SANTA BARBARA COUNTY
DEPARTMENT OF BEHAVIORAL WELLNESS

MENTAL HEALTH SERVICES ACT

THREE-YEAR MHSA PLAN UPDATE
FISCAL YEARS 2020-2023

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

315 Camino Del Remedio
Santa Barbara, CA 93110
Phone: (805) 681-5220
Website: countyofsb.org behavioral-wellness

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Authored by: Lindsay Walter, Caitlin Lepore, Vanessa Ramos, Natalia Rossi, Pam Fisher, John Winckler, Maria Arteaga, Tor Hargens, Elijah Root-Sanchez, Amanda Kirk, and Justice Patocs

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

County Compliance Certification

MHSA County Compliance Certification

County: Santa Barbara

Local Mental Health Director	Program Lead
Name: Alice Gleghorn, Ph.D Telephone: 805-681-5220 Email: agleghorn@co.santa-barbara.ca.us	Name: Lindsay Walter Telephone: 805-681-5236 Email: lwalter@co.santa-barbara.ca.us
County Mental Health Mailing Address: Santa Barbara County Department of Behavioral Wellness 300 N. San Antonio Road Santa Barbara, CA 93110	

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

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

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

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

Alice Gleghorn, Ph.D.

Local Mental Health Director/Designee (PRINT)

Signature

County: Santa Barbara

Date: 7/29/2020

County Fiscal Accountability Certification

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County: Santa Barbara

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

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

Local Mental Health Mailing Address:

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

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

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

Alice Gleghorn, Ph.D. — Local Mental Health Director (PRINT)
Signature
7/29/2020 — Date

I hereby certify that for the fiscal year ended June 30, 2020, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated _____for the fiscal year ended June 30, 2019. I further certify that for the fiscal year ended June 30, 2020, the State MHSA distributions were recorded as revenues in the local MHS Fund; that 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.

Betsy Schaffer, CPA, CPFO — County Auditor/Controller/City Financial Officer (PRINT)
Signature
7/29/2020 — Date

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

Executive Summary

In the FY 2017-2020 Mental Health Services Act (MHSA) Three Year Plan, the Department of Behavioral Wellness committed to focusing on the continued enhancement and evolution of the many programs and initiatives launched during the last Three-Year Plan period. The new Fiscal Year (FY) 2020-2023 plan provides information on completion and improvements in the system during the prior period of FY 2017-2020 while also outlining new proposals and strategies for the upcoming FY 2020-2023 Three Year Plan.

The Department has continued to focus on the most prudent ways to deal with limited fiscal growth. Due to the initiation of mandatory contributions for the new MHSA No Place Like Home (NPLH) initiative passed by California voters in November 2018, continued focus on refining and augmenting existing programs while limiting new programs is the key fiscal strategy for continuance of all operations. The Department applied for two housing projects in 2019 and plans to develop additional NPLH project applications in 2020 to 2023 with the goal of creating 50 new permanent supportive housing units in County.

Beginning in July 2019, the Department commenced a robust MHSA Planning process for the new FY 2020-2023 Three-Year Plan. The Behavioral Wellness Commission supported creation of a planning group made of Commissioners, Department staff, Access Ambassadors, Peers, Family members, and Youth in the community. Three youth served as MHSA interns in development of the plan including assisting with communication ideas, drafting the plan, coordinating stakeholder meetings, and hosting Youth events. Additionally, the Planning group held over 25 meetings throughout the County at new venues such as the Santa Maria Library and at Lompoc schools, in three languages, and marketed the public events on a variety of social media platforms. The support from the community was overwhelmingly positive and feedback was received in various formats such as surveys, comment cards, photos, poems, and painted art.

As the planning group began to draft the Three-Year Plan in March 2020 including development of a variety of new initiatives or intent to apply for grant opportunities, COVID-19 rapidly changed our way of being. At time of publication, the Department maintains essential Behavioral Health services with telehealth, reduced on-site locations, and expanded outreach coordination in the community as many are in isolation. As a result, this document presents the anticipated budget before COVID-19 impacts are considered and the Department intends to modify and reissue program plans with significant changes in the upcoming year as necessary. Although MHSA funding will be dramatically impacted as tax revenues are anticipated to decline, many of these impacts are unknown at time of plan posting. The Department is committed to continued Behavioral Health services in our community and values our partnerships as we all work together to develop solutions during the pandemic.

Proposed initiatives from the 2017-2020 Three Year Plan that were completed include expansion of outreach and linkage services to those experiencing homelessness in Santa Barbara County, establishing level of care tools to help transition consumers within the continuum of care, starting Medication Support services at Recovery Learning Centers, and implementing the County's first Transitional Age Youth focused Full Service Partnership programs in each region.

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

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

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

Example of Mental Health Services Act Community Program Planning Session held at the Santa Maria Library.
This session was tri-lingual with Mixtec, Spanish and English dialogue facilitated by MHSA Chief Lindsay Walter and diverse community leaders.

Performance Data

This year's plan update, where available, also includes program performance reports using data collected by the Department for Fiscal Year 2018-19. As part of the three-year plan, the Department has committed to collect and report this updated data, and intends to expand data collection in some other critical areas, for example, incarceration data, in upcoming years. The outcomes reported depend on the type of program. Psychiatric hospital admissions during program admission are reported for all programs. Higher intensity programs, such as Full-Service Partnership (FSP) programs, have more detailed outcomes. The CANS and MORS continue to be administered as a way to monitor clinical acuity, needs, and strengths. Below is a description of each of the measurement tools used to determine outcomes in our children and adult systems of care.

Child and Adolescent Needs and Strengths (CANS)

The CANS is a multi-purpose tool developed for children's service professionals to identify current needs and strengths of the child and family, to support treatment planning, facilitate quality improvement and to monitor outcomes. Implementation of the CANS began mid-year FY14/15. Due to a state mandated change, Santa Barbara County began using a new version of the CANS (CANS-50) in July 2018. This change in instrumentation made all existing CANS reports (such as compliance and outcomes) obsolete. Due to the analytic complexity of

the CANS and the desire for clinicians and supervisors to be able to review their client strengths and needs over time, Santa Barbara County is in the process of contracting with a CANS and PSC software provider. In addition to changing versions, the CANS age range was also extended to age 20. This means that in future reports, more TAY-aged clients will receive a CANS.

The CANS is scored from zero (no evidence of a problem/well developed strength) to three (immediate or intensive action needed/no strength identified). Therefore, improvement on the CANS is evidenced by a decrease in scores. The CANS-50 is organized into six primary domains (domains have changed slightly from the previous version of the CANS):

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

Milestones of Recovery Scale (MORS)

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

About the Mental Health Services Act

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

WELLNESS • RECOVERY • RESILIENCE

Additionally, MHSA has proven an effective vehicle for leveraging funding and developing integration; opportunities further enhanced through the implementation of the Affordable Care Act. The keys to obtaining true systematic transformation and integration are to focus on the five MHSA Guiding Principles that are outlined in the MHSA regulations.

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

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

To receive funding, Counties are required to develop three-year plans that are consistent with the requirements outlined in the Act. Counties are also obligated to collaborate with community stakeholders to develop plans that are consistent with the MHSA Principles. During the three-year plan, a yearly plan update must be completed which is provided in this document.

County plans are to contribute to achieving the following goals:

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

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

1. Community Services and Supports (CSS); (73.8%); $20.8M in FY 20-21
2. Prevention and Early Intervention (PEI); (20.3%); $5.7M in FY 20-21
3. Workforce Education and Training (WET); (1.3%); $357K in FY 20-21
4. Capital Facilities (Buildings) and Technological Needs (CF/TN); (0.02%); $6,500 in FY 20-21
5. Innovation; (4.7%); $1.3M in FY 20-21

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

Funding for housing development are a separate stream of funds. The remaining Santa Barbara MHSA Housing funding was utilized for the completion of the Residence at Depot Street project in Santa Maria. The “No Place Like Home” initiative has established a new stream of funding for housing projects with implementation plans that have been completed throughout FY 2019-20 and upcoming years. Ongoing MHSA funding for Santa Barbara was diverted and Santa Barbara County was awarded $2.56 million in non-competitive NPLH funding. Funding is available for competitive applications for housing at the State level through FY 2023-24.

Community Program Planning Process for FY 2020-23

Community Program Planning Process

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

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

The first step to creating a 3-year plan is to solicit feedback from stakeholders throughout the County of Santa Barbara on what to include in the initial draft of the plan. Feedback is gathered through Department Action Team meetings on specific programs/needs, at hosted regional community stakeholder forums, in attendance of local community organization meetings with an awareness of mental health needs and engagement with regional key informants.

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

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

After a hearing and review by the Behavioral Wellness Commission, the Commission then votes on presenting the plan for adoption by the County Board of Supervisors. If the Plan hearing is held at the Behavioral Wellness Commission, the plan is then sent to the County Board of Supervisors for approval.

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

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

Santa Barbara County's FY 2020-2023 MHSA Community Program Planning Process Schedule

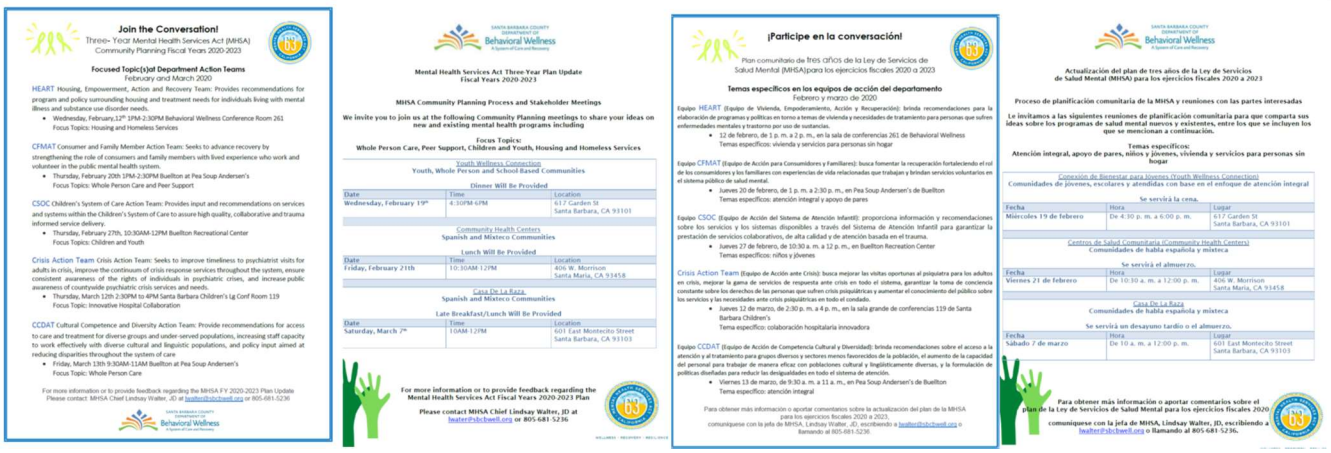
More than 1000 individual stakeholders were invited to participate in the county-wide stakeholder meetings. A total of 750+ individuals participated in the twenty-five stakeholder meetings. including representatives from the Santa Barbara County Sheriffs, National Alliance on Mental Illness (NAMI), Pacific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

These Stakeholder meetings were all tailored to specific populations served in our Mental Health Systems, although anyone form the public was welcome to attend any meeting. Stakeholder meetings hosted specifically oriented to as many of our underserved/unserved populations as we could identify. Targeted stakeholder groups for meetings and in attendance included Consumers and Families; LatinX populations; Migrant and Permanent Agricultural Workers, Mixteco communities; Homeless and At-Risk of Homeless Populations; LGBTQIA+ populations; TAY populations; College and High School students; Older populations; Rural communities; and Veterans.

The 30-day review process was conducted from June 2 to July 2, 2020 in partnership with the local Behavioral Wellness Commission. Additionally, the draft Mental Health Services Act FY 2020-2023 Three-Year Plan Update was e-mailed to nearly 1000 stakeholders. It was available by postal mail on request, posted online and available in the Director's Report. The Behavioral Wellness Commission hosted a Public Hearing on July 15, 2020 and Board of Supervisors Hearing on August 18, 2020. Finally, the Final plan update will be posted to the Department of Behavioral Wellness website and announced in the Director's Report.

For more information about the Community Planning Process or if you missed the opportunity to share input at any of named community planning sessions, you can always email, mail or call MHSA Chief, Lindsay Walter.

Contact Information is MHSA Chief, Lindsay Walter, JD Email: lwalter@sbcbwell.org 315 Camino Del Remedio Santa Barbara, CA 93110 ☎: (805) 621-5236.



Examples of MHSA Community Program Planning Process and Department Action Teams Schedules

Fiscal Years 2020-23 MHSA Community Program Planning Process Schedule	
MHSA Community Planning Workgroup Meeting	
Santa Barbara Work Group Meeting	12/11/2019
Santa Maria Work Group Meeting	1/29/2020
Buellton Work Group Meeting	2/20/2020
Regional MHSA Input Sessions Tri-Lingual Sessions	
Lompoc Regional Evening: Helping Hands of Lompoc	1/27/2020
Santa Maria Regional Morning: Santa Maria Adult Clinic	1/29/2020
Santa Maria Regional Evening: Santa Maria Library	1/29/2020
Santa Barbara Regional Evening: Mental Wellness Center Fellowship Hall	1/30/2020
Santa Maria Community: Spanish/Mixtec/English	2/21/2020
Lompoc School-Based: Spanish/Mixtec/English	2/27/2020
Santa Barbara: Spanish/Mixtec/English	3/7/2020
Department Action Team Meetings	
Client and Family Member Action Team (CFMAT): Session 1	12/19/2019
Housing Empowerment Action and Recovery Team (HEART)	2/12/2020
Client and Family Member Action Team (CFMAT): Session 2	2/20/2020
Children's System of Care (CSOC)	2/27/2020
Crisis Action Team (CAT)	3/12/2020
Community Focus Groups	
University of California in Santa Barbara: Youth Innovation Lab	12/6/2019
Lompoc Community Meetings: MHSA Innovations Help@Hand Project	12/12/2019
Community-Based Organization Collaborative	2/5/2020
Youth Wellness Connection- Youth Council	2/10/2020
Electronic Health Record and Workforce Education Training Discussion	2/19/2020
Santa Ynez Tribal Health Clinic- Opioid Action Coalition	3/3/2020
National Alliance on Mental Illness (NAMI) Policy Meeting- Santa Barbara County Chapter	3/9/2020
Westmont University- College-Based/Faith-Based Innovations	3/12/2020
Focused Targeted Population Surveys	
Evidence-Based Approaches for Integrating Harm Reduction and MAT Strategies Conference: Workforce Development and Prevention and Early Intervention Survey for Attendees	9/6/2019
University of California in Santa Barbara: Youth Innovation Lab: Youth Survey for Attendees	12/6/2019
Mental Wellness Center Recovery Learning Center: Peer and Consumer Survey for CBO Group	March 2020

MHSA Department Action Teams

MHSA Department Action Teams are held monthly at regional locations with tele-conferencing and video-conferencing capabilities to ensure that all interested to join the conversation have access. This platform allows for each action team to have their own objectives and action items. The Action Teams act also as a workgroup for monthly community planning process discussions surrounding MHSA funded programs. Behavioral Wellness Leadership chair and attend monthly meetings; Leadership also gathers input ensuring quality improvement efforts, as noted on the TriWest Report. Action teams provide continuous and ongoing feedback on MHSA programs and assistance in development and improvement of a variety of initiatives, such as guidance on grant opportunities. Your attendance is appreciated and come join us for any of the action teams below!

Children System of Care (CSOC) provides information to schools, agencies, and the community on trauma-informed services available in the community with hosted discussions on MHSA-funded initiatives pertaining to prevention and early intervention. For information on attending contact Tony Hollenbeck by email at: ahollenbeck@sbcbwell.org or call the department at: (805) 681-5220.

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

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

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

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

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

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

Santa Barbara County Demographics and Target Populations

Santa Barbara County has a mountainous interior abutting several coastal plains on the west and south coasts of the county. The largest concentration of population is on the southern coastal plain, referred to as the "south coast" – meaning the part of the county south of the Santa Ynez Mountains. This region includes the cities of Santa Barbara, Goleta, and Carpinteria, as well as the unincorporated areas of Hope Ranch, Summerland, Mission Canyon, Montecito and Isla Vista, along with stretches of unincorporated area such as Noleta. North of the Santa Ynez range in the Santa Ynez Valley are the towns of Santa Ynez, Solvang, Buellton, Lompoc; the unincorporated towns of Los Olivos and Ballard; the unincorporated areas of Mission Hills and Vandenberg Village; and Vandenberg Air Force Base, where the Santa Ynez River flows out to the sea. North of the Santa Ynez Valley are the cities of Santa Maria and Guadalupe, and the unincorporated towns of Orcutt, Los Alamos, Casmalia, Garey, and Sisquoc. In the extreme northeastern portion of the county are the small cities of New Cuyama, Cuyama, and Ventucopa. As of January 1, 2006, Santa Maria has become the largest city in Santa Barbara County.
(Retrieved 1-15-2020 from Wikipedia)

Quick Facts Santa Barbara County United States Census

Population	**446,499**
Population estimates, July 1, 2018, (V2018)	446,527
Population estimates base, April 1, 2010, (V2019)	423,947
Population estimates base, April 1, 2010, (V2018)	423,947
Population, percent change - April 1, 2010 (estimates base) to July 1, 2019, (V2019)	5%
Population, percent change - April 1, 2010 (estimates base) to July 1, 2018, (V2018)	5%
Population, Census, April 1, 2010	423,895
Age and Sex	
Persons under 5 years, percent	6%
Persons under 18 years, percent	22%
Persons 65 years and over, percent	15%
Female persons, percent	50%
Race and Hispanic Origin	
White alone, percent	85%
Black or African American alone, percent	2%
American Indian and Alaska Native alone, percent	2%
Asian alone, percent	6%
Native Hawaiian and Other Pacific Islander alone, percent	0.3%
Two or More Races, percent	4%
Hispanic or Latino, percent	46%
White alone, not Hispanic or Latino, percent	44%
Population Characteristics	
Veterans, 2014-2018	21,908
Foreign born persons, percent, 2014-2018	23%
Housing	
Housing units, July 1, 2018, (V2018)	158,333
Owner-occupied housing unit rate, 2014-2018	52%
Median value of owner-occupied housing units, 2014-2018	$549,900
Median selected monthly owner costs -with a mortgage, 2014-2018	$2,303
Median selected monthly owner costs -without a mortgage, 2014-2018	$600
Median gross rent, 2014-2018	$1,576
Families & Living Arrangements	
Households, 2014-2018	144,962
Persons per household, 2014-2018	2.92
Living in same house 1 year ago, percent of persons age 1 year+, 2014-2018	81%
Language other than English spoken at home, percent of persons age 5 years+, 2014-2018	40%
Computer and Internet Use	
Households with a computer, percent, 2014-2018	91%
Households with a broadband Internet subscription, percent, 2014-2018	85%
Education	
High school graduate or higher, percent of persons age 25 years+, 2014-2018	81%
Bachelor's degree or higher, percent of persons age 25 years+, 2014-2018	34%
Health	
With a disability, under age 65 years, percent, 2014-2018	6%
Persons without health insurance, under age 65 years, percent	12%
Economy	
In civilian labor force, total, percent of population age 16 years+, 2014-2018	64%
In civilian labor force, female, percent of population age 16 years+, 2014-2018	58%
Total accommodation and food services sales, 2012 ($1,000)	1,428,929

Total health care and social assistance receipts/revenue, 2012 ($1,000)	2,637,280
Transportation	
Mean travel time to work (minutes), workers age 16 years+, 2014-2018	19.8
Income & Poverty	
Median household income (in 2018 dollars), 2014-2018	$71,657
Per capita income in past 12 months (in 2018 dollars), 2014-2018	$34,229

Value Notes: Some estimates presented here come from sample data, and thus have sampling errors that may render some apparent differences between geographies statistically indistinguishable. The vintage year (e.g., V2019) refers to the final year of the series (2010 thru 2019). *Different vintage years of estimates are not comparable.* https://www.census.gov/quickfacts/fact/table/santabarbaracountycalifornia/PST045219

Prevention and Early Intervention (PEI) Planning Process and Prioritized Targeted Population Programming

The PEI planning process resulted in stakeholders identifying all seven populations as priorities:
1. Trauma Exposed Individuals
2. Individuals Experiencing Onset of Serious Psychiatric Illness
3. Children and Youth in Stressed Families
4. Children and Youth at Risk for School Failure
5. Children and Youth at Risk of/or Experiencing Juvenile Justice Involvement
6. Underserved Cultural Populations
7. Children and Youth at risk for substance use disorders

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

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

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

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

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

For the first two quarters in Fiscal Year 2019-20 Santa Barbara County has collected data from both our Behavioral Wellness Programs as well as our Contracted Providers to determine our anticipated need as well as our current staffing. The NACT's submitted for January 2020 and April 2020 show that Santa Barbara has successfully met the ratios provided by DHCS and has an adequate network of outpatient SMHS providers to meet the anticipated need for services of our county. Overall, the County strives to ensure a complete network of care for all outpatient services, which are primarily funded in MHSA. This plan will outline each program and those targeted age group populations to ensure our network remains adequate and there is focus toward the unserved and underserved in our Community.

Program Updates

Community Services and Supports and General System Development

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

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

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

Crisis Services

Provider:	**Behavioral Wellness**
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures	$5,572,500
Estimated CSS Funding	$1,953,400
Estimated Medi-Cal FFP	$2,441,300
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	$1,177,800
Estimated Other Funding	
Average Cost Per Consumer	$3,192
Estimated Total of Consumers Served	1746
Target Population Demographics Served	Children, TAY, Adults, Older Adults

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

1. Respond to all Access urgent calls. Crisis Services staff can respond in the field to urgent calls coming into the Access line, or the callers can be directed to come into the Crisis Services offices for services in the three regions.
2. Respond to law enforcement requests for outreach. Crisis Services staff build strong relationships with law enforcement and assist them in outreach to individuals in the community who appear to be struggling with severe mental health issues and are frequently calling 911 or being contacted by law enforcement in the field.
3. Respond to requests for services when an individual is evaluated for a 5150 but a hold is not written. Crisis Services staff work closely with the client to provide urgent follow-up services for these individuals with severe mental health issues who are not meeting criteria for a hold.
4. Assist current outpatient program clients when they are rapidly decompensating and are at risk of hospitalization. Crisis Services staff step in to provide very brief, intensive treatment, medication support and case management for core outpatient clinic clients when needed to prevent hospitalization.

5. Act as an access point for walk-in clients new to Behavioral Wellness or returning clients who are not currently open and can have more difficulty with engagement into services. Crisis Services staff are available to provide an initial assessment to determine if clients meet medical necessity for SPMI services and determine appropriate level of care in the system. The Crisis services staff outreach the clients and the Clients needing intensive stabilization will be served by Crisis Services staff for a short period of time (up to 30 days) before being transferred to an appropriate level of care.
6. Provide hospital discharge services to individuals being discharged from the Psychiatric Health Facility (PHF), Crisis Stabilization Unit (CSU), Telecare & Crestwood Behavioral Health CRT (Crisis Residential Facility), or out-of-county LPS facilities, to individuals who are new to Behavioral Wellness or to returning clients who are not currently linked to services.

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

Program Challenges and Solutions

Primary challenges for crisis teams include limited availability of LPS beds in-county and no adolescent LPS beds in county. Also, out of county LPS facilities are frequently full or for other reasons unable to accept BWELL referrals. In order to reduce the need for LPS placement, reduce burden of boarding 5150/5585 clients by local emergency departments and increase response time to crisis in the field, a number of solutions have been implemented. All Crisis Services Teams are now integrated with the sunsetting of Senate Bill 82 that funded the Crisis Triage teams. The South County Crisis Services team continues to integrate with our Crisis Stabilization Unit and Psychiatric Health Facility to form a Crisis Hub for the south coast community. The Crisis Hub is meant to function as a "one stop shop" for individuals experiencing a mental health crisis. Staff are available 24-7 for law enforcement drop-off or jail discharges needing crisis stabilization. Staff will perform 5150 evaluations and write 5150 holds if needed, and the client can be admitted into the PHF. Preferably, less restrictive options such as the CSU or nearby Crisis Residential Treatment facility can be utilized. In the near future there is also plans for a sobering center on campus which will provide an alternate destination for those needing to sober up before further crisis stabilization can occur. South County Crisis teams also began a pilot Co-Response program in collaboration with the Sheriff's Department. Currently we have one team consisting of a Sheriff Deputy and BWELL Case Worker riding together in a law enforcement vehicle that responds to all crisis calls in the area. Both Sheriff and the Department are seeking grant funding to expand the program into our North and West regions. In North and West regions, we do not currently have Crisis Stabilization Units, but staff are still available during regular business hours for law enforcement drop-off. Staff in these regions can transport clients to the CSU in South County if needed, or utilize the CRT in North County.

Recently, the Department received a MHSAOAC grant for children's crisis services. Our Children's' Triage Program (CCTP) consists of two teams, one practitioner and one parent partner. Teams are located in North and South Counties and either team can respond in West County when needed. Primary goal of the CCTP is to reduce the need for LPS placement of youth. The teams work closely with hospital emergency departments to respond when youth present in the ED's with a mental health crisis. An intensive crisis de-escalation, safety planning and

referral process is geared towards preventing LPS holds in the first place, or rescinding holds so youth do not need to be transferred out of county for LPS placement.

Program Performance (FY 18-19)

Crisis Services

Unique Clients Served					
	Adult Crisis Services*			Youth Crisis Services (SAFTY)^	
	North	South	West	North	South
Age Group					
0-15	44	25	10	378	208
16-25	189	256	65	221	130
26-59	446	572	298	0	0
60+	94	118	67	0	0
Missing DOB	1	1	1	0	0
Total	**774**	**972**	**441**	**599**	**338**
Gender					
Female	387	439	231	340	202
Male	371	526	205	257	136
Missing/Other	16	7	5	2	0
Ethnicity					
White	325	523	523	161	98
Hispanic	289	225	125	267	120
African American	32	43	34	13	4
Asian/Pacific Islander	14	40	5	6	4
Native American	4	4	3	1	0
Other/Not Reported	110	137	21	151	112

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

Client Outcomes

Higher Levels of Care	% during program admission in FY 18-19		
	North	South	West
Incarcerations/Juvenile Hall	--	--	--
Psychiatric Inpatient Care	14%	19%	14%

Note. SAFTY outcomes described under PEI section.

A goal of the crisis service programs is to stabilize clients in the community with safety planning and other supportive services in order to avoid admitting clients to a psychiatric hospital. We continue to make progress towards this goal with intensive crisis de-escalation, safety planning and referral process that prevents holds, or rescinds holds. Demonstrative progress in this area would be a decrease in 5150/5158 holds, while also seeing the same or greater number of consumers served by the Crisis team.

The table above shows the demographics of the unique clients who encountered crisis services.

The client outcomes table displays the percent of clients who experienced an inpatient psychiatric hospitalization during their admission to the program in the 18-19 fiscal year. Fourteen percent of clients in North County,

19% of clients in South County, and 14% of clients in West County experienced hospitalization during their program admission. Clients' admissions to crisis services may not be closed out immediately after the crisis team intervention, so if a client is subsequently hospitalized following the encounter with crisis services then the hospitalization is counted as within the admission. Incarceration/juvenile hall data were unavailable this year and we are unable to report on these metrics.

Partners In Hope

Provider:	**Mental Wellness Center, Transitions Mental Health Association and Behavioral Wellness**
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures	$838,900
Estimated CSS Funding	$838,900
Estimated Medi-Cal FFP	
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer/Families	$571
Estimated Total of Consumers/Families Served	1,470
Target Population Demographics Served	Children, TAY, Adults, Older Adults

Peer Support Services at the Recovery Learning Centers

Santa Barbara Behavioral Wellness Recovery Learning Centers provide Peer Support Service Programs that are peer-run and provide support services to consumers and family members. The program supports Peer Recovery Specialists and Recovery Learning Communities (RLCs) in the South, West and North County. The goal of the peer staff and RLCs is to create a vital network of peer-run supports and services that builds bridges to local communities and engages natural community supports. The RLCs are also supported by other Mental Health Services Act (MHSA) funds to provide technology access to participants. These include computer access and technology training and classes. A highlight in Santa Maria for consumers is the opportunity to participate in the "Growing Grounds Farms" coordinated by Transitions Mental Health Association.

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

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

Santa Barbara Services: Mental Wellness Center

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

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

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

In Santa Barbara, the Family Advocate reaches out to both Spanish- and English-speaking audiences. The Family Advocate meets with adults or small groups individually to address questions about resources and systems navigation on behalf of family members who often have a serious mental illness. The Family Advocate presents current and accurate information that is hard to obtain in the community, and also demonstrates and encourages coping skills and attitudes in the family members. The Family Advocate includes modeling effective strategies that he or she has learned through lived experience as a family member.

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

The Recovery Learning Center at the Fellowship Club is a drop-in, day program for adults living with serious mental illness. The program is staffed by peers experienced in mental health recovery and offers wellness-related activities, hot lunches, and more. It is also a training site for Psychology students for extra interpersonal support.

New to the Mental Wellness Center is the Youth Wellness Connection Club and Council hosted by San Marcos High School as a means to fight back against stigma by educating throughout the campus on mental health awareness and compassionate understanding for those who are impacted by mental illness.

Behavioral Wellness and Mental Wellness Center and TMHA Pilots

Community Connections is an RLC pilot that will establish a new, additional level of care that create a new environment in a community setting that is non-clinical, in which clients can establish stabilization of newly learned skills and management of symptoms with continued staff evaluation and oversight without the clients having to be reinstructed completely in those particular new places and/or with new people, to prevent deterioration. The goal is to provide intervention that will lead to lasting recovery.

The RLC pilot program will establish this by:
1.) Providing the interventions for clients focused on the generalization of acquired skills to continue to decrease impairment due to mental illness. Interventions will specifically target the generalization and use of learned skills in new environments (i.e. outside of the clinic setting) and in new social interactions (i.e. with people other than clinic staff, primarily members of the community).
2.) Providing the interventions that will begin utilizing the technique of prompt fading, gradually reducing the prompting from staff for a response from the client. This prevents prompt dependency when the clients have successfully established a new skill.
3.) Shifting the interventions from the clinic setting to a normal everyday environment.

While participating in the RLC pilot program the clients will receive:
1.) Once-a-month in-person appointments with the medication provider to monitor and evaluate the client's response to medication and symptom management.
2.) Once-a-month phone call with an RA from the clinic to monitor and evaluate the client's generalization of skills.
3.) Medications will either be completed by the pharmacy through home delivery or by client pick up at the pharmacy.
Client will participate in the RLC pilot program for 3-9 months, depending on the client's desire and the staff's treatment recommendations. Once client achieves goals in the RLC pilot program, the client will be supported to enter the next level of care and will transition to a community provider and will be closed to BWELL. Lompoc Adult Outpatient clinic staff will provide linkage and referral to community providers for medication management and support, primarily through phone calls and meeting the client in the community or home environments.

Should the client deteriorate due to an increase in impairments from mental health symptoms while participating in the RLC pilot program: This will be identified if the client experiences any of the following due to mental health symptom impairment: a.) Hospitalization b.) Incarceration c.) Loss of housing d.) Loss of employment. The client will be returned to the Lompoc Adult Outpatient Clinic setting for further treatment, which may include: a.) Increase in types of interventions offered: individual therapy, individual rehabilitation, group therapy, group rehabilitation, medication evaluation and support, crisis intervention, case management, and/or AOD services or b.) Increase in frequency that interventions are provided.

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

Transition Mental Health Association is a non-profit organization serving San Luis Obispo and North Santa Barbara Counties that is dedicated to eliminating stigma and promoting recovery and wellness for people with mental illness through work, housing, community and family support services. Their program's goal is to reduce mental health and substance abuse symptoms resulting in reduced utilization of involuntary care and emergency rooms for mental health and physical health problems.

TMHA's Family Services program has a Family Support Specialist in both Santa Maria and Lompoc. They provide education, information, and assistance with navigating the public and private mental health systems. They create a caring confidential environment that empowers family and friends to understand and cope with the realities of living with mental illness. They do this by meeting with individuals one on one. They also provide weekly family support groups so individuals can learn from and gain support from each other. They assist their families with finding and connecting to the resources that they need. They coordinate monthly events and have special guest speakers at their family support groups to bolster their families' knowledge of the mental health system

and the legal system. You can also find one or both of the Family Support Specialist at any number of local resource fairs.

TMHA's Family Services has also collaborated with NAMI Southern Santa Barbara County to bring NAMI support back to Northern Santa Barbara County. This collaboration culminated in TMHA's Family Service Specialist co-facilitating NAMI's Family-to-Family program in Santa Maria currently being held at Dignity Health. Areas of need is additional staff time for the Lompoc Service Specialist that is currently half time. A full-time specialist is needed to provide the support needed in Lompoc. Both Family Service Specialists are knowledgeable, hard-working and have demonstrated a positive impact on the communities they serve. They often have to rely on grant funds in order to receive training and provide materials for their families and groups.

The Recovery Learning Communities (RLC's) in Lompoc and Santa Maria are run entirely by people in mental health recovery. The RLC staff oversee the daily activities and facilitate involvement of members in wellness and recovery-oriented services in a comfortable and supportive meeting place. The RLC offers support in developing coping skills, vocational support and building a social network. They offer a variety of support groups from job club, computer skills building classes, lunch programs, community outings and emotional wellness groups. The Santa Maria RLC has dedicated intentional outreach to the monolingual Spanish population with a monthly support group. This support group is in its 3rd year and is held in the community at a local church. The group is held after hours to respect this communities need to work which often conflicts with traditional "clinic" hours. The RLC staff distributes food bank and other supplies to group members. Guest speakers present on various topic related to mental health and local resources are provided at every meeting.

After feedback from the last MHSA stakeholder process that the Department of Behavioral Wellness and CBO's lacked consistent collaboration and members not wanting to be "forever clients" of the outpatient clinics, a pilot program was launched at the Lompoc RLC. This program consisted of a Behavioral Wellness psychiatrist treating "graduated" clients at the RLC. This program was designed to move clients out of the clinic and did not include case management services. This program worked well because of the great relationships between the psychiatrist and the RLC staff. The suggestion is to continue to provide this service to RLC members for the long term, and not just for a year period. There continues to be a need for short term counseling services at the RLC. The RLC's also incorporate grant funded programing in each center.

Lived Experience Advocacy Development (LEAD), funded by the McCune Foundation, provides outreach to members of both the Lompoc and Santa Maria RLCs and recruits and trains individuals with lived experience of mental illness to develop an advocacy platform and presentation. The goal is to develop a new generation of community leaders, a group that is deeply invested in the cause of mental health advocacy and can accurately and empathetically represent its peers in the process. Several LEAD members have found their voices and have returned to work and school through their experience with LEAD. Currently 6 LEAD members are full time students at AHC on both the Santa Maria and Lompoc Campus

- LEAD also developed the Alliance for Mental Wellness with AHC and put on the first ever suicide prevention forum. In September 2019, 160 people attended the forum made up of AHC students and community member.
- LEAD coordinated the Longest Night Vigil which honors our community members who are homeless and those who died while homeless. The event hosted speakers, was attended by 50-60 people and raised money and donations that benefitted our local homeless.

The Lompoc RLC continues to receive the Community Development Block Grant funding from the city of Lompoc in order to provide more food and food distribution services to its members.

Both RLC's have strong community relations with other partners through outreach and education since several staff hold certifications in Mental Health First Aid, QPR and WRAP. Certified Staff have held trainings and facilitated support groups for Dignity Health Nurses, AHC college teacher, administration and students, the Santa Ynez Tribal Health Clinic, warming shelter staff, North County Rape Crisis and Child Protection Volunteer Advocates, Spanish Outreach Services.

Both RLC's have had these partner agencies including the Department of Behavioral Wellness host groups in each center. Some of these groups include Seeking Safety, TAY cooking group, and hearing voices.

FY 18/19 TMHA served over 600 consumers. They also facilitated English and Spanish Family Support Groups. They held community events attended by consumers and families and attended education sessions to educate the underserved, bi-lingual community about PIH family services. The Consumer Led RLC's of Santa Maria and Lompoc were highly used by members. The Santa Maria RLC served over 800 meals and over 1200 bags of groceries. A basic computer, Libre Office Writer, and embracing aging computer class was offered. Over 10 groups and 10 events were held, as well as education in mental health resources in Spanish. At the Lompoc RLC over 1400 meals were served and over 1200 bags of groceries were given out. 4 new groups were held and 3 re-occurring groups were sustained, and a whole host of monthly community gatherings were convened and attended. The computer lab served more than 40 unduplicated persons and had more than 550 duplicated contacts.

Program Challenges and Solutions

Budget constraints due to rising costs of minimum wage have an impact on existing staff. As these increases compress wages, loss of staff time is reported. Less staff time equates to less available RLC hours. RLCs try to be creative and provide members with the services they need when they need it however, this becomes difficult when staff time is limited. A further consideration is that the Santa Maria and Lompoc centers share one vehicle and they are located in two cities, this make attending events and coordinating food bank and other activities very difficult. Another van would be very helpful for programing. Review of transportation budget will occur in upcoming year.

Please note that because of the pandemic, service delivery has been modified for the safety of staff and the community members served in all regions. Some in person support continues to be offered if it is necessary and essential. Other services are delivered via telephone or telehealth.

RLC's provide food, prepared meals, activities, information and self-care for members.

TMHA is launching telehealth groups that will be in English and Spanish, evening and weekend groups are included. Other services are available 1:1 via telephone. Food services is available in person and by delivery. Access to membership has been streamlined with a referral that can be emailed in. All materials given to members including the referral form are in English and Spanish.

Program goals for the RLCs remain to provide intervention that will lead to lasting recovery and meet the needs of consumers, including housing placement, and linkages to medical and mental health providers. Demonstrative progress would be an increase in the members of the RLCs, an increase in placement with providers, and an increased satisfaction rate in consumers served. These goals were reviewed and updated in the FY 20-21 contracts with vendors.

Program Performance (FY 18-19)

Partners in Hope

	Activities					
	North		South		West	
	RLC	Family Advocate	RLC	Family Advocate	RLC	Family Advocate
Unduplicated clients	251	289	422	281	193	34
Client visits	3,097	1,786	19,281	1,599	5,122	183
Outreach Events	34^	35	*	*	34^	0
Outreach Event Attendees	2,007^	2,007	*	*	2,007^	0
Support Groups	*	*	33	25	*	*
Support Group Meetings	25 English / 13 Spanish	71 English / 49 Spanish	166	194	*	3 English / 0 Spanish
Classes	37	0	35	*	43	0
Outings, Educational Events	*	12	20	33	*	0
Trainings about consumer and family member issues	*	0	*	*	*	0
Unique clients provided services in Spanish	*	162	*	20	*	1
Underserved population	251	289	422	333	193	34
Linked to additional services	0	40	335	196	0	2

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

In North County, the RLC served 251 clients from underserved populations who had over 3,000 visits and 38 support group meetings (one third provided in Spanish). They provided 37 computer classes. The Family Advocate in North County served almost 300 unique clients from underserved populations, provided almost 1,800 client visits, led 120 support groups (49 in Spanish), attended 35 outreach events that reached 2,000 attendees, attended 12 outings/educational events, and linked 40 clients to additional services. Over half of the clients the family advocate served were provided services in Spanish.

In South County, the RLC served over 400 clients from underserved populations who had almost 20,000 visits. They conducted 166 support group meetings and held 35 classes and 20 outings/events. Over three hundred linkages were made to additional services. The Family Advocate in South County served almost 300 unique clients from underserved populations, provided 1,600 client visits, led nearly 200 support groups, attended 33 outings/events, and linked nearly 200 clients to additional services. Twenty clients were provided services in Spanish.

In West County, the RLC served nearly 200 clients from underserved populations who had over 5,000 visits. They provided 43 computer classes. The Family Advocate in West County position was filled for a partial year in FY

2018-19. The Family Advocate served 34 unique clients from underserved populations, provided 183 client visits, led three support groups, and linked two clients to additional services.

Homeless Outreach Services

Provider:	Behavioral Wellness, Good Samaritan, and United Way
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures	$952,800
Estimated CSS Funding	$454,300
Estimated Medi-Cal FFP	$440,200
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$58,300
Average Cost Per Consumer	$3,439
Estimated Total of Consumers Served	277
Target Population Demographics Served	TAY, Adults, Older Adults

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

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

Meeting the needs of people experiencing both homelessness and behavioral health challenges is an important priority for the Department of Behavioral Wellness. Outreach teams have adopted strategies that meet the specific needs of homeless populations in each region of the county (North, West, and South). Historically, Homeless Outreach Services have been centralized in South Santa Barbara County and there were no standalone Behavioral Wellness Homeless Outreach Services in Lompoc or Santa Maria. In FY 19 – 20, Behavioral Wellness augmented this initiative by securing additional funding to expand Homeless Outreach Services into both the North and West regions of the County. This was accomplished through the utilization of one-time Homeless and Mentally Ill Outreach and Treatment (HMIOT) monies, awarded by the Department of Health Care Services (DHCS) beginning January 1, 2019 for eighteen months. The funding allowed for the hiring of (2) full-time civil service practitioners, (1) full-time civil service case worker, and (1) extra help part-time administrative office professional; the programs remain fully staffed. Homeless Services staff countywide receive ongoing training in trauma-informed care, motivational interviewing, harm reduction, client engagement,

strategies for connecting clients to mainstream resources, and interventions which aim to facilitate housing stability and retention. The expansion of these services has successfully enhanced the mental health system's ability to respond to long-term needs of persons with severe mental illness, who are homeless, or at risk of homelessness, and who are not receiving adequate mental health services.

Critical to the Homeless Services ability to successfully outreach and engage some of our community's most vulnerable, is the teams' ability to readily access available, low-threshold shelter beds in various regions of the county. The Department of Behavioral Wellness provides for approximately 37 shelter beds throughout the county. There are 24 contracted mental health beds at the PATH shelter; Homeless Services works closely with PATH program staff to support residents with engagement in the Coordinated Entry System, while helping residents to become "document-ready" for housing. Clients are also provided with frequent on-site supportive services to support their continued engagement in behavioral health services and connection to mainstream resources. Homeless Services uses a similar model to provide 5 mental health beds at a Salvation Army shelter. The HMIOT monies also allowed for additional contracted shelter beds to be acquired at both the Good Samaritan Shelter in Santa Maria and Bridge House Shelter in Lompoc.

A relatively new project being undertaken by the Department of Behavioral Wellness is the conversion of two mobile vehicles, which will be used for homeless outreach and service delivery. The department's ability to acquire these vehicles was made possible by HMIOT funding and a cash donation that was awarded to the department on behalf of the Gordon Family Trust. The vehicles are being retrofitted with technology and will have the ability to accommodate a multi-disciplinary team comprised of medical personnel, allowing for the treatment of clients in the field. The mobile vehicle will contain a commemoration plaque to the Gordon Trust in recognition of this generous donation.

Successful outreach often involves a high degree of interagency collaboration and multi-disciplinary team coordination of services. Behavioral Wellness Homeless Services continues to strive towards maintaining a high degree of collaboration with other Santa Barbara County Continuum of Care (CoC) providers and hosts a weekly South County Coordinated Outreach Team meeting, providing Homeless Services and housing providers with an opportunity to discuss sub-regional outreach coverage, engagement strategies, outreach collaboration, service coordination and housing retention. This outreach collaborative has been successfully replicated in other sub-regions of the County, including Lompoc and Santa Maria. Additionally, Behavioral Wellness has established bi-monthly meetings with the Santa Barbara City Housing Authority and has strengthened communication and ongoing collaboration with the Housing Authority of the County of Santa Barbara – in order to review current post-placement housing retention services. The goals of these collaborative meetings are to keep consumers housed and prevent unnecessary returns to homelessness. Ensuring ongoing connection to housing resources and housing retention support is also achieved by attending weekly Coordinated Entry System Case Conferencing meetings. The Coordinated Entry System represents a Continuum of Care-wide process for facilitating access to all homeless-designated resources, identifying and assessing the needs of persons experiencing a housing crisis, and referring clients to the most appropriate service strategy or housing intervention.

The program expansions are consistent with the principles of MHSA, including a recovery and resiliency focus, creating a greater continuity of care and cultural competence. The program model utilized is culturally and linguistically competent and appropriate: the only threshold language identified in Santa Barbara County is Spanish. Consequently, the goal has been to have 40% of direct service staff on this team and others be bilingual (Spanish/English) and bicultural.

Program Challenges and Solutions

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

Santa Barbara County has a large gap between its supply of affordable housing and the demand for affordable housing. To increase residents' access to safe, affordable housing, the County will use No Place Like Home (NPLH) funding to build and rehabilitate affordable housing units. The Department of Behavioral Wellness has been working closely with the Housing Authority of the County of Santa Barbara to link children/family, transitional age youth (TAY), and adults/older adults who are homeless, or at risk of homelessness, and have a serious mental health condition to the newly constructed Residences at Depot Street in Santa Maria. To ensure that MHSA eligible tenants have access to ongoing mental health support, Homeless Services will be providing 40 hours per week of onsite support. The clinician assigned to this location will have expertise in interventions aimed at promoting housing stability and will act as a liaison to the larger mental health system of care.

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

Program Performance (FY 18-19)

Homeless Services

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	0	0	0
16-25	13	11	4
26-59	73	101	38
60+	3	33	1
Missing DOB	0	0	0
Total	**89**	**145**	**43**
Gender			
Female	76	53	39
Male	13	92	4
Unknown	0	0	0

	Unique Clients Served		
	North	South	West
Ethnicity			
White	38	71	19
Hispanic	46	41	22
African American	3	12	1
Asian/Pacific Islander	0	3	0
Native American	1	2	0
Other/Not Reported	1	16	1

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

Homeless Services All Contacts

Unique Clients Served	
	South
Age Group	
0-17	1
18-23	2
24-30	14
31-40	23
41-50	26
51-61	40
62+	26
Missing DOB	0
Total open to PATH in FY 18-19	***132***
Total enrolled in PATH in FY 18-19	***129***
Total entered program in FY 18-19	***237***
Total contacted by PATH in FY 18-19	***242***
Gender	
Female	45
Male	85
Transgender male to female	0
Transgender female to male	0
Gender Non-Confirming	1
Not collected	1
Total	***132***
Race (Multiracial individuals counted in all categories)	
White	115
African American	12
Asian	2
Native Hawaiian or Other Pacific Islander	2
Native American or Alaska Native	9
Other/Not Reported	1
Total	**141**
Ethnicity	
Hispanic	29
Non-Hispanic	100

Unique Clients Served	
	South
Not collected	3
Total	**132**
Veteran	
Yes	12
No	120
Total	**132**
Special Needs	
Mental Illness	153
Alcohol Abuse	45
Drug Abuse	54
HIV/AIDS or related disease	1
Developmental Disability	29
Physical Disability	77
Domestic Violence	1
Other	121
Disabled	191

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

Client Outcomes

Milestones of Recovery Scale (MORS) Age: 18+		
	Initial to 6 months (n = 150)	**6 to 12 months (n = 108)**
Showed improvement^	48%	30%
Remained stable^	29%	46%
Living Situation	**Entry (n = 178)**	**Exit (n = 164)**
Place not meant for habitation	110	86
Emergency Shelter	23	29
Transitional Housing for Homeless	6	2
Institution (e.g. Jail, hospital, psych facility, AOD treatment)	17	14
Transitional (with family/friends)	4	0
Permanent	2	28
Other	16	5
Unknown	0	0

Higher Levels of Care	**% during program admission in FY 18-19**		
	North	**South**	**West**
Incarcerations	--	--	--
Psychiatric Inpatient Care	0%	3%	0%

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

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

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

(1) A contact with the program that results in entry into HMIS (n = 242 clients contacted in FY 18-19; n = 237 new clients opened in FY 18-19);

(2) A contact with the program that results in entry into HMIS, and consent to enroll in PATH (n = 129 clients enrolled in FY 18-19); and

(3) A contact with the program that results in enrollment in mental health services through Behavioral Wellness (n = 277); services recorded through EHR (Sharecare/Clinician's Gateway).

In the 2018-2019 fiscal year, clients in South County Homeless Outreach Services had initial, 6-month and 12-month MORS data. In the first six months of engagement, half of clients improved, and in the second six months, one third improved. Over the first twelve months, three quarters of clients either stabilized or improved.

Examining housing status at Program entry and exit, it is important to note that some clients included in this count had only one contact with Behavioral Wellness and were not seen again. Two hundred forty-two individuals seen in FY 18-19 had at least one contact with the program, while 132 of these individuals enrolled in PATH. While many of the total number of clients remained homeless at program exit, 26 clients attained permanent housing.

The client outcomes table displays the percent of clients who experienced an inpatient psychiatric hospitalization during their admission to the program in the 18-19 fiscal year. Three percent of clients in South County and no clients in North or West County experienced hospitalization. Incarceration/juvenile hall data were unavailable this year and we are unable to report on these metrics.

Co-Occurring Mental and Substance Use Outpatient Teams

Provider:	**Behavioral Wellness**
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures	$2,939,500
Estimated CSS Funding	$1,080,200
Estimated Medi-Cal FFP	$1,216,400
Estimated 1991 Realignment	$642,900
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer	$8,569
Estimated Total of Consumers Served	343
Target Population Demographics Served	TAY, Adults, Older Adults

The Co-Occurring Outpatient Teams offer consumer-driven services and customize services based on individual needs. In the past three-year stakeholder process, stakeholders' priorities were to focus on dual diagnosis rather than solely on the consumers' mental health needs. Accordingly, specialized outpatient Co-Occurring Teams are based in North, West and South County, and were designed for adults 18 and older. Consumers diagnosed with a severe mental illness and a co-occurring alcohol or other drug (Substance

Use Disorder (SUD)) issue are identified for this specialized level of service. More specifically, this may include consumers who 1) have SUD-related legal issues, 2) have been recently discharged from a detoxification program, or 3) have a history of substance use.

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

Program Challenges and Solutions

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

Program Performance (FY 18-19)

Behavioral Wellness: Adult Co-Occurring Teams

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	0	0	0
16-25	10	4	1
26-59	98	126	66
60+	7	30	1
Missing DOB	0	0	0
Total	**115**	**160**	**68**
Gender			
Female	50	59	44
Male	65	101	24
Unknown	0	0	0
Ethnicity			

	Unique Clients Served		
	North	South	West
White	45	91	35
Hispanic	60	51	23
African American	5	6	7
Asian/Pacific Islander	1	3	2
Native American	1	1	1
Other/Not Reported	3	8	0

Client Outcomes

Milestones of Recovery Scale (MORS) Age: 18+		
	Initial to 6 months (n = 291)	6 to 12 months (n = 255)
Showed improvement^	31%	26%
Remained stable^	44%	51%

Higher Levels of Care	% during program admission in FY 18-19		
	North	South	West
Incarcerations	--	--	--
Psychiatric Inpatient Care	1%	4%	1%

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

In the 2018-2019 fiscal year, clients in the Adult Co-Occurring Teams had initial, 6-month and 12-month MORS data. In the first six months of engagement, a third of clients improved, while 44% remained stable, and in the second six months, a quarter of clients improved and half remained stable. Taken together, in the first year in the program, three-quarters of clients either improved or remained stable.

The client outcomes table displays the percent of clients who experienced an inpatient psychiatric hospitalization during their admission to the program in the 18-19 fiscal year. One percent of clients in North county, 4% of clients in South County, and 1% of clients in West County experienced hospitalization. Incarceration/juvenile hall data were unavailable this year and we are unable to report on these metrics.

Children Wellness, Recovery and Resiliency (WRR) Teams

Provider:	Behavioral Wellness
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures	$5,557,800
Estimated CSS Funding	$1,374,200
Estimated Medi-Cal FFP	$3,157,300
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	$1,026,300
Estimated Other Funding	
Average Cost Per Consumer	$4,734
Estimated Total of Consumers Served	1,174
Target Population Demographics Served	Children, TAY

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

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

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

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

A specialized service provided within the WRR program is "Katie-A" treatment that focused on intake and assessment of all children referred by Social Services (Child Welfare Services). Those Katie-A children requiring the WRR level-of-care either remain with the clinic-based WRR team or are referred to the Pathways to Wellbeing Program (a program provided by a contracted Community Based Organization, which varies per region), and those Katie-A children requiring a higher level-of-care are connected to more intensive services, such as the clinic's Full Service Partnership (FSP) SPIRIT Program, Intensive Home Based Services (IHBS), Therapeutic Based Services (TBS) and/or Wrap-163. As indicated in the Core Practice Model Guide, developing by the California Department of Health Care Services (DHCS), Katie-A services are provided within a cross-sector, team

environment to build a culturally relevant and trauma-informed system of support and services that is responsive to the strengths and underlying needs of each child and family. Katie-A services include Intensive Care Coordination and Intensive Home-Based Services when a client is requiring a higher level-of-care, in addition to Child and Family Team (CFT) meetings to bring all supportive parties together for the benefit of the child and family. For team consultation related to Wrap-163 and residential treatment referral recommendations, the Interagency Placement Committee (IPC) was implemented in October 2018 to include Behavioral Wellness, Social Services and Probation as the voting representatives. This Committee focuses on streamlining and tracking all children in placement or at risk of placement in partnership with the Department of Social Services, Probation, schools, and the Regional Center. The overarching goal is to further implement the Continuum of Care Reform (CCR) for children across systems.

Program Challenges and Solutions

A significant challenge is that many children are being returned to their home counties with the closure of statewide, out-of-county group homes. This includes group homes closing in our county, as well, which has led to not having the local continuum of care required for higher needs children/youth. As a result, there has been an increase of children/youth being hospitalized out-of-county. In response to this evolving challenge, during the FY 19-20, Behavioral Wellness designating Access and Assessment roles in the Prevention Early Intervention (PEI) Programming to support this function at each of the clinics. Additionally, Behavioral Wellness established Katie-A Practitioner Assessor staff positions in partnership with the Department of Social Services to meet the increased demands of Katie-A referrals countywide. These Katie-A Practitioner Assessors are currently co-located at Social Services to collaborate more directly with social workers for improved care of Katie-A designated youth. In FY 19-20, Behavioral Wellness also pursued interested community partners, who wanted to serve foster care youth within a Therapeutic Foster Care model. Children placement services, including foster care, continues to be reformed statewide, in which the Core Practice Guide Model is being integrated across sectors to expand and improve collaboration efforts between Behavioral Wellness, Social Services, Probation, and Community Based Organizations to improve care. Additionally, beginning in July 2019, Behavioral Wellness' community based organizational partners, Community Action Commission (CAC), augmented their staffing to co-locate Case Workers at the Behavioral Wellness clinics to form a new Full-Service Partnership (FSP) program in each region serving Transitional Aged Youth (TAY) ages 16-25, named FSP New Heights TAY. Behavioral Wellness continues to reviews whether children's crisis residential unit(s) be added to the continuum of care offered within the county through MHSA funding to improve the full breadth of services being provided. In addition, Youth focused proposals are included in this FY 2020-23 Plan Update, see proposal section for details.

Program Performance (FY 18-19)

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

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	403	228	193
16-25	123	167	60
26-59	0	0	0
60+	0	0	0
Missing DOB	0	0	0
Total	**526**	**395**	**253**
Gender			

Female	267	206	133
Male	259	188	120
Missing	0	1	0
Ethnicity			
White	129	106	65
Hispanic	365	249	164
African American	15	5	8
Asian/Pacific Islander	1	2	1
Native American	1	1	1
Other/Not Reported	15	32	14

Client Outcomes

Child & Adolescent Needs & Strengths Assessment (CANS-50) Age: 6-20 years	**Percent Improvement**	
	Initial to 6 months	**6 to 12 months**
Life Functioning (e.g., ability to communicate and interact with families, communication, social functioning and health status)	--	--
Behavioral/Emotional Needs (e.g., symptoms of depression, anxiety, psychosis and other conditions)	--	--
Risk Behaviors (e.g., self-injury, suicidal behavior, bullying, and running away)	--	--
Cultural Factors (e.g., language, traditions, stress)	--	--
Caregiver Resources & Needs (e.g., child supervision skills, family stress levels, residential stability, and caregiver physical/mental health status)	--	--
Strengths (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment)	--	--

Higher Levels of Care	**% during program admission in FY 18-19**		
	North	**South**	**West**
Incarcerations/Juvenile Hall	--	--	--
Psychiatric Inpatient Care	3%	2%	1%

Due to a state mandated change, Santa Barbara County began using a new version of the CANS (CANS-50) in July 2018. This change in instrumentation made all existing CANS reports (such as compliance and outcomes) obsolete. Due to the analytic complexity of the CANS and the desire for clinicians and supervisors to be able to review their client strengths and needs over time, Santa Barbara County is in the process of contracting with a CANS and PSC software provider. In addition to changing versions, the CANS age range was also extended to age 20.

The client outcomes table displays the percent of clients who experienced an inpatient psychiatric hospitalization during their admission to the program in the 18-19 fiscal year. Three percent of clients in North county, 2% of clients in South County, and 1% of clients in West County experienced hospitalization. Incarceration/juvenile hall data were unavailable this year and we are unable to report on these metrics.

Adult Wellness and Recovery Outpatient (WR) Teams

Provider:	Behavioral Wellness
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures	$6,070,000
Estimated CSS Funding	$1,525,100
Estimated Medi-Cal FFP	$2,529,800
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	$2,015,100
Estimated Other Funding	
Average Cost Per Consumer	$8,609
Estimated Total of Consumers Served	705
Target Population Demographics Served	TAY, Adult, Older Adult

The Wellness and Recovery (WRR) teams provide services to adults in a clinic setting that are a lower level of care. All staff have been trained in relevant Evidenced-based Practices, including Cognitive-Behavioral Treatment and Trauma-Informed Care. Team members provide services in a variety of modalities including groups addressing trauma, depression and life skills. Groups related to improved health outcomes have been introduced. Consumers served in this team are also linked with services provided by the Department of Rehabilitation. A manual for Team-Based Care has been developed and implemented which articulates the roles and interactions for each team member and provision of services. In addition, case management services are always available to consumers to assist them with obtaining and maintaining housing, linking them to primary health care providers, and providing financial management support. In Lompoc those clients that are in WRR and are stable are being linked to the Recovery Learning Center (RLC) medication support services. This new service provides medication support and links clients to the RLC within the RLC site. At the RLC site clients are engaged in peer support services where clients are not required to participate in the Adult Behavioral Wellness clinic. The goal is to expand similar services in North and South County in the upcoming year. The RLC in South County was launched in November of 2019 in collaboration with the Mental Wellness Center (MWC). The RLC pilot includes participants who are in the Maintenance Phase of treatment, having met their identified treatment plan goals and would be candidates for medication support services at MWC. Medication support services are provided by a psychiatrist based at MWC two days per week, bi-weekly for 8 hours per day and would provide services to approximately 8 - 10 clients.

Program Challenges and Solutions

The WRR program was initially designed to serve consumers who are higher functioning and will be appropriate for step-down to a lower level of care. In practice, a different reality emerged because of a variety of factors: the lack of step-down options available in the community, especially for Psychiatry, remains non-existent or very limited in all regions, especially if the consumer has Medicare or Medicare/Medi-Cal insurance. Consumers who likely can step down remain at the clinic receiving services as a consequence of the lack of other treatment options. The result of this barrier is that the WRR teams are comprised of consumers with a wide variety of diagnoses and treatment needs that stretches staff resources and impacts good consumer care. The core clinic has implemented a complex capable level of care approach. Levels of care have been augmented with the launch of the RLC pilot program in South County where clients can receive medication support services in their community which allows for a step down in level of care with the ultimate goal of transitioning clients fully into their communities building on client's network of natural supports.

Program Performance (FY 18-19)

Behavioral Wellness: Adult Wellness, Recovery & Resilience Teams

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	0	0	0
16-25	10	2	15
26-59	166	196	190
60+	14	74	38
Missing DOB	0	0	0
Total	**190**	**272**	**243**
Gender			
Female	106	138	149
Male	84	134	94
Unknown	0	0	0
Ethnicity			
White	69	146	126
Hispanic	100	85	78
African American	9	11	22
Asian/Pacific Islander	6	16	7
Native American	2	1	3
Other/Not Reported	4	13	7

Client Outcomes

Milestones of Recovery Scale (MORS) Age: 18+		
	Initial to 6 months (n = 622)	**6 to 12 months (n = 548)**
Showed improvement^	27%	23%
Remained stable^	52%	55%

Higher Levels of Care	**% during program admission in FY 18-19**		
	North	**South**	**West**
Incarcerations	--	--	--
Psychiatric Inpatient Care	1%	3%	2%

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

In the 2018-2019 fiscal year, clients in the Adult Wellness, Recovery, and Resilience Teams had initial, 6-month and 12-month MORS data. In the first six months of engagement, a quarter of clients improved, while half remained stable. In the second six months, almost a quarter of clients improved and 55% remained stable. Taken together, in the first year in the program, almost 80% of clients either improved or remained stable.

The client outcomes table displays the percent of clients who experienced an inpatient psychiatric hospitalization during their admission to the program in the 18-19 fiscal year. One percent of clients in North County, 3% of clients in South County, and 2% of clients in West County experienced hospitalization. Incarceration/juvenile hall data were unavailable this year and we are unable to report on these metrics.

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

Provider:	**CALM, Family Service Agency**
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures	$670,600
Estimated CSS Funding	
Estimated Medi-Cal FFP	$258,500
Estimated 1991 Realignment	$412,100
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer	$5,882
Estimated Total of Consumers Served	114
Target Population Demographics Served	Children, TAY

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

Behavioral Wellness' community-based organizational partner, CALM, provides the Pathways to Well-Being program covering the Santa Barbara (South County) and Lompoc (West County) regions, while community-based organizational partner, Family Services Agency (FSA) provides the Pathways to Well-Being program in the Santa Maria region (North County). The Pathways to Well-Being program in these regions have continued to be enhanced with adjunct services funded through the Department of Social Services. These include Family Drug Treatment Court, the Intensive Family Reunification Program and the Trauma-Informed Parenting Workshop series, all of which provide services to the youth's caregivers and have demonstrated decreased changes in placement and an increase in successful reunifications and adoptions.

Program Challenges and Solutions

While the annual caseloads for Katie-A youth continue to increase, it appears that with the specialization of the Katie-A screening and referral process, more children in foster care are being referred to the appropriate levels-of-care and the Pathways to Well-Being program referrals have declined as more children are being identified for a requiring a higher level-of-care. In FY 18-19, the Department streamlined processes and allowed providers to conduct the assessments, thereby decreasing the amount of wait time from referral to actual service by the

youth and his/her foster family. The wait time in FY 19-20 continues to decrease. Due to the Continuum of Care Reform (CCR), the children that are in presumptive transfer status to our county from another county are typically youth that require a higher level-of-care and therefore would not be appropriately served within the Pathways to Well-Being program (mild-to-moderate mental health needs). With the decline in number of referrals to the Pathways to Well-Being program, the need for increased staffing has emerged to serve Katie-A youth with higher level-of-care needs. With the CCR changes being implemented per the state mandate, this has resulted in a reduction of certified group homes, and thus less intensive treatment resources available to children that require the highest level-of-care. As such, the most severe children are being served in foster care at an outpatient level within our county rather than being able to receive intensive specialty mental health treatment in a 24/7 group home facility. Behavioral Wellness continues to partner closely with the Department of Social Services to with the shared goal to promote continued engagement of community-based partners seeking to provide similar services through becoming certified through the State to provide specialty mental health group home services.

Program Performance (FY 18-19)

Pathways to Well Being

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	20	23	58
16-25	5	4	4
26-59	0	0	0
60+	0	0	0
Missing DOB	0	0	0
Total	**25**	**27**	**62**
Gender			
Female	16	13	33
Male	9	14	29
Unknown	0	0	0
Ethnicity			
White	3	12	13
Hispanic	21	13	42
African American	0	0	3
Asian/Pacific Islander	0	0	0
Native American	0	0	1
Other/Not Reported	4	12	16

Client Outcomes*

Child & Adolescent Needs & Strengths Assessment (CANS-50) Age: 6-20 years	Percent Improvement	
	Initial to 6 months	**6 to 12 months**
Life Functioning (e.g., ability to communicate and interact with families, communication, social functioning and health status)	--	--
Behavioral/Emotional Needs (e.g., symptoms of depression, anxiety, psychosis and other conditions)	--	--
Risk Behaviors (e.g., self-injury, suicidal behavior, bullying, and running away)	--	--
Cultural Factors (e.g., language, traditions, stress)	--	--
Caregiver Resources & Needs (e.g., child supervision skills, family stress levels, residential stability, and caregiver physical/mental health status)	--	--
Strengths (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment)	--	--
Other Outcomes	**Average per quarter**	
	North (FSA)	**South & West (CALM)**
Incarcerations/Juvenile Hall	2%	0%
Out-of-Home Placement	8%	8%
Purposeful Activity (employed, school, volunteer)	99%	100%
Stable/Permanent Housing	--	99%
Higher Levels of Care	**% during program admission in FY 18-19**	
	North (FSA)	**South & West (CALM)**
Psychiatric Inpatient Care	0%	0%

Due to a state mandated change, Santa Barbara County began using a new version of the CANS (CANS-50) in July 2018. This change in instrumentation made all existing CANS reports (such as compliance and outcomes) obsolete. Due to the analytic complexity of the CANS and the desire for clinicians and supervisors to be able to review their client strengths and needs over time, Santa Barbara County is in the process of contracting with a CANS and PSC software provider. In addition to changing versions, the CANS age range was also extended to age 20.

Most outcomes are tracked and reported quarterly by the program; all data provided except inpatient admissions reflects the average per quarter. In the 2018-2019 fiscal year, clients in the Pathways to Well Being Program had quite positive outcomes. In South and West County, no clients experienced any juvenile hall stays, all clients were engaged in purposeful activities, and 99% had stable housing. Eight percent experienced out of home placement. In North County, 2% experienced any juvenile hall stays, and 8% experienced out of home placements, while nearly all clients were engaged in purposeful activities (99%). Housing data was not available for clients in North County.

The client outcomes table also displays the percent of clients who experienced an inpatient psychiatric hospitalization during their admission to the program in the 18-19 fiscal year. No clients in North, South, or West County experienced hospitalization.

Crisis Residential Services North, South, and Agnes

Provider:	Crestwood, Telecare, Behavioral Wellness
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures	$2,816,000
Estimated CSS Funding	$ 584,700
Estimated Medi-Cal FFP	$1,973,300
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$ 258,000
Average Cost Per Consumer	$ 8,559
Estimated Total of Consumers Served	329 (additional consumer anticipated with Agnes)
Target Population Demographics Served	TAY, Adult, Older Adult

The Department of Behavioral Wellness offers voluntary residential recovery programs to clients in crisis in both North (Santa Maria and Agnes) and South (Santa Barbara) County. These facilities were operated by Anka Behavioral Health (Anka) until May 2019. During the 30-day FY 19-20 MHSA posting period, Anka filed bankruptcy and new contracts for the services were authorized for Crestwood and Telecare for July 2019 to December 2020. As a result of COVID-19, these contracts are extended until December 2020 and a Request for Proposals will be issued Summer 2020 for the long-term service provision. The Programs allow clients in crisis, who have a serious mental illness, to receive treatment from Mental Health Practitioners, Caseworkers, Peer Recovery Assistants, and Psychiatrists, while participating in various recovery programs. Clients can stay at either facility for up to 90 days at a time and have designated visitation hours. Residential crisis services aim to:

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

Program Challenges and Solutions

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

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

The South County CRT opened in July 2015. In November 2017, its capacity increased from 8 to 10 beds. North County currently offers 10 beds.
Behavioral Wellness coordinated the development of a new Crisis Residential unit in North County that opened Fall 2019 at Agnes St. The new location has eight beds and the facility development costs are funded by a grant from the California Health Facilities Financing Authority (CHFFA). As a result, a redesign of staffing patterns in all three locations is occurring which will leverage all the resources to accommodate the varied levels of care needed including greater medical support and coordination of services throughout the County.

Focus on the forensic population modified staffing and resources at the North CRT location with implementation of current diversion felony services in coordination with multiple county departments and the Department of the State Hospital (DSH). Facility improvements and service provision for felony services in in development and anticipate full deployment in FY 2020-21. The goal of the DSH grant is to provide six individuals who are incompetent to stand trial in jail a continuum of services in the community for at least thirty days. Activities in the grant include setting up shared workflows in various county departments, common assessment tools, and master leasing for community housing. Step-down housing that links consumers from CRT to a community living location is anticipated in Fall 2020.

Program Performance (FY 18-19)

Crisis Residential

Unique Clients Served		
	North	**South**
Age Group		
0-15	0	0
16-25	32	25
26-59	133	108
60+	15	16
Missing DOB	0	0
Total	**180**	**149**
Gender		
Female	68	56
Male	111	93
Unknown	1	0
Ethnicity		
White	92	82
Hispanic	56	40
African American	19	12
Asian/Pacific Islander	4	3
Native American	1	0
Other/Not Reported	8	12

Client Outcomes

Higher Levels of Care	**% during program admission in FY 18-19**	
	North	**South**

Incarcerations	--	--
Psychiatric Inpatient Care	3%	1%

Psychiatric Inpatient Care

The client outcomes table displays the percent of clients who experienced an inpatient psychiatric hospitalization during their admission to the program in the 18-19 fiscal year. Three percent of clients in North County and 1% of clients in South County experienced hospitalization. Incarceration/juvenile hall data were unavailable this year and we are unable to report on these metrics.

Follow Up Outpatient Services

During fiscal year 2018-2019, approximately 70% of clients served by CRT were connected to long-term outpatient care within the mental health system, which is an increase from the previous fiscal year (fiscal year 2017-2018 saw 66% of clients connected to outpatient care). Within the group who engaged in subsequent outpatient services, 81% of clients attended their first outpatient appointment within 30 days of discharge from the CRT.

Client Satisfaction

Client satisfaction with services received at the Crisis Residential Treatment Program was evaluated at client discharge using the Consumer Satisfaction Questionnaire (CSQ). Because this survey was administered by Anka, it is only available on clients seen in those programs through May, 2019. During Fiscal Year 2018-2019, clients (*N* = 189) indicated that they were satisfied with their experiences at the CRT and treatment by staff members. Average satisfaction in all categories was high and fell between agree = 4 and strongly agree = 5 for an average of three quarters of respondents. Survey items are below:

CRT Satisfaction Survey	
North and South CRT (n = 189)	**% Agree or Strongly Agree**
The program has helped me deal with my problems.	79%
I was able to make choices in the services I received.	79%
I received the services as described to me during intake.	82%
I was helped in obtaining employment or education.	65%
I was satisfied with the services I received.	80%
The facility was clean, comfortable, and inviting.	82%
My questions were answered quickly.	76%
I helped to develop my treatment plan.	77%
I gained tools necessary for my recovery.	80%
The program helped me with my overall needs.	81%
The admission process was prompt and courteous.	80%
I felt understood and respected by staff.	81%
The services I received has helped me to feel better about myself.	82%
I was able to participate in program activities such as chores and groups.	83%
I am leaving the program with a clear discharge/follow up plan.	83%
Program staff worked with me to develop a written housing plan to follow upon discharge.	74%
I was given assistance with obtaining benefits (veterans, SSI/SSDI, Medicaid)	64%
Staff were sensitive to my cultural background (race, religion, language, etc.)	78%
I saw the doctor using telemedicine and the experience was as good as seeing the doctor in person	75%
I felt comfortable talking to the doctor using telemedicine	73%

I would use telemedicine again	75%

Note. This data is for clients served by Anka, which closed in May, 2019. Clients who were seen by Crestwood or Telecare in the last month of the fiscal year are not included.

Client Behavioral Health Symptoms

The Santa Barbara Crisis Residential Program was opened to help improve the active behavioral health symptoms of individuals in crisis due to severe mental illness and substance use while connecting them to outpatient treatment and stable housing. Individuals' self-reported active behavioral health symptoms were measured by the Symptom Checklist (SCL) at intake and discharge. The SCL asks clients to rate themselves on a four-point scale ranging from 0 = *Not at all*, 1 = *A little bit*, 2 = *Moderately*, 3 = *Quite a bit*, and 4 = *Extremely*. Clients' scores on each item were summed for an overall general psychological distress score ranging from 0-10 = *Low distress*, 10-20 = *Moderate distress*, 20-30 = *Quite a bit of distress*, and 30-40 = *Extremely distressed*. Because Anka closed before the end of the fiscal year, data on this metric was only provided on clients from the first two quarters of the fiscal year (n = 204 at intake; n = 159 at discharge). This data is examined in two ways: (1) comparing pre- and post-treatment averages; and (2) comparing client change in their category/level of psychological stress.

(1) For CRT North, clients reported a mean level of symptoms of 13.8 (moderate) at intake, and 10.6 (moderate) at discharge. This corresponds to a 23% reduction in symptoms. For CRT South, clients reported a mean level of symptoms of 18.7 (moderate) at intake, and 11.1 (moderate) at discharge. This corresponds to a 41% reduction in symptoms.

(2) For CRT North, 30% of clients reported experiencing "quite a bit" or "extreme" distress at intake, while at discharge, this was halved to 15%. For CRT South, 51% of clients reported experiencing "quite a bit" or "extreme" distress at intake, while at discharge, this was halved to 25%. Therefore, in looking only at clients who acknowledge significant acute symptoms, and who completed the discharge survey, the number of clients who reported experiencing high levels of distress was halved in both programs.

Housing

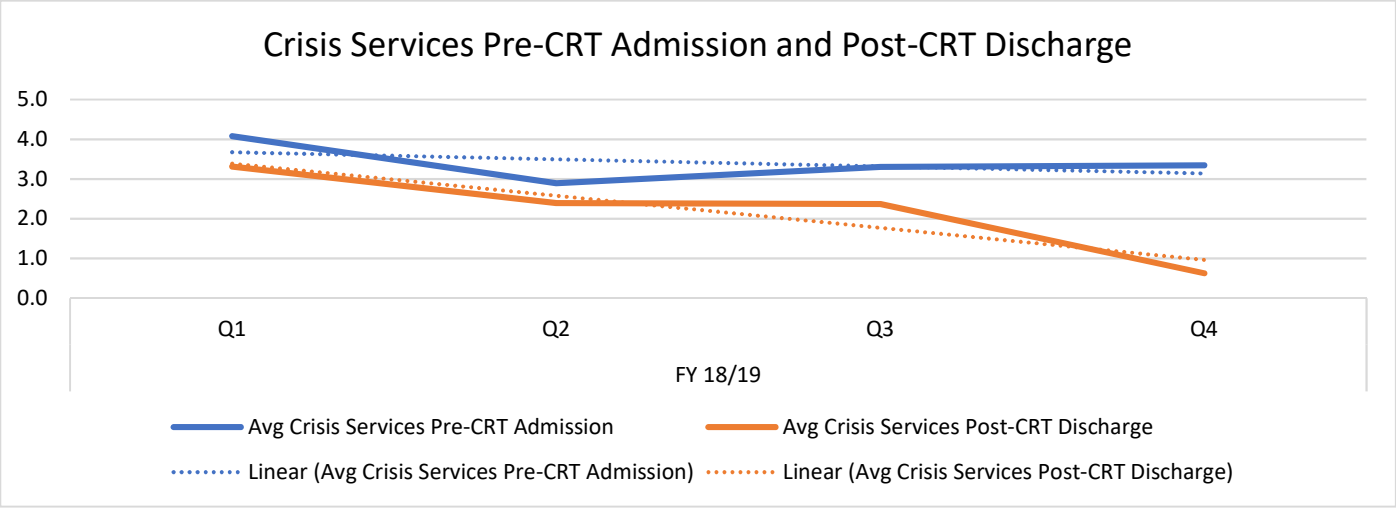
Because Anka closed before the end of the fiscal year, data on this metric was only provided on clients from the first two quarters of the fiscal year. For CRT North, almost two-thirds of clients were homeless (or at imminent risk) at intake while about one-third were in stable or permanent housing. At discharge, a quarter were homeless while 44% were stably housed. It should be noted that housing status was unknown for almost 30% of clients at discharge. Even if the unknown clients did become homeless after discharge, CRT North was able to stabilize housing for 7% of their clients. For CRT South, almost four-fifths of clients entered the program homeless or at imminent risk, while only one-fifth were in stable housing. At discharge, 57% were stably housed, a 35% increase in stable housing for clients.

Program Participation

Clinicians rated clients' Program participation on the Discharge Summary form. Clinicians rated clients as 1 = *Did not engage,* 2 = *Partially engaged,* and 3 = *Fully engaged.* Clients that were rated as partially engaged (2) or fully engaged (3) were considered to be demonstrating high levels of program participation. Because Anka closed before the end of the fiscal year, data on this metric was only provided on clients from the first two quarters of the fiscal year. For CRT North, over half of clients were fully engaged, while another fifth was partially engaged. For CRT South, almost three quarters were fully engaged and 12% were partially engaged. Both programs had about 10% of clients who did not engage.

Crisis Services Pre-CRT Admission and Post-CRT Discharge

To understand the impact of a CRT, stay on client stability, as well as the impact of CRT services on the crisis system, we examined the number of crisis services that clients received in the six months prior to their CRT admission and the six months after their CRT discharge. As seen in the chart below, clients' average number of crisis services billed in the six months prior to their CRT stay was between about 3.4 and 4.1 services. In the six months following their CRT stay, clients billed between 3.2 and 0.6 services. The gap between the two solid lines shows the difference in any one quarter, and it appears that clients' average crisis services declined between 0.5 and 3.0 depending on the quarter. Over the fiscal year, there was a large drop in the number of crisis services billed post-CRT stay. We look forward to seeing if this positive trend continues into next fiscal year.



Medical Integration Program

Provider:	**Behavioral Wellness**
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures	$2,418,200
Estimated CSS Funding	$ 405,300
Estimated Medi-Cal FFP	$ 566,300
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	$1,446,600
Estimated Other Funding	
Average Cost Per Consumer	$ 12,660
Estimated Total of Consumers Served	191
Target Population Demographics Served	TAY, Adult, Older Adult

The specialized Medical Integration teams in each region of the County serve persons with severe mental illness who also experience serious medical problems, including individuals who are 60 years of age and over. Teams address the complex needs of this population, including multiple medication management and the prevalence of significant physical and mental health conditions. In the past year, 191 consumers have been identified and assigned to these teams. With ongoing evaluation and program development the Teams learned that age alone

was not a clinically appropriate determination for assignment to this Program. Each consumer is now being assigned based on the existence of complex medical needs to ensure individualized treatment.

The Teams serve:

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

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

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

Program Challenges and Solutions

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

The original vision for the implementation of three specialized programs (Wellness Resilience Recovery, Medically Integrated Older Adult, and Co-Occurring Disorders) was for staff positions to be flexible. Fiscal structure did not allow for staff movement which created stagnation of consumers in programs that no longer applied to them after specialized treatment was provided. Consumers naturally became attached to their originally assigned clinicians, but were reassigned to new clinicians when transferring from program to program. These transfers created ruptures in therapeutic relationships or a lack of fidelity to fiscal organizational structures when consumers were kept with the original clinician. In order to address these challenges, the Department has recently moved three specialized programs towards becoming Complex Capable. Program staff have been trained to become more Complex Capable and the need to transition clients to different programs within clinics is no longer be necessary minimizing disruption of therapeutic alliances.

Another challenge has been seamlessly transitioning clients who have graduated from their program but still have need for medication management to their primary care providers. Although some community based medical organizations/agencies have been hesitant to manage mental health medications, medical staff continue to outreach in the community to develop relationships with primary care providers.

Program Performance (FY 18-19)

Behavioral Wellness: Medical Integration and Older Adult Teams

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	0	0	0
16-25	1	1	0
26-59	28	17	37
60+	54	36	17
Missing DOB	0	0	0
Total	**83**	**54**	**54**
Gender			
Female	48	38	33
Male	35	16	21
Unknown	0	0	0
Ethnicity			
White	53	26	30
Hispanic	24	23	16
African American	4	2	6
Asian/Pacific Islander	1	1	1
Native American	1	0	0
Other/Not Reported	0	2	1

Client Outcomes

Milestones of Recovery Scale (MORS) Age: 18+		
	Initial to 6 months (n = 177)	**6 to 12 months (n = 153)**
Showed improvement^	25%	17%
Remained stable^	57%	63%

Higher Levels of Care	**% during program admission in FY 18-19**		
	North	**South**	**West**
Incarcerations	--	--	--
Psychiatric Inpatient Care	1%	0%	0%

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

In the 2018-2019 fiscal year, clients in the Medical Integration and Older Adult Program had initial, 6-month and 12-month MORS data. In the first six months of engagement, a quarter of clients improved and over half were stabilized, and in the second six months, 17% of clients improved and nearly two-thirds were stabilized. Examined another way, over the year, about 80% of clients were either stable or made improvements.

The client outcomes table displays the percent of clients who experienced an inpatient psychiatric hospitalization during their admission to the program in the 18-19 fiscal year. One percent of clients in North county and no clients in South or West County experienced hospitalization. Incarceration/juvenile hall data were unavailable this year and we are unable to report on these metrics.

Adult Housing Support Services

Provider:	**Behavioral Wellness, Psynergy, Pathpoint, Mental Wellness Center**
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures	$2,887,100
Estimated CSS Funding	$320,700
Estimated Medi-Cal FFP	$766,600
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	$1,799,800
Estimated Other Funding	
Average Cost Per Consumer	$22,380 (Some provider's support services, others all housing costs, each provider is varied in MHSA support)
Estimated Total of Consumers Served	Prior year of 119 plus Polly's House (10 beds) =129
Target Population Demographics Served	TAY, Adult, Older Adult

During prior years' stakeholder forums, additional housing has been raised as an issue. This year, the Department has opened a 35-unit residence for MHSA eligible clients; opened a new intensive Residential Program; and began construction on a 14-unit No Place Like Home (NPLH) funded housing project. In FY 20-21, the Department plans to begin construction on a 20-unit NPLH-funded housing project; open a Homeless Navigation Respite Center; and apply for competitive NPLH funding for a future housing project. The Department will continue to review and modify the types of adult housing supports, such as rental subsidies, based on funding available.

Included in this program is mental health support services for:

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

- West Cox Cottages: Construction is beginning on a housing project with 13 NPLH-funded units for persons with a serious mental illness who are experiencing homelessness. This project will have an MHSA funded caseworker onsite to provide supportive services and help coordinate additional services.

- Hollister Lofts: The Department has applied, and passed the initial threshold review, for NPLH competitive funding for a 20-unit housing project for persons with a serious mental illness who are experiencing homelessness. If awarded funding, construction would begin in January 2021, and would have a case worker onsite to provide supportive services and help coordinate additional services.

- Homeless Navigation Respite Center: Our Department is currently drafting an RFP to solicit proposal for a homeless service's operational organization. Our plan is to use one-time Homeless Services funding to operate a short-term Homeless Navigation Center that would temporarily house 30 people and provide services and connect residents with long-term services and housing. As a result of COVID-19, the model of this site is on hold pending social distancing and funding protocols.

For the above programs, initially State grant funding would provide the support services for the multidisciplinary support services at this and the other units and the operator's costs at the respite center. Adult Housing Supports or Homeless Outreach Services would provide the ongoing behavioral health support to residents and those sheltering on a long-term basis should MHSA funding be available.

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

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

- **Pathpoint** which offers residential board and care at Phoenix and Mountain House Adult Housing Supports. Behavioral Wellness renegotiated PathPoint's FY 18-19 contract to incorporate services that were previously provided by Phoenix of Santa Barbara, Inc. dba Crescend Health (Crescend Health) due to a merger between the two organization where there was a change of ownership and PathPoint assumed all of Crescend Health's daily operations. This include a redesign from the Phoenix contract to include MHSA principles, peer services, and enhanced focused on case management and support group activities. On July 1, 2018, PathPoint took over the two facilities (Mountain House and Phoenix House) and now operate the two residential programs. Also supported is other Pathpoint residential units support costs as necessary for MHSA clients.

- **Mental Wellness Center's (MWC)** which includes the addition of a new Intensive Residential Program, Polly's House, and extended peer services and group supports. It opened fall of 2019. The intent of the Program is to coordinate housing for adults primarily served through the MHSA. Now that Polly House is fully operational, Mental Wellness Center will provide twenty-four (24) hour per day, seven (7) days per week psychiatric rehabilitation, residential care and room and board services to a caseload of ten (10) clients. The Department is looking to also perhaps partner with MWC to add more beds within MHSA.

Program Challenges and Solutions

The Department continues to work towards building adequate infrastructure, and adding to the housing continuum while acknowledging that additional components may be needed as the demand for housing increases and the type of housing desired varies depending on region. Along with the No Place Like Home initiative, establishment of additional crisis residential, and flexible housing assistance, such as: short-term shelters, rental subsidies, security deposits, utility deposits will be explored to the extent available. Additionally, the Department has partnered with other county agencies utilizing other state Homeless funding in the purchase of Heath House in South County in Spring 2020; whose adult housing support services maybe included in the future based on available grant funding for operations.

Behavioral Wellness also partnered with County Housing and Community Development (HCD) to fund the updated Homeless Housing Plan to ensure adequate supports in County in FY 19-20 along with partnering for a successful Request for Proposal (RFP) for development opportunities. Behavioral Wellness will attempt to seek

providers interested in master leasing and housing services management in FY 20-21 in order to ensure an enhanced support network when housing opportunities of funding become available.

Program Performance (FY 18-19)

Adult Housing Support Services

	Unique Clients						
	Mountain House	Phoenix House	Psynergy	McMillan Ranch	Artisan Court	Bradley Studios	El Carrillo
Age Group	Pathpoint	Pathpoint	Psynergy	Telecare	Pathpoint	Pathpoint	Pathpoint
0-15	0	0	0	0	0	0	0
16-25	0	3	2	0	0	0	0
26-59	13	14	21	8	8	2	17
60+	3	2	6	4	4	1	11
Missing DOB	0	0	0	0	0	0	0
Total	***16***	***19***	***29***	***12***	***12***	***3***	***28***
Gender							
Female	4	10	18	7	6	1	11
Male	12	9	11	5	6	2	17
Unknown	0	0	0	0	0	0	0
Ethnicity							
White	12	13	18	6	8	3	24
Hispanic	2	1	7	4	3	0	4
African American	2	2	2	1	1	0	1
Asian/Pacific Islander	0	1	1	1	0	0	1
Native American	0	0	1	0	0	0	0
Other/Not Reported	0	2	0	0	0	0	0

Program Outcomes*

	Average per Quarter						
	Mountain House	Phoenix House	Psynergy	McMillan Ranch	Artisan Court^	Bradley Studios^	El Carrillo^
Clean and Sober while in Treatment	*	91%	*	*	*		
Incarcerations	0%	0%	*	3%	*		
Physical Health Hospitalization	5%	4%	2%	*	*		
Stable/Permanent Housing	98%	*	*	*	100%		
Purposeful Activity (employed, school, volunteer)	44%	23%	*	50%	30%		
Transferred to Higher Level of Care	2%	4%	3%	3%	1%		

	Average per Quarter						
	Mountain House	**Phoenix House**	**Psynergy**	**McMillan Ranch**	**Artisan Court^**	**Bradley Studios^**	**El Carrillo^**
	% during program admission in FY 18-19						
	Mountain House Support Services	**Phoenix House Support Services**	**Psynergy**	**McMillan Ranch**	**Artisan Court**	**Bradley Studios**	**El Carrillo**
Psychiatric Inpatient Care	0%	9%	17%	8%	0%	0%	0%

* = Data not collected

^ = Data combined across three houses (all served by the same provider)

Examining program outcomes, it is important to note that providers were asked to report on some, but not all, of the same metrics. Therefore, an asterisk signifies that this metric was not assessed. Programs reported on each outcome quarterly to the Department of Behavioral Wellness. Ninety percent of clients per quarter in Phoenix House remained clean and sober while in treatment. No clients in Mountain and Phoenix House experienced incarceration. Similar portions of clients in all programs (2-5%) experienced physical health hospitalizations. Almost all clients in Mountain House, Bradley Studios, Artisan Court, and El Carrillo had stable/permanent housing and between a quarter and half of clients across programs were engaged in purposeful activity. Finally, during their enrollment in each program, very few clients had to be transferred to a higher level of care (1-4%).

The client outcomes table also displays the percent of clients who experienced an inpatient psychiatric hospitalization during their admission to the program in the 18-19 fiscal year. Nine percent of clients in Phoenix House, 17% in Psynergy, and 8% in McMillan Ranch experienced hospitalization during their admission. No clients at Mountain House, Artisan Court, Bradley Studios, or El Carrillo experienced inpatient hospitalization.

Santa Barbara City College
Suicide Prevention/Awareness Event:
Kevin Hines- Survivor, Storyteller

About Full Service Partnerships (FSPs)

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

New Heights TAY FSP

Provider:	**Behavioral Wellness, Community Action Commission, Department of Rehabilitation**
Estimated Funding FY 2020/21	
Estimated Total Mental Health Expenditures	$2,997,400
Estimated CSS Funding	$2,145,400
Estimated Medi-Cal FFP	$852,000
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer	$14,693
Estimated Total of Consumers Served	204
Target Population Demographics Served	Children, TAY, Adults (as they age within TAY continuum)

The New Heights FSP TAY program serves primarily transition-age youth (TAY), ages 16-25, who require assistance for serious emotional conditions or severe mental illness. These young adults age out of the Department of Behavioral Wellness Children's System of Care at age 25 and are at risk for homelessness. The New Heights FSP TAY program serves consumers experiencing mental health and substance abuse conditions. The New Heights FSP TAY program also renewed the Department of Rehabilitation (DOR) contract to continue to improve and enhance supportive employment services. The program model was developed using the TAY Subcommittee Resource Guide as approved by the California Mental Health Directors' Association in May 2005 and the Transition to Independence Process (TIP) System Development and Operations Manual. Beginning in July 2020, New Heights became a specialized FSP program for TAY in each region to allow the "Whatever It Takes" programming specific to this age group. This was a key proposal in the FY 2017-2020 MHSA plan which was achieved.

In FY 19-20, the team focused on both staff training and program implementation targeted towards this group. On December 3rd and 4th 2019, Behavioral Wellness hosted a two-day TIP regional training for our TAY Programs provided by STARS Behavioral Health. This training focused on the pervasive and profound impacts of trauma, and how to equip people with more effective ways to manage and overcome it. Tools for teaching emotional regulation, developing resiliency and self-compassion was shared and practiced.

Program Challenges and Solutions

The challenges encountered have been the increased number of clients that have been identified as Commercial Sexual Exploitation of Children (CSEC) youth or at risk of becoming commercially sexually exploited youth. Behavioral Wellness hosted a 5-part training series to address this specialized training need in order for staff to effectively intervene with this TAY aged sub-population of clients. These trainings took place on December 12, 2019 (Topic: Identification and Communication), January 15, 2020 (Topic: Building Coercion Resilience in the Face of Challenges in Recruitment & Engagement) February 12, 2020 (Topic: Dynamics of Interfamilial Human

Trafficking: Special Considerations in Working with Victims and Survivors) March 18th, 2020 (Topic: building Bridges: a Community-Wide Approach to Counter Gang Controlled Trafficking) and May 7th, 2020 (Topic: Supporting Survivors During COVID) . These trainings further developed the skill set for clinicians to provide effective interventions for TAY aged youth experiencing these challenges. As the Innovations Project for CSEC ends, this program known as RISE, will shift personnel and clients to the newly established New Heights FSP and this specialized expertise will be maintained by personnel on those teams as a high level of the TAY population is at risk for CSEC. The shifting of staff and clients and reconfiguring of the RISE County Facility in Santa Maria to an overall TAY focus begin July 2020.

The challenges encountered have been the increased need to expand employment resources that are specific to the TAY population. TAY specific resources for TAY housing is also a challenge because of the lack of short-term housing resources for this group. Behavioral Wellness and the State Department of Rehabilitation (DOR) and Work Force Development Board continue to work collaboratively to address these issues. In Fall of 2017, DOR and the Behavioral Wellness implemented employment services in each region which have effectively provided vocational supports to aid in linkage and employment for TAY. Moreover, beginning in January 2018, Behavioral Wellness became a Santa Barbara County Continuum of Care member. As a participating agency, we serve as a member of the CoC's Coordinated Entry Committee, and have committed to assess and refer eligible clients for homeless/housing services using a low barrier methodology, the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) through the coordinated entry system. The survey is administered to standardize and expedite the process by which people experiencing homelessness, or who are at risk of homelessness (youth, families, and adults), access housing and homeless resources; this process has been instrumental to successfully link Transitional Age Youth with locally available shelter, transitional housing, and permanent housing resources. TAY clinicians work closely with specially trained BWELL Homeless Outreach clinicians, who serve as mobile points of entry to Santa Barbara County's CES, and who are authorized to conduct field VI-SPDAT assessments. Although the results of the VI-SPDAT are primarily based on self-report, our clinicians are trained and skilled in building trust to elicit honest responses. The ongoing collaboration with BWELL Homeless Outreach has promoted the TAY team's ability to leverage housing and shelter resources for TAY aged youth experiencing homelessness.

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

Program Performance (FY 18-19)

New Heights – Transitional Age Youth (Outpatient level, now FSP in 19-20)

Unique Clients Served			
	North	**South**	**West**
Age Group			
0-15	0	0	4
16-25	83	32	79
26-59	1	5	0
60+	0	0	0
Missing DOB	0	0	0
Total	**84**	**37**	**83**
Gender			
Female	46	16	58
Male	38	21	25
Unknown	0	0	0
Ethnicity			
White	28	15	29
Hispanic	51	16	44
African American	3	1	5
Asian/Pacific Islander	1	1	0
Native American	0	0	0
Other/Not Reported	1	4	5

Client Outcomes

Child & Adolescent Needs & Strengths Assessment (CANS-50) Age: 6-20 years	**Percent Improvement**	
	Initial to 6 months	**6 to 12 months**
Life Functioning (e.g., ability to communicate and interact with families, communication, social functioning and health status)	--	--
Behavioral/Emotional Needs (e.g., symptoms of depression, anxiety, psychosis and other conditions)	--	--
Risk Behaviors (e.g., self-injury, suicidal behavior, bullying, and running away)	--	--
Cultural Factors (e.g., language, traditions, stress)	--	--
Caregiver Resources & Needs (e.g., child supervision skills, family stress levels, residential stability, and caregiver physical/mental health status)	--	--
Strengths (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment)	--	--
Milestones of Recovery Scale (MORS) Age: 18+		
	Initial to 6 months (n=101)	**6 to 12 months (n=91)**

Showed Improvement^		50%	29%
Remained Stable^		39%	45%
Higher Levels of Care	**% during program admission in FY 18-19**		
	North	**South**	**West**
Incarcerations/Juvenile Hall	--	--	--
Psychiatric Inpatient Care	3%	14%	1%

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

Due to a state mandated change, Santa Barbara County began using a new version of the CANS (CANS-50) in July 2018. This change in instrumentation made all existing CANS reports (such as compliance and outcomes) obsolete. Because of the analytic complexity of the CANS and the desire for clinicians and supervisors to be able to review their client strengths and needs over time, Santa Barbara County is in the process of contracting with a CANS and PSC software provider. In addition to changing versions, the CANS age range was also extended to age 20. This means that in future reports, more TAY-aged clients will receive a CANS.

In the 2018-2019 fiscal year, clients in the New Heights program had initial, 6-month and 12-month CANS and MORS data; however, we are only able to report the MORS data at this time. On the MORS, in the first six months of engagement half of clients improved, and in the second six months, over a quarter of clients improved. Further, almost half of clients were stable over the year, suggesting that even when not improving, a large portion of New Heights clients were stabilized. These data are similar to those reported last year.

The client outcomes table displays the percent of clients who experienced an inpatient psychiatric hospitalization during their admission to the program in the 18-19 fiscal year. Three percent of clients in North County, 14% of clients in South County, and 1% of clients in West County experienced hospitalization. Incarceration/juvenile hall data were unavailable this year and we are unable to report on these metrics.

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

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

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

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

Lompoc ACT FSP – Transitions Mental Health Association

Provider:	Transitions Mental Health Association / Behavioral Wellness
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures	$2,178,600
Estimated CSS Funding	$1,070,900
Estimated Medi-Cal FFP	$975,700
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$132,000
Average Cost Per Consumer	$21,151
Estimated Total of Consumers Served	103
Target Population Demographics Served	Adult, Older Adult

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

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

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

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

Program Challenges and Solutions

The West region of the County has limited FSP resource options due to a lack of supported community services program. As a result, the Department and TMHA reviewed how to incorporate FSP supported services into Lompoc and have created the level of care that allows supportive services for transition. Lompoc ACT offers a higher level of care than the Lompoc outpatient clinic and a transitional step down to supported services would possibly improve outcomes and offer individuals a better transition in the system. In Spring 2019, a pilot program

between the Department and TMHA began to offer psychiatric care at the Lompoc Recovery Learning Community for those who transition out of the intensive services. By creating these transition levels, the proposed changes will support clients in their recovery by ensuring adequate support throughout each step. Demonstrative progress towards this goal would be more consumers that are employed, housed, and a decrease in drop outs from our System of Care.

Santa Maria ACT FSP – Telecare

Provider:	**Telecare / Behavioral Wellness**
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures	$2,541,500
Estimated CSS Funding	$1,233,100
Estimated Medi-Cal FFP	$1,308,400
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer	$ 23,104
Estimated Total of Consumers Served	110
Target Population Demographics Served	TAY, Adult, Older Adult

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

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

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

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

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

Comprehensive reviews for each consumer are completed once a month to determine team placement. The Milestones of Recovery Scale (MORS) was implemented in 2015 and is utilized on the first Monday of the month for the prior month. Efforts are underway to be more inclusive of the consumer

in this process and to physically have them present whenever possible in comprehensive planning meetings and treatment plan development. Consumers are encouraged to be involved and take an active role in their own recovery.

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

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

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

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

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

G. Provide continuity across time

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

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

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

Program Challenges and Solutions

The community of Santa Maria has limited safe and affordable housing options; in particular, housing with support such as Room & Boards and Board & Cares. Additionally, some Board & Care facilities and Room & Board homes have recently closed in the region, and as a result, ACT has received an increase in referrals for clients who were homeless or at risk of being homeless. Some ACT clients have experienced hospitalizations due to instability in housing placement causing increased mental health symptoms and functional impairments. The MHSA Housing

Project on Depot St. adds 35 units in Santa Maria which could provide support to Department of Justice (DOJ) step down permanent housing for those who qualify.
SM ACT also had an increase in referrals of clients with active DOJ involvement such as recent incarcerations with Social Security Income (SSI) benefits terminated. ACT has had difficulty finding appropriate community services in order to maintain clients' placement in the community and prevent recidivism. Client involvement in meaningful activities such as employment, education, or volunteering remains a challenge for the ACT population. Telecare attempts to awaken hope and vocational interests in their clients through ongoing rehabilitative services. The Program has been impacted by limited resources and appropriate level-of-care services for clients actively using substances that increase their psychiatric symptoms. In December of 2018, the County's DMC-ODS waiver went live, it is anticipated that Medi-Cal clients with co-occurring substance use disorders will now have access to critical treatment services that will support their mental health treatment as well.

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

In order to provide services in the North region and at the required level of care, staffing will be evaluated between Telecare and the Department to best meet the needs of the Program while ensuring adequate coverage for both the medical staff and provider programming. A proposal includes perhaps hiring medical staff directly under the Telecare contract in order to enhance team cohesiveness and implementing tele-health capability as much as possible.

Santa Barbara ACT FSP – Behavioral Wellness

Provider:	**Behavioral Wellness**
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures	$3,648,600
Estimated CSS Funding	$2,150,900
Estimated Medi-Cal FFP	$1,497,700
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer	$ 31,184
Estimated Total of Consumers Served	117
Target Population Demographics Served	Adult, Older Adult

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

The team meets each morning to give a clinical report on which clients were seen in the last 24 hours and work together to ensure that all consumers are seen as needed; ACT staff collectively develop a master work schedule for the day's activities with clients. Every day and every week, staff are on duty to guarantee that each client receives the needed services and supports detailed in his or her treatment plan, as well as help in urgent or crisis situations. The team operates in a manner consistent with the ACT fidelity model, doing "whatever it takes" to ensure consumers are provided with case management, rehabilitation, therapy, and linkage to other supportive services in the community as needed. The daily staff meeting is attended by all ACT team members

who are on duty at that time. Santa Barbara ACT is committed to reducing homelessness, hospitalizations, incarcerations, and focuses on providing all services using a recovery-based, client-centered approach.

Program Challenges and Solutions

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

Over the past few years, the Santa Barbara ACT team has experienced challenges in staffing, which has impaired their ability to fully implement the fidelity model. This includes completing comprehensive assessments in order to get to know the consumers as fully as possible, thus facilitating the development of a treatment plan based upon the consumers' wishes and needs. Part of the goal for ACT full fidelity is to use the Individual Treatment Team (ITT) to review the summaries of the assessments, and build the treatment plan to be reviewed again with the consumer for final review. This takes place within the first 30 days. However, this has not been implemented, due to staffing challenges.

The team has had some recent changes, which included no longer having Vocational Rehab Specialists on the ACT team, based upon the availability of Vocational Rehab services within the county. This led to an increase in case managers on the ACT team. The team has also incorporated volunteer interns and paid interns to assist in completing each day's assignments. Because of low staffing, the ACT team has not been able to develop as many new groups as they planned (Seeking Safety, Dialectical Behavior Therapy (DBT); physical health (wellness); and co-occurring groups); as positions are filled, the plan is to develop Seeking Safety and DBT groups once fully staffed. The Santa Barbara ACT team is co-located in the same building as Homeless Services and Justice Alliance. This move has allowed for more collaboration between these Programs on clients' behalf; while the Program is field-based, so most client contact is not on-site, some clients who are downtown are able to drop in for appointments or medication more regularly. ACT clients have adapted positively to the change in location. The co-location with Homeless Services in particular, has also promoted greater ease of access to shelter bed and transitional housing resources, which have been of benefit to unsheltered and underhoused ACT clients, who would benefit from being placed in a more stable environment with additional onsite supports. ACT clients experiencing homelessness have also been regularly linked to Santa Barbara County's Coordinated Entry System, which Homeless Services acts as a Point of Entry to. This is another mechanism through which services are being leveraged for ACT clientele whom are homeless, at risk of homelessness, or underhoused. ACT remains focused on reducing returns to homelessness and ensuring housing stability for all consumers.

Another ongoing challenge for ACT is that the team currently only has two County vehicles in which to provide clients transportation to appointments, which has at times been a barrier to client attendance. ACT is working to secure another vehicle although staff have 24/7 access to the County Motor Pool resource if a designated assigned car isn't available. ACT clients also continue to access transportation through CenCal Medi-Cal and Easy Lift transportation services; in particular to access the Mental Wellness Center, which affords them social opportunities.

Program Performance (FY 18-19)

Assertive Community Treatment (ACT)

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	0	0	0
16-25	9	4	18
26-59	67	77	61
60+	34	36	24
Missing DOB	0	0	0
Total	**110**	**117**	**103**
Gender			
Female	47	49	57
Male	63	68	46
Unknown	0	0	0
Ethnicity			
White	62	67	57
Hispanic	35	35	36
African American	7	10	6
Asian/Pacific Islander	4	1	2
Native American	1	0	0
Other/Not Reported	1	4	2

Client Outcomes

Milestones of Recovery Scale (MORS) Age: 18+	**ACT**	
	Initial to 12 months (n = 294)	**12 to 18 months (n = 252)**
Showed improvement^	31%	20%
Remained stable^	47%	62%

	Average per Quarter		
	North	**South**	**West**
Incarcerations	4%	6%	1%
Physical Health Hospitalization	4%	8%	3%
Physical Health Emergency Care	8%	4%	6%
Stable/Permanent Housing	91%	93%	98%
Purposeful Activity (employed, school, volunteer)	18%	*	30%

Transferred to Higher Level of Care	2% (of total)	2% (of total) 36% (of discharges)	1% (of total)
Graduated to Lower Level of Care	*	2% (of total) 40% (of discharges)	8% (of total)
	% during program admission in FY 18-19		
	North	**South**	**West**
Psychiatric Inpatient Care	6%	7%	1%

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

In the 2018-2019 fiscal year, clients in ACT had initial, 12-month and 18-month MORS data. In the first year, about one third of clients improved while almost half stabilized. In the next six months, one-fifth improved while 62% stabilized. Across both time periods about 80% of clients either improved or stabilized.

Most outcomes are tracked and reported quarterly by the program; all data provided except inpatient admissions reflects the average per quarter. Four percent of clients in North County, 6% in South County, and 1% in West County experienced incarceration while in the program. Rates of physical health hospitalization were similar in North and West county (hospitalization: 4% in North and 3% in West), while they were slightly higher in South County (8%). Physical health emergency care was 8% in North County, 4% in South County, and 6% in West County. Nearly all clients had stable housing across the three programs (91-98%), while 18% in North and 30% in West engaged in purposeful activities. During their enrollment in ACT, very few clients had to be transferred to a higher level of care, and 8% graduated to a lower level of care in West County (this metric was not available for clients in North County). In South County this was also examined as a percent of total discharges rather than percent of all clients, and similar portions transitioned to lower and higher levels of care, while the remaining quarter of clients either transferred to a similar level of care or were deceased.

The client outcomes table displays the percent of clients who experienced an inpatient psychiatric hospitalization during their admission to the program in the 18-19 fiscal year. Six percent of clients in North County, 7% of clients in South County, and 1% of clients in West County experienced hospitalization.

Supported Community Services FSP Summary

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

Supported Community Services South - (Santa Barbara) – PathPoint

Provider:	**PathPoint**
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures	$1,163,700
Estimated CSS Funding	$470,00
Estimated Medi-Cal FFP	$622,600
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$71,100

Average Cost Per Consumer	$9,384
Estimated Total of Consumers Served	124
Target Population Demographics Served	TAY, Adult, Older Adult

PathPoint provides Residential Support Services (RSS) and Community Supportive Services (CSS). RSS provides mental health case management services to residents of the El Carrillo, Artisan Court, and Bradley Studios apartments in Santa Barbara. In addition, through CSS, they provide treatment, rehabilitative and supportive services with the goal of helping clients obtain and maintain independent living. Since their merger with Crescend in summer 2018, they also provide housing services at Phoenix and Mountain Houses.

Program Challenges and Solutions

PathPoint began to focus on creating flow (transitioning clients who are ready for a lower level of care). This focus, and increased communication between the other programs (CROPC, ACT, Crisis, etc.) led to an improvement in the program's ability to accept referrals into their program without having to wait until another staff person is hired. This has been identified as an issue by the programs in the past, so this is good to see and assists the entire system of care in meeting the needs of clients. This shift has also led to the staff working more closely with clients on opportunities to graduate down to a lower level of care. Another concern expressed by PathPoint is when they take in clients without current treatment plans or assessments, which impacts their ability to bill for services provided. The treatment planning process is a focus of the Department and a goal to ensure runs smoothly in the upcoming year.

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

Provider:	**Transitions Mental Health Association**
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures	$1,167,600
Estimated CSS Funding	$ 571,000
Estimated Medi-Cal FFP	$ 595,600
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$ 1,000
Average Cost Per Consumer	$ 10,332
Estimated Total of Consumers Served	113
Target Population Demographics Served	TAY, Adult, Older Adult

Santa Maria Supported Community Services provides outpatient mental health treatment for adults and older adults with severe and persistent mental illness. The intensive treatment team helps individuals to recover and live independently within their community. Program participants are assisted in their efforts to gain the skills needed to make choices that reflect their own values, preferences, and goals; supports are developed to meet each person's needs and to empower each individual to attain their highest level of independence and recovery possible. During recent years, the Program has shifted the focus to each consumer's unique recovery journey. Staff and consumers work together to identify recovery goals and to develop a specific "road map" for each individual, with an overall goal of reaching a level of recovery that enables an individual to graduate from the program. Additional Master's level clinical staff have been recruited and more therapeutic groups and individual therapy opportunities have been offered to consumers. Groups have focused on healthy relationships, self-care, stress management, coping skills, art therapy, co-occurring disorder support, and laughter therapy. Supportive Services North has provided care for 113 unique individuals in FY 2018-19.

Program Challenges and Solutions

Although there is robust programming in the North and South regions of Santa Barbara County, the West region is comprised of ACT level services and outpatient and recovery services. The step down from the higher level of care is difficult without a smooth transition for individuals receiving treatment. In the upcoming year, the Department will be evaluating the distribution of services and may transition funding from the higher level (ACT) to supported community services to enable clients to move up and down the continuum easier as occurs in the other regions of the County. TMHA and Behavioral Wellness instituted programming at each level of care to support the transitions and is monitoring status of this change in FY 19-20 and FY 20-21.

Program Performance (FY 18-19)

Supportive Community Services (*formerly Supported Housing*)

	Unique Clients Served	
	North	**South**
Age Group		
0-15	0	0
16-25	3	1
26-59	73	77
60+	37	46
Missing DOB	0	0
Total	**113**	**124**
Gender		
Female	55	50
Male	58	74
Unknown	0	0
Ethnicity		
White	57	93
Hispanic	41	15
African American	5	8
Asian/Pacific Islander	8	3
Native American	1	0
Other/Not Reported	1	5

Client Outcomes

Milestones of Recovery Scale (MORS) Age: 18+		
	Initial to 12 months (n = 230)	**12 to 18 months (n=)**
Showed improvement^	32%	15%
Remained stable^	48%	67%
	Average per Quarter	
	North	**South**

Incarcerations	1%	1%
Physical Health Hospitalization	6%	7%
Physical Health Emergency Care	10%	12%
Stable/Permanent Housing	99%	93%
Purposeful Activity (employed, school, volunteer)	19%	36%
Transferred to Higher Level of Care	1%	1%
Graduated to Lower Level of Care	3%	4%
	% during program admission in FY 18-19	
	North	**South**
Psychiatric Inpatient Care	4%	1%

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

In the 2018-2019 fiscal year, client progress in Supportive Community Services (SCS) were compared using initial, 12-month and 18-month MORS data. Similar to last year, twice as many clients showed improvement in the first year than in the following six months, and it appears that these clients then stabilized after a year. In fact, half of clients in the first year were stable and two-thirds stabilized from 12-18 months, suggesting that program longevity is particularly important in stabilizing clients' mental health.

Most outcomes are tracked and reported quarterly by the program; all data provided except inpatient admissions reflects the average per quarter. Very few clients experienced incarceration while in the program (1% for both North and South County). Clients in North and South County experienced similar levels physical health hospitalization (6-7%) and physical health emergency care (10-12%). Nearly all clients had stable housing in North and South County (93-99%). A fifth of clients in North County engaged in purposeful activities while about a third did in South County. During their enrollment in SCS, very few clients had to be transferred to a higher level of care (1% for both regions), and a few graduated to a lower level of care in North County (3-4%).

The client outcomes table displays the percent of clients who experienced an inpatient psychiatric hospitalization during their admission to the program in the 18-19 fiscal year. Four percent of clients in North County and 1% of clients in South County experienced hospitalization.

SPIRIT FSP Wraparound Services

Provider:	**Behavioral Wellness, CALM**
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures	$2,592,000
Estimated CSS Funding	$1,890,900
Estimated Medi-Cal FFP	$ 666,100
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$ 35,000
Average Cost Per Consumer	$ 38,117
Estimated Total of Consumers Served	68
Target Population Demographics Served	Children, TAY

The SPIRIT Full Service Partnership (FSP) wraparound program for children ages 6-15 and their families is an evidenced-based, intensive treatment model designed around the following MHSA core principles: children and family involvement and empowerment, culturally competent and appropriate services, integration into existing systems, increasing informal supports, collaboration and partnership and wellness and recovery.

The SPIRIT program operates in all three regions of the County as a specialized team that provides intensive, high frequency services to a disenfranchised, underserved population of children and families that have limited resources, have failed to thrive with conventional treatment, and whose children are at risk for placement in out-of-county, high-level group home facilities due to emotional and behavioral issues.

The SPIRIT team strives to implement specialty mental health services within the home and/or community with a 'whatever its takes' approach to the delivery of treatment focusing on outreach and engagement, development of attainable treatment plan goals and promoting stabilization to prevent hospitalization. Children and families are involved at every level of the planning and treatment process aimed at achieving their family vision, hopes and dreams and wellness goals.

The SPIRIT team consists of the following: Mental Health Practitioner/Family Facilitator, Peer Parent Partner and a Case Worker. The SPIRIT team serves children at a 1:15 ratio to ensure that care is available 24/7 with on-call support to clients and families both afterhours and on weekends. SPIRIT children are typically also being served by a Psychiatric Technician and/or Registered Nurse and Psychiatrist. Together they provide a comprehensive, multidisciplinary tam offering an array of intensive services to prevent decompensation.

Program Challenges and Solutions

The SPIRIT team services are designed to provide high-frequency, intensive services within the home and/or community to both the child and family members, in which regular attempts to outreach is critical to engage the most resistant and high-needs children and families. The Department has operationalized and standardized level-of-care tools to ensure that the children with the highest needs are served through the SPIRIT program and are regularly reassessed to determine when they are prepared to transition or step-down to a lower level-of-care as they become stabilized. Secondly, it is not uncommon for SPIRIT children and families to have limited resources and complex socio-economic barriers, thus at times they struggle with transitioning out of SPIRIT's intensive, supportive 24/7 wraparound care. Resolutions to these problems have included expanded collaboration with community-based organizational partners, community resources, school teams, and informal supports, in order to assist families in transitioning to a lower level-of-care as their circumstances improve. Beginning in July 2019, Behavioral Wellness implemented an enhanced staffing structure for the SPIRIT program, in which the Parent Partner is employed by CALM (a community-based organization) and is taking a lead role in engaging parents/caregivers, providing urgent parent response and de-escalation to sustain families, while further promoting that parents collaborate with their children's school teams. Additionally, the changes in the SPIRIT team structure offer increased support outside regular business hours to ensure that parent partners can offer extensive assistance as in alignment with wraparound program model ideals.

Program Performance (FY 18-19)

SPIRIT

	Unique Clients Served		
	North	South	West
Age Group			
0-15	14	15	24
16-25	4	7	4

26-59	0	0	0
60+	0	0	0
Missing DOB	0	0	0
Total	**18**	**22**	**28**
Gender			
Female	8	12	7
Male	10	10	21
Unknown	0	0	0
Ethnicity			
White	2	8	10
Hispanic	16	14	16
African American	0	0	1
Asian/Pacific Islander	0	0	0
Native American	0	0	0
Other/Not Reported	0	0	1

Client Outcomes

Child & Adolescent Needs & Strengths Assessment (CANS-50) Age: 6-20 years	**Percent Improvement**	
	Initial to 6 months	**6 to 12 months**
Life Functioning (e.g., ability to communicate and interact with families, communication, social functioning and health status)	--	--
Behavioral/Emotional Needs (e.g., symptoms of depression, anxiety, psychosis and other conditions)	--	--
Risk Behaviors (e.g., self-injury, suicidal behavior, bullying, and running away)	--	--
Cultural Factors (e.g., language, traditions, stress)	--	--
Caregiver Resources & Needs (e.g., child supervision skills, family stress levels, residential stability, and caregiver physical/mental health status)	--	--
Strengths (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment)	--	--
	Average per quarter	
	All Regions	
Incarcerations/Juvenile Hall	5%	
Out-of-Home Placement	4%	
Purposeful Activity (employed, school, volunteer)	98%	
Stable/Permanent Housing	95%	
	% during program admission in FY 18-19	
	All Regions	
Psychiatric Inpatient Care	6%	

Due to a state mandated change, Santa Barbara County began using a new version of the CANS (CANS-50) in July 2018. This change in instrumentation made all existing CANS reports (such as compliance and outcomes) obsolete. Due to the analytic complexity of the CANS and the desire for clinicians and supervisors to be able to review their client strengths and needs over time, Santa Barbara County is in the process of contracting with a

CANS and PSC software provider. In addition to changing versions, the CANS age range was also extended to age 20.

Most outcomes are tracked and reported quarterly by the program; all data provided except inpatient admissions reflects the average per quarter. In the 2018-2019 fiscal year, clients in the SPIRIT Program had quite positive outcomes. Nearly all SPIRIT clients experienced residential stability (95%) and were engaged in purposeful activity (98%). A quarterly average of 4% experienced out of home placement and 5% experienced juvenile hall stays. The client outcomes table also displays the percent of clients who experienced an inpatient psychiatric hospitalization during their admission to the program in the 18-19 fiscal year. Across all regions, 6% of SPIRIT clients experienced hospitalization.

Forensic FSP Justice Alliance

Provider:	**Behavioral Wellness**
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures	$2,303,300
Estimated CSS Funding	$1,500,900
Estimated Medi-Cal FFP	$636,000
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$166,400
Average Cost Per Consumer	$12,059
Estimated Total of Consumers Served	191
Target Population Demographics Served	TAY, Adult, Older Adult

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

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

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

In addition, Justice Alliance staff provide competency restoration services to misdemeanants found Incompetent to Stand Trial (IST), in both the inpatient PHF and outpatient settings. When providing outpatient restoration services, the team utilizes various residential resources such board and care facilities and crisis residential treatment programs.

Program Challenges and Solutions

In 2018, the Department approved hiring of an Extra-Help Case Worker for the Justice Alliance Santa Barbara team, similar to the Santa Maria region, which was necessary because of the increased rehabilitative service needs. When the team increased efforts to provide outpatient competency restoration treatment—to divert those found to be IST from the PHF—it discovered many of these individuals had time-consuming rehabilitation service needs that were previously not needed when consumers received their primary restoration treatment in the PHF. Hiring the Extra-Help Case Worker freed up time for Practitioners and Psychologists to be engaged in more Assessment and Evaluation activities. Still, the Justice Alliance team experienced an uptick in IST referrals in 2018, up to 60 from 45 in 2017, many of whom required extensive case management. In 2019, the total number of misdemeanant ISTs decreased to 40, however, many exhibited acute care needs that necessitated extensive case management services when placed in the community.

In 2019, the Department allocated two Administrative Office Professional (AOP) positions to Justice Alliance, as it previously had just one .50 EXH AOP assigned to it. In early 2020, the County also approved a contract with the Department of State Hospitals to divert felony ISTs to community-based care; among other things, this contract provided funding for two Case Worker positions to the Justice Alliance program. The Department anticipates filling these vacancies later in 2020, as the COVID-19 pandemic has disrupted hiring procedures.

Program Performance (FY 18-19)

Justice Alliance

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	0	0	0
16-25	9	20	6
26-59	25	104	10
60+	4	12	1
Missing DOB	0	0	0
Total	***38***	***136***	***17***
Gender			
Female	8	29	5
Male	30	107	12
Unknown	0	0	0
Ethnicity			
White	13	70	7
Hispanic	20	36	7
African American	2	16	2

Asian/Pacific Islander	2	1	0
Native American	0	0	1
Other/Not Reported	1	13	0

Client Outcomes

Milestones of Recovery Scale (MORS) Age: 18+			
		Initial to 6 months (n = 89)	6 to 12 Months (n = 63)
Showed improvement^		38%	29%
Remained stable^		31%	48%
	% during program admission in FY 18-19		
	North	South	West
Incarcerations	--	--	--
Psychiatric Inpatient Care	5%	21%	17%

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

In the 2018-2019 fiscal year, clients in the Justice Alliance had initial, 6-month and 12-month MORS data. Over the first six months, two-thirds were either stable or made improvements; over the second six months, three-quarters were either stable or made improvements. Similar to patterns in other programs, more clients improved in the first six months (38% improved and 31% stabilized), while in the latter six months more clients stabilized (29% improved while 48% stabilized).

The client outcomes table displays the percent of clients who experienced an inpatient psychiatric hospitalization during their admission to the program in the 18-19 fiscal year. Five percent of clients in North County, 21% of clients in South County, and 17% of clients in West County experienced hospitalization. These relatively high rates make sense as clients served by Justice Alliance are typically transitioning from hospitalization to the community to be restored to competency, and may even begin services with Justice Alliance staff prior to their release from the hospital. In particular, clients who are deemed Incompetent to Stand Trial (IST) are typically unable to consent to treatment in the community and may require extended inpatient services prior to outpatient services. Data from FY 18/19 may also reflect higher than typical inpatient care because there was a surge of clients in 2018 who were deemed IST. Incarceration/juvenile hall data were unavailable this year and we are unable to report on these metrics.

Crisis Stabilization Unit (CSU) South

Provider:	Behavioral Wellness
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures	$2,916,500
Estimated CSS Funding	
Estimated Medi-Cal FFP	$2,034,400

Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	$ 882,100
Estimated Other Funding	
Average Cost Per Consumer	$ 5,663
Estimated Total of Consumers Served	515
Target Population Demographics Served	TAY, Adult, Older Adult

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

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

Program Challenges and Solutions

The CSU has struggled with adequate referrals and utilization of beds. In an effort to increase census at the CSU, a law enforcement drop-off policy was created that allows law enforcement to bring individuals directly to the CSU after a brief phone screening with our Crisis Services teams. A similar policy was also created for our local "Doctors Without Walls" teams serving the homeless population. Laminated business card size information cards were created with procedures to follow and these were all distributed to law enforcement agencies in the county. An "Open House" was held to re-introduce the community to the CSU and increase awareness of its benefits, and our Crisis Action Team meetings highlighted the new procedures. Since implementing this policy, we have seen an increase in the number of individuals brought directly the CSU instead of first being taken to local emergency departments for medical clearance. Additionally, the South County Crisis Hub and newly opened CREDO47 Sobering Center has assisted in leveraging all crisis services. It is anticipated that these additional features on the Calle Real Campus in Santa Barbara will assist in linking clients to the CSU.

Program Performance (FY 18-19)

Crisis Stabilization Unit (CSU)

Unique Clients Served	
	CSU
	South
Age Group	
0-15	0
16-25	103
26-59	363
60+	49
Missing DOB	0

Total	***515***
Gender	
Female	201
Male	314
Unknown	0
Race/Ethnicity	
White	277
Hispanic	113
African American	52
Asian/Pacific Islander	9
Native American	4
Other/Not Reported	60

Client Outcomes

To evaluate CSU Program utilization, admissions and discharge data was obtained from the CSU. Note that the total admissions in the table below is 518; this is a duplicated count so it is not expected to match the unique count displayed above in the demographics table.

CSU Admissions and discharges (N = 518)	Admission	Discharge
Hospital/Residential Treatment	59%	4%
Crisis Services	19%	0%
Outpatient	12%	1%
Justice	7%	1%
Shelter, Supported/Sober Living, Board and Care	2%	12%
Self	1%	42%
Primary Care	0%	0%
Crisis Residential Treatment	0%	33%
Home	0%	7%

Over half of clients served by the CSU were referred by hospitals (59%). The next largest group was referred by crisis services and outpatient (31% combined). Upon discharge from the CSU, the largest portion of clients were admitted to a Crisis Residential Treatment facility (42%). Some clients were discharged to home (7%), or because they did not meet 5150 criteria to hold, but did not want linkage to another program (self; 42%). Many clients were also discharged to sober living, board and care, or other supported living environment or shelter (12%). Only 4% of clients were discharged to the hospital. This suggests that clients from the CSU are typically stepping down in terms of service intensity.

Higher Level of Care	% with any admissions		
	within 7 days of discharge	within 15 days of dis-charge	within 30 days of dis-charge
Psychiatric Inpatient Care	3.1%	4.9%	7.1%

Psychiatric Hospitalizations

The client outcomes table displays the percent of clients who experienced an inpatient psychiatric hospitalization within 7, 15, and 30 days following their admission to the CSU in the 18-19 fiscal year. Over the first month following a CSU stay, hospitalization rates rose slightly, though overall the CSU was effective in helping clients avoid inpatient treatment.

Senate Bill 82 (S.B. 82)

Senate Bill 82 Summary

California Senate Bill 82 (S.B. 82), the Investment in Mental Health Wellness Act of 2013, uses state MHSA funding to provide grants to counties. The Department of Behavioral Wellness initially received approximately $11 million in S.B. 82 funding. This funding supported the Mobile Crisis West team in Lompoc. It also funded construction/renovation costs for a Crisis Stabilization Unit in Santa Barbara, and the Crisis Residential Facility in Santa Barbara. In addition, provided construction and renovation for a Crisis Residential Facility in Santa Maria at Agnes which was completed in fall of 2019.

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

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

- Mobile Crisis Services West Team (funded by SB 82) through January 2020; now in Crisis Services CSS
- Crisis Stabilization Unit Santa Barbara (funded by SB 82), funded in CSS now
- Crisis Residential Facility Santa Barbara and Santa Maria Agnes (funded by SB 82), funded in CSS now
- North Crisis Residential Facility (funded by MHSA CSS)
- Access and Assessment teams, Santa Maria, Lompoc, Santa Barbara (funded by MHSA PEI)
- Children's Crisis Triage (funded by Children's Crisis Triage Grant with SB82)

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

Children's Crisis Triage Program

Provider:	**Behavioral Wellness**
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures	$ 562,300
Estimated CSS Funding	$ 23,500
Estimated Medi-Cal FFP	$ 260,300
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$ 278,500
Average Cost Per Consumer	$ 8,032
Estimated Total of Consumers Served	70 per year (per grant)
Target Population Demographics Served	Children and TAY (Age 21 and under per grant)

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

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

Program Challenges and Solutions

The upcoming goals of the CCTP include:

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

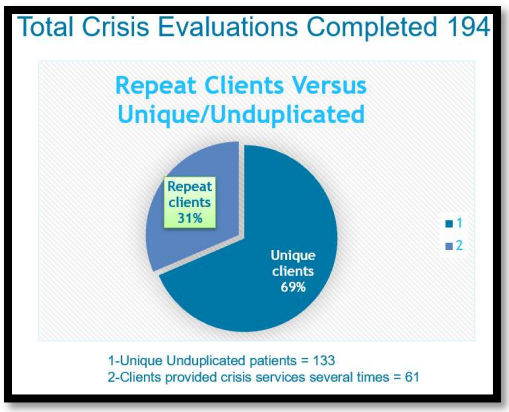
The results of these goals will be presented in upcoming plan update and provided to the grant agency, MHSOAC.

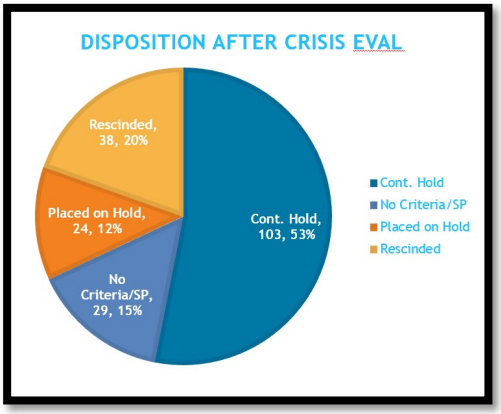
As of May 2020, all positions are filled starting in North County early 2019 and working with Cottage at the tail end of 2019 as buy-in with partners was initially sought. When the grant was written, children on holds in the Emergency Department (ED) was a huge issue for some hospitals and they were excited about the grant and submitted a letter of support. In the interim from grant application to implementation, Cottage Health systems expanded psychiatry to manage all psychiatric patients in the ED and have reduced need for CCTP staff in the ED. As a result, in Santa Barbara, the ED staff will do the crisis evaluations and re-evaluations and they will work closely with the Children's Triage staff in developing safety plans and linking children to CCTP or Casa Pacifica's SAFTY staff for post ED monitoring and linking to services.

In North County, Marian hospital was quite excited from initial start and as of May 2020 are very happy with the services provided to the youth in their ED as they do not have psychiatry in the ED.

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

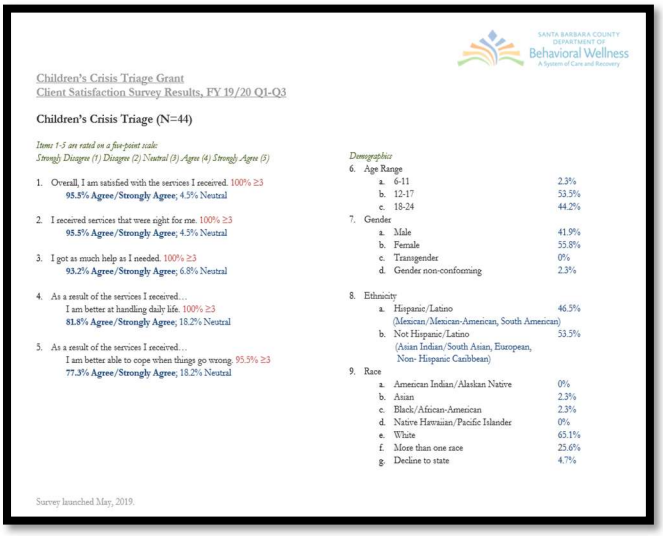
2019 Initial Performance Data





Source: Dr. Altobelli's Update to Community Partners PowerPoint

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



Children's Crisis Triage Grant
Client Satisfaction Survey Results, FY 19/20 Q1-Q3

Children's Crisis Triage (N=44)

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

1. Overall, I am satisfied with the services I received. 100% ≥3
   95.5% Agree/Strongly Agree; 4.5% Neutral
2. I received services that were right for me. 100% ≥3
   95.5% Agree/Strongly Agree; 4.5% Neutral
3. I got as much help as I needed. 100% ≥3
   93.2% Agree/Strongly Agree; 6.8% Neutral
4. As a result of the services I received…
   I am better at handling daily life. 100% ≥3
   81.8% Agree/Strongly Agree; 18.2% Neutral
5. As a result of the services I received…
   I am better able to cope when things go wrong. 95.5% ≥3
   77.3% Agree/Strongly Agree; 18.2% Neutral

Demographics

6. Age Range
   a. 6-11 2.3%
   b. 12-17 53.5%
   c. 18-24 44.2%
7. Gender
   a. Male 41.9%
   b. Female 55.8%
   c. Transgender 0%
   d. Gender non-conforming 2.3%
8. Ethnicity
   a. Hispanic/Latino 46.5%
   (Mexican/Mexican-American, South American)
   b. Not Hispanic/Latino 53.5%
   (Asian Indian/South Asian, European, Non- Hispanic Caribbean)
9. Race
   a. American Indian/Alaskan Native 0%
   b. Asian 2.3%
   c. Black/African-American 2.3%
   d. Native Hawaiian/Pacific Islander 0%
   e. White 65.1%
   f. More than one race 25.6%
   g. Decline to state 4.7%

Survey launched May, 2019.

Children's Crisis Triage Grant
Client Satisfaction Survey Results, FY 19/20 Q1-Q3

Parent/Adult Crisis Triage (N=79)

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

1. Overall, I am satisfied with the services my child and/or family received. 98.8% ≥3
   97.5% Agree/Strongly Agree; 1.3% Neutral
2. The services my child received were right for them. 98.8% ≥3
   97.5% Agree/Strongly Agree; 1.3% Neutral
3. My family got the help we wanted for my child. 97.5% ≥3
   93.7% Agree/Strongly Agree; 3.8% Neutral
4. As a result of the services my child received…
   My child is better at handling daily life. 97.5% ≥3
   74.7% Agree/Strongly Agree; 22.8% Neutral
5. As a result of the services my child received…
   My child is better able to cope when things go wrong. 97.5% ≥3
   60.8% Agree/Strongly Agree; 36.7% Neutral

Demographics

6. Age Range
   a. 28-24 2.6%
   b. 25-59 93.6%
   c. 60+ 3.8%
7. Gender (select all that apply)
   a. Male 34.62%
   b. Female 66.67%
   c. Transgender 0%
   d. Gender non-conforming 0%
8. Ethnicity
   a. Hispanic/Latino 45.5%
   (Mexican/Mexican-American, Central American, South American)
   b. Not Hispanic/Latino 54.5%
   (African, Asian Indian/South Asian, European, Filipino, Middle Eastern, Mixteco, Non-Hispanic Caribbean, Vietnamese)
9. Race
   a. American Indian/Alaskan Native 1.3%
   b. Asian 2.6%
   c. Black/African-American 6.4%
   d. Native Hawaiian/Pacific Islander 0%
   e. White 71.8%
   f. More than one race 12.8%
   g. Decline to state 5.1%

Survey launched May, 2019.

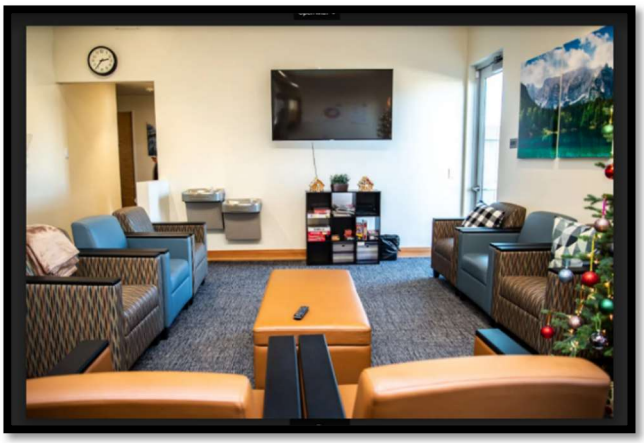
Crisis Residential Agnes – SB 82 and Community Support Services

Crisis Residential – Agnes (formerly Crisis Residential North)	
Provider:	**Behavioral Wellness, Telecare**
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures	$1,155,600
Estimated CSS Funding	$111,500
Estimated Medi-Cal FFP	$500
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	$1,043,200
Estimated Other Funding	
Average Cost Per Consumer	$9,630
Estimated Total of Consumers Served	120
Target Population Demographics Served	Adults and Older Adults

This 10 Bed Crisis Residential opened in Fall 2019. It is located in Santa Maria and serves individuals for stays up to 30 days. Grant funds sponsored the infrastructure and initial start-up costs. The facility renovation was funded by S.B. 82 as part of a grant to increase crisis services infrastructure statewide. On-going services will be contracted for with Community Services Support (CSS) funding and operated in partnership with Telecare Corporation.

Program Challenges and Solutions

Performance Outcomes will be reported in upcoming years as implementation results will be known. In addition, a Request for Proposals will be issued for long-term operator of the facility in FY 2020-21.



Mobile Crisis West – SB82 and Community Support Services [Ended FY 2019-20]

The Mobile Crisis Support Team in the City of Lompoc provides rapid response in mental health emergencies for the West County region of Santa Barbara County. See the "Crisis Services" program description for more information about the program, including FY 18-19 performance outcomes. The grant funding was exhausted in January 2020 and the team members are anticipated in the West Crisis Services budget and narrative.

Prevention and Early Intervention (PEI)

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

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

Mental Health Education and Support to Culturally Underserved Communities

Provider:	**La Casa de la Raza, Community Health Centers of the Central Coast (CHCCC), Santa Ynez Tribal Health Clinic (SYNTHC)**
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures	$253,400
Estimated PEI Funding	$253,400
Estimated Medi-Cal FFP	
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer/Families	Families ($159) Consumers ($29.50)
Estimated Total of Consumers/Families Served	Families 1597 – Participants 8587
Target Population Demographics Served	Children, TAY, Adult, Older Adult

La Casa de La Raza

In the Santa Barbara region, La Casa de La Raza's mission is to empower the Latino community by educating and providing various wellness support groups for individuals and families. One of these wellness support groups established ongoing Spanish speaking community groups called "Cafecitos". During this support group, various

participants receive psychoeducation about mental health wellness and resources that are available. La Casa de la Raza provides various outreach efforts through their work with the Family Resource Center. A result of the high interest in their workshops, La Casa de la Raza offers Saturday workshops called "Sabadito Saludables". The groups are fully active and have a consistent flow of families coming in for support.

Program Challenges and Solutions

Due to the fear of deportation, the LatinX community feels the pressures of social/political changes and expressed anxieties around immigration rights, employment rights, emergency preparedness, mental health support and grief/loss. La Casa de la Raza continues to provide encouragement, referrals to mental health services and support to the community as these social/political changes impact the LatinX Community. The Cultural Diversity Manager will be coordinating meetings with La Casa De la Raza on how to reach this community, especially with the impacts of COVID-19. In May 2020, there is a shift in facility location which will be reviewed in summer of 2020.

During the FY 2020-2023 MHSA Planning process, La Casa de la Raza partnered with Department staff hosted a weekend MHSA planning events at their center. Traditional food was shared and an interactive stakeholder process occurred. As a result, the Department hopes to continue this partnership in the upcoming year.


Examples of MHSA Community Program Planning Process at Casa De La Raza

Community Health Centers of the Central Coast, Inc.

Community Health Centers of the Central Coast, Inc. (CHCCC) is a contracted community partner that provides community based mental health prevention and early intervention services to the most vulnerable populations in Northern Santa Barbara County. As a safety net provider, CHCCC's primary focus is to meet the comprehensive healthcare needs of the underserved and/or unserved communities within the Santa Maria, Guadalupe, New Cuyama, Los Alamos and Lompoc regions of the County. The Mental Health Outreach teams' programmatic focus is the mitigation of the negative social and cultural impacts of immigration in order to improve the mental, physical and behavioral outcomes of these populations. The framework of their "whole-person" approach to population health management is driven by community based participatory activities and interventions.

The goal of the mental health education and outreach activities is to empower newly identified members of special populations and to systematically deconstruct institutional and cultural barriers which have not been

affirming of their healthcare needs. CHCCC created safe space through trauma-informed, network-wide community circles and groups which foster trust between members of these special populations and the larger systems of care. As a result of behavioral health integration initiatives, local community members have been challenging social norms and cultural roles which previously impeded their ability to access mental health services. Through these pointed outreach efforts, the team has addressed multiple barriers to accessing services, such as those related to culture, language, transportation, location, stigma and institutional mistrust or fear due to historical experiences of discrimination and racism. Memorandums of Understanding have been developed and established with local low-income housing programs to provide on-site support groups to predominant monolingual Spanish and limited English proficiency speaking communities. This approach brings the services directly to under-served community members that otherwise would not seek or attend support groups due to stigma, childcare issues and transportation barriers. Furthermore, CHCCC has been successful in developing partnerships with local agricultural employers to gain access to migrant workers at their worksites and has partnered with local Spanish- and Mixtec-language radio stations to bring free lunches to workers while providing mental health education. These lunchtime "meet and greets" allow agricultural workers to interact with CHCCC outreach staff informally and build a personal connection that over time facilitates access and linkage to services. CHCCC also conducts ongoing radio and television outreach, education and anti-stigma efforts and has sponsored and staffed an annual health fair for migrant farmworkers. The health fair focuses on health and mental health education, resources and linkage to services.

Program Challenges and Solutions

In 2021-2023, CHCCC hopes to further expand community-based programs through technology-based educational groups to close the digital divide that exists within the populations served. As healthcare transforms to telehealth platforms, they have found the limited literacy, poor health literacy and subsequent digital illiteracy within many vulnerable populations further contributes to "gaps in care" and results in *perceived* poor patient engagement. In an effort to bridge treatment and services for the Spanish, Mixtec-speaking and limited English proficiency patients, mental health educators have broadened outreach platforms to include text messaging campaigns, telehealth consultation, telephonic care coordination, remote patient monitoring and digital applications. As the MHSA partnership continues, CHCCC would like to expand support and sustain the coordination of care as well as direct clinical services that are being provided by our clinical social workers, primary care providers, psychiatrists, interpreters, nurses and allied health professional to community members. In alignment with their mission and vision as a community health center, CHCCC provides "whole-person" fully integrated behavioral health services regardless of an individual's ability to pay and will continue to link consumers from Behavioral Wellness with their agency.

During the FY 2020-2023 MHSA Planning process, CHCCC partnered with Department staff and hosted MHSA planning events at local schools and housing complexes. This interactive stakeholder process led to three languages (English, Spanish, and Mixteco) spoken in one event and members of the community learning and providing an immense amount of input on future MHSA programming. As a result, the Department hopes to continue this partnership and mechanism of outreach in the upcoming planning years.

Examples of MHSA Community Program Planning Process with Community Health Centers of Central Coast

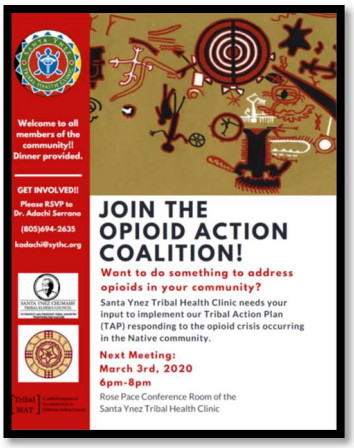
Santa Ynez Tribal Health Clinic

In the mid-county area, Santa Ynez Tribal Health Clinic offers community wellness trainings and activities that are culturally tailored to the native community. Bimonthly, the clinic issues The *Samala* magazine, a publication focused on native community wellness that is distributed to all clinic members or approximately 780 tribal homes. Recent topics covered bullying and health, sleep disorders, diet, stress, and training peer supports on mental health needs of tribal patients at Vandenberg Air Force Base. The clinic has also increased the number of clients served by engaging existing tribal programs, including Camp Kalawa Shaq (tribal youth summer program), and a tribal educational backpack event which attracts a large volume of youth and families and provides ample opportunities for one-on-one education and small group information dissemination. Regional gatherings of tribal organizations and facilities are held that provide educational workshops related to patient engagement in community-based wellness interventions.

In FY 2019-20, the Santa Ynez Tribal Health Clinic hosted community trainings and targeted the Santa Ynez Valley high schools. Community members received training on Opioid misuse. Furthermore, the Santa Ynez Tribal Health Clinic engaged and provided training to the High School staff and students on Suicide Prevention and Leadership training to Righetti High students. This first suicide prevention training at the local high school, where 43 teachers, administration, and coaches attended was very successful. Santa Ynez Tribal Health staff worked on promoting social media platforms (Instagram and Facebook) as a way to engage the community about mental health-related topics. Additionally, there were 17 support groups that took place such as men and women sweat lodges and youth council meetings. The Santa Ynez Tribal Health Clinic Youth council hosted their first Youth Mental Health Awareness Gathering that consisted of multiple mental health tracks in efforts to give the youth a better understanding of mental health and how it impacts everyone. 33 youth attended, and they gained knowledge about suicide prevention, navigating the mental health system, and built protective and leadership factors.

Program Challenges and Solutions

Since Vaping among teens has become a health issue, the Santa Ynez Tribal Health Board expressed concerns and the need to disseminate prevention materials on this topic. Staff plan to publish information on vaping in our bi-monthly tribal magazine to educate our community. Another area of focus is the goal of having programs that focus on the Elders and foster wellbeing.



Program Performance (FY 18-19)

Outreach Events			
PROGRAM	**LCDLR** (4 quarters of data)	**SYTHC** (4 quarters of data)	**CHCCC** (4 quarters of data)
TOTAL # EVENTS	**107**	**119**	**253**
TOTAL # PARTICIPANTS	**2,014**	**595**	**5978**
TOTAL # FAMILIES SERVED	**765**	**170**	**662**
EVENT TYPE	(4 quarters of data)	(4 quarters of data)	(4 quarters of data)
Outreach	8	11	39
Training	11	12	60
Forum	4	36	26
Support Group	84	60	128
PRIMARY LANGUAGE OF EVENT	(2 quarters of data)	(2 quarters of data)	(3 quarters of data)
English	0	22	11
Spanish	224 (groups only)	0	41
Other or both English and Spanish	0	0	15

More detailed information required for PEI reporting is also provided in the PEI Summary (Attachment 1). Each program provided various outreach events, trainings, forums, and support groups to their communities. CHCCC served or "touched" nearly 6,000 (duplicated) individuals in North County through having many outreach events, trainings, and support groups. La Casa de La Raza also served or "touched" over 2,000 (duplicated) individuals in South County. Santa Ynez Tribal Health Clinic served West County, and they served or "touched" almost 600 individuals through their outreach events.

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

Provider:	**CALM, Santa Ynez Valley People Helping People (SYV-PHP)**
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures	$428,100

Estimated PEI Funding	$428,100
Estimated Medi-Cal FFP	
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer	$2,835
Estimated Total of Consumers Served	151
Target Population Demographics Served	Children, TAY, Adult

Provider:	**CALM**
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures	$1,144,400
Estimated PEI Funding	$529,500
Estimated Medi-Cal FFP	$614,100
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$800
Average Cost Per Consumer	$2,477
Estimated Total of Consumers Served	462
Target Population Demographics Served	Children

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

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

There are two Programs funded under this initiative:

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

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

CALM continues to use community outreach to share knowledge of child development and intervention strategies with the public and other community organizations. Some of these outreach engagements include: providing information to the community at Family Day in the Park – YMCA, the Safe Sleep Awareness Campaign, PMAD

training, training Carpinteria parents on Protective Factors and ACES, participation in the Lompoc Public Health Department Meetings and the NICU reunión. CALM is also a member of the following community groups: Early Childhood Family Wellness Coalition, Medically Vulnerable Population Care Coordination, PMAD Stakeholders Meetings, and the Perinatal Wellness Coalition (July-Dec).

Staff receive ongoing clinical training and case consultation at weekly clinical staff meetings as well as individual and group clinical supervision as needed. Great Beginnings staff on the Dialectical Behavior Therapy consultation team receive weekly intensive training in treating suicidal and self-injuring teens. Additionally, staff attended trainings on Youth Mental Health First Aid, Sand Tray Therapy, Family Systems Therapy, Perinatal Mood Disorders Components of Care, Advanced Perinatal Psychotherapy, Neuro-Relational Development, Methods of Telehealth Therapy and Medi-Cal documentation. CALM's Psychiatrist continues to provide monthly consultations for the team.

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

This Program provides services to low-income monolingual Spanish speaking children and families in the Santa Ynez Valley in Central County. Services are based at four school sites. Parents may access services in their neighborhood and in their homes. This component provides needed services in an area of the Central County where program resources are limited. Key goals include providing education and support services to children and families that promote positive parenting by conducting at least three groups a year with cohorts of at least 8-10 parents. In order to assist children and families in their mental health recovery by developing skills needed to lead healthy and productive lives, People Helping People aims to screen and assess at least 80 families that present with mental health issues, provide 45 children with developmental screenings, and provide least 60 referrals to family service coordinators who provide case management and linkages to other needed services in the community. People Helping People exceeded these goals in FY 18-19.

Program Performance

CALM ECMH (Prevention – Great Beginnings)

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	87	46	7
16-25	2	2	0
26-59	4	3	0
60+	0	0	0
Missing DOB	0	0	0
Total	**93**	**51**	**7**
Gender			
Female	43	31	2
Male	50	20	5
Unknown	0	0	0

Ethnicity			
White	6	3	0
Hispanic	85	45	6
African American	1	0	0
Asian/Pacific Islander	0	1	1
Native American	0	0	0
Other/Not Reported	1	2	0

SYVPHP ECMH (Prevention)

Unique Clients Served	
	SYVPHP
Age Group	
0-15	65
16-25	18
26-59	27
60+	0
Missing DOB	0
Total	**110**
Gender	
Female	63
Male	47
Unknown	0
Ethnicity	
White	30
Hispanic	80
African American	0
Asian/Pacific Islander	0
Native American	0
Other/Not Reported	0

CALM ECSMH (Early Intervention – Specialty Mental Health Services)

	Unique Clients Served

	North	South	West
Age Group			
0-15	278	148	36
16-25	0	0	0
26-59	0	0	0
60+	0	0	0
Missing DOB	0	0	0
Total	**278**	**148**	**36**
Gender			
Female	147	66	11
Male	131	82	25
Unknown	0	0	0
Ethnicity			
White	55	24	11
Hispanic	192	115	20
African American	19	5	1
Asian/Pacific Islander	2	1	0
Native American	4	0	1
Other/Not Reported	8	3	4

Client Outcomes

	Prevention CALM ECMH Great Beginnings	**Early Intervention CALM ECSMH Specialty Mental Health**
	Average per quarter	**Average per quarter**
New out-of-primary home placements	1%	0%
Stable/Permanent Housing	94%	98%
	Annual	**Annual**
Children's average level of internalizing behavior will decrease from the 75th percentile to the 50th percentile within 6 months of treatment, as measured by the Child Behavior Checklist.	From 57th to 37th percentile	From 79th to 67th percentile
Children's average level of externalizing behavior will decrease from the 75th percentile to the 50th percentile within 6 months of treatment, as measured by the Child Behavior Checklist.	From 70th to 49th percentile	From 79th to 71st percentile
Parent's average level of parenting-related stress will decrease from the 75th percentile to the 50th percentile within 6 months of treatment, as measured by the *Parenting Stress Index*.	From 61st to 48th percentile	From 66th to 58th percentile
Increased knowledge of child development (care, nutrition, discipline)	100%	100%

Increased knowledge of resources	100%	100%
Families linked to services	100%	100%
Higher Levels of Care	**% with any admissions over FY 18-19**	**% with any admissions over FY 18-19**
Incarcerations/Juvenile Hall	--	--
Psychiatric Inpatient Care in FY	0%	0%

	SYVPHP
Provide 30 parenting education and support groups to families/Parents	36 (120%)
Provide 80 screenings and assessments to families presenting with mental health issues	84 (105%)
Provide developmental screenings to 45 children	54 (120%)
Provide 60 referrals to Family Services Coordinators for case management and linkages/referrals to other needed services	110 (183%)

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

During fiscal year 2018-2019, CALM's Great Beginnings program (ECMH Prevention) served 151 families; 26 more than the contracted 125 families. Very few clients had new out-of-primary home placements and 94% had stable or permanent housing. After six months in treatment, children served in their ECMH program fell in the 37th percentile for internalizing behavior and the 49th percentile for externalizing behavior. After six months of treatment, parents' parenting stress fell in the 48th percentile, and 100% of parents experienced increased knowledge of children development and resources, as well as linkage to appropriate services.

CALM's Specialty Mental Health program (ECSMH Early Intervention) served 462 children and their families across the county in fiscal year 2018-2019. Similar to the Great Beginnings program, very few clients had new out-of-primary home placements and almost all had stable or permanent housing. After six months in treatment, children served in their ECSMH program fell in the 67th percentile for internalizing behavior and the 71st percentile for externalizing behavior. After six months of treatment, parents' parenting stress fell in the 58th percentile, and 100% of parents experienced increased knowledge of children development and resources, as well as linkage to appropriate services.

The client outcomes table displays the percent of clients who experienced an inpatient psychiatric hospitalization during their admission to the program in the 18-19 fiscal year. In all regions, no clients in either ECMH or ECSMH program experienced hospitalization. Incarceration/juvenile hall data were unavailable this year and we are unable to report on these metrics.

Santa Ynez People Helping People (Prevention) served 110 individuals over the 2018-2019 fiscal year. Their performance objectives relate to their program goals of providing education, screenings, and linkage/referrals. They exceeded their contract expectations in all areas. They provided 36 parenting education and support

groups (Nurturing Parenting curriculum; three series), 84 screenings and assessments, 54 developmental screenings to children, and 110 referrals and linkage for additional services.

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

Provider:	**Family Services Agency, Council on Alcoholism and Drug Abuse**
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures	$502,600
Estimated PEI Funding	$341,700
Estimated Medi-Cal FFP	$160,900
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer	$ 2,731
Estimated Total of Consumers Served	184
Target Population Demographics Served	Children, Transitional Age Youth (TAY)

The Support, Treatment, Advocacy and Referral Team (START) Program is provided by Family Service Agency (FSA) and the Council on Alcoholism and Drug Abuse (CADA). This Program provides mental health assessment, screening and treatment, home visits, school collaborations, family interventions, linkage and education for children, transition-age youth (TAY) and families. It also offers prevention and early intervention mental health services to students in Carpinteria public schools experiencing emotional and/or behavioral difficulties. The Program supports children and youth who are uninsured and for whom mental health services would otherwise not be accessible. The Program offers counseling, support, advocacy, treatment, and referrals, including services to individuals experiencing mental health and substance abuse challenges. Program staff members work as a team with school staff and parents to address consumers' social-emotional development, prevent mental health and psychological problems from becoming acute, enhance the consumers' ability to adapt and cope with changing life circumstances, increase consumers' protective factors, and minimize risk factors. The START team assigned to schools includes experts in substance abuse and mental health prevention and treatment. START is available to provide intervention, referrals, programs and services to intervene as early as possible to address learning, behavior, and emotional problems.

Program Challenges and Solutions

The presence of the Department programs or support agencies on campuses is a hot topic. Youth throughout the County and their families/support systems often request behavioral health services on campus and improved linkages to care within the varied health care networks for students in these schools. As a result, Youth

services are a priority for the upcoming Three-Year period and a Youth Proposal is included in this plan. Please review the Children and Youth Proposal update following in the plan for details.

Program Performance (FY 18-19)

School-Based Prevention/Early Intervention Services (START)

	Unique Clients Served		
	START South CADA	School-based South FSA	School-based West FSA
Age Group			
0-15	79	35	40
16-25	8	20	2
26-59	0	0	0
60+	0	0	0
Missing DOB	0	0	0
Total	**87**	**55**	**42**
Gender			
Female	41	29	17
Male	46	26	25
Unknown	0	0	0
Ethnicity			
White	15	3	11
Hispanic	70	44	26
African American	0	2	2
Asian/Pacific Islander	1	2	0
Native American	0	0	1
Other/Not Reported	1	4	2

Client Outcomes

Child & Adolescent Needs & Strengths Assessment (CANS-50) Age: 6-20 years	**Percent Improvement**	
	Initial to 6 months	**6 to 12 months**
Life Functioning (e.g., ability to communicate and interact with families, communication, social functioning and health status)	--	--
Behavioral/Emotional Needs (e.g., symptoms of depression, anxiety, psychosis and other conditions)	--	--
Risk Behaviors (e.g., self-injury, suicidal behavior, bullying, and running away)	--	--
Cultural Factors (e.g., language, traditions, stress)	--	--
Caregiver Resources & Needs (e.g., child supervision skills, family stress levels, residential stability, and caregiver physical/mental health status)	--	--
Strengths (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment)	--	--
Higher Levels of Care	**% with any admissions over FY 18-19**	

	START South	School-based South	School-based West
Incarcerations/Juvenile Hall	--	--	--
Psychiatric Inpatient Care in FY	0%	0%	0%

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

Due to a state mandated change, Santa Barbara County began using a new version of the CANS (CANS-50) in July 2018. This change in instrumentation made all existing CANS reports (such as compliance and outcomes) obsolete. Due to the analytic complexity of the CANS and the desire for clinicians and supervisors to be able to review their client strengths and needs over time, Santa Barbara County is in the process of contracting with a CANS and PSC software provider. In addition to changing versions, the CANS age range was also extended to age 20.

The client outcomes table displays the percent of clients who experienced an inpatient psychiatric hospitalization during their admission to the program in the 18-19 fiscal year. Across the county, no clients in START or School-based Counseling programs experienced hospitalization. Incarceration/juvenile hall data were unavailable this year and we are unable to report on these metrics.

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

Provider:	**Behavioral Wellness**
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures	$826,500
Estimated PEI Funding	$ 69,600
Estimated Medi-Cal FFP	$755,900
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$1,000
Average Cost Per Consumer	$3,609
Estimated Total of Consumers Served	229
Target Population Demographics Served	Children, TAY, Adult (if aging into age 25)

Early Detection and Intervention Teams for Transition-Age Youth (TAY) use evidence-based interventions for adolescents and young adults to help them achieve their full potential without the trauma, stigma, and disabling impact of a fully developed mental illness. Three teams specialize in early detection and prevention of serious mental illness in TAY, ages 16-25. Teams are based in North County (Santa Maria), South County (Santa Barbara) and West County (Lompoc). The Program serves children and TAY consumers who are at risk for serious mental illness, or were diagnosed within the past 12 months. The target population also includes individuals who are homeless and/or experiencing co-occurring mental health and substance abuse conditions. Youth are typically served for approximately one year.

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

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

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

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

Youth empowerment services is being explored where TAY Peers take a leadership role to plan, schedule, and offer weekly activities in the community for TAY consumers. Recreational funds will be set aside in the new FY to assist with the planning and creation of social activities for both PEI and New Heights FSP TAY population.

Program Challenges and Solutions

TAY individuals struggle with a complex array of mental health issues coupled with social and economic challenges, and limited overall resources both personally and environmentally. The challenges for effective treatment for this population have been keeping TAY individuals engaged in services, lack of substance abuse treatment resources, and the lack of specific TAY housing resources. A long-term Full-Service Partnership program for TAY that increased field based, 24/7, outreach type of services for this group was launched in Summer 2019 and will be monitored in coming years for linkage and service provision.

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

Additionally, an Innovations project for modern methods of outreach and peer support is being implemented for mobile apps which will target youth in colleges or those at risk for first episode psychosis. TAY clients' communication styles may respond better to this type of support, which is an outcome that will be tracked as part of the peer technology innovation project. This modern outreach is another layer to increase access to services and coordination with TAY clients' peers who are inadequately served through current methods in the Adult System of Care. Discussions with community partners include possible participation in a TAY Clinical Drop-In Clinic; such as The Foundry or Headspace models. Both the Drop-In Center and the Innovation Project Tech Suite: Help@Hand will be goals to accomplish in the FY 2020-23 period.

Program Performance (FY 18-19)

PEI Early Detection & Intervention

Unique Clients Served			
	North	South	West
Age Group			
0-15	0	1	4
16-25	56	105	61
26-59	1	1	0

60+	0	0	0
Missing DOB	0	0	0
Total	**57**	**107**	**65**
Gender			
Female	31	55	34
Male	26	52	31
Unknown	0	0	0
Ethnicity			
White	9	28	19
Hispanic	44	74	35
African American	2	1	1
Asian/Pacific Islander	0	0	1
Native American	0	0	0
Other/Not Reported	2	4	9

Client Outcomes

Child & Adolescent Needs & Strengths Assessment (CANS-50) Age: 6-20 years	**Percent Improvement**	
	Initial to 6 months	**6 to 12 months**
Life Functioning (e.g., ability to communicate and interact with families, communication, social functioning and health status)	--	--
Behavioral/Emotional Needs (e.g., symptoms of depression, anxiety, psychosis and other conditions)	--	--
Risk Behaviors (e.g., self-injury, suicidal behavior, bullying, and running away)	--	--
Cultural Factors (e.g., language, traditions, stress)	--	--
Caregiver Resources & Needs (e.g., child supervision skills, family stress levels, residential stability, and caregiver physical/mental health status)	--	--
Strengths (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment)	--	--
Milestones of Recovery Scale (MORS) Age: 18+		
	Initial to 6 months (n = 87)	**6 to 12 months (n = 74)**
Showed improvement^	47%	34%
Remained stable^	33%	42%

Higher Levels of Care	**% with any admissions over FY 18-19**		
	North	**South**	**West**
Incarcerations/Juvenile Hall	--	--	--
Psychiatric Inpatient Care in FY	5%	3%	3%

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

Due to a state mandated change, Santa Barbara County began using a new version of the CANS (CANS-50) in July 2018. This change in instrumentation made all existing CANS reports (such as compliance and outcomes)

obsolete. Due to the analytic complexity of the CANS and the desire for clinicians and supervisors to be able to review their client strengths and needs over time, Santa Barbara County is in the process of contracting with a CANS and PSC software provider. In addition to changing versions, the CANS age range was also extended to age 20. This means that in future reports, more TAY-aged clients will receive a CANS.

In the 2018-2019 fiscal year, clients in the New Heights program had initial, 6-month and 12-month CANS and MORS data; however, we are only able to report the MORS data at this time. Looking at the MORS, which the majority of clients completed, 80% of clients in in the first half of the year and 76% in the second half were either stable or made improvements. In fact, almost half showed improvement in the first half of the year, and a third showed improvement in the latter half of the year. Conversely, a third were stable in the first half of the year while 42% were stable in the second half of the year.

The client outcomes table displays the percent of clients who experienced an inpatient psychiatric hospitalization during their admission to the program in the 18-19 fiscal year. Five percent of clients in North county, 3% of clients in South County, and 3% of clients in West County experienced hospitalization. Incarceration/juvenile hall data were unavailable this year and we are unable to report on these metrics.

Safe Alternatives for Children and Youth (SAFTY) Crisis Services

Provider:	**Casa Pacifica**
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures	$1,030,600
Estimated PEI Funding	$586,600
Estimated Medi-Cal FFP	$442,500
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$1,500
Average Cost Per Consumer	$1,099
Estimated Total of Consumers Served	937
Target Population Demographics Served	Children, TAY

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

SAFTY provides children's crisis services in collaboration with Crisis Services Teams county-wide. The SAFTY Program operates a crisis line that receives crisis calls from 8am-8pm, 7 days per week. SAFTY provides quick and accessible service to families by providing specialized crisis intervention, in-home support and linkage to County behavioral health or other appropriate services. By working in collaboration with the child's existing service providers, SAFTY seeks to keep children, youth and families safe in their homes and communities.

Program Challenges and Solutions

In prior years, SAFTY staffing was sometimes inadequate to handle multiple crises in different regions of the County, which continued to slow the response time and required intervention by the Crisis Services teams. To address surges in need and to keep response times reasonably prompt, Behavioral Wellness implemented crisis services, including the Crisis Triage Teams, which has helped to alleviate some of SAFTY's workload, particularly in Emergency Rooms, and helped increase SAFTY's ability to respond to schools, homes and the community, which was a primary goal of the original SAFTY model. Behavioral Wellness and Casa Pacifica negotiated changes to their contract including reducing some supervisorial staff and increasing line staff. Hours of operation

were also changed so that SAFTY operates between the hours of 8am to 8pm seven days per week. This reduction in supervisory staff allows for greater staffing during busier daytime hours which has helped with improving response times and a greater percentage of face-to-face evaluations vs. phone screenings, as well as achieved one of the primary goals of keeping kids out of ER's.

To date, Cottage Hospital continues to decline granting SAFTY hospital privileges; however, the hospital works closely with SAFTY when a youth is evaluated there, and EPS staff would like follow up support to be provided in the home. A Children's Crisis Triage Team has been placed in Marian Hospital ER, and covers Lompoc ER, and consists of a mental health practitioner and a parent partner conducting 5150/5585 evaluations and ongoing support to the youth's parents. SAFTY works closely with this team collaborating each morning on where the need is greatest, and continues to conduct evaluations in Marian and Lompoc ER's as needed, including from 3:00 – 8:00 pm, over the weekend, and on the days the Crisis Triage mental health practitioner is not working. The Children's Crisis Triage Program in South County provides linkage and ongoing stabilization to families in the community and collaborates with SAFTY to ensure all youth receive ongoing support. In the upcoming years, collaboration between SAFTY and the Children's Triage Program will be reviewed as sustainability of this overall crisis response model for Children and TAY will be essential as the Triage grant funding ends.

Program Performance (FY 18-19)

SAFTY

	Unique Clients Served	
	North	**South**
Age Group		
0-15	378	208
16-25	221	130
26-59	0	0
60+	0	0
Missing DOB	0	0
Total	**599**	**338**
Gender		
Female	340	202
Male	257	136
Missing/Other	2	0
Ethnicity		
White	161	98
Hispanic	267	120
African American	13	4
Asian/Pacific Islander	6	4
Native American	1	0
Other/Not Reported	151	112

Client Outcomes

Call Outcomes	Total
Contact Type	
Total Calls	1,802
Crisis Calls	1,529 (85%)
Non-crisis Calls	273 (15%)
Face to Face	867
Reason for Calls	
Suicidal Ideation	36%
Increase in Mental Health Symptoms	14%
5150/5585 Re-Assessment / Bed Search	10%
Resources/Access to Service	9%
In-Person Follow Up	5%
Self-Injurious Behaviors	5%
Suicide Attempt	5%
Aggression Towards Others	4%
5150/5585	3%
Oppositional Behavior	3%
Peer/Family Conflict	2%
Homicidal Ideations	1%
Other	1%
Substance Use/Abuse	0%
Hospitalization	
Hospitalization Rate on Calls (non-crisis excluded)	10%

SAFTY reports call characteristics to Behavioral Wellness. In the 2018-2019 fiscal year, SAFTY reported that the program received a total of 1,802 calls, 867 of which had an in-person response. The most common reason for a call was suicidal ideation; these accounted for over one-third of all calls. The next most common reasons were an increase in mental health symptoms (14%), 5150/5585 re-assessment (10%), seeking resources (9%), an in-person follow up (5%), self-injurious behaviors (5%), and suicide attempts (5%). In examining hospitalization, two rates of hospitalization are provided. *Hospitalization Rate on Calls* examines calls that were designated as crisis, which were 85% of all calls. Ten percent of crisis calls led to hospitalization.

Access and Assessment Teams & ACCESS Line Program

Provider:	Behavioral Wellness
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures	$4,383,400
Estimated PEI Funding	$3,117,900
Estimated Medi-Cal FFP	$1,260,500
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$5,000

Average Cost Per Consumer	$3,487
Estimated Total of Consumers Served	1,257 (based on Access service, no Access Line target)
Target Population Demographics Served	Children, TAY, Adult, Older Adult

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

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

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

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

Program Challenges and Solutions

Behavioral Wellness centralized the Access call center within the Office of Quality Care Management by routing all Access calls to one place. Staff dedicated to this function were hired and trained. The hope was to allow staff in each of the Adult and Children's/Youth Clinics (Santa Barbara, Lompoc, and Santa Maria) to focus more on scheduled assessments coming from community referrals and orientation groups. However, the calls to the access line at times are too great, and this leads to the increase of walk-ins at both the adult and children's clinics. Each team in Santa Barbara, Lompoc, and Santa Maria is bicultural and bilingual. An Access template within the Electronic Health Record is used to track timeliness and then continues to be utilized across the Department to monitor access improvements. Demonstrative progress towards these goals would be an increase in timeliness in links to services, and an increase in consumers served through the access line and a decrease in walk-ins at the outpatient clinics.

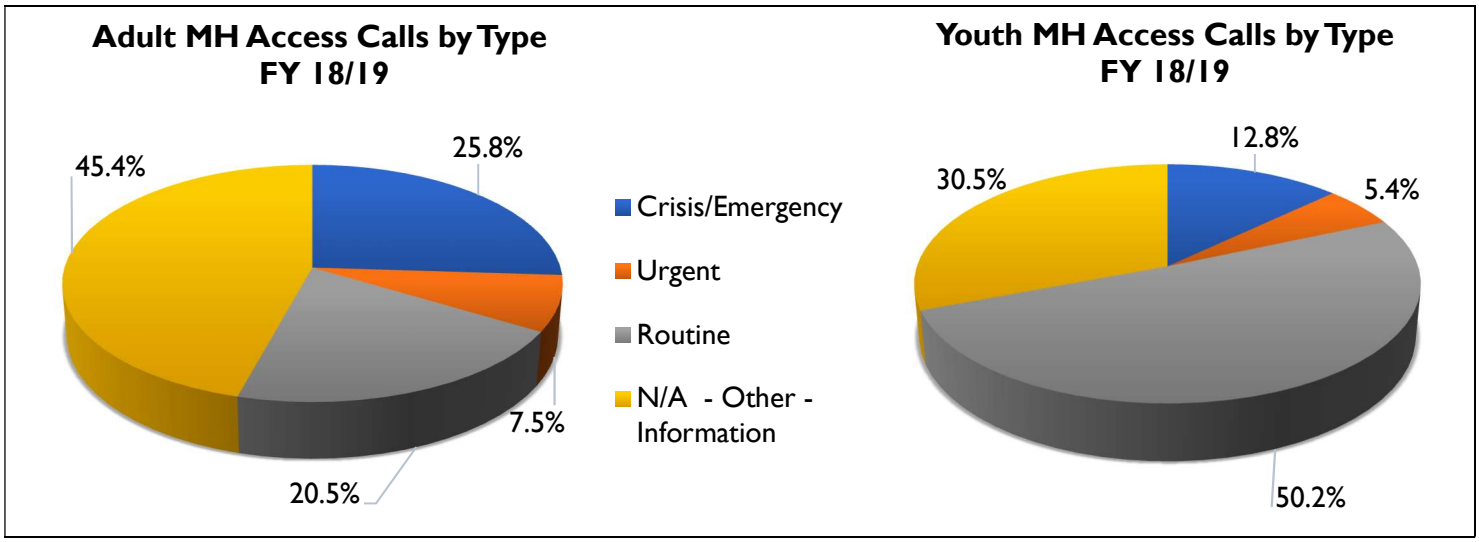
The existing Access staff in each adult, youth or crisis clinic rotate as officers of the day that are available for walk-in routine, urgent and crisis care. This allows for routine requests for service to be quickly scheduled for an assessment and for crisis/urgent services

In the last Three-Year Plan Stakeholder process, Access and Assessment staffing was not included for the Children's and TAY clinics. The same staff that are providing ongoing treatment to consumers respond to walk-ins and ongoing intake and assessment duties- causing an impact on the services for ongoing consumers. As a result, in FY 19-20 staff were assigned for children and TAY access duties rather than staff in the clinics rotating this role which will hopefully improve timeliness to care. In addition, specialized screeners were created in collaboration with the Department of Social Services for Katie a Children referred for access, screening, and service provision.

One idea for walk-in access in the community for Youth is the Drop-In Center idea call "alcove" and being piloted in Santa Clara. Santa Barbara has received immense support from youth, families, and community for applying for any State funding or advocacy for such an initiative should it be available in upcoming years. This type of program would supplement the Access role in our County and the BWELL staff could go to the center or contract access duties with a Community Based Organization.

Mental Health Access Line Program Performance (FY 18-19)

In FY 18/19, there were 8,724 total Mental Health (MH) calls/entries, an average of 727 calls per month, close to last fiscal year's average of 743 calls per month. Nearly half of all calls (46%) were to request information or "other". About one-fifth of all calls were classified as crisis/emergencies (22%), another 7% were urgent calls. Routine calls were about one-quarter of all calls (24%). These are similar proportions to last fiscal year. Calls are displayed below by age and type. While almost half of adult calls were to request information, half of youth calls were "routine." A quarter of adult calls were considered crises (26%) and 13% among youth.



Mental Health Access Line Timeliness

Timeliness, from contact with the 24-hour Access Line to services, serves as a critical set of metrics for the Department. It is important to note that the Access Line structure, staffing, and data collection tools changed in October 2016, and that the State changed reporting requirements and regulations. Therefore, this year's data is only comparable to data collected after October 2016. It is expected that the accuracy of these indicators will continue to improve as the Department further refines data collection tools and processes. This year, the metrics were examined by adults and children in order to more fully understand the differences between groups.

Mental Health Access Timeliness, FY 18/19			
		Adult	**Youth**
Routine	offered an appointment within 10 business days	92%	91%
Urgent	offered an appointment within same/next day	96%	57%
Crisis	offered an appointment within same/next day	99%	97%

The data are displayed slightly differently this year; last year we looked at this data by quarter because Access was still new. This year we are able to provide an overview for the entire year, by adult and child. Compared to last fiscal year, these metrics have improved substantially. Last year, routine calls were offered an appointment within 10 business days between 73-87%; this year, the average was 91% for youth and 92% for adults. For urgent calls, the range last year was between 72-91% for everyone; this year the average for adults was 96% and an average of 57% for youth. The low percentages for urgent calls to youth highlight an area for timeliness improvement that was not identifiable when both age groups were examined together. It is valuable to note that this figure was based on a small N, which allowed screeners to review classification and timeliness, and also led to immediate training for access screeners about the definition of an urgent call and the timeliness standards. Finally, calls designated as crisis improved in timeliness from 86-98% within same/next day last fiscal year to an average of 99% for adults and 97% for youth this fiscal year.

Access and Assessment Staff Program Performance (FY 18-19)

Unique Clients Served			
	Access & Assessment		
	South	**West**	**North**
Age Group			
0-15	0	0	0
16-25	8	31	136
26-59	174	255	532
60+	31	29	60
Missing DOB	0	0	1
Total	***213***	***315***	***729***
Gender			
Female	82	170	329
Male	131	144	400
Unknown	0	1	0
Ethnicity			
White	120	148	286
Hispanic	40	105	368
African American	8	37	35
Asian/Pacific Islander	2	9	8
Native American	3	5	21
Other/Not Reported	40	11	11

Access and Assessment Client Outcomes

	South	**West**	**North**
Incarcerations/Juvenile Hall	--	--	--
Psychiatric Inpatient Care	1%	1%	1%

Access and Assessment Client Outcomes

In the 2018-2019 fiscal year, the Access and Assessment Team in North County saw 2-3 times as many clients as the teams in West and South County. To understand this variation, it is important to understand that clients

have the choice to either complete an initial assessment on the phone with an Access screener or in-person as a walk-in to one of these clinics. Clients may choose, and clients in North County may prefer to speak with someone face-to-face rather than on the phone. Further, North County has a higher portion of their population on Medi-Cal, and therefore may screen more Medi-Cal clients who are then ultimately referred to Holman or the community for a lower level of service intensity.

The client outcomes table displays the percent of clients who experienced an inpatient psychiatric hospitalization during their admission to the program in the 18-19 fiscal year. One percent of clients in North County, 1% of clients in South County, and 1% of clients in West County experienced hospitalization. Incarceration/juvenile hall data were unavailable this year and we are unable to report on these metrics.

Innovations

The Innovations component of MHSA provides funding for projects not to exceed 10 years that:

1. Introduce a mental health practice or approach that is new to the overall mental health system, including, but not limited to, prevention and early intervention.
2. Make a change to an existing practice in the field of mental health, including but not limited to, application to a different population.
3. Apply to the mental health system a promising community-driven practice or approach that has been successful in non-mental health contexts or settings. With the mental health practices or approaches that have already demonstrated effectiveness are only eligible with an adaptation and rationale for the adaptation.

Primary purpose of an Innovation projects normally has one of the following:

1. Increase access to mental health services to underserved groups.
2. Increase the quality of mental health services.
3. Promote interagency and community collaboration related to mental health services and supports or outcomes; or
4. Increase access to mental health services.

The two Innovations Projects are RISE and Technology Suite: Help@Hand.

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

Provider:	**Behavioral Wellness**
Estimated Funding FY 2020/21:	**RISE project completed FY 19/20**
Estimated Total Mental Health Expenditures	$0
Target Population Demographics Served	Children, TAY

Resiliency Interventions for Sexual Exploitation (RISE) was initially funded (2.6 Million) for three years in 2015 and recently received a two-year extension and additional funding (2.6 million) through June 30, 2020. The RISE Project provided bio-psycho-social support services to children and youth exposed to or at risk of sexual exploitation and trafficking. The approach relies on interagency collaboration and multi-layered treatment, training, and education that include partners throughout the community.

RISE services were offered countywide to target populations residing in the Santa Maria, Lompoc, and Santa Barbara regions of Santa Barbara County. Due to a higher rate of sexual exploitation and sex trafficking activity,

the Santa Maria and Lompoc regions were allotted more resources and focus. The priority populations served by the RISE Project were females and LGBT/GNC youth ages 10-24 and their families, specifically underserved African-Americans, Asian/Pacific Islanders, Latinas, indigenous Native Americans, and those identified as LGBT/GNC at risk of sexual exploitation or trauma; identified as Commercially Sexually Exploited Children (CSEC); or at risk of out-of-home placement, are residing in Juvenile Hall, foster care or group homes or "runaway youth".

The core principles of RISE were EMPOWERMENT and RESTORATION achieved through a non-judgmental/non-shaming "survivor-driven", community and system-based service delivery program. Simply put, RISE met youth where they were, both figuratively and literally. Each youth's unique strengths, needs and preferences were assessed through a comprehensive trauma-informed screening process designed to identify several biopsycho-social and "hierarchy of needs" factors including, trauma related symptoms, risk/protective factors, safety, so-cioeconomic/cultural/spiritual background, natural supports, education, AOD supports, medical/reproductive needs, housing/placement, vocational/pro-social, legal restoration and readiness for engagement. RISE worked toward supporting each youth to find their own sense of self, hope, purpose and belonging so she/he/they could become empowered in their own destiny.

Components of RISE:

- An extensively **CSEC trained trauma-informed culturally aware team**
- **Client/Family Driven** goal identification and treatment planning
- **Clinical Lead**: Licensed behavioral health clinician specifically trained to work with sex trauma and sexual exploitation survivors/victims
- **System Navigator**: A member of RISE who had built rapport with each youth to ensure consistent and easy access to services through providing transportation, "warm handoffs", and advocacy within the child welfare, juvenile justice, educational, medical and mental health systems
- **Health and Wellness Advocate**: A licensed medical professional to attend to medical, reproductive, AOD and overall physical wellness. Physical health is greatly impacted by childhood trauma and attending to the biological health needs is paramount to assist in restoration
- **Rehabilitation Specialist**: An experienced practitioner that conducts extensive outreach and engage-ment and will work with each youth on developing a plan which includes numerous community-based resources/supports to address vocational, pro-social and educational restoration and reintegration
- **Peer/Survivor Support:** A trained peer or survivor that can provide a unique parallel and empathetic perspective as well as act as a role model and advocate
- **Biopsychosocial Treatment Model** focusing on wellness, resilience and recovery supports which attend holistically to each youth through a biological, social, psychological, spiritual, cultural, and strengths-based approach
- **CSEC Hierarchy of Needs** to address environmental needs, basic necessities and inalienable human rights i.e., food, clothing, shelter, safety, love, belonging, purpose, self-esteem and self-actualization
- **Coercion Resiliency** through Runaway Youth/Ending the GameTM program
- **Comprehensive Assessment, Screening and Identification Tools** that are culturally sensitive and trauma-informed. RISE helped to create a Santa Barbara County multi-collaborative "First Responder CSEC Identification Tool"

- **Non-Traditional and Easy Access** to services, providers and supports through 24/7 crisis hotlines, mobile intake/treatment, flexible scheduling, transportation to and from appointments/supports, "warm hand-offs" and welcoming intake process
- **Non-Judgmental and Non-Shaming:** RISE provided a "safe haven" for trauma exposed and exploited youth where they could feel free to express themselves in an environment free of shame or judgment
- **RISE Center:** Outside of scheduled classes, groups, wellness activities and counseling, RISE provided a welcoming home-like setting for our youth to come and rest, make a meal, talk to their support team, work on projects, listen to music or obtain reproductive/hygiene/educational supports even if they didn't have an appointment
- **Outcome Measures** and ongoing multi-agency CQI/QA (Continuous Quality Improvements/Quality Assurance). RISE Project collected data on service delivery fidelity and outcomes to test for programmatic efficacy. RISE can be used as a learning tool for providers to develop more effective ways of successfully treating this high-risk population and provide insight into preventative measures including using the Toolkit in their initiatives
- **Early Intervention** to address ways to make youth more resilient and knowledgeable in order to make them less susceptible to victimization (early social emotional skills training, social media awareness for youth and parents)
- **Outreach** for unidentified and underserved trauma exposed youth
- **Flexible Funds** effort to create a way to support non-traditional needs for CSEC that are not typically funded through other resources
- **Psycho-education and Trainings** to improve CSEC identification and Trauma/CSEC informed interventions and protocols county wide
- **Multi-Disciplinary Teams (MDT's):** RISE regularly facilitated and attended MDT's and was an active member in SB County District Attorney's HART Court ("*Helping Achieve Resiliency Treatment*"; a multi-disciplinary treatment team for CSEC youth involved in the Juvenile Justice system)

Program Challenges and Solutions

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

New Senate Bill 855 mandates significant CSEC Administrative protocols that require increased resources. RISE staffing was insufficient to meet the needs of growing intensive caseloads and the lack of other community supports. In response to this challenge, the Department partnered with SB County Law Enforcement, Child Welfare Services, Juvenile Probation, Public Health, Juvenile Court, North County Rape Crisis, Standing Together to End Sexual Assault (STESA), and the District Attorney's Victim Witness Program to receive Tier II CSEC funds. This multi-disciplinary team discussed possible CSEC administrative support through this collaborative. RISE also

collaborated the Victim Witness/District Attorney/Human Trafficking Task Force, who is assisting with the SB855 Multi-Disciplinary Team/Treatment mandates.

The Department identified larger numbers of community youth at risk of CSEC than originally expected, and the CSEC population's needs are higher and more complicated than anticipated, including initial outreach and engagement prior to agreement for services. The Department's solution is to merge RISE into our new existing Full-Service Partnership for TAY youth after the two-year extension ends in June 2020. Staff from RISE will join the TAY teams in the department to offer this specialized expertise to any youth consumers receiving those services and the youth in RISE will be transitioned as best as possible with those staff member's to those teams.

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

Future Directions & Sustainability

The request for extension funding was granted for an increase of $2,600,000 for two additional years of programming from July 2018 – June 30, 2020. The project was extended in September 2018 and anticipates completion of a final evaluation report and Toolkit by December 2020. During this two-year extension time, RISE continued to develop program components and evaluation protocols. The extension addressed six principle areas:

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

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

- *Develop a practical toolkit, "How to Develop an Effective Multi-Disciplinary Approach for Exploited Youth"* to help other counties replicate the Program, avoid the costly and lengthy approach of "reinventing the wheel" and gain the capacity to effectively deal with common barriers to success.
- *Meet an urgent and ongoing community need by continuing the Program*, including staffing, operations, and evaluation, including continued work by the Behavioral Wellness' evaluation team partners with the University of California at Santa Barbara.
- *Deploy the recently developed multi-agency shared screening and assessment tool* to review usefulness across all systems.
- *Continue training, education, and public awareness* regarding signs and risk of mental illness related to sex trafficking for 2,660 individuals.
- *Develop trauma-sensitive crisis interventions available 24/7 to a larger number of survivors* in community because the need is greater than originally anticipated.

- *Increase Survivor Mentor outreach/supports* through partnership with Runaway Youth/Carissa Phelps.
- *Continue safe and therapeutic housing, temporary shelter and relocation efforts.* Resources are low, and costs are high. We have established partnerships with Good Samaritan Safe House for adult survivors, Salvation Army, and Carpinteria SAFE House for youth under 18.
- *Increase outreach and engagement efforts for LGBT/GNC CSEC youth*. RISE and the University of California, Santa Barbara (UCSB) are in the process of finalizing the LGBT/GNC tool, which will facilitate data collection for this mostly un-researched, high-risk CSEC population.
- *Continue to provide specific specialized treatment space in all regions of county*.

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

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

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

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

Sustaining RISE

The County has created new Full-Service Partnership (FSP) Programs with the capability to be reimbursed by Medi-Cal for billable expenditures for TAY (See FY 18-20 Three Year Plan Proposal in this document). Additionally, the Full-Service Partnership Programs perform Access and Assessment, outreach engagement, and linkage services, which are more Prevention and Early Intervention strategies. This was reviewed with additional children-focused staffing in FY 19-20 in Access and Assessment teams. The additional value of extending this for two years was to determine best methods and approaches to serving victims of human trafficking, and also provide prevention to those at risk of trafficking. The tools established in Santa Barbara County are being reviewed as possible best practices and may be replicated in other counties or States. The Program received a large demand due to community collaboration and the number of those whom are victims of trafficking in our county is growing. As a result, systemwide CSEC training will be implemented for all Department staff via the online Relias platform and specialized expertise will be deployed in each of the FSP TAY teams on a permanent basis.

Program Performance (FY 18-19)

RISE (Resiliency Interventions for Sexual Exploitation Project) *

Unique Clients Served	
Age Group	**All Regions***
0-15	22
16-25	45
26-59	0
60+	0
Missing DOB	0
Total	**67**
Gender	
Female	67
Male	0
Missing	0
Ethnicity	
White	7
Hispanic	49
African American	3
Asian/Pacific Islander	2
Native American	1
Other/Not Reported	5

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

Client Outcomes

Child & Adolescent Needs & Strengths Assessment (CANS-50) Age: 6-20 years	**Percent Improvement**	
	Initial to 6 months	**6 to 12 months**
Life Functioning (e.g., ability to communicate and interact with families, communication, social functioning and health status)	--	--
Behavioral/Emotional Needs (e.g., symptoms of depression, anxiety, psychosis and other conditions)	--	--
Risk Behaviors (e.g., self-injury, suicidal behavior, bullying, and running away)	--	--
Cultural Factors (e.g., language, traditions, stress)	--	--

Caregiver Resources & Needs (e.g., child supervision skills, family stress levels, residential stability, and caregiver physical/mental health status)	--	--
Strengths (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment)	--	--
Higher Levels of Care	**% with any admissions over FY 18-19**	
	All Regions	
Incarcerations/Juvenile Hall	--	
Psychiatric Inpatient Care	5%	

Due to a state mandated change, Santa Barbara County began using a new version of the CANS (CANS-50) in July 2018. This change in instrumentation made all existing CANS reports (such as compliance and outcomes) obsolete. Due to the analytic complexity of the CANS and the desire for clinicians and supervisors to be able to review their client strengths and needs over time, Santa Barbara County is in the process of contracting with a CANS and PSC software provider. In addition to changing versions, the CANS age range was also extended to age 20.

The client outcomes table displays the percent of clients who experienced an inpatient psychiatric hospitalization during their admission to the program in the 18-19 fiscal year. Five percent of RISE clients experienced hospitalization. Incarceration/juvenile hall data were unavailable this year and we are unable to report on these metrics.

RISE Program Evaluation Results

The program is evaluated by an external evaluator, Jill Sharkey, PhD. Included below is the Executive Summary of the 2018-2019 RISE Evaluation. The full evaluation is available on the Department website: https://www.countyofsb.org/behavioral-wellness/mhsa-home.sbc

Evaluation Goal #1: Effectiveness and Impact of Using a Shared Screening Tool

RISE partnered with the Santa Barbara County District Attorney's Human Trafficking Task Force (HTTF) to develop and implement a countywide First Responder Identification Tool (FRIT). The FRIT includes indicators of suspected commercial sexual exploitation (CSE) and instructions to make a suspected child abuse report (SCAR). Data from Santa Barbara County Child Welfare Services (CWS) indicate that SCARs for CSE have increased since the implementation of RISE and the FRIT (i.e., from 1-5 reports per quarter in 2015 to 14-22 reports per quarter in 2019) suggesting improved recognition of and responding to CSE.

Additionally, RISE was instrumental in the adoption of the West Coast Children's Clinic Commercial Sexual Exploitation Identification Tool (CSE-IT) for use in service delivery systems. The CSE-IT guides a structured interview to determine if a person has possible or clear concern of commercial sexual exploitation (CSE). CWS data from December 2015 to June 2019 indicate that 39% of children on their caseload ages 10 years or older had a possible or clear concern for CSEC.

RISE has also helped additional county agencies institute CSE protocols. Santa Barbara County Behavioral Wellness implemented screening questions and a response protocol with their 24/7 toll-free crisis response and Service Access line. Santa Barbara County Probation implemented the FRIT for all youth who are booked into the juvenile hall and results of their risk determination are entered into their case management system.

Evaluation Goal #2: Impact of RISE for Young Women Vulnerable to or Involved in CSEC

The RISE Project provides bio-psycho-social support to children and youth exposed to or at risk of sexual exploitation and trafficking. The approach relies on interagency collaboration and multi-layered treatment, training, and education that include partners throughout the community. A comprehensive female specific and trauma-

informed model of services, resources, protocols, education, and training is continually being developed, implemented, and tested for efficacy.

The RISE Project approaches intervention within stages, recognizing that various clients have different needs as they progress through engagement and treatment. Each stage may take days, weeks, or years, depending on each individual's journey. Clients typically cycle between stages, often returning to "stabilization" several times before more consistently advancing into "coping strategies" or "maintenance." To date, very few clients have reached the "leadership" stage, which is a journey that takes several years.

During the 2018-2019-year, multiple smart tools (an LGBT/GNC and a Race, Ethnicity, Culture, and Discrimination Tool) were developed to enhance the assessment of youth needs to more effectively support them starting with program engagement. Overall, demographic data were collected for 134 RISE participants in the Behavioral Wellness data system, which documents the diversity of RISE clients, who were primarily female (96.8%).

ACEs scores were available for 42 clients; their scores ranged from 0 to 10 with an average of 5.1. Common ACEs were sexual abuse, emotional abuse, witness to community violence, witness of family violence, disruption to caregiving/attachment losses, and victim witness to criminal activity. Results indicate that clients in RISE have ACEs scores that put them at extremely elevated risk for health difficulties and early death.

A lifetime history of prior Behavioral Wellness services provided to clients in RISE was available for 149 RISE Clients for all admissions that began prior to June 30, 2019. RISE clients typically have a long history of services in mental health and substance, with an average of 9.6 primary admissions lasting an average total of 3.5 years. Clients were referred for their first set of Behavioral Wellness services primarily by schools (29%) and juvenile probation (17%) followed by Other Community (13%), Social Services (10%), Law Enforcement (9%), Health Care Providers (7%), Friends/Family (7%), and Behavioral Wellness clinics (5%). Only 8% of clients referred to Behavioral Wellness entered the RISE program at their first admission. More common pathways into the Behavioral Wellness system were through crisis services (43%), other Behavioral Wellness programs (19%), outpatient children's services (19%), and juvenile justice (11%).

On July 1, 2017, RISE implemented a detailed daily service provision tracking process aligned with their triage system of intervention. The RISE tracking system consists of ten services categories (therapy, rehabilitation, medication support, rehabilitation health and wellness, plan development, assessment, case management, client support, crisis intervention, and pre-consumer). Each service for each client is tracked on a daily to weekly basis during team meetings. Overall, triage reporting was completed on 4780 activities for 113 clients in 2018-2019. The number of contacts per client ranged from 1 to 175 with an average of 42.3 contacts per client. The evaluator conducted three 90-minute focus groups with RISE staff in order to provide more detail about RISE service provision. These interviews include detailed information about client needs, client engagement, and client safety concerns.

The Pediatric Symptom Checklist (PSC) is administered to clients over multiple time points by a clinician with a client's parents or caregivers to help determine severity of mental health needs. At the first PSC, administered with 47 clients, 61.7% of RISE Clients scored at or above the cut-off indicating risk for overall mental health need. Percent RISE clients scoring above the cut-off score on subscales was 34% for Attention, 38% for Internalizing symptoms, and 38% for Externalizing symptoms. These rates far exceed the 12% of need found within the general population.

RISE Program staff administered 49 consumer surveys to 38 RISE participants between December 2016 and June 2019. Participants were asked to provide feedback about the RISE Project and related services, confidentially.

Results indicate that clients really enjoy RISE because they enjoy being able to talk to and trust people, they get the things they need, they express their emotions, they get support, they learn coping skills, and they are monitored. Girls often felt less favorable about other partner agencies where they have also received services.

Evaluation Goal #3: Interagency Collaboration and Impacts on Improved Recognition and Response
Central to RISE Project success has been the pre-planning process and ongoing collaboration between all partners. These collaborative partnerships have been key in shifting the community toward a CSE– or Trauma–Informed Lens and changing the culture from criminalization to treatment and support. Evidence of such collaboration is found in media reports as well as RISE staff interviews regarding referrals and interagency collaboration. Identification and reporting protocols, multidisciplinary teams, and the Helping to Achieve Resiliency Treatment Court for CSE children (HART Court) are all new and formalized methods of interagency collaboration established in partnership with RISE.

Evaluation Goal #4: Increases in Funding and other Public Support
The RISE Project has been a key partner within the Human Trafficking Task Force (HTTF) to support survivors once identified. Together, partners have provided trainings including developing a documentary that summarizes CSEC in Santa Barbara County. Media coverage demonstrates public support and funding including non-profit partnerships. The RISE project has been designated as a promising program, has been presented about at professional conferences, and has been documented in peer-review publication.

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

Provider:	**Behavioral Wellness**
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures	$1,077,700
Estimated INN Funding	$1,077,700
Estimated Medi-Cal FFP	
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer	$1,078
Estimated Total of Consumers Served	1000
Target Population Demographics Served	Children, TAY, Adult, Older Adult

The Help@Hand Project is a California statewide 14 county and city collaborative project bringing technology-based mental health recovery-based applications to the public mental health system through a “suite” of digital technology. Late 2019, the collaborative project selected to change the project name from Technology Suite to Help@Hand Project to better represent the project’s aim to provide help at hand to Medi-Cal beneficiaries within Californians who are in need.

The collaborative project is working towards expanding access to mental health services by engaging and treating individuals that are underserved in the current traditional care delivery model. Counties will independently test technology for target populations identified by each individual county as is being managed by CalMHSA. The collaborative hopes to leverage digital education and digital wellness tools to better serve those in need and share the county-specific learnings in the process. Focus areas for the collaborative vary from Peer Chat and Digital

Therapeutics, Virtual Evidence Based Therapy Utilizing an Avatar and Passive Data Collection for Early Detection and Intervention. Santa Barbara will only test and adopt technologies that have either Peer to Peer Chat and/or Digital Therapeutics.

To ensure that county projects move forward, CalMHSA at the request of the multi-county collaborative rear-ranged budgeting models allowing for counties select for portion of county dollars to be spent collaboratively while other portions to remain locally. Budgeting portions referred to as "buckets" were developed in sections around Peer, Outreach and Engagement, Marketing, Technology and Evaluation. Most counties agreed to share collaborative funds on Evaluation and Technology dollars now include the "pilot funds". Evaluation efforts will be captured through a contract with University of California in Irvine (UCI). Technology Pilot funds will allow for each county to select, test and evaluate technology and share the learnings of that technology with the collaborative. Pilot structure is based on a three to six-month pilot timeline. Overall adoption of technology will be screened through the Pilot structure created by CalMHSA.

Santa Barbara Technology Peer Career Ladder

In November 2019, the project hired the Healthcare Coordinator serving as Project Manager. The Project Manager reports to the Peer and Ethnic Services Manager and manages the Santa Barbara Help@Hand team. The project is seeking to hire a Case Manger to serve as Outreach Coordinator in Summer of 2020. Recovery Assistants will be hire to serve as Digital Mental Wellness Ambassadors serving within Psychiatric Health Facility (PHF), throughout Department Adult Clinics, Crisis Residential Units and at contracted Recovery Learning Centers with peer-run computer labs. Currently, the project has hired a team of peers through Extra-Help employment opportunities to assist with the adoption of technology and to keep the project current. Refer to the Consumer Empowerment and Peer Employment section of the plan to learn more.

Santa Barbara County's Target Populations

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

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

Digital literacy assessments will be launched Fall of 2020 to better understand target populations digital literacy and accessibility to digital devices such as tablets, smartphones and desktops/laptops. Project will work with UCI to capture the project's baseline data and peer technology and art organization Painted Brain to better engage and empower community with the deployment of the Peer Technology curriculum which is the first of its kind. The three modules will be Trainer-The-Trainer (Digital Peer Support), Digital Empowerment Toolbox (Technology Device basics) and Digital Wellness Toolbox (Introduction to Wellness Apps, Tele-Health and digitalized Public Benefits apps) Project is expected to train staff serving within three target populations.

To ensure that project remains inclusive, the project is exploring creative solutions for multi-lingual and multi-cultural Digital Mental Wellness Ambassadors in response to feedback gathered throughout FY 2019-20 and three-year community program planning process for FY 2020-23. The Digital Mental Wellness Ambassadors will deploy Peer Technology curriculum developed by Painted Brain in conjunction with Project Manager, Department Peer and Ethnic Services Manager and MHSA Chief. Digital Mental Wellness Ambassadors will give project updates monthly at the Cultural Competence and Diversity Action Team and will serve as trainers to the work of contracting agencies under MHSA PEI efforts and trusted peer partners such as Self-Help Groups Santa Barbara.

State-Wide Project Goals:

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

FY 2019-20 Learning Objectives:

1. Establish a system to monitor hospital, crisis stabilization, and crisis residential discharges of Behavioral Wellness clients and ensure that these individuals are offered PPCDT software and provided follow-up guidance and support in its use.
   Status Update: This learning objective has begun and will continue into FY 2020-21 at which time the first adoption of technology is scheduled to launch. Currently, project and IT staff are hosting bi-monthly meetings to discuss and monitor county-sponsored technology devices throughout the county for the peers to test.
2. Reach Behavioral Wellness Adult Clients Residing in Geographically Isolated Areas
   Status Update: This learning objective is being met through outreach efforts work schedules to start May 2020 with peer-run contracted technology organization Painted Brain
3. Connect with TAY Enrolled in Colleges and Universities
   Status Update: This learning objective will continue through the interactions within peer mental health and disability services within Santa Barbara City College, Allan Hancock in Lompoc and Santa Maria.

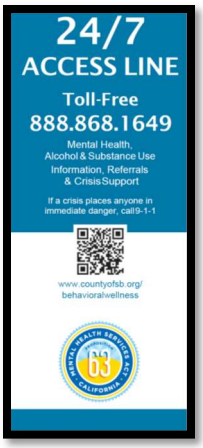
Program Challenges and Solutions

FY 2020-21 Objectives are to:

1) Establish peer chat support available 24/7 available in English and Spanish and link to department website and disseminate software.
   Status Update: Santa Barbara Help@Hand team is currently working through peer-to-peer wellness calls and practicing how to facilitate peer chat lines via ZOOM platform. Adoption of peer-to-peer chat warm line is currently awaiting updates on Peer Certification and current Peer Chat Lines throughout State.
2.) Strategic approaches to access points that will expose individuals in target populations to the Peer to Peer Chat and Digital Therapeutics service.
   Status Update: Access points throughout Carpinteria, Santa Ynez and Guadalupe are currently being vetted and community meetings within community points will be held after the stay-at-home order due to COVID19.
3.) Outcome evaluations of all elements of the project, including research and outcomes.
   Status Update: Santa Barbara and the University of California Irvine team will launch an evaluation May-June 2020 gathering baseline digital literacy data; access to technology and current use and knowledge of digital mental wellness tools.

Refer to Consumer Empowerment and Peer Employment section of the plan to learn more about the current work of the local Santa Barbara Help@Hand team.

Updated UCI Evaluation Materials and Updates from the Project can be found on the Department's website within the Community tab in the MHSA link: countyofsb.org/behavioral-wellness/mhsa-home.sbc



All items are created by peers in English and Spanish
ACCESS Line Bookmark with QR Code created by Help@Hand team
A Guide to Wellness Apps created by Help@Hand team and Painted Brain

NEW: Proposed Hospital Collaboration Project Ideas

Provider:	**Community Partners**
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures:	Set money aside should funding be available
Estimated INN Funding:	Unknown; depends on status of COVID

Where are we today?

The **Crisis Action Team** aims to improve system-wide crisis response services while improving relationships and collaborative communication between Behavioral Wellness, Law Enforcement, Hospitals and American Medical Response (AMR). Through this teamwork, the rights of individuals in psychiatric crises are a key focus and needs are met in the least restrictive manner possible. Over the years, the Crisis Services continuum has been a key priority for MHSA based on continued input from the Crisis Action Team and various stakeholders in planning years. As a result of partnerships, MHSA has a variety of Crisis Programs in the FY 2020-2023 Plan. These include:

Community Services and Supports (CSS) Funded:

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

Senate Bill 82 and CSS Funded:

- Childrens' Crisis Triage Teams in North, South, and West

Prevention and Early Intervention (PEI) Funded:

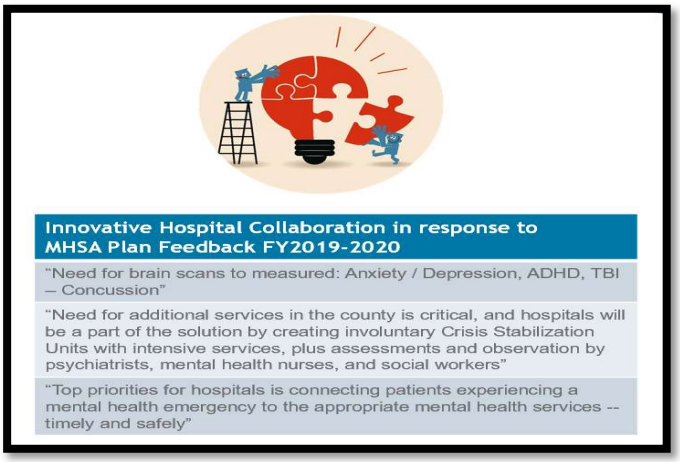
- Safe Alternatives for Children and Transitional Age Youth (SAFTY)
- Access and Assessment and Access Line Service

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

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

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

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



Picture is Example from March 2020 Power point presentation
at Crisis Action Team MHSA Planning for Project Ideas

Future goals and ideas for Collaboration with Hospitals Project?

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

NEW: Hospital Collaboration Project Proposal Idea?

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

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

Housing

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

Completed MHSA Housing Projects:

- **Garden Street Apartments, Santa Barbara**

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

- **Home-based on G Street, Lompoc**

MHSA housing funds support 13 affordable units for persons with mental illness in Central County.

- **Rancho Hermosa, Santa Maria**

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

- **Residences at Depot Street**

MHSA funds support 35 units, including family units, for persons with mental illness including studios, one- and two-bedroom units.

Picture of Residences at Depot St. during construction, photo provided by Housing Authority of County of Santa Barbara

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

The "No Place like Home" Initiative

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

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

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

1) **West Cox Cottages** The Department has jointly applied with the Housing Authority for the County of Santa Barbara for $1.5 million in non-competitive NPLH funds. The application has been approved and awaiting our Letter Awarding Funds. This anticipated money will fund 13 units exclusively for persons with a serious mental illness experiencing homelessness. Construction is anticipated to begin on these units in Spring 2020 in Santa Maria.
2) **Hollister Lofts** The Department has jointly applied with the Housing Authority for the County of Santa Barbara for $4,822,998 in NPLH competitive funds. The application has passed the initial threshold review and we are awaiting a final determination. If awarded, these funds will be used to build 20 units exclusively for persons with a serious mental illness in South County.
3) **Cypress and 7th** The Department will jointly apply with the Housing Authority for the County of Santa Barbara for $250,000 in NPLH non-competitive and $1.5 million in NPLH competitive funding for 19 units exclusively for person with a serious mental illness in mid-County. The Department anticipates applying for these funds in the third round of NPLH competitive funds in December of 2020.

Santa Barbara start-up or "technical assistance" (TA) funds were granted and $50,000 of the $100,000 allocation was provided to the Housing and Community Development Department to renew the Santa Barbara plan to end homelessness. The County-wide Plan to End Homelessness 2019-2029 is now available on our County website. The remainder of TA funds will be used to cover administrative and staffing costs associated with procuring and administering this funding.

Behavioral Wellness assisted in the creation of a Notice of Funding Available in collaboration with Housing and Community Development in Fall of 2019 and has received Letters of Intent from development partners wishing to participate in the No Place like Home Program. Proposals are formally vetted for site control and other requirements and then ranked. The Department has moved forward with two projects listed above, and anticipates applying in the third round of competitive NPLH funding in Fall 2020.

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

Workforce Employment and Training (WET)

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

More specifically, MHSA-WET addresses the fundamental concepts of creating and supporting a workforce (both present and future) that is culturally competent, provides client/family driven mental health services, and adheres to wellness, recovery and resilience values.

Our Department has dedicated WET funding by transferring funds from CSS and through our Regional Partnership to provide trainings and educational opportunities that are culturally competent, further sustain client/family centered services, and reinforce our wellness, recovery and resiliency values.

In the past three years, the Department has used CSS/WET to fund part of the peer empowerment manager position and part-time Recovery Assistant positions in the Department. A result of our continued frugality of Regional Partnership funds, the Department is spending WET Regional Partnership funding from prior years in the upcoming budget while also anticipating committing funds to the New WET Regional Partnership funding requested by the State. Both of these WET funding sources have been utilized to sustain employment through education and training, and recruitment opportunities created through education and training programs.

Consumer Empowerment and Peer Employment (WET)

Provider:	Behavioral Wellness
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures:	$356,800
Estimated CSS Funding to WET:	$356,800
Target Population Demographics Served	CHILDREN, TAY, ADULT, OLDER ADULT

As a result of the State reversion calculations, part of the peer empowerment manager position and twelve part-time employment opportunities was funded by WET through FY 19-20 and sustained by a transfer from CSS in FY 19-20 and in upcoming FY 20-23. The part-time employment opportunities are for graduates of the Workforce and Education Training (WET) Peer Specialist Training as Peer Expert Pool Staff or those community peers interested in getting back in the work force or to gain employment skills.

The Consumer Empowerment Manager also oversees two key peer initiatives beyond WET solely funded activities:

- **Key Peer Initiatives: Santa Barbara's Help@Hand Team**

On July 1, 2019 the Department launched the Santa Barbara Help@Hand Team. This consumer-led project is focused on selecting, piloting, testing and vetting three to four digital peer-to-peer chat and digital therapeutic applications for the multi-county's technology suite. The Help@Hand team develops outreach materials to promote education on digital mental health literacy and recommend self-care mobile applications from a peer support perspective. The project team consists of people with mental health illness who continue to live a life of wellness through personal recovery and resilience efforts. The team is composed of talented members such as administrative staff, peer support specialists, and technology experienced and creative people who identify as marginalized, stigmatized due to their disabilities or preferred gender identity. The Help@Hand project efforts align with the Department's "Guiding Principles" to ensure best outcomes. With Innovation funding, the Department will offer this service at no cost to behavioral health consumers and community members within the target populations who have access to a cell phone, laptop, tablet, desktop computer or similar computing devices.

The project is committed to reaching the identified target populations such as geographically isolated communities (Carpinteria, Santa Ynez and Guadalupe), Transitional Age Youth and individuals discharged for the psychiatric facility thorough augmenting current established groups within Behavioral Wellness clinics, Psychiatric Health Facility (PHF), crisis residential facilities and contracted peer-run facilities. Outreach and engagement efforts will be created to reach geographically isolated communities such as Carpinteria, New Cuyama and Guadalupe. Creative and innovative digital mental health literacy education will be created and launched through close partnerships with regional counseling centers and diverse student leaders at Santa Barbara City College (SBCC), the University of California, Santa Barbara (UCSB) and Allan Hancock College (Lompoc/Santa Maria).

- **Key Peer Initiatives: Consumer and Family Member Action Team**

The Department established the Consumer Family Action Team which is composed of consumers and family members (including individuals who reflect the diverse populations in Santa Barbara County) that provide the consumer and family perspective to the Department regarding programs and services. The Department ensures participation of consumers and family members who reflect cultural diversity on panels, committees, and in stakeholder groups whose work impacts current and future programs and services. An accomplishment in 2019

of the action team is the development of the quarterly peer-led newsletter titled “Together in Our Journey.” This action team meets on a monthly basis.

Consumers and family members participate in many of the hiring panels for the Department. To increase the involvement and comfort level of consumers and family members participating in our hiring panels, the Human Resource Department provides an information session/briefing on hiring ethnical guidelines prior to the interviews. They also provided key support to new Peer initiatives in the Plan Update.

Program Challenges and Solutions

Peer recovery specialists, peer navigators, and peer expert pool for special projects are examples of strategies used in FY18-19. In Spring of 2018, a special-project hiring plan for peers was promoted during the MHSA Stakeholder process and other community venues. For fiscal year 2019-2020, a revised job classification was created to the Recovery Assistant job classification to ensure that peer lived experience has been included within qualifiers increasing the ability for those with lived experience and in recovery to advance with employment opportunities. Resumes have been received, and continue to be submitted, and two special projects were assigned to assist in work skill development for peers seeking workforce growth. Additionally, in FY 18-19 a Training Coordinator started at Behavioral Wellness who created training opportunities for all peer employees and contract staff on Peer Support 101, Recovery, Self-Care and Stress Management, WRAP Plans, resume and hiring tips, and assigned all supervisors in Behavioral Wellness a course on Integrating Peers in the Workplace.

In April 2019, the Peer Empowerment Manager was hired to oversee Peer Support Services. The Department held their first Peer Employee Forum in March 2018 to seek input on the technological suite innovations project using modern technology to connect individuals in the community, including peer linkages and digital chats. The peers requested more regular meetings, which the Department has scheduled on a quarterly basis this has evolved into the Quarterly Peer Support Specialist training platform and Peer Employee Stakeholder forum. This allows for the Peer Manager to gain insight regarding needed improvements within Peer Support Services while highlighting what has worked. During FY 18-19 and 19-20, the peer workforce received trainings that are consistent with the core-competencies of peer support that enhance the skill set of our peer workforce to ensure appropriate delivery of peer support services. As such, the following trainings have been provided to our peer workforce over the past twelve months:

- Peer Support 101 and Recovery 101,
- WRAP I & II Training,
- Self-care and Stress Management,
- Surviving and Thriving,
- Best Approaches to your career advancement,
- Effective Communication: How to communicate with all levels of management,
- How to effectively manage perceived conflict in the workplace,
- Peer Recovery Services Documentation, and
- Access Ambassadors brought Consumer Advocacy and MHSA Leadership State trainings for community and County and Contractor staff.

During FY 20-21, Department peer workforce will receive a Peer Support Specialist Certification training which will be provided by Crestwood Behavioral Health. Additionally, to continue fostering the commitment to peer workforce, a Peer Academy has been created allowing for job advancement and learning opportunities within the community. As the Department continues to explore other possibilities, feedback and input will be gathered at monthly Client and Family Member Action meetings and at the Quarterly Peer Employee Forum. Participants will

receive training on group facilitation skills as well as additional trainings that will strengthen their skill set in order to provide quality care in the delivery of peer support services.

Please also refer to NEW Peer Services Proposal in this Plan Update for all activities proposed on Peer Services.

"NEW" Office of Statewide Health Planning and Development-Southern Counties Regional Partnership

Provider:	**Behavioral Wellness**
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures:	$401,500
Estimated WET Funding:	$401,500

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

On December 2, 2014, our Department became the fiscal and administrative agent for SCRP activities. The funds implemented the Five-Year Plan goals established by OSHPD for FY 2014-2019. Although Behavioral Wellness has received full payment of the SCRP funds, as of January 2020 there remains $1.6 million of available funds for expenditure for implementation of the SCRP's Five-Year Plan. In March 2017 the SCRP members agreed to continue the partnership with Behavioral Wellness as the Fiscal and Administrative agent for SCRP beyond September 2017 until all of the funds have been utilized to achieve their goals. The SCRP Memorandum of Understanding will automatically renew on an annual basis, starting October 1, 2017, subject to funding or termination for convenience by members.

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

Program Challenges and Solutions

In Fiscal Year 19-20 SCRP funds were used to create a year and a half long Clinical Supervision Project. Mental Health Providers that are providing clinical supervision take part in online learning twice a month on different aspects of clinical supervision including cultural competency, legal and ethical issues in clinical supervision, methods and techniques in clinical supervision, and self-care. All ten counties in the SCRP are participating in the Clinical Supervision Project.

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

During Fiscal Year 19-20, the SCRP has also coordinated a series of ten trainings on "Bridges out of Poverty" for the partnership. This is a one-day training workshop that provides both social services staff and mental health

providers' key lessons in dealing with individuals from poverty. Topics include increased awareness of the differences in economic cultures and how those differences affect opportunities for success.

Finally, during FY 19-20 we planned a conference on Person-Centered Engagement Strategies for the partnership. This is the fourth year that the SCRP has offered this conference, all ten counties participate in this two-day conference, and we anticipate 200 attendees. This conference was planned for March 2020, but has been postponed because of the coronavirus pandemic. We are planning to resume hosting our conference on Person-Centered Engagement Strategies in March 2021.

As the Partnership has accommodated the current COVID-19 pandemic, the partnership has modified training topics, changed trainings from in-person to webinars, and considered how to best use of remaining funds under different circumstances than were first contemplated in the SCRP Five Year Plan.

New Proposal for OSHPD and SCRP in Santa Barbara County:

The 2020-2025 Workforce Education and Training (WET) program will address the shortage of mental health practitioners in the public mental health system (PMHS) through a framework that engages Regional Partnerships and supports individuals through pipeline development, undergraduate scholarships, education stipends, and educational loan repayment. The new WET Plan framework calls on the SCRP to administer programs in these five areas. Recognizing the limited amount of available funding, however, OSHPD is permitting the SCRP to select which program components they need most in the region.

Santa Barbara, as the administrative agent for the SCRP, is currently determining which areas and programs our regional partnership wishes to pursue. We will be applying for these funds by July 15th of this year. The partnership must put up a "match" of $3,813,451 and then will receive a total of $ $15,369,364in funding to be spent on the programs that the SCRP wishes to fund. Once funding is awarded, the SCRP will administer the grant funds for the entire ten counties, ensuring that the Partnership has adequate funds for the programs that they deem most necessary for the continued recruitment, education, and training of our workforce. Santa Barbara is anticipated to commit an estimated $140,000 for match purposes with a transfer of CSS to WET for these activities.

Cultural Competency Plan and Achievements/ Cultural Competency and Diversity

During FY 19/20 a new Cultural Competency three-year Plan was re-written to incorporate substance use disorder services program, a Language Assistance Service Plan and a Cultural Competency Training Plan to continue to foster culturally and linguistic appropriate services. Read the Cultural Competency Plan by visiting the Department's website at: https://www.countyofsb.org/behavioral-wellness/Asset.c/5687

According to interpreter utilization data for 2019, Mixtec is the second-most prevalent language at Behavioral Wellness service sites. A Mixtec Culture and Mental Health Training was created in response, to better engage our

service providers with the Mixtec population. Furthermore, during FY 19/20, the Department engaged the Mixtec/Indigena Community Organizing Project to foster a partnership and provide interpretation services and cultural competency trainings.

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

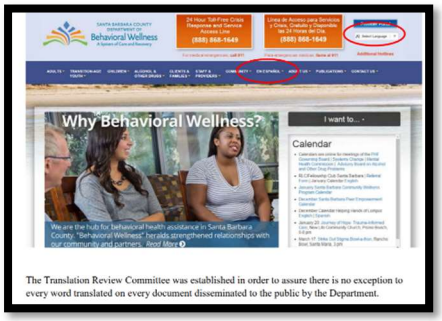
The 24/7 Access Line is key to ensuring all beneficiaries receive timely care and is staffed with both English and Spanish screeners. If a bilingual screener is not available or the caller speaks a language in which the screeners are not proficient, the department utilizes over-the-phone Language Line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

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

New contracts have been developed to assure availability of in-person interpretation needs for county-operated service locations. FY18-19 data for in-person interpretation shows that Spanish interpretation accounted for 96% of services, Mixtec followed with 3% and less than 1% was made of languages of lesser diffusion.

Behavioral Wellness continues to partner with Community Health Centers, Casa de la Raza and the American Indian Health and Services (AIHS) to address linkage and coordination to services and disparities in access to quality, culturally-appropriate mental health services to adults, youth and families within Santa Barbara County.

Members of the Department's Cultural Competence and Diversity Action Team (CCDAT) guided the revision of several documentation templates, including the Comprehensive Assessment and Treatment Plan templates, to strengthen collection of culturally relevant information. A key focusses this year was the integration of the American Psychiatric Association's Cultural Formulation Interview (CFI) questions throughout the assessment. Posing these questions during an assessment enhance a mental health practitioner's clinical understanding of the problem and functional impairments, potential sources of help, and expectations for services from the client's cultural perspective. Also, CCDAT members assisted with providing guidance to the innovation Help@Hand project to ensure the mobile applications are cultural and linguistically appropriate to serve the diverse community of Santa Barbara and will utilize the Help@Hand project to launch better digital wellness education in Spanish and Mixtec.



Capital Facilities and Technological Needs (CF/TN)

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

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

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

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

Electronic Health Records

Electronic Health Records – Capital Facilities and Technological Needs	
Provider:	**Behavioral Wellness**
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures:	$6,500
Estimated CSS Funding to CFTN:	$6,500

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

NEW: Outpatient Electronic Health Record System and Supports

Provider:	**Behavioral Wellness**
Estimated Funding FY 2020/21:	
Estimated Total Mental Health Expenditures:	Set money aside should funding be available
Estimated CSS Funding to CFTN:	Transfer CSS to CFTN for future purchase

Where are we today?

Clinician's Gateway (CG) is the primary documentation tool for both outpatient Mental Health and Alcohol and Drug Program systems of care. Sharecare (SC) handles claims and is the primary admissions, discharges, and transfers system of all information. Both CG and SC have been in production for well over ten years. The Inpatient system (PHF) is largely still paper based and does not have a full EHR, and IT Support Services and Quality Care Management currently manage well over 1000 unique users – many with access to a combination of these systems.

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

There are three separate application systems that are not designed to work together – CG MH, CG ADP, and SC. Including the PHF paper records, a client could in theory have 3 separate medical records that need to be managed. It is difficult to efficiently implement changes within EHR systems that are not widely used by other counties. There is limited interoperability with other vendor products for data exchange (i.e. lack of easy methods to share with partners). Due to old systems, core features of modern EHR products are missing (interoperability/data sharing, single patient record, appointment management, data reporting/design, forms management, etc.). There is also a large staffing burden as 40% of all IT Support Services requests are related to these EHR systems

Future goals and ideas for modern systems?

The Department is actively developing a Request for Proposal for an inpatient (PHF) EHR. Interoperability and data sharing options are key priorities for the next generation BWELL EHR. In the future, a single vendor/product ideally will emerge to replace these legacy systems and support both inpatient and outpatient services. Dedicated EHR Support Services will greatly improve our ability to provide training and expert level support to a growing number of end users. As a result, in the upcoming three to five years, the Department will attempt to invest in a new outpatient EHR for MHSA programs.

NEW CFTN Proposal: **Supporting infrastructure costs of EHR and staffing for project with MHSA Capitol & Information Technology Funds transferred from CSS**

Implementation of new Outpatient electronic health records based on technology that supports interoperability with other systems to ensure a dynamic data exchange with other entities involved in the care of consumers. Given the vast network of BWell's service providers in Santa Barbara County, Santa Barbara seeks to facilitate the use of an electronic health record by both county-owned and operated programs, as well as the contracted provider community. This will allow the most efficient data exchange and coordination of services. In cases where contracting providers already have an electronic health record system in place, standardized data exchange will facilitate the transmittal of data from one system to another to ensure a seamless integration of client data. Should funding be available, the Department will attempt to set aside funds for the investment in a new outpatient EHR.

Update for Proposals in FY 2017-20 and NEW Proposals for FY 2020-23

Update for Proposals in FY 2017-2020 Prior Plan Update

These proposals were introduced to Stakeholders for feedback and program development input during the Stakeholder public forums for the FY 2017-20 Prior Plan. As we have completed this plan period, this is the final update on these proposals.

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

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

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

Update:

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

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

Proposal Two: Reconsider Justice Alliance

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

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

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

Update:

During FY 16/17, greater collaboration occurred between Justice Alliance and the local hospitals and law enforcement including monthly meetings, review of high utilizers, and trainings for the courts, Public Defenders, and Psychiatric Health Facility. The Justice Alliance team continues to serve clients that are FSP until they could engage and link to the longer-term FSP ACT program. In summer of 2018, the Santa Barbara ACT team and Justice Alliance were co-located in a facility to better coordinate care to FSP clients and provide adequate access and transition services to the outpatient and inpatient systems for justice involved individuals. The Forensic Action team continues to support and provide feedback on the development of an in-county Mental Health Rehabilitation Center (MHRC) which will help inform the Department on the needs of the community for Justice Alliance services once critical services are enhanced in the continuum of care. In FY 19/20, additional caseworkers were added to enhance and expand services related to felony forensic involvement and funded by the Department of State Hospitals which anticipates implementation Summer 2020. At this time, Justice Alliance will remain a specialized forensic FSP.

Proposal Three: Increase Programming at the Recovery Learning Centers

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

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

Update:

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

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

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

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

In addition, a modern peer technology innovations plan was approved by the Mental Health Oversight and Accountability Commission to employ peers and use mobile and computer applications to improve access and linkage with the individuals in the community; this is described in the Innovations section of this document and will create employment opportunities for peers, a career ladder, and may be provided by community partners through a request for proposal in FY 2020-21. Overall, the peer program is more robust and anticipate additional goals in the upcoming three years.

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

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

Update:

In FY 17-18, the Chief of Clinical Operations initiated a review of all levels of care in the Department. In this process, she led the Access Transitions Workgroup to collaborate on the design of a system of care which will transition clients based on clinical need using the Adult Level of Care and Recovery Inventory Tool (LOCRI). The Access Transitions Workgroup is comprised of staff across programs and disciplines. In spring 2018, this group supported updating the electronic health record to include the LOCRI tool and piloted the usage of it and worked with community partners in FY's 2018-20. Following initial pilot, the Department found successes with the tool and it is now regularly used in transitioning individuals between programs based on level of need. The transition to a LOCRI system will require complex capable staffing on each outpatient team for the complex individual's needs and eliminate the individuals from having to get a new provider when they make progress in their treatment or require higher needs. In Santa Maria, that teams have been piloting complex capable teams since Fall 2018. The staff have been trained to provide all complex services and have been integrating SUD services and coordination with complex health issues without having to move clients around to multiple teams.

NEW Proposals in FY 2020-23

Identified gaps to current services were gathered throughout the regional and multi-lingual MHSA Community Program Planning Process hosted by the MHSA Chief and Planning Team with the support of community leaders and throughout the FY 2020-23 Planning meetings.

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

I created "Hope" in 2018 as a response to the Thomas Fire and mudslides in Montecito. I wanted my painting to help the people who saw it to feel hopeful for the future. I decided to make the letters big enough so that I could put an image inside each letter. For the first three images I chose plants native to this area: palm trees, a sunflower, and a bird of paradise. For the last image I chose white candles to remember those we have lost. The white candles can also symbolize healing and new beginnings. I chose to make the background different shades of blue, colors that reminded me of the ocean. I think we need hope again during the crisis caused by the coronavirus pandemic so this painting will resonate even more now.
Bridget Hochman © 2018

The 4 focus areas of interest were:

1.) Youth: Children and TAY,
2.) Peer Support,
3.) Housing, and
4.) Whole Person Care and Unique Cultural Approaches.

As a result of feedback received and trends from community voices in the planning process, new proposals for the FY 2020-2023 are:

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

- Creating Youth Led Leadership roles and assisting in developing those skills with Youth such as:
    - Establishing a Youth designated position on the Behavioral Wellness Commission including updating Commission bylaws and providing leadership training to those youth interested in the role,
    - Promoting and marketing youth involvement at each Department Action Team meeting by possibly having virtual access to allow for youth to join during school hours,
    - Inviting youth subject matter experts to work with youth on their topics of interest, such as assisting them in surveying their peers on needs, youth advocacy training, and innovative mechanisms for youth well-being activities such as digital applications for wellness, virtual access to services during school hours, centralized resource information for easy access, etc.
- Increased prevention activities using digital solutions, such as connection with Technology Suite Digital Application Innovations project.
- Advocacy and Support Youth Community Initiatives that are youth-designed and/or youth led such as development of ideas and grant applications like:
    - Youth-Designed Treatment Plans with input from LGBTQ+ professionals,
    - Peer-Run Centers that are navigation hubs for Youth, perhaps near or at libraries, and easily accessible via Bus and have creative technology space like digital blogging stations for all youth to help with their wellness and accessing services,
    - Mental Health First Aid Training for Youth and their Support Systems (Parents, Family, Friends),
    - Enhanced School Collaboration with local Universities and High Schools to increase linkages to care, break down the many “silos” and “doors” into the systems, and
    - Youth Drop in Center pilot (modeled after HeadSpace in Australia, Foundry in Canada, and newly formed alcove as an innovations model in Santa Clara County).
- Expand programming and access in community around:
    - Early Psychosis Intervention, and
    - Transitional Age Youth Department of Rehabilitation services.

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

- Increase Peer staff capacity to provide the opportunity for every mental health program to have a peer support specialist part of the clinic team:
    - Increase Peer Lead Wellness Support Groups, and specialist groups, LGBTQ, TAY, Older Adult groups, etc.
    - Increase Peer Navigators to ensure that consumers connect with the clinic and sustain treatment.
    - Hiring multi-lingual/multi-cultural peers for programming of peer support services.
- Ongoing training for Peers that may lead to employment opportunities within in the department and other organizations:
    - Knowledge and practice of Peer Support Services by engaging Subject Matter Experts who are trusted peer leaders to provide training to peers, by designing our version of a “Peer Pool of Champions.”
    - Mentorship, internship, and workforce skill opportunities for peers.
- Increased peer run community wellness and recovery outreach fair activities; and,
- Access to Peer Certification programs.

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

The goal is to increase housing units by creating at minimum 50 new permanent supportive housing units in County with a development being located in each region that includes Lompoc, Santa Maria, and Santa Barbara. Utilizing No Place Like Home funding rounds is essential to achieving this goal.

Additionally, supportive services for these housing units and others within the County is desired. Proposing model for supportive services is utilizing MHSA and rental income, along with other State Homeless funding as available.

Direct thoughts based on feedback from stakeholders which are important when developing housing options and services are:

- Promoting harm reduction philosophies at housing units including Housing First approach,
- Utilizing "Tiny Home" modeled housing communities,
- Allowing for the children of undocumented people to qualify for lease agreement within BWELL Housing efforts,
- Creating Peer-run supportive programming at housing complexes,
- Providing Credit repair and legal aid supports as people may face evictions or unable to gain housing outside of these opportunities, but help could result in other housing options,
- Establishing a Navigation Hub with lockers and phone charging stations to help those who are in the initial steps of getting resources,
- Creating paid surveying with "river bottom" community to best understand how to meet needs of community,
- Funding a larger BWELL Housing Development Team as they are effective in creating these resources,
- Working with Veterans Community Project for ideas,
- Increasing workforce opportunities within BWELL for people experiencing homelessness,
- Establishing workforce supports for BWELL clients that work but have nowhere to wash, iron and receive basic needs to support work opportunities. Many people experiencing homelessness have recently lost housing yet still work and are in early trauma stage.,
- Assisting with Department of Motor Vehicle tags for those who prefer living in cars and/or non-traditional settings. Traditional housing units may activate people's mental illness symptoms due to negative experiences (rape/domestic violence, harsh hospitalizations/imprisonment).,
- Scattered housing opportunities for people that prefer not to live in isolated housing units; this will help individuals assimilate into society.; and
- Having less rules surrounding drug and alcohol use as many people refuse housing because they are not ready to stop using, however, research shows that with wrap around with harm reduction wrap around services lead to sobriety and/or healthy lifestyle.

Proposal Four: Integrating Whole Person Care philosophies throughout Outpatient services

Whole person care seeks to study, understand and promote the role of health care in relieving suffering and promoting healing in acute and chronic illness. The focus is on the whole person -- physical, emotional, social, and spiritual. As a result, consumers in the Santa Barbara mental health outpatient system of care would attempt to self-manage their health by being fully empowered to play an active role in their health. By removing feelings of helplessness and encouraging hopefulness, clinicians, coaches, and peers can motivate consumers to improve their overall health.

Mental Health America identifies that:

> "Very few people go through life without any chronic health challenges. Cancer, heart disease, chronic pain, diabetes, mental illnesses, and more touch every family at some point. And often mental illnesses and other chronic conditions co-occur. People with cancer often have depression; people with schizophrenia often have diabetes; and people with chronic pain often have both physical and behavioral health challenges.
>
> We know that the underlying environment – the "social determinants" of health – plays a role in the development of both physical and mental health conditions. There is a lack of uniformity across the health spectrum in how illnesses are categorized and deemed as chronic diseases and chronic conditions. Not only does this create confusion, but it may lead professionals across the spectrum to focus on specific illnesses and disregard other aspects of the person being treated, including co-occurring issues like mental health conditions and broader societal conditions such as poverty, trauma, and racism.
>
> To effectively treat an individual, we must look at the whole person, which means examining the connections that exist between traditional chronic physical conditions and mental health concerns. Once a condition is diagnosed, it often becomes not just the primary diagnosis for health care providers, but the primary lens through which that individual is seen. And when a second condition is observed, there is often unnecessary tension among the providers, the individual and sometimes their family, as to what diagnosis takes precedence and who should take the lead in organizing and managing care and support.
>
> Health systems and related stakeholders must commit to understanding and integrating the individual, their needs, and the dueling conditions which impact their lives to effectively identify tools and strategies that reduce the tension among providers of care, services, and supports, and allow the whole individual to emerge along a pathway to recovery." (For more information: https://www.mhanational.org/conditions/co-occurring-mental-health-and-chronic-illness)

Whole Person Care Ideas from the Santa Barbara community are to facilitate development of trainings, support group curriculum, and outreach materials with Unserved and Underserved groups regarding whole person care practices that resonate within their communities. Programming tools should be modeled after the Eight Dimensions of Wellness.

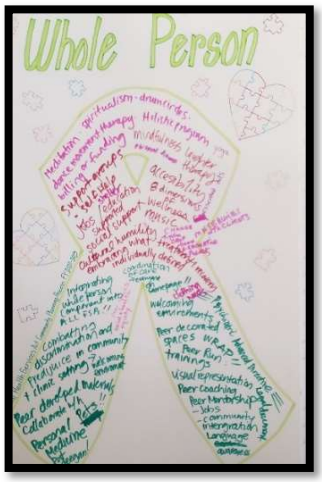
Image Sources: Substance Abuse and Mental Health Services Administration (SAMHSA) and RecoveryAnswers.org

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

Targeted Populations identified from stakeholders include:

i. Native American Community: Tribal members and County Staff could co-develop additional trainings for both clients and providers on how to support them in effectively engaging in services. Ideas include teaching individuals how to heal (impact of shame on recovery retention), integrating spirituality/culture into care, hope (keeping clients/staff motivated), medicine stories (using the power of those living in recovery to empower others, the personal narrative is an honored tradition among Native/Indigenous Tribes), and more information needed on NARCAN and Harm Reduction education. In addition, integrating Tribal/Culture beliefs (Native American traditions), spirituality, and creating group support along with case management/therapy with the availability of psychiatric medications with these practices. One element is identifying a tribal member to serve as a liaison to ensure that communication is shared in a manner where content is not lost; this could be at a community level and/or with one-to-one practices.,
ii. Latino Community,
iii. Mixtecto Community with ideas that include comic books and different outreach events with PEI providers coordinating,
iv. LGBTQ Community,
v. Foster Youth and underserved Youth,
vi. Parents of young children,
vii. Those who suffer from co-occurring mental health and substance use disorders by integrating services and adding NARCAN and Harm Reduction philosophies, and
viii. Geographically Isolated Communities.

Posters developed by Peers for interactive Community Program Planning Process Feedback Sessions were information for the above proposals were gathered:



Supporting Materials

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

Attachment 1: Prevention Early Intervention (PEI) Data Report

Implementation of regulated data collection began in FY 2015/16 by the formation of a PEI Data Workgroup comprised of Santa Barbara County's Mental Health Service Act Chief, Information Technology Chief, Senior Epidemiologist, and later membership additions included the Cultural Competency Manager, Childrens Division Chief, and Public Information Officer. The goal of the workgroup was to develop a system for data tracking and reporting based on the new Prevention and Early Intervention data collection regulations. Data for FY 16/17 was submitted to the Mental Health Services Oversight and Accountability Commission in December 2017 with explanation of anticipated barriers for full collection, including information technology security and privacy assurances of any collection method. A plan was established to start gathering of all PEI regulation elements and the committee attended statewide trainings and webinars on methods for collection. As a result, Vertical Change software was developed and implemented in collaboration with community partners in Fall 2018. The following data from FY 18-19 is that which was available from that year. Moving forward, all required elements should be published starting with services January 2019 and on as initial testing of the software and collection forms were rolled out July to December 2018.

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

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

DEMOGRAPHICS (ALL PROGRAMS)

Unique Clients Served										
	OUTREACH & STIGMA			PREVENTION & EARLY INTERVENTION			UNDERSERVED			ACCESS & LINKAGE
PROGRAM^	LCDLR	SYTHC	CHCCC	CALM	SYVPHP	TAY	CADA	FSA	CP	A & A
TOTAL CLIENTS	**14**	**31**	**250**	**216**	*	**243**	**73**	**7**	**1190**	**1125**
AGE (on last day of FY)										
0-15	0	0	31	207	*	5	70	7	670	0
16-25	0	0	18	4	*	237	3	0	520	151
26-59	4	0	156	5	*	1	0	0	0	857

Unique Clients Served										
	OUTREACH & STIGMA			PREVENTION & EARLY INTERVENTION			UNDERSERVED			ACCESS & LINKAGE
PROGRAM^	LCDLR	SYTHC	CHCCC	CALM	SYVPHP	TAY	CADA	FSA	CP	A & A
60+	10	0	45	0	*	0	0	0	0	116
Unknown/Decline	0	31	31	100	*	0	1	0	0	1
SEX AT BIRTH										
Female	11	25	213	58	*	127	16	1	552	522
Male	3	0	29	51	*	116	13	0	370	602
Unknown/Decline	0	6	8	107	*	0	44	6	268	1
CURRENT GENDER IDENTITY										
Male	3	0	28	0	*	*	13	0	211	*
Female	11	24	209	4	*	*	15	1	303	*
Transgender	0	0	1	0	*	*	0	0	6	*
Genderqueer	0	0	0	0	*	*	0	0	1	*
Questioning	0	0	1	0	*	*	0	0	0	*
Another	0	0	0	0	*	*	0	0	0	*
Unknown/Decline	0	7	11	212	*	*	45	6	669	*
SEXUAL ORIENTATION										
Gay/Lesbian	0	0	2	0	*	*	1	0	1	*
Heterosexual	13	18	219	1	*	*	14	1	28	*
Bisexual	1	0	3	0	*	*	1	0	5	*
Questioning/ Unsure	0	0	2	0	*	*	0	0	1	*
Queer	0	0	0	0	*	*	0	0	0	*
Another	0	0	0	0	*	*	0	0	2	*
Unknown/Decline	0	13	24	215	*	*	57	6	1153	*
PRIMARY LANGUAGE										
English	*	25	13	126	*	*	56	7	995	*
Spanish	*	0	230	88	*	*	17	0	179	*
Other	*	0	6	0	*	*	0	0	5	*
Unknown/Decline	*	6	1	2	*	*	0	0	11	*
VETERAN										
Yes	*	0	11	0	*	*	1	0	0	*
No	*	29	187	3	*	*	28	1	919	*
Unknown/Decline	*	2	52	213	*	*	44	6	271	*

PROGRAM^	LCDLR	SYTHC	CHCCC	CALM	SYVPHP	TAY	CADA	FSA	CP	A & A
RACE										

Unique Clients Served											
	OUTREACH & STIGMA			PREVENTION & EARLY INTERVENTION			UNDERSERVED			ACCESS & LINKAGE	
PROGRAM^	LCDLR	SYTHC	CHCCC	CALM	SYVPHP	TAY	CADA	FSA	CP	A & A	
American Indian/ Alaska Native	0	7	2	0	*	1	1	1	10	22	
Asian	0	0	1	1	*	2	0	0	2	17	
Black/ African American	0	0	0	2	*	7	0	0	34	70	
Native Hawaiian/ Pacific Islander	0	0	0	0	*	3	0	0	3	1	
White	12	0	225	122	*	198	64	3	705	929	
Other	0	0	12	85	*	6	2	2	182	27	
More than one	1	1	1	5	*	18	4	1	4	41	
Unknown/Decline	1	23	9	1	*	8	2	0	250	18	
ETHNICITY: LATINO											
Caribbean	0	0	0	0	*	2	0	0	0	1	
Central American	0	0	4	0	*	0	2	0	1	0	
Mexican/Mex. Amer./ Chicano	14	0	217	88	*	116	51	5	243	320	
Puerto Rican	0	0	0	0	*	1	0	0	1	4	
South American	0	0	3	0	*	0	1	0	0	0	
Another Latino	0	1	11	95	*	44	0	1	218	189	
Unknown/Decline	0	30	15	33	*	14	19	1	727	35	
ETHNICITY: NON-LATINO											
African	0	0	0	2	*	7	0	0	0	70	
Asian Indian/ South Asian	0	0	1	0	*	0	0	0	1	3	
Cambodian	0	0	0	0	*	0	0	0	0	1	
Chinese	0	0	0	0	*	0	0	0	0	0	
Eastern European	0	0	0	0	*	0	0	0	0	0	
European	0	0	0	16	*	198	5	1	3	929	
Filipino	0	0	0	1	*	0	0	0	5	6	
Japanese	0	0	0	0	*	0	1	0	0	2	
Korean	0	0	0	0	*	1	0	0	0	2	
Middle Eastern	0	0	0	0	*	0	0	0	0	0	
Vietnamese	0	0	0	0	*	0	0	0	0	1	
Other	0	0	3	3	*	1	1	0	9	29	
Unknown/Decline	14	31	246	194	*	66	66	6	1172	17	
More than one	0	0	0	0	*	0	0	0	0	0	
PROGRAM^	LCDLR	SYTHC	CHCCC	CALM	SYVPHP	TAY	CADA	FSA	CP	A & A	
DISABILITY											
Difficulty Seeing	2	0	28	1	*	*	2	0	0	*	
Difficulty Hearing / Having Speech Understood	1	0	1	14	*	*	1	0	4	*	
Physical/Mobility	0	0	2	2	*	*	0	0	1	*	
Chronic Health Condition/Pain	7	0	19	0	*	*	0	0	0	*	
Other Mental Disability not Related to Mental Illness	0	0	1	2	*	*	3	0	3	*	

Unique Clients Served											
	OUTREACH & STIGMA			PREVENTION & EARLY INTERVENTION			UNDERSERVED			ACCESS & LINKAGE	
PROGRAM^	LCDLR	SYTHC	CHCCC	CALM	SYVPHP	TAY	CADA	FSA	CP	A & A	
Other	0	0	6	0	*	*	2	1	0	*	
Unknown/Decline	4	31	193	197	*	*	65	6	1182	*	
FAMILY											
# Family Members in Program	2	0	824	362	*	*	13	3	5	*	

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

OUTREACH EVENTS

Outreach Events			
PROGRAM	**LCDLR** (4 quarters of data)	**SYTHC** (4 quarters of data)	**CHCCC** (4 quarters of data)
TOTAL # EVENTS	**107**	**119**	**253**
TOTAL # PARTICIPANTS	**2,014**	**595**	**5978**
EVENT TYPE		(4 quarters of data)	(4 quarters of data)
Outreach	8	11	39
Training	11	12	60
Forum	4	36	26
Support Group	84	60	128
PRIMARY LANGUAGE OF EVENT		(2 quarters of data)	(3 quarters of data)
English	0	22	11
Spanish	224 (groups only)	0	41
Other or both English and Spanish	0	0	15
TRANSLATION PROVIDED		(2 quarters of data)	(3 quarters of data)
Translation to English at Spanish event	NR	N/A	7
Translation to Spanish at English event	NR	0	2
Other or both English and Spanish	NR	0	8
PARTICIPANT AGE		(2 quarters of data)	(3 quarters of data)
0-15	NR	93	117
16-25	NR	67	550
26-59	NR	193	3148
60+	NR	21	314
Missing DOB	NR	0	5
PARTICIPANT GENDER		(2 quarters of data)	(3 quarters of data)
Female	NR	159	2805
Male	NR	50	1329
Unknown/Decline	NR	0	5
PARTICIPANT VETERAN		(2 quarters of data)	(3 quarters of data)
Yes	NR	0	28
No	NR	98	187
Unknown/Decline	NR	91	3914
PARTICIPANT RACE		(2 quarters of data)	(3 quarters of data)
American Indian/ Alaska Native	NR	197	12
Asian	NR	0	16
Black/African American	NR	0	16
Native Hawaiian/ Pacific Islander	NR	0	0
White	NR	NR	238
Other	NR	52	1
More than one	NR	NR	NR
Unknown/Decline	NR	0	0
PARTICIPANT ETHNICITY		(2 quarters of data)	(3 quarters of data)
Latino	NR	NR	3845
Non-Latino	NR	NR	254

*Several categories had partial data collected in FY 18/19 as we were starting up a new data reporting system. Some agencies have not reported this data. All available data is provided.
NR = Not Reported (blank)

Unique Clients Referred										
	OUTREACH & STIGMA			PREVENTION & EARLY INTERVENTION			UNDERSERVED			ACCESS & LINK-AGE
PROGRAM	LCDLR	SYTHC	CHCCC	CALM	SYVPHP	TAY	CADA	FSA	CP	A & A
TYPE (TOTAL #)										
CBO Referral to Behavioral Wellness	*	0	38	N/A	*	N/A	N/A	N/A	*	N/A
Intake to Behavioral Wellness										N/A
Behavioral Wellness Referral Out										N/A
MENTAL/BEHAVIORAL HEALTH SYMPTOMS PRIOR TO REFERRAL / INTAKE										
Yes	*	0	19	N/A	*	N/A	N/A	N/A	*	N/A
If yes, date is completed	*	0	*	N/A	*	N/A	N/A	N/A	*	N/A
No	*	0	13	N/A	*	N/A	N/A	N/A	*	N/A
If no, average duration of sxs	*	0	*	N/A	*	N/A	N/A	N/A	*	N/A
Unable to Determine	*	0	6	N/A	*	N/A	N/A	N/A	*	N/A
ARE YOU CONCERNED THE MENTAL/BEHAVIORAL HEALTH SYMPTOMS REPORTED INDICATE A POSSIBLE SEVERE MENTAL ILLNESS?										
Yes	*	0	1	N/A	*	N/A	N/A	N/A	*	N/A
No	*	0	10	N/A	*	N/A	N/A	N/A	*	N/A
Unable to Determine	*	0	26	N/A	*	N/A	N/A	N/A	*	N/A
WAYS REFERRING PARTY ENCOURAGED CLIENT TO ACCESS SERVICES AND FOLLOW THROUGH ON REFERRAL										
Called	*	0	25	N/A	*	N/A	N/A	N/A	*	N/A
Emailed	*	0	0	N/A	*	N/A	N/A	N/A	*	N/A
Arranged Transport	*	0	0	N/A	*	N/A	N/A	N/A	*	N/A
Arranged Appointment	*	0	1	N/A	*	N/A	N/A	N/A	*	N/A
Other	*	0	12	N/A	*	N/A	N/A	N/A	*	N/A

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

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

On January 30, 2020 the Mental Health Services Oversight and Accountability Commission provided guidance to counties as to the implementation of Prevention and Early Intervention Program Planning (Welfare and Institutions Code (WIC), Section 5840.7). The Commission requested Counties focus use of the PEI funds on Commission-established priorities or other priorities as determined through their local stakeholder processes. As of 2020, the Commission did not establish additional priorities to those specifically enumerated in Welfare and Institutions Code Section 5840.7(a).

As a result, Santa Barbara has listed below each of the PEI Programs, the program's Category of PEI within the WIC, the percentage amount of funding from PEI for each PEI program, and relevant feedback from stakeholders in relation to program activities. This attachment is intended to show how Santa Barbara meets the required PEI Component Programming as requested by the Commission's January 2020 notice.

Program & MHSA Category	Category of PEI	Total PEI funding %	Relevant Stakeholder Input
Outreach/Outreach & Stigma			
La Casa De La Raza	Culturally competent & linguistically appropriate prevention & intervention	1.0%	Need more outreach materials and programming on what BWELL does and who BWELL serves and on-site presence or group participation Q&A with BWELL staff
Santa Ynez Tribal Health Clinic	Culturally competent & linguistically appropriate prevention & intervention	0.3%	Native BWELL liaison to best engage with SYTHC. There is a disconnect and a lack of trust. BWELL does not communicate with Elders in a manner that Elders see as respectful. Treatment need to include of cultural preferences.
Community Health Centers of the Central Coast	Culturally competent & linguistically appropriate prevention & intervention	1.7%	Need to increase staffing to best reach community. Promotoras have minimal funding, would like increased.
Early Childhood Mental Health			
Santa Ynez Valley People Helping People	Childhood trauma prevention & early intervention, & mood disorder & suicide prevention programming that occurs across the lifespan; Early identification programming of mental health symptoms & disorders, including but not limited to, anxiety, depression and psychosis Early Childhood Mental Health	1.4%	Native community holds cultural traditions that need to be respected. Parents of children may have mistrust of BWELL clinicians. BWELL clinicians need trainings on cultural norms of Native people. Clinicians minimize preferred cultural healing practices and look down on the belief of power in "sweat lodges" "sage cleanses"; suggest enhance cultural competency trainings.

Program & MHSA Category	Category of PEI	Total PEI funding %	Relevant Stakeholder Input
CALM ECMH Great Beginnings	Childhood trauma prevention & early intervention, & mood disorder & suicide prevention programming that occurs across the lifespan; Early identification programming of mental health symptoms & disorders, including but not limited to, anxiety, depression and psychosis	4.9%	Need coordinated comprehensive community outreach programming.
CALM ECMHS Special Needs	Early identification programming of mental health symptoms & disorders, including but not limited to, anxiety, depression and psychosis	13.2%	BWELL needs to invite disability organizations to the table and create an outreach event with disability organizations and advocates present. This should include children programming.
County Early Detection & Intervention	Childhood trauma prevention & early intervention, & mood disorder & suicide prevention programming that occurs across the lifespan;	9.5%	Need to enhance program with the state of CA new suicide prevention plan. Educational series maybe created with guest speakers (peers). Prevention and early intervention for children is key.
Underserved			
School-Based Counseling Council on Alcohol and Drug Abuse	Youth outreach & engagement strategies that target secondary school & transition age youth, w/ a priority on partnership w college mental health programs; Early identification programming of mental health symptoms & disorders, including but not limited to, anxiety, depression and psychosis	2.9%	Interactive programming would help for families to understand how to assist child's outcomes through empowering children to learn about wellness plans. More programming on what is mental illness/what are mood disorders/ Peer speakers. Many resources at schools are desired as students are captive audience.

Program & MHSA Category	Category of PEI	Total PEI funding %	Relevant Stakeholder Input
School-Based Counseling Family Service Agency	Youth outreach & engagement strategies that target secondary school & transition age youth, w/ a priority on partnership w college mental health programs; Early identification programming of mental health symptoms & disorders, including but not limited to, anxiety, depression and psychosis	2.9%	Create programming allowing for youth to help create programming. Include youth while receiving services to help with programming materials.
Access & Linkage			
County Access & Assessment and Access Line Program	Early identification programming of mental health symptoms & disorders, including but not limited to, anxiety, depression and psychosis	50.4%	Need more people answering calls. Wait times may aggravate symptoms. Request better hold system while people wait with calming sounds or soothing information talking about referrals sources or talk down recording while people wait to speak to assessor.

Budget Review by Funding Component
Mental Health Services Act Proposed Budget
Community Services and Supports (CSS)

	Community Services and Supports (CSS) Programs	TOTAL MHSA Plan CSS Expenditures	CSS Funded	Medi-Cal FFP Funded	Realignment/ Grant/ Other Funded
FY 2018-19 (Actuals)	Full-Service Partnership (FSP)	$15,598,472	$8,346,675	$6,216,470	$1,035,326
	Non-FSP	$32,092,268	$7,345,671	$13,402,871	$11,343,726
	FSP Programs as % CSS Programs		***53%***		
	CSS Administration Total	$ 7,564,363	$ 1,742,360	$ 3,408,714	$ 2,413,289
	TOTAL CSS Programs Expenditures	$ 55,255,102			

	Community Services and Supports (CSS) Programs	TOTAL MHSA Plan CSS Expenditures	CSS Funded	Medi-Cal FFP Funded	Realignment/ Grant/ Other Funded
FY 2019-20 (Estimated)	Full-Service Partnership (FSP)	$ 16,310,400	$ 9,299,400	$ 6,659,800	$ 351,200
	Non-FSP	$ 35,923,900	$ 9,284,200	$ 15,338,100	$ 11,301,600
	FSP Programs as % CSS Programs		50%		
	CSS Administration Total	$ 8,071,600	$ 4,382,800	$ 3,688,800	$ -
	TOTAL CSS Programs Expenditures	$ 60,305,900			

	Community Services and Supports (CSS) Programs	TOTAL MHSA Plan CSS Expenditures	CSS Funded	Medi-Cal FFP Funded	Realignment/ Grant/ Other Funded
FY 2020-21 (Recommended)	Full-Service Partnership (FSP)	$ 18,592,700	$ 11,033,100	$ 7,154,100	$ 405,500
	Non-FSP	$ 35,357,700	$ 8,672,200	$ 15,644,900	$ 11,040,600
	FSP Programs as % CSS Programs		***56%***		
	CSS Administration Total	$ 8,220,200	$ 2,789,200	$ 3,823,400	$ 1,607,600
	TOTAL CSS Programs Expenditures	$ 62,170,600			

Budget Review by Funding Component

Mental Health Services Act Proposed Budget

Prevention and Early Intervention (PEI)

	Prevention and Early Intervention (PEI) Programs	TOTAL MHSA Plan PEI Expenditures	PEI Funded	Medi-Cal FFP Funded	Realignment/ Grant/ Other Funded
FY 2018-19 (Actuals)	**Early Intervention**	**$ 5,063,482**	**$ 1,864,899**	**$ 3,194,523**	**$ 4,060**
	Prevention	**$ 681,677**	**$ 681,677**	**$ -**	**$ -**
	Early Intervention Programs as % PEI Programs		***83%***		
	PEI Administration Total	**$ 336,202**	336,202		
	TOTAL PEI Programs Expenditures	**$ 6,081,361**	**2,882,778**	**3,194,523**	**4,060**

	Prevention and Early Intervention (PEI) Programs	TOTAL MHSA Plan PEI Expenditures	PEI Funded	Medi-Cal FFP Funded	Realignment/ Grant/ Other Funded
FY 2019-20 (Estimated)	**Early Intervention**	**$7,501,700**	**$4,363,500**	**$4,363,500**	**$8,300**
	Prevention	**$606,600**	**$606,600**	**$606,600**	$-
	Early Intervention Programs as % PEI Programs		***88%***	***88%***	
	PEI Administration Total	**$398,300**	**398,300**	**398,300**	
	TOTAL PEI Programs Expenditures	**$8,506,600**	**5,368,400**	**5,368,400**	**8,300**

	Prevention and Early Intervention (PEI) Programs	TOTAL MHSA Plan PEI Expenditures	PEI Funded	Medi-Cal FFP Funded	Realignment/ Grant/ Other Funded
FY 2020-21 (Recommended)	**Early Intervention**	**$7,887,500**	**$4,645,300**	**$3,233,900**	**$8,300**
	Prevention	**$681,500**	**$681,500**	$-	$-
	Early Intervention Programs as % PEI Programs		***88%***		
	PEI Administration Total	**$379,100**	379,100		
	TOTAL PEI Programs Expenditures	**$8,948,100**	**5,705,900**	**3,233,900**	**8,300**

Budget Review by Funding Component

Mental Health Services Act Proposed Budget
Workforce, Education and Training (WET)

	Workforce, Education and Training (WET) Programs	TOTAL MHSA Plan WET Expenditures	CSS	Medi-Cal FFP Funded	Realignment/ Grant/ Other Funded
FY 2018-19 (Actuals)	**WET**				
	2991 – Peer Training	$241,215	$241,215	-	-
	2994 -- SCRP	$559,119			$559,119
	WET Administration Total	**$0**	0		
	TOTAL WET Programs Expend-itures	**$ 800,334**	**$241,215**	**-**	**$559,119**

	Workforce, Education and Training (WET) Programs	TOTAL MHSA Plan WET Expenditures	CSS	Medi-Cal FFP Funded	Realignment/ Grant/ Other Funded
FY 2019-20 (Estimated)	**WET**				
	2991 – Peer Training	$ 252,800	$252,800	-	-
	2994 -- SCRP	$ 608,900			$608,900
	WET Administration Total	**$0**	0		
	TOTAL WET Programs Expend-itures	**$ 861,700**	**$252,800**	**-**	**$608,900**

	Workforce, Education and Training (WET) Programs	TOTAL MHSA Plan WET Expenditures	CSS	Medi-Cal FFP Funded	Realignment/ Grant/ Other Funded
FY 2020-21 (Recommended)	**WET**				
	2991 – Peer Training	$ 356,800	$356,800	-	-
	2994 -- SCRP	$ 401,500			$401,500
	WET Administration Total	**$0**	0		
	TOTAL WET Programs Expend-itures	**$ 758,300**	**$356,800**	**-**	**$401,500**

Note: The Peer Training Program is funded through a transfer of CSS component allocation.

Budget Review by Funding Component

Mental Health Services Act Proposed Budget
Innovations (INN)

	Innovation (INN) Programs	TOTAL MHSA Plan INN Expenditures	INN Funded	Medi-Cal FFP Funded	Realignment/ Grant/ Other Funded
FY 2018-19 (Actuals)	**Innovation**	**$1,452,114**	**$ 1,237,167**	**$ 214,947**	**$ -**
	2995 -- Tech Suite (INN)	$-	0	-	-
	2996 -- RISE (INN)	$1,452,114	1,237,167	214,947	
	INN Administration Total	**$232,146**	232,146		
	TOTAL PEI Programs Expenditures	**$1,684,260**	**1,469,312**	**214,947**	**-**

	Innovation (INN) Programs	TOTAL MHSA Plan INN Expenditures	INN Funded	Medi-Cal FFP Funded	Realignment/ Grant/ Other Funded
FY 2019-20 (Estimated)	**Innovation**	**$2,044,800**	**$ 1,792,500**	**$ 252,300**	**$ -**
	2995 -- Tech Suite (INN)	$972,400	972,400	-	
	2996 -- RISE (INN)	$1,072,400	820,100	252,300	
	INN Administration Total	**$246,000**	246,000		
	TOTAL INN Programs Expenditures	**$2,290,800**	**2,038,500**	**252,300**	**-**

	Innovation (INN) Programs	TOTAL MHSA Plan INN Expenditures	INN Funded	Medi-Cal FFP Funded	Realignment/ Grant/ Other Funded
FY 2020-21 (Recommended)	**Innovation**	**$1,077,700**	**$1,077,700**	**$-**	**$-**
	2995 -- Tech Suite (INN)	$1,077,700	1,077,700	-	-
	2996 -- RISE (INN)	$-	0		
	INN Administration Total	**$231,000**	231,000		
	TOTAL INN Programs Expenditures	**$1,308,700**	**1,308,700**	**-**	**-**

Budget Review by Funding Component

Mental Health Services Act Proposed Budget
Capital Facilities/Technological Needs (CFTN)

	Capital Facilities / Technological Needs (CFTN) Programs	TOTAL MHSA Plan CFTN Expenditures	CSS	Medi-Cal FFP Funded	Realignment/ Grant/ Other Funded
FY 2018-19 (Actuals)	**CFTN**				
	Capital Information Technology (CIT)	$ 272,762	$272,762	-	-
	CFTN Administration Total	**$0**	0		
	TOTAL CFTN Programs Expenditures	**$ 272,762**	**$272,762**	**-**	

	Capital Facilities / Technological Needs (CFTN) Programs	TOTAL MHSA Plan CFTN Expenditures	CSS	Medi-Cal FFP Funded	Realignment/ Grant/ Other Funded
FY 2019-20 (Estimated)	**CFTN**				
	Capital Information Technology (CIT)	$ 312,400	$312,400	-	-
	CFTN Administration Total	**$0**	0		
	TOTAL CFTN Programs Expenditures	**$ 312,400**	**$312,400**	**-**	

	Capital Facilities / Technological Needs (CFTN) Programs	TOTAL MHSA Plan CFTN Expenditures	CSS	Medi-Cal FFP Funded	Realignment/ Grant/ Other Funded
FY 2020-21 (Recommended)	**CFTN**				
	Capital Information Technology (CIT)	$ 6,500	$ 6,500	-	-
	CFTN Administration Total	**$0**	0		
	TOTAL CFTN Programs Expenditures	**$ 6,500**	**$ 6,500**	**-**	

Note: The Capital Information Technology Program is funded through a transfer of CSS component allocation.

Budget Review by Funding Component

MHSA Housing Funds $2.3M:

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

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

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

No Place Like Home (NPLH) Initiative:

On November 6, California voters approved Proposition 2, No Place Like Home. This ratified the proposed use of MHSA dollars to service the debt on statewide bonds that will finance permanent supportive housing for people with SMI who are homeless or at risk of becoming homeless.
Impact on Santa Barbara County is estimated at $1.4 million of MHSA funds to be diverted annually for 30 years. Technical Assistance funds of $100,000: $50,000 in Technical funds were used to create a new Homeless Housing Plan that was released in 2019. The remaining $50,000 in Technical Assistance funds were used to administer and overhead of the grant and were expended by June 2020.
Stakeholder survey in FY 18-19 supported primary focus in South County; internal goal of 50 units for the entire county-with three potential projects in the pipeline. The initiative will provide $2.5 Million in non-competitive funds towards the development of new permanent housing with intention to also compete for the larger funding with mid-size counties. We have applied for $1.5 million in non-competitive funding to fund 13 NPLH one-bedroom units in Santa Maria. The Department is awaiting our Acceptance Letter. The Department applied for $4,822,998 in competitive funds, to be used for 20 one-bedroom units in South County. We have passed the Initial Threshold review for this project and are hoping to be awarded funds.

The Department anticipates applying for $1.5 million in competitive funding and $250,000 in non-competitive funding to be used for 19 one-bedroom units in Mid-County. Department will apply for these funds in the third round of competitive funding, the Notice of Funding Award for these funds will be released in Fall 2020, and application will be due in December of 2020.

MHSA Prudent Reserve Fund Balance

	7/1/2019 ACTUAL Balance	Use of Reserves	6/30/2020*Revised *Projected* Ending Balance	Budgeted Use of Reserves	6/30/2021 *Budgeted* Ending Balance
MHSA Prudent Reserve	2,023,113	2,023,113	0	0	0
MHSA Operating Reserves	7,868,246	5,954,416	1,913,830	1,913,830	0
Total MHSA Fund Reserve Balances	9,891,358	7,977,528	1,913,830	1,913,830	0

* Due to the COVID-19 pandemic, MHSA revenues are projected to be lower by approximately 18% ($4.4M) as compared to budgeted FY 2019/20 MHSA revenue. This results in the need to use our entire Prudent Reserve balance of $2.02M, as well as an additional $2.38M of operating reserves to end the fiscal year without program reductions. These additional uses of reserves will leave only $1.91M of Operating reserves available for FY 2020/21. We anticipate using this entire balance in FY 2020/21 to avoid program reductions to the greatest extent possible.

Attachment 4: MHSA Fiscal Three-Year Community Planning Process Program PowerPoint

Mental Health Services Act Fiscal Years 2020-2023 Three-Year Community Planning Process Program Power-Points were shared regionally and translated into Spanish with Mixtec live interpretation available throughout the county.

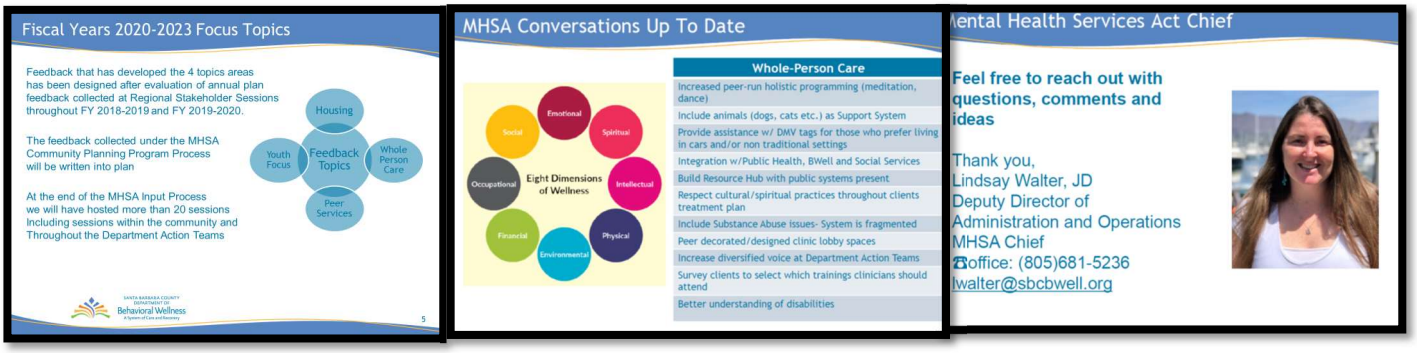
Refer to Attachment 5: Public Comments to read through community feedback gathered

General MHSA FY2020-23 PowerPoints included are:

Mental Health Services Act Overview; Annual Percentage of MHSA Funding and MHSA General Standards Three-Year MHSA Community Planning Process; Current Funded MHSA Programs; FY 2020-23 Focus Topics Feedback gathered throughout FY2018-19 FY 2019-20; and Open Discussions.

Examples of PowerPoint:

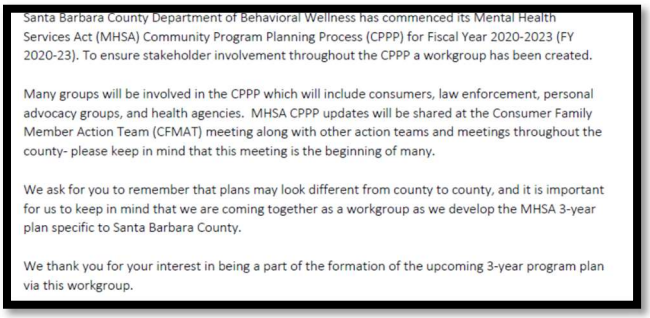
Examples of Focused Topics:



Attachment 5: Public Comments Regarding the MHSA Three Year Plan Update

Public Comments Regarding the MHSA Three Year Plan Update December 2019– April 2020 are below which methods of feedback from over 25 meetings, emails sent in, art submitted or illustrations, and calls received. Public comments regarding the MHSA Three Year Plan Update were gathered at Department Action Meetings, Community Meetings, and throughout the region. Below is feedback gathered through different methods ensuring it was inclusive and reflective of the needs of the community.

MHSA Community Planning Workgroup Meetings Feedback



Santa Barbara County Department of Behavioral Wellness has commenced its Mental Health Services Act (MHSA) Community Program Planning Process (CPPP) for Fiscal Year 2020-2023 (FY 2020-23). To ensure stakeholder involvement throughout the CPPP a workgroup has been created.

Many groups will be involved in the CPPP which will include consumers, law enforcement, personal advocacy groups, and health agencies. MHSA CPPP updates will be shared at the Consumer Family Member Action Team (CFMAT) meeting along with other action teams and meetings throughout the county- please keep in mind that this meeting is the beginning of many.

We ask for you to remember that plans may look different from county to county, and it is important for us to keep in mind that we are coming together as a workgroup as we develop the MHSA 3-year plan specific to Santa Barbara County.

We thank you for your interest in being a part of the formation of the upcoming 3-year program plan via this workgroup.

Example of email sent to workgroup

Santa Barbara Work Group Meeting December 11, 2019

Consumer and Family Members and Key Regional Community contacts joined MHSA Chief, Lindsay Walter, and Peer and Ethnic Services Manager, Maria Arteaga, in the first roundtable discussion where FY 2020-23 Planning were discussed. This Planning workgroup identified needs and focused on how effective community program planning efforts would be reached. Ideas shared were the inclusion of child care, meetings in easily accessed locations such as local libraries, community sessions with Spanish and Mixtec Community, live translation capabilities and the need to increase social media awareness and better use of Department of Behavioral Wellness website. The workgroup consisted of members within NAMI, ACCESS California, contracted CBO's such as the Helping Hands of Lompoc and LEAD leaders within Transitions Mental Health Association, AmeriCorps, Behavioral Wellness Commissioners and Behavioral Wellness staff. Demographics of the workgroup included transitioned-aged youth, adults and older adults throughout the three regions of the county.

Santa Maria Community Planning Workgroup Meeting January 29, 2020

Workgroup continued conversations and examined feedback approaches thus far. Clinical along with peer-based sessions have shown to deliver the need for information pertaining to current MHSA Funded programs along with the need to host Department Action Team meetings. The need to create PowerPoints that speak to focus topics for different populations was mentioned. Key members reported feeling included and congratulate MHSA Chief, Lindsay Walter's efforts as this three-year plan community program planning process time has never been as promising for community as a whole.

Buellton Community Planning Workgroup Meeting February 20, 2020

Disability rights advocate Elizabeth Stone and members from the Spanish and Mixtec community spoke to the need for accessibility for people that have physical impairments and the need of child care. Peer and Ethnic Services Manager, Maria Arteaga and Help@Hand Project Manager Vanessa Ramos explored the need to provide food in traditional settings where community already gathers as the need to feel safe is important to migrant community. Conversations held promoted the need for lower level access as much as possible to ensure

that mobility needs are met. Spanish and Mixtec interpretations were practiced to ensure that the validity of messaging was accurate as directed highly important by MHSA Chief, Lindsay Walter.

Regional MHSA Input Sessions Feedback- Trilingual Sessions

Lompoc Evening Regional Meeting: Helping Hands of Lompoc- January 27, 2020

On January 27th, 2020 a regional input session was held at Helping Hands of Lompoc from 5:30-7:30PM. Stakeholders discussed housing and youth focus in particular in great detail. This group of stakeholders represented organization such as Access California, Behavioral Wellness, the Help at Hand Project, the North County Rape Crisis Center, the Lompoc Recovery Learning Center, Transitions Mental Health Agency, and Public Health Center, as well as the Community Action Center. Interest in supporting those experiencing homelessness with banking and paying rent, having peer run groups, helping them follow rules, having showering units with clinical peers close by placed in transitional housing support areas, the existence of support along the continuum from homelessness to home-owning stability, interest in using county property for this continuum of housing support, a desire to fund veterinarian bills for to build trust, and a hub of resources with lockers and charging stations for phones for those experiencing homelessness, along with transitional housing for transition age youth, were all ideas offered by stakeholders at the Lompoc community input session. A similar number of ideas were proffered to the county regarding peer support, whole person care, and youth focus. Manager, Sandy Rives spoke to the need to learn more about peer-run agencies such as SHARE! in Culver City. Sandy Rives has noticed the improvements of comforts with creating peer friendly environments that are inclusive which she learned about at SHARE!

Comment: Lindsay does an excellent job in describing MHSA programs and the process. She is a good leader in drawing out information from attendees to get new idea.

Comment: A person with mental health disorder is placed in facility which FOR people with mental health disorders. That person is then kicked out of that facility for doing something that people with mental health disorders do! This person needs to be held by the system, not kicked to the streets. PEER RESPITE MODELS ARE NEEDED. Visit SHARE! in Culver City.

Comment: Youth drop in centers are needed- especially in Lompoc, support youth crisis residential, support dual diagnosis programs, in favor of transitional housing support or navigation centers, support of mind-body programs, yoga/tapping/ nutrition, meditation.

Comment: Tech suite is going to be good. Loop into as many ways as possible. People need to learn about technology. Vanessa is good with the community.

Comment: Pertaining to electronic signatures, make them require print thumb, eliminate fraud. Homeless models, FEMA Housing: grading in mental health services, and medical services, full time. New Program: (Support offered services outreach program) = Services medications around the clock, monitor rents, utilities, Bank accounts, food, transportation, service animals, vet bills, social skills, following rules, law, landlord requests, drugs, alcohol. New division made Head Department- 24 workers- service SB county area.

Comment: Great presentation, a great deal of information in a short amount of time. Would recommend encouraging shorter on “popcorn” comments on bullet points. Would also encourage periodic open dialogue during the presentation geared at editing ideas. Well done! Wonderful to have youth input at meeting.

Comment: Peer Academy needs to be implemented and managed by BWELL to standardize the method in which peer services are delivered. PHF needs to be run like a Peer Respite.

Comment: Please consider utilizing helping hands of Lompoc (RLC) is a possible site for a TAY Center. Weekends and Evenings are typical quiet HL because the center is not being used. There is a lot of discussion in Lompoc about youth gangs due to a lack of services/ a place to go. I believe Lompoc would be a great place to pilot a youth center (FSA) Dan Mosby and community have been meeting with other locals to run a youth center that would offer programming & vocational training.

Comment: Have more Art classes, music classes in our society. Connecting to all elements training everybody.

Santa Maria Morning Regional Meeting: Santa Maria Adult Clinic- January 29, 2020

Stakeholders from Access California, the Santa Maria RLC, Santa Maria Bonita School District, Lead, the Good Samaritan Shelter, Community Health Centers, the Independent, Calm, North County Crisis Center, Behavioral Wellness, Olga Zed School, and the Community Action Commission gathered to learn about and discuss the MHSA 3-year plan. Food was provided and a presentation given on the MHSA. Stakeholder feedback was once more requested and focused breakout sessions were held on each of the 4 areas of focus for the MHSA 3-Year Plan. Community members shared gratitude with MHSA Lindsay Walter's assistance of including the Growing Grounds in last year's plan update. The need to add funding to the RLCs within Santa Maria and Lompoc was noted. Santa Maria RLCs members spoke to the success of the LEAD program that Transitions has established. The need to educate consumers and family members on how to best advocate and collaborate with county was discussed. The success of the movement within the utilization of funds was mentioned. Community members highlighted the need to include Santa Maria regions including Guadalupe and New Cuyama feedback is important. The community shared the need to better understand the role of contractors and the services that they provide versus the role of Behavioral Wellness. Santa Maria Clinic expressed increase of utilization of peers and would like to enhance programming but need funds to support staffing needs. Community inquired on Depot Street and the need for wraparound services within housing funding. Community highlighted the need to add harm reduction programming within housing and clinical programs with the legislation surrounding the legalization of marijuana use. The need to find creative ways for people who may not hold legal documentation such as farm workers need an adaptation of mental health services and housing that are culturally and linguistically appropriate. Currently, the migrant community is an "after thought" yet migrant workers are a large population of the Santa Maria community. The request to better utilize space within the Santa Maria Adult Clinic is needed said many. The request to complete walk-throughs of clinics was discussed. The need to better use outdoor space was explored as supported employment hubs that may be created regionally by BWELL was highlighted. The need to increase supportive services for people who are homeless and work was a main concern. Community members spoke to the need to increase a standard method for community and county staff to share information was discussed. Community members requested Regional Navigation Hubs be created to ensure that people have one stop shops and "safe zones" for people to use computers and book on-line medical appointments. Enhanced communication surrounding harm reduction and NARCAN education was requested in response to the opioid epidemic that the country currently faces. Clinic programming around Nutrition and Wellness need funding to allow for groups to be interactive and supported. Innovative housing models that include "tiny home" and safe parking zones are needed and Santa Maria region has vacant space.

Comment: Dr. Gleghorn had a hard start. She is finally shaping this county into place.

Comment: Santa Maria RLC needs more funding for staff. There is a lot that we can do but we need more funds.

Comment: People need a safe place to live.

Comment: Lindsay always does great with the annual meetings that she hosts. She is smart she always brings food and gives us time to speak.

Comment: Where is the disabled community? We need more programming for people that cannot reach care.

Comment: More EDUCATION is need year-round on MHSA Funding and inclusion of SUD. Quarterly MHSA education meetings are needed.

Comment: Foster Rd Adult Clinic has "lots of wasted space" There are areas that may be invested in to hold trainings and community gatherings. Department needs to invest in space that they already have.

Santa Maria Evening Regional Meeting: Santa Maria Library- January 29, 2020

MHSA Chief Lindsay Walter with consumers and family members led the community feedback session. An increased need to have activities outside of the RLCs were mentioned. Community members from Lompoc and Santa Maria along with community organizations to look into current ways that space within Regional BWELL Clinics and RLCs can be best used. The need to improve Department Action Team meetings with consumers and people with lived experience in that category is needed. Increase need to better highlight peer support services through data gathering efforts is needed to show improvements. Increased internal advocacy support is needed to allow for the RLCs members and BWELL Clinic clients to move ahead in their lives. Diversified peer support is needed. Currently, there are not enough peers within all divisions. Harm reduction education is needed. RLCs have noticed an increase to the need to better understand the "umbrella of care within substance use disorder" Community highlighted the need to implement standards throughout the way that services are delivered to include recovery-models throughout RLCS and Clinics. RLC Community highlight the need for BWELL to host trainings to their contractors that deliver Peer Services that include SAMSHAs evidence base models- this will create a standard that will elevate the success of community membership within all RLCs. The need to create a peer respite was explored with the possibility of including a peer respite feel to the Psychiatric Health Facility to help allow for clients to feel safe and working towards recovery and not like a hospital which can scare people.
Comment: First I want to thank you for the very informative talk today. It's my first time coming to one of these forums and I learned a lot. My mom is diagnosed with bipolar disorder and she only speaks Spanish so throughout the years we have found some challenges finding services in Spanish. My main suggestion will be to hire more Spanish speaker staff such as; psychiatrists, nurses, therapists, etc. She goes to the Behavioral Wellness center in Goleta and the staff there is wonderful and so helpful but I believe they are understaffed, so more Spanish speaker employees in the Mental Health system will be a HUGE help for the community in Santa Maria considering that 50% of the population is Hispanic.

Comment: Open more housing centers/partnering up with property owners.

Comment: When I was in SBCC I attended a program called the Emmaus program. It was a weekend retreat with different activities and workshops. This program had a great impact in my life. For the first time I felt connected with other teens like me that were struggling at home and in their personal life. The activities will be based on trust and personal development. I think a program like this for teens that have a family member with mental illness or themselves will be great for our community and a bilingual (English/Spanish) even better. :) Now I live in Santa Maria- there is nothing up here.

Comment: Offering meditation sessions at schools and different mental health support centers. More Spanish exposure about available services. Maybe going to schools and advertise the services more in Spanish speaking communities and ESL Classes: Schott center in turnpike and padre SBCC extended learning, Allan Hancock EOPS programming and Santa Maria Adult School can benefit from programming.

Comment: I stated on the cards: (1) the graduation process needs overhauling: the process needs to be a gradual process. Step down with client, case manager, and doctor on the same page. With client giving full disclosure to when they really think they can graduate. Not this evaluating quick style and you have reached all your criteria. Left in the cold. Setting the client on a backward status. Not moving forward to recovery. The handoff system needs to be more open where the client feels comfortable making the change with their approval not being pressured to say we are graduating you to make room for another new client coming in. After the graduation all records, medications, bloodwork etc. follow immediately to the new doctor. All bloodwork, meds etc. do not refer back to mental health. For months back and forth like a yoyo: for 6 months or more. This happens quite often after graduation in North County. Dignity healthcare who Dr. Garcia works for wants the Dr. Garcia to make his diagnosis then send the client back to their primary care doctor. The problem is if you are a client with the county clinic either the doctor there or the administrator are not equipped to take over the Mental Health problems with clients either medication or evaluate and services to the clients. The clients are told your case is closed. If you have any other problems you are welcome back into the system, however you have to start over from the beginning/ Our system needs to keep the network open on a suspension basis for a minimum say 3 years then close it. That helps the client who might have a relapse. The graduation requires the opportunity to take WRAP classes as part of the graduation process. I have taken wrap classes for over 4 years every time it is opened. It keeps you updated on your Recovery and wellness. (2) I have one comment on the homeless shelters. For cold and rainy weather, the homeless I talk to every day in Santa Maria do not like the way the shelter operates. I don't mind if Santa Barbara uses the money for the shelter, however, if the weather doesn't qualify in South County but applies in North County, open the shelter for either cold or rain. Let each region be responsible for their own homeless population. Do what is necessary for their area. And not be on this quick we do not have to open because we don't have to open. This is part of Mental Health services act provides towards homeless., those with mental illness and substance abuse. Give them dignity. Anyone of you could be homeless today or tomorrow. Remember most average people in this county are only a paycheck away from homelessness.

Comment: Here's a radical idea on improving daily homeless services of food and activities: REQUIRE THEM TO CONTRIBUTE. It will raise their self-esteem and increase moral. A lot of people are sort of 'babied'. They get something and are required to do nothing. Let it be 'their club'; 'their lunch project'. If they are able-bodied: let them help serve, prepare, clean up as a REQUIREMENT to receive a full meal. If they are handicapped physically ask of them to provide an artistic expression like a poem or draw a picture and then hang them on the wall. It is revolutionary, but even when it comes to housing, people can provide vast amounts of labor and talent. INCLUDE THEM IN HOUSING/EATING and watch them blossom towards a sense of purpose.

Santa Barbara Evening Community Meeting- January 30, 2020

MHSA Chief, Lindsay Walter along with consumer and family members led d discussions on MHSA and the funded programs. Community members shared need to include pets as natural supports along with the need for an increase in youth programming. The waitlist on ACCESS Line proved the need for more services within BWELL and better communication on what services are available within contractors. Fellowship Hall hosted within the Mental Wellness Center needs funding as it is a centralized location for many accessing services with 12step "Alano Clubs" in close

proximity allowing for people to get lunch and go to a 12step meeting. RLC funding increases were mentioned as the need to have BWELL peer staff on site providing linkages to services as well as creating an information hub within the hall to ensure that homeless community have a safe hub. Members from the Youth Wellness Connection spoke for the need to have a youth drop in center where youth can access services in a non-stigmatizing manner. The youth spoke to the importance of having youth run and youth decorated spaces as a way to ensure that youth seeking services have a "safe place" to receive care. The need for a Youth Commissioner at the Behavioral Wellness Commission was discussed as currently the outreach and engagement methods that the Department applies seem disconnected from youth. Youth peer internships within BWELL were discussed to ensure that youth seeking services have Youth mentors. The need to enhance whole person care services to include holistic practices including nutrition and exercise need expanding. Educational workshops on medication support and the understanding symptoms was discussed. Increased need for BWELL to work with organizations like Wellpath were highlighted as there need to be better access to treatment for people that are incarcerated. The need for visual representation for disabled community was mentioned as there are a lot of people with disabilities that live with depression and lack the ability to access services. Better transportation or BWELL workers that go out into the community via telehealth measures.

Comment: Peers have unique talents and strengths that they can contribute to BWELL in different ways. Some of them attend meetings, some want to be in leadership positions, and some want to facilitate groups. Many are artistically or creatively inclined and can create artwork, play instruments, sing, and write poetry. Some can contribute articles for a peer newsletter. Some can design the layout of the peer newsletter using software on the computer. Some can edit and proofread well and can check newsletters, documents, flyers, and presentations for spelling and grammatical errors. Some are fluent in Spanish and can translate all written materials so they can reach a wider audience of peers. Some peers are comfortable asking questions and sharing comments or suggestions during a meeting. Others are better at writing out their ideas on paper. Anyway, every peer has something to contribute. The important thing to remember is that peers are all different and should be encouraged use their unique gifts and share their knowledge and perspectives from their personal experiences.

Comment: Peers who are not able to find employment opportunities, can volunteer and network until they find employment. Volunteer work can lead to employment because the volunteer coordinator can give the peer a good reference. Peers can also take classes to learn new skills or get the satisfaction of completing a difficult project or assignment. Classes and trainings can lead to employment because the teacher or trainer can give the peer a good reference.

Comment: Peers need to stay positive and have realistic goals that they can achieve step by step. They need to remember that disappointments and setbacks happen to everyone and should never make them doubt their abilities or worth.

Comment: 1) BH into jail sx – d/c planning 2) direct communication between jail staff and bx health. Discuss medications, etc., I am the Regional Director of Mental Health for Wellpath and would love to work together to get this done! Let's get into the jails! I am requesting a meeting with Lindsay to discuss possible strategy to get BWELL into SB jail.

Comment: We need a Youth Commissioner at Behavioral Wellness Commission. Better serving youth were consisted of including youth roles throughout the Department of Behavioral Wellness possibly adding youth roles at Behavioral Wellness Commission along with intern opportunities with MHSA Chief Lindsay Walter and tech project with Vanessa Ramos to start. Create data for quarterly success and then grow the internship opportunities for all positions within the Department of Behavioral Wellness

Santa Maria Community Meeting- February 21,2020

Behavioral Wellness staff led by Peer and Ethnic Services Manager, Maria Arteaga and Community Health Centers of the Central Coast staff facilitated discussion with farmworkers and indigenous farm workers to be able to capture the needs of the population which are predominately Spanish and Mixtec speaking. Discussions surrounding housing access, whole person health/mental health care, adolescent services, and barriers to care. There were 154 adults and 96 children in attendance at the event. Participants engaged in dialogue giving feedback and asking questions regarding mental health services. Behavioral Wellness contracted Efren's Mexican Restaurant which reported serving about 500 individuals including children and although they were contracted to serve 150 they donated 150 food plates to make sure that all in attendance received food. Overall the event was a huge success with a total of 500 adults/children in attendance and 250 adults participating in the discussion and feedback section of the forum.

Lompoc Community Meeting- February 27,2020

Behavioral Wellness Peer and Ethnic Services, Maria Arteaga and Community Health Centers of the Central Coast staff led discussion at the Lompoc Adult Education center with community leaders, consumers and family members are joined discussions on the history of MHSA and the importance of open and engaging community feedback sessions. Community members shared that there is an increased need to better engage Spanish and Mixtec community. The need for prevention and early intervention outreach and educational workshops are needed throughout the community. Enhanced community connections amongst BWELL and the community is needed to better understand who the community is and how they live with mental health challenges. The need to increase resources for programs like Promotoras and workshops on what is mental illness, what is depression and how do Latinx communities handle mental illnesses is important as many in attendance shared the stigma surrounding mental illness. People requested for better language access programming as currently the Spanish ACCESS Line takes a long time and there are too many questions for people to answer which is a barrier in seeking services.

Santa Barbara Community Meeting- March 7, 2020

Behavioral Wellness Peer and Ethnic Services Manager, Maria Arteaga, Chief of Compliance, Celeste Andersen, Help@Hand Project Manager, Vanessa Ramos and Casa De La Rasa staff held a community MHSA discussion where topics such as barriers to services, youth focused, housing and peer services was discussed. Community members highlighted the need around creating vibrant mental health education programming where community-based organizations and BWELL create messaging. Community members requested accessibility to holistic care that felt culturally appropriate to community. Community members talked about traditional teas that are commonly used by LatinX families. Conversations requesting better programming within BWELL where staff are training in cultural competence. Community members spoke to their enjoyment of receiving services like Casa De La Raza because they felt embraced and welcomed. Community members highlighted their enjoyment of Zumba classes and social gathering for older adults. Community requested to have Help@Hand project return to host educational groups on digital literacy and digital mental wellness. Community spoke to the wanting to create outreach and engagement groups with BWELL where materials and mental health wellness topics are discussed in further at common LatinX gatherings such as parks. Community spoke to having barriers to care such as not being able to attain services via the ACCESS Line due to the long wait times and the long list of questions that were asked.

Community spoke to the need to better understand information hubs such as 211. Community requested for contracted community-based organizations to serve as an information hub with BWELL presence once a week to best answer questions that community may have in person as calling in for help is not a common practice within LatinX community. Community requested information being given to them by LatinX peer staff. Older adults are finding it hard to connect with their children and are requesting empowerment sessions. The need for community gardens areas for older adults to work together with TAY clients regionally was discussed with great excitement from participants. Better transportation access proves to be a need throughout LatinX community calling for BWELL to come to community regularly.

Community Focus Groups

Youth Innovation Lab - December 6, 2019

In efforts to diversify the community planning process through engagement with leadership at all levels, Santa Barbara hosted the Youth Innovation Lab at University of California at Santa Barbara with partnership of the Mental Health Oversight and Accountability Commission expanding multi-cultural stakeholder advocacy. The Youth Innovation Lab was designed to support the inclusion of youth perspective with a focus on partnership with school and community leadership serving as Adult Allies. Santa Barbara's Youth Leaders were a diverse group of five transitioned-aged youth some of which identified as LGBTQ+ and some of which identify as Mixteco that were able to bring light to the disparities within the two underserved populations- LGBTQ+ and Mixtec with mental health needs within the K-12 public education system. The youth infused voice and vision project development process for the project focused on three goals: (1) identify mental health challenges facing youth, (2) identify potential solutions to those challenges, and (3) support the presentation of solutions to county leaders for innovation investment.

In response to the preventive mental health needs of LGBTQ+ youth(s) in the public educational school system with mental health needs, the project development process identified the following challenges facing LGBTQ+ youth(s); Youth leaders identified that practices that requiring parent involvement for mental health services pertaining LGBTQ+ youth can hinder the youth's opportunity to disclose their personal gender identity prior to full knowledge and comfortability which may affect their mental health. Solutions that were identified were 1. Implementing mandatory LGBTQ+ cultural sensitivity trainings for all school staff including after-school staff; 2. Ensuring that LGBTQ+ support groups such as Parents and Families of Lesbian and Gay (PFLAG) were included throughout school resources and in counseling offices and shared with parents of LGBTQ+ families; 3.) Working with school officials to ensure that LGBTQ+ youth were able to access information pertaining to specific laws that protect LGBTQ+ community members that are minors- specific laws can include and educate on name change accessibility and gender form change that is protected and respected throughout education system.

In response to mental health needs of Mixtec youth(s) in the public educational school system, the project development process identified the following challenges facing Mixtec youth(s); Youth leaders identified that practices that require language assistance including testing need to be treated as a priority as youths that do not come from homes that culturally read and write as a form of communication may be at a disadvantage as the youths may not have adequate support services at home causing increased levels of stress and anxiety. Solutions that were identified were 1. Creating study zones that include you tube video access to allow for students to conduct research in a supportive environment; 2. Increase communication efforts with parents through active community outreach that teaches families about Department of Education mandatory school testing to ensure

that families are empowered with knowledge of the educational system that their children are exposed to; 3.) Support on-going Mixtec language mental health translation services at school and/or community centers to bridge the therapeutic communication gap that exists within the Mixtec community.

Chill zones on campuses and health centers off campus that are open to anyone were additional ideas supported by majority in attendance, if they were designed and youth led (informed) throughout development and operations.

With the information gathered through key informants in the process, action items will be brought to the Department's action team meetings by the county staff involved with the event.

Lompoc Help at Hand Community Meeting – MHSA Innovations December 12th 2019

Community members within the Lompoc region gathered at the Lompoc Children's Clinic with Help@Hand Innovations Project Manager, Vanessa Ramos to discuss MHSA Innovation funding with the Help@Hand project. Community group agreed to beginning the project with a mobile application that was less invasive such as Headspace, a self-guided meditation application. Community members looked into evaluation needs and agreed that University of California in Irvine provided a great resource for the upcoming pilot process.

Feedback Received:
Headspace seems like a good app to start with; At first I didn't trust this project- learning about it regularly has taught me more than what I imagined; People need basic computer and phone skills- where is the educational component to this project; Information must be made in Spanish and Mixtec; This is great and all but where are people going to charge their phones- the "Obama phones" have a low battery life; Who is going to teach the community about data plans; I trust Vanessa's selection on technology she brings us back good information; Peers need to be hired and involved in all aspects of this project- technology is tricky with our population;

Update the last plan- too many changes have happen; Where is the peer-to-peer chat; Vanessa needs to be seen in the clinics and community not only the RLCs- she needs to invite people out of the RLCs so that more people can feel comfortable sharing their thoughts; Data privacy is a must- they will sell our info to pharmaceutical companies- by the time we find out it's too late; More community sessions regarding project; Contract peer-run organizations; Give updates to ACCESS CA- they are very knowledgeable and ACCESS tells us the truth

Comment: Very good meeting. Vanessa did a very good job. Community meditation was excellent. I understand headspace much better, I feel connected

Comment: Went well. We talked about meeting place and moving the pilot into BWELL buildings (Children's Clinic) Talked about the difference mediator and how headspace works. We talked about the pros and cons of location changing.

Comment: I learned more about meditation & the app application. I need more information I will keep coming back. I believe the pilot project is moving along, however, I felt it needs more input from the community. They need to have the meetings in a County Property, away from the RLC's

Comment: I enjoy being in a county building and focused the meeting was. I am expected to see where we are going!

Comment: We covered a lot of ground. I like we at a BWELL location. I feel really comfortable with the meetings being consumer run. Everyone's voices were heard. I am excited about where the project is going.

Community-Based Organizations Meeting- February 5, 2020

Department Assistant Director, Pam Fisher and MHSA Chief, Lindsay Walter began the meeting by outlining the next stakeholder meetings and their focus topics which included homeless outreach and housing, whole person care, youth, and upcoming Spanish sessions. Discussions were held on the MHSA planning process and the discussed community feedback surrounding the need for client and family driven outreach and prevention activities that were being contracted out to community-based organizations highlighting the need to have people within the focus involved. Conversations around Workforce Education and Trainings (WET) were discussed with an upcoming grant from OSPHD. A subject matter expert presented on LGBTQ needs and trainings surrounding diversity, sensitivity and corresponding resources available for the LGBTQ community along with the people who provide services to LGBTQ people. An update was then given on the electronic health records system, and resounding support for updating it was expressed. Attendees included representatives from Behavioral Wellness, Pathpoint, Santa Maria Valley Youth & Family Center and Family Services Agency, Aegis, Council on Alcoholism and Drug, Casa Pacifica, People Helping People, Sanctuary Centers, Compliance – Behavioral Wellness, Child Abuse Listening Meditation, Help at Hand, Telecares, Crestwood CRT, Good Samaritan, Coast Valley, Transitions Mental Health Services, Community Health Care Centers, Fighting Back: Santa Maria Valley.

Youth Wellness Connection Council- February 10, 2020

MHSA Chief Lindsay Walter joined the youth-led conversations on MHSA focus topic areas. Youth discussed:
1. What is working well? a. What has been successful on campus b. What do you think is working as far as supporting mental health in schools?
2. How do we better serve our youth? a. What are we missing? b. What could we do better? c. What do youth feel they need the most? d. What do you see as the most pressing issue facing youth wellness.

3. Communication & Outreach a.) Best way to communicate with students to increase awareness of available services? b.) How do we create communication that is compelling? Youth Panel leading the conversations were Youth from Mission Harbor Behavioral Health, University of California in Santa Barbara, Just Communities, and serve from local high schools ranging from 10th to 12th grade.

Feedback gathered spoke to the need for digital technology education and ensuring that we do not lose face to face therapy visits in adopting technology. Success was spoken surrounding on-site mental health awareness workshops during health class and mental health blurbs during school speaker announcements within school programming. Communication & Outreach solutions were based in creating youth-led designed messaging. More thinktank sessions with youth pertaining to youth programming.

Electronic Health Record and Workforce Education and Training- February 19, 2020

MHSA Chief Lindsay Walter along with IT Division Chief Marshall Ramsey and Project Coordinator Natalia Rossi presented on the finalized conversion of paper records to electronic records in the inpatient Psychiatric Health Facility and continue funding licensing agreements related to technology. Conversation was held speaking to the limited funding within CF/TN and WET proposal. Discussion on the need to continue to work on technology projects to ensure that the Department was up-to-date to avoid any breeches of security along with other items that may delay the Department's ability to provide care in today's world.

Comment: We need Social Media platforms to better share information with the community.
Comment: I support funding the loan repayment program for WET funds.

Comment: I support whatever Marshall Ramsey sees as best for EHR though Capital funding and technology funds.

Comment: Put money towards new her.

Comment Although every EHR system has its pros and cons, Netsmart/Avatar is a system used in other counties, allows for interoperability and has capacity for single record platform across multiple services systems. Plus, many features that you can turn off/on for monitoring and data reporting.

Comment: Full support in updating/modernizing the EHR!! The amount of time spent addressing difficulties with the current system leads to lower staff morale. Frustration with technology and ultimately decreased efforts for clients. Updated EHR would be a huge relief.

Comment: I am in favor of improving the EHR system. More efficient documentation, an all-inclusive system (intake, docs, scheduling, billing, reporting) would be wonderful. Any system that could also interface with CBO EHRs for data/info- sharing would be great too.

Comment: I advocate for the use of MHSA funding to support our current and expanded strengthening families programming to prevent MH and AOD disorder.

Comment: I think we should develop a robust pipeline for MH/SUD careers with WET money. I really, really think that we should have dedicated EHR support services with CFTN money. I think we should purchase a single product to replace our legacy systems with CFTN money.

March 3, 2020 Native Indigenous Community- Opioid Coalition Meeting

Behavioral Wellness staff, Santa Barbara County Sherriff's Department, Community Health Leadership and other community members were present at the Opioid Coalition meeting held at the Santa Ynez Tribal Health Center. Conversations surrounding services that BWELL offers and the needed services on mental health and alcohol and drug services were held. The group requested more information than what our brochures currently provide in a culturally competent fashion. The groups present encouraged the Department to include members within the community to help shape the method in which information is shared. The groups celebrated the opening of the Sobering Center. There is a need for client follow up and monitoring possibly "Check-In" sessions. Tribal staff shared that they were interested in co-developing more training for both clients and providers on how to support them effectively engage in services. Ideas that were raised included: teaching clients how to heal (impact of shame on recovery retention), integrating spirituality/culture into care, hope (keeping clients/staff motivated), medicine stories (using the power of those living in recovery to empower others, the personal narrative is an honored tradition among Native/Indigenous Tribes). The topic of Peers came up and the potential/interest in Tribal members becoming Peers for BWELL. Along with more information needed on NARCAN and Harm Reduction education. Participants felt that integrating Tribal/Culture beliefs (Native American traditions), integrating spirituality, group support along with case management/therapy along with the availability of psychiatric meds would be the most effective. The group acknowledged the value/benefit of treating the "whole person" using a holistic approach to care. The group identified the need for a tribal member to serve as a liaison to ensure that communication is shared in a manner where content is not lost.

National Alliance on Mental Illness (NAMI) Policy Meeting- March 9th, 2020

MHSA Chief Lindsay Walter and Help@Hand Project Manager Vanessa Ramos presented the FY 2020-23 MHSA presentation including conversations on Intervention after 1st system, Peer-to-Peer Trainings and Policy Reform. At the request of leaders within NAMI such as Lynne Gibbs and George Kaufman, FSP data from FY 2018-19 and FY2019-20 start up data from the "NEW" Transitional Age Youth FSPs was shared. NAMI group requested that BWELL continue to support NAMIs attention to Laura's Law as well as the need for BWELL staff to attend NAMIs policy meetings to gain a better understanding on some of the pressing issues that continue to arise including the need to better understand the upcoming involuntary medication that will be given by Santa Barbara Sherriff's Department. Discussions on what jail programs are like for people who mental illness is treated like a crime are needed. MHSA Chief or Staff will continue to attend NAMI policy meetings to better understand the organizations stance on upcoming programs and to clarify possible upcoming changes to MHSA laws. NAMI requested more information on how MHSA monies would be affected with the implementation of SUD use of MHSA and in supporting the youth drop in center and early psychosis grant programming applications.

Westmont University- March 12, 2020

Behavioral Wellness staff and Westmont University students joined the MHSA community feedback sessions to explore a Youth Drop-In Center Innovations grant opportunity. A huge support of the grant was shared from students speaking for the need to have a safe place to access services for short term care. Students spoke to the need to have youth peers participate in the full creation of a model like the Foundry model that was referenced. The need to explore education to reduce stigma is important many students said with the idea for BWELL staff to work with youth to create t-shirts and goodies for outreach and engagement sessions at local schools to help promote the idea of this innovation grant. A need for transportation and better access to services through centralized locations was discussed. The students encouraged for creation of the innovation model or any BWELL facility to feel less like a hospital and more like a place to get care.

Comment: Need coffee shop vibes.

Comment: Peer support is a good idea. Westmont needs BWELL to come out and talk to students about what BWELL does.

Comment: Programming around LGTBQ needs is important. Many LGBTQ youth are dropping out of school and are getting kicked out from homes because of their gender identity ending up homeless.

Comment: Drop in center needs to be open to all. Sometimes Santa Barbara centers are not diversified.

Comment: Place needs a youth council. BWELL may also have a Youth Council within TAY Clinics.
Comment: Jobs, people need jobs, especially young people that are bored.

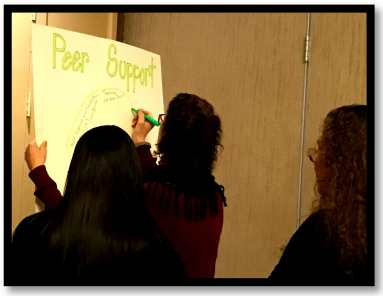
Department Action Meetings

Consumer and Family Members Action Team-December 19, 2020

Community included representatives from Access California, Santa Barbara Behavioral Wellness, North County Rape Crisis Center, and the Recovery Learning Center of Santa Maria. Engaging in working groups and discussing current funding of MHSA programs, significant progress was made during this fruitful time of community engagement. Current barriers and solutions were discussed with stakeholders at this meeting as well, as further steps forward were determined.

Comment: Tighten the drop-down policy on graduation of clients in the system to insure the clients are involved more in the system data surprise issue and the paperwork, blood tests, etc. smoother?

Comment: Wage Increase for Peers $15-$25 per hour.



Comment: Eight Dimensions of Wellness need to be taught and work around better understanding disability needs and what that means.

Comment: Pool of Champions to be started and started in a correct fashion.

Comment: Why can't Tina Wooton be included into the work that the Department does. Can Tina help with the Peer Quarterly Forum?

Comment: We are happy with the way that things are moving in the department.

Comment: Better transportation or access to meetings.

Comment: When is Vanessa going to teach about the PHONES??? We can't use technology without phones and knowledge around phone use.

Comment: We need to be able to go to out of town trainings at SHARE!

Comment: More MHSA information throughout the year. It's great that finally the Department is having real community input. Only took forever.

Housing, Empowerment Action and Recovery Team Meeting February 12, 2020

MHSA Chief, Lindsay Walter welcomed local stakeholders and gave an update on the MHSA 3-Year plan. Natalia Rossi noted that the Depot Street housing complex was "up and running" and will have a full-time caseworker. How money was being spent on housing as well as the awarding of 2.456 million was discussed, along with an update on the No Place Like Home project. Behavioral Wellness discussed the timeline of applications to receive more money for housing projects. Local stakeholders then began discussing a mobile mental health van to respond to homeless crises and crisis respite navigation centers. Stakeholders expressed a desire for lower client to support team ratio. As attendees spoke about current housing, concerns arose surrounding the sustainability of current housing support, and solutions were offered by Lindsay Walter and others present who gave input. Attendees included representatives from Behavioral Wellness, Pathpoint, the local school district, the county of Santa Barbara, the National Alliance on Mental Illness, United Way, Families Act, and the FTHC.

Comment: Where are the homeless people at? Are they even invited?

Comment: This action team needs to take place in the community not at the BWELL

Comment: Innovative housing options need to be explored with people who are homeless.

Comment: HUD is a waste of time. BWELL needs to expand Housing staff to include a real team of people. Natalia, Sara and Laura together can probably do a lot more than other community agencies.

Client and Family Member Action Team February 20, 2020

MHSA Chief Lindsay Walter, Peer and Ethnic Services Manager, Maria Arteaga and Help@Hand Project Manager Vanessa Ramos hosted the Client and Family Action Team held meeting discussing several topics, such as Help@Hand project, Behavioral Wellness Trainings, the Mental Health Services Act Fiscal Year 2020-2023 Plan, and Peer Support. Discussions on how to respectfully get cellphones in the hands of people who need them, and it was revealed that grants are available for this. Increased programming around digital literacy needs were highlighted. Consumer and Family Action Team discussed the importance of Behavioral Wellness Trainings. It was noted that family members have previously said that these trainings have saved lives. A Student Health Services workshop will be held at Alan Hancock. Behavioral Wellness stated their commitment to the enhancement of peers through these trainings, but it is questioned if clients will have access to these trainings. The Consumer and Family Action Team then moved on to discuss subcommittee updates. The newsletter's graphics and layout were discussed. Consumer and Family Action Team also revealed that that there will be a training at Helping Hands of Lompoc, and there will be an additional training offered in Spanish. The Mental Health Services Act Fiscal Year 2020- 2023 Plan updates were discussed next. These updates included, housing initiatives in collaboration with people experiencing homelessness, the integration of substance abuse and mental health services, and the increase of education of mental health services to decrease the stigma around mental health.

Four goals were established for the Mental Health Services Act Fiscal Year 2020-2023 Plan, including updating the by-laws Youth position on behavioral wellness commission, having peers host a peer-led conference by the end of three years, and having peer-led groups represent consumer voice. The Consumer and Family Action Team continued their discussion of Peer Support, including subjects such as Peer Academy, Transportation Aid and DMV assistance, peer trainings and conferences, and peer work hubs.

Submitted formal request pertaining to Pool of Champions written by ACCESS Ambassadors Chuck Hughes and Jacob McDuffee with Elizabeth Stone on behalf of CFMAT Committee

County of Santa Barbara
MHSA Team
315 Camino Del Remedio, 2nd Floor, Santa Barbara CA 93110.
MHSA Manager
Lindsay Walter JD.

As Santa Barbara County experiences growth in many areas we recognize that there are many consumers stakeholders who not in Behavioral Wellness workforce as well as in the workforce. That would contribute uniquely to all stages of new programs and services planning, implementation, execution and administration oversight. As well as being present at various Behavioral Wellness committee panel and board meetings. To be successful we suggest a pool of informed consumers and family members who are trained in advocacy Behavioral Wellness protocol and procedures by subject matter consumer expert. This would require an expense in locating and securing a facility for training, paying for the instructor, food, course material and transportation cost. This pool would be organized and managed by the Behavioral Wellness Consumer Manager or appointee who would organize and facilitate ongoing trainings we think the robust and vital input that is given from the consumer perspective is the sensual to sustainable successful collaborations on any committee at every level. This is where members from the pool champions could be called on to serve and their greatest capacity.
Thank you in advance for your consideration in this important mater.

Sincerely,
Consumer and Family Action Team

Children's System of Care- February 27, 2020

Department Assistant Director Pam Fisher and MHSA Chief Lindsay Walter, representatives from Behavioral Wellness, Council on Alcoholism and Drugs, Family Service Agency, Santa Maria- Bonita School District, Channel Islands University Student Nurse, Santa Barbara County Local Plan Area, Santa Barbara County Education Office-Transitional Youth Services, Fighting Back Santa Maria Valley, Santa Barbara Public Health, Child Abuse Listening Mediation, Community Action Commission, Casa Pacifica, and Child Welfare were present at the Children's System of Care meeting. This meeting focused on prevention and early intervention care, and it was noted that it is important to educate youth as young as possible on mental health. Currently, community members struggle with how to access to these kinds of resources. Youth drop- in centers are discussed as a result. Stakeholders brought up issues with wraparound services and the lack of these services. A variety of modalities of treatment available at these youth drop-in centers was brought up, and it was suggested that MHSA could reach out to local community health who are currently doing these diverse modalities of treatment. Early psychosis programming was discussed with a highlighted need to include services at a younger start with outreach materials to be created including the youth perspective.

Crisis Action Team- March 12, 2020

MHSA Chief Lindsay Walter presented FY 2020-23 MHSA CPPP Crisis Action Team Presentation with 12 ppl in attendance and 2 call in members. The attending members represented NAMI. Crestwood, Casa Pacifica, SAFTY, Cottage Hospital, Vista Del Mar, BWELL Administration, BWELL Compliance and Marian Regional Medical Center. Presentation highlighted MHSA History, MHSA Funding, current focus with shared implementations previous MHSA plan feedback. MHSA Chief discussed feedback received for the implementation of an Innovative Hospital Collaboration in response to MHSA FY 2019-20. Community members discussed the need for brain scans to measure anxiety, depression, ADHA and concussions. The discussion for the need of involuntary Crisis Stabilization Units with intensive services, plus assessments and observation by medical professionals and social workers. The group discussed feedback around hospital needs in connecting patients experiencing a mental health emergency to appropriate mental health services in a timely and safe manner. Community services and supports programing such as Crisis Services, Crisis Residential Services North, South and Agnes St were discussed along with Crisis Stabilization Unit (CSU) South, SAFTY Crisis programming. Senate Bill 82 updates were shared pertaining Children's Crisis Triage Teams, Crisis Residential North and Mobile Crisis West.

Comment: I would like to see MHSA Funding used to support school aged youth from pre-school to high school to provide information, support and services as needed to reduce the risk of these youth becoming severely emotionally disturbed in the future. This could include mental health support and services around family dynamics, physical and sexual abuse, school. Bullying and pressure to engage in risky behaviors including substance use and sexual activity. Not all families have the knowledge and understanding of how to support their children if and when the children face these difficult issues. Many times, adults may take the position that they are not sure if the child is telling the truth. Empowering youth, concerned adults and the educational community with the information and resources for stopping and preventing life altering situations would be a step in the right direction for creating a healthier community.

Comment: Need CSUs for kids.

Comment: Bridge Clinic-psych clinic can bridge treatment from hospital until patient is able to receive care and needs through BWELL.

Comment: Change current CSU- They are very hard to work with-they don't want patients.

Comment: We need More research is need for MHSA dollars to be used for involuntarily care.

Comment: Not many are using current CSU- maybe increase programming and use space for CSU for kids.

Comment: NAMI would support MHSA voluntarily and non-voluntary hospital.

Comment: Create innovations project possibly match with Medi-Cal.

Comment: Examine CSU barriers before implementing new program.

Comment: Create a list of what can be done more effectively.

Comment: We need locked youth units, increased transportation for youth and families, we need a youth CSU

Comment: Youth focused care is needed- youth CSU created with a youth peer council.

Comment: Look into Cottage and duplicate

Comment: Use Crisis Action Team as a governing body in the creation of the grant- invite collaborate partners that can share input on barriers such as PD- PD has several barriers but for the most part they do not want to provide services to only one call for the entire shift.

Comment: Expansion ability of other hospitals able to write 5150.

Comment: Building support/communications- BWELL needs to learn how to collaborate with other counties.

Comment: Information exchange- 211, section funding and information needs to be held at regional information hubs at regional clinics and at libraries.

Additional Written/Emailed Feedback:

Comment: We need funding for the Peer Pool of Champions, which should be included in the new 3-year MHSA plan for 2020-2023 because due to the fact this group of clients and family members replaces the group of 87 people that went through the 3-year Workforce Educational trainings between 2010-2013. These people graduated from the training put into a pool in case an opening in the ADMHS services came up these people were trained to fill the gap. Of the 120+ people who participated in the trainings 25 got employment. Some declined, including myself. I was a member of the Mental Health Commission at the time. The Pool of Peer Champions is included in the CFMAT bylaws. These people will engage in all the MHSA Stakeholder processes, after they have been properly trained and educated in all the processes of knowledge of system navigation, budget allocations, service delivery and all funding [insert] 5% of the MHSA service act goes to somewhat of these trainings for clients and family members. Underserved communities pertaining to the public mental health system in the workings. The Change in the system for the better requires leadership to value the clients voice to have helpful engagement, candid feedback, recommendations and budget issues. Without help and funding from the leadership for trainings. The clients have to gain all their information on their own. No understanding what they are reading with the trainings The Pool can be there when the hiring process occurs. Pool members need to be in the hiring process. North and South County being present. We believe in the phrase “Nothing about us without us”. This is our overriding theme. Others have been lost in the shuffle. Through hard, collaboration with Behavioral Wellness and other stakeholders all can work together with the Pool to impact MHSA program funding. The Pool priority of consumer training and empowerment, will result in scholarships to support the members, to attend statewide trainings and conferences. Work with BWELL and the Executive Committee to host and plan a Central California Mental Health Recovery Conference that is held annually.

Comment: Considering MHSA is supposed to be incorporating non-traditional treatments it would be nice to see Acupuncture, Shamsi hired to provide services in the service delivery system within BWELL and contracted agencies using MHSA monies and a table at each clinic with non-traditional resources available

Comment: There should be a consumer and a family member that is not in the Behavioral Wellness workforce involved in writing the request for proposals of programs that are using MHSA money. There should be a consumer and a family member that is not in the Behavioral Wellness workforce that oversees the CBO quarterly reports and program updates of programs accepting MHSA monies.

Comment: We need a peer academy. Tina talked about a peer academy years ago and the department did not allow her to build one.

Comment: More peers on Department Action Teams

Comment: BWELL needs to do a better job at explaining upcoming laws. We are tired of being the last to know.

Comment: When will this county wake up and realize that we need Harm Reduction Education.

Comment: We need better services for people that are not in crisis. Why does it have to be so extreme before someone gets help.

Comment; What are we doing about the Lompoc River bottom community? Will there be any feedback sessions for homeless people?

Comment: Please go to Pacific Pride. BWELL needs to better understand how to understand LGBTQ needs.

Comment: Thank you for the MHSA presentation at CSOC yesterday. I did not complete a feedback form at the meeting because I wanted to think about what may be the greatest MHSA need for TCRC. I have attached a feedback form that explains 1 item that could benefit both of our agencies. If this idea does not make it to the 3-year plan, maybe we can at least start a conversation on how we can support Be Well clinical staff on the best strategies to support the folks in our community who have co-occurring issues (behavior and developmental disabilities). Best of luck in developing the 3-year plan!

Comment: Can MHSA funds be used to support BWELL clinical staff on adapting therapy approaches to those with Developmental Disorders- Autism, Int Development, those that are non-verbal? There are many folks served by BWELL that have a co-occurring developmental disability also supported by the regional center system. Perhaps these 2 systems can find a way to share resources so more folks can access BWELL services in their community.

Comment: We need respectful and supportive inclusion of peers in the delivery of services to clients in Santa Barbara County- and by that, I mean- Peers at the highest level of planning and leadership in the Behavioral Wellness Department. The Behavioral Wellness Department must educate itself on the role of peers in recovery and that can be done by inviting a diverse group of peers throughout the county to brainstorm with Behavioral Wellness Administration about what recovery literally means to us. We welcome conversations with the Behavioral Wellness Administration to create ways in which peers can be represented and heard and important parts of the delivery recovery services in Santa Barbara County.

Comment: I have serious concerns regarding informed consent, user privacy and data security of the Tech Suite program for target populations leaving the PHF and CARES and how this information will be used and interpreted. SB Behavioral Wellness is forging with plans to spend over One Million Dollars in MHSA funds- public tax payer dollars- to implement social and behavioral markers from patients smart phones requiring only minimal, if any, active involvement of the subjects and other unvetted technology programs in the Public Mental Health System to be tested on public mental health clinics and even if such programs work great, Behavioral Wellness would not be increasing in-person direct services to meet the very mental health needs these apps are designed to uncover. Behavioral Wellness will be paying private for-profit corporations to create Digital programs, diverting scare public mental health resources to wealthy, well-connected tech companies founded by Google Executives and backed by venture capitalists and pharmaceutical companies. These profit-driven businesses are not in need public subsidization and shouldn't have unrestricted access to a treasure trove of data gathered through digital surveillance of public mental health clients. Client data will be used to enhance these companies'

products and increase their profits, without any clear lasting benefits to clients and the overall Public Mental Health System. Most apps and programs created for commercial use by private tech companies do not need FDA approval and do not have to comply with HIPPA. Since we already know that personal data is extremely valuable and info gathered from Digital programs can be used for targeted advertising, how safe can clients' data, really be? These are my comments regarding the MHSA Community Program Planning Process 3year plan FY 2020-23. We covered a lot of ground. I like that we met at BWELL locations and in the community. Consumers do not feel comfortable going to BWELL offices. Lindsay did a good job at taking the MHSA meetings out into the community. I like the fact that consumers were in on the MHSA Community Planning Workgroup- all involved were consumers as well as family members and BWELL Administrators. We set a precedence for the rest of the State to model. I am excited that Dr. Gleghorn and Lindsay Walter is allowing for ACCESS to host regional conference here in Santa Barbara. We need more consumer-focused trainings and more MHSA trainings throughout the year like having ACCESS host. These are more comments on Innovations: CalMHSAs primary purpose is to increase access to mental health care and to promote early detection of symptoms, even predict the onset of mental illness INSTEAD of promoting recovery concepts which is a key component of MHSA law. I feel that CalMHSA is not the appropriate organization to roll out the Tech Suite project and absolutely NOT the peer components as the organization does not employ more than one peer on a very large project- I was happy to hear CalMHSA report out to ACCESS and enjoyed reading the Stakeholder Report. I hope that this continues. However, peer components of the project should be contracted to peer run organizations. Santa Barbara peers understand the needs of this specific community. It is known that counties across the state view peers in different ways. I do not trust sharing dollars that were meant to be peer run dollars for peer run projects with an organization that is not equip to respect recovery and wellness created and delivered by peers. More information on the California Consumer Privacy Act is also needed. This project touches on privacy concerns that the project continues to ignore. Digital phenotyping needs to be better explained. I understand that Santa Barbara is not participating in digital phenotyping yet, we still need to be informed to understand what is going on. CalMHSA continues to avoid questions such as: who will hold client data that is held by digital vendors? Are more peers going to be hired on the project on a state level? Does CalMHSA report out to MHSOAC- Ethnic Services committee? Does CalMHSA understand peer wants wishes and desires when it comes to recovery programs? My peers with ACCESS California believe and understand the importance of keeping dollars local. Local clients and stakeholders are better equipped to develop local Innovation programs. As local peers know what kind of recovery programs are needed and better prepared and know the most effective way to deliver them. Local stakeholders will more easily remain involved in planning, development, oversight, and evaluation of local tech programs throughout the entire project. Consumers need education like you know, basic phone skills, need access to technology devices, people need access to charging stations and need the basic before all this money is spent on technology that we don't UNDERSTAND!!!- Chuck Hughes- ACCESS Ambassador

Comment: Please add to your topics for public consideration: Peer Participation in service delivery and especially Peers employed in intensive housing support of persons especially prone to eviction because of mental illness- Jan Winter- Behavioral Wellness Commissioner

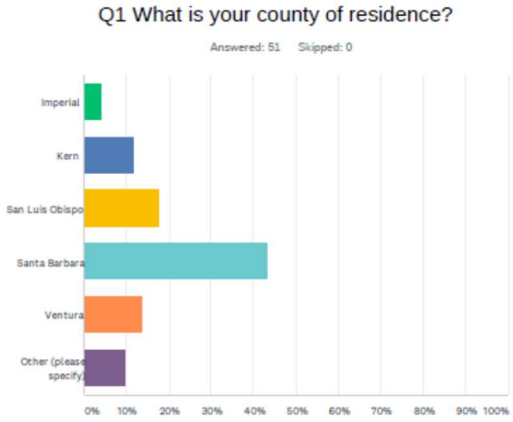
Comment: Tighten the drop-down policy on graduation of clients in the system to ensure the clients are involved more in the system not a surprise issue and the paperwork, blood tests, etc. are smoother. We need a Peer Respite. I believe all the venues this day have done really good. I mentioned changing the graduation process. I also would like to help persuade Santa Maria Police to join South County to help put a peer in the police car on a mental health issue and non-hatred towards mental health clients, tattoos, stigma. I am glad that the Latino population gave us some ideas at the Santa Maria Library evening meeting. I am glad that the Mental Health RLCs showed up this morning. I got some great ideas. We need funding for the pool of champions which should be included in the new 3-year MHSA plan for 2020-23 due to the fact this group of clients and family members replaces the group of 87 people that went through the 3-year workforce education training between 2010-2013.

These people graduated from the training put into a pool in case an opening in the ADMHS services came up these people came in to fill the gap. Of the 120 people who participated in the training 25 got employment. Some declined including myself. I was a member of the mental health commission at that time. The pool of champions is included in the CFMAT By Laws. These people will engage in all the MHSA Stakeholder Processes of knowledge of the system navigation, budget allocations, service delivery and all funding streams. 5% of the MHSA services act money goes to invest in these trainings for clients and family members, underserved communities pertaining to the public mental health system in workings. The change in the system for the better requires leadership to value the clients voice to have helpful engagement candid feedback, recommendations and budget issues. Without help and funding from the leadership for trainings the clients have to gain all their information on their own- not understanding what they are reading. With trainings the pool of champions can be there when the hiring process occurs. Pool members need to be in the hiring process. Both client and family members- North and South County being present. We believe in the phrase "nothing about us with us" This is our overriding theme. It has been lost in the shuffle. Through hard work collaboration will Behavioral Wellness and other stakeholders all can work together with the pool to impact MHSA program funding. The pool priority of consumer training and empowerment will result in scholarships to support the members to attend statewide trainings and conferences, work with BWELL and the Executive Committee to host and plan the Central California Mental Health Recovery Conference that is held annually. 1.) The graduation process needs overhauling: The process needs to be a gradual process. Step down with client, case manager, doctor on the same page. With clients giving full disclosure to when they really think they can graduate. Not this evaluation quick style sets the client on a backwards status. Not moving forward to recovery. The handoff system needs to be more open where the client feels comfortable making the change with their approval not being persuaded to say we are graduating you to make room for a new client coming in! After the graduations, all records, medications, bloodwork, etc. to follow immediately to the new doctor. All blood work meds, etc. do not refer back to mental health for months back and forth like a yoyo for 6 months or more. This happens quite often after graduation in North County. We have the Holman Group Dr. Garcia. Dignity Health who Dr. Garcia works for wants the Dr. Garcia to make his diagnosis then send the client back to their Primary Care Doctor. The problem is if you are a client with the County Clinic either the Doctor there or the administrator are not equipped to take over the mental health problems with clients either medication or evaluations and services to the clients. The clients are told your case is closed. If you have any further problems you are welcomed back onto the system however you have to start over from the beginning. Our system needs to keep the doors open or a suspension basis for a minimum of say 3 years then closet. That helps that might have or has relapse. Those graduating be given the opportunity to take the WRAP classes as put of the graduation process. I have to be in WRAP classes for over 14 years every time it is offered. It helps you updated on your recovery and wellness. 2.) I have one comment on the homeless shelters for cold and rainy weather the homeless I talk too every day in Santa Maria do not like the way the shelter operates. I don't mind if Santa Barbara runs money for shelters however, if the weather doesn't qualify in South County but applies in North County open the shelter for either cold or rain. Let each region be responsible for their own area homeless population. Do what is necessary for their area and not be on this kick. We do not have to open business we don't have to open. This is part of mental health services act priorities towards homeless, those with mental illness and substance abuse. Give them dignity. Anyone of you could be homeless today or tomorrow. Remember most average person in the county are only 1 paycheck away from homelessness. Chuck Huffines- Behavioral Wellness Commissioner

Survey Feedback:

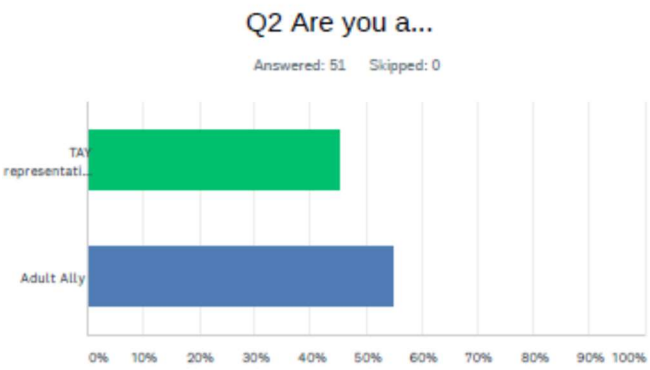
Survey results from the Youth Innovations Lab held at the University of California in Santa Barbara December 2019

Question 1: What is your county if residence?



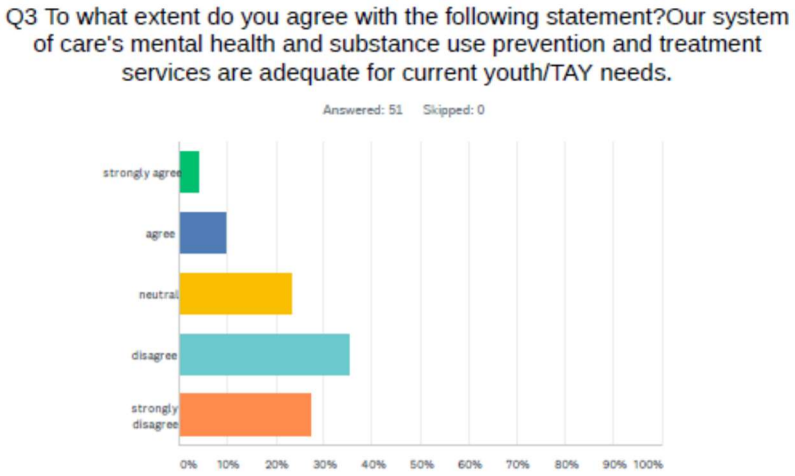
Imperial 3.92%
Kern 11.76%;
San Luis Obispo 17.65%;
Santa Barbara 43.14%;
Ventura 13.73%;
Other 9.80%
(Tulare; Fresno; Sacramento; Shasta; Los Angeles)

Question 2: Are you a TAY Representative or Adult Ally?



TAY representative (under age 25) 45.10%
Adult Ally 54.90%

Question 3: To what extent do you agree with the following statement? Our system of care's mental health and substance use prevention and treatment services are adequate for current youth/TAY needs



Strongly agree 3.9%
Agree 9.80%
Neutral 23.5%
Disagree 35.29%
Strongly disagree 27.45%

Comments:

TAY needs are often mixed in with adult needs - but the needs of the TAY population are quite different from adults in the counties' mental health systems. The TAY population needs to be considered as a unique group.

I feel as if most therapy is catered to what the parents need not what the youth need. As a youth who has gone through substance abuse and mental health programs this seems to be the trend, instead of working with how the teen wants treatment they usually focus on what the parents say even if falsified

I don't believe the level of accessibility to any prevention and treatment services are adequate. I believe there are variables such as privacy (from parents), socioeconomic status, lack of any services in their area, gender identity, and more that show we have basically nothing when it comes to the needs. There is so much to build up on when it comes to especially the under 18, or people not in a college/university setting who don't have the luxury of a health/wellbeing center.

Adequate, yes, because there are youth getting served. But, we can do better.

I have been delivering services under both MH and SUD contracts for over 40 years. I have worked as provider for 25 years, 4 years in DAPD and 4 years as AOD administrator in Monterey County. Access to services has been given to those with the most severe of disorders, siloed and fragmented. Prevention and early intervention are insufficient and siloed HOWEVER THANK YOU FOR ASKING THIS QUESTION AND INCLUDING MH AND SUD in one question.

Lots of resources, but not always known how to access and limited locations.

They agree we need the services to create longevity in change, but struggle when implementing services.

But can always be improved!

Drug use is not talked about.

There is an unfortunate gap between school districts and mental health services. Agencies in Kern often work in silos.

We need more assistance for our youth in Santa Ynez Valley! Santa Ynez High School according Healthy Kids Survey is highest in drug and alcohol abuse in SB County! All of our small two school districts all feed into SYHS! Our School Wellness Plans need to be reviewed and recognized to support Mental Health, Nutrition, Physical, overall Wellness for students, teachers and staff as well as our communities!

We r moving in the appropriate direction but innovated work and solutions must be complemented

Youth involvement in planning is fantastic, but ultimately, we need more funding.

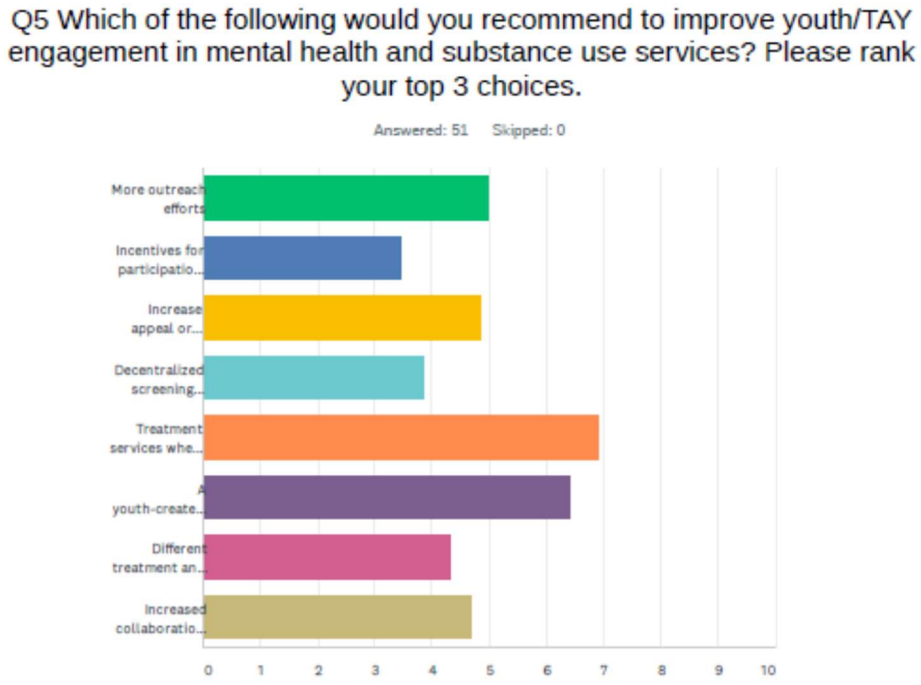
I don't really understand what the question is exactly concerning but my take is that it asking if the current system for these issues are adequate for youth needs (like in schools). I believe it isn't because although it is being brought up and talked about more, it isn't catching the attention of youth because of the way it is told and talked about to us youth.

Question 4: What are the barriers you perceive in reaching YOUTH/TAY who are not currently engaged in treatment?

Lack of education on resources Stigma; homelessness; appropriate and engaging messaging that is inclusive, engaging and non-judgmental; educating families about what mental health is and also getting rid of that stigma that prevent youth from wanting to reach out to professional help; Not considering how to specifically engage them. Youth/TAY have particular interests and are drawn to different activities than other populations; Anger Management and substance abuse classes; Many younger people have an idea stuck in their head that seeking treatment makes you weak or for myself my parents wouldn’t allow me to seek treatment due to my situation; Systems designed based on youth needs, too many silos of care.; inadequate follow up services; Stereotypes; unstable housing; Teachers have to want to teach in order to be a good teacher for health classes; People not educated People in denial People who are uncomfortable with vulnerability; The difficulty in connecting them to resources. Too many stipulations to how they qualify for services, if there are any available. Too complicated to connect them; Wellness center open hours Lack of outreach; Lack of communication and lack of easy to understand/obtainable resources; socioeconomic, gender, race, accessibility, privacy, stigma surrounding mental health needs, location, education, time constraints, parent's neglecting youth & unwillingness to cooperate; Fear of judgment and being misunderstood; stigma, lack of trust between adults and youth, cost; A lot of youth/Tay don't like reaching out to people because they are too afraid to be judged; Not enough behavior health counselors offered at our schools across our county; Providing a safe environment and ally to speak openly to. Follow up and education on matters that are stigmatized.; Marginalized groups do not get the same access, and face additional barriers; models of care are not youth specific; In the SUD field the Tx is designed based on adult models. Engagement and intervention should be delivered where youth live. and communication should be relevant to the social media world; Need to listen to the Lack of awareness; mental health stigma; transportation; Stigma, safe places for treatment, connection to systems.; Trusting adults; Transportation, getting youth to and from an event and giving the youth enough time to get comfortable with one another and get into the groove of conversation.; reducing stigma in seeking mental health resources, and advertise resources to everyone and create resources; Reaching out to under-served communities such as indigenous and Chicano/Chicana youth, and communities that have specific needs, such as LGBTQIA; They may not want to seek help. Self-harm issues; Lack of stable housing and access to basic needs, as well as discrimination due to legal status or ethnicity (ex: indigenous communities).; Stigma, logistical barriers (e.g. transportation), lack of knowledge regarding mental health and mental health treatment, parents' reluctance, cost, navigation of

insurance, lack of cultural competence in mental health care; Stigma; relatable messaging; multiple points of warm contact; Money, location, awareness; lack of accessible treatment services fostered stigma by the schools and the community about engaging in treatment; Societal stigmas and taboos, lack of access to resources in certain communities; Stigmatization and poor communication; More Education in dangers in vaping, marijuana and alcohol for parents and well as youth!; Information to youth/Tay; Really understanding the culture of the youth and how that impacts their mental health/wellness needs. We need to hear the needs directly from the mouths of the youth!; Perceived stigma, individuality, access to services, autonomy, transportation; Policy; They don't know the resources available or don't want to get help because of the stigma around mental health.; Stigma and access (insurance or not; esp. private pay); More Patience; Funding!; People can be scared to come out and say that they are struggling and need/want help. Since there is a stigma around it, people don't feel automatically comfortable "exposing" themselves.; Youth need more information and easier access to services.

Question 5: Which of the following would you recommend to improve youth/TAY engagement in mental health and substance use services? Please rank your top 3 choices



	1	2	3	4	5	6	7	8	TOTAL	SCORE
More outreach efforts	16.67% 6	8.33% 3	22.22% 8	8.33% 3	13.89% 5	16.67% 6	13.89% 5	0.00% 0	36	5.00
Incentives for participation through food or gift cards	3.23% 1	9.68% 3	9.68% 3	12.90% 4	16.13% 5	9.68% 3	0.00% 0	38.71% 12	31	3.48
Increase appeal or attractiveness of current activities (such as more/different locations or activities)	9.76% 4	19.51% 8	21.95% 9	12.20% 5	0.00% 0	12.20% 5	17.07% 7	7.32% 3	41	4.85
Decentralized screening process	0.00% 0	6.67% 2	13.33% 4	20.00% 6	16.67% 5	16.67% 5	16.67% 5	10.00% 3	30	3.87
Treatment services where youth/TAY frequent such as in schools, after school, recreational locations	39.13% 18	36.96% 17	10.87% 5	4.35% 2	6.52% 3	2.17% 1	0.00% 0	0.00% 0	46	6.91
A youth-created/led integrated care site (a youth/TAY service hub with co-located services, such as the Headspace or Foundry model)	40.48% 17	19.05% 8	19.05% 8	4.76% 2	4.76% 2	4.76% 2	7.14% 3	0.00% 0	42	6.43
Different treatment and or prevention models and strategies	11.76% 4	8.82% 3	17.65% 6	8.82% 3	11.76% 4	11.76% 4	14.71% 5	14.71% 5	34	4.32
Increased collaboration with referral sources	3.13% 1	21.88% 7	25.00% 8	9.38% 3	12.50% 4	3.13% 1	9.38% 3	15.63% 5	32	4.69

Question 6: What activities or services do you think youth in your community like and want more of?

TAY Inspired events; social supportive activities, resources fairs, seminars, peer-led and peer-interaction oriented activities; Outdoor settings. We live in a beautiful city and being outdoors in nature can help. Do a group at the beach or park. Something outdoors; They want to socialize with each other around outdoor activities and events as well as gaming. More active engagement rather than sitting in a room with a therapist or case worker- they seem to disengage from that setting;

Question 7: Do you have any ideas about programs you would like to see or world like to expand?

RESPONSES
TAY programming efforts through Transitions- Mental Health Association
SUD Residential housing
interactive, experiential programs that are guided by ideas generated by TAY
unsure.
Hiking and naturalist groups; teen hub where kids can come for various reasons - not just for mental health support; art programs; volunteerism - such as at a humane society; helping young children or seniors; vocational rehabilitation focused on youth interest and skills - not just generic like working at the local CVS as a clerk.
Anger Management Head space rooms Activities for youth
I'd like to see youth drug therapy and youth 12 step programs because they're usually aimed to older communities which make the meetings uncomfortable for a younger audience
Out of campus treatment locations
N/a
inpatient substance use treatment programs
Wellness centers for al schools!
Well-being / mental health support centers
I would like to see our RLCs being used as a hub on weeknights/weekends
Mental health week with class education assemblies and providing ways to outreach. Always with follow ups!
Currently working on seeing if I could implement mindfulness in high school settings during morning announcements.
I'd like for more assemblies and motivational speakers to reach out to schools.
Expand Youth Wellness council
REACH Club, mental health awareness in health classes, and wellness centers in school
More mental health surrounding activities and programs.
mental wellness groups. a Mandatory 1 week mental health, substence abuse, how to get help; course for all health classes/ all students.
Collaboration with existing clubs and organizations, not another program. But, adding to existing resources.
more caring adult allies in the lives of young people.
1. one stop availability where youth frequent. schools, drop in sites, recreation site. 2. safe space for socialization that includes accesss right there for reproductive, mh and sud concerns including tobacco. vaping. HARM REDUCTION MODEL
Youth-specific services
GSAs (Gay Straight Alliance) in ALL schools
youth centers with free and accessible counselors
Wellness Wednesday (a mental health day at schools), having zen gardens available in school, offering yoga in place of in school PE, Peer led supports based in a local youth centers were other resources are available to the community, and PEER MENTORS in all aspects (school, drop in center, and other mental health resources
Wellness centers on campuses.
No.
TAY Tunnel would be an amazing example to duplicate in various other cities. They provide the

Question 8: Please describe which part of the idea lab you felt was most helpful

RESPONSES
The group brainstorming process which was TAY led
presentation of ideas
the round table discussions
The ending where every group presented what they discussed.
Sitting together at the group table, problem solving the issue we had selected - it was fabulous hearing the youth brainstorm to solve a problem in which they are interested.
LGBT because it can open doors to many programs and help with issues associated with it to help people get a better understanding of it and to get the word about to educate it
I liked that we came up with ways to make the ideas work in our personal community
Youth led ideas
social part
group conversations on new ideas
the end, where groups presented on their topic
I really liked doing the whole chart
when we all shared and collaborated as a whole group of people
Groups discussions at the tables.
Having the youth lead & direct the table discussions as to what they envision
The sharing at the end
hearing youth from all over and different counties be able to speak about their experiences and hear their ideas
Getting to see the perspectives of both adults and teens
Collaborating with youth from cities across the state, different from our own experiences.
collaborating with teenagers my age about such sensitive topics was something very new and eye opening
I believe the gallery was the most helpful because it gave a lot of ideas to grow off of.
open flow of ideas.
Most helpful was the small group discussions.
the concept of bringing youth together to hear their voices.
It was clearly a voice for youth leadership. as an adult ally I was profoundly affected by the openness and leadership of the youth. however, as an adult ally I was impacted by the decripiton of stress, anxiety and sadness that was described by these youth
Putting the images from discussion onto post-its to give a visual of ideas to relate back to
Being around everyone and thinking creatively.
interacting with the youth and hearing their perspective and having it youth driven
The framework of the conversation (sprouted concept, barriers, etc) and all the sprouted concepts from each of the group.
The panel .... to me just because not being exposed to the power mapping method seeing it on a large scale and having the youth see before engaging themselves into the power mapping... ii made me excited to start power mapping.
Allowing the youth from different counties to collaborate and shop around ideas based on their unique experiences.
Interacting with other youth and adult allies aside from those in my own group. Meeting new people was cool.
The most effective part of the idea lab was getting to hear ideas and various views from the youth.
I thought that the mind map activity was extremely helpful. We were able to turn our grievance with the state of mental health care into something productive.
Structure of planning session & mix of people in each group.
Hearing from students!!! The fact that they felt important and heard was amazing!
The mapping exercise was very helpful and tangible.
The shared discussion of each's groups ideas was the most helpful part of the idea lab to me.
Collaborating with like minded people who are passionate about improving mental health
Students sharing their ideas of wanting to meet other peers from different clubs!
Students wanting to be heard and not shoved to the side, for example, detention
Just hearing the youth speak in am protected environment that was willing and ready to hear their voices
Youth led was helpful!
Discussion groups
Talking and collaborating with different counties in California to see what programs are happening in other districts and what we all agree needs to be done.
Round table discussions with power mapping
To express my ideas
Discussion and planning with the youth was fantastic
collaborating with other people from different places to find a balance/middle-ground to come up with the best overall solutions
I liked hearing from the various groups. Not sure how the pictures tied into the project... they were nice to see, but I wish I heard more about what the groups thought

Question 9: Please describe how we can improve the idea lab

RESPONSES
I thought it was everything that I hoped for
Just keep doing the Lab and other wonderful activities. This was TERRIFIC, CREATIVE and ENERGIZING.
I think the idea lab was very well done in a number of ways. If anything, I would like to see this type of lab conducted with more students. My sense is that the students appreciate a forum where they are the focus and they are listened to instead of "talked to." The more students who feel heard, the more likely they are to engage and understand that they can be a part of the solution. Kudos to all the individuals who coordinated this event. It was very well done.
Nothing I can see so far
Some sort of way to get everyone to socialize and break the ice among other youth
Closer to outlying areas. San Diego based conference
hot topics such as homelessness should have had a bigger table
I really liked the youth lab, it was very to the point and we got a lot done
longer !
Bring events like this to school or district sites, so that they are accessible to more students and groups.
I can't think of anything
Simpler discussions process with the groups
feedback maybe requested sooner or right after, better training in facilitation of topics--> having people who can learn to expand on ideas and not try to find one place to get everyone to go but to allow things to flow more naturally -Instead of already thought out topics for people (e.g. I was in the wellness center application for high schools) have people choose maybe topics/words they resonate with ex: lgbtq rights, stigma, needing more trusting adults nature, wellness center, etc. and then separating people by those groups and having them come up with something they would like to see that relates to that word, i think this would offer more collaboration and allow unique ideas throughout the room!
Make smaller groups
Avoid analogy terms such as "Sprouting ideas", "rich soil", etc.
maybe next time have the leaders/ adult allies know what they're doing
More interaction with other groups of people instead of just the one group we are in.
simplify idea mapping process for table groups.
Keep small collaborative groups. Idea lab facilitators can take back what they learned to mentall health organizers.
increase opportunity to meet youth from other areas and connect to the work being done
I think you did a great job. However, while i was pleased and surprised by your first question that include AOD/SUD it was absent from the problem/solution boards. DO MORE
A more specific explanation of the power mapping
Further discussions and development with more events
I thought it was perfect
great work. Id like to see more of these, with longer time to advertise, sign up and sponsor youth to participate.
having more time during the lab to have organic conversation and allow follow up within each other
Less complexity in the instructions/process of building up their ideas, a lot of the kids seemed to tune out.
Better topics. A lot of topics strayed from their own and turned it into a completely new idea, which is cool still, but not ideal. More topics towards high school students, as one myself, I felt that many of the topics were aimed towards college students making me feel uncomfortable. I had some anxiety upon initial contact with the older students, feeling like I couldn't relate to some aspects of life due to college and lifestyle differences.
Have greater representation from various cities especially cities like Oakland and LA where TAY homelessness and mental health is a defining factor.
More balance of topics - seemed odd that so many were on such similar themes. More balance when groups describe their results. Felt sorry for the first 2 since they followed direction and were brief but most of the later groups talked in much greater detail. Concerned that the group focused on low income challenges felt more marginalized because their topic seemed to be treated as of lower importance.
Our table facilitators were not well trained in the process we were asked to engage in with the problem/solution scenario so we spent a lot of time with them just trying to understand what was being asked of us.
Please provide context to the activities. It felt as though we entered halfway through a conversation.
One suggestion for the idea lab is having a visual representation of each group's sprouted concepts and solutions tie into each other, as many of the finalized solutions shared concepts from other groups.
Create discussion circles separate from the collaboration time maybe even a group mindfulness activity
Sharing with SB City College and Hancock College! And all local high schools as well!!
Allow time for fun. The lab was all work no play. Bring out team building acivities
It was very short notice with this type of planning. We could have gotten stronger more active voices at the table if we had more planning time
Have organized roles and structured conversation. Organized roles for adult allies as well
Giving more time to read all of the gallery ideas
More locations across California so we can hear from different areas.
Start earlier so more mapping can happen before lunch, then go as long or longer to include a targeted brainstorming session among area participants.
Unsure
N/A
Alter the activity we did just a little to make it easier to understand what is being asked of us so that we can productively work together on finding potential solutions
Less time on the process work and more time collaborating as a group, sharing ideas. It felt forced to have to follow your pattern...

MHSA Recovery Learning Center Guidance Council Survey
Mental Wellness Center
617 Garden Street
Santa Barbara, CA
93101

Survey Questions

1. Are you receiving services from SB Behavioral Wellness? If so, please tell us more.

2. Do you think the Latino community is receiving proper mental health services?

3. Do you think the African American community is receiving proper mental health services?

4. Do you find that information offering supportive programs and services are easily and readily available to you?

5. The county is working on a new three-year plan. What do you think is crucial to our community that should be added to the plan?

Response #1

1. Are you receiving services from SB Behavioral Wellness? If so, please tell us more.
   Yes, mostly classes- opportunity to be of service
2. Do you think the Latino community is receiving proper mental health services?
   They have clinics – neighborhood, but they could use more
3. Do you think the African American community is receiving proper mental health services?
   Am not sure
4. Do you find that information offering supportive programs and services are easily and readily available to you?
   No
5. The county is working on a new three-year plan. What do you think is crucial to our community that should be added to the plan?
   A shelter for abused women. No, they don't have to sleep in parks

Response #2

1. Are you receiving services from SB Behavioral Wellness? If so, please tell us more.
   No
2. Do you think the Latino community is receiving proper mental health services?
   Yes
3. Do you think the African American community is receiving proper mental health services?
   Yes
4. Do you find that information offering supportive programs and services are easily and readily available to you?
   Yes
5. The county is working on a new three-year plan. What do you think is crucial to our community that should be added to the plan?
   Yes

Response #3

1. Are you receiving services from SB Behavioral Wellness? If so, please tell us more.
   Group therapy, individual therapy 2x week relationship therapy once a week

2. Do you think the Latino community is receiving proper mental health services?
   Unsure but we do have Spanish staff here
3. Do you think the African American community is receiving proper mental health services?
   Yes, many are here already but I have noticed they don't attend groups
4. Do you find that information offering supportive programs and services are easily and readily available to you?
   Yes, love the monthly schedule and services. love pop up resources
5. The county is working on a new three-year plan. What do you think is crucial to our community that should be added to the plan?
   Family get togethers, more celebrations and events that are happening in the community. Free activities for SB Behavioral Wellness clients

Response #4

1. Are you receiving services from SB Behavioral Wellness? If so, please tell us more.
   No
2. Do you think the Latino community is receiving proper mental health services?
   I think this community is often reluctant to seek out government help of any kind because Sinophobia this current president magnified this problem
3. Do you think the African American community is receiving proper mental health services?
   I think this county often would rather throw these persons in prison than get them proper mental health services also this community is often uninformed about the services available
4. Do you find that information offering supportive programs and services are easily and readily available to you?
   Am still learning about what's available so that I can help other find the help they need
5. The county is working on a new three-year plan. What do you think is crucial to our community that should be added to the plan?
   Getting the word out in underserved communities about the services available Also helping to combat the fear of the stigma of receiving mental healthcare

Response #5

1. Are you receiving services from SB Behavioral Wellness? If so, please tell us more.
   Yes AmeriCorps
2. Do you think the Latino community is receiving proper mental health services?
   yes
3. Do you think the African American community is receiving proper mental health services?
   yes
4. Do you find that information offering supportive programs and services are easily and readily available to you?
   yes
5. The county is working on a new three-year plan. What do you think is crucial to our community that should be added to the plan?
   Finding clients, a place to live

Response #6

1. Are you receiving services from SB Behavioral Wellness? If so, please tell us more.
   I was last year
2. Do you think the Latino community is receiving proper mental health services?
   No not in the best way they should not be though But so many are afraid to admit to it getting checked out just an opinion
3. Do you think the African American community is receiving proper mental health services?
   Yes, but could be better assistance that all I'm going to say
4. Do you find that information offering supportive programs and services are easily and readily available to you?

no

5. The county is working on a new three-year plan. What do you think is crucial to our community that should be added to the plan?
   You don't want my answer to that

Response #7

1. Are you receiving services from SB Behavioral Wellness? If so, please tell us more.
   Yes, I go to the wellness center to paint and have lunch at fellowship
2. Do you think the Latino community is receiving proper mental health services?
   I have no idea
3. Do you think the African American community is receiving proper mental health services?
   Don't know that one either
4. Do you find that information offering supportive programs and services are easily and readily available to you?
   Not sure
5. The county is working on a new three-year plan. What do you think is crucial to our community that should be added to the plan?
   May a folding sign in the days and weeks activities

Response #8

1. Are you receiving services from SB Behavioral Wellness? If so, please tell us more.
   None
2. Do you think the Latino community is receiving proper mental health services?
   No
3. Do you think the African American community is receiving proper mental health services?
   Yes, but we need more target based focused help
4. Do you find that information offering supportive programs and services are easily and readily available to you?
   yes
5. The county is working on a new three-year plan. What do you think is crucial to our community that should be added to the plan?
   More help with transportation and housing supportive services

Response #9

1. Are you receiving services from SB Behavioral Wellness? If so, please tell us more.
   No
2. Do you think the Latino community is receiving proper mental health services?
   Yes
3. Do you think the African American community is receiving proper mental health services?
   Yes
4. Do you find that information offering supportive programs and services are easily and readily available to you?
   Yes
5. The county is working on a new three-year plan. What do you think is crucial to our community that should be added to the plan?
   A newsletter monthly or quarterly to keep us informed of services

Response #10

1. Are you receiving services from SB Behavioral Wellness? If so, please tell us more.
   yes
2. Do you think the Latino community is receiving proper mental health services?
   Yes

3. Do you think the African American community is receiving proper mental health services?
   Yes
4. Do you find that information offering supportive programs and services are easily and readily available to you?
   Yes
5. The county is working on a new three-year plan. What do you think is crucial to our community that should be added to the plan?
   Not sure

Response #11

1. Are you receiving services from SB Behavioral Wellness? If so, please tell us more.
   I am receiving a place to go for food and conversation which keeps me from being alone and drinking
2. Do you think the Latino community is receiving proper mental health services?
   I am not sure but they do not discriminate so I am sure they get the affection they need
3. Do you think the African American community is receiving proper mental health services?
   Again, I am not sure but the few African Americans have been getting taken care of as equals as they should
4. Do you find that information offering supportive programs and services are easily and readily available to you?
   Yes, everything is available to us
5. The county is working on a new three-year plan. What do you think is crucial to our community that should be added to the plan?
   People that are ready to help themselves

Response #12

1. Are you receiving services from SB Behavioral Wellness? If so, please tell us more.
   yes
2. Do you think the Latino community is receiving proper mental health services?
   Absolutely
3. Do you think the African American community is receiving proper mental health services?
   Absolutely
4. Do you find that information offering supportive programs and services are easily and readily available to you?
   Absolutely
5. The county is working on a new three-year plan. What do you think is crucial to our community that should be added to the plan?
   More yoga one on one support

MHSA Plan Posting Feedback Received from June 2, 2020 to July 2, 2020
Responses noted are from:
Lindsay Walter, JD
Deputy Director of Administration and Operations- MHSA Chief
County of Santa Barbara – Department of Behavioral Wellness
Phone: 805-681-5236 Email: lwalter@sbcbwell.org

Email: Anonymous
Message: Our department is not able to meet the MHSA needs due to difficulties with recruiting and retaining staff at all levels, including managers, team supervisors, and clinicians. FSP programs like TAY and SPIRIT, are rarely fully staffed, due to high turnover rates, difficulty with the CAC and CALM CBO portion of the program getting staff. The TAY FSP does not have the med support needed from nursing and prescribers, in order to accommodate the medication challenges that many first episode and/or other SPMI clients need, compared to the medical support from ACT. Another challenge is the lack of housing for homeless youth, youth with children, and TAY that are wanting to move into a safe environment.

Email: Anonymous
Message: PLEASE: MHSA funding for Student Loan Repayment. PLEASE

Name: John Doyel; Email: jdoyel@sbcbwell.org
Organization: Behavioral Wellness
Message: This is impressive document. On behalf of ADP, thank you. I would respectfully include a 7th priority population for PEI: 7.) Children and youth at risk for substance use disorders.

Response: Thank you for the input John. I support this addition and I think based on the joint survey we did at the Harm Reduction conference, data from the MH and ODS EQRO's, and the survey from the UCSB lab, this is a needed target population. Thanks for all the contribution and efforts; it's definitely a positive integrated approach!

Name: Krista Armenta-Belen; Email: karmenta-belen@sythc.org
Organization: Behavioral Health Director, Santa Ynez Tribal Health Clinic

Message: Consider ways to increase access to services in mid-county (limited local services offered & extremely limited transportation to support attending programming in other areas); nearly all content discussed specifically in regards to sites misses mid-county & unincorporated areas of the county, some of which have high numbers of minority members - Incorporate additional content in cultural competency trainings to include local minority histories & land-based understanding or doing the work we do on tribal land & the importance of that acknowledgement -consider expanding impact of cultural competency training by extending access to online content for broader range of community partner agencies (so county staff AND all agencies that execute work within the county plan participate in/ have access to the county's cultural competency training content)

Response: Thank you for the MHSA comments. I will add these to the plan and have included Maria Arteaga, our Ethnic Services Manager, as we continue to add to our cultural competency plan and department's prevention activities with goals for the upcoming three years. I've also included our Training Manager to review the online suggestion as we adapt our Relias capabilities and other online training methods.

Name: Community Members within the Santa Maria region (Chuck Huffines; Joe Hettich)

Message: The innovations plan was created while public computers were available within public libraries, college/University & recovery learning centers were open to the community. With closures due to COVID19, the community is no longer able to access WIFI & computers.

1: Invest project funds to purchase the WIFI and laptops for the community project's target populations. Community members have the funds to pay the low-cost WIFI monthly fees afforded by service providers. However, community members are having a difficult time paying the set-up/start-up fees to start the service and the laptop (appx. $200 WIFI and Laptop)

2: Invest technology funds to purchase ZOOM as the mobile application selected for the project

3: Launch basic digital literacy around ZOOM & Telehealth to ensure proper linkage with BWELL and BWELL contracted providers.

Response: Thank you for your comment. The Innovations project is currently looking into this matter and are identifying solutions. Tele-Health Grant opportunities will be shared at Department Action Team meetings to ensure that the community-based organizations associated with the Department have the opportunity to fill this gap for the communities that they serve.

County of Santa Barbara

Behavioral Wellness Commission

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

Behavioral Wellness Commission (BWC) Meeting Agenda

The Santa Barbara County Behavioral Wellness Commission announces the Public Hearing for the Mental Health Services Act (MHSA) Fiscal Year 2020 - 23 Plan, Wednesday July 15, 2020, 3:00 pm to 5:00 pm. The public is invited to attend to ask questions and offer feedback about the plan. **Remote Virtual Participation Only.**

IMPORTANT NOTICE REGARDING PUBLIC PARTICIPATION. Based on guidance from the California Department of Public Health and the California Governor's Stay at Home Executive Order N-33-20 issued on March 19, 2020 to protect the health and well-being of all Californians and to establish consistency across the state in order to slow the spread of COVID-19, the Behavioral Wellness Commission meetings will no longer provide in-person participation. To participate in this meeting, the public are invited to observe and address the Commission telephonically or electronically. Instructions for public participation are below:

The meeting will be hosted through Zoom. Pursuant to the Governor's Executive Order N-29-20, issued on March 17, 2020, Commissioners will attend electronically or telephonically; the meeting will have no location to physically attend. The public may observe the meeting online at Zoom.us by going to https://us02web.zoom.us/j/81045274131?pwd=NjJKUktNUlBZVnBVZ2lBQ213MU5iZz09. The Meeting ID is 810 45 27 4131 and the password is 649552. If you are unable to join the online meeting, you may also call in to (669) 900 6833 and when prompted, enter the Meeting ID 810 4527 4131 and the password 649552. Persons desiring to address the meeting participants can use one of the options below:

1. **Online via Zoom**
   a. You may 'raise your hand' via a hand icon on your screen. The Chair will call on you, open your mic, and let you address the commission for up to 2 minutes.
   b. You may indicate your wish to speak in the chat window. The Chair will call on you, open your mic, and let you address the commission for up to 2 minutes.

2. **By phone** – If you would like to make a comment by phone, please call (805) 681-5221 before 3:05 p.m. the day of the meeting. The Chair will call on you, open your mic, and let you address the Commission for up to 2 minutes.

3. **Distribution to the Behavioral Wellness Commission** – Submit your comment via email, preferably limited to 250 words or less, to the Program Administrator at kcampos@sbcbwell.org prior to noon the day before the meeting. Your comment will be placed into the record and distributed appropriately. To assist staff in identifying the agenda item to which the comment relates, the public is encouraged to indicate the meeting date and agenda item or state "general comment" for items not on the day's agenda.

4. **Read into the record at the meeting:** Submit your comment via email, preferably limited to 250 words or less, to the Program Administrator at kcampos@sbcbwell.org prior to the start of the meeting. To assist staff in identifying the agenda item to which the comment relates, the public is encouraged to indicate the meeting date and agenda item or state "general comment" for public comment for items not on the day's agenda.

Individuals with disabilities who desire to request a reasonable accommodation or modification to observe or participate in the meeting may make such request by contacting Karen Campos at (805) 681-5221 or by sending an email to kcampos@sbcbwell.org . The request should be made no later than noon on the day prior to the meeting in order to provide time for the County to address the request.

The Commission's rules on hearings and public comment remain applicable to each of the participation methods listed above. The Chair may set reasonable rules as needed to conduct the meeting in an orderly manner.

County of Santa Barbara

Behavioral Wellness Commission

300 North San Antonio Road, Bldg. 3, Santa Barbara, CA 93110
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TIME	ITEM	PRESENTER
3:00 p.m.	**1. Call-to-Order and Conduct Roll-Call**	Karen Campos
3:03 p.m.	**2. Establish Quorum** a quorum shall be one person more than one-half the number of appointed members including the Board of Supervisors member or his/her designee.	Sharon Byrne
3:05 p.m.	**3. Welcome and Introductions** **Action:** No action.	Sharon Byrne
3:10 p.m.	**4. General Public Comment** (2 minutes per person) - members of the public can testify before the meeting participants on any matter not appearing on the agenda **Action:** No action.	Public Members
3:20 p.m.	**5. Mental Health Services Act (MHSA)** Fiscal Year 2020-23 Three Year Plan Update (attachment 5a) 1. Public Hearing Overview 2. Commission's Role and Legal Aspects 3. Fiscal Year 2020-23 Plan Update Summary **Action:** No action.	Lindsay Walter
4:00 p.m.	**6. Public Comment regarding MHSA Plan Update** (3 minutes per person) - Members of the public can testify before the meeting participants on any matter pertaining to the MHSA Plan Update. **Action:** No action.	All
5:00 p.m.	**7. Adjournment** **Action:** No action.	Sharon Byrne

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"Writings that are a public record under Government Code § 54957.5(a) and that relate to an agenda item for open session of a regular meeting of the Behavioral Wellness Commission and that are distributed to the majority of the members of the Behavioral Wellness Commission less than 72 hours prior to that meeting shall be available for public inspection at the Santa Barbara County Administration Building at 105 E. Anapamu Street, 1st Floor in Santa Barbara, and also on the Behavioral Wellness website at: www.countyofsb.org/behavioral-wellness

Further Information Regarding Meetings:

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

Correspondence: to the Behavioral Wellness Commission regarding items appearing on the agenda should be directed to Karen Campos at kcampos@sbcbwell.org. Please call (805) 681-5221 for directions to submit correspondence in a format other than email.

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

Disability Access: Individuals with disabilities who desire to request a reasonable accommodation or modification to observe or participate in the meeting may make such request by contacting Karen Campos at (805) 681-5221 or by sending an email to kcampos@sbcbwell.org The request should be made no later than noon on the day prior to the meeting in order to provide time for the County to address the request.

American Sign Language interpreters, Spanish language interpretation and sound enhancement equipment may be arranged by contacting Karen Campos at kcampos@sbcbwell.org by 4:00 p.m. three days prior to the meeting date.

DRAFT NOTES PENDING FINAL APPROVAL IN AUGUST MEETING

Department of Behavioral Wellness Commission Meeting
Wednesday, July 15, 2020
3:00 p.m. - 5:00 p.m.
Remote Virtual Participation Only

Public Hearing Notes

Meeting Facilitator: Sharon Byrne, 4st District, Chair.
Commission Members Present: Wayne Mellinger, 1st District; **Rod Pearson**, 1st District; **Jan Winter**, 1st District; **Gregg Hart**, 2nd District Supervisor; **Marcos Olivarez**, 2nd District; **Angie Swanson-Kyriaco**, 2nd District; **Sharon Rumberger**, 2nd District; **Tom Franklin,** 3rd District; **Mary Richardson**, 3rd District; **Bill Cirone**, 3rd District; **Victoria King-Kondos**, 3rd District; **Sharon Byrne**, 4th District, Chair**; Kelly Mcloughlin**, 4th District; **Valerie Cantella**, 5th District; **Donald Case-bolt**, 5th District; **Charles Huffines**, 5th District
Commission Members Excused: Jeffrey Moore, 1st District.
Behavioral Wellness Department Staff: Alice Gleghorn, Director; **John Doyel,** Division Chief, ADP; **Karen Campos**, BWC Program Administrator; **Lindsay Walter**, Deputy Director of Administration and Operations
Chris Ribeiro, Chief Financial Officer; **Vanessa Ramos**, MHSA Program Coordinator; **Caitlin Lepore**, Research and Evaluation; **Jessica Korsan**, Quality Care Management Coordinator; **Shana Burns**, Santa Maria Regional Manager; **Natalia Rossi**, Training Coordinator.

1. **Call-to-Order and Conduct Roll-Call:** Chair Byrne called the meeting to order at 3:04 p.m. Karen Campos, BWC Program Administrator, conducted roll-call.

2. **Establish Quorum:** Chair Byrne established quorum.

3. **Welcome and Introductions:** Chair Byrne welcomed everyone in attendance.

   Action: No action.

4. **General Public Comment:**

   No public comment at this meeting.
   Action: No action.

5. **Mental Health Services Act (MHSA)** Fiscal Year 2020-23 Three Year Plan Update (attachment 5a)

   Ms. Walter begins by sharing the commission's role and legal aspects of the public hearing, goes over housekeeping reminders and public comment guidelines. Followed by an overview of PowerPoint, *Mental Health Services Act Three Year Plan FY 2020 – 2023* which goes over Proposition 63: Mental Health Services Act General Standards and Annual Percentage of MHSA Funding; Rules and Regulations; Public's Role as Stakeholders; Fiscal Years 2017-2020 Achievements; Community Program Planning Process; Thank you to all Participants; Fiscal Years 2020 – 2023 Four Key Proposals; DATA Collection Reported for Programs (Performance Data, Child and Adolescent Needs and Strengths (CANS), Milestone of Recovery Scale (MORS); New Prevention Early Intervention (PEI) Priorities Table; COVID 19 Planning and Budget Impacts; and the Next Steps.

   Commissioner Cirone comments on how impressed he is with the four target areas as well as the grants for housing the homeless; "good work and good report… going in the right direction".

Commissioner Huffines thanked Ms. Walter and entire staff for putting this together; the amount of information received has been great and appreciates the focus on youth.
Commissioner Winter appreciates all of the data shared in the report and highlights the TAY youth program for early psychosis and medication support. However, she requested a reconsideration of the participation timeline for medication support as she believes a longer timeframe will be more beneficial for clients.
Commissioner Pearson asked for clarification on the prudent reserve as he would like to get a better understanding; Mr. Ribeiro provided clarification.
Commissioner Mellinger submits comment via Zoom comment section stating the following "excellent report – broad in scope, informative and thorough". The full involvement of our community in providing feedback is especially impressive and your leadership has been essential. I remember when MHSA reports were always months behind. Our programs are improving in many areas. I follow our homeless services and crisis programs and have seen marked improvement in these. In the Great Recession of 2008 – 2009 homeless services were the first cut – 4 full time outreach workers for CARES lost their jobs. Please do not let this happen again. We still have a long way to go".
Chair Byrne asked when does the Department anticipate getting an update on how finances are shaping up due to COVID. Mr. Ribeiro shares that they receive updates on a monthly basis, however he does not anticipate knowing what the true impact was until March of 2022.
No further comments from the Commission.
Ms. Walter announced that the plan will go before the Board of Supervisors for approval on August 18th and needs to be submitted to DHCS by August 31st. Chair Byrne shared that she would like to see commissioners make public comment during this item.

Action: No action.

6. **Public Comment Regarding MHSA Plan Update**

Families Act board member shares that he has been through the Department's system on several occasions as he has a son who is bipolar and wanted to share his experience navigating the system, constantly being directed in multiple directions, the access line asks too many questions and would like to suggest for the Department to set up a "one stop shop" to provide guidance and direction for those seeking services.

Action: No action.

7. **Adjournment:** Chuck Huffines made a motion to adjourn the meeting. Commissioner King-Kondos seconded. No objections. Motion carried. Meeting adjourned at 4:52 p.m.

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