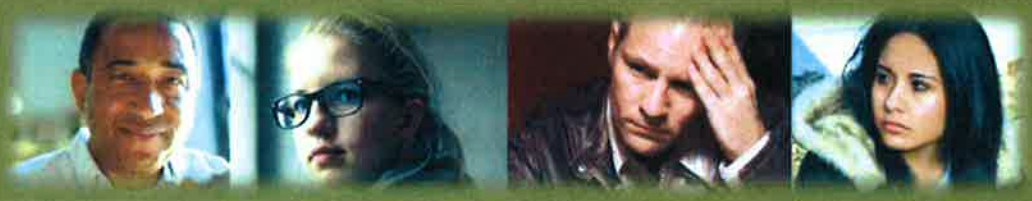
Santa Barbara County
Department of
Behavioral Wellness

MHSA PLAN UPDATE



FISCAL YEAR 2016-2017

300 N. San Antonio Rd.
Santa Barbara, CA 93110
(805) 681-5220
countyofsb.org/behavioral-wellness

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

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

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

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

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

_____

Local Mental Health Director/Designee (PRINT) Signature Date

County: _____

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:
Telephone Number: 805-681-5220	Telephone Number:
Email: agleghorn@co.santa-barbara.ca.us	Email:
Local Mental Health Mailing Address: Santa Barbara County Department of Behavioral Wellness, 300 N. San Antonio Rd., Santa Barbara, CA 93110	

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

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

Alice Gleghorn, Ph.D.

Local Mental Health Director (PRINT) Signature Date

I hereby certify that for the fiscal year ended June 30, 2013, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated _____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 County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

Theo Fallati, CPA, CPFO

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

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

Executive Summary

The original FY 14/15 Plan Update established the foundation for significant systemic changes to the Department of Behavioral Wellness outpatient service delivery system. This Plan Update covering FY 16-17 reports on MHSA funding components approved for Santa Barbara County: Community Services and Supports (CSS), Prevention and Early Intervention (PEI) Workforce Education and Training (WET), Innovation (INN), and Capital Facilities and Technological Needs (CF/TN).

Proposed MHSA funding for twenty CSS programs totals $14,698,756. Seven PEI projects total $3,808,026. Two Innovation projects total $1,263,127; the remaining WET resources total $200,575. The total funds remaining in the Technological Needs component is $352,258.

Changes in the Plan Update impact the CSS and PEI funding components. Although no new programs are proposed, as was noted in the 14/15 update, several crisis components funded by grants will eventually be sustained, in part, by MHSA. In FY 16/17 MHSA CSS funding will support: Crisis Residential North ($147,246) and Crisis Residential South ($231,378).

In the MHSA PEI component, the most significant change is the elimination of the Integrated Mental Health and Primary Care component. This component was intended to serve individuals with mental health needs who do not fit the public mental health criteria of severe mental illness. The program was developed prior to the passage of the Affordable Care Act (ACA) and at that time it filled a much-needed service gap. ACA now has a service provision that allows individuals with mild-to-moderate mental illness to receive care. We feel this is a prudent decision that enables the more efficient allocation of PEI funds without creating a significant negative impact for clients and creates an opportunity for sustainability of services with funding outside of MHSA.

The proposed Plan Update will be posted to the Department website. Stakeholders may comment on the proposed Plan Update for 30 days and offer comments at a public hearing following the public comment period.

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%); $3.1M in FY 16-17
2. Community Services and Supports (CSS) (45%); $14.7M in FY 16-17
3. Workforce Education and Training (WET) (10%); $200K in FY 16-17
4. Capital Facilities (Buildings) and Technological Needs (CF/TN) (10%); $400K in FY 16-17
5. Prevention and Early Intervention (PEI) (20%); $720K in FY 16-17
6. Innovation (5%); $1.5M in FY 16-17

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. As a result, the Three-Year plan from 14-15 through 16-17 continues to focus on this goal of system transformation.

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 FY 2016-17 MHSA Planning Process

The Three Year Planning Process of FY 14/15 is in its second year of implementation. The initial changes that were proposed in FY 14/15 are still at the core of the plan. The FY 16/17 Plan Update stakeholder process consisted of three stakeholder meetings that were scheduled at central locations in each of the three major regions of the county. These meetings allowed the department to update stakeholders on the progress of the multi-year implementation plan, and provided a forum for community stakeholders to share ideas and concerns.

Over 700 individual stakeholders were invited to participate in the county-wide stakeholder meetings. A total of 38 individuals participated in the three stakeholder meetings. These included representatives from the Mental Health Commission, The Oversight and Accountability Commission, NAMI, Community Based Organizations, Client Family Member Advisory Committee, Probation, Law Enforcement, Social Services, and other community partners.

The following stakeholder forums were convened:

- March 10, 2016. Marriott, Buellton
- March 14, 2016. Cen Cal Building
- March 16, 2016. Main Public Library, Santa Maria

The 30-day review process was conducted on July 20 to August 19, 2016 and conducted in partnership with the local Mental Health Commission. Additionally, the draft FY 2016-17 MHSA Plan Update was e-mailed to nearly 700 stakeholders. It was also made available by postal mail on request. In addition, the plan update was posted to the Department of Behavioral Wellness website. On August 31, 2016, the Mental Health Commission conducted a Public Hearing to review this plan.

Santa Barbara County Demographics

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

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

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

Demographic data from the U.S. Census Bureau:

People QuickFacts	Santa Barbara County	California
Population, 2014 estimate	440,668	38,802,500
Population, 2010 (April 1) estimates base	423,939	37,254,503
Population, percent change - April 1, 2010 to July 1, 2014	3.9%	4.2%
Population, 2010	423,895	37,253,956
Persons under 5 years, percent, 2014	6.4%	6.5%
Persons under 18 years, percent, 2014	22.4%	23.6%
Persons 65 years and over, percent, 2014	14.0%	12.9%
Female persons, percent, 2014	49.9%	50.3%
White alone, percent, 2014 (a)	85.9%	73.2%
Black or African American alone, percent, 2014 (a)	2.4%	6.5%
American Indian and Alaska Native alone, percent, 2014 (a)	2.2%	1.7%
Asian alone, percent, 2014 (a)	5.7%	14.4%
Native Hawaiian and Other Pacific Islander alone, percent, 2014 (a)	0.2%	0.5%
Two or More Races, percent, 2014	3.5%	3.7%
Hispanic or Latino, percent, 2014 (b)	44.4%	38.6%
White alone, not Hispanic or Latino, percent, 2014	45.9%	38.5%
Living in same house 1 year & over, percent, 2009-2013	79.0%	84.2%
Foreign born persons, percent, 2009-2013	23.4%	27.0%
Language other than English spoken at home, pct age 5+, 2009-2013	40.2%	43.7%
High school graduate or higher, percent of persons age 25+, 2009-2013	79.1%	81.2%
Bachelor's degree or higher, percent of persons age 25+, 2009-2013	31.3%	30.7%
Veterans, 2009-2013	26,102	1,893,539
Mean travel time to work (minutes), workers age 16+, 2009-2013	19.4	27.2
Housing units, 2014	154,401	13,900,766
Homeownership rate, 2009-2013	52.6%	55.3%
Housing units in multi-unit structures, percent, 2009-2013	29.6%	31.0%

Median value of owner-occupied housing units, 2009-2013	$453,000	$366,400
Households, 2009-2013	141,720	12,542,460
Persons per household, 2009-2013	2.89	2.94
Per capita money income in past 12 months (2013 dollars), 2009-2013	$30,352	$29,527
Median household income, 2009-2013	$62,779	$61,094
Persons below poverty level, percent, 2009-2013	16.0%	15.9%

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

Last Revised: Wednesday, 14-Oct-2015 15:53:19 EDT

FY 2016-17 Through FY 2018-19 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Santa Barbara County

Date: 9/12/16

	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 (includes Wraparound)	2,339,529	997,097	871,300	0	436,132	35,000
2. Lompoc ACT	2,005,639	822,939	1,182,700	0	0	0
3. Santa Maria ACT	2,689,320	1,344,170	1,345,150	0	0	0
4. Santa Barbara ACT	2,470,570	1,671,722	741,190		0	57,658
5. Supported Housing - North	1,188,737	662,897	525,840	0	0	0
6. Supported Housing - South	1,393,283	617,480	647,200	70,945	0	57,658
7. Justice Alliance	1,449,876	1,182,496	267,380	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	3,541,566	278,763	1,724,250	1,081,513	0	457,040
2. Adult Recovery & Resilience	3,491,144	283,192	3,129,608	78,344	0	0
3. Co-Occuring	3,036,278	133,291	1,639,060	1,263,927	0	0
4. Partners in Hope	1,400,227	1,374,727	25,500	0	0	0
5. Child Recovery & Resilience (with Katie A)	4,824,574	452,583	2,173,900	0	2,198,091	0
6. New Heights TAY	1,605,002	64,129	1,149,240		391,633	0
7. HOPE	1,043,360	0	530,100	0	513,260	0
8. CARES Crisis Res - North	1,446,390	147,246	652,200	379,294	168,554	99,096
9. CARES Crisis Res - South	980,678	231,378	674,900		0	74,400
10. Crisis Stabilization Unit	2,875,394	1,222,357	768,700	0	634,337	250,000
11. Crisis Triage	3,464,160	0	538,140	0	147,446	2,778,574
12. Homeless Services	713,973	148,369	128,190	0	356,223	81,191
13. Medical Integration	2,352,974	0	908,810	717,530	726,634	0
14.						
15.	0					
16.	0					
17.	0					
18.	0					
CSS Administration	10,915,155	3,063,920	3,750,520	0	0	4,100,715
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	55,227,829	14,698,756	23,373,878	3,591,553	5,572,310	7,991,332
FSP Programs as Percent of Total	62.7%					

FY 2016-17 Through FY 2018-19 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Santa Barbara County

Date: 9/12/16

	Fiscal Year 2017/18					
	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)	2,360,740	957,108	932,500	0	436,132	35,000
2. Lompoc ACT	2,026,760	808,070	1,218,690	0	0	0
3. Santa Maria ACT	2,695,488	1,309,618	1,385,870	0	0	0
4. Santa Barbara ACT	2,527,220	1,600,956	741,330	127,276	0	57,658
5. Supported Housing - North	1,195,804	654,114	541,690	0	0	0
6. Supported Housing - South	1,398,984	603,371	667,010	70,945	0	57,658
7. Justice Alliance	1,490,634	1,215,154	275,480	0	0	0
8.	0	0	0	0	0	0
9.						
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15.						
16.						
17.						
18.						
Non-FSP Programs						
1. CARES Mobile Crisis	3,604,627	615,284	1,775,790	1,081,513	0	132,040
2. Adult Recovery & Resilience	3,579,926	354,988	3,224,938	0	0	0
3. Co-Occuring	3,111,922	159,255	1,688,740	1,263,927	0	0
4. Partners in Hope	1,408,226	1,381,926	26,300	0	0	0
5. Child Recovery & Resilience (with Katie A)	4,887,019	1,035,641	2,237,400	0	1,613,978	0
6. New Heights TAY	1,619,612	78,090	1,183,640	0	357,882	0
7. HOPE	1,043,360	0	546,000	0	497,360	0
8. CARES Crisis Res - North	1,451,347	10,990	671,800	100,907	568,554	99,096
9. CARES Crisis Res - South	984,411	0	758,900	151,111	0	74,400
10. Crisis Stabilization Unit	2,975,092	779,784	768,700	0	1,176,608	250,000
11. Crisis Triage	3,556,287	1,339,240	554,430		157,141	1,505,476
12. Homeless Services	727,146	162,807	132,120	0	351,028	81,191
13. Medical Integration	2,319,757	260,530	936,730	717,530	404,967	0
14.		0				
15.	0					
CSS Administration	11,273,462	3,422,522	3,750,520	0	0	4,100,420
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	56,237,824	16,749,448	24,018,578	3,513,209	5,563,650	6,392,939
FSP Programs as Percent of Total	53.6%					

FY 2016-17 Through FY 2018-19 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Santa Barbara County

Date: 9/12/16

	Fiscal Year 2018/19					
	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	2,360,740	957,108	932,500	0	436,132	35,000
2. Lompoc ACT	2,026,760	808,070	1,218,690	0	0	0
3. Santa Maria ACT	2,695,488	1,309,618	1,385,870	0	0	0
4. Santa Barbara ACT	2,527,220	1,600,956	741,330	127,276	0	57,658
5. Supported Housing - North	1,195,804	654,114	541,690	0	0	0
6. Supported Housing - South	1,398,984	603,371	667,010	70,945	0	57,658
7. Justice Alliance	1,490,634	1,215,154	275,480	0	0	0
8.						
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18.						
Non-FSP Programs						
1. CARES Mobile Crisis	3,604,627	615,284	1,775,790	1,081,513	0	132,040
2. Adult Recovery & Resilience	3,579,926	354,988	3,224,938	0	0	0
3. Co-Occuring	3,111,922	159,255	1,688,740	1,263,927	0	0
4. Partners in Hope	1,408,226	1,381,926	26,300	0	0	0
5. Child Recovery & Resilience (with Katie A)	4,887,019	1,035,641	2,237,400	0	1,613,978	0
6. New Heights TAY	1,619,612	78,090	1,183,640	0	357,882	0
7. HOPE	1,043,360	0	546,000	0	497,360	0
8. CARES Crisis Res - North	1,451,347	10,990	671,800	100,907	568,554	99,096
9. CARES Crisis Res - South	984,411	0	758,900	151,111	0	74,400
10. Crisis Stabilization Unit	2,975,092	740,878	784,074	0	1,200,140	250,000
11. Crisis Triage	3,556,287	2,844,716	554,430	0	157,141	
12. Homeless Services	727,146	162,807	132,120	0	351,028	81,191
13. Medical Integration	2,319,757	260,530	936,730	717,530	404,967	0
14.	0	0	0	0	0	0
15.						
CSS Administration	12,373,511	3,422,522	3,750,520	0	0	5,200,469
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	57,337,873	18,216,018	24,033,952	3,513,209	5,587,182	5,987,512
FSP Programs as Percent of Total	48.3%					

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:	Behavioral Wellness
Estimated Funding FY 2016/17:	
Estimated Total Mental Health Expenditures:	$3,541,566
Estimated CSS Funding	$278.753
Estimated Medi-Cal FFP:	$1,724,250
Estimated 1991 Realignment:	$1,081,513
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$457,040

In FY 2015/2016, the access and assessment component formerly performed by CARES was handled by three Access and Assessment teams funded through the Prevention and Early Intervention (PEI) component. As in the past, crisis services are performed by CARES mobile crisis staff and staff with a number of new crisis system components, including crisis triage teams in all regions, a South County crisis residential facility, and a new Mobile Crisis West team in Lompoc. A crisis residential facility in North County has operated for a number of years. A new crisis stabilization unit in South County opened in January 2016, and a new South County crisis residential facility opened in July 2015.

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. Crisis Teams are now located in Northern, Southern, and West Santa Barbara County. The Mobile Crisis Teams serve adults experiencing a psychiatric crisis or mental health emergency and substantially enriches crisis options, providing clients appropriate alternatives to hospitalization whenever possible. The staffing for these programs includes Peer Recovery Specialists, Mental Health Practitioners and Psychiatric Nurses. Although mobile crisis teams were based in Santa Maria and Santa Barbara, December 2015 marked the start of Mobile Crisis team, based in Lompoc funded by Senate Bill 82 grants

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 work closely with local law enforcement professionals and hospital staff. When feasible,

they refer to the CARES Residential facility in north or south Santa Barbara County, as an alternative to involuntary hospitalization.

In response to community feedback, the Department of Behavioral Wellness has long identified improved responsiveness to crises as a top departmental goal.. Mobile programs offer a range of expertise in staffing that enables the team to provide interventions to a diverse community. A multidisciplinary team includes medical staff availability to address medication issues that, if left unattended, may result in the need for emergency, involuntary care. The Countywide Mobile Crisis team is linked to the CARES North and South intake units.

Between July 1, 2014 and June 30, 2015, CARES Mobile Crisis served 2,037 unduplicated persons.

Age Group	Number of Unduplicated Persons Served
16-25	597
26-59	1,183
60+	255
Missing DOB	2
Total	2037
Cost per Client	$1,739

Program Challenges and Solutions

As noted in the previous update, Crisis and Recovery Emergency Services (CARES) was conceived as a crisis response program and serves as a primary access point for the public behavioral health system. High utilization, 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. The most critical challenges involve coordinating and reassigning staff across the larger crisis system.

As was predicted, the development of additional crisis services has reduced the pressure on this program. New programs, such as the Crisis Triage, a Crisis Stabilization Unit, an additional Crisis Respite Facility in South County and a new Mobile Crisis West team, substantially enhanced the capacity of the department to respond to behavioral health crises and to afford clients more alternatives to hospitalization, substantially reducing the need for hospitalization. Additionally, the design of the new Access and Assessment teams also improved access to non-crisis outpatient services.

The expansion of crisis services has led the department to create an acute/crisis care system that links the 24/7 and extended hour programs that operate as a team. Staff

has initiated cross training and plans call for flexible staff assignments to facilitate adequate coverage and seamless transitions for clients.

New Heights (General System Development)

Provider:	Behavioral Wellness and Mental Health Systems
Estimated Funding FY 2016/17:	
Estimated Total Mental Health Expenditures:	$1,605,002
Estimated CSS Funding	$64,129
Estimated Medi-Cal FFP:	$1,149,240
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$391,633
Estimated Other Funding:	$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 Department of Behavioral Wellness Children's System of Care and are at risk for homelessness. TAY clients experiencing co-occurring mental health and substance abuse conditions are also treated in these components. 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 and includes services in partnership with a community based provider.

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, 2014 and June 30, 2015, New Heights served 169 unduplicated individuals.

Age Group	Number of Unduplicated Persons Served
0-15	4
16-25	165
Total	169
Cost per client	$9,497

Program Challenges and Solutions

One of the successes encountered in the past years has been an increased focus on developing employment resources. The creation of new client-focused, client-centered teams has allowed for a specific focus on the needs of special populations such as TAY. TAY-specific strategies and interventions are being explored by the

teams and include resource development in employment and housing. This new focus has also allowed staff to develop partnerships with the Department of Rehabilitation (DOR) and Work Force Development Board. These partnerships have garnered additional resources and services in the area of TAY employment. The Department of Behavioral Wellness will continue to work with stakeholders to develop additional resources for TAY clients, including a possible teen drop-in center and the development of additional TAY employment staff funded through DOR.

Partners in Hope (General System Development)

Provider:	Behavioral Wellness, Mental Wellness Center, Transitions-Mental Health Association
Estimated Funding FY 2016/17:	
Estimated Total Mental Health Expenditures:	$1,400,227
Estimated CSS Funding	$1,374,727
Estimated Medi-Cal FFP:	$25,500
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$0

Partners in Hope is a peer-run program that provides peer support services to consumers and family members. The program supports Peer Recovery Specialists and Recovery Learning Communities (RLCs) in South, 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 the Department of Behavioral Wellness 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 RLC's are also supported by other MHSA funds to provide technology access to participants. These include computer access and technology training and classes. There are currently three RLC's throughout the county. Coincidentally, the RLC's are each located at pre-existing MHSA-funded Housing Developments, including Garden Street in Santa Barbara, Home Base on G in Lompoc, and Rancho Hermosa in Santa Maria.

Partners in Hope primarily serves adults with severe mental illness, including those with co-occurring substance use disorders at risk of admission to psychiatric care and/or criminal justice involvement. 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). At this time, both providers offer bilingual services to family members.

Partners in Hope served approximately 104 unduplicated individuals during FY 2014-15. Please note that the cost per client for unduplicated individuals does not include client numbers for the Recovery Learning Centers (RLC's) and therefore reflects a higher cost. Steps are being taken to ensure that reporting for RLC's is collected accurately and that it represents specific data associated with MHSA funding.

Age Group	Number of Unduplicated Persons Served
16-25	12
26-59	81
60+	11
Total	104
Cost per Client	$13,463

Program Challenges and Solutions

Peer services have been evolving in our county since the inception of MHSA. The original CSS Plan initially included three peer staff. Since that time, most MHSA programs have integrated peer staff into their teams. Peer services are quickly becoming an integral part of all of our service teams.

The most significant challenge faced by our peer components has been the lack of a well-defined career ladder. The increase in staff positions has provided additional opportunities for people with lived experience, and a number of peer staff has been hired in civil service positions. Additional strategies to increase access for peers have included part-time employment opportunities for consumers and family members using a Peer Expert Pool funded through Workforce Education and Training (WET).

Homeless Services

Provider:	Behavioral Wellness, Good Samaritan, Transitions-Mental Health Association
Estimated Funding FY 2016/17:	
Estimated Total Mental Health Expenditures:	$713,973
Estimated CSS Funding	$148,369
Estimated Medi-Cal FFP:	$128,190
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$356,223
Estimated Other Funding:	$81,191

In response to stakeholder input, homeless services were created in Central County (Lompoc) and North County (Santa Maria). South County (Santa Barbara) services, although previously in existence, were augmented. The enhancements have allowed us to respond to long-term needs of persons with severe mental illness who are homeless or at-risk of homelessness, and who are not receiving adequate mental health services.

The program expansions are consistent with the principles of MHSA, including a recovery and resiliency focus, creating a greater continuity of care and cultural competence. The Homeless Services program is providing extensive outreach and engagement services. Teams have also adopted strategies that meet the specific needs of homeless populations in each region. Teams also provide housing support and assistance, employment and education support, rehabilitation services and other necessary supports for families and individuals. The program model utilized is culturally and linguistically competent and appropriate; the only threshold language identified in Santa Barbara County Spanish. Consequently, our goal has been to have 40% of direct service staff on this team and others be bilingual (Spanish/English) and bicultural. This team provided services to approximately 60 individuals.

During FY 2014-15, the Homeless Services program served 60 unduplicated individuals.

Age Group	Number of Unduplicated Persons Served
16-25	4
26-59	49
60+	7
Total	60
Cost per Client	$11,899

Program Challenges and Solutions

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

In other areas of the county, additional staff members were contracted to community-based organizations. Homeless outreach staff were hired in Lompoc (west county), and the department has expanded collaboration with local shelters to provide support for clients. In Santa Maria (North County), two staff persons will be hired through a local provider and work with the local shelter.

Co-Occurring Mental Health and Substance Use Outpatient Teams

Provider:	Behavioral Wellness
Estimated Funding FY 2016/17:	
Estimated Total Mental Health Expenditures:	$3,036,278
Estimated CSS Funding	$133,291
Estimated Medi-Cal FFP:	$1,639,060
Estimated 1991 Realignment:	$1,263,927
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$0

This program was designed for adults 26 and older. Clients diagnosed with a severe mental illness and a co-occurring alcohol or other drug (AOD) issues were identified for this specialized level of service.

The co-occurring outpatient teams offer client-driven services and customize services based on individual needs. The co-occurring specialization was developed in direct response to stakeholder priorities. Specialized outpatient co-occurring teams are based in North, Central and South County. A broad array of co-occurring-capable services maximizes opportunities to serve individuals with difficulties engaging in traditional services.

Co-occurring teams 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). Living in Balance has been ordered.

The program was designed to serve clients who 1) may have AOD-related legal issues, 2) who have been recently discharged from detox, 3) who have a history of substance use and/or 4) those who opt for co-occurring services. Program staff may provide access and support to Medical Assisted Treatment and other needed AOD services.

As with all MHSA-funded programs, program models are culturally and linguistically competent. To address threshold languages identified in Santa Barbara County, a goal is to maintain a minimum of 40 percent of direct service staff who are bilingual (Spanish/English) and bicultural. This program provided services to approximately 763 individuals countywide during the 15/16 Fiscal Year.

During FY 2014-15 the Co-Occurring Program served 833 unduplicated individuals.

Age Group	Number of Unduplicated Persons Served
16-25	92
26-59	695
60+	46
Total	833
Cost per Client	$3,645

Program Challenges and Solutions

Recruitments for new positons took longer than expected, but most teams have been staffed. Training specific to co-occurring care and team-based care was also a major focus of our last year. This upcoming year should result in the development of a cohesive team with a strong co-occurring focus.

Children's Wellness and Resiliency (WR) Teams

Provider:	Behavioral Wellness
Estimated Funding FY 2016/17:	
Estimated Total Mental Health Expenditures:	$4,824,574
Estimated CSS Funding	$452,583
Estimated Medi-Cal FFP:	$2,173,900
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$2,198,091
Estimated Other Funding:	$0

Adult Wellness and Recovery (WR) Teams

Provider:	Behavioral Wellness
Estimated Funding FY 2015/16:	
Estimated Total Mental Health Expenditures:	$3,491,144
Estimated CSS Funding	$283,192
Estimated Medi-Cal FFP:	$3,129,608
Estimated 1991 Realignment:	$78,344
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$0

The Wellness and Resiliency program for children and the Wellness and Recovery program for adults were designed to serve clients who have a higher level of function, those who may be stable and require a lower level of care, and those who may have graduation potential or successful step- down from clinics to a lower level of care or discharge from clinics.

One adult and one children's team serves each of the three major regions of the county-north, west/central and south. Services provided to clients include:

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

Wellness and Resiliency teams for children and Wellness and Recovery teams for adults use several evidence-based practices to maximize specialization, wellness and recovery. Stable treatment relationships are maintained. Client-centered and individualized approaches are sensitive to challenging diagnoses and responsive to client hopes and dreams. Clients will also assist adult clients with referrals to Recovery Learning Communities (RLCs), to other community resources and to psychotherapy services.

Department and community-based organization (CBO) staff members identified several evidence-based practices for the Children's component. The models include Family Behavior Therapy (FBT), Cognitive Behavioral Therapy (CBT), Seeking Safety.

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

Adult Wellness and Resiliency Teams (FY 2014-15)	
Age Group	Number of Unduplicated Persons Served
16-25	137
26-59	1158
60+	174
Total	1469
Cost per Client	$2,377

Children's Wellness and Resiliency Teams (FY 2014-15)	
Age Group	Number of Unduplicated Persons Served
0-15	574
16-25	186
Other	3
Total	763
Cost per Client	$6,323

Program Challenges and Solutions

Developing fully staffed components has taken longer than anticipated. Furthermore, although evidence-based practice (EBP) training for staff has been an ongoing process, significant care has been given to ensuring that staff understand and implement a team- focused, clients centered approach. Despite the differences in specialized care that our new teams provide, all teams need to embrace the team-focused approach.

Along with the programmatic challenges, staff members have also worked very hard to ensure that clients were transitioned and welcomed into programs appropriately. The team-based care concept was also new to clients, and staff members were critical in ensuring that clients felt comfortable with their teams.

HOPE

Provider:	CALM, Santa Maria Valley Youth and Family Center
Estimated Funding FY 2016/17:	
Estimated Total Mental Health Expenditures:	$1,043,360
Estimated CSS Funding	$0
Estimated Medi-Cal FFP:	$530,100
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$513,260
Estimated Other Funding:	$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. CALM is the local provider of this program and has managed to successfully serve 163 clients throughout the county.

During FY 2014-15, HOPE served 163 unduplicated clients.

Age Group	Number of Unduplicated Persons Served
0-15	149
15-25	19
Total	163
Cost per Client	$6,210

Program Challenges and Solutions

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

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

Anka Crisis Residential North

Provider:	Anka Behavioral Health
Estimated Funding FY 2016/17:	
Estimated Total Mental Health Expenditures:	$1,446,390
Estimated CSS Funding	$147,246
Estimated Medi-Cal FFP:	$652,200
Estimated 1991 Realignment:	$379,294
Estimated Behavioral Health Subaccount:	$168,554
Estimated Other Funding:	$99,096

Anka Crisis Residential South

Provider:	Anka Behavioral Health
Estimated Funding FY 2016/17:	
Estimated Total Mental Health Expenditures:	$980,678
Estimated CSS Funding	$231,378
Estimated Medi-Cal FFP:	$674,900
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$74,400

Crisis Residential North/South

The eight-bed Crisis Residential South facility offers voluntary crisis residential services for up to 30 days and opened as Anka Santa Barbara Crisis Residential opened in July 2015, the beginning of FY 2016/17. The 12-bed Anka Crisis Residential North (formerly operated by Telecare Corp) and the new Anka South offer voluntary crisis residential services for up to 30 days. During FY 2014-15, Crisis Residential North served 285 unduplicated clients.

Crisis Residential provides therapeutic rehabilitative services to individuals experiencing psychiatric emergencies. These services are provided in a non-institutional residential which provides a structured program as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis. Services include a range of activities that support clients in their efforts to restore, maintain, and apply interpersonal and independent living skills, and to access community support systems. Services are available 24 hours a day, seven days a week. Crisis services include:

- Assessment and evaluation of mental health and co-occurring substance abuse conditions

- Crisis intervention including emotional support and de-escalation for crisis situations
- Development of a service recovery plan
- Collaborating with clients, family members, and professionals who may already be serving the client
- Providing temporary respite from living situations that may be contributing to the crisis
- Education regarding mental health disorders, co-occurring substance abuse issues, and community resources
- Intensive planning aftercare planning, including safe and stable housing

Anka Crisis Residential North (FY 2014-15)	
Age Group	Number of Unduplicated Persons Served
16-25	40
26-59	214
60+	31
Total	285
Cost per Client	$8,516

Housing

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

Current projects:

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

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

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

On February 11, 2016, a proposal for a new MHSA Housing allocation was posted for 30-day public review. There were two comments submitted in support of this project. In partnership with the Santa Barbara County Housing Authority, a site has been secured for The Residences at Depot Street in the city of Santa Maria in North County. The proposed mixed population development is an 80-unit project with 35 MHSA units. This development is a two phase project that will attempt to distribute MHSA units equally across phases. The distribution of unit type is still under discussion but should include studios, one-bedroom, two-bedroom and three-bedroom units. Some units will be designated for homeless veterans.

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

Medical Integration and Older Adult Program

Estimated Funding FY 2016/17

Provider:	Santa Maria Valley Youth and Family Center
Estimated Funding FY 2016/17	
Estimated Total Mental Health Expenditures:	$2,352,974
Estimated CSS Funding	$0
Estimated Medi-Cal FFP:	$ 908,810
Estimated 1991 Realignment:	$717,530
Estimated Behavioral Health Subaccount:	$726,634
Estimated Other Funding:	$0

Stakeholders identified the need to improve services to older adults with severe mental illness, including individuals with co-occurring health issues, as a top priority for system transformation. Specialized Medical Integration/Older Adult teams address the complex needs of this population, including multiple medication management and the prevalence of significant physical and mental health conditions. Teams serve:

- Newly diagnosed individuals with chronic/severe health conditions
- Persons with poorly managed health conditions
- Individuals with multiple and complex health conditions
- Persons with limited mobility and/or incapacities due to health conditions
- Elderly and infirm people
- Dually diagnosed individuals with a medical condition
- Persons with infectious/chronic conditions

Increased access to primary care through the Affordable Care Act and a growing older adult population create unique challenges. The timing is 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.

Specialized teams in each region of the county serve persons with severe mental illness who also experience serious medical problems, including individuals who are 60 years of age and over. In the past year, 386 clients have been identified and assigned to these teams. Teams have initiated ongoing partnerships with all relevant agencies, including, but not limited to, Public Health, alcohol and other drug providers and senior service organizations.

Teams are also in the process of developing protocols to ensure seamless and continuous treatment, especially when medical conditions challenge mental health care.

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

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

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

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

IMPACT, Cognitive Behavioral Therapy (CBT), Seeking Safety and Motivational Interviewing, are all embedded with the system-wide focus on wellness, recovery, and resiliency. Additionally, the department is in the process of implementing a 3-4-50 program which is focused on improving health outcomes for all MH clients. Training for these teams has been ongoing and will continue in the upcoming year.

Age Group	Number of Unduplicated Persons Served
2193	3
26-59	219
60+	193
Total	415
Cost per Client	$5,669

Program Challenges and Solutions

As with our other new programs, teams were composed of existing staff and, in some cases, new positions were recruited. Internal staff members were afforded opportunities to be part of these teams, and clients for these programs were identified and carefully transitioned. Recruitment across the department was slower than anticipated, but it has been addressed. Training specific to team-based care required a significant shift from our prior traditional model of individual therapist caseloads. The teams have been very successful in integrating a team-based approach and have successfully adopting clients into their new teams.

About Full Service Partnerships (FSPs):

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.

Adult Assertive Community Treatment (ACT) programs for adults include Santa Maria ACT FSP (Provider: Telecare; capacity 100), Santa Barbara ACT FSP (Provider: Behavioral Wellness; capacity 100); Lompoc ACT FSP (Provider: Transitions Mental Health; capacity 100), Supported Housing North FSP (Provider: Transitions Mental Health; capacity 130) and Supported Housing South FSP (Provider: PathPoint; capacity 130). ACT is an evidence-based approach for helping people with severe mental illness, including those experiencing co-occurring conditions. ACT programs offer integrated treatment, rehabilitation and support services through a multidisciplinary team approach to transition-age youth and adults with severe mental illness at risk of homelessness. ACT seeks to assist 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.

Lompoc ACT FSP

Provider:	Transitions-Mental Health Association
Estimated Funding FY 2016/17:	
Estimated Total Mental Health Expenditures:	$2,005,639
Estimated CSS Funding	$882,939
Estimated Medi-Cal FFP:	$1,182,700
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$0

Between July 1, 2014 and June 30, 2015, 108 unduplicated individuals were served by Lompoc ACT.

Lompoc ACT	
Age Group	Number of Unduplicated Persons Served
16-25	17
26-59	74
60+	17
Total	108
Cost per Client	$18,571

Santa Maria ACT FSP

Provider:	Telecare Corporation
Estimated Funding FY 2016/17:	
Estimated Total Mental Health Expenditures:	$2,689,320
Estimated CSS Funding	$1,344,170
Estimated Medi-Cal FFP:	$1,345,150
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$0

Between July 1, 2014 and June 30, 2015, 111 unduplicated individuals were served by Santa Maria ACT.

SM ACT	
Age Group	Number of Unduplicated Persons Served
16-25	4
26-59	82
60+	25
Total	111
Cost per Client	$24,228

Santa Barbara ACT FSP

Provider:	Behavioral Wellness
Estimated Funding FY 2016/17:	
Estimated Total Mental Health Expenditures:	$2,470,570
Estimated CSS Funding	$1,671,722
Estimated Medi-Cal FFP:	$741,190
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$57,658

Between July 1, 2014 and June 30, 2015, 98 unduplicated clients were served by Santa Barbara ACT.

SB ACT	
Age Group	Number of Unduplicated Persons Served
16-25	3
26-59	69
60+	26
Total	98
Cost per Client	$25,209

Supported Housing South FSP

Provider:	PathPoint
Estimated Funding FY 2016/17	
Estimated Total Mental Health Expenditures:	$1,393,283
Estimated CSS Funding	$614,480
Estimated Medi-Cal FFP:	$647,20
Estimated 1991 Realignment:	$70,945
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$57,658

Between July 1, 2014 and June 30, 2015. 137 unduplicated individuals were served by Supported Housing South.

SB Supported Housing	
Age Group	Number of Unduplicated Persons Served
16-25	2
26-59	97
60+	38
Total	137
Cost per Client	$10,169

Supported Housing North

Provider:	Transitions-Mental Health Association
Estimated Funding FY 2016/17:	
Estimated Total Mental Health Expenditures:	$1,188,737
Estimated CSS Funding	$662,897
Estimated Medi-Cal FFP:	$528,840
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$0

Between July 1, 2014 and June 30, 2015, 144 unduplicated clients were served by Supported Housing North.

SM Supported Housing	
Age Group	Number of Unduplicated Persons Served
16-25	3
26-59	109
60+	32
Total	144
Cost per Client	$8,255

Program Challenges and Solutions

In the last several years, ACT programs have faced challenges related to fidelity compliance, service level compliance and staff turnover. In many cases, turnover has had a considerable impact on staff-to-client ratios and tends to impact compliance to fidelity unless a robust training component was instituted.

During the past year, concerns related to fidelity and program consistency were addressed by conducting an in-depth fidelity review of all three ACT programs. The review included all aspects of care and identified critical areas for improvement, including coordination of staff schedules, ongoing client review, and service level review. Low service levels are critical because they impact client care and may result in lower non-MHSA revenue generation.

To ensure the highest standard of fidelity to the ACT model, internal training for all ACT Program and staff has been scheduled to occur within the next three months (July/Aug. 2016). Behavioral Wellness staff members with ACT expertise have been assigned to provide technical assistance to ACT programs. MHSA staff members are also working with all FSP Programs to ensure compliance with required FSP forms and key event updates. California FSP expert, Mark Regins, has been engaged to provide technical assistance training in early Fall.

SPIRIT FSP

Provider:	Behavioral Wellness
Estimated Funding FY 2016/17:	
Estimated Total Mental Health Expenditures:	$2,339,529
Estimated CSS Funding	$997,097
Estimated Medi-Cal FFP:	$871,300
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$436,132
Estimated Other Funding:	$35,000

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 Department of Behavioral Wellness 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, 2014 and June 30, 2015, SPIRIT served 128 unduplicated individuals.

Age Group	Number of Unduplicated Persons Served
0-15	99
16-25	29
Total	128
Cost per Client	$18,277

SPIRIT Program Challenges and Successes

SPIRIT staff has continued to serve children and their families at a rate higher than expected. Efforts by bilingual staff members to reach Spanish speaking and other diverse populations have resulted in increased participation. Staff services and supports are consistent with service level goals and objectives.

Forensic FSP (Justice Alliance)

Provider:	Behavioral Wellness
Estimated Funding FY 2016/17:	
Estimated Total Mental Health Expenditures:	$1,449,876
Estimated CSS Funding	$1,182,496
Estimated Medi-Cal FFP:	$267,380
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$0

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 the Department of Behavioral Wellness treatment teams to make treatment recommendations, facilitate access to treatment and provide follow-up progress reports to the court and other appropriate parties. Justice Alliance Staff are responsible for the initial ACT screening and disposition process. Staff members identify appropriate ACT clients and ensure that clients are placed in the appropriate regional ACT Teams or Supported Housing Teams. When clients do not qualify for ACT services, staff will refer clients to the appropriate specialized outpatient teams such as Medical Integration, Co-occurring, or Wellness and Recovery.

In FY 2014-15, the Justice Alliance program served 146 unduplicated individuals.

Justice Alliance	
Age Group	Number of Unduplicated Persons Served
16-25	23
26-59	118
60+	5
Total	146
Cost per Client	$9931

Program Challenges and Solutions

This team was expanded to provide more comprehensive care to clients through linkage to community services upon discharge where appropriate. Continuing training on this model is important to provide evidence-based care to mentally ill who are arrested and incarcerated.

Senate Bill 82 (S.B. 82)

California Senate Bill 82 (S.B. 82), the Investment in Mental Health Wellness Act of 2013, uses state MHSA funding to provide grants to counties. The Department of Behavioral Wellness received approximately $11 million in S.B. 82 funding. This funding supports 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 Santa Maria, and the Crisis Respite facility in Santa Barbara and Lompoc.

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

1. All Department of Behavioral Wellness 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 (funded by MHSA)
- Santa Maria and Santa Barbara Mobile Crisis Teams (funded by MHSA)
- Mobile Crisis West Team (funded by SB 82)
- CARES North Crisis Residential (funded by MHSA)
- Crisis Triage Teams, Santa Maria, Lompoc, Santa Barbara (funded by SB 82)
- Crisis Stabilization Unit Santa Barbara and Santa Maria (funded by SB 82)
- Crisis Respite Facility Santa Barbara and Lompoc (funded by SB 82)

Crisis Triage Teams (SB 82)

Provider:	Behavioral Wellness
Estimated Funding FY 2016/17:	
Estimated Total Mental Health Expenditures:	$3,464,160
Estimated CSS Funding	$0
Estimated Medi-Cal FFP:	$538,140
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$147,446
Estimated Other Funding:	$2,778,574

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

crisis services. Client experiences are improved through a more seamless array of services designed to prevent future crises.

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

Between July 1, 2014 and June 30, 2015, Crisis Triage teams served 431 unduplicated individuals.

Crisis Triage	
Age Group	Number of Unduplicated Persons Served
0-15	6
16-25	150
26-59	582
60+	78
Age Unknown	5
Total	821
Cost per Client	$4,219

Crisis Stabilization Unit South (SB 82)

Provider:	Behavioral Wellness
Estimated Funding FY 2016/17:	
Estimated Total Mental Health Expenditures:	$2,875,394
Estimated CSS Funding	$1,222,357
Estimated Medi-Cal FFP:	$768,700
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$634,337
Estimated Other Funding:	$250,000

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

Staffing includes a 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 offers a calming, stable environment to help individuals move away from crisis. Services include assessments, peer counseling, referrals for continued treatment, emergency medications, nursing assessment and access to psychiatric consultation.

The South Santa Barbara facility, located in Santa Barbara County campus, opened in January 2016. The North County Crisis Stabilization Unit in Santa Maria is slated to open in July of 2017. Funding for this component is a combination of SB 82 resources, Medi-Cal, and some MHSA funding. Services are focused on short-term, rapid stabilization for individual's experiencing psychiatric emergencies. Brief evaluations, linkage and referrals to follow-up care are available to clients. Teams are composed of multi-disciplinary teams including nurses, psychiatrists, practitioners, and peer support staff.

ANKA Crisis Residential South

The eight-bed facility offers voluntary crisis residential services for up to 30 days and opened as Anka Santa Barbara Crisis Residential opened in July 2015.

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

Mobile Crisis West

Data for this Lompoc-based addition to mobile crisis services are included in the Mobile Crisis listing in the Community Services and Supports (CSS) section of this update.

FY 2016-17 Through FY 2018-19 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Santa Barbara County

Date: 9/12/16

	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. Community Mental Health Education	341,256	341,256	0	0	0	0
2. ECSMH (Great Beginnings)	428,059	428,059	0	0	0	0
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Early Childhood Mental Health	1,122,000	170,018	527,700	0	424,282	0
12. Early Detection & Intervention	1,546,309	680,780	651,810	0	213,719	0
13. Carpinteria START - School based TAY	492,705	134,263	180,100	0	178,342	0
14. Access/Assessment	2,348,157	1,064,200	592,130	0	378,793	313,034
15. Crisis Services for Underepresented TAY	985,275	289,531	385,800	0	309,944	0
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	701,419	699,919	1,500	0	0	
PEI Assigned Funds						
Total PEI Program Estimated Expenditures	7,965,180	3,808,026	2,339,040	0	1,505,080	313,034

FY 2016-17 Through FY 2018-19 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Santa Barbara County

Date: 9/12/16

	Fiscal Year 2017/18					
	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	341,256	341,256	0	0	0	0
2. ECSMH (Great Beginnings)	428,059	428,059	0	0	0	0
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
PEI Programs - Early Intervention						
11. Early Childhood Mental Health	1,122,000	145,558	543,500	0	432,942	0
12. Early Detection & Intervention	1,571,986	686,897	671,370	0	213,719	0
13. Carpinteria START - School based TAY	492,705	128,863	185,500	0	178,342	0
14. Access/Assessment	2,401,841	1,100,014	610,000	0	378,793	313,034
15. Crisis Services for Underepresented TAY	985,275	277,931	397,400	0	309,944	0
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	722,461	720,961	1,500	0	0	
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	8,065,583	3,829,539	2,409,270	0	1,513,740	313,034

FY 2016-17 Through FY 2018-19 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Santa Barbara County

Date: 9/12/16

	Fiscal Year 2018/19					
	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	341,256	341,256				
2. ECSMH (Great Beginnings)	428,059	428,059				
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
PEI Programs - Early Intervention						
11. Early Childhood Mental Health	1,122,000	145,558	543,500	0	432,942	0
12. Early Detection & Intervention	1,571,986	686,897	671,370	0	213,719	0
13. Carpinteria START - School based TAY	492,705	128,863	185,500	0	178,342	0
14. Access/Assessment	2,449,878	1,122,014	622,200	0	386,369	319,295
15. Crisis Services for Underepresented TAY	985,275	277,931	397,400	0	309,944	0
16.						
17.						
18.						
19.						
20.						
PEI Administration	722,461	720,961	1,500	0	0	
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	8,113,620	3,851,539	2,421,470	0	1,521,316	319,295

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 2016/17:	
Estimated Total Mental Health Expenditures:	$341,256
Estimated PEI Funding	$341,256
Estimated Medi-Cal FFP:	$0
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$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.

Department of Behavioral Wellness 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; 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.

Community Health Centers of the Central Coast (CHCC) continues to use its mobile clinics to reach remote outposts of the community to provide primary care access and mental health education and support. Furthermore, CHCC has been successful in developing partnerships with local agricultural employers to gain access to migrant workers in the community. They also conduct ongoing radio and television outreach, education and anti-stigma efforts and have undertaken an annual health fair for migrant farmworkers. The health fair focuses on health and mental health support and information services. Last year's 2015 health fair alone reached 890 people from Santa Maria. Many of the participants were Spanish and Mixteco Speaking farm workers. Mental health and educational services are delivered in a culturally informed primary care setting that promotes the integration of care. Community health educators working for the CHCC served approximately 1,070 clients during the 2014-15 FY.

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

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

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. These challenges and other reporting issues have obligated us to discontinue the Santa Ynez Valley initiative.

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. In fact, members of this organization are currently Mental Health First Aid-certified and have been conducting outreach to faith-based leaders and other members of the African American community.

Integrating Primary and Mental Health Care in Community Clinics

Community Health Centers (CHCC) was originally contracted to offer 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. Because these services are not required of the Department, and because the services are now required to be provided and funded by primary care providers as parf of the Affordable Care Act, MHSA funding has been discontinued.

Program Challenges and Solutions

Unfortunately, the clinical leadership of the Primary Care and Mental Health Integration component suffered from staff turnover leading to challenges in communications and reporting.

In addition, when the original PEI component was developed, individuals with mild-to-moderate mental illness were considered un-served and fell within the prevention category of PEI regulations. However, the Affordable Care Act (ACA) now supports services for clients with mild-to-moderate mental illness.

As a result, this program will be discontinued in FY 2016-2017. During the transition, Behavioral Wellness will work with CHCC to ensure that clients receive appropriate behavioral health care and individuals who meet the criteria for services from the Department of Behavioral Wellness are enrolled.

PEI Early Childhood Mental Health (ECMH)

Providers:	CALM, Santa Ynez Valley People Helping People, Santa Barbara County Education Office
Great Beginnings	
Estimated Funding FY 2016/17:	
Estimated Total Mental Health Expenditures:	$428,059
Estimated PEI Funding	$428,059
Estimated Medi-Cal FFP:	$0
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$0
Early Childhood Mental Health	
Estimated Funding FY 2016/17:	
Estimated Total Mental Health Expenditures:	$1,122,000
Estimated PEI Funding	$170,018
Estimated Medi-Cal FFP:	$527,700
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$424,282
Estimated Other Funding:	$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.

This program assists children in need of mental health services and their helps parents navigate systems through enhanced referrals and support for follow-up. In-home support, health and development screening, parent education and skills training, psychotherapy, advocacy, resources and referrals, postpartum support groups and father outreach are provided.

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

1) The Great Beginnings - CALM
   This program features a multidisciplinary team that uses a strengths-based approach to provide home and center-based services to low-income families of children prenatal to age five, with a specific focus on the Latino populations.

2) ECMH Special Needs Counseling - Santa Ynez Valley People Helping People
   The program provides services to low-income monolingual Spanish speaking children and families in the Santa Ynez Valley in Central County. Services are based at four school sites. Parents may access services in their neighborhood and in their homes. This component provides needed services in an area of the Central County where resources are limited.

3) CATCH - SBCOEO
   The CATCH Program 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.

Data for FY 2014-2015 for Child Abuse Listening Mediation (CALM), People Helping People, and the Santa Barbara County Office of Education (CATCH) was not reliably collected and cannot be reported at this time. This data is consolidated between provider and other funding streams. Steps are being taken to ensure that reporting is segregated and accurately represents specific data associated with MHSA funding.

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

Providers:	Family Service Agency, Council on Alcoholism and Drug Abuse
Estimated Funding FY 2016/17:	
Estimated Total Mental Health Expenditures:	$492,705

Estimated PEI Funding	$134,263
Estimated Medi-Cal FFP:	$180,100
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$178,342
Estimated Other Funding:	$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. Due to recent changes in coverage for undocumented children under Proposition 75, this program will be evaluated.

Program staff members work 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 97 unduplicated individuals between July 1, 2014 and June 30, 2015.

START	
Age Group	Number of Unduplicated Individuals Served
0-15	91
16-25	25
Total	116
Cost per Client	$4,247

PEI Early Detection and Intervention Teams for Children and TAY

Providers:	Behavioral Wellness
Estimated Funding FY 2015/16:	
Estimated Total Mental Health Expenditures:	$1,546,309
Estimated PEI Funding	$680,780
Estimated Medi-Cal FFP:	$651,810
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$213,719

Estimated Other Funding: $0

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

Three teams specialize in early detection and prevention of serious mental illness in transition-age youth, 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. Youth are typically served for approximately one year.

Mental Health Systems previously contracted some of these services, but that contract was discontinued in June 2016, so all these services will be provided by Behavioral Wellness.

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 140 unduplicated individuals between July 1, 2014 and June 30, 2015.

PEI Early Detection and Intervention	
Age Group	Number of Unduplicated Individuals Served
0-15	5
16-25	142
26-59	9
Total	156
Cost per Client	$9,912

Program Challenges and Solutions

Over the past 2015/16 FY, PEI TAY services have developed increased partnership with other TAY Services and providers. Housing and employment resources in particular, have been identified as critical areas of need. Housing is a significant challenge across the county and unfortunately TAY clients often face different challenges due to their age. However, gainful employment is a possible solution to finding housing. Staff from different county teams have been successful in developing strong partnerships and increased employment opportunities for TAY. The upcoming changes in Workforce Investment Act Funding look promising due to the focus on TAY populations. It is our hope that additional TAY employment positions can be leveraged in the upcoming year.

The Mental Health System contract was terminated and clients were transitioned to Behavioral Wellness staff. This process progressed well.

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

Provider:	Casa Pacifica
Estimated Funding FY 2016/17:	
Estimated Total Mental Health Expenditures:	$985,275
Estimated PEI Funding	$289,531
Estimated Medi-Cal FFP:	$385,800
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$309,944
Estimated Other Funding:	$0

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

SAFTY provides children's crisis services in collaboration with CARES (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 behavioral health or other appropriate services. By working in collaboration with the child's existing service providers, SAFTY seeks to keep children, youth and families safe in their homes and communities. SAFTY served 559 unduplicated individuals between July 1, 2014 and June 30, 2015.

Age Group	Number of Unduplicated Individuals Served
0-15	350
16-25	229
Total	579
Cost per Client	$1,702

Program Challenges and Solutions

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

To date, some local hospitals have 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.

Access and Assessment Teams

	Provider: Behavioral Wellness
Estimated Funding FY 2016/17:	
Estimated Total Mental Health Expenditures:	$2,348,157
Estimated PEI Funding	$1,064,200
Estimated Medi-Cal FFP:	$592,130
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$378,793
Estimated Other Funding:	$313,034

Equitable and improved access to services is single most urgent priority identified by stakeholders. The implementation of a clear, simple, and consistent process for entry into the county behavioral health system is a high priority for many community members. Stakeholders have 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 deployment of 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 are based in Lompoc, Santa Maria and Santa Barbara. The teams are 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 access and assessment function has been conducted by staff members who must also provide ongoing treatment. In contrast, the new specialized Access and Assessment Teams focus on access, assessment, as well as appropriate disposition and referrals for clients who do not meet Behavioral Wellness criteria. This type of specialized focus constitutes a major innovation. Access and Assessment Teams simplify and improve access to care, reduce wait times, improve access, reduce barriers and increase consistency throughout the county.

Assessments and referrals are customized to ensure that appropriate cultural and linguistic needs of each client are identified and accommodated. Furthermore, each team includes staff members who are bicultural and bilingual in the primary threshold language (Spanish). The program served 498 unduplicated individuals during FY 2014-15.

Age Group	Number of Unduplicated Individuals Served
16-25	90
26-59	366
60+	41
Age Unknown	1
Total	498
Cost per Client	$4,715

FY 2016-17 Through FY 2018-19 Three-Year Mental Health Services Act Expenditure Plan Innovation (INN) Component Worksheet

County: Santa Barbara County

Date: 9/12/16

	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. **RISE**	1,388,744	1,142,944	245,800	0	0	0
2.	0	0	0	0	0	0
3.	0	0	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	120,183	120,183	0	0	0	
Total INN Program Estimated Expenditures	1,508,927	1,263,127	245,800	0	0	0

FY 2016-17 Through FY 2018-19 Three-Year Mental Health Services Act Expenditure Plan Innovation (INN) Component Worksheet

County: Santa Barbara County

Date: 9/12/16

	Fiscal Year 2017/18					
	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. **RISE**	1,330,979	1,077,779	253,200	0	0	0
2.	0	0				
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
INN Administration	123,789	123,789	0	0	0	
Total INN Program Estimated Expenditures	1,454,768	1,201,568	253,200	0	0	0

FY 2016-17 Through FY 2018-19 Three-Year Mental Health Services Act Expenditure Plan Innovation (INN) Component Worksheet

County: Santa Barbara County

Date: 9/12/16

	Fiscal Year 2018/19					
	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. **RISE**	1,357,599	1,099,335	258,264	0	0	0
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
INN Administration	126,265	126,265		0	0	
Total INN Program Estimated Expenditures	1,483,863	1,225,599	258,264	0	0	0

Innovation

Stakeholder input provided the basis for two new programs under the Innovation component: Resiliency Interventions for Sexual Exploitation (RISE) and the development of Culturally Adapted and Recovery Focused Models of Care. The RISE project is a three-year component, while the Culturally Adapted Recovery Focused Models of Care component is envisioned as two-year pilot project.

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

Resiliency Interventions for Sexual Exploitation (RISE) Project

Estimated Funding FY 2016/17

Provider:	Behavioral Wellness
Estimated Funding FY 2016/17:	
Estimated Total Mental Health Expenditures:	$1,388,744
Estimated INN Funding	$1,142,944
Estimated Medi-Cal FFP:	$245,800
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$0

This project offers services to youth involved in sex trafficking, their siblings and their family members. A widespread information and education campaign has also been launched to train and raise awareness of county staff, CBO staff, first-responders, medical personnel, school personnel, community members, private citizens, etc. Approximately 200 individuals have been trained and educated about commercial sexual exploitation and its behavioral health impacts on victims.

RISE has worked in partnership 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. to ensure the use of a universal screening tool. The greatest accomplishment of the partnership has been the validation that sexually exploited youth need behavioral health treatment and assistance.

A comprehensive model of services, resources, protocols, education and training has been designed and is in process of implementation, including early intervention strategies for those juvenile justice involved females “at risk” for sexual exploitation.

The RISE Program has developed the following protocols and strategies:

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 focused on wellness, resilience and recovery through mind/body/spiritual awareness, positive psychology, DBT, pro-social and mindfulness approaches
5. Essential resources
6. Advocates assisting youth in navigating legal and 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

Program Challenges and Solutions

Due to the complexity of the clients served in this program and the multiple jurisdictions and departments involved, the RISE supervisor has spent a considerable amount of time developing programmatic procedures and ironing out referral protocols. Staff recruitment has moved slowly, and some initial interventions have been provided to clients. However, it is clear that the process, roles of partners, and response protocols are essential and necessary steps that must be completed prior to piloting services.

Additional challenges that have had to be resolved have been related to office space. Due to the significant risk factors faced by this population, a site location had to be selected very carefully. Although there were delays in identifying locations in Santa Barbara and Santa Maria, locations have been selected and are being secured. The Santa Maria site will be the first to be renovated and will be ready for move in no later than June of 2016. The Santa Barbara facility should be secured by June 2016 as well. However, renovation may delay the move-in date.

The development of, and agreement on, a universal screening tool is a significant accomplishment. Shifting the perspective of all our partners towards the recognition that these young women are victims is also extremely important. Additionally, staff members have educated the community and partners regarding the need for identification of high-risk young women.

In February 2016 program staff members were afforded an opportunity in Fresno to present to a progress report to a state-wide information summit. The presentation was

met with exceptional enthusiasm and assisted in developing strong partnerships with local victim advocates with lived experience. Significant achievements also include the integration of curriculums and expertise that emphasize the importance of individuals with lived experience who have survived sexual exploitation.

We are optimistic that beginning July of 2016 the program should be almost fully staffed, and all agreements with partners should be completed. Once this occurs, program staff members will begin to fully implement the component as designed. Additionally, staff is currently working to develop metrics and tools to collect data in order to appropriately measure outcomes and progress.

FY 2016-17 Through FY 2018-19 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: Santa Barbara County

Date: 9/12/16

	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	171,504	171,504	0	0	0	0
2. Southern Counties Regional Partnership	1,303,084	0	0	0	0	1,303,084
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	29,071	29,071				
Total WET Program Estimated Expenditures	1,503,659	200,575	0	0	0	1,303,084

FY 2016-17 Through FY 2018-19 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: Santa Barbara County

Date: 9/12/16

	Fiscal Year 2017/18					
	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	172,557	172,557	0	0	0	0
2. Southern Counties Regional Partnership	1,316,057	0	0	0	0	1,316,057
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	29,943	29,943				
Total WET Program Estimated Expenditures	1,518,557	202,500	0	0	0	1,316,057

FY 2016-17 Through FY 2018-19 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: Santa Barbara County

Date: 9/12/16

	Fiscal Year 2018/19					
	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	172,557	172,557				
2. Southern Counties Regional Partnership	1,342,378	0				1,342,378
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	29,943	29,943				
Total WET Program Estimated Expenditures	1,544,878	202,500	0	0	0	1,342,378

Workforce Education and Training (WET)

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

Support to Law Enforcement

For the past 10 years, Behavioral Wellness has implemented the Crisis Intervention Training (CIT), which is designed to assist law enforcement personnel and other first responders in effectively dealing with persons experiencing psychiatric crises. In the past year, the Santa Barbara County Sheriff's Department has been actively involved in developing a Peace Officers Standards and Training (POST)-certified CIT. Behavioral Wellness has been working in partnership with law enforcement to support their trainings and to assist in any way we can to help them achieve their POST certification. However, FY 2016/17 is the first year that our department was supporting CIT efforts through the Sherriff's Department and not leading this effort.

Peer Expert Pool (ongoing)

Estimated Funding FY 2016/17

Provider:	Behavioral Wellness
Estimated Funding FY 2016/17:	
Estimated Total Mental Health Expenditures:	$171,504
Estimated WET Funding	$171,504
Estimated Medi-Cal FFP:	$0
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$0

Following the completion of three annual 10-day Peer Support Specialist trainings and three annual rounds of six-month internships (2010 – 2012), the Peer Expert Pool was created to provide stipends for a variety of projects at Behavioral Wellness 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. Eight past interns are currently engaged in the Peer Expert Pool.

Program Challenges and Solutions

Although the WET Peer Specialist Training and Internship Program were successful, the limited internships required us to develop the expert pool as an additional employment opportunity for peers. The most significant challenge to our system continues to be the creation of additional peer positions and career opportunities that affords promotional experience to peer staff members in a peer support capacity.

FY 2016-17 Through FY 2018-19 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Santa Barbara County

Date: 9/12/16

	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. Capital Information Technology (CIT)	352,258	352,258	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	352,258	352,258	0	0	0	0

FY 2016-17 Through FY 2018-19 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Santa Barbara County

Date: 9/12/16

	Fiscal Year 2017/18					
	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. Capital Information Technology (CIT)	390,442	390,442	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	390,442	390,442	0	0	0	0

FY 2016-17 Through FY 2018-19 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Santa Barbara County Date: 9/12/16

	Fiscal Year 2018/19					
	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. Capital Information Technology (CIT)	390,442	390,442				
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	390,442	390,442	0	0	0	0

Capital Facilities & Technological Needs (CF/TN)

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 County, 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.

Consumers are provided access to computer resources and tools to gather information, research mental health conditions, 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 will allow for timely feedback about mental health services and increased involvement by consumers.

Electronic Health Records Enhancement

The Electronic Health Records (EHR) Enhancement Project will expand and build on the currently operational Integrated Information System at Santa Barbara County Behavioral Wellness. The project will create system-wide access to clinical, administrative and financial information in digital format, and staff members 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.

Provider:	Behavioral Wellness and Mental Health Systems

Estimated Funding FY 2016/17:

Estimated Total Mental Health Expenditures:	$352,258
Estimated CFTN Funding	$352,258
Estimated Medi-Cal FFP:	$0
Estimated 1991 Realignment:	$0
Estimated Behavioral Health Subaccount:	$0
Estimated Other Funding:	$0

Program Challenges and Accomplishments

The Capitol Facilities & Technological Needs component has implemented most of the components successfully. The funding for this component may be exhausted by the end of this fiscal year. This will depend on the number of technology enhancements that need to be made to complete electronic enhancements. We recently hired a new IT manager who will be responsible for finalizing this component.

Participation in training programs conducted by Recovery Learning Communities (RLCs) is ongoing. Consumers continue to frequent the centers at high rates. However, the ongoing upkeep of computers and software maintenance has been identified as a need. Our IT staff is working with the RLCs to address these issues and will identify hardware that may need to be replaced or repaired.

Supporting Materials

Attachment 1: MHSA Funding Summary
Attachment 2: Glossary
Attachment 3: Public Comments Prior to the Public Hearing
Attachment 4: Mental Health Commission Meeting Agenda for Public Hearing
Attachment 5: Minutes of the Public Hearing
Attachment 6: Evidence of Santa Barbara County Board of Supervisors' Approval (pending)

Attachment 1

FY 2016-17 Through FY 2018-19 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary

County: Santa Barbara County

Date: 9/12/16

	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 2016/17 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	1,199	0	1,754,255	130,328	352,258	
2. Estimated New FY2016/17 Funding	14,823,178	3,705,795	975,209			
3. Transfer in FY2016/17[a/]	(70,247)			70,247	0	0
4. Access Local Prudent Reserve in FY2016/17	0	102,231				(102,231)
5. Estimated Available Funding for FY2016/17	14,754,130	3,808,026	2,729,464	200,575	352,258	
B. Estimated FY2016/17 MHSA Expenditures	14,698,756	3,808,026	1,263,127	200,575	352,258	
C. Estimated FY2017/18 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	55,374	0	1,466,337	(0)	0	
2. Estimated New FY2017/18 Funding	14,909,231	3,727,308	980,870			
3. Transfer in FY2017/18[a/]	(592,942)			202,500	390,442	0
4. Access Local Prudent Reserve in FY2017/18	1,377,372	102,231				(1,479,603)
5. Estimated Available Funding for FY2017/18	15,749,035	3,829,539	2,447,207	202,500	390,442	
D. Estimated FY2017/18 Expenditures	16,749,448	3,829,539	1,201,568	202,500	390,442	
E. Estimated FY2018/19 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	(1,000,413)	0	1,245,639	(0)	0	
2. Estimated New FY2018/19 Funding	15,207,416	3,801,854	1,000,487			
3. Transfer in FY2018/19[a/]	(592,942)			202,500	390,442	0
4. Access Local Prudent Reserve in FY2018/19	0	49,685				(49,685)
5. Estimated Available Funding for FY2018/19	13,614,060	3,851,539	2,246,126	202,500	390,442	
F. Estimated FY2018/19 Expenditures	18,216,018	3,851,539	1,225,599	202,500	390,442	
G. Estimated FY2018/19 Unspent Fund Balance	(4,601,958)	(0)	1,020,527	(0)	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2016	1,631,519
2. Contributions to the Local Prudent Reserve in FY 2016/17	0
3. Distributions from the Local Prudent Reserve in FY 2016/17	(102,231)
4. Estimated Local Prudent Reserve Balance on June 30, 2017	1,529,288
5. Contributions to the Local Prudent Reserve in FY 2017/18	0
6. Distributions from the Local Prudent Reserve in FY 2017/18	(1,479,603)
7. Estimated Local Prudent Reserve Balance on June 30, 2018	49,685
8. Contributions to the Local Prudent Reserve in FY 2018/19	0
9. Distributions from the Local Prudent Reserve in FY 2018/19	(49,685)
10. Estimated Local Prudent Reserve Balance on June 30, 2019	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.

Attachment 2: 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, renamed the Department of Behavioral Wellness in February 2016.
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.
Anka Behavioral Health: the community-based provider that took over management of the Department of Behavioral Wellness Crisis Residential North and South in 2015 following a competitive bidding process.
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, Department of Behavioral Wellness 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 the Department of Behavioral Wellness 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 Department of Behavioral Wellness 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 Department of Behavioral Wellness 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: A Department of Behavioral Wellness 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: Department of Behavioral Wellness 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.
GSD: General System Development
Health Care Reform: See Affordable Care Act
HOPE: A Department of Behavioral Wellness 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: A Department of Behavioral Wellness 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 Department of Behavioral Wellness staff, other provider staff and community representatives that provides advice to Behavioral Wellness 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 Mental Health Services Act
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 the Department of Behavioral Wellness.
Partners in Hope: A Department of Behavioral Wellness 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 the Department of Behavioral Wellness 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 the Department of Behavioral Wellness 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: A proposed name for the Department of Behavioral Wellness 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 Department of Behavioral Wellness 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.
RISE (Resiliency Interventions for Sexual Exploitation): An Innovation project to assist girls and young women involved in, or at-risk of, commercial sexual exploitation.
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. The Department of Behavioral Wellness 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.
SPIRIT: The Department of Behavioral Wellness MHSA wraparound, full service partnership program for children in Santa Barbara County.
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 of Department of Behavioral Wellness 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 the Department of Behavioral Wellness 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 the Department of Behavioral Wellness (formerly "ADMHS") outpatient programs and services. TriWest issued a comprehensive report in May 2013 that may be found on the Department of Behavioral Wellness web site, countyofsb.org/behavioral-wellness.
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 the Department of Behavioral Wellness 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.

Attachment 3: Public Comments Submitted Prior to the Public Hearing

Public Comments Submitted Between July 26 and August 30, 2016

There are no outcomes to justify continuing funding for any of the MHSA programs. Numbers of people and the cost per each don't reveal their effectiveness in improving -or not- the lives of the Mentally Ill target population.

Our department has implemented the Milestones of Recovery Scale (MORS) and Child Adolescent Needs and Strengths (CANS) as tools for ensuring that programs are measuring effectiveness of care in terms of improving client wellbeing. The MORS is a recovery-based outcome tool that identifies the effectiveness of services for adults and will identify quality of life improvements.
The CANS provides a structured assessment for children with a set of dimensions relevant to case service decision-making. The CANS provides information regarding the service needs of the child and their family for use during plan development. The assessment is strengths-based and should improve care and outcomes for children.

It appears that MHSA funds are being used to fund SB 82 programs when those monies run out. How can that be done without cutting back on other CSS programs? Have "stakeholders" been informed and approve of this move? Surely this needs to be explained.

As of August of 2016, the Mental Health Service Act Oversight and Accountability Commission (MHSAOAC) has informed counties that grant funding for Triage and Crisis Services may be released in January of 2017 for application by counties. We are hopeful that these funds will continue to support the programs currently sustained by SB 82. Otherwise, the department will need to prioritize the ongoing model of care and how to fund within the continuum of prioritized services.
3. The cost of the Family Advocate positions in the Partners in Hope program is highly questionable at $13000+ per each individual contacted.

The total cost of the Partners in Hope Program includes the Recovery Learning Centers (RLC) and Peer Staff. The cost for the advocates is only a small portion of the total budget. Additionally, the data available to us at this time did not include the number of clients in the RLC's throughout the county.

How were CBO's notified of the March 2016 meetings? I personally did not receive notification of those meetings, but perhaps being new to my position, I wasn't on an email list.

Emails were sent to a broad list of stakeholders including various partnerships and groups. Additionally, the MHSA Division Chief attended several key partnership meetings to invite participants to attend. We have verified that more than ten individuals from this particular agency did receive notification.

What are the planned changes for the HOPE program as referenced on page 23: "Our current intensive in-home services may be consolidated in order to create a more comprehensive and seamless system. Therefore, HOPE and other services may be reconfigured in the upcoming year." a. Can CALM be part of these discussions?
Are there forums scheduled for this discussion, other than the MHSA plan update process?

Due to statewide legislative changes impacting foster care and other local factors, Behavioral Wellness will be consolidating therapeutic foster care services. The stakeholder process has not been developed. Once the process has been completed, all pertinent stakeholders will be informed.

CALM is listed on page 26 as provider of Medical Integration & Older Adult Program. This isn't accurate.

This error will be corrected.

On page 44, referencing PEI Early Childhood Mental Health (ECMH), it states that "data for FY 2014-15 for CALM, People Helping People and the Santa Barbara County Office of Education (CATCH) is inaccurate and cannot be reported at this time." Can you clarify this?

The data available to us at this time was not reliable. Therefore, we felt it was prudent not to publish it.

Is ACT working well? What are the outcomes being measured?

Over the last 10 years ACT Services have provided care to some of our most seriously mentally ill clients across the county. During that time we have identified areas of improvement for programs specifically in regards to maintaining the fidelity of the programs; as was outlined in the Plan Update. Training for all program staff in this area has been conducted. The outcome areas of focus by Full Service Partnerships (includes ACT) are: Residential (includes hospitalization and incarceration); Education; Employment; Legal Issues / Designations; Emergency Intervention; Health Status; and Substance Abuse.

On page 43, the plan lists the $1,122,000 that goes to Early Childhood Specialty Mental Health, but these services are not described in the MHSA plan.

Page 44 provides a description of services and the current providers that are funded under this initiative.

Is it true that 51% of MHSA dollars are supposed to be allocated to children? Is this occurring in SB County?

51% of all PEI funding is required to be allocated for services to Children and Transition Aged Youth. Our county is complying with this requirement.

Dear Colleagues,

My name is Wayne Mellinger and I serve on the Mental Health Commission of the County of Santa Barbara. I am also a "peer consumer" of services from the Behavioral Wellness Department, working through the Calle Real Clinic. I also am a community advocate passionate about social justice -- I sit on the Board of Clergy and Laity United for Economic Justice (CLUE). The following are my comments on the MHSA Plan for Fiscal Year 2016. Actually, I am only addressing one program in these comments. I have been a close observer of the Behavioral Wellness Department since 2007, when I began working with New Beginning Counseling Center as a counselor and outreach worker focusing on the needs of people with mental health challenges living on the streets. I have also worked for Casa Esperanza (now PATH), Transition House and WillBridge of Santa Barbara.

After years of neglect and underfunding the Behavioral Wellness Department is regaining competence and I am hopeful about it's future. As a peer consumer I have played a semi-active role in the "System Change" efforts within the department. I have seen substantial improvements in the quality of services and with the morale of employees over the past couple years. Dr. Gleghorn has brought vision and managerial finesse to her departmental responsibilities. Just yesterday she presented an outstanding report to the Board of Supervisors on the needs of those who are on the streets suffering severe mental health challenges, so I know that she is keenly aware of the issues I address.
I want to specifically speak to the needs of those with mental health challenges who live on the streets of our County. As someone who has become homeless three times in the past 17 years, I have become very familiar with this population. These connections have been strengthen through my professional activities.

The US Department of Housing and Urban Development (HUD) mandates that all communities do a "point in time" count every two years in which homeless populations are tallied. In recent years the Central Coast Collaborative on Homelessness (C3H) in conjunction with Common Grournd and over 300 volunteers has canvased all neighborhoods of our county to survey those without homes using a tool called the VI-SPDAT. Surveyed individuals are placed on the Vulnerability Index with a score ranking their health needs and other relevant data.

We recently counted about 1400 people without permanent housing on the streets of Santa Barbara County (see a summary athttp://commongroundsb.org/2015_registry_week_communit.pdf) . HUD recommends a "multiplier" of two or three, giving us a total of between 3000 and 4000 people experiencing homelessness each year in our County. Analyzing the survey data we know that about half of these people self-report having mental health challenges. This means that there are probably about 1500 people who are without housing and dealing with mental illness in our county.
I see a crisis in mental health care all over the streets of Santa Barbara. A short walk from Stearns Wharf up State Street to the Public Library on any day of the week will reveal the severity of problem. In eleven blocks there are far more than eleven people who seem to be severely mentally ill and living on the streets. Likely there are more than a couple of dozen.

Unfortunately, many of these people are "service-resistant", meaning that they tend to avoid institutional contexts, refuse programs aimed at them and generally shy away from those trying to help them. Often spending over a decade on the streets and having repeated bad experiences in shelters and programs, as well as other grave life events, have left these people fearful and filled with trauma. Outreach to this population is a time-intensive process leaving even seasoned outreach workers frustrated.

When I first saw the chart on page 19 of the MHSA Report stating that 60 individuals who are experiencing homelessness were served by the Homeless Service Program I was disappointed but not very surprised. Years of underfunding by the Board of Supervisors has left the department understaffed and without the resources needed to deal with this crisis. While many other counties our size in the state of California spend about 6% of the general budget on mental health, I have learned that we spend about 3%.

I have reached out to the department's epidemiologist inquiring how many people without homes are being served by other departmental programs, but have not received an answer yet. Thus, the 60 figure in the MHSA Report probably doesn't tell the whole story.

Currently, it is my understanding that Behavioral Wellness has only one full-time outreach worker to address these needs and that this person holds regular office hours at all the shelters. In 2007 there were four full-time outreach workers (from CARES) with an increased ability to canvas the streets, waterfront, library and parks.

It is my suggestion that Behavioral Wellness massively scale up the Homeless Services Program over the next 3-5 years. Also, I think that we need to restore the outreach teams to its former size by hiring three additional employees. Moreover, there is a need to have outreach workers do more than have office hours at the shelters. We need trauma-informed outreach workers who canvas the waterfront, the parks, State Street, the library and many other area. The

problem is not one of people being denied mental health services, it is one of people needing mental health services!
While the department already has some healthy collaborations with C3H and other service providers, this could be enhanced by having staff members work closely with all outreach teams in our community, especially those of C3H, Common Ground and Doctors without Walls.

Recently the HEART action team has confronted these same issues and recommended a plan to address the housing needs and bed capacities for those without homes in our county
Clearly, to implement the changes I am suggesting would require the Board of Supervisors to substantially increase funding to the department. According to California code each county's board of supervisors is responsible for the health care needs of those who are indigent. We need to insist that our board fulfills its mandate.

"1. The entire concept of "a plan" requires that the plan precede action. Discussing a plan and offering feedback allows for possible adjustments before the plan is implemented. Reviewing a plan late, seems to lack meaning and relevance.

2. The current draft plan lacks sufficient information to make any judgment about the performance of current programs.
Simply noting the number of clients served, the budget and the cost per client is not sufficient to make any inference about the efficiency, effectiveness or relative value of particular programs.
Each program should be described showing client characteristics, program productivity (e.g. units of service) and when possible Outcome measures such as the recently implemented MORS and CANS measures.

Most programs have operated for years, thus program descriptions should include at least the last 3 years of history to indicate how programs have changed or stayed the same.

3. In the future, MHSA programs may be expanded, curtailed or modified in various ways. When the time comes for such changes, it will be important to have detailed information on the programs and their performance.

Attachment 4

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

Mental Health Commission
Special Meeting Agenda

The Santa Barbara County Mental Health Commission will hold a special meeting to review and approve the Mental Health Services Act (MHSA) Plan Update for fiscal year 2016 to 2017 from 1:00 pm to 2:30 pm on Wednesday, August 31, 2016 at the Santa Barbara Children's facility, 429 North San Antonio Road, Santa Barbara. Video conferencing will be available to the public in the Santa Maria Clinic, Annex Room, 500 West Foster Road, Santa Maria.

I. 1:00 pm - Welcome and Introductions

II. 1:05 pm - Establish Quorum

III. 1:10 pm – Public Comment – (Up to 5 minute time limit per topic. Submit Request to Speak to chairperson prior to start of meeting)

V. 1:30 pm - Announcements by Chairperson

VI. Presentations

- 1:40 pm – Review and Vote for Fiscal Year 2016-2017 MHSA Annual Plan – Behavioral Wellness Staff

VII. 2:30 pm - Adjournment

Attachment 5: Minutes from Public Hearing

Mental Health Commission
300 North San Antonio Road, Bldg. 3, Santa Barbara, CA 93110
Public Hearing Meeting Minutes
August 31, 2016 - 1:00 p.m. to 2:30 p.m.
Santa Barbara, CA

Commission Members Present: James Rohde, 3rd District; **Jan Winter**, 1st District, Chair; **Charles Huffines**, 5th District, Vice Chair; **Manny Casas, PhD.**, 1st District; **Wayne Mellinger**, 1st District, Alternate; **Thomas Urbanske**, 4th District; **Tom Franklin,** 3rd District, Alternate; **Julie Solomon**, 3rd District; **Alicia Journey**, 2nd District; Alternate. **Commission Members Absent: John Truman**, 5th District; **Ann Eldridge,** 5th District.

Behavioral Wellness Staff: Karen Campos, Administrative Office Professional Senior; **Alice Gleghorn, PhD**, Director; **Lindsay Walter**, Deputy Director, Chief of Administration Operations ; **Refugio Rodriguez**, MHSA Division Chief . **Guests: Jessica Adams; Anita Fernandez-Low; Debbie McCoy; George Kaufman.**

I. **Welcome and Introductions** Chair Winter called the meeting to order at 1:00 PM, followed by self-introductions.

II. **Establish Quorum:** Yes.

III. **Public Comment**:
George Kauffman – refers to page 17 regarding Partners in Hope statistics – is it meant to include all the contacts of people served? He comments that the data is extremely misleading. At the very minimum if there is data missing – it should be noted on the report.

Cuco Rodriguez - the data should include Recovery and Learning Centers (RLC) and that's why the number in the data is very high. Cuco Rodriguez agreed to add a note on the report.

Mike Gorodezky shared the following input:

1. The entire concept of "a plan" requires that the plan precede action. Discussing a plan and offering feedback allows for possible adjustments before the plan is implemented. Reviewing a plan late, seems to lack meaning and relevance.

2. The current draft plan lacks sufficient information to make any judgment about the performance of current programs.

Simply noting the number of clients served, the budget and the cost per client is not sufficient to make any inference about the efficiency, effectiveness or relative value of particular programs.

Each program should be described showing client characteristics, program productivity (e.g. units of service) and when possible Outcome measures such as the recently implemented MORS and CANS measures.

Most programs have operated for years, thus program descriptions should include at least the last 3 years of history to indicate how programs have changed or stayed the same.

3. In the future, MHSA programs may be expanded, curtailed or modified in various ways. When the time comes for such changes, it will be important to have detailed information on the programs and their performance.

IV. **Announcements by Chairperson** Chair Winter stated that Commissioner Ann Eldridge was not able to be present today as she is out of town.

V. Presentations
Review and Vote for Fiscal Year 2016 – 2017 Mental Health Services Act Annual Plan –

Chair Winter expressed her confusion of where we are in the plan, what year in the three year plan?

Cuco Rodriguez – shares that this is the third year of our three year plan cycle. However, we are required to submit an update every year regardless of where we are within the three year plan cycle.

Chair Winter – in addition to the public comment she has heard feedback from family members and members of the public in regards to crisis service, she stated that some of her questions come from some of these contacts. Why does the 8 million amount show up so early when we had state funding from SB 82? (Referencing pages 34-35).

In response to Chair Winter's question, Cuco Rodriguez shared that the answer can be found in the section, public comment responses.

As of August of 2016, the Mental Health Service Act Oversight and Accountability Commission (MHSAOAC) has informed counties that grant funding for Triage and Crisis Services may be released in January of 2017 for application by counties. They are hopeful that these funds will continue to support the programs currently sustained by SB 82. Otherwise, the department will need to prioritize the ongoing model of care and how to fund within the continuum of prioritized services.

To sustain the SB 82 component. Dr. Gleghorn shares that Request for Application (RFA) in needed for counties to apply for SB 82 funding but that funding does not sustain the programs forever. However, the state occasionally gives additional money – for example additional funds were given for Lompoc triage staffing.

Commissioner Casas - What *happens if we don't get additional money from "occasional funds given" from the State as explained by Alice? Also, what happened to Community Health Clinic MHSA funding?*

Dr. Gleghorn - last page – we expect to be fully expended by this point – you get the grant and figure out how to sustain the funding – if there is a huge drop in funds – then we would have to make shifts in funding.

Lindsay Walter clarifies. The funding summary, Attachment 1 – the negative amount is assuming that the funds are no longer available which means that we need to look at different options/ prioritize. This attachment gives the big picture. Pg. 66a

Cuco Rodriguez - In response to Dr. Casas regarding community health clinics – there are 5 funding components in MHSA – 2 of them were one time funding opportunities with a 10 year reversion window. Prevention and Early Intervention, which is 25% of MHSA funding is an ongoing funding stream and originally funded the integration of mental health and primary care for people who did not meet criteria of our Department. These clients would be considered mild to moderate. This component was developed prior to the development of Affordable Care Act (ACA). At that time, there was no funding mechanism to support this population, except for Prevention and Early Intervention (PEI). Community Health Center (CHC) is a Federally Qualified Health Center and has leveraged ACA which supports funding and allows for considerable support for this population. Due to this duplication of funding, MHSA resources were no longer needed for this initiative.

Commissioner Alicia Journey - How does the grant funding process work- is there a department focused on this?

Lindsay Walter stated that the leadership team who is involved at state level brings back grant options which then get reviewed by Suzanne Grimmesey who then determines if the department qualifies to apply for any particular grant. For this grant – we know the funds will run out; however the State is saying that funds will more likely be available and we will need to apply for funds.

Commissioner Chuck Huffines - Reduction of funding coming from MHSA – how is that going to affect our projections over the next couple of years and will Medi Cal revenue be able to sustain the difference?

Dr. Gleghorn shares that this bill will allow counties to apply for subsidies to house homeless in the short term but long term this will allow for long term housing bonds. The full extent of fiscal impact is estimated a max of 1.4 million dollars.

Chair Winter - Will there be enough funds for the three year pilot or should we be looking at MHSA funds?

Dr. Gleghorn shares that at this moment there is no need to worry as we are funded for three years. The Board of Supervisors will see the results and will decide what happens next.

Question number 7 – On page 44 there is a reference to data collection and Child Abuse Listening Mediation (CALM). Can you clarify this?

Cuco Rodriguez - We didn't feel that the data available for reporting was reliable. Therefore, we did not want to include that in this report. This was not due to the fault of the contractor. With our new data collection efforts, we are hopeful this will improve in the coming years. We are in our first year of implementation and are hopeful that by the end of the year we will have enough data to get a better idea of where we stand.

Chair Winter now opened the meeting to any other questions from members of the public.

Chair Winter – line on innovations program – evidenced based practices pg. 51 – information is ambiguous - what is evidence based practices?

Action: Cuco Rodriguez will go back and eliminate that item as it will need to be submitted on a separate innovation plan aside from this plan.

George Kaufmann – I think that Partners in Hope is all contracted out – can't we get the providers to provide the data?

See previous response to Partners in Hope.

Commissioner Solomon – pg. 13 – lower right hand corner – asked for clarification on the big gap of about 1 million between pg. 12 and pg. 13 under other funding.

Lindsay Walter - Most likely driven by salaries.

Commissioner Julie Solomon – the format used to present the report – must it be in this form?

Cuco Rodriguez – the format has been changed from previous feedback on previous plans / budgets tables are a specific format.

Commissioner Julie Solomon suggests adding some columns showing the percentage change from the prior year.

Commissioner Dr. Casas hopes that we can get back on track with getting the plans in a timely manner to be able to get more information to the community.

Commissioner Journey made a motion to table indefinitely the vote to approve the MHSA Plan Update 2016/17 due to insufficient time to review the plan and insufficient information provided. Commissioner Huffiness seconded. 6 votes in favor of the motion. One abstention and 2 oppositions. Motion carried by majority vote.

VII. Adjournment Commissioner Casas made a motion to adjourn the meeting. Commissioner Huffines seconded. No oppositions. Motion carried. Meeting adjourned at 2:30 p.m.