Reported | 115 | 77 | 18 | 142 | 89 |
| | | | | | |
| **Hispanic or Latino** | | | | | |
| Hispanic or Latino | 289 | 247 | 200 | 270 | 123 |
| Not Hispanic or Latino | 313 | 660 | 382 | 109 | 59 |
| Not Reported | 123 | 121 | 25 | 219 | 124 |

**Mobile Crisis and Crisis Triage still provided separately in Lompoc have been combined under West County Crisis Services for easier comparison and counting of unique clients.*
*^SAFTY is funded and described in detail in PEI programs but is included here to display all outpatient crisis services together.*

**Client Outcomes (Adult Crisis Services*)**

| **Higher Levels of Care** | **% during program admission in FY 19-20** | | |
|---|---|---|---|
| | **North** | **South** | **West** |
| **Incarcerations** | 3% | 9% | 2% |
| **Psychiatric Inpatient Care** | 14% | 13% | 13% |

**Note. Youth outcomes (SAFTY) described under PEI section.*

A goal of the crisis service program is to stabilize clients in the community with safety planning and other supportive services in order to avoid admitting clients to a psychiatric hospital. The table above shows the demographics of the unique clients who encountered crisis services.

The client outcomes table displays the percent of unique clients who experienced a higher level of care during their admission to the program (adult crisis services) in the 19-20 fiscal year. Youth outcomes for the SAFTY program are described in the PEI section. The source of incarceration data is the Santa Barbara Jail and therefore only includes adults; clients were matched from the county electronic health record to the FY 19/20 jail roster. The source of psychiatric inpatient data is the electronic health record. Three percent of clients in North County, 9% of clients in South County, and 2% of clients in West County experienced a jail stay during their admission. Fourteen percent of clients in North County, 13% of clients in South County, and 13% of clients in West County experienced hospitalization during their program admission. Clients' admissions to crisis services may not be closed out immediately after the crisis team intervention, so if a client is subsequently hospitalized following the encounter with crisis services, then the hospitalization is counted as within the admission.

## Partners in Hope

| Provider: | Mental Wellness Center, Transitions Mental Health Association and Behavioral Wellness |
|---|---|
| **Estimated Funding FY 2021/22:** | |
| Estimated Total Mental Health Expenditures | $839,500 |
| Estimated CSS Funding | $803,200 |
| Estimated Medi-Cal FFP | $ 36,300 |
| Estimated 1991 Realignment | |
| Estimated Behavioral Health Subaccount | |
| Estimated Other Funding | |
| Average Cost Per Consumer/Families | $270 |
| Estimated Total of Consumers/Families Served | 3,100 |
| Target Population Demographics Served | Children, TAY, Adults, Older Adults |

**Peer Support Services at the Recovery Learning Centers**

Santa Barbara Behavioral Wellness Recovery Learning Centers provide Peer Support Service Programs that are peer-run and provide support services to consumers and family members. The program supports Peer Recovery Specialists and Recovery Learning Communities (RLCs) in the South, West and North County. The goal of the peer staff and 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. A highlight in Santa Maria for consumers is the opportunity to participate in the "Growing Grounds Farms" coordinated by Transitions Mental Health Association that is a linkage from the RLC in West and North County.

Recovery Learning Center staff primarily serve 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 underserved ethnic population in Santa Barbara County.

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

**Santa Barbara Services: Mental Wellness Center**

In Santa Barbara, the Mental Wellness Center, a community-based nonprofit organization, works with consumers to improve their mental wellbeing. By utilizing their peer staff, Mental Wellness Center provides basic needs, family support and advocacy, mental health education to consumers, families and community on self-care practices.

Staffing at the Mental Wellness Center's Recovery Learning Center (RLC) consists of all peer providers that reflect the ethnic distribution of the RLC membership. This includes the program staff, a kitchen crew that provides 80-100 lunches daily, and computer laboratory and art room facilitators. Over the last 15 months during the COVID pandemic restrictions, the RLC adapted and continued services by utilizing our 5000 square

foot outdoor patio to offer daily support, updated community resource information and a "lunch to go" program. Computer and phone stations are set up outdoors for client use and Partner community agencies were invited to access the outdoor patio space in a safe, socially distanced manner to offer resources to clients who came by the RLC for food and resources. Doctors Without Walls, free LifeLine cellular phone programs, and homeless outreach teams have utilized this space and coordination of service. The RLC staff are collaborating in a local Vaccination Equity Project to provide information and access to increase vaccinations to our clients. Vaccination Clinics are being offered at the RLC.

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.

Besides creating greater employment access both through in-house peer staff positions and through supported training opportunities, the Santa Barbara RLC also 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 several group activities per week. During the last 15-month COVID pandemic restrictions, all support groups and education program activities were adapted to Zoom. Participation and utilization of services increased and new groups were formed to address the needs, including new monolingual Spanish support groups for parents of teens who live with a mental health diagnosis.

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.

The Family Advocate is a pivotal position at 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 a month 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. Furthermore, the NAMI Family to Family course is taught two to three times a year. Monthly speaker presentations are hosted at the facility, and several other presentations are offered throughout the year on various topics of interest. All weekly support groups and monthly education meetings have been adapted to Zoom and have grown in the utilization of participants.

**Lompoc and Santa Maria Services: Transition Mental Health Association (TMHA)**

Transitions Mental Health Association (TMHA) is a non-profit organization serving San Luis Obispo and North Santa Barbara Counties. The agency is committed to eliminating stigma, promoting recovery and wellness for people who live with mental illness, and fighting against all forms of discrimination. TMHA operates over 40 programs with a wide variety of services to assist individuals and family members in their recovery journey.

These services include housing, family support, work, community, and clinical services. In addition, TMHA hosts events and educational events throughout the year such as Journey of Hope and the Alliance for Mental Wellness Mental Health Forums.

The Santa Maria Recovery Learning Community and Helping Hands Recovery Learning Community in Lompoc are 100% client-designed and client-led recovery centers. All leadership, operational decisions, program design, and advocacy efforts are made by the membership, all of whom are individuals with lived experience in mental health. The Recovery Learning Communities (RLCs) provide a safe, welcoming, and supportive meeting place where people with mental illness engage in educational, vocational and recreational activities, support groups, meaningful interactions and, above all, the support of their peers. The program promotes independence and revitalization through self-governed activities as members work toward recovery. The RLCs also provide dedicated outreach to the local LatinX community through bilingual Mental Health Advocates. In FY 2020-21, the two RLCS provided services to 366 unduplicated individuals YTD.

TMHA hired its first Family Advocate to work with family members in North Santa Barbara County in 1997, and that program expanded into Partners in Hope in 2007. Our Family Support Specialists work directly with families and also lead regular family support groups. In FY 2020-21, Partners in Hope served 709 unduplicated family members YTD, and we are prepared to facilitate even greater collaboration between this program and our two RLCs. TMHA's Family Support Specialists are bilingual, bicultural and have longstanding ties and involvement in their respective communities.

During the 2020-2021 fiscal year, the COVID-19 pandemic caused a surge in demand for mental health services, largely because of the effects of lockdown. Transitions-Mental Health Association transitioned many clinical services, case management, mental health support groups, family support groups and classes to a virtual, telehealth delivery, while continuing to provide in-person services when essential. Food and meal programs at our Recovery Learning Communities were expanded, and deliveries for members made available. The staff completed COVID trainings throughout the year and maintained safety with social distancing, remote services, face masks, temperature checks and routine COVID testing.

The need and use for technology skyrocketed and TMHA diligently worked to secure grants to equip every staff member with critical technology including laptops, smartphones, webcams, encrypted hard drives, blue tooth printers, etc. Grants also allowed the agency to acquire technology for clients and members who often live below poverty level and do not have the means to acquire such items. TMHA provided iPads to loan out to clients, members and families to keep them connected with services and staff during one of the most tumultuous times our community has experienced.

**Program Challenges and Solutions**

One of the upcoming challenges the Recovery Learning Communities will face is adequate space for services. The RLC is pleased to add additional staffing to the team for expanded programing. In addition, Family Services (also known as Partners in Hope) will be joining the RLC program, requiring additional space for support groups, educational events, trainings and classes. The program would also like to revisit adding a psychiatric component to the services offered as was piloted with the Lompoc RLC. This will require additional space as well. In FY 2020-21 a request for proposal was issued and the two current vendors were awarded these programs and new contracts established as of July 2021 for three years including additional technology support with the Help@Hand Innovations project to help enhance consumer's literacy and digital awareness.

**Program Performance (FY 19-20)**

**Partners in Hope**

| | Activities | | | | | |
|---|---|---|---|---|---|---|
| | North | | South | | West | |
| | RLC | Family Advocate | RLC | Family Advocate | RLC | Family Advocate |
| Unduplicated clients | 716 | 406 | 499 | 362 | 994 | 123 |
| Client visits | 2,273 | * | 18,933 | 1,241 | 6,269 | * |
| Outreach Events | * | 39^ | * | * | * | 39^ |
| Outreach Event Attendees | * | 4,698^ | * | * | * | 4,698^ |
| Support Groups | * | 78 | 23 | 33 | * | 40 |
| Support Group Meetings | * | * | 260 | 242 | * | * |
| Classes | 37 | 8^ | 12 | * | * | 8^ |
| Outings, Educational Events | * | 8^ | 2 | 12 | * | 8^ |
| Trainings about consumer and family member issues | * | * | * | * | * | * |
| Unique clients provided services in Spanish | * | 123 | * | 14 | * | 19 |
| Underserved population | 716 | 406 | 499 | 362 | 994 | 123 |
| Linked to additional services | * | 155 | 316 | 141 | * | 28 |

^ = Data shared by RLC combined North and West County activities so this number reflects both sites.
* = not reported, not applicable, or not recorded.

In North County, the RLC served 716 clients from underserved populations who had over 2,000 visits. They provided 37 classes. The Family Advocate in North County served over 400 unique clients from underserved populations, led  support groups, and linked 155 clients to additional services. Between North and West County, the family advocates attended 39 outreach events that reached almost 4,700 attendees, attended 8 outings/educational events and led 8 classes. Over one-third of the clients the Family Advocate served were provided services in Spanish.

In South County, the RLC served 500 clients from underserved populations who had almost 19,000 visits. They conducted 260 support group meetings and held 12 classes and 2 outings/events. Over three hundred linkages were made to additional services. The Family Advocate in South County served 362 unique clients from underserved populations, provided over 1,200 client visits, led over 200 support groups, attended 12 outings/events, and linked 141 clients to additional services. Fourteen clients were provided services in Spanish.

In West County, the RLC served nearly 1,000 clients from underserved populations who had over 6,000 visits. The Family Advocate served 123 unique clients from underserved populations, led 40 support groups, and

linked 28 clients to additional services. Between North and West County, the family advocates attended 39 outreach events that reached almost 4,700 attendees, attended 8 outings/educational events and led 8 classes. The family advocate provided 19 clients services in Spanish.

## Homeless Outreach Services

| **Provider:** | **Behavioral Wellness, Good Samaritan, PATH, Housing Authorities of the City and County, Salvation Army** |
|---|---|
| **Estimated Funding FY 2021/22:** | |
| Estimated Total Mental Health Expenditures | $5,207,300 |
| Estimated CSS Funding | $ 90,400 |
| Estimated Medi-Cal FFP | $ 537,900 |
| Estimated 1991 Realignment | |
| Estimated Behavioral Health Subaccount | |
| Estimated Other Funding | $4,579,000 |
| Average Cost Per Consumer | $15,270 (costs include grants and specialized projects) |
| Estimated Total of Consumers Served | 341 |
| Target Population Demographics Served | TAY, Adults, Older Adults |

The Department of Behavioral Wellness Homeless Services program provides outreach and engagement to those experiencing homelessness, or at imminent risk of homelessness, and also experiencing serious, persistent mental illness and/or chronic substance abuse in Santa Barbara County. The needs of chronically homeless individuals, who are hard to engage, are usually complex and require greater time invested to promote stability and engagement in services. Outreach services are delivered to the community at-large, special population groups, human service agencies, and to unserved/underserved homeless individuals. These services aim to enhance the mental health of the general population, prevent the onset of mental health problems in individuals and communities, and assist those persons experiencing distress, who are not reached by traditional mental health treatment services, to obtain a more adaptive level of functioning.

Successful outreach often involves a high degree of inter-agency collaboration and multi-disciplinary team outreach. Behavioral Wellness Homeless Services coordinates their operations through case management conferences, referrals for service, and coordinated multi-agency team outreach. Homeless Services collaborates with various different community-based organizations and public service agencies to ensure that the needs of our homeless beneficiaries are being met. This requires having an in-depth understanding of the unserved/underserved population's service needs by utilizing engagement strategies, which are specifically tailored towards this unique sub-population, and working strategically with other Behavioral Wellness outpatient treatment teams and community-based organizations to ensure linkage to long-term care and mainstream resources.

Meeting the needs of people experiencing both homelessness and behavioral health challenges is an important priority for Santa Barbara County Department of Behavioral Wellness. Outreach teams have adopted strategies that meet the specific needs of homeless populations in each region of the county (North, West, and South). Historically, Homeless Outreach Services have been centralized in South Santa Barbara County and there were no stand-alone Behavioral Wellness Homeless Outreach Services in Lompoc or Santa Maria. In FY 20200-21, Behavioral Wellness augmented this initiative by securing additional funding to expand Homeless Outreach Services into the North, West and South regions of the County. This was accomplished through the utilization of one-time Homeless Emergency Assistance Program (HEAP) funds. The funding

allowed for the hiring of a practitioner and two extra help caseworkers, one who is located in Santa Barbara and one who has the flexibility to work between the cities of Lompoc and Santa Maria. The additional staff have allowed for expanded outreach to individuals experiencing homelessness in Lompoc, Santa Barbara and Santa Maria. The program remains fully staffed in FY 2021-22 with additional State Housing Supportive Services grants. Homeless Services staff countywide receive ongoing training in trauma-informed care, motivational interviewing, harm reduction, client engagement, strategies for connecting clients to mainstream resources, and interventions which aim to facilitate housing stability and retention. The expansion of these services has successfully 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.

Critical to the Homeless Services ability to successfully outreach and engage some of our community's most vulnerable, is the teams' ability to readily access available, low-threshold shelter beds in various regions of the county. The Department of Behavioral Wellness provides for approximately 37 shelter beds throughout the county. There are 22 contracted mental health beds at the PATH shelter; Homeless Services works closely with PATH program staff to support residents with engagement in the Coordinated Entry System, while helping residents to become "document-ready" for housing. Clients are also provided with frequent on-site supportive services to support their continued engagement in behavioral health services and connection to mainstream resources. Homeless Services uses a similar model to provide 5 mental health beds at a Salvation Army shelter. The HEAP monies also allowed for additional contracted shelter beds to be acquired at both the Good Samaritan Shelter in Santa Maria and Bridge House Shelter in Lompoc.

The Department of Behavioral Wellness received two customized vans in May 2021, which will be used for homeless outreach and service delivery. The Department's ability to acquire these vehicles was made possible by Homeless Mentally Ill Outreach and Treatment grant funding and a cash donation that was awarded to the Department on behalf of the Gordon Family Trust. The vehicles have been retrofitted with technology and will have the ability to accommodate a multi-disciplinary team comprised of medical personnel, legal staff and mental health providers to allow for the treatment of clients in the field. The mobile vehicle will contain a commemoration plaque to the Gordon Trust in recognition of this generous donation.

*The vehicles have been retrofitted with technology and will have the ability to accommodate a multi-disciplinary team comprised of medical personnel and mental health providers to allow for the treatment of clients in the field. The mobile vehicle will contain a commemoration plaque to the Gordon Trust in recognition of this generous donation.*

Homeless Services continues to strive towards maintaining a high degree of collaboration with other Santa Barbara County Continuum of Care (CoC) providers and hosts a weekly South County Coordinated Outreach Team meeting, providing Homeless Services and housing providers with an opportunity to discuss sub-regional outreach coverage, engagement strategies, outreach collaboration, service coordination and housing retention. This outreach collaborative has been successfully replicated in other sub-regions of the County, including Lompoc and Santa Maria. Additionally, Behavioral Wellness has established bi-monthly meetings with the Santa Barbara City Housing Authority and has strengthened communication and ongoing collaboration with the Housing Authority of the County of Santa Barbara – in order to review current post-placement housing retention services. The

goals of these collaborative meetings are to keep consumers housed and prevent unnecessary returns to homelessness. Ensuring ongoing connections to housing resources and housing retention support is also achieved by attending weekly Coordinated Entry System Case Conferencing meetings. The Coordinated Entry System represents a Continuum of Care-wide process for facilitating access to all homeless-designated resources, identifying and assessing the needs of persons experiencing a housing crisis, and referring clients to the most appropriate service strategy or housing intervention.

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 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.

**Program Challenges and Solutions**

As the Coordinated Entry System increasingly identifies and prioritizes the most vulnerable individuals for homeless housing, all HUD-funded programs will be more likely to encounter serving people with moderate to severe mental health conditions and substance use disorders. To safely be able to manage and accommodate the needs of this population, intensive wraparound/housing retention services continue to be needed to provide housing stability, retention, and prevent returns to homelessness. While Homeless Services have historically worked with those who are literally homeless and/or at risk of homelessness, the program has been called upon to support newly housed persons with moderate to severe mental health conditions. Because of the collaborative relationships the team has formed with local City and County Housing providers, Homeless Services has been able to intervene quickly and facilitate linkage to the necessary services (mental health services and/or mainstream resources) to ensure long-term housing stability. The Department of Behavioral Wellness also sees the needs for additional intensive wrap-around services to serve recently-housed clients, especially during their first 9 months after entering permanent housing, to promote a stable transition and to connect clients with mainstream supports. In order to achieve housing retention goals, the Department will be working with County's Community Services Department to issue a request for proposal for a specialized team to support over 200 new housing vouchers for County residents, including leveraging mental health services.

Santa Barbara County continues to have a large gap between its supply of affordable housing and the demand for affordable housing. To increase residents' access to safe, affordable housing, the County will use No Place Like Home (NPLH) funding to build and rehabilitate affordable housing units. The Department of Behavioral Wellness has been working closely with the Housing Authority of the County of Santa Barbara to link children/family, transitional age youth (TAY), and adults/older adults who are homeless, or at risk of homelessness, and have a serious mental health condition to the Residences at Depot Street in Santa Maria. To ensure that MHSA eligible tenants have access to ongoing mental health support, Homeless Services will be providing 20 hours per week of onsite support. The clinician assigned to this location will have expertise in interventions aimed at promoting housing stability and will act as a liaison to the larger mental health system of care. The Residences at Depot Street has experienced challenges during COVID 19 including lack of a sense of community with other residents due to social distancing and no access to the community room to celebrate holidays and other activities. A few residents exhibited behaviors that indicate that they were not ready for independent living and require a great deal of support to maintain their apartment. Project Homekey Studios a permanent supportive housing program in Lompoc was completed in December 2020. A caseworker employed by Good Samaritan Shelters is assigned to work 20 hours onsite in supporting the residents in maintaining their

housing.  Project Homekey studios is in walking distance for residents to access their treatment providers at Santa Barbara County Department of Behavioral Wellness in the city of Lompoc. Heath House, a permanent supportive housing program for women opened in February 2021 ,the house will be managed by the City of Santa Barbara Housing Authority. Heath House is located in downtown Santa Barbara and will provide easy access to shopping and access to other needed community resources to help residents maintain their housing. The West Cox Cottages is the next No Place Like Home Project being developed in Santa Maria. The permanent supportive housing project is scheduled to begin leasing to individuals experiencing homelessness with a serious mental illness in late 2021. The Department will be providing twenty hours a week onsite supportive services to assist tenants in the transition to independent living.

Long term progress for this program will be an increase in linkages to affordable housing, an increase in sustained housing, and an increase in homeless persons with serious or persistent mental illness being served by mental health providers. The Department is collaborating with various county partners and anticipates utilizing additional State homeless grant funds in this effort in the upcoming years.

## Program Performance (FY 19-20)

### Homeless Services

| | Unique Clients Served | | |
|---|---|---|---|
| | **North** | **South** | **West** |
| **Age Group** | | | |
| 0-15 | 0 | 0 | 0 |
| 16-25 | 16 | 8 | 6 |
| 26-59 | 89 | 98 | 66 |
| 60+ | 11 | 44 | 3 |
| Missing DOB | 0 | 0 | 0 |
| ***Total*** | **116** | **150** | **75** |
| | | | |
| **Gender** | | | |
| Female | 80 | 48 | 50 |
| Male | 36 | 102 | 25 |
| Unknown | 0 | 0 | 0 |
| | | | |
| **Ethnicity** | | | |
| American Indian or Alaska Native | 4 | 7 | 0 |
| Asian | 1 | 4 | 0 |
| Black or African American | 4 | 13 | 2 |
| Mixed Race | 3 | 27 | 1 |
| Native Hawaiian or Pacific Islander | 0 | 0 | 0 |
| White | 98 | 97 | 67 |
| Other/Not Reported | 6 | 2 | 5 |
| | | | |
| **Hispanic or Latino** | | | |
| Hispanic or Latino | 57 | 33 | 32 |
| Not Hispanic or Latino | 55 | 115 | 41 |
| Not Reported | 4 | 2 | 2 |

*Note*. Source for this data is Clinician's Gateway, which only captures contacts with individuals who met medical necessity and agreed to be open to mental health services.

**Homeless Services All Contacts**

| **Unique Clients Served** | | | | |
|---|---|---|---|---|
| | **North Street Outreach** | **South Street Outreach** | **South Supportive Services** | **West Street Outreach** |
| | | | | |
| 0-17 | 0 | 0 | 0 | 0 |
| 18-23 | 3 | 3 | 3 | 2 |
| 24-30 | 5 | 6 | 1 | 4 |
| 31-40 | 22 | 11 | 8 | 6 |
| 41-50 | 19 | 15 | 14 | 11 |
| 51-61 | 13 | 25 | 7 | 9 |
| 62+ | 3 | 12 | 4 | 2 |
| Missing DOB | 0 | 0 | 0 | 0 |
| ***Total contacted by PATH*** | **98** | **114** | **69** | **53** |
| ***Total open to PATH*** | **65** | **72** | **37** | **34** |
| ***Total new enrollments in PATH*** | **59** | **55** | **25** | **32** |
| ***Total entered mental health services*** | **0** | **27** | **24** | **0** |
| | | | | |
| **Gender** | | | | |
| Female | 36 | 21 | 15 | 21 |
| Male | 27 | 50 | 22 | 13 |
| Transgender male to female | 1 | 0 | 0 | 0 |
| Transgender female to male | 0 | 0 | 0 | 0 |
| Gender Non-Confirming | 1 | 1 | 0 | 0 |
| Not collected | 0 | 1 | 0 | 0 |
| ***Total*** | **65** | **72** | **37** | **34** |
| | | | | |
| **Ethnicity (Multiracial individuals counted in all categories)** | | | | |
| White | 50 | 59 | 32 | 27 |
| Black or African American | 6 | 4 | 4 | 5 |
| Asian | 2 | 1 | 0 | 1 |
| Native Hawaiian or Other Pacific Islander | 0 | 2 | 1 | 0 |
| American Indian or Alaska Native | 13 | 10 | 5 | 2 |
| Other/Not Reported | 1 | 1 | 0 | 0 |
| ***Total*** | **72** | **77** | **42** | **35** |
| | | | | |
| **Ethnicity** | | | | |
| Hispanic/Latino | 22 | 13 | 7 | 6 |
| Non-Hispanic/Latino | 41 | 59 | 29 | 28 |
| Not collected | 2 | 0 | 1 | 0 |
| ***Total*** | **65** | **72** | **37** | **34** |
| | | | | |
| **Veteran** | | | | |
| Yes | 2 | 5 | 3 | 1 |
| No | 63 | 67 | 34 | 33 |
| ***Total*** | **65** | **72** | **37** | **34** |

| Co-Occurring Disorder | | | | |
|---|---|---|---|---|
| Co-occurring substance use disorder | 36 | 34 | 24 | 18 |
| No co-occurring substance use disorder | 29 | 37 | 13 | 16 |
| Unknown | 0 | 1 | 0 | 0 |
| ***Total*** | 65 | **72** | **37** | 34 |

*Note*. Source for this data is Homeless Management Information System (HMIS), which captures all contacts regardless of medical necessity or program engagement.

**Client Outcomes**

| **Milestones of Recovery Scale (MORS) Age: 18+** | | | |
|---|---|---|---|
| | | **Initial to 6 months (n = 181)** | **6 to 12 months (n = 138)** |
| **Showed improvement^** | | 41% | 27% |
| **Remained stable^** | | 35% | 45% |
| **Living Situation (combined across four locations)** | | **Entry (n = 208)** | **Exit* (n = 163)** |
| Place not meant for habitation | | 112 | 93 |
| Emergency Shelter | | 55 | 27 |
| Transitional Housing for Homeless | | 0 | 5 |
| Institution (e.g. Jail, hospital, psych facility, AOD treatment) | | 26 | 8 |
| Transitional (with family/friends) | | 10 | 8 |
| Permanent | | 2 | 16 |
| Other | | 0 | 3 |
| Unknown | | 3 | 3 |
| **Higher Levels of Care** | **% during program admission in FY 19-20** | | |
| | **North** | **South** | **West** |
| **Incarcerations** | 1% | 15% | 3% |
| **Crisis Services** | 5% | 13% | 11% |
| **Psychiatric Inpatient Care** | 0% | 3% | 1% |

^*Note.* "Showed Improvement" and "Remained Stable" reflects the percent of clients whose MORS scores improved or stayed the same between time periods.
**Note.* Forty-five clients were still active at the end of the fiscal year so their living situation at exit is missing.

Because the Homeless Services provides outreach services, they have many contacts with clients that are not captured in Clinician's Gateway, the health record system. In FY 2019-20, North and West County Homeless Services expanded to offer street outreach in addition to the previously provided mental health services. Therefore, the "all contacts" table, taken from the Homeless Management Information System (HMIS) is expanded from last year to include the new PATH programs. Outreach programs provide services to individuals experiencing homelessness living in a situation not meant for human habitation. Homeless Supportive Services provides support to clients experiencing homelessness who are living in transitional living situations and need support in accessing community resources and learning skills to help them gain and maintain housing.

In looking at the Homeless Services data, there are three tiers of participation:

(1) A contact with the program that results in entry into HMIS (n = 334 clients contacted in FY 19-20; n = 208 new clients opened in FY 19-20);
(2) A contact with the program that results in entry into HMIS, and consent to enroll in PATH (n = 171 clients enrolled in FY 19-20); and
(3) A contact with the program that results in enrollment in mental health services through Behavioral Wellness (n = 341); services recorded through EHR (Sharecare/Clinician's Gateway).

In the FY 2019-20, clients in Homeless Outreach Services had initial, 6-month and 12-month MORS data. In the first six months of engagement, 41% clients improved, and in the second six months, more than a quarter improved. Over the first twelve months, about three quarters of clients either stabilized or improved. Examining housing status at Program entry and exit, it is important to note that some clients included in this count had only one contact with Behavioral Wellness and were not seen again. Three hundred thirty-four individuals seen had at least one contact with the program, while 208 of these individuals enrolled in PATH. While many of the total number of clients remained homeless at program exit, 16 clients attained permanent housing.

The client outcomes table displays the percent of unique clients who experienced a higher level of care during their admission to Homeless Services in the 19-20 fiscal year. The source of incarceration data is the Santa Barbara Jail and therefore only includes adults; clients were matched from the county electronic health record to the FY 2019-20 jail roster. The source of psychiatric inpatient and crisis services data is the electronic health record. One percent of clients in North County, 15% of clients in South County, and 3% of clients in West County experienced a jail stay during their admission. Five percent of clients in North County, 13% of clients in South County, and 11% of clients in West County had crisis services contact during their program admission. Zero percent of clients in North County, 3% of clients in South County, and 1% of clients in West County experienced hospitalization during their program admission.

## Co-Occurring Mental and Substance Use Outpatient Teams

| **Provider:** | **Behavioral Wellness** |
|---|---|
| **Estimated Funding FY 2021/22:** | |
| Estimated Total Mental Health Expenditures | $2,720,000 |
| Estimated CSS Funding | $ 886,500 |
| Estimated Medi-Cal FFP | $1,833,500 |
| Estimated 1991 Realignment | |
| Estimated Behavioral Health Subaccount | |
| Estimated Other Funding | |
| Average Cost Per Consumer | $7,838 |
| Estimated Total of Consumers Served | 347 |
| Target Population Demographics Served | TAY, Adults, Older Adults |

The Co-Occurring Outpatient Teams offer consumer-driven services and customize services based on individual needs. Specialized outpatient Co-Occurring Teams are based in North, West and South County, and designed for adults 18 and older. Consumers diagnosed with a severe mental illness and a co-occurring substance use disorder (SUD) 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 continue to receive ongoing trainings 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 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.

The Department of Behavioral Wellness continues to offer telephone, telehealth, and in-person appointments to assist clients in successfully meeting treatment plan goals. Certain clinic locations have a designated room setup with audio and video for those without access to technology. Groups meet outside while socially distanced (adhering to CDC guidelines) and via Zoom since the beginning of the COVID 19 pandemic.

**Program Challenges and Solutions**

There has been a lack of a comprehensive system of care for people in recovery in the community that results in consumers being displaced into jails, hospitals, Emergency Rooms, the inpatient Psychiatric Health Facility, and other types of inpatient facilities. 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 had been primarily for women, and there was not enough resources for men. With the launch of the Drug Medi-Cal Organized Delivery System (DMC-ODS) on December 1, 2018, Drug Medi-Cal treatment services were greatly expanded. With the DMC-ODS, new covered services are available like Case Management, Recovery Support Services, expanded Individual Counseling, Residential Services and Withdrawal Management. Behavioral Wellness is proud to contract with Residential and withdrawal Management Providers in each region of the County. Behavioral Wellness has expanded our 24/7 Access Line to screen and refer clients for SUD services, using the ASAM Placement Screening Tool to ensure individualized referrals to the most appropriate level of care. Medication Assisted Treatment (MAT) access is being expanded through Behavioral Wellness' new SUD Wellness and Recovery Access Point in South County as psychiatrists were trained and new grants received for deployment of infrastructure. It resides in our Crisis HUB next to the Crisis Stabilization Unit, the Psychiatric Health Facility and the CREDO 47 Stabilization Center in South County. Referrals can be received from mental health clinics, County Jail, from any of the Crisis Hub locations and through the Access Line to connect people who need screenings for MAT and inductions for Suboxone. This has been especially successful for clients who have had a history of difficulty in following through with referrals to community providers. Once induced, then referrals to these providers can be made for longer term treatment.

**<u>Program Performance (FY 19-20)</u>**

**<u>Behavioral Wellness: Adult Co-Occurring Teams</u>**

| | Unique Clients Served | | |
|---|---|---|---|
| | **North** | **South** | **West** |
| **Age Group** | | | |
| 0-15 | 0 | 0 | 0 |
| 16-25 | 19 | 2 | 1 |

| | | | |
|---|---|---|---|
| 26-59 | 117 | 118 | 45 |
| 60+ | 10 | 33 | 2 |
| Missing DOB | 0 | 0 | 0 |
| ***Total*** | **146** | **153** | **48** |
| | | | |
| **Gender** | | | |
| Female | 63 | 61 | 31 |
| Male | 83 | 92 | 17 |
| Unknown | 0 | 0 | 0 |
| | | | |
| **Ethnicity** | | | |
| American Indian or Alaska Native | 5 | 4 | 0 |
| Asian | 1 | 2 | 1 |
| Black or African American | 6 | 9 | 6 |
| Mixed Race | 1 | 21 | 2 |
| Native Hawaiian or Pacific Islander | 0 | 0 | 1 |
| White | 132 | 115 | 38 |
| Other/Not Reported | 1 | 2 | 0 |
| | | | |
| **Hispanic or Latino** | | | |
| Hispanic or Latino | 65 | 43 | 18 |
| Not Hispanic or Latino | 80 | 105 | 30 |
| Not Reported | 1 | 5 | 0 |

**Client Outcomes**

| **Milestones of Recovery Scale (MORS) Age: 18+** | | | |
|---|---|---|---|
| | | **Initial to 6 months (n = 299)** | **6 to 12 months (n = 276)** |
| **Showed improvement^** | | 30% | 27% |
| **Remained stable^** | | 46% | 48% |
| **Higher Levels of Care** | **% during program admission in FY 19-20** | | |
| | **North** | **South** | **West** |
| **Incarcerations** | 7% | 11% | 6% |
| **Crisis Services** | 18% | 3% | 6% |
| **Psychiatric Inpatient Care** | 0% | 2% | 2% |

*^"Showed Improvement" and "Remained Stable" reflects the percent of clients whose MORS scores improved or stayed the same between time periods.*

In 2019-20, clients in the Adult Co-Occurring Teams had initial, 6-month and 12-month MORS data. In the first six months of engagement, almost a third of clients improved, while 46% remained stable, and in the second

six months, a little more than a quarter of clients improved and half remained stable. Taken together, in the first year in the program, three-quarters of clients either improved or remained stable.

The client outcomes table displays the percent of unique clients who experienced a higher level of care during their admission to Adult Co-Occurring Teams in the FY 2019-20. The source of incarceration data is the Santa Barbara Jail and therefore only includes adults; clients were matched from the county electronic health record to the FY 2019-20 jail roster. The source of psychiatric inpatient and crisis services data is the electronic health record. Seven percent of clients in North County, 11% of clients in South County, and 6% of clients in West County experienced a jail stay during their admission. Eighteen percent of clients in North County, 3% of clients in South County, and 6% of clients in West County had crisis services contact during their program admission. Zero percent of clients in North County, 2% of clients in South County, and 2% of clients in West County experienced hospitalization during their program admission.

## Children Wellness, Recovery and Resiliency (WRR) Teams

| **Provider:** | **Behavioral Wellness** |
|---|---|
| **Estimated Funding FY 2021/22:** | |
| Estimated Total Mental Health Expenditures | $5,968,700 |
| Estimated CSS Funding | $0 |
| Estimated Medi-Cal FFP | $3,475,500 |
| Estimated 1991 Realignment | |
| Estimated Behavioral Health Subaccount | |
| Estimated Other Funding | $2,493,200 |
| Average Cost Per Consumer | $5,007 |
| Estimated Total of Consumers Served | 1,192 |
| Target Population Demographics Served | Children, TAY |

The Wellness, Recovery and Resiliency (WRR) program is designed to serve children ages 6-15 who demonstrate moderate-to-severe mental health needs, although are at a higher level of functioning still meeting criteria for specialty mental health services. The goal is to provide short-term treatment, offering treatment in order to step children down to a lower level-of-care in the community. Services provided to children in the WRR program include:

- Initial/Comprehensive Clinical Assessments
- Rehabilitation
- Case Management
- Individual and/or Family Therapy
- Group Therapy

Services in WRR are focused on prevention, learning healthy behaviors and coping skills to improve functioning through a Team-Based Care (TBC) model. TBC is a multi-disciplinary approach in which all clinic/program members share joint responsibility in providing services, supports and treatment to children. Each treatment team carries together an assigned caseload of children, and each team member – based on his/her role, expertise and scope of practice – contributes towards a child's success, recovery and goal achievement. Children therefore are receiving services that are coordinated and integrated, while still individualized to their specific needs.

The WRR team treats all referrals from the schools, Probation, Social Services (Child Welfare) and from providers and others in the community in collaboration with other specialty teams to ensure children are receiving the appropriate level-of-care. The WRR team provides evidence-based, trauma-informed treatment to children to include: Mental Health Practitioners, Case Workers, Parent Partners, a Psychiatric Nurse Technician and/or a Registered Nurse and a Psychiatrist.

A specialized service provided within the WRR program is "Katie-A" treatment that focused on intake and assessment of all children referred by Social Services (Child Welfare Services). Those Katie-A children requiring the WRR level-of-care either remain with the clinic-based WRR team or are referred to the Pathways to Well-being Program (a program provided by a contracted Community Based Organization, which varies per region), and those Katie-A children requiring a higher level-of-care are connected to more intensive services, such as the clinic's Full Service Partnership (FSP) SPIRIT Program, Intensive Home Based Services (IHBS), Therapeutic Based Services (TBS) and/or Wrap-163. As indicated in the Core Practice Model Guide, developed by the California Department of Health Care Services (DHCS), Katie-A services are provided within a cross-sector, team environment to build a culturally relevant and trauma-informed system of support and services that is responsive to the strengths and underlying needs of each child and family. Katie-A services include Intensive Care Coordination and Intensive Home-Based Services when a client is requiring a higher level-of-care, in addition to Child and Family Team (CFT) meetings to bring all supportive parties together for the benefit of the child and family. For team consultation related to Wrap-163 and residential treatment referral recommendations, the Interagency Placement Committee (IPC) was implemented in October 2018 to include Behavioral Wellness, Social Services and Probation as the voting representatives. This Committee focuses on streamlining and tracking all children in placement or at risk of placement in partnership with the Department of Social Services, Probation, schools, and the Regional Center. The overarching goal is to further implement the Continuum of Care Reform (CCR) for children across systems.

The Department of Behavioral Wellness continues to offer telehealth services and in-person appointments for clients that are not able to successfully participate in telehealth services or that require in person interventions in order to successfully meet treatment plan goals and maintain their mental health treatment. Certain clinic locations have a designated room setup with audio and video for those without access to technology. Groups meet outside while socially distanced (adhering to CDC guidelines) and via Zoom since the beginning of the COVID 19 pandemic.

**Program Challenges and Solutions**

A significant challenge is that many children are being returned to their home counties with the closure of state-wide, out-of-county group homes. This includes group homes closing in our county as well, which has led to not having the local continuum of care required for higher needs children/youth. As a result, there has been an increase of children/youth being hospitalized out-of-county. In response to this evolving challenge, Behavioral Wellness has supported two different group homes efforts to become Short Term Residential Treatment Programs (STRTPs) including a year-long process of becoming certified through Department of Health Care Services. During this time Behavioral Wellness provided all mental health services to these clients placed at STRTPs as well as other administrative supports including crisis intervention trainings, documentation trainings and Note Reviewer supports (to ensure the STRTPs ability to accurately document to DHCS standards).

Additionally, Behavioral Wellness designated Access and Assessment roles in the Prevention Early Intervention (PEI) Programming to support this function at each of the clinics. Behavioral Wellness established Katie-

A Practitioner Assessor staff positions in partnership with the Department of Social Services to meet the increased demands of Katie-A referrals countywide. These Katie-A Practitioner Assessors are currently co-located at Social Services to collaborate more directly with social workers for improved care of Katie-A designated youth.

Behavioral Wellness also pursued interested community partners, who wanted to serve foster care youth within a Therapeutic Foster Care model. Children placement services, including foster care, continues to be reformed statewide, in which the Core Practice Guide Model is being integrated across sectors to expand and improve collaboration efforts between Behavioral Wellness, Social Services, Probation and Community Based Organizations to improve care.

Additionally, beginning in July 2019 and in its second year, Behavioral Wellness' community based organizational partners, Community Action Commission (CAC), now known as Communify, augmented their staffing to co-locate Case Workers at the Behavioral Wellness clinics to form a new Full-Service Partnership (FSP) program in each region serving Transitional Aged Youth (TAY) ages 16-25, named FSP New Heights TAY. A continued challenge for the PEI TAY and New Heights FSP TAY program are staffing shortages requiring staff from other programs (within the Children's clinic) to assist with providing these higher level of care services so there is no interruption of services. This presents some challenges including staff burnout.

Behavioral Wellness continues to review whether children's crisis residential unit(s) be added to the continuum of care offered within the county through MHSA funding to improve the full breadth of services being provided. In addition, Youth focused proposals are included in this Plan Update, see proposal section for details.

**Program Performance (FY 19-20)**

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

| | Unique Clients Served | | |
|---|---|---|---|
| | **North** | **South** | **West** |
| **Age Group** | | | |
| 0-15 | 324 | 183 | 271 |
| 16-25 | 157 | 169 | 83 |
| 26-59 | 2 | 3 | 0 |
| 60+ | 0 | 0 | 0 |
| Missing DOB | 0 | 0 | 0 |
| ***Total*** | **483** | **355** | **354** |
| | | | |
| **Gender** | | | |
| Female | 267 | 182 | 192 |
| Male | 216 | 173 | 162 |
| Missing | 0 | 0 | 0 |
| | | | |
| **Ethnicity** | | | |
| American Indian or Alaska Native | 4 | 2 | 6 |
| Asian | 10 | 3 | 6 |
| Black or African American | 20 | 10 | 23 |
| Mixed Race | 5 | 18 | 8 |

| | | | |
|---|---|---|---|
| Native Hawaiian or Pacific Islander | 0 | 1 | 1 |
| White | 432 | 289 | 303 |
| Other/Not Reported | 12 | 32 | 7 |
| | | | |
| **Hispanic or Latino** | | | |
| Hispanic or Latino | 344 | 229 | 235 |
| Not Hispanic or Latino | 117 | 94 | 100 |
| Not Reported | 22 | 32 | 19 |

**Client Outcomes**

| **Child & Adolescent Needs & Strengths Assessment (CANS-50) Age: 6-20 years** | **Percent Improvement*** | |
|---|---|---|
| | **Initial to 6 months (n = 410)** | **6 to 12 months (n = 223)** |
| **Life Functioning** (e.g., ability to communicate and interact with families, communication, social functioning and health status) | - 30.2% | - 50.8% |
| **Behavioral/Emotional Needs** (e.g., symptoms of depression, anxiety, psychosis and other conditions) | - 22.0% | - 54.4% |
| **Risk Behaviors** (e.g., self-injury, suicidal behavior, bullying, and running away) | - 38.0% | - 51.0% |
| **Cultural Factors** (e.g., language, traditions, stress) | 0.0% | - 63.2% |
| **Strengths** (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment) | - 10.8% | - 48.8% |

| **Higher Levels of Care** | **% during program admission in FY 19-20** | | |
|---|---|---|---|
| | **North** | **South** | **West** |
| **Juvenile Hall** | -- | -- | -- |
| **Crisis Services** | 15% | 11% | 7% |
| **Psychiatric Inpatient Care** | 2% | 2% | 2% |

**Note.* On the CANS-50, a higher the score indicates more actionable needs (greater problems). A negative percent change indicates that client scores are improving because they have fewer actionable needs.

Due to a state mandated change, Santa Barbara County began using a new version of the CANS (CANS-50) in July 2018. In addition to changing items and domains, the CANS age range was extended to age 20. This means that more TAY-aged clients now receive a CANS. *Cultural Factors* is a new 3-item domain. We did not present *Caregiver Resources and Needs* for these analyses because caregivers that are entered in the Caregiver A section often change across timepoints and are not currently tracked to allow for a matched comparison.

Clients in the Children's Wellness, Recovery and Resiliency program saw reductions in the number of actionable needs across all CANS domains. While children saw a reduction in actionable needs in both time period comparisons, the group of clients that had a CANS administered at six and twelve months (n = 223) saw greater reductions in their number of actionable needs than the larger group seen from intake to six months.

The client outcomes table displays the percent of unique clients who experienced a higher level of care during their admission to Children's Wellness, Recovery and Resiliency Teams in the 19-20 fiscal year. Juvenile hall data were unavailable this year and we are unable to report on these metrics. The source of psychiatric inpatient and crisis services data is the electronic health record. Two percent of clients in North County, 5% of clients in South County, and 1% of clients in West County had crisis services contact during their program admission. Two percent of clients in North County, 2% of clients in South County, and 2% of clients in West County experienced hospitalization during their program admission.

## Adult Wellness and Recovery Outpatient (WRR) Teams

| **Provider:** | **Behavioral Wellness** |
|---|---|
| **Estimated Funding FY 2021/22:** | |
| Estimated Total Mental Health Expenditures | $6,383,000 |
| Estimated CSS Funding | $3,088,000 |
| Estimated Medi-Cal FFP | $3,294,700 |
| Estimated 1991 Realignment | |
| Estimated Behavioral Health Subaccount | |
| Estimated Other Funding | $0 |
| Average Cost Per Consumer | $9,400 |
| Estimated Total of Consumers Served | 679 |
| Target Population Demographics Served | TAY, Adult, Older Adult |

The Wellness and Recovery (WRR) teams provide services to adults in a clinic setting that are a lower level of care. All staff have 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. Other groups introduced during the pandemic are Anger Management, a Technology group in order to support clients in accessing virtual services, Grief and Loss, Budgeting and learning to manage Anxiety. Clients are also linked with services provided by the Department of Rehabilitation (D.O.R.) by referral from the WRR program and are eligible to participate in a specialized D.O.R. Co-Op program where the client receives specialized supports in achieving their vocational goals. Services in WRR are focused on prevention, learning healthy behaviors and coping skills to improve functioning through a Team-Based Care (TBC) model. TBC is a multi-disciplinary approach in which all clinic/program members share joint responsibility in providing services, supports and treatment to adult clients. Each treatment team carries together an assigned caseload of adults (age 18+), and each team member – based on his/her role, expertise and scope of practice – contributes towards an adult's success, recovery and goal achievement. Adults therefore are receiving services that are coordinated and integrated, while still individualized to their specific needs.

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. In Lompoc those clients that are in WRR and are stable are being linked to the Recovery Learning Center (RLC) medication support services. This new service provides medication support and links clients to the RLC within the RLC site. At the RLC site clients are engaged in peer support services where clients are not required to participate in the Adult Behavioral Wellness clinic. The goal is to expand similar services in North and South County in the upcoming year. The RLC

in South County was launched in November of 2019 in collaboration with the Mental Wellness Center (MWC). The RLC pilot includes participants who are in the Maintenance Phase of treatment, having met their identified treatment plan goals and would be candidates for medication support services at MWC. Medication support services are provided by a psychiatrist based at MWC two days per week, bi-weekly for 8 hours per day and would provide services to approximately 8 - 10 clients.

In response to the COVID-19 Pandemic the Department continues to offer a mix of telehealth services and in-person appointments regionally for clients that are not able to successfully participate in telehealth services or that require in person interventions in order to successfully meet treatment plan goals and maintain their mental health treatment. Certain clinic locations have a designated room setup with audio and video for those without access to technology. Groups meet outside while socially distanced (adhering to Center of Disease Control (CDC) guidelines) and via Zoom since the beginning of the COVID 19 pandemic.

**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 because of a variety of factors including limited step-down options available in the community. Consumers who likely can step down remain at the clinic receiving services as a consequence of the lack of other treatment options. 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. The core clinic has implemented a complex capable level of care approach. Levels of care have been augmented with the launch of the RLC pilot program in South County where clients can receive medication support services in their community which allows for a step down in level of care with the ultimate goal of transitioning clients fully into their communities building on client's network of natural supports. Since implementation in South County referrals and participation in this program have remained consistent and been continuous despite adaptations and challenges inherent in quickly switching from in person services to telehealth services during the COVID 19 pandemic. This program may be expanded to further accommodate clients who are receiving medication only services at the core clinic because of the continuous limited options for psychiatry services in the community.

**Program Performance (FY 19-20)**

**Behavioral Wellness: Adult Wellness, Recovery & Resilience Teams**

| | Unique Clients Served | | |
|---|---|---|---|
| | **North** | **South** | **West** |
| **Age Group** | | | |
| 0-15 | 0 | 0 | 0 |
| 16-25 | 22 | 4 | 15 |
| 26-59 | 178 | 157 | 186 |
| 60+ | 16 | 60 | 41 |
| Missing DOB | 0 | 0 | 0 |
| ***Total*** | **216** | **221** | **242** |

| Gender | | | |
|---|---|---|---|
| Female | 122 | 111 | 145 |
| Male | 94 | 110 | 97 |
| Unknown | 0 | 0 | 0 |
| | | | |
| **Ethnicity** | | | |
| American Indian or Alaska Native | 3 | 3 | 4 |
| Asian | 6 | 12 | 8 |
| Black or African American | 6 | 11 | 26 |
| Mixed Race | 2 | 18 | 5 |
| Native Hawaiian or Pacific Islander | 0 | 0 | 0 |
| White | 194 | 172 | 196 |
| Other/Not Reported | 5 | 5 | 3 |
| | | | |
| **Hispanic or Latino** | | | |
| Hispanic or Latino | 111 | 67 | 70 |
| Not Hispanic or Latino | 103 | 146 | 172 |
| Not Reported | 2 | 8 | 0 |

**Client Outcomes**

| Milestones of Recovery Scale (MORS) Age: 18+ | | | |
|---|---|---|---|
| | | Initial to 6 months (n = 626) | 6 to 12 months (n = 582) |
| **Showed improvement^** | | 29% | 24% |
| **Remained stable^** | | 48% | 52% |
| **Higher Levels of Care** | % during program admission in FY 19-20 | | |
| | **North** | **South** | **West** |
| **Incarcerations** | 1% | 2% | 4% |
| **Crisis Services** | 8% | 0% | 8% |
| **Psychiatric Inpatient Care** | 3% | 2% | 2% |

^"Showed Improvement" and "Remained Stable" reflects the percent of clients whose MORS scores improved or stayed the same between time periods.

In the FY 2019-20, clients in the Adult Wellness, Recovery, and Resilience Teams had initial, 6-month and 12-month MORS data. In the first six months of engagement, more than a quarter of clients improved, while half remained stable. In the second six months, almost a quarter of clients improved and 52% remained stable. Taken together, in the first year in the program, almost 80% of clients either improved or remained stable.

The client outcomes table displays the percent of unique clients who experienced a higher level of care during their admission to Adult Wellness, Recovery & Resilience Teams in FY 2019-20. The source of incarceration data is the Santa Barbara Jail and therefore only includes adults; clients were matched from the county electronic health record to the FY 2019-20 jail roster. The source of psychiatric inpatient and crisis services data

is the electronic health record. One percent of clients in North County, 2% of clients in South County, and 4% of clients in West County experienced a jail stay during their admission. Eight percent of clients in North County, 0% of clients in South County, and 8% of clients in West County had crisis services contact during their program admission. Three percent of clients in North County, 2% of clients in South County, and 2% of clients in West County experienced hospitalization during their program admission.

## Pathways to Well Being (Formerly "HOPE" Program) Teams

| **Provider:** | **CALM, Family Service Agency** |
|---|---|
| **Estimated Funding FY 2021/22:** | |
| Estimated Total Mental Health Expenditures | $637,000 |
| Estimated CSS Funding | |
| Estimated Medi-Cal FFP | $404,100 |
| Estimated 1991 Realignment | |
| Estimated Behavioral Health Subaccount | |
| Estimated Other Funding | $232,900 |
| Average Cost Per Consumer | $4,683 |
| Estimated Total of Consumers Served | 136 |
| Target Population Demographics Served | Children, TAY |

The HOPE Program was renamed as the Pathways to Well-Being Program. This program provides comprehensive assessments and specialty mental health services to foster care youth (Katie-A) ages 6-15, who are determined by state terms to meet CLASS (mild-to-moderate) mental health criteria. The goals of the Katie-A Pathways to Well-Being Program are to maintain the stability of children in their homes and placements thereby reducing the necessity for multiple placements, while providing trauma-informed care to foster care children and their caregivers. Previously, mild-to-moderate Katie-A children were being linked to the community-based Holman Group or private insurance providers making it difficult to track services and monitor at risk Katie-A children that may later need to be re-referred. Currently, all Katie-A children are referred by Social Services through the Behavioral Wellness designated Katie-A Practitioner Assessors, who conduct the initial assessments to determine whether a Katie-A youth requires specialty mental health services. These Katie-A Practitioner Assessors are co-located at the Social Services offices for improved care coordination and collaboration in alignment with the state's Continuum of Care Reform (CCR).

Behavioral Wellness' community-based organizational partner, CALM, provides the Pathways to Well-Being program covering the Santa Barbara (South County) and Lompoc (West County) regions, while community-based organizational partner, Family Services Agency (FSA) provides the Pathways to Well-Being program in the Santa Maria region (North County). The Pathways to Well-Being program in these regions have continued to be enhanced with 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 decreased changes in placement and an increase in successful reunifications and adoptions.

**Program Challenges and Solutions**

While the annual caseloads for Katie-A youth initially decreased in the beginning of the pandemic, the department saw an increase of referrals once school began to resume via Zoom in Fall of 2020. The upward

trend continued during the last two quarters of 2020. The increase of lower level needs impacted the wait time to Pathway to Wellbeing services. The effects of the pandemic has impacted not only the clients, but the staff too. There is an overall shortage of Community Based and clinic providers in mental health that has impacted the wait time for mental health services. The Behavioral Wellness higher level of care staff continued to provide treatment to the Katie A consumers, while waiting for services to begin with the lower level of care. There has been an increase of Telehealth services, and less face to face contact. Adjunct services were added, such as Intensive In-Home services to support placements. Behavioral Wellness continues to partner closely with the Department of Social Services to the shared goal to promote continued engagement of community-based partners seeking to provide similar services through becoming certified through the State to provide specialty mental health group home services.

During the past year, the Department was awarded the Mental Health Services Student Services Act (MHSSA) grant which is a collaboration with the Santa Barbara County Education Office and local school districts to increase access and linkage to care for all students, focusing on those vulnerable in the school system. This grant funds additional health navigators, a manager, and practitioners who can assess all students and attempt to link them to their health care networks and coordinate support and education to families and educators about behavioral health. Additionally, the Alcohol and Drug Program (ADP) received a grant to open a youth center in Lompoc and enhance school outreach regarding opioid use using navigators in North County. As the Department expands its outreach and engagement in these areas, it is intended to create community activism and enhance services to youth across the continuum.

## Program Performance (FY 19-20)

### Pathways to Well Being

| | Unique Clients Served | | |
|---|---|---|---|
| | **North** | **South** | **West** |
| **Age Group** | | | |
| 0-15 | 38 | 20 | 70 |
| 16-25 | 4 | 2 | 2 |
| 26-59 | 0 | 0 | 0 |
| 60+ | 0 | 0 | 0 |
| Missing DOB | 0 | 0 | 0 |
| ***Total*** | **42** | **22** | **72** |
| | | | |
| **Gender** | | | |
| Female | 21 | 14 | 44 |
| Male | 21 | 8 | 28 |
| Unknown | 0 | 0 | 0 |
| | | | |
| **Ethnicity** | | | |
| American Indian or Alaska Native | 0 | 0 | 1 |
| Asian | 2 | 0 | 0 |
| Black or African American | 1 | 0 | 7 |
| Mixed Race | 1 | 0 | 1 |
| Native Hawaiian or Pacific Islander | 0 | 0 | 1 |
| White | 38 | 21 | 61 |
| Other/Not Reported | 0 | 1 | 1 |

| Hispanic or Latino | | | |
|---|---|---|---|
| Hispanic or Latino | 34 | 8 | 51 |
| Not Hispanic or Latino | 7 | 11 | 20 |
| Not Reported | 1 | 3 | 1 |

**Client Outcomes***

| **Child & Adolescent Needs & Strengths Assessment (CANS-50) Age: 6-20 years** | **Percent Improvement*** | |
|---|---|---|
| | **Initial to 6 months (n = 70)** | **6 to 12 months (n = 31)** |
| **Life Functioning** (e.g., ability to communicate and interact with families, communication, social functioning and health status) | - 28.4% | - 53.8% |
| **Behavioral/Emotional Needs** (e.g., symptoms of depression, anxiety, psychosis and other conditions) | - 9.2% | - 66.1% |
| **Risk Behaviors** (e.g., self-injury, suicidal behavior, bullying, and running away) | - 20.0% | - 25.0% |
| **Cultural Factors** (e.g., language, traditions, stress) | 0.0% | - 100.0% |
| **Strengths** (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment) | - 15.8% | - 59.1% |
| **Other Outcomes** | **Average per quarter** | |
| | **North (FSA)** | **South & West (CALM)** |
| **Juvenile Hall** | 0% | 0% |
| **Out-of-Home Placement** | 7% | 3% |
| **Purposeful Activity (employed, school, volunteer)** | 100% | 98% |
| **Stable/Permanent Housing** | 99% | 100% |
| **Higher Levels of Care** | **% during program admission in FY 19-20** | |
| | **North (FSA)** | **South & West (CALM)** |
| **Crisis Services** | 5% | 2% |
| **Psychiatric Inpatient Care** | 0% | 0% |

**Note.* On the CANS-50, a higher the score indicates more actionable needs (greater problems). A negative percent change indicates that client scores are improving because they have fewer actionable needs.

Due to a state mandated change, Santa Barbara County began using a new version of the CANS (CANS-50) in July 2018. In addition to changing items and domains, the CANS age range was extended to age 20. This means that more TAY-aged clients now receive a CANS. *Cultural Factors* is a new 3-item domain. We did not present *Caregiver Resources and Needs* for these analyses because caregivers that are entered in the Caregiver A section often change across timepoints and are not currently tracked to allow for a matched comparison.

Clients in Pathways to Well Being saw reductions in the number of actionable needs across all CANS domains. While children saw a reduction in actionable needs in both time period comparisons, the group of clients that had a CANS administered at six and twelve months (n = 31) saw greater reductions in their number of actionable needs than the larger group seen from intake to six months.

Most outcomes are tracked and reported quarterly by the program. In the FY 2019-20, clients in the Pathways to Well Being Program had quite positive outcomes. In all regions, no clients experienced juvenile hall stays, and nearly all clients were engaged in purposeful activities and had stable housing. Seven percent experienced in North County and 3% in South and West County experienced out-of-home placement.

The client outcomes table displays the percent of unique clients who experienced a higher level of care during their admission to the program in the FY 2019-20. Juvenile hall data were unavailable this year and we are unable to report on these metrics. The source of psychiatric inpatient and crisis services data is the electronic health record. Five percent of clients in North County and 2% of clients in South and West County had crisis services contact during their program admission. No clients in North, South, or West County experienced hospitalization during their program admission.

## Crisis Residential Services North, South, and Agnes (North)

| **Provider:** | **Crestwood, Telecare, Behavioral Wellness** |
|---|---|
| **Estimated Funding FY 2021/22:** | |
| Estimated Total Mental Health Expenditures | $4,913,500 |
| Estimated CSS Funding | $1,518,800 |
| Estimated Medi-Cal FFP | $2,604,600 |
| Estimated 1991 Realignment | |
| Estimated Behavioral Health Subaccount | |
| Estimated Other Funding | $ 790,100 |
| Average Cost Per Consumer | $17,120 |
| Estimated Total of Consumers Served | 287 |
| Target Population Demographics Served | TAY, Adult, Older Adult |

The Department of Behavioral Wellness offers voluntary residential recovery programs to clients in crisis in both North (Santa Maria and Agnes) and South (Santa Barbara) County. These facilities were operated by Anka Behavioral Health (Anka) until May 2019. During the 30-day FY 19-20 MHSA posting period, Anka filed bankruptcy and new contracts for the services were authorized for Crestwood and Telecare for a limited period. As a result of COVID-19, these contracts were extended and a Request for Proposals was issued in 2021 for the long-term service provision. The three locations offer 30-32 residential treatment beds on any given day to consumers in the 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 90 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.

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 are typically 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. Clients consistently experience significantly less homelessness at discharge than intake as a result of coordinating and planning discharge activities during their residential treatment time at the CRT.

**Program Challenges and Solutions**

The main program objectives for this year have been maintaining staffing and managing COVID-19. Due to the COVID-19 pandemic, all CRT's quickly implemented all necessary COVID protocols to manage the spread within the facilities. At times, staffing was a challenge due to staff either being exposed to COVID-19 or testing positive. There were a few small outbreaks that caused some disruption in bed availability, but overall all facilities did a good job managing the impacts of the pandemic.

A challenge for the continuum was that all clients at CRT's have completed assessments and treatment plans as a result of virtual capability. While many clients that are referred to CRT's are existing Department clients with assessments and treatment plans in place, some individuals referred will be coming directly from the PHF, CSU or possibly one of the crisis teams following a crisis evaluation that did not result in a hold being written and the CRT's are being used as part of a safety plan. This last group of individuals referred would not have an existing assessment or treatment plan so the responsibility to complete them falls on CRT. Each CRT has a licensed Practitioner as part of its staffing, and that practitioner is assigned to quickly meet with the client and compete the assessment and treatment plan. Due to staffing challenges, at times a CRT may have the practitioner position vacant, and a solution was that BWELL staff would need to be identified to meet with client and complete the documentation.

Additionally, in FY 2020-21, a request for proposal was issued for all three CRT locations. Crestwood and Telecare were both issued the contracts for another three-year period which were renewable and effective in July 2021. Enhanced outcome reporting and clinical delivery were goals in the proposal process which both vendors strived to propose in their program design.

Focus on the forensic population modified staffing and resources at the North CRT location with implementation of current diversion felony services in coordination with multiple county departments and the Department of the State Hospital (DSH). Facility improvements and service provision for felony services were developed. The goal of the DSH grant is to provide six individuals who are incompetent to stand trial in jail a continuum of services in the community for at least thirty days. Activities in the grant include setting up shared workflows in various county departments, common assessment tools, and master leasing for community housing. Step-down housing that links consumers from CRT to a community living location was opened in December 2020. A step-down housing opportunity was created with Good Samaritan in Santa Maria, for those who leave the CRT in the felony diversion program. This housing opportunity has support services and living options for six months to a year for forensic involved clients who are leave the CRT and need that next step of outpatient support.

**Program Performance (FY 19-20)**

**Crisis Residential**

| Unique Clients Served | | |
|---|---|---|
| | North (Two Locations) | South |

| Age Group | | |
|---|---|---|
| 0-15 | 1 | 0 |
| 16-25 | 34 | 12 |
| 26-59 | 130 | 85 |
| 60+ | 20 | 15 |
| Missing DOB | 0 | 0 |
| ***Total*** | **185** | **112** |
| | | |
| **Gender** | | |
| Female | 75 | 38 |
| Male | 110 | 74 |
| Unknown | 0 | 0 |
| | | |
| **Ethnicity** | | |
| American Indian or Alaska Native | 6 | 3 |
| Asian | 6 | 2 |
| Black or African American | 11 | 8 |
| Mixed Race | 14 | 14 |
| Native Hawaiian or Pacific Islander | 1 | 0 |
| White | 146 | 83 |
| Other/Not Reported | 1 | 2 |
| | | |
| **Hispanic or Latino** | | |
| Hispanic or Latino | 77 | 38 |
| Not Hispanic or Latino | 108 | 72 |
| Not Reported | 0 | 2 |

**Client Outcomes**

| Higher Levels of Care | % during program admission in FY 19-20 | |
|---|---|---|
| | **North** | **South** |
| **Incarcerations** | 9% | 14% |
| **Crisis Services** | 19% | 13% |
| **Psychiatric Inpatient Care** | 2% | 4% |

In October 2019, a grant funded the opening of a Crisis Residential Treatment Center in North County. Therefore, the numbers in North County reflect a full year for partial year for the 10-bed Agnes St. CRT (North County; operated by Telecare), a full year of operation for the 12-bed Carmen Lane CRT (North County; operated by Telecare), and a full year of operation for the 10-bed South County CRT (operated by Crestwood).

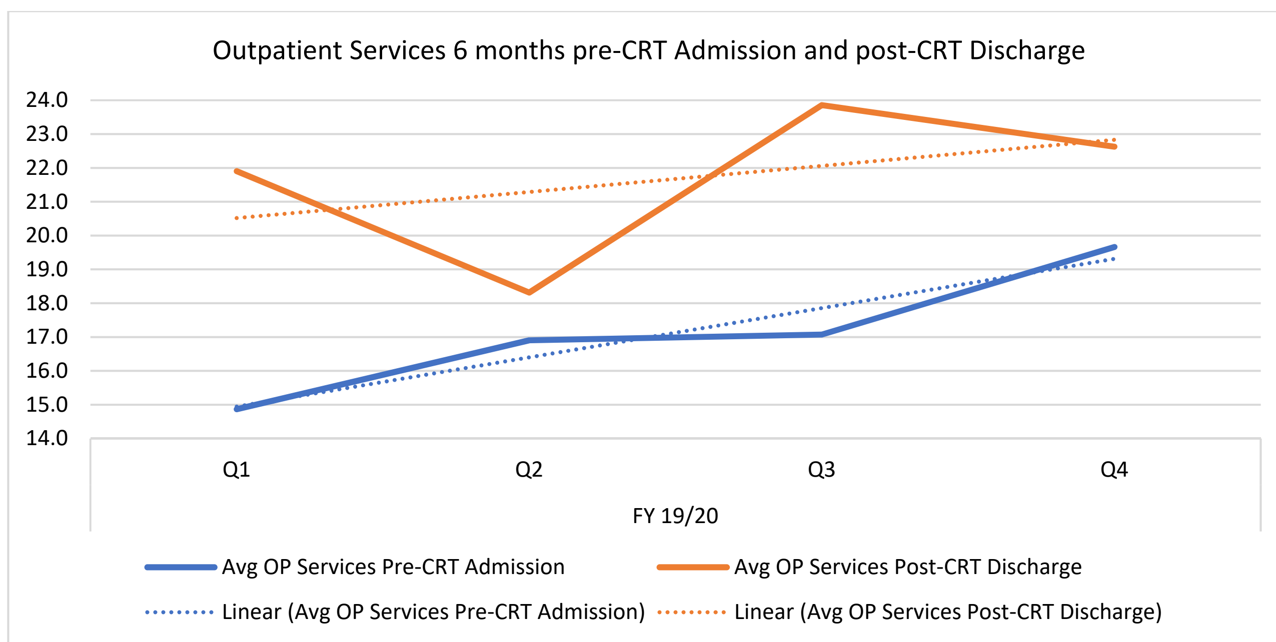
## Higher Levels of Care

The client outcomes table displays the percent of unique clients who experienced a higher level of care during their admission to Crisis Residential in FY 2019-20. The source of incarceration data is the Santa Barbara Jail and therefore only includes adults; clients were matched from the county electronic health record to the FY 2019-20 jail roster. The source of psychiatric inpatient and crisis services data is the electronic health record. Nine percent of clients in North County and 14% of clients in South County experienced a jail stay during their

admission. Nineteen percent of clients in North County and 13% of clients in South County had crisis services contact during their program admission. Two percent of clients in North County and 4% of clients in South County experienced hospitalization during their program admission.

**Outpatient Services Pre-CRT Admission and Post-CRT Discharge**

To understand the impact of a CRT, stay on client stability, as well as the impact of CRT services on the crisis system, we examined the number of outpatient services that clients received in the six months prior to their CRT admission and the six months after their CRT discharge. The gap between the two solid lines in one quarter shows the difference in outpatient service engagement pre- and post-CRT stay for the clients served in that quarter. For example, in the first quarter of FY 19/20, clients' average number of outpatient services attended in the six months prior to their CRT stay was about 15 services while in the six months following their CRT stay, clients attended about 22 services. In other words, pre-CRT stay, clients attended 2.5 appointments per month and after their CRT stay they attended 3.7 appointments per month. This trend of an increase in outpatient service attendance persisted over the fiscal year, though encouraging, client appointment attendance both pre-stay and post-stay increased over the year. We look forward to seeing if this positive trend continues into next fiscal year.




## Medical Integration Program

| **Provider:** | **Behavioral Wellness** |
|---|---|
| **Estimated Funding FY 2021/22:** | |
| Estimated Total Mental Health Expenditures | $2,250,000 |
| Estimated CSS Funding | $1,640,200 |
| Estimated Medi-Cal FFP | $ 609,800 |
| Estimated 1991 Realignment | |
| Estimated Behavioral Health Subaccount | |
| Estimated Other Funding | |

| Average Cost Per Consumer | $17,175 |
|---|---|
| Estimated Total of Consumers Served | 131 |
| Target Population Demographics Served | TAY, Adult, Older Adult |

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. 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;

Forging new partnerships with primary care and substance use treatment providers is essential and remains an ongoing effort. 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, 3-4-50) also have been ongoing.

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.

The Department of Behavioral Wellness continues to offer telehealth services and in-person appointments for clients that are not able to successfully participate in telehealth services or that require in person interventions in order to successfully meet treatment plan goals and maintain their mental health treatment. Certain clinic locations have a designated room setup with audio and video for those without access to technology. Groups meet outside while socially distanced (adhering to CDC guidelines) and via Zoom since the beginning of the COVID 19 pandemic.

**Program Challenges and Solutions**

During FY 2021-22, a pharmacy will be constructed in the adult outpatient clinic in South County Santa Barbara of which will provide ease of access to filling medications and other related services for all clients including those that have limited mobility and/or incapacities due to health conditions in this program.

This program was originally developed to serve older adults and now serves 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 requires evolving 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. Staff turnover and continued staffing allocation patterns remain a challenge in providing these specialized services to clients. This last year has proven especially challenging with the lack of nursing staff in our communities, increased demands for nurses throughout Santa Barbara County and clients presenting with further complicating medical issues which were exacerbated by the COVID 19 pandemic.

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 did not 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 a therapeutic relationship 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 has recently moved three specialized programs towards becoming Complex Capable. Program staff have been trained to become more Complex Capable and the need to transition clients to different programs within clinics is no longer necessary minimizing disruption of therapeutic alliances. The Department has continued to provide both elective and mandatory ongoing trainings in order to support fidelity in the three different Complex Capable teams thus allowing for clients to remain with their treatment team. Another challenge has been seamlessly transitioning clients who have graduated from their program but still have need for medication management to their primary care providers. Although some community based medical organizations/agencies have been hesitant to manage mental health medications, medical staff continue to outreach in the community to develop relationships with primary care providers. This remains an ongoing effort as their remains limited availability of psychiatrists and community-based providers who are comfortable with managing mental health medications.

## Program Performance (FY 19-20)

### Behavioral Wellness: Medical Integration and Older Adult Teams

| | Unique Clients Served | | |
|---|---|---|---|
| | North | South | West |
| **Age Group** | | | |
| 0-15 | 0 | 0 | 0 |
| 16-25 | 1 | 1 | 0 |
| 26-59 | 20 | 17 | 23 |
| 60+ | 31 | 25 | 13 |
| Missing DOB | 0 | 0 | 0 |

| Total | 52 | 43 | 36 |
|---|---|---|---|
| | | | |
| **Gender** | | | |
| Female | 31 | 27 | 24 |
| Male | 21 | 16 | 12 |
| Unknown | 0 | 0 | 0 |
| | | | |
| **Ethnicity** | | | |
| American Indian or Alaska Native | 1 | 0 | 0 |
| Asian | 1 | 1 | 0 |
| Black or African American | 2 | 1 | 6 |
| Mixed Race | 0 | 3 | 0 |
| Native Hawaiian or Pacific Islander | 0 | 0 | 1 |
| White | 48 | 38 | 29 |
| Other/Not Reported | 0 | 0 | 0 |
| | | | |
| **Hispanic or Latino** | | | |
| Hispanic or Latino | 14 | 16 | 8 |
| Not Hispanic or Latino | 38 | 27 | 28 |
| Not Reported | 0 | 0 | 0 |

**Client Outcomes**

| Milestones of Recovery Scale (MORS) Age: 18+ | | | |
|---|---|---|---|
| | | Initial to 6 months (n = 125) | 6 to 12 months (n = 119) |
| **Showed improvement^** | | 23% | 15% |
| **Remained stable^** | | 58% | 65% |
| **Higher Levels of Care** | % during program admission in FY 19-20 | | |
| | North | South | West |
| **Incarcerations** | 0% | 2% | 0% |
| **Crisis Services** | 8% | 9% | 0% |
| **Psychiatric Inpatient Care** | 2% | 9% | 3% |

*^"Showed Improvement" and "Remained Stable" reflects the percent of clients whose MORS scores improved or stayed the same between time periods.*

In the 2019-2020 fiscal year, clients in the Medical Integration and Older Adult Program had initial, 6-month and 12-month MORS data. In the first six months of engagement, a quarter of clients improved and over half were stabilized, and in the second six months, 15% of clients improved and nearly two-thirds were stabilized. Examined another way, over the year, about 80% of clients were either stable or made improvements.

The client outcomes table displays the percent of unique clients who experienced a higher level of care during their admission to Medical Integration and Older Adult Teams in the 19-20 fiscal year. The source of

incarceration data is the Santa Barbara Jail and therefore only includes adults; clients were matched from the county electronic health record to the FY 19/20 jail roster. The source of psychiatric inpatient and crisis services data is the electronic health record. Zero percent of clients in North County, 2% of clients in South County, and 0% of clients in West County experienced a jail stay during their admission. Eight percent of clients in North County, 9% of clients in South County, and 0% of clients in West County had crisis services contact during their program admission. Two percent of clients in North County, 9% of clients in South County, and 3% of clients in West County experienced hospitalization during their program admission.

## Adult Housing Support Services

| **Provider:** | **Behavioral Wellness, Psynergy, Pathpoint, Telecare, Mental Wellness Center, Good Samaritan** |
|---|---|
| **Estimated Funding FY 2021/22:** | |
| Estimated Total Mental Health Expenditures | $2,725,500 |
| Estimated CSS Funding | $1,000,500 |
| Estimated Medi-Cal FFP | $1,094,800 |
| Estimated 1991 Realignment | |
| Estimated Behavioral Health Subaccount | |
| Estimated Other Funding | $ 630,200 |
| Average Cost Per Consumer | $22,903 (Some provider's support services, others all housing costs, each provider is varied in MHSA support) |
| Estimated Total of Consumers Served | 119 |
| Target Population Demographics Served | TAY, Adult, Older Adult |

During prior years' stakeholder forums, additional housing has been raised as an issue. This year, the Department opened a 35-unit residence for MHSA eligible clients in Santa Maria (Depot Street); opened a 14 studio Housing Development in Lompoc dedicated to MHSA-eligible tenants (Homekey Studios); opened a six-bedroom permanent supportive housing project in Santa Barbara (Heath House) and completed construction on a 13-unit No Place Like Home (NPLH) funded housing project in Santa Maria (West Cox Cottages). All three sites have an onsite supportive services staff. In FY 21-22, the Department plans to begin construction on a 20-unit NPLH-funded housing project; apply for NPLH non-competitive funding for a housing project in West County; and apply for competitive NPLH funding for two future housing projects in South County. The Department will continue to review and modify the types of adult housing supports, such as rental subsidies, based on funding available.

***Included in this program is mental health support services for:***

- *Depot Street Housing:* Opened Fall 2020 for 35 MHSA-eligible families. The Department will be providing onsite supportive services to all MHSA tenants, including a case worker onsite to provide supportive services and help coordinate additional services.

- *Heath House*: Opened Winter 2021 for Women experiencing homelessness. The Department provides case workers to support tenants with independent living skills and connects them to County and community-based organizations as needs arise.

- *West Cox Cottages*: Construction was anticipated to be complete Summer 2021 and lease-up begin on this Housing Project although delayed due to utility construction. There are 13 NPLH-funded units for persons with a serious mental illness who are experiencing homelessness. This project will have an

MHSA funded caseworker onsite to provide supportive services and help coordinate additional services.

• *Hollister Lofts:* The Department has been awarded funding for over 4 million dollars in NPLH competitive funding for an 18-unit housing project for persons with a serious mental illness who are experiencing homelessness. It is anticipated that construction will begin on this project in 2022. Once complete, this project will have a full-time case worker onsite to provide supportive services and help coordinate additional services.

• *Cypress and 7th:* The Department anticipates applying for our remaining non-competitive NPLH funding for a 14-unit Housing Project in Lompoc entirely dedicated to persons with a serious mental illness who are experiencing homelessness.

For the above programs, initially State grant funding would provide the support services for the multidisciplinary support services provided. Adult Housing Supports or Homeless Outreach Services would provide the ongoing behavioral health support to residents and those sheltering on a long-term basis should MHSA funding be available.

***Ongoing adult housing costs and mental health service support costs from MHSA programming include***:

• **Psynergy Programs, Inc.** which is an Institute for Mental Disease (IMD) alternative facility located in the Bay Area. They work with clients in IMDs to identify which may be ready to step down to a lower level of care, then work to step clients down through three progressions of residential care, with the eventual goal of equipping clients to return to Santa Barbara County to live independently.

• **Pathpoint** which offers residential board and care at Phoenix and Mountain House Adult Housing Supports. This program design includes MHSA principles, peer services, and enhanced focused on case management and support group activities. PathPoint operates two residential programs. Also supported are other Pathpoint residential scattered site community locations that serve MHSA clients.

• **Mental Wellness Center's (MWC)** manages Intensive Residential Programs and extended peer services and group supports. The intent of the Programs is to coordinate housing for adults primarily served through the MHSA. Mental Wellness Center will provide twenty-four (24) hour per day, seven (7) days per week psychiatric rehabilitation, residential care and room and board services in 4 locations and several apartments in the community. The Department is looking to also perhaps partner with MWC to add more beds within MHSA.

• **Telecare** offers McMillan Ranch in Santa Maria which is an intensive residential program with support from the Santa Maria full services partnership teams.

• **The Residences at Depot Street** will have an onsite case manager at a minimum of 20 hours per week funded with MHSA.

• **West Cox Cottages** will have an onsite case manager at a minimum of 20 hours per week funded with MHSA.

**Program Challenges and Solutions**

The Department continues to work towards building adequate infrastructure, and adding to the housing continuum while acknowledging that additional components may be needed as the demand for housing increases and the type of housing desired varies depending on region. Along with the No Place Like Home initiative, establishment of additional crisis residential locations, and flexible housing assistance, such as: short-term shelters, rental subsidies, security deposits, utility deposits will be explored to the extent available.

Behavioral Wellness has also applied for, and been awarded various grants to provide funding for onsite supportive services. The Department will continue to creatively pursue State and Federal funding opportunities to fund onsite supportive services. Behavioral Wellness will attempt to seek providers interested in master leasing and housing services management in FY 21-22 in order to ensure an enhanced support network when housing opportunities of funding become available. Ongoing housing support services is critical and MHSA is a stable source for this as new housing options are created, however, community support and leveraging MHSA funds is necessary for sustainability of these housing support and step-down service options.

Behavioral Wellness also partnered with County Housing and Community Development (HCD) to fund the updated Homeless Housing Plan to ensure adequate supports along with partnering for a successful Request for Proposal (RFP) for development opportunities. Behavioral Wellness will attempt to seek providers interested in master leasing, board and care, and other housing services management in FY 21-22 in order to ensure an enhanced support network when housing opportunities of funding become available, which is a key proposal in this plan.

**Program Performance (FY 19-20)**

**Adult Housing Support Services**

| | **Unique Clients Served** | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Provider** | **Pathpoint** | | **MWC** | **Psynergy** | **Telecare** | **Pathpoint Residential Support Services** | | |
| **Site** | **Mountain House** | **Phoenix House** | **Polly's House** | **Psynergy** | **McMillan Ranch** | **Artisan Court** | **Bradley Studios** | **El Carrillo** |
| **Age Group** | | | | | | | | |
| 0-15 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 16-25 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 26-59 | 15 | 15 | 8 | 16 | 11 | 6 | 1 | 14 |
| 60+ | 4 | 3 | 5 | 6 | 4 | 2 | 1 | 8 |
| Missing DOB | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| ***Total*** | ***19*** | ***18*** | ***13*** | ***22*** | ***15*** | ***8*** | ***2*** | ***22*** |
| | | | | | | | | |
| **Gender** | | | | | | | | |
| Female | 6 | 9 | 7 | 16 | 9 | 4 | 0 | 8 |
| Male | 13 | 9 | 6 | 6 | 6 | 4 | 2 | 14 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Unknown | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | | | | | | | |
| **Race** | | | | | | | | |
| American Indian or Alaska Native | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Asian | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 |
| Black or African American | 3 | 2 | 2 | 3 | 0 | 1 | 0 | 1 |
| Mixed Race | 0 | 1 | 1 | 0 | 1 | 0 | 0 | 1 |
| Native Hawaiian or Pacific Islander | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| White | 16 | 14 | 10 | 18 | 13 | 6 | 2 | 20 |
| Other/Not Reported | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 0 |
| | | | | | | | | |
| **Hispanic or Latino** | | | | | | | | |
| Hispanic or Latino | 3 | 3 | 2 | 6 | 6 | 3 | 2 | 2 |
| Not Hispanic or Latino | 16 | 15 | 11 | 16 | 9 | 11 | 0 | 20 |
| Not Reported | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

**Program Outcomes***

| | **Average per Quarter** | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | **Mountain House** | **Phoenix House** | **Polly's House** | **Psynergy^** | **McMillan Ranch** | **Artisan Court** | **Bradley Studios** | **El Carrillo** |
| **Physical Health Hospitalization** | 0% | 2% | * | 0% | 8% | 8% | | |
| **Physical Health Emergency Care** | 7% | 11% | * | * | 80% | 11% | | |
| **Stable/Permanent Housing** | 93% | 96% | * | * | 88% | 100% | | |
| **Purposeful Activity (employed, school, volunteer)** | 28% | 33% | * | * | 100% | 25% | | |
| | **% during program admission in FY 19-20** | | | | | | | |
| | **Mountain House Support Services** | **Phoenix House Support Services** | **Polly's House** | **Psynergy** | **McMillan Ranch** | **Artisan Court** | **Bradley Studios** | **El Carrillo** |
| **Incarcerations** | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% |
| **Crisis Services** | 11% | 17% | 23% | 5% | 13% | 0% | 0% | 0% |
| **Psychiatric Inpatient Care** | 16% | 6% | 15% | 18% | 7% | 0% | 0% | 0% |

* = Data not collected
^ = Reflects three of four quarters of data

Examining program outcomes, it is important to note that providers were asked to report on some, but not all, of the same metrics. Therefore, an asterisk signifies that this metric was not assessed. Programs reported on each outcome quarterly to the Department of Behavioral Wellness. Not many clients across all programs experienced physical health hospitalizations (2-8%), though more clients experienced physical health

emergency care. McMillan Ranch reported that 80% of their clients needed emergency care during their stay. Almost all clients had stable/permanent housing (expected, given that these are housing programs) and between 25% and 100% of clients across programs were engaged in purposeful activity.

The client outcomes table displays the percent of unique clients who experienced a higher level of care during their admission to Housing Support Services in the 19-20 fiscal year. The source of incarceration data is the Santa Barbara Jail and therefore only includes adults; clients were matched from the county electronic health record to the FY 19/20 jail roster. The source of psychiatric inpatient and crisis services data is the electronic health record. No clients experienced a jail stay during their admission. Between 0-23% of clients had crisis services contact during their program admission, and 0-18% of clients in West County experienced hospitalization during their program admission.

## About Full Service Partnerships (FSPs)

Full Service Partnership (FSP) plans for and provides the full spectrum of services, mental health and non-mental health services and supports to advance client's goals and support their recovery, wellness and resilience.

### New Heights Transitional Age Youth (TAY) FSP

| **Provider:** | **Behavioral Wellness, CommUnify (formerly Community Action Commission, Department of Rehabilitation** |
|---|---|
| **Estimated Funding FY 2021/22** | |
| Estimated Total Mental Health Expenditures | $3,358,600 |
| Estimated CSS Funding | $2,055,800 |
| Estimated Medi-Cal FFP | $663,000 |
| Estimated 1991 Realignment | |
| Estimated Behavioral Health Subaccount | |
| Estimated Other Funding | |
| Average Cost Per Consumer | $28,705 |
| Estimated Total of Consumers Served | 117 |
| Target Population Demographics Served | Children, TAY, Adults (as they age within TAY continuum) |

The New Heights FSP TAY program serves primarily 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 FSP TAY program serves consumers experiencing mental health and substance abuse conditions. The New Heights FSP TAY program also coordinates the Department of Rehabilitation (DOR) contract to continue to improve and enhance supportive employment services. The program model was developed using the TAY 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. Beginning in July 2020, New Heights became a specialized FSP program for TAY in each region to allow the "Whatever It Takes" programming specific to this age group. This was a key proposal in the FY 2017-2020 MHSA plan which was achieved.

The team focuses on both staff training and program implementation targeted towards this group. Training focused on the pervasive and profound impacts of trauma, and how to equip people with more effective ways to manage and overcome it are key for staff members. Tools for teaching emotional regulation, developing resiliency and self-compassion are utilized in daily programming.

**Program Challenges and Solutions**

The challenges encountered have been the increased number of clients that have been identified as Commercial Sexual Exploitation of Children (CSEC) youth or at risk of becoming commercially sexually exploited youth. The TAY-FSP has been trained and develop this specialized skill set for clinicians to provide effective interventions for TAY aged youth experiencing these challenges. As the Innovations Project for CSEC ended in June 2020, this program known as RISE, shifted personnel and clients to the newly established New Heights FSP and this specialized expertise is maintained by personnel on those teams as a high level of the TAY population is at risk for CSEC. The shifting of staff and clients and reconfiguring of the RISE County Facility in Santa Maria to an overall TAY focus began in July 2020 and continues to be a focus for the upcoming year.

The challenges encountered have been the increased need to expand employment resources that are specific to the TAY population. TAY specific resources for TAY housing is also a challenge because of the lack of short-term housing resources for this group. Behavioral Wellness and the State Department of Rehabilitation (DOR) and Work Force Development Board continue to work collaboratively to address these issues

Behavioral Wellness has continued to work with stakeholders to develop additional resources for TAY consumers. The higher mental health needs for TAY had not 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. Consequently, Behavioral Wellness successfully launched the TAY Full Service Partnership (FSP) level of care to meet the needs of this age group within the Children's system of care. Caseworkers were added to each of our TAY New Height's programs and expanded to make them all Full-Service Partnerships. This was recommended by the Department as part of the 2017-2020 Three-Year Plan. The goal of this new program is to ensure that TAY mental health needs are met, and that this population is adequately served and engaged. Additionally, the Children's Transitional Services weekly meeting was developed regionally for contracted providers and Behavioral Wellness staff to refer clients needing to change levels of care. This meeting allows for robust discussion and collaboration tailoring services to meet the unique needs of TAY aged clients. As this is a new program, the effectiveness and design will be monitored during the 2020-2023 Three-Year Plan period.

**Program Performance (FY 19-20)**

**New Heights – Transitional Age Youth (Outpatient level, now FSP in 20-21)**

| Unique Clients Served | | | |
|---|---|---|---|
| | North | South | West |
| **Age Group** | | | |
| 0-15 | 1 | 0 | 2 |
| 16-25 | 35 | 36 | 43 |
| 26-59 | 0 | 0 | 0 |

| | | | |
|---|---|---|---|
| 60+ | 0 | 0 | 0 |
| Missing DOB | 0 | 0 | 0 |
| ***Total*** | **36** | **36** | **45** |
| | | | |
| **Gender** | | | |
| Female | 21 | 14 | 30 |
| Male | 15 | 22 | 15 |
| Unknown | 0 | 0 | 0 |
| | | | |
| **Ethnicity** | | | |
| American Indian or Alaska Native | 0 | 0 | 0 |
| Asian | 0 | 0 | 1 |
| Black or African American | 2 | 1 | 4 |
| Mixed Race | 0 | 8 | 0 |
| Native Hawaiian or Pacific Islander | 1 | 0 | 0 |
| White | 33 | 25 | 39 |
| Other/Not Reported | 0 | 2 | 1 |
| | | | |
| **Hispanic or Latino** | | | |
| Hispanic or Latino | 21 | 15 | 30 |
| Not Hispanic or Latino | 13 | 17 | 15 |
| Not Reported | 2 | 4 | 0 |

**Client Outcomes**

| Child & Adolescent Needs & Strengths Assessment (CANS-50) Age: 6-20 years | Percent Improvement* | |
|---|---|---|
| | **Initial to 6 months (n = 16)** | **6 to 12 months (n = 4)** |
| **Life Functioning** (e.g., ability to communicate and interact with families, communication, social functioning and health status) | - 47.8% | - 70.8% |
| **Behavioral/Emotional Needs** (e.g., symptoms of depression, anxiety, psychosis and other conditions) | - 51.4% | - 64.7 % |
| **Risk Behaviors** (e.g., self-injury, suicidal behavior, bullying, and running away) | - 66.7% | - 75.0% |
| **Cultural Factors** (e.g., language, traditions, stress) | - 50.0% | - 100.0% |
| **Strengths** (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment) | 13.3% | - 61.8% |
| **Milestones of Recovery Scale (MORS) Age: 18+** | | |
| | **Initial to 6 months (n=50)** | **6 to 12 months (n=44)** |
| **Showed Improvement^** | 36% | 39% |
| **Remained Stable^** | 40% | 43% |

| Higher Levels of Care | % during program admission in FY 19-20 | | |
|---|---|---|---|
| | **North** | **South** | **West** |
| **Incarcerations** | 2% | 8% | 0% |

| | | | |
|---|---|---|---|
| **Crisis Services** | 14% | 19% | 24% |
| **Psychiatric Inpatient Care** | 8% | 17% | 4% |

*^"Showed Improvement" and "Remained Stable" reflects the percent of clients whose MORS scores improved or stayed the same between time periods.*

**Note.* On the CANS-50, a higher the score indicates more actionable needs (greater problems). A negative percent change indicates that client scores are improving because they have fewer actionable needs.

Due to a state mandated change, Santa Barbara County began using a new version of the CANS (CANS-50) in July 2018. In addition to changing items and domains, the CANS age range was extended to age 20. This means that more TAY-aged clients now receive a CANS. *Cultural Factors* is a new 3-item domain. We did not present *Caregiver Resources and Needs* for these analyses because caregivers that are entered in the Caregiver A section often change across timepoints and are not currently tracked to allow for a matched comparison.

Clients in the FSP New Heights TAY program saw reductions in the number of actionable needs across all CANS domains with the exception of the *Strengths* domain from intake to six months (n = 16). While transitional age youth saw a reduction in actionable needs in both time period comparisons, the group of clients that had a CANS administered at six and twelve months (n = 4) saw greater reductions in their number of actionable needs than the larger group seen from intake to six months. It should be noted that for transitional age youth many clients switch from the CANS to the MORS mid-treatment (when they turn 21). This change in assessment tool reduces the number of CANS comparisons that are available because clients often "age out" of the CANS while still in treatment.

On the MORS, in the first six months of engagement over one third of clients improved, and in the second six months, almost 40% of clients improved. Further, over both time periods 40% of clients were stable, suggesting that even when not improving, a large portion of FSP New Heights clients are not deteriorating. At a time when mental illness symptoms often worsen and risk-taking behaviors escalate, keeping TAY stable is especially critical. Note that because the TAY New Heights program transitioned to an FSP towards the end of the fiscal year, the number of clients captured in these two clinical outcome tools may be slightly lower as many clients experienced administrative transfers from the former non-FSP New Heights TAY program to the new FSP program. As a result, their initial CANS or MORS scores would have been captured under the old program.

The client outcomes table displays the percent of unique clients who experienced a higher level of care during their admission to FSP New Heights TAY in the 19-20 fiscal year. The source of incarceration data is the Santa Barbara Jail and therefore only includes adults; clients were matched from the county electronic health record to the FY 19/20 jail roster. Juvenile hall data were unavailable this year and we are unable to report on these metrics. The source of psychiatric inpatient and crisis services data is the electronic health record. Two percent of clients in North County, 8% of clients in South County, and 0% of clients in West County experienced a jail stay during their admission. Fourteen percent of clients in North County, 19% of clients in South County, and 24% of clients in West County had crisis services contact during their program admission. Eight percent of clients in North County, 17% of clients in South County, and 4% of clients in West County experienced hospitalization during their program admission.

## Assertive Community Treatment (ACT) / Assisted Outpatient Treatment (AOT): Santa Barbara, Lompoc and Santa Maria

Adult Assertive Community Treatment (ACT) Programs for adults include Santa Maria ACT FSP (Provider: Telecare; estimated 100 slots), Santa Barbara ACT FSP (Provider: Behavioral Wellness; estimated 100 slots); Lompoc ACT FSP (Provider: Transitions Mental Health Association/Merakey Allos; estimated 85 slots). Each of these teams encompass Assisted Outpatient Treatment (AOT), which is known as "Laura's Law."

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, rehabilitation and support. Many consumers experience co-occurring mental health conditions and substance abuse disorders.

## Lompoc ACT FSP – Transitions Mental Health Association

| **Provider:** | **Transitions Mental Health Association in prior years and Merakey Allos in FY 2021-22 / Behavioral Wellness** |
|---|---|
| **Estimated Funding FY 2021/22:** | |
| Estimated Total Mental Health Expenditures | $2,727,800 |
| Estimated CSS Funding | $1,114,900 |
| Estimated Medi-Cal FFP | $1,480,900 |
| Estimated 1991 Realignment | |
| Estimated Behavioral Health Subaccount | |
| Estimated Other Funding | $ 132,000 |
| Average Cost Per Consumer | $25,493 |
| Estimated Total of Consumers Served | 107 |
| Target Population Demographics Served | Adult, Older Adult |

Transitions Mental Health Association (TMHA) provided ACT services in Lompoc until June 2021 and Merakey Allos is a new vendor effective July 2021. As an ACT Model Program, the staff functions as a team and provide services for adults and older adults with severe 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.

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 was 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. Merakey Allos has initiated the transition plan with Transitions Mental Health Association to ensure linkage to all Lompoc services as they start services in the County.

Lompoc ACT staff are skilled at walking clients through the process of treatment with the final goal of graduation. Clients have the expectation at the outset of ACT services that they will ultimately transition back to the clinic or to community services. However, clients are welcomed back if circumstances change; ACT services are available when a person needs them with recovery as the constant goal. ACT team works well with the Lompoc Adult clinic and referrals into and transitions out of the program have been seamless for clients.

Lompoc ACT staff receive all AOT referrals from the Department of Behavioral Wellness. The ACT model prepares staff for the intensive outreach and engagement techniques that play a significant role in the AOT program. At times, the teams receive little information about the referred individual—it can be a brief description, a photo and locations where the person is known to have frequented. Other times, the referrals are individuals that live in the areas around Lompoc, making outreach attempts time-intensive. Despite these challenges, Lompoc ACT staff make the 3 attempted connections per week to locate and engage clients in AOT. During engagement, staff are informally assessing services that will benefit the client. This may be substance use treatment, a socialization program, housing, or all of those services. Staff discuss the benefits of treatment in meeting the client's short term and long term needs and report back to the full AOT team via weekly phone call. Assessment needs are discussed and Behavioral Wellness or ACT staff will conduct the clinical assessment if the AOT client is ready to be referred and admitted for services. If not, staff will locate the most appropriate community resources and connect the clients directly with those services and supports. Lompoc ACT has 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.

**Program Challenges and Solutions**

With the close of the current Fiscal Year, Transitions-Mental Health Association ceased operation of Lompoc ACT, as the County contracted the program to a new provider, Merakey Allos, as a result of a request for proposal process. That transition, and the continuity of care for all clients, will be the key focus in 2021-22.

It is critically important to provide experienced and appropriate staffing for the AOT portion of the ACT program. It is ideal for dedicated staff to be assigned to AOT in order for the 1:10 staff to client ratio to be fulfilled. This has created challenges as a result of COVID-10 and the region of Lompoc, as a Federally recognized health care staffing shortage area. While Lompoc ACT and AOT have been blended together, they require different levels of service and response which is monitored in the service delivery models. One additional option was the addition of nursing and psychiatry staff contracted by the ACT/AOT providers in each region rather than the Department. Having the cohesive team hopefully will allow increased collaboration by the providers for this population. Additionally, in fall of 2020, Crestwood Behavioral Health opened a new Institute of Mental Disease (IMD) in Lompoc with assistance from Behavioral Wellness and Behavioral Wellness moved its adult clinic to create long term housing options at B Street for those who are homeless and mentally ill. The Lompoc region is a continued focus area for the Department as it attempts to create a robust system of care at all levels for clients to navigate and be supported.

## Santa Maria ACT FSP – Telecare

| Provider: | Telecare / Behavioral Wellness |
|---|---|
| Estimated Funding FY 2021/22: | |
| Estimated Total Mental Health Expenditures | $2,929,700 |
| Estimated CSS Funding | $1,588,100 |
| Estimated Medi-Cal FFP | $1,341,600 |
| Estimated 1991 Realignment | |
| Estimated Behavioral Health Subaccount | |
| Estimated Other Funding | |
| Average Cost Per Consumer | $26,393 |
| Estimated Total of Consumers Served | 111 |
| Target Population Demographics Served | TAY, Adult, Older Adult |

Telecare Corporation provides Assertive Community Treatment (ACT) services 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. Consumers involved with forensic systems are supported in Mental Health/Drug Court as well as Probation obligations. Offered 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.

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

C. 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.

D. No matter with which culture or cultures the consumer identifies, it is the goal of the Program to recognize the unique differences, strengths, knowledges and experiences of each person served. Inclusion into the community as an active, independent, healthy, and productive citizen is the Program's goal.

E. Majority 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.

F. Provide continuity across time as m any 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.

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

**Program Challenges and Solutions**

The community of Santa Maria has limited safe and affordable housing options; in particular, housing with support such as Room & Boards and Board & Cares. The MHSA Housing Project on Depot St. added 35 units in Santa Maria in Fall of 2020 and Step-Down Housing for forensic diversion was initiated in Winder of 2020 in partnership with Good Samaritan. Continued focus on long term housing for ACT/AOT clients is critical to their success.

The ACT program isn't always fully staffed due to retention and recruitment hardships in the region. Telecare has proactively strategized hiring plans and continues to monitor to adequately employ peer and family members and those who are bilingual in the staffing pattern. They continue to come up with innovative strategies for hiring, but this is a consistent challenge over the years.

Transitioning the nursing and psychiatry services to Telecare from the Department started in 2021 and will be evaluated for effectiveness along with the new contract which was an award from the Request for Proposal issued Fall of 2020.

## Santa Barbara ACT FSP – Behavioral Wellness

| Provider: | Behavioral Wellness |
|---|---|
| **Estimated Funding FY 2021/22:** | |
| Estimated Total Mental Health Expenditures | $4,009,200 |
| Estimated CSS Funding | $2,535,000 |
| Estimated Medi-Cal FFP | $1,474,200 |
| Estimated 1991 Realignment | |
| Estimated Behavioral Health Subaccount | |
| Estimated Other Funding | |
| Average Cost Per Consumer | $31,321 |
| Estimated Total of Consumers Served | 128 |
| Target Population Demographics Served | Adult, Older Adult |

Santa Barbara ACT/AOT functions as a multi-disciplinary team; teamwork ensures that the ACT multi-disciplinary staff delivers intensive, continuous, community – based treatment, rehabilitation, and support services to adults with severe and persistent mental illnesses. The ACT/AOT team is comprised of Mental Health Practitioners, Nurses, Case Managers, a Physician's Assistant, an Alcohol and Drug Specialist, and Recovery Assistants.

The team meets each morning to give a clinical report on which clients were seen in the last 24 hours and work together to ensure that all consumers are seen as needed; ACT staff collectively develop a master work schedule for the day's activities with clients. Every day and every week, staff are on duty to guarantee that each client receives the needed services and supports detailed in his or her treatment plan, as well as help in urgent or crisis situations. 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. The daily staff meeting is attended by all ACT team members who are on duty at that time. Santa Barbara ACT/AOT is committed to reducing homelessness, hospitalizations, incarcerations, and focuses on providing all services using a recovery-based, client-centered approach.

**Program Challenges and Solutions**

The SB ACT/AOT team continues to struggle with staffing shortages. As a result, the County entered into an independent consultant evaluation with a firm called KPMG US LLG. They are reviewing the effectiveness of the design of the ACT/AOT by the Department. The team was able to fill a number of positions during the year, but had a number of staff resign during the COVID-19 period. In addition, the program has had turnover in the Manager and Team Supervisor positions. During this past fiscal year, the Team Supervisor moved to another position in the Department and the Manager resigned to re-locate out of state. The Regional Manager, Forensics Manager and Division Chief of Clinical Operations stepped in to share the SB ACT Team Supervisor and Manager duties. Recently a new Manager was hired and recruitment for a Team Supervisor is underway. The staffing vacancies cause existing ACT staff to have higher than typical caseloads and impact the ability for the program to run to true fidelity. Despite the staff shortages the program continues to maintain its stated maximum caseload of 100 clients. Compounding the staffing vacancies, the COVID pandemic caused staff to take time off intermittently due to either testing positive for COVID or being exposed and needing to quarantine. Also due to COVID, all clinics reduced in-clinic staffing to minimum levels to reduce the risk of COVID exposure. The team developed a rotation of staff working in the clinic or telecommuting. For staff who were telecommuting, they continued to meet clients in the field and completed documentation remotely.

The SB ACT team was able to secure a third vehicle. This issue was addressed in previous years challenges as the team only had two county vehicles assigned to it which created difficulties in transporting clients. The team now has three dedicated vehicles. Despite the third vehicle, the team continues to report some difficulty in access to a vehicle when needed to transport clients and/or deliver medications. We are looking at additional options including re-allocating a vehicle from another program that is underutilizing theirs due to increased use of telehealth, or pooling cars from the three programs that are located in the building used by SB ACT/AOT.

**Program Performance (FY 19-20)**

**Assertive Community Treatment (ACT)**

| | Unique Clients Served | | |
|---|---|---|---|
| | North | South | West |
| **Age Group** | | | |
| 0-15 | 0 | 0 | 0 |
| 16-25 | 7 | 3 | 17 |
| 26-59 | 74 | 84 | 68 |

| | | | |
|---|---|---|---|
| 60+ | 30 | 41 | 22 |
| Missing DOB | 0 | 0 | 0 |
| ***Total*** | **111** | **128** | **107** |
| | | | |
| **Gender** | | | |
| Female | 51 | 52 | 60 |
| Male | 60 | 76 | 47 |
| Unknown | 0 | 0 | 0 |
| | | | |
| **Ethnicity** | | | |
| American Indian or Alaska Native | 0 | 2 | 2 |
| Asian | 6 | 1 | 2 |
| Black or African American | 6 | 9 | 9 |
| Mixed Race | 2 | 9 | 0 |
| Native Hawaiian or Pacific Islander | 0 | 0 | 0 |
| White | 95 | 106 | 93 |
| Other/Not Reported | 2 | 1 | 1 |
| | | | |
| **Hispanic or Latino** | | | |
| Hispanic or Latino | 36 | 36 | 40 |
| Not Hispanic or Latino | 75 | 92 | 66 |
| Not Reported | 0 | 0 | 1 |

**Client Outcomes**

| **Milestones of Recovery Scale (MORS) Age: 18+** | | **ACT** | |
|---|---|---|---|
| | | **Initial to 12 months (n = 319)** | **12 to 18 months (n = 298)** |
| **Showed improvement^** | | 31% | 20% |
| **Remained stable^** | | 44% | 57% |
| | **Average per Quarter** | | |
| | **North** | **South** | **West** |
| **Physical Health Hospitalization** | 6% | 5% | 5% |
| **Physical Health Emergency Care** | 13% | 7% | 13% |
| **Stable/Permanent Housing** | 68% | 96% | 93% |
| **Purposeful Activity (employed, school, volunteer)** | 20% | * | 29% |
| **Transferred to Higher Level of Care** | 25% | 23% | 0% |
| **Graduated to Lower Level of Care** | 38% | 22% | 89% |
| | **% during program admission in FY 19-20** | | |
| | **North** | **South** | **West** |
| **Incarcerations** | 4% | 13% | 3% |
| **Crisis Services** | 8% | 10% | 8% |

| Psychiatric Inpatient Care | 6% | 9% | 5% |
|---|---|---|---|

*^"Showed Improvement" and "Remained Stable" reflects the percent of clients whose MORS scores improved or stayed the same between time periods.*
**Data not available during the reporting period.*

In the 2019-2020 fiscal year, clients in ACT had initial, 12-month and 18-month MORS data. In the first year, about than one third of clients improved while almost half stabilized. In the next six months, one-fifth improved while 57% stabilized. Across both time periods about 80% of clients either improved or stabilized.

Most outcomes are tracked and reported quarterly by the program; all data provided except inpatient admissions reflects the average per quarter. Rates of physical health hospitalization were similar in all regions (5-6%). Physical health emergency care was 7% in South County and 13% in both North and West County. Nearly all clients in South and West County had stable housing (93-96%), while about two-thirds of clients in North County had stable/permanent housing. An average of a quarter of clients engaged in purposeful activities in North and West County while this information was not available for South County. During their enrollment in ACT, about a quarter of discharged clients were transferred to a higher level of care, while 22-89% of clients graduated to a lower level of care. Circumstances that comprise the group of clients who did not have a change in level of care at discharge were typically that they discharged because they moved or discontinued their FSP partnership, they transferred to a similar level of care, or were deceased.

The client outcomes table displays the percent of unique clients who experienced a higher level of care during their admission to Assertive Community Treatment in the 19-20 fiscal year. The source of incarceration data is the Santa Barbara Jail and therefore only includes adults; clients were matched from the county electronic health record to the FY 19/20 jail roster. The source of psychiatric inpatient and crisis services data is the electronic health record. Four percent of clients in North County, 13% of clients in South County, and 3% of clients in West County experienced a jail stay during their admission. Eight percent of clients in North County, 10% of clients in South County, and 8% of clients in West County had crisis services contact during their program admission. Six percent of clients in North County, 9% of clients in South County, and 5% of clients in West County experienced hospitalization during their program admission.

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## **AOT Data and Reporting**

The Santa Barbara County Board of Supervisors authorized the court-ordered Assisted Outpatient Treatment (AOT) Pilot Program for individuals with mental illness who meet the criteria established by Laura's Law. The Department of Behavioral Wellness launched the Pilot Program in January of 2017 and hired Harder+Company Community Research to conduct an external evaluation of the early implementation and initial outcomes. This report summarizes cumulative data for the full three years of the Pilot. A total of 138 individuals were referred to the Pilot Program for outreach and engagement services since its inception in January 2017. Even though 20 of these referrals were not opened (12 were received when the program was at capacity, 6 did not meet AOT criteria based on initial screening, and 2 were referred by a non-eligible party), program staff followed up with these individuals to provide information about other community resources available to them and/or ensure they were receiving the care needed. Unless otherwise noted, this report presents findings based on 118 referrals received from January 2017 to December 2019, which includes 8 individuals that have been referred to the Pilot Program more than once.

Following three full years of implementation, the services provided in the Pilot Program show signs of impact in four key areas:

- **Effective system of referrals.** The Pilot Program's intensive outreach and education efforts have built a highly effective referral system. The majority of referrals to the pilot are *appropriate*, meaning that most individuals who are referred are found to meet criteria for program involvement once the individual is located and fully assessed.

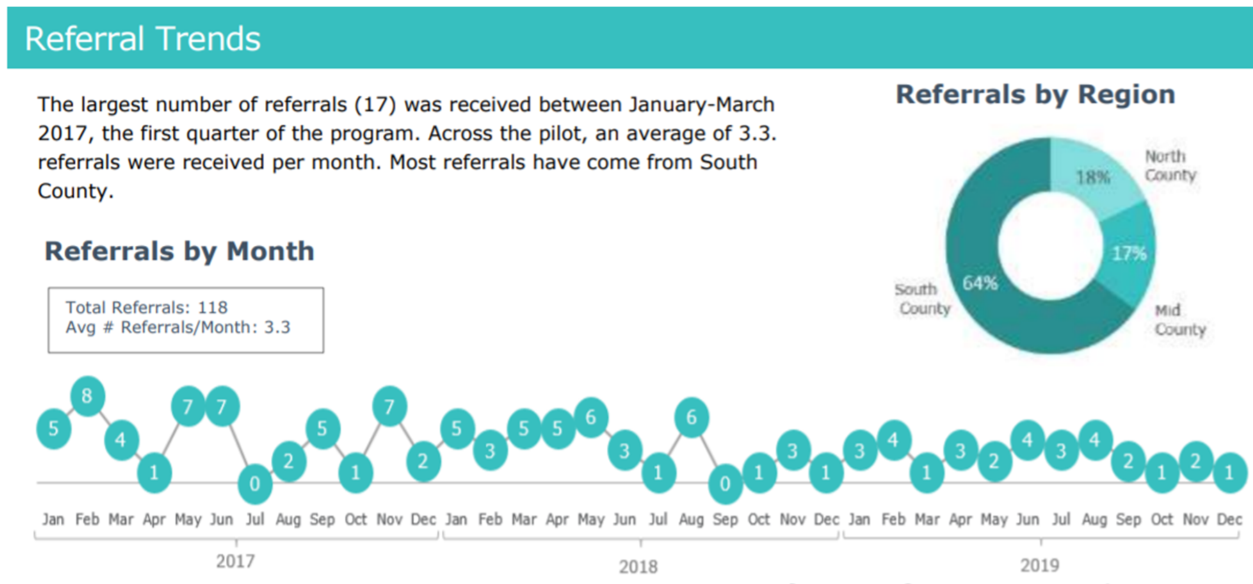
- **Ongoing engagement.** The Pilot Service Team is largely meeting, and often exceeding, the goal of engaging Pilot Program participants three times a week.

- **Supporting voluntary uptake of services.** The Intensive Outreach and Engagement efforts have been highly successful at supporting individuals in voluntarily choosing treatment services. At the end of 2019, 19 individuals had accepted voluntary treatment and only three individuals were court-ordered into treatment through the AOT process. This demonstrates that program staff are able to build relationships with individuals during the Intensive Outreach and Engagement period and successfully support them in choosing to engage in treatment.

- **Reduction in use of crisis calls, crisis services and incarcerations for individuals participating in Intensive Outreach and Engagement services and once connected to treatment.** Although these decreases were not statistically significant once pilot clients were connected to treatment through the IOE or the AOT court mandated process, there is preliminary evidence showing that individuals who received ongoing outreach and support experienced some decreases in crisis calls, crisis services and incarcerations during the engagement period. Community ACT clients experienced statistically significant reductions in use of crisis calls, crisis services and psychiatric hospitalizations after being connected to treatment.

Link to full report prepared by Harder+Co can be found at:
https://www.countyofsb.org/behavioral-wellness/asset.c/6223

**AOT Referral Trends:**




## Supported Community Services FSP Summary

Individuals enroll in a voluntary program that provides a broad range of supports to accelerate their recovery. FSP includes a "whatever-it-takes" commitment to progress on concrete recovery goals. Serves clients that meet System Development (SD) criteria AND are un- or underserved and at risk of homelessness, incarceration, or hospitalization.

### Supported Community Services South - (Santa Barbara) – PathPoint

| **Provider:** | **PathPoint** |
|---|---|
| **Estimated Funding FY 2021/22:** | |
| Estimated Total Mental Health Expenditures | $1,195,100 |
| Estimated CSS Funding | $ 428,900 |
| Estimated Medi-Cal FFP | $ 766,200 |
| Estimated 1991 Realignment | |
| Estimated Behavioral Health Subaccount | |
| Estimated Other Funding | |
| Average Cost Per Consumer | $9,122 |
| Estimated Total of Consumers Served | 131 |
| Target Population Demographics Served | TAY, Adult, Older Adult |

Pathpoint connects with clients in the Southern region of Santa Barbara County at various housing locations through the supportive services mental health model. PathPoint also provides Residential Support Services (RSS). RSS provides mental health case management services to residents of the El Carrillo, Artisan Court, and Bradley Studios apartments in Santa Barbara. They provide treatment, rehabilitative and supportive

services with the goal of helping clients obtain and maintain independent living. PathPoint also provides housing and supports at 2 Adult residential facilities, Phoenix and Mountain Houses.

**Program Challenges and Solutions**

Through a competitive process in winter of 2021, PathPoint was selected as the program provider. PathPoint continues to focus on creating flow (transitioning clients who are ready for a lower level of care). This focus, and increased communication between the other programs (Outpatient clinics, ACT, Crisis, etc.) led to an improvement in the program's ability to accept referrals into their program without having to wait until another staff person is hired. This has been identified as an issue by the programs in the past, so this is good to see and assists the entire system of care in meeting the needs of clients. This shift has also led to the staff working more closely with clients on opportunities to graduate down to a lower level of care, including to community-based services, utilizing warm handoffs throughout all transitions. The Department and Pathpoint continue to work together to ensure treatment plans and assessments accompany clients who are admitted to PathPoint to allow PathPoint to adequately document and bill for services provided.

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

| **Provider:** | **Transitions Mental Health Association** |
|---|---|
| **Estimated Funding FY 2021/22:** | |
| Estimated Total Mental Health Expenditures | $1,132,400 |
| Estimated CSS Funding | $ 525,100 |
| Estimated Medi-Cal FFP | $ 607,300 |
| Estimated 1991 Realignment | |
| Estimated Behavioral Health Subaccount | |
| Estimated Other Funding | $0,000 |
| Average Cost Per Consumer | $11,324 |
| Estimated Total of Consumers Served | 100 |
| Target Population Demographics Served | TAY, Adult, Older Adult |

Transitions was awarded a three-year contract, which began in July 2021, through a competitive process, instead of putting that in the challenges section below. Santa Maria Supported Community Services provides outpatient mental health treatment for TAY, 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. During recent years, the 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. 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.

**Program Challenges and Solutions**

An inevitable challenge for a program that continues to increase in scope and size is the need for more adequate office space. The program is currently housed in cramped quarters with a lack of private meeting space and innovative options have been reviewed and enhanced funding for new equipment was created in 2021-22 as a result of the Request for Proposal that Transitions was awarded for the upcoming three years starting July 2021.

Hiring and coordination are key focuses in the upcoming year. Hiring new clinicians is particularly challenging, as market pay and restrictions precluding the credentialing of staff with a secondary number have narrowed hiring options in the region. Staff has identified a growing need to develop a better working relationship with Santa Barbara County Mobile Crisis for 5151 evaluations. Improved communication would increase the efficiency and effectiveness of services being delivered by both Supportive Services and Mobile Crisis.

**Program Performance (FY 19-20)**

**Supportive Community Services (*formerly Supported Housing*)**

| | Unique Clients Served | |
|---|---|---|
| | **North** | **South** |
| **Age Group** | | |
| 0-15 | 0 | 0 |
| 16-25 | 3 | 0 |
| 26-59 | 64 | 81 |
| 60+ | 33 | 50 |
| Missing DOB | 0 | 0 |
| ***Total*** | **100** | **131** |
| | | |
| **Gender** | | |
| Female | 48 | 59 |
| Male | 52 | 72 |
| Unknown | 0 | 0 |
| | | |
| **Ethnicity** | | |
| American Indian or Alaska Native | 0 | 1 |
| Asian | 9 | 3 |
| Black or African American | 6 | 9 |
| Mixed Race | 1 | 6 |
| Native Hawaiian or Pacific Islander | 0 | 1 |
| White | 81 | 108 |
| Other/Not Reported | 3 | 3 |
| | | |
| **Hispanic or Latino** | | |
| Hispanic or Latino | 44 | 19 |
| Not Hispanic or Latino | 55 | 112 |
| Not Reported | 1 | 0 |

**Client Outcomes**

| **Milestones of Recovery Scale (MORS) Age: 18+** | | |
|---|---|---|
| | **Initial to 12 months (n = 224)** | **12 to 18 months (n = 216)** |
| **Showed improvement^** | 33% | 16% |
| **Remained stable^** | 48% | 63% |
| | **Average per Quarter** | |
| | **North** | **South** |
| **Physical Health Hospitalization** | 5% | 7% |
| **Physical Health Emergency Care** | 13% | 11% |
| **Stable/Permanent Housing** | 93% | 93% |
| **Purposeful Activity (employed, school, volunteer)** | 29% | 31% |
| **Transferred to Higher Level of Care** | 0% | 17% |
| **Graduated to Lower Level of Care** | 89% | 29% |
| | **% during program admission in FY 19-20** | |
| | **North** | **South** |
| **Incarcerations** | 2% | 2% |
| **Crisis Services** | 4% | 5% |
| **Psychiatric Inpatient Care** | 2% | 4% |

*^"Showed Improvement" and "Remained Stable" reflects the percent of clients whose MORS scores improved or stayed the same between time periods. *This metric was not available during the reporting period.*

In the 2019-2020 fiscal year, client progress in Supportive Community Services (SCS) were compared using initial, 12-month and 18-month MORS data. Similar to last year, twice as many clients showed improvement in the first year than in the following six months, and it appears that these clients then stabilized after a year. In fact, half of clients in the first year were stable and two-thirds stabilized from 12-18 months, suggesting that program longevity is particularly important in stabilizing clients' mental health.

Most outcomes are tracked and reported quarterly by the program; all data provided except inpatient admissions reflects the average per quarter. Clients in North and South County experienced similar levels of physical health hospitalization (5-7%) and physical health emergency care (11-13%). Housing stability was also similar for clients in North and South County and the vast majority experienced stability (93% for both regions). A little less than a third of clients were engaged in purposeful activity (29% in North County; 31% in South County). During their enrollment in SCS, few discharged clients had to be transferred to a higher level of care (0% in North County and 17% in South County). The majority of clients in North County graduated to lower levels of care while about one-third in South County graduated to a lower level of care.

The client outcomes table displays the percent of unique clients who experienced a higher level of care during their admission to Supportive Community Services in the 19-20 fiscal year. The source of incarceration data is the Santa Barbara Jail and therefore only includes adults; clients were matched from the county electronic health record to the FY 19/20 jail roster. The source of psychiatric inpatient and crisis services data is the electronic health record. Two percent of clients in North County and 2% of clients in South County experienced a jail stay during their admission. Four percent of clients in North County and 5% of clients in South

County had crisis services contact during their program admission. Two percent of clients in North County and 4% of clients in South County experienced hospitalization during their program admission.

## SPIRIT FSP Wraparound Services

| **Provider:** | **Behavioral Wellness, CALM, Casa Pacifica** |
|---|---|
| **Estimated Funding FY 2021/22:** | |
| Estimated Total Mental Health Expenditures | $2,609,200 |
| Estimated CSS Funding | $1,519,500 |
| Estimated Medi-Cal FFP | $1,054,700 |
| Estimated 1991 Realignment | |
| Estimated Behavioral Health Subaccount | |
| Estimated Other Funding | $ 35,000 |
| Average Cost Per Consumer | $36,749 |
| Estimated Total of Consumers Served | 71 |
| Target Population Demographics Served | Children, TAY |

The SPIRIT Full Service Partnership (FSP) wraparound program for children ages 6-15 and their families is an evidenced-based, intensive treatment model designed around the following MHSA core principles: children and family involvement and empowerment, culturally competent and appropriate services, integration into existing systems, increasing informal supports, collaboration and partnership and wellness and recovery. The SPIRIT program operates in all three regions of the County as a specialized team that provides intensive, high frequency services to a disenfranchised, underserved population of children and families that have limited resources, have failed to thrive with conventional treatment, and whose children are at risk for placement in out-of-county, high-level group home facilities due to emotional and behavioral issues.

The SPIRIT team strives to implement specialty mental health services within the home and/or community with a 'whatever its takes' approach to the delivery of treatment focusing on outreach and engagement, development of attainable treatment plan goals and promoting stabilization to prevent hospitalization. Children 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 Case Worker. The SPIRIT team serves children at a 1:15 ratio to ensure that care is available 24/7 with on-call support to clients and families both afterhours and on weekends. SPIRIT children are typically also being served by a Psychiatric Technician and/or Registered Nurse and Psychiatrist through the Behavioral Wellness Children's Clinic. Together they provide a comprehensive, multidisciplinary team offering an array of intensive services to prevent decompensation.

**Program Challenges and Solutions**

The SPIRIT team services are designed to provide high-frequency, intensive services within the home and/or community to both the child and family members, in which regular attempts to outreach is critical to engage the most resistant and high-needs children and families. The Department has operationalized and standardized level-of care tools to ensure that the children with the highest needs are served through the SPIRIT program and are regularly reassessed to determine when they are prepared to transition or step-down to a lower level-of-care as they become stabilized. Secondly, it is not uncommon for SPIRIT children and families to have

limited resources and complex socio-economic barriers, thus at times they struggle with transitioning out of SPIRIT's intensive, supportive 24/7 wraparound care. Resolutions to these problems have included expanded collaboration with community based organizational partners, community resources, school teams, and informal supports, in order to assist families in transitioning to a lower level-of-care as their circumstances improve.

Since July 2019, Behavioral Wellness implemented an enhanced staffing structure for the SPIRIT program, in which the Parent Partner is employed by CALM (a community-based organization) and is taking a lead role in engaging parents/caregivers, providing urgent parent response and de-escalation to sustain families, while further promoting that parents collaborate with their children's school teams. Additionally, the changes in the SPIRIT team structure offer increased support outside regular business hours to ensure that parent partners can offer extensive assistance as in alignment with wraparound program model ideals.

During the COVID-19 pandemic CALM continued to provide uninterrupted mental health services to our SPIRIT families. These services were largely provided via telehealth platforms to ensure the safety and well-being of clients and staff. When clinically indicated, services were also provided in-person while following all safety guidelines such as the use of masks and social distancing. CALM began the transition back to in-person service continues to monitor based on pandemic requirements. The program looks forward to maintaining the ability to continue to provide services via tele-health whenever that is clinically indicated.

**Program Performance (FY 19-20)**

**SPIRIT**

| | **Unique Clients Served** | | |
|---|---|---|---|
| | **North** | **South** | **West** |
| **Age Group** | | | |
| 0-15 | 16 | 16 | 28 |
| 16-25 | 2 | 8 | 2 |
| 26-59 | 0 | 0 | 0 |
| 60+ | 0 | 0 | 0 |
| Missing DOB | 1 | 0 | 0 |
| ***Total*** | **19** | **24** | **28** |
| | | | |
| **Gender** | | | |
| Female | 7 | 14 | 12 |
| Male | 12 | 10 | 18 |
| Unknown | 0 | 0 | 0 |
| | | | |
| **Ethnicity** | | | |
| American Indian or Alaska Native | 0 | 0 | 1 |
| Asian | 0 | 0 | 0 |
| Black or African American | 0 | 1 | 1 |
| Mixed Race | 0 | 2 | 0 |
| Native Hawaiian or Pacific Islander | 0 | 0 | 0 |
| White | 18 | 19 | 26 |
| Other/Not Reported | 1 | 2 | 2 |

| | | | |
|---|---|---|---|
| **Hispanic or Latino** | | | |
| Hispanic or Latino | 15 | 15 | 19 |
| Not Hispanic or Latino | 3 | 6 | 8 |
| Not Reported | 1 | 3 | 3 |

**Client Outcomes**

| **Child & Adolescent Needs & Strengths Assessment (CANS-50) Age: 6-20 years** | **Percent Improvement*** | |
|---|---|---|
| | **Initial to 6 months (n = 9)** | **6 to 12 months (n = 4)** |
| **Life Functioning** (e.g., ability to communicate and interact with families, communication, social functioning and health status) | - 8.0% | - 43.5% |
| **Behavioral/Emotional Needs** (e.g., symptoms of depression, anxiety, psychosis and other conditions) | - 11.1% | - 62.5% |
| **Risk Behaviors** (e.g., self-injury, suicidal behavior, bullying, and running away) | - 66.7% | - 100.0% |
| **Cultural Factors** (e.g., language, traditions, stress) | 0.0% | - 100.0% |
| **Strengths** (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment) | 16.1% | - 55.6% |
| | **Average per quarter** | |
| | **All Regions** | |
| **Juvenile Hall** | 3% | |
| **Out-of-Home Placement** | 3% | |
| **Purposeful Activity (employed, school, volunteer)** | 96% | |
| **Stable/Permanent Housing** | 99% | |
| | **% during program admission in FY 19-20** | |
| | **All Regions** | |
| **Juvenile Hall** | -- | |
| **Crisis Services** | 16% | |
| **Psychiatric Inpatient Care** | 3% | |

**Note.* On the CANS-50, a higher the score indicates more actionable needs (greater problems). A negative percent change indicates that client scores are improving because they have fewer actionable needs.

Due to a state mandated change, Santa Barbara County began using a new version of the CANS (CANS-50) in July 2018. In addition to changing items and domains, the CANS age range was extended to age 20. This means that more TAY-aged clients now receive a CANS. *Cultural Factors* is a new 3-item domain. We did not present *Caregiver Resources and Needs* for these analyses because caregivers that are entered in the Caregiver A section often change across timepoints and are not currently tracked to allow for a matched comparison.

Clients in SPIRIT saw reductions in the number of actionable needs across all CANS domains with the exception of the *Strengths* domain from intake to six months (n = 9). While transitional age youth saw a reduction in actionable needs in both time period comparisons, the group of clients that had a CANS administered at six and twelve months (n = 4) saw greater reductions in their number of actionable needs than the larger group seen from intake to six months.

Most outcomes are tracked and reported quarterly by the program; all data provided except inpatient admissions reflects the average per quarter. In the 2019-2020 fiscal year, clients in the SPIRIT Program had quite positive outcomes. Nearly all SPIRIT clients experienced residential stability (99%) and were engaged in purposeful activity (96%). A quarterly average of 3% experienced out of home placement and 3% experienced juvenile hall stays.

The client outcomes table displays the percent of unique clients who experienced a higher level of care during their admission to SPIRIT in the 19-20 fiscal year. Juvenile hall data were unavailable this year and we are unable to report on these metrics. The source of psychiatric inpatient and crisis services data is the electronic health record. Across all regions, 16% of SPIRIT clients had crisis services contact during their program admission and 3% of SPIRIT clients experienced hospitalization.

## Forensic FSP Justice Alliance

| **Provider:** | **Behavioral Wellness, Good Samaritan** |
|---|---|
| **Estimated Funding FY 2021/22:** | |
| Estimated Total Mental Health Expenditures | $2,118,100 |
| Estimated CSS Funding | $1,812,100 |
| Estimated Medi-Cal FFP | $ 306,000 |
| Estimated 1991 Realignment | |
| Estimated Behavioral Health Subaccount | |
| Estimated Other Funding | |
| Average Cost Per Consumer | $13,405 |
| Estimated Total of Consumers Served | 158 |
| Target Population Demographics Served | TAY, Adult, Older Adult |

The Justice Alliance countywide program is a time-limited, outreach and engagement, specialized Full-Service Partnership (FSP) program that seeks to provide transitional, supportive services and linkage to individuals with mental health needs, who are criminal justice-involved. The Justice Alliance program was designed to remove barriers to accessing treatment, while assisting individuals with navigating both the criminal justice and behavioral health systems. The Justice Alliance team provides services that promote stabilization, reintegration in the community and reduced recidivism with the goal of linking them to longer-term care, such as the Assertive Community Treatment (ACT) program or an outpatient clinic. The individuals served often have co-occurring substance abuse disorders. Many of the individuals assessed are underserved or unserved members of ethnically diverse populations in need of integrated, customized, mental health and/or substance abuse treatment.

Justice Alliance team members work closely with a variety of forensic partners to include the Court, Probation, Public Defender, Sheriff, District Attorney, Community-Based Organizations and other Department of Behavioral Wellness treatment teams to make treatment recommendations, facilitate access and linkage to treatment. Justice Alliance also provides ongoing progress reports to the Court supporting client’s reintegration with the goal being to prevent recidivism, reincarceration and decompensation. Justice Alliance practitioners are responsible for the initial assessments to determine the client’s level-of-care need and ensure a warm hand-off to the most appropriate long-term mental health and/or substance abuse treatment program(s) in the community.

In addition, Justice Alliance psychologists provide competency restoration services to misdemeanants found to be Incompetent to Stand Trial (IST) in both the inpatient Psychiatric Hospital Facility (PHF), Crisis Residential Treatment (CRT) and board and care placement settings. When providing restoration services, the team utilizes various residential resources such board and care facilities and crisis residential treatment programs.

**Program Challenges and Solutions**

Justice Alliance has had a mix of staffing additions including extra help case managers and administrative office professionals in the past few years. This has freed up time for Practitioners and Psychologists to be engaged in assessments, evaluations for the court and linkage to services although hiring psychologists who can do forensic assessments is an upcoming goal with a request for proposal in FY 2021-22.

In early 2020, the County approved a contract with the Department of State Hospitals (DSH) to divert felony ISTs (per AB1810) to community-based mental health care in lieu of going to a state hospital or being further incarcerated. The DSH contract funded 2 full-time Case Workers in the north and south county regions to serve the AB1810 DSH-selected clients (the contracted census includes 6 clients per year for 3 years). The program continues to require an additional .50 EXH Case Worker for the north county as the diversion referrals and IST continue to rise and this grant program leverages the justice alliance programming and step-down housing with other justice related grant activities. In the upcoming year, an analysis is being prepared by Social Finance, an outside evaluator, in collaboration with Behavioral Wellness, the Sheriff's Department, and other county partners to review impacts of co-response and other activities on the safety services system. These grant projects and evaluations will help determine the ongoing sustainability plan for the Justice Alliance FSP.

**Program Performance (FY 19-20)**

**Justice Alliance**

| | Unique Clients Served | | |
|---|---|---|---|
| | **North** | **South** | **West** |
| **Age Group** | | | |
| 0-15 | 0 | 0 | 0 |
| 16-25 | 19 | 6 | 1 |
| 26-59 | 37 | 74 | 4 |
| 60+ | 5 | 11 | 1 |
| Missing DOB | 0 | 0 | 0 |
| ***Total*** | ***61*** | ***91*** | ***6*** |
| | | | |
| **Gender** | | | |
| Female | 11 | 16 | 1 |
| Male | 50 | 75 | 5 |
| Unknown | 0 | 0 | 0 |
| | | | |
| **Ethnicity** | | | |
| American Indian or Alaska Native | 0 | 6 | 0 |
| Asian | 3 | 0 | 0 |
| Black or African American | 3 | 4 | 0 |
| Mixed Race | 7 | 21 | 0 |
| Native Hawaiian or Pacific Islander | 0 | 1 | 0 |

| | | | |
|---|---|---|---|
| White | 46 | 58 | 6 |
| Other/Not Reported | 2 | 1 | 0 |
| | | | |
| **Hispanic or Latino** | | | |
| Hispanic or Latino | 41 | 30 | 3 |
| Not Hispanic or Latino | 20 | 59 | 3 |
| Not Reported | 0 | 2 | 0 |

**Client Outcomes**

| **Milestones of Recovery Scale (MORS) Age: 18+** | | | |
|---|---|---|---|
| | | **Initial to 6 months (n = 89)** | **6 to 12 Months (n = 78)** |
| **Showed improvement^** | | 40% | 28% |
| **Remained stable^** | | 26% | 50% |
| | **% during program admission in FY 19-20** | | |
| | **North** | **South** | **West** |
| **Incarcerations** | 21% | 29% | 11% |
| **Crisis Services** | 21% | 6% | 38% |
| **Psychiatric Inpatient Care** | 7% | 7% | 17% |

^"Showed Improvement" and "Remained Stable" reflects the percent of clients whose MORS scores improved or stayed the same between time period.

In the 2019-2020 fiscal year, clients in the Justice Alliance had initial, 6-month and 12-month MORS data. Over the first six months, two-thirds were either stable or made improvements; over the second six months, over three-quarters were either stable or made improvements. Similar to patterns in other programs, more clients improved in the first six months (40% improved and 26% stabilized), while in the latter six months more clients stabilized (28% improved while 50% stabilized).

The client outcomes table displays the percent of unique clients who experienced a higher level of care during their admission to Justice Alliance in the 19-20 fiscal year. The source of incarceration data is the Santa Barbara Jail and therefore only includes adults; clients were matched from the county electronic health record to the FY 19/20 jail roster. The source of psychiatric inpatient and crisis services data is the electronic health record. Twenty-one percent of clients in North County, 29% of clients in South County, and 11% of clients in West County experienced a jail stay during their admission. These high percentages make sense in light of the work that Justice Alliance staff do; both because the target population is justice-involved and because the staff work with clients in the jail. Twenty-one percent of clients in North County, 6% of clients in South County, and 38% of clients in West County had crisis services contact during their program admission. Seven percent of clients in North County, 7% of clients in South County, and 17% of clients in West County experienced hospitalization during their program admission. These relatively high psychiatric hospitalization rates make sense as clients served by Justice Alliance are often transitioning from hospitalization to the community to be restored to competency, and may even begin services with Justice Alliance staff prior to their release from the hospital. In particular, clients who are deemed Incompetent to Stand Trial (IST) are typically unable to

consent to treatment in the community and may require extended inpatient services prior to outpatient services. Note that West County percentages are also impacted by the low number of clients open in that region.

## Crisis Stabilization Unit (CSU) South and North

The North location is NEW in MHSA in 2022, anticipated opening winter 2021 with other funds.

| **Provider:** | **Behavioral Wellness; New unit in Santa Maria with Dignity Health in FY 2021-22, utilitizing MHSA Funding in FY 2022-23** |
|---|---|
| **Estimated Funding FY 2021/22:** | |
| Estimated Total Mental Health Expenditures | $3,660,900 (budget in FY 2021/22 only reflects South Unit) |
| Estimated CSS Funding | $ 60,600 |
| Estimated Medi-Cal FFP | $1,841,000 |
| Estimated 1991 Realignment | |
| Estimated Behavioral Health Subaccount | |
| Estimated Other Funding | $1,759,300 |
| Average Cost Per Consumer | $10,197 |
| Estimated Total of Consumers Served | 359 |
| Target Population Demographics Served | TAY, Adult, Older Adult |

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 for infrastructure. 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, a 24-hour on-call Psychiatrist who conducts on-site rounds morning and evening, Practitioners and peers. 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.

**Program Challenges and Solutions**

The CSU continues to struggle with adequate referrals and utilization of beds. Law Enforcement drop-offs that were instituted helped initially but has since decreased. The CSU did see increased usage with the addition of the CREDO 47 Stabilization Center and assisting in screening for CREDO47 as the center is located in the Crisis Hub of South County.

The biggest challenges this year have been related to the COVID Pandemic. In the initial phases of the Pandemic, and in an effort to keep the unit safe, operational and minimize the risk of COVID exposure the CSU made required physical changes to the unit (plexi-glass barriers, 6ft spacing signage posted, etc.) as well as COVID screening for all people entering the CSU. Public Health required weekly COVID testing/tracking/reporting of all staff. And the CSU began COVID testing direct referrals to avoid the need of an emergency room

(ER) visit. As ER's began to fill to capacity, the CSU agreed to admit individuals on 5150 holds on a limited basis, mostly for individuals on grave disability holds that were not a danger to themselves or the public.

Staffing issues related to the pandemic were also a challenge. The greatest staffing challenges occurred at our Psychiatric Health Facility which saw frequent staff shortages due to COVID related absences. In order to keep the PHF open at all costs, we began floating staff from our CSU to the PHF so it could maintain minimum staffing levels. This floating of staff in turn caused the CSU to need to close at times. In order to keep the CSU open even when floating the majority of their staff to the PHF, the department quickly trained all available outpatient nursing staff and Peer Recovery Assistants to work at the CSU. As CSU staff were pulled to the PHF to cover vacancies there, outpatient staff were pulled from their duties in the clinics and assigned to the CSU so CSU could remain open. Hopefully, in the upcoming year as COVID impacts are reduced, operations will be at full capacity.

Additionally, MHSA will be funding a new Crisis Stabilization Unit with Dignity Health at Marian Hospital in Santa Maria beginning in FY 2022-23. The new CSU anticipates opening late 2021 as a three-year pilot with initial funding from Medi-Cal and General Funds for the first year and MHSA and Medi-Cal in years two and three. This was an initiative as a result of ongoing feedback regarding Hospital Innovations in the MHSA Stakeholder Process, and described in the plan under Innovations.

***<u>Opportunities of creating CSUs for improvement of current barriers and challenges:</u>***

**South County CSU**

In January 2016 the Department opened the County's first CSU in South Santa Barbara County. The County CSU was partly funded through Senate Bill 82. Senate Bill 82 "Investment in Mental Wellness" was a State grant that financed the development of CSUs across California. Santa Barbara County was awarded $1,500,000 which provided rehabilitation of a County owned building for the South County CSU. The actual cost of renovations totaled $499,644, and the balance of funds was reallocated to purchase and rehabilitate a Crisis Residential Treatment facility in Santa Maria.

**Need for North County CSU**

In order to reduce the length of time Clients in a psychiatric emergency or mental health crisis who present at Marian's Emergency Department (ED) remain in the ED, and provide timely mental health crisis stabilization services, Marian will medically clear and transfer these Clients to its newly constructed 8 bed CSU for crisis stabilization services lasting less than 24 hours, in accordance with C.C.R., Title 9, Section 1810.210. Marian will be subcontracting out performance of direct services to Clients and also management of the CSU. Marian will be fully responsible for all services performed by its subcontractor. Marian funded the construction of the CSU.

Additionally, this proposed agreement is for three years in order to evaluate the program's effectiveness and impact on the overall system of care. As a pilot program, the program goals are aligned with the Mental Health Services Act (MHSA) as the program will be monitored and reported on to stakeholders as part of the MHSA 2020-2023 Three Year Plan and Yearly Updates. If MHSA growth funds are available, the program will be sustained by MHSA funds and Medi-Cal reimbursements in subsequent years.

The maximum contract amount was established based on a 1.6 County Medi-Cal Client census per service day totaling $1,600,000 per year. It is estimated that the maximum contract amount will be funded equally from Medi-Cal reimbursements and County matching funds. The census estimates were provided by Marian during

the development process. Marian's CSU has capacity to serve 8 patients. Marian will also be accepting privately insured patients in addition to County Clients.

**Program Goals of the North CSU**

*The goals of the Program are to*:

-  Increase Clients' access to mental health crisis stabilization services by providing timely access to such services;
-  Improve the efficacy and integration of medical and mental health crisis services;
-  Reduce Marian's ED length of stay for Clients requiring mental health crisis stabilization;
-  Reduce unnecessary psychiatric hospitalizations;
-  Provide rapid treatment and resolve mental health crisis in the least restrictive setting;
-  Reduce use of more restrictive measures for treatment for Clients undergoing mental health crisis;
-  Ensure services are individualized, person-centered, recovery-based, and trauma informed in order to build upon strengths and promote stabilization in the community;
-  Improve Clients' level of functioning and refer them to an appropriate community resource for Clients returning to the community; and
-  Increase coordination to continuity of care plan for Client linkage to mental health and alcohol and drug treatment services.

**Five-Year Project Development**

The proposed Marian CSU agreement is the result of ongoing discussions between the County and Marian since approximately 2016. In 2021, a program implementation team comprised of Marian representatives (CEO, ED physician, hospital administrator and legal counsel) and County staff (Assistant CEO, BWELL's Director and Assistant Directors, CFO, Contract Manager and program staff subject matter experts, along with County Counsel) was established to work out the details of establishing a North County CSU through Marian. This workgroup met regularly to develop the agreement. During that process, staff conducted extensive reviews of regulations, policies and procedures utilized in other similar units in the State, and information provided by Department of Health Care Services and the California Behavioral Health Director's Association.

**Medi-Cal Site Certification**

Per CCR Title 9 Section 1810.435, the Mental Health Plan (MHP) must certify that a provider other than the MHP meets the criteria set forth in the regulations governing Specialty Mental Health Services. This site certification to be completed by BWELL staff includes verification of a County contract, verification of a valid fire clearance, verification that the head of service is a licensed mental health professional, and an on-site visit which occurred on April 22, 2021. The on-site review consisted of ensuring that the facility is clean, sanitary, and in good repair; that safety policies and procedures are in place; that the client records meet the requirements of all applicable state and federal standards; that medications are stored and dispensed according to all state and federal standards; and that patient's rights are being accommodated.

Because Marian will be subcontracting out performance of direct services to Clients and also management of the CSU, the site certification will not be completed until the subcontracts receive the County's, through the Director of BWELL's, written consent.

The information collected prior to and during the site visit will be submitted to DHCS for approval. Following the initial site certification, BWELL will complete an additional annual site visit to ensure that all policies, procedures, and regulations are being followed and that Medi-Cal site certification can be maintained. Thereafter, Medi-Cal recertification occurs every two years and follows the same procedure as the initial site certification. The Department looks forward to the opportunity of offering CSU services in North County.

**Program Performance (FY 19-20)**

**Crisis Stabilization Unit (CSU)**

| **Unique Clients Served** | |
|---|---|
| | **CSU** |
| | **South** |
| **Age Group** | |
| 0-15 | 1 |
| 16-25 | 46 |
| 26-59 | 266 |
| 60+ | 46 |
| Missing DOB | 0 |
| ***Total*** | ***359*** |
| | |
| **Gender** | |
| Female | 138 |
| Male | 221 |
| Unknown | 0 |
| | |
| **Race/Ethnicity** | |
| American Indian or Alaska Native | 7 |
| Asian | 12 |
| Black or African American | 21 |
| Mixed Race | 43 |
| Native Hawaiian or Pacific Islander | 0 |
| White | 274 |
| Other/Not Reported | 2 |
| | |
| **Hispanic or Latino** | |
| Hispanic or Latino | 106 |
| Not Hispanic or Latino | 253 |
| Not Reported | 0 |

### Client Outcomes

To evaluate CSU Program utilization, admissions and discharge data was obtained from the CSU. Note that the total admissions in the table below is 471; this is a duplicated count of all admissions so it is not expected to match the unique count displayed above in the demographics table.

| CSU Admissions and discharges (N = 471) | Admission | Discharge |
|---|---|---|
| Hospital/Residential Treatment | 48.4% | 6.4% |

| Crisis Services | 20.2% | 0.0% |
|---|---|---|
| Outpatient | 14.2% | 0.6% |
| Justice | 14.2% | 0.4% |
| Shelter, Supported/Sober Living, Board and Care | 0.8% | 17.6% |
| Self / Home | 0.8% | 46.3% |
| CRT | 0.0% | 26.1% |
| CREDO47 Center | 1.3% | 2.5% |

Half of clients served by the CSU were referred by hospitals (48%). The next largest group was referred by crisis services and outpatient (34% combined). Upon discharge from the CSU, a quarter of clients were admitted to a CRT (26%). Some clients were discharged to home or "self" because they did not meet 5150 criteria to hold, but did not want linkage to another program (self; 46%). Many clients were also discharged to sober living, board and care, or other supported living environment or shelter (18%). Only 6% of clients were discharged to the hospital or a residential treatment facility, suggesting that clients from the CSU are typically stepping down in terms of service intensity.

| **Higher Level of Care** | **% with any admissions** | | | |
|---|---|---|---|---|
| | within 24 hours of discharge | within 7 days of discharge | within 15 days of discharge | within 30 days of discharge |
| **Psychiatric Inpatient Care** | 0.4% | 4.5% | 6.4% | 7.6% |

**Psychiatric Hospitalizations**

The client outcomes table displays the percent of clients who experienced an inpatient psychiatric hospitalization within 1, 7, 15, and 30 days following their admission to the CSU in the 19-20 fiscal year. Over the first month following a CSU stay, hospitalization rates rose incrementally as would be expected, though overall the CSU was effective in helping clients avoid inpatient treatment.

## 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 initially received approximately $11 million in S.B. 82 funding. This funding supported the Mobile Crisis West team in Lompoc. It also funded construction/renovation costs for a Crisis Stabilization Unit in Santa Barbara, and the Crisis Residential Facility in Santa Barbara. In addition, S.B. 82 funded construction and renovation for the Crisis Residential Facility in Santa Maria at Agnes which was completed in fall of 2019.

A description of the enhanced crisis services made possible by S.B. 82 funding is included in this Plan update because all of the Department's 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 (SOCR) includes the following components:

- Mobile Crisis Services West Team (funded by SB 82) through January 2020; now in Crisis Services CSS
- Crisis Stabilization Unit Santa Barbara (funded by SB 82), funded in CSS now
- Crisis Stabilization Unit Santa Maria (New, will be funded by CSS or other MHSA funds in FY 2022-23)
- Crisis Residential Facility Santa Barbara and Santa Maria Agnes (funded by SB 82), funded in CSS now
- North Crisis Residential Facility (funded by MHSA CSS)
- Access and Assessment teams, Santa Maria, Lompoc, Santa Barbara (funded by MHSA PEI)
- Children's Crisis Triage (funded by Children's Crisis Triage Grant with SB82, extended additional year to FY 2022-23)

If a Program is covered elsewhere in the Plan Update, there is a reference to the area of the Plan Update where you can attain more details as most SB82 programs were sustained and operational within ongoing MHSA funding.

## Children's Crisis Triage Program

| **Provider:** | **Behavioral Wellness** |
|---|---|
| **Estimated Funding FY 2021/22:** | |
| Estimated Total Mental Health Expenditures | $ 534,000 |
| Estimated CSS Funding | |
| Estimated Medi-Cal FFP | $ 214,500 |
| Estimated 1991 Realignment | |
| Estimated Behavioral Health Subaccount | |
| Estimated Other Funding | $ 319,500 |
| Average Cost Per Consumer | $7,628 |
| Estimated Total of Consumers Served | 70 per year (per grant) |
| Target Population Demographics Served | Children and TAY (Age 21 and under per grant) |

The Children's Crisis Triage Program (CCTP) was awarded in the Spring of 2018 by a Mental Health Services Oversight and Accountability Commission (MHSOAC) grant. This grant funds two full time licensed Practitioners for three years. Two half-time Peer Parent Partner (PPP) positions are funded with Medi-Cal and MHSA funds. The Practitioner and PPPs work as a team to respond to children/adolescents (up to age 21) who are experiencing a mental health crisis in the community. The teams may respond to the home, school or hospitals to assess for 5585/5150 criteria, write holds if indicated or deescalate the situation and provide safety planning and link to ongoing mental health services.

The CCTP Teams also plays a vital role in the emergency departments (ED) when there are children/adolescents in the ED's on psychiatric holds awaiting placement in an inpatient psychiatric facility. The Practitioner will work closely with the youth to provide crisis intervention, short-term therapy services aimed at helping the youth develop coping skills, and hopefully resolve the crisis so that the hold can be rescinded and the child returned to the community with an extensive safety plan and therefore avoid an inpatient psychiatric hospitalization. The PPPs focus services on the parent/care giver using a peer wellness model. They also assist

the parent/care giver with skill building, behavioral interventions, encourage parent involvement and engagement in services, resources and referrals all aimed at developing a home environment that will prevent recurrent crisis situations and support the youth in returning home.

**Program Challenges and Solutions**

The upcoming goals of the CCTP include:

- Providing assessment to 70 youth clients presenting at the EDs annually in program years 1, 2, and 3.
- Providing on-going reassessments of youth in the ED on 5150/5585 holds of 80% of youth presenting at the ED in program years 1, 2, and 3.
- Reducing the number of unnecessary hospitalizations of youth presenting at EDs in a psychiatric emergency by 20% in the first program year and an additional 10% in year 2 and 10% in year 3.
- Improving care coordination so that clients receive service within 24 hours of discharge 85% of the time and coordinate and schedule the first appointment at the clinic for a client within 7 days of discharge 95% of the time.
- Obtain a client satisfaction rating of 8 or higher on a 10-point scale with 1 representing the worst possible care and 10 representing the best possible care on at least 80% of the surveys conducted at the end of each program year. Staffing program-initiated Winter 2018 and anticipate initial operations Spring 2019.

The results of these goals will be presented at upcoming plan updates and provided to the grant agency, MHSOAC.

All positions were filled starting in North County early 2019 with Cottage at the tail end of 2019 as buy-in with partners was initially sought. When the grant was written, children on holds in the Emergency Department (ED) was a huge issue for some hospitals and they were excited about the grant and submitted a letter of support. In the interim from grant application to implementation, Cottage Health systems expanded psychiatry to manage all psychiatric patients in the ED and have reduced need for CCTP staff in the ED. As a result, in Santa Barbara, the ED staff will do the crisis evaluations and re-evaluations and they will work closely with the Children's Triage staff in developing safety plans and linking children to CCTP or Casa Pacifica's SAFTY staff for post ED monitoring and linking to services.

One key challenge has been transportation for youth coming back from out-of-county LPS facilities. Some children travel as far as the Bay Area and San Diego and it's a hardship for some families to go get them and bring them back to Santa Barbara County. The Department has been exploring options that include hiring extra help recovery assistant personnel in North County who are "on call" to provide transportation, offering families gas cards to help them pay for cost of driving to go get their child; and working with the Health Authority and CenCal, who has a free transportation benefit for those eligible for Medi-Cal through Ventura Transit. These methods will be utilized in order to assist with the ongoing transportation as there are limited facilities throughout the State for children.

Data will be reported as available in the upcoming plan based on grant evaluation. The grant was anticipated to end in October 2021, but has been extended for another year, which will end in FY 2022-23. The services have been supported greatly with Medi-Cal funds and it is anticipated the grant services will be sustained with MHSA and Medi-Cal once the grant concludes.

**Examples of current data collection from new Client Satisfaction Survey for the CCTP:**

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

Children's Crisis Triage Grant
Client Satisfaction Survey Results, FY 19/20 Q1-Q4

**Children's Crisis Triage (N=48)**

*Items 1-5 are rated on a five-point scale:*
*Strongly Disagree (1) Disagree (2) Neutral (3) Agree (4) Strongly Agree (5)*

1. Overall, I am satisfied with the services I received. 100% ≥3
   **95.8% Agree/Strongly Agree**; 4.2% Neutral
2. I received services that were right for me. 100% ≥3
   **95.8% Agree/Strongly Agree**; 4.2% Neutral
3. I got as much help as I needed. 100% ≥3
   **93.7% Agree/Strongly Agree**; 6.3% Neutral
4. As a result of the services I received…
   I am better at handling daily life. 100% ≥3
   **83.3% Agree/Strongly Agree**; 16.7% Neutral
5. As a result of the services I received…
   I am better able to cope when things go wrong. 95.9% ≥3
   **79.2% Agree/Strongly Agree**; 16.7% Neutral

*Demographics*

6. Age Range
   a. 6-11 4.3%
   b. 12-17 51.1%
   c. 18-24 44.7%
7. Gender
   a. Male 40.4%
   b. Female 57.5%
   c. Transgender 0%
   d. Gender non-conforming 2.2%
8. Ethnicity
   a. Hispanic/Latino 42.6%
   (Mexican/Mexican-American, South American)
   b. Not Hispanic/Latino 57.4%
   (Asian Indian/South Asian, European, Non- Hispanic Caribbean)
9. Race
   a. American Indian/Alaskan Native 0%
   b. Asian 2%
   c. Black/African American 2%
   d. Native Hawaiian/Pacific Islander 0%
   e. White 66%
   f. More than one race 26%
   g. Decline to state 4%

Survey launched May, 2019.

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

Children's Crisis Triage Grant
Client Satisfaction Survey Results, FY 19/20 Q1-Q4

**Parent/Adult Crisis Triage (N=83)**

*Items 1-5 are rated on a five-point scale:*
*Strongly Disagree (1) Disagree (2) Neutral (3) Agree (4) Strongly Agree (5)*

1. Overall, I am satisfied with the services my child and/or family received. 98.8% ≥3
   **97.6% Agree/Strongly Agree**; 1.2% Neutral
2. The services my child received were right for them. 98.8% ≥3
   **97.6% Agree/Strongly Agree**; 1.2% Neutral
3. My family got the help we wanted for my child. 97.6% ≥3
   **94% Agree/Strongly Agree**; 3.6% Neutral
4. As a result of the services my child received…
   My child is better at handling daily life. 97.6% ≥3
   **75.9% Agree/Strongly Agree**; 21.7% Neutral
5. As a result of the services my child received…
   My child is better able to cope when things go wrong. 97.5% ≥3
   **61.4% Agree/Strongly Agree**; 36.1% Neutral

*Demographics*

6. Age Range
   a. 18-24 2.4%
   b. 25-59 91.6%
   c. 60+ 4.8%
7. Gender (select all that apply)
   a. Male 32.5%
   b. Female 67.5%
   c. Transgender 0%
   d. Gender non-conforming 0%
8. Ethnicity (*2 missing responses)
   a. Hispanic/Latino 43.4%
   (Mexican/Mexican-American, Central American, South American)
   b. Not Hispanic/Latino 54.2%
   (African, Asian Indian/South Asian, European, Filipino, Middle Eastern, Mixteco, Non-Hispanic Caribbean, Vietnamese)
9. Race (*1 missing response)
   a. American Indian/Alaskan Native 1.2%
   b. Asian 2.4%
   c. Black/African-American 6.0%
   d. Native Hawaiian/Pacific Islander 0%
   e. White 72.3%
   f. More than one race 12%
   g. Decline to state 4.8%

Survey launched May, 2019.

## Prevention and Early Intervention (PEI)

Prevention and Early Intervention (PEI) services, funded by MHSA are designed to prevent mental illness and emotional disturbance from becoming severe, disabling and costly to individuals, families, communities and the State. PEI Programs are intended to improve access to mental health services for persons underserved and reduce the negative effects, including costs, of untreated mental illness such as: suicide, homelessness, incarceration, school failure or drop-out, removal of children and older adults from their homes, prolonged suffering and unemployment.

PEI programs are focused on children and youth in stressed families, trauma exposed individuals and families including veterans, underserved ethnic and cultural populations and individuals experiencing the onset of serious mental illness.

### Mental Health Education and Support to Culturally Underserved Communities

| **Provider:** | **La Casa de la Raza, Community Health Centers of the Central Coast (CHCCC), Santa Ynez Tribal Health Clinic (SYNTHC)** |
|---|---|
| **Estimated Funding FY 2021/22:** | |
| Estimated Total Mental Health Expenditures | $ 254,000 |
| Estimated PEI Funding | $ 254,000 |
| Estimated Medi-Cal FFP | |
| Estimated 1991 Realignment | |
| Estimated Behavioral Health Subaccount | |
| Estimated Other Funding | |

| Average Cost Per Consumer/Families | Families ($206) Consumers ($34.24) |
|---|---|
| Estimated Total of Consumers/Families Served | Families 1,231 – Participants 7,418 |
| Target Population Demographics Served | Children, TAY, Adult, Older Adult |

**Community Health Centers of the Central Coast, Inc.**

Community Health Centers of the Central Coast, Inc. (CHCCC) is a contracted community partner that provides community-based mental health prevention and early intervention services to the most vulnerable populations in Northern Santa Barbara County which includes: indigenous, Latinx, Limited English Proficiency individuals, migrants, agricultural farmworkers, the unhoused, LGBTQ+ individuals, rural residents, and low-income individuals. As a safety net provider, CHCCC's primary focus is to meet the comprehensive healthcare needs of the underserved and/or unserved communities within Santa Maria, Guadalupe, New Cuyama, Los Alamos, and Lompoc regions of the County. The Mental Health Outreach teams' programmatic focus is the mitigation of the negative social and cultural impacts of immigration in order to improve the mental, physical and behavioral outcomes of these populations. The framework of their "whole-person" approach to population health management is driven by community-based participatory activities and interventions. The goal of the mental health education and outreach activities is to empower newly identified members of special populations such as monolingual Mixtec or Spanish speakers to systematically deconstruct institutional and cultural barriers which have not been responsive to their healthcare needs. This improves timely access to prevention and early intervention services through coordinated collaboration while reducing mental health stigma and barriers to care. CHCCC's Mental Health Outreach team addresses the community's lack of knowledge and understanding of mental wellness by providing linguistically accessible, culturally relevant, and evidence-based mental health education. CHCCC created safe health space through trauma-informed, network-wide community circles and groups that foster trust between members of these special populations and the larger systems of care. As a result of behavioral health integration initiatives, empowered community members have been challenging social norms and cultural roles which previously impeded their ability to access mental health services. Through these pointed outreach efforts, the team has addressed multiple barriers to accessing services, such as those related to culture, language, transportation, location, stigma, and institutional mistrust or fear due to historical experiences of discrimination and racism.

Memorandums of Understanding have been developed and established with local low-income housing programs to provide on-site support groups to predominant monolingual Spanish and limited English proficiency speaking communities. This approach brings the services directly to under-served community members that otherwise would not seek or attend support groups due to stigma, childcare issues, and transportation barriers. Furthermore, CHCCC has been successful in developing partnerships with local agricultural employers to gain access to migrant workers at their worksites and has partnered with local Spanish and Mixtec-language radio stations to bring free lunches to workers while providing mental health education. These lunchtime "meet and greets" allow agricultural workers to interact with CHCCC outreach staff informally and build a personal connection that over time facilitates access and linkage to services. CHCCC also conducts ongoing radio and television outreach, education, and anti-stigma efforts and has sponsored and staffed an annual health fair for migrant farmworkers. CHCCC's health fair focuses on health and mental health education, resources, and linkage to services.

**Program Challenges and Solutions**

As the healthcare industry continues to expand telehealth platforms, CHCCC has found that limited English proficiency, poor health literacy, and subsequent digital illiteracy among vulnerable populations have resulted

in gaps in care and in perceived poor patient engagement. In an effort to bridge treatment and services for the Spanish, Mixtec-speaking, and limited English proficiency patients, CHCCC mental health educators have broadened outreach platforms to include text messaging campaigns, telehealth consultation, telephonic care coordination, remote patient monitoring, virtual community engagement, and digital adaptation of services. CHCCC's mental health and behavioral health prevention and direct services include care coordination, relevant resource linkage, emergency department utilization follow-up, and language access.

Further, CHCCC's mental health outreach activities include quick, effective, evidence-based interventions from The Trauma Resource Institute's Community Resiliency Model which can be taught to anyone in any setting, language, or culture to reset the nervous system. All of these activities helped mitigate the disruption of services throughout the COVID-19 pandemic by having a hybrid model of virtual, telephonic, in-clinic, and in-neighborhood services. Further, expanded virtual services allowed CHCCC to reach more young patients including transitional age youth.

During the FY 2020-2023 MHSA Planning process, CHCCC partnered with the Santa Barbara County Behavioral Wellness Department staff and hosted MHSA planning events at local schools and housing complexes. This collaborative stakeholder process led to the inclusion of three languages (English, Spanish, and Mixteco) in one event and to the learning and contribution from members of the community on future MHSA programming. As a result, the Department hopes to continue this partnership and outreach strategy in the upcoming planning years.

In 2021-2023, CHCCC hopes to further expand community-based programs through accessible, technology-based educational groups in an effort to close the digital divide that adversely affects the populations served. As the MHSA partnership continues, CHCCC would like to sustain the care coordination services and expand the direct clinical services that are being provided by their clinical social workers, primary care providers, psychiatrists, interpreters, nurses, and allied health professionals to the most vulnerable community members. In alignment with their mission and vision as a network of safety-net community health centers, CHCCC provides "whole-person" fully integrated behavioral health services regardless of an individual's ability to pay and will continue to link clients from the Department to their organization.

**Santa Ynez Tribal Health Clinic**

The Santa Ynez Tribal Health Clinic (SYTHC) is dedicated to providing comprehensive medical, dental, and behavioral health services. It is located on the Santa Ynez Band of Chumash Indians reservation, federally recognized in 1901. The SYTHC is a Federally Qualified Health Center (FQHC) and receives funding through various grants, including the Indian Health Services (IHS). The target population is Native Americans, although they also provide sliding fees based on income and accept Medicare, Medi-Cal, and most major insurance plans. The services that the Santa Ynez Tribal Health Clinic offers are expansive: from general family practice, internal medicine, pediatrics, nutrition; to general dentistry, individual and family psychotherapy, psychiatry and substance abuse services. They offer about 20,000 patient visits per year with an active patient population over 4,600.

**Program Challenges and Solutions**

During the 2020-2021 fiscal year the Santa Ynez Tribal Health Clinic facilitated a plethora of virtual trainings, due to COVID-19 circumstances. Community gatekeepers (youth, adults, elders, and families) community partners, and even clinic staff were able to attend. This was a breakthrough as pre-pandemic support groups,

sweat lodge, and other in-person activities had been suspended to adhere to public health guidance. As adjustments were made to continue to reach goals, sweat lodge support groups became zoom circle calls and meetings and circles met virtually in order to host a space for the community to talk and gather amidst difficult times. SYTHC hosted community workshops with the AHO Youth Council and community addressing various parts of physical, mental, emotional, and spiritual wellness. They increased focused on social media platforms (Instagram and Facebook) as a way to engage the community about mental health-related topics and continued to find new and different ways to connect when social isolation was impacting many.

**La Casa De La Raza**

In the Santa Barbara region, La Casa de La Raza's mission is to empower the Latino community by educating and providing various wellness support groups for individuals and families. One of these wellness support groups established ongoing Spanish speaking community groups called "Cafecitos". During this support group, various participants receive psychoeducation about mental health wellness and resources that are available. La Casa de la Raza provides various outreach efforts through their work with the Family Resource Center. A result of the high interest in their workshops, La Casa de la Raza offers Saturday workshops called "Sabadito Saludables". The groups were fully active and had consistent flow of families coming in for support. As of winter 2021, they have ceased providing services due to a recent bankruptcy filing.

**Program Challenges and Solutions**

Due to the fear of deportation, the LatinX community feels the pressures of social/political changes and expressed anxieties around immigration rights, employment rights, emergency preparedness, mental health support and grief/loss. La Casa de la Raza continues to provide encouragement, referrals to mental health services and support to the community as these social/political changes impact the LatinX Community. The Cultural Diversity Manager has been coordinating meetings with La Casa De la Raza on how to reach this community, especially with the impacts of COVID-19.

During the FY 2020-2023 MHSA Planning process and this year, La Casa de la Raza partnered with Department staff hosted a weekend MHSA planning events at their center. The Department hopes to continue this partnership in the upcoming year with all the outreach partners to ensure that the MHSA stakeholder process is offered in multiple language and formats, which included Spanish and Mixteco surveys, PowerPoints, and flyers.

**Program Performance (FY 19-20)**

| Outreach Events | | | |
|---|---|---|---|
| **PROGRAM** | **LCDLR** | **SYTHC** | **CHCCC** |
| **TOTAL # EVENTS** | **92** | **84** | **223** |
| **TOTAL # PARTICIPANTS** | **3,613** | **960** | **6,792** |
| **TOTAL # FAMILIES SERVED** | 927 | 59 | 1,172 |
| | | | |
| **EVENT TYPE** | | | |
| Outreach | 9 | 6 | 30 |
| Training | 19 | 9 | 45 |
| Forum | 4 | 19 | 45 |
| Support Group | 60 | 50 | 103 |
| | | | |
| **PRIMARY LANGUAGE OF EVENT** | | | |
| English | 0 | 84 | 47 |
| Spanish | 92 | 0 | 176 |
| Other or both English and Spanish | 0 | 0 | 0 |

More detailed information required for PEI reporting is also provided in the PEI Summary (Attachment 1). Each program provided various outreach events, trainings, forums, and support groups to their communities. CHCCC served or "touched" over 6,000 (duplicated) individuals in North County through having many outreach events, trainings, and support groups. Santa Ynez Tribal Health Clinic served West County, and they served or "touched" almost 1000 individuals through their outreach events, trainings, forums, and support groups.  La Casa de La Raza serves individuals in South County but data was not available on their activities this year due to issues in the reporting system Vertical Change at time of reporting.

## PEI Early Childhood Mental Health (ECMH) – Prevention and Early Intervention

| **Provider:** | **CALM, Santa Ynez Valley People Helping People (SYV-PHP)** |
|---|---|
| **Estimated Funding FY 2021/22:** | |
| Estimated Total Mental Health Expenditures | $ 428,000 |
| Estimated PEI Funding | $ 428,000 |
| Estimated Medi-Cal FFP | |
| Estimated 1991 Realignment | |
| Estimated Behavioral Health Subaccount | |
| Estimated Other Funding | |
| Average Cost Per Consumer | $3,890 |
| Estimated Total of Consumers Served | 110 |
| Target Population Demographics Served | Children, TAY, Adult |

| **Provider:** | **CALM** |
|---|---|
| **Estimated Funding FY 2021/22:** | |
| Estimated Total Mental Health Expenditures | $1,083,600 |
| Estimated PEI Funding | $ 424,800 |
| Estimated Medi-Cal FFP | $ 658,800 |

| Estimated 1991 Realignment | |
| --- | --- |
| Estimated Behavioral Health Subaccount | |
| Estimated Other Funding | |
| Average Cost Per Consumer | $2,225 |
| Estimated Total of Consumers Served | 487 |
| Target Population Demographics Served | Children |

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 underserved 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 two Programs funded under this initiative:

**The Great Beginnings and Special Needs Teams – CALM – Prevention and Early Intervention**

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 ten, with a specific focus on the LatinX populations. The Program includes both prevention and early intervention activities and provides mental health services to children and their families in order to reduce functional impairments, decrease problem behaviors, and improve parent children relations. Services include Child Parent Psychotherapy (CPP), Postpartum Depression screening and support, Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Parent-Child Interaction Therapy (PCIT), Healthy Families Groups in both Spanish and English, as well as other evidence-based practices as clinically indicated. In addition to these MHSA Prevention and Early Intervention services focused on prenatal concerns and client's birth to age 5, Great Beginnings team also provides specialty mental health services to Medi-Cal beneficiaries from birth through age 10.

During the COVID-19 pandemic CALM continued to provide uninterrupted mental health services and education. These services were largely provided via telehealth platforms to ensure the safety and well-being of clients and staff. When clinically indicated, services were also provided in-person while following all safety guidelines such as the use of masks and social distancing. As of June 15, 2021, based on the re-opening of California, CALM is beginning the transition back to in-person service and hopes that by the end of August we will have completed this transition. We look forward to maintaining the ability to continue to provide services via tele-health whenever that is clinically indicated.

CALM continues to use community outreach via on-line platforms during COVID-19 to share knowledge of child development and intervention strategies with the public and other community organizations. Some of these outreach engagements include: providing information to the community at Family Day in the Park – YMCA, the Safe Sleep Awareness Campaign, PMAD training, training Carpinteria parents on Protective Factors and ACES, participation in the Lompoc Public Health Department Meetings and the NICU reunion. CALM is

also a member of the following community groups: Early Childhood Family Wellness Coalition, Medically Vulnerable Population Care Coordination, PMAD Stakeholders Meetings, and the Perinatal Wellness Coalition.

Staff receive ongoing clinical training and case consultation at weekly clinical staff meetings as well as individual and group clinical supervision as needed. Great Beginnings staff on the Dialectical Behavior Therapy consultation team receive weekly intensive training in treating suicidal and self-injuring teens. Additionally, staff attended trainings on Dialectical Behavioral Therapy, Narrative Family Therapy, DSM for Children 0-6, Advanced Perinatal Psychotherapy, Neuro-Relational Development, Methods of Telehealth Therapy and Medi-Cal documentation. CALM's Psychiatrist continues to provide monthly consultations for the team.

**Special Needs Counseling – Santa Ynez Valley People Helping People (SYVPHP) – Prevention**

This 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. Key goals include providing education and support services to children and families that promote positive parenting by conducting at least three groups a year with cohorts of at least 8-10 parents. In order to assist children and families in their mental health recovery by developing skills needed to lead healthy and productive lives, People Helping People aims to screen and assess at least 80 families that present with mental health issues, provide 45 children with developmental screenings, and provide at least 60 referrals to family service coordinators who provide case management and linkages to other needed services in the community. People Helping People exceeded these goals in FY 19-20.

**Program Challenges and Solutions**

In addition to the impacts of COVID-19, Cencal who is the Health Authority in Santa Barbara County, has additional funding for Medi-Cal beneficiaries for family therapy and behavioral health supports to parents or their children who need services based on a new service benefit in their Health Plan. This new benefit requires coordination and linkage to services between the Department, Community Based Organizations, and Cencal providers. As a result, the Department will be working with CenCal to identify the best design to create a well-resourced program for their system and will monitor how the program is delivered within MHSA to ensure funding is appropriately aligned and system's resources are allocated well for the parents and youth.

**Program Performance**

**CALM ECMH (Prevention – Great Beginnings)**

| | Unique Clients Served | | |
|---|---|---|---|
| | North | South | West |
| **Age Group** | | | |
| 0-15 | 58 | 40 | 7 |
| 16-25 | 1 | 0 | 0 |
| 26-59 | 2 | 2 | 0 |
| 60+ | 0 | 0 | 0 |

| | | | |
|---|---|---|---|
| Missing DOB | 0 | 0 | 0 |
| ***Total*** | **61** | **42** | **7** |
| | | | |
| **Gender** | | | |
| Female | 31 | 25 | 3 |
| Male | 30 | 17 | 4 |
| Unknown | 0 | 0 | 0 |
| | | | |
| **Ethnicity** | | | |
| American Indian or Alaska Native | 0 | 0 | 0 |
| Asian | 0 | 1 | 0 |
| Black or African American | 2 | 0 | 1 |
| Mixed Race | 0 | 1 | 1 |
| Native Hawaiian or Pacific Islander | 0 | 0 | 0 |
| White | 58 | 37 | 5 |
| Other/Not Reported | 1 | 3 | 0 |
| | | | |
| **Hispanic or Latino** | | | |
| Hispanic or Latino | 55 | 38 | 6 |
| Not Hispanic or Latino | 5 | 3 | 1 |
| Not Reported | 1 | 1 | 0 |

**SYVPHP ECMH (Prevention)**

| Unique Clients Served | |
|---|---|
| | **SYVPHP** |
| **Age Group** | |
| 0-15 | 36 |
| 16-25 | 21 |
| 26-59 | 88 |
| 60+ | 28 |
| Missing DOB | 9 |
| ***Total*** | **182** |
| | |
| **Gender** | |
| Female | 105 |
| Male | 77 |
| Unknown | 0 |
| | |
| **Ethnicity** | |
| American Indian or Alaska Native | 5 |
| Asian | 2 |
| Black or African American | 5 |
| Mixed Race | 0 |
| Native Hawaiian or Pacific Islander | 0 |
| White | 101 |

| | |
|---|---|
| Other/Not Reported | 69 |
| | |
| **Hispanic or Latino** | |
| Hispanic or Latino | 42 |
| Not Hispanic or Latino | 0 |
| Not Reported | 140 |

**CALM ECSMH (Early Intervention – Specialty Mental Health Services)**

| | Unique Clients Served | | |
|---|---|---|---|
| | **North** | **South** | **West** |
| **Age Group** | | | |
| 0-15 | 267 | 185 | 35 |
| 16-25 | 0 | 0 | 0 |
| 26-59 | 0 | 0 | 0 |
| 60+ | 0 | 0 | 0 |
| Missing DOB | 0 | 0 | 0 |
| ***Total*** | **267** | **185** | **35** |
| | | | |
| **Gender** | | | |
| Female | 130 | 87 | 15 |
| Male | 137 | 98 | 20 |
| Unknown | 0 | 0 | 0 |
| | | | |
| **Ethnicity** | | | |
| American Indian or Alaska Native | 6 | 0 | 1 |
| Asian | 1 | 1 | 0 |
| Black or African American | 12 | 3 | 1 |
| Mixed Race | 1 | 3 | 3 |
| Native Hawaiian or Pacific Islander | 0 | 0 | 0 |
| White | 238 | 166 | 28 |
| Other/Not Reported | 9 | 12 | 2 |
| | | | |
| **Hispanic or Latino** | | | |
| Hispanic or Latino | 201 | 149 | 24 |
| Not Hispanic or Latino | 58 | 29 | 11 |
| Not Reported | 8 | 7 | 0 |

**Client Outcomes**

| Child & Adolescent Needs & Strengths Assessment (CANS-50)<br>Age: 6-20 years | | |
|---|---|---|
| | **Early Intervention CALM ECSMH Specialty Mental Health Percent Improvement*** | |
| | **Initial to 6 months**<br>(n = 147) | **6 to 12 months** |

| | | (n = 63) |
|---|---|---|
| **Life Functioning** (e.g., ability to communicate and interact with families, communication, social functioning and health status) | - 34.2 % | -71.3% |
| **Behavioral/Emotional Needs** (e.g., symptoms of depression, anxiety, psychosis and other conditions) | - 41.8% | - 62.2% |
| **Risk Behaviors** (e.g., self-injury, suicidal behavior, bullying, and running away) | 100.0% | - 87.5% |
| **Cultural Factors** (e.g., language, traditions, stress) | 0.0% | - 25.0% |
| **Strengths** (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment) | - 17.2% | - 61.7% |
| **Child Behavior Checklist & Parenting Stress Index** | | |
| | **Prevention CALM ECMH Great Beginnings** | **Early Intervention CALM ECSMH Specialty Mental Health** |
| At least 65% of children/youth scoring in the Clinical range of **Internalizing Behavior** at intake will be in the Non-Clinical range at most recent follow up, as measured by the *Child Behavior Checklist*. | 100% | 55% |
| At least 65% of children/youth scoring in the Clinical range of **Externalizing Behavior** at intake will be in the Non-Clinical range at most recent follow up, as measured by the *Child Behavior Checklist*. | 0% | 38% |
| At least 65% of parents scoring in the Clinical range of **Total Parenting Stress** at intake will be in the Non-Clinical range at most recent follow up, as measured by the *Parenting Stress Index*. | N/A<br>No clinical range scores at intake | 100% |
| **Increased knowledge of child development** (care, nutrition, discipline) | 100% | 100% |
| **Increased knowledge of resources** | 100% | 100% |
| **Families linked to services** | 100% | 100% |
| **Other Outcomes** | | |
| | **Average per quarter** | **Average per quarter** |
| **New out-of-primary home placements** | 3% | 1% |
| **Purposeful Activity (employed, school, volunteer)** | 100% | 100% |
| **Stable/Permanent Housing** | 95% | 98% |
| **Higher Levels of Care** | | |
| | **% with any admissions over FY 19-20** | **% with any admissions over FY 19-20** |
| **Juvenile Hall** | -- | -- |
| **Crisis Services** | 0% | 0% |
| **Psychiatric Inpatient Care** | 0% | 0% |

**Note.* On the CANS-50, a higher the score indicates more actionable needs (greater problems). A negative percent change indicates that client scores are improving because they have fewer actionable needs.

| Activities | SYVPHP |
|---|---|
| Provide 30 parenting education and support groups to families/Parents | 73 (203%) |
| Provide 80 screenings and assessments to families presenting with mental health issues | 84 (105%) |
| Provide developmental screenings to 45 children | 74 (164%) |
| Provide 60 referrals to Family Services Coordinators for case management and linkages/referrals to other needed services | 531 (885%) |

Due to a state mandated change, Santa Barbara County began using a new version of the CANS (CANS-50) in July 2018. In addition to changing items and domains, the CANS age range was extended to age 20. This means that more TAY-aged clients now receive a CANS. *Cultural Factors* is a new 3-item domain. We did not present *Caregiver Resources and Needs* for these analyses because caregivers that are entered in the Caregiver A section often change across timepoints and are not currently tracked to allow for a matched comparison.

Clients in the ECSMH Specialty Mental Health program saw reductions in the number of actionable needs across all CANS domains with the exception of *Risk Behaviors* and *Cultural Factors* from intake to six months. Cultural Factors remained unchanged with an average of 0.03 actionable needs at both time points, and risk factors changed from an average 0.025 to 0.05 actionable needs. Both of these domains in this program experienced the floor effect and positive skew. In the *Risk Behaviors* domain, clients went from an average of 0.025 risk factors to an average of 0.05 risk factors; both very low. While children saw a reduction in actionable needs in both time period comparisons, the group of clients that had a CANS administered at six and twelve months (n = 63) saw greater reductions in their number of actionable needs than the larger group seen from intake to six months.

More detailed information required for PEI reporting is also provided in the PEI Summary (Attachment 1). Note that in the ECMH Great Beginnings Program, there are a few clients who fall outside the age range of 0-6 years old; this is because pregnant women are able to start services in the prenatal period. After giving birth, services are transferred to their child. Therefore, while the baby is always the client, services are initially captured under the parent.

**During fiscal year 2019-2020, CALM's Great Beginnings program (ECMH Prevention)** served 110 families. Three percent of clients had new out-of-primary home placements and 95% had stable or permanent housing. After six months in treatment, 100% of children who fell in the clinical range for internalizing behaviors at intake were in the non-clinical range at follow up, and 0% of the children who fell in the clinical range for externalizing behaviors were in the non-clinical range at follow up. All parents who participated in the program experienced increased knowledge of children development and resources, as well as linkage to appropriate services.

**CALM's Specialty Mental Health program (ECSMH Early Intervention)** served 487 children and their families across the county in fiscal year 2019-2020. Similar to the Great Beginnings program, very few clients (1%) had new out-of-primary home placements and almost all (98%) had stable or permanent housing. After six months in treatment, 55% of children who fell in the clinical range for internalizing behaviors at intake were in the non-clinical range at follow up, and 38% of the children who fell in the clinical range for externalizing behaviors were in the non-clinical range at follow up. Furthermore, 100% of parents who were in the clinical range for parenting stress at intake were in the non-clinical range at follow up. All parents who participated in the

program experienced increased knowledge of children development and resources, as well as linkage to appropriate services.

The client outcomes table displays the percent of clients who experienced an inpatient psychiatric hospitalization during their admission to the program in the 19-20 fiscal year. In all regions, no clients in either ECMH or ECSMH program experienced hospitalization or contact with crisis services. Note that these outcomes would be quite rare due to the age of the children served. Juvenile hall data were unavailable this year and we are unable to report on these metrics, though this is similarly an unlikely occurrence for this age group.

**Santa Ynez People Helping People (Prevention)** served 182 individuals over the 2019-2020 fiscal year. Their performance objectives relate to their program goals of providing education, screenings, and linkage/referrals. They exceeded their contract expectations in all areas. They provided 73 parenting education and support groups (Nurturing Parenting curriculum; three series), 84 screenings and assessments, 74 developmental screenings to children, and 531 referrals and linkage for additional services.

## School-Based Prevention/Early Intervention Services for Children and TAY (START)

| **Provider:** | **Family Services Agency, Council on Alcoholism and Drug Abuse** |
|---|---|
| **Estimated Funding FY 2021/22:** | |
| Estimated Total Mental Health Expenditures | $ 477,400 |
| Estimated PEI Funding | $ 356,200 |
| Estimated Medi-Cal FFP | $ 121,200 |
| Estimated 1991 Realignment | |
| Estimated Behavioral Health Subaccount | |
| Estimated Other Funding | |
| Average Cost Per Consumer | $2,893 |
| Estimated Total of Consumers Served | 165 |
| Target Population Demographics Served | Children, Transitional Age Youth (TAY) |

The START (Support, Treatment, Advocacy and Referral Team) Program is a partnership between Family Service Agency (FSA), the Council on Alcoholism and Drug Abuse (CADA), and Santa Barbara County Behavioral Wellness. This Program provides mental health assessment, screening and treatment, school collaborations, family interventions, linkage and education for children, transition-age youth (TAY) and families. START offers prevention and early intervention mental health services to students within the Carpinteria Unified School District experiencing social, emotional, and/or behavioral difficulties. The START program supports children and youth for whom mental health services would otherwise not be accessible. START offers counseling, support, advocacy, treatment, and referrals, including services to individuals experiencing mental health and substance abuse challenges. Program staff 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.

**Program Challenges and Solutions**

One of the challenges for the START program this year was client engagement in telehealth services. While the COVID-19 pandemic posed many challenges and hardships within our community, the START program experienced a rise in disengagement and a decline in participation in telehealth services. Many students and families expressed a "burn out" in regards to screen time and opted to not participate in telehealth services. Fortunately, as the county Covid-19 cases decreased in 2021, Carpinteria public schools were able to reopen and students were able to return to campus. START program staff were allowed back on school campuses in April 2021 and were able to resume in-person services. The START program continues to work with school staff, students and families to meet the mental health needs of children and families within the Carpinteria community.

## Program Performance (FY 19-20)

### School-Based Prevention/Early Intervention Services (START)

| | Unique Clients Served | | |
|---|---|---|---|
| | START South | School-based South | School-based West |
| **Age Group** | | | |
| 0-15 | 69 | 38 | 28 |
| 16-25 | 10 | 15 | 5 |
| 26-59 | 0 | 0 | 0 |
| 60+ | 0 | 0 | 0 |
| Missing DOB | 0 | 0 | 0 |
| ***Total*** | **79** | **53** | **33** |
| | | | |
| **Gender** | | | |
| Female | 37 | 39 | 19 |
| Male | 42 | 14 | 14 |
| Unknown | 0 | 0 | 0 |
| | | | |
| **Ethnicity** | | | |
| American Indian or Alaska Native | 0 | 1 | 1 |
| Asian | 0 | 0 | 1 |
| Black or African American | 0 | 0 | 1 |
| Mixed Race | 1 | 1 | 0 |
| Native Hawaiian or Pacific Islander | 0 | 1 | 1 |
| White | 77 | 48 | 28 |
| Other/Not Reported | 1 | 2 | 1 |
| | | | |
| **Hispanic or Latino** | | | |
| Hispanic or Latino | 62 | 46 | 24 |
| Not Hispanic or Latino | 16 | 6 | 9 |
| Not Reported | 1 | 1 | 0 |

**Client Outcomes**

| Child & Adolescent Needs & Strengths Assessment (CANS-50) Age: 6-20 years | | Percent Improvement* | |
|---|---|---|---|
| | | Initial to 6 months (n = 129) | 6 to 12 months (n = 59) |
| **Life Functioning** (e.g., ability to communicate and interact with families, communication, social functioning and health status) | | - 24.5% | - 69.3% |
| **Behavioral/Emotional Needs** (e.g., symptoms of depression, anxiety, psychosis and other conditions) | | - 34.0% | - 58.5% |
| **Risk Behaviors** (e.g., self-injury, suicidal behavior, bullying, and running away) | | - 47.1% | -88.9% |
| **Cultural Factors** (e.g., language, traditions, stress) | | - 18.8% | - 84.6% |
| **Strengths** (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment) | | - 12.7% | - 50.7% |
| **Other Outcomes** | **Average per quarter** | **Average per quarter** | **Average per quarter** |
| | **START South** | **School-based South** | **School-based West** |
| **New out-of-primary home placements** | 0% | 0% | 0% |
| **Purposeful Activity (employed, school, volunteer)** | 100% | 100% | 100% |
| **Stable/Permanent Housing** | 97% | 100% | 98% |
| **Higher Levels of Care** | | **% with any admissions over FY 19-20** | |
| | **START South** | **School-based South** | **School-based West** |
| **Juvenile Hall** | 0% | 0% | 0% |
| **Crisis Services** | 3% | 2% | 9% |
| **Psychiatric Inpatient Care** | 0% | 0% | 0% |

**Note.* On the CANS-50, a higher the score indicates more actionable needs (greater problems). A negative percent change indicates that client scores are improving because they have fewer actionable needs.

Due to a state mandated change, Santa Barbara County began using a new version of the CANS (CANS-50) in July 2018. In addition to changing items and domains, the CANS age range was extended to age 20. This means that more TAY-aged clients now receive a CANS. *Cultural Factors* is a new 3-item domain. We did not present *Caregiver Resources and Needs* for these analyses because caregivers that are entered in the Caregiver A section often change across timepoints and are not currently tracked to allow for a matched comparison.

Clients in START and School-based Counseling saw reductions in the number of actionable needs across all CANS domains. While children saw a reduction in actionable needs in both time period comparisons, the group of clients that had a CANS administered at six and twelve months (n = 59) saw greater reductions in their number of actionable needs than the larger group seen from intake to six months.

During fiscal year 2019-2020, START and School-Based Counseling Programs served a combined 165 clients. No clients had new out-of-primary home placements, all were engaged in purposeful activity, and across all regions, an average of 98% had stable or permanent housing. The client outcomes table also displays the percent of unique clients who experienced a higher level of care during their admission to START or School-

based Counseling in the 19-20 fiscal year. Juvenile hall data were reported by programs in their quarterly reports. The source of psychiatric inpatient and crisis services data is the electronic health record. Across all regions, zero percent of clients had a stay in juvenile hall. Three percent of clients in START in South County, 2% of clients in School-based Counseling in South County, and 9% of clients in School-based Counseling in West County had crisis services contact during their program admission. Across the county, no clients in START or School-based Counseling programs experienced hospitalization during their program admission.

## PEI Early Detection and Intervention Teams for Children for Transition-Age Youth (TAY)

| **Provider:** | **Behavioral Wellness** |
|---|---|
| **Estimated Funding FY 2021/22:** | |
| Estimated Total Mental Health Expenditures | $ 696,300 |
| Estimated PEI Funding | $ |
| Estimated Medi-Cal FFP | $ 696,300 |
| Estimated 1991 Realignment | |
| Estimated Behavioral Health Subaccount | |
| Estimated Other Funding | $0,000 |
| Average Cost Per Consumer | $2,865 |
| Estimated Total of Consumers Served | 234 |
| Target Population Demographics Served | Children, TAY, Adult (if aging into age 25) |

Early Detection and Intervention Teams for Transition-Age Youth (TAY) 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 TAY, ages 16-25. Teams are based in North County (Santa Maria), South County (Santa Barbara) and West County (Lompoc). The Program serves children and 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.

**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; and
- Coordination with primary care and other services.

The staffing involves Psychiatrist, Psychiatric Technician, practitioners, case workers and extra help TAY peers.

An Innovations project for modern methods of outreach and peer support has been implemented for mobile apps which targets youth in colleges or those at risk for first episode psychosis. TAY clients' communication styles may respond better to this type of support, which is an outcome that will be tracked as part of the peer technology innovation project. This modern outreach is another layer to increase access to services and co-ordination with TAY clients' peers who are inadequately served through current methods in the Adult System of Care. Discussions with community partners include possible participation in a TAY Clinical Drop-In Clinic; such as The Foundry or Headspace models. Both the Drop-In Center and the Innovation Project Tech Suite: Help@Hand goals are important components to be reviewed in upcoming years.

Youth empowerment services are being explored where TAY Peers take a leadership role to plan, schedule, and offer weekly activities in the community for TAY consumers. Recreational funds will be set aside in the new FY to assist with the planning and creation of social activities for both PEI and New Heights FSP TAY population.
We will be providing training for all staff working in the PEI program to implement use of the Coordinated specialty care model (CSC). CSC programs include peer and family advocacy and support, substance abuse management and cognitive behavioral therapy for psychosis.

The PEI teams will be encouraged to use CSC teams to use a family- oriented approach even for the adult clients in which all aspects of an individual support network are engaged at every level of care. An effective and stable support network is the key to wellness for our clients.

The gold-standard clinical and functional assessments will be implemented to measure and ensure accurate and reliable diagnosis of mental health conditions. The staff will be trained in the structural clinical interview for DSM 5 and the structured interview for Prodromal syndromes, functioning outcome measures and the Columbia suicide severity rating scale to ensure ongoing reliability in utilizing assessment instruments.
The Santa Maria TAY clinic moved into a new building. The department is working on expanding services, creating drop in centers, outreach, family support with the implementation of more caseworkers and peers to the programs.

**Program Challenges and Solutions**

TAY individuals 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 individuals engaged in services, underutilized substance abuse treatment resources, and the lack of specific TAY housing resources. A long-term Full-Service Partnership program for TAY that increased field based, 24/7, outreach type of services for this group was launched in Summer 2019 and will be monitored in coming years for linkage and service provision.

The biggest challenge this past year was being able to provide in person face to face services due to the COVID-19 pandemic. In following pandemic safety protocol, the clinics were required to reduce staff presence. All providers transitioned to Telehealth and rotate their shifts to in-clinic presence. Many youths did not have access to internet and thus virtual sessions were not feasible. Youth that did have access to internet were not engaging due to fatigue of being on the computer. Staff began to provide outdoors therapy sessions.

There is a need to increase social activities that can more readily engage the TAY PEI population. Implementing the Youth empowerment services is a step in the right direction. The hope is to provide rich activities at the same time providing psycho-education that can help reduce stigma. Creating a drop-in center can expand on the youth empowerment services. This was delayed due to the pandemic.

## Program Performance (FY 19-20)

### PEI Early Detection & Intervention

| Unique Clients Served | | | |
|---|---|---|---|
| | North | South | West |
| **Age Group** | | | |
| 0-15 | 2 | 0 | 6 |
| 16-25 | 54 | 93 | 7 |
| 26-59 | 0 | 2 | 0 |
| 60+ | 0 | 0 | 0 |
| Missing DOB | 0 | 0 | 0 |
| ***Total*** | **56** | **95** | **83** |
| | | | |
| **Gender** | | | |
| Female | 24 | 53 | 53 |
| Male | 32 | 42 | 30 |
| Unknown | 0 | 0 | 0 |
| | | | |
| **Ethnicity** | | | |
| American Indian or Alaska Native | 0 | 0 | 0 |
| Asian | 0 | 1 | 5 |
| Black or African American | 2 | 1 | 3 |
| Mixed Race | 1 | 13 | 4 |
| Native Hawaiian or Pacific Islander | 1 | 0 | 1 |
| White | 49 | 71 | 65 |
| Other/Not Reported | 3 | 9 | 5 |
| | | | |
| **Hispanic or Latino** | | | |
| Hispanic or Latino | 42 | 59 | 42 |
| Not Hispanic or Latino | 10 | 31 | 35 |
| Not Reported | 4 | 5 | 6 |

**Client Outcomes**

| **Child & Adolescent Needs & Strengths Assessment (CANS-50) Age: 6-20 years** | **Percent Improvement*** | |
|---|---|---|
| | **Initial to 6 months (n = 62)** | **6 to 12 months (n = 36)** |
| **Life Functioning** (e.g., ability to communicate and interact with families, communication, social functioning and health status) | - 47.1% | -32.3% |

| | | |
|---|---|---|
| **Behavioral/Emotional Needs** (e.g., symptoms of depression, anxiety, psychosis and other conditions) | - 34.4% | - 46.6% |
| **Risk Behaviors** (e.g., self-injury, suicidal behavior, bullying, and running away) | - 60.0% | - 70.0% |
| **Cultural Factors** (e.g., language, traditions, stress) | - 33.3% | 83.3% |
| **Strengths** (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment) | - 23.2% | - 43.2% |
| **Milestones of Recovery Scale (MORS) Age: 18+** | | |
| | **Initial to 6 months (n = 89)** | **6 to 12 months (n = 73)** |
| **Showed improvement^** | 47% | 35% |
| **Remained stable^** | 34% | 46% |

| **Higher Levels of Care** | **% with any admissions over FY 19-20** | | |
|---|---|---|---|
| | **North** | **South** | **West** |
| **Incarcerations** | 0% | 4% | 1% |
| **Crisis Services** | 5% | 5% | 7% |
| **Psychiatric Inpatient Care** | 2% | 3% | 4% |

**Note.* On the CANS-50, a higher the score indicates more actionable needs (greater problems). A negative percent change indicates that client scores are improving because they have fewer actionable needs.
^*Note.* "Showed Improvement" and "Remained Stable" reflects the percent of clients whose MORS scores improved or stayed the same between time periods.

Due to a state mandated change, Santa Barbara County began using a new version of the CANS (CANS-50) in July 2018. In addition to changing items and domains, the CANS age range was extended to age 20. This means that more TAY-aged clients now receive a CANS. *Cultural Factors* is a new 3-item domain. We did not present *Caregiver Resources and Needs* for these analyses because caregivers that are entered in the Caregiver A section often change across timepoints and are not currently tracked to allow for a matched comparison.

Clients in the PEI Early Detection and Intervention TAY program saw reductions in the number of actionable needs across all CANS domains with the exception of the *Cultural Factors* domain from six to twelve months. Because average actionable needs scores in this domain experienced positive skew and a floor effect, these relatively small changes (an average 0.1 increase) corresponded to a fairly large percent change (83.3%).

Looking at the MORS, which the majority of clients completed, 81% of clients in in the first half of the year and in the second half were either stable or made improvements. In fact, almost half showed improvement in the first half of the year, and over a third showed improvement in the latter half of the year. Conversely, a third were stable in the first half of the year while 46% were stable in the second half of the year.

The client outcomes table displays the percent of unique clients who experienced a higher level of care during their admission to PEI TAY in the 19-20 fiscal year. The source of incarceration data is the Santa Barbara Jail and therefore only includes adults; clients were matched from the county electronic health record to the FY 19/20 jail roster. Juvenile hall data were unavailable this year and we are unable to report on these metrics. The source of psychiatric inpatient and crisis services data is the electronic health record. Zero percent of clients in North County, 4% of clients in South County, and 1% of clients in West County experienced a jail stay during their admission. Five percent of clients in North County, 5% of clients in South County, and 7% of

clients in West County had crisis services contact during their program admission. Two percent of clients in North County, 3% of clients in South County, and 4% of clients in West County experienced hospitalization during their program admission.

## Safe Alternatives for Children and Youth (SAFTY) Crisis Services

| **Provider:** | **Casa Pacifica** |
|---|---|
| **Estimated Funding FY 2021/22:** | |
| Estimated Total Mental Health Expenditures | $1,030,600 |
| Estimated PEI Funding | $ 662,100 |
| Estimated Medi-Cal FFP | $ 368,500 |
| Estimated 1991 Realignment | |
| Estimated Behavioral Health Subaccount | |
| Estimated Other Funding | $0,000 |
| Average Cost Per Consumer | $1,140 |
| Estimated Total of Consumers Served | 904 |
| Target Population Demographics Served | Children, TAY |

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 Crisis Services Teams county-wide. The SAFTY Program operates a crisis line that receives crisis calls from 8am-8pm, 7 days per week. The other hours of the week are covered by Behavioral Wellness Crisis Services.

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.

**Program Challenges and Solutions**

In prior years, SAFTY staffing was sometimes unable to handle multiple crises in different regions of the County, which continued to slow the response time and required intervention by the Crisis Services teams. To address surges in need and to keep response times reasonably prompt, Behavioral Wellness implemented crisis services, including the Crisis Triage Teams, which has helped to alleviate some of SAFTY's workload, particularly in Emergency Rooms, and helped increase SAFTY's ability to respond to schools, homes and the community, which was a primary goal of the original SAFTY model. Improvement in response has occurred, but staffing challenges continue within the crisis continuum including SAFTY providers.

**Program Performance (FY 19-20)**

**SAFTY**

| | **Unique Clients Served** | |
|---|---|---|
| | **North** | **South** |
| **Age Group** | | |

| | | |
|---|---|---|
| 0-15 | 356 | 184 |
| 16-25 | 242 | 122 |
| 26-59 | 0 | 0 |
| 60+ | 0 | 0 |
| Missing DOB | 0 | 0 |
| ***Total*** | **598** | **306** |
| | | |
| **Gender** | | |
| Female | 336 | 170 |
| Male | 261 | 134 |
| Missing/Other | 1 | 2 |
| | | |
| **Ethnicity** | | |
| American Indian or Alaska Native | 6 | 1 |
| Asian | 5 | 6 |
| Black or African American | 25 | 5 |
| Mixed Race | 4 | 13 |
| Native Hawaiian or Pacific Islander | 1 | 0 |
| White | 415 | 192 |
| Other/Not Reported | 142 | 89 |
| | | |
| **Hispanic or Latino** | | |
| Hispanic or Latino | 270 | 123 |
| Not Hispanic or Latino | 109 | 59 |
| Not Reported | 219 | 124 |

**Client Outcomes**

| Call Outcomes | Total |
|---|---|
| **Contact Type** | |
| Total Calls | 1,846 |
| Crisis Calls | 1,498 (81%) |
| Non-crisis Calls | 348 (19%) |
| Face to Face | 676 (45%) |
| **Reason for Calls** | |
| Suicidal Ideation | 42% |
| Increase in Mental Health Symptoms | 5% |
| 5150/5585 Re-Assessment / Bed Search | 4% |
| Resources/Access to Service | 11% |
| In-Person Follow Up | 3% |
| Self-Injurious Behaviors | 7% |
| Suicide Attempt | 6% |
| Aggression Towards Others | 7% |
| 5150/5585 | 4% |
| Oppositional Behavior | 3% |

| Peer/Family Conflict | 4% |
|---|---|
| Homicidal Ideations | 2% |
| Other | 3% |
| Substance Use/Abuse | 1% |
| **Hospitalization** | |
| Hospitalization Rate on Calls (non-crisis excluded) | 11% |

SAFTY reports call characteristics to Behavioral Wellness. In the 2019-2020 fiscal year, SAFTY reported that the program received a total of 1,846 calls, 676 of which had an in-person response. The most common reason for a call was suicidal ideation; these accounted for over 40% of all calls. The next most common reasons were resources and access to service (11%), self-injurious behaviors (7%), aggression towards others (7%), suicide attempts (6%), and increase in mental health symptoms (5%). In examining hospitalization, two rates of hospitalization are provided. *Hospitalization Rate on Calls* examines calls that were designated as crisis, which were 81% of all calls. Eleven percent of crisis calls led to hospitalization. It is important to note that this data includes a portion of the shut down due to COVID-19 and school being closed.

## Access and Assessment Teams & ACCESS Line Program

| **Provider:** | **Behavioral Wellness** |
|---|---|
| **Estimated Funding FY 2021/22:** | |
| Estimated Total Mental Health Expenditures | $3,684,900 |
| Estimated PEI Funding | $2,356,200 |
| Estimated Medi-Cal FFP | $1,328,700 |
| Estimated 1991 Realignment | |
| Estimated Behavioral Health Subaccount | |
| Estimated Other Funding | $0,000 |
| Average Cost Per Consumer | $2,804 |
| Estimated Total of Consumers Served | 1,314 (based on Access service, no Access Line target) |
| Target Population Demographics Served | Children, TAY, Adult, Older Adult |

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.

The Department has restructured its operations to a centralized access approach, and an Access call center continues to be expanded and improved. Access screeners handle behavioral health crisis calls and calls from new consumers requesting mental health and substance use disorder (SUD) services. Callers are screened for appropriate assignment to a level of care within the Mental Health Plan (MHP and/ or the Drug Medi-Cal Organized Delivery System (DMC-ODS). The access and assessment component for the MHP is handled by the 3 Adult and 3 Children's Access and Assessment teams that focus 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) and all staff are trained in how to access and utilize our multiple Interpreter Service contractors.

**Program Challenges and Solutions**

Behavioral Wellness centralized the Access call center within the Office of Strategic Management and Quality Care by routing all Access calls to one place. Staff dedicated to this function were hired and trained to screen all calls coming into the Access Line and connecting them to the most appropriate level of care. In December of 2018, Behavioral Wellness launched centralized Access for the Drug Medi-Cal Organized Delivery System (DMC-ODS) to screen and refer all beneficiaries seeking substance use disorder (SUD) treatment. Since the launch, calls into the Access Line have doubled, increasing average wait times and abandoned calls. In response, Behavioral Wellness started and completed a Performance Improvement Project (PIP) with target goals to decrease average wait times and decrease abandoned calls. Over the last year interventions included increasing full time staff on the Access Team and a comprehensive all-staff training targeted at increasing efficiencies of screenings. At the end of calendar year 2020 the program examined the years' worth of data, concluding our PIP after reaching our goals. Despite a stressful year with unforeseen staffing issues due to COVID-19, the program, decreased average wait times from a baseline of 4 minutes and 30 seconds down to 1 minute and 23 seconds. Additionally, the abandoned call rates went down from a baseline of 25.6% to 8.2%. of all calls. The program will continue to monitor these indicators through our Quality Improvement Committee Work Plan to ensure it continues to keep these measures low, ensuring beneficiaries are able to have consistent access to be screened for mental health and substance use disorder treatment services in a timely manner.

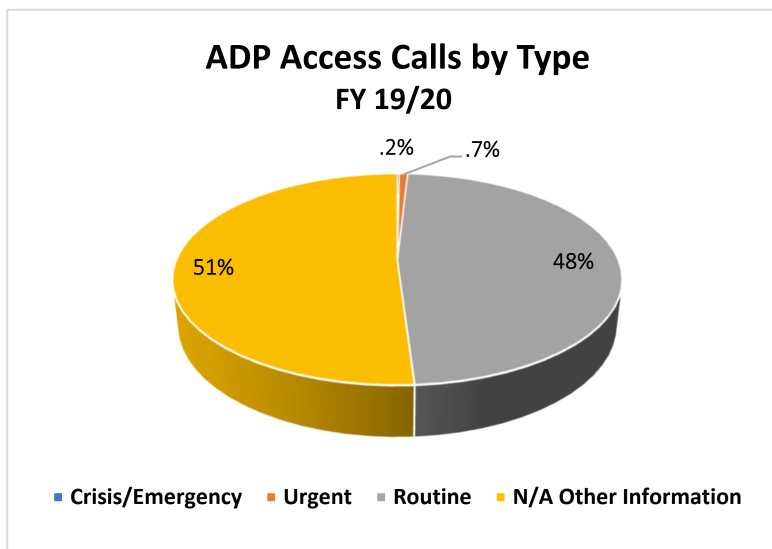
As the Access Line is a toll-free number for people experiencing mental health crises and to be screened and referred to routine and urgent mental health and SUD services, staffing is always a challenge. As the line receives calls 24 hours a day, 7 days a week there is a team who screens and refers Monday through Friday during business hours the Department has contracted with a provider, ProtoCall, to cover nights and weekends. ProtoCall staff are trained at safety planning with callers in crisis and connecting them with our Mobile Crisis staff. Over the last year, the program successfully cross-trained all Mobile Crisis staff to be able to answer the Access Line when they are not out on crisis calls. Now calls can be answered by County Crisis staff to be screened and referred to needed services after hours. The Department continues to contract with ProtoCall and calls will continue to roll over after hours if all Crisis Staff are in the field attending to crises in the community.

While most of the services are centralized, there is availability at many of our outpatient clinics for walk-ins of consumers. For Mental Health Plan (MHP) services, the clinics continue to accept walk-ins in our regional Children's, Adult, and Crisis Clinics. All services through the DMC-ODS require calling the Access Line with the exception of Opioid Treatment Programs who can accept walk-ins into their clinics. For all other outpatient SUD services if they walk-in to a clinic, staff assist beneficiaries in using a phone and calling the Access Line.

**Mental Health Access Line Program Performance (FY 19-20)**

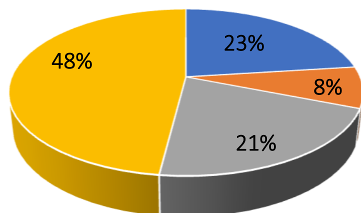
**Alcohol and Drug Access Calls**

During FY 19/20 there were 5,860 SUD Access calls. About half (48%) of all adult and youth calls were routine calls; the remaining half of calls were almost entirely requests for information (very few crisis or urgent). Though few of the calls were urgent and most were informational, the Access screeners have been trained to expand the definition of urgency to include residential treatment and to ask additional questions of those who want "information only" to identify possible treatment needs.



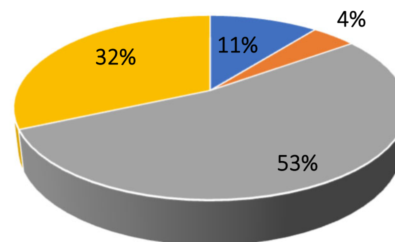

**Mental Health Access Calls**
In FY 19/20, there were 9,491 total Mental Health (MH) calls/entries, an average of 791 calls per month, close to last fiscal year's average of 743 calls per month. Nearly half of all calls for adults (48%) were to request information or "other". About one-fifth of all calls were classified as crisis/emergencies (23%), another 8% were urgent calls. Routine calls were 21% of all calls. These are similar proportions to last fiscal year. Calls are displayed below by age and type. While almost half of adult calls were to request information, half of youth calls were "routine" (53%). About a third of calls were to request information or "other" for youth, 11% were classified as crisis/emergencies, and another 4% were urgent calls.

**Adult MH Access Calls by Type FY 19/20**




Crisis/Emergency · Urgent · Routine · N/A Other Information

**Youth MH Access Calls by Type FY 19/20**




Crisis/Emergency · Urgent · Routine · N/A Other Information

### Alcohol and Drug Program Timeliness

See table below. For *routine* calls for alcohol and drug services, 88% of adults were offered an appointment within 10 days, while this standard was met for 92% of youth. For *urgent* calls, 78% of adults were offered a same or next day appointment; 100% of youth calls met this standard. Finally, for *crisis* calls, 100% of adults were offered a same or next day appointment; there were no youth calls that were designated as crisis.

| **ADP Access Timeliness, FY 19/20** | | | |
|---|---|---|---|
| | | **Adult** | **Youth** |
| **Routine** | Offered an appointment within 10 business days | 88% | 92% |
| **Urgent** | Offered an appointment within same/next day | 78% | 100% |
| **Crisis** | Offered an appointment within same/next day | 100% | N/A |

### Mental Health Timeliness

See table below. For *routine* calls for mental health services, 88% of adults were offered an appointment within 10 days, while this standard was met for 95% of youth. For *urgent* calls, 95% of adults were offered a same or next day appointment; 72% of youth calls met this standard. The low percentages for *urgent* calls to youth highlight an area for timeliness improvement that was not identifiable when both age groups were previously examined together. It is valuable to note that this figure was based on a small N, which allowed screeners to review classification and timeliness, and also led to immediate training for access screeners about the definition of an urgent call and the timeliness standards. Finally, calls designated as *crisis* remained similar to last year's averages: of 98% of adults were offered a same or next day appointment, while 97% youth calls met this standard.

| Mental Health Access Timeliness, FY 19/20 | | | |
|---|---|---|---|
| | | **Adult** | **Youth** |
| **Routine** | Offered an appointment within 10 business days | 88% | 95% |
| **Urgent** | Offered an appointment within same/next day | 95% | 72% |
| **Crisis** | Offered an appointment within same/next day | 98% | 97% |

## Access and Assessment Staff Program Performance (FY 19-20)

| Unique Clients Served | | | | | | |
|---|---|---|---|---|---|---|
| | Access & Assessment ADULT | | | Access & Assessment YOUTH | | |
| | North | South | West | North | South | West |
| **Age Group** | | | | | | |
| 0-15 | 0 | 0 | 0 | 133 | 98 | 0 |
| 16-25 | 107 | 4 | 29 | 59 | 67 | 0 |
| 26-59 | 384 | 133 | 190 | 0 | 0 | 0 |
| 60+ | 62 | 22 | 26 | 0 | 0 | 0 |
| Missing DOB | 0 | 0 | 0 | 0 | 0 | 0 |
| ***Total*** | ***553*** | ***159*** | ***245*** | ***192*** | ***165*** | ***0*** |
| | | | | | | |
| **Gender** | | | | | | |
| Female | 260 | 71 | 148 | 99 | 88 | 0 |
| Male | 291 | 87 | 96 | 93 | 77 | 0 |
| Unknown | 2 | 1 | 1 | 0 | 0 | 0 |
| | | | | | | |
| **Ethnicity** | | | | | | |
| American Indian or Alaska Native | 9 | 4 | 7 | 1 | 3 | 0 |
| Asian | 6 | 2 | 6 | 0 | 4 | 0 |
| Black or African American | 16 | 9 | 16 | 4 | 3 | 0 |
| Mixed Race | 9 | 26 | 3 | 3 | 9 | 0 |
| Native Hawaiian or Pacific Islander | 0 | 0 | 1 | 0 | 0 | 0 |
| White | 495 | 105 | 208 | 179 | 130 | 0 |
| Other/Not Reported | 18 | 13 | 4 | 5 | 16 | 0 |
| | | | | | | |
| **Hispanic or Latino** | | | | | | |
| Hispanic or Latino | 265 | 58 | 99 | 149 | 111 | 0 |
| Not Hispanic or Latino | 271 | 81 | 141 | 37 | 38 | 0 |
| Not Reported | 17 | 20 | 5 | 6 | 16 | 0 |

**Access and Assessment Client Outcomes**

| | Access & Assessment ADULT | | | Access & Assessment YOUTH | | |
|---|---|---|---|---|---|---|
| | North | South | West | North | South | West |
| **Incarcerations** | 1% | 4% | 1% | -- | -- | NA |
| **Crisis Services** | 7% | 7% | 2% | 1% | 5% | NA |
| **Psychiatric Inpatient Care** | 2% | 2% | 0% | 1% | 1% | NA |

In the 2019-2020 fiscal year, the Access and Assessment Team in North County saw 2-3 times as many clients as the teams in West and South County. To understand this variation, it is important to understand that clients have the choice to either complete an initial assessment on the phone with an Access screener or in-person as a walk-in to one of these clinics. Clients may choose, and clients in North County may prefer to speak with someone face-to-face rather than on the phone. Further, North County has a higher portion of their population on Medi-Cal, and therefore the Access and Assessment Team may screen more Medi-Cal clients who are then ultimately referred to Holman or the community for a lower level of service intensity.

The client outcomes table displays the percent of unique clients who experienced a higher level of care during their admission to the Access and Assessment program in the 19-20 fiscal year. The source of incarceration data is the Santa Barbara Jail and therefore only includes adults; clients were matched from the county electronic health record to the FY 19/20 jail roster. Juvenile hall data were unavailable this year and we are unable to report on these metrics. The source of psychiatric inpatient and crisis services data is the electronic health record. In the adult program, 1% of clients in North County, 4% of clients in South County, and 1% of clients in West County experienced a jail stay during their admission. Seven percent of clients in North County, 7% of clients in South County, and 2% of clients in West County had crisis services contact during their program admission. Two percent of clients in North County, 2% of clients in South County, and 0% of clients in West County experienced hospitalization during their program admission. In the child program, 1% of clients in North County and 5% of clients in South County had crisis services contact during their program admission while 1% of clients in North County and 1% of clients in South County experienced hospitalization during their program admission.

## NEW: PEI Mental Health Student Services Act (MHSSA) Grant

| **Provider:** | **Behavioral Wellness, Santa Barbara County Education Office (SBCEO) – Health Linkages, Community Partners** |
|---|---|
| **Estimated Funding FY 2021/22:** | |
| Estimated Total Mental Health Expenditures | $1,061,100 |
| Estimated PEI Funding | |
| Estimated Medi-Cal FFP | |
| Estimated 1991 Realignment | |
| Estimated Behavioral Health Subaccount | |
| Estimated Other Funding | $1,061,100 (State MHSA) |
| Average Cost Per Consumer | TBD with Grantor |
| Estimated Total of Consumers Served | TBD with Grantor |
| Target Population Demographics Served | Children, TAY |

This is a new collaborative grant with Behavioral Wellness, Santa Barbara County Education Office (SBCEO) – Health Linkages, and Community Partners such as Youth Well Coalition and Mental Wellness Center.

The target population demographics to be served are school-aged youth PK through 12th grade with a focus on high-risk youth including foster, LGBTQ and students who have been removed from the school environment through suspension and/or expulsion.

In July 2020, Behavioral Wellness was awarded a Mental Health Student Services Act grant to bring mental health and substance use resources to the Santa Barbara County schools. The Department collaborated with Santa Barbara County Education Office, Mental Wellness Center and YouthWell to develop the plan which provides participating schools with Navigators and Clinicians to help connect students and families with mental health resources and make direct referrals to community-based organizations and County resources. MHSSA programming focuses on providing education, prevention and early intervention in order to decrease the need for higher levels of care. It will also create additional referral pathways for higher levels of care while collaborating with additional partners to increase access to services.

Activities will include suicide awareness and prevention, drop-out prevention and outreach to high-risk youth including foster, LGBTQ and students who have been removed from the school environment through suspension and/or expulsions. Outreach and educational opportunities for students, teachers, administrators, other school staff, parents and community members will include training around Youth Mental Health First Aid, mental health awareness and stigma reduction, substance use issues. Additional professional development opportunities will also be extended to increase awareness of MHSSA funded activities while increasing staff capacity to identify and address emerging mental health and/or substance use issues.

Funding includes hiring Behavioral Health Clinicians (1.5 FTE) and contracting with a community-based organization for Service Navigators (6.0 FTE) to provide direct services and linkages to students and their families. Additional personnel include a .25 FTE Research/Evaluator to assist with data collection, analysis, and grant reporting and a 1.0 FTE Project Manager to coordinate grant programming along with ensuring the goals of the MHSSA Grant are met.

Performance Measurement for the grant:

1. Preventing mental illness from becoming severe and disabling,
2. Improving timely access to services for underserved populations,
3. Providing outreach to families, employers, primary health care providers, and other to recognize the early signs of potentially severe and disabling mental illness,
4. Reducing the stigma associated with the diagnosis of a mental illness or seeking mental health services,
5. Reducing discrimination against people with mental illness, and
6. Preventing negative outcomes in the targeted population, including, but not limited to:
    - a. Suicide and attempted suicide
    - b. Incarceration
    - c. School failure and dropout
    - d. Unemployment
    - e. Prolonged suffering
    - f. Homelessness
    - g. Removal of children from their homes, and

h. Involuntary mental health detentions.

**Program Challenges and Solutions**

The presence of the Department programs or support agencies on campuses is a hot topic. Youth throughout the County and their families/support systems often request behavioral health services on campus and improved linkages to care within the varied health care networks for students in these schools. As a result, Youth services are a priority for the Three-Year period and a Youth Proposal is included in this plan. This grant award is a component of the Youth Proposal as increased collaboration between schools, community agencies, and health care plans is essential to increasing awareness of services, improved access to care, and reduction of stigma. The impact of COVID-19 on the initial launch of the grant beginning in October 2020 may extend the grant an extra year along with initial grant services targeted for Fall 2021 in schools and linkages to Mental Health First Aid trainings with community providers in Summer 2021. Grant Reporting will be coordinated with the Mental Health Oversight and Accountability Commission who established the grant.

## NEW: Early Psychosis Intervention Grant Project

| Provider: | Behavioral Wellness |
|---|---|
| **Estimated Funding FY 2021/22:** | |
| Estimated Total Mental Health Expenditures | $ 401,800 |
| Estimated PEI Funding | |
| Estimated Medi-Cal FFP | |
| Estimated 1991 Realignment | |
| Estimated Behavioral Health Subaccount | |
| Estimated Other Funding | $ 401,800 (State MHSA) |
| Average Cost Per Consumer | TBD with Grantor |
| Estimated Total of Consumers Served | TBD with Grantor |
| Target Population Demographics Served | TAY |

In August 2020, Behavioral Wellness was awarded by the Mental Health Oversight and Accountability Commission an Early Psychosis Intervention grant to implement a Coordinated Specialty Care (CSC) a high-quality, evidenced based program focused on treating transitional-aged youth who are currently or have recently experienced a First Episode Psychosis. Program components include case management, recovery-oriented psychotherapy and relapse prevention, family psychoeducation and psychotherapy, educational and vocational support, and pharmacotherapy and primary care coordination. The CSC model seeks to improve the lives of transitional-aged youth with mental health needs before escalation of symptoms to the level of severe or disability while decreasing the duration of untreated psychosis and mood disorders. Targeted population is youth ages 16-24.

A key strategy for positive outcomes includes reduction of time between onset of symptoms and receiving treatment. Therefore, access to early intervention mental health services within a comprehensive, integrated system of care is essential to achieving improved outcomes for youth experiencing episodes of psychosis or mood disorder. CSC staff will identify and address the unique needs of each participant through a shared decision-making approach. Individuals and their families will be supported through a team-based structure of support which provides a full continuum of services to assist in their recovery. By implementing this whole person approach, clients and their support systems will be engaged throughout the treatment process leading

to an increase in long-term positive outcomes, including allowing clients to obtain life goals they set before experiencing mental health challenges.

**Program Challenges and Solutions**

Although the Team Lead was hired in late December 2020, hiring additional staff has been slow with initial implementation. Additionally, the TAY clinic in North County was not large enough to accommodate the expansion of staff. Other barriers include impacts due to COVID including lack of staff to implement the changes from all departments countywide including General Services due to low supplies of materials needed to make infrastructure changes and being short staffed. General Services has also committed to completing the facility improvements by end of 2021 including Department leasing of additional space to provide grant services.

Grant funding includes Technical Assistance through University of California, Davis. The support was not available until late May 2021 which has impacted the initial implementation of setting up an evaluation plan and staff trainings. Staff dedicated to the CSC program will need to be trained on the model prior to providing services. The training is anticipated to start within the next three months, by which time CSC staff should all be hired. Historically, the Department has served a relatively low population of youth presenting with First Episode Psychosis. Therefore, the CSC model will not be a standalone program, but rather will need to be integrated within our current TAY-focused services due to the small size of the program. The Department looks forward to working with Technical Assistance to design an integrated CSC program that will best serve the youth in our community with this State MHSA grant program.

## Innovations

### Resiliency Interventions for Sexual Exploitation (RISE) Project [Ended FY 2019-2020]

| **Provider:** | **Behavioral Wellness** |
|---|---|
| **Estimated Funding FY 2021/22:** | **RISE project completed FY 19/20** |
| Estimated Total Mental Health Expenditures | $0 – Including summary to publish evaluation data for stakeholders |
| Target Population Demographics Served | Children, TAY |

The Resiliency Interventions for Sexual Exploitation (RISE) Project empowered and supported 163 youth participants, ages 10 to 28, who were either at risk or exposed to commercial sexual exploitation (CSE). From 2015-2020, the RISE Project collaborated with several partner agencies across Santa Barbara County (SBC) to offer a multi-faceted approach that addressed participants' needs and built on their strengths. Providing bio-psycho-social support, the RISE Project approached intervention within stages, recognizing that clients have diverse needs as they progress through engagement and treatment. Each stage lasted days, weeks, or years, depending on each participant's journey. At the onset of treatment, when clients were in the engagement and stabilization stages, the focus was on rapport and trust building before implementing assessment protocols. The RISE Project developed and implemented new "smart" tools to support gender- and cultural-specific service goals. Assessment data indicate that participants entered with a long history of prior admissions to mental health services and a significant history of adverse childhood experiences. Fortunately, RISE Project participants also presented with personal strengths they could build on. Participants typically cycled between stages, often returning to "stabilization" several times before advancing into "coping strategies" or "maintenance." Thus, few clients reached the "leadership" stage, which is a journey that took several years. Overall,

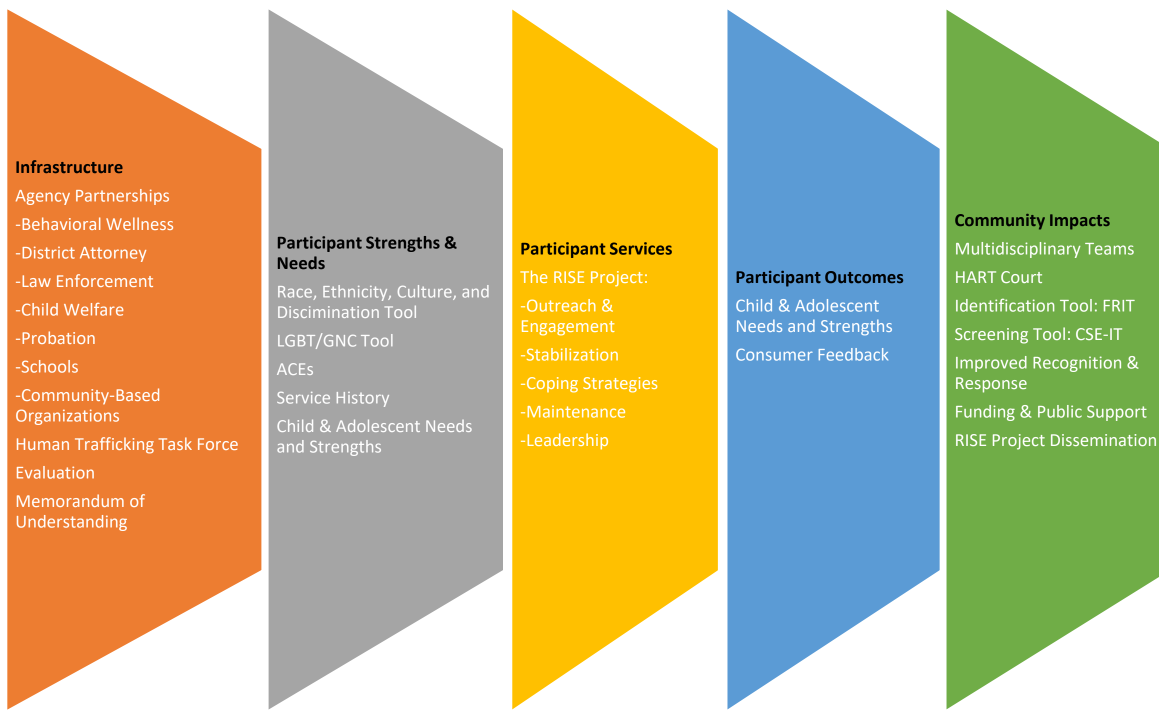
participants tended to be highly satisfied with services and felt supported by the RISE Project staff. Results suggest that the RISE Project was experienced as a safe and supportive program that provided meaningful support and opportunities.

The RISE Project helped several Santa Barbara County agencies institute CSE trainings, protocols, prevention, and intervention activities. Central to RISE Project success was the pre-planning process and collaboration between County partners. These collaborative partnerships were key in shifting the community toward a trauma–informed lens and transforming the culture from criminalization to treatment and support. This included partnering with the SBC District Attorney's Human Trafficking Task Force to implement a countywide First Responder Identification Tool, which includes indicators of suspected CSE and instructions to make a suspected child abuse report. The RISE Project was also key in adopting the WestCoast Children's Clinic Commercial Sexual Exploitation Identification Tool for use in service delivery. Multidisciplinary teams and the Helping to Achieve Resiliency Treatment Court for CSE children were also new and formalized methods of interagency collaboration established in partnership with RISE. Media coverage and newly developed partner resources about CSE reflect the improved recognition and response to CSE achieved since the RISE Project implementation. Together, partners have provided trainings including developing a documentary that summarizes CSE in SBC. The RISE Project has been designated as a promising program, been presented about at professional conferences, and has been documented in peer-review publication. The RISE Project also developed a Toolkit for Developing an Effective Multidisciplinary Response to Serve Exploited Youth to help disseminate lessons learned to other counties, behavioral health departments, and community-based organizations.

This Evaluation Summary of the Project was made available in collaboration with Jill Sharkey and other community partners. The full final program evaluation can be viewed on the Behavioral Wellness website.

**RISE Executive Evaluation Summary:**

The Resiliency Interventions for Sexual Exploitation (RISE) Project aimed to empower and support youth, ages 10 to 28, who are either at risk or exposed to sexual exploitation or trafficking. From 2015-2020, the RISE Project collaborated with several partner agencies across Santa Barbara County to offer a multi-faceted approach that addressed participants' needs and built on their strengths as depicted in the following logic model.




The report addresses accomplishments in each of the four project target areas.

| **Evaluation Goal #1: Effectiveness and Impact of Using a Shared Screening Tool** | | | |
|---|---|---|---|
| Objective | Met? | Evidence | Barriers |
| Implement Countywide First Responder Identification Tool (FRIT) | **Met** | FRIT integrated as practice with: Behavioral Wellness, Child Welfare, & Probation | Expanding FRIT to additional agencies, Schools, Law Enforcement, Other youth-serving agencies |
| Implement Sexual Exploitation Identification Tool for in-depth screening (CSE-IT) | **Met** | CSE-IT integrated as practice with: Juvenile Hall & Child Welfare | Expanding use and increasing sustainability. |
| Increase identification of youth at-risk for or with clear concern of CSECY. | **Met** | Agencies have identified 430 youth, some duplicated–far more than ever identified. | Broader implementation with more agencies and unduplicated counts. |

The RISE Project partnered with the Santa Barbara County District Attorney's Human Trafficking Task Force (HTTF) to develop and implement a countywide First Responder Identification Tool (FRIT). The FRIT includes indicators of suspected commercial sexual exploitation (CSE) and instructions to make a suspected child abuse report (SCAR). In addition, the RISE Project was key in adopting the WestCoast Children's Clinic Commercial Sexual Exploitation Identification Tool (CSE-IT) for use in service delivery systems. The CSE-IT guides a structured interview to determine if a person has possible or clear concern of CSE. The RISE Project helped county agencies institute CSE protocols. For example, Santa Barbara County Behavioral Wellness implemented screening questions and a response protocol with their 24/7 toll-free crisis response and service "Access" line.

| **Evaluation Goal #2: Impact of RISE for Young Women Vulnerable to or Involved in CSECY** |
|---|

| Objective | Met? | Evidence | Barriers |
|---|---|---|---|
| Engage participants in services that address their needs | Met | A total of 163 unique participants were engaged in services specifically tailored to build on their strengths and address their needs. | The RISE Project was in high demand for providing training, outreach, and direct services throughout a geographically large county. A more coordinated effort across agencies would support more survivors. |
| Increase engagement for LGBT/GNC CSEC youth. | Partially Met | Developed and pilot tested the *LGBTGNC Tool* | Consistent implementation with participants who identify as LGBTGNC |
| Increase attention to race, ethnicity, culture, and discrimination. | Partially Met | Developed and pilot tested the *Race, Culture, and Discrimination Tool* | Consistent implementation with all participants. |
| Increase participant strengths | Met | Participants' strengths were higher at later assessments; most strengths showed more positive than negative growth at 12 months for matched participants. | Some participants showed negative growth at 12 months. Without an experimental design and control group it is impossible to know how participants would have functioned without intervention. Moreover, staff felt that CANS were challenging to rate at intake and results may have been more accurate over time. |
| Reduce participant needs | Met | Participants' highest needs were lower at later assessments; most needs showed more positive than negative growth at 12 months for matched participants. | |
| Achieve participant satisfaction | Met | Clients provided anonymous feedback about RISE and it was very strongly positive. | Obtaining consistent feedback from all participants. |

The RISE Project provided bio-psycho-social support to children and youth exposed to or at risk of sexual exploitation and trafficking. The approach relied on interagency collaboration and multi-layered treatment, training, and education that included partners throughout the community. A comprehensive female specific and trauma-informed model of services, resources, protocols, education, and training was developed, implemented, and tested for efficacy.

The RISE Project approached intervention within stages, recognizing that clients have different needs as they progress through engagement and treatment. Each stage may take days, weeks, or years, depending on each individual's journey. At the onset of treatment, when clients are in the engagement and stabilization stages, the focus is on developing rapport and gaining trust before implementing relatively invasive assessment protocols. Participants typically cycle between stages, often returning to "stabilization" several times before more consistently advancing into "coping strategies" or "maintenance." Thus, few clients reached the "leadership" stage of the RISE Project, which is a journey that takes several years.

Overall, demographic data were collected for 163 RISE Project participants in the Behavioral Wellness data system although not all clients received all assessments. Most participants received a diagnosis of Post-

Traumatic Stress Disorder (57.7%) followed by Major Depressive Disorder (17.1%). ACEs scores were available for 51 clients with an average of 5 to 6 ACEs. Common ACEs were sexual abuse, emotional abuse, witness to community violence, witness of family violence, disruption to caregiving/attachment losses, and victim witness to criminal activity. A lifetime history of prior Behavioral Wellness services provided to clients in RISE was available for 159 RISE Project participants. Only 9% of clients referred to Behavioral Wellness entered the RISE program at their first admission. More common pathways into the Behavioral Wellness system were through children and youth outpatient (32%), Crisis Services (26%), Alcohol and Drug Prevention (15%), and juvenile justice (10%).

The RISE Project developed and piloted two smart tools to enhance the assessment of youth needs to more effectively support them starting with program engagement. The **LGBT/GNC Tool** was developed because youth with minority sexual orientation or gender identity are common within the CSECY population and may require specialized treatment to process experiences of discrimination and/or support identity development. The **Race, Culture, and Discrimination Tool** was developed because youth from certain racial/ethnic groups–including African American, Asian Pacific Islander, Hispanic/Latino(a), and indigenous Native Americans–have been historically underrepresented in mental health treatment and in the research and evaluation of evidence-based treatments.

RISE administered the CANS as a multi-purpose tool used across systems of care to identify participant strengths and needs. The most common strength at intake was Educational (54.8%) followed by Talents and Interests (45.2%), Natural Supports (37%), Family Strengths (28.1%), Spiritual Religious (24.4%), Community Life (23.7%), and Interpersonal (17.8%). At subsequent CANS time points, more participants were rated with having most strengths. The most common need at intake was Social Functioning (66.6%) followed by Family Functioning (64.4%), Depression (61.5%), Adjustment to Trauma (60.7%), School Achievement (55.5%), Anxiety (54.8%), and Living Situation (54.8%). Social Functioning, Family Functioning, Depression, School Achievement, and Living Situation saw large decreases in the percentage of youth with these needs at 12 months.
Participants were asked to provide feedback about the RISE Project and related services, confidentially. Results indicate that clients really enjoy RISE because they enjoy being able to talk to people they trust, they get the things they need, they express their emotions, they get support, they learn coping skills, and they are monitored.

| **Evaluation Goal #3: Interagency Collaboration and Impacts on Improved Recognition and Response** | | | |
|---|---|---|---|
| Objective | Met? | Evidence | Barriers |
| CSECY Interagency MOU | **Met** | An MOU was developed and executed. | Maintaining trust and collaboration over time. |
| Participant referrals and interagency collaboration | **Met** | Multidisciplinary Teams included RISE; HART Court was developed, approved, and functioning. | Engaging schools, medical professionals, and additional service providers in the MDTs. |
| Increased public awareness of CSECY | **Met** | Media coverage, consultation requests, & county partner resources | Continuing to address myths and sustain trainings |

Central to RISE Project success was the pre-planning process and ongoing collaboration between all partners. These collaborative partnerships have been key in shifting the community toward a CSE– or Trauma–Informed

Lens and changing the culture from criminalization to treatment and support. Evidence of such collaboration is found in media reports as well as RISE staff interviews regarding referrals and interagency collaboration. Identification and reporting protocols, multidisciplinary teams, and the Helping to Achieve Resiliency Treatment Court for CSE children (HART Court) are all new and formalized methods of interagency collaboration established in partnership with RISE. Media coverage and newly developed partner resources about CSECY are evidence of the improved recognition and response to CSECY achieved since the RISE Project was implemented.

| **Evaluation Goal #4: Increases in Funding and other Public Support** | | | |
|---|---|---|---|
| Objective | Met? | Evidence | Barriers |
| Countywide CSECY Toolkit developed and published | **Met** | The Toolkit is posted on the Behavioral Wellness Website | Dissemination. |
| RISE Project Public Support | **Met** | RISE documentary; media coverage | Updating the documentary and sustaining media coverage. |
| RISE Project Professional Support | **Met** | RISE was designated as a promising practice; has been presented about at professional conferences; and is published in a peer-reviewed journal | Funding is needed to support the full spectrum of services the RISE Project was able to deliver that TAY-FSPs cannot. |
| Increased funding for CSECY | **Partially Met** | Santa Barbara County District Attorney and Sheriff have been awarded six-years of funding for human trafficking work | Countywide coordination is needed, alongside additional dedicated funding, to support survivors outside the parameters of full-service partnerships. |

The RISE Project has been a key partner within the Human Trafficking Task Force (HTTF) to support survivors once identified. Together, partners have provided trainings including developing a documentary that summarizes CSECY in Santa Barbara County. Media coverage demonstrates public support and funding including nonprofit partnerships. The RISE project has been designated as a promising program, been presented about at professional conferences, and has been documented in peer-review publication. These collaborations have supported additional grant funding to the county and efforts to sustain the wide array of programming offered by the RISE Project.

**CONCLUSION**

The RISE Project had a positive impact on awareness of CSECY and the identification, screening, and intervention with survivors of CSECY. Moreover, the RISE Project supported dozens of identified survivors previously served within juvenile justice systems including juvenile detention. The RISE Project was instrumental in radically shifting the perspective that services need to be provided in communities to youth wherever they are most comfortable. CSECY is a lucrative, hidden, and pervasive problem that needs ongoing innovative work to address in Santa Barbara County and beyond. The RISE Project provided Santa Barbara County with the resources and a toolkit to serve as a road map for continuing this important work.

Moving forward, a key to engaging all survivors of CSECY, regardless of their readiness for participation in a TAY-FSP, will be coordinating across the county with other agencies and nonprofit organizations to develop

continuum of care to efficiently prevent, identify, engage, house and fully support CSECY. The MHSA Innovations funding accelerated Santa Barbara County's understanding of what innovations it takes within the mental health system of care to accomplish this and found that a) it takes specialized training in CSECY in order to do this work and b) no one agency can tackle this alone. Institutional partners including the district attorney, department of social services, schools, law enforcement, and nonprofit agencies must work together to establish a continuum of care and build capacity until it is possible to eradicate CSECY and identify and serve all children and youth survivors of CSECY.

## Program Performance (FY 19-20)

### RISE (Resiliency Interventions for Sexual Exploitation Project) *

| Unique Clients Served | |
|---|---|
| | **All Regions*** |
| **Age Group** | |
| 0-15 | 16 |
| 16-25 | 43 |
| 26-59 | 0 |
| 60+ | 0 |
| Missing DOB | 0 |
| ***Total*** | **59** |
| | |
| **Gender** | |
| Female | 59 |
| Male | 0 |
| Missing | 0 |
| | |
| **Ethnicity** | |
| American Indian or Alaska Native | 1 |
| Asian | 0 |
| Black or African American | 3 |
| Mixed Race | 3 |
| Native Hawaiian or Pacific Islander | 0 |
| White | 46 |
| Other/Not Reported | 5 |
| | |
| **Hispanic or Latino** | |
| Hispanic or Latino | 44 |
| Not Hispanic or Latino | 12 |
| Not Reported | 3 |

**Note. Regions are combined for the RISE program. Client region data in Clinician's Gateway captures the region a client was opened, which is most often North County due to the location of the services (such as juvenile hall or group homes). However, clients come from across the county so combining regions is more accurate for the RISE program.*

**Client Outcomes**

| Child & Adolescent Needs & Strengths Assessment (CANS-50) Age: 6-20 years | Percent Improvement | |
|---|---|---|
| | Initial to 6 months (n = 39) | 6 to 12 months (n = 20) |
| **Life Functioning** (e.g., ability to communicate and interact with families, communication, social functioning and health status) | 0.6% | -53.5% |
| **Behavioral/Emotional Needs** (e.g., symptoms of depression, anxiety, psychosis and other conditions) | -9.5% | -42.7% |
| **Risk Behaviors** (e.g., self-injury, suicidal behavior, bullying, and running away) | 14.3% | -56.3% |
| **Cultural Factors** (e.g., language, traditions, stress) | 200.0% | -11.1% |
| **Strengths** (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment) | 3.3% | -56.8% |
| **Higher Levels of Care** | % with any admissions over FY19-20 | |
| | All Regions | |
| **Incarcerations** | 5% | |
| **Crisis Services** | 22% | |
| **Psychiatric Inpatient Care** | 7% | |

**Note.* On the CANS-50, a higher the score indicates more actionable needs (greater problems). A negative percent change indicates that client scores are improving because they have fewer actionable needs.

Due to a state mandated change, Santa Barbara County began using a new version of the CANS (CANS-50) in July 2018. In addition to changing items and domains, the CANS age range was extended to age 20. This means that more TAY-aged clients now receive a CANS. *Cultural Factors* is a new 3-item domain. We did not present *Caregiver Resources and Needs* for these analyses because caregivers that are entered in the Caregiver A section often change across timepoints and are not currently tracked to allow for a matched comparison.

In the first six months of treatment, clients in the RISE program saw slight increases in the number of actionable needs in four of the five domains (*Behavioral and Emotional Needs* was the only domain that saw an improvement). This apparent lack of progress aligns with the program's experience of the necessity of a long period of engagement and trust-building with clients before they are able to engage in more typical therapeutic processes. Further, as clinicians get to know clients better, they often learn additional information that a client may not have initially revealed when the intake CANS was completed. Therefore, while it appears that clients' symptoms are worsening, the six-month scores may actually be a more accurate baseline assessment of functioning. In looking at the *Cultural Factors* domain, average actionable needs scores in this domain experienced positive skew and a floor effect, and these relatively small changes corresponded to a fairly large percent change (200.0%). In looking at six to twelve-month progress, client in RISE experienced gains in all domains.

The client outcomes table displays the percent of unique clients who experienced a higher level of care during their admission to RISE in the 19-20 fiscal year. The source of incarceration data is the Santa Barbara Jail and therefore only includes adults; clients were matched from the county electronic health record to the FY 19/20 jail roster. Juvenile hall data were unavailable this year and we are unable to report on these metrics. The source of psychiatric inpatient and crisis services data is the electronic health record. Across all regions, 5% of clients experienced a jail stay during their admission, 22% had crisis services contact during their program admission, and 7% percent experienced hospitalization during their program admission.

## Technology Suite Project- Help@Hand: Technology Advancing to Access and Recovery

| **Provider:** | **Behavioral Wellness** |
|---|---|
| **Estimated Funding FY 2021/22:** | |
| Estimated Total Mental Health Expenditures | $ 896,400 |
| Estimated INN Funding | $ 896,400 |
| Estimated Medi-Cal FFP | |
| Estimated 1991 Realignment | |
| Estimated Behavioral Health Subaccount | |
| Estimated Other Funding | |
| Average Cost Per Consumer | $1,318 |
| Estimated Total of Consumers Served | 680 |
| Target Population Demographics Served | Children, TAY, Adult, Older Adult |

**Statewide Collaborative Project Overview**

Help@Hand is a statewide Collaborative project that began in 2018. With fourteen Counties and Cities leveraging interactive technology-based mental health solutions, Help@Hand helps shape the future by improving accessibility and outcomes to connect people with care across the state. Technology has many benefits, but there are also many challenges and questions. The participating Cities/Counties are at the forefront of innovation in understanding how technology is introduced and works within the public behavioral health system of care. This means Help@Hand is not one project, but many projects across multiple Cities and Counties. The Collaborative offers the benefit of a shared learning experience that increases choices for Counties/Cities, accelerates learning, and adds in cost sharing. The focus of Help@Hand remains on pursuing a shared vision with common goals. Change at the scale of this project necessitates a robust readiness and a change management approach. The project team has focused on building activities that address these areas for both the project team and the community.

The Help@Hand project leads innovation efforts through factors such as:

- Peer Engagement - integrating those with lived experience of mental health issues/co-occurring issues throughout the project,
- Safety & Security - making sure we prioritize the safety and security of the users and their data,
- Incorporating Stakeholder Feedback - the project has a lot of stakeholders with different priorities. Help@Hand tries to find ways to meet the needs of most while adopting an understanding with conflicting feedback it may not be possible to meet the needs of everyone,
- Innovative Technology - always exploring if and how technology fits into the behavioral health system of care,
- Lessons Learned - applying the and incorporating the lessons learned as we continue to demonstrate progress and the responsible use of resources.

Typically, projects are considered successful based on if a project directly improved consumer welfare. However, the test of success in an innovation project can be more nuanced. Innovation is about transforming the system itself, and therefore additional determinations of success includes two questions:

1. *Did participating Cities/Counties learn something proportionate to the investment they made in the project?*

2. Have other Cities/Counties learned from what participants have done and implemented the elements that are valuable to that City/County?

**State-Wide Project Goals:**

1) Detect and acknowledge mental health symptoms sooner;
2) Reduce stigma associated with mental illness by promoting mental wellness;
3) Increase access to the appropriate level of support and care;
4) Increase purpose, belonging, and social connectedness of individuals served; and
5) Analyze and collect data to improve mental health needs assessment and service delivery

**Local Santa Barbara Project Overview**

**Santa Barbara County Target Populations**

Santa Barbara County's target populations for the innovations project are:

1.) Behavioral Wellness Adult Clients Residing in Geographically Isolated Areas;
2.) Transition-age youth (TAY) age 16-25 Enrolled in Colleges and Universities; and
3.) Individuals Discharged from Psychiatric Hospitals and/or Recipients of Crisis Services

**Santa Barbara County Help@Hand Team**

Currently, the project has hired a Project Manager and team of peers through extra-help employment opportunities to assist with the adoption and implementation of new technologies. For Summer of 2021, the project is hired (1) Case Manager to serve as Outreach Coordinator and (2) Recovery Assistants to serve as Digital Mental Wellness Ambassadors serving as experts in the roll-out of wellness apps such as Headspace, support digital literacy efforts and continue the increase of assisting community members connect with smartphones and data/WIFI plans. The local team supports departmental efforts in a myriad of ways from enhancing outreach materials through art, to participating in the development of upcoming grants. This allows for local team to strengthen their employment skills as they seek to further advance their employment opportunities.

**FY 2020-21 Learning Objectives:**

*1) Establish 24/7 Digital Therapeutics Application in English and Spanish*

Status Update: The local Help@Hand team is launching the exploration of Headspace with transition-age youth and youth providers, Behavioral Wellness staff, consumers of mental health services, staff of Crisis Residential Treatment centers and attendees of the Peer Empowerment Conference. Currently, Headspace mindfulness videos are shared with consumers of Behavioral Wellness services and contracted partners at the beginning of groups. This allows for the system of care to prepare for the implementation of technologies while better understanding the stakeholder selected digital therapeutics application of Headspace.

*2.) Strategic approaches to access points that will expose individuals in target populations to the Digital Therapeutics service.*

Status Update: The project is working with recovery learning communities at Transitions Mental Health Association's Helping Hands of Lompoc and Santa Maria RLC along with Mental Wellness Center's Fellowship Club of Santa Barbara to expand outreach and engagement strategies using digital implementation strategies explored by project partners at San Francisco Mental Health America used to deploy Headspace in San Francisco. The project leverages CalMHSA support through bi-weekly Implementation calls attended by research staff with Behavioral Wellness, contracted research staff with University of California at Irvine, Help@Hand team members and contracted Implementation Manager with CalMHSA. The local Santa Barbara team continues to develop ongoing partnerships with community partners serving the project's target populations such as, CommUnify , Transitions Mental Health Association, Mental Wellness Center, Crestwood, Psychiatric Health Facility, Telecare, Santa Barbara Sherriff's Office, Santa Barbara Probation Department, Housing Authority of Santa Barbara, Allan Hancock, Santa Barbara City College and University of California at Santa Barbara to ensure upcoming exposure of the digital therapeutics application.

*3.) Outcome evaluations of all elements of the project, including research and outcomes.*

Status Update: Santa Barbara is actively involved in the development of a research instrument of Headspace. This survey is designed in collaboration with several other counties and is led by digital mental health experts from the University of California at Irvine that will capture data on the statewide learning objectives (July 26, 2018) which are:

- Detect and acknowledge mental health symptoms sooner;
- Reduce stigma associated with mental illness by promoting mental wellness;
- Increase access to the appropriate level of support and care;
- Increase purpose, belonging, and social connectedness of individuals served; and,
- Analyze and collect data to improve mental health needs assessment and service delivery.

The latest Mental Health Services Act Innovation Technology Suite Evaluation Report can be located at:

https://www.countyofsb.org/behavioral-wellness/asset.c/6064

Local researchers are working with the project to develop a survey that capture the likeability and adaptability of technologies selected. Surveys will be distributed with those exploring the digital therapeutics application of Headspace to ensure the project captures engagement. Project is developing a stakeholder feedback report that will hold survey information received along with testimonials from focus groups that are currently being planned.

**Program Challenges and Solutions:**

*1) Access to Technology*

Continuous stakeholder sessions have identified the need to connect community members with smartphones that have data and WIFI plans. To meet this need, the project is working with an authorized Lifeline vendor to train members of the Lompoc and Santa Maria Recovery Learning Centers and a Santa Barbara Help@Hand team member to provide community members with smartphones that have a data and WIFI plan. Help@Hand project also provides unhoused consumers currently receiving services at the in-patient Psychiatric Health Facility with pre-paid phones through TracPhones.

More than 75 community members have received smartphones with data/WIFI plans
More than 10 unhoused community members have received pre-paid phones

*2.) Increasing Digital Literacy*

Continuous stakeholder sessions have identified the need to increase digital literacy with consumers of mental health services and BeWell System of Care providers. To meet the need, the project has contracted Painted Brain to train local Help@Hand staff and work with community partners at Casa De La Raza, Transitions Mental Health Association's Helping Hands of Lompoc and Santa Maria RLC, consumers of mental health services and BeWell System of Care providers through interactive sessions known as "Appy Hours" where topics such as How to Create A Gmail Address, How to Create A Password, How to Use Your Camera Phone, How to Use A QR Reader, How to Zoom, How to Download An App, Using Technology to Support Your Wellness are taught.

More than 150 digital literacy groups have been held throughout Santa Barbara County with over 200 participants

*3.) Deploying Technology Wellness Application*

Continuous stakeholder sessions have identified the need to provide community members with an intro to technology wellness applications. The team leverages the use of Guide to Wellness App Brochure that was created in collaboration with Painted Brain to enhance preparation of deploying a wellness application. Technology and Your Wellness groups are held at the in-patient Psychiatric Health Facility (PHF), Crisis Residential Treatment facilities in Santa Barbara and Santa Maria and throughout the community led by the local Help@Hand team. The project is currently exploring Headspace with transition age youth and youth providers, Behavioral Wellness staff, consumers and staff of Crisis Residential Treatment centers and attendees of the Peer Empowerment Conference. A short survey is given to these participants in order to better understand local end-user's adaptability of the application. The project is working with Brock Travis, a mindful expert, to create an outreach and engagement mindfulness sessions where Brock will host live sessions using the digital therapeutics application of Headspace to answer questions that target populations may have.

## Proposed Hospital Collaboration Project Ideas

| **Provider:** | **Community Partners** |
|---|---|
| **Estimated Funding FY 2021/22:** | |
| Estimated Total Mental Health Expenditures: | Set money aside should funding be available |
| Estimated INN Funding: | Unknown; depends on status of COVID. |

***Where are we today?***

The Crisis Action Team aims to improve system-wide crisis response services while improving relationships and collaborative communication between Behavioral Wellness, Law Enforcement, Hospitals and American Medical Response (AMR). Through this teamwork, the rights of individuals in psychiatric crises are a key focus and needs are met in the least restrictive manner possible. Over the years, the Crisis Services continuum has been a key priority for MHSA based on continued input from the Crisis Action Team and various stakeholders

in planning years. As a result of partnerships, MHSA has a variety of Crisis Programs in the FY 2020-2023 Plan. These include:

**Community Services and Supports (CSS) Funded:**

- Crisis Services in North, South, and West
- Crisis Residential Services North, South, and Agnes
- Crisis Stabilization Unit South

**Senate Bill 82 and CSS Funded:**

- Children's' Crisis Triage Teams in North, South, and West

**Prevention and Early Intervention (PEI) Funded:**

- Safe Alternatives for Children and Transitional Age Youth (SAFTY)
- Access and Assessment and Access Line Service

**Other Non-MHSA Funded:**

- Crisis Stabilization Sobering Center for Substance Use Disorders [Prop 47 Grant]
- Crisis Stabilization North with Dignity Health [NEW: General Funds in 20-21 and then MHSA in 21-22 and 22-23]

***What are some of the current obstacles in our system of care?***

As the Crisis Hub in South County was established with a CSU, Crisis Services, and a new sobering center on one campus, there has been continued interest in partnership in all regions and design of services at a Hospital or close to a Hospital. Centralized services and innovative collaboration have been identified as new mechanisms to provide crisis services.

The Hospital network which includes Marion Medical Center, Lompoc Hospital, and Cottage Health Systems have all supported the implementation of crisis grants in prior years. These include Crisis Triage Adult and Children Programs, Crisis Stabilization development, Crisis Residential Units implementation, and establishment of the sobering center.

Stakeholder feedback from the Crisis Action Team during the planning period and from other stakeholder meetings was focused on a variety of crisis elements. Feedback included interest in focus on how to provide crisis residential or stabilization services to Youth and TAY, ensuring capacity for new CSU's since current CSU underutilized, review if current CSU design and location is essential or could be changed if new CSU's at hospitals, review if MHSA could fund a CSU that is involuntary and if so, possibly setting these up as Involuntary units.



***Future goals and ideas for Collaboration with Hospitals Project?***

The guidelines for Innovations include that "An Innovations project could be an opportunity to try a "new approach" to inform current or future practices in our community… the primary purpose can to promote interagency and community collaboration related to mental health services or supports or outcomes."

***NEW: Hospital Collaboration Project Proposal Idea?***

County, Community, and Hospital collaboration involving crisis services, such as implementing hospital-based Crisis Stabilization Unit(s) for adults, and perhaps Children and TAY, if feasible.

A continued partnership with the County to collaborate on expansion of service by development of additional Crisis Stabilization Units at or near hospitals has been proposed. This would be an innovative proposal that the collaborative partners would create and submit for approval to the Mental Health Oversight and Accountability Commission after stakeholder input process. In order to utilize Innovation funding, the availability of funding is key. As a result of the pandemic, the projection of these funds and rules regarding usage of this funding source are not clear. The Department will be monitoring status of these funds availability and policies on utilization of funds.

***Program Challenges and Solutions***

Behavioral Wellness plans to open a Crisis Stabilization Unit in partnership with Dignity Health at Marian Regional Medical Center. The County agreement will support Marian's new CSU unit for voluntary outpatient Crisis Stabilization services for Santa Barbara County Medi-Cal beneficiaries who are experiencing a psychiatric emergency or mental health crisis. It will be located in Santa Maria as the first North County CSU. The Department anticipates requesting Board of Supervisor's approval of a pilot agreement for three years and opening in late 2021. The Medi-Cal operations is estimated to be $1,600,000 per year from Medi-Cal and matching funds for an average of 1.6 slots per service day. Initially, the matching funds will be general funds and in future years, MHSA will be an option if there is funding available as a result of growth. The funding streams likely will be Community Services and Supports (CSS) although Innovations could be an alternative pending MHSOAC approval if the project contained innovative elements. The new CSU is designed for 8 slots per day. The County has been collaborating with all three local hospitals and the Hospital Association for additional projects in this continuum of care and will continue discussions regarding crisis services in the upcoming year.

*Dignity Health CSU Grand Opening- article image from Santa Barbara KEYT News Channel*

# 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. The Depot Street project was finalized this year and added 34 new Permanent supported housing units in Santa Maria. In addition, a state funding source HomeKey was leveraged to create homeless housing for those homeless or at risk of homelessness.

## MHSA Housing Projects:

- **Garden Street Apartments, Santa Barbara**

MHSA housing funds support ten affordable units for persons with mental illness in South County.

- **Home-based 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.

- **Residences at Depot Street**

MHSA funds support 34 units, including family units, for persons with mental illness including studios, one- and two-bedroom units.

Picture of Residences at Depot St. during construction, photo provided by Prop 63 funded Help@Hand team

## The "No Place like Home" Initiative

The Department is entering the final stages of the States No Place like Home initiative, established pursuant to AB 1618/1628. This Initiative diverted 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 and have a serious mental illness. 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 could 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 for a minimum of twenty years.

Santa Barbara County is fully participating in this initiative, and has submitted proposals for both funding allocations:

1) **West Cox Cottages**: The Department  jointly applied with the Housing Authority for the County of Santa Barbara for $1.5 million in non-competitive NPLH funds, and were awarded this funding June 2020. This money funded 13 units exclusively for persons with a serious mental illness experiencing homelessness. Construction is pending and leasing of units is anticipated to begin late 2021. It is expected that the development will be fully housed and supportive services in place by the end of this summer.

2) **Hollister Lofts:** The Department  jointly applied with the Housing Authority for the County of Santa Barbara for $4,822,998 in NPLH competitive funds. We were awarded funding in June 2020. These funds will be used to build 18 units exclusively for persons experiencing homelessness and with a serious mental illness in South County. Construction is expected to begin on this development in 2022.

3) **Hollister II:** The Department has jointly applied with Sanctuary Center of Santa Barbara  for both competitive and non-competitive funding for 16 Single Residency Units to be used exclusively for persons

with a serious mental illness experiencing homelessness. The Development will be located in downtown Santa Barbara. The Department has been awarded non-competitive funding for two units and will possibly reapply for competitive funding in the winter of 2022.

4) **Cypress and 7th:** The Department will jointly apply with the Housing Authority for the County of Santa Barbara for $550,000 in NPLH non-competitive funding 14 units exclusively for persons experiencing homelessness and with a serious mental illness in mid-County.

### Other Housing Projects:

This fiscal year the Department was able to participate in a broad-based community project leveraging "HomeKey" funding from the state to create homeless housing. The Department sold a building in Lompoc, used for staff offices, but formerly a motel, to Housing Authority of the County of Santa Barbara. Several county departments were deeply involved in facilitating this project including General Services, the CEO, and Housing and Community Development. These units were constructed in record time and occupancy for all units occurred by January 2021. Funding was provided for onsite case management 20 hours a week by a community-based partner and these services will be shifted to MHSA funding in time.

## Workforce Employment and Training (WET)

Workforce Education and Training (WET) is one of the five components of MHSA which supports the broad continuum of Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Capital Facilities, Technology and Innovation.

The WET component of MHSA addresses the fundamental concepts of developing and enhancing a workforce (both current and future workforce resources) that is culturally competent, provides client/family driven mental health services, and adheres to values of wellness, recovery and resiliency. Our Department has dedicated WET funding by transferring funds from CSS and through our WET Regional Partnership (Southern Counties Regional Partnership or SCRP) to achieve this goal.

In the past year, the Department has used CSS/WET to fund part of the peer empowerment manager position, part-time Recovery Assistant positions in the Department and has helped to fund a WET Coordinator position and supportive training staff. Through wise and prudent spending of the Southern Counties Regional Partnership (SCRP) funds, the Department is continuing to utilize SCRP funding from prior years and has committed additional funds this year to the new WET SCRP grant opportunity through the State. Santa Barbara County Behavioral Wellness continues to act as the fiscal agent for the SCRP and will assist in managing the new WET grant that has been awarded to the SCRP. These existing and new WET funding sources will be utilized to sustain employment through education and training, and recruitment opportunities created through education and training programs.

**Internships and Training Programs:**

During FY 2019-20 funding was allocated for a Manager of Training and Special Projects. This position was to fill the role of the WET Coordinator to assist with SCRP activities and develop internship and training programs for the Behavioral Wellness department. During FY 2020-21 the manager of training and internships has worked to develop new relationships with a variety of educational institutions and has been involved in revitalizing other existing relationships to foster internship programs and student placement. Other infrastructure has been created with the development of two new department policies on supervision of pre-licensed clinicians/students and internship programs. These policies help to clarify duties, responsibilities, and structure of recruitment, onboarding, supervision, and due process for internship problems. The manager has also worked on an internal level to work to enhance the department capacity to provide internship opportunities. Clinical supervision training has been provided to prepare new licensed staff for the roll of a clinical supervisor, collaboration with HR to clarify job specifications to allow for additional staffing classes to act in the roll of a clinical supervisor, and a documentation support group to begin to lessen the number of staff on note review status which will open up additional space to take on students within the various clinics.

**Program Challenges and Solutions:**

With the internships and training programs for both administrative writing and clinical internships, the current staffing of the department is very challenged with hard-to-fill positions remaining unfilled over an extended period of time and with delays in filling open positions or promoting existing staff. This creates a strained staffing infrastructure and thus limits the number of internships that can be offered to students. Activities will continue to address these challenges in FY 2021-22 in order to grow the internship program.

## Consumer Empowerment and Peer Employment (WET)

| **Provider:** | **Behavioral Wellness** |
|---|---|
| **Estimated Funding FY 2021/22:** | |
| Estimated Total Mental Health Expenditures: | $122,800 |
| Estimated CSS Funding to WET: | $122,800 |
| Target Population Demographics Served | CHILDREN, TAY, ADULT, OLDER ADULT |

Part of the peer empowerment manager position and part-time employment opportunities for peers continue to be funded by WET sustained by a transfer from CSS through FY 2020-21. The part-time employment opportunities are for peers that have completed the Workforce and Education Training (WET) Peer Specialist training as Peer Expert Pool Staff and continue to complete ongoing training that is provided through the Quarterly Peer Employee Forum. In addition to peer employment as a Recovery Assistant, peers have also been employed through the Help@Hand Innovation project. This is described in the update section on Innovation plans.

The Peer Empowerment Manager and the Manager of Internships and Special Projects have participated in a variety of focus groups, informational sessions and advisory group meetings during the year regarding the new Peer Certification bill that was signed into law in 2020. After receiving final guidance from DHCS, the department will move forward with finalizing plans to implement the peer certification activities within the department. During FY 2020-21, Department peer workforce received a Peer Support Specialist training which was provided by Crestwood Behavioral Health. Additionally, plans have begun to implement a peer support specialist internship program which will provide training and development activities for peers that are new to this profession and interested in a career pathway as a Peer Support Specialist and completing the Peer Certification process. Training will be enhanced in FY 2021-22 to meet the specifications of the Peer Certification requirements and to support any new peers in the internship program.

- **Peer Workforce**

Throughout FY 2020-2021, the Peers workforce continued to receive trainings at the quarterly Peer Employee Forums, Behavioral Wellness training department and Relias Learning Platform to enhance their skill set to ensure appropriate delivery of peer support services. The Peer Employee Forum is a Peer Support Specialist training platform and Peer Employee Stakeholder forum. Also, during this period, peer staff continued to participate in the MHSA Community Planning Program Process and provide input/feedback regarding peer programming, peer certification and the Process Improvement Project- Psychiatric Health Facility Discharge project (warm-handoff).

In addition, the Peer Empowerment Program achieved great accomplishments. A highlight during this fiscal year is peer support staff and community-based organization peer support staff were trained in the practice of Peer Support services by Crestwood Behavioral Health through a grant from the Office of Statewide Health Planning and Development. Twenty-five Peers participated in the Peer Personnel Program and received a certification of accomplishment. To further support peer staff and the practice of peer support services, all managers and supervisors received training on peer support services and how to supervise peer support. Another accomplishment during this period is peer staff received a five-day Wellness and Recovery Action Plan (WRAP) II training that certified them to lead WRAP Groups. WRAP helps clients with serious mental

illness develop plans towards their wellness and recovery, and make these plans a part for their therapeutic process.

Furthermore, the peer workforce received trainings that are consistent with the core-competencies of peer support services. As such, the following trainings have been provided to our peer workforce over the past twelve months:

- Mindfulness Technique skill development training
- Peer Recovery Services Documentation
- Group Facilitation Skill Development
- Employment Preparation-Application and Resume development
- Introduction of facilitating a Hearing Voices Support group
- Professional Boundaries
- Mandated Reporter
- Access Ambassadors brought Consumer Advocacy and MHSA Leadership State trainings for community and County and Contractor staff.

**Program Challenges and Solutions**

In FY 2019-20, a revised job classification was created for the Recovery Assistant job classification to ensure that peer lived experience is included within qualifiers increasing the ability for those with lived experience and in recovery to advance with employment opportunities. It will be helpful to continue to work on clarity about roles and responsibilities of employed peers and to establish an additional career pathway with a peer supervisor that oversees the peer providing services within the clinics.

With the passage of Senate Bill 803, the Peer Empowerment Manager will continue to work with various State administrators, training manager, department managers/supervisors, peer staff and various stakeholders to implement the Peer Certification Program. In collaboration with the Human Services Department, the Peer Manager will additionally be working on a Peer Support Specialist new job classification. Current and future focus will continue to be the following:

- Standardized practice onboarding of peer support specialist
- Establish a Peer Internship Program
- Establish a pipeline for hiring Peers utilizing the Southern California Regional Partnership Grant
- Increase Peer Support groups within Behavioral Wellness and in the community

Please also refer to the update by the Peer Empowerment Manager and the update to the Help@Hand Innovation for additional updates on Peer Services.

| **Provider:** | **Behavioral Wellness** |
|---|---|
| **Estimated Funding FY 2021/22:** | **Includes grant funds from all 10 partner counties** |
| Estimated Total Mental Health Expenditures: | $430,700 |
| Estimated WET Funding: | $430,700 |

The Mental Health Services Act (MHSA) requires each county mental health department to develop a local Workforce Education and Training (WET) Plan, and to participate in regional partnerships among the mental health system and the educational system to expand outreach to multicultural communities, increase the diversity of the mental health workforce, reduce the stigma associated with mental illness, and to promote the use of web-based technologies, and distance learning techniques. Five Regional Partnerships have been formed under WET throughout the State.

On December 2, 2014, our Department became the fiscal and administrative agent for SCRP activities. The funds implemented the Five-Year Plan goals established by OSHPD for FY 2014-2019. Although Behavioral Wellness has received full payment of the SCRP funds, as of June 2021 there remains $600,000 of available funds for the future years. In March 2017 the SCRP members agreed to continue the partnership with Behavioral Wellness as the Fiscal and Administrative agent for SCRP beyond September 2017 until all of the funds have been utilized to achieve their goals. The SCRP Memorandum of Understanding will automatically renew on an annual basis, starting October 1, 2017, subject to funding or termination for convenience by members.

As fiscal and administrative agent, the Department has implemented a number of recruitments, education and training-based projects.

**Program Challenges and Solutions**

In Fiscal Year 20-21 SCRP funds were used to complete a year and a half long Clinical Supervision Project. Mental Health Providers that are providing clinical supervision took part in online learning twice a month on different aspects of clinical supervision including cultural competency, legal and ethical issues in clinical supervision, methods and techniques in clinical supervision, and self-care. All ten counties in the SCRP are participating in the Clinical Supervision Project. The project included an online learning module of a train-the-training program which creates a pathway for the ten counties to be able to train new clinical supervisors in a sustainable program.

SCRP funds were used to provide a series of Trauma-Informed Care trainings, including a new curriculum on Disaster and Trauma, to all counties in the partnership. Each county chose up to four trainings on different aspects of providing Trauma-Informed Care, and these trainings have been very well attended throughout the partnership.

We are in the process of drafting a contract to provide multiple trainings in Suicide Assessment, Treatment and Prevention to all ten counties, including outreach and engagement on this topic with special populations.

Finally, during FY 20-21 we planned a conference on Person-Centered Engagement Strategies for the partnership. This is the fourth year that the SCRP has offered this conference, all ten counties participate in this two-day conference, and we anticipate 200 attendees. This conference was planned for March 2020, but has been

postponed because of the coronavirus pandemic. We are planning to resume hosting our conference on Person-Centered Engagement Strategies in November 2021.

## OSHPD Southern California Regional Partnership "SCRP"- Round Two

| Provider: | Behavioral Wellness |
|---|---|
| **Estimated Funding FY 2021/22:** | |
| Estimated Total Mental Health Expenditures: | $626,100 |
| Estimated WET Funding: | $626,100 |

The 2020-2025 Workforce Education and Training (WET) program addresses the shortage of mental health practitioners in the public mental health system (PMHS) through a framework that supports individuals through pipeline development, undergraduate scholarships, education stipends, and educational loan repayment programs and staff retention. The five-year WET Plan engages regional partnerships across the State to administer various workforce development programs in these five areas. Recognizing the limited amount of available funding, however, OSHPD is permitting the partnerships to select which program components they need most in the region.

Santa Barbara, as the administrative agent for the Southern Counties Regional Partnership (SCRP), has determined to focus on four of the five program areas and will implement programs for educational stipends, loan repayment, pipeline development, and staff retention. In this second round of funding, the SCRP initial funding of $9,804,288.45 has been awarded. The SCRP will receive a total of $3,806,372 in matching funds from the ten counties, and a final award of $1,730,168.55 from OSHPD in 2024. The entire funding for the SCRP from 2020-2025 is anticipated to be $15,340,829.

Santa Barbara will administer the grant funds for the entire ten counties, ensuring that the Partnership has adequate funds for the programs that they deem most necessary for the continued recruitment, education, and training of our workforce. Santa Barbara will commit $130,337 of MHSA WET for match purposes with a transfer of CSS to WET for these activities.

During FY 20-21 SCRP-WET activities have included finalizing an updated MOU between the 10 counties to receive the new funding, prioritizing program activities, identifying trainings to provide, and establishing a revised budget for the SCRP. Approximately 50% of the new grant funding has been dedicated to a loan assumption program, 25% towards a stipend program for graduate students engaged in clinical training programs, 20% towards staff retention activities which will include a variety of training, and 5% towards pipeline programs to support peer employee development and activities for exposing individuals to careers in public mental health.

**Program Challenges and Solutions:**

Due to the multiple counties involved in the SCRP there are a variety of workforce needs across the partnership and a variety conflicting pressures or demands on workforce development. It has been challenging to navigate the logistics of the county agreements such as the SCRP MOU in addition to the individual participation agreements with the entity that is collecting and verifying the individual county matching funds. It has been necessary to have many planning meetings to clarify how the new grant funding will be employed, how each county will have a benefit in proportion to their matching fund requirement, and to meet the individual county workforce

needs with regional programs. It has also been challenging to navigate the fiscal process of establishing contracts for certain programs such as the loan assumption program and the stipend program. This process has required creating an RFP and reviewing those applications and to then move into the contract process. It is expected that these steps will be completed and the majority of the programming can officially begin towards end of 2021.

## Cultural Competency Plan and Achievements/ Cultural Competency and Diversity

During the fiscal year 2020-2021 the Department focused on outreach and engagement, stakeholder involvement, and implementing recommendations from the cultural competency organizational needs assessment. Additionally, the Department saw an increase in stakeholder participation in the Cultural Competence and Diversity Action Team meetings. We continued to work closely with our outreach and engagement contract providers. Our commitment to serve unserved, underserved, and marginalized communities remained our central focus in ensuring access to services, and providing culturally and linguistically responsive care.

As part of our community outreach and engagement efforts, the Department worked closely with Santa Barbara County, Public Health Department and was available to provide emotional support due to the COVID-19 pandemic. As a response, Cultural Competency and the Diversity/Ethnic Services/Peer Empowerment Manager engaged in the Immigrant Health Rapid Response Task Force. In June 2020, the task force expanded and was renamed the Latinx and Indigenous Migrant COVID-19 Response Task Force. The mission was to create a rapid response task force to address the COVID-19 pandemic, as a collaboration between the Santa Barbara County Department of Public Health (SBCDPH); Community-based Organizations (CBO's) such as Community Health Clinic of Central Coast, Project Heal of Santa Barbara and Casa de la Raza who work with immigrant and indigenous communities in Santa Barbara County; colleagues at UC Santa Barbara (UCSB) and other partners. The members agreed to share updates about new concerns, strategies and resources to act on the COVID-19 pandemic in order to support and strengthen existing and new community organizing efforts and services.

Led by Cultural Competency and Diversity/Ethnic Services/Peer Empowerment Manager, the Mental Health & Wellness Working Group (MHWWG) was formed in May 2019 to develop strategies to support community mental health and well-being during the COVID-19 pandemic. The MHWWG formed the following three subcommittees: Emergency/Safety Planning, Youth/Teen Support & Resources, and outreach/Engagement/ Messaging. Utilizing a Logic Model framework, each subcommittee developed a strategic plan for deliverables. The following are some culturally and linguistically appropriate outreach materials that were created:

- *COVID-19 Safety Wellness Plan*
- *Magnet promoting the Eight Dimensions of Wellness and COVID-19 safety precautions*
- *Youth focus care package: "Take Five Booklet and Inspirational/Hope Book Marks*
- *Established community based COVID-19 support groups in collaboration with Dr. Jonathan Martinez, PhD from California State University of Northridge*
- *Mental wellness compassionate center live presentations in collaboration with Santa Barbara Response Network*
- *Videos/audio recordings on mental wellness tips*

Following the recommendations from the organizational needs assessment, the Department focused on providing staff training on how to use an interpreter and client and staff awareness of language assistances resources. In addition, three new language assistance vendors were contracted to ensure linguistic services

are available, free of charge, to those who need language support. The Cultural Competency and Diversity Ethnic Services Manager established the Translation Review Committee. This committee is responsible for reviewing the accuracy, readability and field testing of translated documents in the Threshold Language-Spanish. The Translation Review Committee also developed a translation resource guide and translation request form for tracking request and data collection. Also, the 5150-training and the Patient Rights Advocate presentation was revised to include the importance of language assistance and how to secure interpretation services. As of May 2021, Spanish interpretation accounted for 94.6% of services, Mixteco followed with 2.3% and less than 1% Portuguese.

Another key recommendation was providing staff with a variety of cultural competency trainings on various topics. Due to the pandemic, cultural competency trainings were offered via Relias Learning Platform, and as well as through virtual learning opportunities by departmental sponsored events and various organizations such as: The Department National Hispanic and Latino Prevention Technology Transfer Center, CBHDA CCESJC and LGBTQ+ Workgroup, California Institute for Behavioral Health Solutions and other state recognized mental health organizations. The Department utilizes "Relias Training Management Platform", to assign, track and report trainings quickly and efficiently. Cultural competency trainings are announced via email with reminders sent periodically. For fiscal year 19/20 approximately 435 Behavioral Wellness staff enrolled in a Cultural Competency training.

During fiscal year 2020-2021 saw an increase in membership in the Cultural Competence and Diversity Action Team (CCDAT) from eight to 29 individuals. Due to the global pandemic, monthly meetings were held via the Zoom platform making meetings accessible to consumers and community members while also eliminating transportation barriers. CCDAT continued to research and develop appropriate language access recommendations for all who need linguistic services. Also, a resource guide on how to access interpretation services for staff was developed. The action team continued to support the MHSA Innovations Project Help@Hand with recommendations on how to appropriately engage diverse communities.

Throughout the 2020-2021 fiscal year, the CCDAT worked on meeting four central goals relating to language access services, outreach and engagement, cultural competence trainings, and the Alcohol and Drug Program (ADP). All CCDAT members joined one of four subgroups focusing on these goals. The Language Access Services group assembled the Language Access Guide, Translation Request Form, and video script for consumers/family members on interpretations services that are available. The Outreach and Engagement group developed strategies to increase consumer, family member, and community participation in CCDAT. The team developed a Spanish video covering the Beneficiary Handbook, and designed a new Cultural Competency Webpage that is more inviting, inclusive, and informative for consumers and community members.
Also, Mental Health Services Act Community Program Planning sessions were held in Spanish virtually in Santa Maria, Santa Barbara and Lompoc. These sessions were provided in unserved, underserved, and marginalized communities. The Department also did a survey during a food distribution event where members of the Mixteco population were present to get feedback and input regarding the MHSA plan.

Overall, during the fiscal year 2020-2021 we continued to work closely with stakeholders to provide culturally appropriate and high-quality care to unserved, underserved, and marginalized communities.

## Capital Facilities and Technological Needs (CF/TN)

A portion of the MHSA funds have been set aside for Capital Facilities and Technology (CFTN) to support the efficient implementation of the MHSA. CFTN projects shall produce lasting benefits that move the mental health system towards the goals of wellness, recovery, resiliency, cultural competence, prevention and early intervention, and expansion of opportunities for accessible community-based services for clients and their families to reduce disparities among underserved groups.

A "Capital Facility" is a building secured to a foundation which is permanently affixed to the ground and used for the delivery of MHSA services to individuals with mental illness and their families or for offices that support the administration of these services.

Capital Facility expenditures must result in a capital asset which increases the Department's infrastructure on a permanent basis; and an expansion of the capacity of, or of consumer and family member access to, new or existing MHSA services.

The Technological Needs Project(s) must meet the goals of modernization/ transformation or client/ family empowerment within a framework of an Integrated Information Systems Infrastructure.

### Electronic Health Records and Outpatient Electronic Health Record

| **Electronic Health Records – Capital Facilities and Technological Needs** | |
|---|---|
| **Provider:** | **Behavioral Wellness** |
| **Estimated Funding FY 2021/22:** | |
| Estimated Total Mental Health Expenditures: | $53,000 |
| Estimated CSS Funding to CFTN: | $53,000 |

CFTN was one of the original components of MHSA. This was one-time funding that was time limited as Counties had 10 years to spend their funding. After the original funding was expended counties could assign funding from CSS funding for CFTN activities. Once monies are dedicated to CFTN they are irrevocable, but do not have a 3-year useful life as other MHSA funds to allow fund to grow for infrastructure investments. This was the original Santa Barbara CFTN project being funded. In order to complete finalization of moving all paper charts to electronic methods and IT consultation services, this program supports that project at a minimal funding level.

Behavioral Wellness will be engaging a new Electronic Health Record model for inpatient services at the Psychiatric Health Facility in 2021-22. During Fall 2020, the Department issued a Request for Proposal (RFP) process to identify a vendor in the inpatient space. Part of the RFP requested information on the vendor's capability to expand to outpatient services. Cerner was selected and would be capable of further expansion in the outpatient MHSA system following initial implementation at the Psychiatric Health Facility.

The Department has been striving to be part of the modern healthcare infrastructure IT systems. Behavioral Wellness was awarded twelve Telehealth grants in 2020-21 in order to respond to the COVID-19 Pandemic. The Department deployed laptops and docking stations, upgraded conference rooms for social distancing with telehealth capabilities for group sessions, and supported services being delivered by Zoom or other

telephonic means. In over one year, the Department went from delivering 3-5% of outpatient services via telehealth to 70-80%.

Additionally, the CalAim Medi-Cal initiative may require more modern electronic systems. In order to enhance the Electronic Health Records for MHSA outpatient services that align with Medi-Cal standards, funding will be transferred from CSS to CFTN as available, to ensure the electronic infrastructure is sufficient in future years to provide sufficient medical records for all consumers.

## Update for Proposals Included in FY 2020-2023 Three-Year Plan

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

Please also refer to Attachment 5: Public Comments Regarding the MHSA Three Year Plan Update to read feedback submitted.

As a result of feedback received and trends from community voices in the planning process, progress and updates to the Three-Year Plan proposals for the FY 2021-2022 Update are:

### Proposal One: Implementation of expanded Youth-Focused Care and Youth-Driven Initiatives including:

This proposal focuses on the creation Youth Led Leadership and the assistance of Youth in the development of those skills. Potential avenues identified include establishing a Youth designated position on the Behavioral Wellness Commission, promoting and marketing youth involvement at each Department Action Team meeting, and inviting youth subject matter experts to work with youth on their topics of interest.

Other goals include increased prevention activities using digital solutions, such as connection with MHSA Innovations Help@Hand project, formerly known as Technology Suite. Additionally, this proposal supports Advocacy and Support Youth Community Initiatives that are youth-designed and/or youth led. This encompasses the development of ideas and grant applications, such as Youth-Designed Treatment Plans, Peer-Run Centers with creative technology spaces, Mental Health First Aid Training for Youth and their Support Systems, and a Youth Drop in Center. This proposal also aims to expand community programming and access around Early Psychosis Intervention, and Transitional Age Youth Department of Rehabilitation services.
**Update:**

During FY 20/21, the Behavioral Wellness Commission outreached to fill newly-created Transitional Age Youth (TAY) positions on the Commission and are amending their bylaw with approval of the Board of Supervisor by end of 2021 to add these positions. The TAY Help@Hand Team continues to support and expand advocacy and youth community initiatives by creating peer digital literacy training, youth gaming listening sessions, and digital peer support groups focused on LBGTQ and meditation. In March 2021, a grant awarded in collaboration with Family Services Agency funded the creation of a Youth Center in Lompoc. This Youth Center focused on Substance Use with a link to MHSA mental health services, and is targeted for opening during June 2021. Other grant awards include an Early Psychosis Grant from MHSOAC, set to start spring and summer 2021, and a School Navigator and Prevention Grant award in collaboration with SBCEO, YouthWell, and the Mental Wellness Center.

## Proposal Two: Increased utilization of Peer Services and integration of Peer Philosophies in Department and Contract Services.

This proposal aimed to increase Peer staff capacity in order to provide every mental health program with the opportunity to have a peer support specialist on the clinic team. This encompasses an increase in Peer Lead Wellness Support Groups and specialist groups (LGBTQ+, TAY, Older Adult groups, etc.), an increase in Peer Navigators to ensure consumers connect with clinics and sustain treatment, and hiring multi-lingual/multi-cultural peers for peer support services programming.

Goals for this proposal also includes an ongoing Peer training program that may lead to later employment opportunities, highlighting the knowledge and practice of Peer Support Services by engaging trusted, Subject Matter Experts to provide training to peers, as well as mentorship, internship and workforce skill opportunities for peers. Additionally, noted was the need for increased peer run community wellness and recovery outreach fair activities, as well as access to Peer Certification programs.

**Update:**

During FY 20/21, the Department added peer casework leaders with TAY and expanded peer recovery assistants for Early Psychosis services. To increase the capacity of peer employment and services, the Help@Hand TAY team expanded hiring of TAY peers for digital application programs. Additionally, the expansion of community activities and peer led support groups included new curriculum development, Mental Health Awareness campaigns during COVID, and PHF discharge and digital literacy support groups. Peer training and advocacy initiatives within the community and systems of care have promoted partners' trainings/groups, including the distribution of Quarterly Peer Newsletters. Additionally, the first MHSA Peer Advocacy and Empowerment Conference was held in May 2021. The Department is committed to Peer Certification and will actively be participating in State planning and working with Santa Barbara consumers and peers on this process.

## Proposal Three: Expansion of Housing Developments and Housing Support Services for those at risk, or experiencing, Homelessness

The goal was to increase housing units by creating a minimum of 50 new permanent supportive housing units in County, and development locations included regions in Lompoc, Santa Maria, and Santa Barbara. Utilizing No Place Like Home funding was identified as essential in achieving this goal. Additionally, supportive services for these housing units and others within the County was desired. Proposed models for supportive services included utilizing MHSA and rental income, along with other State Housing Supportive Services funding as available.

In developing this proposal, prior feedback from stakeholders on what is important when developing housing options and services included: promoting harm reduction philosophies at housing units with a Housing First approach, utilizing "Tiny Home" modeled housing communities, creating Peer-run supportive programming at housing complexes, providing credit repair and legal aid support for people facing evictions or unable to gain housing outside of these opportunities, establishing a Navigation Hub with lockers and phone charging stations to help those who are in the initial steps of getting resources, increasing workforce opportunities

within Behavioral Wellness for people experiencing homelessness, and assisting with Department of Motor Vehicle tags for those who prefer living in cars and/or non-traditional settings.

**Update:**

During FY 20/21, over 50 new housing units were developed with support from No Place Like Home, Homekey COVID funding, MHSA Housing, and HEAP grants. 28 units were funded in Lompoc, 54 units in Santa Maria, and 39 units in Santa Barbara. Behavioral support services were created for a variety of locations across the three target areas. Due to the impacts of COVID-19, goals for the FY 21/22 will focus on developing peer support services at housing locations, including continuing tele-health and linkages to Recovery Learning Centers digital services and Outpatient clinic services.

## Proposal Four: Integrating Whole Person Care philosophies throughout Outpatient services

Whole person care seeks to study, understand and promote the role of health care in relieving suffering and promoting healing in acute and chronic illness. Whole Person Care Ideas from the Santa Barbara community are to facilitate development of trainings, support group curriculum, and outreach materials with Unserved and Underserved groups regarding whole person care practices that resonate within their communities. Programming tools should be modeled after the Eight Dimensions of Wellness.

Image Sources: Substance Abuse and Mental Health Services Administration (SAMHSA) and RecoveryAnswers.org

Curriculum could include peer-run holistic approaches, such as meditation, dance, and cooking for nutrition. The addition of animals (dog, cats) as a mechanism to unique support systems each person has. Integration with other health and wellness networks such as Public Health, Social Services, Employment services, Legal Aid, Credit assistance, Educational assistance with local colleges, and Alcohol and Drug Programs. Peer coordinated materials for support groups about digital health literacy, tele-health, and specialized focus on each dimension of wellness with phone applications (such as nutrition, dieting, gardening, fitness, coloring, etc.).

Targeted Populations identified from stakeholders include:

i. Native American Community
ii. LatinX Community
iii. Mixtecto Community
iv. LGBTQ Community

v. Asian Community
vi. Foster Youth and underserved Youth
vii. Parents of young children
viii. Those who suffer from co-occurring mental health and substance use disorders by integrating services and adding NARCAN and Harm Reduction philosophies, and
ix. Geographically Isolated Communities.

**Update:**

During FY 20/21, the Department of Behavioral Wellness coordinated with the Public Health department to implement substance use care coordinators, linking individuals with all appropriate resources based upon their needs. Peer-run holistic approaches included COVID friendly drum circles, Help@Hand digital literacy training, and youth listening sessions. Additionally, the expansion of Tele-Health availability led to an increase from 2% to 85% of services over the past year, ensuring that consumers could receive care in their own safe space. The Department anticipates engaging in specialized focus areas in the Cultural Competency and Diversity Action Team.

## Supporting Materials

Attachment 1: Prevention Early Intervention (PEI) Data Report
Attachment 2: Prevention Early Intervention (PEI) Priorities Table
Attachment 3: MHSA Budget Summaries
Attachment 4: MHSA Fiscal Three-Year Community Planning Process Program PowerPoint
Attachment 5: Public Comments Regarding the MHSA Three Year Plan Update
Attachment 6: Behavioral Wellness Commission Meeting Agenda for Public Hearing (Placeholder)
Attachment 7: Minutes of Public Hearing (Placeholder)
Attachment 8: Evidence of Santa Barbara County Board of Supervisors’ Approval (Placeholder)

## Attachment 1: Prevention Early Intervention (PEI) Data Report

The following are the PEI programs and providers for each MHSA Category. Tables of client demographics, provider events, and referrals follow.

| MHSA Category | PROGRAMS | PROVIDERS |
|---|---|---|
| OUTREACH & STIGMA | Mental Health Educators | La Casa De La Raza (LCDLR) |
| OUTREACH & STIGMA | Mental Health Educators | Santa Ynez Tribal Health Clinic (SYTHC) |
| OUTREACH | Mental Health Educators | Community Health Centers of the Central Coast (CHCCC) |
| PREVENTION | Early Childhood Mental Health | Child Abuse Listening & Mediation (CALM) |
| PREVENTION | Early Childhood Mental Health | Santa Ynez Valley People Helping People (SYVPHP) |
| EARY INTERVENTION | Early Childhood Specialty Mental Health | Child Abuse Listening & Mediation (CALM) |
| EARY INTERVENTION | Early Detection & Intervention | Transitional Age Youth<br>(TAY; Department of Behavioral Wellness) |
| UNDERSERVED | Carpentaria START School Based Counseling | Council on Alcoholism & Drug Abuse (CADA) |
| UNDERSERVED | Carpentaria START School Based Counseling | Family Services Agency (FSA) |
| UNDERSERVED | Crisis Services for Under-Represented | Casa Pacifica (CP) |
| ACCESS & LINKAGE | Access/Assessment | Access and Assessment<br>(A & A; Department of Behavioral Wellness) |

## DEMOGRAPHICS (ALL PROGRAMS)

| Unique Clients Served | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | OUTREACH | | | PREVENTION & EARLY INTERVENTION | | | | UNDERSERVED | | | ACCESS & LINKAGE |
| | & STIGMA | | | PREVENTION | | EARLY INT. | | | | | |
| **PROGRAM^** | LCDLR | SYTHC | CHCCC | CALM | SYVPHP | TAY | CALM | CADA | FSA | CP | A & A |
| **TOTAL CLIENTS** | **12** | **27** | **775** | **110** | **182** | **243** | **531** | **84** | **89** | **1,081** | **1,442** |
| **AGE** | | | | | | | | | | | |
| 0-15 | 0 | 0 | 53 | 105 | 36 | 8 | 530 | 74 | 67 | 630 | 233 |
| 16-25 | 0 | 0 | 121 | 1 | 21 | 233 | 1 | 10 | 22 | 451 | 288 |
| 26-59 | 4 | 0 | 107 | 4 | 88 | 2 | 0 | 0 | 0 | 0 | 800 |
| 60+ | 8 | 0 | 25 | 0 | 28 | 0 | 0 | 0 | 0 | 0 | 121 |
| Unknown/Decline | 0 | 27 | 469 | 0 | 9 | 0 | 0 | 0 | 0 | 0 | 0 |
| **SEX AT BIRTH** | | | | | | | | | | | |
| Female | 11 | 22 | 557 | 59 | 105 | 136 | 254 | 39 | 60 | 609 | 717 |
| Male | 1 | 0 | 171 | 51 | 77 | 107 | 277 | 45 | 29 | 467 | 721 |
| Unknown/Decline | 0 | 4 | 11 | 0 | 0 | 0 | 0 | 0 | 0 | 5 | 4 |
| **CURRENT GENDER IDENTITY** | | | | | | | | | | | |
| Male | 1 | 21 | 169 | * | 0 | * | * | 2 | * | 276 | * |
| Female | 11 | 5 | 552 | * | 0 | * | * | 3 | * | 192 | * |
| Transgender | 0 | 0 | 2 | * | 0 | * | * | 0 | * | 5 | * |
| Genderqueer | 0 | 0 | 0 | * | 0 | * | * | 0 | * | 0 | * |
| Questioning | 0 | 0 | 1 | * | 0 | * | * | 0 | * | 0 | * |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Another | 0 | 0 | 1 | * | 0 | * | * | 0 | * | 0 | * |
| Unknown/Decline | 0 | 0 | 14 | * | 182 | * | * | 0 | * | 177 | * |
| **SEXUAL ORIENTATION** | | | | | | | | | | | |
| Gay/Lesbian | 0 | 0 | 5 | * | 0 | * | * | 0 | * | 0 | * |
| Heterosexual | 11 | 16 | 683 | * | 0 | * | * | 3 | * | 10 | * |
| Bisexual | 1 | 0 | 6 | * | 0 | * | * | 0 | * | 1 | * |
| Questioning/ Unsure | 0 | 0 | 4 | * | 0 | * | * | 0 | * | 0 | * |
| Queer | 0 | 0 | 0 | * | 0 | * | * | 0 | * | 0 | * |
| Another | 0 | 0 | 0 | * | 0 | * | * | 0 | * | 2 | * |
| Unknown/Decline | 0 | 10 | 41 | * | 182 | * | * | 2 | * | 637 | * |
| **PRIMARY LANGUAGE** | | | | | | | | | | | |
| English | 0 | 21 | 155 | * | 110 | * | * | 7 | * | 663 | * |
| Spanish | 12 | 0 | 583 | * | 72 | * | * | 4 | * | 131 | * |
| Other | 0 | 0 | 35 | * | 0 | * | * | 0 | * | 6 | * |
| Unknown/Decline | 0 | 6 | 2 | * | 0 | * | * | 0 | * | 21 | * |
| **VETERAN** | | | | | | | | | | | |
| Yes | 0 | 0 | 11 | * | 6 | * | * | 0 | * | 614 | * |
| No | 12 | 26 | 530 | * | 0 | * | * | 5 | * | 1 | * |
| Unknown/Decline | 0 | 0 | 198 | * | 176 | * | * | 0 | * | 0 | * |
| | | | | | | | | | | | |

| **(cont.)** | **OUTREACH** | | | **PREVENTION & EARLY INTERVENTION** | | | | **UNDERSERVED** | | | **ACCESS & LINKAGE** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **& STIGMA** | | | **PREVENTION** | | **EARLY INT.** | | | | | |
| **PROGRAM^** | LCDLR | SYTHC | CHCCC | CALM | SYVPHP | TAY | CALM | CADA | FSA | CP | A & A |
| **RACE** | | | | | | | | | | | |
| American Indian/ Alaska Native | 0 | 5 | 2 | 0 | 5 | 0 | 7 | 0 | 2 | 9 | 28 |
| Asian | 0 | 0 | 5 | 1 | 2 | 6 | 2 | 0 | 1 | 13 | 21 |
| Black/ African American | 0 | 1 | 4 | 3 | 5 | 6 | 18 | 0 | 1 | 35 | 53 |
| Native Hawaiian/ Pacific Islander | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 2 | 2 | 1 |
| White | 10 | 0 | 533 | 100 | 101 | 193 | 470 | 82 | 79 | 751 | 1,227 |
| Other | 0 | 0 | 169 | 3 | 0 | 12 | 10 | 0 | 1 | 14 | 36 |
| More than one | 1 | 1 | 1 | 2 | 0 | 18 | 9 | 1 | 1 | 24 | 51 |
| Unknown/Decline | 1 | 22 | 63 | 1 | 0 | 6 | 15 | 1 | 2 | 233 | 25 |
| **ETHNICITY: LATINO** | | | | | | | | | | | |
| Caribbean | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Central American | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Mexican/Mex. Amer./ Chicano | 12 | 0 | 622 | 1 | 36 | 101 | 21 | 60 | 61 | 271 | 461 |
| Puerto Rican | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5 |
| South American | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other Latino | 0 | 0 | 71 | 98 | 6 | 51 | 383 | 7 | 12 | 204 | 173 |
| Unknown/Decline | 0 | 27 | 0 | 2 | 0 | 15 | 15 | 1 | 1 | 371 | 66 |
| **ETHNICITY: NON-LATINO** | | | | | | | | | | | |
| African | 0 | 0 | 2 | 2 | 5 | 5 | 15 | 0 | 1 | 22 | 45 |
| Asian Indian/ South Asian | 0 | 0 | 3 | 0 | 0 | 1 | 0 | 0 | 0 | 2 | 1 |
| Cambodian | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Chinese | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| Eastern European | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| European | 0 | 0 | 10 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Filipino | 0 | 0 | 2 | 0 | 0 | 2 | 1 | 0 | 0 | 6 | 5 |
| Japanese | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5 |
| Korean | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 1 | 1 | 0 |
| Middle Eastern | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Vietnamese | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Other | 0 | 0 | 5 | 0 | 0 | 1 | 2 | 0 | 0 | 0 | 1 |
| Unknown/Decline | 12 | 27 | 24 | 9 | 0 | 81 | 108 | 17 | 14 | 574 | 643 |
| More than one | 0 | 0 | 7 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | | | | | | | | | | |

| **(cont.)** | **OUTREACH** | | | **PREVENTION & EARLY INTERVENTION** | | | | **UNDERSERVED** | | | **ACCESS & LINKAGE** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **& STIGMA** | | | **PREVENTION** | | **EARLY INT.** | | | | | |
| **PROGRAM^** | LCDLR | SYTHC | CHCCC | CALM | SYVPHP | TAY | CALM | CADA | FSA | CP | A & A |
| **DISABILITY** | | | | | | | | | | | |
| Difficulty Seeing | 1 | 0 | 19 | * | 0 | * | * | 1 | * | 0 | * |
| Difficulty Hearing / Having Speech Understood | 1 | 0 | 2 | * | 0 | * | * | 1 | * | 4 | * |
| Physical/Mobility | 0 | 0 | 5 | * | 0 | * | * | 0 | * | 1 | * |
| Chronic Health Condition/Pain | 7 | 0 | 10 | * | 0 | * | * | 0 | * | 0 | * |
| Other Mental Disability not Related to Mental Illness | 0 | 0 | 2 | * | 0 | * | * | 0 | * | 3 | * |
| Other | 0 | 0 | 3 | * | 0 | * | * | 0 | * | 0 | * |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Unknown/Decline | 0 | 0 | 0 | * | 0 | * | * | 0 | * | 0 | * |
| **FAMILY** | | | | | | | | | | | |
| # Family Members in Program | 2 | 0 | 158 | * | 259 | * | 2 | 0 | * | 1 | * |

^LCDLR = La Casa De La Raza; SYTHC = Santa Ynez Tribal Health Clinic; CHCCC = Community Health Centers of the Central Coast; CALM = Child Abuse Listening & Mediation; SYPHP = Santa Ynez Valley People Helping People; TAY = Department of Behavioral Wellness TAY Program; CADA = Council on Alcoholism & Drug Abuse; FSA = Family Services Agency; CP = Casa Pacifica; A & A = Department of Behavioral Wellness Access and Assessment Teams. Note that CADA and FSA both served clients in the START program. All data currently available is provided.

| |
|---|
| ORANGE data sourced from Vertical Change and quarterly reports |
| BLUE data sourced from EHR; some demographic data is not available on PEI categories |
| GREEN data sourced from provider's report |

# OUTREACH EVENTS

| Outreach Events | | | |
|---|---|---|---|
| PROGRAM | LCDLR | SYTHC | CHCCC |
| **TOTAL # EVENTS** | **92** | **84** | **223** |
| **TOTAL # PARTICIPANTS** | **3,613** | **617** | **6,792** |
| **EVENT TYPE** | | | |
| Outreach | 9 | 6 | 30 |
| Training | 19 | 9 | 45 |
| Forum | 4 | 19 | 45 |
| Support Group | 60 | 50 | 103 |
| **PRIMARY LANGUAGE OF EVENT** | | | |
| English | 0 | 84 | 47 |
| Spanish | 92 | 0 | 176 |
| Other or both English and Spanish | 0 | 0 | 0 |
| **TRANSLATION PROVIDED** | | | |
| Translation to English at Spanish event | NR | 0 | 0 |
| Translation to Spanish at English event | NR | 0 | 0 |
| Other or both English and Spanish | NR | 0 | 43 |
| **PARTICIPANT AGE** | | | |
| 0-15 | NR | 270 | 408 |
| 16-25 | NR | 63 | 843 |
| 26-59 | NR | 113 | 5095 |
| 60+ | NR | 12 | 361 |
| Missing DOB | NR | 159 | 85 |
| **PARTICIPANT GENDER** | | | |
| Female | NR | 55 | 4394 |
| Male | NR | 43 | 2290 |
| Unknown/Decline | NR | 519 | 108 |
| **PARTICIPANT VETERAN** | | | |
| Yes | NR | 0 | 2 |
| No | NR | 0 | 0 |
| Unknown/Decline | NR | 617 | 6,790 |
| **PARTICIPANT RACE** | | | |
| American Indian/ Alaska Native | NR | 174 | 28 |
| Asian | NR | 0 | 46 |
| Black/African American | NR | 0 | 31 |
| Native Hawaiian/ Pacific Islander | NR | 0 | 0 |
| White | NR | 0 | 739 |
| Other | NR | 3 | 5247 |
| More than one | NR | 0 | 0 |
| Unknown/Decline | NR | 440 | 701 |
| **PARTICIPANT ETHNICITY** | | | |
| Latino | NR | NR | 5862 |
| Non-Latino | NR | NR | 867 |

NR = Not Reported (blank)
*Note that this data reflects a compilation of Vertical Change data and/or quarterly reports. Therefore, it does not always correspond to the data in the pivot tables collected in Vertical Change.

| Unique Clients Referred | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | OUTREACH & STIGMA | | | PREVENTION & EARLY INTERVENTION | | | UNDERSERVED | | | ACCESS & LINK-AGE |
| **PROGRAM** | LCDLR | SYTHC | CHCCC | CALM | SYVPHP | TAY | CADA | FSA | CP | A & A |
| **TYPE (TOTAL #)** | | | | | | | | | | |
| CBO Referral to Behavioral Wellness | 0 | 5 | 392 | N/A | NR | N/A | N/A | N/A | NR | N/A |
| Intake to Behavioral Wellness | | | | | | | | | | N/A |
| Behavioral Wellness Referral Out | | | | | | | | | | N/A |
| **MENTAL/BEHAVIORAL HEALTH SYMPTOMS PRIOR TO REFERRAL / INTAKE** | | | | | | | | | | |
| Yes | 0 | 5 | 366 | N/A | NR | N/A | N/A | N/A | NR | N/A |
| If yes, date is completed | 0 | 0 | 0 | N/A | NR | N/A | N/A | N/A | NR | N/A |
| No | 0 | 0 | 19 | N/A | NR | N/A | N/A | N/A | NR | N/A |
| If no, average duration of sxs | 0 | 0 | 0 | N/A | NR | N/A | N/A | N/A | NR | N/A |
| Unable to Determine | 0 | 0 | 7 | N/A | NR | N/A | N/A | N/A | NR | N/A |
| **ARE YOU CONCERNED THE MENTAL/BEHAVIORAL HEALTH SYMPTOMS REPORTED INDICATE A POSSIBLE SEVERE MENTAL ILLNESS?** | | | | | | | | | | |
| Yes | 0 | 5 | 0 | N/A | NR | N/A | N/A | N/A | NR | N/A |
| No | 0 | 0 | 8 | N/A | NR | N/A | N/A | N/A | NR | N/A |
| Unable to Determine | 0 | 0 | 26 | N/A | NR | N/A | N/A | N/A | NR | N/A |
| **WAYS REFERRING PARTY ENCOURAGED CLIENT TO ACCESS SERVICES AND FOLLOW THROUGH ON REFERRAL** | | | | | | | | | | |
| Called | NR | NR | 28 | N/A | NR | N/A | N/A | N/A | NR | N/A |
| Emailed | NR | NR | 0 | N/A | NR | N/A | N/A | N/A | NR | N/A |
| Arranged Transport | NR | NR | 0 | N/A | NR | N/A | N/A | N/A | NR | N/A |
| Arranged Appointment | NR | NR | 7 | N/A | NR | N/A | N/A | N/A | NR | N/A |
| Other | NR | NR | 16 | N/A | NR | N/A | N/A | N/A | NR | N/A |

All available data is provided. We are still figuring out the best way to capture this data while minimizing the burden on providers. N/A for internal Behavioral Wellness programs and other programs that provide therapy as clients are already connected to mental health services.
Note that data was also obtained from provider quarterly reports.

## Attachment 2: Prevention Early Intervention (PEI) Priorities Table

| Program & MHSA Category | Category of PEI | Relevant Stakeholder Input |
|---|---|---|
| La Casa De La Raza | Culturally competent & linguistically appropriate prevention & intervention | Need more outreach materials and programming on what BWELL does and who BWELL serves and on-site presence or group participation Q&A with BWELL staff |
| Santa Ynez Tribal Health Clinic | Culturally competent & linguistically appropriate prevention & intervention | Native BWELL liaison to best engage with SYTHC. There is a disconnect and a lack of trust. BWELL does not communicate with Elders in a manner that Elders see as respectful. Treatment need to include of cultural preferences. |
| Community Health Centers of the Central Coast | Culturally competent & linguistically appropriate prevention & intervention | Need to increase staffing to best reach community. Promotoras have minimal funding, would like increased. |
| Santa Ynez Valley People Helping People | Childhood trauma prevention & early intervention, & mood disorder & suicide prevention programming that occurs across the lifespan;<br><br>Early identification programming of mental health symptoms & disorders, including but not limited to, anxiety, depression and psychosis<br>Early Childhood Mental Health | Native community holds cultural traditions that need to be respected. Parents of children may have mistrust of BWELL clinicians. BWELL clinicians need trainings on cultural norms of Native people. Clinicians minimize preferred cultural healing practices and look down on the belief of power in "sweat lodges" "sage cleanses"; suggest enhance cultural competency trainings. |

| Program & MHSA Category | Category of PEI | Relevant Stakeholder Input |
| --- | --- | --- |
| La Casa De La Raza | Culturally competent & linguistically appropriate prevention & intervention | Need more outreach materials and programming on what BWELL does and who BWELL serves and on-site presence or group participation Q&A with BWELL staff |
| Santa Ynez Tribal Health Clinic | Culturally competent & linguistically appropriate prevention & intervention | Native BWELL liaison to best engage with SYTHC. There is a disconnect and a lack of trust. BWELL does not communicate with Elders in a manner that Elders see as respectful. Treatment need to include of cultural preferences. |
| Community Health Centers of the Central Coast | Culturally competent & linguistically appropriate prevention & intervention | Need to increase staffing to best reach community. Promotoras have minimal funding, would like increased. |
| Santa Ynez Valley People Helping People | Childhood trauma prevention & early intervention, & mood disorder & suicide prevention programming that occurs across the lifespan;<br><br>Early identification programming of mental health symptoms & disorders, including but not limited to, anxiety, depression and psychosis<br>Early Childhood Mental Health | Native community holds cultural traditions that need to be respected. Parents of children may have mistrust of BWELL clinicians. BWELL clinicians need trainings on cultural norms of Native people. Clinicians minimize preferred cultural healing practices and look down on the belief of power in “sweat lodges” “sage cleanses”; suggest enhance cultural competency trainings. |

| Program & MHSA Category | Category of PEI | Relevant Stakeholder Input |
|---|---|---|
| CALM<br>ECMH Great Beginnings | Childhood trauma prevention & early intervention, & mood disorder & suicide prevention programming that occurs across the lifespan;<br><br>Early identification programming of mental health symptoms & disorders, including but not limited to, anxiety, depression and psychosis | Need coordinated comprehensive community outreach programming. |
| CALM<br>ECMHS Special Needs | Early identification programming of mental health symptoms & disorders, including but not limited to, anxiety, depression and psychosis | BWELL needs to invite disability organizations to the table and create an outreach event with disability organizations and advocates present. This should include children programming. |
| County<br>Early<br>Detection &<br>Intervention | Childhood trauma prevention & early intervention, & mood disorder & suicide prevention programming that occurs across the lifespan; | Need to enhance program with the state of CA new suicide prevention plan. Educational series maybe created with guest speakers (peers). Prevention and early intervention for children is key. |

| Program & MHSA Category | Category of PEI | Relevant Stakeholder Input |
|---|---|---|
| School-Based Counseling Council on Alcohol and Drug Abuse | Youth outreach & engagement strategies that target secondary school & transition age youth, w/ a priority on partnership w college mental health programs;<br><br>Early identification programming of mental health symptoms & disorders, including but not limited to, anxiety, depression and psychosis | Interactive programming would help for families to understand how to assist child's outcomes through empowering children to learn about wellness plans.<br>More programming on what is mental illness/what are mood disorders/ Peer speakers. Many resources at schools are desired as students are captive audience. |
| School-Based Counseling Family Service Agency | Youth outreach & engagement strategies that target secondary school & transition age youth, w/ a priority on partnership w college mental health programs;<br><br>Early identification programming of mental health symptoms & disorders, including but not limited to, anxiety, depression and psychosis | Create programming allowing for youth to help create programming. Include youth while receiving services to help with programming materials. |
| County Access & Assessment and Access Line Program | Early identification programming of mental health symptoms & disorders, including but not limited to, anxiety, depression and psychosis | Need more people answering calls. Wait times may aggravate symptoms. Request better hold system while people wait with calming sounds or soothing information talking about referrals sources or talk down recording while people wait to speak to assessor. |

## Attachment 3: MHSA Budget Summaries

**FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan Funding Summary**

County: Santa Barbara County                                        Date: 3/11/21

| | MHSA Funding | | | | | |
|---|---|---|---|---|---|---|
| | A | B | C | D | E | F |
| | Community Services and Supports | Prevention and Early Intervention | Innovation | Workforce Education and Training | Capital Facilities and Technological Needs | Prudent Reserve |
| **A. Estimated FY 2020/21 Funding** | | | | | | 2,023,113 |
| 1. Estimated Unspent Funds from Prior Fiscal Years | 110,857 | 2,506,141 | 748,611 | 0 | 0 | |
| 2. Estimated New FY2020/21 Funding | 19,963,600 | 4,990,900 | 1,313,400 | | | |
| 3. Transfer in FY2020/21[a/] | (170,400) | | | 112,500 | 57,900 | 0 |
| 4. Access Local Prudent Reserve in FY2020/21 | 759,000 | 0 | | | | (759,000) |
| 5. Estimated Available Funding for FY2020/21 | 20,663,057 | 7,497,041 | 2,062,011 | 112,500 | 57,900 | |
| **B. Estimated FY2020/21 MHSA Expenditures** | 18,509,300 | 4,179,600 | 748,000 | 112,500 | 57,900 | |
| **C. Estimated FY2021/22 Funding** | | | | | | |
| 1. Estimated Unspent Funds from Prior Fiscal Years | 2,153,757 | 3,320,143 | 1,573,383 | 0 | 0 | |
| 2. Estimated New FY2021/22 Funding | 21,904,200 | 5,476,100 | 1,441,100 | | | |
| 3. Transfer in FY2021/22[a/] | (175,800) | | | 122,800 | 53,000 | 0 |
| 4. Access Local Prudent Reserve in FY2021/22 | | 0 | | | | 0 |
| 5. Estimated Available Funding for FY2021/22 | 23,882,157 | 8,796,243 | 3,014,483 | 122,800 | 53,000 | |
| **D. Estimated FY2021/22 Expenditures** | 22,957,800 | 4,931,900 | 897,100 | 122,800 | 53,000 | |
| **E. Estimated FY2022/23 Funding** | | | | | | |
| 1. Estimated Unspent Funds from Prior Fiscal Years | 924,357 | 3,864,343 | 2,117,383 | 0 | 0 | |
| 2. Estimated New FY2022/23 Funding | 22,342,284 | 5,585,622 | 1,469,922 | | | |
| 3. Transfer in FY2022/23[a/] | (284,544) | | | 231,544 | 53,000 | 0 |
| 4. Access Local Prudent Reserve in FY2022/23 | 712,685 | | | | | (712,685) |
| 5. Estimated Available Funding for FY2022/23 | 23,694,782 | 9,449,965 | 3,587,305 | 231,544 | 53,000 | |
| **F. Estimated FY2022/23 Expenditures** | 23,694,782 | 5,080,368 | 915,028 | 125,256 | 53,000 | |
| **G. Estimated FY2022/23 Unspent Fund Balance** | 0 | 4,369,597 | 2,672,277 | 106,288 | 0 | |

| **H. Estimated Local Prudent Reserve Balance** | |
|---|---|
| 1. Estimated Local Prudent Reserve Balance on June 30, 2020 | 2,023,113 |
| 2. Contributions to the Local Prudent Reserve in FY 2020/21 | 0 |
| 3. Distributions from the Local Prudent Reserve in FY 2020/21 | (759,000) |
| 4. Estimated Local Prudent Reserve Balance on June 30, 2021 | 1,264,113 |
| 5. Contributions to the Local Prudent Reserve in FY 2021/22 | 0 |
| 6. Distributions from the Local Prudent Reserve in FY 2021/22 | 0 |
| 7. Estimated Local Prudent Reserve Balance on June 30, 2022 | 1,264,113 |
| 8. Contributions to the Local Prudent Reserve in FY 2022/23 | 0 |
| 9. Distributions from the Local Prudent Reserve in FY 2022/23 | (712,685) |
| 10. Estimated Local Prudent Reserve Balance on June 30, 2023 | 551,428 |

a/ Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five year

# FY 2020-21 Through 2022-23 MHSA Plan Update
# Community Services and Supports (CSS) Component Worksheet

County: Santa Barbara County

| | Fiscal Year 2020/21 | | | |
|---|---|---|---|---|
| | A | B | C | D |
| | Estimated Total Mental Health Expenditures | Estimated CSS Funding | Estimated Medi-Cal FFP | Estimated Realignment & Other Funding |
| **FSP Programs** | | | | |
| 1. SPIRIT FSP Wraparound Services | 2,484,600 | 1,380,800 | 1,068,800 | 35,000 |
| 2. Lompoc ACT FSP | 1,806,100 | 776,500 | 897,600 | 132,000 |
| 3. Santa Maria ACT FSP | 2,354,700 | 1,418,000 | 936,700 | 0 |
| 4. Santa Barbara ACT FSP | 3,190,700 | 1,409,500 | 1,619,200 | 162,000 |
| 5. Supported Community Services North | 1,098,200 | 550,300 | 547,900 | 0 |
| 6. Supported Community Services South | 1,343,300 | 558,100 | 785,200 | 0 |
| 7. Forensic FSP (Justice Alliance) | 1,407,700 | 1,089,500 | 318,200 | 0 |
| 8. New Heights TAY FSP | 2,908,600 | 1,590,300 | 709,600 | 608,700 |
| 9. | 0 | | | |
| 10. | 0 | | | |
| **Non-FSP Programs** | | | | |
| 1. Crisis Services | 6,580,000 | 0 | 3,328,900 | 3,251,100 |
| 2. Adult Wellness and Recovery Outpatient (WR) Teams | 4,726,500 | 918,500 | 3,667,800 | 140,200 |
| 3. Co-Occurring Mental Health and Substance Use Outpatient Te | 2,247,700 | 188,200 | 2,059,500 | 0 |
| 4. Partners in Hope | 844,900 | 806,500 | 38,400 | 0 |
| 5. Children Wellness, Recovery and Resiliency (WRR) Teams | 5,237,300 | 0 | 3,702,100 | 1,535,200 |
| 6. Pathways to Well Being | 637,000 | 0 | 417,400 | 219,600 |
| 7. Crisis Residential Services North/South | 4,989,700 | 2,514,500 | 1,771,800 | 703,400 |
| 8. Adult Housing Support Services | 3,216,500 | 448,400 | 1,188,100 | 1,580,000 |
| 9. Crisis Stabilization Unit South | 2,886,600 | 368,800 | 795,100 | 1,722,700 |
| 10. Homeless Outreach Services | 1,602,900 | 173,600 | 570,800 | 858,500 |
| 11. Medical Integration | 1,941,100 | 1,250,500 | 690,600 | 0 |
| 12. Children's Crisis Triage Teams | 428,900 | 0 | 222,500 | 206,400 |
| 13. | 0 | 0 | 0 | 0 |
| **CSS Administration** | 11,069,000 | 3,067,300 | 5,490,000 | 2,511,700 |
| **CSS MHSA Housing Program Assigned Funds** | 0 | | | |
| **Total CSS Program Estimated Expenditures** | 63,002,000 | 18,509,300 | 30,826,200 | 13,666,500 |
| **FSP Programs as Percent of Total** | 56.8% | 28% | 50% | |

| | Fiscal Year 2021/22 | | | |
|---|---|---|---|---|
| | A | B | C | D |
| | Estimated Total Mental Health Expenditures | Estimated CSS Funding | Estimated Medi-Cal FFP | Estimated Other Funding |
| **FSP Programs** | | | | |
| 1. SPIRIT FSP Wraparound Services | 2,609,200 | 1,519,500 | 1,054,700 | 35,000 |
| 2. Lompoc ACT FSP | 2,727,800 | 1,114,900 | 1,480,900 | 132,000 |
| 3. Santa Maria ACT FSP | 2,929,700 | 1,588,100 | 1,341,600 | 0 |
| 4. Santa Barbara ACT FSP | 4,009,200 | 2,535,000 | 1,474,200 | 0 |
| 5. Supported Community Services: North/Santa Maria | 1,132,400 | 525,100 | 607,300 | 0 |
| 6. Supported Community Services: South/Santa Barbara | 1,195,100 | 428,900 | 766,200 | 0 |
| 7. Forensic FSP Justice Alliance | 2,118,100 | 1,812,100 | 306,000 | 0 |
| 8. New Heights TAY FSP | 3,358,600 | 2,055,800 | 663,000 | 639,800 |
| 9. | | | | |
| 10. | | | | |
| **Non-FSP Programs** | | | | |
| 1. Crisis Services | 5,859,000 | 155,800 | 3,103,400 | 2,599,800 |
| 2. Adult Wellness and Recovery Outpatient (WR) Teams | 6,383,000 | 3,088,300 | 3,294,700 | 0 |
| 3. Co-Occurring Mental Health and Substance Use Outpatient Te | 2,720,000 | 886,500 | 1,833,500 | 0 |
| 4. Partners in Hope | 839,500 | 803,200 | 36,300 | 0 |
| 5. Children Wellness, Recovery and Resiliency (WRR) Teams | 5,968,700 | 0 | 3,475,500 | 2,493,200 |
| 6. Pathways to Well Being | 637,000 | 0 | 404,100 | 232,900 |
| 7. Crisis Residential Services North/South | 4,913,500 | 1,518,800 | 2,604,600 | 790,100 |
| 8. Adult Housing Support Services | 2,725,500 | 1,000,500 | 1,094,800 | 630,200 |
| 9. Crisis Stabilization Unit South | 3,660,900 | 60,600 | 1,841,000 | 1,759,300 |
| 10. Homeless Outreach Services | 5,207,300 | 90,400 | 537,900 | 4,579,000 |
| 11. Medical Integration | 2,250,000 | 1,640,200 | 609,800 | 0 |
| 12. Childrens Crisis Triage Teams | 534,000 | 0 | 214,500 | 319,500 |
| 13. | | 0 | | 0 |
| 14. | | 0 | | |
| | 0 | | | |
| **CSS Administration** | 9,572,100 | 2,134,100 | 5,497,000 | 1,941,000 |
| **CSS MHSA Housing Program Assigned Funds** | 0 | | | |
| **Total CSS Program Estimated Expenditures** | 71,350,600 | 22,957,800 | 32,241,000 | 16,151,800 |
| **FSP Programs as Percent of Total** | 56% | | | |

| | Fiscal Year 2022/23 | | | |
|---|---|---|---|---|
| | A | B | C | D |
| | Estimated Total Mental Health Expenditures | Estimated CSS Funding | Estimated Medi- Cal FFP | Estimated Other Funding |
| **FSP Programs** | | | | |
| 1.SPIRIT FSP Wraparound Services | 2,661,384 | 1,550,590 | 1,075,794 | 35,000 |
| 2.Lompoc ACT FSP | 2,782,356 | 1,139,838 | 1,510,518 | 132,000 |
| 3.Santa Maria ACT FSP | 2,988,294 | 1,619,862 | 1,368,432 | 0 |
| 4.Santa Barbara ACT FSP | 4,089,384 | 2,585,700 | 1,503,684 | 0 |
| 5.Supported Community Services: North/Santa Maria | 1,155,048 | 535,602 | 619,446 | 0 |
| 6.Supported Community Services: South/Santa Barbara | 1,219,002 | 437,478 | 781,524 | 0 |
| 7.Forensic FSP Justice Alliance | 2,160,462 | 1,848,342 | 312,120 | 0 |
| 8.New Heights TAY FSP | 3,425,772 | 2,109,712 | 676,260 | 639,800 |
| 9. | | | | |
| 10. | | | | |
| **Non-FSP Programs** | | | | |
| 1.Crisis Services | 5,976,180 | 210,912 | 3,165,468 | 2,599,800 |
| 2.Adult Wellness and Recovery Outpatient (WR) Teams | 6,510,660 | 3,150,066 | 3,360,594 | 0 |
| 3.Co-Occurring Mental Health and Substance Use Outpatient Te | 2,774,400 | 904,230 | 1,870,170 | 0 |
| 4.Partners in Hope | 856,290 | 819,264 | 37,026 | 0 |
| 5.Children Wellness, Recovery and Resiliency (WRR) Teams | 6,088,074 | 49,864 | 3,545,010 | 2,493,200 |
| 6.Pathways to Well Being | 649,740 | 4,658 | 412,182 | 232,900 |
| 7.Crisis Residential Services North/South | 5,011,770 | 1,564,978 | 2,656,692 | 790,100 |
| 8.Adult Housing Support Services | 2,780,010 | 1,033,114 | 1,116,696 | 630,200 |
| 9.Crisis Stabilization Unit South | 3,734,118 | 96,998 | 1,877,820 | 1,759,300 |
| 10.Homeless Outreach Services | 5,311,446 | 183,788 | 548,658 | 4,579,000 |
| 11.Medical Integration | 2,295,000 | 1,673,004 | 621,996 | 0 |
| 12. | | 0 | | 0 |
| 13. | 0 | | 0 | |
| 14. | 0 | 0 | 0 | 0 |
| **CSS Administration** | 9,763,542 | 2,176,782 | 5,606,940 | 1,979,820 |
| **CSS MHSA Housing Program Assigned Funds** | 0 | | | |
| **Total CSS Program Estimated Expenditures** | 72,232,932 | 23,694,782 | 32,667,030 | 15,871,120 |
| **FSP Programs as Percent of Total** | 55.0% | | | |

## FY 2020-21 Through 2022-23 MHSA Plan Update
## Prevention and Early Intervention (PEI) Component Worksheet

County: Santa Barbara County 2/16/21

| | Fiscal Year 2020/21 | | | |
|---|---|---|---|---|
| | A | B | C | D |
| | Estimated Total Mental Health Expenditures | Estimated PEI Funding | Estimated Medi-Cal FFP | Estimated Other Funding |
| **PEI Programs - Prevention** | | | | |
| 1. Mental Health Education | 254,000 | 254,000 | 0 | 0 |
| 2. Early Childhood Mental Health (ECMH) | 428,000 | 428,000 | 0 | 0 |
| 3. | 0 | | | |
| 4. | 0 | | | |
| 5. | 0 | | | |
| 6. | 0 | | | |
| 7. | 0 | | | |
| 8. | 0 | | | |
| 9. | 0 | | | |
| 10. | 0 | | | |
| **PEI Programs - Early Intervention** | | | | |
| 11. Early Childhood Mental Health | 1,080,000 | 400,300 | 679,700 | 0 |
| 12. PEI Early Detection and Intervention Teams for TAY | 599,900 | 518 | 599,382 | |
| 13. School-Based Prevention/Early Intervention Services | 494,000 | 376,800 | 117,200 | 0 |
| 14. Access and Assessment Teams/ACCESS Line | 3,225,000 | 1,659,082 | 1,565,918 | |
| 15. Safe Alternatives for Children and Youth Crisis Servic | 1,030,600 | 636,100 | 394,500 | |
| 16. Mental Health Student Services Act | 316,000 | 0 | | 316,000 |
| 17. | | | | |
| 18. | 0 | | | |
| 19. | 0 | | | |
| 20. | 0 | | | |
| **PEI Administration** | 424,800 | 424,800 | 0 | |
| **PEI Assigned Funds** | | | | |
| **Total PEI Program Estimated Expenditures** | 7,852,300 | 4,179,600 | 3,356,700 | 316,000 |

| | Fiscal Year 2021/22 | | | |
|---|---|---|---|---|
| | A | B | C | D |
| | **Estimated Total Mental Health Expenditures** | **Estimated PEI Funding** | **Estimated Medi-Cal FFP** | **Estimated Other Funding** |
| **PEI Programs - Prevention** | | | | |
| 1. Mental Health Education | 254,000 | 254,000 | 0 | 0 |
| 2. Early Childhood Mental Health (ECMH) | 428,000 | 428,000 | 0 | 0 |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |
| **PEI Programs - Early Intervention** | | | | |
| 11. Early Childhood Mental Health | 1,083,600 | 424,800 | 658,800 | 0 |
| 12. Early Detection and Intervention Teams for TAY | 696,300 | 0 | 696,300 | 0 |
| 13. School-Based Prevention/Early Intervention Services | 477,400 | 356,200 | 121,200 | 0 |
| 14. Access and Assessment Teams/ACCESS Line | 3,684,900 | 2,356,200 | 1,328,700 | 0 |
| 15. Safe Alternatives for Children and Youth Crisis Servic | 1,030,600 | 662,100 | 368,500 | 0 |
| 16. Mental Health Student Services Act | 1,061,100 | | | 1,061,100 |
| 17. Early Psychosis Intervention Grant | 401,800 | | | 401,800 |
| 18. | 0 | | | |
| 19. | 0 | | | |
| 20. | 0 | | | |
| **PEI Administration** | 450,600 | 450,600 | 0 | |
| **PEI Assigned Funds** | 0 | | | |
| **Total PEI Program Estimated Expenditures** | 9,568,300 | 4,931,900 | 3,173,500 | 1,462,900 |

| | Fiscal Year 2022/23 | | | |
|---|---|---|---|---|
| | A | B | C | D |
| | Estimated Total Mental Health Expenditures | Estimated PEI Funding | Estimated Medi-Cal FFP | Estimated Other Funding |
| **PEI Programs - Prevention** | | | | |
| 1. Mental Health Education | 254,000 | 254,000 | | |
| 2. Early Childhood Mental Health (ECMH) | 428,000 | 428,000 | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |
| **PEI Programs - Early Intervention** | | | | |
| 11. Early Childhood Mental Health | 1,105,272 | 446,472 | 658,800 | 0 |
| 12. Early Detection and Intervention Teams for TAY | 710,226 | 13,926 | 696,300 | 0 |
| 13. School-Based Prevention/Early Intervention Services | 486,948 | 365,748 | 121,200 | 0 |
| 14. Access and Assessment Teams/ACCESS Line | 3,758,598 | 2,429,898 | 1,328,700 | 0 |
| 15. Safe Alternatives for Children and Youth Crisis Servic | 1,051,212 | 682,712 | 368,500 | 0 |
| 16. Mental Health Student Services Act | 1,082,322 | | | 1,082,322 |
| 17. Early Psychosis Intervention Grant | 409,836 | | | 409,836 |
| 18. | | | | |
| 19. | | | | |
| 20. | | | | |
| **PEI Administration** | 459,612 | 459,612 | 0 | |
| **PEI Assigned Funds** | 0 | | | |
| **Total PEI Program Estimated Expenditures** | 9,746,026 | 5,080,368 | 3,173,500 | 1,492,158 |

## FY 2020-21 Through 2022-23 MHSA Plan Update

## Innovations (INN) Component Worksheet

County: Santa Barbara County                                        2/16/21

| | Fiscal Year 2020/21 | | | |
|---|---|---|---|---|
| | A | B | C | D |
| | Estimated Total Mental Health Expenditures | Estimated INN Funding | Estimated Medi Cal FFP | Estimated Other Funding |
| **INN Programs** | | | | |
| 1. **Peer Tech Suite** | 747,700 | 747,700 | 0 | 0 |
| 2. | 0 | 0 | 0 | 0 |
| 3. | 0 | 0 | 0 | 0 |
| 4. | 0 | | | |
| **INN Administration** | 300 | 300 | 0 | |
| **Total INN Program Estimated Expenditures** | 748,000 | 748,000 | 0 | 0 |

| | Fiscal Year 2021/22 | | | |
|---|---|---|---|---|
| | A | B | C | D |
| | Estimated Total Mental Health Expenditures | Estimated INN Funding | Estimated Medi Cal FFP | Estimated Other Funding |
| **INN Programs** | | | | |
| 1. **Peer Tech Suite** | 896,400 | 896,400 | | 0 |
| 2. | | 0 | | |
| 3. | | | | |
| 4. | | | | |
| **INN Administration** | 700 | 700 | 0 | |
| **Total INN Program Estimated Expenditures** | 897,100 | 897,100 | 0 | 0 |

| | Fiscal Year 2022/23 | | | |
|---|---|---|---|---|
| | A | B | C | D |
| | Estimated Total Mental Health Expenditures | Estimated INN Funding | Estimated Medi Cal FFP | Estimated Other Funding |
| **INN Programs** | | | | |
| 1. **Peer Tech Suite** | 914,328 | 914,328 | 0 | 0 |
| 2. | | 0 | | |
| 3. | | | | |
| 4. | | | | |
| **INN Administration** | 700 | 700 | | |
| **Total INN Program Estimated Expenditures** | 915,028 | 915,028 | 0 | 0 |

**FY 2020-21 Through 2022-23 MHSA Plan Update**
**Workforce, Education and Training (WET) Component Worksheet**

County: Santa Barbara County 2/16/21

| | Fiscal Year 2020/21 | | | |
|---|---|---|---|---|
| | A | B | C | D |
| | Estimated Total Mental Health Expenditures | Estimated WET Funding | Estimated Medi-Cal FFP | Estimated Other Funding |
| **WET Programs** | | | | |
| 1. Peer Training | 112,500 | 112,500 | 0 | 0 |
| 2. Southern Counties Regional Partnership | 653,500 | 0 | 0 | 653,500 |
| 3. OSHPD Southern Counties Regional Partnership | 278,700 | | | 278,700 |
| 4. | 0 | | | |
| **WET Administration** | | 0 | | |
| **Total WET Program Estimated Expenditures** | 1,044,700 | 112,500 | 0 | 932,200 |

| | Fiscal Year 2021/22 | | | |
|---|---|---|---|---|
| | A | B | C | D |
| | Estimated Total Mental Health Expenditures | Estimated WET Funding | Estimated Medi-Cal FFP | Estimated Other Funding |
| **WET Programs** | | | | |
| 1. Peer Training | 122,800 | 122,800 | 0 | 0 |
| 2. Southern Counties Regional Partnership | 626,100 | 0 | 0 | 626,100 |
| 3. OSHPD Southern Counties Regional Partnership | 430,700 | | | 430,700 |
| 4. | 0 | | | |
| **WET Administration** | 0 | 0 | | |
| **Total WET Program Estimated Expenditures** | 1,179,600 | 122,800 | 0 | 1,056,800 |

| | Fiscal Year 2022/23 | | | |
|---|---|---|---|---|
| | A | B | C | D |
| | Estimated Total Mental Health Expenditures | Estimated WET Funding | Estimated Medi-Cal FFP | Estimated Other Funding |
| **WET Programs** | | | | |
| 1. Peer Training | 125,256 | 125,256 | | |
| 2. Southern Counties Regional Partnership | 638,622 | 0 | | 638,622 |

| | | | | |
|---|---|---|---|---|
| 3. OSHPD Southern Counties Regional Partnership | 439,314 | | | 439,314 |
| 4. | 0 | | | |
| **WET Administration** | 0 | 0 | | |
| **Total WET Program Estimated Expenditures** | 1,203,192 | 125,256 | 0 | 1,077,936 |

## FY 2020-21 Through 2022-23 MHSA Plan Update
## Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Santa Barbara County 3/11/21

| | Fiscal Year 2020/21 | | | |
|---|---|---|---|---|
| | A | B | C | D |
| | Estimated Total Mental Health Expenditures | Estimated CFTN Funding | Estimated Medi-Cal FFP | Estimated Other Funding |
| **CFTN Programs - Capital Facilities Projects** | | | | |
| 1. | | | | |
| 2. | 0 | | | |
| 3. | 0 | | | |
| 4. | 0 | | | |
| **CFTN Programs - Technological Needs Projects** | | | | |
| 11. Capital Information Technology (CIT) | 57,900 | 57,900 | 0 | 0 |
| 12. | 0 | | | |
| 13. | 0 | | | |
| 14. | 0 | | | |
| **CFTN Administration** | 0 | | | |
| **Total CFTN Program Estimated Expenditures** | 57,900 | 57,900 | 0 | 0 |

| | Fiscal Year 2021/22 | | | |
|---|---|---|---|---|
| | A | B | C | D |
| | Estimated Total Mental Health Expenditures | Estimated CFTN Funding | Estimated Medi-Cal FFP | Estimated Other Funding |
| **CFTN Programs - Capital Facilities Projects** | | | | |
| 1. | 0 | | | |
| 2. | 0 | | | |
| 3. | 0 | | | |
| 4. | 0 | | | |

| | | | | |
|---|---|---|---|---|
| **CFTN Programs - Technological Needs Projects** | | | | |
| 11. Capital Information Technology (CIT) | 53,000 | 53,000 | 0 | 0 |
| 12. | 0 | | | |
| 13. | 0 | | | |
| 14. | 0 | | | |
| **CFTN Administration** | 0 | | | |
| **Total CFTN Program Estimated Expenditures** | 53,000 | 53,000 | 0 | 0 |

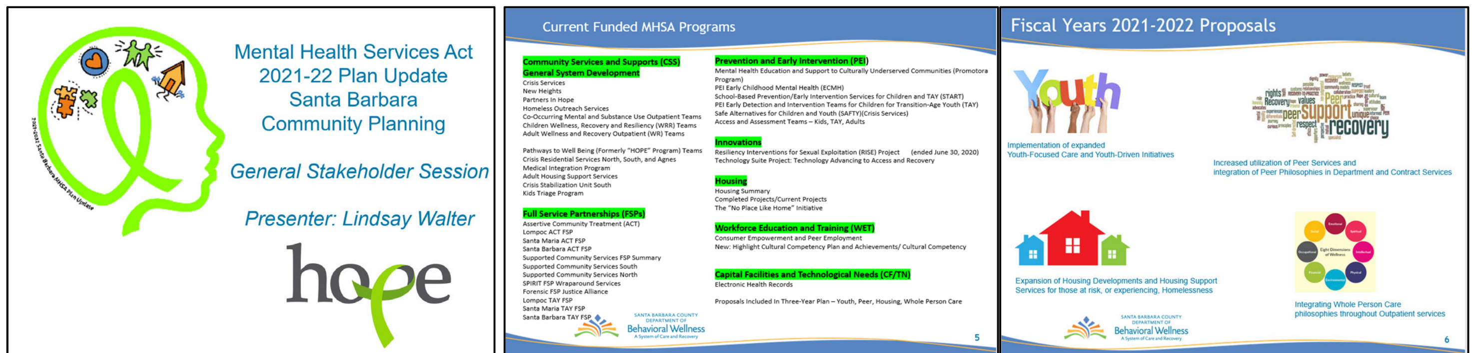
| | **Fiscal Year 2022/23** | | | |
|---|---|---|---|---|
| | **A** | **B** | **C** | **D** |
| | **Estimated Total Mental Health Expenditures** | **Estimated CFTN Funding** | **Estimated Medi-Cal FFP** | **Estimated Other Funding** |
| **CFTN Programs - Capital Facilities Projects** | | | | |
| 1. | 0 | | | |
| 2. | 0 | | | |
| 3. | 0 | | | |
| 4. | 0 | | | |
| **CFTN Programs - Technological Needs Projects** | | | | |
| 11. Capital Information Technology (CIT) | 53,000 | 53,000 | | |
| 12. | 0 | | | |
| 13. | 0 | | | |
| 14. | 0 | | | |
| **CFTN Administration** | 0 | | | |
| **Total CFTN Program Estimated Expenditures** | 53,000 | 53,000 | 0 | 0 |

# Attachment 4: MHSA Fiscal Three-Year Community Planning Process Program PowerPoint

Mental Health Services Act Fiscal Years 2021-2022 One-Year Community Planning Process Program PowerPoints were shared virtually, regionally, and translated into Spanish with Mixtec live interpretation available throughout the county.

The PowerPoints included and Mental Health Services Act Overview; Annual Percentage of MHSA Funding and MHSA General Standards Three-Year MHSA Community Planning Process; Current Funded MHSA Programs; FY 2021-22 Focus Topics Feedback gathered throughout FY2020-23; and Open Discussions.

Examples of PowerPoint:




# Attachment 5: Public Comments for the MHSA Three Year Plan Update

Public Comments regarding the MHSA Annual Plan Update in December 2020 – May 2021 were gathered. Feedback from over 17 meetings, two surveys, emails sent in, art submitted or illustrations, and calls received are below.

Public comments regarding the MHSA Annual Plan Update were gathered at Department Action Meetings, Community Meetings, and throughout the region. Below is feedback gathered through different methods ensuring it was inclusive and reflective of the needs of the community.

**Virtual MHSA Community Planning Workgroup Meeting Feedback**

**Client Family Member Action Team Meeting- Workgroup 1- December 17th, 2020**

The Client Family Member Action Team (CFMAT) Meeting had a large number of attendees and included presentations by Help@Hand Manager Vanessa Ramos and MHSA Chief Lindsay Walter. Vanessa discussed the ongoing efforts to include more youth within BeWell and increase digital literacy as a means of improving mental wellness. Lindsay facilitated a discussion about future peer support services and CFMAT inclusion within the 2021-22 MHSA Plan Update. She explained the six system-building components MHSA funding is

allocated to including Community Collaboration, Cultural Competence, Client Driven, Family Driven, Wellness, Recovery, and Resilience, and Integrated Services Experience. Feedback gathered from stakeholders allow for future proposals and goals to receive funding and therefore provide services and resources to the community. Lindsay discussed a specific proposal to increase the utilization of peer services within specialist groups, increase peer training that will lead to employment opportunities, increased peer-run community wellness and recovery outreach opportunities, and access to Peer Certification programs. Lindsay concluded the presentation by asking attendees for their input and participation in the Plan Update including planning virtual stakeholder meetings, providing input on questions to ask the community, and providing input on informing the community of MHSA activities and goals.

Comment: Ability for peers to have mentors

Comment: Assemble peer support personnel, with their experience in the roles they act as the experts, support with NAMI peer certification and value of those with lived experience. They can participate in many ways and NAMI discussing with head of Jail Mental Health services to have peer support in the jail. Once curriculum decided upon, peers would have a lot of credibility in jail and other places. Peer Manager should be lead contact for interested partners

Comment: Nami Peer to Peer class is a wonderful first step in guiding peers into recovery and looking at short term and long-term goals. This would be a great step to get people involved

Comment: Nami Peer to Peer class is a good first step. It is fun and useful.

Comment: Priority to communicate ongoing trainings to support and promote peer certification.

Comment: Perhaps we can get Commission support

Comment: Subcommittee for Peer Certification at CFMAT

Comment: Press release frequency on Peer Certification

Comment: Let's have a standing MHSA Update in the CFMAT newsletter
That sounds good there is definitely synergy between the group and sub-committee there.

**Peer Employee Forum- December 17th, 2020**

MHSA Chief Lindsay Walter hosted a peer-focused community stakeholder session for BeWell Peer staff serving throughout all regions in the county.

She shared an overview of MHSA including annual percentage of MHSA funding and MHSA General Standards. Lindsay identified a focus goal, Peer Support Services, developed through stakeholder feedback given throughout the 2021-2023 MHSA Community Planning Process. This proposal includes increasing peer staff capacity so every mental health group has a support peer specialist, ongoing trainings for peers that lead to future employment opportunities, increased peer run community wellness and recovery outreach opportunities and Peer Certification programs. Lindsay discussed the history of Peer role in Santa Barbara including the SB Peer Innovations Project including Help@Hand which aims to increase digital literacy to improve

mental wellness and increase youth voice within BeWell. The presentation closed by asking attendees for their feedback on the future of peer support services.

Comment: Until Santa Barbara County's Behavioral Wellness Department has a real consumer for a Consumer Empowerment Manager the consumer's voice in Santa Barbara County will continue be stifled. The person currently in that position is not a consumer. Although she tries to go through the motions of organizing and representing consumers she has no desire or knowledge in how to represent them. She serves more to re-strain the consumers' wants, wishes, and desires and instead promotes the Departments wants wishes and desires. Santa Barbara Behavioral Wellness Dept needs and clients have a right to have a real consumer, one that carries a mental health diagnosis and has actually been in mental health services as a Consumer Empow-erment Manager. As well as that should be full time. Not a split position as it now the case.

**Client Family Member Action Team Meeting Workgroup 2- January 21st, 2021**

MHSA Chief Lindsay Walter led a stakeholder presentation describing the objective of the Community Pro-gram Planning Process (CPP) and the importance of the Mental Health Services Act in utilizing funding for BeWell programs. She explained how feedback gathered from stakeholders in the community allows MHSA funding to be used for necessary and needed resources and services. Lindsay informed attendees of the 2021-22 update to the MHSA Plan including an expanded budget and hiring of youth writing interns to assist with the update. To determine where funding will be utilized in the future, feedback will be gathered through more virtual stakeholder sessions as well as through an online survey.

**Leadership Team- January 25th, 2021**

MHSA Chief Lindsay Walter held a presentation discussing an overview of the Mental Health Services Act (MHSA) Plan and the Community Planning Process (CPP). The CPP is a requirement of MHSA to ensure stake-holders, including consumers, personal advocacy groups, law enforcement, community groups, and health agencies, are involved in the MHSA program plans and annual updates. Lindsay then informed attendees of the tentative MHSA Plan Update timeline and process including holding CFMAT planning meetings, hiring youth MHSA writing interns, hosting public input zoom meetings, and providing an online survey for stake-holders to give feedback. Lindsay asked attendees for their input on how to outreach and how best to utilize Zoom and Survey Monkey.

**Community-Based Organization Collaborative- February 3rd, 2021**

MHSA Chief Lindsay Walter facilitated a lively discussion surrounding MHSA Prevention and Early Intervention (PEI) planning. PEI is a current funded Mental Health Services Act program and CBO members provided input on how funding can be best utilized to ensure services are accessible to anybody who may need them. Mem-bers also discussed ideas to improve or change aspects of PEI to best serve the community. Lindsay concluded the meeting by informing members of the MHSA Plan Feedback Survey and upcoming stakeholder meetings where they can continue to provide input regarding programs funded under MHSA.

**Housing Empowerment Action and Recovery Team (HEART)- February 10th, 2021**

Fourteen members were in attendance to discuss updates regarding current funded MHSA program “No Place Like Home” Initiative. West Cox, an ongoing housing development project in Santa Maria, has constructed 13 No Place Like Home (NPLH) units and 13 Homeless Emergency Aid Program (HEAP) units, and a public notice

will be issued to start getting individuals on the waitlist. Hollister was awarded funding for 18 housing units and Cypress & 7th in Lompoc will be applying for funding for 16 units in Spring 2021. Depot Street in Santa Maria has 34 fully leased units and, under Project Home key, the Home key studios in Lompoc have 14 fully leased units specifically for those experiencing mental illness. A current goal of HEART is to identify and secure a location for the Navigation Center, which will temporarily house the homeless for up to 6 months and provide them with a link to all services with the goal of transferring them to long-term housing.

**Consumer Family Member Action Team Workgroup 3- February 18th, 2021**

This workgroup session was attended by 19 individuals representing Behavioral Wellness across Santa Barbara, Santa Maria, and Lompoc. Vanessa Ramos started the meeting by providing a Help@Hand update including a partnership with San Mateo County to share Headspace, a meditation phone application, within BeWell clinics. Four listening sessions are planned for transition age youth (TAY) to determine if digital literacy has a space within that community. Lindsay Walter led an MHSA Community Planning Process CFMAT Advisory Discussion and provided updates including the hiring of a UCSB writing intern and the development of a survey by the Evaluation Committee. She discussed the efforts of having youth members on the BeWell Commission and the success of Home Key housing projects with 16 people already moved in. She held a presentation with an overview of MHSA and proposals for the 21-22 fiscal year. She specifically highlighted increasing Peer Support Services by adding more peer staff to every mental health program, ongoing trainings for peers that may lead to employment opportunities, and access to Peer Certification Programs and peer-run wellness and recovery outreach fairs. A survey link was provided to gather feedback from attendees.

Comment: What about homeless TAY peers?

Comment: I have concerns in regarding to any homeless being housed and what happens after that.
Many of our homeless when they are housed they may have no education on taking responsibilities and maintaining housing by not breaking rules. One example is Depot Street Complex.

Comment: Some of the places they had peers as Housing Residence manager and that was very beneficial at one point.

Comment: For support services, awesome the north county has the homeless housing at Depot and B street. What happened to a north county CSU or the possibility of a sobering center in Santa Maria?

Comment: Yes, my experience through my own homeless, my heart is to have others become their best and successful.

**Peer Employee Forum- March 18th, 2020**

MHSA Chief Lindsay Walter hosted a community stakeholder session with a Peer Focus to BeWell Peer staff serving throughout all regions in the county.

She shared an overview of MHSA including annual percentage of MHSA funding and MHSA General Standards. Lindsay trained on MHSA Community Collaboration process and provided an overview of the planning process calendar. Currently funded MHSA programs were identified and the 4 proposals identified in the FY2020-2023 were reviewed. Lindsay went into detail on Proposal 2: Increased utilization of Peer Services and Integration of Peer Philosophies in Department and Contract Services and presented a visual outline of activities

throughout FY 2020-2021. Lindsay held discussion on Access to Peer Certifications and State Peer Certification Legislation; Capacity for Peer Employment/Services and Training and Advocacy for Peers in Community and Within System of Care.

Comment: Documentation is key for productivity, since working outpatient it's been a challenge and a learning curve to properly document on CG. Relias is OK, the support from Peers is helpful, but having a standardized training would great.

Comment: Peer recovery documentation group please.

Comment: What about homeless TAY peers?

Comment: I have concerns in regarding to any homeless being housed and what happens after that. Many of our homeless when they are housed they may have no education on taking responsibilities and maintaining housing by not breaking rules. One example is Depot Street Complex.

Comment: Some of the places they had peers as Housing Residence manager and that was very beneficial at one point.

Comment: For support services, awesome the north county has the homeless housing at Depot and B street. What happened to a north county CSU or the possibility of a sobering center in Santa Maria?

Comment: Yes, my experience through my own homeless, my heart is to have others become their best and successful.

**MHSA CPPP Sessions**

**Cultural Competency and Diversity Action Team Meeting- March 12, 2021**

MHSA Chief Lindsay Walter introduced MHSA and how community planning and collaboration helps support the programs currently funded. She discussed 2021-2022 plan proposals, specifically the Whole Person Care Initiative to better integrate a variety of services related to emotional, physical, social, and spiritual healing. Ideas for curriculum include dance, meditation, and nutritional cooking as well as integration of tele-health and additional wellness services such as Employment services, Legal Aid, Educational Services, Alcohol and Drug Programs, Public Health, and Social Services. Implementation of digital literacy to improve mental wellness and increase access to services is also a current key-focus, especially during the unprecedented COVID-19 pandemic. The target populations for this initiative include the Native American Community, Latino Community, Mixtecto Community, LGBTQ+ Community, foster youth and underserved youth, parents of young children, individuals who suffer from co-occurring mental health and substance use disorders, and geographically isolated communities. A survey was shared to be filled out and returned for feedback.

Comment: TAY-aged clients enjoy groups for socialization and reducing isolation but also skill development, such as cooking/nutrition or budget/financial literacy.

Comment: A conversation needs to be started in regards to challenges faced by the Asian American Community including increased bias and violence in-part due to the COVID-19 Pandemic. It would be beneficial to

reach out to support groups and communities in the area to offer our services and support and to collaborate on potential initiative ideas.

Comment: We need to make sure the changes our initiatives are implementing are truly benefitting the communities we are trying to support instead of constantly chasing a moving cart in various directions.

Comment: A vegetable garden and cooking groups could be beneficial program ideas.

Comment: What feedback is appropriate and how can it be integrated into delivery of services?

Comment: Thank you, Lindsay. Great presentation.

**Consumer and Family Member Action Team (CFMAT)- March 18th, 2021**

The meeting was attended by 29 individuals representing Behavioral Wellness across Santa Barbara, Santa Maria, and Lompoc. Vanessa Ramos, Help@Hand Manager provided an update on ongoing efforts which include increasing digital literacy, hosting two groups at the Psychiatric Health Facility, and upcoming Listening Sessions. Lindsay Walter provided a full presentation of the MHSA Planning process including an overview of funding and the Community Planning Process to gather stakeholder feedback. She discussed the current funded MHSA programs and a key focus of helping underserved communities including Asian Americans and Pacific Islanders. Increasing peer support services is another key focus and proposal for the 21-22 MHSA Plan Update. This includes expanded peer training to include peers within every mental health program offered and increasing the amount of youth peers within BeWell. Lindsay informed attendees of a survey to gather feedback.

**General Community Listening Session on MHSA Planning and Updates- March 23rd, 2021**

MHSA chief Lindsay Walter attended the General MHSA Plan Update Session and provided a PowerPoint presentation discussing both general MHSA projects and specific goals for the future. 16 individuals were in attendance representing NAMI, TAY BWELL Peer staff, College Enrolled Youth residents, North County Contract Providers, Family members, and Youth consumers. Lindsay emphasized ongoing efforts to integrate programs that provide mental health services with programs that provide substance abuse services and the importance of community and stakeholder feedback to best assess the needs of the community. She discussed the MHSA programs that are currently funded, including efforts to house individuals with underlying mental health conditions or those that may be experiencing homelessness and efforts to innovate by using technology to improve access to mental health services. Tele-health services rose from 2% to 85%, due, in big part, to the COVID-19 health crisis. Project proposals for the 2021-2022 fiscal year were introduced, including expanding youth-focused care, increasing utilization of peer services and capacity to train and hire more peers, further expansion of housing services, and the integration of Whole Person Care philosophies throughout outpatient services. The MHSA Feedback Survey was provided in the chat-box for participants.

Comment: Sustainability and the environment and how that connects to mental health, is there a linkage we can address and a way to integrate them?

Comment: In regards to digital literacy: COVID-19 has reduced the amount of printing we do as an organization. We could work with clients on filling out PDF forms as increasing digital literacy cuts down on printing, tying into sustainability and the environment.

Comment: Gardening throughout crisis residential treatment facilities proves to be very healing. They have gardening beds and they go on walks that are healing for the community. The "Picture This" app identifies type of plants for you and gives individuals experiencing homelessness a way to adapt to environment and see life from a different point of view. Helps to avoid poison oak and other potentially dangerous plants.

Comment: It has been cool, thanks to Lindsay's efforts, to see the youth initiatives come to the forefront

Comment: Regarding youth initiatives: It makes me really happy, it has been cool to see how it has been evolving and building upon each other

Comment: How can we combat against corporate discrimination against people with disabilities? It seems like discrimination is part of the reason people with disabilities end up on the street. Are there any corporate partners BWELL has that hire people with disabilities?

Comment: Follow-up on job discrimination. Word got out that I was "unstable" and I was unable to hold job positions. It could be beneficial to find new peers or those that have the potential to recover and foster that relationship in order to get these individuals back into the corporate world. Creating gateways between corporate life and the way non-profits can onboard people. How do we connect peers through that pipeline?

Comment: Definitely linkages to non-profits, possible cohorts where we can train people to rehabilitate through work or some type of work force training situation. Wellness Intervention at the PHF made it to Agnes Street and now we are in direct contact with the community through multiple linkages.

Comment: Our mental health needs have gone in the way of school or completing school because our education system is not supportive of the different things we need. We can't get a job because we don't have a degree but we can't get a degree because we're not well. Clients at the PHF tend to be most excited to work but it is difficult to find a job.

Comment: If someone is at the PHF and they will be leaving but want to start volunteering, can they volunteer with us?

Comment: We do have those opportunities but they are not fully developed yet. We are also creating a peer internship program with training money thru the SCRP grant. Volunteer work is informal and individualized right now.

Comment: Building off previous comment, the significance of empowering work and support systems within a job is so important. Lindsay encouraged me when I was having a bad time & related her experiences to me to offer her support. If it wasn't for being employed by the county, it is very likely I wouldn't be alive. Housing would have gone through, food would have been hard to get, and I would have withdrawn. The importance of a safe-space has allowed me to get back on medication and actively seek behaviors that help me instead of hurt me. It is important to have a space where you get paid to exist in one sense as we all have bad days, that is just how people work.

Comment: Psychological safety; government is usually done a certain way but Lindsay has made efforts to build the system around the individual worker and their needs.

Comment: Check out tiny home villages in LA.

Comment: Are you familiar with the Community Car Care Project? Happening in Goleta as of March 15th, an article was posted about it. It looks like it is facilitated by the Community Hot Rod Projects. It sounds like it is veering in the direction of something that could be really cool for the county to develop as well. It would be super important for all ages, the TAY community, and those experiencing homelessness or living in their cars to know how to fix their cars or use the training vocationally and then get a job.

**Children's System of Care (CSOC)- March 25th, 2021**

MHSA Chief Lindsay Walter provided an overview of MHSA funding and how it helps to develop and expand mental health services as well as a presentation of current and future goals. She explained the difficulties COVID-19 has had on budget determinations and the efforts made to keep programs sustainable without making cuts. Lindsay discussed the specific principles MHSA must embody including community collaboration, cultural competency, resiliency, and the integration of services. One of MHSA's current goals is to further integrate mental health services with substance abuse services, resulting in one integrated program as opposed to having separate programs. Eventually, physical health will be integrated, creating one plan that encompasses all three of these aspects of wellness. Lindsay the introduced currently funded programs including the "No Place Like Home" initiative and youth-focused initiatives. A need for more youth-driven voices was addressed by opening up the BWELL Commission to TAY, holding listening sessions at UCSB and for the TAY community to understand their wellness needs, hiring more youth within the county system, and focusing on housing needs within the TAY population. Lindsay concluded her presentation by asking for feedback and providing a survey.

Comment: Do the TAY commissioners receive any sort of compensation?

Comment: Commission meetings are during school hours, which is a barrier when it comes to the youth voice. Needs to be addressed.

Comment: YAB North County homeless outreach for youth, could we somehow partner? These two groups often reach out to the same youth, so it probably would be beneficial to collaborate.

Comment: You are right on about some of the initiatives you are doing for the youth. I love the ideas about the drop-in center. I think, one thing we talk a lot about, is a homeless drop-in center. We should look at these two as similar; TAY can go to chill-out and also those living on the street can make connections.

Comment: It just really lifts my heart to see all the stuff you guys have accomplished. We appreciate all the collaboration surrounding our youth. Are you connected with the south coast youth partnership? They have community engagement teams and providers. All of the work around resilience and working with the medical community to learn about at-risk child experiences. We received a network of care grant that is very collaborative and is looking to expand the network of care to figure out buffering resources and understanding that behavioral wellness resources are useful, but not the only resources out there. It seems like that should be part of the prevention work. ACES information. We reached out to BWELL to have someone on the leadership team, we would love to have BWELL be a part of that.

Comment: You mentioned the youth center focused on substance use in Lompoc, would there be an opportunity for more work around substance abuse for youth b/c that comes up frequently at our inter agency placement committee. Some of our foster family agencies that have high needs teens placed in their resource homes, the caregivers are really struggling to work with the kids who have substance abuse issues. Frequently those kids are asking for support and we have continued to work around navigating those services. Pathway family services has connected but it still seems like there could be more.

Comment: We are seeing a greater number of kids in STRTP placement, who are burning out their placement. What happens is that we get called and told to remove a youth and have to start the process over again. Could we create some type of intensive intervention youth team? Something we can do before youth needs to be removed from an STRTP to help them be successful. Acuity of youth is higher than some STRTPs can handle.

Comment: level of mental health services we expect are not being provided in our programs. We think they are getting a great array of services but in reality, they aren't. It needs a more targeted approach.
Comment: I agree. Drug and Alcohol treatment is greatly needed especially now around youth using substances cope with COVID stressors and being home and unsupervised during distance learning.

Comment: AB808- youth crisis program to address STRTP and their vision not aligning with reality. Pilot program is to work with counties to develop an array of children's crisis mental health services.

Comment: Along lines of STRTP, we see a lot of struggles with online learning. When they don't have consistent school schedules they tend to get into more trouble or substance abuse.

Comment: BeWell and our CBO's have specialty services for that population to provide support (i.e. mental health, case management, substance abuse, housing, employment, medication management, etc.)

Comment: Amazing and exciting vision, Lindsay. Kudos to you for making this all possible. There is a lot to improve as we are seeing mental health acuity over the top. A lot of creativity, innovation, and using our resources wisely, I am very excited at what we can accomplish.

Comment: there has been discussion in the past about the need/vision to integrate our current TAY FSP teams with an on-site substance abuse component (much like on the adult side of the house we have a full time AOD Specialist and a "Co-Occurring" team/template), we desperately need this type of model in working with BeWell/CBO TAY FSP youth.

Comment: Have an AOD Specialist (BeWell employee or a CBO) to become an integrated part of the care team, connect youth/families with treatment options, resources and provide education/engagement/outpatient treatment to youth in need of support. The AOD Specialist can also connect the youth to a higher level of care when needed.

Comment: Our current model of calling the Access line and offering youth a higher level of care has not been successful. The teams struggle with responding effectively and acknowledge this as a "gap" in our current system of care.

**National Alliance on Mental Illness Speaker Session for Families - Housing and Homeless Service Focus- April 14th, 2021**

Natalia Rossi, Program Coordinator, Santa Barbara Co. Dept. of Behavioral Wellness and Emily Allen. Program Director of Homeless & Veteran Impact Initiatives, Northern Santa Barbara County United Way presented on Housing Opportunities for People with Mental Health Conditions in Santa Barbara County with a focus on activities of the County in partnership with MHSA and other funders. Adequate housing is one of the greatest challenges faced by individuals and families impacted by mental health conditions on their path to recovery. Ms. Rossi manages the Behavioral Wellness' partnership with the County Housing Authority and all applications for MHSA No Place Like Home funding. An overview of recently opened affordable housing units as well as those in planning stage which also offer supportive services for people with mental health conditions was defined. Emily Allen, a long-time affordable housing advocate, discussed the application process for these housing opportunities which is known as the Coordinated Entry System.

Comments from attendees and discussion with presenters included:

1) Heath House was one an AIDS Respite house, and then a Peer-run shelter house, it would be nice to have peer involvement at this site.
2) We should have a master list on our website that lists all the housing opportunities for consumers and how to apply for them.
3) We should have better inclusion/instruction on how to apply for and receive mainstream Section 8 Housing Vouchers
4) How much MHSA funding has been diverted to No Place Like Home?
5) Considering how NPLH funding we have been granted, are we gaining funds through NPLH funding? What about long term? We are receiving NPLH funding now, but we will be getting less in MHSA funding for the next twenty years?

**Housing Empowerment Action and Recovery Team (HEART)- Housing and Homeless Service Focus- April 14th, 2021**

MHSA Chief Lindsay Walter held an MHSA Plan Update presentation for 17 attendees representing BeWell and Good Samaritan with a focus on housing services. She started by introducing the allocation of funding and the general standards MHSA must follow including community collaboration, cultural competence, and integrated service experience, among others. She went through the current funded MHSA programs and proposals for fiscal years 2021-22 with a specific focus on housing and homelessness initiatives. Goals of the proposal include creating a minimum of 50 new supportive housing units throughout Lompoc, Santa Maria, and Santa Barbara and creating a peer-run supportive program at these housing complexes. Lindsay further discussed the initiatives of 2020-21 including the establishment of over 50 new housing opportunities with No Place Like Home, HomeKey COVID Funding, and MHSA Housing and HEAP grants. Multiple locations also have 20 to 40 hours a week of behavioral support services offered. Lindsay concluded her presentation by asking for feedback and providing a link for a survey.

**Spanish Speaking Session focusing on Underserved/Unserved Community in Lompoc – April 19, 2021**

The Department of Behavioral Wellness held an MHSA Community Program Planning Spanish Speaking Session for the community of Lompoc on April 19, 2021. Maria Arteaga provided a presentation informing attendees of the Mental Health Services Act. Topics discussed included general standards that MHSA must encompass such as community collaboration, cultural competence, and wellness, recovery, and resilience. Maria went over the specific process that community planning entails and highlighted the importance of stakeholder feedback within that process. Further discussed were both the currently funded and the proposed future MHSA programs, with a specific focus on the Housing and Homelessness Initiative.

Comment: There is a lack of behavioral health services in Lompoc in Spanish, specifically grief therapy.

Comment: Another attendee also expressed an inability to find services in Spanish in Lompoc.

Comment: Many people are not even aware of mental health services offered and end up finding them randomly, like through a class. Spreading information to parents through their kids and kids' schools is recommended.

Comment: Attendee shared about her brother-in-law passing away and how she was unable to find mental health services for her mother-in-law in Lompoc. She kept being redirected to people who could also not assist her.

Comment: Attendee shared her experience in being unable to find psychologists or therapists for her daughter in Lompoc. She could only get scheduled in Santa Maria or Buellton, which creates a distance-barrier.

Comment: Insurance plans often don't cover mental health services. Recommended to look closely at individual plans.

Comment: Attendee recommended more funding for alcohol and drug counselors in schools. She has a 13-year-old daughter and would like her to have a reliable counselor to talk to once she enters high school.

Comment: Attendee recommends using other destigmatizing words such as "cafecito" instead of "mental health" to incentivize people to attend more events. There needs to be a strong destigmatizing mental health and drug and alcohol campaign so more people can get help.

Comment: Navigating people to the correct resources is super important. Empathetic resources are also very important.

**Spanish Speaking Session focusing on LatinX Community and Family Members in South County – May 11, 2021**

The Department of Behavioral Wellness held an MHSA Community Program Planning Spanish Speaking Session on May 11, 2021 for target population LatinX South Family Members. Attendees included consumers, family members, staff at Casa de la Raza, and staff at the Promotora network of the Santa Barbara County Education Office Health Linkages Program. Maria Arteaga provided a PowerPoint presentation to inform attendees of the Mental Health Services Act. Topics of discussion included the community planning process and the importance of stakeholder feedback in developing the MHSA plan. Maria also discussed the currently funded MHSA programs as well as proposals for future programs. These programs must fall under an umbrella of specific standards including community collaboration, cultural competency, client-driven, and wellness,

recovery, and resilience focused. The current Housing and Homelessness Initiatives were highlighted with over 50 new housing opportunities having been established and more planned for the future.

Comment: The lack of having a Social Security number or a green card is an obstacle for many.They do not qualify for many programs. The programs that they do qualify do very little because of their immigration status.

Comment: Programs are designed for the English-speaking American communities and not for the Hispanic population.

Comment: People are not very welcoming of the Hispanic community.

Comment: People are not aware of how to access mental health services or available resources.

Comment: In regards to the mental health workforce, there is not enough clinicians that speak comprehensible Spanish.

Comment: Undocumented individuals do not have access to alcohol and drug programs and mental health services.

Comment: More Spanish mental health and alcohol and drug workshops for the community.

Comment: The possibility of having a workshop to help people navigate Zoom or WhatsApp.

Comment: Teach the Hispanic population about how to use technology to better access mental health and alcohol and drug information and programs.

Comment: Have Spanish-speaking support groups to discuss mental health and wellness.

Comment: Inform the community about mental health services through radio.

Comment: Bring mental health and alcohol and drug programming throughout all regions.

Comment: A huge hurdle is the stigma behind mental health. The Hispanic population often struggles to speak about mental health and alcohol and drug issues.

Comment: There is a limited amount of behavioral health resrouces for families that have children with Autism.

Comment: Emphasize and encourage everyone to complete the MHSA survey in order to get their voices heard and represented.

Comment: Many people expressed interest in needing to learn about various housing situations the County offers due to different compromised living situations.

Comment: People praised the Spanish support groups and recognized their strong impact in the community to bring awareness to mental health services.

**Transition-Aged Youth Listening Sessions**

**BeWell Transition-Aged Youth Clients- March 3rd, 2021**

Help@Hand, in collaboration with Painted Brain, facilitated a virtual listening session for youth clients to gather feedback for development of a digital literacy wellness curriculum in collaboration with Painted Brain. The importance of this feedback to ensure the curriculum is culturally relevant was explained to attendees and three focus topics, recovery & resilience, safety practices, and basic computer skills, were identified. A demographics poll was conducted to gather relevant info about attendees. Attendees were split up into 3 Zoom break-out rooms to discuss the 3 focus topics. Participants engaged in lively discussions facilitated by the Help@Hand team and shared many ideas regarding online safety, necessary computer skills, and what recovery & resilience mean to the individual. After break-out room discussion, attendees had a chance to further share their thoughts and input with the whole group. Feedback was gathered by Painted Brain and will be utilized for curriculum development.

**Virtual Game Night- March 24th, 2021**

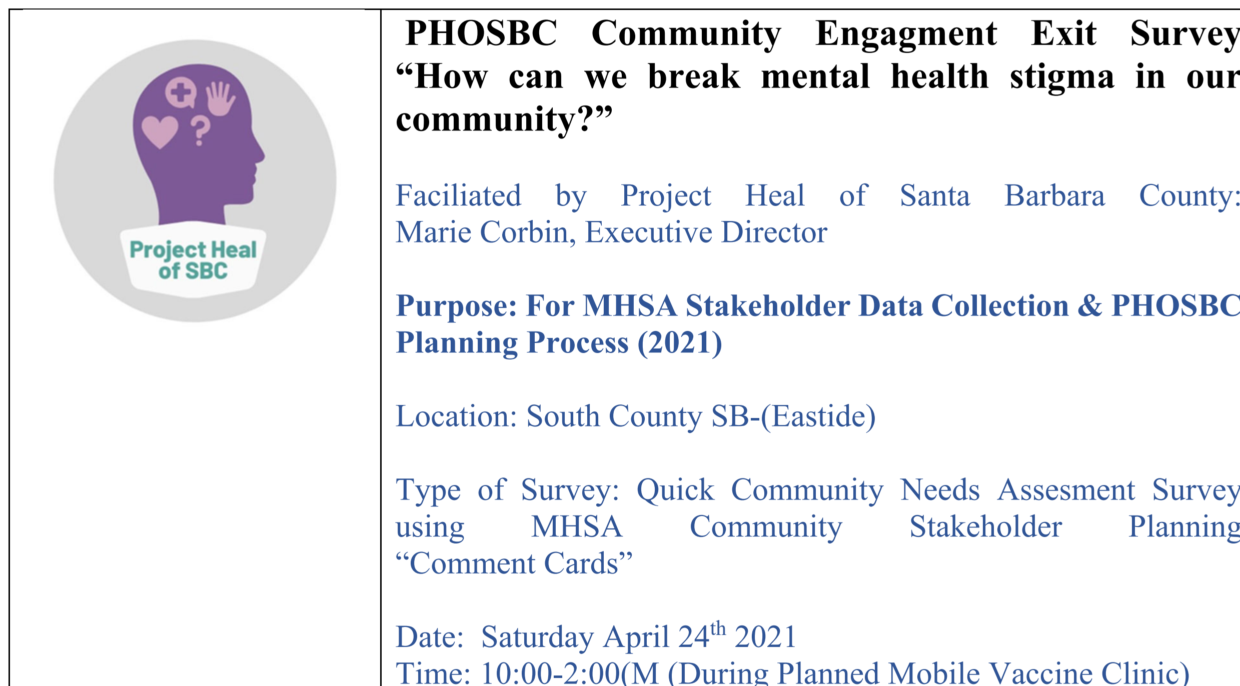
Help@Hand, in collaboration with Painted Brain, hosted a virtual game night geared towards college-aged youth to gather relevant feedback for a digital literacy curriculum. Flyers were distributed primarily at SB county colleges including UCSB, Westmont, SBCC, and Allen Hancock, though any TAY were invited to attend. Help@Hand introduced themselves and the purpose of the listening session as well as explained the 3 focus topics, recovery & resilience, safety practices, and basic computer skills. Attendees were given a demographics poll to gather information relevant to curriculum development. Attendees were put into Zoom break-out rooms to discuss the 3 focus topics and play games. Feedback was gathered by Painted Brain and will be utilized for curriculum development.

**Community Session- April 7th, 2021**

Help@Hand, in collaboration with Painted Brain, hosted a virtual community feedback session geared towards Transition-Age Youth to develop a digital literacy wellness curriculum for TAY. Attendees were given an overview of Help@Hand and the necessity of stakeholder feedback in order to develop resources relevant to the specific community. Help@Hand identified three focus topics, recovery & resilience, safety practices, and basic computer skills, and informed attendees they would be put into Zoom break-out rooms to discuss the topics. Attendees rotated between each topic and had the opportunity to give their input on all three of them. The listening session closed with a whole group discussion about what was shared in the break-out rooms. Feedback was gathered by Painted Brain and will be used for curriculum development.

**Spanish Session- May 22nd, 2021**

Help@Hand, in collaboration with Painted Brain, hosted a virtual feedback session for the Spanish-speaking TAY community to gather feedback for a digital literacy program and ensure it is culturally relevant. Attendees were informed of the purpose of the listening session and how their feedback is necessary to create a curriculum that is beneficial for mental wellness. Help@Hand identified three focus topics: Recovery & resilience, safety practices, and basic computer skills. Attendees had a chance to discuss all three topics and provide their input and feedback, which was gathered by Painted Brain in order to develop the curriculum.




**PHOSBC Community Engagment Exit Survey “How can we break mental health stigma in our community?”**

Faciliated by Project Heal of Santa Barbara County: Marie Corbin, Executive Director

**Purpose: For MHSA Stakeholder Data Collection & PHOSBC Planning Process (2021)**

Location: South County SB-(Eastide)

Type of Survey: Quick Community Needs Assesment Survey using MHSA Community Stakeholder Planning “Comment Cards”

Date: Saturday April 24th 2021
Time: 10:00-2:00(M (During Planned Mobile Vaccine Clinic)

**Participants:**
Approximately N=40-Registered & walk In’s appointments for Covid 19 Vaccines Dose #1.

Facilitator Total Surveyed N=19 - Exit Survey conducted by PHOSBC at the New Friendship Missionary Baptist Church in Santa Barbara Ca. During a SB County Mobile Vaccine Clinic demographic data: (Blacks)-n=10, (Whites)-n=2, (LatinX)-n=5, (16-18yrs)-n=2.

**What would you say are barriers to accesing mental health service in your community?**

Transportation, Internet Connection access, Judgement of others, Shame, embarrassment.
Not enough colored Therapists, Religious Beliefs, Cultural beliefs, lack of trust.

**What opportunities would you like to see happen as it relates to talking about mental healh stigmas or challenges?**

Planned in-person events sponsored by local faith-based organizations and community-based organization to discuss openly mental health stigmas and ways to combat it. More targeted Outreach for people of color include Black/Brown/LatinX/Caribe and Native Americans.

**What are your experiences with mental health conditions?**

Most interviewed knew of someone with a mental health condition or identified as having a mental health condition and would like to see stigmas addressed.

**Discussion points: How can we address mental health stigmas in our community?**

Have more options in choices and ways to access mental health services.

Include more English/Spanish trainings and services.
More outreach from faith-based organizations.
More Black and Brown clinicians should be available to us.

### Points to Highlight:

It appears there does need to be more listening sessions or open forums to be able to address concerns that couldn't be addressed due to the event overshadowing the spontaneous community assessment. The barriers are however trusting issues in the community towards past interactions with local organizations here that still need to be addressed.

### What is working in your opinion when it comes to accessing services for healthcare in your community?

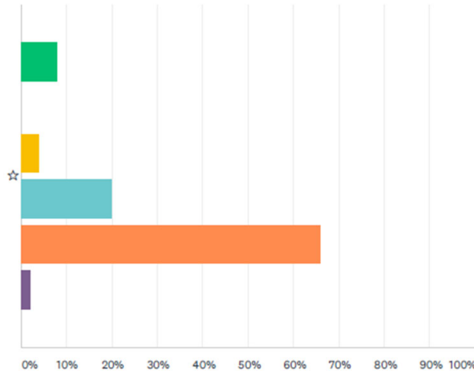
Most surveyed felt that Behavioral Wellness is visible in the community but would like to see more interactions with the black community and people of color that are unrepresented.

## MHSA Planning Survey Feedback:

Survey results from the Santa Barbara County MHSA 2021-2022 Planning Survey. This survey solicited feedback from stakeholders on Department activities in relation to the new proposals identified in the initial 2020-2023 MHSA plan. The survey was disseminated to key stakeholder--including individuals who experience or have experienced mental health challenges and/or their family members, individuals who use or have used mental-health services or supports, and providers of or administrators in mental-health services—and was promoted during department action team meetings and community program planning meetings. During this feedback process, the MHSA Chief Lindsay Walter worked with the Peer and Ethnic Services manager to ensure that the voice of the community was heard and key informants throughout the community were spoken to. The MHSA Evaluation team prepared the survey to align with MHSA required data elements and managed collating the data.

The MHSA Planning Survey was distributed electronically via SurveyMonkey in English and Spanish, and was completed by stakeholders from March to May 2021. One hundred and thirty-two people responded to the survey; 24% of respondents took the Spanish survey. The English version took respondents on average 6.5 minutes complete and had an 84% completion rate. The Spanish version took respondents just over 8 minutes to complete and had a 71% completion rate.

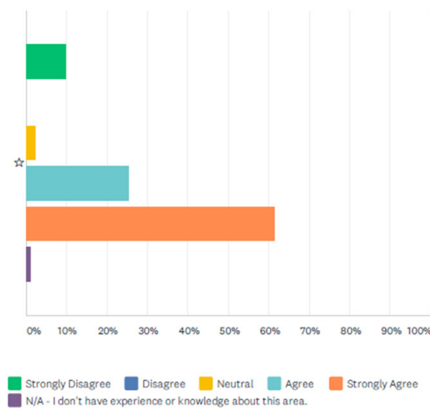
**Question 1:** To what extent do you agree that these activities align with Youth-Focused Care and Youth-Driven Initiatives?




Strongly agree 66%
Agree 20%
Neutral 4%
Disagree 0%
Strongly disagree 8%

**Question 2**: If you have any suggestions related to these activities, what additional input or ideas do you have to achieve Youth-Focused Care and Youth-Driven Initiatives? – Data provided in Survey Monkey.

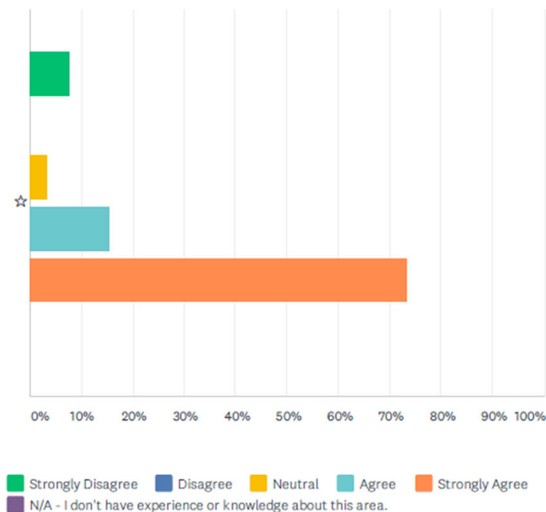
**Question 3:** To what extent do you agree that these activities align with Increased utilization of Peer Services and integration of Peer Philosophies? – Data provided in Survey Monkey.




Strongly agree 61.54%
Agree 25.27%
Neutral 2.20%
Disagree 0%
Strongly disagree 9.89%

**Question 4**: If you have any suggestions related to these activities, what additional input or ideas do you have to achieve Increased utilization of Peer Services and integration of Peer Philosophies? Data in Survey Monkey.

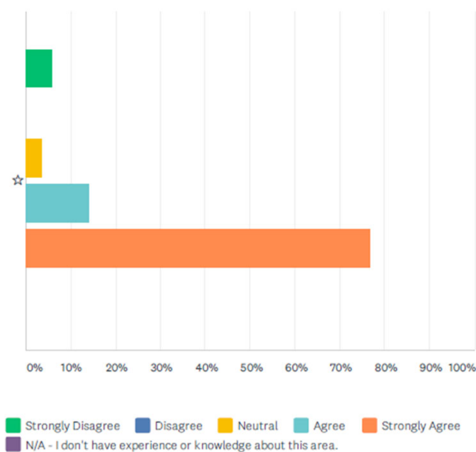
**Question 5:** To what extent do you agree that these activities align with Expansion of Housing Developments and Housing Support Services for those at risk, or experiencing, Homelessness?




Strongly agree 73.33%
Agree 15.56%
Neutral 3.33%
Disagree 0%
Strongly disagree 7.78%

**Question 6:** If you have any suggestions related to these activities, what additional input or ideas do you have to achieve Expansion of Housing Developments and Housing Support Services for those at risk, or experiencing, Homelessness? – Data provided in Survey Monkey.

**Question 7:** To what extent do you agree that these activities align with Integrating Whole Person Care Philosophies throughout Outpatient services?

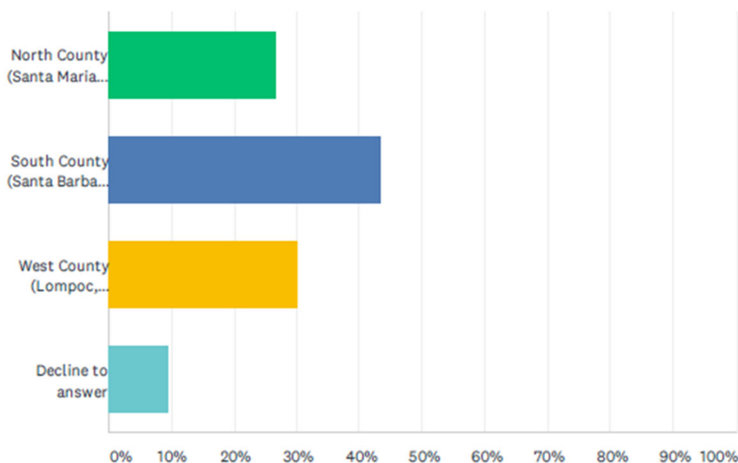



Strongly agree 76.74%
Agree 13.95%
Neutral 3.49%
Disagree 0%
Strongly disagree 5.81%

**Question 8:** If you have any suggestions related to these activities, what additional input or ideas do you have to achieve Integrating Whole Person Care Philosophies throughout Outpatient services? Data in Survey Monkey.

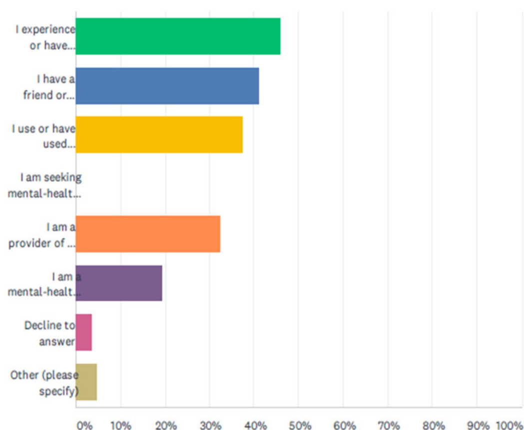
**Question 9:** Do you have any other input or suggestions you would like to share related to the MHSA Plan and activities? Data in Survey Monkey.

**Question 10:** In which region of the county do you live or represent/work? (Check all that apply)




North County (Santa Maria, Guadalupe, New Cuyama) 26.51%
South County (Santa Barbara, Goleta, Carpinteria) 43.37%
West County (Lompoc, Buellton, Santa Ynez) 30.12%
Decline to answer 9.64%

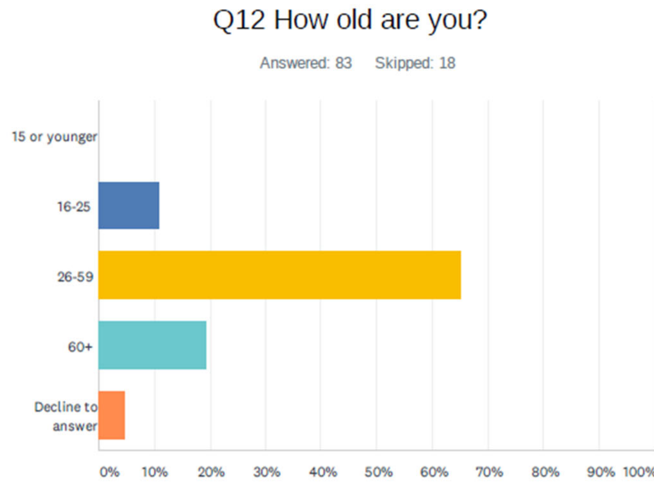
**Question 11:** Which of the following describes you? (Check all that apply)




I experience or have experienced mental-health challenges 45.78%
I have a friend or family member who experiences or has experienced mental-health challenges 40.96%
I use or have used mental-health services or supports 37.35%
I am seeking mental-health services or supports 0%
I am a provider of or administrator in mental-health services 32.53%
I am a mental-health advocate representing a specific racial/ethnic, cultural, or other group 19.28%

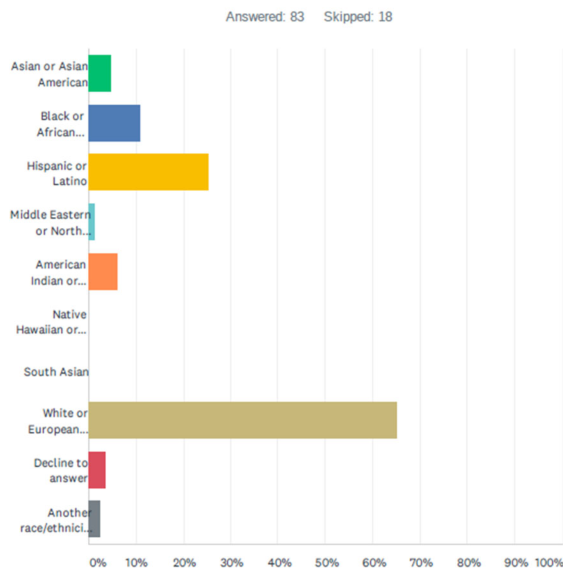
Decline to answer 3.61%
Other (please specific) 4.82%

**Question 12:** How old are you?



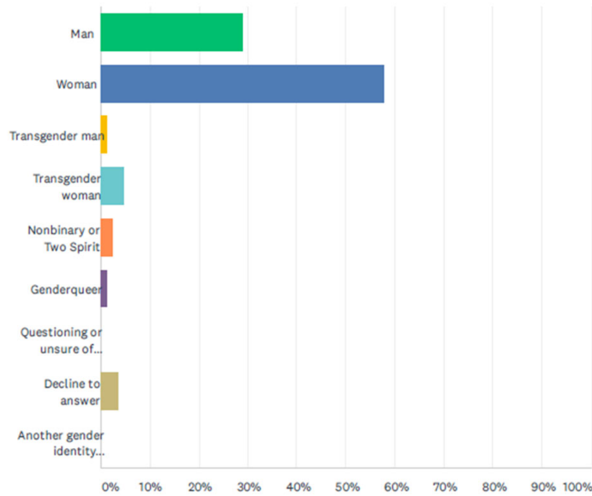

15 or younger 0%
16-25 10.84%
26-59 65.06%
60+ 19.28%
Decline to answer 4.82%

**Question 13:** What is your race/ethnicity?



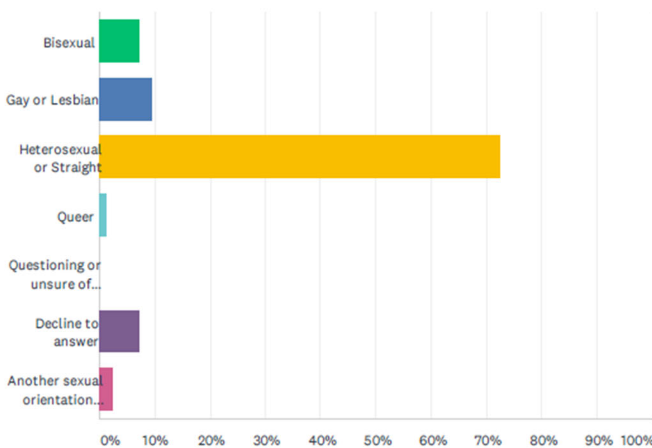

Asian or Asian American 4.82%
Black or African American 10.84%
Hispanic or Latino 25.30%
Middle Eastern or North African 1.20%
American Indian or Alaska Native 6.02%
Native Hawaiian or other Pacific Islander 0%
South Asian 0%
White or European American 65.06%
Decline to answer 3.61%
Another race/ethnicity (please specific) 2.41%

**Question 14:** What is your gender identity?




Man 28.92%
Woman 57.83%
Transgender man 1.20%
Transgender woman 4.82%
Nonbinary or Two Spirit 2.41%
Genderqueer 1.20%
Questioning or unsure of gender identity 0%
Decline to answer 3.61%
Another gender identity (please specify) 0%

**Question 15:** What is your sexual orientation?




Bisexual 7.23%
Gay or Lesbian 9.64%
Heterosexual or Straight 72.29%
Queer 1.20%
Questioning or unsure of sexual orientation 0%
Decline to answer 7.23%
Another sexual orientation (please specify) 2.41%

## MHSA Plan Posting Feedback Received from July 17, 2020 to August 17, 2020

Responses noted are from:
Lindsay Walter, JD
Deputy Director of Administration and Operations- MHSA Chief
County of Santa Barbara – Department of Behavioral Wellness
Phone: 805-681-5236 Email: lwalter@sbcbwell.org

Name: Kelly Griffin; Email: kgriffin@sbcbwell.org
Affiliation/Position Title: BWell Practioner II Lompoc PEI TAY Program

Message: Need for more focus on prevention for folks at high risk for homelessness, instead of focus on chronic homeless. Youth aging out of foster care and probation systems, LGBTQ, parenting and pregnant youth.

Response: Thanks for the feedback. We will be issuing a new request for proposal of all contracted PEI services in MHSA this year and collaborating with CenCal to increase the family therapy benefit that is new for their plan. Lots more to do in this area of our community!

Name: Guillermo Gutierrez; Email: ggutierrez@chccc.org
Organization: Community Health Centers of the Central Coast

Message: Preventive mental health care for Spanish-speaking communities deserve greater attention from us due to the persistence of the stigma about suffering from an emotional disorder and, on the other hand, due to the negative effects left by the pandemic this year and a half. that we have suffered it.
In my opinion, greater coverage should be given with support groups of various kinds and not only in Spanish, but also in other languages with a considerable number of speakers, in an effort to achieve greater self-care of mental health as well as the timely search for professional care .
In this order of ideas, it is necessary to adapt the services in general around the cultural diversity of our population; which implies not only the training of the existing professional staff but also of the promoters and volunteer personnel in order to achieve full accessibility to the services.

Response: Thank you for your feedback for the MHSA plan. This is very timely as we are also doing a COVID impact response plan at the County; I've included Suzanne Grimmesey who is performing the assessment and can use this valuable input too.

Name: Noemi Velasquex; Email: noemiv@chccc.org
Affiliation/Position Title: Federally Qualified Health Center

Message: We encountered a lot of families who have low digital literacy creating a barrier to care. It is inevitable that outreach and education services continue not only to de-stigmatize the talk around mental illness but also to provide access to information for families and individuals to be able to find mental health services. We serve four large pockets of town and provide ongoing outreach. What we found out is that it's important to continue outreach efforts that provide direct verbal information that is culturally and linguistically appropriate to all populations. This is because the population is “mobile” and frequently moves; we were able to identify 40-100 new families/individuals at every outreach event needing education and resources. The

predominant population in Northern Santa Barbara County are agriculture workers that are mobile and suffer disproportionately from social and economic barriers causing stress, depression, anxiety and discrimination. Outreach and education are important in order to eliminate stigma associated with mental illness and increase access to care .

Response: Thanks for sending in the feedback which I'll add to the plan.
Good timing since Suzanne is coordinating a needs assessment for Post-Covid impact in the community and this is super relevant. I've added this comment for her too in that process.
Thanks again for the continued partnership.

Name: Anonymous

Message: Service providers need more funding to support added clinicians and support staff. More funds are needed to get the staff that can provide direct services. These funds should have stipulations to hire bi-lingual clinicians with equitable compensation. Outreach and education are important but direct services are critical. Also, the materials released from this agency should be more accessible to an audience with a sixth-grade education.

# Attachment 6: 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

**Board of Supervisors**
Das Williams - 1st District
Gregg Hart - 2nd District
Joan Hartmann - 3rd District
Bob Nelson - 4th District
Steve Lavagnino - 5th District

**Officers**

*Chairperson*
Victoria King-Kondos – 3rd District

*Vice Chairperson*
Valerie Cantella – 4th District

**Members**
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Vacant - 1st District
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Jan Winter - 1st District

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**Governing Board**
Gregg Hart - Member
2nd District Supervisor

**Program Administrator**
Kristine Haugh

Web site:
http://countyofsb.org/behavioral-wellness

## Behavioral Wellness Commission (BWC) Meeting Agenda

The Santa Barbara County Behavioral Wellness Commission announces the Public Hearing for the Mental Health Services Act (MHSA) One Year Plan Update Fiscal Year 2021-2022, Wednesday August 18, 2021, 3:00 pm to 5:00 pm. The public is invited to attend to ask questions and offer feedback about the plan. **Remote Virtual Participation Only.**

IMPORTANT NOTICE REGARDING PUBLIC PARTICIPATION. On June 11, 2021 and effective immediately, Governor Newsom issued Executive Orders N-07-21 and N-08-21, which rescinded some prior Executive Orders related to COVID-19, but Executive Order N-08-21 stated that some other prior Executive Orders related to COVID-19 still remain necessary to help California respond to, recover from, and mitigate the impacts of the COVID-19 pandemic. Consistent with Executive Order N-08-21, the Behavioral Wellness Commission will meet via teleconferencing, and members of the public may observe and address the Commission as shown below, but may not participate in-person.

The meeting will be hosted through Zoom. Pursuant to the Governor's Executive Order N-08-21, issued on June 11, 2021, Commissioners will attend electronically or telephonically; the meeting will have no location to physically attend. The public may observe the meeting online at Zoom.us by going to https://sbcbwell.zoom.us/j/92429933545?pwd=TVMyNFhvNGtJQTlUbkFoaVVnVFZpQT09. The Meeting ID is 924 2993 3545 and the passcode is 90712649. If you are unable to join the online meeting, you may also call in to (213) 338-8477 and when prompted, enter the Meeting ID 924 2993 3545 and the password 90712649. Persons desiring to address the meeting participants can use one of the options below:

1. **Online via Zoom**
   a. You may 'raise your hand' via a hand icon on your screen. The Chair will call on you, open your mic, and let you address the commission for up to 2 minutes.

2. **By phone** – If you would like to make a comment by phone, please call (805) 681-5232 before 2:30 p.m. the day of the meeting. The Chair will call on you, open your mic, and let you address the Commission for up to 2 minutes.

3. **Distribution to the Behavioral Wellness Commission** – Submit your comment via email, preferably limited to 250 words or less, to the Program Administrator at khaugh@sbcbwell.org prior to noon the day before the meeting. Your comment will be placed into the record and distributed appropriately. To assist staff in identifying the agenda item to which the comment relates, the public is encouraged to indicate the meeting date and agenda item or state "general comment" for items not on the day's agenda.

4. **Read into the record at the meeting:** Submit your comment via email, preferably limited to 250 words or less, to the Program Administrator at khaugh@sbcbwell.org prior to the start of the meeting. To assist staff in identifying the agenda item to which the comment relates, the public is encouraged to indicate the meeting date and agenda item or state "general comment" for public comment for items not on the day's agenda.

Individuals with disabilities who desire to request a reasonable accommodation or modification to observe or participate in the meeting may make such request by contacting Kristine Haugh at (805) 681-5232 or by sending an email to khaugh@sbcbwell.org. The request should be made no later than noon on the day prior to the meeting in order to provide time for the County to address the request.

The Commission's rules on hearings and public comment remain applicable to each of the participation methods listed above. The Chair may set reasonable rules as needed to conduct the meeting in an orderly manner.

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Gregg Hart - Member
2nd District Supervisor

**Program Administrator**
Kristine Haugh

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| TIME | ITEM | PRESENTER |
|---|---|---|
| 3:00 p.m. | **1. Call-to-Order and Conduct Roll-Call** | Kristine Haugh |
| 3:03 p.m. | **2. Establish Quorum** a quorum shall be one person more than one-half the number of appointed members including the Board of Supervisors member or his/her designee. | Victoria King-Kondos<br>BWC Chair |
| 3:05 p.m. | **3. Welcome and Introductions** chairperson asks for guest introductions.<br><br>**Action:** No action. | Victoria King-Kondos |
| 3:10 p.m. | **4. General Public Comment** (2 minutes per person) - members of the public can testify before the meeting participants on any matter not appearing on the agenda.<br><br>**Action:** No action. | Public Members |
| 3:20 p.m. | **5. Mental Health Services Act (MHSA) One Year Plan Update Fiscal** Year 2021-2022 (attachment 5a)<br>1. Public Hearing Overview<br>2. Commission's Role and Legal Aspects<br>3. Fiscal Year 2020-23 Plan Update Summary<br><br>**Action:** No action. | Lindsay Walter<br>Principal Management Analyst<br>Santa Barbara County Executive Office |
| 4:00 p.m. | **6. Public Comment regarding MHSA Plan Update**<br>(3 minutes per person) - Members of the public can testify before the meeting participants on any matter pertaining to the MHSA Plan Update.<br><br>**Action:** No action. | All |
| 5:00 p.m. | **7. 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 the Santa Barbara County Administration Building at 105 E. Anapamu Street, 1st 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.

# County of Santa Barbara

## Behavioral Wellness Commission

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Correspondence: to the Behavioral Wellness Commission regarding items appearing on the agenda should be directed to Kristine Haugh at khaugh@sbcbwell.org. Please call (805) 681-5232 for directions to submit correspondence in a format other than email.

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: Individuals with disabilities who desire to request a reasonable accommodation or modification to observe or participate in the meeting may make such request by contacting Kristine Haugh at (805) 681-5232 or by sending an email to khaugh@sbcbwell.org The request should be made no later than noon on the day prior to the meeting in order to provide time for the County to address the request.

American Sign Language interpreters, Spanish language interpretation and sound enhancement equipment may be arranged by contacting Kristine Haugh at khaugh@sbcbwell.org by 4:00 p.m. three days prior to the meeting date.

# Attachment 7: Minutes of Public Hearing

**Department of Behavioral Wellness Commission Meeting**
Wednesday, August 18, 2021
3:00 p.m. - 5:00 p.m.
Remote Virtual Participation Only

**Public Hearing Notes**
**MHSA One Year Plan - Fiscal Year 2021-2022**

**Meeting Facilitator: Valerie Cantella**, 5th District, Vice Chair.

**Commission Members Present: Rod Pearson**, 1st District; **Jan Winter**, 1st District; **Sharon Rumberger**, 2nd District; **Ruth Ackerman**, 2nd District; **Anahid Papakian**, 2nd District; **Bill Cirone**, 3rd District; **Tom Franklin,** 3rd District; **Rev. Mary Richardson**, 3rd District; **Sharon Byrne**, 4th District; **Valerie Cantella**, 5th District, Vice Chair.

**Commission Members Excused: Gregg Hart**, 2nd District Supervisor; **Wayne Mellinger**, 1st District; Marcos **Olivarez**, 2nd District; **Kelly Mcloughlin**, 4th District; Victoria **King-Kondos**, 3rd District, Chair; **Donald Casebolt**, 5th District.

**Behavioral Wellness Department Staff: Pam Fisher**, Acting Director; **Lindsay Walter**, Principal Management Analyst for Santa Barbara County Executive Office / Mental Health Services Act Chief; **Maria Arteaga**, Cultural Competency/Ethnic Services/Peer Empowerment Manager; **Carla Cross**, Manager of Clinical Training and Special Projects; **Caitlin Lepore**, Research & Program Evaluation; **Amy Lopez,** *ADP/CalWORKs Project Manager*; **Jessica Korsan,** Quality Care Management Coordinator; **Tianna White**, MHSA Writing Intern; **Tor Hargens**, Cost Analyst II, Fiscal Operations Division; **Vanessa Ramos**, Help@Hand Project Manager; **Kristine Haugh,** BWC Program Administrator/Executive Assistant to the Director.

1. **Call-to-Order and Conduct Roll-Call:** Vice Chair Cantella called the meeting to order at 3:03 p.m. Kristine Haugh, conducted roll-call.

2. **Establish Quorum:** Quorum was established at 3:15 pm

3. **Welcome and Introductions:** Vice Chair Cantella welcomed everyone in attendance and asked guests to introduce themselves.

   **Action:** No action.

4. **General Public Comment:** no public comment at this meeting.

   **Action:** No action.

5. **Mental Health Services Act (MHSA)** One Year Plan Update Fiscal Year 2021-2022 (attachment 5a & Late Addition Attachment 5a-2)

   Ms. Walter begins by sharing the commission's role and legal aspects of the public hearing, goes over housekeeping reminders and public comment guidelines. Followed by an overview of PowerPoint Presentation (Attachment 5a-2): **Proposition 63: Mental Health Services Act**: MHSA General Standards, Annual Percentage of MHSA Funding; **Rules and Regulations**, California Code of Regulations (CCR) §3310 and California Welfare and Institutions Code (WIC)§ 5847 states); **Public Comment – Public's Role as Stakeholders**; **Current Funded MHSA Programs**, Community Services and Supports (CSS) General System Development, Full Service Partnerships (FSPs), Prevention and Early Intervention (PEI), Innovations, Housing, Workforce Education and Training (WET), Capital Facilities and Technological Needs (CF/TN); **Community Program Planning Process**; **MHSA FY 2020-2023 Community Planning** Partnerships; MHSA Community Planning Process; **DATA Collection Reported for Programs,** Performance Data, Child and Adolescent Needs and Strengths (CANS), Milestones of Recovery Scale (MORS); **COVID-19 Planning and Budget Impacts to MHSA; Fiscal Years 2021-2022 Proposals; Peer Support Initiatives in 2020-21 and 2021-22 – A Visual of Activities; Peer Support Initiatives in 2020-21 and 2021-22:** Access to Peer Certifications and State Peer Certification Legislation, Capacity for Peer Employment/Services, Training and Advocacy for Peers in Community and Within Systems of Care; **Whole Person Care Initiative**: Integrating Whole Person Care philosophies throughout Outpatient services; **Whole Person Initiatives in 2021-22**; **Housing and Homelessness Initiatives:** Expansion of Housing Developments and Housing Support Services for those at risk, or experiencing Homelessness; **Housing and Homelessness Initiatives in 2020-21 and 2021-22 – A Visual of Activities**; **Housing and Homelessness Initiatives in 2020-21 and 2021-22**; **Youth Initiatives in 2020-21 and 2021-22: A Visual of Activities; Youth Driven and Youth Led Initiatives in 2020-21 and anticipated 2021-22**; **Public Comment, Action, and Next Steps**.

   **Action:** No action.

6. **Public Comment regarding MHSA Plan Update** (3 minutes per person) - Members of the public can testify before the meeting participants on any matter pertaining to the MHSA Plan Update.

   - Commissioner Rumberger requested that Lindsay Walter expand on a specific Behavioral Wellness action point which involves Cal AIM planning. Lindsay Walter explained that it involves case coordination and working with community partners to standardize healthcare– Cal Aim is a system wide tool intended to remove silos and assist with coordination.
   - Commissioner Franklin commended Lindsay Walter for her work with MHSA and with the BWELL department and asked about the use of MHSA funds for the AOT program. Lindsay Walter responded that funding for AOT has been provided by general fund dollars in the past, this year funds will be utilized from FSP, and then MHSA will fund for the long term. Pam Fisher confirmed and explain the general approach of AOT and ACT teams.
   - Commissioner Cirone commented on being impressed with housing progress.
   - Commissioner Ackerman – offered gratitude for the enormous amount of work that has gone into MHSA and asked 2 questions.
     - Question 1. How will the issue of staffing and adequacy be met? Lindsay Walter answered that the Healthcare workforce in general is tired. There has been a strain on the system; the demand is higher than the supply for the profession. Pam Fisher commented that grant funding provides for more programs that then require more staff. There is currently not enough staff and it will likely get worse. BWELL providers have reported beginning to offer hiring bonuses for specific positions that have been difficult to fill. BWELL is looking at hiring options and salaries of many hard to fill positions.

Discussion ensued regarding services, staffing issues within BWEL and CBOs and solutions.

- Question 2. Are general funds needed? Lindsay Walter responded that because MHSA is used as an outpatient system there is no need to use the general fund at this time beyond anything budgeted. If the inpatient side of the costs go up, the department may need to use the general fund, but that is not MHSA funded.

- Commissioner Winter thanked Lindsay Walter and her Staff for their hard work and creativity which have increased stakeholder input over the last 3 years.
- Lindsay Walter Commended Maria Arteaga and her staff & peer support staff in also increasing stakeholder input.
- Lindsay Walter, in her new position with the CEOs office wants to invite clients to feel welcome to the 4th floor.
- Lindsay Walter encouraged members to share information and partnering on grants and other opportunities and collaboration.
- Lindsay Walter thanked Sharon Byrne for her guidance during the first few years of the MHSA public meetings

**The following definitions were offered for clarity for those not familiar with BWELL acronyms:**

- AOT -Assisted Outpatient Treatment – don't refer themselves for treatment instead reach specific eligibilities for treatment
- ACT – Assertive Community Treatment – services go out to the clients who cannot get to the facilities
- CalAIM –California Advancing and Innovating Medi-Cal – this is a revision of Mental Health Services which implements New Mental Health capacities for efficiency, collaboration, assisted outreach & case management services, and prevention. There are 32 initiatives in Cal AIM with the goal of helping a person based on all of their needs

Lynn Chacon requested hard copy of MHSA report (181 pages)

**Action:** No action.

7. **Adjournment** - Commissioner Ackerman made a motion to adjourn the meeting at 4:22 pm. Commissioner Papakhian seconded. No objections. Motion carried.

# Attachment 8: Evidence of Santa Barbara County Board of Supervisors' Approval (Placeholder)