Attachment A –

MHSA Plan Annual Update FY 2025-26

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

SANTA BARBARA COUNTY MENTAL HEALTH SERVICES ACT

ANNUAL UPDATE FY 25-26 TO THE 2023-2026 THREE YEAR PLAN

MENTAL HEALTH SERVICES ACT · PROPOSITION 63 · CALIFORNIA

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Authored by: Nakisa Shojaie, FayAnn Wooton-Raya, Natalia Rossi, Elise Ramacciotti, Caitlin Lepore, Gabrielle Seneres, Tor Hargens

Section A: Compliance Certification

MHSA County Compliance Certification

County: Santa Barbara

Local Mental Health Director	**Program Lead**
Name: Antonette Navarro	Name: Natalia Rossi
Telephone: 805-681-5161	Telephone: 805-681-5220
Email: anavarro@sbcbwell.org	Email: nrossi@sbcbwell.org
County Mental Health Mailing Address	
Santa Barbra 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.

Antonette Navarro, LMFT

DocuSigned by:
Antonette "Toni" Navarro
2095C5A16FE1474...

Local Mental Health Director/Designee (PRINT) Signature

County: Santa Barbara Date: 4/9/2025

Section A: Fiscal Accountability Certification

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County: Santa Barbara

■ Program and Expenditure Plan Annual Update
Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller/City Financial Officer
Name: Antonette Navarro	Name: Betsy Schaffer
Telephone Number: 805-681-5220	Telephone Number: (805) 568-2100
Email: anavarro@sbcbwell.org	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.

Antonette Navarro	DocuSigned by: Antonette Navarro 202SC5A16FE1474...	3/26/2025
Local Mental Health Director (PRINT)	Signature	Date

I hereby certify that for the fiscal year ended June 30, 2024, 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, 2023. I further certify that for the fiscal year ended June 30, 2024, the State MHSA distributions were recorded as revenues in the local MHS Fund; that CountylCity MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the CountylCity has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

Betsy Schaffer, CPA, CPFO	DocuSigned by: Betsy M Schaffer 825AE342EF7B425...	4/3/2025
County Auditor/Controller/City Financial Officer (PRINT)	Signature	Date

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

About the Mental Health Services Act

In November 2004, voters in the State of California passed Proposition 63, the Mental Health Services Act (MHSA). This act was designed to expand and transform California's county mental health service system by imposing an additional one percent tax on solely individual taxable income in excess of 1 million dollars. Becoming law in January 2005, the MHSA represented the culmination of a series of efforts in California to provide better coordinated and more comprehensive care to those with serious mental illness, particularly in underserved populations.

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

The five MHSA Guiding Principles, which direct planning and implementation activities, are defined as such:

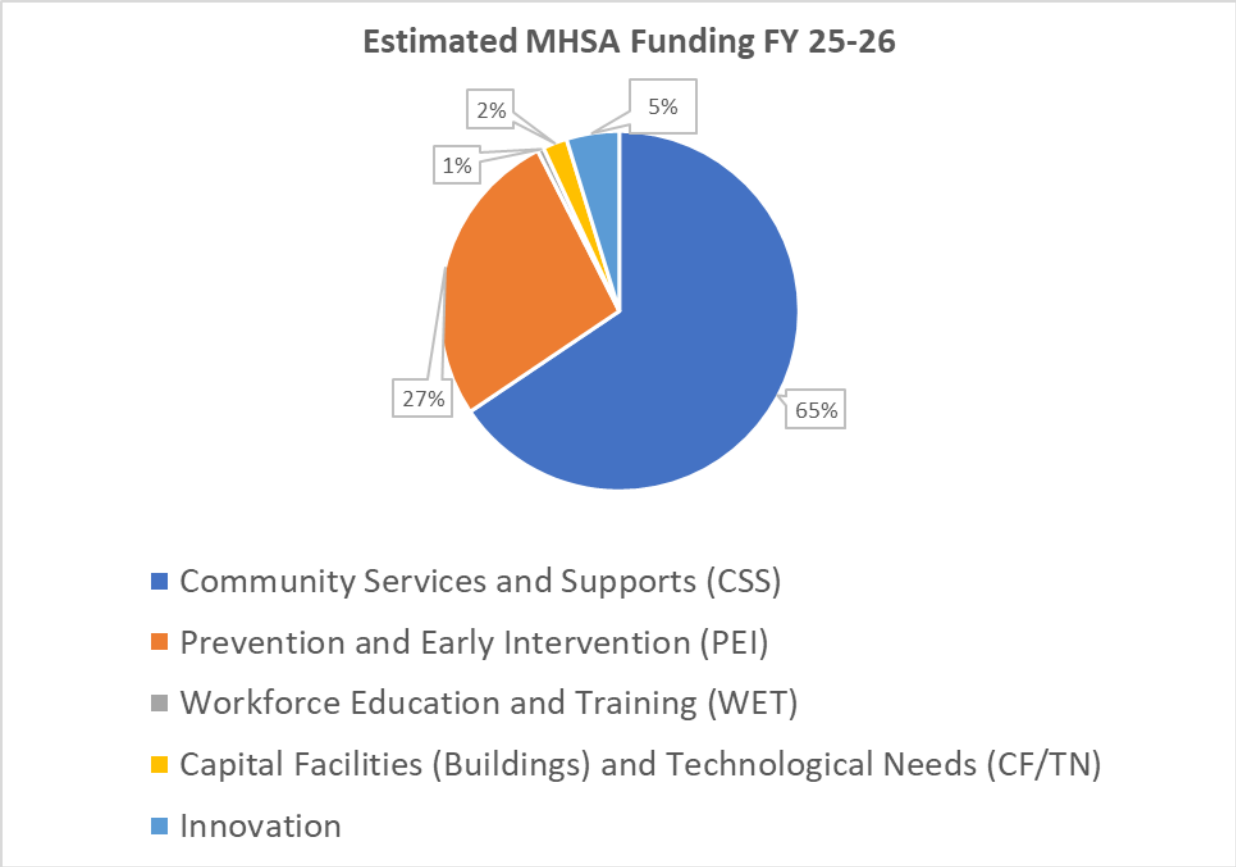
1. Cultural Competence-Services should reflect the cultural values, customs, beliefs, health and languages of the populations served, provide services in the preferred language and eliminate disparities in service access;
2. Community Collaboration- Services should strengthen partnerships with diverse 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 Mental Health Services 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 every year after the posting of the three-year plan.

Santa Barbara County Department of Behavioral Wellness is applying MHSA funds in following proportion for FY 25-26, with a total of $51,505,950 for MHSA Expenditures.

1. Community Services and Supports (CSS); $33,888,800
2. Prevention and Early Intervention (PEI); $13,738,050
3. Workforce Education and Training (WET); $300,000

4. Capital Facilities (Buildings) and Technological Needs (CF/TN): $1,125,100
5. Innovation; $2,454,000



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. In FY 24-25 BWell intends to make a one-time transfer from CSS to WET to fund workforce training and retention.

Proposition 1: Significant Changes to MHSA Ahead

Proposition 1, passed by a narrow margin in March 2024, signifies major shifts in the landscape of mental health services and substance use treatment in California.

The proposition redefines the framework established by the Mental Health Services Act in 2004, now rebranded as the Behavioral Health Services Act (BHSA).

As Santa Barbara County gears up to comply with new BHSA regulations staring July 2026, it is important to note that this transition does not come with new funding. We will navigate the task of expanding certain services while redefining BHSA support for other programs, including prevention initiatives, workforce support and primary treatment.

The initial planning for theses service adjustments have begun internally at BWell, with a comprehensive planning process slated for Fall 2025. The implementation of BHSA will commence with the FY 26/27-28-29 Three-Year Plan.

Section B: Description and Characteristics of County

I. County Demographics

Santa Barbara County has a mountainous interior abutting several coastal plains on the west and south coasts of the county. The largest concentration of population in Santa Barbara County 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 areas 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 Space 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.

The 2020 Census population of Santa Barbara County is 448,229 persons, increasing by 5.7 percent or 24,334 persons since 2010. The proportion of Santa Barbara County's population relative to the state population has declined since 1970. For essential programs and services that rely on population to distribute funds, a lower percentage represents a smaller proportion of Statewide population and potential funding. According to the U.S. Census, Santa Barbara County's poverty rate is 14.9%. As of 2022, 38% of residents in Santa Barbara County are not in the workforce, a higher proportion compared to 36.6% of overall California residents. The population of 60 and older was 23% percent of the population in 2022. Individuals with disabilities account for 10.2% of the Santa Barbara County population.

In the City of Santa Barbara, the poverty rate is 13.1% and the population is 88,665 persons, as per the 2020 Census. Hispanic/Latino residents make up 36.8% of the population, 1.3% of residents are Black or African American, 3.8% of residents are Asian, 0.2% of residents are Native Hawaiian or Other Pacific Islander, 53.4% of residents are White alone, not Hispanic or Latino, 1.3% of residents are Native American or Alaska Native, and 16.6% of residents are Two or More Races, meaning that they identify in more than one of the census categories.

According to the 2020 U.S. Census, with a population of slightly more than 109,000, Santa Maria's poverty rate is at 15.5%. In Santa Maria, Hispanic/Latino residents make up more than 78.9% of the population, 1% of residents are Black or African American, 4.3% of residents are Asian, 0.0% of residents are Native Hawaiian or Other Pacific Islander, 14.1% of residents are White alone, not Hispanic or Latino, 3.2% of residents are Native American or Alaska Native and

38.3% of residents are Two or More Races, meaning they identify in more than one of the census categories.

Conversely, according to the 2020 U.S. Census, with a population of slightly more than 44,000, Lompoc poverty rate is 16.8%. In Lompoc, Hispanic/Latino residents make up more than 61.8% of the population, 3.9% of residents are Black or African American, 3.3% of residents are Asian, 0.2% of residents are Native Hawaiian or Other Pacific Islander, 27.9% of residents are White alone, not Hispanic or Latino, 2.4 % of residents are Native American or Alaska Native, and 25.9% of residents are Two or More Races, meaning that they identify in more than one of the census categories.

(Retrieved from Wikipedia, US Census and World Population Review, CenCal Population Needs Assessment 2024).

Santa Barbara County Demographics

Age Group	% of Total	Race	% of Total	Language Spoken	% of Total	Threshold (Y/N)
Persons Under 5 years	6.0	White	60.79	English	60.1	No
Persons under 18 years	22.2	African American	1.89	Spanish	32.63	Yes
18-64 yrs.	54.7	Asian	5.46	Asian or Pacific Islander Languages	3.79	No
65 & older	17.1	Pacific Islander	0.13	Other Indo-European Language	2.62	No
		Native American	1.37			
		Other	12.35			
		Two or More	18			
Military Status	**% of Total**	**Ethnicity**	**% of Total**			
Veteran	4.13%	Hispanic	46.62			
		Non-Hispanic	53.38			

II. Who We Serve: Assessment and Narrative Analysis of Mental Health Needs

In order to assess the mental health needs of MHSA-eligible populations, we reviewed Santa Barbara County demographic data; Santa Barbara County Mental Health Plan Medi-Cal Eligible population (MHP) data; Santa Barbara County Homeless Management Information System (HMIS) data; Santa Barbara County Mental Health Services Community Services and Supports (CSS) data; CenCal Population Needs Assessment (PNA) data, County of Santa Barbara Public Health Community Health Needs Assessment (CHNA) data and additional demographic information on Mixteco-speaking populations.

Narrative Analysis of Mental Health Needs Including Identification of Issues:

Unserved:

1) Individuals who may have serious mental illness and/or serious emotional disturbance and have had only emergency or crisis-oriented contact with and/or services from the County.

Data:

Total Number of Unique Clients with a Crisis Service in FY 22/23	2313
Medi-Cal YES clients	1,660
Medi-Cal NO clients	653
ALL clients with 0 follow-up services	1531
ALL clients with 1-2 follow-up services	99
ALL clients with 3+ follow-up services	683
WITH MEDI_CAL clients with 0 follow-up services	923
WITH MEDI_CAL clients with 1-2 follow-up services	72
WITH MEDI_CAL clients with 3+ follow-up services	665

Analyzing Data Sources: BWell examined the number of unique clients that received a crisis intervention and compared this with the number of clients with follow-up services after a crisis intervention. This data shows that there are 737 Medi-Cal eligible individuals that did not receive additional services. This is the unserved population that we are prioritizing. Additional data is needed, including data on how many attempts there were to engage individuals in

services post-crisis intervention. Also, data is needed for persons with Serious and Persistent Mental Illness that receive emergency room services and do not receive follow up services.

Identification of Issues: The most prominent issue is providing more behavioral health services post-crisis to those that receive a crisis intervention. Starting in January of 2024, the Crisis Services Team now provides a follow-up interaction to all individuals post-crisis intervention. The Crisis Services Team is now receiving additional Motivational Interviewing training to try and persuade more individuals post-crisis to engage in services.

Starting in FY 25-26 the Crisis Team will have a hospital liaison role. This position will be part of a redefinition of the peer position for the team and will serve as the primary point of communication with all hospitals to ensure appropriate post-crisis care and follow-up. A key goal for this role is to collaborate with the Behavioral Wellness Access Team to provide follow-up support for individuals whose primary reason for an emergency visit was related to mental health or substance misuse, ensuring they receive the necessary ongoing care. This position will work closely with the utilization management team.

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2) Adults with severe mental illness who are involved with the justice system after they are released from incarceration.

Data: The needed data is the population that is incarcerated in this County that has a Serious and Persistent Mental Illness and that is getting offered a discharge plan that includes behavioral health services upon release. Currently, we receive data on those that are incarcerated with a Serious and Persistent Mental Illness and are referred to our Justice Alliance Full Service Partnership. This is a subset of the total population needing our services; we do not currently have data on everyone with a Serious Mental Illness who is eligible for BWell services upon release.

Analyzing Data Sources: BWell will be determining what additional data we need to collect. Starting Fiscal Year 2024-25, BWell will be providing services for the purpose of linkage through PATH 3 grant funding. PATH 3 is a new grant funding incentive for Behavioral Health departments to begin allocating or hiring staff who specifically provide services to justice involved individuals for discharge planning and re-entry services. (DHCS Website). BWell will be assisting in developing discharge plans for those in the Behavioral Health Unit prior to discharge from County Jail in collaboration with the Sheriffs' and Probation Departments.

Beginning in FY 2024-25, we started reporting on how many people were eligible for BWell services and then comparing these numbers to how many people received services from BWell post-incarceration.

Identification of Issues: The most prominent issues deterring BWell from adequately serving this population are not knowing how many people leaving incarceration are eligible for BWell

services, and therefore not providing enough access to BWell services. Starting in FY 25-26, BWell will begin having staff members provide discharge planning and additional resources to help identify everyone that is justice involved and eligible for BWell services. Once identified, we will help them reach those services by providing additional supports like transportation to help access services.

Underserved/Inappropriately Served:

1) Hispanic/LatinX Population:

Data: 46.6% of Santa Barbara County residents identify as Hispanic/LatinX. Santa Barbara Census data cites that 33% of people residing in Santa Barbara County primarily speak Spanish. Spanish is a threshold language for Santa Barbara County. Examining Medi-Cal eligible population data for Santa Barbara County, we can identify that we are underserving the Hispanic/LatinX population. Our County's penetration rate for Hispanic/ LatinX populations is 2.06% compared with the State Penetration rate of 3.51%, and mid-sized county average penetration rate of 2.86%. For 2022, while 28% of Hispanic/Latino members were eligible for services, only 19% were served. And in 2024, 18% of CenCal Health members were disengaged entirely from care and within that group, 47.4% of those disengaged were Hispanic. Using Workforce Needs Assessment data, 22% of staff with Direct Client contact were identified as Bilingual.

Analyzing Data Sources: We can identify that both the Spanish speaking and Hispanic/LatinX communities are underserved by our department, particularly adults ages 25-59 and older adults ages 60+. For complete demographic information broken down by age group, please see the tables below.

Identification of Issues: Increasing our penetration rates with Hispanic/LatinX populations is a priority for our department. Of special concern is that over the last three years, our penetration rate decreased, despite increased outreach activities during this time period to Hispanic/LatinX populations.

We have identified that the most prominent issues deterring Hispanic/LatinX populations from receiving services are that they do not know about our services; do not know when to seek our services; and have difficulty accessing our services. We are expanding targeted outreach efforts in LatinX communities to increase services awareness and access; recruit more Spanish and Mixtec speaking direct service providers and have our outpatient clinics open outside of traditional business hours to remedy these issues.

In FY 25-26 we are expanding our outreach team. All members of the outreach team are bilingual and live in the communities they serve. These staff will also provide trainings to community members on how to recognize early signs of mental health and substance misuse

concerns, and fostering a more informed and supportive community. The outreach team will also expand outreach and resource education for older adults in Spanish and target Spanish speaking communities. BWell will also support Latinx older adults through stigma-reduction campaigns.

We are also piloting extended hours at our Santa Maria clinic to ease availability of services for working clients and families and are specifically advertising these new service hours to LatinX communities.

2) Mixteco Speaking Population

Data: Mixtec populations are not identified in Medi-Cal eligible population data and census demographic data. Using data provided by Mixteco Indigena Community Organizing Project (MICOP) we estimate that there are 25,000 Mixtec persons living in Santa Barbara County. Linguistic barriers (e.g., not being able to communicate or not having enough bilingual providers) in conjunction with lack of access to basic services or solely the language barrier, serve as an entry barrier to many Indigenous, Latino, and migrant communities (Retrieved from Population Data Information Mixteco.org). Countywide stakeholders recognize that while COVID-19 has complicated matters across the board for the medical field, linguistic diversity and cultural competency still remain prominent issues and obstacles to mental health access. (CenCal Health 2024 Population Needs Assessment)

Analyzing Data Sources: We currently do not track demographic data on behavioral health services for Mixtec populations; instead, they would be categorized as Hispanic/LatinX. We currently do not track data on how many staff with direct client contact speak Mixtec. Analyzing the available data and acknowledging that additional data information is needed, we can identify Mixtec speaking populations as underserved by our department.

Identification of Issues: The most prominent issues we have identified are that Mixtec populations do not know about our services, do not know how to recognize mental illness, do not know when to seek services and have difficulty accessing our services in Mixtec.

In FY 25-26 we will continue to contract with Mixteco Indigena Community Organizing Project (MiCOP) in North County to provide outreach to Mixtec-speaking communities. We are expanding outreach in North County because over 95% of Mixtec speakers reside in North County in the Santa Maria and Guadalupe areas. Outreach workers will provide prevention services in Mixtec and will educate Mixtec speaking populations about when and how to access behavioral health services from our department. All of our direct services providers can and do use interpretation services when working with Mixtec speaking individuals. However, direct service providers that could speak Mixtec would be able to provide ease and cultural understanding for Mixtec populations. Hence, our department is looking at ways to incentivize Mixtec-speaking individuals to work for our department in direct services positions. Methods

being considered include offering a tri-lingual salary bonus for staff that speak English, Spanish and Mixtec. For FY 25-26 we plan to expand tabling at Career Fairs at local high schools in North County to provide information about working in public behavioral health and incentivizing Mixtec and Spanish speaking individuals to consider working in the public behavioral health workforce.

(Retrieved from Population Data Information Mixteco.org; CenCal Health 2024 Population Needs Assessment)

3) Unhoused Population:

Data: In 2023, Santa Barbara County Homeless Management Information System (HMIS) served a total of 6,501 unique persons. Of those they served, 1,937 identified as having a mental health disorder. Considering the large number of unhoused people in Santa Barbara that identify as having a mental health disorder, we can identify this as an underserved population. We do not compare our rate of services to homeless Medi-Cal eligible populations with other counties at the state level, so we do not have information on the penetration rate for this population.

In 2023, 6,131 Social Determinants of Health diagnoses were submitted to CenCal Health; of these diagnoses 49.9% were related to homeless. Stable housing is amongst the highest needs of Medi-Cal populations based on the Social Determinants of Health diagnoses of 2023. Furthermore, the highest concentration of homeless adults throughout the county is in the city of Santa Barbara. Lastly, in 2022, Santa Barbara's rate of people aged 55+ who sought homeless services is 20% higher than the California state average. A demonstrated need is shown -- that our unhoused population is larger and more underserved than state averages.

Of these SDOH diagnoses in 2023, 49.9% were related to homelessness and 38% of diagnoses were experienced by the Hispanic/Latinx population, the highest percentage of all racial categories.

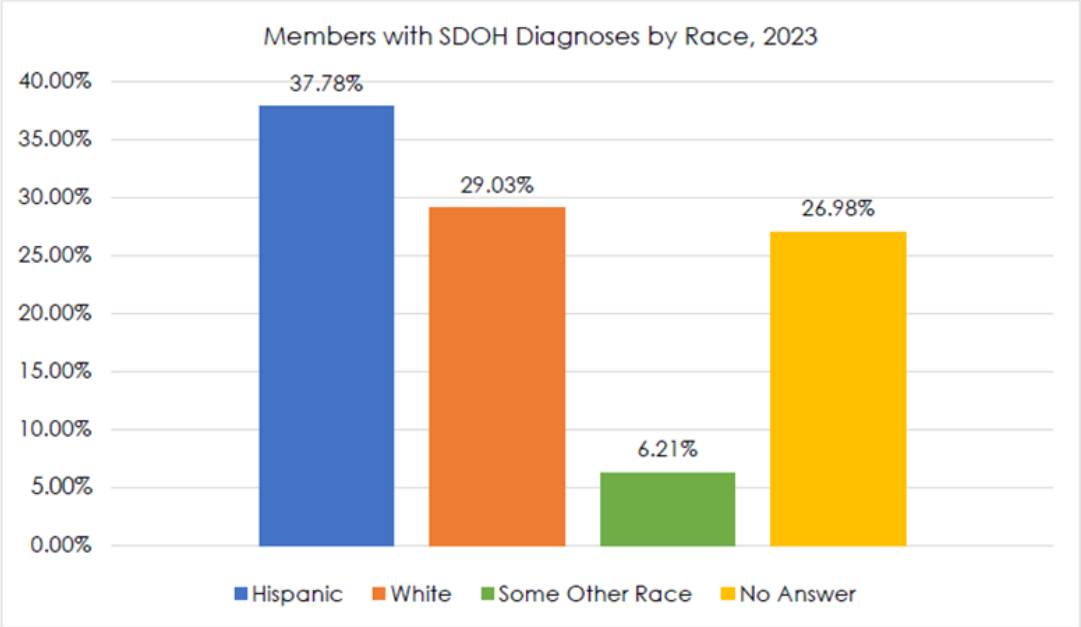
Analyzing Data Sources: Analyzing Community Supports and Services (CSS) data, we can estimate that we provided outreach to approximately 982 homeless individuals during FY 23-24. Using HMIS data we can estimate that at least 1200 persons in this category are eligible for services from BWell, and therefore we can identify unhoused people as an underserved population. Analyzing the *CenCal Health 2024 Population Needs Assessment* data, we can identify that populations with Social Determinants of Health diagnoses are underserved. For complete demographic information broken down by age group please see the tables below.

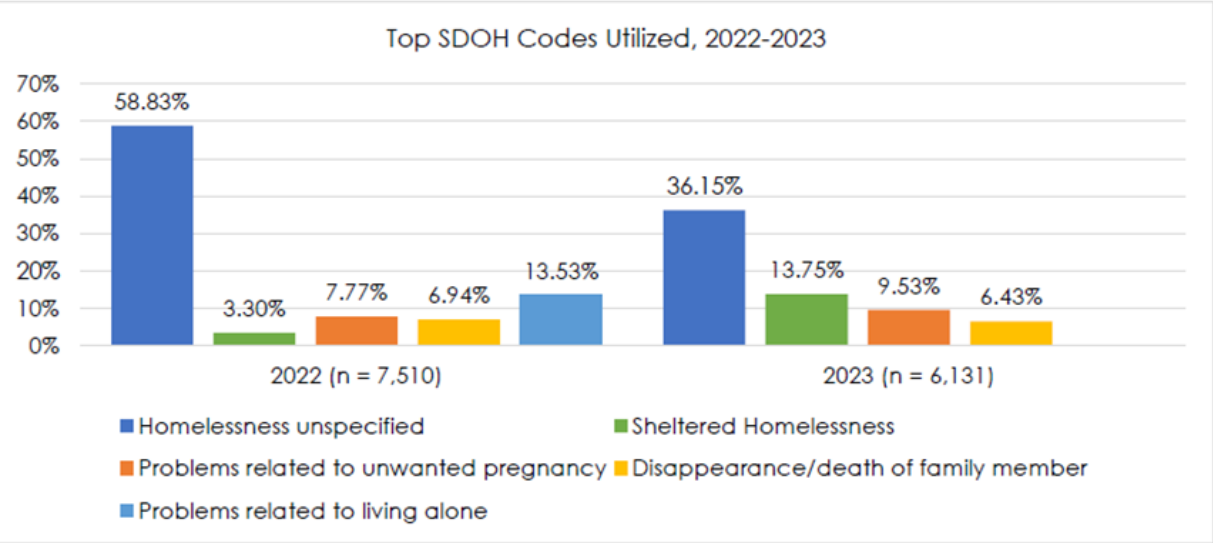
Identification of Issues: We have identified difficulty engaging unhoused populations in services and difficulty retaining housing as the most prominent issues preventing unhoused populations from accessing our services. Because unhoused populations group in rural or difficult to access

locations, and often mistrust authority figures, BWell staff have difficulty both locating unhoused populations, and gaining their trust once staff have located these populations.

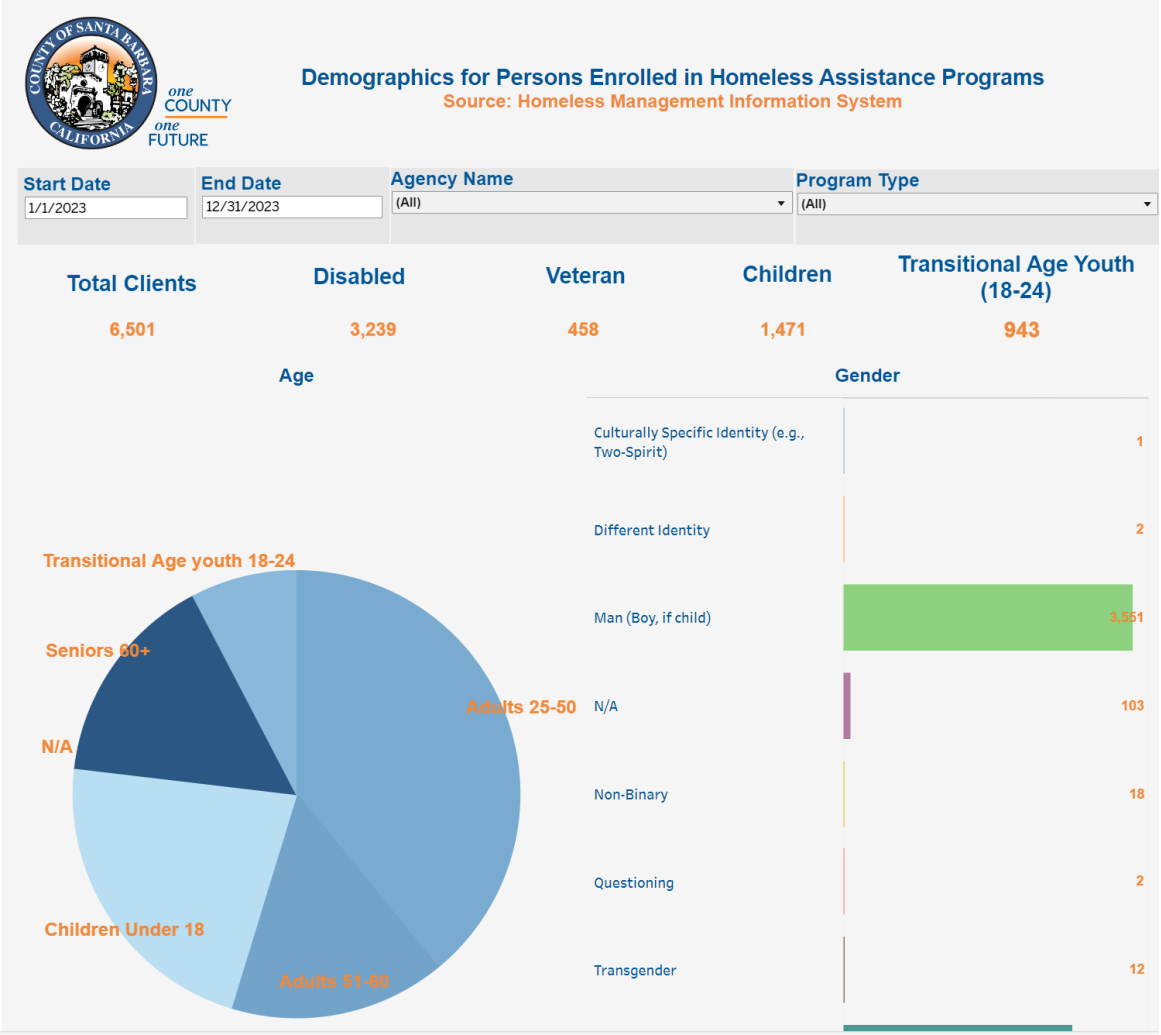
In Fiscal year 2024-25, we divided our Homeless Outreach team into an Outreach and Engagement team, and an Early Intervention team to streamline services. This way, outreach teams can reach more unhoused people, and the Early Intervention team can then provide mental health services to unhoused people that are ready to receive services.

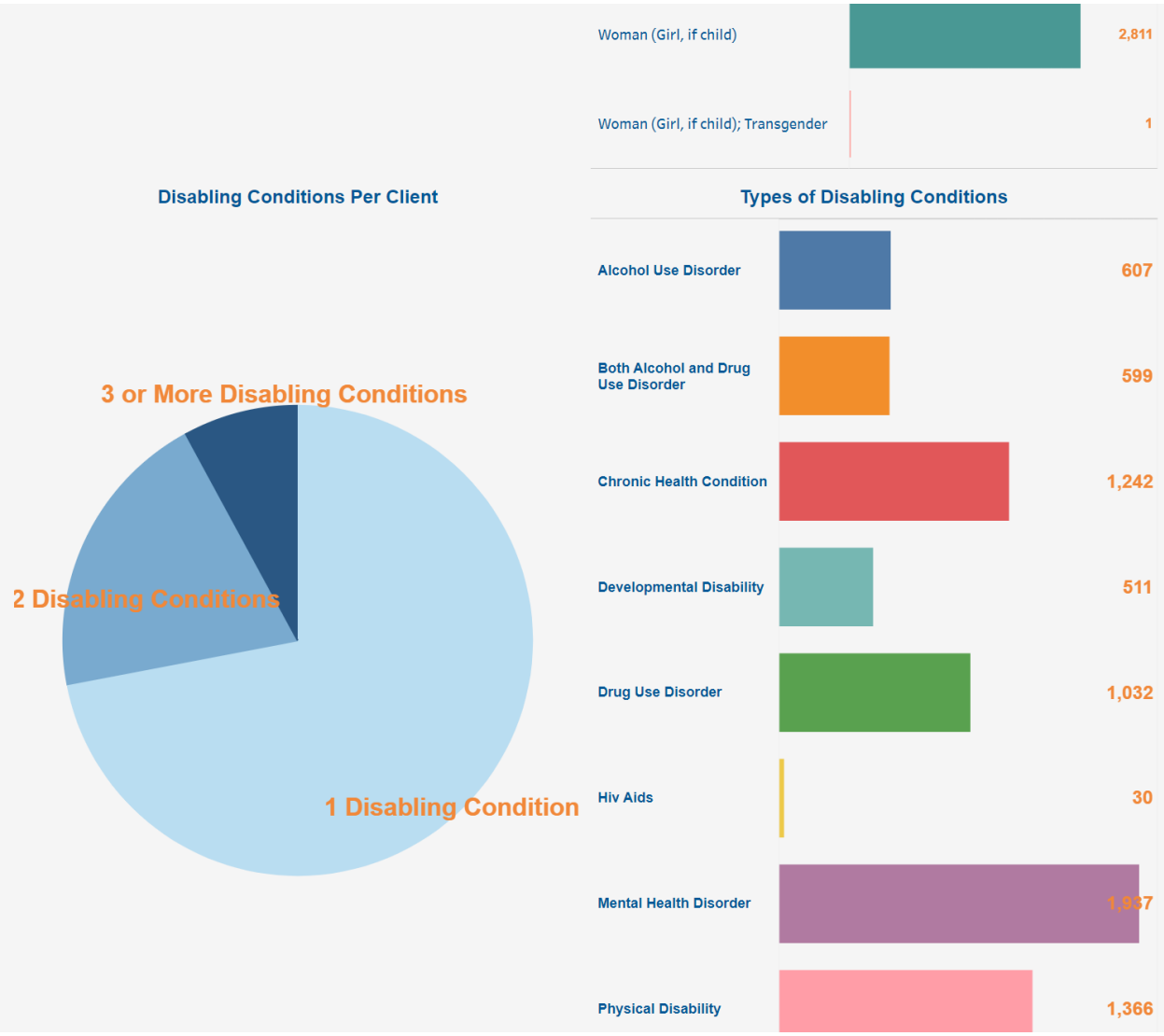
For FY 25-26 we are expanding homeless outreach and early intervention efforts. Our teams are working in close partnership with Santa Barbara ACT and the End Homelessness Initiative to develop a strategic outreach plan. The goal is to identify and provide services to the 75 highest-need individuals experiencing homelessness who require behavioral health interventions. Additionally, a targeted effort will be made to secure stable housing for at least 35 Behavioral Wellness clients as part of our ongoing commitment to supporting long-term recovery and stability.





CenCal Health 2024 Population Needs Assessment





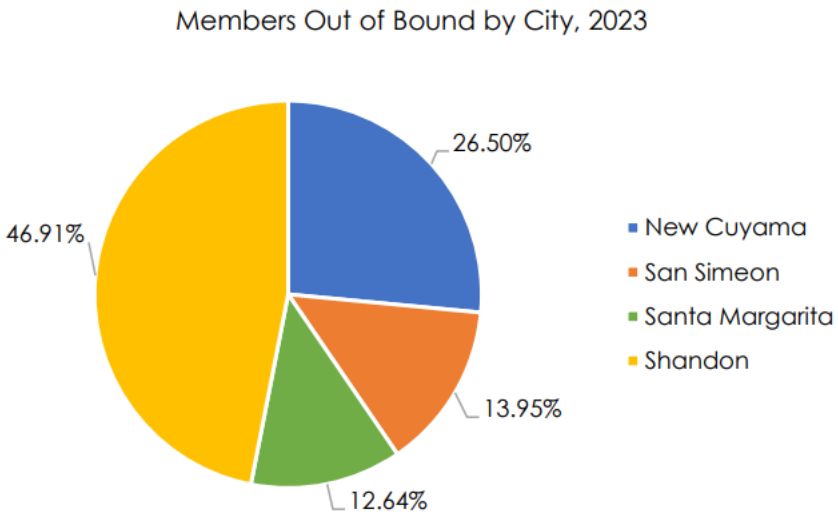
(Retrieved from Community Data Dashboard Homeless Management Information System—Demographics for Persons Enrolled in Homeless Assistance Programs).

4) Community members in geographically isolated areas (such as Carpinteria, New Cuyama, Guadalupe, Santa Ynez).

Data: Using county-wide demographic information, we can estimate that those living in geographically isolated areas comprise about 9% of the County total population. However, these populations are in areas that are over thirty minutes by car from the nearest BWell Clinic, and few of these areas have public transportation that can connect them to our service clinics.

Based on the data provided in CenCal Health's 2024 Population Needs Assessment, about 0.47% of CenCal Health's total population were geographically out of bounds in 2023. The data shows that 51% of members identify as Hispanic and 71% identify as English speaking. Given

this information, there should be consideration for outreach to ensure this population is aware of their health benefits.



*Data from 2024 Population Needs Assessment

Analyzing Data Sources: We have determined that community members in geographically isolated areas are an underserved population in our county. With data provided by the 2024 Population Needs Assessment performed by CenCal, we can determine an increased need to reach out to engage geographically out of bounds members in New Cuyama.

Identification of Issues: The most significant barriers for community members in geographically isolated areas are a lack of awareness about BWell services and limited access because of their remote locations.

We offer telehealth services to those that are unable to come to our clinics in person but having private spaces with reliable internet connectivity remain issues for rural populations. We have partnered with the Family Resource Center and Public Library in Cuyama to offer spaces for telehealth. This past year, our Outreach team partnered with Lived Experience and Advocacy Development (LEAD) to provide outreach and education and how to access BWell services in Cuyama, Los Alamos and Carpinteria in order to educate rural populations about our services and how to access them. Our Outreach team also provided mental health education trainings for students and staff in New Cuyama.

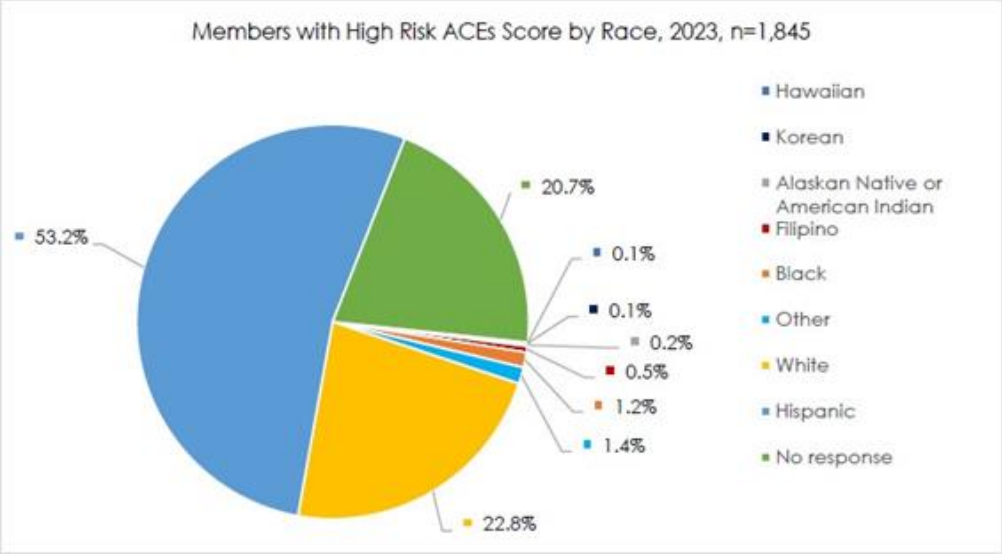
5) Community Members with High Adverse Childhood Experience (ACE) Scores

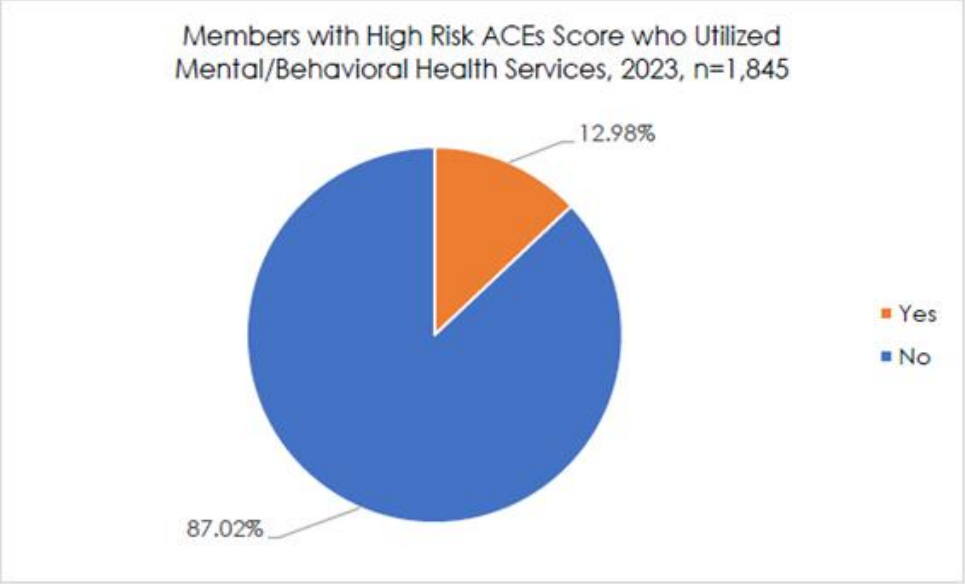
Data: Adverse childhood experiences (ACEs) are potentially traumatic events that occur in childhood (0-17 years). Data collected for CenCal Health's 2024 Population Needs Assessment

finds that only 12.98% of individuals with High-Risk ACE scores utilized mental or behavioral health services in 2023. Individuals with High-Risk ACE scores also overlap with underserved populations identified by our department, such as the Hispanic/Latinx community: 53% of individuals with high ACE scores in 2023 were Hispanic.

Analyzing Data Sources: We can identify that populations with high ACE scores are underserved. For complete demographic information broken down by age group please see the tables below.

Identification of Issues: Early Intervention services are needed to treat people with high ACE scores. Because of the overlap with high-risk ACE scores and Hispanic/LatinX populations in our county, outreach and access to services have been identified as the means with which to increase early intervention services to populations with high-risk ACE scores.





CenCal Health 2024 Population Needs Assessment

Fully Served:

Fully Served individuals are those that are currently served by our Community Services and Supports programs.

I. Assessment Data

1). Demographics for All MHSA Programs

The data provided below is based on data reported in the most recent MHSA Annual Update, which includes all clients served in an MHSA funded program for FY 23/24.

MHSA Community Services and Supports funded programs served a total **9,488** people in Fiscal Year 23-24

The charts below reflect the demographics of the clients served.

	Number of Clients	%
	9,488	**100%**
Program Demographics – Total Population		
Age Group		
0-15	2,030	21.4%
16-25	1,915	20.2%
26-59	4,496	47.4%
60+	1,167	12.3%
Gender		
Female	4,498	47.4%
Male	4,543	47.9%
Unknown/Not Reported	447	4.7%
Ethnicity		
Hispanic	3,874	40.8%
Non-Hispanic	2,955	31.1%
More Than One Ethnicity	17	<1%
Unknown/Not Reported	2,642	27.8%
Race		
African American or Black	300	3.2%
Alaska Native or Native American	106	1.1%
Asian	113	1.2%
Native Hawaiian or Other Pacific Islander	16	<1%
White or Caucasian	5,766	60.8%
More Than One Race	646	6.8%
Unknown/Not Reported	2,360	24.9%
Sexual Orientation		

Lesbian or Gay	74	<1%
Heterosexual	2,681	28.3%
Bisexual	109	1.1%
Unsure or Questioning	29	<1%
Transgender	11	<1%
Unknown/Not Reported	6,584	89.4%
Language Spoken		
English	6,653	70.1%
Spanish	771	8.1%
Unknown/Not Reported	2,016	21.2%
Veteran		
Yes	40	<1%
No	7,072	74.5%
Unknown/Not Reported	2,376	25.0%

2). Table: Penetration Rates of Medi-Cal Eligible Populations

Santa Barbara MHP County Medi-Cal Eligible Population, Members Served, and Penetration Rates by Age, CY 2022

Age Groups	Total Members Eligible	# of Members Served	MHP PR	County Size Group PR	Statewide PR
Ages 0-5	20,980	315	1.50%	1.15%	1.82%
Ages 6-17	44,830	1,783	3.98%	4.80%	5.65%
Ages 18-20	9,997	333	3.33%	3.47%	3.97%
Ages 21-64	85,654	2,569	3.00%	3.60%	4.03%
Ages 65+	12,748	287	2.25%	1.98%	1.86%

Santa Barbara MHP PR Members Served by Race/Ethnicity, CY 2022

Race/Ethnicity	Total Members Eligible	# of Members Served	MHP PR	Statewide PR
African American	1,981	154	7.77%	7.08%
Asian/Pacific Islander	3,005	64	2.13%	1.91%
Hispanic/Latino	48,797	1,005	2.06%	3.51%
Native American	458	22	4.80%	5.94%
Other	31,880	1,445	4.53%	3.57%
White	88,089	2,597	2.95%	5.45%

Figure 6: Hispanic/Latino PR, CY 2020-22

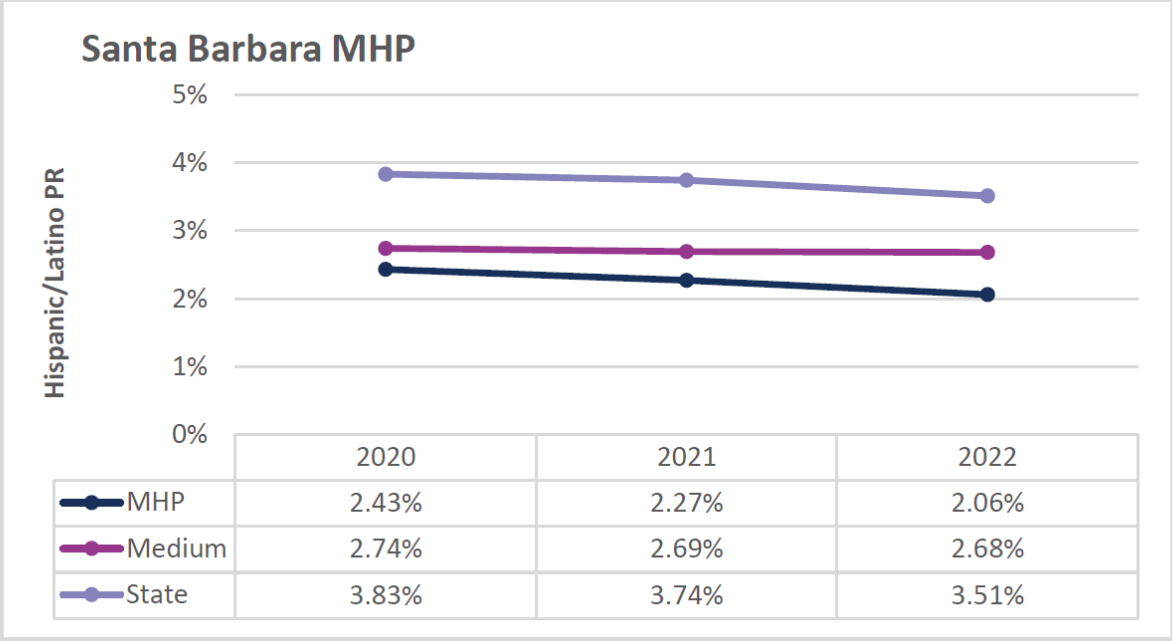


Table 8: Services Delivered by the Santa Barbara MHP to Adults, CY 2022

II. How We Serve: County Capacity to Implement Mental Health Programs and Services

Analysis of Data for BWell Capacity to Serve: Workforce Recruitment and Retention has been identified as a priority for our department. Some of the key strategies we are implementing to address workforce shortages include: partnering with community organizational providers; expanding the use of peer specialists within the workforce; and addressing burnout and compassion fatigue of direct service staff.

In FY 24-25 we saw great improvements in workforce recruitment and retention. We had no vacancies for Practitioners, and the vacancy rate for Associate Practitioners reflects that those positions become vacant as Associates matriculate to Licensed Practitioner roles. The same data is reflected for Peer Support Specialists, we had no vacancies, and the vacancies for Peer Support Trainees reflects that these positions become vacant as Trainees matriculate to Licensed Peer Support Specialists. The Peer Trainee positions are also often entry level positions and staff become Case Workers, or they pursue higher education while in those Peer positions.

We continue to have high vacancy rates for both Psychiatrists and Psychiatric Nurses. Although we have increased the number of Spanish speaking direct client care staff every year since

2021, we still need to recruit more staff that are fluent in the County's threshold language of Spanish.

Data Sources: Santa Barbara County has collected data from the Santa Barbara County Network Adequacy Certification Tool (NACT); the Department of Behavioral Wellness Staff Language Capacity Survey; the BWell FY 23-26 Strategic Plan; Santa Barbara County's Community Health Needs Assessment Report 2022; and the Department of Behavioral Wellness Workforce Needs Assessment for FY 23-24. This data was used to assess our County's capacity to have the staffing to implement mental health programs and services. We have assessed both our Behavioral Wellness Programs as well as our Contracted Providers to determine our anticipated need as well as our current staffing. The Network Adequacy submitted for FY 23-24 shows that Santa Barbara has successfully met the ratios provided by the Department of Healthcare Services (DHCS), and has an adequate network of outpatient Specialty Mental Health Service 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 that there is focus toward the unserved and underserved in our community.

1) Santa Barbara Network Adequacy

Santa Barbara County completes monthly Network Adequacy Reporting through the "274 submission". This monthly submission replaced the annual Network Adequacy Certification Tool (NACT) as directed by Information Notice 18-011 and Information Notice 20-012. The 274 network adequacy reporting is used to determine if the County has enough outpatient Specialty Mental Health Services (SMHS) providers and psychiatrists to serve the anticipated need of the County. It also ensures that the appropriate treatment modalities and levels of care are offered as well as determining if the county has meet timeliness standards for access to care and member grievances and appeals. This information is provided to the Department of Health Care Services (DHCS) which reviews and approves the 274 based on predetermined ratios. If the County does not meet the ratios, the County must provide a corrective action plan in order to resolve any concerns.

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

- Adult (21+) SMHS 1 provider to 85 clients,
- Children (0-20) SMHS 1 provider to 49 clients
- Adult (21+) Psychiatry 1 provider to 457 clients
- Children (0-20) Psychiatry 1 provider to 267 clients

2) Vacancy Tables from Workforce Needs Assessment

Job Classifications w/highest vacancy rates	Vacancies 2024-25	Filled 2024-25	Total # of positions 2024-2025	Vacancy % 2024-25
Practitioner - Licensed	0	38	38	0%
Practitioner - Associates	6	26	32	18.75%
Psychiatrist	4	10	14	28.57%
Psychiatric Nurse I/II	3	19	22	13.64%
Case Worker	4	52	57	7.02%
Peer Support Specialist Trainee	3	9	12	25%
Peer Certified Support Specialist	0	11	11	0%

The Complete Workforce Needs Assessment for FY 23-24 is included as an Appendix to this document

3) Staff Language Capacity Survey:

The Language Capacity Survey was distributed to 419 Behavioral Wellness staff. One hundred eighty-eight (188) staff members responded to the survey, of those participants, 53.59% (97) indicated speaking a language other than English. For staff who spoke one language other than English, the majority spoke Spanish (86.60%) followed by almost sixteen percent (15.46%) who indicated speaking other languages.

The following examines the non-English languages represented among bilingual staff:

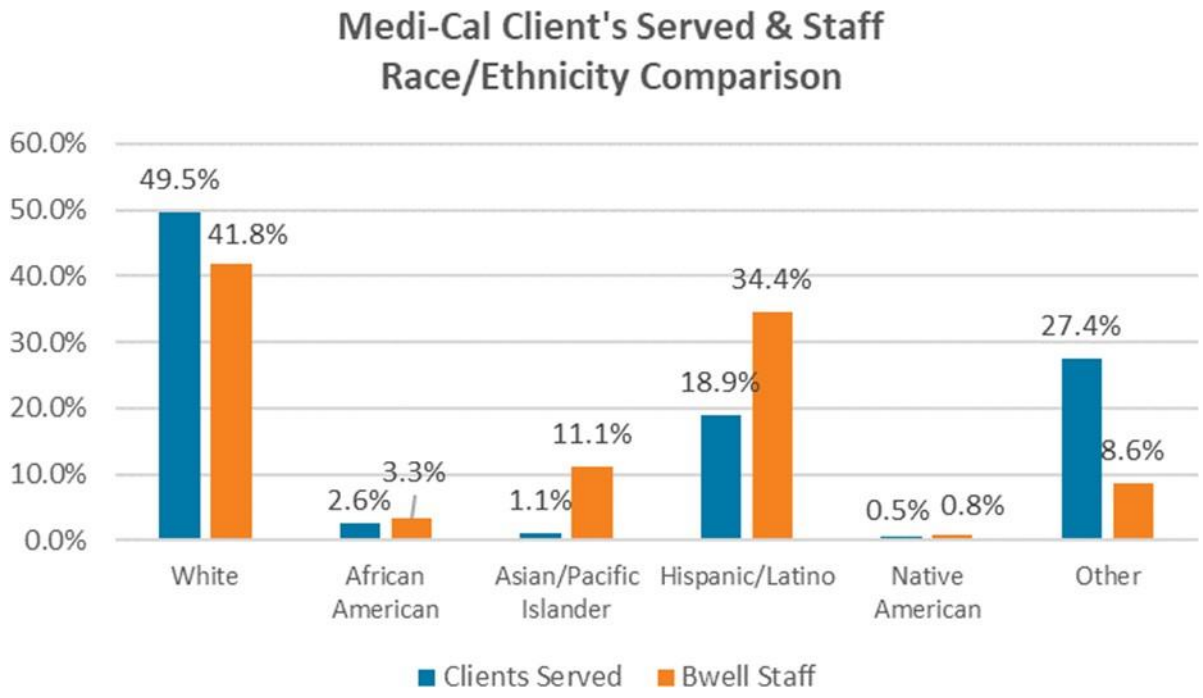
Staff Bilingual Capacity in any language and have Direct Client Contact:

- Santa Barbara (South County) 38.9%
- Santa Maria (North County) 36.7%

- Lompoc (West County) 10.0%

4) Staff Racial and Ethnic Diversity

Data was collected from the EQRO MediCal claim data (CY 2022) regarding the race/ethnicity of clients in relation to diversity of department staff. Overall, the data indicates that Behavioral Wellness staff is representative of clients race or ethnicity of clients that are being served in the Department's system of care. There is one category that is not well matched which is the "other" category, but it is suspected that this is due to the large number of Medi-Cal clients that have identified as "Other". This data needs to be explored further.



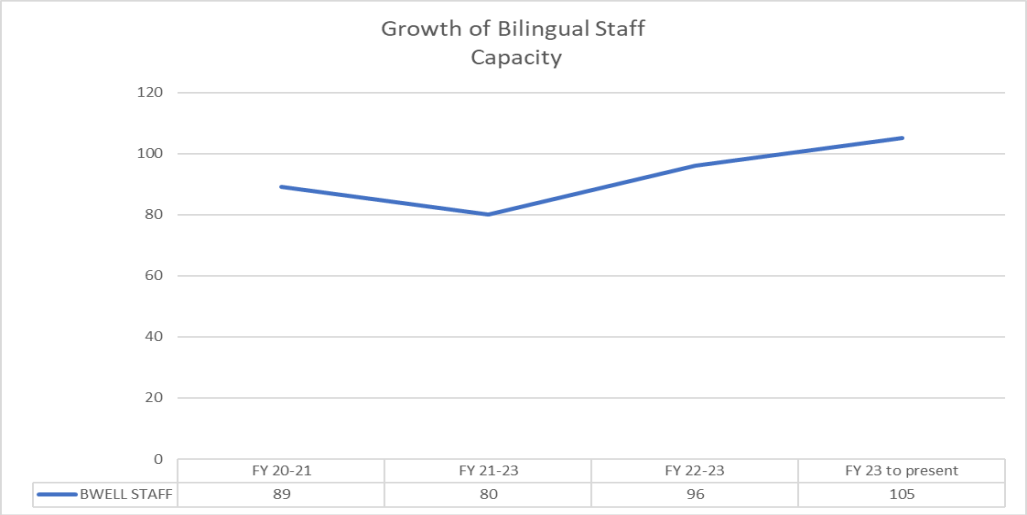
**Note: data from the Santa Barbara County - Behavioral Wellness Department Cultural Competency 3-year Plan 2023-26*

Language Capacity

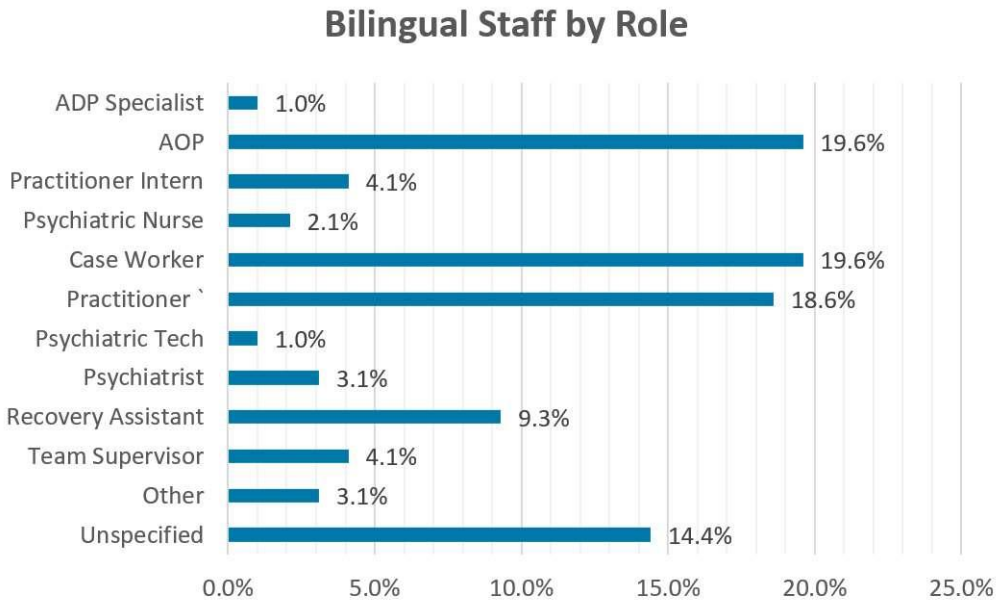
A Listening Tour was conducted in 2022 by Santa Barbara County for the Community Health Needs Assessment, which gathered public opinion from over 200 individuals who represent broad interest of the community, including medically underserved, vulnerable and youth populations. Input was gathered from community leaders and members, including public health officials, health providers, nonprofit workers, Cottage Health employees, and government leaders.

From opinions gathered throughout the Listening Tour, there is a community call for linguistically and culturally competent service providers. At the state level, recommendations included advocacy in the roll-out of programs to include multiple languages in their training curriculum. At the local level, diversifying hiring practices as a way to counter implicit bias is mentioned as one possible solution to the staffing shortage. CHNA PG 100

BWell has seen an overall increase in bilingual staff from FY 21-22 through the present.



**Note: data from the Santa Barbara County - Behavioral Wellness Department Cultural Competency 3-year Plan 2023-2026*



*Represents BWell staff only

Threshold Language of Santa Barbara MHP Medi-Cal Members Served in CY 2022

Threshold Language	# of Members Served	% of Members Served
Spanish	1,052	20.54%
Threshold language source: Open Data per BHIN 20-070		

III. Issues Prioritized for MHSA Plan

MHSA Priorities Established for the Three-Year Plan, Based on Stakeholder Feedback

Priority Number One
Increase Full Service Partnership Capacity

FY 22-24 Accomplishments

- Increased FSP budgets to include flex funding to spend on client's non-mental health needs including rent, rental deposits, medical and dental needs
- Increased Assisted Outpatient Treatment (AOT) staff to increase outreach to FSP-eligible populations county-wide through braided SAMHSA funding
- Created FSP Manager position to create better uniformity of care, continuity of services and aid in retention of employees
- Continue to report on new client-focused outcomes the prioritize quality of life for adult FSP clients, and focus on improvement in healthcare outcomes for FSP clients

FY 25-26: Priorities

1. **Enhance the transition process within the system of care** by educating clients on the purpose and benefits of stepping down to a lower level of care, equipping staff with best practices for successful transitions, and leveraging new supports such as Enhanced Care Management to ensure continuity of care.
2. **Strengthen client-centered outcome reporting** by continuing to track measures that prioritize quality of life for adult Full-Service Partnership (FSP) clients**,** with a focused effort on improving healthcare outcomes within the FSP population.

Priority Number Two:
Increasing Timeliness and Navigation Services for Those Entering our System of Care

FY 22-24 Accomplishments

- Implemented new Mobile Crisis Benefit as part of Cal-AIM payment reform
- Created new Peer Assessment Team that specifically reaches out to new client's post-hospitalization and post-crisis intervention to begin providing peer support services and help people entering our system of care to participate in services
- Added two additional case workers to support CARE Act referrals
- Expanded Access Screening Team to accommodate increase in call volume and referrals
- Created new Early Intervention for Persons Experiencing Homelessness team

FY 25-26 Priorities

1. **Establish a Hospital Liaison Role to Coordinate Care**. These new positions are identified as peer positions and will serve as the primary point of communication with all hospitals to ensure appropriate post-crisis care and follow-up. A key goal for this role is to collaborate with the Behavioral Wellness Access Team to provide follow-up support for individuals whose primary reason for an emergency visit was related to mental health or substance misuse, ensuring they receive the necessary ongoing care. This position will work closely with the utilization management team.
2. **Enhance Peer Support in Navigating the System of Care.** Peers will now serve as the first point of contact for individuals entering outpatient clinics, playing a vital role in guiding new clients through the intake and access process. This new intake model is designed to improve engagement, reduce barriers, and ensure that clients feel supported as they begin their behavioral health journey.
3. **Expand Homeless Outreach and Early Intervention Efforts**. Our teams are working in close partnership with Santa Barbara ACT and the End Homelessness Initiative to develop a strategic outreach plan. The goal is to identify and provide services to the 75 highest-need individuals experiencing homelessness who require behavioral health interventions. Additionally, a targeted effort will be made to secure stable housing for at least 35 Behavioral Wellness clients as part of our ongoing commitment to supporting long-term recovery and stability.

Priority Number Three:
Increasing of Mental Health Education and Prevention Programming for Youth and Families

FY 22-24 Accomplishments

- Expanded New Lived Experience and Advocacy Development (LEAD) Program
- Implemented New Casa Pacifica Suicide Prevention Training for Schools and Staff
- Implemented New County-Wide Youth Council: had over 30 high school students county-wide participate as Peer Advocates to serve as trusted sources for mental health resources information
- Contracted with YouthWell to support a Countywide Youth Advisory Board for High School youth, to teach leadership and development skills around mental health advocacy
- Implemented New Mental Health Education program to Mixtec Youth and Families in North County
- Participated in three Family Engagement Fairs across the County to provide information to a large group of families and youth about Behavioral Wellness services and how to access Behavioral Wellness services

FY 25-26 Priorities

1. **Expand "Mental Health 101" Training for Youth in North and Mid-County**. The LEAD team has developed a customizable "Mental Health 101" presentation, tailored to different audiences. In FY 25-26, this training will be expanded to reach junior high and high school students in North and Mid-County, equipping youth with essential knowledge on mental health education and stigma reduction. This training is different than T-MHFA and much broader in who can receive the training throughout the school system.
2. **Strengthen Community Outreach and Awareness**. Behavioral Wellness is expanding its community engagement and outreach team by hiring additional extra help staff to increase public awareness of Behavioral Health resources. These staff will also provide trainings to community members on how to recognize early signs of mental health and substance misuse concerns, and fostering a more informed and supportive community.
3. **Enhance Community and Staff Suicide Prevention Training**. Community training opportunities will be expanded to include suicide prevention trainings such as Question, Persuade, Respond (QPR). These trainings are available to staff, community-based organizations and all members of the public.
4. **System Training on Community Determined Evidence Based Practices.** Behavioral Wellness staff will receive training on Community-Determined Evidence-Based Practices, ensuring culturally responsive and effective care delivery.

Priority Number Four:
Implementing Mental Health Programs Specifically for Older Adults

FY 22-24 Accomplishments

- Implemented New Wellness Promotion for Seniors Program: a new Prevention Program for Seniors living in Senior Housing Developments throughout the County
- Implemented New Peer & Parent Partners in Wellness and Recovery for Families: Program designed to provide outreach and support to families with adults living with unmet or undiagnosed mental health, social, health care needs
- Implemented specific outreach to older LatinX adults with trusted community leaders County Wide

FY 25-26 Priorities

1. **Expand Outreach and Resource Education for Older Adults**. Increase efforts to connect older adults with mental health and wellness resources by conducting targeted outreach in senior centers, retirement homes, and care facilities, ensuring greater access to needed services.
2. **Support Latinx Older Adults Through Stigma-Reduction Campaigns**. Partner with organizations such as the Latino Elder Outreach Network and Abuelos in Carpinteria to develop culturally responsive campaigns that address mental health stigma and improve access to behavioral health support for Latinx older adults.
3. **Strengthen Cross-Agency Collaboration to Improve Older Adult Well-Being**. Enhance Behavioral Wellness partnerships with Social Services and other county departments to align efforts and implement shared strategies that support the mental health, housing stability, and overall well-being of older adults.

Priority Number Five:
Retention and Recruitment of the Behavioral Health Workforce

FY 22-24 Accomplishments

- Masters in Social Work Scholarship Program. Behavioral Wellness funded up to $25,000 for 4 staff this year pursuing MSW degrees and intends to fund up to 4 more scholarships next year
- Staff Retention and Training Program: Provide best practices, cultural competency and leadership trainings for interested staff to aid in retention and development of a diverse and competent workforce

FY 25-26 Priorities

1. **Broaden Recruitment Efforts Across Local Higher Education Institutions**. Strengthen recruitment initiatives by actively engaging with all universities and colleges in Santa Barbara County, fostering a diverse and qualified behavioral health workforce.
2. **Expand Workforce Pipeline Development Through High School Outreach**. Increase awareness of behavioral health careers by participating in job fairs at high schools countywide, inspiring the next generation to consider careers in mental health and social services.
3. **Develop Lived Experience Roles and Mentorship Programs**. Partner with Transitions Mental Health to establish a Speakers' Bureau composed of Behavioral Wellness staff with lived experience, providing mentorship and advocacy training while creating opportunities for peer-led support and public education.
4. **Strengthen Workforce Retention Through Loan Repayment Incentives**. Continue the third year of the Behavioral Wellness Loan Repayment Program, offering four awards of up to $25,000 for staff completing their Master's in Social Work (MSW) to promote retention and professional growth within the department.

Section C: Community Program Planning and Local Review Process

Community Program Planning and Stakeholder Process

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

The first step of the Community Program Planning Process is to solicit feedback from stakeholders throughout Santa Barbara County on what to include in the initial draft of the plan. Feedback is gathered through Department Action Team meetings on specific programs/needs, at regional community stakeholder forums, in attendance of local community organization meetings with an awareness of mental health need, and engagement with regional key informants. A Survey Monkey was distributed to meeting attendees and interested community members to provide additional public comment for our review.

The received feedback is used to guide 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, such as online and by mail upon request. During this time, stakeholders are able to comment on the initial plan through emailing, calling, or writing MHSA Manager Natalia Rossi, or posting anonymous feedback for the plan on our website.

Once the 30-day period is complete, the plan is presented to the Behavioral Wellness Commission at a public hearing specifically for the proposed plan. This allows for public comment, testimony, and presentation.

After a hearing and review by the Behavioral Wellness Commission, the Commission then votes on presenting the plan to the County Board of Supervisors for adoption. If the vote passes, 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 Manager, Natalia Rossi.

Position Responsible for Community Program Planning Process

The MHSA Team (MHSA Manager Natalia Rossi, Prevention and Early Intervention Health Care Program Coordinator FayAnn Wooton-Raya, and MHSA Department Business Specialist Nakisa Shojaie) led Santa Barbara County's CPPP process. BWell has designated their MHSA Manager to be responsible for the overall Community Program Planning Process, the coordination and management of the CPPP, and ensuring that stakeholders have the opportunity to participate in the CPPP. You can find the job description for our MHSA Manager attached in the appendix to this Plan.

Fiscal Years 2025-2026 MHSA Community Program Planning Process Schedule	
MHSA CPPP Sessions – Stakeholder Focus Groups Meetings/Tabling	
Housing Authority Youth, Annual Update Presentation	7.30.24
Independent Living Resource Center, Annual Update Presentation	8.5.24
Wellness Promotion for Seniors, Annual Update Presentation	8.7.24
Santa Maria Staff Lunch	8.14.24
Consumer and Family Member Action Team, Annual Update Presentation	8.15.24
New Cuyama Food Distribution, Annual Update Presentation	8.16.24
Lompoc Staff Lunch	8.21.24
Stay and Play, Annual Update Presentation	8.22.24
Mental Wellness Center: Fellowship Club	8.27.24
Alan Hancock Bow Wow WOW, Annual Update Presentation	8.28.24
CBO Collaborative, Annual Update Presentation	9.4.24
Santa Barbara Staff Lunch	9.4.24
MHSA Steering Committee, Annual Update Presentation	9.5.24
MHSA PEI Quarterly Meeting, Annual Update Presentation	9.10.24
Tri County Regional, Annual Update Presentation	9.11.24
Santa Barbara Cottage Hospital, Annual Update Presentation	9.11.24
NAMI, Annual Update Presentation	9.13.24
Coordinated Entry System, Annual Update Presentation	9.19.24
Justice Alliance Action Team Meeting, Annual Update Presentation	9.25.24

Network of Family Resource Centers (NFRC), Annual Update Presentation	10.1.24
Noah's Anchorage Family Services Staff, Annual Update Presentation	10.8.24
Depot St. Santa Maria Housing Site, Annual Update Presentation	10.9.24
Helping Hands of Lompoc (H2L), Annual Update Presentation	10.15.24
Santa Barbara Public Library, Annual Update Presentation	10.21.24
Santa Maria Wellness Center, Annual Update Presentation	10.30.24
Alan Hancock B.I.G.E, Annual Update Presentation	11.1.24
Santa Maria Public Library, Annual Update Presentation	11.2.24
UCSB Basic Needs Rehousing, Annual Update Presentation	11.5.24
MHSA Steering Committee	11.7.24
Lompoc Public Library, Annual Update Presentation	11.12.24
Virtual Session, Annual Update Presentation	12.4.24
Youth Linkages Network, Annual Update Presentation	12.13.24
YouthWell Youth Action Board, Annual Update Presentation	2.10.25
Survey Monkey – Virtual MHSA Feedback Survey	
"MHSA Stakeholder Survey, FY 25-26",	175 Respondents

Training Provided to Staff

Every Department of Behavioral Wellness staff member completes a 1-hour online training overviewing MHSA principles within the first 30 days of employment with our Department. This includes the five funding components and how MHSA principles are applied throughout the department.

Training Provided to Stakeholders

All thirty-three events hosted this season began with a section training the audience on what MHSA is, including explaining the CPPP process and timeline.

At each stakeholder event and meeting, our MHSA Annual Update FY 25-26 PowerPoint presentation began with a thorough breakdown of MHSA policy and procedures. This included the history of the MHSA, its essential elements, the public's role as stakeholders, MHSA rules and regulations, the plan creation process, the five funding components, and budget

distribution. It is our policy to begin all stakeholder events with a training on MHSA, so that the public is constantly re-educated on MHSA principles and regulations.

Stakeholders Involved in Community Program Planning Process

More than **517** stakeholders participated in **thirty-three stakeholder meetings**. The stakeholders involved in our planning process include the Helping Hands of Lompoc, National Alliance on Mental Illness, Santa Maria Mental Wellness Center, JAAT, CBO Coalition, Coordinated Entry System Santa Barbara, Mental Wellness Center, Santa Maria Behavioral Wellness, the Consumer and Family Member Action Team, Alan Hancock College, the Library Advisory Board, Independent Living Resource Center, Youth Action Board (YouthWell), Tri Counties Regional Center, Noah's Anchorage Family Services, and many more.

These Stakeholder meetings were all tailored to specific demographics served in our Mental Health Systems, although anyone from the public was welcome to attend any meeting. Stakeholder meetings were hosted and specifically oriented to as many of our underserved/unserved populations as we could identify. Targeted stakeholder groups for meetings and in attendance included: Consumers and Families; Spanish Speaking Populations; LatinX populations; Mixtec communities; Homeless and At-Risk of Homeless Populations; LGBTQIA+ populations; TAY populations; College and High School students; staff and tenants at Supportive Housing sites; Primary care Providers; Veterans; Law Enforcement staff; School counselors and Psychologists; Justice involved populations; and Older Populations.

We prioritized our unserved and underserved populations by meeting them where they were: we held events at Peer Wellness Centers, Santa Barbara County Public Libraries (Santa Barbara, Santa Maria and Lompoc), BWell Staff Break Rooms, Extracurricular High School Events, and other places where we anticipated unserved and underserved populations might attend.

Stakeholder Education on the MHSA

Our MHSA Annual Update FY 25-26 PowerPoint presentation presented at each stakeholder event began with a thorough breakdown of MHSA policy and procedures. This included the history of the MHSA, its essential elements, the public's role as stakeholders, MHSA rules and regulations, the plan creation process, the five funding components, and budget distribution. Each MHSA component had its own dedicated slide describing its focus, what it could fund, and what it could not fund. After each component was presented, MHSA Manager Natalia Rossi invited stakeholders to voice any questions, concerns, or suggestions for that specific component.

Meaningful Stakeholder Involvement

Robust conversations ensued at all public stakeholder events. Extensive notes were taken of all public comments, and every public comment is recorded in the Attachments of this plan. Main constituent desires fell into the following areas and topics:

Full Service Partnerships: Focusing more on outreach and engagement; Incentives for attracting and keeping employees; Increasing client capacity; More services for older adults

Community Services and Supports: Extending hours at Outpatient Clinics so that people working have access to services; Increasing warm handoff and navigation services for those in crisis; Incentives for attracting and keeping employees

Outreach and Engagement: More case workers and peer recovery specialists; Laundry program in Lompoc for unhoused populations to aid in engagement, Incentives for attracting and keeping employees; Increase outreach efforts to unhoused populations staying in hotels/motels

Workforce Education and Training: Student loan repayment program to retain employees; More peer positions and Peer Supervisor Positions; Incentives for Peers who complete Peer Certification process; Internship training program for peers and case workers

Prevention and Early Intervention: More outreach and Mental Health Education to high school students; Non-traditional forms of prevention like art therapy, yoga, and meditation; More parent education and family supports; Mental health education for younger students in elementary schools; Mental Health Education for the broader community

A Survey Monkey was disseminated throughout the stakeholder process and made available in both English and Spanish. The first was our "MHSA Annual Update Survey FY 25-26", which we offered at every in-person and virtual stakeholder meeting through physical copies or an online link. This survey ran from 9/20/23 to 3/3/24. We received **175 responses.** The survey asked for feedback from stakeholders on each of the five MHSA priorities we had determined for our MHSA FY 23-26 Three-Year Plan. This feedback, along with our extensive notes on live public comments from the events, helped inform the topics of most interest to focus on in our programming goals.

We hosted four large, live stakeholder events open to the public; three events took place in-person at public libraries throughout Santa Barbara County (in Santa Barbara City, Santa Maria and Lompoc), and one virtual event was held through Zoom. We offered Spanish translation at all stakeholder events, both in-person and virtual, and the "MHSA Annual Update Survey FY 24-25" was provided in both Spanish and English. We received only 2 Spanish Surveys, but surveys were completed at Spanish Language Stakeholder events with the help of a translator and recorded as English surveys in some instances. While we received few Spanish surveys, we did receive robust live public comment from Spanish-speaking community members during these stakeholder events. We also had 6 Spanish-speaking community members register for our virtual session – making up 30% of total attendees – which provides us insight to use virtual events to better engage this core community in future MHSA planning and discussion. Reaching more Spanish-only populations is a continued priority for our department, and this year's events provided great insight.

Additionally, across the four large stakeholder events, we had 10 organizations table to provide our attendees with easy access to a variety of community resources. These organizations included: Mixteco Indigena Organizing Project (MiCOP), California Farmworker Organization (CFF), Savie Health Free Clinic, Family Service Agency of Santa Barbara County (FSA), Noah's Anchorage and the Navigation Center, Casa Pacifica, Mental Wellness Center, and Transitions-Mental Health Association.

The MHSA Annual Update Survey FY 25-26 was distributed to the MHSA Distribution list as well as the PEI distribution lists, allowing us to reach community contacts for those unable to attend meetings or wishing to provide additional online feedback.

We will continue to find ways to increase involvement in survey completion across the County. Survey results showed enthusiastic support for proposed projects, and survey responders had many additional ideas for our key proposals and addressed areas needing improvement.

In the Appendices, documentation that demonstrates stakeholders provided input during the CPPP is included: email distributions and flyers, as well as web postings, and public comments from all stakeholder events.

BHSA Steering Committee

Beginning in Fall 2023, the MHSA Team developed the MHSA Steering Committee and began recruiting for stakeholders to join as regular members. Official meetings began in January 2024, and the committee continues to meet every other month throughout the year. Starting in January 2025, we transitioned into the BHSA Steering Committee, in light of State Proposition 1.

The primary responsibility of the Santa Barbara County BHSA Steering Committee is to ensure the BHSA plans properly reflect community needs and priorities, encompass a well-balanced range of services, and align with criteria set by MHSA/BHSA regulations.

The MHSA/BHSA stipulates that training, education programs, and MHSA/BHSA decisions are to be conducted "in consultation with mental health stakeholders" (WIC **§** 5840(e)) and shall promote the "meaningful inclusion of mental health consumers and family members and incorporate their viewpoint and experiences" (WIC § 5822(h)). As key stakeholders, members play a crucial role in guiding and directly contributing to MHSA programming decisions. The BHSA steering Committee will provide valuable insight into the Community Program Planning Process, the formulation of the MHSA/BHSA Three-Year Program and Expenditure plan (MHSA Plan), and the Annual Updates.

The Santa Barbara County BHSA Steering Committee is open to the public but is steered by our 22 active members. The Santa Barbara County BHSA Steering Committee meets every other month, with an optional meeting in July. All BHSA Steering Committee meeting dates, agendas

and minutes are accessible on the County website at: Mental Health Services Act | Santa Barbara County, CA - Official Website (countyofsb.org).

BHSA Steering Committee membership is currently 20% Consumers and Family Members and our goal is to have at least 50% of members identify as consumers or family members. Members also include behavioral health providers, social services providers and non-profit agencies working with the community.

County MHSA plans must be developed with "local stakeholders including adults and seniors with severe mental illness, families of children, adults and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies and other important interests" (WIC § 5848(a)). Stakeholders shall include individuals from all backgrounds and professions in order to have a diverse group of peers, family members, consumers, staff, community partners and contract providers.

This includes:

- Clients and consumers
- Families of children, adults and senior clients/consumers
- Providers of social services
- Program Leads for MHSA funded Programs
- Education field
- Persons with disabilities, including providers
- Public Health
- Veterans and/or representatives from veteran's organizations
- Law enforcement
- Other interests (faith-based, aging and adult services, youth advocates, etc.)
- College-age youth
- National Alliance for Mental Illness (NAMI)
- LGBTQ+ community members

Our core group of staff involved in the process and present at every meeting include our MHSA Manager (facilitating), our Prevention and Early Intervention Coordinator, and our MHSA Department Business Specialist. Program managers and Behavioral Wellness staff are invited to present on relevant areas of MHSA programming to answer questions and receive feedback from our committee members.
Regular Agenda items include:

- Welcome, introductions, and goals for meeting
- CSS Program Outcomes Report
- FSP Program Outcomes Report
- PEI Program Outcomes Report
- Fiscal Update

For any questions regarding the Steering Committee, please reach out to MHSA Manager Natalia Rossi.

NEW Mental Health Services Act Prevention and Early Intervention Quarterly Meetings

In the fall of 2023, the development and creation of the Mental Health Services Act Prevention and Early Intervention Quarterly Meetings began, and the meetings officially launched in February of 2024. Meetings are led by the Mental Health Services Act (MHSA) Team, and the committee continues to meet every quarter throughout the year. Membership includes all contracted Prevention and Early Intervention (PEI) Program Provider's, of which are funded under the Mental Health Services Act. Attendees include program leads and their teams, as this is a closed group, and not open to the public.

The mission of the Mental Health Services Act Prevention and Early Intervention Quarterly Meetings is to provide a safe space for prevention and early intervention providers to gather together to collaborate on delivering the best services possible. The intentions for this group are to have respectful collaboration and innovation on treatment, sustainability and longevity of these preventative services.

The goals of this group include providers to attend quarterly meetings, providers to share and provide updates about their programs (struggles and accomplishments), to act as resources for other PEI programs, to collaborate with other PEI providers and to advocate for what their community needs.

The MHSA stipulates that training, education programs, and MHSA decisions are to be conducted "in consultation with mental health stakeholders" (WIC **§** 5840(e)) and shall promote the "meaningful inclusion of mental health consumers and family members and incorporate their viewpoint and experiences" (WIC § 5822(h)). As key stakeholders, PEI Contracted Providers play a crucial role in guiding and directly contributing to MHSA programming decisions. The PEI Quarterly Meeting members will provide valuable insight into the Community Program Planning Process, the formulation of the MHSA Three-Year Program and Expenditure plan (MHSA Plan), and the Annual Updates. Members include community-based organizations and non-profit agencies working with the community.

The core team consistently involved in the process and present at every meeting includes the MHSA Manager, the Prevention and Early Intervention Coordinator (who facilitates the meetings), and two MHSA Department Business Specialists. Program managers and Behavioral Wellness staff are invited to present on relevant areas of MHSA programming to answer questions and receive feedback from our PEI Providers.

Regular Agenda items include:

- Welcome, introductions, and goals for meeting
- PEI MHSA Team Updates
- Action Item Follow Up and Updates
- Behavioral Health Services Act (BHSA) Updates
    - The PEI Quarterly Meeting attendees determined to have this be a priority focus topic for the FY 25-26 Meetings, in order to help their programs prepare best for the BHSA Transition
- PEI Provider Updates

Topic-Based Items include but are not subject to:

- Welcome and Introduction of new staff and/or programs
- Provide updates on quarterly and annual reporting requirements, trainings, BHSA Updates, program updates
- Participation in community outreach, upcoming events, hosting of events and areas to collaborate
- Focusing on results of Community Program Planning Process, and strategizing how to meet needs for their program's clients
- Discuss how best to prepare for the BHSA Transition and provide PEI providers with updated BHSA roll-out materials
- Receive training from Behavioral Wellness Staff, Community Determined Evidence Based Practices, Guest Speakers and In-Person Meetings

For any questions regarding the Mental Health Services Act Prevention and Early Intervention Quarterly Meetings, please reach out to Prevention and Early Intervention Health Care Program Coordinator, FayAnn Wooton-Raya.

NEW BWELL Suicide Prevention Taskforce

Santa Barbara County Department of Behavioral Wellness' Suicide Prevention Taskforce was developed after the MHSA team attended a two-day conference hosted by the Zero Suicide Institute in July 2024. Zero Suicide provided our county with a framework designed to reduce and prevent suicides and suicide attempts within healthcare systems. Through the use of core values, systems management revisions and the implementation of evidence-based clinical care practices, this framework works to close gaps in health care systems and improve outcomes.

Starting in the late Summer of 2024, we began to use the Zero Suicide framework as a guide to collect research on our department's suicide safe policies, assess the need for the taskforce, and recruit committee members. The first official meeting was held in November of 2024 and the taskforce continues to meet every month.

The Suicide Prevention Taskforce (SPTF) is committed to reducing the prevalence of suicide in Santa Barbara County by implementing evidence-based strategies, fostering community collaboration, and ensuring accessible, compassionate care for individuals, families and communities at risk of suicide. The SPTF aims to create a coordinated, systemic approach to suicide prevention, grounded in the Zero Suicide framework. By leveraging policies, workforce training, and community partnerships, the Task Force seeks to:

1. Enhance the county's capacity to identify, support, and care for individuals at risk.
2. Foster a culture of safety and resilience within the behavioral health workforce
3. Increase public awareness and reduce stigma surrounding mental health and suicide.

Goals

1. System Improvement: Integrate the Zero Suicide Framework into all Behavioral Wellness operations, including safety planning, screening, and care transitions.
2. Workforce Development: Ensure staff have the training, resources, and confidence to implement suicide prevention practices effectively.
3. Community Engagement: Strengthen partnerships with local organizations, schools and community leaders to expand outreach and education efforts.
4. Data-Informed Strategies: Utilize data from tools like workforce surveys, incident reports, and follow-up care metrics to guide policies and practices.
5. Policy Review and Updates: Regularly evaluate and redefine policies, such as critical incident debriefing and safety planning, to align with national best practices.

Structure

Membership: Currently Includes representatives from Behavioral Wellness staff and will include our county partners and community and organizational providers in the development of data collection and work plan.

Frequency of Meeting: Monthly meetings, with additional sessions as needed.

Contact Information

Natalia Rossi, MHSA Manager: nrossi@sbcbwell.org

NEW BWELL Community Advisor Training

In the winter of 2025, the MHSA Team designed a Community Advisor Training to offer at public BHSA listening events and stakeholder sessions. The training educates community members on the Santa Barbara County Behavioral Wellness Department and the Mental Health Services Act, as well as the Community Program Planning Process (CPPP); it also emphasizes how providing feedback as a Community Advisor influences the provision of behavioral health services throughout our county.

After learning about these crucial topics during the training portion of an in-person MHSA Listening Session, participants are recognized as official Community Advisors and receive a $25 gift card. Community Advisors are required to stay the for the entire in-person session, participate, and sign out with a member of the MHSA team to receive a gift card. The training overview consists of:

- Intro to BWELL
- MHSA Overview and History
- Community Advisor Description
- Your Role as A Community Advisor
- What it Takes to be/Values of a Community Advisor
- What is the MHSA Community Program Planning Process?
- Community Advisor Role in the Community Program Planning Process
- Compensation/Reimbursement for Participating in Community Events as a Community Advisor

The Community Advisor position was also designed to encourage and incentivize active participation from community members at MHSA stakeholder events. Trained community advisors are expected to:

- Attend public Mental Health Services Act (MHSA) stakeholder events
- Actively participate at these events
- Gain a more established sense of responsibility and leadership within our community
- Use the opportunity to provide feedback on personal experiences

The MHSA team plans to advertise this training and position by sending flyers to community organizations and partnering providers throughout Santa Barbara County. Verbal advertisements were announced and opinions about the training were gathered at recent stakeholder meetings throughout the winter, such as the bi-monthly MHSA Steering Committee.

For any questions or feedback regarding Community Advisor Trainings, please contact:

Natalia Rossi, MHSA Manager: nrossi@sbcbwell.org

Circulation of Three-Year Plan for Public Comment

The 30-day review process is conducted from April 21st, 2025 to May 21st, 2025 in partnership with the local Behavioral Wellness Commission. Additionally, the draft Mental Health Services Act Annual Update FY 2025-2026 is emailed to nearly 300 stakeholders. It is available by postal mail on request, posted online and available in the Director's Report.

Any substantive comments received during the 30-day Public Comment period and Public Hearing, staff responses to those comments, and details of any substantive changes made

based on those comments, will be included in the Appendix to this plan, and we will indicate if no substantive comments/recommendations for revision were received.

The Behavioral Wellness Commission will be hosting a Public Hearing on May 21st, 2025, and a Board of Supervisors' hearing is anticipated on June 3rd 2025. Lastly, the Final plan update will be posted to the Department of Behavioral Wellness website and announced in the Director's Report.

Notices of the Behavioral Wellness Commission Agenda and Minutes approving the Plan, and Notice of the Board of Supervisors Agenda for approval of the Plan, will be included in the Appendix of this plan.

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

Contact Information is MHSA Manager Natalia Rossi, JD

Email: nrossi@sbcbwell.org

315 Camino Del Remedio Santa Barbara, CA 93110

☎: (805) 448-1337.

Date of Adoption by County Board of Supervisors: June 4th, 2025

About 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 rehabilitation or other services; needs assessment; individual Services and Supports Plans; crisis intervention/stabilization; family education; improving of the service delivery system; and reducing ethnic/racial disparities.

About Full-Service Partnerships (FSPs)

Full-Service Partnership (FSP) plans for and provides the full spectrum of services, from mental health to non-mental health services, and advances and supports clients' goals towards their recovery, wellness and resilience. The FSP philosophy is to do “whatever it takes” to help individuals achieve their goals. Services may include, but are not limited to, mental health treatment, housing, medical care, vocational training, and crisis support. FSP funding and services are intended to reduce the amount of psychiatric hospitalizations, homelessness, incarceration, and the prolonged suffering of the most severe mental illnesses.

Community Services and Supports, FSP Services: Report on Prior Fiscal Year Activities AND Program Plan

New Heights Transitional Age Youth Full Services Partnership (TAY)

Program Population(s) of Focus

Homeless	
Forensic	
Involved in Social Services System	
Unserved/Underserved	X
Cultural Population (specify below)	
Veterans	
Other (Specify Below)	X
Children, TAY	X

Program Summary*:* The New Heights Transitional Age Youth (TAY FSP) supports individuals aged 16-25 in their transition to adulthood through psychiatric, therapeutic, and vocational aid, emphasizing peer support and life skill development. Goals include reducing incarceration and acute psychiatric care rates while ensuring active participation in purposeful activities. The program prioritizes inclusivity, offering tailored services to underserved populations and expanding support to encompass financial aid and medication coverage for holistic care.

Available data on this program's outcomes for the prior fiscal year period, FY 23-24 is included as an Appendix to this document.

Program Performance, FY 24-25

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. This population also includes individuals who are experiencing co-occurring mental health and substance abuse conditions. The Lompoc Region works with the local substance treatment agencies to accept referrals for uninsured youth or youth involved with child welfare services. Additional training of Certified Alcohol and Drug specialists added to the team would increase the staff's ability to respond to and provide treatment for co-occurring mental health and substance abuse conditions within this program.

New Heights TAY FSP program in the Lompoc and Santa Maria regions were fully staffed in the year 2024 with a bilingual case manager available to support monolingual and bilingual families. Staff are able to provide opportunities for services outside of traditional business hours, which allows for services to be offered to migrant workers, rural populations, and unhoused populations. Staff are also able to provide services in the community setting, which also allows for services to be offered to unserved/underserved populations. Staff provide services in the Lompoc Wellness Center to make services available to youth who reside in the supported housing complex.

The major challenge for the New Heights TAY FSP program is adequately serving the population eligible for FSP level services. At times, there has been a low caseload.

The Santa Maria region TAY FSP team is fully staffed and currently providing services to 16 clients. The clinician and case worker are both fluent in Spanish. They see clients in the community and provide family support.

Addressing Community Issues

The New Heights FSP TAY program serves mental health consumers ages 16-25 experiencing mental health and substance abuse conditions. The New Heights FSP TAY program also coordinated with the Department of Rehabilitation (DOR) to continue to improve and enhance supportive employment services for clients.

Notable Community Impact

The Lompoc Region provides several groups including a “cooking group” (e.g. cooking, food purchasing, food preparation, healthy options, etc.) This has become the most popular weekly group in the clinic. They also provide a “Health and Wellness” group, and will be starting a DMV Prep” group, as the majority of clients do not have their driver’s license or even a CA ID. If the youth is not able to meet in a group format, the case workers go into the youth’s home to provide this skill building treatment.

Staff also target “safe social engagement skills” with this population. Lompoc region staff consistently participate in communication with the local housing department to get early notification of vacancies to help these youth submit housing applications that make them eligible for housing. This includes providing the skillset of organization and preparation for this application process. The youth are provided an accordion folder, in which they are coached to keep their important housing documents, so they can get through the housing application process quickly and completely. The meeting also discusses any challenges these youth experience while they are having their first independent housing experience (e.g. paying rent on time, safety concerns).

Youth have participated in community college bridge and then transferred to a 4-year college. Staff provides education on how to access the school's resources and take youth on tours of the local community college, Allan Hancock.

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

Recently, the members of the team assisted three separate clients with gaining stable housing treatment, contributing to better client outcomes.

Santa Maria TAY FSP has been providing services for Child Welfare and Probation involved youth. These youth typically receive Wraparound Senate Bill-163 services rather than TAY FSP; however, this program has been short staffed and was unable to take clients for part of 2024.

Program Plan for FY 25-26

Provider:	**Behavioral Wellness**
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$1,925,000
Estimated CSS Funding	$1,068,100
Estimated Medi-Cal FFP	$856,900
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$0
Average Cost Per Consumer	$15,400
Estimated Total of Consumers Served	125

Estimated Consumers Served by Age FY 2023/24		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	
Estimated Total Consumers Age 15-26 Served	128	$22,665.63
Estimated Total Consumers Served Age 26-59		
Estimated Total Consumers Served Age 60+		

Estimated Consumers Served by Age FY 2024/25		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	
Estimated Total Consumers Age 15-26 Served	128	$22,665.63
Estimated Total Consumers Served Age 26-59		
Estimated Total Consumers Served Age 60+		

Estimated Consumers Served by Age FY 2025/26		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	
Estimated Total Consumers Age 15-26 Served	123	$15,400
Estimated Total Consumers Served Age 26-59	2	$15,400
Estimated Total Consumers Served Age 60+		

Program Description

For the New Heights TAY FSP program, the clients are age 16-25 years old and are in the developmental stage of transitioning into adulthood. Psychiatry, Med Support, Case Management, Therapy and Rehab, Groups/Social Skills, and modeling behaviors are employed to improve interpersonal relationships. We focus on education and exploration of employer resources and furthering client's vocational skills and interests. Teen Parenting skills and support is another aspect of treatment for this age group. Post-Partum is sometimes a focus of treatment. Treatment Focus is on Peer Support to enhance life skills and learning how to navigate services in the community on their own without the support of the parental unit.

Performance Goals and Intended Outcomes

Performance Goal	Intended Outcome	Data Source
Less than 5% of unique clients incarcerated/ Juvenile Hall	To provide services to prevent incarceration	Quarterly Program Report
Less than 10% admitted to Acute Inpatient Psychiatric	To provide mental health services earlier and prevent	Quarterly Program Report

Facilities	need for acute care	
More than 90% of clients engaged in Purposeful Activity	To help clients with recovery and avoid higher mental health care	Quarterly Program Report

Strategies to Address Service Disparities for Unserved and Underserved Populations

For the New Heights TAY FSP program, staff consistently evaluate and attend to the needs for unique and client-centered services needed by the unserved and underserved populations. Individuals within the unserved and underserved populations are referred for evaluation to the clinic. Referrals are often received from, but not limited to, Primary Care Provider, schools, probation, CWS, school attendance review board, shelters, substance use providers, community agencies, and hospitals. Once a referral is made, staff are trained to include in the evaluation process aspects such as geographic location, age, gender, and race/ethnicity to be able to offer individuals in the unserved and underserved populations the opportunity to participate in services. This is consistent with priorities identified in the Community Planning Process.

Program Alignment with the General Standards of the MHSA

Community Collaboration: Staff routinely and consistently participate in collaboration with community resources and agencies in the form of collaborative offering of services, activities, and outreach in addition to participation in collaborative meetings that review the needs and planning to provide services for clients

Cultural Competence: Staff participate in cultural competence training annually. Training targets increasing competence in the areas of providing access to services, treatment interventions and outreach interventions, program development and implementation, understanding of diverse belief systems and the impact of forms of discrimination and its impact in the mental health system.

Client and Family Driven: Clients have the primary decision-making role to identify their needs, preferences, and strengths and staff offer treatment recommendations that take these identified areas into consideration. Clients and families participate in decision making that supports collaboration between clients, families, and staff to identify the most effective and helpful supports to the client.

Wellness, Recovery, and Resilience Focused: Staff are trained to focus on and integrate into treatment the key concepts such as hope, personal empowerment, respect, social connections, self-responsibility, and self-determination. Staff provide interventions that uphold these key concepts in addition to linking clients and families to resources within the community that also uphold these key concepts.

Integrated Service Experiences for Clients and Families: Staff consistently link families and clients to a range of services through a client's time in treatment that integrate multiple agencies within the community, as well as community programs and resources. Staff will offer a variety of supports to assist client's and families in accessing, qualifying/gaining admittance to, attending, and participating in services with multiple agencies within the community.

Criteria for Enrollment in FSP Services

Criteria for enrollment in an FSP is that, for children and youth, they meet criteria for an emotionally seriously disturbed disorder and are unserved or underserved. Once a referral is made, staff are trained to include in the evaluation process aspects such as geographic location, age, gender, and race/ethnicity to be able to offer individuals in the unserved and underserved populations the opportunity to participate in services. This is consistent with priorities identified in the Community Planning Process.

Changes to Service Delivery

The Santa Maria New Heights TAY FSP is working on engaging clients to increase attendance and participation in the program.

The Lompoc New Heights TAY FSP is working on community outreach to increase referrals.

This program is now fully staffed by Bwell; services are no longer provided by CommUnify.

Program Demographics

Reporting FY 23-24


125
# of Clients
Female Male Unknown or Not Reported
74
51
Age Group
123
16-25
3
26-59
Veteran Status
Unknown or Not Reported 20
No 105
Ethnicity
75
Hispanic
33
Non-Hispanic
16
Unknown or Not Reported
1
More Than One Ethnicity
Sexual Orientation
Transgender 1
Bisexual 7
Heterosexual/ Straight 29
Unknown or Not Reported 86
Race
97
White
12
More Than One Race
9
Unknown or Not Reported
4
African American or Black
2
Asian
1
Other
Primary Language
100
English

Community Services and Supports, FSP Services: Report on Prior Fiscal Year Activities AND Program Plan

Santa Barbara Adults/Older Adults Full Service Partnership (Formerly Assertive Community Treatment)—Behavioral Wellness

Program Population(s) of Focus

Homeless	
Forensic	
Involved in Social Services System	
Unserved/Underserved	X
Cultural Population (specify below)	
Veterans	
Other (Specify Below)	X
Adults/ Older Adults	X

Program Summary: The Santa Barbara Adults/Older Adults Full-Service Partnership (formerly Assertive Community Treatment Program) offers comprehensive 24/7 services for individuals aged 26 or older with severe mental illnesses, emphasizing crisis support, independent living skills, and targeted case management. Priorities include expanding services to underserved populations like the homeless and justice-involved while maintaining low rates of hospitalization and incarceration, and ensuring stable housing for over 90% of participants.

Available data on this program's outcomes for the prior fiscal year period, FY 23-24 is included as an Appendix to this document.

Program Performance, FY 24-25

We utilize a recovery-based, client-centered approach. Care coordinators work with clients to rehabilitate into the community, focusing on client goals, hopes and dreams. The team helps create individualized services and supports plans (ISSPs) to help clients reach their recovery and personal goals; these ISSPs help to empower clients to increase their independence by helping them develop effective coping strategies for their symptoms and gain valuable independent living skills. The goal of the program is to give clients the skills needed to establish and maintain stability so they can focus on their goals, with the plan of graduating clients to a lower level/ least restrictive level of care once they are ready. Family involvement is encouraged as long as clients consent to their participation in their treatment. Services that are provided include, but are not limited to: rehabilitation services, individual psychotherapy, psycho-education,

medication support and administration, crisis services, case management services linking clients to various resources (i.e. social security and health benefits), educational and vocational support, substance use/abuse support, provider services, outreach, advocacy, and housing support.

Addressing Community Issues

Santa Barbara Adults/Older Adults FSP is continuing to try and connect clients to housing but the housing crisis in Santa Barbara is increasing the difficulty in finding housing placement. BWell has budgeted additional client expense funds to help clients with rental deposits and short-term rent deficits. Santa Barbara Adults/Older Adults serves individuals at risk of homelessness, incarceration and hospitalization. The population involves many individuals with co-morbid medical issues. The team works to ensure all clients are linked to medical care and are receiving regular medical appointments. Due to the increasing number of referrals from our justice involved services teams, SB Adults/OA has worked to step individuals down to lower levels of care whenever indicated in order to make more room in the program for the new referrals.

Notable Community Impact

Over the last year we have connected clients to housing, increased benefits acquisition and lowered return rates to incarceration. We have also supported clients and parents with navigating the complexities of mental illness and the challenges associated with it. We have given presentations in the community on the services provided as listed above. We have also integrated the Assisted Outpatient Treatment (AOT) team and the CARE Act team. All three programs are housed in the same building.

Program plan for FY 25-26

Provider:	**Behavioral Wellness**
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$5,031,800
Estimated CSS Funding	$3,522,600
Estimated Medi-Cal FFP	$1,012,300
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$497,000
Average Cost Per Consumer	$42,284.03
Estimated Total of Consumers Served	119
Target Population Demographics Served	Adult, Older Adult

Estimated Consumers Served by Age FY 2023/24		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	$41,618
Estimated Total Consumers Age 15-26 Served	7	$41,618
Estimated Total Consumers Served Age 26-59	70	$41,618
Estimated Total Consumers Served Age 60+	39	$41,618

Estimated Consumers Served by Age FY 2024/25		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	$41,618
Estimated Total Consumers Age 15-26 Served	7	$41,618
Estimated Total Consumers Served Age 26-59	70	$41,618
Estimated Total Consumers Served Age 60+	39	$41,618

Estimated Consumers Served by Age FY 2025/26		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	$42,284.03
Estimated Total Consumers Age 15-26 Served	5	$42,284.03
Estimated Total Consumers Served Age 26-59	72	$42,284.03
Estimated Total Consumers Served Age 60+	42	$42,284.03

Program Description

Our program offers a “whatever it takes” approach and provides services 24/7 including independent living skills, crisis support, targeted case management, employment support services and medication management. We serve consumers 18 years of age or older.

Individuals served are suffering from a mental illness as defined by Welfare and Institutions Code (WIC) 5600.3 (b) (2)-(b) (3). We are a client-centered, recovery-oriented behavioral health service delivery model that has received substantial empirical support for reducing psychiatric hospitalizations, facilitating community living, and enhancing recovery for persons with serious mental illnesses. Santa Barbara Adults/Older Adults FSP is designed specifically for persons who have the most severe and persistent mental illnesses, have severe symptoms and impairments, and who historically have not benefited from traditional outpatient programs. Our teams provide person-centered services addressing the breadth of a client's needs, helping them achieve their personal goals

Top Community Issues

Our top community issues include increasing FSP capacity and increasing services to underserved/unserved populations; unhoused populations, and those that are Justice Involved. The Adult/Older Adults FSP Program is working to recruit and retain their mental health workers, so that this program can operate at full capacity and increase outreach to unhoused and justice-involved populations to better support these underserved populations.

Performance Goals and Intended Outcomes

Performance Goal	Intended Outcome	Data Source
Psychiatric Inpatient Hospitalization	5% or less	Quarterly Report
Visits to Emergency Care	10% or less	Quarterly Report
Medical Inpatient Hospitalization	5% or less	Quarterly Report
Incarceration	5% or less	Quarterly Report
Stable Housing	90% or greater	Quarterly Report
Purposeful Activities	15% or greater	Quarterly Report
Of clients discharged, the number referred for a lower level of care	85% or greater	Quarterly Report

Strategies to Address Service Disparities for Unserved and Underserved Populations

All of our clients are unserved or underserved Medi-Cal eligible populations with frequent instances of homelessness, incarceration and institutionalization. Our goal is to bring services to people who cannot advocate for themselves to get them.

Program Priorities

The Adult/Older Adults FSP was established to serve those who were discharged from mental health hospitals with no treatment and housing. We are a targeted case management program that specifically works with individuals to get them out of crisis and into a long-term mental health program to avoid unnecessary incarcerations, medical issues, and homelessness. We do this by offering the services listed above and by creating compassionate and solid relationships with our clients, our resources in the community, and the community in general.

Program Alignment with the General Standards of the MHSA

Community Collaboration: We want our community of FSP clients to be productive members of the larger community as they are tremendous individuals who have the ability to give back. We are hoping to have mental health awareness events for the community.

Cultural Competence: The Adult/Older Adults FSP strives to have the upmost cultural competence and we do this through educating one another, through listening and learning from our clients and engaging in trainings that address different cultures.

Client and Family Driven: Our clients are family and when they feel they don't have family support, our groups and services provide this so that they are not isolated. We work with clients to reestablish community and family ties and provide counseling for families. We also do our best to support the caregivers who are supporting loved ones that are struggling with severe mental health challenges.

Wellness, Recovery, and Resilience Focused: The Adult/Older Adults FSP is about recognizing strengths and building off them. We see the goodness in our clients and celebrate it and praise it.

Integrated Service Experiences for Clients and Families: Our team is a multidisciplinary team that works with clients in different ways but always with wellness and recovery at the heart. We also have connections with the resources in the community that can assist in supporting our clients with more care, less care, and different kinds of care.

Criteria for Enrollment in FSP Services

Medi-Cal beneficiaries with serious mental illnesses or serious emotional disturbances are eligible to receive specialty mental health services in the form of Full-Service Partnerships (FSPs) through Behavioral Wellness and associated CBO's. Full Service Partnership services are designed for adults, older adults, TAY, or children with a serious mental illness and/or co-occurring diagnosis of substance use disorders or physical health impairments.

Changes to Service Delivery

Assertive Community Treatment (ACT) program changed to a Full Service Partnership program last year. We have switched to a new Electronic Health Records system (SmartCare). Santa Barbara Adults/ Older Adults FSP provides additional non-mental health supports such as financial assistance to aid in housing, help paying for medications not covered by insurance, and other supports needed to help consumers meet their treatment plan goals. We are moving in the direction of becoming a full fidelity Assertive Community Treatment program in the next year, which will be monitored using the TM-ACT tool.

Program Demographics

Reporting FY 23-24


119
# of Clients
Female
Male
Unknown or Not Reported
48
71
Age Group
72
42
5
16-25
26-59
60+
Veteran Status
No 119
Ethnicity
83
33
3
Non-Hispanic
Hispanic
Unknown or Not Reported
Sexual Orientation
Heterosexual/Straight 21
Unknown or Not Reported 98
Race
96
11
7
2
2
1
White
More Than One Race
African American or Black
Asian
Other
Alaska Native or Native American
Primary Language
98
English

Community Services and Supports, FSP Services: Report on Prior Fiscal Year Activities AND Program Plan

Lompoc Adults/Older Adults Full Service Partnership (Formerly Assertive Community Treatment)—TMHA

Program Population(s) of Focus

Homeless	
Forensic	
Involved in Social Services System	
Unserved/Underserved	X
Cultural Population (specify below)	
Veterans	
Other (Specify Below)	X
Adults/ Older Adults	X

Program Summary: The Lompoc Adults/Older Adults Full-Service Partnership (formerly Assertive Community Treatment Program) managed by Transitions Mental Health Association/Behavioral Wellness provides 24/7 crisis support, comprehensive mental health services, and targeted case management for adults and older adults facing severe mental illnesses. Goals include reducing homelessness, lowering ER visits, and enhancing community involvement, aiming to support clients towards stability and quality of life.

Available data on this program's outcomes for the prior fiscal year period, FY 23-24 is included as an Appendix to this document.

Program Performance, FY 24-25

Lompoc FSP only serves the unserved and underserved populations. The people we serve are those experiencing the highest level and most persistent mental illness in our community. Our contracted goals are created to reduce the disparities between those we serve and the larger population. Our main goal as a team is to invite those who are often ostracized to be able to have a community and the resources that all people should have the right to.

The Lompoc FSP team was managed by Merakey Alos from July 1st 2022 through April 2024. TMHA became the contracted provider for the Lompoc FSP in May of 2024. By the beginning of summer, we became fully staffed, and began the work of readmitting all the clients, conducting comprehensive assessments, and determining the best treatment approach while simultaneously training the new team of staff. The team focused on helping clients obtain and

maintain housing, mental wellness, limit police contacts, crisis, hospitalizations and homelessness.

Continued barriers in Lompoc include the limited emergency health resources and hospitalization resources. Another concern facing this community is lack of housing options. Our current clients who are experiencing homelessness have limited options and long waiting lists for housing.

Addressing Community Issues

Our program is a major contributor to keeping people living in the community and avoiding hospitalizations, homelessness, and incarceration. We serve the underserved and facilitate recovery in our client's mental health wellness. The ultimate goal is to catch folks when they are almost in crisis or are in crisis and help them get to a place where they feel comfortable stepping down to a lower level of care. The team accomplishes this through crisis management, targeted case management, psychiatric and psychological counseling, and connections to all the resources in the community that we have access to.

Notable Community Impact

The Lompoc FSP program has notably impacted the clients we serve, and has also lessened the burden of utilizing emergency services. The program resumed relationships with previous clients, established new ones, and supported clients throughout the system of care as needed.

We have resumed weekly groups that build community and encourage wellness. We include family services to support the families of the clients we serve. We provide a 24-hour crisis line to create a safety net to process and receive support before the business day. With our support and encouragement, our clients have made great strides in working towards their goals, including successfully securing employment, graduating from university, attaining housing, starting recovery treatment, regaining custody of their children, and maintaining independent living. Other accomplishments include helping clients attain SSDI, securing medical appointments for our clients, creating community with each other, helping clients repair relationships and make healthy new ones, and encouraging clients to utilize patient's rights services in order to advocate for themselves.

Program Plan for FY 25-26

Provider:	**Transitions Mental Health Association (TMHA)**
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$2,050,900
Estimated CSS Funding	$1,641,900
Estimated Medi-Cal FFP	$409,000
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$0
Average Cost Per Consumer	$22,787.77
Estimated Total of Consumers Served	90
Target Population Demographics Served	Adult, Older Adult

Estimated Consumers Served by Age FY 2023/24		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	$21,743
Estimated Total Consumers Age 15-26 Served	9	$21,743
Estimated Total Consumers Served Age 26-59	60	$21,743
Estimated Total Consumers Served Age 60+	25	$21,743

Estimated Consumers Served by Age FY 2024/25		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	$21,743
Estimated Total Consumers Age 15-26 Served	9	$21,743
Estimated Total Consumers Served Age 26-59	60	$21,743
Estimated Total Consumers Served Age 60+	25	$21,743

Estimated Consumers Served by Age FY 2025/26		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	$22,787.77
Estimated Total Consumers Age 15-26 Served	8	$22,787.77
Estimated Total Consumers Served Age 26-59	58	$22,787.77
Estimated Total Consumers Served Age 60+	25	$22,787.77

Program Description

Our program offers 24/7 crisis support, medication management and education, activities of daily living skills, financial management and coaching, support with attending to health care needs, substance use counseling, gateways to housing, mental health counseling, groups, one-to-one case management, connections to employment, family therapy and education, support with education, referrals and resources for better quality of life, and of course compassion and a feeling of belonging.

Top Community Issues

Our top community issues include increasing FSP capacity and increasing services to underserved/unserved populations; unhoused populations, and those that are Justice Involved. The Adult/Older Adults FSP Program is working to recruit and retain their mental health workers, so that this program can operate at full capacity and increase outreach to unhoused and justice-involved populations to better support these underserved populations.

Performance Goals and Intended Outcomes

Performance Goal	Intended Outcome	Data Source
Reduce the number of clients experiencing homelessness	Increase access to housing	Data Collection and Reporting (DCR)
Stepping down 20% of our client to lower levels of care over the next year.	Ability to take in more clients with severe need and to assist them to find quality of life and stability in their wellness.	Key events and our discharge and intake spread sheet
Have a full staff to be able to serve the clients in need adequately	To have clients have meaningful encounters on average eight times a month.	We keep a master excel sheet with visits, attempt, collaterals.
Reduce number of ER visits.	Have more primary appointments and psychiatric appointments and clients stable on their medication	Key Events- DCR

Reduce rates of incarceration	For clients to feel like productive members of our community and avoid the trauma of incarceration.	DCR-Key events
Have more clients attending meaningful activities in their lives.	To improve the client's quality of life.	DCR- Key events.
More events with community participation.	The community can learn more about mental health and have more compassion	Quarterly Program Reports

Strategies to Address Service Disparities for Unserved and Underserved Populations

All of our clients are unserved or underserved Medi-Cal eligible populations with frequent instances of homelessness, incarceration and institutionalization. Our goal is to bring services to people who cannot advocate for themselves to get them.

Program Priorities

The Adult/Older Adults FSP was established to serve those who were discharged from mental health hospitals with no treatment and housing. We are a Targeted Case Management program that specifically works with folks to get them out of crisis and into a long-term mental health program to avoid unnecessary incarcerations, medical issues, and homelessness. We do this by offering the services listed above and by creating compassionate and solid relationships with our clients, our resources in the community, and the community in general.

Program Alignment with the General Standards of the MHSA

Community Collaboration: We want our community of FSP clients to be productive members of the larger community as they are tremendous individuals who have the ability to give back to Lompoc. We are hoping to have mental health awareness events for the community.

Cultural Competence: The Adult/Older Adults FSP strives to have the upmost cultural competence and we do this through educating one another, through listening and learning from our clients and engaging in trainings that address different cultures.

Client and Family Driven: Our clients are family, and when they feel they don't have family support, our groups and services provide the support so they are not isolated. We work with clients to reestablish community and family ties and provide counseling for families. We also do our best to support the caregivers who are supporting loved ones that are struggling with severe mental health challenges.

Wellness, Recovery, and Resilience Focused: The Adult/Older Adults FSP is about recognizing strengths and building off them. We see the goodness in our clients and celebrate it and praise it.

Integrated Service Experiences for Clients and Families: Our team is a multidisciplinary team that works with clients in different ways but always with wellness and recovery at the heart. We also have connections with the resources in the community that can assist in supporting our clients with more care, less care, different kinds of care.

Criteria for Enrollment in FSP Services

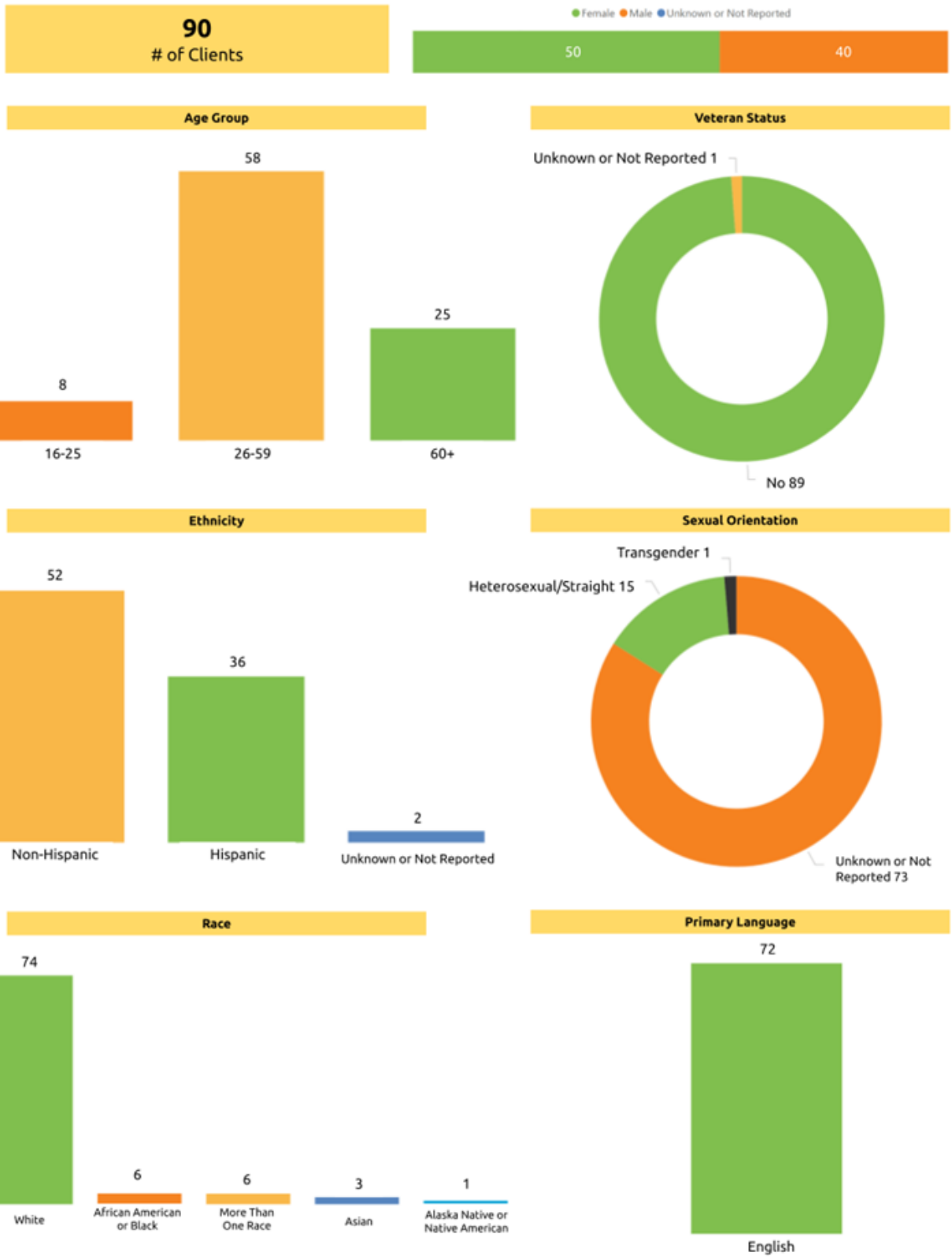
Medi-Cal beneficiaries with serious mental illnesses or serious emotional disturbances are eligible to receive specialty mental health services in the form of Full-Service Partnerships (FSPs) through Behavioral Wellness and associated CBO's. Full Service Partnership services are designed for adults, older adults, TAY, or children with a serious mental illness and/or co-occurring diagnosis of substance use disorders or physical health impairments.

Changes to Service Delivery

TMHA assumed provider status for this program May 2024; the previous provider was Merakey Allos. The Lompoc FSP was given a new Electronic Health Record System to utilize and we continue making gains with learning the program and using it strategically. The transition has been difficult to navigate with the new fee-for-service model.

Program Demographics

Reporting FY 23-24


90
# of Clients
Female
Male
Unknown or Not Reported
50
40
Age Group
58
8
25
16-25
26-59
60+
Veteran Status
Unknown or Not Reported 1
No 89
Ethnicity
52
36
2
Non-Hispanic
Hispanic
Unknown or Not Reported
Sexual Orientation
Transgender 1
Heterosexual/Straight 15
Unknown or Not Reported 73
Race
74
6
6
3
1
White
African American or Black
More Than One Race
Asian
Alaska Native or Native American
Primary Language
72
English

Community Services and Supports, FSP Services: Report on Prior Fiscal Year Activities AND Program Plan

Santa Maria Adults/Older Adults Full Service Partnership (Formerly Assertive Community Treatment)-- Telecare

Program Populations of Focus

Homeless	
Forensic	
Involved in Social Services System	
Unserved/Underserved	X
Cultural Population (specify below)	
Veterans	
Other (Specify Below)	X
Adults/ Older Adults	X

Program Summary: The Santa Maria Adults/Older Adults Full-Service Partnership (formerly Assertive Community Treatment Program), managed by Telecare, focuses on community-based interventions for individuals facing severe mental illnesses, offering multidisciplinary support including therapy, case management, and rehabilitation services. Priorities involve expanding services for underserved populations, reducing hospitalizations and incarcerations, and ensuring stable housing for over 90% of participants.

Available data on this program's outcomes for the prior fiscal year period, FY 23-24 is included as an Appendix to this document.

Program Performance, FY 24-25

Telecare Corporation provides services in Santa Maria. Santa Maria Adults/Older Adults FSP employs the following Program Goals to fulfill consumer outreach objectives:

- Continue to create and 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 whole team approach, as well as this "primary" point-person.

- Provide a culture of recovery through Telecare's Recovery-Centered Clinical Systems (RCCS) treatment modality
- Admissions are voluntary and prioritized based on the needs 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 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.
- No matter which culture or cultures the consumer identifies with, it is the goal of the Program to recognize the unique differences, strengths, knowledge and experiences of each person served. Inclusion into the community as an active, independent, healthy, and productive citizen is the Program's goal.
- Majority of services are provided in the community and use natural supports whenever possible. Development of a broad support network is necessary for continued growth and achievement of life goals.
- Provide continuity across time as many of SM FSP's consumers have long-term relationships with team members
- Operate as a comprehensive, self-contained service.
- Telecare is in process of becoming Dual Diagnosis Capable to meet criteria of Senate Bill 43 by January 2026.

Addressing Community Issues

One challenge with program implementation is that housing continues to be very limited in the Santa Maria region. Our case management team continues to work closely with room and board operators in the community to ensure proper placement. Shelters, sober living facilities and Board and Care are also utilized as housing options when appropriate.

Approximately 30% of the current census is over the age of 60. A growing number of long-term Santa Maria FSP clients have chronic medical issues in addition to mental health issues. Meeting the needs of these clients is challenging due to limited resources in the region. Cooperation with hospitals and Skilled Nursing Facilities has been crucial in the placement of these clients.

Our top priority is engaging the most vulnerable populations by creating a warm handoff with the referring agency. We meet potential members in the community to increase opportunities for providing services. Telecare Santa Maria FSP averages 7 Days from referral to enrollment.

Notable Community Impact

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: necessary medical care; psychiatric crisis; being unable to make effective choices which thereby leads to high risk behaviors; forensic services involvement; necessary specialized group participation (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.

Program Plan FY 25-26

Provider:	**Telecare**
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$3,352,500
Estimated CSS Funding	$1,606,700
Estimated Medi-Cal FFP	$1,745,800
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$0
Average Cost Per Consumer	$28,653.84
Estimated Total of Consumers Served	117
Target Population Demographics Served	TAY, Adult, Older Adult

Estimated Consumers Served by Age FY 2023/24		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	
Estimated Total Consumers Age 15-26 Served	10	$27,795
Estimated Total Consumers Served Age 26-59	78	$27,795
Estimated Total Consumers Served Age 60+	29	$27,795

Estimated Consumers Served by Age FY 2024/25		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	
Estimated Total Consumers Age 15-26 Served	10	$27,795
Estimated Total Consumers Served Age 26-59	78	$27,795
Estimated Total Consumers Served Age 60+	29	$27,795

Estimated Consumers Served by Age FY 2025/26		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	
Estimated Total Consumers Age 15-26 Served	8	$28,653
Estimated Total Consumers Served Age 26-59	81	$28,653
Estimated Total Consumers Served Age 60+	28	$28,653

Program Description

Treatment takes place in member's community and focus on challenges in that environment. Program services include the treatment, rehabilitation and the supportive services a member needs e.g. assistance meeting daily living needs, housing, financial, physical health and dental care; personal and psychological well-being; work, education, social relationships and recreation; support and education to family, significant others, and community members. This is accomplished by providing a multidisciplinary team approach. This approach includes medication support, therapy, individual rehabilitation, targeted case management and therapeutic groups.

Top Community Issues

Our top community issues include increasing FSP capacity and increasing services to underserved/unserved populations; unhoused populations, and those that are Justice Involved. The Adult/Older Adults FSP Program is working to recruit and retain their mental health workers, so that this program can operate at full capacity and increase outreach to unhoused and justice-involved populations to better support these underserved populations. The major challenge for our program this fiscal year is vacant positions in our staffing.

Performance Goals and Intended Outcomes

Performance Goal	Intended Outcome	Data Source
Inpatient Hospitalization	5% or less	Quarterly Report
Incarceration	5% or less	Quarterly Report
Stable Housing	90% or greater	Quarterly Report

Strategies to Address Service Disparities for Unserved and Underserved Populations

All of our clients are underserved and have been unserved at one point. Our goal is to bring services to people who can't advocate for themselves to acquire them.

Program Priorities

The Adult/Older Adults FSP was established to serve those who were discharged from mental health hospitals with no treatment and housing. We are a targeted case management program that specifically works with folks to get them out of crisis and into a long-term mental health program to avoid unnecessary incarcerations, medical issues, and homelessness. We do this by offering the services listed above and by creating compassionate and solid relationships with our clients, our resources in the community, and the community in general.

Program Alignment with the General Standards of the MHSA

Community Collaboration: We want our community of FSP clients to be productive members of the larger community as they are tremendous individuals who have the ability to give back. We are hoping to have mental health awareness events for the community.

Cultural Competence: The Adult/Older Adults FSP strives to have the upmost cultural competence and we do this through educating one another, through listening and learning from our clients and engaging in trainings that address different cultures.

Client and Family Driven: Our clients are family and when they feel they don't have family support our groups and services provide that so they are not isolated. We work with clients to reestablish community and family ties and provide counseling for families. We also do our best to support the caregivers who are supporting loved ones that are struggling with severe mental health challenges.

Wellness, Recovery, and Resilience Focused: The Adult/Older Adults FSP is about recognizing strengths and building off them. We see the goodness in our clients and celebrate it and praise it.

Integrated Service Experiences for Clients and Family: Our team is a multidisciplinary team that works with clients in different ways but always with wellness and recovery at the heart. We also have connections with the resources in the community that can assist in supporting our clients with more care, less care, and different kinds of care.

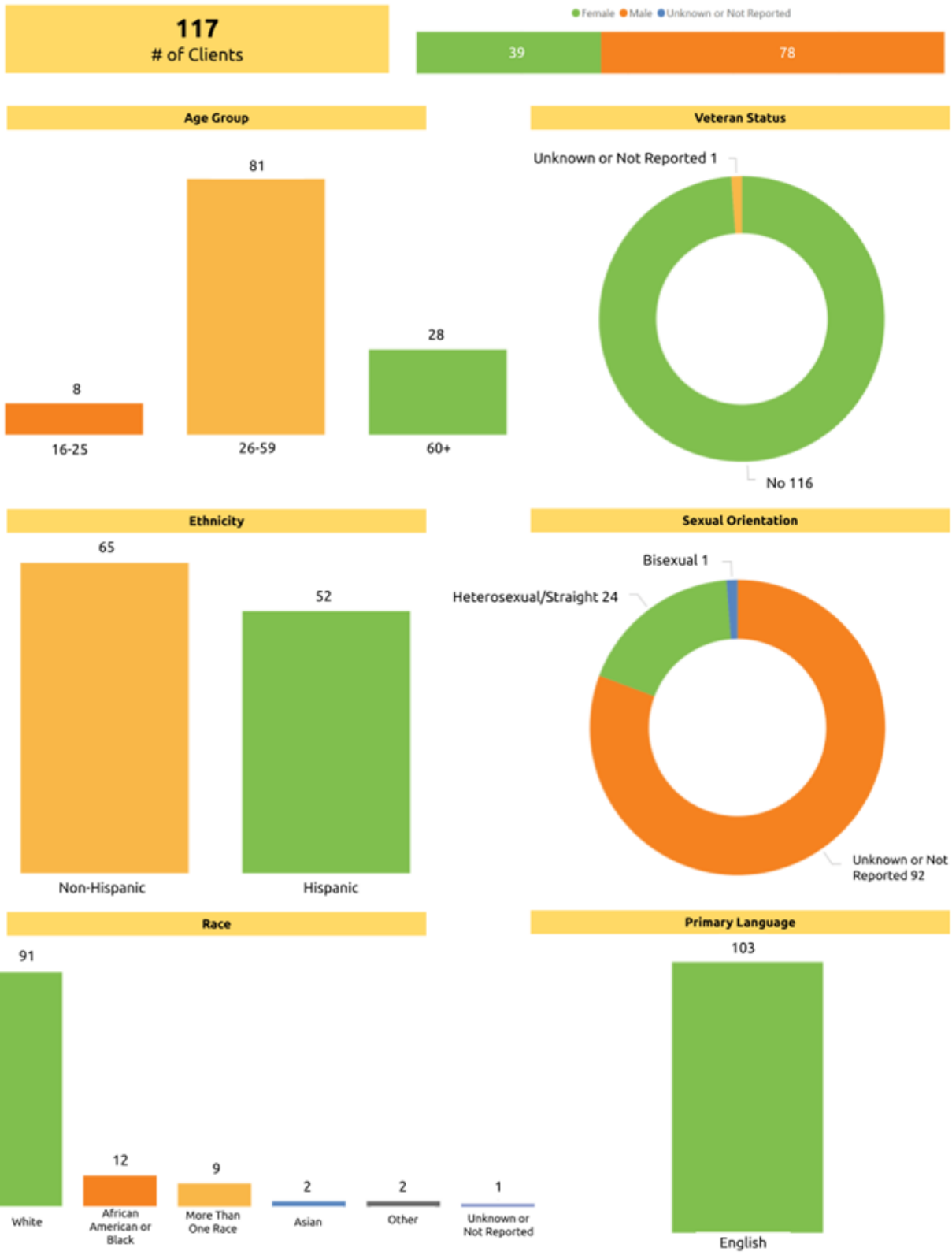
Criteria for Enrollment in FSP Services

Medi-Cal beneficiaries with serious mental illnesses or serious emotional disturbances are eligible to receive specialty mental health services in the form of Full-Service Partnerships (FSPs) through Behavioral Wellness and associated CBO's. Full Service Partnership services are designed for adults, older adults, TAY, or children with a serious mental illness and/or co-occurring diagnosis of substance use disorders or physical health impairments.

Changes to Service Delivery

Changes to service delivery will include reducing travel time in the field through the use of the Avatar drive time optimization tool, increasing use of telehealth and creating more efficient ways to complete collaborative documentation. Additionally, Santa Maria Adults/Older Adults FSP will now provide additional non-mental health supports such as financial assistance to aid in housing, funding for medications not covered by insurance, and other supports needed to help consumers meet their treatment plan goal. Telecare is in process of becoming Dual Diagnosis Capable to meet criteria of Senate Bill 43 by January 2026.

Program Demographics Reporting FY 23-24


117
# of Clients
Female
Male
Unknown or Not Reported
39
78
Age Group
8
16-25
81
26-59
28
60+
Veteran Status
Unknown or Not Reported 1
No 116
Ethnicity
65
Non-Hispanic
52
Hispanic
Sexual Orientation
Bisexual 1
Heterosexual/Straight 24
Unknown or Not Reported 92
Race
91
White
12
African American or Black
9
More Than One Race
2
Asian
2
Other
1
Unknown or Not Reported
Primary Language
103
English

Program: FSP Housing McMillan Ranch – North (Telecare)

Community Services and Supports, FSP Services: Report on Prior Fiscal Year Activities AND Program Plan

South Community Full Service Partnership (Formerly Supported Community Services) – PathPoint

Program Populations of Focus

Homeless	
Forensic	
Involved in Social Services System	
Unserved/Underserved	X
Cultural Population (specify below)	
Veterans	
Other (Specify Below)	X
Adults, Older Adults	X

Program Summary: The South Community Full Service Partnership (formerly Supported Community Services South) by PathPoint focuses on providing comprehensive support for individuals dealing with severe mental illnesses. Their multidisciplinary team offers field-based services including case management, therapy, and crisis assistance, aiming to expand access to underserved populations while reducing hospitalizations and incarcerations.

Available data on this program's outcomes for the prior fiscal year period, FY 23-24 is included as an Appendix to this document.

Program Performance, FY 24-25

We connect with clients in the Southern region of Santa Barbara County at various housing locations using the supportive-services mental health model. The underserved populations we work with in this FSP program are primarily people experiencing homelessness, dual diagnosis, and adults experiencing severe and persistent mental illness. Oftentimes we serve clients who have complex medical needs, such as mental health challenges combined with low-income economic situations. To provide services to Spanish speakers in our community we have maintained a workforce in the past fiscal year of four fluent Spanish speaking providers who have provided culturally and linguistically appropriate and effective care and coordination. When needed, we have also utilized the Language Line for any interpretation services needed for appointments. This field-based program reduces transportation barriers many face in our community by providing these services at home or in community service locations.

Addressing Community Issues

Full-service partnerships include a “whatever-it-takes” commitment to progress on concrete recovery goals. South Community FSP serves clients that meet System Development (SD) criteria AND are unserved/underserved and at risk of homelessness, incarceration, or hospitalization. By providing clinically appropriate, field based, 1/1 weekly in person support services to vulnerable populations and attempting to reduce some of the top community issues mentioned above through early intervention and prevention. Each staff has a 1/1 relationship with their client that then gets relayed to a larger team that includes psychiatric and RN guidance, intervention and support. By providing a person-centered approach to mental health services and a ‘walk alongside’ attitude, South Community FSP strengthens relationships which ultimately make connections that many of the high system utilizers may need to attain symptom reduction and community functioning. South Community FSP attends a weekly case conferencing meeting with other BWell partners and programs, which provides opportunity to coordinate services and triage those needing immediate care to ultimately reduce community impact.

Notable Community Impact

We continue to focus on transitioning clients who are ready for a lower level of care. This focus, and increased communication between the other programs (Outpatient clinics, Santa Barbara Adults/Older Adults, 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 shift has also led to the staff working more closely with clients on opportunities to graduate down to a lower level of care, including to community-based services, utilizing warm handoffs throughout all transitions. We also had many homeless clients who attained housing.

Program Plan for FY 25-26

Provider:	**PathPoint**
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$1,953,600
Estimated CSS Funding	$ 1,215,800
Estimated Medi-Cal FFP	$737,800
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$0
Average Cost Per Consumer	$15,144.18
Estimated Total of Consumers Served	129
Target Population Demographics Served	Adult, Older Adult

Estimated Consumers Served by Age FY 2023/24		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	
Estimated Total Consumers Age 15-26 Served	1	$15,656
Estimated Total Consumers Served Age 26-59	75	$15,656
Estimated Total Consumers Served Age 60+	50	$15,656

Estimated Consumers Served by Age FY 2024/25		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	$15,656
Estimated Total Consumers Age 15-26 Served	1	$15,656
Estimated Total Consumers Served Age 26-59	75	$15,656
Estimated Total Consumers Served Age 60+	50	$15,656

Estimated Consumers Served by Age FY 2025/26		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	
Estimated Total Consumers Age 15-26 Served	1	$15,144
Estimated Total Consumers Served Age 26-59	77	$15,144
Estimated Total Consumers Served Age 60+	51	$15,144

Program Description

All PathPoint programs provide the following services and supports:

- Independent living skills: Practical skills that include budgeting, personal hygiene, time management, health maintenance, etc.

- Activity skills: Community involvement, vocational opportunities, volunteering, goal setting, emotional tolerance, etc.
- Social skills: interpersonal, communication, cooperation, conflict management, communal living, boundary setting, overcoming isolation, anger management, self-advocacy, etc.
- Emotional skills such as anxiety reduction, relaxation, self-soothing, coping skills, emotional expression, mindfulness, impulse control, etc.
- Cognitive skills: positive thinking, challenging negative beliefs, acceptance, developing intentions.
- Skills for coping with mental illness: symptom management and recognition, learning about their mental illness, understanding medication, accepting their mental illness

South Community FSP consists of an FSP multidisciplinary team of staff including 2 Registered Nurses, 1 Psychiatrist, and a team of case managers who provide field-based community services to 115 clients living from Goleta to Carpinteria and downtown Santa Barbara. This FSP provides weekly in person case management, collateral, rehabilitation, therapy, and crisis services to adults experiencing severe and persistent mental illness.

Top Community Issues

The MHSA Community Planning Process identified expanding access to FSPs and shortening wait times to admittance in an FSP as a top priority. This program is attempting to increasing staffing in both North and South County to meet community need for FSP services

Performance Goals and Intended Outcomes

Performance Goal	Intended Outcome	Data Source
Inpatient Hospitalization	5% or less	Quarterly Report
Incarceration	5% or less	Quarterly Report
Stable Housing	90% or greater	Quarterly Report
Increase total number of persons served	Serve approximately 135 clients by the end of June 2026	Data Tracking Reports
Work with BWell to increase program capacity	Hire 1 FTE to serve approximately 15 new clients to expand program by the end of June 2026	Program Caseload Spreadsheet

Strategies to Address Service Disparities for Unserved and Underserved Populations

Our goal is to maintain Spanish speaking case workers and utilize the Language Line when needed to attain interpretation services. By increasing community access through field based and home-based services, barriers like transportation are reduced. By meeting a client where they feel most comfortable in their community this increases opportunity for family

involvement inside a household for example or peer support via community programs. South Community FSP is comprised of staff with unique backgrounds and experience levels which provides opportunity to serve a diverse population. By attaining and maintaining a diverse workforce we hope to reduce barriers and increase connections to those most vulnerable in our communities. Strong connections to other industry leaders and partners (Housing Authority, Cottage Hospital, BWell, PATH, Rescue Mission, Mental Wellness Center and others) provide another form of outreach and coordination to those interested in receiving services who may not be engaged already.

Program Alignment with the General Standards of the MHSA

Community Collaboration: Resources are shared in a collaborative process between agencies in each program though weekly team meetings designed to share resources, collaborate on client issues, and resource gathering. By making and maintaining strong community partnerships with local agencies PathPoint uses its reputation to build on these relationships to foster information sharing for families, clients and staff

Cultural Competence: PathPoint addresses Cultural Competency through multiple channels via Trainings: Implicit Bias, Cultural Humility, Onboarding-Person Centered Approach to working with individuals, Community: (Mental health First Aid, collateral interventions) and Workplace Culture: (Diversity and Inclusion Taskforce)

Client and Family Driven: Staff work alongside their clients relying on their input and direction to create goals and outcomes for their care. Involve family whenever possible to educate support and encourage engagement in client's care.

Wellness, Recovery, and Resilience focused: Staff in each program is trained and encouraged to promote hope, personal empowerment, respect, social connections, self-responsibility and self-determination. Staff do this by embodying these core values of recovery and reflecting it in their one-on-one interventions with their clients. Interventions are client driven and designed to foster personal growth and development and independence.

Integrated Service Experiences for Clients and Families: PathPoint uses its community connectedness as a way to share resources with family of those we support and encourage their participation when appropriate. By connecting to the larger community for resources PathPoint acts as a funnel for understanding available community resources.

Criteria for Enrollment in FSP Services

Referrals are people are already open to BWell and have met criteria for needing specialty mental health services with our county. Each referral is also reviewed by the program manager to ensure that the client will benefit from the level of care this FSP provides. Referring parties may address this by using a LOCRI and MORS as basic tools to demonstrate appropriate level of care. This along with clinic collaboration on referrals ensures clients are being enrolled in an

appropriate program and meet criteria for medical necessity. Enrollment for FSP include diagnosis of SPMI, multiple hospitalizations, incarcerations or incidents of homelessness.

Changes to Service Delivery

All PathPoint programs are exploring expansion of services due to high need. Expansion of services makes good fiscal sense since we already have the infrastructure in place and programs operating. South Community FSP is exploring increasing capacity to serve 15 more people. Additionally, South Community FSP will now provide additional non-mental health support such as financial assistance to aid in housing and help consumers meet their treatment plan goals.

Program Demographics

Reporting FY 23-24


129
# of Clients
Female
Male
Unknown or Not Reported
58
71
Age Group
77
51
1
16-25
26-59
60+
Veteran Status
No 129
Ethnicity
106
23
Non-Hispanic
Hispanic
Sexual Orientation
Heterosexual/Straight 14
Unknown or Not Reported 114
Race
101
12
11
1
1
1
1
1
White
African American or Black
More Than One Race
Alaska Native or Native American
Asian
Native Hawaiian or Other Pacific Islander
Other
Unknown or Not Reported
Primary Language
117
English

Community Services and Supports, FSP Services: Report on Prior Fiscal Year Activities AND Program Plan

North Community Full Service Partnership (Formerly Supported Community Services North)—TMHA

Program Populations of Focus

Homeless	
Forensic	
Involved in Social Services System	
Unserved/Underserved	X
Cultural Population (specify below)	
Veterans	
Other (Specify Below)	X
Adults/ Older Adults	X

Program Summary: The North Community Full Service Partnership (formerly Supported Community Services North) provides outpatient mental health treatment for severe and persistent mental illnesses, focusing on individual recovery roadmaps for independence and graduation from the program. Services cover community resources, employment support, and symptom management, with goals to reduce hospitalizations and incarcerations, as well as enhance housing stability and purposeful activities.

Available data on this program's outcomes for the prior fiscal year period, FY 23-24 is included as an Appendix to this document.

Program Performance, FY 24-25

The Transitions-Mental Health Association (TMHA) Santa Maria Full-Service Partnership (FSP) provides comprehensive outpatient mental health treatment for Transitional Age Youth (TAY), adults, and older adults experiencing severe and persistent mental illness. The intensive treatment team works to empower individuals by supporting their recovery, fostering independent living, and providing essential community-based mental health services. Participants receive assistance in developing skills that align with their values, preferences, and goals, ensuring they achieve the highest level of independence and recovery possible.

To address ethnic and cultural disparities, all staff receive ongoing training in Diversity, Equity, and Inclusion (DEI) and Trauma-Informed Care. Additionally, we prioritize language accessibility,

ensuring that clients receive services in their preferred language either directly from their provider or through translation services.

Addressing Community Issues

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.

Notable Community Impact

The program demonstrated notable success in serving the community:

- Total Clients Served: 85 unique individuals in FY 2023-2024.
- Psychiatric Hospitalization Rate: Only 1% of Santa Maria FSP clients required inpatient psychiatric hospitalization, significantly below the 5% target.
- Emergency Department Utilization: 4% of clients visited the emergency department, with an additional 4% hospitalized for physical health concerns.
- Incarceration Rate: Averaged at 1%, well below the 5% target.
- Stable Housing: 95% of clients maintained stable, permanent housing throughout the year.

These outcomes highlight the program's effectiveness in reducing emergency services utilization, lowering incarceration rates, and ensuring housing stability for vulnerable populations.

Program Plan for FY 25-26

Provider:	**Transitions Mental Health Association**
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$2,078,500
Estimated CSS Funding	$ 1,663,500
Estimated Medi-Cal FFP	$ 415,000
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$0
Average Cost Per Consumer	$24,452
Estimated Total of Consumers Served	85

Target Population Demographics Served	TAY, Adult, Older Adult

Estimated Consumers Served by Age FY 2023/24		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	
Estimated Total Consumers Age 15-26 Served	2	$18,996
Estimated Total Consumers Served Age 26-59	60	$18,996
Estimated Total Consumers Served Age 60+	27	$18,996

Estimated Consumers Served by Age FY 2024/25		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	
Estimated Total Consumers Age 15-26 Served	2	$18,996
Estimated Total Consumers Served Age 26-59	60	$18,996
Estimated Total Consumers Served Age 60+	27	$18,996

Estimated Consumers Served by Age FY 2025/26		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	
Estimated Total Consumers Age 15-26 Served	2	$24,452
Estimated Total Consumers Served Age 26-59	57	$24,452
Estimated Total Consumers Served Age 60+	26	$24,452

Program Description

North Community FSP provides outpatient mental health treatment for TAY, adults and older adults with severe and persistent mental illness. The intensive treatment team helps individuals to recover and live independently within their community. Program participants are assisted in their efforts to gain the skills needed to make choices that reflect their own values, preferences, and goals; supports are developed to meet each person's needs and to empower each individual to attain their highest level of independence and recovery possible. During recent years, the Program has shifted the focus to each consumer's unique recovery journey. Staff and consumers work together to identify recovery goals and to develop a specific "road map" for each individual, with an overall goal of reaching a level of recovery that enables an individual to graduate from the program. Program services include the following: Community resources; employment and educational supports; social system intervention; housing support; peer support; community integration; symptom assessment, management and individual supportive therapy; medication prescription, administration, monitoring and documentation, and substance abuse services.

Top Community Issues

The Community Program Planning Process identified expanding access to FSPs and shortening wait times to admittance in a FSP as a top priority. This program is attempting to increasing staffing in both North and South County to meet community need for FSP services.

Performance Goals and Intended Outcomes

Performance Goal	Intended Outcome	Data Source
Reduce psychiatric hospitalizations	Maintain hospitalizations at 5% or lower per quarter	Individual client tracking, FSP key events form, quarterly reports
Reduce incarcerations	Maintain incarcerations at 5% or lower per quarter	Individual client tracking, FSP key events form, quarterly reports
Increase stable/permanent housing	Maintain housing stability for 90% or more clients per quarter	Individual client tracking, FSP key events form, quarterly reports
Reduce physical health hospitalizations	Maintain hospitalizations at 5% or lower per quarter	Individual client tracking, FSP key events form, quarterly reports
Reduce emergency room visits	Maintain ER visit rates at 5% or lower per quarter	Individual client tracking, FSP key events form, quarterly reports
Increase purposeful activity	Increase engagement in meaningful activities by 15% per quarter	Individual client tracking, FSP key events form, quarterly reports

Improve MORS scores	Improve Milestones of Recovery Scale (MORS) scores by 20% per quarter	Monthly team assessments of individual MORS scores

Strategies to Address Service Disparities for Unserved and Underserved Populations

The program hires bilingual/bicultural staff when possible to ensure we can adequately serve our population. Our staff are also given frequent opportunities to attend diversity, equity and inclusion trainings annually.

Program Alignment with the General Standards of the MHSA

Community Collaboration: The program works with community agencies who can provide adjunct services and supports to clients for services the program does not provide.

Cultural Competence: Staff are required to attend diversity, equity and inclusion training throughout the year. These trainings include topics of serving unhoused and justice involved populations.

Client and Family Driven: The team supports client families by connecting them with our family services program. The team works to support a healthy family dynamic.

Wellness, Recovery, and Resilience Focused: The program focuses on strengths, wellness rather than on illness and diagnosis.

Integrated Service Experiences for Clients and Family: The program leverages the support of our multiple TMHA programs to support clients in their recovery: Family Services, Supported Employment Program, Growing Grounds Farm, The Recovery Learning Communities, and Central Coast Hotline

Criteria for Enrollment in FSP Services

Referred people are already open to BWell and have met criteria for needing specialty mental health services with our county. Each referral is also reviewed by the program manager to ensure that the client will benefit from the level of care this FSP provides. Referring parties may address this by using a LOCRI and MORS as basic tools to demonstrate appropriate level of care. This along with clinic collaboration on referrals ensures clients are being enrolled in an appropriate program and meet criteria for medical necessity. Enrollment for FSP include diagnosis of Serious and Persistent Mental Illness, multiple hospitalizations, incarcerations or incidents of homelessness.

Changes to Service Delivery

For the upcoming fiscal year, several adjustments are planned to enhance service delivery:

1. Peer Certification Implementation: With California's recognition of the value of peer support, we plan to integrate peer-certified staff into our FSP team. However, their effectiveness is currently limited by restricted Current Procedural Terminology (CPT) coding authorization. Advocacy is needed to expand billing codes, ensuring peers can operate at their full capacity.

2. CalAIM Payment Reform & EHR Transition: The shift to the new electronic health record (EHR) system and CalAIM payment reform posed operational challenges.

3. Staffing Shortages: Recruiting and retaining clinical staff continues to be a critical challenge. Clinical personnel are essential for conducting assessments, determining levels of care, providing therapy, and overseeing treatment teams. Persistent workforce shortages have placed a strain on service delivery.

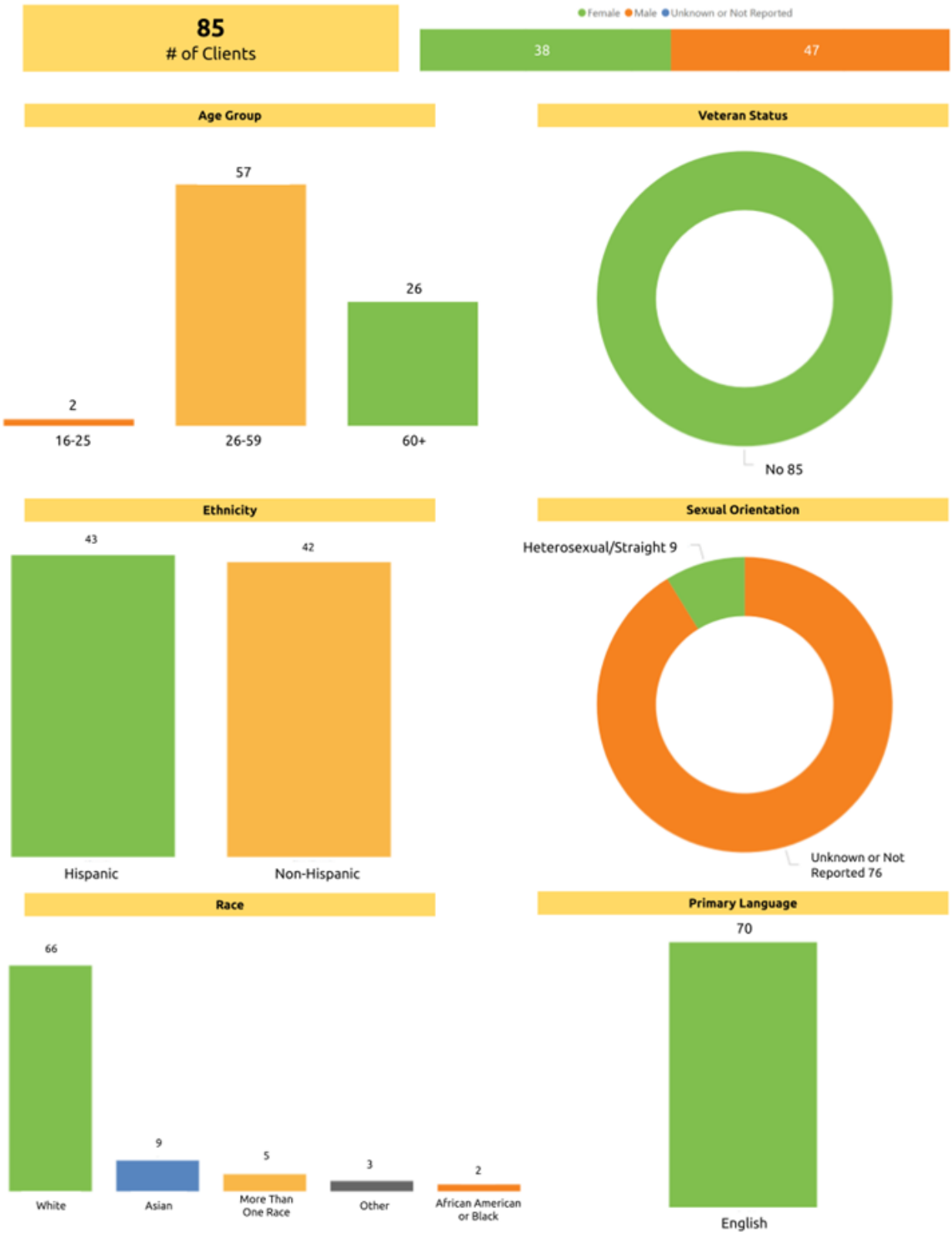
4. Administrative & Compliance Struggles: The evolving system of care has required additional external guidance, particularly regarding compliance with the Department of Health Care Services (DHCS). The reliance on third-party hiring agencies to fill vacant roles has significantly increased financial burdens, diverting resources away from direct services.

5. Contractual Incentives: Tracking, reporting, and maintaining compliance with contractual incentives required substantial administrative effort, stretching our already limited capacity.

To address these challenges, it is crucial to advocate for enhanced internal support, streamlined hiring processes, and sustainable workforce development strategies. Without these improvements, our capacity to deliver high-quality, consistent care remains at risk.

Program Demographics

Reporting FY 23-24


85
# of Clients
Female Male Unknown or Not Reported
38
47
Age Group
57
26
2
16-25
26-59
60+
Veteran Status
No 85
Ethnicity
43
42
Hispanic
Non-Hispanic
Sexual Orientation
Heterosexual/Straight 9
Unknown or Not Reported 76
Race
66
9
5
3
2
White
Asian
More Than One Race
Other
African American or Black
Primary Language
70
English

Community Services and Supports, FSP Services: Report on Prior Fiscal Year Activities AND Program Plan

SPIRIT FSP Wraparound Services

Program Population(s) of Focus

Homeless	
Forensic	
Involved in Social Services System	
Unserved/Underserved	X
Cultural Population (specify below)	
Veterans	
Other (Specify Below)	X
Children	X

Program Summary: The SPIRIT FSP aids children (ages 6-15) and families through therapy, crisis evaluations, and accessing vital services. Priorities include enhancing mental health programs for youth, addressing service disparities and aligning with MHSA standards, while eligibility involves significant functional impairments and involvement in or being at risk of criminal justice entanglement due to mental health conditions.

Available data on this program's outcomes for the prior fiscal year period, FY 23-24 is included as an Appendix to this document.

Program Performance, FY 24-25

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. This population typically has limited resources, has failed to thrive with conventional treatment, and has children at risk for placement in out-of-county, high-level group home facilities due to emotional and behavioral issues.

The SPIRIT team consists of the following: Mental Health Practitioner/Family Facilitator, Peer Parent Partner and a Caseworker. 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 after hours and on weekends. SPIRIT children are typically also being served by a Psychiatric Technician and/or Registered Nurse and Psychiatrist through the Behavioral Wellness Children's Clinic. Together they provide a comprehensive, multidisciplinary team offering an array of intensive services to prevent decompensation.

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 are 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.

SB Children's Clinic continues to utilize bilingual case workers and parent partner in the SPIRIT FSP program. We also use Language Line and other contracted provider services for translation as necessary.

During FY 24-25, we have had vacancies in both the case worker and practitioner position during the course of the year. By Nov 2024 we had hired these positions and are now fully staffed with a practitioner, case worker and parent partner in each region. The caseload had significantly decreased because of staffing, but it is now steadily growing.

Addressing Community Issues

The SPIRIT team strives to implement specialty mental health services within the home and/or community with a 'whatever it 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.

We continue to try and meet the needs of every client and their family. To do this, we utilize assessments, interviews, and weekly sessions. We offer support and services referrals as needed, including transportation and helping to fill out applications or writing letters of recommendation.

Notable Community Impact

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.

Program Plan for FY 25-26

Provider:	**Behavioral Wellness**
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$3,056,600
Estimated CSS Funding	$1,682,000
Estimated Medi-Cal FFP	$1,330,600
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$44,000
Average Cost Per Consumer	$37,275.60
Estimated Total of Consumers Served	82
Target Population Demographics Served	Children, TAY

Estimated Consumers Served by Age FY 2023/24		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	76	$36,035
Estimated Total Consumers Age 15-26 Served	11	$36,035
Estimated Total Consumers Served Age 26-59	0	
Estimated Total Consumers Served Age 60+	0	

Estimated Consumers Served by Age FY 2024/25		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	76	$36,035
Estimated Total Consumers Age 15-26 Served	11	$36,035
Estimated Total Consumers Served Age 26-59	0	
Estimated Total Consumers Served Age 60+	0	

Estimated Consumers Served by Age FY 2025/26		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	65	$37,275
Estimated Total Consumers Age 15-26 Served	17	$37,275
Estimated Total Consumers Served Age 26-59	0	
Estimated Total Consumers Served Age 60+	0	

Program Description

The Spirit FSP serves Children and Youth aged 6-15 and their families. This FSP provides wraparound evidence-based practices, meaning that a comprehensive, individualized, and family-centered approach to addressing the complex needs of children is used with every family. This FSP provides therapy, case management, crisis evaluations, and evaluations for involuntary hospitalization; interviews clients to obtain pertinent information including psychiatric, social, educational, and vocational history; makes field visits to evaluate clients to determine needs for services; assists clients in obtaining suitable services such as housing, vocational rehabilitation, financial assistance, and employment; helps clients develop necessary skills for everyday living; provides transportation for clients to obtain needed services; cooperates with other agencies and professionals to coordinate services for mutual clientele; Participates in interdisciplinary team reviews/ Team Based Care meetings for collaborative assessment and treatment planning to ensure quality care; conducts social, recreational, or occupational skill development in accordance with the treatment plan; observes and reports to licensed staff observations of client's behaviors; confers with licensed staff regarding needed services and referrals to other community agencies; Serves as a point of contact to community agencies or contract service providers when programmatic issues arise; Documents client activity according to established departmental guidelines under supervision of licensed professional staff.

Top Community Issues

Low staffing in mental health services make receiving services more difficult to obtain or take longer to obtain, this results in longer wait times for services for children and their families.

Performance Goals and Intended Outcomes

Performance Goal	Intended Outcome	Data Source

Unique clients engaged in purposeful activity	95% or higher	Quarterly Program Report
Unique clients discharged to higher level of care	10% or less	Quarterly Program Report
Unique clients discharged to lower level of care	90% or lower	Quarterly Program Report

Strategies to Address Service Disparities for Unserved and Underserved Populations

Strategies to be implemented include more services provided in the community and at times that work for clients and families (i.e. outside "regular" working hours) and using engagement strategies to engage clients in services.

Program Priorities

The Community Program Planning Process identified increasing mental health programs and interventions for Youth and Families.

Program Alignment with the General Standards of the MHSA

Community Collaboration: We work with CBOs to provide the most appropriate services to our clients

Cultural Competence: Staff continue to receive annual cultural competency training.

Client and Family Driven: Staff work with clients and families (when appropriate) to make and progress towards client goal.

Wellness, Recovery, and Resilience Focused: Services are evidenced-based and a team-based approach. Staff are trained and educated in client's wellness, recovery, and resiliency.

Integrated Service Experiences for Clients and Family: Staff include family and cultural pieces to best serve our clients. Should more appropriate services be needed, referrals will be made.

Criteria for Enrollment in FSP Services

- Age 5-16
    - Client has been diagnosed with a Serious Emotional Disturbance; Client has significant functional impairments in the following areas as demonstrated by at least one of the following conditions:
- At risk of losing home placement (i.e. risk of homelessness, psychiatric hospitalization, residential treatment or multiple foster placements) due to their mental health condition.
- Involvement or at risk of involvement in the criminal justice system due to their mental health condition.

- High risk behaviors (i.e. self-injurious, run away, potential for CSEC involvement).
- Inability or limited ability to perform daily living tasks without prompts or support, which are likely to lead to significant consequences (i.e. client is not able to manage hygiene/self-care to the point where there is serious risk).
- Inability or limited ability at maintaining consistent employment or achieving educational goals (i.e. suspension, expulsion, failing classes, not making credits, excessive absences or dropping out, risk of losing job, etc.), and/or social/behavioral impairment due to their mental health condition.
- Client displays one or more of the following problems, which are indicators of continuous increased service needs:
    - 2 or more contacts per year with crisis services and/or emergency room and/or psychiatric hospitalization within the last 6 months, or at current risk of hospitalization.
    - Severe mental health symptoms/impairments, such as symptoms of psychosis, suicidality, disassociation, delusions, paranoia, etc. physical aggression to the point where it affects functioning in an important area of the consumer's life.
    - Dual Diagnosis (substance abuse and mental health diagnosis) of significant duration, and/or Severe Emotional Conditions (with an included primary mental health diagnosis)
    - Difficulty effectively utilizing traditional office-based outpatient services. Consumer requires support to increase engagement in services.
    - Consumer is currently receiving multiple clinic-based services and adjunct services and is requiring more intensive services.

Changes to Service Delivery

Spirit FSP will now provide additional non-mental health supports such as financial assistance to help consumers meet their treatment plan goals. The department continues to offer both onsite, in community and virtual services as preferred by clients which assists with ameliorating any geographical barriers to efficient access to all types of services offered.

The department has also increased support to FSP staff regionally (in additional to clinic leadership) both on the adult and children's system of care with the new hire of the FSP Manager.

Program Demographics: Reporting FY 23-24


82
# of Clients
Female Male Unknown or Not Reported
48
34
Age Group
65
17
0-15
16-25
Veteran Status
Unknown or Not Reported 6
No 76
Ethnicity
59
16
7
Hispanic
Non-Hispanic
Unknown or Not Reported
Sexual Orientation
Heterosexual/ Straight 9
Unknown or Not Reported 73
Race
70
3
3
2
2
1
1
White
Alaska Native or Native American
Unknown or Not Reported
Asian
More Than One Race
African American or Black
Other
Primary Language
59
English

Community Services and Supports, FSP Services: Report on Prior Fiscal Year Activities AND Program Plan

Justice Alliance FSP

Program Populations of Focus

Homeless	
Forensic	X
Involved in Social Services System	
Unserved/Underserved	X
Cultural Population (specify below)	
Veterans	
Other (Specify Below)	X
Adults/Older Adults	X

Program Summary: The Justice Alliance program aids justice-involved individuals via specialized court initiatives, linking them to mental health treatment and community resources to resolve legal issues. It aims to reduce higher levels of care, track referrals and monitor client progress using assessments. Through court collaboration and additional non-mental health supports like financial assistance for housing, the program seeks to enhance services for client recovery and stability.

Available data on this program's outcomes for the prior fiscal year period, FY 23-24 is included as an Appendix to this document.

Program Performance, FY 24-25

The Justice Alliance countywide program is a specialized Full Service Partnership (FSP) designed to provide transitional and supportive services to individuals with mental health needs who are justice-involved. Its primary focus is to eliminate barriers to treatment access and help individuals navigate both the criminal justice and behavioral health systems. The program aims to stabilize clients, support their reintegration into the community, and reduce recidivism, ultimately connecting them to longer-term care options such as the Adult/Older Adults FSP program or outpatient clinics.

The individuals served often face co-occurring substance use disorders, with many coming from underserved or unserved ethnically diverse populations. These clients require integrated, personalized mental health and substance use treatment.

The program continues to face significant challenge due to the ongoing changes and implementation of Senate Bill 317, which mandates that individuals found incompetent to stand trial with a misdemeanor charge receive a placement recommendation within 30 days. This has significantly increased the number of court referrals, leading to a higher workload for Justice Alliance staff, who must produce treatment recommendations in 15 working days or less. These recommendations often require a thorough review of arrest reports and mental health histories. When the program receives 2-3 court referrals per day, it becomes increasingly difficult to meet the demands of the placement process.

Additionally, the program faced challenges as a result of the expansion of Assembly Bill 1810, which increased the number of referrals for individuals with felony charges who are believed to suffer from a mental health disorder and are referred for mental health diversion. This has led to further strain on program resources, as clinicians are tasked with quickly evaluating and preparing treatment plans, ensuring appropriate placements within the mandated timelines.

Moreover, the program faces delays due to the need for court approval of treatment plans, including a release order from custody. Caseworkers are also tasked with completing Crisis Residential Treatment (CRT) packets and coordinating placements at CRTs in both north and south counties. The transportation of clients from Santa Maria to Santa Barbara for CRT placement adds further complexity to the case management process.

In response to these challenges, Behavioral Wellness has forged several new partnerships to improve service delivery. These include collaborations with the Public Defenders' and District Attorney's Offices to launch the Rapid Diversion Pilot program in Santa Maria, which identifies individuals eligible for diversion to treatment, reducing jail time and criminal convictions. Additionally, Behavioral Wellness has worked with the Public Defenders' Office and the Probation Department to develop the Familiar Faces program, targeting high utilizers of community services to reduce crisis events and encourage engagement in treatment. The newly implemented Behavioral Health Linkages program, in collaboration with the Sheriff's Office, Public Defenders' Office, and Probation Department, facilitates the smooth transition of individuals from custody to appropriate outpatient or FSP programs, aiming to reduce recidivism and ensure continuity of care.

Addressing Community Issues

Justice Alliance team members work closely with a variety of forensic partners to include the Court, Probation, Public Defender, Sheriff, District Attorney, Community-Based Organizations and other Department of Behavioral Wellness treatment teams to make treatment

recommendations and facilitate access and linkage to treatment. Justice Alliance also provides ongoing progress reports to the Court supporting client's reintegration with the goal of preventing recidivism, reincarceration and decompensation. Justice Alliance practitioners are responsible for the initial assessments to determine the client's level-of-care need and ensure a warm hand-off to the most appropriate long-term mental health and/or substance abuse treatment program(s) in the community.

Notable Community Impact

The Justice Alliance team has had a significant impact on the community, particularly through its support of clients released from county jails to Crisis Residential Treatment (CRT) programs for mental health care and reintegration into the community. The team has worked closely with the Behavioral Wellness Homeless Services team to transition clients from CRTs to dedicated shelter beds in both northern and southern counties, as well as to residential treatment programs and board and care facilities when appropriate.

Through these linkages, the Justice Alliance team has helped prevent homelessness and provided structure and support for clients' daily activities. The emphasis on short-term engagement through the Justice Alliance program encourages clients to accept treatment, maintain regular meetings with their mental health teams, and adhere to prescribed medications. These efforts have led to positive outcomes, with clients successfully transitioning to long-term mental health programs that offer continued services in their home communities.

In the past year, Justice Alliance received a total of 393 referrals, which included discharge planning for CRTs, Mental Health Diversion Plans, Mental Health Treatment Court screenings, and Misdemeanor IST treatment plans. The overarching goal is to reduce the likelihood of clients being re-arrested, incarcerated, or hospitalized.

Program Plan for FY 25-26

Provider:	**Behavioral Wellness**
Estimated Funding FY 2024/25:	
Estimated Total Mental Health Expenditures	$3,555,600
Estimated CSS Funding	$2,553,300
Estimated Medi-Cal FFP	$1,002,300
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$0

Average Cost Per Consumer	$9,047
Estimated Total of Consumers Served	393
Target Population Demographics Served	TAY, Adult, Older Adult

Estimated Consumers Served by Age FY 2023/24		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	$14,961
Estimated Total Consumers Age 15-26 Served	21	$14,961
Estimated Total Consumers Served Age 26-59	171	$14,961
Estimated Total Consumers Served Age 60+	23	$14,961

Estimated Consumers Served by Age FY 2024/25		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	$14,961
Estimated Total Consumers Age 15-26 Served	21	$14,961
Estimated Total Consumers Served Age 26-59	171	$14,961
Estimated Total Consumers Served Age 60+	23	$14,961

Estimated Consumers Served by Age FY 2025/26		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	
Estimated Total Consumers Age 15-26 Served	41	$9,047
Estimated Total Consumers Served Age 26-59	321	$9,047
Estimated Total Consumers Served Age 60+	31	$9,047

Program Description

The Justice Alliance program provides services and supports to a number of different programs:

Incompetent to Stand Trial (IST) Court: The Behavioral Wellness clinical psychologist and post-doctoral intern who are part of the Behavioral Wellness Justice Alliance team meet with clients who have been found incompetent to stand trial on misdemeanor charges. They meet with the client to determine if a client is receptive to mental health treatment and can benefit from placement at crisis residential treatment facility (CRT). The clinical psychologist and post-doctoral intern are part of a court team that includes the judge, public defender and the district attorney who review client cases on a weekly basis. Justice Alliance caseworkers provide linkage from clients being released from county jail to a Crisis Residential Treatment program (CRT). Justice Caseworkers work with the clients in reactivating health care benefits if necessary, identifying shelter beds and housing opportunities for clients after their 90-day stay at the CRT. Clients who show a willingness to engage in mental health treatment and are active and consistent in ongoing mental health treatment can successfully graduate and have their charges dropped.

Mental Health Treatment Court/ Mental Health Diversion: Justice Alliance staff (i.e. Practitioner, Post Doc Intern and Peer Recovery Assistant) attend these treatment courts and determine if a client is eligible for Mental Health Treatment Court via a screening or assessment. The court team consists of a judge, public defender/ client's legal counsel, district attorney, probation, Behavioral Wellness staff and a representative from Sanctuary Centers. The client is informed that participating in MHTC can assist clients in resolving, and in most cases, having their legal charges dismissed, if the client is able to show consistency in receiving mental health treatment. Clients already receiving mental health services with a Behavioral Wellness program can qualify for mental health treatment court. Clients who are active Behavioral Wellness clients can be found eligible for Mental Health Diversion to address their legal charges through consistent mental health treatment. Justice Alliance staff including Clinical Psychologist and BWell Practitioner) staff will complete mental health diversion plans for clients referred by the court who appear to have a qualifying mental health disorder. The Justice Alliance team attends treatment courts in north and south county regions respectively to provide treatment updates on clients receiving services Behavioral Wellness and the department's identified contracted programs (i.e. TMHA, TeleCare , Merakey, Crestwood and Telecare Crisis Residential Treatment program). The Justice Alliance team is the primary mental health treatment provider with some of the clients in MHTC. The Justice Alliance team provides targeted case management to link clients to community resources (i.e. shelter, housing, medical care, food stamps, health care benefits, medication support, substance use disorder treatment and identify healthy community supports).

Assembly Bill 1810 Department of State Hospital Diversion Program: Clients referred to the Assembly Bill 1810 program are clients who have been charged with a felony and have been

found not competent to stand trial. The program offers an opportunity to receive mental health treatment in the community instead of placement at Department of State Hospitals (DSH). The client must show a willingness to accept mental health treatment. The Client must have a qualifying diagnosis of one of the following: Bipolar Disorder, Schizoaffective disorder or Schizophrenia. The client must not pose a danger to the community. Client must accept being in the AB1810 program for two years. Clients are placed at Crisis Residential Treatment Facility (CRT) upon release from jail and then transition to the Good Samaritan Life House. Clients can transition from Life House to other housing programs and housing opportunities in the community with additional funds, while the client is in the AB1810 program. The Justice Alliance team supports clients by transitioning the client from county jail to CRT. The JA caseworker assists in clients accessing resources in the community, including: applying for a CA ID card, health care benefits, (i.e. Cencal) Cal Fresh benefits, Social Security disability benefits, housing referrals, substance abuse treatment referrals and identifying healthy community supports to help the client maintain in the community.

Top Community Issues

Justice Involved populations remain a high priority population as identified by the Community Program Planning Process. The Justice Alliance FSP serves 18 years or older individuals that are Justice Involved.

Performance Goals and Intended Outcomes

Performance Goal	Intended Outcome	Data Source
Track number referrals to the three CRTs in Santa Barbara County and placement outcome from county jail to Crisis Residential Treatment (CRT)	Track the number of clients who were referred from county jail and successfully admitted into the CRT	Crisis Residential Treatment (CRT) Smartsheet
Track the decrease in the number of clients meeting FSP level of care at Level 4, transitioning to lower levels f care such as Community Support, Clinc Level, or Wellness Center/Community Level.	Monitor progress of clients receiving mental health treatment, tracking if they transition to a lower level of care upon discharge.	Adult Needs and Strengths Assessment (ANSA)

Strategies to Address Service Disparities for Unserved and Underserved Populations

The Justice Alliance team assists clients to access needed community resources and services. Here are some examples: to gain CA ID cards, health benefits, general relief benefits, apply for Social Security disability benefits or regular Social Security benefits if the client meets the age criteria. Client can access services and necessities (i.e. healthcare, food, hygiene products, and money to pay for housing and banking services) when they are linked to these resources.

Program Priorities

Increasing services to those that are Justice Involved is a priority identified in the Community Program Planning Process.

Program Alignment with the General Standards of the MHSA

Community Collaboration: Justice Alliance team collaborates with our court partners, treatment providers and housing programs in Santa Barbara County.

Cultural Competence: Staff provide services in the language preferred by the client with bilingual staff or throughout the language line. Staff will review cultural norms for a client outside the staff's own experience with the client's culture.

Client and Family Driven: Client and their families are informed of the benefits of receiving mental health treatment with the Justice Alliance team to resolve their legal charges and improve the client's quality of life.

Wellness, Recovery, and Resilience Focused: The Justice Alliance team provide positive reinforcement on the client's healthy choices to promote an overall sense of wellbeing. The Justice Alliance team will encourage client to seek treatment to address a substance use disorder that places the client at risk of decompensation and risk of incarceration in county jail. Justice Alliance staff are aware that each client's path to recovery will vary and provides support to the client when there is a period of inconsistency in mental health treatment and relapse into drug use. The Justice Alliance team will remind the client of their strengths and the challenges the client has overcome in their recovery journey.

Integrated Service Experiences for Clients and Families: The Justice Alliance team will collaborate with the client and their families in assisting the client access needed community resources to maintain in the community and decrease the risk of arrest with new legal charges.

Criteria for Enrollment in FSP Services

Justice Alliance clients are those that are referred via Mental Health Treatment Court and meet the criteria for FSP eligibility. FSP eligibility is: Medi-Cal beneficiaries with serious mental illnesses or serious emotional disturbances are eligible to receive specialty mental health services in the form of Full-Service Partnerships (FSPs) through Behavioral Wellness. Full Service Partnership services are designed for adults, older adults, TAY, or children with a serious mental illness and/or co-occurring diagnosis of substance use disorders or physical health impairments.

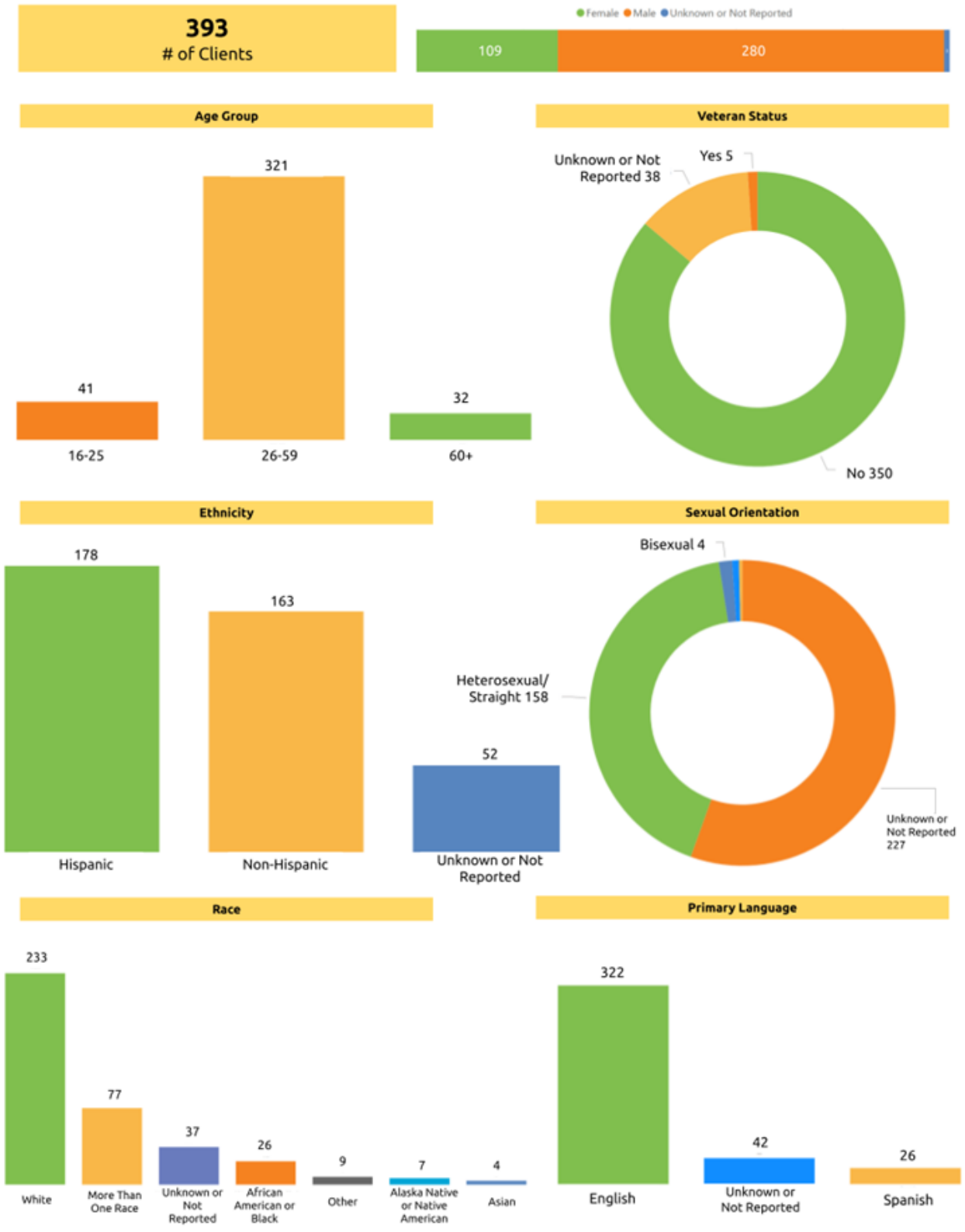
Changes to Service Delivery

For FY 25-26, the Department of Behavioral Wellness will expand the Justice Alliance FSP by adding two supervisors, a manager and peer recovery specialists to enhance service delivery and meet the growing needs of diversion programs, more specifically the Department of State Hospital Assembly Bill 1810 Diversion program. These additions will help the team provide a comprehensive array of services as these clients will require daily contact with Behavioral Wellness staff, including four weekly group sessions, as part of their FSP-level care.

Additionally, the Justice Alliance FSP will now offer expanded non-mental health support services, including financial assistance for housing and other resources to help clients meet their treatment goals.

Program Demographics

Reporting FY 23-24



Sexual Orientation not collected in FY22/23; will start collecting in FY23/24

Outreach and Engagement Program: Report on Prior Fiscal Year Activities AND Program Plan

Homeless Outreach Services—Behavioral Wellness, Good Samaritan

Program Populations of Focus

Homeless	X
Forensic	
Involved in Social Services System	
Unserved/Underserved	
Cultural Population (specify below)	
Veterans	
Other (Specify Below)	X
TAY, Adults, Older Adults	X

Program Summary: The Homeless Outreach program aims to assist homeless individuals by providing them with mental health services, substance use disorder treatment, and essential support to become eligible for housing opportunities. It focuses on transitioning clients from homelessness to shelters/interim housing, facilitating access to health and cash benefits, and aiding in securing permanent supportive housing or rentals with housing vouchers.

Available data on this program's outcomes for the prior fiscal year period, FY 23-24 is included as an Appendix to this document.

Program Performance FY 24-25

Good Sam:

In the current fiscal year, beginning July 1, 2024, Good Samaritan Shelter's Homeless Clinicians Program has successfully served 102 adult individuals who qualified for specialty mental health services based on the results of their CalAIM assessments. All individuals served by the Homeless Clinicians Program are either currently experiencing homelessness, have recently experienced homelessness, and/or are enrolled in substance use treatment programs. These populations often face significant barriers to accessing care, including systemic ethnic and cultural disparities. By providing mental health services tailored to their specific needs, the program has been able to engage these hard-to-reach populations, ensuring they receive timely and effective care.

A key success of the program is Good Samaritan Shelter's ability to connect individuals to a lower level of care through our Cencal Health contract for behavioral health services after they successfully meet all of their treatment goals through the specialty mental health services provided. This demonstrates the program's effectiveness in delivering treatment that not only addresses immediate mental health needs but also supports long-term stability and recovery with continuity of care. Clients are typically served an average of 223 days in a specialty mental health services treatment episode through Good Samaritan Shelter's Homeless Clinicians program.

BWELL:

The Department of Behavioral Wellness Homeless Services program has two branches, the Homeless Outreach team and the Early Intervention team (see PEI section to learn more); these teams provide early intervention, 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. Chronically homeless individuals have needs that 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 and to unserved/underserved homeless individuals. There are several bilingual staff to address linguistic and cultural disparities. 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.

The Early Intervention team consists of Behavioral Wellness staff (2 caseworkers, one supervisor/practitioner, a psychiatric nurse and Administrative Office Professional), Santa Barbara County Public Defender's Office (Holistic Defense) staff and Santa Barbara Public Health nurses and administrator has made positive impacts in the collaboration to work with complex cases consisting of clients with a mental health disorder, involvement with the legal system and a physical health condition. The Early Intervention team developed a referral system that will allow the community to make a client referral to the Early Intervention team. A tight housing market has contributed to a lack of housing opportunities, yet we continue to help find permanent supportive housing to individuals experiencing homelessness.

The Homeless Outreach team also has Behavioral Wellness staff (a Practitioner and 2 caseworkers and also utilize the psychiatric nurse, supervisor and Administrative Office Professional staff.) These staff work with general referrals and administer the beds and tiny homes at La Posada, the Path shelter, and the Salvation Army.

The Early Intervention team and the Homeless Outreach team have addressed ethnic and cultural barriers by hiring native Spanish speaking staff to improve outreach and rapport with Spanish

speaking clients. Also, the Early Intervention team and general team use interpreter services when needed for all ethnic and cultural groups encountered.

Addressing Community Issues

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.

The Homeless Outreach program is addressing the community's concern about homelessness by outreaching to individuals experiencing homelessness. The Homeless outreach team works to transition individuals experiencing homelessness to identified shelter beds and assist clients to become document ready for housing opportunities. The Homeless outreach team advocates for clients to be considered for housing opportunities in permanent supportive housing and other housing opportunities with a tenant or project-based housing voucher through collaboration with our county partners including Santa Barbara County Housing Authority. Our community partners including City Net and Good Samaritan Shelters assist our clients in being considered for housing opportunities in different regions of the county. Our team aids clients in developing a safe and stable living situation that allows most clients to live in their respective communities. These housing opportunities allow The Homeless outreach team assist clients to gain a California ID, health care benefits, Cal Fresh benefits, Social Security cards and SSI benefits if eligible. These benefits help clients access needed health care, nutrition, banking services to purchase needed items The Homeless Outreach team offers the clients to consider and hopefully accept mental health treatment. The Homeless Outreach team provides a warm handoff for the client to continue mental health treatment with a long-term care outpatient mental health treatment program.

Notable Community Impact

Good Samaritan:

Good Samaritan Shelter's Homeless Clinicians Program continues to make a significant impact in addressing the mental health needs of unsheltered and underserved populations in our community. By expanding the locations where services are provided, the program aims to reduce barriers to care and reach clients in the environments where they are most comfortable. This approach underscores our commitment to meeting clients "where they are" – both

physically and mentally – ensuring that services are accessible to those who may face challenges in visiting traditional clinical settings.

Expansion of Service Locations and Outreach Efforts: During the past fiscal year, the program significantly expanded its service delivery to unsheltered individuals, particularly those living in riverbeds and waterways. Two of our clinicians regularly went out into these locations, providing on-site screening, assessments, and individual therapy sessions to individuals who are unsheltered and homeless. This direct outreach has allowed the program to engage individuals who might otherwise have been excluded from traditional services due to physical or psychological barriers.

In addition to these outreach efforts, the Homeless Clinicians Program regularly provides on-site mental health services at six shelter locations across Santa Barbara County:

1. Santa Maria Emergency Shelter
2. Lompoc Bridgehouse
3. Hope Village Santa Maria
4. Hedges House of Hope Goleta
5. Dignity Moves Santa Barbara
6. La Posada Santa Barbara

The program also operates in three residential treatment settings:

1. Recovery Way Home in Lompoc
2. TC House in Santa Maria
3. Santa Maria Acute Care

This wide-reaching service network has helped ensure that individuals in shelters and residential treatment settings receive timely mental health support, reducing the need for clients to seek out external services and enabling more consistent care. By expanding services into these diverse locations, the Homeless Clinicians Program has made a tangible impact in reducing barriers to mental health services. Unsheltered individuals, many of whom face complex challenges related to both homelessness and mental health issues, are now able to receive care where they reside. This has improved engagement with mental health services, allowing for more comprehensive care for vulnerable populations.

Furthermore, the program's ability to provide on-site care at both shelters and residential treatment facilities means that clients enrolled in treatment for substance use disorders can receive concurrent mental health support, ensuring a holistic approach to their overall well-being.

The expansion of service locations and outreach efforts has significantly contributed to improving access to care for homeless and at-risk individuals across the county, reducing gaps in service provision and helping to build a more inclusive, accessible mental health system.

BWell: The increase in staffing for the Behavioral Wellness team has allowed our clients to have access to needed community resources. It has also allowed us to provide outreach to individuals who are difficult to engage in various homeless encampment sites along the south county region of Santa Barbara County. The hiring of the psychiatric nurse allows for our Homeless services team to treat the whole person. The psychiatric nurse has provided medication support to assist our clients in their mental health recovery process. The Early Intervention team and the Outreach team continue to move people from the street into temporary housing or shelters and tiny homes and then on to permanent supportive housing.

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.

In a review of current FY 2024-2025 Homeless Management Information System (HMIS) Data for Behavioral Wellness Homeless Services, in the first two quarters of FY 24-25, The Homeless Services team facilitated 49 exits from homelessness into a shelter setting. A total of 45 clients have moved into permanent supportive housing. A total of 39 clients secured housing with a housing voucher. A total of two clients have transitioned from homelessness to living with family.

Program Plan for FY 25-26

Provider:	**Behavioral Wellness**
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$1,291,300
Estimated CSS Funding	$81,100
Estimated Medi-Cal FFP	$ 1,116,200
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$94,000 (PATH Funding)

Average Cost Per Consumer	$1,989
Estimated Total of Consumers Served	649
Target Population Demographics Served	TAY, Adults, Older Adults
Provider:	**Good Samaritan**
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$522,100
Estimated CSS Funding	$322,100
Estimated Medi-Cal FFP	$200,000
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer	$2,623
Estimated Total of Consumers Served	199
Target Population Demographics Served	TAY, Adults, Older Adults

Estimated Consumers Served by Age FY 2025/26 (Behavioral Wellness)		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	1	$1,989
Estimated Total Consumers Age 15-26 Served	36	$1,989
Estimated Total Consumers Served Age 26-59	486	$1,989
Estimated Total Consumers Served Age 60+	91	$1,989

Estimated Consumers Served by Age FY 2025/26 (Good Samaritan)		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served		
Estimated Total Consumers Age 15-26 Served	21	$2,623
Estimated Total Consumers Served Age 26-59	144	$2,623
Estimated Total Consumers Served Age 60+	34	$2,623

Program Description

The Homeless Services outreach program conducts outreach in all three regions of the county. The outreach team through building rapport and trust, work to link clients with mental health treatment with Santa Barbara County Department of Behavioral Wellness and substance use disorder treatment if indicated. The Homeless Outreach team works to have clients become "document-ready" to be eligible for housing opportunities. The following services are provided to individuals experiencing homelessness:

1. Assessment
2. Targeted Case Management
3. Access and Linkages to community resources
4. Crisis Intervention
5. Individual Rehabilitation- Caseworkers work with clients on building skills including daily hygiene regimen, role modeling appropriate social interactions with others, applying for health-care, housing, social security benefits paying bills, steps to clean their new apartment/ housing effectively.
6. Individual therapy

Performance Goals and Intended Outcomes

BWELL:

Performance Goal	Intended Outcome	Data Source
45% of clients enrolled will have successful exits from Homelessness to Emergency shelter/interim housing	Clients will transition living on the streets to living in a shelter/ interim housing	Homeless Management Information System (HMIS)
35% of clients will gain health benefits or cash benefits	Clients will be able to access health care and purchase needed items.	HMIS
40% of clients will enter into permanent supportive housing or a rental with a housing voucher	Demonstrate clients getting housed through Behavioral Wellness Homeless Services.	HMIS

Strategies to Address Service Disparities for Unserved and Underserved Populations

The Behavioral Wellness Homeless Outreach team has staff that read and speak Spanish that help individuals experiencing difficulty accessing services due to a language barrier. The Behavioral Wellness Homeless Outreach team offers clients the opportunity to access mental health care and gain benefits that will allow clients to access other needed community

resources including health care, nutrition, shelter/ housing and financial support. Clients have reported how having a CA ID has allowed them to access banking services including cashing a check. The Behavioral Wellness Homeless Outreach team assists clients to pay for application fees and deposits required for move into an apartment or other types of housing.

Top Community Issues

Increasing outreach and mental health supports to unhoused populations is a priority identified in the Community Planning Process. The Homeless Outreach program aligns with supporting recovery, wellness and resiliency.

Program Alignment with the General Standards of the MHSA

Community Collaboration: This program is embedded with other department programs to provide a Multi-Disciplinary Team

Cultural Competence: This program provides staff that receive Cultural Competency training and train others in how to provide services in a competent manner to those that are unhoused.

Client and Family Driven: This program aims to have clients themselves plan their Treatment and Recovery goals.

Wellness, Recovery, and Resilience Focused: The Homeless Outreach program aligns with supporting recovery, wellness and resiliency.

Integrated Service Experiences for Clients and Family: This program is a cross-departmental team with Public Health and Public Defender staff members as part of a multi-disciplinary team.

Changes to Service Delivery

BWell:

The Homeless Outreach team will be facilitating street exits for individuals experiencing homelessness to both the shelter system and new interim housing programs, including: the Good Samaritan Shelter and Hope Village in Santa Maria; the Bridgehouse Shelter and The Path shelter in Lompoc; the Salvation Army and Hedges House shelters, and the Dignity Moves and La Posada tiny homes in Santa Barbara. A review of the interim housing programs and their need for mental health support may lead to future consideration of expanding the Homeless Services program in both north and south regions to address each region's needs.

The implementation of CARE Court in 2025 in Santa Barbara County will likely lead to an increase in referrals to the Early Intervention Team. The increase in referrals will likely lead to a discussion of expansion of staff to provide mental health treatment and physical health treatment to the participants in CARE Court.

Starting in FY 24-25, the Homeless Outreach Team continued to provide outreach and engagement, and mental health services in south county, and the Early Intervention team will now provide early intervention services including behavioral health screenings, assessments, and treatment services to unhoused populations county-wide.

Good Sam:

As we look ahead to the upcoming fiscal year, we will continue to provide on-site mental health services at six shelter locations and three residential treatment settings, as well as at our outpatient offices where clients can access face-to-face services. This multi-site approach remains at the core of our service delivery, ensuring that clients can receive support in environments that are familiar and accessible to them. Our key focus for the upcoming year is to continue growing our role as the first point of entry for over 5,500 clients who are served annually across Good Samaritan Shelter's continuum of care in Santa Barbara County, so that we can continue to provide seamless, easy-to-access mental health services to clients as they enter various touchpoints within our organization. This includes individuals residing in shelters, engaging in residential treatment, or accessing outpatient services.

In looking to the future year of our partnership with Santa Barbara County's Department of Behavioral Wellness, we will ensure immediate access to mental health support for clients, which is crucial for both short-term stabilization and long-term mental health recovery. Our goals are always to streamline service delivery, reducing the need for clients to seek external services and enhancing their ability to engage with comprehensive care plans from the outset.

We are committed to delivering high-quality mental health services that are easily accessible, reduce barriers to care, and provide the support necessary for clients to flourish in the long term. This focus on being the first point of entry for clients allows us to provide more integrated, client-centered care, ultimately contributing to better health outcomes and greater continuity of care across our programs and community at large.

Program Demographics

Reporting FY 23-24

Total Clients by Region		
North	**South**	**West**
n= 409	n= 332	n= 262

Program: Homeless Outreach Services – Behavioral Wellness

Program: Housing Mental Health Services—Good Samaritan

Total Clients by Region		
North	**South**	**West**
n= 54	n= 123	n= 27

Community Services and Supports, Non-FSP Services: Report on Prior Fiscal Year Activities AND Program Plan

Crisis Services

Program Populations of Focus

Homeless	X
Forensic	X
Involved in Social Services System	
Unserved/Underserved	X
Cultural Population (specify below)	
Veterans	
Other (Specify Below)	X
TAY, Adults, Older Adults	X

Program Summary: The Crisis Services Program by Behavioral Wellness offers 24/7 mobile crisis response, crisis clinics, and co-response teams pairing clinicians with law enforcement officers for behavioral health crises. With goals to minimize psychiatric hospitalizations, increase discharges to lower care levels, and reduce incarcerations, the program collaborates daily with law enforcement, hospitals, and advocacy groups.

Available data on this program's outcomes for the prior fiscal year period, FY 23-24 is included as an Appendix to this document.

Program Performance, FY 24-25

As part of the continued effort to meet the requirements of the Mobile Crisis Benefit program, the Crisis Services Program has undergone a thorough evaluation through a third-party consultant which resulted in significant changes to the Crisis Services Program over the past fiscal year.

We are fully staffed with our Co-Response teams and continue to maintain four Co-Response teams with the Sheriff's Office (two in south county, one in north county and one in west county); two teams with Santa Barbara Police Department and one team with Santa Maria Police department. In addition to responding to active behavioral health crisis calls that come in

through 911 dispatch, these teams also conduct regular follow-up check-ins with individuals who are frequent callers of 911, were recently in crisis or are routinely getting the attention of community members. The Co-Response teams are used for cases where there is a higher level of criminal behavior, greater risk of danger to self or other's and in situations where threat assessments are being conducted.

Lastly, it is worth noting that the Crisis Stabilization Unit (CSU) has been contracted with Crestwood, Inc. and reopened in May of 2024 as a locked facility capable of accepting individuals on a 5150 hold. Initially the CSU only accepted clients from Cottage Hospital Emergency Department and over time procedures have been developed to allow for community walk-ups, Law Enforcement drop-offs, and treatment of current jail inmates. The data reflects a trend of increased utilization since the initial opening.

Addressing Community Issues

The goal of the Crisis Services program is to respond to all Access crisis calls; respond to law enforcement requests for outreach; respond to requests for services when an individual is evaluated for a 5150 but a hold is not written; assist current outpatient program clients when they are rapidly decompensating and are at risk of hospitalization; act as an access point for walk-in clients new to Behavioral Wellness or returning clients who are not currently open and can have more difficulty with engagement into service; and, provide hospital discharge services to individuals being discharged from the Psychiatric Health Facility (PHF), Crisis Stabilization Unit (CSU), Telecare & Crestwood Behavioral Health Crisis Residential Treatment Facilities (CRTs), or out-of-county LPS facilities for individuals who are new to Behavioral Wellness or to returning clients who are not currently linked to services. This program is addressing the identified community issue of increasing warm handoff and navigation services for those in crisis.

The Crisis Services team often conduct crisis evaluations with individuals experiencing homelessness and assist in getting them help. Crisis Services also works collaboratively with our two jails and our Juvenile Justice Center to conduct crisis evaluations in those facilities when needed. If holds are written in the jail settings we assist in having the inmate brought to an LPS facility for treatment.

Notable Community Impact

The systemic changes have resulted in a decrease in Law Enforcement involvement in Crisis Services evaluations from roughly 91% in calendar year 2024 to roughly 75% in calendar year 2025. We have also seen a significant drop in the number of 5150/5585 holds being written during crisis evaluations from 65% in calendar year 2024 to 45% in calendar year 2025, indicating that the Crisis Services team is responding and deescalating more effectively resulting in less need for involuntary holds.

Program Plan FY 25-26

Provider:	Behavioral Wellness
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$8,258,000
Estimated CSS Funding	$53,000
Estimated Medi-Cal FFP	$1,209,800
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$6,995,200
Average Cost Per Consumer	$3,663
Estimated Total of Consumers Served	2254
Target Population Demographics Served	Children, TAY, Adults, Older Adults

Estimated Consumers Served	Estimated Consumers Served by Age FY 2025/26	Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	123	$3,663
Estimated Total Consumers Age 15-26 Served	473	$3,663
Estimated Total Consumers Served Age 26-59	1302	$3,663
Estimated Total Consumers Served Age 60+	372	$3,663

Program Description

The Crisis Services Program is a 24/7 Mobile Crisis response team, including crisis evaluation, de-escalation, safety planning, and LPS placement if indicated. The Co-Response Teams include a BWELL clinician paired with a law enforcement officer who respond to active behavioral health crisis in the community as well as doing outreach and follow-ups to those at risk for or recently in crisis.

Populations of Focus

Homeless	
Forensic	
Involved in Social Services System	
Unserved/Underserved	X
Cultural Population (specify below)	
Veterans	

Other (Specify below)	X
Persons in Crisis	X

Performance Goals and Intended Outcomes

Performance Goal	Intended Outcome	Data Source
Number of unique clients admitted to acute in-patient psychiatric care	Less than 10%	Quarterly Reports
Number of Unique clients discharged to lower level of care	More than 90%	Quarterly Reports
Number of unique clients incarcerated/ Juvenile Hall	Less than 10%	Quarterly Reports

Top Community Issues

Crisis Services response teams are designed to meet the needs of the most vulnerable in the community needing crisis/urgent behavioral health services including elderly, those experiencing homelessness and incarcerated individuals.

Program Alignment with the General Standards of the MHSA

Community Collaboration: Daily collaboration with all law enforcement agencies in the community, hospital emergency departments, AMR. Crisis Action Team attendees include NAMI and other advocacy groups (Families ACT).

Cultural Competence: All staff trained annually in cultural competency.

Client and Family Driven: This program aims to have clients themselves plan their Treatment and Recovery goals.

Wellness, Recovery, and Resilience Focused: The Crisis Services program aligns with supporting recovery, wellness and resiliency.

Integrated Service Experiences for Clients and Family: The Crisis Services Program works in alignment with other County Departments and outside organizations such as Cottage Hospital to provide comprehensive care for those in crisis and their families.

Changes to Service Delivery

The Crisis Clinics have now been embedded into the outpatient clinics, thus leaving Mobile Crisis and Co-Response teams as the core functions of the program. These teams have successfully provided support and outreach to consumers, law enforcement, outpatient

program clients, local Emergency Departments and various community members seeking urgent mental health supports and aid. Additionally, a Hospital Liaison role has been added to the Crisis Services Program to further support with linkage and warm hand-offs to those who are connecting with services after a crisis has occurred. Lastly, we have pivoted to having all requests for mobile crisis services go through the Access Line to request a mobile crisis dispatch and, as a result, we have expanded our Access team staffing and hours to meet the increase in demand. Our Access Line now operates from 8am-8pm Monday – Friday with weekends, nights, and holidays being covered by a contracted provider: Crestwood, Inc.

Because of the cost and difficulty of staffing overnight shifts it was determined that it would be a better fit to contract out the delivery of overnight Mobile Crisis services and Access Line to Crestwood Inc. for after-hours coverage. Anyone requesting a Mobile Crisis response is able to contact the Access Line 24/7 and the call will be routed to the appropriate team. Access Line staff will conduct a screening that includes a risk assessment. When deemed safe, based on the risk assessment, the Access Line staff will dispatch the Mobile Crisis team to the location of the individual in crisis. If the screening determines law enforcement should be sent to the scene, the Access Line or the Mobile Crisis Team will contact 911 to coordinate an appropriate response. From 7am-7pm, the Mobile Crisis teams will be dispatched from either Santa Barbara or Santa Maria and from 7pm-7am the Mobile Crisis teams will be dispatched from Lompoc. From 7pm-7am weekdays, and on weekends, Crestwood mobile crisis team will respond to all crisis interventions.

Program Demographic Data

Reporting FY 23-24

North	South	West
n= 1,065	n= 900	n= 445

All Regions
n= 57


2,254
# of Clients
Female
Male
Unknown or Not Reported
963
1,093
198
Age Group
123
0-15
473
16-25
1,302
26-59
372
60+
Veteran Status
Yes 14
Unknown or Not Reported 690
No 1,550
Ethnicity
788
Unknown or Not Reported
771
Non-Hispanic
691
Hispanic
4
More Than One Ethnicity
Sexual Orientation
Bisexual 18
Heterosexual Straight 613
Unknown or Not Reported 1,596
Race
1,164
White
712
Unknown or Not Reported
208
More Than One Race
72
African American or Black
39
Asian
30
Other
25
Alaska Nativ or Native American
4
Native Hawaiian or Other Pacific Islander
Primary Language
1,515
English
576
Unknown or Not Reported
146
Spanish

Community Services and Supports Non-FSP Services: Report on Prior Fiscal Year Activities AND Program Plan

Wellness Centers

Santa Barbara: Santa Barbara Mental Wellness Center

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

Program Populations of Focus

Homeless	
Forensic	
Involved in Social Services System	
Unserved/Underserved	
Cultural Population (specify below)	
Veterans	
Other (Specify Below)	X
Tay, Adults, Older Adults	X

Program Summary: The Wellness Centers, operated by Mental Wellness Center and Transitions Mental Health Association (TMHA), offer peer-led support, activities, and family services for diverse demographics including TAY, adults, and older adults. Programs focus on reducing isolation, stigma, and offering a safe space for socialization while addressing community needs such as language-specific support groups and peer training.

Available data on this program's outcomes for the prior fiscal year period, FY 23-24 is included as an Appendix to this document

Program Performance FY 24-25

Santa Barbara Behavioral Wellness 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 Wellness Centers in the South, West and North County. The goal of the peer staff is to create a vital network of peer-run supports and services that builds bridges to local communities and engages natural community supports. There are currently three Wellness Centers 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:

The last Fiscal year has been successful for the Santa Barbara Mental Wellness Center's Fellowship Club and its members. The Fellowship Club/Wellness Center staff consists of four Certified Peer Support Specialists and one staff member obtaining their certification. Two bilingual and bicultural staff allow us to serve the Spanish-speaking community. In addition to serving Spanish-speaking members, we continue to provide holistic care to Serious Mentally Ill individuals. Other underserved populations we serve include unhoused populations, justice-involved populations, Monolingual Spanish-speaking individuals, low-income, poverty-level individuals, and older adults.

In 2024, 226 new members registered for the Fellowship Club program. In total, 20,041 visits to the Fellowship Club were made in 2024. This also means we cook and serve over twenty thousand lunches a year! We are a major provider of daily and weekly services to our community. We are becoming more popular, which is exciting, yet we are at capacity. The Fellowship Club's capacity is 80 individuals a day. In October, we were at capacity for 21 days out of 23 days in the month. In November, we were 16 out of 17 days of the month, and in December, we were 15 out of 21. While we are encouraged to see our services at a maximum, we also know this means we must turn community members away. The Fellowship Club is the only space in Santa Barbara where individuals with serious mental illness can take part in a safe peer-run program.

Our Family Advocate connects Spanish-speaking and English-speaking individuals with mental health services, including counseling and psychiatric appointments. In 2024, we helped 685 individuals navigate the mental health system and other community resources. Our Family Advocate has daily walk-in hours to support anyone with a resource need or a question. This service is free to the community and offers a safe and confidential session to ask questions about any situation. Many individuals we see state they are in need of behavioral health support, usually for themselves or a loved one. There is no paperwork or forms to fill out to receive services, and we can provide these services in our office, on Zoom, or over the phone.

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

Last fiscal year, both the Lompoc and Santa Maria RLC changed their names to Wellness Centers. Both centers have retained their model of being 100% peer-designed and peer-led recovery centers. All leadership, operational decisions, program design, and advocacy efforts are made by the peers who are employed and who attend the center. The Helping Hands of Lompoc Wellness Center underwent a major transition as the entire team moved on to other employment opportunities or retired. With several positions being open for 6 months or longer, the center was forced to reduce hours and pull from the Santa Maria Wellness Center staff to provide coverage for seven months in an effort to keep the Lompoc Wellness Center open. This greatly impacted the functional and operational scope of both centers. However, during this time both wellness centers maintained bilingual staff who assisted Spanish speaking center members in accessing services and participating in groups and activities such as the weekly food bank distribution. Santa Maria Wellness Center also supported its senior population and

those who were working by delivering foodbank bags and monthly hot lunches to those who were unable to make it to the center. Now that both programs are nearly fully staffed, targeted outreach to the monolingual Spanish population is underway.

Addressing Community Issues

Mental Wellness Center:

Our priority is to provide services to severely persistently mentally ill individuals and their family members. We also provide services to individuals who are undocumented and uninsured. In both our Fellowship Club program and our Family Advocate our goal is to provide wraparound services so clients and families can find pathways to services. We are also excited to have certified peer support specialists on our team. We have dedicated time and resources to increase the number of peer support specialists in our agency. They provide services in several of our programs.

Wellness 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.

TMHA:

Bilingual/Bicultural staff are hired whenever possible in order to deliver services in the clients preferred language if Spanish. The staff are required to participate in diversity, equity and inclusion trainings annually. The program partners with community agencies that serve the unhoused population to engage these community members in services. Under the Wellness Center umbrella is our LEAD –Lived Experience Advocacy Development Program which engages members to advocate on behalf of community members living with mental illness/justice involved for improved services and support

Notable Community Impact

Santa Barbra Wellness Center: Last year, we were able to house four of our members. This was a massive transition for each of them, and they continued to come to the club for support. We also obtained CA driver's licenses and Social Security Cards for club members. As you know, many locations require identification to get a job or service. In helping the members obtain these items, we are inching them back into the community, where they can reconnect to services, jobs, and future life.

We offer clothing and shoes to our community. Four days a week, our store is open for Fellowship Club members to come in and shop for clothing and accessories. This store allows the members to shop in a dignified and private manner. Almost all our members live below the

poverty level, and having access to clothing and shoes is a great benefit for them. It allows the few funds they have to stretch a bit further.

Our Family Advocate makes over 50 community referrals a month. These referrals are to mental health providers, support groups, housing providers, and other community resources. At the Mental Wellness Center, we use the Findhelp.org website as our tool to communicate with other service providers. This website also lets us communicate with providers and offers warm hand-offs. By utilizing Findhelp.org, we can track our referrals and broker resources. This data will be helpful to analyze in the future.

Transitions Mental Health Association: Both centers partner with community agencies that serve the unhoused population to engage these community members in services. In Lompoc, the staff have helped link members to homeless outreach and several have been housed and in Santa Maria several unhoused members have returned to work or school. Additionally, both centers offer regular foodbanks, meal programs and snack bars to all its members.

Program Plan for FY 25-26

Provider:	**Mental Wellness Center, Transitions Mental Health Association**
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$1,167,300
Estimated CSS Funding	$1,068,100
Estimated Medi-Cal FFP	$99,200
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$0
Average Cost Per Consumer/Families	$369
Estimated Total of Consumers/Families Served	3,162
Target Population Demographics Served	TAY, Adults, Older Adults

Estimated Consumers Served	Estimated Consumers Served by Age FY 2025/26	Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	
Estimated Total Consumers Age 15-26 Served	362	$369
Estimated Total Consumers Served Age 26-59	2000	$369
Estimated Total Consumers Served Age 60+	800	$369

Program Description

Santa Barbara Mental Wellness Center: The Fellowship Club/Wellness Center is open five days a week, providing socialization and group programming to individuals who have severe and persistent mental illness and/or who are unhoused. We have a low barrier referral process and provide support for the clients' goals around wellness and recovery. The program also is a safe place for individuals to build a community and socialize in a positive and supportive way. Reducing isolation and stigma takes place in the group activities and in the club itself.

The NAMI groups and Spanish speaking family support groups are safe places for family members to come and ask questions and get support on mental health. Many of these family members find themselves isolated and overwhelmed by caregiving needs. These families also need support to navigate the behavioral health system for their child/loved one to receive care.

Lompoc and Santa Maria Services: Transitions Mental Health Association (TMHA): Peer-led wellness and recovery-oriented groups and trainings, as well as one-to-one peer support; Assistance to persons with mental illness to develop social relationships and activities in the community; Connections among individuals living with mental illness; Peer support competencies and leadership skills for those clients interested in achieving these goals; Family support and empowerment activities, such as family support groups; Digital literacy, mobile application technical support groups and/or workshops; Resource information for community members, clients, and families of individuals with mental illness, to increase understanding of mental illness and bolster the community's ability to support persons with mental illness; Provide or facilitate transportation to stakeholder meetings (i.e. CFMAT and MHSA Community Planning sessions).

Top Community Issues

The three Wellness Centers continue to provide outreach and engagement services to those with serious mental illness and their families.

Performance Goals and Intended Outcomes

MWC:

Performance Goal	Intended Outcome	Data Source
Update Fellowship Club Admission Registration forms	The registration forms have not been updated since 2020. The updated documents will include photos, medications, other providers they have working on their team, and emergency contact information.	Completed Registration forms.

Arrange at least two field trips a year	Have 60 members a year experience a field trip	Sign in Sheets

TMHA:

Performance Goal	Intended Outcome	Data Source
Transition to Medi-Cal Billable Program	Provide source of revenue that will provide stability and sustain services	SmartSheet Weekly Log
Increase utilization of the Wellness Center	Increase the number of duplicate attendance number of consumers attending weekly	Weekly Log
Increase Spanish Services	Provide direct support, education and linkage to community resources	Weekly Log
Increase the number of Spanish speaking families attending NAMI and evening family support groups	Expand community support in the Latinx and Spanish speaking community	Increase attendance in Spanish speaking group

Strategies to Address Service Disparities for Unserved and Underserved Populations

MWC: The Mental Wellness Center has dedicated time and resources to hire certified peer support staff, bilingual bicultural staff and have created low barriers to participate in all programs.

THMA: The Wellness Centers provide services in Spanish and English and continue to prioritize hiring bi-lingual staff and those with lived experience of mental illness.

Program Priorities

The Wellness Centers continue to offer services to consumer and family members and have peer-led programs. Providing services to consumers and family members and hiring peers throughout our public mental health workforce are priorities identified in the MHSA Community Planning Process.

Program Alignment with the General Standards of the MHSA

Santa Barbara Mental Wellness Center:

Community Collaboration: With our family advocate and our NAMI programs we collaborate consistently with providers. Our Fellowship Club collaborates with various CBO's including Doctors Without Walls, City Net and Behavioral Wellness.

Cultural Competence: Our team is trained in cultural humility. We work with a vulnerable population that requires us to be thoughtful, trauma informed and able to communicate with our clients in their language.

Client and Family Driven: Our Fellowship Club/RLC has monthly client-led meetings at which clients lead the agenda and offer suggestions for future programs. The NAMI and family advocate position are all family driven. We listen to what the families and the clients need and advocate on their behalf.

Wellness, Recovery, and Resilience Focused: In the Fellowship Club/RLC our focus is wellness and recovery defined by each client. We take a harm reduction approach and meet each person where they are at.

Integrated Service Experiences for Clients and Family: The Mental Wellness Center has a variety of programs that usually can support both individuals and families along the continuum of care. We can support newly diagnosed individuals and their families with our NAMI programs, Family Advocate and the Fellowship Club/RLC. If an individual or family member has decades of experience, our services are still appropriate and of service.

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

Community Collaboration: The program collaborates with several community partners and agencies to promote other services that could benefit members (housing, showers, food, etc.)

Cultural Competence: Staff attend diversity, equity and inclusion trainings to support their work with community members.

Client and Family Driven: The program offers services and supports to both the individual with mental health challenges and their families.

Wellness, Recovery, and Resilience Focused: The program offers an array of services that promotes recovery, self-care, resilience, personal responsibility and community.

Integrated Service Experiences for Clients and Family: The program leverages the support of several TMHA programs to support RLC members such as Growing Grounds Farm, Supported Employment and Central Coast Hotline. In addition, the RLC's work with several community agencies to support members with services TMHA can't provide.

Changes to Service Delivery

Santa Barbara Mental Wellness Center: Currently, there are no changes to our delivery service or programs. We are always looking for funding to expand the hours of operation. We want to be open on weekends or holidays since many of our members have no family or other support.

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

TMHA continues to promote and support peer certification training. We are in the process of preparing and training Wellness Center staff to include Medi-Cal documentation for individual and group rehabilitation services beginning in March of 2025. Staff wages have been increased to meet workforce demands and in anticipation of the higher level of work and documentation that will be expected.

Program Demographics FY 23-24

*****The Wellness Centers do not track consumers served by age categories, but instead only serve those above the age of 18.**

	North		South		West	
Activities	**Wellness Center**	**Family Advocate**	**Wellness Center**	**Family Advocate**	**Wellness Center**	**Family Advocate**
Client Visits	3578	1322	16816	1021	2648	664
Unduplicated Clients	679	463	935	397	505	183
Outreach Events	8	84	19	*	9	17
Outreach Event Attendees	987	2023	0	*	265	613
Computer Classes	54	*	95	*	28	*
Client Visits to Computer Labs	360	*	1114	*	363	*
Classes	*	312	*	*	*	115
Digital Literacy Events Hosted	*	*	89	*	*	*
Consumer/Family Member Trainings	*	*	*	46	*	*
Support Group Meetings	126	96	339	*	216	81
Outings, Educations Events	39	*	10	*	62	*
Unique Clients Provided Services in Spanish	*	299	*	39	*	89
Tech Suite Groups	*	*	591	*	*	*
Links to Additional Services	347	429	24	202	140	164

* = not reported, not applicable, or not recorded

Community Services and Supports Non-FSP Services: Report on Prior Fiscal Year Activities AND Program Plan

Children Wellness, Recovery and Resiliency (WRR) Teams

Program Populations of Focus

Homeless	
Forensic	
Involved in Social Services System	
Unserved/Underserved	X
Cultural Population (specify below)	
Veterans	
Other (Specify Below)	X
Children/TAY	X

Program Summary: The Children Wellness, Recovery and Resiliency (WRR) Teams deliver therapy, case management, and crisis evaluations for children and TAY, striving for over 95% engagement in purposeful activities and fewer than 5% discharges to higher care levels.

Available data on this program's outcomes for the prior fiscal year period, FY 23-24 is included as an Appendix to this document.

Program Performance FY 24-25

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

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

A specialized service provided within the WRR program is “Katie-A” treatment, which focuses 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 contracted providers CALM, Inc. and Family Service Agency).

SB Children’s Clinic continues to utilize bilingual clinicians and case workers in the WRR program. We also use Language Line if necessary. The staff are trained on cultural competency on an annual basis and have the opportunity to engage in further trainings to help reduce ethnic and cultural disparities. This is the same for Lompoc Children’s clinic. We also have one Katie A assessor who is bilingual Spanish to provide services in Spanish.

Addressing Community Issues

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.

Additionally, a large percentage of this population meets the 200% Federal Poverty Level (threshold of living in poverty) which presents challenges with navigating the county-managed welfare system. This requires persistence, literacy and advocacy at a level most families are not capable of. Furthermore, these case managers and rehab specialists were providing direct support to single and parental units that are experiencing levels of mental health symptoms themselves and are likely needing to be connected to services as well.

We continue to try and meet the needs of every client and their family. To do this, we utilize assessments, interviews, and weekly sessions. We offer support and services referrals as needed; including transportation and helping to fill out applications or writing letters of recommendation. We also work hand in hand with Child Welfare Services and Probation to ensure clients get the support they need.

Notable Community Impact

Clients are receiving family supports that include group therapy sessions and connections to other resources including social and vocational services. The program impacts families in need to help them build protective factors and transition to less intensive needs for behavioral health care.

Program Plan for FY 25-26

Provider:	**Behavioral Wellness**
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$6,133,000
Estimated CSS Funding	$1,686,500
Estimated Medi-Cal FFP	$3,149,000
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$1,297,500
Average Cost Per Consumer	$5,319
Estimated Total of Consumers Served	1153
Target Population Demographics Served	Children, TAY

Estimated Consumers Served by Age FY 2024/25		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	627	$5,319
Estimated Total Consumers Age 15-26 Served	519	$5,319
Estimated Total Consumers Served Age 26-59	14	$5,319
Estimated Total Consumers Served Age 60+	2	$5,319

Program Description

The Children Wellness, Recovery, and Resiliency (WRR) Team provides services as follows: Provides therapy, case management, crisis evaluations, and evaluations for involuntary hospitalization; interviews clients to obtain pertinent information including psychiatric, social, educational, and vocational history; makes field visits to evaluate clients to determine needs for services; assists clients in obtaining suitable services such as housing, vocational rehabilitation, financial assistance, and employment; helps clients develop necessary skills for everyday living; provides transportation for clients to obtain needed services; cooperates with other agencies and professionals to coordinate services for mutual clientele; Participates in interdisciplinary team reviews/ Team Based Care meetings for collaborative assessment and treatment planning to ensure quality care; conducts social, recreational, or occupational skill development in accordance with the treatment plan; observes and reports to licensed staff observations of client's behaviors; confers with licensed staff regarding needed services and referrals to other

community agencies; Serves as a point of contact to community agencies or contract service providers when programmatic issues arise; Documents client activity according to established departmental guidelines under supervision of licensed professional staff.

Performance Goals and Intended Outcomes

Performance Goal	Intended Outcome	Data Source
Unique Clients Discharged to Higher Level of Care	Less than 5%	Quarterly Reports
Unique Clients Discharged to lower Level of Care	More than 90%	Quarterly Reports
Unique Clients Engaged in purposeful activity	More than 95%	Quarterly Reports

Strategies to Address Service Disparities for Unserved and Underserved Populations

We continue to include client's support (family, friends, etc.) to help with services and supporting client's mental health and well-being. We respect cultural aspects of client's life and support it as much as possible.

Program Priorities

This program provides mental health services to children and their families that are considered unserved or underserved populations

Program Alignment with the General Standards of the MHSA

Community Collaboration: We work with CBOs to provide the most appropriate services to our clients

Cultural Competence: Staff continue to receive annual cultural competency training.

Client and Family Driven: Staff work with clients and families (when appropriate) to make and progress towards client goals.

Wellness, Recovery, and Resilience Focused: Services are evidenced-based and a team-based approach. Staff are trained and educated in client's wellness, recovery, and resiliency.

Integrated Service Experiences for Clients and Family: Staff include families and care givers in treatment to best serve our clients. Should more appropriate services for family and care givers be needed, referrals will be made.

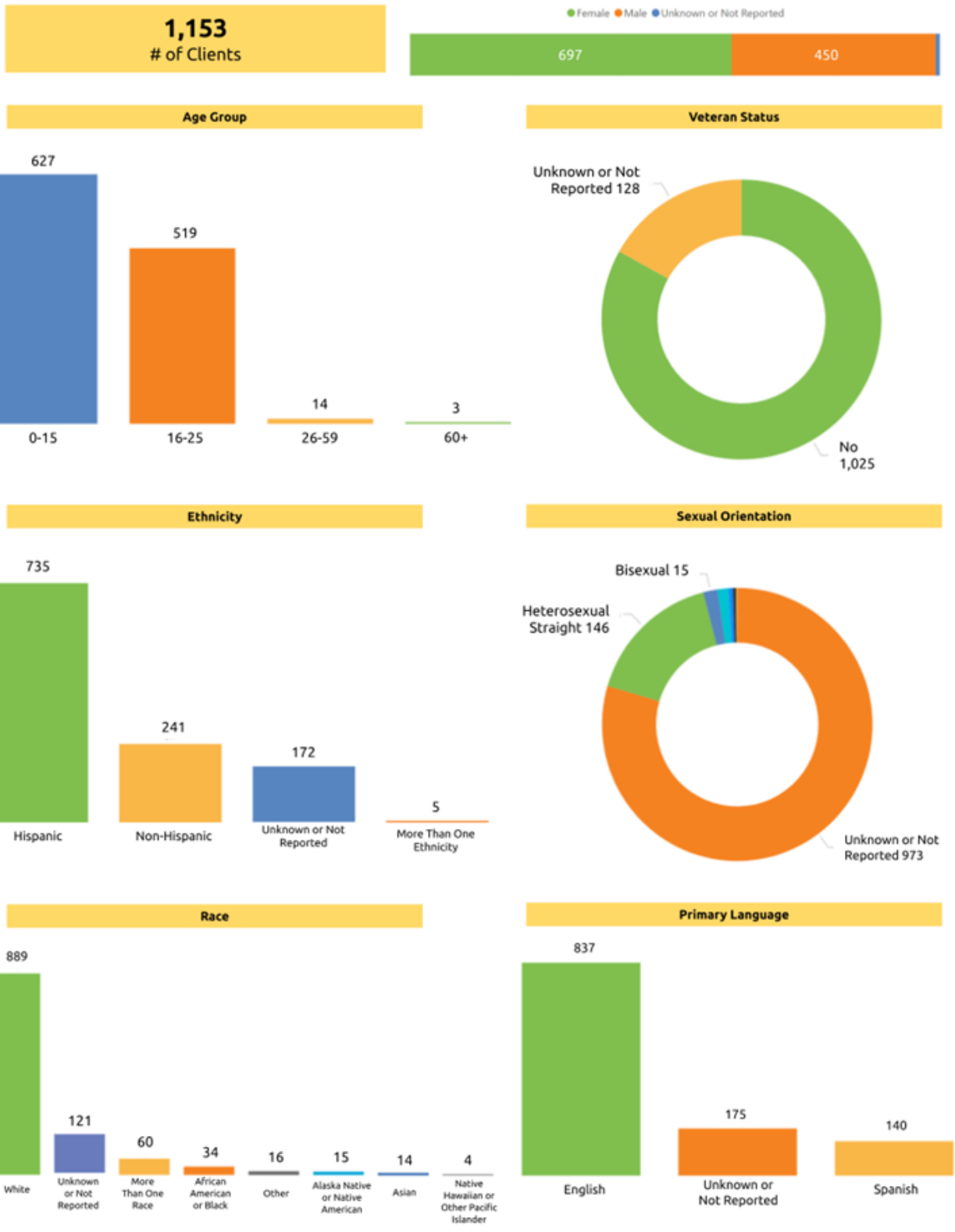
Changes to Service Delivery

There are no anticipated changes to this program. This program has struggled with staffing, over the previous year, already the staffing is improving and projected to be fully staffed by the end of this current fiscal year.

Program Demographics

Reporting FY 23-24

Total Clients by Region		
North	**South**	**West**
n= 617	n= 275	n= 292


1,153
# of Clients
Female
Male
Unknown or Not Reported
697
450
Age Group
627
519
14
3
0-15
16-25
26-59
60+
Veteran Status
Unknown or Not Reported 128
No 1,025
Ethnicity
735
241
172
5
Hispanic
Non-Hispanic
Unknown or Not Reported
More Than One Ethnicity
Sexual Orientation
Bisexual 15
Heterosexual Straight 146
Unknown or Not Reported 973
Race
889
121
60
34
16
15
14
4
White
Unknown or Not Reported
More Than One Race
African American or Black
Other
Alaska Native or Native American
Asian
Native Hawaiian or Other Pacific Islander
Primary Language
837
175
140
English
Unknown or Not Reported
Spanish

Community Services and Supports Non-FSP Services: Report on Prior Fiscal Year Activities AND Program Plan

Adult Wellness and Recovery Outpatient (WRR) Teams

Program Populations of Focus

Homeless	
Forensic	
Involved in Social Services System	
Unserved/Underserved	X
Cultural Population (specify below)	
Veterans	
Other (Specify Below)	X
Adult, Older Adult	X

Program Summary:

The Wellness and Recovery (WRR) teams focuses on providing services to underserved adults (18+) in a clinic setting at a lower level of care. Services are provided through a variety of modalities, including groups addressing trauma, depression and life skills, and are issued using a Team Based Care (TBC) model, a multi-disciplinary approach in which all clinic/program members share joint responsibility in providing services and treatment to adult clients.

Available data on this program's outcomes for the prior fiscal year period, FY 23-24 is included as an Appendix to this document.

Program Performance FY 24-25

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 evidence-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.

Program Challenges and Solutions: The WRR program was initially designed to serve consumers who are lower need 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 nonexistent or very limited in all regions, and the majority of Primary care physicians are uncomfortable prescribing psychotropic medications. 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, which stretches staff resources and impacts ideal consumer care. The effects of the pandemic continue to impact service delivery with a lack of staffing for this program. Clinics are continuing to initiate and offer a variety of group therapy activities to help support clients in ways other than individual therapy which supports the staff in seeing clients in rotation from individual, rehab and group supports. Some solutions to these challenges have been continuing to have complex capable teams which alleviates some of the impacts from staffing shortages.

Effective March 1, 2024, the Medical Integration/Older Adult (MIOA) and Co-Occurring Disorders (COD) programs were merged with our Adult Outpatient Wellness, Recovery and Resiliency programs.

This change was implemented for the following reasons:

1. Acknowledgement that ongoing assessment and triage of physical health conditions and substance use to identify and connect to appropriate treatment is necessary across the entire adult population being served at BWell

2. To increase flexibility in staffing

3. To streamline and simplify administrative processes including timecard completion, evaluation of program outcomes, and documentation in the electronic health record

Addressing Community Issues

This program serves people who are homeless or at risk of homelessness; People with mental health and substance use disorders and people who are otherwise underserved in our community.

Notable Community Impact

The core clinic continues to have complex capable teams, which has alleviated some of the impacts to staffing shortages as staff across programs stepped in and assisted in providing services to clients across programs. The core clinic continues to have an augmented lower level of care with the Wellness Center programs where clients receive medication support services and has seen some success with clients graduating from this program to independent functioning within their community.

The core clinic has integrated a crisis triage team, when fully staffed will serve our clients who are experiencing a crisis without having to potentially wait until Mobile Crisis is dispatched.

Clients who are being discharged from the hospital will be able to receive services sooner with an integrated triage team.

The Department has provided Motivational Interviewing training with extended coaching.

The Department has provided collaborative documentation to assist staff with partnering with clients when documenting services. This helps to clarify the client's needs and empowers the client to collaborate with their treatment.

The core clinic collaborates with the Public Health Department and CenCal to assist clients with the step-down process.

The core clinic has implemented a diverse choice of groups that assist clients with improving their social skills, practicing coping strategies and improving health by participating in our walking groups.

Program Plan for FY 25-26

Provider:	**Behavioral Wellness**
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$16,690,500
Estimated CSS Funding	$10,303,900
Estimated Medi-Cal FFP	$6,386,600
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$0
Average Cost Per Consumer	$13,460
Estimated Total of Consumers Served	1240
Target Population Demographics Served	Adult, Older Adult

Estimated Consumers Served by Age FY 2024/25		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served		
Estimated Total Consumers Age 15-26 Served	51	$11,962
Estimated Total Consumers Served Age 26-59	878	$11,962
Estimated Total Consumers Served Age 60+	271	$11,962

Program Description

The Wellness and Recovery (WRR) teams provide services to adults in a clinic setting that are a lower level of care. Staff have been trained in relevant Evidence-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.

Services in WRR are focused on prevention, learning healthy behaviors and coping skills to improve functioning through a Team Based Care (TBC) model. TBC is a multi-disciplinary approach in which all clinic/program members share joint responsibility in providing services, supports and treatment to adult clients. Each treatment team carries together an assigned caseload of adults (age 18+), and each team member – based on his/her role, expertise and scope of practice – contributes towards an adult's success, recovery and goal achievement.

Adults therefore are receiving services that are coordinated and integrated, while still individualized to their specific needs. A manual for Team-Based Care has been developed and implemented which articulates the roles and interactions for each team member and provision of services. In addition, case management services are always available to consumers to assist them with obtaining and maintaining housing, linking them to primary health care providers, and providing financial management support. Post COVID-19, the Department continues to offer a mix of telehealth services and in-person appointments regionally for clients that are not able to successfully participate in telehealth services or that require in person interventions in order to successfully meet treatment plan goals and maintain their mental health treatment. Certain clinic locations have a designated room setup with audio and video for those without access to technology.

Performance Goals and Intended Outcomes

Performance Goal	Intended Outcome	Data Source
Unique Clients Discharged to Higher Level of Care	Less than 10%	Quarterly Reports
Unique Clients Discharged to lower level of care	More than 85%	Quarterly Reports
Unique Clients Engaged in Purposeful Activity	More than 95%	Quarterly Reports

Strategies to Address Service Disparities for Unserved and Underserved Populations

BWell's South County adult clinic and Justice Alliance FSP (JA) team are currently collaborating in developing a performance improvement plan to initiate new clinical and administrative

strategies to increase client engagement and coordination of care for individuals in the Mental Health Treatment Court (MHTC) being recommended for mental health services. MHTC is a problem-solving court that combines judicial supervision with community mental health treatment and support services.

Santa Barbara's MHTC aims to reduce criminal activity and improve quality of life for participants. As part of MHTC, clients are assessed by JA clinicians and referred to mental health treatment and/or services appropriate for the level of care clients need.

Once connected with a clinician at Calle Real, clients are assessed and an individualized care plan is created for them. MHTC court hearings may occur between 1-4x per month and the JA clinician updates the court on client engagement in mental health services. Currently, clients are not engaged in sufficient outpatient mental health services to meet their complex and significant behavioral health needs. In addition to the significant mental health impacts of inconsistent treatment engagement, low service engagement can have legal ramifications such as going back through the legal process. This could impact their future employment, housing, and other aspects of functioning. Furthermore, treatment disengagement may result in increased likelihood of recidivism which impacts the community and justice systems. In order to address these concerns, the PIP aims to increase client engagement in mental health services. Mental health service engagement is important for clients for several reasons: (1) to minimize the possibility of recidivism; (2) to connect clients to supports in the community, including housing, employment, as they transition from jail back to the community; and (3) to increase client stability through taking medications as prescribed and engaging in treatment.

Program Priorities

Recruitment and Retention of Public Health Workforce-SM Adults program is facilitating clinical rotation for nursing students from local college to expose them to nature of public mental health work and provide information about job opportunities with the County.

Program Alignment with the General Standards of the MHSA

Community Collaboration: The Adult Outpatient System of Care was designed with community input.

Cultural Competence: All staff are trained in cultural competence and we aim for staff ratios to reflect the demographics of our County.

Client and Family Driven: Clients and families, when appropriate, are involved in directing services for the client.

Wellness, Recovery, and Resilience Focused: Our Adult Outpatient System of Care is founded on the principles of wellness, recovery and resiliency.

Integrated Service Experiences for Clients and Family: The Adult Outpatient System of Care presents an integrated service experience in which clients are connected to services provided by other Departments and Community Based Organizations.

Changes to Service Delivery

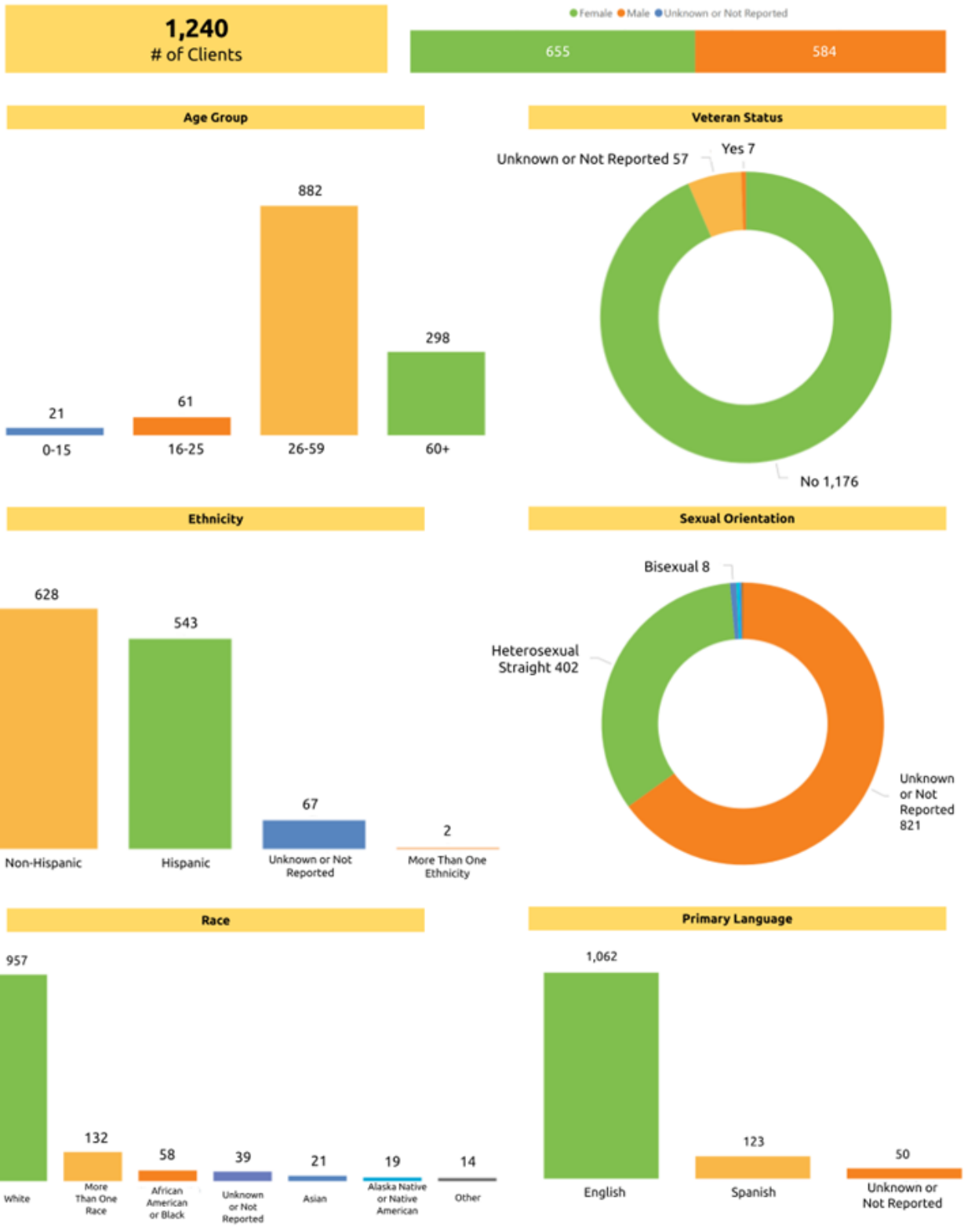
The Department is implementing a new Peer Access program in order to begin engagement sooner with clients who are seeking treatment. This will allow community members to begin to establish quality relationships with staff and promote the feeling of inclusion in their healing process. Our Certified Peers will be working 1:1 with clients to assist in scheduling assessments, problem solve transportation issues and integrate the client either into core clinic services or establishing care at the community level.

The Department has also implemented moving the Mobile Crisis teams into the outpatient clinic. Currently the Lompoc Adult Outpatient Clinic was provided with one case worker and one open practitioner position. Once fully staffed this program should improve the timeliness for service outcomes with our crisis clients. Our Crisis triage has also been able to respond to established clients who are in crisis in the community or in the office with a faster response time than was available previously. For instance, we would have to wait for mobile crisis or AMR to transfer the client to the hospital.

Program Demographic Data Reporting FY 23-24

Adult Wellness, Recovery and Resiliency

Total Clients by Region		
North	**South**	**West**
n= 514	n= 470	n= 285


1,240
# of Clients
Female
Male
Unknown or Not Reported
655
584
Age Group
21
0-15
61
16-25
882
26-59
298
60+
Veteran Status
Unknown or Not Reported 57
Yes 7
No 1,176
Ethnicity
628
Non-Hispanic
543
Hispanic
67
Unknown or Not Reported
2
More Than One Ethnicity
Sexual Orientation
Bisexual 8
Heterosexual Straight 402
Unknown or Not Reported 821
Race
957
White
132
More Than One Race
58
African American or Black
39
Unknown or Not Reported
21
Asian
19
Alaska Native or Native American
14
Other
Primary Language
1,062
English
123
Spanish
50
Unknown or Not Reported

Community Services and Supports Non-FSP Services: Report on Prior Fiscal Year Activities AND Program Plan

Pathways to Well-Being

Contracted by CALM, inc. and Family Services Agency

Program Populations of Focus

Homeless	
Forensic	
Involved in Social Services System	X
Unserved/Underserved	
Cultural Population (specify below)	
Veterans	
Other (Specify Below)	X
Children, TAY	X

Program Summary: The Pathways to Wellbeing Program focuses on supporting foster care youth and their families by providing comprehensive mental health services and trauma-informed care. The contracted providers for this program are CALM, inc. and Family Services Agency (FSA). Collaborating with Child Welfare Services and Behavioral Wellness staff, the program aims to maintain stable placements, reduce relocations, and increase successful reunifications and adoptions, as measured by quarterly reports on client discharges and engagement in purposeful activities.

Available data on this program's outcomes for the prior fiscal year period, FY 23-24 is included as an Appendix to this document.

Program Performance FY 24-25

Using an outpatient model of mental health assessment, The Pathways to Wellbeing program provides mental health services for foster youth and their foster families to solve problems in the home environment. Comprehensive assessments and specialty mental health services are provided to foster care youth (Katie-A) ages 0-21, 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.

The Pathways to Wellbeing Program provides services to children and youth (ages 0-21) who have a diagnosis of Serious Emotional Disturbance (SED) or are Medi-Cal beneficiaries diagnosed as needing specialty mental health services (as described in C.C.R., Title 9, Chapter 11, commencing with Section 1810.100 et seq.); are residing in foster or residential placement; and are assessed at a high level of risk based on County's outcomes and level of care instrument, as directed by Behavioral Wellness and regardless if the client is served by Behavioral Wellness Children's Clinics. Services shall also be provided to each client's foster family. Many of these families are part of the Latinx community and are involved with Child Welfare Services (CWS).

CALM:

During the past fiscal year, the program has continued to provide critical mental health services to children in foster care, with a focus on increasing access for unserved and underserved populations. A significant portion of the children served identify as Latinx and Spanish-speaking, reinforcing the need for culturally and linguistically responsive services. Our bilingual staff remain essential in reducing barriers to care and ensuring equitable access.

A key development has been strengthening service continuity in Lompoc by allowing clients to transition from Pathways to Wellbeing to Intensive In-Home Services (IIH) within CALM. This year, we successfully transitioned one foster youth in Lompoc to IIH, ensuring they could receive a higher level of care while remaining with their established provider. This represents an important step toward reducing disruptions in services for children who require intensive support.

While Santa Barbara has seen a decline in referrals, foster youth who do enter the program have been connected to services without delays. Lompoc continues to carry the majority of referrals, reinforcing the ongoing high demand for services in that community. This highlights the importance of sustaining resources and staff capacity to meet client needs effectively.

Family Service Agency:

The Pathways to Well-Being Program is an outpatient model of mental health assessment for Katie A. CLASS mild-to-moderate clients open to Child Welfare Services (CWS) and their foster family to solve problems in the home environment. Program staff demonstrate and implement evidence-based practices with the youth and foster family as a means to improve the client's behavior and provide structure and routine to the foster home environment. The Program offers individualized, and if clinically indicated, family counseling services to children and youth, and their foster families. Program staff seek to develop, support, and empower family units by identifying strengths and needs and teaching problem solving skills. Services are aimed at preventing further incidents of behavioral, emotional, and/or social disturbance that may lead to removal from the foster home or out-of-county placement.

During fiscal year 23-24 we served a quarterly average of 14.8 unique clients for a total of 59 clients during the fiscal year. Of these 0% were incarcerated; 0% admitted to acute psychiatric care; 100% had stable/permanent housing; and 99% engaged in purposeful activity. A total of 15 clients were discharged in the fiscal year. Of these 0% were discharged to a higher level of care; 94% graduated successfully or were discharged to a lower level of care; and 1% were placed in new out-of-primary home placement.

Addressing Community Issues

Once a Katie A. child has been determined to meet CLASS status, Behavioral Wellness ensures the provision of ongoing services through its contracted providers. CALM delivers the Pathways to Well-Being program in the Santa Barbara (South County) and Lompoc (West County) regions, while Family Services Agency (FSA) provides the 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.

Pathways to Well-Being is a program that serves children who have intersected with Child Welfare Services and who are at-risk or have met criteria for a mental health diagnosis. Children receive mental health treatment to support stabilization in their environment. Central to this program is inter-disciplinary collaboration and coordination between the caregiver, mental health team, Child Welfare Services, and the community to optimize child and family well-being. Goals are to reduce mental health symptomology and stabilize placement.

Santa Barbara County Foster Youth and the resource parents who care for them are a particularly vulnerable population with a higher risk for loss of placement, future victimization as well as CWS and juvenile justice involvement in addition to the high levels of specialty mental health impairments or risk of impairment due to CWS involvement and the circumstance leading to this involvement.

Notable Community Impact

CALM: The program's impact on the community is strengthened by our commitment to using evidence-based treatment models that are proven to support healing and resilience in children and families. Through Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Eye Movement Desensitization and Reprocessing (EMDR), Child-Parent Psychotherapy (CPP), and Cognitive Behavioral Therapy (CBT), we ensure that clients receive interventions tailored to their unique needs, grounded in research and best practices.

By integrating these models into our services, we provide a structured, effective approach to addressing trauma, anxiety, depression, and attachment challenges. For example, TF-CBT has helped children process and make meaning of difficult experiences, leading to reductions in Post-Traumatic Stress Disorder (PTSD) symptoms and improved emotional regulation. EMDR has been particularly beneficial for children who struggle with distressing memories, allowing them to reprocess traumatic events in a safe and supportive environment. Meanwhile, CPP has strengthened the bond between caregivers and young children, enhancing relational security and fostering healthier family dynamics.

The impact of these approaches extends beyond individual clients to the broader community. As children gain coping skills and emotional regulation strategies, they are better equipped to succeed in school, form healthy relationships, and engage positively in their communities. Caregivers, too, benefit from increased confidence in supporting their children's emotional well-being.

By maintaining a strong foundation in evidence-based practices, we ensure that our clients receive the most effective care possible, leading to long-term benefits for families and the community as a whole.

Family Services Agency: The Pathways to Well-Being Program utilizes a variety of effective evidence-based treatment methods to provide intensive in-home interventions, which may include:

1. Assisting foster family members with stress management;

2. Building communication skills;

3. Teaching anger management skills;

4. Teaching and modeling effective parenting skills;

5. Working with biological parents and the clients as needed to assist with reunification;

6. Assisting foster families to develop links to community partners and encouraging and empowering families to use those resources. Examples may include clergy, family members, and friends;

7. Developing and guiding parents in behavioral interventions;

8. Using evidence-based practices to identify and reinforce appropriate family roles and relationships;

9. Identifying communication patterns among family members and teaching family members appropriate response and coping mechanisms; and

10. Utilizing a recovery-oriented, strengths-based approach in delivering treatment service

Program Plan FY 25-26

Provider:	**CALM, Family Services Agency**
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$798,100
Estimated CSS Funding	$0
Estimated Medi-Cal FFP	$130,500
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$667,600
Average Cost Per Consumer	$8,143
Estimated Total of Consumers Served	98
Target Population Demographics Served	Children, TAY

Estimated Consumers Served by Age FY 2024/25		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	77	$8,143
Estimated Total Consumers Age 15-26 Served	21	$8,143
Estimated Total Consumers Served Age 26-59	0	0
Estimated Total Consumers Served Age 60+	0	0

Program Description

The Pathways to Well-Being Program includes an outpatient model of mental health assessment (to determine class/subclass Katie-A status) and mental health service delivery for foster youth who meet class criteria, and their foster family, to solve problems in the home environment. Comprehensive assessments and specialty mental health services are provided to foster care youth (Katie-A) ages 0-21, 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 Cen-Cal 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 Behavioral Wellness to designated Katie-A Practitioner Assessors. Behavioral Wellness practitioners conduct initial assessments on Katie A children ages 6-21, while CALM practitioners provide the initial assessments for children 0-5. These initial assessments determine whether a Katie-A youth requires specialty mental health services. The Behavioral Wellness Katie-A Practitioner Assessors for children 6-21, 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). CALM's Katie-A assessors are located in each of CALM's offices county-wide (Santa Barbara, Lompoc and Santa Maria).

For the provision of on-going services once a Katie A child has been determined to meet class status, 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.

Top Community Issues

This program is specifically for Foster Care youth and their families. Foster Care youth are considered an underserved population.

Performance Goals and Intended Outcomes

FSA and CALM

Performance Goal	Intended Outcome	Data Source
Unique Clients Incarcerated	≤5%	Smart Care/Smart Sheet
Of the total number of discharges from incarceration, follow up after discharge from jail within 7 days	≥95%	Smart Care/Smart Sheet
Unique Clients Admitted to Acute Psychiatric Inpatient Care	≤5%	Smart Care/Smart Sheet
Of the total number of discharges from inpatient admission, follow up after discharge within 7 days	≥95%	Smart Care/Smart Sheet

Unique Clients Received Crisis Services	≤10%	Smart Care/Smart Sheet
CANS Completion (Ages 0-20)	≥95%	Smart Care/Smart Sheet
Pediatric Symptom Checklist (PSC) Completion (Ages 3-17)	≥95%	Smart Care/Smart Sheet
Unique Clients With Stable/Permanent Housing	≥95%	Smart Care/Smart Sheet
Unique Clients Engaged in Purposeful Activity	≥95%	Smart Care/Smart Sheet
Unique Clients Discharged to Lower Level of Care	≥85%	Smart Care/Smart Sheet
Unique Clients Discharged to Higher Level of Care	≤15%	Smart Care/Smart Sheet

Strategies to Address Service Disparities for Unserved and Underserved Populations

We provide services out in the community, whether it is in the home, school, or the community. As indicated, we work collaboratively with resource parents, CWS, Behavioral Wellness staff, school staff and others who have meaningful relationships with the client. We provide a wide array of services and have flexibility with hours of services. We also provide trauma informed parenting classes to new resource parents who are learning to parent children impacted by trauma

Program Priorities

Pathways does require a team effort with Child Family Team (CFT) engaging all service providers and natural supports to assist in the treatment and stabilization of these children's mental health, housing and justice involvement. There is a component of education for resource parents to prevent disruption of placement and thus further trauma to the child. These families are all Child Welfare Services (CWS) involved.

Program Alignment with the General Standards of the MHSA

Community Collaboration: We work with resource parents, CWS, schools and BWell staff to collaborate on cases.

Cultural Competence: For Spanish speaking clients and resource parents we have staff who are bilingual and bi-cultural who provide services in the native language. For other languages we use professional interpreters.

Client and Family Driven: We provide CFT meetings to focus on child and family needs and strengths, and use the CANS to inform these meetings.

Wellness, Recovery, and Resilience Focused: Services are strength-based, focused on building resilience.

Integrated Service Experiences for Clients and Family: We collaborate with CWS and BWell and the CBOs (CALM, FSA and Casa Pacifica) to support families. In CFTs we also invite client's natural supports.

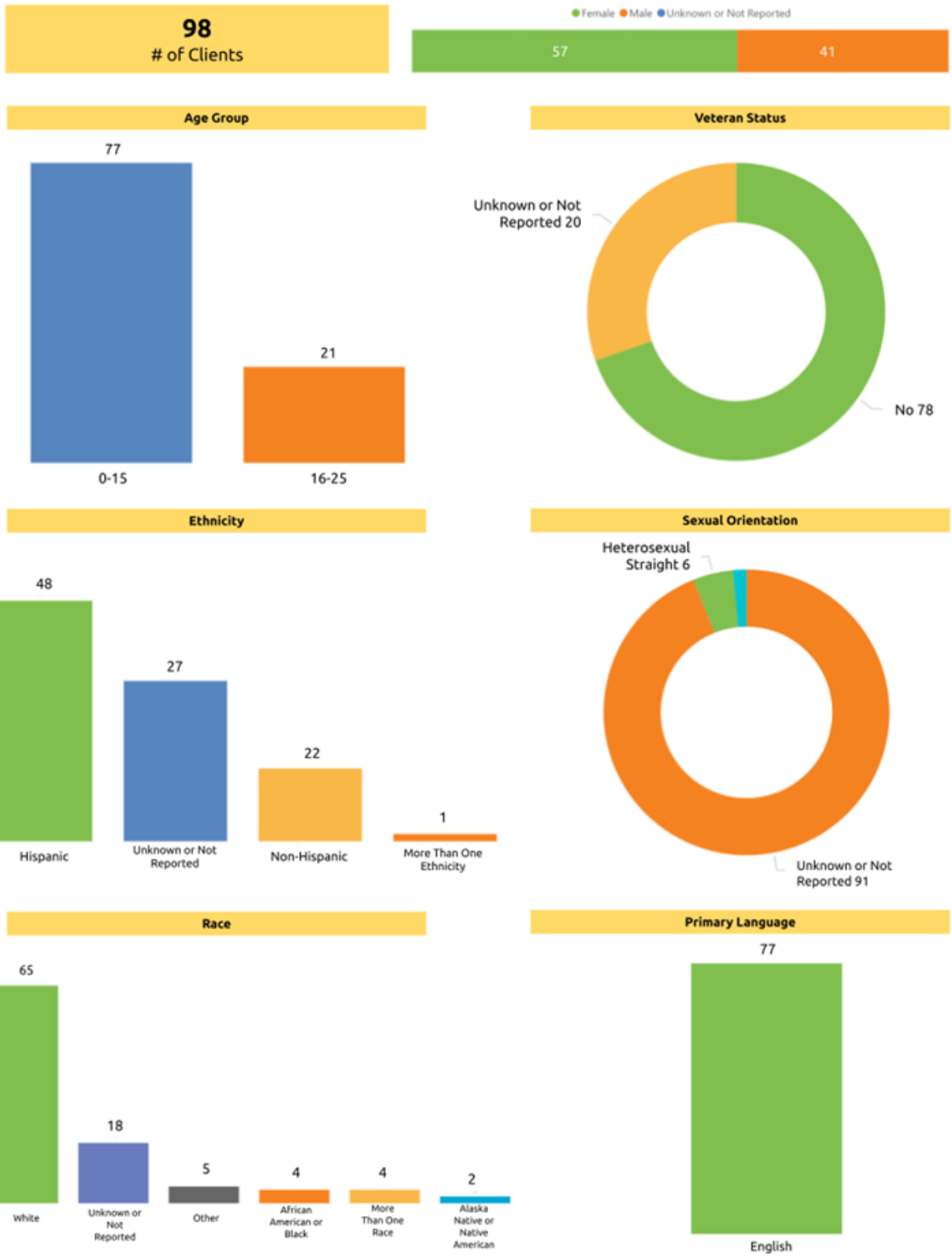
Changes to Service Delivery

CALM: For the upcoming year, we have made adjustments to service delivery in response to lower-than-expected referral volume. To ensure clinicians maintain steady caseloads, some have taken on clients outside of this program. This approach is necessary given our fee-for-service structure, allowing us to sustain operations while continuing to provide high-quality care to those who need it.

FSA: Due to the fiscal impact of payment reform, FSA has had to change its approach to service delivery for mental health services across the agency. Many therapists' caseloads are now diversified, servicing multiple contracts and demographics. This has resulted in a total net reduction of staffing and deliverables for the Pathways to Well-Being Program.

Program Demographic Data

Reporting FY 23-24


98
# of Clients
Female
Male
Unknown or Not Reported
57
41
Age Group
77
21
0-15
16-25
Veteran Status
Unknown or Not Reported 20
No 78
Ethnicity
48
27
22
1
Hispanic
Unknown or Not Reported
Non-Hispanic
More Than One Ethnicity
Sexual Orientation
Heterosexual Straight 6
Unknown or Not Reported 91
Race
65
18
5
4
4
2
White
Unknown or Not Reported
Other
African American or Black
More Than One Race
Alaska Native or Native American
Primary Language
77
English

Community Services and Supports Non-FSP Services: Report on Prior Fiscal Year Activities AND Program Plan

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

Program Populations of Focus

Homeless	X
Forensic	X
Involved in Social Services System	
Unserved/Underserved	
Cultural Population (specify below)	
Veterans	
Other (Specify Below)	X
TAY, Adult, Older Adult	X

Program Summary: The Crisis Residential Treatment (CRT) programs, situated across North and South County, offer voluntary residential recovery services to individuals in crisis, aiming to alleviate active behavioral health symptoms and distress while ensuring stable housing post-discharge. Utilizing measurement tools like the Symptom Checklist and Severity Scale, significant improvements are reported in clients' conditions during and after their stay in CRT. The programs prioritize serving underserved populations, including the homeless and those involved in the justice system, as well as those facing crises, providing psychiatric rehabilitation, temporary housing, and various recovery programs with a focus on cultural competence and client-driven support.

Available data on this program's outcomes for the prior fiscal year period, FY 23-24 is included as an Appendix to this document.

Program Performance FY 24-25

The Department of Behavioral Wellness offers voluntary residential recovery programs to clients in crisis in both North (Santa Maria and Agnes) and South County. These facilities are operated by Crestwood and Telecare.

The Programs allow clients in crisis, who have a severe mental illness, to receive treatment from Mental Health Practitioners, Caseworkers, Residential Counselors, 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.

There are currently no changes in performance of the program. We serve clients referred by BeWell and additional community-based organizations. We serve the following underserved populations: Unhoused, Step Down from Higher Levels of Care, Justice Involved, and Impoverished clients are served. We strive to have staff who are bilingual, and all staff are trained in cultural competency. To meet Senate Bill-43 initiative, Telecare programs will become Dual Diagnosis Capable by January 2026 to better services the population.

Crestwood CRT:

We experience frequent challenges with housing after CRT. The only source of housing are shelters, which are not a viable place to send folks after stabilizing at CRT. Our county could benefit from a longer stay, like a "Bridge Program". Crestwood has a similar program in another county where clients transition from CRT to the Bridge Program for longer supported treatment. We have had successes with "warm hand-offs" getting clients back to their home cities/states with family, and connecting them to mental health services.

Our bed availability fluctuates frequently since it is a "voluntary" program and folks are admitted and discharged at different times. Most of the time we have beds and there are no issues with availability. Referral packets are received daily and weekly. Overnight staffing has retention issues; there is a high turnover rate, and a high amount of college students seeking entry level (seasonal) employment.

Addressing Community Issues

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

Notable Community Impact

Telecare's mission is to deliver excellent and effective behavioral health services that engage individuals with complex needs in recovering their health, hopes and dreams.

We further stabilize BWell-referred clients in various situations until they are ready to discharge to the community. Temporary Housing options remain challenging for unhoused folks with no source of income or family support.

Program Plan for FY 25-26

Provider:	**Crestwood, Telecare**
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$6,241,300
Estimated CSS Funding	$2,021,500
Estimated Medi-Cal FFP	$3,924,900
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$ 294,900
Average Cost Per Consumer	$24,285
Estimated Total of Consumers Served	257
Target Population Demographics Served	TAY, Adult, Older Adult

Estimated Consumers Served by Age FY 2023/24		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	22,668
Estimated Total Consumers Age 15-26 Served	33	22,668
Estimated Total Consumers Served Age 26-59	214	22,668
Estimated Total Consumers Served Age 60+	27	22,668

Estimated Consumers Served by Age FY 2024/25		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	22,668
Estimated Total Consumers Age 15-26 Served	33	22,668
Estimated Total Consumers Served Age 26-59	214	22,668
Estimated Total Consumers Served Age 60+	27	22,668

Estimated Consumers Served by Age FY 2025/26		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	24,285
Estimated Total Consumers Age 15-26 Served	31	24,285
Estimated Total Consumers Served Age 26-59	201	24,285
Estimated Total Consumers Served Age 60+	25	24,285

Performance Goals and Intended Outcomes

Performance Goal	Intended Outcome	Data Source
Unique clients discharged to higher level of care	Less than 5%	Quarterly Report
Unique clients discharged to lower level of care	More than 95%	Quarterly Report
Unique Clients Engaged in Purposeful Activity	More than 95%	Quarterly Report

Strategies to Address Service Disparities for Unserved and Underserved Populations

We provide Psychiatric Rehabilitation services and temporary housing to underserved population, including those in crisis, unhoused and/or justice-involved. We serve clients referred to us via BWell.

Program Priorities

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 Alignment with the General Standards of the MHSA

Community Collaboration: CBO Provider for BWell, collaborating with referral sources, social workers, and other Community Providers.

Cultural Competence: Ongoing staff trainings on Cultural Competence and Cultural Humility.

Client and Family Driven: Encouraging family support/visitation while client is in treatment has proven successful.

Wellness, Recovery, and Resilience Focused: We utilize WRAP (Wellness, Recovery Action Plan) in our curriculum.

Integrated Service Experiences for Clients and Family: The Crisis Residential Treatment Facilities provide a full range of services and connect clients to other services provide by BWell, Department of Social Services, Department of Rehabilitation and Community-Based Organizations.

Changes to Service Delivery

Telecare is in process of becoming Dual Diagnosis Capable by January 2026 to better services the population and combat the substance epidemic and impact on the clients served.

Crestwood: We would like to respond clinically to the many positive Urine Drug Screenings (UDSs) we have after clients go into the community by adding a Certified Drug and Alcohol Counselor to our staffing pattern. Having a certified drug and alcohol counselor will allow to expand the clinical services we provide in a responsive manner to the incidents we are seeing and experiencing most in our programs.

Program Demographics

Reporting FY 23-24

Total Clients by Provider	
North	**South**
n= 182	n= 90


257
# of Clients
Female Male Unknown or Not Reported
99
158
Age Group
32
16-25
201
26-59
25
60+
Veteran Status
Yes 1
Unknown or Not Reported 28
No 228
Ethnicity
119
Non-Hispanic
106
Hispanic
31
Unknown or Not Reported
1
More Than One Ethnicity
Sexual Orientation
Bisexual 4
Heterosexual / Straight 100
Unknown or Not Reported 147
Race
157
White
48
More Than One Race
23
Unknown or Not Reported
17
African American or Black
6
Other
4
Alaska Native or Native American
2
Asian
Primary Language
216
English
28
Unknown or Not Reported

Community Services and Supports Non-FSP Services: Report on Prior Fiscal Year Activities AND Program Plan

Adult Housing Support Services

Program Populations of Focus

Homeless	X
Forensic	
Involved in Social Services System	
Unserved/Underserved	
Cultural Population (specify below)	
Veterans	
Other (Specify Below)	X
TAY, Adult, Older Adult	X

Program Summary: The Adult Housing Support Services program, operated by various providers, caters to transitional and stable housing for the unhoused and previously homeless individuals. Through licensed residential facilities, on-site supportive services and case management, the program aims to foster stability, reduce recidivism and improve living conditions for underserved populations, including those facing mental health challenges. Ongoing strategies involve close collaboration with community partners, bilingual staff deployment, and plans for potential expansions to meet the increasing demand for these critical services.

Available data on this program's outcomes for the prior fiscal year period, FY 23-24 is included as an Appendix to this document.

Program Performance FY 24-25

Good Sam: Good Samaritan Shelter continues to provide essential supportive services at Homekey, West Cox, and the Depot Street apartments, supporting individuals as they transition from homelessness. Many residents face complex challenges, including co-occurring disorders and severe, persistent mental illness. To address their needs, the program offers onsite case management, structured engagement activities, and comprehensive care coordination.

We are actively working to strengthen our relationships with Housing Authority staff, as we have found that early involvement with clients upon move-in leads to better long-term outcomes. This collaborative approach has helped ensure smoother transitions, greater housing stability, and improved engagement in supportive services.

Mental Wellness Center: Our services specifically serve LatinX, African American, Unhoused and Justice involved populations. Each of our four Adult Residential Facilities are composed of a wide range of ethnicities. We have a high retention rate and low percentage of clients discharging to higher level of care (LOCs) or being incarcerated.

PathPoint Onsite Supportive Housing Services: The underserved populations we work with in Residential Supportive Services (RSS) are primarily people transitioning from homelessness, dual diagnosis, and adults experiencing moderate to severe and persistent mental illness. This program provides on-site support to help residents maintain their housing and learn to live successfully in an independent living setting. On-site support uses early intervention as a way to reduce evictions by addressing resident issues as they develop early on. We have one staff person who speaks conversational Spanish to reduce the barrier language can provide to engaging in supports. The on-site convenience also reduces transportation barriers.

Residential (Mountain & Phoenix Houses): The unserved/underserved populations we work with are primarily people who have experienced homelessness or would be at risk of homelessness without access to Mountain & Phoenix House Board & Care level of care. We work closely with treatment teams including Justice Alliance to support our residents who would otherwise be at risk of criminal justice system involvement if homeless or with untreated mental illness.

Psynergy: We serve county residents in their transition back to County services post-hospitalization. We provide twenty placements at two different adult residential facilities.

Addressing Community Issues

Good Sam: The Good Samaritan supportive services program provides the supportive services component tied to permanent housing throughout the mid and northern county. This program allows for vulnerable community members to have support and permanent housing.

Mental Wellness Center: The bulk of our clients would most likely be incarcerated, in locked facilities or homeless without the services our Adult Residential Facilities provide. Underserved individuals are our primary population.

PathPoint Onsite Supportive Housing Services: By working with Housing Authority partners to identify those who may need mental health support Pathpoint utilized early intervention prevention to manage symptoms and ultimately increase housing stability. Being located on site at three different properties owned and operated by Housing Authoritya provides ease of access to support which can increase likelihood of residents struggling with mental health to engage in supportive services.

PathPoint RESIDENTIAL (Mountain & Phoenix Houses): Ensuring adequate housing for our residents, Phoenix and Mountain House staff are able to support our residents with accessing their treatment teams, which include Psychiatrists, Case Managers, and Primary Care

Physicians. Stable & safe housing allows our residents the opportunity to address mental health symptoms and strengthen collaboration with treatment teams to access resources that serve to increase the likelihood of consistently engaging in purposeful activities.

Notable Community Impact

Mental Wellness Center: Examples of notable community impact include a reduction of incarcerations, hospitalizations (mental and physical health), and Emergency Management Services. Our clients reside in permanent housing with 24/7 support in addition to low-level case management, medication support, Activities of Daily Living /Instrumental Living Skills support, and additional residential services.

PathPoint Onsite Supportive Housing Services: Housing Authority of the County of Santa Barbara houses our community's vulnerable members, thereby making an impact on increasing the number housed.

PathPoint supported 21 residents for the 2024-2025 FY in maintaining housing and providing support to persons served. These residents continue to live independently at El Carillo, Artisan Court, and Bradley Studios.

PathPoint RESIDENTIAL (Phoenix & Mountain Houses): We serve 26 people at Mountain & Phoenix Houses, and keep our facilities at capacity based on county referrals. During this fiscal year were able to adequately house 30 individuals who have been diagnosed with a severe mental illness. Staff actively work with residents of Mountain & Phoenix houses to address mental health symptoms that would likely go untreated if unhoused.

Good Sam (Homekey, West Cox and Depot Street): Good Samaritan Shelter's supportive services at Homekey, West Cox, and Depot Street apartments have made a significant impact on the community by fostering stability and long-term housing success for formerly homeless individuals. Over the past year, several residents have successfully transitioned to lower levels of care, demonstrating the effectiveness of our person-centered approach.

The caseworker at West Cox served 13 unique tenants, and all tenants maintained stable housing and were engaged in meaningful activities. The case worker helped two clients each quarter with property management issues as well, and linked 8 unique clients to substance use disorder and/or mental health services.

The caseworker at Depot Street served 24 unique tenants with 100% of tenants maintaining stable housing, and 99% were engaging in meaningful activities. The case worker helped two clients across quarters with property management issues and linked 4 unique clients to substance use disorder and/or mental health services. All 24 unique residents were also linked to benefits by the caseworker.

The caseworker at Homekey served 16 unique tenants and 100% of tenants maintained stable housing. The case worker helped a total of 5 clients across quarters with property management issues and linked 11 clients to substance use disorder and/or mental health services. All unique residents were also linked to benefits by the caseworker.

Program Plan for FY 25-26

Provider:	**Psynergy, Pathpoint, Mental Wellness Center, Good Samaritan**
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$6,892,200
Estimated CSS Funding	$2,145,100
Estimated Medi-Cal FFP	$3,745,200
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer	$60,457 (Some provider's support services, others all housing costs, each provider is varied in MHSA support)
Estimated Total of Consumers Served	114
Target Population Demographics Served	TAY, Adult, Older Adult

Estimated Consumers Served by Age FY 2025/26		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	$60,457
Estimated Total Consumers Age 15-26 Served	2	$60,457
Estimated Total Consumers Served Age 26-59	76	$60,457
Estimated Total Consumers Served Age 60+	36	$60,457

Program Description

Mental Wellness Center: The MWC operates four Licensed Adult Residential Facilities with a total capacity of 29 beds.

PathPoint Onsite Supportive Housing Services: This program provides on-site case management, rehabilitation, collateral and crisis services to BWell residents at three separate Housing Authority owned and operated apartment style housing locations designated to low

income or workforce residents in our community. This program serves between 20-35 residents between locations to provide in person support to help residents live as successfully as possible in their homes. The largest site, El Carrillo, is made up of clients who were previously unhoused which results in the need for many basic supports around caring for a household in a communal atmosphere. RSS is there to assist residents navigate the challenges. Having on site staff means transportation barriers are reduced for residents enrolled and services can be accessed quickly when needed.

Pathpoint RESIDENTIAL: Mountain & Phoenix House provide 24/7 supports to persons who have been diagnosed with a mental illness. Pathpoint residences are CCL Licensed Adult Residential Facilities contracted to provide services to assist clients in managing their mental health symptoms and impairments and live the life they choose.

Top Community Issues

The Adult Housing Support Program entirely serves unhoused and formerly unhoused individuals, which are identified as an underserved population.

Performance Goals and Intended Outcomes

Performance Goal	Intended Outcome	Data Source
Residential Supportive Services (RSS) – Increase total number of persons served	Serve approximately 27 clients by the end of June 2026	Quarterly Reports
Residential – Considering increasing Phoenix House population from 12 to 15	Increase the number of beds for unserved/underserved populations in Santa Barbara county	Quarterly Reports
MWC: Reduce incarceration, less than 5%	Less than 5%	Quarterly reports
MWC: Permanent residency, 95%+	More than 95%	Quarterly Reports
MWC: Discharges to higher Level Of Care	Less than 10%	Quarterly Reports
Good Sam: Retain Housing	More than 90%	Quarterly Reports

Strategies to Address Service Disparities for Unserved and Underserved Populations

Mental Wellness Center: Strategies include close collaboration with BWELL/CBO case management teams. Mental Wellness Center clients are provided support to maintain their housing placement through the various services and supports we provide in-home.

Pathpoint Onsite Supportive Housing Services: Pathpoint maintains Spanish speaking case workers and utilizes the Language Line when needed to attain interpretation services. By increasing community access through field based and home-based services barriers like transportation are reduced. By meeting a client where they feel most comfortable in their community this increases opportunity for family involvement inside a household, such as, peer support via community programs. Pathpoint teams are comprised of staff with unique backgrounds and experience levels which provides opportunity to serve a diverse population. By attaining and maintaining a diverse workforce we hope to reduce barriers and increase connections to those most vulnerable in our communities. Strong connections to other industry leaders and partners (Housing Authority, Cottage Hospital, BWell, PATH, Rescue Mission, Mental Wellness Center and others) provide another form of outreach and coordination to those interested in receiving services who may not be engaged already.

Pathpoint RESIDENTIAL (Phoenix and Mountain Houses): The Pathpoint hiring team is actively working with Santa Barbara City College and Antioch University to recruit Residential Interns. Residential Interns are typically candidates who want experience working in the mental health field. Our goal is to help interns learn about the mental health field and develop a desire for working with unserved/underserved populations.

Program Alignment with the General Standards of the MHSA

MWC:

Community Collaboration: MWC has close collaboration with BWELL and Community-Based Organization case management teams to coordinate care.

Cultural Competence: MWC participates in annual BWELL trainings, and places bilingual staff where monolingual Spanish speaking residents are housed in addition to utilization of translation services

Client and Family Driven: MWC tailors supports to fit the client's treatment goals and housing retention.

Wellness, Recovery, and Resilience Focused: MWC offers various outings and works closely with the Recovery Learning Center (MWC program) to provide wellness activities to our residents.

Integrated Service Experiences for Clients and Family: MWC coordinates with case management agencies, connect and transport our clients to services outside the home (Psychiatry, primary care, specialty care, etc.)

Pathpoint RSS:

Community Collaboration: Resources are shared in a collaborative process between agencies in each program though weekly team meetings designed to share resources, collaborate on client issues, and resource gathering. By making a maintaining strong community partnerships with local agencies, PathPoint uses its reputation to build on these relationships to foster information sharing for families, clients and staff.

Cultural Competence: Pathpoint addresses Cultural Competency through multiple channels via Trainings: Implicit Bias, Cultural Humility, Onboarding-Person Centered Approach to working with individuals, Community: (Mental health First Aid, collateral interventions) and Workplace Culture: (Diversity and Inclusion Taskforce).

Client and Family Driven: Staff work alongside their clients relying on their input and direction to create goals and outcomes for their care. Pathpoint involves family whenever possible to educate, support and encourage engagement in client's care.

Wellness, Recovery, and Resilience Focused: Staff in each program are trained and encouraged to promote hope, personal empowerment, respect, social connections, self-responsibility and self-determination. Staff do this by embodying these core values of recovery and reflecting it in their one-on-one interventions with their clients. Interventions are client-driven and designed to foster personal growth, development, and independence.

Integrated Service Experiences for Clients and Family: Pathpoint uses our community connectedness as a way to share resources with family of those we support, and encourages their participation when appropriate. By connecting to the larger community for resources, PathPoint acts as a funnel for understanding available community resources.

Pathpoint Residential:

Community Collaboration: Mountain & Phoenix House staff assist our residents with identifying needs and learning to navigate self-advocacy to be able to effectively collaborate with partner agencies.

Cultural Competence: PathPoint addresses Cultural Competency through multiple channels via Trainings: Implicit Bias, Cultural Humility, Onboarding-Person Centered Approach to working with individuals, Community: (Mental health First Aid, collateral interventions) and Workplace Culture: (Diversity and Inclusion Taskforce).

Client and Family Driven: Staff work with clients to create a culture that promotes self-advocacy meant to address their needs and encourage family and support system involvement in their treatment when appropriate.

Wellness, Recovery, and Resilience Focused: Mountain and Phoenix Houses staff encourage our residents to live the life they choose. Our staff work with residents to build connections that are based in respect and compassion for the person they are. We support residents to

build independence that recognizes strengths and encourages self-advocacy in determining their goals.

Integrated Service Experiences for Clients and Family: Mountain and Phoenix rely on collaboration from our partner agencies to be able to coordinate care for our residents. Consistent collaboration helps our residents maintain housing. In the upcoming year, RSS hopes to be able to expand the clients served by increasing their staffing model and braiding other funding.

Changes to Service Delivery

MWC:

The MWC is currently in the process of renovating two of our facilities with the assistance of county and state grants. These renovations are being done on the two properties we own, Polly's House and Casa Juana Maria.

Polly's House just received a new roof, the wrap-around porch was opened up and we will be painting the house within the next few months. Other improvements to the interior of the house are also planned.

MWC is in the planning stages of adding two ADA accessible beds to Casa Juana Maria. These beds will replace two non-ADA beds. We will be adding a wheelchair lift to the front porch and widening the front doorway along with two doorways in the newly remodeled room. The connected bathroom will be completely redone, as well as the kitchen. Lastly, we will be turning the garage into a usable area for clients to congregate. All areas of the house will be wheelchair accessible.

Pathpoint (Onsite & Residential):

All PathPoint programs are exploring the expansion of services due to high need. Expansion of services makes good fiscal sense since we already have the infrastructure in place and programs operating.

Residential is exploring expanding by three more beds. PathPoint is also looking at the relocation of Mountain House due to consistent costly repairs at the current location.

Good Samaritan Shelters, Inc.:

For the upcoming year, Good Samaritan Shelter will continue providing supportive services at Homekey, West Cox, and Depot Street apartments, with several enhancements aimed at improving client outcomes. One key change is the expansion of transportation services, following the addition of another vehicle. This will allow us to further assist residents in

accessing medical care, behavioral health services, and other critical resources, ensuring greater consistency in engagement.

Additionally, we are strengthening our collaboration with Housing Authority staff to provide earlier and more proactive support to newly housed clients. By being involved at the point of move-in, we aim to improve housing stability, increase client engagement in case management, and prevent early lease violations.

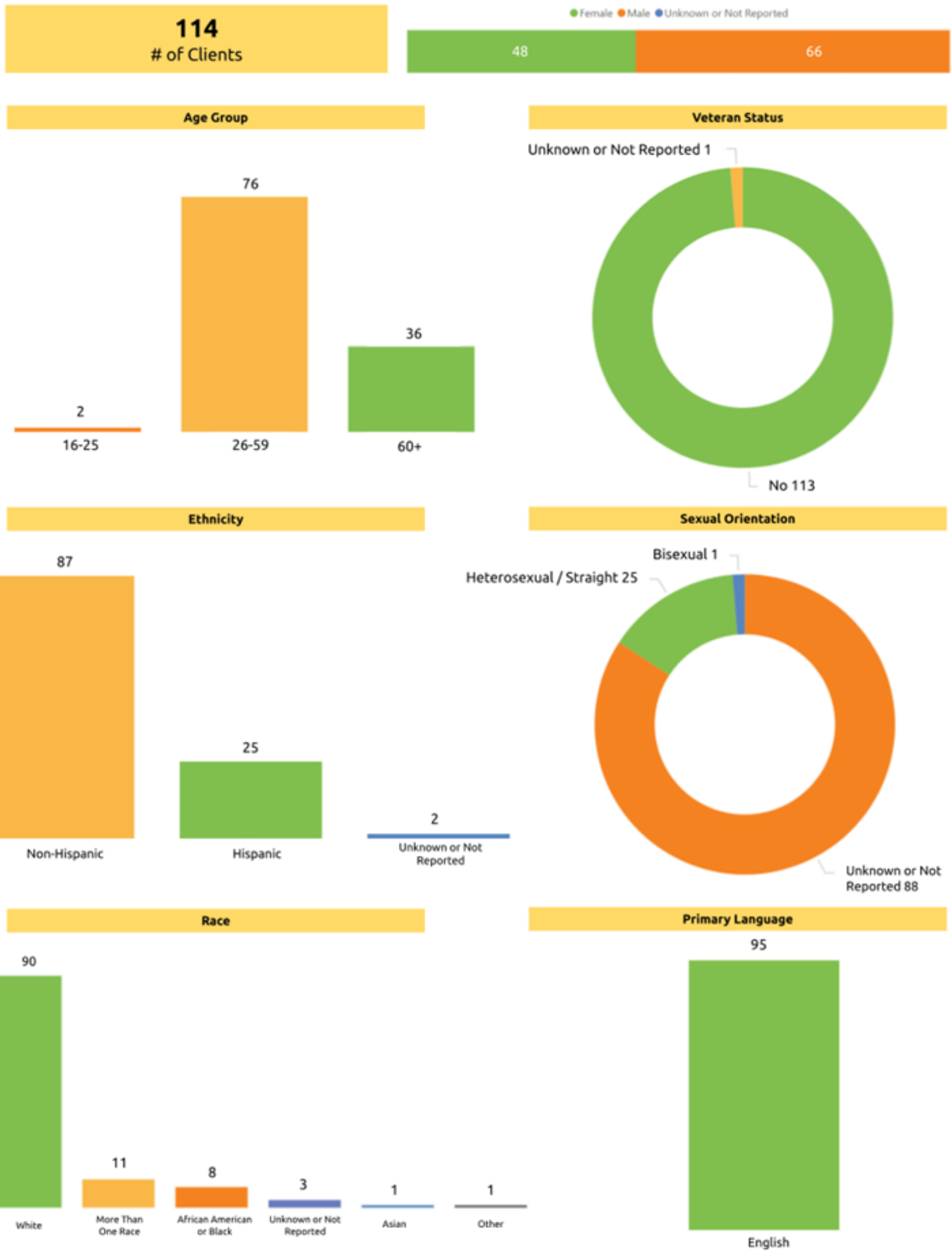
We are also placing a greater emphasis on transitioning eligible clients to lower levels of care, as we have seen success in helping individuals reach greater independence. This shift will allow us to focus more targeted support on those with the highest service needs while continuing to provide ongoing stability for those progressing toward self-sufficiency.

Program Demographic Data

Reporting FY 23-24

Total Clients by Provider						
Mountain House n= 19	**Phoenix House** n= 15	**Polly's House** n= 13	**Psynergy** n= 41	**Artisan Court** n= 7	**Bradley Studios** n= 2	**El Carrillo** n= 22

Homekey n= 21	**West Cox** n= 30	**Depot** n= 24	**Casa Juana Maria** n= 6	**Alameda House** n= 6	**CG House** n= 7


114
# of Clients
Female
Male
Unknown or Not Reported
48
66
Age Group
2
16-25
76
26-59
36
60+
Veteran Status
Unknown or Not Reported 1
No 113
Ethnicity
87
Non-Hispanic
25
Hispanic
2
Unknown or Not Reported
Sexual Orientation
Bisexual 1
Heterosexual / Straight 25
Unknown or Not Reported 88
Race
90
White
11
More Than One Race
8
African American or Black
3
Unknown or Not Reported
1
Asian
1
Other
Primary Language
95
English

Community Services and Supports Non-FSP Services: Report on Prior Fiscal Year Activities AND Program Plan

Crisis Stabilization Unit (CSU) South and North

Program Populations of Focus

Homeless	X
Forensic	X
Involved in Social Services System	
Unserved/Underserved	X
Cultural Population (specify below)	
Veterans	
Other (Specify Below)	X
Adults, Older Adults	X

BWell currently has two Crisis Stabilization Units in Santa Barbara County: one located at Marian Hospital in Santa Maria, and one located on the BWell Campus in Santa Barbara operated by Crestwood, Inc.

Program Summary: The Crisis Stabilization Unit (CSU) provides rapid crisis intervention and stabilization services within a 23-hour timeframe, catering to the underserved, the homeless, and individuals in crisis. The CSU in South County transitioned from voluntary to a locked LPS unit to accommodate both voluntary and involuntary admissions, potentially reducing strain on emergency departments and increasing daily census for more effective crisis management.

Available data on this program's outcomes for the prior fiscal year period, FY 22-23, is included as an Appendix to this document.

Program Performance FY 24-25

North: The Marian Hospital Crisis Stabilization Unit (CSU) opened on September 8, 2022. Since opening, the unit has served approximately 1800 patients from Santa Maria, Lompoc, Vandenberg, San Luis Obispo, Atascadero, Paso Robles, and its surrounding communities. The Central Coast communities continue to be underserved when it comes to mental health care; the CSU serves the neediest amongst this population by taking the vast majority of its referrals from local emergency departments. All patients are accepted based on medical need regardless of ability to pay. Given the cultural and ethnic diversity in our communities, the CSU has engaged with our Mixtec interpreters at Marian Regional, who have provided language

services and consultation with several complex cases this last year. The CSU continues to focus our care initiatives on providing individualized treatment, specific to the emotional, cultural, and psychiatric needs of our patients.

South: In January 2016, the Department of Behavioral Wellness opened the County's first Crisis Stabilization Unit (CSU) in Santa Barbara (South County). The CSU provides a safe, nurturing short-term, 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 a locked LPS unit to accommodate both voluntary and involuntary admissions, 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 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 Santa Barbara CSU was closed for over a year due to staffing shortages in our nursing classifications, but our department contracted with Crestwood and reopened the CSU in 2024. Since reopening, it has served an increased number of consumers. In FY 2024-2025, the CSU admitted and served a total of 220 individuals across the first two quarters. Furthermore, across the first two quarters, 84% of patients in the CSU were discharged to a lower level of care; 97% of these patients were connected to physical healthcare services and 71% were connected with mental or behavioral health services upon discharge.

Addressing Community Issues

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.

Additionally, the CSU has historically served a high number of individuals experiencing homelessness as well as those involved in the criminal justice system. The CSU was developed as a drop-off location for law enforcement with individuals experiencing a mental health crisis but not needing to go to jail. Similarly, Public Defender advocates have used the CSU to assist their clients in mental health stabilization.

Notable Community Impact

North: The CSU has been actively involved with coordinating discharge plans and linkage to the community mental health providers and resources. Providing seamless care throughout the behavioral health care continuum is key for this vulnerable population in terms of reducing recidivism and relapse. Ninety-eight percent of all patients discharged from the CSU have a follow up visit scheduled. By developing referral workflows and direct communication between community providers and the CSU, we are able to ensure timely follow up and access to services available in the community. Thirty-nine percent of patients are sent home or to a

lower level of care upon discharge. Prior to the CSU opening, the majority of patients with severe to moderate behavioral health crises were transferred to a higher level of care from the Emergency Departments, typically outside of the County. The CSU aims to facilitate the continuity of care more efficiently than an inpatient facility located in another county.

South:

The Crisis Stabilization Unit was closed in May of 2022 due partly to department wide staffing shortages, especially in the Psych Nurse and Psych Tech job classifications. During this time, BWELL created a locked, LPS designated unit. The CSU reopened in May 2024 and is led by Crestwood, Inc. our contracted provider.

Program Plan for FY 25-26

Provider:	**Marian Hospital, Crestwood**
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$9,243,500
Estimated CSS Funding	$0
Estimated Medi-Cal FFP	$9,145,600
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$97,900
Average Cost Per Consumer	$26,185
Estimated Total of Consumers Served	353
Target Population Demographics Served	TAY, Adult, Older Adult

Estimated Consumers Served by Age FY 2024/25		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	26,185
Estimated Total Consumers Age 15-26 Served	86	26,185
Estimated Total Consumers Served Age 26-59	239	26,185
Estimated Total Consumers Served Age 60+	28	26,185

Program Description

CSU is a 23-hour crisis stabilization unit that provides crisis de-escalation, stabilization, linkage and discharge planning. Services include assessment, medication administration, rehab counseling and discharge planning.

Performance Goals and Intended Outcomes, South

Performance Goal	Intended Outcome	Data Source
Unique clients discharged to higher level of care	Less than 5%	Quarterly Reports
Unique clients discharged to lower level of care	More than 95%	Quarterly Reports
Unique clients incarcerated/ Juvenile Hall	Less than 5%	Quarterly Reports

Performance Goals and Intended Outcomes, North

Performance Goal	Intended Outcome	Measure	FY 25/26 Result	Data Source
Assist clients in their mental health recovery process by arranging for and advocating for the appropriate level of care in the continuum upon discharge.	A. % of patients upon discharge that transition to a higher level of care B. % of patients upon discharge that transition to a lower level of care.	< 40% > 60%	39% 61%	Discharge Summary
Assess client need for mental health services and community support services.	Assessment is made during stay for the need for any of the following services: outpatient mental health, substance use disorder services, primary care, domestic violence, elder or dependent adult abuse	> 90%	98%	Medical Record
Provide client linkage to appropriate mental health services and/or community support services.	Referral is made prior to discharge for follow up to one of the following or equivalent services: outpatient mental health, substance use disorder services, primary care, domestic violence, elder or	> 45%	98%	Discharge Summary

	dependent adult abuse			
Client input regarding the care setting and service provided is collected through a patient experience questionnaire and measured	Administer a patient satisfaction survey tool to collect input at a meaningful participation rate (Returned Surveys/Clients).	> 35%	58%	Patient Surveys
Advocate for behavioral health awareness and services through community outreach activities, committee participation, education events or equivalent	Number of annual events, boards, committees, presentations attended where behavioral health access, awareness and collaboration were addressed.	> 8	8	Leadership Calendar
Expand referral sources to the CSU in order to improve access to behavioral health services	Increase referral sources to CSU annually	1	5	Admission Referral

Program Priorities

This program is entirely for those in crisis, an underserved population.

Program Alignment with the General Standards of the MHSA

Community Collaboration: CSU collaborates closely with other county departments including law enforcement, Public Defender and Public Health.

Cultural Competence: All CSU staff are continually educated in cultural competence and health disparities

Wellness, Recovery, and Resilience Focused: Length of stay at the CSU is only 23 hours, so CSU staff are very focused on rapid crisis stabilization and linkage to more long-term behavioral health programs to assist clients in achieving wellness, recovery and resilience.

Integrated Service Experiences for Clients and Family: CSU staff work closely with family members of clients on the unit to develop effective, safe discharge planning.

Changes to Service Delivery

North: The CSU will continue to have the goal of expanding their outreach efforts to not only Marian Regional, but to include other Emergency Departments and community mental health

providers in the Central Coast Region of California. The continued goal is to increase awareness of this treatment option and improve access points of care for this vulnerable and underserved patient population.

The CSU has also undertaken a review process of the higher level of care facilities that admit patients for longer treatment. We are assessing the quality of the facilities to ensure patients receive high-quality, safe and consistent care. It is hoped that this vetted group of facilities will become a more integrated continuum of care.

South: CSU has moved from a voluntary unit to a locked LPS unit. This allows the unit to continue taking individuals requesting voluntary services, and also to take individuals who are on a 5150 involuntary hold. This will help to alleviate the number of individuals on 5150 holds who are waiting for LPS placement in local ED's. We anticipate this move to locking the unit will also help to increase average daily census and therefore reducing the non-reimbursable costs for this program.

Program Demographic Data

Reporting FY 23-24

Total Clients by Provider	
North	**South**
n= 327	n= 26


353
# of Clients
Female
Male
Unknown or Not Reported
159
186
Age Group
86
16-25
239
26-59
28
60+
Veteran Status
Yes 3
Unknown or Not Reported 50
No 300
Ethnicity
171
Hispanic
122
Non-Hispanic
58
Unknown or Not Reported
2
More Than One Ethnicity
Sexual Orientation
Gay / Lesbian 5
Heterosexual / Straight 143
Unknown or Not Reported 200
Race
245
White
50
Unknown or Not Reported
31
More Than One Race
9
African American or Black
8
Asian
6
Other
4
Alaska Native or Native American
Primary Language
273
English
56
Unknown or Not Reported
23
Spanish

About 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.

Outreach for Increasing Early Recognition of Early Signs of Mental Illness: Prevention and Early Intervention (PEI): Report on Prior Fiscal Year Activities AND Program Plan

Mental Health Education and Support to Culturally Underserved Communities

Provider: Santa Ynez Tribal Health Clinic

Program Description: This program offers culturally based workshops, peer support and community engagement, including talking circles, to Chumash and other Indigenous communities in mid and north county. This program also offers talking circles at Santa Ynez High School for Native American transitional age youth.

Available data on this program's outcomes for the prior fiscal year period, FY 23-24, is included as an Appendix to this document.

Program Type(s):

- Outreach for Increasing Recognition of Early Signs of Mental Illness Program

Priority Area(s):

	Childhood Trauma Prevention and Early Intervention
	Early Psychosis and Mood Disorder Detection and Intervention
X	Youth Outreach and Engagement Strategies Targeting Secondary School and TAY, Priority on College MH Program
X	Culturally Competent and Linguistically Appropriate Prevention and Intervention
	Strategies Targeting the Mental Health Needs of Older Adults
	Early Identification Programming of Mental Health Symptoms and Disorders
	Other Locally identified Priority: _____

Program Performance FY 24-25

This year, the Santa Ynez Tribal Health Clinic (SYTHC) started enhancing its Community Outreach Services. Within this program, we currently facilitate one talking circle on the Reservation per month, and one community talking circle per quarter. We are continuing to work with Lompoc High School, and it is our hope that with future funding, we could expand this to other schools in our region. The team meets with Native Youth clients who are incarcerated at juvenile hall. We have found that working with individuals who have been formerly incarcerated allows for a smoother reentry transition. While working with these groups, we have found that basic needs must be met, and part of that is providing consistent

support and communication. Once client trust is established, we are then able to provide deeper support; they feel more comfortable to open up and our team is able to focus on the greater issues.

The core mission of SYTHC is to serve Native Americans living in Santa Barbara County. SYTHC hosted community workshops addressing various parts of physical, mental, emotional, and spiritual wellness. SYTHC met with community leaders including: One Community Action, Corazon De Pueblo, American Indian Health Services, Santa Ynez High School Wellness Program, Community Health Centers of the Central Coast, and the Tomol Paddlers Group. SYTHC created educational and informational resources to disseminate at health fairs to promote prevention and early intervention services for Youth, TAY, and adults who may experience an emerging mental health condition.

The recognition of native people from this side of the border has been a major obstacle, with many schools and organizations focusing on other indigenous groups and specific Diversity Equity and Inclusion (DEI) categories. Native Americans are feeling left out and identifying with their Mexican heritage to feel some sense of belonging.

Program Plan for FY 25-26

Provider:	**Santa Ynez Tribal Health Clinic (SYNTHC)**
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$ 126,370
Estimated PEI Funding	$ 126,370
Estimated Medi-Cal FFP	
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer/Families	$27.16
Estimated Total of Consumers/Families Served	4652
Target Population Demographics Served	Children, TAY, Adult, Older Adult

Estimated Consumers Served by Age FY 2024/25		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	158	$27.16
Estimated Total Consumers Age 15-26 Served	503	$27.16
Estimated Total Consumers Served Age 26-59	163	$27.16
Estimated Total Consumers Served Age 60+	7	$27.16
Unknown/Decline	3803	$27.16

Addressing Community Issues

In addition to the above-mentioned interactions with underserved/unserved populations, SYTHC now has a self-funded Care Coordinator, who works with individuals who need assistance in navigating basic needs. We also provide a comprehensive list of resources throughout the county that provide cultural competency and focus on Indigenous wellness. Santa Ynez Tribal Health Clinic provided four community trainings focused on reducing stigma and discrimination related to mental illness.

Notable Community Impact

At each of the talking circles held at the high schools, we have seen an increase in participation and learning, and also an increase in attendance. At each circle, we have also had youth approach us to let us know that they are Native, and to thank us for allowing them the chance to reconnect to their identity. We have observed an increased sense of pride within the Indigenous people we interact with.

Santa Ynez Tribal Health Clinic transitioned from virtual to in-person sweat lodge support groups. Because of the importance of this practice for cultural and spiritual healing, we have seen a much higher rate of attendees. Each program provided various outreach events, trainings, forums, and support groups to their communities. Santa Ynez Tribal Health Clinic served West County and had over 600 contacts through their outreach events, trainings, forums, and support groups that focus on culturally specific wellness practices.

Multiple youth within the program have stated that they know they are Native American but choose to claim their Mexican ancestry when going to school and while holding talking circles. When asked why they do not claim that they are Native American, they state their struggles would not be recognized within the Native American culture compared to if they said they were Mexican. One student stated most adults make them feel uncomfortable when they say they are native but not Chumash.

Problem/Community Need	Activity
• Culturally appropriate services	• Talking circle, workshops, sweat lodge ceremony • Taking these services to them (off of the Reservation)
• Access to culturally appropriate services	• Taking these services to them (off of the Reservation) • Tabling on school campuses (i.e., during lunch, etc.).
• Equity and visibility of Indigenous communities	• Community gatherings, and representation amongst all Indigenous groups
• Basic youth needs	• Providing a home-cooked meal at all youth gatherings because with Indigenous communities, food offers a sense of community, family and allows barriers to be broken down

Methods Used for Outreach and Engagement of Potential Responders

SYTHC will continue to maintain working relationships and communication with teachers and other support staff who may see students on a more regular basis, keeping these individuals abreast of upcoming Indigenous events and services focused on prevention and early intervention. SYTHC is also working with 3 different high schools in Santa Ynez, Lompoc and Santa Maria area on how to continue services for those students in need. The comprehensive resource list, as previously mentioned, will continue to be utilized as the need arises. Making a presence in schools as well as other community events throughout the county has allowed SYHTC to do two very important things:

The potential responders can identify who is Native American, which is often a major fact that is overlooked.

Additionally, finding people who are culturally attuned and culturally competent is a major factor. There is a diverse collection of different nations in Santa Maria alone, and the lack of representation can be a barrier. The symptoms of SMI within the native community look the same on the outside as they do with another group; it is the treatment and acknowledgement that is different. Approaches cannot be one size fits all, because that can cause more damage to the individual as it brings up inherited feelings of assimilation.

Changes to Service Delivery

Aside from expanding services to work with three different high schools in Santa Maria and Lompoc area, there will not be many changes. SYTHC has steadily seen number increases for groups and has been getting more requests from schools for additional groups to be held. After seeing the growth with the youth, formerly incarcerated, and homeless populations, we would like to be able to expand our services to add more support for family units.

Program Demographics

Program Performance (FY 23-24)

PROGRAM	SYTHC
TOTAL CLIENTS	**49**
AGE	
0-15	0
16-25	14
26-59	31
60+	4
Unknown/Decline	0
SEX AT BIRTH	
Female	20
Male	29
Unknown/Decline	0
CURRENT GENDER IDENTITY (if over 12 years)	
Male	28
Female	20
Transgender	0
Genderqueer	0
Questioning	0
Another	0
Unknown/Decline	1
SEXUAL ORIENTATION (if over 12 years)	
Gay/Lesbian	0
Heterosexual	0
Bisexual	0
Questioning/ Unsure	0
Queer	0
Another	0
Unknown/Decline	49
PRIMARY LANGUAGE	
English	0
Spanish	45
Other	0
Unknown/Decline	4
VETERAN (if over 12 years)	
Yes	0
No	0
Unknown/Decline	49

RACE	
American Indian/ Alaska Native	0
Asian	0
Black/ African American	0
Native Hawaiian/ Pacific Islander	0
White	0
Other	49
More than one	0
Unknown/Decline	0
ETHNICITY: LATINO	
Caribbean	0
Central American	0
Mexican/Mex. Amer./ Chicano	49
Puerto Rican	0
South American	0
Other Latino	0
Unknown/Decline	0
ETHNICITY: NON-LATINO	
African	0
Asian Indian/ South Asian	0
Cambodian	0
Chinese	0
Eastern European	0
European	0
Filipino	0
Japanese	0
Korean	0
Middle Eastern	0
Vietnamese	0
Other	0
Unknown/Decline	0
More than one	0
DISABILITY	
Physical/mobility	0
Chronic Health Condition/pain	0
Difficulty Seeing	0
Difficulty Hearing	0
Other	0
Other Mental Disability	0
Unknown/Decline	49
FAMILY	
# of Family Members in Program	0

Outreach for Increasing Early Recognition of Signs of Mental Illness:

Prevention and Early Intervention (PEI): Report on Prior Fiscal Year Activities AND Program Plan

Mental Health Education and Support to Culturally Underserved Communities

Provider: Community Health Centers of the Central Coast

Program Description: This is an outreach and engagement program to increase recognition of early signs of mental illness in the Santa Maria area.

Available data on this program's outcomes for the prior fiscal year period, FY 23-24, is included as an Appendix to this document

Program Type(s):

- Outreach for Increasing Recognition of Early Signs of Mental Illness Program

Priority Area(s):

	Childhood Trauma Prevention and Early Intervention
	Early Psychosis and Mood Disorder Detection and Intervention
	Youth Outreach and Engagement Strategies Targeting Secondary School and TAY, Priority on College MH Program
X	Culturally Competent and Linguistically Appropriate Prevention and Intervention
	Strategies Targeting the Mental Health Needs of Older Adults
	Early Identification Programming of Mental Health Symptoms and Disorders
	Other Locally identified Priority: _____

Program Performance FY 24-25

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 marginalized populations in Northern Santa Barbara County, which includes: Indigenous, Latinx, limited English proficiency individuals, migrants, agricultural workers, the unhoused, LGBTQ+ individuals, rural residents, as well as low-income individuals. The Mental Health Outreach teams' programmatic focus is the mitigation of the negative social and cultural barriers of immigration, as well as intergenerational trauma, to improve the mental, physical and behavioral outcomes of these populations. As a safety-net provider, CHCCC's primary focus is to meet the comprehensive healthcare needs of the under-resourced

and subsequently underserved communities within Santa Barbara County. The “whole-person” approach to population engagement is driven by community-based participatory activities and interventions.

The goal of mental health education and outreach activities are to empower newly bridged members of special populations, such as monolingual Spanish speakers, to bring their voice and culture into their care. Through this process, we systematically deconstruct institutionalized racism within the mental health system which has led to health disparities within these populations. CHCCC’s Mental Health Outreach team increases the community’s knowledge and understanding of mental wellness by providing linguistically accessible, culturally relevant, and evidence-based mental health education.

CHCCC created a safe community wellness space through trauma-informed approaches, such as county-wide community circles where art activities are incorporated. As a result of CHCCC’s education and outreach initiatives, community members have overcome social norms and cultural barriers which previously impeded their ability to access mental health services. Through these targeted educational campaigns, CHCCC’s 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. Our community-centered approach brings our outreach team directly to under-resourced and subsequently underserved community members that otherwise would not seek or attend support groups or community education due to stigma, childcare issues, and transportation barriers. CHCCC has developed partnerships with local agricultural employers to gain access to migrant workers at their worksites.

Through outreach strategies, we are able to increase the recognition of early signs of mental illness by engaging, encouraging, and educating community members to recognize and respond to the early signs of mental illness. The anti-stigma efforts include targeted education and training, direct contact with the population, and utilizing a culturally and linguistically appropriate approach.

Program Plan for FY 25-26

Provider:	**Community Health Centers of the Central Coast**
Estimated Funding FY 2023/24:	
Estimated Total Mental Health Expenditures	$ 146,565
Estimated PEI Funding	$ 146,565
Estimated Medi-Cal FFP	
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$0
Average Cost Per Consumer	$6.05
Estimated Total of Consumers Served	22,406
Target Population Demographics Served	Children, TAY, Adult, Older Adult

Estimated Consumers Served by Age FY 2025/26		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	9620	$6.05
Estimated Total Consumers Age 15-26 Served	2437	$6.05
Estimated Total Consumers Served Age 26-59	11,280	$6.05
Estimated Total Consumers Served Age 60+	572	$6.05
Unknown/decline	15	$6.05

Addressing Community Issues

Our primary focus is to increase mental wellness education for youth and families by working with parents, guardians, and caregivers and creating family-centered spaces. Based on community feedback, we believe it is essential to educate our community through a family systems approach, where we support parents/caregivers who find their children/ adolescents' mental health as a stressor of their own well-being. We focus on increasing the awareness and understanding of mental health issues with parents so that they are able to connect both themselves and their children to services when symptoms and signs are present.
Due to the stigma associated with mental health amongst monolingual Spanish and Indigenous speakers, it is important to bring awareness and education within family units (children, adolescents, seniors, etc.). As such, we have tailored our program to reach parents, adults, aunties/uncles, grandparents, etc.

Additionally, Latino youth are at increased risk for emotional stress. This is due to stressors, including discrimination, acculturation, racism, family communication, education, immigration, and marginalization. While there is great diversity within the Latino community, there are some shared cultural factors that connect people regardless of origin. For some, their indigenous roots are a source of pride as well as a shared language. There are strong family bonds, community connections, and a strong focus on life and work.

We design our program in alignment with cultural values such as "familismo," (familialism) a cultural foundation that emphasizes connectedness to one's family. Due to the existing stigma, some community members lack information and may not recognize the symptoms of mental health conditions or know where to seek help. This is why education at the community and family level is given to increase awareness and reduce the stigma associated with mental health. We found we can destigmatize mental health topics and issues through this engagement strategy; this will be sustained by the elders.

Notable Community Impact

We provide information through verbal and visual educational tools that are resonant and reflective of the population. We build upon the Indigenous framework of healing through natural resources that are often led by matriarchal figures. We specifically engage parents and elders, knowing that is one of the most culturally informed ways to reach whole family systems including adolescents and children. Enabled partnerships with other Mental Health Services Act Prevention and Early Intervention contracted providers allow us to join forces and expand our reach within the communities that we individually serve.

Problem/Community Need	Activities
• Increasing of Mental Health Education and Prevention Programming for Youth and Families	• Community based education to increase awareness of symptoms associated with mental health.
• Access to mental health education in a community setting "Proveer información en nuestro idioma" • Provide information in the appropriate language	• Psychoeducation in a group setting to focus on topics and provide education on depression, anxiety, mental health in general, stress, emotions, grief, communication, negative thoughts, etc. • Services are offered in Spanish and Mixteco

• Need for Mental Health Education and Prevention Programming for Youth and Families	• Community-based education to increase awareness of symptoms associated with mental health • Establish collaborative partnerships with other Latinx and Indigenous serving organizations to create safe spaces (for families and youth) and share resources with community members.
• "Juntas comunitarias para aprender a obtener ayuda" • Community gatherings to learn how to get assistance • Need for spaces that promote physical and psychological safety within centralized community settings. • Need for verbal and visual information for monolingual Spanish and Indigenous speakers	• Will provide workshops in community settings around early signs of mental illness and available mental health services • Collaborative Partnerships established to create annual community events. Indigenous Inter-Tribal Resource Gathering Created groups in a community setting where agriculture workers reside and feel safe • Psychoeducation in a group setting that focuses on mental wellness topics and provides education in a culturally appropriate manner on depression, anxiety, mental health in general, stress, emotions, grief, communication, negative thoughts, etc. • Services are offered in Spanish & Mixteco Provide information verbally and visually for individuals who speak Spanish and Indigenous languages.
Need for education and information on local mental health resources available at a local, state, and national level in community settings.	• Information about mental health resources for local and national crisis numbers, mental health providers, and health center information. • Provide targeted outreach and education to families and individuals to increase service uptake amongst Latinx & Indigenous populations in our service area.
• Need for warm handoff and navigation services for those experiencing a behavioral health crisis	• Need for warm handoff and navigation services for those experiencing a behavioral health crisis

• Need to increase services to underserved/unserved populations	• Need to increase services to underserved/unserved populations

Methods Used for Outreach and Engagement of Potential Responders

We utilize verbal, visual, and written education around mental health to increase awareness of signs and symptoms and prevent serious mental illness. The education is given in both Spanish and Mixtec and considers the population's literacy level.

Prevention is a critical intervention for those responding in community settings. Continuity in contact with communities is essential to facilitate the trust required for self-reporting and early detection of signs and symptoms of SMI. The trust built over time creates opportunities for the community to self-disclose changes in their mental well-being.

Changes to Service Delivery

In an effort to engage family and youth, we are engaging in more health fairs and community events. We are utilizing teaching tools that developed by the outreach department to provide education. We are providing intentional education geared at increasing direct community connection and participation in support groups and community events.

Program Demographics

RACE	
American Indian/ Alaska Native	0
Asian	0
Black/ African American	0
Native Hawaiian/ Pacific Islander	0
White	1
Other	80
More than one	0
Unknown/Decline	80
ETHNICITY: LATINO	
Caribbean	0
Central American	1
Mexican/Mex. Amer./ Chicano	157
Puerto Rican	0
South American	0
Other Latino	0
Unknown/Decline	3
ETHNICITY: NON-LATINO	
African	0
Asian Indian/ South Asian	0
Cambodian	0
Chinese	0
Eastern European	0
European	0
Filipino	0
Japanese	0
Korean	0
Middle Eastern	0
Vietnamese	0
Other	0
Unknown/Decline	161
More than one	0
DISABILITY	
Physical/mobility	1
Chronic Health Condition/pain	0
Difficulty Seeing	0
Difficulty Hearing	0
Other	1
Other Mental Disability	0
Unknown/Decline	159
FAMILY	

# of Family Members in Program	0

PROGRAM	CHCCC
TOTAL CLIENTS	**161**
0-15	0
16-25	13
26-59	139
60+	7
Unknown/Decline	2
Female	134
Male	24
Unknown/Decline	3
Male	22
Female	116
Transgender	0
Genderqueer	0
Questioning	0
Another	0
Unknown/Decline	23
Gay/Lesbian	0
Heterosexual	49
Bisexual	0
Questioning/ Unsure	0
Queer	0
Another	0
Unknown/Decline	112
English	2
Spanish	143
Other	2
Unknown/Decline	14
Yes	0
No	0
Unknown/Decline	161

GREEN data sourced from Smartsheet. Note that for outreach providers, data is only for individual-level activities (i.e. support groups). Demographic information about individuals engaged in outreach activities are provided in the sections for *Attendee Demographics*.

BLUE data sourced from EHR; some demographic data is not available on PEI categories.

Outreach for Increasing Early Recognition of Signs of Mental Illness:

Prevention and Early Intervention (PEI): Report on Prior Fiscal Year Activities AND Program Plan

Mental Health Education and Support to Culturally Underserved Communities

Provider: MICOP (Mixteco Indígena Community Organizing Project)

Program Description: This is an outreach and engagement program to increase recognition of early signs of mental illness in the Santa Maria area.

Program Type(s):

- Program to Improve Timely Access to Services for Underserved Populations
- Outreach for Increasing Recognition of Early Signs of Mental Illness Program

Priority Area(s):

	Childhood Trauma Prevention and Early Intervention
	Early Psychosis and Mood Disorder Detection and Intervention
	Youth Outreach and Engagement Strategies Targeting Secondary School and TAY, Priority on College MH Program
X	Culturally Competent and Linguistically Appropriate Prevention and Intervention
	Strategies Targeting the Mental Health Needs of Older Adults
	Early Identification Programming of Mental Health Symptoms and Disorders
	Other Locally identified Priority: _____

Program Performance FY 24-25

The *Alas de Esperanza Indígena* mental health prevention and early intervention program within MICOP was initiated in September 2024, but due to team hiring and onboarding delays, it officially began in November 2024. From November 2024 to March 2025, the team supported several internal programs, including Community Organizing, Healing the Community, and the Housing and Homeless Incentive Program. Additionally, the team attended external training, such as *QPR Training on Suicide Prevention*, and participated in community events like *Weeks of Hope 2024: Thanksgiving*, where they shared information about the agency's services and engaged with community members. A key milestone was when we launched a focus group on February 14, where feedback on mental health was gathered to better understand and address the community's needs and perspective on mental health. Some of the feedback we received was that when the community migrates from one place to another or from one country to

another, they come with very clear objectives, and they do not prioritize mental health. We also heard that usually the community refers to *curanderas* or *curanderos* when a family is going through something mentally. However, they do not refer to them anymore because their service started to be very expensive, and the community feels like they can no longer rely on them.

Currently, the program is overseen by a program manager and four navigators who speak varying dialects of Mixtec. The Mixtec dialects spoken by the team are as follows: San Marin Peras, San Jorge Rio Frijol, and San Juan Piña. The team's linguistic diversity creates connections and builds trust which supports in reaching unserved and underserved populations, especially our Mexican Indigenous speaking communities. The ability to provide services in an Indigenous language has been crucial in connecting with the community who may have faced barriers to accessing mental health resources. Starting in last week of February 2025, we are taking in our first cases, marking an important step in the program's development.

Program Plan for FY 25-26

Provider:	Mixtec Indigena Community Organizing Project
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$ 442,974
Estimated PEI Funding	$ 442,974
Estimated Medi-Cal FFP	
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer	$295
Estimated Total of Consumers Served	1500
Target Population Demographics Served	Children, TAY, Adult, Older Adult

Estimated Consumers Served by Age FY 2025/26		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	200	$295
Estimated Total Consumers Age 15-26 Served	200	$295
Estimated Total Consumers Served Age 26-59	900	$295
Estimated Total Consumers Served Age 60+	200	$295

PROGRAM DEMOGRAPHICS ***Because this is a new program that started in FY 24-25, Estimated Consumers Served by Age for FY 23-24 is not available. Data on consumers served for FY 24-25 will be reported in next year's Plan.

Addressing Community Issues

Mixtecs in Ventura County, and throughout the state, are culturally and linguistically isolated. MICOP is working to aid Mixtecs to draw on their community strengths and overcome existing barriers along California's Central Coast. Additionally, MICOP has opened a new office in Gudalupe area, and is providing outreach to the Mixtec community there. The communal tradition of "tequio", or community obligation, promotes a spirit of mutual assistance and community building. Our celebrations of cultural traditions build community strength and pride and add to the richness and diversity of the Central Coast life. MICOP assists their community with addressing Labor Justice issues and efforts, medical system gaps, and promotes Indigenous Pride and advocacy amongst youth in the schools.

Notable Community Impact

Our outreach efforts have informed our team of community members' initial approach to dialogues on mental health. Some individuals express interest and want to learn more, while others dismiss the idea, saying they do not need services, but know someone who might. Through these observations, we are able to inform our program's approach and pivot strategies for community engagement. One of our first steps was to open community conversations to understand how our community is approaching conversations on mental health. This effort was implemented through a focus group, which is where we were able to directly receive impactful community engagement that helped us understand our current programmatic gaps.

The most impactful feedback has come from our focus group. We reached out to our internal programs to see if they have any participants that would be interested. It was through them that we gathered 10 community members participate. Since we are aware that these conversations can take up time, we offered snacks and aguas frescas. We wanted the participants to be fully present, so we offered childcare as well. Many community members shared that while they have heard the term "mental health" in places like their children's school meetings, it is often not explained in detail due to linguistic barriers. Hearing about mental health in their preferred language made a significant difference in their understanding and identifying behavioral characteristics. Many expressed a desire for more in-depth information, as current discussions are often too brief or unclear. While there is some initial hesitation, the community is eager to engage in conversations about mental health.

Problem/Community Need	Activities

MiCop: • Outreach for Increasing Recognition of Early Signs of Mental Illness	MiCop: • Mental Health Case Workers (MHCW's): Our team will attend public events each month where Indigenous migrants and farmworkers are present to share information about how to identify early signs of mental illness. Information will be shared in Mixteco, Purepecha and other Indigenous languages common in this region. • MHCW's will disseminate information about signs of mental illness, and how to respond to them while meeting and assessing individuals for services. Information will be given orally and through literature as appropriate.
MiCop: • Early Intervention Program (Indigenous language accessible)	MiCop: • Mental Health Case Worker's will intervene by supporting families with Child Welfare Services involvement, or who are at risk of Child Welfare Service involvement and at risk of children being taken out of the home. Interventions will include connecting families to intervention services and working to ensure follow-through. Resources may include counseling, legal resources, housing, basic needs, and translation. • Intervene with families demonstrating a current mental health condition or crisis by linking them to resources (same as above), and ensuring follow-through once resources are accessed.
MiCop: • Prevention Program	• We will engage in prevention activities by targeting risk factors that are present in families needing case management support. Families with youth experiencing behavioral challenges in school for example will be referred to MICOP's TEQUIO youth group or other community agencies such as CHC,

	CALM, TMHA, Family Services agency, and BWell. • Situational risk factors that may lead to mental health issues will be addressed and alleviated through our Alas de Esperanza Indigena program as well as other linkages, referrals and coordinated support between Alas de Esperanza Indigena and other community agencies • A number of 15 support groups will be conducted to provide a safe space for community members to share their experiences and openly express their feelings. The goal is to create an environment where individuals can vent, reflect, and support one another, fostering a sense of solidarity and collective healing. Through these discussions, we hope to empower the community to better understand and address mental health challenges together, strengthening the bonds of mutual support
MiCop: • Trusted Community Leaders to help sustain trust and outreach in Mixtec communities in North County	MiCop • MiCop Program coordinator will attend community collaboratives with shared goals, and work to increase access to community services for migrant families and the Health Navigators.
Recognition of Early Signs of Mental Illness	• The Alas de Esperanza Indigena team will attend 12 public outreach events where Indigenous community members are present to share information about how to identify early signs of mental illness. • Alas de Esperanza Indigena program will provide pre and post assessments during their weekly workshop meetings
Indigenous language accessible	• Intakes will be done in their preferred language • Referrals, linkages, presentations, support groups and follow ups will be done

	consistently and in Spanish and Mixtec or preferred language
Outreach	• Alas de Esperanza Indigena team will attend outreach events, reunion comunitaria/food distribution, Health fairs, give schools presentations, and local clinics or other community agencies

Methods Used for Outreach and Engagement of Potential Responders

50 case managed families will have increased knowledge of signs and risk factors for mental illness such as anxiety, depression, and ideas of suicide, with outcomes measured by pre and post surveys.

1,000 Indigenous migrant community members will have increased knowledge of resources when struggling with a health and basic needs crisis, with outcomes measured by the number of Indigenous migrants reached at community events by the PEI program's Mental Health Navigators/Caseworkers.

Indigenous case managed families struggling with an initial crisis associated with mental health risks will be given services and referrals that stabilize that crisis, measured by pre and post surveys, and case notes.

Our program offers a valuable opportunity for responders to identify diverse individuals who may be exhibiting early signs and symptoms of serious mental illness, including conditions such as anxiety, depression, and suicidal ideation. Through a series of 20 workshops, we aim to increase community knowledge about these risk factors. These workshops will be open to our Indigenous migrant community members, allowing our navigators to engage directly with individuals and to become better equipped to recognize early warning signs in real-world settings. Additionally, the program will begin with a focus group to gain insights into the community's current understanding of mental health, which will help our team identify gaps in knowledge and tailor their outreach efforts effectively.

As part of our outreach, we will engage with at least 50 families through support groups, helping to prevent the onset of serious mental illness by identifying early indicators in individuals at risk. Through these discussions, we hope to build a community-based support system, empowering families to recognize and address mental health challenges before they escalate.

To engage potential responders and public mental health service providers, we will conduct a variety of outreach activities to identify potential collaborators. This includes hosting

workshops and support groups which bring together community members and service providers to learn how to identify and respond to the early signs of mental illness. These workshops will cover key mental health topics such as anxiety, depression, and suicide risk factors, and will include culturally specific approaches tailored to the needs of Indigenous Mexican migrants.

Additionally, we will promote the program through flyers, a dedicated Instagram page, and other digital platforms to engage community members and responders. Our Mental Health Navigators will reach at least 1,000 Indigenous migrant community members at community events, providing information about available resources and how to respond to mental health crises. These outreach efforts will be tracked through metrics such as the number of people reached, social media engagement, and feedback collected from pre-and post-surveys.

Through this collaborative learning approach, our team and mental health providers will work together to deepen their understanding of how to recognize the signs of emerging mental health conditions and respond with the appropriate resources and referrals. This will help create a more informed and supportive network within the community to address mental health challenges in a timely and culturally sensitive manner.

Outreach for Increasing Early Recognition of Signs of Mental Illness:

Prevention and Early Intervention (PEI): Report on Prior Fiscal Year Activities AND Program Plan

Mental Health Education and Support to Culturally Underserved Communities

Provider: Resilience Institute

Program Description: This is an outreach and engagement program to increase recognition of early signs of mental illness in the Santa Barbara area.

Program Type(s):

- Outreach for Increasing Recognition of Early Signs of Mental Illness Program

Priority Area(s):

	Childhood Trauma Prevention and Early Intervention
	Early Psychosis and Mood Disorder Detection and Intervention
X	Youth Outreach and Engagement Strategies Targeting Secondary School and TAY, Priority on College MH Program
X	Culturally Competent and Linguistically Appropriate Prevention and Intervention
	Strategies Targeting the Mental Health Needs of Older Adults
	Early Identification Programming of Mental Health Symptoms and Disorders

	Other Locally identified Priority: _____

Program Performance FY 24-25

Successes include setting a formal agreement with the Youth Safety Taskforce, the Santa Barbara Unified School District, and the Goleta Unified School District. We also established a partnership with the Santa Barbara Neighborhood Clinics, so they would assess clients at Casa de la Raza as a bridge to their wellness services at the clinic. We also found some success in partnering with Among Friends, a senior service agency provider from Oxnard, that comes into La Casa de la Raza to provide Case Management Wellness services to seniors in need.

Notice of Provider Ending:

This was a short-term contract with Resilience Institute to participate in our Mental Health Education Prevention program, their participation ended on December 31st, 2024.

Program Demographics FY 23-24

PROGRAM	RI
TOTAL CLIENTS	**49**
0-15	0
16-25	14
26-59	31
60+	4
Unknown/Decline	0
Female	20
Male	29
Unknown/Decline	0
Male	28
Female	20
Transgender	0
Genderqueer	0
Questioning	0
Another	0
Unknown/Decline	1
Gay/Lesbian	0
Heterosexual	0
Bisexual	0
Questioning/ Unsure	0
Queer	0
Another	0
Unknown/Decline	49
English	0
Spanish	45
Other	0
Unknown/Decline	4
Yes	0
No	0
Unknown/Decline	49

RACE	
American Indian/ Alaska Native	0
Asian	0
Black/ African American	0
Native Hawaiian/ Pacific Islander	0
White	0
Other	49
More than one	0
Unknown/Decline	0
Caribbean	0
Central American	0
Mexican/Mex. Amer./ Chicano	49
Puerto Rican	0
South American	0
Other Latino	0
Unknown/Decline	0
African	0
Asian Indian/ South Asian	0
Cambodian	0
Chinese	0
Eastern European	0
European	0
Filipino	0
Japanese	0
Korean	0
Middle Eastern	0
Vietnamese	0
Other	0
Unknown/Decline	0
More than one	0
DISABILITY	
Physical/mobility	0
Chronic Health Condition/pain	0
Difficulty Seeing	0
Difficulty Hearing	0
Other	0
Other Mental Disability	0
Unknown/Decline	49
# of Family Members in Program	0

Outreach for Increasing Early Recognition of Signs of Mental Illness:

Prevention and Early Intervention (PEI): Report on Prior Fiscal Year Activities AND Program Plan

Youth Action Board

Provider: Youthwell

Program Description: This is a county-wide program to increase recognition of early signs of mental illness for high school students.

Available data on this program's outcomes for the prior fiscal year period, FY 23-24, is included as an Appendix to this document.

Program Type(s):

- Outreach for Increasing Recognition of Early Signs of Mental Illness Program

Priority Area(s):

	Childhood Trauma Prevention and Early Intervention
	Early Psychosis and Mood Disorder Detection and Intervention
X	Youth Outreach and Engagement Strategies Targeting Secondary School and TAY, Priority on College MH Program
	Culturally Competent and Linguistically Appropriate Prevention and Intervention
	Strategies Targeting the Mental Health Needs of Older Adults
	Early Identification Programming of Mental Health Symptoms and Disorders
	Other Locally identified Priority: _____

Program Performance FY 24-25

The 2024 - 2025 Youth Advocacy Board (YAB) consists of 45 youth interns, grades 10-12, from South, Mid, and North County high schools and alternative high school programs. This year's YAB consists of 15 members from Mid and North SB County, which is double the number from last year's cohort.

39 YAB members have completed and received certification in Teen Mental Health First Aid and all YAB members continue to engage in mental health education through our monthly Mental Health Mentor Sessions. The YAB collaborated with YouthWell staff to plan and deliver the Student Advocacy & Mental Wellness Summit in November 2024. The Summit brought together over 90 student leaders to learn from each other and local changemakers about the connections between advocacy, mental health, and the importance of self-care in sustaining their work. We also engaged over 20 adult allies from different community-based organizations to speak on panels and co-facilitate our youth-led workshops.

This year's summit was held in Goleta, but over one third of student attendees came from Mid and North Santa Barbara County. This was a significant increase over the previous fiscal year's event. Additionally, we partnered with Once Community Action and MICOP, both organizations brought a cohort of students, and 8 of these students were monolingual Spanish. We hired a live language interpreter to provide simultaneous interpretation for those students as well as the English-speaking students at their tables and in their breakout groups so that everyone could engage seamlessly.

15 Youth Advocacy Board members have spoken publicly about their lived experiences and perspectives on mental health services and systems at the SB County Behavioral Wellness Commission and at both the November 2024 and February 2025 Youth Linkages Network Retreats. YAB members helped to organize and participate in an MHSA stakeholder feedback session, as well as continue to gather stakeholder input from their peers.

Program Plan for FY 25-26

Provider:	**YouthWell**
Estimated Funding FY 2023/24:	
Estimated Total Mental Health Expenditures	$ 143,100
Estimated PEI Funding	$ 143,100
Estimated Medi-Cal FFP	
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$0
Average Cost Per Consumer	$3,180
Estimated Total of Consumers Served	45
Target Population Demographics Served	Children, TAY, Adult, Older Adult

Estimated Consumers Served by Age FY 2024/25		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	9	$3,180
Estimated Total Consumers Age 15-26 Served	21	$3,180
Estimated Total Consumers Served Age 26-59	0	
Estimated Total Consumers Served Age 60+	0	

Addressing Community Issues

Student advocates will raise mental health awareness, promote wellness, and reduce stigma on their campuses through education, outreach, and a suicide awareness campaign. Student advocates will educate community leaders on the challenges they see in their communities and on their school campuses. Students will become advocates for suicide prevention, learn about current issues, and learn about community resources from speakers. Students will learn to recognize the warning signs and how to connect someone to services by being trained and certified in Teen Mental Health First Aid. This program is designed to educate and empower high school students to be proactive with their mental health needs, and to advocate for mental health resources on their school campuses.

Notable Community Impact

Youth Action Board (YAB) Interns at schools throughout the county took action on their campuses. Many of them worked with administrators at their schools to get permission to post Helpline posters and rack cards in campus bathrooms. Many of them hosted tables during lunch on their campuses to spread the message of "You Matter" and provide their peers with mental health and crisis helpline resources. During our local cohort meetings, YAB Interns planned for these outreach activities and created the materials and communications needed to implement them. YAB interns hosted tables/"You Matter" walls at Dos Pueblos High School, Laguna Blanca School, Orcutt Academy, Righetti High School, and Fusion Academy. YAB Interns worked with administrators to post Crisis Helpline Resources (posters & rack cards) in campus bathrooms at Bishop Diego High School, Laguna Blanca School, Dos Pueblos High School, San Marcos High School, Santa Barbara High School, Santa Ynez Valley High School, Orcutt Academy, Pioneer Valley High School, and Righetti High School.

Problem/Community Need	Activities
Eliminate the stigma around mental health. Create linkages to local resources and services. Amplify youth voice to inform and the systems and programs aimed to serve youth and families.	Host monthly Youth Advisory Board [YAB] Meetings with high school students to discover what they want to learn and where we can help educate regarding mental health and awareness. Offer free Youth Mental Health First Aid to community members Trained all Youth Advisory Board members in Teen Mental Health First Aid. Supporting YAB students in creating mental wellness clubs and centers on campus and

	advocating within their school and communities. YAB students engage in collaborative research projects and deliver presentations on common Mental Health Challenges. YouthWell planned and hosted The Student Advocacy & Mental Wellness Summit, a day-long workshop for youth and adult allies to learn and build their skills around advocacy and mental wellness. Promote 988, local helplines, and Youth & Family Mental Health & Wellness Resource Directory. Share YAB events with the Youth Linkages Network and Community Collaborative Promote services and topics related to mental health in monthly Youth Linkages Network meetings Promote a safe platform for open discussion Youth Mental Health First Aid training offered to the community and YouthWell Team to increase abilities in recognizing when and how to support a struggling youth **Teen Mental Health First Aid (TMHFA) and Question, Persuade and Refer (QPR Training:** All YAB Interns receive training and certification in both TMHFA and QPR modalities. These trainings are required for YAB Interns and will be open and promoted to youth who are affiliated with other

	community-based organizations and programs. **Campus Outreach and Organizing:** We continue to support YAB interns to create, partner with, and sustain mental health and wellness related clubs and campaigns on their campuses. **Podcast, Newsletter, and Social Media Content:** YAB Interns will work collaboratively with YouthWell staff to produce multi-media content that raises awareness and reduces stigma about mental health challenges and promotes seeking support for behavioral health & wellness. **Workshops:** YAB Interns will work collaboratively with YouthWell staff to design, coordinate, and facilitate Wellness Workshops for youth and families throughout SB County. Topics will be informed by youth input and information gathered from local research and stakeholder feedback. **Advocacy and Public Speaking:** YAB Interns receive training and support to speak and advocate effectively in the public sphere. We will expand the participation of YAB interns in the YLN programming and continue to pursue opportunities for YAB interns and other youth to speak at local government committees and community-based forums.
Share youth perspectives from around Santa Barbara County	1-2x year - Provide an opportunity for the Youth Advisory Council to PRESENT to the Youth Linkages Network

	3 Youth Advisory Board Students spoke on a panel and answered questions at the YLN In-Person Retreat in February 2024 YAB students providing feedback to BeWell on MHSA programming. We are pursuing opportunities for YAB students to meet with and make presentations to local boards and commissions such as the Behavioral Wellness Commission, the SB County Association of PTAs, the SB County School Board Association, and district Boards of Education.

Methods Used for Outreach and Engagement of Potential Responders

Youth Action Board (YAB) interns all receive training and certification in Teen Mental Health First Aid and Question Persuade Refer (QPR) to learn how to support their peers in accessing resources and help. Additionally, YAB interns participate alongside YouthWell staff in community outreach and tabling throughout Santa Barbara County.

The YouthWell Resource Directory and the YouthWell Community Calendar allow for opportunity to engage youth and those that work with youth to connect clients to other services and or, further educational opportunities for their systems of care.

YAB Members are able to present and participate at Youth Linkages Network retreats and meetings, as well as other commissions, boards, and associations throughout the county.

At all YouthWell tabling events, rack cards are distributed to the community. They provide education on recognizing early signs of a mental health challenges, highlight resource navigators, share links to YouthWell resource directory and the Behavioral Wellness website, increase behavioral health messaging to families and youth, educate on how to make self-care a priority in their daily lives, educate the community on how to seek help when they need it, recognize the early signs of a mental health challenge, empower youth and families to advocate for what they need, provide education on how to show compassion for others when someone is struggling and treat their mental health challenges with the same respect and care we show someone with a physical illness or injury.

PROGRAM	YouthWell
TOTAL CLIENTS	**30**
AGE	
0-15	9
16-25	21
26-59	0
60+	0
Unknown/Decline	0
SEX AT BIRTH	
Female	26
Male	4
Unknown/Decline	0
CURRENT GENDER IDENTITY (if over 12 years)	
Male	2
Female	23
Transgender	0
Genderqueer	0
Questioning	0
Another	3
Unknown/Decline	2
SEXUAL ORIENTATION (if over 12 years)	
Gay/Lesbian	0
Heterosexual	0
Bisexual	0
Questioning/ Unsure	0
Queer	0
Another	0
Unknown/Decline	30
PRIMARY LANGUAGE	
English	30
Spanish	0
Other	0
Unknown/Decline	0
VETERAN (if over 12 years)	
Yes	0
No	29
Unknown/Decline	1

RACE	
American Indian/ Alaska Native	0
Asian	5
Black/ African American	1
Native Hawaiian/ Pacific Islander	0
White	17
Other	7
More than one	0
Unknown/Decline	0
ETHNICITY: LATINO	
Caribbean	0
Central American	0
Mexican/Mex. Amer./ Chicano	6
Puerto Rican	0
South American	0
Other Latino	0
Unknown/Decline	24
ETHNICITY: NON-LATINO	
African	0
Asian Indian/ South Asian	0
Cambodian	0
Chinese	1
Eastern European	0
European	0
Filipino	0
Japanese	1
Korean	1
Middle Eastern	0
Vietnamese	1
Other	1
Unknown/Decline	25
More than one	0
DISABILITY	
Physical/mobility	1
Chronic Health Condition/pain	1
Difficulty Seeing	0
Difficulty Hearing	0
Other	0
Other Mental Disability	0
Unknown/Decline	0
FAMILY	

# of Family Members in Program	0

Outreach for Increasing Early Recognition of Signs of Mental Illness:

Prevention and Early Intervention (PEI): Report on Prior Fiscal Year Activities AND Program Plan

Cal-MHSA Statewide Prevention Program

Provider: CalMHSA

This is a media campaign tool kit and data on items and media campaigns during FY 24-25 is included below

Program Description: This program builds community capacity that addresses mental health needs and promotes mental health well-being, increase awareness of mental health services and resources, reduce stigma associated with mental health though prevention projects and/or activities within diverse communities.

Participating California counties pool local Prevention and Early Intervention (PEI) funds through the California Mental Health Services Authority (CalMHSA) to support the ongoing implementation of the PEI Project statewide. The PEI Project consists of a series of campaigns designed to raise awareness about mental health needs, reduce stigma, prevent suicides and promote mental wellness.

In 2021, CalMHSA, following direction from its Board of Directors, began reimagining the next phase of its PEI Project, which led to the creation of "Take Action for Mental Health." This multi-faceted statewide public awareness initiative encourages individuals to take proactive steps for their own mental health and the mental health of others through three key pillars: Check In, which promotes staying connected and engaged in conversations about well-being; Learn More, which emphasizes the importance of mental health education to reduce stigma and increase understanding; and Get Support, which encourages individuals to seek professional help or access community resources to address mental health challenges.

The PEI Project's impact extends beyond county lines, spreading the message of "Take Action for Mental Health" throughout California. This statewide effort is essential for fostering a culture of mental wellness, regardless of where people live, work or play.

Program Type(s)

- Suicide Prevention Program
- Outreach for Increasing Recognition of Early Signs of Mental Illness

Priority Area(s):

	Childhood Trauma Prevention and Early Intervention
	Early Psychosis and Mood Disorder Detection and Intervention
X	Youth Outreach and Engagement Strategies Targeting Secondary School and TAY, Priority on College MH Program
X	Culturally Competent and Linguistically Appropriate Prevention and Intervention
	Strategies Targeting the Mental Health Needs of Older Adults
	Early Identification Programming of Mental Health Symptoms and Disorders
X	Other Locally identified Priority: Suicide Prevention _____

Program Performance FY 24-25

This program's objective was to administer grant opportunities that are intended to build community capacity that addresses mental health needs and promotes mental health well-being, increase awareness of mental health services and resources, reduce stigma associated with mental health though prevention projects and/or activities within diverse communities.

The goals set in place with this partnership will disseminate and direct Statewide PEI project campaigns, programs, resources, and materials; provide subject matter in suicide prevention and stigma and discrimination reduction (SOR) to support local PEI efforts; and develop local and statewide capacity building support and new outreach materials for counties and community stakeholders. The primary focus of this Program is to promote mental health and wellness, suicide prevention, and health equity throughout California communities, with additional focus on diverse and/or historically underserved communities.

Program Plan for FY 25-26

This program ended in FY 24-25.

Addressing Community Issues

We promote emotional health and reduce the likelihood of mental illness, substance use, and suicide among all Californians in diverse communities, schools, health care, and the workplace. CalMHSA, with service providers, will undertake the following efforts:

- Continued implementation of the Take Action for Mental Health social marketing and public education campaign activities to expand and develop emotional wellbeing for Californians.
- Expand stakeholder partnership networks and promote grassroots stakeholder engagement with current and new community partners.
- Continue to increase outreach and dissemination of programs and resources, including mental health engagement materials.

- Provide resource, technical assistance, and capacity building support to County Behavioral Health Agencies and their partners to support local PEI and leverage resources.
- Implement the annual Directing Change Program, which educates young people about critical health topics like suicide prevention and mental health and wellbeing through the medium of film and art.
- Provide data and evaluation of the reach of programs within counties and statewide.

Notable Community Impact

CalMHSA Love Over Loneliness - September Materials:

Love Over Loneliness is the theme of this year's suicide prevention week. The linked digital toolkit includes the following materials:

- Resources
  - Theme overview one sheeter
  - Resource guide for "Love Over Loneliness" for all ages
  - Substance Use and Suicide Prevention Resource guide
- Digital backgrounds for your web meetings (Zoom, Teams, etc.)
- Web banners
- Love Over Loneliness - playlist by TakeAction4MH | Spotify
- Digital Toolkit Items on substance use and can be found here: Substance Use One-Sheet - Dropbox

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September Influencer Campaign:

September's Suicide Prevention Month's influencer campaign is Justin Mensinger. Bio (justinmensinger.com) Justin is known for being an influential participant of HBO's season one of The Hype where he shared his story about loss to suicide.

CalMHSA collaborated with Justin's team to create a replica of his clothing pieces for our contributing county members.

CalMHSA Transgender Awareness Week and Transgender Day of Remembrance Digital Toolkit:

Linked below is a digital toolkit for Transgender Awareness Week (Nov. 13-19) and Transgender Day of Remembrance (Nov. 20).

This toolkit is an important part of the Take Action campaign, helping to honor the transgender and nonbinary individuals who have lost their lives to violence for living authentically.
All materials are provided in both English and Spanish.

Within the digital toolkit you will find:

- A resource booklet
  - How to Be an Ally: Transgender Day of Remembrance & Beyond
- Social media posts
  - Images
  - Suggested messaging
- Web banners
- Zoom backgrounds

A similar set of materials is available for public use on the Take Action website.

CalMHSA Winter Wellness Toolkit:

Linked below are the links for Take Action's 2024 Winter Wellness Toolkit, created to assist with outreach and education related to commonly occurring mental health conditions in the winter season.

All materials are provided in both English and Spanish.

Within the digital toolkit:

- A resource booklet
  - Creating Wellness This Winter
- Social media posts
  - Images
  - Suggested messaging
- Web banners
- Zoom backgrounds

A similar set of materials is available for public use on the Take Action website.

Statewide PEI Black History Month Micro-Campaign Materials and Educational Campaign:

February is Black History Month, a time to celebrate the incredible contributions of Black individuals and communities. It is also a time to recognize the importance of mental health and well-being, especially in light of the challenges that continue to affect our communities.

To help raise awareness and support meaningful conversations, below is a set of resources for the Statewide PEI Black History Month micro-campaign. These materials are meant honor the past, present, and future while encouraging attention to mental health.

In the folder here is the following:

- **A One-Sheet Resource:**
  - Standard One-Sheet Format (both digital and print versions)
  - Bi-fold Format (both digital and print versions)
- **Social Media Posts**: Including a posting guide and two images (one for each post)
- **Web Banners**: Two images – either or both can be used
- **Zoom Backgrounds**: Two images – either or both can be used

These materials can also be found on the Take Action website.

May is Mental Health Month. Materials will be distributed to various Community-Based Organizations hosting “May is Mental Health Month” events throughout the County.

Mental Health Month: Mental Health as a Continuum ToolKit:

- This theme challenges the binary idea of "healthy" versus "unhealthy" mental health, normalizing the wide range of mental health experiences and encouraging individuals to embrace and accept the full spectrum of their well-being.
- Physical items will be delivered to you in mid-March:
  - Resource booklet, journal, recipe cards for meditation
  - Aluminum water bottles, bucket hats, hygiene kits, plush toys, stickers
- Digital items:
  - Zoom backgrounds
  - Banners
  - Social media posts
- **AAPI Heritage Month Toolkit** (digital only)
  - 2 digital guides
  - Zoom backgrounds, web banners, social media posts
- **Maternal Mental Health Toolkit** (digital only)
  - 2 resource guides
  - Zoom backgrounds, web banners, social media posts

Problem/Community Need	Activities
Promote emotional health and reduce the likelihood of mental illness, substance use, and suicide among all Californians in diverse communities, schools, health care, and the workplace, CalMHSA, with service providers, will undertake the following efforts:	Continued implementation of the Take Action for Mental Health social marketing and public education campaign activities to expand and develop emotional wellbeing for Californians.
Increase Community Awareness of Mental Health and How to Access Services	Continue to increase outreach and dissemination of programs and resources, including mental health engagement materials.
Increase Youth Awareness and Involvement in Mental Health Services and Suicide Prevention	Implement the annual Directing Change Program, which educates young people about critical health topics like suicide prevention and mental health and wellbeing through the medium of film and art
Increase data around Prevention activities so that we can make data-driven decisions regarding Prevention Programming	Provide data and evaluation of the reach of programs within counties and statewide

Methods Used for Outreach and Engagement of Potential Responders

This year, MHSA worked on a large, special items order for the department, and specific teams including Community Engagement and Outreach, Justice Alliance, Homeless Services, Housing Assistance and Crisis Services Teams all utilized these new materials. All materials that are sent to the MHSA team are distributed both digitally and physically. The PEI coordinator then sends all digital materials to the PEI Programs Distribution List and MHSA Distribution List. The physical documents are then brought to contracted providers and Behavioral Wellness staff for them to distribute to their clients. Materials are also brought to all tabling events that the MHSA Team and Community Engagement and Outreach Teams participate in. Behavioral Wellness is throwing a May is Mental Health Month kickoff event on site, and all materials will be present at the event.

Items ordered and distributed to our clients and the public include:

- Flashlights with the Behavioral Wellness Logo and Access Line Number (English and Spanish)
- Fidget Keychains with the Behavioral Wellness Logo and Access Line Number (English and Spanish)
- Magnets with the Behavioral Wellness Logo and Access Line Number (English and Spanish)
- Regular Pencils with the Behavioral Wellness Logo and Access Line Number (English and Spanish)
- Colored Pencils with the Behavioral Wellness Logo and Access Line Number (English and Spanish)
- Suicide Prevention Know the Signs Educational Tent Cards with the Behavioral Wellness Logo (English and Spanish)
- Water Bottles with the Behavioral Wellness Logo and Access Line Number
- Highlighters with the Behavioral Wellness Logo and Access Line Number
- Black Tote Bags with the Behavioral Wellness Logo and Access Line Number
- Tan Tote Bags with the Behavioral Wellness Logo and Access Line Number
- Chapstick with the Behavioral Wellness Logo and Access Line Number
- Stickers with the Behavioral Wellness Logo and Access Line Number
- Temporary Tattoos with the Behavioral Wellness Logo and Access Line Number
- Blue and Black Pens with the Behavioral Wellness Logo and Access Line Number
- Stress Balls with the Behavioral Wellness Logo and Access Line Number
- Hand Sanitizer Pens with the Behavioral Wellness Logo and Access Line Number
- Hygiene Kits with the Behavioral Wellness Logo and Access Line Number
- Feminine Hygiene Kits with the Behavioral Wellness Logo and Access Line Number
- English and Spanish Journals with Mental Health journaling activities, coloring and prompts (English and Spanish)

Outreach for Increasing Early Recognition of Signs of Mental Illness:

Prevention and Early Intervention (PEI): Report on Prior Fiscal Year Activities AND Program Plan

Youth Linkages Network

Provider: Youthwell

Program Description: This is a prevention program to connect school staff and others in the community that work with youth to educate on prevention-based care and practices.

Available data on this program's outcomes for the prior fiscal year period, FY 23-24, is included as an Appendix to this document

Program Type(s):

- Prevention Program

Priority Area(s):

	Childhood Trauma Prevention and Early Intervention
	Early Psychosis and Mood Disorder Detection and Intervention
X	Youth Outreach and Engagement Strategies Targeting Secondary School and TAY, Priority on College MH Program
	Culturally Competent and Linguistically Appropriate Prevention and Intervention
	Strategies Targeting the Mental Health Needs of Older Adults
	Early Identification Programming of Mental Health Symptoms and Disorders
	Other Locally identified Priority:

Program Performance FY 24-25

We are seeing continued growth in the Youth Linkages Network (YLN) membership. As organizations transition roles, we are consistently being updated on who will take over in attending, which shows a huge collaborative effort in relationship building and desire to see these educational meetings continue.

Our two in-person retreats were a resounding success, with our North County retreat receiving more than double the engagement in registrations to the point of requiring a waitlist. We were able to host about 100 guests at the North County location, a jump of about 40 from the previous year. Our South County Retreat saw about the same number of attendees as the prior year – just above 100. Both retreats hosted adult and youth panels, which we received positive feedback on due to the impact of bringing youth needs and perspectives to the forefront.

Program Plan for FY 25-26

Provider:	Youthwell
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$ 34,082
Estimated PEI Funding	$ 34,082
Estimated Medi-Cal FFP	
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$0
Average Cost Per Consumer	$6.50
Estimated Total of Consumers Served	**5,241**
Target Population Demographics Served	Children, TAY

Estimated Consumers Served by Age FY 2024/25		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	$6.50
Estimated Total Consumers Age 15-26 Served	58	$6.50
Estimated Total Consumers Served Age 26-59	478	$6.50
Estimated Total Consumers Served Age 60+	63	$6.50
Missing DOB	4642	$6.50

Addressing Community Issues

The Youth Linkages Network consists of 60 partnering agencies in Santa Barbara County including school districts, community-based organizations, providers, healthcare, law enforcement, faith communities, and caregivers. They meet monthly to educate 50+ resource navigators, probation officers, local crisis lines, and school counselors so that they are better equipped to support families.

Notable Community Impact

We have had an increased presence and participation at our in-person retreats. Feedback that we received was that these were “valuable spaces for connection” and to “do these more often”.

Hosting in-person retreats means holding space for stronger community connections, which is a huge factor in continuing these events. We have heard multiple times from participants that they are grateful for "the opportunity to attend and hear from both the youth and adult panel—it was a valuable and insightful experience".

All of the topics we cover come from requests, trends, and challenges our community are currently facing. Our October meeting covered Neurodivergent Youth – both experiences and resources. This meeting received an abundance of positive feedback, especially due to having two parents with lived experience speak on the call. We were able to promote our parent support group, FamilyTools+, for parents with neurodivergent children which multiple participants informed us was a resource they are sharing with their families. Additionally, having providers that serve neurodivergent populations helped to educate our participants on differences between diagnoses, how to support families on school campuses, and how to navigate an Individualized Education Program (IEP)/504 plan.

Program Type(s)

- Prevention Program
- Outreach for Increasing Recognition of Early Signs of Mental Illness Program

Priority Area(s):

- Youth Outreach and Engagement Strategies Targeting Secondary School and TAY, Priority on College MH Program

Problem/Community Need and Program Activities

Problem/Community Need	Activities
Promote positive attitudes and understanding of recovery among mental health providers.	Host monthly Youth Linkages Network meetings in partnership with the SBC BWell and SBCEO Ensure questions that panelists speak to cover the broad understanding of a given topic, challenge, system, etc. versus a focus specifically on a single organization or program.
Eliminate the stigma around mental health and create linkages to services.	Educate those working with youth (including resource navigators, family advocates, probation officers, and school counselors) Offer free Youth Mental Health First Aid to community members

	Encourage relationship building within YLN meetings through breakout groups Hold space at YLN retreats to collaborate on scenarios and come to solutions Include a student panel at YLN retreats to understand their perspective and come up with solutions to issues they bring up
Ensure navigators are aware of all existing community programs for students in order to connect youth to services with mild to severe mental health challenges in a timely manner	Promote 988, local helplines, and Youth & Family Mental Health & Wellness Resource Directory. Share YAB events with the Youth Linkages Network and Community Collaborative Promote services and topics related to mental health in monthly Youth Linkages Network meetings Highlight available support groups and other programs to the Network and continue to share out resources in follow up.
Learn (from navigators and school counselors) and better understand the barriers to access.	Provide a safe platform for open discussion Work directly with high school counselors in Santa Barbara through new Cottage BHI Pilot Project
Teach importance of listening to youth and families to create a patient-led relationship “nothing about us without us”.	Provide 2 in-person retreats for the Navigators Themes of Empowerment and Hope during the in-person retreats Active listening activities and discovery questions to highlight the importance of meeting the family where they need to be met Youth Mental Health First Aid training offered to the community and YouthWell Team to

	increase abilities in recognizing when and how to support a struggling youth. A theme of Growth Mindset at retreats and interactive scenarios to collaboratively come up with solutions for challenges we are seeing today.
Share the youth perspective from around Santa Barbara County	1-2x year - Provide an opportunity for the Youth Advisory Council to PRESENT to the Youth Linkages Network 3 Youth Advisory Board Students spoke on a panel and answered questions at the YLN In-Person Retreat in February 2024 Both YLN Retreats hosted a youth panel ranging from 4 to 6 students to share their experiences and passions around mental health Learn from what students share at local YAB cohort meetings, visits in office, and outreach events Invite students to speak in public forums like the Behavioral Wellness Commission or Retreats

Methods Used for Outreach and Engagement of Potential Responders

We educate resource navigators, probation officers, and school counselors so they are aware of existing community programs for students in order to connect youth to services in a timely manner. Additional methods used include:

- Provide Resource Rack Cards: educate on recognizing early signs of a mental health challenges, highlight Resource Navigators, share links to YouthWell resource directory and BWell website.
- *Increase messaging to families and youth:*
    - Make self-care a priority in their daily lives.
    - Seek help when they need it.

    - Recognize the early signs of a mental health challenge
- Empower youth and families to advocate for what they need.
- Show compassion when someone is struggling and treat their mental health challenges with the same respect and care we show someone with a physical illness or injury.

Methods Used for Outreach and Engagement of Potential Responders

Further methods used to reach out and engage youth and those that work with youth, and the methods to be used for youth and school staff to learn together about how to identify and respond supportively to signs and symptoms of potentially serious mental illness include:

Having Youth Linkages Network members learning new tools monthly via online meetings and at the in-person retreats to help identify opportunities to support youth mental health. Members build connections to better refer families and youth navigating a mental health challenge to services.

YouthWell is offering and promoting to the Youth Linkages Network and Community Collaborative Meetings a robust calendar of community classes in Youth Mental Health First Aid and Question Persuade and Refer (QPR) which is a suicide prevention training.

Sharing the YouthWell Community Calendar with community partners

Youth Action Board Members presenting at Youth Linkages Network retreats and meetings, as well as other commissions, boards, and associations throughout the county.

Program Demographics

	Youth Advisory Board	*Youth Linkages Network*
PROGRAM	**Youth Well**	
TOTAL # EVENTS	**9**	**47**
TOTAL # PARTICIPANTS	**367**	**5241**
TOTAL # FAMILIES SERVED	**0**	**1108**
EVENT TYPE		
Outreach (Health Fairs, Other Outreach)	0	37
Training (Trainings, Workshops)	7	3
Forum (Meetings w/ Community Leaders)	1	7
Support Group	1	0
Distribution of Materials	0	0
PRIMARY LANGUAGE OF EVENT		
English	N/A	N/A
Spanish	N/A	N/A
Other or both English and Spanish	N/A	N/A

TRANSLATION PROVIDED		
Translation to English at Spanish event	N/A	N/A
Translation to Spanish at English event	N/A	N/A
Other or both English and Spanish	N/A	N/A
PARTICIPANT AGE		
0-15	49	0
16-25	186	58
26-59	71	478
60+	9	63
Missing DOB	27	4642
PARTICIPANT GENDER		
Female	279	487
Male	58	94
Unknown/Decline	25	4660
PARTICIPANT VETERAN		
Yes	0	0
No	171	0
Unknown/Decline	191	5241
PARTICIPANT RACE		
American Indian/ Alaska Native	4	16
Asian	33	7
Black/African American	9	1
Native Hawaiian/ Pacific Islander	0	0
White	178	202
Other	115	10
More than one	2	0
Unknown/Decline	20	4670
PARTICIPANT ETHNICITY		
Latino	106	236
Non-Latino	246	0
Unknown/Decline	10	4425

Early Intervention: Prevention and Early Intervention (PEI): Report on Prior Fiscal Year Activities AND Program Plan

School-Based Counseling and Support, Treatment, Advocacy and Referral Team (START) Program

Provider: Family Service Agency (FSA)

Program Description: The START program is an early intervention program contracted with Family Services Agency (FSA) to provide school-based mental health services to children and youth in the Carpinteria area. School-Based Counselling is a program that provides school-based counselling services in the Santa Barbara, Goleta and Lompoc areas through FSA and in the Santa Ynez area through Santa Ynez Valley People Helping People.

Available data on this program's outcomes for the prior fiscal year period, FY 23-24, is included as an Appendix to this document.

Program Type:

- Early intervention

Priority Area(s):

X	Childhood Trauma Prevention and Early Intervention
	Early Psychosis and Mood Disorder Detection and Intervention
X	Youth Outreach and Engagement Strategies Targeting Secondary School and TAY, Priority on College MH Program
	Culturally Competent and Linguistically Appropriate Prevention and Intervention
	Strategies Targeting the Mental Health Needs of Older Adults
X	Early Identification Programming of Mental Health Symptoms and Disorders
	Other Locally-identified Priority:_____

Program Performance FY 24-25

The START Therapists participate in the school district and school site-specific mental health team meetings on a regular basis. This participation strengthens Family Services Agency's (FSA) partnership with school staff and supports the START Therapists' ability to serve students who might normally "fly under the radar" and not receive mental health support (underserved students). Many START clients are receiving mental health services because they are accessible (during school hours), affordable (no cost to client/family), and culturally informed. FSA strives to hire clinicians who are bilingual/bicultural and communicate a strong interest in serving youth. The START Therapists continue to support the S.O.S. (Signs of Suicide) program and take an active role in providing crisis assessment and intervention to students who are risk for harming self and/or others.

During the summer of 2024, the school district leadership did not want school-based therapy services to continue throughout the entire summer, so for the first time in several years, there was a pause in services during July and the first three weeks in August of 2024.

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 includes psychiatrist, psychiatric technician, practitioners, case workers and extra help transitional aged youth peers. The START program has a long tradition of providing services for underserved populations. Year after year, approximately 85% of START clients are LatinX. We have not encountered any challenges with reaching and engaging this population in services.

Program Plan for FY 25-26

Provider:	**Family Services Agency**
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$783,831
Estimated PEI Funding	$783,831
Estimated Medi-Cal FFP	
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer	$18,228
Estimated Total of Consumers Served	43
Target Population Demographics Served	Children, Transitional Age Youth (TAY)

Estimated Consumers Served by Age FY 2024/25		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	29	$18,228
Estimated Total Consumers Age 15-26 Served	14	$18,228
Estimated Total Consumers Served Age 26-59	0	
Estimated Total Consumers Served Age 60+	0	

Addressing Community Issues

The START (Support, Treatment, Advocacy and Referral Team) Program is a partnership between Family Service Agency (FSA), the Carpinteria Unified School District (CUSD) and Santa Barbara County Department of Behavioral Wellness. This Program provides mental health assessment, screening and treatment, school collaborations, family interventions, linkage and education for children, transition-age youth (TAY) and families.

START offers prevention and early intervention mental health services to students within the Carpinteria Unified School District experiencing social, emotional, and/or behavioral difficulties. The START program supports children and youth for whom mental health services would otherwise not be accessible. START offers counseling, support, advocacy, treatment, and referrals, including services to individuals experiencing mental health and substance abuse challenges. Program staff work as a team with school staff and parents to address consumers' social-emotional development, prevent mental health and psychological problems from becoming acute, enhance the consumers' ability to adapt and cope with changing life circumstances, increase consumers' protective factors, and minimize risk factors. The START team assigned to schools includes experts in substance abuse and mental health prevention and treatment.

START is available to provide intervention, referrals, programs and services to intervene as early as possible to address learning, behavior, and emotional problems. As mentioned previously, we support the community at large by providing school-based mental health services to students who normally would not be able to access services or would not feel comfortable with accessing services off campus. Approximately 85% of START clients are LatinX. Our clients are typically referred by school staff who have already established a trusting relationship with the referred student. This "warm hand off" approach between the school staff and the START team creates an environment of safety and reduces the stigma that often interferes with students asking for mental health support. The START Therapists are also instrumental in helping school staff navigate students in acute mental health crisis. The START team works collaboratively with SAFTY and school staff to help these students receive the appropriate level of care.

Notable Community Impact

Clients in START and School-based Counseling saw reductions in the number of actionable needs across all Child and Adolescent Needs and Strengths (CANS) domains. While children saw a reduction in actionable needs in both time period comparisons, the group of clients that had a CANS administered at six and twelve months (n = 38) saw greater reductions in their number of actionable needs than the larger group seen from intake to six months.

The START program was initiated, in part, due to a cluster of teenage suicides that occurred in the Carpinteria community before 2006. Since START began providing services in 2006, there has

only been one reported teenage suicide in the Carpinteria community (that we are aware of). The START Therapists support the schools when they provide the SOS (Signs of Suicide) curriculum to middle school and high school students. This curriculum encourages students to seek out support from a trusted adult when they notice that they are struggling with their mental health, or a friend is struggling. This message promotes a help-seeking culture and reduces the stigma around seeking mental health support.

Problem/Community Need and Program Activities

Problem/Community Need	Activities
More accessible mental health services for the Carpinteria community	Continue providing START services to eligible clients
Initial mental health screenings to help identify the most appropriate level of support	START Therapists conduct initial mental health screenings for referred students and make a treatment recommendation. If START services are not appropriate, the therapist will help link the student to appropriate services.
Address concern for rising rates of suicidal ideation in youth (nationwide problem)	Continue to support the S.O.S. program and provide START services to appropriate clients. START Therapists follow up with students who have elevated scores on SAEBRS (universal screener, school plans to administer 2x per school year). Will initiate crisis protocol and/or assist linking student to appropriate services (may include START services.)

Methods Used for Outreach and Engagement of Potential Responders

The START Therapists are continuing to support the SOS program that reaches middle school and high school students. The START Therapists attend weekly mental health team meetings at their school sites and the supervisor attends the monthly district mental health team meetings. At these meetings, the START Team collaborates with school staff in order to help respond effectively to students who present with mental health concerns. They also discuss district-wide or school-wide program or initiatives that are designed to promote social-emotional learning that can be instrumental in preventing potentially serious mental illness.

For the mental illness or illnesses treated in this program for which there is an early onset, we treat the following DSM diagnoses: Separation Anxiety Disorder, Reactive Attachment Disorder, PTSD or any of the trauma-stressor-related disorders, ADHD, Disruptive Mood Dysregulation Disorder. Autism Spectrum Disorder, any of the depressive disorders (Major Depressive Disorder or Persistent Depressive Disorder), Social Phobia, Generalized Anxiety Disorder

Clinical assessment and referral to psychologist or MD/psychiatrist as needed is how each participant's early onset of a potentially serious mental illness will be determined.

Changes to Service Delivery

In FY 24-25, the Council on Alcohol and Drug Abuse (CADA) ended their contract as a START program provider and FSA took over as the sole contracted provider for the START program.

As mentioned previously, the START program has experienced very good engagement and the referral bridge between school staff and the START Therapists is consistently strong. We don't anticipate any changes in service delivery for the upcoming year.

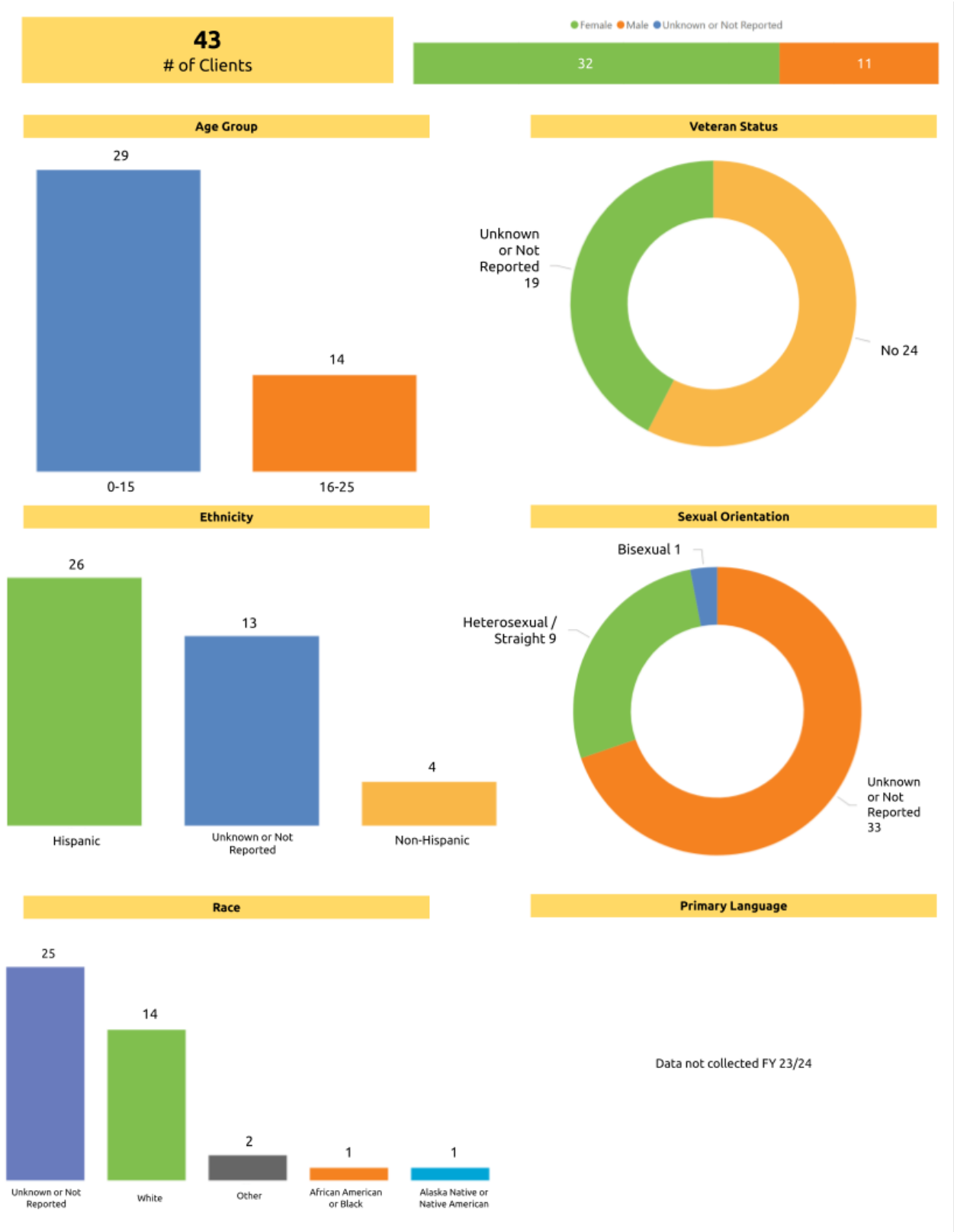
Program Demographics FY 23-24

The mental illness or illnesses treated by this program for which there is an early onset: We treat the following DSM diagnoses: separation anxiety disorder, Reactive Attachment Disorder, PTSD or any of the trauma-stressor-related disorders, ADHD, Disruptive Mood Dysregulation Disorder. Autism Spectrum Disorder, any of the depressive disorders (MDD or PDD), Social Phobia, Generalized Anxiety Disorder

A brief description of how each participant's early onset of a potentially serious mental illness will be determined:

Increased frequency of screenings and use of additional focused screenings such as Beck's Depression Inventory, increased referrals for specialized assessments and care to Behavioral Health Department.

Total Clients by Region	
South	**West**
n= 31	n= 13


43
# of Clients
Female
Male
Unknown or Not Reported
32
11
Age Group
29
14
0-15
16-25
Veteran Status
Unknown or Not Reported 19
No 24
Ethnicity
26
13
4
Hispanic
Unknown or Not Reported
Non-Hispanic
Sexual Orientation
Bisexual 1
Heterosexual / Straight 9
Unknown or Not Reported 33
Race
25
14
2
1
1
Unknown or Not Reported
White
Other
African American or Black
Alaska Native or Native American
Primary Language
Data not collected FY 23/24

Early Intervention: Prevention and Early Intervention (PEI): Report on Prior Fiscal Year Activities AND Program Plan

School-Based Counseling and START Program

Provider: Santa Ynez Valley People Helping People

Program Description: This is an early intervention program to provide school-based mental health services to children, youth and families in the Santa Ynez Valley area.

Available data on this program's outcomes for the prior fiscal year period, FY 23-24, is included as an Appendix to this document.

Program Type(s):

- Prevention Program

Priority Area(s):

X	Childhood Trauma Prevention and Early Intervention
	Early Psychosis and Mood Disorder Detection and Intervention
X	Youth Outreach and Engagement Strategies Targeting Secondary School and TAY, Priority on College MH Program
X	Culturally Competent and Linguistically Appropriate Prevention and Intervention
	Strategies Targeting the Mental Health Needs of Older Adults
	Early Identification Programming of Mental Health Symptoms and Disorders
	Other Locally-identified Priority:_____

Program Performance FY 24-25

Santa Ynez Valley People Helping People (SYVPHP)school-based counselling program serves elementary through high school students in the Santa Ynez area. The compelling issues we seek to address include: adverse social media influence, addiction, inappropriate content and related anxiety, self-harm and suicide ideation, lack of motivation and school refusal, social anxiety and anxiety over academic performance, social emotional intelligence gaps compounded by social isolation and social distancing (with our youngest clients) and family support for youth expressing and identifying as LBGTQ+. SYVPHP works to destigmatize mental wellness concerns by meeting the clients where they are and offering safe and supportive services at no cost. PHP provides early intervention offering evidence-based family services.

Our Prevention and Early Intervention Program is directed towards addressing the needs of youth and families in our community and reducing the negative outcomes for individuals with early onset of potentially serious mental illness. The program aims to provide access to mental wellness services through support, education, resources, and mentorship.

Program Plan for FY 25-26

Provider:	Santa Ynez Valley People Helping People
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$ 120,600
Estimated PEI Funding	$ 120,600
Estimated Medi-Cal FFP	$ 0
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer	$1,370
Estimated Total of Consumers Served	88
Target Population Demographics Served	Children, Transitional Age Youth (TAY)

Estimated Consumers Served by Age FY 2024/25		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	59	$1,370
Estimated Total Consumers Age 15-26 Served	20	$1,370
Estimated Total Consumers Served Age 26-59	7	$1,370
Estimated Total Consumers Served Age 60+	2	$1,370

Addressing Community Issues

Some of the unmet needs and trends we are experiencing include, more transitional aged youth graduating local high school, needing support in launching/college anxiety, depression, suicide ideation, self-harm, parents wanting parent-child therapy to improve communication, single parents wanting individual services for parenting support, more referrals from people that cannot afford their deductible and copayments and an increase in junior high and high-school age questioning sexuality and gender identity.

For over 31 years, PHP has been responsive to the needs of our community. One of our founding Board Member, Dr. Mary Ann Evans, saw firsthand the need for mental health and wellness care here in the mid-county areas of Santa Barbara which gave rise to our program. There was and continues to be a scarcity of mental health and wellness providers in the Valley and SYVPHP has been able to fill this gap through our Mental Wellness programming. What we have seen is an increase year over year in the demand for therapeutic counseling services. In order to evaluate and support all of our programs, SYVPHP routinely conducts a needs assessment survey of our clients, community leaders and other community-based organizations. The most recent

assessment was conducted in June 2021. The survey indicated Mental Wellness support services as a high priority in our community. SYVPHP staff and Board also work with a strategic planning, 3- year plan that incorporates assessment of our programs and community needs. The most recent plan was adopted in October of 2022.

Notable Community Impact

Counseling services were provided to youth through school-based counseling, onsite at our Solvang office, and through Telehealth. We offer family and school support by meeting with parents and teachers and participating in Student Support Team (SST) and Individualized Education Plan (IEP) meetings when requested for integrated care. We facilitated social skills groups for students to promote a successful school experience, encourage self-awareness, and support well-being.

Problem/Community Need and Program Activities

Problem/Community Need	Activities
Barriers to services for underserved families and culturally sensitive outreach and education.	Provide culturally sensitive outreach and education. Offer evening, weekend, or Telehealth services. Provide transportation or alternate meeting locations. Provide warm handoffs for referrals.
Need for a bilingual therapist for bilingual and monolingual Spanish speaking families.	Continue to work with case managers to support monolingual Spanish speaking parents and families. Continue outreach efforts for bilingual therapist. Continue parent cafes offered in English and Spanish to promote positive parenting and connection in the community.
Education, support, and awareness for mental health issues and early signs of mental illness.	Providing psychoeducation and support to students and parents. Organizing workshops and training sessions on coping skills, stress management, and self-

	care practices to increase awareness and well-being.
Individual and group counseling sessions to address emotional and behavioral challenges. Facilitating mentorship programs to provide guidance and support to youth in need.	Collaborating with schools, community organizations, and mental health professionals to create a comprehensive support network for youth and supportive services to serve as a gateway to accessing mental wellness support.

Methods Used for Outreach and Engagement of Potential Responders

We employ methods to be used for potential responders and public mental health service providers to learn together about how to identify and respond supportively to signs and symptoms of potentially serious mental illness.

SYVPHP clients are primarily members of the community who have low incomes. We generally will meet our clients through one of our gate way programs in emergency services and basic needs. SYVPHP seeks to address gaps and disparity in services by addressing the social determinants of health which have proven to significantly impact people's health, well-being, and quality of life. Our core programs address food insecurity, housing stability, education, work force development and language and life skills. SYVPHP's Mission has always been to provide clients with the support networks and education to attain self-sufficiency. To thrive, consumers need to have improved conditions in their environment as well. Outreach and education take many forms at SYVPHP. For example, SYVPHP provides flyers and other material regarding our core programming, which includes our Mental Wellness Program, at weekly food distribution sites and at our school-based offices. PHP provides opportunities through Parent Cafes for families to learn how to recognize signs and be proactive to address potential issues.

SYVPHP has two (2) family resource centers that are located throughout the service area on two (2) area school campuses that provide low barrier access to services. The centrally located Service Center provides access to multiple programs "under one roof'. Clients are able to participate in various support services and programs through the actions of one case manager. SYVPHP provides transportation services, telehealth services, delivery service and in-person consultations. All facilities providing services are Americans with Disabilities Act (ADA)-compliant.

The mental illness or illnesses treated by this program for which there is an early onset: We treat the following DSM diagnoses: separation anxiety disorder, Reactive Attachment Disorder, PTSD or any of the trauma-stressor-related disorders, ADHD, Disruptive Mood Dysregulation Disorder. Autism Spectrum Disorder, any of the depressive disorders (MDD or PDD), Social Phobia, Generalized Anxiety Disorder

A brief description of how each participant's early onset of a potentially serious mental illness will be determined:

Increased frequency of screenings and use of additional focused screenings such as Beck's Depression Inventory, increased referrals for specialized assessments and care to Behavioral Health Department.

Changes to Service Delivery

The program summary will cover children and families ages 0-16 (with some exceptions for high school students that attain the age of 18 but are still in need of support. We will be reporting on screenings and assessments but will no longer track the developmental assessments that do not relate to mental health.

Program Demographics FY 23-24

	n
	88
Participant Individual-Level Demographics	
Age	
0-15	59
16-25	20
26-59	7
60+	2
Sex at Birth	
Female	51
Male	37
Unknown/Not Reported	0
Current Gender Identity (if over 12 years)	
Male	50
Female	36
Transgender	0
Genderqueer	1
Questioning	0
Another	1
Unknown/Not Reported	0
Race	
African American or Black	1
Alaska Native or Native American	1
Asian	3
Native Hawaiian or Other Pacific Islander	1
White or Caucasian	87
Other	0
More Than One Race	3

Unknown/Not Reported	0
Disability	
Chronic Health	1
Other Mental Disability	3
Unknown/Not Reported	4
Sexual Orientation (if over 12 years)	
Gay/Lesbian	4
Heterosexual	49
Bisexual	5
Questioning/Unsure	1
Queer	0
Another	1
Unknown/Not Reported	29
Primary Language	
English	63
Spanish	25
Unknown/Not Reported	0
Veteran	
Yes	8
No	79
Unknown/Not Reported	1
Family	
# of Family Members in Program	109

Early Intervention: Prevention and Early Intervention (PEI): Report on Prior Fiscal Year Activities AND Program Plan

Early Childhood Specialty Mental Health Program

Provider: Childhood Trauma Prevention and Treatment (CALM)

Program Description: This is an early intervention program to provide early intervention mental health services to children 0-9 years old.

Available data on this program's outcomes for the prior fiscal year period, FY 23-24, is included as an Appendix to this document.

Program Type(s):

- Early intervention

Priority Area(s):

X	Childhood Trauma Prevention and Early Intervention
	Early Psychosis and Mood Disorder Detection and Intervention
	Youth Outreach and Engagement Strategies Targeting Secondary School and TAY, Priority on College MH Program
X	Culturally Competent and Linguistically Appropriate Prevention and Intervention
	Strategies Targeting the Mental Health Needs of Older Adults
	Early Identification Programming of Mental Health Symptoms and Disorders
	Other Locally-identified Priority:_____

Program Performance FY 24-25

Early Childhood Specialty Mental Health (ECSMH) services provide **developmentally appropriate, evidence-based interventions** that address trauma, build resilience, and prevent long-term mental health challenges. CALM's **trauma-informed, family-centered, and culturally responsive approach** ensures that both children and caregivers receive the support they need.

Progress in Serving Unserved and Underserved Populations:

This year, CALM continued delivering evidence-based parent-child treatment, prioritizing **proven models** such as:

Parent Child Care (PC-Care)
Parent-Child Interaction Therapy (PCIT)
Cognitive Behavioral Therapy (CBT) & Trauma-Focused CBT

Eye Movement Desensitization and Reprocessing (EMDR)
Child-Parent Psychotherapy (CPP)

The majority of clients identify as Hispanic/Latino, with approximately 30% preferring services in Spanish. To enhance accessibility, CALM updated its website and outreach materials to ensure they reflect current programming and are available in both English and Spanish. The agency remains committed to reducing ethnic and cultural disparities by implementing targeted outreach strategies and ensuring equitable access to mental health services.

Key Challenges & Differences in Implementation:

Workforce Shortages:
Recruitment of qualified applicants—particularly in mid and north county—has been an ongoing challenge. As a result, maintaining the contracted **140 active clients** at any given time has been difficult.

Reduced Referrals (July-October):
Referral volume declined in the first quarter of the fiscal year but has increased in recent months, demonstrating an upward trend.

Katie A. Assessments:
As the designated Katie A. assessor for the 0-5 population, CALM has already exceeded projected deliverables for the year. However, this component of the program carries significant administrative burdens that are non-reimbursable, creating additional financial strain on the agency.

Program Plan for FY 25-26

Provider:	**CALM**
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$1,461,600
Estimated PEI Funding	$ 918,800
Estimated Medi-Cal FFP	$ 542,800
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$0
Average Cost Per Consumer	3,248
Estimated Total of Consumers Served	450
Target Population Demographics Served	Children

Estimated Consumers Served by Age FY 2024/25		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	446	$3,248
Estimated Total Consumers Age 15-26 Served	1	$3,248
Estimated Total Consumers Served Age 26-59	3	$3,248
Estimated Total Consumers Served Age 60+	0	0

Addressing Community Issues

CALM's PEI program addresses the community need of prevention and early intervention programming for youth and families. The purpose of our program is to provide early intervention to identify adverse childhood experiences that can cause future mental health issues and provide support to promote a healthy trajectory of child development. The support we provide includes evidence-based modalities to build the parent-child relationship, promote family strengths and resiliency, and provide parenting support to help parents build capacity to respond to their children's needs. Evidenced-based modalities we use include but are not limited to Healthy Families of America (HFA), Parent-Child Care (PC-CARE), Parent Child Interaction Therapy (PCIT), Eye Movement Desensitization and Reprocessing (EMDR), Interpersonal Therapy (IPT), and Cognitive Behavioral Therapy (CBT). We also use evidence-based parenting curriculum including Partners for a Healthy Baby and The Incredible Years to further empower parents.

Notable Community Impact

CALM's approach to services creates a very notable community impact because it is very unique amongst community agencies and targets the needs of underserved populations. Our trauma-informed, strength-based services are tailored to the one-on-one needs of our clients.

CALM provides a comprehensive and tailored prevention/intervention strategy by utilizing home visitation as both comprehensive support system and a gateway referral source for our specialized perinatal mental health services i.e. perinatal mental health and infant and toddler mental health.

Our prevention and early intervention program met a crucial niche in our community. In the last couple of years, funding in Santa Barbara County for essential prevention programs such as home visitation have been diverted to other target populations. This is problematic considering the need already outweighed our capacity, due to high demand. PEI funds allow us to continue to provide this essential program that has been proven to improve the health, safety and

education of children and families, mitigating the impact of poverty and adverse early childhood experiences.

CALM's approach to services creates a very notable community impact because it is very unique amongst community agencies and targets the needs of underserved populations. Our trauma-informed, strength-based services are tailored to the one-on-one needs of our clients.

Regarding home visitation services, we are able to meet hard-to-reach clients, including teen mothers that do not have transportation or migrant families that live in shared living spaces with multiple children, in the community or at-home. An example of a notable client that is currently receiving services is the following:

A 16-year-old, first time mom was referred to CALM for HFA services by Marian Hospital. She needed support in caring for her newborn. The teen mom was living with her boyfriend at the time, and he was working full time to support the family. As a first-time mother, the client wasn't sure of what to expect and was interested in learning age-appropriate child developmental milestones as well as parenting skills. Not unlike many families who get services at CALM, the mother and child's father were undocumented and living with another family because housing is challenging to secure. Given this set of circumstances, the home visitor had to build trust and rapport with this young mother. At the beginning of services, the mother struggled to attend to and interact with her baby in a nurturing manner. She also needed support in learning how to read the baby's cues. For example, the mother would often leave the baby lying down with a bottle propped up for feeding, or soothing while she went about her tasks. These are the types of interactions a home visitor can watch for and then coach a parent on how to use these moments for connection and bonding. This mother has been with CALM now for two years, steadily improving her relationship with and understanding of her child. She married the baby's father, and while housing is still somewhat unstable and the family must move a lot, this mother has continued with the program and made great strides in learning how to read the baby's cues and bond with her baby. Now that the baby is two years old, the mother is learning how to follow her lead in engaging in stimulating, interactive play. She considers her home visitor to be such a source of support that she has been reluctant to graduate the program and has expressed interest in seeking further services in parenting education with CALM.

Regarding mental health services during the perinatal period, we can provide services to a very specific population with specialized treatment aimed at addressing caregiver mental health issues that impact the parent-child relationship and early infant and toddler mental health. Our treatment is focused on addressing perinatal mood and anxiety disorders, building the caregiver's peer supports, enhancing caregiver and child attachment, addressing infant and toddler mental health within the dyadic relationship, and providing linkage and referral tailored to perinatal/postpartum community referrals.

CALM provides a comprehensive and tailored prevention/intervention strategy by utilizing home visitation as both a stand-alone comprehensive case management/support intervention and as gateway for assessment and referral source for our specialized perinatal mental health services i.e. perinatal mental health and infant and toddler mental health.

The program's impact on the community is strengthened by our commitment to evidence-based treatment models that support healing and resilience in children and families. This year, CALM received funding from the Department of Health Care Services to expand access to Child-Parent Psychotherapy (CPP) across Santa Barbara County, ensuring more families receive trauma-informed, relationship-based mental health care. CPP is a vital intervention within Early Childhood Specialty Mental Health services, helping young children heal from trauma by strengthening their bond with caregivers. By addressing emotional distress within the child's primary relationships, CPP fosters resilience, emotional security, and healthy development while equipping caregivers with effective support strategies. This approach not only mitigates the long-term impact of trauma but also promotes family stability, preventing future mental health challenges. CALM trained 18 clinicians, including clinical supervisors and program managers, to ensure the model is implemented with fidelity and sustained beyond the length of the grant.

Problem/Community Need and Program Activities

Problem/Community Need	Activities
Increased need for Specialty Mental Health Services for children and families under the age of 10	CALM provides Targeted Case Management, Assessments and Treatment Plans and Goals that involve the whole family
Increase supports so that families and children can build resiliency and recovery	CALM works on building Life Functioning Skills; addressing Behavioral/Emotional Needs; Reducing Risk Behaviors and increasing Cultural Factors when providing care
Specialized trauma-treatment to address toxic stress in children ages 0-5 and their caregivers	Mental health practitioners specializing in dyadic treatment provide therapeutic service for children 0-5 and their caregivers

Methods Used for Outreach and Engagement of Potential Responders

Intensive Care Coordination, Intensive Home-Based Services, Plan Development and Rehabilitation services are all incorporated into service delivery. CALM's goal is to continue to support and expand training that allows us to provide the specialized services needed to work with underserved populations.

The mental illness or illnesses treated in this program for which there is an early onset: We treat the following DSM diagnoses: separation anxiety disorder, Reactive Attachment Disorder, Post Traumatic Stress Disorder or any of the trauma-stressor-related disorders, Disruptive Mood Dysregulation Disorder, any of the depressive disorders (MDD or PDD), Social Phobia, Generalized Anxiety Disorder

How each participant's early onset of a potentially serious mental illness will be determined:

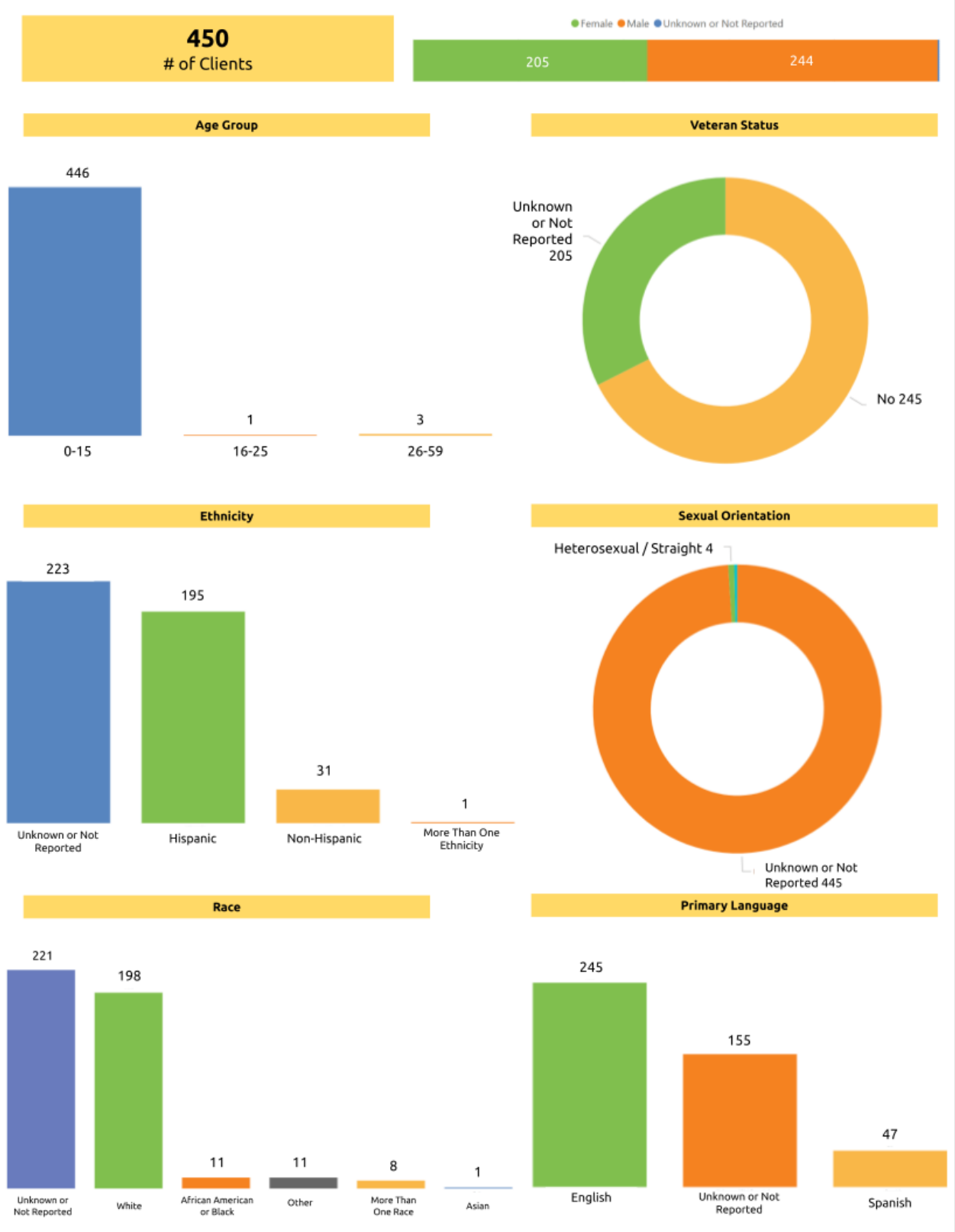
CALM plays a pivotal role in assessing the needs of young children involved with Child Welfare Services through the Katie A Assessor program. Clinicians specializing in early childhood mental health conduct screenings and comprehensive assessments to establish appropriate clinical recommendations. These assessments ensure that children receive the necessary support and interventions to promote healing and stability.

Any client accessing care at CALM undergoes a thorough clinical assessment and referral to psychologist or MD/psychiatrist as needed.

Program Demographics FY 23-24

Early Intervention: Early Childhood Specialty Mental Health (ECSMH) – CALM

Total Clients by Region		
North	**South**	**West**
n= 192	n= 139	n= 123


450
# of Clients
Female Male Unknown or Not Reported
205
244
Age Group
446
1
3
0-15
16-25
26-59
Veteran Status
Unknown or Not Reported 205
No 245
Ethnicity
223
195
31
1
Unknown or Not Reported
Hispanic
Non-Hispanic
More Than One Ethnicity
Sexual Orientation
Heterosexual / Straight 4
Unknown or Not Reported 445
Race
221
198
11
11
8
1
Unknown or Not Reported
White
African American or Black
Other
More Than One Race
Asian
Primary Language
245
155
47
English
Unknown or Not Reported
Spanish

Early Intervention: Prevention and Early Intervention (PEI): Report on Prior Fiscal Year Activities AND Program Plan

PEI Early Detection and Intervention Teams for Children and TAY

Provider: Behavioral Wellness

Program Description: This is an early intervention program to provide mental health services for youth ages 16-25.

Available data on this program's outcomes for the prior fiscal year period, FY 23-24, is included as an Appendix to this document.

Program Type(s):

- Early Intervention

Priority Area(s):

	Childhood Trauma Prevention and Early Intervention
X	Early Psychosis and Mood Disorder Detection and Intervention
	Youth Outreach and Engagement Strategies Targeting Secondary School and TAY, Priority on College MH Program
	Culturally Competent and Linguistically Appropriate Prevention and Intervention
	Strategies Targeting the Mental Health Needs of Older Adults
	Early Identification Programming of Mental Health Symptoms and Disorders
	Other Locally-identified Priority:_____

Program Performance FY 24-25

The Prevention and Early Intervention (PEI) Transitional Ages Youth (TAY) teams are multidisciplinary and work as integrated teams who share in decision making that is central to the individualized needs of the client. Disciplines on the teams include psychiatrists, nurses, mental health practitioners, and case workers. The overall TAY division and respective teams operate with high energy, passion for their work and a keen optimism on the therapeutic process allowing for recovery, based on the individualized needs of those served. The team aims to instill hope and a plan for the future for those they serve.

Program Plan for FY 25-26

Provider:	Behavioral Wellness
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$ 1,968,200
Estimated PEI Funding	$ 1,424,200
Estimated Medi-Cal FFP	$ 544,000
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$0
Average Cost Per Consumer	$11,646
Estimated Total of Consumers Served	169
Target Population Demographics Served	Children, TAY, Adult (if aging into age 25)

Estimated Consumers Served by Age FY 2024/25		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	6	$11,646
Estimated Total Consumers Age 15-26 Served	162	$11,646
Estimated Total Consumers Served Age 26-59	1	$11,646
Estimated Total Consumers Served Age 60+	0	

Addressing Community Issues

The fundamental values and principles of the PEI TAY program recognize that Transition Age Youth experience dramatic changes across all areas of development during their transition to adulthood. Their decisions, choices, and associated experiences set a foundation for their transition to future adult roles in the domains of employment, education, living situation, and community-life functioning. This period of transition becomes an even greater challenge for those experiencing early onset, or their first onset, of psychosis or other mental health disorders. The PEI TAY program believes in early intervention and engagement in treatment to help stabilize symptoms, psycho education for TAY and their families, and in the value of helping TAY achieve their goals across the various transition domains which may have been temporarily interrupted. The PEI TAY program was designed to focus on early intervention and on recovery.

In light of staffing shortages, particularly in the practitioner classification, the PEI Tay team in Santa Maria has recently underfilled a vacant practitioner position with a second bilingual

caseworker to effectively serve the Latino TAY population and better meet the range of needs that TAY clients present. These needs include, but are not limited to: outreach and engagement, connecting clients to basic resources, coordinating transportation to key appointments (employment interviews, medical care, educational assessments, mental health sessions) and engaging in prosocial activities.

In addition to staffing reconfigurations, BWell leadership met with local Community Based Organizations (Fighting Back Santa Maria and Noah's Anchorage) who provide a range of support services to homeless TAY to identify barriers to accessing and engaging in mental health services, and to begin to strategize ways to increase engagement with this population. We also identified ways for PEI TAY and these organizations to increase collaboration and partnership in serving TAY across the County.

Notable Community Impact

In the last year, Santa Maria PEI TAY has worked on improving timely access to services. We understand that when community members are interested in services, it is best to engage and assess as soon as possible. The team is also training to better serve those clients with first episode psychosis.

Problem/Community Need and Program Activities

Problem/Community Need	Activities
Increased need for Early Interventions for Youth that 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 Increased need for early interventions for youth that 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	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.
Engagement and involvement of TAY in their treatment	Youth empowerment services are being explored where TAY Peers take a leadership role to plan, schedule, and offer weekly activities in the community for TAY consumers.
Increasing family Involvement in the program	TAY Early Detection and Intervention Teams will be encouraged to use Coordinated Specialty Care teams to use a family-oriented approach for the

	adult clients in which all aspects of an individual support network are engaged at every level of care.

Methods Used for Outreach and Engagement of Potential Responders

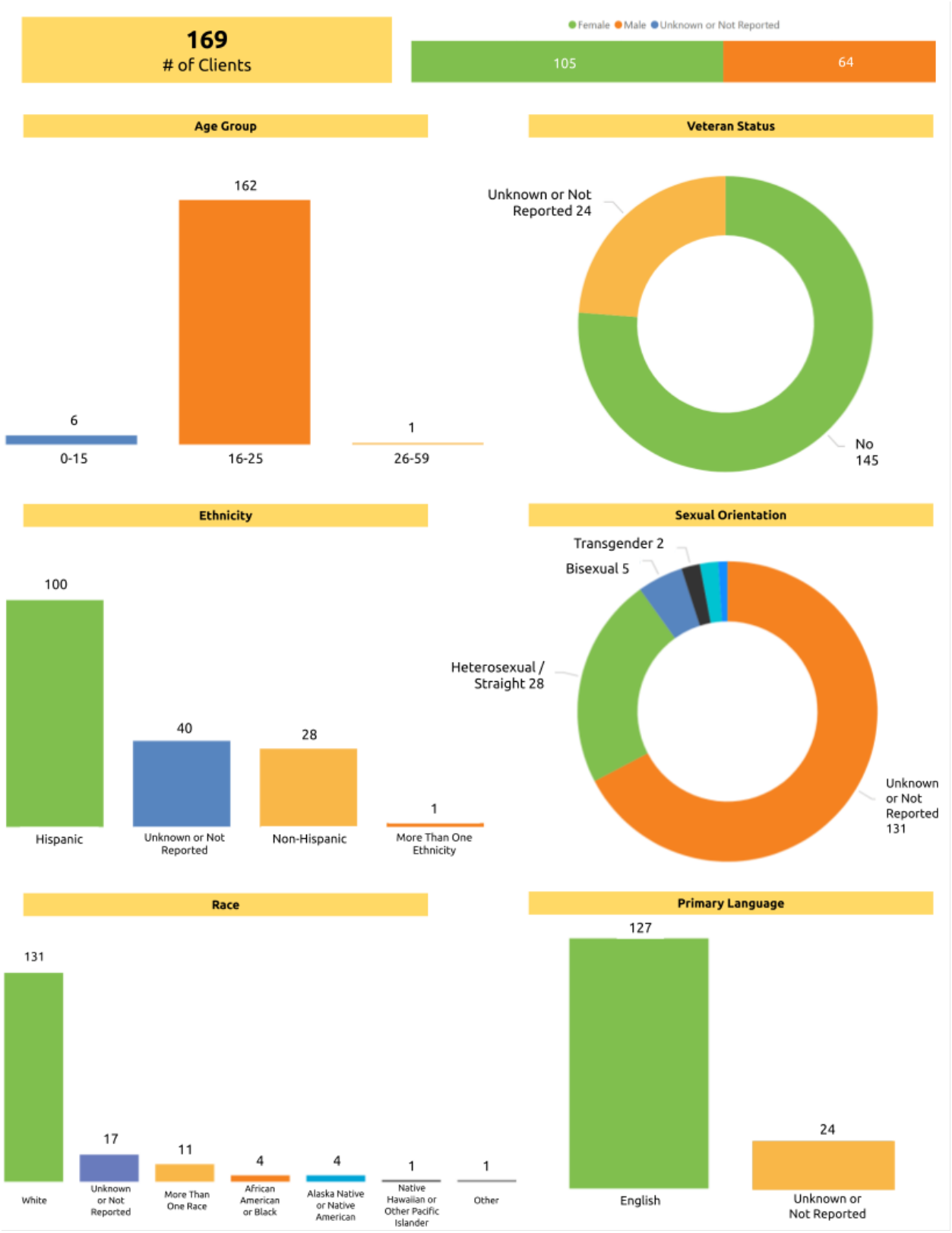
TAY individuals struggle with a complex array of mental health issues coupled with social and economic challenges and limited overall resources, both personally and environmentally. The challenges for effective treatment for this population have been keeping TAY individuals engaged in services, lack 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 has been instrumental in providing the full range of treatment options to this age group.

The mental illness or illnesses treated in this program for which there is an early onset – We treat the following DSM diagnoses: separation anxiety disorder, Reactive Attachment Disorder, PTSD or any of the trauma-stressor-related disorders, ADHD, Disruptive Mood Dysregulation Disorder. Autism Spectrum Disorder, any of the depressive disorders (MDD or PDD), Social Phobia, Early Onset Psychosis, Generalized Anxiety Disorder

How each participant's early onset of a potentially serious mental illness will be determined; Clinical assessment and referral to psychologist or MD/psychiatrist as needed.

Program Demographics FY 23-24

Total Clients by Region		
North	**South**	**West**
n= 47	n= 59	n= 64


169
# of Clients
Female
Male
Unknown or Not Reported
105
64
Age Group
6
0-15
162
16-25
1
26-59
Veteran Status
Unknown or Not Reported 24
No 145
Ethnicity
100
Hispanic
40
Unknown or Not Reported
28
Non-Hispanic
1
More Than One Ethnicity
Sexual Orientation
Transgender 2
Bisexual 5
Heterosexual / Straight 28
Unknown or Not Reported 131
Race
131
White
17
Unknown or Not Reported
11
More Than One Race
4
African American or Black
4
Alaska Native or Native American
1
Native Hawaiian or Other Pacific Islander
1
Other
Primary Language
127
English
24
Unknown or Not Reported

Early Intervention: Prevention and Early Intervention (PEI): Report on Prior Fiscal Year Activities AND Program Plan

Homeless Early Intervention Team

Provider: Behavioral Wellness

Program Description: This is an early intervention program that goes out into the community and offers mental health treatment services to homeless populations.

Available data on this program's outcomes for the prior fiscal year period, FY 23-24, is included as an Appendix to this document as part of the Homeless Intervention Team

Program Type(s):

- Early Intervention

Priority Area(s):

	Childhood Trauma Prevention and Early Intervention
	Early Psychosis and Mood Disorder Detection and Intervention
	Youth Outreach and Engagement Strategies Targeting Secondary School and TAY, Priority on College MH Program
	Culturally Competent and Linguistically Appropriate Prevention and Intervention
	Strategies Targeting the Mental Health Needs of Older Adults
X	Early Identification Programming of Mental Health Symptoms and Disorders
X	Other Locally-identified Priority: Early Intervention Treatment Services for Homeless Populations

Program Performance FY 24-25

The Department of Behavioral Wellness Homeless Services program has two branches, the Homeless Outreach team and the Early Intervention team; these teams provide early intervention, 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. Chronically homeless individuals have needs that 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. There are several bi-lingual staff to address ethnic and cultural disparities. 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.

The Homeless Early Intervention team consists of Behavioral Wellness staff (2 caseworkers, supervisor/practitioner, psychiatric nurse and Administrative Office Professional), Santa Barbara County Public Defender's Office (Holistic Defense) staff and Santa Barbara Public Health nurses and administrator made positive impacts in the collaboration to work with complex cases consisting of clients with a mental health disorder, involvement with the legal system and a physical health condition. The Early Intervention team developed a referral that allows the community to make a client referral to them. A tight housing market has contributed to a lack of housing opportunities, yet we continue to help find permanent supportive housing to individuals experiencing homelessness in south county.

The Early Intervention team and the Homeless Outreach team have addressed ethnic and cultural barriers by hiring native Spanish speaking staff to improve outreach and rapport with Spanish speaking clients. Also, the Early Intervention team and general team use interpreter services when needed for all ethnic and cultural groups encountered.

Program Plan for FY 25-26

Provider:	**Behavioral Wellness**
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$1,953,600
Estimated PEI Funding	$1,684,700
Estimated Medi-Cal FFP	$0
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$268,900
Average Cost Per Consumer	$13,024
Estimated Total of Consumers Served	150*
Target Population Demographics Served	Adult/Older Adults

*****_this is a new program, we are estimating consumers served in FY 25-26_

Estimated Consumers Served by Age FY 2025/26		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served		
Estimated Total Consumers Age 15-26 Served	25	$13,024
Estimated Total Consumers Served Age 26-59	100	$13,024
Estimated Total Consumers Served Age 60+	25	$13,024

Projected Date of Implementation/First Date of Services: **7/1/2024**

Addressing Community Issues

The Homeless Early Intervention program is addressing the community's concern about homelessness by outreaching to individuals experiencing homelessness. Our community partners including City Net and Good Samaritan Shelters assist our clients in being considered for housing opportunities in different regions of the county. The Homeless Outreach team provides a warm handoff for the client to continue mental health treatment with a long-term care outpatient mental health treatment program.

Notable Community Impact

The Early Intervention team continues to move people from the street into temporary housing, or shelters and tiny homes, and then help them transition to permanent supportive housing.

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.

In a review of current FY 2024-2025 Homeless Management Information System (HMIS) Data for Behavioral wellness Homeless Services, in FY 24-25 has facilitated 49 exits from homelessness into a shelter setting. A total of 45 clients have moved into permanent supportive housing. A total of 39 clients secured housing with a housing voucher. A total of 2 clients have transitioned from homelessness to live with family.

Problem/Community Need and Program Activities

Problem/Community Need	Activities
Increased need for Early Interventions for Homeless individuals that offers immediate mental health treatments without waiting for housing placement and provided to the individuals at or near their place of dwelling	Care management; Crisis assessment and intervention; 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.
Need for Homeless Individuals to Access and Linkages to community resources	Activities of daily living support; Employment and educational support; Community integration
Need for Homeless Individuals to receive social benefits they are entitled to	Individual Rehabilitation- Caseworkers work with clients on building skills including daily hygiene regimen, role modeling appropriate social interactions with others, applying for healthcare, housing and social security benefits
Clients will transition living on the streets to living in a shelter/ interim housing	45% of clients enrolled will have successful exits from homelessness to emergency shelter/interim housing
Clients will be able to access health care and purchase needed items.	35% of clients will gain health benefits or cash benefits
Demonstrate clients getting housed through Behavioral Wellness Homeless Services.	40% of clients will enter into permanent supportive housing or a rental with a housing voucher

Methods Used for Outreach and Engagement of Potential Responders

The mental illness or illnesses treated in this program for which there is an early onset – We treat the following DSM diagnoses: separation anxiety disorder, Reactive Attachment Disorder, PTSD or any of the trauma-stressor-related disorders, ADHD, Disruptive Mood Dysregulation Disorder. Autism Spectrum Disorder, any of the depressive disorders (MDD or PDD), Social Phobia, Early Onset Psychosis, Generalized Anxiety Disorder

How each participant's early onset of a potentially serious mental illness will be determined; Clinical assessment and referral to psychologist or MD/psychiatrist as needed.

Access and Linkage: Prevention and Early Intervention (PEI): Report on Prior Fiscal Year Activities AND Program Plan

Safe Alternatives for Child and Youth Crisis Services (SAFTY) Program

Provider: Casa Pacifica

Program Description: This is a crisis intervention program and crisis line for youth in Santa Barbara County ages 0-20 available 7 days a week from 8am to 8pm.

Available data on this program's outcomes for the prior fiscal year period, FY 23-24, is included as an Appendix to this document

Program Type:

- Early Intervention
- Access and Linkage to Treatment Program

Priority Area(s):

X	Childhood Trauma Prevention and Early Intervention
	Early Psychosis and Mood Disorder Detection and Intervention
	Youth Outreach and Engagement Strategies Targeting Secondary School and TAY, Priority on College MH Program
	Culturally Competent and Linguistically Appropriate Prevention and Intervention
	Strategies Targeting the Mental Health Needs of Older Adults
	Early Identification Programming of Mental Health Symptoms and Disorders
	Other Locally identified Priority: _____

Program Performance FY 24-25

SAFTY is a mobile crisis team that operates 7 days per week from 8am to 8pm, serving all youth aged 20 and under within Santa Barbara County. SAFTY crisis line services are openly accessible and free for the community to utilize. The data for FY 23-24 indicates 2,075 calls across 888 unduplicated clients. Of those, 51.28% of the total calls to the crisis line were in the north county region (Santa Maria, Guadalupe), 15.66% were in the west county region (Lompoc, Santa Ynez Valley), 27.61% were in the south county region (Santa Barbara, Goleta, Carpinteria) and 5.45% other county/unknown location. Demographic data in crisis responses is difficult to gather as there are many marked as "unknown" or "other," however the FY 23-24 data show the following demographics: 201 as Mexican/Mexican American, 265 as other Hispanic/Latin, 140 as not Hispanic, and 198 clients with monolingual Spanish speaking parents. SAFTY utilizes language interpretation services for clients and/or guardians that speak Spanish and/or Mixteco.

The year-to-date data for FY 24-25(7/1/2024 through 1/31/2025) indicates 49.95% of the total calls to the crisis line were in the North County region (Santa Maria, Guadalupe), 14.69% were in the West County region (Lompoc, Santa Ynez Valley), 29.92% were in the South County region (Santa Barbara, Goleta, Carpinteria) and 5.44% other county/unknown.

Year-to-date data for FY 24-25(7/1/2024 through 1/31/2025) shows the following demographics: 85 as Mexican/Mexican American, 144 as other Hispanic/Latin, 49 as not Hispanic, and 109 clients with monolingual Spanish speaking parents. SAFTY utilizes language interpretation services for clients and/or guardians that speak Spanish and/or Mixtec.

Program Plan for FY 25-26

Provider:	**Casa Pacifica**
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$1,406,800
Estimated PEI Funding	$ 1,094,700
Estimated Medi-Cal FFP	$ 312,100
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$0
Average Cost Per Consumer	$1,561
Estimated Total of Consumers Served	901
Target Population Demographics Served	Children, TAY

Estimated Consumers Served by Age FY 2024/25		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	503	$1,561
Estimated Total Consumers Age 15-26 Served	413	$1,561
Estimated Total Consumers Served Age 26-59	0	$0
Estimated Total Consumers Served Age 60+	0	$0

Addressing Community Issues

SAFETY Staff work with youth experiencing a wide range of issues including suicide risk, self-harm behavior, homicidal risk, grave disability, emotional disturbances (anxiety, depression, hopelessness, isolation, irritability, behavioral issues). A variety of intervention methods to contain/prevent a crisis are employed, including quick and accessible specialized intervention over the phone or in person. SAFTY staff are authorized to place a psychiatric hold (involuntary hospital placement up to 72 hours) on a child/youth, if necessary, to keep them safe. SAFTY's treatment philosophy, however, is to utilize the least restrictive intervention possible. SAFTY provides children's crisis services in collaboration with Crisis Services Teams county-wide. SAFTY provides quick and accessible service to families by providing specialized crisis intervention, in-home support and linkage to County behavioral health or other appropriate services. By working in collaboration with the child's existing service providers, SAFTY seeks to keep children, youth, and families safe in their homes and communities. SAFTY is a community-based alternative that prevents acute psychiatric hospitalization and reduces involvement of law enforcement that could result in criminalization of youth with mental health issues.

For Medi-Cal recipients not linked to services SAFTY provides 30-60 days of crisis stabilization (proactive cases) in the home and connects the family to long term services. A SAFTY clinician completes a clinical assessment and develops a treatment plan to meet the family's needs for stabilization and linkage. The SAFTY staff continue to assess for ongoing risk a client may be experiencing, while teaching coping mechanisms to aid in reducing additional crises.

SAFTY addresses the following community issues:

- **Increasing services to underserved/unserved populations.** Mobile crisis response to all of Santa Barbara County for all youth aged 20 and under. SAFTY staff support on the phone as well as go into the community and meet youth wherever they are, increasing the community's access to quick crisis support. SAFTY understands the importance of flexibility when working with youth and families; it is important to have the flexibility to meet the youth and family where and when it is convenient and helpful for them to increase access to services.
- **Recruitment and Retention of Public Health Workforce**. SAFTY actively hires and trains mental health workers for the SAFTY program for both the Santa Maria and Goleta offices. SAFTY staff are at times eligible to receive funding to support with staff retention through student loan pay off awards through programs such as CalMHSA WET Program.
- **Increasing of Mental Health Education and Prevention Programming for Youth and Families.** SAFTY is active with outreach services throughout the County of Santa Barbara. For example, SAFTY attends tabling events at health fairs, provides workshops at school parent nights on youth mental health and crisis services, and trains clinicians at various youth focused community-based organizations on suicide prevention and risk

assessment. SAFTY has submitted a proposal to add a position for a bilingual outreach coordinator.

Notable Community Impact

The year-to-date data for FY 24-25(7/1/2024 through 1/31/2025) indicates 1103 calls across 512 unduplicated clients. The SAFTY crisis hotline has provided 335 face-to-face risk assessment responses; SAFTY provided face-to-face responses to 34% of the calls to the SAFTY crisis hotline that were categorized as crisis. Of the total crisis calls, that of the, 94.6% of the responses were able to develop safety plans and avoid hospitalizations. SAFTY provided 724 crisis stabilization calls, and 289 daily stabilization calls at the request of our Behavioral Wellness County partners.

Of the total calls to the crisis line some of the common presenting issues include: 348 of the calls due to youth having suicidal ideation, 38 of the calls due to a suicide attempt, 54 calls due to self-harm behaviors, 53 of the calls due to aggression to others, 25 calls due to homicidal ideation, 31 of the calls due to youth having an increase in mental health symptoms, and 118 of the calls were youth and their support system looking for access to resources. SAFTY received 78 referrals to SAFTY Proactive services to date.

Problem/Community Need and Program Activities

Problem/Community Need	Activities
Need for increased staff in the SAFTY program with increased funding for staff retention and bilingual pay differential.	• Increase the ability of SAFTY to attend to crisis calls in the community and offer ongoing prevention/education services to reduce youth engaging in risk behaviors, increase linkage to necessary services, and reduce use of emergency services (911) and/or emergency departments in hospitals. • Increase capacity for SAFTY Proactive services (in-home short-term intensive services for Medi-Cal clients) to keep youth in their support system and reduce risk of youth needing a higher level of care (psychiatric hospitalization). • Increase bilingual English/Spanish staffing.

Linkages to Mental Health Services

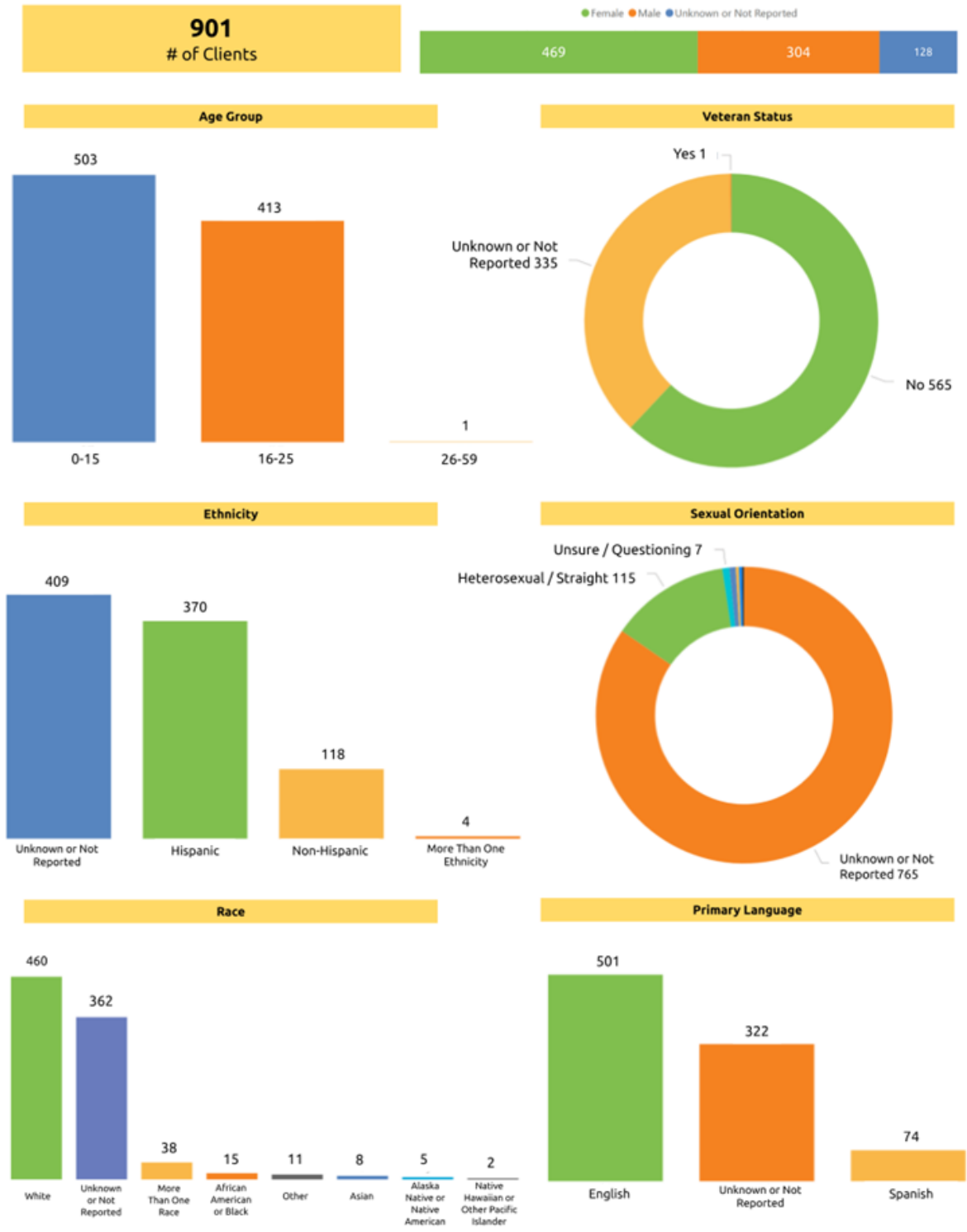
SAFTY assesses a youth's need for mental health services when a call comes into the crisis line. SAFTY offers follow up services to all crisis calls. Referrals and recommendations are made based on the youth's insurance. The most common referrals for Medi-Cal clients are SAFTY in-home Proactive services or ACCESS line (Santa Barbara County Department of Behavioral Wellness Clinics or Cencal). SAFTY Private Proactive services accepts Anthem insurance. SAFTY will respond to all crisis calls received to the Hotline from 8:00 am – 8:00 pm, seven days a week. The SAFTY Crisis Hotline is a dedicated crisis line for client's up to their 21st birthday who are in danger of serious physical harm to self or others, gravely disabled, and/or experiencing a mental health crisis. SAFTY accepts all calls. If a consumer is not eligible for SAFTY services, such as outside of SAFTY age range, already a consumer of a full-service partnership program, located outside of Santa Barbara County, etc. then the caller will be referred to appropriate resources. If there is an immediate safety concern SAFTY staff will contact emergency responders despite consumer eligibility.

How our Program and Strategies create Access and Linkage to Treatment for individuals with serious mental illness: SAFTY assesses a youth's need for mental health services when a call comes into the crisis line. SAFTY offers follow-up services to all crisis calls. Referrals and recommendations are made based on the youth's insurance and presenting issue(s). The most common referrals for Medi-Cal clients are SAFTY in-home Proactive services or ACCESS line (Santa Barbara County Department of Behavioral Wellness Clinics or CenCal). SAFTY Private Proactive services accept Anthem and Aetna insurance; Private Proactive services through Anthem/Aetna are typically provided for approximately 6 months to 1 year.

After every crisis contact, SAFTY offers time-limited follow-up services to develop coping strategies that promote safety in the youth's environment and linkage to appropriate community resources including linking to BWell, the Behavioral Health department, and CenCal the Managed Care Provider for Medi-Cal in Santa Barbara County. SAFTY collaborates with the client's support system.

SAFTY offers follow-up services to all crisis calls. Proactive Services: For Medi-Cal recipients not linked to services SAFTY provides short term (approximately 60-90 days) of crisis stabilization in the home and connects the family to long term services. A SAFTY clinician completes a clinical assessment and develops a treatment plan to meet the family's needs for stabilization and linkage. The SAFTY staff continue to assess for ongoing risk a client may be experiencing, while teaching coping mechanisms to aid in reducing additional crises. The SAFTY staff support the referral to BWell or CenCal services as is appropriate and attempts to support a 'warm handoff' prior to the completion of SAFTY Proactive services.

Program Demographics: Program Performance (FY 23-24)



Total Clients by Region

North	South
n= 620	n= 291

Access and Linkage: Prevention and Early Intervention (PEI): Report on Prior Fiscal Year Activities AND Program Plan

Access and Assessment Teams and ACCESS Line

Provider: Behavioral Wellness

Program Description: This is a program to access and assess unserved/underserved community members for mental health services and access.

Available data on this program's outcomes for the prior fiscal year period, FY 23-24, is included as an Appendix to this document

Program Type

- Access and Linkage to Treatment Program

Priority Area(s):

	Childhood Trauma Prevention and Early Intervention
	Early Psychosis and Mood Disorder Detection and Intervention
	Youth Outreach and Engagement Strategies Targeting Secondary School and TAY, Priority on College MH Program
	Culturally Competent and Linguistically Appropriate Prevention and Intervention
	Strategies Targeting the Mental Health Needs of Older Adults
X	Early Identification Programming of Mental Health Symptoms and Disorders
	Other Locally identified Priority: _____

Program Performance FY 24-25

In the first two quarters of this fiscal year (July 1, 2024, to December 31, 2024) the Access Line took 7,117 calls during business hours (Monday through Friday.) Assessments and referrals are customized to ensure that appropriate cultural and linguistic needs of each consumer are identified and accommodated. On the Access Line, our team includes staff who are bicultural and bilingual in the primary threshold language (Spanish) and all staff are trained on how to access and utilize our Interpreter Service contractor. In the last year, Behavioral Wellness leadership has decided to expand the Access Line to include a second office in Santa Maria (the original office is in Santa Barbara.) The reason for this shift and expansion to Santa Maria was to increase recruitment of Spanish-speaking staff and to better serve the Spanish-speaking community.

As of February 2025, the Access Line went from having four bilingual Spanish Access screeners to now six out of our total 11 screeners. Now, over half of the entire Access Team are bilingual in Spanish which more accurately mirrors our county's demographics. Our call volume from the Spanish-speaking community has risen in response to the change. We also hired a Spanish-speaking Recovery Assistant, a Peer with lived experience who can assist with outreach for the

Access Line in the primarily Spanish-speaking Santa Maria region. A Recovery Assistant (Peer) is a new position to the Access Line that has traditionally been staffed by practitioners. We also hired two Alcohol and Drug Service Specialists with unique backgrounds in substance abuse to widen our reach. In addition, the Access Line works closely with Behavioral Wellness' Homeless Services program to link unhoused clients to resources they need beyond mental health and substance use treatment.

Program Plan for FY 25-26

Provider:	**Behavioral Wellness**
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$4,065,200
Estimated PEI Funding	$3,513,600
Estimated Medi-Cal FFP	$ 551,600
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$0
Average Cost Per Consumer	$1,753
Estimated Total of Consumers Served	2,319
Target Population Demographics Served	Children, TAY, Adult, Older Adult

Estimated Consumers Served by Age FY 2025/26		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	544	$1,753
Estimated Total Consumers Age 15-26 Served	608	$1,753
Estimated Total Consumers Served Age 26-59	1004	$1,753
Estimated Total Consumers Served Age 60+	266	$1,753

Addressing Community Issues

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.

The Access Line works very closely with both the Santa Barbara County Jail and the Santa Maria Jail to increase access to services for inmates once they are released from jail. The Access Line schedules in-custody screenings 3 days per week with the jail either by phone or Zoom to link clients who are in custody to both substance use and mental health services. In addition, the Access line supervisor attends a weekly collaboration meeting with the jails, probation and Justice Alliance to improve communication and streamline processes to increase the efficiency of screenings, referrals and access to services.

The Access Line has improved processes involving warm hand offs of clients in crisis-to-crisis services. Rather than having the Access Line warm transfer a call directly to crisis services, the Access Line screener contacts a regional crisis supervisor/Triage Coordinator to triage the call and determine the best plan of action and person/team to respond according to the schedule. This increases the likelihood of timely response by crisis services, because the supervisor/coordinator can ensure someone is available to respond according to the crisis staff schedule.

Notable Community Impact

The Access Line has increased its referrals to Medication Assisted Treatment (MAT) services in response to the opioid crisis. Every client who reports opioid use is offered a referral to MAT Services either through Behavioral Wellness or an outside program. They are also given information on how to obtain free Naloxone (Narcan) and testing strips if needed.

Problem/Community Need and Program Activities

Problem/Community Need	Activities
Lack of understanding/awareness about first on-set of SPMI and intervention/resources available.	On the Access Line we get many calls from concerned family members about their family member developing first or new mental health symptoms and wanting to know the best course of action. The Access Line provides a lot of psychoeducation about the first onset of mental health issues and how to address it. We also refer family members to organizations such as NAMI and the Family-to-Family support group.

Lack of awareness of resources including the Access Line among the County's Spanish speaking community.	Opened an Access Office in Santa Maria, a region with over 77% Latinx population. Hired more bilingual and bicultural Access screeners. (We quadrupled this.) Hired a bilingual and bicultural Spanish speaking Recovery Assistant (Peer) who can do outreach in the community.
Lack of understanding/awareness about first onset of Serious and Persistent Mental Illness (SPMI) and intervention/resources available, especially among the Latinx community.	On the Access Line, we get many calls from concerned family members about their family member developing first or new mental health symptoms and wanting to know the best course of action. The Access Line provides a lot of psychoeducation about the first onset of mental health issues and how to address it. We also refer family members to organizations such as National Alliance on Mental Illness (NAMI) and the Family-to-Family support group. Our Peer Support Specialist attended a training called "La Clave", which is an easy guide to the Symptoms of Serious mental illness written for the Latinx community to increase awareness of some common mental health symptoms that they can recognize in others. Symptoms outlined in the guide include delusional thinking, disorganized speech, hallucinations and seeing or hearing things that others do not. Upon taking this training, our Access Peer support specialist has been able to help community members and train the other screeners to identify symptoms early and intervene early which increases the prognosis for treatment and recovery of the individual.

Linkages to Mental Health Services

Access screeners handle behavioral health crisis calls and calls from new consumers requesting mental health and substance use disorder (SUD) services. Callers are screened for appropriate assignment to a level of care within the Mental Health Plan (MHP and/ or the Drug Medi-Cal Organized Delivery System (DMC-ODS). The access and assessment component for the MHP is handled by the 3 Adult and 3 Children's Access and Assessment teams that focus on performing assessments on new consumers referred by the Access screeners, as well as initial assessments for walk-in consumers, and for hospital discharge appointments.

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

How our Program and Strategies create Access and Linkage to Treatment for individuals with serious mental illness: For clients 21 and over, they receive the DHCS Adult Screening Tool for Medi-Cal Mental Health Services. If the client scores a "6" or above, they are referred to the BWell County Mental Health Level of Care, which serves those with more moderate to severe mental health symptoms and impairments. If the client scores 0-5, or in the mild to moderate range, they are referred to CenCal Behavioral Health for mental health treatment. If a client scores in the mild to moderate range and does not have CenCal insurance, they are referred to low-cost community providers and/or their primary doctor for treatment. They are also given information on how to apply for Medi-Cal/CenCal. The Access Line also refers clients with CenCal Insurance to CenCal Health for a Primary Care Provider if needed. For those without Medi-Cal/CenCal they are referred to low-cost community providers such as a Neighborhood Clinic.

If a caller is referred to BWell for a comprehensive assessment, a BWell staff member will follow up a minimum of three times if the client does not make their appointment. If callers show up for their comprehensive assessment, engagement in services begins with the first appointment. If a caller is referred to CenCal for mental health care supports, CenCal will follow up and attempt to re-engage if the caller does not show up for treatment. BWell has also recently begun utilizing Peer Support Specialists to do outreach and support before a client's first appointment to begin the intake process and to begin to build a relationship and familiarity with the client.

The way in which individuals will be identified as needing assessment or treatment for a serious mental illness or serious emotional disturbance that is beyond the scope of an Early Intervention Program is by a screener determining that the client falls into the criterium of which they are experiencing symptoms of the moderate to severe level of care need for mental health and or substance use care. They are then referred to a licensed clinician who will

perform the two-to-three-hour assessment. Once the assessment is taken, if the client scores a "6" or above, they are referred to the County Mental Health Level of Care, Behavioral Wellness, which serves those with more moderate to severe mental health symptoms and impairments. An appointment is made for the client at one of BWell's clinics or via telehealth.

Changes to Service Delivery with Follow Up & Referral to Support Engagement in Treatment

Starting in July 2023, the Access Line implemented the new Mental Health Screening tool for adults and children as mandated by DHCS. All Counties in California are required to transition to this tool and it creates consistency among all Counties. It has also resulted in more efficiency in linkage to mental health services, as the tool is much shorter and simpler. Now, it is not a requirement that the screener administering the tool be a licensed clinician as it was with the old tool. This allowed the Access Line more flexibility and opportunity to hire staff such as Caseworkers or AOD (Drug and alcohol) Specialists to be screeners. We have also increased the pool of Spanish speaking staff, because it is often challenging for Spanish speakers to utilize the Access line with an interpreter. Having 7 of our screeners speak Spanish has increased the amount of calls we receive on behalf of our Spanish-speaking community. We recently expanded our hours to 8:00 PM to capture a larger population of working adults.

For Substance Use referrals, Access screeners can refer a client to our ADP Care Coordinators at the time of the referral, for those identified as being at risk of not following through or for those identified as having serious risk factors that make the referral more urgent (pregnant, injecting, etc.) The Care Coordinators conduct special outreach to these clients to increase their likelihood of linking and engaging in treatment.

Behavioral Wellness has been focusing on social media and other outreach efforts, uplifting the community to call the Access Line in times of need – with the ultimate aim of suicide prevention. Behavioral Wellness now has paid ads launching in English and Spanish.

Program Demographics FY 23-24


1,282
# of Clients
Female
Male
Unknown or Not Reported
644
613
Age Group
20
0-15
125
16-25
973
26-59
168
60+
Veteran Status
Yes 8
Unknown or Not Reported 243
No 1,031
Ethnicity
559
Hispanic
491
Non-Hispanic
229
Unknown or Not Reported
3
More Than One Ethnicity
Sexual Orientation
Bisexual 21
Heterosexual / Straight 555
Unknown or Not Reported 691
Race
880
White
163
Unknown or Not Reported
138
More Than One Race
53
African American or Black
16
Alaska Native or Native American
16
Asian
15
Other
1
Native Hawaiian or Other Pacific Islander
Primary Language
1,040
English
130
Unknown or Not Reported
109
Spanish

Access and Assessment, Adult

Total Clients by Region		
North	**South**	**West**
n= 577	n= 417	n= 320

Access Line Calls for FY 23-24

	Number of Calls
Access Line FY 23/24	
Mental Health	5329
Substance Use	3727
Info Only	1028
Other	761

Access and Linkage: Prevention and Early Intervention (PEI): Report on Prior Fiscal Year Activities AND Program Plan

Access Peer Team Program

Provider: Behavioral Wellness

Program Description: This is a program to provide outreach, and peer supports to all new BWell clients. This includes outreach to both Youth and Adults post-hospitalization and to all people who have received a screening from the ACCESS team prior to their first clinical appointment.

Program Type

- Access and Linkage to Treatment Program

Priority Area(s):

	Childhood Trauma Prevention and Early Intervention
	Early Psychosis and Mood Disorder Detection and Intervention
	Youth Outreach and Engagement Strategies Targeting Secondary School and TAY, Priority on College MH Program
	Culturally Competent and Linguistically Appropriate Prevention and Intervention
	Strategies Targeting the Mental Health Needs of Older Adults
X	Early Identification Programming of Mental Health Symptoms and Disorders
X	Other Locally identified Priority: *Providing outreach to all new clients PRIOR to fist appointment*

Program Performance FY 24-25

We embedded Certified Peer Support Specialists across outpatient programs to enhance engagement and care coordination from Access Line screening to service completion. Peers are supporting transitions from crisis stabilization, post-hospitalization, and criminal justice facilities while assisting treatment teams with intakes, assessments, and orientation. Peer Support Specialists are the first follow-up contact. If the client who has been referred does not make their appointment, peers follow up a minimum of three times to attempt to engage. Peers continue engagement throughout the orientation and comprehensive assessment process.

Program Plan for FY 25-26

Provider:	**Behavioral Wellness**
Estimated Funding FY 2025/26:	**This program does not have a separate budget, it is included as part of the Access and Assessment Program budget**

***Started Collecting data for this program in FY 24-25. Program data on Consumers Served by this program will be included in next year's Plan**

Estimated Consumers Served by Age FY 2025-26		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	25	$1680
Estimated Total Consumers Age 15-26 Served	50	$1680
Estimated Total Consumers Served Age 26-59	100	$1680
Estimated Total Consumers Served Age 60+	25	$1680

Projected Date of Implementation/First Date of Services: **7/1/2024**

Addressing Community Issues

This program addresses a notable community issue: providing support to new clients as soon as they are given an appointment with BWell. New clients often have to wait up to a month before going into the clinics for an Assessment, and those post-hospitalization have to wait up to seven days. The goal of this program is to start providing peer support services immediately and assist individuals and their families to feel comfortable with our system of care and make it to their appointments.

Notable Community Impact

Notable community impacts may include a decrease in involuntary Psychiatric Hospitalization; a decrease in crisis intervention and an increase in new clients engaging in services.

Peer Support Specialists are conducting and ensuring continuous engagement and linkage for services provided throughout our system of care, and within our community.

Problem/Community Need and Program Activities

Problem/Community Need	Activities
Increasing timeliness of services and access to services, especially for those new to our system post-hospitalization	Reaching out to new clients as soon as they have an appointment to receive services to begin providing peer support services and help utilizing services
Preventing dissatisfaction and early dismissal of services for new clients	Providing outreach to new clients as soon as they are provided with an appointment to shorten length of time before interactions with BWell staff

Linkages to Mental Health Services

The Access Peer Team was designed to help new clients feel that they are not abandoned and left to deal with symptoms on their own after being screened for services.

Changes to Service Delivery with Follow Up & Referral to Support Engagement in Treatment

The Access Peer team will follow up with all new clients given a linkage to services to ensure that they make it to service appointments. The team interacts with clients after they are assessed and will ensure that individuals and their parents, caregivers and other family members are supported enough to engage in the services they have been linked to. They will then follow up with all new clients post referral and perform a warm handoff to their new treatment team once new clients are fully engaged.

Access and Linkage: Prevention and Early Intervention (PEI): Report on Prior Fiscal Year Activities AND Program Plan

CARE Act Access and Linkages Program

Provider: Behavioral Wellness

Program Description: CARE Act Access and Linkages program is a program that provides intensive outreach and linkages to treatments for referrals received by court order for individuals diagnosed with schizophrenia or another psychotic disorder

Program Type

- Access and Linkage to Treatment Program

Priority Area(s):

	Childhood Trauma Prevention and Early Intervention
	Early Psychosis and Mood Disorder Detection and Intervention
	Youth Outreach and Engagement Strategies Targeting Secondary School and TAY, Priority on College MH Program
	Culturally Competent and Linguistically Appropriate Prevention and Intervention
	Strategies Targeting the Mental Health Needs of Older Adults
X	Early Identification Programming of Mental Health Symptoms and Disorders
X	Other Locally identified Priority: *Access and Linkages for CARE Court Referrals*

Program Performance FY 24-25

The CARE Act was implemented in our County on December 1st, 2024. Since that time, we have had 12 petitions come through CARE Act; one was already open to services, one did not meet criteria, one was found not to be suitable for CARE Act at this time, one has entered into a CARE Agreement, and the other 8 are in various stages of engagement and assessment. This program provides services to those unserved or underserved in our communities who are struggling with a mental health disorder, and/or who are being referred by their conservators for a lower level of care. Ethnic and cultural challenges are addressed as they arise. We utilize interpreters as needed.

Some of the challenges this year were program implementation and reporting guidelines for filing and monitoring services. While we are learning more every week about this, it has been challenging to keep up with the pace of referrals at times, as we are just implementing the program and only have one person in Santa Barbara area that is providing the outreach and engagement, and one person doing the assessments. So far, most referrals into CARE Act have been in the Santa Barbara area, with two in the Lompoc area.

Program Plan for FY 25-26

Provider:	**Behavioral Wellness**
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$390,000

Estimated PEI Funding	$390,000
Estimated Medi-Cal FFP	$0
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$0
Average Cost Per Consumer	$16,250
Estimated Total of Consumers Served	24
Target Population Demographics Served	Adult/Older Adult

*****Because this was a new program that started in FY 24-25, Estimated Consumers Served by Age was not previously collected. Will report data on Consumers Served for this program in next year's Plan.**

Estimated Consumers Served by Age FY 2025-26		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served		
Estimated Total Consumers Age 15-26 Served	8	$16,250
Estimated Total Consumers Served Age 26-59	14	$16,250
Estimated Total Consumers Served Age 60+	2	$16,250

Projected Date of Implementation/First Date of Services: 12/1/2024

Addressing Community Issues

This program will address a notable community issue: engaging individuals in treatment with Anosognosia who have resisted mental health treatments in the past. Engaging people with Serious and Persistent Mental Illness (SPMI) in voluntary treatment is a community priority.

Notable Community Impact

This program is designed to provide intensive outreach and engagement for persons at risk of institutionalization to try and stabilize individuals and begin their recovery.

Problem/Community Need and Program Activities

Problem/Community Need	Activities
Housing	Housing remains at the top of our list of concerns that we see in implementing CARE

	Act successfully. While we do have some resources, such as beds at La Posada and Hedges House, these resources do not meet the level of care needed and being recommended by staff assessing the CARE Act respondents (clients). The bulk of referrals so far have been for those under conservatorship, who need a higher level of support than a shelter bed can provide.
Staffing	While we anticipate having another Caseworker soon for CARE Act, this individual will be stationed in Santa Maria and will travel to Lompoc as needed. We will also utilize peer support specialists from Assisted Outpatient Treatment (AOT). to assist with outreach and engagement who will be stationed in Lompoc and Santa Maria.
Training	We will be continuing trainings with the community as well as other programs throughout the coming year.

Linkages to Mental Health Services

CARE Act Access and Linkages Program will provide specific, sustained outreach to identified individuals. Once trust is established, this team will provide the linkage to mental health services, the transportation to mental health services and a warm handoff to mental health treatment team to achieve mental health treatment goals for selected individuals.

Changes to Service Delivery with Follow Up & Referral to Support Engagement in Treatment

CARE Act Access and Linkages Program directly links individuals to Assessment services and provides transportation services to the Assessment once a referral is willing to accept treatment. Program staff accompany the referral to the Assessment and continue to provide outreach and engagement services until a warm handoff to BWell Clinical Services Team. Establishing a continued, sustained relationship with referrals is essential to engaging a referral in services, and the referral will be handed off to Clinical Services Team in a way that is sensitive to the referral's needs. Once referred, part of the referral is to have an assessment completed

by a Behavioral Wellness clinician. The assessment identifies the diagnosis, needs, symptoms and impairments that will guide the treatment plan.

For all individuals referred to this program, and, as applicable, their parents, caregivers and other family members, program staff will attempt to link to BWell specialty mental health services, a primary care provider and other needed treatment services. This is the main objective of this program. The staff engage in extensive and sustained outreach and engagement to build trust so that referrals will engage in mental health treatment services.

Individuals referred and found to meet criteria are opened into a CARE Agreement, and mental health staff provide services and support and eventual linkage to a long-term specialty mental health team. This arrangement is typically either a full-service partnership or assertive community treatment (ACT) team.

Referrals are discussed every week in meetings with the conservator, public defender, advocates for clients, county counsel and the CARE Act staff. The CARE Act manager dispatches the team almost immediately to provide outreach and engagement to those referred, unless referred by their conservator. At that time, the clinician doing the assessment begins engagement and provides a report prior to the other staff member engaging the client.

Prevention Programs: Prevention and Early Intervention (PEI): Report on Prior Fiscal Year Activities AND Program Plan

Early Childhood Mental Health Program

Provider: CALM

Program Description: This program provides outreach and prevention strategies for parents and children under age five.

Available data on this program's outcomes for the prior fiscal year period, FY 23-24, is included as an Appendix to this document

Program Type(s):

- Prevention Program

Priority Area(s):

x	Childhood Trauma Prevention and Early Intervention
	Early Psychosis and Mood Disorder Detection and Intervention
	Youth Outreach and Engagement Strategies Targeting Secondary School and TAY, Priority on College MH Program
x	Culturally Competent and Linguistically Appropriate Prevention and Intervention

	Strategies Targeting the Mental Health Needs of Older Adults
	Early Identification Programming of Mental Health Symptoms and Disorders
	Other Locally-identified Priority:_____

Program Performance FY 24-25

During this fiscal year, CALM's Prevention and Early Intervention (PEI) program has made significant strides in reducing child abuse and mental health issues by addressing risk factors, such as parental stress and trauma, before they escalate. By strengthening parent-child relationships through evidence-based programs, we foster emotional security and resilience, ultimately improving long-term mental health outcomes. Investing in early support enhances children's development and school readiness while reducing the need for costly interventions, leading to healthier families and communities.

This year, CALM continued to provide evidence-based PEI services, including home visitation, parent education, and treatment for perinatal mood and anxiety disorders. We prioritize proven models such as Healthy Families America (HFA), Nurturing Parenting Programs, Parent-Child Care (PC-CARE), Parent-Child Interaction Therapy (PCIT), Interpersonal Psychotherapy (IPT), Cognitive Behavioral Therapy (CBT), and Eye Movement Desensitization and Reprocessing (EMDR). We consistently receive referrals from community partners and individuals seeking services directly.

CALM has exceeded contract deliverables this fiscal year, with a significant portion of referrals coming from Santa Maria. The majority of clients identify as Hispanic/Latino, and approximately 50% prefer services in Spanish. This year we updated our website and outreach materials to ensure information reflects current programming and is available in English and Spanish. We remain committed to serving unserved and underserved populations, with a strong focus on reducing ethnic and cultural disparities. Through targeted outreach and evidence-based services, CALM ensures equitable mental health support reaches those who need it most.

The main challenge this year has been recruiting qualified staff to fill vacancies. Despite this, our performance remains strong. Additionally, CALM continues to struggle aligning documentation procedures for evidence-based programs with the county's electronic health record requirements. The county's EHR requirements create an unnecessary documentation burden for some prevention services.

Program Plan for FY 25-26

Provider:	**CALM**
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$ 481,800

Estimated PEI Funding	$ 481,800
Estimated Medi-Cal FFP	
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer	$5,018
Estimated Total of Consumers Served	96
Target Population Demographics Served	Children, TAY, Adult

Estimated Consumers Served by Age FY 2024/25		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	52	$5,018
Estimated Total Consumers Age 15-26 Served	13	$5,018
Estimated Total Consumers Served Age 26-59	31	$5,018
Estimated Total Consumers Served Age 60+	0	

Addressing Community Issues

During the previous fiscal year, CALM's **Prevention and Early Intervention (PEI)** program has played a vital role in ensuring that children and their caregivers have access to the critical support needed to prevent problems from escalating. This program serves as a safety net, removing barriers to care and providing early intervention to strengthen family well-being.

Over the past year, CALM has observed several pressing community issues impacting the families we serve, including:

- **Parental stress and anxiety**, often exacerbated by economic hardship and limited access to mental health resources.
- **Limited social support systems for families**, particularly among immigrant and low-income communities, leading to increased isolation and difficulty accessing services.
- **Increase in perinatal mood and anxiety disorders (PMADs)**, affecting parental well-being and the early attachment process.
- **High levels of interpersonal conflict and intimate partner violence**, placing children and caregivers at increased risk of trauma.

These challenges directly impact parental capacity, making it more difficult for caregivers to provide stable, nurturing environments for their children. Through home visitation, parent

education, and evidence-based prevention and early intervention, CALM works to mitigate these issues and promote healthy family functioning.

Notable Community Impact

The program's impact on the community is strengthened by our commitment to using evidence-based treatment models that are proven to support healing and resilience in children and families. Through Healthy Families America (HFA), Nurturing Parenting, Parent-Child Interaction Therapy (PCIT), Parent Child Care (PC-Care), Eye Movement Desensitization and Reprocessing (EMDR), Cognitive Behavioral Therapy (CBT), and Interpersonal Psychotherapy (IPT), we ensure that clients receive interventions tailored to their unique needs, grounded in research and best practices. By integrating these models into our services, we provide a structured, effective approach to prevention and early intervention, delivering services in CALM's clinic offices and community settings.

Notable Community Impact: Linda's Story

Linda, a single mother in her mid-30s, lives with her three children and her mother, who provides childcare support. In August 2022, she sought Home Visitation services at the strong encouragement of her doctor and was found eligible for CALM's Healthy Families America (HFA) program.

During her initial home visit, Linda expressed her biggest fear: struggling to bond with her newborn. She shared, *"Sometimes I don't feel anything. I am just going through the motions."* This concern was compounded by an ongoing battle with cancer, which required treatment throughout her pregnancy and postpartum period. In addition to her health challenges, she faced a two-hour daily commute for work and lacked reliable childcare. During the initial assessment, she also disclosed a history of punitive and harsh discipline in her own childhood and expressed a strong desire to learn positive parenting strategies to support her daughter's healthy development.

Despite these challenges, Linda remained determined to create a nurturing environment for her child. Through participation in CALM's HFA program, she gained knowledge and support to strengthen her bond with her baby. She discovered that attachment could be fostered through shared routines and intentional interactions, including singing, taking walks, and showering together.

As Linda progressed through the program, she engaged in evidence-based parenting education that covered key topics such as safe sleep practices, supporting developmental milestones, positive discipline and parenting strategies, choosing quality childcare, and goal setting for family stability

With case management support, she was able to find a job closer to home, significantly reducing her commute and allowing her to spend more time with her children. She also secured quality, reliable childcare. Through a connection with Children's Resources & Referral, her mother became her primary childcare provider, ensuring consistency in care while also helping support the family financially.

Now, after two years of being cancer-free, Linda is preparing to graduate from CALM's HFA program in April. Her weekly visits have gradually transitioned to monthly check-ins, and she takes great pride in the secure and loving relationship she has built with her daughter. Her child, now a thriving toddler, has met all developmental milestones, and bonding has become second nature to Linda. She is now focusing on learning positive parenting strategies for potty training, another important milestone in her parenting journey.

By maintaining a strong foundation in evidence-based practices, CALM ensures that families receive the most effective, research-backed care. Through early intervention, we are not only transforming individual lives but also building a healthier, more resilient community for future generations.

Program Type(s)

- Prevention Program
- Program to Improve Timely Access to Services for Underserved Populations(s)

Priority Area(s)

- Childhood Trauma Prevention and Early Intervention
- Culturally Competent and Linguistically Appropriate Prevention and Intervention

Problem/Community Need and Program Activities

Problem/Community Need	Activities
Parenting support for families with children 0-5 years of age	Home visitation using HFA model; parenting education; child development screenings (ASQs); referrals to community resources; targeted case management
Mental health services for perinatal mood and anxiety disorders and infant mental health to enhance attachment and mitigate risk factors.	Individual and dyadic therapy using evidence-based modalities; referrals to community resources; targeted case management

Minimal access to individual prevention and early intervention services for children 0-5	Mental health practitioners specializing in dyadic treatment provide therapeutic service for children 0-5 and their caregivers

Methods Used for Outreach and Engagement of Potential Responders

Early detection and outreach are key to preventing child abuse, trauma, and parent-child bonding issues that contribute to future serious mental illness. CALM connects with medical facilities such as doctor's offices, Public Health, and hospitals (i.e. Marian Medical Regional Medical Center) to promote early detection and referral to our preventative services. We further connect with other community agencies providing basic needs assistance (i.e. Family Service Agency) or specializing in other community services such as domestic violence (I.e. Domestic Violence Solutions).

Changes to Service Delivery

For the upcoming year, CALM would like to continue to strengthen fidelity to our evidence-based modalities and further expand our use of these modalities across Santa Barbara County to all of our office locations. For example, we have staff that are practicing HFA at our Santa Maria location, and we are currently expanding use of the model to our Santa Barbara location. This ensures consistency of our service approach and impact across the county. Along the same lines, we would like to create more formal structural procedures to ensure fidelity to our evidence-based models such as fidelity checklists for staff and procedure manuals.

CALM would also like for our service outcomes to better reflect the purpose of our preventative work and have this better represented through appropriate clinical measures. For example, instead of using the Child Behavior Checklist (CBCL) to measure changes in child symptomology, we would like to use the Protective Family Survey (PFS) and/or the Maternal Attachment Inventory (MAI) to measure family protective factors and strength of the parent-infant relationship.

In this next year we would like to update the PEI scope of work to more accurately reflected services provided. Currently our PEI contract outcomes are the same as all the other contracts funded by county behavioral health. However, these outcomes don't necessarily capture the specific work being done in this program.

Furthermore, would like to utilize current funds to provide developmental toy kits for parents. These kits were a crucial component of our home visitation program and were previously provided by First 5 prior to funding be diverted to other populations. These kits were utilized by home visitors and caregivers to demonstrate age-appropriate play, enhance child development, and support parent-child relationship. Having these materials would help our staff engage more effectively with their families and reinforce interventions in the home.

Intensive Care Coordination, Intensive Home-Based Services, Plan Development and Rehabilitation services are all incorporated into service delivery. CALM's goal is to continue to support and expand training that allows us to provide the specialized services needed to work with underserved populations.

Program Demographic Data

	ECMH
PROGRAM	**CALM**
TOTAL CLIENTS	**96**
AGE	
0-15	52
16-25	13
26-59	31
60+	0
Unknown/Decline	0
SEX AT BIRTH	
Female	N/A
Male	N/A
Unknown/Decline	N/A
CURRENT GENDER IDENTITY (if over 12 years)	
Male	35
Female	59
Transgender	0
Genderqueer	0
Questioning	0
Another	0
Unknown/Decline	2
SEXUAL ORIENTATION (if over 12 years)	
Gay/Lesbian	0
Heterosexual	4
Bisexual	0
Questioning/ Unsure	0
Queer	0
Another	0
Unknown/Decline	92
PRIMARY LANGUAGE	
English	25
Spanish	0
Other	0
Unknown/Decline	64
VETERAN (if over 12 years)	
Yes	0
No	28
Unknown/Decline	68

RACE	
American Indian/ Alaska Native	1
Asian	0
Black/ African American	1
Native Hawaiian/ Pacific Islander	0
White	24
Other	1
More than one	0
Unknown/Decline	69
ETHNICITY: LATINO	
Caribbean	N/A
Central American	N/A
Mexican/Mex. Amer./ Chicano	N/A
Puerto Rican	N/A
South American	N/A
Other Latino	N/A
Unknown/Decline	N/A
ETHNICITY: NON-LATINO	
African	N/A
Asian Indian/ South Asian	N/A
Cambodian	N/A
Chinese	N/A
Eastern European	N/A
European	N/A
Filipino	N/A
Japanese	N/A
Korean	N/A
Middle Eastern	N/A
Vietnamese	N/A
Other	N/A
Unknown/Decline	N/A
More than one	N/A
DISABILITY	
Physical/mobility	N/A
Chronic Health Condition/pain	N/A
Difficulty Seeing	N/A
Difficulty Hearing	N/A
Other	N/A
Other Mental Disability	N/A
Unknown/Decline	N/A
FAMILY	

# of Family Members in Program	N/A

Prevention Programs: Prevention and Early Intervention (PEI): Report on Prior Fiscal Year Activities AND Program Plan

Growing Grounds Program

Provider: Transitions Mental Health Association (TMHA)

Program Description: This Program provides relapse prevention and vocational development to adults with a serious and persistent mental illness.

Available data on this program's outcomes for the prior fiscal year period, FY 23-24, is included as an Appendix to this document

Program Type(s):

- Prevention Program

Priority Area(s):

	Childhood Trauma Prevention and Early Intervention
	Early Psychosis and Mood Disorder Detection and Intervention
	Youth Outreach and Engagement Strategies Targeting Secondary School and TAY, Priority on College MH Program
	Culturally Competent and Linguistically Appropriate Prevention and Intervention
	Strategies Targeting the Mental Health Needs of Older Adults
	Early Identification Programming of Mental Health Symptoms and Disorders
X	Other Locally identified Priority: *Relapse Prevention Program stressing resiliency factors and supported employment for mental health consumers*

Program Performance FY 24-25

Growing Grounds Farm hires and supports workers with a moderate to severe mental health condition or in recovery of a mental health condition. This is one of the more underserved and stigmatized populations in the county. Most referrals come from BWell, the Department of Rehabilitation, and through Community Partner Organizations.

As of January 2025, Growing Grounds Farm has provided employment, vocational training services and therapeutic horticulture sessions to 48 unique individuals. Of the 48 clients we

have served so far this FY, 11 have moved on to competitive employment in the community. This represents 96% of our expected annual outcomes.

Additionally, we have conducted 48 vocational planning sessions, providing an opportunity for each transitional employee client we serve to set recovery and vocational goals. Additionally, we have conducted 30 weekly vocational training sessions and 30 weekly horticultural therapy sessions.

Two farm staff have attended 4-day intensive courses with the Horticultural Therapy Institute covering advanced professional horticultural therapy and horticultural therapy techniques

With Transitions-Mental Health Association, we combine horticultural therapy and vocational training to provide individuals with mental illness employment and a supportive environment where personal growth can be realized.

Most employees are referred to us by the Santa Barbara County Department of Behavioral Wellness. Employees are diagnosed with persistent illnesses such as schizophrenia, bipolar disorder, anxiety disorder or major depression.

Program Plan for FY 25-26

Provider:	**TMHA**
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$ 385,000
Estimated PEI Funding	$ 385,000
Estimated Medi-Cal FFP	
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$0
Average Cost Per Consumer	$7,264
Estimated Total of Consumers Served	53
Target Population Demographics Served	TAY, Adult, Older Adult

Estimated Consumers Served by Age FY 2024/25		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	
Estimated Total Consumers Age 15-26 Served	19	$7,264
Estimated Total Consumers Served Age 26-59	29	$7,264
Estimated Total Consumers Served Age 60+	3	$7,264
Unknown/Decline	2	$7,264

Addressing Community Issues

A program of Transitions-Mental Health Association, we combine horticultural therapy and vocational training to provide individuals with mental illness employment and a supportive environment where personal growth can be realized. Most employees are referred to us by the Santa Barbara County Department of Behavioral Wellness. Employees are diagnosed with persistent illnesses such as schizophrenia, bipolar disorder, anxiety disorder or major depression.

Notable Community Impact

The Farm has seen an increase in utilization of the program by other local agencies, such as: Momentum, Achievement House, PathPoint and BWell's gardening group who use the Farm program for vocational training, volunteer engagement and wellness activities for their participants; all through funding from their programs.

The Farm staff continue to prioritize community engagement opportunities, notably participating in MHSA Stakeholder events, Santa Maria Chamber of Commerce meetings and local school outreach events.

The Farm staff has sought out opportunities to engage and collaborate with other local non-profit agencies to partner and support each other's missions, such as: The Bridgehouse Farm in Lompoc, The Bridge Cafe in San Luis Obispo, The Family Care Network and the SLO City Farm.

The Farm has hosted a number of community engagement events this fiscal year, including our Summer Succulent Celebration in August and our Grow Native plant event in October. These events spread awareness of the Farm program and available community mental health resources as new customers become aware of the Farm and our mission. Program participants at the Farm also work with TMHA's supported Employment Program, which supports workers with work readiness assessments and job preparation when they are prepared to search for

competitive employment in the private sector. Staff also work closely with other community partners to ensure they have the linkages and supports to be successful.

We have also displayed information about local mental health resources and events at our weekly farm stands and seasonal events that are attended by the public.

Program Type(s):

- Prevention Program

Priority Area(s):

- Other Locally identified Priority: Relapse Prevention Program stressing resiliency factors and supported employment for mental health consumers

Problem/Community Need and Program Activities

Problem/Community Need	Activities
To provide employment and vocational training that engage, orient, prepare, and support an at-risk population of adults living with a mental illness (client employees) to work independently in the community.	Vocational assessment, job preparation, essential job skills training to assist in gaining competitive employment in the community
To provide horticultural therapy as a component of daily employment and vocational training.	Growing Grounds staff will receive horticultural therapy training, and work on the farm will be done from a perspective of healing. A new position of Case Worker (peer preferred) will be added to staff, with responsibilities including the leading of mindfulness exercises, collaborating with client employees to create recovery goals, the promotion of events and informational materials on mental health, and providing linkages to BWell. Staff will collaborate with client employees to create recovery goals, promote events and informational materials on mental

	health, and provide appropriate linkages to BWell.
To reduce the stigma and stereotypes of mental illness through our social enterprise that directly serves our community.	Provide educational materials on mental health and available services to the general public on site at Growing Grounds Farm.
There is a high rate of unemployment for those in the Santa Barbara County suffering from mental illness or substance abuse. This population also has a high need of equitable opportunities to work and be gainfully employed.	Provide Vocational assessments, job preparation, and essential job skills training to assist clients in gaining competitive employment in the community To provide employment and vocational training that engages and prepares the at-risk population of adults living with mental illness to re-join the competitive workforce. To employ community members suffering from mental illness at the Growing Grounds Farm who receive pay for their work.
There is a high need in Northern Santa Barbara County for persons with mental health challenges to be employed in environments that support their mental health recovery while also providing them with income to help support themselves.	Growing Grounds staff will receive horticultural therapy training, and work on the farm will be done from a perspective of healing. A new position of Case Worker (peer preferred) will be added to staff, with responsibilities including the leading of mindfulness exercises, collaborating with client employees to create recovery goals, the promotion of events and informational materials on mental health, and providing linkages to BWell. Staff will collaborate with client employees to create recovery goals, promote events and informational materials on mental health, and provide appropriate linkages to Behavioral Wellness.

There is a high degree of stigma and stereotypes about mental illness in the community.	Provide educational materials on mental health and available services to the general public on site at Growing Grounds Farm.

Program Demographics

PROGRAM	THMA
TOTAL CLIENTS	**53**
AGE	
0-15	0
16-25	19
26-59	29
60+	3
Unknown/Decline	2
SEX AT BIRTH	
Female	13
Male	36
Unknown/Decline	4
CURRENT GENDER IDENTITY (if over 12 years)	
Male	32
Female	10
Transgender	0
Genderqueer	0
Questioning	0
Another	3
Unknown/Decline	8
SEXUAL ORIENTATION (if over 12 years)	
Gay/Lesbian	0
Heterosexual	3
Bisexual	0
Questioning/ Unsure	0
Queer	0
Another	0
Unknown/Decline	50
PRIMARY LANGUAGE	
English	36
Spanish	13
Other	0
Unknown/Decline	4
VETERAN (if over 12 years)	
Yes	0
No	14
Unknown/Decline	39
RACE	

American Indian/ Alaska Native	1
Asian	0
Black/ African American	1
Native Hawaiian/ Pacific Islander	0
White	17
Other	0
More than one	0
Unknown/Decline	34
ETHNICITY: LATINO	
Caribbean	0
Central American	1
Mexican/Mex. Amer./ Chicano	9
Puerto Rican	0
South American	0
Other Latino	0
Unknown/Decline	43
ETHNICITY: NON-LATINO	
African	0
Asian Indian/ South Asian	0
Cambodian	0
Chinese	0
Eastern European	0
European	2
Filipino	0
Japanese	0
Korean	0
Middle Eastern	0
Vietnamese	0
Other	0
Unknown/Decline	51
More than one	0
DISABILITY	
Physical/mobility	0
Chronic Health Condition/pain	5
Difficulty Seeing	0
Difficulty Hearing	0
Other	0
Other Mental Disability	6
Unknown/Decline	43
FAMILY	
# of Family Members in Program	0

Prevention Programs: Prevention and Early Intervention (PEI): Report on Prior Fiscal Year Activities AND Program Plan

Wellness Promotion for Seniors

Provider: Family Services Agency (FSA)

Available data on this program's outcomes for the prior fiscal year period, FY 23-24, is included as an Appendix to this document

Program Description: This program provides fun, educational activities for adults aged 60 and older living in Santa Barbara County Housing Authority sites to prevent and address isolation. Drop-in hours are available to help participants link to other community resources.

Program Type(s):

- Prevention Program

Priority Area(s):

	Childhood Trauma Prevention and Early Intervention
	Early Psychosis and Mood Disorder Detection and Intervention
	Youth Outreach and Engagement Strategies Targeting Secondary School and TAY, Priority on College MH Program
	Culturally Competent and Linguistically Appropriate Prevention and Intervention
X	Strategies Targeting the Mental Health Needs of Older Adults
	Early Identification Programming of Mental Health Symptoms and Disorders
	Other Locally identified Priority:

Program Performance FY 24-25

We made great strides last year as we were finally fully staffed, allowing us to provide activities and office hours on a regular consistent basis. Staff engaged in outreach to gather and increase attendees through the distribution of flyers, and knocking on resident's doors. Staff have been mindful of unserved and underserved populations and have paid particular attention to those folks who need additional services, referrals and resources. As staff increased familiarity and rapport with the residents, they intentionally included both Spanish-speaking activities melded with English-speaking activities to create community and curious learning of other cultures in the residential communities. Activities are often conducted in both Spanish and English building mutuality, respect and community. Upon the commencement of Chair Yoga with Klaudia Paletta, many residents found similarities and common interests not only in exercise but also in everyday life.

Major challenges continue to surround limited attendance by the majority of residents. However, we do understand the logistical inability to provide the appropriate amount of space if we did indeed drastically increase our attendance numbers.

Program Plan for FY 25-26

Provider:	**Family Service Agency**
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$ 494,053
Estimated PEI Funding	$ 494,053
Estimated Medi-Cal FFP	
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$0
Average Cost Per Consumer	$1,604
Estimated Total of Consumers Served	308
Target Population Demographics Served	Older Adults

Estimated Consumers Served by Age FY 2024/25		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	
Estimated Total Consumers Age 15-26 Served	0	
Estimated Total Consumers Served Age 26-59		
Estimated Total Consumers Served Age 60+	308	$1,604

Addressing Community Issues

It is no secret that our senior population is growing and changing. Many seniors have adult children at home, are raising grandchildren, or caring for their elderly parents. Marital discord, financial woes, depression, isolation, loneliness and unresolved life issues are just some of the challenge's older adults face. Family Service Agency offers older adults the tools they need to live meaningful, independent and healthy lives, providing them with the support they need to age comfortably and safely in the comfort of their own home for as long as possible. Our services are free to those who are 60 years and older or are caring for someone who is. Our Senior Mental Health services provide counseling for individuals, families and couples with an

emphasis on direct evidence-based, solution-oriented treatment strategies and well-defined therapeutic goals. Services are offered in English and Spanish.

Notable Community Impact

Participants are enjoying the activities and look forward to weekly engaging with the other participants and the activity facilitators. This engagement leads to reduced isolation and loneliness. Exercise helped seniors to share goals and spend time together as they participate and enjoy a happy class in their different locations. Seniors have approached the wellness navigators during office hours and have made appts a week before.

Program Type(s)

- Prevention Program

Priority Area(s):

- Strategies Targeting the Mental Health Needs of Older Adults

Problem/Community Need	Activities
Enriching and Community-Building Activities for Seniors living in residential settings	Activities are tailored to the needs and interests of the housing property residents, and may include: • Healthy movement and exercise classes like Chair Yoga in all SB locations. • Celebrations such as fiestas • Mobile library and/or book club • Presentation and discussions on topics of interest • Crafting activities • Bingo and/or other games • Groups focusing on topics such as mindfulness and wellness

Case Management / Connection to Resources for Seniors living in residential settings	Connection to and support navigating various community resources such as Cal Fresh, health insurance, immigration resources, utility assistance, health and mental health services. Reading and understanding documents Advance care directives and end of life planning. Tools for successfully aging in place Screen residents for participation in the PEARLS Program offered by FSA
Older Adult Isolation, Depression and Loneliness	Screen residents for participation in the PEARLS Program offered by FSA. PEARLS (Program to Encourage Active Rewarding Lives) is a program designed to help older adults manage mild depressive symptoms, loneliness and isolation by solving problems, building social engagement and increasing physical activity. Offering office hours to residents as an opportunity to express their emotions, situations and needs. Advocating for residents to have their needs met. Referring people to FSA and BWell Mental Health Services.

Community Communication / Empowering/ Building trust and Promoting leadership through participation	Talking about the importance of communication and participation with seniors Sharing flyers with different resources Doing outreach in the locations to promote the activities while building communication and trust Presentations about communication skills and barriers Empowering seniors' skills while working on projects Letting seniors lead and personalize their projects according to their knowledge. Recognizing the uniqueness of everyone.

How Individuals Will be Linked to Mental Health Treatment

Through weekly office hours for appointments and drop-ins, FSA Wellness Promotion Specialists will provide the following types of support:

a. Connection to and support navigating various community resources such as Cal Fresh, health insurance, immigration resources, utility assistance, health and mental health services
b. Reading and understanding documents
c. Advance care directives and end of life planning
d. Tools for successfully aging in place

The evidence-based CSQ-8 satisfaction survey will be utilized to measure satisfaction with the services, and a second evidence-based assessment tool (pre-post) will be identified to measure life satisfaction. In addition, some of the activities conducted may be evidence-based, such as a mindfulness wellness group.

Estimated Individuals to be Served

Family Service Agency is proposing to work in partnership with Santa Barbara County's two Housing Authorities to provide "Wellness Promotion for Seniors" at a minimum of twelve senior housing properties across the county. Senior housing properties vary in size, having anywhere

from 30 to 130 units. 100% of senior residents will have access to the Health Promotion services, and our experience has shown that at least 50% of residents actively engage with one or more of the offerings. If the average number of units per property is about 60, then 60 older adults x 12 properties = 720 seniors will have access to the services, and at least half of those, 360, will actively engage with the services.

Program Demographics

	Wellness Promotion for Seniors
PROGRAM	**FSA**
TOTAL # EVENTS	**99**
TOTAL # PARTICIPANTS	**308**
TOTAL # FAMILIES SERVED	**302**
EVENT TYPE	
Outreach (Health Fairs, Other Outreach)	65
Training (Trainings, Workshops)	2
Forum (Meetings w/ Community Leaders)	32
Support Group	0
Distribution of Materials	0
PRIMARY LANGUAGE OF EVENT	
English	N/A
Spanish	N/A
Other or both English and Spanish	N/A
TRANSLATION PROVIDED	
Translation to English at Spanish event	N/A
Translation to Spanish at English event	N/A
Other or both English and Spanish	N/A
PARTICIPANT AGE	
0-15	0
16-25	0
26-59	0
60+	308
Missing DOB	0
PARTICIPANT GENDER	
Female	236
Male	71
Unknown/Decline	3

PARTICIPANT VETERAN	
Yes	20
No	263
Unknown/Decline	7
PARTICIPANT RACE	
American Indian/ Alaska Native	0
Asian	0
Black/African American	3
Native Hawaiian/ Pacific Islander	0
White	232
Other	54
More than one	0
Unknown/Decline	9
PARTICIPANT ETHNICITY	
Latino	95
Non-Latino	205
Unknown/Decline	5

Prevention Programs: Prevention and Early Intervention (PEI): Report on Prior Fiscal Year Activities AND Program Plan

Peer and Parent Partners in Wellness and Recovery

Provider: Mental Wellness Center

Program Description: This is a peer-led outreach and engagement program for family members living with an adult with serious and persistent mental illness

Available data on this program's outcomes for the prior fiscal year period, FY 23-24, is included as an Appendix to this document

Program Type(s):

- Prevention Program

Priority Area(s):

	Childhood Trauma Prevention and Early Intervention
	Early Psychosis and Mood Disorder Detection and Intervention
	Youth Outreach and Engagement Strategies Targeting Secondary School and TAY, Priority on College MH Program
	Culturally Competent and Linguistically Appropriate Prevention and Intervention
	Strategies Targeting the Mental Health Needs of Older Adults
	Early Identification Programming of Mental Health Symptoms and Disorders

X	Other Locally identified Priority: Outreach and Support to Family Members of a person with a serious mental illness

Program Performance FY 24-25

We have successfully completed the first year of the Peer & Parent Partners in Wellness. The Mental Wellness Center's interdisciplinary team works in a family's home or at our offices to engage and support the mental health needs of referred families who have adult children with mental illness. We supported a total of 36 families. Our current caseload is 22 families, with 1 on the waiting list. Currently, we have discharged 6 families. Discharging families has been more difficult than we thought. The main reason for discharge is the adult child with SMI does not want to participate. We usually try to contact the adult child for up to three to four months and try several different approaches to the situation before discharge. As our team reviewed each of the cases we decided to approach the adult child sooner in the onboarding process. By approaching the identified patient sooner than later, the team would have a better idea if the case remained open. Even though we discharge a family from the program, we still maintain contact and make referrals to other MWC programs, such as one of our three family support groups and National Alliance on Mental Illness (NAMI) educational classes. At discharge, we sent the family a Client Satisfactory Questionnaire (CSQ) 8 questionnaire. Some of the comments have been:

- "It's been a great experience getting to meet with Frank (peer) and talk to him about what's going on in my life and get support and advice."
- "More is offered than I can utilize"
- "Having someone to talk to who understands the circumstances I'm experiencing and who can provide guidance and advice on how to handle difficult situations."

Program Plan for FY 25-26

Provider:	**Mental Wellness Center**
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$ 559,075
Estimated PEI Funding	$ 559,075
Estimated Medi-Cal FFP	
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$0
Average Cost Per Consumer	$15,529

Estimated Total of Consumers Served	36
Target Population Demographics Served	Adult, Older Adult

Estimated Consumers Served by Age FY 2024/25		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	
Estimated Total Consumers Age 15-26 Served	6	$15,529
Estimated Total Consumers Served Age 26-59	20	$15,529
Estimated Total Consumers Served Age 60+	10	$15,529

Addressing Community Issues

Our services are provided in a manner that breaks down barriers to seeking help while promoting recovery and resilience for the entire family.

Notable Community Impact

One Example of Client and Team Interactions: After several home visits where the client and peer played card games and dominos the client felt comfortable going on a walk. The peer and the client took a walk around the client's neighborhood while they noticed trees and other nature landscaping the client mentioned that he had never been to the restaurant located in his neighborhood. The peer mentioned that at their next meeting they could go to the restaurant for lunch. The peer was excited and agreed to the outing. The next week a few hours before the scheduled session the client called to confirm the meeting and also wanted to confirm that they would be having lunch together. This was the first time the client called the peer without any assistance. When the peer arrived for the session, they were open to the possibility of the client not wanting to leave the house or even explore the new restaurant BUT to everyone's surprise the client was eager for the adventure. As they walked to the restaurant the peer explained how the restaurant works and some of the menu items to make the client feel comfortable. Once in the restaurant the client selected a table and gave his order without any hesitation. There were times when the noise of the restaurant startled the client, but they all managed to complete the meal and walk home in good spirits!

Case Presentation:

Client: Father with major depression and paranoia

Family Members: Wife, young adult son (Spanish-speaking) Referral: Cottage Hospital Psychiatric Unit (Post-discharge) Interventions: Education, Peer Support, Family Therapy, Medication Management, LEAP Method

Initial Phase

Family Shock: The family is in shock upon learning about mental illness.

Education: Several sessions with the wife and son focused on mental health, mental illness, wellness, and medication.

Peer Support: The client is paired with a certified peer specialist. Initial sessions were short due to clients' mental health issues. The client would not get out of bed.

Family Support

Overcoming Stigma: The family struggled, wishing for the father to just "snap out of it."

Communication: Interventions focused on improving family communication and support.

Medication Management: Worked closely with psychiatrists. The client was prescribed lithium after several months, resulting in positive changes and a reduction in negative symptoms.

Ongoing Activities

Group Walks: Family, peer specialist, and clinician engaged in regular group walks on Cabrillo Blvd.

Communication Skills: The Clinician worked with the wife and son to improve their communication using the LEAP method.

Son's Stigma: Son was initially concerned about medication stigma but changed his mind after witnessing his father's improvement.

Current Status

Weekly Runs: Peer and client meet every Friday at the beach for a run.

Positive Outcomes: Improved family communication, reduced stigma, and enhanced client well-being.

The team's efforts to build the family up, educate them, and facilitate open communication have clearly had a positive impact. It's inspiring to see such progress in our program.

Program Type(s)

- Prevention Program

Priority Area(s):

- Other Locally identified Priority: Outreach and Support to Family Members of a person with a serious mental illness

Problem/Community Need and Program Activities

Problem/Community Need	Activities
Increasing Education for Family Members	• Connect peers and parents with MWC and NAMI educational groups and activities that build deeper understanding of recovery • Progress (1): MWC has successfully connected with 15 families to provide P+P Services. Two of the 15 primary clients identify as Females. Three of the primary clients are Spanish speaking. The majority of the primary clients in the program are between the ages of 25 to 34 years; a total of 7 clients. Seven primary clients completed the ACES Screener; the average score was 4 with the highest score of a 7. • In January 2025, 47 sessions were completed. 15 visits were conducted at home, 11 in the community, and 21 in the office. • All of the Peer and Parent families were invited to take the nine-week NAMI Family-2-Family class. • Our staff use Dr. Almodovar's Learning Evaluating and Planning (LEAP) curriculum with families. This curriculum teaches parents how to communicate and set boundaries while maintaining self-care.
Increasing Education for Family Members	• Increasing family understanding of mental illness including signs, symptoms and basic strategies for self-care • Provide information about common objections/barriers to treatment,

	understanding anosognosia and stigma. • When appropriate offer more specific information about effective treatment options and the process of accessing treatment. • Progress (2): As of January 31, 2024, MWC conducted 32 Educational Trainings. Educational Trainings covered some of the following topics, coping with family estrangement, understanding the mental health diagnoses, love languages, the four agreements, self-care planning, wellness recovery planning and communication style. • During 102 sessions completed, the families were provided with support and discussion around overcoming barriers to treatment, understanding anosognosia, and decreasing stigma. Th P+P team utilized Motivational Interviewing interventions to engage families in the discussions. • As of January 31, 2024, eight referrals and linkage services to Community Resources have been provided.
Increasing Outreach to Family Members	• In the first two quarters we hosted 29 training/presentations • We created 60 educational and informational publications
Increasing Service Delivery	• After the engagement and education phase of the program the Team will address the individual needs of family members for topics that may include secondary strains on employment, financial stress, reduced quality of life, fatigue, anticipatory grief and depression experienced by the caregivers.

	• the Team will address person centered planning with the identified peer and barriers to independence and treatment • Progress: As of January 31, 2023, three out of the fifteen families have collaborated with the Peer Specialist. Five families are currently in the "Peer Intro Planning" phase. • One primary client has begun to attend the Fellowship program. Many of the primary clients have developed recovery plans that include reconnecting to nature, meditation, social connections, sleeping and eating better. • Key Differences: • The program focuses on using a holistic strength-based approach to engage clients in services. Each individual family is provided with interventions, psychoeducation, and coaching skills based on each family member's needs. The program recognizes that all family members and social support for the primary client have an important role in their recovery journey. The P+P team includes a Family Advocate, Clinician, and Peer Specialist. They all continuously assess, collaborate, and modify interventions to build trusting relationships. • Challenges: As families begin to reach the program goals of engaging in services, the program has begun to address discharge planning. A concern is that not all our County is set up to support clients with severe mental illness in a holistic way. During a crisis

	episode of hallucinations or delusions, law enforcement continues to incarcerate individuals. These actions continue to perpetuate the cycle of jail being the pathway to treatment. • The length of the family's participation in our program is longer than expected. The primary clients' parents require more time and support to allow their adult child to have their own independence.
Increasing Service to consumers	• In the first two quarters over 200 consumers have taken the Wellness Recovery Action Plan (WRAP) program

How Individuals Will be Linked to Mental Health Treatment

A trained, diverse team of peers, family advocates and clinical staff will work in the home or in the field and at the Mental Wellness Center to engage and support the mental health needs of referred families. The team will establish individual relationships with both the caregiving family members and the identified peer with the goal of providing education, support and connection to natural support and mental health resources in the community.

Estimated Individuals to be Served

Families with adults living with unmet or undiagnosed mental health, social, health care needs. The priority demographic of the identified peer would be 18-30 years of age, residing in the caregiver's home and exhibiting signs of resistance to treatment or anosognosia. The region served in this pilot program will be south Santa Barbara County. Anticipated referral sources would be BWell, Justice Alliance Team, Public Defenders office, or MWC Family Advocate in conjunction with NAMI.

Program Demographics FY 23-24

	Peer & Parent Partners
PROGRAM	**MWC**
TOTAL CLIENTS	**24**
AGE	
0-15	0
16-25	1
26-59	7
60+	0
Unknown/Decline	10
SEX AT BIRTH	
Female	1
Male	8
Unknown/Decline	9
CURRENT GENDER IDENTITY (if over 12 years)	
Male	6
Female	1
Transgender	0
Genderqueer	0
Questioning	0
Another	0
Unknown/Decline	11
SEXUAL ORIENTATION (if over 12 years)	
Gay/Lesbian	0
Heterosexual	1
Bisexual	0
Questioning/ Unsure	0
Queer	0
Another	0
Unknown/Decline	17
PRIMARY LANGUAGE	
English	7
Spanish	1
Other	0
Unknown/Decline	10
VETERAN (if over 12 years)	
Yes	0
No	2
Unknown/Decline	16

RACE	
American Indian/ Alaska Native	1
Asian	0
Black/ African American	0
Native Hawaiian/ Pacific Islander	0
White	0
Other	0
More than one	0
Unknown/Decline	17
ETHNICITY: LATINO	
Caribbean	0
Central American	0
Mexican/Mex. Amer./ Chicano	0
Puerto Rican	0
South American	0
Other Latino	0
Unknown/Decline	18
ETHNICITY: NON-LATINO	
African	0
Asian Indian/ South Asian	0
Cambodian	0
Chinese	0
Eastern European	0
European	0
Filipino	0
Japanese	0
Korean	0
Middle Eastern	0
Vietnamese	0
Other	0
Unknown/Decline	0
More than one	18
DISABILITY	
Physical/mobility	0
Chronic Health Condition/pain	0
Difficulty Seeing	0
Difficulty Hearing	0
Other	0
Other Mental Disability	0
Unknown/Decline	18
FAMILY	
# of Family Members in Program	24

Suicide Prevention Programs: Prevention and Early Intervention (PEI): Report on Prior Fiscal Year Activities AND Program Plan

School-Based Suicide Prevention Program

Provider: Casa Pacifica

Available data on this program's outcomes for the prior fiscal year period, FY 23-24, is included as an Appendix to this document

Program Description:

This is a peer-led outreach and engagement program for family members living with an adult with serious and persistent mental illness.

Program Type(s):

- Suicide Prevention Program

Priority Area(s):

X	Childhood Trauma Prevention and Early Intervention
	Early Psychosis and Mood Disorder Detection and Intervention
X	Youth Outreach and Engagement Strategies Targeting Secondary School and TAY, Priority on College MH Program
	Culturally Competent and Linguistically Appropriate Prevention and Intervention
	Strategies Targeting the Mental Health Needs of Older Adults
	Early Identification Programming of Mental Health Symptoms and Disorders
	Other Locally identified Priority:

Program Performance FY 24-25

Since August 1st, 2024, Casa Pacifica has conducted and attended the following activities:

- Downtown Friday Resource Fair (Santa Maria)
- Back to School Health Fair (Santa Barbara)
- Olive Grove Charter School Inservice
- Allan Hancock College Hello/Hola (Santa Maria)
- Back to School Health Fair (Lompoc)
- Back to School Health Fair (Santa Maria)
- Allan Hancock College Hello/Hola (Lompoc)
- Santa Barbara Pride Festival
- Allan Hancock College Bulldog Bow Wow (Santa Maria)

- Allan Hancock College Bulldog Bow Wow (Lompoc)
- Suicide Prevention Presentation (Orcutt Academy High School)
- SAFTY Lunch Tabling (Orcutt Academy High School)
- Suicide Prevention Presentation (Orcutt Academy High School)
- Suicide Prevention Workshop (Righetti High School)
- SAFTY Lunch Tabling (Kermit McKenzie Intermediate School)
- SAFTY Lunch Tabling (Santa Maria High School)
- SAFTY Presentation (Santa Maria High School)
- Out of the Darkness Walk (Goleta)
- Suicide Prevention Workshop (Pioneer Valley High School)
- Mental Health Resource Fair (Santa Maria High School)
- Open Streets Community Event (Santa Maria)
- Mental Health Resource Fair (Righetti High School)
- MHSA Presentation & Feedback Session (Santa Barbara)
- Dia De Los Muertos Resource Fair (Santa Maria)
- MHSA Presentation & Feedback Session (Santa Maria)
- Mental Health Resource Fair (Pioneer Valley High School)
- SAFTY Training (McKinley Elementary)
- Suicide Prevention Workshop (Santa Maria High School)
- Clinical Risk Assessment Training (Santa Barbara Unified School District)
- Clinical Risk Assessment Training (McKinley Elementary)
- MHSA Presentation & Feedback Session (Lompoc)
- Counselors in the Quad (Righetti High School)
- Mental Health School Presentation (Santa Barbara Middle School)
- Mental Health School Presentation (Santa Barbara Middle School)
- Mental Health School Presentation (Santa Barbara Middle School)
- Santa Barbara Unified Resources Training
- El Camino Junior High Mental Health Presentations (Santa Maria)
- SAFTY Training (El Camino Junior High)
- Wellness Center Activity (Righetti High School)
- Santa Barbara Unified Responding to Behaviors in Youth
- Wellness Center Activity (Pioneer Valley High School)
- Mental Health Presentations (Arellanes Jr. High School)
- Responding to Behaviors in Youth Inservice (Washington Elementary School)
- Allan Hancock College Bulldog Bow Wow (Santa Maria)
- 211 Resource Fair (Santa Barbara)
- Allan Hancock College Bulldog Bow Wow (Lompoc)

We have conducted parent trainings in both English and Spanish and work hard to have a bilingual staff at community events, ensuring we can communicate with members of our community.

The biggest challenge with the implementation of the program currently is staffing. More schools in South Santa Barbara County are requesting presentations on suicide awareness and prevention and early intervention strategies and more than once multiple events have been scheduled at the same date and time. Other Casa Pacifica program staff within SAFTY, TBS and Wraparound have stepped into help.

Program Plan for FY 25-26

Provider:	**Casa Pacifica**
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$ 123,000
Estimated PEI Funding	$ 123,000
Estimated Medi-Cal FFP	
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$0
Average Cost Per Consumer	$4.23
Estimated Total of Consumers Served	29,070
Target Population Demographics Served	Children, TAY

Estimated Consumers Served by Age FY 2025-26		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	1768	$4.23
Estimated Total Consumers Age 15-26 Served	2543	$4.23
Estimated Total Consumers Served Age 26-59	251	$4.23
Estimated Total Consumers Served Age 60+	25	$4.23
Missing DOB	22849	$4.23

Addressing Community Issues

All services provided of have helped increase awareness of suicide risk in our schools and community, increased an understanding of coping skills and self-care, as well as how to assess for risk and link students to resources or call for emergency intervention when needed.

Notable Community Impact

The Suicide Prevention Outreach Coordinator has done an outstanding job in increasing awareness about mental health issues in students, parents, school staff, and the community at large.

Many of the student workshops include specific coping skills taught to students to support their overall mental health wellbeing and to provide resources. The Outreach Coordinator has developed a strong partnership with the Student Wellness Centers within the North County schools to support the students and families utilizing those centers.

Additionally, this year our Risk Assessment Trainings have incorporated CSEC (Commercially Sexually Exploited Children) Awareness and interventions, and to date we have completed two trainings:

- 11/8/2024 Santa Barbara Unified School District
- 11/12/2024 McKinley Elementary in Santa Barbara

We have two more trainings scheduled for this fiscal year:

- 2/28/2025 Santa Maria Joint Union High School District
- 3/13/ 2025Santa Barbara Unified School District

Many community members believe that the sex trafficking of minors does not exist in Santa Barbara County, when in fact this county is one of the major hubs for which traffickers use across the state. These trainings have had a major impact in increasing school personnel's awareness of the issues so that they may know the risk, as well as know who to reach out to for help/support.

Program Type(s):

- Prevention Program

Priority Area(s):

- Childhood Trauma Prevention and Early Intervention
- Youth Outreach and Engagement Strategies Targeting Secondary School and TAY, Priority on College MH Program
- Early Identification Programming of Mental Health Symptoms and Disorders

Problem/Community Need	Activities
Suicide prevention trainings at schools throughout Santa Barbara County CSEC (commercially sexual exploitation of children) awareness and prevention training at school and the general public across Santa Barbara County	• Provide outreach activities to increase public knowledge on how and when to access mental health services. • Providing presentations, trainings, and workshops in classrooms on mental health and suicide awareness and prevention. • Present at events such as school assemblies and parent night.
Increase visibility of resources using culturally sensitive and linguistically appropriate materials/interventions	• Tabling on school campuses (i.e., during lunch, etc.). • Tabling at community events directed towards youth and families. • Providing schools with resource brochures, flyers and swag. • Utilizing bilingual staff for community events.
How to identify and assess for risk in youth and know when to call a crisis line for immediate assessment and intervention.	• How to identify and assess for risk in youth and know when to call a crisis line for immediate assessment and intervention.
Increase awareness of youth mental health and wellness needs	• The Outreach Coordinator would work closely with the MWELL program, other county providers, and school districts to provide educational opportunities
Identify Individuals who may need linkage and access to services and treatment such as: - Youth experiencing homelessness - Justice involved youth Youth found with substance use on school campus	• Through partnerships with schools and school campus Wellness Centers work with school personnel to create access and linkage to connect students to the appropriate care • Implement trauma informed approaches with early intervention services

Methods Used for Outreach and Engagement of Potential Responders

The Suicide Prevention Outreach Coordinator serves as a liaison/partner with Casa Pacifica, Santa Barbara County Department of Behavioral Wellness, and the Mental Health Student Services (MWELL), to provide prevention and early intervention services, education, training, linkage and support within Santa Barbara County's schools. This outreach and early intervention help identify and link individuals and their families who may be affected by some level of mental health issues. Providing mental health education, outreach and early identification mitigates costly negative long-term outcomes for youth and their families. Methods and activities used include and are not limited to the following:

1. Provide presentations/trainings in classrooms on mental health and suicide awareness and prevention that focus on normalizing and destigmatizing mental health issues.
2. Present at events such as school assemblies and parent nights to help parents and students understand warning signs of mental health issues.
3. Train school staff and other professionals in the community (doctor's offices, law enforcement, social workers, etc.) on how to identify and assess for risk in youth and know when to call a crisis line for immediate assessment and intervention.
4. Provide outreach and suicide prevention education and training to schools and community partners to prevent youth crises while teaching students various coping skills to reduce risk.
5. Provide prevention efforts focused around identifying and reducing mental health risk factors by teaching coping skills and identifying signs of suicide.
6. Focus on building knowledge of prevention factors and skills to promote positive cognitive, social and emotional development while encouraging a state of well-being.
7. Increase mental health supports to youth and families by providing linkage services to youth and families.
8. Increase understanding in school personnel, family members and youth themselves on mental, social, and emotional health and identifying points where intervention is needed.

Program Demographics

	Suicide Prevention
PROGRAM	**CP**
TOTAL # EVENTS	**107**
TOTAL # PARTICIPANTS	**29070**
TOTAL # FAMILIES SERVED	**9146**
EVENT TYPE	
Outreach (Health Fairs, Other Outreach)	13
Training (Trainings, Workshops)	21

Forum (Meetings w/ Community Leaders)	22
Support Group	0
Distribution of Materials	51
PRIMARY LANGUAGE OF EVENT	
English	N/A
Spanish	N/A
Other or both English and Spanish	N/A
TRANSLATION PROVIDED	
Translation to English at Spanish event	N/A
Translation to Spanish at English event	N/A
Other or both English and Spanish	N/A
PARTICIPANT AGE	
0-15	1768
16-25	2543
26-59	251
60+	25
Missing DOB	22849
PARTICIPANT GENDER	
Female	1688
Male	1490
Unknown/Decline	23664
PARTICIPANT VETERAN	
Yes	0
No	1050
Unknown/Decline	23778
PARTICIPANT RACE	
American Indian/ Alaska Native	0
Asian	0
Black/African American	0
Native Hawaiian/ Pacific Islander	0
White	0
Other	20
More than one	87
Unknown/Decline	12650
PARTICIPANT ETHNICITY	
Latino	1812
Non-Latino	845
Unknown/Decline	23767

Suicide Prevention Programs: Prevention and Early Intervention (PEI): Report on Prior Fiscal Year Activities AND Program Plan

Suicide Prevention Campaign

Provider: Behavioral Wellness

Available data on this program's outcomes for the prior fiscal year period, FY 23-24, is included as an Appendix to this document.

Campaign Description: BWell developed a targeted Suicide Prevention Campaign in coordination with our local contracted mental health organizations to increase awareness of suicide ideation and local and national resources, including the new National 988 hotline. The campaign specifically targeted local communities and relied on existing trusted partners in these communities to increase awareness. Preventing suicide requires a collaborative approach that integrates prevention, intervention, and postvention strategies. Our department is developing a Suicide Prevention Plan which outlines the county's strategic aims and goals, aligning with state and national initiatives to ensure coordinated suicide prevention efforts. Our department is dedicated to continuing outreach and education revolving around decreasing the stigma on mental illness and suicide.

Program Type(s):

- Suicide Prevention Program

Priority Area(s):

	Childhood Trauma Prevention and Early Intervention
	Early Psychosis and Mood Disorder Detection and Intervention
X	Youth Outreach and Engagement Strategies Targeting Secondary School and TAY, Priority on College MH Program
	Culturally Competent and Linguistically Appropriate Prevention and Intervention
	Strategies Targeting the Mental Health Needs of Older Adults
	Early Identification Programming of Mental Health Symptoms and Disorders
X	Other Locally identified Priority: *Suicide Prevention*

Program Performance FY 24-25

This year, Behavioral Wellness has been focusing on social media and other outreach efforts, uplifting the community to call the Access Line in times of need – with the ultimate aim of suicide prevention. Behavioral Wellness launched paid advertisements in both English and Spanish across all social media platforms. We have been successful in hiring more Outreach Staff to meet the community where they are, provide educational resources, assistance and

knowledge about the Department, Access Line, and to normalize the conversation around Behavioral Health. We also increased advertisements on the Access Line around the holiday season to support our community in times of need and to let them know that asking for help is okay, and that help is available.

Program Plan for FY 25-26

Provider:	Behavioral Wellness
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$ 108,000
Estimated PEI Funding	$ 108,000
Estimated Medi-Cal FFP	
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$0
Average Cost Per Consumer	$360
Estimated Total of Consumers Served	300
Target Population Demographics Served	TAY, Adult, Older Adult

Estimated Consumers Served by Age FY 2024/25		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	
Estimated Total Consumers Age 15-26 Served	50	$360
Estimated Total Consumers Served Age 26-59	100	$360
Estimated Total Consumers Served Age 60+	150	$360

Addressing Community Issues

Suicide is a critical public health concern in Santa Barbara County, affecting individuals, families, and communities. Throughout the United States, 47,000 lives are lost to suicide in each year (Centers for Disease Control). Suicide is the second leading cause of death among individuals ages 15-34, and more than 4,000 Californians die by suicide annually. In 2023, Santa Barbara County lost 45 community members to death by suicide and in 2024 (through October), 31 community members have been lost to death by suicide. Over 90% of those who die by suicide

have a diagnosable and treatable mental health condition, although often that condition is not recognized or treated. Together, as a community, we have the power to create a future where every life is valued, support is accessible, and no one faces their struggles alone - because suicide is preventable, and Santa Barbara County is committed to building a culture of connection, resilience, and hope.

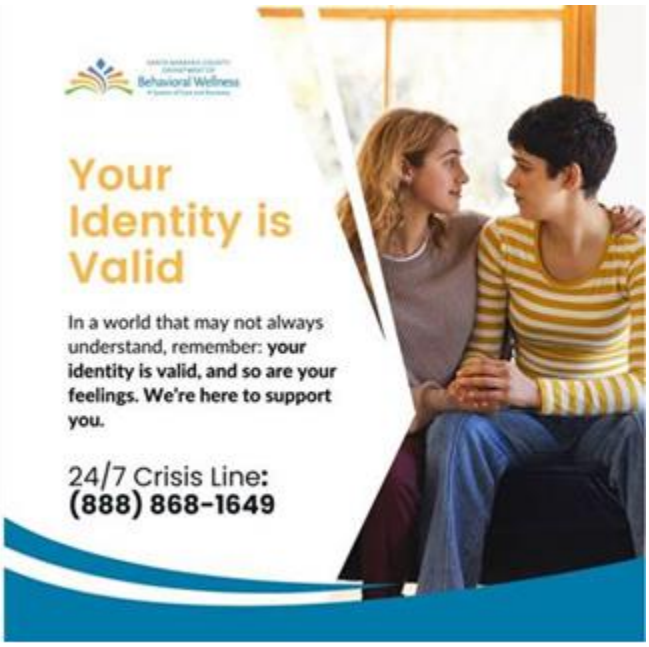
Stigma surrounding mental health and suicide prevents individuals from seeking help. By promoting accurate information and adopting non-stigmatizing language, we can encourage open conversations and access to support.

Notable Community Impact

In August, there was a focus on expanding social media outreach for the department, which include paid advertisements, with the aim of expanding our reach further within the community. Key highlights include:

- **21 new organic posts** centered on mental health, self-care, and suicide awareness content.
- **Significant growth on Facebook**: 46.1% increase in organic post engagement and a 1,700% surge in overall engagement. This was a really important area to improve in as our LatinX stakeholders tell us this is the best way to outreach – and all posts have been in Spanish and English.
- **Instagram saw a decline**, but combined reach on both platforms increased by **30k users**, reaching 523,930.
- **Paid campaign**: Reached **621,014 users** with an average cost per 1,000 people of $1.44.

These metrics reflect strong community engagement and effective audience expansion efforts. The below post, by far, got more engagement as compared to all others:



Due to the promotion of the Access line before the holidays, as this is a time of year when people can feel very alone and suicide rates increase, our call volume immediately went up. In January and February, this is the time of year when Access Line call rates normally decline however, the 400 monthly calls increase we see in November and December, stayed persistent in these months. For the calls that launched the mobile crisis team – it had been then case that 65% of Mobile crisis calls resulted in a person being hospitalized, but since the start of the year, only 45% of individuals calling the access line due to a behavioral health crisis have been hospitalized. This tells us that people are calling the Access line for help at the right time and getting the help they need before things escalate.

Problem/Community Need and Program Activities

Problem/Community Need	Activities
Stigma surrounding suicide and mental health	• Launching ads to be publicized within the community to allow for more awareness and allow for discussion, normalizing the topic of mental health, suicide and struggling
Awareness about Suicide Prevention Resources, especially 988 Hotline	• Behavioral Wellness Suicide Prevention Taskforce, Hotline and Crisis Resources, Community Partnerships
Lack of knowledge on resources, the department, getting help for behavioral health services	• Hiring more outreach staff to connect with the community to create awareness

Methods and Activities Used to Change Attitudes and Behavior Regarding Suicide

Methods include increased dialogue about suicide awareness, recognizing the signs and how to talk to others, and linkage to resources. This has been achieved through a variety of strategies aimed to reduce stigma, including, community presentations; community trainings; public information shared to targeted audiences through a variety of means including newspaper ads, television and social media platforms; hosting community and staff support and debriefings after critical incidences within the community. Santa Barbara County is committed to establishing a strong foundation for suicide prevention. The Department will be looking at the 2024 National Strategy for Suicide Prevention to ensure a cohesive approach to reducing the rate of deaths by suicide in Santa Barbara County.

Estimated Individuals to be Served

The targeted groups include LGBTQIA+; transitional aged youth; teens, healthcare providers, non-governmental organizations + mental health organizations, military, law enforcement, LatinX populations, the unhoused population, those at risk of being unhoused, those struggling with substance use disorders and/or mental health struggles, and older adults.

Changes to Service Delivery

This is a new campaign that our department has been working on. Through increasing public notification regarding the Access Line to increase Access Line calls, developing a BWell Suicide Prevention Taskforce and launching ads, our department will continue to spread awareness and hopefully destigmatize mental health and suicide. This includes leadership commitment, policy development, training programs, and resource coordination.

- **Behavioral Wellness Suicide Prevention Taskforce:** A dedicated group working toward systemic improvements in suicide prevention efforts.
- **Hotline & Crisis Resources:** 24/7 Behavioral Wellness Access Line: **888-868-1649**
- **Community Partnerships:** Engaging healthcare providers, schools, law enforcement, and advocacy groups in suicide prevention strategies.

Behavioral Wellness also recognizes the value of the 2024 National Strategy for Suicide Prevention and the importance of ensuring a cohesive approach to reducing the rate of deaths by suicide in Santa Barbara County. In this report, the national strategic directions and goals will be reflected alongside Santa Barbara County's existing goals, highlighting areas for alignment and opportunities for enhancement.

Program Demographics

Program demographics are not available for this program, it is a media campaign, but all outcomes data, including demographic groups targeted as part of this media campaign, is included in the Appendices of this Plan.

Suicide Prevention Programs: Prevention and Early Intervention (PEI): Report on Prior Fiscal Year Activities AND Program Plan

Out of Darkness Walk

Provider: Behavioral Wellness

Program Description: Out of the Darkness Walks take place in cities nationwide. In our Community, Campus and Overnight Walks, those affected by suicide – and those who support them – raise awareness and much-needed funds, strongly sending the message that suicide can be preventable, and that no one is alone. The Community Walks, held in hundreds of cities across the country, are the core of the Out of the Darkness movement, which began in 2004.

These events give people the courage to open up about their own connections to the cause, and a platform to create a culture that's smarter about mental health. Friends, family members, neighbors and coworkers walk side-by-side, supporting each other and in memory of those we've lost. Now, more than ever, it's important to be there for one another and take steps to safeguard our mental health and prevent suicide.

Program Type(s):

- Suicide Prevention Program

Priority Area(s):

	Childhood Trauma Prevention and Early Intervention
	Early Psychosis and Mood Disorder Detection and Intervention
X	Youth Outreach and Engagement Strategies Targeting Secondary School and TAY, Priority on College MH Program
	Culturally Competent and Linguistically Appropriate Prevention and Intervention
	Strategies Targeting the Mental Health Needs of Older Adults
	Early Identification Programming of Mental Health Symptoms and Disorders
	Other Locally identified Priority: *Suicide Prevention for Youth and Families*

Program Performance FY 24-25 and Notable Community Impact

279 community members of Santa Barbara County participated in the 2024 Out of Darkness Walk. Of these participants, 79% were new participants. Within the total number of participants, there were 29 walk teams, which was a 7% increase from the year prior. Overall, the community raised $45,773.86 for suicide prevention and education! Behavioral Wellness continued in their role as one of the sponsors for the event and this year also had a staff who served as the walk co-chair and will be continuing in her role as walk chair for the 2025 walk as well. New ideas on how to expand community awareness of this event are already underway for the 2025 walk. This powerful community gathering serves as a source of healing for many who have lost a loved one to death by suicide but also serves to expand Santa Barbara's education on suicide awareness and prevention.

Program Plan for FY 24-25

The Behavioral Wellness Public Information Officer/Chief of Strategy and Community Engagement continues as the co-chair for Santa Barbara Out of the Darkness Suicide Awareness Walk which involves year-round outreach and planning with local organizations.

Costs for this program are assigned to the Suicide Prevention Program; see budget above.

Addressing Community Issues

The Out of the Darkness Walk allows the local community to join a national effort to support survivors of suicide loss, educate our community on prevention of suicide, and decrease stigma of mental illness. As the primary objective of the Out of Darkness Walk is to bring attention to mental health, suicide, and suicide prevention, all preparatory activities including outreach and engagement with the community and organizations – serves to support this process. Participants, including family, friends, church members, and coworkers, gather in memory of loved ones lost to suicide. Members of the community gathered together to share intimate stories of their loved ones that we lost to suicide, and the everlasting effects of those who have survived the aftermath of suicide. Also, organizational providers join, and many offer a resource table for participants to learn more of where and how to access support. As Behavioral Wellness is not only a sponsor but is a co-chair for the local event, it allows us to directly lead and engage the community outreach efforts.

Program Type(s):

- Suicide Prevention Program

Priority Area(s):

- Culturally Competent and Linguistically Appropriate Prevention and Intervention

Problem/Community Need and Program Activities

Problem/Community Need	Activities
Awareness about Suicide Risks	• Work with community-based organizations already providing suicide prevention activities to develop a county-wide Suicide Prevention messaging
Awareness about Suicide Prevention Resources, especially 988 Hotline	• Work to with community partners to develop new county-wide messaging on the National 988 Suicide Prevention Hotline

Methods and Activities Used to Change Attitudes and Behavior Regarding Mental Illness

Suicide Prevention Campaign: BWell will develop a targeted Suicide Prevention Campaign in coordination with our local contracted mental health organizations to increase awareness of suicide ideation and local and national resources, including the new National 988 hotline. The campaign will be specifically targeted to local communities and will rely on existing trusted partners in these communities to increase awareness. This program will buttress the new PEI

Suicide Prevention for Youth Program that Casa Pacifica will be providing services for starting this year. With such a large amount in increases in teams, participants and donation funds, you can see that Santa Barbara's education on suicide awareness has increased within the past year.

Estimated Individuals to be Served

The targeted groups include LGBTQ+; TAY; Teens, LatinX populations and Older Adults. Final numbers of participants were 374, including 27 teams and many Community-Based Organizations participating as support to participants and provided many mental health and suicide related educational resources.

Program Demographics *the report on number of participants is included as an appendix to the Plan*

Anti-Stigma and Discrimination Reduction Programs: Prevention and Early Intervention (PEI): Report on Prior Fiscal Year Activities AND Program Plan

LEAD (Lived Experience Advocacy Development)

Provider: Transitions Mental Health Association (TMHA)

Program Description: This is a peer-led program that offers free trainings in suicide prevention QPR (Question, Persuade, Refer), Adult and Youth Mental Health First Aid along with mental health presentations that seek to reduce stigma, provide information linkages to mental health services and educate community gatekeepers in Northern Santa Barbara County.

Available data on this program's outcomes for the prior fiscal year period, FY 23-24, is included as an Appendix to this document

Program Type(s):

- Anti-Stigma and Discrimination Reduction Program

Priority Area(s):

	Childhood Trauma Prevention and Early Intervention
	Early Psychosis and Mood Disorder Detection and Intervention
X	Youth Outreach and Engagement Strategies Targeting Secondary School and TAY, Priority on College MH Program
	Culturally Competent and Linguistically Appropriate Prevention and Intervention
	Strategies Targeting the Mental Health Needs of Older Adults

	Early Identification Programming of Mental Health Symptoms and Disorders
X	Other Locally identified Priority: *Development of Peer and Family Member-led Stigma and Discrimination Programming*

Program Performance FY 24-25

LEAD was given 6-month PEI contract from January through June 2024. In the third quarter, Sandy Rives and Mira Green have conducted 6 evidence-based training courses and 7 community presentations, reaching 189 community members (excluding outreach events). They have not only met but exceeded all expected goals for the fiscal year ending in June.

During the 4th quarter, their focus was on enhancing their teaching abilities and engaging with key community figures who could benefit from their training. As the new year began, they shifted their attention to delivering presentations to a wider audience. In their free time between presentations, Sandy and Mira have started developing new classes covering various mental health topics such as coping skills, anger management, positive thinking, and wellness toolboxes. By creating and delivering these classes at the Northern Branch Jail, High School Wellness Centers, and The Santa Maria Public Library, they address a need highlighted in the previous quarterly report. LEAD has struggled to find worthy issues to focus their advocacy efforts on. Their goal for 2024 was to advocate that the county offer evening/weekend hours for Behavioral Health Services on Foster Road; however, it seems the county will be piloting these efforts soon.

- LEAD has struggled to find worthy issues to focus their advocacy efforts on. Their goal for 2024 was to advocate that the county offer evening/weekend hours for Behavioral Health Services on Foster Road; however, it seems the county will be piloting these efforts soon.
- LEAD continues to work on creating partnerships with local schools. It has been a slow process.
- LEAD is finding it difficult to create collaborations with faith-based networks. Many religious organizations have expressed disinterest in partnering with our non-affiliated organization, either due to preconceived notions about what it means to receive mental health training, time constraints, or partnerships with other organizations.

Program Plan for FY 25-26

Provider:	TMHA
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$ 230,000
Estimated PEI Funding	$ 230,000
Estimated Medi-Cal FFP	
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$0
Average Cost Per Consumer	$173.97
Estimated Total of Consumers Served	1,322
Target Population Demographics Served	Children, TAY, Adult, Older Adult

Estimated Consumers Served by Age FY 2024/25		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	148	$174
Estimated Total Consumers Age 15-26 Served	454	$174
Estimated Total Consumers Served Age 26-59	518	$174
Estimated Total Consumers Served Age 60+	60	$174
Missing DOB	143	$174

Addressing Community Issues

Originating with our North Santa Barbara Recovery Learning Communities, LEAD is a team of adults with lived experience of a mental illness who speak to the community and advocate for important changes in local policy. The program represents a new generation of community leaders, deeply invested in the cause of mental health advocacy and accurately and empathically represents its peers in the process.

Notable Community Impact

Examples of our impact include:

Continued partnership with the SB County Northern Branch Jail: LEAD Advocate presentations expanded to general population units, offering wellness groups on the Behavioral Health Unit's.

New and improved LEAD Advocate Application designed to filter out applicants unable to meet the role's technical demands.

Creation and implementation of new Mental Health classes tailor-made to each organization that requests them (including WELL Sessions in Lompoc, Behavioral Health Units at Jail, and the Santa Maria Library).

Continued partnership with Pioneer Valley High to offer monthly groups at the on-campus Wellness Center.

Problem/Community Need and Program Activities

Problem/Community Need	Activities
The lack of knowledge about mental illness and suicide prevention and how each individual can play a positive role in the lives of others	Deliver a minimum of one evidence-based training per month to at least 15 participants in one of the following areas: Mental Health First Aid, Youth Mental Health First Aid, or QPR (Question, Persuade, Refer). These trainings aim to enhance participants' understanding of the early warning signs of mental illness, substance use, and suicide, resulting in a 20% increase in knowledge.
The stigma and stereotypes of mental illness.	Continue to design and facilitate monthly mental health presentations aimed at enhancing mental health literacy, reducing stigma associated with mental illness, and connecting individuals to community resources. These presentations will highlight personal journeys of individuals living with mental illness, emphasizing their path to emotional wellness and the coping and self-care strategies that have strengthened their resilience. Each session will be led by a LEAD speaker with lived experience in mental health recovery, integrating their personal story with evidence-based educational components. These presentations will be accessible to diverse audiences, including school

	classrooms, faith-based organizations, youth groups, family members, secure facilities, and the general public. The objective is to deliver at least one presentation per month throughout the grant period. Additionally, LEAD will continue to coordinate and host the annual Alliance for Mental Wellness forum, fostering broader community engagement and dialogue on mental health.
The lack of a "voice" or strong advocacy for individuals living with a mental illness.	Continue to advocate for improved mental health policies and innovations.
The lack of knowledge in the community about where to get help and how to access free community mental health services.	All trainings and presentations will include a comprehensive list of free community mental health resources, which will be distributed to all attendees. Additionally, dedicated time will be allocated to review the available resources and address any questions, ensuring participants have a clear understanding of how to access support services.
A disconnect between mental health resources and those who might benefit in Northern Santa Barbara County.	Partner with the Northern Santa Barbara County Jail, faith-based organizations, and local educational institutions to enhance awareness of available community resources through meetings and presentations.

Methods Used to Change and Measure Attitudes/Behavior Regarding Mental Illness

LEAD is actively recruiting/seeking a diverse pool of advocates (bilingual, BIPOC, male/nonbinary, LGBTQ+, TAY) to connect with a larger demographic. LEAD plans to focus more efforts on creating partnerships in Santa Ynez Valley and offering trainings to agencies serving our Spanish-speaking communities. Lead wants to reach out to rural/isolated communities like New Cuyama and Los Alamos. LEAD has translated marketing fliers in Spanish to become more accessible to Spanish-speaking and Mixtec communities. LEAD is partnering with Allan Hancock

College Student Health Services to plan the Alliance for Mental Wellness. The event will include a screening of the documentary, "My Ascension", entertainment, a resource fair, and more.

Program Influence	***Methods & Activities***
Gatekeeper Community Members- teachers, students, clergy, jail staff, other social service providers, first responders, business owners and the general public.	Provide specialized training in Mental Health First Aid, Youth Mental Health First Aid, QPR (Question, Persuade, Refer), and suicide prevention tailored to each group. Work with clergy and faith leaders to integrate mental health discussions into their communities and provide resources.
Gatekeeper Community Members teachers, students, clergy, jail staff, other social service providers, first responders, business owners and the general public.	Provide evidence-based trainings and peer support groups to incarcerated individuals in the Behavioral Health Units at the Northern Branch Jail. Provide the men and women in the BHUs with classes such as: Taking Action for Whole Health and Wellbeing, Seeking Safety, Pathways to Recovery, Mental Health First Aid, and Whole Health Action Management. These classes will provide the men and women an opportunity to learn recovery tools that can be utilized while incarcerated as well as upon release. Trainings are designed to reduce stigma and increase awareness of community mental health resources by 20%.

Program Demographics

	LEAD
PROGRAM	**THMA**
TOTAL # EVENTS	**50**
TOTAL # PARTICIPANTS	**1322**

TOTAL # FAMILIES SERVED	**114**
EVENT TYPE	
Outreach (Health Fairs, Other Outreach)	12
Training (Trainings, Workshops)	38
Forum (Meetings w/ Community Leaders)	0
Support Group	0
Distribution of Materials	0
PRIMARY LANGUAGE OF EVENT	
English	N/A
Spanish	N/A
Other or both English and Spanish	N/A
TRANSLATION PROVIDED	
Translation to English at Spanish event	N/A
Translation to Spanish at English event	N/A
Other or both English and Spanish	N/A
PARTICIPANT AGE	
0-15	148
16-25	454
26-59	518
60+	60
Missing DOB	143
PARTICIPANT GENDER	
Female	765
Male	435
Unknown/Decline	121
PARTICIPANT VETERAN	
Yes	65
No	221
Unknown/Decline	823
PARTICIPANT RACE	
American Indian/ Alaska Native	27
Asian	12
Black/African American	35
Native Hawaiian/ Pacific Islander	16
White	251
Other	39
More than one	33
Unknown/Decline	934
PARTICIPANT ETHNICITY	

Latino	526
Non-Latino	235
Unknown/Decline	500

About 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.

Capital Facilities and Technological Needs (CFTN): Report on Prior Fiscal Year Activities AND Program Plan

Electronic Health Records

In 2020, the State of California introduced California Advancing and Innovating Medi-Cal (Cal-AIM) with the stated goal to advance and innovate Medi-Cal; this program created a long-term commitment to transforming and strengthening Medi-Cal by offering Californians a more equitable, coordinated, and person-centered approach to maximizing their health and life trajectory.

However, advancement in our healthcare required a new, more advanced and more integrated Electronic Healthcare Records System. CalAIM will change how we bill for Medi-Cal related services, and in order to receive payments we will have to implement a new Electronic Healthcare Records System.

Behavioral Wellness contracted with California Mental Health Services Association (CalMHSA) along with the majority of other counties in the State of California, to conduct surveys to identify counties' needs and deficits; a subcontractor was then chosen to create a new Electronic Healthcare Records System tailored to counties' needs.

Program Summary: The Behavioral Wellness department is upgrading its Electronic Healthcare Records (EHR) System in response to California's CalAIM initiative, which changes Medi-Cal billing procedures. Collaborating with CalMHSA, the department plans to select a subcontractor to tailor-make an advanced EHR system based on county-specific needs. This transition, supported by stakeholder input and approved by supervisory bodies, involves transferring one-time funding from Community Services and Supports; we expect an $829,900 expenditure for 2023-24 and an ongoing spending pattern until the total $5,519,400 cost is covered over the next four years.

Continued from prior year plan or update

Provider:	**Behavioral Wellness**
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures:	$1,125,100
Estimated CSS Funding to CFTN:	$1,125,100

Description of Technology Needs (TN) Project

Capital Facilities and Technological Needs (CFTN) focuses on improvements to facilities, infrastructure, and technology of the local mental health system to account for the changing technology needs after the implementation of new Medi-Cal billing standards.

Top Technological Needs Priorities

Behavioral Wellness staff, as users of the EHR, are the primary stakeholders for this transfer and helped advocate for this change; we agree that this is a good use of MHSA funds. A draft amendment was posted explaining this change, and two community stakeholder events were hosted to request the transfer of one-time funding from CSS to CF/TN for this project. The presentation for these meetings included a brief introduction of the Mental Health Services Act (MHSA) as well as a review of the proposed MHSA plan under consideration to receive these funds. Following these presentations, all stakeholder comments and feedback were incorporated into the final MHSA Plan amendment.

This plan was presented to the Behavioral Wellness Commission on September 21st 2022, approved, and was presented to the Santa Barbara County Board of Supervisors for final adoption and approval on November 1st, 2022.

Last fiscal year, we transferred a total of $5,519,400 from Community Services and Supports to fund the five-year implementation of the new Electronic Health Records System. During fiscal year 2023-24, $1,301,500 was spent from this total transfer. This year, we anticipate spending $1,125,100 and will continue to spend down the total cost ($5,519,400) of this program over the remaining two years.

About Workforce Employment and Training (WET)

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

The WET component of MHSA addresses the fundamental concepts of developing and enhancing a workforce (both current and future workforce resources) that is culturally competent, provides client/family driven mental health services, and adheres to values of wellness, recovery and resiliency. Our department has supported WET activities by utilizing department funds and participating in our WET Regional Partnership (Southern Counties Regional Partnership) to achieve this goal.

Workforce Education and Training (WET): Report on Prior Fiscal Year Activities AND Program Plan

WET Program Names	Provider: Behavioral Wellness	
Estimated Funding FY 2023/24:		
Peer Training	Estimated Total Mental Health Expenditures:	240,800
	Estimated WET Funding	240,800
	Estimated Other Funding	
	Target Population Demographics Served	Public Mental Health Workforce
Office of Statewide Health Planning and Development (OSHPD) Southern Counties Regional Partnership	Estimated Total Mental Health Expenditures:	3,880,200
	Estimated WET Funding:	0
	Estimated Other Funding	3,880,200
	Target Population Demographics Served	Public Mental Health Workforce
WET Workforce Retention	Estimated Total Mental Health Expenditures:	100,000
	Estimated WET Funding:	100,000
	Estimated Other Funding	
	Target Population Demographics Served	Public Mental Health Workforce
Total Program Estimated Expenditures	$340,800	

WET Program Names	Provider: Behavioral Wellness	
Estimated Funding FY 2024/25:		
Peer Training	Estimated Total Mental Health Expenditures:	235,400
	Estimated WET Funding	235,400

	Estimated Other Funding	
	Target Population Demographics Served	Public Mental Health Workforce
OSHPD Southern Counties Regional Partnership	Estimated Total Mental Health Expenditures:	3,339,800
	Estimated WET Funding:	
	Estimated Other Funding	3,339,800
	Target Population Demographics Served	
WET Workforce Retention	Estimated Total Mental Health Expenditures:	100,000
	Estimated WET Funding:	100,000
	Estimated Other Funding	
	Target Population Demographics Served	
Total Program Estimated Expenditures	$300,000	

WET Program Names	**Provider: Behavioral Wellness**	
Estimated Funding FY 2025/26:		
Peer Training	Estimated Total Mental Health Expenditures:	200,000
	Estimated WET Funding	200,000
	Estimated Other Funding	
	Target Population Demographics Served	Public Mental Health Workforce
WET Workforce Retention	Estimated Total Mental Health Expenditures:	100,000
	Estimated WET Funding:	100,000
	Estimated Other Funding	

	Target Population Demographics Served	Public Mental Health Workforce
OSHPD Southern Counties Regional Partnership	Estimated Total Mental Health Expenditures	1,081,000
	Estimated WET Funding	
	Estimated Other Funding	1,081,000
Total Program Estimated Expenditures	$300,000	

Program Performance FY 24-25

During the prior fiscal year, the County conducted the following activities and major accomplishments in the following areas: training and technical assistance, mental health career pathways, residency and internship programs, and financial incentive programs.

Training and Technical Assistance

Training and technical support continues to be provided to establish staff competency regarding various areas of documentation and treatment. Training topics have included CalAIM documentation, SmartCare (the new electronic health record), cultural competency, and a variety of clinical trainings. This support and training enhanced the service delivery skills of the staff and quality of services provided to clients. Some of these trainings are funded through the Southern Counties Regional Partnership (SCRP) grant and others by the Behavioral Wellness Department WET budget.

A significant focus this year has been to provide a comprehensive training program on Motivational Interviewing across all department service areas. This program included a 12-hour training and 4 individual coaching sessions for each staff member, so they are able to practice the newly acquired skills and receive feedback. Clinical training was also provided on suicide assessment, intervention and prevention, seeking safety, dialectic behavioral therapy, cognitive behavioral therapy, and safety training using the Crises Prevention Intervention (CPI) model. Staff working on the crisis service teams completed the training modules now required by the new Mobile Crises Benefit program.

Updated documentation training was provided by the Quality Care Management (QCM) staff which included new guidelines issued by the State. Staff continued to complete training as needed to maintain certifications in Crises Prevention Intervention, Adult Needs and Strengths Assessment (ANSA), and Child and Adolescent Needs and Strengths (CANS).

Peer Training and Support: Peers continue to be supported in acquiring their State certification through the Peer Stipend program funded by the SCRP. Training was also provided

to peers to enhance their skills and also to other staff to support the effective inclusion of peers throughout the department.

The training and technical assistance programs address the following outcomes:

- Incorporating MHSA Standards: Training in evidenced-based practices and best practices included MHSA principles and general concepts of wellness and recovery. The training in additional outcome measurement tools such as the ANSA and CANS provided more consistent and relevant assessment of outcomes of services to guide future training of staff.
- Promote Job Retention: providing additional training and support created a more prepared and competent workforce for performing their job-related duties. This will lead to more confidence and job satisfaction.
- Culturally Competent staff: The training programs which are inclusive of diversity and equitable access aid existing staff in providing more culturally relevant and sensitive services.

Mental Health Career Pathway Programs

In an effort to support a mental health career pathway program, funding through the SCRP was used for a high school pipeline project. During the beginning of the fiscal year, a high school career fair was provided to high school students in Lompoc, providing opportunities to students from diverse and underserved communities to learn about behavioral health career options. This mental health career fair included inspirational speakers, several workshops related to mental health career options, and a tabling event that provided information about behavioral health careers and local employers. During this second half of the year, the high school internship program is being implemented by a community-based organization. This will include shadowing opportunities for high school students where they can learn about human service career pathways and receive a $200 stipend to support their participation.

The department continued to support the peers that are employed within the department through a peer stipend program. Through the SCRP grant, $500 stipends have been issued to 10 additional peers that have completed the peer certification process. This stipend was structured to provide support and incentives to peers while acquiring their certification as Peer Support Specialists. This enables peers to provide peer specific services that now have a unique service code in the Medi-Cal system.

Residency and Internship Programs

The internship programs through the Santa Barbara County public behavioral health system continue to be supported by the graduate student stipend program, funded through the SCRP grant. This stipend program remains available for clinical graduate students participating in a traineeship or internship program within the Behavioral Wellness system of care. For this program, graduate students apply through a centralized application process with Department

of Health Care Access and Information (HCAI) and, if selected, receive $6,000 for completing a graduate clinical training in a public behavioral health setting (either directly with Behavioral Wellness or through a contracted agency). Applicants for the final cycle of the program are being reviewed, and 10 stipends will be awarded in April to graduate students completing clinical training within the Santa Barbara County public mental health system of care.

Due to the numerous systemic changes in MHSA and other State systems, the department has elected to pause on offering graduate student placements in direct county-run clinics for students that are from outside of the department. This pause is to ensure the proper infrastructure is in place for future clinical training programs for student success. The department will continue to provide clinical training opportunities to existing staff that are enrolled in graduate programs and those recipients of the Mater's in Social Work (MSW) Scholarship program as a staff retention activity.

Financial Incentive Programs

The Behavioral Wellness department continues to participate in the Loan Repayment Program that is funded through the SCRP grant. The program is finalizing and making awards for the final cycle of the program. The 16 award recipients will receive approximately $7,500 per award toward their educational loans related to clinical degrees.

MSW Staff Scholarship Program: A new financial incentive program was initiated in the previous fiscal year. This program awards scholarships to selected BWell staff that are enrolled in a Master's in Social Work program. Recent workforce needs assessments determined that there was a shortage of licensed clinical social workers within the Department. This interferes with the ability to employ clinical social work associates because an Liscensed Clinical Social Worker (LCSW) is required for a portion of their supervision per the licensing board. This new scholarship program is designed to retain staff by supporting them in their graduate programs and to ultimately increase the number of clinical social workers within the department.

Issues that have impeded the County's ability to accomplish the objectives identified in the County's WET Plan

1. Objective: Provide clinical training programs to create a pathway to employment for local graduate students.

   Challenge: The department currently does not have sufficient infrastructure to support graduate students from outside of the department. There are limitations on licensed staff available to provide supervision to graduate student interns and there are significant systemic changes this fiscal year which currently require our department's attention.

2. Objective: Create a streamline and efficient process for the MSW Scholarship application and awards to increase staff diversity and support staff retention.

   Challenge: As this was a new program to the County, there was an unexpected delay in setting up the staff agreement document and establishing a fiscal process for issuing payments to staff. Completing these steps caused a delay in being able to issue the scholarship awards by almost a year. The department is now on track with this process now complete, and the next application cycle will be quicker and more streamlined.

3. Objective: Develop a pipeline project by partnering with a community agency to provide behavioral health career pathway opportunities to high school students from a diverse and underserved population.

   Challenge: It has been challenging to arrange for internships for high school students within the department's behavioral health system. There were concerns about confidentiality and safety concerns if minors assumed intern roles in clinics, and a lack of actual duties that they could be involved in. This has been addressed by utilizing a broader spectrum for these internships, so the students are still getting exposed to health care and human service settings within the County but outside of the Behavioral Wellness clinics.

Program Plan for FY 25-26

Peer Training (WET)

Funding category: Training and Technical Assistance

The peer training program continues to provide training and support for peer support specialists within the department. Peers participate in an 80-hour peer support specialist training from an approved organization and receive ongoing support and training by the Peer Empowerment Manager. The Peer Empowerment Manager is involved in the recruitment and onboarding of new peers interested in pursuing employment as a peer support specialist. The funding in this category will support the training of these new peers and the Peer Empowerment Manager will coordinate this training program. Peers in the training program are encouraged to pursue peer certification, and the department continues to utilize funding through the SCRP grant to provide peer certification stipends to incentivize peers in the completion of the certification process.

Addressing Workforce Shortages and Deficits

- Recruitments efforts will continue by increasing Social Media presence
- Increase attendance at job fairs
- Review job postings for inclusive language

This program will achieve the following outcomes:

- Incorporate MHSA Standards: Peer training will include training in evidence-based practices and will incorporate MHSA principles and general concepts of wellness and recovery.
- Promote Job Retention: By providing additional training and support the peer staff will feel more prepared and competent in performing their job-related duties. This will lead to more comfort and satisfaction with their job. Receiving this training and support will lead to an increased sense of job satisfaction and will support retention in the workplace.
- Increase Clients/Family Employed: This program will have a direct path on employment for peers engaged in the training program for these positions.

WET Workforce Retention

NEW: MSW Scholarship

Projected Date of Implementation/First Date of Services: This program started in FY 23-24.

Funding category: Financial Incentive Programs

This program will include recruitment of department staff that are interested in pursuing a master's degree in social work. Participants will receive a $25,000 scholarship towards a MSW program. This program will require the applicant to be responsible for the remainder of the MSW program costs through available financial aid or educational loans through the school. Participants will also be able to complete internship hours for their graduate degree within the public behavioral health system while maintaining their employment. A specific Staff Internship program will be designed to support this component of the educational program. Participants will be required to pursue employment with the Behavioral Wellness Department as a Practitioner I following graduation with the MSW and must maintain employment in a service delivery position for a minimum of 2 years within the department. This program will also be supported by the clinic team supervisors by providing clinical internship experience, and by the Training Team in assisting with recruitment, onboarding, and liaison support services.

In the first cycle, 4 scholarship recipients were selected in FY 23-24 and are each receiving a $25,000 scholarship award in this fiscal year. These scholarship recipients are required to maintain their employment while they attend school outside of the work hours and will also complete a 2-year work obligation as a clinician in the BWell system after completing their degrees A second application cycle will open in the spring of FY 25-26, and through a competitive process, another 4 MSW scholarships will be awarded to BWell staff completing their Masters in Social Work.

Addressing Workforce Shortages and Deficits

Practitioner positions have been identified as hard to fill and hard to retain. In particular, there is a shortage of licensed clinical social workers within the Behavioral Wellness system. Clinical social workers bring a different perspective to working with the department's clients and

increasing this category of licensed staff within the department will bring a benefit to the services that are provided. This will also ultimately assist in covering the required clinical supervision for a Clinical Social Worker (CSW) Associate in which a set number of hours of experience can only be supervised by someone with an LCSW license.

This program will achieve the following outcomes:

- **Incorporate MHSA Standards:** Existing staff throughout our department are trained in Wellness and Recovery concepts and have completed relevant training as part of their county employment. By supporting existing staff in completing their graduate program in clinical social work, they will already understand MHSA standards and will support these concepts within the system.
- **Promote Job Retention:** This program directly encourages increased job retention by connecting financial incentives to a 2-year post-degree work obligation.
- **Encourage Diversity in the Workforce:** Priority is given to staff that are bicultural and/or bilingual, and to those that have lived experience to reflect the cultural diversity of the community. This program will enhance the language capacity within the department to provide services in the county's threshold language (Spanish), increase the diversity of staff providing services to our clients, and provide a progressive career pathway to peers interested in acquiring advanced clinical degrees.

WET Programs through the SCRP Grant:

Santa Barbara Behavioral Wellness continues to participate in the workforce development programs funded by the Southern Counties Regional Partnership (SCRP). The Behavioral Wellness department also continues to act as the fiscal agent for the SCRP. These following categories continue to be funded by the SCRP grant:

- Staff Retention
- Loan Repayment Program
- Graduate student Stipend Program
- Pipeline Projects (which also includes stipends for peers)

Continuing programs include stipends for graduate students, stipends for peers within the public behavioral health system, pipeline projects for each county, loan repayment program for existing staff, and staff retention activities which provide a variety of training. In addition to various clinical training, the grant also provides funding for ongoing clinical supervision training and provides an annual SCRP conference that focuses on best practices for public mental health services.

Each of these programs work to enhance the workforce in a variety of ways such as recruitment of new staff and peers through internship programs, stipends and pipeline projects, retention of staff through loan repayment programs, and staff retention activities.

SCRP Grant Funded WET Programs:			
Programs	**# of participants /Events**	**$ Per participant or training event**	**$$**
New: Clinical Supervision Support	6 hours/week	52 weeks	$28,080
Continued: Loan Repayment	Approx 20	$7,500	$172,500
Continued: Graduate Student Stipends	Approx 11	$6,000	$66,000.00
Continued: Peer Stipends	15	$500	$7,500.00
Continued: Pipeline Projects		$30,102	$30,102.00
Administrative Staffing Support (0.5 FTE)	0.5	$80,000	$40,000
		TOTAL	**$344,182**

The following is the language in which staff (County and contract providers) proficiency is required.

County Threshold Languages: Spanish

About Innovations

The Innovations (INN) component funds projects designed to test new or changing mental health practices that have not yet been demonstrated as effective. This component responds to the high costs and profound suffering associated with the limitations of current services and seeks to provide consistently innovative and improving care. Five percent of MHSA funds are dedicated to this component, and projects are time-limited to a maximum of five years to demonstrate an effective approach, strategy, or element to mental health treatment. INN projects infuse new, effective mental health approaches into the current mental health system, both statewide and countywide. These projects should serve to either increase access to underserved groups, increase the quality of mental health services, promote community collaboration, or increase overall access to mental health services.

Innovation (INN): Report on Prior Fiscal Year Activities AND Program Plan

Help@Hand

Project Overview

Help@Hand is a statewide Collaborative project that is working with fourteen counties and cities to leverage interactive technology-based mental health solutions. Help@Hand helps shape the future by improving accessibility and outcomes to connect people with care across the state. This project aims to provide relief to those who are receiving unsatisfactory care in traditional mental health service settings by establishing technology-based mental health solutions. Within the Santa Barbara community, Help@Hand members are directly connected with individuals discharged from psychiatric hospitals and recipients of Crisis Services, transition-age youth (age 16-25) individuals enrolled in colleges and universities, and Behavioral Wellness adult clients residing in geographically isolated areas. Help@Hand intends to implement wellness technology within these target populations of Santa Barbara in an effort to accomplish the state-wide goal of acknowledging and destigmatizing mental health by improving access to care and service delivery.

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

Program Summary: The Help@Hand program in Santa Barbara County leverages technology-based mental health solutions to destigmatize mental health and enhance care accessibility for specific populations. It pilots wellness applications and engages in community outreach to improve mental health outcomes and reduce stigma.

Program Description

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

- Peer Engagement - integrating those with lived experience of mental health issues/co-occurring issues throughout the project
- Safety & Security - making sure we prioritize the safety and security of the users and their data
- Incorporating Stakeholder Feedback - this project has a lot of stakeholders with different priorities. Help@Hand tries to find ways to meet the needs of most while adopting an understanding with conflicting feedback it may not be possible to meet the needs of everyone

● Innovative Technology - always exploring if and how technology fits into the behavioral health system of care
● Lessons Learned - applying and incorporating the lessons learned as we continue to demonstrate progress and the responsible use of resources
Typically, projects are considered successful if they directly improved consumer welfare. However, the test of success in an innovation project can be more nuanced. Innovation is about transforming the system itself, and therefore additional determinations of success includes two questions:

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

Identify which of the three INN project General Requirements the project will implement:

X Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention

Learning Goals/Project Aims

Help@Hand project goals are composed of the following:

1. Detect and acknowledge mental health symptoms sooner
2. Reduce stigma associated with mental illness as reported by users
3. Increase access to the appropriate level of care
4. Increase purpose, belonging and social connectedness of individuals served
5. Analyze and collect data from a variety of sources to improve mental health needs assessment and service delivery

To achieve these goals, the Help@Hand project has piloted the Headspace wellness application with community members across Santa Barbara County. Based on feedback, we can expand the partnership to have Headspace as an established application that is regularly offered across county sites (e.g., at clinics). Additionally, staff provides specific education and services to populations that have specific needs (i.e., postpartum). The overall learning for this project is to normalize the ability to use a mobile application as a means to help with symptoms, which is beneficial to clients and clinicians alike (i.e., Application can be used as a tool for self-regulation). The purpose is to empower clients to use tools for their wellness.

Additionally, the Help@Hand team continues outreach and engagement efforts with community members to decrease stigma, establish connections to resources, and establish a presence to build trusting relationships and a trusting environment.

Project Goals

The Help@Hand project strives to better understand the effectiveness of utilizing mobile applications for wellness (i.e., does it decrease stigma, are more people understanding what wellness is, etc.). This project offers an innovative approach towards wellness, which means there is limited data on this subject matter. Additionally, due to COVID-19, there has been a transition to the increased use of technology across the county. Utilizing an application for wellness may be beneficial for those who have limited childcare, lack of transportation, etc.

Learning Goals

All Help@Hand project initiatives (Mommy Connecting to Wellness, Headspace, Digital Literacy Classes, Community Engagement, etc.) directly relate to the project goals:

1. Detect and acknowledge mental health symptoms sooner
2. Reduce stigma associated with mental illness as reported by users
3. Increase access to the appropriate level of care
4. Increase purpose, belonging and social connectedness of individuals served
5. Analyze and collect data from a variety of sources to improve mental health needs assessment and service delivery

Program Priorities

The Help@Hand team prioritizes increasing services to the unserved/underserved, unhoused, and Justice Involved populations. The Help@Hand Project strives to increase mental health literacy, prevention programming, and access to mental health services for youth, families, and unserved/underserved populations.

Help@Hand project initiatives are consistent with the following Community Planning Process priorities:

- Increased utilization of Peer Services and integration of Peer Philosophies in Department and Contract Services
- Integrating Whole Person Care philosophies throughout Outpatient services

Program Alignment with the General Standards of the MHSA

Community Collaboration: Partnerships with CBOs and stakeholders have been established throughout the planning and implementation of the tech suite project.

Cultural Competence: The Help@Hand project has ensured that the unserved/underserved populations are part of the target populations served. Staff provide culturally and linguistically

responsive services, and are reflective of the diverse community served. Additionally, resources are provided in both English and Spanish, and translations are assessed for cultural appropriateness and delivery.

Client and Family Driven: Feedback and input gathered from stakeholder meetings, engagement, etc. has been considered throughout the planning and implementation phases. Through the input provided, clients have been driving the strategies and the direction of the Help@Hand project.

Wellness, Recovery, and Resilience Focused: Workshops and all engagement activities are recovery and resilience focused. Peer staff utilizes a wellness, recovery, and resilience approach when assisting community members.

Integrated Service Experience for Clients and Family: The Help@Hand project continues to provide services that are inclusive of the family members, and links individuals to community resources centered on whole person care. For example, Headspace licenses are not just for clients, they can be shared with family members, caregivers, etc., and workshops are clients and caregiver focused. Additionally, all outreach and engagement activities include connection to community resources for mental health, housing, food, insurance, etc.

Cultural Competence and Meaningful Stakeholder Participation

The Help@Hand team is currently collaborating with California State University, Northridge (P.U.E.N.T.E. Lab) to develop culturally and linguistically appropriate workshop-specific surveys to measure the effectiveness of the workshops provided to the community. The anonymous measures will be given in English and Spanish, and will assess any learning that took place as a result from the information provided via the workshops. These measures will also be used as a format to collect feedback from community members.

An additional anonymous measure has been developed specifically for tabling events which will assess perceptions on mental health and substance use disorder, while also identifying any additional resources that may be needed.

Community Stakeholders

Feedback is regularly gathered through stakeholder sessions (i.e., Consumer and Family Member Action Team; Cultural Competency and Diversity Action Team; etc.) and through informal one-on-one interactions during community outreach and engagements activities (i.e., tabling events, workshops, etc.). Additional listening sessions are held with community members on an as needed basis.

Moreover, the Help@Hand team began collecting anonymous data from attendees at tabling events to assess perceptions on mental health, substance use disorder, and to gather feedback and identify additional resources that are needed by community members.

Client Services

All clients can continue to have access to a variety of services and technology through established partnerships with agencies such as Transitions Mental Health Association (THMA), and the Mental Wellness Center (MWC). A peer technology component is written into the contract with TMHA and the MWC via the scope of work to continue fostering a learning environment regarding technology and mobile applications.

Program Progress for FY 24-25

Project Summary and Analysis

Through stakeholder engagement, we discovered an increased need among the community for digital literacy, health literacy, and increased access to technology (i.e., access to smartphones, unstable internet connection, etc.). Per stakeholder input, the department shifted the focus of the Help@Hand project to center on bridging the digital divide that exists across our county and expanding our target population to include the entire community of Santa Barbara residents. These changes remained consistent with the overall project goals:

1. Detect and acknowledge mental health symptoms sooner
2. Reduce stigma associated with mental illness as reported by users
3. Increase access to the appropriate level of care
4. Increase purpose, belonging and social connectedness of individuals served
5. Analyze and collect data from a variety of sources to improve mental health needs assessment and service delivery

The project continued to meet its objectives by facilitating digital and health literacy workshops to increase mental health literacy and decrease mental health related stigma, as well as through providing peer support and linking community members across the county with technology (i.e., smartphones). Workshops are regularly held at county sites (i.e., weekly presentations at the psychiatric health facility) and with community-based organizations who cater towards unserved/underserved populations with a variety of needs (i.e., Housing Authority, FoodBank of Santa Barbara, etc.). Educational workshops are provided in-person to increase knowledge of available resources and social connectedness.

The Help@Hand project aimed to increase access to the appropriate level of care for those in need. To fulfill this goal, team members provide information on accessing mental health services, along with access cards and referrals to community-based organizations, throughout all outreach and engagement events.

Meeting Learning Goals

The Help@Hand team was key in supporting the department to collect countywide anonymous data, which was used to assess perceptions on mental health and substance use disorder, identify additional resources needed by community members. Over 2000 participants, many of whom were Spanish speakers, completed these surveys in paper form, including some north county community members whose primary language was not English and or Spanish.

Data Collected on Project Outcomes

During FY 23-24, the Help@Hand Project's County Wide Principle Evaluator, through CalMHSA, was the University of California, Irvine's Research and Evaluation Department. Data was collected on a quarterly basis and included populations served, implementation sites and approaches, devices used or plan to use, and activities such as presentations, canvassing and tabling/resource fairs. Lessons learned and recommendations data was also collected.

The Help@Hand team continued to work closely with partners such as the Mental Wellness Center, the Transition Mental Health Association recovery learning centers, the department's Psychiatric Health Facility, Housing Authority of the County of Santa Barbara, school districts, and the Santa Barbara County Promotores Network. Establishing these ongoing partnerships allows us to reach underserved, low-income populations; some populations may already receive services, but some still need to be connected to resources and services. These partnerships allowed us to increase service awareness, reduce stigma and increase early intervention through the ability to detect and acknowledge mental health symptoms sooner.

Various community outreach techniques such as tabling, canvassing, Psychiatric Health Facility (PHF) presentations, and workshops have allowed the Help@Hand team to engage with community members throughout the county. During FY 23-24, the Help@Hand team participated in 108 events, ranging from workshops, tabling/health fairs, presentations to the public and CBOs, and canvassing. These events included sharing information on how to access behavioral health services, crisis resource information and workshops to promote overall wellness through the Eight Dimensions of Wellness by specifically using a brochure created for the Help@Hand project – the Digital Wellness App brochure. All of these tools and resources serve to open conversations around mental health to reduce stigma and increase self-help seeking behaviors through technology. The Help@Hand team reached 3132 individuals through these activities.

In FY 23-24, Help@Hand launched a partner program to Mommy Connecting to Wellness (MCW) called Daddy Connecting to Wellness (DCW). Daddy Connecting to Wellness focuses on the same concepts of building a social support system, reducing mental health-related stigma, and increasing help-seeking behavior but centers around fatherhood. One of the goals of this specific workshop is to educate and expand the father's use of technology to include self-care and overall wellness, particularly through the use of Headspace.

Through the partnership with University of California, Irvine's Research and Evaluation Department, Help@Hand had the ability to compare the data collected between the two workshops, analyze the differences in responses, and measure the impact and successes.

The aims of the Mommy Connecting to Wellness project and the Daddy Connecting to Wellness Project are in line with the overall Help@Hand Project goals, which include:

1. Detecting and acknowledging mental health symptoms sooner
2. Reducing stigma associated with mental illness as reported by users
3. Increasing access to the appropriate level of care
4. Increasing purpose, belonging and social connectedness of individuals served
5. Analyzing and collecting data from a variety of sources to improve mental health needs assessment and service delivery.

Changes Made During Project's Implementation

The Help@Hand team developed individual presentations on the Eight Dimensions of Wellness and provided relevant apps to support each dimension. Presentations were created in both English and Spanish. Through connecting with our established community partners, the team was able to bring these workshops directly to the community through presentations within Recovery Learning Centers, Housing Authority sites, Transition House and other countywide community-based organizations (CBOs).

The Help@Hand Team continued to experience staff shortages through FY 23-24, which is why focus shifted to increasing workshops, developing the Mommy Connecting to Wellness (MCW) and Daddy Connecting to Wellness (DCW) workshops, and reducing the number of large outreach events. The opportunity to build more intimate connections with participants allowed us to build trust in the services/department.

Lessons learned from MCW guided our decision to have a promotor that was able to speak Spanish and Mixtec which allowed to clearly communicate in real time; we also recruited a male promotor, who is also a dad, so clients felt supported, understood and safe in sharing their experiences with him. We identified a misconception that although the Mixteco community is male dominated, the participants' spouses were the ones that managed emails, passwords and other important online information. This created a struggle when enrolling and accessing Headspace because dads did not know what their emails were or their passwords in order to access or download apps.

Some, but not all, of the DCW participants were partners to the MCW participants; these relationships created a strong mix of participants, as some members had more knowledge on what we were discussing, and some had never heard of the mental health and overall health

topics discussed. Participants expressed interest in receiving referrals and resources that they could share with their spouses.

The Help@Hand project offered La CLAve training, which was developed to support the Hispanic community in understanding and talking about severe mental health through specific visually and culturally appropriate content and language. This was a great resource for addressing and reducing stigma. To continue meeting the needs of the community and create sustainability, the La CLAve training was provided to 10 Behavioral Wellness staff and 11 CBO partners.

The required INN Annual Report for the Final Evaluation Report is included as an Appendix to this document.

Help@Hand

This program ended on June 30th, 2024 therefore there is no budget for FY 25-26

PROGRAM DEMOGRAPHICS: REPORTING FY 23-24

Expected start and end dates of this INN project: 7/1/19- 6/30/24

Specify the total timeframe (duration) of this INN project: Five Years

Age Group	# of individuals	Race	# of individuals	Sexual Orientation	# of individuals	Gender Identity	# of individuals	Language Spoken	# of individuals
0-15 yrs.	135	White	28	Lesbian or Gay	NA	Female	147	English	NA
16-25 yrs.	545	African American or Black	NR	Heterosexual	NA	Male	58	Spanish	NA
26-59 yrs.	381	Asian	NR	Bisexual	NA	Transgender woman	NA	Vietnamese	NA
60 & older	127	Native Hawaiian or Other Pacific Islander	0	Queer, pansexual, and/or questioning	NA	Transgender man	NA	Cantonese	NA
Age Unk/Declined to Answer	5598	Alaska Native or Native American	6			Genderqueer	NA	Mandarin	NA
		Other	3	Other	NA	Other	NA	Tagalog	NA
		More Than One Race	105	Declined to Answer	NA	Declined to Answer	6581	Cambodian	NA
		Declined to Answer	6644	**Disability**			**# of individuals**	Hmong	NA
Veteran	**# of individuals**	**Ethnicity**	**# of individuals**	**Communication**	**# of individuals**	Mental (not SMI)	NA	Russian	NA
				Seeing	NA	Physical/Mobility	NA	Farsi	NA

Yes	282	Hispanic	61	Hearing or Having Speech Understood	NA	Chronic Health Condition	NA	Arabic	NA
No	5	Non-Hispanic	6					Other	NA
Declined to Answer	6499	More Than One Ethnicity	NA	Other (specify)	NA	Other (specify)	NA		
		Unknown/Not Reported	6719						
				None	NA	Declined to Answer	NA		
Total Number of Individuals Served during the Prior Fiscal Year Period:					**6786**	**Cost Per Individual:**	**$**		

Housing Assistance and Retention Team (HART)

Project Overview

Some of our MHSA and NPLH tenants are being evicted or facing charges of housing infractions, even though we currently provide twenty hours a week of onsite supportive services at our new housing sites (The Residences at Depot Street, Homekey Studios, and West Cox Cottages). After talking with tenants, clients, and onsite staff, we have discovered that current provisions are not enough support for tenants, many of whom have not successfully lived independently for years. Tenants would benefit from holistic services that are strengths-based and needs-driven, including Peer Support, intensive case management support, intensive social service benefits counselling, independent living skills curriculum, and a twenty-four-hour-a-day “warm line” that all tenants can call and reach a peer for any supportive services, housing questions, or social unease that they are feeling. Housing management and providers are also in need of additional training, including Mental Health First Aid, Trauma-Informed Approaches, Housing First policies and Housing Rights for Tenants.

In summary, problems indicating the need for a solution include:

- Tenants being evicted from permanent supportive housing, often because they lack the necessary supports when first entering housing after periods of being unhoused
- Tenants lack basic supplies, food and transportation especially when they are transitioning to housing
- Tenants are not enrolled in the social benefits programs to which they are entitled
- We do not keep adequate data on people once they are housed; we are not tracking why they lose housing to try and prevent this in the future
- Property management staff are not properly trained on how to best support this unique population

Program Summary: The Housing Assistance and Retention Team (HART) supports MHSA and NPLH tenants at risk of eviction by providing holistic support, intensive case management, and skill-building activities to stabilize housing. It prioritizes collaboration, cultural competence, client-driven services, and ongoing evaluation to ensure effectiveness and sustainability.

Program Description

The HART Team will consist of a Housing Program Manager, SOAR trained case workers, a Peer Team Supervisor, and peer support specialists. The case workers and peer support specialists will work with consumers to help them maintain and strengthen their independent living skills, as well as to connect them to mental health and substance use services. They will provide necessary transportation for tenants, have flex funding available to make sure tenants have the necessary items they need when they first move in, and be available on the 'warm line" to provide twenty-four hour a day peer support.

Case worker and peer support specialists will directly serve all MHSA, Homekey and NPLH housing sites and will work with BWell-supported tenants, particularly with individuals who are transitioning to housing after being unsheltered for extended lengths of time. The population served will be anyone living in a unit funded by MHSA, Homekey or NPLH. Tenants will not have to be actively engaged in services with BWell to receive services from the HART team. They will be homeless or at risk of homelessness, and may include:

· Consumers stepping down from transitional housing

· Consumers who are discharged from the Psychiatric Health Facility or Crisis Stabilization Unit

· Consumers who are stepping down from Full-Service Partnership levels of care and still need case management services

· Individuals who are in our Coordinated Entry System and have a serious mental illness

Tenant skills-building activities may include creating a structure and routine in their daily lives to get their needs met; coordinating care with community-based agencies providing services/supports to the consumer; linking consumers to physical and mental health services; coordinating care and problem solving with landlords; learning how to work collaboratively with family members; developing coping strategies; learning and practicing activities of daily living; participating in onsite community building activities like gardening, yoga and cooking; involvement with the local Resource Learning Center, and many more activities designed to assist tenants to be successful community members.

Ongoing case management will be implemented in our community through HART and will allow us to better understand the needs of our consumers once housing has been secured. We hope the support provided to individuals as they transition to housing results in less evictions, greater income and social service benefits acquisition, community integration and progression to independent living for our consumers.

When developing the program, we discovered that educational opportunities and training have not been provided to Housing Authority or property management staff regarding the targeted population. Additionally, we also learned that the Department does not currently have

methods to collect data on our housing program residents. Therefore, HART staff will develop and implement a training program and data collection methods to meet this need.

Identify which of the three INN project General Requirements the project will implement:

Implements navigation services to increase access to physical health care, social services benefits acquisition, mental health services, including but not limited to services provided through permanent supportive housing.

Promotes interagency and community collaboration related to mental health services or supports or outcomes.

Increases access to mental health services for underserved groups.

Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite.

Developing Project Model

The HART program will support housing first principles, which have been identified as best practices when working with this population. The housing first approach seeks to quickly connect individuals and families to permanent housing without pre-conditions such as sobriety. The HART program will work to support participant housing stability by providing essential navigation services, increasing access to social service benefits, physical healthcare, legal services, tenant advocacy, and mental health services. This innovative and necessary approach is needed for our community, as it is an identified gap in our continuum of care within the various county agencies providing services to individuals experiencing homelessness.

We believe that this project will be a successful component with our No Place Like Home (NPLH), MHSA and Homekey funded housing sites, since current services are not meeting the intensive needs of new and struggling residents.

When developing our HART model, we reviewed Innovation Plans from other counties and determined that while they had some of the components our residents were requesting, the models did not have quite enough support or serve the specific population we are serving, and didn't have a peer-led model for housing retention that partnered a BWell department with an outside organization. Creating and implementing a "new tenant living skills curriculum" program will allow residents to have additional supports from the application process through the first year of independent living. Should tenants need additional support beyond the first year, full-time staff at the site will continue to assist clients with their needs.

Individuals Expected to be Served

HART estimates to serve 170 households annually. The current Behavioral Wellness supported unit capacity is 99 units, with an additional 71 units expected to become available in the next several years. The estimate was derived from the Housing Authority current tenant lists and from the projected assignment of units from upcoming developments. The project target populations are individuals who have met the MHSA criteria of persons experiencing homelessness, at risk of homelessness, and persons transitioning from homelessness to permanent supportive housing. Demographic characteristics will be gathered as the program progresses.

Learning Goals/Project Aims

Goal 1: Increase housing retention for MHSA, Homekey and NPLH tenants

Goal 2: Increase tenants' ability to secure social service benefits and income

Goal 3: Increase positive resident physical and mental health outcomes

Goal 4: Implement independent living eight-week skill building curriculum course for new residents

Goal 5: Implement regular training for property management staff

Goal 6: Develop systems to connect HMIS and Clinical data sources for a robust, comprehensive collection and reporting process.

Learning Questions include:

1. Does an intensive eight-week independent living skills course increase our residents' ability to retain housing for longer periods of time?

2. What measures help track reduction in evictions: changes in behavior, interventions, linkages and referrals made, independent living skills classes?

3. Are residents able to secure social service benefits in a timely manner, increase their income and employment opportunities, and have ready access to community supports with the addition of peer supported full-time, on-site housing retention staff?

4. Do residents report a positive increase in their physical and mental health as a result of wraparound services during their first two to three months of residency?

5. Do residents report that the eight-week skill building program has increased their confidence to live independently?

6. Do residents report improved relationships with property management staff?

7. How does the impact of comprehensive data collection affect our ability to identify trends?

Program Priorities

Provide education and training to housing authority and property management staff on how to serve this vulnerable population; provide/promote mental health first aid training, motivational interviewing; promote trauma informed care trainings, housing first policy trainings, and housing rights for tenant trainings.

Increase housing retention within Santa Barbara County's permanent supportive housing program; provide supportive wrap-around services; improve client confidence in independent living; improve client health; facilitate client community integration; increase client income as a way to support stabilization; improve housing retention.

The county can expect to better understand both facilitators and barriers to tenant housing retention, as well as the delivery of wrap-around services to the target population. These goals are prioritized to fulfill the need for holistic, on-site permanent supportive housing and on-site services. Process measures provide an understanding about how the HART Project is being implemented, what successes and challenges are experienced in implementation, and any potential points for improvement. Quantitative process measures, which document program activities, and qualitative process measures, which provide context about program implementation, will be included in the annual and final evaluation reports.

The key approaches adapted by the project will support the objectives and overall goal of increasing housing retention within Santa Barbara County. The learning goals provide new insight into the benefits and barriers of wrap-around, on-site services

Stakeholders also agree with these program priorities, with community members placing housing and supportive services as a top focus. For instance, in the stakeholder process for the MHSA 2020-2023 Three Year Plan, over 120 responses in surveys and stakeholder meetings ranked providing more housing and supportive services as one of the top priorities for MHSA support. Stakeholders ranked serving persons experiencing homelessness as the number one population not being adequately served by current MHSA programs, and many participants in stakeholder meetings spoke about inadequate case management services and the need for more case workers and services.

In stakeholder meetings for the MHSA 2022-23 Annual Update, stakeholders continued to place addressing homelessness and adequate housing supports as a top priority, with this need being

discussed at all fourteen stakeholder events and in written comments provided during the process. Comments included providing services and supports to address the difficulty of keeping clients housed due to mental health issues. This specific Housing Retention INN plan proposal was brought to stakeholders at every meeting, and approval and feedback for this specific INN proposal was provided in our MHSA survey. Over 90% of respondents either agreed or strongly agreed with this Housing Retention INN proposal.

Program Alignment with the General Standards of the MHSA

Community Collaboration: Community Collaboration will be an integral part of the HART Team. We will be working with developers of low barrier housing; the owners and managers of current housing projects; Santa Barbara County Department of Housing and Community Development; Good Samaritan Shelters; the Santa Barbara/Santa Maria Continuum of Care; the Santa Barbara ACT on Homelessness Alliance; the Santa Barbara, Lompoc and Santa Maria Assertive Community Treatment Programs; City Net Homeless Outreach Services; BWell Homeless Outreach Team; the Santa Barbara, Lompoc and Santa Maria Mobile Crisis Teams; BWell Justice Alliance Team; the Santa Barbara County Chapter of the National Alliance for the Mentally Ill (NAMI); and the Homeless Youth Advisory Board, to name just a few of the agencies, organizations, businesses and community groups with which we will collaborate.

Cultural Competence: The Ethnic Services and Diversity Manager for BWell will assist with program development and implementation to ensure that the project is maximized to meet the needs of culturally underserved groups in the county. The project will be staffed with bilingual/bicultural Peer Specialists with lived experience in behavioral health recovery to further ensure culturally competent services.

Client and Family Driven: In HART, as with all other BWell services, the concurrent documentation strategy is used, with staff collaborating with consumers during assessment, service planning and intervention sessions to complete as much housing documentation as possible, including working collaboratively on a treatment plan. Since HART staff includes three Recovery Specialists, their input as mental health consumers will also be a factor in the services provided. Moreover, HART has built consumer surveys into the project to ensure consumer voice. Additionally, if tenants have family members (defined by the client) whom they would like to involve in their recovery, those family members will be engaged in recovery planning and actions. In addition, family member representatives will be sought to participate in the HART Advisory Council which will guide the development, engagement and evaluation of HART.

Wellness, Recovery, and Resilience Focused: Wellness, recovery and resilience are built into the client services provided by BWell. Consumers are encouraged and supported to live, work and participate fully in their communities. HART will promote concepts key to recovery for mental illness, such as hope, personal empowerment, respect, social connections and self-determination and will emphasize employment, health, and sense of purpose as part of the path to recovery.

Integrated Service Experiences for Clients and Family: HART services will be provided through the BWell Housing program. Consumers will not have to navigate through multiple agencies to get their needs met. Case workers and Peer Support Assistants will navigate residents through the myriads of community-based services and will assist consumers in coordinating services for an integrated service experience and a "warm hand off" to outside agency.

The HART program will leverage the strengths of individuals with lived experience; services will be provided by 6 caseworkers, 6 peer support assistants, and 2 peer supervisors. The project will seek to increase cultural competence through a series of trauma-informed care trainings provided to the HART program contractor, housing authority staff and landlords. The HART program will also collaborate with stakeholders and program participants to implement a tenant/housing advocates speakers bureau. The program staff will work with the participants to develop individualized housing success plans based on the unique needs of the residents. The housing success plan will be used to identify that range of services that HART will support the clients to access.

Cultural Competence and Meaningful Stakeholder Participation

To provide a culturally competent evaluation which is inclusive of the experiences of the under-served and vulnerable populations, the HART project will use a mixed-methods evaluation design that uses both qualitative and quantitative approaches; this approach will offer insights that might be overlooked by one approach alone, and is provides a sensitivity and awareness of consumer diversity related to culture, language and identities. Survey materials distributed to clients and stakeholders will use inclusive language and be accessible in multiple languages.

The Cultural Competency and Diversity Action Team (CCDAT) consists of BWell staff, community-based organizations, local advocacy groups, cultural and faith-based organizations and other stakeholders who seek to increase access to services for under-served populations, particularly in high poverty areas and minority groups. The CCDAT aims to increase the capacity of staff to work effectively with diverse cultural and linguistic populations, and revise or develop policies on cultural competency and disparities to ensure relevance and consistency.

Community Stakeholders

The qualitative process measures will be designed to understand the barriers and facilitators of our strategies, as well as client and stakeholder experiences within the HART Project. These qualities will be assessed through monthly Client Check-ups, HART Staff Meetings, the Training Satisfaction Survey, and the Client Satisfaction and Assessment Survey. These surveys will allow key stakeholders and consumers to provide valuable input and evaluation of programs.

Client Services

Tenants will be homeless or at risk of homelessness, and may include:

· Consumers stepping down from transitional housing

· Consumers who are discharged from the Psychiatric Health Facility or Crisis Stabilization Unit

· Consumers who are stepping down from Full-Service Partnership levels of care and still need case management services

· Individuals who are in our Coordinated Entry System and have a serious mental illness

Individuals with serious mental illness will receive services from this project. The team will collaborate with larger multidisciplinary care teams and systems as needed, including Psychiatry, Community Based organizations and Physical Healthcare providers. When the project ends, they will continue to receive services through Medi-Cal billing, MHSA FSP funding and Realignment funding. Also, we are having a huge influx of housing and people new to housing for the next four to five years as new projects are built. The HART team will work with tenants to stem evictions and stabilize housing so that the need for these intensive services will be lessened five years from now.

BWell will evaluate the HART plan at regular intervals to ensure we are providing the services outlined above. Keeping individuals housed is a community priority and one that promotes positive treatment outcomes for BWell consumers; therefore, we expect that this project would continue well past the Innovation timeframe and will be supported by funding identified during the Innovation period. We will focus on Medi-Cal billing through the new CalAIM initiative to allow billing for supportive housing services by partnering with our Medi-Cal Managed Care Health Plan to leverage the CalAIM initiative to bill for Enhanced Case Management Services. Under the new Peer Certification Program, we hope that we will also be able to sustain services through Medi-Cal billing for certified peer services. Finally, as tenants receive outreach and engagement services and get connected to mental healthcare providers, those whose care needs will be provided Full Service Partnership services will leverage MHSA funding for their housing supportive services. Constant evaluation of program elements that are not effective or are redundant with other services will be eliminated.

Program Progress for FY 25-26

Project Summary and Analysis

This project will strive to expand current County efforts in the overarching goal of improving housing retention, which has been identified as a gap in services by numerous county agencies. HART will provide a missing intensive supportive component within this continuum by providing necessary services and goods for newly housed people and increasing their ability to successfully live independently. The HART program will work to gather better data on the supported MHSA, NPLH, and Homekey funded sites. HART will track the intensive navigation

services employed to reduce the high return to homelessness rate and share our findings with other county departments and housing providers county and state-wide.

During FY 23-24 this project hired a Program Manager, an Epidemiologist, and completed a Request for Proposal process and awarded a contract to Telecare to provide Peer Support Services and a Peer Supervisor for the outreach team. This project is now fully staffed and has begun providing housing retention services.

In FY 24-25, our pending contract with Telecare Corp was approved. In June 2024, Telecare started onboarding new staff, implementing SMARTCARE EHR, HMIS and SOAR trainings, as well as trauma informed trainings, and motivational interviewing. As of August 2024, we began providing services to clients in North and South County.

A full timeline on HART project activities:

09/2023- HART Manager hired

09/2023- HART Evaluator hired

10/2023- RFP published

11/2023- RFP bids due

12/23-Contractor selected (Telecare Corp)

06-2024- Contract approved by Board of Supervisors

06/2024 – Contractor startup activities, e.g. establishing offices, onboarding new staff, training, credentialing processes, SMARTCARE EHR, HMIS, SOAR trainings, trauma informed trainings, motivation interviewing.

08/2024 - Began providing services to clients in North and South County in August of 2024

Meeting Learning Goals

The HART Project will implement the above activities through the hiring and training of BWell staff, Housing Authority staff, and external contractors to provide these wrap-around services. Keeping individuals housed is a community priority and one that promotes positive treatment outcomes for BWell consumers; therefore, we expect that this project would continue well past the Innovation timeframe and will be supported by funding identified during the Innovation period. We will focus on Medi-Cal billing through the new California Advancing and Innovating Medi-Cal (Cal-AIM) initiative to allow billing for supportive housing services by partnering with our Medi-Cal Managed Care Health Plan to leverage the Cal-AIM initiative to bill for Enhanced

Case Management Services. Under the new Peer Certification Program, we hope that we will also be able to sustain services through Medi-Cal billing for certified peer services. Finally, as tenants receive outreach and engagement services and get connected to mental healthcare providers, those whose care needs will be provided Full Service Partnership services will leverage MHSA funding for their housing supportive services.

We have implemented the following techniques in FY24-25 to ensure the HART project meets its learning goals and evaluation results reflect stakeholder perspectives:

- Expanded services to reach out to individuals in need of housing, in addition to those currently residing in permanent supported housing units.
- Develop a referral and tracking system to track participant progress and outcomes.
- Access the county's homeless information management system (HMIS) to gather data on participants who are part of the coordinated entry process.

Data Collected on Project Outcomes

This program began collecting data in FY 24-25, as we began providing services to clients in North and South County in August of 2024. Starting in FY 24-25, HART began to identify and provide services to individuals that would benefit from supportive services. Our new online referral system has also led to referrals from the community that we may not have had otherwise. And we, in partnership with Telecare, have flexibly shifted to targeting individuals who are newly transitioning into PSH, or out of La Posada.

Changes Made During Project's Implementation

The county can expect to better understand facilitators and barriers to tenant housing retention and delivery of wrap-around services to the target population. These goals have been prioritized to fulfill the need for holistic, on-site permanent supportive housing on-site services. Process measures provide an understanding about how the HART Project is being implemented, successes and challenges experienced in implementation, and potential points for improvement. Quantitative process measures that document program activities and qualitative process measures that provide context about program implementation will be included in the annual and final evaluation reports.

The initial HART plan focused on providing tenancy-sustaining services to individuals and families residing in six permanent supportive housing sites and 40 tiny home cabins designated as transitional living/shelter.

The HART team filled in the gaps in existing services to help BWell eligible clients maintain their PSH placements. Increased collaboration with the County Housing Authority allowed for further assessment of existing site services and providers who are taking part in Cal-AIM's Enhanced Care Management (ECM). The project plans were refined with the determination that housing

assistance and retention services would be extended to BWell eligible clients regardless of unit location.

Typical HART program services are available to program participants for 60 to 180 days. The majority of existing and new permanent supportive housing sites have designated site providers at the time of opening and lease-up. The expansion of HART services to eligible participants at scattered site locations allows the program to avoid conflicts with existing contracted service providers over concerns about duplicative services and patient care revenue.

Our department has determined that we will not be applying for Enhanced Care Management service status. Instead, this program will focus on providing Community Supports as outlined in the Community Supports Guideline.

Provider:	Behavioral Wellness
Estimated Funding FY 2025/26:	
Estimated Total Mental Health Expenditures	$ 2,454,000
Estimated INN Funding	$ 2,454,000
Estimated Medi-Cal FFP	
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer	$12,270
Estimated Total of Consumers Served	200
Target Population Demographics Served	TAY, Adult, Older Adult

Estimated Consumers Served by Age FY 2024/25		Estimated Cost Per Consumer by Age Category
Estimated Total Consumers Age 0-15 Served	0	
Estimated Total Consumers Age 15-26 Served	50	$12,270
Estimated Total Consumers Served Age 26-59	100	$12,270
Estimated Total Consumers Served Age 60+	50	$12,270

PROGRAM DEMOGRAPHICS

This program did not collect any demographic information in FY 23-24.

Expected start and end dates of this INN project: 2/1/23- 6/30/27

Total timeframe (duration) of this INN project: 4.5 years

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary

County: Santa Barbara County Date: 3/27/25

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2023/24 Funding						2,023,113
1. Estimated Unspent Funds from Prior Fiscal Years	13,556,949	8,938,633	3,013,126	0	3,592,076	
2. Estimated New FY2023/24 Funding	34,724,400	8,681,100	2,284,500			
3. Transfer in FY2023/24[a/]	(340,800)			340,800	0	0
4. Access Local Prudent Reserve in FY2023/24	0	0				0
5. Estimated Available Funding for FY2023/24	47,940,549	17,619,733	5,297,626	340,800	3,592,076	
B. Estimated FY2023/24 MHSA Expenditures	30,143,300	10,335,060	1,753,400	340,800	1,302,400	
A. Estimated FY 2024/25 Funding						2,023,113
1. Estimated Unspent Funds from Prior Fiscal Years	18,287,780	9,830,672	3,986,974	0	2,501,749	
2. Estimated New FY2024/25 Funding	31,898,600	7,974,600	2,098,600			
3. Transfer in FY2024/25[a/]	(335,400)			335,400	0	0
4. Access Local Prudent Reserve in FY2024/25	0	0				0
5. Estimated Available Funding for FY2024/25	49,850,980	17,805,272	6,085,574	335,400	2,501,749	
B. Estimated FY2024/25 MHSA Expenditures	29,092,400	8,980,293	1,880,200	335,400	1,071,900	
C. Estimated FY2025/26 Funding						2,023,113
1. Estimated Unspent Funds from Prior Fiscal Years	20,758,580	8,824,979	4,205,374	0	1,429,849	
2. Estimated New FY2025/26 Funding	25,861,600	6,465,400	1,701,400			
3. Transfer in FY2025/26[a/]	(300,000)			300,000	0	0
4. Access Local Prudent Reserve in FY2025/26		0				0
5. Estimated Available Funding for FY2025/26	46,320,180	15,290,379	5,906,774	300,000	1,429,849	
D. Estimated FY2025/26 Expenditures	33,888,800	13,738,050	2,454,000	300,000	1,125,100	
E. Estimated FY2025/26 Unspent Fund Balance	12,431,380	1,552,329	3,452,774	0	304,749	2,023,113

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2024	2,023,113
2. Contributions to the Local Prudent Reserve in FY 2024/25	0
3. Distributions from the Local Prudent Reserve in FY 2024/25	0
4. Estimated Local Prudent Reserve Balance on June 30, 2025	2,023,113
5. Contributions to the Local Prudent Reserve in FY 2025/26	0
6. Distributions from the Local Prudent Reserve in FY 2025/26	0
7. Estimated Local Prudent Reserve Balance on June 30, 2026	2,023,113

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

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Santa Barbara County Date: 3/27/25

	Fiscal Year 2023/24			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi Cal FFP	Estimated Other Funding
FSP Programs				
1. SPIRIT FSP Wraparound Services	2,752,200	1,590,000	1,119,600	42,600
2. Lompoc ACT FSP	2,012,600	1,655,000	357,600	0
3. Santa Maria ACT FSP	3,006,500	955,500	2,051,000	0
4. Santa Barbara ACT FSP	3,641,800	3,020,400	621,400	0
5. Supported Community Services North	1,530,900	850,200	680,700	0
6. Supported Community Services South	1,651,400	744,900	906,500	0
7. Forensic FSP (Justice Alliance)	2,804,800	2,591,600	213,200	0
8. New Heights TAY FSP	2,268,200	1,813,800	454,400	0
9.	0			
10.	0			
Non-FSP Programs				
1. Crisis Services	7,182,100	0	272,600	6,909,500
2. Adult Wellness and Recovery Outpatient (WR) Teams	6,109,800	2,939,200	3,170,600	0
3. Co-Occurring Mental Health and Substance Use Outpatient Tea	4,341,700	4,341,700	0	0
4. Wellness Centers	1,114,300	1,057,200	57,100	0
5. Children Wellness, Recovery and Resiliency (WRR)	5,333,300	109,100	2,142,700	3,081,500
6. Pathways to Well Being	553,600	0	335,100	218,500
7. Crisis Residential Services North/South	5,200,600	609,400	4,299,200	292,000
8. Adult Housing Support Services	5,131,200	1,292,100	3,839,100	0
9. Crisis Stabilization Units	4,067,300	162,900	3,904,100	300
10. Homeless Outreach Services	3,502,700	796,000	469,500	2,237,200
11. Medical Integration	2,176,000	2,176,000	0	0
12. Childrens Crisis Triage Teams	105,900	0	0	105,900
13.	0	0	0	0
CSS Administration	10,654,100	3,438,300	6,415,800	800,000
CSS MHSA Housing Program Assigned Funds	0			
Total CSS Program Estimated Expenditures	75,141,000	30,143,300	31,310,200	13,687,500
FSP Programs as Percent of Total	49.5%			

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Santa Barbara County Date: 3/27/25

	Fiscal Year 2025/26			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated Other Funding
FSP Programs				
1. SPIRIT Wraparound FSP	3,056,600	1,682,000	1,330,600	44,000
2. Lompoc Adult/Older Adults FSP	2,050,900	1,641,900	409,000	0
3. Santa Maria Adult/Older Adults FSP	3,352,500	1,606,700	1,745,800	0
4. Santa Barbara Adult/Older Adults FSP	5,031,800	3,522,600	1,012,200	497,000
5. North Community FSP	2,078,500	1,663,500	415,000	0
6. South Community FSP	1,953,600	1,215,800	737,800	0
7. Justice Alliance FSP	3,555,600	2,553,300	1,002,300	0
8. New Heights TAY FSP	1,925,000	1,068,100	856,900	0
Non-FSP Programs				
1. Crisis Services	8,258,000	53,000	1,209,800	6,995,200
2. Adult Wellness and Recovery Outpatient (WR) Teams	16,690,500	10,303,900	6,386,600	0
3. Wellness Centers	1,167,300	1,068,100	99,200	0
4. Children Wellness, Recovery and Resiliency (WRR)	6,133,000	1,686,500	3,149,000	1,297,500
5. Pathways to Well Being	798,100	0	130,500	667,600
6. Crisis Residential Services North/South	6,241,300	2,021,500	3,924,900	294,900
7. Adult Housing Support Services	6,892,200	2,145,100	3,745,200	1,001,900
8. Crisis Stabilization Units	9,243,500	0	9,145,600	97,900
9. Homeless Outreach Services	1,813,400	203,200	1,516,200	94,000
	0			
CSS Administration	11,222,700	1,453,600	8,159,600	1,609,500
CSS MHSA Housing Program Assigned Funds	0			
Total CSS Program Estimated Expenditures	91,464,500	33,888,800	44,976,200	12,599,500
FSP Programs as Percent of Total	46.1%			

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Santa Barbara County 3/27/25

	Fiscal Year 2023/24			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated Other Funding
PEI Programs - Prevention				
1. Early Childhood Mental Health (ECMH)	481,374	481,374	0	0
2. Growing Grounds	385,000	385,000		
3. Wellness Promotion for Seniors	494,053	494,053		
4. Peer & Parent Partners in Wellness and Recovery	549,654	549,654		
PEI Programs - Early Intervention				
5. Early Childhood Specialty Mental Health	1,370,500	528,800	841,700	0
6. Early Detection and Intervention Teams for TAY	1,664,500	1,142,800	521,700	0
7. School-Based Prevention/Early Intervention Services	896,700	896,700	0	0
PEI Programs - Access and Linkage				
8. Access and Assessment Teams	2,953,800	2,578,200	375,600	
9. Safe Alternatives for Children and Youth Crisis Services	1,298,000	674,300	623,700	
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness				
10. Mental Health Education	589,539	589,539		
11. County-Wide Youth Council	142,240	142,240		
12. Youth Linkages Network	45,000	45,000		
13. CalMHSA State-Wide Prevention	120,000	120,000		
PEI Programs - Stigma and Discrimination Reduction				
14. Anti Stigma and Discrimination Program	200,000	200,000		
15. LEAD	120,000	120,000		
16. Health Equities Conference	120,000	120,000		
PEI Programs - Suicide Prevention				
17. School-Based Suicide Prevention	123,000	123,000		
18. Suicide Prevention Campaign	97,000	97,000		
PEI Administration	1,047,400	1,047,400	0	
PEI Assigned Funds	0			
Total PEI Program Estimated Expenditures	12,697,760	10,335,060	2,362,700	0

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Santa Barbara County 3/27/25

	Fiscal Year 2024/25			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated Other Funding
PEI Programs - Prevention				
1. Early Childhood Mental Health (ECMH)	481,374	481,374	0	0
2. Growing Grounds	385,000	385,000		
3. Wellness Promotion for Seniors	300,000	300,000		
4. Peer & Parent Partners in Wellness and Recovery	559,075	559,075		
PEI Programs - Early Intervention				
5. Homeless Early Intervention	1,829,900	1,561,000	0	268,900
6. Early Childhood Specialty Mental Health	914,400	351,600	562,800	0
7. Early Detection and Intervention Teams for TAY	1,792,500	1,152,400	640,100	0
8. School-Based Prevention/Early Intervention Services	461,085	447,227	13,858	0
PEI Programs - Access and Linkage				
9. Access and Assessment Teams	2,573,000	1,362,900	1,210,100	
10. Safe Alternatives for Children and Youth Crisis Services	911,300	588,700	322,600	
11. CARE Court Access and Linkages	84,100	84,100	0	
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness				
12. Mental Health Education	272,935	272,935		
13. County-Wide Youth Council	143,100	143,100		
14. Youth Linkages Network	55,900	55,900		
PEI Programs - Stigma and Discrimination Reduction				
15. LEAD	229,982	229,982		
PEI Programs - Suicide Prevention				
16. School-Based Suicide Prevention	123,000	123,000		
17. Suicide Prevention Campaign	88,300	88,300		
PEI Administration	793,700	793,700	0	0
PEI Assigned Funds	0			
Total PEI Program Estimated Expenditures	11,998,651	8,980,293	2,749,458	268,900

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Santa Barbara County 3/27/25

	Fiscal Year 2025/26			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated Other Funding
PEI Programs - Prevention				
1. Early Childhood Mental Health (ECMH)	361,200	361,200	0	0
2. Growing Grounds	385,000	385,000		
3. Wellness Promotion for Seniors	494,053	494,053		
4. Peer & Parent Partners in Wellness and Recovery	559,075	559,075		
PEI Programs - Early Intervention				
5. Homeless Early Intervention	1,953,600	1,684,700	0	268,900
6. Early Childhood Specialty Mental Health	1,461,600	918,800	542,800	0
7. Early Detection and Intervention Teams for TAY	1,968,200	1,424,200	544,000	0
8. School-Based Prevention/Early Intervention Services	904,431	904,431		0
PEI Programs - Access and Linkage				
9. Access and Assessment Teams	4,065,200	3,513,600	551,600	
10. Safe Alternatives for Children and Youth Crisis Services	1,406,800	1,094,700	312,100	
11. CARE Court Access and Linkages	390,000	390,000	0	
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness				
12. Mental Health Education	715,909	715,909		
13. County-Wide Youth Council	143,100	143,100		
14. Youth Linkages Network	34,082	34,082		
PEI Programs - Stigma and Discrimination Reduction				
15. LEAD	230,000	230,000		
PEI Programs - Suicide Prevention				
16. School-Based Suicide Prevention	123,000	123,000		
17. Suicide Prevention Campaign	108,000	108,000		
PEI Administration	654,200	654,200	0	0
PEI Assigned Funds	0			
Total PEI Program Estimated Expenditures	15,957,450	13,738,050	1,950,500	268,900

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Santa Barbara County 3/27/25

	Fiscal Year 2023/24			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated Other Funding
INN Programs				
1. Peer Tech Suite	899,900	899,900	0	0
2. Housing Retention and Benefit Acquisition Team	712,100	712,100	0	0
3.	0	0	0	0
4.	0			
INN Administration	141,400	141,400	0	
Total INN Program Estimated Expenditures	1,753,400	1,753,400	0	0

	Fiscal Year 2024/25			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated Other Funding
INN Programs				
1. Housing Retention and Benefit Acquisition Team	1,818,400	1,818,400	0	0
2.	0	0	0	0
3.	0			
INN Administration	61,800	61,800	0	
Total INN Program Estimated Expenditures	1,880,200	1,880,200	0	0

	Fiscal Year 2025/26			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated Other Funding
INN Programs				
1. Housing Retention and Benefit Acquisition Team	2,283,000	2,390,400		0
2.				
3.				
INN Administration	63,600	63,600	0	
Total INN Program Estimated Expenditures	2,346,600	2,454,000	0	0

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: Santa Barbara County 3/27/25

	Fiscal Year 2023/24			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated Other Funding
WET Programs				
1. Peer Training	240,800	240,800	0	0
2. OSHPD Southern Counties Regional Partnership	3,880,200	0	0	3,880,200
3. WET Workforce Retention	100,000	100,000		
4.	0			
WET Administration	0	0		
Total WET Program Estimated Expenditures	4,221,000	340,800	0	3,880,200

	Fiscal Year 2024/25			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated Other Funding
WET Programs				
1. Peer Training	235,400	235,400	0	0
2. OSHPD Southern Counties Regional Partnership	2,339,800	0	0	2,339,800
3. WET Workforce Retention	100,000	100,000		
4.	0			
WET Administration	0	0		
Total WET Program Estimated Expenditures	2,675,200	335,400	0	2,339,800

	Fiscal Year 2025/26			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated Other Funding
WET Programs				
1. Peer Training	200,000	200,000	0	0
2. OSHPD Southern Counties Regional Partnership	1,081,000	0	0	1,081,000
3. WET Workforce Retention	100,000	100,000		
4.	0			
WET Administration	0	0		
Total WET Program Estimated Expenditures	1,381,000	300,000	0	1,081,000

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Santa Barbara County 3/27/25

	Fiscal Year 2023/24			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated Other Funding
CFTN Programs - Capital Facilities Projects				
1.				
2.	0			
CFTN Programs - Technological Needs Projects				
11. Capital Information Technology (CIT)	900	900	0	0
12. Electronic Health Records	1,301,500	1,301,500		
CFTN Administration	0			
Total CFTN Program Estimated Expenditures	1,302,400	1,302,400	0	0

	Fiscal Year 2024/25			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated Other Funding
CFTN Programs - Capital Facilities Projects				
1.				
2.	0			
CFTN Programs - Technological Needs Projects				
11. Capital Information Technology (CIT)	0	0	0	0
12. Electronic Health Records	1,301,500	1,071,900		
CFTN Administration	0			
Total CFTN Program Estimated Expenditures	1,301,500	1,071,900	0	0

	Fiscal Year 2025/26			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated Other Funding
CFTN Programs - Capital Facilities Projects				
1.	0			
2.	0			
CFTN Programs - Technological Needs Projects				
11. Capital Information Technology (CIT)	0	0	0	0
12. Electronic Health Records	1,125,100	1,125,100		
CFTN Administration	0			
Total CFTN Program Estimated Expenditures	1,125,100	1,125,100	0	0

APPENDICES

The appendices for the MHSA 25-26 Plan can be found as a separate document uploaded alongside the Plan. The appendices contain the following:

A. COMMUNITY PROGRAM PLANNING PROCESS

1. The County Community Program Planning Process Policy

2. The Job Description(s) of County Staff responsible for conducting the CPPP

3. The Outline (or copy of presentation) of the training provided to County staff responsible for the CPPP

4. The Outline (or copy of presentation) of the training offered and/or provided to stakeholders, clients, and family members of clients who are participating in the CPPP

5. Copies of email blasts, website screenshots, flyers, notices in social and print media, etc. used to offer the training to stakeholders, clients, and family members of clients who are participating in the CPPP

6. Documentation that demonstrates stakeholders provided input during the CPPP

7. Copies of email blasts, website screenshots, flyers, notices in social and print media, etc. that were used to circulate, for the purpose of eliciting public comment on the draft Plan/Update to community stakeholders and any other interested party who requested a copy

8. Documentation of the Public Hearing conducted by the County Behavioral Health Advisory Board (BHAB) or Commission

9. Documentation of the adoption of the Plan or Update by the County Board of Supervisors such as Board Resolution or Minute Order

B. COMMUNITY SERVICES AND SUPPORTS FY 2022-23 DATA AND PROGRAM OUTCOMES

C. PREVENTION AND EARLY INTERVENTION FY 2022-23 ANNUAL (or FOUR- YEAR) EVALUATION REPORT

D. INNOVATION FY 2022-23 ANNUAL (or FINAL) EVALUATION REPORT

E. COUNTY WORKFORCE NEEDS ASSESSMENT

F. WORKFORCE EDUCATION & TRAINING COORDINATOR JOB DESCRIPTION