SANTA BARBARA COUNTY DEPARTMENT OF BEHAVIORAL WELLNESS MENTAL HEALTH SERVICES ACT PLAN

PLAN UPDATE FISCAL YEAR 2019-2020

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

300 N. San Antonio Rd

Santa Barbara, CA 93110

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countyofsb.org/behavioral-wellness

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MHSA County Compliance Certification (Placeholder)

MHSA County Fiscal Accountability Certification

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
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Local Mental Health Mailing Address:

Santa Barbara County Department of Behavioral Wellness, 300 N. San Antonio Rd., Santa Barbara, CA 93110

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

Alice Gleghorn, Ph.D. — Local Mental Health Director (PRINT) | Signature | 5/16/19 Date

I hereby certify that for the fiscal year ended June 30, 2018, the CountyICity has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated 8/28/18 for the fiscal year ended June 30, 2018. I further certify that for the fiscal year ended June 30, 2018, 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.

Betsy Schaffer, CPA, CPFO — County Auditor/Controller/City Financial Officer (PRINT) | Signature | 5/17/19 Date

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)

Executive Summary

In the FY 2017-2020 Mental Health Services Act (MHSA) Three Year Plan, the Department of Behavioral Wellness committed to focusing on the continued enhancement and evolution of the many programs and initiatives launched during the last Three Year Plan period. The FY 19-20 Plan Update provides information on the progress and improvements in the system during FY 17-18 and FY 18-19 while outlining strategies for FY 19-20.
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 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.

In FY 18-19, the Department applied for and was awarded two grants: 1) Children's Triage Grant with the Mental Health Services and Accountability Commission (MHSOAC) and the 2) Homeless and Mentally Ill Outreach and Treatment Grant with the Department of Health Care Services. Both of these grants help bolster homeless and crisis services. The Department has also moved forward with the Peer Technology Suite project that was included as part of the FY 18-19 Plan Update. The Technology Suite Collaborative Innovation Plan was approved by the MHSOAC on September 27, 2018 along with a two year Innovations extension of the RISE Program. Detailed information for each of these are included in the Plan Update.

On October 1, 2018, new Prevention and Early Intervention and Innovations reporting requirements went into effect. In order to track this data, the Department contracted with software production company Subvertical, LLC. Coordination of these new data collection efforts and reporting mechanisms were reviewed and discussed at various venues with community partners and the new mechanisms were instituted in Fall and Spring of FY 18-19. Additional data elements for FY 17-18 are reported in Prevention and Early Intervention and Innovations programs along with a detailed summary in the attachment section on status of this reporting initiative.
Based on input received during the three year planning process, the Department continues to move forward on four key proposals which include:

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

Updates on each of these is included in the Plan Update.

In addition, 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 include topics such as Adults, Childrens' System of Care, Change Agents, Cultural Competence and Diversity, Crisis Services, Homeless Services, Housing, Peers, and Forensic Service. 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.

Background

About the Mental Health Services Act

On November 2004, voters in the State of California passed Proposition 63, the Mental Health Services Act (MHSA), which was designed to expand and transform California's county mental health service system. The MHSA is funded by imposing an additional one percent tax on individual, but not corporate, taxable income in excess of 1 million dollars. Becoming law in January 2005, the MHSA represented another California legislative movement, begun in the 1990s, to provide better coordinated and more comprehensive care to those with serious mental illness, particularly in 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 system transformation and integration are to focus on the five principles outlined in the MHSA regulations:

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

To receive funding, Counties are required to develop three-year plans that are consistent with the requirements outlined in the Act. Counties are also obligated to collaborate with community stakeholders to develop plans that are consistent with the MHSA Principles. 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
- A network of supportive relationships
- Timely access to needed help, including in times of crisis
- Reduction in incarceration in jails and juvenile halls
- Reduction in involuntary services, including 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); (70.2%); $19.0M in FY 19-20
2. Prevention and Early Intervention (PEI); (20.7%); $5.6M in FY 19-20
3. Workforce Education and Training (WET); (0.6%); $157K in FY 19-20
4. Capital Facilities (Buildings) and Technological Needs (CF/TN); (0.5%); $125K in FY 19-20
5. Innovation; (8.1%); $2.2M in FY 19-20

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 has also been a separate stream of funds. The remaining Santa Barbara MHSA Housing funding is currently being used for the completion of the Residence at Depot Street project in Santa Maria projected to be open Fall 2019. However, the "No Place Like Home" initiative has established a new stream of funding for housing projects with a plan to be implemented in 2019 and upcoming years.

The FY 2019-20 MHSA Planning Process

Santa Barbara County Department of Behavioral Wellness engaged in community stakeholder forums throughout its MHSA planning. More than 700 individual stakeholders were invited to participate in seven (7) stakeholder meetings. The attendees included representatives from partner agencies, community organizations, advocates, Department staff, Commission members, as well as consumers, family members, and individuals from the community interested in learning more about the MHSA planning process.

The following stakeholder forums were convened:

Mental Health Services Act Stakeholder Forums Calendar

• **Santa Maria Adult Clinic**	• February 6, 2019
• **Helping Hands RLC of Lompoc**	• February 12, 2019
• **Mental Wellness Center- Fellowship Club RLC**	• February 13, 2019
• **Behavioral Health Commission- Timeline Setting**	• February 20, 2019
• **Behavioral Wellness- Client Family Member Advisory Committee Meeting**	• February 21, 2019
• **Behavioral Wellness- Peer Employee Forum**	• March 14, 2019
• **Behavioral Health Commission- Public Hearing Santa Barbara and Santa Maria Board of Supervisors Hearing Rooms**	• May 30, 2019

The 30-day review process has been conducted in partnership with the local Behavioral Wellness Commission. The draft FY 2019-2020 one year MHSA Plan update was emailed to nearly 700 stakeholders on April 23rd 2019 for a 30 day comment and posting period. At commencement of the posting period, the Behavioral Wellness Commission MHSA Public Hearing was held May 30th, 2019 from 3-5 pm at the Santa Maria and Santa Barbara Board of Supervisors Hearing Rooms. The update was made available by postal mail upon request.

In addition, the Plan update will be posted to the Department of Behavioral Wellness website: www.countyofsb.org/behavioral-wellness.

Santa Barbara County Demographics

Santa Barbara County has a mountainous interior abutting several coastal plains on the West and South coasts of the County. The largest concentration of the population is on the Southern coastal plain, referred to as the "South Coast" – meaning the part of the County South of the Santa Ynez Mountains. This region includes the cities of Santa Barbara, Goleta, and Carpinteria, as well as the unincorporated areas of Hope Ranch, Summerland, Mission Canyon, Montecito and Isla Vista. North of the mountains are the towns of Santa Ynez, Solvang, Buellton, and Lompoc; the unincorporated towns of Los Olivos and Ballard; the unincorporated areas of Mission Hills and Vandenberg Village; and Vandenberg Air Force Base, where the Santa Ynez River flows out to the sea. North of the Santa Ynez Valley are the cities of Santa Maria and Guadalupe, and the unincorporated towns of Orcutt, Los Alamos, Casmalia, Garey, and Sisquoc. In the extreme Northeastern portion of the County are the small cities of Cuyama, New Cuyama, and Ventucopa. As of January 1, 2006, Santa Maria became the largest city in Santa Barbara County.

(From Wikipedia, retrieved 7-19-16.)

Quick Facts Santa Barbara County United States Census Bureau

Population	
Population estimates, July 1, 2017 (V2017)	448,150
Population estimates, April 1, 2010 (V2017)	423,949
Population, percent change April 1, 2010 (estimates base) to July 1, 2017, (V2017)	6%
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	86%
❖ Hispanic or Latino percent 46%	
❖ White alone, not Hispanic or Latino, percent 44%	
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	0%
Two or More Races, percent	4%
Population Characteristics	
Veterans, 2012-2017	22,974
Foreign born persons, percent, 2013-2017	23%
Housing	
Housing units, July 1, 2017, (v2017)	157,039
Owner-occupied housing unit rate, 2013-2017	52%
Median value of owner-occupied housing units, 2013-2017	$509,400
Median selected monthly owner costs -with a mortgage, 2013-2017	$2,241
Median selected monthly owner costs -without a mortgage, 2013-2017	$580

Median gross rent, 2013-2017	$1,496
Building permits, 2017	1280
Families and Living Arrangements	
Households, 2013-2017	144,015
Persons per household, 2013-2017	3
Living in same house 1 year ago, percent of persons age 1 year+, 2013-2017	80%
Language other than English spoken at home, percent of persons age 5 years+, 2013-2017	40%
Computer and Internet Use	
Households with a computer, percent, 2013-2017	90%
Households with a broadband Internet subscription, percent, 2013-2017	82%
Education	
High school graduate or higher, percent of persons age 25 years+, 2013-2017	80%
Bachelor's degree or higher, percent of persons age 25 years+, 2013-2017	33%
Health	
With a disability, under age 65 years, percent, 2013-2017	6%
Persons without health insurance, under age 65 years, percent	10%
Economy	
In civilian labor force, total, percent of population age 16 years+, 2013-2017	64%
In civilian labor force, female, percent of population age 16 years+, 2013-2017	59%
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
Total manufacturers' shipments, 2012 ($1,000) (c)	4,157,565
Total merchant wholesalers sales, 2012 ($1,000) (c)	3,475,600
Total retail sales, 2012 ($1,000) (c)	4,853,808
Transportation	
Mean travel time to work (minutes), workers age16 years+, 2013-2017	19
Income and Poverty	
Median household income (in dollars), 2013-2017	$68,023
Per capita income in past 12 months (in 2017 dollars), 2013-2017	$32,872
Persons in poverty, percent	14%
Fact Notes	

These geographic level of poverty and health estimates are not comparable to other geographic levels of these estimates. Some estimates presented here come from sample data, and thus have sampling errors that may render some apparent differences between geographies statistically indistinguishable. The vintage year (e.g., V2018) refers to the final year of the series (2010 thru 2018).

Data Source: www.census.gov/quickfacts/fact/table/santabarbaracountycalifornia

Program Updates

Community Services and Supports (CSS)

Crisis Services

Crisis Services	
Provider:	Behavioral Wellness
Estimated Funding FY 2019/20:	
Estimated Total Mental Health Expenditures	$7,480,400
Estimated CSS Funding	$804,280
Estimated Medi-Cal FFP	$2,279,700
Estimated 1991 Realignment	$342,700
Estimated Behavioral Health Subaccount	$934,320
Estimated Other Funding	$3,119,400
Average Cost Per Consumer (3,973 Consumers)	$1,882

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

- 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.
- 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.
- 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.
- Assist current outpatient program clients when they are rapidly decompensating and are at risk of hospitalization. Crisis Services triage staff step in to provide very brief (up to 14 days) intensive treatment and case management for core outpatient clinic clients when needed to prevent hospitalization.
- 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.
- Provide hospital discharge services to individuals being discharged from the Psychiatric Health Facility (PHF), Crisis Stabilization Unit (CSU), Anka Behavioral Health (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 as above, conduct initial assessments to determine if clients meet medical necessity for Severe and

Persistent Mental Illness (SPMI) services and determine appropriate level of care in the system. In addition, 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 will allow a closer working relationship between the different programs and eventually a law enforcement "drop-off" location for individuals experiencing a mental health crisis is being pursued. Individuals are able to receive immediate evaluation to determine 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

The Crisis Triage Teams were previously funded by the Senate Bill 82 (SB 82) grants which ended in June 2018. The realignment of staff and redesign of the program was necessary when the grant sunsetted. The vacant Triage positions were eliminated through attrition and not backfilled resulting in no staffing cuts with Civil Service staff positions remaining. At the start of the current Fiscal Year, the program name was changed to Crisis Services. In Santa Barbara, Santa Maria, and Lompoc the Crisis Services programs include all of the previously existing Mobile and Triage Crisis Staff and are now called South County Crisis Services, North County Crisis Services and West County Crisis Services, respectively. Due to continued SB82 funding for Mobile Crisis services in Lompoc (see SB 82 section below), the existing Lompoc Mobile Crisis staff will not be merged into the West County crisis team until January 2020 but the Lompoc Triage program is now working together with the triage West County crisis team. In all three regions, greater cross training and integration of the mobile and triage programs has begun with less delineation between the roles of the staff in Mobile versus Triage. The original Mobile Crisis Services staffing in all three regions have remained the same. These staff have remained in their current offices under the supervision and management of the Crisis Team Supervisor and Crisis Manager. Hours of operation have not changed.

The Triage component provides a vital role in our Access levels of care, review and linkages with clients. Mobile Crisis covers all incoming crisis situations needing immediate care. The core outpatient clinics cover all incoming routine referrals (needing to be seen within 10 working days) and Triage duties fills the gap, covering all urgent referrals (needing to be seen within 24 hours). The current Crisis Services program has maintained these urgent functions while also assisting in other areas of care focused on outreach to community members with suspected Severe Persistent Mental Illness (SPMI) and reducing risks of decompensation of current Behavioral Wellness clients leading to hospitalization.

Program Performance (FY 17-18)

Crisis Services

Unique Clients Served									
	Mobile Crisis			Crisis Triage			SAFTY (child/youth)		
	North	South	West	North	South	West	North	South	OOC*
Age Group									
0-15	26	35	15	0	0	0	391	199	46
16-25	162	277	102	55	59	38	230	163	51
26-59	401	522	241	207	286	133	0	0	0
60+	72	115	51	21	52	14	0	0	0
Missing DOB	8	0	1	0	0	0	0	0	0
Total	***669***	***949***	***410***	***283***	***397***	***185***	***621***	***362***	***97***
Gender									
Female	364	449	209	154	188	107	354	218	47
Male	291	498	189	126	208	77	267	144	50
Unknown	14	2	12	3	1	1	0	0	0
Ethnicity									
White	289	523	220	116	207	103	181	91	21
Hispanic	251	198	114	125	115	54	285	136	51
African American	26	30	17	14	17	16	17	5	1
Asian/Pacific Islander	11	34	5	5	10	3	6	6	1
Native American	2	9	1	2	2	2	2	2	0
Other/Not Reported	90	53	155	21	46	7	130	122	23

**OOC = out of county*

**Combined Crisis Services teams initiated FY 18-19; data reflects prior design*

Client Outcomes

No Hospital Admission	North	South	West	Total
Mobile Crisis	75%	69%	79%	75%
Crisis Triage	75%	66%	82%	75%
SAFTY (child/youth)	93%			93%

A goal of the crisis service programs is to stabilize clients in the community with safety planning and other supportive services in order to avoid admitting clients to a psychiatric hospital. The table above shows the percent of clients who encountered each crisis service who also did not have any hospitalizations over the fiscal year. It does not display whether a hospitalization was avoided because of the encounter. Compared to last fiscal year, all three crisis programs saw fewer clients who were hospitalized: across all regions, mobile crisis improved from 68% to 75% of clients not hospitalized, crisis triage improved from 65% to 75% of clients not hospitalized, and SAFTY from 88% to 93% of clients not hospitalized.

New Heights (General System Development) – Behavioral Wellness, Community Action Commission and Department of Rehabilitation (DOR) [Augment to Full Service Partnership in FY 19-20]

New Heights FSP	
Provider:	Behavioral Wellness, Community Action Commission, Department of Rehabilitation
Estimated Funding FY 2019/20:	
Estimated Total Mental Health Expenditures	$1,573,100
Estimated CSS Funding	$79,600
Estimated Medi-Cal FFP	$1,393,500
Estimated 1991 Realignment	$0
Estimated Behavioral Health Subaccount	$100,000
Estimated Other Funding	$0
Average Cost Per Consumer (215 Consumers)	$7,317

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

In FY 18-19, the team focused on both staff training and program implementation targeted towards this group. On October 17th and 18th 2018, the Behavioral Wellness hosted a two-day TIP regional training for our TAY Programs provided by STARS Behavioral Health. Behavioral Wellness also provided a Strengthening Families Program (SFP) two-day training to staff employed at the Santa Barbara Children's Outpatient Clinics. The focus of the SFP includes providing clients and parents with communication skills, coping strategies, psycho education on substance use prevention and parenting skills. The goal is to oversee activities where families can learn and practice interpersonal skills, promote cooperation, create emotional connections, and immerse themselves in content about positive social engagement and goal-setting. The SFP was implemented at the Children's Clinic in January 2019. Additionally, the Children's Clinic created a TAY Orientation Group that promotes engagement and timely access to care for our consumers.

Program Challenges and Solutions

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 due to the lack of short-term housing resources for this group. Behavioral Wellness has continued to develop partnerships with the State Department of Rehabilitation (DOR) and Work Force Development Board to address these issues. In Fall of 2017, DOR and the Department collaborated to implement employment services in each region and will be evaluating the effectiveness of this model in the upcoming year and foresee a continued partnership.

Behavioral Wellness will continue to work with stakeholders to develop additional resources for TAY consumers, including a possible teen drop-in center similar to the Headspace model in Australia. The higher mental health needs for TAY have not currently been met within the New Heights program causing consumers to be transitioned to the adult ACT teams where they drop out or do not engage. Due to this, there is a need to develop a TAY Full Service Partnership (FSP) level of care to meet the needs of this age group within the Children's system of care. This next year we are adding caseworkers to each of our TAY New Height's programs and expanding them to make them all Full Service Partnerships, additionally we are adding TAY peers to help with leadership training, scheduling and planning specific TAY recreational activities. This was recommended by the Department as part of the 2017-2020 Three-Year Plan. Initial steps to implement this anticipated to begin July 2019 in partnership with Community Action Commission (CAC) and other Behavioral Wellness as vocational support services and employment coordination are strategized and being developed Spring 2019. Overall, New Heights will begin operating as a Full Service Partnership the upcoming year.

Program Performance (FY 17-18)

New Heights-Transitional Age Youth

Unique Clients Served			
	North	**South**	**West**
Age Group			
0-15	3	0	9
16-25	67	39	88
26-59	6	3	0
60+	0	0	0
Missing DOB	0	0	0
Total	***76***	***42***	***97***
Gender			
Female	39	21	57
Male	36	21	40
Unknown	1	0	0
Ethnicity			
White	27	13	33
Hispanic	44	21	50
African American	1	1	6
Asian/Pacific Islander	1	2	2
Native American	1	0	1
Other/Not Reported	2	4	6

Client Outcomes – New Heights

Child & Adolescent Needs & Strengths Assessment (CANS) Age: 6-17 years	Percent Improvement*	
	Initial to 6 months (n=6)	6 to 12 months (n=4)
Life Functioning (e.g., ability to communicate and interact with families, communication, social functioning and health status)	16%	-18%
Behavioral/Emotional Needs (e.g., symptoms of depression, anxiety, psychosis and other conditions)	17%	32%
Child Risk Behaviors (e.g., self-injury, suicidal behavior, bullying, and running away)	56%	14%
School (e.g., behavior, attendance and grades)	20%	77%
Caregiver Needs & Strengths (e.g., child supervision skills, family stress levels, residential stability, and caregiver physical/mental health status)	-8%	-2%
Child Strengths (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment)	4%	6%
Milestones of Recovery Scale (MORS) Age: 18+		
	Initial to 6 months (n=125)	6 to 12 months (n=103)
Showed Improvement^	49%	27%
Remained Stable^	42%	47%

Higher Levels of Care	% with any admissions over FY 17/18		
	North	South	West
Incarcerations/Juvenile Hall	--	--	--
Psychiatric Inpatient Care	5%	19%	6%

**"Percent improvement" for CANS scores reflects the % change between the group's mean scores.*
^"Showed Improvement" and "Remained Stable" reflects the percent of clients whose MORS scores improved or stayed the same between time periods.

In the 2017-2018 fiscal year, clients in the New Heights program had initial, 6-month and 12-month CANS and MORS data. Percent improvement in the CANS varied across time periods from -18% to 77%. The large variability in these numbers is due to the low number of clients who were eligible for a CANS. Despite these small numbers, the overall trends suggest that clients made gains in improved behavioral/emotional functioning, risk-taking behaviors, and school. The data also suggest that caregiver needs and strengths did not improve, while child strengths did see improvement. On the MORS, in the first six months of engagement half of clients improved, and in the second six months, over a quarter of clients improved. Further, over 40% of clients were stable over the year, suggesting that even when not improving, a large portion of New Heights clients were stabilized.

It is important to note that data examining higher levels of care reflect any inpatient psychiatric care throughout the year, regardless of when in the year the client participated in the program. Thus, an inpatient stay that led to a subsequent Program entry would still count as a hospitalization. Further, incarceration/juvenile hall data were unavailable this year and we are unable to report on these metrics. Clients in North and West County had similar levels of hospitalizations (5% and 6%, respectively), while South County clients were more likely to be hospitalized over the year (19%).

Partners In Hope

Partners In Hope	
Provider:	Mental Wellness Center, Transitions Mental Health Association and Behavioral Wellness
Estimated Funding FY 2019/20:	
Estimated Total Mental Health Expenditures	$901,800
Estimated CSS Funding	$901,800
Estimated Medi-Cal FFP	$0
Estimated 1991 Realignment	$0
Estimated Behavioral Health Subaccount	$0
Estimated Other Funding	$0
Average Cost Per Consumer (1,274 Consumers)	$708

Partners in Hope is a peer-run Program that provides peer support services to consumers and family members. The Program supports Peer Recovery Specialists and Recovery Learning Communities (RLCs) in the South, West and North County. Added for one year is Growing Grounds Farm in Santa Maria coordinated by Transitions Mental Health Association.

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. There are currently three RLCs throughout the County, each located at pre-existing housing developments that include MHSA-funded units, including Garden Street Apartments in Santa Barbara, Home Base on G in Lompoc, and Rancho Hermosa in Santa Maria.

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

Partners in Hope also includes a Family Advocate in each region of the County. Family Advocates provide support to family members throughout the County. The Family Peer Program is operated by two community-based organizations (CBOs): Mental Wellness Center (MWC) and Transitions Mental Health Association. At this time, both providers offer bilingual services to family members. In addition, recovery assistants offer peer services in the clinical teams for Behavioral Wellness as County staff. In prior years, most of these staff were included in the Partners In Hope budget, but salary costs have been transitioned to the clinical teams as they are integrated.

Santa Barbara Services

In the past three years at the Mental Wellness Center's RLC, staffing has converted to all peer providers. This includes the program staff (Manager plus three specialists), a kitchen crew of three that provides seventy lunches daily, and computer laboratory and art room facilitators. An effort has been made to ensure that the staff reflects the ethnic distribution of the RLC members. In addition, the Santa Barbara RLC has developed multiple supported employment positions, especially around a Vintage Clothing Care Closet that has many

benefits, including retail and stocking positions for RLC members to learn and practice employment skills that are in high demand in the community. The Closet provides gently used clothing and hygiene items, which are particularly useful for consumers who are homeless.

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

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 monthly at community events to increase awareness of mental health and available resources. At the Santa Barbara site, three to four support groups for family members are scheduled regularly each week in the evenings. In addition, the NAMI Family to Family course is taught 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.

Lompoc and Santa Maria Services

Transitions Mental Health Association (TMHA) has 100% staff in Santa Barbara County that are family members of individuals with mental health experience or have lived mental health experience. Additional strategies to increase access for peers have included part-time employment opportunities for consumers and family members in most Community Based Organizations.

TMHA has developed grant-funded programs to specifically engage the RLC membership and cultivate leadership and employment potential. TMHA Career Opportunities in Recovery for Preventive Services (CORPS), funded by the California Wellness Foundation, aims to outreach, enroll, train, and help place people with lived mental health experience and family members into the behavioral health workforce. Lived Experience Advocacy Development (LEAD), funded by the McCune Foundation, and providers outreach to members of both the Lompoc and Santa Maria RLCs and recruits and trains individuals with lived experience of mental illness to develop an advocacy platform and presentation. The goal is to develop a new generation of community leaders, a group that is deeply invested in the cause of mental health advocacy and can accurately and empathetically represent its peers in the process. Additionally, both the Lompoc and Santa Maria RLCs receive Community Development Business Grant funding from the cities in order to provide more food and outreach to members in the Latino community, respectively. Growing Grounds Farm requested funding for continued peer support funding, which was supported for Transitions for 2019-2020 with a contract amendment from their current funded programs.

Program Challenges and Solutions

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

The increase in staff positions has provided additional opportunities for people with lived experience, and a number of peer staff have been hired in Civil Service positions. Additional strategies to increase access for peers have included part-time employment opportunities for consumers and family members using a Peer Expert Pool funded through Workforce Education and Training (WET) and/or Community Service Supports (CSS). At the Santa Barbara RLC site, consumers are encouraged to develop skills in house and transfer them into the community. This process involves selecting work that the consumers are comfortable with performing and which doesn't interfere with their government benefits and other supports. Again, peer support is proving valuable in navigating employment pathways. Partners in Hope peer services provided by County staff were fully integrated into their respective outpatient clinical team in FY 17-18 and peer navigators began integrating in this Fiscal Year.

The most significant challenge faced by peer staff has been the lack of a well-defined career ladder. Professional standards have not been established with any degree of uniformity, although this is changing. Mental Health America has come up with a peer specialist credential program that may serve as a model for other programs. Establishing professional standards will help define the steps of a career ladder. In addition, there is also a lack of mentors: there are few people with a lot of experience as peer providers that can closely help those entering the field. This, too, will change as the staff at the three sites gain more experience over time. Sharing their experience will be valuable to new staff. During FYs 2018-2020, the Department is encouraging peer staff to attend advanced peer certification trainings, such as a series called "Advanced Peer Specialist" provided by Share and funded by the Office of Statewide Health Planning and Development (OSHPD). Staff and many stakeholders are also following and supporting legislative proposals to create and reimburse California Behavioral Health departments for peer support activities which would enhance these roles statewide. This statewide legislation was not supported in FY 17-18, but has been moving forward in Sacramento in FY 18-19.

During FY 18-19 MHSA Stakeholder Process, many stakeholders concerned about TMHA contract due to growing operating costs. Behavioral Wellness partnered to increase the contract to sustain the staffing with a contract budget increase. In FY 19-20, the Department is working on augmenting and supporting Growing Grounds Farm as an additional location for Partners in Hope services to MHSA clients.

The Family Advocate at the Santa Barbara site is facing decreased challenges in terms of stigma and lack of knowledge about mental health. This is indicated by the increasing number of visits by care-giving family members, and the additional awareness-building events and opportunities that have been made available recently within the community. Still, these challenges do exist and continue to be a barrier to achieving better mental health for people who live here. Growing parent partner capacity to assist families in the Department is desired and a recent grant award for Children's Triage included the addition of a Peer Parent Partner position.

There is a lack of consistent collaboration between the Department's Outpatient Clinics and Community Based Organization treatment providers working within the RLCs. Consumers continue to report that they do not wish to be "forever clients" of the system and would like to step down to RLC level of care, but still have access to

some clinical services. Consumers have reported in stakeholder meetings their desire to see psychiatric services and low end counseling at the RLCs. As a result of a supported proposal included in the 2017-2020 Three Year Plan, the planning for this pilot program began in Lompoc in mid-2018 in collaboration with TMHA and was launched in February 2019. There is an intent to make it county-wide by the end of 2019 with other community partners. Initial response from Lompoc is positive and requests for additions throughout County has been consistent.

In addition, our Technology Suite Collaborative Innovation Plan which was approved by the Mental Health Services Oversight and Accountability Commission in September 2018 will employ peers and use mobile and computer applications to improve access and linkage with the individuals in the community. More about this Plan is described in the Innovations section of this document.

Program Performance (FY 17-18)

Partners in Hope

	Activities					
	North		South		West	
	RLC	Family Advocate	RLC	Family Advocate	RLC	Family Advocate
Unduplicated clients	287	297	308	185	159	38
Client visits	3,414	1,694	14,760	1,600	5,329	260
Outreach Events	*	18	*	*	*	7
Outreach Event Attendees	*	1,945	*	*	*	*
Support groups	400	47 English 48 Spanish	138	110	626	27
Classes	44	0	28	0	44	0
Outings, Educational Events	52	12	14	10	20	0
Trainings about consumer and family member issues	0	0	8	2	0	0
Unique clients provided services in Spanish	30	178	4	12	3	0
Underserved population	287	297	308	185	159	38
Linked to additional services	0	251	229	95	0	21

* = not reported or not recorded.

In North County, the RLC served almost 300 clients from underserved populations who had over 3,400 visits. They conducted 400 support groups and held 44 classes and 52 outings/events. Thirty clients were provided services in Spanish. The Family Advocate in North County served almost 300 unique clients from underserved populations, provided almost 1,700 client visits, led 95 support groups (half in Spanish), and attended 18 outreach events that reached almost 2,000 attendees, attended 12 outings/events, and linked 251 clients to

additional services. Almost two hundred of the clients served (60% of all clients served) were provided services in Spanish.

In South County, the RLC served over 300 clients from underserved populations who had almost 15,000 visits. They conducted 138 support groups and held 28 classes and 14 outings/events. Four clients were provided services in Spanish, and over two hundred linkages were made to additional services. Eight trainings about consumer and family member issues occurred. The Family Advocate in South County served almost 200 unique clients from underserved populations, provided 1,600 client visits, led 110 support groups, attended 10 outings/events, and linked 95 clients to additional services. Twelve clients were provided services in Spanish. Furthermore, two trainings about consumer and family member issues occurred.

In West County, the RLC served over 150 clients from underserved populations who had over 5,000 visits. They conducted 626 support groups and held 44 classes and 20 outings/events. Three clients were provided services in Spanish. The Family Advocate in West County served 38 unique clients from underserved populations, provided 260 client visits, led 27 support groups, attended seven outreach events, and linked 21 clients to additional services.

Homeless Outreach Services – Behavioral Wellness, Good Samaritan, United Way

Homeless Outreach Services	
Provider:	Behavioral Wellness, Good Samaritan, and United Way
Estimated Funding FY 2019/20:	
Estimated Total Mental Health Expenditures	$916,100
Estimated CSS Funding	$178,800
Estimated Medi-Cal FFP	$679,200
Estimated 1991 Realignment	$0
Estimated Behavioral Health Subaccount	$0
Estimated Other Funding	$58,100
Average Cost Per Consumer (182 Consumers)	$5,033

The Department of Behavioral Wellness Homeless Services program provides outreach and engagement to those experiencing homelessness, or at imminent risk of homelessness, and serious persistent mental illness and/or chronic substance abuse in South Santa Barbara County. The needs of chronically homeless individuals, whom are hard to engage, are usually complex, which 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 or 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. Homeless Services works with the local Continuum of Care (CoC), the Housing Authorities of the City and County of Santa Barbara, the United Way North's Home for Good, local emergency and transitional shelters, and other agencies serving those experiencing homelessness or at risk of homelessness in our community.

Meeting the needs of people experiencing both homelessness and behavioral health challenges is an important priority for the Department of Behavioral Wellness. Recently, Behavioral Wellness augmented this initiative by securing additional funding to expand Homeless Outreach Services into both the North and West regions of the County. This will be accomplished through the utilization of one time Homeless and Mentally Ill Outreach and Treatment (HMIOT) monies, awarded by the Department of Health Care Services (DHCS) beginning January 1, 2019 for eighteen months. 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. The funding will allow for the hiring of (2) full time civil service practitioners, (1) full time civil service case worker, and (1) extra help part time administrative office professional. The continued expansion of Homeless Services, in all three regions of the County, will only continue to enhance 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. The newly constructed teams will adopt engagement strategies that meet the specific need of homeless populations in each region.

In addition to the newly secured HMIOT funding, the Department was awarded a cash donation on behalf of the Gordon Family Trust. Behavioral Wellness plans to use the donation and grant funds to purchase at least one mobile vehicle for homeless outreach and service delivery. The mobile vehicle will be retrofitted with technology and potentially have the ability to accommodate medical personnel for the treatment of clients in the field. The medical staff will provide ongoing medical assistance and connect clients to available shelters as necessary. This mobile outreach team will be able to reach homeless and difficult to engage clients in locations around the County. These services will be an extension of those currently provided by Homeless Outreach and Crisis teams. The mobile vehicle will contain a commemoration plaque to the Gordon Trust in recognition of this generous donation.

Successful outreach often involves a high degree of interagency collaboration and multi-disciplinary team outreach. Behavioral Wellness Homeless Services continues to strive towards maintaining a high degree of collaboration with other Santa Barbara County CoC providers and recently established and is responsible for facilitating a weekly South County Coordinated Outreach Team meeting, providing CoC service providers with an opportunity to discuss sub-regional outreach coverage, engagement strategies, outreach collaboration, and service coordination. We hope to replicate this in other sub-regions of the County, in conjunction with program expansion into these regions.

Additionally, of significance to these efforts is the ongoing partnership Behavioral Wellness has with the United Way North, which acts as the lead agency for Santa Barbara County's Coordinated Entry System. The CES represents a CoC-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. Coordinated entry is the community process by which the Santa Maria/Santa Barbara County CoC supports the development of a comprehensive and efficient crisis response system that improves ease of access to resources in the CoC's geographic area. Homeless Services regularly attends the bi-monthly CES case conference to ensure that there is access to staff who can appropriately respond to people experiencing homelessness and assist with connection to the mental health system of care.

The United Way North provides 4 FTE AmeriCorps members to serve with Behavioral Wellness. The resulting expansion of these services, through the inclusion of the AmeriCorps members, has also 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, and has enabled the mental health system to more efficiently connect those experiencing homelessness to Santa Barbara County's Continuum of Care (CoC) and thereby their enrollment in the County's Coordinated Entry System (CES).

The Program expansions are consistent with the principles of MHSA, including a recovery and resiliency focus, creating a greater continuity of care and cultural competence. The Homeless Services program is providing extensive outreach and engagement services. Teams have also adopted strategies that meet the specific needs of homeless populations in each region. Teams also provide housing retention support and assistance, employment and education support, rehabilitation services and other necessary supports for individuals experiencing homelessness or at imminent risk of homelessness. 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 increasingly 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 will be needed to serve the recently housed, chronically homeless clients, whom are Severe Persistent Mentally Ill. This is essential to promote a more stable transition into permanent housing, to prevent recidivism, and to connect clients with mainstream supports.

The Department of Behavioral Wellness is actively working with Santa Barbara County's Coordinated Entry System to develop a protocol for sharing client data electronically, which will enhance the ability of the system to identify and count homeless youth with serious emotional disturbances. Although Behavioral Wellness serves many youth who have serious emotional disturbances, as well as many homeless youth, youth are tracked based on mental health, rather than based on their housing status, and so the number of youth who are both homeless and experiencing a serious emotional disturbance is not currently being tracked in a reportable fashion.

Enhancing information technology for adequate data housing resources are essential. Behavioral Wellness partnered are with the County Housing and Community Development in updating the Countywide Homeless Housing Plan. The first phase posted for public review completed March 2019 and anticipate Phase II with more stakeholder feedback in FY 19-20.

Program Performance (FY 17-18)

Homeless Services

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	0	0	0
16-25	10	1	12
26-59	45	42	58
60+	1	12	1
Missing DOB	0	0	0
Total	***56***	***55***	***71***
Gender			
Female	44	17	53
Male	12	38	18
Unknown	0	0	0
Ethnicity			
White	21	35	28
Hispanic	32	12	40
African American	0	4	3
Asian/Pacific Islander	0	0	0
Native American	3	1	0
Other/Not Reported	0	3	0

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	
	South
Age Group	
0-15	0
18-23	1
24-30	8
31-40	20
41-50	26
51-61	28
62+	23
Missing DOB	0
Total enrolled in PATH	***106***
Total entered program in FY 17-18	***252***
Total contacted by PATH in FY 17-18	***268***
Gender	
Female	37
Male	64
Unknown	5
Total	***106***
Race	
White	139
African American	5
Asian/Pacific Islander	3
Native American	1
Multiracial	11
Other/Not Reported	93
Total	***252***
Ethnicity	
Hispanic	22
Non-Hispanic	230
Total	***252***
Veteran	
Yes	8
No	244
Total	***252***
Special Needs	
Mental Illness	125
Alcohol Abuse	81
Drug Abuse	67
HIV/AIDS or related disease	1
Developmental Disability	19
Physical Disability	82
Domestic Violence	0
Other	151
Disabled	140

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 = 79)	6 to 12 months (n = 36)
Showed improvement^		56%	19%
Remained stable^		25%	42%
Living Situation		**Entry (n = 252)**	**Exit (n = 268)**
Place not meant for habitation		128	124
Emergency Shelter		17	18
Transitional Housing for Homeless		7	22
Institution (e.g. Jail, hospital, psych facility, AOD treatment)		5	5
Hotel or with family/friends		1	2
Permanent		1	17
Other		93	14
Unknown		0	66
Higher Levels of Care	**% with any admissions over FY 17/18**		
	North	**South**	**West**
Incarcerations	--	--	--
Psychiatric Inpatient Care	1%	5%	2%

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

Because the South County Homeless Services is an outreach program, they have many contacts with clients that are not captured in Clinician's Gateway. North and West County Homeless Services program provides mental health services for clients in shelter beds, not outreach services, so their contacts are captured in the table pulled from Clinician's Gateway. Therefore, an "all contacts" table, taken from the Homeless Management Information System (HMIS), is also provided for South County's Homeless Services to more accurately reflect program activities.

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

(1) A contact with the program that results in entry into HMIS, but not enrollment into PATH (n = 162 clients contacted in FY 17/18; n = 157 new clients opened in FY 17/18);

(2) A contact with the program that results in entry into HMIS, and consent to enroll in PATH (n = 106 clients contacted in FY 17/18; n = 95 new clients opened in FY 17/18); and

(3) A contact with the program that results in entry into HMIS, and enrollment in mental health services through Behavioral Wellness (n = 55).

In the 2017-2018 fiscal year, clients in South County Homeless Outreach Services had initial, 6-month and 12-month MORS data. In the first six months of engagement, over half of clients improved, and in the second six

months, 19% of clients improved. Examined another way, in the first six months, over 80% of clients were either stable or improving, and in the second six months, over 60% were either stable or improving.

Examining housing status at Program entry and exit, it is important to note that many of the clients included in this count had only one contact with Behavioral Wellness and were not seen again. One hundred sixty-two individuals seen in FY 17/18 did not consent to participate in PATH, while 106 participated. While many of the total number of clients remained homeless at Program exit, 15 more clients attained transitional housing and 16 more clients attained permanent housing.

It is important to note that data examining higher levels of care reflect any inpatient psychiatric care throughout the year, regardless of when in the year the client participated in the Program. Thus, an inpatient stay that led to a subsequent program entry would still count as a hospitalization. Further, incarceration/juvenile hall data were unavailable this year and we are unable to report on these metrics. Clients in North and West County had similar levels of hospitalizations (1% and 2%, respectively), while South County clients were more likely to be hospitalized over the year (5%).

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

Co-Occurring Mental Health and Substance Use Outpatient Teams	
Provider:	Behavioral Wellness
Estimated Funding FY 2019/20:	
Estimated Total Mental Health Expenditures	$2,866,100
Estimated CSS Funding	$1,002,300
Estimated Medi-Cal FFP	$972,400
Estimated 1991 Realignment	$936,400
Estimated Behavioral Health Subaccount	$0
Estimated Other Funding	$0
Average Cost Per Consumer (406 Consumers)	$7,059

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

All staff in the Adult Clinics have received training in selected evidence-based practices to ensure that they are co-occurring informed and competent. Evidence- based practices include Motivational Interviewing, Seeking Safety, and Cognitive Behavioral Therapy (CBT). Staff working on Co-Occurring Team utilizes a wide variety of treatment modalities in their treatment including weekly groups based on "Living in Balance," for group facilitation, and 1:1 SUD coaching and counseling; Medication Assisted Treatment and linkage to medical or social detox facilities and sober living homes; and local Alcoholics Anonymous or Narcotics Anonymous

groups. All of the Department's psychiatrists have been trained and are able to provide Medication Assisted Treatment.

Program Challenges and Solutions

There is a lack of a comprehensive system of care for people in recovery in the community that results in consumers being displaced into jails, hospitals, Emergency Rooms, the inpatient Psychiatric Health Facility, and other types of inpatient containment. As a solution, the Department continues to collaborate with community agencies in an attempt to bridge gaps in community system of care resources. Rehabilitative SUD treatments that are available locally are primarily for women, and there are not enough resources for men. However, the development of expanded Drug-MediCal services through the Organized Delivery System (ODS) was implemented on December 1, 2018. The ODS expanded Substance Use Disorder referrals for co-occurring consumers throughout the countywide healthcare system. In addition, the Behavioral Wellness will be piloting a new level of care tool in the upcoming year to strategize how to best serve individuals based on need rather than distinct teams for certain types of care. This may impact the team structure and is included as a three year plan proposal under review.

Program Performance (FY 17-18)

Behavioral Wellness: Adult Co-Occurring Teams

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	0	0	0
16-25	8	2	5
26-59	107	154	95
60+	5	20	10
Missing DOB	0	0	0
Total	***120***	***176***	***110***
Gender			
Female	58	65	71
Male	62	111	39
Unknown	0	0	0
Ethnicity			
White	62	103	64
Hispanic	51	48	29
African American	4	10	9
Asian/Pacific Islander	1	3	2
Native American	0	3	3
Other/Not Reported	2	3	9

Client Outcomes

Milestones of Recovery Scale (MORS) Age: 18+			
		Initial to 6 months (n=339)	6 to 12 months (n=265)
Showed improvement^		30%	24%
Remained stable^		45%	51%
Higher Levels of Care	% with any admissions over FY 17/18		
	North	South	West
Incarcerations	--	--	--
Psychiatric Inpatient Care	13%	5%	6%

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

In the 2017-2018 fiscal year, clients in the Adult Co-Occurring Teams had initial, 6-month and 12-month MORS data. In the first six months of engagement, a third of clients improved, while almost half remained stable, and in the second six months, a quarter of clients improved and half remained stable.

It is important to note that data examining higher levels of care reflect any inpatient psychiatric care throughout the year, regardless of when in the year the client participated in the program. Thus, an inpatient stay that led to a subsequent program entry would still count as a hospitalization. Further, incarceration/juvenile hall data were unavailable this year and we are unable to report on these metrics. Clients in South and West County had similar levels of hospitalizations (5% and 6%, respectively), while North County clients were more likely to be hospitalized over the year (13%).

Children Wellness, Recovery and Resiliency (WRR) Teams

Children Wellness, Recovery and Resiliency (WRR) Teams	
Provider:	Behavioral Wellness
Estimated Funding FY 2019/20:	
Estimated Total Mental Health Expenditures	$5,744,800
Estimated CSS Funding	$30,900
Estimated Medi-Cal FFP	$2,858,000
Estimated 1991 Realignment	$0
Estimated Behavioral Health Subaccount	$2,746,200
Estimated Other Funding	$171,500
Average Cost Per Consumer (1061 Consumers)	$5,414

The Wellness, Recovery and Resiliency (WRR) program for children is designed to serve consumers who have a higher level of function but still meet criteria for specialty mental health services, who may have graduation potential, or need to step down to other lower level of care and need support to connect to outside resources. Services provided to consumers include:

- Focus on Prevention (3-4-50 Health Program) and healthy behaviors
- Skill building & retaining skills
- Vocational Rehabilitation services
- Empowerment and Self Reliance Skills
- Case Management
- Individual/family therapy
- Initial Assessments for Katie-A children/youth

Services in WRR are provided based on a model of Team-Based Care (TBC). TBC is a multi-disciplinary approach in which all clinic/program members share joint responsibility in providing services, supports and treatment to consumers. Each treatment team carries together an assigned caseload of consumers, and each team member – based on his/her role, expertise and scope of practice – contributes towards a consumer's success, recovery and goal achievement. Consumers therefore are receiving services that are coordinated and integrated while still individualized.

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

A specialized service provided within the WRR program is the "Katie-A" Services that focus on intake and assessment of all children referred by Social Services. Those children that are lower end either remain in the WRR team or the Pathways to Wellbeing Program, and those Katie-A children that require a higher level of care are connected to higher end services such as Spirit, intensive in home, or Wrap-163. The services are provided in collaboration with the Department of Social Services. As indicated in the Core Practice Model, the Katie-A services strives to work within a team environment, with the Department of Social Services, to build a culturally relevant and trauma informed system of support and services that is responsive to the strengths and underlying needs of families. The Katie- A services include Intensive Care Coordination, Intensive Home Based Services when a client is requiring a higher level of care, and provides Child and Family Team (CFT) meetings in conjunction with all other core clinic support services for all Katie-A clients. For Katie- A and probation children that are shared with Behavioral Wellness, the Interagency Placement Committee (IPC) was implemented in October 2018. This Committee focuses on streamlining and tracking all children in placement or at risk of placement. This IPC committee is in partnership with the Department of Social Services, Probation, schools, and the Regional Center. The goal is to further implement the Continuum of Care Reform (CCR) for children. Treatment Team members can include any or all of the following: Mental Health Practitioners, Case Worker, Psychiatric Technicians, Registered Nurses, and Psychiatrists.

Program Challenges & Solutions

A significant challenge is many children are being returned to counties with the closure of many group homes. Including some group homes closing in our county that has let to not having the continuum of care for higher

needs children/youth. As a result there has been an increase of children/youth being hospitalized out of county. A specific challenge within our service programs was not having developed designated Access staff in the Children System of Care in the MHSA plan. Not having assigned Access staffing takes away from ongoing consumer care from staff who rotate these duties. As a result, in FY 19-20 Behavioral Wellness will be designating Access and Assessment roles in the Prevention Early Intervention Programming who will support this function at the clinics. Another new element to assist is the newly established Katie A Practitioner staff developed in partnership, with the Department of Social Services. These designated staff will provide all access and assessment services for initial referral. In FY 19-20, Behavioral Wellness will be pursuing interested community partners whom would like 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, CWS, Probation, and Community Based Organizations to improve care. Additionally, Community Action Commission services which may have been connected to these programs will be augmented to support the new full service partnership for New Heights TAY. In addition, children's crisis residential unit(s) could be added with MHSA funds to ensure necessary levels of care continuum in-county.

Program Performance (FY 17-18)

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

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	345	197	189
16-25	122	149	59
26-59	0	0	0
60+	0	0	0
Missing DOB	0	0	0
Total	***467***	***346***	***248***
Gender			
Female	242	173	144
Male	225	172	104
Unknown	0	1	0
Ethnicity			
White	106	76	55
Hispanic	330	230	167
African American	17	7	12
Asian/Pacific Islander	1	2	2
Native American	1	1	1
Other/Not Reported	12	30	11

Client Outcomes

Child & Adolescent Needs & Strengths Assessment (CANS) Age: 6-17 years	Percent Improvement*	
	Initial to 6 months (n=183)	**6 to 12 months (n=122)**
Life Functioning (e.g., ability to communicate and interact with families, communication, social functioning and health status)	30%	12%
Behavioral/Emotional Needs (e.g., symptoms of depression, anxiety, psychosis and other conditions)	20%	2%
Child Risk Behaviors (e.g., self-injury, suicidal behavior, bullying, and running away)	28%	-2%
School (e.g., behavior, attendance and grades)	18%	7%
Caregiver Needs & Strengths (e.g., child supervision skills, family stress levels, residential stability, and caregiver physical/mental health status)	-3%	-5%
Child Strengths (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment)	12%	1%

Higher Levels of Care	% with any admissions over FY 17/18		
	North	**South**	**West**
Incarcerations/Juvenile Hall	**--**	--	--
Psychiatric Inpatient Care	2%	7%	2%

**"Percent improvement" for CANS scores reflects the % change between the group's mean scores.*

In the 2017-2018 fiscal year, clients in the Children's Wellness, Recovery, and Resiliency Teams had initial, 6-month and 12-month CANS data. Overall, clients made more gains in the first six months of program than in the second, but remained stable and exhibited small gains in the second six months. The only exception to this was caregiver needs and strengths, where caregivers' averages CANS scores declined slightly across both time periods. The largest gains were made in life functioning, where clients' scores improved by 30% in the first six months and 12% in the second six months of program.

It is important to note that data examining higher levels of care reflect any inpatient psychiatric care throughout the year, regardless of when in the year the client participated in the program. Thus, an inpatient stay that led to a subsequent program entry would still count as a hospitalization. Further, incarceration/juvenile hall data were unavailable this year and we are unable to report on these metrics. Clients in North and West County had similar levels of hospitalizations (2% for both), while South County clients were more likely to be hospitalized over the year (7%).

Adult Wellness and Recovery (WR) Teams - Behavioral Wellness

Adult Wellness and Recovery (WR) Teams	
Provider:	Behavioral Wellness
Estimated Funding FY 2019/20:	
Estimated Total Mental Health Expenditures	$4,825,600
Estimated CSS Funding	$2,799,500
Estimated Medi-Cal FFP	$2,026,100
Estimated 1991 Realignment	$0
Estimated Behavioral Health Subaccount	$0
Estimated Other Funding	$0
Average Cost Per Consumer (786 Consumers)	$6,139

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

Program Challenges and Solutions

The WRR program was initially designed to serve consumers who are higher functioning and will be appropriate for step-down to a lower level of care. In practice, a different reality emerged due to a variety of factors: the lack of step-down options available in the community, especially for Psychiatry, remains non-existent or very limited in all regions especially if the consumer has Medicare or Medicare/Medi-Cal insurance. Consumers who likely can step down remain at the clinic receiving services due to the lack of other treatment options. The result of this barrier is that the WRR teams are comprised of consumers with a wide variety of diagnoses and treatment needs that stretches staff resources and impacts good consumer care. Implementation of a complex capable level of care approach as a proposal in this Three Year Plan may assist in serving individuals more appropriately based on need; refer to “Update to New Proposals for this Three-Year Plan” included in this document for status.

Program Performance (FY 17-18)

Behavioral Wellness: Adult Wellness, Recovery & Resilience Teams

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	0	0	0
16-25	10	9	16
26-59	183	239	194
60+	19	79	37
Missing DOB	0	0	0
Total	***212***	***327***	***247***
Gender			
Female	112	177	149
Male	100	150	98
Unknown	0	0	0
Ethnicity			
White	90	179	121
Hispanic	99	102	85
African American	9	17	22
Asian/Pacific Islander	9	17	8
Native American	1	2	5
Other/Not Reported	4	10	6

Client Outcomes

Milestones of Recovery Scale (MORS) Age: 18+		
	Initial to 6 months (n=691)	**6 to 12 months (n=559)**
Showed improvement^	27%	21%
Remained stable^	51%	56%

Higher Levels of Care	**% with any admissions over FY 17/18**		
	North	**South**	**West**
Incarcerations	--	--	--
Psychiatric Inpatient Care	6%	8%	3%

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

Pathways to Well Being (Formerly "HOPE" Program- CALM, Family Service Agency)

Pathways to Wellbeing	
Provider:	CALM, Family Service Agency
Estimated Funding FY 2019/20:	
Estimated Total Mental Health Expenditures	$730,600
Estimated CSS Funding	$35,300
Estimated Medi-Cal FFP	$695,300
Estimated 1991 Realignment	$0
Estimated Behavioral Health Subaccount	$522,500
Estimated Other Funding	$0
Average Cost Per Consumer (124 Consumers)	$5,891

The HOPE Program was renamed this past year as the Pathways to Well Being Program. This program provides comprehensive assessments to foster youth (Katie-A) and specialty mental health treatment when determined to meet CLASS (mild-to-moderate) criteria. The goals are to maintain the stability of children in their homes and placements thereby reducing the necessity of multiple placements in order to provide trauma-informed care to the children and their caregivers. Previously, mild/moderate Katie-A children were being linked to the Holman Group or private providers making it difficult to track services and difficult to monitor at risk Katie-A children that would need to be re-referred. Now all Katie-A children are referred by Social Services through the Behavioral Wellness new Katie A Practitioner staff at the clinics, then the referral will be triaged and linked to Pathways to Well Being if the children are mild to moderate need.

The CALM Pathways to Well Being program covers the Santa Barbara and Lompoc regions. Family Services Agency is the provider for the Pathways to Well Being services in the Santa Maria region (North County). The Pathways to Well Being program in these regions will continue 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 a decrease in changes in placement and an increase in successful reunifications and adoptions.

Program Challenges and Solutions

The annual caseloads for Katie-A has been increasing. It appears that with the specialization of the Katie-A screening and referral process, more children in foster care are being referred to the appropriate levels of care and Pathways to Well Being has reduced in referrals as more children are being identified for a needing higher level of care. For example, in FY13-14 ninety-four (94) referrals were received by the program, forty-two (42) referrals were made in FY 14-15, and thirty-four (34) in FY 15-16. In FY 18-19, we streamlined processes and allowed providers to conduct the assessments, thereby decreasing the amount of wait time from referral to actual service by the youth and his/her foster family. Due to Continuum of Care Reform (CCR), the children that are in presumptive transfer to our county from another county are typically kids that require a higher level of care and therefore would not be appropriately served within the Pathways to Well Being program. Due to this, the number of referrals in Pathways to Well Being has reduced and additional staffing is required in the higher level of care programs. With the CCR changes, group homes have been closing which causes the County to have less resources available to children that need the highest level of care and these children must be served within

our County. Behavioral Wellness will be partnering with the Department of Social Services to attempt to engage community based partners seeking to provide similar services and certified through the State.

Program Performance (FY 17-18)

Pathways to Well Being

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	14	53	44
16-25	1	11	1
26-59	0	0	0
60+	0	0	0
Missing DOB	0	0	0
Total	***15***	***64***	***45***
Gender			
Female	7	24	21
Male	8	40	24
Unknown	0	0	0
Ethnicity			
White	3	17	11
Hispanic	12	41	33
African American	0	0	0
Asian/Pacific Islander	0	1	0
Native American	0	3	1
Other/Not Reported	0	2	0

Client Outcomes

	Average per quarter	
	North (FSA)	**South & West (CALM)**
Incarcerations/Juvenile Hall	0%	0%
Psychiatric Inpatient Care	0%	1%
Out-of-Home Placement	0%	6%
Purposeful Activity (employed, school, volunteer)	100%	98%
Stable/Permanent Housing	100%	95%

In the 2017-2018 fiscal year, clients in the Pathways to Well Being Program had quite positive outcomes. In North County, no clients experienced any juvenile hall stays, psychiatric inpatient stays, or out of home placements, while all clients were engaged in purposeful activities and had stable housing. In South County, no clients experienced any juvenile hall stays, while 1% had a psychiatric inpatient stay and 6% had an out of home placements. Nearly all clients were engaged in purposeful activities (98%) and had stable housing (95%).

Crisis Residential Services North/South

Crisis Residential Services- North and South	
Provider:	Crestwood, Telecare, Behavioral Wellness
Estimated Funding FY 2019/20:	
Estimated Total Mental Health Expenditures	$3,517,500
Estimated CSS Funding	$1,075,000
Estimated Medi-Cal FFP	$2,010,900
Estimated 1991 Realignment	$0
Estimated Behavioral Health Subaccount	$0
Estimated Other Funding	$431,600
Average Cost Per Consumer (352 Consumers)	$9,993

The Department of Behavioral Wellness offers voluntary residential recovery programs to clients in crisis in both North (Santa Maria) and South (Santa Barbara) County. These facilities were operated by Anka Behavioral Health (Anka) until May 2019. During the 30 day posting period, Anka filed bankruptcy and new contracts for the services were authorized for Crestwood and Telecare for July 2019 to June 2020. The Programs allow clients in crisis, who have a serious mental illness, to receive treatment from Mental Health Practitioners, Caseworkers, Peer Recovery Assistants, and Psychiatrists, while participating in various recovery programs. Clients can stay at either facility for up to 30 days at a time and have designated visitation hours. Residential crisis services aim to:

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

Program Challenges and Solutions

The primary objectives for Crisis Residential Treatment (CRT) programs are to reduce the client's active behavioral health symptoms and psychological distress. Using the Symptom Checklist and Triage Severity Scale as a measurement toll at intake and discharge, significant improvements were reported at both North and South CRT facilities. Another primary objective for CRT staff is ensuring stable housing for clients upon discharge from CRT programs. Across all quarters evaluated, clients at both facilities consistently experienced significantly less homelessness at discharge than intake.

The Santa Barbara and Santa Maria CRT programs' focus has been to better collaborate and problem-solve with the County's Psychiatric Health Facility (PHF) , Crisis Stabilization Unit (CSU), Triage teams and other County resources with the goal of maximizing the bed occupancy at the CRTs. Anka worked toward this goal by providing a driver to assist in the transportation of clients from the PHF and CSU to the CRT programs; and by working with their own staff to be more flexible with admission hours and working collaboratively with the County on challenging clients. Although ongoing effort by the parties is required for beds to be consistently full, progress has been made with collaboration and problem-solving. During FY 18-19 contract period, it was decided that Mental Health Practitioners would be added in each location. This is included in the FY 19-20 contracts with Telecare and Crestwood.

The South County CRT opened in July 2015. In November 2017, its capacity increased from 8 to 10 beds. North County offers 10 beds.

Behavioral Wellness is coordinating the development of a new Crisis Residential unit in North County anticipated to open fall 2019. The new location will have eight beds and the facility development costs will be funded by a grant from the California Health Facilities Financing Authority (CHFFA). As a result, a redesign of staffing patterns in all three locations is occurring which will leverage all the resources to accommodate the varied levels of care needed including greater medical support and coordination of services throughout the County. Focus on the forensic population will shift staffing and resources in fall 2019 at the North crisis residential location with implementation of current diversion felony services in coordination with multiple county departments and the Department of the State Hospital (DSH)

Program Performance (FY 17-18)

Crisis Residential

Unique Clients Served		
	North	**South**
Age Group		
0-15	0	0
16-25	23	23
26-59	172	109
60+	17	8
Missing DOB	0	0
Total	***212***	***140***
Gender		
Female	116	56
Male	96	84
Unknown	0	0
Ethnicity		
White	123	83
Hispanic	63	33
African American	13	5
Asian/Pacific Islander	1	2
Native American	1	2
Other/Not Reported	11	15

Client Outcomes

	North	**South**
Incarcerations	--	--
Psychiatric Inpatient Care	35%	42%

Psychiatric Inpatient Care

It is important to note that data examining higher levels of care reflect any inpatient psychiatric care throughout the year, regardless of when in the year the client participated in the program. Thus, an inpatient stay that led to a subsequent program entry would still count as a hospitalization. Further, incarceration/juvenile hall data were unavailable this year and we are unable to report on these metrics. One-third of clients in North County experienced a psychiatric hospitalization, while 42% of clients in South County experienced hospitalization.

Follow Up Outpatient Services

During fiscal year 2017/2018, approximately 66% of clients served by CRT were connected to long-term outpatient care within the mental health system, which is an increase from the previous fiscal year (fiscal year 2016/2017 saw 58% of clients connected to outpatient care).

Client Satisfaction

Client satisfaction with services received at the Crisis Residential Treatment Program was evaluated using the Consumer Satisfaction Questionnaire (CSQ) at discharge. During Fiscal Year 2017/2018, clients (*N* = 68) indicated that they were satisfied with their experiences at the CRT and treatment by staff members. Average satisfaction in all categories was high and fell between agree = 4 and strongly agree = 5 for effectiveness, efficiency, client involvement, staff treatment, satisfaction, accessibility, and overall satisfaction.

Client Behavioral Health Symptoms

The Santa Barbara Crisis Residential Program was opened in July of 2015 to help improve the active behavioral health symptoms of individuals in crisis due to severe mental illness and substance use while connecting them to outpatient treatment and stable housing. Individuals' self-reported active behavioral health symptoms were measured by the Symptom Checklist (SCL) at intake and discharge. The SCL asks clients to rate themselves on a four-point scale ranging from 0 = *Not at all*, 1 = *A little bit*, 2 = *Moderately*, 3 = *Quite a bit*, and 4 = *Extremely*. Clients' scores on each item were summed for an overall general psychological distress score ranging from 0-10 = *Low distress*, 10-20 = *Moderate distress*, 20-30 = *Quite a bit of distress*, and 30-40 = *Extremely distressed*. During fiscal year 2017/2018, clients reported an average reduction in active behavioral health symptoms of 47%.

Housing

In fiscal year 2017/2018, approximately 55% of individuals served at the CRT left the Program with stable housing.

Program Participation

Clinicians rated clients' Program participation on the Discharge Summary form. Clinicians rated clients as 1 = *Did not engage,* 2 = *Partially engaged,* and 3 = *Fully engaged.* Clients that were rated as partially engaged (2) or fully engaged (3) were considered to be demonstrating high levels of program participation. In fiscal year 2017/2018, 80% of clients were partially or fully engaged in the CRT program.

Medical Integration Program - Behavioral Wellness

Medical Integration Program	
Provider:	Behavioral Wellness
Estimated Funding FY 2019/20:	
Estimated Total Mental Health Expenditures	$2,309,800
Estimated CSS Funding	$1,370,500
Estimated Medi-Cal FFP	$521,500
Estimated 1991 Realignment	$417,800
Estimated Behavioral Health Subaccount	$0
Estimated Other Funding	$0
Average Cost Per Consumer (270 Consumers)	$8,554

The specialized Medical Integration teams in each region of the County serve persons with severe mental illness who also experience serious medical problems, including individuals who are 60 years of age and over. Teams address the complex needs of this population, including multiple medication management and the prevalence of significant physical and mental health conditions. In the past year, 270 consumers have been identified and assigned to these teams. With ongoing evaluation and program development the Teams learned that age alone was not a clinically appropriate determination for assignment to this Program. Each consumer is now being assigned based on the existence of complex medical needs to ensure individualized treatment.

The Teams serve:

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

Forging new partnerships with primary care and substance use treatment providers is essential. In monthly meetings, each region is collaborating with the Public Health Department, Community Based Organizations (CBO's), other community health providers and service agencies to improve the care of mutual consumers and to develop seamless processes of referral. Services provided to consumers in the Medical Integration Team are mostly medication support services and intensive case management services. Groups addressing pain management and healthy living (i.e. nutrition, exercise, 3-4-50) also have been introduced.

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

Program Challenges and Solutions

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 into levels of care that include medical integration at all levels, being mindful that each program level will require a different level of coordination and services. A 3-4-50 Health Program Manual and trainings have been developed and implemented including groups such as Rethink your Drink, movement, pain management, healthy eating, yoga, and walking to assist consumers with improving physical concerns which impact their mental health.

The original vision for the implementation of three specialized programs (Wellness Resilience Recovery, Medically Integrated Older Adult, and Co-Occurring Disorders) was for staff positions to be flexible. Fiscal structure 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 therapeutic relationships or a lack of fidelity to fiscal organizational structures when consumers were kept with the original clinician. In order to address these challenges, the Department has recently moved three specialized programs towards becoming Complex Capable. Once all Programs staff is trained to become more Complex Capable, the need to transition clients to different programs within clinics will no longer be necessary and the disruption of therapeutic alliances will be minimized.

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

Program Performance (FY 17-18)

Behavioral Wellness: Medical Integration and Older Adult Teams

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	0	0	0
16-25	1	0	1
26-59	49	24	51
60+	73	51	20
Missing DOB	0	0	0
Total	***123***	***75***	***72***
Gender			
Female	73	49	46
Male	50	26	26
Unknown	0	0	0
Ethnicity			
White	70	45	40
Hispanic	35	19	19
African American	14	5	10
Asian/Pacific Islander	1	1	1
Native American	1	1	0
Other/Not Reported	2	4	2

Client Outcomes

Milestones of Recovery Scale (MORS) Age: 18+		
	Initial to 6 months (n=223)	**6 to 12 months (n=178)**
Showed improvement^	25%	19%
Remained stable^	54%	62%

Higher Levels of Care	**% with any admissions over FY 17/18**		
	North	**South**	**West**
Incarcerations	--	--	--
Psychiatric Inpatient Care	0%	8%	2%

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

In the 2017-2018 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 in the second six months, 19% of clients improved. Examined another way, over the year, about 80% of clients were either stable or showed improvement.

It is important to note that data examining higher levels of care reflect any inpatient psychiatric care throughout the year, regardless of when in the year the client participated in the program. Thus, an inpatient stay that led to a subsequent program entry would still count as a hospitalization. Further, incarceration/juvenile hall data were unavailable this year and we are unable to report on these metrics. Clients in North and West County had similarly low levels of hospitalizations (0% and 2%, respectively), while South County clients were more likely to be hospitalized over the year (8%).

Adult Housing Support Services

Adult Housing Support Services	
Provider:	Behavioral Wellness, Psynergy, Pathpoint, Mental Wellness Center
Estimated Funding FY 2019/20:	
Estimated Total Mental Health Expenditures	$2,864,200
Estimated CSS Funding	$1,446,100
Estimated Medi-Cal FFP	$806,300
Estimated 1991 Realignment	$0
Estimated Behavioral Health Subaccount	$611,800
Estimated Other Funding	$0
Average Cost Per Consumer (49 Consumers *not of all vendors due to implementation phase*)	$58,453

During prior years' stakeholder forums, additional housing has been raised as an issue. In the upcoming year, the Department plans to add 10 licensed board and care beds and an additional 10 Crisis Residential beds to the continuum. In addition, we are working with care providers to establish low barrier housing and room and board placements and have become partners in the Coordinated Entry process to prioritize those most in need receive opportunities for housing. 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:

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. During the first two quarters of FY 18-19, Psynergy's caseload ranged between 11-15 clients at any given time.

Pathpoint which offers residential board and care at Pheonix and Mountain House Adult Housing Supports. Last fiscal year, Behavioral Wellness renegotiated PathPoint's FY 18-19 contract to incorporate services that were previously provided by Phoenix of Santa Barbara, Inc. dba Crescend Health (Crescend Health) due to a merger between the two organization where there was a change of ownership and PathPoint assumed all of Crescend Health's daily operations. This include a redesign from the Phoenix contract to include MHSA

principles, peer services, and enhanced focused on case management and support group activities. On July 1, 2018, PathPoint took over the two facilities (Mountain House and Phoenix House) and now operate the two residential programs.

Additionally, the Department partners with Mental Wellness Center's (MWC) include the addition of a new Intensive Residential Program, Polly's House, including extended peer services and group supports. The intent of the Program is to coordinate housing for adults primarily served through the MHSA. Once Polly House is fully operational, 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 to a caseload of ten (10) clients. This is anticipated to open Summer 2019 as construction timelines delayed FY 18-19 implementation.

Program Challenges and Solutions

The Department continues to work towards the purpose of building adequate infrastructure, and adding to the housing continuum while acknowledging that additional components may be needed while 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, and flexible housing assistance, such as rental subsidies, security deposits, utility deposits will be explored to the extent available.

Behavioral Wellness also partnered with County Housing and Community Development (HCD) to fund the update to Homeless Housing Plan to help ensure adequate supports in County in FY 18-19 along with partnering for a successful Request for Proposal (RFP) for development opportunities. Behavioral Wellness will be attempting to seek providers interested in master leasing and housing services management in FY 19-20 in order to ensure an enhanced support network when housing opportunities of funding become available.

Program Performance (FY 17-18)

Adult Housing Support Services

	Unique Clients		
	Mountain House Support Services	Phoenix House Support Services	Psynergy
Age Group			
0-15	0	0	0
16-25	1	6	1
26-59	9	6	17
60+	5	0	4
Missing DOB	0	0	0
Total	***15***	***12***	***22***
Gender			
Female	6	7	12
Male	9	5	10
Unknown	0	0	0
Ethnicity			
White	10	7	17
Hispanic	3	4	3
African American	1	1	1
Asian/Pacific Islander	1	0	0
Native American	0	0	0
Other/Not Reported	0	0	1

Program Outcomes

	Average per Quarter		
	Mountain House Support Services	Phoenix House Support Services	Psynergy
Clean and Sober while in Treatment	--	65%	--
Incarcerations	0%	2%	--
Psychiatric Inpatient Care	--	--	5%
Physical Health Hospitalization	0%	5%	8%
Stable/Permanent Housing	95%	--	--
Purposeful Activity (employed, school, volunteer)	39%	33%	--
Transferred to Higher Level of Care	2%	2%	3%

Examining program outcomes, it is important to note that providers were asked to report on some, but not all, of the same metrics. Therefore, a dashed line signifies that this metric was not assessed. Programs reported on each outcome quarterly to the Department of Behavioral Wellness. An average of two-thirds of clients per quarter in Phoenix House remained clean and sober while in treatment each quarter. Also, few clients in Mountain and Phoenix House experienced incarceration (0-2%). Clients in Psynergy low levels of psychiatric

inpatient stays (5%). Psynergy reported the highest rates of physical health hospitalizations (8%) compared to 0% at Mountain House and 5% at Phoenix House. Almost all of clients at Mountain House had stable/permanent housing, while about one-third of clients at Mountain and Phoenix Houses were engaged in purposeful activity. Finally, during their enrollment in each program, very few clients had to be transferred to a higher level of care (2-3%).

About Full Service Partnerships (FSPs)

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

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

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.

In August, 2018, Behavioral Wellness conducted a Fidelity Review as follow up to the 2015 review. Final results are pending and focus on fidelity and service provision will be of continued importance in upcoming year. Each program is detailed below.

Lompoc ACT FSP

Lompoc ACT FSP	
Provider:	Transitions Mental Health Association / Behavioral Wellness
Estimated Funding FY 2019/20:	
Estimated Total Mental Health Expenditures	$2,342,200
Estimated CSS Funding	$1,604,900
Estimated Medi-Cal FFP	$737,300
Estimated 1991 Realignment	$0
Estimated Behavioral Health Subaccount	$0
Estimated Other Funding	$0
Average Cost Per Consumer (108 Consumers)	$21,687

Transitions Mental Health Association (TMHA) provides ACT services in Lompoc. As an ACT Model Program, the staff functions as a team and provide services for adults, older adults, and transitional age youth with 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 has been able to connect consumers with our own employment programs and employment opportunities at the Growing Grounds Farm and Recovery Learning Communities (RLC). ACT consumers have been employed at the farm, the RLC, as well as in-house paid job training positions.

This Program has also shifted its staffing pattern to employ more Master's Level clinical staff. This has resulted in more therapeutic offerings and group treatment options and has benefited the ACT population.

During FY 17-18 and FY 18-19, a significant change was made to this contract to create a tiered Program. An estimated 45 clients at any given time were enrolled in to Tier 3 services which require 2-3 contacts per week, with the flexibility to offer 2-3 contacts per day; 45 clients at any given time were enrolled in Tier 2 Supported Community Level services, requiring 1 contact per week with the flexibility to offer up to 3 contacts per week (thus fulfilling the need in West County for a Supportive Community Services Level Program); and 10 at any given time were enrolled into Tier 1 services. This level of client is ready to graduate from intensive services to a lower level of care and have ACT staff assist in navigating the process of leaving intensive level services for transition assistance and relapse prevention. In FY 19-20, as demand for services has ranged from 60-80 clients on an ongoing basis, the tier approach will be modified and expected consistent client services will be for approximately 80 slots.

Program Challenges and Solutions

The West region of the County has limited FSP resource options due to a lack of supported community services program. As a result, the Department and TMHA are reviewed how to incorporate FSP supported services into Lompoc and created the level of care to allow supportive services for transition. This being reviewed for impacts as established. Lompoc ACT offers a higher level of care than the Lompoc outpatient clinic and a transitional step down to supported services would possibly improve outcomes and offer individuals a better transition in the system. In Spring 2019, a pilot program between the Department and TMHA began to offer psychiatric care at the Lompoc Recovery Learning Community for those who transition out of the intensive services. By creating these transition levels, the proposed changes will support clients in their recovery by ensuring adequate support throughout each step.

Santa Maria ACT FSP – Telecare

Santa Maria ACT FSP	
Provider:	Telecare / Behavioral Wellness
Estimated Funding FY 2019/20:	
Estimated Total Mental Health Expenditures	$3,154,100
Estimated CSS Funding	$1,831,400
Estimated Medi-Cal FFP	$1,322,700
Estimated 1991 Realignment	$0
Estimated Behavioral Health Subaccount	$0
Estimated Other Funding	$0
Average Cost Per Consumer (113 Consumers)	$27,912

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

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

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

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

1) Team A – This team is for those newly admitted to the program or those who are poorly coping, at risk for crisis, or minimally engaging. This team meets with consumers more than once a week.
2) Team B – Consumers in this team may be somewhat coping but are engaged in treatment or may be coping and actively working on rehabilitation. Consumers are seen at least once a week.
3) Team C – This team works with those who have achieved early recovery and are ready to graduate to the next level of recovery. The team focuses on community linkage and preparation for clinic services. Consumers are seen at least once a week with a gradual plan to reduce direct staff services to every other week in preparation for transition to outpatient clinic services.

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

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

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

D. 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.

E. 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.

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

G. Provide continuity across time

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

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

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

In August 2018, Telecare was re-accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) for three more years. In September 2018, Telecare was recertified as a Medi-Cal provider for another three years. In October 2018, ACT celebrated ten years of providing services with an Open House that showcased Telecare's Evidence-Based Practice methods, Telecare's Recovery-Centered Clinical Systems principles, Telecare's Whole Person Care approach, and a program overview.

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. Additionally, some Board & Care facilities and Room & Board homes have recently closed in the region, and as a result, ACT has received an increase in referrals for clients who were homeless or at risk of being homeless. Some ACT clients have experienced hospitalizations due to instability in housing placement causing increased mental health symptoms and functional impairments. The MHSA Housing Project on Depot St. will add 35 units in Santa Maria which could provide support to Department of Justice (DOJ) step down permanent housing for those who qualify.

SM ACT also had an increase in referrals of clients with active DOJ involvement such as recent incarcerations with Social Security Income (SSI) benefits terminated. ACT has had difficulty finding appropriate community services in order to maintain clients' placement in the community and prevent recidivism. Client involvement in meaningful activities such as employment, education, or volunteering remains a challenge for the ACT

population. Telecare attempts to awaken hope and vocational interests in their clients through ongoing rehabilitative services. The Program has been impacted by limited resources and appropriate level-of-care services for clients actively using substances that increase their psychiatric symptoms. With the County's ODS waiver going live in December, 2018, it is anticipated that Medi-Cal clients with co-occurring substance use disorders will now have access to critical treatment services that will support their mental health treatment as well.

At the beginning of the fiscal year 17-18, the ACT program was not fully staffed and did not have any Spanish-speaking staff. However, 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. Over the year they filled several vacant positions and hired a Bilingual-certified Personal Services Coordinator.

Santa Maria Act and the Department have worked on transitioning clients throughout the system of care which was an issue in prior years. Graduations of clients to a lower-level of care have improved. However, staffing in the region continues to be different due to the limited personnel qualified. In order to provide services in the North region and at the required level of care, staffing will be evaluated between Telecare and the Department to best meet the needs of the Program while ensuring adequate coverage for both the medical staff and provider programming.

Santa Barbara ACT FSP

Santa Barbara ACT FSP	
Provider:	Behavioral Wellness
Estimated Funding FY 2019/20:	
Estimated Total Mental Health Expenditures	$3,686,200
Estimated CSS Funding	$2,632,300
Estimated Medi-Cal FFP	$789,100
Estimated 1991 Realignment	$0
Estimated Behavioral Health Subaccount	$0
Estimated Other Funding	$264,800
Average Cost Per Consumer (119 Consumers)	$30,976

Santa Barbara ACT functions as a multi-disciplinary team, meeting every morning to review the status of all clients and develop the Daily Organizational Schedule. The Daily Organization Schedule enables the team to determine which services will be provided that day based upon consumer acuity and regular rehabilitation and medication support visits. ACT services are provided to transitional age youth (18-25); adults (26 to 59), and older adults (60 and over) with severe and persistent mental illness. Because of current low staffing, there is only one ACT group, with the goal of creating a second group as staff positions are filled. The ACT group includes Mental Health Practitioners, a Nurse, Case Managers, a Vocational Rehabilitation Specialist, a Psychiatrist, an Alcohol and Drug Specialist, Recovery Assistants. The team reports each morning on what happened during the last 24 hours, and work together to ensure that all consumers are seen as needed. The team operates in a manner consistent with the ACT fidelity model, doing "whatever it takes" to ensure consumers are provided with case management, rehabilitation, therapy, and linkage to other supportive services in the community as

needed. Santa Barbara ACT is committed to reducing homelessness, hospitalizations, and incarceration and focuses on providing all services using a recovery-based, client-centered approach.

Program Challenges and Solutions

In the last several years, ACT Programs have faced challenges related to fidelity compliance. Concerns related to fidelity and program consistency were addressed by conducting an in-depth fidelity review of all three ACT Programs during this last three- year period. The review tool used was the updated Tool for Measurement of ACT (TM-ACT) which has 47 items rated on a 5-point scale, as compared to the former Dartmouth Assertive Community Treatment Scale (DACTS).

Over the past few years, the Santa Barbara ACT team has experienced changes in staffing, and continues to use the fidelity model. This includes completing comprehensive assessments in order to get to know the consumers as fully as possible, thus facilitating the development of a treatment plan based upon the consumers' wishes and needs. The multi-disciplinary team meets as part of the Individual Treatment Team (ITT) to review the summaries of the assessments, and build the treatment plan to be reviewed again with the consumer for final review. This takes place within the first 30 days.

The team also recently added another full-time Mental Health Practitioner, a part-time Mental Health Practitioner, a caseworker, and a Volunteer Intern (all Master's level), which has increased the ability to provide clinical services needed. These additional staff will assist the team in meeting consumers more to work on rehabilitation, leading to a reduction in hospital days and jail days. Because of low staffing, the ACT team has not been able to develop as many new groups as they planned (Seeking Safety, Dialectical Behavior Therapy (DBT); physical health (wellness); and co-occurring groups); as positions are filled, they will develop these groups. The Santa Barbara ACT team recently moved from the Main Campus to the De La Vina Street location in 2018 and is now located in the same building as Homeless Services and Justice Alliance. This move has allowed for more collaboration between these Programs on clients' behalf; and while the Program is field-based so most client contact is not on-site, some clients who are downtown are able to drop in for appointments or medication. ACT clients have adapted positively to the change in location.

One ongoing challenge for ACT is that the team currently only has two County vehicles in which to provide clients transportation to appointments, which has at times been a barrier to client attendance. ACT is working to secure another vehicle. ACT clients also continue to access transportation through CenCal medi-cal and Easy Lift transportation services; in particular to access the Mental Wellness Center, which affords them social opportunities.

Program Performance (FY 17-18)

Assertive Community Treatment (ACT)

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	0	0	0
16-25	8	4	13
26-59	72	85	73
60+	33	30	22
Missing DOB	0	0	0
Total	***113***	***119***	***108***
Gender			
Female	56	61	62
Male	57	58	46
Unknown	0	0	0
Ethnicity			
White	64	75	61
Hispanic	37	30	38
African American	8	7	5
Asian/Pacific Islander	2	2	2
Native American	1	0	0
Other/Not Reported	1	5	2

Client Outcomes

Milestones of Recovery Scale (MORS) Age: 18+	**ACT**	
	Initial to 12 months (n=287)	**12 to 18 months (n=251)**
Showed improvement^	28%	23%
Remained stable^	49%	62%

	Average per Quarter		
	North	**South****	**West**
Incarcerations	1%	5%	0%
Psychiatric Inpatient Care	3%	10%	3%
Physical Health Hospitalization	4%	5%	4%
Physical Health Emergency Care	17%	3%	7%
Stable/Permanent Housing	94%	*	93%
Purposeful Activity (employed, school, volunteer)	7%	*	7%
Transferred to Higher Level of Care	1%	0%	2%
Graduated to Lower Level of Care	3%	1%	5%

*^"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.*

***Data was compiled on a monthly basis in South County; percentage listed is a monthly average.*

In the 2017-2018 fiscal year, clients in ACT had initial, 12-month and 18-month MORS data. During both time periods, about a quarter of clients improved, while half of clients were stable in the first year and 62% were stable after 18 months. It appears that the 12-18 month period is particularly helpful for most clients; in this time period 85% of clients in the Program either improved or remained stable, suggesting that Program longevity may further stabilize clients' mental health.

Examining other outcomes, in North and West County very few clients experienced incarceration while in the Program. Clients in South County were slightly higher; a monthly average of 5% were incarcerated. Clients in North and West County experienced similar levels of psychiatric inpatient stays while enrolled in ACT (3% for both regions), while in South County clients were three times more likely to have an inpatient stay (10%). Rates of physical health hospitalization were similar across the county (4% for North and West; 5% in South). In North County, 17% of clients experienced emergency care for their physical health; 7% of clients in West County and 3% in South County. Nearly all clients had stable housing in North and West County (94% and 93%, respectively), while few clients engaged in purposeful activities (7% for both regions). This metric was not available for South County. During their enrollment in ACT, very few clients had to be transferred to a higher level of care, and few graduated to a lower level of care in West and South County (this metric was not available for clients in North County).

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

Supported Community Services South (Santa Barbara) – PathPoint

Supported Community Services: Santa Barbara	
Provider:	PathPoint
Estimated Funding FY 2019/20:	
Estimated Total Mental Health Expenditures	$1,247,200
Estimated CSS Funding	$451,300
Estimated Medi-Cal FFP	$667,300
Estimated 1991 Realignment	$70,900
Estimated Behavioral Health Subaccount	$0
Estimated Other Funding	$57,700
Average Cost Per Consumer (108 Consumers)	$11,548

PathPoint's Behavioral Health Division provides supportive housing services that assist individuals challenged with behavioral health diagnosis to live independently, be connected to community resources, and receive medical support & therapy support for dealing with symptoms that might interfere with daily living. Paths to Recovery (PTR) mobile team is PathPoint's MHSA funded Full Service Partnership providing Supported Housing services to individuals living in South Santa Barbara County. The PTR mobile team consists of a Psychiatrist, Nursing staff, Marriage & Family Therapists (and Interns), and Qualified Mental Health Rehabilitation Specialists with expertise in "lived experiences," substance recovery, mental illness, and vocational services. This mobile team fans out across the community each day to meet with PathPoint consumers served by PTR in the community, and helps them continue on the path to wellness. This aid takes the form of basic medical care (injections, medications,

medical advice, etc.), psychological therapy, crisis and eviction prevention, and social and vocational skills training. Many persons enrolled in the PTR program live in PathPoint-operated, and HUD subsidized, properties in Santa Barbara.

Outcome goals include reduction of unnecessary hospitalizations, increase in access to primary health care services, increased understanding and competency in symptom self-management, and reduction in levels of measureable pain and discomfort from medical conditions. Supportive Services South has provided care for 113 unique individuals in FY 2017-2018.

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

Supported Community Services: Santa Maria	
Provider:	Transitions Mental Health Association
Estimated Funding FY 2019/20:	
Estimated Total Mental Health Expenditures	$1,135,300
Estimated CSS Funding	$348,100
Estimated Medi-Cal FFP	$787,200
Estimated 1991 Realignment	$0
Estimated Behavioral Health Subaccount	$0
Estimated Other Funding	$0
Average Cost Per Consumer (124 Consumers)	$9,155

Santa Maria Supported Community Services provides outpatient mental health treatment for adults and older adults with severe and persistent mental illness. The intensive treatment team helps individuals to recover and live independently within their community. Program participants are assisted in their efforts to gain the skills needed to make choices that reflect their own values, preferences, and goals; supports are developed to meet each person's needs and to empower each individual to attain their highest level of independence and recovery possible. 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. Supportive Services North has provided care for 124 unique individuals in FY 2017-18.

Program Challenges and Solutions

Although there is robust programming in the North and South regions of Santa Barbara County, the West region is comprised of ACT level services and outpatient and recovery services. The step down from the higher level of care is difficult without a smooth transition for individuals receiving treatment. In the upcoming year, the Department will be evaluating the distribution of services and may transition funding from the higher level (ACT) to supported community services to enable clients to move up and down the continuum easier as occurs in the other regions of the County. TMHA and Behavioral Wellness instituted programming at each level of care to support the transitions and is monitoring status of this change in FY 18-19 and FY 19-20

Program Performance (FY 17-18)

Community Supportive Services (*formerly Supported Housing*)

	Unique Clients Served	
	North	**South**
Age Group		
0-15	0	0
16-25	1	1
26-59	80	67
60+	43	45
Missing DOB	0	0
Total	***124***	***113***
Gender		
Female	59	44
Male	65	69
Unknown	0	0
Ethnicity		
White	63	88
Hispanic	46	14
African American	5	7
Asian/Pacific Islander	8	2
Native American	0	0
Other/Not Reported	2	2

Client Outcomes

Milestones of Recovery Scale (MORS) Age: 18+		
	Initial to 12 months (n=226)	**12 to 18 months (n=210)**
Showed improvement^	31%	16%
Remained stable^	52%	65%
	Average per Quarter	
	North	**South**
Incarcerations	0%	2%
Psychiatric Inpatient Care	3%	3%
Physical Health Hospitalization	2%	4%
Physical Health Emergency Care	11%	10%
Stable/Permanent Housing	99%	98%
Purposeful Activity (employed, school, volunteer)	26%	13%
Transferred to Higher Level of Care	0%	1%
Graduated to Lower Level of Care	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 2017-2018 fiscal year, clients in Community Supportive Services (CSS) had initial, 12-month and 18-month MORS data. Almost 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, over half 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.

Examining other outcomes, very few clients experienced incarceration while in the Program. During Program enrollment, clients in North and South County experienced similar levels of psychiatric inpatient stays (3% for both regions), physical health hospitalization (2% in North County; 4% in South County), and physical health emergency care (11% in North County; 10% in South County). Nearly all clients had stable housing in North and South County (99% and 98%, respectively). A quarter of clients in North County engaged in purposeful activities while about half as many did in South County. During their enrollment in CSS, very few clients had to be transferred to a higher level of care (0% in North County; 1% in South County), and a few transferred to a lower level of care in North County (4%; this metric was not available for clients in South County).

SPIRIT FSP Wraparound Services – Behavioral Wellness/CALM

SPIRIT FSP Wraparound Services	
Provider:	Behavioral Wellness, CALM
Estimated Funding FY 2019/20:	
Estimated Total Mental Health Expenditures	$2,826,000
Estimated CSS Funding	$837,400
Estimated Medi-Cal FFP	$1,020,400
Estimated 1991 Realignment	$0
Estimated Behavioral Health Subaccount	$968,200
Estimated Other Funding	$0
Average Cost Per Consumer (92 Consumers)	$30,717

This Full Service Partnership (FSP) for children and their families is an evidenced based, Wraparound program known as the SPIRIT TEAM is designed around the following MHSA core principles: consumer 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 Team estimated slots operates in all three regions of the County as a specialized team that provides intensive, high frequency services to a disenfranchised, underserved population of consumers and families that have limited resources, failed to thrive with conventional treatment, and whose children are at risk for placement in Out-Of-County high level facilities.

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

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

Program Challenges and Solutions

SPIRIT Team services are designed to be high frequency and intensive to engage the most resistant and high needs consumers and families. There a few challenges, first the need to standardize the level of care tools so the consumers with the highest needs are served through the SPIRIT Program and are reassessed to ensure they are ready to transition to different services. Second, the families with very limited resources and high social/ emotional needs struggle with transitioning out of SPIRIT's intensive supportive 24/7 care; they also struggle to maintain some of the necessary changes they learned during their involvement with SPIRIT. It will be important to improve collaboration with CBO's, community resources, schools, and informal supports in order to assist families in transitioning to a lower level of care as they stabilize. It will be important to reconsider the existing program structure. The enhanced structure can focus on the parent partner taking on more of a lead role in engaging parents/caregivers, providing urgent parent response and de-escalation to sustain families. Expand training for parent partners to be able to encourage parents to engage and collaborate with schools. Additionally, the changes in the SPIRIT structure can provide more support outside of the county scheduling structure to ensure that parent partners can work outside the normal work hours and are more available after hours and weekends as evidenced based wraparound indicates. In order for parent partners to have more flexibility, it may be necessary to rethink which positions are contracted versus County-based in order to better meet the needs for these families. The Department will be coordinating this review with CALM for redesign of roles in FY 19-20.

Program Performance (FY 17-18)

SPIRIT

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	13	31	18
16-25	9	13	8
26-59	0	0	0
60+	0	0	0
Missing DOB	0	0	0
Total	***22***	***44***	***26***
Gender			
Female	11	21	10
Male	11	23	16
Unknown	0	0	0
Ethnicity			
White	8	9	4
Hispanic	13	31	15
African American	0	3	3
Asian/Pacific Islander	0	0	0
Native American	0	0	1
Other/Not Reported	1	1	3

Client Outcomes

Child & Adolescent Needs & Strengths Assessment (CANS) Age: 6-17 years	Percent Improvement*	
	Initial to 6 months (n=15)	6 to 12 months (n=12)
Life Functioning (e.g., ability to communicate and interact with families, communication, social functioning and health status)	30%	12%
Behavioral/Emotional Needs (e.g., symptoms of depression, anxiety, psychosis and other conditions)	23%	10%
Child Risk Behaviors (e.g., self-injury, suicidal behavior, bullying, and running away)	21%	6%
School (e.g., behavior, attendance and grades)	1%	20%
Caregiver Needs & Strengths (e.g., child supervision skills, family stress levels, residential stability, and caregiver physical/mental health status)	-9%	1%
Child Strengths (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment)	14%	21%

	North	South	West
Psychiatric Inpatient Care	9%	13%	0%

*"Percent improvement" for CANS scores reflects the % change between the group's mean scores.

In the 2017-2018 fiscal year, clients in the SPIRIT Program had initial, 6-month and 12-month CANS data. Despite the small number of clients enrolled in the Program, the overall trends suggest that clients made gains in improved life functioning, behavioral/emotional needs, risk-taking behaviors, school, and child strengths. The data also suggest that caregiver needs and strengths decline in the first six months and seemed to stabilize in the second six months.

It is important to note that data examining higher levels of care reflect any inpatient psychiatric care throughout the year, regardless of when in the year the client participated in the program. Thus, an inpatient stay that led to a subsequent program entry would still count as a hospitalization. Psychiatric inpatient care varied across the regions. Clients in South County experienced the highest levels of psychiatric inpatient care (13%), while 9% of clients in North County were hospitalized, and 0% of clients in West County.

Forensic FSP Justice Alliance

Forensic FSP Justice Alliance	
Provider:	Behavioral Wellness
Estimated Funding FY 2019/20:	
Estimated Total Mental Health Expenditures	$1,968,500
Estimated CSS Funding	$1,821,200
Estimated Medi-Cal FFP	$147,300
Estimated 1991 Realignment	$0
Estimated Behavioral Health Subaccount	$0
Estimated Other Funding	$0
Average Cost Per Consumer (371 Consumers)	$5,305

Justice Alliance provides licensed mental health professionals in each region of the County to link persons involved with the legal system to wellness- and recovery- oriented services. The Justice Alliance Program serves adults with severe mental illness in custody, out of custody and on probation or at risk of being in custody. Clinicians conduct outreach and assessments in the county jail, courts and community, and provides Full Service Partnership (FSP) services to those clients that qualify until they are able to link the consumer to the longer term FSP Program such as ACT or Community Supports services. Justice Alliance also provides treatment in partnership with existing programs in the outpatient clinics, and assists PHF personnel with treatment of individuals committed there by the courts for competency restoration. Overall, this is a "specialized FSP program" serving a specialized forensic population. This program ensures access to and engagement to appropriate level of care for this special population.

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

Justice Alliance staff members work closely with the Court, Probation, Public Defender, Sheriff, District Attorney, Community-Based Organizations and other Department of Behavioral Wellness treatment teams to make treatment recommendations, facilitate access to treatment and provide follow-up progress reports to the Court and other appropriate parties. Justice Alliance staff are responsible for the initial assessment for levels of care and disposition process. Staff members identify appropriate ACT consumers and ensure that consumers are placed in the appropriate regional ACT Programs or Community Supports Teams through outreach, engagement, and coordination with the FSP teams. When consumers do not qualify for ACT services, staff will refer consumers to the appropriate specialized outpatient teams.

In addition, Justice Alliance staff provide competency restoration services to misdemeanants found Incompetent to Stand Trial (IST), as well as providing treatment to individuals receiving outpatient competency restoration services. When providing outpatient restoration services, the team utilizes various residential resources including Alameda House and Cottage Grove housing facilities and crisis residential units.

Program Challenges and Solutions

In 2018, the Department approved hiring of an Extra-Help Case Worker for the Justice Alliance Santa Barbara team, similar to the Santa Maria region, which was necessary because of the increased rehabilitative service needs. When the team increased efforts to provide outpatient competency restoration treatment—to divert

those found to be IST from the PHF—it discovered many of these individuals had time consuming rehabilitation service needs that were previously not needed when consumers were in the PHF. Hiring the Extra-Help Case Worker freed up time for Practitioners and Psychologists to be engaged in more Assessment and Evaluation activities. Still, the Justice Alliance team experienced an uptick in IST referrals in 2018, up to 60 from 45 in 2017, many of whom required extensive case management. Initial data suggests the workload will continue to increase in 2019.

With the above considerations in mind due to increased community restorations, the Department has been examining the feasibility of providing additional support staff to the Justice Alliance team, to include Administrative Office Professionals (AOPS) and Case Workers. The Department has applied for grant funding from the AB 1810 diversion bill, to fund two full time Case Workers for the team, and it has prioritized the forensic services for new AOP positions. Behavioral Wellness anticipated hiring additional case workers with the grant funding starting Summer 2019.

Program Performance (FY 17-18)

Justice Alliance

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	0	0	0
16-25	18	51	3
26-59	65	186	21
60+	2	23	2
Missing DOB	0	0	0
Total	***85***	***260***	***26***
Gender			
Female	36	64	13
Male	49	196	13
Unknown	0	0	0
Ethnicity			
White	31	127	10
Hispanic	44	72	10
African American	2	18	3
Asian/Pacific Islander	4	4	2
Native American	0	3	0
Other/Not Reported	4	36	1

Client Outcomes

Milestones of Recovery Scale (MORS) Age: 18+			
		Initial to 6 months (n=123)	6 to 12 Months (n=80)
Showed improvement^		42%	24%
Remained stable^		35%	51%
Higher Levels of Care	**% with any admissions over FY 17/18**		
	North	**South**	**West**
Incarcerations/Juvenile Hall	--	--	--
Psychiatric Inpatient Care	18%	18%	34%

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

In the 2017-2018 fiscal year, clients in the Justice Alliance had initial, 6-month and 12-month MORS data. Over a year, three-quarters of clients in both time periods were either stable or made improvements; more clients made improvements in the first six months. Specifically, 42% improved in the first six months of engagement, while a quarter improved in the second six months. A third remained stable in the first six months while half remained stable in the second six months.

It is important to note that data examining higher levels of care reflect any inpatient psychiatric care throughout the year, regardless of when in the year the client participated in the program. Thus, an inpatient stay that led to a subsequent program entry would still count as a hospitalization. Further, incarceration/juvenile hall data were unavailable this year and we are unable to report on these metrics. One-third of clients in West County had inpatient psychiatric care (34%), while North and South County rates were about half of those West County (18% for both regions).

Crisis Stabilization Unit South- Behavioral Wellness

Crisis Stabilization Unit South (SB 82)	
Provider:	Behavioral Wellness
Estimated Funding FY 2019/20:	
Estimated Total Mental Health Expenditures	$2,726,600
Estimated CSS Funding	$40,700
Estimated Medi-Cal FFP	$1,796,900
Estimated 1991 Realignment	$0
Estimated Behavioral Health Subaccount	$970,400
Estimated Other Funding	$0
Average Cost Per Consumer (471 Consumers)	$5,788

*Initial infrastructure funded by SB 82.

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 Performance (FY 17-18)

Crisis Stabilization Unit (CSU)

Unique Clients Served	
	CSU
	South
Age Group	
0-15	0
16-25	77
26-59	385
60+	9
Missing DOB	0
Total	***471***
Gender	
Female	188
Male	283
Unknown	0
Ethnicity	
White	265
Hispanic	124
African American	30
Asian/Pacific Islander	4
Native American	5
Other/Not Reported	43

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 550; this is a duplicated count so it is not expected to match the unique count displayed above in the demographics table.

CSU Admissions and discharges (N = 550)

	Admission	Discharge
Hospital	68.2%	4.7%
CRT	0.5%	37.1%
Mobile Crisis	18.2%	0.0%
Outpatient	9.6%	2.2%
Justice	1.5%	0.2%
Supported/Sober Living, Board and Care	1.3%	15.8%
Self	0.7%	17.8%
Home	0.0%	22.2%

Two-thirds of clients served by the CSU were referred by hospitals (68%), and were either referred by hospital staff or crisis services staff. The next largest group was referred by mobile crisis in the field and outpatient (28% combined). Upon discharge from the CSU, the largest portion of clients were admitted to a CRT (37%). Almost a quarter of clients were discharged to home (22%), or because they did not meet 5150 criteria to hold, but did not want linkage to another program (self; 18%). Many clients were also discharged to sober living, board and care, or other supported living environment or shelter (16%). Only 5% of clients were discharged to the hospital. This suggests that clients from the CSU are typically stepping down in terms of service intensity.

Higher Levels of Care	% with any admissions within 30 days of discharge
CRT	**42%**
Psychiatric Health Facility (PHF)	**8%**

Psychiatric Hospitalizations and CRT Admissions

Clients whose later mental health services were captured in Clinician's Gateway, a subset of the total CSU population, were examined for subsequent hospitalization at the PHF or CRT placement. Eight percent of clients discharged from the CSU were subsequently hospitalized within 30 days of discharge, while 42% of clients discharged from the CSU were admitted to the CRT within 30 days of discharge.

Senate Bill 82 (S.B.82)

Senate Bill 82 Summary

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 supports 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, it is allocated to provide construction and renovation for a Crisis Residential Facility in Santa Maria to be 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 December 2020
- Crisis Stabilization Unit Santa Barbara (funded by SB 82)
- Crisis Residential Facility Santa Barbara and Santa Maria (funded by SB 82)
- North Crisis Residential Facility (funded by MHSA)
- Access and Assessment teams, Santa Maria, Lompoc, Santa Barbara (funded by MHSA)
- Children's Crisis Triage (funded by Children's Crisis Triage Grant)

Following is a description of each of the Programs beginning 2019 that are new to the Crisis SOCR. 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.

New: Children's Crisis Triage Program

Children's Crisis Triage	
Provider:	Behavioral Wellness
Estimated Funding FY 2019/20:	
Estimated Total Mental Health Expenditures	$517,300
Estimated CSS Funding	$0
Estimated Medi-Cal FFP	$108,200
Estimated 1991 Realignment	$0
Estimated Behavioral Health Subaccount	$0
Estimated Other Funding	$409,100
Average Cost Per Consumer (70 Consumers)	$7,390

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 will be funded with Medi-Cal and MHSA funds. The Practitioner and PPPs will 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 will also play a vital role in the emergency departments (ED) when there are children/adolescents in the ED's on psychiatric hold 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 will focus services on the parent/care giver using a peer wellness model. They will 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.

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.

New: Crisis Residential North

Crisis Residential North	
Provider:	Behavioral Wellness, Telecare
Estimated Funding FY 2019/20:	
Estimated Total Mental Health Expenditures	$1,096,200
Estimated CSS Funding	$336,200
Estimated Medi-Cal FFP	$660,000
Estimated 1991 Realignment	$0
Estimated Behavioral Health Subaccount	$0
Estimated Other Funding	$100,000

This 10 Bed Crisis Residential is presently under construction and is scheduled to open fall 2019. It is located in Santa Maria and will serve individuals for stays up to 30 days. Grant funds sponsored the infrastructure and initial start-up costs.

The facility renovation was funded by S.B. 82 as part of a grant to increase crisis services infrastructure statewide. Ongoing services will be contracted for with Community Services Support (CSS) fund in partnership with Telecare Corporation.

Mobile Crisis West

The Mobile Crisis Support Team in the City of Lompoc provides rapid response in mental health emergencies for the West County region of Santa Barbara County. See the “Crisis Services” program description for more information about the program. The grant funding is exhausted in December 2020 and the team members are anticipated in the West Crisis Services budget and narrative.

Prevention and Early Intervention (PEI)

Mental Health Education and Support to Culturally Underserved Communities (Promotora Program) - La Casa de la Raza, Community Health Centers of the Central Coast, Santa Ynez Tribal Health Clinic

Mental Health Education and Support to Culturally Underserved Communities (Promotora Program)	
Provider:	La Casa de la Raza, Community Health Centers of the Central Coast (CHCCC), Santa Ynez Tribal Health Clinic (SYNTHC)
Estimated Funding FY 2019/20:	
Estimated Total Mental Health Expenditures	$253,400
Estimated CSS Funding	$253,400
Estimated Medi-Cal FFP	$0
Estimated 1991 Realignment	$0
Estimated Behavioral Health Subaccount	$0
Estimated Other Funding	$0
Average Cost Per Consumer (7223 Consumers)	$33

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

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

Program Challenges and Solutions

Community Health Centers of the Central Coast (CHCCC) is contracted to provide Community Mental Health Educators who connect with unserved or underserved communities in the Santa Maria, Guadalupe, and Lompoc areas of the County. Activities address multiple barriers to accessing services, such as those related to culture, language, transportation, location, stigma and institutional mistrust or fear. Specifically, CHCCC utilizes mobile clinics to reach remote outposts of the community to provide primary care access and mental health education and support. Memorandums of Understanding have been developed and established with local low-income housing programs to program on-site support groups to predominant Spanish-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 Mixteco-language radio stations to bring free lunches to

workers. 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 have undertaken an annual health fair for migrant farmworkers. The health fair focuses on health and mental health support and information services. Many of the participants are Spanish- and Mixteco-speaking farm workers. Mental health and educational services are delivered in a culturally informed primary care setting that promotes the integration of care.

In the mid-county area, Santa Ynez Tribal Health Clinic offers community wellness trainings and activities. Bimonthly, the clinic issues The Samala magazine, a publication focused on native community wellness that is distributed to all clinic members or approximately 780 tribal homes. Recent topics covered bullying and health, sleep disorders, diet, stress, and training peer supports on mental health needs of tribal patients at Vandenberg Air Force Base. The clinic has also increased the number of clients served by engaging existing tribal programs, including Camp Kalawa Shaq (tribal youth summer program), and a tribal educational backpack event which attracts a large volume of youth and families and provides ample opportunities for one-on-one education and small group information dissemination. In July 2018, the clinic hosted their first safeTALK training that teaches participants to recognize and engage persons who might be having thoughts of suicide and to connect them with community resources trained in suicide intervention; 14 community participants attended. A regional gathering of tribal organizations and facilities was also held that provided educational workshops related to patient engagement in community-based wellness interventions.

In the Santa Barbara region, Casa de La Raza established ongoing Spanish speaking community groups called "Cafecitos". Their other outreach efforts, include their work with the Family Resource Center. The groups are fully active and have a consistent flow of families coming in for support and will be reviewing the length and quantity of weekly groups in FY 18-19 by testing bi-weekly meetings that are shorter in duration.

Program Performance (FY 17-18)

Outreach Events			
PROGRAM*	**LCDLR**	**SYTHC^**	**CHCCC**
TOTAL # EVENTS	**93**	**41**	**181**
TOTAL # PARTICIPANTS	**523**	**390**	**6,310**
TOTAL # FAMILIES SERVED	**249**	*	**487**
EVENT TYPE			
Outreach	4	1	27
Training	12	40	43
Forum	5	0	7
Support Group	72	0	104
PRIMARY LANGUAGE OF EVENT			
English	0	*	0
Spanish	253 (groups only)	*	31 (groups only)
Other	0	*	0

*Data not reported by provider.

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 exceeded their contract goals by serving or "touching" thousands of individuals in North County through having many outreach events, trainings, and support groups. La Casa de La Raza also exceeded its contract goals and

served or “touched” over 500 individuals in South County. Santa Ynez Tribal Health Clinic served West County, and they served or “touched” almost 400 individuals through their outreach events.

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

PEI Early Childhood Mental Health (ECMH)	
Provider:	CALM, Santa Ynez Valley People Helping People (SYPHP)
Estimated Funding FY 2019/20:	
Estimated Total Mental Health Expenditures	$428,100
Estimated CSS Funding	$132,100
Estimated Medi-Cal FFP	$296,00
Estimated 1991 Realignment	$0
Estimated Behavioral Health Subaccount	$0
Estimated Other Funding	$0
Average Cost Per Consumer (185 Consumers)	$2,314

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 Team – CALM

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 seven, with a specific focus on the Latino 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. The Program services children who are experiencing emotional and behavioral problems.

CALM continues to use community outreach to share knowledge of child development and intervention strategies with the public and other community organizations. Some of these outreach engagements include: interfacing with public and private preschool programs, visiting the neonatal intensive care unit at Marion Hospital in Santa Maria, meeting with Perinatal Mood and Anxiety Disorders-PMAD Stakeholders at Marion Hospital, providing Disaster support counseling to schools impacted by fire and mudslides (Cold Spring, Cleveland, Adelante), fundraising for Ladies Get Loud at the Santa Maria Country Club, teaching YMCA Santa Maria parenting class on positive discipline techniques and presentations on Health and Well-Being and “Good

Touch/Bad Touch," Santa Maria Community Supporters presentation on ACEs and how CALM services address ACEs, a Lompoc Open House at Lompoc CALM office, Goleta Neighborhood Clinic, Integrative Care Unit, Compassionate Care of Carpinteria, Santa Barbara School District event for Father Involvement, Child Abuse Prevention Council Parent Leadership Awards and Trainings, Santa Barbara Response Network for Disaster Relief, Pathways to Success: 4 outreach events at local Junior Highs in Santa Maria, and a Suicide prevention parent meeting at Santa Maria elementary school.

Staff attended trainings on Perinatal Mood Disorders of Components of Care in San Luis Obispo, Using new technology to help with our jobs, Play Therapy, Parent Child Attunement Therapy, Client and Parent Engagement, Pathpoint Youth Services, LGBTQ training by Pacific Pride Foundation, Casa Pacifica's Safety Program, Behavioral Wellness Children's Clinic, the Child and Adolescent Needs and Strengths (CANS), Human Trafficking by the Rape Crisis Center, A nontraditional approach to treating traumatized children by Mariposa Project, The Effects of Adverse Childhood Experiences by California First Five, and Medi-Cal documentation. CALM's Psychiatrist continues to provide monthly consultations for the team.

Special Needs Counseling – Santa Ynez Valley People Helping People

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 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 17-18.

Program Performance

ECMH

	Unique Clients Served	
	North	**South**
Age Group		
0-15	90	83
16-25	1	2
26-59	3	5
60+	0	0
Missing DOB	0	0
Total	***94***	***91***
Gender		
Female	39	52
Male	55	39
Unknown	0	0
Ethnicity		
White	5	7
Hispanic	87	80
African American	1	1
Asian/Pacific Islander	1	0
Native American	0	0
Other/Not Reported	0	3

	SYVPHP
Provide 30 parenting education and support groups to families/Parents	36 (120%)
Provide 80 screenings and assessments to families presenting with mental health issues	123 (153%)
Provide developmental screenings to 45 children	58 (128%)
Provide 60 referrals to Family Services Coordinators for case management and linkages/referrals to other needed services	69 (115%)

During fiscal year 2017-2018, SYVPHP provided 36 parenting education and support groups (Nurturing Parenting curriculum; three series), 123 screenings and assessments, 58 developmental screenings to children, and 69 referrals and linkage for additional services.

Client Outcomes

	CALM	
	Average per quarter	
New out-of-primary home placements	0.5%	
Stable/Permanent Housing	92.5%	
	Annual	
Children's average level of internalizing behavior will decrease from the 75th percentile to the 50th percentile within 6 months of treatment, as measured by the Child Behavior Checklist.	51st percentile	
Children's average level of externalizing behavior will decrease from the 75th percentile to the 50th percentile within 6 months of treatment, as measured by the Child Behavior Checklist.	47th percentile	
Parent's average level of parenting-related stress will decrease from the 75th percentile to the 50th percentile within 6 months of treatment, as measured by the *Parenting Stress Index*.	49th percentile	
Increased knowledge of child development (care, nutrition, discipline)	100%	
Increased knowledge of resources	100%	
Families linked to services	100%	
	North	**South**
Incarcerations/Juvenile Hall	--	--
Psychiatric Inpatient Care	0%	0%

More detailed information required for PEI reporting is also provided in the PEI Summary (Attachment 1). People Helping People has objectives related to their program goals of providing education, screenings, and linkage/referrals. They exceeded their contract expectations in all areas.

During fiscal year 2017-2018, CALM served 190 families; 65 more than the contracted 125 families. Very few clients had new out-of-primary home placements and 93% had stable or permanent housing. After six months in treatment, children served in their ECMH program fell in the 51st percentile for internalizing behavior and the 47th percentile for externalizing behavior. After six months of treatment, parents' parenting stress fell in

the 49th percentile, and 100% of parents experienced increased knowledge of children development and resources, as well as linkage to appropriate services.

It is important to note that data examining higher levels of care reflect any inpatient psychiatric care throughout the year, regardless of when in the year the client participated in the program. Thus, an inpatient stay that led to a subsequent program entry would still count as a hospitalization. Further, incarceration/juvenile hall data were unavailable this year and we are unable to report on these metrics. No clients enrolled in ECMH experienced psychiatric inpatient care, which makes sense given that this program serves very young children.

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

School-Based Prevention/Early Intervention Services for Children and TAY (START)	
Provider:	Family Services Agency, Council on Alcoholism and Drug Abuse
Estimated Funding FY 2019/20:	
Estimated Total Mental Health Expenditures	$502,600
Estimated CSS Funding	$354,400
Estimated Medi-Cal FFP	$148,200
Estimated 1991 Realignment	$0
Estimated Behavioral Health Subaccount	$0
Estimated Other Funding	$0
Average Cost Per Consumer (100 Consumers)	$5,026

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

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

Program Performance (FY 17-18)

START

	Unique Clients Served
	South
Age Group	
0-15	84
16-25	16
26-59	0
60+	0
Missing DOB	0
Total	***100***
Gender	
Female	40
Male	60
Unknown	0
Ethnicity	
White	20
Hispanic	77
African American	1
Asian/Pacific Islander	1
Native American	0
Other/Not Reported	1

Client Outcomes

Child & Adolescent Needs & Strengths Assessment (CANS) Age: 6-17 years	**Percent Improvement***	
	Initial to 6 months (n=27)	**6 to 12 months (n=12)**
Life Functioning (e.g., ability to communicate and interact with families, communication, social functioning and health status)	11%	15%
Behavioral/Emotional Needs (e.g., symptoms of depression, anxiety, psychosis and other conditions)	11%	1%
Child Risk Behaviors (e.g., self-injury, suicidal behavior, bullying, and running away)	-5%	16%
School (e.g., behavior, attendance and grades)	10%	4%
Caregiver Needs & Strengths (e.g., child supervision skills, family stress levels, residential stability, and caregiver physical/mental health status)	0%	1%
Child Strengths (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment)	4%	8%
Higher Levels of Care	**% with any admissions over FY 17/18**	
	South	
Incarcerations/Juvenile Hall	--	
Psychiatric Inpatient Care	0%	

**"Percent improvement" for CANS scores reflects the % change between the group's mean scores.*

In the 2017-2018 fiscal year, clients in the START program had initial, 6-month and 12-month CANS data. About half as many clients had 12-month data as had 6-month data. Modest gains were seen in child life functioning, behavioral/emotional needs, school, and child strengths over the year. Interestingly, initially client risk behaviors seemed to worsen slightly in the first six months and then improved in the second six months of treatment. Consistent with other child programs, caregiver needs and strengths did not demonstrate improvement.

It is important to note that data examining higher levels of care reflect any inpatient psychiatric care throughout the year, regardless of when in the year the client participated in the program. Thus, an inpatient stay that led to a subsequent program entry would still count as a hospitalization. Further, incarceration/juvenile hall data were unavailable this year and we are unable to report on these metrics. No clients enrolled in START experienced psychiatric inpatient care over the year.

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

PEI Early Detection and Intervention Teams for Transition-Age Youth (TAY)	
Provider:	Behavioral Wellness
Estimated Funding FY 2019/20:	
Estimated Total Mental Health Expenditures	$1,179,900
Estimated CSS Funding	$0
Estimated Medi-Cal FFP	$1,179,900
Estimated 1991 Realignment	$0
Estimated Behavioral Health Subaccount	$0
Estimated Other Funding	$0
Average Cost Per Consumer (202 Consumers)	$5,841

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 TAY consumers who are at risk for serious mental illness, or were diagnosed within the past 12 months. The target population also includes individuals who are homeless and/or experiencing co-occurring mental health and substance abuse conditions. Youth are typically served for approximately one year.

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

- Care management;
- Crisis assessment and intervention;
- Housing services and supports;
- Activities of daily living support;
- Employment and educational support;
- Community integration;

- Peer and support services;
- Symptom assessment/self-management;
- Individual support;
- Substance abuse/co-occurring conditions support;
- Medication management;
- Coordination with primary care and other services.

The staffing involves Psychiatrist, Psychiatric Technician, practitioners, case workers and extra help TAY peers. The staff are trained with evidenced based model of First Episode Psychosis (FEP) focusing on the use of the TIP model. The staff are trained annually to ensure fidelity of the program.

Youth empowerment services is 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 TAY population.

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, lack of substance abuse treatment resources, and the lack of specific TAY housing resources. Some long term solutions may be to develop a Full Service Partnership program for TAY that can increase field based, 24/7, outreach type of services for this group. This is one of the proposals of this Three Year Plan.

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.

Additionally, an Innovations project for modern methods of outreach and peer support being implemented for mobile apps which will target 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 coordination 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.

Program Performance (FY 17-18)

PEI Early Detection & Intervention

Unique Clients Served			
	North	**South**	**West**
Age Group			
0-15	0	0	5
16-25	61	75	58
26-59	1	2	0
60+	0	0	0
Missing DOB	0	0	0
Total	***62***	***77***	***63***
Gender			
Female	32	33	38
Male	30	43	25
Unknown	0	1	0
Ethnicity			
White	9	20	16
Hispanic	50	50	38
African American	2	0	4
Asian/Pacific Islander	0	0	2
Native American	0	0	0
Other/Not Reported	1	7	3

Client Outcomes

Child & Adolescent Needs & Strengths Assessment (CANS) Age: 6-17 years	**Percent Improvement***	
	Initial to 6 months (n=12)	**6 to 12 months (n=3)**
Life Functioning (e.g., ability to communicate and interact with families, communication, social functioning and health status)	5%	30%
Behavioral/Emotional Needs (e.g., symptoms of depression, anxiety, psychosis and other conditions)	-3%	-38%
Child Risk Behaviors (e.g., self-injury, suicidal behavior, bullying, and running away)	-13%	-22%
School (e.g., behavior, attendance and grades)	29%	-40%
Caregiver Needs & Strengths (e.g., child supervision skills, family stress levels, residential stability, and caregiver physical/mental health status)	-7%	10%
Child Strengths (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment)	-1%	9%
Milestones of Recovery Scale (MORS) Age: 18+		
	Initial to 6 months (n=105)	**6 to 12 months (n=79)**
Showed improvement^	47%	33%
Remained stable^	34%	47%

Higher Levels of Care	% with any admissions over FY 17/18		
	North	South	West
Incarcerations/Juvenile Hall	--	--	--
Psychiatric Inpatient Care	4%	16%	6%

**"Percent improvement" for CANS scores reflects the % change between the group's mean scores.*
^"Showed Improvement" and "Remained Stable" reflects the percent of clients whose MORS scores improved or stayed the same between time periods.

In the 2017-2018 fiscal year, clients in the PEI Early Detection and Intervention Program had initial, 6-month and 12-month CANS and MORS data. Percent improvement in the CANS varied across time periods from -40% to 30%. The large variability in these numbers is due to the low number of clients who were eligible for a CANS. In fact, because only three clients were administered a 12-month CANS, the data should not be interpreted. Examining the twelve clients with initial and 6-month data, improvements were seen in school, and caregiver needs and strengths worsened. Looking at the MORS, which the majority of clients completed, 80% of clients in both halves of the year were either stable or made improvements. In fact, almost half showed improvement in the first half of the year, and a third showed improvement in the latter half of the year. Conversely, a third were stable in the first half of the year while almost half were stable in the second half of the year.

It is important to note that data examining higher levels of care reflect any inpatient psychiatric care throughout the year, regardless of when in the year the client participated in the program. Thus, an inpatient stay that led to a subsequent program entry would still count as a hospitalization. Further, incarceration/juvenile hall data were unavailable this year and we are unable to report on these metrics. Clients in North and West County had similar levels of hospitalizations (4% and 6%, respectively), while South County clients were more likely to be hospitalized over the year (16%).

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

Safe Alternatives for Children and Youth (SAFTY) Crisis Services	
Provider:	Casa Pacifica
Estimated Funding FY 2019/20:	
Estimated Total Mental Health Expenditures	$1,030,600
Estimated CSS Funding	$611,600
Estimated Medi-Cal FFP	$419,000
Estimated 1991 Realignment	$0
Estimated Behavioral Health Subaccount	$0
Estimated Other Funding	$0
Average Cost Per Consumer (1080 Consumers)	$954

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. SAFTY provides quick and accessible service to families by providing specialized crisis intervention, in-home support and linkage to

County behavioral health or other appropriate services. By working in collaboration with the child's existing service providers, SAFTY seeks to keep children, youth and families safe in their homes and communities. SAFTY served over one thousand individuals between July 1, 2017 and June 30, 2018; approximately 43% were male.

Program Challenges and Solutions

In prior years, SAFTY staffing was sometimes inadequate 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 supported SAFTY moving to a per diem model, which allows rapidly deploying additional staff when the need is high along with changing the hours of operation and responsibilities related to aftercare. The implementation of expanded crisis services as previously described, including the Crisis Services Teams, has helped to alleviate some of SAFTY's workload. Behavioral Wellness and Casa Pacifica negotiated changes to their contract including reducing some supervisorial staff and increasing line staff. Hours of operation were also changed so that SAFTY operates between the hours of 8am to 8pm seven days per week. Behavioral Wellness Crisis Services staff respond to child/adolescent crisis situations between 8pm and 8am and are adding assigned children's staff coverage for walk ins in the PEI Access/Assessment teams in FY 19-20 to ensure adequate linkages to care. This reduction in SAFTY coverage hours allows for greater staffing during busier daytime hours which has helped with improving response times and a greater percentage of face-to-face evaluations vs. phone screenings.

To date, some local hospitals continue to decline granting SAFTY hospital privileges. To avoid having Crisis Services staff respond to all hospital emergency room calls with person's under 21 years of age, Crisis Services staff requested and are now allowed to escort SAFTY staff into the Emergency Departments. SAFTY staff conduct the 5150 evaluations with Crisis Services staff observing. SAFTY has initiated meetings with the emergency rooms to enhance relationships and discuss barriers. In addition, the Children's Crisis Triage Program will provide onsite services in emergency rooms in all three regions with mental health practitioners and parent peer partners.

Program Performance (FY 17-18)

SAFTY

	Unique Clients Served		
	North	**South**	**OOC***
Age Group			
0-15	391	199	46
16-25	230	163	51
26-59	0	0	0
60+	0	0	0
Missing DOB	0	0	0
Total	***621***	***362***	***97***
Gender			
Female	354	218	47
Male	267	144	50
Unknown	0	0	0
Ethnicity			
White	181	91	21
Hispanic	285	136	51
African American	17	5	1
Asian/Pacific Islander	6	6	1
Native American	2	2	0
Other/Not Reported	130	122	23

Client Outcomes

	Total
Contact Type	
Total Calls	2,220
Face to Face	575
Reason for Calls	
Aggression Towards Others	3%
Increase in Mental Health Symptoms	15%
Oppositional Behavior	3%
Peer/Family Conflict	2%
Resources/Access to Service	8%
Substance Use/Abuse	0%
Homicidal Ideations	2%
Suicide Attempt	5%
Suicidal Ideation	36%
Self-Injurious Behaviors	6%
In-Person Follow Up	0%
5150/5585 Re-Assessment / Bed Search	7%
Other	15%
Hospitalization	
Clients with No Hospital Admission	93%
Hospitalization Rate on Calls	9%

SAFTY also reports their own call characteristics to Behavioral Wellness. In the 2017-2018 fiscal year, SAFTY reported that the program received a total of 2,220 calls, 575 of which had an in-person response. The most common reason for a call was suicidal ideation; these accounted for over one-third of all calls. The next most common reason was an increase in mental health symptoms (15%), seeking resources (8%), a 5150/5585 re-assessment (7%), self-injurious behaviors (6%), and suicide attempts (5%). In examining hospitalization, two rates of hospitalization are provided. *Clients with No Hospital Admission* shows the percent of clients SAFTY served who also did not have any hospitalizations over the fiscal year. Compared to last fiscal year, SAFTY clients had reduced rates of hospitalization: from 88% to 93% of clients were not hospitalized. *Hospitalization Rate on Calls* examined calls that were designated as crisis, which were 77% of all calls. Nine percent of crisis calls with SAFTY led to hospitalization.

Access and Assessment Teams – Behavioral Wellness

Access And Assessment Teams	
Provider:	Behavioral Wellness
Estimated Funding FY 2019/20:	
Estimated Total Mental Health Expenditures	$3,698,400
Estimated CSS Funding	$3,153,500
Estimated Medi-Cal FFP	$544,900
Estimated 1991 Realignment	$0
Estimated Behavioral Health Subaccount	$0
Estimated Other Funding	$0
Average Cost Per Consumer (857 Consumers)	$4,316

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 calls from new consumers requesting services. Callers are screened for appropriate assignment to a level of care within the system. Starting December 1, 2018, all substance use disorder calls are channeled through the Access Line. The access and assessment component handled by the three Access and Assessment teams now focuses on performing assessments on new consumers referred by the Access screeners, as well as initial assessments for walk-in consumers, and for hospital discharge appointments.

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

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

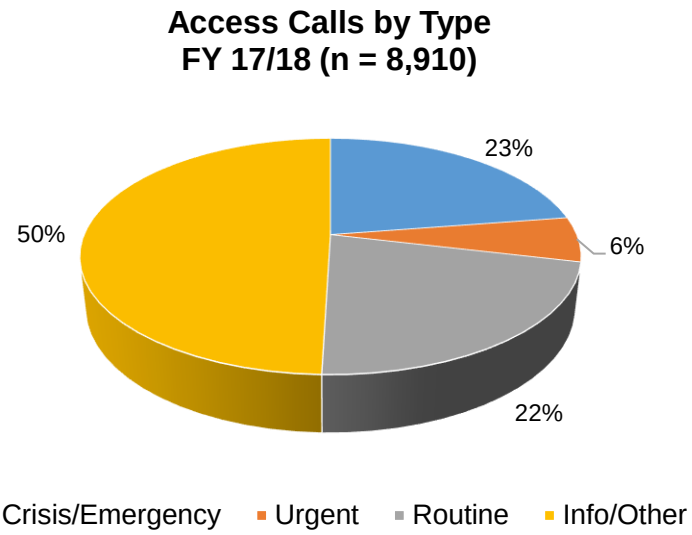
Program Challenges and Solutions

Behavioral Wellness centralized the Access call center within the Office of Quality Care Management by routing all Access calls to one place. Staff dedicated to this function were hired and trained. The hope was to allow staff in each of the Adult and Children's/youth Clinics (Santa Barbara, Lompoc, and Santa Maria) to conduct more scheduled assessments and referrals through orientation group process. However, the calls to the access line at times are too great, that it leads to the increase of walk-ins at both the adult and children's clinics. Each team in Santa Barbara, Lompoc, and Santa Maria is bicultural and bilingual. An Access template within the EHR is used to track timeliness continues to be utilized across the Department to monitor access improvements.

The existing staff in each clinic, adult, youth, or crisis centers rotate as officers of the day that are available for walk-in urgent care. This allows for all urgent services to be offered/provided the same day/next day to help support clients and hopefully avoid crisis situations, however this also takes away from ongoing care needs. The hope is to add Access and Assessment staff to the children's clinics to help standardize and streamline the access process.

In the last Three Year Plan Stakeholder process, Access and Assessment staffing was not included for the Children's and TAY clinics. The same staff that are providing ongoing treatment to consumers respond to walk-ins and ongoing intake and assessment duties- causing an impact on the services for ongoing consumers. As a result, in FY 19-20 staff will be assigned for children and TAY access duties rather than staff in the clinics rotating this role which will hopefully improve timeliness to care.

Access Line Program Performance (FY 17-18)



Access Line: Timeliness		Quarter				Average
		Q1	Q2	Q3	Q4	
Routine	offered an appointment within 14 days	87%	73%	79%	78%	**79%**
Urgent	offered an appointment within 24 hours	72%	84%	91%	90%	**84%**
Crisis	offered an appointment within 24 hours	86%	98%	98%	98%	**95%**

Access Line Client Outcomes

About half of all calls to the Access line were requests for information or designated as "other." In examining calls that requested services, an additional metric that is considered is timeliness of offered appointments. Almost a quarter of calls were considered a crisis or emergency, and of these, an average of 95% of clients were offered an appointment within 24 hours. Additionally, since the second quarter, 98% of clients have been offered an appointment within 24 hours, suggesting that there have been sustained improvements in this metric. Six percent of calls were considered "urgent" and documentation of appointment offer within 24 hours also steadily improved over the year, from 72% in the first quarter to 90% in the fourth quarter. Finally, almost a quarter of calls were considered "routine," and over three-quarters of these calls were offered an appointment within two weeks.

Access & Assessment Teams Program Performance (FY 17-18)

Unique Clients Served			
	Access & Assessment		
	South	West	North
Age Group			
0-15	0	0	0
16-25	12	16	112
26-59	111	149	375
60+	22	12	48
Missing DOB	0	0	0
Total	***145***	***177***	***535***
Gender			
Female	50	100	280
Male	91	77	255
Unknown	4	0	0
Ethnicity			
White	76	90	222
Hispanic	38	60	273
African American	6	16	22
Asian/Pacific Islander	3	3	7
Native American	2	2	1
Other/Not Reported	20	6	10

Access & Assessment Teams Client Outcomes

	South	West	North
Incarcerations/Juvenile Hall	**--**	--	--
Psychiatric Inpatient Care	11%	5%	8%

In the 2017-2018 fiscal year, the Access and Assessment Team in North County saw three times as many clients as the team in Lompoc, and almost four times as many clients as the team in 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 may screen more Medi-Cal clients who are then ultimately referred to Holman or the community for a lower level of service intensity.

It is important to note that data examining higher levels of care reflect any inpatient psychiatric care throughout the year, regardless of when in the year the client participated in the Program. Thus, an inpatient stay that led to a subsequent Program entry would still count as a hospitalization. Further, incarceration/juvenile hall data were unavailable this year and we are unable to report on these metrics. Clients in West County had the lowest levels of hospitalizations (5%), while South County clients had the highest (11%), and North County fell in the middle (8%). Because the Access and Assessment screeners are often used for psychiatric hospital discharge

appointments, it may make sense that these numbers are higher than most other programs, and that numbers in South County are the highest. Because the PHF is located in South County, a client is more likely to be discharged immediately to a South County Access and Assessment appointment, receive an intake assessment, and then be linked to the appropriate program in their own region. Further, because clients in South County are more likely to have a psychiatric hospitalization, these numbers are consistent with other regional differences.

Innovation

Resiliency Interventions for Sexual Exploitation (RISE) Project

Resiliency Interventions for Sexual Exploitation Project (RISE)	
Provider:	Behavioral Wellness
Estimated Funding FY 2019/20:	
Estimated Total Mental Health Expenditures	$1,461,100
Estimated CSS Funding	$1,308,500
Estimated Medi-Cal FFP	$152,600
Estimated 1991 Realignment	$0
Estimated Behavioral Health Subaccount	$0
Estimated Other Funding	$0
Average Cost Per Consumer (70 Consumers)	$20,873

Resiliency Interventions for Sexual Exploitation (RISE) was initially funded (2.6 Million) for three years in 2015 and recently received a two-year extension and additional funding (2.6 million) through June 30, 2020. The RISE Project provides bio-psycho-social support services to children and youth exposed to or at risk of sexual exploitation and trafficking. The approach relies on interagency collaboration and multi-layered treatment, training, and education that include partners throughout the community. As RISE is still in the "innovation" phase, a comprehensive gender specific and trauma-informed model of services, supports, resources, protocols, education, and training is continually being developed, implemented, and tested.

RISE services are offered countywide to target populations residing in the Santa Maria, Lompoc, and Santa Barbara regions of Santa Barbara County. Due to a higher rate of sexual exploitation and sex trafficking activity, the Santa Maria and Lompoc regions have been allotted more resources and focus. The priority populations served by the RISE Project are females and LGBT/GNC youth 10-24 and their families, specifically underserved African-Americans, Asian/Pacific Islanders, Latinas, indigenous Native Americans, and those identified as LGBT/GNC at risk of sexual exploitation or trauma; identified as Commercially Sexually Exploited Children (CSEC); or at risk of out-of-home placement, are residing in Juvenile Hall, foster care or group homes or "runaway youth".

The core principles of RISE are EMPOWERMENT and RESTORATION achieved through a non-judgmental/non-shaming "survivor-driven", community and system based service delivery program. Simply put, RISE meets youth where they are, both figuratively and literally. Each youth's unique strengths, needs and preferences will be assessed through a comprehensive trauma-informed screening process designed to identify several biopsychosocial and "hierarchy of needs" factors including, trauma related symptoms, risk/protective factors, safety, socioeconomic/cultural/spiritual background, natural supports, education, AOD supports, medical/reproductive needs, housing/placement, vocational/pro-social, legal restoration and readiness for

engagement. RISE works toward supporting each youth to find their own sense of self, hope, purpose and belonging so she/he/they can become empowered in their own destiny.

Components of RISE:

- An extensively **CSEC trained trauma-informed culturally aware team**
- **Client/Family Driven** goal identification and treatment planning
- **Clinical Lead**: Licensed behavioral health clinician who is specifically trained to work with sex trauma and sexual exploitation survivors/victims
- **System Navigator**: A member of RISE who has built rapport with each youth to ensure consistent and easy access to services through providing transportation, "warm handoffs", and advocacy within the child welfare, juvenile justice, educational, medical and mental health systems
- **Health and Wellness Advocate**: A licensed medical professional to attend to medical, reproductive, AOD and overall physical wellness. Physical health is greatly impacted by childhood trauma and attending to the biological health needs is paramount to assist in restoration
- **Rehabilitation Specialist**: An experienced practitioner that conducts extensive outreach and engagement and will work with each youth on developing a plan which includes numerous community based resources/supports to address vocational, pro-social and educational restoration and reintegration
- **Peer/Survivor Support:** A trained peer or survivor that can provide a unique parallel and empathetic perspective as well as act as a role model and advocate
- **Biopsychosocial Treatment Model** focusing on wellness, resilience and recovery supports which attend holistically to each youth through a biological, social, psychological, spiritual, cultural, and strengths based approach
- **CSEC Hierarchy of Needs** to address environmental needs, basic necessities and inalienable human rights i.e., food, clothing, shelter, safety, love, belonging, purpose, self-esteem and self-actualization
- **Coercion Resiliency** through Runaway Youth/Ending the GameTM program
- **Comprehensive Assessment, Screening and Identification Tools** that are culturally sensitive and trauma-informed. RISE helped to create a Santa Barbara County multi-collaborative "First Responder CSEC Identification Tool"
- **Non Traditional and Easy Access** to services, providers and supports through 24/7 crisis hotlines, mobile intake/treatment, flexible scheduling, transportation to and from appointments/supports, "warm hand-offs" and welcoming intake process
- **Non-Judgmental and Non-Shaming:** RISE will provide a "safe haven" for trauma exposed and exploited youth where they feel free to express themselves in an environment free of shame or judgment
- **RISE Center:** Outside of scheduled classes, groups, wellness activities and counseling, RISE provides a welcoming home-like setting for our youth to come and rest, make a meal, talk to their support team, work on projects, listen to music or obtain reproductive/hygiene/educational supports even if they don't have an appointment
- **Outcome Measures** and ongoing multi-agency CQI/QA (Continuous Quality Improvements/Quality Assurance). RISE Project will also collect data on service delivery fidelity and outcomes to test for programmatic efficacy. We believe RISE can be used as a learning tool for providers to develop more effective ways of successfully treating this high risk population and provide insight into preventative measures
- **Early Intervention** to address ways to make our youth more resilient and knowledgeable in order to make them less susceptible to victimization (early social emotional skills training, social media awareness for youth and parents)
- **Outreach** for unidentified and underserved trauma exposed youth

- **Shelter/Placements:** RISE has contracted with Uffizi to seek out ways to fund and furnish 2-3 apartments to provide temporary to longer term shelter/placements for sexually exploited females between the ages of 18-25
- **Flexible Funds** effort to create a way to support non-traditional needs for CSEC that are not typically funded through other resources
- **Psycho-education and Trainings** to improve CSEC identification and Trauma/CSEC informed interventions and protocols county wide
- **Multi-Disciplinary Teams:** RISE regularly facilitates or participates in MDT's and is an active member in SB County District Attorney's HART Court ("*Helping Achieve Resiliency Treatment*"; a multi-disciplinary treatment team for CSEC youth involved in the Juvenile Justice system)

Program Challenges and Solutions

There has been a challenge in finding temporary and permanent safe shelter/placements for Commercially Sexually Exploited Children (CSEC) (under 18 victims/survivors of sexual exploitation) and Adult (18-24yo) survivors of sexual exploitation. Runaway and/or homelessness are the number one vulnerability factors that increase the likelihood of sexual exploitation. Behavioral Wellness-RISE is currently partnering with community groups and partners, which are working specifically on finding safe and "homelike" shelters and placement options for victims and survivors of sexual exploitation. Through sexual exploitation community collaboratives, County Partners and Behavioral Wellness RISE, shelter/placement solutions were successfully funded and launched in early 2018. Behavioral Wellness RISE continues to strongly support and participate in the development and coordination of placements at these new locations. RISE has been able to assist in placing several exploitation survivors/victims in Santa Barbara County shelter and placements.

New Senate Bill 855 mandates significant CSEC Administrative protocols that require increased resources. Current RISE staffing is insufficient to meet the needs of growing intensive caseloads and the lack of other community supports. In response to this challenge, the Department has partnered with SB County Law Enforcement, Child Welfare Services, Juvenile Probation, Public Health, Juvenile Court, North County Rape Crisis, Standing Together to End Sexual Assault (STESA), and the District Attorney's Victim Witness Program to receive Tier II CSEC funds. This multi-disciplinary team discusses possible CSEC administrative support through this collaborative. RISE has also been collaborating with the Victim Witness/District Attorney/Human Trafficking Task Force, which also is assisting with the SB855 Multi-Disciplinary Team/Treatment mandates. The RISE Project remains an active and central participant in development of exploitation protocols and procedures, providing trauma informed and timely services to victims/survivors. Although the multi-disciplinary process has made some recent gains, it is labor intensive and requires more resources from all partners to better address the growing demand for services and trainings in our community.

The Department has identified larger numbers of CSEC clients than originally expected, and the CSEC population's needs are higher and more complicated than expected, including initial outreach and engagement prior to agreement for services. The RISE Project has found it difficult to find staff with experience or provide the extensive training necessary to meet the needs of this particular population. One solution would be to expand the program or merge it into an existing Full Service Partnership after the two year extension ends in June 2020. In order to best develop the programming and a sustainable model, continued evaluation of services based on RISE unique demands and treatment models will be necessary.

A recent study found that three in ten children currently served by Santa Barbara County partners are at risk of sexual exploitation and trafficking in Santa Barbara County, thus requiring a larger review of services and

development of a long term multi-disciplinary and multi-agency strategy using RISE established practices. In practice, it has been difficult to accurately count clients receiving RISE services through existing electronic health records because clients often do not consent to be opened within the RISE Program but do receive outreach and engagement services. RISE has addressed this problem by keeping their own data on the clients they serve and working with the University of California Santa Barbara to collect additional outcome data (data from both sources are presented in the *Program Performance* and *Outcomes* sections). Additionally, because client location is identified through electronic health records by the location of service (often juvenile hall or a group home in North County), data from the electronic health record often do not reflect the place of origin of clients. In fact, West County has the highest rates per capita of CSEC youth.

Future Directions & Sustainability

The request for extension funding was granted for an increase of $2,600,000 for two additional years of programming from July 2018 – June 30, 2020. During this time, RISE will continue to develop program components and evaluation protocols. The extension addresses six principle areas:

(1) *Additional time.* Start-up of the Program began slowly as initial infrastructure, staffing, and agreements between community partners were established. The process was labor- and time-intensive.

(2) *Additional funding.* Delays in start-up and the fact that outreach and engagement activities took longer than initially anticipated have meant that RISE goals have not been fully realized. The funding enables us to:

- *Develop a practical toolkit, "How to Develop an Effective Multi-Disciplinary Approach for Exploited Youth"* to help other counties replicate the Program, avoid the costly and lengthy approach of "reinventing the wheel" and gain the capacity to effectively deal with common barriers to success.
- *Meet an urgent and ongoing community need by continuing the Program*, including staffing, operations, and evaluation, including continued work by the Behavioral Wellness' evaluation team partners with the University of California at Santa Barbara.
- *Deploy the recently developed multi-agency shared screening and assessment tool* to review usefulness across all systems.
- *Continue training, education, and public awareness* regarding signs and risk of mental illness related to sex trafficking for 2,660 individuals.
- *Develop trauma-sensitive crisis interventions available 24/7 to a larger number of survivors* in community because the need is greater than originally anticipated.
- *Increase Survivor Mentor outreach/supports* through partnership with Runaway Youth/Carissa Phelps.
- *Continue safe and therapeutic housing, temporary shelter and relocation efforts.* Resources are low, and costs are high. We have established partnerships with Good Samaritan Safe House for adult survivors, Salvation Army, and Carpinteria SAFE House for youth under 18.
- *Increase outreach and engagement efforts for LGBT/GNC CSEC youth*. RISE and the University of California, Santa Barbara (UCSB) are in the process of finalizing the LGBT/GNC tool, which will facilitate data collection for this mostly un-researched, high-risk CSEC population.
- *Continue to provide specific specialized treatment space in all regions of county*.

(3) *Respond to community need by serving a larger population*. With increased training on exploitation and new education and screening efforts, we've observed a marked increase in youth identified with risk factors. According to local Child Welfare data (CSE-IT Tool), an estimated three in 10 youth involved in Santa Barbara County Juvenile Probation and Child Welfare systems are at risk for trafficking, substantially greater than the regional average of one in 10. We have encountered a higher than expected population of exploitation victims age 18 and over exploitation victims with significant alcohol and other drug issues, domestic violence, developmental and/or cognitive and legal issues. Resources for adult exploitation victims have significant resource gaps compared to minor victims in our community. Also, migrants subjected to sex and labor trafficking are higher than expected and particularly difficult to reach due to their increased fear related to immigration issues/climate. Effective service delivery to this population require specialized culturally-specific efforts and cross-agency collaboration.

(4) *Effectively document and share critical learning.* Determine if cross-agency collaborations result in improved recognition and response to survivors' mental health issues. We are using several baseline tools (ACE, SEHS, CANS, MAYSI, SBARA, arrest records, the length and frequency of incarceration and placement stability reports and consumer surveys). The University of California, Santa Barbara is in the process of gathering and assessing the data, but we need more consistent participation and larger sample size. We have found that youths involved in the Juvenile Justice (JJ) system need more intensive outreach and engagement supports than youths in Child Welfare and those not involved in the system.

(5) *Create a shared database* with partner agencies to improve identification efforts, data collecting, ensure proper and timely service delivery.

(6) *Complete the collaborative development of Medical Community ID Tool* (currently in process with the University of California, Santa Barbara, Public Health, Dr. Carrick Adam and Cottage Hospital). Our exploited youth have higher-than-expected medical needs and have often had numerous contacts with medical professionals prior to being identified as CSEC and obtaining help.

Sustaining RISE

The County continues to plan to create an MHSA community support or Full Service Partnership Program with the capability to be reimbursed by Medi-Cal for billable expenditures for TAY (See Three Year Plan Proposal in this document). Additionally, RISE performs Access and Assessment- outreach engagement, and linkage services which are more Prevention and Early Intervention strategies. This will be reviewed with additional children focused staffing in FY 19-20 in Access and Assessment teams. The additional value of extending this for two years will be determining best methods and approaches to serving victims of human trafficking, but also provide prevention to those at risk of trafficking. The tools established in Santa Barbara County are being reviewed as possible best practices and may be replicated in other counties or States. The Program receives a large demand due to community collaboration and the number of those whom are victims of trafficking in our county is growing.

Program Performance (FY 17-18)

In addition to data collected by the Department of Behavioral Wellness, RISE has a partnership with the University of California, Santa Barbara (UCSB) to provide an extensive and comprehensive program evaluation. Data from both sources are presented, though it should be noted that data from the electronic health records system (Clinician's Gateway) is an underestimate of the number of clients served. This is because clients often do not consent to be opened as RISE clients, but engage in RISE outreach services. Sometimes they are concurrently a part of a different County mental health program. Therefore, data provided by UCSB and the RISE program are also provided.

RISE (Resiliency Interventions for Sexual Exploitation Project)

	Unique Clients Served
	All Regions*
Age Group	
0-15	20
16-25	50
26-59	0
60+	0
Missing DOB	0
Total	***70***
Gender	
Female	67
Male	1
Unknown	2
Ethnicity	
White	9
Hispanic	51
African American	1
Asian/Pacific Islander	2
Native American	2
Other/Not Reported	5

**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) Age: 6-17 years	**Percent Improvement***	
	Initial to 6 months (n=24)	**6 to 12 months (n=10)**
Life Functioning (e.g., ability to communicate and interact with families, communication, social functioning and health status)	26%	-2%
Behavioral/Emotional Needs (e.g., symptoms of depression, anxiety, psychosis and other conditions)	24%	11%
Child Risk Behaviors (e.g., self-injury, suicidal behavior, bullying, and running away)	13%	6%
School (e.g., behavior, attendance and grades)	45%	19%
Caregiver Needs & Strengths (e.g., child supervision skills, family stress levels, residential stability, and caregiver physical/mental health status)	0%	-1%
Child Strengths (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment)	3%	3%

Higher Levels of Care	**% with any admissions over FY 17/18**		
	North	**South**	**West**
Incarcerations/Juvenile Hall	**--**	--	--
Psychiatric Inpatient Care	3%	22%	16%

**"Percent improvement" for CANS scores reflects the % change between the group's mean scores. ^"Showed Improvement" and "Remained Stable" reflects the percent of clients whose MORS scores improved or stayed the same between time periods.*

In the 2017-2018 fiscal year, clients in RISE had initial, 6-month and 12-month CANS data. Less than half of clients had 12-month data as had 6-month data. Overall, clients made more gains in the first six months of program than in the second, but remained stable and exhibited small gains or stabilization in the second six months (*It is important to note that CSEC youth tend to have numerous relapses and returns to treatment in the first 12-18 months*). The largest gains were made in school, where clients' average scores improved by 45% in the first six months and 19% in the second six months of program. Consistent gains were also seen over both time periods in behavioral/emotional needs and child risk behaviors. Life functioning initially improved by 26%, and then stabilized in the second half of the year. Caregiver needs and strengths, and child strengths both exhibited minimal to no change over both time periods.

It is important to note that data examining higher levels of care reflect <u>any</u> inpatient psychiatric care throughout the year, regardless of when in the year the client participated in the program. Thus, an inpatient stay that led to a subsequent program entry would still count as a hospitalization. Further, incarceration/juvenile hall data were unavailable this year and we are unable to report on these metrics. Clients in North County had the lowest levels of hospitalizations (3%), while South County clients had the highest rates (22%) and West County clients fell in the middle (16%).

University of California, Santa Barbara (UCSB) RISE Program Evaluation Results

RISE and UCSB also track RISE clients. The RISE Program reports that they served 102 unique clients during FY 17-18. Most recent outcome data available from UCSB captures all clients served through March 31, 2018.

Trauma History

RISE participants complete the Adverse Childhood Experiences (ACEs) Screener, which captures the experience of exposure to potentially-traumatic events including emotional, physical, or sexual abuse, domestic violence, and other family risk factors. Thirty RISE participants who were administered the ACE had an average ACE score of 5.43; 83% of clients scored 4 or higher and 50% scored 6 or higher. Studies have shown that people with four or more ACEs, compared to people with none, experienced much higher risk for health risk, health problems, and disease conditions.

Juvenile Justice History

RISE participants also had significant involvement with the juvenile justice system. Probation charges data were available for 51 RISE participants. The most common charges that led to probation were for crimes against persons and narcotics and drugs. Overall, 57 of the RISE youths were incarcerated at least once. The number of times youths were incarcerated ranged from zero to 22, with a mean of 6.44 incarcerations per youth (*SD* = 4.85).

The Santa Barbara Assets and Risks Assessment (SBARA) is a measure designed to assess a variety of risk factors and potential assets in delinquent youth to predict recidivism. Among youths who participated in RISE, SBARA scores ranged from 24.6 to 42.7 with a mean of 34.7 (*SD* = 4.35). Overall, 12.5% of youths were classified as Low Risk (*n* = 6), and 87.5% were classified as High Risk (*n* = 42).

Technology Suite: Technology Advance Access and Recovery

Technology Suite	
Provider:	Behavioral Wellness
Estimated Funding FY 2019/20:	
Estimated Total Mental Health Expenditures	$703,000
Estimated CSS Funding	$703,000
Estimated Medi-Cal FFP	$0
Estimated 1991 Realignment	$0
Estimated Behavioral Health Subaccount	$0
Estimated Other Funding	$0

People with behavioral health challenges are often stigmatized and isolated, which contributes to feelings of hopelessness, lack of treatment and unnecessarily high levels of hospitalization, incarceration, morbidity and mortality. On the other hand, when people are offered the social and therapeutic supports they need to live productive lives, limited law enforcement, acute care and social service resources will be available to others in need. Assisting individuals with behavioral health challenges with new pre-crisis options is cost- effective and beneficial to the community.

For decades, greater access to behavioral health services, including crisis response and crisis triage, as well as improved communications among clients, family members, clinicians and peer specialists have been top concerns of Santa Barbara County stakeholders. These concerns have been expressed over and over at Mental Health Services Act (MHSA) stakeholder forums, town halls, Mental Health Commission meetings and other venues.

Thanks to funding from MHSA and Senate Bill 82 (SB 82), in recent years the Santa Barbara County Department of Behavioral Wellness has substantially expanded crisis response and crisis triage services countywide. However, a great deal of work remains in increasing engagement of underserved, hard-to-reach and marginalized communities, improving communications and increasing access to services, especially at non-crisis levels.

Project Aim:

*Below is a description of this multi-county project

1) Initiate and sustain peer-to-peer digital communications (PPCPT)with members of each of the three at-risk and/or underserved target populations;
2) Decrease isolation and feelings of hopelessness among individuals in each of the three target populations; and
3) Reduce negative life events, such as hospitalization, visits to Emergency Rooms and incarceration among members of each of the three target populations.

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.

LEARNING OBJECTIVES:

1) Establish a system to monitor hospital, crisis stabilization, and crisis residential discharges of Behavioral Wellness clients and ensure that these individuals are offered PPCDT software and provided follow-up guidance and support in its use;
2) Reach Behavioral Wellness Adult Clients Residing in Geographically Isolated Areas;
3) Connect with TAY Enrolled in Colleges and Universities.

OBJECTIVES:

1) Establish peer chat support available 24/7 available in English and Spanish; link to department website and disseminate software;
2) Strategic approaches to access points that will expose individuals in target populations to the Peer to Peer Chat and Digital Therapeutics service; and
3) Outcome evaluations of all elements of the project, including research and outcomes.

On February 12th, 2019 the County of Santa Barbara Board of Supervisors approved the Technology Suite Personnel Resolution for FY 18-19 effective February 25, 2019 to add peer staffing. Data will be available in the MHSA Plan Update FY 2020-21 about hiring and initial implementation following project kick off.

MHSA Housing

The Department has worked to create a final housing development with these funds in partnership with local housing stakeholders. The MHSA Housing Program has supported major housing projects in each of the three largest cities in Santa Barbara County. Despite the number of units purchased, the Housing budget final allocation occurred this year to add 35 new Permanent supported housing units in Santa Maria.

Completed 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.

Current Project: Residences on Depot Street, Santa Maria

On February 11, 2016, a proposal for a new MHSA Housing allocation was posted for 30-day public review. There were two comments submitted in support of this project. In partnership with the Santa Barbara County Housing Authority, a site has been secured for The Residences at Depot Street in the city of Santa Maria in North County. The proposed mixed population development is an 80-unit project with 35 MHSA units. The groundbreaking occurred in September of 2018 and the project should be completed by September 2019. Instead of developing

the project in phases as initially contemplated, the revised plan is to build all 80 units continuously from start to finish. The distribution of unit type will include studios, one-bedroom, and two-bedroom units. Some units will be designated for homeless veterans. The project is supported by tax credits, other federal funds and MHSA. This development uses the remaining balance of Santa Barbara County's MHSA Housing funds.

The "No Place Like Home" Initiative

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

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

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

1) Non-competitive funds based on County population of homeless (Santa Barbara County's estimated allocation: $2.5 million)
2) Competitive funds which may be awarded, after application and analysis, out of a pool of funds for medium sized counties.

Santa Barbara start-up or "technical assistance" (TA) funds were granted and $50,000 of the $100,000 allocations was provided to the Housing and Community development department to renew the Santa Barbara plan to end homelessness.

Behavioral Wellness assisted in the creation of a Notice of Funding Available in collaboration with Housing and Community Development in Fall of 2018 and has received Letters of Intent from development partners wishing to participate in the No Place Like Home Program. Proposals will be formally vetted for site control and other requirements over the coming months with a target of application for funding in the 2nd No Place Like Home round in September of 2019.

Ongoing MHSA Funds will be diverted to create the bond funding. Santa Barbara anticipates $1.4M a year.

Workforce Education and Training (WET)

Consumer Empowerment and Peer Employment

Provider:	Behavioral Wellness
Estimated Funding FY 2018/19:	
Estimated Total Mental Health Expenditures:	$918,300
Estimated WET Funding	$157,300
Estimated Medi-Cal FFP:	$0
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$761,000

The Workforce Education and Training (WET) funding component was conceived to be time-limited; it is not a continuous source of funding like CSS, PEI and Innovation. To maximize the use of WET funding, we transferred many of the functions to the entire system of care including peer staff in outpatient clinics, capacity of our contract providers to hire peers and have trainings for staff, and creation of the Client and Family Member Advisory Committee (CFMAC) which has been meeting for at least 15 years. The remaining ongoing budgeted activities are supported by a transfer from Community Support Services (CSS) funding to WET to maintain the Consumer Empowerment Manager and Peer Employment activities.

As a result of the State reversion calculations, part of the peer empowerment manager position and twelve part-time employment opportunities for graduates of the WET Peer Specialist Training as Peer Expert Pool staff will be funded by WET through FY 19-20 and sustained by a transfer from CSS. Peer recovery specialists, peer navigators, and peer expert pool for special projects are examples of strategies used in FY 18-19. In Spring of 2018, a special projects hiring plan for peers was promoted during the MHSA Stakeholder process and other community venues. Resumes have been received, and continue to be submitted, and two special projects were assigned to assist in work skill development for peers seeking workforce growth.

In addition, in FY 18-19 a Training Coordinator started in Behavioral Wellness and created training opportunities for all peer employees and contract staff on Peer Support 101, Recovery, WRAP Plans, Resume and Hiring Tips, and assigned all supervisors in Behavioral Wellness Ethics, Boundaries, and Confidentiality. The Department held their first Peer Employee Forum in March 2018 to seek input on the technological suite innovations project using modern technology to connect individuals in the community, including peer linkages and digital chats. The peers requested more regular meetings, which the Department has scheduled on a quarterly basis through FY 18-19 and setting new goals for FY 19-20. In March 2019, staff attended the Southern Counties Regional Partnership (SCRP) Workforce Conference in Pomona, California. The Department acts as the fiscal agent for this project and staff assist in the coordination and preparation of the conference on behalf of ten Southern California counties. Included as part of the conference was a workshop for “Onboarding Peers, Recovery, and Core Competencies for Peer Employees.”

Highlight Cultural Competency Plan and Achievements/ Cultural Competency and Diversity

According to interpreter utilization data for 2017, Mixteco is the second-most prevalent language at Behavioral Wellness service sites. A Mixtec Culture and Mental Health training was created in response, to better engage our service providers with the Mixtec population.

Through partnerships made available by the Reducing Racial and Ethnic Disparities (RED) grant awarded to the department from the California Board of State and Community Corrections, UCSB led research has identified areas for growth. As result, customized implicit bias training focused on clinical assessment, diagnosis, and treatment practices within the behavioral health setting have been offered.

The 24/7 Access Line is key to ensuring all beneficiaries receive timely care and is staffed with both English and Spanish screeners. If a bilingual screener is not available or the caller speaks a language in which the screeners are not proficient, the department utilizes over-the-phone Language Line services, available 24/7 and in over 240+ languages.

Many new policies and procedures have been developed to address system-wide cultural competency. Some of these new policies include Non-discrimination, Accessibility for Persons with Disabilities, Notice of Adverse Benefit Determination, Mandatory "Cultural Competence Training," 24/7 provision of language capability through the Toll-free Access Line, and Network Adequacy Standards and Monitoring to ensure sufficient cultural competent service providers.

New contracts have been developed to assure availability of in-person interpretation needs for county-operated service locations. FY17-18 data for in-person interpretation shows that Spanish interpretation accounted for 95% of services, Mixteco followed by 4.3% and .7% was made of languages of lesser diffusion.

Behavioral Wellness has partnered with the American Indian Health and Services (AIHS) to address disparities in access to quality, culturally-appropriate mental health services to Native youth and families within Santa Barbara County.

Members of the Department's Cultural Competence and Diversity Action Team (CCDAT) guided the revision of several documentation templates, including the Comprehensive Assessment and Treatment Plan templates, to strengthen collection of culturally relevant information. A key focus this year was the integration of the American Psychiatric Association's Cultural Formulation Interview (CFI) questions throughout the assessment. Posing these questions during an assessment enhance a mental health practitioner's clinical understanding of the problem and functional impairments, potential sources of help, and expectations for services from the client's cultural perspective.

Capital Facilities and Technological Needs (CF\TN)

Electronic Health Records / Capital Information Technology

Provider:	Behavioral Wellness
Estimated Funding FY 2019/20:	
Estimated Total Mental Health Expenditures:	$124,500
Estimated CFTN Funding	$124,500
Estimated Medi-Cal FFP:	$0
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$0

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

Update for Proposals Included in Three-Year Plan

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

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

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

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

Update:

During FY 16/17, vocational rehabilitation services were initiated in the TAY teams in all three regions to enhance service capability if a FSP was developed. In order to adequately build an FSP, housing support will be an initial barrier and ongoing funding for staffing due to the 24/7 support required. In FY 18-19, Behavioral Wellness worked on enhanced training with staff and review of current contracted supports necessary to implement an FSP. In, FY 19-20 services with Community Action Center (CAC) will be re-designed to create a model necessary with staffing from the New Heights Program for a FSP. Initial pilot and testing of this will begin in July 2019 to

review capacity and demand of the FSP whatever it takes programming with the partnership of CAC, New Heights, and Department of Rehabilitation.

In addition, the MHSA Chief, Peer Empowerment Manager, and a Clinician have researched and participated in Statewide and Santa Barbara learning groups regarding HeadSpace and Foundry Models used in Australia and British Columbia to serve the youth in their communities. This approach may be an option in the future with interested community partners collaborating, including School Districts, Cottage Health Systems, Mental Wellness Center, and more. During the FY 19/20 plan process, stakeholders confirmed interest and the Mental Health Oversight and Accountability Commission announced approval of an Innovations Project in Santa Clara implementing the Foundry model with Stanford University providing technical assistance to others interested. Community Partners will be meeting in FY 19/20 to brainstorm this clinical setting approach for youth with multiple community agencies co-located in one setting.

Proposal Two: Reconsider Justice Alliance

Currently, Justice Alliance is a specialized forensic Full Service Partnership (FSP) providing the following services:

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

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

Update:

During FY 16/17, greater collaboration occurred between Justice Alliance and the local hospitals and law enforcement including monthly meetings, review of high utilizers, and trainings for the courts, Public Defenders, and Psychiatric Health Facility. The Justice Alliance team continues to serve clients that are FSP until they could engage and link to the longer-term FSP ACT program. In summer of 2018, the Santa Barbara ACT team and Justice Alliance were co-located in a facility to better coordinate care to FSP clients and provide adequate access and transition services to the outpatient and inpatient systems for justice involved individuals. The Forensic Action team continues to support and provide feedback on the development of an in-county Mental Health Rehabilitation Center (MHRC) which will help inform the Department on the needs of the community for Justice Alliance services once critical services are enhanced in the continuum of care. In FY 19/20, additional caseworkers will be added to enhance and expand services related to felony forensic involvement and funded by the Department of State Hospitals. At this time, Justice Alliance will remain a specialized forensic FSP.

Proposal Three: Increase Programming at the Recovery Learning Centers

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

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

Update:

Partners in Hope peer services provided by county staff were fully integrated into their respective outpatient clinical team starting in FY 2017-18 and peer navigators initiated in Santa Maria in FY 2018-19 and planned countywide in FY 2019-20. These staff will help connect individuals to all resources, including the RLCs.

During 2018-2020, the Department is encouraging peer staff to attend advanced peer certification trainings, such as a series called "Advanced Peer Specialist" provided by Share! and funded by the Office of Statewide Health Planning and Development (OSHPD). The Lompoc RLC held a 12 week academy called H2L in October of 2017. The idea was to activate peer members to take a next step in their recovery through an array of classes.

Growing parent partner capacity to assist families in the Department was desired and a the Department received partial funding from the Mental Health Oversight and Accountability Commission to provide parent family support at hospitals to provide triage and connections to community, such as accessing the RLC, NAMI, or navigation of the school system for children. This is supported with MHSA and grant funding as part of the new Childrens' Triage Team which launched spring 2019.

There was a lack of consistent collaboration between the Department's Outpatient Clinics and Community Based Organizations treatment providers working within the RLCs. Consumers continue to report that they do not wish to be "forever clients" of the system and would like to step down to RLC level of care, but still have access to some clinical services. Consumers have reported in stakeholder meetings their desire to see psychiatric services and low end counseling at the RLCs. As a result of this supported proposal, a pilot of this program began in Lompoc in spring 2019 in collaboration with TMHA. Additionally, Medi-Cal case management services are occurring in the South region with connection to outpatient clinic and the Department is monitoring how to adequately provide step-down support and intended to have collaboration for medication support county-wide by 2020 that is located onsite at each RLC.

In addition, a modern peer technology innovations plan was approved by the Mental Health Oversight and Accountability Commission to employ peers and use mobile and computer applications to improve access and linkage with the individuals in the community; this is described in the Innovations section of this document and will create employment opportunities for peers, a career ladder, and may be provided by community partners through a request for proposal in FY 2019-20.

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

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

Update:

In FY 17-18, the Chief of Clinical Operations initiated a review of all levels of care in the Department. In this process, she led the Access Transitions Workgroup to collaborate on the design of a system of care which will transition clients based on clinical need using the Adult Level of Care and Recovery Inventory Tool (LOCRI). The Access Transitions Workgroup is comprised of staff across programs and disciplines. In spring 2018, this group supported updating the electronic health record to include the LOCRI tool and will be piloting the usage of it and working with community partners in FY's 2018-20. Following initial pilot, the Department will report to stakeholders on the successes and barriers to determine if Levels of Care is effective and will lead to the redesign the continuum of care. In future years, the wellness and recovery, medical integration, and co-occurring teams could be shifted to complex capability for all levels of care rather than staffed with specific separate teams. The current model requires clients to move between teams to the staff who are trained in that area, such as medical integration for medically compromised adults. Stakeholder feedback indicated large support for clients remaining in one team with the same providers, but requiring teams to have capacity to provide all levels of care through enhanced training. The transition to a LOCRI system will require complex capable staffing on each outpatient team for the complex individual's needs and eliminate the individuals from having to get a new provider when they make progress in their treatment or require higher needs. In Santa Maria, that teams have been piloting complex capable teams since Fall 2018. The staff have been trained to provide all complex services and have been integrating SUD services and coordination with complex health issues without having to move clients around to multiple teams.

Supporting Materials

Attachment 1: Prevention Early Intervention (PEI) FY 2017-2018 Data Report
Attachment 2: MHSA Budget Summaries
Attachment 3: Prudent Reserve Assessment - FY 18-19
Attachment 4: MHSA and Innovations Plan Update PowerPoint Presentation
Attachment 5: Public Comments Regarding the MHSA Three Year Plan Update
Attachment 6: Behavioral Wellness Commission Meeting Agenda for Public Hearing
Attachment 7: Minutes of Public Hearing
Attachment 8: Evidence of Santa Barbara County Board of Supervisors' Approval

Attachment 1: Prevention Early Intervention (PEI) FY 2017-2018 Data Report

Implementation of regulated data collection began in FY 2015/16 by the formation of a PEI Data Workgroup comprised of Santa Barbara County's Mental Health Service Act Chief, Information Technology Chief, Senior Epidemiologist, and later membership additions included the Cultural Competency Manager, Childrens Division Chief, and Public Information Officer. The goal of the workgroup was to develop a system for data tracking and reporting based on the new Prevention and Early Intervention data collection regulations. Data for FY 16/17 was submitted to the Mental Health Services Oversight and Accountability Commission in December 2017 with explanation of anticipated barriers for full collection, including information technology security and privacy assurances of any collection method. A plan was established to start gathering of all PEI regulation elements and the committee attended statewide trainings and webinars on methods for collection. As a result, Vertical Change software was developed and implemented in collaboration with community partners in Fall 2018. The following data from FY 17-18 is that which was available from that year. Moving forward, all required elements should be published starting with services January 2019 and on as initial testing of the software and collection forms were rolled out July to December 2018.

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)
PREV & EARY INT	Early Childhood Mental Health	Child Abuse Listening & Mediation (CALM)
PREV & EARY INT	Early Childhood Mental Health	Santa Ynez Valley People Helping People (SYVPHP)
PREV & EARY INT	Early Detection & Intervention	Transitional Age Youth (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 (A & A; Department of Behavioral Wellness)

DEMOGRAPHICS (ALL PROGRAMS)

Unique Clients Served										
	OUTREACH & STIGMA			PREVENTION & EARLY INTERVENTION			UNDERSERVED			ACCESS & LINKAGE
PROGRAM^	LCDLR	SYTHC	CHCCC	CALM	SYVPHP	TAY	CADA	FSA	CP	A & A
TOTAL CLIENTS	*	*	*	**91**	**94**	**202**	**69**	**31**	**1080**	*
AGE										
0-15	*	*	*	84	90	5	84		636	*
16-25	*	*	*	2	1	194	16		444	*
26-59	*	*	*	5	3	3	0		0	*
60+	*	*	*	0	0	0	0		0	*
Unknown/Decline	*	*	*	0	0	0	0		0	*
SEX AT BIRTH										
Female	*	*	*	52	39	103	40		619	*
Male	*	*	*	39	55	98	60		461	*
Unknown/Decline	*	*	*	0	0	1	0		0	*
CURRENT GENDER IDENTITY										
Male	*	*	*	*	*	*	*	*	*	*
Female	*	*	*	*	*	*	*	*	*	*
Transgender	*	*	*	*	*	*	*	*	*	*
Genderqueer	*	*	*	*	*	*	*	*	*	*
Questioning	*	*	*	*	*	*	*	*	*	*
Another	*	*	*	*	*	*	*	*	*	*
Unknown/Decline	*	*	*	*	*	*	*	*	*	*
SEXUAL ORIENTATION										
Gay/Lesbian	*	*	*	*	*	*	*	*	*	*
Heterosexual	*	*	*	*	*	*	*	*	*	*
Bisexual	*	*	*	*	*	*	*	*	*	*
Questioning/ Unsure	*	*	*	*	*	*	*	*	*	*
Queer	*	*	*	*	*	*	*	*	*	*
Another	*	*	*	*	*	*	*	*	*	*
Unknown/Decline	*	*	*	*	*	*	*	*	*	*
PRIMARY LANGUAGE										
English	*	*	*	*	*	*	*	*	*	*
Spanish	*	*	*	*	*	*	*	*	*	*
Other	*	*	*	*	*	*	*	*	*	*
Unknown/Decline	*	*	*	*	*	*	*	*	*	*
VETERAN										
Yes	*	*	*	*	*	*	*	*	*	*
No	*	*	*	*	*	*	*	*	*	*
Unknown/Decline	*	*	*	*	*	*	*	*	*	*

(cont.)	OUTREACH & STIGMA			PREVENTION & EARLY INTERVENTION			UNDERSERVED			ACCESS & LINKAGE
PROGRAM^	LCDLR	SYTHC	CHCCC	CALM	SYVPHP	TAY	CADA	FSA	CP	A & A
RACE										
American Indian/ Alaska Native	*	*	*	0	0	0	0		4	*
Asian	*	*	*	0	1	2	1		13	*
Black/ African American	*	*	*	1	1	6	1		23	*
Native Hawaiian/ Pacific Islander	*	*	*	*	*	*	*		*	*
White	*	*	*	7	5	45	20		293	*
Other	*	*	*	3	0	11	0		275	*
More than one	*	*	*	*	*	*	*		*	*
Unknown/Decline	*	*	*	79	87	138	78		472	*
ETHNICITY: LATINO										
Caribbean	*	*	*	*	*	*	*		*	*
Central American	*	*	*	*	*	*	*		*	*
Mexican/Mex. Amer./ Chicano	*	*	*	*	*	*	*		*	*
Puerto Rican	*	*	*	*	*	*	*		*	*
South American	*	*	*	*	*	*	*		*	*
Other Latino	*	*	*	*	*	*	*		*	*
Unknown/Decline	*	*	*	80	87	138	77		472	*
ETHNICITY: NON-LATINO										
African	*	*	*	*	*	*	*	*	*	*
Asian Indian/ South Asian	*	*	*	*	*	*	*	*	*	*
Cambodian	*	*	*	*	*	*	*	*	*	*
Chinese	*	*	*	*	*	*	*	*	*	*
Eastern European	*	*	*	*	*	*	*	*	*	*
European	*	*	*	*	*	*	*	*	*	*
Filipino	*	*	*	*	*	*	*	*	*	*
Japanese	*	*	*	*	*	*	*	*	*	*
Korean	*	*	*	*	*	*	*	*	*	*
Middle Eastern	*	*	*	*	*	*	*	*	*	*
Vietnamese	*	*	*	*	*	*	*	*	*	*
Other	*	*	*	*	*	*	*	*	*	*
Unknown/Decline	*	*	*	*	*	*	*	*	*	*
More than one	*	*	*	*	*	*	*	*	*	*

(cont.)	OUTREACH & STIGMA			PREVENTION & EARLY INTERVENTION			UNDERSERVED			ACCESS & LINKAGE
PROGRAM^	LCDLR	SYTHC	CHCCC	CALM	SYVPHP	TAY	CADA	FSA	CP	A & A
DISABILITY										
Difficulty Seeing	*	*	*	*	*	*	*	*	*	*
Difficulty Hearing / Having Speech Understood	*	*	*	*	*	*	*	*	*	*
Physical/Mobility	*	*	*	*	*	*	*	*	*	*
Chronic Health Condition/Pain	*	*	*	*	*	*	*	*	*	*
Other Mental Disability not Related to Mental Illness	*	*	*	*	*	*	*	*	*	*
Other	*	*	*	*	*	*	*	*	*	*
Unknown/Decline	*	*	*	*	*	*	*	*	*	*
FAMILY										
# Family Members in Program	*	*	*	*	*	*	*	*	*	*

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, and data are combined for this reporting period. Several data categories were not collected in FY 17/18 as new regulations were not yet established. All available data is provided, and data for the new PEI demographics categories will be completed in future fiscal years.

OUTREACH EVENT

Outreach Events			
PROGRAM*	**LCDLR**	**SYTHC^**	**CHCCC**
TOTAL # EVENTS	**93**	**41**	**181**
TOTAL # PARTICIPANTS	**523**	**390**	**6,310**
EVENT TYPE			
Outreach	4	1	27
Training	12	40	43
Forum	5	0	7
Support Group	72	0	104
PRIMARY LANGUAGE OF EVENT			
English	0	*	0
Spanish	253 (groups only)	*	31 (groups only)
Other	0	*	0
TRANSLATION PROVIDED			
English	*	*	*
Spanish	*	*	*
Other	*	*	*
PARTICIPANT AGE			
0-15	*	*	*
16-25	*	*	*
26-59	*	*	*
60+	*	*	*
Missing DOB	*	*	*
PARTICIPANT GENDER			
Female	*	*	*
Male	*	*	*
Unknown/Decline	*	*	*
PARTICIPANT VETERAN			
Yes	*	*	*
No	*	*	*
Unknown/Decline	*	*	*
PARTICIPANT RACE			
American Indian/ Alaska Native	*	*	*
Asian	*	*	*
Black/African American	*	*	*
Native Hawaiian/ Pacific Islander	*	*	*
White	*	*	*
Other	*	*	*
More than one	*	*	*
Unknown/Decline	*	*	*
PARTICIPANT ETHNICITY			
Latino	*	*	*
Non-Latino	*	*	*

*Several data categories were not collected in FY 17/18 as new regulations were not yet established. All available data is provided, and data for the new PEI demographics categories will be completed in future fiscal years.

^Reflects three quarters of data; provider did not provide data for 4th quarter.

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

*Referral data categories were not collected in FY 17/18 as new regulations were not yet established. All available data is provided, and data for the new PEI demographics categories will be completed in future fiscal years

Attachment 2: MHSA Budget Summaries

Budget Review by Funding Component

Mental Health Services Act Proposed Budget

Community Services and Supports (CSS)

FY 2017-18					FY 2018-19				FY 2019-20			
Community Services and Supports (CSS) Programs	TOTAL MHSA Plan CSS Expenditures	CSS Funded	Medi-Cal FFP Funded	Realignment / Grant/ Other Funded	TOTAL MHSA Plan CSS Expenditures	CSS Funded	Medi-Cal FFP Funded	Realignment / Grant/ Other Funded	TOTAL MHSA Plan CSS Expenditures	CSS Funded	Medi-Cal FFP Funded	Realignment / Grant/ Other Funded
Full Service Partnership (FSP)	13,010,100	7,741,153	4,760,767	1,611,829	11,688,021	6,852,524	4,374,797	460,700	13,520,883	8,734,755	4,392,727	1,581,529
Non-FSP	30,469,363	5,334,275	13,269,754	9,531,465	29,857,949	6,520,346	11,288,703	12,048,900	31,443,971	7,682,438	12,509,073	6,675,540
FSP Programs as % CSS Programs		*56%*				*51%*				*53%*		
CSS Administration Total	8,795,744	3,824,254	4,125,700	845,790	8,846,205	3,851,848	4,125,700	868,657	8,607,438	3,544,458	4,150,000	912,980
TOTAL CSS Programs Expenditures	52,275,207	16,899,682	22,156,221	12,006,512	52,801,537	18,069,030	25,292,019	9,440,488	53,572,291	19,961,651	21,051,800	9,170,048

Budget Review by Funding Component

Mental Health Services Act Proposed Budget

Prevention and Early Intervention (PEI)

	FY 2017-18				FY 2018-19				FY 2019-20			
Prevention and Early Intervention (PEI) Programs	TOTAL MHSA Plan PEI Expenditures	MHSA PEI Funded	Medi-Cal FFP Funded	Realignment / Grant/ Other Funded	TOTAL MHSA Plan PEI Expenditures	MHSA PEI Funded	Medi-Cal FFP Funded	Realignment / Grant/ Other Funded	TOTAL MHSA Plan PEI Expenditures	MHSA PEI Funded	Medi-Cal FFP Funded	Realignment / Grant/ Other Funded
Prevention	660,041	660,041	0	0	681,500	392,700	288,800	0	681,500	385,500	296,000	0
Early Detection & Intervention	944,350	(57,279)	1,001,629	0	1,095,100	(120,100)	1,215,200	0	1,179,900	(55,400)	1,235,300	0
PEI Administration	555,326	555,326	0	0	555,326	555,326	0	0	555,326	555,326	0	0
Total PEI Program Expenditures	6,211,086	3,180,154	2,717,898	313,034	6,539,901	3,302,285	3,237,616	0	8,818,107	5,557,020	3,261,086	0
Estimated Avaialable Funding	7,495,921	4,464,989	2,717,898	313,034	7,282,216	4,044,600	3,237,616	0	7,590,286	4,329,200	3,261,086	0
Estimated remain / (deficit)	1,284,835	1,284,835	0	0	742,315	742,315	0	0	(1,227,820)	(1,227,820)	0	0

Budget Review by Funding Component

Mental Health Services Act Proposed Budget

Workforce, Education and Training (WET)

FY 2017-18					FY 2018-19				FY 2019-20			
Workforce, Education and Training (WET) Programs	TOTAL MHSA Plan WET Expenditures	MHSA WET Funded	Medi-Cal FFP Funded	Realignment / Grant/ Other Funded	TOTAL MHSA Plan WET Expenditures	MHSA WET Funded	Medi-Cal FFP Funded	Realignment / Grant/ Other Funded	TOTAL MHSA Plan WET Expenditures	MHSA WET Funded	Medi-Cal FFP Funded	Realignment / Grant/ Other Funded
Peer Training	13,779	157,058	0	0	0	195,200	0	0	0	157,300	0	0
Southern Counties Regional Partnership	751,212	0	0	751,212	822,800	0	0	822,800	761,000	0	0	761,000
WET Administration	0	0	0	0	0	0	0	0	0	0	0	0
Total WET Program Expenditures	764,991	157,058	0	751,212	822,800	195,200	0	822,800	761,000	157,300	0	761,000
Estimated Avaialable Funding	908,270	157,058	0	751,212	1,018,000	195,200	0	822,800	918,300	157,300	0	761,000
Estimated remain / (deficit)	143,279	0	0	0	195,200	0	0	0	157,300	0	0	0

** Ongoing funding after reversion used will be from a transfer from Community Services and Supports (CSS) **

Budget Review by Funding Component

Mental Health Services Act Proposed Budget

Innovations (INN)

FY 2017-18					FY 2018-19				FY 2019-20			
Innovations (INN) Programs	TOTAL MHSA Plan INN Expenditures	MHSA INN Funded	Medi-Cal FFP Funded	Realignment/ Grant/ Other Funded	TOTAL MHSA Plan INN Expenditures	MHSA INN Funded	Medi-Cal FFP Funded	Realignment/ Grant/ Other Funded	TOTAL MHSA Plan INN Expenditures	MHSA INN Funded	Medi-Cal FFP Funded	Realignment/ Grant/ Other Funded
RISE	1,368,447	1,191,525	176,922	0	1,341,500	1,199,000	142,500	0	1,461,100	1,308,500	152,600	0
Tech Suite		0	0	0		0	0	0	703,100	703,100	0	0
INN Administration	232,386	232,386	0		232,386	232,386	0		232,386	232,386	0	
Total INN Program Expenditures	1,600,833	1,423,911	176,922	0	1,573,886	1,431,386	142,500	0	2,396,586	2,243,986	152,600	0
Estimated Avaialable Funding	1,600,833	1,423,911	176,922	0	1,573,886	1,431,386	142,500	0	2,396,586	2,243,986	152,600	0
Estimated remain / (deficit)	0	0	0	0	0	0	0	0	0	0	0	0

Budget Review by Funding Component

Mental Health Services Act Proposed Budget

Capital Facilities/Technological Needs (CFTN)

	FY 2017-18				FY 2018-19				FY 2019-20			
Capital Facilities/ Technological Needs (CFTN) Programs	TOTAL MHSA Plan CFTN Expenditures	MHSA CFTN Funded	Medi-Cal FFP Funded	Realignment / Grant/ Other Funded	TOTAL MHSA Plan CFTN Expenditures	MHSA CFTN Funded	Medi-Cal FFP Funded	Realignment / Grant/ Other Funded	TOTAL MHSA Plan CFTN Expenditures	MHSA CFTN Funded	Medi-Cal FFP Funded	Realignment / Grant/ Other Funded
Capital Information Technology (CIT)	264,760	264,760	0	0	186,883	186,883	0	0	124,500	124,500	0	0
CFTN Administration	0	0	0	0	0	0	0	0	0	0	0	0
Total CFTN Program Expenditures	264,760	264,760	0	0	186,883	186,883	0	0	124,500	124,500	0	0
Estimated Avaialable Funding	264,760	264,760	0	0	186,883	186,883	0	0	124,500	124,500	0	0
Estimated remain / (deficit)	0	0	0	0	0	0	0	0	0	0	0	0

Budget Review by Funding Component

MHSA Housing Funds $2.3M:

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

- On February 28, 2017, this item went before the Board of Supervisors who approved and authorized the request.
- The funds are to be used to provide housing assistance to the MHSA target population.

In September 2018, funds were distributed to County Housing Authority of Santa Barbara for the 35 unit Depot Street project anticipated open September 2019.

No Place Like Home (NPLH) Initiative:

- On November 6, California voters approved Proposition 2, No Place Like Home. This ratified the proposed use of MHSA dollars to service the debt on statewide bonds that will finance permanent supportive housing for people with SMI who are homeless or at risk of becoming homeless.
- Impact on Santa Barbara County is estimated at $1.4 million of MHSA funds to be diverted annually for 30 years.
- Technical Assistance funds of $100,000 helped sponsor creation of new Homeless Housing Plan to be released in 2019 and required by NPLH.
- Stakeholder survey in FY 18-19 supported primary focus in South County; internal goal of 50 units county wide with two potential projects in the pipeline.
- The initiative will provide $2.5 Million in non-competitive funds towards the development of new permanent housing with intention to also compete for the larger funding with mid-size counties.

MHSA Prudent Reserve Fund Balance

	7/1/2018 Beginning Balance	6/30/2019 Estimated Actual Increases	6/30/2019 Estimated Ending Balance	6/30/2020 Decreases	6/30/2020 Recommended Ending Balance
MHSA Prudent Reserve	2,023,113	-	2,023,113	-	2,023,113
Purpose of Fund	6,530,951	723,000	7,254,751	4,272,600	2,982,151
Total Fund Balance	**8,554,064**	**723,800**	**9,277,864**	**4,272,600**	**5,005,264**

- MHSA Prudent Reserve Account cannot be used to expand programs

Attachment 3: Prudent Reserve Assessment

State of California
Health and Human Services Agency

Department of Health Care Services

MENTAL HEALTH SERVICES ACT
PRUDENT RESERVE ASSESSMENT/REASSESSMENT

County/City: Santa Barbara County

Fiscal Year: FY 2013-14, FY 2014-15, FY 2015-16, FY 2016-17, FY 2017-18

Local Mental Health Director

Name: Alice Gleghorn

Telephone: 805.319.9947

Email: agleghorn@co.santa-barbara.ca.us

I hereby certify[1] under penalty of perjury, under the laws of the State of California, that the Prudent Reserve assessment/reassessment is accurate to the best of my knowledge and was completed in accordance with California Code of Regulations, Title 9, section 3420.20 (b).

Alice Gleghorn — Local Mental Health Director (PRINT NAME)

Signature

4/8/19 — Date

[1] Welfare and Institutions Code section 5892 (b)(2)

DHCS 1819 (02/19)

FISCAL YEARS	TOTAL	CSS	PEI	INN
FY2017/18	$23,339,860.24	$17,738,293.78	$4,434,573.45	$1,166,993.01
FY2016/17	$21,210,436.99	$16,119,932.11	$4,029,983.03	$1,060,521.85
FY2015/16	$16,508,549.74	$12,546,497.80	$3,136,624.45	$825,427.49
FY2014/15	$20,091,479.75	$15,269,524.61	$3,817,381.15	$1,004,573.99
FY2013/14	$14,353,410.15	$10,908,591.71	$2,727,147.93	$717,670.51
	$95,503,736.87	$72,582,840.02	$18,145,710.01	$4,775,186.84
Average Yr	$19,100,747.37	$14,516,568.00	$3,629,142.00	$955,037.37
Prudent reserve max %	33%	$4,790,467.44		

Prudent Reserve Balance 7/1/2018 **$2,023,112.72**

Additional Prudent Reserve possible $2,767,354.72

Source: MHSUDS INFORMATION NOTICE NO.: 19-017

MENTAL HEALTH SERVICES ACT: IMPLEMENTATION OF WELFARE AND INSTITUTIONS CODE (W&I) SECTIONS 5892 and 5892.1.

Establish a Prudent Reserve that does not exceed 33 percent of the average Community Services and Supports (CSS) revenue received for the Local Mental Health Services Fund (LMHSF) in the preceding five years. Each county must reassess this amount every five years.

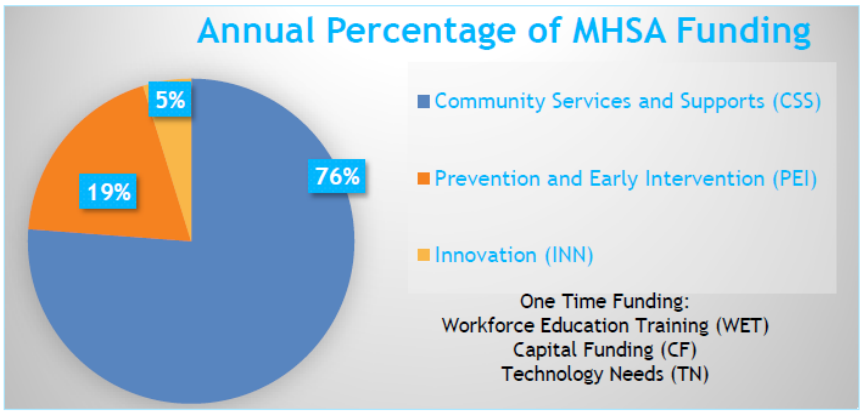
Attachment 4: MHSA and Innovations Plan Update PowerPoint Presentation


FY 2019-2020
Mental Health Services Act
Plan Update
Stakeholder Presentation
Presented by:
Lindsay Walter and Pam Fisher
SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery
Art by Friends of Behavioral Wellness:
The Healing Arts, by Patrick Bergin; Garden Fountain and
Dreaming of You, by Bridget Hochman

MHSA OVERVIEW

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.

To accomplish its objectives MHSA applies a specific portion of funding to each of six system-building components:



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What is the Mental Health Services Act?

Approved in 2004 and becoming law in January 2005 by California voters, the MHSA represented another California legislative movement, begun in the 1990s, to provide better coordinated and more comprehensive care to those with serious mental illness, particularly in under- served populations. Additionally, MHSA has proven an effective vehicle for leveraging funding and developing integration.

Providing a transformed system to change the way clients received mental health care in California the following standards are adopted:

- Community collaboration
- Cultural competence
- Client driven
- Wellness, recovery, and resilience focused
- Integrated service experiences for clients and their families

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Rules and Regulations

California Code of Regulations (CCR) § 3310 and California Welfare and Institutions Code (WIC) § 5847 states:

- The county shall update the Plan annually;
- Updates address elements that have changed; and
- Updates includes estimated expenditure projections for each Component per fiscal year

The MHSA Plan Update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests. The mental health board shall conduct a public hearing on the draft Annual Update at the close of the 30 day comment period.

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Your Role As A Stakeholder

The Annual Update is developed with local stakeholders including consumers, families, service providers, veterans, and representatives from law enforcement, education, social services, veterans, alcohol and drug and health care organizations.

Additionally, the stakeholder process will include:

- Representatives of unserved and/or underserved populations and family members;
- Stakeholders who represent the diversity of the demographics of the county (i.e., Location, age, gender, race/ethnicity);
- Consumers living with serious mental illness and/or serious emotional disturbance and their family members.

County partnership with constituents and stakeholders throughout the process includes stakeholder involvement on:

- Mental health policy;
- Program planning;
- Implementation;
- Monitoring;
- Quality improvement;
- Evaluation;
- Budget allocations

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FY 2019-2020 MHSA PLAN UPDATE GOALS

UPDATE:	REVIEW:	DISCUSS:	REVIEW:
Update on FY 2018-19 Progress and FY 2019-20 Solutions	Review the status of No Place Like Home Initiative and MHSA Housing Priorities with expanded programs	Discuss status of FY 2017-2020 Three Year Plan proposals and updates to correlated programming	Review any significant changes including the new Childrens Triage Grant Services and No Place Like Home budget impacts

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THREE YEAR PLAN AREAS FOR FOCUS- GAPS

Focus Area	Solution
Quick Response	• Creation of Crisis Services (grants ended) • Childrens Triage grant with local hospitals • Ten bed North County Crisis Residential
Peer Services	• Creation Peer Career Ladder • Regular Peer Employee Forums • Integration of Peers in Clinical Programs • Peer Tech Suite Approval in FY 2018-2019
Technology	• Use of modern ways to respond to clients and deliver services to increase access and quality: Tech Suite; Centralized Access Line; Electronic Signature Pads
Transitional Age Youth (TAY)	• TAY Vocational Rehab services • RISE Extension Approval in FY 2018-2019 • Review of TAY Full Service Partnership or Headspace like models in FY 2019-2020
Outreach and Engagement	• Co-Response with Law enforcement pilot • Homeless Services expansion and HMIOT Grant • Assembly Bill 1810 Grant (LEAD and Justice Diversion Services)

TECH SUITE: DRAFT PEER CAREER LADDER

Crisis Services Peer Navigator	Peer Outreach Coordinator	Project Manager	Consumer Empowerment Manager
• Provide training to PHF clients upon discharge, outreach and engagement activities to connect consumer-friend-users with the new Technology Suite application services; • Offer group and 1:1 information and user instructions about TS applications at PHF unit • Act as active user in night hours after PHF discharge	• Responsible for all marketing materials for the Tech Suite; • Responsible for the recruitment of "Super Users"; • Interface with system providers and advocacy organizations regarding TS Responsible for training • Provide outreach to community and oversight of these organizations; • Create local connections from TS to provider agencies	• Assists WET Manager in providing overall advocacy and guidance regarding Peer role standards and competencies and assurance that Peer Voice is represented at all levels of State and County TS activities; • Assists WET Manager in developing and overseeing Peer engagement plans; • Provides reports on peer activities, user engagement efforts and End-User feedback;	• Provide overall advocacy & guidance regarding Peer role standards, competencies and assurance the Peer Voice is represented at all levels of State & County TS activities; • Advise on policy-level activities, interface with internal organizational leaders & external system partners & advocacy organizations; • Responsible for hiring supervisor, role development, and overall design of TS Peer activities; • Ensures TS Peers reflect the diverse needs of the community

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MHSA Housing and Adult Housing Supports

- Breaking ground on **Depot St. Residences** occurred September 2018, using the last MHSA Housing funds to create 35 units for Behavioral Wellness clients
- **Created new Adult Housing Supports Program**
  - Out of County step down housing and services from IMD services,
  - Eight new board and care beds in County with Mental Wellness Center, and
  - New design for 22 beds at Phoenix and Mountain House now operated by Pathpoint including peer positions.

HOUSING CONTINUUM

Polly's House	McMillan Ranch	Phoenix House	Cottage Grove	Alameda House	Mountain House	Casa Juana Maria	Casa Del Mural
Beds: 8 Beds	**Beds:** 10 Beds	**Beds:** 12 Beds	**Beds:** 6 Beds	**Beds:** 6 Beds	**Beds:** 14 Beds	**Beds:** 6 Beds	**Beds:** 12 Beds
•Intensive Residential Board and Care Services •Provides Psychiatric rehab	•Residential Board and Care Services •1 year+ stay with a contractor review of client plan every 90 days	•Residential Care with Rehab •Room and Board Services	•Intensive Residential Board and Care Services •1 year+ stay with a review of client plan w/ county every 90 days	•Intensive Residential Board and Care Services	•Residential Care with Rehab •Room and Board Services	•Intensive Residential Board and Care Services •1 year+ stay with a review of client plan w/ county every 90 days	• Permanent & Supportive Housing

*Casa Juana Maria , Cottage Grove, and Alameda board//care is not Non-MHSA funded
*Support services at Casa Del Mural are funded by MHSA

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No Place Like Home (NPLH) Initiative

- On November 6, California voters approved Proposition 2, No Place Like Home. This ratified the proposed use of MHSA dollars to service the debt on statewide bonds that will finance permanent supportive housing for people with SMI who are homeless or at risk of becoming homeless.
- Impact on Santa Barbara County is estimated at $1.4 million of MHSA funds to be diverted annually for 30 years
- Technical Assistance funds of $100k helped sponsor creation of new Homeless Housing Plan to be released in 2019 and required by NPLH
- Stakeholder survey in FY 18-19 supported primary focus in South County; internal goal of 50 units county wide with two potential projects in the pipeline
- The initiative will provide $2.5 Million in funds towards the development of new permanent housing.

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Updates on Proposals and Budget Issues Identified in Three Year Plan

- **Continued Focus on Enhancing Crisis Services -** BeWell's Mobile Crisis and Triage teams were combined to create a new crisis service response model. Reduction in triage service times and all triage civil service positions sustained by creation of the new model. Last Mobile Crisis for Lompoc grant ends January 2020 and will be combined with this model. Newly awarded Childrens Triage grant expanding response in local hospitals. Continued prioritization of law enforcement co-response, crisis stabilization, crisis residential, intensive outreach and supportive housing solutions for adequate step-down and prevention continuum.

- **Impacts of new legislation-** New fiscal regulations creating limits on prudent reserves, useful life of funding limited to three years, clarity on reversion and interest accounting, and new MHSA Audits in counties every three years starting January 2019.

- **Updates for Proposals of Three Year Plan** which are review of TAY Programming expansion similar to Full Service Partnership services, reconsideration of design of Justice Alliance, increased programming at Recovery Learning Centers, and further integrating existing treatment into Levels of Care model.

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What Do You Think?

This is your time to share your input, thought or feedback for Santa Barbara County's

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Next Steps for Feedback or Input

- Take the ideas and feedback presented today; please email any other ideas to:
  MHSA Chief Lindsay Walter- lwalter@co.santa-Barbara.ca.us
- Any issues can also be submitted to MHSA Issue Resolution on website:
  https://www.countyofsb.org/behavioral-wellness/mhsares.sbc

  Santa Barbara County Department of Behavioral Wellness Quality Care Management
  Beneficiary Concerns Coordinator
  315 Camino del Remedios, #257, Santa Barbara, CA 93110 or
  E-mail to: BWELLDGQCM@sbcbwell.org or Fax: (805) 934-6314
- Development of draft plan(s)
- Distribution draft plan(s)
- Presentation to the Behavioral Wellness Commission
- Approval by Board of Supervisors and submission to State by June 30, 2019

Mental Health Services Act (MHSA) Issue Resolution Form
Santa Barbara County Department of Behavioral Wellness

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For more information on today's presentation contact:

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Deputy Director of Operations and Administration
Santa Barbara County Department of Behavioral Wellness
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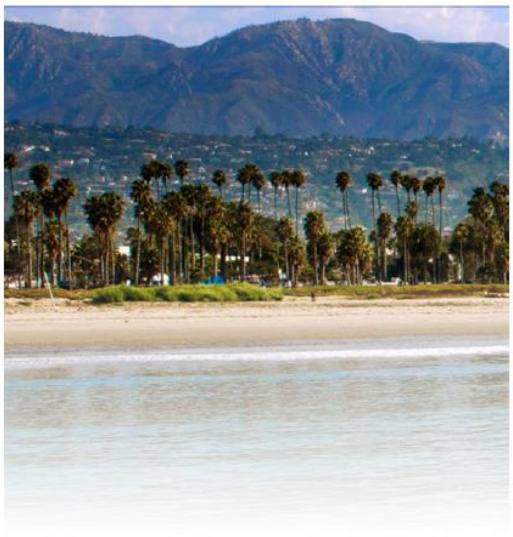

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Attachment 5: Public Comments Regarding the MHSA FY 2019-20 Plan Update

Stakeholder Forum- Santa Maria Clinic February 6, 2019

Several staff members from Santa Maria community organizations and Behavioral Wellness staff attended and responded to the Plan Update Stakeholder Presentation. This forum was hosted in the Santa Maria Adult Clinic on Foster Rd. Presentation was conducted by Deputy Director of Administration and Operations, Lindsay Walter and Division Chief of Compliance, Celeste Anderson. Forum was opened with presenter introductions followed by PowerPoint presentation of the 2019-2020 Mental Health Services Act Plan Update. Community members held dialogue with a focus on creating housing opportunities in North County and have requested funding for Growing Grounds of Santa Maria. A need for staffing that can assist the Mixteco community and a better utilization of TAY services was discussed. Below are comments during the Stakeholder Forum- Santa Maria Clinic February 6, 2019

Comment: TAY and Rise programming needs to continue- both programs are so effective in supporting youth. Also, immediate housing is extremely important in North County. Homelessness is a huge issue and it is not underground. So go to any Starbucks, library or the mall in Santa Maria and you will see the faces of the homeless.

Comment: I think that the Headspace model seems like a good idea. My recent focus has been to connect community college students in need of mental health services with community resources. TAY is a good description of the group that I believe is underserved. Prevention and early intervention fits properly into the TAY category. Wrap around services are definitely needed for this demographic, but a lower level of care or basic initial services and contact are lacking in the community.

Comment: We need full-time staff that can work with the Mixteco community, outreach efforts, linkage and to provide support to the whole family.

Comment: How can or what would be the process of securing funding for possible projects related to:

MH service provider training and capacity building for treatment of individual with co-occurring psychiatric disorders and developmental disabilities

(0-5 Population) Mental Health therapy and parent-training for children with social, attachment and trauma but are at-risk for developing a long term disability

Comment: Need services in SM, we are limited to refer our clients and families. Services availability and medical/MH services and advocacy for monolingual families. Educate the Hispanic community by outreach. Educating the bilingual staff to do outreach to parents and what to look out for in their children. Welcoming the Hispanic community to our clinic without fears. Educating parents in the community .Services in the RLC at housing complex need to be available in the evenings as well for the working parents to utilize and for parents support since clients are children. Educate our Managers, Supervisors of how teams can us the MHSA money for clients and team projects educational groups, parents, self-care, parents support groups etc. each time we have less and less access to our funds for our funds.

Comment: Adding a contract to fund the Growing Grounds. County MH utilized Growing Grounds are suffering financially getting the contract will help sustain the program and help our clients to have a place to work and/or work on their recovery.

Comment: The County is doing a lot of work to provide housing at every level. I would like to see vocational employment for peers at every level. The Growing Grounds in Santa Maria is unable to continue to exist without a county contract. Both Ventura and San Luis Obispo have farms in their counties that are funded by the county. This is the only program like

it in Santa Barbara County. $150,000 contract would assist in this program survival. I would like more supportive adult housing program to be created in Santa Maria and Lompoc. Place Clinical staff on homeless outreach team.

Comment: We need a van for our TAY program. Our clients call our van the “ghetto van” We take out our client’s weekly out into the community and they enjoy the outings such as hikes, bowling, going out to the beach. The TAY program should have their own credit card to take the clients out.

Comment: I would like to help with developing FSP TAY program. Current program could use more funding and access to larger transportation vehicles. Housing with case management and therapy services consider reaching out to John Fowler CEO from Duncan Group/Peoples Self Help Housing who already run something similar works well.

Comment: I’m asking for an annual behavioral wellness contract of $150,000 for the 19/20 fiscal year for TMHAs Growing Grounds. They haven’t had a new contract with the county since 2008 TMHA employs 50 people part time. Exclusively running on private funds. These funds are running out. We need a sustainable funding plan. Growing Grounds made almost $100K in revenue last year and invested it all back into the program. SLO spends $220,000 (65 people helped) Ventura spends $300,000 (100 people) Going back to work can make all the difference in a person’s recovery and these jobs are hard to find. Last year, 14 people were able to move on to other local employment. Please consider a contract with TMHA for the Growing Grounds.

Stakeholder Forum- Transition Mental Health Association (TMHA) Helping Hands of Lompoc February 12, 2019

Several staff members from Transitions Mental Health Association (TMHA), other community organizations and Behavioral Wellness staff attended and responded to the Plan Update Stakeholder Presentation. This forum was hosted at the Helping Hands of Lompoc. The Presentation was conducted by Deputy Director of Administration and Operations, Lindsay Walter and Housing Services Manager, Laura Zeitz. The forum was opened with Behavioral Wellness introductions followed by PowerPoint presentation of the 2019-2020 Mental Health Services Act Plan Update. Community members held dialogue with a focus on bettering employment opportunities for Peers especially TAY and maximizing efforts with community organizations to increase training and housing. Below are comments during the Stakeholder Forum- Helping Hands of Lompoc on February 12, 2019:

Comment: I really enjoyed and was enlightened about the broader picture around what is happening. Planning and future intentions. Residential housing while housing units are goo the clear lack of beds for those with SMI that can and will not be able to live in on their own need room and board (food and bed, 24-7 supervision, work with treatment)) and more so board and care needs med support, assisted living, transportation etc. There is a pattern of operators getting older and retiring. As well as, an aging population of clients need of adult and senior board and care is needed county wide. We need more housing in Lompoc and housing needs to be equalized. Clearly the focus is SB and this appears unbalanced, possibly perceived as bias. Population leans toward North County. We need IST, step down, homelessness, Senior and Adult B&Cs enhanced (McMillian Ranch is a shining example) we need more than another Crisis Residential beds not already fully utilized.

Comment: Thank you for the information on the development of program in Santa Barbara County. I can echo a lot of what I have heard about the need for immediate shelter/emergency for the homeless population. I think many may agree Lompoc is generally underserved with services available to homeless and mental health patients. As the MHSA plan is being developed, I hope this can be looked at. In Lompoc, immediate shelter bed funding with supportive services at the shelter is a need. At the other shelters, the county funds and provides services at the shelter. SM has public health on site for example. Again, please look at how services are being dispersed amongst the county.

Comment: We would love to see a bridge between Behavioral Wellness and the Hancock College. We have students that could benefit from services and support. How can we develop a relationship/collaboration between us to have student's access services as a prevention to possible legal problem and to support their health?

Comment: Expand collaboration with Allan Hancock College Campus Assessment and Support Team (C.A.S.T) Lompoc Valley and Santa Maria Campuses would be great. How do we make our individual teams/resources part of a collaborative triage support system (Transitional Age Youth Mobile Outreach and Mobile Crisis Response, Homeless Services, Family Support Services, Early Detection and Prevention)? AHC already participating in Mental Health First Aid (2 trainings since Dec 2018), AHC police attending 40HR CIT (Feb 2019), 8HR CIT (CA Post Req.), and Mental Health First Aid Training (Dec 2018, Feb 2019)

Comment: Make Lompoc Family Advocate full time by augmenting existing half time family advocate with children's triage grant funds. TAY FSP Team is a good idea. Utilize both Lompoc and Santa Maria RLCs to have after-school programs and groups for TAY. Homeless Outreach FSP team in Santa Maria. Small footprint housing is a model that works well in Lompoc (3-10 beds)

Comment: It seems that when SB Well takes on projects, in-house, it is more expensive than when partnered with a non-profit community agency to pair the strengths of both.

Comment: All the RLCs are well positioned to be part of a career ladder for people with lived experience with mental illness, they need more funding to offset the increase in minimum wage, expand hours and hire more peers

Comment: David Wheeler is a great resource for employment and works directly with both State Voc. Rehab and clients of all ages. He could be very helpful with TAY employment.

Comment: Partner with social worker with law enforcement in Lompoc and Santa Maria

Comment: More speakers in recovery; cards at all facilities to hand out; newsletter to Homebase; RLC has homeless groups and lunches; mobile PHC; come to RLC for Farmers Market to reach more people; more youth advertising for youth AA and NA; RLC provides so much for TAY, homeless and mental health groups they need more funding; Peer Counseling needed at RLC; funding needed

Comment: Helping Hands of Lompoc is a very important program for this community because people homeless or not can come for groups to develop skills, have lunch, enjoy friendships or rest watching shows. Without this program people wouldn't have the opportunity to survive. Helping Hands of Lompoc really is a key to survive, recovery and develop skills. Santa Maria Growing Grounds needs funding. More funding for Helping Hands of Lompoc.

Comment: Why are you not getting funds from corporations? As a working person that does not make a lot of money it seems odd that individuals have to fund these programs. Why don't you go where the money is? Individuals like me always have to carry the weight that corporations should be carrying. The additional taxes, lower wages, due to budget cuts, dead end jobs, little or no funding maybe supporting the programs you already have better would be a great start. Why do you focus on low income housing there are working people that struggle with not having housing. Maybe focusing on more affordable housing for average folks too many low income housing already, affordable housing now! Lompoc is filled with low income housing.

Comment: Would like some mental health first aid group support. This involves: Manuals purchased and Stipend/fee for trainers

Comment: TMHA can offer assistance with qualification and ways to build peers into care. In addition, they have a good tiered system for reference for EQRO

Comment: More funding for positions at Helping Hands to extend hours and offer more peer positions a. Policy changes at TMHA for not allowing hours without paid staff changed this and b. minimum wage changes also took a toll

Comment: There are many vocational opportunities at “The Farm” nearby perhaps for TAY programs

Comment: Sustainable model to keep helping hands going and funded

Comment: Transportation to the RLC are there funds for this

Comment: Why aren’t we running crisis services out of the RLC?

Comment: Why don’t we have staff here in the evenings?

Stakeholder Forum- Mental Wellness Center (MWC) Fellowship Club, February 13, 2019

Several staff members from the Mental Wellness Center, other community organizations and Behavioral Wellness staff attended and responded to the Plan Update Stakeholder Presentation. This forum was hosted at the MENTAL WELLNESS CENTER. The Presentation was conducted by Deputy Director of Administration and Operations, Lindsay Walter and Behavioral Wellness Assistant Director, Pam Fisher. The forum was opened with Behavioral Wellness introductions followed by PowerPoint presentation of the 2019-2020 Mental Health Services Act Plan Update. Community members held dialogue with a focus on creating a TAY drop in center and filling cultural competency gap. Below are comments during the Stakeholder Forum-Mental Wellness Center on February 13, 2019:

Comment: Definitely still learning about SBMH programs and services but want to uplift the following for your considerations: Does your data separate Mixteco/TriQui/Zapateco identities from Latino clients? Separating sheriffs and SBPD from crisis response or coordinating a training on the needs and concerns of immigrant communities re: law enforcement. Create Picto-graphics or fototnovela apps to overcome a lack of literacy. What language capacity does the onsite hospital clinician have? Do Farmworkers count or qualify under the homeless services?

Comment: Always great to have immediate resources available. I appreciate the focus on a career ladder for peers. It does feel like peers is a code word for client and former clients. Is it meant to be empowering? The use of apps can be a game changer and definitely to be pursued. The Headspace sounds amazing. I wonder if youth have been consulted in the plans/proposals. Sounds innovative as is but tech and kids is moving very quickly. So much potential there. Happy crisis teams seem to be working well. Great to hear law enforcement is working to better understand mental health.

Comment: I am interested in working with MHSA on cultural competence initiatives- Dr Lori Santamaria l.santamaria@mixteco.org

Comment: The mental health app would definitely work for some folks but will not work for underrepresented population. I do think the Headspace like model will help the transitional age youth. High school youth and TAY will definitely use teen centers to see a doctor or counselor

Comment: I am glad Santa Barbara County has created these new housing support programs to serve clients more housing programs like these are needed.

Comment: I would definitely like to see more community feedback through the stakeholders

Comment: Some MHSA funding has been used for school counseling. This is an effective use of funds- having significant positive impacts.

Comment: We are supportive of the Headspace model and are interested in helping with the conceptualization and implementation. We have significant services for youth in Santa Maria, Lompoc and Santa Barbara so could help in any of these areas. I forgot to mention Carpentaria as a part of where we provide services for youth.

Comment: I would recommend a use of prevention and early intervention funds be used to fund a TAY aged Family Advocate expansion to the Adult Family Advocate positions.

The MENTAL WELLNESS CENTER has a growing number of parents of teens that need support and education-enough to warrant at least a half time position for this need.

I believe that a youth integrated clinic Headspace or Foundry model is a great response to community need for all youth aged 12-24 regardless of payment source. This would require multiple agency partners to contribute toward a blended financing models and should governance/design. Furthermore, I strongly recommend that some MHSA funds be allocated to do the feasibility work and planning.

I suggest that the tech suite program be expanded to include high school students.

I suggest the expansion of TAY Employment Services to have cross referral to the MENTAL WELLNESS CENTER Employment Services like the Adult Coop work is done.

Comment: Pam and Lindsay presented and comprehensive detailed update to the MHSA Plan. Good Job! Most questions asked by Stakeholders were actually covered later in the presentation. Other questions were answered to the satisfaction of stakeholders. They demonstrated how questions/concerns from previous years' reviews were taken into account in this year's update. The Headspace model sounds very much worth looking into.

Stakeholder Forum- Client Family Member Advisory Committee (CFMAC), February 21, 2019

Several staff Behavioral Wellness staff members along with Peers (Consumers and Family members) throughout the county met to review the MHSA Plan Update for FY 2019-2020 at the monthly CFMAC meeting. Deputy Director, Lindsay Walter and Department Assistant Director, Pam Fisher presented the plan update. Below are comments shared during the Stakeholder Forum- CFMAC on February 21, 2019**-**

Comment: Thank you for the update. I would like to see more Peer involvement throughout the County at every level.

Comment: I would like to see trainings for Peers to enhance their careers.

Comment: We need to open up trainings and events to all members of the County not just Peers that work directly for the County. This will help all understand how we can work together to strengthen the Peer voice.

Comment: There are so many resources available the County needs to do a better job of connecting clients to the resources, there is a disconnect throughout the County mental health system.

Comment: There needs to be County involvement throughout the entire County not just in the city of Santa Barbara. Lompoc and Santa Maria are often left out of the decision making process.

Comment: There should be more seats on the Behavioral Wellness Commission to ensure that the Peer voice is heard and understood.

Comment: We need to rally up and make sure that the Peer Certification bill is passed. We need to work together to make this happen.

Comment: Housing projects should not use MHSA dollars if there will not be built in mental health services available.

Stakeholder Forum- Peer Employee Forum, March 14, 2019

Behavioral Wellness Peer staff members from all regions of the County met at the Quarterly Peer Employee Forum to review the MHSA Plan Update for FY 2019-2020. Deputy Director, Lindsay Walter and Department Assistant Director, Pam Fisher presented the plan update. Below are comments shared during the Stakeholder Forum- Peer Employee Forum on March 14, 2019**:**

Comment: This plan looks good.

Comment: The peer career ladder will help us finally be able to grow.

Comment: For a long time, there was no growth path for us.

Comment: We need to help those peers in Mixteco community. There are so many services in English and Spanish but not enough information reaches Mixteco.

Comment: We need to invest money into safety vehicles for us. We transport children and adults that maybe be triggered and it's scary to drive knowing that something bad can happens to us.

Comment: We need to make sure that there are more job classifications. There needs to be a change in the way that we hire.

Comment: Job classifications limit the roles for peers. There could be a ladder but without a change to the way that we hire its basically not going to help us progress.

Comment: HR needs to better scan who is a peer and who is not. Peers are not being considered for jobs that are meant to be for peers.

Comment: Some of us do not know how to apply properly. Thank you for bringing us trainings that can help us grow and understand the County system.

The following comments were sent in electronically or via mail in response to the MHSA Plan Stakeholder Forums:

The following comments were sent in electronically or via mail in response to the MHSA Plan Stakeholder Forums:

Name: Thomas Kinder

Affiliation: Baslyne Brain Scan

Comment: We are working with a number of county Behavioral Health Departments/Mental Health Departments to submit grant requests for Innovation, CSS and PEI initiatives. Our objective is to help to improve school attendance and graduation rates by working with students ages 14-18 to measure indications for the following potential mental/behavioral issues using an FDA cleared medical device (portable EEG). Indications measured: Anxiety / Depression, ADHD, TBI – Concussion, PTSD. Data suggests that these ages are at a high risk for future mental health issues if they go unrecognized and treated where necessary. Data: 50% of lifetime cases for mental illness begin at age 14 (Source NAMI.org) 50% of the students with a mental disorder drop out of school. (Source NAMI.org) 32% of the students felt sad or hopeless. (Sources Office of Adolescent Health November 14, 2018 / CDC/ Samhsa.gov) 13% experienced depressive episodes (Source Office of Adolescent Health November 14, 2018 / CDC/ Samhsa.gov) 17% considered suicide. Male 12% Female 22% (Source: Office of Adolescent Health November 14, 2018 / CDC/ Samhsa.gov)

Response: Thanks for your inquiry. At this time, we have initiated a new innovations project and aren't drafting new proposals in FY 19-20. In PEI, we will be reviewing our continuum and add you to our distribution list for future requests for proposals and MHSA opportunities.

Name: Sylvia Barnard

Affiliation: Good Samaritan

Comment: 1) Mental Health Shelter Beds - Good Samaritan Shelter has the same four beds contracted in Santa Maria that we have had for the past 20 years. During those 20 years, we have gone from 28 beds to a 500 shelter bed agencies (with 130 beds of emergency shelter in Santa Maria alone). We really need at least 4 - 6 more mental health beds contracted

at the Santa Maria Emergency Shelter. Also, our funding amount for those beds has never increased during those 20 years. At the Lompoc Bridge house Shelter, we only have one mental health bed contract and that is only because we worked hard to save a cut from our mental health contract to at least accommodate homeless mental health clients in the Lompoc region. We would like to increase our Lompoc Emergency Shelter bed contract to a total of 8 - 10 beds just in that facility alone. 2) Mental Health Contract - We would like to increase our Medi-Cal Mental Health contract as we continue to diversify our funding and provide more services to those in need. We are estimating an increase of an additional $100,000 for next year. 3) Mental Health Homeless Outreach Teams - I believe your department is already working on this gap in services through some new funding that you just received. Good Samaritan Shelter would welcome homeless outreach teams in both the Lompoc and Santa Maria region.

Name: Nikkita Bloomfield

Affiliation: The Recovery Village

Comment: I came across your page here: http://www.countyofsb.org/behavioral-wellness/externalresources.sbc while researching mental health resources and wanted to reach out. I'm a team member of The Recovery Village. We strive to have our website be an educational resource by featuring helpful articles, blog posts, and resource pages to increase understanding and awareness of these mental health disorders that can affect so many.

Would you be able to assist us in helping individuals and their loved ones seeking support by sharing our new mental health resource https://www.therecoveryvillage.com/mental-health/ on your site? It includes valuable information on mental health support, co-occurring disorders, and treatment options as well as phone numbers for The Recovery Village, alcohol abuse, drug abuse, and other national hotlines. With your assistance, we'll be able to raise mental health awareness and provide support to those in need.

Response: Thank you for the inquiry. We have reviewed the website link proposed, which has very good content. Yet, due to the service and referral links with an unknown vendor, posting to our website would not be within our information dissemination procedures.

Name: Charles Hughes

Affiliation: MHSA Stakeholder

Comment: Concern- As I stated earlier there are many consumers and family members in Santa Barbara County that are not in the workforce. That would like to be in on the planning stages as well as to serve on Behavioral Health committees, panels and boards. What is lacking: 1. A pools of informed consumers and family members, champions. That have training in advocacy and BeWell protocol & procedures 2. A standing pool of consumer champions that can be drawn on for the consumer perspective in service at any and all levels of decision making on administration affairs What it will look like: When there are panels and committees are lacking the consumer perspective at any level on committees or panels. Members of the Pool of Champions could be called on to serve on the same.

Response: Thank you. This will be included in MHSA plan comment section and I will forward your comment to the new Peer Manager once hired as they set goals and priorities for their office.

Name: Audra Strickland

Affiliation: Hospital Association of Southern California

Comment: The need for additional services in the county is critical, and hospitals will be a part of the solution by creating involuntary Crisis Stabilization Units with intensive services, plus assessments and observation by psychiatrists, mental health nurses, and social workers. Many to most emergencies will be resolved in a calm, less-restrictive setting, improving patient care and conserving critical inpatient services for only the most urgent needs. The County's support for Medi-Cal patients in Crisis Stabilization Units is necessary and crucial to filling the gaps in the continuum of care within the county. A shortage of crisis mental health services exists across the State. Many counties have few to no services for the critically mentally ill. We are fortunate to have a county committed to serve these individuals in the appropriate treatment setting as close to home as possible. County resources spent on Crisis Stabilization Unit services will provide patients with one more tool to get this urgent care close to home.

Response: Thank you for your input.

Name: Charles Hughes

Affiliation: MHSA Stakeholder

Comment: It is nice to know that consumers and family members in the workplace are consulted in the original planning and development of new programs and enhancements! However there are many consumers and family members in Santa Barbara County that are not in the workplace. Who would like to and could be in the discussions for developing new programs. They apparently are not considered part of the community that MHSA is supposed to be collaborating with. An idea would be to utilize CFMAC meeting for ideas for programs development prior to the drafting of the one year updates and 3 year plan.

Response: Thank you for your feedback. At our next Client Family Member Advisory Committee (CFMAC) meeting on February 21, 2019, let's discuss who can be added to the distribution for peers and what format(s) would work for this during the MHSA planning discussion on the upcoming February agenda. We had a Peer Action Team for Systems Change and perhaps a format like that would work. The Stakeholder Forums at both Recovery Learning Centers, the Peer Employee Forums, Cultural Competency Meetings, CFMAC, Staff Quarterly meetings, and Behavioral Wellness Commission meetings are the regular stakeholder groups who we have been presented to and provided feedback in the last year for new programs or changes. These groups represent both internal and external stakeholders. If we need to expand or amend attendees or format for peer involvement, CFMAC will be a very good place to discuss. Looking forward to seeing you there!

Name: Audra Strickland

Affiliation: Hospital Association of Southern California

Comment: The Hospital Association of Southern California represents more than 180 hospitals in Southern California – including the hospitals in Santa Barbara County. HASC works to lead, represent and serve hospitals, and work collaboratively with other stakeholders to enhance community health.

Among top priorities for hospitals is connecting patients experiencing a mental health emergency to the appropriate mental health services -- timely and safely. This has been a challenge across the county as sufficient emergency mental health services have not existed. Each year, mental health patients spend more than 50,000 hours in hospital Emergency Departments waiting for transfer to critical, inpatient psychiatric services. Sometimes those services are provided in the county, but most of the time, patients are transferred as far away as Bakersfield and Pasadena to receive necessary care.

Name: Wayne Mellinger, Ph.D

Affiliation: Commissioner, Santa Barbara County Behavioral Wellness Commission

Comment: As you know, I am passionate about the needs of those with mental health issues who remain unhoused. Several years ago I made a fuss when the MHSA Report stated that 60 homeless people were receiving services from the department. Given that the then current Point in Time count estimated that up to 400 in the city of Santa Barbara alone were probably in need of some form of treatment, the number sixty seemed shockingly low. I place most of the blame for these inadequacies on the Board of Supervisors who historically underfund the department. Our County often gives about half the amount compared to other similar Counties--something like 3% compared with their 6%. Director Gleghorn has made significant strides in addressing the many gaps that there were in the department when she arrived. I do not doubt that she "gets it". Coming from San Francisco with its significant 'homeless problem", how could she not. The re-visioning of psychiatric crisis services since Gleghorn arrived is impressive! There are more alternatives to the PHF and ways that consumers can 'step up" for more services or 'step down' if they need less. The re-visioning of homeless outreach services has also been impressive. Led by the skilled Sara Grasso, there is a much stronger homeless outreach team. When we add the AmeriCorps workers, many who I have met and find bright and motivated, we should have a much greater picture of who is out there and what their needs are. I do not know the numbers of homeless currently receiving services. (Could someone send me that information?) . My sense is that we still have a long way to go. I understand the challenges in getting many of these people into treatment. So many are what has been called service-resistant, avoiding contact with professionals, filled with trauma and distrust and often self-sabotaging the efforts that have been made. I think that there are still so many people out there suffering that there is a continued need to expand services to these populations. Creative and innovative solutions are needed and the old ways of doing things must be set aside. Related to all this has been the Department entry into housing. This is a bold and much needed move and greatly appreciated. We also need to find innovative and creative solutions here. No one can get well while unhoused and even middle class people have challenges finding housing in Santa Barbara. I think that we need to consider more group homes. Perhaps taking the model of "sober living homes " and modifying them for the needs of those with mental illness could provide more housing. "Master leasing" such as done now by the Mental Wellness Center needs to be scaled up to address our grave needs. Something needs to be done about landlords discriminating against people with Section 8 Vouchers. That seems to effect many. Isn't that income discrimination? I have heard of other communities using "supported employment" to help people have meaning lives, some income and things to do. I have heard that the ACT teams are much stronger than several years past and wonder if they might be used more to serve those on the streets. I was pleased to hear that you are re-thinking the role of peer consumers in the department. Five years ago I did the WET training with Tina Wooten along with 40-50 others. Virtually none of them have gotten employed in the department. The "us / them" thinking is still pervasive. I had a personal story regarding the discharge policies I want to share with you and agree that the Commission should have an opportunity to gi e input on items like this. I lost my phone several months ago and had to wait 10f days for the SIM card to be mailed to me. During that time I missed my reminder call from the Calle Real Clinic. A week later a letter came from the Clinic that I did not realize was urgent. It stated that I had just a few days to contact the Clinic to remain a client. By the time I called the Clinic I had been dropped as a client. Being outgoing and assertive I was able to be re-instated. But it all happened so quickly. If someone was in criss they might not have the ability to be assertive and get re-instated. I apologize for the rambling nature of this letter and lack of detailed exploration of any issue. Thank you for your efforts to improve the department.

Response: Thanks for your feedback. Once we publish the draft plan, the demographics for Homeless Services will be reflected and updated for the FY 17-18 year. I'm also encouraged by the Department's recent expansion for West and North County Homeless Services as a result of the Homeless Mentally Ill Outreach and Treatment Grant. Ms. Grasso is leading the implementation and it is about to launch! Development of a mobile vehicle for outreach/services is a key step too. It which hopefully will be purchased and available in County in the next year. I have provided your feedback about the discharge policy to our Compliance Officer, Celeste Andersen, as she guides our Policy and Procedure workflow. Your input regarding master leasing and housing is critical and aligned with the priorities of the Department. We look forward to your commitment for support of the homeless population and consistent feedback as we initiate No Place Like Home and other housing support opportunities. Please also join us at the Consumer Family Member Advisory Committee meetings as we set new goals for the year.

Name: Kara Roberts

Affiliation: Practitioner Intern

Comment: Will MHSA provide any student loan grants this year? Could some funding be allocated to student loan repayment for interns (MHSA workforce Development Funding- Mental Health Loan Assumption Program (MHLAP)?

Response: Thanks for the question about MHSA Workforce Development funding. At this time, the Mental Health Loan Assumption Program (MHLAP) was not in the current year budget from the State. I have not heard of a new release for this opportunity. Here is the link to the program should they release more cycles: https://oshpd.ca.gov/loans-scholarships-grants/loan-repayment/mhlap/ Yet, there are other grant opportunities from the agency who oversees this program. Here is the link for these: https://oshpd.ca.gov/loans-scholarships-grants/grants/

MHSA Plan Posting Feedback Received from April 23, 2019 to May 30, 2019

Email Sent: Wednesday, April 24, 2019
First/Last Name: Zamora, Katarina
Email: kzamora@co.santa-barbara.ca.us
Affiliation: County of Santa Barbara

Message: There is a spelling error for Carpinteria throughout document and Santa Barbara on the Demographics page. This is an interesting document, and well done!

Response: Thanks for taking reading the plan and these edits will be made in the final document. Thanks again

Email Sent: Friday, May 10, 2019
First/Last Name: Velasquez, Noemi
Email: noemiv@chccc.org
Affiliation: CHCCC

Message: I wanted to let the Commission know that Outreach is a very important component to mental health services. This need was also expressed in the Stakeholder meetings by constituents. We work very closely with families who are monolingual Spanish and Mixteco speaking. The families tend to be isolated and are unaware of available services in our county. A lot of times adults and or children are in need of mental health services and if Outreach and Educational programs are unavailable families fall through the cracks and do not obtain services until they develop lifelong mental health illnesses and or are identified through suicide attempts and crisis incidents. We provide outreach and education/ support groups to families who otherwise would not utilize services to be able to normalize the talk around mental health. Individuals also engage in dialogue in support groups to understand there conditions and or help others within their social circles who suffer with mental health illnesses. As restricted as the budget is it is imperative that we continue Outreach to create access.

Response: Thank you for your comment and continued support of MHSA Outreach activities.

Email Sent: Tuesday, May 21, 2019
First/Last Name:
Email:
Affiliation:

Message: With the incorporation of a Full Service Partnership for the TAY youth, the Department of Behavioral Wellness needs to ensure that there is sufficient staff to meet the needs of all of the TAY clients. Sufficient staff will ensure that the youth get the required level of services to support them in becoming functioning members of the community. Licensed practitioners and caseworkers need to be available to serve all of the TAY youth needs, not just the clients with the highest level of needs and in the FSP. The Department of Behavioral Wellness needs to ensure that the rest of the TAY youth will have enough Practitioners and Caseworkers to meet the needs of the lower level as well. The TAY program is extremely important and these youth need much support. In the Rolling out of the FSP it is advisable to hire a Clinician who will be responsible for this program and not take away from the other TAY programs in efforts to provide this high level of service that we know the community needs. Lets make sure that the other programs are not effected by the roll out of the FSP.

Response: Thanks for your feedback. As we implement this program we will continuously review data regarding services to this age group. Part of the transition includes adding case workers provided by Community Action Commission to the current New Heights teams. Rather than adding a new program, the intent is to expand an existing one to allow more robust service capacity and programming. This will streamline each program creating better transitions of care and overall improved structures. In addition, a Prevention and Early Intervention practitioner is being added in each region to focus on access and assessment for children and TAY and a Katie-A practitioner has been added to complete all the Katie-A intakes. The additional access and Katie-A assessment staff will provide the current New Heights TAY team with the ability to focus on direct ongoing services to clients rather than these varied roles. We will also continue to monitor during implementation and adjust as needed.

Attachment 6: Behavioral Wellness Commission Meeting Agenda Setting (2/2019) and Agenda (5/30/2019) Public Hearing

County of Santa Barbara

Behavioral Wellness Commission

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

Behavioral Wellness Commission (BWC) Meeting Agenda

The Santa Barbara County Behavioral Wellness Commission will meet from 3:00 p.m. to 5:00 p.m. on Wednesday, February 20, 2019 at the Santa Barbara Children's Clinic (Large Conference Room), 429 North San Antonio Road, Santa Barbara, CA 93110. Videoconferencing will be available to the public at the Santa Maria Adult Clinic (Annex Conference Room), 500 W. Foster Road, Santa Maria, CA 93455 & Lompoc Childrens Clinic (New Port Harbor Conference Room), 401 E. Ocean, Lompoc, CA 93436.

Persons desiring to address the meeting participants can complete and deliver to the staff the form which is available at the room entrance prior to the commencement of this comment period. This is an opportunity for members of the public to speak on items that are not on the agenda for today's meeting. Times listed for agenda items are estimated only and may change depending on item discussions.

Time	Item	Presenter
3:00 p.m.	**1. Call-to-Order and Conduct Roll-Call**	Karen Campos
3:01 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.	Sharon Byrne
3:02 p.m.	**3. Welcome and Introductions** chairperson asks for member introductions**.** **Action:** No action.	Sharon Byrne
3:04 p.m.	**4. General Public Comment** (2 minutes per person) - Members of the public can testify before the meeting participants on any matter appearing on the agenda. **Action:** No action.	Public Members
3:14 p.m.	**5. Chairperson Announcements** **Action:** No action.	Sharon Byrne
3:15 p.m.	**6. Review and Approve Minutes of the January 16, 2019 BWC Meeting** (Attachment 6a) **Action:** Approve January 16, 2019 BWC Meeting Minutes.	All
3:17 p.m.	**7. Executive Director's Report** highlights monthly Department & County news (Attachment 7a) **Action:** No action.	Alice Gleghorn

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New Business:

3:40 p.m.	**8. Mental Health Services Act (MHSA) Update** **Action:** Vote on designating part of the April or May Behavioral Wellness Commission meeting to the MHSA public hearing.	Lindsay Walter
3:55 pm	**9. Behavioral Wellness Current Year Financial Status Update** **Action:** No action.	Chris Ribeiro

Commission Business:

4:20 p.m.	**10. Reports of Officers, Boards: Chair, Site Visits, Liaisons to other Committees and BWC Special Committees**	
	A. BWC Site Review Compilation Ad Hoc Subcommittee Update	R. Pearson T. Franklin
	B. Sheriff's Community Corrections Input Group Update	M. Richardson
	C. Ballot Initiative Exploration Ad Hoc Subcommittee Update	S. Byrne T. Franklin R. Pearson S. Rumberger
	D. Data Notebook Subcommittee Update	J. Blue R. Pearson S. Rumberger W. Mellinger S. Byrne J. Winter J. Moore
	E. California Association of Local Behavioral Health Boards & Commissions (CALBHBC) Update	T. Franklin
	F. Bylaws Ad Hoc Subcommittee Update: propose an amendment to the BWC bylaws for Board of Supervisors (BOS) consideration to include a Nominating Committee.	J. Winter A. Eldridge S. Rumberger

Action: Review and approve amendment proposed for BOS consideration to the BWC Bylaws in adding a nominating committee.

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4:50 p.m.	**11. Medicaid Exclusion Waiver Letter of Support to BOS** (Attachment 11a) **Action:** Review and approve the letter to BOS regarding Medicaid Exclusion Waiver.	J. Winter
4:55 pm	**12. Upcoming Agenda Items**	All
5:00 p.m.	**13. Adjournment**	

"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 Clerk of the Board at 105 E. Anapamu Street, 4th Floor in Santa Barbara, and also on the Behavioral Wellness website at: www.countyofsb.org/behavioral-wellness

Further Information Regarding Meetings:

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

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

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

Disability Access: The locations for this meeting are the Santa Barbara Children's Clinic large conference room located at 429 North San Antonio Road, Santa Barbara, CA. Videoconferencing will be available to the public at the Santa Maria Adult Clinic, 500 W. Foster Road, Santa Maria The meeting rooms are wheelchair accessible. Accessible public parking is available.

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

Attachment 7: Minutes of Public Hearing

Department of Behavioral Wellness Commission Special Meeting
Thursday, May 30, 2019
3:00 p.m. - 5:00 p.m.
Santa Barbara Board of Supervisors Conf. Rm.
Santa Maria Board of Supervisors Conf. Rm.

Meeting Minutes

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

Commission Members Present: Rod Pearson, 1st District; **Jan Winter**, 1st District; **Wayne Mellinger**, 1st District; **Jeffrey Moore**, 1st District, Vice Chair; **Gregg Hart**, 2nd District Supervisor; **Marcos Olivarez**; 2nd District; **Judy Blue**, 2nd District; **Bill Cirone**, 3rd District; **Mary Richardson**, 3rd District; **Heather Moselle**, 3rd District; Sharon Byrne, 4th District, Chair; **Donald Casebolt,** 5th District; **Charles Huffines**, 5th District.

Commission Members Excused: Sharon Rumberger, 2nd District; **Angie Swanson-Kyriaco**, 2nd District; **Tom Franklin,** 3rd District; **Julia Lara,** 4th District; **Kelly McLoughlin,** 4th District; **Ann Eldridge,** 5th District.

Behavioral Wellness Department Staff: Lindsay Walter, Deputy Director of Administration and Operations; **Pam Fisher,** Assistant Director of Clinical Operations; **Chris Ribeiro**, Chief Financial Officer; **Karen Campos**, BWC Program Administrator; **John Doyel**, Division Chief of Alcohol Drug Program; **Vanessa Ramos**, Healthcare Program Coordinator; **Maria Arteaga**, Peer Empowerment Manager; **Qiuana Lopez**, Department Business Specialist; **Wade Schoonveld**, Administrative Office Professional I; **Christopher Shurland**, Contracts Supervisor; **Caitlin Lepore**, Research and Program Evaluator; **Shereen Khatapoush**, Research and Program Evaluator.

1. **Call-to-Order and Roll-Call:** Chair Byrne called the meeting to order at 3:05 p.m. Behavioral Wellness Commission Program Administrator, Karen Campos conducted roll-call.
2. **Establish Quorum:** Chair Byrne established quorum.
3. **General Public Comment:** none.
4. **Welcome and Introductions:** Chair Byrne welcomed everyone and had all staff and members of the public introduce themselves.
5. **Mental Health Services Act (MHSA) Fiscal Year 2019-20 Annual Plan** (attachment 5a)

   Lindsay Walter, Deputy Director of Administration and Operations, provided a high level overview of the draft FY 2019-2020 MHSA Plan Update. The presentation included detailed information on the following: MHSA background; FY 2019-20 MHSA planning process; Santa Barbara County demographics; Program Updates on all programs under Community Services and Supports (CSS) including Full Service Partnerships, status of Prevention and Early Intervention (PEI), Housing, Workforce Education and Training (WET), Capital Facilities and Technological Needs (CF/TN) and the status of two approved Innovations projects. She elaborated on the role the local mental health board in holding the hearing at the close of the thirty day posting period to hear public feedback on MHSA. Following her presentation, stakeholders, including commissioners and public, provided their feedback

and comments to the draft plan.

6. **Public Comment regarding MHSA Plan Update:**

- We need more clarity of the types of staff who are providing Outreach and Engagement for instance, are those providing services Licensed Clinicians, Caseworkers? Are they 5150 trained in order to participate?

- We need for HMIOT to be defined. Reviewed definition is the Homeless Mentally Ill Outreach and Treatment grant.

- Are the Three Year plan areas for focus as presented in addition to what the County provides or added/enhancements? If the purpose to expand or to change?

- Are the 22 housing beds mentioned at Pathpoint in addition to the beds accounted for Crescend?

- With No Place Like Home, will the County be adding 50 beds in Santa Maria or will the beds be in the City of Santa Barbara?

- Please use caution with the Technology Suite as there are many vendors that are selling the information of consumers for profit. Digital phenotyping is an area of concern from family members of those in Families Act.

- Parents and family members need more educational information on the types of services that are available for their loved ones coming out of the justice system.

- We need integrative healthcare to closer relationships to treat the whole person including substance use programming in our mental health programs.

- We need more information on how we are connecting to services. More work needs to be done that highlight linkage to services.

- Three Year community planning needs help. The community needs to be educated on what stakeholder meetings are for and understand that they help build the three year plan. Behavioral Wellness needs to host stakeholder educational training(s).

Feedback from Commission Members

- The RISE program has not provided the data that we were hoping for. We will need to look at this program closely as it winds down by next July. RISE clients cost about $20,000 a person. Maybe other agencies can help this population.

- The Santa Barbara census data with demographics information may be misrepresenting the true demographics of the County of Santa Barbara.

- The Technology Suite is confusing and many older adults are being missed and will not be helped by this project.

- Commission should participate in stakeholder planning group for the three year MHSA plan.

- The Technology Suite is for people that have phones and many homeless people do not have charging stations and have government provided phones that do not work.

- We need more data on if Homeless Services at the Recovery Learning Centers (RLC) are effective. I know that homeless consumers participate in the lunch at the RLC but are they receiving services or linking to services within Behavioral Wellness?

- Is $900,000 enough for the Homeless Services? Let's look at this information. Housing is a roadblock and Co-Occurring programs need more funding.

- We need clarity on why South County is getting more funding than north and west when South is not reflecting as effective for ACT services?

- With Anka going bankrupt, will developments to Depot on Agnes St. be interfered or will Depot St still be open Oct/Nov 2019?

- The Cultural Competence plan reflects that transportation and stipends for consumers participating in the Client and Family Advisory Committee are covered but they are not, has there been a change?

- The Commission is committed to being a part of the planning process that goes into the next MHSA Three Year Plan.

- The Crisis Text Line is a great platform and could possibly provide information on applications that the Technology Suite is implementing.

- Commission needs to do a better job by taking an active role in marketing the Behavioral Wellness MHSA Hearing each year to ensure that the meeting is well attended by stakeholders for public comment.

7. **Adjournment:** Commissioner Pearson made a motion to adjourn the public hearing at 5:00 pm. Commissioner Olivarez seconded. No abstentions. No objections. Motion carried.

Attachment 8: Evidence of Santa Barbara County Board of Supervisors' Approval (Placeholder)

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