Santa Barbara County Mental Health Services Act

MHSA PLAN UPDATE

FY 2014-15

Santa Barbara County

Department of Alcohol, Drug and

Mental Health Services

(ADMHS)

www.countyofsb.org/admhs

Alice Gleghorn, Ph.D., Director

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December 8, 2014

How this Plan Update is Organized

- ✓ This Plan Update is divided into three major sections**:** **Background**, **Program Updates** and **Supporting Materials**.
- ✓ The **program updates** are listed by Mental Health Services Act (MHSA) **funding component**: Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Innovation (INN), Capital Facilities and Technological Needs (CF/TN) and Workforce Education and Training (WET).
- ✓ Information about **new and expanded programs** appears within their respective MHSA funding components (CSS, PEI, Innovation, CF/TN and WET). A "new" icon is displayed each time a new or substantially modified program is presented.
- ✓ Enhanced crisis services made possible by **S.B. 82** grants are funded primarily through state MHSA allocations. However, S.B. 82 crisis enhancements are included in the Plan Update because (1) all outpatient programs and service sites will adhere to MHSA guiding principles and (2) SB 82-funded crisis programs will be an integral part of the new crisis system of care and recovery, alongside crisis components supported primarily by county MHSA funding.

Navigational Tools

- ✓ To help readers pinpoint specific items of interest, in addition to the **Table of Contents**, the PDF version of this document features **bookmarks** with direct links to specific sections of interest.
- ✓ A **glossary** is provided as Attachment 10 (see page 100).
- ✓ **Programs at a Glance** lists ADMHS outpatient programs by age group and funding source (see page 24.)

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MHSA COUNTY COMPLIANCE CERTIFICATION

County: Santa Barbara

Local Mental Health Director	Program Lead
Name: Alice Gleghorn, Ph.D. Telephone Number: (805) 681-5220 Email: agleghorn@co.santa-barbara.ca.us	Name: Refugio "Cuco" Rodriguez-Rodriguez Telephone Number: 805-681-4505 Email: cucorodriguez@co.santa-barbara.ca.us
Local Mental Health Mailing Address: Santa Barbara County ADMHS 300 N. San Antonio Rd. Santa Barbara, CA 93110	

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

This annual update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft annual update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on March 17, 2015 .

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

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

Alice Gleghorn, Ph.D. Director

Local Mental Health Director/Designee (PRINT) Signature Date

County: Santa Barbara ADMHS

Date: _____

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County: Santa Barbara

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

Local Mental Health Director	County Auditor-Controller/City Financial Officer
Name: Alice Gleghorn, Ph.D.	Name: Robert W. Geis
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Local Mental Health Mailing Address:

Santa Barbara County ADMHS
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 Date

I hereby certify that for the fiscal year ended June 30, 2013, the CountylCity 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_____for the fiscal year ended June 30, 2013. I further certify that for the fiscal year ended June 30, 2013, 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.

Robert W. Geis, CPA, CPFO

County Auditor/Controller/City Financial Officer (PRINT) Signature Date

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

Executive Summary

A Changing Environment

The FY 2014-15 MHSA Plan Update is a result of broad-based community input from consultant interviews with more than 450 groups and individuals, MHSA stakeholder forums, systems change entities (change agents, action teams, steering committee), Mental Health Commissioners, community-based providers and advisory groups, community advocates and leaders and a new MHSA planning group that includes representatives of the systems change steering committee.

Several forces have made the proposed Santa Barbara County Department of Alcohol, Drug and Mental Health Services (ADMHS) FY 2014-15 Mental Health Services Act (MHSA) Three-Year Expenditure Plan the most transformative proposal since the original MHSA plan was introduced almost a decade ago:

- The Affordable Care Act (ACA) is widening access to mental health services and emphasizing the integration of physical health, mental health and substance abuse care. ACA is in complete alignment with the MHSA guiding principles of wellness and recovery and the seamless delivery of services.

- Launched in June 2013, a substantial ADMHS systems change initiative has been designed to enhance efficiency, collaboration, welcoming, hopefulness, an outcome-focused, recovery, innovation, diversity, service integration, complexity capability and cultural competence. Guided by a steering committee that reflects the scope and diversity of county behavioral health stakeholders, a sustained and unprecedented level of stakeholder collaboration has shaped the proposed redesign of outpatient programs. Like the Affordable Care Act, the systems change initiative is wholly aligned with the guiding principles of MHSA.

- Although many past "reform" efforts have met with limited success, the current systems change effort is fundamentally different. Departmental efforts have gained broad support from both stakeholders and the County Executive Office, which has played a proactive role in systems change. In addition, the Santa Barbara County Board of Supervisors expressed strong support during a public hearing held on April 22, 2014.

Reorganized Outpatient Services

The FY 2014-15 MHSA Plan Update proposes a system-wide transformation of children's and adult outpatient programs and services through the adoption of the MHSA guiding principles by *all* programs. Specialized team will work in an environment that promotes a welcoming, trauma-sensitive, culturally competent, client and family-focused, strengths-based, resiliency/recovery-oriented approach.

The evidence-based Comprehensive Continuous Integrated System of Care (CCISC) is being used as a framework for system-wide implementation. CCISC guides the leveraging of all resources in a quality improvement partnership among consumers/families/front line staff and change agents throughout the system. The goal is to ensure that all programs and staff members are welcoming, recovery/resiliency oriented, trauma-sensitive, culturally competent, and co-occurring/complexity capable. CCISC has been used for system improvement in more than a dozen California counties and in more than 30

states.

The restructuring of outpatient programs will establish standardized, system-wide practices in all programs. All current ADMHS adult service sites will become Wellness and Recovery Centers, and all children's service sites will become Wellness and Resiliency Centers operating in full accordance with MHSA principles.

New and expanded specialized services will address longstanding community needs use evidence-based and promising practices, culturally adapted to meet the specific needs of un-served and under-served populations.

Specialized outpatient teams will use evidence-based practices such as Cognitive Behavioral Therapy (with individualized, population and diagnosis-specific application); Dialectical Behavior Therapy; Motivational Enhancement Therapy; Seeking Safety; Eye Movement Desensitization and Reprocessing (EMDR)**;** Cognitive Enhancement Therapy; Family Behavior Therapy; IMPACT depression treatment and Moral Reconation Therapy to address criminogenic risk. For more details, please see Attachment 9, Selected Evidence-Based Practices.

Although specialized outpatient teams will improve outcomes for many clients, and they are *not* intended to increase fragmentation. In fact, the intent of redesigned outpatient service delivery system is to create *greater access* for clients into the system, as well as within the system. This will improve systemwide cooperation and increase seamless delivery for clients and families.

Principles of Access and Service

Four principles will determine how clients gain access:

1. Specialized outpatient teams will operate in an environment that promotes welcoming, cultural competence, complexity-capability, a focus on clients and families and an approach that is strengths-based and resiliency/recovery-oriented.

2. Each client will be assigned a specialized program based on his or her highest level of need, not payer source.

3. Supplemental services from other programs are available to clients as needed.

4. Each program will strive to serve individuals of varying levels of acuity to the fullest extent possible.

A diagram illustrating access under the transformed outpatient service system appears on page 26.

Existing Programs Maintained

No existing MHSA programs are recommended for elimination. Continued programs by funding component are:

Community Services and Supports (CSS): Assertive Community Treatment (ACT) children's wraparound (SPIRIT), Crisis and Recovery Emergency Services Mobile Crisis (CARES), Bridge to Care (a program in Lompoc that provides medication support to individuals with co-occurring

conditions) and Partners in Hope, which supports peer recovery specialists and recovery learning communities countywide. The Justice Alliance, which supports licensed mental health liaisons to courts in Santa Barbara, Santa Maria and Lompoc, will be expanded into three forensic teams.

Prevention and Early Intervention (PEI): Early Childhood Mental Health; Integration of Mental Health and Primary Care; Community Health Educators; School-Based Mental Health Services; Prevention and Intervention for Transition-Age Youth (TAY), children's crisis services (SAFTY) and school-based services in Carpinteria (START, or Support Treatment, Advocacy and Referral Team).

The Innovation funding component will continue, but in accordance with Innovation guidelines, the Innovation *projects* will change (see below).

Proposed New and Expanded Programs

New and expanded programs proposed for adults and funded by the Community Services and Supports (CSS) component (except where otherwise noted below) are designed to address significant gaps in the continuum of care and recovery:

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Streamlined access for clients and families: Access and Assessment Teams for each region of the county funded by the Prevention and Early Intervention (PEI) component. This will eliminate a number of barriers to access by providing rapid, field-based intake assessments. The Access and Assessment Teams will collaborate with the Mobile Crisis Triage Teams, performing pre-crisis interventions and hospital discharge planning. Mobile Crisis Teams conduct crisis assessments and determine if there is a need for acute inpatient care

Wellness and Recovery specialized outpatient teams for adults and *Wellness and Resiliency* teams for children will be established in Lompoc, Santa Maria and Santa Barbara.

Justice-involved clients with mental health needs will be served through the expansion of the Justice Alliance program into a more richly-staffed Forensic FSP.

Homeless Services Teams will expand services in Santa Barbara and Santa Maria and initiate services in Lompoc.

Specialized Co-Occurring outpatient teams will serve clients requiring a focus on co-occurring mental health and substance use challenges.

Teams serving Older Adults with Medical Needs will be based in Lompoc, Santa Maria and Santa Barbara.

Proposed new Innovation projects will serve sexually exploited and at-risk young women in the juvenile justice system; Medical Integration and Older Adult Teams; and Culturally Adapted and Recovery-Focused Models of Care.

New Crisis Triage Teams in Lompoc, Santa Maria and Santa Barbara funded by grants made possible through California Senate Bill 82 (S 82*A crisis stabilization unit and a crisis residential facility* in Santa Barbara funded by S.B. 82 grants.

A Mobile Crisis Team in Lompoc funded by S.B. 82.

The CSS component will fund the crisis residential facility in Santa Maria and the HOPE program for children.

Expansion of Full Service Partnerships

Full Service Partnership (FSP) is a category of MHSA Community Services and Supports funding that refers to programs serving particular un-served and under-served populations and deploying a "whatever it takes" approach to comprehensive and effective service delivery.

A new FSP is proposed to serve court-involved individuals, addressing a longstanding community needs expressed repeatedly in stakeholder forums going back at least to the inception of MHSA a decade ago, if not earlier.

FSP requirements are listed on page 43. A map of current and proposed adult FSP appears on page 44.

Inclusion of S.B. 82-Funded Programs

New crisis programs funded by S.B. 82 grants are primarily supported by state, not county, MHSA funding. However, S.B. 82-funded crisis enhancements are included in this Plan Update because 1) all outpatient programs will be guided by MHSA principles and 2) the S.B. 82-funded components will work very closely with "traditional" crisis programs. An understanding of the new crisis system of care and recovery requires familiarity with both existing and new crisis programs.

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 one million dollars. Becoming law in January 2005, the MHSA represents the latest in a California legislative movement, begun in the 1990s, to provide better coordinated and more comprehensive care to those with serious mental illness, particularly in under-served populations. Additionally, MHSA has proven an effective vehicle for leveraging funding and developing integration, opportunities enhanced through the Affordable Care Act.

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

1. Community program planning and administration (10%)
2. Community Services and Supports (CSS) (45%)
3. Workforce Education and Training (WET) (10%)
4. Capital Facilities (Buildings) and Technological Needs (CF/TN) (10%)
5. Prevention and Early Intervention (PEI) (20%)
6. Innovation (5%)

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

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

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

County plans are to contribute to achieving the following goals:

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

MHSA Three-Year Program and Expenditure Plan

Counties are required to develop three-year MHSA component plans and to update those plans on an annual basis. During the development of the annual update process for FY13/14, stakeholders expressed the need to improve departmental transparency and inclusiveness and to maximize opportunities for service integration. These efforts aligned with implementation of both the Affordable Care Act and recommendations made by the TriWest Group for transforming outpatient programs and services.

MHSA Funding Components

MHSA allots funding according to five major components: Community Services and Supports (CSS), Workforce Education and Training (WET), Prevention and Early Intervention (PEI), Capital Facilities and Technological Needs (CF/TN) and Innovation (INN). Two of these components, WET and CF/TN, are time-limited; these funding components were not structured to be permanent funding components. CSS, PEI and Innovation are ongoing, although MHSA guidelines call for changing Innovation projects every few years.

The CSS component consists of three funding *categories*: Outreach and Engagement, General System Development and Full Service Partnerships (FSPs). MHSA requires that counties allot at least 51% of CSS funds to Full Service Partnerships.

The ADMHS Systems Change Initiative

As a result of substantial, ongoing criticism, over the past year the Santa Barbara County Alcohol, Drug and Mental Health Services (ADMHS) has undergone a systems change effort. In 2012 the TriWest Group and Health Management Associates were hired by the County Executive Office to review ADMHS financial processes, inpatient and outpatient operations, service delivery options, procedures and practices and more.

At the same time, Health Care Reform has also increased the urgency to create more efficient services requiring full integration of MHSA into outpatient operations.

TriWest Report Issued

Health Management Associates and The TriWest Group, consultants hired by the Santa Barbara County Executive Office, interviewed more than 450 groups and individuals, analyzed data and provided sweeping recommendations. The outpatient report was officially adopted by the Board of Supervisors on May 21, 2013. The full report and key recommendations are available online at http://www.countyofsb.org/admhs/admhs2.aspx?id=43555&id2=43556

Steering Committee Formed

In response to the report, the Santa Barbara County Executive office made a significant commitment to systems change for behavioral health services and convened the comprehensive System Change Steering Committee. The Steering Committee is made up of consumers, family members, front line staff, change agents, community-based organization representatives, mental health advocates, law enforcement, and others. A list of Steering Committee members is provided as **Attachment 7**. This body guides and evaluates system change efforts. The systems change initiative is widely seen as an unprecedented opportunity to reshape programs and services that are more responsive to community needs.

The Steering Committee adopted a vision and guiding principles to inform all system change efforts and to support continuous quality improvement. The Steering Committee's vision and guiding principles are fully compatible with, and supportive of, the MHSA and are included as **Attachment 8**.

Action Teams and Change Agents

To advance systems change, the Steering Committee chartered six action teams that concentrate on cultural competence, crisis services, children's services, peers, forensics and housing. The action teams use a continuous quality improvement (CQI) process designed to identify problems/barriers, measure relevant data, decide on specific changes, measure the effect of changes, and make recommendations to the Steering Committee and ADMHS Executive Team.

In addition to action teams, a change agent team has held monthly meetings since fall 2013. Change agents represent consumer and family organizations, service providers and front line ADMHS staff from all clinical programs and administrative services. More than 100 individuals have attended change agent meetings. Five change agents serve on the Steering Committee.

Systems change initiatives undertaken over the past year have included:

- *Improving access to psychiatric care* (recently wait time was reduced by approximately 30% for adults and children, although more work is needed)
- *Preparing for the Affordable Care Act* – materials developed, analysis conducted of high users of services, budget impact assessed and application developed to obtain Certified Enrollment Entity status for the department
- *MHSA Planning for an enhanced stakeholder process* integration into systems change
- *Increasing co-occurring capability*: Change Agent trainings support universal development of recovery-oriented, co-occurring capable practices; initiating baseline self-assessments of co-occurring capability in various programs
- *Integrating alcohol, drug, mental health and primary care services*
- *Improving the Psychiatric Health Facility* to decrease length of stays, strengthen programming, and issue of a request for information to learn about inpatient partnership opportunities and creative operational models
- *Enhancing welcoming at all ADMHS service sites,* including a commitment to find a solution to facility issues in Lompoc
- *Developing welcoming crisis policies* and protocols for individuals with complex and co-occurring needs in crisis.
- *Increasing inpatient capacity*: A partnership with Marian Medical Center is exploring the use the old Marian West Hospital for a behavioral health facility that would include inpatient locked psychiatric beds, geriatric inpatient beds and other services
- *Implementing a South County Crisis Residential facility* and exploring the feasibility of other step-down supportive housing proposals and opportunities.
- *Updating and strengthening the ADMHS compliance program*
- *Establishing a career ladder for ADMHS peer staff*
- *Advancing innovative programs* in the Juvenile Justice Mental Health Services unit
- *Creating a new psychologists' group* to maximize use their skills and expertise
- *Improving forensic services* through participation in a jail-to-community collaborative
- *Improving referrals to, and utilization of, CARES Crisis Residential Unit in Santa Maria*
- *Advancing innovative programs in the Juvenile Justice Mental Health Services unit*

Extensive materials from the Systems Change Steering Committee, action teams, change agents and related documents may be found online at http://www.countyofsb.org/admhs/admhs2.aspx?id=43555&id2=43556 (or visit www.admhs.org and click on "systems change" in the "welcome" section of the home page.)

The MHSA Planning Process

As a result of the commitment to systems change guided by broad stakeholder engagement of the Steering Committee, for the first time, ADMHS initiated an MHSA Planning Group. This group helped determine the stakeholder planning process for the 13/14 MHSA Plan Update and the 14-15 Three-Year Program and Expenditure Plan.

The MHSA Planning Group included community providers, peers, family advocates, Mental Health Commissioners, internal staff and representatives of under-served and ethnic communities. This group coordinated planning efforts with the Mental Health Commission and ADMHS County of Santa Barbara's System Change Steering Committee, which includes members from MHSA-required stakeholder groups.

Strengthened stakeholder participation in planning, including input on the number and type of stakeholder events, ensured full community partnership in shaping the FY 2014-15 Plan Update.

The MHSA Planning Group created a robust, transparent, and inclusive stakeholder process that followed the Three Year Expenditure Plan guidelines while supporting the larger system change initiative.

The FY 2014-15 MHSA Plan Update marks the first year of a three-year course of action to transform all ADMHS outpatient clinics and crisis service centers into MHSA-funded Recovery Centers (adults) and Resiliency Centers (children). These centers will offer standardized assessments, referrals, and linkages to behavioral health programs and services located within the centers, as well as elsewhere in the community.

New specialized service teams in both the adult and children's systems will serve specific populations guided by MHSA principles and relevant evidence-based practices. Among the many new proposals, perhaps the most profound changes are increasing access to services and elevating standards for clinical excellence.

<u>Increasing Access and Fairness</u>

The FY 2014-15 MHSA Three Year Expenditure Plan maximizes the use of MHSA funding and leverages other support to create systems capable of delivering care to clients based on clinical necessity rather than the ability to pay for services.

Under the "traditional" system, uninsured individuals, many of whom are undocumented ethnic minorities, typically receive very limited care compared to Medi-Cal beneficiaries, who may access substantially more treatment options. A proposed new outpatient funding hierarchy will use MHSA funding first and foremost to ensure equal access to outpatient services for uninsured and un-served/under-served populations. The previous multi-tiered system that prioritized payer source over clinical need will be eliminated.

Through the TriWest consultant report and additional stakeholder input, the community overwhelmingly directed ADMHS to address the issue of equitable access. Creating a new standard of access based on clinical need is arguably the greatest single example of how MHSA principles are being used to transform the entire outpatient system of care and recovery.

Achieving Clinical Excellence and Cultural Competence

Stakeholders articulated a vision of Santa Barbara County behavioral health services that are welcoming, recovery oriented, trauma-sensitive, complexity-capable and culturally competent. The FY 2014-15 Plan Update supports specialized teams capable of better responding to complex client needs and specific populations. The creation of specialized outpatient teams will be guided by evidence-based and community-recognized practices and MHSA principles -- a significant departure the previous service delivery system. Each specialized team will offer a range of services based on individual client needs.

Stakeholders identified approximately 10 different evidence-based or community-tested and recognized practices. Training and implementation of these models/practices will strengthen partnerships with stakeholders and content experts in recovery, integration (co-occurring capability), and cultural competency. Additional specialized practices for under-served/un-served populations and practices will also be identified and adopted.

Community-based organizations, the system-wide change agent team and other partners have begun identifying system resources and creating a practice improvement and training plan. This plan will draw on local expertise to the fullest extent possible. The ongoing engagement of stakeholders remains essential for ensuring that implemented models incorporate key principles of recovery and cultural competence.

Additional strategies that support competency and threshold language access will ensure that staff teams are adequately trained to be culturally sensitive to the needs of diverse populations. The selection of evidence-based practices will be based on research with the populations served and modified accordingly. In addition, ADMHS will continue to require that at least 40% of all staff be bilingual and bicultural (Spanish/English) to meet the needs of threshold language populations in Santa Barbara County.

Ensuring Stakeholder Engagement

The stakeholder engagement process for the FY 2014-15 MHSA Plan Update consists of four phases.

Phase 1: Building a Foundation for Broad Community Engagement:
Informed by the results of the TriWest Group's engagement of stakeholders, a new MHSA Planning Group that includes representatives of the ADMHS Systems Change Steering Committee was formed. The MHSA Planning Group includes the ADMHS Cultural Competence Manager, the ADMHS Consumer Empowerment Manager, the ADMHS Assistant Director for Clinical Operations and several community representatives from the ADMHS Systems Change Steering Committee. Two of these representatives are executive directors of community-based providers and a third is an educator and Latino advocate who is also a member of the Mental Health Commission. Several meetings addressed the conceptual framework for the Plan Update and appropriate community forums.

Phase 2: Creating Stakeholder Opportunities:
A number of groups involved with the ADMHS systems change initiative, including the Cultural Competence Action Team, the Crisis Action Team, and the Peer Action Team discussed the

proposed transformation of outpatient clinical programs and services guided by the principles of MHSA. An additional countywide stakeholder forum, solicited input from stakeholders and under-served groups on December 5, 2013.

A significant change to the stakeholder process is a greater range of opportunities for engagement beyond the initial request for input. Once initial input was gathered from stakeholders, proposed service components, potential interventions, and target populations were identified and considered.

The new framework was presented to the Mental Health Commission, the ADMHS System Change Steering Committee, the County Board of Supervisors, action teams and broader stakeholder groups during an April 11, 2014 forum. This ensured that stakeholders were engaged throughout the process. Overall, stakeholders have responded very positively and feel that the proposed plan was an accurate reflection of priorities and concerns.

In addition, the change agent team has held monthly meetings since fall 2013. Change agents represent consumer and family organizations and service providers as well as front line ADMHS staff from all clinical programs and administrative services. More than 100 individuals have attended change agent meetings. Five change agents serve on the Steering Committee.

The following stakeholder engagement opportunities occurred prior to the 30-day public comment period and public hearing:

- MHSA Planning Group meetings
- Systems Change Steering Committee discussion
- Mental Health Commission discussions
- Action Team meetings
- Stakeholder Event (12/05/13)
- Change Agent meetings
- ADMHS Team Supervisors' input
- ADMHS Psychologists recommendations
- Community-based organization meetings
- Consultation with Mental Health Services Oversight and Accountability Committee (MHSOAC) on the stakeholder process and proposed transformation of the whole outpatient system
- System-wide survey on treatments and training needs
- Six regional meetings (two each in the three regions)
- Briefings to Steering Committee, Latino Advisory Committee, Consumer and Family Member Advisory Committee, Cultural Competence Action Team, Mental Health Commission
- Stakeholder Event (Plan Preview and Update 4/11/14)
- Board of Supervisor Plan Update Preview (4/22/14)

Phase 3: Informal Plan Update Review

In another change from previous years, members of the Mental Health Commission, the Systems Change Steering Committee, the Consumer and Family Member Advisory Committee, the Latino Advisory Committee and the ADMHS Clinical Operations group that represents all ADMHS service units were sent copies of the draft Plan Update and invited to submit feedback *prior* to the posting and 30-day public comment period.

Phase 4: Formal 30-Day Public Comment Period

A draft plan update was posted to the ADMHS web site December 8, 2014. Approximately 900 stakeholders were invited to comment on the plan and notified that hard copies were available on request. People notified included of leaders and advocates who typically forward ADMHS communications to their own networks and constituencies, increasing the overall audience reached.

Stakeholders were also invited to attend a public hearing on the Plan Update convened by the Mental Health Commission on January 16, 2015.

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 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, Cuyama, and Ventucopa. As of January 1, 2006, Santa Maria became the largest city in Santa Barbara County. (From *Wikipedia*, retrieved 10-24-13.)

Demographic data from the U.S. Census Bureau:

American Community Survey
Santa Barbara County Estimates 2008-2012

From:
http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk

SEX AND AGE	Estimate	Percent
Total population	423,594	
Male	212,662	50.2%
Female	210,932	49.8%
Under 5 years	27,600	6.5%
5 to 9 years	25,982	6.1%
10 to 14 years	26,300	6.2%
15 to 19 years	37,860	8.9%
20 to 24 years	44,513	10.5%
25 to 34 years	56,486	13.3%
35 to 44 years	50,385	11.9%
45 to 54 years	54,554	12.9%
55 to 59 years	24,295	5.7%
60 to 64 years	20,747	4.9%
65 to 74 years	27,083	6.4%
75 to 84 years	17,865	4.2%
85 years and over	9,924	2.3%

People QuickFacts	Santa Barbara County	California
Population, 2013 estimate	435,697	38,332,521
Population, 2010 (April 1) estimates base	423,798	37,253,959
Population, percent change, April 1, 2010 to July 1, 2013	2.8%	2.9%
Population, 2010	423,895	37,253,956
Persons under 5 years, percent, 2013	6.5%	6.5%
Persons under 18 years, percent, 2013	22.6%	23.9%
Persons 65 years and over, percent, 2013	13.7%	12.5%
Female persons, percent, 2013	49.7%	50.3%
White alone, percent, 2013 (a)	86.0%	73.5%
Black or African American alone, percent, 2013 (a)	2.4%	6.6%
American Indian and Alaska Native alone, percent, 2013 (a)	2.2%	1.7%
Asian alone, percent, 2013 (a)	5.6%	14.1%
Native Hawaiian and Other Pacific Islander alone, percent, 2013 (a)	0.2%	0.5%
Two or More Races, percent, 2013	3.5%	3.7%
Hispanic or Latino, percent, 2013 (b)	44.1%	38.4%
White alone, not Hispanic or Latino, percent, 2013	46.5%	39.0%
Living in same house 1 year & over, percent, 2008-2012	79.0%	84.2%
Foreign born persons, percent, 2008-2012	23.5%	27.1%
Language other than English spoken at home, pct age 5+, 2008-2012	39.9%	43.5%
High school graduate or higher, percent of persons age 25+, 2008-2012	79.7%	81.0%
Bachelor's degree or higher, percent of persons age 25+, 2008-2012	31.5%	30.5%
Veterans, 2008-2012	26,280	1,952,910
Mean travel time to work (minutes), workers age 16+, 2008-2012	19.4	27.1
Housing units, 2013	153,521	13,790,495
Homeownership rate, 2008-2012	53.2%	56.0%
Housing units in multi-unit structures, percent, 2008-2012	29.8%	30.9%
Median value of owner-occupied housing units, 2008-2012	$482,400	$383,900
Households, 2008-2012	141,247	12,466,331
Persons per household, 2008-2012	2.87	2.93
Per capita money income in past 12 months (2012 dollars), 2008-2012	$30,114	$29,551
Median household income, 2008-2012	$62,723	$61,400
Persons below poverty level, percent, 2008-2012	15.3%	15.3%

Business QuickFacts	Santa Barbara County	California
Private nonfarm establishments, 2012	11,229	864,913[1]
Private nonfarm employment, 2012	134,241	12,952,818[1]
Private nonfarm employment, percent change, 2011-2012	0.3%	2.0%[1]
Nonemployer establishments, 2012	31,764	2,926,065
Total number of firms, 2007	39,834	3,425,510
Black-owned firms, percent, 2007	S	4.0%
American Indian- and Alaska Native-owned firms, percent, 2007	1.1%	1.3%
Asian-owned firms, percent, 2007	5.9%	14.9%
Native Hawaiian and Other Pacific Islander-owned firms, percent, 2007	F	0.3%
Hispanic-owned firms, percent, 2007	13.9%	16.5%
Women-owned firms, percent, 2007	28.3%	30.3%
Manufacturers shipments, 2007 ($1000)	3,174,119	491,372,092
Merchant wholesaler sales, 2007 ($1000)	4,023,586	598,456,486
Retail sales, 2007 ($1000)	4,983,368	455,032,270
Retail sales per capita, 2007	$12,443	$12,561
Accommodation and food services sales, 2007 ($1000)	1,361,476	80,852,787
Building permits, 2012	461	58,549

Geography QuickFacts	Santa Barbara County	California
Land area in square miles, 2010	2,735.09	155,779.22
Persons per square mile, 2010	155.0	239.1
FIPS Code	083	06
Metropolitan or Micropolitan Statistical Area	Santa Maria-Santa Barbara, CA Metro Area	

From: http://quickfacts.census.gov/qfd/states/06/06083.html

1: Includes data not distributed by county.

(a) Includes persons reporting only one race.
(b) Hispanics may be of any race, so also are included in applicable race categories.

D: Suppressed to avoid disclosure of confidential information
F: Fewer than 25 firms

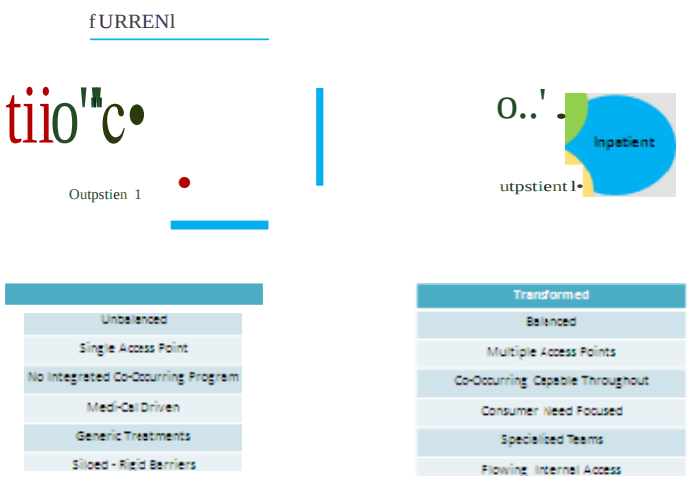
FN: Footnote on this item for this area in place of data
NA: Not available
S: Suppressed; does not meet publication standards
X: Not applicable
Z: Value greater than zero but less than half unit of measure shown

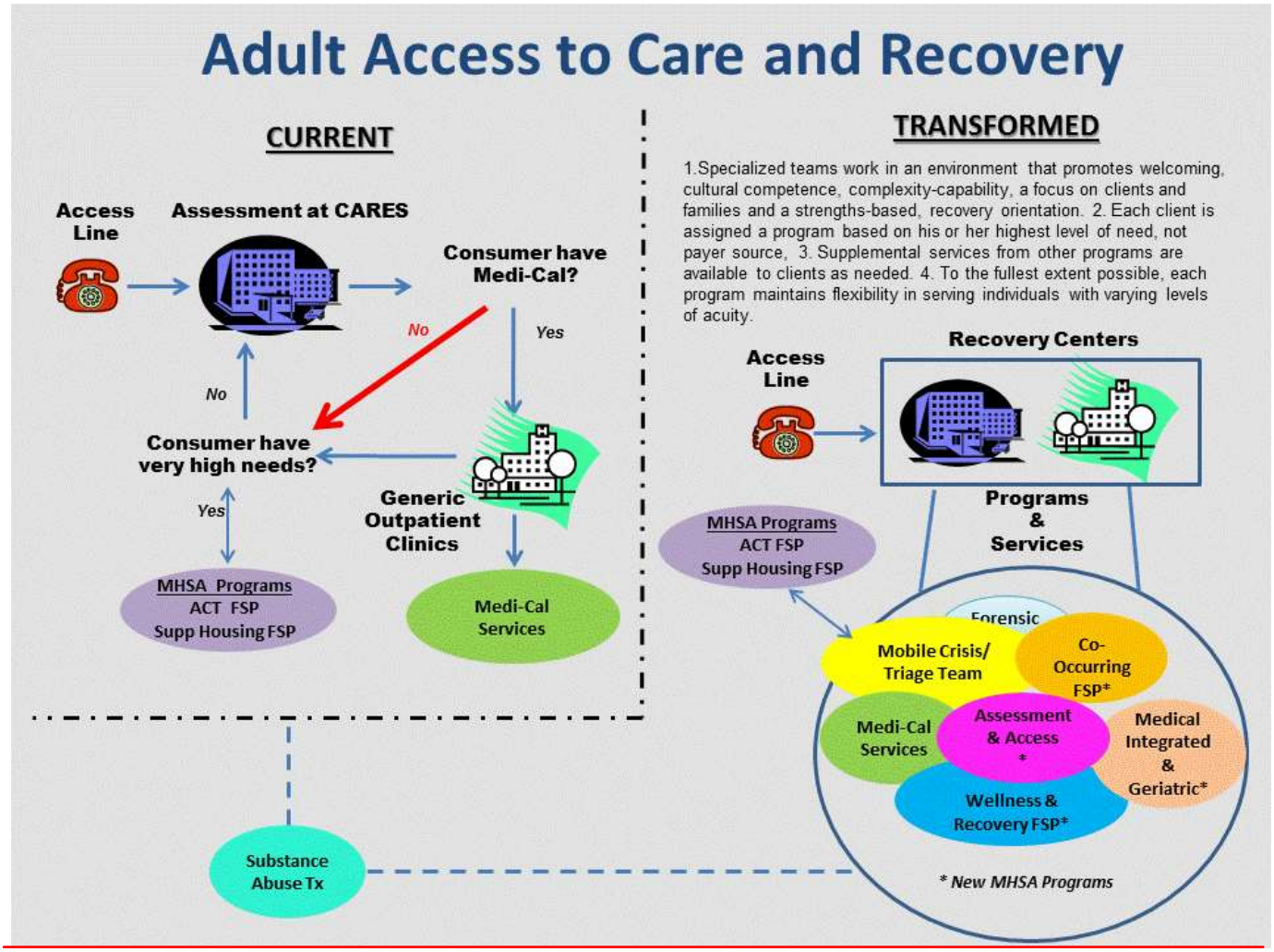
Source U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, American Community Survey, Census of Population and Housing, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits
Last Revised: Tuesday, 08-Jul-2014 06:42:54 EDT

Programs at a Glance

Name	MHSA Funding Source	Page
ADULTS		
Access and Assessment Teams (all ages)	PEI	66
Benefits Acquisition Teams	Innovation	71
Bridge to Care	CSS	35
CARES	PEI	63
CARES Mobile Crisis (Santa Maria and Santa Barbara)	CSS	32
Co-Occurring Outpatient Teams	CSS	37
Crisis Residential North	CSS	42
Crisis Stabilization Unit	SB 82 (State MHSA)	52
Crisis Triage Teams	SB 82 (State MHSA)	51
Mobile Crisis West	SB 82 (State MHSA)	54
Culturally Adapted and Recovery-Focused Models of Care (all ages)	Innovation	82
Forensic FSP (formerly Justice Alliance)	CSS	49
Girls' Resiliency Restoration and Reintegration aLiance	Innovation	73
Homeless Services	CSS	36
Housing (primarily adults, some family units)	CSS	39
Integration of Primary and Mental Health Care	PEI	59
Lompoc ACT FSP	CSS	45
Medical Integration and Older Adults	CSS	85
Mobile Crisis West (Lompoc)	SB 82 (State MHSA)	54
Residential Respite House South	SB 82 (State MHSA)	53
Partners in Hope	CSS	34
Support Housing FSP (North and South)	CSS	47
Wellness & Recovery Outpatient Teams	CSS	40
Santa Maria ACT FSP	CSS	46
Support to Culturally Underserved Communities (Promotora)	PEI	58
TRANSITION-AGE YOUTH (TAY)		
New Heights	CSS	33
PEI-TAY	PEI	62
CHILDREN		
Early Childhood Mental Health Services	PEI	60
HOPE	CSS	40
SAFTY Mobile Crisis	PEI	65
SPIRIT FSP	CSS	48
START (School-Based Services)	PEI	62
Wellness and Resiliency Outpatient Teams	CSS	40

ADM HS System Overview





Principles of Access, Care and Recovery

As also noted in the diagram above:

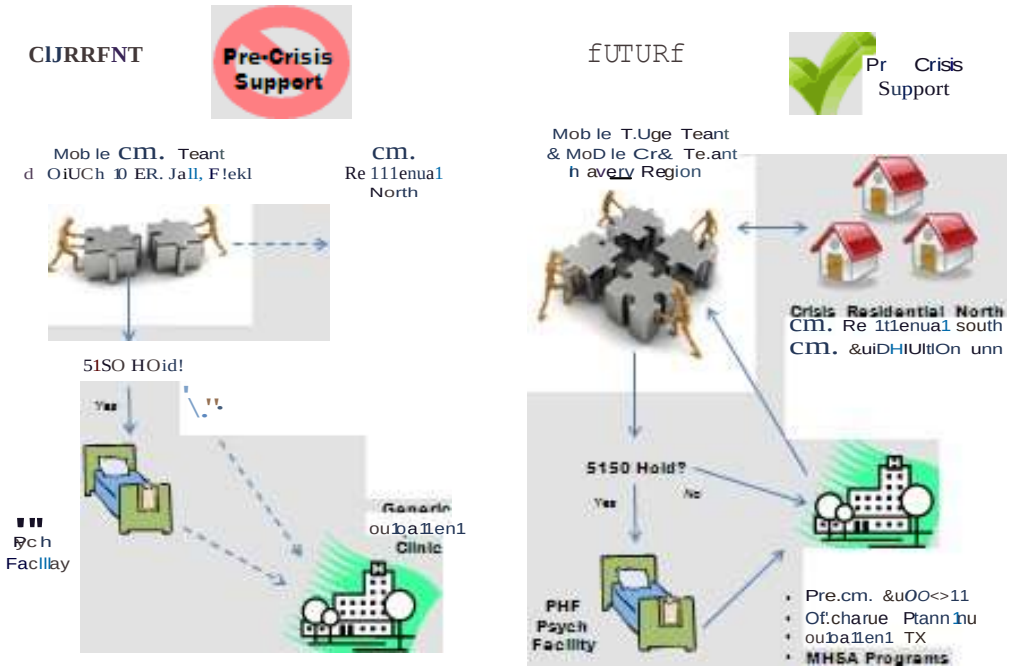
1) Specialized outpatient teams will operate in an environment that promotes welcoming, cultural competence, complexity-capability, a focus on clients and families and an approach that is strengths-based and recovery/resiliency-oriented.

2) Each client will be assigned to an outpatient program based on his or her *highest level of need*, not payer source.

3) As needed, clients may also receive *supplementary specialized services* from another program that is not his or her primary specialty team.

4) To the fullest extent possible, each program will *maintain flexibility* in serving clients with varying levels of acuity.

ADMHS Crisis System of Care



FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary

County: Santa Barbara County Date:

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2014/15 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	300	0	983,407	431,958	1,152,856	
2. Estimated New FY2014/15 Funding	12,975,956	3,243,989	853,681			
3. Transfer in FY2014/15[a/]	0			0	0	0
4. Access Local Prudent Reserve in FY2014/15	0	706,647				(706,647)
5. Estimated Available Funding for FY2014/15	12,976,256	3,950,636	1,837,088	431,958	1,152,856	
B. Estimated FY2014/15 MHSA Expenditures	12,330,290	3,950,636	1,408,734	181,668	710,005	
C. Estimated FY2015/16 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	645,966	0	428,354	250,290	442,851	
2. Estimated New FY2015/16 Funding	13,237,578	3,309,394	870,893			
3. Transfer in FY2015/16[a/]	0			0	0	0
4. Access Local Prudent Reserve in FY2015/16	60,969	720,255				(781,223)
5. Estimated Available Funding for FY2015/16	13,944,512	4,029,649	1,299,248	250,290	442,851	
D. Estimated FY2015/16 Expenditures	13,944,512	4,029,649	1,004,781	185,301	442,851	
E. Estimated FY2016/17 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	0	0	294,466	64,989	0	
2. Estimated New FY2016/17 Funding	13,502,329	3,375,582	888,311			
3. Transfer in FY2016/17[a/]	0			0	0	0
4. Access Local Prudent Reserve in FY2016/17	428,194	107,048				(535,242)
5. Estimated Available Funding for FY2016/17	13,930,523	3,482,631	1,182,777	64,989	0	
F. Estimated FY2016/17 Expenditures	14,223,402	4,110,242	1,024,877	64,989	0	
G. Estimated FY2016/17 Unspent Fund Balance	(292,879)	(627,611)	157,900	(0)	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2014	2,023,113
2. Contributions to the Local Prudent Reserve in FY 2014/15	0
3. Distributions from the Local Prudent Reserve in FY 2014/15	(706,647)
4. Estimated Local Prudent Reserve Balance on June 30, 2015	1,316,466
5. Contributions to the Local Prudent Reserve in FY 2015/16	0
6. Distributions from the Local Prudent Reserve in FY 2015/16	(781,223)
7. Estimated Local Prudent Reserve Balance on June 30, 2016	535,242
8. Contributions to the Local Prudent Reserve in FY 2016/17	0
9. Distributions from the Local Prudent Reserve in FY 2016/17	(535,242)
10. Estimated Local Prudent Reserve Balance on June 30, 2017	0

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

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Santa Barbara County Date: 11/24/14

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. SPIRIT (includes Wraparound)	2,241,275	732,236	1,064,606	0	105,283	339,150
2. Lompoc ACT	2,020,587	972,913	1,047,674	0	0	0
3. Santa Maria ACT	2,814,921	1,355,384	1,459,537	0	0	0
4. Santa Barbara ACT	2,933,756	825,058	1,521,152	472,231	0	115,315
5. Supported Housing North	1,261,994	607,650	654,344	0	0	0
6. Supported Housing South	1,378,243	593,398	714,619	70,226	0	0
7. Justice Alliance	2,032,022	978,419	1,053,603	0	0	0
8.	0	0	0	0	0	0
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
Non-FSP Programs						
1. CARES Mobile Crisis	3,757,939	848,488	1,948,491	0	0	960,960
2. Adult Recovery & Resilience	2,767,726	415,159	1,435,066	917,501	0	0
3. Co Occuring	3,876,318	581,448	2,009,871	1,284,999	0	0
4. Partners in Hope	1,432,499	214,875	742,751	474,873	0	0
5. Child Recovery & Resilience (with Rehab Spec)	2,691,950	403,793	1,395,776	0	892,381	0
6. New Heights TAY	1,440,448	318,788	684,213	0	437,448	0
7. HOPE	1,162,420	58,120	552,149	0	552,150	0
8. CARES Crisis Res North	1,376,794	908,684	468,110	0	0	0
9. CARES Crisis Res South	1,055,139	291,374	313,765	0	0	450,000
10. Crisis Stabilization Unit	2,352,243	380,261	409,482	0	0	1,562,500
11. Katie A.	1,421,563	0	710,782	0	710,782	0
12. Crisis Triage	3,082,360	0	729,806	0	0	2,352,554
13. Homeless Services	746,377	332,184	357,710	0	0	56,483
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
CSS Administration	8,374,796	1,512,060	3,931,558	837,480	2,093,699	0
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	50,221,370	12,330,290	23,205,064	4,057,311	4,791,742	5,836,962
FSP Programs as Percent of Total	56.1%					

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Santa Barbara County Date: 11/24/14

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. SPIRIT (includes Wraparound)	2,286,101	746,881	1,085,898	0	107,389	345,933
2. Lompoc ACT	2,060,999	992,371	1,068,628	0	0	0
3. Santa Maria ACT	2,871,219	1,382,492	1,488,727	0	0	0
4. Santa Barbara ACT	2,992,431	841,559	1,551,576	481,676	0	117,621
5. Supported Housing North	1,287,234	619,803	667,431	0	0	0
6. Supported Housing South	1,405,808	605,266	728,911	71,631	0	0
7. Justice Alliance	2,072,662	997,987	1,074,675	0	0	0
8.	0	0	0	0	0	0
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
Non-FSP Programs						
1. CARES Mobile Crisis	3,782,098	1,560,473	1,987,461	0	0	234,164
2. Adult Recovery & Resilience	2,823,081	423,462	1,463,767	935,851	0	0
3. Co Occuring	3,953,844	593,077	2,050,068	1,310,699	0	0
4. Partners in Hope	1,461,149	219,172	757,606	484,371	0	0
5. Child Recovery & Resilience (with Rehab Spec)	2,745,789	411,868	1,423,692	0	910,229	0
6. New Heights TAY	1,469,257	325,163	697,897	0	446,196	0
7. HOPE	1,185,668	59,283	563,192	0	563,193	0
8. CARES Crisis Res North	1,404,330	926,858	477,472	0	0	0
9. CARES Crisis Res South	596,139	276,099	320,040	0	0	0
10. Crisis Stabilization Unit	869,288	387,866	417,671	0	0	63,750
11. Katie A.	1,449,994	0	724,997	0	724,997	0
12. Crisis Triage	3,144,007	0	744,402	0	0	2,399,605
13. Homeless Services	761,305	338,828	364,864	0	0	57,613
14. Medical Integration	2,606,794	391,019	1,351,622	864,152		
15.	0					
CSS Administration	8,844,976	1,844,985	4,010,189	854,229	2,135,573	0
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	52,074,172	13,944,512	25,020,788	5,002,609	4,887,577	3,218,685
FSP Programs as Percent of Total	51.1%					

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Santa Barbara County Date: 11/24/14

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. SPIRIT	2,331,823	761,819	1,107,616	0	109,536	352,852
2. Lompoc ACT	2,102,219	1,012,218	1,090,000	0	0	0
3. Santa Maria ACT	2,928,644	1,410,142	1,518,502	0	0	0
4. Santa Barbara ACT	3,052,280	858,390	1,582,607	491,309	0	119,974
5. Supported Housing North	1,312,979	632,199	680,779	0	0	0
6. Supported Housing South	1,433,924	617,371	743,490	73,063	0	0
7. Justice Alliance	2,114,116	1,017,947	1,096,169	0	0	0
8.	0	0	0	0	0	0
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
Non-FSP Programs						
1. CARES Mobile Crisis	3,857,740	1,591,683	2,027,210	0	0	238,847
2. Adult Recovery & Resilience	2,879,542	431,931	1,493,043	954,568	0	0
3. Co Occuring	4,032,921	604,938	2,091,070	1,336,913	0	0
4. Partners in Hope	1,490,372	223,556	772,758	494,058	0	0
5. Child Recovery & Resilience	2,800,705	420,106	1,452,165	0	928,434	0
6. New Heights TAY	1,498,642	331,667	711,855	0	455,120	0
7. HOPE	1,209,381	60,468	574,456	0	574,457	0
8. CARES Crisis Res North	1,432,416	945,395	487,022	0	0	0
9. CARES Crisis Res South	608,062	281,621	326,441	0	0	0
10. Crisis Stabilization Unit	886,674	395,624	426,025	0	0	65,025
11. Katie A.	1,478,994	0	739,497	0	739,497	0
12. Crisis Triage	3,206,887	0	759,290	0	0	2,447,597
13. Homeless Services	776,531	345,604	372,162	0	0	58,765
14. Medical Integration	2,658,929	398,839	1,378,655	881,435	0	0
15.	0					
CSS Administration	9,021,875	1,881,885	4,090,393	871,314	2,178,284	0
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	53,115,655	14,223,402	25,521,204	5,102,661	4,985,329	3,283,059
FSP Programs as Percent of Total	51.1%					

Community Services and Supports (CSS)

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

CARES Mobile Crisis (General System Development)

Provider: ADMHS

Estimated Funding FY 2014/15

Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
$3,757,939	$848,488	$1,948,491	0	0	$960,960

The Crisis and Recovery Emergency Services (CARES) Mobile Crisis Program serves adults and older adults (18 years +) experiencing a psychiatric crisis or mental health emergency in northern and southern Santa Barbara County. The CARES Mobile Crisis Program substantially enriches crisis services, providing clients appropriate alternatives to hospitalization whenever possible. CARES Mobile Crisis staff members are guided by a recovery vision and attitude of outreach and collaboration in identifying intervention options.

Staff members work closely with consumers, family members and friends to identify natural supports and strategies consistent with the culture and values of the individual and family. When feasible, they refer to the CARES Residential Unit, a 12-bed facility in north Santa Barbara County, as an alternative to involuntary hospitalization.

ADMHS has long identified improved responsiveness to crises as a top departmental goal. To best support clients during times of crisis, ADMHS separated crisis services from long term-care. Mobile response offers a range of expertise in staffing that enables the team to provide interventions to a diverse community. A multidisciplinary team includes medical staff availability to address medication issues that, if left unattended, may result in the need for emergency, involuntary care. The Countywide Mobile Crisis team is linked to the CARES North and South intake units.

Between July 1, 2013 and May 31, 2014, CARES Mobile Crisis served 1,547 unduplicated persons.

Age Group	Number of Unduplicated Individuals Served	Cost Per Client
0-15	74	$1,290
16-25	388	$1,344
26-59	912	$1,565
60+	156	$1,663
Missing DOB	17	$1.092
Total	1,547	$1,501

Program Challenges and Solutions

As noted in the previous update, CARES was conceived as a crisis response program and serves as a primary access point for the public behavioral health system. High utilization and limited capacity at the primary clinic sites and specialized programs throughout the system continue to create bottlenecks within CARES. Clients have remained in the CARES program longer than intended, and the deviation from initial design has required shifts in funding allocations. This change was first reflected in the previous Plan Update.

With the development of additional crisis services, improvements in client flow and the ability for consumers to access a broader range of crisis services are now likely. Funded through California Senate Bill 82, the new Crisis Triage program, a Crisis Stabilization Unit and a Crisis Respite Facility in South County and a new Mobile Crisis West team will substantially enhance the capacity to respond to behavioral health crises. An expanded and comprehensive crisis response program will substantially reduce the need for hospitalization. In addition, the proposed new Access and Assessment teams will expand initial access to non-crisis outpatient services.

New Heights (General System Development)

Provider: ADMHS and Mental Health Systems, Inc.

Estimated Funding FY 2014/15

Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
$1,440,448	$318,788	$684,213	0	$437,448	0

New Heights serves transition-age youth (TAY), 16-25, who require assistance for serious emotional conditions or severe mental illness. Some of these young adults are aging out of the ADMHS Children's System of Care and are at risk for homelessness.

Many TAY clients experience co-occurring mental health and substance abuse conditions. New Heights is designed to support the recovery and full functioning of transition-age youth (TAY), 16-25, based upon individual talents, strengths, personal dreams and goals. The capacity of this program is 80.

The program model has been 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.

Between July 1, 2013 and May 31, 2014, New Heights served 222 unduplicated individuals.

Age Group	Number of Unduplicated Individuals Served	Cost per Client
0-15	6	$5,519
16-25	218	$5,799
26-59	5	$5,860
Total	229	$5,690

Program Challenges and Solutions

The TAY population is in need of added service capacity and additional support for care and recovery. TAY clients often struggle with different issues than adults and do not feel comfortable in adult settings. Welcoming and accessible environments dedicated to TAY clients are essential. ADMHS will continue to work with stakeholders to develop additional resources for TAY clients, including a possible teen drop-in center.

The implementation of evidence-based practices such as trauma-sensitive care and co-occurring specialization will enhance the effectiveness of TAY services.

Partners in Hope (General System Development)

Provider: ADMHS, Transitions-Mental Health Association, Mental Wellness Center

Estimated Funding FY 2014/15

Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
$1,432,499	$214,875	$742,751	$474,873	0	0

Partners in Hope is a peer-run program intended to provide peer support services to consumers and family members. The program supports Peer Recovery Specialists and Recovery Learning Communities (RLCs) in South, Central and North County.

The three peer recovery specialists are an integral part of county-operated clinic teams. The integration of the consumer staff within ADMHS has made a considerable impact on the system, advancing a transformative shift toward a stronger person-centered service system and substantially increasing outreach to the under-served Latino community. The goal of the RLC's is to create a vital network of peer-run supports and services that build bridges to local communities and engages natural community supports.

The target population for Partners in Hope is 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. Clients may also be homeless or at risk of homelessness. The program is linguistically and culturally capable of providing services to the under-served ethnic populations in Santa Barbara County, including Spanish-speaking consumers.

Partners in Hope also includes a family advocate in each region of the county. Family advocates provide supports to family members throughout the county. The family peer program is operated by two community-based organizations (CBOs).

Peer Recovery Specialists served approximately 378 unduplicated individuals in FY 2012-13.

Program Challenges and Solutions

The Partners in Hope program has been very successful. As the demand for peer support grows, it is becoming an increasingly important component of service delivery.
Unfortunately, the current program structure has offered an inadequate number of peer staff positions. These challenges are being addressed by increasing the number of peer staff and creating a peer staff career ladder to improve recruitment and retention. An additional solution is offering part-time employment opportunities for consumers and family members using a Peer Expert Pool funded through Workforce Education and Training (WET).

Bridge to Care (General System Development)

Provider: ADMHS

(FY 2014/15 funding included in Co-Occurring Outpatient Team budget.)

Bridge to Care is a Lompoc-based program that provides psychiatric medication evaluation, prescriptions and medication monitoring to stabilize people with co-occurring substance abuse and serious mental illness. A psychiatrist offers a medication "bridge" for people in recovery programs awaiting assessment and intake at the mental health service delivery sites or who may be in need of short-term medication support that allows them to be diverted from outpatient clinics or ADMHS acute care service locations. The capacity of Bridge to Care is 170.

Bridge to Care is linguistically and culturally capable of providing services to the under-served ethnic populations in Lompoc, including Spanish-speaking consumers. To advance the goals of the MHSA, medical staff for Bridge to Care closely coordinates services on a regular basis to ensure seamless transition through programs and agencies, placing sustained recovery as the top priority.

Between July 1, 2013 and May 31, 2014, the Bridge to Care program served 86 unduplicated individuals.

Age Group	Number of Unduplicated Individuals Served	Cost per Client
16-25	14	$ 908
26-59	69	$1,526
60+	3	$1,501
Total	86	$1,424

Program Challenges and Solutions

The Bridge to Care Program provides services in Lompoc exclusively. Additional needs also exist in Santa Barbara and Santa Maria. Over the past several years, funding limitations have prevented

expansion of Bridge to Care. Fortunately, the addition of specialized co-occurring teams, as described elsewhere in this Plan Update, will likely reduce the need for expanding Bridge to Care to Santa Maria and Santa Barbara.

The new specialized co-occurring outpatient teams will provide similar access to some of the same populations. In addition, the Forensic Full Service Partnership will enhance services to people who are involved in the Adult Justice System.

Justice Alliance (General System Development)

Provider: ADMHS

(FY 2014-15 budget information listed under "Forensic Teams.")

The 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 and older adults with severe mental illness in custody, out of custody and on probation or at risk of being in custody.

These individuals may or may not have co-occurring substance abuse conditions. Many of the individuals assessed are un-served or under-served members of ethnically diverse populations, and in need of integrated and simultaneous mental health and substance abuse treatment.

Justice Alliance staff members work closely with the Court, Probation, Public Defender, District Attorney, community-based organizations and ADMHS treatment teams to make treatment recommendations, facilitate access to treatment and provide follow-up progress reports to the court and other appropriate parties.

In FY 2013-14, the Justice Alliance program served 1,304 unduplicated contacts countywide and conducted 818 assessments.

Homeless Services

Provider: ADMHS**,** Good Samaritan, and Transitions-Mental Health Association

Estimated Funding FY 2014/15

Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
$746,377	$332,184	$357,710	0	0	$56,483

In response to stakeholder input, homeless services will be created in Central County (Lompoc) and North County (Santa Maria). In South County (Santa Barbara), homeless services will be

augmented. This enhancement responds to long-term concerns by a broad section of community stakeholders that persons with severe mental illness who are homeless or at-risk of homelessness are not receiving adequate mental health services.

The proposed expansion is consistent with many of the principles of MHSA, including a recovery and resiliency focus, creating a greater continuity of care and cultural competence. Evidence-based practices identified by stakeholders and under consideration include Dialectical Behavior Therapy (DBT), Cognitive Behavioral Therapy (CBT), Motivational Interviewing (MI), Seeking Safety, IMPACT for treating depression, Eye Movement Desensitization and Reprocessing (EMDR) and Cognitive Enhancement Therapy (CET).

The Homeless Program will provide extensive outreach and engagement services. Teams will also adopt strategies that meet the needs of homeless populations in each region. For example, in Santa Barbara, homeless people in need of behavioral health services are primarily unrelated individuals who may or may not reside in shelters. In Santa Maria and Lompoc, homelessness tends to be far more family- and shelter-based.

Teams will provide housing support and assistance, employment and education support, rehabilitation services and other necessary supports for families and individuals. Peer staff will also work as part of the Santa Barbara team. The program model will be culturally and linguistically competent and appropriate. To address threshold languages identified in Santa Barbara County, 40% of direct service staff will be bilingual (Spanish/English) and bicultural. This partnership will provide services to approximately 280 individuals.

Santa Maria staffing:

1 FTE Practitioner II, I or Intern

Lompoc staffing:

1 FTE Practitioner II

Santa Barbara staffing:

1 FTE Practitioner Intern
1 FTE Practitioner I, II or Intern
2 FTE Case Worker
1 FTE Peer Recovery Assistant

Specialized Co-Occurring Mental Health and Substance Use Outpatient Teams

Provider: ADMHS

Estimated Funding FY 2014/15

Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
$3,876,318	$581,448	$2,009,871	$1,284,999	0	0

Please note that the criteria for Full Service Partnership programs are discussed on page 43.

This program is designed for adults and older adults 26 and older. Clients have been diagnosed with a severe mental illness and a co-occurring alcohol or drug issue and would benefit from a specialized level of service.

The co-occurring outpatient teams will offer client-driven services and will customize services based on individual needs. The creation of this program, which has a low staff-to-client ratio, 24/7 crisis service availability, and co-occurring specialization, is in direct response to stakeholder priorities. Specialized outpatient co-occurring teams will be based in North, Central and South County

Many clients with co-occurring behavioral health and substance use conditions are receiving or will receive services in programs such as ACT, the Forensic FSP, and the Homeless FSP. In fact, individuals and families with co-occurring challenges will be welcomed and served in *all* programs. However, a broader array of co-occurring-capable services will maximize opportunities to serve individuals who have experienced difficulties engaging in traditional services

Co-occurring teams will focus on recovery and resiliency. Evidence-based practices identified by stakeholders under consideration are Motivational Interviewing, Seeking Safety, Cognitive Behavioral Therapy (CBT), contingency management, and Dialectical Behavior Therapy (DBT). The co-occurring capable teams will work with the Change Agent team to provide technical assistance and consultation to other teams and providers to help develop universal co-occurring capability.

The program will assist with housing, employment and education in addition to providing mental health services and integrated treatment for individuals who have a co-occurring mental health and substance abuse disorder. In-home services will be available, as well as in the community and in other settings. Peer staff will also be an integral part of these teams, and will provide individual and group support.

As with all MHSA funded programs, program models will be culturally and linguistically competent. Forty percent of direct service staff will be bilingual (Spanish/English) and bicultural, to address threshold languages identified in Santa Barbara County. This Full Service Partnership program will provide services to approximately 560 individuals countywide.

Santa Maria staffing:

2 FTE Practitioner I, II or Intern
2 FTE Practitioner II
1 FTE Peer Recovery Assistant

Lompoc staffing:

1 FTE Case Worker
1 FTE Practitioner II
1 FTE Practitioner I or II
1 FTE Recovery Assistant

Santa Barbara staffing:

1 FTE Practitioner II, I or Intern
1 FTE Practitioner I
2 FTE Case Worker
1 FTE Practitioner Intern

Housing

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

Current projects are:

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

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

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

Additional projects are under consideration or development, and we will share more information as it becomes available.

Adult Wellness and Recovery (WR) Teams

Provider: ADMHS

Estimated Funding FY 2014/15

Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
$2,767,726	$415,159	$1,435,006	$917,501	0	0

Children's Wellness and Resiliency (WR) Teams

Provider: ADMHS

Estimated Funding FY 2014/15

Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
$2,691,950	$403,793	$1,395,776	0	$892,381	0

Clients with personality disorders were identified by multiple stakeholder groups as a priority population. Currently, no specialized services are available for this population. Stakeholders suggested developing programs using intervention models that have proven effective. Personality disorder treatment can be difficult, and this particular client population often struggles with traditional forms of treatment. Furthermore, if there is a co-occurring disorder like depression, substance use or another issue, treatment is further complicated.

More specialized services for other long-term clients, such as those challenged by schizophrenia, severe anxiety and mood disorders, are also needed. Although each client receives individualized service, the generic nature of ADMHS outpatient clinics and the lack of specialization are significant limitations. In addition, a system is grounded in the medical model is sometimes resistant to transition to a model based on recovery and wellness.

The proposed solution includes developing teams that use several evidence-based practices that maximize specialization, wellness and recovery. Stable treatment relationships will be maintained. Client-centered and individualized approaches will be sensitive to challenging diagnoses and responsive to client hopes and dreams.

Three Wellness and Recovery teams, one each in Santa Barbara, Santa Maria, and Lompoc will address the needs of adult populations. Three Wellness and Resiliency Teams will also be created to serve children, youth and their families in Lompoc, Santa Barbara, and Santa Maria.

The evidence-based practices under consideration for the adult programs include: Dialectical Behavior Therapy (DBT), Trauma Affect Regulation: Guide for Education and Therapy (TARGET), Motivational Interviewing (MI), Seeing Safety, Cognitive Enhancement Therapy (CET), Cognitive Behavioral Therapy (CBT), and Eye Movement Desensitization and Reprocessing (EMDR). The teams' long-term goal is to decrease symptoms and improve the ability to function well in the community, at work and at home. Personality disorder treatment will be personalized according to the experience of the client and the specific disorder.

Stakeholders identified several evidence-based practices for the Children's component, including Family Behavior Therapy (FBT), Cognitive Behavioral Therapy (CBT), Seeking Safety and EMDR.

Individual and group therapy, skills acquisition, and ongoing case management will also be required to maintain consistent monitoring of the patient.

The Wellness and Resiliency/Wellness and Recovery Teams will provide services in community settings and in natural environments. Teams will also assist clients with housing, employment, and education. As with all MHSA-funded programs, program models will be culturally and linguistically competent. Additionally, 40% of direct service staff will be bilingual (Spanish/English) and bicultural, to address threshold languages identified in Santa Barbara County.

It is expected that approximately 320 clients will be served between the Santa Maria and Santa Barbara Adult Teams. Children's WR teams will serve approximately 360 clients throughout the county.

Santa Maria Adult Staffing:

3 FTE Practitioners II, I or Intern
1 FTE Case Worker
1 FTE Practitioner II

Lompoc Adult Staffing:

2 FTE Practitioners II
1 FTE Case Worker

Santa Maria Children Staffing:

1 FTE Team Supervisor/Clinical Psychologist
1 FTE Psychiatric Tech II
1 FTE Psychiatrist
1 FTE Admin. Office Pro. II
2 FTE Practitioner II
1 FTE Case Worker
1 FTE Clinical Psychologist II, I or Intern

Lompoc Children Staffing:

.75 FTE Psychiatrist
.75 FTE Psychiatric Nurse II
2 FTE ADMHS Practitioner Intern
1 FTE Team Supervisor/Practitioner
1 FTE Admin. Office Pro II

Santa Barbara Children staffing:

1 FTE Clinical Psychologist Postdoc Intern
1 FTE Clinical Psychologist II
1 FTE Case Worker

HOPE

Provider: CALM, Santa Maria Valley Youth and Family Center

Estimated Funding FY 2014/15

Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
$1,162,420	$58,120	$552,149	0	$552,150	0

HOPE provides an array of intensive in-home services available to foster home and extended family home placements. The goals are to maintain the stability of children in their homes and placements and reduce multiple placements.

Crisis Residential North

Provider: Telecare Corporation

Estimated Funding FY 2014/15

Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
$1,376,794	$908,684	$468,110	0	0	0

The 12-bed facility offers voluntary crisis residential services fo up to 30 days. It is not a new program, but its funding through MHSA is new.

About Full Service Partnerships:

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

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

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

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

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

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

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

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

A map of current and proposed Santa Barbara County adult FSPs by region appears on the next page.

Santa Barbara County Adult Full Service Partnerships

- **SANTA MARIA ACT,** 100
- **SUPPORTED HOUSING**, 130
- **FORENSIC**

- **LOMPOC ACT,** 75 Adults/Older Adults, 25 TAY
- **FORENSIC**

- **SANTA BARBARA ACT,** 100
- **SUPPORTED HOUSING**, 130
- **FORENSIC**

Lompoc ACT Full Service Partnership

Provider: Transitions-Mental Health Association

Estimated Funding FY 2014/15

Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
$2,020,587	$972,913	$ 1,047,674	0	0	0

Lompoc ACT is a Full Service Partnership using an Assertive Community Treatment (ACT) program. Lompoc ACT (capacity 100) provides intensive wraparound treatment. Individuals served by this program are at risk of homelessness and may or may not experience co-occurring substance abuse conditions in addition to severe mental illness.

Services offered to support clients in recovery include housing subsidy/vouchers to secure transitional/emergency housing; housing services; supported employment and education; vocational skills enhancement; medication support; counseling support by mental health, alcohol and drug specialists; peer counseling and support; and social skills development. The ACT team also links clients to community resources such as consumer self-help organizations that strengthen available supports and meaningful relationships critical to recovery.

All staff members contribute to the assessment process and provide a range of services within their range of experience and skill. A "whatever it takes" attitude promotes healing and meaningful lives for clients. Staff members assist clients with housing issues and collaborate with an existing ADMHS housing specialist to best help clients link to housing benefits/resources. Services are provided either at the Lompoc ACT location or in the community and homes of the people enrolled.

Between July 1, 2013 and May 31, 2014, 114 unduplicated individuals were served by Lompoc ACT.

Lompoc ACT		
Age Group	Number of Unduplicated Individuals Served	Cost per Client
16-25	23	$ 8,458
26-59	77	$19,409
60+	14	$24,234
Total	114	$17,792

Santa Barbara County ACT Full Service Partnership (consists of Santa Maria ACT, Santa Barbara ACT, Supported Housing North, Supported Housing South)

Santa Maria ACT Provider: Telecare Corp.

Estimated Funding FY 2014/15

Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
$2,814,921	$1,335,384	$1,459,537	0	0	0

Santa Barbara ACT Provider: ADMHS

Estimated Funding FY 2014/15

Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
$2,933,756	$825,058	$1,521,152	$472,231	0	$115,315

Supported Housing North Provider: Transitions-Mental Health Association

Estimated Funding FY 2014/15

Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
$1,261,994	$607,650	$654,344	0	0	0

Supported Housing South Provider: PathPoint

Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
$1,378,243	$593,398	$714,619	$70,226	0	0

This program includes Santa Maria ACT FSP (capacity 100), Santa Barbara ACT FSP (capacity 100), Supported Housing North FSP (capacity 130) and Supported Housing South FSP (capacity 130). The Assertive Community Treatment (ACT) is an evidence-based approach for helping people with severe mental illness, including those experiencing co-occurring conditions. The Santa Barbara County FSP provides 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.

Santa Barbara County FSP is a multi-disciplinary, recovery-oriented program that integrates treatment, rehabilitation and support services to assist clients' functioning in major life domains.

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

Between July 1, 2013 and May 31, 2014, the Santa Barbara County Full Service Partnership -- Santa Barbara ACT, Santa Maria ACT and Supported Housing North and South – served 476 unduplicated individuals.

Santa Barbara County FSP (Santa Maria ACT, Santa Barbara ACT and Supported Housing North & South)		
Age Group	Number of Unduplicated Individuals Served	Cost per Client
16-25	16	$20,138
26-59	349	$12,921
60+	111	$15,329
Total	476	$13,725

The following table presents hospitalization rates by age group for clients of the three ACT Programs – Lompoc ACT, Santa Maria ACT and Santa Barbara ACT between July 1, 2013 and May 31, 2014:

	Unique Consumers	Unique Admissions	Hospitalization Rate
Total	336	104	31%
Age 16-25	31	9	29%
Age 26-59	241	80	33.2%
Age 60 and over	64	15	23.4%

ACT Program Challenges and Solutions

ACT programs have faced challenges related to staff turnover. The intensity of services and 24/7 availability of services in ACT programs create a workforce dynamic not typically found in many other programs. Furthermore, even the smallest amount of turnover has considerable impact on staff-to-client ratios. An external consultant group identified a need to reevaluate the existing ACT model used throughout Santa Barbara County and to screen more strictly for referrals to the ACT teams. The TriWest consultant report suggested that an updated ACT model might be more cost-effective and improve outcomes:

> … available evidence for ACT teams shows wide divergence from current fidelity requirements. The ACT teams were formed in 2008 and the last training they received was in 2009, nearly five years ago. Furthermore, the standards used at that time were among the best available (the NAMI ACT standards), but developments in the field over the last five years have advanced the Tool for Measurement of Assertive Community Treatment (TMACT) Version 1.0 as the leading standard for fidelity. (TriWest Group, May 2013, page 52.)

The system change process is attempting to address this issue. Within the current ADMHS system, the lack of specialized treatment, beyond ACT and supported housing, for individuals with co-occurring conditions or Axis II disorders has resulted in extension of the ACT model to clients for whom ACT is not ideal. The proposed creation of additional Full Service Partnership programs that target under-served or un-served populations will improve care for many high-need clients at risk of hospitalization or incarceration.

SPIRIT Full Service Partnership

Provider: ADMHS

Estimated Funding FY 2014/15

Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
$2,241,275	$732,236	$1,064,606	0	$105,283	$339,150

This Full Service Partnership (capacity 75) provides family-centered, strengths-based service for helping children and their families. The children and youth, 0-21, and their families eligible to receive SPIRIT services include un-served and under-served individuals. In spite of previous interventions, eligible children and youth continue to experience extreme distress at home in their families, in school or in the community to the extent that out-of-home placement is seriously considered.

Three culturally competent wraparound teams have been established, one at each of the three regional ADMHS children's service sites. The SPIRIT program offers an individualized planning process aimed at helping clients achieve important outcomes by meeting unmet needs, both within and outside of formal human services systems while they remain in their neighborhoods and homes whenever possible.

SPIRIT teams are enhanced by parent partners who reflect the culture and language of those being served and mental health professionals on each team. SPIRIT staff members ensure that care is available 24/7 to families to keep youth and families stable and safe.

Between July 1, 2013 and May 31, SPIRIT served 69 unduplicated individuals.

Age Group	Number of Unduplicated Individuals Served	Cost per Client
0-15	54	$ 7,719
16-25	14	$ 6,852
26-59	1	$ 3,894
Total	69	$ 7,618

How New FSPs Were Selected

Even before the original MHSA stakeholder planning process initiated in 2005, dozens of community forums and meetings identified major service gaps in the Santa Barbara County behavioral health service delivery system. The proposed new FSPs address longstanding needs, such as more

services for individuals with co-occurring mental health and substance use conditions and for people with behavioral health challenges involved in the justice system. A sampling of stakeholder feedback is included as **Attachment 6.**

Expansion of Justice Alliance into a Forensic Full Service Partnership

Provider: ADMHS

Estimated Funding FY 2014/15

Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
$2,032,022	$978,419	$1,053,603	0	0	0

Stakeholders have consistently expressed a concern to reduce the "revolving door effect" of persons with severe mental illness frequently cycling in and out of jail. For FY 2014/15, converting the Justice Alliance Program into a Full Service Partnership (FSP) is proposed.

The enhanced Justice Alliance program will deploy regional forensic teams that will provide a wider array of services to more clients, including mental health evaluations for persons in jail or recently released from jail. The evidence-based practices identified by stakeholders and under consideration for use by the Forensic FSP include Moral Reconation Therapy (MRT), Dialectical Behavior Therapy (DBT), Cognitive Behavioral Therapy (CBT), Motivational Interviewing (MI) and Seeking Safety.

The core element of Justice Alliance, a licensed mental health professional serving as a liaison to the courts in each region of the county, will be retained. Staffing will be expanded to better serve individuals involved in the justice system.

Stakeholders clearly identified this population as a priority requiring for more in-depth, comprehensive services. As a Full Service Partnership, the Forensic Team will be staffed appropriately and will respond to the needs of clients involved with the courts. More importantly, the team will now have the capacity to ensure follow up care is provided and recidivism reduced.

The Forensic FSP Program will provide services in community settings and in natural environments. Teams will also assist clients with housing, employment and education. Consistent with an ongoing commitment to MHSA Principles, peer staff will also be a part of these teams. As with all MHSA funded programs, program models will be culturally and linguistically competent and appropriate.

The Forensic Team will also refer clients who don't meet the eligibility requirements for this program to other appropriate resources and services.

Additionally, to address threshold languages identified in Santa Barbara County. 40% of direct service staff will be bilingual (Spanish/English) and bicultural, This Full Service Partnership program will provide services to approximately 75 individuals at one time.

Proposed staffing for Justice Alliance includes:

Santa Maria staffing

.5 FTE Psychiatrist
.3 FTE Team Supervisor-Practitioner
1.0 FTE Peer Recovery Assistant
1.0 FTE ADMHS Practitioner

Lompoc staffing

.3 FTE Team Supervisor-Practitioner
1.0 FTE Practitioner

Santa Barbara

.5 FTE Psychiatrist
1.0 FTE Practitioner
.3 FTE Team Supervisor-Practitioner
1.0 FTE Peer Recovery Assistant

Program Challenges and Solutions

Stakeholders and partner agencies in the justice system have criticized the behavioral health system for slow initial response, difficulty accessing care, fragmentation in services, discontinuity when clients move between regions or settings and disconnection between substance use and mental health services.

By providing a clinical staff person in the courts at each major region of the county (Santa Barbara, Lompoc, and Santa Maria), the Justice Alliance has been effective in working with clients while they are going through court proceedings or in custody. However, limitations in staffing have made after-care quite challenging.

Mental health clients involved in the justice system often require additional support and after-care services to decrease the probability of recidivism. It is clear that a more robust and higher level program is needed. Stakeholders clearly identified this as a priority population during the FY 2014-15 MHSA stakeholder engagement process. This feedback resulted in the proposed expansion of the Justice Alliance to a Full Service Partnership. The new program design will better address service needs and decrease recidivism.

Senate Bill 82 (S.B. 82)

California Senate Bill 82 (S.B. 82), the Investment in Mental Health Wellness Act of 2013, uses state MHSA funding to provide grants to counties. ADMHS recently received approximately $11 million in S.B. 82 funding. This will support new crisis triage teams in Santa Maria, Santa Barbara and Lompoc, a Mobile Crisis West team in Lompoc, a new Crisis Stabilization Unit in Santa Barbara and a Crisis Respite facility in Santa Barbara.

A description of the enhanced crisis services made possible by S.B. 82 funding is included in this Plan Update for several reasons:

1. All ADMHS outpatient programs, regardless of funding source, will be integrated by following the guiding principles of MHSA and by using consistent evidence-based practices.

2. The use of S.B. 82 state MHSA along with county MHSA funding serves as an important illustration of how funds can be effectively leveraged to meet community needs.

3. Those seeking a basic understanding of the expanded crisis response system need to be familiar with the new S.B. 82-funded programs, as well as those supported by "traditional" MHSA funding.

Consequently, the expanded Crisis System of Care and Recovery includes the following components:

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

Crisis Triage Teams (SB 82)

Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
$3,082,360	0	$729,806	0	0	$2,352,554

Based in Santa Maria, Lompoc and Santa Barbara, crisis triage teams will focus on assisting individuals experiencing behavioral health crises who do not meet the criteria for involuntary hospitalization. Services include short-term interventions to promote wellness and recovery and helping individuals gain access to effective outpatient and crisis services. Client experiences will be

improved through a more seamless array of services designed to prevent future crises.

The program is intended to reduce costs associated with expensive inpatient and emergency room care by better serving people in the least restrictive manner possible, including those in a pre- crisis state and those discharged from a hospital. The field-based triage workforce will engage in proactive case management, peer support and clinical care before, during and after a behavioral health crisis. Follow-up services for individuals who have been hospitalized will be designed to reduce readmission.

Santa Maria staffing:

2 FTE Practitioner II, I or Intern
2 FTE Case Worker
3 FTE Peer Recovery Assistant
.5 FTE Psychiatrist

Lompoc staffing:

2 FTE Practitioner II, I or Intern
2 FTE Case Worker
3 FTE Peer Recovery Assistant
.5 FTE Psychiatrist

Santa Barbara staffing:

3 FTE Practitioner II, I or Intern
2 FTE Case Worker
3 FTE Peer Recovery Assistant
.5 FTE Psychiatrist

No salary models for the SB 82 Crisis Stabilization Unit (CSU) and Crisis Respite Facility are included in this document because salaries will be determined by contractors. Staffing includes 10.0 FTE in the Salary Model for the CSU, with 3.75 in the base budget and 6.25 in the budget expansion request. The 10.0 FTE are for 6 months, so in FY 15-16, there will be 20 FTE consisting of five nurses, five practitioners and 10 recovery assistants.

Crisis Stabilization Unit (SB 82)

Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
$2,352,243	$380,261	$409,482	0	0	$1,562,500

ADMHS will open the county's first Crisis Stabilization Unit, designed to provide a safe, nurturing short-term, voluntary emergency treatment option for individuals experiencing a behavioral health emergency. The program will accommodate up to eight individuals daily for stays of up to 23 hours. To be located on the county campus in Santa Barbara, the facility will offer 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 will include a Peer Recovery Specialist and a Psychiatric RN**,** as well as a 24-hour on-call psychiatrist with on-site rounds morning and evening. The comfortable, non-clinical setting will provide a calming, stable environment to help individuals move away from crisis. Services will include assessments, peer counseling, referrals for continued treatment, emergency medications, nursing assessment and access to psychiatric consultation.

Residential Respite House South (SB 82)

Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
$1,055,139	$291,374	$313,765	0	0	$450,000

A Crisis Respite Residential House will be established on the county campus in Santa Barbara to offer a voluntary, non-institutional, homelike setting for behavioral health clients to receive up to 30 days of respite, peer support and linkages to ongoing services and resources. The County will contract with a recovery-oriented organization experienced in operating residential programs for individuals with behavioral health needs.

Residents are admitted based on referrals from ADMHS and community-based provider staff. The facility will accommodate up to eight clients. Program staff will be coordinated and supervised by a masters-level clinician serving as Program Director and staffed with mental health specialists, including consumer and family member peers.

Trained consumer and family member peers will provide in-house program services to include support groups in recovery topics (e.g., skill development in cooking, laundry, shopping, using the bus, budgeting), assistance connecting with community resources (e.g., local learning resource

centers, housing, accessing supportive community groups) and building ongoing personal support systems (e.g., therapy, peer support groups, involvement in a faith community, connections with family and/or friends).

The Crisis Respite Residential House will be accessed by clients voluntarily who are motivated to obtain help to recover from their current crisis situations and want to learn skills and access community resources to prevent further crisis situations. Residential stays will also be used as "transitional" experiences for people re-entering the community from higher levels of care, such as an inpatient stay, to reduce the potential for re-hospitalization.

Mobile Crisis West Team (SB 82)

The new Mobile Crisis West Team serves adults experiencing a psychiatric crisis or mental health emergency and substantially enriches crisis options, providing clients appropriate alternatives to hospitalization whenever possible. The staffing will include a Peer Recovery Specialist, Mental Health Practitioner and Psychiatric Nurse. Although mobile crisis teams are based in Santa Maria and Santa Barbara, until now, there has been no team based in central county.

Mobile Crisis staff members are guided by a recovery vision and attitude of outreach and collaboration in identifying intervention options. Staff members work closely with consumers, family members and friends to identify natural supports and strategies consistent with the culture and values of the individual and family. Like their counterparts in north and south county, Mobile Crisis West staff members will work closely with local law enforcement professionals and hospital staff.

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Santa Barbara County Date:

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Community Mental Health Education	338,639	338,639	0	0	0	0
2. Mental Health Primary Care	331,500	331,500	0	0	0	0
3. ECSMH (Great Beginnings)	377,059	377,059	0	0	0	0
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Early Childhood Mental Health	1,122,000	489,050	532,950	0	100,000	0
12. Early Detection & Intervention	1,108,235	533,615	574,620	0	0	0
13. CATCH	40,800	40,800	0	0	0	0
14. Carpinteria START School based TAY	492,705	311,423	181,282	0	0	0
15. Access/Assessment	2,171,298	660,446	1,125,818	0	0	385,034
16. Crisis Services for Underepresented TAY	985,275	617,638	367,638	0	0	
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	1,022,310	250,466	434,482	102,231	235,131	
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	7,989,822	3,950,636	3,216,789	102,231	335,131	385,034

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Santa Barbara County Date:

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Mental Health Educators	345,412	345,412	0	0	0	0
2. Mental Health First Aid	338,130	338,130	0	0	0	0
3. Mental Health Primary Care	384,601	384,601	0	0	0	0
4.						
5.						
6.						
7.						
8.						
9.						
10.						
PEI Programs - Early Intervention						
11. Early Childhood Mental Health	1,144,440	498,831	543,609	0	102,000	0
12. Early Detection & Intervention	1,130,400	544,287	586,112	0	0	0
13. CATCH	41,616	41,616	0	0	0	0
14. Carpinteria START School based TAY	502,559	317,651	184,908	0	0	0
15. Access/Assessment	2,214,724	673,655	1,148,334	0	0	392,735
16. Crisis Services for Underepresented TAY	1,004,981	629,990	374,990	0	0	0
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	1,042,757	255,475	443,172	104,276	239,834	
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	8,149,618	4,029,649	3,281,125	104,276	341,834	392,735

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Santa Barbara County Date:

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Mental Health Educators	352,320	352,320				
2. Mental Health First Aid	344,893	344,893				
3. Mental Health Primary Care	392,293	392,293				
4.						
5.						
6.						
7.						
8.						
9.						
10.						
PEI Programs - Early Intervention						
11. Early Childhood Mental Health	1,167,329	508,808	554,481	0	104,040	0
12. Early Detection & Intervention	1,153,008	555,173	597,834	0	0	0
13. CATCH	42,448	42,448	0	0	0	0
14. Carpinteria START School based TAY	512,610	324,004	188,606	0	0	0
15. Access/Assessment	2,259,018	687,128	1,171,301	0	0	400,589
16. Crisis Services for Underepresented TAY	1,025,080	642,590	382,490	0	0	0
17.						
18.						
19.						
20.						
PEI Administration	1,063,612	260,585	452,035	106,361	244,631	
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	8,312,611	4,110,242	3,346,748	106,361	348,671	400,589

Prevention and Early Intervention (PEI)

Mental Health Education and Support to Culturally Under-Served Communities (Promotora Program)

Provider: Community Health Centers of the Central Coast, La Casa de la Raza, Santa Ynez Tribal Health Clinic, Mental Wellness Center

Estimated Funding FY 2014/15

Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
$338,639	$338,639	0	0	0	0

This program uses community health educators from culturally under-served populations who provide educational workshops, discussion groups and support groups to address individual and family mental health and wellness topics. Culturally appropriate training sessions are provided for community leaders and service providers. Culturally and linguistically appropriate services ensure linkages to services. Cultural wellness practices are integrated into outreach, consultation and early intervention activities.

ADMHS contractors Community Health Centers of the Central Coast, Casa De La Raza and the Santa Ynez Tribal Health Clinic provide targeted outreach and services to Spanish speaking communities; gay, lesbian, bisexual, transgender, and questioning populations; Oaxacan communities; and Native-American communities. These community-based organizations have effectively engaged under-served populations by employing culturally appropriate interventions in settings familiar and comfortable to the people being served.

Providers have also implemented radio and television outreach, education and anti-stigma efforts. Another successful outreach intervention is the use of Community Health Centers of the Central Coast (CHCC) mobile clinics. Mental health and educational services are delivered in a culturally informed primary care setting that promotes the integration of care. Community health educators working for the CHCC served an average of 522 persons per month during FY 2012-13.

In addition, funding supports training in Mental Health First Aid provided by the Mental Wellness Center. Mental Health First Aid is an eight-hour course that teaches non-professionals how to help someone who is developing a mental health problem or experiencing a mental health crisis. The training helps identify, understand, and respond to signs of mental illnesses and substance use disorders.

Program Challenges and Solutions

The Promotora / Mental Health Educator Program has been difficult to implement in the Santa Ynez Valley because the contractor has struggled to establish a community connection to Latino clients with mental health issues. However, their work with the Native American population has been exceptional; they are re-negotiating the contract to solely serve Native American populations. Other providers who serve Latino communities will be assisting in additional outreach.

Other challenges include the loss of a provider to the LGBTQ populations. A longstanding provider, Pacific Pride, terminated the contract, and we have been unable to identify a replacement provider within Santa Barbara County. Two providers were identified, but neither was willing to undertake this component. Despite ending the contract, Pacific Pride remains an active participant in the systems change Cultural Competence Action Team.

Recent outreach has identified an opportunity to provide education and services to the African American community. A newly established partnership with the African American faith-based community has created a promising foundation for new community partnerships We will continue to seek providers that can offer outreach and education services to the LGBTQ population.

The Cultural Competence Action Team has developed into a visible and consistent forum for expanding engagement with minorities and the under-served communities. This team brought forward the first major systems change request; i.e., that MHSA principles and funding be used to transform the outpatient system so that access is determined primarily by clinical need, not by funding source. This request laid the philosophical foundation for the current MHSA Plan Update. The Action Team will be an effective forum for expanding outreach and partnership with groups that support wellness and recovery but traditionally have not been directly involved in mental health service delivery, such as faith-based communities.

Integrating Primary and Mental Health Care in Community Clinics

Provider: Community Health Centers of the Central Coast

Estimated Funding FY 2014/15

Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
$331,500	$331,500	0	0	0	0

Community health clinics offer bilingual training and education to clinic visitors in mental health, resiliency and risk factors. This project offers an expansion of mental health services by providing services to individuals with mental health needs who do not fit the public mental health criteria of severe mental illness. Offering prevention and early intervention for mild-to-moderate mental health conditions ensures that individuals and family members receive help before conditions worsen.

Education about mental health lessens stigma and assists clients and family members in identifying the need for early and appropriate intervention for their loved ones, with attention to cultural considerations. Medical care, health education, early intervention, nutritional instruction and mental health services are provided in one location. Services include trauma screening, consultation, psychiatric evaluations, counseling, and prescribing to under-served clinic patients, who are referred by their primary care provider within a single setting.

The Community Health Centers of the Central Coast (CHCC) provides services at three clinics in Santa Maria and one in Lompoc (North and Central County). The evidence-based IMPACT program screens older adults for depression and provides follow-up as needed. Expanded mental health

resources in each community health clinic strengthen the capacity to assess, treat, and refer individuals at risk for the development of a serious mental health condition. As the program was implemented, data collection processes needed to be modified to ensure consistency with the IMPACT model.

The biggest challenge encountered was ensuring that IMPACT and mental health data collection tools were compatible with existing primary care data systems being used. This issue has been resolved. All components of the community clinic program continue to operate effectively**.** During the first three quarters of FY 2013-14, CHCC served approximately 2,874 unduplicated clients.

Program Challenges and Solutions

The Integrated Primary Care and Mental Health Component team and representatives from ADMHS meet on a regular basis to troubleshoot, discuss cases, facilitate client movement to higher or lower levels of care and maintain open lines of communication. This has helped to ease the transfer of clients from ADMHS to CHCC. However, the Santa Barbara provider, Neighborhood Clinics, withdrew from their contract two years ago. A new contract with a different provider has not been established. Changes underway at ADMHS also delayed the re-establishment of the Santa Barbara component.

PEI Early Childhood Mental Health (ECMH)

Provider: CALM, Santa Ynez Valley People Helping People, Santa Barbara County Education Office, Community Action Commission

Estimated Funding FY 2014/15 (Great Beginnings)

Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
$377,059	$377,059	0	0	0	0

Estimated Funding FY 2014/15 (Early Childhood Mental Health)

Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
$1,122,000	$489,050	$532,950	0	$100,000	0

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

PEI funding enhances the services available to children, birth to five years, by adding staff to provide services to Lompoc and Santa Maria in the North County. A new Mental Health Consultation component is also part of this project. This is a selective prevention and early intervention parenting and support program targeting families whose children are at the greatest risk for development of behavioral problems. Services for women experiencing perinatal mood disorders may include medication, individual counseling and group counseling.

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. In addition, parents and caregivers are provided skills, knowledge, and the support they need to oversee their children's healthy development.

The three primary programs in this initiative are:

1) *The Great Beginnings* program features a multidisciplinary team that uses a strengths-based approach to provide home and center-based services to low-income families of children prenatal to age five, with a focus on the Latino population countywide. Special outreach efforts target the African American community in Lompoc and the Asian and Pacific Islander community in Santa Maria.

2) *ECMH Special Needs Counseling* 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 resources are limited.

3) *A countywide program, CATCH*, assists preschoolers who exhibit challenging behaviors and do not qualify for special education. This program uses an evidence-based curriculum to train teachers and to support parents of preschoolers with challenging behaviors. This program accepts referrals for any "at risk" child exhibiting behavioral challenges. Services support children to be successful in their preschool setting. Direct support is also offered to other children in the school. Parent and teacher consultations are also provided.

One-hundred seventy-five unduplicated individuals were served between July 1, 2013 and May 31, 2014 by Child Abuse Listening Mediation (CALM), People Helping People, and the Santa Barbara County Office of Education (CATCH).

<u>Program Challenges and Solutions</u>

ECMH programs have developed effective outreach strategies in Latino communities. Consequently, in the next year, the need to expand services to keep up with the increased needs of children and their families will be assessed.

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

Provider: Family Service Agency, Council on Alcoholism and Drug Abuse
Estimated Funding FY 2014/15 (Early Childhood Mental Health)

Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
$492,705	$311,423	$181,282	0	0	0

This program provides mental health assessment, screening and treatment, home visits, school collaborations, family interventions, linkage and education for children, transition-age youth (TAY) and families. A school-based program offers prevention and early intervention mental health services to students in Carpinteria public schools experiencing emotional and/or behavioral difficulties. This program supports children and youth who are uninsured and for whom mental health services would otherwise not be accessible. Approximately 43% 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 works as a team with school staff and parents to address clients' social-emotional development, prevent mental health and psychological problems from becoming acute, enhance the clients' ability to adapt and cope with changing life circumstances, increase clients' protective factors, and minimize risk factors. A Support, Treatment, Advocacy and Referral Team (START) team assigned to schools includes experts in substance abuse and mental health prevention and treatment. START is available to provide intervention, referrals, programs, and services to intervene as early as possible to address learning, behavior, and emotional problems**.** START staff persons served 110 unduplicated individuals between July 1, 2013 and May 31, 2014.

PEI Early Detection and Intervention Teams for Children and TAY

Provider: ADMHS and Mental Health Systems, Inc.

Estimated Funding FY 2014/15

Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
$1,108,235	$533,615	$574,620	0	0	0

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

Three teams specialize in early detection and prevention of serious mental illness in transition-age youth, ages 16-25. Teams are based in North County (Santa Maria), South County (Santa Barbara) and Central County (Lompoc). The program serves transition-age youth 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.

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

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

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

PEI Children and TAY served 435 unduplicated individuals between July 1, 2013 and May 31, 2014.

Age Group	Number of Unduplicated Individuals Served	Cost Per Client - Prevention
0-15	244	$ 762
16-25	165	$ 6,241
26-59	26	$ 545
Total	435	$ 2,827

Crisis and Recovery Emergency Services (CARES)

Provider: ADMHS, Council on Alcoholism and Drug Abuse, Good Samaritan Services

In FY 2014/2015, the access and assessment component formerly performed by CARES will be handled by three Access and Assessment teams funded through the Prevention and Early Intervention (PEI) component. Crisis services will continue to be performed by CARES mobile crisis staff and staff with a number of new crisis system components, including a crisis stabilization unit (CSU) in South County, crisis triage teams in all regions, a south county crisis residential facility, and a new Mobile Crisis West team in Lompoc. In addition, a crisis residential facility in north county has operated for a number of years.

CARES has consolidated crisis stabilization, intake and access to service for behavioral health emergencies. Staffed by mental health professionals, CARES has provided crisis support on a 24/7 basis. CARES also has provided under-served children, adolescents, and families in crisis the

supports and services to prevent emerging mental health conditions from worsening, assists at-risk children and youth to stay in their homes and helps children and adolescents succeed in school.

By serving as an entry point to mental health services, providing crisis intervention and delivering psychiatric treatment and case management services, CARES has addressed the onset of psychiatric symptoms as early as possible, reduce the duration of untreated mental illness and prevent the prolonged adverse impacts of serious mental health conditions (e.g., difficulty maintaining housing or employment). CARES also has sought to reduce the need for more expensive mental health services.

Many of the individuals treated by CARES are indigent. Many suffer the effects of co-occurring symptoms of mental illness and substance abuse. The process of diagnosing the mental health needs of these persons often requires a prolonged assessment process, as well as a high frequency of case management, alcohol/drug treatment and support services.

Due to their lack of financial resources and complicated mental health and/or alcohol drug issues, CARES clients are unable to access traditional resources. CARES has sought to mitigate disparities in access to care. The CARES PEI component served 1,154 unduplicated individuals between July 1, 2013 and May 31, 2014.

To ensure sustainability of the Crisis and Recovery Emergency Services (CARES) functions, we propose moving CARES Mobile Crisis to the MHSA Community Services and Supports (CSS) component. The PEI CARES portion that provides intake and assessment will remain under PEI and be restructured as regional teams serving north, central and south county.

During FY 2012-13, CARES served the following:

Age Group	Number of Unduplicated Individuals Served	Cost Per Client - Prevention
16-25	120	$ 1,591
26-59	959	$ 2,065
60+	75	$ 2,103
Total	1,154	$ 2,019

Program Challenges and Solutions

CARES was originally designed to provide short-term crisis and intake services. A lack of longer-term resources have resulted in many CARES clients remaining in CARES for periods much longer than originally envisioned. This has led to bottlenecks in the outpatient system that are being addressed by developing additional crisis services, described earlier in this Plan Update.

Improvements in client flow and an expanded range of MHSA-funded programs will offer clients a more service choices. Funded through California Senate Bill 82, the Crisis Triage Program, Crisis Stabilization Unit, a Mobile Crisis West team based in Lompoc and a Crisis Respite Facility constitute a major step toward achieving comprehensive crisis services that will substantially reduce the need for psychiatric hospitalizations.

Crisis Services for Children and Youth (SAFTY)

Provider: Casa Pacifica

Estimated Funding FY 2014/15

Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
$1,025,080	$642,590	$382,490	0	0	0

Crisis services for children and youth were provided by Casa Pacifica through the Safe Alternatives for Treating Youth (SAFTY) mobile crisis response program, available to all Santa Barbara County youth up to the age of 21. For Fiscal Year 12-13, 278 unduplicated clients were either not insured or had private insurance. That is about 42% of the total number of unduplicated clients seen last year.

SAFTY provides children's crisis services in collaboration with CARES (Crisis and Recovery Emergency Services). The SAFTY program is available 24 hours a day, seven days a week. SAFTY provides quick and accessible service to families by providing specialized crisis intervention, in-home support and linkage to county alcohol, drug and mental 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 601 unduplicated individuals between July 1, 2013 and May 31, 2014.

Program Challenges and Solutions

SAFTY staffing is sometimes inadequate when there are multiple crises in different regions of the County, which slows the response time and requires intervention by the CARES team. To address surges in need and keep response times reasonably prompt, ADMHS supports SAFTY moving to a per diem model, which allows rapidly deploying additional staff when the need is high. Also, the implementation of expanded crisis services as described previously, including the mobile crisis triage teams, will alleviate some SAFTY's workload.

Local hospitals have heretofore declined to grant SAFTY hospital privileges, which require that CARES staff respond when persons under 21 are taken to the emergency room for crisis psychiatric assessment and intervention. Discussions with the hospitals to address their concerns have been initiated, The largest emergency departments located at Marian Medical Center and Cottage Hospital have agreed to pilot a procedure that will afford SAFTY access to emergency rooms.

Access and Assessment Teams

Estimated Funding FY 2014/15

Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
$2,214,724	$673,655	$1,148,334	0	0	$392,735

Equitable and improved access was single most urgent priority identified by stakeholders. A priority for many community members is the implementation of a clear, simple, and consistent process for entry into the county behavioral health system. Stakeholders also identified the need to handle effectively the disposition and referral of clients who do not meet medical necessity criteria for county behavioral health services.

The proposed solution calls for developing three regional teams specializing in access and assessment, with special attention to cultural considerations, such as unique presentations of crises among minorities and the importance of accessing family and community supports. The new regional teams will be based in Lompoc, Santa Maria and Santa Barbara. The teams will be guided by recovery and resiliency concepts and will improve access to services by operating in the field throughout the county.

Due to system bottlenecks, the current access and assessment function is currently conducted by staff members who must also provide ongoing treatment. In contrast, the new specialized Access and Assessment Teams will *only* focus on access, assessment, as well as appropriate disposition and referrals for clients who do not meet ADMHS criteria. This type of specialized focus constitutes a major departure from the current system. The creation of Access and Assessment Teams will simplify and improve access to care, reduce wait times, improve access, reduce bottlenecks and increase consistency throughout the county.

Assessments and referrals will be customized to ensure that appropriate cultural and linguistic needs of each client are identified and accommodated. Furthermore, each team will include staff members who are bicultural and bilingual in the primary threshold language (Spanish). The program intends to serve approximately 2200 clients per year. For more information about the proposed transformation of outpatient programs, please see the diagram that appears on page 26.

Lompoc staffing:

2 FTE Practitioner II

Santa Maria staffing:

1 FTE Practitioner II
3 FTE Practitioner II, I or Intern

Santa Barbara staffing:

3 FTE Practitioner II, I or Intern

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Santa Barbara County Date:

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Medical Integration	2,555,680	383,352	1,325,120	847,208	0	0
2. Evidence Based Practices Training	208,508	208,508	0	0	0	0
3. **G**irls **R**esiliency **R**estoration and **R**eintegration a**L**liance	639,249	639,249	0	0	0	0
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	1,014,999	177,625	431,375	203,000	203,000	
Total INN Program Estimated Expenditures	4,418,436	1,408,734	1,756,495	1,050,208	203,000	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Santa Barbara County Date:

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. **G**irls **R**esiliency **R**estoration and **R**eintegration a**L**liance	925,000	925,000	0	0	0	0
2.						
3.						
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20.						
INN Administration	138,750	79,781	58,969	0	0	
Total INN Program Estimated Expenditures	1,063,750	1,004,781	58,969	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Santa Barbara County Date: _____

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. **G**irls **R**esiliency **R**estoration and **R**eintegration a**L**liance	943,500	943,500	0	0	0	0
2.						
3.						
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11.						
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19.						
20.						
INN Administration	141,525	81,377	60,148	0	0	
Total INN Program Estimated Expenditures	1,085,025	1,024,877	60,148	0	0	0

Innovation

Although the Innovation funding component is ongoing, it consists of short-term projects that may typically last between one and three years. This section of the Plan Update begins with a discussion of the Benefits Acquisition Team project that has concluded, as then describes several proposed new projects.

The *Benefit Acquisitions Team project* concluded at the end of FY 2013/14. It consisted of teams in North and South County assisting at-risk adults with severe mental illness in acquiring the benefits necessary to advance recovery. The program also provided the necessary mental health services to ensure that clients are stable and engaged during the benefits acquisition process. One team was based at the Crisis and Recovery Emergency Services (CARES) in Santa Maria and another in CARES Santa Barbara. This component also provided funding for a .5 FTE position that links persons with severe mental illness leaving Santa Barbara County jail.

The Innovation project was based on a modified SSI/SSDI Outreach, Access and Recovery (SOAR) model, developed by the Substance Abuse and Mental Health Services Administration (SAMHSA). The Innovation project began as a benefits acquisition team that included a service component. Initially, the project intended to serve 300 clients. The original target of 300 was derived from the SOAR model itself. The model recommended that each staff person could serve approximately 50 clients per year. We estimated the program's total target population to be 300 individuals. However, since implementation, several lessons have been learned regarding the needs of the target population.

The benefits for indigent clients have been substantial. Many clients who are by the Innovation teams are among the most impoverished individuals in our community and may not have had access to service for long periods of time. Upon entering into the Innovation project, clients gain access to psychiatric support, medication, peer support, and case management. Services provided through the Innovation Program greatly improve the mental health, well-being, and quality of life. Once benefits are acquired, including stable housing, health care, and income to meet basic needs, long-term quality of life greatly improves.

ADMHS Innovation Program
3 Year SSI/SSDI Results
August 2013

	Year 1: March 1, 2011- February 29, 2012	Year 2: March 1, 2012- February 29, 2013	Year 3: * March 1, 2013- February 29, 2014	Total to Date
Number of Clients Served	85	76	36	197
SSI/SSDI Approvals (Innovation Staff)	18	19	8*	45

SSI/SSDI Approvals (Non-Inn Staff)	12	4	1*	17
Total Approvals	***30 56% Approval Rate***	***23 77% Approval Rate***	***9* 60% Approval Rate***	***62 63%***
SSI/SSD Denials	24	7	6*	37
Total Decisions	54	30	15*	99

* Data reflects March 1, 2013 - August 31st, 2013

Program Challenges and Solutions

The main challenges to the Benefit Acquisition Project are due to inconsistencies in how clients are diagnosed, staffing changes and staff turnover. However, significant lessons were identified during the last three years of project development. The most significant finding is related to the recognition that the uninsured population is not a monolithic group. The original design of the program identified a significant number of uninsured clients in our systems potentially eligible for Social Security Insurance (SSI) Benefits. It is now clear that many individuals severely impacted by mental health conditions are *not* eligible for SSI benefits.

In many cases, illnesses were not considered severe enough to qualify. For a number of individuals with co-occurring mental health and substance use conditions; the substance was a barrier to benefit acquisition. Without significant periods of sobriety, their alcohol or drug use is identified by those determining benefits qualification as the primary reason for their impairment.

Homeless individuals also presented significant challenges, primarily due to their lack of documentation and the additional resources required to engage and retain these clients. Overall, the knowledge acquired throughout this process will allow ADMHS to improve future benefits acquisition activities. Although the project will no longer be funded through MHSA, key elements of the SOAR Model *will* be maintained as part of Affordable Care Act implementation.

Girls Resiliency Restoration and Reintegration aLliance (GRRRL) (Innovation)

Provider: ADMHS

Estimated Funding FY 2014/15

Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
$885,837	$885,837	$	0	0	0

Stakeholder input provided the basis for three new programs under the Innovation component. These are the Girls Resiliency Restoration and Reintegration Alliance (GRRRL) project, Medical Integration and Older Adult Program, and the development of Culturally Adapted and Recovery Focused Models of Care. The GRRRL project is a three-year component, while the Medical Integration and Culturally Adapted Recovery Focused Models of Care components are envisioned as one-year pilot projects.

Consistent with objectives of the Innovation guidelines, these proposed projects increase access to under-served populations, improve outcomes for un-served and/or under-served populations and strengthen collaboration with system partners.

Background

ADMHS is an active member of the Santa Barbara County Juvenile Justice Coordinating Council and works closely with a variety of agencies, including the District Attorney's Office, the Public Defender, Probation, the courts and the Rape Crisis Center. For example, ADMHS has collaborated with a number of agencies on public awareness campaigns about sexual exploitation of children and on a proposed Girl's Court. The GRRRL project is the result of extensive multi-agency consultation and has gained considerable support among a broad spectrum of leaders working in the juvenile justice system as well as other agencies working with vulnerable youth.

Key stakeholders identified girls who are victims of, or at risk for, sexual exploitation as an un-served and extremely vulnerable population in need of services. The lack of appropriate interventions that address the specific mental health needs and cultural depth of this ethnically diverse population confirmed that this component is worthy of Innovation consideration.

Due to the secrecy and an underground network of sexual exploitation of adolescent girls, especially those in the juvenile justice system, it is often difficult to recognize the extent of this problem in communities. Often, the lack of centralized data collection obscures the issue and makes it difficult to assess its prevalence.

Further compounding the problem, systems may not always recognize that young women are victims in these situations, instead defining them as perpetrators and prosecuting them accordingly.

Although agencies are doing much better in appropriately identifying this population, additional efforts are needed to raise awareness throughout multiple systems that come in contact with these young women.

Models developed to address this issue will greatly enhance the field of mental health and should be replicated throughout the state. Unfortunately, the lack of statewide coordination and inconsistency in awareness is an additional barrier to be addressed through successful application and replication of the proposed intervention.

Girls and young women in Santa Barbara County are at risk of becoming victims of commercial sexual exploitation of children (CSEC). Those commonly victimized have also suffered from traumatic childhood experiences. The Adverse Childhood Experiences (ACE) Study, noted a "highly significant relationship between adverse childhood experiences and depression, suicide attempts, alcoholism, drug abuse, sexual promiscuity, domestic violence, cigarette smoking, obesity, physical inactivity, and sexually transmitted diseases. In addition, the more adverse childhood experiences reported, the more likely a person was to develop heart disease, cancer, stroke, diabetes, skeletal fractures, and liver disease."
(http://www.traumacenter.org/products/pdf_files/preprint_dev_trauma_disorder.pdf). Other evidence indicates that the average lifespan of sexually trafficked girls is tremendously reduced.

A 2013 California Legislative Brief stated that in the U.S. an estimated 100,000 youth are at risk of being trafficked every year. Traffickers target the vulnerable, such as runaway and homeless youth or children who have been mistreated or abandoned. Many of these children are vulnerable due to child welfare and foster care systems which are ill-equipped to serve the needs of sexually exploited children. Sex trafficking victims are compelled or induced to engage in acts of prostitution by their traffickers, which often results in the victim being convicted of prostitution.

The average age of entry into prostitution/sexual exploitation for a female child victim in the United States is 12-14 years old. (*U.S. Department of Justice*). Sex trafficking is not prostitution; through sex trafficking a pimp can make $150,000-$200,000 per child each year, and the average pimp controls between four and six girls. *(U.S. Justice Department, National Center for Missing and Exploited Children), and the* average victim may be forced to have sex up to 20-48 times a day. *(Polaris Project).*

Although there are no published data from Santa Barbara County, staff have interviewed and assessed female youth incarcerated in Juvenile Hall for approximately one year and found, on average, over 50% were either strongly suspected of, or had admitted to, sexual exploitation/trafficking. Almost all knew of someone involved in trafficking or had a sophisticated understanding of trafficking, the terminology used, and how one would become involved in trafficking or sexual exploitation.

Many girls reported being exploited while they were in local, low-level, easy-to-abscond-from group home/foster placements. Probation, Department of Social Services, the District Attorney and ADMHS have observed a significant increase in the number of diverse youth who are affected by sexual exploitation.

According to the 2010 Census, the Hispanic and Latino populations in Santa Barbara County make up 42% (181,687) of the total population, and of the approx.182K Hispanic and Latino residents, approximately 19.5% are between the ages of 10-19 (35K). As minorities are significantly more involved in the criminal justice system, this program will deliver services in a culturally competent manner. Bicultural and bilingual staff, interpretation services and bilingual/bicultural support groups will be available as needed.

Because victims often struggle with alcohol and drug abuse, face mental health challenges, have on-going medical needs, and are involved in the juvenile justice system, a multi-systemic, trauma-sensitive, and recovery/strength-based approach is required. The County of Santa Barbara is committed to addressing the issue of child sexual exploitation of culturally diverse juvenile justice involved females in a comprehensive manner.

The comprehensive approach will include direct services to youth involved in sex trafficking, their siblings, and their family members. A widespread information and education campaign will be launched to train and inform county staff, CBO staff, first-responders, medical personnel, school personnel, community members, private citizens, etc. A Santa Barbara County task force noted that currently there are no specialized treatment teams or providers in the community that can adequately serve this high-risk vulnerable population.

<u>The Proposed Project</u>

Currently, the County of Santa Barbara has no specialized program or services for young women involved in or at-risk of becoming victims to sex trafficking. Furthermore, their siblings and family members do not have resources available to find help for themselves or their loved ones. The **G**irls **R**esiliency **R**estoration and **R**eintegration a**L**liance (**GRRRL)** Innovation project will use a three-part process:

- *First*, providing services to young women using a comprehensive, multi-systemic, culturally competent and strength-based approach.

- *Second*, offering services to siblings and family members to decrease the chance of sibling involvement and increase the positive involvement of family members in promoting the recovery and reintegration of victims.

- *Third*, educating friends, families, service providers, and community members as to how to recognize the signs of sex trafficking, and what to do if you suspect someone is in danger.

Locally, a Sex Trafficking Task Force has formed, but no program specific to this population has been created that offers comprehensive services in a trauma -sensitive, recovery-based program with coordinated services. Mental health services will be an essential element to this project.

The program will use an interagency multi-layered treatment, training and education approach which will include extensive community collaboration with law enforcement, courts, social services, alcohol and drug services, mental health providers, schools, pediatricians, public health, first responders, community based organizations, parents, foster parents, peers, etc.

A comprehensive model of services, resources, protocols, education and training will be designed, implemented and tested; this will include early intervention strategies for those juvenile justice

involved females “at risk” for sexual exploitation. The GRRRL project will cover outreach, education, training, interventions, peer supports, outcome measurements, and ongoing Continuous Quality Improvement.

The GRRRL project will be composed of these integrated elements:

1. Initial intake/ongoing/out-processing screenings and assessments to collect/evaluate data to ensure program efficacy as well as provide compatible treatment interventions
2. Comprehensive Treatment Planning and Development with team, youth and family/caretakers
3. Trauma Sensitive Crisis care interventions 24/7
4. Treatment will focus on wellness, resilience and recovery through mind/body/spiritual awareness, positive psychology, DBT, pro-social, and mindfulness approaches, including:

    a. Yoga
    b. Writing Workshops
    c. Artistic Activities
    d. Meditation/Mindfulness/Intentional Thinking
    e. Pro-social opportunities through pro-social and resiliency building group activities
    f. Mindfulness/DBT/Positive Psychology/Trauma Informed Groups
    g. Individual Therapy/Counseling/Supports
    h. Peer Mentor Program
    i. Family Therapy

5. Linkages to recovery-driven resources
6. Advocates to assist youth in navigating services including: legal, social services, school, immigration, mental health, and medical systems.
7. Medication Support
8. Regular Treatment Team meetings with youth and family to review progress and problem solve
9. Meaningful and pro-social incentive program to keep youth engaged

This project seeks to make a change to existing behavioral health services by enhancing the understanding and approach to young females who are vulnerable or involved in sex trafficking. Current programs for juvenile justice involved youth have not been successful in making a significant impact with this vulnerable population. This proposed innovation will seek to provide care specifically designed for the needs of this population. It will also serve as a learning tool to determine appropriate and effective ways to successfully treat this high risk vulnerable population.

Staffing

GRRRL's Staffing Recommendations:
2.5 FTE Case Worker
1.0 Psychiatric Nurse
1.0 FTE Practitioner II
1.0 FTE Practitioner-Intern
1.25 FTE Recovery Assistant
1.0 FTE Rehabilitation Specialist
1.0 FTE Team Supervisor-Practitioner
.5 FTE Admin. Office Pro II
.25 FTE Psychiatrist II

GRRRL's Training and Education Costs:
Education and training costs are estimated at $150,000 over three years and will encompass training/education provided at several levels, with training and education to at least 7500 individuals:

1. Law and justice system:
    a. Juvenile Probation Staff
    b. District Attorney
    c. Juvenile Court
    d. Law Enforcement
2. Behavioral Health Providers:
    a. ADMHS Children and Adults
    b. CBO's
    c. Network Providers
3. Family Support Systems
    a. DSS
4. Medical Community
    a. EMT's
    b. Family and Adolescent Doctors
    c. Emergency Rooms
5. Education System:
    a. SB County School Districts
6. Family and Community

Training and education regarding child sexual exploitation and high-risk juvenile justice involved females (JJIF) will maintain two general foci:

1. Education/Awareness
    a. Improving overall awareness of sexual exploitation and high risk JJIF and in the community including schools, juvenile hall, jails, foster homes, social service agencies, medical clinics, service industries, law enforcement, etc…of the emotional/physical

impact to the victims; the legal/monetary/criminal impact to community and strategies for intervening.

2. Training/Education
    a. Educating first responders" (Emergency Medical Technicians, Pregnancy Prevention/Sexual Health Agencies, Pediatricians, Child Welfare Workers, and Law Enforcement/Probation Officers) on the issues surrounding sexual exploitation and high risk girls.
    b. Training ongoing/longer term behavioral health care providers (Counselors, Rehab Specialists etc.) Trauma Informed Care, DBT, MDT

Training and Education Costs:

Total education and training costs are estimated at $250,000 over a one-year period and will provide training and education to approximately 350 individuals. This will include ADMHS and Community-Based Organization staff. Furthermore, one FTE Psychologist is part of this budget. The position will assist in the adaptation of the models selected by stakeholders, and will assist in the implementation and training of these models. The position will also work with stakeholders and staff to ensure that fidelity tools are selected/created and incorporated into program design and operation. This position will also serve as a content expert and Technical Assistance Expert for our system and programs.

Contribution to Learning

GRRRL

Through the GRRRL project we will learn:

1. If using a shared universal and measurable trauma/risk screening tool will result in a comprehensive understanding of this population and increase trauma sensitive treatment of the young ladies by:
    a. Identification of at risk or currently sexually exploited JJIF's
    b. Continuity of care and collaboration between agencies/organizations who treat or provide services to these high risk females
    c. Increasing early intervention services to reduce the number of sexually exploited females
    d. Reducing the incidents of sex trafficking in our County

2. If offering services in a trauma-sensitive, recovery based approach using a wellness, mind-body-spirit integration, and resiliency approach to increase rapport and participation from the young women, resulting in:
    a. Reductions in runaway behaviors
    b. Reduction of substance use/abuse
    c. Reduction of further sexual exploitation
    d. Reduction in contact with unhealthy peer groups
    e. Increase in pro-social activities
    f. Increase in positive self-esteem and body image
    g. Healthy view of sexuality

3. Will community education/awareness efforts, including informing media, businesses and policy makers, of the GRRRL project increase the engagement of bystanders or witnesses who may be able to aid in the cessation of current and prevention of future child sexual abuse and exploitation?

4. Will increasing community and policy maker awareness increase funding sources to develop longer term housing and emergency shelters for these exploited girls?

Annual Number of people served:
The two teams based in Santa Barbara and Santa Maria will serve approximately 160 young women in the first year. However, it must be noted that due to the lack of data, these estimates may need to be revised based on identified needs. The program will reach approximately 2,660 individuals regarding the signs and risks of sex trafficking.

Timeline
The project schedule covers three years from the approval date. The tentative schedule proposed is from August 2014 – August 2017. The timeline will allow sufficient time to effectively implement the project, develop appropriate data collection tools and parameters, collect data, and assess the effectiveness of the project. The final six months of the project will allow a team to analyze data, and if outcomes are favorable, compile a plan for replication. Additionally, an annual analysis of the project will be conducted to allow for program adjustments or changes.

August 2014
- Develop the model for the Innovation project
- Assemble a GRRRL stakeholder committee
- Develop Program Implementation Plan with stakeholder committee

September – October 2014
- Identify specific program outcomes
- Recruit and hire personnel
- Establish data tracking method
- Develop outcome/evaluation tools and process

October – December 2014
- Identify and write program and inter-agency protocols
- Draft and initiate MOUs with collaborating agencies.
- Establish training plan and timeline
- Develop training guidelines and program handbook
- Train program staff on best practices and Trauma sensitive care

December 2014-January 2015
- Meet with plan committee and provide update and gather input
- Initiate program implementation
- Make adjustments to the implementation plan as needed
- Develop Evaluation Report and disseminate to all stakeholders. The report will include an analysis of success in achieving the learning objectives.

FY 2015-2016

- Complete quarterly reviews, assessments, and adjustments
- Publish quarterly Evaluation Report
- Publish Annual Evaluation and Outcomes Report
- Plan for any program adjustments or enhancements to begin July 2016

FY 2016-2017

- Complete quarterly reviews, assessments, and adjustments
- Publish quarterly Evaluation Report
- Publish Annual Evaluation and Outcomes Report
- Plan for any program and funding changes to begin June 30, 2017

Project Measurement

Four project areas will be measured: (1) Effectiveness and impact of using a shared screening tool; (2) The impact of using a specific approach when working with young women who are vulnerable to or involved in sex trafficking; (3) Enhanced inter-agency collaboration; and (4) Effectiveness of efforts resulting in public funds being dedicated to serving this population.

Project Evaluation Team

A project evaluation team composed of diverse stakeholders, including consumers, family members and representatives of ethnic communities will evaluate the project's success in meeting the learning objectives and assist in the dissemination of the evaluation to stakeholders

Objective 1 Effectiveness and impact of using a shared screening tool

This learning objective concerns the effectiveness of having multi-agencies and multi-departments use the same screening tool. It is anticipated that by using the same screening tool the agencies will work in a more coordinated and collaborative way, increasing the chances of providing young women coordinated, cohesive, and complimentary services resulting in a more positive impact.

Objective 2: Effectiveness of specifically designed approach.

By using a multi-layered, trauma-sensitive and recovery-based approach, results will illustrate the impact on girls and young women at risk of or involved in sex trafficking. It is our hope that the specialized program will result in more young women seeking help or avoiding involvement. Currently, the approach taken by community services when working with females in the juvenile justice system have not had a positive impact on this population. A specialized program may result in a positive impact which may be replicated in other populations or other counties.

Objective 3: Learning about interagency collaboration

The interagency collaboration has already begun with a stakeholder process including current and planned collaborations with the Sex Trafficking Task Force, the DA and law enforcement.

The process will not only help young women who are currently at risk or involved in the sex trafficking trade, it will help future generations by informing county departments, CBOs, schools, and

communities about the risks and signs of sex trafficking. We will learn if increasing our inter-agency collaboration results in more agencies having an increased an understanding of sex trafficking, increases the knowledge of sex trafficking victims, and improves the way that the victims are treated within the legal system. The collaboration may result in the use of trauma-sensitive and strength-based approaches throughout the broader systems.

Objective 4: Learning if the increase of public awareness increases funding.

Currently, sex trafficking is not commonly understood in Santa Barbara County, and no public funds have been allocated to abolish sex trafficking in the county. This public awareness campaign may result in more community members becoming aware of the problem and prioritizing the provision of services to support the victims and decrease the influence of sex traffickers.

Leveraging Resources

The Innovation project intends to work closely with multiple partners and agencies as outlined under learning objectives 1 & 3. Our partnerships will allow us to leverage services to clients, increase our access to information, and provide training to staff, community leaders, and members. The services to the program and client will be important contributors to the success of the project. Partnerships with ADMHS, CWS, Probation, Law Enforcement, Courts, Parole, District Attorney's Office, Community Centers, Schools, Public Health, Foster Care and others will allow young women at risk of or involved in the sex trafficking trade to find support and guidance in order to decrease the likelihood that they will be involved in sex trafficking and/or increase their ability to make different choices. We will work closely with the Sex Trafficking Task Force as well as other agencies to disseminate information about sex trafficking, leveraging the extensive sites and connections that the above named groups offer.

Culturally Adapted and Recovery Focused Models of Care (Innovation)

Estimated Funding FY 2014/15

Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
$300,619	$300,619	0	0	0	0

A report of the U.S. Surgeon General released in 2001 counted the number of individuals from ethnic minorities who participated in a variety of studies designed to test the effectiveness of a variety of behavioral health evidence-based practices. Between 1986 and 2001, only 7.1% of the participants were from ethnic communities.

For example, out of 9,266 participants in randomized controlled trials evaluating the efficacy of interventions for bipolar disorder, schizophrenia, depression, and ADHD only 561 African Americans (6 percent), 99 Latinos (1 percent), 11 Asian Americans/Pacific Islanders (0.1 percent), 0 American Indians/Alaska Natives were identified, and not a single study analyzed the efficacy of the treatment by ethnicity.

Clearly, this lack of evidence with ethnic and other marginalized populations merits cultural- and recovery-focused adaptations. Since many recognized evidence-based practices, commonly adopted by mental health systems may lack data to substantiate efficacy with ethnic and other marginalized populations, there is need to ensure that use of EBPs is culturally adapted to increase client engagement and maximize effectiveness.

Members of culturally diverse populations are also more likely to drop out of treatment and be uninsured. This means they experience less access to preventive care and prescription medications, higher rates of avoidable hospitalizations, and later-stage diagnosis of health problems at higher rates than their white counterparts. Adequate training and the lack of culturally congruent therapeutic approaches are credited with contributing to these disparities. Although many programs may develop an increased awareness of the importance of cultural competence, critical skills and treatment adaptations that can be incorporated into clinical practice are often lacking.

One of the recommendations in a 2005 report issued by the National Advisory Mental Health Council's Workgroup on Clinical Trials states that "The NIMH [National Institute of Mental Health] should expand its efforts to involve historically under-represented populations in clinical research including women, ethnic and racial populations, and children and the elderly." It also noted "as the population of elderly ethnic/racial groups is expected to rise dramatically over the next several decades, treatment trials need to do more than merely include 'adequate numbers' of racially diverse groups….The Workgroup recommends particular emphasis on treatment studies of disorders that are

poorly represented in the current portfolio; studies of psychosocial treatments, and treatment trials focused toward specific racial/ethnic groups of older patients."

Much work remains in adapting evidence-based practices to meet the needs of underserved communities. For example, Haeok Lee, R.N., Ph.D., Joyce J. Fitzpatrick, MBA, Ph.D. and Sung-Yi Baik, R.N., Ph.D, found that health disparities among racial/ethnic minorities are persistent in spite of the adoption of standardized evidence-based practices. (*Applied Nursing Research*, Volume 26, Issue 4, November 2013.) The authors concluded that "EBP implementation should be contextualized within the sociocultural environments in which patients are treated rather than solely focusing on the health problems."

In "A Toolkit for Applying the Cultural Enhancement Model To Evidence-Based Practice (2013)," Walker, Trupin, and Hansen note that historically, public and private mental health systems have not addressed the needs of diverse populations, specifically ethnic populations with linguistic and cultural differences. Consequently, people of color and other diverse groups experience significant disparities in access to mental health services, and in the quality of services they receive.

The authors recommend that cultural adaptations serve as a bridge between the evidence-based practice and cultural competency needs of diverse populations. To successfully expand the reach of evidence-based knowledge into clinical practice, a co-design or cultural adaptation of treatment is necessary.

Improving the Santa Barbara County Behavioral Health System of Care and Recovery

Culturally specialized and evidence-based practices were identified by Santa Barbara County stakeholders as a critical deficit in the behavioral health system. Consequently, stakeholders suggested the use of multiple evidence-based practices and community-recognized practices. The opportunity to develop evidence-based and community-tested practices that incorporate recovery and cultural adaptations is a unique and progressive opportunity to ensure that the new system of care is responsive to the needs of all diverse populations of Santa Barbara County.

Although some interventions may exist that incorporate cultural adaptations, the adaptation of recovery principles and cultural needs has not been implemented using multiple evidence-based and other models simultaneously. The development of a model or process that makes these adaptations to multiple evidence- based and community-recognized practices, relying on community stakeholder and other cultural broker expertise, is quite innovative.

The proposed model will make adaptations at the administrative, service delivery, and clinical level to reflect and respond to the cultural dimensions of diverse populations. Culturally adapted care is culturally competent care that must be incorporated into the planning and implementation process as early as possible.

Culturally competent care requires administrative commitment, foresight, and ongoing support that bolsters the success of models selected. With appropriate participation and inclusion of diverse populations in planning, the models selected and identified by stakeholders will provide competent care in service delivery and will translate into competent care at the clinical level, as well.

In summary, the project manager will:

1) Create appropriate adaptations to evidence-based practices to meet the needs of under-served and un-served cultural and ethnic populations in Santa Barbara County;

2) Incorporate the adapted evidence-based practices into a system-wide training plan that ensures consistency across regions and target populations;

3) Monitor fidelity to implementing EBPs throughout the behavioral health service delivery system.

Recommended Staffing

1 FTE Clinical Training and Implementation Coordinator

Contribution to Learning

As previously discussed, evidence-based practices have historically lacked data to substantiate efficacy with ethnic and other marginalized populations. The objective of this Innovation project is to increase or contribute to the knowledge base in this area. The effective integration of recovery and cultural competency into evidence-based and community-recognized practices will expand the success of these models to reach under-represented populations effectively. The adaptations made in these two primary areas will be documented to allow for their replication.

Clients Served

Approximately 450 internal and external staff will be impacted by this component. The intent is to phase in these trainings over the upcoming year while working in partnership with stakeholders and key content experts to ensure a recovery and cultural competency focus.

Timeline

Quarter 1

- Work with stakeholders to identify appropriate models for interventions.
  - Identify system wide interventions and models
  - Identify specialty services
- Identify recovery and cultural competency experts to assist in making adaptations to selected models.
- Identify existing fidelity tools
- Develop training plan and schedule to phase in training components

Quarters 2-4

- Initiate training plan
- Provide ongoing follow up and TA upon implementation
- Assess progress on implementation of practices and interventions
- Apply fidelity tools to programs to ensure compliance
- Develop and implement client feedback tools will be

Project Measurement

The success of this program will be measured by collecting data documenting the number and types of adaptations that are made to each practice or model. Furthermore, the process of implementing these adaptations will also be important to document. Collecting data on the engagement and retention of under-represented populations will ultimately be the best indicator of successful implementation and integration.

Medical Integration and Older Adult Program (Innovation)

Estimated Funding FY 2014/15

Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
$2,555,680	$383,352	$1,325,120	$847,208	0	0

Stakeholders have identified need to improve service to older adults with severe mental illness, including individuals with co-occurring health issues, as a top priority for system transformation. It became clear that a specialized team is necessary to address the complex needs of this population, including multiple medication management and the prevalence of significant physical and mental health conditions.

Increased access to primary care through the Affordable Care Act and a growing older adult population create unique challenges. The timing ideal for developing innovative approaches to serving older adults with complex needs. Forging new partnerships with primary care and substance use treatment providers is essential.

The objective of this project is to develop specialized teams in each region of the county to serve persons with severe mental illness who also experience serious medical problems, including individuals who are 60 years of age and over. Teams will also develop ongoing partnerships \ with all relevant agencies, including, but not limited to, Public Health, Alcohol and Other Drug providers and senior service organizations. The creation of these partnerships will be critical to meeting the needs of mental health clients of all ages, including older adults.

The teams will also develop protocols to ensure seamless and continuous treatment, especially when exacerbation of medical conditions threatens to interfere with mental health care. In the current behavioral health system, as elsewhere, the complexity often transcends treatment team boundaries and impedes effective service delivery. Sometimes the result is functional decline for clients.

The Medical Integration/Older Adult teams will include a strong nursing component to ensure that medical complications are addressed within the scope and licensure of staff, who will be well-equipped to coordinate care with acute care and ongoing medical providers. In addition, the team will specialize in addressing the unique challenges of aging, along with the changing psychiatric presentation common in older adults.

Preliminary evidence-based practices have been selected and will be refined for specialized application to this population, including IMPACT for treating depression, Cognitive Behavioral

Therapy (CBT), Seeking Safety and Motivational Interviewing, all embedded with the system-wide focus on wellness, recovery, and resiliency. Two teams will serve as a one-year pilot. If successful, support for the teams will be integrated into other funding components.

Medical Integration and Older Adult Staffing Recommendations:

Santa Maria staffing:
1 FTE Psychiatric Nurse II
1 FTE Psychiatric Nurse I or II
2 FTE Case Workers
1 FTE Practitioner II, I or Intern
1.5 Practitioner II

Santa Barbara Staffing:
1 FTE ADMHS Practitioner II
1 ADMHS Case Worker
.5 FTE Psychiatric Nurse
1 FTE Case Worker
1 FTE Practitioner II, I or Intern
.5 FTE Psychiatric Nurse I or II

Contribution to Learning

The intent of this program is to (a) improve coordination between primary care and mental health systems and (b) increase the ability to serve individuals with medical and behavioral health challenges effectively and efficiently, even when medical complications make mental health treatment more difficult. Therefore, the major contribution to learning exists in the opportunity to develop a seamless, specialized service experience for older adults and others dealing with co-occurring medical conditions.

This opportunity will enable the identification of practical approaches and interventions that will increase access and improve outcomes. Although models have been developed for geriatric populations, the models typically address physical health in an ancillary way. Too often these models cannot account for unique community issues such as barriers to ethnic communities or variances in available resources to uninsured populations.

By developing a local model, specific community needs associated with age, ethnicity and language access will be addressed. The process will also allow identification of, and collaboration with, a broad spectrum of primary care providers, social service agencies and community-based organizations that serve insured and uninsured populations.

Annual Number of people served:

Approximately 320 clients will be served countywide by this program.

Timeline

This project is a one-year pilot program. If successful, the project will be expanded. The sustainability of this project will be through other MHSA funding components or through ACA funding.

Implementation will begin in August of 2014. Ongoing analysis of the project will be conducted to ensure that challenges are addressed and necessary adjustments made.

July 2014

- Develop the model for the project
- Recruit and hire staff
- Reassign current staff
- Develop client criteria

August – October 2014

- Establish training plan and timeline
- Develop training guidelines and program handbook
- Identify client populations to be served
- Identify specific program outcomes
- Develop data collection methods and tools
- Train project staff on best practices and Trauma sensitive care

October 2014 – February 2015

- Establish inter-agency partnerships with primary care providers and other partners
- Develop interagency MOUs and other necessary agreements
- Develop ongoing quality improvement process
- Initiate program implementation

December 2014-January 2015

- Make adjustments to the implementation plan as needed

January 2015 – March 2015

- Collect project data
- Make necessary changes and improvements to program
- Generate and disseminate outcome report to partners

March 2015 – June 2015

- Develop outcome analysis of project data
- Document ongoing changes and improvements
- Begin development of final Innovation report

<u>Project Measurement</u>

The key measurements of the project will include assessing the reduction in hospitalization and ER visits; assessing if coordination leads to a reduction in service duplication, and improvement in medication management; assessing if improved coordination reduces costs in primary and mental health care; and an assessment in improved quality of life issues.

- *Reduction of hospitalization*
  Client data will be collected to benchmark hospitalization and Emergency Room rates prior to program participation and will be compared to rates during the time of enrollment.

- *Improvement in services coordination*

The establishment of a specialized teams equipped to address co-occurring conditions will reduce the duplication of services, improve service coordination and medication management. A tool will be developed to measure progress in these areas.

- *Reduction of long- term primary and mental health care costs*
  Data on ER and Hospitalization will provide a partial analysis of this outcome. Data related to costs in services prior to enrollment will also assist in developing a comparative analysis.

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

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Santa Barbara County Date:

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. CIT	710,005	710,005	0	0	0	0
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	710,005	710,005	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Santa Barbara County Date:

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. CIT	442,851	442,851	0	0	0	0
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	442,851	442,851	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Santa Barbara County Date:

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0

Capital Facilities and Technological Needs (CF/TN)

Estimated Funding FY 2014/15

Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
$710,005	$710,005	0	0	0	0

Client/Family Access to Resources

This project provides computers and trainings for consumers and family members at the three regional Recovery Learning Communities (RLCs). Consumer-focused training and access to technology is offered in each of the three primary population centers in Santa Barbara Count: Santa Barbara, Santa Maria, and Lompoc. Access is intended to promote wellness, recovery, and resiliency of consumers. In addition, video conferencing capabilities have increased access to meetings for individuals, including consumers throughout the County. This has enhanced consumer participation, including in system change events.

Consumers are being provided access to computer resources and tools to gather information, research mental health conditions, and gain knowledge to become a well-informed and active partner in their own treatment. Training resources are being made available to promote the well-being of consumers by enabling them to acquire skills that improve their opportunities for education and gainful employment. On-line surveys and program needs assessments allow for timely feedback about mental health services and increased involvement by consumers.

Accomplishments

- Installed videoconference equipment in Lompoc, Santa Maria and Santa Barbara to increase access to meetings.
- Purchased desktop hardware for consumer training centers.
- Provided consumers access to computer resources and tools to gather information and gain knowledge to become active partners in their own treatment.
- Installed and maintained computers at regional Recovery Learning Centers in Lompoc, Santa Maria and Santa Barbara.
- Selected training providers for the RLCs and initiated consumer training under CBO direction.

Electronic Health Records Enhancement

This project creates system-wide access to clinical, administrative and financial information in digital format. The Electronic Health Records (EHR) Enhancement Project will expand and build on the currently operational Integrated Information System at Santa Barbara County ADMHS. The project will create system-wide access to clinical, administrative and financial information in digital format; staff will be trained to access and record accurate and timely data. The project will allow for the capture of digital information and eventual elimination of a paper-based system.

Accomplishments

- Facilitated secure system-wide access to clinical and administrative information; ensured data security and reduced risk of potential identity theft.
- Ordered, received and deployed desktops throughout the county.
- Developed specifications for server software; installed signature pads countywide; trained staff in their use.

Consumer Security and Confidentiality

This project facilitates secure system-wide access to clinical and administrative information; ensures data security and reduces risk of potential identity theft. The Consumer Security and Confidentiality Project builds on the security efforts currently in place at ADMHS. The security standards are matching other Santa Barbara County Departments in their effort to meet state-mandated requirements. The project is facilitating secure system-wide access to clinical and administrative information, providing access to the consumer health data system and improving continuity of care on a daily basis and in case of an emergency. This improved system is also aiding staff in performing consumer benefit and insurance-related support and demographic information gathering, enhancing patient access to services to which they are entitled.

Accomplishments

- Created system-wide access to clinical, administrative and financial information in digital format and identified benefit specialists roles and responsibilities and project manager.
- Hired Supervising Computer System Specialist and implemented state-mandated passwords for MEDS accounts and completed security evaluation for physical plant security.
- Initiated off-site storage program and installed physical plant security measures and trained benefits specialists in new security requirements.

Program Challenges

The Capital Facilities and Technology component has implemented most of the components successfully. Several challenges that have been encountered exist in the full EHR conversion in areas beyond outpatient services. The EHR conversion in the Psychiatric Health Facility is still in progress. The ADMHS IT Department is assessing the challenges and will implement appropriate solutions in the upcoming year, ensuring full EHR conversion throughout the county behavioral health system.

Another challenge involves computer access for consumers at the Recovery Learning Communities. Participation in training programs is constant. Consumers continue to frequent the centers at high rates. However, the ongoing upkeep of computers and software maintenance has been identified as a need. ADMHS IT staff persons are working with the Recovery Learning Communities to address these issues and will identify hardware that needs to be replaced or repaired.

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: Santa Barbara County Date:

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Peer Training	154,012	154,012	0	0	0	0
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	27,656	27,656				
Total WET Program Estimated Expenditures	181,668	181,668	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: Santa Barbara County Date:

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Peer Training	157,092	157,092	0	0	0	0
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	28,209	28,209				
Total WET Program Estimated Expenditures	185,301	185,301	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: Santa Barbara County Date:

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Peer Training	45,000	45,000				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	19,989	19,989				
Total WET Program Estimated Expenditures	64,989	64,989	0	0	0	0

Workforce Education and Training (WET)

As explained earlier in this Plan Update, 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. However, to maximize the use of WET funding, we eliminated the position of WET manager. The savings have been used to continue offering an annual Crisis Intervention Training (CIT) and to create part-time employment opportunities for graduates of the WET Peer Specialist Training through a Peer Expert Pool.

Crisis Intervention Training (CIT)
(ongoing)

Crisis Intervention Training (CIT) is a program designed to assist law enforcement personnel and other first responders in effectively dealing with persons experiencing psychiatric crises. This training program prepares officers to recognize the signs and symptoms of severe mental illness, with or without the co-occurring condition of substance abuse, and provides them with the skill and knowledge to respond effectively. Safety of the officers, the person in crisis and the community are focused on as the main goal of CIT. ADMHS offers CIT to law enforcement professionals and first responders from all over the county on an annual basis.

Peer Training and Internships (completed)

On August 24, 2012 36 consumer and family peers graduated from the third Peer Support Specialist training funded by the MHSA Workforce Education and Training component. Eight graduates were selected to participate in six-month internships held at various ADMHS service sites throughout the County. The internships concluded in October 2013. A profile of some of the interns was featured on page four of the summer 2013 issue of the ADMHS newsletter, *Connections*, which may be accessed online:
http://www.countyofsb.org/uploadedFiles/admhs_new/resources/Newsletters/Connections%20Summer%202013.pdf

Peer Expert Pool (ongoing)

Following the completion of three annual 10-day Peer Support Specialist trainings and three rounds of six-month internships (2010 – 2012), the Peer Expert Pool was created to provide stipends for a variety of projects at ADMHS service sites for individuals who have successfully completed WET internships. Examples of projects include facilitating bilingual peer support groups, conducting telephone surveys of clients, and supporting peer activities. Seven past interns are currently engaged in the Peer Expert Pool.

Program Challenges

Although the WET Peer Specialist Training and Internship Program were extremely successful, funding was insufficient to create enough internships to serve many of the WET training graduates.

To maximize WET resources, in previous years WET-funded staff positions have transferred to other funding components. These changes allowed for a partial extension of the program beyond original estimates. After completion of the three-year internship and training program, some of the remaining

WET funds have been used to maintain a Peer Export Pool that offers part-time employment to some of the WET training graduates, consistent with plans to expand the role of peers within the system.

The Affordable Care Act also provided opportunities for WET training graduates and other peers. Approximately 10 peer staff members were trained as Certified Enrollment Counselors and have been assisting with ACA enrollment.

Supporting Materials

Attachment 1: Glossary

Attachment 2: Mental Health Commission Meeting Agenda for Public Hearing

Attachment 3: Evidence of Mental Health Commission Approval of the Plan Update

Attachment 4: Evidence of Santa Barbara County Board of Supervisors' Approval

Attachment 5: Stakeholder Comments from 30-Day Public Comment Period and Public Hearing

Attachment 6: Stakeholder Input Prior to the Formal Posting of the Plan Update

Attachment 7: Systems Change Steering Committee Members

Attachment 8: Systems Change Steering Committee Vision and Guiding Principles

Attachment 9: Selected Evidence-Based Practices

Attachment 1: Glossary

The definitions below are derived from numerous sources, including a variety of online dictionaries, Wikipedia and the Substance Abuse and Mental Health Services Administration (SAMHSA).

5150: Provision of the California Welfare and Institutions Code defining standards for involuntary inpatient treatment for individuals with mental illness. It is frequently used to refer to a 72-hour involuntary hold in an inpatient psychiatric facility.
Access: The extent to which an individual who needs services is able to receive them.
ACA: See Affordable Care Act
ACT: See Assertive Community Treatment
Action Team: a quality improvement team that includes representatives with varying perspectives who focus on a particular issue and recommend plans for change.
ADMHS: Santa Barbara County Department of Alcohol, Drug and Mental Health Services.
Affordable Care Act: The Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act or "Obamacare," a United States federal statute signed into law by President Barack Obama on March 23, 2010. Together with the Health Care and Education Reconciliation Act, it represents the most significant regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965.
Assertive Community Treatment: (Sometimes referred to as Program of Assertive Community Treatment (PACT). A team-based approach to the provision of treatment, rehabilitation, and support services. ACT/ PACT models of treatment are built around a self-contained multidisciplinary team that serves as the fixed point of responsibility for all patient care for a fixed group of clients. In this approach, normally used with clients with severe and persistent mental illness, the treatment team typically provides all services using a highly integrated approach to care. Hallmark features include 24/7/365 availability, a "whatever it takes" approach to problem-solving, a low client-staff ratio and services brought to clients where they reside.
Bridge to Care: An MHSA-funded program based in Lompoc that provides medication support for individuals with co-occurring mental health and substance use conditions.
CARES: Crisis and Recovery Emergency Services**,** ADMHS service sites in Santa Maria and Santa Barbara that provide access, intake, crisis response and mobile crisis teams.
CATCH (Child Assistance Team Creating Hope): An early childhood mental health program operated by the Santa Barbara County Education Office funded by MHSA Prevention and Early Intervention.
CBO: See Community-Based Organization
CBT: See Cognitive Behavioral Therapy
CCISC: See Comprehensive, Continuous, Integrated System of Care
CET: See Cognitive Enhancement Therapy
CFMAC: See Consumer and Family Member Advisory Committee
Change Agents: Individuals who represent consumers, families, county and contracted administrative and clinical programs and partner agencies. They work as a team to partner with leadership to advance changes in the county system of behavioral health care and recovery.
CHCCC: See Community Health Centers of the Central Coast
Child Assistance Team Creating Hope: See CATCH
CIT: See Crisis Intervention Training
Cognitive Behavioral Therapy: a type of psychotherapy in which negative patterns of thought about the self and the world are challenged to alter unwanted behavior patterns or treat mood disorders such as depression.
Cognitive Enhancement Therapy: a cognitive rehabilitation training program for adults with chronic or early-course schizophrenia or schizoaffective disorder who are stabilized and maintained on antipsychotic medication and not abusing substances.
Community-Based Organization: usually refers to nonprofit or for-profit provider of alcohol, drug and/or mental health services, but may also mean any local non-government organization in Santa Barbara County
Community Health Centers of the Central Coast: a nonprofit organization that operates community clinics and is contracted by ADMHS to provide prevention and early intervention services in Santa Maria and Lompoc.

Community Services and Supports: The first MHSA funding category that supports a number of ADMHS programs, such as ACT, New Heights, Partners in Hope, Justice Alliance and CARES Mobile Crisis.
Comprehensive, Continuous, Integrated System of Care: a vision-driven system "transformation" process for re-designing behavioral health and other related service delivery systems to be organized at every level. (Minkoff & Cline, 2004, 2005).
Consumer and Family Member Advisory Committee: a stakeholder group composed of consumers and family members who meet monthly to review ADMHS programs and services and make recommendations.
Contingency Management or Systematic use of Reinforcement is a type of treatment used in the mental health or substance abuse fields.
Co-Occurring Conditions: Two or more behavioral or medical health challenges existing simultaneously in an individual. It may involve two or more of the following problems: mental illness, physical illness, substance use disorders and developmental disabilities. In public mental health, co-occurring conditions often refers to individuals experiencing both mental illness and substance use disorders.
Criminogenic: Producing or tending to produce crime or criminals.
Crisis and Recovery Emergency Services: See CARES
Crisis Intervention Training: Established in Memphis in 1987, Crisis Intervention Training (CIT) programs educate and prepare law enforcement professionals who come into contact with people with severe mental illnesses. CIT helps in identifying the signs and symptoms of these illnesses and in responding effectively and appropriately to people who are experiencing a psychiatric crisis. Because law enforcement officers are often the first responders in these incidents, it is essential that they know how critical periods of mental illness alter behaviors and perceptions, assess what is needed in the moment and bring understanding and compassion to bear when handling difficult situations.
Crisis Respite/Residential Facility: a voluntary, short-stay residential facility for individuals experiencing significant behavioral health challenges but who do not require inpatient services.
Crisis Stabilization Unit: a program that provides very short-term treatment and observation in an effort to resolve a mental health crisis without involuntary hospitalization.
Crisis Triage Team: An ADMHS program that provides interventions for individuals experiencing mental health crises below the level of acuity that may lead to an involuntary hold.
CSS: See Community Services and Supports
CSU: See Crisis Stabilization Unit
Cultural Competence: The practice of continuous self-assessment and community awareness on the part of service providers to ensure a focus on the cultural, linguistic, socio-economic, educational and spiritual experiences of consumers and their families/ support systems relative to their care.
Dialectical Behavior Therapy: a cognitive-behavioral treatment approach with two key characteristics: a behavioral, problem-solving focus blended with acceptance-based strategies and an emphasis on dialectical processes.
DBT: See Dialectical Behavior Therapy
Early Childhood Mental Health: ADMHS programs that serve children 0-5 and their families. ECMH services include in-home support, health and development screening, parent education and skills training, infant parent psychotherapy, advocacy, resources and referrals, postpartum support groups and father outreach.
EBP: See Evidence-Based Practice
ECMH: See Early Childhood Mental Health
EMDR: See Eye Movement Desensitization and Reprocessing
Evidence-Based Practice: Services supported by research or suggested by other evidence.
Eye Movement Desensitization and Reprocessing: a one-on-one form of psychotherapy that is designed to reduce trauma-related stress, anxiety, and depression symptoms associated with posttraumatic stress disorder (PTSD) and to improve overall mental health functioning.
Family Behavior Therapy: an outpatient behavioral treatment aimed at reducing drug and alcohol use in adults and youth along with common co-occurring problem behaviors such as depression, family discord, school and work attendance and conduct problems in youth.
FBT: See Family Behavior Therapy
Forensic: Pertaining to the courts.
FSP: See Full Service Partnership

Full Service Partnership: One of three categories of MHSA Community Services and Supports funding. Full Service Partnerships allot funds to provide all necessary services and supports for designated populations. Counties are required to request the majority of their total CSS funding for Full Service Partnerships.
General System Development (GSD): one of three categories of funding within the MHSA Community Services and Supports (CSS) component.
GRRRL (Girls Resiliency Restoration and Reintegration aLliance): A new Innovation project proposed in the FY 2014-15 MHSA Plan to assist young women involved in or at-risk of becoming victims to sex trafficking.
GSD: General System Development
Health Care Reform: See Affordable Care Act
HOPE: An ADMHS program for children that provides an array of intensive in-home services available to foster home and extended family home placements. HOPE seeks to maintain the stability of children in their homes and placements and reduce multiple placements.
IMPACT: (Improving Mood--Promoting Access to Collaborative Treatment) is an intervention for adults who have a diagnosis of major depression or dysthymia, often in conjunction with another major health problem.
Innovation: A funding component of MHSA that supports time-limited demonstration projects that promote learning about new approaches to behavioral health service delivery.
JJIF: Juvenile Justice Involved Females
Justice Alliance: an MHSA-funded program that provides licensed mental health professionals who serve as court liaisons in Lompoc, Santa Maria and Santa Barbara to assist individuals with mental illness who are involved in the justice system.
Juvenile Justice Mental Health: An ADMHS unit that serves youth in the Santa Barbara County Juvenile Probation institutions, including juvenile hall, the Los Prietos Boys Camp, and the Los Prietos Academy. JJMHS staff members also conduct evaluations for the juvenile court and provide outpatient psychotherapy for Probation youth.
LAC: See Latino Advisory Committee
Latino Advisory Committee: A group composed of ADMHS staff, other provider staff and community representatives that provides advice to ADMHS on issues of cultural competence, diversity and multicultural practices.
Medical Model: the term coined by psychiatrist R. D. Laing in his *The Politics of the Family and Other Essays* (1971), for the "set of procedures in which all doctors are trained." This set includes complaint, history, physical examination, ancillary tests if needed, diagnosis, treatment, and prognosis with and without treatment.
Medical Necessity: Health care services and supplies deemed by health care entities to be appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care.
Mental Health Commission: an oversight body for county behavioral health systems established by the California Welfare and Institutions Code. In Santa Barbara County, the 11-member Commission's responsibilities include reviewing and evaluating the community's mental health needs, services, facilities and problems; reviewing the County Short-Doyle Plan; advising the Board of Supervisors and Mental Health Director on any aspect of local mental health programs; and submitting an annual report to the Board of Supervisors.
Mental Health Services Act: A ballot initiative passed by California voters in November 2004. Also known as Prop 63, MHSA places a one percent tax on California incomes over $1 million to fund innovative mental health programs and services.
Mental Health Services Oversight and Accountability Commission (MHSOAC): A state commission that oversees the Adults and Older Adults Systems of Care Act; Human Resources; Innovative Programs; Prevention and Early Intervention Programs; and the Children's Mental Health Services Act. The Commission replaced the advisory committee that had been established pursuant to Welfare and Institutions Code Section 5814. Enhancement Therapy
MHSA: See M
MET: See Motivational Enhancement Therapy
MHSOAC: See Mental Health Services Oversight and Accountability Commission
MI: See Motivational Interviewing

Moral Reconation Therapy: a systematic treatment strategy that seeks to decrease recidivism among juvenile and adult criminal offenders by increasing moral reasoning.
Motivational Enhancement Therapy: an adaptation of motivational interviewing (MI) that includes normative assessment feedback to clients presented and discussed in a non-confrontational manner.
Motivational Interviewing: a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence.
MRT: See Moral Reconation Therapy
New Heights: An MHSA-funded program serving transition-age youth county-wide.
Partner Agency: A county or city government agency that works with ADMHS.
Partners in Hope: An ADMHS MHSA-funded program that supports three peer recovery specialists, three family advocates and Recovery Learning Communities in Santa Barbara, Lompoc and Santa Maria.
Peer: an individual with lived experiences with mental health challenges or a member of a family that includes a person with lived mental health experiences.
Peer Recovery Specialist: A consumer or family member employed by ADMHS to conduct peer support, advocacy and outreach.
Peer Support: 1) a category of approved Medicaid reimbursable services 2) a generic reference to any service that is provided by a consumer or family member to assist another consumer or family member.
PEI: See Prevention and Early Intervention
PHF: See Psychiatric Health Facility
Prevention and Early Intervention: An MHSA funding component that supports a variety of Santa Barbara County programs, such as integration of primary and mental health care, early childhood mental health services, community health educators, CARES crisis services and mobile crisis services for children.
Promotora: A community health educator who typically reflects the ethnic and cultural background of the people he or she serves.
Psychiatric Health Facility: A 16-bed inpatient unit operated by ADMHS that accepts individuals on involuntary holds.
RLC: see Recovery Learning Community
Recovery: A process of change through which individuals improve their health and wellness, live a self-directed life and strive to reach their full potential.
Recovery Center: The new name for ADMHS adult clinics guided by MHSA principles and using specialized teams to address client needs in an environment that values a welcoming, strengths-based, client-centered and recovery-oriented approach.
Recovery Learning Community: Centers in Lompoc, Santa Maria and Santa Barbara that provide consumer-oriented classes, support groups, employment opportunities and social activities.
Recovery Model: an approach to behavioral health disorders that emphasizes and supports a person's potential for recovery. Recovery is seen as a personal journey rather than a set outcome, and one that may involve developing hope, a secure base and sense of self, supportive relationships, empowerment, social inclusion, coping skills, and meaning.
Resiliency Center: The new name for reorganized ADMHS children's clinics guided by MHSA principles using specialized teams to address client and family needs in an environment that values a welcoming, strengths-based, client-centered and resiliency-oriented approach.
Safe Alternatives for Treating Youth: See SAFTY.
SAFTY: The Santa Barbara County children's mobile crisis program operated by Casa Pacifica.
S.B. 82: California Senate Bill 82, the Investment in Mental Health Wellness Act of 2013, which authorizes behavioral health grants to counties. ADMHS received grants totaling approximately $11 million to provide new crisis triage teams in Santa Maria, Santa Barbara and Lompoc, a Mobile Crisis West team based in Lompoc, a new Crisis Stabilization Unit in Santa Barbara and a Crisis Respite facility in Santa Barbara.
Seeking Safety: a present-focused treatment for clients with a history of trauma and substance abuse. The treatment was designed for flexible use: group or individual format, male and female clients, and a variety of settings (e.g., outpatient, inpatient, residential).
Short/Doyle Medi-Cal or SD/MC: Federal Medicaid funding in California used for the "public" mental health treatment services. This source of funding has typically been "capped", with 51% of the costs reimbursed from

the Feds (referred to as Federal Financial Participation or FFP) with a mandated 49% match from state allocations to county mental health.
SOAR: See SSI/SSDI Outreach, Access and Recovery
SPIRIT: The ADMHS MHSA wraparound, full service partnership program for children in Santa Barbara County.
SSI/SSDI Outreach, Access and Recovery: a national project funded by the Substance Abuse and Mental Health Services Administration designed to increase access to SSI/SSDI for eligible adults who are homeless or at risk of homelessness and who have a mental illness and/or a co-occurring substance use disorder.
START (Support, Treatment, Advocacy and Referral Team)**:** a school-based program serving Carpinteria children funded by MHSA Prevention and Early Intervention.
Stakeholder: a) a person or group of people who impacts or is impacted by behavioral health services; (b) a person who represents others' interests in regard to behavioral health services.
Steering Committee: Established by the Santa Barbara County Executive Office in 2013, a body composed ADMHS executives, line staff, and a diverse group of community stakeholders. The steering committee determines guiding principles and charters/oversees the work of action teams focusing on specialized areas, such as children's services, peer issues, cultural competence, crisis services, forensics and housing.
Support, Treatment, Advocacy and Referral Team: See START.
Systems Change: An initiative launched in 2013 by the Santa Barbara County Executive Office in concert with ADMHS and community stakeholders to address a wide range of problems with the operations of the county behavioral health care system. The goal of systems change is to organize the mental health and substance use disorder systems across Santa Barbara County around the needs and hopes of the individuals and families with behavioral health issues and other complex needs who seek help.
TARGET: Trauma Affect Regulation: Guide for Education and Therapy is a strengths-based approach to education and therapy for survivors of physical, sexual, psychological, and emotional trauma. TARGET teaches a set of seven skills (summarized by the acronym FREEDOM--Focus, Recognize triggers, Emotion self-check, Evaluate thoughts, Define goals, Options, and Make a contribution) that can be used by trauma survivors to regulate extreme emotion states, manage intrusive trauma memories, promote self-efficacy and achieve lasting recovery from trauma.
TAY: See Transition-Age Youth
TIP: See Transition to Independence Process
Threshold Language: A term used by the state of California to denote a language spoken by 3,000 beneficiaries or 5% of the Medi-Cal population, whichever is lower, whose primary language is not English.
Transition-Age Youth: Individuals between the ages of 16 and 25 who have serious emotional disorders/severe mental illness. They may be at risk for homelessness or involuntary hospitalization and/or aging out of children's mental health, child welfare and/or juvenile justice system.
Transition to Independence Process (TIP): An evidence-based approach that stresses the importance of providing access to community-based outreach and support, engages transition-age youth in shaping their own future planning process, and uses a focus on each individual's strengths, engages transition-age youth in shaping their own future planning process, and uses a focus on each individual's strengths.
Trauma: results from an event, series of events or set of circumstances that are experienced as physically or emotionally harmful or threatening and make a lasting adverse impact on functioning and physical, social emotional or spiritual well-being.
Trauma Affect Regulation: Guide for Education and Therapy: See TARGET.
Trauma-Sensitive Care: Treatment that appreciates the high prevalence of traumatic experiences in persons who receive mental health services. Trauma-sensitive care incorporates a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on the individual and addresses these effects, is Care that addresses these effects, is collaborative, supportive and skill based.
TriWest (TriWest Group): The consulting firm hired by the County Executive Office to analyze ADMHS outpatient programs and services. TriWest issued a comprehensive report in May 2013 that may be found on the ADMHS web site, www.admhs.org.
Welcoming: The initial and ongoing activities that encourage feelings of belonging and result in a willingness to engage.

Wellness and Recovery: A specialized adult outpatient team.
Wellness and Resiliency: A specialized children's outpatient team.
WET: See: Workforce Education and Training
Workforce Education and Training: a time-limited MHSA funding component that has supported ADMHS peer specialist trainings and Crisis Intervention Training for law enforcement and first responders.
Wraparound: A family centered, community-oriented, strengths-based, highly individualized planning process aimed at helping people achieve important outcomes by meeting their unmet needs both within and outside of formal human services systems while they remain in their neighborhoods and homes, whenever possible.
WR: May refer to either Wellness and Resiliency, a specialized outpatient team serving children or Wellness and Recovery, a specialized outpatient team serving adults.

County of Santa Barbara
MENTAL HEALTH COMMISSION
300 North San Antonio Road, Bldg. 3, Santa Barbara, CA 93110
TEL: (805) 681-5232 FAX: (805) 681-5262

Attachment 2

Mental Health Commission
Agenda

The Santa Barbara County Mental Health Commission will meet from 1:00 p.m. to 4:30 p.m. on Friday, January 16, 2015 at the Santa Maria Clinic, 500 West Foster Road, Santa Maria; CA. Video Conferencing will be available to the public in large conference room of the Santa Barbara Children's facility, 429 North San Antonio Road, Santa Barbara. Teleconference available 805-681-5400 Code: 737876.

I. Welcome and Introductions – 5 minutes

II. Establish Quorum – 2 minutes

III. Approve Meeting Minutes for December 19, 2014 – 3 minutes

IV. Announcements by Chairperson – 3 minutes

V. Public Comment – 20 minutes (Up to 5 minute time limit per topic. Submit Request to Speak to chairperson prior to start of meeting)

VI. Presentations

- Mental Health Services Act Plan Approval – Refugio Rodriguez & Micahel Craft – 60 minutes
- Santa Maria Regional Manager Update – Deana Huddleston - 20 minutes
  - Challenges
  - Achievements
  - Information being used to manage the organization
  - Significant aspects of systems change that have occurred – (clinic transformation).
  - Learning
- Systems Change Update – Michael Craft – 20 minutes

Break - 5 minutes

VII. Directors Report – Michael Craft for Alice Gleghorn, PhD– 20 minutes

VIII. Commission Business
A. Correspondence – none
B. Action item: approve letter to be written and sent to Board of Supervisors regarding Human Resources lengthy recruitment process
C. Committee/Liaison Reports – 10 minutes
   a. Advisory Board on Drug and Alcohol
   b. Latino Advisory Committee
   c. Consumer and Family Advisory Committee
D. Other
E. Adjournment

County of Santa Barbara
Mental Health Commission
300 North San Antonio Road, Bldg. 3, Santa Barbara, CA 93110
Meeting Minutes
January 16, 2015 -1:00 p.m. to 4:30 p.m.
Santa Maria, CA

Commission Members Present: James Rohde, 3rd District; **Jan Winter**, 1st District; **Thomas Urbanske**, 4th District; **Ann Eldridge,** 5th District, Alternate; **Carolyn Wood**, 1st District, Alternate; **Julie Solomon**, 3rd District, Alternate; **Lorraine Neenan**, 3rd District; **Charles Huffines**, 5th District.

Commission Members Absent: Lisa Morinini, 4th District, Alternate; **Sandra Brown**, 4th District; **Ken Bonner**, 5th District; **Michelle Brenner**, 2nd District, Alternate; **Michael Gorodezky**, 2nd District, Chair; **Alice Villarreal - Redit**, 2nd District, Vice Chair; **Manny Casas**, P.H.D., 1st District.

ADMHS Staff: Alice Gleghorn, PhD, Director (by phone); **Michael Camacho - Craft,** Assistant Director of Clinical Operations; **Deana Huddleston** Santa Maria Regional Manager; **Karen Campos**, Office Professional Senior; **Refugio Rodriguez,** Division Chief.

I. Welcome and Introductions: Ex- Officio Chair , James Rohde called the meeting to order at 1:06 PM, followed by self-introductions.

II. Establish Quorum: Yes.

III. Approve Meeting Minutes for December 19, 2014: Motion was made by Commissioner Jan Winter to approve the December meeting minutes as presented. Commissioner Lorraine Neenan seconded. Motion carried.

IV. Announcements by Chairperson: None.

V. Public Comment:

Victim – Witness Assistance Program Director, Megan Rheinschil who facilitates the Human Trafficking Task Form shared her support for the Girls program. She expressed that ADMHS has been an enormous partner and educating the community and working collaboratively is a top priority.

Lisa Conn also shared her support for the Girls program, her and her staff has been working to address mental health issues involved with these cases and have been working closely with Juvenile Hall . She shared the importance for the task force to develop protocols to partner with ADMHS. Currently doing needs assessment with Santa Barbara Scholarship Foundation.

Presentations:

Mental Health Services Act Plan Approval

Division Chief of Mental Health Services Act (MHSA), Refugio Rodriguez shared with the Commission that although this has been a lengthy process, this has been the first year that numerous stakeholders have been able to review the plan and provide their input.

The Commission was given the opportunity to ask any additional questions regarding the plan and give input before the plan was to be voted on.

Questions presented by the Commission members:

1. Is it a 3 year commitment?

   Mr. Rodriguez: "Although we are submitting for three years, we have to update every year. It's not a full 3 year commitment".

2. Can the vote be done in February when the Commission Chair and Vice Chair are present?

   Mr. Rodriguez: "It's ultimately the Commission's decision". Mr. Craft, Director of Clinical Operations and Dr. Gleghorn, ADMHS Director shared that they rather not further delay the approval process.

3. Commissioner Ann Eldridge shared concern with the Girls Innovations program, "we have not had the chance to have a dialog with the Director about this plan". Commissioner Eldridge is looking for actual numbers involving this population who reportedly needs mental health services. Lisa Conn with Juvenile Justice Mental Health shared that about two years ago, they began to see cases where girls were reporting rape and then it would turn out that they were being trafficked by people who would take advantage of their runaway situation and were lured in as a survival mechanism. Ms. Conn reported that they are currently working with 38 girls (half of them are verified trafficking cases, the other half are suspected victims). The City of Lompoc currently has 22 girls proven to be trafficked. Most of these girls are treated as criminals for the simple fact that there are no services available to them, it has been noticed that they are being put on detention for longer sentences just for not having enough services for these girls. Commissioner Eldridge requested numbers representing what is being shared today.

4. What's the immigration status of these girls?

   Ms. Conn : "No, rarely. The majority of the girls we see are Latinas and African American. The Girls program is designed to do early intervention". Commissioner Eldridge shared concern that there is still not enough evidence to prove that this is primarily a mental health issue.

   Dr. Gleghorn shared that she has experience with this type of activity involving vulnerable individuals with extreme levels of trauma – mental health needs for this populations are great and she commends those who are taking this project on. Dr. Gleghorn is in full support of this component of the MHSA plan.

   Commissioner Winter feels that the lead should be taken by the Department of Social Services and Child Protective Services as opposed to ADMHS. "We have severely mentally ill homeless who are in need of our services. These funds will serve less than 100 people in our County. Three million dollars over three years? That's a lot of money for less than 100 people".

   Ms. Conn: "we have many people that are at risk who these funds can also go to".

   Mr. Rodriguez added that the Department would not put forth a program if this was not a population that was in need of our services. These young women have multiple diagnoses. It's disproportionally woman of color which is a priority/target population defined by the MHSA guidelines. There is no treatment for this population who primarily has mental health issues. We have partnered with agencies and have doubled homeless and justice alliance staff.

   Commissioner Eldridge expressed concerned that the information presented today is not reflected in the plan.

   Mr. Rodriguez : "true, however it will be recorded in the minutes of this meeting".

Commissioner Julie Solomon commented "this looks like an intervention model, how will this program function?"

Ms. Conn shared the case of a girl who they found on craigslist and was brought to Juvenile Hall when she was twelve years old as she had been raped that day by nine men. She was a chronic runaway who was born addicted to spice and methamphetamine. She was treated, got better and was followed by their team while she got used to new relationship – but that was not enough – she ended up coming back. The new funding would bolster what we have already been doing but with increased staff. There would be a relationship already established when released – MHSA funding would facilitate this.

The new model would be a team, they would be assigned a main clinician with a managing team to assist.

Commissioner Solomon: "Will there be the notion that these girls have a primary person supporting them?

Ms. Conn: The funding will allow having a specialized team, including 2 ½ case workers or practitioners and a ½ time psychiatrist and a nurse.

5. 25 % vacancy is the existing rate – based upon salary model approved by the board. Working with HR folks as to where we are with vacancies.

6. Are innovative funding amounts designated to each county or state wide?

   Mr. Rodriguez: "It's assigned to each County. There's an annual allocation for this particular County".

Mr. Craft shared that this plan reflects a conceptual description of where the Department is headed, we are in the implementation process. There have been no substantial changes made to the clinics. The idea is to have specialized levels of care and a team based approach.

Commissioner Eldridge made a motion to postpone the approval of this plan until the Chair, Vice Chair and Department Director were present. Commissioner Winter seconded. Commissioner Rohde objected. Commissioner Neenan agrees with Commissioner Rohde and sees this as a blueprint. Commissioner Huffines commented that many questions have been answered at this meeting and agrees with Ann that the Chair and Vice Chair should be here but supports the girls program, however he is ready to move forward with the voting of this plan.

Mr. Craft shared the consequences of postponing the approval of the plan which include; delay in presenting to the Board of Supervisors which may mean that the funds would no longer be available, not able to focus on 15-16 plan and a delay in implementing the girls program.

Dr. Gleghorn believes that it's important to move forward with the approval of this plan; her physical presence is not necessary for the Commission to vote.

Commissioner Eldridge withdraws her motion to postpone the vote for the MHSA Plan.

Commissioner Solomon made a motion to approve the MHSA Plan as presented with the addition of question and answers discussed today in the comment section of the plan. Commissioner Huffines seconded. Commissioners Eldridge and Winter opposed. MHSA Plan approved by majority vote.

Mr. Craft – thanked the Commission and shared that he appreciates the comments and assured them that the questions and concerns presented today would be added to the supplemental comments section. The Commission requested to see the medical billing portion of the Girls program.

Attachment 4:

Evidence of Approval by the
Santa Barbara County Board of Supervisors

Attachment 5:
Public Comments on the FY 2014 15 Plan Update
During the Public Comment Period

The FY 2014 15 MHSA Plan Update was emailed to stakeholders and posted to the ADMHS web site on December 9, 2014. A public hearing on the Plan Update was conducted by the Santa Barbara County Mental Health Commission in Buellton California on January 6, 2015. The following comments were made between December 26, 2014 and January 6, 2015:

December 26:
Charletha Anderson: Hats off to Cuco Rodriguez, Dr. Wada, members of the Cultural Competency Team and others that have been working diligently to affect the changes suggested to make the system work for individuals and not just to continue to go along with what was the status quo. I feel that the plan that has been put forth for 2014 2015 and the upcoming year 2015 2016 should be implemented without further delay. I understand the need to want evidence based practices, but let us be real, what has been done in the past has not worked (except for a privileged few) therefore we need to try something new and document the results and re evaluate as we go along, eliminating what does not work and adding to what is proven effective. One change I would like to make is that monies be distributed to culturally diverse groups to assist with educating the public regarding the system change.

January 6:
(Anonymous): Changes are not meaningful until the vacant positions of essential front line staff are filled. Changes in the way certain practitioners practice should not be made without consulting that category of practitioners. The children's group needs to set meeting times with plenty of notice and have nursing and child psychiatry representation.

January 6:
Suzanne Riordan, Executive Director, Families ACT!: The attention to needs which have been severely neglected as reflected in the proposals for "Specialized Co Occurring Teams," the "Forensic Full Service Partnership" and "Homeless Services" is laudable.

In reality, however, all the best intentions for providing appropriate linkages and a seamless continuum of care are limited by the critical lack of licensed intensive transitional residential treatment beds and supported permanent housing units.

Many of the "forensic" clients who have served time in the Santa Barbara County Jail ended up incarcerated by default, due to the lack of adequate residential treatment options and many due to the lack of affordable supported housing options.

All the "housing support and assistance" in the world is meaningless without actual housing options.

Families ACT! has helped to evolve Next Steps a uniquely cost effective model for cost effective residential treatment and supported housing with on site employment opportunities—which could put some teeth in the plans to address the needs of forensic, homeless and co occurring sub populations, [among others] in Santa Barbara County.

How can MHSA funding be used to help bring this model into actuality?

A “welcoming, strengths based, client centered and recovery oriented approach” is but empty rhetoric if the basic building blocks are missing in a system of care.

January 6:
Lynne Gibbs, NAMI and Families Act member and Peer: One of the major recommendations in the 2013 TriWest report (p. 55) states: "Transitions between treatment programs are a major area of challenge both within ADMHS and between ADMHS and other contract and hospital providers."

Yet, the MHSA plan includes the restructuring of the treatment landscape into a large number of boutique programs, based upon identifying clients with particular problems, such as substance abuse, homelessness and personality disorders. I combed the plan looking for a rationale or model for this new structure, but I could find neither.

The report says such “specialized outpatient teams … are not intended to increase fragmentation,” and will “increase seamless delivery for clients and families,” but I could find no explanation of how increased fragmentation of an already fragmented system will be avoided as new independently operating teams are added. How will the creation of additional treatment silos promote seamlessness and coherence in a system already struggling with the major problem of fragmentation? “Specialized Co Occurring outpatient teams will serve clients requiring a focus on co occurring mental health and substance use challenges.”

But, according to ADMHS, a majority of clients have co occurring issues! What about those who are also homeless and justice involved? This scheme assumes a static client identity and places clients in silos based on negative appellations contrary to the MHSA philosophy of strengths based approach. Why create a specialized team for a small number with this issue? Wouldn’t it be better that more clients with co occurring issues receive attention from staff trained and specialized in this area?

Regarding homelessness, the report say a new Homeless Program “will provide housing support and assistance, employment and education support, rehabilitation services and other necessary supports for families and individuals.” A selected group of ADMHS clients will be served by this new team. But, the plan notes other special teams and programs also addressing homelessness for their specific clients: New Heights, Partners in Hope, ACT, PEI Early Detection and Intervention Teams for Children, TAY, in addition to clients presently served by the Calle Real clinics, and others achieving insurance coverage for the first under the Affordable Care Act.

Within this structure, each of these teams is expected to work with the same group of housing providers seeking housing for their specific clients, while dealing with all of the clients’ various needs including housing. Might it not confuse housing providers to have random contact with various ADMHS team leaders seeking housing for their designated clients? Why not appoint an ADMHS Housing Coordinator (and staff?) with specialized knowledge of local housing options and housing issues, to serve as liaison with ADMHS staff, as well as non profits and CBOs? Wouldn’t this be more effective in operation, and more cost effective, and wouldn’t it ensure better integration within ADMHS and with the community at large?

How do clients leave the Homeless team when they have housing? How do clients leave the Co occurring team when the stop using non prescribed substances? This requires that a good deal of time

and energy be assigned to oversight, regular reviews, and transition of clients from one team to another. Is this time ADMHS staff have to spare from serving clients? ADMHS has stated its goal is to ensure clients' stability by having them stay with the same team of providers. Does this mean they will stay with a team labeled with a problem they no longer have?

All in all, it seems a re organization creating a structure predicated on client issues is counter intuitive and in opposition to MHSA philosophy. At least, the substantial time and effort needed to effect such a change justifies a rationalization for it. One might not agree with it, but one would have it. But nowhere is this presented; nor is there any explanation as to how this change will improve operations and outcomes. I don't think it will.

January 6

MHSA FY 2014 15 Plan Update Public Hearing Meeting Notes

- Community based providers would like a clear explanation of how they can apply for MHSA funds for new or expanded services. This process is not clear.
- Family advocates Jan Winter and Ann Eldridge felt that MHSA should serve the most needy individuals in the community.
- Ann Eldridge stated that the Mental Health Commission would like a role in decision making about program design before each MHSA Plan Update is written.
- Mike Goredezky stated that the MHSA decision making process is not clear. For example, how do some stakeholder preferences for new programs or services get selected over others? What is the process for considering new proposals?
- Ann Eldridge expressed concern that ADMHS does not have adequate staffing for the new outpatient specialty teams.
- Mike Goredezky pointed out that some plan elements have been executed prior to the plan's approval, but it is not clear which programs have been implemented.
- Several stakeholders were concerned with the notion that the FY 15 16 MHSA Plan Update would be a "status quo" plan with no significant changes from the 14 15 Plan. They felt more flexibility is needed in making necessary corrections to the FY 15 16 Plan Update.
- Mike Goredezky suggested that in the future, a public, user friendly document accompany the Plan Updates that are submitted to the State. Selena Rockwell suggested that this document be organized around criteria including challenges, service gaps and solutions.
- Ann Eldridge asked if demographics are being considered in long term planning for MHSA programs.
- Mike Goredezky stated that consistent data be included for each program in future plan updates.

January 16 (Public Hearing)

- Considerable debate centered on the proposed GRRRL Innovation project, principally from Commissioner Eldridge. She felt that the Probation Department should take the programmatic and financial lead with support from ADMHS. She also questioned whether it was an appropriate project for learning and felt the program design lacked necessary details, including a description of the target population and justification for projections of the number of clients to be served. She felt that staff clarifications made during the Public Hearing provided details that should have been included in the program description.
- Most of the Commissioners in attendance were in support of the GRRRL Innovation project.

- A representative of the District Attorney's Office praised the strong cooperation it has received from ADMHS.
- A representative of a community provider would like ADMHS to clarify the process by which community providers may make proposals for new MHSA funded programs
- Commissioners Eldridge and Winter expressed concern that the GRRRL project would divert money desperately needed to serve existing clients, including homeless individuals, who are not being adequately served. The concern was also expressed that the GRRRL project might divert staff needed in other programs.
- Commissioners Eldridge and Winter were also concerned that the Plan Update overpromises services that may be very hard to deliver, especially in light of the fact that the Department currently has a 25% rate of vacant staff positions, and recruitment has been unacceptably slow.
- Several Commissioners felt that the stakeholder process for the MHSA 14 15 Plan Update adequately informed them about the Plan contents and direction that the Department is taking in restructuring outpatient services.
- Commissioner Eldridge inquired about the flexibility of the plan approval process. For example, could part of the plan be approved and approval of other parts of the proposed plan be delayed or rescinded?
- Commissioners Eldridge and Winter felt there is a lack of clarity about client flow in the new outpatient system that features specialty teams. How would continuity of care be ensured?

Attachment 6

MHSA Plan Update FY 2014-2015

Summary of Stakeholder Feedback

(*Prior* to the Formal Posting of the 30-Day Public Comment Period)

	Benefits	Service Needs	Un-served/Under-served Populations
Breakout Group #1 12 5 13	• Will help people of all ages with complex needs and their families • Will produce better outcomes • Increased collaboration among multiple agencies and providers • Improved services for persons with co occurring disorders • Clear information on access points is available to the community • Service Providers accept family members, significant others as partners • Partners are present in all steps of treatment • Community partners and resources are strengthened • Improved system of care flow • Strengthening of neighborhood based natural supports increases empowerment. • Reduction of acuity and trauma • Improved information sharing reduces crises • Providers are all on the same page with consistent use of evidence based practices system wide • Outcomes based • Accountable • Helps staff organize/prioritize • Assist staff with standards of care and ability to individualize treatment • Staff is allocated to focus areas similar to action teams • More staff resources for system development	• Incorporate public/health, medical needs into services. • Family oriented services for children • Therapeutic Response Aid Services for Children & TAY • Outreach workers to help entry and engagement • Peer workers, family members, including bicultural/bilingual in volunteer and staff capacities for outreach • TAY mentors • Peer run respite programs in various settings (board and care, group homes, supportive housing) • Peer driven recovery services • Supported and professional employment • Strengthen DOR relationship for employment support and job skills development • Transition homes for persons with AOD involvement • Crisis residential facilities • Crisis beds for children; more crisis beds for adults • Central resource centers and information provided on service locations • 23 hour crisis stabilization unit • Transportation service coverage for families and for clients leaving hospitals, PHF and jail • Improve re entry of clients to the community • Improve after care services • Peers assist clients in transition such as from PHF to clinics with transportation, etc. • Innovative/create prevention and intervention services for TAY	• Returning veterans • Older Adults • Uninsured children • Children without full scope Medi Cal • Homeless without an address and benefits; people of all ages who live on the streets • Dually diagnosed children (mental illness plus developmental disability or AOD) • Latinos, immigrants • People in poverty • People with SMI • Persons who need supportive housing without benefits

	• Expand funding sources to build capacity • Replicate services that work in all county locations • Reduced clinic caseloads • Reduced wait time to see a doctor • Reduced TAY crime • Improved client information sharing among authorized providers • Culture values thinking "outside the box." • Families are educated in how to exert positive influence • Improved follow up and linkage to resources; PHF, jail and hospitals help clients obtain services after discharge • Increased service retention • Focus on welcoming and relationships • Better relationships with partners • Increased communications	• Integration of traditional and nontraditional services	
	Benefits	**Service Needs**	**Un-served/Under-served Populations**
Breakout Group #2 12 5 13	• Clinicians are well prepared as generalists and know how to work with all populations • Community provider meetings inform everyone what each organization does • Services are sustained • Multiple points of access to care • Welcoming/no wrong door • People receive integrated care and are viewed holistically • AOD and mental health services are integrated • Levels of care are integrated so that no one component is overwhelmed •	• 23 hour crisis stabilization unit • More education on the whole system so ADMHS and CBO staff may better serve clients • Use media to educate community about services • Comprehensive co occurring education for all staff • Transitions teams assist clients while in inpatient settings to assist with transition to community; continued transition services after discharge • Community outreach to educate college age and younger about mental health • Specialized treatment teams that focus on specific mental health conditions • Integration of mental health and primary care • Integration of AOD and primary care • SBIRT (Screening Brief Intervention, Referral and Treatment) at public health clinics • Open RLCs to all in need	• Individuals with AOD issues • People who are not SPMI • People not in the "system," such as persons who do not want help or know they need services • Persons with co occurring conditions • Undocumented individuals • Homeless people • Youth and TAY • LGBT

		• Outreach staff who visit drop in centers • Integration of AOD and mental health services • Improved treatment protocols appropriate to specific diagnoses and populations • Change community perceptions and reputation regarding care • Peer run respite • Identify junior high and high school students with suicidality and mental health issues	
	Benefits	**Service Needs**	**Un-served/Under-served Populations**
Breakout Group #3	• Easy and timely care • Services are holistic, integrated • Individuals understand how to access services • More people are served • Greater quality of care improves the community • AOD and mental health services are integrated and providers have improved communication • Client and family stress is reduced • All services are available at a single site • Policies and procedures are simplified and consistent • Treatment is based on clinical need • The system is welcoming and solutions oriented • Information about how to access services is clear • Silos are reduced; collaboration is increased • A greater emphasis is placed on wellness and recovery • Parity between regions of the county will be achieved • Services will be improved for persons involved in the justice system • Incarcerations of individuals with mental health conditions should decline • Investment of funds into	• Greater collaboration with justice system to provide better care • More support groups • More peer jobs and internships • More transportation for clients • Improved information sharing regarding client care • More services, including counseling, in Spanish; parity between English and Spanish services • More bilingual/bicultural service providers • Decreased caseloads • More skill building groups • Psychiatrists are on call for staff • Psychiatrists write 5150s when needed • Expand hours of service • Staff should not turn anyone away who is talking about suicide or self harm • Clients receive help for medical conditions and wellness coaching • Health screening and peer support services • Clients are able to see a psychiatrist or a nurse one time per week if needed • More services for older adults • More residential beds • More crisis beds • Peer Respite • Increased vocational support • Greater outreach and education, including for people who would feel stigma in going to a clinic • Education targeted to Latino community • More respect for other cultures, not	• Persons involved with criminal justice system • Transition Age Youth • School age youth • Undocumented individuals • Homeless individuals, including homeless TAY and recent homeless • Older Adults • Veterans • Home bound individuals, including adults living with parents and uninsured • Families • LGBT • HIV Positive • Latinos and other Groups • TAY in foster care • TAY released from probation • Persons in transition from adolescence to adulthood • People who do not qualify for HUD assistance • Persons at risk for homelessness • Persons who live in high density situations • Persons in jail • People who need transition services • Individuals with eating disorders • Individuals with personality disorders • Individuals with a dual diagnosis

	mental health will be seen as more cost effective	just Latino • More assistance for higher functioning individuals • Strengthened continuum of care • Peers conduct follow up services for clients missing appointments • Improve quality control for services • Hire more promotores, peer recovery specialists, family advocates • Ensure that clients re entering the system does not have to start over • Improve/expand services at all levels, maintenance, wraparound, transitional • Strengthen use of Friendship Line • Conduct consistent telephone follow up • Create a welcoming environment with multiple points of access; do not require that individuals be in crisis to receive services • Staff trainings should be mandated relevant to all populations served • Put a complaint button on the web site and include suggestions and compliments • End preferential treatment of Santa Maria ACT clients in regard to CARES Crisis Residential admittance. • Increase accountability and transparency • Peers should help clients complete evaluations of programs and services. • Navigators assist clients in obtaining services • Regular community forums should monitor systems change • Staff meeting notes should be posted on the web site • Mental Health Commission should increase reporting from staff and CBOs, monitor progress, and solicit and respond to suggestions; line staff should also attend Commission meetings • Police need to be trained in mental health • Reduce wait time to see a psychiatrist • Provide same day care; do not require that individuals be suicidal to receive treatment • MHSA guidelines should apply throughout whole system, including	• Geographically isolated persons • People who miss appointments

		CBOs. • CBOS should be able to serve un served and under served clients. • A mental health intervention should be available to clients in crisis that does not include law enforcement. • When law enforcement is sent to mental health crises, personnel should be non uniformed. • AOD individuals should not be turned away from CARES; AOD serves should be integrated with mental health. • ADMHS should respond to people in crisis who do not meet 5150 criteria. • Better communication of concrete outcomes for clients should be reported; information should be easy to understand. Use email to communicate this information. • Increase participation in meetings through call in capability. • Simplify language used to communicate information about systems change and MHSA. • Make meetings accessible; mid county sites are difficult for many.	
	Benefits	**Service Needs**	**Un-served/Under-served Populations**
Peer Action Team		• Look at the whole individual instead of trying to fit individuals into diagnostic boxes • Support peer run respite centers • The department should make an explicit commitment to peer support in the MHSA Plan Update • More peers should participate in all ADMHS programs • ADMHS staff should be accountable and regularly provide outcomes for various populations • Peers should make in home visits to clients to avoid hospitalization • A crisis residential unit is needed in Santa Barbara that offers after care to persons discharged from hospitals • Peers should be part of mobile crisis teams • ADMHS should create at least one additional peer administrative position	

	Benefits	Service Needs	Un-served/Under-served Populations
Cultural Competence Action Team	• MHSA principles would be applied system wide • Greater support for persons with co occurring conditions • People would be welcomed regardless of ability to pay; there is "no wrong door" • A more holistic approach • A "warm handoff" would guide people to appropriate services • All staff would be guided by the principle "do the right thing" • Lines staff engage in welcoming and relationship building, but the people at the top need to show support to encourage staff • Peers should be integrated into staff to demonstrate commitment to recovery model • Build a culture of compassion demonstrated by hugs or eye contact that demonstrate staff members are honest and caring and treat others with respect and listen to clients • Opportunities are created for open communications that incorporate many perspectives and individuals are not defined by their disabilities. • All employee evaluations should include welcoming	• Offer trainings that cover welcoming, respect for clients, de escalation, a client focus. • Develop a culture that embodies respect, honor, and understanding leading to a new attitude system wide that is embraced by staff at all levels. • A focus on solutions and recovery should be adopted by all staff • Adopt a continuous quality improvement approach • All staff, should maintain high ethical standards and accountability • All staff should receive training relevant to the new welcoming and compassionate culture and be accountable • Encourage all staff to adhere to guiding principles and support each other • Front desk personnel should be welcoming • Maintain communications with clients to track their well being and needs. • Be creative; reduce the impact of Medi Cal on decision making • Schedule underpaid and overworked line staff in a manner that reduces fatigue. • CBOs would like written support from ADMHS regarding implementation of MHSA principles. • Take measures to reduce low staff morale and burnout • Use strength based assessment • Mandate that psychiatrists and executives attend trainings and meetings. • Provide multicultural services • Improve welcoming while taking staff safety into account	

	Benefits	Service Needs	Un-served/Under-served Populations
Latino Advisory Committee	•	• The following programs are working well: Coast Valley Lompoc, co occurring disorders; promotores; community health fairs; Community Health Centers of the Central Coast serving undocumented individuals; Peer Recovery Specialists; Peer Expert Pool • Facilities are needed to treat individuals with co occurring SMI and AOD involvement • Policy review of copay back pay: How can under served receive services? • Expand outreach and promotores; reach out to those who are already trained but not currently used • Make decisions from a culturally aware perspective; increase culturally competent perspective of executives • MFTs and other service providers should make field/home visits. • Bilingual support should be available in all medical services • Increase educational outreach • Increase centralized services that treat and educate people about physical and mental issues and how they are connected • Greater access/response to caregivers asking for assistance on behalf of others	• Latino/Oaxaqueño • Latino men • Persons with co occurring mental health and substance use disorders • Uninsured • Older Adults

	Benefits	• Service Needs	Un-served/Under-served Populations
ADMHS Psychologists' Group	• Satisfaction of clients and staff will increase • Clients will return, and the continuum of care will work better • Decrease in no shows because they will receive improved services	• Provide follow up to college students with serious AOD involvement after leaving PHF and CARES • Improve after care plans for youth in Juvenile Hall and Los Prietos • Collaborate with hospitals to ensure follow up care for AOD individuals involved in auto accidents. • Serve AOD individuals, including youth, at clinics. • Restore competence in state hospitals for people of all ages • More assistance is needed for persons with co occurring conditions • Detox • Housing • Medication • Physical Health Services • Train therapists to provide AOD services with mental health services • Assessments performed every 90 days • AOD counselors should provide AOD groups • Mental health counselors should not perform drug testing • Clear roles among AOD counselors, mental health counselors and psychologists should be established • Clear scope of practice and competence should be established, such as for AOD counselors • Minimize issues of dependency and treatment management	• Maternal substance abusers • Pregnant and depressed (future and recent mothers with partum and pre partum)' • Undocumented individuals • Older adults, including those at PHF and those with co occurring disorders • College students with serious AOD involvement • People who go to Public Health but really have mental health conditions • Forensic population • People involved in the court system • Youth in Juvenile Hall or Los Prietos • AOD individuals involved in auto accidents • People of all ages released from hospitals • Homeless individuals • Disabled individuals • LGBTQ

		by teaching strategies for coping that is not counseling • Psychologists should deal with clients with SMI and serve as team supervisors • MFT/LCSW should deal with relationships; psychologists with SMI • More AOD counseling is needed • Too many clients per staff member • Staff training needed to standardize services across regions • Greater efforts should be made to match staff abilities and skills to client needs • Staff needs to be educated in relevant EBPs • Staff rotations would increase staff knowledge and capabilities • Help staff floaters who move through the system and provide assistance to help staff cover for absent staff (e.g., retired treatment providers) • Build bridges to community partners to "hand off" clients in a manner that does not make them dependent on a provider; create a continuum of care and proper transitions • Track outcomes related to treatment plans • Staff should focus on case conceptualization, treatment plans, barriers and limited time • Partner more closely with CBOs to support clients transitioning	

		from clinic to community services. • Improve external and internal relationships. • Physically accompany clients to appointments to support them in making links to community services • Use the HARP program to train peers to run a process/program • Build job skills for TAY, including resume writing and practice interviews	

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Santa Barbara County - Behavioral Health System
Vision and Guiding Principles

Greetings! Santa Barbara County's Behavioral Health Steering Committee, focusing on system change, is pleased to announce the release of the ***Vision and Guiding Principles*** to guide us as we evolve the system to best serve the community.

Designed to guide and inspire innovation and quality improvement in both the short and long term, the ***Vision and Guiding Principles*** were adopted by the Steering Committee Nov 21, 2013.

The committee, which was convened by the office of the Chief Executive Officer of Santa Barbara County, is dedicated to ensuring our behavioral health system upholds this vision and these guiding principles over time.

We will be assessing the quality of our system's adherence to these principles, and we invite your feedback as this process moves forward.

One way for you to participate is to go to http://www.countyofsb.org/admhs and click on the "Systems Change" link.

We value a behavioral health care system that is

- welcoming
- hopeful
- client-focused
- inclusive
- culturally-competent
- seamless
- outcomes-oriented
- recovery-based
- collaborative
- adequately-resourced
- accessible
- innovative
- complexity-capable

Vision

- Our behavioral health system is **welcoming**, with every door the client approaches being the "right" door;
- We provide the highest **quality** of care and services to aid rehabilitation;
- We work to help each client achieve the **wellness** inherent in recovery;
- Our services are
  - **efficient**
  - **integrated**
  - **evidence-based**
  - delivered with **respect**, preserve client **dignity** and provide every client an environment to reach his or her full **potential**;
- We value **ongoing improvement**, and welcome ideas to improve our system from staff, clients, family members, advocates, and others in the community who care that we have the best system possible

Guiding Principles

- **Client- and family-driven system of care**: Individuals and families participate in decision making at all levels, empowering clients to drive their own recovery.
- **Partnership culture**: We develop partnerships with clients, family members, leaders, advocates, agencies, and businesses. We welcome individuals with complex needs, spanning behavioral health, physical health, and substance use disorders, and strive to provide the best possible care.
- **Peer Employment**: Client and family employees are trained, valued, and budgeted-for in ever-increasing numbers as part of a well-trained workforce.
- **Integrated service experiences**: Client-driven services are holistic, easily accessible, and provide consistent and seamless communication and coordination across the entire continuum of care delivery providers, agencies and organizations.
- **Cultural competence, diversity and inclusivity**: Our culturally diverse workforce represents this community. We work effectively in cross-cultural situations, consistently adopting behaviors, attitudes and policies that enable staff and providers to communicate with people of all ethnicities, genders, sexual orientations, religious beliefs, and abilities.
- **Focus on wellness, recovery and resilience:** We believe that people with psychiatric and/or substance use disorders are able to recover, live, work, learn and participate fully in their communities.
- **Strengths-based perspective:** Recovery is facilitated by focusing on strengths more than weaknesses, both in ourselves and in our clients.
- **Fiscal responsibility**: We efficiently leverage finite resources to provide the highest quality care to our clients, including those whom are indigent.
- **Transparency and accountability**: There are no secrets. We do what we say we will do, or we explain why we can't.
- **Continuous quality improvement**: We reliably collect and consistently use data on outcomes in our system of clients and other pertinent populations (such as incarcerated and homeless), as well as data related to perceptions of families, employees, and community-based organizations, to fuel a continuous quality improvement process.

*The **Steering Committee** that adopted the Vision and Guiding Principles comprised the following stakeholders from throughout the County:*

• Celeste Andersen, JD	Compliance
• Charletha Anderson	Central Coast Baptist Assoc & CORDS Foundation
• Ole Behrendtsen, MD	Co-Chair; ADMHS Medical Director
• Sylvia Barnard	CBO rep; Exec Director, Good Samaritan
• Michelle Brenner	Vice Chair, Mental Health Commission
• Annmarie Cameron	CBO Rep, Exec Director, Mental Wellness Center
• Manuel Casas, PhD	Mental Health Commission, & Latino Advisory Committee
• Todd Cook	Cottage Health System
• John Doyel, M.A.	Program Manager, ADMHS Alcohol & Drug Programs
• Ann Eldridge	NAMI Rep; Mental Health Commission member
• Michael Evans	ADMHS Deputy Director, Finance
• Jonathan Eymann, MFT	ADMHS Program Manager, Calle Real Clinic
• Suzanne Grimmesey, MFT	Programs Representative (ADMHS)
• Mark Kofler, MD	Psychiatrist, Calle Real Clinic (ADMHS)
• Raquel Lopez	La Casa de la Raza
• John Lovern	Professor, Allan Hancock College; Change Agent
• Jon Nibbio	Family Member; Chief Operations Officer, Family Care Network
• Daniel Nielson	Director, Department of Social Services
• Terri Nisich , MPA	Chair, Assistant CEO, Santa Barbara County
• Carlos Olson	ADMHS Line Staff; Change Agent
• John Richards	Co-Chair; Alcohol & Drug Program Advisory Board - Chair
• Cecilia Rodriguez, MFT	CBO Rep; Exec Director, CALM
• Cuco Rodriguez, M.A.	MHSA Division Chief, ADMHS
• Sara Scofield	Labor Representative – Clinicians
• Bev Taylor	County Probation, Department Director
• Larisa Traga	ADMHS Line Staff; Change Agent
• J. T. Turner, MFT	Co-Chair, CBO Rep; Exec Director, Phoenix of Santa Barbara
• Takashi Wada, MD, MPH	Public Health Director/Interim ADMHS Director
• Phylene Wiggins	Program Officer, Santa Barbara Foundation
• Tina Wooton	ADMHS Consumer Empowerment Manager

Consultants and ADMHS Systems Change Staff on the Steering Committee

(ADMHS is Santa Barbara County's Dept of Alcohol, Drug & Mental Health Services)

Andy Keller, Ph.D., Consultant, TriWest
Ken Minkoff, MD, Consultant, Zia Partners
Chris Cline, MD, Consultant, Zia Partners
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Michael Camacho-Craft, MFT, ADMHS Deputy Director, Programs
Andrew Vesper, LCSW, ADMHS Regional Manager
Dana Fahey, ADMHS MIS Manager
April Howard, Ph.D. ADMHS System Change Evaluator
Lyra Monroe, MPA, ADMHS, System Change Design Team member

Attachment 9

Selected Evidence-Based Practices (EBPs)

Researched by Elisa Gottheil, Ph.D.
Primary Source:
SAMHSA's National Registry of Evidence-based Programs and Practices
http://www.nrepp.samhsa.gov/Index.aspx

Evidence-Based Program/Description	Ages Served
Brief Strengths-Based Case Management for Substance Abuse Brief Strengths-Based Case Management (SBCM) for Substance Abuse is a one-on-one social service intervention for adults with substance use disorders designed to reduce the barriers and time to treatment entry and improve overall client functioning.	**18-55+**
Cognitive Behavioral Social Skills Training Cognitive Behavioral Social Skills Training (CBSST) is a psychosocial rehabilitation intervention designed to help middle-aged and older outpatients with schizophrenia and other forms of serious mental illness achieve their functioning goals related to living, learning, working, and socializing in their community of choice.	**26-55+**
Cognitive Enhancement Therapy Cognitive Enhancement Therapy (CET) is a cognitive rehabilitation training program for adults with chronic or early-course schizophrenia or schizoaffective disorder (per DSM-III-R or DSM-IV criteria) who are stabilized and maintained on antipsychotic medication and not abusing substances.	**18-55**
Dialectical Behavior Therapy Dialectical Behavior Therapy (DBT) is a cognitive-behavioral treatment approach with two key characteristics: a behavioral, problem-solving focus blended with acceptance-based strategies, and an emphasis on dialectical processes.	**18-26; 19-55**
Eye Movement Desensitization and Reprocessing Eye Movement Desensitization and Reprocessing (EMDR) is a one-on-one form of psychotherapy that is designed to reduce trauma-related stress, anxiety, and depression symptoms associated with posttraumatic stress disorder (PTSD) and to improve overall mental health functioning.	**13-55**
Family Behavior Therapy Family Behavior Therapy (FBT) is an outpatient behavioral treatment aimed at reducing drug and alcohol use in adults and youth along with common co-occurring problem behaviors such as depression, family discord, school and work attendance, and conduct problems in youth. This treatment approach owes its theoretical underpinnings to the Community Reinforcement Approach and includes a validated method of improving enlistment and attendance**.**	**13-17;** **18-25;** **26-55**
IMPACT (Improving Mood--Promoting Access to Collaborative Treatment) IMPACT (Improving Mood--Promoting Access to Collaborative Treatment) is an intervention for adult patients who have a diagnosis of major depression or dysthymia, often in conjunction with another major health problem.	**18-55+**
Matrix Model The Matrix Model is an intensive outpatient treatment approach for stimulant abuse and dependence that was developed through 20 years of experience in real-world treatment settings. The intervention consists of relapse-prevention groups, education groups, social-support groups, individual counseling, and urine and breath testing delivered over a 16-week period.	**18-55**

Evidence-Based Program/Description	Ages Served
Moral Reconation Therapy Moral Reconation Therapy (MRT) is a systematic treatment strategy that seeks to decrease recidivism among juvenile and adult criminal offenders by increasing moral reasoning. Its cognitive-behavioral approach combines elements from a variety of psychological traditions to progressively address ego, social, moral, and positive behavioral growth.	**13-55**
Motivational Interviewing Motivational Interviewing (MI) is a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. The operational assumption in MI is that ambivalent attitudes or lack of resolve is the primary obstacle to behavioral change, so that the examination and resolution of ambivalence becomes its key goal.	**18-55+**
Seeking Safety Seeking Safety is a present-focused treatment for clients with a history of trauma and substance abuse. The treatment was designed for flexible use: group or individual format, male and female clients, and a variety of settings (e.g., outpatient, inpatient, residential).	**13-55**
Trauma focused CBT: trauma informed system of care Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a psychosocial treatment model designed to treat posttraumatic stress and related emotional and behavioral problems in children and adolescents. Initially developed to address the psychological trauma associated with child sexual abuse, the model has been adapted for use with children who have a wide array of traumatic experiences, including domestic violence, traumatic loss, and the often multiple psychological traumas experienced by children prior to foster care placement	**childhood through adulthood**
Trauma Affect Regulation: Guide for Education and Therapy (TARGET) Trauma Affect Regulation: Guide for Education and Therapy (TARGET) is a strengths-based approach to education and therapy for survivors of physical, sexual, psychological, and emotional trauma. TARGET teaches a set of seven skills (summarized by the acronym FREEDOM--Focus, Recognize triggers, Emotion self-check, Evaluate thoughts, Define goals, Options, and Make a contribution) that can be used by trauma survivors to regulate extreme emotion states, manage intrusive trauma memories, promote self-efficacy, and achieve lasting recovery from trauma.	**13-55**
Trauma Recovery and Empowerment Model (TREM) The Trauma Recovery and Empowerment Model (TREM) is a fully manualized group-based intervention designed to facilitate trauma recovery among women with histories of exposure to sexual and physical abuse. Drawing on cognitive restructuring, psychoeducational, and skills-training techniques, the gender-specific 24- to 29-session group emphasizes the development of coping skills and social support.	**18-55**